The South Heartland District Community Health Needs Assessment 2012

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

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SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

Adams, Clay, Nuckolls and Webster Counties in Nebraska

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Public Health Core Functions and Essential Services

(1) Core Public Health Function: Assessment

Essential Service 1: Monitor health status and understand health issues facing the community.

What's going on in our District? Do we know how healthy we are?

Essential Service 2: Protect people from health problems and health hazards.

Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?)

(2) Core Public Health Function: Policy Development

Essential Service 3: Give people the information they need to make healthy choices.

How well do we keep all people and segments of our district informed about health issues?

Essential Service 4: Engage the community to identify and solve health problems.

How well do we really get people and organizations engaged in health issues?

Essential Service 5: Develop policies and plans that support individual and community health efforts.

What policies promote health in our district? How effective are we in planning and in setting health policies?

(3) Core Public Health Function: Assurance

Essential Service 6: Enforce laws and regulations that protect health and ensure safety.

When we enforce health regulations are we up-to-date, technically competent, fair and effective?

Essential Service 7: Help people receive health services.

Are people receiving the medical care they need?

Essential Service 8: Maintain a competent public health workforce.

Do we have a competent public health staff? How can we be sure that our staff stays current? How are we assisting our community and professional partners to stay current on public health interventions?

Essential Service 9: Evaluate and improve programs and interventions.

Are we doing any good? Are we doing things right? Are we doing the right things?

Essential Service 10: Contribute to and apply the evidence base of public health.

Are we discovering and using new ways to get the job done?

Introduction

Under the Core Function of Assessment, one of South Heartland District Health Department's roles (Essential Service 1) is to find out what is going on in our district, determining how healthy we are so we can find the gaps in services, identify community health problems, and know our baselines in order to plan and measure improvement in the health of our district's population. One way that we monitor health status is by conducting a comprehensive community needs assessment every 5-6 years. This is the third community needs assessment conducted by public health for the four-county South Heartland area.

This document, as a summary of the community needs assessment process and key results, is intended for use by public health, our community partners, and the public. The staff and Board for South Heartland District Health rely on this process and the resulting information as the basis for carrying out all ten of the essential services of public health (refer to page 5 for a list of the 10 Essential Services of Public Health).

The South Heartland Health District

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

The four counties, each approximately 24 x 24 miles square, are laid out in a 2 x 2 block totaling 2,289 square miles. The SHDHD serves a population of 46,218 (U.S. Census, 2010) with just over half of the population residing in the city of Hastings and the remainder of the district averaging under 12 persons per square mile.

SHDHD is governed by a fifteen member Board of Health consisting of one appointed board member from the governing boards of each of the four counties, two public-spirited citizens per county appointed by the respective county boards, and three professional representatives (physician, dentist, and veterinarian) appointed by the Board of Health.

The Board of Health is responsible for policy development, resource stewardship, legal authority, partner engagement, continuous improvement, and oversight of the health department. A full-time Executive Director, four full-time staff and eleven part-time staff carry out the Department's Mission.

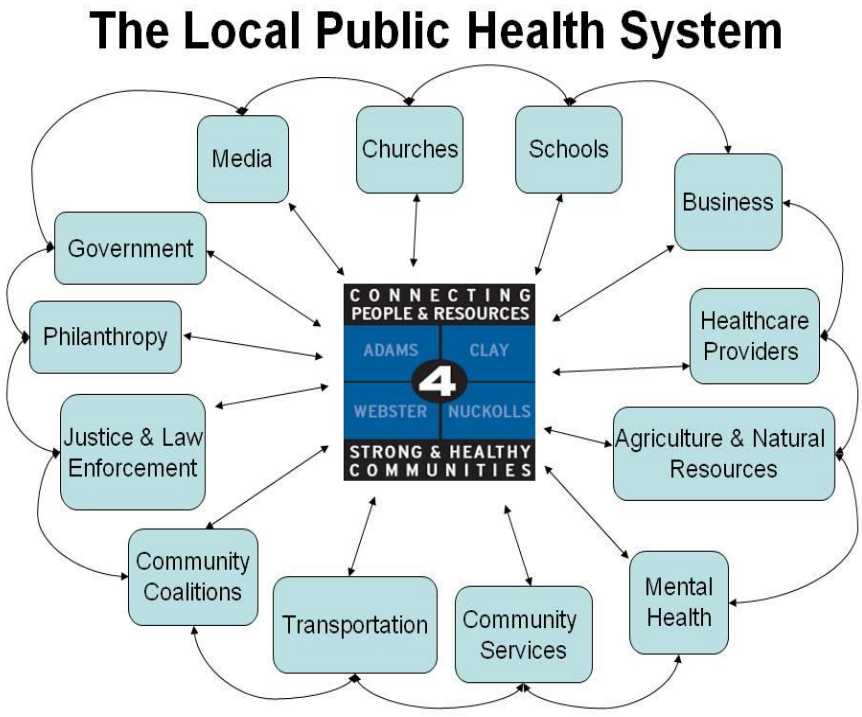
Mission: The South Heartland District Health Department is dedicated to preserving and improving the health of residents of Adams, Clay, Nuckolls and Webster counties. We work with local partners to develop and implement a Community Health Improvement Plan and to provide other public health services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

Community Health Needs Assessment – Process Overview [1]

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

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

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



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

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

Using MAPP as the framework for the community needs assessment allowed SHDHD to focus on the 10 essential services of public health to define who is responsible for the community's health and well-being.

The 10 Essential Public Health Services are:

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

The MAPP process is diagrammed by the following MAPP model:

In this model, the phases of the process are diagramed in the center. The entire process is informed by data and the four assessments that produce these data are shown in the arrows around the outside. The phases of the MAPP process are: Organizing/Partnership Development, Visioning, Assessment, Identifying Strategic Issues, Formulating Goals and Strategies, and the Action Cycle for the resulting Community Health Improvement Plan (CHIP).

Community Health Needs Assessment – South Heartland's Process

The SHDHD MAPP/CHIP process began with identification of core planning team members, whose responsibilities were to review the MAPP process, complete a readiness assessment, discuss and define "community" for each hospital, review stakeholder categories, identify stakeholders, determine timelines and discuss resources to implement the process. All three hospitals in the district committed to participate with SHDHD in MAPP & signed Memoranda of Understanding outlining their contributions; including resources. Hospital administrators identified staff members to participate in the core team. This team was also responsible for overseeing the implementation and management of the process. The core team included 8 members: hospital administrators and/or appointed staff from Brodstone Memorial Hospital, Mary Lanning Healthcare and Webster County Community Hospital; Clay County Health Department director; SHDHD Board of Health president; and SHDHD director. The first planning meeting was held September 2, 2011.

The Core Team developed an overall timeline for the process which was realized as follows:

November 2011 – *Local Public Health System Assessment* (CDC Field Test Site)
February 2012 – *Forces of Change* Assessment (focus groups – one per county)
February – May 2012 – *Community Themes and Strengths Assessment* (Intercept Survey)
May 2012 – August 2012 – *Health Status Assessment*
September 2012 – *Identify Strategic Issues* (Priority-Setting)
October - December 2012 – *Formulate Goals & Strategies*

The Assessment Phase consisted of implementing all four of the MAPP Assessments and was carried out, with assistance by a contracted facilitator, during the period of October 1, 2011 – August 30, 2012. Following the assessment phase, the community (via stakeholder work groups) identified strategic issues and formulated goals and strategies for addressing each issue. Community stakeholders collaborated in a facilitated development of a Community (district-wide) Health Improvement Plan (CHIP). In 2013 and beyond, work groups for each priority will move the plan components into the Action Phase (CHIP implementation), with oversight and evaluation planning from the MAPP/CHIP core team, which will continue to meet 1-2 times a year for the duration of the CHIP.

Key Partners

The Core Team included two health department staff (Executive Director Michele Bever and Health Surveillance Assistant Jessica Warner), one Board of Health member (BOH President Peggy Meyer), at least one representative from each hospital assigned by the respective CEOs, and Clay County Health Department Director Janis Johnson. Dr. Michele Bever, Executive Director, led the Core Team and core team members served as the planning and decision-making body for the process, overseeing the assessment, identifying stakeholders, committing in-kind and cash resources, and committing staff to be participants in the assessments.

Each hospital's CEO appointed a representative for their respective organizations: Becky Sullivan, Wellness Department Manager represented Mary Lanning Memorial HealthCare (primary service area is Adams County); Karen Tinkham, Public Relations Director, represented Brodstone Memorial Hospital (primary service area is Nuckolls County); Marianna Harris, CEO,

represented Webster County Community Hospital (primary service area is Webster County). Both Brodstone and Mary Lanning have health clinics in Clay County, which was also represented by Clay County Health Director Janis Johnson. Webster County Community Hospital participated although they were not required to complete a community needs assessment under the IRS requirement for hospitals.

The core team identified 34 stakeholder categories (Attachment 1) and made every effort to invite representation from each of these to participate in the various assessments. We began by targeting active stakeholder participants from the previous MAPP process (in 2007).

Additional key partners included the State of Nebraska Department of Health and Human Services for the Community Themes and Strengths data, MAPP guidance, and facilitation assistance, and CDC staff from the NPHPSP Field Test project who provided the framework, tool, and timeline for the Local Public Health System Assessment.

Our contracted facilitator was Bluestem Interactive, Inc. Bluestem assisted with the Local Public Health System Assessment, Forces of Change focus groups, and Priority-Setting meetings and also facilitated the Goals and Strategies meetings.

Assessments

Local Public Health System Assessment

This assessment was a comprehensive review of the public health system (all those entities that contribute to the public's health) to answer the following questions:

- What are the activities, competencies, and capacities of our local public health system?
- How well are the 10 Essential Public Health Services being provided to our community?

Using this assessment allowed us to

- Identify strengths and weaknesses to be addressed in quality improvement efforts
- Provide a baseline on performance to use in preparing the local health department for participation in accreditation
- Provide a benchmark for public health practice improvements, by setting a "gold standard' to which public health systems aspire.

Methods:

SHDHD was invited to work with the Centers for Disease Control and Prevention to field test the newest version of the Local Public Health System Assessment Instrument. The field test instrument was ready for use by September 2011 and the field test needed to be completed by December 2011, so this was the first assessment conducted by SHDHD (Attachment 2). Approximately 70 stakeholders attended this day-long meeting on November 21, 2011. The participants represented many organizations that contribute to the public health system, the essential services, and the health and well-being of the population in Adams, Clay, Nuckolls and Webster counties (Attachment 3). A number of the participating organizations provide service to all four of the counties in the South Heartland Health District jurisdiction. The participants represented a broad range of perspectives and expertise and were encouraged to "wear the

multiple hats" (figuratively) of their various interests and expertise and of their multiple professional and community roles.

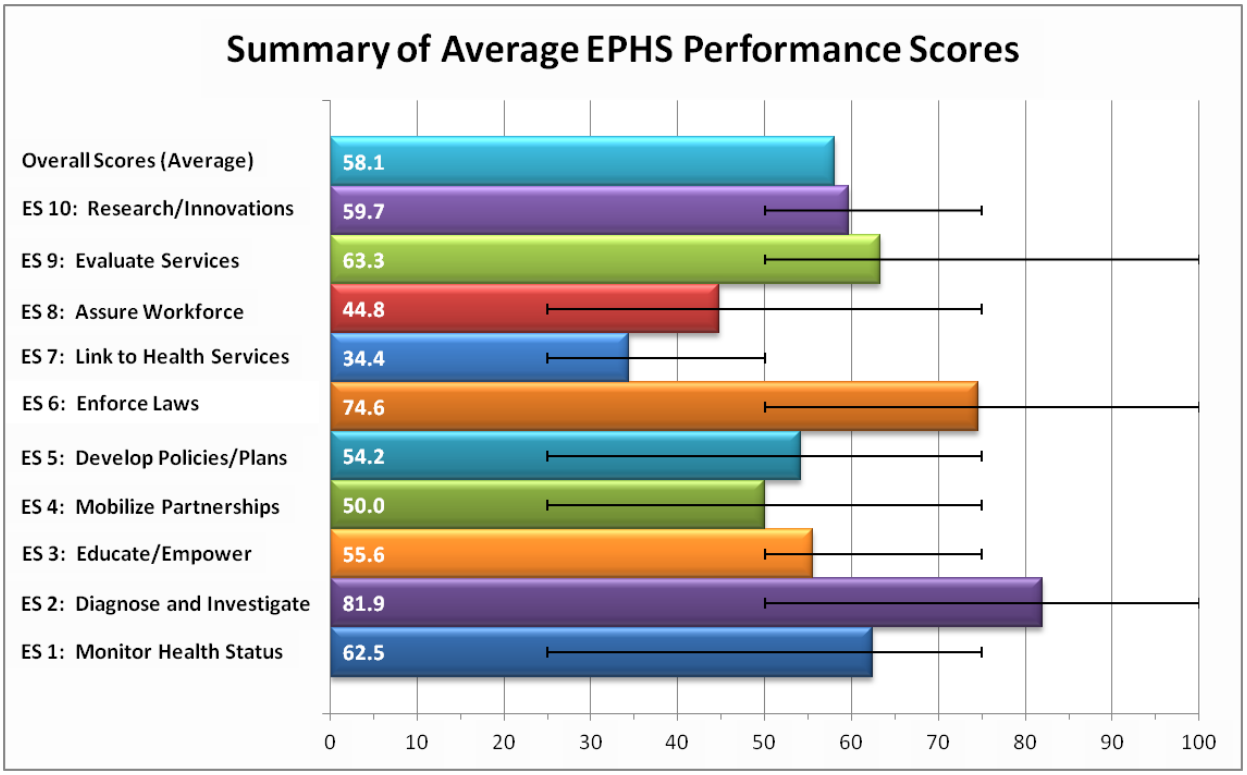
Participants broke out into small groups by Essential Service (Attachment 2). Essential Services 1 – 5 were assessed in the morning session, while Essential services 6-10 were assessed in the afternoon. Facilitators in each group guided the stakeholders through the assessment tool, serving as neutral guides, keeping discussion on topic and on time, and ensuring a fair process and input from all. Recorders (human and audio) documented the discussion, identifying themes, recording scores and opportunities. Each facilitated group went through the following process:

- Review model standards for each Essential Service
- In-depth discussion on one model standard at a time
- Vote on level of current activity in the local public health system
- More discussion
- Consensus
- Repeat

At the end of the morning and afternoon sessions, a participant from each Essential Service breakout group reported back to the large group and shared their group's key findings. The score data and other materials were submitted to the Centers for Disease Control and Prevention (CDC) on December 5, 2012 and the Key Findings Report from CDC was returned on January 6, 2012 (Attachment 4).



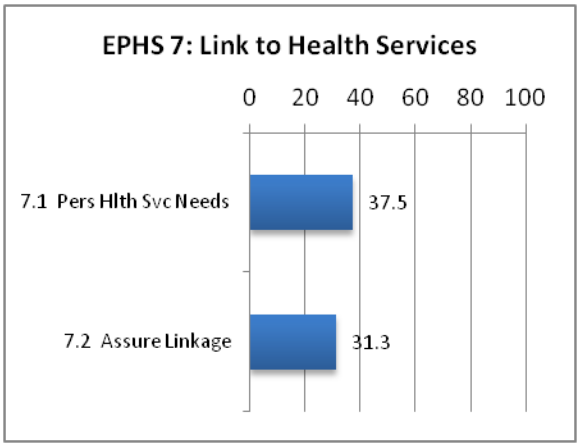

Findings:
The full SHDHD Key Findings Report from CDC is provided in Attachment 4. The overall scores for each essential service are provided below.



The performance scale for the Local Public Health System Assessment had 5 levels:

No activity	(none of the activity described in the model standards is met)
Minimal Activity	(>0%, but no more than 25% of the activity is met)
Moderate Activity	(>25% but less than 50% of the activity is met)
Significant Activity	(>50% but less than 75% of the activity is met)
Optimal Activity	(>75% of the activity described within the model standards is met)

The core team reviewed the local public health system report and noted that the lowest scoring essential service was ES7: linking people to needed health services. ES7 consists of two model standards: (1) Identifying personal health service needs of populations, and (2) Assuring linkage of people to personal health services. The scores for each of the model standards for this essential service indicated moderate activity (greater than 25% activity but less than 50% activity).



The questions for discussion and final scoring of each model standard for ES 7 are provided below.

ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable		
7.1	**Model Standard: Identification of Personal Health Service Needs of Populations**	
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	50%
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	25%
7.1.3	Defines roles and responsibilities for partners to respond to the unmet needs of the community?	25%
7.1.4	Understand the reasons that people do not get the care they need?	50%
7.2	**Model Standard: Assuring the Linkage of People to Personal Health Services**	
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	50%
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	25%
7.2.3	Help people sign up for public benefits that are available to them (e.g. Medicaid or Medical and Prescription Assistance Programs)?	25%
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	25%

After reviewing these data and the data for each of the other essential services, the core team completed a priority-setting discussion exercise and came to consensus that Essential Service 7 *Access to Care* would be included in the Community Health Improvement Plan as the Essential Service Priority Issue.

SHDHD Community Essential Service Priority
Essential Service 7
Access to Care Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

Forces of Change Assessment

This assessment focused on identifying forces such as legislation, technology, natural and economic events or other impending changes that could affect the context in which the community/county and the public health system operates. The assessment was conducted to answer the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats of opportunities are generated by these occurrences?

Methods:

A facilitator conducted one *Forces of Change* focus group discussion in each county. These two-hour meetings including the following components:

- Brief overview of the big picture (how "the local public health system" is defined, what the full assessment process consists of and the goal/outcome for the full process)
- Goal for this assessment activity
- Introductions – What knowledge/experience each participant brings to discussion
- How the process will work – 1) identify key forces of change; 2) identify opportunities/threats related to each force
- Roles: participants/facilitator/recorder
- Ground rules
- Forces of Change Process
- Debrief
- Thanks/evaluation

The Forces of Change focus groups were held from February 20 to February 23, 2012 and drew a total of 74 participants. The Webster County *Forces of Change* focus group was hosted by Webster County Community Hospital and held at the Red Cloud Community Center from 5:30 to 7:30 on Monday, February 20, 2012. There were 10 participants in Webster County. The Nuckolls County *Forces of Change* focus group was hosted from noon to 2:00 pm on Tuesday, February 21, 2012, at the Brodstone Memorial Hospital Conference Rooms. There were 13 participants in Nuckolls County. The Adams County *Forces of Change* focus group was hosted from 11:30 am – 1:30 pm on Wednesday, February 22, 2012, at Mary Lanning HealthCare Classrooms in Hastings. There were 34 participants in Adams County. The Clay County *Forces of Change* focus group was held on Thursday, February 23 from 6:00 pm – 8:00 pm at the Clay County Fairgrounds in Clay Center. There were 17 participants in Clay County.

Findings:
The Forces of Change Assessment results are provided in Attachment 5. The identified changes, opportunities and threats are provided by county and were grouped according to type of change: demographics, economic, family/social, technological, healthcare, health risks, and community attitudes, activities and services.

Some of the common themes of change identified in the four-county area included the following:

- Rural locations away from interstate
- Changing Demographics (more diverse population, increasing older population, increasing single parent households)
- Prosperous Local Healthcare System, more health services options
- Government programs: ACA, state funding cuts, increasing regulations
- Increased use of technology and social media
- Closure of care facilities (Nursing Homes and Regional Center)
- Youth/Family Issues (changes in family structure, more demands on time and money, stress, kids are busy with lots of activities, parents working multiple jobs)
- Kids introduced to drugs and alcohol at younger ages, more socially acceptable
- Less social interaction within communities, decreased volunteerism
- Decrease in disposable household income, increase in cost of living
- Greater support for creating healthy environments
- Decrease in locally controlled public transportation options
- Increase in Medicare patients and students who qualify for school lunch program
- Medicaid is now handled through call centers
- School consolidation
- Agricultural sector is strong, but fewer jobs with more mechanization

Key Opportunities Identified for selected forces of change:

- Rural location: Build on relationships; opportunities for interagency collaboration & resource pooling; rural business opportunities to attract service sector where less start-up capital is needed.
- Aging Population: Focus on growing population of older adults by recruiting businesses that meet their needs while building community and volunteerism, and opportunities for intergenerational interaction.
- Technology: Increased accessibility to information instantly, potential for more jobs (can work from anywhere, home-based businesses), better informed public, better access and quality of healthcare, increased collaboration between health services providers, better patient self-care.
- Youth/Family Issues: Kids learn responsibility/independence; youth have more time to spend on school work, life skills learning and volunteering, intergenerational interaction; grow services through involvement of young people; community commitment to education and accountability; opportunities to educate parents.

Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment contributed to a deeper understanding of what issues residents felt were important by answering these questions:

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

Methods:

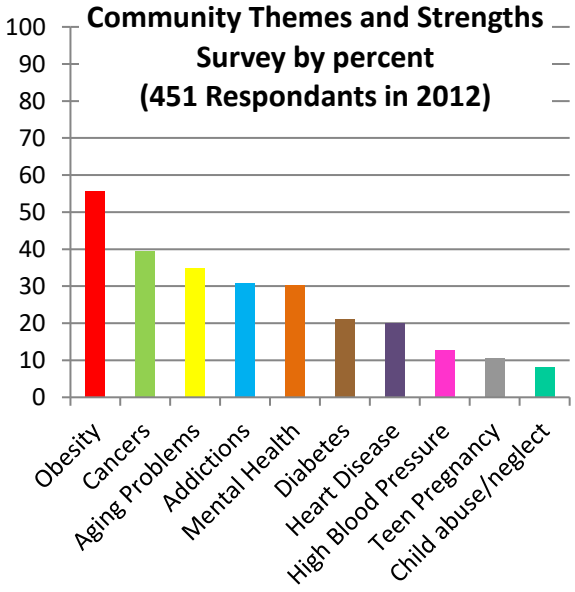
Two Community Themes and Strengths Assessment (CTSA) surveys were conducted. The first was conducted by Nebraska Department of Health and Human Services as an oversample for the South Heartland heath district. The survey included questions on demographics, community satisfaction, community assets, individual health and community health. Using a stratified design and random digit dial methods, the survey was administered by telephone using to South Heartland residents between July and October 2011. This method achieved completed surveys with 496 residents. DHHS provided a summary report of the SHDHD data (Attachment 6).

The second CTSA survey was a modified version of the first survey. The core team converted it to paper/pencil and SurveyMonkey formats, revised some and added other questions and also developed a Spanish version (English version, Attachment 7). It included Likert scale, open-ended and ranking questions. Hard copies or links to the web-based version were distributed widely by the core team, Board of Health members and other community partners. This "intercept" CTSA survey had 451 total respondents in the South Heartland District. Survey responses received in hard copy were entered into SurveyMonkey manually and summary data were exported to Excel.

Findings:
The CTSA intercept survey assessed community satisfaction, community assets, individual health and community health. The full CTSA results, including all of the qualitative answers to the open-ended questions, is included as Attachment 8. Highlights of the report include:

- Lack of local (within 1 hour) emergency care facilities, doctors/health clinics, behavioral health providers and medical specialists
- Residents without a medical "home" (12.3%) using emergency rooms, urgent care clinics, chiropractors, free clinics, or delaying care as long as possible
- Residents without a dental "home" (17.1%)
- Uninsured – pay cash for health care (10.5%)
- Cost of medical care is a barrier to accessing health care services
- Residents perceived their communities as good places to raise children, but were concerned about the lack of affordable childcare and lack of after school opportunities for children
- Need for meal programs and other community social services for older adults
- Need for local employment opportunities and local leisure time activities for adults
- Lack of "family friendly" jobs in local communities (flexible scheduling, health insurance, etc.)
- Need for quality, affordable housing
- Lack of volunteers to fill community needs

The CTSA results included a ranking of perceived health-related problems in the community. Respondents were most concerned about obesity, cancer, aging issues, addictions and mental health.



Responses to top three most troubling health–related problems in our community
CTSA Intercept Survey (SHDHD, 2012)

The top 5 most risky behaviors residents identified as having the most impact on the health and well-being of their community were: alcohol abuse (52.3%), not enough exercise (38.2%), distracted driving (38.5%), poor eating habits (34.7%), and drug abuse (33.9%).
Survey respondents also recommend which health-related problems or risky behaviors should be addressed first in their communities, with substance abuse issues ranking highest, followed by distracted driving, physical activity and nutrition.

Of the health related problems and risky behaviors listed above, which one would you say your community should be addressed first?

CATEGORY	NUMBER OF RESPONSES	PERCENT of TOTAL RESPONSES
Alcohol Abuse	86	18.9%
Drug Use/Abuse	72	15.9%
Distracted/Risky Driving	61	13.4%
Exercise inc. Not Enough	55	12.1%
Eating Habits inc. Poor	37	8.1%

Community Health Status Assessment

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

- How healthy are our residents?
- What does the health status of our community look like?

Methods:

South Heartland health surveillance staff gathered data from a variety of local, state and national sources such as, but not limited to, Nebraska Vital Records, Behavioral Risk Factor Surveillance System reports, County Health Rankings, hospital discharge data, local mental health needs assessment, and local infectious disease reports. Categories of data included:

- Population characteristics
- Socioeconomic characteristics
- Health Resource Availability
- Quality of Life
- Behavioral Risk Factors
- Environmental Health Indicators
- Social and Mental Health
- Maternal and Child Health
- Death, Illness and Injury
- Infectious Disease

Whenever possible, data were collected at the county level and compared to the 4-county health district, the state of Nebraska, and the United States. Data were also reviewed over a period of years to assess trends.

Results:
The full Health Status Assessment Results Tables are provided in Attachment 9, along with the 2012 County Health Rankings report. These data were analyzed, then summarized as fact sheets prepared for 14 health topic areas to share with stakeholders (Attachment 10):

- Cardiovascular Disease
- Diabetes
- Overweight and Obesity
- Injury
- Mental Health
- Drugs
- Alcohol
- Tobacco
- Cancer
- Environmental
- Reproductive Health
- Sexually-transmitted Diseases
- Communicable Diseases
- Oral Health

The fact sheets were developed with data from the health status assessment results and the community themes and strengths survey results, and augmented with additional information on economic impact, community burden, health disparities, quick facts taken from a variety of sources, and/or additional information on risk factors or prevention strategies (Refer to Attachment 10).

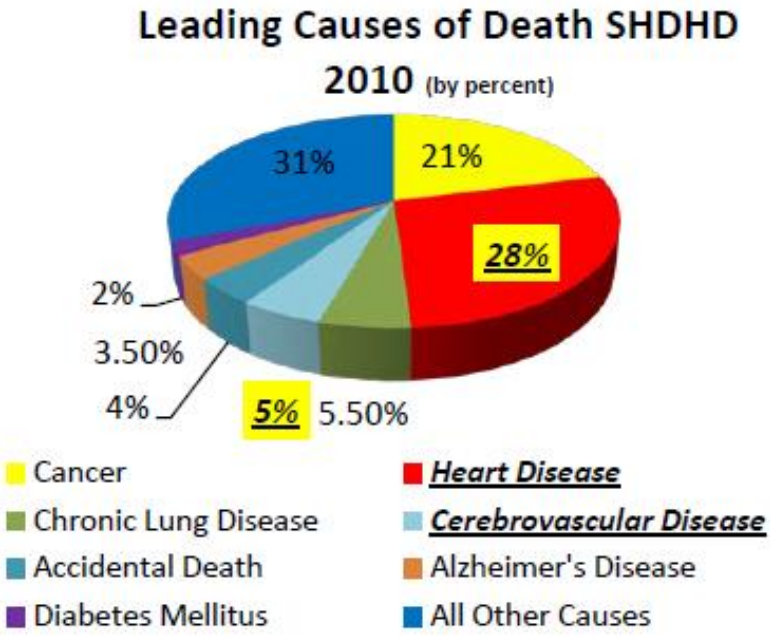
Population demographic highlights and leading causes of death and hospitalization are provided below.

Population demographics highlights:

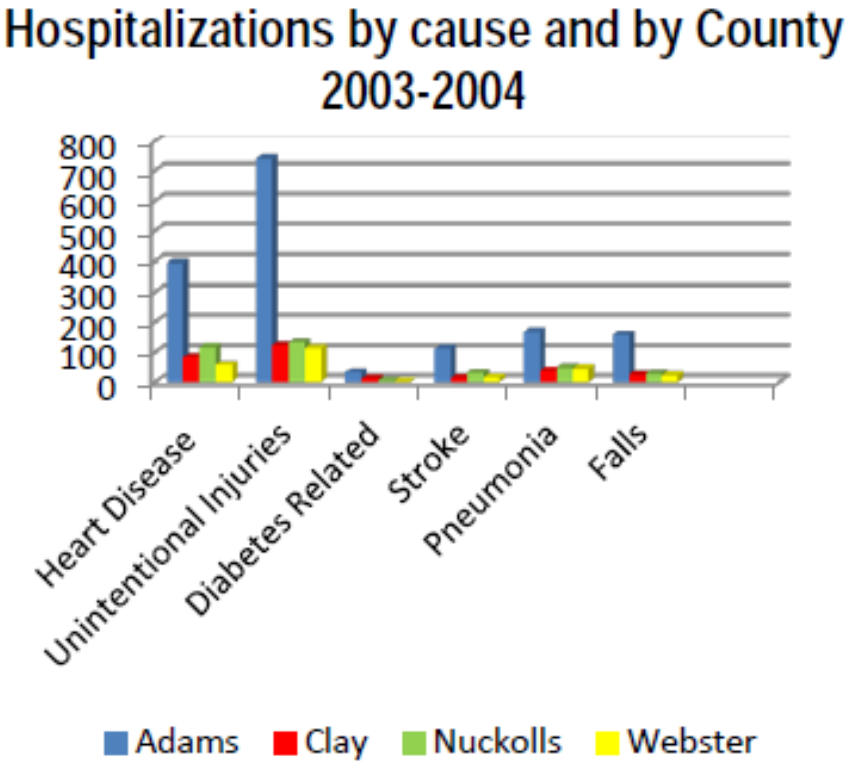
- Population declined in three of the four counties (U.S. Census, 2000 to 2010):
    - Adams County (+0.7%)
    - Clay County (-7.1%)
    - Nuckolls County (-11%)
    - Webster County (-6.1%)
- Adams and Clay Counties have the largest minority population (Hispanic/Latino). The percentage of population that is Hispanic/Latino by county (U.S. Census Quick Facts, 2006-2010):
    - Adams County 8.1%
    - Clay County 7.7%
    - Nuckolls County 2.2%
    - Webster County 3.5%
- Nuckolls County has the highest and Clay County has the lowest percent of the population below poverty level:
    - Adams County 13.5%
    - Clay County 8.3%
    - Nuckolls County 18.0%
    - Webster County 15%

Leading Causes of Death and Hospitalization highlights:

- Cardiovascular disease (heart disease plus cerebrovascular disease) is the leading cause of death for the South Heartland District and the second leading cause of death in Nebraska. (Nebraska DHHS Vital Statistics reports 2005-2010).



- Unintentional injuries and heart disease are the leading causes for hospitalizations in all four South Heartland counties.



Community Review of Needs Assessment Data and Priority Setting

Methods/Process:
Fact Sheets were created for each of the following health areas: Oral Health, Communicable Diseases, Reproductive Health and Maternal Child Health, Environmental Health, Cancer, Substance Abuse, Mental Health, Injury, Obesity, Diabetes, and Cardiovascular/Stroke. The fact sheets included information such as incidence prevalence, demographics, comparisons, trends, perceived need/importance from Community Themes and Strengths Assessment, behavioral and other risk factors, disparities, data sources, and other pertinent information. Participant packets (Attachment 10) were developed containing overview health status information, the fact sheets, criteria-weighting worksheets and priority-ranking (health issue score card) worksheets.

Stakeholders convened with the primary facilitator in Hastings and additional stakeholders joined by telehealth videoconferencing from Brodstone Memorial Hospital and Webster County Community Hospital. Two meetings were held, for 2.5 hours each, on September 11th and 25th, 2012 in order to present, discuss and rank the health issues. The activities for these meetings included the following components:

1. Welcome/Overview/Ground Rules
2. Criteria Weighting Exercise: participants rated the importance of 4 criteria as important (1 pt), very important (3 pts) or most important (5 pts):
    a. Incidence/Prevalence (how many people are impacted?)
    b. Magnitude of Burden on Community (what are the economic and social burdens?)
    c. Community Perception of Need (does the community think it is important?)
    d. Trend Over Time (is it getting worse or better?)

    (Later SHDHD staff averaged the ratings from all stakeholders to arrive at a final weighting factor for each criterion.)
3. Stakeholders were presented with information/data on each health status issue, including reviewing the fact sheets in their packets and additional information presented by local experts in that health issue.
4. Stakeholders ask questions of the experts and each other, and discuss the issue.
5. Stakeholders rate the health issue according to each of the 4 criteria, using their health issue score card worksheet.
6. Repeat steps 3-5 for each health issue.
7. Stakeholders completed an evaluation of the process.

For each health issue considered, SHDHD staff averaged the stakeholder scores for each of the 4 criteria, then weighted each criterion score and, lastly, summed the weighted criteria scores to produce an overall issue score. Issue scores were ranked, and the top 4 issues were chosen for inclusion in the Community Health Improvement Plan.

Priorities:
Through the priority-setting process, stakeholders ranked 11 health issues as follows:

Ranked Weighted Health Issues:

	Health Issue Area	Issue Score
1	Obesity	4.13
2	Cancer	3.85
3	Substance Abuse	3.55
4	Mental Health	3.25
5	Cardiovascular	3.04
6	Injury	2.98
7	Environmental	2.82
8	Diabetes	2.81
9	Communicable Disease /Vaccine Preventable Disease	2.75
10	Reproductive Health/ Maternal & Child Health	2.72
11	Oral Health	2.60

The top four health priorities resulting from this exercise were: Obesity, Cancer, Substance Abuse, and Mental Health.

Defining Goals and Strategies

Stakeholders were brought together again on October 24, 2012 for 3.5 hours to begin setting strategies for health improvement. Each stakeholder chose one of the five health priorities s/he wanted to work on:

SHDHD Top 4 Community Health Issues, Ranked
Health Issue Area
1 - Obesity
2 - Cancer
3 - Substance Abuse
4 - Mental Health

SHDHD Community Essential Service Priority
Essential Service 7
Access to Care Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

Using facilitators, the resulting work groups for each priority issue (1) reviewed local data on that health issue, (2) identified current community resources/strategies and, (3) reviewed state and national prevention plans and other evidence-based prevention strategies for that health issue. Work groups met again on December 4th or 5th to review results of the previous work session and to propose and/or refine local strategies to address each health priority.

Data to Action: Community Health Improvement Planning

Community partners and stakeholders are in the process of identifying which health issues and which strategies they or their organizations will "own" or contribute to. At SHDHD, staff members are determining the target outcomes for each health issue based on local baselines and are aligning these target outcomes with Nebraska state plans and Healthy People 2020. The final Community Health Improvement Plan (CHIP) will include goals and target outcomes for each of the five priority areas, along with identified strategies and objectives. Finally, work groups (coalitions) for each priority will develop Priority Action Plans for their health priority, to include community partners responsible for or contributing to each strategy/objective, activities or steps needed for each objective, and a time-frame for action and completion. Individual stakeholder organizations, such as hospitals and health departments, will also develop their own organization-level plans that describe how they will carry out their CHIP responsibilities.

Attachments

Attachment 1: MAPP Stakeholder Categories

Attachment 2: National Public Health Performance Standards Program (NPHPSP)
Local Public Health System Assessment Instrument - Draft for Field Test

Attachment 3: Public Health System Assessment Participants & Assignments

Attachment 4: SHDHD Public Health System Assessment Report

Attachment 5: Forces of Change Focus Groups Report

Attachment 6: DHHS Community Themes & Strengths Summary Tables

Attachment 7: SHDHD Community Themes & Strengths Intercept Survey Tool – English

Attachment 8: SHDHD Community Themes & Strengths Intercept Survey Results

Attachment 9: SHDHD Health Status Assessment Data Tables

Attachment 10: Stakeholder Packets with Community Health Assessment Fact Sheets

- Cardiovascular Disease
- Diabetes
- Overweight & Obesity
- Injury
- Mental Health
- Drugs
- Alcohol
- Tobacco
- Cancer
- Environmental
- Reproductive Health
- Sexually-transmitted Diseases
- Communicable Disease
- Oral Health

Public Health
Prevent. Promote. Protect.

MAPP 2011-2012
Stakeholder Categories

1) **Aging/Senior Services**
   a) AARP
   b) Area Agencies on Aging
   c) Assisted Living
   d) Caregivers/Respite Care
   e) Good Samaritan Village
   f) Meals on Wheels
   g) Nursing Homes
   h) Senior Citizen Centers/Organizations
   i) Senior Center Directors
2) **Agriculture/Farm**
   a) Cattlemen's Association
   b) Corn Board
   c) Dairy Farms
   d) Elevators
   e) Farmers Co-ops
   f) Feedlots
   g) Hog Confinements
   h) Irrigation Companies
   i) Irrigation Districts
   j) Meat Animal Research Center (MARC)
   k) Poultry Producers
   l) Soybean Board
3) **Alcohol/Drug**
   a) Agency on Alcoholism
   b) Drug Court
   c) Mothers Against Drunk Driving (MADD)
   d) Rehab Centers
   e) South Central Substance Abuse and Prevention Coalition
4) **Animal Services**
   a) Animal Shelters
   b) Humane Societies
   c) Veterinarians/ Vet Clinics
5) **Businesses/Services**
   a) Beauty/Barber Shops
   b) Chambers of Commerce
   c) Golf Courses
   d) Grocery Stores
   e) Funeral Home Directors
   f) Lawn Care Companies
   g) Lumber Yards
   h) Manufacturing
   i) Restaurants
   j) Retail Leaders
6) **Colleges/Universities**
   a) Hastings College
   b) Central Community College

7) **Communications**
   a) Cable Companies
   b) Cellular Companies
   c) Newspapers
   d) Public Access
   e) Radio Stations
   f) Telephone Companies
   g) Television Stations
8) **Early Childhood**
   a) Central Nebraska Early Childhood Mental Health System of Care Project
   b) Daycares/Childcare Providers
   c) Headstart
   d) Pre-Schools
   e) Region 9 Early Childhood Care & Education Training Consortium
9) **Emergency Services**
   a) Dispatch/9-1-1
   b) Emergency Managers
   c) EMTs/Paramedics
   d) Fire Departments/Fire Chiefs
   e) Local Emergency Planning Committees (LEPCs)
10) **Faith-Based**
   a) Adult Church Groups
   b) Church Councils
   c) Clergy
   d) Health Ministries Network
   e) Knights of Columbus
   f) Ministerial Associations
   g) Parish Nurses
   h) Youth Church Groups
11) **Financial Services**
   a) Banks
   b) Trusts
   c) Credit Unions
12) **Foundations**
   a) Mary Lanning Foundation
   b) Hastings Community Foundation
13) **Government Offices/Agencies (City/Village)**
   a) City Administrators
   b) City Clerks
   c) City Council Members
   d) City Planners
   e) Community Centers
   f) Libraries
   g) Mayors/Chairmen of Boards
14) **Government Offices/Agencies (County)**
   a) County Attorneys
   b) County Commissioners/Supervisors
   c) Extension Offices
   d) Landfills
   e) Veteran Services Office
   f) Weed Control

15) Government Offices/Agencies (State)

a) Natural Resource Districts (NRDs)
b) Nebraska Dept. of Labor/Workforce Development
c) Nebraska Department of Health
d) Nebraska Health & Human Services System
e) Social Security Administration
f) Vocational Rehab

16) Government Offices/Agencies (U.S.)

a) Dept. of Agriculture
b) Dept. of Environmental Quality
c) Fish & Wildlife Service
d) Postal Service
e) National Weather Service

17) Healthcare

a) Brodstone Memorial Hospital
b) Cancer Coalitions
c) Cancer Survivors
d) Clinics
e) Chiropractors
f) Dentists
g) Good Beginnings
h) Health Coalitions
i) Health Departments (City/County/District)
j) Health Department Board Members
k) Healthy Beginnings
l) Home Health Agencies
m) Home Equipment Suppliers
n) Hospice
o) Hospital Staff
p) Mary Lanning Memorial Hospital
q) Nurses
r) Optometrists/Ophthalmologists
s) Pharmacists
t) Physicians
u) Private Caregivers
v) Webster County Community Hospital

18) Housing

a) Home Construction Companies
b) Hotel/Motel Owners
c) Housing Authority
d) Housing Development
e) Retirement/Low Income Housing
f) Habitat for Humanity

19) Human/Social Services

a) Building Nebraska Families
b) Catholic Social Services
c) Crossroads
d) Homeless Shelters
e) Human Interagency Services-Nuckolls County
f) Planned Parenthood
g) Pregnancy Crisis Centers

h) SASA Crisis Centers
i) Social Workers
j) South Central Partnership

20) Insurance
a) CHIP
b) Insurance Agents/Agencies

21) Judicial System
a) Attorneys
b) Probation
c) Juvenile Diversion
d) Judges
e) Youth Correction Center-Hastings

22) Law Enforcement
a) DARE
b) Local Police
c) County Sheriffs
d) State Patrol

23) Leadership
a) Leadership Groups
b) Women Business Leaders

24) Mental Health Services
a) Counseling Centers
b) Hastings Regional Center
c) Mental Health Clinics
d) Mental Health Practitioners

25) Mentoring
a) Big Brothers/Big Sisters
b) TeamMates

26) Military
a) National Guard

27) Minority
a) Diversity Committee-Hastings Chamber
b) Interpreters/Translators
c) Minority Organizations
d) Special Needs Organizations

28) Recreation/Fitness
a) Parks and Recreation Depts.
b) Fitness Centers
c) YMCA
d) YWCA
e) Wellness Centers

29) Schools-Elementary/Secondary (Public, Private, Parochial)
a) Educational Service Units (ESUs)
b) Parent-Teacher Associations/Organizations
c) School Administrators
d) School Board Members
e) School Counselors
f) School Nurses
g) Student Councils
h) Retired Teachers

30) Service Organizations/Clubs

a) Auxiliaries
b) Kiwanis
c) Lions Clubs
d) Masons
e) PEO
f) Red Cross
g) Rotary Clubs
h) Salvation Army
i) Superior Mothers Club
j) United Way

31) Transportation

a) Airport Authorities
b) Gas/Fuel Stations
c) Ethanol Plants
d) Railroads
e) Road Construction Companies
f) Road Departments (County/State)

32) Utilities

a) Natural Gas Companies
b) Hastings Utilities
c) Trailblazer
d) Nebraska Public Power District
e) Southern Public Power District

33) Youth Organizations

a) 4-H Clubs
b) Boy Scouts
c) Future Business Leaders of America (FBLA)
d) Future Farmers of America (FFA)
e) Future Family & Consumer Science Leaders of America (FFCLA)
f) Girl Scouts
g) Sunny D's
h) Mayor's Youth Councils

34) Miscellaneous

a) League of Human Dignity
b) League of Women Voters
c) Public-Spirited Consumers
d) Public Relation Firms
e) Veterans

NPHPSP

National Public Health Performance Standards Program

Local Public Health System Performance Assessment Instrument

Draft for Field Test, Fall 2011

LPHS Essential Service 1:

Monitor Health Status to Identify Community Health Problems

What's going on in our community?
Do we know how healthy we are?

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

- Accurate, ongoing assessment of the community's health status.
- Identification of threats to health.
- Determination of health service needs.
- Attention to the health needs of groups that are at higher risk than the total population.
- Identification of community assets and resources that support the public health system in promoting health and improving quality of life.
- Use of appropriate methods and technology to interpret and communicate data to diverse audiences.
- Collaboration with other stakeholders, including private providers and health benefit plans, to manage multisectoral integrated information systems.

Partners gathered to discuss the performance of the local public health system in monitoring health status to identify community health problems may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other governing entity
- ❑ University or academic institutions
- ❑ Public health laboratories
- ❑ Health/hospital system
- ❑ Managed care organizations
- ❑ Local chapter of national health-related group (e.g. March of Dimes)
- ❑ State health department
- ❑ National level agency or organization
- ❑ Community-based organizations
- ❑ Epidemiologists
- ❑ Environmental health data experts
- ❑ Emergency preparedness team members
- ❑ Health and well-being focused coalition members
- ❑ The general public
- ❑ Other _____

LPHS Model Standard 1.1 Population-Based Community Health Profile (CHP)

The local public health system (LPHS) develops a community health profile (CHP) using data from a detailed community health assessment (CHA) to give an overall look at the community's health. The CHA includes information on health status, quality of life, risk factors, social determinants of health, and strengths of the community at least every 3 years. Data included in the community health profile are accurate, reliable, and interpreted according to the evidence base for public health practice. CHP data and information are displayed and updated according to the needs of the community.

With a CHA, a community receives an in-depth picture or understanding of the health of the community. From the CHA and CHP, the community can identify the most vulnerable populations and related health inequities, prioritize health issues, identify best practices to address health issues and put resources where they are most needed. The CHP also tracks the health of a community over time and compares local measures to other local, state, and national benchmarks.

To accomplish this, members of the LPHS work together to:

- Conduct regular community health assessments.
- Provide and update community health profile reports with current information.
- Make the community health profile available and promote its use among community members and partners.

NOTES:

Model Standard 1.1 Discussion Questions

Awareness
- ✓ Did most of you know about the assessment?
- ✓ Do you all have access to the CHP?

Involvement
- ✓ How many of you (or those listed on the previous page) participated in the assessment?

Frequency
- ✓ How often is the CHA completed?
- ✓ How often is all the data updated in the CHP?

Quality and Comprehensiveness
- ✓ Which data sets are included in the CHP?
- ✓ How is the CHP used to monitor progress towards local health priorities? State health priorities? Healthy People 2020 national objectives?
- ✓ How is the CHP looking at data over time to track trends?
- ✓ How is the data helping the LPHS identify health disparities?

Utility
- ✓ How easily accessible to the general public is the CHP?
- ✓ How is the CHP promoted to the community?
- ✓ How is the CHP used to inform health policy and planning decisions?

Performance Measures

At what level does the local public health system…

1.1.1 Conduct regular community health assessments?
- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

1.1.2 Provide and update community health profile reports with current information?
- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

1.1.3 Make the community health profile available and promote its use among community members and partners?
- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 1.2: Current Technology to Manage and Communicate Population Health Data

The local public health system (LPHS) provides the public with a clear picture of the current health of the community. Health problems are looked at over time and trends related to age, gender, race, ethnicity, and geographic distribution are examined. Data are shown in clear ways, including graphs, charts, and maps while the confidential health information of individuals is protected. Software tools are used to understand where health problems occur, allowing the community to plan efforts to lessen the problems and to target resources where they are most needed. The Community Health Profile (CHP) is available in both hard copy and online formats, and is regularly updated. Links to other sources of information are provided on websites.

To accomplish this, members of the LPHS work together to:

- Use the best available technology and methods to combine and show data on the public health.
- Analyze health data, including geographic information, to see where health problems exist.
- Use computer software to create charts, graphs, and maps which show trends over time and compare data for different population groups.

NOTES:

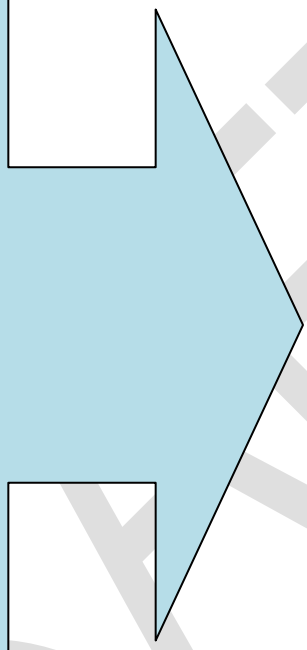
Model Standard 1.2 Discussion Questions

Awareness

- ✓ What technology is available to local public health system partners to support health profile databases?

Quality and Comprehensiveness

- ✓ How does the LPHS use technology to support health profile databases?
- ✓ At what level does the LPHS have access to and include geocoded health data?
- ✓ How local is the data available?
- ✓ How does the LPHS use geographic information systems (GIS)?
- ✓ How does the LPHS use computer-generated graphics?



Performance Measures

At what level does the local public health system…

1.2.1 Use the best available technology and methods to combine and show data on the public health?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

1.2.2 Analyze health data, including geographic information, to see where health problems exist?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

1.2.3 Use computer software to create charts, graphs, and maps which show trends over time and compare data for different population groups?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 1.3: Maintenance of Population Health Registries

The local public health system (LPHS) collects data on health-related events for use in population health registries. These registries allow more understanding of major health concerns, such as birth defects and cancer, and tracking of some healthcare delivery services, such as vaccination records. Registries also allow the LPHS to give timely information to at-risk persons. The LPHS assures accurate and timely reporting of all the information needed for health registries.

Population health registry data are collected by the LPHS according to standards, so that they can be compared with other data from private, local, state, regional, and national sources. With many partners working together to contribute complete data, population registries provide information for policy decisions, program implementation, and population research.

Members of the LPHS work together to:

- Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards.
- Use information from population health registries in community health assessments or other analyses.

NOTES:

Model Standard 1.3 Discussion Questions

Involvement

- ✓ Which of you or the other partners listed for Essential Service 1, contribute to and/or maintain population health registries?
- ✓ Which population health registries are contributed to and/or maintained within the LPHS?

Quality

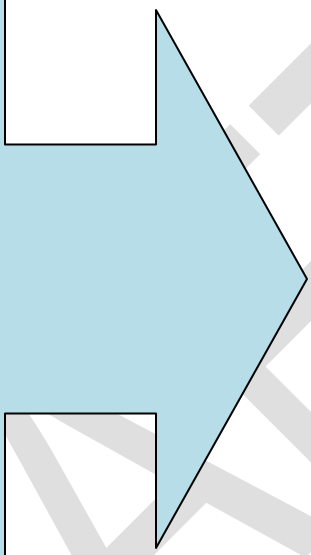
- ✓ What specific standards are in place for data collection?
- ✓ What established processes are there for reporting health events to the registries? Are they followed?
- ✓ What, if any, systems are in place to ensure accurate, timely, and unduplicated reporting?

Utility

- ✓ How are population health registries used by the LPHS?

Frequency

- ✓ How often are the data used by the LPHS for such activities? Have they been used in the past year?



Performance Measures

At what level does the local public health system…

1.3.1 Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

1.3.2 Use information from population health registries in community health assessments or other analyses?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 1.1: Population-Based Community Health Profile (CHP)			
Model Standard 1.2: Current Technology to Manage and Communicate Population Health Data			
Model Standard 1.3: Maintenance of Population Health Registries			

LPHS Essential Service 2:

Diagnose and Investigate Health Problems and Health Hazards

Are we ready to respond to health problems or threats in my community?
How quickly do we find out about problems?
How effective is our response?

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

- Access to a public health laboratory capable of conducting rapid screening and high-volume testing.
- Active infectious disease epidemiology programs.
- Technical capacity for epidemiologic investigation of disease outbreaks and patterns of infectious and chronic diseases and injuries and other adverse health behaviors and conditions.

Partners gathered to discuss the performance of the local public health system in diagnosing and investigating health problems and health hazards may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Long-term care facilities
- ❑ Preschool and day care programs
- ❑ Public and private schools
- ❑ Colleges and universities
- ❑ Employers
- ❑ Managed care organizations
- ❑ Primary care clinics, including Federally Qualified Health Centers (FQHCs)
- ❑ Physicians
- ❑ Public safety and emergency response organizations
- ❑ Public health laboratories

LPHS Model Standard 2.1: Identification and Surveillance of Health Threats

The local public health system (LPHS) conducts surveillance to watch for outbreaks of disease, disasters and emergencies (both natural and manmade), and other emerging threats to public health. Surveillance data includes information on reportable diseases and potential disasters, emergencies or emerging threats. The LPHS uses surveillance data to notice changes or patterns right away, determine the factors that influence these patterns, investigate the potential dangers, and find ways to lessen the impact on public health. The best available science and technologies are used to understand the problems, determine the most appropriate solutions, and prepare for and respond to identified public health threats. To ensure the most effective and efficient surveillance, the LPHS connects it surveillance systems with state and national systems. To provide a complete monitoring of health events, all parts of the system work together to collect data and report findings.

Members of the LPHS work together to:

- Participate in a comprehensive surveillance system with national, state and local partners to identify, monitor, share information, and understand emerging health problems and threats.
- Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade).
- Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise.

NOTES:

Model Standard 2.1 Discussion Questions

Awareness

- ✓ How many of you are aware of the LPHS contributions to surveillance system(s) designed to monitor health problems and identify health threats?

Quality and Comprehensiveness

- ✓ Which data sets are included in the surveillance system?
- ✓ How well is the surveillance system integrated with national and/or state surveillance systems?
- ✓ Is the surveillance system compliant with national and/or state health information exchange guidelines?
- ✓ What types of resources are available to support health problem and health hazard surveillance and investigation activities within the LPHS?

Frequency

- ✓ What is the time-frame for submitting reportable disease information to the state or the LPHS?

Utility

- ✓ How does the LPHS use the surveillance system(s) to monitor changes in the occurrence of health problems and hazards?

Performance Measures

At what level does the local public health system…

2.1.1 Participate in a comprehensive surveillance system with national, state and local partners to identify, monitor, share information, and understand emerging health problems and threats?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.1.2 Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade)?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.1.3 Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 2.2: Investigation and Response to Public Health Threats and Emergencies

The local public health system (LPHS) stays ready to handle possible threats to the public health. As a threat develops – such as an outbreak of a communicable disease, a natural disaster, or a chemical, radiological, nuclear, explosive, or other environmental event – a team of LPHS professionals works closely together to collect and understand related data. Many partners support the response, with communication networks already in place among health-related organizations, public safety, rapid response teams, the media, and the public. In a public health emergency, a jurisdictional Emergency Response Coordinator leads LPHS partners in the local investigation and response. The response to an emergent event is in accordance with current emergency operations coordination guidelines.

Members of the LPHS work together to:

- 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.
- Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters.
- Designate a jurisdictional Emergency Response Coordinator.
- Rapidly and effectively respond to public health emergencies according to emergency operations coordination guidelines.
- Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or radiological public health emergencies.
- Evaluate exercises and incidents for effectiveness and opportunities for improvement.

NOTES:

Model Standard 2.2 Discussion Questions

Quality and Comprehensiveness

- ✓ How does the LPHS use written processes and standards for implementing a program of case finding, contact tracing, source identification, and containment for communicable diseases or toxic exposures?
- ✓ How are LPHS personnel prepared to rapidly respond to natural and intentional disasters?

Involvement

- ✓ Who is the LPHS designee serving as the Emergency Response Coordinator within the jurisdiction?
- ✓ How does the Emergency Response Coordinator coordinate emergency activities within the LPHS?
- ✓ Does the LPHS maintain a current list of personnel with the technical expertise to respond to natural and intentional emergencies and disasters?
- ✓ How does the LPHS ensure a timely response from emergency personnel, including sufficient numbers of trained professionals?
- ✓ How does the LPHS mobilize volunteers during a disaster?

Utility

- ✓ How does the LPHS evaluate public health emergency response incidents for effectiveness and opportunities for improvement (e.g., After Action Reports)?
- ✓ How are the findings used to improve emergency plans?

Performance Measures

At what level does the local public health system…

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?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.2.2 Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.2.3 Designate a jurisdictional Emergency Response Coordinator?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.2.4 Rapidly and effectively respond to public health emergencies according to emergency operations coordination guidelines?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Model Standard 2.2

Performance Measures

At what level does the local public health system…

2.2.5 Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or radiological public health emergencies?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.2.6 Evaluate exercises and incidents for effectiveness and opportunities for improvement?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 2.3: Laboratory Support for Investigation of Health Threats

The local public health system (LPHS) has the ability to produce timely and accurate laboratory results for public health concerns. Whether a laboratory is public or private, the LPHS sees that the correct testing is done and that the results are made available on time. Any laboratory used by public health meets all licensing and credentialing standards.

Members of the LPHS work together to:

- Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring.
- Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards.
- Use only licensed or credentialed laboratories.
- Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results.

NOTES:

Model Standard 2.3 Discussion Questions

Quality and Comprehensiveness

- ✓ Where does the LPHS maintain ready access to laboratories able to meet routine diagnostic and surveillance needs including analysis of clinical and environmental specimens?
- ✓ How does the LPHS use laboratory services to support time-sensitive investigations of public health threats, hazards, and emergencies?
- ✓ What mechanisms are in place to ensure the laboratories used are all licensed and/or credentialed?
- ✓ What current guidelines or protocols are in place for the handling of laboratory samples?

Performance Measures

At what level does the local public health system…

2.3.1 Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.3.2 Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.3.3 Use only licensed or credentialed laboratories?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

2.3.4 Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 2.1: Identification and Surveillance of Health Threats			
Model Standard 2.2: Investigation and Response to Public Health Threats and Emergencies			
Model Standard 2.3: Laboratory Support for Investigation of Health Threats			

LPHS Essential Service 3:

Inform, Educate, and Empower People about Health Issues

How well do we keep all segments of our community informed about health issues?

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

- Community development activities.
- Social marketing and targeted media public communication.
- Provision of accessible health information resources at community levels.
- Active collaboration with personal healthcare providers to reinforce health promotion messages and programs.
- Joint health education programs with schools, churches, worksites, and others.

Partners gathered to discuss the performance of the local public health system in informing, educating, and empowering people about health issues may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Public and private schools
- ❑ Colleges and universities
- ❑ Health educators
- ❑ Local businesses and employers
- ❑ Managed care organizations
- ❑ Faith-based institutions
- ❑ Non-profit organizations/advocacy groups
- ❑ Civic organizations
- ❑ Neighborhood organizations
- ❑ Other community/grassroots organizations
- ❑ Public information officers
- ❑ Media

LPHS Model Standard 3.1: Health Education and Promotion

The local public health system (LPHS) designs and puts in place health promotion and health education activities to enable and support efforts to exert control over the determinants of health and to create environments that support health. These promotional and educational activities are coordinated throughout the LPHS to address risk and protective factors at the individual, interpersonal, community, and societal levels. The LPHS includes the community in identifying needs, setting priorities and planning health promotional and educational activities. The LPHS plans for different reading abilities, language skills, and access to materials.

To accomplish this, members of the LPHS work together to:

- Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies.
- Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels.
- Engage the community in setting priorities, developing plans and implementing health education and health promotion activities.

NOTES:

Model Standard 3.1 Discussion Questions

Involvement

- ✓ How many of you provide information on community health to the general public, policymakers, and public and private stakeholders?
- ✓ How do your organizations work together to plan, conduct, and implement health education and promotion activities?
- ✓ How do your organizations work with others beyond your usual LPHS system partners on specific health promotion activities (e.g., supermarkets and nutrition interventions)?
- ✓ How do LPHS entities work with community advocates and local media outlets to publicize health promotion activities (e.g. campaigns to change laws, media campaigns)?

Quality and Comprehensiveness

- ✓ How are the health education and health promotion campaigns based on sound theory, evidence of effectiveness, and/or best practice?
- ✓ How does the LPHS support healthy behavior?
- ✓ How does the LPHS tailor campaigns for populations with higher risk of negative health outcomes?
- ✓ How does the LPHS design campaigns to reach populations in specific settings?
- ✓ How are the health education programs and/or health promotion campaigns evaluated?

Utility

- ✓ How are evaluation results used to revise and strengthen the programs?

Performance Measures

At what level does the local public health system…

3.1.1 Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

3.1.2 Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

3.1.3 Engage the community in setting priorities, developing plans and implementing health education and health promotion activities?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 3.2: Health Communication

The local public health system (LPHS) uses health communication strategies to contribute to healthy living and healthy communities, including: increasing awareness of risks to health; ways to reduce health risk factors and increase health protective factors; promoting healthy behaviors; advocating organizational and community changes to support healthy living; increasing demand and support for health services; building a culture where health is valued; and creating support for health policies, programs and practices. Health communication uses a broad range of strategies, including print, radio, television, the internet, media campaigns, social marketing, entertainment education, and interactive media. The LPHS reaches out to the community through efforts ranging from one-on-one conversations to small group communication, to communications within organizations and the community, to mass media approaches. The LPHS works with many groups to understand the best ways to present health messages in each community setting and to find ways to cover the costs.

To accomplish this, members of the LPHS work together to:

- Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations.
- Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience.
- Identify and train spokespersons on public health issues.

NOTES:

Model Standard 3.2 Discussion Questions

Involvement

- ✓ How many of your organizations have developed health communication plans?
- ✓ How do your organizations work collaboratively to link the communication plans?

Quality and Comprehensiveness

- ✓ Do the communications plans include policies and procedures for creating, sharing, and disseminating information with partners and key stakeholders?
- ✓ How are different sectors of the population identified in order to create targeted public health messages for various audiences?
- ✓ How does the LPHS coordinate with local media to develop information or features on health issues?
- ✓ What mechanism is in place to document and respond to public inquiries?
- ✓ Who, if anyone, has been designated as public information officers (PIOs) to provide important health information and answers to public and media inquiries?
- ✓ How are designated spokespersons trained in providing accurate, timely, and appropriate information on public health issues for different audiences?

Utility

- ✓ What policies and procedures are in place to coordinate responses and public announcements related to public health issues?

Performance Measures

At what level does the local public health system…

3.2.1 Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

3.2.2 Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

3.2.3 Identify and train spokespersons on public health issues?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 3.3 Risk Communication

The local public health system (LPHS) uses health risk communications strategies to allow individuals, groups and organizations, or an entire community to make optimal decisions about their health and well-being in emergency events. The LPHS recognizes a designated Public Information Officer for emergency public information and warning. The LPHS organizations work together to identify potential risks (crisis or emergency) that may affect the community and develop plans to effectively and efficiently communicate information about these risks. The plans include pre-event, event, and post-event communication strategies for different types of emergencies.

Members of the LPHS work together to:

- Develop an emergency communications plan for each stage of an emergency to allow for the effective creation and dissemination of information.
- Make sure that systems and mechanisms are in place and enough resources are available for a rapid emergency communication response.
- Provide crisis and emergency communication training for employees and volunteers.

NOTES:

Model Standard 3.3 Discussion Questions

Involvement

- ✓ Who is involved in or aware of the LPHS emergency communications plans?
- ✓ How do multiple agencies coordinate emergency communication planning within the LPHS?

Quality and Comprehensiveness

- ✓ Can the emergency communication plans be adapted to different types of emergencies (i.e., disease outbreaks, natural disasters, bioterrorism)?
- ✓ Do the plans include established lines of authority, reporting, and responsibilities for emergency communications teams in accordance with the National Incident Management System (NIMS)?
- ✓ How do the plans alert communities, including special populations, about possible health threats or disease outbreaks?
- ✓ How do the plans provide information from emergency operation center situation reports, health alerts, and meeting notes to stakeholders, partners, and the community?
- ✓ What type of technology is in place to ensure rapid communication response? (e.g. local Health Alert Network, reverse 911 warning system, local PSAs, broadcast text, email, fax)
- ✓ What staff persons are available to develop or adapt emergency communications materials and to provide communications for all stakeholders and partners in the event of an emergency?
- ✓ What type of crisis and emergency communications training is available within the LPHS for new and current staff?
- ✓ How does the LPHS maintain a directory of emergency contact information for media liaisons, partners, stakeholders, and PIOs?

Performance Measures

At what level does the local public health system…

3.3.1 Develop an emergency communications plan for each stage of an emergency to allow for the effective creation and dissemination of information?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

3.3.2 Make sure that systems and mechanisms are in place and enough resources are available for a rapid emergency communication response?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

3.3.3 Provide crisis and emergency communication training for employees and volunteers?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 3.1: Health Education and Promotion			
Model Standard 3.2: Health Communication			
Model Standard 3.3: Risk Communication			

LPHS Essential Service 4:

Mobilize Community Partnerships to Identify and Solve Health Problems

How well do we get people engaged in local health issues?

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 gathered to discuss the performance of the local public health system in mobilizing community partnerships to identify and solve health problems may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Public and private schools
- ❑ Colleges and universities
- ❑ Health educators
- ❑ Local businesses and employers
- ❑ Managed care organizations
- ❑ Faith-based institutions
- ❑ Non-profit organizations/advocacy groups
- ❑ Civic organizations
- ❑ Neighborhood organizations
- ❑ Other community/grassroots organizations
- ❑ Public information officers
- ❑ Media
- ❑ The general public

LPHS Model Standard 4.1: Constituency Development

The local public health system (LPHS) actively identifies and involves community partners -- the individuals and organizations (constituents) with opportunities to contribute to the health of communities. These stakeholders may include health, transportation, housing, environmental, and non-health related groups, as well as community members. The LPHS manages the process of establishing collaborative relationships among these and other potential partners. Groups within the LPHS communicate well with one another, resulting in a coordinated, effective approach to public health so that the benefits of public health are understood and shared throughout the community.

To accomplish this, members of the LPHS work together to:

- Follow an established process for identifying key constituents related to overall public health interests and particular health concerns.
- Encourage constituents to participate in community health assessment, planning and improvement efforts.
- Maintain a complete and current directory of community organizations.
- Create forums for communication of public health issues.

NOTES:

Model Standard 4.1 Discussion Questions

Awareness

- ✓ How is awareness regarding the importance of public health issues developed with the community-at-large and organizations within the LPHS through communication strategies?

Involvement

- ✓ What organizations are active parts of the LPHS?
- ✓ How are new individuals/groups identified for constituency building?
- ✓ How are constituents encouraged to participate in improving community health?
- ✓ How are members of the community-at-large engaged to improve health?

Quality and Comprehensiveness

- ✓ Does the LPHS maintain a current and accessible directory of organizations that comprise the LPHS?
- ✓ What is the LPHS's process for identifying key constituents or stakeholders?
- ✓ How does the LPHS maintain names and contact information for individuals and key constituent groups?

Utility

- ✓ How accessible is the directory of LPHS organizations?
- ✓ How does the LPHS create forums for communication of public health issues?

Performance Measures

At what level does the local public health system…

4.1.1 Maintain a complete and current directory of community organizations?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

4.1.2 Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

4.1.3 Encourage constituents to participate in community health assessment, planning and improvement efforts?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

4.1.4 Create forums for communication of public health issues?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 4.2: Community Partnerships

The local public health system (LPHS) encourages individuals and groups to work together so that community health may be improved. Public, private, and voluntary groups – through many different levels of information sharing, activity coordination, resource sharing, and in-depth collaborations – strategically align their interests to achieve a common purpose. By sharing responsibilities, resources, and rewards, community partnerships allow each member to share its expertise with others and strengthen the LPHS as a whole. A community group follows a collaborative, dynamic, and inclusive approach to community health improvement; it may exist as a formal partnership, such as a community health planning council, or as a less formal community group.

Members of the LPHS work together to:

- Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community.
- Establish a broad-based community health improvement committee.
- Assess how well community partnerships and strategic alliances are working to improve community health.

NOTES:

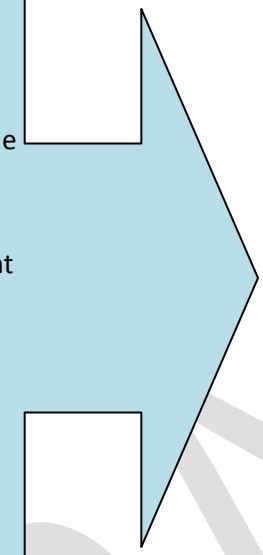
Model Standard 4.2 Discussion Questions

Involvement

- ✓ What types of partnerships exist in the community to maximize public health improvement activities?
- ✓ How do organizations within these partnerships interact?

Quality and Comprehensiveness

- ✓ What types of activities does the LPHS engage in?
- ✓ If there is a broad-based community health improvement committee, what does the committee do?
- ✓ How does the LPHS review the effectiveness of community partnerships and strategic alliances?



Performance Measures

At what level does the local public health system…

4.2.1 Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

4.2.2 Establish a broad-based community health improvement committee?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

4.2.3 Assess how well community partnerships and strategic alliances are working to improve community health?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 4.1: Constituency Development			
Model Standard 4.2: Community Partnerships			

LPHS Essential Service 5:

Develop Policies and Plans that Support Individual and Community Health Efforts

What local policies in both the government and private sector promote health in my community?

How well are we setting healthy local policies?

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

- Leadership development at all levels of public health.
- Systematic community-level and state-level planning for health improvement in all jurisdictions.
- Development and tracking of measurable health objectives from the community health plan as a part of continuous quality improvement strategy plan.
- Joint evaluation with the medical healthcare system to define consistent policy regarding prevention and treatment services.
- Development of policy and legislation to guide the practice of public health.

Partners gathered to discuss the performance of the local public health system in developing policies and plans that support individual and community health efforts may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Health officer/public health director
- ❑ Elected officials and policymakers
- ❑ Public health attorneys
- ❑ Community health planners
- ❑ Emergency services personnel
- ❑ Law enforcement agencies
- ❑ Healthcare providers
- ❑ Colleges and universities
- ❑ Local businesses and employers
- ❑ Managed care organizations
- ❑ Faith-based institutions
- ❑ Non-profit organizations/advocacy groups
- ❑ Civic organizations
- ❑ Neighborhood organizations
- ❑ Other community/grassroots organizations
- ❑ Media

LPHS Model Standard 5.1: Governmental Presence at the Local Level

The local public health system (LPHS) includes a governmental public health entity dedicated to the public health. The LPHS works with the community to make sure a strong local health department (or other governmental public health entity) exists and that it is doing its part in providing essential public health services. The governmental public health entity can be a regional health agency with more than one local area under its jurisdiction. The local health department (or other governmental public health entity) is accredited through the national voluntary accreditation program.

Members of the LPHS work together to:

- Support the work of a governmental local public health entity dedicated to the public health to make sure the essential public health services are provided through the LPHS.
- See that the local health department is accredited through the national voluntary accreditation program.
- Assure that the governmental local public health entity has enough resources to do its part in providing essential public health services.

NOTES:

Model Standard 5.1 Discussion Questions

Involvement

- ✓ What type of governmental local public health presence (i.e., local health department) within the LPHS is available to *assure* the provision of Essential Public Health Services to the community?
- ✓ How is the LHD being supported to prepare for and obtain national voluntary public health accreditation?

Quality and Comprehensiveness

- ✓ How does the governmental local public health entity document its statutory, chartered, and/or legal responsibilities?
- ✓ How does the governmental local public health entity assess its functions against the operational definition of a functional local health department?
- ✓ What types of services does the governmental local public health entity provide?
- ✓ How does the LPHS assure the availability of resources for the governmental local public health entity's contributions to the Essential Public Health Services?
- ✓ How does the governmental local public health entity work with the state public health agency and other state partners to assure the provision of public health services?

Frequency

- ✓ How often does the LPHS assure that the governmental local public health entity has enough resources to do its part in providing essential public health services?

Performance Measures

At what level does the local public health system…

5.1.1 Support the work of a local health department dedicated to the public health to make sure the essential public health services are provided through the LPHS?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.1.2 See that the local health department is accredited through the national voluntary accreditation program?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.1.3 Assure that the local health department has enough resources to do its part in providing essential public health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 5.2: Public Health Policy Development

The local public health system (LPHS) develops policies that will prevent, protect or promote the public health. Public health problems, possible solutions, and community values are used to inform the policies and any proposed actions, which may include new laws or changes to existing laws. Additionally, current or proposed policies that have the potential to affect the public health are carefully reviewed for consistency with public health policy through health impact assessments.

The LPHS and its ability to make informed decisions are strengthened by community member input. The LPHS, together with the community, works to identify gaps in current policies and needs for new policies to improve the public health. The LPHS educates the community about policies to improve the public health and serves as a resource to elected officials who establish and maintain public health policies.

Members of the LPHS work together to:

- Contribute to new or modified public health policies by engaging in activities that inform the policy development process and facilitate community involvement.
- Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies.
- Review existing policies at least every three to five years.

NOTES:

Model Standard 5.2 Discussion Questions

Awareness

- ✓ How does the LPHS alert policymakers and the public of public health impacts from current and/or proposed policies?

Involvement

- ✓ How does the LPHS contribute to the development of public health policies?
- ✓ How does the LPHS engage constituents in identifying and analyzing issues?
- ✓ Within the past year, how has the LPHS been involved in activities that influenced or informed the public health policy process?

Quality and Comprehensiveness

- ✓ How does the LPHS advocate for prevention and protection policies related to health disparities within the community?
- ✓ How does the LPHS work together to see that public health considerations become a part of all policies?

Frequency

- ✓ Does the LPHS conduct reviews of public health policies at least every three to five years?
- ✓ How often are health impact assessments developed and used?

Performance Measures

At what level does the local public health system…

5.2.1 Contribute to new or modified public health policies by engaging in activities that inform the policy development process and facilitate community involvement?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.2.2 Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.2.3 Review existing policies at least every three to five years?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

The local public health system (LPHS) seeks to improve community health by looking at it from many sides, such as environmental health, healthcare services, business, economic, housing, land use, health equity, and other concerns that impact the public health. The LPHS leads a community-wide effort to improve community health by gathering information on health problems, identifying the community's strengths and weaknesses, setting goals, and increasing overall awareness of and interest in improving the health of the community. This community health improvement process provides ways to develop a community-owned plan that will lead to a healthier community. With the community health improvement effort in mind, each organization in the LPHS makes an effort to include strategies related to community health improvement goals in their own strategic plans.

Members of the LPHS work together to:

- Establish a community health improvement process, with broad- based diverse participation, that uses information from both the community health assessment and the perceptions of community members.
- Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps.
- Connect organizational strategic plans with the Community Health Improvement Plan.

NOTES:

Model Standard 5.3 Discussion Questions

Awareness

- ✓ What community health assessment and planning process is used by the LPHS (e.g., MAPP, PACE EH)?

Involvement

- ✓ What organizations are involved in community health assessment and planning processes?

Quality and Comprehensiveness

- ✓ What types of activities are involvedin the community health assessment and planning process?
- ✓ Does the process result in the development of a community health improvement plan?
- ✓ How is the community health improvement plan linked to a state health improvement plan?
- ✓ How are the strategic plans of LPHS partners, including the lhd, aligned with the community health improvement plan?

Frequency

- ✓ Does the LPHS have plans to revisit community health assessment and planning processes in 3-5 years?

Utility

- ✓ How has the LPHS developed strategies to address community health objectives?
- ✓ How are the individuals or organizations accountable for the implementation of these strategies identified?

Performance Measures

At what level does the local public health system…

5.3.1 Establish a community health improvement process, with broad- based diverse participation, that uses information from both the community health assessment and the perceptions of community members?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.3.2 Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.3.3 Connect organizational strategic plans with the Community Health Improvement Plan?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 5.4: Plan for Public Health Emergencies

The local public health system (LPHS) adopts an emergency preparedness and response plan which describes what each organization in the LPHS should be ready to do in a public health emergency. The plan describes community interventions necessary to prevent, monitor, and manage all types of emergencies, including both natural and intentional disasters. The plan also looks at challenges of possible events, such as nuclear, biological, or terrorist events. Practicing for possible events takes place through regular exercises or drills. A task force sees that the necessary organizations and resources are included in the planning and practicing for all types of emergencies.

Members of the LPHS work together to:

- Maintain a task force to develop and maintain preparedness and response plans.
- Develop a 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.
- Test the plan through regular drills and revise the plan as needed, at least every two years.

NOTES:

Model Standard 5.4 Discussion Questions

Involvement

- ✓ Which LPHS organizations participate in a task force or coalition of community partners to develop and maintain local and/or regional emergency preparedness and response plans?

Quality and Comprehensiveness

- ✓ Does the LPHS have an all-hazards emergency preparedness and response plan? What is included?
- ✓ How does the LPHS test the plan through simulations or "mock events"?

Frequency

- ✓ How often is the All-Hazards plan reviewed and, if appropriate, revised?

Utility

- ✓ How is the plan evaluated? Are opportunities for improvement identified and implemented?

Performance Measures

At what level does the local public health system…

5.4.1 Maintain a task force to develop and maintain preparedness and response plans?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.4.2 Develop a 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?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

5.4.3 Test the plan through regular drills and revise the plan as needed, at least every two years?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 5.1: Governmental Presence at the Local Level			
Model Standard 5.2: Public Health Policy Development			
Model Standard 5.3: Community Health Improvement Process and Strategic Planning			
Model Standard 5.4: Plan for Public Health Emergencies			

LPHS Essential Service 6:

Enforce Laws and Regulations that Protect Health and Ensure Safety

When we enforce health regulations are we technically competent, fair, and effective?

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

- Enforcement of sanitary codes, especially in the food industry.
- Protection of drinking water supplies.
- Enforcement of clean air standards.
- Animal control activities.
- Follow-up of 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).
- Review of new drug, biologic, and medical device applications.

Partners gathered to discuss the performance of the local public health system in developing policies and plans that support individual and community health efforts may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Health officer/public health director
- ❑ Public health attorneys
- ❑ Emergency services personnel
- ❑ Law enforcement agencies
- ❑ Healthcare providers
- ❑ Local businesses and employers
- ❑ Managed care organizations
- ❑ Non-profit organizations/advocacy groups
- ❑ Civic organizations
- ❑ Neighborhood organizations
- ❑ Other community/grassroots organizations
- ❑ Media

LPHS Model Standard 6.1: Review and Evaluation of Laws, Regulations, and Ordinances

The local public health system (LPHS) reviews existing laws, regulations, and ordinances related to public health, including laws that prevent health problems, promote, or protect public health. The LPHS looks at federal, state, and local laws to understand the authority provided to the LPHS and the potential impact of laws, regulations, and ordinances on the health of the community. The LPHS also looks at any challenges involved in complying with laws, regulations, or ordinances, whether community members have any opinions or concerns, and whether any laws, regulations, or ordinances need to be updated.

Members of the LPHS work together to:

- Identify public health issues that can be addressed through laws, regulations, or ordinances.
- Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels.
- Review existing public health laws, regulations, and ordinances at least once every five years.
- Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances.

NOTES:

Model Standard 6.1 Discussion Questions

Awareness

- ✓ What has the LPHS identified that can best be addressed through laws, regulations, and ordinances?

Quality and Comprehensiveness

- ✓ How do LPHS organizations stay-up-to-date regarding federal, state, and local laws, regulations, and ordinances that protect the public health?
- ✓ Do governmental entities within the LPHS have access to legal counsel to assist with the review of laws, regulations, and ordinances related to the public's health?

Frequency

- ✓ Are the reviews conducted at least once every three to five years?

Utility

- ✓ How are laws, regulations, and ordinances that protect public health reviewed by the LPHS to ensure appropriate compliance?

Performance Measures

At what level does the local public health system…

6.1.1 Identify public health issues that can be addressed through laws, regulations, or ordinances?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.1.2 Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.1.3 System review existing public health laws, regulations, and ordinances at least once every five years?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.1.4 Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 6.2: Involvement in the Improvement of Laws, Regulations, and Ordinances

The local public health system (LPHS) works to change existing laws, regulations, or ordinances – or to create new ones – when they have determined that changes or additions would better prevent, protect or promote public health. To advocate for public health, the LPHS helps to draft the new or revised legislation, regulations, or ordinances, takes part in public hearings, and talks with lawmakers and regulatory officials.

Members of the LPHS work together to:

- Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances.
- Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health.
- Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances.

NOTES:

Model Standard 6.2 Discussion Questions

Awareness

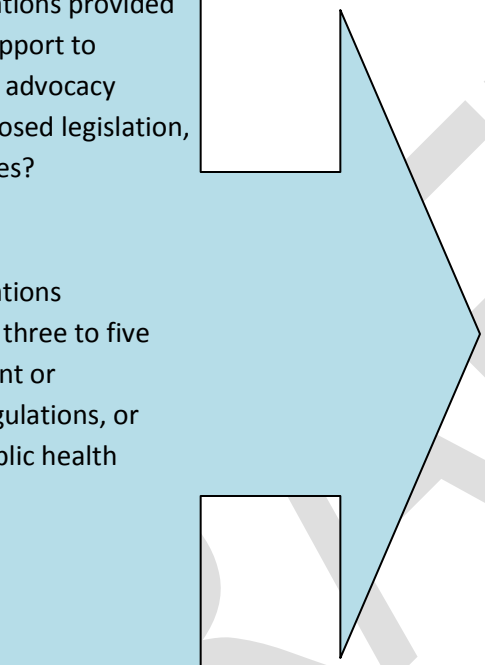
- ✓ What examples are there of identified local public health issues that are not adequately addressed through existing laws, regulations, and ordinances?

Involvement

- ✓ How have LPHS organizations provided technical guidance or support to legislative, regulatory or advocacy groups for drafting proposed legislation, regulations, or ordinances?

Frequency

- ✓ How have LPHS organizations participated (in the past three to five years) in the development or modification of laws, regulations, or ordinances for those public health issues?



Performance Measures

At what level does the local public health system…

6.2.1 Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.2.1 Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.2.3 Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 6.3: Enforcement of Laws, Regulations, and Ordinances

The local public health system (LPHS) sees that public health laws, regulations, and ordinances are followed. The LPHS knows which governmental agency or other organization has the authority to enforce any given public health-related requirement within its community, supports all organizations tasked with enforcement responsibilities, and assures that the enforcement is conducted within the law. The LPHS has sufficient authority to respond in an emergency event. The LPHS also makes sure that individuals and organizations understand the requirements of relevant laws, regulation, and ordinances. The LPHS communicates the reasons for legislation and the importance of compliance.

Members of the LPHS work together to:

- Identify organizations that have the authority to enforce public health laws, regulations, and ordinances.
- Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies.
- Assure that all enforcement activities related to public health codes are done within the law.
- Inform and educate individuals and organizations about relevant laws, regulations, and ordinances.
- Evaluate how well local organizations comply with public health laws.

NOTES:

Model Standard 6.3 Discussion Questions

Awareness

- ✓ What authority do governmental public health entities within your LPHS have to enforce laws, regulations, or ordinances related to the public's health?
- ✓ How are the roles and responsibilities related to the authority documented?

Quality and Comprehensiveness

- ✓ How are those responsible for enforcement activities trained on compliance and enforcement?
- ✓ How is the LHD or governmental public health entity empowered through laws and regulations to implement necessary community interventions in the event of a public health emergency?
- ✓ How does the LPHS assure that all enforcement activities are conducted in accordance with laws, regulations, and ordinances?
- ✓ How has the LPHS assessed the compliance of institutions and businesses in the community (e.g., schools, food establishments, day care facilities) with laws, regulations, and ordinances designed to ensure the public health?
- ✓ What is included in the assessment?

Frequency

- ✓ How often does the LPHS assess the compliance of institutions and businesses with laws, regulations, and ordinances?

Utility

- ✓ Is dissemination of this information integrated with other public health activities (e.g., health education, communicable disease control, health assessment, planning)?
- ✓ Does the LPHS provide information to the individuals and organizations who are required to comply with certain laws, regulations, or ordinances?

Performance Measures

At what level does the local public health system…

6.3.1 Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.3.2 Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.3.3 Assure that all enforcement activities related to public health codes are done within the law?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.3.4 Inform and educate individuals and organizations about relevant laws, regulations, and ordinances?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

6.3.5 Evaluate how well local organizations comply with public health laws?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 6.1: Review and Evaluation of Laws, Regulations, and Ordinances			
Model Standard 6.2: Involvement in the Improvement of Laws, Regulations, and Ordinances			
Model Standard 6.3: Enforcement of Laws, Regulations, and Ordinances			

LPHS Essential Service 7:

Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

Are people in my community receiving the medical care they need?

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

- Assurance of effective entry for socially disadvantaged people into a coordinated system of clinical care.
- Culturally and linguistically appropriate materials and staff to ensure linkage to services for special population groups.
- Ongoing "care management."
- Transportation services.
- Targeted health education/promotion/disease prevention to high-risk population groups.

Partners gathered to discuss the performance of the local public health system in linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Service providers
- ❑ Service recipients
- ❑ Managed care organizations
- ❑ Non-profit organizations/advocacy groups
- ❑ Nursing Homes

LPHS Model Standard 7.1: Identification of Personal Health Service Needs of Populations

The local public health system (LPHS) identifies the personal health service needs of the community and identifies the barriers to receiving these services, especially among particular groups that may have difficulty accessing personal health services. The LPHS has defined roles and responsibilities for the local health department (or other governmental public health entity) and other partners (e.g. hospitals, managed care providers, and other community health agencies) in relation to overcoming these barriers and providing services.

Members of the LPHS work together to:

- Identify groups of people in the community who have trouble accessing or connecting to personal health services.
- Identify all personal health service needs and unmet needs throughout the community.
- Defines roles and responsibilities for partners to respond to the unmet needs of the community
- Understand the reasons that people do not get the care they need.

NOTES:

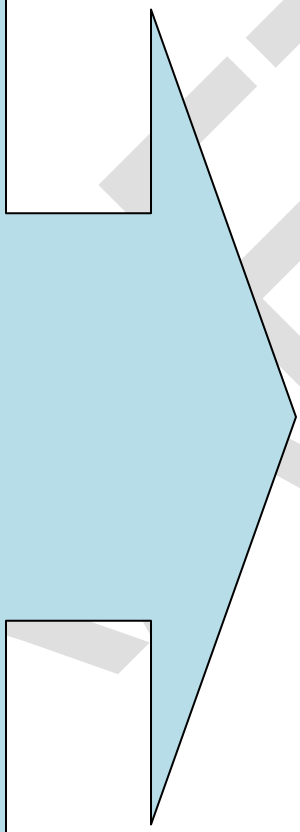
Model Standard 7.1 Discussion Questions

Awareness

- ✓ How has the LPHS assessed the extent to which personal health services are utilized by populations who may experience barriers to care?

Quality and Comprehensiveness

- ✓ How does the LPHS identify any populations who may experience barriers to personal health services?
- ✓ Which populations are taken into account?
- ✓ How has the LPHS identified the personal health service needs of populations in its jurisdiction, including the needs of populations who may experience barriers to care?
- ✓ Which types of personal health services has the LPHS determined to be unmet?



Performance Measures

At what level does the local public health system…

7.1.1 Identify groups of people in the community who have trouble accessing or connecting to personal health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

7.1.2 Identify all personal health service needs and unmet needs throughout the community?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

7.1.3 Defines roles and responsibilities for partners to respond to the unmet needs of the community?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

7.1.4 Understand the reasons that people do not get the care they need?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 7.2: Assuring the Linkage of People to Personal Health Services

The local public health system (LPHS) partners work together to meet the diverse needs of all populations. Partners see that persons are signed up for all benefits available to them and know where to refer people with unmet personal health service needs. The LPHS develops working relationships between public health, primary care, oral health, social services, and mental health systems as well as organizations that are not traditionally part of the personal health service system, such as housing, transportation, and grassroots organizations.

Members of the LPHS work together to:

- Connect (or link) people to organizations that can provide the personal health services they may need.
- Help people access personal health services, in a way that takes into account the unique needs of different populations.
- Help people sign up for public benefits that are available to them (e.g. Medicaid or Medical and Prescription Assistance Programs).
- Coordinate the delivery of personal health and social services so that everyone has access to the care they need.

NOTES:

Model Standard 7.2 Discussion Questions

Involvement

- ✓ Who handles the coordination?
- ✓ What gaps exist in coordination of services among providers?

Quality and Comprehensiveness

- ✓ How does the LPHS link populations to needed personal health services?
- ✓ How does the LPHS assure the provision of services to populations who may encounter barriers to care?
- ✓ How does the LPHS provide assistance to vulnerable populations in accessing needed health services?
- ✓ What types of initiatives does the LPHS have to enroll eligible individuals in public benefit programs such as Medicaid and/or other medical or prescription assistance programs?

Utility

- ✓ How does the LPHS coordinate the delivery of personal health and social services to optimize access to services for populations who may encounter barriers to care?

Performance Measures

At what level does the local public health system…

7.2.1 Connect (or link) people to organizations that can provide the personal health services they may need?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

7.2.2 Help people access personal health services, in a way that takes into account the unique needs of different populations?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

7.2.3 Help people sign up for public benefits that are available to them (e.g. Medicaid or Medical and Prescription Assistance Programs)?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

7.2.4 Coordinate the delivery of personal health and social services so that everyone has access to the care they need?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 7.1: Identification of Personal Health Service Needs of Populations			
Model Standard 7.2: Assuring the Linkage of People to Personal Health Services			

LPHS Essential Service 8:

Assure a Competent Public Health and Personal Health Care Workforce

Do we have a competent public health staff?
How can we be sure that our staff stays current?

Ensuring a competent public and personal health care workforce encompasses the following:

- Education, training, and assessment of personnel (including volunteers and other lay community health workers) to meet community needs for public and personal health services.
- Efficient processes for licensure of professionals.
- Adoption of continuous quality improvement and lifelong learning programs.
- 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 gathered to discuss the performance of the local public health system in ensuring a competent public and personal healthcare workforce may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Colleges and universities
- ❑ Employers
- ❑ Managed care organizations
- ❑ Foundations
- ❑ Human resources departments
- ❑ Advocacy organizations

LPHS Model Standard 8.1: Workforce Assessment, Planning, and Development

The local public health system (LPHS) assesses the local public health workforce – all who contribute to providing essential public health services for the community. Workforce assessment looks at what knowledge, skills, and abilities the local public health workforce needs and the numbers and kinds of jobs the system should have to adequately prevent, protect and promote health in the community. The LPHS also looks at the training that the workforce needs to keep its knowledge, skills, and abilities up to date. After the workforce assessment determines the number and types of positions the local public health workforce should include, the LPHS identifies gaps and works on plans to fill the gaps.

Members of the LPHS work together to:

- Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector.
- Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce.
- 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.

NOTES:

Model Standard 8.1 Discussion Questions

Quality and Comprehensiveness

- ✓ What types of public health workforce assessments have been conducted within the community?
- ✓ Whether or not a formal assessment has been conducted, what types of shortfalls and/or gaps within the LPHS workforce been identified?
- ✓ How have the organizations within the LPHS implemented plans for correction?
- ✓ Is there a formal process to evaluate the effectiveness of plans to address workforce gaps?

Frequency

- ✓ Within the past three years, has an assessment of the LPHS workforce been conducted?

Utility

- ✓ How is this knowledge used to develop plans to address workforce gaps?
- ✓ How are results from formal or informal workforce assessments and/or gap analysis shared with LPHS organizations for use in strategic or operational plans?

Performance Measures

At what level does the local public health system…

8.1.1 Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.1.2 Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

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?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 8.2: Public Health Workforce Standards

The local public health system (LPHS) maintains standards to see that workforce members are qualified to do their jobs, with the certificates, licenses, and education that are required by law or in local, state, or federal guidance. Information about the knowledge, skills, and abilities that are needed to provide essential public health services are used in personnel systems, so that position descriptions, hiring, and performance evaluations of workers are based on public health competencies.

Members of the LPHS work together to:

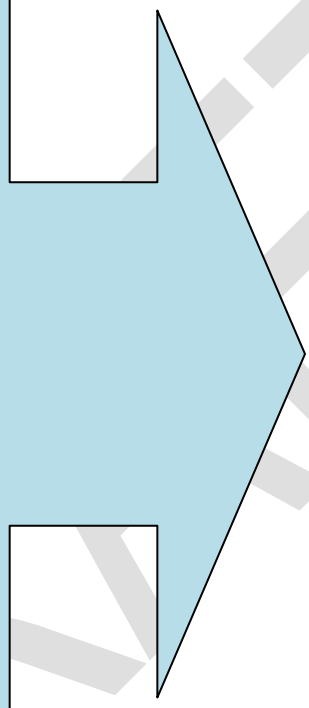
- Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law.
- Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services.
- Base the hiring and performance review of members of the public health workforce in public health competencies.

NOTES:

Model Standard 8.2 Discussion Questions

Quality and Comprehensiveness

- ✓ What types of guidelines and/or licensure/certification requirements are required for staff of the organizations within the LPHS who contribute to the Essential Public Health Services?
- ✓ How do organizations within the LPHS make sure they are in compliance with those guidelines and/or licensure/certification requirements?
- ✓ Do most or all organizations within the LPHS have written job standards and/or position descriptions for all personnel contributing to the Essential Public Health Services? Are these job standards tied to public health competencies?
- ✓ Do most or all organizations within the LPHS conduct annual performance evaluations?



Performance Measures

At what level does the local public health system…

8.2.1 Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.2.2 Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.2.3 Base the hiring and performance review of members of the public health workforce in public health competencies?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 8.3: Life-Long Learning through Continuing Education, Training, and Mentoring

The local public health system (LPHS) encourages lifelong learning for the public health workforce. Both formal and informal opportunities in education and training are available to the workforce, including workshops, seminars, conferences, and online learning. Experienced staff persons are available to coach and advise newer employees. Interested workforce members have the chance to work with academic and research institutions, particularly those connected with schools of public health, public administration, and population health. As the academic community and the local public health workforce collaborate, the LPHS is strengthened.

The LPHS trains its workforce to recognize and address the unique culture, language and health literacy of diverse consumers and communities and to respect all members of the public. The LPHS also educates its workforce about the many factors that can influence health, including interpersonal relationships, social surroundings, physical environment, and individual characteristics (such as economic status, genetics, behavioral risk factors, and health care).

Members of the LPHS work together to:

- Identify education and training needs and encourage the workforce to participate in available education and training.
- Provide ways for workers to develop core skills related to essential public health services.
- Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases.
- Create and support practice-academic collaborations between public health workforce members and faculty and students of research institutions.
- Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health.

NOTES:

Model Standard 8.3 Discussion Questions

Involvement

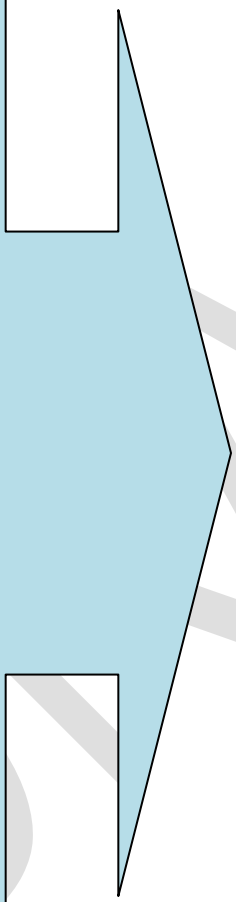
- ✓ What type of opportunities exist for interaction between staff of LPHS organizations and faculty from academic and research institutions, particularly those connected with schools of public health?

Quality and Comprehensiveness

- ✓ How does the LPHS identify education and training needs for workforce development? What types of workforce development are encouraged and/or provided?
- ✓ How are updates and refresher courses delivered within the LPHS for key public health issues (e.g., HIPAA, non-discrimination, and emergency preparedness)?
- ✓ How does the LPHS provide opportunities for all personnel to develop core public health competencies?
- ✓ How comprehensive are the training opportunities?
- ✓ What types of incentives are provided to the workforce to participate in educational and training experiences?

Utility

- ✓ Does the LPHS have dedicated resources, such as a budget and personnel to coordinate training, for training and education?



Performance Measures

At what level does the local public health system…

8.3.1 Identify education and training needs and encourage the workforce to participate in available education and training?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.3.2 Provide ways for workers to develop core skills related to essential public health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.3.3 Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.3.4 Create and support practice-academic collaborations between public health workforce members and faculty and students of research institutions?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.3.5 Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 8.4: Public Health Leadership Development

Leadership within the local public health system (LPHS) is demonstrated by organizations and individuals that are committed to improving the health of the community. Leaders work to continually develop the local public health system, create a shared vision of community health, find ways to make the vision happen, and to make sure that public health services are delivered. Leadership may come from the health department, from other governmental agencies, nonprofits, the private sector, or from several partners. The LPHS encourages the development of leaders that represent different groups of people in the community and respect community values.

Members of the LPHS work together to:

- Provide access to formal and informal leadership development opportunities for employees at all organizational levels.
- Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together.
- Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources.
- Provide opportunities for the development of leaders representative of the diversity within the community.

NOTES:

Model Standard 8.4 Discussion Questions

Awareness

- ✓ How do organizations within the LPHS promote the development of leadership skills?
- ✓ Have leaders within the LPHS and community collaborated to create a shared vision for the community?
- ✓ How have leaders within the LPHS and community collaborated for participatory decision making?

Involvement

- ✓ How does the LPHS recruit and retain new leaders who are representative of the population diversity within their community?

Quality and Comprehensiveness

- ✓ How do organizations across the LPHS communicate to ensure informed participation in decision making? (e.g., forums, list serve)?
- ✓ How does the LPHS provide leadership opportunities for individuals and/or organizations in areas where their expertise or experience can provide insight, direction, or resources?

Utility

- ✓ How are coaching and mentoring used within the LPHS to develop community leadership?

Performance Measures

At what level does the local public health system…

8.4.1 Provide access to formal and informal leadership development opportunities for employees at all organizational levels?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.4.2 Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.4.3 Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

8.4.4 Provide opportunities for the development of leaders representative of the diversity within the community?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 8.1: Workforce Assessment, Planning, and Development			
Model Standard 8.2: Public Health Workforce Standards			
Model Standard 8.3: Life-Long Learning through Continuing Education, Training, and Mentoring			
Model Standard 8.4: Public Health Leadership Development			

LPHS Essential Service 9:

Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-based Health Services

Are we doing any good?
Are we doing things right?
Are we doing the right things?

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

- Assessing program effectiveness.
- Providing information necessary for allocating resources and reshaping programs.

Partners gathered to discuss the performance of the local public health system in evaluating effectiveness, accessibility, and quality of personal and population-based health services may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Service providers
- ❑ Service recipients
- ❑ Managed care organizations
- ❑ Non-profit organizations/advocacy groups
- ❑ Consultants

LPHS Model Standard 9.1: Evaluation of Population-Based Health Services

The local public health system (LPHS) evaluates population-based health services, which are aimed at disease prevention and health promotion for the entire community. Many different types of population-based health services are evaluated for their quality and effectiveness in targeting underlying risks. The LPHS uses nationally recognized resources to set goals for their work and identify best practices for specific types of preventive services (e.g. Healthy People 2020 or the Guide to Community Preventive Services). The LPHS uses data to evaluate whether population-based services are meeting the needs of the community and the satisfaction of those they are serving. Based on the evaluation, the LPHS may make changes and may reallocate resources to improve population-based health services.

Members of the LPHS work together to:

- Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved.
- Assess whether community members, including those with a higher risk of having a health problem, are receiving services and are satisfied with the approaches to preventing disease, illness, and injury.
- Identify gaps in the provision of population-based health services.
- Use evaluation findings to improve plans and services.

NOTES:

Model Standard 9.1 Discussion Questions

Quality and Comprehensiveness

- ✓ How does the LPHS evaluate population-based health services?
- ✓ What are the defined criteria for evaluation?
- ✓ How does the LPHS determine community satisfaction with population-based health services?

Frequency

- ✓ How often are each of the services evaluated?

Utility

- ✓ How are the results of population-based health services evaluation used by LPHS organization in the development of strategic and operational plans?
- ✓ How does the LPHS identify gaps in where population-based health services are provided?
- ✓ Do evaluations look at the extent to which program goals are achieved for population-based health services?
- ✓

Performance Measures

At what level does the local public health system…

9.1.1 Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.1.2 Assess whether community members, including those with a higher risk of having a health problem, are receiving services and are satisfied with the approaches to preventing disease, illness, and injury?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.1.3 Identify gaps in the provision of population-based health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.1.4 Use evaluation findings to improve plans and services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Model Standard 9.2: Evaluation of Personal Health Services

The local public health system (LPHS) regularly evaluates the accessibility, quality, and effectiveness of personal health services. These services range from preventive care, such as mammograms or other preventive screenings or tests, to hospital care to care at the end of life. The LPHS sees that the personal health services in the area match the needs of the community, with available and effective care for all ages and groups of people. The LPHS works with communities to measure satisfaction with personal health services through multiple methods, including a survey that includes people who have received care and others who might have needed care or who may need care in the future. The LPHS uses findings from the evaluation to improve services and program delivery, using technological solutions such as electronic health records when indicated, and modifying organizational strategic plans as needed.

Members of the LPHS work together to:

- Evaluate the accessibility, quality, and effectiveness of personal health services.
- Compare the quality of personal health services to established guidelines.
- Measure satisfaction with personal health services.
- Use technology, like the internet or electronic health records, to improve quality of care or communication among health care providers.
- Use evaluation findings to improve services and program delivery, and modify strategic plans as needed.

NOTES:

Model Standard 9.2 Discussion Questions

Awareness

- ✓ How have organizations within the LPHS evaluated personal health services for the community? What has been evaluated in the past?

Quality and Comprehensiveness

- ✓ Which personal health services in the community are evaluated against established standards (e.g., JCAHO, State licensure, HEDIS)?
- ✓ How is client satisfaction with personal health services determined? Do the clients who provide input represent past, current and potential users of services?

Frequency

- ✓ How often are access, quality and effectiveness of personal health service evaluated?

Utility

- ✓ How is information technology used by the LPHS to assure quality of personal health services?
- ✓ How is information technology used to facilitate communication among providers (e.g., Health Information Exchange or Regional Health Information Organizations) and improve quality of care?
- ✓ How are the results of the evaluation used by organizations in the LPHS in the development of strategic and operational plans?

Performance Measures

At what level does the local public health system…

9.2.1 Evaluate the accessibility, quality, and effectiveness of personal health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.2.2 Compare the quality of personal health services to established guidelines?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.2.3 Measure satisfaction with personal health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.2.4 Use technology, like the internet or electronic health records, to improve quality of care or communication among health care providers?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.2.5 Use evaluation findings to improve services and program delivery, and modify strategic plans as needed?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 9.3: Evaluation of the Local Public Health System

The local public health system (LPHS) evaluates itself to see how well it is working as a whole. Representatives from all groups (public, private, and voluntary) that provide essential public health services gather to conduct a systems evaluation. Together, using guidelines (such as this tool) that describe a model LPHS, participants evaluate LPHS activities and identify areas of the LPHS that need improvement. The results of the evaluation are also used during a community health improvement process.

Members of the LPHS work together to:

- Identify all public, private, and voluntary organizations that provide essential public health services.
- 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 essential public health services.
- Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services.
- Use results from the evaluation process to improve the LPHS.

NOTES:

Model Standard 9.3 Discussion Questions

Awareness

- ✓ Have all the community organizations or entities that contribute to the delivery of the Essential Public Health Services been identified as part of the LPHS within the community?

Quality and Comprehensiveness

- ✓ Has a partnership assessment been conducted that evaluates the relationships among organizations that comprise the LPHS?
- ✓ How is the exchange of information among the organizations in the LPHS assessed?
- ✓ How are linkage mechanisms among the providers of population-based services and personal health services assessed (e.g., referral systems, memoranda of understanding)?

Frequency

- ✓ Is a comprehensive evaluation of the LPHS (like the NPHPSP) conducted every three to five years?

Utility

- ✓ How is the use of resources (e.g., staff, communication systems) to support the coordination among LPHS organizations assessed?
- ✓ How does the LPHS use results from the evaluation process to guide community health improvements?

Performance Measures

At what level does the local public health system…

9.3.1 Identify all public, private, and voluntary organizations that provide essential public health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

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 essential public health services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.3.3 Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

9.3.4 Use results from the evaluation process to improve the LPHS?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 9.1: Evaluation of Population-Based Health Services			
Model Standard 9.2: Evaluation of Personal Health Services			
Model Standard 9.3: Evaluation of the Local Public Health System			

LPHS Essential Service 10:

Research for New Insights and Innovative Solutions to Health Problems

Are we discovering and using new ways to get the job done?

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

- Full continuum of innovation, ranging from practical field-based efforts to fostering change in public health practice to more academic efforts to encourage new directions in scientific research.
- Continuous linkage with institutions of higher learning and research.
- Internal capacity to mount timely epidemiologic and economic analyses and conduct health services research.

Partners gathered to discuss the performance of the local public health system in researching for new insights and innovative solutions to health problems may include:

- ❑ The local health department or other governmental public health agency
- ❑ The local board of health or other local governing entity
- ❑ Hospitals
- ❑ Colleges and universities
- ❑ Employers
- ❑ Managed care organizations
- ❑ Foundations
- ❑ Human resources departments
- ❑ Advocacy organizations

LPHS Model Standard 10.1: Fostering Innovation

Local public health system (LPHS) organizations try new and creative ways to improve public health practice. In both academic and practice settings, such as universities and local health departments, new approaches are studied to see how well they work.

Members of the LPHS work together to:

- 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.
- Suggest ideas about what currently needs to be studied in public health to organizations that do research.
- Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health.
- Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results.

NOTES:

Model Standard 10.1 Discussion Questions

Quality and Comprehensiveness

- ✓ How do LPHS organizations encourage staff to develop new solutions to health problems in the community?
- ✓ How do LPHS organizations provide time and/or resources for staff to pilot test or conduct studies to determine new solutions?
- ✓ How do LPHS organizations identify and stay current with best practices?

Frequency

- ✓ During the past two years, have LPHS organizations proposed one or more public health issues for inclusion in a research organizations agenda?

Utility

- ✓ How do LPHS organizations encourage community participation in the development or implementation of research?

Performance Measures

At what level does the local public health system…

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?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

10.1.2 Suggest ideas about what currently needs to be studied in public health to organizations that do research?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

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?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

10.1.4 Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 10.2: Linkage with Institutions of Higher Learning and/or Research

The local public health system (LPHS) establishes relationships with colleges, universities, and other research organizations. The LPHS is strengthened by ongoing communication between academics and LPHS organizations. They freely share information and best practices, and setting up formal or informal arrangements to work together. The LPHS connects with other research organizations, such as federal and state agencies, associations, private research organizations, and research departments or divisions of business firms. The LPHS does community-based participatory research, including the community as full partners from selection of the topic of study to design to sharing of findings. The LPHS works with one or more colleges, universities, or other research organizations to co-sponsor continuing education programs.

Members of the LPHS work together to:

- Develop relationships with colleges, universities, or other research organizations to create formal and informal arrangements to work together.
- Partner with colleges, universities, or other research organizations to do public health research, including community-based participatory research.
- Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education.

NOTES:

Model Standard 10.2 Discussion Questions

Awareness

- ✓ Do any of your organizations or others within the LPHS have relationships with institutions of higher learning and/or research organizations?

Quality and Comprehensiveness

- ✓ Do any LPHS organization partner with at least one institution of higher learning and/or research organization to conduct research related to the public health? What are the results of these efforts, if any?
- ✓ How does the LPHS encourage collaboration between the academic and practice communities?

Performance Measures

At what level does the local public health system…

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?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

10.2.2 Partner with colleges, universities, or other research organizations to do public health research, including community-based participatory research?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

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?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

LPHS Model Standard 10.3: Capacity to Initiate or Participate in Research

The local public health system (LPHS) takes part in research to help improve the performance of the LPHS. This research includes the examination of how well LPHS members provide the Essential Public Health Services in the community (public health systems and services research) as well as studying what influences health care quality and service delivery in the community (health services research). The LPHS has access to researchers with the knowledge and skills to design and conduct health-related studies, supports their work with funding and data systems, and provides ways to share findings. Research capacity includes access to libraries and information technology, the ability to analyze complex data, and ways to share research findings with the community and use them to improve public health practice.

Members of the LPHS work together to:

- Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies.
- Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources.
- Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc.
- Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice.

NOTES:

Model Standard 10.3 Discussion Questions

Awareness

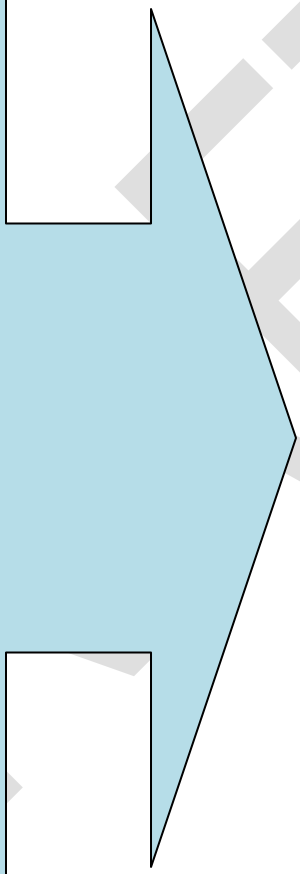
- ✓ Does the LPHS have access to researchers (either on staff or through other organizations)?

Quality and Comprehensiveness

- ✓ What type of research expertise and/or experience is available to the LPHS?
- ✓ What types of resources are available within the LPHS to facilitate research?
- ✓ How does the LPHS evaluate its research activities?

Utility

- ✓ How does the LPHS share findings from their research?



Performance Measures

At what level does the local public health system…

10.3.1 Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

10.3.2 Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

10.3.3 Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

10.3.4 Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice?

- ❑ No Activity
- ❑ Minimal
- ❑ Moderate
- ❑ Significant
- ❑ Optimal

Summary Notes

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

Strengths	Weaknesses	Opportunities for Immediate Improvements/ Partnerships	Priorities or Longer Term Improvement Opportunities
Model Standard 10.1: Fostering Innovation			
Model Standard 10.2: Linkage with Institutions of Higher Learning and/or Research			
Model Standard 10.3: Capacity to Initiate or Participate in Research			

National Public Health Performance Standards Program
Local Public Health System Assessment Priority of Model Standards Questionnaire

OVERVIEW: This questionnaire is made available so that sites may consider the priority of each model standard to their system. Sites choosing to complete this supplemental questionnaire will receive an additional component to their reports which will depict their performance scores in relation to how they have prioritized model standards. This information may serve to catalyze or strengthen the performance improvement activities resulting from the assessment process.

INSTRUCTIONS: Using a scale of 1 to 10 (with 1 being the lowest and 10 being the highest), please rate the priority of each model standard without regard to performance scores or rank order. In considering this questionnaire, the following questions may be helpful for participants. Example A: "On a scale of 1 to 10, what is the priority of this model standard to our public health system?" Example B: "On a scale of 1 to 10, how important is it to improve our performance in this activity (e.g., through a quality improvement process, increased emphasis or resources)?" Sites may complete this questionnaire in a single group, either at the same time of the assessment or shortly thereafter, so that there is a consistent approach to responding to the questions across the model standards.

Model Standard Number	Question	Response *(please circle)*
Essential Service #1 - Monitor health status to identify health problems		
P1.1	On a scale of 1 to 10, what is the priority of this model standard - Population-based Community Health Profile - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P1.2	On a scale of 1 to 10, what is the priority of this model standard - Current Technology to Manage and Communicate Population Health Data - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P1.3	On a scale of 1 to 10, what is the priority of this model standard - Maintenance of Population Health Registries - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #2 - Diagnose and investigate health problems and health hazards		
P2.1	On a scale of 1 to 10, what is the priority of this model standard - Identification and Surveillance of Health Threats - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P2.2	On a scale of 1 to 10, what is the priority of this model standard - Investigation and Response to Public Health Threats and Emergencies - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P2.3	On a scale of 1 to 10, what is the priority of this model standard - Laboratory Support for Investigation of Health Threats - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #3 - Inform, educate and empower people about health issues		
P3.1	On a scale of 1 to 10, what is the priority of this model standard - Health Education and Promotion - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P3.2	On a scale of 1 to 10, what is the priority of this model standard - Health Communication - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P3.3	On a scale of 1 to 10, what is the priority of this model standard - Risk Communication - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #4 - Mobilize community partnerships to identify and solve health problems		
P4.1	On a scale of 1 to 10, what is the priority of this model standard - Constituency Development - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P4.2	On a scale of 1 to 10, what is the priority of this model standard - Community Partnerships - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #5 - Develop policies and plans that support individual and community health efforts		
P5.1	On a scale of 1 to 10, what is the priority of this model standard - Governmental Presence at the Local Level - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P5.2	On a scale of 1 to 10, what is the priority of this model standard - Public Health Policy Development - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P5.3	On a scale of 1 to 10, what is the priority of this model standard - Community Health Improvement Process and Strategic Planning - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P5.4	On a scale of 1 to 10, what is the priority of this model standard - Plan for Public Health Emergencies - to our local public health system?	1 2 3 4 5 6 7 8 9 10

Model Standard Number	Question	Response *(please circle)*
Essential Service #6 - Enforce laws and regulations that protect health and ensure safety		
P6.1	On a scale of 1 to 10, what is the priority of this model standard - Review and Evaluation of Laws, Regulations and Ordinances - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P6.2	On a scale of 1 to 10, what is the priority of this model standard - Involvement in the Improvement of Laws, Regulations, and Ordinances - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P6.3	On a scale of 1 to 10, what is the priority of this model standard - Enforcement of Laws, Regulations, and Ordinances - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #7 - Link people to needed personal health services and assure the provision of health care when otherwise unavailable		
P7.1	On a scale of 1 to 10, what is the priority of this model standard - Identification of Personal Health Service Needs of Populations - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P7.2	On a scale of 1 to 10, what is the priority of this model standard - Linkage of People to Personal Health Services - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #8 - Assure a competent public health and personal health care workforce		
P8.1	On a scale of 1 to 10, what is the priority of this model standard - Workforce Assessment, Planning and Development - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P8.2	On a scale of 1 to 10, what is the priority of this model standard - Public Health Workforce Standards - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P8.3	On a scale of 1 to 10, what is the priority of this model standard - Life-Long Learning through Continuing Education, Training and Mentoring - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P8.4	On a scale of 1 to 10, what is the priority of this model standard - Public Health Leadership Development - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #9 - Evaluate effectiveness, accessibility, and quality of personal and population-based health services		
P9.1	On a scale of 1 to 10, what is the priority of this model standard - Evaluation of Population-based Health Services - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P9.2	On a scale of 1 to 10, what is the priority of this model standard - Evaluation of Personal Health Services - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P9.3	On a scale of 1 to 10, what is the priority of this model standard - Evaluation of the Local Public Health System - to our local public health system?	1 2 3 4 5 6 7 8 9 10
Essential Service #10 - Research for new insights and innovative solutions to health problems		
P10.1	On a scale of 1 to 10, what is the priority of this model standard - Fostering Innovation - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P10.2	On a scale of 1 to 10, what is the priority of this model standard - Linkage with Institutions of Higher Learning and/or Research - to our local public health system?	1 2 3 4 5 6 7 8 9 10
P10.3	On a scale of 1 to 10, what is the priority of this model standard - Capacity to Initiate or Participate in Research - to our local public health system?	1 2 3 4 5 6 7 8 9 10

National Public Health Performance Standards Program
Local Public Health System Assessment Agency Contribution Questionnaire

OVERVIEW: This optional questionnaire is made available so that sites may consider the contribution that the local health department has to each model standard. This information may serve to catalyze or strengthen the performance improvement activities resulting from the assessment process.

INSTRUCTIONS: Using a similar scale used to assess the model standards in the assessment, use the following scale:

0 – for no contribution to the model standard

25 – for agency contribution of 0-25%

50 – for agency contribution of 26-50%

75 – for agency contribution of 51-75%

100 – for agency contribution of 76-100%

Sites may complete this questionnaire in a single group, either at the same time of the assessment or shortly thereafter, so that there is a consistent approach to responding to the questions across the model standards.

National Public Health Performance Standards Program
Local Public Health System Assessment
Supplemental Questionnaire - Agency Contribution

Please use this questionnaire to indicate the contribution of the local health department to each model standard. The responses to this questionnaire can be developed at the same time of the assessment or shortly thereafter.

Indicator Number	Question	Response
Essential Service #1 - Monitor health status to identify health problems		
A1.1	How much of this model standard - Population-based Community Health Profile - is achieved through the direct contribution of the local health department?	
A1.2	How much of this model standard - Current Technology to Manage and Communicate Population Health Data - is achieved through the direct contribution of the local health department?	
A1.3	How much of this model standard - Maintenance of Population Health Registries - is achieved through the direct contribution of the local health department?	
Essential Service #2 - Diagnose and investigate health problems and health hazards		
A2.1	How much of this model standard - Identification and Surveillance of Health Threats - is achieved through the direct contribution of the local health department?	
A2.2	How much of this model standard - Investigation and Response to Public Health Threats and Emergencies - is achieved through the direct contribution of the local health department?	
A2.3	How much of this model standard - Laboratory Support for Investigation of Health Threats - is achieved through the direct contribution of the local health department?	
Essential Service #3 - Inform, educate and empower people about health issues		
A3.1	How much of this model standard - Health Education and Promotion - is achieved through the direct contribution of the local health department?	
A3.2	How much of this model standard - Health Communication - is achieved through the direct contribution of the local health department?	
A3.3	How much of this model standard - Risk Communication - is achieved through the direct contribution of the local health department?	
Essential Service #4 - Mobilize community partnerships to identify and solve health problems		
A4.1	How much of this model standard - Constituency Development - is achieved through the direct contribution of the local health department?	
A4.2	How much of this model standard - Community Partnerships - is achieved through the direct contribution of the local health department?	
Essential Service #5 - Develop policies and plans that support individual and community health efforts		
A5.1	How much of this model standard - Governmental Presence at the Local Level - is achieved through the direct contribution of the local health department?	
A5.2	How much of this model standard - Public Health Policy Development - is achieved through the direct contribution of the local health department?	
A5.3	How much of this model standard - Community Health Improvement Process and Strategic Planning - is achieved through the direct contribution of the local health department?	
P5.4	How much of this model standard - Plan for Public Health Emergencies - is achieved through the direct contribution of the local health department?	
Indicator Number	**Question**	**Response**
Essential Service #6 - Enforce laws and regulations that protect health and ensure safety		
A6.1	How much of this model standard - Review and Evaluation of Laws, Regulations and Ordinances - is achieved through the direct contribution of the local health department?	

A6.2	How much of this model standard - Involvement in the Improvement of Laws, Regulations, and Ordinances - is achieved through the direct contribution of the local health department?	
A6.3	How much of this model standard - Enforcement of Laws, Regulations, and Ordinances - is achieved through the direct contribution of the local health department?	
Essential Service #7 - Link people to needed personal health services and assure the provision of health care when otherwise unavailable		
A7.1	How much of this model standard - Identification of Personal Health Service Needs of Populations - is achieved through the direct contribution of the local health department?	
A7.2	How much of this model standard - Linkage of People to Personal Health Services - is achieved through the direct contribution of the local health department?	
Essential Service #8 - Assure a competent public health and personal health care workforce		
A8.1	How much of this model standard - Workforce Assessment, Planning and Development - is achieved through the direct contribution of the local health department?	
A8.2	How much of this model standard - Public Health Workforce Standards - is achieved through the direct contribution of the local health department?	
A8.3	How much of this model standard - Life-Long Learning through Continuing Education, Training and Mentoring - is achieved through the direct contribution of the local health department?	
A8.4	How much of this model standard - Public Health Leadership Development - is achieved through the direct contribution of the local health department?	
Essential Service #9 - Evaluate effectiveness, accessibility, and quality of personal and population-based health services		
A9.1	How much of this model standard - Evaluation of Population-based Health Services - is achieved through the direct contribution of the local health department?	
A9.2	How much of this model standard - Evaluation of Personal Health Services - is achieved through the direct contribution of the local health department?	
A9.3	How much of this model standard - Evaluation of the Local Public Health System - is achieved through the direct contribution of the local health department?	
Essential Service #10 - Research for new insights and innovative solutions to health problems		
A10.1	How much of this model standard - Fostering Innovation - is achieved through the direct contribution of the local health department?	
A10.2	How much of this model standard - Linkage with Institutions of Higher Learning and/or Research - is achieved through the direct contribution of the local health department?	
A10.3	How much of this model standard - Capacity to Initiate or Participate in Research - is achieved through the direct contribution of the local health department?	

SHDHD NPHPSP Assessment Participants 11.21.11

	ES1: Health Status	ES2: Epi/Response	ES3: Education	ES4: Partnerships	ES5: Policies/Plan
	(Colleen/ Vicki)	(Greg/Amy)	(Lori/Lynette)	(June/Kim)	(Jeff/Allison)
1	Auten, Shelley	Bower, Pam	Armstrong, Justin	Beck, Cindi	Allgood, Jill
9	Duntz, Merrill	Brailita, Dr. Dan	Burmeister, Michie	Benten, Fr. James	Bever, Michele
2	Field, Kori	Dericks, Diane	Davis, Pam	Breinig, Carrie	Cox, Sally
5	Frei, Barb	Ehly, Ronda	Hamik, Carol	Budnick, Joseph	Delka, Mary
7	Henrie, Susan	Griffin, Dr. Dee	Horst, Celest	Christensen, Eric	Eddy, Steve
6	Honley, Elizabeth	Kemnitz, Marcie	Johnson, Janis	Cloet, Wanda	Harris, Michell
3	Kennedy, Candy	Korte, Chad	Keele, Wendy	Danehey, Susan	Kleeb, Jane
10	Loettrle, Jon	Mangus, Mindy	Kohmetscher, Michelle	Fox, Tabitha	Krings, Michael
4	Nore, Jaci	Morgan, Jim	Perez, Jorge	Hackler, Jinx	Melvin, Jill
8	Panec, Bill	Nelson, Marsha	Rinne, Desiree	Junker, Belva	Neet, Brad
11	Sidley, Renee	Pughes, Ron?	Rose, Bob	Junker, Chris	Neumann, Dr. Chuck
12	Strasheim, Cindy	Salyards, Dr. Phyllis	Sandeen, Judy	Lewis, Jennifer	Samuelson, Eric
13	Sullivan, Anita	Smith, Shelley	Sedlacek, Colleen	Meyer, Peggy	Schneider, Jeff
14		Steele, Gary	Segelke, Jolynn	Staehr, Janet	Stemper, Scott
15		Volcek, Chip	Stichka, Jean	Stevens, Sandi	Thoren, Chief Larry
16			Sullivan, Becky	Vrooman, Kris	Uden, Loren
17			Tinkham, Karen	Watson, Verlene	Zajack, Mark
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SHDHD NPHPSP Assessment Participants 11.21.11

	ES6: Enforce Laws/Regs	ES7: Link to Services	ES8: Competent Workforce	ES9: Evaluate	ES10: Research/Innovate
	(Jeff/Amy)	(Colleen/Erin)	(Lori/Kim)	(June/Allison)	(Greg/Lynnette)
1	Allgood, Jill	Auten, Shelley	Davis, Pam	Burmeister, Michie	Bever, Michele
2	Armstrong, Justin	Beck, Cindi	Duntz, Merrill	Christensen, Eric	Brailita, Dr. Dan
3	Bower, Pam	Benten, Fr. James	Frei, Barb	Ehly, Ronda	Griffin, Dr. Dee
4	Dericks, Diane	Breinig, Carrie	Harris, Michell	Field, Kori	Neet, Brad
5	Eddy, Steve	Budnick, Joseph	Henrie, Susan	Fox, Tabitha	Nore, Jaci
6	Kleeb, Jane	Cox, Sally	Johnson, Janis	Junker, Chris	Reimer, Judy
7	Kohmetscher, Michelle	Danehey, Susan	Kemnitz, Marcie	Lewis Jennifer	Richardson, Dr. Charles
8	Krings, Michael	Delka, Mary	Korte, Chad	Loettrle, Jon	Stitchka, Jean
9	Morgan, Jim	Hackler, Jinx	Mangus, Mindy	Meyer, Peggy	Strasheim, Cindi
10	Neumann, Dr. Chuck	Hamik, Carol	Pughes, Ron	Rinne, Desiree	
11	Panec, Bill	Honley, Elizabeth	Sidley, Renee	Sedlacek, Colleen	
12	Rose, Bob	Horst, Celest	Steele, Gary	Segelke, Jolynn	
13	Samuelson, Eric	Junker, Belva	Sullivan, Anita	Stemper, Scott	
14	Smith, Shelley	Kennedy, Candy	Uden, Loren	Stevens, Sandi	
15	Sprague, Barb	Nelson, Marsha	Zajack, Mark	Sullivan, Becky	
16	Thoren, Chief Larry	Perez, Jorge		Tinkham, Karen	
17	Trausch, Angie	Sandeen, Judy		Vrooman, Kris	
18	Volcek, Chip	Staehr, Janet			
19		Watson, Verlene			
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SHDHD NPHPSP Assessment Participants 11.21.11

	ES1: Health Status	
	(Colleen/ Vicki)	Organization
1	Auten, Shelley	Head Start Child & Family Development
2	Duntz, Merrill	Key Accounts Mgr, South Central Nebraska Public Power District; SHDHD Board of Health
3	Field, Kori	D.O.N., Brodstone Memorial Hospital
4	Frei, Barb	Director, Hastings Family Planning
5	Henrie, Susan	South Central Behavioral Services
6	Honley, Elizabeth	Good Samaritan Society - Hastings
7	Kennedy, Candy	Federation of Families
8	Loettrle, Jon	Counseling Services, Hastings College
9	Nore, Jaci	Morrison Cancer Center (Mary Lanning Memorial HealthCare)
10	Panec, Bill	Food Sanitarian (NE Dept of Ag) - Adams, Nuckolls Counties
11	Sidley, Renee	Mary Lanning Memorial HealthCare – VP Patient Strategy
12	Strasheim, Cindy	UNL Extension – Clay County
13	Sullivan, Anita	South Heartland District Health Department – Health Surveillance Coord; VFC Coordinator

	ES2: Link to Services	
	(Greg/Amy)	Organization
1	Bower, Pam	Infection Control - Brodstone Memorial Hospital
2	Brailita, Dr. Dan (MD)	Central Nebraska Infectious Disease (Mary Lanning Memorial HealthCare)
3	Dericks, Diane	Good Samaritan Village-Hastings (Home Health)
4	Ehly, Ronda	Mary Lanning Memorial HealthCare
5	Griffin, Dee (DVM)	Feedlot Production Mgr (USDA-MARC); Professor, Univ of NE Great Plains Vet Ed Center; LEDRS
6	Kemnitz, Dr. Marcie	Associate Dean of Allied Health, Central Community College
7	Korte, Chad	Rural Metro Ambulance Service
8	Mangus, Mindy?	American Red Cross
9	Morgan, Jim	Public Health Risk Coordinator, SHDHD
10	Nelson, Marsha	School Nurse, Hastings Public Schools
11	Pughes, Ron?	Central Nebraska Medical Reserve Corps Coordinator
12	Salyards, Dr. Phyllis (MD)	Retired family physician; SHDHD Board of Health (Board Physician)
13	Smith, Shelley	Public Health Nurse, SHDHD
14	Steele, Gary?	DHHS - EMS Education
15	Volcek, Chip	Adams County Emergency Management

	ES3: Education	
	(Lori/Lynnette)	Organization
1	Armstrong, Justin	Webster Co. Commissioner; SHDHD Board of Health
2	Burmeister, Michie	K-9 and Friends
3	Davis, Pam	School-Community Liaison, Hastings Public Schools
4	Hamik, Carol	Nurse, MLMH; SAFE Kids South Central; VFC Vaccinator
5	Horst, Celest	Hastings Family Planning
6	Johnson, Janis	Director, Clay County Health Department
7	Keele, Wendy	CASA Advocate
8	Kohmetscher, Michelle	Area Substance & Alcohol Prevention (ASAAP)
9	Perez, Jorge	Minority Health Coordinator, SHDHD
10	Rinne, Desiree	Health Educator, SHDHD
11	Rose, Bob	SHDHD Board of Health; Edgar Emergency Management
12	Sandeen, Judy	SHDHD VFC Nurse; Retired Director of Health Services at Hastings College
13	Sedlacek, Colleen	Director, Adams County Senior Services
14	Segelke, Jolynn	SASA
15	Stichka, Jean	UNL Extension - Nuckolls County
16	Sullivan, Becky	Mary Lanning Memorial HealthCare - Business Health
17	Tinkham, Karen	Brodstone Memorial Hospital – Public Relations Director

	ES4: Partnerships	
	(June/Kim)	Organization
1	Beck, Cindi	Midlands Area Agency on Aging
2	Benten, Fr. James	St. Joseph Catholic Church, Harvard, NE
3	Breinig, Carrie	Clay County Senior Services - Transportation
4	Budnick, Joseph	District 10 Probation
5	Christensen, Eric	City of Hastings Parks and Recreation
6	Cloet, Wanda	Dental Hygiene Program Director, Central Community College-Hastings
7	Danehey, Susan	Healthy Beginnings
8	Fox, Tabitha	United Way
9	Hackler, Jinx	Respite Care
10	Junker, Belva	Nebraska Vocational Rehab
11	Junker, Chris	HIV/AIDS Prevention Coordinator Nebraska Department of Education; ASAAP Board
12	Lewis, Jennifer	Director, Hastings YWCA
13	Meyer, Peggy	SHDHD Board of Health (Pres); Positive Solutions (LICSW, MSW)
14	Staehr, Janet	Public Health Nurse, SHDHD
15	Stevens, Sandi	Community Health Education Coordinator, SHDHD
16	Vrooman, Kris	Energy Pioneer Solutions; Health Hastings Coalition
17	Watson, Verlene	Brodstone Memorial Hospital (Republican Valley SAFE Kids; Good Beginnings)

	ES5: Policies/Plan	
	(Jeff/Allison)	Organization
1	Allgood, Jill	Superior Police Department
2	Bever, Michele	Executive Director, SHDHD
3	Cox, Sally	South Central Behavioral Services
4	Delka, Mary	Director, Webster County Senior Services
5	Eddy, Steve	National Weather Service, Hastings; Adams County LEPC (Pres)
6	Harris, Michell	Brodstone Memorial Hospital (Wound Ostomy Continence Nurse)
7	Kleeb, Jane	School Board, Hastings Public Schools; BOLD Nebraska
8	Krings, Michael	Hastings City Council; YMCA (Director)
9	Melvin, Jill	Five Points Bank
10	Neet, Brad	Mary Lanning Memorial HealthCare (CEO); SHDHD Board of Health
11	Neumann, Chuck (DVM)	Adams County Supervisor; SHDHD Board of Health (VP)
12	Samuelson, Eric?	Clay County Supervisor; SHDHD Board of Health
13	Schneider, Jeff	Hastings Public Schools – Director of Business
14	Stemper, Scott	Area Substance and Alcohol Prevention (Director)
15	Thoren, Chief Larry?	Hastings Police Department
16	Uden, Loren	Clay County Emergency Management
17	Zajack, Mark	Hastings College, Asst Professor of Psychology

	ES6: Enforce Laws/Regs	
	(Jeff/Amy)	Organization
1	Allgood, Jill	Superior Police Department
2	Armstrong, Justin	Webster County Commissioner; SHDHD BOH
3	Bower, Pam	Brodstone Memorial Hospital –Infection Control
4	Dericks, Diane	Good Samaritan Village – Hastings (Home Health)
5	Eddy, Steve	National Weather Service, Hastings; Adams County LEPC (Pres)
6	Kleeb, Jane	School Board, Hastings Public Schools; BOLD Nebraska
7	Kohmetscher, Michelle?	Area Substance and Alcohol Abuse Prevention
8	Krings, Michael	Hastings City Council; YMCA (Director)
9	Morgan, Jim	Public Health Risk Coordinator - SHDHD
10	Neumann, Chuck (DVM)	Adams County Supervisor; SHDHD Board of Health (VP)
11	Panec, Bill?	Food Sanitarian (NE Dept of Ag) - Adams, Nuckolls Counties
12	Rose, Bob	SHDHD Board of Health; Edgar Emergency Management
13	Samuelson, Eric?	Clay County Supervisor; SHDHD Board of Health
14	Smith, Shelley	Public Health Nurse, SHDHD
15	Sprague, Barb	Red Cloud City Council; SHDHD Board of Health
16	Thoren, Chief Larry?	Hastings Police Department
17	Trausch, Angie	Five Points Bank
18	Volcek, Chip	Adams County Emergency Management

SHDHD NPHPSP Assessment Participants 11.21.11

	ES7: Link to Services	
	(Colleen/Erin)	Organization
1	Auten, Shelley	Head Start Child and Family Development
2	Beck, Cindi	Midland Area Agency on Aging
3	Benten, Fr. James	St. Joseph Catholic Church, Harvard, NE
4	Breinig, Carrie	Clay County Senior Services - Transportation
5	Budnick, Joseph	District 10 Probation
6	Cox, Sally	South Central Behavioral Services
7	Danehey, Susan	Healthy Beginnings
8	Delka, Mary	Webster County Senior Services
9	Hackler, Jinx	Respite Care
10	Hamik, Carol	Nurse, MLMH; SAFE Kids South Central; VFC Vaccinator
11	Honley, Elizabeth	Good Samaritan Society - Hastings
12	Horst, Celest	Hastings Family Planning
13	Junker, Belva	Nebraska Vocational Rehab
14	Kennedy, Candy	Federation of Families
15	Nelson, Marsha	School Nurse – Hastings Public Schools
16	Perez, Jorge	Minority Health Coordinator - SHDHD
17	Sandeen, Judy	SHDHD VFC Nurse; Retired Director of Health Services at Hastings College
18	Staehr, Janet	Public Health Nurse, SHDHD
19	Watson, Verlene	Brodstone Memorial Hospital (Republican Valley SAFE Kids; Good Beginnings)

	ES8: Competent Workforce	
	(Lori/Kim)	Organization
1	Davis, Pam	Head Start Child and Family Development
2	Duntz, Merrill	Key Accounts Mgr, South Central Nebraska Public Power District; SHDHD Board of Health
3	Frei, Barb	Director, Hastings Family Planning
4	Harris, Michell	Brodstone Memorial Hospital (Wound Ostomy Continence Nurse)
5	Henrie, Susan	South Central Behavioral Services
6	Johnson, Janis	Clay County Health Department (Director)
7	Kemnitz, Marcie	Associate Dean of Allied Health, Central Community College
8	Korte, Chad	Rural Metro Ambulance Service
9	Mangus, Mindy?	American Red Cross
10	Pughes, Ron	Central Nebraska Medical Reserve Corps Coordinator
11	Sidley, Renee	Mary Lanning Memorial Hospsital (VP of Patient Strategy)
12	Steele, Gary?	DHHS - EMS Education
13	Sullivan, Anita	SHDHD - Health Surveillance Coordinator, VFC Coordinator
14	Uden, Loren	Clay County Emergency Management
15	Zajack, Mark	Hastings College – Asst Prof of Psychology
16		

SHDHD NPHPSP Assessment Participants 11.21.11

	ES9: Evaluate	
	(June/Allison)	Organization
1	Burmeister, Michie	K-9 & Friends
2	Christensen, Eric	City of Hastings Parks and Rec
3	Ehly, Ronda	Mary Lanning Memorial HealthCare
4	Field, Kori	Brodstone Memorial Hospital – D.O.N.
5	Fox, Tabitha	United Way
6	Junker, Chris	HIV/AIDS Prevention Coordinator Nebraska Department of Education; ASAAP Board
7	Lewis Jennifer	YWCA - Director
8	Loettrle, Jon	Counseling Services, Hastings College
9	Meyer, Peggy	SHDHD Board of Health (Pres); Positive Solutions (LICSW, MSW)
10	Rinne, Desiree	SHDHD – Health Educator
11	Sedlacek, Colleen	Adams County Senior Services
12	Segelke, Jolynn	SASA
13	Stemper, Scott	Area Substance & Alcohol Abuse Prevention - Director
14	Stevens, Sandi	SHDHD – Community Health Education Coordinator
15	Sullivan, Becky	Mary Lanning Memorial Hospital – Business Health
16	Tinkham, Karen	Brodstone Memorial Hospital – Public Relations
17	Vrooman, Kris	Energy Pioneer Solutions; Health Hastings Coalition

	ES10: Research/Innovate	
	(Greg/Lynnette)	Organization
1	Bever, Michele	SHDHD – Executive Director
2	Brailita, Dr. Dan	Central Nebraska Infectious Disease (Mary Lanning Memorial HealthCare)
3	Griffin, Dee	Feedlot Production Mgr (USDA-MARC); Professor, Univ of NE Great Plains Vet Ed Center; LEDRS
4	Neet, Brad	Mary Lanning Memorial HealthCare – CEO; SHDHD Board of Health
5	Nore, Jaci	Morrison Cancer Center – Mary Lanning Memorial HealthCare
6	Reimer, Judy	SHDHD Board of Health; Hastings LWV; Health Ministries
7	Richardson, Dr. Charles?	Psychiatry (Retired)
8	Stitchka, Jean	UNL Extension - Nuckolls County
9	Strasheim, Cindi	UNL Extension – Clay County

NPHPSP
NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS PROGRAM

STRENGTHENING SYSTEMS, IMPROVING THE PUBLIC'S HEALTH

National Public Health Performance Standards Program (NPHPSP) Local Public Health System Assessment Report 2011 Field Test

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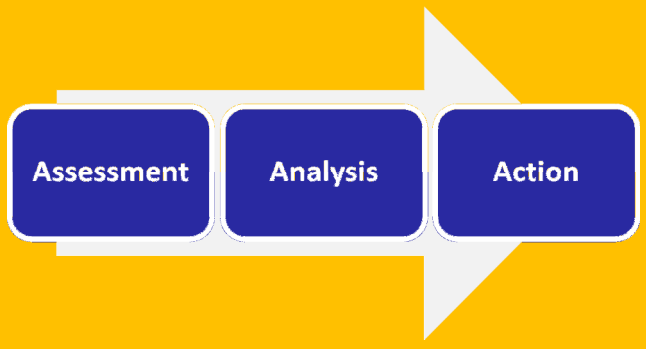

CDC

Centers for Disease Control and Prevention
Office for State, Tribal, Local and Territorial Support
Division of Public Health Performance Improvement
Agency and Systems Improvement Branch

NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS PROGRAM

Local Public Health System Assessment

2011 Field Test Report

NPHPSP
NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS PROGRAM

STRENGTHENING SYSTEMS, IMPROVING THE PUBLIC'S HEALTH

Program Partner Organizations

American Public Health Association
www.apha.org

Association of State and Territorial Health Officials
www.astho.org

Centers for Disease Control and Prevention
www.cdc.gov

National Association of County and City Health Officials
www.naccho.org

National Network of Public Health Institutes
www.nnphi.org

Public Health Foundation
www.phf.org

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Acknowledgements

The National Public Health Performance Standards Program (NPHPSP), 2011 re-engineered version, was developed collaboratively by the program's national public health partner organizations. The NPHPSP Partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes (NNPHI); and the Public Health Foundation (PHF).

Our deep appreciation is also extended to the many state, local and board of health representatives who provided input on the 2011 re-engineered assessment instruments. Feedback based on their experiences with the NPHPSP assessment instruments and process has resulted in a more streamlined and meaningful instrument for all NPHPSP users.

We thank all those who contributed their time and expertise in the creation of the re-engineered 'local public health system assessment instrument' that supports the findings contained in this report.

Background

The NPHPSP is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPSP assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.

The NPHPSP assessments are intended to help users answer questions such as "What are the activities and capacities of our public health system?" and "How well are we providing the Essential Public Health Services in our jurisdiction?" The dialogue that occurs in the process of answering the questions in the assessment instrument can help to identify strengths and weaknesses, determine opportunities for immediate improvements, and establish priorities for long term investments for improving the public health system.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- State Public Health System Performance Assessment Instrument,
- Local Public Health System Performance Assessment Instrument, and
- Local Public Health Governance Performance Assessment Instrument.

The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation's public health as a whole.

NPHPSP Mission and Goals

To improve the quality of public health practice and performance of public health systems by:

1. Providing performance standards for public health systems and encouraging their widespread use;
2. Engaging and leveraging national, state, and local partnerships to build a stronger foundation for public health preparedness;
3. Promoting continuous quality improvement of public health systems; and
4. Strengthening the science base for public health practice improvement.

The development of the NPHPSP was initiated in 1998 under the leadership of CDC and in strong collaboration with national public health partners. The original assessment instruments were released in 2002 and remained in the field until 2007. An update was conducted from 2005-2007, and the NPHPSP Version 2 instruments were released in 2007 and are currently in the field. Through December 1, 2011, it is estimated that one or more of the instruments (state, local, and/or governance) has been used in 45 states (state instrument = 27; local instrument = 612; and governance instrument = 254). Of these, approximately 37 tribal organizations have utilized the NPHPSP instruments (state instrument = 4; local instrument = 27; and governance instrument = 6).

The National Public Health Performance Standards Program (NPHPSP) is designed to measure and improve public health system performance at the state and local levels. To fulfill this role effectively, the standards and program guidance for assessment and improvement activities are periodically updated to reflect current practice, experience from the field, and new developments in public health practice. After three years in the field, the currently available standards and instruments have been update to reflect relevant public health content and increased process guidance. The timing of updating the instruments has also presented a unique opportunity to initiate a reengineering process that addressed several important and relevant developments in public health practice, most notably the recent launch of national voluntary public health agency accreditation in 2011. **This report reflects results based on the 2011 re-engineered local public health system assessment**.

The challenge of preventing illness and improving health is ongoing and complex. The ability to meet this challenge rests on the capacity and performance of public health systems. Through well equipped, high-performing public health systems, this challenge can be addressed. Public health performance standards are intended to guide the development of stronger public health systems capable of improving the health of populations. The development of high-performing public health systems will increase the likelihood that all citizens have access to a defined optimal level of public health services. Through periodic assessment guided by model performance standards, public health leaders can improve collaboration and integration among the many components of a public health system, and more effectively and efficiently use resources while improving health intervention services.

Introduction

The NPHPSP Local Public Health System Assessment Report is designed to help health departments and public health system partners create a snapshot of where they are relative to the National Public Health Performance Standards and to progressively move toward refining and improving outcomes for performance across the public health system.

The NPHPSP state, local and governance instruments also offer opportunity and robust data to link to health departments, public health system partners and/or community-wide strategic planning processes, as well as to Public Health Accreditation Board (PHAB) standards. For example, assessment of the environment external to the public health organization is a key component of all strategic planning, and the NPHPSP assessment readily provides a structured process and an evidence-base upon which key organizational decisions may be made and priorities established. The assessment may also be used as a component of community health improvement planning processes, such as *Mobilizing for Action through Planning and Partnerships* (MAPP) or other community-wide strategic planning efforts, including state health improvement planning and community health improvement planning. The NPSPSP process also drives assessment and improvement activities that may be used to support a Health Department in meeting Public Health Accreditation Board Standards. Regardless of whether using MAPP or another health improvement process, partners should use the NPHPSP results to support quality improvement.

The self-assessment is structured around the Model Standards for each of the ten essential public health services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health. Figure 1 below shows how the ten essential public health services align with the three core functions of public health (assessment, policy development, and assurance).

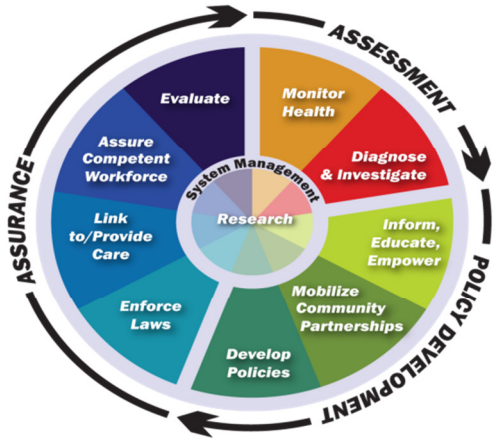


Figure 1. The ten essential public health services and how they relate to the three core functions of public health.

Purpose

The primary purpose of the NPHPSP Local Public Health System Assessment Report is to promote continuous improvement that will result in positive outcomes for system performance. Local health departments and their public health system partners can use the Assessment Report as a working tool to:

- Better understand current system functioning and performance;
- Identify and prioritize areas of strengths, weaknesses, and opportunities for improvement;
- Articulate the value that quality improvement initiatives will bring to the public health system;
- Develop an initial work plan with specific quality improvement strategies to achieve goals;
- Begin taking action for achieving performance and quality improvement in one or more targeted areas; and
- Re-assess the progress of improvement efforts at regular intervals.

This Report is designed to facilitate communication and sharing among and within programs, partners, and organizations , based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference by everyone in the system will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

The Centers for Disease Control and Prevention has created this NPHPSP LPHS Assessment Report as a concise, yet comprehensive resource designed to provide 2011 field test sites with resources for understanding and analyzing your assessment data, identifying priorities for improvement and establishing an initial Action Plan with your public health system partners. Using this report will increase your knowledge and awareness of improving the delivery of essential public health services in your system.

About the Report

Calculating the scores

The NPHPSP assessment instruments are constructed using the Essential Public Health Services (EPHS) as a framework. Within the Local Instrument, each EPHS includes between 2-4 Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard is followed by assessment questions that serve as measures of performance. Each site's responses to these questions indicate how well the Model Standard - which portrays the highest level of performance or "gold standard" - is being met.

All field test sites responded to assessment questions in the 2011 re-engineered instrument using the response options in Table 1 below. These same categories are used in this report to characterize levels of activity for Essential Services and Model Standards. Using the responses to all of the assessment questions, a scoring process generates scores for each first-tier or "stem" question, Model Standard, Essential Service, and one overall assessment score.

Table 1. Summary of Assessment Response Options

No Activity	**0% or absolutely no activity**
Minimal Activity	**Greater than zero, but no more than 25% of the activity described within the question is met.**
Moderate Activity	**Greater than 25%, but no more than 50% of the activity described within the question is met.**
Significant Activity	**Greater than 50%, but no more than 75% of the activity described within the question is met.**
Optimal Activity	**Greater than 75% of the activity described within the question is met.**

Understanding data limitations

Respondents to the self-assessment should understand what the performance scores represent and potential data limitations. All performance scores are an average; Model Standard scores are an average of the stem question scores within that Model Standard, Essential Service scores are an average of the Model Standard scores within that Essential Service and the overall assessment score is the average of the Essential Service scores. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which may be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-

assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Because of the limitations noted, the results and recommendations associated with these reported data should be used for quality improvement purposes. More specifically, results should be utilized for guiding an overall public health infrastructure and performance improvement process for the public health system. These data represent the collective performance of all organizational participants in the assessment of the local public health system. The data and results should not be interpreted to reflect the capacity or performance of any single agency or organization.

Presentation of results

The NPHPSP has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. Results are presented in a Microsoft Word document, which allows users to easily copy and paste or edit the report for their own customized purposes.

For ease of use, many figures and tables use short titles to refer to Essential Services, Model Standards, and questions. If in doubt of the meaning, please refer to the full text in the assessment instruments.

Sites may have chosen to complete two additional questionnaires - one which asks about the priority of each Model Standard and the second which assesses the local health department's contribution to achieving the Model Standard. Sites that submitted responses for these questionnaires will see the results included as an additional component of their report.

Results

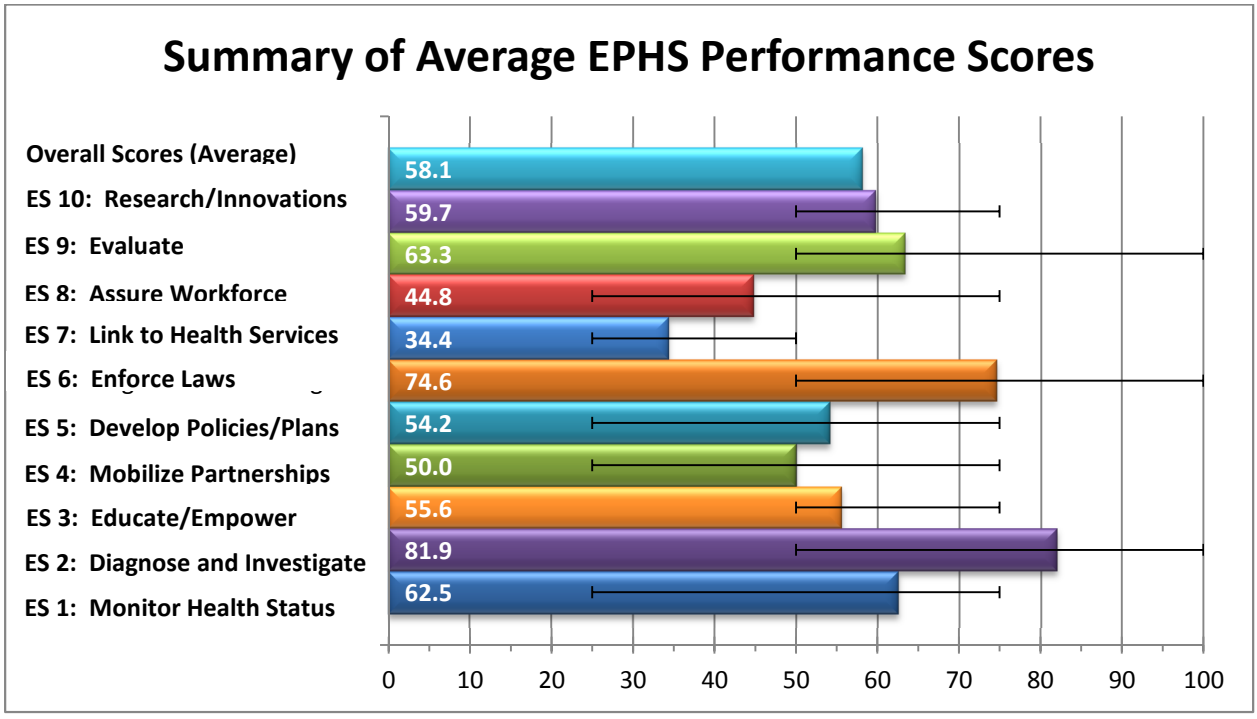
Now that your assessment is completed, one of the most exciting, yet challenging opportunities is to begin to review and analyze the findings. As you recall from your assessment, the data you created now establishes the foundation upon which you may set priorities for performance improvement and identify specific quality improvement (QI) projects to support your priorities.

Based upon the responses you provided during your assessment, an average was calculated for each of the ten Essential Public Health Services (EPHS). Each Essential Service score can be interpreted as the overall degree to which your public health system meets the performance standards (quality indicators) for each Essential Service. Scores can range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum value of 100% (all activities associated with the standards are performed at optimal levels).

Figure 2 displays the average score for each Essential Service, along with an overall average assessment score across all 10 Essential Services. Take a look at the overall performance scores for each Essential Service. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses. Note the black bars that identify the range of performance score responses within each Essential Service.

Overall Scores for Each Essential Service

Figure 2. Summary of Average EPHS Performance Scores



Performance Scores by Essential Service for Each Model Standard

Figure 3 and Table 2 on the following pages display the average score for each of the performance Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Note: In Table 2 – each score (performance, priority, and contribution scores) at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service.

Figure 3. Performance Scores by Essential Service for Each Model Standard

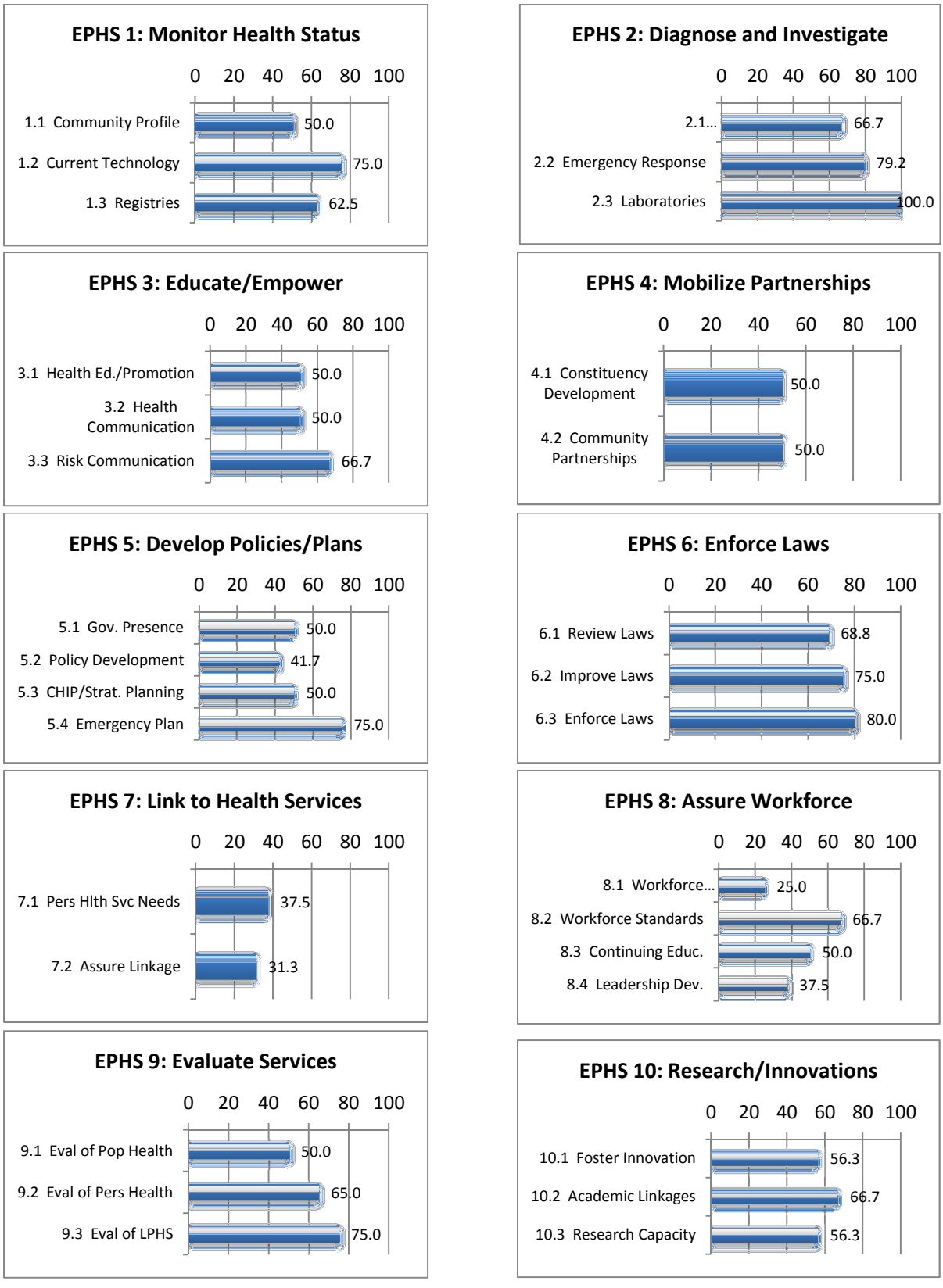


Table 2. Performance, Priority and Contribution Scores by Essential Service for Each Model Standard

	Performance Score (%)	Priority Score (1 to 10)	LHD Contribution Score (%)
ES 1: Monitor Health Status	**62.5**		
1.1 Community Profile	50.0	N/A	100
1.2 Current Technology	75.0	N/A	50
1.3 Registries	62.5	N/A	25
ES 2: Diagnose and Investigate	**81.9**		
2.1 Identification/Surveillance	66.7	N/A	75
2.2 Emergency Response	79.2	N/A	100
2.3 Laboratories	100.0	N/A	25
ES 3: Educate/Empower	**55.6**		
3.1 Health Education/Promotion	50.0	N/A	75
3.2 Health Communication	50.0	N/A	75
3.3 Risk Communication	66.7	N/A	100
ES 4: Mobilize Partnerships	**50.0**		
4.1 Constituency Development	50.0	N/A	100
4.2 Community Partnerships	50.0	N/A	100
ES 5: Develop Policies/Plans	**54.2**		
5.1 Governmental Presence	50.0	N/A	100
5.2 Policy Development	41.7	N/A	100
5.3 CHIP/Strategic Planning	50.0	N/A	100
5.4 Emergency Plan	75.0	N/A	199
ES 6: Enforce Laws	**74.6**		
6.1 Review Laws	68.8	N/A	100
6.2 Improve Laws	75.0	N/A	100
6.3 Enforce Laws	80.0	N/A	75
ES 7: Link to Health Services	**34.4**		
7.1 Personal Health Svc Needs	37.5	N/A	75
7.2 Assure Linkage	31.3	N/A	75
ES 8: Assure Workforce	**44.8**		
8.1 Workforce Assessment	25.0	N/A	25
8.2 Workforce Standards	66.7	N/A	25
8.3 Continuing Education	50.0	N/A	75
8.4 Leadership Development	37.5	N/A	50
ES 9: Evaluate Services	**63.3**		
9.1 Evaluation of Pop Health	50.0	N/A	50
9.2 Evaluation of Personal Health	65.0	N/A	50
9.3 Evaluation of LPHS	75.0	N/A	100
ES 10: Research/Innovations	**59.7**		
10.1 Foster Innovation	56.3	N/A	75
10.2 Academic Linkages	66.7	N/A	75
10.3 Research Capacity	56.3	N/A	50
Overall Scores	**58.1**		**74.2**
Median	**54.9**		

Performance Relative to Optimal Activity

Figures 4 and 5 display the proportion of performance measures that met specified thresholds of achievement for performance standards. The five threshold levels of achievement used in scoring these measures are shown in the legend below. For example, measures receiving a composite score of 76-100% were classified as meeting performance standards at the optimal level. Figure 4 summarizes the composite performance measures for all 10 Essential Service and Figure 5 summarizes the composite measures for all 30 Model Standards.

Figure 4. Percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 1.

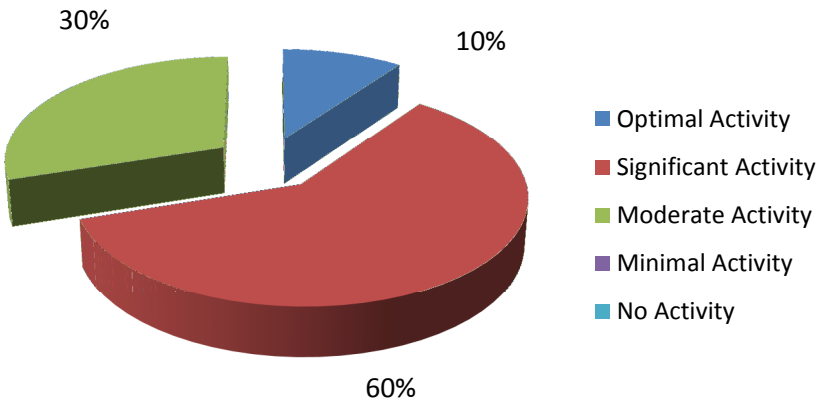
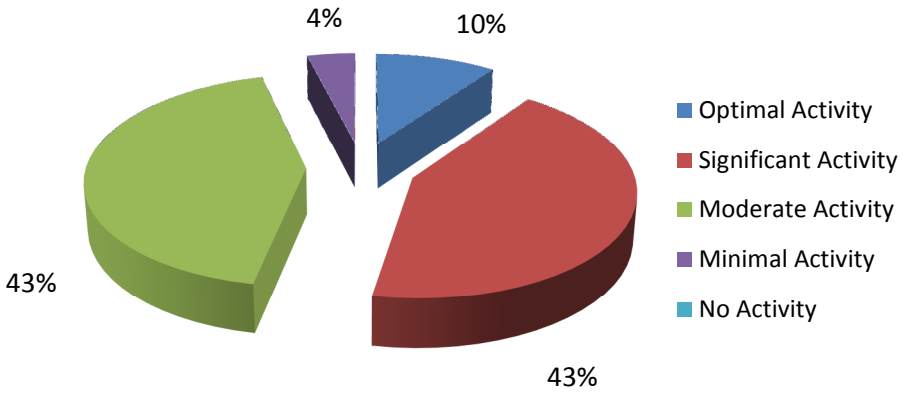


Figure 5. Percentage of the system's Model Standard scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 3.



Model Scores and Priority Rankings

If you completed the Priority Survey at the time of your assessment, your results are displayed in this section for each Essential Service and each Model Standard, arrayed by the priority ranking assigned to each. The four quadrants, which are based on how the performance of each Essential Service and/or Model Standard compares with the priority rating, should provide guidance in considering areas for attention and next steps for improvement.

In Figure 6 below, the upper left quadrant (A) contains activities that were considered to have high importance and low performance and may need increased attention. Activities appearing in the top right quadrant (B) were considered to have high importance and high performance – and you may want to consider how to maintain these efforts. The lower right quadrant (C) contains activities that were considered to have low importance and high performance and consideration may be given to reducing efforts in these areas. Finally, the lower left quadrant (D) contains activities that were considered to have low importance and low performance – and may need little or no attention.

Recipients of the priority results section may find that the scatter plot figures include data points that overlap. This is unavoidable when presenting results that represent similar data; in these cases, sites may find that the table (Table 3) listing of results will more clearly show the results found in each quadrant.

Figure 6. Identifying Priorities Basic Framework

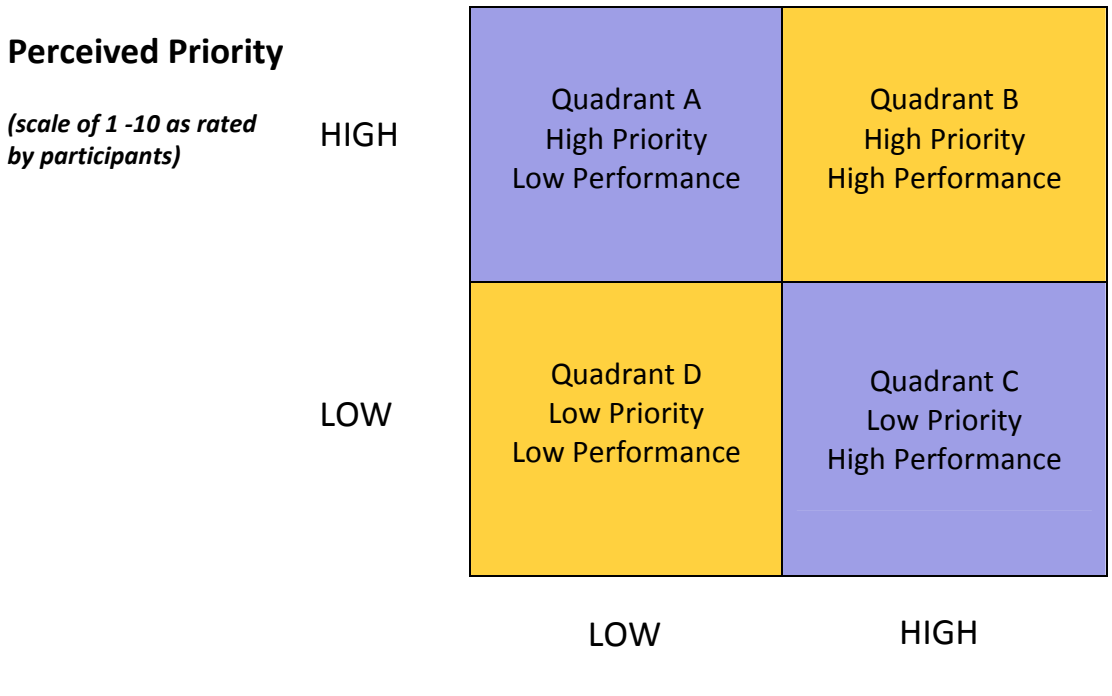


Figure 7. Summary of EPHS Model Standard Scores and Priority Ratings

(Priority Survey not completed)

Table 3 below displays priority ratings (as rated by participants on a scale of 1-10, with 10 being the highest priority) and performance scores for Model Standards, arranged under the four quadrants. Consider the appropriateness of the match between the importance ratings and current performance scores and also reflect back on the qualitative data in Appendix B to identify potential priority areas for action planning.

Table 3. Model Standards by priority and performance score, with areas for attention

Model Standard	Priority Rating	Performance Score
Quadrant A (High Priority/Low Performance) - These important activities may need increased attention.		
Quadrant B (High Priority/High Performance) - These activities are being done well, and it is important to maintain efforts.		
Quadrant C (Low Priority/High Performance) - These activities could be improved, but are of low priority. They may need little or no attention at this time.		
Quadrant D (Low Priority/Low Performance) - These activities are being done well, but the system can shift or reduce some resources or attention to focus on higher priority activities.		

PRIORITY SURVEY NOT COMPLETED

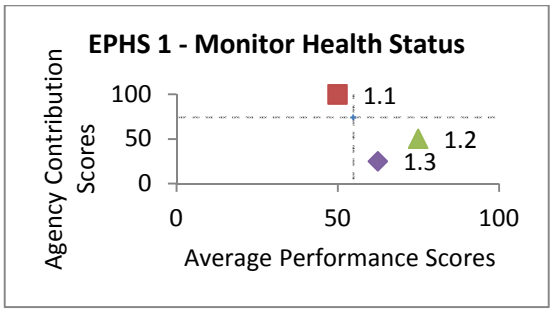
Agency Contribution Scores

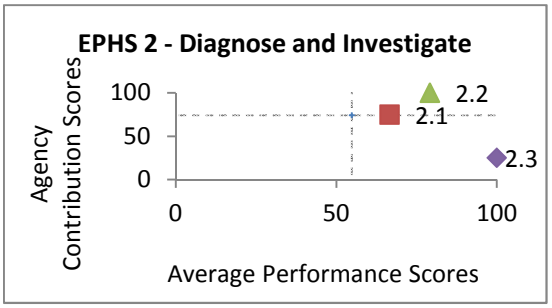
How much does your Local Health Department contribute to the system's performance, as perceived by assessment participants? Which Model Standards does your Local Health Department contribute most significantly to within your system? Table 4 and Figures 8 and 9 on the following pages display Essential Service and Model Standard Scores arranged by Local Health Department (LHD) contribution, priority and performance scores.

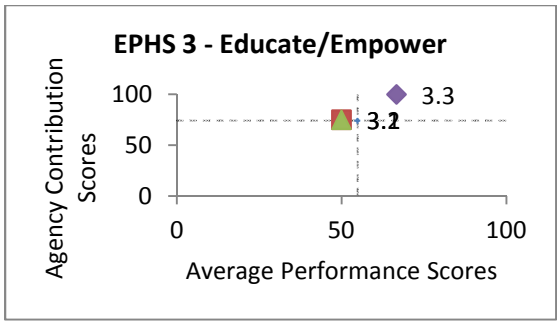
Table 4. Summary of Contribution and Performance Scores by Model Standard

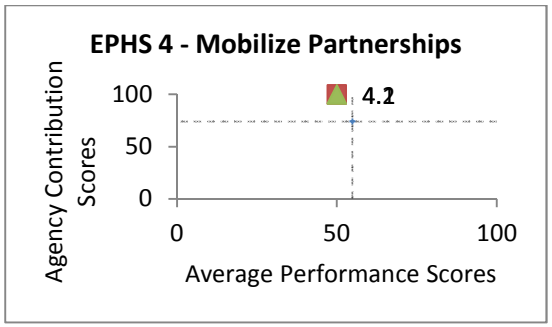
Model Standard	LHD Contribution	Performance Score	Questions to Consider
1.1 Population-Based Community Health Profile (CHP)	100	Moderate (50%)	**Quadrant A**
1.2 Access to and Utilization of Current Technology to Manage, Display, Analyze and Communicate Population Health Data	50	Significant (75%)	Quadrant C
1.3 Maintenance of Population Health Registries	25	Significant (62.5%)	Quadrant C
2.1 Identification and Surveillance of Health Threats	75	Significant (66.7%)	Quadrant C
2.2 Investigation and Response to Public Health Threats and Emergencies	100	Optimal (79.2%)	Quadrant B
2.3 Laboratory Support for Investigation of Health Threats	25	Optimal (100.0%)	Quadrant C
3.1 Health Education and Promotion	75	Moderate (50%)	Quadrant D
3.2 Health Communication	75	Moderate (50%)	Quadrant D
3.3 Risk Communication	100	Significant (66.7%)	Quadrant B
4.1 Constituency Development	100	Moderate (50%)	**Quadrant A**
4.2 Community Partnerships	100	Moderate (50%)	**Quadrant A**
5.1 Government Presence at the Local Level	100	Moderate (50%)	**Quadrant A**
5.2 Public Health Policy Development	100	Moderate (41.7%)	**Quadrant A**
5.3 Community Health Improvement Process	100	Moderate (50%)	**Quadrant A**
5.4 Plan for Public Health Emergencies	100	Moderate (75%)	Quadrant B
6.1 Review and Evaluate Laws, Regulations, Ordinances	100	Significant (68.8%)	Quadrant B
6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances	100	Significant (75%)	Quadrant B
6.3 Enforce Laws, Regulations and Ordinances	75	Optimal (80%)	Quadrant C
7.1 Identification of Populations with Barriers to Personal Health Services	75	Moderate (37.5%)	Quadrant D
7.2 Assuring Linkage of People to Personal Health Services	75	Moderate (31.3%)	Quadrant D
8.1 Workforce Assessment Planning, and Development	25	Minimal (25%)	Quadrant D
8.2 Public Health Workforce Standards	25	Significant (66.7%)	Quadrant C
8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring	75	Moderate (50%)	Quadrant D
8.4 Public Health Leadership Development	50	Moderate (37.5%)	Quadrant D
9.1 Evaluation of Population-based Health Services	50	Moderate (50%)	Quadrant D
9.2 Evaluation of Personal Health Care Services	50	Significant (65%)	Quadrant C
9.3 Evaluation of the Local Public Health System	100	Significant (75%)	Quadrant B
10.1 Fostering Innovation	75	Moderate (56.3%)	Quadrant B
10.2 Linkage with Institutions of Higher Learning and/or Research	75	Significant (66.7%)	Quadrant C
10.3 Capacity to Initiate or Participate in Research	50	Significant (56.3%)	Quadrant C

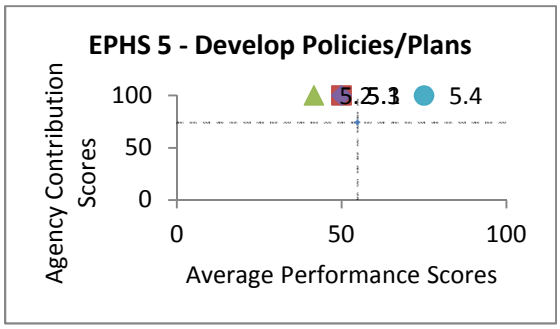
Figure 8. Summary of EPHS Performance Scores and Contributions Ratings

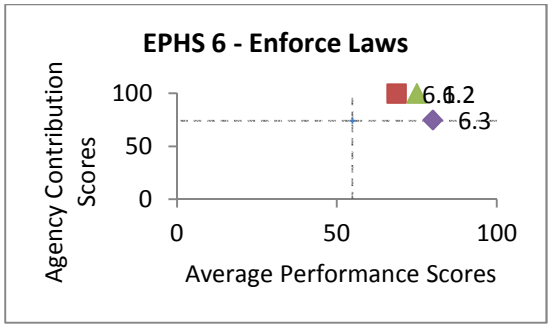


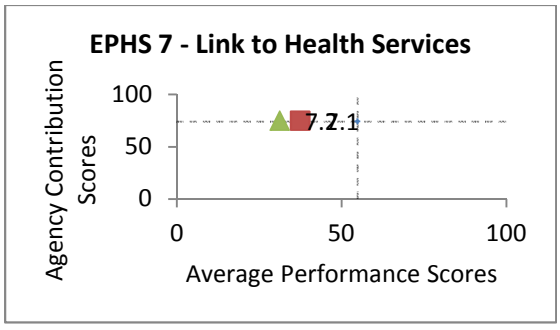


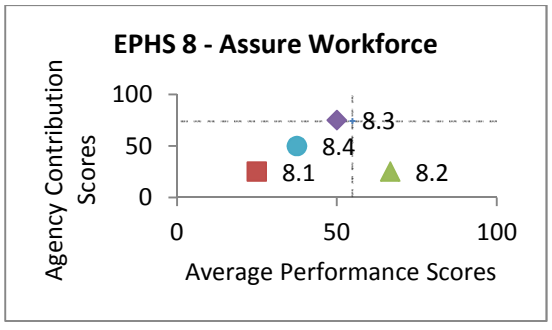


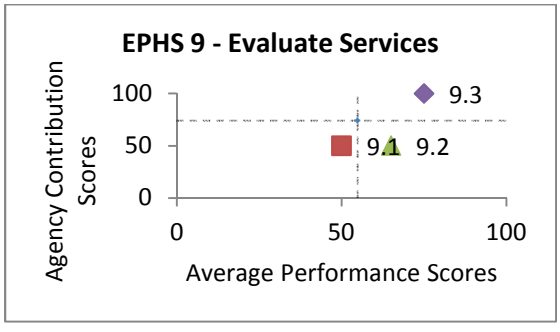












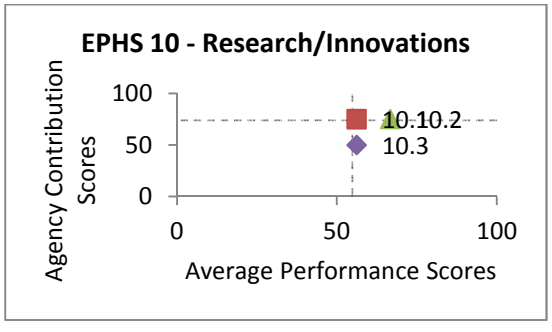


Figure 9. Summary of Agency Contribution and Priority Scores

(Priority Survey not completed)

Analysis and Discussion Questions

Having a standard way in which to analyze the data in this report is important. This process does not have to be difficult; however, drawing some initial conclusions from your data will prove invaluable as you move forward with your improvement efforts. It is crucial that participants fully discuss the performance assessment results. The bar graphs, charts, and summary information in the Results section of this NPHPSP report should be helpful in identifying high and low performing areas. On the pages that follow you will find a set of Discussion Questions to help guide you as you analyze the data found in the previous section of the report.

Using the results in this report will help you to generate priorities for improvement, as well as possible improvement projects. Your data analysis should be an interactive process, enabling everyone to participate. Do not be overwhelmed by the potential of many possibilities for QI projects – the point is not that you have to address them all now. Consider this step as identifying possible opportunities to enhance your system performance. **Keep in mind both your quantitative data (Appendix A) and the qualitative data that you collected during the assessment (Appendix B).**

Overall Scores for Each Essential Service

Questions for Discussion

As you review Figure 2, consider the following questions below. As your group reviews your report, you may choose to identify a recorder who can make notes on a large flip chart to capture the discussion.

- ✓ Identify the Essential Services with the highest performance scores and record here:

  _____

- ✓ Identify the Essential Services with the lowest performance scores and record here:

  _____

- ✓ Identify Essential Services where you scored Optimal (76-100%) and record here:

  _____

- ✓ Identify Essential Services where you scored No Activity (0%) or Minimal Activity (1-25%):

  _____

- ✓ Identify the Essential Services where you see the greatest opportunity for improvement at this time. **When considering this question, also review the qualitative data you collected at the time of your assessment, including strengths, weaknesses and opportunities for improvement for each Essential Service (Appendix B).**

  _____

- ✓ Identify the Essential Services where you see the least opportunity for improvement at this time. Make note of the reasons why improvement is not feasible. **When considering this question, take a moment to review the qualitative data you collected at the time of your assessment (Appendix B)**.

  _____

- ✓ Overall, what is your response to the scores? How well do they match your perceptions and experiences of your public health system? Are they surprising?

  _____

Performance Scores by Essential Service for Each Model Standard

Questions for Discussion

As a next step, analyzing your Model Standard scores in Figure 3 and Table 2 will help you to identify more specific areas for improvement. The Essential Service score is an average of the Model Standard scores within that service, and, in turn, the Model Standard scores represent the average of stem question scores for that standard. If there is great range or difference in scores, focusing attention on the Model Standard(s) or questions with the lower scores will help to identify where performance inconsistency or weakness may be.

Referring back to the original question responses (Appendix A) and your qualitative notes (Appendix B) may also be helpful in determining where weaknesses or inconsistencies in performance may be occurring.

As you review Figures 3 and Table 2, consider the following questions below. Once you have completed the questions, do you note any themes or trends across the Essential Services?

- ✓ Identify the Model Standards with the highest scores and record them here:
  _____
  _____
- ✓ Identify the Model Standards with the lowest scores and record them here:
  _____
  _____
- ✓ Identify the Model Standards where you scored Optimal (76-100%) and record here: _____
  _____
- ✓ Identify the Model Standards where you scored No Activity (0%) or Minimal Activity (1-25%) and record here: _____

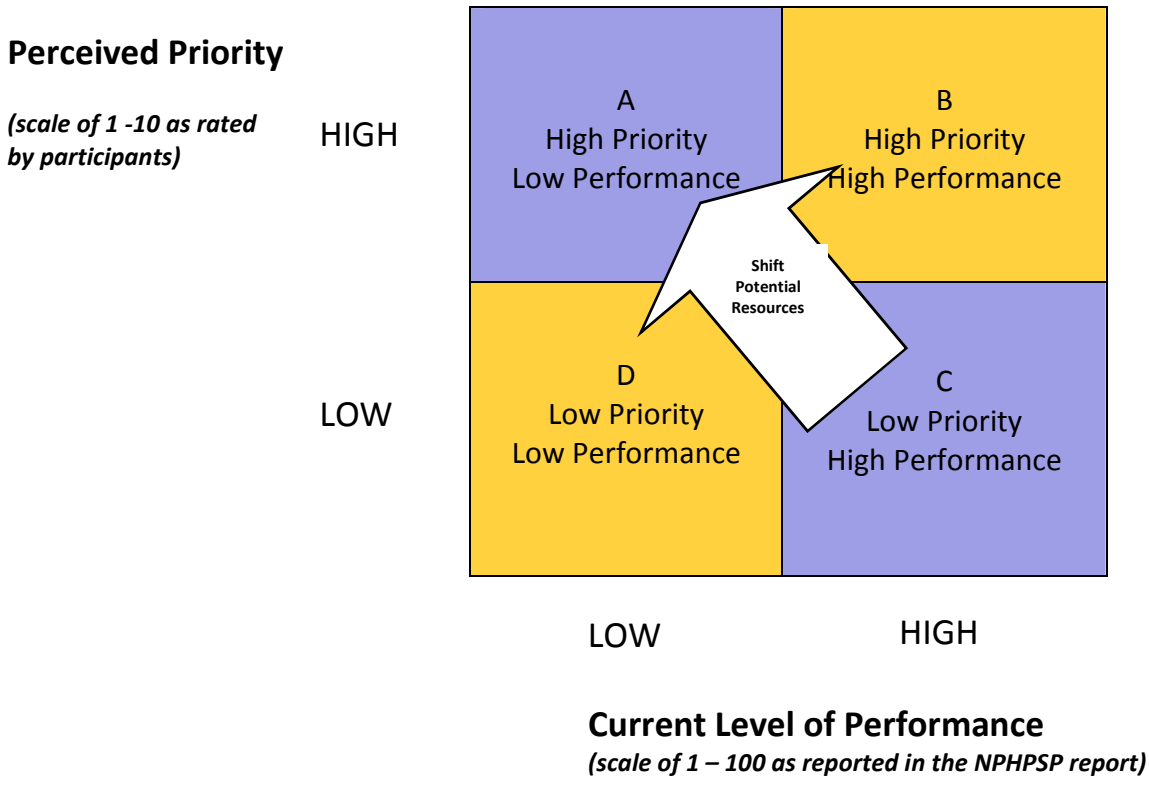
Model Scores and Priority Rankings

As you continue to review your results, consider Figure 10 below that previously identified the four priority quadrants in the Results section of the report. Now begin to think about how you may be able to shift potential resources to address your priorities. Shifting resources may mean for example, performing less of an activity that you identified as Low Priority/High Performance in Quadrant C, to enable additional resources to be dedicated to an activity you identified as being High Priority/Low Performance in Quadrant A.

Use Figure 7 from the Results section to review the Model Standards by each Essential Service. Use Table 3 to review a listing of all the Model Standards by Quadrant, along with the performance score and priority score you assigned to it during the assessment Remember to consider the appropriateness of the match between the importance ratings and current performance scores.

Complete the Discussion Questions on the following pages to determine if you are able to identify any themes or trends from your data. As your group reviews your report, identify a recorder who can make notes on a large flip chart to capture the discussion. If there is a specific area where you scored high or low, and want to review further, use Appendix A to review individual questions and their scores. Be sure to take into consideration the qualitative data you collected where appropriate in your discussion (Appendix B).

Figure 10. Identifying Priorities Basic Framework



Questions for Discussion

- ✓ Review the Model Standards in the **Left Upper Quadrant (A)**. Record those you think are most important to address.

  _____

- ✓ Review the Model Standards in the **Right Upper Quadrant (B)**. You have identified these as a priority to continue to perform well. Consider how you will sustain these.

  _____

- ✓ Review the Model Standards in the **Right Lower Quadrant (C)**. You have identified these as a low priority to improve and are performing them well. Can you shift any resources to address higher level priorities in quadrant A?

  _____

- ✓ Review the Model Standards in the **Left Lower Quadrant (D)**. Consider again whether these Model Standards need additional attention and record any you think must be addressed.

  _____

- ✓ Continue your discussion to identify the priorities you will include in your Action Plan and list them here.

  _____

  _____

  _____

  _____

  _____

  _____

Agency Contribution Scores

You may also want to consider the questions in Table 5 to further examine the relationship between the system and Department in achieving Essential Services and Model Standards performance. Questions to consider are suggested based upon the four categories or "quadrants" displayed in Figure 6 and Table 2 on the Results section.

Table 5. Questions for Discussion

Quadrant		Questions to Consider	Notes
A	Low Performance/ High Department Contribution	• Is the Department effective at what it does, and does it focus on the right things? • Is the level of Department effort sufficient for the jurisdiction's needs? • Should partners be doing more, or doing different things? • What else within or outside of the Department might be causing low performance?	
B	High Performance/ High Department Contribution	• What does the Department do that may contribute to high performance in this area? Could any of these strategies be applied to other areas? • Is the high Department contribution appropriate, or is the Department taking on what should be partner responsibilities? • Could the Department do less and maintain satisfactory performance?	

C	High Performance/ Low Department Contribution	• Who are the key partners that contribute to this area? What do they do that may contribute to high performance? Could any of these strategies be applied to other areas? • Does the low Department contribution seem right for this area, or are partners picking up slack for Department responsibilities? • Does the Department provide needed support for partner efforts? • Could the key partners do less and maintain satisfactory performance?	
D	Low Performance/ Low Department Contribution	• Who are the key partners that contribute to this area? Are their contributions truly high, or do they just do more than the Department? • Is the total level of effort sufficient for the jurisdiction's needs? • Are partners effective at what they do, and do they focus on the right things? • Does the low Department contribution seem right for this area, or is it likely to be contributing to low performance? • Does the Department provide needed support for partner efforts? • What else might be causing low performance?	

Next Steps - Developing Your Action Plan

In keeping with the purpose of the National Public Health Performance Standards Program (NPHPSP), and having completed your assessment and data analysis, you are ready to move toward the next step in establishing an action plan. A primary goal of the NPHPSP is that data is analyzed and information is used proactively to monitor, assess, and improve the quality of essential public health services.

As noted in the Introduction of this report NPHPSP data may be used to inform a variety of organization and/or systems planning and improvement processes. Typically, it is critical to incorporate the key findings and analyses from the NPHPSP assessment, including the main strengths, weaknesses and priorities for action identified through the discussion questions included in this document (Appendix B).

If you are following an established planning framework such as MAPP, now is the time to refer to that framework for guidance on incorporating your NPHPSP results and analysis into your improvement process (see Appendix C for specific links to MAPP). Otherwise, you may follow the guidance provided in the remainder of this section, along with the resources offered in Appendix C, to develop specific goals for improvement within your public health system and move from assessment and analysis toward action.

In any systems improvement and planning process, it is important to involve all public health system partners in determining ways to improve the quality of essential public health services provided by the system. Participation in the improvement and planning activities included in your action plan is the responsibility of all partners within the public health system.

Consider the following as you build an Action Plan using the priorities you have selected.

- Each public health system partner is an important contributor to quality in your system
- The success of your improvement activities are dependent upon the active participation and contribution of each and every member of the system
- An integral part of performance improvement is to work continuously to improve the quality of essential public health services delivered by the system
- A multi-disciplinary approach, using ongoing measurement, is key to accomplishing and sustaining improvements

Establishing an Action Plan for improvement means not only establishing baseline assessment data to measure your performance, but implementing improvement activities that enable you to monitor your progress over time. It means using multi-disciplinary problem-solving and a systematic approach to improve the services delivered across the public health system.

Now that you have analyzed the data that represents the performance of your local public health system, development of an Action Plan is a way in which you can develop specific projects and activities to improve system performance. The activities you identify can be conducted over any period of time that you define, and your plan can be changed at any time as you continue to monitor and evaluate your efforts.

Remember, for each priority you have selected you want to answer:

What are we trying to accomplish?
What change can we make that will result in improvement?
How will we measure the improvement?

Consider the following objectives of an Action Plan for the priorities you have established for your local public health system. An Action Plan:

- Provides a framework for continuously monitoring and improving the quality of essential public health services
- Collects performance data consistently and systematically
- Provides for regular analysis of data among public health system partners
- Improves responsiveness of and relationships within the system
- Facilitates the redesign of key processes to achieve optimal performance.

You may find that using the simple acronym, 'FOCUS' as a way to help you to move from assessment and analysis to action.

F **Find** an opportunity for improvement using your results.

O **Organize** a team of public health system partners to work on the improvement. Someone in the group should be identified as the team leader. Team members should represent the appropriate organizations that can make an impact.

C **Consider** the current process, where simple improvements can be made and who should take the improvements.

U **Understand** the problem, how and why it is occurring and the factors that contribute to it. Once you have identified priorities, finding solutions entails delving into possible reasons, or "root causes," of the weakness or problem. Only when participants determine why performance problems (or successes!) have occurred will they be able to identify workable solutions that improve future performance. Most performance issues may be traced to well-defined system causes, such as policies, leadership, funding, incentives, information, personnel or coordination. Many QI

tools are applicable. You may consider using basic QI tools such as brainstorming, 5-whys, prioritization, or cause and effect diagrams to better understand the problem (refer to Appendix C for resources).

S **Select** the improvement strategies to be made. Consider using a table or chart to summarize your Action Plan. Many resources are available to assist you in putting your plan on paper, but in general you'll want to include the priority selected, the goal, the improvement activities to be conducted, who will carry them out, and the timeline for completing the improvement activities. When complete, your Action Plan should contain documentation on the indicators to be used, baseline performance levels and targets to be achieved, responsibilities for carrying out improvement activities and the collection and analysis of data to monitor progress. (Additional resources may be found in Appendix C.)

Monitoring and Evaluation

Keys To Success

Developing your Action Plan is a systematic process of monitoring the results of improvement activities over time, collecting and analyzing information to track progress toward intended outcomes and using that information to inform decision-making.

Monitoring your action plan is a highly proactive and continuous process that is far more than simply taking an occasional "snap-shot" that produces additional data. Evaluation, in contrast to monitoring, provides ongoing structured information that focuses on why results are or are not being met, what unintended consequences may be, or on issues of efficiency, effectiveness, and/or sustainability.

Monitoring and Evaluation provide an avenue by which public health system partners are able to identify further opportunities for improvement and to develop corrective actions and plans as needed. It enables public health system partners to become more accountable for the provision of the EPHS, as well as the performance and effectiveness of those services. The intent is that all partners in the public health system are committed to continually improving the delivery of public health Essential Services.

Continuous Improvement

Monitoring and evaluation continues after your Action Plan is implemented to determine whether the actions actually improved the Essential Service and that the improvement is maintained. Your conclusions will provide the evidence needed to determine whether the activities you implemented were effective. If the Essential Service performance does not improve within the expected time, additional evaluation must be conducted (an additional QI cycle) to determine why and how you can update your Action Plan to be more effective. Ultimately, you will want to show that meaningful improvement is accomplished and maintained by the activities you have implemented.

Communicating Results

As an integral component of your Monitoring and Evaluation Plan, do not overlook the importance of communicating results across the public health system and to relevant individuals and groups within the system. Consider using this opportunity to obtain additional comments, reactions, and information from partners regarding the results you share. It is an opportunity to keep public health system partners engaged and to leverage their expertise as you strive for optimal performance.

APPENDIX A: Individual Questions and Responses

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems		
1.1	**Model Standard: Population-Based Community Health Profile (CHP)**	
1.1.1	Conduct regular community health assessments?	75%
1.1.2	Provide and update community health profile reports with current information?	50%
1.1.3	Make the community health profile available and promote its use among community members and partners?	25%
1.2	**Model Standard: Current Technology to Manage and Communicate Population Health Data**	
1.2.1	Use the best available technology and methods to combine and show data on the public health?	75%
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	75%
1.2.3	Use computer software to create charts, graphs, and maps which show trends over time and compare data for different population groups?	75%
1.3	**Model Standard: Maintenance of Population Health Registries**	
1.3.1	Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?	75%
1.3.2	Use information from population health registries in community health assessments or other analyses?	50%

ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards		
2.1	**Model Standard: Identification and Surveillance of Health Threats**	
2.1.1	Participate in a comprehensive surveillance system with national, state and local partners to identify, monitor, share information, and understand emerging health problems and threats?	75%
2.1.2	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade)?	50%
2.1.3	Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?	75%
2.2	**Model Standard: Investigation and Response to Public Health Threats and Emergencies**	
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?	75%
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	75%
2.2.3	Designate a jurisdictional Emergency Response Coordinator?	100%
2.2.4	Rapidly and effectively respond to public health emergencies according to emergency operations coordination guidelines?	75%
2.2.5	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or radiological public health emergencies?	75%
2.2.6	Evaluate exercises and incidents for effectiveness and opportunities for improvement?	75%
2.3	**Model Standard: Laboratory Support for Investigation of Health Threats**	
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	100%
2.3.2	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	100%
2.3.3	Use only licensed or credentialed laboratories?	100%
2.3.4	Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?	100%

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues		
3.1	**Model Standard: Health Education and Promotion**	
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	50%
3.1.2	Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?	50%
3.1.3	Engage the community in setting priorities, developing plans and implementing health education and health promotion activities?	50%
3.2	**Model Standard: Health Communication**	
3.2.1	Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?	50%
3.2.2	Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?	50%
3.2.3	Identify and train spokespersons on public health issues?	50%
3.3	**Model Standard: Risk Communication**	
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective creation and dissemination of information?	75%
3.3.2	Make sure that systems and mechanisms are in place and enough resources are available for a rapid emergency communication response?	75%
3.3.3	Provide crisis and emergency communication training for employees and volunteers?	50%

ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems		
4.1	**Model Standard: Constituency Development**	
4.1.1	Maintain a complete and current directory of community organizations?	50%
4.1.2	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	25%
4.1.3	Encourage constituents to participate in community health assessment, planning and improvement efforts?	75%
4.1.4	Create forums for communication of public health issues?	50%
4.2	**Model Standard: Community Partnerships**	
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	50%
4.2.2	Establish a broad-based community health improvement committee?	50%
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	50%

ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts		
5.1	**Model Standard: Governmental Presence at the Local Level**	
5.1.1	Support the work of a local health department dedicated to the public health to make sure the essential public health services are provided through the LPHS?	75%
5.1.2	See that the local health department is accredited through the national voluntary accreditation program?	25%
5.1.3	Assure that the local health department has enough resources to do its part in providing essential public health services?	50%
5.2	**Model Standard: Public Health Policy Development**	
5.2.1	Contribute to new or modified public health policies by engaging in activities that inform the policy development process and facilitate community involvement?	50%
5.2.2	Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies?	50%
5.2.3	Review existing policies at least every three to five years?	25%
5.3	**Model Standard: Community Health Improvement Process and Strategic Planning**	
5.3.1	Establish a community health improvement process, with broad- based diverse participation, that uses information from both the community health assessment and the perceptions of community members?	75%
5.3.2	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?	50%
5.3.3	Connect organizational strategic plans with the Community Health Improvement Plan?	25%
5.4	**Model Standard: Plan for Public Health Emergencies**	
5.4.1	Maintain a task force to develop and maintain preparedness and response plans?	75%
5.4.2	Develop a 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?	75%
5.4.3	Test the plan through regular drills and revise the plan as needed, at least every two years?	75%

ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety		
6.1	**Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances**	
6.1.1	Identify public health issues that can be addressed through laws, regulations, or ordinances?	75%
6.1.2	Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels?	75%
6.1.3	System review existing public health laws, regulations, and ordinances at least once every five years?	50%
6.1.4	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?	75%
6.2	**Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances**	
6.2.1	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	75%
6.2.2	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health?	75%
6.2.3	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?	75%
6.3	**Model Standard: Enforcement of Laws, Regulations, and Ordinances**	
6.3.1	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?	100%
6.3.2	Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?	75%
6.3.3	Assure that all enforcement activities related to public health codes are done within the law?	100%
6.3.4	Assure that all enforcement activities related to public health codes are done within the law?	75%
6.3.5	Evaluate how well local organizations comply with public health laws?	50%

ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable		
7.1	**Model Standard: Identification of Personal Health Service Needs of Populations**	
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	50%
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	25%
7.1.3	Defines roles and responsibilities for partners to respond to the unmet needs of the community?	25%
7.1.4	Understand the reasons that people do not get the care they need?	50%
7.2	**Model Standard: Assuring the Linkage of People to Personal Health Services**	
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	50%
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	25%
7.2.3	Help people sign up for public benefits that are available to them (e.g. Medicaid or Medical and Prescription Assistance Programs)?	25%
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	25%

ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce		
8.1	**Model Standard: Workforce Assessment, Planning, and Development**	
8.1.1	Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector?	25%
8.1.2	Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce?	25%
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?	25%
8.2	**Model Standard: Public Health Workforce Standards**	
8.2.1	Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law?	75%
8.2.2	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services?	75%
8.2.3	Base the hiring and performance review of members of the public health workforce in public health competencies?	50%
8.3	**Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring**	
8.3.1	Identify education and training needs and encourage the workforce to participate in available education and training?	75%
8.3.2	Provide ways for workers to develop core skills related to essential public health services?	50%
8.3.3	Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases?	25%
8.3.4	Create and support practice-academic collaborations between public health workforce members and faculty and students of research institutions?	50%
8.3.5	Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health?	50%
8.4	**Model Standard: Public Health Leadership Development**	
8.4.1	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?	25%
8.4.2	Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together?	50%
8.4.3	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?	50%
8.4.4	Provide opportunities for the development of leaders representative of the diversity within the community?	25%

ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services		
9.1	**Model Standard: Evaluation of Population-Based Health Services**	
9.1.1	Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved?	50%
9.1.2	Assess whether community members, including those with a higher risk of having a health problem, are receiving services and are satisfied with the approaches to preventing disease, illness, and injury?	50%
9.1.3	Identify gaps in the provision of population-based health services?	50%
9.1.4	Use evaluation findings to improve plans and services?	50%
9.2	**Model Standard: Evaluation of Personal Health Services**	
9.2.1	Evaluate the accessibility, quality, and effectiveness of personal health services?	50%
9.2.2	Compare the quality of personal health services to established guidelines?	50%
9.2.3	Measure satisfaction with personal health services?	75%
9.2.4	Use technology, like the internet or electronic health records, to improve quality of care or communication among health care providers?	75%
9.2.5	Use evaluation findings to improve services and program delivery, and modify strategic plans as needed?	75%
9.3	**Model Standard: Evaluation of the Local Public Health System**	
9.3.1	Identify all public, private, and voluntary organizations that provide essential public health services?	75%
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 essential public health services?	100%
9.3.3	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?	50%
9.3.4	Use results from the evaluation process to improve the LPHS?	75%

ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems		
10.1	**Model Standard: Fostering Innovation**	
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?	50%
10.1.2	Suggest ideas about what currently needs to be studied in public health to organizations that do research?	50%
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?	75%
10.1.4	Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results?	50%
10.2	**Model Standard: Linkage with Institutions of Higher Learning and/or Research**	
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?	75%
10.2.2	Partner with colleges, universities, or other research organizations to do public health research, including community-based participatory research?	50%
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?	75%
10.3	**Model Standard: Capacity to Initiate or Participate in Research**	
10.3.1	Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?	50%
10.3.2	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?	50%
10.3.3	Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc?	75%
10.3.4	Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice?	50%

APPENDIX B: Qualitative Assessment Data Submitted By Field Test Site

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 1.1 Develop a Population-Based Community Health Profile Summary				
N/A	• Vaccinations—NESSIS • Information sharing (both SH and clay Co. HD) • Providing services and taking care of people now • Convenient care—good Dr's hours • Electronics communicatio n allow us to communicate better • The last assessment was done when SH was in the initial stages and gave an idea of where to go with the Health Department—There was a paper report. • SH does operate within the Essential Services and that is a result of the first assessment • Outcomes of assessment are known by	• Growing need in the population that has not used the system and doesn't know how to use it. The visibility of PH-not everyone knows there is a health Dept. Haven't seen the assessments—seen that they are done • We don't have cooperation between all of the organizations that prevents information exchange—need to get everyone to the table. • Makes one question the accuracy of the data cause we haven't seen it. • All the info can be out there and sometimes people aren't seeing it. Especially if we are using the computer some people don't have access. • Some used to people read the newspaper, only get their info from the radio or TV • If we don't know it is on the web we	There is an opportunity to get the information about the outcomes of this assessment out to partners and the public. Would there be a way to identify who should have been involved in relation to who was here? BOH is informed about progress toward the essential services at each meeting Public is sent out an annual report by SH. What types of Data sets are included—guess yes, but not specifically sure. BRFSS; census; Mobility and Morbidity	• None

	Dept and BOH, but not necessarily by partners.	don't get the info. • Mixed response—some knew about the past assessments and some did not.		
Model Standard 1.2 Technologies to Manage & Communicate Population Health Data				
N/A	• Data that the Dept gets is captured and reported; and the state sends out data reports • Pretty good at informing the local media if there is influenza, head lice, or whatever that effects the population. • Not just when there is a problem, but education. • SH has the proper equipment to do what is needed; computer; software; teleconference –other agencies may or may not have the necessary equipment • Have a good Health Alert network for Medical providers and partners • Breast CA	• Does the general public know. Partners may know about where to look for things • It is difficult to know where to put things out in the public—the grocery store? • General public cares when they see that problem effects them—other wise they don't see or access the information. • Lots of people have smart phones they could use an app for this • Not much use of GIS—hard to stay up to date on the info---other agencies may have it, but don't know how to access the info from it. Everyone has to put it in, but don't have the resources, time to push to get the info back	• Get a Public Health App for smart phones. Utilize other technology resources to get the message out—twitter, facebook, etc. • There could be a networked database to get and share info. • There could be a shared directory • Push system to get data to the partners and the public	•

	awareness information was very good • There are people who are already using the new technologies to get info out			
Model Standard 1.3 Maintenance of Population Health Registries				
N/A	• 1.3 Have local sentinel physician for Influenza like illness; lab system through NEDDS; NEISSES (immunization reg), Hospital (ML) ER room for Influenza like Illness. • Registrations are consistently populated-accurate • Up to date information • NEHI (electronic record system) helps hospital/medical partners to share info • Behavioral health data system in place; helps to assure people get priority when needed—especially pregnant women. This is not public	• Many different ways to enter data, but there isn't a central way to get the data • How safe is the information? Many hackers • Electronic record systems are still new and not used by all	•	•

	info—pt. has control of info			

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 2.1 Identification and Surveillance of Health Threats				
N/A	• Dee-we didn't used to have a health dept. but now we do! • Pam-Excellent Mary Lanning lab and Dr. Brailita • Molly-HANs	Dee--improved communications between all partners • Phyllis-improved first responder training • Ronda-strengthen your collaboration and broaden your scope of who you would include as stakeholders	• Dan-assign responsible person at school to receive and distribute communications from the health dept. Enhance communications-find that health liaison. • Ronda-first responder potential risks (education to them)-gown/glove before they come in the door. During H1N1, education ahead of time on processes and safety issues.	• Add
Model Standard 2.2 Investigation and Response to Public Health Threats and Emergencies				
N/A	• Molly-good communication between responders and health department and Emergency Management • Chip-written rules-almost all organizations have them • Jim-Broadstone and Mary Lanning are good with training and exercises.	• Jim-One issue with Emergency Management is that some are very part time. • Chip-plans are not reviewed or exercised (organizations) • Jim-some inconsistancies about exercises with hospitals • Diane-not knowing who to call for responding to what things. A short who	• Diane-education on who to call for what • Phyllis-education with first responders • Dan-education should include when to call 911 and when to not. Flow chart of response.	• Add

		to call list for what things organizations are responding to.		
Model Standard 2.3 Laboratory Support for Investigation of Health Threats				
N/A	• Ronda-good State Lab • Molly- good communications with State lab	• Ronda-more education on collaboration with State Lab. Some communications issues.	• Pam-says that she is not the right person to answer these questions.	• Add

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 3.1 Health Education and Promotion				
N/A	• Good collaboration across county boundaries • Lots of connections and information • Lots of people and groups working on issues- high interest level of people working on health education • All do a good job not duplicating services, but partner and piggyback	• Some entities are not included. Silos, and underrepresented groups, geographic, minorities, elderly (not sure if it is a gimmick) … lots of groups, yet not everyone represented. No overall coordination. Non intentional, but not linked traditionally to health care system. (economic issues IE: gas, gro.) • Policy maker engagement • Same good people around the table, with burnout possibilities. • One way to get a hold of people. (technology/ marketing) Radio, Tweeter, Paper, Computer	• None	• None
Model Standard 3.2 Health Communication				
N/A	• None	• None	• None	• None

Model Standard 3.3 Risk Communication				
N/A	• Karen – lots of collaboration with TRIMRS	• None	• None	• None

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 4.1 Constituency Development				
N/A	• Collaboration • Communication	• Language barrier • Transportation • Diversity is not represented at community meetings	• Media Collaboration • Social Media use • Timing of information • Approach people in venues where they are likely to listen • Keeping legislators aware of system needs	• Transportation • Educate to promote responsibility and accountability in program users
Model Standard 4.2 Constituency Partnerships				
N/A	• None	• None	• None	• None

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 5.1 Government Presence at the Local Level				
N/A	• None	• None	• None	• None
Model Standard 5.2 Public Health Policy Development				
N/A	• None	• None	• None	• None
Model Standard 5.3 Community Health Improvement Process				
N/A	• None	• None	• None	• None
Model Standard 5.4 Plan for Public Health Emergencies				
N/A	• None	• None	• None	• None

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 6.1 Review and Evaluate Laws, Regulations, and Ordinances				
N/A	• None	• None	• None	• None
Model Standard 6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances				
N/A	• None	• None	• None	• None
Model Standard 6.3 Enforce Laws, Regulations and Ordinances				
N/A	• Support system is giving authority to enforce rules and regs. • Great local public health department • Good review of local public health laws and regs.	• Lack of public health attorney or knowledge of how to access it • People being informed of what the public health department does- Education • People don't know there are resources out there to help them (ex) mental health that they will have to travel a great distance to get those services.	• None	• None

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 7.1 Identification of Populations with Barriers to Personal Health Services				
N/A	• Emergency dental program • Provided access to dental college for careers • Hastings wide variety of providers. Nuckolls & Webster as well close enough other counties. • Teamed • Immunization Clinic	• Cost of Care • Limit of Medicaid patients by physicians • Vision and hearing lack of help. Pay out of pockets. • Mental Health • Way we consume or buy medical services. No control over services ordered. • Language barrier • Transportation • Primary & behavior linkage • Importance of health care education.	• None	• None
Model Standard 7.2 Assuring the Linkage of People to Personal Health Services				
N/A	• Communication & understanding amount different agencies because we are a small community. • Health Fairs • Hastings has linkages working with churches for family with food needs • Lots of organization working for access to basic needs	• Magellan – gate keeper of services. Not always agreement for best services. • Pre emgerencent health care. No traditional hours. • Bigger cities offer more at pharmacies. Strep test. • Wait until we are deathly ill because don't want to spend the money to see a physician.	• None	• None

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 8.1 Workforce Assessment Planning, and Development				
N/A	• None	• None	• None	• None
Model Standard 8.2 Public Health Workforce Standards				
N/A	• None	• None	• None	• None
Model Standard 8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring				
N/A	• None	• None	• None	• None
Model Standard 8.4 Public Health Leadership Development				
N/A	• None	• None	• None	• None

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 9.1 Evaluation of Population-Based Health Services				
N/A	• HD does well at assessing community, partnerships work at bringing partners to the table • Every partner has some type of evaluation in place, we work at targeting our interventions, working on goal-setting • Quality and accessibility of HD data • Willingness to share data is the strength	• Communication between partners, integration between partners – as each agency makes decisions, do we integrate others data? - do we have the time to digest everyone's data? – • Ronda – we need to have a way to look at all the data – if not, you're doing things in isolation • Don't always have the time to integrate the data • Agencies don't know how to get the data they need • We don't know who has what data	• None	• None
Model Standard 9.2 Evaluation of Personal Health Services				
N/A	• Technology • Agencies are evaluating and using the information • Everyone is familiar and knows how to do it • We are gathering clear-cut answers versus making assumptions	• Not everyone has access to the technology – for example dentists • There isn't always a lot of feedback from the surveys that are sent out – rate of return is poor	• Find ways to get better feedback – to increase the rate of return (Poll everywhere is a way to gather feedback by phone) • Opportunity for sharing evaluation techniques and outcomes within the health system	• None
Model Standard 9.3 Evaluation of the Local Public Health System				

N/A	• We're doing this evaluation today • There is consistency within the health system when it comes to evaluation • Diversity of the people who are here today – representing a variety of agencies and the average community member	• Maybe have the right people at the table – the agencies are here, but maybe not the right people from those agencies. Schools need to be here, Hispanic population – only one is here • Diversity of people here is low – the cultures of our community are not here • Not all service receivers are here, the service providers may be here • Not a lot of businesses represented here	• None	• None

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

Priority by Performance Quadrant	Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
Model Standard 10.1 Fostering Innovation				
N/A	• More resources than we are aware of and interest in innovations of research • More activities than we realize	• Lack of resources and committed time. •	• Contact president Milligan and say we want to get access to their library system. • Collaboration, UNL partnerships and resources	• None
Model Standard 10.2 Linkage to Institutes of Higher Learning and/or Research				
N/A	• Campaigns - IE flu (HD, schools, church) West Nile, HD feeds it and gets ready (guides issues) Marketing and social media (College of public Health have best practices) • Multiple places of higher learning	• Population that needs to be disseminated to those at a level everyone can understand. (think in Tweeter-ees) • Populations (minority) communities the information is culturally appropriate (accessed in the same way) [IE: info from church is "good" information] • Are the populations subjects in the research and their input thought	• Social media options [Tweeter starts within the public health system]	• None
Model Standard 10.3 Capacity to Initiate or Participate in Research				
N/A	• Partners are in place and everyone is doing something, just needs to be connected	• Linkage between the people who have the primary information and how to put it at a level to disseminate to the public • Priority – weighing	• Structure a community convenience survey with education brought to you by the local public health system.	• None

		devoted time with researchers; is it a priority for the community to be involved in research		

APPENDIX C: Additional Resources

General

Association of State and Territorial Health Officers (ASTHO)
http://www.astho.org/

CDC/Office of State, Tribal, Local, and Territorial Support (OSTLTS)
http://www.cdc.gov/ostlts/programs/index.html

Guide to Clinical Preventive Services
http://www.ahrq.gov/clinic/pocketgd.htm

Guide to Community Preventive Services
www.thecommunityguide.org

National Association of City and County Health Officers (NACCHO)
http://www.naccho.org/topics/infrastructure/

National Association of Local Boards of Health (NALBOH)
http://www.nalboh.org

Being an Effective Local Board of Health Member: Your Role in the Local Public Health System
http://www.nalboh.org/pdffiles/LBOH%20Guide%20-%20Booklet%20Format%202008.pdf

Public Health 101 Curriculum for governing entities
http://www.nalboh.org/pdffiles/Bd%20Gov%20pdfs/NALBOH_Public_Health101Curriculum.pdf

Accreditation

ASTHO's Accreditation and Performance Improvement resources
http://astho.org/Programs/Accreditation-and-Performance/

NACCHO Accreditation Preparation and Quality Improvement
http://www.naccho.org/topics/infrastructure/accreditation/index.cfm

Public Health Accreditation Board
www.phaboard.org

Health Assessment and Planning (CHIP/ SHIP)

Healthy People 2010 Toolkit

Communicating Health Goals and Objectives
http://www.healthypeople.gov/2010/state/toolkit/12Marketing2002.pdf
Setting Health Priorities and Establishing Health Objectives
http://www.healthypeople.gov/2010/state/toolkit/09Priorities2002.pdf

Healthy People 2020
www.healthypeople.gov

MAP-IT: A Guide To Using Healthy People 2020 in Your Community
http://www.healthypeople.gov/2020/implementing/default.aspx

Mobilizing for Action through Planning and Partnership
http://www.naccho.org/topics/infrastructure/mapp/

MAPP Clearinghouse
http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/
MAPP Framework
http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm

National Public Health Performance Standards Program
http://www.cdc.gov/nphpsp/index.html

Performance Management /Quality Improvement

American Society for Quality; Evaluation and Decision Making Tools: Multi-voting
http://asq.org/learn-about-quality/decision-making-tools/overview/overview.html

Improving Health in the Community: A Role for Performance Monitoring
http://www.nap.edu/catalog/5298.html

National Network of Public Health Institutes Public Health Performance Improvement Toolkit
http://nnphi.org/tools/public-health-performance-improvement-toolkit-2

Public Health Foundation – Performance Management and Quality Improvement
http://www.phf.org/focusareas/Pages/default.aspx

Turning Point
http://www.turningpointprogram.org/toolkit/content/silostosystems.htm

US Department of Health and Human Services Public Health System, Finance, and Quality Program
http://www.hhs.gov/ash/initiatives/quality/finance/forum.html

Evaluation

CDC Framework for Program Evaluation in Public Health
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm

Guide to Developing an Outcome Logic Model and Measurement Plan (United Way)
http://www.yourunitedway.org/media/Guide_for_Logic_Models_and_Measurements.pdf

National Resource for Evidence Based Programs and Practices
www.nrepp.samhsa.gov

W.K. Kellogg Foundation Evaluation Handbook
http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx

W.K. Kellogg Foundation Logic Model Development Guide
http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx

How has life in Adams County changed in the in last ten years?

Demographics:

- population increase
- more of a diverse population
- increasing older population
- increase in single parent households
- increasing college population

Economy:

- Regional Center closed
- closing or down-sizing of some businesses
- expansion of coal fire plant
- revitalization of downtown area
- development of North 281 - business growth north of town
- disposable household income has decreased
- more people are returning to school
- funding commitment from the state but in general state support has decreased
- more federal regulations on environmental issues
- better agricultural economy
- no mall

Technology:

- technology use is up
- social media boon

Healthcare:

- expanded healthcare at hospital
- South Heartland District Health Department development
- opening of convenient care
- mental health reform
- increase in Medicare patients
- increased price of ambulance service and health care
- obesity rates up, smoking down

Youth:

- new middle school
- increased cooperation between 3 area schools/mayors youth council
- 4 elementary schools participating in healthy eating habits
- collaboration for kids in need: Zone afterschool program, backpack programs, truancy program
- bullying is a big issue
- greater need for weekend services for kids and families
- youth more outspoken and want to be involved (i.e. youth leadership group)
- increase in the number of students who qualify for reduced school lunches

Substance abuse:

- strides made in substance abuse prevention – meth coalition
- Cocaine influx: drugs still a problem

- pharmaceutical drug abuse rising

Community attitudes, activities & services:

- Strong support for military veterans and those in service
- more community support to help other agencies
- increased awareness about sexual orientation differences, safe school environment, suicide prevention
- growing, active volunteer population
- green movement, more environmentally aware
- greater support for creating healthy environments: new trail, new water park, smoke- free environments, healthful food
- transportation used to be housed locally but it is now controlled by Kearney and is limited in the outer counties - public transportation on evenings and weekends unavailable
- sack lunches available for people in need

Adams County: Forces, Opportunities, Threats

Force of Change	Opportunities	Threats
Location: • Away from interstate • Rural setting/small town feel	Strong partnerships among local organizations, friendly feel, resources more available, you are "a name not a number"	Lack of interstate access can hamper attraction for some business
Local economy: • Stable/slow, steady growth • Expansion of power plant • Increase in land values/commodity prices • Closing of some businesses, mall stores	More employment opportunities; Increased use of ethanol; international relationships; more ag-related businesses; businesses combining to lower overhead; unleash creativity for new businesses; mall has space for more business, is a great indoor walking trail	Ag bubble bursts; environmental legislation; lack of stores can make it difficult for employment recruitment (cancer center doctors); mall management prevents development
Increasing community diversity	Learn to compromise, be tolerant, open to new ideas, learn more about cultures and the world; translation opportunities	Problems with communication barriers, acceptance, customs
Health Care: • Hospital expansion • Health care reform • Reimbursement changes	Wellness prevention focus, better access, more services, healthier community, better use of dollars; increased partnerships and collaborations; more jobs	Overburden system; may increase costs; turnover in physician population (retirement); shortage of healthcare workers; more regulations
Closing of Regional Center	Community-based services; use of site in productive manner	Lack of mental health services; safety risks
Focus on education: • More people attending college • New middle school • Increasing school collaboration • No Child Left Behind (NCLB)	Healthier students; better educated workforce; help for poor performing schools; can extend education without leaving community	NCLB: Limited focus, teaching to test, penalizes schools with a high ratio of kids with special learning needs
Increased influence/use of media/technology:	Increased accessibility to information instantly; more jobs; can work anywhere; extends	Loss of privacy; changed communication skills (no eye contact, etc); more sedentary lifestyle; instant

• Internet • Social media • Electronic medical records	community; mass outreach	communication (good and bad), internet bullying
Split families/changing parental roles/decreased family time	Learn to choose priorities and find balance; community commitment to education and accountability; all people accountable to each other and other families; make time together quality time; teach kids time management; educate parents	Loss of family unit morals and values; vicious cycle; truancy, children on own, less accountability, stressors, need for youth services
Decreased disposable income: • Increasing prices (gas, medical care) • Economic instability (foreclosures, stock market)	More opportunity for service projects; learn efficiencies, cost savings; low-cost family activities; consolidation, living more simply	Not enough for basic human needs; less dental/health care; increased need for services
Government programs/regulations	public protection; services; funding; better education, improved community health and well-being; educational opportunities for self-sufficiency	Sense of entitlement; distrust; abuse of resources; increased division/conflict; hidden agendas; no personal accountability and responsibility; overstep constitutional limitations, generate radicals
9/11	Community pride, increased security awareness; different organizations working together	Overly protective
Abuse/Scandals (Penn State, etc.)	Policy development	Loss of trust; compromise integrity
Climate Change	Increased awareness of environmental issues, “greener” focus on sustainability; better stewards of the land	Expense of managing; weather disasters; loss of control of land

How has life in Clay County changed in the in last ten years?

Demographics:

- shift in population centers (some towns have grown - others not)
- outmigration
- fewer young people around

Economics:

- cost of living gone up (ex. gas prices): more people using commodities, food pantries, trying to get assistance
- local businesses suffer as people shop elsewhere – except in Sutton where businesses have grown
- increase in ag related businesses in the last couple of years
- more seniors working to older age

Technology:

- more technology, texting, use of social media and internet

Healthcare:

- health services increasing countywide
- fewer people going to health classes (face to face)
- less people seeking preventive care/more reactive
- cost of prescriptions/over the counter medications gone up along with insurance costs and deductibles

Family life:

- more demand on people's time and money
- more emphasis on sports and other activities students are involved in – more parental involvement in these activities
- structure of family has changed – fast food on the go, more single parents, more male single parents, less family connections /meals/interaction
- fewer young people in churches or volunteering
- working people sandwiched between generations

Youth:

- school district consolidation
- more children in poverty
- more youth activities now than before – kids busy
- young people don't seem to sense the need for volunteerism
- kids introduced much younger to drugs, alcohol, etc.
- more youth need counseling

Community attitudes and activities:

- less social interaction within community
- desire to volunteer down, concern about liability up

- sense of community among younger people lacking - older emergency volunteers and shortage of emergency volunteers
- banks and other businesses contribute more for things like senior services
- more senior activities, worsening of transportation for older population
- youth of various cultures forming bonds but divisions remain between parents

More regulations

Clay County: Forces, Opportunities, Threats

Force of Change	Opportunities	Threats
Rural location • Railroad and highway access • Distance from population centers • No hospital in county	Room to expand businesses/services; clean air; access to additional services; more people traveling through county; need for in-home care services	Isolation; easy for people to leave; distance from some services; railroad accidents/hazmat problems
Changing demographics: • Declining population • More older residents (working longer, living alone) • Increasing ethnically-diverse population	Care opportunities, opening of senior centers; need for assisted living/group housing for elderly; intergeneration interaction, social activities; know history of area; grow services through involvement of younger people; meals on wheels; build on relationships between youth of all cultures, hold ethnic festivals, learn other customs	Isolation/separation; school consolidation; increased depression, worry, stress; decline in physical, mental spiritual health; burden on resources (time, $, family); challenges accommodating seniors needs
Economy • Business closures/fewer jobs • New businesses opened in hub communities • Cost of living increasing • More people in poverty • Increased land values/commodity prices	Capitalize on needs of the aging population by recruiting businesses that meet their needs while building community and volunteerism; learn old ways of self-sufficiency (gardening, canning, walking); increase desire to brainstorm/collaborate and pool resources; community centers; increased support of local businesses	Less connection to community if work elsewhere; lacking some services; younger people move away to find jobs; less dollars in community; increased dependency on assistance programs; empty older homes, vandalism
MARC	Brings jobs and educated people and potential leaders into community; global recognition, research/new discoveries	Disease/terror threats; incoming people not attached to county
9/11	Interagency collaboration; opportunities for public safety and preparedness; federal funding for medical research, public safety; jobs; chance to spark desire for community involvement; increased vigilance	Increased regulation; economic burden; decreased trust in others, attitude of “look out for yourself”
Changing health care: • Clinic services in county	Better health care; research options; new healthcare available in county; county and district	Increased costs; seniors could choose to move to larger cities for services or closer to children for assistance if

• Health care reform • Medicare payment changes • Access NE wait times • EMT regulations	health department services; need for more satellite clinics that make for a short drive for medical care: pharmacy/eye clinic/therapy	services not available; harder to find EMTs
Technology explosion	Independence; growth and learning skills; increased access to health information; opportunities to teach others; home-based businesses, keep people home; online shopping	Loss of human contact, focus on technology, not people; less exercise; dollars go out of community
Community attitudes and activities: • Decreased community leadership • More reliance on government assistance vs church/neighbor support	Involvement and growth for new people; more community activities to pull people together and learn to trust each other; neighborhood watch program; invite youth involvement	Lack of trust in government and each other; loss of growth and wisdom passed from elders

How has life in Nuckolls County changed in the in last ten years?

Demographics:

- population declining; outmigration
- fewer younger people (aging population)

Economics:

- some business growth and closing of other businesses; some businesses have gone and then come back
- more home-based businesses
- fewer job opportunities
- strong ag sector-farmland prices up; bigger farms but there are fewer of them
- income levels are lower
- minimum wage went up

Technology:

- growing use of Internet and other technology

Healthcare:

- better/beautiful medical facilities
- more access to medical specialty services
- more medical staff now
- greater collaboration
- Medicaid now handled through call center

Family life:

- people are moving into town
- more families co-habitating
- more single parents, blended and non-traditional families, divorce more acceptable
- less people in churches fewer children in Sunday schools : more sharing of pastors
- change in values: generational differences in parental expectations, discipline in homes and school
- parents used to be more likely to volunteer (coach, girl scout leaders, etc)
- more parents are working and some with multiple jobs
- domestic violence up
- growing attitude to "just get by"

Youth:

- school consolidations, fewer students in schools
- students have changed
- better college opportunities, more kids going to college
- more activities/opportunities for kids to participate in currently
- kids cannot get jobs because labor laws have changed especially in the agriculture
- more internet bullying, etc.
- differing opinions if use of drugs in school is down or up; DARE program still active

Community attitudes and activities:

- not as many volunteers: no more Relay for Life
- drug and alcohol use is more socially acceptable and spans generations
- less focus on programs to support prevention

Nuckolls County: Forces, Opportunities and Threats

Force of Change	Opportunities	Threats
Rural location: • Distance from cities, interstate/airports • Lower housing costs • Increasing land values and crop prices	Less crime; room for people to come and settle; good quality of life/air; people coming back (especially retirees); increased tax revenue (from land values); higher commodity prices can keep farmers spending money; eliminate substandard housing and create more green space	Out of way location can be appealing to transient populations and undesirables with no desire to work; housing deterioration; harder to buy land for first-time buyers; farm transitions to others (relatives or others) who are not local and spend assets elsewhere
Economy: • Loss of industries • Higher costs of gas, food, medical care • Lower average income/fewer middle class • More working parents	Service job creation/jobs using technology to keep work close to home, reduce need to travel; seek outside funding to provide needed services for working poor; working parents increasing family resources and future security need daycare and other support services; opportunities to support local businesses	Increased use of credit/more credit problems; more stress on families; increased need for hospital charity care
Changing demographics: • Decreased Population • Older Population • More people with lower incomes	Less people/less crime, more community spirit/bonding, quiet neighborhoods; seniors with resources have the opportunity to spend money on things that they want or need; may be more philanthropic, possess sense of history/knowledge, more time to volunteer, while some are working longer and more active, others need more healthcare; opportunities to create service jobs that meet residents' needs: senior care	Fewer businesses, fewer workers-hard to replace professionals and business transitions; increased reliance on assistance programs; less population to support grant requests to fund services; effect on school systems of fewer children in schools
Prosperous Local Healthcare System	Access to more medical specialties, easier to get appointments and information, community draw, less travel and improved healthcare; more choices	Higher cost of care, challenge to maintain good communication between specialties
Increased use of technology	Better informed public, telemedicine/telehealth, increased job opportunities, call centers, more home-based businesses so parents can spend more time with kids, better access and quality of healthcare, increased collaboration between clinics saving resources for other things, better patient self-care	Access limited – older people can be less inclined to use technolgy; stress of fast-pace, danger of losing social/personal interaction, own capabilities (think less); making sure info is credible, information overload, challenge of organization/recordkeeping; risk of poorer health due to inactivity (sitting in front of

		screen); lack of good communication/collaboration could result in malpractice or mismanaged care
Government programs: • State funding cutbacks • Obama care • Increasing regulations	Community forced to rely more on itself, increased local and regional collaboration; potential for increased access to medical care, improved health and safety of everyone (some disagreement)	Increased costs/complications, smaller towns die or feel pinched, loss of Medicare funds
Nelson Nursing Home closure	New business could develop/use space; the facility could be used for a fitness center, prayer center, etc., it could go back on the tax roles	Loss of jobs, out migration
Youth/Family issues: • Change in family structure (single parent families, etc.) • School consolidation • Change in family values • Fewer youth working	Kids learn responsibility/independence; youth have more time to spend doing school work, exercise, life skills learning and volunteering; meet students from other communities; school could run year-round; after-school programs could involve faith-based organizations and create opportunities to learn and positive places to play at no/low cost; create mentorship programs - community organizations can step up to help families be stronger/more balanced and help shape community values; more jobs are available for adults	Less family income, risk that family businesses will close; increased sense of entitlement, lack of work ethics, job experiences; more risky behaviors, delinquency, cost/stress on legal system,; youth inactivity -"sitting" watching videos/obesity; farther distances to travel for school, risk of more accidents
Community spirit and local activities: • Fewer people doing more • Less volunteerism	Be pro-active in creating positive environment for change; invite involvement from youth, seniors	Negative or pessimistic views

How has life in Webster County changed in the last ten years?

Demographics:

- population is smaller
- older

Economics:

- local shopping is down, fewer businesses in town, more people shopping in Hastings
- people are more mobile, travel more
- more families living with lower incomes
- less farming jobs available with more mechanization
- bigger farms
- new feedlots providing employment
- more people traveling to work outside community
- some people don't want to work

Healthcare:

- more health clinics in county
- expansion of hospital services
- wonderful health care services and workforce
- many towns have volunteer EMTs

Technology:

- More reliance on technology

Family life:

- more stressed families, single parents, dysfunctional families
- more parental involvement by some but there are also a lot who don't want to parent
- some families have both parents working: less time with kids
- more families on public assistance

Youth:

- less out of school activities for youth: youth don't have much to do if they don't play sports
- not a strong need for activities that are available

Community attitudes and activities:

- less feeling of community
- community attitudes about drugs/alcohol have changed
- lack of trust with state & federal gov.
- less volunteerism than in the past
- Home Town Committee trying to keep young people in town and get people to come back
- more senior services, transportation

Webster County: Forces, Opportunities and Threats

Force of Change	Opportunities	Threats
Healthcare: • Funding for Critical Access hospital and increased services locally • Affordable Care Act (National healthcare) w/insurance exchanges • Preparedness funding • Less state/national funding available for some initiatives	More people with access to care closer to home, reducing travel; Increased services; more individualized care; greater emphasis on prevention initiatives; healthier people	Not enough medical workforce; small businesses may not be able to bear the burden of cost; increased regulations; lowered reimbursements; risk of losing government assistance in long term care;
Pervasive Advertising (prevent health risks, personal wellness, don't drive and drink)	More people actively involved in improving their health status	Not everyone getting message
Internet	Opens the world; can get anything from anywhere, educate yourself – opens new job opportunities; lowers cost of medical care (telehealth); opens opportunities for collaboration	Money leaving community; less personal interaction; decrease in community spirit; loss of privacy; unregulated information – accurate?
Rural location: • 2 main towns at opposite ends of county • Proximity to major highways with access to larger communities, but no railroad or interstate close • Less expensive to live	More tourism and senior living opportunities; keep purchases local; community knows each other; less capital output needed for start-up businesses; attract service sector	Less industry/jobs; Not many tax breaks to draw businesses; healthcare deliveries are not consistent (few sales reps come this far): Limited availability/selection of items; difficult to recruit/retain workers; Residents can shop/work elsewhere
Unstable Economy: • Loss of industry/jobs • More corporate stores less hometown stores • Less need for ag workers • Rising gas prices	More people seeking jobs locally; needs could draw some small service businesses, phone centers, on-line ordering	Rise in Medicaid-eligible; A lot of uncertainty especially with rising health care costs and coverage issues
Changing demographics: • More residents becoming seniors • Number of low-income residents increasing • Non-traditional families increasing	Seniors provide a good pool of volunteers; More senior services are being developed; more federal dollars may be available to serve lower income; opportunities to create affordable housing/senior living; increased	Loss of elder $. Less people around with larger income – moving to retirement villages elsewhere; May not have enough workforce to provide services to seniors; resources may disappear; schools closing; businesses not able to survive

	need for medical services and repair services; More education and information opportunities available for all ages; Opportunities to provide services to assist nontraditional families; Promote the community and capitalize on services that serve the population	
Youth issues: • Educational quality and future prospects • Increase in depression, bullying, marijuana use, energy drinks • Fewer kids going out for sports, etc.	Many enthusiastic students: HTC offers opportunities to involve young people; School facility improvements attract young families; More access to funds and loans for further education; New positive after-school activities could be developed	High cost of furthering education can put a burden on families; less involvement in afterschool activities can mean more time to get into trouble
Community spirit and local issues: • Perception of less community spirit/involvement • Differing values (property upkeep) • Future road development	Reach out to new residents and invite them to get involved	Brick street issue dividing community (heritage vs. funding to repair)
Increased illegal drug use among all ages	Inform the public of the problem and how to recognize it	Negative impact on the lives of family and friends; Increase need for rehab; less safe roads

2011 Nebraska Community Themes and Strengths Assessment Survey Results

South Heartland District Health Department

Covering: Adams, Clay, Nuckolls, and Webster Counties

Prepared by the Nebraska Department of Health and Human Services

December 5, 2011

Department of Health & Human Services
DHHS
NEBRASKA

Introduction and Methodology

The following is a brief overview of the methods used to collect and report data from the 2011 Nebraska Community Themes and Strengths Assessment Survey. Survey administration was conducted by the University of Nebraska Medical Center while the analysis and reporting of information presented within this document was conducted by the Nebraska Department of Health and Human Services (NDHHS).

The purpose of the survey is to better inform state and local health planning efforts. The NDHHS and many local health departments (LHDs) are in the process of implementing the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning process. One of the four MAPP assessments is to conduct a community themes and strengths assessment. This survey is being used to meeting this assessment component of the State of Nebraska MAPP process.

Questionnaire Design
The questionnaire used in this study was based largely on a 2008 Community Health Survey developed jointly by representatives from LHDs in Nebraska as well as the NDHHS. The 2008 survey was designed as a paper and pencil survey and has been used by many LHDs when conducting their MAPP assessments. This survey was modified from the original version to expand the scope and breadth of the topics covered on the questionnaire and to convert the questionnaire from a paper and pencil format to a telephone format. The survey was modified following a review of surveys from other states and communities and by utilizing guidance and feedback from LHDs, the Public Health Association of Nebraska (PHAN), NDHHS, and a questionnaire design expert.

Survey Administration
The survey was administered via telephone between July and October 2011 using random digit dial methods. The sample was stratified by 18 regions in Nebraska, which consisted of 17 LHDs who chose to be part of the stratified design and the remaining four non-participating LHDs lumped together in the remaining stratum. To ensure that each participating LHD had sufficient numbers for local analysis and reporting the sample was divided equally across the 18 regions with a total of 500 completed surveys being targeted in each region. A total of 9,077 surveys were collected and a raw database was delivered by UNMC to the NDHHS in late October 2011.

Data Analysis
The sample was compiled by telephone area code and prefix. While this is a common and largely accurate sampling selection process telephone numbers can sometimes fall outside of the county or region for which they are targeted. Individuals who complete the survey are asked to report which county and zip code they live in, and in some instances their self reported county of residence was different than the survey stratum they were grouped in during the data collection process. As a result, the self reported county of residence variable was used to group respondents into the 18 regions, which did result in some regions having slightly less than 500 completed surveys and some having slightly more (the range was from 466 in one LHD to 592 in the non-participating LHD region).

Data were weighed by LHD region, gender, and age to be reflective of the LHD and State of Nebraska population. All analyses presented in this report were conducted using SAS, Version 9.2, and to obtain correct standard errors for weighted percentages, SAS-callable SUDAAN, Version 10.0.1, was used.

On some of the survey questions a fairly large percentage of respondents answered ‘don’t know.’ To allow for the calculation of survey means these responses were coded as missing, along with a very small number who refused to answer some of the questions. The number and percentage of missing data is presented within each table in this document.

See footnotes under each data table for further description of the survey methods and to inquire further about the survey methods or data results you can contact the NDHSS at 402-471-2353.

Table 1a: Mean Values for Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
1a1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	493	1.65	(1.51 - 1.80)	3	0.6%	8,998	1.59	(1.53 - 1.64)	79	0.9%	NS
Region^^	490	1.28	(1.21 - 1.35)	6	1.2%	8,994	1.36	(1.32 - 1.41)	83	0.9%	NS
1a2. The healthcare services that are available in your community/region are excellent:											
Community^	492	1.93	(1.78 - 2.07)	4	0.8%	8,969	1.82	(1.76 - 1.89)	108	1.2%	NS
Region^^	483	1.68	(1.58 - 1.79)	13	2.6%	8,895	1.58	(1.53 - 1.64)	182	2.0%	NS
1a3. There are enough medical specialists available in your:											
Community^	486	2.36	(2.15 - 2.57)	10	2.0%	8,890	2.07	(2.00 - 2.15)	187	2.1%	+
Region^^	478	1.79	(1.64 - 1.94)	18	3.6%	8,851	1.69	(1.63 - 1.75)	226	2.5%	NS
1a4. The hospital care being provided in your *community/region* is excellent:											
Community^	489	2.17	(1.98 - 2.36)	7	1.4%	8,859	1.92	(1.86 - 1.99)	218	2.4%	NS
Region^^	472	1.64	(1.52 - 1.76)	24	4.8%	8,790	1.63	(1.57 - 1.69)	287	3.2%	NS
1a5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (Scale Flipped)*	487	3.11	(2.86 - 3.37)	9	1.8%	8,907	3.24	(1.00 - 3.34)	170	1.9%	NS
1a6. Percentage who personally received healthcare services in their region during the past 12 months**	496	73.9%	(66.4 - 80.3)	0	0.0%	9,059	72.0%	(68.9 - 74.9)	18	0.2%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value (or percentage where noted) weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean or percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean/percentage significantly higher than the state ($p < 0.05$); "-" = LHD mean/percentage significantly lower than the state ($p < .05$); "NS" = LHD mean/ percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

* This survey question (i.e., data measure) was asked in the opposite direction compared almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, the scale for this question was recoded to make results comparable to the mean value for the other questions, where a value of 1 was recoded to a value of 5, 2 to 4, 3 remained the same, 4 to 2, and 5 to 1. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

** Received health case services at a hospital, emergency room, doctors' office, or health clinic in their region (including their community and/or broader region) during the past 12 months

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 1b: The Percentage who Somewhat or Strongly Disagree with Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
1b1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	493	9.7%	(6.2 - 15.0)	3	0.6%	8,998	9.1%	(7.8 - 10.8)	79	0.9%	NS
Region^^	490	1.8%	(0.9 - 3.6)	6	1.2%	8,994	4.2%	(3.2 - 5.5)	83	0.9%	NS
1b2. The healthcare services that are available in your community/region are excellent:											
Community^	492	13.9%	(10.1 - 19.0)	4	0.8%	8,969	12.2%	(10.6 - 14.0)	108	1.2%	NS
Region^^	483	6.0%	(3.9 - 9.1)	13	2.6%	8,895	6.3%	(5.0 - 7.9)	182	2.0%	NS
1b3. There are enough medical specialists available in your:											
Community^	486	26.1%	(20.1 - 33.1)	10	2.0%	8,890	20.8%	(18.8 - 22.9)	187	2.1%	NS
Region^^	478	10.6%	(6.9 - 15.8)	18	3.6%	8,851	10.6%	(9.0 - 12.5)	226	2.5%	NS
1b4. The hospital care being provided in your community/region is excellent:											
Community^	489	20.1%	(15.0 - 26.3)	7	1.4%	8,859	15.0%	(13.3 - 16.8)	218	2.4%	NS
Region^^	472	6.8%	(4.0 - 11.1)	24	4.8%	8,790	7.0%	(5.6 - 8.8)	287	3.2%	NS
1b5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (% who somewhat/strongly agree)*	487	51.5%	(43.9 - 59.0)	9	1.8%	8,907	56.2%	(1.0 - 59.1)	170	1.9%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

* This survey question (i.e., data measure) was asked in the opposite direction compared to almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, to be consistent with the other measures in this table, the percentage for this measure reflects the undesirable response, which in this case is the percentage who answered somewhat or strongly agree. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 2a: Mean Values for Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older who have personally received healthcare services within their region during the past 12 months*, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
2a1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	373	1.71	(1.52 - 1.89)	2	0.5%	6,707	1.57	(1.51 - 1.64)	43	0.6%	NS
Region^^	369	1.29	(1.21 - 1.37)	6	1.6%	6,684	1.35	(1.29 - 1.40)	66	1.0%	NS
2a2. The healthcare services that are available in your community/region are excellent:											
Community^	373	1.97	(1.81 - 2.13)	2	0.5%	6,685	1.80	(1.73 - 1.87)	65	1.0%	NS
Region^^	368	1.69	(1.58 - 1.80)	7	1.9%	6,637	1.55	(1.49 - 1.61)	113	1.7%	NS
2a3. There are enough medical specialists available in your:											
Community^	369	2.44	(2.20 - 2.68)	6	1.6%	6,627	2.08	(2.00 - 2.16)	123	1.8%	+
Region^^	362	1.82	(1.65 - 2.00)	13	3.5%	6,602	1.66	(1.60 - 1.72)	148	2.2%	NS
2a4. The hospital care being provided in your *community/region* is excellent:											
Community^	370	2.24	(2.02 - 2.46)	5	1.3%	6,610	1.89	(1.82 - 1.96)	140	2.1%	+
Region^^	356	1.70	(1.56 - 1.84)	19	5.1%	6,571	1.60	(1.53 - 1.66)	179	2.7%	NS
2a5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (Scale Flipped)**	369	2.99	(2.71 - 3.27)	6	1.6%	6,636	3.19	(3.08 - 3.31)	114	1.7%	NS

* Received health case services at a hospital, emergency room, doctors' office, or health clinic in their region (including their community and/or broader region) during the past 12 months

[a] Non-weighted number of survey respondents, among those reported having personally received healthcare services within their region during the past 12 months (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

** This survey question (i.e., data measure) was asked in the opposite direction compared almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, the scale for this question was recoded to make results comparable to the mean value for the other questions, where a value of 1 was recoded to a value of 5, 2 to 4, 3 remained the same, 4 to 2, and 5 to 1. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 2b: The Percentage who Somewhat or Strongly Disagree with Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older who have personally received healthcare services within their region during the past 12 months*, 2011

	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
Data Measure	**Sample Size (n)[a]**	**% Who Disagree[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**% Who Disagree[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	
2b1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	373	11.7%	(7.1 - 18.7)	2	0.5%	6,707	9.4%	(7.8 - 11.3)	43	0.6%	NS
Region^^	369	2.2%	(1.0 - 4.5)	6	1.6%	6,684	3.9%	(2.8 - 5.4)	66	1.0%	NS
2b2. The healthcare services that are available in your community/region are excellent:											
Community^	373	14.1%	(9.5 - 20.3)	2	0.5%	6,685	11.7%	(9.9 - 13.7)	65	1.0%	NS
Region^^	368	5.8%	(3.6 - 9.2)	7	1.9%	6,637	5.5%	(4.2 - 7.3)	113	1.7%	NS
2b3. There are enough medical specialists available in your:											
Community^	369	27.8%	(20.7 - 36.3)	6	1.6%	6,627	20.8%	(18.6 - 23.2)	123	1.8%	NS
Region^^	362	10.8%	(6.4 - 17.5)	13	3.5%	6,602	9.6%	(8.0 - 11.5)	148	2.2%	NS
2b4. The hospital care being provided in your *community/region* is excellent:											
Community^	370	20.9%	(14.8 - 28.6)	5	1.3%	6,610	13.9%	(12.2 - 15.8)	140	2.1%	NS
Region^^	356	7.2%	(3.9 - 12.7)	19	5.1%	6,571	6.2%	(4.8 - 8.0)	179	2.7%	NS
2b5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (% who somewhat/strongly agree)**	369	47.4%	(39.0 - 55.9)	6	1.6%	6,636	54.9%	(51.5 - 58.2)	114	1.7%	NS

* Received health case services at a hospital, emergency room, doctors' office, or health clinic in their region (including their community and/or broader region) during the past 12 months

[a] Non-weighted number of survey respondents, among those reported having personally received healthcare services within their region during the past 12 months (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

** This survey question (i.e., data measure) was asked in the opposite direction compared to almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, to be consistent with the other measures in this table, the percentage for this measure also reflects the undesirable response, which in this case is the percentage who responded with an answer of somewhat or strongly agree. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 3a: Mean Values for Measures related to Supports for Raising Children, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
3a1. Safe and affordable childcare is available within your community	381	2.12	(1.93 - 2.30)	115	23.2%	7,329	2.11	(2.02 - 2.20)	1,748	19.3%	NS
3a2. Your community has excellent schools	477	1.56	(1.45 - 1.67)	19	3.8%	8,745	1.66	(1.58 - 1.74)	332	3.7%	NS
3a3. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	389	2.69	(2.47 - 2.92)	107	21.6%	7,346	2.43	(2.33 - 2.53)	1,731	19.1%	NS
3a4. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	426	1.97	(1.77 - 2.17)	70	14.1%	8,023	2.02	(1.94 - 2.11)	1,054	11.6%	NS
Among Those with Kids <18 Living at Home											
3a5. Safe and affordable childcare is available within your community	85	2.23	(1.89 - 2.58)	12	12.4%	1,972	2.11	(1.96 - 2.26)	155	7.3%	NS
3a6. Your community has excellent schools	96	1.52	(1.33 - 1.72)	1	1.0%	2,104	1.67	(1.51 - 1.83)	23	1.1%	NS
3a7. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	89	2.79	(2.37 - 3.21)	8	8.2%	1,980	2.45	(2.28 - 2.63)	147	6.9%	NS
3a8. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	94	2.12	(1.72 - 2.53)	3	3.1%	2,034	2.00	(1.87 - 2.14)	93	4.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 3b: Percentage who Somewhat or Strongly Disagree with Measures related to Supports for Raising Children, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
3b1. Safe and affordable childcare is available within your community	381	16.2%	(11.1 - 22.9)	115	23.2%	7,329	14.9%	(12.5 - 17.7)	1,748	19.3%	NS
3b2. Your community has excellent schools	477	4.5%	(2.7 - 7.4)	19	3.8%	8,745	8.6%	(6.5 - 11.3)	332	3.7%	NS
3b3. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	389	33.2%	(25.9 - 41.4)	107	21.6%	7,346	27.0%	(24.0 - 30.2)	1,731	19.1%	NS
3b4. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	426	17.4%	(12.1 - 24.3)	70	14.1%	8,023	16.0%	(13.8 - 18.6)	1,054	11.6%	NS
Among Those with Kids <18 Living at Home											
3b5. Safe and affordable childcare is available within your community	85	19.9%	(10.6 - 34.3)	12	12.4%	1,972	15.8%	(11.9 - 20.8)	155	7.3%	NS
3b6. Your community has excellent schools	96	3.0%	(0.9 - 9.7)	1	1.0%	2,104	10.2%	(6.4 - 16.0)	23	1.1%	NS
3b7. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	89	35.8%	(23.1 - 50.9)	8	8.2%	1,980	28.3%	(23.5 - 33.6)	147	6.9%	NS
3b8. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	94	23.7%	(13.7 - 38.0)	3	3.1%	2,034	15.5%	(12.3 - 19.4)	93	4.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 4a: Mean Values for Measures related to Supports for Older Adults, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
4a1. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	472	2.16	(1.98 - 2.33)	24	4.8%	8,615	2.29	(2.20 - 2.39)	462	5.1%	NS
4a2. There is enough transportation available in your community to take older adults to medical facilities and shopping	454	2.66	(2.39 - 2.92)	42	8.5%	8,419	2.77	(2.67 - 2.86)	658	7.2%	NS
4a3. There are enough programs that provide meals for older adults in your community	452	2.29	(2.12 - 2.46)	44	8.9%	8,241	2.48	(2.38 - 2.58)	836	9.2%	NS
4a4. There are a lot of social networks and groups in your community available for older adults that are living alone	427	2.69	(2.48 - 2.91)	69	13.9%	7,646	2.82	(2.72 - 2.91)	1,431	15.8%	NS
Among Survey Respondents Aged 65+											
4a5. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	213	1.79	(1.64 - 1.95)	11	4.9%	3,495	2.13	(2.01 - 2.25)	153	4.2%	-
4a6. There is enough transportation available in your community to take older adults to medical facilities and shopping	207	1.92	(1.76 - 2.08)	17	7.6%	3,386	2.50	(2.36 - 2.63)	262	7.2%	-
4a7. There are enough programs that provide meals for older adults in your community	209	1.88	(1.69 - 2.07)	15	6.7%	3,371	2.12	(1.99 - 2.24)	277	7.6%	NS
4a8. There are a lot of social networks and groups in your community available for older adults that are living alone	192	2.30	(2.06 - 2.54)	32	14.3%	3,041	2.70	(2.56 - 2.84)	607	16.6%	-

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 4b: Percentage who Somewhat or Strongly Disagree with Measures related to Supports for Older Adults, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
4b1. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	472	19.1%	(14.1 - 25.4)	24	4.8%	8,615	23.5%	(20.5 - 26.7)	462	5.1%	NS
4b2. There is enough transportation available in your community to take older adults to medical facilities and shopping	454	37.7%	(29.9 - 46.1)	42	8.5%	8,419	36.0%	(32.8 - 39.4)	658	7.2%	NS
4b3. There are enough programs that provide meals for older adults in your community	452	21.2%	(15.9 - 27.8)	44	8.9%	8,241	26.4%	(23.2 - 29.8)	836	9.2%	NS
4b4. There are a lot of social networks and groups in your community available for older adults that are living alone	427	36.3%	(28.5 - 44.8)	69	13.9%	7,646	34.2%	(30.9 - 37.6)	1,431	15.8%	NS
Among Survey Respondents Aged 65+											
4b5. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	213	11.7%	(8.0 - 17.0)	11	4.9%	3,495	20.5%	(16.8 - 24.7)	153	4.2%	NS
4b6. There is enough transportation available in your community to take older adults to medical facilities and shopping	207	11.8%	(8.1 - 17.0)	17	7.6%	3,386	29.6%	(25.7 - 33.8)	262	7.2%	-
4b7. There are enough programs that provide meals for older adults in your community	209	14.9%	(9.9 - 21.9)	15	6.7%	3,371	19.4%	(15.9 - 23.3)	277	7.6%	NS
4b8. There are a lot of social networks and groups in your community available for older adults that are living alone	192	23.2%	(15.6 - 33.2)	32	14.3%	3,041	33.6%	(29.1 - 38.5)	607	16.6%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 5a: Mean Values for Measures related to Recreational and Leisure Options, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department						State of Nebraska						LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]		Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]		Missing Data[d]	% Missing[e]	
5a1. There are a lot of places to exercise and play in your community, such as parks, walking/biking trails, swimming pools, gyms, fitness centers, and so forth	491	1.92	(1.75	2.09)	5	1.0%	8,978	1.81	(1.75	1.88)	99	1.1%	NS
5a2. There are a lot of arts, music, and cultural events in your community	482	2.94	(2.68	3.21)	14	2.8%	8,734	2.63	(2.55	2.71)	343	3.8%	NS
5a3. There are a lot of organized leisure time activities available for young adults in your community, such as groups, clubs, teams, and other social activities:													
Among all respondents	429	3.05	(2.85	3.26)	67	13.5%	8,030	2.83	(2.73	2.92)	1,047	11.5%	NS
Among respondents 18-49 years old	103	3.17	(2.84	3.50)	4	3.7%	2,230	2.86	(2.72	3.01)	94	4.0%	NS
5a4. There are a lot of organized leisure time activities available for middle-age adults in your community, such as groups, clubs, teams, and other social activities:													
Among all respondents	455	2.95	(2.76	3.14)	41	8.3%	8,212	2.79	(2.70	2.88)	865	9.5%	NS
Among respondents 50-64 years old	161	3.03	(2.72	3.34)	4	2.4%	2,847	2.80	(2.68	2.91)	202	6.6%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 5b: Percentage who Somewhat or Strongly Disagree with Measures related to Recreational and Leisure Options, among Nebraska Adults aged 18 and Older, 2011

	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
Data Measure	**Sample Size (n)[a]**	**% Who Disagree[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**% Who Disagree[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	
5b1. There are a lot of places to exercise and play in your community, such as parks, walking/biking trails, swimming pools, gyms, fitness centers, and so forth	491	14.1%	(9.5 20.4)	5	1.0%	8,978	12.8%	(10.9 15.0)	99	1.1%	NS
5b2. There are a lot of arts, music, and cultural events in your community	482	43.4%	(35.9 51.2)	14	2.8%	8,734	34.1%	(31.4 36.8)	343	3.8%	NS
5b3. There are a lot of organized leisure time activities available for young adults in your community, such as groups, clubs, teams, and other social activities:											
Among all respondents	429	46.3%	(38.4 54.4)	67	13.5%	8,030	38.9%	(35.7 42.2)	1,047	11.5%	NS
Among respondents 18-49 years old	103	49.6%	(36.1 63.1)	4	3.7%	2,230	40.5%	(35.5 45.7)	94	4.0%	NS
5b4. There are a lot of organized leisure time activities available for middle-age adults in your community, such as groups, clubs, teams, and other social activities:											
Among all respondents	455	43.9%	(36.3 51.8)	41	8.3%	8,212	36.9%	(33.9 40.1)	865	9.5%	NS
Among respondents 50-64 years old	161	46.8%	(36.9 57.0)	4	2.4%	2,847	37.5%	(33.3 41.8)	202	6.6%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 6a: Mean Values for Measures related to Jobs and the Economy, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
6a1. There are enough jobs, either in town or a short drive away, for people living in your community	464	3.09	(2.84 - 3.33)	32	6.5%	8,635	2.82	(2.72 - 2.91)	442	4.9%	NS
6a2. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	438	3.10	(2.85 - 3.34)	58	11.7%	8,226	2.99	(2.90 - 3.07)	851	9.4%	NS
6a3. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	424	2.79	(2.61 - 2.97)	72	14.5%	8,109	2.68	(2.59 - 2.77)	968	10.7%	NS
6a4. The economy in your community is strong	483	2.77	(2.56 - 2.97)	13	2.6%	8,821	2.57	(2.49 - 2.66)	256	2.8%	NS
Among the Working Age (18-64 year olds)											
6a5. There are enough jobs, either in town or a short drive away, for people living in your community	263	3.20	(2.90 - 3.50)	9	3.3%	5,274	2.80	(2.69 - 2.92)	99	1.8%	NS
6a6. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	256	3.10	(2.79 - 3.40)	16	5.9%	5,145	2.96	(2.86 - 3.05)	228	4.2%	NS
6a7. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	254	2.81	(2.59 - 3.03)	18	6.6%	5,127	2.67	(2.57 - 2.78)	246	4.6%	NS
6a8. The economy in your community is strong	267	2.86	(2.61 - 3.11)	5	1.8%	5,290	2.57	(2.47 - 2.67)	83	1.5%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 6b: Percentage who Somewhat or Strongly Disagree with Measures related to Jobs and the Economy, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
6b1. There are enough jobs, either in town or a short drive away, for people living in your community	464	45.4%	(37.8 - 53.1)	32	6.5%	8,635	38.5%	(35.4 - 41.7)	442	4.9%	NS
6b2. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	438	48.0%	(40.3 - 55.9)	58	11.7%	8,226	41.3%	(38.2 - 44.5)	851	9.4%	NS
6b3. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	424	35.8%	(29.1 - 43.2)	72	14.5%	8,109	32.0%	(29.0 - 35.2)	968	10.7%	NS
6b4. The economy in your community is strong	483	36.1%	(29.0 - 43.8)	13	2.6%	8,821	29.9%	(26.9 - 33.1)	256	2.8%	NS
Among the Working Age (18-64 year olds)											
6b5. There are enough jobs, either in town or a short drive away, for people living in your community	263	48.9%	(39.5 - 58.4)	9	3.3%	5,274	38.3%	(34.7 - 42.0)	99	1.8%	NS
6b6. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	256	48.8%	(39.3 - 58.4)	16	5.9%	5,145	40.3%	(36.7 - 44.1)	228	4.2%	NS
6b7. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	254	36.6%	(28.4 - 45.6)	18	6.6%	5,127	31.6%	(28.2 - 35.3)	246	4.6%	NS
6b8. The economy in your community is strong	267	38.4%	(29.5 - 48.0)	5	1.8%	5,290	29.7%	(26.1 - 33.5)	83	1.5%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 7a: Mean Values for Measures related to Housing, Safety & Security, and Social Support & Civic Responsibility, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Housing											
7a1. There is enough quality housing available in your community, including homes and apartments	482	2.22	(2.04 - 2.39)	14	2.8%	8,717	2.07	(2.00 - 2.14)	360	4.0%	NS
7a2. Quality housing in your community is affordable for the average person	461	2.42	(2.24 - 2.61)	35	7.1%	8,425	2.51	(2.42 - 2.61)	652	7.2%	NS
Safety and Security											
7a3. Your community is a safe place to live, work, and play	495	1.50	(1.40 - 1.59)	1	0.2%	9,038	1.60	(1.53 - 1.67)	39	0.4%	NS
7a4. There is a lot of crime in your community (Scale Flipped)*	488	1.84	(1.70 - 1.98)	8	1.6%	8,935	2.10	(2.03 - 2.18)	142	1.6%	-
7a5. Neighbors know and trust one another and look out for each other in your community	489	1.63	(1.51 - 1.75)	7	1.4%	8,979	1.72	(1.64 - 1.80)	98	1.1%	NS
Social Support and Civic Responsibility											
7a6. There are enough support networks in your community for individuals and families during times of stress and need, such as support groups, faith community outreach, community agencies, and so forth	458	2.24	(2.07 - 2.40)	38	7.7%	8,394	2.43	(2.34 - 2.51)	683	7.5%	NS
7a7. People in your community pitch in and help out the community in times of need	480	1.62	(1.48 - 1.77)	16	3.2%	8,901	1.71	(1.63 - 1.79)	176	1.9%	NS
7a8. There are a lot of opportunities for individuals in your community to volunteer	477	1.71	(1.54 - 1.88)	19	3.8%	8,807	1.72	(1.65 - 1.80)	270	3.0%	NS
7a9. A lot of individuals in your community do volunteer work	461	2.09	(1.88 - 2.29)	35	7.1%	8,492	2.13	(2.05 - 2.21)	585	6.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* This survey question (i.e., data measure) was asked in the opposite direction compared almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, the scale for this question was recoded to make results comparable to the mean value for the other questions, where a value of 1 was recoded to a value of 5, 2 to 4, 3 remained the same, 4 to 2, and 5 to 1. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 7b: Percentage who Somewhat or Strongly Disagree with Measures related to Housing, Safety & Security, and Social Support & Civic Responsibility, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Housing											
7b1. There is enough quality housing available in your community, including homes and apartments	482	21.7%	(16.5 - 27.9)	14	2.8%	8,717	18.2%	(16.2 - 20.3)	360	4.0%	NS
7b2. Quality housing in your community is affordable for the average person	461	26.2%	(20.7 - 32.6)	35	7.1%	8,425	28.1%	(25.0 - 31.4)	652	7.2%	NS
Safety and Security											
7b3. Your community is a safe place to live, work, and play	495	3.7%	(2.2 - 6.2)	1	0.2%	9,038	7.0%	(5.4 - 9.2)	39	0.4%	NS
7b4. There is a lot of crime in your community (% who somewhat/strongly agree)*	488	13.8%	(10.4 - 18.2)	8	1.6%	8,935	22.6%	(20.4 - 25.0)	142	1.6%	-
7b5. Neighbors know and trust one another and look out for each other in your community	489	7.3%	(4.9 - 10.7)	7	1.4%	8,979	9.3%	(7.2 - 11.8)	98	1.1%	NS
Social Support and Civic Responsibility											
7b6. There are enough support networks in your community for individuals and families during times of stress and need, such as support groups, faith community outreach, community agencies, and so forth	458	19.7%	(14.6 - 26.0)	38	7.7%	8,394	24.7%	(21.9 - 27.7)	683	7.5%	NS
7b7. People in your community pitch in and help out the community in times of need	480	6.6%	(3.6 - 11.8)	16	3.2%	8,901	8.4%	(6.3 - 11.1)	176	1.9%	NS
7b8. There are a lot of opportunities for individuals in your community to volunteer	477	10.4%	(5.8 - 18.1)	19	3.8%	8,807	9.9%	(7.9 - 12.4)	270	3.0%	NS
7b9. A lot of individuals in your community do volunteer work	461	18.4%	(12.1 - 27.0)	35	7.1%	8,492	15.8%	(13.3 - 18.6)	585	6.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* This survey question (i.e., data measure) was asked in the opposite direction compared to almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, to be consistent with the other measures in this table, the percentage for this measure reflects the undesirable response, which in this case is the percentage who answered somewhat or strongly agree. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 8a: Mean Values for How Serious Various Health Issues are in the Community (on an 11-point scale ranging from 0=not serious at all to 10=extremely serious), among Nebraska Adults aged 18 and Older, 2011

	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
Health Issue	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Aging problems (arthritis, hearing/vision loss)	468	6.14	(5.81 - 6.47)	28	5.6%	8,483	5.83	(5.66 - 6.01)	594	6.5%	NS
Cancer	471	7.00	(6.67 - 7.32)	25	5.0%	8,661	6.66	(6.46 - 6.85)	416	4.6%	NS
Child abuse and neglect	452	4.17	(3.80 - 4.54)	44	8.9%	8,243	4.07	(3.89 - 4.25)	834	9.2%	NS
Diabetes	449	6.47	(6.16 - 6.78)	47	9.5%	8,372	6.30	(6.11 - 6.50)	705	7.8%	NS
Heart disease	451	6.13	(5.78 - 6.47)	45	9.1%	8,315	6.02	(5.82 - 6.22)	762	8.4%	NS
High blood pressure	458	6.81	(6.50 - 7.12)	38	7.7%	8,395	6.46	(6.26 - 6.66)	682	7.5%	NS
Infectious diseases (flu, other viruses/infections)*	462	5.15	(4.80 - 5.49)	34	6.9%	8,522	4.88	(4.74 - 5.02)	555	6.1%	NS
Injuries (resulting from crashes, falls, violence, etc.)	459	4.00	(3.68 - 4.32)	37	7.5%	8,414	4.44	(4.26 - 4.63)	663	7.3%	NS
Mental health (including depression)	441	4.99	(4.61 - 5.37)	55	11.1%	8,119	4.65	(4.47 - 4.84)	958	10.6%	NS
Overweight and obesity	484	7.08	(6.78 - 7.39)	12	2.4%	8,886	6.83	(6.65 - 7.01)	191	2.1%	NS
Poor dental health	440	4.80	(4.45 - 5.14)	56	11.3%	8,056	4.51	(4.31 - 4.70)	1,021	11.2%	NS
Sexually transmitted diseases (STDs)	343	3.65	(3.19 - 4.11)	153	30.8%	6,582	4.34	(4.10 - 4.57)	2,495	27.5%	NS
Stroke	453	5.91	(5.58 - 6.24)	43	8.7%	8,225	5.57	(5.37 - 5.76)	852	9.4%	NS
Suicide	456	3.00	(2.64 - 3.36)	40	8.1%	8,392	3.23	(3.03 - 3.43)	685	7.5%	NS
Teenage pregnancy	443	4.82	(4.39 - 5.26)	53	10.7%	8,149	4.81	(4.59 - 5.02)	928	10.2%	NS
Unsafe environment (poor air/water, chemical expos.)	476	3.12	(2.64 - 3.59)	20	4.0%	8,817	3.02	(2.85 - 3.19)	260	2.9%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on an 11-point scale ranging from 0 to 10 where 0 = not serious at all in your community and 10 = extremely serious in your community

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* Includes infectious diseases, such as the flu, and other viruses and infections that are transmitted from person-to-person (excluding STDs)

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 8b: Percentage who Responded with a Value of 8, 9, or 10 for How Serious Various Health Issues are in the Community (based on an 11-point scale ranging from 0=not serious at all to 10=extremely serious), among Nebraska Adults aged 18 and Older, 2011

	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
Health Issue	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Aging problems (arthritis, hearing/vision loss)	468	29.5%	(23.3 - 36.7)	28	5.6%	8,483	23.9%	(21.6 - 26.3)	594	6.5%	NS
Cancer	471	49.4%	(41.8 - 57.1)	25	5.0%	8,661	41.6%	(38.6 - 44.8)	416	4.6%	NS
Child abuse and neglect	452	11.3%	(7.1 - 17.7)	44	8.9%	8,243	10.9%	(9.2 - 13.0)	834	9.2%	NS
Diabetes	449	33.9%	(27.3 - 41.2)	47	9.5%	8,372	35.0%	(32.1 - 38.1)	705	7.8%	NS
Heart disease	451	31.5%	(25.0 - 38.9)	45	9.1%	8,315	29.6%	(26.8 - 32.7)	762	8.4%	NS
High blood pressure	458	42.9%	(35.2 - 50.9)	38	7.7%	8,395	37.1%	(34.0 - 40.2)	682	7.5%	NS
Infectious diseases (flu, other viruses/infections)*	462	15.2%	(10.5 - 21.5)	34	6.9%	8,522	13.6%	(11.7 - 15.8)	555	6.1%	NS
Injuries (resulting from crashes, falls, violence, etc.)	459	8.2%	(4.8 - 13.7)	37	7.5%	8,414	10.5%	(8.3 - 13.1)	663	7.3%	NS
Mental health (including depression)	441	17.7%	(13.1 - 23.6)	55	11.1%	8,119	15.0%	(12.7 - 17.7)	958	10.6%	NS
Overweight and obesity	484	54.6%	(47.0 - 62.0)	12	2.4%	8,886	42.6%	(39.6 - 45.6)	191	2.1%	+
Poor dental health	440	12.2%	(8.6 - 17.1)	56	11.3%	8,056	12.0%	(9.9 - 14.4)	1,021	11.2%	NS
Sexually transmitted diseases (STDs)	343	7.4%	(4.2 - 12.7)	153	30.8%	6,582	17.0%	(14.0 - 20.4)	2,495	27.5%	-
Stroke	453	21.0%	(16.1 - 26.9)	43	8.7%	8,225	22.0%	(19.3 - 24.9)	852	9.4%	NS
Suicide	456	6.1%	(3.6 - 10.1)	40	8.1%	8,392	8.5%	(6.5 - 11.1)	685	7.5%	NS
Teenage pregnancy	443	18.4%	(12.1 - 26.9)	53	10.7%	8,149	18.1%	(15.7 - 20.9)	928	10.2%	NS
Unsafe environment (poor air/water, chemical expos.)	476	11.0%	(6.5 - 18.0)	20	4.0%	8,817	8.7%	(7.3 - 10.3)	260	2.9%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered with a value of 8, 9, or 10 on an 11-point scale ranging from 0 to 10 where 0 = not serious at all in your community and 10 = extremely serious in your community

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* Includes infectious diseases, such as the flu, and other viruses and infections that are transmitted from person-to-person (excluding STDs)

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 9a: Mean Values for How Much Different Behaviors Impact Overall Health in the Community (on an 11-point scale ranging from 0=no impact on overall health to 10=huge impact on overall health), among Nebraska Adults aged 18 and Older, 2011

	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
Health Issue	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	
Alcohol abuse	473	5.94	(5.59 - 6.29)	23	4.6%	8,670	5.99	(5.80 - 6.18)	407	4.5%	NS
Drug abuse	456	5.85	(5.42 - 6.28)	40	8.1%	8,366	5.80	(5.60 - 6.00)	711	7.8%	NS
Drunk driving	468	5.97	(5.55 - 6.39)	28	5.6%	8,675	6.10	(5.90 - 6.29)	402	4.4%	NS
Not enough exercise	476	6.52	(6.14 - 6.89)	20	4.0%	8,807	6.61	(6.46 - 6.76)	270	3.0%	NS
Not getting vaccine 'shots' to prevent disease	443	4.65	(4.21 - 5.09)	53	10.7%	8,189	4.76	(4.55 - 4.96)	888	9.8%	NS
Not using child safety seats (or improper use)	449	4.34	(3.91 - 4.76)	47	9.5%	8,135	4.36	(4.16 - 4.57)	942	10.4%	NS
Not using seat belts while driving	479	5.11	(4.72 - 5.51)	17	3.4%	8,632	5.07	(4.87 - 5.26)	445	4.9%	NS
Poor eating habits	468	6.60	(6.31 - 6.88)	28	5.6%	8,637	6.50	(6.34 - 6.65)	440	4.8%	NS
Talking on a cell phone while driving	478	6.87	(6.52 - 7.22)	18	3.6%	8,762	6.85	(6.67 - 7.04)	315	3.5%	NS
Texting while driving	445	6.78	(6.40 - 7.17)	51	10.3%	8,327	6.77	(6.58 - 6.97)	750	8.3%	NS
Tobacco use (cigarettes and smokeless)	472	6.30	(5.96 - 6.64)	24	4.8%	8,697	6.35	(6.19 - 6.51)	380	4.2%	NS
Violence (domestic violence, fighting, etc.)	458	4.61	(4.20 - 5.02)	38	7.7%	8,471	4.86	(4.67 - 5.06)	606	6.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on an 11-point scale ranging from 0 to 10 where 0 = no impact on overall health in your community and 10 = huge impact on overall health in your community

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 9b: Percentage who Responded with a Value of 8, 9, or 10 for How Much Different Behaviors Impact Overall Health in the Community (based on an 11-point scale ranging from 0=no impact to 10=huge impact), among Nebraska Adults aged 18 and Older, 2011

	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
Health Issue	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Alcohol abuse	473	29.7%	(23.0 - 37.4)	23	4.6%	8,670	29.9%	(27.1 - 32.7)	407	4.5%	NS
Drug abuse	456	35.1%	(27.7 - 43.3)	40	8.1%	8,366	31.9%	(29.1 - 35.0)	711	7.8%	NS
Drunk driving	468	32.4%	(25.2 - 40.5)	28	5.6%	8,675	35.0%	(32.0 - 38.1)	402	4.4%	NS
Not enough exercise	476	36.0%	(29.7 - 42.9)	20	4.0%	8,807	38.5%	(35.5 - 41.6)	270	3.0%	NS
Not getting vaccine 'shots' to prevent disease	443	17.6%	(12.7 - 23.9)	53	10.7%	8,189	20.7%	(18.1 - 23.6)	888	9.8%	NS
Not using child safety seats (or improper use)	449	13.2%	(8.0 - 20.8)	47	9.5%	8,135	19.2%	(16.7 - 22.0)	942	10.4%	NS
Not using seat belts while driving	479	19.8%	(14.2 - 26.9)	17	3.4%	8,632	23.5%	(21.1 - 26.1)	445	4.9%	NS
Poor eating habits	468	39.3%	(32.1 - 47.1)	28	5.6%	8,637	36.8%	(33.8 - 39.9)	440	4.8%	NS
Talking on a cell phone while driving	478	46.7%	(39.2 - 54.3)	18	3.6%	8,762	48.2%	(45.1 - 51.3)	315	3.5%	NS
Texting while driving	445	44.2%	(36.6 - 52.2)	51	10.3%	8,327	46.1%	(42.9 - 49.3)	750	8.3%	NS
Tobacco use (cigarettes and smokeless)	472	32.8%	(25.7 - 40.8)	24	4.8%	8,697	34.9%	(31.9 - 37.9)	380	4.2%	NS
Violence (domestic violence, fighting, etc.)	458	16.0%	(10.1 - 24.5)	38	7.7%	8,471	20.6%	(18.0 - 23.5)	606	6.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered with a value of 8, 9, or 10 on an 11-point scale ranging from 0 to 10 where 0 = no impact on overall health in your community and 10 = huge impact on overall health in your community

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 10: Top 15 Responses to the Question "What do you think is the single most important health issues or health behavior that needs to be addressed in your community?*," among Nebraska Adults aged 18 and Older, 2011

	South Heartland District Health Department		State of Nebraska	
	Top 15 Health Issues/Behaviors (in rank order)	**%[a]**	**Top 15 Health Issues/Behaviors (in rank order)**	**%[a]**
1.	Overweight and Obesity	23.4%	Overweight and Obesity	24.3%
2.	Cancer	9.5%	Alcohol abuse	8.6%
3.	Alcohol abuse	9.0%	Cancer	7.0%
4.	Drug abuse	8.6%	Drug abuse	6.7%
5.	Healthcare-related (quality, access, cost, coverage)[+]	6.7%	Healthcare-related (quality, access, cost, coverage)[+]	5.9%
6.	Unhealthy eating and/or poor nutrition[!]	6.3%	Not enough exercise[#]	5.5%
7.	Aging population and elderly conditions/needs^	5.3%	Unhealthy eating and/or poor nutrition[!]	4.8%
8.	Drunk driving	5.2%	Distracted driving (texting, cell phone use)	4.5%
9.	Mental health and/or suicide	4.4%	Drunk driving	3.7%
10.	Not enough exercise[#]	3.3%	Tobacco use (cigarettes and/or smokeless)	2.9%
11.	Tobacco use (cigarettes and/or smokeless)	3.2%	Violence/crime/safety[x]	2.7%
12.	Heart disease	2.3%	Mental health and/or suicide	2.7%
13.	Distracted driving (texting, cell phone use)	2.2%	Diabetes	2.5%
14.	Infectious diseases (flu, other viruses/infections)[i]	1.3%	Heart disease	2.4%
15.	Teen pregnancy	0.9%	Aging population and elderly conditions/needs^	2.4%
	Sample size (n)[b]	396	Sample size (n)[b]	7,377
	Missing data[c]	100	Missing data[c]	1,700
	Percentage Missing Data[d]	20.2%	Percentage Missing Data[d]	18.7%

* This survey question was open-ended, meaning that respondents could provide any response they wanted without prompt. However, 28 fields were pre-populated for interviewer coding, which reflected the health issues and behaviors asked about in survey questions 33-60. Responses outside of these pre-defined categories were typed in by the interviewer and analyzed for themes during the analysis process, in which case they were added to existing categories or new categories were created. Statewide, a total of 1,513 respondents, or 20.5% of all valid (non-missing) responses to this question did not fall into a pre-defined category and were typed in by the survey interviewer. Answers that covered multiple issues (e.g., diet and exercise) were kept as valid but not coded to a specific condition presented in this table, with the exception of 'aging population and elderly conditions/needs,' (see other footnote)

[a] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those gave an answer for each health issue out of the total number of valid respondents.

[b] Non-weighted number of survey respondents (excluding missing data)

[c] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer, or were otherwise missing

[d] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer, or were otherwise missing

[+] Consists of responses of healthcare-related quality, access, cost, insurance, nursing care, elder care, and utilization of healthcare services

[#] Consists of responses of not enough exercise and sedentary lifestyle as well as lack of exercise facilities and programs

[!] Consists of responses of unhealthy eating, overeating, poor nutrition, hunger, availability of healthy foods

[x] Consists of responses of violence (domestic violence, fighting, etc.), crime, and general safety

^ Consists of responses where aging problems (arthritis, Alzheimer's, dementia, etc.), older adults, and the elderly or elderly-related responses were mentioned. In some cases the response overlapped with another category (such as elderly medical care falling under 'healthcare related'). As a result, some respondents in this category are also included in another top 15 category (69 respondents statewide (<1% of valid respondents) fell into this category and another top 15 category).

[i] Consists of responses the flu, and other viruses and infections that are transmitted from person-to-person (excluding STDs)

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 11a: Mean Values for Measures related to Alcohol Use and Prevention, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
11a1. Alcohol use among individuals under 21 years old is a big problem in your community	468	2.04	(1.89 - 2.18)	28	5.6%	8,678	2.26	(2.16 - 2.35)	399	4.4%	NS
11a2. Your community should do more to prevent alcohol use among individuals under 21 years old	478	1.87	(1.68 - 2.06)	18	3.6%	8,757	2.02	(1.93 - 2.10)	320	3.5%	NS
11a3. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	491	4.11	(3.95 - 4.28)	5	1.0%	8,893	4.03	(3.96 - 4.11)	184	2.0%	NS
Among Female Respondents											
11a4. Alcohol use among individuals under 21 years old is a big problem in your community	309	2.00	(1.79 - 2.20)	24	7.2%	5,388	2.12	(2.02 - 2.22)	292	5.1%	NS
11a5. Your community should do more to prevent alcohol use among individuals under 21 years old	318	1.75	(1.55 - 1.95)	15	4.5%	5,455	1.90	(1.82 - 1.99)	225	4.0%	NS
11a6. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	329	4.15	(3.93 - 4.37)	4	1.2%	5,554	4.15	(4.06 - 4.23)	126	2.2%	NS
Among Male Respondents											
11a7. Alcohol use among individuals under 21 years old is a big problem in your community	159	2.07	(1.86 - 2.29)	4	2.5%	3,290	2.40	(2.24 - 2.56)	107	3.1%	NS
11a8. Your community should do more to prevent alcohol use among individuals under 21 years old	160	1.99	(1.67 - 2.31)	3	1.8%	3,302	2.14	(2.00 - 2.28)	95	2.8%	NS
11a9. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	162	4.07	(3.82 - 4.33)	1	0.6%	3,339	3.92	(3.79 - 4.04)	58	1.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 11b: Percentage who Somewhat or Strongly Agree with Measures related to Alcohol Use and Prevention, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Agree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Agree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
11b1. Alcohol use among individuals under 21 years old is a big problem in your community	468	80.4%	(74.7 - 85.0)	28	5.6%	8,678	72.0%	(68.7 - 75.1)	399	4.4%	NS
11b2. Your community should do more to prevent alcohol use among individuals under 21 years old	478	82.2%	(75.8 - 87.2)	18	3.6%	8,757	76.9%	(74.0 - 79.5)	320	3.5%	NS
11b3. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	491	19.0%	(14.5 - 24.5)	5	1.0%	8,893	18.9%	(16.9 - 21.1)	184	2.0%	NS
Among Female Respondents											
11b4. Alcohol use among individuals under 21 years old is a big problem in your community	309	79.3%	(71.0 - 85.7)	24	7.2%	5,388	75.2%	(71.6 - 78.5)	292	5.1%	NS
11b5. Your community should do more to prevent alcohol use among individuals under 21 years old	318	85.4%	(77.6 - 90.8)	15	4.5%	5,455	79.7%	(76.4 - 82.6)	225	4.0%	NS
11b6. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	329	19.1%	(13.2 - 26.8)	4	1.2%	5,554	17.8%	(15.3 - 20.6)	126	2.2%	NS
Among Male Respondents											
11b7. Alcohol use among individuals under 21 years old is a big problem in your community	159	81.4%	(73.1 - 87.6)	4	2.5%	3,290	68.8%	(63.2 - 73.9)	107	3.1%	NS
11b8. Your community should do more to prevent alcohol use among individuals under 21 years old	160	79.0%	(68.2 - 86.8)	3	1.8%	3,302	74.0%	(69.0 - 78.4)	95	2.8%	NS
11b9. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	162	19.0%	(12.7 - 27.4)	1	0.6%	3,339	20.1%	(16.9 - 23.7)	58	1.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly agree on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 12a: Mean Values for Measures related to Overall Health and Quality of Life, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
12a1. How healthy is your community*	486	2.32	(2.20 - 2.43)	10	2.0%	8,933	2.37	(2.30 - 2.44)	144	1.6%	NS
12a2. How would you rate the overall quality of life in your community**	490	2.45	(2.33 - 2.57)	6	1.2%	9,035	2.41	(2.35 - 2.48)	42	0.5%	NS
Among Female Respondents											
12a3. How healthy is your community*	325	2.32	(2.18 - 2.46)	8	2.4%	5,573	2.39	(2.32 - 2.46)	107	1.9%	NS
12a4. How would you rate the overall quality of life in your community**	329	2.55	(2.41 - 2.68)	4	1.2%	5,647	2.42	(2.36 - 2.48)	33	0.6%	NS
Among Male Respondents											
12a5. How healthy is your community*	161	2.31	(2.14 - 2.48)	2	1.2%	3,360	2.35	(2.22 - 2.48)	37	1.1%	NS
12a6. How would you rate the overall quality of life in your community**	161	2.35	(2.15 - 2.54)	2	1.2%	3,388	2.40	(2.28 - 2.51)	9	0.3%	NS
Among Respondents 18-64 Years Old											
12a7. How healthy is your community*	268	2.38	(2.24 - 2.52)	4	1.5%	5,320	2.44	(2.35 - 2.52)	53	1.0%	NS
12a8. How would you rate the overall quality of life in your community**	271	2.51	(2.37 - 2.66)	1	0.4%	5,362	2.45	(2.38 - 2.53)	11	0.2%	NS
Among Respondents Aged 65 and Older											
12a9. How healthy is your community*	218	2.09	(1.97 - 2.22)	6	2.7%	3,563	2.06	(2.00 - 2.12)	85	2.3%	NS
12a10. How would you rate the overall quality of life in your community**	219	2.23	(2.08 - 2.39)	5	2.2%	3,622	2.22	(2.14 - 2.30)	26	0.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. See footnotes * and ** for further description of the response scales.

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* The response option scale for this question consisted of 1=very healthy, 2=somewhat healthy, 3=neither healthy nor unhealthy, 4=somewhat unhealthy, and 5=very unhealthy

** The response option scale for this question consisted of 1=excellent, 2=very good, 3=good, 4=fair, and 5=poor

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 12b: Indicators related to Overall Health and Quality of Life, among Nebraska Adults aged 18 and Older, 2011

Data Measure	South Heartland District Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
12b1. Feel that the overall health in their community is somewhat or very unhealthy*	486	12.6%	(8.4 - 18.6)	10	2.0%	8,933	17.3%	(14.6 - 20.2)	144	1.6%	NS
12b2. Feel that the overall quality of life in their community is fair or poor**	490	8.1%	(5.2 - 12.5)	6	1.2%	9,035	10.9%	(8.9 - 13.3)	42	0.5%	NS
Among Female Respondents											
12b3. Feel that the overall health in their community is somewhat or very unhealthy*	325	16.6%	(10.9 - 24.5)	8	2.4%	5,573	18.2%	(15.6 - 21.1)	107	1.9%	NS
12b4. Feel that the overall quality of life in their community is fair or poor**	329	9.4%	(5.1 - 16.8)	4	1.2%	5,647	10.6%	(8.7 - 12.8)	33	0.6%	NS
Among Male Respondents											
12b5. Feel that the overall health in their community is somewhat or very unhealthy*	161	8.5%	(3.4 - 19.7)	2	1.2%	3,360	16.3%	(12.0 - 21.9)	37	1.1%	NS
12b6. Feel that the overall quality of life in their community is fair or poor**	161	6.8%	(3.6 - 12.4)	2	1.2%	3,388	11.2%	(7.9 - 15.7)	9	0.3%	NS
Among Respondents 18-64 Years Old											
12b7. Feel that the overall health in their community is somewhat or very unhealthy*	268	13.5%	(8.2 - 21.2)	4	1.5%	5,320	19.0%	(15.9 - 22.6)	53	1.0%	NS
12b8. Feel that the overall quality of life in their community is fair or poor**	271	8.3%	(4.8 - 13.9)	1	0.4%	5,362	11.5%	(9.2 - 14.3)	11	0.2%	NS
Among Respondents Aged 65 and Older											
12b9. Feel that the overall health in their community is somewhat or very unhealthy*	218	9.8%	(5.9 - 16.0)	6	2.7%	3,563	9.6%	(7.6 - 12.0)	85	2.3%	NS
12b10. Feel that the overall quality of life in their community is fair or poor**	219	7.6%	(4.0 - 13.8)	5	2.2%	3,622	8.2%	(5.4 - 12.1)	26	0.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* The response option scale for this question consisted of 1=very healthy, 2=somewhat healthy, 3=neither healthy nor unhealthy, 4=somewhat unhealthy, and 5=very unhealthy

** The response option scale for this question consisted of 1=excellent, 2=very good, 3=good, 4=fair, and 5=poor

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 13: Demographics of Survey Respondents, among Nebraska Adults aged 18 and Older, 2011

NOTE: The demographic data presented below are simply to provide information about who completed the survey, and are not intended to be used to help explain differences between the LHD and State of Nebraska presented in Tables 1-12. The results presented in Tables 1-12 were weighed by participating local health department region, gender, and age to be reflective of the LHD and State of Nebraska population, where the resulted presented within this table are unweighted.

	SHDHD		State of NE	
Demographic	**n[a]**	**%[b]**	**n[a]**	**%[b]**
Total	496	100.0%	9,077	100.0%
Gender				
Female	333	67.1%	5,680	62.6%
Male	163	32.9%	3,397	37.4%
Missing Data	*0*	*0.0%*	*0*	*0.0%*
Age				
18-34	38	7.7%	662	7.3%
35-44	35	7.1%	959	10.6%
45-54	78	15.7%	1,617	17.9%
55-64	121	24.4%	2,135	23.7%
65-74	100	20.2%	1,734	19.2%
75+	124	25.0%	1,914	21.2%
Missing Data	*0*	*0.0%*	*56*	*0.6%*
Race/Ethnicity				
African American, NH	1	0.2%	51	0.6%
Asian/Pacific Islander, NH	3	0.6%	28	0.3%
Native American, NH	0	0.0%	65	0.7%
White, NH	471	96.7%	8,573	95.8%
Other, NH	0	0.0%	0	0.0%
Hispanic	12	2.5%	233	2.6%
Missing Data[c]	*9*	*1.8%*	*127*	*1.4%*

	SHDHD		State of NE	
Demographic	**n[a]**	**%[b]**	**n[a]**	**%[b]**
Education				
Less than High School	23	4.6%	490	5.4%
High School/GED	205	41.4%	3,159	34.9%
Some College	133	26.9%	2,786	30.8%
College Graduate	134	27.1%	2,616	28.9%
Missing Data	*1*	*0.2%*	*26*	*0.3%*
How long have you lived in your community?				
< 1 year	10	2.0%	130	1.4%
1-2 years	10	2.0%	254	2.8%
3-4 years	22	4.5%	349	3.8%
5-9 years	39	7.9%	802	8.8%
10+ years	413	83.6%	7,530	83.1%
Missing Data	*2*	*0.4%*	*12*	*0.1%*
How do you pay for most of your healthcare?				
Pay cash (no insurance)	39	8.0%	825	9.2%
Private health insurance	223	45.8%	4,623	51.7%
Medicaid	22	4.5%	256	2.9%
Medicare	185	38.0%	2,853	31.9%
Veteran's Administration	12	2.5%	212	2.4%
Indian Health Service	0	0.0%	18	0.2%
Other method	6	1.2%	147	1.6%
Missing Data	*9*	*1.8%*	*143*	*1.6%*

[b] Non-weighted number of survey respondents

[a] Non-weighted percentage of survey respondents by category

[c] Missing data reflect the number and percentage of survey respondents who answered 'don't know/not sure,' refused to answer, or were otherwise missing

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Mobilizing for Action through Planning and Partnerships
Community Themes & Strengths Assessment:
Adams, Clay, Nuckolls & Webster Counties

Please help us discover the most pressing local health issues that can be addressed through community action.

Take the Survey in English or Spanish:
http://southheartlandhealth.org/?p=949

This survey should take between 10-20 minutes.
For more information contact: South Heartland District Health Department
1-877-238-7595 or desiree.rinne@southheartlandhealth.org

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Movilizándonos hacia la Acción a través de Planificación y Alianzas
Evaluación de Temas & Fortalezas de la Comunidad:
Condados de Adams, Clay, Nuckolls & Webster

Esta encuesta es para los residentes de los condados de Adams, Clay, Nuckolls y Webster. Si usted es un estudiante o residente temporal, por favor complete la encuesta basado en sus experiencias en estos condados.

Tome la Encuesta en Ingles o en Español:
http://southheartlandhealth.org/?p=949

Esta encuesta debe tomar entre 10-20 minutos..
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Movilizándonos hacia la Acción a través de Planificación y Alianzas
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Mobilizing for Action through Planning and Partnerships

Community Themes & Strengths Assessment: Adams, Clay, Nuckolls & Webster Counties

This survey is for residents in Adams, Clay, Nuckolls & Webster Counties. If you are a student or temporary resident, please complete the survey based on your experiences in these counties.

Please help us discover the most pressing local health issues that can be addressed through community action. For this survey: Community is defined as the village, town or city you live in or is closest to your home if you do not live in town. County is defined as the county where you live (Adams, Clay, Nuckolls or Webster). Region, on the other hand, is defined as the area within one hour drive from your home, which includes your community. This survey should take between 10-20 minutes.

The first set of questions asks about the health care system in your community, county and region. For each statement, please indicate your level of agreement or disagreement with the statement.

	Please circle the number that best reflects your level of agreement with each of the following statements.	**Agree**				**Disagree**	
1.	There are enough hospitals, emergency rooms, urgent care clinics and so forth available: a. In my community (town/city closest to where I live)	5	4	3	2	1	
	b. In my county (county where I live)	5	4	3	2	1	
	c. In my region (within 1 hour drive from my home)	5	4	3	2	1	
2.	There are enough doctor's offices, health clinics and so forth available: a. In my community (town/city closest to where I live)	5	4	3	2	1	
	b. In my county (county where I live)	5	4	3	2	1	
	c. In my region (within 1 hour drive from my home)	5	4	3	2	1	
3.	The health care services that are available: a. In my community are excellent.	5	4	3	2	1	N/A
	b. In my county are excellent.	5	4	3	2	1	
	c. In my region are excellent.	5	4	3	2	1	
4.	There are enough medical specialists available: a. In my community.	5	4	3	2	1	
	b. In my county	5	4	3	2	1	
	c. In my region (within 1 hour drive from my home).	5	4	3	2	1	
5.	There are enough behavioral health services (counselors, licensed mental health practitioners) a. In my community.	5	4	3	2	1	
	b. In my county.	5	4	3	2	1	
	c. In my region (within 1 hour drive from my home).	5	4	3	2	1	
6.	The hospital care being provided: a. In my community is excellent.	5	4	3	2	1	N/A

	b. In my county is excellent	5	4	3	2	1	N/A
	c. In my region (within 1 hour drive from my home) is excellent.	5	4	3	2	1	N/A
7.	Sometimes the cost of medical care prevents me from getting the care I need for myself or my immediate family.	5	4	3	2	1	
8.	Sometimes language or cultural barriers prevent me from getting the care I need for myself or my immediate family.	5	4	3	2	1	
9.	Sometimes I have difficulty finding transportation to health care providers.	5	4	3	2	1	
10.	The regular hours of operation at doctor's offices and health clinics are sometimes not convenient for scheduling care for myself or my immediate family.	5	4	3	2	1	
11.	During the past 12 months, I have personally received health care services at a hospital or emergency room located a. In my county	Yes		No			N/A
	b. In my region (within 1 hour drive from my home).	Yes		No			
12.	During the past 12 months, I have personally received health care services at a doctor's office, health clinic, or health department located a. In my community.	Yes		No			N/A
	b. In my county.	Yes		No			
	c. In my region (within 1 hour drive from my home).	Yes		No			
13.	I have one person I think of as my personal doctor or health care provider (my medical "home" where I go for most health care needs)	Yes		No			

14. If you answered **NO** on #13:

Instead, when I need them I receive my health care services from (check all that apply):

- ☐ Free clinics
- ☐ Community Health Center
- ☐ Health Department / Immunization Clinic
- ☐ Family Planning Agency
- ☐ Emergency Room at a hospital
- ☐ Urgent Care Clinic
- ☐ Chiropractor
- ☐ I delay care as long as possible or refuse care
- ☐ Other (please specify):_____

15.	During the past 12 months, I have personally received dental care	Yes	No

	services at a dental clinic located a. in my community.		
	b. in my county.	Yes	No
	c. in my region (within 1 hour drive from my home).	Yes	No
16.	I have one person I think of as my personal dentist	Yes	No
17.	During the past 12 months, I have personally received behavioral health services (counseling, life coaching, etc.) a. in my community.	Yes	No
	b. in my county.	Yes	No
	c. in my region (within 1 hour drive from my home).	Yes	No
18.	Please provide additional comments on the health care system in your community, county or region:		

The next set of questions asks about supports for raising children in your community. Again, please indicate your level of agreement or disagreement with each statement.

	Please circle the number that best reflects your level of agreement with each of the following statements.	**Agree**			**Disagree**		Don't Know
19.	My community is a good place to raise children.	5	4	3	2	1	DK
20.	Safe childcare is available in my community.	5	4	3	2	1	DK
21.	Affordable childcare is available in my community.	5	4	3	2	1	DK
22.	I am satisfied with the school system in my community.	5	4	3	2	1	DK
23.	There are adequate after school opportunities for elementary age children (including those run by schools and community groups).	5	4	3	2	1	DK

24.	There are adequate after school opportunities for middle and high school age students (sports teams, clubs, groups, etc.).	5	4	3	2	1	DK
25.	There are adequate recreation opportunities for children and youth in my community.	5	4	3	2	1	DK
26.	Please provide additional comments on supports for raising children in your community:						

The following set of questions asks about supports for older adults in your community.

	Please circle the number that best reflects your level of agreement with each of the following statements.	**Agree**				**Disagree**	
27.	This community is a good place to grow old.	5	4	3	2	1	Don't Know
28.	There are adequate recreation and exercise opportunities (parks, trails, fitness centers) for older adults in my community.	5	4	3	2	1	DK
29.	There are adequate housing options (assisted living, retirement centers, maintenance-free homes/apartments) for older adults in my community.	5	4	3	2	1	DK
30.	There are adequate transportation options (public buses, shuttles, handi-vans, taxis) available to take older adults to medical facilities and shopping.	5	4	3	2	1	DK
31.	There are adequate programs that provide meals for older adults in my community.	5	4	3	2	1	DK
32.	There are a range of available services (social clubs, social services, groups) in my community for older adults that are living alone.	5	4	3	2	1	DK
33.	There are adequate local options (residential care, intermediate and skilled nursing homes) for persons who need long-term care services.	5	4	3	2	1	DK

34.	Please provide additional comments on supports for older adults in your community:

The next set of questions asks about recreational and leisure options available in your community.

	Please circle the number that best reflects your level of agreement with each of the following statements.	**Agree**			**Disagree**		
35.	There are adequate places to exercise and play in my community (parks, walking/biking trails, swimming pools, gyms, fitness centers, and so forth).	5	4	3	2	1	Don't Know
36.	There are adequate music, art, theater, and cultural events in my community.	5	4	3	2	1	DK
37.	There are adequate organized leisure time activities available in my community (such as groups, clubs, teams, and other social activities): a. for young adults	5	4	3	2	1	DK
	b. for middle-aged adults	5	4	3	2	1	DK
38.	Please provide additional comments on recreational and leisure-time options in your community:						

The following set of questions asks about jobs and the economy in your community.

	Please circle the number that best reflects your level of agreement with each of the following statements.	**Agree**			**Disagree**		
39.	For people living in my community, there are enough jobs a. located in town or a short drive away	5	4	3	2	1	Don't Know
	b. located within the county.	5	4	3	2	1	DK
	c. located within the region (within 1 hour drive from my home)	5	4	3	2	1	DK
40.	There are opportunities for employment advancement (promotions, job training, higher education) a. In my community	5	4	3	2	1	DK
	b. In my county	5	4	3	2	1	DK
	c. In my region (within 1 hour drive from my home)	5	4	3	2	1	DK

41.	Jobs in my county are “family friendly” (allow for flexible scheduling, reasonable hours, health insurance, and so forth)	5	4	3	2	1	DK
42.	My employer encourages/promotes healthy behaviors.	5	4	3	2	1	N/A
43.	The economy is strong in my community.	5	4	3	2	1	DK
44.	Please provide additional comments on <u>jobs and the economy</u> in your community:						

The following set of questions asks about <u>housing</u> in your community.

Please circle the number that best reflects your level of agreement with each of the following statements.		**Agree**			**Disagree**		
45.	There is enough quality housing available in my community, including homes and apartments.	5	4	3	2	1	Don't Know
46.	Quality housing in my community is affordable for the average person.	5	4	3	2	1	DK
47.	Please provide additional comments on <u>housing</u> in your community:						

The next set of questions asks about <u>safety and social support</u> in your community.

Please circle the number that best reflects your level of agreement with each of the following statements.		**Agree**			**Disagree**		

48.	My community is a safe place to live, work, and play.	5	4	3	2	1	Don't Know
49.	There are support networks in my community that help during times of stress and need (neighbors, support groups, faith community outreach, community organizations, etc.).	5	4	3	2	1	DK
50.	There are an adequate number of volunteers to fill the volunteer needs in my community.	5	4	3	2	1	DK

51. Please provide additional comments on safety and social support in your community:

The following questions ask about health issues in your community.

52. Thinking about what you know from your personal experience and/or the experiences of others you know, what do you think are the 3 most troubling health-related problems in your community?

Choose only 3:

- ☐ Aging problems (arthritis, hearing/vision loss, falls)
- ☐ Addictions
- ☐ Asthma
- ☐ Cancers
- ☐ Child abuse or neglect
- ☐ Diabetes
- ☐ Domestic violence
- ☐ Heart disease
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Infant death
- ☐ Injuries (from crashes, falls, violence, etc)
- ☐ Mental health issues (including depression)
- ☐ Motor vehicle crash injuries
- ☐ Overweight / Obesity
- ☐ Poor dental health
- ☐ Rape / sexual assault
- ☐ Respiratory / lung disease
- ☐ Sexually transmitted diseases
- ☐ Stroke
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Infectious diseases (hepatitis, TB, pertussis, flu, other diseases transmitted from person to person)
- ☐ Unsafe environment (poor air/water quality, chemical exposures)
- ☐ Other _____

The next set of questions asks about risky behaviors in your community.

53. From the following list, choose the 3 risky behaviors that you think have the most impact on health and well-being in your community?

Choose only 3:

- ☐ Alcohol abuse
- ☐ Drunk driving
- ☐ Drug abuse
- ☐ Distracted driving (cell phone use, texting, etc.)
- ☐ Not getting vaccine "shots" to prevent disease
- ☐ Tobacco use (including smokeless tobacco)
- ☐ Not using child safety seats (or not using correctly)
- ☐ Not using seatbelts
- ☐ Not managing stress
- ☐ Unsafe sex
- ☐ Poor eating habits
- ☐ Not enough exercise
- ☐ Violence (domestic violence, fighting, etc.)
- ☐ Avoiding routine visits to health professional

Health issue PRIORITIES *in your community*

54. Of the health-related problems and risky behaviors listed above, which one would you say your community should address first? (choose only one)

Issue that should be addressed first:

55. Please provide additional comments on community health issue priorities:

The following questions ask about alcohol use and prevention in your community.

	Please circle the number that best reflects your level of agreement with each of the following statements.	**Agree**				**Disagree**	
56.	Alcohol use among individuals under 21 years old is a problem in my community.	5	4	3	2	1	Don't Know
57.	My community should do more to prevent alcohol use among individuals under 21 years old.	5	4	3	2	1	DK
58.	People sometimes say that "drinking is a rite of passage for youth" meaning that it is an important milestone for them as they move into adulthood. What is your level of agreement?	5	4	3	2	1	DK

59. Please provide additional comments on alcohol use and prevention in your community:

60. How would you rate the overall quality of life in your community?
- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

61. How would you rate your own personal health?
- ☐ Very unhealthy
- ☐ Unhealthy
- ☐ Somewhat healthy
- ☐ Healthy
- ☐ Very Healthy

62. Approximately how many hours per month do you volunteer your time to community service? (e.g., schools voluntary organizations, churches, hospitals, etc.)
- ☐ None
- ☐ 1-5 hours
- ☐ 6-10 hours
- ☐ Over 10 hours

63. Considering stressors in your life, would you say you:
- ☐ feel alone with nowhere to turn
- ☐ know who to turn to in time of need
- ☐ do not think stress is a significant factor for you

64. How do you pay for your health care? (check all that apply)
- ☐ Pay cash (do not have insurance)
- ☐ Veterans' Administration/ TRICARE
- ☐ Medicaid
- ☐ Medicare
- ☐ Private Health Insurance (e.g., Blue Cross, HMO, including insurance through an employer)
- ☐ Indian Health Services
- ☐ Other: _____

65. How do you pay for dental care? (check all that apply)
- ☐ Pay cash (do not have insurance)
- ☐ Veterans' Administration/ TRICARE
- ☐ Medicaid
- ☐ Medicare
- ☐ Private Health Insurance (e.g., Blue Cross, HMO, including insurance through an employer)
- ☐ Indian Health Services
- ☐ Other: _____

66. How many children less than 18 years of age live in your household? ☐

67. How long have you lived in your community?
- ☐ Less than one year
- ☐ 1-2 years
- ☐ 3-4 years
- ☐ 5-9 years
- ☐ 10 or more years

68. What county do you live in?
- ☐ Webster
- ☐ Adams
- ☐ Nuckolls
- ☐ Clay

69. Zip Code where you live: ___ ___ ___ ___ ___

70. Age:
- ☐ under 18 years
- ☐ 18-24 years
- ☐ 25-39 years
- ☐ 40-54 years
- ☐ 55-64 years
- ☐ 65-80 years
- ☐ over 80 years

71. Gender: ☐ Male ☐ Female

72. Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Never Married
- ☐ Member of an unmarried couple

73. Which of the following best reflects your race?
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian / Pacific Islander
- ☐ Other: _____

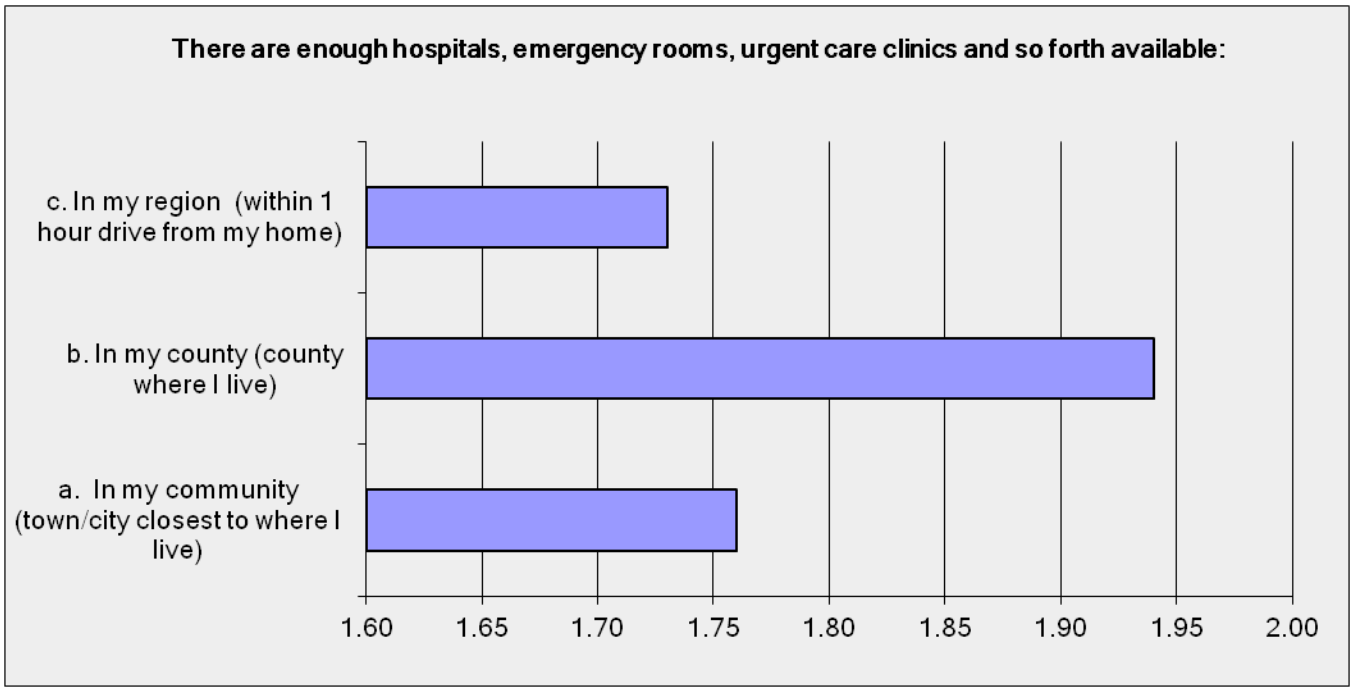
74. Are you Hispanic or Latino? ☐ Yes ☐ No

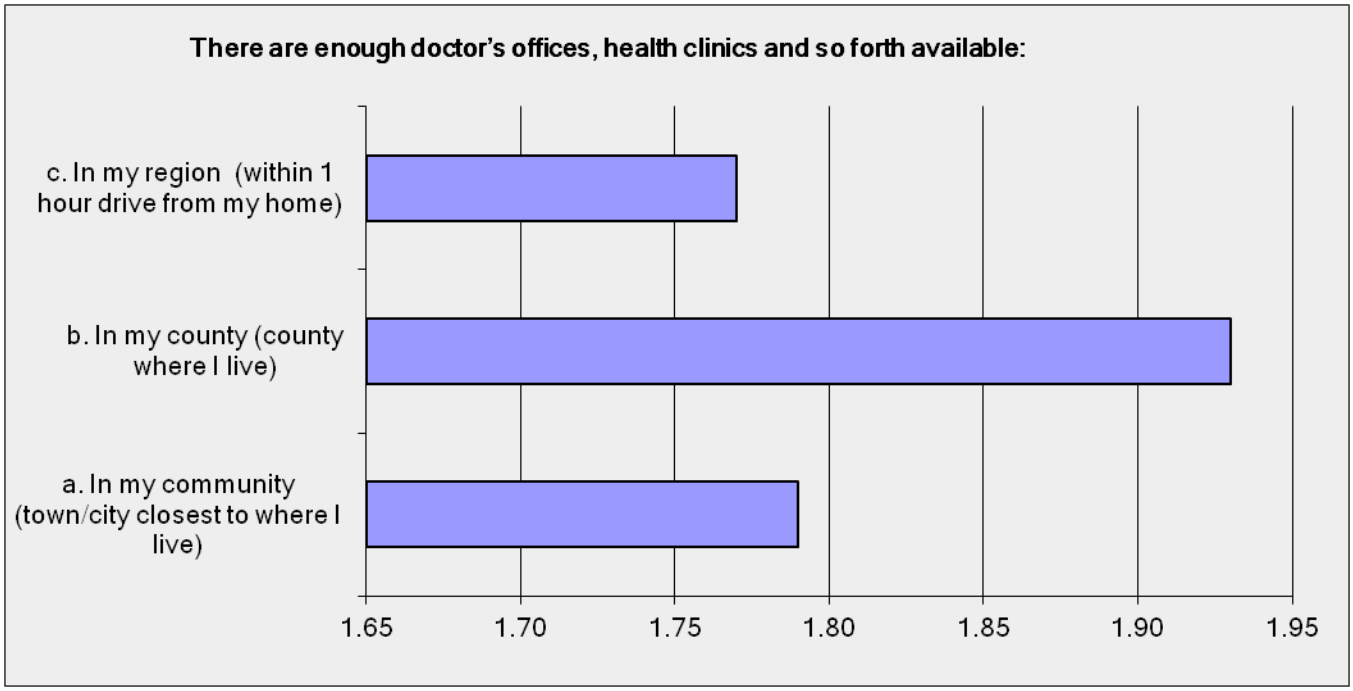
75. Education: Highest Year of School Completed?
- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1-8 (Elementary)
- ☐ Grades 9-11 (Some high school)
- ☐ Grade 12, High school graduate or GED
- ☐ College 1 to 3 years (some college or technical school)
- ☐ College 4 years or more (college graduate)
- ☐ Post-college (Graduate school / Advanced Degree)

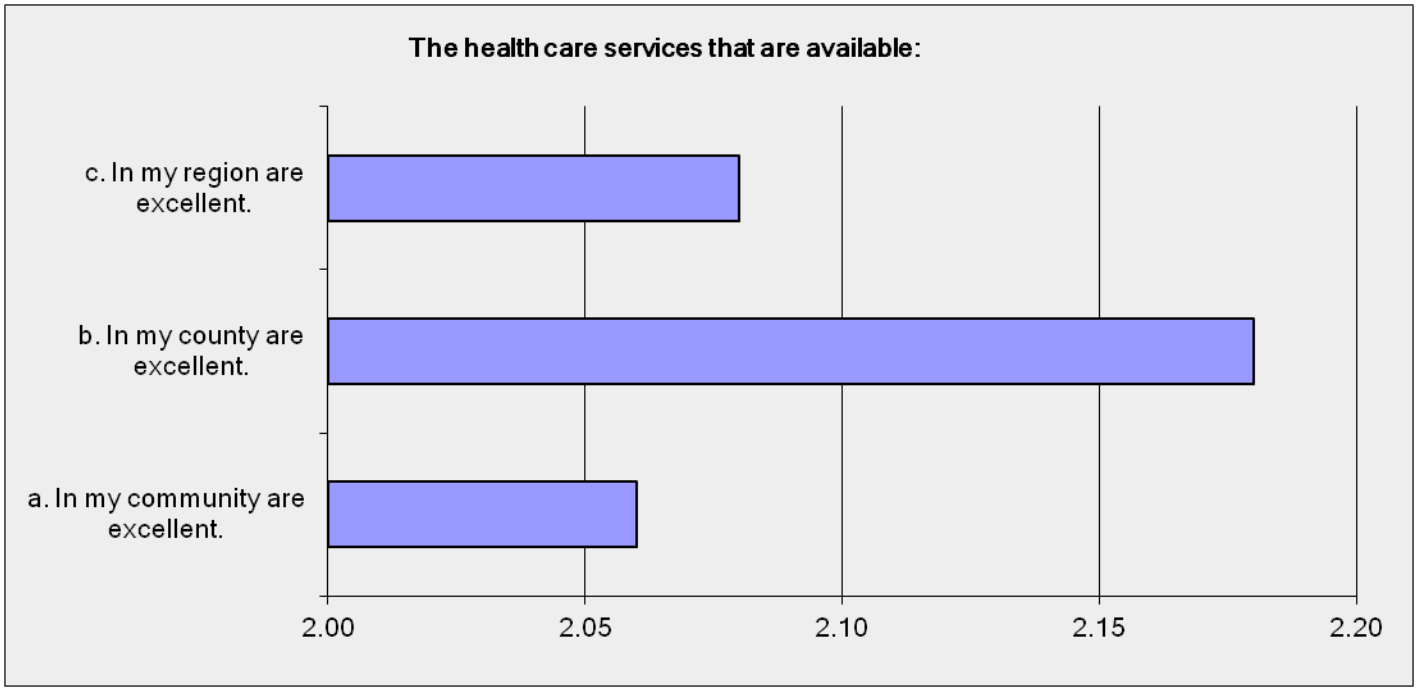
76. Household income:
- ☐ Less than $20,000
- ☐ $20,000 to $29,999
- ☐ $30,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ Over $100,000

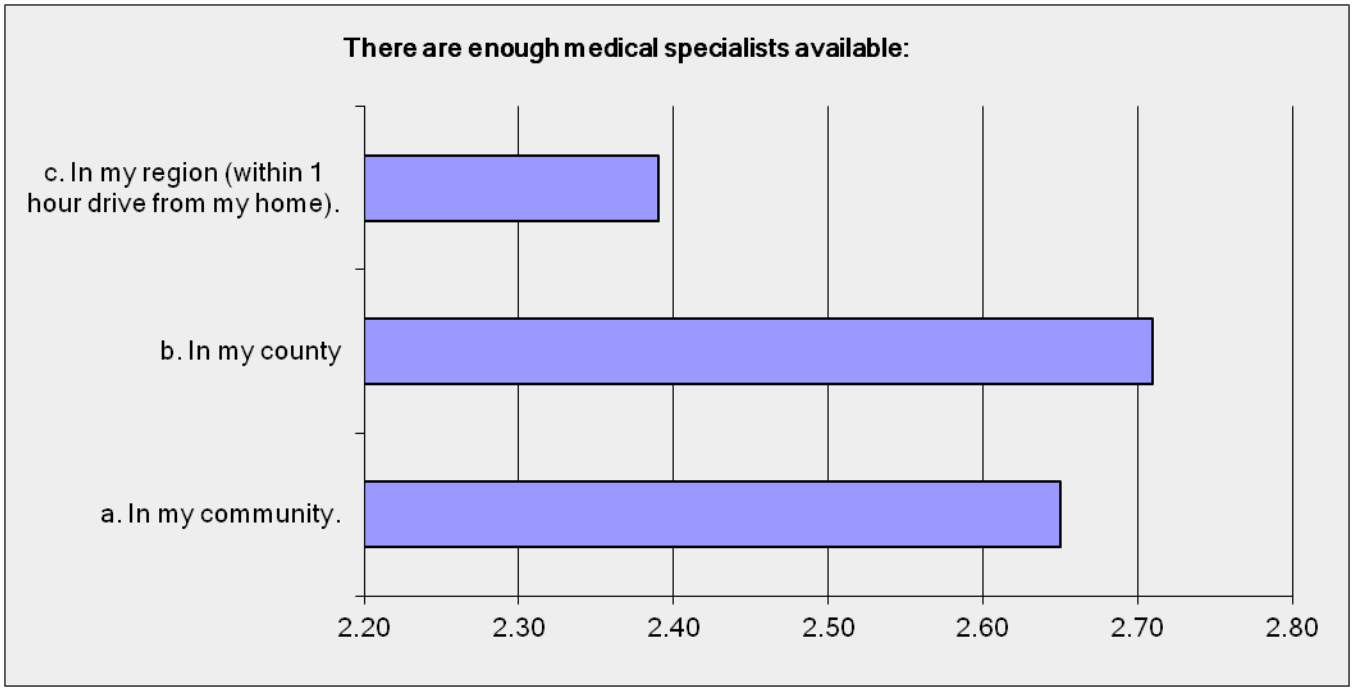
Thank you *for your input! For more information about the Community Assessment process contact South Heartland District Health Department 1-877-238-7595*

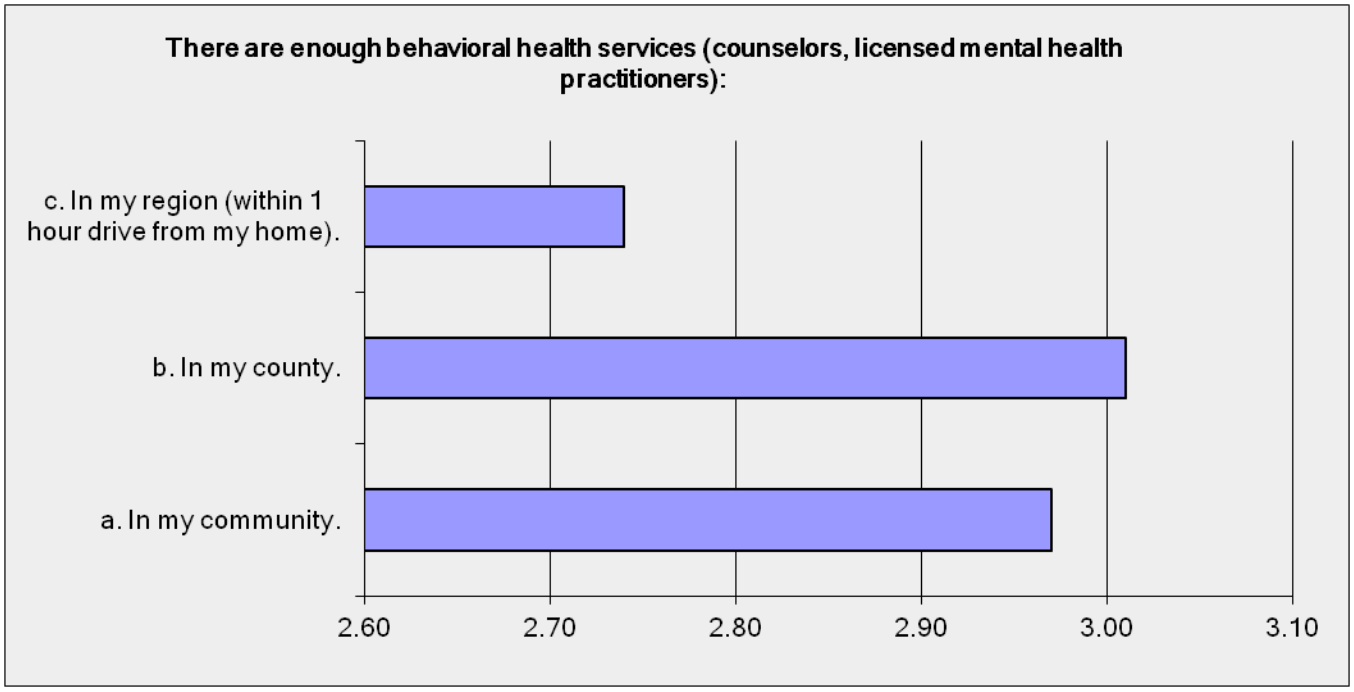
Community Themes & Strengths Assessment, SHDHD 2012

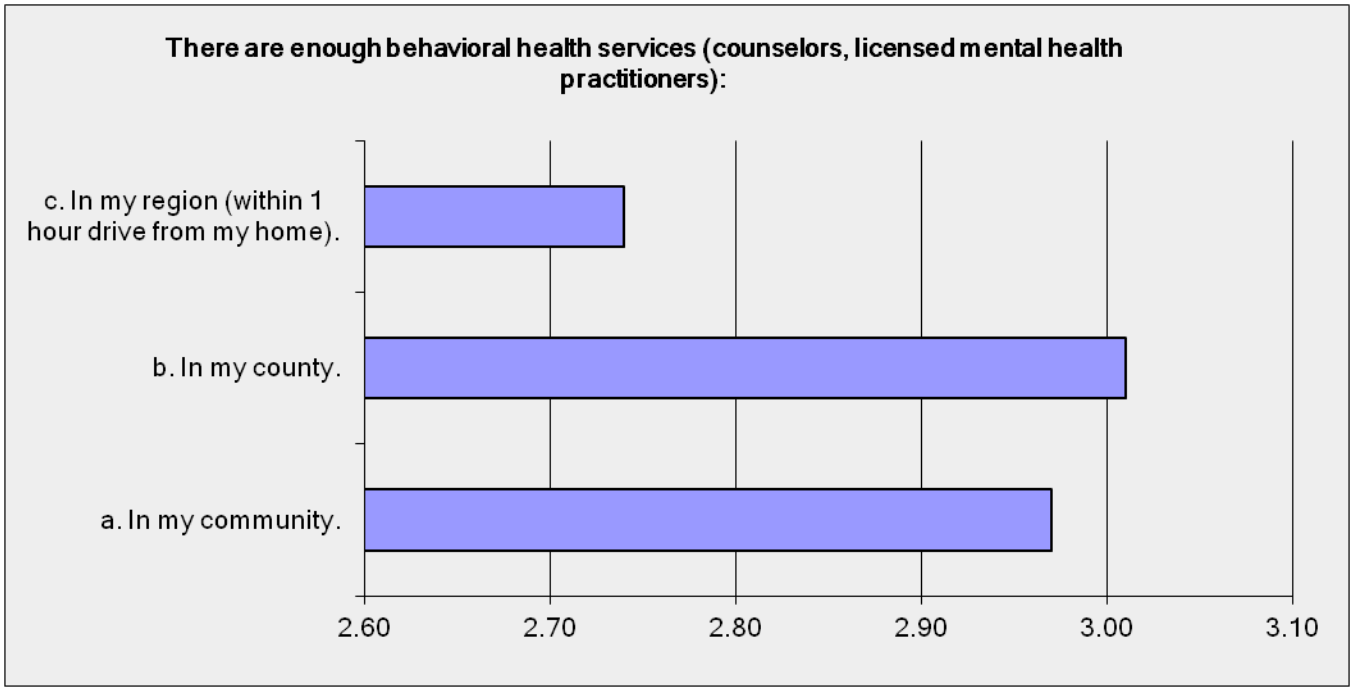





The health care services that are available:
c. In my region are excellent.
b. In my county are excellent.
a. In my community are excellent.
2.00
2.05
2.10
2.15
2.20


There are enough medical specialists available:
c. In my region (within 1 hour drive from my home).
b. In my county
a. In my community.
2.20
2.30
2.40
2.50
2.60
2.70
2.80





Sometimes the cost of medical care prevents me from getting the care I need for myself or my immediate family.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Rating Average	Response Count
Sometimes the cost of medical care prevents me from	117	128	68	112	55	2.71	480
						answered question	**480**
						skipped question	**0**

Sometimes language or cultural barriers prevent me from getting the care I need for myself or my immediate family.

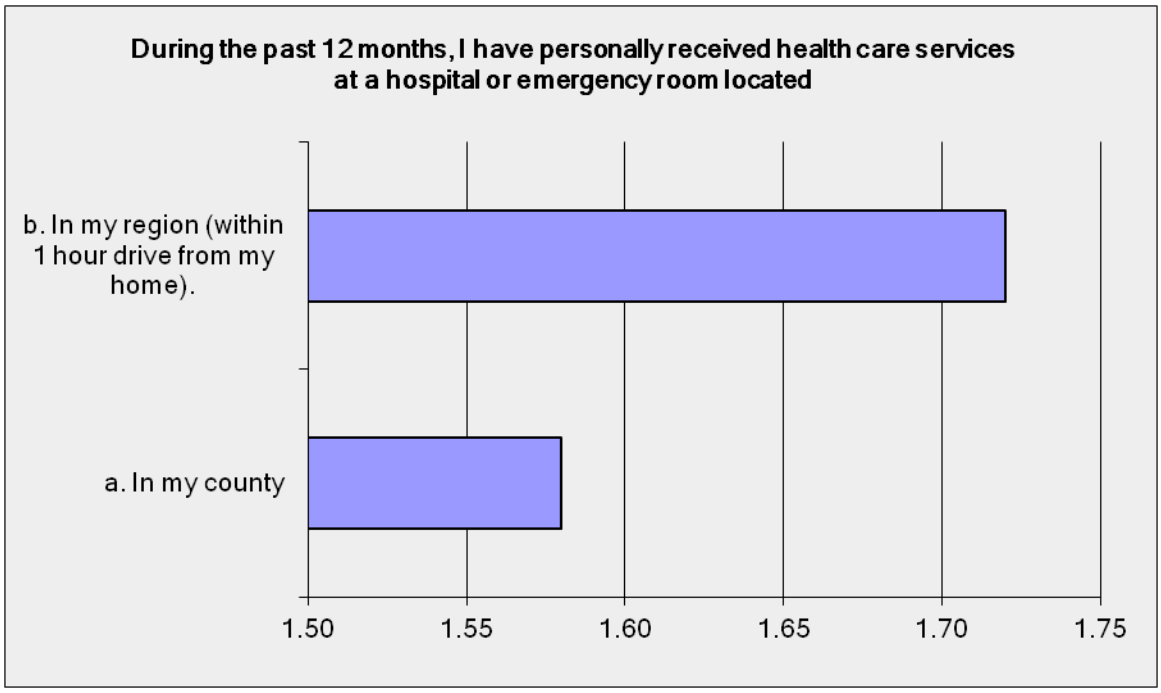
Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Rating Average	Response Count
Sometimes language or cultural barriers prevent me	16	11	79	150	224	4.16	480
						answered question	**480**
						skipped question	**0**

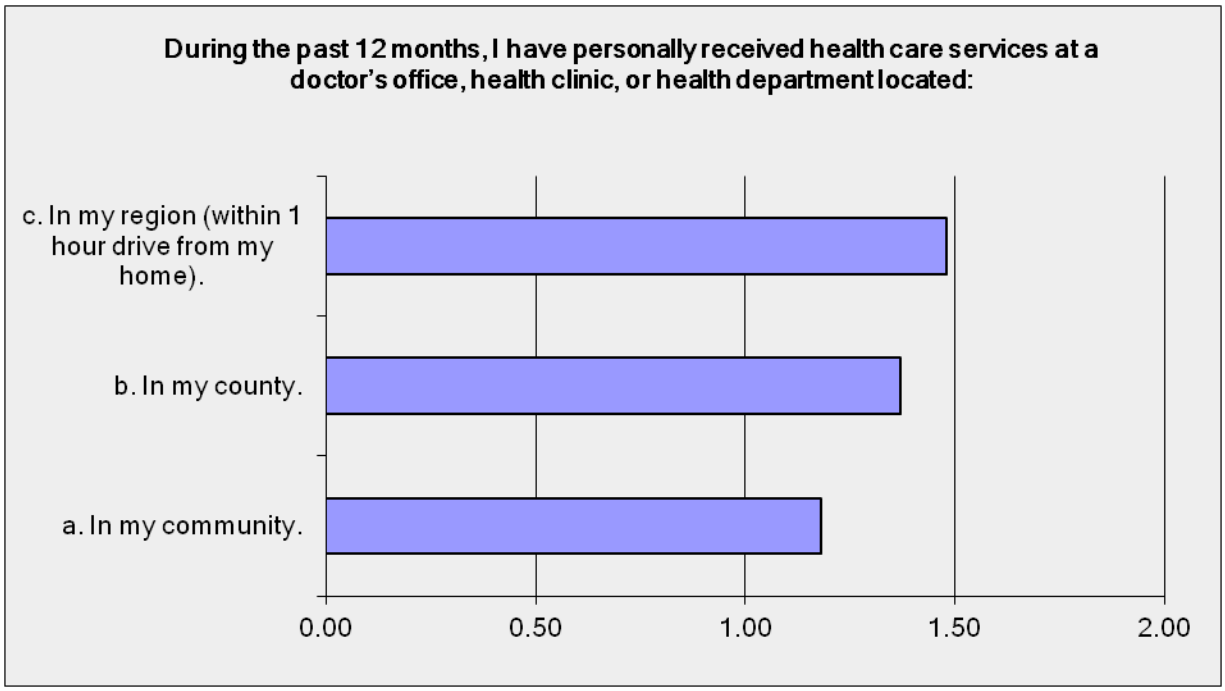
Sometimes I have difficulty finding transportation to health care providers.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Rating Average	Response Count
Sometimes I have difficulty finding transportation to	19	21	63	160	217	4.11	480
						answered question	**480**
						skipped question	**0**

The regular hours of operation at doctor's offices and health clinics are sometimes not convenient for scheduling care for myself or my immediate family.

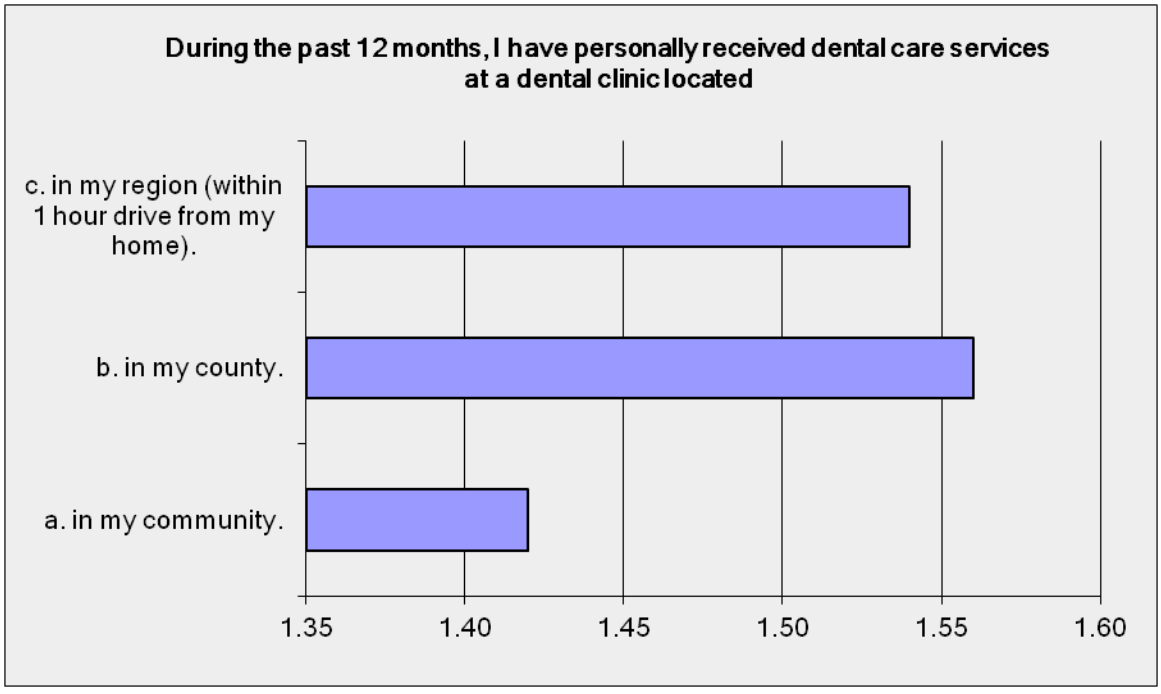
Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Rating Average	Response Count
The regular hours of operation at doctor's offices and	49	151	76	141	63	3.04	480
						answered question	**480**
						skipped question	**0**



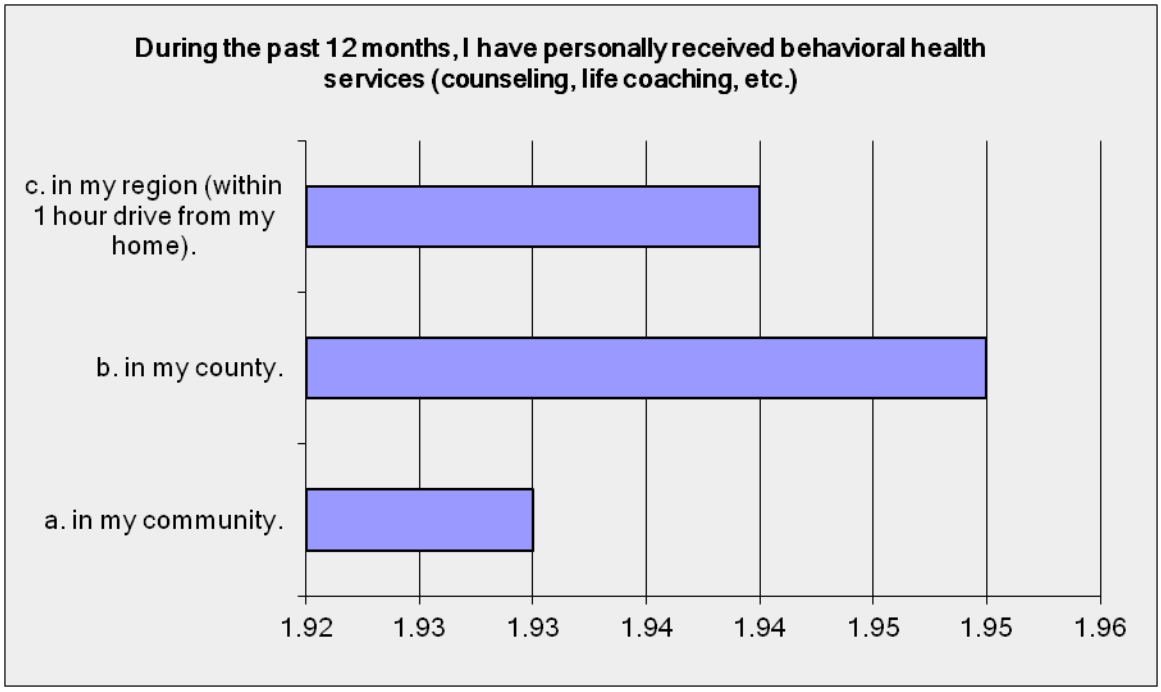


I have one person I think of as my personal doctor or health care provider (my medical "home" where I go for most health care needs)		
Answer Options	**Response Percent**	**Response Count**
Yes	87.7%	421
No	12.3%	59
answered question		480
skipped question		0

If you answered NO on #13: Instead, when I need them I receive my health care services from (check all that apply):		
Answer Options	**Response Percent**	**Response Count**
Free clinics	18.4%	14
Community Health Center	9.2%	7
Health Department / Immunization Clinic	7.9%	6
Family Planning Agency	10.5%	8
Emergency Room at a hospital	14.5%	11
Urgent Care Clinic	14.5%	11
Chiropractor	26.3%	20
I delay care as long as possible or refuse care	23.7%	18
N/A	32.9%	25
Other (please specify)		19
answered question		76
skipped question		404



I have one person I think of as my personal dentist		
Answer Options	**Response Percent**	**Response Count**
Yes	82.9%	398
No	17.1%	82
answered question		480
skipped question		0



Please provide additional comments on the health care system in your community, county or region:

The Webster Co Hospital in Red Cloud is a tax liability to the tax payer in Webster Co! Residents of Webster Co should not be required to support this facility if they chose not to use it.

It needs to be more affordable.

need to be more sliding scale or free.

Sucks

Need pediatric specialists

i work in mental health and we are swamped...leading me to believe there is a shortage of providers in our area. we are scheduling new evals 3 months out, esp. for kids!

Cost of health care is preventive, $161.00 to have a prescription refilled for a year? Too much! The cost of obtaining medical care must be the new take on "preventive medicine", Did I mention the medication alone is over $400.00 for a 90 day supply? I'm semi-retired and by the time I am retired I will have to go on the "preventive medicine" program simply because of the preventive cost.

There is a great need for urgent care clinics in the Hastings area. Too many times we see patients in the ER that could and shoud be better taken care of in a urgent care facility.

Had to wait a very long time to be scheduled for an appointment for a psychologist and a psychiatrist.

Mary Lanning's prices are astronomical. I also believe there should be limitations on how many office visits are allowed for people on medicaid. I sometimes have a hard time getting in to see my own doctor because these individuals milk the system and go 2 and 3 times a week to the doctor.

My county has no hospital

I DON'T GET THE MEDICAL CARE I NEED CAUSE OF THE HIGH DEDUCTABLE FOR OUR FAMILY TO SEE THE DOCTOR OF MY CHOICE

I would like to see a local dermatology practice, a gerontologist, and variety in urology practice.

There also needs to be a stronger support system between the practioners within our community and the hospitals.

It seems these days that some Dr. are more worried about the money that they wont recieve from a patient more then the care they can provide a patient. That just seems sad to me. I thought Dr. went into the field to help people not refuse them because they could pay at the time.

My biggest problem with health care providers is the wait time. I arrive at my appointment on time and have to wait on average an hour before I am taken to a room and an additional twenty minutes in the patient room before I am seen.

Very disappointed with the customer service provided at Family Medical on 14th street. Several people along with myself will never go back there.

clinic office hours in my community are only half days and times vary, hard to keep track of schedule

I would like to clarify my answer to question #8. It is not always the person seeking care that speaks a different language. I find it very difficult to communicate with Dr's who are from other countries and there seem to be a lot of those in this area, especially specialists.

I rely on health care in Hastings for medical and Minden for dental.
Sometimes when you have a problem they just blow it off.
Need more dentists providning services at adequate costs.
We need to have more dentists available for low income individuals.
We need to have more dentists available for low income individuals.
Very poor health care in Hastings!!! Why do the Dr.'s send everybody to Lincoln?? Or Omaha??
Specialization of services is not realistic for every county or community. If it is available within one hour drive - that is realistic
Veteran
It could be better.
It could be better.
Prices are so high that I cannont afford to go to the doctor.
All of the above are available for me.
We have good care with Webster Clinic and Hospital.
They give excellent care
Our health needs have been met in our county and are very accessible. Specialists are always available.
Too many hospital owened clinics. Not the caring attmospheres. Too political versus private owned and not the personal care - especially with billing questions.
Need more clinics that care about the patient's needs and not about the bottom dollar. I have a 26 year old son that does not have health insurance-visiting the doctor is a big issue (cos t& medication) becuase he does not make enough money to allow him to visit the doctor, chiropracter, dentist, as much has he should. Need clinics with sliding scales.
I believe the health care in my community, county or region is good. The only change I would like to see is possibly an evening clinic maybe one day a week and a Saturday Morning Clinic.
hospital is too focused on facility, instead of quality of care.
We are fortunate to have an excellent hospital, clinic and primary care physicians within 12 miles of my home.
Yery good.
I live in Clay county and we don't have a hospital in the county.
there is a real shortage of dentist in the Hastings area who accept adults with medicaid.
Recently I attempted to place my 16 year old daughter into a residential drug/alcohol treatment center and found it very difficult to find a place that would accept under 18 years of age. Some accept Medicaid but most want private insurance only. Even if they accept Medicaid it is hard to get placement accomplished. Drug/alcohol treatment is VERY expensive.
I just moved to Hastings and havent needed health/dental care yet. Nor was I insured until March 1. When I need care, I will seek it from Hastings providers.
We are well satisfied with our health care system in our community.
I believe we have very good health care in south central Nebr.
We used to have a doctor in Edgar every day but now it is only 2 or 3 times a week.
EMT service is great, but state regulations are not encouraging new EMT's to join service.
For the size of our community, our health care services are excellent.
I think they need to make sure they are fair and have the same things they give to pasients expically at the hospital.
Red Cloud, NE 68970
I think we probably need more mental health counselors in the area. We also need a full-time endocrinologist. I also think we may need more clinics/drs offices and urgent care walk-in clinics.
I am fortunate to have insurance; I imagine these answers are very different for those who do not have insurance (obviously), and I hope you can obtain data from those individuals.
We need more options for families without insurance.
I happen to live in the town that has the only hospital in our county
99% of these do not focus on HEALTH--only sickness and symptoms.
I do not like tele-psych.
Need more urgent care facilities or later hours at doctor's offices; the cost of medical care is too expensive; need better payment options for medical bills
appreciate having specialists like cardiologists at NHI come from Lincoln so we didn't have to go 200 miles round trip
Need more Urgent Health Care Clinics that are open later into the evening and on weekends.

Mental Health care as a whole is lacking and confusing when someone you know needs help. Hospitals

will not take people with a mental health issue and your only option may be 100 plus miles away.

Since Mary Lanning has taken charge of medical offices in the area costs at those locations have gone up and many patients have to look else where for the services they need. They will switch offices, making those offices more stressed,use urgent care or go without regular exams. People will try to avoid the doctor whenever possible.

Need more specialists in Hastings so we don't have to go to Lincoln or Omaha all the time.

Mary Lanning is the worst

I think we have excellent health care in our community - very happy and satisfied with it

Excellent

I hope that the evening hospital emergency has improved with Drs. who care and have knowledge. I have not gone within the last 12 months.

I think we are lacking in Behavioral health , but I dom not have personal experience

My individual experiences with health care in our area are fine, but I am an upper-income professional with a flexible schedule, reliable transportation and few health issues.

I like the availability of seeing a specialist in our local clinic.

Coming from an urban area I have always been pleasantly surprised with the care available in Superior.

We could use ANOTHER DOCTOR!!! However, the lack of mental health care services/ psychiatrists in the region is a serious problem in my opinion.

We have a wonderful hospital, Brodstone Memorial Hospital but I worry that retiring doctors will be difficult to replace. We have a great facility and we need to utilize it!

excellent caregivers and services

The billing process is poor. How did we ever get to the point that medical providers can charge for services not asked for directly by the patient. For example, going in for a procedure and getting bills from medical providers that are unknown to me.

ambulance services needed, we lack EMT's and transfer services.

Wish Saturday hours were broader.

I think we are very fortunate in Nuckolls county to have such wonderful healthcare facilities. The hospital and clinic in Superior are wonderful for the size of our town or any town for that matter.

My community is a good place to raise children.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
My community is a good place to raise children.	215	190	46	7	2	12	1.79	472
							answered question	472
							skipped question	8

Safe childcare is available in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
Safe childcare is available in my community.	143	186	69	16	4	54	2.39	472
							answered question	472
							skipped question	8

Affordable childcare is available in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
Affordable childcare is available in my community.	89	132	111	35	9	96	3.07	472
							answered question	472
							skipped question	8

I am satisfied with the school system in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
I am satisfied with the school system in my community.	103	198	72	47	11	41	2.55	472
							answered question	472
							skipped question	8

There are adequate after school opportunities for elementary age children (including those run by schools and community groups).

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate after school opportunities for	49	99	103	96	32	93	3.51	472
							answered question	472
							skipped question	8

There are adequate after school opportunities for middle and high school age students (sports teams, clubs, groups, etc.).								
Answer Options	**Strongly Agree**	**Agree**	**Neither Agree Nor**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Rating Average**	**Response Count**
There are adequate after school opportunities for	59	164	89	61	20	79	3.12	472
							answered question	**472**
							skipped question	**8**

There are adequate recreation opportunities for children and youth in my community.								
Answer Options	**Strongly Agree**	**Agree**	**Neither Agree Nor**	**Disagree**	**Strongly Disagree**	**Don't Know**	**Rating Average**	**Response Count**
There are adequate recreation opportunities for	57	162	98	82	33	40	2.98	472
							answered question	**472**
							skipped question	**8**

Please provide additional comments on supports for raising children in your community:

Too much emphasis on Husker Football and hunting.

Opportunities for high ability learners is needed

Hastings High School needs to step up and be a real school and resource for children. Some of the teachers use bad language & are NOT good role models for our children. I will NOT send my child there if there is an option to go to Adams Central unless the make some obvious improvements.

no 24 hr child care is available- MLMH child care facility was suppose to be 24hr when it was built

there are some options for kids after school but more options would be helpful!

I am always concerned about education quality in the schools and have concerns about the amount of money spent/wasted on items I feel are "nonessential" for proper education

I raised a child with learning disabilities who could not participate in sports, there aren't any clubs she qualified for in high school.

I don't have any children.

Wish there were more activities for toddlers in the community.

Income might be the biggest deciding factor regarding children and youth activities.

This community needs a teen center but I know the Mayor and Perry will not ailow it.

We need a place like the old Tiger-Hawk Den for teenagers. Clean Fun.

I'm not sure

I have no children at home.

No programs

There are many people that provide care for little children after school. There are both girl and boy scout groups available

There are childre's and youth programs available through most-if not all-community churches. however, a large number of children and youth don not participate-attend churches and the activities provided. Perhaps that is becuase the parents may not be encouraging the involvement and/or are not interested in church or ichurch activities.

rolling skating and movies in the winter and swimming and movies in the summer

My children are grown and gone but they got the education they needed in my community to get the jobs they wanted.

Hastings Catholic Schools and Zion Lutheran are great!

There are too many children affected by drugs and alcohol in this community as well as getting pregnant before graduating high school. This is what I am disappointed about most, that we don't have a better system to help them, that we can't find a group for them to be included in to raise their self esteem so they don't get caught in this cycle.

the school gyms need to be open more for recreation weekends and summer. we as tax payers are paying for them

Skateboard park would be a great addition.

I am not impressed on the curriculum in the high school in my community. I do not thing the teachers are pushing our children to challenge themselves in their studies in some areas. I do not think this is in turn preparing our children for college adequately.

they need more sports for the kids that are not star athletes just for fun.

Lack fine arts such as music or dance

I have no school age children, so I have no personal knowledge of many of the questions.

There are awesome child care in the community but it is so hard to get into one because they are always full.

Perhaps a need for parenting classes or support groups?

need to keep pool, movie theater and skating rink open

There are recreation opportunities available for a cost which many can not afford. My child is not athletic so sports in school isn't a choice for her. It also costs to be in the sports/clubs at school. I can barely make ends meet at home let alone come up with extra money for groups or clubs.
I live in a small rural community that does not have alot of opportunities available .We live within 20-30 minutes of a city that would offer those after school child situations but not feasible to get child to the city.
We chose to take our children to a school and community events in a different county. In the other county, I would mark everything as Agree or Strongly Agree.
I just moved to Hastings and I dont have any school age kids.
Hastings is a great place to raise children. I am supportive of the efforts of the local non-profit groups and attractions. Quality daycare was difficult to find but we were lucky and got into the daycare of our choice after being on the waiting list for 10 months. We pay $600 per month for daycare which would not be affordable for many families.
Once again, for the size of our community, support is excellent
Our city/county is smaller and I don't feel there are many activities for children to do. There is the YMCA but lots of times the price is to high for family to afford to go but don't fit in the low income spot. As far as day care its hard to find someone good and reasoniable. I have even hird a recent horry story about a friend picking up a kid and the day car tryed sending the friend home with two children!
Hastings High School has a bad reputation! There are teachers that use curse words in front of students and pregnancy rates are OUTRAGEOUS!!
need more art classes of various types for kids of all ages
Don't have any children
I do not have school-aged children, but I am aware that the Y has a LOT of programs for children and youth in this community (but that is my only knowledge), and I am not sure that this is adequate for a town of our size (but again, I do not know what is offered by other schools,etc).
Regarding recreation, the YWCA is cost prohibitive for many, myself included
There are too many activities, Not enough transportation to get them to and from school (need buses)
I wish there was free public school transportation
This town has too many students per teacher.

More opportunities needed to be available for children from low income families.
I am not a user of child care or after school care
For middle- and upper-income families, resources are available. For others, finding child care and after-school activities is challenging.
There is childcare in the community, but not enough especially for infants.
Few enrichment opportunties for young children/elementary age children. Too much emphasis on sports---the arts (visual, music, etc.) have practically disappeared but hey, we have three gymnasiums in Superior.
We have a wholesome community but small rural communities could always use more recreational opportunities for our youth.
opportunities are available, but cost and transportation can deter participation.

This community is a good place to grow old.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
This community is a good place to grow old.	126	243	53	17	7	22	2.15	468
							answered question	468
							skipped question	12

There are adequate recreation and exercise opportunities (parks, trails, fitness centers) for older adults in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate recreation and exercise	62	184	78	94	27	23	2.81	468
							answered question	468
							skipped question	12

There are adequate housing options (assisted living, retirement centers, maintenance-free homes/apartments) for older adults in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate housing options (assisted living,	62	173	74	82	22	55	2.99	468
							answered question	468
							skipped question	12

There are adequate transportation options (public buses, shuttles, handi-vans, taxis) available to take older adults to medical facilities and shopping.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate transportation options (public	42	113	97	106	42	68	3.42	468
							answered question	468
							skipped question	12

There are adequate programs that provide meals for older adults in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate programs that provide meals for	50	181	85	45	15	92	3.15	468
							answered question	468
							skipped question	12

There are a range of available services (social clubs, social services, groups) in my community for older adults that are living alone.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are a range of available services (social clubs,	29	102	112	83	25	117	3.69	468
							answered question	468
							skipped question	12

There are adequate local options (residential care, intermediate and skilled nursing homes) for persons who need long-term care services.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate local options (residential care,	59	167	94	60	21	67	3.04	468
							answered question	468
							skipped question	12

Please provide additional comments on supports for older adults in your community:

havent researched elder care in our area, seems like enough but im not sure?

Explain "adequate"

transportation is always an issue with the elderly--esp those that do not drive. Also the meals on wheels do not offer low sodium menus for elderly

It would be nice to have additional skill care facilities in the immediate Hastings area. I have heard several that could not get into Perkins, so have elected to go to Kenesaw or Edgar.

30 to 50 age needing mental health help need more in the assisted living arena. They don't fit with the 80 year olds but there is no where else.

there is not enough recreation for the elderly like dances,or weekend entertainment of any kine

We need chruch sponsored senior meets, people social clubs, and parents without partners.

Very good.

Need more support.

Need more support.

They don't like youger group.

These are available but too many older people stay in their homes when they should take advantage to the places that are there.

There are opportunities for older adults to serve as volunteers. Also good housing, transportation, Health care, assisted living, nursing home, hospital, and groups socializing with hobbies or similar interests.

Need more afforable housing. Had to take my mom to a smaller community in order for her to afford housing. She lives in a newer duplex now with a garage and no up keep like mowing etc.

why are our tax dollars used to take people out of towm to shop?

There are waiting lists for some older care facilities

Services for long term are not affordable.

Meals on wheels quality is poor

I'm not of the age to take advantage of some of these so I'm not familiar with them.

Need choices/competition in skilled nursing homes.

I dont know any older adults in the community yet, I just moved here. Nor am I an elderly adult.

Question #30 I think the handibus should run on sundays for people to go to church. and to let people know it is for all ages and not just the elderly

There is public transportation available but most seems to be offered only during daytime hours.

I think the care for adults in our town when they half to leave there home is high. As far as food I think there is only one group who does food and I dont think they have much of a change in menu.

Again, I have little experience with this particular issue, but I think this is a good place for older adults and feel that there are good services (but again, am not certain).

The bus services are TOTALLY INADEQUATE. Too costly and NOT FLEXIBLE.

More facilities are needed for dementia people and their families.

The transportation is limited and not available on weekends

I will retire this summer, so I guess I'll find out whether resources for older adults are adequate :).

While we may have what I consider adequate resources, that which determines a rate of success is the way they are used.

Re older adults: it is safe, home helpers can be hired, Vestey Center in Superior provides meals at center or home delivered. Handi-bus available as well. Good medical center BUT NOT MUCH GOING ON---kind of boring for active older adults.

We need a safe walking place

A skilled care retirement facility has been scheduled for our community and is needed....hope it's affordable!

Right now I do feel we are lacking a bit in regards to having enough assisted living or retirement locations for the age of our population, but the plans for a new assisted living/retirement center in town will help out immensely.

There are adequate places to exercise and play in my community (parks, walking/biking trails, swimming pools, gyms, fitness centers, and so forth).

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate places to exercise and play in	93	204	68	79	20	2	2.43	466
							answered question	466
							skipped question	14

There are adequate music, art, theater, and cultural events in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are adequate music, art, theater, and cultural	36	112	94	154	49	21	3.28	466
							answered question	466
							skipped question	14

There are adequate organized leisure time activities available in my community (such as groups, clubs, teams, and other social activities):

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
a. for young adults	31	106	100	144	36	49	3.42	466
b. for middle-aged adults	23	121	96	141	38	47	3.41	466
							answered question	466
							skipped question	14

Please provide additional comments on recreational and leisure-time options in your community:

Need more live music and rec opportunities for young adults.

Need more walking/biking trails

We need to keep promoting walking, biking and being more active for all ages!

After 50 and before 70 , the" ignored or unwanted generation". Sorta like the uncoordinated kid at a sandlot baseball game, wants to have fun and play but nobody wants to pick you for the team. Retired, with talents to give, and life to live.

Need walking paths on west side of town'

Need a roller skating rink, laser tag and a "night club" type of place for teens and younger adults.

The bike/hike trail is nice, however it is only 5 miles long and crosses almost every major street in Hastings.

Need more hiking and biking trails. More organized physical activities

We need to plan a day for the Inspirado group to get together this summer and do a group walk.

We need to plan a day for the Inspirado group to get together this summer and do a group walk.

Medium.

Do not use except the senior center activities.

Need more golf courses

The community building is available all the time for walking, bicycling, and various thing in a room.

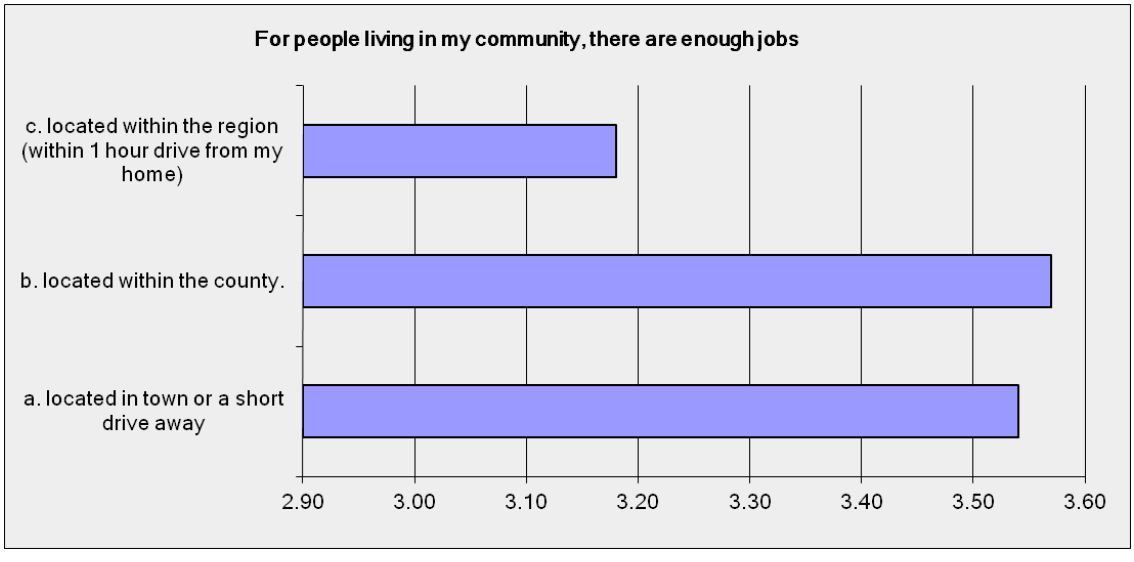
A majority of things I see advertised involve alcohol or are not free to the public.

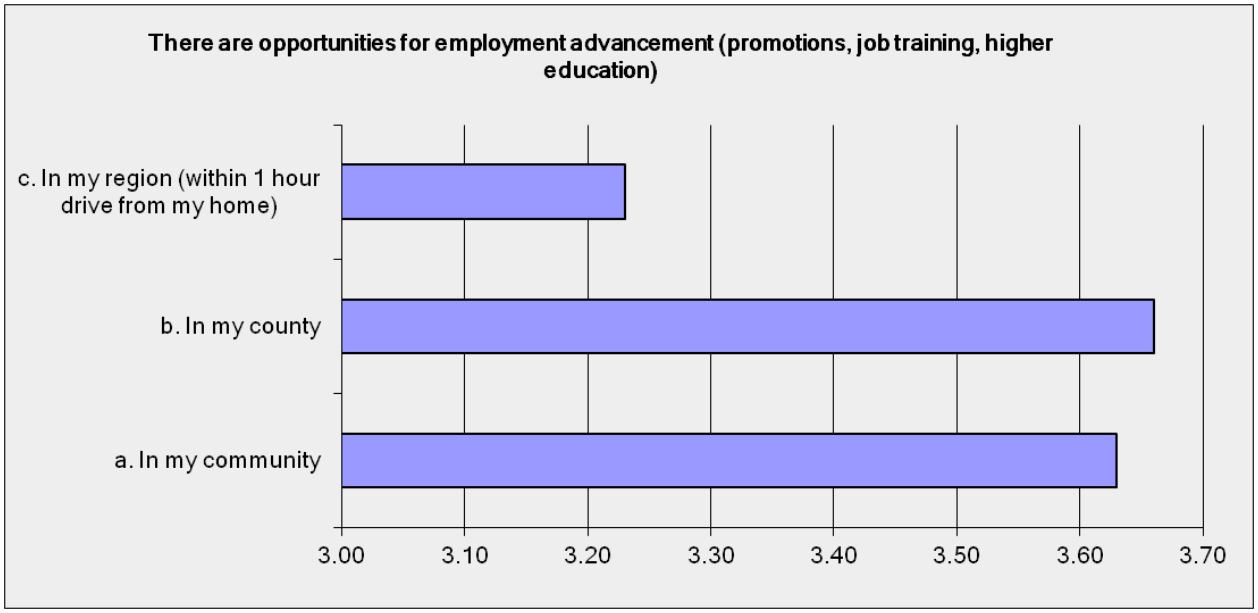
it is not the resposibility ofr tax payers to provided these services for people other then opening plsces like gyms that are there already

It would be great to have a recreation planning person to organize events in town.
I live in Hastings so there are some, but needs to be more biking and walking trails. It does have one 5-6 mile trail, but downtown needs to be much more bike / pedestiran friendly than it is now. I think parks and lakes areas in the city are good. There are also cultural events if you look for them and attend them. The library is really good for the facility they have. Hopefully that will be taken care of in the future.
It would be nice to have a community center that offers exercise equipment that would be at a minimal cost other than the Y or 24 hour Fitness.
Wish we had more of them.
Again, just moved here. I dont know what's out there yet.
There could always be more! We need activities for young and middle aged adults that do not include drinking.
Fairly strong considering population size
Depends on time of day at places for exercise there can be not enough equipment in eveninig hours
I think we need more kid pools and pools other then the water park. Its nice to swim outside withought having the slides running right into the swimming area. The college and community theator are our mane forms of art, music, etc. I think that there is not enought for children to do!
need more green space parks & trails
I think we have a very active community with varied opportunities (but we could always do better). I think the college helps with this, as there are always a wide range of events to attend.
If you do not belong to a church...there are no organized groups...except weight watchers...quilting and such....we make our own recreation...camping...fishing...etc
Co-ed sporting leagues
More young adults in the community
Movie theatre
NEED MORE BICYCLE TRAILS !!!!
More opportunities need to be available for middle school age people.
I am not sure about Leisure time activities . Sometimes people need to seek tham out
Wish we had a community theater, city band or orchestra, or community chorus that was going all year long
would love a year round pool!!!
Our churches provide most of the activities for older adults here.
Need more parks, hiking trails, etc.
I would like to see the bike/walk path continue to expand.

For people living in my community, there are enough jobs

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
a. located in town or a short drive away	17	104	71	179	58	31	3.54	460
b. located within the county.	17	98	86	168	48	43	3.57	460
c. located within the region (within 1 hour drive from my	37	153	92	95	32	51	3.18	460
							answered question	460
							skipped question	20





Jobs in my county are "family friendly" (allow for flexible scheduling, reasonable hours, health insurance, and so forth)

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
Jobs in my county are "family friendly" (allow for	20	131	112	108	35	54	3.37	460
							answered question	460
							skipped question	20

My employer encourages/promotes healthy behaviors.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Not Applicable	Rating Average	Response Count
My employer encourages/promotes healthy	126	190	58	31	11	44	2.44	460
							answered question	460
							skipped question	20

The economy is strong in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
The economy is strong in my community.	15	121	128	126	41	29	3.31	460
							answered question	460
							skipped question	20

Please provide additional comments on jobs and the economy in your community:

Our biggest problem is the people who have no expectation or motivation to ever earn a living and support themselves because they and their families have been on medicaid, etc. for so long! A sense of entitlement and NO self-responsibility! If this continues it will eventually consume every resource and destroy our society.

My mentally challenged daughter has been looking for a job for three years. Places like Wal-Mart and the hospital now make you take a pre-employment test - no one wants to hire her - even since working with vocational rehab.

Fair and medium.

Could be much better.

Could be much better.

Gas and groceries cost too much.

Very few jobs available for women. Only animal jobs. Pig and cattle, large forms (for feeding and shipping)

Some available hobs are not advertised locally, and (seemingly) suddenly an individual or family moves (or returns) to our town, dilling positions that were not generally known were "open" or available.

There are a few minimum wage jobs. No really organized businesses that provide benefits and support for employees. Most have no goals to get better but are satisfied with the status quo.

Lost my job due to business closing its doors and was unemployed for 6 months and a couple other co-workers still unemployed.

My employer wants to encourage healthy behaviors but my direct boss wants to only when it's convenient for her.

only minimum wage jobs are available. Only farm income is strong.
Employment that supplies a "living wage" is how the question should be asked. There are many minimum wage, part time jobs, but is that what you are considering "employment" ? Also I think there is a general lack of a work ethic out there and people want things given to them and don't want to work their way up in a business to earn them. They have to have a decent wage and some benefits to get started though.
Our economy is not the greatest but it's not the worst by far!
health insurance is not family friendly - very costly
I feel like the city miss handles the the towns money to let the superior employees drive the company trucks home for lunch or some have them to drive to work home for lunch and home for the end of the day. Some even live out of town. We dont see firemen taking the fire trucks home and they are in a hurry when they need them and have to go pick them up. Also to see them at least 2 times a day go to snack food and go back to the shop and have at least a 30 minute break 2 times a day. This has gone on a long time and people are tired of it. Same thing happens with the cop cars.
Quality, professional well paying jobs are difficult to find. My job is flexible in terms of hours but many are not.
We need more higher paying jobs that can support a family.
I think our Economic Development could be more aggressive in attracting new employers.
I think there are becoming more people unemployed and it harder to find jobs It's also harder for people to find things to do that dont cost much money on a tight budget!
low paying jobs mostly
I think we have a very strong community in a lot of ways, but I imagine that the answer to most of these questions is "it depends." Regarding flexibility, MY job is certainly flexible and "family friendly" but I am not sure about other jobs. Compared to the US unemployment rate, NE is doing well (but I am not sure about Hastings). I DO have concerns about our poverty rate (higher than Nebraska's average, I think).
prices are high, and I think rent etc is high too for peoples income
We are lucky in that the local farm economy has not suffered during the recession period and that helps sustain our area.
We are a service community....retailers can not get affordable insurance for their employees. Farming is also a carreer that does not afford good income for the hired hands.
Wages are too low
Limited jobs for people with college education

Opportunities for advancement are very small
The business climate in hastings is NOT frendly .. the town is dying a slow death ... thank you city council.
We need more job opportunities for skilled people.
We have a ;low level pf pay so many people live unable to maintain a satisfactory lifestyle
I have been fortunate in my employment here, but I know others who have not, people with abilities, etc., similar to mine..
We bemoan the lack of industry but seem so wikking to go out of town to buy rather that stay in town not sure how much small employers can afford to contribute but most educated young people do leave Superior/Nuckolls Co.
We need small industries to create jobs for families so that our community can grow!

There is enough quality housing available in my community, including homes and apartments.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There is enough quality housing available in my	20	143	82	147	26	42	3.31	460
							answered question	**460**
							skipped question	**20**

Quality housing in my community is affordable for the average person.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
Quality housing in my community is affordable for the	20	131	109	122	32	46	3.33	460
							answered question	**460**
							skipped question	**20**

Please provide additional comments on housing in your community:

Housing costs, whether buying or renting, seem pretty high for a town this size.

Also there are not enough newer, clean, well-maintained rentals available.
i have a friend who searched for a rental for her family for months
Not enough houses/apartments to rent in this community.
We looked to buy a house is a specific price range for over one year before we found one.
Needs to be more affordable clean apartments for students.
Good.
There's lots of old run down houses in this city.
There are 2 Gov't buildings and city owned new assisted living (one year old and not filled) Many houses with for sale signs.
There seem to be plenty of older homes available but not apartments or rentals.
There are too many slum landlords that don't take care of their houses. I lived in a termite infested house for many years because I never made enough money to get out. Even after going to college I am still not considered to be paid the "average" wage for my community.
Community should be able to support 3 Habitat for Humanity homes in 2 years.
The better quality housing is not affordable for a single parent family of 3. I have lived in houses that are not healthy for my family and pay $400 a month.
We need more quality apartments for young adults.
N/A
I think its harder to find apartments because of the hard economy people are selling there homes and moving to apartments!
Again, from my perspective, I agree with these statements; people in a different SES level may disagree (perhaps strongly).
Quality of housing options is very poor

Many properties should be torn down and basic, simple homes built
Hopusing is not comparable to income levels
Housing for middle- and upper-income people is fine--reasonable prices, lots of options. For lower-income people I'm not so sure.
Hosuing is in bad state and there is a large number of working poor who do not have average incomes to spend on rent or purchasing a home.
Affordable housing for retirees is needed!

My community is a safe place to live, work, and play.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
My community is a safe place to live, work, and play.	117	270	58	11	2	2	1.95	460
							answered question	460
							skipped question	20

There are support networks in my community that help during times of stress and need (neighbors, support groups, faith community outreach, community organizations, etc.).

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are support networks in my community that help	58	218	97	40	15	32	2.63	460
							answered question	460
							skipped question	20

There are an adequate number of volunteers to fill the volunteer needs in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Rating Average	Response Count
There are an adequate number of volunteers to fill the	26	115	101	133	27	58	3.42	460
							answered question	460
							skipped question	20

Please provide additional comments on safety and social support in your community:

Could be better.
Could be better.
The churches are on place of social support-that is some of the individuals in various churches are caring and give soicial, and emotional support. of course, I can't speak for EVERY person but there are many who are supporting and care about other indivduals.
During my 20 years of living in my community my home/vehicles have been burglarized, vandalized or destroyed by drunk drivers in a total of 12 incidents.

there are too many parents who want their children to have activities but will not help with the programs their kids are in

Volunteering isn't something alot of younger people want to do or know how to do. I think it should be a requirement of all high schools and colleges in a community that the students have a volunteer component in thier educational program.

Need more EMT's

need more volunteers especially 25+ and older

#49 - People are not as social as they used to be. You can't count on your "neighbors" like it once was in the past. People are more cautious.

we have never had much in crime but lately in superior all the break-ins and the person was in over 20 some homes and went to court and only got probation. Many dont like that the cops dont keep things to themselves if you want to know "something" ask a superior cop and they will tell you.

Many many programs out there need more volunteers to reach more needy people and staff the programs currently in place.

You can never have enough volunteers. There is always a shortage of blood donors.

We need more EMT's

Friendly and caring people make safety and social support a reality in Hastings.

A good community runs on volunteers. i do volunteer and I understand its hard to find time!

People in this community are incredibly generous and willing to help.

The same good people help with everything. We need a way to encourage more participation of volunteers.

#51 In general, people don't want to step up and volunteer and it becomes the same people taking this on over and over. (And I am just as guilty of not doing my part to step up.)

We are having a difficult time recruiting and maintaining EMT's. Response time is too long because of no help.

Social supports need to improve.

There are many volunteer opportunities , but some people choose not tol volunteer

The aging baby boomers who can no longer do the volunteering in our community have no one in the wings to replace us!

In the senior populations many volunteers exist, not sure of other ages.

Thinking about what you know from your personal experience and/or the experiences of others you know, what do you think are the 3 most troubling health-related problems in your community? (Choose ONLY 3)

Answer Options	Response Percent	Response Count
Overweight / Obesity	55.7%	251
Cancers	39.5%	178
Aging problems (arthritis, hearing/vision loss, falls)	34.6%	156
Addictions	30.8%	139
Mental health issues (including depression)	30.4%	137
Diabetes	21.1%	95
Heart disease	20.0%	90
High blood pressure	12.6%	57
Teenage pregnancy	10.6%	48
Child abuse or neglect	8.0%	36
Injuries (from crashes, falls, violence, etc)	6.0%	27
Respiratory / lung disease	4.7%	21
Domestic violence	4.2%	19
Poor dental health	4.0%	18
Motor vehicle crash injuries	2.4%	11
Unsafe environment (poor air/water quality, chemical exposures)	2.2%	10
Infectious diseases (hepatitis, TB, pertussis, flu, other diseases transmitted from person to person)	2.0%	9
Stroke	1.8%	8
Asthma	1.6%	7
Sexually transmitted diseases	1.6%	7
Suicide	0.7%	3
Rape / sexual assault	0.4%	2
HIV / AIDS	0.2%	1
Infant death	0.2%	1
answered question		451
skipped question		29

From the following list, choose 3 risky behaviors that you think have the most impact of health and well-being in your community? Choose only 3

Answer Options	Response Percent	Response Count
Alcohol abuse	52.3%	235
Not enough exercise	39.2%	176
Distracted driving (cell phone use, texting, etc)	38.5%	173
Poor eating habits	34.7%	156
Drug abuse	33.9%	152
Tobacco use (including smokeless tobacco)	21.2%	95
Drunk driving	20.9%	94
Avoiding routine visits to health professional	14.3%	64
Not managing stress	13.4%	60
Not using seatbelts	9.8%	44
Not using child safety seat (or not using correctly)	6.2%	28
Unsafe sex	6.2%	28
Violence (domestice violence, fighting, etc.)	6.2%	28
Not getting vaccine "shots" to prevent disease	1.8%	8
answered question		449
skipped question		31

Of the health related problems and risky behaviors listed above, which one would you say your community should be addressed first?

CATEGORY	NUMBER OF RESPONSES	PERCENT of TOTAL RESPONSES
Alcohol Abuse	86	18.9%
Drug Use/Abuse	72	15.9%
Distracted/Risky Driving	61	13.4%
Exercise inc. Not Enough	55	12.1%
Eating Habits inc. Poor	37	8.1%
Drunk Driving	27	5.9%
Routine Visits to Healthcare Providers (avoidance of)	13	2.9%
Tobacco	13	2.9%
Managing Stress	8	1.8%
Seatbelts	8	1.8%
Alcohol and Drug Abuse	8	1.8%
Child Safety Seats	7	
Teen Pregnancy/Unsafe Sex	7	
Violence inc. Domestic	6	
Stress	6	
Eating AND Exercise	4	
Healthcare	3	
Obesity	3	
Addiction	2	
All	2	
Cancer	2	
Cell Phone Use	2	
Shots/Vaccinations	2	
Price of Health Office Visits	2	
Affordable Health Care	1	
Alcohol and Mental Health	1	
Early Childhood Education	1	
Lifequest Unsafe	1	
Not Using Birth Control	1	
Diabetes Prevention	1	
Sleep Disorders	1	
Don't Know/Undecided/Didn't Answer	11	
	454	

Please provide additional comments on community health issue priorities:

Teen pregnancy needs to be a lot more addressed.

this is a problem that impacts others on the list and impacts everyone in the community

There are far too many people killed on the roads every year, most are not wearing seatbelts. This could be an immediate improvement if they started wearing them. In particular our youth.

distracted driving is a growing issue - not just the kids, but adults as well. will probably become as big a killer as drunk driving before much more time has passed. I have notice a huge increase in traffic violations as well while driving...running stop signs, red lights, excessive speed. couple that with the distracted driving and disaster is a blink away. people have become so self-centered and unconcerned with the safety of others (and themselves) that traffic laws have been thrown away.

Child safety restraint is still a very big issue!!!!

People will go for health care for acute illness but many won't go for health maintenance /wellness. Either because they don't understand the need, or they are afraid they will find something "wrong" or they don't want to be told they need to lose weight, eat healthy, exercise, etc. Sometimes it's due to cost but much of the time that's just a convenient excuse-they still can afford living on fast food, going to the nail salon, smart phones, concert tickets, cigarettes, etc.! People need to become accountable for their own health again and quit expecting health care to fix them no matter how badly they neglect their health!

for exercise..how about some fun active activities that arent just exercise like a street dance?? or some creative gatherings that get people up and moving but less rigid than exercise, more enjoyable!

These days everybody is more stressed out then the year before. We have to work multiple jobs to pay the bills, we see our familys less but the work load at home never changes. like the old saying To little time to much to do, yet we try to do it all

Think Mary Lanning could benefit by providing some kind of Obesity Clinic

There is to much drug use in this town.

Is clean.

Should be more in home care at a reasonable price to be available when you need it.

Should be more in home care at a reasonable price to be available when you need it.

Too many young people getting pregnant.

Child sagety seats would be second. You see small children standing in seats too often.

Not mamaging stress is one, but many try to manage stress with alcohol and or drug use. Domestic biloence sometimes is caused by the use of these also poor eating habits is often becuase of stress.

Just saying no doesn't work. These kids grow up cynical about drugs in this community because they aren't taken away from drug abusing parents and taught a healthy lifestyle.

physical fittness should be the number one priority. many other problems would be solved if people of all ages were physically involved & fit.

Educating the public on how proper eating habits impact everything else is important.

if people knew proper nutrition, not the SAD diet, but eating the Fresh organic fruits and vegetables needed for proper nourishment, and daily excercize, there would be less obesity, heart disease and cancer.

Don't Know

too many bars, not enough family activities to keep people busy which causes people to drink and fight

We need to get our kids to stop having sex and spreading the diseases. Or educate them on how to protect themselves.

Providing access to affordable activities for adults that don't involve drinking should be a priority!

not good parenting in this community

You could address all of the above behaviors,as they all are bad.

The rate of protection orders just continue to grow everyday

If exercise is addressed, I think it will have long term effects in controlling obesity.

It would be nice to have a program where people could help the dr or the office or other people to help pay for doctor bills! I saw another community on TV that does this!

A top concern that I have is distracted driving, but I could only choose 3 (and stress, eating, exercise seem important). I would also add routine visits to health professional (and mental health professional).

UNDERAGE DRINKING

Old people driving when they do not belong on the street in a car!

Education of dangers of marijuana/meth, etc

Need low-cost exercise programs.

lack of family values/morals

Drugs

Alcohol & drug abuse are the cousins to tobacco use ...

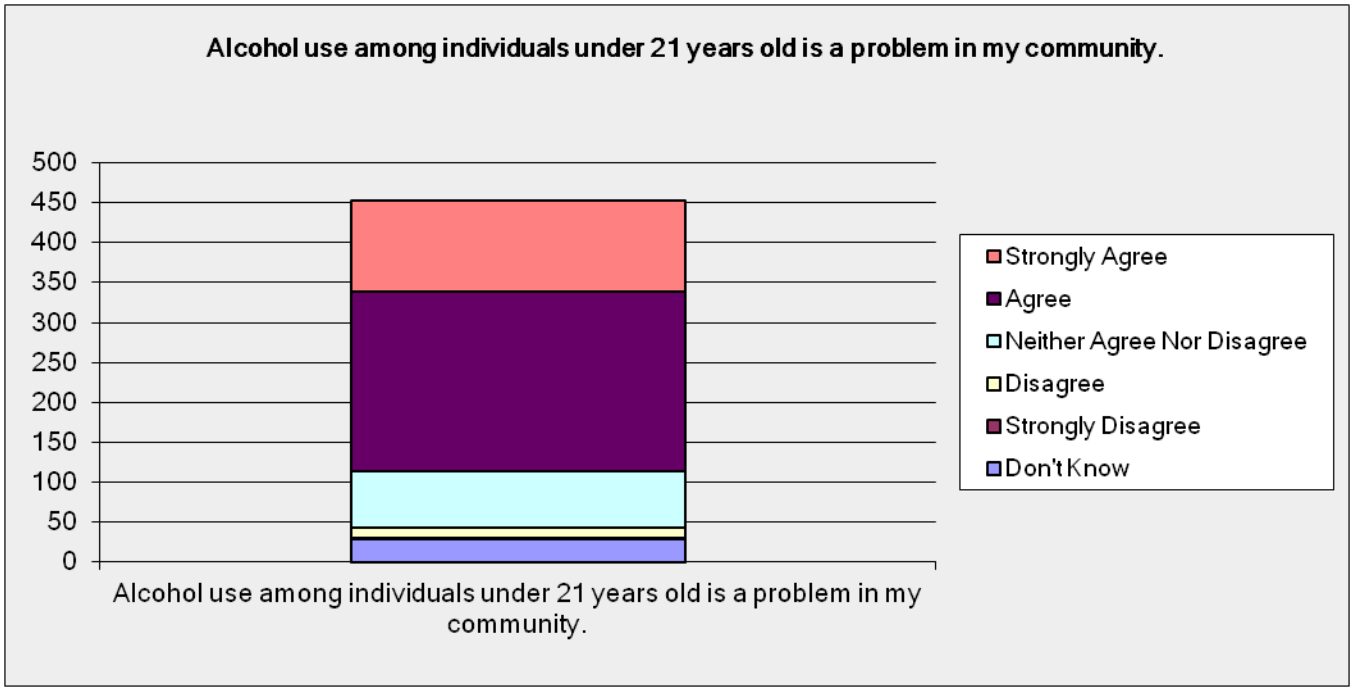
Depression from living in a struggling rural economy is very stressful and leads to behaviors that compromise a healthy life.

Family support: maternal/child/family health and mental health support services, especially to help with substance abuse issues which so directly impact child welfare, ability of the adults to provide a stable family life.

immunizations low cost are needed

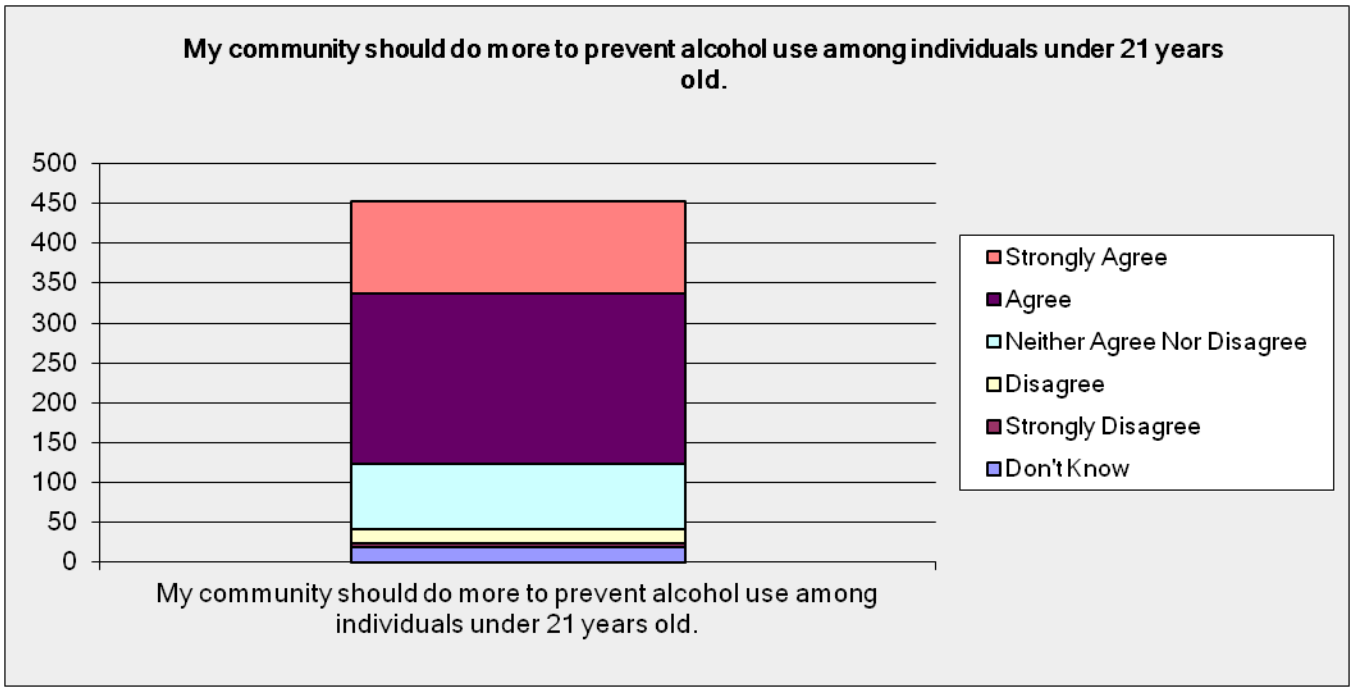
Alcohol use among individuals under 21 years old is a problem in my community.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Response Count
Alcohol use among individuals under 21 years old is a	114	226	70	14	1	29	454
						answered question	**454**
						skipped question	**26**

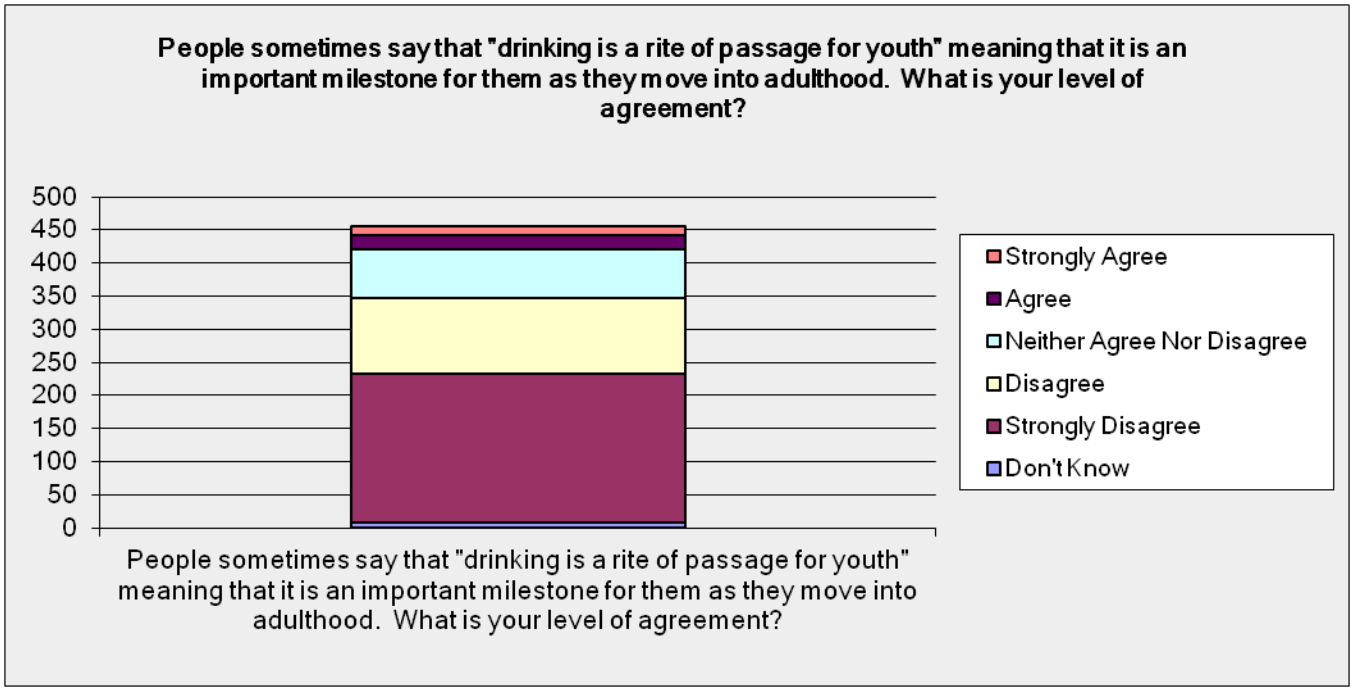


My community should do more to prevent alcohol use among individuals under 21 years old.

Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Response Count
My community should do more to prevent alcohol use	117	213	83	17	4	20	454
						answered question	**454**
						skipped question	**26**



People sometimes say that "drinking is a rite of passage for youth" meaning that it is an important milestone for them as they move into adulthood. What is your level of agreement?							
Answer Options	Strongly Agree	Agree	Neither Agree Nor	Disagree	Strongly Disagree	Don't Know	Response Count
People sometimes say that "drinking is a rite of	14	21	74	114	225	8	454
						answered question	454
						skipped question	26



Please provide additional comments on alcohol use and prevention in your community:

Alcohol kills more people then smoking or drugs. It should not be around at all.

ALCOHOL USE SHOULD BE ADDRESSED MORE SERIOUSLY ON THE COLLEGE CAMPUSES

start with more teaching about the long term effects of alcohol abuse for younger kids in school! Graphic shots of liver cirrhosis and smokers lungs! Scare them out of the activity!

You can't prevent stupid or excessive behaviors,

I believe the role of the parent has been overlooked in some cases. The city should not be expected to raise the childen,,,,,the parents have the first duty and obligation

Kids are going to drink if they want - no matter how educated they are. I don't think government should get involved in telling Americans what to do. Let them do it if they are stupid enough.

Alcohol has major health consequences

*58: Communities should not be heald accountable, parents should.

If our society has changed attitudes toward smoking, we can change our attitudes toward alcohol and drugs.

need more activites for youth.

none drinkers.

Alcohol shgold not be so much available in all areas.

Alcohol should no be so available in all areas.

Drinking was a "rite of passage" for me as a youth moving into adulthood. This does not mean that I would choose for my children to have the same behavior/milestone.

education starts at home

Alcohol is available in many homes and otherwise it is purchased for under 21.

Alcohol use-abuse sometimes is used to reudce stress as mentioned in comment above. The myth that drinking alcohol or using drugs makes an individual more mature, part of the "In crowd" promotes apoor goal. The birtues so often considered "Old Fashioned, Out of Date", etc should be held up as attainable and practical goals-for youth and adults. Now in this modern invironment and not ridiculed.

Part of growing up and makeing decisions and being treated like an adult not a child. Giving youth a chance to express themselves.

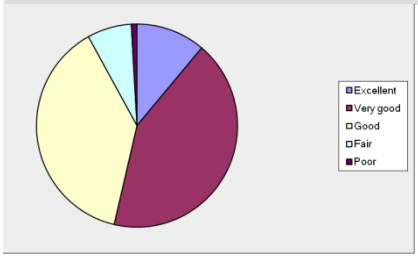
Underage drinking is inevitable, no matter where you are.

The problem with cracking down on alcohol abuse is that kids will use other illegal (or legal means such as canned air, correction fluid, cough syrup) to get high. Which is better? alcohol or drugs?

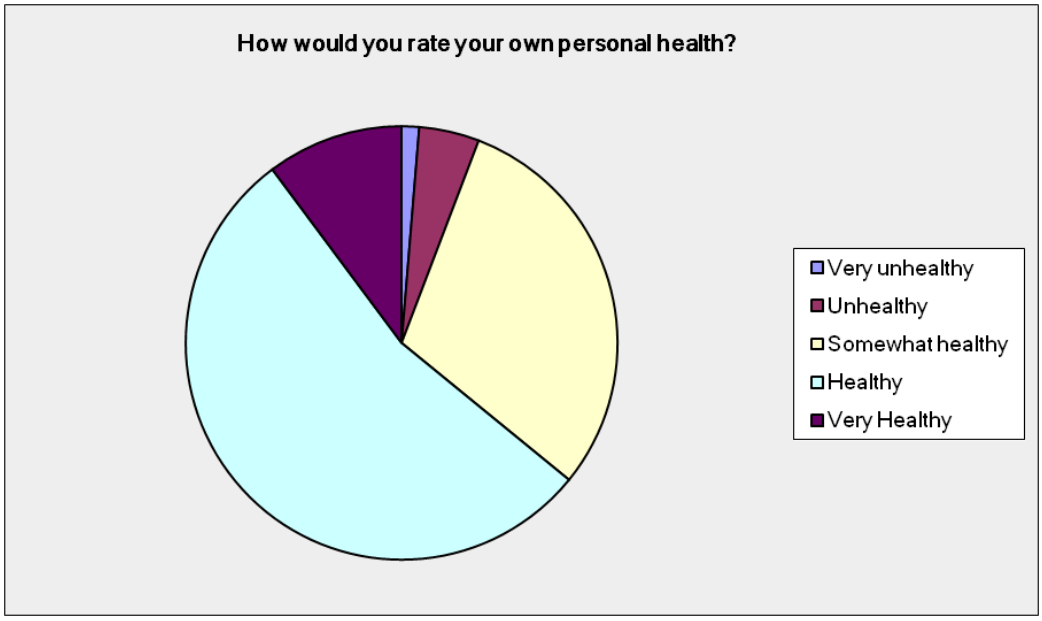
none
Kids should be educated about the dangers of drinking. Not just drinking and driving but also alcohol poisoning, becoming an alcoholic, etc.
Provide alternatives!
People that condon underage drinking should be criminally prosecuted.
I have heard that funds to our Substance Abuse programs will be greatly cut and we may loose our local programs this is not a good thing. I know there are to many drug and alcohol rellated health issues in our communities for this to be dropped
We should provide other things to do in our community.
As a child I behaved as a child, but when I became an adult, I put away childish things.
The number of MIP's in this area is an indication of how pervasive the problem is.
I don't agree with drinking. It's the persons choice, I think our town tries to stop under age drinking but one again its a choice.
I wish there was a lawful way to get rid of alcohol use altogether
I honestly do not have my finger on the pulse of alcohol-related issues for our young citizens. I know this is a concern for the STATE (and there was a great documentary on NET TV about this: "Your children are drinking" or something like that).
Parents need to take responsibility for their children.
Peer pressure and drinking should be addressed
alcohol kills--PERIOD
We know right from wrong
If you had more (much more) functions for under aged persons to attend, the need to "find something to do" would not be an issue.
If the high school and middle school kids had more to do they might not drink as much
I think the data suggests minors using alcohol are more apt to be alcoholics. ... CHURCHS don't do enough to help with the effort to curb alcohol use ... wonder if they may be afraid to stepping on their members toes?
Alcohol use is highly overrated and people would be much better off if they didn't drink at all or only drank 1 or 2 drinks occasionally - not sure what we can do about this -
alcohol abuse among the over 21 age group needs to be addressed.
First adults must feel and believe that "drinking is not a rite of passage for youth". They need to show a good example.
We should never encourage underage drinking
People see drinking by young people as a rite of passage--and that outlook is a problem
Alcohol use is not taken seriously enough by parents....in my opinion.
I personally do consume some alcohol but am appalled at attitudes of some adults and a lot of teens towards alcohol abuse. It is a problem!

How would you rate the overall quality of life in your community?

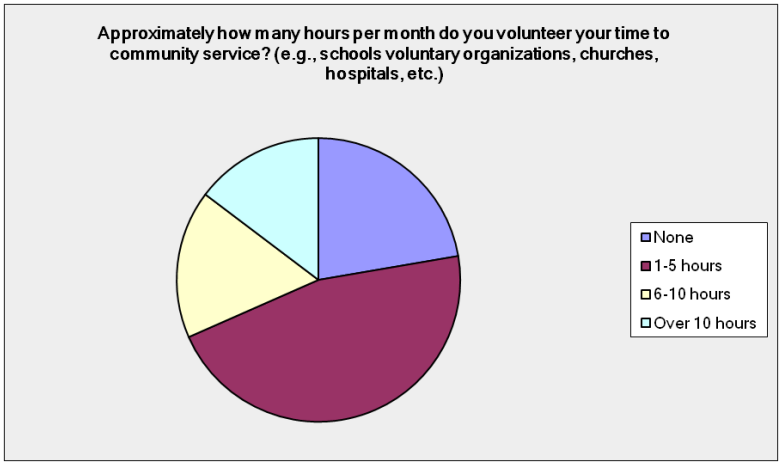
Answer Options	Response Percent	Response Count
Excellent	11.1%	50
Very good	42.5%	191
Good	38.3%	172
Fair	7.1%	32
Poor	0.9%	4
answered question		449
skipped question		31



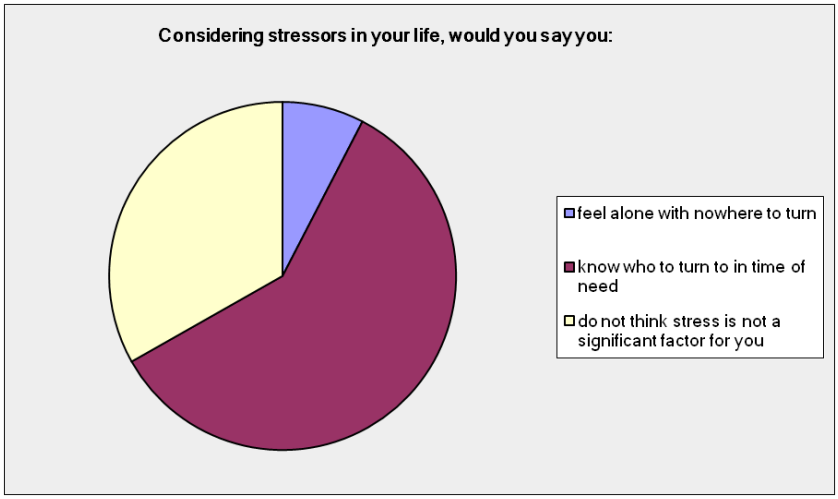
How would you rate your own personal health?		
Answer Options	**Response Percent**	**Response Count**
Very unhealthy	1.3%	6
Unhealthy	4.5%	20
Somewhat healthy	30.1%	135
Healthy	53.9%	242
Very Healthy	10.2%	46
	answered question	449
	skipped question	31



Approximately how many hours per month do you volunteer your time to community service? (e.g., schools voluntary organizations, churches,		
Answer Options	**Response Percent**	**Response Count**
None	22.3%	100
1-5 hours	46.1%	207
6-10 hours	16.9%	76
Over 10 hours	14.7%	66
	answered question	449
	skipped question	31



Considering stressors in your life, would you say you:		
Answer Options	**Response Percent**	**Response Count**
feel alone with nowhere to turn	7.6%	34
know who to turn to in time of need	59.2%	266
do not think stress is not a significant factor for you	33.2%	149
answered question		449
skipped question		31



How do you pay for your health care? (check all that apply)		
Answer Options	**Response Percent**	**Response Count**
Pay cash (do not have insurance)	10.5%	47
Veterans' Administration/ TRICARE	2.0%	9
Medicaid	1.8%	8
Medicare	12.5%	56
Private Health Insurance (e.g., Blue Cross, HMO,	86.0%	386
Indian Health Services	0.2%	1
Other (please specify)		26
answered question		449
skipped question		31

Other (please specify)

when I have the cash to go.
I don't
And pay cash
daughter medicaid and me private-regional care
usually cash, never meet deductible
private pay
pay cash for noncovered costs (deductibles)
cash plus premiums for insurance as deductible generally not met
High deductables
medicare supplement insurance
Cash
Also cash, as Medicare doesn't pay 100% of all med bills.
paying cash for the high deductibles

Never been able to afford insurance for the rest of my family but mine is free through my employer
high deduct
Christian Healthcare Ministry
make payments
Have $2500 deductible
Pay Cash - high deductible insurance
If it wasent for having health insurance throught work I don't think we would have it. Just like dentil and eye is to expensive for us so we dont have it!
Includes a co-pay and deductible amount that is out of pocket
plus a supplement
supplemental insurance
self--no employer
very high deducticble
Provided by Employer

How do you pay for dental care? (check all that apply)

Answer Options	Response Percent	Response Count
Pay cash (do not have insurance)	38.3%	172
Veterans' Administration/ TRICARE	0.4%	2
Medicaid	1.1%	5
Medicare	1.8%	8
Private Health Insurance (e.g., Blue Cross, HMO,	63.5%	285
Indian Health Services	0.0%	0
Other (please specify)		24
	answered question	449
	skipped question	31

Other (please specify)

didn't get any
no cash to go.
I don't
and cash
doesnt pay well
private pay
plus cash for premiums and co-pay
High deductables
I do not have insurance for dental.
unknown
myself
Cash and minimal insurance
paying cash for the deductibles
high deduct
dental co-pay
make payments
Pay Cash - high deductible insurance
I go to a relative for free
To expensive!
plus cash
Insurance is not good for dental
Includes a co-pay and deductible that is out of pocket
do not go to the dentist

Provided by Employer

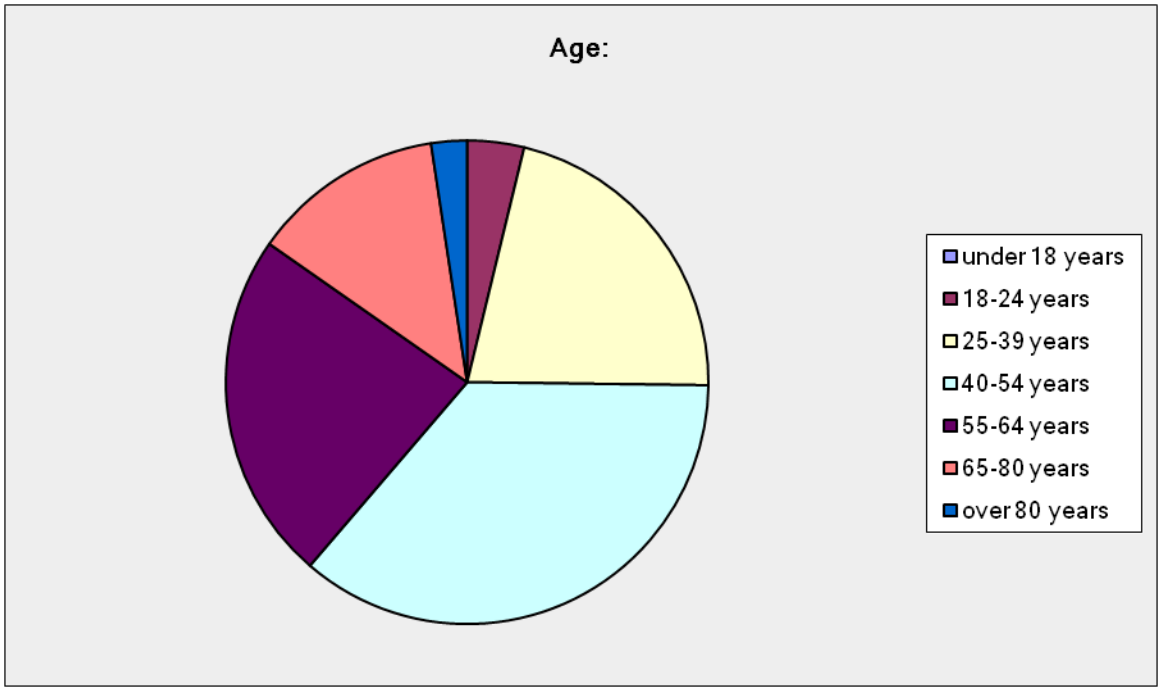
How many children less than 18 years of age live in your household?	
Answer Options	**Response Count**
	449
answered question	**449**
skipped question	**31**

How long have you lived in your community?		
Answer Options	**Response Percent**	**Response Count**
Less than one year	4.7%	21
1-2 years	3.3%	15
3-4 years	4.2%	19
5-9 years	10.5%	47
10 or more years	77.3%	347
answered question		**449**
skipped question		**31**

What county do you live in?		
Answer Options	**Response Percent**	**Response Count**
Webster	12.0%	54
Adams	53.5%	240
Nuckolls	29.0%	130
Clay	5.6%	25
answered question		**449**
skipped question		**31**

Zip Code where you live:	
Answer Options	**Response Count**
	449
answered question	**449**
skipped question	**31**

Age:		
Answer Options	**Response Percent**	**Response Count**
under 18 years	0.0%	0
18-24 years	3.8%	17
25-39 years	21.4%	96
40-54 years	36.1%	162
55-64 years	23.4%	105
65-80 years	12.9%	58
over 80 years	2.4%	11
answered question		**449**
skipped question		**31**



Gender:

Answer Options	Response Percent	Response Count
Male	24.7%	111
Female	75.3%	338
answered question		449
skipped question		31

Marital Status

Answer Options	Response Percent	Response Count
Married	71.5%	321
Divorced	9.1%	41
Separated	1.1%	5
Widowed	7.6%	34
Never Married	7.6%	34
Member of an unmarried couple	3.1%	14
answered question		449
skipped question		31

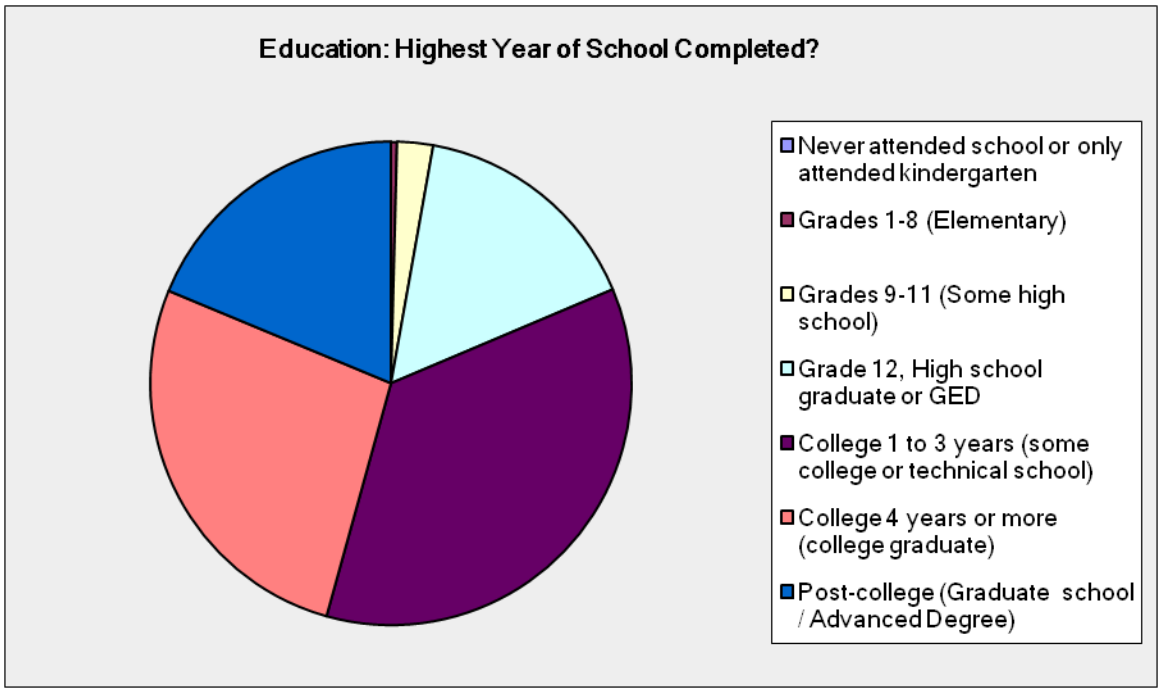
Which of the following best reflects your race?

Answer Options	Response Percent	Response Count
White	99.6%	447
Black or African American	0.4%	2
Asian	0.0%	0
American Indian or Alaska Native	0.0%	0
Native Hawaiian / Pacific Islander	0.0%	0
Other (please specify)		6
answered question		449
skipped question		31

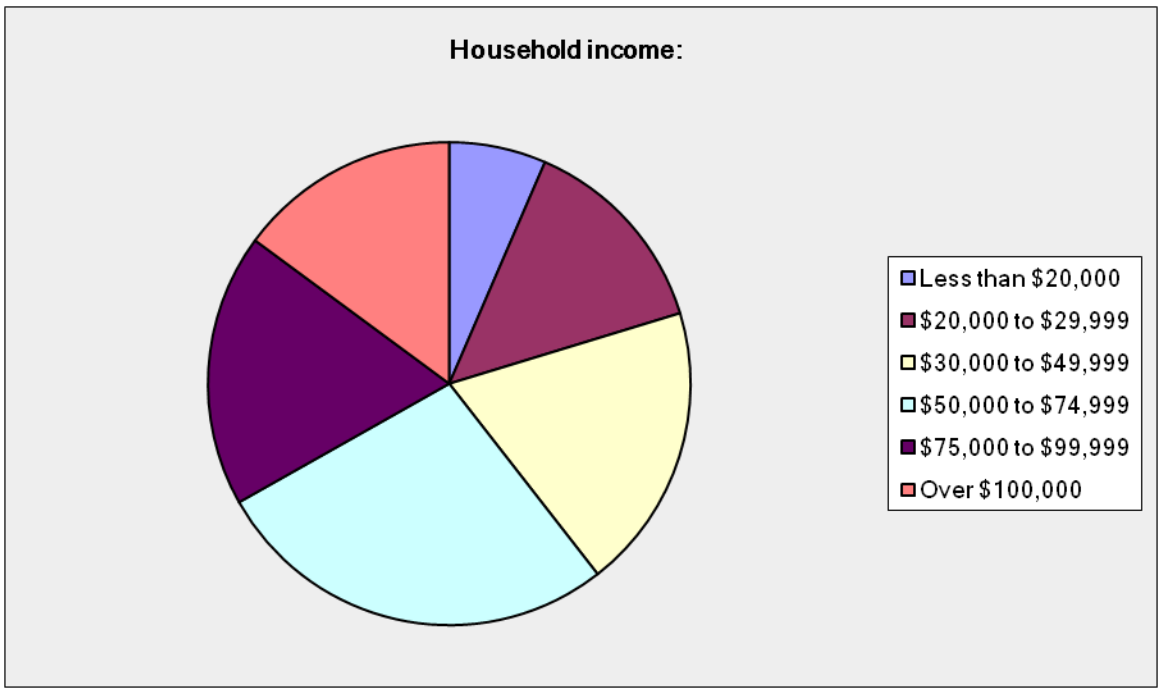
Other (please specify)
other
Mexican
granddaughter is white, black and American Indian
Mexicano
Mexicano
hispanic origin

Are you Hispanic or Latino?		
Answer Options	**Response Percent**	**Response Count**
Yes	3.3%	15
No	96.7%	434
answered question		**449**
skipped question		**31**

Education: Highest Year of School Completed?		
Answer Options	**Response Percent**	**Response Count**
Never attended school or only attended kindergarten	0.0%	0
Grades 1-8 (Elementary)	0.4%	2
Grades 9-11 (Some high school)	2.4%	11
Grade 12, High school graduate or GED	15.8%	71
College 1 to 3 years (some college or technical	35.6%	160
College 4 years or more (college graduate)	26.9%	121
Post-college (Graduate school / Advanced Degree)	18.7%	84
answered question		**449**
skipped question		**31**



Household income:		
Answer Options	**Response Percent**	**Response Count**
Less than $20,000	6.5%	29
$20,000 to $29,999	13.8%	62
$30,000 to $49,999	19.2%	86
$50,000 to $74,999	27.4%	123
$75,000 to $99,999	18.3%	82
Over $100,000	14.9%	67
	answered question	449
	skipped question	31



Health Status Assessment Indicator Summary Table with Nebraska Healthy People 2010 Objectives and National Healthy People 2020 Objectives

	Population	Data Type	Data Source	SHDH					NEBRASKA					UNITED STATES				Nebraska Healthy People 2010 Objectives	Healthy People 2020 Objectives	Internet Source
				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Population Characteristics - Socioeconomic																				
Percentage of persons living below the poverty level	All Persons	Survey (self-report)	ACS (Census)	08-10 combined	12.7%	5,489	Worsening	2000 vs. 08-10 combined	2010	11.8%	215,508	Worsening	2000 vs. 06-10 combined	2010	13.8%	-	Better	No Objective Set	No Objective Set	http://www.census.gov/cgi-bin/saipe/s
Percentage of persons living below the poverty level	0-17 years old	Population-based	ACS (Census)	2010	15.4%	1,662	Worsening	2000 vs. 2010	2010	15.5%	71,179	Worsening	2000 vs. 06-10 combined	2010	19.2%	-	Better	No Objective Set	No Objective Set	http://www.census.gov/cgi-bin/saipe/s
Unemployment rate	Eligible Working	Population-based	Dept. of Labor	May-12	3.3%		Stable (3.7)	May-11	2010	4.0%	41,010	Improving	Past Year	January 2011	8.3%	-	Better	No Objective Set	No Objective Set	http://doi.nebraska.gov/infolink/Counties/An
Cohort-four year high school graduation rate	High School Seniors	Population-based	Nebraska Dept. of Ed	10-11 School Year	85.8%	*	*	*	NA	85.8%	3,196*	NA	NA	NA	NA	NA	NA	Different Measure Used	No Objective Set	
General Health Status																				
Health-Related Quality of Life																				
General health is fair or poor	Adults 18+	Survey (self-report)	BRFSS	2010	14.0%	6,387	Stable	07-09 vs 2010	2010	12.0%	164,054	Stable	01-10	2010	14.7%	-	Better	No Objective	No Objective Set	http://public-dhhs.ne.go
Average (mean) number of days in past 30 when physical health was not good	Adults 18+	Survey (self-report)	BRFSS	2010	3.7	NA	Worsening (3.2)	07-08 vs 2010	2010	3.0	NA	Stable	01-10	2010	3.6	-	Better	No Objective Set	No Objective Set	http://public-dhhs.ne.gov/brfss/
Average (mean) number of days in past 30 when mental health was not good	Adults 18+	Survey (self-report)	BRFSS	2010	3.1	NA	Worsening (2.8)	07-08 vs 2010	2010	2.9	NA	Stable	01-10	2010	3.4	-	Better	No Objective Set	No Objective Set	http://public-dhhs.ne.gov/brfss/
Average (mean) number of days in past 30 when activities were limited due to poor physical and/or mental health	Adults 18+	Survey (self-report)	BRFSS	2010	4.4	NA	Worsening (3.8)	07-08 vs 2010	2010	1.8	NA	Stable	01-10	2010	2.3	-	Better	No Objective Set	No Objective Set	http://public-dhhs.ne.gov/brfss/
Healthcare Access and Utilization																				
No healthcare coverage	Adults 18-64	Survey (self-report)	BRFSS	2010	11.7%	3,177	Stable	07-09 vs 2010	2010	16.5%	184,873	Stable	01-10	2010	17.8%	-	Better	0%	0% or 100% who have coverage	http://public-dhhs.ne.gov/Brfss/Home.aspx
No personal healthcare provider	Adults 18+	Survey (self-report)	BRFSS	2007-2008	10.6%	3,735	Improving (16.3)	05 vs 07-08	2010	14.5%	198,369	Stable	01-10	2010	16.7%	-	Better	16.1%	16.1% who don't or 83.9% who do	.ne.gov/publichealth/Documents/AppendixA
Unable to see doctor due to cost during past 12 months	Adults 18+	Survey (self-report)	BRFSS	2009-2010	9.5%	3,347	Stable (9.5)	07-08 vs 09-10	2010	10.5%	143,548	Stable	03-10	2010	13.1%	-	Better	4.2%	No Objective Set	.ne.gov/publichealth/
Had routine checkup during past 12 months	Adults 18+	Survey (self-report)	BRFSS	2010	60.3%	13,988*	Stable	07-09 vs 2010	2010	56.8%	590,596*	Worsening	05-10	2010	67.1%	-	Worse	No Objective Set	No Objective Set	c-dhhs.ne.gov/Brfss/Ho
Chronic Disease and Associated Risk and Protective Factors																				
Heart Disease and Stroke																				

	Population	Data Type	Data Source	SHDH					NEBRASKA					UNITED STATES				Nebraska Healthy People 2010 Objectives	Healthy People 2020 Objectives	Internet Source
				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Deaths due to Heart Disease per 100,000 population (age-adjusted)	All Persons	Vital Records-Death	Population-based	2010	168.9	134	Improving (222.5)	00-04 vs 2010	2010	153.6	3,344	Improving	01-10	2009	180.1	154.0	Better	Different Objective	100.8 deaths per 100,000	http://dhhs.ne.gov/publichealth/Vital%20Statistics%20R
Deaths due to Stroke per 100,000 population (age-adjusted)	All Persons	Vital Records-Death	Population-based	2010	36.0	25	Improving (49.6)	00-04 vs 2010	2010	40.5	877	Improving	01-10	2009	38.9	40.3	Similar	47.4	33.8 deaths per 100,000	http://dhhs.ne.gov/publichealth/Vital%20Statistics%20R
Hospitalizations due to Heart Disease per 10,000 population (age-adjusted)	All Persons	Hospital Discharge Data	Population-based	2010	93.6	605	NA	NA	2010	869.9	17,670	NA	NA	NA	NA	NA	NA	Different Objective	Different Measure	e objectives
Hospitalizations due to Stroke per 10,000 population (age-adjusted)	All Persons	Hospital Discharge Data	Population-based	2010	26.5	166		NA	2010	206.5	4,218	NA	NA	NA	NA	NA	NA	No Objective Set	No objective Set	
Ever told they had a Heart Attack or MI, or have Angina or Coronary Heart Disease	Adults 18+	BRFSS	Survey (self-report)	2009-2010	5.0%	1,762	Worsening (4.3)	07-08 vs 09-10	2010	5.7%	77,926	Stable	03-10	2010	6.0%	-	Similar	No Objective Set	No Objective Set	.ne.gov/publichealth/Documents
Ever told they had a Stroke	Adults 18+	BRFSS	Survey (self-report)	2010	2.0%	705	Stable	07-09 vs 2010	2010	2.4%	32,811	Stable	03-10	2010	2.7%	-	Similar	No Objective Set	No Objective Set	.ne.gov/publichealth/Documents
Ever told they have High Blood Pressure	Adults 18+	BRFSS	Survey (self-report)	2009-2010	33.5%	11,803	Worsening (24.5)	07-08 vs 09-10	2009	27.1%	370,490	Worsening	01-10	2010	28.7%	-	Better	16%	26.9%	c-dhhs.ne.gov/Brfss/Ho
Had a Cholesterol Screening during past five years	Adults 18+	BRFSS	Survey (self-report)	2009-2010	74.6%	8,949	Worsening (71.5)	07-08 vs 09-10	2009	73.9%	356,818*	Improving	01-10	2009	77.0%	-	Worse	80%	82.1%	.ne.gov/publichealth/Documents
Ever told they have High Blood Cholesterol (among those who have ever had it checked)	Adults 18+	BRFSS	Survey (self-report)	2009-2010	41.0%	14,446	Worsening (35.2)	07-08 vs 09-10	2009	37.4%	400,248	Worsening	01-10	2009	37.5%	-	Similar	17%	13.5%	http://dhhs.ne.gov/publichealth/Documents/South-
Diabetes																				
Deaths due to Diabetes per 100,000 population (age-adjusted)	All Persons	Vital Records-Death	Population-based	2010	11.7	10	Improving (64.2)	00-04 vs 2010	2009	21.6	450	Stable	01-10	2009	20.9	22.0	Similar	25.0	Different Measure Used	http://dhhs.ne.gov/publichealth/Vital%20Sta
Hospitalizations due to Diabetes per 10,000 Population (age-adjusted)	All Persons	Hospital Discharge Data	Population-based	2010	9.5	52	NA	NA	2010	112.8	2,131	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Ever told they have Diabetes (excluding pregnancy)	Adults 18+	Survey (self-report)	BRFSS	2007-2008	7.1	2,502	Improving (9.4)	05 vs 07-08	2010	7.7%	105,268	Worsening	01-10	2010	8.7%	-	Better	2.5%	7.2%	.ne.gov/publichealth/Documents
Check their Blood Glucose at least once per day-- among those with diabetes	Adults 18+	Survey (self-report)	BRFSS	*	*	*	*	*	2010	65.6%	36,212*	Stable	01-10	2010	63.9%	-	Similar	65%	70.4%	
Had Clinical Foot Exam during past 12 months-- among those with diabetes	Adults 18+	Survey (self-report)	BRFSS	*	*	*	*	*	2010	76.3%	24,949*	Stable	01-10	2010	74.0%	-	Similar	80%	Different Data	
Had Dilated Eye Exam during past 12 months-- among those with diabetes	Adults 18+	Survey (self-report)	BRFSS	*	*	*	*	*	2010	69.0%	32,633*	Worsening	01-10	2010	69.8%	-	Similar	75%	Different Data	

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				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Had Influenza Vaccination during past 12 months-- among those with diabetes	Adults 18+	Survey (self-report)	BRFSS	*	*	*	*	*	2010	70.0%	31,580*	Stable	01-10	2010	62.1%	-	Better	No Objective Set	No Objective Set	.ne.gov/publichealth/Documents
Ever had Pneumonia Vaccination--among those with diabetes	Adults 18+	Survey (self-report)	BRFSS	*	*	*	*	*	2010	64.7%	37,160*	Improving	01-10	2010	58.4%	-	Better	No Objective Set	No Objective Ser	
Cancer																				
Deaths due to All Cancers Combined per 100,000 Population (age-adjusted)	All Persons	Population-based	Vital Records-Death	2010	147.5	101	Improving (178)	00-04 vs 2010	2010	167.4	3,437	Improving	01-10	2009	173.2	167.7	Similar		160.6 deaths per 100,000	.ne.gov/publichealth/Vital%20Statistics%20R
Deaths due to Lung Cancer per 100,000 Population (age-adjusted)	All Persons	Population-based	Vital Records-Death	2006-2010	31.2	*	*	*	2010	46.0	928	Improving	01-10	2009	48.5	45.0	Better		45.5 deaths per 100,000	
Deaths due to Colorectal Cancer per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records-Death	2006-2010	16.8	*	*	*	2010	17.3	358	Stable	01-10	2009	15.9	16.7	Similar		14.5 deaths per 100,000	
Deaths due to Female Breast Cancer per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records-Death	2006-2010	22.6	*	*	*	2010	19.3	225	Improving	01-10	2009	22.3	19.6	Similar		20.6 deaths per 100,000	
Deaths due to Cervical Cancer per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records-Death	2006-2010	0.0	*	*	*	2010	2.6	24	Stable	01-10	2009	2.3	1.3	Similar		2.2 deaths per 100,000	
Deaths due to Prostate Cancer per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records-Death	2006-2010	29.8	*	*	*	2010	20.0	167	Stable	01-10	2009	22.0	23.9	Similar		21.2 deaths per 100,000	
Incidence of All Cancers Combined per 100,000 population	All Persons	Population-based	Cancer Registry	2003-2007	477.3	*	*	*	2008	465.3	8,930	Improving	99-08	2008	462.9	-	Similar		No Objective Set	
Incidence of Lung Cancer per 100,000 population	All Persons	Population-based	Cancer Registry	2003-2007	66.2	*	*	*	2008	61.3	1,170	Improving	99-08	2008	65.6	-	Better		No objective set	
Incidence of Colorectal Cancer per 100,000 population	All Persons	Population-based	Cancer Registry	2003-2007	64.7	*	*	*	2008	51.2	1,001	Improving	99-08	2008	44.6	-	Worse		No Objective Set	
Incidence of Female Breast Cancer per 100,000 population	All Persons	Population-based	Cancer Registry	2003-2007	128.9	*	*	*	2008	129.3	1,306	Stable	99-08	2008	121.7	-	Worse		No Objective Set	
Incidence of Cervical Cancer per 100,000 population	All Persons	Population-based	Cancer Registry	2003-2007	9.9	*	*	*	2008	6.1	52	Stable	99-08	2008	7.8	-	Similar		No Objective Set	
Incidence of Prostate Cancer per 100,000 population	All Persons	Population-based	Cancer Registry	2003-2007	161.3	*	*	*	2008	141.1	1,248	Improving	99-08	2008	144.6	-	Similar		No Objective Set	

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Had recent Colorectal Cancer screening (FOBT in past year or sigmoidoscopy/colonoscopy in past 10 years)	Adults 50-75	Survey (self-report)	BRFSS	2009-2010	11.2%	*	*	*	2010	60.3%	185,215*	Improving	01-10	2010	63.5%	-	Worse		70.5%	.ne.gov/publichealth/Documents/South-Heartland-District-
Had recent Breast Cancer screening (mammogram in past 2 years)	Women 50-75	Survey (self-report)	BRFSS	2009-2010	67.9%	2,137*	Stable (67.5)	07-08 vs 09-10	2010	75.8%	57,607*	Stable	02-10	2010	79.4%	-	Worse		81.1%	.ne.gov/publichealth/Documents
Had recent Cervical Cancer screening (pap test in past 3 years)	Women 21-65	Survey (self-report)	BRFSS	2009-2010	70.2%	3,631*	Worsening (73.2)	07-08 vs 09-10	2010	87.0%	68,127*	Worsening	02-10	2010	87.0%	-	Similar		93.0%	.ne.gov/publichealth/Documents
Arthritis																				
Ever told they have Arthritis	Adults 18+	Survey (self-report)	BRFSS	2009	33.6%	11,839	Worsening (26.2)	07 vs 09	2010	25.9%	354,084	Stable	01-10	2009	26.0%	-	Similar	No Objective Set	No Objective Set	c-dhhs.ne.gov/Brfss/Ho
Currently have activity limitations due to Arthritis	Adults 18+	Survey (self-report)	BRFSS	2009	42.5%	14,974	Worsening (32.2)	07 vs 09	2010	11.2%	153,117	Stable	02-10	2009	11.9%	-	Similar	Different Measure Used	Different Measure Used	c-dhhs.ne.gov/Brfss/Qu
Asthma																				
Hospitalizations due to Asthma per 10,000 Population (age-adjusted)	All Persons	Hospital Discharge Data	Hospital Discharge Data						2010	70.6	1,311	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Ever told they have Asthma	Adults 18+	Survey (self-report)	BRFSS	2007-2008	11.7%	4,122	Improving (13.4)	05 vs 07-08	2010	12.2%	166,789	Stable	01-10	2010	13.8%	-	Better	No Objective Set	No Objective Set	http://dhhs.ne.gov/publichealth/Documents
Currently have Asthma	Adults 18+	Survey (self-report)	BRFSS	2007-2008	9.3%	3,277	Worsening (5.4)	05 vs 07-08	2010	7.8%	106,635	Stable	01-10	2010	9.1%	-	Better	No Objective Set	No Objective Set	http://dhhs.ne.gov/publichealth/Documents
Ever told they have Asthma	High school students	Survey (self-report)	YRBS	2012	19.5%	*	Stable (19%)	03,05,11	2010	19.2%	18,628	Stable	03-10	2009	22.0%	unavailable	Similar	No Objective Set	No Objective Set	
Currently have Asthma	High school students	Survey (self-report)	YRBS	Not Avail	Not Avail	*	Not Avail	N/A	2010	9.6%	9,314	NA	NA	2009	10.8%	unavailable	Similar	No Objective Set	No Objective Set	
Tobacco																				
Current Cigarette Smoking	Adults 18+	Survey (self-report)	BRFSS	2009-2010	13.4%	4,721	Improving (18.1)	07-08 vs 09-10	2010	17.2%	235,145	Improving	01-10	2010	17.3%	-	Similar	12%	12.0%	.ne.gov/publichealth/Documents
Current Smokeless Tobacco use	Adults 18+	Survey (self-report)	BRFSS	2010	6.2%	2,185	Improving (9.8)	07-08 vs 2010	2010	5.3%	72,457	Stable	01-10	2010	4.0%	-	Worse	Different Objective	0.3%	c-dhhs.ne.gov/Brfss/Ho
Lifetime Use of Smokeless Tobacco	6th Graders	Survey (self-report)	NRPFSS	2010	1.0%	*	Improving	03-07 vs 2010	2010	2.0%	*	*	*	*	*	*	*		No Objective Set	
Lifetime Use of Smokeless Tobacco	8th Graders	Survey (self-report)	NRPFSS	2010	12.0%	*	Worsening	03-07 vs 2010	2010	7.0%	*	*	*	2010	10.0%	*	*		No Objective Set	
Lifetime Use of Smokeless Tobacco	10th Graders	Survey (self-report)	NRPFSS	2010	17.0%	*	Stable	03-07 vs 2010	2010	17.0%	*	*	*	2010	17.0%	*	*		No Objective Set	

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Lifetime Use of Smokeless Tobacco	12th Graders	Survey (self-report)	NRPFSS	2010	29.0%	*	Improving	03-07 vs 2010	2010	29.0%	*	*	*	2010	18.0%	*	*		No Objective Set	
Smoked Cigarettes during past 30 days	High school students	Survey (self-report)	YRBS	2012	13.7%	*	Improving	2003-2011	2010	15.0%	14,553	Improving	03-10	2009	19.5%	unavailable	Better	15%	16.0%	
Used Smokeless Tobacco during past 30 days	High school students	Survey (self-report)	YRBS	2012	7.2%	*	Improving	2003-2011	2010	6.4%	6,209	Improving	03-10	2009	8.9%	unavailable	Similar	6%	6.9%	
Lifetime Use of Cigarettes	6th Graders	Survey (self-report)	NRPFSS	2010	1.0%	*	Improving	03-07 vs 2010	2010	4.0%	*	*	*	*	*	*	*		No Ojective Set	
Lifetime Use of Cigarettes	8th Graders	Survey (self-report)	NRPFSS	2010	12.0%	*	Improving	03-07 vs 2010	2010	15.0%	*	*	*	2010	20.0%	*	*		No Objective Set	
Lifetime Use of Cigarettes	10th Graders	Survey (self-report)	NRPFSS	2010	27.0%	*	Improving	03-07 vs 2010	2010	28.0%	*	*	*	2010	33.0%	*	*		No Objective Set	
Lifetime Use of Cigarettes	12th Graders	Survey (self-report)	NRPFSS	2010	41.0%	*	Improving	03-07 vs 2010	2010	43.0%	*	*	*	2010	42.0%	*	*		No Objective Set	
Overweight and Obesity																				
Obese (BMI ≥ 30.0)	Adults 18+	Survey (self-report)	BRFSS	2010	29.1%	10,782	Stable	07-09 vs 2010	2010	27.5%	375,958	Worsening	01-10	2010	27.5%	-	Similar	15%	30.6%	.ne.gov/publichealth/Documents
Overweight or Obese (BMI ≥ 25.0)	Adults 18+	Survey (self-report)	BRFSS	2010	64.2%	23,325	Stable (63.1)	07-08 vs 09-10	2010	64.9%	887,261	Worsening	01-10	2010	64.5%	-	Similar	No Objective Set	No objective set	.ne.gov/publichealth/Documents
Obesity Based on BMI for age (95th percentile or above)	Children Grades K-12	Survey (self-report)	Community Alliance for Healthy Children in Healthy	2008-2010	*	#VALUE!	Worsening	2003 vs. 2007	2007	15.8%	35,205	Worsening	2003 vs. 2007	2007	16.4%	-	Similar	5%	14.6%	
Overweight or Obese based on BMI for age (85th percentile or above)	Children Grades K-12	Survey (self-report)	Community Alliance for Healthy Children in Healthy	2008-2010	36.0%	#REF!	Worsening	2003 vs. 2007	2007	31.4%	81,903	Worsening	2003 vs. 2007	2007	31.6%	-	Similar	No Objective Set	No objectives set	
Nutrition																				
Consumption of Fruits and Vegetables 5+ times per day	Adults 18+	BRFSS	Survey (self-report)	2009-2010	22.9%	27,165*	Worsening (49.8)	07-08 vs 09-10	2010	20.9%	1,081,392*	Stable	01-09	2009	23.4%	-	Worse	No Objective Set	Different Measure	.ne.gov/publichealth/Documents
Consumption of Fruits and Vegetables 5+ times per day	High school students	YRBS	Survey (self-report)	Not Avail	Not Avail	*	*	*	2010	16.5%	81,013*	Stable	03-10	2009	22.3%	unavailable	Worse	No Objective Set	Different Measure	
Drank Soda 1+ times per day during past 7 days	High school students	YRBS	Survey (self-report)	2012	21.1%	*	*	*	2010	26.2%	25,420	NA	NA	2009	29.2%	unavailable	Similar	No Objective Set	No Objective Set	

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Drank any Sugar-Sweetened Beverages 1+ times per day during past 7 days	High school students	YRBS	Survey (self-report)	2012	66.1%	*	*	*	2010	65.9%	63,937	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Physical Activity and Sedentary Behavior																				
Do Not engage in Any Leisure-Time Physical Activity	Adults 18+	BRFSS	2010	2009-2010	27.3%	9,619	Improving (25.0)	07-08 vs 09-10	2010	24.7%	337,679	Stable	01-10	2010	23.9%	-	Similar	15%	numbers different	.ne.gov/publichealth/Documents
Engage in the Recommended amount of Physical Activity	Adults 18+	BRFSS	2009	2009-2010	45.9%	19,062*	Worsening (49.7)	07-08 vs 09-10	2009	51.1%	228,137*	Improving	01-09	2009	51.0%	-	Similar	Different Measure Used	different measure	.ne.gov/publichealth/Documents
Engage in regular Vigorous Physical Activity	Adults 18+	Survey (self-report)	BRFSS	2009-2010	26.3%	25,967*	Improving (25.4)	07-08 vs 09-10	2009	29.7%	167,345*	Improving	01-09	2009	29.4%	-	Similar	30%	Different Measure Used	.ne.gov/publichealth/Documents
Engage in the Recommended amount of Physical Activity	High school students	Survey (self-report)	YRBS	2011	54.0%	503		*	2010	53.7%	44,921*	Improving	2005 vs. 2010	2009	37.0%	unavailable	Better	Different Measure Used	Different Measure Used	
Engage in regular Strengthening Exercises	High school students	Survey (self-report)	YRBS	2011	58.0%	633		*	2010	57.7%	41,040*	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Watch 3+ hours of Television during average school day	High school students	Survey (self-report)	YRBS	2011	25.0%	579		2003-2011	2010	25.2%	24,449	Stable	03-10	2009	32.8%	unavailable	Better	No Objective Set	Different Measure Used	
Play Video Games/Computer not for school 3+ hours during average school day	High school students	Survey (self-report)	YRBS	2011	21.0%	548		*	2010	21.1%	20,471	NA	NA	2009	24.9%	unavailable	Better	No Objective Set	Different Measure Used	
Have 3+ hours of non-school Screen Time during average school day	High school students	Survey (self-report)	YRBS	2011	50.0%	*			2010	50.1%	48,608	NA	NA	NA	NA	unavailable	NA	No Objective Set	Different Measure Used	
Communicable Disease																				
Influenza and Pneumonia																				
Deaths due to Influenza per 100,000 population (AAR)	All Persons	Vital Records-Death	Population-based	*	*	*	*	*	2010	0.0	1	Cyclical	01-10	2009	0.9	0.4	Similar	No Objective Set	No ojective Set	
Deaths due to Pneumonia per 100,000 population (AAR)	All Persons	Population-based	Vital Records-Death	*	*	*	*	*	2010	11.8	264	Improving	01-10	2009	15.6	11.2	Better	No Objective Set	No Objective Set	
Hospitalizations due to Influenza per 10,000 population (age-adjusted)	All Persons	Population-based	Hospital Discharge Data	2010	*	*	NA	NA	2010	1.8	34	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Hospitalizations due to Pneumonia per 10,000 population (age-adjusted)	All Persons	Population-based	Hospital Discharge Data	2010	44.0	278	NA	NA	2010	357.1	7,200	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Had Influenza vaccination during past 12 months	Adults 18+	Survey (self-report)	BRFSS	2010	50.6%	17,406*	Stable	07-09 vs 2010	2010	48.6%	702,700*	Improving	01-10	2010	42.6%	-	Better	No Objective Set	adults 18-65: goal-80%	c-dhhs.ne.gov/Brfss/Home.aspx
Had Influenza vaccination during past 12 months	Adults 65+	Survey (self-report)	BRFSS	2010	76.8%	1,875*	Stable	07-09 vs 2010	2010	71.1%	71,290*	Stable	01-10	2010	67.4%	-	Better	90%	90.0%	http://public-dhhs.ne.go
Ever had Pneumonia vaccination	Adults 65+	Survey (self-report)	BRFSS	2010	72.8%	2,198*	Stable	07 vs 2010	2010	70.9%	71,783*	Improving	01-10	2010	68.8%	-	Better	90%	90.0%	c-dhhs.ne.gov/Brfss/Ho
Sexually Transmitted Diseases (STD's)																				

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Incidence of all STD's per 100,000 population	All Persons	Population-based	NDHHS	2010	242.3	107.0	Stable	08-11	2010	384.6	7,025	Stable	01-10	NA	NA	NA	NA	No Objective Set	No Objective Set	NEDSS
Incidence of Gonorrhea per 100,000 population	All Persons	Population-based	NDHHS	2010	15.1	7.0	Stable (6 ave.)	08-11	2010	65.0	1,187	Stable	01-10	2010	100.8	-	Better	17.0	Different Measure Used	http://dhhs.ne.gov/publichealth/Pages/
Incidence of Chlamydia per 100,000 population	All Persons	Population-based	NDHHS	2010	177.4	82.0	Stable (86 ave.)	08-11	2010	280.1	5,115	Stable	01-10	2010	426.0	-	Better	Different Measure Used	Different Measure Used	http://dhhs.ne.gov/publichealth/Pages/
Incidence of Primary and Secondary Syphilis per 100,000 population	All Persons	Population-based	NDHHS	2010	4.3	2.0	Stable (1 ave.)	08-11	2010	0.7	12	Stable	01-10	2010	4.5	-	Better	0.2	Different Measure Used	http://dhhs.ne.gov/publichealth/Pages/
Incidence of Genital Herpes per 100,000 population	All Persons	Population-based	NDHHS	2010	32.4	15.0	Stable (19 ave.)	08-11	2010	36.2	661	Stable	01-10	NA	NA	NA	NA	No Objective Set	No Objective Set	http://dhhs.ne.gov/publicheal
HIV/AIDS																				
Incidence of HIV per 100,000 population	All Persons	Population-based	NDHHS	2010	conf.	*	Stable	08-11	2010	6.0	110	Stable	01-10	2010	17.4	-	Lower	Different Measure Used	Different Measure Used	
Ever been tested for HIV (other than blood donation)	Adults 18-64	Survey (self-report)	BRFSS	2010	24.8%	20,418*	Stable	07-09 vs 2010	2010	26.8%	754,055*	Worsening	01-10	2010	36.7%	-	Lower	No Objective Set	Different Measure Used	http://publi c-dhhs.ne.gov/Brfss/Ho
Other Reportable Diseases																				
Incidence of Acute Hepatitis A cases per 100,000 population	All Persons	NEDSS	Population-based	2011	0.46	1	Stable (.5)	08-11	2009	1.5	27	Stable	01-09	2009	0.7	-	Similar	Different Measure	0.3%	
Incidence of Acute Hepatitis B cases per 100,000 population	All Persons	Population-based	NEDSS	2011	0.46	1	Improving (2)	08-11	2009	1.2	22	Improving	01-09	2009	1.1	-	Similar	Different Measure Used	1.5%	
Prevalence of Chronic Hepatitis B (carrier) cases per 100,000 population	All Persons	Population-based	NEDSS	2011	?	?		08-11	2009	13.5	243	Stable	03-09	NA	NA	NA	NA	No Objective Set	No Objective Set	
Prevalence of Hepatitis C (acute and chronic) cases per 100,000 population	All Persons	Population-based	NEDSS	2011	6.90	15	Improving (21)	08-11	2009	67.3	1,209	Improving	03-09	NA	NA	NA	NA	No Objective Set	0.2%	
Incidence of Pertussis cases per 100,000 population	All Persons	Population-based	NEDSS	2011	9.66	21	Cyclical (28)	08-11	2009	7.8	140	Cyclical	01-09	2009	5.5	-	Similar	Different Measure Used	Different Measure Used	
Incidence of Salmonellosis cases per 100,000 population	All Persons	Population-based	NEDSS	2011	2.30	5	Stable 5.5	08-11	2009	19.2	344	Worsening	01-09	2009	16.2	-	Worse	No Objective Set	No Objective Set	
Incidence of Campylobacter cases per 100,000 population	All Persons	Population-based	NEDSS	2011	4.60	10	Stable (11.5)	08-11	2009	21.0	377	Stable	01-09	2009	13.0	-	Worse	No Objective Set	No Objective Set	
Incidence of Mumps cases per 100,000 population	All Persons	Population-based	NEDSS	2011	1.38	3	Cyclical (1.5)	08-11	2009	0.4	8	Cyclical	01-09	2009	0.7	-	Similar	No Objective Set	Different Measure	
Incidence of West Nile Virus cases per 100,000 population	All Persons	Population-based	NEDSS	2011	0.0	0	Improving (WN Fever) (3)	08-11	2009	2.9	52	Improving	01-09	2009	0.1	-	Worse	No Objective Set	No Objective Set	
Injury																				

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				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Deaths due to All Unintentional Injury per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records	2010	*	21	Stable	07-09 vs 2010	2010	35.5	696	Stable	01-10	2009	37.3	35.7	Similar	19.4	36	
Deaths due to Falls per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records	2010	*	7	Worsening	07-09 vs 2010	2010	9.1	199	Stable	01-10	2009	7.5	8.9	Worse	Different Measure Used	7	
Deaths due to Motor Vehicle Crashes per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records	2010	*	10	Stable	07-09 vs 2010	2010	11.2	209	Improving	01-10	2009	11.7	13.9	Worse	12.0	12.4	
Fatal Motor Vehicle Crash rate per 100 million vehicle miles traveled	All Persons	Population-based	Nebraska Dept. of Roads	2011	0.84	4 fatal crashes	Improving	NA	2010	0.84	164 fatal crashes	Improving	01-11	NA	NA	NA	NA	Different Measure Used	1.2	
Deaths resulting from homicide per 100,000 population (age-adjusted)	All Persons	Population-based	Vital Records	*	*	*	*	*	2010	3.3	58	Stable	01-10	2009	5.5	2.7	Better	2.0	5.5	
Hospitalizations due to All Unintentional Injury per 10,000 population (age-adjusted)	All Persons	Population-based	E code	2010	195.7	1,143	NA	NA	2010	40.5	8,065	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Hospitalizations due to Falls per 10,000 population (age-adjusted)	All Persons	Population-based	E code	2010	38.1	252	NA	NA	2010	24.3	5,033	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Hospitalizations due to Motor Vehicle Crashes per 10,000 population (age-adjusted)	All Persons	Population-based	E code	2010	6.5	30	NA	NA	2010	5.5	1,005	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Hospitalizations due to Assault per 10,000 population (age-adjusted)	All Persons	Population-based	E code	2010	0.8	3	NA	NA	2010	1.8	318	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Injured due to a Fall during past 3 months	Adults 45+	Survey (self-report)	BRFSS	*	*	*	*	*	2010	4.8%	34,492	Worsening	03-10	2010	5.2%	-	Similar	No Objective Set	Different Measure USed	
Had a fall in the past three months	Adults 45+	Survey (self-report)	BRFSS	2010	14.7%	*	Improving (22.8)	08 vs 2010											Different Measure Used	
Always wear a Seatbelt when driving or riding in car	Adults 18+	Survey (self-report)	BRFSS	2010	64.2%	12,614*	Stable	08 vs 2010	2010	71.8%	385,528*	Improving	02-10	2010	85.2%	-	Worse	92%	92.4%	http://publi c-dhhs.ne.go
Rarely or never wear a Seatbelt while riding in a car driven by someone else	High school students	Survey (self-report)	YRBS	2011	16.0%	*	*	*	2010	15.7%	15,232	Improving	03-10	2009	9.7%	-	Worse	No Objective Set	No Objective Set	
Texted or Emailed while driving during past 30 days	High school students	Survey (self-report)	YRBS	2011	45.0%	*	Not Avail	N/A	2010	45.0%	43,659	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Talked on a Cell Phone while driving during past 30 days	High school students	Survey (self-report)	YRBS	2011	49.0%	*	Not Avail	N/A	2010	49.4%	47,928	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Maternal and Child Health																				
Infant Mortality Rate per 1,000 live births	All Live Births	Population-based	Vital Records	2010	2.4	4	Improving (5.9)	00-04 vs 2010	2010	5.2	136	Improving	01-10	2009	6.4	5.4	Similar	4.5	6	http://dhhs .ne.gov/pu blichealth/

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				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Births that were Low Birth Weight (weight <2,500 grams)	All Live Births	Population-based	Vital Records	2010	4.6%	33	Improving (5.6%)	02-06 vs 2010	2010	7.1%	1,843	Stable	01-10	2009	8.2%	7.1%	Better	5.0%	7.8%	http://dhhs.ne.gov/publichealth/Vital%20Sta
Births that were Premature (Born <37 Weeks Gestation)	All Live Births	Population-based	Vital Records	2010	9.2%	47	Worsening (5.5%)	02-06 vs 2010	2010	9.8%	2,551	Stable	01-10	2009	12.2%	9.7%	Better	No Objective Set	11.4%	.ne.gov/publichealth/Vital%20Sta
Births by Induction of labor	Live Births Women <35	Population-based	Vital Records	*	*	*	*	*	2010	29.4%	6,739	Stable	01-10	2009	23.2%	28.9%	Worse	No Objective Set	NO Objective Set	
Births by Caesarean section	Live Births Women 35+	Population-based	Vital Records	*	*	*	*	*	2010	44.2%	1,306	Worsening	01-10	2009	43.9%	44.9%	Similar	No Objective Set	No Objective Set	
Infants born to women receiving Prenatal Care beginning in the first trimester	All Live Births	Population-based (self-report)	Vital Records	2010	*	449	Improving	07-09 vs 2010	2010	73.2%	18,979	Stable	05-10	NA	NA	NA	NA	90%	77.9%	.ne.gov/publichealth/Vital%20Sta
Live births that were Unintended at the time of conception	All Live Births	Survey (self-report)	PRAMS	2005-2010	46.4%	*	*	*	2009	39.9%	10,745	Stable	00-09	NA	NA	NA	NA	No Objective Set	No Objective Set	
Maternal Depression among new mothers (SHDHD numbers are those with no depressive symptoms)	All Live Births	Survey (self-report)	PRAMS	2005-2008	90.5%	*	*	*	2009	12.5%	3,366	Stable	04-09	NA	NA	NA	NA	No Objective Set	No Objective Set	
Infants still being Breastfed at 6 months of age	All Live Births	Survey (self-report)	PRAMS	*	*	*	*	*	2009	43.8%	11,796	Improving	00-09	NA	NA	NA	NA	50%	60.6%	
Teen Birth Rate per 1,000 population	Females 15-17	Population-based	Vital Records	2010	7.60%	42	Improving (9.9%)	06-10 vs 2010	2010	14.4	544	Improving	01-10	2009	20.1	17.4	Better	No Objective Set	No Objective Set	http://dhhs.ne.gov/publichealth/Vital%20Sta
Incidence of Chlamydia per 1,000 population	Females 15-19	Population-based	NDHHS	2010	20.4	1,281	Worsening	01-10	2010	20.4	1,281	Worsening	01-10	2009	27.9	21.5	Better	No Objective Set	Developing the objective	
Incidence of Gonorrhea per 1,000 population	Females 15-19	Population-based	NDHHS	2010	3.0	190	Stable	01-10	2010	3.0	190	Stable	01-10	2009	6.4	4.0	Better	No Objective Set	Different Measure	of new cas
Deaths due to Suicide per 100,000 population	Youth 15-19	Population-based	Vital Records	2010	2.85	4	Improving (10.7)	02-06 vs 2010	2010	6.2	8	Improving	01-10	2008	7.5	12.9	Worse	No Objective Set	10.2	.ne.gov/publichealth/Vital%20Sta
Environmental Health																				
Population served by Community Water Systems with optimal levels of Fluoride	All Persons	Population-based	NDHHS	2010					2010	68.2%	471,348	Stable	03-10	2008	72.4%	69.9%	Worse	No Objective Set	91.0%	
Have Blood Lead levels exceeding 10 ug/dL-- among those tested for blood lead	Children 1-6	Population-based	NDHHS	2010					2010	2.9%	374 positive tests	NA	NA	NA	NA	NA	NA	0%	0.0%	
Housing units built prior to 1980	All Persons	Survey (self-report)	ACS (Census)	2010	81.4%	16,886 units	NA	NA	06-10 combined	68.6%	540,427 units	NA	NA	06-10 combined	59.0%	-	Worse	No Objective Set	No Objective Set	http://factfinder2.census.gov/faces/tableservi
All Radon tests performed in Nebraska that had a Radon level over 4.0 (pCi/L)	All Tested Units	Population-based	NDHHS	All tests up to 2009					All tests up to 2009	56.8%	39,739 positive tests	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Substance Abuse																				
Alcohol																				

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Estimated number of Alcohol-related deaths	All Persons	ARDI CDC	Population-based	01-05					01-05	-	average 388 deaths/year	NA	NA	NA	NA	NA	NA	No Objective Set	71,681 deaths	w.healthypeople.gov/2020/topics objectives2
Trauma center admissions in which the patient had a BAC ≥ 0.08 at the time of admission (from the 7 lead hospitals)	All Persons	Nebraska Trauma Registry	Population-based	2010	*	17	*	*	2010	7.9%	547	Stable	06-10	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of substance abuse treatment admissions in which Alcohol was listed as the primary drug of choice	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)	68.1%	366 persons admitted	Stable	07-11 (300)	FY2011 (July 2010 - June 2011)	68.1%	10,879 persons admitted	Stable	07-11	NA	NA	NA	NA	No Objective Set	Different Measure Used	
Percentage of substance abuse treatment admissions in which Alcohol was listed as one of the top three drugs of choice	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)	83.9%	461 persons admitted	Stable	07-11 (429)	FY2011 (July 2010 - June 2011)	83.9%	13,414 persons admitted	Stable	07-11	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of fatal motor vehicle crashes in which Alcohol was involved	All Persons	Nebraska Dept. of Roads	Population-based	2011	0.0%	0 fatal crashes w/ alcohol	Improving	09-10 vs 2011	2011	32.3%	53 fatal crashes w/ alcohol	Stable	01-11	NA	NA	NA	NA	Different Measure Used	No Objective Set	http://www.transportation.nebraska.gov/no
Alcohol-related fatal crash rate per 100 million vehicle miles traveled	All Persons	Nebraska Dept. of Roads	Population-based	2011	0.00	0 fatal crashes w/ alcohol	Improving	09-10 vs 2011	2011	0.27	53 fatal crashes w/ alcohol	Improving	01-11	NA	NA	NA	NA	Different Measure Used	0.38%	http://www.transportation.nebraska.gov/nohs/pdf/com
Percentage of all arrests resulting from DUI	All Persons	Nebraska Crime Commission	Population-based	2010	21.1%	266 arrests	Worsening	07-09 vs 2010	2010	15.0%	12,614 arrests	Worsening	01-10	2009	10.5%	15.4%	Worse	No Objective Set	No Objective Set	w.ncc.ne.gov/statistics/data_search/arrest/ar
Percentage of all arrests resulting from non-DUI Alcohol-related offenses	All Persons	Nebraska Crime Commission	Population-based	2010	15.6%	196 arrests	Improving	07-09 vs 2010	2010	12.7%	10,636 arrests	Stable	01-10	2009	8.5%	13.2%	Worse	No Objective Set	No Objective Set	w.ncc.ne.gov/statistics/data_search/arrest/ar
Drank Alcohol during past 30 days	Adults 18+	BRFSS	Survey (self-report)	2010	52.1%	18,357	Stable	07-09 vs 2010	2010	59.0%	806,601	Stable	01-10	2010	54.6%	-	Worse	No Objective Set	No Objective Set	http://public-dhhs.ne.gov/Brfss/Ho
Binge Drank during past 30 days	Adults 18+	BRFSS	Survey (self-report)	2009-2010	14.9%	5,250	Improving (18.1)	07-08 vs 09-10	2010	19.4%	265,221	Stable	01-10	2010	15.1%	-	Worse	6%	24.3%	http://dhhs.ne.gov/publichealth/Documents
Alcohol-Impaired Driving during past 30 Days	Adults 18+	BRFSS	Survey (self-report)	2010	2.3%	810	Stable	2008 vs 2010	2010	2.9%	39,646	Improving	02-10	2010	1.8%	-	Worse	1%	No Objective Set	c-dhhs.ne.gov/Brfss/Ho
Ever drank Alcohol	High school students	YRBS	Survey (self-report)	*	*	*	*	*	2010	60.6%	58,795	Improving	03-10	2010	72.5%	unavailable	Better	Different Measure Used	No Objective Set	
Lifetime Use of Alcohol	6th Graders	Survey (self-report)	NRPFSS	2010	11.0%	*	Improving	03-07 vs 2010	2010	14.0%	*	*	*	*	*	*	*		No Objective Set	Nebraska Risk and Protective

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Lifetime Use of Alcohol	8th Graders	Survey (self-report)	NRPFSS	2010	27.0%	*	Improving	03-07 vs 2010	2010	28.0%	*	*	*	2010	36.0%	*	*		No Objective Set	Nebraska Risk and Protective Factor
Lifetime Use of Alcohol	10th Graders	Survey (self-report)	NRPFSS	2010	43.0%	*	Improving	03-07 vs 2010	2010	49.0%	*	*	*	2010	58.0%	*	*		No Objective Set	Nebraska Risk and Protective Factor
Lifetimes Use of Alcohol	12th Graders	Survey (self-report)	NRPFSS	2010	71.0%	*	Improving	03-07 vs 2010	2010	68.0%	*	*	*	2010	71.0%	*	*		70.5%	Nebraska Risk and Protective Factor
Drank Alcohol during past 30 days	High school students	YRBS	Survey (self-report)	2012	24.2%	193	*	*	2010	26.6%	25,808	Improving	03-10	2010	41.8%	unavailable	Better	No Objective Set	No Objective Set	
Alcohol Use in the past 30 days	6th Graders	Survey (self-report)	NRPFSS	2010	1.0%	*	Improving	03-07 vs 2010	2010	3.0%	*	*	*	*	*	*	*		No Objective Set	Nebraska Risk and Protective Factor
Alcohol Use in the past 30 days	8th Graders	Survey (self-report)	NRPFSS	2010	9.0%	*	Improving	03-07 vs 2010	2010	8.0%	*	*	*	2010	14.0%	*	*		No Objective Set	Nebraska Risk and Protective Factor
Alcohol Use in the past 30 days	10th Graders	Survey (self-report)	NRPFSS	2010	23.0%	*	Improving	03-07 vs 2010	2010	21.0%	*	*	*	2010	29.0%	*	*		No Objective Set	Nebraska Risk and Protective
Alcohol Use in the past 30 days	12th Grades	Survey (self-report)	NRPFSS	2010	36.0%	*	Improving	03-07 vs 2010	2010	35.0%	*	*	*	2010	41.0%	*	*		No Objective Set	Nebraska Risk and Protective Factor
Binge Drank during past 30 days	High school students	YRBS	Survey (self-report)	2012	14.6%	116	Improving	2010	2010	16.4%	15,911	Improving	03-10	2010	24.2%	unavailable	Better	25%	Different Measure Used	
Alcohol-Impaired Driving during past 30 Days	High school students	YRBS	Survey (self-report)	2012	6.1%	49	Improving	2010	2010	7.2%	6,986	Improving	03-10	2010	9.7%	unavailable	Similar	10%	No Objective Set	
Driven a vehicle after had been drinking alcohol in the past 30 days	8th Graders	Survey (self-report)	NRPFSS	2010	2.3%			*	2010	0.08%	*	*	*						No Objective Set	Nebraska Risk and Protective Factor
Driven a vehicle after had been drinking alcohol in the past 30 days	10th Graders	Survey (self-report)	NRPFSS	2010	3.7%		*	*	2010	3.7%	*	*	*						No Objective Set	Nebraska Risk and Protective Factor
Driven a vehicle after had been drinking alcohol in the past 30 days	12th Graders	Survey (self-report)	NRPFSS	2010	17.0%	*	*	*	2010	12.8%	*	*	*						No Objective Set	Nebraska Risk and Protective
Rode with a Drinking Driver during past 30 days	High school students	YRBS	Survey (self-report)	2012	22.7%	181	Improving	2010	2010	23.9%	23,188	Improving		2010	28.3%	unavailable	Better	30%	25.5%	
Rode in a vehicle driven by someone who had been drinking alcohol in the past 30 days	6th Graders	Survey (self-report)	NRPFSS	2010	23.0%	*	*	*	2010	19.6%	*	*	*						25.5%	Nebraska Risk and Protective Factor Student
Rode in a vehicle driven by someone who had been drinking alcohol in the past 30 days	8th Graders	Survey (self-report)	NRPFSS	2010	29.3%	*	*	*	2010	19.1%	*	*	*						25.5%	Nebraska Risk and Protective Factor

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Rode in a vehicle driven by someone who had been drinking alcohol in the past 30 days	10th Graders	Survey (self-report)	NRPFSS	2010	28.4%	*	*	*	2010	20.1%	*	*	*						25.5%	Nebraska Risk and Protective Factor
Rode in a vehicle driven by someone who had been drinking alcohol in the past 30 days	12th Graders	Survey (self-report)	NRPFSS	2010	33.1%	*	*	*	2010	24.8%	*	*	*						25.5%	Nebraska Risk and Protective Factor Student
Substance Abuse - Drug Use																				
Drug-induced deaths per 100,000 population (age-adjusted)	All Persons	Vital Records	Population-based	*	*	*	*	*	2010	5.7	98	Worsening	01-10	2009	12.6	5.5	Better	No Objective Set	11.3 per 100,000	
Trauma center admissions in which the patient had an illicit drug (exclud. opiates) in their system at the time of admission (from the 7 lead hospitals)	All Persons	Nebraska Trauma Registry	Population-based	2010	*	0	*	*	2010	6.8%	477	Stable	07-10	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of substance abuse treatment admissions in which marijuana was listed as the primary drug of choice	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)		82 persons admitted	Stable	07-11 (72)	FY2011 (July 2010 - June 2011)	10.8%	1,719 persons admitted	Stable	07-11	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of substance abuse treatment admissions in which marijuana was listed as one of the top three drugs of choice	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)		220 persons admitted	Stable	07-11 (230)	FY2011 (July 2010 - June 2011)	35.0%	5,589 persons admitted	Stable	07-11	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of substance abuse treatment admissions in which cocaine was listed as one of the top three drugs of choice	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)		33 persons admitted	Improving	07-11 (41)	FY2011 (July 2010 - June 2011)	9.2%	1,478 persons admitted	Improving	07-11	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of substance abuse treatment admissions in which meth was listed as one of the top three drugs of choice	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)		94 persons admitted	Improving	07-11 (145)	FY2011 (July 2010 - June 2011)	16.8%	2,680 persons admitted	Improving	07-11	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of substance abuse treatment admissions in which non-heroin opioids was listed as one of the top three drugs of choice	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)		20 persons admitted	Stable	07-11 (19)	FY2011 (July 2010 - June 2011)	6.8%	1,081 persons admitted	Worsening	07-11	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of all arrests resulting from drug-related offenses	All Persons	Nebraska Crime Commission	Population-based	2010	7.5%	95 arrests	Stable	07-09 vs 2010	2010	12.2%	10,202 arrests	Stable	01-10	2009	12.2%	11.4%	Similar	No Objective Set	No Objective Set	http://www.ncc.ne.gov/statistics/data_search
Any illicit drug use in past month	Persons 12 and older	NSDUH	Survey (self-report)	*	*	*	*	*	08-09 combined	6.7%	101,521	Stable	02-09	08/09 combined	8.4%	-	Better	No Objective Set	7.1%	http://www.healthypeople.gov/2020/topics

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Marijuana use in past month	Persons 12 and older	NSDUH	Survey (self-report)	*	*	*	*	*	08-09 combined	5.4%	81,823	Stable	02-09	08/09 combined	6.4%	-	Similar	No Objective Set	6.0%	
Non-marijuana illicit drug use in past month	Persons 12 and older	NSDUH	Survey (self-report)	*	*	*	*	*	08-09 combined	2.8%	42,427	Stable	02-09	08/09 combined	3.5%	-	Similar	No Objective Set	Different Measure Used	
Non-medical use of pain relievers in past year	Persons 12 and older	NSDUH	Survey (self-report)					*	08-09 combined	3.6%	54,549	Stable	03-09	08/09 combined	4.8%	-	Better	No Objective Set	Not Applicable	http://www.healthypeople.gov/2020/topics
Ever used marijuana	High school students	YRBS	Survey (self-report)	2012	23.0%	182	Improving	1991-2011	2010	25.0%	24,255	Improving	03-10	2010	36.8%	unavailable	Better	No Objective Set	No objective set	pdf
Lifetime Use of marijuana	6th Graders	Survey (self-report)	NRPFSS	2010	0.0%	*	Improving	03-07 vs 2010	2010	1.0%	*	*	*	*	*	*	*		No Objective Set	Nebraska Risk and Protective
Lifetime Use of marijuana	8th Graders	Survey (self-report)	NRPFSS	2010	2.0%	*	Improving	03-07 vs 2010	2010	7.0%	*	*	*	2010	17.0%	*	*		No Objective Set	Nebraska Risk and Protective
Lifetime Use of marijuana	10th Graders	Survey (self-report)	NRPFSS	2010	16.0%	*	Worsening	03-07 vs 2010	2010	18.0%	*	*	*	2010	33.0%	*	*		No Objective Set	Nebraska Risk and Protective
Lifetime Use of marijuana	12th Graders	Survey (self-report)	NRPFSS	2010	24.0%	*	Worsening	03-07 vs 2010	2010	29.0%	*	*	*	2010	44.0%	*	*		No Objective Set	Nebraska Risk and Protective
Used marijuana during past 30 days	High school students	YRBS	Survey (self-report)	2011	13.0%	*	Improving	1991-2011	2010	12.7%	12,322	Improving	03-10	2010	20.8%	unavailable	Better	5%	6.0%	
Past 30 day marijuana use	10th Graders	Survey (self-report)	NRPFSS	2010	8.0%	*	Worsening	03-07 vs 2010	2010	8.0%	*	*	*	2010	17.0%	*	*		No Objective Set	Nebraska Risk and Protective
Past 30 day marijuana use	12th Graders	Survey (self-report)	NRPFSS	2010	11.0%	*	Worsening	03-07 vs 2010	2010	12.0%	*	*	*	2010	21.0%	*	*		No Objective Set	Nebraska Risk and Protective
Ever used cocaine/crack	High school students	YRBS	Survey (self-report)	2011	4.0%	*	Stable	1991-2011	2010	4.2%	4,075	Improving	03-10	2010	6.4%	unavailable	Better	No Objective Set	No Objective Set	
Lifetime Use of cocaine/crack	10th Graders	Survey (self-report)	NRPFSS	2010	2.0%	*	Stable	03-07 vs 2010	2010	2.0%	*	*	*	2010	4.0%	*	*		No Objective Set	Nebraska Risk and Protective
Lifetime Use of cocaine/crack	12th Graders	Survey (self-report)	NRPFSS	2010	4.0%	*	Stable	03-07 vs 2010	2010	3.0%	*	*	*	2010	6.0%	*	*		No Objective Set	Nebraska Risk and Protective
Ever used inhalants	High school students	YRBS	Survey (self-report)	2011	10.0%	*	Stable	2003-2011	2010	9.7%	9,411	Stable	03-10	2010	11.7%	unavailable	Similar	No Objective Set	Different Measure Used	
Lifetime Use of inhalants	10th Graders	Survey (self-report)	NRPFSS	2010	6.0%	*	Improving	03-07 vs 2010	2010	6.0%	*	*	*	2010	12.0%	*	*		No Objective Set	Nebraska Risk and Protective
Lifetime Use of inhalants	12th Graders	Survey (self-report)	NRPFSS	2010	5.0%	*	Worsening	03-07 vs 2010	2010	5.0%	*	*	*	2010	9.0%	*	*		No Objective Set	Nebraska Risk and Protective

	Population	Data Type	Data Source	SHDH					NEBRASKA					UNITED STATES				Nebraska Healthy People 2010 Objectives	Healthy People 2020 Objectives	Internet Source
				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Ever used heroin	High school students	YRBS	Survey (self-report)	2011	2.0%	*	Stable	2003-2011	2010	1.9%	1,843	Stable	03-10	2010	2.5%	unavailable	Similar	No Objective Set	No Objective Set	
Ever used methamphetamines	High school students	YRBS	Survey (self-report)	2011	3.0%	*	Improving	2003-2011	2010	2.7%	2,620	Improving	03-10	2010	4.1%	unavailable	Better	No Objective Set	No Objective Set	
Lifetime Use of methamphetamines	10th Graders	Survey (self-report)	NRPFSS	2010	1.0%	*	Stable	03-07 vs 2010	2010	1.0%	*	*	*	2010	3.0%	*	*		No Objective Set	Nebraska Risk and Protective Factor
Lifetime Use of methamphetamines	12th Graders	Survey (self-report)	NRPFSS	2010	2.0%	*	Stable	03-07 vs 2010	2010	2.0%	*	*	*	2010	2.0%	*	*		No Objective Set	Nebraska Risk and Protective Factor
Ever used ecstasy	High school students	YRBS	Survey (self-report)	2011	5.0%	*	Stable	2003-2011	2010	4.5%	4,366	Stable	03-10	2010	6.7%	unavailable	Better	No Objective Set	No Objective Set	Nebraska Risk and Protective Factor
Ever used steroids	High school students	YRBS	Survey (self-report)	2011	3.0%	*	Stable	1991-2011	2010	2.8%	2,717	Stable	03-10	2010	3.3%	unavailable	Similar	No Objective Set	No Objective set	pdf
Lifetime Use of steroids	10th Graders	Survey (self-report)	NRPFSS	2010	1.0%	*	Stable	03-07 vs 2010	2010	1.0%	*	*	*	2010	2.0%				Different Measure Used	Nebraska Risk and Protective Factor
Lifetime Use of Steroids	12th Graders	Survey (self-report)	NRPFSS	2010	1.0%	*	Stable	03-07 vs 2010	2010	1.0%	*	*	*	2010	2.0%				Different Measure Used	Nebraska Risk and Protective
Ever used prescription drugs for non-medical reasons	High school students	YRBS	Survey (self-report)	2011	12.0%	*	Not Avail	N/A	2010	12.4%	12,031	NA	NA	NA	NA	NA	NA	No Objective Set	Different Measure Used	
Lifetime Use of prescription drugs	10th Graders	Survey (self-report)	NRPFSS	2010	6.0%	*	Improving	03-07 vs 2010	2010	7.0%	*	*	*						No Objective Set	Nebraska Risk and Protective Factor
Lifetime Use of prescription drugs	12th Graders	Survey (self-report)	NRPFSS	2010	11.0%	*	Worsening	03-07 vs 2010	2010	11.0%	*	*	*						No Objective Set	Nebraska Risk and Protective Factor
Mental Health and Suicide																				
Never or rarely get the social and emotional support they need	Adults 18+	BRFSS	Survey (self-report)	2010	5.2%	1,832	Improving (7.5)	08 vs 2010	2010	7.3%	99,800	Stable	05-10	2010	7.3%	-	Similar	No Objective Set	No Objective Set	http://public-dhhs.ne.gov/Brfss/Ho
Dissatisfied with their life	Adults 18+	BRFSS	Survey (self-report)	2010	2.7%	951	Improving (4.6)	08 vs 2010	2010	4.0%	54,685	Stable	05-10	2010	5.1%	-	Better	No Objective Set	No Objective Set	http://public-dhhs.ne.go
Ever told they have an anxiety disorder	Adults 18+	BRFSS	Survey (self-report)	2007-2008	6.9%	2,431	*	*	2010	10.7%	146,282	Stable	06-10	NA	NA	NA	NA	No Objective Set	No Objective Set	.ne.gov/publichealth/Documents
Ever told they have a depressive disorder	Adults 18+	BRFSS	Survey (self-report)	2007-2008	14.0%	4,933	*	*	2010	15.4%	210,536	Stable	06-10	NA	NA	NA	NA	No Objective Set	No Objective Set	.ne.gov/publichealth/Documents
Had Significant Depressive Symptoms in Past 14 Days	Adults 18+	BRFSS	Survey (self-report)	*	*	*	*	*	2010	6.6%	90,230	Stable	06-10	NA	NA	NA	NA	No Objective Set	No Objective Set	

	Population	Data Type	Data Source	SHDH					NEBRASKA					UNITED STATES				Nebraska Healthy People 2010 Objectives	Healthy People 2020 Objectives	Internet Source
				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Never told that they had a depressive disorder among those with significant depressive symptoms in past 14 days	Adults 18+	BRFSS	Survey (self-report)	*	*	*	*	*	2010	43.0%	38,799	Stable	06-10	NA	NA	NA	NA	No Objective Set	No Objective set	
Depressed during the past 12 months	High school students	YRBS	Survey (self-report)	2011	21.0%	*	25%	2003 & 2005	2010	21.0%	20,374	Improving	03-10	2009	26.1%	unavailable	Better	No Objective Set	No Objective Set	
Considered suicide during the past 12 months	High school students	YRBS	Survey (self-report)	2011	14.0%	*	18%, 17%	2003 & 2005	2010	14.2%	13,777	Improving	03-10	2009	13.8%	unavailable	Similar	No Objective Set	No Objective Set	
Attempted suicide during the past 12 months	High school students	YRBS	Survey (self-report)	2011	8.0%	*	9%	1991-2005	2010	7.7%	7,471	Stable	03-10	2009	6.3%	unavailable	Similar	Different Measure Used	No Objective Set	
Deaths due to suicide per 100,000 population (age-adjusted)	All Persons	Vital Records	Population-based	2010	2.9	4	Improving (11.2)	02-06 vs 2010	2010	10.1	186	Stable	01-10	2009	11.8	9.4	Better	8.2	10.2	
Hospitalizations due to self-inflicted injuries per 10,000 population (age-adjusted)	All Persons	E code	Population-based	2010					2010	4.7	823	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Number of emergency protective custody admissions	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)	107 admiss-ions				FY2011 (July 2010 - June 2011)	2,611 admiss-ions	2,438 people	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Number of mental health treatment admissions	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)	1060 admiss-ions				FY2011 (July 2010 - June 2011)	54,983 admiss-ions	21,829 people	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Percentage of mental health treatment admissions that were for attempted suicide	All Persons	Magellan Treatment Database	Records of Persons Served	FY2011 (July 2010 - June 2011)	5.8%	62	Stable	07-11	FY2011 (July 2010 - June 2011)	2.9%	1,594	NA	NA	NA	NA	NA	NA	No Objective Set	No Objective Set	
Oral Health																				
EPSDT-eligible children covered by Medicaid who received preventive dental services during the past year	Medicaid Enrollees 1-9	NDHHS	Population-based	2010					2010	42.7%	NA	Improving	03-10	NA	NA	NA	NA	Different Measure Used	29.4%	
Visited Dentist for Any Reason during past 12 months	Adults 18+	BRFSS	Survey (self-report)	2010	67.4%	11,486*	Stable (70.1%)	2008 vs 2010	2010	69.5%	416,972*	Worsening	01-10	2010	69.7%	-	Similar	No Objective Set	Different measure used	http://www.dhhs.ne.gov/publichealth/Documents
Visited Dentist for Any Reason during past 12 months	High school students	YRBS	Survey (self-report)	2011	75.0%	*	Not Avail	N/A	2010	75.1%	24,158*	NA	NA	NA	NA	NA	NA	No Objective Set	Different measure used	
Had Teeth Cleaned during past 12 months - among those with one or more permanent teeth	Adults 18+	BRFSS	Survey (self-report)	2010	64.4%	12,543*	Stable	2008 vs 2010	2010	68.2%	261,716*	Worsening	01-10	2010	68.2%	-	Similar	No Objective Set	No Objective Set	http://publhc-dhhs.ne.gov/Brfss/Home.aspx
Had Any Permanent Teeth Extracted due to tooth decay or gum disease	Adults 18+	BRFSS	Survey (self-report)	2010	46.3%	18,921*	Stable	2008 vs 2010	2010	39.8%	544,114	Stable	01-10	2010	43.6%	-	Better	Different Measure Used	Different Measure Used	http://publhc-dhhs.ne.gov/Brfss/Ho

	Population	Data Type	Data Source	SHDH					NEBRASKA					UNITED STATES				Nebraska Healthy People 2010 Objectives	Healthy People 2020 Objectives	Internet Source
				Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Past Rate & Trend **	Trend Period	Data Year	Percent or Rate	Estimated or Actual Number of Persons at Risk	Trend	Trend Period	Data Year	Percent or Rate	Data for Comparable US Year (if different)	Nebraska vs. Nation			
Lost All Permanent Teeth due to tooth decay or gum disease	Adults 65+	BRFSS	Survey (self-report)	2010	7.0%	566	Stable (6%)	2008 vs 2010	2010	15.2%	37,495	Improving	01-10	2010	16.9%	-	Better	Different Measure Used	21.6%	c-dhhs.ne.gov/Brfss/Ho

** Estimated number who did not engage in the healthy behavior (i.e., the "at risk" population)*
*** Actual number of cases of reportable diseases*

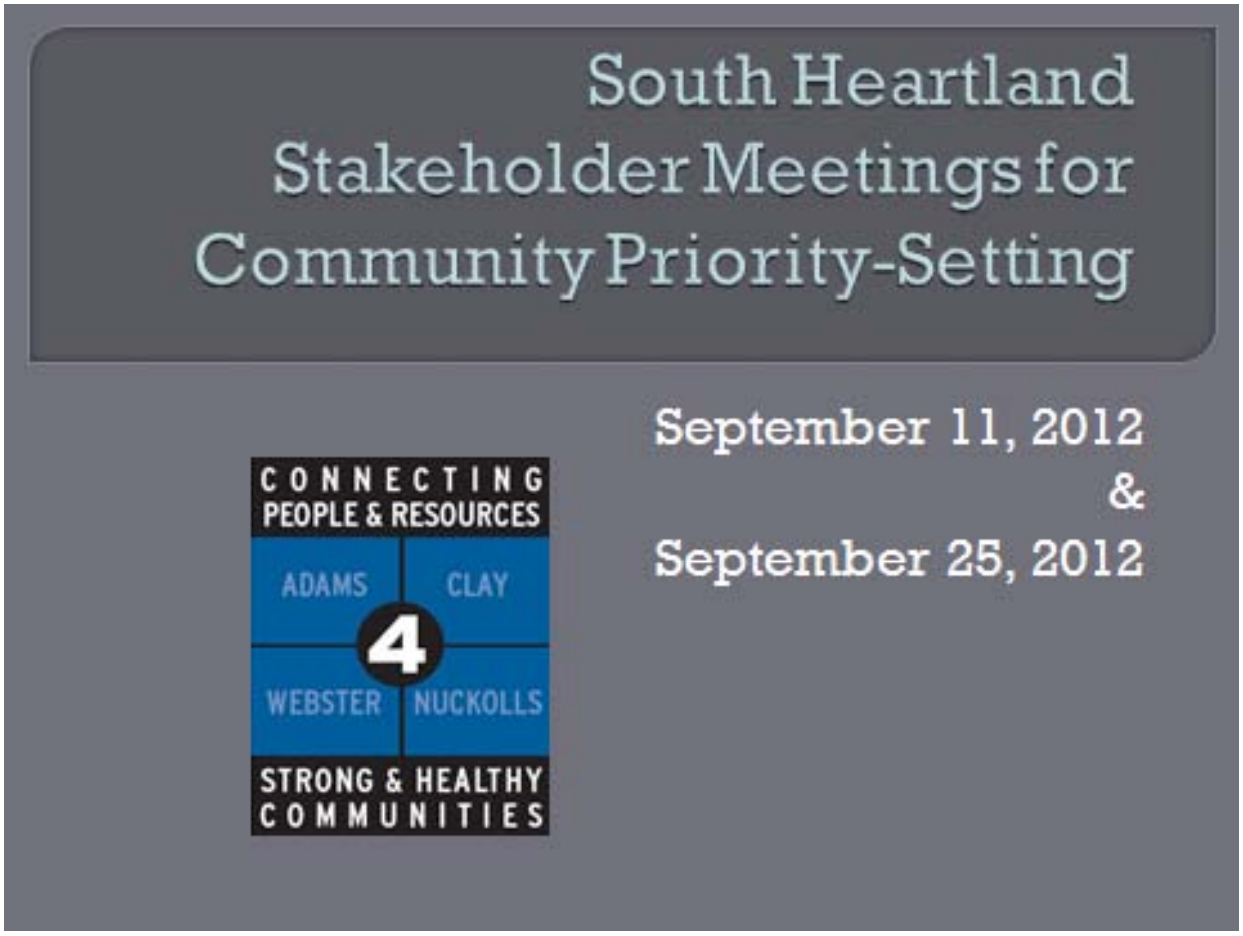
purple - confidence interval did not change the trend
orange - confidence interval did change the trend
yellow- combined numbers and do not know how to combine confidence intervals

Health Status Assessment Population Characteristics Summary Table, 2012 CHNA

People QuickFacts	Adams County	Clay County	Nuckolls County	Webster County	SHDHD	Nebraska
Population, 2011 estimate	NA	NA	NA	NA		1,842,641
Population, 2010	31,364	6,542	4,500	3,812	46218	1,826,341
Population, percent change, 2000 to 2010	0.7%	-7.1%	-11.0%	-6.1%		6.7%
Population, 2000	31,151	7,039	5,057	4,061	47308	1,711,263
Persons under 5 years, percent, 2010	6.7%	6.2%	5.2%	6.1%		7.2%
Persons under 18 years, percent, 2010	24.0%	25.2%	21.2%	22.6%		25.1%
Persons 65 years and over, percent, 2010	15.4%	17.9%	26.1%	23.7%		13.5%
Female persons, percent, 2010	50.3%	49.9%	50.5%	52.2%		50.4%
White persons, percent, 2010 (a)	91.9%	93.0%	97.4%	96.0%		86.1%
Black persons, percent, 2010 (a)	0.8%	0.3%	0.1%	0.5%		4.5%
American Indian and Alaska Native persons, percent, 2010 (a)	0.4%	0.5%	0.2%	0.2%		1.0%
Asian persons, percent, 2010 (a)	1.4%	0.2%	0.2%	0.3%		1.8%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	Z	0.0%	0.0%	0.3%		0.1%
Persons reporting two or more races, percent, 2010	1.3%	1.5%	1.4%	1.5%		2.2%
Persons of Hispanic or Latino origin, percent, 2010 (b)	8.1%	7.7%	2.2%	3.5%		9.2%
White persons not Hispanic, percent, 2010	88.5%	90.8%	96.3%	94.1%		82.1%
Living in same house 1 year & over, 2006-2010	81.2%	89.3%	91.0%	85.9%		82.6%
Foreign born persons, percent, 2006-2010	4.9%	2.7%	0.7%	1.2%		5.9%
Language other than English spoken at home, pct age 5+, 2006-2010	7.1%	7.5%	1.2%	2.1%		9.7%
High school graduates, percent of persons age 25+, 2006-2010	89.1%	89.7%	90.5%	86.9%		90.0%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	21.5%	16.4%	12.4%	12.7%		27.7%
Veterans, 2006-2010	2,580	502	482	383		149,594
Mean travel time to work (minutes), workers age 16+, 2006-2010	14.4	18.4	14.7	15.4		17.9
Housing units, 2010	13,350	3,001	2,465	1,912		796,793
Homeownership rate, 2006-2010	70.4%	77.2%	79.7%	75.7%		68.6%
Housing units in multi-unit structures, percent, 2006-2010	17.9%	9.3%	5.7%	5.8%		19.3%
Median value of owner-occupied housing units, 2006-2010	$95,000	$73,700	$54,200	$58,700		$123,900
Households, 2006-2010	12,403	2,621	2,060	1,478		711,771
Persons per household, 2006-2010	2.42	2.45	2.22	2.24		2.46
Per capita money income in past 12 months (2010 dollars) 2006-2010	$23,084	$21,147	$20,299	$18,906		$25,229
Median household income 2006-2010	$44,443	$42,909	$31,761	$38,015		$49,342
Persons below poverty level, percent, 2006-2010	13.5%	8.3%	18.0%	15.0%		11.8%
Business QuickFacts	Adams County	Clay County	Nuckolls County	Webster County		Nebraska
Private nonfarm establishments, 2009	963	193	186	83		51,633
Private nonfarm employment, 2009	14,205	1,174	1,138	632		779,508
Private nonfarm employment, percent change 2000-2009	-0.1%	-8.2%	-10.0%	6.4%		3.8%
Nonemployer establishments, 2009	1,947	504	336	284		117,596
Total number of firms, 2007	2,853	876	487	523	1886	159,665

Black-owned firms, percent, 2007	F	F	F	F		1.8%
American Indian- and Alaska Native-owned firms, percent, 2007	S	F	F	F		0.4%
Asian-owned firms, percent, 2007	F	F	F	F		1.4%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	F	F	F		0.0%
Hispanic-owned firms, percent, 2007	S	F	F	F		1.9%
Women-owned firms, percent, 2007	22.5%	24.1%	S	S		25.7%
Manufacturers shipments, 2007 ($1000)	D	0	0	0		40,157,999
Merchant wholesaler sales, 2007 ($1000)	499,735	155,623	147,022	58,861		24,019,868
Retail sales, 2007 ($1000)	360,802	60,659	53,345	23,738		26,486,612
Retail sales per capita, 2007	$10,976	$9,604	$11,844	$6,642		$14,965
Accommodation and food services sales, 2007 ($1000)	43,747	1,388	2,118	D		2,685,580
Building permits, 2010	176	4	2	4		5,401
Federal spending, 2009	230,494	67,341	50,227	45,312		16,791,188
Geography QuickFacts	Adams County	Clay County	Nuckolls County	Webster County		Nebraska
Land area in square miles, 2010	563.27	572.29	575.16	574.91	2285.63	76,824.17
Persons per square mile, 2010	55.7	11.4	7.8	6.6	20.22	23.8
FIPS Code	1	35	129	181		31
Metropolitan or Micropolitan Statistical Area	gs, NE Micro Area	Hastings	None	None		

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.
FN: Footnote on this item for this area in place of data
NA: Not available
D: Suppressed to avoid disclosure of confidential information
X: Not applicable
S: Suppressed; does not meet publication standards
Z: Value greater than zero but less than half unit of measure shown
F: Fewer than 100 firms
Source: US Census Bureau State & County QuickFacts



Mobilizing for Action Through Planning and Partnerships (MAPP)

A Community Needs Assessment and Health Priority-Setting Process
that will lead us to a new Community Health Improvement Plan

SOUTH
HEARTLAND
DISTRICT
HEALTH DEPARTMENT

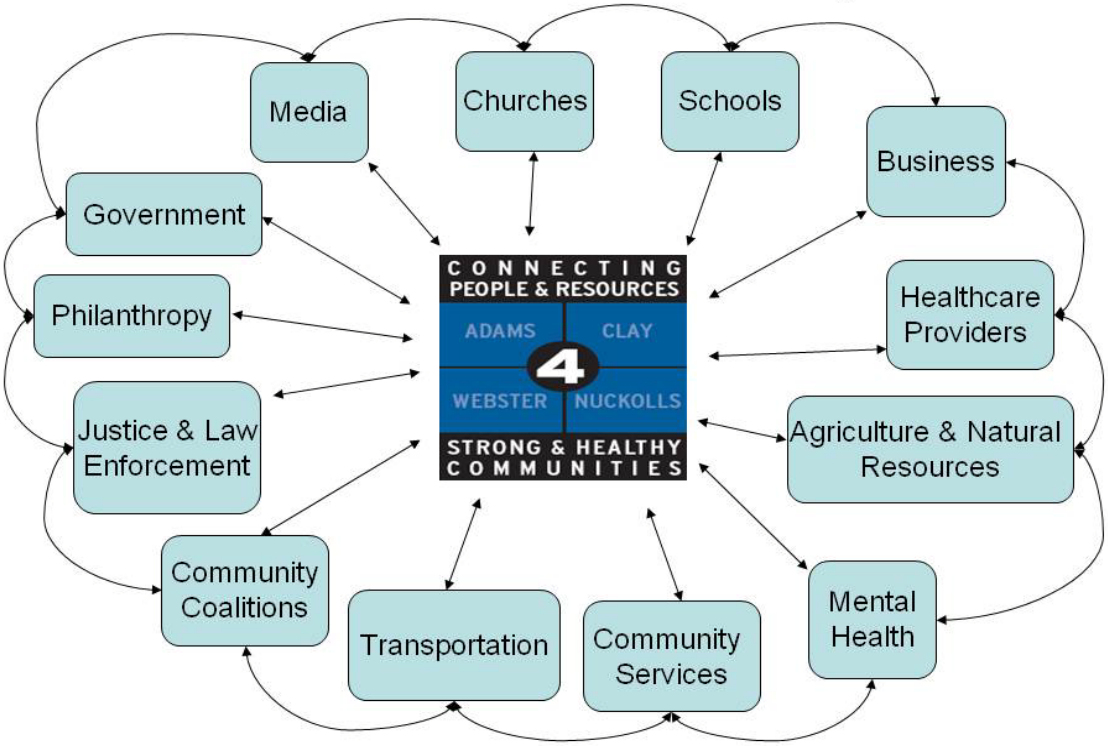
South Heartland MAPP Core Planning Committee:

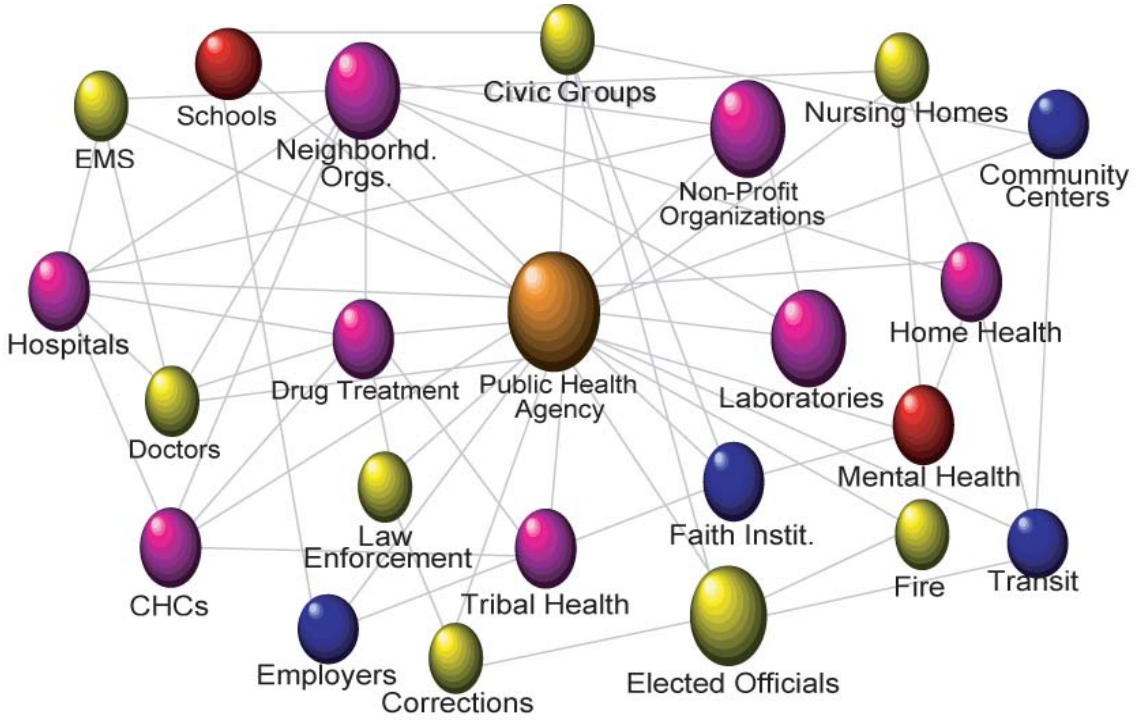
- Peggy Meyer – South Heartland District Health Department, Board of Health
- Michele Bever, Jessica Warner – South Heartland District Health Department
- Becky Sullivan - Mary Lanning Healthcare
- Candy Peters, Marianna Harris - Webster County Community Hospital
- Karen Tinkham, Michell Harris, Kori Field - Brodstone Memorial Hospital
- Janis Johnson - Clay County Health Department

Facilitation: Lori Vidlak, Bluestem Interactive, Inc.

Mobilizing for Action through Planning and Partnerships (MAPP)

The Local Public Health System





	Nebraska	Adams	Clay	Nuckolls	Webster	Measure	Wt
Health Outcomes		**29**	**11**	**62**	**44**		
Mortality		20	27	30	30		
Premature death	6,193	5,717	6,333			Premature death (years of potential life lost before age 75 per 100,000 pop)	50%
Morbidity		47	8	65	44		
Poor or fair health	12%	14%	11%	13%	12%	Poor or fair health (percent of adults reporting fair or poor health)	10%
Poor physical health days	2.9	2.9	2.6	2.9	2.9	Poor physical health days (average number in past 30 days)	10%
Poor mental health days	2.6	2.7	2.5	2.6	2.7	Poor mental health days (average number in past 30 days)	10%
Low birthweight	7.0%	6.2%		8.5%		Low birthweight (percent of live births with weight < 2500 grams)	20%
Health Factors		**35**	**50**	**27**	**44**		
Health Behaviors		27	52	16	38		
Adult smoking	19%	18%	14%	14%	15%	Adult smoking (percent of adults that smoke)	10%
Adult obesity	29%	30%	35%	30%	30%	Adult obesity (percent of adults that report a BMI >= 30)	8%
Physical inactivity	25%	24%	33%	30%	34%	Physical inactivity (percent of adults that report no leisure time physical activity)	3%
Excessive drinking	19%	17%	12%	18%	16%	Excessive drinking (percent of adults who report heavy or bringe drinking)	3%
Motor vehicle crash death rate	16	15	49			Motor vehicle crash deaths per 100,000 population	3%
Sexually transmitted infections	305	123	64	0	29	Sexually transmitted infections (chlamydia rate per 100,000 population)	3%
Teen birth rate	36	38	20	30		Teen birth rate (per 1,000 females ages 15-19)	3%
Clinical Care		20	45	13	38		
Uninsured	13%	14%	15%	14%	15%	Uninsured (percent of population < age 65 without health insurance)	5%
Primary care physicians	713:1	737:1	3,135:1	442:1	694:1	Ratio of population to primary care physicians	5%
Preventable hospital stays	66	69	61	86	94	Preventable hospital stays (rate per 1,000 Medicare enrollees)	5%
Diabetic screening	84%	88%	84%	87%	93%	Diabetic screening (percent of diabetics that receive HbA1c screening)	5%
Mammography screening	66%	68%	66%	70%		Mammography screening	5%
Social & Economic Factors		61	36	64	43		
High school graduation	86%	84%	94%	85%	93%	High school graduation	5%
Some college	69%	63%	60%	54%	52%	Some college (Percent of adults aged 25-44 years with some post-secondary education)	5%
Unemployment	4.7%	4.7%	4.6%	4.2%	4.3%	Unemployment rate (percent of population age 16+ unemployed)	10%

	Nebraska	Adams	Clay	Nuckolls	Webster	Measure	Wt
Children in poverty	17%	18%	16%	21%	17%	Children in poverty (percent of children under age 18 in poverty)	10%
Inadequate social support	17%	18%	16%	20%	18%	Inadequate social support (percent of adults without social/emotional support)	3%
Children in single-parent households	26%	20%	18%	32%	16%	Percent of children that live in single-parent household	3%
Violent crime rate	307	166		37	75	Violent crime rate per 100,000 population	5%
Physical Environment		16	54	3	76		
Air pollution-particulate matter days	0	0	1	1	1	Air pollution-particulate matter days (average number of unhealthy air quality days)	2%
Air pollution-ozone days	0	0	0	0	0	Air pollution-ozone days (average number of unhealthy air quality due to ozone)	2%
Access to recreational facilities	12	15	0	46	0	Access to recreational facilities	2%
Limited access to healthy foods	7%	1%	16%	14%	38%	Limited access to health foods (percent of population who lives in poverty and more than 1	2%
Fast food restaurants	48%	58%	17%	0%	25%	Fast food restaurants (percent of all restaurants that are fast food)	2%

Source: County Health Rankings & Roadmaps: A Healthier Nation, County by County

A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

	Source	Year(s)
Health Outcomes		
Mortality		
Premature death	Vital Statistics, National Center for Health Statistics (NCHS)	2006-2008
Morbidity		
Poor or fair health	Behavioral Risk Factor Surveillance System (BRFSS)	2004-2010
Poor physical health days	BRFSS	2004-2010
Poor mental health days	BRFSS	2004-2010
Low birthweight	Vital Statistics, NCHS	2002-2008
Health Factors		
Health Behaviors		
Adult smoking	BRFSS	2004-2010
Adult obesity	National Center for Chronic Disease Prevention and Health Promotion,	2009
Physical inactivity	National Center for Chronic Disease Prevention and Health Promotion,	2009
Excessive drinking	BRFSS	2004-2010
Motor vehicle crash death rate	Vital Statistics, NCHS	2002-2008
Sexually transmitted infections	CDC, National Center for Hepatitis, HIV, STD, and TB Prevention	2009
Teen birth rate	Vital Statistics, NCHS	2002-2008
Clinical Care		
Uninsured	Census/American Community Survey (ACS)—Small Area Health Insurance	2009
Primary care physicians	Health Resources and Services Administration, Area Resource File	2009
Preventable hospital stays	Medicare claims/Dartmouth Atlas	2009
Diabetic screening	Medicare claims/Dartmouth Atlas	2009
Mammography screening	Medicare claims/Dartmouth Atlas	2009
Social & Economic Factors		
High school graduation	State sources and the National Center for Education Statistics	Varies by state, 2008-2009 or 2009-
Some college	ACS	2006-2010
Unemployment	Local Area Unemployment Statistics, Bureau of Labor Statistics	2010

	Source	Year(s)
Children in poverty	Census/CPS—Small Area Income and Poverty Estimates (SAIPE)	2010
Inadequate social support	BRFSS	2004-2010
Children in single-parent households	ACS	2006-2010
Violent crime rate	Uniform Crime Reporting, Federal Bureau of Investigation –State data	2007-2009
Physical Environment		
Air pollution-particulate matter days	CDC-Environmental Protection Agency (EPA) Collaboration Data not available	2007
Air pollution-ozone days	CDC-Environmental Protection Agency (EPA) Collaboration Data not available	2007
Access to recreational facilities	Census County Business Patterns	2009
Limited access to healthy foods	United States Department of Agriculture, Food Environment Atlas	2006
Fast food restaurants	Census County Business Patterns	2009

Source: County Health Rankings & Roadmaps: A Healthier Nation, County by County

A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

South Heartland District Health Department Summary

Summary of Significant Differences Compared to Nebraska

- In 2007-2008, rates for the adult population were significantly better for two indicators in the South Heartland District Health Department area. A smaller proportion of adults said they did not have a personal doctor or health care provider, compared to Nebraska. More adults aged 50 and older reported having a blood stool test in the past two years.
- Rates for two indicators were significantly worse in the South Heartland District, compared to the state. A greater proportion of adults reported symptoms indicating they experienced serious psychological distress (SPD) in the past 30 days. Fewer adults aged 50 and older ever had a colonoscopy or sigmoidoscopy.

Summary of Significant Differences over Time

- Improvements were noted in the South Heartland District for two indicators. The proportion of adults who participated in the recommended level of moderate and/or vigorous physical activity increased significantly from the 2005 baseline.
- Prevalence of current cigarette smoking decreased significantly from the 2005 rate.

Health Care Access

Among respondents aged 18 to 64 years in the South Heartland, 15.9 percent reported having no health insurance at the time of the survey.

In 2007-2008, 10.6 percent of adults stated they did not have a personal doctor or health care provider—a significantly lower rate than the state average of 15.7 percent. Men in the South Heartland (12.8 percent) were also significantly less likely than men statewide (20.1 percent) to report not having a personal physician.

At some time in the past year, 9.5 percent of South Heartland adults needed to see a doctor but could not due to the potential cost of care.

In the current study, 60.5 percent of adults in this area reported visiting a doctor for a routine checkup in the past year. Men (54.5 percent) were significantly less likely than women (66.6 percent) in this area to have had a checkup in the last 12 months.

General Emergency Preparedness

In the South Heartland District, 10.5 percent of adults indicated their household was not prepared for a major disaster. Eight out of ten adults (78.2 percent) stated that they did not have a written disaster evacuation plan.

More than one-half of BRFSS respondents in this area (56.0 percent) did not have a three-day supply of water on hand. Although most households in this county had a three-day supply of non-perishable food, respondents from 13.0 percent of households said they did not. Similarly, 6.9 percent of respondents indicated they did not have a three-day supply of prescription drugs on hand for all household members who required them.

In this area, 14.5 percent of respondents did not have a working battery-powered radio, while 2.7 percent of households did not have a working battery-powered flashlight at the time of the survey.

The great majority of BRFSS respondents in the South Heartland said they would leave their homes if public authorities announced a mandatory evacuation due to a large-scale disaster or emergency, but 6.3 percent stated they would not do so.

Three-fourths of the respondents in this district (73.3 percent) indicated they would use a cell phone as their primary means of communication with family and friends in an emergency situation.

More than one-half (53.3 percent) said they would use a radio as their means of getting information from public officials in the event of a disaster.

Health-Related Quality of Life

Among South Heartland adults, 85.0 percent considered their general health "good", "very good", or "excellent. Women in this district (83.0 percent) were significantly less likely than Nebraska women overall (88.3 percent) to rate their health this positively.

Adults averaged 3.2 days in the past month when their physical health was "not good", while they reported an average of 2.8 days when their mental health was "not good".

Among adults who reported days when physical or mental health was "not good", these problems prevented them from participating in their usual activities an average of 3.8 days in the past month.

Disability

In 2007-2008, 18.6 percent of adults in this area stated that they have experienced limitation in one or more activities due to physical, mental, or emotional problems.

A health problem that requires them to use special equipment such as a cane, wheelchair, a special bed, or a special telephone was reported by 6.1 percent of adults in this area.

Mental Health

Compared to Nebraska adults overall (2.4 percent), a significantly larger proportion of South Heartland adults (7.0 percent) reported symptoms indicating that they experienced serious psychological distress (SPD) in the past 30 days.

Current depression (based on a Severity of Depression score of 10 or more) was reported by 5.2 percent of adults in this district.

A larger proportion of adults (14.0 percent) said they had ever been diagnosed with a depressive disorder, while 6.9 percent stated they had received a diagnosis of an anxiety disorder at sometime in their life.

Cardiovascular Disease

In the South Heartland area, 4.3 percent of adults said they ever had a heart attack. Men (6.7 percent) were significantly more likely than women in the area (2.3 percent) to report ever having a heart attack.

The proportion of BRFSS respondents who were ever told they had angina or coronary heart disease was 4.4 percent in this area.

Fewer South Heartland respondents (1.9 percent) said they had ever been told by a health professional that they had a stroke.

The proportion of adults who had ever been told by a doctor or other health professional that they have high blood pressure was 25.4 percent in 2007.

Three-fourths of South Heartland adults (75.0 percent) ever had their cholesterol level checked and 71.5 percent had it tested in the past five years. Women were significantly more likely than men to say they ever had their cholesterol checked (83.4 percent vs. 67.2 percent for men). They were also significantly more likely than to report having this test during the past five years (80.1 percent for women vs. 63.3 percent for men).

Among respondents who ever had their blood cholesterol level checked, 35.2 percent had been told it was high.

Diabetes

Among adults in this district, 7.1 percent had ever been told they have diabetes. (This estimate does not include persons told they had gestational diabetes or pre-diabetes).

Arthritis

Nearly one-fourth of adults in this area (23.0 percent) reported ever being diagnosed with arthritis.

Asthma

The proportion of adults in the South Heartland who had ever been told they had asthma was 11.7 percent, while 9.3 percent currently have this disease.

Overweight and Obesity

Three out of ten respondents in this district (29.8 percent) reported heights and weights that placed them in the "obese" category (Body Mass Index = 30.0+). An additional 33.3 percent were classified as "overweight" (Body Mass Index = 25.0-29.9). Thus, 63.1 percent of adults in this district were overweight or obese in 2007-2008.

Men in the South Heartland area (39.2 percent) were significantly more likely than women (27.0 percent) to report heights and weights that placed them in the "overweight" category.

Fruit and Vegetable Consumption

Less than one-fifth of South Heartland adults (18.7 percent) consumed fruits and/or vegetables five or more times daily.

Physical Activity

One-fourth of the respondents in this district (25.0 percent) stated that they had not participated in any leisure-time physical activity (outside of work) in the past month.

One-half of South Heartland adults (49.7 percent) engaged in the recommended level of "moderate and/or vigorous" physical activity in a usual week. The current rate represents a significant increase from the 2005 rate of 34.2 percent.

Participation in the recommended level of "vigorous" physical activity in a usual week was reported by 25.4 percent of respondents from this area. Women in this district (17.3 percent) were significantly less likely than women statewide (27.0 percent) to engage in this level of activity. They were also significantly less likely than men in this district (32.7 percent) to have participated in vigorous physical activity.

Tobacco Use

Among adults in the South Heartland District, 18.1 percent said they currently smoke cigarettes, either daily or on some days of the month. This rate represents a significant decrease in prevalence from 30.0 percent in this district in 2005.

In the current study, women in the South Heartland (13.5 percent) were significantly less likely to smoke cigarettes than men (22.6 percent).

Among current smokers, 58.9 percent reported trying to quit smoking at least once in the past 12 months.

The proportion of male respondents who said they had ever used smokeless tobacco was 39.8 percent in the South Heartland area, while 9.8 percent stated they currently use these tobacco products.

Alcohol Consumption

Binge drinking in the past month was reported by 18.1 percent of adults in this area, with men in this district (27.8 percent) significantly more likely than women (8.4 percent) to engage in binge drinking.

Heavy drinking during the past 30 days was reported by 3.6 percent of adults in the South Heartland.

Drinking and driving was reported by 6.5 percent of adults in this area in the last month. Men in this district (10.3 percent) were significantly more likely than women (0.5 percent) to state that they engaged in this risk behavior. South Heartland women were also significantly less likely than Nebraska women overall (3.8 percent) to report drinking and driving.

Cancer Screening

Among women aged 40 and older in the South Heartland, 67.5 percent stated they had a mammogram in the past two years.

Among women aged 18 and older, 93.5 percent reported ever having a Pap test, while 73.2 percent said they had this test within the past three years.

Most men aged 50 and older (80.1 percent) in this area indicated that they ever had a PSA test to screen for prostate cancer, while 66.7 percent said they had this test in the past two years.

In the South Heartland District, 43.7 percent of adults aged 50 and older reported ever having a colonoscopy or sigmoidoscopy. This screening rate was significantly lower than the Nebraska rate (56.1 percent). Screening prevalence for men in this district (44.2 percent) was also significantly lower than the rate for men statewide (55.4 percent), as was screening for women (43.6 percent vs. 56.8 for women statewide).

Prevalence of blood stool testing in the past two years among persons aged 50 and older in the South Heartland District (33.1 percent) was significantly higher than the Nebraska rate (22.8 percent). Two-year screening rates were also significantly higher for South Heartland men (29.9 percent) and women (36.1 percent) than they were for Nebraska men (21.4 percent) and women (24.2 percent).

Immunization

More than three-fourths of adults aged 65 and older in this district (78.9 percent) said they had been vaccinated for influenza in the past 12 months, while 73.5 percent reported ever having a pneumonia vaccination.

Oral Health

Seventy percent of respondents in the South Heartland (70.0 percent) had visited a dentist in the past 12 months, while 69.9 percent had their teeth cleaned within the past year. Women in this district (77.1 percent) were significantly more likely than men (62.5 percent) to have had their teeth cleaned within the last 12 months.

Three out of ten district respondents (31.1 percent) stated they had one or more teeth extracted due to decay or gum disease. Among respondents aged 65 and older, 16.2 percent reported having all their teeth extracted due to decay or gum disease.

South Heartland District Health Department: Summary Table

Indicators	Overall			Men			Women			
	Sample Size	Weighted % or Mean	Compared to State	Sample Size	Weighted % or Mean	Compared to State	Sample Size	Weighted % or Mean	Compared to State	Gender Difference Significant?
Health Care Access										
1. No health care coverage among adults 18-64 years old	873	15.9	NS	367	17.5	NS	506	14.2	NS	No
2. Did not have one or more than one person that they thought of as their personal doctor or health care provider	1,316	10.6	Sig.	515	12.8	Sig.	801	8.4	NS	No
3. Needed to see a doctor in past year but could not because of cost	1,319	9.5	NS	515	6.3	NS	804	12.6	NS	No
4. Visited a doctor for a routine checkup within the past year	1,293	60.5	NS	504	54.5	NS	789	66.6	NS	Yes
General Emergency Preparedness										
1. Household not prepared for major disaster	487	10.5	NS	196	6.7	NS	291	15.0	NS	No
2. Household has no disaster evacuation plan	489	78.2	NS	195	76.3	NS	294	80.2	NS	No
3. Does not have at least 3-day supply of water	491	56.0	NS	198	52.2	NS	293	59.1	NS	No
4. Does not have at least 3-day supply of non-perishable food	489	13.0	NS	196	11.8	NS	293	14.7	NS	No
5. Does not have at least 3-day supply of prescription drugs	492	6.9	NS	197	3.7	NS	295	10.5	NS	No
6. Household has no working battery-powered radio	487	14.5	NS	193	11.6	NS	294	17.8	NS	No
7. Household has no working battery-powered flashlight	489	2.7	NS	196	2.8	NS	293	2.7	NS	No
8. Household would not leave home if evacuation were required	451	6.3	NS	178	10.6	NS	273	3.3	NS	No
9. Household would use cell phone as main source of communication	456	73.3	NS	185	72.7	NS	271	74.5	NS	No
10. Household would use radio as main source of information	463	53.3	NS	190	53.7	NS	273	53.9	NS	No
Health-Related Quality of Life										
1. General health was 'good' to 'excellent'	1,317	85.0	NS	515	86.8	NS	802	83.0	Sig.	No
2. Average number of days (in past month) that physical health was not good	1,282	3.2	NS	504	3.2	NS	778	3.2	NS	No
3. Average number of days (in past month) that mental health was not good	1,298	2.8	NS	509	2.6	NS	789	3.1	NS	No
4. Average number of days (in past month) that poor physical or mental health prevented usual activities	656	3.8	NS	231	4.4	NS	425	3.4	NS	No
Disability										
1. Limited in any way in any activities due to physical, mental or emotional problems	1,309	18.6	NS	513	18.8	NS	796	18.5	NS	No
2. Have health problems requiring use of special equipment	1,313	6.1	NS	514	5.3	NS	799	6.9	NS	No
Mental Health										
1. Had serious psychological distress (SPD) in past 30 days	244	7.0	Sig.	110	5.4	NS	134	8.1	NS	No
2. Have current depression (based on Severity of Depression score of 10+)	231	5.2	NS	92	4.2	NS	139	6.2	NS	No
3. Lifetime diagnosis of depressive disorder	252	14.0	NS	98	9.4	NS	154	19.2	NS	No
4. Lifetime diagnosis of anxiety disorder	250	6.9	NS	97	5.2	NS	153	8.4	NS	No

South Heartland District Health Department: Summary Table

Indicators	Overall			Men			Women			
	Sample Size	Weighted % or Mean	Compared to State	Sample Size	Weighted % or Mean	Compared to State	Sample Size	Weighted % or Mean	Compared to State	Gender Difference Significant?
Cardiovascular Disease										
1. Ever told they had a heart attack or myocardial infarction	1,315	4.3	NS	514	6.7	NS	801	2.3	NS	Yes
2. Ever told they had angina or coronary heart disease	1,309	4.4	NS	513	5.7	NS	796	3.4	NS	No
3. Ever told they had a stroke	1,315	1.9	NS	514	1.7	NS	801	1.9	NS	No
4. Ever told blood pressure was high	508	25.4	NS	206	26.6	NS	302	23.3	NS	No
5. Ever had cholesterol level checked	503	75.0	NS	204	67.2	NS	299	83.4	NS	Yes
6. Had cholesterol level checked during the past five years	499	71.5	NS	202	63.3	NS	297	80.1	NS	Yes
7. Ever told cholesterol was high, among those who had ever been screened	437	35.2	NS	170	37.3	NS	267	33.7	NS	No
Diabetes										
1. Ever told they had diabetes (excluding gestational and pre-diabetes)	1,321	7.1	NS	516	7.1	NS	805	7.4	NS	No
Arthritis										
1. Ever diagnosed with arthritis	495	23.0	NS	201	21.6	NS	294	24.2	NS	No
Asthma										
1. Ever told they had asthma	1,314	11.7	NS	514	10.9	NS	800	12.4	NS	No
2. Currently have asthma	1,313	9.3	NS	513	8.4	NS	800	10.3	NS	No
Overweight and Obesity										
1. Obese (BMI=30+)	1,261	29.8	NS	511	32.0	NS	750	27.3	NS	No
2. Overweight (BMI=25.0-29.9)	1,261	33.3	NS	511	39.2	NS	750	27.0	NS	Yes
Fruit and Vegetable Consumption										
1. Consumed fruits and vegetables 5 or more times per day	498	18.7	NS	203	13.6	NS	295	24.2	NS	No
Physical Activity										
1. Did not engage in any leisure-time physical activity, outside of work, in past 30 days	1,319	25.0	NS	515	25.8	NS	804	24.1	NS	No
2. Participated in recommended level of moderate or vigorous physical activity in a usual week	468	49.7	NS	195	55.4	NS	273	43.2	NS	No
3. Participated in vigorous physical activity 20+ minutes per day, 3+ days per week in a usual week	488	25.4	NS	200	32.7	NS	288	17.3	Sig.	Yes
Tobacco Use										
1. Currently smoke cigarettes (either every day or on some days of the month)	1,314	18.1	NS	512	22.6	NS	802	13.5	NS	Yes
2. Attempted to quit smoking in past 12 months (among current smokers)	197	58.9	NS	102	52.8	NS	95	64.6	NS	No
3. Ever used smokeless tobacco (males)	--	--	--	304	39.8	NS	--	--	--	--
4. Currently use smokeless tobacco (males)	--	--	--	113	9.8	NS	--	--	--	--

South Heartland District Health Department: Summary Table

Indicators	Overall			Men			Women			
	Sample Size	Weighted % or Mean	Compared to State	Sample Size	Weighted % or Mean	Compared to State	Sample Size	Weighted % or Mean	Compared to State	Gender Difference Significant?
Alcohol Consumption										
1. Engaged in binge drinking in the past 30 days	519	18.1	NS	216	27.8	NS	303	8.4	NS	Yes
2. Engaged in heavy (chronic) drinking in the past 30 days	1,288	3.6	NS	496	5.0	NS	792	2.2	NS	No
3. Engaged in drinking and driving in the past 30 days	366	6.5	NS	181	10.3	NS	185	0.5	Sig.	Yes
Cancer Screening										
1. Among women aged 40+, had a mammogram in the past two years	--	--	--	--	--	--	526	67.5	NS	--
2. Among women aged 18+, ever had a Pap test	--	--	--	--	--	--	626	93.5	NS	--
3. Among women aged 18+, had a Pap test in the past three years	--	--	--	--	--	--	611	73.2	NS	--
4. Among men aged 50+, ever had a Prostate-Specific Antigen (PSA) test	--	--	--	59	80.1	NS	--	--	--	--
5. Among men aged 50+, had a Prostate-Specific Antigen (PSA) test in past two years	--	--	--	59	66.7	NS	--	--	--	--
6. Among men aged 50+, ever had a digital rectal exam (DRE)	--	--	--	59	76.0	NS	--	--	--	--
7. Among men aged 50+, had a DRE in past two years	--	--	--	59	42.4	NS	--	--	--	--
8. Among adults aged 50+, ever had a colonoscopy or sigmoidoscopy	701	43.7	Sig.	259	44.2	Sig.	442	43.6	Sig.	No
9. Among adults aged 50+, had a blood stool test in past two years	648	33.1	Sig.	245	29.9	Sig.	403	36.1	Sig.	No
Immunization										
1. Had a flu shot in past 12 months (aged 65+)	442	78.9	NS	145	81.5	NS	297	77.1	NS	No
2. Ever had a pneumonia vaccination (aged 65+)	435	73.5	NS	141	70.0	NS	294	75.9	NS	No
Oral Health										
1. Visited the dentist in past 12 months	808	70.0	NS	308	63.8	NS	500	76.2	NS	No
2. Had teeth cleaned in past 12 months	729	69.9	NS	283	62.5	NS	446	77.1	NS	Yes
3. Had one or more teeth extracted due to decay or gum disease	799	31.1	NS	309	30.7	NS	490	31.6	NS	No
4. Had all of their teeth extracted (aged 65+)	278	16.2	NS	82	11.9	NS	196	19.4	NS	No

NOTES:
"Weighted % or mean" is weighted by health district, gender, and age.
"NS" = Not Significant and "Sig." = Significant. These denote whether or not the district percentage/mean is significantly different from the State of Nebraska

Summary Table for South Heartland District Health Department 2009-2010

Indicators	Overall						Men						Women					
	LHD			State			LHD			State			LHD			State		
	%	L %	U %	%	L %	U %	%	L %	U %	%	L %	U %	%	L %	U %	%	L %	U %
Health Care Access																		
No health care coverage, 18-64 years old	12.1	9.0	15.2	15.8	14.6	17.1	10.3	5.6	15.1	16.6	14.7	18.4	14.0	10.0	18.0	15.1	13.4	16.8
Could not see a doctor in past year due to cost	9.5	7.1	11.8	10.9	10.0	11.7	9.0	5.0	13.0	9.2	8.0	10.4	9.9	7.3	12.5	12.5	11.2	13.7
Visited a doctor for a routine checkup in past year	60.0	56.2	63.8	58.0	56.8	59.3	53.8	47.7	60.0	51.3	49.4	53.2	65.8	61.5	70.1	64.5	63.0	66.1
Cardiovascular Disease																		
Ever told had a heart attack	5.0	4.0	6.0	3.7	3.4	3.9	7.4	5.4	9.3	4.9	4.5	5.3	2.8	1.9	3.6	2.5	2.2	2.7
Ever told had angina or coronary heart disease	4.5	3.6	5.5	3.9	3.5	4.2	5.8	4.1	7.5	4.6	4.2	5.0	3.3	2.3	4.3	3.1	2.7	3.6
Ever told had a stroke	2.7	2.0	3.4	2.3	2.1	2.6	2.4	1.3	3.5	2.3	1.9	2.7	2.9	2.0	3.9	2.4	2.1	2.7
Ever told blood pressure was high	33.5	28.4	38.5	27.1	25.9	28.4	35.5	26.5	44.5	29.0	26.9	31.1	31.6	26.8	36.4	25.3	23.9	26.7
Had cholesterol level checked during past 5 years	74.6	68.7	80.5	73.9	72.1	75.6	70.6	60.5	80.6	72.0	69.3	74.7	78.5	72.4	84.6	75.7	73.4	77.9
Ever told cholesterol was high, among not screened	41.0	35.9	46.1	37.4	35.8	39.0	44.2	35.4	53.0	39.7	37.1	42.3	38.3	32.5	44.0	35.3	33.4	37.2
Overweight and Obesity																		
Overweight (BMI=25.0-29.9)	35.6	32.1	39.2	37.0	35.8	38.1	44.3	38.3	50.3	43.6	41.7	45.4	27.0	23.3	30.8	30.4	29.0	31.8
Obese (BMI=30+)	30.6	27.2	34.0	28.1	27.0	29.1	30.5	25.0	36.0	30.4	28.8	32.1	30.7	26.6	34.7	25.7	24.4	27.0
Fruit / Vegetable Consumption																		
Consumed fruits and vegetables 5+ times per day	22.9	18.6	27.1	21.1	19.8	22.4	18.0	11.3	24.7	15.7	14.0	17.5	27.3	22.0	32.7	26.1	24.3	28.0
Physical Activity (PA)																		
No leisure-time PA in past 30 days	27.3	24.2	30.4	24.5	23.5	25.4	23.3	18.6	28.1	23.1	21.7	24.5	31.0	27.1	34.9	25.8	24.5	27.1
Moderate or vigorous PA in a usual week	45.9	40.5	51.3	47.8	46.1	49.5	44.6	35.5	53.6	48.7	46.1	51.4	47.3	41.2	53.3	46.9	44.7	49.0
Vigorous PA 20+ min/day, 3+ days per week	26.3	21.6	30.9	29.7	28.0	31.4	24.8	17.4	32.2	31.9	29.2	34.5	27.6	21.7	33.4	27.6	25.4	29.8
Alcohol Consumption / Tobacco Use																		
Engaged in binge drinking in the past 30 days	14.9	11.8	18.0	18.7	17.6	19.7	22.5	16.9	28.0	25.2	23.5	26.9	8.0	5.3	10.7	12.5	11.3	13.7
Current smoker (at least some days of the month)	13.4	10.8	16.1	17.0	16.0	18.0	15.3	10.7	20.0	18.4	16.9	19.9	11.7	9.0	14.3	15.6	14.3	16.9
Attempted to quit smoking in past 12 months	47.4	36.7	58.2	56.6	53.4	59.8	41.5	25.0	57.9	54.6	49.9	59.2	54.8	42.7	67.0	59.0	54.7	63.2
Cancer Screening																		
Had a colonoscopy in past two years, 50+	11.2	8.9	13.4	11.8	11.0	12.7	11.5	7.9	15.1	13.1	11.7	14.6	10.8	8.0	13.6	10.7	9.7	11.7
Ever had a prostate cancer screening, male 50+	.	.	.	.	.	.	7.6	4.7	10.5	6.8	5.8	7.8	.	.	.	.	.	.
Had a mammogram in past two years, female 40+	.	.	.	.	.	.	.	.	.	.	.	.	67.9	63.3	72.5	71.5	69.9	73.2
Had a Pap test in past three years, female 18+	.	.	.	.	.	.	.	.	.	.	.	.	70.2	64.7	75.7	73.2	71.2	75.1

Note: % is weighted by health district, gender, and age; L% and U% are the lower and upper limits for the 95% confidence interval, respectively.

LHD=local/district health department; BMI=body mass index

From the following list, choose 3 risky behaviors that you think have the most impact of health and well-being in your community? Choose only 3

Answer Options	Response Percent	Response Count
Alcohol abuse	52.3%	235
Not enough exercise	39.2%	176
Distracted driving (cell phone use, texting, etc)	38.5%	173
Poor eating habits	34.7%	156
Drug abuse	33.9%	152
Tobacco use (including smokeless tobacco)	21.2%	95
Drunk driving	20.9%	94
Avoiding routine visits to health professional	14.3%	64
Not managing stress	13.4%	60
Not using seatbelts	9.8%	44
Not using child safety seat (or not using correctly)	6.2%	28
Unsafe sex	6.2%	28
Violence (domestic violence, fighting, etc.)	6.2%	28
Not getting vaccine "shots" to prevent disease	1.8%	8
answered question		449
skipped question		31

Thinking about what you know from your personal experience and/or the experiences of others you know, what do you think are the 3 most troubling health-related problems in your community? (Choose ONLY 3)

Answer Options	Response Percent	Response Count
Overweight / Obesity	55.7%	251
Cancers	39.5%	178
Aging problems (arthritis, hearing/vision loss, falls)	34.6%	156
Addictions	30.8%	139
Mental health issues (including depression)	30.4%	137
Diabetes	21.1%	95
Heart disease	20.0%	90
High blood pressure	12.6%	57
Teenage pregnancy	10.6%	48
Child abuse or neglect	8.0%	36
Injuries (from crashes, falls, violence, etc)	6.0%	27
Respiratory / lung disease	4.7%	21
Domestic violence	4.2%	19
Poor dental health	4.0%	18
Motor vehicle crash injuries	2.4%	11
Unsafe environment (poor air/water quality, chemical exposures)	2.2%	10
Infectious diseases (hepatitis, TB, pertussis, flu, other diseases transmitted from person to person)	2.0%	9
Stroke	1.8%	8
Asthma	1.6%	7
Sexually transmitted diseases	1.6%	7
Suicide	0.7%	3
Rape / sexual assault	0.4%	2
HIV / AIDS	0.2%	1
Infant death	0.2%	1
answered question		451
skipped question		29

Of the health related problems and risky behaviors listed above, which one would you say your community should be addressed first?

CATEGORY	NUMBER OF RESPONSES	PERCENT of TOTAL RESPONCES
Alcohol Abuse	86	18.9%
Drug Use/Abuse	72	15.9%
Distracted/Risky Driving	61	13.4%
Exercise inc. Not Enough	55	12.1%
Eating Habits inc. Poor	37	8.1%
Drunk Driving	27	5.9%
Routine Visits & Avoidance Thereof	13	2.9%
Tobacco	13	2.9%
Managing Stress	8	1.8%
Seatbelts	8	1.8%

Community Themes & Strengths Assessment of SHDHD, conducted by NDHHS 2012

(weighted)

Table 10: Top 15 Responses to the Question "What do you think is the single most important health issues or health behavior that needs to be addressed in your community?*," among Nebraska Adults aged 18 and Older, 2011

	South Heartland District Health Department			State of Nebraska	
	Top 15 Health Issues/Behaviors (in rank order)	%[a]		Top 15 Health Issues/Behaviors (in rank order)	%[a]
1.	Overweight and Obesity	23.4%		Overweight and Obesity	24.3%
2.	Cancer	9.5%		Alcohol abuse	8.6%
3.	Alcohol abuse	9.0%		Cancer	7.0%
4.	Drug abuse	8.6%		Drug abuse	6.7%
5.	Healthcare-related (quality, access, cost, coverage)[+]	6.7%		Healthcare-related (quality, access, cost, coverage)[+]	5.9%
6.	Unhealthy eating and/or poor nutrition[!]	6.3%		Not enough exercise[#]	5.5%
7.	Aging population and elderly conditions/needs^	5.3%		Unhealthy eating and/or poor nutrition[!]	4.8%
8.	Drunk driving	5.2%		Distracted driving (texting, cell phone use)	4.5%
9.	Mental health and/or suicide	4.4%		Drunk driving	3.7%
10.	Not enough exercise[#]	3.3%		Tobacco use (cigarettes and/or smokeless)	2.9%
11.	Tobacco use (cigarettes and/or smokeless)	3.2%		Violence/crime/safety[x]	2.7%
12.	Heart disease	2.3%		Mental health and/or suicide	2.7%
13.	Distracted driving (texting, cell phone use)	2.2%		Diabetes	2.5%
14.	Infectious diseases (flu, other viruses/infections)[i]	1.3%		Heart disease	2.4%
15.	Teen pregnancy	0.9%		Aging population and elderly conditions/needs^	2.4%
	Sample size (n)[b]	396		Sample size (n)[b]	7,377
	Missing data[c]	100		Missing data[c]	1,700
	Percentage Missing Data[d]	20.2%		Percentage Missing Data[d]	18.7%

Percentage who Responded with a Value of 8, 9, or 10 for How Serious Various Health Issues are in the Community (based on an 11-point scale ranging from 0=not serious at all to 10=extremely serious), among Nebraska Adults aged 18 and Older, 2011

Health Issue	Percent
Overweight and obesity	54.6%
Cancer	49.4%
High blood pressure	42.9%
Diabetes	33.9%
Heart disease	31.5%
Aging problems (arthritis, hearing/vision loss)	29.5%
Stroke	21.0%
Teenage pregnancy	18.4%
Mental health (including depression)	17.7%
Infectious diseases (flu, other viruses/infections)	15.2%
Poor dental health	12.2%
Child abuse and neglect	11.3%
Unsafe environment (poor air/water, chemical expos.)	11.0%
Injuries (resulting from crashes, falls, violence, etc.)	8.2%
Suicide	6.1%

Nebraska: Burden of Chronic Diseases

2008

The Burden of Chronic Diseases

Chronic diseases – such as heart disease, stroke, cancer, and diabetes – are among the most prevalent, costly, and preventable of all health problems. Leading a healthy lifestyle (avoiding tobacco use, being physically active, and eating well) greatly reduces a person's risk for developing chronic disease. Access to high-quality and affordable prevention measures (including screening and appropriate follow-up) are essential steps in saving lives, reducing disability and lowering costs for medical care.

Heart Disease and Stroke

Heart disease and stroke, the first and third leading causes of death in the United States, are the most common cardiovascular diseases.

- Heart disease accounted for 24% of deaths in Nebraska in 2005, while stroke caused 7% of deaths.
- In 2007, 27% of adults in Nebraska reported having high blood pressure (hypertension) and 37% of those screened reported having high blood cholesterol, which puts them at greater risk for developing heart disease and stroke.

Cancer

Cancer is the second leading cause of death in the United States, accounting for almost one in every four deaths.

- 22% of all deaths in Nebraska in 2005 were due to cancer.
- The American Cancer Society estimates that 8,720 new cases of cancer were diagnosed in Nebraska in 2007, including 920 new cases of colorectal cancer and 1,160 new cases of breast cancer in women.

Diabetes

In 2005, diabetes was the sixth leading cause of death in the U.S. Likely to be underreported as a cause of death, the risk of death among people with diabetes is about twice that of people without diabetes of similar age.

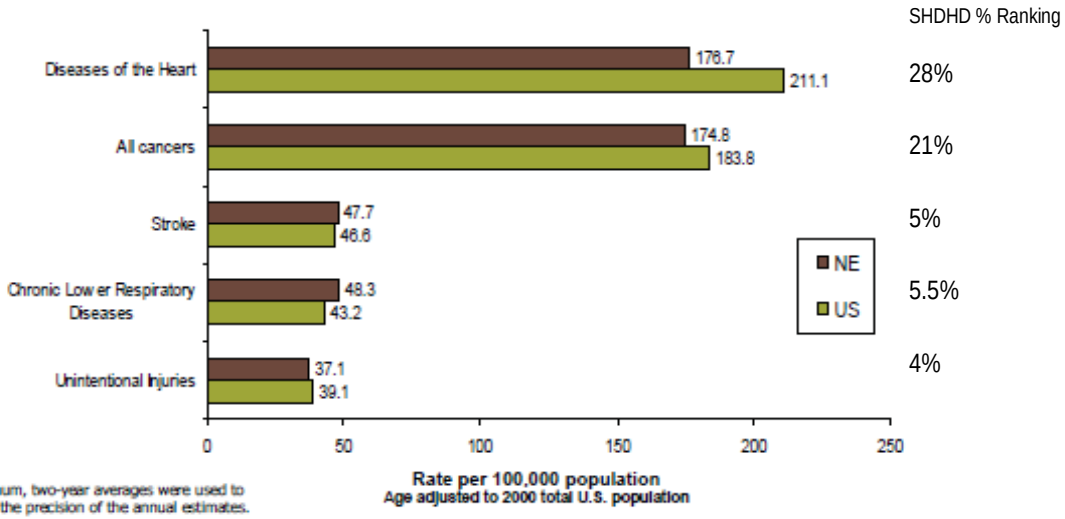
- 449 adults in Nebraska died from diabetes mellitus in 2005.
- In 2007, 7% of adults in Nebraska reported being diagnosed with non-pregnancy related diabetes.[◦]

Arthritis

Arthritis is the most common cause of disability in the U.S., affecting more than 46 million Americans.

- In 2007, 28% of adults in Nebraska reported being diagnosed with arthritis.

5 Most Common Causes of Death, Nebraska Compared with United States, 2005



◦ At minimum, two-year averages were used to improve the precision of the annual estimates.

Nebraska: Risk Factors and Preventive Services

Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, an estimated 438,000 people in the U.S. die prematurely from smoking or exposure to second hand smoke, and another 8.6 million have a serious illness caused by smoking. For every person who dies from smoking, 20 more people suffer from at least one serious tobacco-related illness.

- In 2007, 20% of adults in Nebraska reported being current smokers.

Nutrition, Physical Activity, and Overweight/ Obesity

In the past 30 years, the prevalence of overweight and obesity has increased sharply for both adults and children. Physical inactivity and unhealthy eating contribute to overweight and obesity and a number of chronic diseases, including some cancers, cardiovascular disease, and diabetes.

- In 2007, 65% of adults in Nebraska were overweight or obese, based on self-reported height and weight.
- 76% of adults in Nebraska consumed fewer than 5 fruits and vegetables per day.
- 48% of adults in Nebraska were not engaged in sufficient moderate or vigorous physical activity.

Early Detection

Mammography is a screening method that has been shown to reduce mortality due to breast cancer by approximately 20-25% over 10 years among woman aged 40 years and over.

- In 2006, 27% of women in Nebraska aged 40 years or older, reported not having had a mammogram within the last 2 years.

Up to 60 percent of deaths from colorectal cancer could be prevented if persons aged 50 and older were screened regularly. Colorectal cancer can be prevented by removing precancerous polyps or abnormal growths, which can be identified during a fecal occult blood test, sigmoidoscopy or colonoscopy.

- In 2006, among adults in Nebraska aged 50 years or older, 49% reported never having had a sigmoidoscopy or colonoscopy.
- 72% reported not having had a fecal occult blood test within the past two years.

No Health Care Coverage

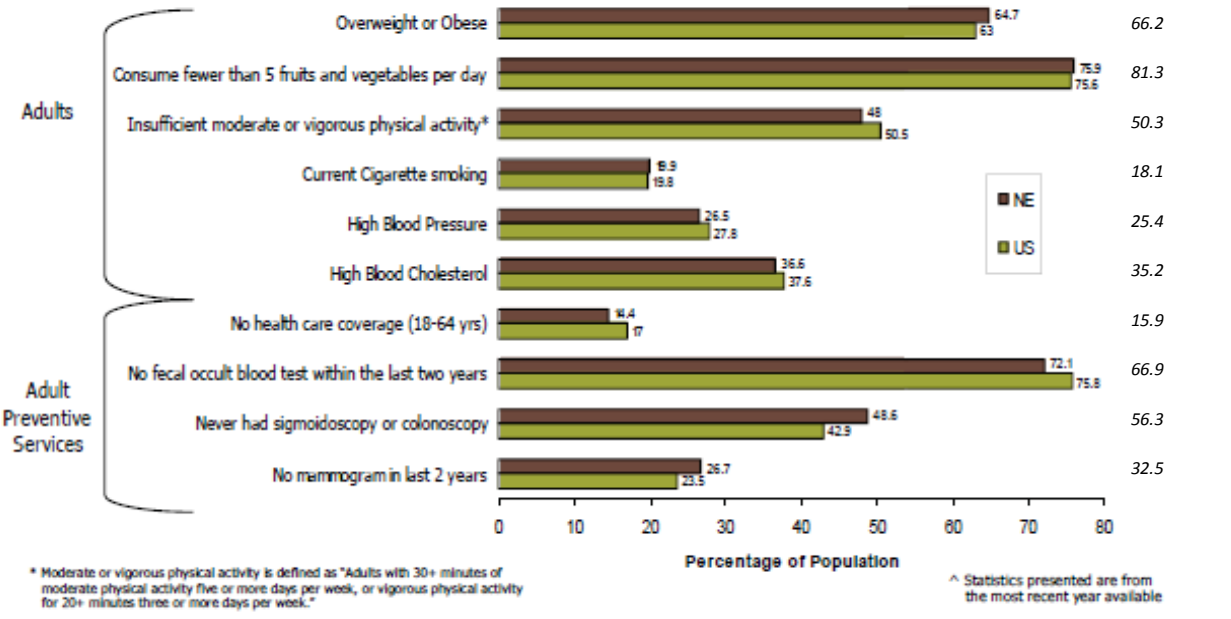
With the U.S. health care system changing rapidly, health care plans (e.g. health insurance, HMOs and Medicaid/Medicare) need to ensure that all Americans have access to affordable, high-quality preventive services.

- In 2007, 14% of adults aged 18-64 in Nebraska reported having no health care coverage.

SHDHD

Preventive Services and Risk Factors, Nebraska Compared with United States

2007-2008



* Moderate or vigorous physical activity is defined as "Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week."

^ Statistics presented are from the most recent year available

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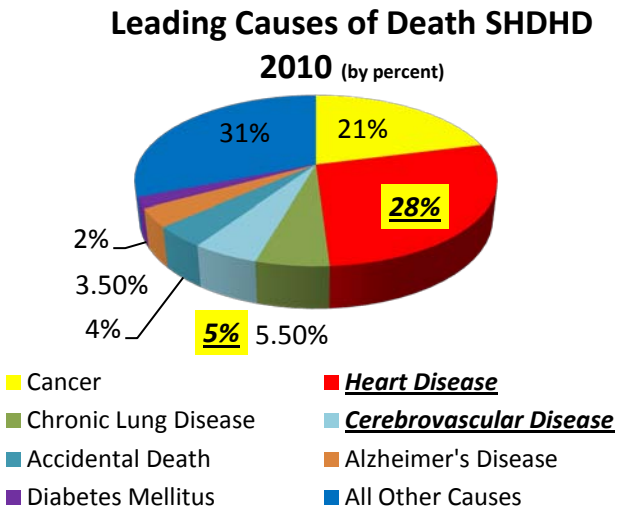
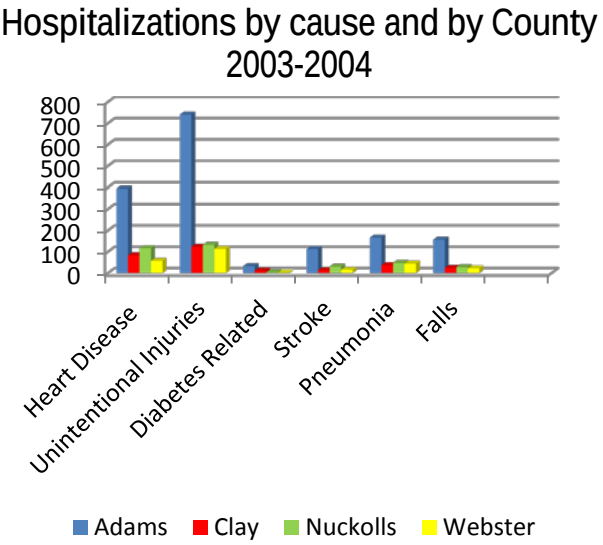
Fact Sheet

Cardiovascular Heart Disease/Stroke

Incidence and Prevalence



Heart disease is the leading cause of death for the South Heartland District and the second leading cause of death in Nebraska[1]



In 2008, 26,742 hospitalizations occurred among Nebraska Residents due to CVD averaging $34,000 per admit.

Source: Nebraska Hospital Discharge Data. Year 2008.

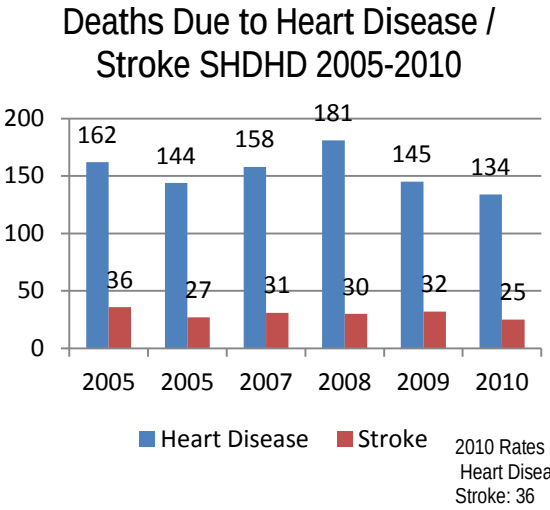
Mortality

Number of deaths due to Heart Disease and Stroke 2010

	Heart Disease (134)	Stroke (25)
Adams	85	15
Clay	24	4
Nuckolls	16	2
Webster	9	4

According to the BRFSS survey (2009), approximately 5% or 1,762 SHDHD residents reported a history of Heart Attack or MI, or have Angina or Coronary Heart Disease. Heart disease was the cause of 134 deaths for SHDHD residents in 2010. [1]

1 Data Source: Nebraska Department of Health and Human Services Vital Statistics Reports (2005-2010)



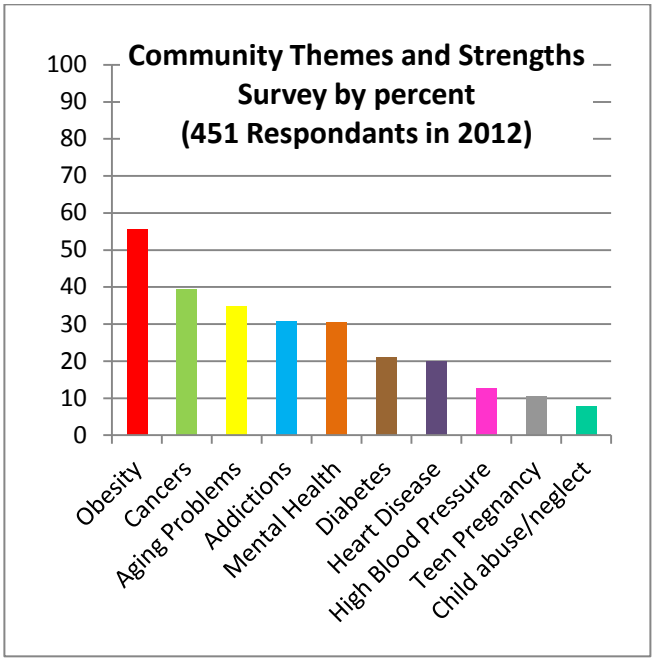
2010 Rates (per 100,000)
Heart Disease: 168.9
Stroke: 36

About 1 in every 10 Nebraska adults reported that they have been diagnosed with or had a heart attack or stroke during their lifetime. Subsequently, these individuals are at extremely high risk for a recurrent heart attack or stroke. [1]

Public Health
Prevent. Promote. Protect.

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

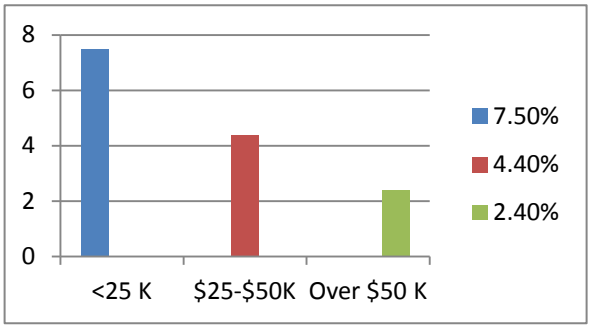
Perceived Need



Responses to top three most troubling health–related problems in our community

Demographics

Prevalence of coronary heart disease among adults, by household income, 2010



Source: NE BRFSS 2010

Nebraska Adults earning less than $25,000. (2010) are more than twice as likely to be affected by CHD as those who earn over $50,000.

Heart Disease / Stroke Rates: 2006-2010

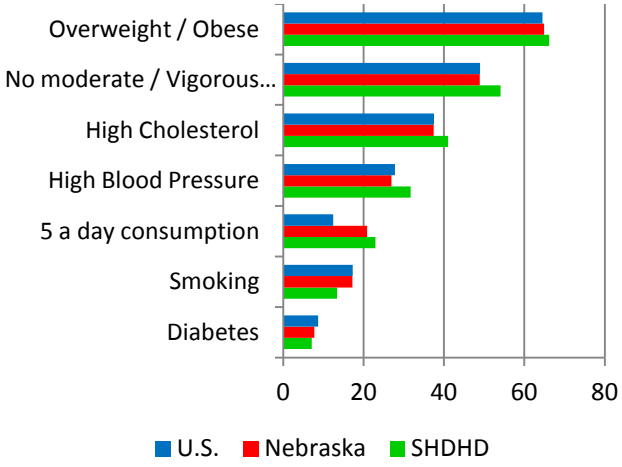
Adams	213.5	
Clay	188	
Nuckolls	217.4	
Webster	199.8	
SHDHD	204.7	40.7 (stroke)

Risk Factors

Preventable Risk Factors
- Type-2 Diabetes
- High Blood Cholesterol
- High Blood Pressure
- Lack of Physical Activity
- Overweight and Obesity
- Unhealthy Eating
- Smoking

Non-Preventable Risk Factors
- Increasing Age
- Male Gender
- Race/Ethnicity
- Family History of Premature CVD

Behavioral Risk Factors (by Percent)



Sources: NE BRFSS Data 2008, 2010

Note: 2008 Data used for SHDHD Diabetes and 5 a day consumption categories

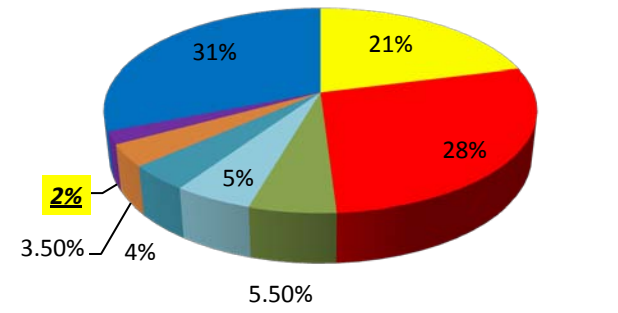
BRFSS Quick Facts – SHDHD 2010:

- Overall, the percentage of adults who have coronary heart disease has remained relatively stable for SHDHD over the past five years.
- 66.2 % of adults are considered overweight or obese.
- 33.5% of adults have been told by a medical provider they high blood pressure.
- 45.9 % of adults report moderate or vigorous physical activity in a usual week.
- Statewide, adults with total household incomes of less than $25,000 were more likely to have coronary heart disease than those with higher incomes.

Fact Sheet
Diabetes

Incidence and Prevalence

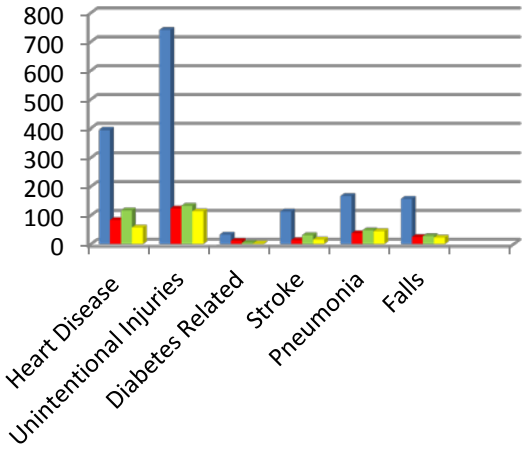
Leading Causes of Death SHDHD 2010
(by percent)



- Cancer
- Heart Disease
- Chronic Lung Disease
- Cerebrovascular Disease
- Accidental Death
- Alzheimer's Disease
- ***Diabetes Mellitus***
- All Other Causes

Morbidity

Number of hospitalizations by cause SHDHD, 2010[1]



According to 2007 data from DHHS, the medical and indirect costs of diabetes in Nebraska are over $750 million a year.

Mortality

An estimated 104,000 Nebraska adults have diabetes, and over 250,000 are undiagnosed, according to 2009

Deaths due to Diabetes (2010) [1]

		Estimated Persons that have ever been diagnosed with Diabetes[2]
Adams	3	2760
Clay	0	458
Nuckolls	4	320
Webster	3	271

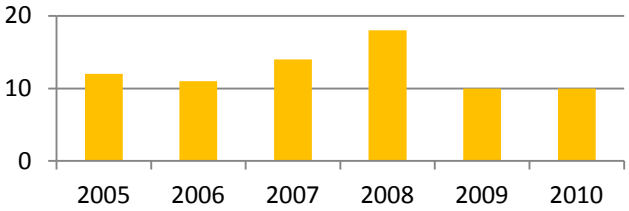
- Since 2005, 75 deaths can be directly attributed to diabetes. [1]
- SHDHD- Ever been diagnosed with Diabetes= 7.1% (per 100,000 pop.) [2]

[1] Data Source: Nebraska Department of Health and Human Services Vital Statistics Reports (2005-2010)

[2]Source: BRFSS, 2010

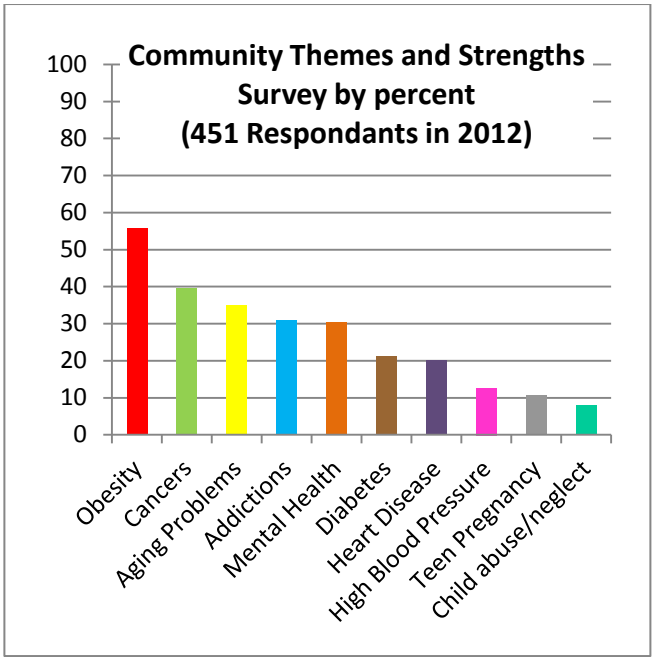
Trends

Deaths Due to Diabetes SHDHD 2005-2010[1] ***by number***



About 1 in every 10 Nebraska adults reported that they had been diagnosed with diabetes at some point in their lives. Diabetes has been associated with an increased risk for other chronic diseases such as heart disease, stroke and a leading cause of kidney failure, non-traumatic lower-limb amputations, and blindness among adults.

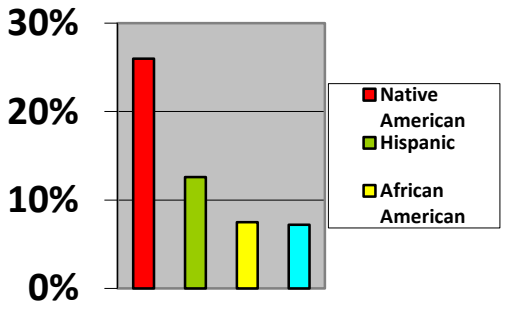
Perceived Need



Responses to top three most troubling health–related problems in our community

Demographics

Diabetes Prevalence by Race, 2007



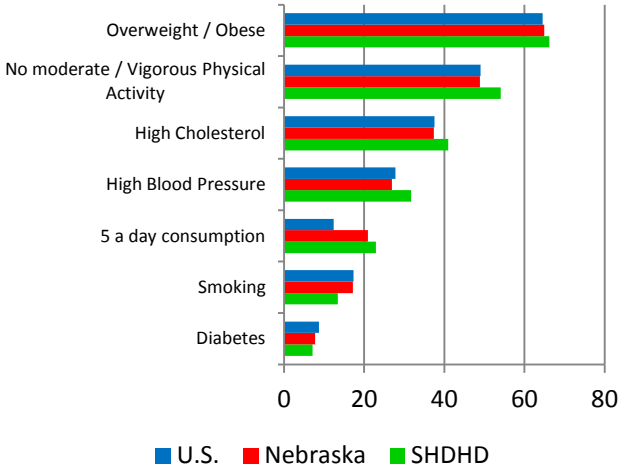
Source: NE BRFSS 2007

Nebraska BRFSS data show the percentage of adults with diabetes is greatest among those with the least education and the lowest household income. Racial minorities are at high risk for developing diabetes.

Risk Factors

- Family history of diabetes
- History of gestational diabetes or giving birth to at least one baby weighing 9 lbs. or more
- African American, Hispanic/ Latino, American Indian, Native Hawaiian, or Pacific Islander heritage
- Physical inactivity
- High blood pressure
- Being overweight or obese
- Being age 45 years or older
- Impaired glucose tolerance (IGT) and/or impaired fasting glucose (IFG)
- Low HDL cholesterol or high triglycerides

Behavioral Risk Factors (by Percent)



Sources: NE BRFSS Data 2008, 2010

DHHS Quick Facts – 2010:

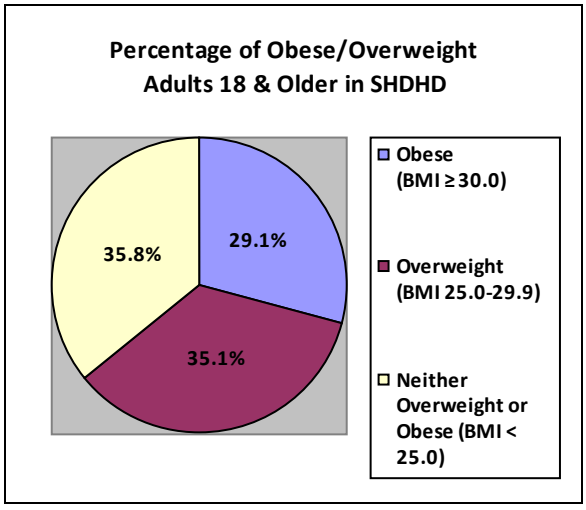
- In Nebraska, the prevalence of obesity has doubled in less than two decades, and close to two-thirds of Nebraska adults are now above their healthy weight, putting them at increased risk for developing diabetes.
- According to the 2008 BRFSS, about one of every six (17.2%) Nebraska residents 65 and older have been diagnosed with diabetes, compared to only about one in 18 (5.6%) among those under the age of 65.
- There were 671 lower-extremity amputations (LEAs) performed among Nebraska residents with diabetes during 2006 and 2007, and this number excludes amputations that were the result of trauma.
- Diabetes is the 7th leading cause of death in the U.S

Source: DHHS, The Impact of Diabetes in Nebraska 2010

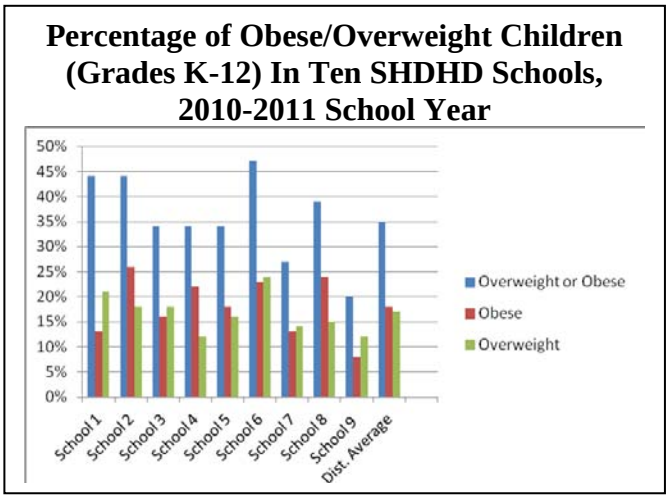
Fact Sheet

Overweight/Obesity

Incidence and Prevalence

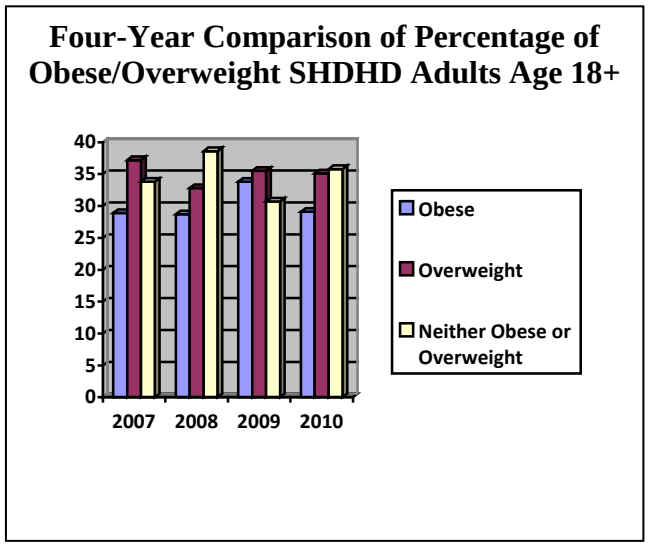


Source: NE BRFSS 2010

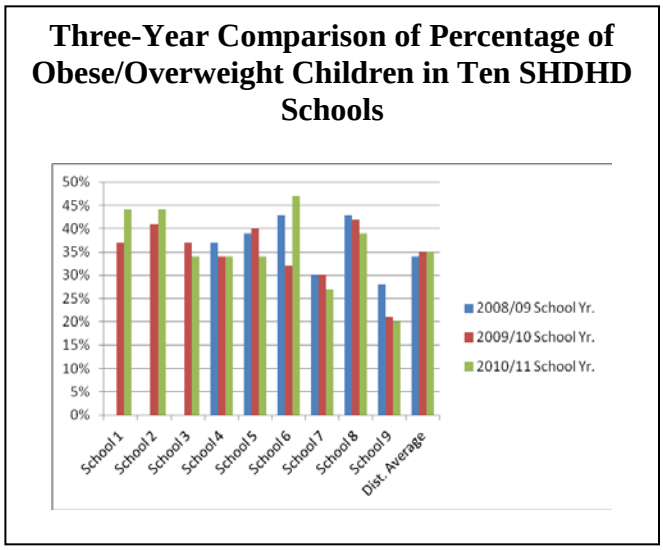


Source: Community Alliance for Healthy Children in Healthy Schools Data

Trends

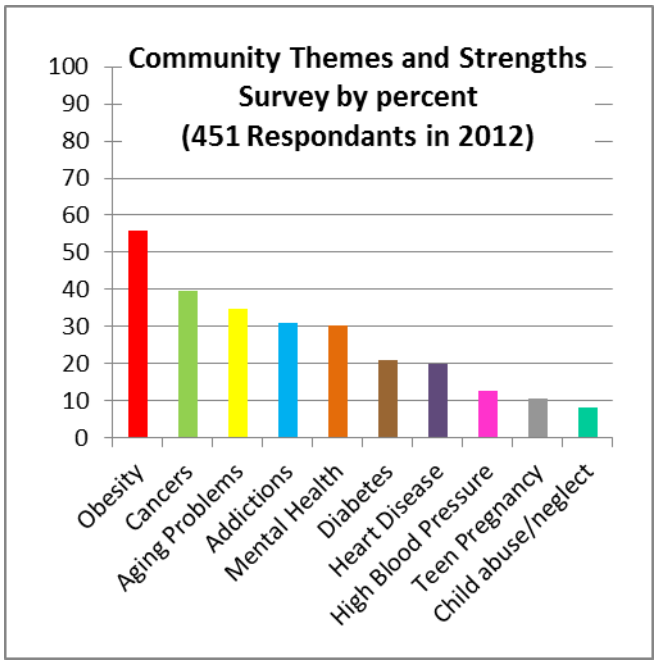


Source: NE BRFSS 2007, 2008, 2009, 2010



Source: Community Alliance for Healthy Children in Healthy Schools Data

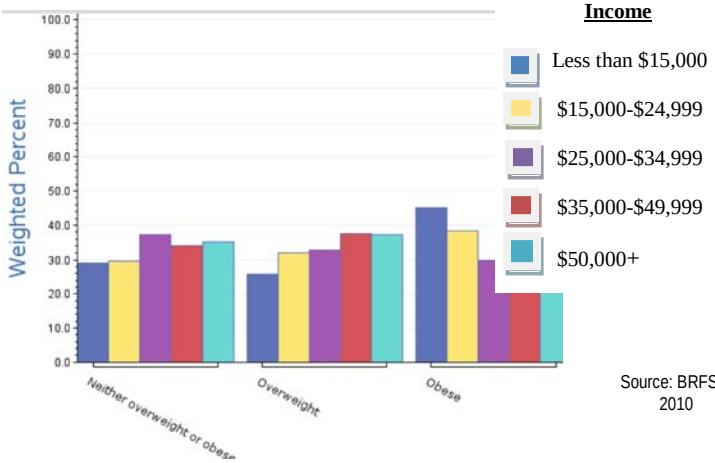
Perceived Need



Responses to top three most troubling health–related problems in our community

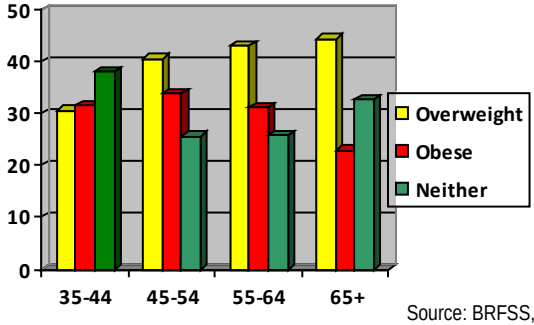
Demographics

BMI Categories by Income - 2010



Source: BRFSS, 2010

Percent Body Mass Index Categories by Age

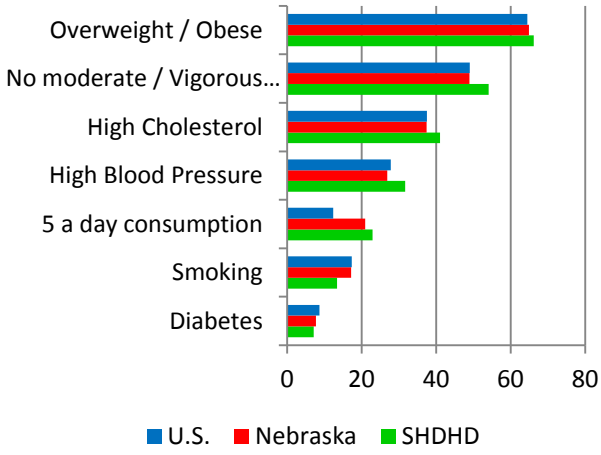


Source: BRFSS, 2010

Risk Factors

- Genetics
- Inactivity
- Unhealthy diet and eating
- Family lifestyle
- Quitting smoking
- Pregnancy
- Lack of sleep
- Age
- Certain medications
- Social and economic issues
- Certain medical conditions

Behavioral Risk Factors (by Percent)



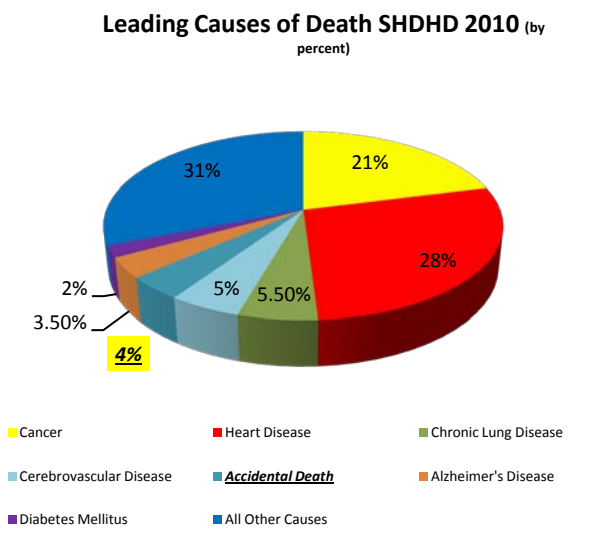
2010 Nebraska BRFSS Quick Facts:

Sources: BRFSS 2008, 2010

- Nearly 2 in 3 adults were overweight or obese
- Males were more likely to be overweight than females (also true for SHDHD)
- The percentage of adults who were overweight and obese has remained relatively stable since 2005
- Overweight and obese individuals are at increased risk of hypertension, type 2 diabetes, coronary heart disease, stroke, osteoarthritis, sleep apnea, and certain cancers.

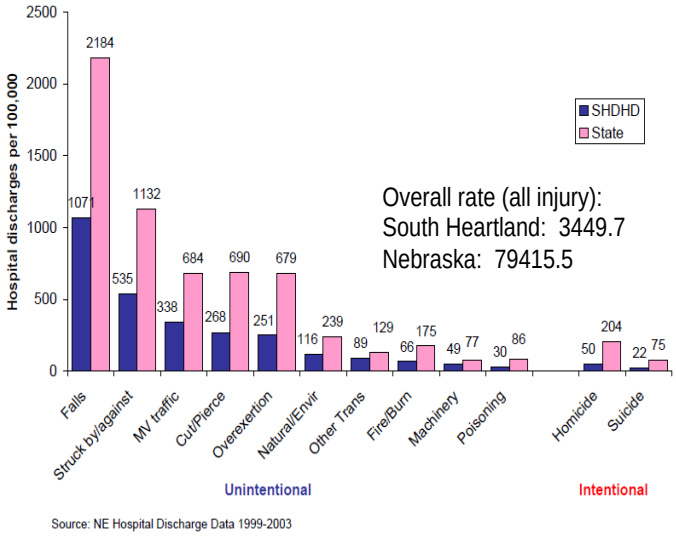
Fact Sheet
Injury

Incidence and Prevalence



- Accidental Death is the 5th leading cause of death in for South Heartland

Age-adjusted Injury Hospital Discharge Rates by Cause, 1999-2003



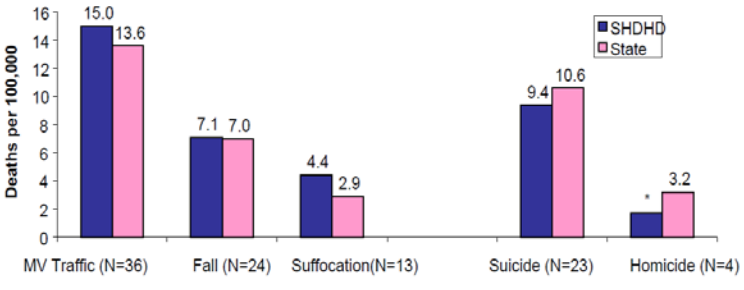
Overall rate (all injury):
South Heartland: 3449.7
Nebraska: 79415.5

Source: NE Hospital Discharge Data 1999-2003

2008 Injury Report: SHDHD had the 2nd lowest overall injury, unintentional injury, suicide attempt, and assault injury discharge rates.

Mortality

Age-adjusted Injury Death Rates by Cause, 1999-2003 (per 100,000 pop.)



* Fewer than five deaths

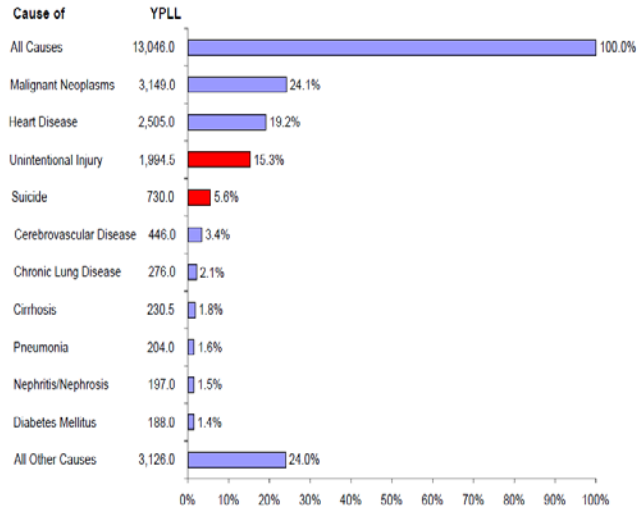
Source: DHHS Death certificate Data 1999-2003

Injury death rate overall:
South Heartland: 49.2
Nebraska: 48.9

Motor vehicle crashes were the leading cause of injury death in the counties served by SHDHD. Suicide was the second leading cause of injury death; falls were third.

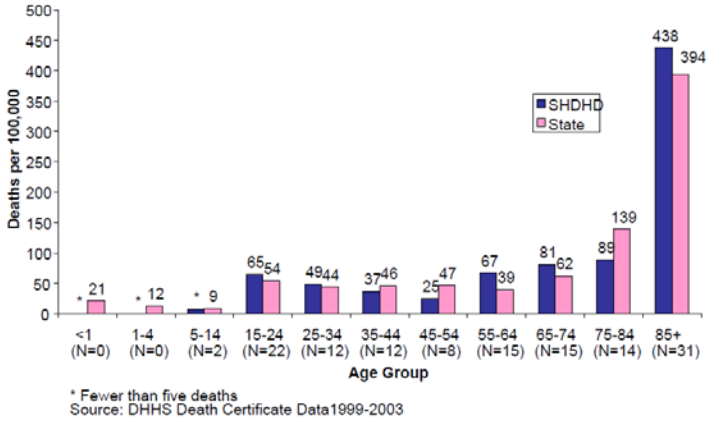
Burden

Years of Potential Life Lost (YPLL) Before Age 75 by Cause of Death, SHDHD, 1999-2003



Demographics

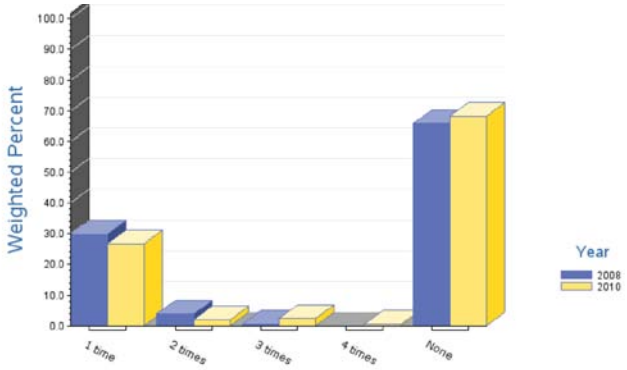
All Injury Death Rates by Age, 1999-2003



More males (65.7%) died from all injury-related causes than females (34.4%) in the SHDHD coverage area.

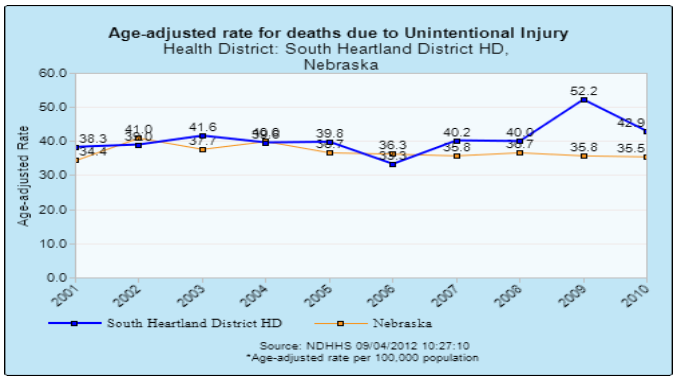
Behavioral Risk Factors

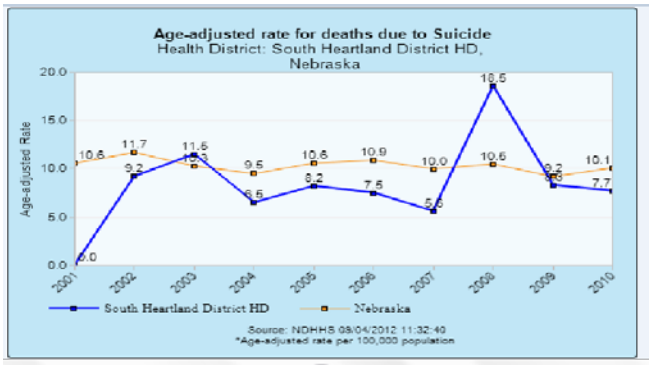
Percentage of Adults Aged 18+ who had a fall that caused an injury in past thirty days which limited regular activity for at least a day or required a visit to doctor (SHDHD 2008, 2010)

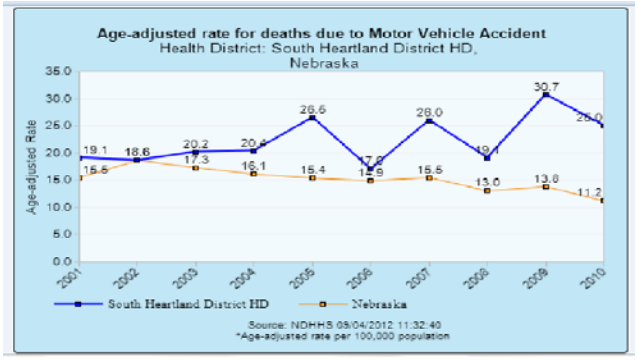


Source: NE BRFSS 2008, 2010

Trends







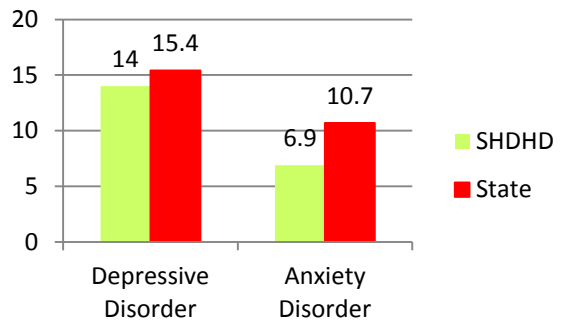
Quick Facts from the DHHS Injury Report, 1999-2003

- From 1999-2003, in addition to 100 injury deaths, over 600 residents in Adams, Clay, Nuckolls and Webster Counties were hospitalized and more than 9,000 residents were treated at hospitals for injuries
- More than 62% of deaths due to fall injuries were among persons 85 years and older
- Teens and young adults age 15-24 had the highest percentage (30.4%) of suicide deaths compared to those in other age groups in the SHDHD area.
- More than half (52%) of all injury death for teens and young adults age 15-24 years were caused by MV crashes.

Fact Sheet
Mental Health

Incidence and Prevalence

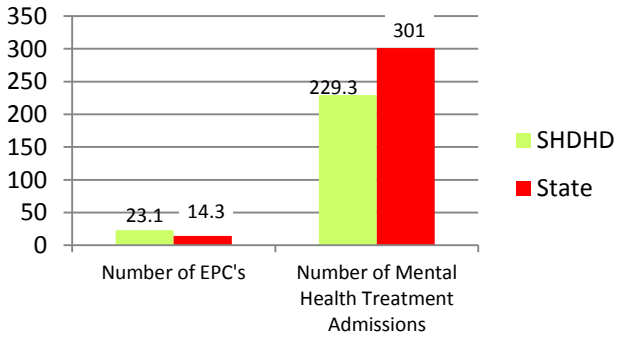
Percentage of Lifetime Diagnosis of Depressive or Anxiety Disorders among Adults Aged 18+ (2007-2008)



Source: BRFSS (2007-2008) District and State respondents who answered yes when they were asked if they had "Ever been told they have a Depressive Disorder or Anxiety Disorder".

Morbidity

Mental Health Treatment Admissions per 10,000 Adults Aged 18+ (2010-2011)



Source: Magellan Treatment Database: 2010 -2011.

Mortality

Deaths due to Suicide (2010)[1]

	2010	04'-08'
Adams	4	13
Clay	0	3
Nuckolls	0	1
Webster	0	4

Source: Nebraska Department of Health and Human Services Vital Statistics Reports (2008, 2010)

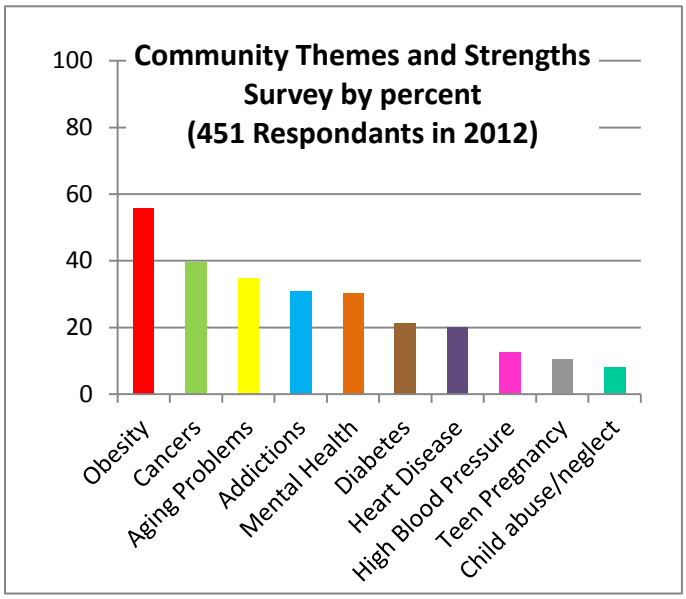
Trends

Behavioral Health Consumer Survey Summary of Results: Agreement Rate Adults Aged 18+ (2006-2011)

	2006	2007	2008	2009	2010	2011
Access	77.1%	81.4%	76.3%	82.1%	82.4	80.3%
Treatment Quality	82.2%	84.9%	81.9%	87.8%	88.7%	86.3%
Outcomes	68.4%	72.9%	72.0%	71.5%	75.6%	74.5%
General Satisfaction	78.6%	81.1%	75.9%	86.3%	84.8%	83.6%
Participation in Treatment Plan	73.0%	78.1%	73.1%	79.8%	80.3%	79.9%
Improved Functioning	71.4%	77.4%	80.4%	73.7%	78.5%	77.0%
Social Connectedness	87.7%	74.5%	76.3%	75.2%	81.6%	77.7%

Source: DHHS-DBH 2011 Behavioral Health Consumer Survey Results

Perceived Need



Responses to top three most troubling health–related problems in our community

Perceived Barriers to Behavioral Health Services

Cost	**74.8%**
Not knowing what services are available	**64.2%**
Stigma (embarrassment and/or fear of "being judged")	**62.9%**
Insurance won't cover the cost of services	61.7%
Services are not well advertised	53.6%
Not knowing about behavioral health issues	49.2%
Lack of transportation	39.4%
Too far to travel	36.0%
Long wait time to receive services	24.8%
Services aren't available	22.5%
Specialized services not available	17.8%
Conflict of interest with available services and/or providers	16.3%
Lack of good services	12.3%
Other	3.8%

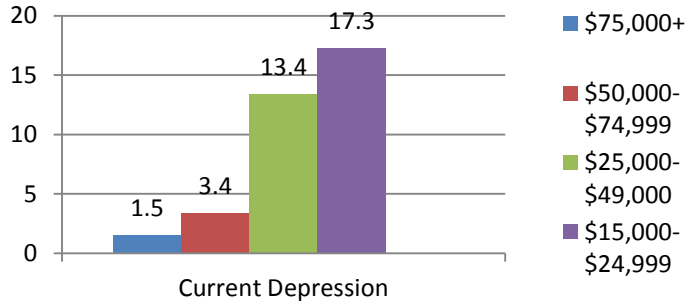
Source: Schmeeckle, J. (2012).
Behavioral Health and Integrated Care Needs Assessment.
Schmeeckle Research Inc.

Importance of Surveillance for Mental Illness

"We know that mental illness is an important public health problem in itself and is also associated with chronic medical diseases such as cardiovascular disease, diabetes, obesity, and cancer. The report's findings indicate that we need to expand surveillance activities that monitor levels of mental illness in the United States in order to strengthen our prevention efforts." *—Ileana Arias, Ph.D., Principle Deputy Director, Centers for Disease Control and Prevention (CDC)*

Demographics

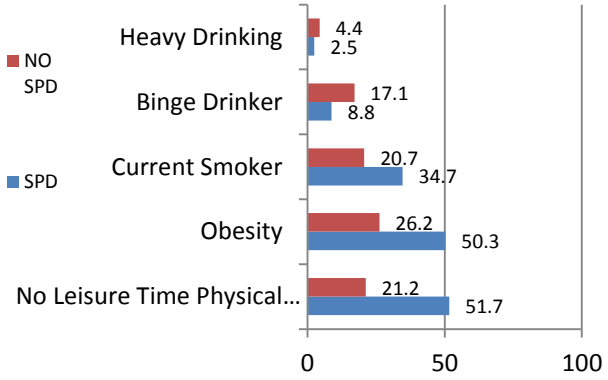
Prevalence of Current Depression by Household Income: Adults Aged 18+ (Nebraska - 2008)



Source: NE BRFSS 2008

Behavioral Risk Factors

Prevalence by Percentage of Unhealthy Behaviors by presence of Serious Psychological Distress(SPD) in Past Month Adults Aged 18+ (Nebraska 2007-2008)



Source: NE BRFSS 2007- 2008

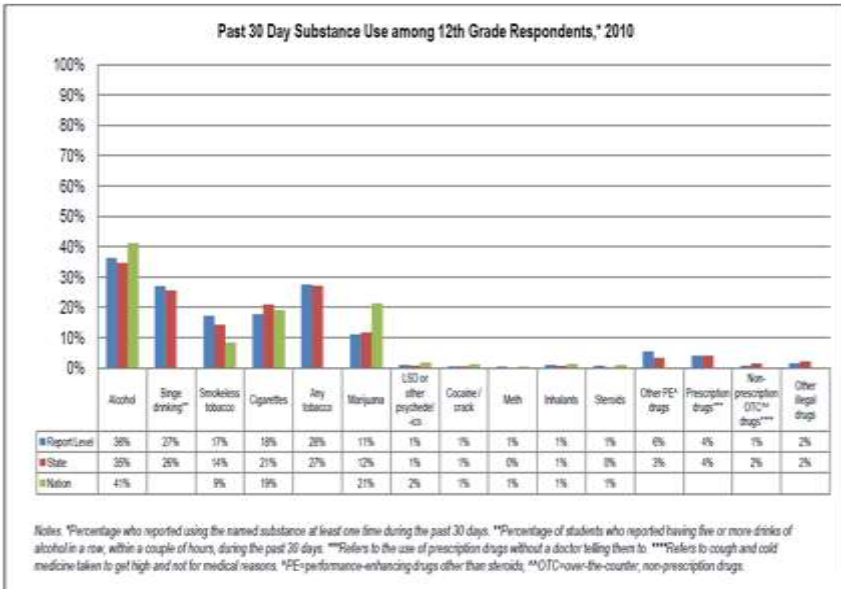
Risk Factors

- having a biological relative, such as a parent or sibling, with a mental illness
- in utero exposure to biological or environmental hazards stressful life situations, such as unemployment, financial problems, a loved one's death or divorce
- substance abuse
- abuse, neglect or other childhood trauma
- chronic medical conditions, such as cancer
- traumatic experiences such as assault or military combat
- having few friends or few healthy relationship

Fact Sheet
Drug Abuse

Incidence and Prevalence

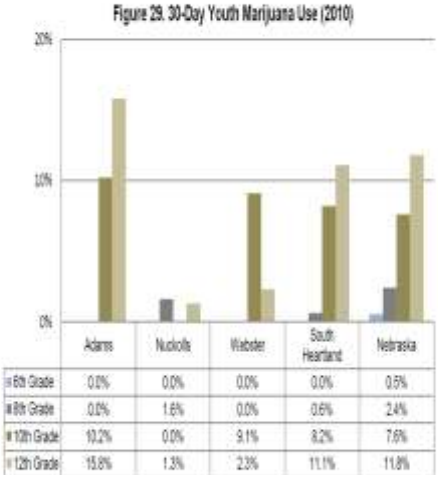
SHARP | NRPFSS 2010



Notes. *Percentage who reported using the named substance at least one time during the past 30 days. **Percentage of students who reported having five or more drinks of alcohol in a row, within a couple of hours, during the past 30 days. ***Refers to the use of prescription drugs without a doctor telling them to. ****Refers to cough and cold medicine taken to get high and not for medical reasons. *PE=performance-enhancing drugs other than steroids; **OTC=over-the-counter, non-prescription drugs.

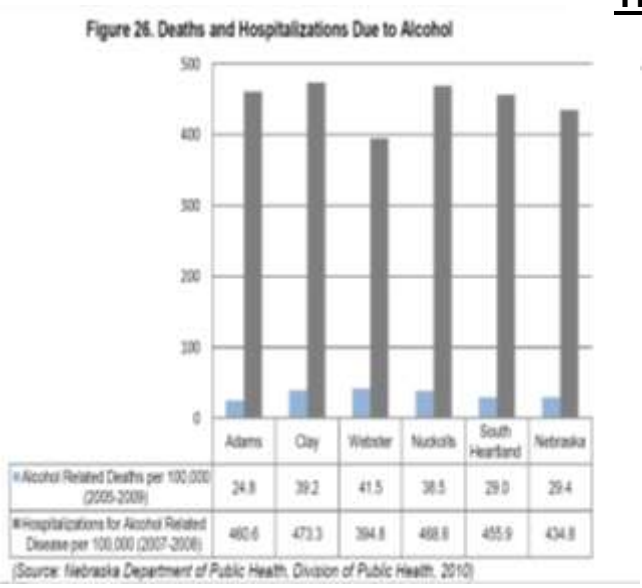
Morbidity / Mortality

Reported rates of past 30-day marijuana use were comparable between the district and the for 10th and 12th graders. However, 10th and 12th graders from Adams County reported higher rates of marijuana use than their peers in the state (Figure 29).

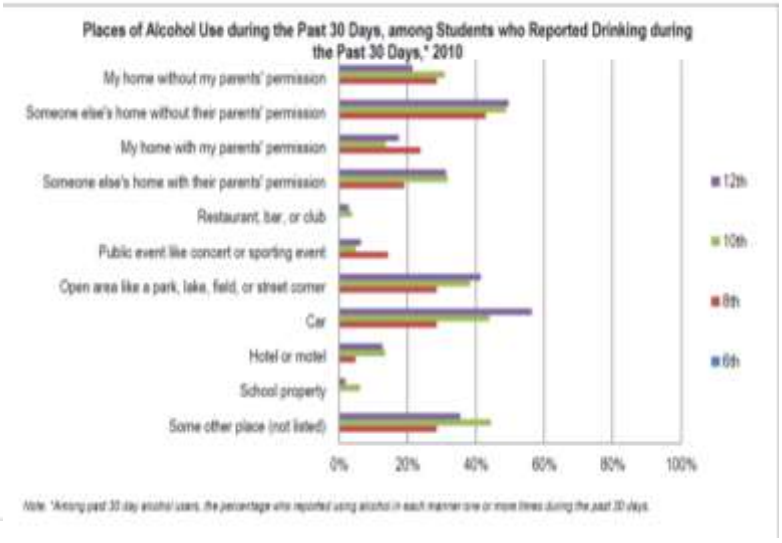


(Source: Nebraska Department of Public Health, Division of Public Health, 2010)

Trends



(Source: Nebraska Department of Public Health, Division of Public Health, 2010)

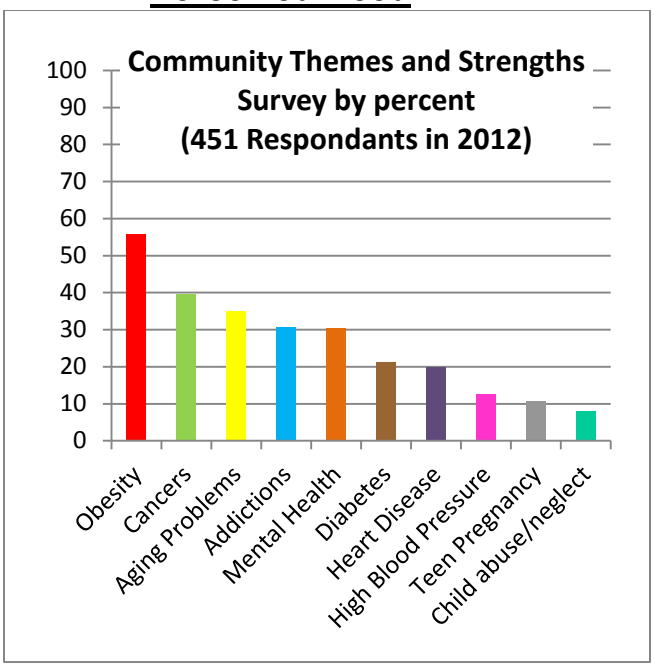


Note. *Among past 30 day alcohol users, the percentage who reported using alcohol in each manner one or more times during the past 30 days.

Public Health

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

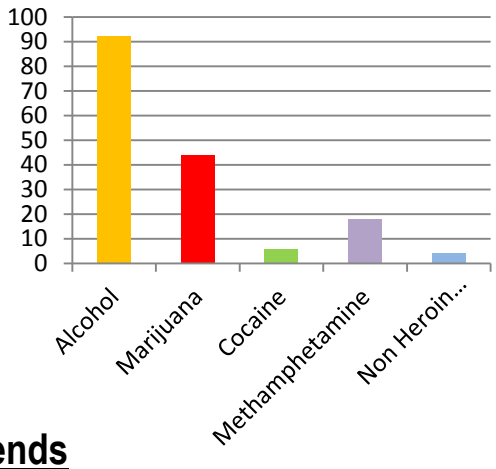
Perceived Need



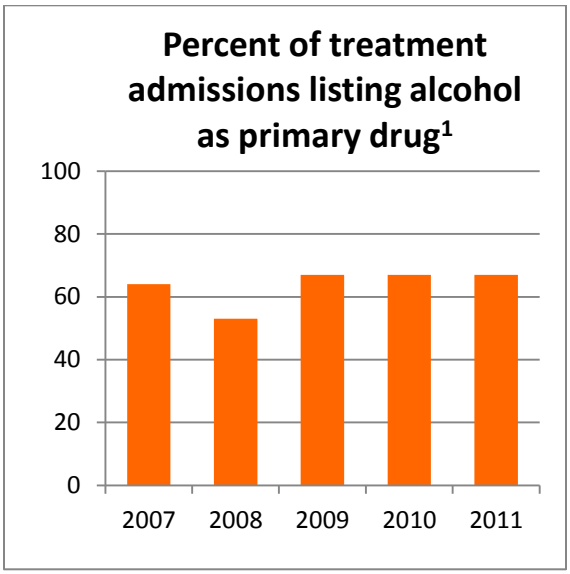
Demographics

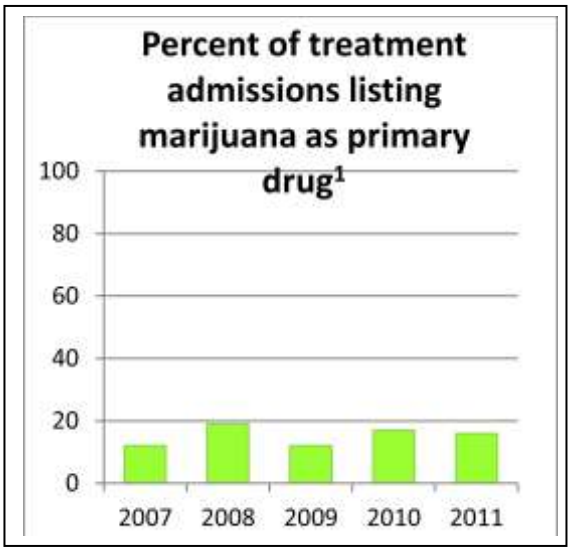
Top three drugs of choice for admissions: Magellan, 2010

(by percent)



Trends





[1]*Data source: Magellan June 2012 data extract.*

Consequences of Underage Drinking

Youth who drink alcohol are more likely to experience

- Abuse of other drugs.
- Changes in brain development that may have life-long effects.
- Unwanted, unplanned, and unprotected sexual activity.
- Legal problems, such as arrest for driving or physically hurting someone while drunk.
- Physical and sexual assault.
- Higher risk for suicide and homicide.
- Alcohol-related car crashes and other unintentional injuries, such as burns, falls, and drowning.

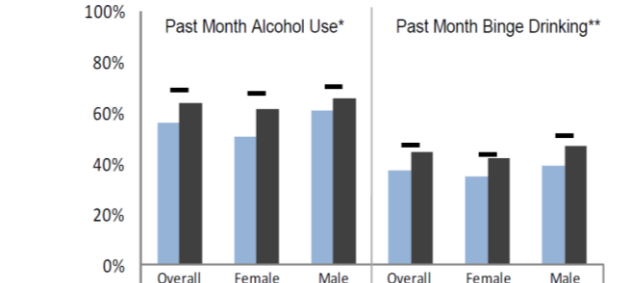
Youth who start drinking before age 15 years are five times more likely to develop alcohol dependence or abuse later in life than those who begin drinking at or after age 21 years.

Fact Sheet
Alcohol Use

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

Incidence and Prevalence

Figure 30: Past Month Alcohol Use and Binge Drinking Among 19-25 Year Olds: South Heartland Region and State Comparisons



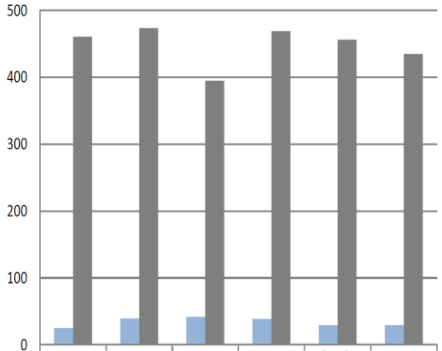
	Overall	Female	Male	Overall	Female	Male
2010	55.9%	50.5%	60.8%	37.0%	34.9%	38.8%
2012	63.6%	61.3%	65.7%	44.6%	41.9%	47.1%
2012 State Average	69.1%	67.7%	70.4%	47.3%	43.5%	50.9%

*Percentage who reported having at least one alcoholic beverage during the 30 days preceding the survey.
**Percentage who reported having five or more drinks for men/four or more drinks for women within a couple of hours on at least one of the 30 days preceding the survey.

(Source: Nebraska Young Adult Alcohol Opinion Survey, 2012)

Morbidity / Mortality

Figure 26. Deaths and Hospitalizations Due to Alcohol

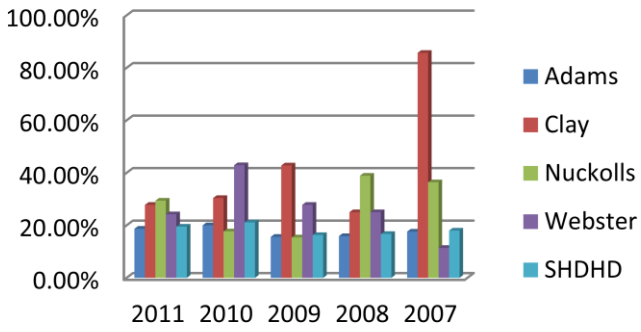


	Adams	Clay	Webster	Nuckolls	South Heartland	Nebraska
Alcohol Related Deaths per 100,000 (2005-2009)	24.8	39.2	41.5	38.5	29.0	29.4
Hospitalizations for Alcohol Related Disease per 100,000 (2007-2008)	460.6	473.3	394.8	468.8	455.9	434.8

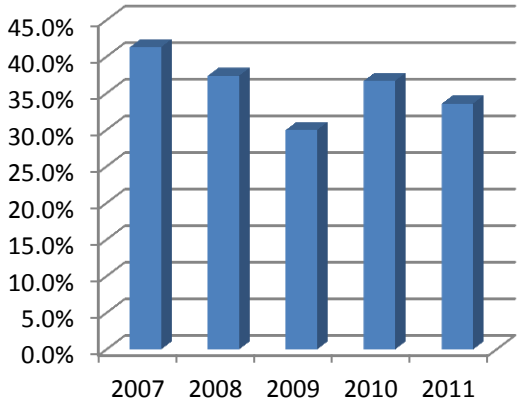
(Source: Nebraska Department of Public Health, Division of Public Health, 2010)

Trends

Percentage of DUI Related Arrests[1]



Alcohol Related Arrests SHDHD 2007-2011[1]

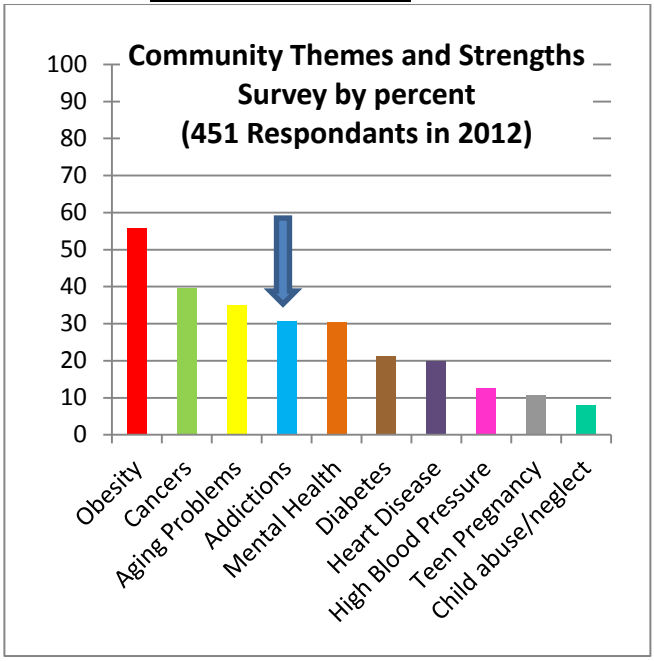


[1]Source: Nebraska Crime Commission Arrest and Offense Data

Public Health
Prevent. Promote. Protect.

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

Perceived Need



Responses to top three most troubling health–related problems in our community

Demographics

Table 17	Percent of Adults Reporting Chronic Heavy Drinking by Gender		
	2007	2008	2009
South Heartland Male	4.5%	5.4%	9.8%
Nebraska Male	5.4%	5.1%	6.6%
South Heartland Female	3.2%	1.1%	1.9%
Nebraska Female	3.6%	4.4%	3.6%
South Heartland Total	3.8%	3.2%	5.8%
Nebraska Total	4.5%	4.7%	5.1%

(Source: Nebraska Behavioral Risk Factors Survey, 2010)

Alcohol use by grade

Nebraska Data	6th	8th	10th	12th
Lifetime	14%	28%	49%	68%
Past 30 Days	3%	8%	21%	35%

Source: NRPFSS, 2010

Local college student alcohol usage and their estimates of other students' usage.

	Student usage	Estimate of peers' usage
1. Within the last year, about how often have you had an alcoholic drink?	1-1.4 times per week	2.5 - 3.3 times a week
2. When you drink alcohol how many drinks do you typically drink in one sitting?	4.0- 5.7 drinks in one sitting	5.9 - 7.5 drinks
3. Think back over the last 30 days. How many times have you had 5 or more alcoholic drinks (for males, 4 for females) in one sitting?	2.2 - 3.4 times	5.5 - 6.6 times
4. Think of the one occasion during the past 30 days when you drank the MOST. How many alcoholic drinks did you have?	5.6 - 6.9 drinks	8.9 -9.2 drinks

In general, students greatly overestimate the amount of drinking behavior of <u>other</u> students compared to their own reported drinking behavior. They estimate <u>other</u> students (1) drink two and a half times more frequently, (2) typically drink 50% more in one sitting, (3) binge drink one and a half times more frequently, and (4) drink 59% more when they drank the most number of drinks in one sitting (in the last 30 days).

Note: Lower rates are indicative of students who have been involved in extensive alcohol related prevention programs. Higher rates indicated students who have not been offered such programs.

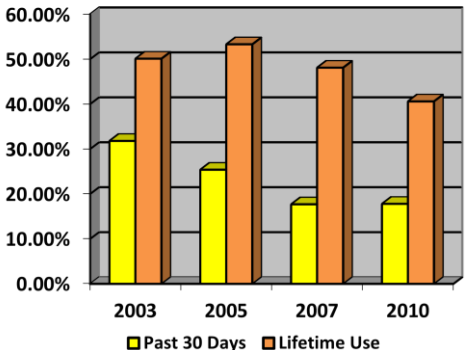
Source: Analysis of local colleges Alcohol Survey (Fall, 2011)

Fact Sheet
Tobacco Use

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

Incidence and Prevalence

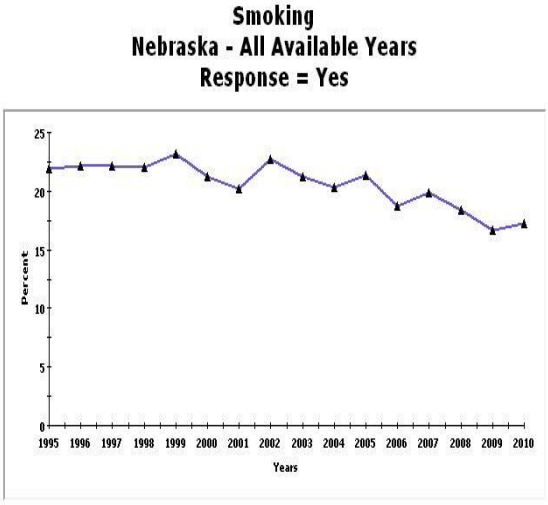
Cigarette use among SHDHD Youth, 12th Grade[1] (2010) by percent



	6th Grade		8th Grade		10th Grade		12th Grade	
	LT	30D	LT	30D	LT	30D	LT	30D
Smokeless	2%	1%	7%	2%	17%	8%	2%	14%
Cigarettes	4%	1%	15%	5%	28%	12%	4.3%	21%
Any	6%	1%	17%	6%	32%	49%	49%	27%

[1]Source: NRPFSS, 2010

Tobacco Use Aged 18+ (1995-2010), by Percent



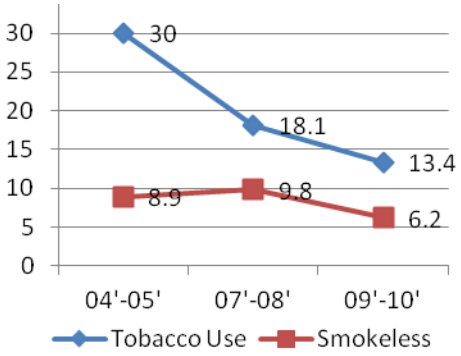
Adults who currently smoke by percent (BRFSS 2004-2010)

NE	Adams	Clay	Nuckolls	Webster
19%	18%	14%	14%	15%

Source: County Health Rankings, 2012

Current Tobacco Use among Adults Aged 18+ SHDHD- , '05-'10

by percent



Sources: NE BRFSS Data: 2004- 2010

Economic Impact

Estimated Smoking Attributable Expenditures - Nebraska (2012)

- **$573.** Residents' state & federal tax burden from smoking-caused government expenditures
- **$537 million:** Annual health care costs in Nebraska directly caused by smoking
- **$134 million:** Portion covered by the state Medicaid program

Source: The Toll of Tobacco in Nebraska, *Tobacco Free Kids.org*.

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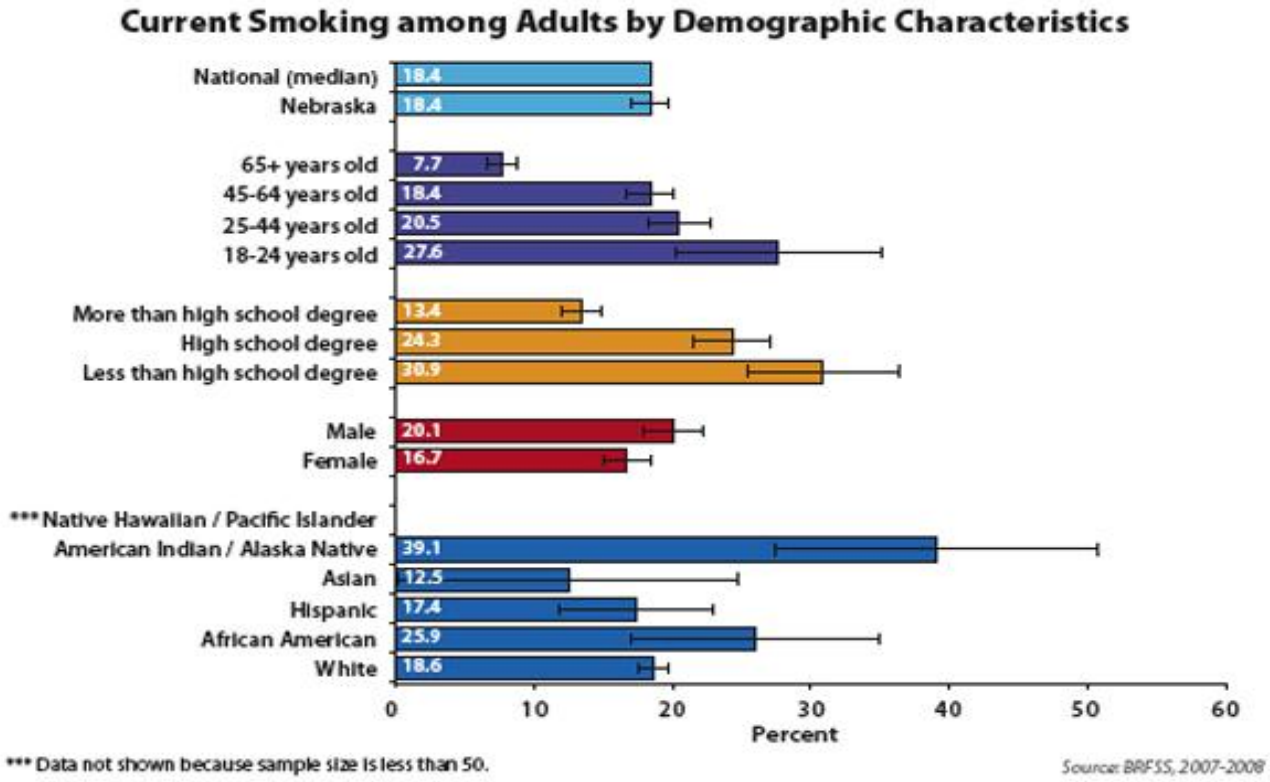
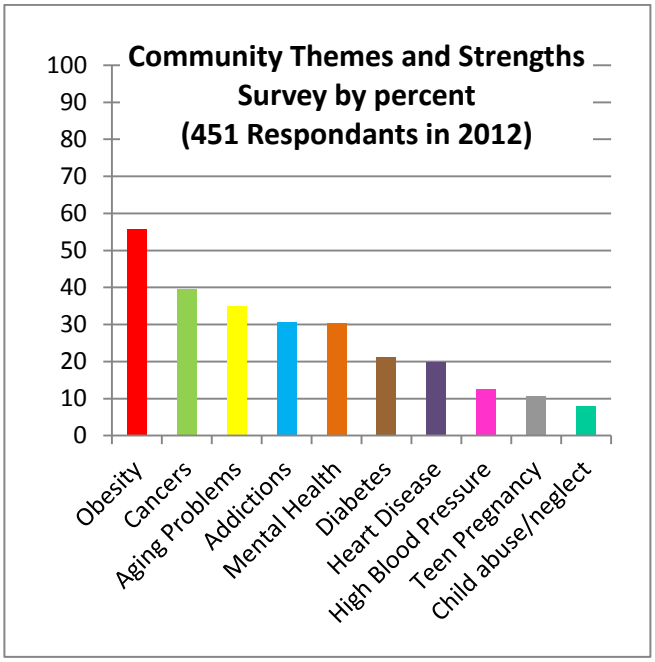
Demographics

Nebraska Tobacco Prevention and Control Strategic Plan (CDC, 2007-2008)



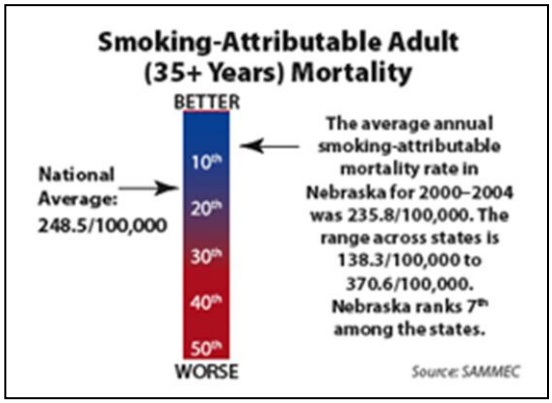
Perceived Need



Responses to top three most troubling health–related problems in our community

Sources: ***Sources:*** *Nebraska Behavioral Risk Factor Surveillance System (BRFSS), Nebraska Youth Risk Behavior Survey (YRBS), Nebraska Youth Tobacco Survey (YTS), Nebraska Vital Statistics, Nebraska Adult Tobacco/Social Climate Survey, Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), U.S. Centers for Disease Control and Prevention, Campaign for Tobacco-Free Kids*

Mortality



Tobacco Use Facts:

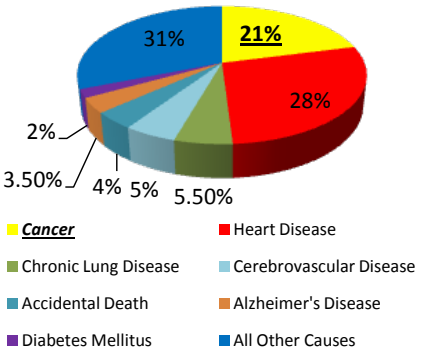
- 96,000 Children are exposed to secondhand smoke at home
- Including both cigarette and smokeless tobacco marketing, the tobacco companies spent $10.5 billion on marketing in 2008, or nearly $29 million each day.[1,2]
- Nearly 2,200 Nebraskans die each year from smoking

Fact Sheet

Cancer

Incidence and Prevalence

Leading Causes of Death
SHDHD 2010 (by percent)



Cancer Incidence Rates (per 100,000 population)
2004-2008 (combined)

	Adams	Clay	Webster	Nuckolls	SHDHD	NE
LUNG cancer	67.4	88.8	68.3	38.9	66.7	64.8
BREAST cancer	130.2	85.3	154.2	127.6	125.3	125.3
CERVICAL cancer	5.4	13.1	29.7	5.7	8.7	6.9
COLORECTAL cancer	60.7	68.6	96.4	63.0	65.2	55.3
PROSTATE cancer	152.4	235.6	163.3	144.1	167.0	157.4
MELANOMA	21.5	38.6	12.4	34.0	24.4	17.9
LYMPHOMA	23.1	31.0	9.4	30.6	24.4	24.0
LEUKEMIA	9.8	15.0	26.9	10.1	12.1	14.4

Source: Nebraska Cancer Registry

Mortality

Age-Adjusted Mortality Rates (per 100,000 population)
2006-2010 (combined)

	Adams	Clay	Webster	Nuckolls	SHDHD	NE
LUNG cancer	48.2	68.7	41.8	31.2	47.9	46.7
BREAST cancer	21.7	10.6	7.2	22.6	18.4	20.3
CERVICAL cancer	0.0	0.0	0.0	0.0	0.0	1.8
COLORECTAL cancer	12.4	20.2	37.7	16.8	16.6	18.0
PROSTATE cancer	19.7	32.7	26.4	29.8	24.0	23.5
MELANOMA	4.8	4.0	4.8	4.7	4.7	3.0
LYMPHOMA	8.1	16.0	7.7	4.0	8.8	7.4
LEUKEMIA	7.1	11.1	8.2	1.9	7.1	6.9

Source: Nebraska Death Certificate Data

Breast Cancer Deaths-Males
Nebraska, 2006-2007

2006 - 1

2007 - 2

2008 - 1

2009 - 1

2010 - 5

Source: Nebraska 2010 Vital Statistics Report

Morbidity

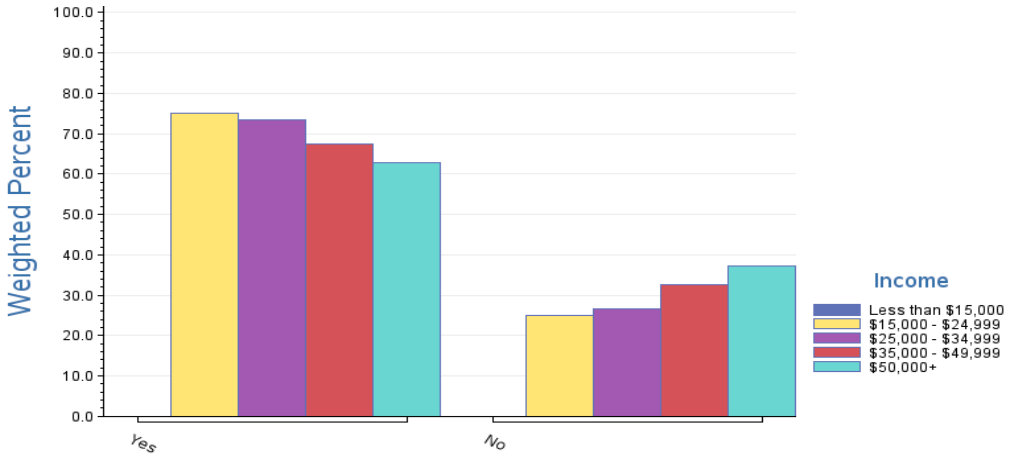
Nebraska Resident Acute Hospital Discharges
2001-2010, SHDHD

Type of Cancer	Year										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Oral	4	1	2	5	4	2	3	2	0	8	31
Digestive	68	54	57	45	49	48	51	53	44	32	501
Respiratory	18	41	17	21	27	24	23	33	29	23	256
Skin, Breast, Bone	10	11	15	13	7	12	18	19	22	17	144
Genitourinary	49	46	36	44	43	44	50	43	45	33	433
Unspecified	82	58	64	52	80	73	33	22	42	36	542
Lymphatic	24	22	19	26	13	18	12	29	23	8	194
Benign	55	52	39	36	40	34	32	39	34	36	397
Total	310	285	249	242	263	255	222	240	239	193	2498

Behavioral Risk Factors (by Percent)

Women Aged 40+ Who Have Had a Mammogram in the Past Two Years SHDHD, 2010

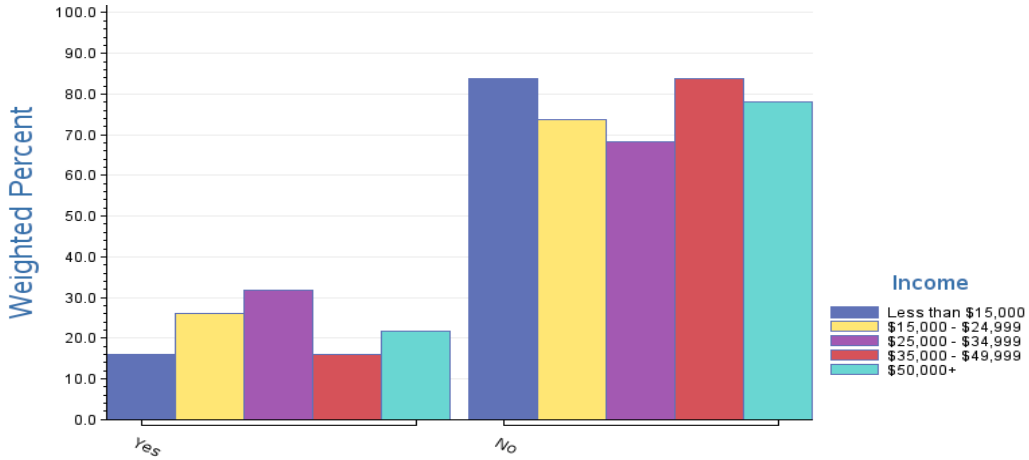
Source: Nebraska BRFSS, 2010



According to the 2010 NE BRFSS Report, 67.9% of the female respondents aged 40+ in the SHDHD coverage area had a mammogram in the past two years, compared to 71.5% statewide.

Adults Aged 50+ Who Have Had a Blood Stool Test in the Past Two Years SHDHD, 2010

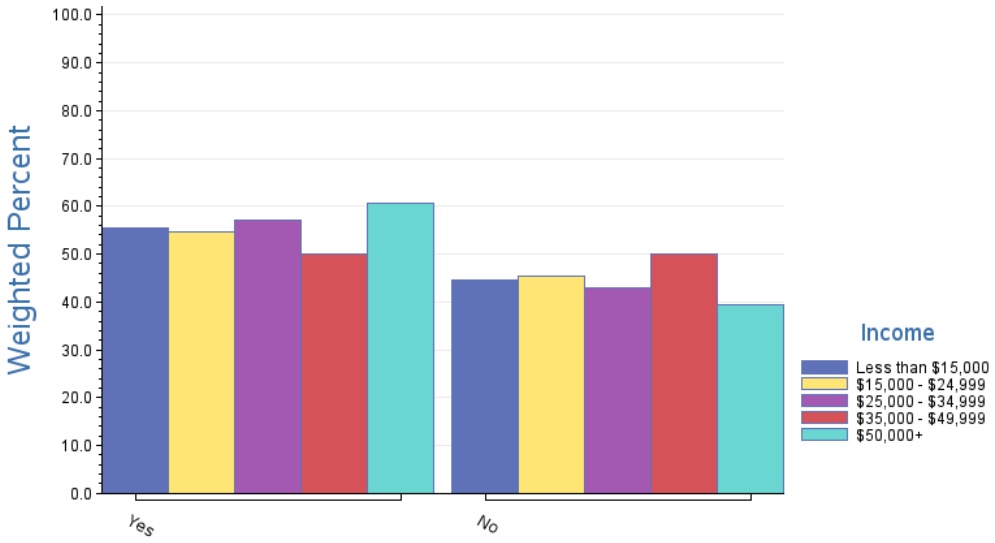
Source: Nebraska BRFSS, 2010



According to the 2010 NE BRFSS Report, 23.2% of the respondents aged 50+ in the SHDHD coverage area had a blood stool test in the past two years, compared to 15.3% statewide.

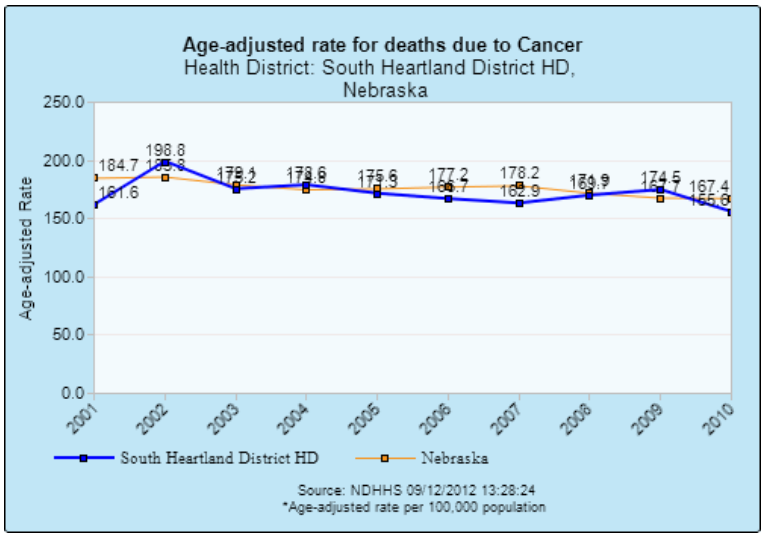
Adults Aged 50+ Who Have Had a Sigmoidoscopy or Colonoscopy in the Past Two Years
SHDHD, 2010

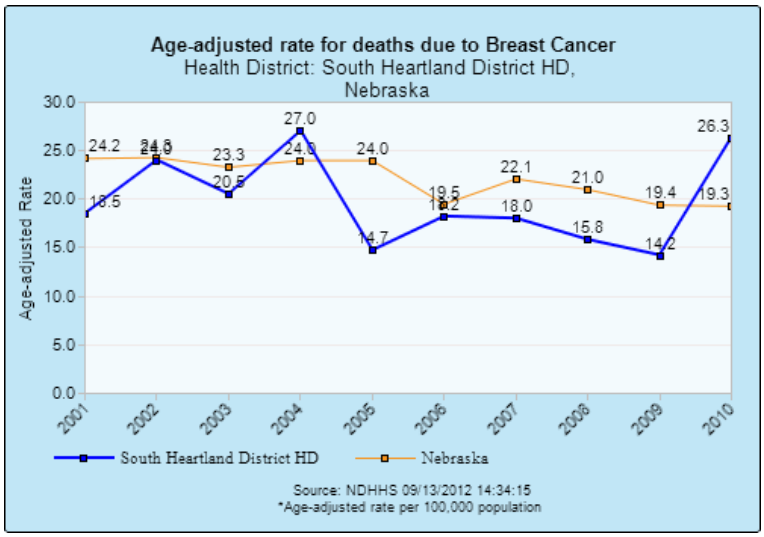
Source: Nebraska BRFSS, 2010

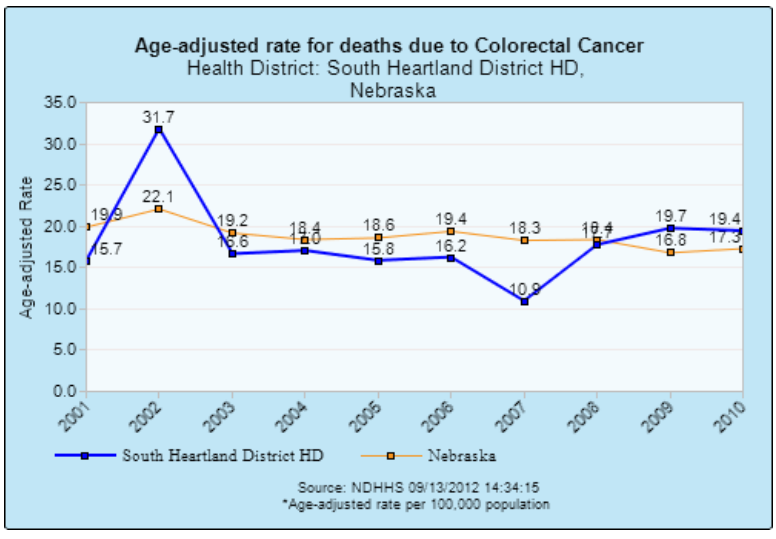


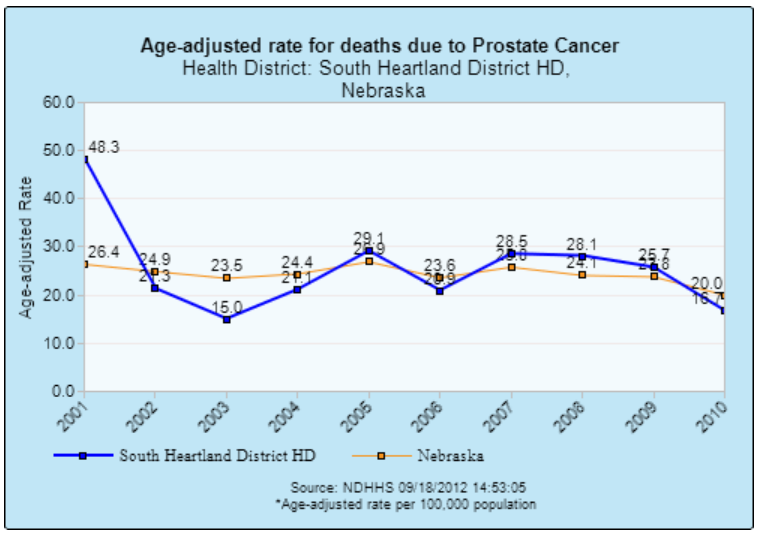
According to the 2010 NE BRFSS Report, 55.7% of the respondents aged 50+ in the SHDHD coverage area had a sigmoidoscopy or colonoscopy in the past two years, compared to 61.8% statewide.

Trends









Demographics

Cancer Incidence
Number of Cases & Rates, All Sites and Top Ten Primary Sites, By
Race and Ethnicity
Nebraska (2000-2009)

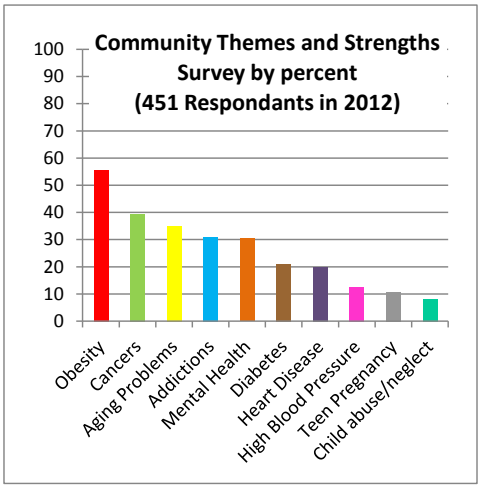
	White			African-American			Native American			Asian/Pacific Islander			Hispanic		
	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate
	All Sites	83,663	473.5	All Sites	2,471	513.8	All Sites	343	371.9	All Sites	453	287.2	All Sites	1,330	278.7
Rank															
1	Prostate	12,085	152.3	Prostate	423	206.0	Lung & Bronchus	44	58.8	Lung & Bronchus	63	43.6	Female Breast	152	60.2
2	Female Breast	12,032	129.3	Lung & Bronchus	398	89.1	Female Breast	40	68.5	Colon & Rectum	62	50.0	Colon & Rectum	130	31.7
3	Lung & Bronchus	11,219	63.3	Female Breast	324	116.6	Colon & Rectum	40	44.7	Female Breast	55	54.1	Prostate	125	70.6
4	Colon & Rectum	10,055	55.5	Colon & Rectum	292	66.4	Kidney & Renal Pelvis	36	34.1	Prostate	36	72.5	Lung & Bronchus	107	31.3
5	Urinary Bladder	3,871	21.4	Kidney & Renal Pelvis	100	20.6	Prostate	30	84.8	Liver & Intrahepatic Bile Duct	29	17.1	Thyroid	68	9.1
6	Non-Hodgkin Lymphoma	3,634	20.6	Non-Hodgkin Lymphoma	82	15.3	Non-Hodgkin Lymphoma	15	16.2	Non-Hodgkin Lymphoma	25	13.2	Kidney & Renal Pelvis	65	13.0
7	Melanoma	2,656	15.6	Pancreas	68	15.4	Liver & Intrahepatic Bile Duct	13	15.3	Thyroid	22	8.3	Leukemia	62	7.7
8	Kidney & Renal Pelvis	2,633	15.0	Liver & Intrahepatic Bile Duct	61	11.4	Oral Cavity & Pharynx	13	13.7	Uterine Cervix	19	17.4	Non-Hodgkin Lymphoma	61	11.2
9	Uterine Corpus & Unspecified	2,578	27.6	Myeloma	56	12.1	Leukemia	11	10.1	Oral Cavity & Pharynx	18	8.9	Stomach	52	12.7
10	Leukemia	2,471	13.9	Urinary Bladder	55	12.6	Uterine Corpus & Unspecified	8	14.7	Pancreas	14	10.5	Liver & Intrahepatic Bile Duct	46	12.3

Rates are per 100,000 population, excluding gender-specific sites (prostate, female breast, ovary), which are per 100,000 male or female population. All rates are age-adjusted to the 2000 U.S. population.

Ways to Reduce Cancer Incidence and Death

- Screening
- Vaccines (HPV, Hepatitis B)
- Receive regular medical care
- Avoid tobacco and second-hand smoke
- Limit alcohol use
- Avoid excessive exposure to UV rays from the sun and tanning beds
- Eat a diet rich in fruits and vegetables
- Maintain a healthy weight
- Be physically active
- Reduce Radon levels in homes

Perceived Need

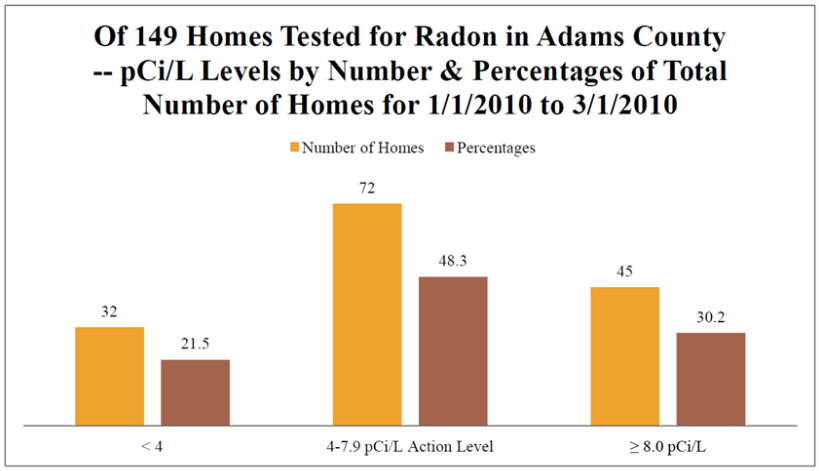


Responses to top three most troubling health–related problems in our community

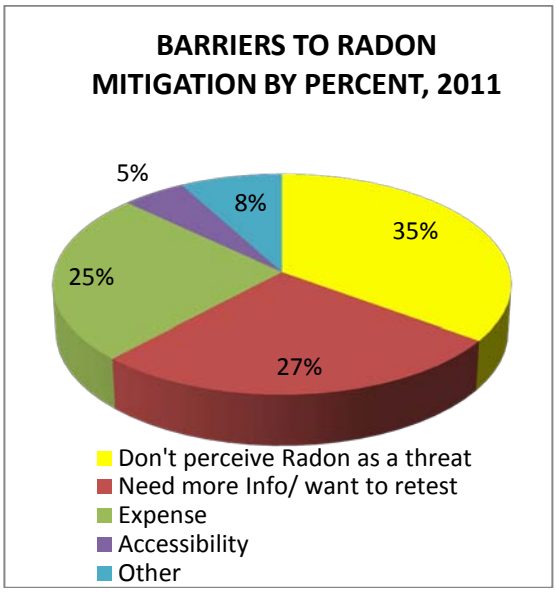
Fact Sheet

Environmental- Radon / Air Quality

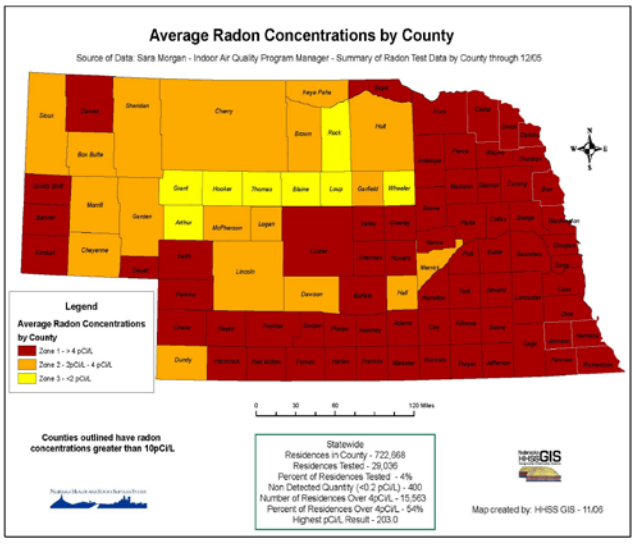
Incidence and Prevalence



The Surgeon General of the United States issued a Health Advisory in 2005 warning Americans about the health risk from exposure to radon in indoor air. The Nation's Chief Physician urged Americans to test their homes to find out how much radon they might be breathing. Dr. Carmona also stressed the need to remedy the problem as soon as possible when the radon level is 4 pCi/L or more. Dr. Carmona noted that more than 20,000 Americans die of radon-related lung cancer each year.
Source: EPA: Radon Health Risks, 2012



Results from a telephone survey conducted on 60 South Heartland District respondents with elevated residential radon levels (2011).



- Average radon levels above 4pCi/L are indicated in red.
- South Heartland has reported results as high as 63.4 pCi/L.
- Approximately 78% of homes tested in 2011 were found to have levels greater than 4pCi/L.

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Trends

SHDHD Radon Program Test Results, Adams County, 2010-2012[1]

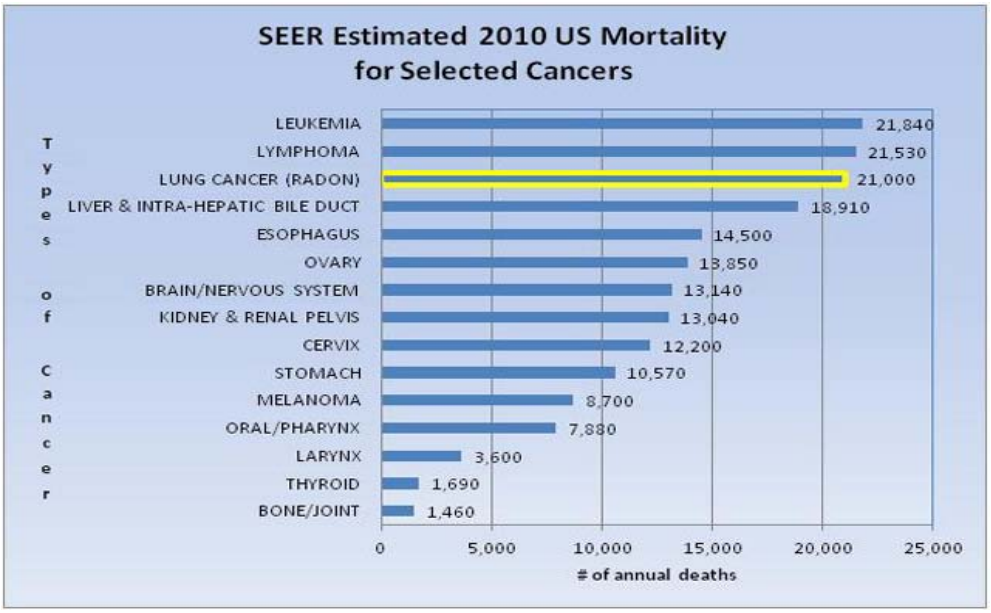
County & Testing Year	Average Indoor Radon Level (pCi/L)	Highest Test Result	# Results over 4 pCi/L	% Test Results over 4 pCi/L
Adams, 2010	7.2	52	149	78.5%
Adams, 2011	7.5	37.9	133	78%
Adams, 2012	6.9	19.1	60	74%
Nebraska Summary through 12/2009[1]	5.9	203.0	39,739	57%

[1]*Source: http://dhhs.ne.gov/publichealth/Documents/countydata09.pdf*

SHDHD Radon Program Test Results, 2011; 2012[1]

County	Avg Indoor Radon Level (2011; 2012) (pCi/L)	Highest Result (2011; 2012)	# Results above 4 pCi/L (2011; 2012)	% Results over 4 pCi/L (2011; 2012)
Adams	7.6; 7.1	31.9; 19.1	136; 64	80%; 76%
Clay	8.3; 9.3	15.6; 25.2	11; 16	85%; 80%
Nuckolls	11.0; 10.3	63.4; 21.2	27; 18	84%; 95%
Webster	11.0: 10.8	39.9; 23.5	15; 13	88%; 100%

[1]Results from rapid tests performed by Air Check, Inc. with a usual exposure of 72 to 168 hours (three to seven days).



Sources: National Cancer Institute's 2010 SEER estimated US mortality numbers, EPA estimates annual radon-related lung cancer deaths, 2003.

Rates of Asthma and Lung Disease – SHDHD

	Adams	Clay	Nuckolls	Webster	SHDHD	Nebraska
Asthma inpatient hospital discharges (patients), per 10,000 (2007-2008)[1]	42.8	11.5	36.9	45.4	40.6	49.7
Deaths due to COPD (aka chronic lower respiratory disease), per 100,000 (2004-2008)[2]	29.1	50.2	53.9	40.0	36.7	46.3
Chronic lung disease deaths, per 100,000 (2004-2008)[3]	23.7	38.9	49.7	32.8	30.3	40.6

[1]Source: Nebraska DHSS, Division of Public Health, Community Health Section, Public Health Support Unit, Hospital Discharge data.

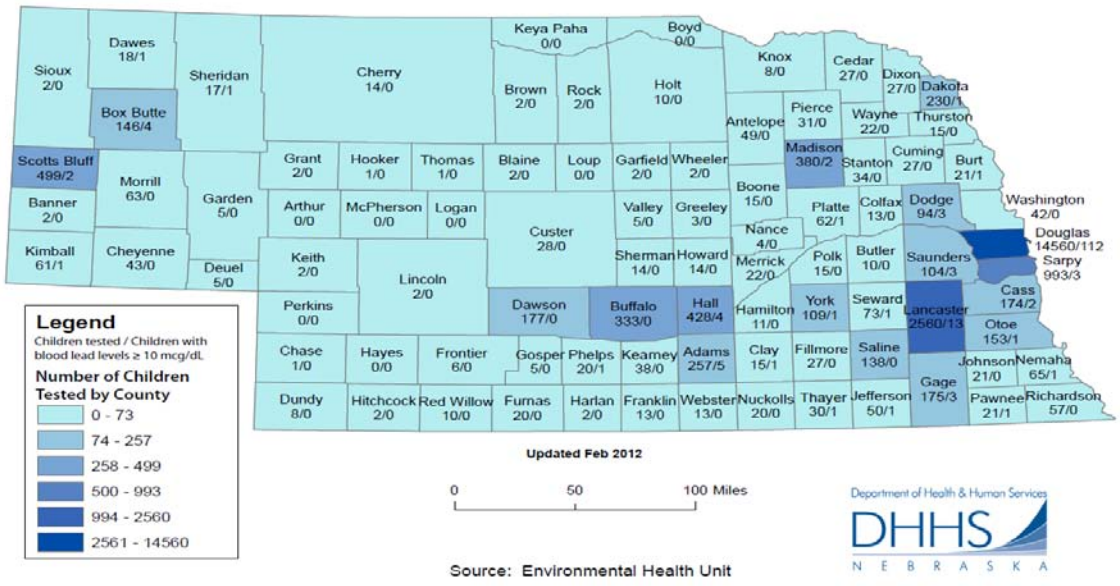
[2]Age-adjusted to 2000 standard. Source: Nebraska DHSS, Division of Public Health, Community Health Section, Public Health Support Unit, Vital Statistics data.

[3] Source: Nebraska DHSS, Division of Public Health, Community Health Section, Public Health Support Unit, Vital Statistics data.

Environmental- Lead

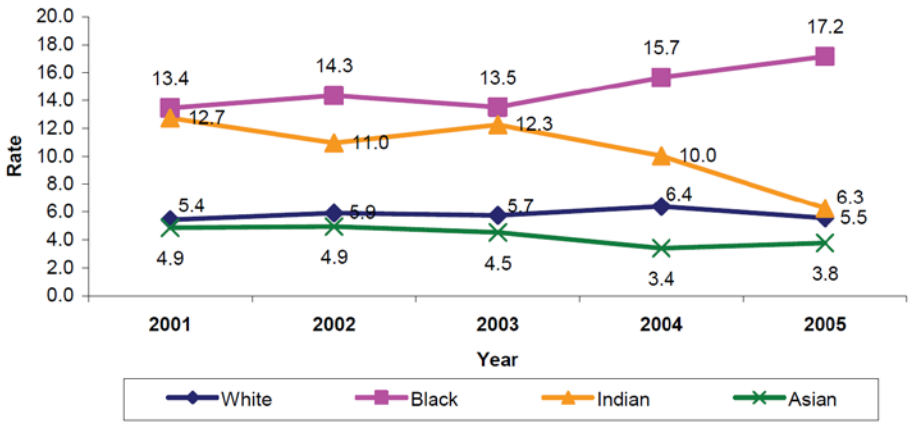
Elevated Blood Lead Level (EBLL) Rates # per 100 children screened; EBLL is BLL > 10 µg/dL					
Year	**2001**	**2002**	**2003**	**2004**	**2005**
Adams	7.69	7.27	3.74	5.52	5.61
Clay	5.00	1.96	14.29	3.84	5.48
Nuckolls	0	0	2.38	0	0
Webster	6.67	0	3.57	8.00	5.56
SHDHD	6.86	3.91	5.25	5.27	5.21
NE	2.04	1.38	1.54	1.37	1.33
US	3.03	2.56	2.00	1.76	1.58

2010 Nebraska Blood Lead Tests Compared with the Number of Elevated Blood Lead Levels in Children Under Age 7



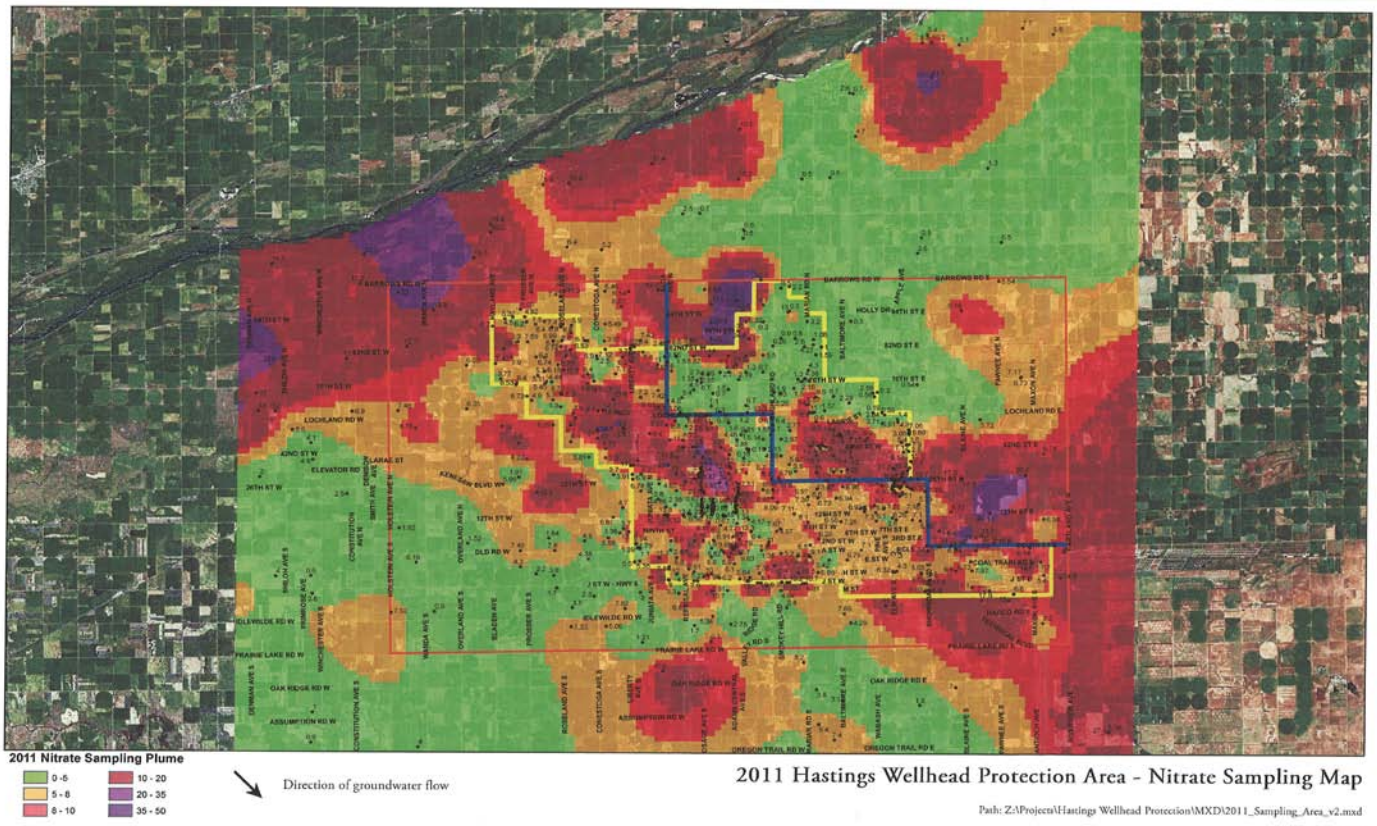
- **Lead poisoning screening rate of children by race**

Fig. 2.4 Lead Poisoning Screening Rate by Race



Environmental- Water Quality

Nitrate Levels



Nitrate levels identified in red and purple (above 10 ppm) indicate unsafe levels for drinking water. Groundwater flow from Northwest to Southeast is being monitored for nitrate levels that may cause nitrate contamination. Nitrate violations in public water systems between 2004 and 2012 have been minimal.

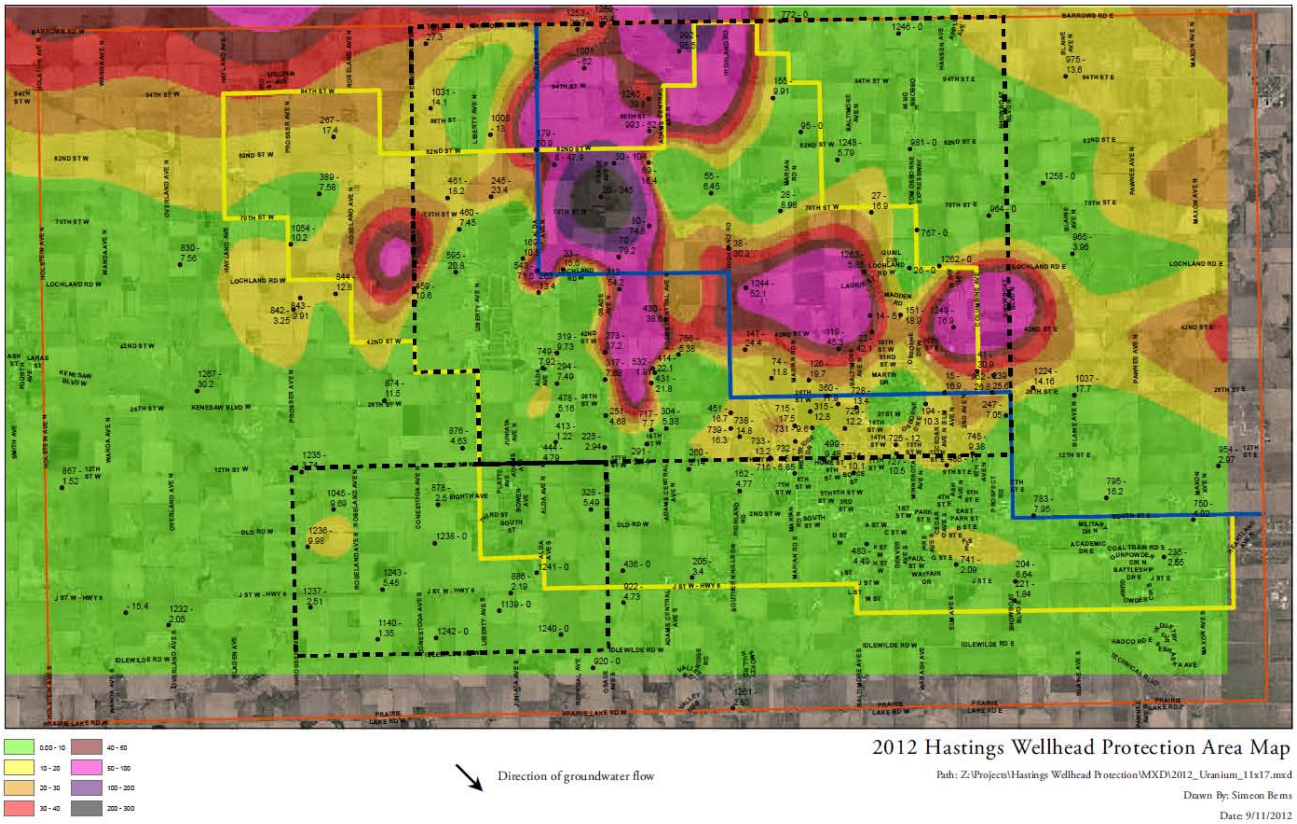
County/City Population* # Nitrate Violations (Highlights)

City	Population	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
Hastings	24,064			1							1
Edgar	539	1								2	3
Glenvil	332							1			1
Hardy	179				1						1
Superior	2,055			1							1
Blue Hill	867				1						1
Guide Rock	245		1								1
Total		1	1	2	2	0	0	1	0	2	9

Reported Nitrate violations for cities and counties within South Heartland District, 2004-2011.

- Population data from US Census Bureau, 2000 census. http://www.census.gov/
- Rules and Regulations for Nebraska public water systems can be found here: http://www.dhhs.ne.gov/reg/t179.htm
- * Population served by Community Water Systems

Uranium Levels



Uranium levels in red, pink, purple and grey (above 35 mci) indicate unsafe levels for drinking water. Studies suggest that ingesting of high levels of uranium may be associated with an increased risk of kidney damage[1]. Exposure to soluble uranium in drinking water has not been shown to increase the risk of developing cancer. The Environmental Protection Agency (EPA) has estimated that the additional lifetime risk associated with drinking water that contains uranium at the concentration allowed in a public water supply is about 1 in 10,000. One fatal cancer in per 10,000 people exposed might occur from Uranium exposure after 70 years of drinking approximately two liters of public water per day.

[1]Source: University of Nebraska-Lincoln Extension, Institute of Agricultural and Natural Resources, (2008).

Fact Sheet

Reproductive Health / Maternal & Child Health

Incidence and Prevalence/Demographics

Births by Sex, Race and Hispanic Origin, By Place of Residence, 2010

Source: Nebraska 2010 Vital Statistics Report

Place	Total Births	Sex		Race					Hispanic Origin**
		M	F	White	Black	Am. Indian	Asian	Other	
State	25,916	13,217	12,699	20,319	1,759	417	687	2,734	3,939
Adams	412	204	208	357	1	1	3	50	59
Hastings	365	179	186	311	1	1	3	49	58
Balance of County	47	25	22	46	0	0	0	1	1
Clay	65	41	24	55	0	1	0	9	9
Nuckolls	37	16	21	34	0	0	0	3	3
Webster	40	15	25	37	1	0	0	2	4

** Persons of Hispanic origin may be any race.

Teen Births by Place of Residence, 2010 and 2006-2010

Source: Nebraska 2010 Vital Statistics Report

Place	2010			2006-2010		
	Teen Births	Total Births	% Teen Births	Teen Births	Total Births	% Teen Births
State	1,975	25,916	7.6	10,968	133,497	8.2
Adams	33	412	8.0	224	2,122	10.6
Clay	5	65	7.7	31	368	8.4
Nuckolls	*	37	*	21	208	10.1
Webster	*	40	*	10	192	5.2

Teen Births = Ages 19 and under
* For reasons of confidentiality, Teen Births are not provided for 2010 if there were less than five for any given county.

Incidence of SIDS per 1000 Live Births (2004-2008)

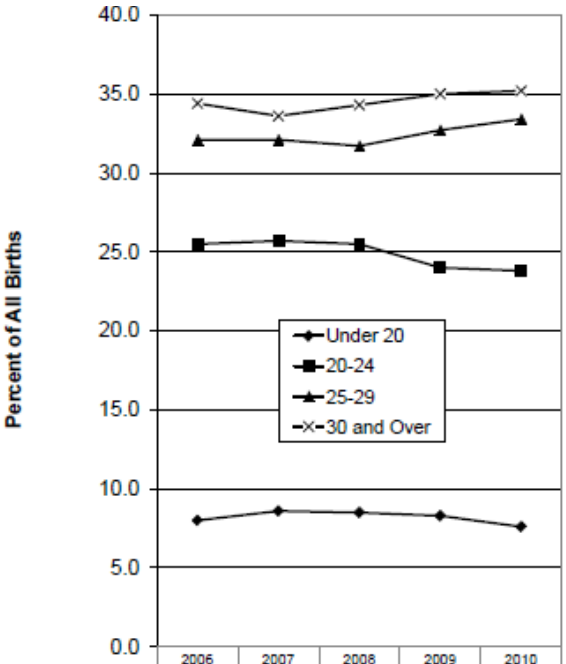
Adams	Clay	Webster	Nuckolls	South Heartland	Nebraska
0.92	0	0	4.08	1.01	0.74

Source: Nebraska DHSS, Division of Public Health, Community Health Section, Public Health Support Unit, Vital Statistics

First Trimester Prenatal Care (% of births), 2004-2008

Adams	Clay	Webster	Nuckolls	South Heartland	Nebraska
79.03	77.1	79.21	82.04	79.06	74.15

Percent of All Births by Age of Mother Nebraska, 2006-2010



	2006	2007	2008	2009	2010
Under 20	8.0	8.6	8.5	8.3	7.6
20-24	25.5	25.7	25.5	24.0	23.8
25-29	32.1	32.1	31.7	32.7	33.4
30 and Over	34.4	33.6	34.3	35.0	35.2

Source: Nebraska 2010 Vital Statistics Report

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Mortality

Infant and Neonatal Deaths by Place of Residence, 2010 and 2006-2010

Source: Nebraska 2010 Vital Statistics Report

Place	2010		2006-2010		2010		2006-2010	
	Infant Deaths	Rate	Infant Deaths	Rate	Neonatal Deaths	Rate	Neonatal Deaths	Rate
State	136	5.2	758	5.7	96	3.7	500	3.7
Adams	4	9.7	13	6.1	1	2.4	5	2.4
Hastings	4	11.0	11	6.2	1	2.7	4	2.3
Balance of County	0	-	2	5.6	0	-	1	2.8
Clay	0	-	0	-	0	-	0	-
Nuckolls	0	-	1	4.8	0	-	0	-
Webster	0	-	1	5.2	0	-	1	5.2

Infant and Neonatal death rates are per 1,000 live births.
INFANT DEATH – Death of a person under one year of age.
NEONATAL DEATH – Death of a person under 28 days of age.

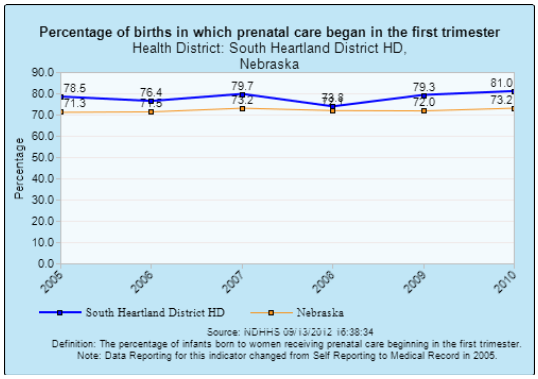
Perinatal and Fetal Deaths by Place of Residence, 2010 and 2006-2010

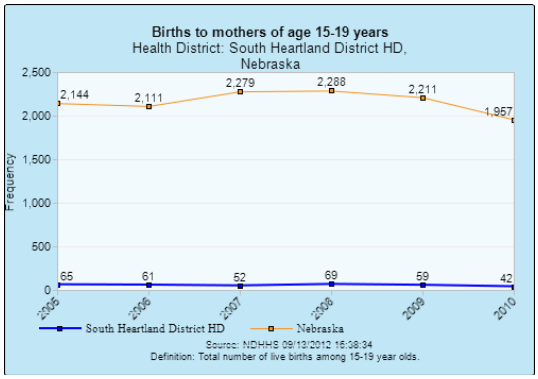
Source: Nebraska 2010 Vital Statistics Report

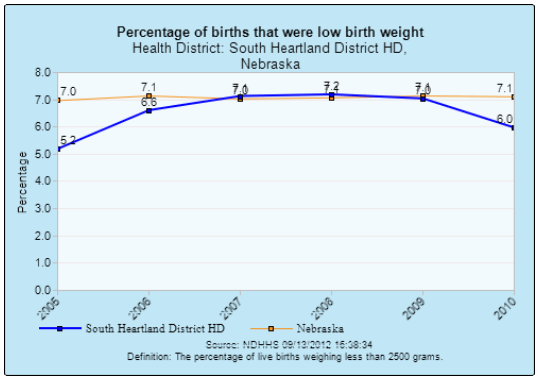
Place	2010		2006-2010		2010		2006-2010	
	Perinatal Deaths	Rate	Perinatal Deaths	Rate	Fetal Deaths	Rate	Fetal Deaths	Rate
State	229	8.8	1,273	9.5	133	5.1	773	5.8
Adams	1	2.4	10	4.7	0	-	5	2.4
Hastings	1	2.7	8	4.5	0	-	4	2.3
Balance of County	0	-	2	5.6	0	0	1	2.8
Clay	0	-	1	2.7	0	-	1	2.7
Nuckolls	0	-	1	4.8	0	-	1	4.8
Webster	0	-	2	10.4	0	-	1	5.2

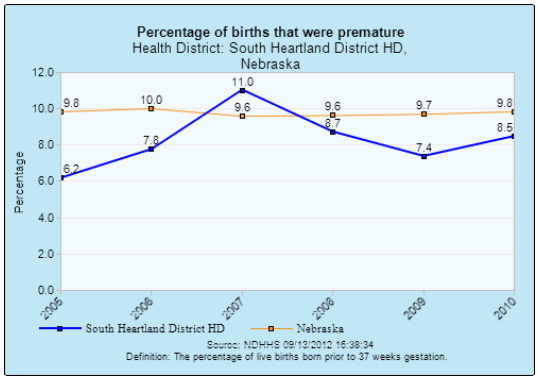
Perinatal and fetal death rates are per 1,000 live births.
PERINATAL DEATH – Fetal deaths plus neonatal deaths.
FETAL DEATH – Death prior to the complete expulsion or extraction of a product of conception from its mother, irrespective of the duration of pregnancy. Until the pregnancy has reached 20 weeks duration, it is not required that such a death be reported.

Trends









Morbidity

Medical Risk Factors of the Mother, Nebraska, 2010

Medical Risk Factors*	Number	Percent of Births
Prepregnancy Diabetes	184	0.7
Gestational Diabetes	1,290	5.0
Prepregnancy Hypertension	246	1.0
Gestational Hypertension	937	3.6
Previous Pre-Term Births	449	1.7
Poor Pregnancy Outcomes	1,109	4.3
Vaginal Bleeding	281	1.1
Infertility Treatment	260	1.1
Previous Cesarean	3,530	13.6

* More than one medical risk factor may be reported.

Source: Nebraska 2010 Vital Statistics Report

Birth Defects by County of Residence, 2010 and 2006-2010

	2010		2006-2010	
Place	**Number of Cases**	**Percent of Total Births***	**Number of Cases**	**Percent of Total Births***
State	917	3.5	5,970	4.4
Adams	27	6.6	103	4.8
Clay	4	6.2	9	2.4
Nuckolls	2	5.4	15	7.2
Webster	3	7.5	13	6.7

* Total number of live births and fetal deaths

Source: Nebraska 2010 Vital Statistics Report

Characteristics of Labor & Delivery, Nebraska, 2010

Characteristics of Labor and Delivery	Number	Percent of Births
Induction of Labor	7,488	28.9
Augmentation of Labor	8,131	31.4
Non-Vertex Presentation	398	1.5
Steriods	130	0.5
Antibiotics	5,587	21.6
Chorioamnionitis	183	0.7
Meconium Staining	922	3.6
Fetal Intolerance	1,957	7.6
Anesthesia	19,852	76.6

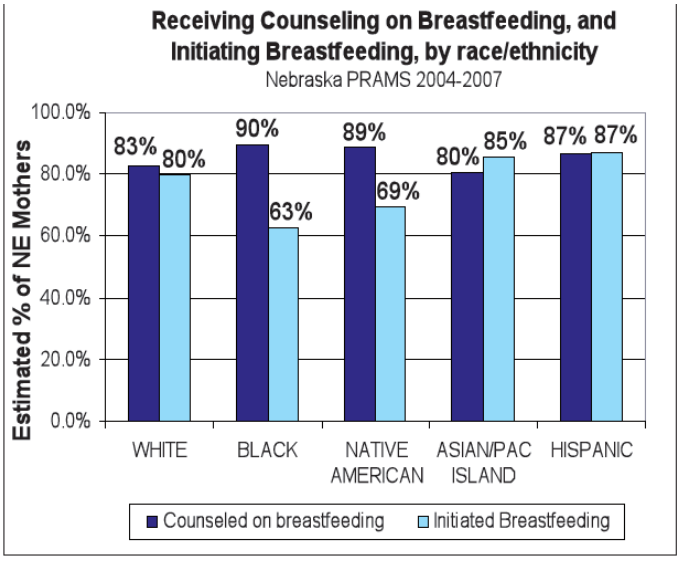
Source: Nebraska 2010 Vital Statistics Report

WIC Data From SHDHD Four Counties for a Sample Month in FY2011

-Total number of WIC participants served: 1064
-Number of Pregnant Women: 93
-Number of breastfeeding clients: 43
-Number of clients who breastfed for at least 6 months: 16
-Number of postpartum women, by county: 92
-Number of infants, by county: 246

Source: State of NE Computer data from Community Action Partnership of Mid-Nebraska WIC Program

Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) Quick Facts

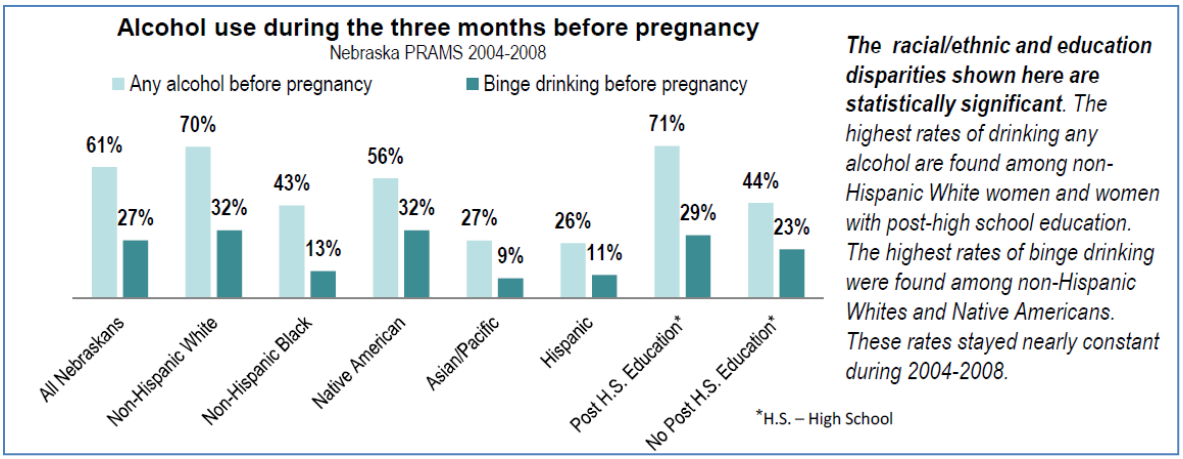


Response rates among some racial/ethnic groups were lower than 70%, (as low as 59% for Native Americans) but analysis showed that potential bias due to a low response rate would not create substantive changes in these results.

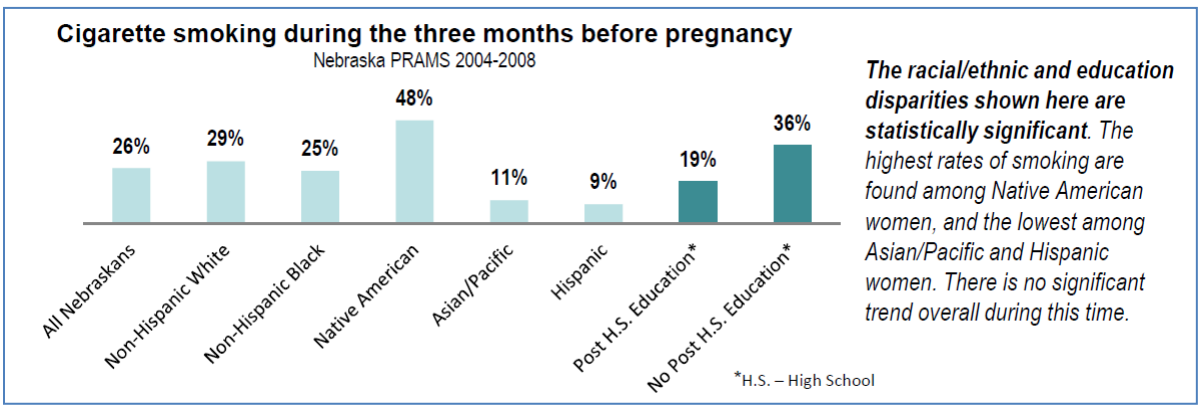
- There were statistically significant differences in breastfeeding rates by ***race/ethnicity***,* with African Americans and Native Americans more likely to receive counseling and less likely to initiate breastfeeding.

- Mothers who were covered by Medicaid during prenatal care are significantly more likely to receive counseling, but less likely to initiate breastfeeding than those who had other modes of payment (private insurance, no insurance, self-pay, Indian Health Service).

- The estimated percentage of women who initiate breastfeeding is lowest among teens, and increases with maternal age, decreasing slightly after age 30.



***The racial/ethnic and education disparities shown here are statistically significant**. The highest rates of drinking any alcohol are found among non-Hispanic White women and women with post-high school education. The highest rates of binge drinking were found among non-Hispanic Whites and Native Americans. These rates stayed nearly constant during 2004-2008.*

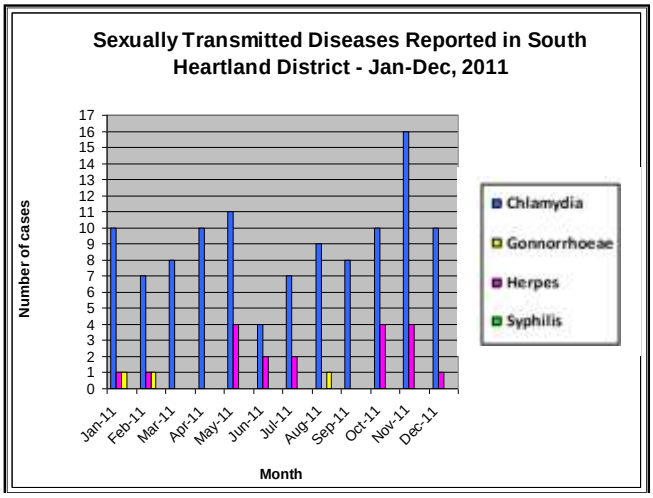


***The racial/ethnic and education disparities shown here are statistically significant**. The highest rates of smoking are found among Native American women, and the lowest among Asian/Pacific and Hispanic women. There is no significant trend overall during this time.*

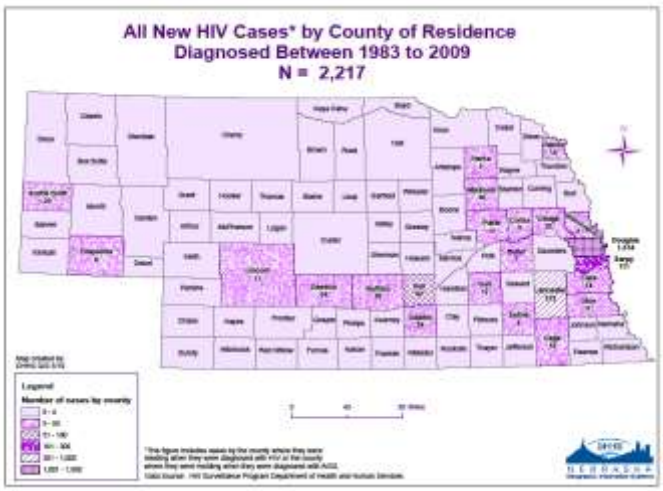
Fact Sheet

Sexually Transmitted Diseases

Incidence and Prevalence

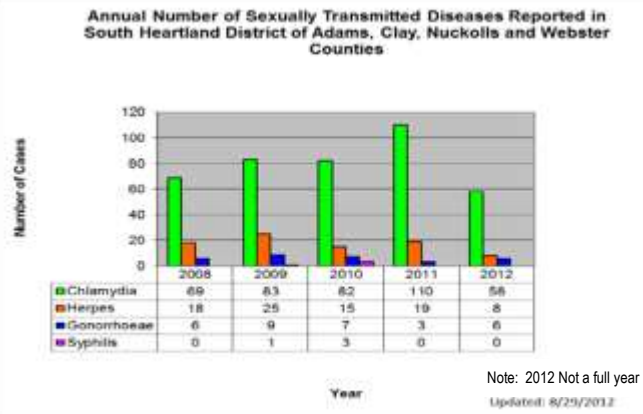


Note: "Herpes" category includes Type 1 and Type 2 of genital herpes.

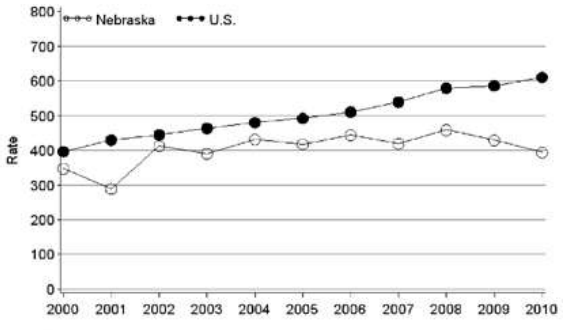


- District Total: 24 HIV cases (Adams County only)

Trends



Note: 2012 Not a full year

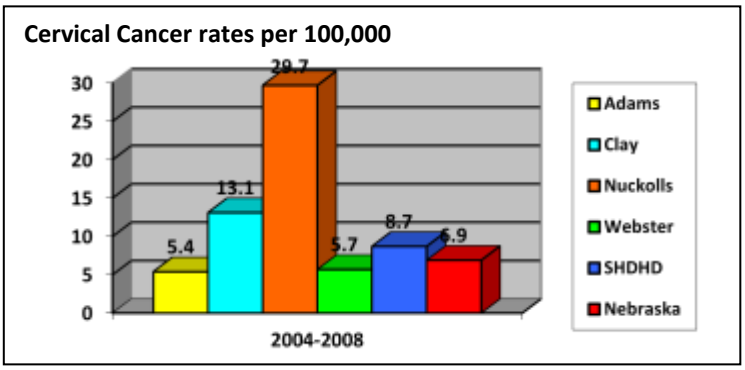


Chlamydia Rates of Infection per 100,000

- SHDHD: 177.4
- Nebraska: 280.1
- U.S.: 426.0

Chlamydia is the most commonly reported STD in the United States

Sources: SHDHD Surveillance / CDC STD Surveillance 2010



Source: Statehealthfacts.org

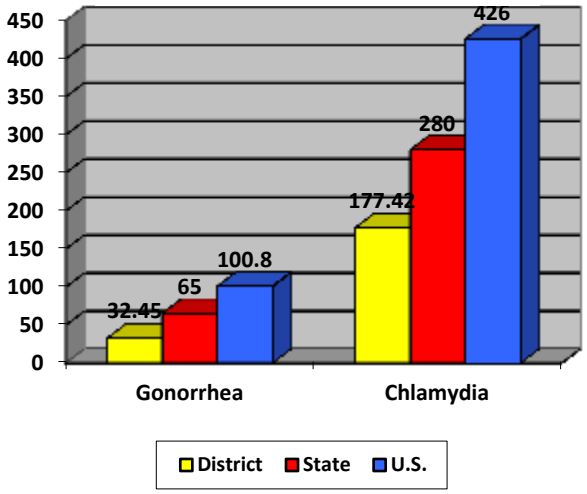
- Average annual count of HPV cancers: Nebraska = 159
- Cervical Cancer rates per 100,000 (2008): Nebraska = 6.1 / U.S.= 7.8

Public Health

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

Infection Rates: District, State, National

Infection Rates per 100,000 Chlamydia, Gonorrhea 2010



Sources: SHDHD Surveillance / CDC STD Surveillance 2010

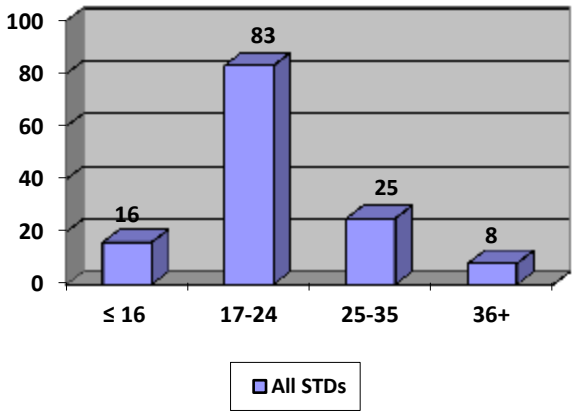
Demographics

Nebraska Infection rates were 6th lowest for Chlamydia in 2010

Screening / Economic Impact

- Less than half of people who should be screened receive recommended STD screening.
- CDC estimates that there are 19 million new infections every year in the United States.
- STDs cost the U.S. health care system $17 billion every year—and cost individuals even more in immediate and life-long health consequences.

Number of STD Infections by age group – SHDHD 2011



- Includes Gonorrhea, Chlamydia, Syphilis, Herpes
- Group Aged ≤ 16 had only Chlamydia infections

STD Rates (2003-2007)

Rates	Adams	Clay	Nuckolls	Webster	SHDHD	Nebraska
STD rate per 100,000 ages < 18	135.6	55.2	56.1	21.7	110.4	135.6
STD rate per 100,000 ages 18 +	262.6	92.9	34.4	81.9	203.1	262.6

- Sexually transmitted diseases included here are: chlamydia, gonorrhea, early syphilis, and genital herpes.

Source: Nebraska DHSS, Division of Public Health, Community Health Section, Health Promotion Unit, Sexually Transmitted Disease (STD) Program

CDC Quick Facts[1]

Bacterial Vaginosis	Having BV can increase a woman's susceptibility to other STDs. Pregnant women may deliver premature or low birth-weight babies
Chlamydia	Easy to cure, chlamydia can impact a woman's ability to have children if left untreated
Gonorrhea	In women, gonorrhea can spread into the uterus (womb) or fallopian tubes (egg canals) and cause pelvic inflammatory disease (PID).
Herpes	There is no cure for herpes, but treatment is available to reduce symptoms and decrease the risk of transmission to a partner
HIV /AIDS	STD treatment reduces an individual's ability to transmit HIV**.** Studies have shown that treating STDs in HIV-infected individuals decreases both the amount of HIV in genital secretions and how frequently HIV is found in those secretions
Human Papillomavirus	Persistent infection with high-risk human papillomavirus (HPV) can lead to development of anogenital cancers (e.g., cervical cancer).
Syphilis	Syphilis is a sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum*. It has often been called "the great imitator" because so many of the signs and symptoms are indistinguishable from those of other diseases

[1]Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2010.* Atlanta: U.S. Department of Health and Human Services; 2011

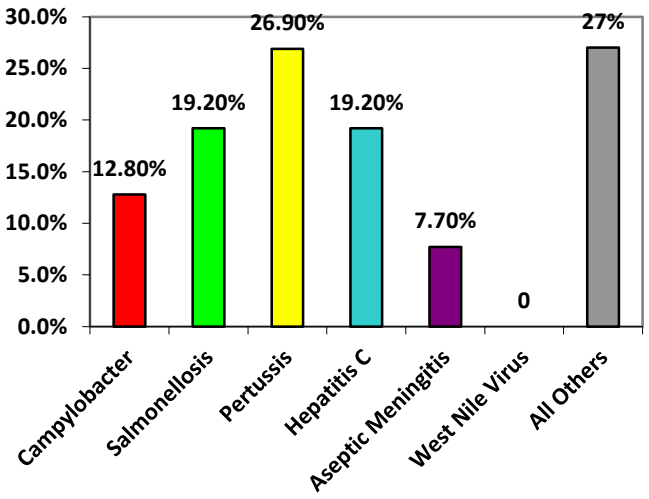
Fact Sheet

Communicable Disease

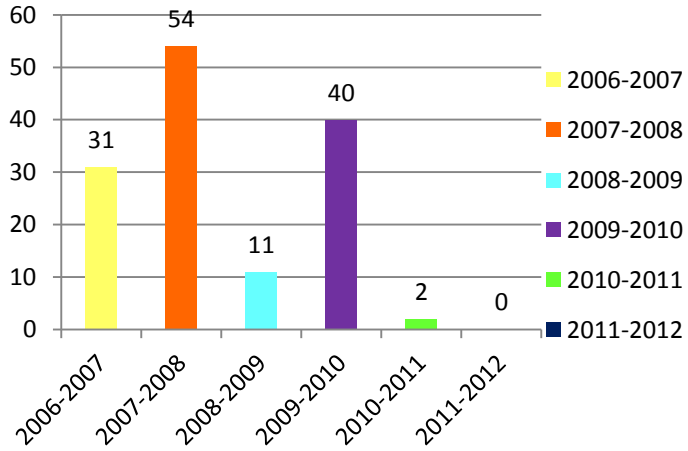
CONNECTING PEOPLE & RESOURCES
ADAMS CLAY 4 WEBSTER NUCKOLLS
STRONG & HEALTHY COMMUNITIES

Incidence and Prevalence

SHDHD Reportable Disease Investigations by Percent, 2011

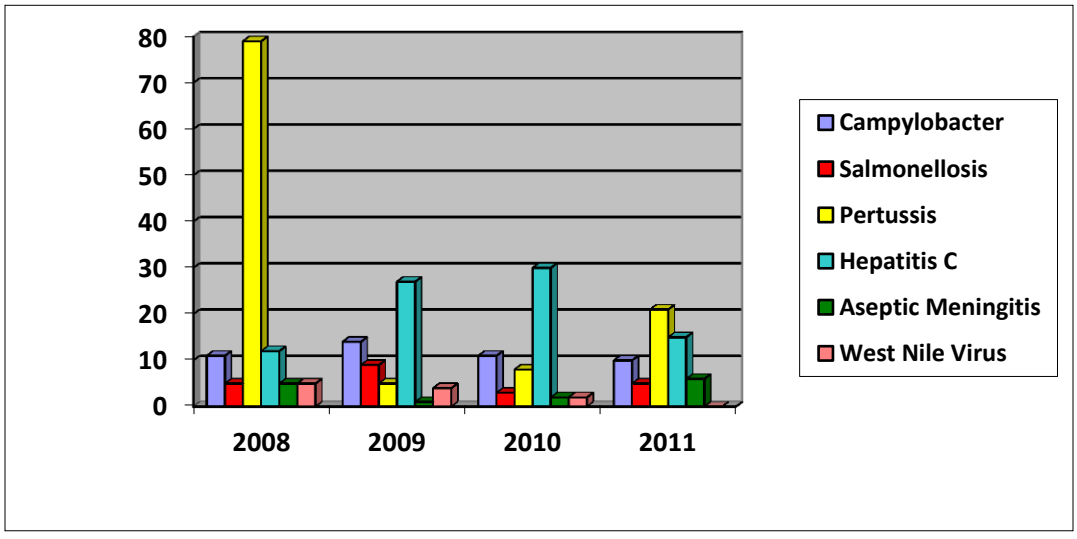


Influenza Like Illness Admissions SHDHD, 2006-2012



Trends

Reportable Diseases – SHDHD 2008-2011



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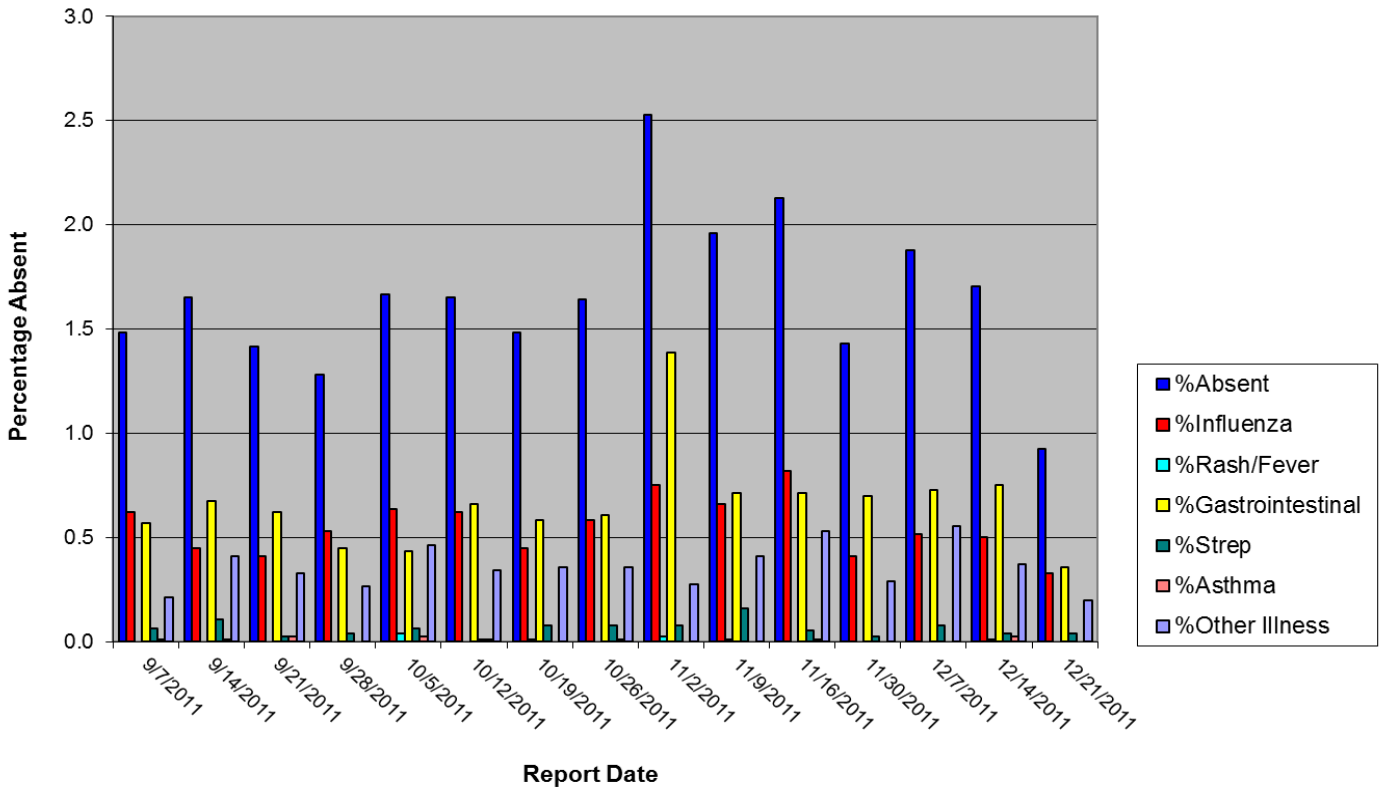
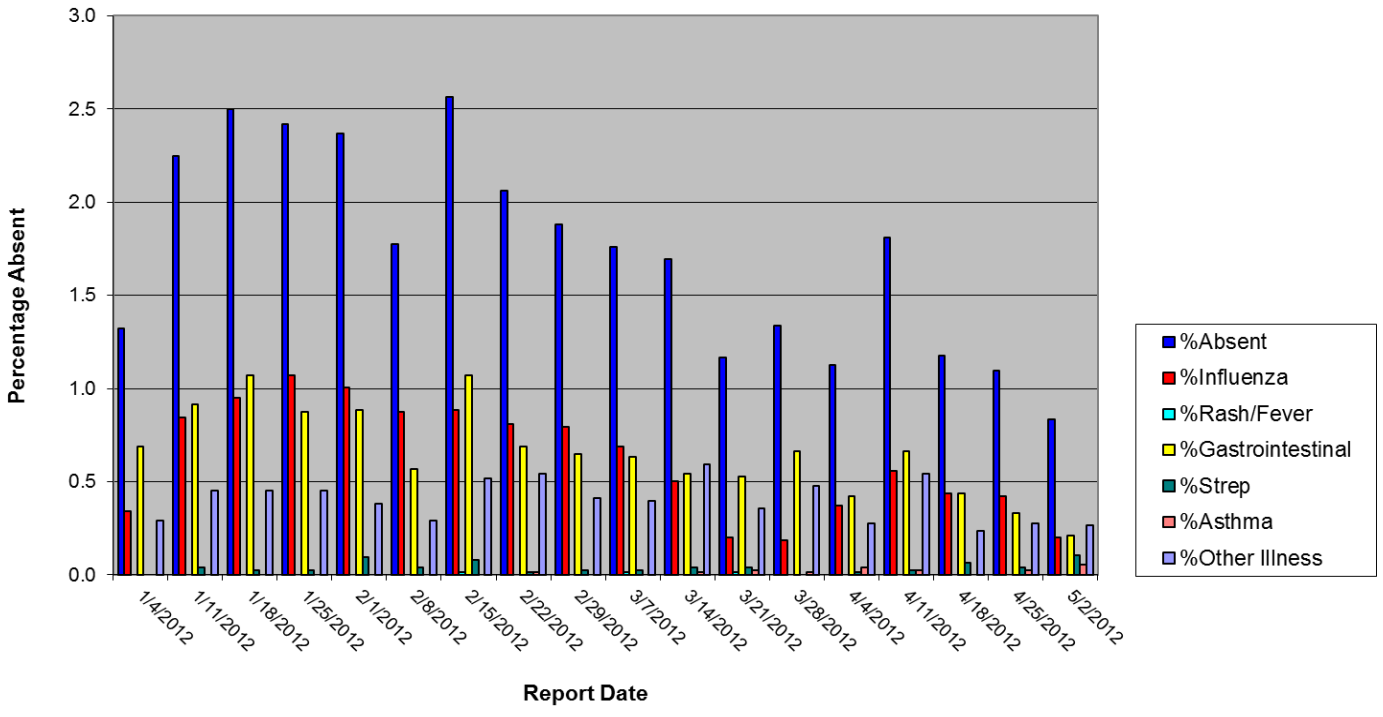
Percentage of Students Absent due to Illness in Schools in South Heartland District - Fall Semester, 2011



Percentage of Students Absent due to Illness in Schools in South Heartland District - Spring Semester, 2012



Percent of students absent due to illness in South Heartland District Schools (Adams, Clay, Nuckolls, and Webster Counties) on Wednesdays each week of fall semester for the 2011-2012 school year. Thirty-eight schools, with a total enrollment of 7,558 students, participate in this weekly.

Incidence of vaccine-preventable diseases: Hepatitis A & B (2003-2007)

	Adams	Clay	Nuckolls	Webster	SHDHD	Nebraska
Hepatitis A & B*	8.5	6.1	5.4	4.3	7.5	16.2

*Number of new hepatitis A and B cases per 100,000 population.

Source: Nebraska DHSS, Division of Public Health, Community Health Section, Public Health Support Unit.

Adult Immunizations (Age 65+)

	Adams	Clay	Nuckolls	Webster	SHDHD	Nebraska
Pneumonia* (2008)	74.1	74.1	74.1	74.1	74.1	70.7
Influenza* (2007)	79.5	79.5	79.5	79.5	79.5	76.8
Influenza* (2008)	78.3	78.3	78.3	78.3	78.3	75.7

Pneumonia (2007). Percent of BRFSS respondents aged 65+ who said they had ever had a pneumonia shot.

Influenza (2007 and 2005). Percent of BRFSS respondents aged 65+ who stated they had a flu shot in the past 12 months.

Source: Nebraska DHSS, Division of Public Health, Community Health Section, Public Health Support Unit, BRFSS.

Community Burden

- Between 5% and 20% of the U.S. population comes down with the flu every year[1] resulting in more than 200,000 hospitalizations and 36,000 deaths.[2]
- The financial costs of flu are not insignificant. Ultimately, annual influenza epidemics incur a national economic burden of $87.1 billion.

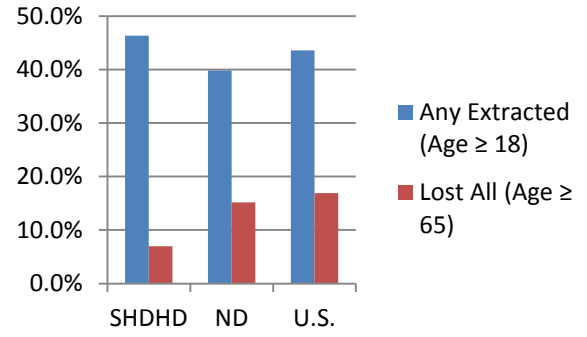
Source: Vaccine. 2007;25(27):5086-5096

Fact Sheet
Oral Health

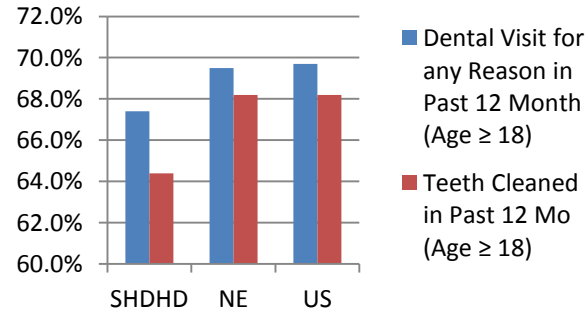
Incidence and Prevalence

Percentage of Adults Age 18+ who have had Any Teeth Extracted and Percentage of Adults Age 65+ who have Lost All Permanent Teeth due to Tooth Decay or Gum Disease, 2010

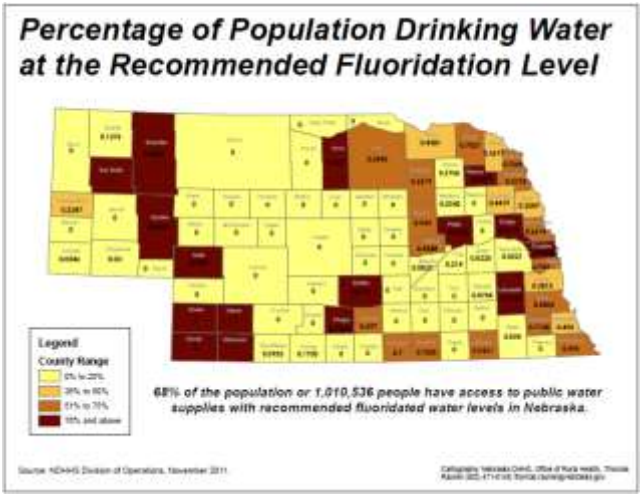
Source: BRFSS (2010)

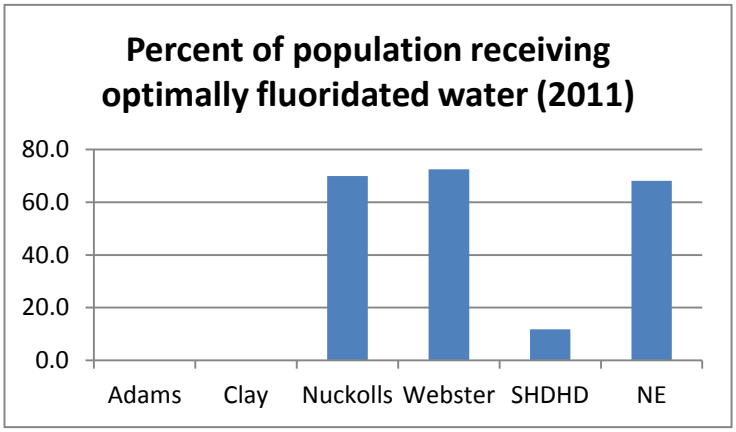


Percentage of Adults Age 18+ who have had Teeth Cleaned or Visited Dentist for Any Reason in the Past 12 Months, 2010



Source: BRFSS (2010)





Trends

Percentage of Children Receiving Any Dental Service, 2000 and 2009

State	*2000*	*2009*	*% Change*
Nebraska	*60%*	*48%*	*-20%*
Natl Avg	*27%*	*40%*	*47%*

Source: Use of Dental Services in Medicaid and CHIP, September 2011

In Nebraska...

- 60% of children experience dental disease by the third grade and 17% have untreated dental decay or cavities. (Open Mouth Survey, 2005)

In the U.S...

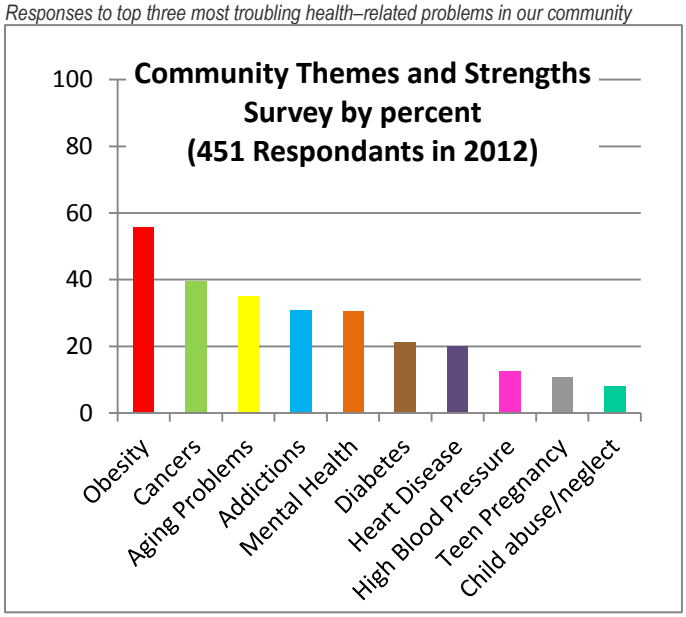
- Dental caries (tooth decay) is the single most common chronic childhood disease – 5 times more common than asthma and 7 times more common than hay fever (Surgeon General's Report, 2000). It is found in 25% of children aged 6-11 years and 59% of adolescents aged 12-19 years; 20% of all adolescents currently have untreated decay. (CDC: www.cdc.gov/oralhealth)
- Over 50% of 5- to 9-year-old children have at least one cavity or filling, and that proportion increases to 78% among 17-year-olds. (Surgeon General's Report, 2000)

Public Health

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

Perceived Need

Responses to top three most troubling health–related problems in our community



Source: SHDHD CT&S Convenience Survey, 2012

Percentage who Responded with a Value of 8, 9, or 10 for How Serious Various Health Issues are in the Community (based on an 11-point scale ranging from 0=not serious at all to 10=extremely serious), among Nebraska Adults aged 18 and Older, 2011

Health Issue	Percent
Overweight and obesity	54.6%
Cancer	49.4%
High blood pressure	42.9%
Diabetes	33.9%
Heart disease	31.5%
Aging problems (arthritis, hearing/vision loss)	29.5%
Stroke	21.0%
Teenage pregnancy	18.4%
Mental health (including depression)	17.7%
Infectious diseases (flu, other viruses/infections)	15.2%
Poor dental health	12.2%
Child abuse and neglect	11.3%
Unsafe environment (poor air/water, chemical expos.)	11.0%
Injuries (resulting from crashes, falls, violence, etc.)	8.2%
Suicide	6.1%

Source: SHDHD/DHHS Weighted CT&S Survey, 2011

Risk Factors for Dental Disease

- Diabetes
- Taking prescription or over-the-counter medications
- Cavity in the last 3 years
- Frequently eat or drink sugary substances
- Child goes to bed with bottle containing milk or juice
- Smoke cigarettes, pipe or cigars or chew tobacco
- Periodontal (gum) surgery which left receded gums
- Head or neck radiation treatment (reduces saliva production)
- Live in a community that does not have fluoride in the water supply

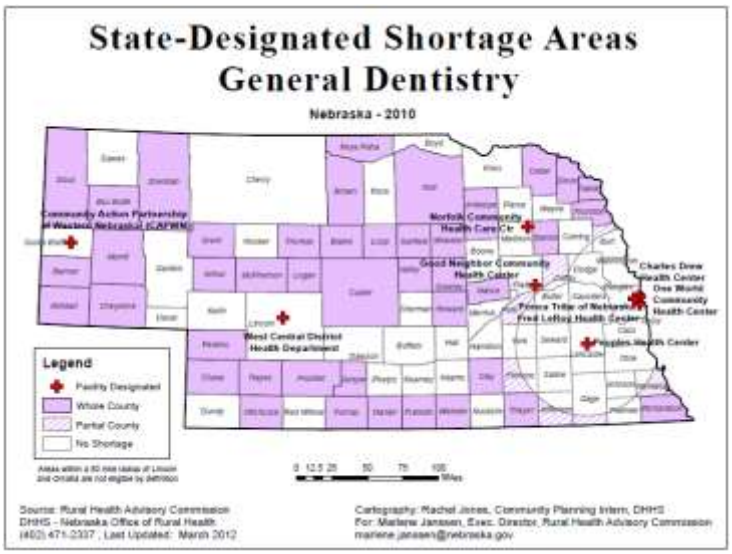
Community Burden of Dental Disease

- The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental related illness. Poor children suffer nearly 12 times more restricted-activity days than children from higher income families. Pain and suffering due to untreated diseases can lead to problems in eating, speaking, and attending to learning.
- Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated. Children living below the poverty line (annual income of $17,000 for a family of four) have more severe and untreated decay.
- Expenditures for dental services alone made up 4.7 percent of the nation's health expenditures in 1998 -- $53.8 billion out of $1.1 trillion. These expenditures underestimate the true costs to the nation, however, because data are unavailable to determine the extent of expenditures and services provided for craniofacial health care by other health providers and institutions.
- Insurance coverage for dental care is increasing but still lags behind medical insurance. For every child under 18 years old without medical insurance, there are at least two children without dental insurance; for every adult 18 years or older without medical insurance, there are three without dental insurance.
- Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than one in five Medicaid-covered children received a single dental visit in a recent year-long study period.
- Water fluoridation has helped improve the quality of life in the United States by reducing pain and suffering related to tooth decay, time lost from school and work, and money spent to restore, remove, or replace decayed teeth. An economic analysis has determined that in most communities, every $1 invested in fluoridation saves $38 or more in treatment costs. Fluoridation is the single most effective public health measure to prevent tooth decay and improve oral health over a lifetime, for both children and adults.

Source: U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General – Executive Summary. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

"In Nebraska, public health nurses employed by local health departments contracted with Medicaid to perform a variety of outreach activities. These activities include contacting new enrollees to inform families of benefits, educate them on the importance of utilizing benefits, and assistance with accessing those services. These nurses also provided support for providers, including dentists, by following up with patients who are "no shows" or miss their dental appointments."

Source: Innovative State Practices for Improving The Provision of Medicaid Dental Services: Summary of Eight State Reports, January 2011.



South Heartland Health District

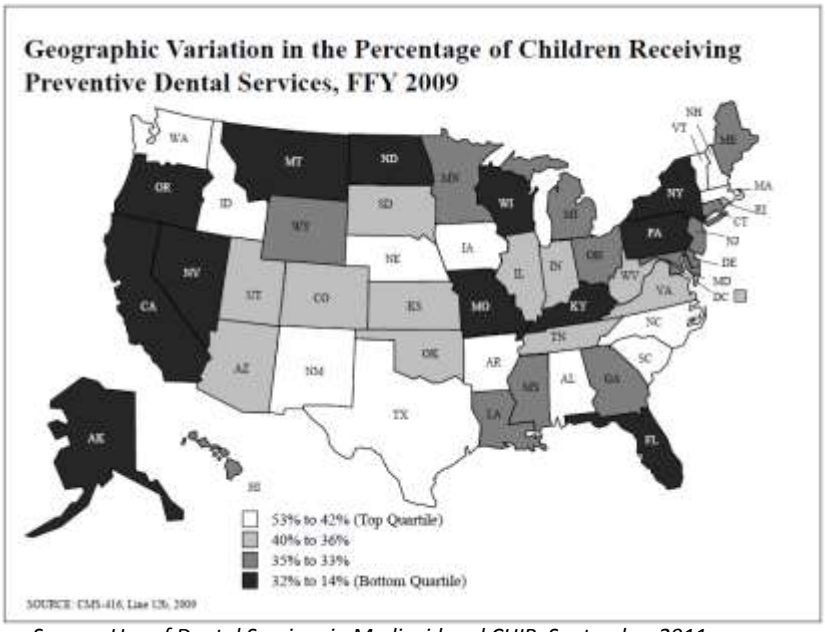
My Water's Fluoride

County	City / Village / Water System	Fluoridation?	Fluoride Concentration (mg/L)	Population
Adams	Hastings	No	0.30	24,092
	HRC	No	0.30	500
	Holstein	No	0.40	229
	Juniata	No	0.40	811
	Kenesaw	No	0.30	873
	Prosser	No	0.40	74
	Roseland	No	0.30	240
Clay	Clay Center	No	0.30	867
	Deweese	No	0.30	80
	Edgar	No	0.30	540
	Fairfield	No	0.30	458
	Glenvil	No	0.40	332
	Harvard	No	0.30	980
	Ong	No	0.30	73
	Sutton	No	0.30	1340
	Trumbull	No	0.30	225
Nuckolls	Hardy	No	0.40	176
	Lawrence	No	0.60	311
	Nelson	Yes [1975]	1.00	627
	Ruskin	No	0.30	187
	Superior	Yes [1951]	1.00	2055
Webster	Bladen	No	0.20	296
	Blue Hill	Yes [1971]	1.00	867
	Gala Gardens	No	0.40	41
	Guide Rock	No	0.00	250
	Red Cloud	Yes [1974]	1.00	1200

Source: Centers for Disease Control and Prevention: My Water's Fluoride: http://apps.nccd.cdc.gov/MWF/CountydataV.asp?State=NE Last Updated: 2008

Oral Health Selected as a *Healthy People 2020* Leading Health Indicator

The Department of Health and Human Services (HHS) has selected oral health as one of the 12 Leading Health Indicators (LHIs) for *Healthy People 2020*. HHS will focus on oral health and the actions that can be taken toward the goal to "increase the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months."



Source: Use of Dental Services in Medicaid and CHIP, September 2011