Community Health Needs Assessment
Community Health Improvement Plan

Brodstone
HEALTHCARE

520 East 10th
Superior NE 68978

Fiscal Year Ending April 30, 2022

Demographics & Introduction

Brodstone Healthcare is located in Superior, Nebraska. The service coverage area is Nuckolls County, with a population of 4,244. The residents of Nuckolls County are 93.8% white with 27.2% over the age of 65 years and 9.8% are below poverty level.

Brodstone Healthcare opened its doors January 2, 1928 with a gift from Evelyn Brodstone Vestey & her brother. The tradition of medical excellence in that 25-bed hospital has carried on through the years. Brodstone Healthcare is a critical access hospital led by a six-member Board of Managing Trustees and is unique in that the by-laws require four of the six trustees to be women. Today Brodstone Healthcare has a medical staff of three physicians and six mid-levels with a total staff of 225 employees. Twenty-nine specialty providers hold monthly clinics at the facility. Seventy-five percent of the hospital's patients are Medicare patients. Brodstone Healthcare is the largest employer in Nuckolls County and is a vital part of the community.

Brodstone Healthcare has three medical clinics. Brodstone Family Medical Center, Superior is located adjacent to the hospital with office hours five and a half days a week. Brodstone Family Medical Center Nelson is served by the same group of nine healthcare providers and is open one full day and three half days a week. Brodstone Family Medical Center Edgar is served by a nurse practitioner and is open two full days and one half day a week. These facilities are the only medical clinics in each respective community.

Our Mission

To provide exceptional and progressive healthcare to the communities we serve.

Our Vision

To be the region's preferred healthcare choice for generations to come.

Our Values

--Caring
--Advocating
--Reliable
--Engaged

The Community Health Needs Assessment, which was conducted over the last few months in cooperation with South Heartland District Health Department, includes data for the four counties that the health department serves. Brodstone Healthcare's service area is primarily Nuckolls County, Nebraska.

Following the assessment is Brodstone Healthcare's Community Health Improvement Plan (CHIP). This plan was a collaborative effort by representatives from the community in cooperation with the staff of Brodstone Healthcare. There are objectives, goals, measures and outcome for each of the five areas that were identified in the Community Health Needs Assessment:

1. Access to Health Care
2. Mental Health
3. Substance Misuse
4. Obesity & Related Health Conditions
5. Cancer

Final approval by Brodstone Healthcare's Board of Managing Trustees and distribution information may be found following the Community Health Improvement Plan.

Brodstone
HEALTHCARE

2021 South Heartland District Health Department

Community Health Needs Assessment

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

Report prepared by Schmeeckle Research in conjunction with the South Heartland District Health Department

Acknowledgements

The staff at South Heartland District Health Department (SHDHD) would like to recognize the many community partners who contributed to the community health assessment. Their input and commitment were instrumental to a productive and successful assessment process and the updates to the 2019-2024 Community Health Improvement Plan (CHIP). We also are indebted to the external CHA Core Team members, who provided guidance, advice and county-level assistance throughout this process. The assessments and planning were supported by resources from the Nebraska Department of Health and Human Services Office of Community and Rural Health, Brodstone Memorial Hospital, Mary Lanning Healthcare and United Way of South Central Nebraska.

South Heartland CHA Core Team

Treg Vyzourek, MBA
Chief Executive Officer
Brodstone Memorial Hospital

Karen Tinkham
Project Manager
Brodstone Memorial Hospital

Kori Field, RN, BSN
Chief Nursing Officer
Brodstone Memorial Hospital

Heather Erickson
Director of Foundation
Brodstone Memorial Hospital

Becky Sullivan, MS
Manager, Wellness Department
Mary Lanning Healthcare

Jodi Graves
Executive Director
United Way of South Central Nebraska

Brady Rhodes
Collaborative Coordinator
Community IMPACT Network
United Way of South Central Nebraska

Michele Bever, PhD, MPH
Executive Director
South Heartland District Health Department

Janis Johnson, RN, BSN
Accreditation Coordinator
South Heartland District Health Department

Public Health
Prevent. Promote. Protect.

Table of Contents

Executive Summary/Overview of Key Findings

The following table presents highlighted data organized by indicators of need and indicators of progress across eight key areas of public health from the 2016 South Heartland Community Health Needs Assessment.

CHIP Performance Measures

1. Access to Health Care
    a. Adults in the South Heartland District report having a personal doctor at higher rates compared to Nebraska as a whole (85.0% in South Heartland compared to 79.6% for Nebraska, Fig 1).
    b. In 2019, about three-fourths (74.3.%) of adults in the South Heartland District reported visiting a doctor for a routine exam in the past year (Fig 2). This represents a notable increase from 2016.
    c. From 2018 to 2019, there were slight increases of adults in the South Heartland District reporting that they are without health insurance (16.6% in 2019, Fig 3) and that cost is a barrier to visiting a doctor (14.6% in 2019, Fig 4). Compared to Nebraska as a whole, Clay, Nuckolls, and Webster Counties have slightly higher percentages of children under age 19 without health insurance (Fig 7).
2. Mental Health
    a. More than one-third (35.5%) of high school students in the South Heartland District reported depression (Fig 8) and more than one-in-ten (11.4%) reported attempting suicide (Fig 9), in the past year in 2018/2019. Additionally, nearly one-in-five (18.2%) of adults in the South Heartland District reported in 2019 that they have been diagnosed with depression (Figure 10). All of these rates are higher than Nebraska as a whole.
    b. There has been a general upward trend in calls to the Hastings Police Department related to mental health from 2015-2019 (Fig 13).
3. Substance Misuse
    a. In 2018/2019, 30.4% of South Heartland District high school students reported vaping tobacco in the past 30 days, compared to 17.1% for the state as a whole. This rate of vaping tobacco nearly doubled among South Heartland District high school students from 2016/2017 to 2018/2019 (Fig 18).
    b. In 2018/2019, just over one-in-four (26.0%) South Heartland district high school students reported using alcohol in the past 30 days (compared to 21.0%) for Nebraska as a whole (Fig 14).
    c. Compared to their peers across the state, South Heartland district high school students report higher rates of binge drinking (Fig 24) and past 30 day alcohol impaired driving (Fig 25).
4. Obesity
    a. Obesity is slightly higher among both high school students and adults in the South Heartland district compared to the state. Based on the most current data,

31.2% of South Heartland district high school students and 71.1% of South Heartland adults are identified as obese (Figs 27 and 28).

b. Compared to the rest of the state, there have been consistently higher rates of adults in the South Heartland district reporting that they have ever had a heart attack (Fig 32) and that they have no leisure-time physical activity (Fig 33).

5. Cancer
    a. Since baseline, the most currently available data show increases for female breast, colorectal, and prostate cancers. Incidences of prostate and lung cancer show a decreasing trend. Most alarming, incidence rates for melanoma have more than doubled since baseline (Figs 36 – 40).
    b. Compared to Nebraska as a whole, rates of all cancer types have been consistently higher in the South Heartland District (Fig 42).
6. Motor vehicle safety
    a. A notably lower rate of adults in the South Heartland district report always wearing a seat belt when driving or riding in a car. In 2018, just two-thirds (66.4%) of adults in the district reported always wearing a seat belt, compared to 75.2% for Nebraska as a whole (Fig 44).
    b. South Heartland district has a higher rate of fatalities from motor vehicle crashes than the state (Fig 47).
7. Maternal-Child Health
    a. Adams and Clay Counties have higher rates of births to teen mothers compared to the state (Fig 51).
    b. Child and infant mortality rates are higher in Adams County compared to the state. Data are unavailable for Clay, Nuckolls, and Webster Counties (Figs 53 & 54).
    c. Compared to Nebraska as a whole, Clay, Nuckolls, and Webster Counties have slightly higher percentages of children under age 19 without health insurance (Fig 55).

CTSA Survey

1. Demographics
    a. There was an overrepresentation of residents of Adams and Nuckolls counties, overrepresentation of racial and ethnic minorities, except for Nuckolls County.
    b. There was an overrepresentation of females (75% of respondents).
    c. Most respondents were between the ages of 25 and 64, with about 1/3 being between the ages of 40 and 54 (Fig 57).
    d. There were large differences in respondent education by race/ethnicity (Fig 58) with white, non-Hispanic respondents being more likely to have some college, a college degree, or an advanced degree compared to non-white/Hispanic individuals.
    e. There were large racial/ethnic differences by field of work (Fig 59), specifically in the fields of health care and the service industry (with white, non-Hispanic

respondents being more likely to work in health care/behavioral health compared to non-white/Hispanic respondents being more likely to work in the service industry compared to white, non-Hispanic respondents).

2. Access to healthcare
    a. A large majority of all respondents agree that they have access to services like hospitals and doctors' offices within an hour of where they live (Fig 60 & 61); however, access to substance misuse, medical specialists, and weight management programs was less common, with white, non-Hispanic respondents reporting greater access to these services compared to non-white/Hispanic respondents (Fig 63-65).
3. Barriers to care
    a. When asked about the reasons they did not get the medical care they needed, cost was the most selected (Fig 66). Not knowing where to access care was selected by about a quarter of all respondents, followed closely by language and/or cultural barriers. Transportation was the least selected barrier. These four barriers had large racial/ethnic differences, with white, non-Hispanic respondents choosing them at lower rates than non-white/Hispanic respondents.
4. Personal provider
    a. A large majority of all respondents had a person they consider their health care provider, while few (less than 15%) have a mental health provider (Fig 67). Non-white/Hispanic respondents were about a third less likely than white, non-Hispanic respondents to say they had a dentist or optometrist.
    b. In terms of other sources of health care services, non-white, Hispanic respondents were more likely than white, non-Hispanic respondents to use the health department, federally qualified health centers, free clinics, and family planning agencies (Fig 68). White, non-Hispanic respondents were more likely to use urgent care and telehealth and were more likely to say they didn't use any other services. White, non-Hispanic respondents were twice as likely as non-white/Hispanic respondents to delay care as long as possible; however, only 10% of respondents said that they do this.
    c. Over half of respondents said they received most of their healthcare in their own community – but this was twice as likely for white, non-Hispanic respondents than for non-white/Hispanic respondents (Figure 69). Half of non-white/Hispanic respondents said they received most healthcare in their county (but not the closest town), more than double the number of white, non-Hispanic respondents.
5. Pandemic-related questions
    a. Respondents were asked what care they received during the pandemic (Figure 70). About nine out of ten said they saw a doctor, with slightly more white, non-Hispanic respondents making that claim than non-white/Hispanic respondents. Two thirds of white, non-Hispanic respondents saw a dentist and/or optometrist during that time, nearly twice the number of non-white/Hispanic respondents.

Breast and cervical cancer screenings were at least twice as common for white, non-Hispanic women than non-white/Hispanic women.

b. Overall, dental cleanings were the most likely to be delayed during the pandemic, selected by about half of respondents (Fig 71). However, nearly two-thirds of non-white/Hispanic respondents said they delayed seeing a doctor since the pandemic started, more than double the number of white, non-Hispanic respondents.
c. Non-white/Hispanic respondents were more likely to say that their mental/behavioral healthcare needs increased since the start of the pandemic (Fig 72).
d. About one in five respondents reported an increase in alcohol, tobacco, and/or e-cigarette use during this time. Opioid and other drug use increased for about 13% of respondents. There were more changes in alcohol use for non-white/Hispanic respondents than for white, non-Hispanic respondents (Fig 74-77).
e. Non-white/Hispanic respondents were more likely than white, non-Hispanic respondents to say they had difficulty with certain issues and basic needs because of the pandemic (Fig 84).
f. Since the beginning of the pandemic, a third of respondents tested positive for COVID-19, but this was much higher for non-white, Hispanic respondents (Figure 86).

6. Physical activity and nutritional opportunities
    a. White, non-Hispanic respondents were more likely to say that they have access to nutrition, physical activity, and weight education/management programs within an hour of home (Fig 81).
    b. More than half selected poor eating habits, stress, and exercise as behaviors they were most concerned about (Fig 83). Stress was more likely to be selected by non-white/Hispanic respondents. Avoiding routine healthcare and gambling were also chosen more often by non-white/Hispanic respondents. White, non-Hispanic respondents were at least twice as likely as non-white/Hispanic respondents to select distracted driving, not getting vaccinated, and tobacco use as top concerns.
    c. When asked an open-ended question about what worried respondents the most about their/their family's own health, COVID-19 and healthcare costs/access were the mostly commonly cited themes.

Community Health Improvement Plan (CHIP)

Introduction

The South Heartland District Health Department (SHDHD) serves Adams, Clay, Nuckolls, and Webster Counties in South Central Nebraska. In 2019, SHDHD developed a five-year Community Health Improvement Plan (CHIP) to guide it's activities for 2019 through 2024. The CHIP addresses five key priority areas which SHDHD intends to address during this five year period:

Priority Area 1: Access to Health Care	Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.
Priority Area 2: Mental Health	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services
Priority Area 3: Substance Misuse	Reduce substance misuse / risky use to protect the health, safety, and quality of life for all.
Priority Area 4: Obesity & Related Health Conditions	Reduce obesity and related health conditions through preventaoin and chronic disease management.
Priority Area 5: Cancer	Reduce the number of new cancer cases as well as illness, disability, and death caused by cancer.

SHDHD identified performance measures for each of these priority areas. This report presents an update of the most available current data on these performance measures. A green "thumbs up" icon is used if the 2024 performance measure has already been met while a red "thumbs down" icon is if the 2024 performance measure has not yet been met. In addition, other relevant data for each of these prioirty areas are included.

Demographics

The four-county South Heartland District has a total population of 45,571, with nearly 70% of this population residing in Adams County (Table 1).

Table 1	**Population (2019)**			
Adams County	**Clay County**	**Nuckolls County**	**Webster County**	***SHDHD total***
31,587	6,203	4,244	3,537	***45,571***

As a whole, the South Heartland District has a population that is mostly White (non-Hispanic/Latino), with a relatively small, but notable, Hispanic, or Latino minority population residing across the four counties in the district (Table 2).

Table 2	**Race/Ethnicity (2019)**		
	White (non-Hispanic/Latino)	**Hispanic or Latino (of any race)**	**All other races/ethnicities**
Adams County	85.9%	10.3%	3.8%
Clay County	89.2%	8.9%	1.9%
Nuckolls County	94.6%	2.8%	2.6%
Webster County	91.5%	5.1%	3.4%
SHDHD total	***87.6%***	***9.0%***	***3.4%***
Nebraska	***79.0%***	***10.9%***	***10.1%***

Compared to the rest of Nebraska, the four counties within the South Heartland District each have a higher percentage of the population that is 65 years and over (Table 3).

Table 3	**Percentage of Population 65 years and over (2019)**				
Adams County	**Clay County**	**Nuckolls County**	**Webster County**	***SHDHD total***	***Nebraska***
17.7%	19.9%	26.6%	26.5%	***19.2%***	***15.4%***

Poverty among all people within the four counties of the South Heartland District is generally comparable to the rest of Nebraska. However, poverty among the under 18 population is slightly higher in each of the four counties of the district as compared to Nebraska (Table 4).

Table 4	Poverty (2019)					
	Adams County	**Clay County**	**Nuckolls County**	**Webster County**	***SHDHD total***	***Nebraska***
All people	12.5%	10.5%	11.2%	10.8%	***12.0%***	***11.1%***
Under 18 years	16.8%	14.4%	19.4%	15.4%	***16.6%***	***13.9%***

The median household income is lower in each of the four counties of the South Heartland District, as compared to Nebraska as a whole (Table 5).

Table 5	Median household income (2019)			
Adams County	**Clay County**	**Nuckolls County**	**Webster County**	***Nebraska***
53,023	$57,173	$43,388	$46,188	***$61,439***

The percentage of the population with a disability is higher in each of the four counties of the South Heartland District, as compared to Nebraska as a whole (Table 6).

Table 6	Percentage of population with a disability (2019)				
Adams County	**Clay County**	**Nuckolls County**	**Webster County**	***SHDHD total***	***Nebraska***
13.4%	14.8%	17.1%	14.4%	***14.0%***	***11.6%***

The percentage of the population with a high school degree or equivalent is comparable in the South Heartland District to the rest of the state. Yet, the percentage of the population with a Bachelor's degree or higher is lower in the South Heartland District compared to the rest of the state (Table 7).

Table 7	Educational attainment of the population age 25 years and over					
	Adams County	**Clay County**	**Nuckolls County**	**Webster County**	***SHDHD total***	***Nebraska***
High school degree or equivalent	90.0%	91.5%	91.9%	93.8%	***90.7%***	***91.4%***
Bachelor's degree or higher	24.3%	19.9%	20.9%	23.0%	***23.3%***	***31.9%***

Priority Area 1: Access to Health Care

Performance Measures

Discussion

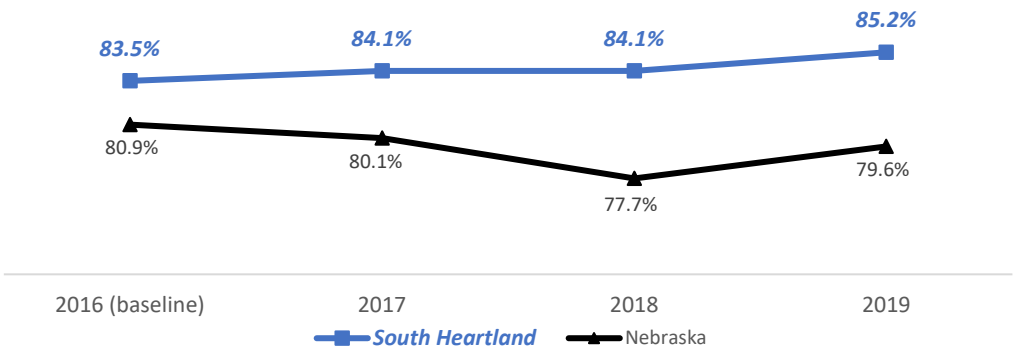
In general, adults in the South Heartland District report a comparable level of access to health care as adults across all of Nebraska. However, one notable exception is that adults in the South Heartland District report having a personal doctor at higher rates compared to Nebraska as a whole (85.0% in South Heartland compared to 79.6% for Nebraska, Figure 1).

There was a notable increase in the percentage of adults who reported visiting a doctor for a routine exam in the past year from 2017 to 2018 in the South Heartland District and across the entire state. In 2019, about three-fourths (74.3.%) of adults in the South Heartland District reported visiting a doctor for a routine exam in the past year (Figure 2).

From 2018 to 2019, there were slight increases of adults in the South Heartland District reporting that they are without health insurance (16.6% in 2019, Figure 3) and that cost is a barrier to visiting a doctor (14.6% in 2019, Figure 4).

Data (Figures 1 – 5)

Figure 1. Adults (18+) with a personal doctor or health care provider

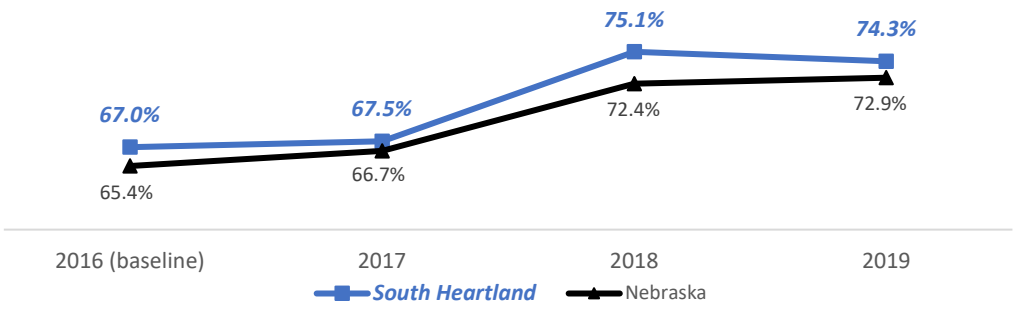


Performance Measure

2024 Target: 84.0%

Source: BRFSS

Figure 2. Adults (18+) who report visiting the doctor for a routine exam in the past year

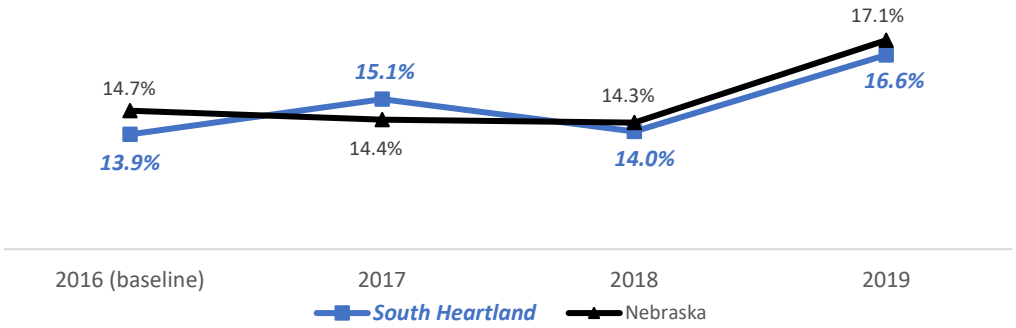


Performance Measure

2024 Target: 71.0%

Source: BRFSS

Figure 3. Persons aged 18-64 years without healthcare coverage

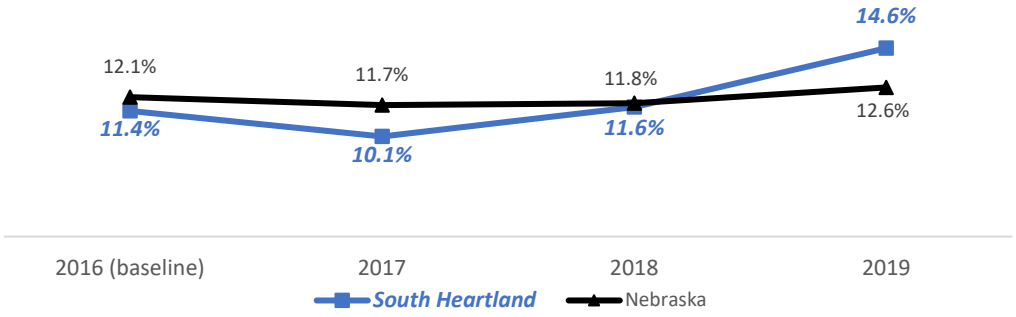


Performance Measure

2024 Target: 13.0%

Source: BRFSS

Figure 4. Adults (18+) reporting cost as a barrier to visiting a doctor in the past year

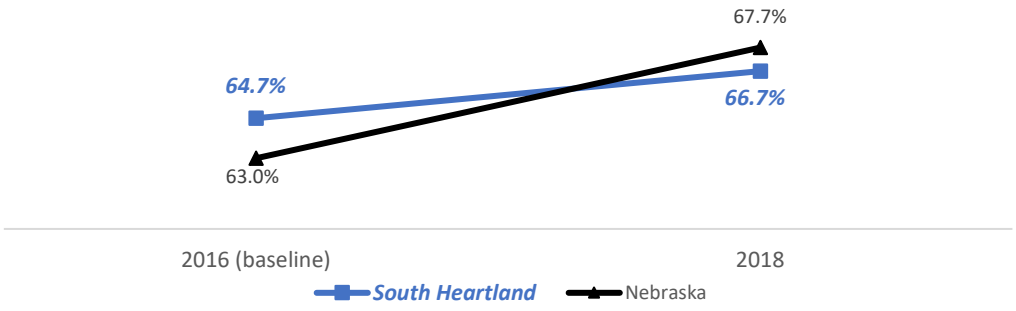


Performance Measure

2024 Target: 10.7%

Source: BRFSS

Figure 5. Adults (18+) who report visiting a dentist for any reason in the past year



Performance Measure

2024 Target: 68.5%

Source: BRFSS

Additional Measures

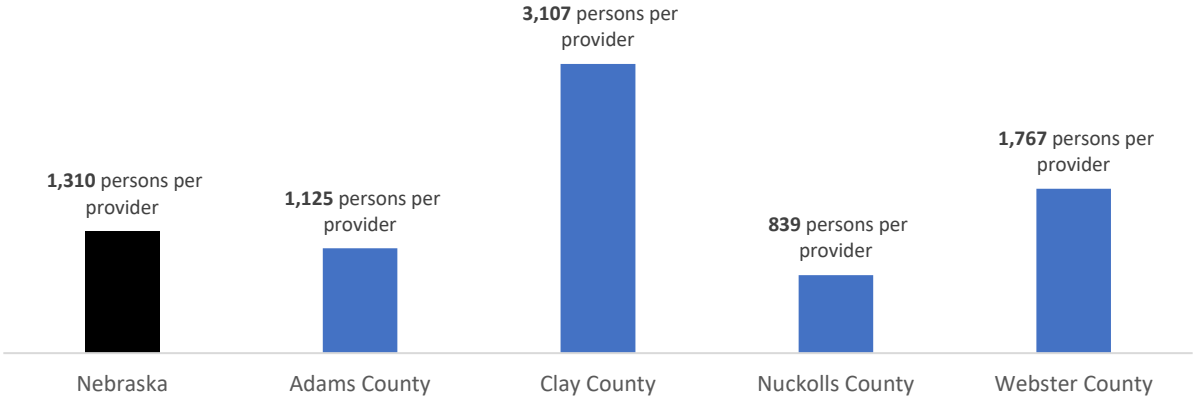
Discussion

Clay and Webster Counties have a notably high ratio of popuation to primary care physicians compared to the rest of the state. In Clay County, there are 3,107 persons per primary care physician. However, Adams and Nuckolls Counties somewhat make up for this lack of primary care physicians in Clay County (Figure 6).

Compared to Nebraska as a whole, Clay, Nuckolls, and Webster Counties have slightly higher percentages of children under age 19 without health insurance (Figure 7).

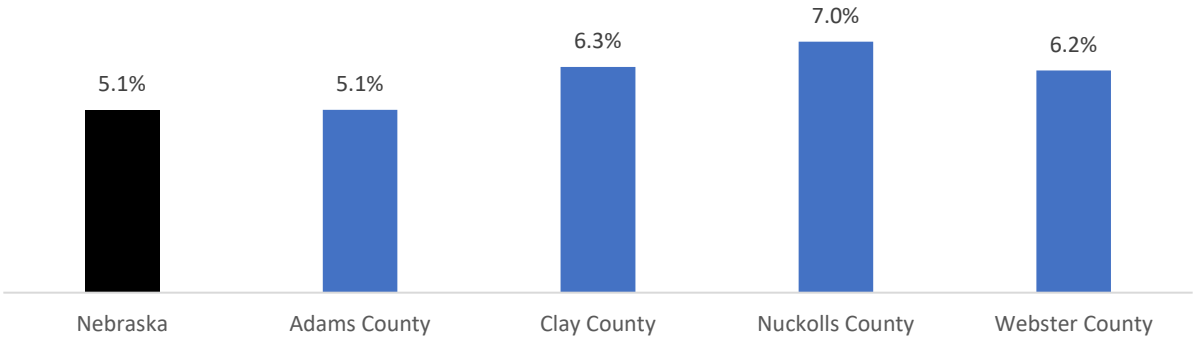
Data (Figures 6 & 7)

Figure 6. Ratio of population to primary care physicians (2018)



Source: County Health Rankings

Figure 7. Percentage of children under age 19 without health insurance (2018)



Source: County Health Rankings

Priority Area 2: Mental Health

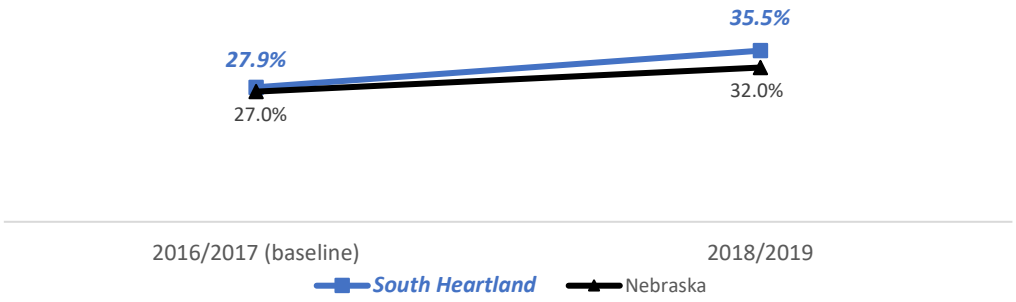
Performance Measures

Discussion

There are some concerning indicators for mental health among high school students (grades 9 – 12) and adults in the South Heartland District. More than one-third (35.5%) of high school students in the South Heartland District reported depression (Figure 8) and more than one-in-ten (11.4%) reported attempting suicide (Figure 9), in the past year in 2018/2019. Additionally, nearly one-in-five (18.2%) of adults in the South Heartland District reported in 2019 that they have been diagnosed with depression (Figure 10). All of these rates are higher than Nebraska as a whole.

Data (Figures 8 – 11)

Figure 8. High school students reporting feeling sad or hopeless almost every day for two weeks or a more in a row causing abandonment of usual activities during the past year

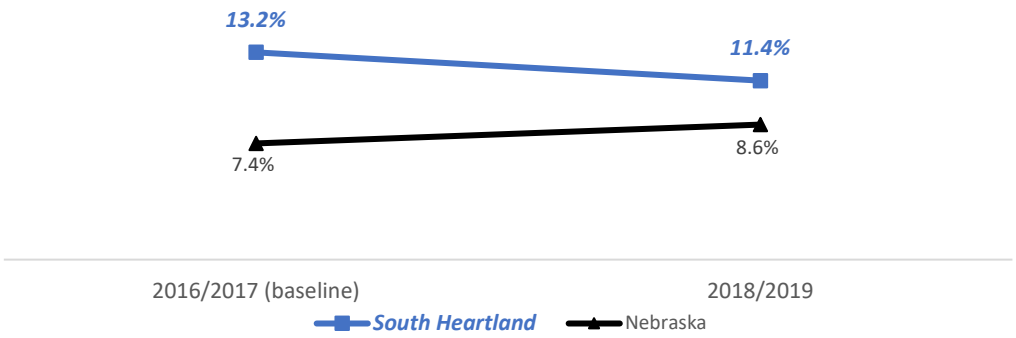


Performance Measure

2024 Target: 26.2%

Source: YRBS

Figure 9. Reported suicide attempts by high school students during the past year

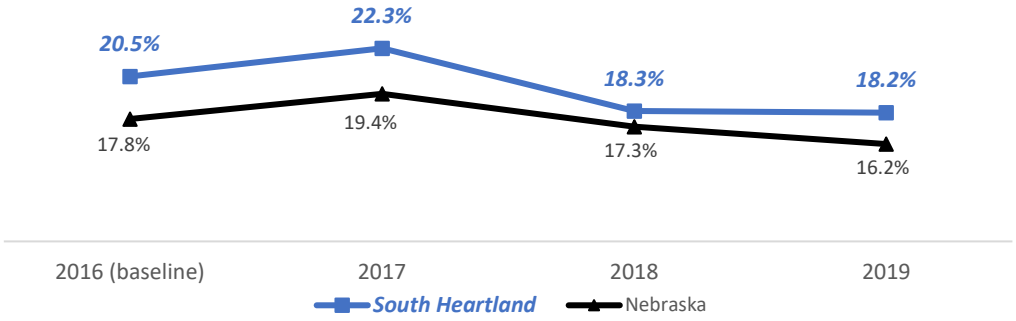


Performance Measure

2024 Target: 12.4%

Source: YRBS

Figure 10. Proportion of adults (18+) who reported ever being diagnosed with depression

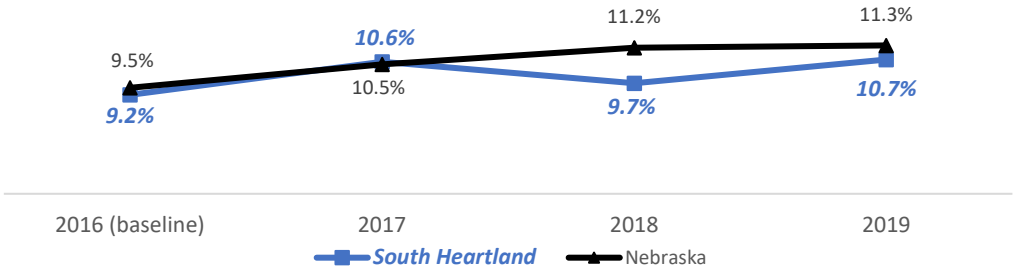


Performance Measure

2024 Target: 19.3%

Source: BRFSS

Figure 11. Adults (18+) reporting frequent mental distress* in the last 30 days



Performance Measure

2024 Target: 8.7%

*14 or more self-reported mentally unhealthy days in the past 30 days.

Source: BRFSS

Additional Measures

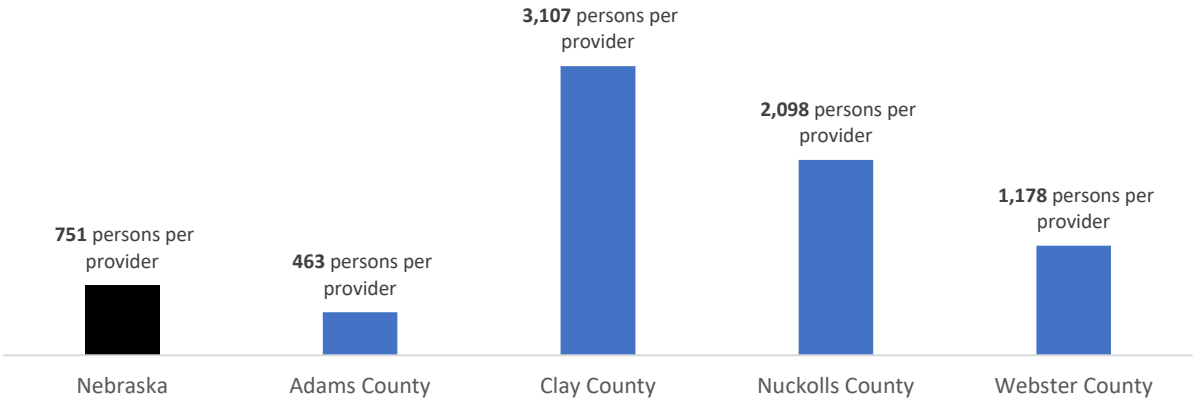
Discussion

Clay, Webster, and Nuckolls Counties all have notably high rates of population per behavioral health provider, as compared to Nebraska as a whole. Yet, Adams County may make up for this lack of behavioral providers, at least in part, in the more rural areas of the district (Figure 12).

On average, the Hastings Police Department receives more than three calls related to mental health every day. From 2015 to 2019, there has been a general upward trend in such calls (Figure 13).

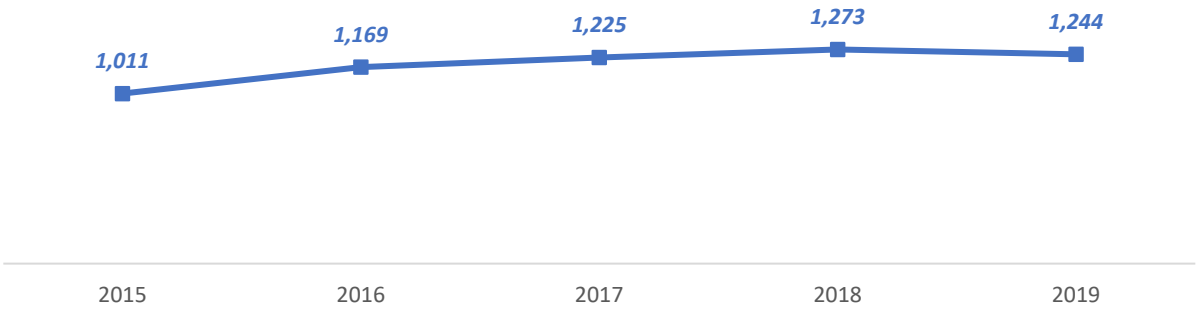
Data (Figures 12 & 13)

Figure 12. Ratio of population to behavioral health providers (2018)



Source: BHECN

Figure 13. Mental health related calls to Hastings Police Department



Source: Hastings Police Dept.

Priority Area 3: Substance Misuse

Performance Measures

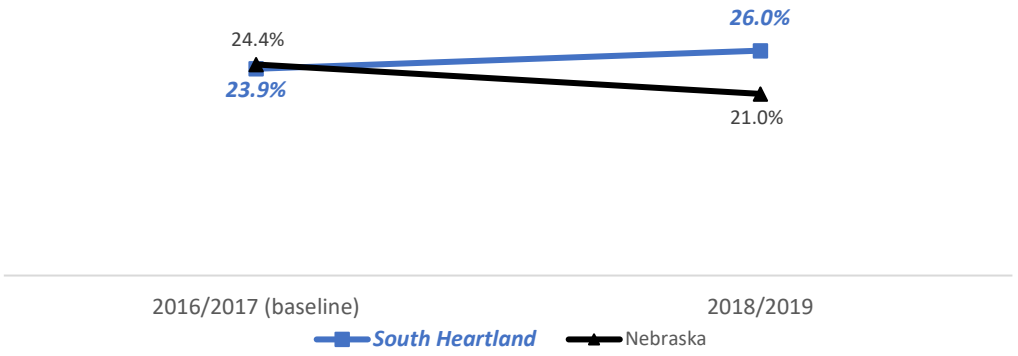
Discussion

Among the performance measures chosen for the prioroity area of subtance misuse, one stands out for it's alarming trend: past 30 day electronic vapor product (e-cigarette) use among high school students. In 2018/2019, 30.4% of South Heartland District high school students reported vaping tobacco in the past 30 days, compared to 17.1% for the state as a whole. This rate of vaping tobacco nearly doubled among South Heartland District high school students from 2016/2017 to 2018/2019 (Figure 18).

In 2018/2019, just over one-in-four (26.0%) South Heartland district high school students reported using alcohol in the past 30 days (compared to 21.0%) for Nebraska as a whole (Figure 14). Among adults, nearly one-in-five (19.5%) in the South Heartland district reported binge drinkings in the past 30 days in 2019, which is comparable to the rate of 20.9% for Nebraska as a whole (Figure 19).

Data (Figures 14 – 22)

Figure 14. Past 30 day alcohol use among high school students

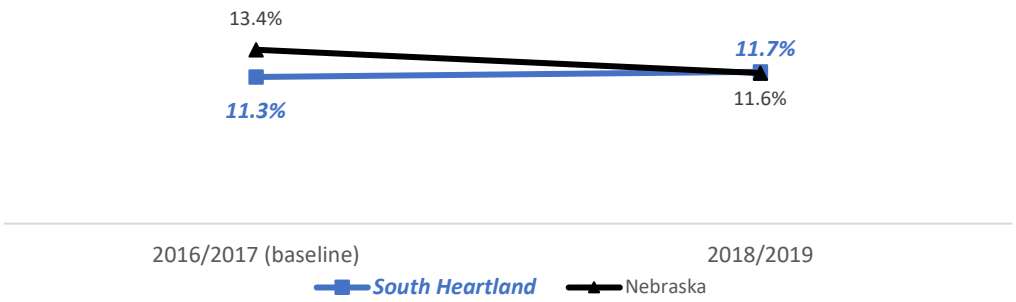


Performance Measure

2024 Target: 22.5%

Source: YRBS

Figure 15. Past 30 day marijuana use among high school students

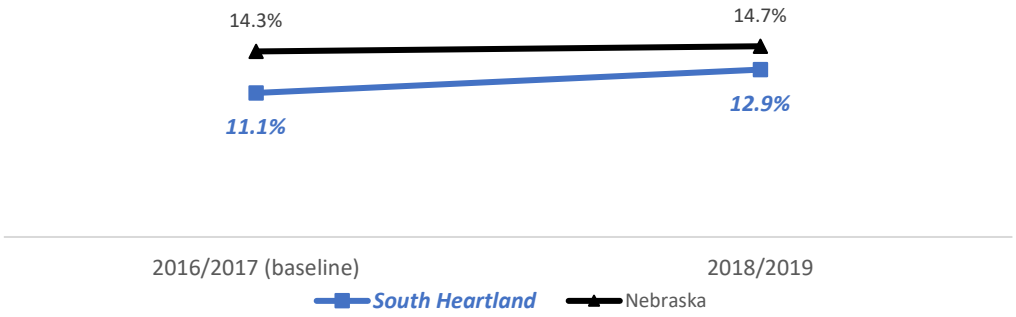


Performance Measure

2024 Target: 10.6%

Source: YRBS

Figure 16. Lifetime misuse/abuse of prescription drugs among high school students

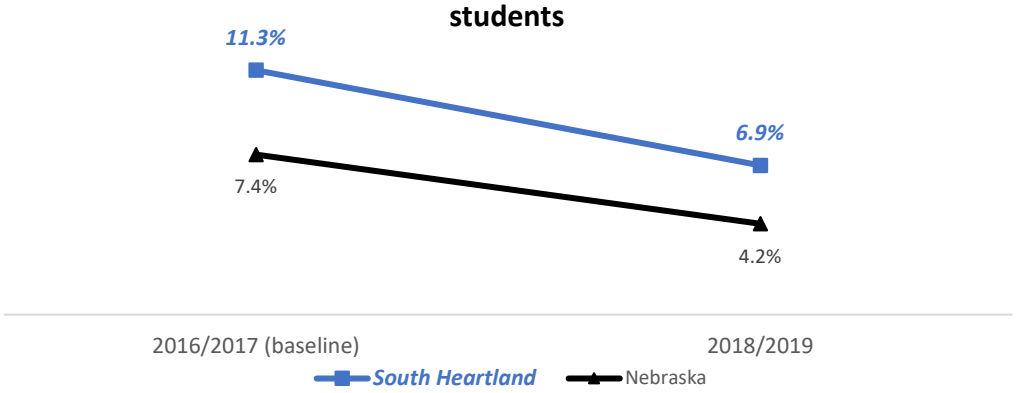


Performance Measure

2024 Target: 10.4%

Source: YRBS

Figure 17. Past 30 day cigarette use among high school students

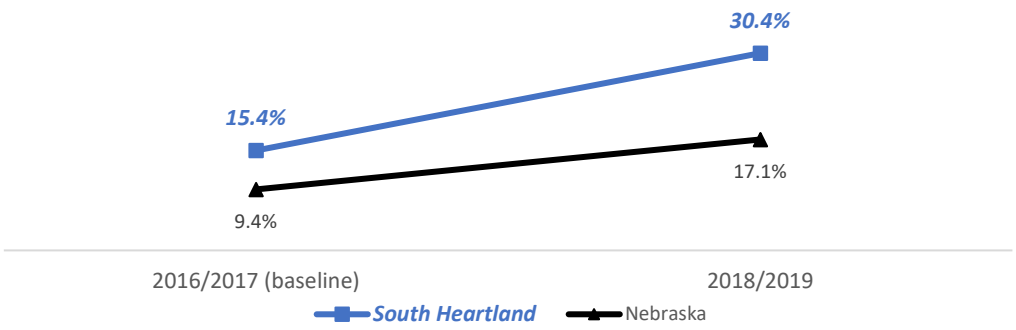


Performance Measure

2024 Target: 10.6%

Source: YRBS

Figure 18. Past 30 day electronic vapor product (e-cigarette) use among high school students

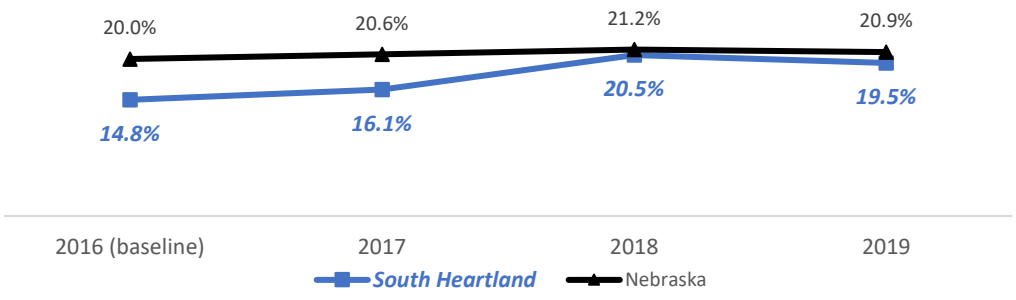


Performance Measure

2024 Target: 14.5%

Source: YRBS

Figure 19. Binge drinking (four drinks for females, five for males, in a row) among adults (18+) in the past 30 days

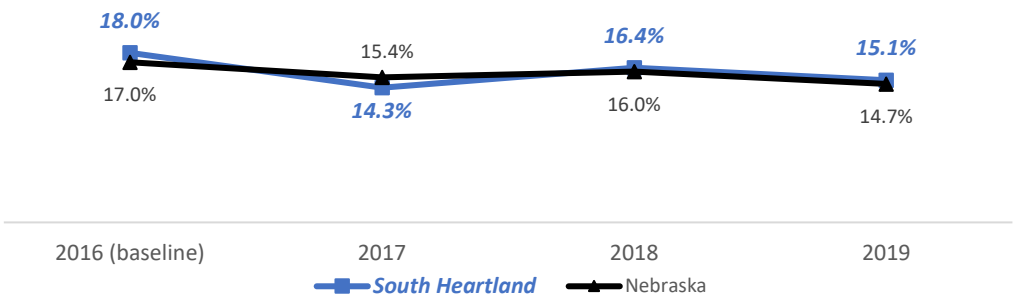


Performance Measure

2024 Target: 13.9%

Source: BRFSS

Figure 20. Current cigarette smoking among adults (18+)

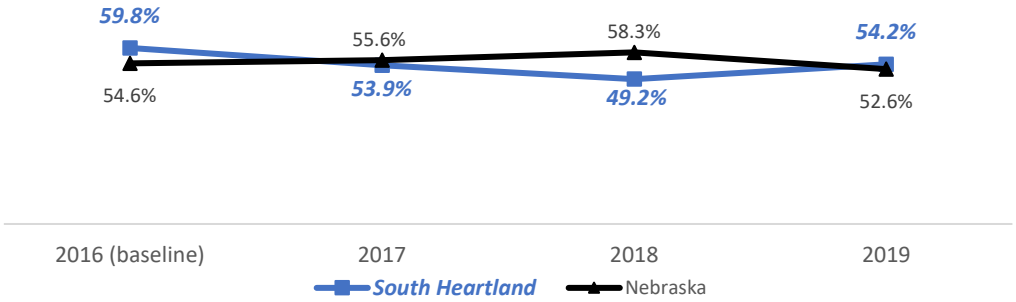


Performance Measure

2024 Target: 16.9%

Source: BRFSS

Figure 21. Current smokers (adults 18+) who reportedly attempted to quit smoking in the past year

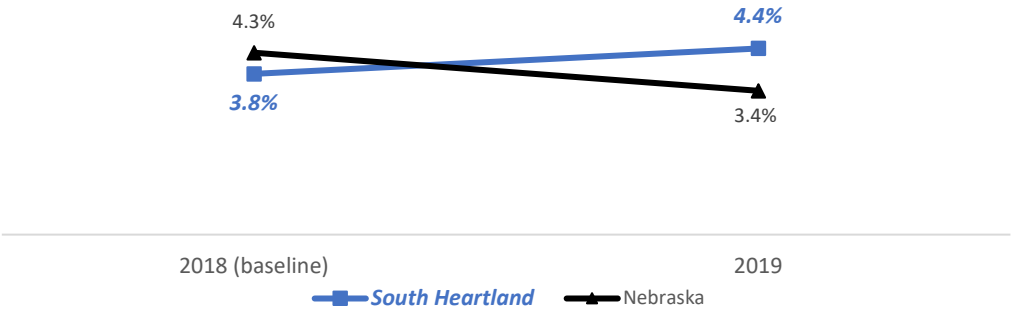


Performance Measure

2024 Target: 56.3%

Source: BRFSS

Figure 22. Opioid misuse (use of opioid prescription medication outside of prescription guidelines) among (adults 18+) in the past year



Performance Measure

2024 Target: 4.4%

Source: BRFSS

Additional Measures

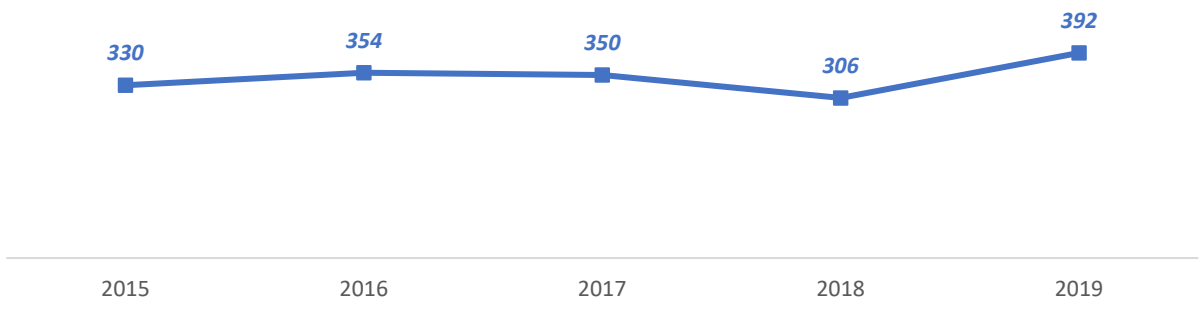
Discussion

The Hastings Police Department reports approximately one drug related call per day on average. In 2019, there was a total of 392 such calls, marking the highest yearly total over the previous five years (Figure 23).

Compared to their peers across the state, South Heartland district high school students report higher rates of binge drinking (Figure 24) and past 30 day alcohol impaired driving (Figure 25).

Data (Figures 23 – 26)

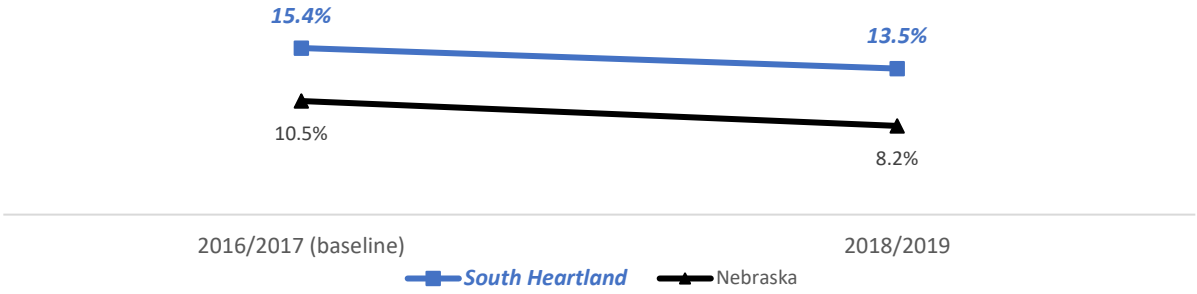
Figure 23. Drug related calls to Hastings Police Department



Source: Hastings Police Dept.

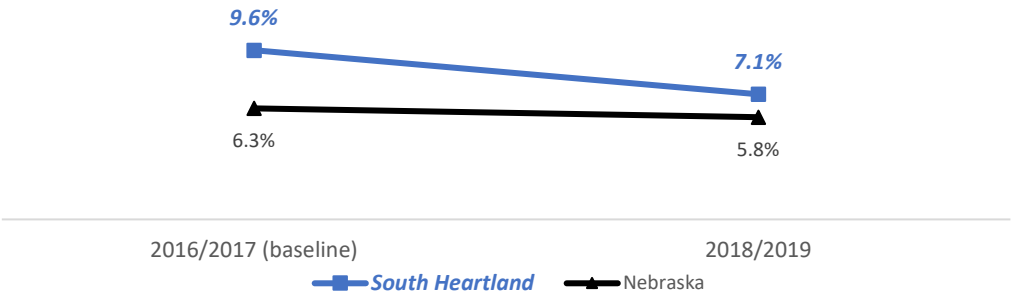
Figure 24. Past 30 day binge drinking among high school students

(four or more drinks of alcohol in a row for female students or five or more drinks of alcohol in a row for male students, that is, within a couple of hours)



Source: YRBS

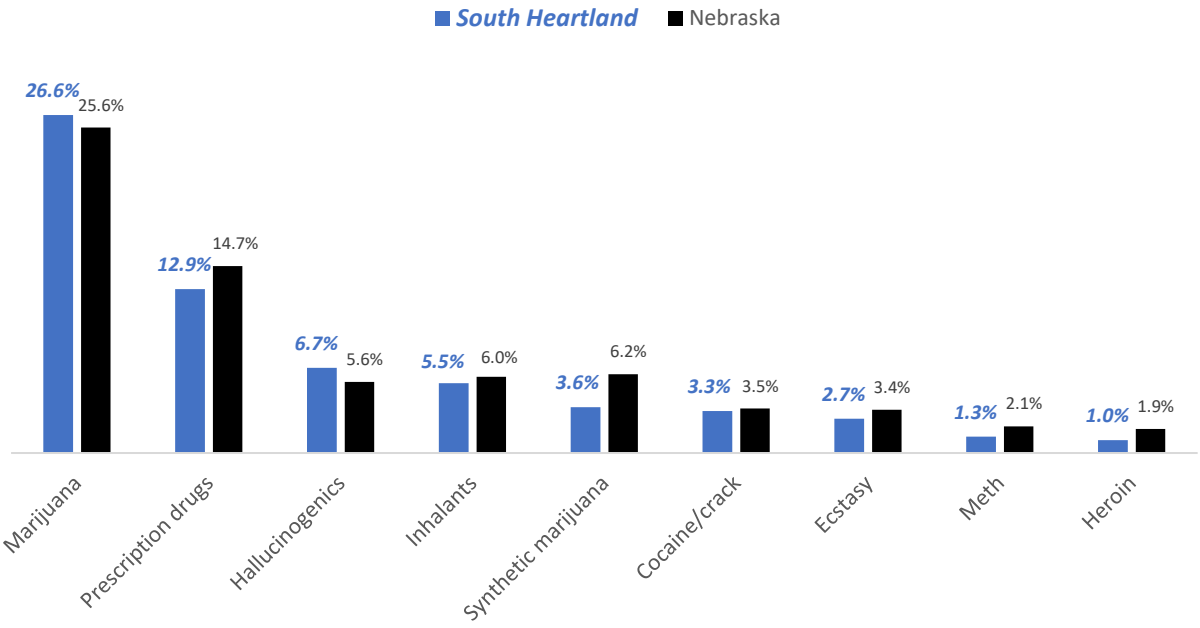
Figure 25. Past 30 day alcohol impaired driving among high school students



In 2018, 3.9% of SHDHD adults age 18+ reported alcohol impaired driving in the past 30 days (compared to 3.0% statewide).

Sources: YRBS and BRFSS

Figure 26. Lifetime use of substances among high school students (2018/2019)



Source: YRBS

Priority Area 4: Obesity & Related Health Conditions

Performance Measures

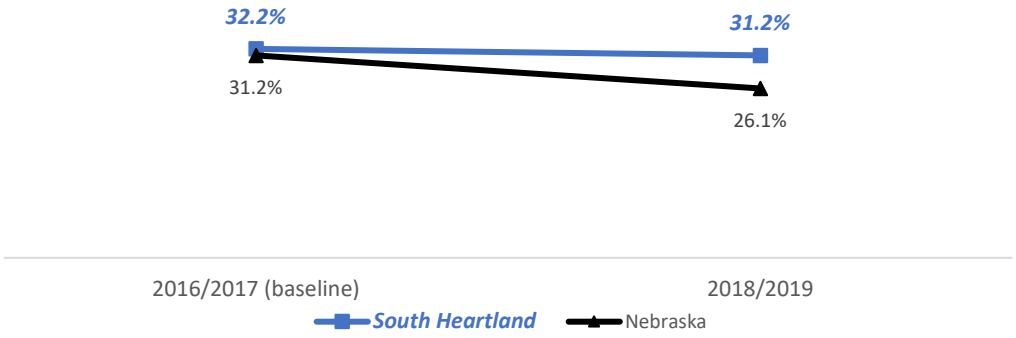
Discussion

Obesity is slightly higher among both high school students and adults in the South Heartland district compared to the state. Based on the most current data, 31.2% of South Heartland district high school students and 71.1% of South Heartland adults are identified as obese (Figures 27 and 28).

Self-reported diabetes, high blood pressure, and coronoary heart disease are also slightly higher among South Heartland adults compared to Nebraska as a whole (Figures 29 – 31).

Data (Figures 27 – 31)

Figure 27. High school students who are overweight or obese
(BMI 85th percentile or higher based on 2000 CDC growth charts)

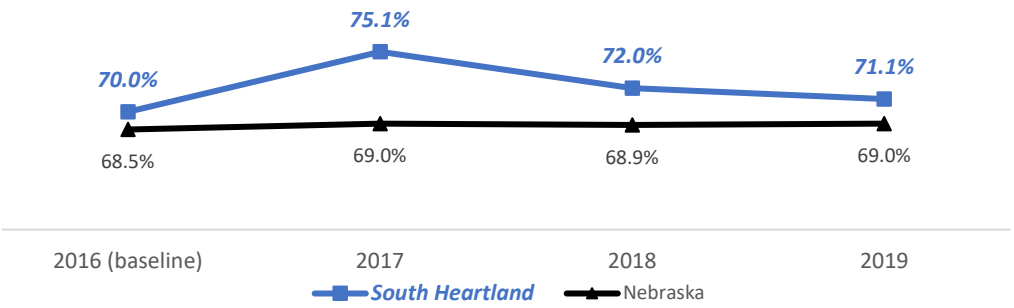


Performance Measure

2024 Target: 30.6%

Source: YRBS

Figure 28. Overweight or obesity (BMI > 25) among adults (18+)

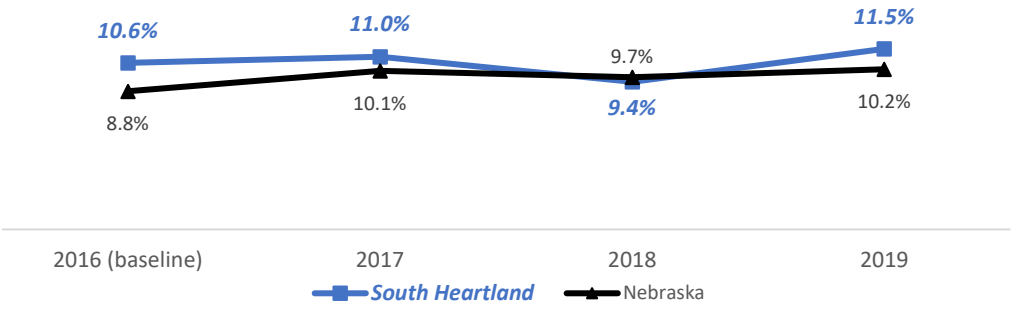


Performance Measure

2024 Target: 65.8%

Source: YRBS

Figure 29. Adults (18+) who have ever been told they have diabetes (excluding pregnancy)

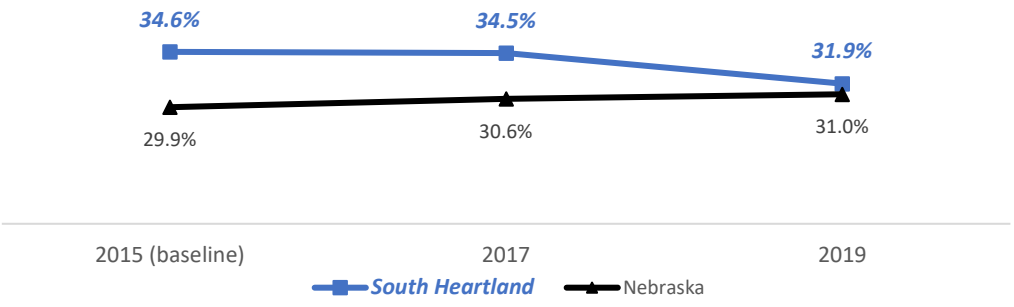


Performance Measure

2024 Target: 9.0%

Source: BRFSS

Figure 30. Adults (18+) who have ever been told they have high blood pressure (excluding pregnancy)

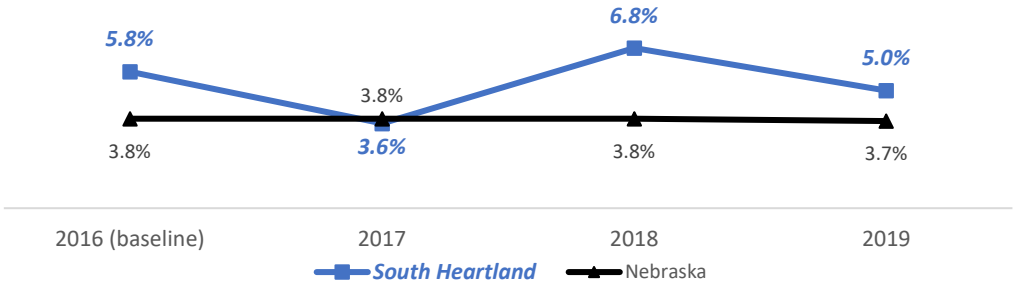


Performance Measure

2024 Target: 32.5%

Source: BRFSS

Figure 31. Adults (18+) who have ever been told they have coronary heart disease



Performance Measure

2024 Target: 5.4%

Source: BRFSS

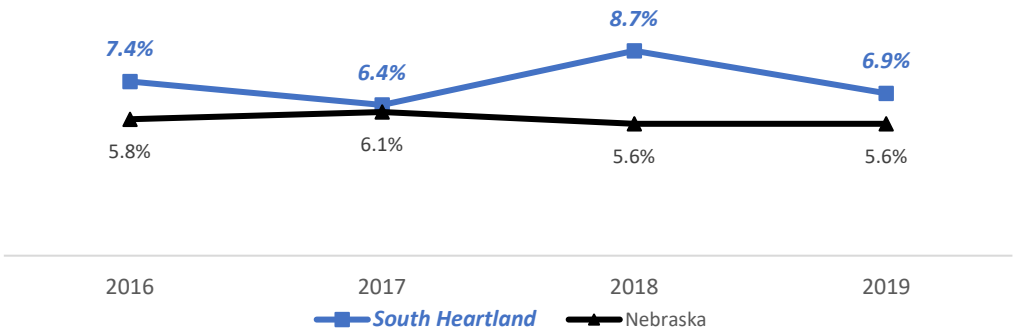
Additional Measures

Discussion

Compared to the rest of the state, there have been consistently higher rates of adults in the South Heartland district reporting that they have ever had a heart attack (Figure 32) and that they have no leisure-time physical activity (Figure 33).

Data (Figures 32 – 35)

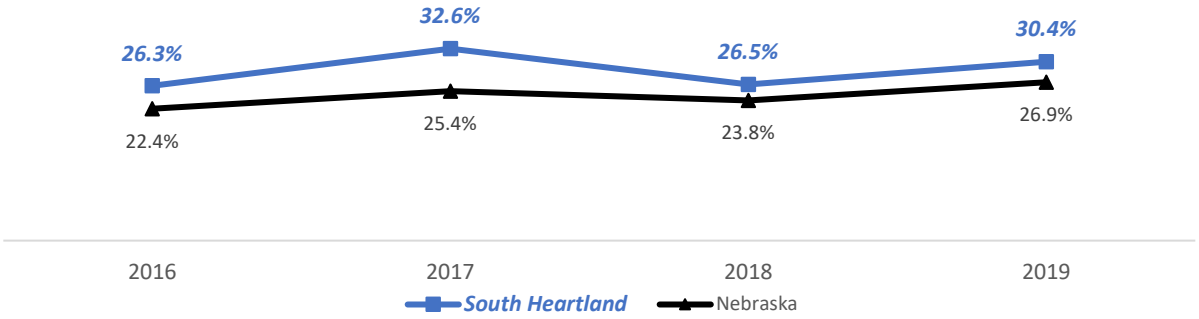
Figure 32. Adults (18+) who have ever been told they had a heart attack or coronary heart disease



In 2019, 28.4% of SHDHD adults reported taking aspirin to prevent or control heart disease or stroke (compared to 21.5% statewide)

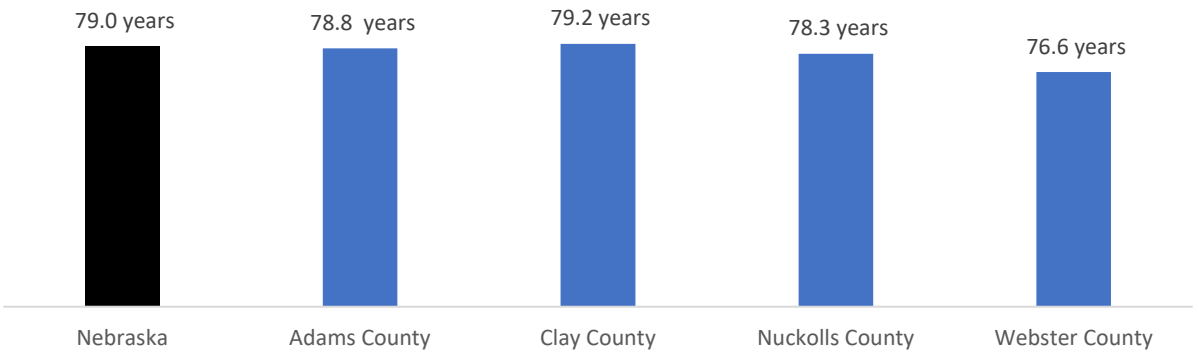
Source: BRFSS

Figure 33. Adults (18+) with no leisure-time physical activity in the past 30 days



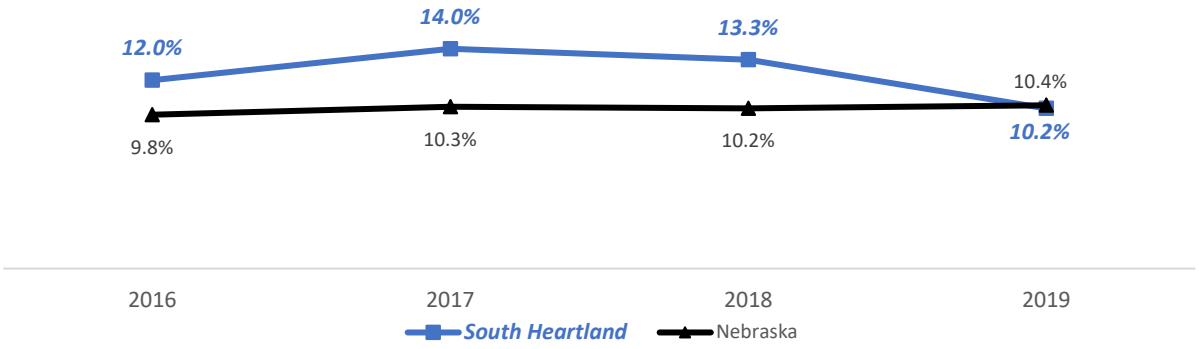
Source: BRFSS

Figure 34. Life expectancy (2017-2019)



Source: County Health Rankings

Figure 35. Adults (18+) who report their physical health was not good on 14 or more of the past 30 days



Source: BRFSS

Priority Area 5: Cancer

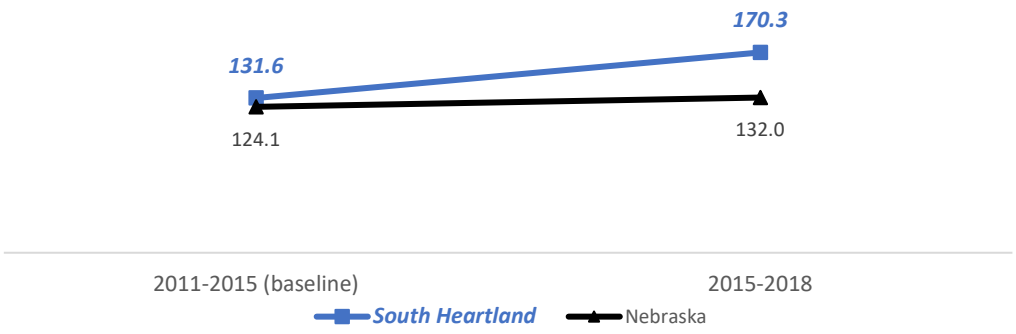
Performance Measures

Discussion

SHDHD developed performance measures for five types of cancer: female breast, colorectal, prostate, melanoma of the skin, and lung. Since baseline, the most currently available data show increases for three of these types of cancer. Incidences of prostate and lung cancer are the only performance measure with a decreasing trend. Most alarming, incidence rates for melanoma have more than doubled since baseline (Figure 36 – 40).

Data (Figures 36 – 40)

Figure 36. Incidence Rates of Female Breast Cancer per 100,000

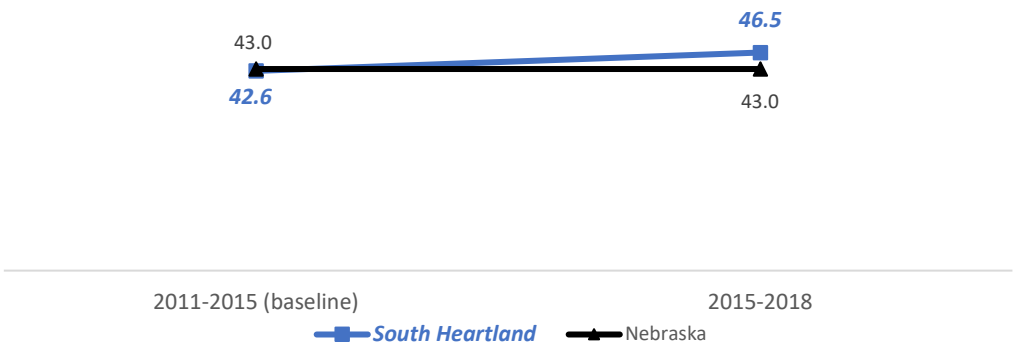


Performance Measure

2024 Target: 123.7

Source: Nebraska Cancer Registry

Figure 37. Incidence Rates of Colorectal Cancer per 100,000

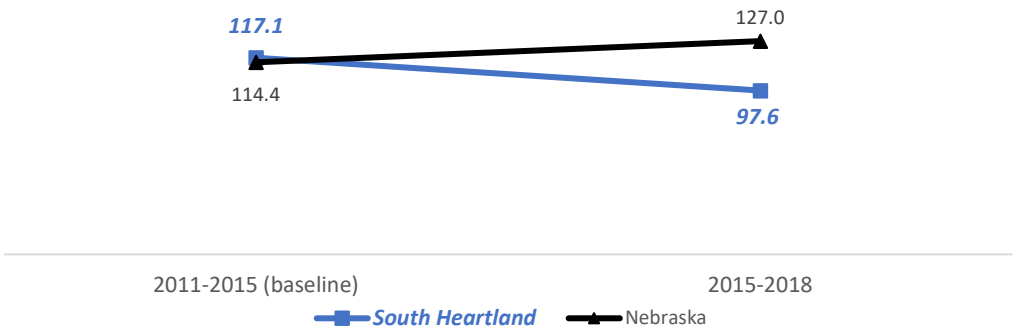


Performance Measure

2024 Target: 40.0

Source: Nebraska Cancer Registry

Figure 38. Incidence Rates of Prostate Cancer per 100,000

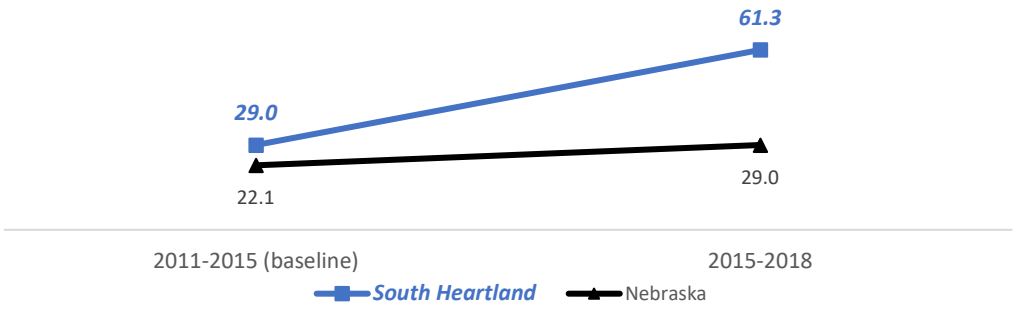


Performance Measure

2024 Target: 110.1

Source: Nebraska Cancer Registry

Figure 39. Incidence Rates of Melanoma of the Skin Cancer per 100,000

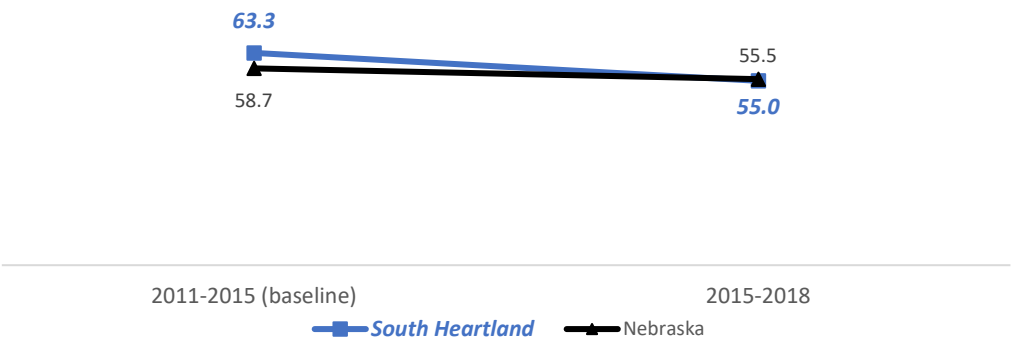


Performance Measure

2024 Target: 27.3

Source: Nebraska Cancer Registry

Figure 40. Incidence Rates of Lung Cancer per 100,000



Performan.c e Measure

2024 Target: 59.5

Source: Nebraska Cancer Registry

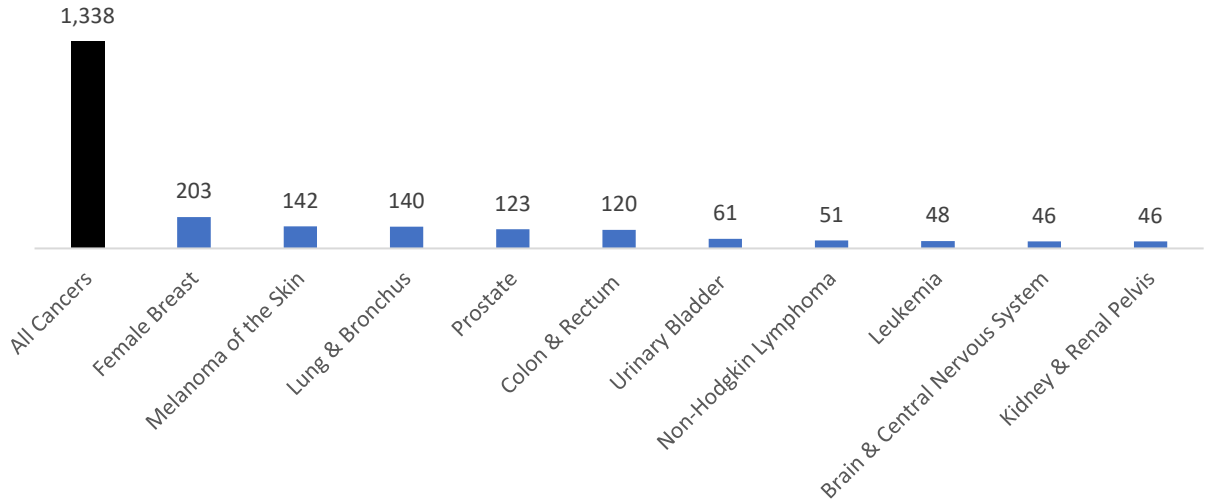
Additional Measures

Discussion

Compared to Nebraska as a whole, rates of all cancer types have been consistently higher in the South Heartland District (Figure 42). In 2019, 13.5% of adults in the district reported that they have ever had cancer of any type (including Melanoma) (Figure 43).

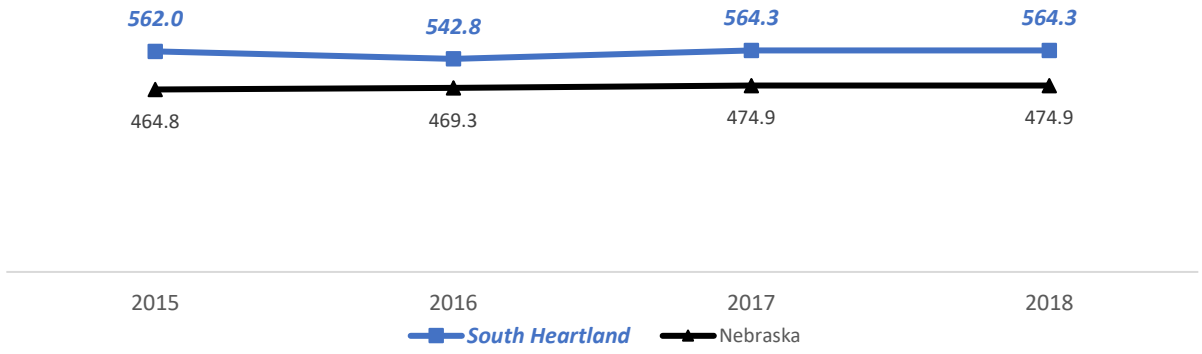
Data (Figures 41 – 43)

Figure 41. Incidences of the Top Ten Cancer Types in the South Heartland District (2015-2018)



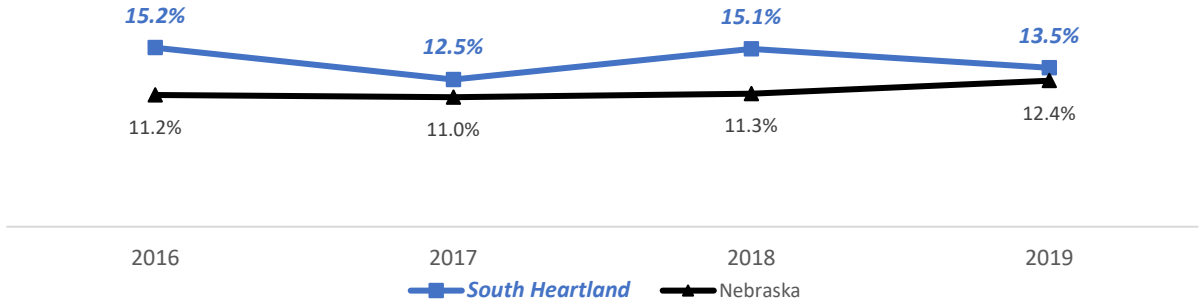
Source: Nebraska Cancer Registry

Figure 42. Rates of Cancer (all sites) per 100,000



Source: Nebraska Cancer Registry

Figure 43. Adults (18+) who have ever been told they have cancer in any form (including skin cancer)



Source: BRFSS

Appendix: Additional Data (Non-Priority Areas)

Two additional areas of data are included in this appendix: motor vehicle safety and maternal child health. These two areas were chosen for inclusion in this report because of the potential public health concern that certain indicators wihin each area demonstrate.

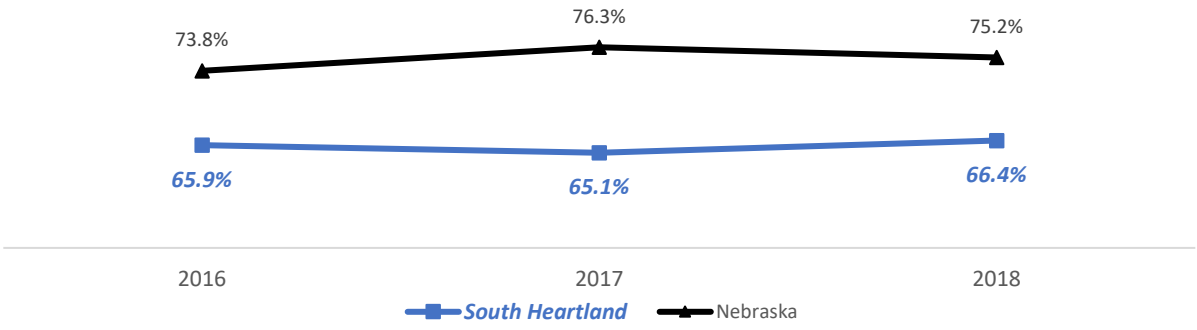
Motor Vehicle Safety

Discussion

A notably lower rate of adults in the South Heartland district report always wearing a seat belt when driving or riding in a car. In 2018, just two-thirds (66.4%) of adults in the district reported always wearing a seat belt, compared to 75.2% for Nebraska as a whole (Figure 44). Additionally, just half (50.1%) of South Heartland district high school students reported that they always wear a seat belt when riding in a car, which is comparable to the rate of 51.8% for the state as a whole (Figure 45).

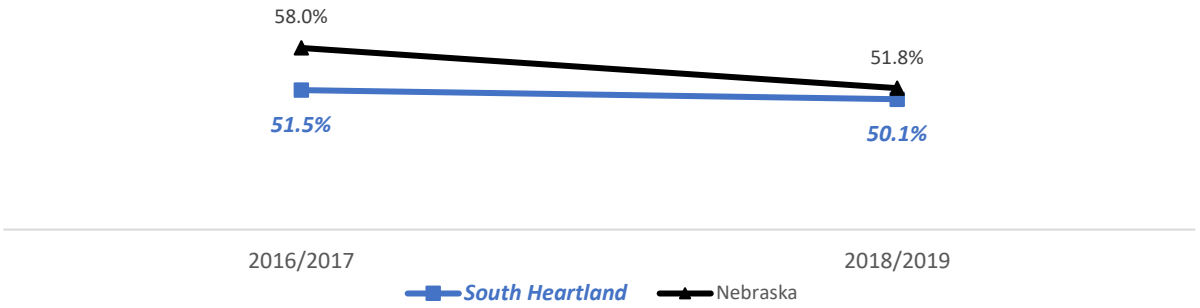
Likely because of this low rate of seat belt use, fatalities from car crashes are higher in the South Heartland district compared to Nebraska as a whole. The South Heartland district has a lower rate of motor vehicle crashes compared to the state (Figure 46). Because of this lower rate of motor vehicle crashes, one would expect a lower rate of fatalities. Yet, the inverse is true: the South Heartland district has a higher rate of fatalities from motor vehicle crashes than the state (Figure 47).

Figure 44. Adults (18+) who always wear a seat belt when driving or riding in a car



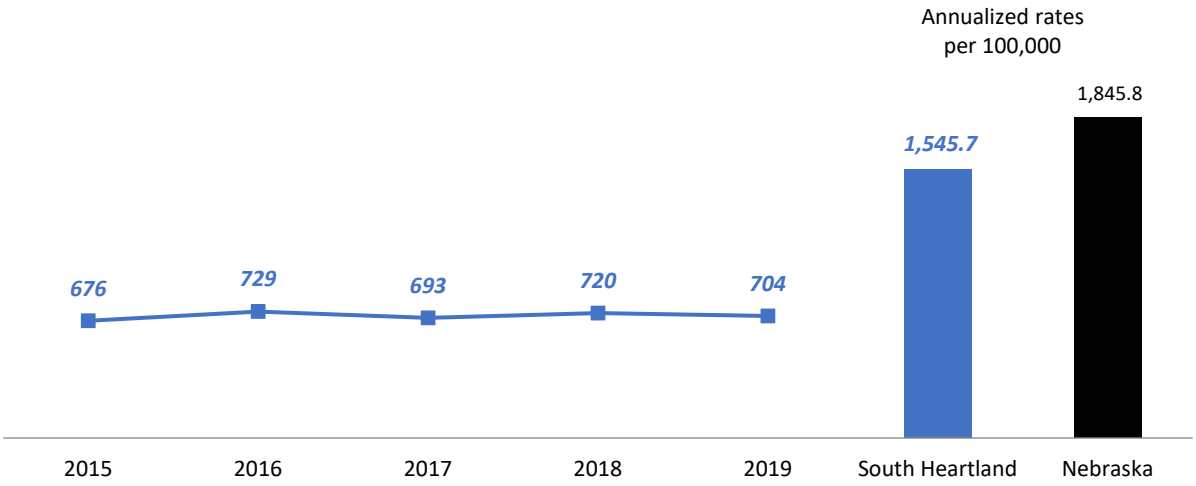
Source: BRFSS

Figure 45. High school students who always wear a seat belt when riding in a car driven by someone else



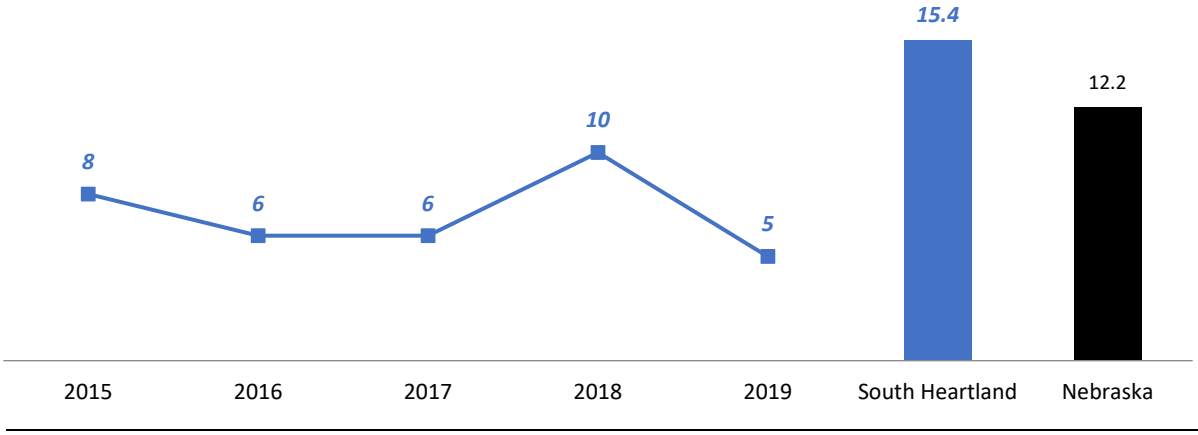
Source: YRBS

Figure 46. South Heartland Motor Vehicle Crashes



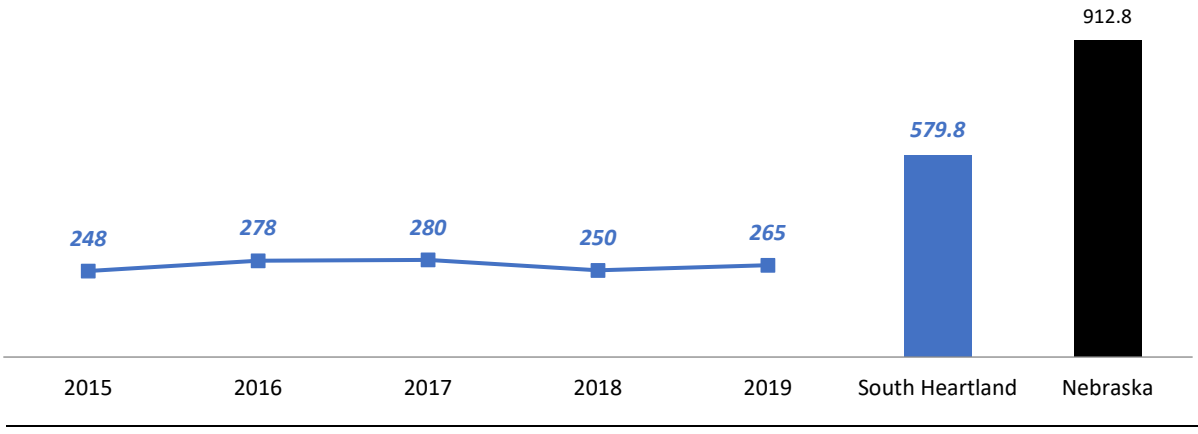
Source: Nebraska DOT Highway Safety Office

Figure 47. South Heartland Fatalities from Motor Vehicle Crashes



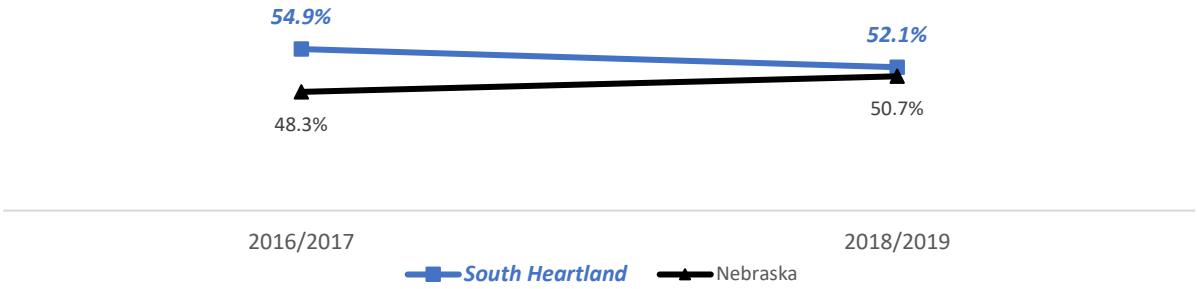
Source: Nebraska DOT Highway Safety Office

Figure 48. South Heartland Injuries from Motor Vehicle Crashes



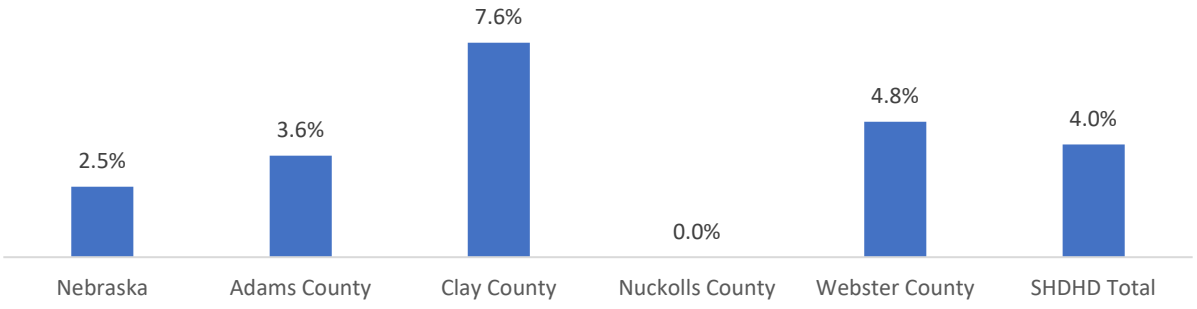
Source: Nebraska DOT Highway Safety Office

Figure 49. High school students who texted or e-mailed while driving a car or other vehicle in the past 30 days



Source: YRBS

Figure 50. Percentage of motor vehicle crashes with alcohol involement (2019)



Source: County Health Rankings

Maternal Child Health

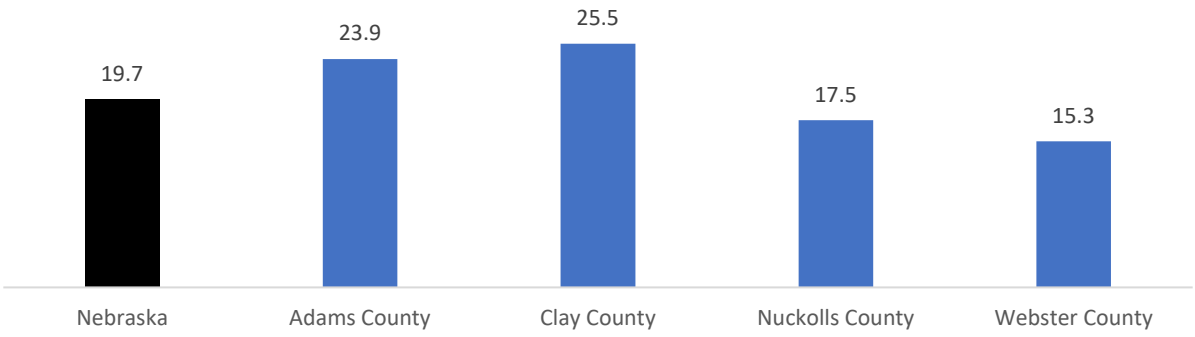
Discussion

Adams and Clay Counties have higher rates of births to teen mothers compared to the state (Figure 51).

Child and infant mortality rates are higher in Adams County compared to the state. Data are unavailable for Clay, Nuckolls, and Webster Counties (Figures 53 & 54).

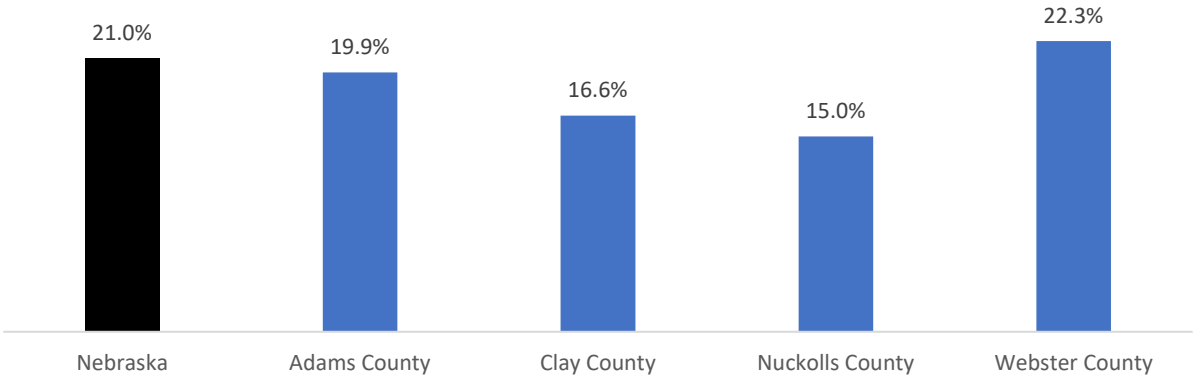
Compared to Nebraska as a whole, Clay, Nuckolls, and Webster Counties have slightly higher percentages of children under age 19 without health insurance (Figure 55).

Figure 51. Teen birth rate (2013-2019)
(number of births per 1,000 female population ages 15-19)



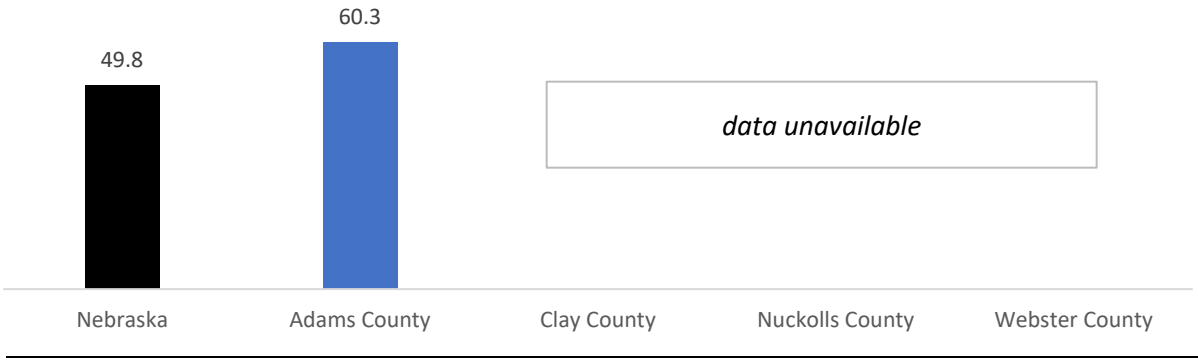
Source: County Health Rankings

Figure 52. Percentage of children in single parent households (2015-2019)



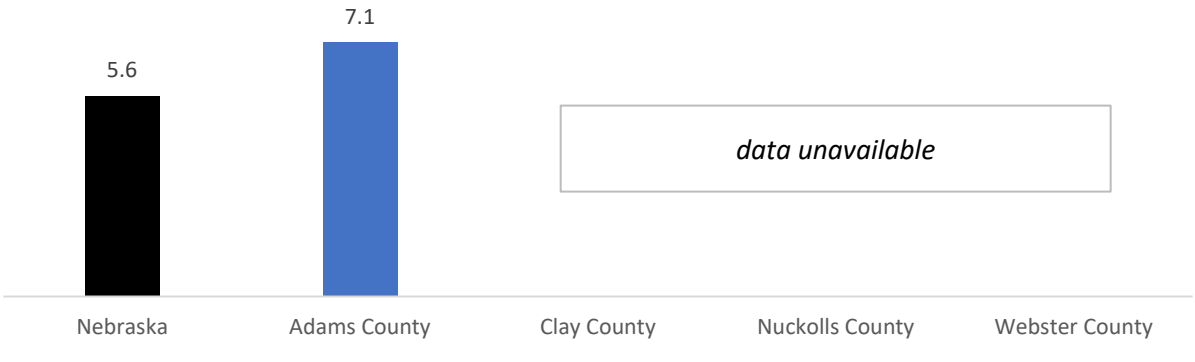
Source: County Health Rankings

Figure 53. Child mortality rate (2016-2019)
(number of deaths among children under age 18 per 100,000 population)



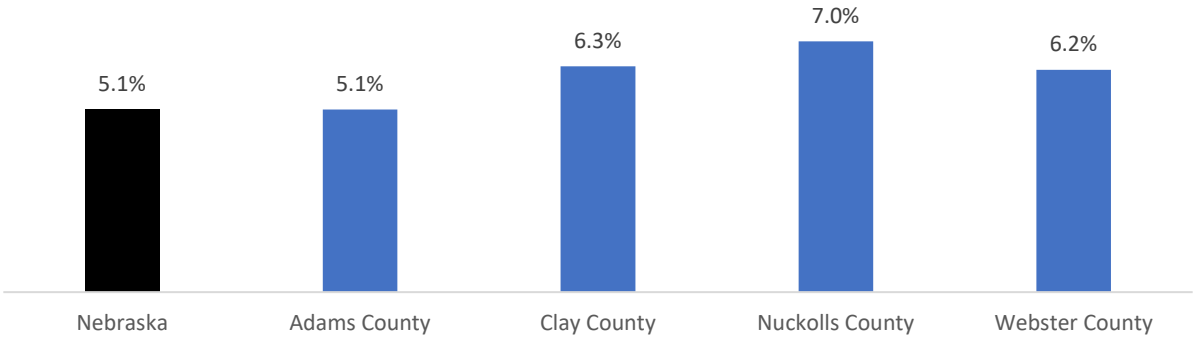
Source: County Health Rankings

Figure 54. Infant mortality rate (2013-2019)
(number of infant deaths per 1,000 live births)



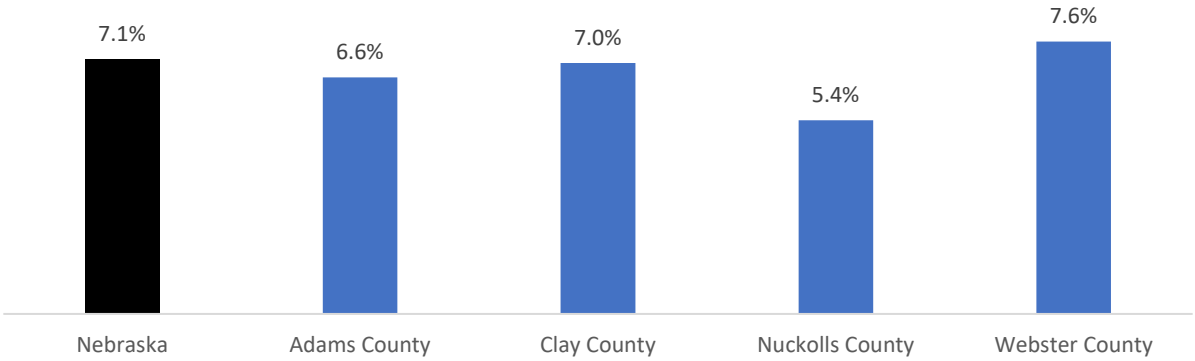
Source: County Health Rankings

Figure 55. Percentage of children under age 19 without health insurance (2018)



Source: County Health Rankings

Figure 56. Percentage of children born with low birthweight (5.5 pounds) (2013-2019)



Source: County Health Rankings

Community Themes and Strengths Assessment

The section describes data from the Community Themes & Strengths Assessment (CTSA) for Adams, Clay, Nuckolls, and Webster Counties. The survey was conducted via online and paper modes and was offered in both English and Spanish. All survey responses, whether collected online or via paper, were entered into the Qualtrics platform. The Qualtrics link had been followed 1520 times by mid-December 2021 when the survey closed. After removing cases without data, 1192 cases remained.

SHDHD employed several outreach efforts to distribute the CTSA, including the following:

1. Used door to door communication with racial/ethnic minority residents.
2. Hosted a racial/ethnic minority focused planning session to identify key people/locations/events to distribute the survey.
3. Utilized partners (two area hospitals and United Way) to deliver the survey through paper copies.
4. Posted the online survey link on their website for over a month.
5. Posted several posts to promote the survey link on social media.
6. SHDHD staff went to nail shops in Hastings to reach racial/ethnic minority populations other than Hispanic/Spanish-speaking.
7. Reached out to clinics to connect with their patients.
8. Reached out to schools to share with their families.

Demographics

The respondents to the survey came from all four counties in the South Heartland District, although not in the same representation. Table 8 shows the population breakdown from the CHIP data, compared to the data from the CTSA. Adams and Nuckolls County residents were overrepresented in the CTSA data. Table 8 also includes comparisons by race/ethnicity - since there were fewer than 30 CTSA respondents who were neither white nor Hispanic, they were grouped with Hispanic respondents for the group differences shared in this section. Except for Nuckolls County, racial and ethnic minorities were over-represented compared to the population.

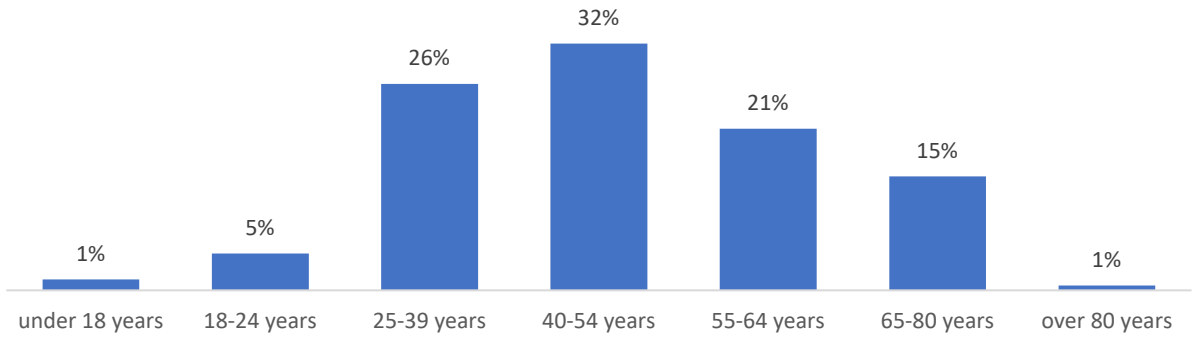
Table 8

	2019 CHIP Population (% tot)	2021 CTSA Respondents (% tot)	White, non-Hispanic	
			2019 CHIP	2021 CTSA
Adams County	31,587 (69%)	826 (75%)	85.9%	69%
Clay County	6,203 (14%)	87 (8%)	89.2%	85%
Nuckolls County	4,244 (9%)	152 (14%)	94.6%	97%
Webster County	3,537 (8%)	37 (3%)	91.5%	86%

SHDHD total	***45,571***	***1,102***	***87.6%***	***75%***

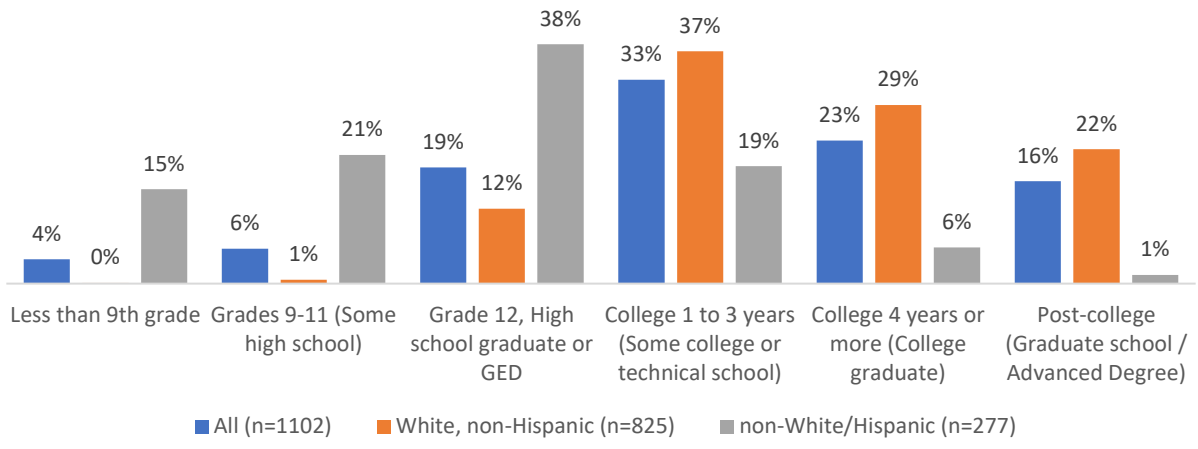
Three-quarters of respondents (75%) to the CTSA identified as female, 23% as male, and the rest as gender minorities or they preferred not to say. Figure 57 shows the breakdown of respondents by age – nearly a third were between the ages of 40-54 years of age. Only one in ten respondents lived alone, with a two-person household being the most common (35%), with approximately one in five in households of 3 (19%), 4 (18%), and 5 or more (18%).

Figure 57. The majority of respondents were between the ages of 25-64 (n=1102)



The respondents to the CTSA were more educated than the state averages (32% of Nebraskans ages 25 and older have a bachelor's degree or higher). As Figure 58 shows, there were large differences by race/ethnicity. Three percent of respondents were currently in the military or were a veteran, and 17% had an immediate family member in the military. White, non-Hispanic respondents were four times as likely to have a family military attached to the military (21% vs 5%).

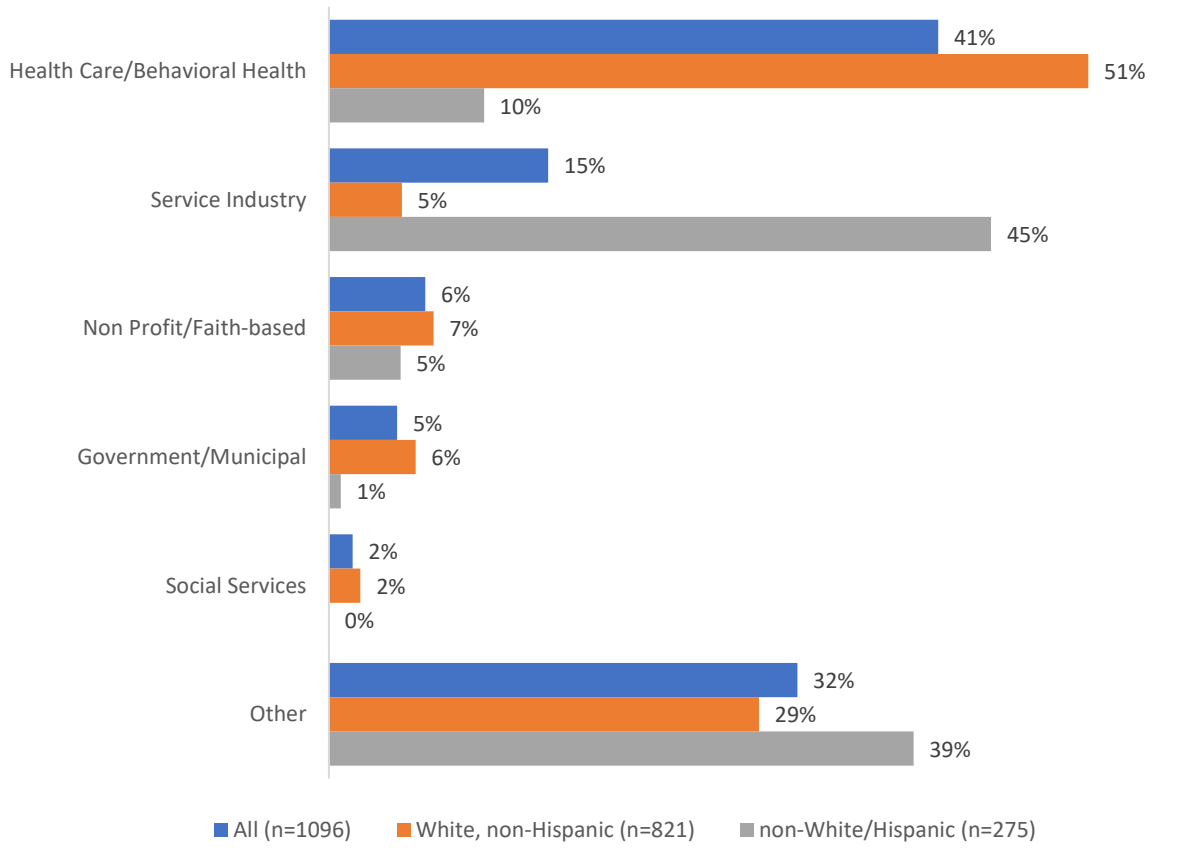
Figure 58. Respondent education by race/ethnicity



Two out of every five respondents (41%) either worked or had an immediate family member working in an industry related to agriculture. Non-white and Hispanic respondents were twice as likely to be in this group than white respondents (68% vs. 32%). There were also large

differences by field of work (Figure 59), specifically in the fields of health care and the service industry. (The “other” category included education (4%), agriculture (4%), retirees (3%), and industry (such as fiberglass and manufacturing - 2%).

Figure 59. Field of work by race/ethnicity



Access to Healthcare

Most respondents in the South Heartland District said they do have access to services like hospitals and doctors’ offices within an hour of where they live (Figures 60 & 61). Access to behavioral health services was less common. There were not differences by the race/ethnicity of the respondent.

Figure 60. Access to hospitals, emergency rooms, urgent care clinics, etc. w/in an hour of home

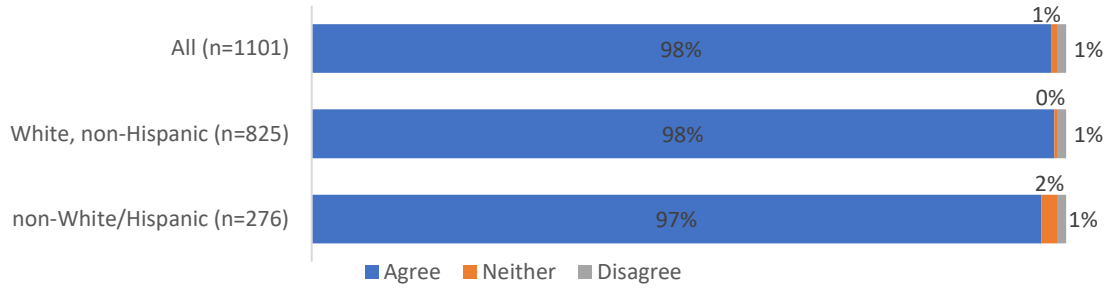


Figure 61. Access to doctors' offices, health clinics, etc. w/in an hour of home

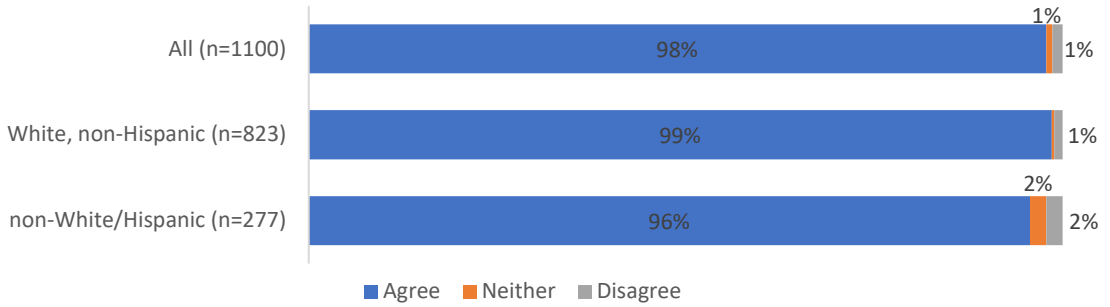
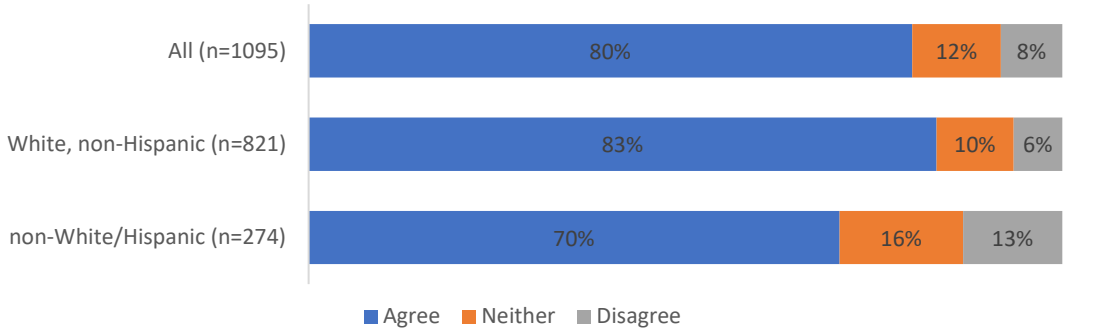


Figure 62. Access to behavioral health services w/in an hour of home



Access to substance misuse, medical specialists, and weight management programs was less common, with large differences by race/ethnicity. White, non-Hispanic respondents were half as likely as non-white/Hispanic respondents to say they did not have access to substance misuse services (Figure 63). White, non-Hispanic respondents were twice as likely to say they were within proximity to specialists than non-white, Hispanic respondents (Figure 64), with a similar pattern for access to weight management services (Figure 65).

Figure 63. Access to substance misuse services w/in an hour of home

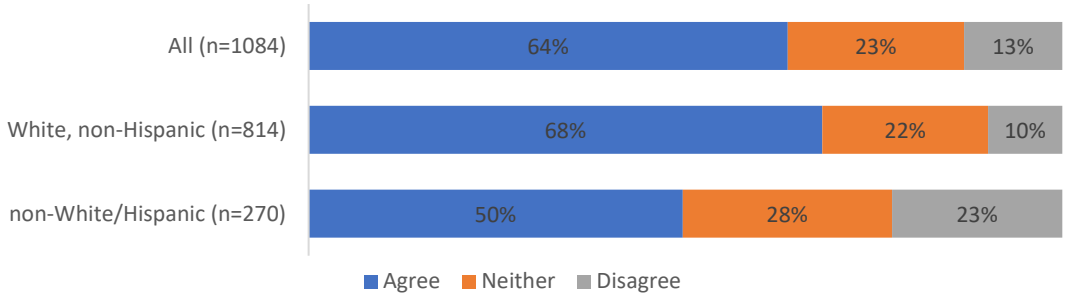


Figure 64. Access to medical specialists w/in an hour of home

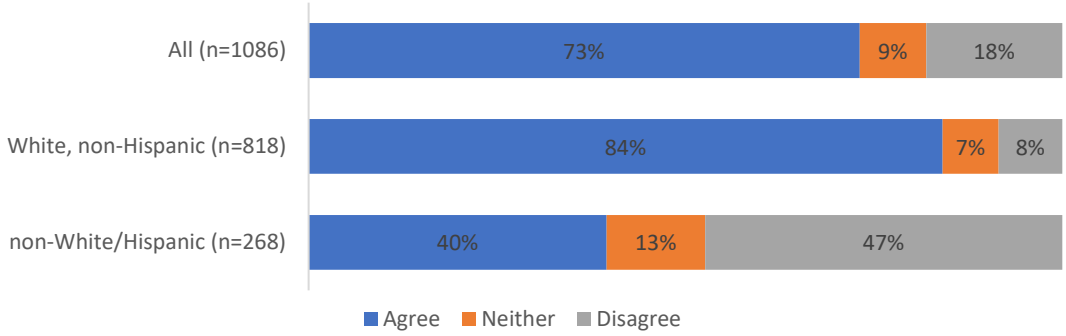
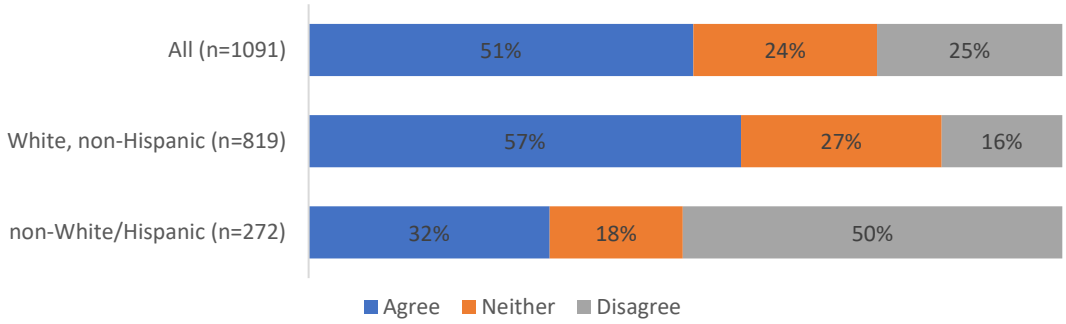


Figure 65. Access to adequate services that support people needing assistance with weight management w/in an hour from home

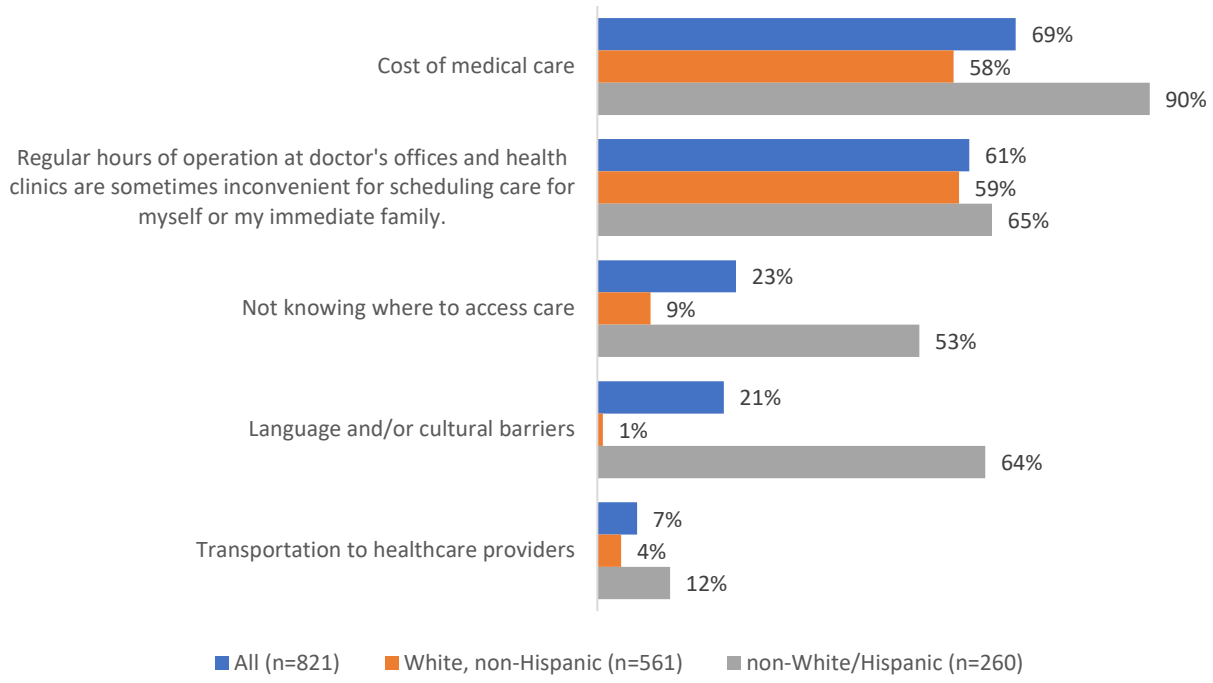


Barriers to Care

When asked about the reasons they did not get the medical care they needed, cost was the most selected reason (Figure 66). Not knowing where to access care was selected by a third as many respondents, followed closely by language and/or cultural barriers. Transportation was the least selected barrier. These four barriers had large racial/ethnic differences, with white, non-

Hispanic respondents choosing them at lower rates than non-white/Hispanic respondents. Scheduling was a barrier for about three out of five respondents, regardless of race/ethnicity.

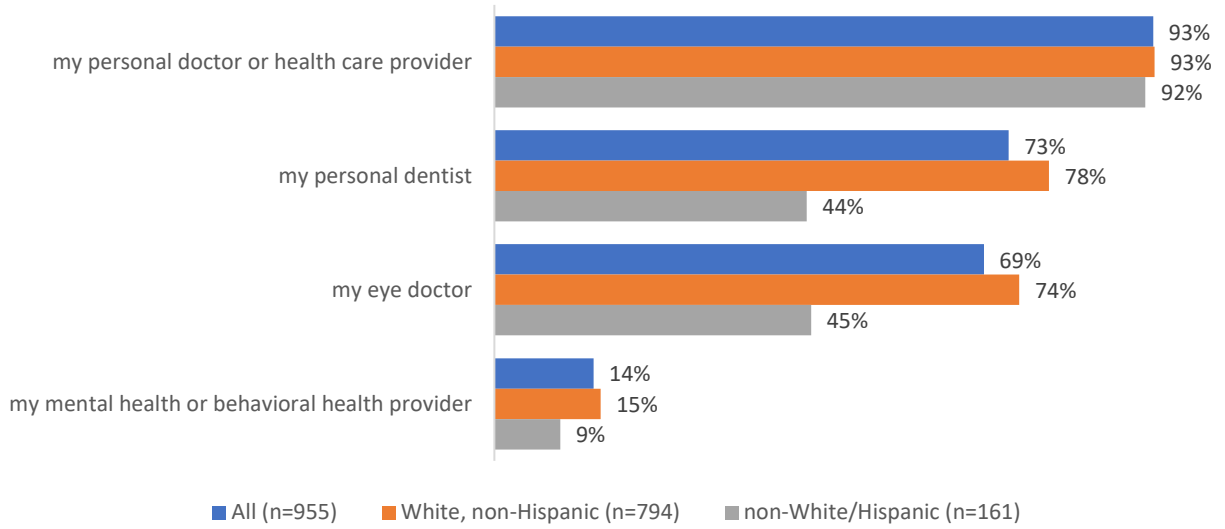
Figure 66. Barriers to care for self & immediate family



Personal Provider

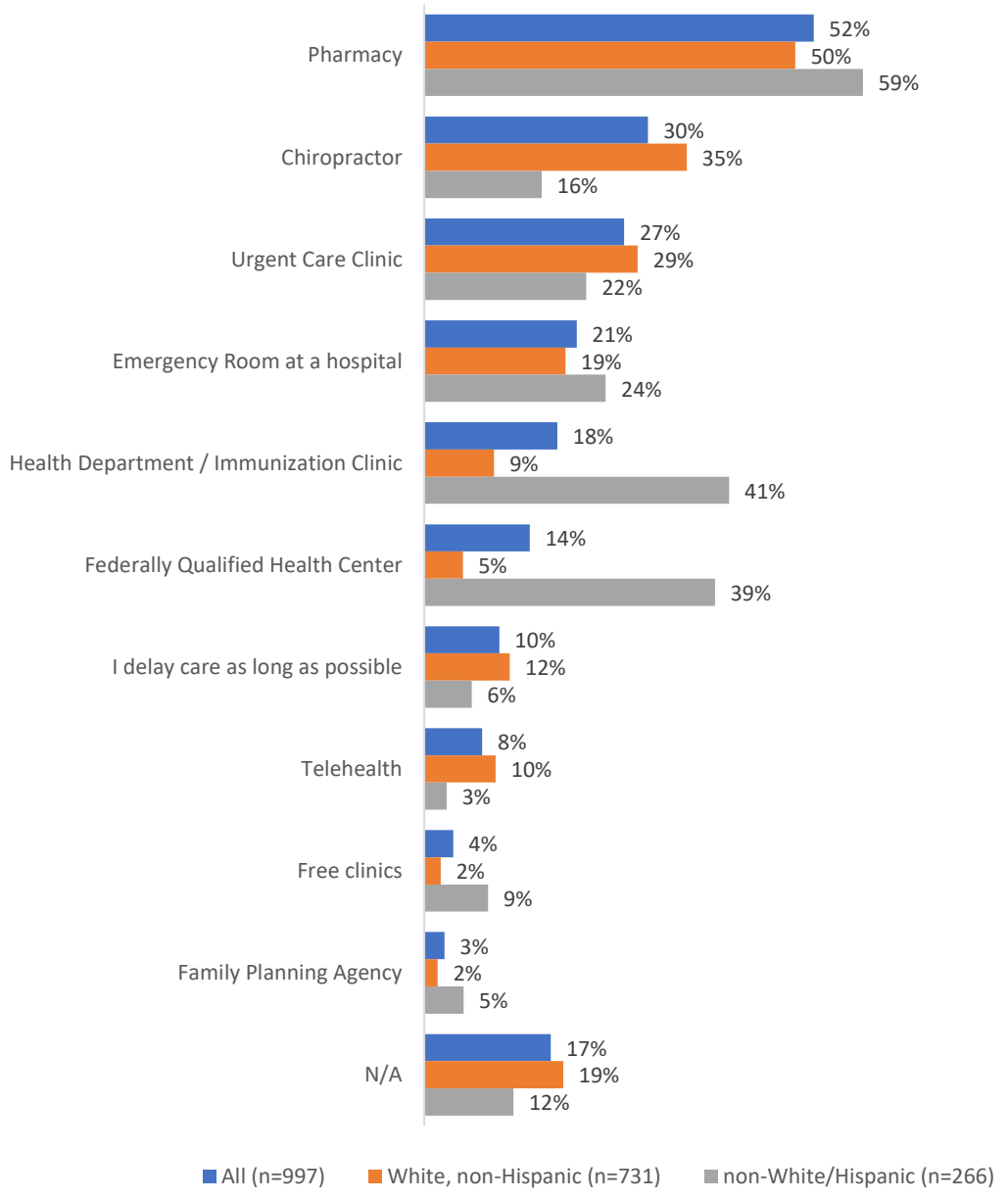
Most respondents had a person they consider their health care provider, while few have a mental health provider (Figure 67). Non-white/Hispanic respondents were about a third less likely than white, non-Hispanic respondents to say they had a dentist or optometrist.

Figure 67. Have someone considered...



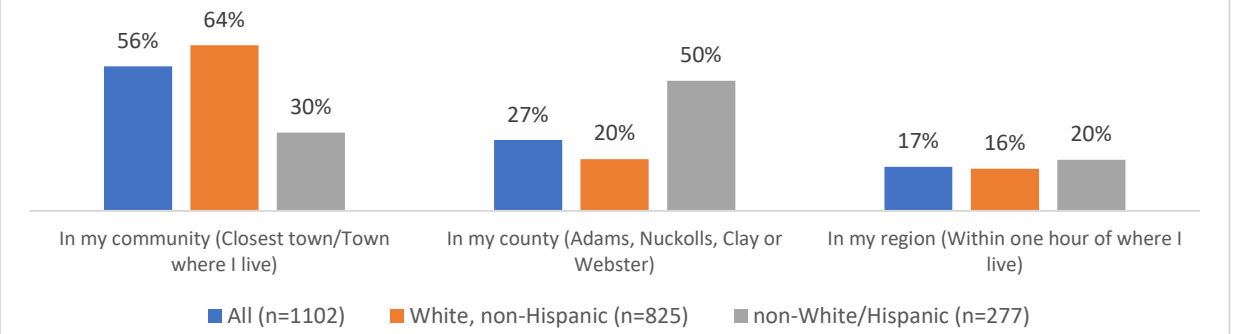
Respondents were asked about other sources of health care services (Figure 68). More than half of respondents selected pharmacy, with slightly more non-white/Hispanic respondents than white, non-Hispanic respondents making that choice. Non-white/Hispanic respondents were also more likely than white, non-Hispanic respondents to use the health department, federally qualified health centers, free clinics, and family planning agencies. White, non-Hispanic respondents were more likely to use urgent care and telehealth and were more likely to say they didn't use any other services. White, non-Hispanic respondents were twice as likely as non-white/Hispanic respondents to delay care as long as possible. Other sources written in included were massage, therapists, physical therapists, and specific providers.

Figure 68. Other sources of health care services



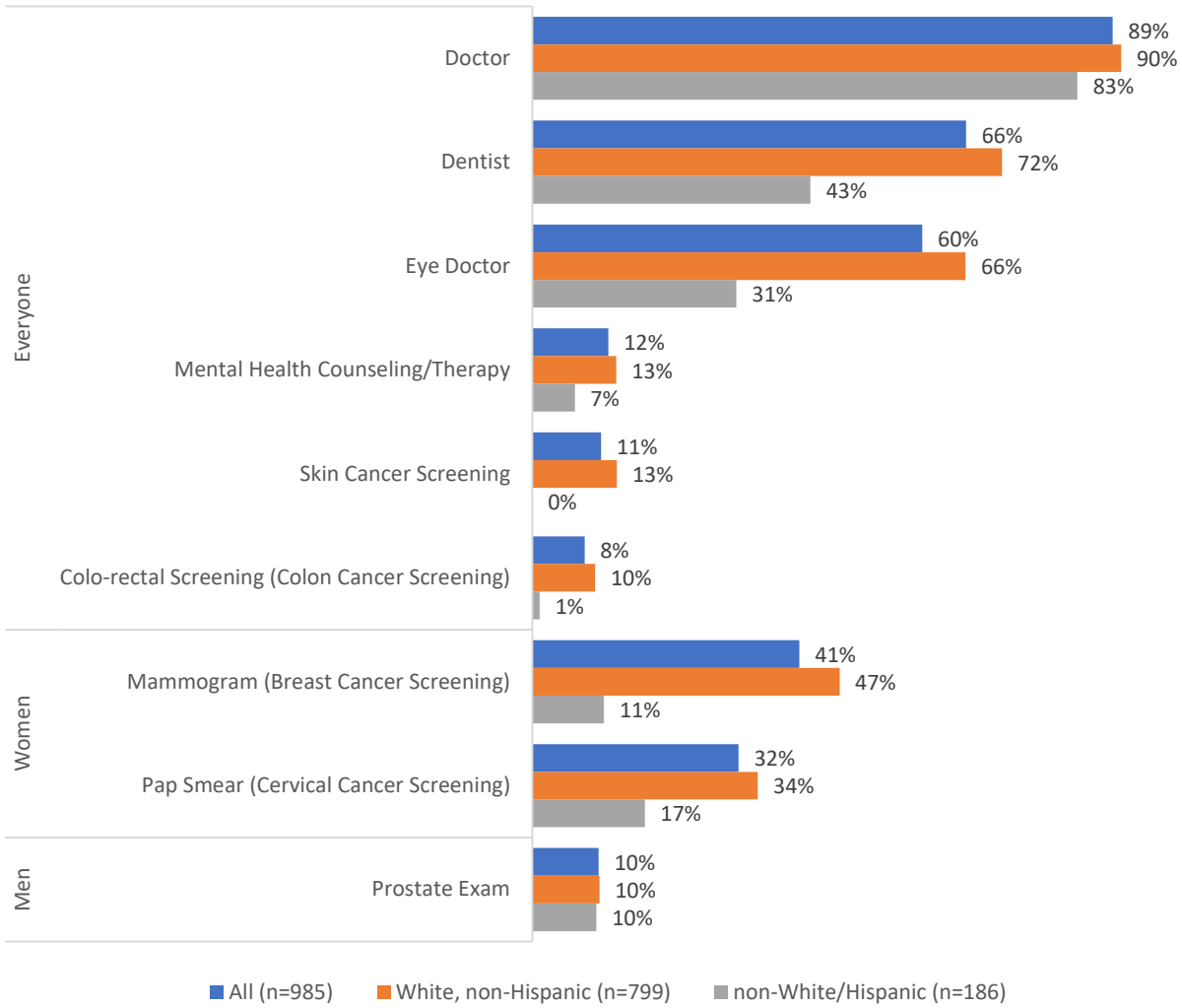
Over half of respondents said they received most of their healthcare in their own community – but this was twice as likely for white, non-Hispanic respondents than for non-white/Hispanic respondents (Figure 69). Half of non-white/Hispanic respondents said they received most healthcare in their county (but not the closest town), more than double the number of white, non-Hispanic respondents. Accessing healthcare in their region was similar across groups.

Figure 69. Most healthcare received...



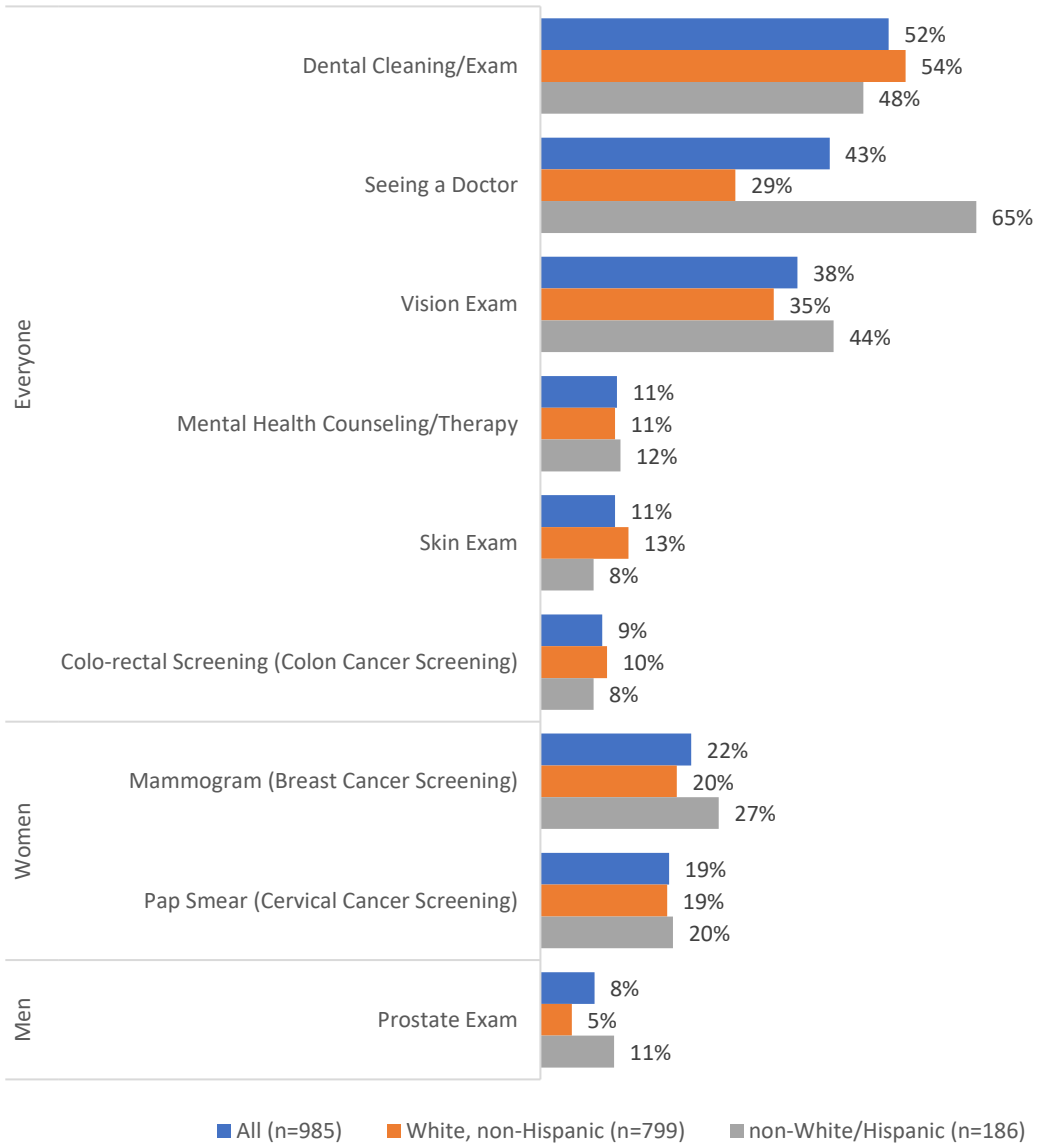
Respondents were asked what care they received during the pandemic (Figure 70). About nine out of ten said they saw a doctor, with slightly more white, non-Hispanic respondents making that claim than non-white/Hispanic respondents. Two thirds of white, non-Hispanic respondents saw a dentist and/or optometrist during that time, nearly twice the number of non-white/Hispanic respondents. While far less common, therapy, skin cancer and colon cancer screenings all had racial/ethnic differences. Breast and cervical cancer screenings were at least twice as common for white, non-Hispanic women than non-white/Hispanic women.

Figure 70. Care <u>received</u> since January 2020



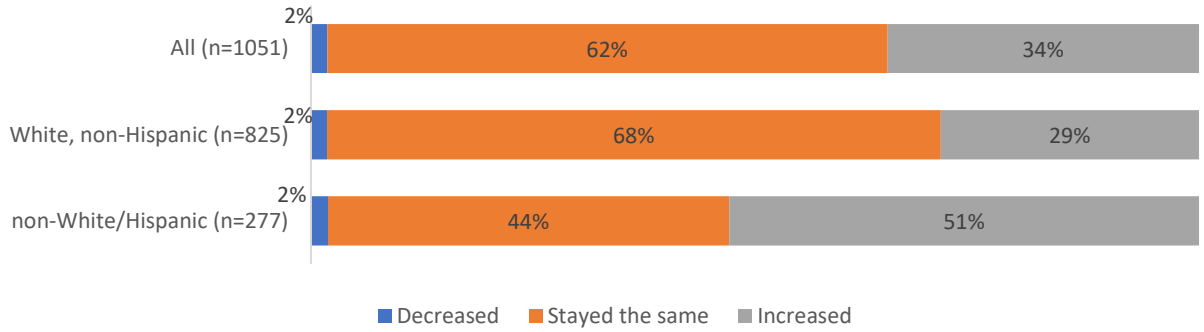
Respondents were also asked about what services they delayed during the pandemic (Figure 71). Overall, dental cleanings were the most likely to be delayed, selected by about half of respondents. However, nearly two-thirds of non-white/Hispanic respondents said they delayed seeing a doctor since the pandemic started, more than double the number of white, non-Hispanic respondents. White, non-Hispanic respondents were also less likely to delay their vision exams. The slight racial/ethnic variation in other services were not statistically different.

Figure 71. Care delayed since January 2020



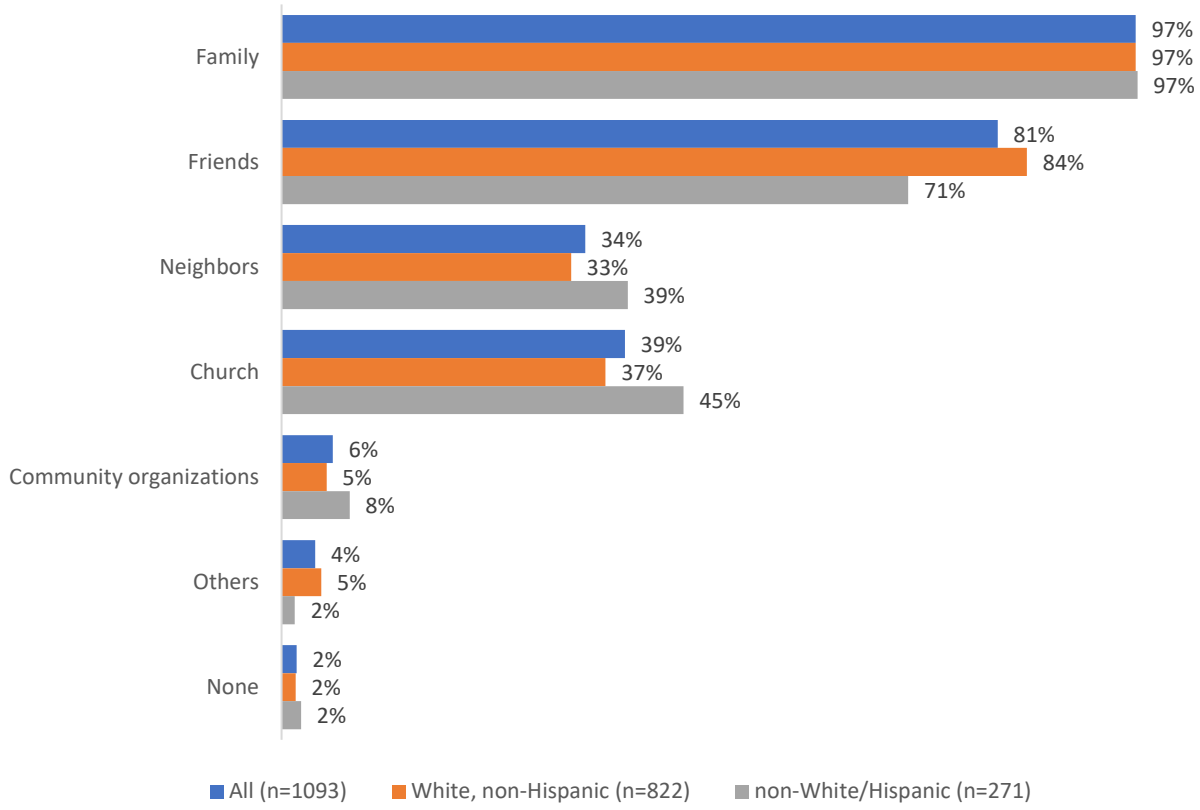
Respondents were asked about their mental/behavior healthcare needs since January 2020 (during the COVID-19 Pandemic). Figure 72 shows overall, one in three people said their needs increased, but this was greater for non-white/Hispanic respondents.

Figure 72. Mental/behavioral healthcare needs since January 2020 have...



A list of social supports during the pandemic was given, with room to write in other answers (Figure 73). Nearly all respondents said family was a support, followed by friends. Half as many respondents said neighbors or the church. Friends were more common for white, non-Hispanic respondents than non-white/Hispanic respondents, while non-white/Hispanic respondents were more likely to select church. Written in community answers included organization like Kiwanis and YWCA, and co-workers was a common write-in for other.

Figure 73. Safety and social support since January 2020



Respondents were asked about changes in their substance use during the previous two years (Figures 74-78). Approximately 13% of respondents said their alcohol and tobacco use decreased in the past two years, and about 7% said the same about e-cigarettes, opioids, and other drugs. About one in five respondents reported an increase in alcohol, tobacco, and/or e-cigarette use during this time. Opioid and other drug use increased for about 13% of respondents. There were more changes in alcohol use for non-white/Hispanic respondents than for white, non-Hispanic respondents. While there was variation by race/ethnicity for the other substances, the small number of respondents responding to these questions makes those tests unreliable.

Figure 74. Change in alcohol use over last 2 years

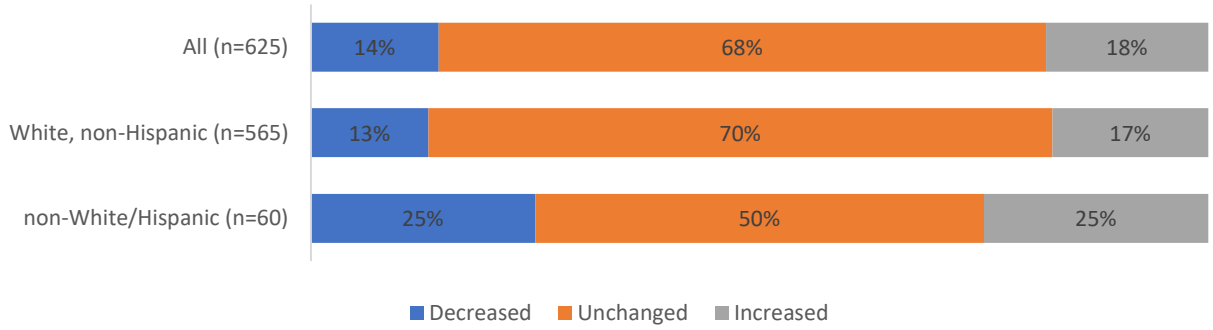


Figure 75. Change in tobacco use over last 2 years

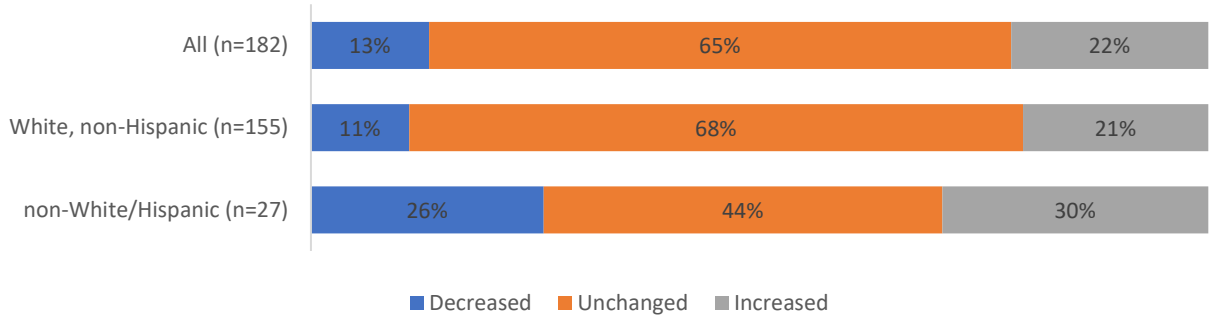


Figure 76. Change in e-cigarette use over last 2 years

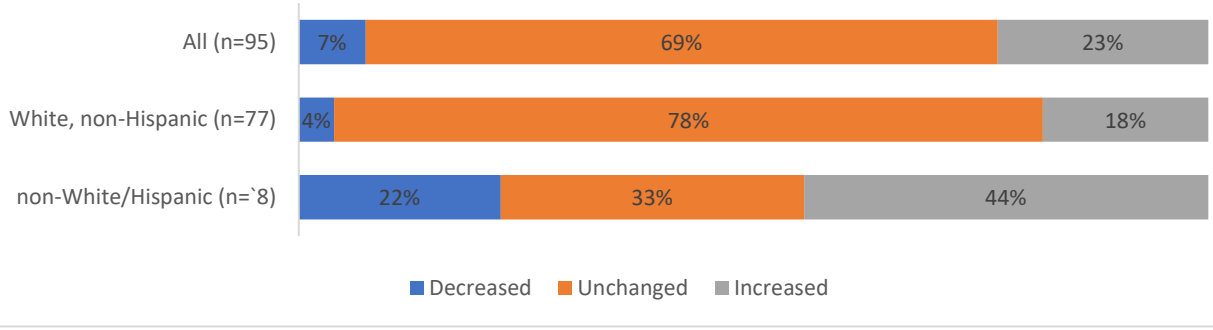


Figure 77. Change in opioid use over last 2 years

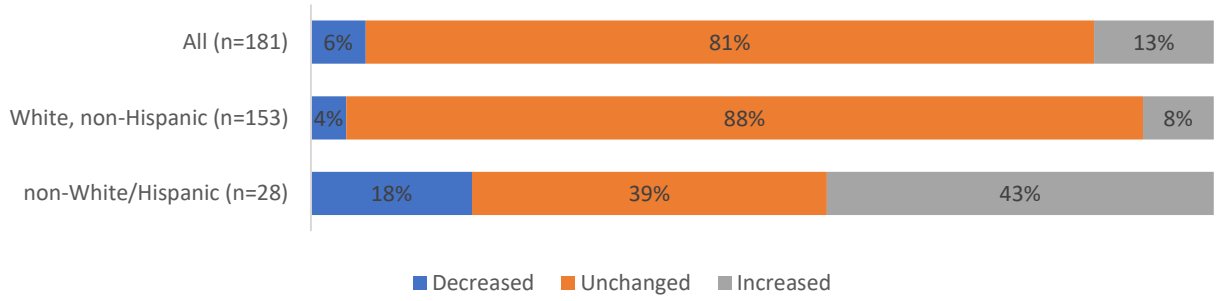
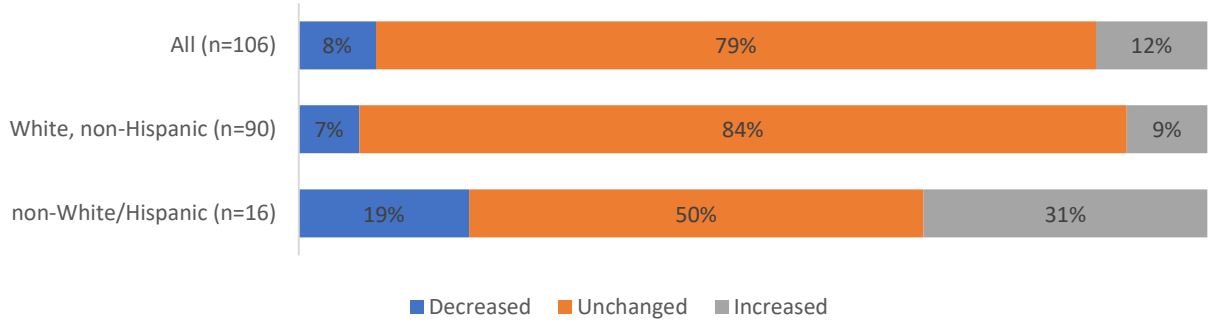


Figure 78. Change in other drug use over last 2 years



Physical Activity and Nutritional Opportunities

Three questions covered regional access to parks, cultural events, and education programs (Figures 79-81). Nine out of ten respondents had access to places to exercise and play (Figure 79). Almost two-thirds of respondents said they had access to cultural events, with stronger agreement among white, non-Hispanic respondents than non-white/Hispanic respondents (Figure 80). Access to nutrition, physical activity, and weight management programs had the greatest variability by race/ethnicity (Figure 81).

Figure 79. Access to places to exercise and play w/in an hour of home

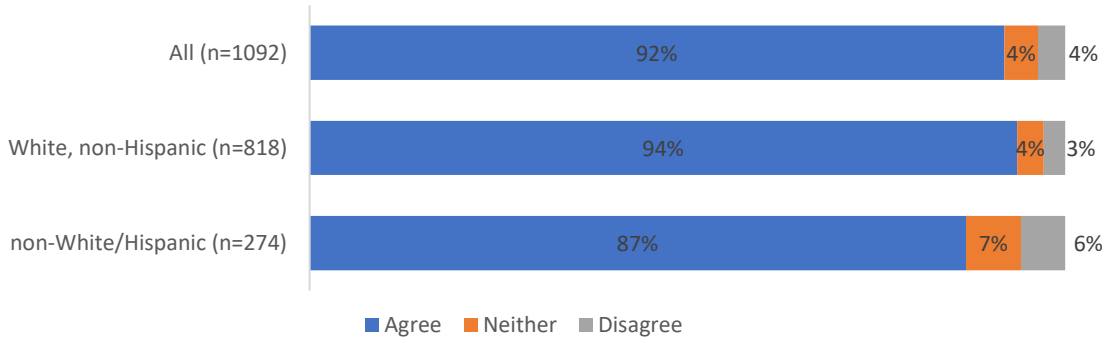


Figure 80. Access to music, art, theater, and cultural events w/in an hour of home

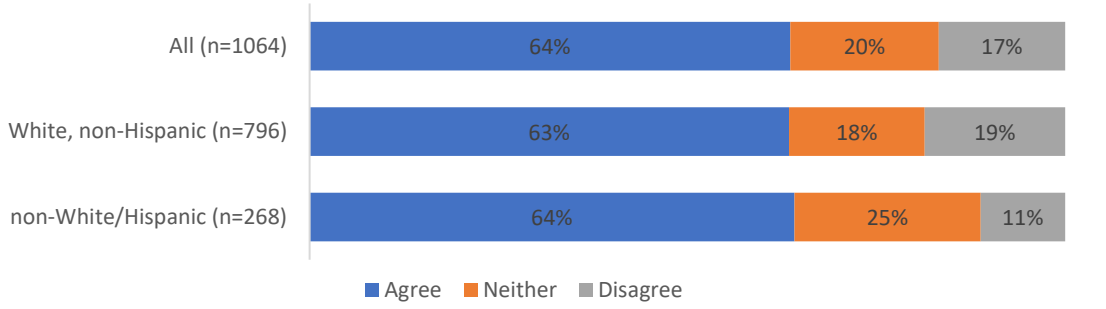
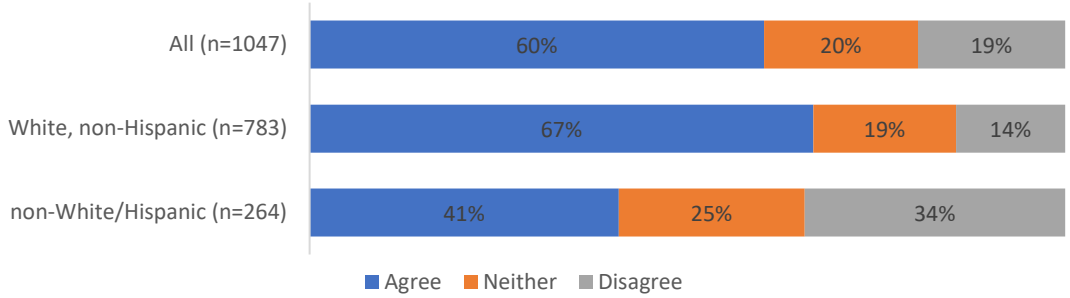
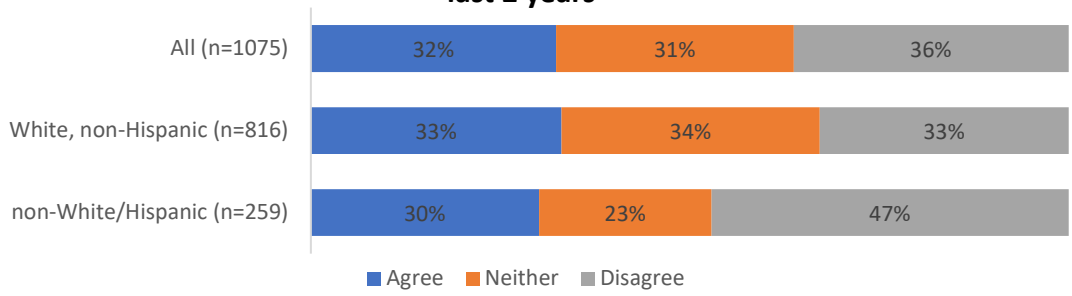


Figure 81. Access to nutrition, physical activity, and weight education and management programs w/in an hour of home



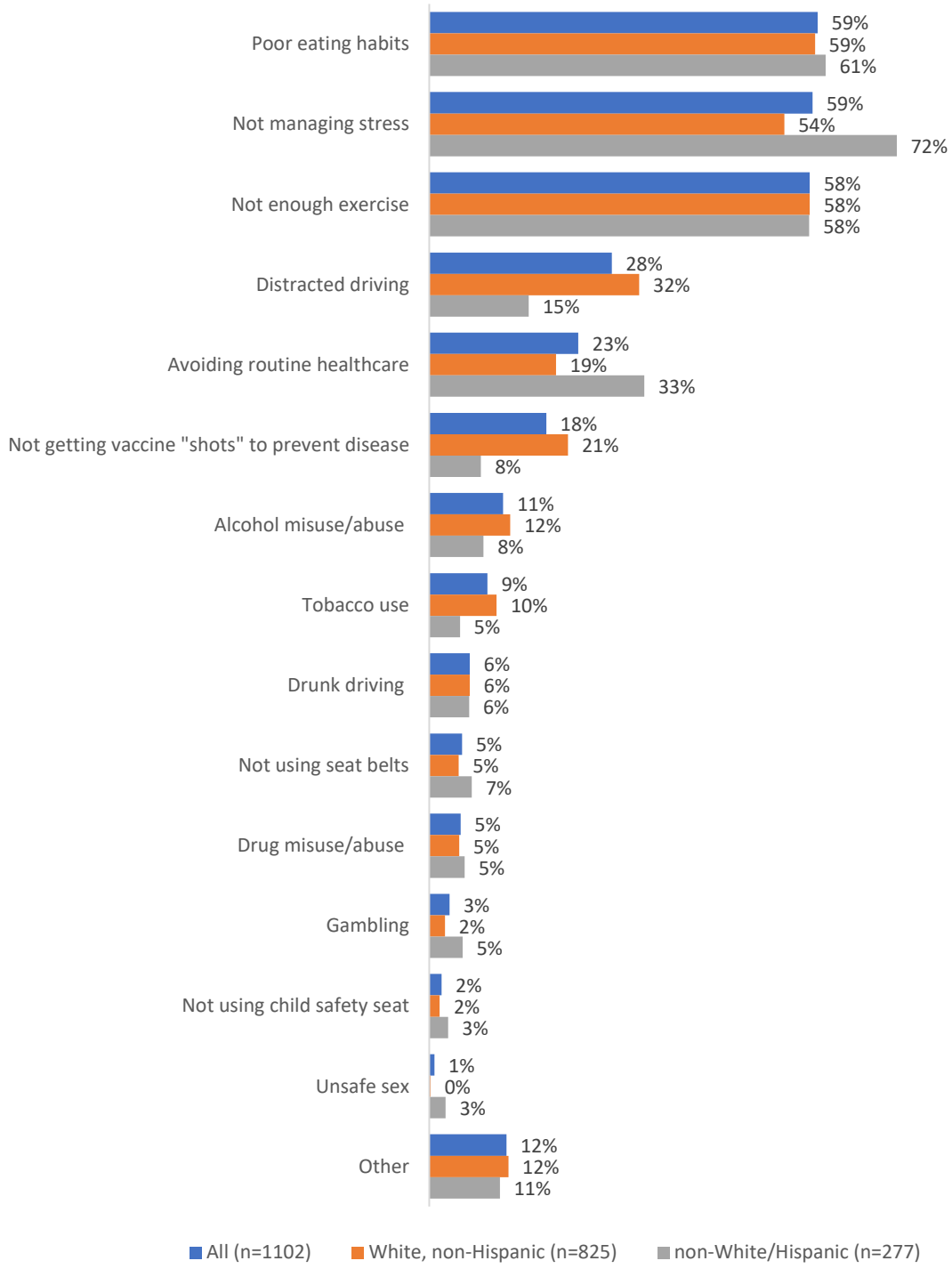
Positive change in physical activity habits was nearly equal between agree, disagree, and neither agree nor disagree (Figure 82). Nearly half of non-white/Hispanic respondents disagreed with the statement.

Figure 82. Physical activity habits have changed for the better w/in the last 2 years



The respondents were asked to select the three behaviors they were most concerned about from a list of 15 (with room to write in a 16th). More than half selected poor eating habits, stress, and exercise (Figure 83). Stress was more likely to be selected by non-white/Hispanic respondents. Avoiding routine healthcare and gambling were also chosen more often by non-white/Hispanic respondents. White, non-Hispanic respondents were at least twice as likely as non-white/Hispanic respondents to select distracted driving, not getting vaccinated, and tobacco use as top concerns. Most write-in answers were about selecting less or more than three behaviors, with multiple comments about school, mental health, and vaccination effects.

Figure 83. Top 3 concerns impacting health & well being



When asked an open-ended question about what worried them most about their own health and the health of their families, the 609 responses covered a wide variety of answers, often covering multiple topics. A quarter of the answers discussed COVID-19, and often in reference to the relationship in their lives.

"*COVID. My children are too young to get vaccinated. My children are also too young to have something happen their parents.*"

"*Not being able to get in if medical care needed.*"

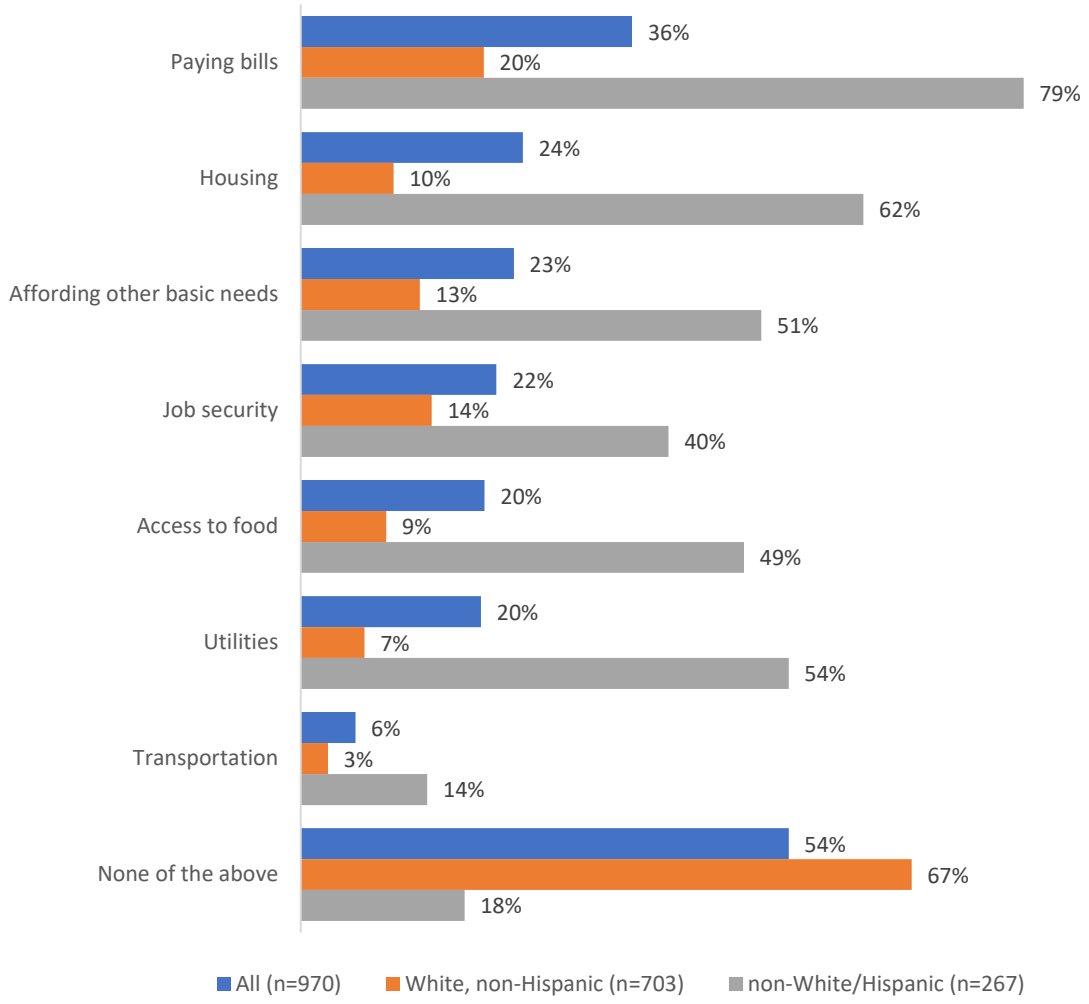
Costs was another common theme – including healthcare costs, insurance deductibles, and the ability to pay for basic needs. Healthcare was often included in comments about costs, but also access.

Another area of high concern was potential health issues. Many comments were about COVID ("*Getting covid or a terminal disease*"), but many were about family histories ("*Mine and my husband's family history of cancer*"), or broad concerns ("*Getting an incurable illness*").

Comments about mental health, access to care, weight, and specific illnesses (like asthma, diabetes, epilepsy) were mentioned by over 50 respondents. Over 50 respondents said they had no health concerns.

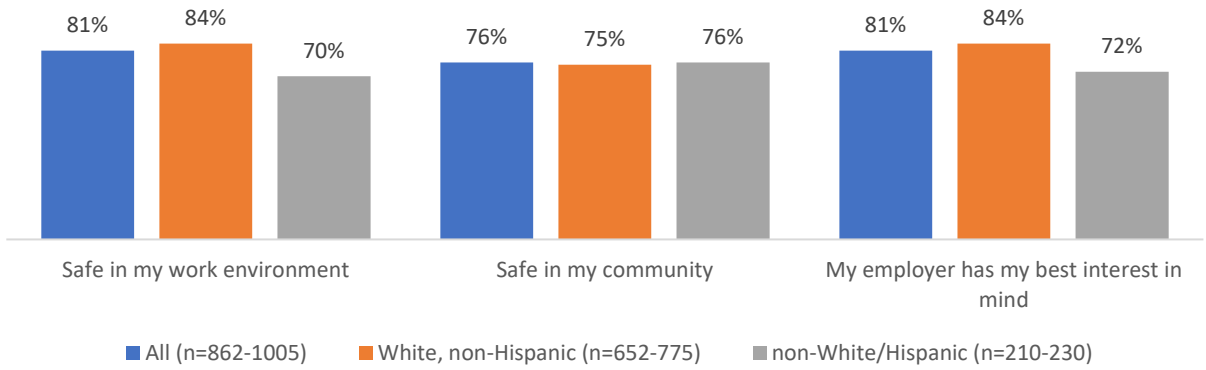
A question asked whether various issues were made more difficult by the pandemic (Figure 84). For each of the seven categories listed, non-white/Hispanic respondents were several times more likely than white, non-Hispanic respondents to say they had greater difficulty. White, non-Hispanic respondents were more than three times more likely compared to non-white/Hispanic respondents to say they did not have difficulty with any of the issues listed.

Figure 84. Greater difficulty because of the pandemic



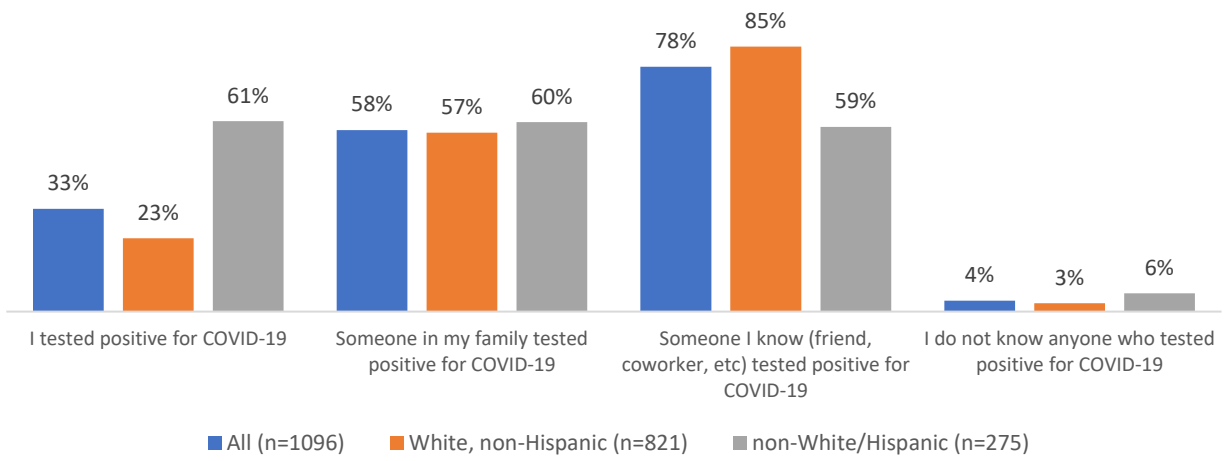
During the pandemic, most respondents felt safe in their work environment, their communities, and thought their employer had their best interest at heart (Figure 85). While there were not any differences in their feelings in their communities, non-white/Hispanic respondents felt less positive about their workplace and employer than white, non-Hispanic respondents.

Figure 85. Feelings during the pandemic



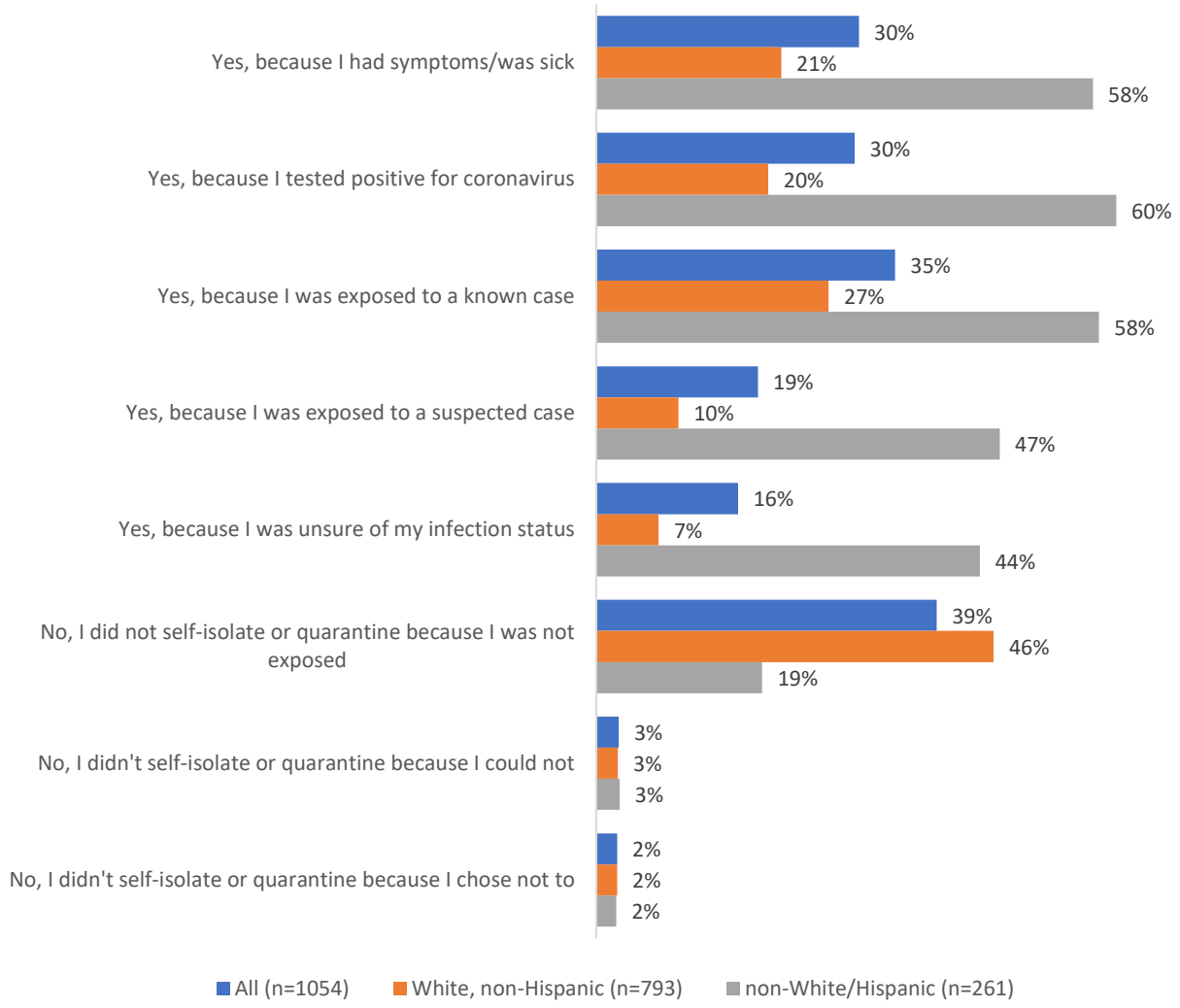
Since the beginning of the pandemic, a third of respondents tested positive for COVID-19, but this was much higher for non-white, Hispanic respondents (Figure 86). They were also twice as likely to say they didn't know anyone who tested positive. White, non-Hispanic respondents were more likely than non-white/Hispanic respondents to say someone they knew tested positive for COVID-19.

Figure 86. COVID-19 testing status



At the time of the survey, nearly all white, non-Hispanic respondents (86%) had the opportunity to get the COVID-19 vaccine, compared to 87% on non-white/Hispanic respondents (93% overall). They were also asked whether anyone had informed them they needed to self-isolate or quarantine since January 2020. This was a select all question, and many people selected multiple answers. For all the yes answers, non-white/Hispanic respondents were more than twice as likely as white, non-Hispanics to say they had been told they needed to isolate (Figure 87). White, non-Hispanic respondents were more than twice as likely to say they did not self-isolate because they were not exposed.

Figure 87. Isolation/quarantine since January 2020



Community Focus Group

Introduction

During January and February 2022, three focus groups were conducted with a total of 33 people in three different counties within the South Heartland District Health Department's service area. All of the focus groups were originally scheduled to occur at the end of 2021 but some were delayed due to the COVID-19 pandemic. A fourth focus group, in Nuckolls County, was unable to occur due to scheduling difficulties. This county was represented instead through a process of individual conversations with 14 individuals that took place between December 2021 and February 2022. The demographic breakdown of the individuals is represented below in Table 9. In addition, two minority listening sessions were held in Adams and Clay counties. A summary of those responses is included in the 2022 SHDHD Minority Health Assessment Report.

Table 9	**Community Focus Group Demographics**			
County	**Number of participants**	**Gender**	**Race/Ethnicity**	**Number of participants who were Veterans**
Adams	7	Male – 2 Female – 5	Hispanic or Latino – 4 White – 2 Black or African American - 1	1
Clay	21	Male – 8 Female – 13	Hispanic or Latino – 13 White – 8	2
Webster	5	Male – 1 Female – 4	White – 5	1
Nuckolls	14	Male – 6 Female – 8	**	**
Overall	**47**	**Male – 11 Female – 22**	**Hispanic or Latino – 17 White – 15 Black or African American - 1**	**4**

** individual conversations that took place between December 2021 and February 2022, no demographics captured

Results

Overall themes and key findings from the focus groups, organized by questions asked, are summarized in Tables 10-17. In terms of worries about participants' health or the health of their

family, cost of care and insurance were consistent themes between the counties as well as barriers to access (such as services being too far away or not being able to see a provider who speaks the same language). A few participants expressed worries related to mental health.

Participants expressed many concerns when asked to share their top 3 health concerns in their family/community. Nutrition, physical activity, and/or weight-related concerns and mental health concerns were the most consistent themes that emerged, followed by concerns about access to care. Access to care, language barriers, and dealing with health systems or insurance were common barriers that participants experienced when seeking or receiving care. When asked to share what they believe is missing in order for them to receive adequate healthcare, participants noted specific services/settings, specialists, and resources that are not available to them in their communities.

When participants were asked to share something they do to be healthy, exercise was the most common response, followed by eating healthy or engaging in good nutrition practices. In terms of what would be needed to make their neighborhood a healthier place, participants commonly cited the need for better access to adequate facilities for physical activity, and some noted the need to have better access to healthier foods and nutrition-related resources.

When asked to talk about whether people who need mental health services are able to get the help they need, participants either noted that specific services were not available in their community or that there were barriers (such as stigma, cost, language-related) that prevented them from accessing available services.

For the final question, participants were invited to share anything else they wanted to say regarding health services in their community and experiences with trying to be healthy/address health concerns. Respondents from each county shared different concerns, including: concerns about health equity and injustices, issues with childcare, and barriers regarding access to necessary health and social services.

The same set of questions were asked during two listening sessions with groups of Hispanic participants from Hastings and Harvard in November and December 2021. Participants from these listening sessions gave similar responses to the questions when compared to the responses from the focus group participants. Both sets of respondents cited access to care barriers related to insurance, high healthcare costs, transportation barriers, language barriers, and lack of appropriate care/services. Both sets of respondents also noted issues with access to specialty care and mental health services. Respondents from the listening sessions, who all identified as Hispanic, were more likely to cite the need to have more resources specific to the needs and unique circumstances of Hispanics/Latinos (e.g., help getting financial aid or finding healthcare for individuals who do not have a social security number).

Table 10	Question 1: What worries you most about your health or the health of your family?
Adams (=7)	Financial/insurance-related ● Understanding bills and paying for healthcare. – noted by 2 participants ● Healthcare depends on what insurance someone carries and your financial status. If I have Medicaid, I feel like I am not treated well or equally in clinics. Barriers to access (travel, language, etc.) ● Clinics can be too far away that accept certain insurances/Medicaid. ● Language barriers – providers do not understand us or things get lost in translation. ● Mental health in small towns is not available, especially for children and those speaking Spanish only. Mental health-related ● There is not enough education for families about mental health and that it's not taboo. Other/personal health ● Healthy eating is a struggle.
Clay (n=21)	Financial/insurance-related ● COVID – especially if we do not have health insurance Access to information/resources ● How to find resources for kids if we do not have Medicaid. ● How to stay healthy. Barriers to access (travel, language, etc.) ● A lot of clinics do not have interpreters, or only use an app translator – in person is so much better. Other/personal health ● High blood pressure. ● Eating well.
Webster (n=5)	Financial/insurance-related ● Daughter does not have health insurance…spouse left and took military health care with him. Son has braces and could not get healthcare. Outrageous health costs. She does not qualify. No one has helped her find other insurance. ● Marketplace insurance is expensive, Medicare is very difficult to understand and when they don't cover something, the secondary insurance won't cover it either. ● High deductibles are unbearable. Mental health-related ● Veteran PTSD, mental health. ● Mental health. Standards to get started are tough. Specifically, depression. First visit being in person is too hard…would prefer telehealth.

	Barriers to access (travel, language, etc.) ● Too far to travel for the in-person appt. Navigating health insurance and systems ● The system is overwhelming. I don't mind jumping through hoops if there is a positive result, but sometimes I am on the phone with different people for a long time and get nowhere (speaking about Medicare). ● No appeal process or support for Medicare Part B – application process was not correct. ● Getting an answer from DHHS. The process and customer service is so tough – takes a long time on the phone
Nuckolls (n=14)	General access ● Access to clinics and providers.

Table 11	**Question 2: In your experience, what are the top 3 health concerns in your family? In your community?**
Adams (=7)	Nutrition, physical activity, and/or weight-related ● Healthy food, healthy eating. ● Weight control. ● Lack of healthiness of food in care facilities. Specific diseases or conditions (apart from mental health) ● Generational sickness, i.e.: cancer, diabetes. ● Obesity in children. Health system or insurance-related ● Filling out form is more complicated than it needs to be. The people who write them do not understand who is completing them. ● Obtaining health insurance. ● Access to trainers to help with PT, insurance makes this very difficult for most to afford. Mental health-related ● Mental health for those that English is a second language, or no English at all. ● Accessible mental health services, removing the stigma around mental health. ● Being able to afford healthcare services, even with insurance.
Clay (n=21)	Healthcare costs ● Having the money to pay the bills ● Meeting the deductible for insurance and understanding how that works. ● Sometimes the cost is too much - I wait to go until I can pay my current bill. ● Hard to find a way to make a payment plan – 2 participants mentioned this. ● Navigating and paying for bills. ○ 75% of the group did not have someone to help them solve health care cost challenges. Access to care ● The clinic here is not open every day

	Nutrition, physical activity, and/or weight-related ● Not enough areas to do physical activities, especially for adults…need an indoor place to exercise. ● When we have younger kids, need nutrition programs to help with overweight kids. Specific diseases or conditions (apart from mental health) ● High blood pressure, liver disease, obesity (indicated by 2 participants). Mental health-related ● Need mental health support - especially with teenagers, going through so much. ● Lots of anxiety in teens – repeated by multiple participants. ● Parents have anxiety with their own children. Equity issues within healthcare system ● No follow-up when bringing a health concern to the clinic (this thread of not feeling like the Hispanic community was treated equally at the clinic was echoed a number of times).
Webster (n=5)	Nutrition, physical activity, and/or weight-related ● Price of healthy food is too much…junk food is too cheap. ○ Son was going to go on a healthy diet but could not afford it. ○ Food pantry food is not healthy sometimes. ○ Shortage of healthy food. Access to care ● Fear of looking for healthcare, especially for mental health (but also just anything). Asking for help is intimidating and it keeps me from getting care. ● We do not have an urgent care for non-emergency needs on the weekend (ear infection at 6pm on Friday for example). ● Our hospital does not have a ventilator, and I know someone who could not get oxygen - they had to go to Broken Bow. ● Hard to get the supplies I needed to treat my diabetes (insurance did not help get a tester). Awareness & education ● Public health awareness - people do not read the paper so how do they learn about health issues? ○ Obesity and diabetes (I did not know what that was, now the education is better).
Nuckolls (n=14)	Access to care ● Availability of providers. ● Transportation to out of town appointments. Mental health-related ● Mental health.

Table 12	Question 3: What kind of barriers are you experiencing in receiving the health care you need? What gets in the way of you receiving health care where and when you need it?
Adams (=7)	<u>Language</u> ● The group agreed that language is the biggest barrier. ● Translation does not work well and the providers do not seem to have patience to take the time to understand.
Clay (n=21)	<u>Access to care</u> ● The clinic here does not have all the medications they need. So, they need to find it in another town and then travel. ● Technology - not having it and then it is too difficult to use it (specific examples were accessing Medicaid online portal). <u>Health systems/insurance related</u> ● Getting a response from Medicaid when we call. Difficulty understanding.
Webster (n=5)	<u>Health systems/insurance related</u> ● Wait time on the help desk for Medicaid - takes a long time to answer the question. ● Bureaucracy for Medicaid. ● Red tape with insurance is the biggest barrier. Anytime you have to call and find out something there is a long wait and not great answers. Repeated by several. <u>Cost</u> ● Cost: paying co-pays - repeated. <u>COVID</u> ● Used to give presentations about healthy eating, these have all been canceled due to COVID. ● Free lunches in Red Cloud have been canceled too due to COVID.
Nuckolls (n=14)	<u>Access</u> ● Having to travel to see most specialists and not being able to afford to do so. ● If a specialist is scheduled but they don't have enough clients they cancel.

Table 13	Question 4: What do you believe is missing in order for you to receive adequate health care? (it could be certain types of specialty medical care or dentistry or vision or mental health services, it could be language help, or classes that teach you about how to take care of certain health concerns…)
Adams (=7)	<u>Resources</u> ● A place where people can go to access resources in one place. ● An in-person cooking class for Spanish speaking.
Clay (n=21)	<u>Types of healthcare settings/services</u> ● A place to go for vision care. ● There are no dental places that take Medicaid! (Repeated concern.) ● Lots of concern with what to do if undocumented

Webster (n=5)	Specialists ● If we don't have enough patients for a particular specialist, they don't come that day, so if you are one person then they don't come and that person does not get treated. ● The specialist schedule does get published in the paper and that would help.
Nuckolls (n=14)	Resources and Specialists ● More providers, especially physicians that specialize in elder adult care and children. ● Dentists in the area are few, and must travel to them. ● We do not have anywhere for people to go to get parenting classes.

Table 14	**Question 5: What is something you do to be healthy?**
Adams (=7)	No response or other ● There were no responses from this county.
Clay (n=21)	Exercise ● Use the community center (but the equipment is broken or old). ● Walk when it is warm. No response or other ● There were no responses to this question from most of the people and a general "head shake".
Webster (n=5)	Exercise ● Go bowling, hunting, and fishing. Travel. Walk so I can be ready to travel. Eat well/good nutrition practices ● I drink water. Take my vitamins and supplements. Go to the doctor ● Call my doctor if I need to. ● Keep my appointments. No response or other ● I don't do much of anything.
Nuckolls (n=14)	Exercise ● Walking. Eat well/good nutrition practices ● Eating healthy.

Table 15	**Question 6: What would make your neighborhood a healthier place for you or your family?**
Adams (=7)	Better access to adequate facilities for physical activity ● Memberships to places to work out is very expensive, and not everyone knows the YMCA has scholarships. ● Other cities have facilities open to the public, gardens, exercise areas, places to make connections, etc. Hastings Middle School garden is a great place to visit.

	Better access to healthy foods ● Grocery store doesn't always have fresh healthy food - that would help if that could be a focus ● Transportation can be an issue since we don't have very many grocery stores, and 2 are very close together. ● Healthy foods are so expensive. Resources for healthy eating ● More healthy cooking classes, as well as preparing food ahead of time. Mental health resources ● Making sure that you feel that you have a safe place to talk to someone.
Clay (n=21)	Better access to adequate facilities for physical activity ● Access to physical activities Resources for healthy eating ● Someone to come share more about nutrition and eating healthy
Webster (n=5)	Better access to adequate facilities for physical activity ● A better community center. The one we have now costs money, crowded and does not have much available. Needs to be updated. ● Community center does not have enough stuff. Equipment is old. Very small. NO weights anymore…. ● Yoga used to happen, but not anymore. Resources for healthy eating ● No organized groups for healthy eating. Other ● Need motivation to be healthy. Need someone to encourage or make it important.
Nuckolls (n=14)	Better access to adequate facilities for physical activity ● An outside gym at area parks. Other ● City code enforcement.

Table 16	**Question 7: Behavioral health refers to health problems related to mental health or substance use issues. Talk about whether you think that people who need behavioral health services (i.e., depression screening or medication, treatment for substance use, etc.) are able to get the help they need when they need it?**
Adams (=7)	Stigma ● Able to get it, but there is stigma. Accessing services ● Difficult to access the Mary Lanning clinic - you have to be there at a certain time and there is no guarantee you will be seen. Hard to understand. ● I don't know how to get mental health services. ● There is no compatible program, like the Bridge, for men.
Clay (n=21)	Barriers to access (language, cost, etc.)

	● Language barriers, stigma, resources - too much to pay for it. <u>Certain services not available (translators, etc.)</u> ● There are no residential treatment places for men with kids who have a substance use disorder, SUD. ● There are no mental health therapists who speak Spanish. It all has to be translated. ● Families do not feel as open if there is the translator in between.
Webster (n=5)	<u>Certain services not available (translators, etc.)</u> ● There is nothing available here. There is an AA group but it is not advertised, so who could you learn about it from? ● There are only the school counselors and even then, you would be referred out of town. ● Our hospital does not offer mental health providers. Telehealth used to be at the hospital - used to come once a month, other times could do telehealth. They do not do that anymore.
Nuckolls (n=14)	<u>Barriers to access (language, cost, etc.)</u> ● Good services at Brodstone but they can't serve everyone. Waitlists for treatments are long.

Table 17	**Question 8: What else do you want to say about health services in your community and your experiences with keeping healthy and being able to take care of your health concerns?**
Adams (=7)	<u>No response or other</u> ● There were no responses from this county.
Clay (n=21)	<u>Health equity/injustice issues</u> ● Participants are made to feel like they do not have the same rights, same benefits, same equal treatment because they speak Spanish. ● There was a long conversation about translators and, in general, they were worried that the translator was not representing their concerns correctly.
Webster (n=5)	<u>Childcare</u> ● Childcare is a problem…even with the new center the cost is too much. $1000/6 weeks. Childcare assistance between divorced parents (one has, one does not) does not transfer. Mom can bring when kids are with her, dad cannot. <u>Closures of services due to COVID</u> ● Senior center - no longer doing activities due to COVID and we need that to restart.
Nuckolls (n=14)	<u>Barriers to access (language, cost, etc.)</u> Good services at Brodstone but they can't serve everyone. Waitlists for treatments are long.

Health Priority Goal #1: Access to Care

Goal: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Develop Healthcare navigator program	Decrease barriers for access and improve continuity of care	Enroll 10 patients into program	Improve outcome and experience with these patients	
	Institute centralized scheduling	Evaluate potential for centralized scheduling process system wide	Decrease number of calls to patient and increase efficiency	
Patient Convenience	Institute appointment reminder via text	Implement text message reminders for patients	Decrease phone calls to patients for appointment confirmation	
Increase Access to Specialty Care	Add specialties offered	Add new specialty areas i.e. Dermatology, Endocrinology, Nephrology, Infection Disease and Gastroenterology	Be creative with recruitment-potential employment options; Partner with organizations through Telehealth	
	Add more days per month for Cardiology, Neurology & Podiatry	Number of days added per month	Provide more option for patients	
	Expansion of DME with area pharmacies	Evaluate program to partner with local pharmacies	Create expanded access to DME in communities we server	

Health Priority Goal #1: Access to Care

Goal: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
	Expand Transportation Service	Work with patient access to identify a need for transportation	Develop a transportation plan that meets the needs of our patients	
Recruit Family Practice Doctor	Fully staffed RHC and satellite clinics	At least 4 Doctors and 7 Mid-levels employed	At least 4 Doctors and 7 Mid-levels employed Current Provider involvement	
Improve Financial literacy of our patients	Provide estimate for patients	100% of all non-government insured patients will receive estimate	Improved financial wellbeing of patients by reducing accounts turned over to collections	
	Create patient friendly billing experience	Establish online bill pay	Increased usage of online bill pay	
Open communication with our patients	Develop a patient community advisory team	Increase HCAHPS top box score	Improved patient satisfaction	

Health Priority Goal #1: Access to Care

Goal: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Business Wellness-Partnership outside of healthcare	Establish a consistent opportunity for communication	Semi-Annual meetings	Improved communication	
Improve access through tele-health	Expand tele-health opportunities with special attention to home-bound patient	Increase number of virtual visits per month by 10%	Improve patient access to care	
Increase availability of same day visits	Utilize dedicated provider or on-call provider	Increase patient satisfaction	Decrease lag time for scheduling in person appts	
Improve patient engagement and overall health literacy	In person education	Number of patients attending each session	More educated patients	
	YouTube Videos	Add one video per quarter to impact healthcare literacy	Patients engaging utilizing YouTube Videos	
	Increase Patient Portal Users/Change platform to be more user friendly	Number of patients utilizing Patient Portal, currently 1500, 10% increase FY 2023, FY 2024 and FY 2025	Patients transfer to new patient portal	

Health Priority Goal #1: Access to Care

Goal: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Establish Support Groups	Establish Arthritis Support & Joint Replacement Support Group	Availability of support group and number attending	Patients more engaged in their own healthcare	
Increase access to non-emergent transportation	Develop program within organization (Thrive Van)	Evaluate availability of Thrive Van, establish 2 drivers, number of rides provided, Implement by Q2 2023	Patient don't have the excuse of missing appts because of transportation	
Partner with schools for additional opportunities for youth to experience hospital culture	Encourage children to consider a healthcare career with more tours	Expand current programs, look beyond pre-k	More students going into the healthcare field	
	Additional job shadowing opportunities	Work with schools to increase number of job shadowing students by 10%	Students exposed to healthcare career opportunities	
	Educational opportunities	Community CPR classes, First Aid, Safe Serve, Mental Health First Aid for Adults & Youth, David Ramsey's Financial Peace University	Number attending classes	

Health Priority Goal #1: Access to Care

Goal: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Partner with other health systems to provide educational opportunities	Increase attendance EMT classes, other ideas, number of partnership, number of attendees	Increase attendees in EMT classes by 10%, partner with one training program in FY 2024	Increased communication with other health partners, cost savings	

Health Priority Goal #2: Mental Health

Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Establish Support Groups	Food insecurity, Grief, Trauma	Establish 2 consistent support groups based on community need	Structured program	
Expand Outpatient mental health services	Expand outpatient mental health program that includes counseling/med management	Increase outpatient mental health visits by 10%	Increase visits to mental health provider	
Expand emergent telehealth mental health services	Expand access to emergency mental health services with multiple providers	Decrease wait time	Better access to emergent needs	
Mental Health first aid program	Offer the course at BH for staff and communities	Provide pediatric and adult mental health first aid annually	Build mental health literacy	
Provide opportunity for David Ramsey's Financial Peace University	Reduce financial stress for participants, thus improving their overall mental health	Evaluate program, track number of attendees	Improve overall "financial health"	

Health Priority Goal #2: Mental Health

Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Mental Health Education	Provide education to public about services offered and make referrals when necessary	Number of attendees, number of referrals, number of inquires	Improve access to mental health	
Expand Mental Health Programs	Continue with current mental health programs, work on expanding, additional age groups	Number of patients currently serving, expand by 10% by the end of FY 2023	Improve access to mental health	
Improve Mental Health for adolescents	Start mental health education in classrooms	Program in place by FY 2023	Decreased depression	
	Establish group therapy	Program in place by FY 2024	Increase participants	
	Parenting classes for parents of adolescents	Program in place by FY 2025	Reduce stress for parents of adolescent children	

Health Priority Goal #3: Substance Misuse

Goal: Reduce substance misuse/risky use to protect the health, safety and quality of life for all.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Develop Substance Abuse Support Group	Provide access to substance abuse support locally	Establish consistent support group based on community need	Structured program	
Develop Opioid Prescription practice	Provide education to staff and public on Opioid prescription practices	Decrease Opioid prescriptions by 50	Reduce number of Opioid prescriptions given	
Partner with county/city on substance misuse education for local schools	Provide or support programs that educate youth on substance misuse	1-2 educational opportunities offered	Reduce substance misuse	
Educate students on the dangers of vaping and electronic cigarettes	Hold regional event in FY 2023	Number of schools involved and number of attendees	Reduce the number of youth using electronic cigarettes and vaping	
Educate students on the dangers of alcohol misuse	Hold regional event in FY 2024	Number of schools involved and number of attendees	Reduce the number of youth misusing alcohol	

Health Priority Goal #4: Obesity & Related Health Conditions

Goal: Reduce obesity and related health conditions through prevention and chronic disease management.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Expand Chronic care program	Implement home based monitoring for COPD and Hypertension	10% at risk patients contacted routinely	5% decreased spending per patient over the last year	
	Evaluate patient need for program expansion opportunities	5% increase in program participants	Program available to accept all chronic care patients identified	
Develop and Expand Transitional Care program	Consolidate transitional care process for all diagnoses	100% of all readmission risk patients taken through process	Decreased 30-day all cause readmission rate (currently at 15.9%)	
Diabetes Support Group	Increase participation in diabetic support group	Currently approximately 12 in attendance, with 150 invitations mailed	Improved community education of available resources for diabetic patients	
Expand Brodstone Fit	Establish year-round community wellness program for all ages/abilities with the help of a fulltime personal trainer	There are currently 19 participants in Boot camp and 53 in Walking Club	Improved community activity levels	

Health Priority Goal #4: Obesity & Related Health Conditions

Goal: Reduce obesity and related health conditions through prevention and chronic disease management.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
	Increase the number of days and or times per day for fitness programs	Number of sessions offered	Improved community activity levels	
	Expand the availability of wellness programs to other communities such as Nelson, Lawrence and Edgar	Number of communities that have programs, number of sessions offered	Improved community activity levels	
Provide healthier options in dietary	Work with dietician to change cafeteria option	Add 3 healthier options per week	Provide the opportunity for healthier eating	
Partner with local organizations for wellness activities and resource management	Wellness activities that partner with library, theatre, book clubs, cooking demonstrations	Add one new activity each FY, number of attendees	Add activities that get people off of their couch	
Improved wellness and community interaction through educational opportunities	Provide education through website, radio, schools, newsletters (include job openings)	A newsletter semi-annually in FY 2023, add a YouTube video in FY 2024, add quarterly radio spots in FY 2025	Improve Communications and community engagement	

Health Priority Goal #4: Obesity & Related Health Conditions

Goal: Reduce obesity and related health conditions through prevention and chronic disease management.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
	Wellness passport to include activities such as golf, swimming, pickle ball, disc golf, attending a movie, meeting with a patient advocate, attending a financial well-being meeting, or setting up a patient portal	Evaluate the program in FY 2024	Establishment of a wellness program that impacts the communities in our region	
	Monthly opportunities for blood pressure, diabetes, heart health, health fairs	Evaluate programs to meet the needs of the community	Increased access to services for the region	
Dietician on staff	Expand the role of the dietician	Establish Nutritional program	Educate and effect change for the community in reducing obesity	
Expand Wellness Events	Provide more opportunities for patients to consult a dietician	Add one new event in each FY 2023, 2024, 2025	Increase total participation	

Health Priority Goal #4: Obesity & Related Health Conditions

Goal: Reduce obesity and related health conditions through prevention and chronic disease management.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Establish Wellness Center	Partner with school & auditorium for facility	Evaluate possible locations	Develop comprehensive wellness program	
	Health Fitness Program	Survey community for wants/needs, Develop Program	Develop comprehensive wellness program	
	Fitness Challenges for community	Add an additional challenge each FY 2023, 2024, 2025	Develop comprehensive wellness program	
	Obesity education/prevention	Develop Program	Develop comprehensive wellness program	

Health Priority Goal #5: Cancer

Goal: Reduce the number of new cancer cases as well as illness, disability and death caused by cancer.

Objective	Goals 2023-2025	Measures	Outcome	Progress/Action
Achieve ACO Goals,	Provider proactive with patient wellness visits and screenings	compliance of wellness visits and screenings	10% increase in wellness visits and screenings per year	
	Increase utilization of preventative services	Create Ad campaign for awareness in Colon, Breast, & BMI screenings	10% increase in these 3 screenings per year	
Establish tobacco cessation program	Increase number of participants	15 participants in the program per year	Reduce number of tobacco users in the region	
Develop Cancer Care Navigator Program	Evaluate need and develop program for cancer care navigators	Structured program in place to support patients	Improved healthcare literacy and patient engagement during cancer treatment	
Develop a Radiation Cancer Program	Evaluate the need for a Radiation Cancer Center	Conduct a feasibility study for a radiation cancer center	Improve access to radiation therapy locally	

Approval and Distribution

The Brodstone Healthcare Community Health Needs Assessment & Community Health Improvement Plan was approved by the Board of Managing Trustees at its regular monthly meeting, held April 26, 2022. This report is accessible to the public and may be viewed on the hospital website, http://brodstonehospital.org/. Written copies are also be available upon request.

Patricia McCord April 26, 2022
Pat McCord, President, Board of Managing Trustees
Brodstone Healthcare

Treg Vyzourek April 26, 2022
Treg Vyzourek, Chief Executive Officer
Brodstone Healthcare

Brodstone
HEALTHCARE