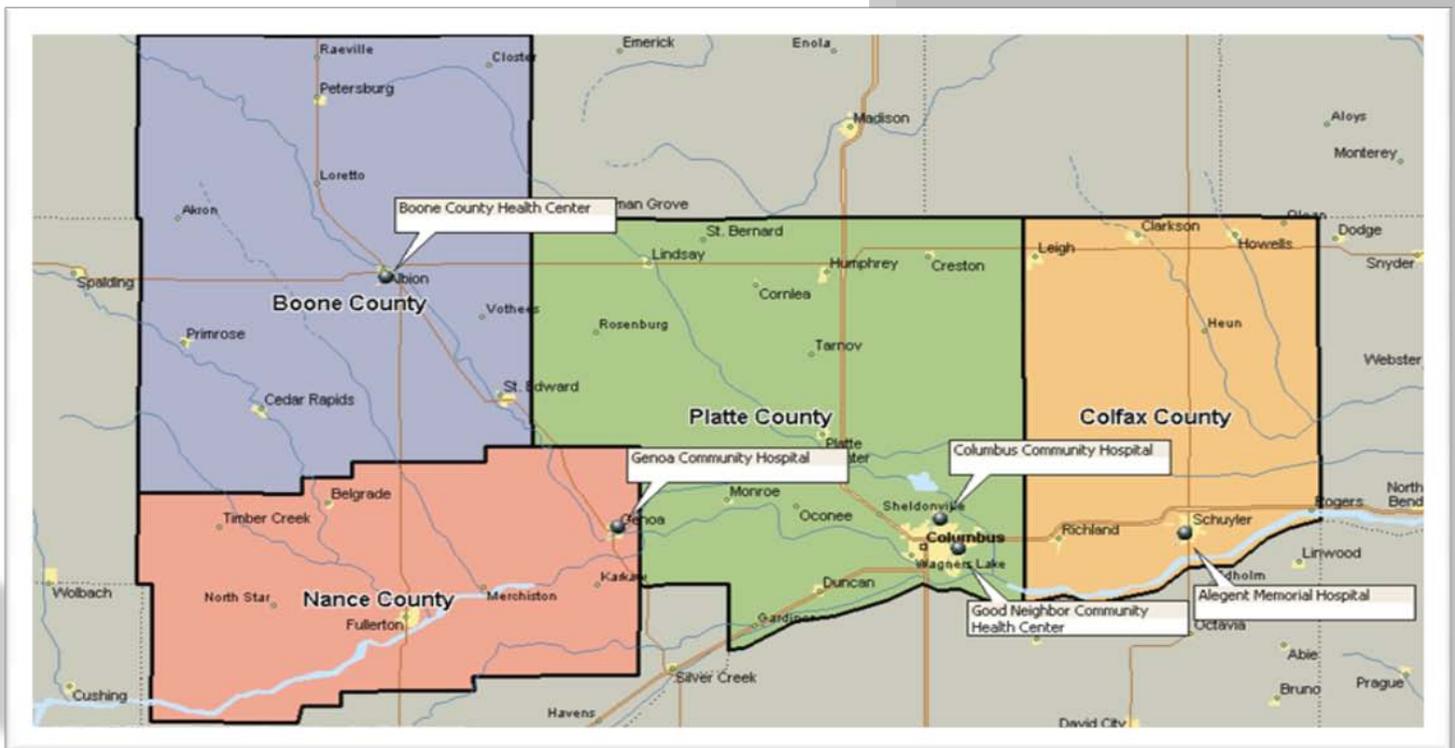


East Central District Health Department

Four County Health Improvement Plan



For the period of
November 15, 2012 - December 31, 2015

Approved by the board on November 15, 2012



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East Central District Health Department (ECDHD): Four County Community Health Improvement Plan (CHIP)

The East Central District Health Department (ECDHD) is a state approved district health department that provides a broad array of services to its service area. The ECDHD serves four rural Nebraska counties—Boone, Colfax, Nance, and Platte—that cover 2,219 square miles. The ECDHD has been providing services to the four county area since 2002. The ECDHD started out in 1999 as the Platte-Colfax County District Health Department and at that time only served Platte and Colfax Counties.

ECDHD is well recognized locally, state-wide and nationally for its community health assessment, planning and implementation work. The district has completed the Mobilizing for Action through Planning and Partnership (MAPP) process twice from beginning to end and this document is part of its third iteration. This third iteration of MAPP has been designed to be broader than either of the first two iterations and has been done to meet not only the Community Health Needs Assessments of the District but also to meet the needs of the area hospitals two of which must comply with new IRS requirements.

MAPP - The evidenced based process used for the CHNA and CHIP

East Central District Health Department has been responding to community needs using the Mobilizing for Action through Planning and Partnership (MAPP) process since 2002. The MAPP process was developed by and is recommended for community assessment by the National Association of City and County Health Officials (NACCHO) and Center for Disease Control (CDC). MAPP was also a recommended community assessment by the Nebraska Rural Health Association in its *“Community Health Assessment Collaborative Preliminary recommendations for Nebraska’s community, nonprofit hospitals to comply with new requirements for tax exempt status enacted by the Patient Protection and Affordable Care Act”* (September of 2011).

MAPP was chosen in part because the process allows for input from parties who represent broad interests in the communities. Input from diverse sectors including medically underserved, low-income, minority populations and individuals from diverse age groups was obtained through surveys, targeted focus groups, open public meetings and target invitations to community leaders and agencies.

Most of the four individual hospitals in the four county area have participated with the two previous MAPP assessments, including Columbus Community Hospital. During this third iteration of the MAPP process ECDHD served as the co-lead agency with strong support from the hospital in both personnel and financial resources.

Understanding MAPP

MAPP involves gathering together multiple community stakeholders for a shared assessment, strategic planning, and implementation process. The MAPP cycle has well defined steps and processes to capture community input and move a community or organization to make positive changes.



The third Community Health Needs Assessment (CHNA) was completed in January of 2012. This most recent assessment is 260 pages in length and took eighteen months to complete and is available on line for public review at www.ecdhd.com as well on the websites of at least two of the four partnering hospitals. A better explanation of the MAPP assessments can also be found later in this document under the data collection and also is included in the CHNA on pages 3-5.

MAPP Process Adapted From Previous Iterations

In the past ECDHD completed community health needs assessments, community health improvement plans and ECDHD strategic plans every five years. The first cycle was completed in 2002 and the second cycle completed in 2007. This three tiered planning process has been essential in driving forward the work of the department and the strategic plans have been actively and regularly reported on to the governing board of ECDHD. This third MAPP process differs significantly from the first two processes in several ways.

- While ECDHD was due for a repeat of the three tiered process in 2012 the process will now occur every three years instead of every five years. This will require the department to become more efficient at the gathering of data for the Community Health Needs Assessment (CHNA).
- The local hospitals shared the costs for the Community Health Needs Assessment (CHNA). In the past the entire cost has been borne by the ECDHD.

- With the additional funding the ECDHD was able to hire an independent research firm to help with the written presentation of collected data and to also synthesize the data into initial priorities.
- The second major shift is the switch from one district wide Community Health Improvement Plan meeting to three separate meetings that are very county and community specific. The plans developed at these meetings are very specific to the individual hospital and county area.
- The community health improvement plans developed at these individual CHIP meetings were then compiled into one ECDHD Community Health Improvement Plan (CHIP).
- The final ECDHD CHIP product includes the overall ECDHD CHIP and four hospital and county specific CHIP plans that should meet the requirements of the new IRS regulations.
- While ECDHD has always worked with its hospitals on past CHIP efforts this is the first time that the hospitals shared a responsibility with ECDHD for the development and implementation of the CHIP plans. In the past the primary ownership of the CHIP rested with the ECDHD. Now the primary ownership of the individual county plans rest with the hospitals with ECDHD having primary ownership of the plan included with this document and serving as a collaborative partner and technical consultant.

Special knowledge or expertise for MAPP and CHIP processes

The ECDHD has been recognized or cited by the National Association of City and County Health Officials (NACCHO) for its MAPP work several times during the past ten years. Several articles have been written on the MAPP work by the district including “*New Health Department MAPPs its way to a Successful Start: The East-Central Nebraska Story*” which is a story from the field written in 2007 and it is available on the NACCHO website at the following site: www.naccho.org/topics/infrastructure/mapp/upload/Nebraska-Story.pdf - 2010-04-05. In addition, the ECDHDs initial MAPP evaluation is also part of the MAPP toolkit where East Central District Health Department is also cited multiple times.

Rebecca Rayman, the ECDHD Executive Director has participated in training other local public health systems around the country on the MAPP process as part of the NACCHO MAPP team including the Chicago Health Department System, the Los Angeles Health Department System and the New Jersey State MAPP trainings.

Rayman has presented workshops on MAPP for the National Association of Local Boards of Health, the National Association of City and County Health Officials at a variety of conferences. In addition Rayman was a member of the National Association of City and County Health Officials MAPP workgroup for nine years. In December of 2011 she was a presenter at a National meeting titled the “*National Conversation on Community Health Assessments*” held in Washington DC where major hospital

associations, public health associations and government officials gathered to discuss the new hospital IRS regulations.

Rayman, has also participated in Nebraska MAPP activities and provided technical assistance and workshops to Nebraska local health departments as requested.

Rayman sat on the *Nebraska Rural Health Associations Community Health Assessment Collaborative* which made recommendations for how Nebraska hospitals and Public Health Departments could work in collaboration to meet the new IRS requirements.

IN 2012, Rayman co-presented at the annual American Public Health Association conference titled MAPP, Community Benefit, and HP2020.

The CHIP process also benefited from consultation with the ECDHD Good Neighbor Community Health Center (GNCHC) which is the only federally qualified health center within the district and serves a high minority low-income population allowing us access to this population. The GNCHC has its site in Platte County.

I. Background Data to Support Hospital and Local Public Health Joint Ownership in the Community Health Improvement Plan

There are many reasons why in this third iteration of MAPP it was logical for the East Central District Health Department to partner with its four hospitals to complete a joint Community Health Improvement Plan (CHIP). The major reason is to improve overall community health, but there are other pressing reasons for collaboration. Two of our four local hospitals (Columbus Community Hospital and Alegent Health Memorial Care) are now required to complete both a Community Health Needs Assessment and Community Health Improvement Plan to meet IRS requirements to maintain their non-profit status. While the other two hospitals (Boone County Health Center and Genoa Community Hospital) are not required to complete a Community Health Needs Assessment or Community Health Improvement Plan working with them to create community specific plans will help to make ECDHD's overall Community Health Improvement plan more meaningful.

Some of the major drivers toward a newer higher level of collaboration between the health department and the hospital include:

- Nebraska State Statutes

Nebraska Statutes under 71-1628.04 provide guidance into the roles public health departments must play and provide the following four of ten required elements which fit into public health role in the Community Health Improvement Plan.

...Each local public health department shall include the essential elements in carrying out the core public health functions to the extent applicable within its geographically defined community and to the extent funds are available. The essential elements include, but are not limited to, (a) monitoring health status to identify community health problems, (b) diagnosing and investigating health problems and health hazards in the community, (c) informing, educating, and empowering people about health issues, (d) mobilizing community partnerships to identify and solve health problems.....

- A History of Working Together of Previous Community Improvement Plans

The East Central District Health Department has completed a Community Health Needs Assessment and developed a community improvement plan every five years since 2002 using the MAPP process to meet the requirements of the Nebraska Statute. The ECDHD has worked to involve all the hospitals in its service area in this process since 2002.

- The Patient Protection and Affordable Care Act Impact on Hospitals

The historic passage of the Patient Protection and Affordable Care Act (PPACA) has called on non-profit hospitals to increase their accountability to the communities they serve. PPACA creates a new Internal Revenue Code Section 501(r) clarifying certain responsibilities for tax-exempt hospitals. Although tax exempt hospitals have long been required to disclose their community benefits, PPACA adds several new requirements.

Under the new Code section tax-exempt hospitals need to assess community health needs and develop and implement plans to meet those needs. Section 501(r) requires a tax-exempt hospital to conduct a community health needs assessment every 3 years. The community-needs assessment must take into account input from persons who represent the broad interests of the community served, especially those of public health, and must be made available to the public.

The PPCA requires non-profit hospitals to conduct a community health needs assessment, widely publicize assessment results, and adopt an implementation strategy to meet needs identified by the assessment.

According to the new hospital regulations an Implementation Strategy MUST be written and adopted by the governing body of the organization that addresses how a hospital plans to meet EACH of the health care needs identified through the Community Health Improvement planning process.

As mentioned earlier this requirement affects two of the four hospitals in the ECDHD service area.

- Redefinition of Hospital Community Benefit

Hospitals have been providing community benefit for many years in a variety of ways, for providing community benefits hospitals receive a variety of tax exemptions (local, state, and federal). The activities listed under “community benefit” are reported on the hospitals IRS 990 report.

Community benefit has now been defined by the Internal Revenue Service (IRS) as “the promotion of health for a class of persons sufficiently large so the community as a whole benefits. Simply put, community benefit is composed of programs and services designed to address identified needs and improve community health. While

at this writing we are not sure if that will apply to two or our four hospitals or all four. If it applies to all four they will have a plan for community benefit. To qualify as community benefit, initiatives must respond to an identified community need and meet at least one of the following criteria:

- Improve access to healthcare services;
- Enhance health of the community;
- Advance medical or health knowledge; or
- Relieve or reduce the burden of government or other community efforts.

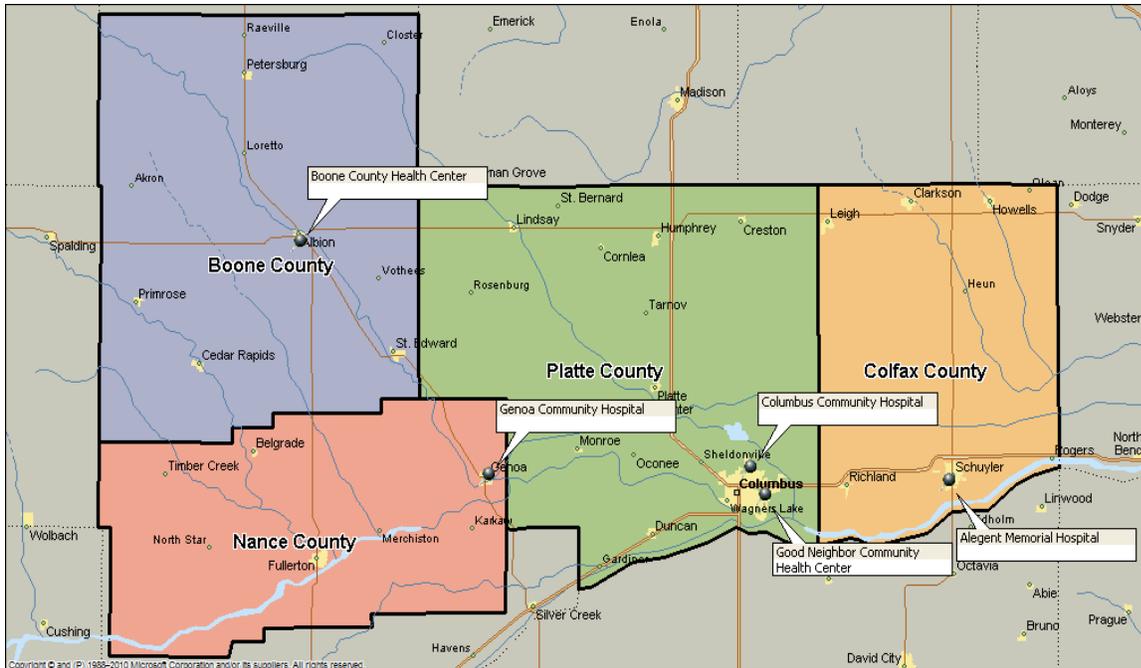
- Public Health Accreditation Requirements

In July of 2011, the Public Health Accreditation Board (PHAB) released the first the Public Health standards for the launch of national public health department accreditation. All local health departments (LHD's) must have completed a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PHAB Version 1.0 has standards that require (LHD) to:

- Standard 1.1 requires LHD participate in or conduct a collaborative process resulting in a comprehensive community health assessment.
- Standard 1.2 LHD must collect and maintain reliable, comparable and valid data.
- Standard 5.2.1 LHD must conduct a process to develop community health improvement plan.
- Standard 5.2 .2 LHD must produce a community health improvement plan as a result of the community health improvement process.
- Standard 5.2.3 LHD must implement elements and strategies of the health improvement plan in partnership with others.
- Analyze public health data to identify health problems.....that affect the public's health.
- Provide and use the results of the health data analysis to develop recommendations regarding public health policy, processes, programs or interventions.

II. Core Agencies involved in the ECDHD CHIP

The hospitals and the ECDHD are identified on the map provided below.



The East Central District Health Department

ECDHD is a state approved health department that provides a broad array of services, which are listed below.

- Early Development Network Services
- HIV Counseling Testing and Referral
- Environmental Health Programs
- Immunizations
- Transportation Services
- Women, Infants, and Children (WIC) Program
- Community Health Needs Assessment and Strategic Planning
- Environmental Health Programs
- Infectious Disease Tracking and Surveillance Programs
- Public Health Outreach Nursing and Education (PHONE) Program
- Public Health Emergency Response Program
- Tobacco Prevention Program and Coalition
- West Nile Surveillance Program
- Minority Health
- Youth Substance Prevention Program and Back to Basics Coalition
- Services in Spanish

The Good Neighbor Community Health Center

The GNCHC has special expertise in providing service to low-income, medically underserved and minority populations. GNCHC was the first entity in Nebraska to obtain Medicaid Meaningful Use. The GNCHC is TJC accredited and in the process of

obtaining Patient Centered Medical Home recognition. GNCHC has a robust electronic medical record and is a repository of information on chronic disease management for its population.

GNCHC serves a highly uninsured population and provides the following services

- Dental Health Services
- Reproductive Health Clinic
- Family Medical Care
- Mental Health Services
- Substance Abuse Evaluations
- Services in Spanish
- Transportation Services

Notable for the GNCHC is the high percent of uninsured children served as compared to the state and the nation and the low percent of recipients of Medicaid/CHIP served by the Good Neighbor Center. See the table below.

Table 1	Patients Served at the Good Neighbor Center by Insurance Status with Comparisons to State and National FQHCs⁷		
	Good Neighbor	Nebraska	National
Uninsured	57.6%	56.7%	37.5%
<i>Children Uninsured (age 0-19 years)</i>	43.4%	36.5%	20.3%
Medicaid/CHIP	15.3%	26.5%	39.7%
Medicare	5.0%	4.2%	7.5%
Other Third Party	22.1%	12.6%	15.2%

Columbus Community Hospital (Platte County)

There is one hospital located in Platte County. The hospital defines its primary service area as Platte County. Columbus Community Hospital is a community-owned, not-for-profit hospital. The facility opened its doors at its new location in August 2002 and is located on 60 acres in the northwest part of Columbus, NE. The 186,000 square foot hospital is a four story, prairie-style building with an attached 40,000 square foot one-story medical office building, housing local and visiting physicians.

The Hospital is a 47 bed acute care facility (certified for swing beds), with 4 skilled nursing beds and 14 ambulatory outpatient beds, all private rooms. Columbus Community Hospital is licensed by the Nebraska State Board of Health and is accredited through The Joint Commission. The Hospital is also a member of the Nebraska Hospital Association (NHA), American Hospital Association (AHA), Voluntary Hospital Association (VHA) and Heartland Health Alliance (HHA).

Columbus Community Hospital's success can be measured in the quality of its facilities and the commitment of volunteers, staff, board, and physicians. Leadership consists of an 11 member Board of Directors, President/CEO, 4 Vice-Presidents, 38 members of the Medical Staff, over 550 employees, and 300+ volunteers.

In October, 2010 the Hospital began construction on a 30,000 square foot addition: 20,000 square feet to the 1st floor and 10,000 square feet to the 2nd floor which was completed in July, 2012. The addition has allowed the Hospital to expand services in the Emergency Department, increase patient privacy in the registration area and create a women's imaging center.

For over 150 years, the Columbus area medical professionals have been committed to providing the best patient-centered care. Their dedication to the community and loyalty to the Hospital enables CCH to provide the highest quality care to area residents.

The hospital offers a variety of services to include:

- Cardiopulmonary Rehabilitation
- Diabetes and Health Education
- Diagnostic Imaging
- Emergency Department/Trauma Services
- Gift Shop
- Home Health
- Hospice
- Hospitalist Services
- Lifeline
- Maternal Child Health
- Occupational Health Services
- Pain Management
- Rehabilitative Services
- Respiratory Care
- Sleep Lab
- Surgical Services
- Women's Health
- Wound Healing Center

Alegent Health Memorial Hospital (Colfax County)

There is one hospital located in Colfax County. The hospital defines its primary service area as Colfax County.

Alegent Health Memorial Hospital, located in Schuyler, Nebraska, is a 25 bed Critical Access Hospital. The physicians, nurses, and other associates at this faith based community hospital are committed to delivering personalized, compassionate care to approximately 10,441 individuals that reside in Colfax County. Such care takes many forms - technologically advanced medical services, quality health education, health screenings, and more. Beyond the hospital walls, Memorial Hospital works closely with businesses, community groups, churches, schools, social service agencies, and others to build a healthier community.

Acute care and outpatient services include general medical surgical care, skilled nursing care, home health care, outpatient specialty care that includes general surgery, cardiology, urology, gastrointestinal, orthopedic, gynecology, otolaryngology, nephrology, and podiatry services. Restorative services such as physical therapy and cardiac rehabilitation are also available. A full complement of diagnostic services are

offered for the laboratory and radiology which include: CT, MRI, mammography, ultrasound, nuclear medicine, echocardiograms, and vascular exams.

Boone County Hospital (Boone County)

There is one hospital located in Boone County. The hospital defines its primary service area as Boone County. Boone County Hospital is a county-owned hospital. Boone County Health Center, located in Albion, Nebraska, is a recognized leader in providing a continuum of healthcare to the 10,000 rural residents in Boone, Antelope, Greeley, western Madison and Platte, Nance and Wheeler Counties. The Health Center and its five clinics are the singular and primary source of healthcare for the rural communities it serves. The hospital is a twenty-five bed, five nursery facility which operates five clinics in the towns of Albion, Spalding, Newman Grove, Fullerton and Elgin.

In addition, two affiliate physician clinics are in St. Edward and Cedar Rapids. The Health Center is a county hospital that sees over 70,000 outpatient visits and over 30,000 clinic visits on an annual basis. With eight physicians and four physician assistants, a well rounded medical staff is present to meet the needs of the patients and their families.

Services provided by the 250 employees at the Health Center include; cardiac rehab, physical therapy, occupational therapy, speech therapy, radiology (ultra sound, digital mammography, nuclear medicine, CT, open MRI, dexta scanner, fluoroscopy and general x-ray), full laboratory services, oncology, aesthetics care, full OB services, home health and mental health services.

In addition to the services provided by our local staff, a full range of seventeen specialty clinics are scheduled throughout the month to allow patients the ability to obtain these services at home.

Genoa Community Hospital (Nance County)

Genoa Medical Facilities (GMF) is the sole health care facility in Nance County, Nebraska, located in the city of Genoa, NE. GMF is comprised of the hospital, long-term care, and assisted living facilities. The hospital is a 19-bed, critical access, city owned, non-profit facility. GMF provides healthcare for a community of almost 5,000 people within a 10-mile radius. The 35-bed long term care unit and the 20-unit assisted living facility provide a home for those whose needs include additional living care. Most importantly, GMF provides the care for the people of the community. The care people receive here pales by comparison to the services offered at large facilities. For this reason, the community is uniquely supportive of the hospital's mission, which is to be "Champions for Rural Healthcare."

Organizations that collaborated in conducting the CHNA and CHIP

Over forty entities listed below had one or more participants in this process. Most of the CHIP meeting had board leadership present. Attendance was directly proportional to county size. The most populated county had the most attendees (approximately 70 participants) and the least populated county had the fewest attendees (nine participants). The agencies participating are listed in alphabetical order.

- 1 Alegent Memorial Hospital-Schuyler
- 2 American Red Cross
- 3 ARC of Platte County
- 4 Behlen Manufacturing
- 5 Board Member/ Medical user of the GNCHC
- 6 Center for Survivors
- 7 Central Community College
- 8 Central Nebraska Community Services
- 9 City of Columbus
- 10 City of Columbus Parks and Recreation Department
- 11 Columbus Chamber of Commerce
- 12 Columbus Family Practice (Private Medical Clinic)
- 13 Columbus Housing Authority
- 14 Columbus Police Department
- 15 Columbus Public Schools
- 16 Columbus Telegram
- 17 Columbus Urgent Care
- 18 Connect Columbus
- 19 Crisis Navigators
- 20 East Central District Health Department
- 21 Family Resource Center
- 22 First Nebraska Bank
- 23 Genoa Community Hospital.
- 24 Golden Living Center
- 25 Good Neighbor Community Health Center
- 26 Greystone Manufacturing
- 27 Harold Stevens Accounting
- 28 HDR Architectural Firm

- 29 Jackson Services
- 30 Local Board of Health public minded citizen
- 31 Nebraska Department of Health and Human Services
- 32 Nebraska State Patrol
- 33 Nebraska State Senator - District 22
- 34 Platte County Attorney
- 35 Platte County Emergency Management
- 36 Progressive Swine Technologies
- 37 Public Minded Citizens
- 38 Rainbow Center – Mental Health Center
- 39 Schuyler Public Schools
- 40 Sertoma Service Club
- 41 Time for Change - Gang Prevention
- 42 United Way
- 43 Youth for Christ
- 44 Victim Assistance

III. Community Health Improvement Plan Process

The template below can serve as a summary of the process used in planning both the joint CHNA and joint CHIP for the ECDHD and for its four hospital partners. This figure was developed and used in the Nebraska Rural Health Association document referenced earlier. As you can see the plan involves three major themes the Community Health Needs Assessment (CHNA), the Community Health Improvement Plan (CHIP) and the Plan Implementation. Under these sections are various activities that are part of the overall process.

It is important to note that Community Engagement is an overarching concept over the majority of the CHNA and CHIP process and will be discussed under each area. Community Engagement was also a major part of the data gathering process.

Community Health/Needs Assessment				Community Health Improvement Plan				Plan Implementation		
Data Gathering		Community Engagement								
Secondary Data	Primary Data	Data Analysis	Prioritize Issues	Team Communications	Public Communications	Service Gap Analysis	Review of Evidence Based Interventions	Develop Action Plan	Develop Monitoring Plan	Performance Management
				Communications						

Step 1. Data Gathering a Part of the CHNA

In looking at our plan process template it can be seen that data gathering is the first step in completing the CHNA. Data gathering was accomplished using the four MAPP model assessments and included both Primary and Secondary Data sources.



The first assessment is the Community Themes and Strengths Assessment which is a subjective look at how the community views their health to capture the perceived needs of the community. This assessment ranks high for Community Involvement. This step was completed through focus groups in the counties, written surveys at a variety of settings to include local pharmacies, libraries, health clinics and hospitals, surveys were also available at the local county fairs. Telephone surveys were completed by the State of Nebraska in each district as well to gather information for the Community Themes and Strengths Assessment. The data for this assessment was conducted over a six month period and included; 500 written and 500 telephone surveys; six focus group results (Hispanic and non-Hispanic, adult and youth).

The second assessment is the Forces of Change assessment. This assessment is done in one town hall style meeting to capture the community's perception of the current trends that are affecting the health of the community (a good example would be health care reform). This assessment also ranks high in Community Involvement as the data is obtained directly from the community.

The third assessment is the Community Health Status Assessment. This assessment provides the data, from the federal government (an example would be Census data), the State (an example would be vital statistic data), the ECDHD as a district health department (an example would be Immunization rates for the district), the GNCHC (an example would be Community Health Center (CHC) specific data on diabetes outcomes) collects. Information for this assessment was gathered over an eighteen

month period. Data gathered for compilation came from the following sources: national surveys such as the BRFSS, YRBS, US Census, and Youth Protective Factor Survey. In total there are 30 sources of data; community profiles; access to health care/quality of life; mental health; physical health; health risk factors; social programs and crime. Data collected represents every age group from pre-birth (pre-natal data) to elderly.

The last assessment is the Local Public Health System Assessment which is how our district health department and the other public health system agencies (hospitals, the CHC, law enforcement, etc.) are doing on the ten essential public health services. This was the first assessment completed for the third MAPP process in 2011, in the three MAPP cycles that have been completed this was the smoothest completion of this assessment.

Community Involvement in Data Gathering

The current MAPP assessment the department is involved with is the most thorough assessment to date with the most participation having over 100 individuals participate in the process to date from the district, this does not count the 1,000 individuals surveyed or the participants in focus groups.

The CHNA – a separate stand alone document

Nearly 18 months after the assessments began; the results were released into a 260 page document entitled the *Community Health Needs Assessment (CHNA)* of which includes a profile of the district as a whole and a profile of each individual county where a hospital is located. The CHNA also identifies the top problems of the district and identification of the top problems for each individual county.

Step 2: Data Analysis and Initial Prioritization of Data – a Part of the CHNA

Because of the breadth and depth of the CHNA, an independent local research firm was engaged to review the data and provide a draft set of community health needs for the district overall and for each individual county.

The research firm identified prominent themes according to the importance to the community, whether the issue was measurable, the extent to which the issue was an outlier in comparison to state and US data, and whether the community would get active and make a difference. This step identified seven cross-cutting themes for each County, and a total of 13 for the district. Schmeckle Research, Inc. assembled this assessment of public health and community well-being under the provision of the East Central District Health Department and the four participating hospitals.

The greatest needs identified by the CHNA at the district level are summarized in the table below.

Table 2. Community Health Needs and Priorities for the East Central District

Community Health	Rationale for Selection
------------------	-------------------------

Needs and Priorities	
➤ Accidental Death	<ul style="list-style-type: none"> • High rates of unintentional, motor vehicle, and work-related accidental deaths as compared to the state.
➤ Aging Population	<ul style="list-style-type: none"> • High percentage of the population is over 65 for the district. • High percentage of elderly individuals report lacking a social network.
➤ Cancer	<ul style="list-style-type: none"> • The top perceived health problem in three of the four counties, and the overall top perceived health problem in both the <i>Community Health Survey</i> and the <i>Community Themes and Strengths Assessment Survey</i> • High instances of breast, colorectal, and prostate cancers district wide. • High instances of cancer may be partly or largely attributable to the aging population.
➤ Diabetes	<ul style="list-style-type: none"> • Increases each year from 2007 to 2009 in percent of adults with diabetes. • The number three perceived health problem in the district.
➤ Drug and Alcohol Use	<ul style="list-style-type: none"> • Alcohol abuse was the top perceived risky behavior in every county; drug abuse was second overall. • High community perception of underage alcohol use as an issue that needs greater attention. • High rates of youth riding with a driver who had been drinking. • High rates of hospitalization for alcohol and tobacco related disease. • Also a concern among focus group participants and community agencies participating in the <i>Forces of Change Assessment</i>.
➤ Health Professional Shortages	<ul style="list-style-type: none"> • More individuals served per health professional for every health profession as compared to the state except for LPNs. • Several areas with state and federally designated health professional shortages.
➤ Mental Health Services	<ul style="list-style-type: none"> • High percentage of mental health patients seen at the Good Neighbor Center. • Federally designated shortage of mental health professionals in every county in the district.
➤ Health Screening	<ul style="list-style-type: none"> • Low rates of health screening, especially among women for mammogram, clinical breast exam, and PAP exam as compared to the state.
➤ Immunization for	<ul style="list-style-type: none"> • Low rates of immunization for pneumonia and influenza

the over 65 Population	among the over 65 population as compared to the state.
➤ Non-Sports-Related Activities for Children	<ul style="list-style-type: none"> • Lack of activities for youth expressed by focus group participants and noted as a contributor to drug and alcohol use. • Low community perception of the availability of non-sports-related activities for children in the <i>Community Health Survey</i>.
➤ Obesity	<ul style="list-style-type: none"> • A community-wide concern, noted especially in the <i>Forces of Change Assessment</i>, the <i>Obesity Summit</i>, and <i>Community Themes and Strengths Assessment Survey</i>. • High rates of obesity for the overall population, and especially for the minority population. • High percentage of youth overweight. • A low percentage of leisure time devoted to physical activity as compared to the state. • County-level data were not available for obesity. Thus, it has been selected as an overall community health need.
➤ Rape and Forced Sexual Intercourse	<ul style="list-style-type: none"> • High rates of reported cases of rape as compared to the state. • High rates of self-reported forced sexual intercourse by youth.
➤ Teen Pregnancy and Sexual Activity	<ul style="list-style-type: none"> • The number two perceived health problem in the district, and the number one for the Hispanic population, among whom the teen birth rate is very high. • Teens in the district are more sexually active than their peers in Nebraska. • A concern among focus group participants and community agencies.

Pre-selected Priority Areas

The top community health needs and priorities for each of the four counties were pre-selected by an independent research firm. These priorities are listed in the appendix of this document with a brief description of the rationale for selection. The CHNA provides the tables used to support the pre-selection of priority areas are identified.

During the four CHIP processes participants were encouraged to refer to the community health needs for the overall East Central District as well as the individual county health needs in the selection of their strategies as well to obtain a complete data picture. For example, obesity, diabetes, health screening, and teen sexual activity data are partly or entirely unavailable at the county-level, but these issues might be prevalent health needs in the county, and might be viable strategy options.

IV. The Community Health Improvement Planning Meeting Process

Data Analysis and Final Prioritization a Part of CHIP

Each of the four counties in the service area is unique and while the ECDHD has one shared Comprehensive Community Health Needs Assessment (CHNA) the district conducted four county-specific strategic issues and planning processes to develop a Community Health Improvement Plan (CHIP) for each county/hospital.

During this third iteration of MAPP the CHIP meetings have been held at the local hospital (the district has one hospital in each county) using a trained Technology of Participation (ToP) facilitator.

The CHIP meetings in the individual counties were held from March 2nd to August 21st of 2012. All of the four individual CHIP meetings focused on their identified primary service area.

	Date of CHIP Meeting	Facilitator
Platte-Columbus Community Hospital	March 2, 2012	Deb Burnight
Boone- Boone County Medical Center	June 7 th , 2012	Roberta Miksch
Colfax – St. Benedictine Center	July 18 th , 2012	Roberta Miksch
Nance – Genoa Community Hospital	August 22 nd , 2012	Roberta Miksch

Pre-meeting preparation

In preparation for the CHIP meeting there were several activities that took place in one or more counties to prepare for the meeting.

- Phone calls and or e-mails occurred with the individual county core team to plan the meeting.
- Several phone conference calls and or e-mails were held with the facilitator to go over meeting plans.
- In two of the four counties a 15 minute presentation specific to the county was developed to use at service clubs and area meetings to stimulate interest in the project. This presentation was done one to three times in the county prior to the CHIP by the ECDHD Health Director. Presentations include rotary clubs, hospital auxiliaries and community agencies.
- A one-hour data presentation specific to the county was developed, highlighting pre-identified themes from the research agency along with additional data the core team believed was important.
- Written invitations were sent out to key stakeholders by the hospitals.

- Newspaper advertisements were ran in some of the County newspapers inviting the public to attend.

CHIP - meeting format

Community leaders met in facilitated session hosted by each hospital to launch the 2012 County Community Health Improvement Planning process (CHIP). Overall the Community Health Improvement Plan Meetings were very well attended. Diverse sectors were represented including public officials, clergy, business leaders, physicians, hospital staff, health department staff, state senator, county officials, city administrators, state public health officials and community agencies. There was good representation from the Spanish speaking community in two of the counties which is the largest minority in the area.

The overarching focus question guiding the discussion in the day-long session was:

“Based on the results of our community assessment, what will we choose to focus on over the next three years to improve the health of all who live, work and play in _____ County and how will we mobilize our efforts?”

The working agenda was:

- Planning Context
- Data Presentation
- Prioritization of Strategic Issues
- Community Mobilization – Chartering Action to Address Priority Issues
- Debrief/Next Steps

Following time for networking and check-in, in most of the hospitals the hospital administrator or CEO welcomed the participants to the session and introduced East Central District Health Department Executive Director Rebecca Rayman. Rayman provided background information on the CHIP process and introduced one of the two trained facilitator’s Deb Burnight or Roberta Miksch both trained in the TOP facilitation process. Participants introduced themselves and shared the agencies or coalitions they represented.

The participants confirmed the proposed agenda. The facilitator shared the following process suggestions to guide the work of the day:

- Test assumptions and inferences
- Share all relevant information
- Hear and be heard
- Share the air
- Use specific examples and agree on what important words mean
- Electronics off (or in silent mode)

Presentation of the Overview of the Community Health Needs Assessment

In order to inform the work of the day, Rebecca Rayman presented an overview of health data collected as part of the recently completed Community Health Assessment. Included in her presentation was information from:

- 30 Sources of data including community agencies work products
- Nearly 500 Written Surveys
- Nearly 500 Telephone Surveys
- Six Focus Groups
- Other Community Surveys
- National Surveys (BRFSS, Census, YRBS , Youth Protective)

The complete 260-page Community Health Assessment was available at each participant table during the meeting. Included in the handouts at the CHIP was a profile of the District as a whole and a profile of the individual specific county. The profiles included identification of the top problems for the District and the identification of the top problems for that County. Every participant also received a copy of the one hour power-point handout. (See Appendix 1- one hour presentation handouts, Appendix 2- 15 minute presentation handouts)

The data presentation from the CHNA was done by the ECDHD Health Director Rebecca Rayman using the one hour power point. Data was presented using a variety of formats including county and district specific which were then often compared to state and National Data. Throughout the data presentation the TOP facilitators probed the participants on what surprised them, what insights they gathered, and what questions they had, resulting in a very interactive process with strong audience participation.

After a set of data was shared in large group discussion small group discussion was encouraged and occurred at participant tables. Again the conversations revolved around what surprises did you hear, what did you already know, what concerns you, and how have your thoughts shifted because of what you have heard? The participants from the four individual CHIP meetings offered the following observations, insights and questions related to the data shared:

SURPRISES:

- Poverty levels: Question - What demographic? Answer: Working poor, Single parent families with children under 5, Platte and Colfax especially
- 1600% increase in minority population
- Desire for more specialists (access and availability) What is driving this?
- Uninsured at 40% (not including underinsured) – How many have chosen this? How to explain? No access to government programs?
- Fatalities in the district
- Lack of seatbelt use in Platte County
- 2/3 of US obese – even making seatbelts bigger to accommodate
- Platte County among highest in distracted driving
- Loss of over 65 year olds in Colfax County
- Loss of 35-44 year olds in Colfax County
- Increase in percentage of forced sexual intercourse

- More awareness on forced sexual intercourse (increased awareness over the years may have been a contributing factor as to the increased reporting of forced sexual intercourse....Roberta's comment added)
- Hepatitis A and B rates – contributing factors for this may be:
 - Hand washing (education)
 - IV Drug Use
 - STI's
- Diabetes being the 5th perceived health concern – would have expected it to be higher
- Surprised that safe and affordable daycare is not higher for Boone
- Housing/affordable/health – how do these tie together?
- Law enforcement only have a specific number of hours in a town like Albion
- Statistic sharing might make a difference – sharing with parents, community
- More education needed
- Law enforcement needs to see stats
- American Indian population in Nance
- Older people not coming to doctor in the District
- Low rate of people with Bachelor's Degrees
- Youth (12th graders) rate of getting into a car by someone who had been drinking wasn't higher
- Unintentional injuries rate
- High rates of 6th grader tobacco use
- Higher rate than Platte County for tobacco and alcohol related deaths
- Surprised that there were not more teen pregnancies in Nance
- Child abuse and neglect cases
- Underage binge drinking isn't more than 30% for senior HS

INSIGHTS

- Social determinants of health are critical
- Parents often do not establish a need for a medical home – perhaps this is driving a need for specialists
- More reporting of sexual assault – high because of good Platte County programming in place?
- Little funding for breast cancer screening and education
- Obesity jump may correlate with worsening economy
- Many things fit together that suggest why teens are having problems: low income, alcohol, suicide, teen pregnancy, etc.
- Latino girls do not generally drink alcohol (not accepted in culture)
- Young Latino's forced to drop out of school to "take care" of family
- High school students interested in marijuana (per comment from health fair) rather than alcohol
- Younger healthy people with less health care needs
- Trading sexual intercourse for a place to sleep
- Sexual abuse among teens increases with drug and alcohol use
- Language Barriers
- Transportation Barriers

- Child care Barriers
- People who go to Columbus Community Hospital for detox are instructed to go to Genoa Hospital (participant offered this information)
- 6th graders riding in car with someone who had been drinking...maybe the driver is parent
- In some families the family may drink together
- Parties known in community, tie in to law enforcement and responsibilities/duties
- Unintentional accidental rates could be due to elderly
- Tie back into poverty (some issues may tie right back to being in poverty)
- Cancer –maybe people don't go to doctor for prevention (such as prostate screenings, etc.)
- Accessibility – money for transportation and gas (to get to screenings)
- Daycare ties into poverty - have to work (so they have to get day care)

QUESTIONS

- Why fewer white collar jobs?
- What is the definition of “white collar?”
- Why do we have higher numbers of children?
- Can we anticipate a higher 3-5 year birthrate?
- How does all of this impact daycare status?
- How would private school demographics impact the poverty rates?
- Why the low number of bachelor's degrees?
- Do we have representation of undocumented in data– tried to collect in written surveys
- Any info related to fetal alcohol syndrome? – LB 599 Bill to restore fetal care
- What do health insurance rates look like for 2010/2011?
- What is attitude of parents to alcohol?
- Does the data for 12th grade smoking rates include those who may already be 18 years old?
- What is the cause of death for youth?
- Is older population educated on cancer prevention?

A specific example of how this process worked is provided for context. One of the pieces of information shared with the community group as a whole included the top five perceived risky behaviors by county and ethnicity. The data for this particular table was obtained by the completion of 500 written surveys (telephone surveys were random the written surveys were targeted) during the summer of 2011. The written surveys were completed at libraries, pharmacies, medical clinics, hospitals and county fairs. The following table was one of the slides shared and indicates what the top five behaviors were for each county.

Table 3		Top Five Perceived Risky Behaviors by County and Ethnicity¹⁵					
	Boone	Colfax	Nance	Platte	Hispanic	Non-Hispanic	East Central
1st	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse
2nd	Being Overweight	Being Overweight	Tobacco Use	Drug Abuse	Drug Abuse	Drug Abuse	Drug Abuse
3rd	Tobacco Use	Racism	Lack of Exercise	Being Overweight	Racism	Being Overweight	Being Overweight
4th	Lack of Exercise	Drug Abuse	Being Overweight	Tobacco Use	Being Overweight	Tobacco Use	Tobacco Use
5th	Not Using Seat Belts	Unsafe Sex	Not Using Seat Belts	Lack of Exercise	Lack of Exercise	Lack of Exercise	Lack of Exercise

While all the counties were unique in their discussions some of the data promoted similar discussions in the counties. As this slide and others were shared with the community groups gathered in Platte County, Boone and Nance County a great deal of discussion came about from the fact that the top risky behavior for all four counties was alcohol abuse. This was discussed in relationship to crime related data and youth substance abuse and led to discussions about what was the “core issue”.

Prioritization of CHIP Strategic Issues

The first step in the prioritization of community health issues was to determine the criteria for selection. The group was lead by the facilitator through a process to self-select meaningful criteria that all participants could agree to abide by. Not all counties had the same criteria but there were common themes. These criteria would serve as the filtering process to identify and prioritize strategic issues that could guide the CHIP process for the next three years. Initially, participants offered the following suggestions per county as criteria to guide decisions regarding choosing priority issues:

Criteria for Strategic Issue Selection			
Platte	Boone	Colfax	Nance
Multiple wins – catalytic actions	Community supported/driven	Measurable	Resources /finances
Root causes	Resources (finances/human/ people)	Evidence-based	Community involvement
Feasible, realistic		Funding/ resources	/participation
Measurable	Resources to		

	address the issues	Sustainability	Key players at table
Easy, short-term wins (low-lying fruit that could gain momentum)	Something we can impact as a community	Culturally competent/CLAS	Evidence based
Aligned with identified community health needs/priorities	Evidence based (effective)	Community engagement	Narrowing topics
Find underlying motivation for change	Consensus of the group	Data driven Realistic	Stick to strategic areas not action steps
People power, passion	Root Causes of the problems should be explored	Time specific (short, medium, long term)	Sustainability
Research/evidence based	Serve the majority of the population		Looking at a specific time frame
Sustainability – will last	Collaboration		
Adaptability...respond to change			
Focus-target population(s)			

At the end of this discussion, participants in each of the four counties were asked the next question:

What are the most critical issues we might prioritize for community action?

Participants were encouraged to write down individually and then in table groups the top health priorities for their county/community. The process used for each table was that

every group would then submit their top five most critical issues, based on the data presented, the conversations they had been having during the morning, and criteria list. These were collected for display on a “sticky wall” using the TOP process and were clustered according to common theme by the larger group. This process was repeated until every strategic issue listed by the group was captured in the process. This process resulted in the identification of “issue arenas.” These issue arenas were all identified health needs for the community. Some of the issue arenas had been identified by the independent researchers as cross-cutting themes, and some were not; however, all issue arenas were supported with data.

The large group then reviewed the criteria for strategic area selection once more. Table teams were then asked to talk through the list of strategic issues using the criteria for prioritization. Prioritization took place in one of two formats depending upon the county. The first was to rank order the strategic issues that emerged from the clustering exercise from 1 to 10, with #1= Most Important, #2 Next Important, #3 and so on. The second way prioritization took place was to have participants vote with sticky “dots” and count the dots to see which issues were of the most concern to participants.

A discussion was held in each county about how many strategic areas the county CHIP group could manage effectively. Following plenary discussion, the participants then decided by consensus to choose between two to five (5) areas as priority strategic issues around which to mobilize collaborative action over the next three years (with the understanding that the other issues may be able to feed into the priority issues, i.e. a focus of Access to Health Care would be cancer screenings, etc) or may be chosen in three years when the next planning process occurs.

In general the individual CHIP groups felt that while it was important to not lose any of the priority issues, too many areas may dilute the entire process and make it less effective. The identified community health needs or priority issues for the individual CHIP meetings came out to seven distinct issues. Some of the issues such as Obesity and Substance Abuse or Youth Substance Abuse were identified in three of the four counties. In addition three of the four counties picked issues related to the support of young families (family support or safe care for children). A couple of issues were unique to county CHIP processes such as Cancer and Bullying in Boone County. The table on the next page compares the strategic issues selected. See also the individual county CHIPs for more information about overall strategic issue selection and to see all the issues identified at the meetings.

Strategic Issue Areas			
Platte	Boone	Colfax	Nance
Access to Health Care	Cancer	Obesity	Substance Abuse
	Childhood Obesity	Family Support for Children	Lack of Participation in

Obesity		Living in Poverty	Health Care
	Bullying		
Family Support (Child Well Being)	Youth Substance Abuse Prevention	Access to Care (plan to be developed by Alegent later)	
Substance Abuse			
	Mental Health		
Mental Health			

The formation of Community Work Groups around the chosen Strategic Issues

Once these topics were decided upon, individuals in the individual county CHIP meetings then self-selected which topic they could envision themselves working with for the next three years and the larger group then divided into individual topic areas. New table teams emerged based on these individual topic areas. The new strategic issue table teams were named based on the community health need title. The groups then self-selected a chair to oversee the process and a recorder from the East Central District Health Department provided the documentation of their discussion using forms specially designed for the CHIP process. The table teams were now tasked with the beginning of formation of the specific plans. The teams were asked to articulate goals, baseline data to support the need for the goal, SMART (Specific, Measurable, Achievable, Realistic, Time-bound) success indicators and objectives.

The individual groups determined the frequency with which they would meet to keep their plan moving forward. The larger CHIP groups all determined to meet quarterly for the next three years under the responsibility, supervision and guidance of the local hospital. Progress updates from each individual strategic health need subgroups will occur at County CHIP quarterly meetings. The hospital will coordinate the community meetings and serve as support for the CHIP Action Team champions. The East Central District Health Department will provide technical assistance and support for the CHIP groups as a whole and for the individual strategic health need subgroups as requested. ECDHD will also have an active role in all the CHIP plans as can be seen by the workplans.

While this initial report out is a rough draft it provided the basis for the plans and the process was able to move to the next steps on the CHIP. This includes service gap analysis and reviewing evidenced based interventions in the five areas chosen by the community.

Community Health/Needs Assessment					Community Health Improvement Plan				Plan Implementation	
Data Gathering		Community Engagement								
Secondary Data	Primary Data	Data Analysis	Prioritize Issues	Team Communications	Public Communications	Service Gap Analysis	Review of Evidence Based Interventions	Develop Action Plan	Develop Monitoring Plan	Performance Management
				Communications						

V. The Community Health Needs Selected by the District Reviewed

The Community Health Needs selected by the CHIP participants in the four counties are further explored here. The section that follows includes the initial gap and resource analysis completed on the day of the CHIP. In all approximately seven distinct issues emerged from the four counties that are reviewed below. Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans and is considered to provide National state-of-the-art guidance for health improvement. The website for information on Healthy People 2020 is www.healthypeople.gov. Objectives from Healthy People 2020 and evidenced based interventions were not available on the day of the assessment, however, they are included in the CHIP to help guide the final development of the work plans.

Access to Health Care or Lack of Participation in Health Care

Data to support the need for this as a strategic area are included in the Community Health Needs Assessment on pages 29-34. The *Healthy People website* lists the Healthy People 2020 goals. The Healthy People 2020 goal for Access to Health Care is to “*Improve access to comprehensive, quality health care services*”.

Access to care is important according to Healthy People 2020 because:

“Disparities in access to health services affect individuals and society. Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. Common barriers to services include: Lack of availability, High cost and Lack of insurance coverage.

According to the website these barriers to accessing health services lead to: *unmet health needs, delays in receiving appropriate care, inability to get preventive services and hospitalizations that could have been prevented.* When people have access to healthcare it improves their overall physical, social, and mental health status, prevents disease and disability, allows for the detection and treatment of health conditions, improves the quality of life, prevents early death and improves life expectancy.

- a) Service Gap Analysis: The following were identified during the CHIP meeting as gaps in Access to Health Care
 - i) Public Transportation is limited to take individuals to medical appointments
 - ii) Lack of financial resources to provide transportation
 - iii) Shortage of some specialized health care services and providers in the service area
 - iv) Affordable screenings for diseases that are culturally and linguistically appropriate.
 - v) Need to improve health literacy in the area.

- vi) High rate of individuals who are uninsured.
 - vii) A greater percentage of the 18-64 year old without health care coverage than the state.
 - viii) Residents in the East Central District consistently see a doctor less than the average for all of Nebraska.
 - ix) Compared to the state, the East Central district has a notably higher rate of residents without health insurance.
 - x) Some area Nursing homes are at capacity.
 - xi) Of the 20 NE health districts, ECDHD district ranked 17th in the percentage of individuals reporting good to excellent health in 2009, in addition minorities in ECDHD rank last in the state in this indicator.
 - xii) Health professional shortages.
- a) Assets and Resources Identified: The following were identified during the CHIP meeting
- i) Hospital has a completed analysis on health care shortage areas.
 - ii) The area has a taxi service
 - iii) The Hospital has a large number of volunteers that might be accessed for transportation
 - iv) The area has a Federally Qualified Health Center for low-income patients
 - v) Most of the health care providers in the area use interpreters for non-English speakers.
- b) Healthy People 2020 Information and Objectives related to this strategic area
- i) Overview: Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. This topic area focuses on four components of access to care: coverage, services, timeliness, and workforce.
 - ii) Importance: Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires 3 distinct steps:
 - (1) Gaining entry into the health care system.
 - (2) Accessing a health care location where needed services are provided.
 - (3) Finding a health care provider with whom the patient can communicate and trust.
- c) Related Evidenced Based Interventions from “*The Guide to Community Preventive Services*” from the CDC
- i) Reducing out-of-pocket costs to increase cancer screening may include providing vouchers, reimbursing clients, or reducing health insurance costs associated with screening tests.
 - ii) Reducing structural barriers to increase screening may include increasing hours of operation, providing child care, or addressing language or cultural factors.
 - iii) Case management involves planning, coordinating, and providing health care for all people affected by a disease, such as diabetes.

Obesity

Data to support the need for this as a strategic area are included in the Community Health Needs Assessment on pages 44-48. Nutrition and Weight Status is the best match for Obesity and is the closest topic area listed in the *Healthy People website*. The Nutrition and Weight Status goal is to “*Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights*”. A complementary strategic area is Physical Activity. The Physical Activity goal is to “*Improve health, fitness, and quality of life through daily physical activity*”.

Nutrition and Access to care is important according to Healthy People 2020 because: Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions including: Overweight and obesity, Heart disease, High blood pressure, Dyslipidemia (poor lipid profiles), Type 2 diabetes, Osteoporosis, Diverticular disease and some cancers. All of these conditions can lead to higher health care costs and decreased life expectancy.

In addition to the Healthy People 2020 the state of Nebraska has a *Nebraska Physical Activity and Nutrition State Plan 2011-2016*. This plan is designed to address the problems of obesity and related chronic disease and represents a comprehensive and consistent effort to promote evidence-based strategies.

- d) Service Gap Analysis- The following were identified during the CHIP meeting as gaps in Obesity
 - i) Unavailability of affordable programs to address obesity at worksites
 - ii) No worksite wellness plan for Platte County
 - iii) No funding for obesity work in Platte County
- e) Assets and Resources Identified
 - i) PACE worksite plan
 - ii) Childhood obesity consortium in Platte County
 - iii) NAP SACC program for addressing pre-school obesity
- f) Healthy People 2020 selected Objectives to this strategic area
 - i) Increase the proportion of schools that offer nutritious foods and beverages outside of school meals.
 - ii) Increase the proportion of primary care physicians who regularly measure the body mass index of their patients
 - iii) Increase the proportion of physician office visits that include counseling or education related to nutrition or weight
 - iv) Increase the proportion of worksites that offer nutrition or weight management classes or counseling
 - v) Increase the proportion of adults who are at a healthy weight
 - vi) Reduce the proportion of adults who are obese
 - vii) Reduce the proportion of children and adolescents who are considered obese
 - viii) Prevent inappropriate weight gain in youth and adults

- ix) Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older
- x) Reduce the proportion of adults who engage in no leisure-time physical activity
- xi) Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity
- xii) Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity
- xiii) Increase the proportion of the Nation's public and private schools that require daily physical education for all students
- xiv) Increase regularly scheduled elementary school recess in the United States
- xv) Increase the proportion of school districts that require or recommend elementary school recess for an appropriate period of time
- xvi) Increase the proportion of children and adolescents who do not exceed recommended limits for screen time
- xvii) Increase the proportion of the Nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations)
- xviii) Increase the proportion of physician office visits that include counseling or education related to physical activity
- xix) Increase the proportion of employed adults who have access to and participate in employer-based exercise facilities and exercise programs
- xx) Increase the proportion of trips made by walking
- xxi) Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities

g) Nebraska State Plan selected Strategies

- i) Strategy 1: Enhance access to physical activity opportunities, including physical education, in Nebraska schools, childcare and afterschool facilities.
- ii) Strategy 2: Enhance policies for physical activity, inclusive of physical education, in Nebraska schools.
- iii) Strategy 3: Enhance the transportation systems built environment and policies that improve access to physical activity in Nebraska communities.
- iv) Strategy 4: Enhance community planning and design practices through built environment and policy changes that improve access to physical activity in Nebraska communities.
- v) Strategy 5: Enhance the parks and recreation built environment and policies that improve access to physical activity in Nebraska communities.
- vi) Strategy 6: Enhance worksite and healthcare supports for physical activity.

h) Evidenced Based Interventions

- i) Behavioral Counseling in Primary Care to Promote a Healthy Diet. The U.S. Preventive Services Task Force (USPSTF) recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk

- factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
- ii) The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
 - iii) Screening for Obesity in Children and Adolescents. The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
 - iv) Obesity Prevention and Control, Interventions in Community Settings: Worksite Programs. Worksite nutrition and physical activity programs are designed to improve health-related behaviors and health outcomes. From the CDC Community Guide.
 - v) Worksite Health Promotion: Assessment of Health Risks with Feedback to Change Employees' Health
This intervention includes an assessment of personal health habits and risk factors; an estimation or assessment of risk of death and other adverse health outcomes; and provision of feedback in the form of educational messages and counseling. From the CDC Community Guide.
 - vi) Campaigns and Informational Approaches to Increase Physical Activity: Community-Wide Campaigns
Community-wide campaigns to increase physical activity involve many community sectors; include highly visible, broad-based, component strategies; and may also address other cardiovascular disease risk factors. From the CDC Community Guide.
 - vii) Creation of or enhancing access to places for physical activity involves the efforts of worksites, coalitions, agencies, and communities as they attempt to change the local environment to create opportunities for physical activity. Such changes include creating walking trails, building exercise facilities, or providing access to existing nearby facilities.

Family Support / Child Well Being or Family Support for Children Living in Poverty /

Data to support the need for this as a strategic area are included in the Community Health Needs Assessment on pages 16-32. There are two topic areas listed in the Healthy People 2020 website that focus on the intention of the Platte County CHIP group for Family Support. The first is Maternal, Infant, and Child Health, this topic area's goal most closely matches the Platte County CHIP. The Maternal, Infant, and Child Health goal is to *"Improve the health and well-being of women, infants, children, and families"*.

According to the Healthy People website, *"Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system"*.

Child health status in Platte County and Nationwide varies by both race and ethnicity, as well as by family income. The website has material that reinforces that family support is an important goal for a healthy community. According to the Healthy People website “*Furthermore, children reared in safe and nurturing families and neighborhoods, free from maltreatment and other social adversities, are more likely to have better outcomes as adults*”.

The second topic area is Early and Middle Childhood. While the Early and Middle Childhood goal does not seem to match the Platte County CHIP process it does have correlations with the group’s intentions and provides evidence for it’s inclusion in the Platte County CHIP. For example the overview includes this statement,

“ There is increasing recognition in policy, research, and clinical practice communities that early and middle childhood provide the physical, cognitive, and social-emotional foundation for lifelong health, learning, and well-being.”

In addition the material provided asks and answers the question *Why Is Early and Middle Childhood Important?*

“Evidence shows that experiences in the 1st years of life are extremely important for a child’s healthy development and lifelong learning. How a child develops during this time affects future cognitive, social, emotional, and physical development, which influences school readiness and later success in life. Research on a number of adult health and medical conditions points to predisease pathways that have their beginnings in early and middle childhood.”

The CHIP participants agree that working as a community to develop knowledgeable and nurturing families, parents, and caregivers will help create supportive and safe environments in schools, communities, and homes and thereby Increase the current and future health of these children.

- i) Service Gap Analysis
 - i) Lack of community wide knowledge of resources available
 - ii) Lack of communication between all agencies who serve families
 - iii) Cultural differences within the community
 - iv) Lack of public transportation
 - v) Lack of buy-in from parents
 - vi) Lack of resources and information on “*how to be a good dad*”

- j) Assets and Resources Identified
 - i) The 211 line was listed as a community resource to strengthen families
 - ii) Local churches were felt to be a community resource
 - iii) Connect Columbus was listed as a community resource

- k) Selected Healthy People 2020 Objectives related to this strategic area
 - i) Increase the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting.
 - (1) Increase the proportion of parents who report a close relationship with their child

- (2) Increase the proportion of parents who use positive communication with their child
 - (3) Increase the proportion of parents who read to their young child
 - (4) Increase the proportion of parents who receive information from their doctors or other health care professionals when they have a concern about their children's learning, development, or behavior
 - (5) Increase the proportion of parents with children under the age of 3 years whose doctors or other health care professionals talk with them about positive parenting practices
 - ii) Decrease the proportion of children who have poor quality of sleep
 - iii) Reduce the rate of fetal and infant deaths
 - iv) Reduce the rate of child deaths
 - v) Reduce the rate of adolescent and young adult deaths
 - vi) Reduce low birth weight (LBW) and very low birth weight (VLBW)
 - vii) Reduce preterm births
 - viii) Increase the proportion of young children with an Autism Spectrum Disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in early intervention services in a timely manner
 - ix) Increase the proportion of children, including those with special health care needs, who have access to a medical home
- l) Selected Evidenced Based Interventions
- i) Adolescent Health: Person-to-Person Interventions to Improve Caregivers' Parenting Skills
Person-to-person interventions aim to modify adolescents' risk/protective behaviors and health outcomes by improving their caregivers' parenting skills
 - ii) Pyramid Model for promoting Social Emotional Competence in Infants and Young Children (includes PIWI and PCIT) has been promoted by the Center on the Social and Emotional Foundations for Early Learning at www.vanderbilt.edu/csefel
 - iii) There a large variety of Evidenced Based Pre-natal interventions for better pregnancy outcomes

Substance Abuse/ Youth Substance Abuse / Youth Substance Abuse Prevention

Data to support the need for this as a strategic area are included in the Community Health Needs Assessment on pages 98-108. The *Healthy People website* lists the Healthy People 2020 goals. The healthy people 2020 goal for Substance Abuse is “to reduce substance abuse to protect the health, safety, and quality of life for all, especially children.” In addition to providing a goal, the Healthy People website offers the following definition of substance abuse which points out its importance for health and wellness.

“Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most

complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.”

During the Platte County CHIP process substance abuse was discussed at length and its relationship with other district and county wide problems. These problems included, teenage pregnancy rates, sexually transmitted diseases (STDs), domestic violence, child abuse, motor vehicle crashes, aggression and fighting, crime and suicide. It was felt that by addressing substance abuse many of these other community problems would be addressed as well.

- m) Service Gap Analysis- The following were identified during the CHIP meeting as gaps for substance abuse.
 - i) Funding for effective programming
 - ii) The ability to sustain current substance abuse programs in the community.
 - iii) Lack of participation from key sectors to include business, schools and mental health.

- n) Assets and Resources Identified
 - i) Back to Basics Coalition
 - ii) Current SPIF-SIG funding which will end September 30th, 2012
 - iii) Youth for Christ GAPS programming
 - iv) D.A.R.E. Programming
 - v) T4C- Time for Change
 - vi) YMCA
 - vii) Columbus Public Library's after school programming
 - viii) Faith based Youth groups throughout the County
 - ix) Columbus Skate and Hockey Center
 - x) Columbus Schools
 - xi) B-D
 - xii) Behlen
 - xiii) ADM
 - xiv) Medical Community

- o) Selected *Healthy People 2020* Objectives related to this strategic area
 - i) Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol
 - ii) Increase the proportion of adolescents never using substances
 - iii) Increase the proportion of adolescents who disapprove of substance abuse
 - iv) Increase the proportion of adolescents who perceive great risk associated with substance abuse
 - v) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department
 - vi) Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI)

- vii) Reduce past-month use of illicit substances
 - viii) Reduce the proportion of persons engaging in binge drinking of alcoholic beverages
 - ix) Reduce the proportion of adults who drank excessively in the previous 30 days
 - x) Decrease the rate of alcohol-impaired driving (.08+ blood alcohol content [BAC]) fatalities
 - xi) Reduce the past-year nonmedical use of prescription drugs
- p) Selected Evidenced Based Interventions
- i) The U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
 - ii) Decrease the rate of alcohol-impaired driving (.08+ blood alcohol content [BAC]) fatalities
 These programs provide education and training to servers of alcoholic beverages with the goal of altering their serving practices to prevent customer intoxication and alcohol-impaired driving. Practices may include offering customers food with drinks, delaying service to rapid drinkers, refusing service to intoxicated or underage consumers, and discouraging intoxicated customers from driving.
 - iii) Preventing Excessive Alcohol Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors.
 Enhanced enforcement programs initiate or increase the frequency of retailer compliance checks for laws against the sale of alcohol to minors in a community. Retailer compliance checks, or “sting operations,” are conducted by, or coordinated with local law enforcement or alcohol beverage control (ABC) agencies, and violators receive legal or administrative sanctions
 - iii) Reducing Alcohol-Impaired Driving: Mass Media Campaigns. Mass media campaigns intended to reduce alcohol-impaired driving are designed to persuade individuals either to avoid drinking and driving or to prevent others from doing so. Common campaign themes include fear of arrest; fear of injury to self, others, or property; and characterizing drinking drivers as irresponsible and dangerous to others.
 - iv) Reducing Alcohol-impaired Driving: Multi-component Interventions with Community Mobilization
 - v) Multi-component interventions to reduce alcohol-impaired driving can include any or all of a number of components, such as sobriety checkpoints, training in responsible beverage service, education and awareness-raising efforts, and limiting access to alcohol.
 - vi) Reducing Alcohol-impaired Driving: School-Based Programs. School-Based programs to reduce alcohol-impaired driving include: instructional programs; peer organizations such as Students Against Destructive Decisions (SADD); and social norming campaigns

vii) Reducing Alcohol-impaired Driving: Sobriety Checkpoints. At sobriety checkpoints, law enforcement officers use a system to stop drivers to assess their level of alcohol impairment.

viii) Worksite Health Promotion: Assessment of Health Risks with Feedback to Change Employees' Health

This intervention includes an assessment of personal health habits and risk factors; an estimation or assessment of risk of death and other adverse health outcomes; and provision of feedback in the form of educational messages and counseling.

Mental Health

Data to support the need for this as a strategic area are included in the Community Health Needs Assessment on page 42. The *Healthy People website* lists the Healthy People 2020 goal for Mental Health is *"Improve mental health through prevention and by ensuring access to appropriate, quality mental health services"*

Access to care is important according to Healthy People 2020 because:

"Disparities in access to health services affect individuals and society. Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. Common barriers to services include: Lack of availability, High cost and Lack of insurance coverage."

According to the Healthy People website, "Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the National Institute of Mental Health (NIMH), in any given year, approximately 1 in 17 will have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States accounting for 25 percent of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year."

q) Service Gap Analysis: The following were identified during the CHIP meeting as gaps for mental health.

i) No pre-EPC swing bed availability in Platte County.

ii) No local detox bed in the County

iii) No pre-EPC assessment, action steps, resources or services available.

iv) No pre-EPC current protocols, policies or process

v) No differentiation of adult and child process/program.

vi) Lack of funding

vii) Lack of follow-through

viii) No consequences when clients do not follow-through

r) Assets and Resources Identified

i) Law enforcement

- ii) Crisis Navigators
 - iii) Local Mental Health Providers
 - iv) School Authorities
 - v) DHHS
 - vi) Neighbors
 - vii) Resources from distant community health
- s) Selected Healthy People 2020 Objectives related to this strategic area
- i) Reduce the suicide rate
 - ii) Reduce suicide attempts by adolescents
 - iii) Reduce the proportion of persons who experience major depressive episode (MDE)
 - iv) Increase the proportion of children with mental health problems who receive treatment
 - v) Increase the proportion of adults with mental health disorders who receive treatment
 - vi) Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders
 - vii) Increase depression screening by primary care providers
- t) Evidenced Based Interventions
- i) Major Depressive Disorder in Children and Adolescents: The U.S. Preventive Services Task Force (USPSTF) recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up
 - ii) Screening for Depression in Adults: The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up
 - iii) Collaborative Care for the Management of Depressive Disorders: Collaborative care aims to increase primary care providers' knowledge and skills, improve client understanding and awareness of depressive disorders, and to reorganize the system of care into an optimal environment for management of depression and depressive disorders
 - iv) Interventions to Reduce Depression Among Older Adults: Clinic-Based Depression Care Management
Clinic-based depression care management involves active screening for depression, measurement-based outcomes, trained depression care managers, case management, a primary care provider and patient education, antidepressant treatment and psychotherapy, and a supervising psychiatrist

Cancer

Data to support the need for this as a strategic area are included in the Community Health Needs Assessment on pages 65 and 111. Cancer as a topic is listed on the

Healthy People website. The Cancer goal is to “Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.”

Cancer remains the second leading cause of death in the United States, second only to heart disease.

u) Service Gap Analysis- The following were identified during the CHIP meeting as gaps for Cancer

- i) Poor screening rates for colorectal and breast cancer.
- ii) The district has a slightly higher incidence of cancer than the state average.
- iii) East Central has higher rates of colorectal cancer deaths than the state average.

v) Assets and Resources Identified

- i) Hospital and Clinic Prevention efforts
- ii) Pool Cool skin cancer program

w) Healthy People 2020 selected Objectives to this strategic area

- i) Increase the proportion of adults who were counseled about cancer screening consistent with current guidelines
 - (1) Increase the proportion of women who were counseled by their providers about mammograms
 - (2) Increase the proportion of women who were counseled by their providers about Pap tests
 - (3) Increase the proportion of adults who were counseled by their providers about colorectal cancer screening
- ii) Reduce the lung cancer death rate
- iii) Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines
- iv) Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines
- v) Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines
- vi) Reduce the oropharyngeal cancer death rate
- vii) Reduce the prostate cancer death rate
- viii) Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn
 - (1) Increase the proportion of adolescents in grades 9 through 12 who follow protective measures that may reduce the risk of skin cancer
 - (2) Increase the proportion of adults aged 18 years and older who follow protective measures that may reduce the risk of skin cancer
- ix) Increase the mental and physical health-related quality of life of cancer survivors

x) Evidenced Based Interventions

- i) The U. S. Preventive Services Task Force (USPSTF) recommends counseling children, adolescents, and young adults aged 10 to 24 years who

- have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- ii) The U.S. Preventive Services Task Force (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.
- iii) The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.
- iv) The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
- v) The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
- vi) Client reminders to include letters, postcards or phone calls to alert clients that it is time for their cancer screening.
- vii) One-on-one education provided in person or by telephone to encourage individuals to be screened for cancer.
- viii) Small media such as videos, letters, brochures, and newsletters can be used to inform and motivate people to be screened for cancer; they can be tailored to specific persons or targeted to general audiences.
- ix) Reducing out-of-pocket costs to increase cancer screening may include providing vouchers, reimbursing clients, or reducing health insurance costs associated with screening tests.
- x) Reducing structural barriers to increase screening may include increasing hours of operation, providing child care, or addressing language or cultural factors.

Bullying

Data to support the need for this as a strategic area are included in the Community Health Needs Assessment on pages 97 and 98. There are no Healthy People 2020 goals and objectives related to bullying. Bullying is unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Both kids who are bullied and who bully others may have serious, lasting problems.

- y) Service Gap Analysis- The following were identified during the CHIP meeting as gaps for Bullying
 - i) School policies regarding bullying are unknown to the group
 - ii) Group is not sure of what action steps are taken by the school when bullying occurs
- z) Assets and Resources Identified
 - i) School Counselors and Teachers
 - ii) Parents

- iii) Clergy
- iv) Gina Baker the local mental health provider

Table 4		Availability of Health Resources by County⁶			
	County Hospital/ Health Clinic	Not Present in the County	Present but not adequate to meet the needs of the County	Present and adequate to meet the needs of the County	Bilingual Service in Spanish or through an Interpreter
Primary Care Physicians for adults	Boone			√	√
	Colfax		√		√
	Nance			√	√
	Platte			√	√
Primary Care Physicians for Children	Boone			√	√
	Colfax		√		√
	Nance			√	
	Platte			√	√
OB/GYN Services	Boone			√	√
	Colfax		√		√
	Nance			√	
	Platte			√	√
Services for Adolescent Sexual Health	Boone			√	
	Colfax		√		
	Nance			√	
	Platte			√	√
Services for Children with Special Needs	Boone			√	
	Colfax		√		
	Nance			√	
	Platte			√	√

Cardiology Services	Boone			√	
	Colfax		√		
	Nance			√	
	Platte			√	√
Neurology Services	Boone			√	
	Colfax	√			
	Nance	√			
	Platte			√	√
Orthopedic Services	Boone			√	
	Colfax		√		
	Nance	√			
	Platte			√	√
Urology Services	Boone			√	
	Colfax		√		
	Nance			√	
	Platte			√	√
Pulmonary Services	Boone			√	
	Colfax	√			
	Nance			√	
	Platte			√	√
Radiology and Imaging Services	Boone			√	
	Colfax			√	√
	Nance			√	
	Platte			√	√

	County Hospital/ Health Clinic	Not Present in the County	Present but not adequate to meet the needs of the County	Present and adequate to meet the needs of the County	Bilingual Service in Spanish or through an Interpreter
Hospice Care	Boone			√	
	Colfax		√		
	Nance			√	
	Platte			√	√
Respite Care for Adults	Boone			√	
	Colfax		√		
	Nance			√	
	Platte			√	√
Respite Care for Children	Boone			√	
	Colfax		√		
	Nance			√	
	Platte			√	√
Dental Care Services for adults	Boone			√	
	Colfax		√		
	Nance	√			
	Platte			√	√
Dental Care Services for Children	Boone			√	
	Colfax		√		
	Nance	√			
	Platte			√	√
Behavioral Health	Boone			√	
	Colfax	√			

Services	Nance			√	
	Platte			√	√
Substance Abuse Services	Boone			√	
	Colfax	√			
	Nance	√			
	Platte			√	√

VI. Communications – A Part of the CHNA and CHIP

The core responsibility for communications during the CHNA and up to the selection of strategic issues was the responsibility of the ECDHD with the Columbus Community Hospital in charge of the invitations to the CHIP.

The general public has been invited to all CHIP meetings, with advertisements run in local newspapers, in addition to sending out targeted invitations. The communications plan for the CHIP strategic issues groups is primarily to use e-mail to keep the strategic groups together. In Platte County, the largest ECDHD’s county, approximately 70 individuals attended the day-long meeting CHIP meeting. Participants included local leaders in health and healthcare, the business community, schools, law enforcement, local non-profit agencies, as well as elected or appointed local and state-level government officials.

Communications after the CHIP have included internal strategic work-group communications, communications from the hospitals for the follow-up meetings and communication between ECDHD and the hospital.

VII. Capacity to Complete the CHIP and Address the Needs of the Community

Initially the ECDHD was formed in 1998 as a Platte Colfax District Health Department. The agency was formed by a community lead coalition and the state approved district health department hired its first staff member in 1999 and immediately began providing services. The ECDHD is as mentioned earlier nationally recognized for its previous community mobilization efforts and leans heavily on partnerships to bring about community change. This system of community and health department collaboration and partnership has worked well over ECDHDs history. The agency has been able to effectively coordinate services because of the strength of its staff and a structure that promotes regular monitoring of activities. Roberta Miksch the Deputy Director has been with the agency since 2002 and is familiar with working with state and local grant funding and has been critical to the MAPP and CHIP process in this third iteration.

The health department currently manages a five million dollar per year budget and owns three buildings in two counties. The department is in good standing on all grant and

contracts and its finances are in order as confirmed by independent audits. The department employs eighty full or part-time employees and coordinates multiple coalitions and health improvement teams in addition to providing direct medical, dental and mental health services.

ECDHD provides all services with attention to ADA accessibility, cultural and linguistic competency, accessibility, and is now actively working on health literacy as a core function in all of its programs. In addition cultural and linguistic appropriateness is critical to ECDHD success since the districts population includes a high percentage of low English Proficiency (LEP) speakers. The department employs bi-lingual providers, nurses, accounting staff, senior managers and health educators. The ECDHD not only provides culturally and linguistically appropriate care it conducts regular CLAS assessments to determine areas for improvement and the Executive Director and other staff members have provided training on working with the Hispanic/Latino population to other agencies. The department also engages those it serves including the Hispanic/Latino community using focus groups and patient satisfaction surveys to determine the relevance of its services. ECDHD uses evidenced based decision making and evidence-informed strategies whenever available. All programs are required to complete quarterly performance measures to measure program successes and maintain a focus on outcomes.

ECDHD operates under the four M's. Maximize Revenue, Maximize Encounters, Minimize Errors and Minimize Expenses. By paying attention to the four Ms, ECDHD is able to maintain the cost of operations within the limits of available funding while meeting program requirements and maximizing available resources. The ECDHD has proven over the past thirteen years that it has the experience and structure to safeguard the assets the agency has been entrusted with. Most of the regular funding obtained to operate ECDHD is grant dollars which speaks to the capacity of the agency to manage large and small awards year after year. The largest grant under current management is a new award for \$5,000,000 to build a new building with federal funds from the affordable healthcare act. ECDHD has a strong management structure with the same Executive Director since the department opened its doors. Ms. Rayman also serves on several boards to include the Executive Board of the Nebraska Association of Local Health Directors, the Executive Board of the Health Center Association of Nebraska, the leadership board of the Columbus morning Rotary and is a board member of the Columbus Community Hospital.

The department has had thirteen years of strong fiscal management with the same financial director Ms. Rosario Velasco for over ten years. The agency uses the Sage MIP non-profit accounting software and is able to keep all the pertinent grant information electronically to facilitate grant management. Ms. Velasco has taken federal circular courses as well as holds a degree in accounting. Records at the agency are kept well organized and the department has had many successful program and financial audits. The department has a long history of clean audits and for the past five years have not even had a finding for segregation of duties. The department manages scores of contractual arrangements without difficulty and monitors financial performance for all programs. Program coordinators are given profit and loss statements on their programs monthly and required to review expenditures against program activities.

Monthly program requisitions are pulled at random for review with generally accepted accounting standards.

ECDHD has a commitment to provide quality services that is evidenced by being the only accredited health department in the state and only one of three Joint Commission accredited health departments in the nation. ECDHD currently holds two Joint Commission Accreditations. ECDHD is currently preparing for Public Health Accreditation Board (PHAB) and has a quality council that meets monthly, board quality committee meetings and a quality review process for every program.

VIII. The CHIP Work plans

The initial CHIP plans from the four counties are included in the appendix section of this document; these plans will be updated from time to time during the three year implementation period.

Community Health Needs and Priorities Overall East Central District

Following the demographic profile of selected characteristics, the top 13 community health needs and priorities for the entire East Central District are listed alphabetically in Table 3.1 below with a brief description of the rationale for selection. Following the table are data that support the selection and prioritization of the community health needs.

Demographic Profile: East Central District

Population: 51,992

Density (people per square mile): 23.6

% White: 88.0%

% Hispanic: 17.1%

% over 65: 15.5%

Median Household Income: \$46,892

% at or below Poverty Line: 8.6%

% without High School Degree or GED/Equivalent: 14.2%

Table 3.1: Community Health Needs and Priorities for the East Central District	
Community Health Needs and Priorities	Rationale for Selection
➤ Accidental Death	<ul style="list-style-type: none"> High rates of unintentional, motor vehicle, and work-related accidental deaths as compared to the state.
➤ Aging Population	<ul style="list-style-type: none"> High percentage of the population is over 65 for the district. High percentage of elderly individuals report lacking a social network.
➤ Cancer	<ul style="list-style-type: none"> The top perceived health problem in three of the four counties, and the overall top perceived health problem in both the <i>Community Health Survey</i> and the <i>Community Themes and Strengths Assessment Survey</i> High instances of breast, colorectal, and prostate cancers district wide. High instances of cancer may be partly or largely attributable to the aging population.
➤ Diabetes	<ul style="list-style-type: none"> Increases each year from 2007 to 2009 in percent of adults with diabetes. The number three perceived health problem in the district.
➤ Drug and Alcohol	<ul style="list-style-type: none"> Alcohol abuse was the top perceived risky behavior in every county;

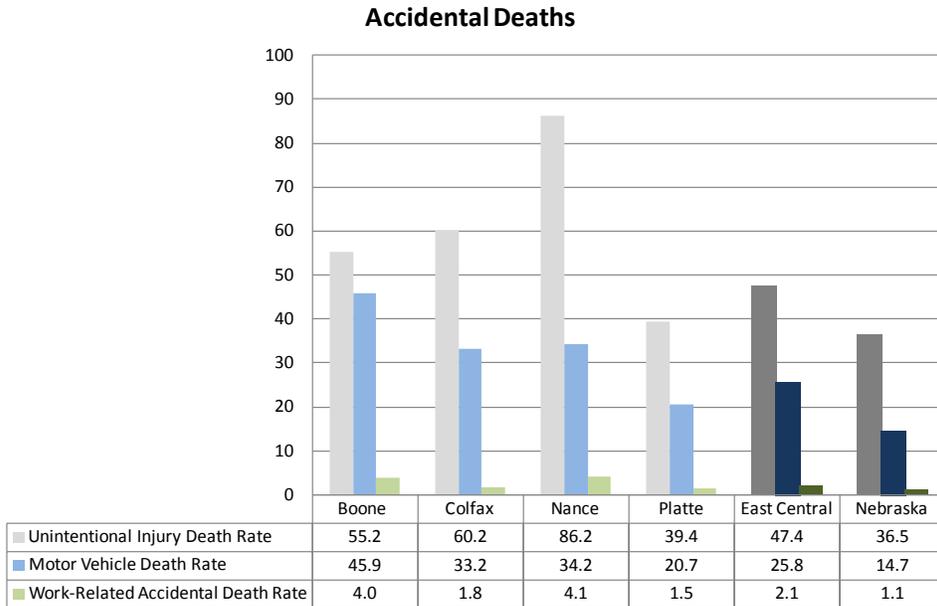
Appendix 1. Community Health Needs- Overall District

<p>Use</p>	<p>drug abuse was second overall.</p> <ul style="list-style-type: none"> • High community perception of underage alcohol use as an issue that needs greater attention. • High rates of youth riding with a driver who had been drinking. • High rates of hospitalization for alcohol and tobacco related disease. • Also a concern among focus group participants and community agencies participating in the <i>Forces of Change Assessment</i>.
<p>➤ Health Professional Shortages</p>	<ul style="list-style-type: none"> • More individuals served per health professional for every health profession as compared to the state except for LPNs. • Several areas with state and federally designated health professional shortages.
<p>➤ Mental Health Services</p>	<ul style="list-style-type: none"> • High percentage of mental health patients seen at the Good Neighbor Center. • Federally designated shortage of mental health professionals in every county in the district.
<p>➤ Health Screening</p>	<ul style="list-style-type: none"> • Low rates of health screening, especially among women for mammogram, clinical breast exam, and PAP exam as compared to the state.
<p>➤ Immunization for the over 65 Population</p>	<ul style="list-style-type: none"> • Low rates of immunization for pneumonia and influenza among the over 65 population as compared to the state.
<p>➤ Non-Sports-Related Activities for Children</p>	<ul style="list-style-type: none"> • Lack of activities for youth expressed by focus group participants and noted as a contributor to drug and alcohol use. • Low community perception of the availability of non-sports-related activities for children in the <i>Community Health Survey</i>.
<p>➤ Obesity</p>	<ul style="list-style-type: none"> • A community-wide concern, noted especially in the <i>Forces of Change Assessment</i>, the <i>Obesity Summit</i>, and <i>Community Themes and Strengths Assessment Survey</i>. • High rates of obesity for the overall population, and especially for the minority population. • High percentage of youth overweight. • A low percentage of leisure time devoted to physical activity as compared to the state. • County-level data were not available for obesity. Thus, it has been selected as an overall community health need.
<p>➤ Rape and Forced Sexual Intercourse</p>	<ul style="list-style-type: none"> • High rates of reported cases of rape as compared to the state. • High rates of self-reported forced sexual intercourse by youth.
<p>➤ Teen Pregnancy and Sexual Activity</p>	<ul style="list-style-type: none"> • The number two perceived health problem in the district, and the number one for the Hispanic population, among whom the teen birth rate is very high. • Teens in the district are more sexually active than their peers in Nebraska.

- Also a concern among focus group participants and community agencies participating in the *Forces of Change Assessment*.

Accidental Death

Figure 3.1: Accidental Death Rate per 100,000 Population (2005-2009)¹⁰



Aging Population

Table 3.2	Percent of the Population 65 and over (2010) ¹¹
	Percent of the Population over 65
Boone	21.2%
Colfax	13.6%
Nance	19.1%
Platte	14.8%
East Central	15.5%
Nebraska Total	13.6%
United States	13.1%

Appendix 1. Community Health Needs- Overall District

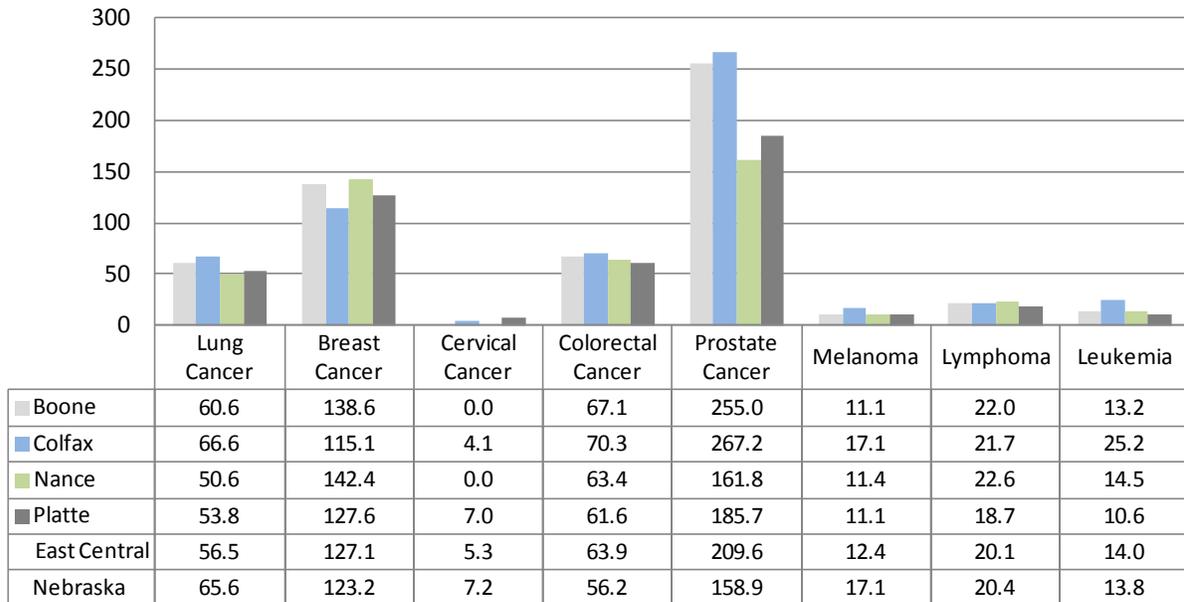
Table 3.3	Perceptions of Resources for the Elderly among Those who are 65 and Older: <i>Nebraska Community Themes and Strengths Assessment (2011)</i> ¹⁶	
	% Who Disagree	
	East Central	Nebraska
	There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments.	17.1% 20.5%
	There is enough transportation available in your community to take older adults to medical facilities and shopping.	27.1% 29.6%
	There are enough programs that provide meals for older adults in your community.	12.8% 19.4%
	There are a lot of social networks and groups in your community available for older adults that are living alone.	29.6% 33.6%

Cancer

See also Table 3.10 below.

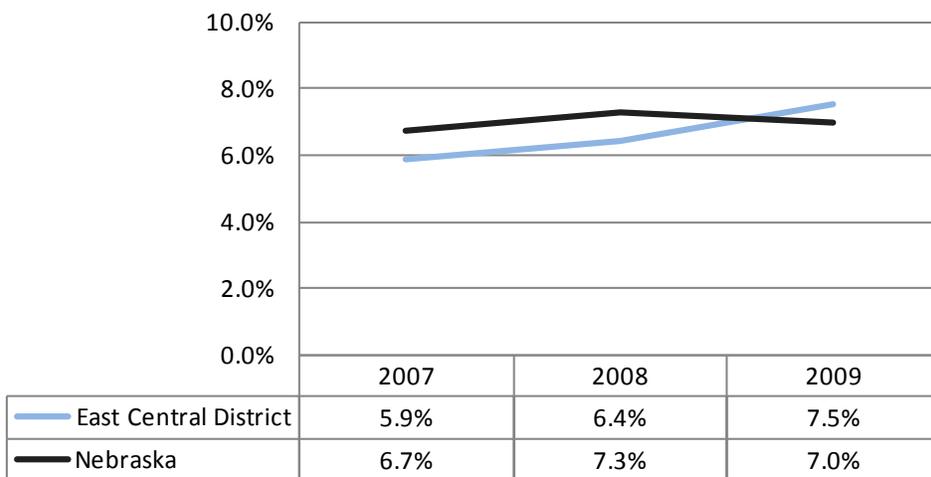
Table 3.4	Top Five Perceived Health Problems by County and Ethnicity ¹⁵						
	Boone	Colfax	Nance	Platte	Hispanic	Non-Hispanic	East Central
1st	Cancer	Teenage Pregnancy	Cancer	Cancer	Teenage Pregnancy	Cancer	Cancer
2nd	Heart Disease and Stroke	Cancer	Heart Disease and Stroke	Diabetes	Diabetes	Heart Disease and Stroke	Teenage Pregnancy
3rd	Aging Problems	Diabetes	Aging Problems	Teen Pregnancy	Cancer	Aging Problems	Diabetes
4th	Affordable and Safe Housing	Aging Problems	Diabetes	Heart Disease and Stroke	Child Abuse/Neglect	Diabetes	Aging Problems
5th	Diabetes	Heart Disease and Stroke	Affordable and Safe Housing	Aging Problems	High Blood Pressure	Teenage Pregnancy	Heart Disease and Stroke

Figure 3.2: Incidence of Cancer by Type per 100,000 Population (2003-2007)¹⁰



Diabetes

Figure 3.3: Prevalence of Diabetes among Adults¹⁰



Drug and Alcohol Use

Table 3.5	Top Five Perceived Risky Behaviors by County and Ethnicity ¹⁵						
	Boone	Colfax	Nance	Platte	Hispanic	Non-Hispanic	East Central
1st	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse	Alcohol Abuse
2nd	Being Overweight	Being Overweight	Tobacco Use	Drug Abuse	Drug Abuse	Drug Abuse	Drug Abuse

Appendix 1. Community Health Needs- Overall District

3rd	Tobacco Use	Racism	Lack of Exercise	Being Overweight	Racism	Being Overweight	Being Overweight
4th	Lack of Exercise	Drug Abuse	Being Overweight	Tobacco Use	Being Overweight	Tobacco Use	Tobacco Use
5th	Not Using Seat Belts	Unsafe Sex	Not Using Seat Belts	Lack of Exercise	Lack of Exercise	Lack of Exercise	Lack of Exercise

Table 3.6 Perceptions of Underage Alcohol Use: <i>Nebraska Community Themes and Strengths Assessment (2011)</i> ¹⁶		
	% Who Agree	
	East Central	Nebraska
Alcohol use among individuals under 21 years old is a big problem in your community.	79.5%	72.0%
Your community should do more to prevent alcohol use among individuals under 21 years old.	80.5%	76.9%
Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood.	22.0%	18.9%

Figure 3.4: Percent of Youth Who Rode in a Car in the Past 30 Days Driven by Someone Who Had Been Drinking Alcohol (2010)²⁹

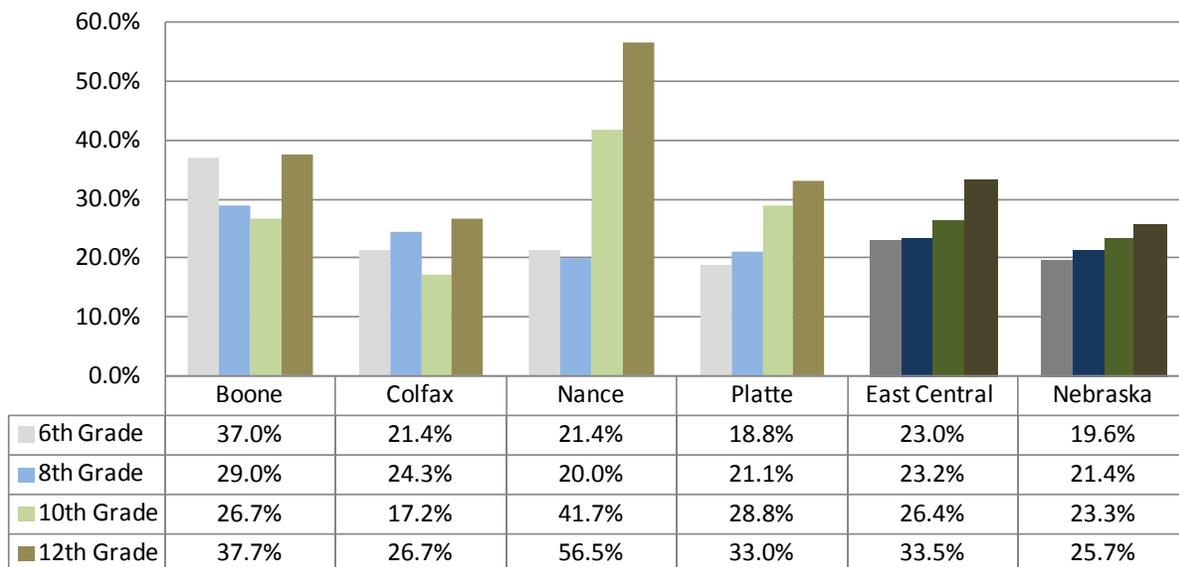


Figure 3.5: Hospitalizations for Alcohol and Tobacco Related Diseases per 100,000 Population (2007-2008)¹⁰

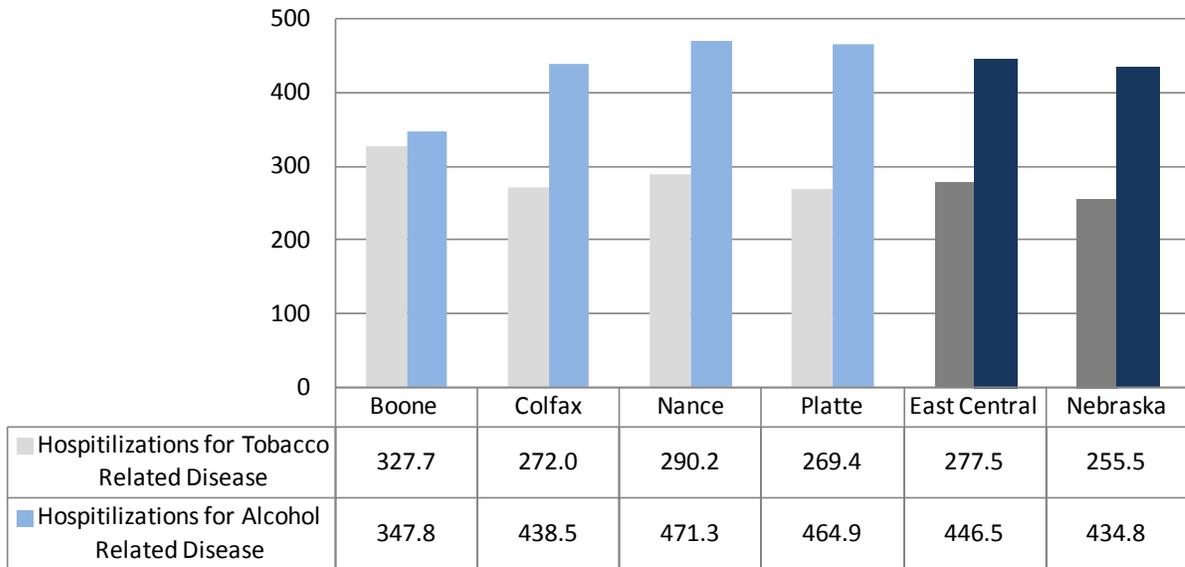
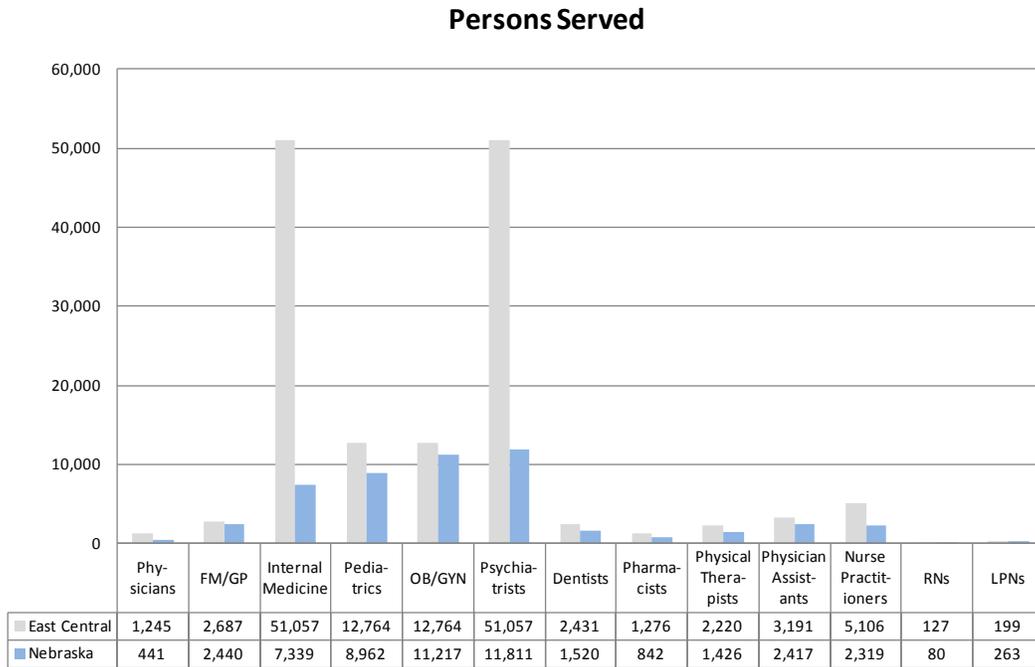


Table 3.7 State Designated Health Professional Shortages (2010)¹⁰					
	Boone	Colfax	Nance	Platte	East Central
Family Practice		√	√		partial
General Surgery			√	√	partial
Internal Medicine	√	√	√	√	√
Pediatrics		√	√	√	partial
Obstetrics/Gynecology	√	√	√		partial
Psychiatrics	√	√	√	√	√
Dental		<i>partial</i>	√		partial
Pharmacy		√	√		partial
Occupational Therapy		<i>partial</i>			partial
Physical Therapy					

Health Professional Shortages

Figure 3.6: Persons Served per Health Profession:

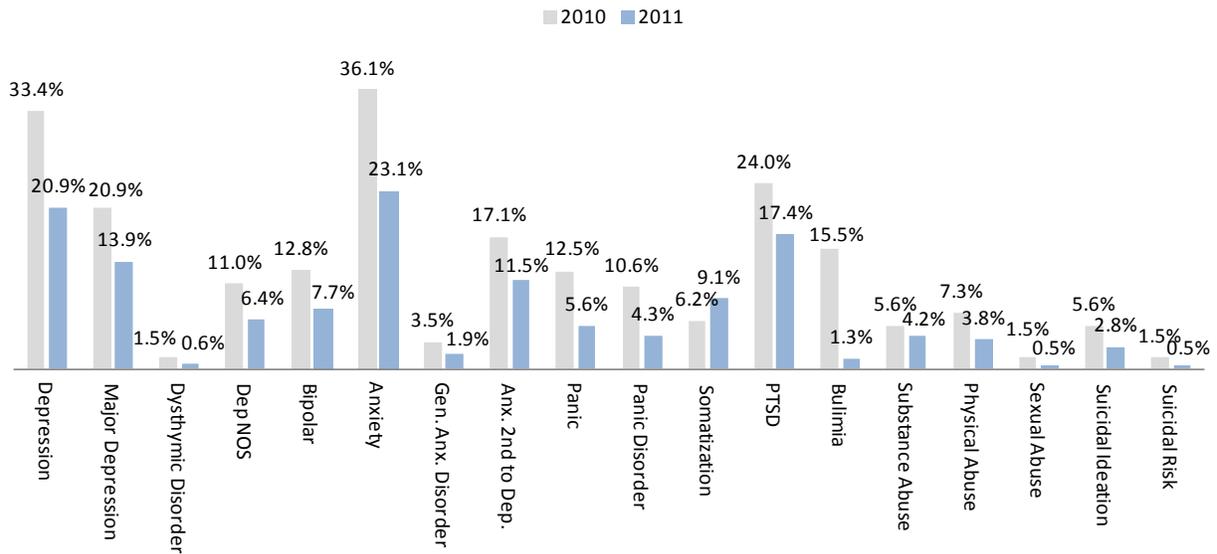


Mental Health Services

See also the shortage in psychiatrists in Figure 3.6 above.

Table 3.8	Services Used at the Good Neighbor Center with Comparisons to State and National FQHCs⁷		
	Good Neighbor	Nebraska	National
Medical	54.2%	65.5%	72.2%
Dental	16.3%	17.8%	12.0%
Mental Health	21.1%	6.7%	5.5%
Substance Abuse	0.8%	0.1%	1.3%
Other Professional Services	1.9%	0.8%	1.3%
Vision	0.3%	0.0%	0.5%
Enabling	5.2%	9.2%	6.5%

Figure 3.7: Mental Health Comorbidity: Patients at the Good Neighbor Center⁸



Note: the above graph shows the percentage of regular patients to the Good Neighbor Center that also have mental health issues. The statistic is *not* for those who visited the Good Neighbor Center for mental health, but rather the percentage of patients coming in for another reason (e.g., routine checkup), and who were given a mental health screen as part of the regular visit and the screen identified characteristics associated with behavioral health issues as secondary to their primary visit.

Table 3.9	Federally Designated Health Professional Shortages (2008) ¹⁰				
	Boone	Colfax	Nance	Platte	East Central
Primary Care			✓		Partial
Mental Health	✓	✓	✓	✓	✓
Dental Health		✓			Partial

Health Screening

Table 3.10	Percent of Population Receiving Health Screenings ¹⁰	
	East Central District	Nebraska
Had a colonoscopy in past ten years (50+) [2009]	48.4%	50.1%
Had a prostate specific antigen (PSA) in past two	66.4%	62.4%

Appendix 1. Community Health Needs- Overall District

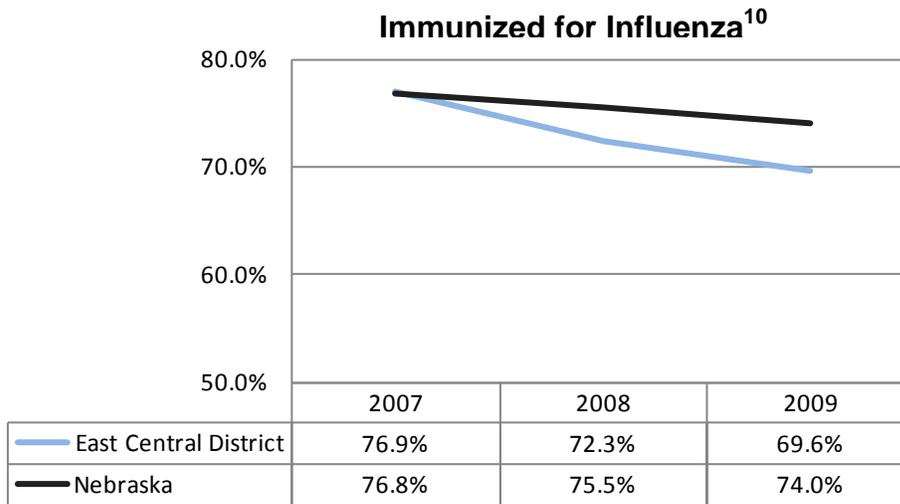
years (males 50+) [2009]		
Had a digital rectal exam (DRE) in past two years (males 50+) [2009]	44.1%	51.5%
Mammogram screening in past year (women 40+) [2008]	46.4%	54.5%
Clinical breast exam (CBE) in past year (women 40+) [2008]	54.4%	63.0%
Had PAP test in past three years [2008]	71.4%	77.9%

Immunization for the over 65 Population

Figure 3.8: Percent of Population over 65 Immunized for Pneumonia¹⁰



Figure 3.9: Percent of Population over 65



Non-Sports-Related Activities for Youth

Table 3.11	There are plenty of non sports-related activities for children in my community. ¹⁵					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean (1-5 scale)
Boone	0.0%	44.4%	29.6%	25.9%	0.0%	2.8
Colfax	12.2%	44.7%	22.0%	14.6%	6.5%	2.6
Nance	5.3%	47.4%	21.1%	26.6%	0.0%	2.7
Platte	8.3%	39.1%	32.0%	20.3%	0.4%	2.7
Hispanic	12.6%	29.1%	34.0%	18.4%	5.8%	2.8
Non-Hispanic	7.1%	45.7%	26.9%	19.6%	0.8%	2.6
East Central	8.1%	41.8%	28.3%	20.0%	1.9%	2.7

Obesity See also Table 3.5 above.

Figure 3.10: Percent of Population Identified As Obese¹⁰

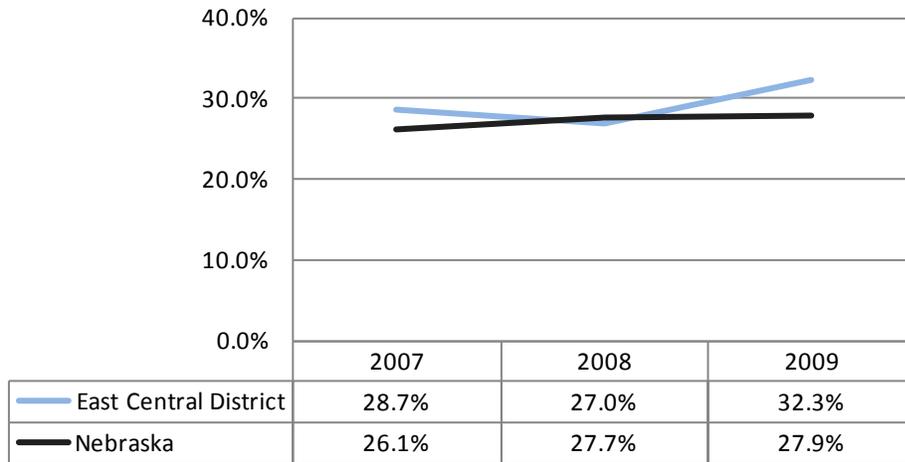


Table 3.12	Percent of Minorities Identified As Obese ¹⁰	
Year	East Central District	Nebraska
2008	40.8%	37.3%
2009	34.8%	32.7%

Figure 3.11: Percent of Youth Overweight¹⁹

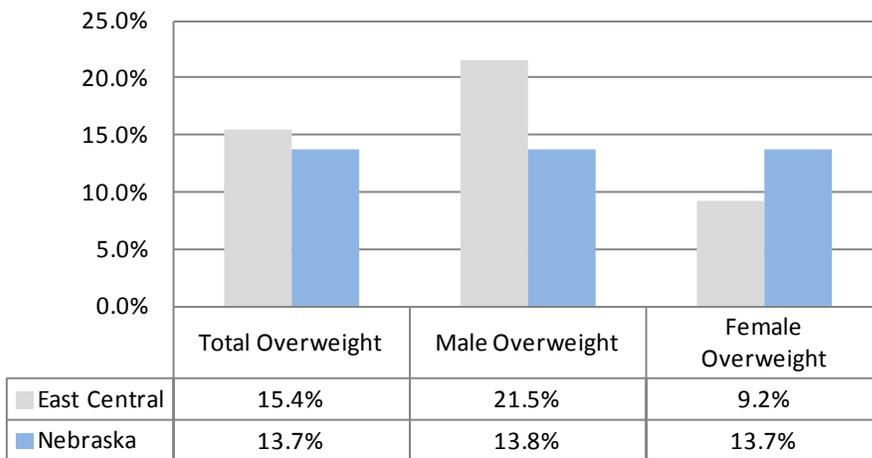
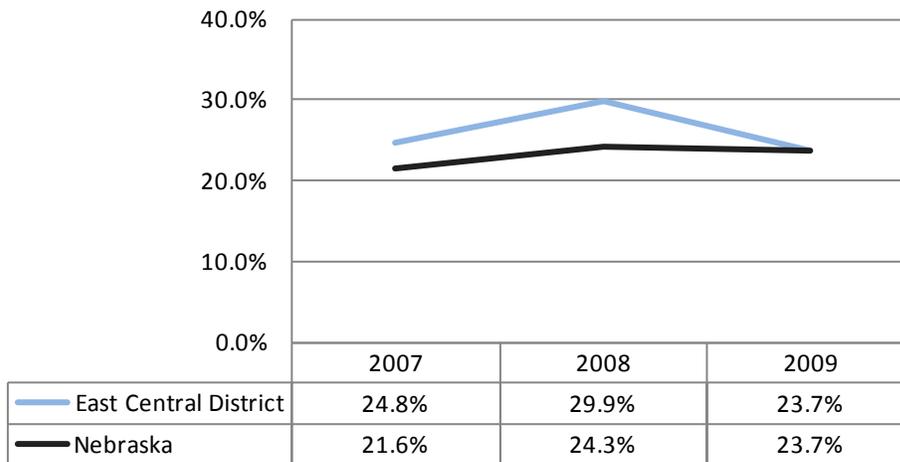


Figure 3.12: Percent of Population With No Leisure Time Devoted to Physical Activity¹⁰



Rape and Forced Sexual Intercourse

Figure 3.13: Reported Forcible Rape Offenses 1,000 Population (2007-2009)¹⁰

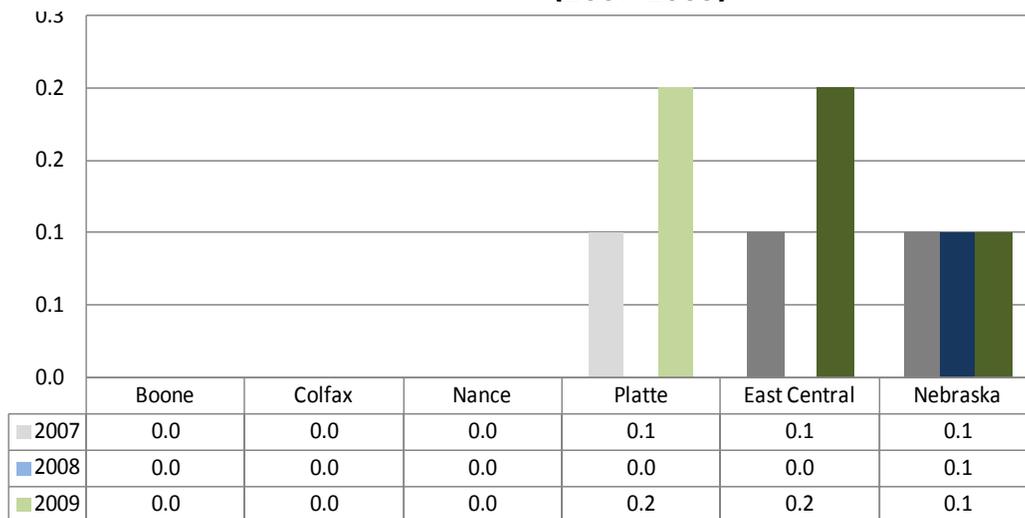


Table 3.13 Percent of Teens Physically Forced to Have Sexual Intercourse, 2001 and 2010 Comparisons^{18,19}					
	9th Grade	10th Grade	11th Grade	12th Grade	Overall
East Central District 2001	4.5%	4.4%	7.4%	6.1%	5.6%
East Central District 2010	8.8%	7.4%	13.0%	11.8%	10.4%
Nebraska 2010	6.3%	6.6%	7.9%	10.0%	7.5%

Appendix 1. Community Health Needs- Overall District

Table 3.14	Percent of Teens Physically Forced to Have Sexual Intercourse by Gender (2010)¹⁹				
	9th Grade	10th Grade	11th Grade	12th Grade	Overall
East Central District Males	5.7%	6.8%	10.9%	9.3%	8.1%
Nebraska Males	4.9%	3.5%	7.0%	4.3%	5.2%
East Central District Females	11.6%	8.3%	15.3%	13.4%	12.6%
Nebraska Females	7.7%	10.0%	8.4%	14.9%	9.4%

Teenage Pregnancy and Sexual Activity

See also Table 3.4 above.

Table 3.15	Teen Births as Percent of Total Births (2005-2009)¹⁰		
	Total Live Births	Number of Teen Births	Teen Births as % of Total Live Births
Boone	298	20	6.7%
Colfax	1,046	140	13.4%
Nance	206	6	2.9%
Platte	2,427	247	10.2%
East Central	3,977	413	10.4%
Nebraska Total	133,723	11,165	8.4%

Figure 3.14: Births to Mothers Ages 13-15 per 1,000 Population by Caucasian and Hispanic 2005-2009¹⁰

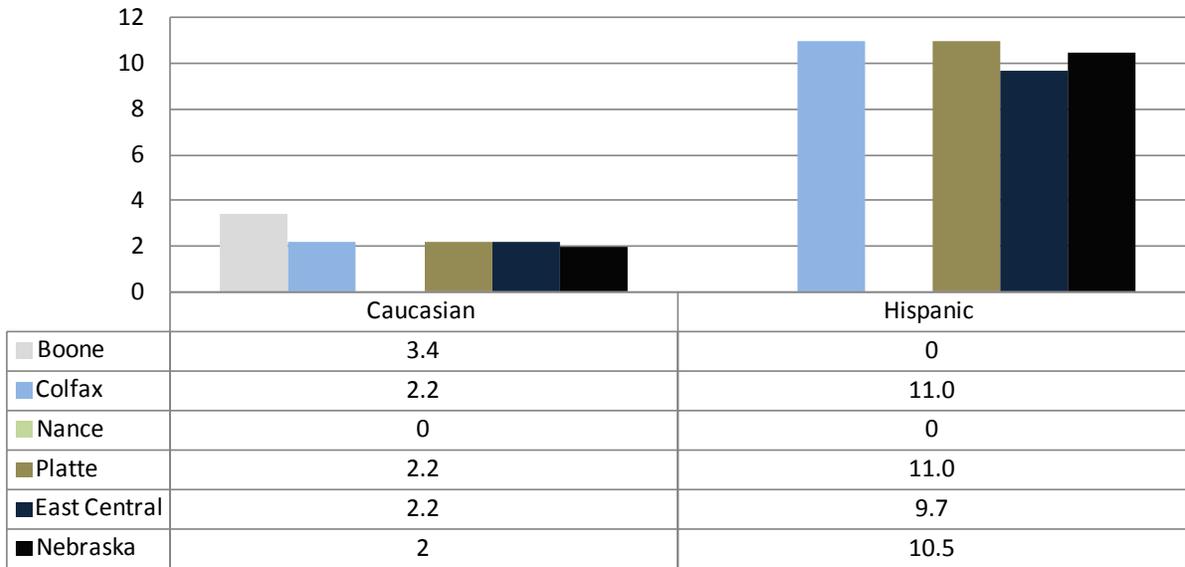
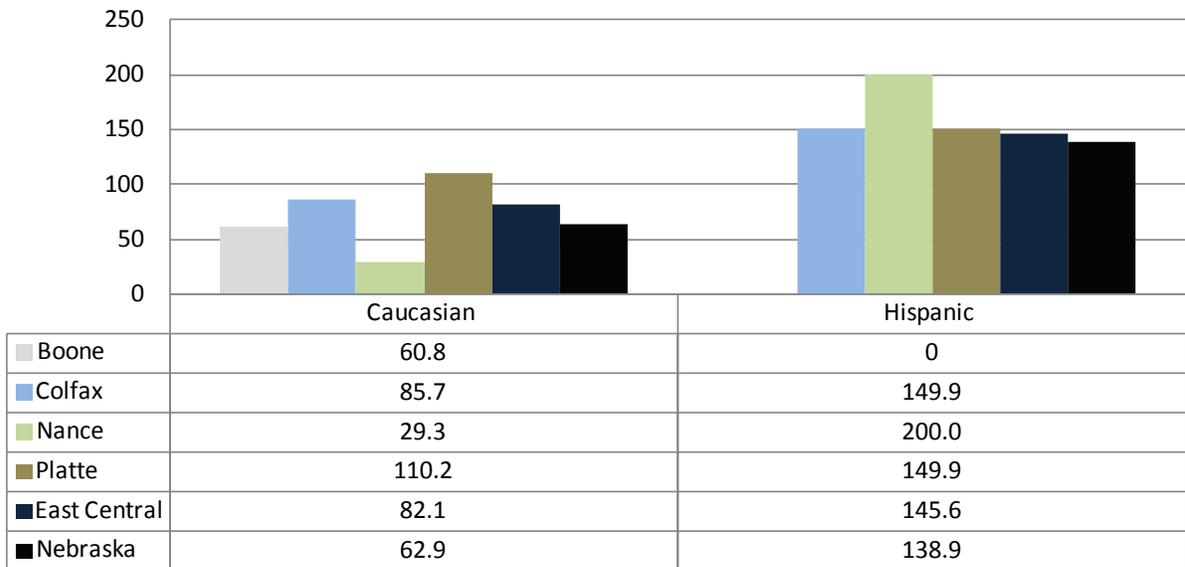


Figure 3.15: Births to Mothers Ages 16-19 per 1,000 Population by Caucasian and Hispanic 2005-2009¹⁰



Appendix 1. Community Health Needs- Overall District

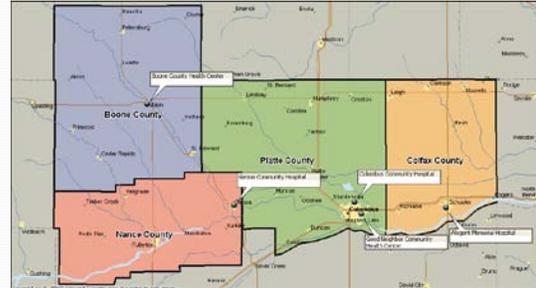
Table 3.16		Percent of Teens Sexually Active 2001 and 2010 Comparisons^{18,19}			
	9th Grade	10th Grade	11th Grade	12th Grade	Overall
East Central District 2001	20.0%	19.7%	35.2%	43.2%	29.8%
East Central District 2010	19.7%	38.2%	49.8%	51.9%	38.0%
Nebraska 2010	17.2%	31.9%	47.7%	51.4%	34.9%

On the following pages in Appendix 2, are Powerpoint slides of the Comprehensive Community Assessment for Platte County presentation.

2011 Comprehensive Community Assessment: Selected Results for Platte County



The East Central Health District



Community and District Wide Project

- Alegent Health Memorial Hospital in Schuyler
- American Red Cross
- ARC of Platte County
- Board Member and medical user of the Community Health Center
- Boone County Hospital
- Catholic Charities
- Center for Survivors
- Central Community College
- The Child Well-Being Initiative
- City of Columbus Parks and Recreation Department
- Columbus Chamber of Commerce
- Columbus Community Hospital
- Columbus Family Practice (Private Medical Clinic)
- Columbus Public Library
- Columbus Public Schools
- Connect Columbus
- Crisis Navigators
- Department of Health and Human Services
- East Central District Health Department
- ESU #7
- First United Methodist Church
- Genoa Community Hospital
- Good Neighbor Community Health Center
- Greystone Manufacturing
- Harold Stevens Accounting
- Local Board of Health public minded citizen
- Loup Public Power
- Meadows Behavioral Health
- Platte County Emergency Management
- Platte Valley Division
- Quality of Life Center Committee
- Rainbow Center - Mental Health Center
- Sertoma Service Club
- Time a Change
- United Way of Columbus
- Village of Duncan
- The YMCA

Comprehensive Community Health Needs Assessment CHNA



- Assessment took about 18 months to complete
- Will be repeated every three years
- Available to the public – will soon be posted on ECDHD website, CCH website, Columbus Telegram website in Columbus

What are the Top Health Problems in our area?



What is in the CHNA?



- 30 Sources of data.
- Nearly 500 Written Surveys
- Nearly 500 Telephone Surveys
- Six Focus Groups
- Other Community Surveys
- National Surveys:
- BRFSS Census
- YRBS Youth Protective

What's in the final product?

- 260 Pages of Data
- Profile of the District as a Whole
- Profile of each individual County
- Identification of the top problems for the District
- Identification of the top problems for the Counties

Some Data included in the CHNA

- Description of Health Resources
- Community Profile (Population/Education)
- Access to Health Care / Quality of Life
- Mental Health
- Physical Health (Various conditions)
- Health Risk Factors
- Social Programs and Crime

Demographic Characteristics 2000 to 2010 Population Change

Table 1	2000- 2010 Population Change		
	2000	2010	Percent Change
Boone	6,259	5,505	-12.0%
Colfax	10,441	10,515	+0.7%
Nance	4,038	3,735	-7.5%
Platte	31,662	32,327	+2.1%
East Central	52,400	51,992	-0.8%

- Population losses in Boone and Nance Counties
- Population growth in Colfax and Platte Counties

Demographic Characteristics Hispanic/Latino Population

Table 2	2010 Hispanic/Latino Population	
	2010 Hispanic/Latino Population	Percent of Total Population
Boone	65	1.2%
Colfax	4,315	41.0%
Nance	65	1.7%
Platte	4,452	13.8%
East Central	8,897	17.1%

- Hispanic/Latino population concentrated primarily in Platte and Colfax Counties (i.e., the cities of Columbus and Schuyler)

Job Perception

- 2011 Focus Groups that felt jobs were a strength of their community
- 2008 Columbus Public Library focus group mentioned the lack of "white collar" jobs for those with higher education
- Compared to the rest of the state, East Central participants in the 2011 Nebraska Community Themes and Strengths Assessment have more positive perceptions of jobs and the economy in their community than the state.
- Also, as compared to the state, the perception of the economy is much more positive in the East Central District.

Income

Table 4	2009 Income: Household and per Capita	
	Per Capita Income	Median Household Income
Boone	\$22,360	\$43,891
Colfax	\$18,384	\$45,919
Nance	\$19,678	\$40,729
Platte	\$23,085	\$48,359
East Central	\$21,837	\$46,892
Nebraska	\$24,568	\$47,995
United States	\$27,041	\$51,425

- Platte County has the highest per capita and median household income in the district
- The district as a whole has a lower per capita and median household income compared to the state and nation

Appendix 2. Comprehensive Community Assessment- County Presentations

U.S. Census Bureau, 2009 American Community Survey, 5-Year Estimates.

Percent Families in Poverty

	Per Capita Income	Median Household Income	Percent Families with Related Children under 18 below Poverty	Percent of Individuals below Poverty
Boone	\$22,360	\$43,891	4.9%	7.4%
Colfax	\$18,384	\$45,919	8.9%	11.0%
Nance	\$19,678	\$40,729	7.9%	11.4%
Platte	\$23,085	\$48,359	9.0%	7.8%
East Central	\$21,837	\$46,892	8.5%	8.6%

Poverty by Race/Ethnicity

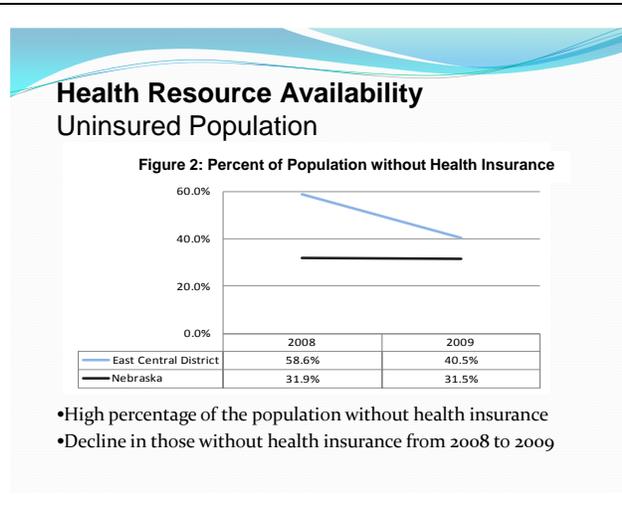
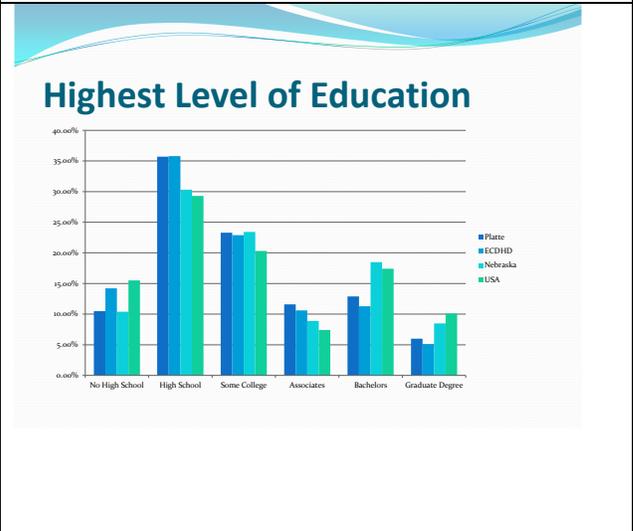
	White (non-Hispanic)	Hispanic/Latino	American Indian	Two or More Races
Boone	7.3%	36.0%	-	-
Colfax	4.8%	20.1%	0.0%	67.6%
Nance	11.3%	23.7%	55.0%	0.0%
Platte	7.2%	14.0%	31.5%	16.5%
East Central	7.2%	17.3%	32.9%	32.4%

- White non-Hispanics are the least impoverished racial/ethnic group in the district
- American Indians and those of two or more races are the most impoverished racial/ethnic groups in the district

Selected School Districts Data

School District	Free and Reduced Lunch	English Language Learners	Special Education	School Mobility Rate	Graduation Rate	Enrollment
Schuyler Community Schools	72.7%	28.4%	9.5%	11.7%	91.7%	1,777
Columbus Public Schools	46.7%	15.1%	16.9%	14.1%	88.2%	3,714
Humphrey Public Schools	33.6%	0.0%	12.2%	9.8%	unavailable*	250
Lakeview Community Schools	40.7%	12.1%	14.5%	12.3%	98.8%	734
East Central District Total	48.9%	13.4%	14.2%	12.3%	90.8%	8,650
State of Nebraska Total	42.6%	6.7%	15.2%	12.1%	90.0%	298,177

- High rates of students receiving free and reduced lunches
- High rates of English language learners



Top 5 Perceived Health Problems

Written Survey

	Platte	East Central
1st	Cancer	Cancer
2nd	Diabetes	Teenage Pregnancy
3rd	Teen Pregnancy	Diabetes
4th	Heart Disease and Stroke	Aging Problems
5th	Aging Problems	Heart Disease and Stroke

Top 5 Perceived Health Problems Telephone Survey

East Central District	State of Nebraska
1. Overweight and Obesity	1. Overweight and Obesity
2. Cancer	2. Alcohol Abuse
3. Alcohol Abuse	3. Cancer
4. Distracted Driving	4. Drug Abuse
5. Drug Abuse	5. Health care (Access/Cost)

PLATTE COUNTY TRAFFIC DEATHS

FACTS SHOW:

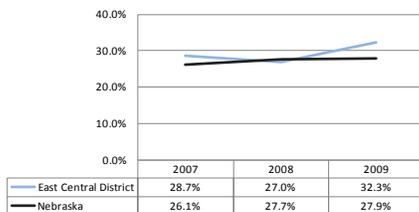
- Only 56% of drivers in Platte County use seatbelts compared to 84% statewide.
- Survival rates are at least 50% higher when seatbelts are in any use in any crash.
- Platte County has historically had more fatalities than Douglas and Lancaster Counties when based on their respective populations.
- Platte County has had 49 fatalities in the last 8 years. This doubles the number in Madison County, which has had 24 during the same period.

Your family wants you home alive.
Make the smart choice to **Buckle UP.**



Obesity

Figure 3: Percent of Population Identified as Obese

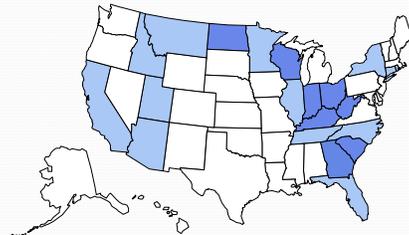


•Higher rates of obesity in the district compared to the state

Obesity Trends* Among U.S. Adults

BRFSS, 1985

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

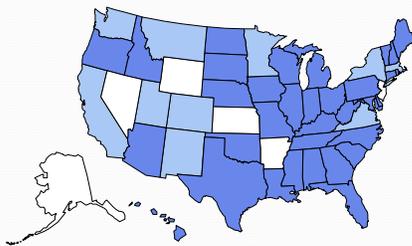


Legend: No Data, <10%, 10%-14%

Obesity Trends* Among U.S. Adults

BRFSS, 1990

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



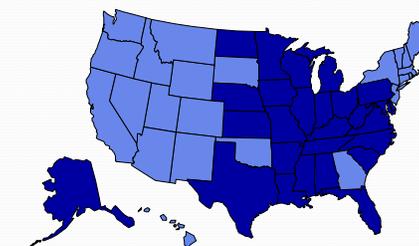
Legend: No Data, <10%, 10%-14%



Obesity Trends* Among U.S. Adults

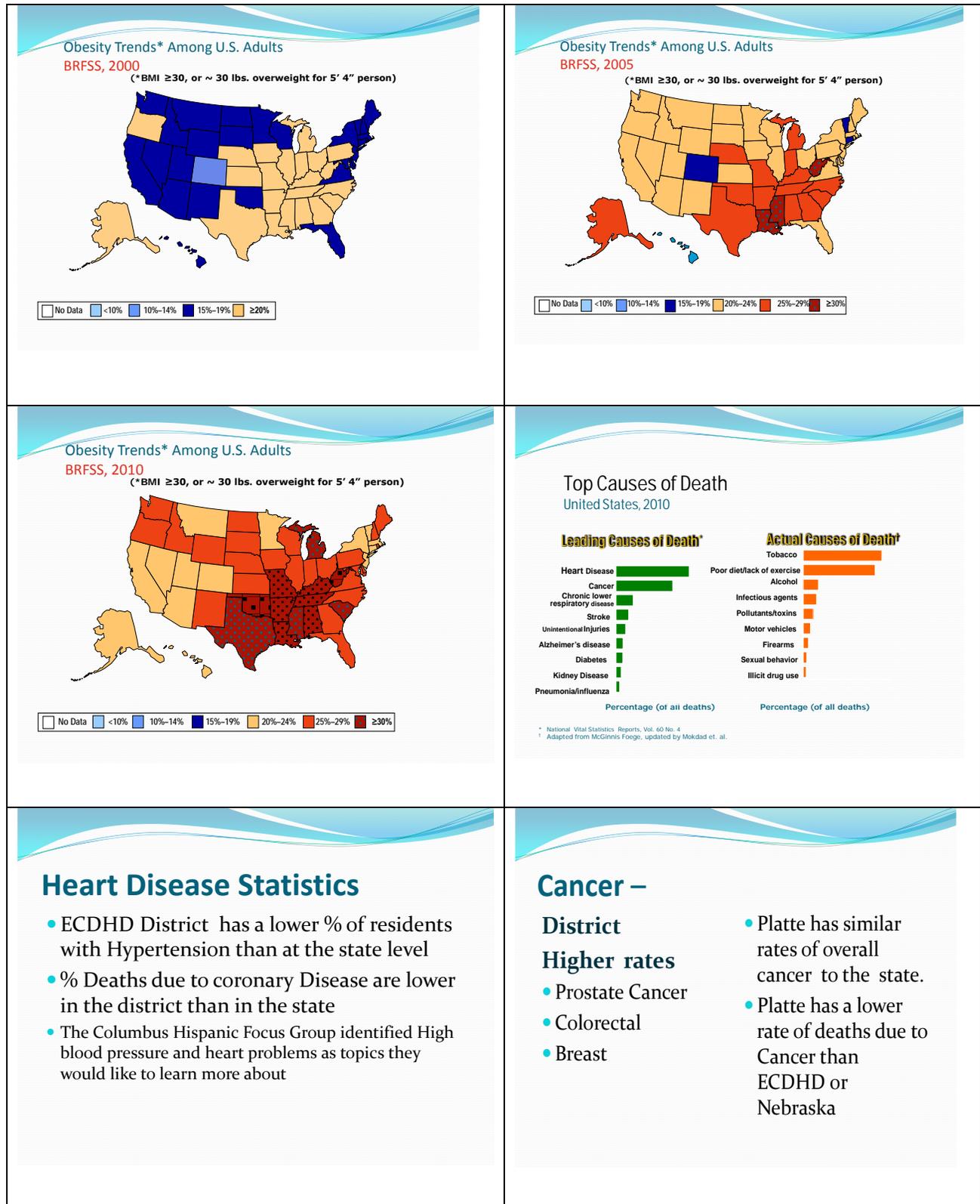
BRFSS, 1995

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Legend: No Data, <10%, 10%-14%, 15%-19%

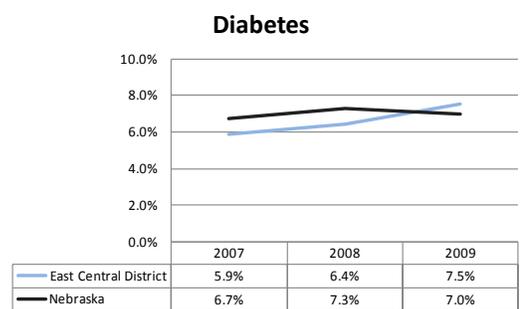
Appendix 2. Comprehensive Community Assessment- County Presentations



Poorer rate of Cancer Screening

Table 2.48	Percent of Population Receiving Health Screenings ¹⁰	
	East Central District	Nebraska
Had a colonoscopy in past ten years (50+) [2009]	48.4%	50.1%
Had a prostate specific antigen (PSA) in past two years (males 50+) [2009]	66.4%	62.4%
Had a digital rectal exam (DRE) in past two years (males 50+) [2009]	44.1%	51.5%
Mammogram screening in past year (women 40+) [2008]	46.4%	54.5%
Clinical breast exam (CBE) in past year (women 40+) [2008]	54.4%	63.0%
Had PAP test in past three years [2008]	71.4%	77.9%

Diabetes – higher than state%

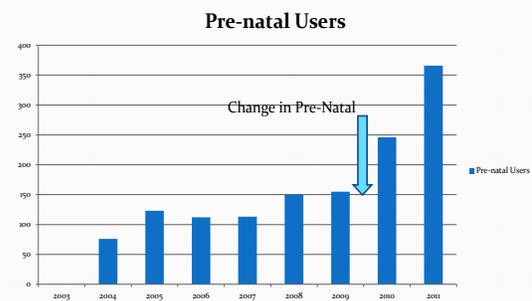


Maternal and Child Health Births to Teenage Mothers

Table 11	Teen Births as Percent of Total Births (2005-2009)		
	Total Live Births	Number of Teen Births	Teen Births as % of Total Live Births
Boone	298	20	6.7%
Colfax	1,046	140	13.4%
Nance	206	6	2.9%
Platte	2,427	247	10.2%
East Central	3,977	413	10.4%
Nebraska Total	133,723	11,165	8.4%

•High rate of births to teen mothers in Colfax and Platte Counties

Pre-natal Users



Teen Sexual Activity

- Compared to 2001, more youth in grades 9-12 were more sexually active in 2010.
- Youth in the East Central District in 2010 were also more sexually active than youth in the State.
- 9th and 10th graders in the District were more sexually active than the state average.
- Of youth that were sexually active in 2010
 - 13.0% used no method to prevent pregnancy
 - 6.9% used withdrawal
 - Condoms at 55.3% were the most commonly used

Pre-natal Statistics - 2011

- Before 2010 - 84% with early pre-natal care.
- 2011 only 40% receiving early pre-natal care.
- 8.4% no pre-natal care until the last trimester.
- 67% of the women delivered in Columbus
- 0.5% of our pre-natal patients < 14 years.
- 17% of our pre-natal patients were teenagers.
- 5 low birth-weight babies (80%) late care.

Forced Sexual Intercourse

	9th Grade	10th Grade	11th Grade	12th Grade	Overall
East Central District 2001	4.5%	4.4%	7.4%	6.1%	5.6%
East Central District 2010	8.8%	7.4%	13.0%	11.8%	10.4%
Nebraska 2010	6.3%	6.6%	7.9%	10.0%	7.5%

- The rate of teens reporting being forced to have sexual intercourse nearly doubled from 2001 to 2010
- Higher rates of teens reporting being forced to have sexual intercourse in the district compared to the state

Top Problems in the District

- Cancer
- Teen Pregnancy
- Drug and Alcohol Use
- Obesity
- Mental Health Services
- Health Professional Shortages
- Aging Population

Social and Mental Health

Youth Depression and Suicide Statistics

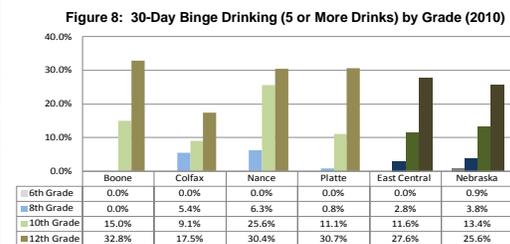
	East Central 2001	East Central 2010	Nebraska 2010
During past 12 months, felt hopeless and sad almost every day for two or more weeks in a row	20.3%	18.0%	21.0%
During past 12 months, seriously considered attempting suicide	17.0%	12.7%	14.1%
During past 12 months, attempted suicide	15.0%	11.2%	9.2%

- Lower suicide and depression rates in the district compared to 2001
- Higher percentage of youth attempting suicide in the district compared to the state

Alcohol Use – Still problematic

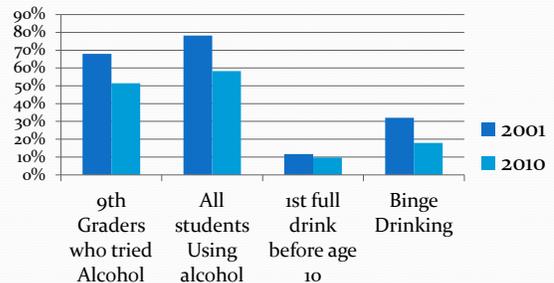
- More of our teens try alcohol in high school than the US
- We have more teens who drink and drive than the state of Nebraska and more teens who ride with someone who has been drinking than the state average.
- Columbus Youth Focus group self-identified alcohol as an important issue

Underage Binge Drinking



- High rates of 12th graders in Platte County reporting having binge drank in the past 30 days

Some improvement on Alcohol



Alcohol Associated Problems

- **Car Accidents:** Alcohol is a factor in 41% of all deaths from motor vehicle crashes.
- **Teen Pregnancy/ Assault:** Excessive alcohol use is commonly involved in youth sexual assault. Research suggests that there is an increase in the risk of rape or sexual assault when both the attacker and victim have used alcohol prior to the attack.
- **Alcohol increases the chances of engaging in risky sexual activity** including unprotected sex, sex with multiple partners, or sex with a partner at risk for sexually transmitted diseases.

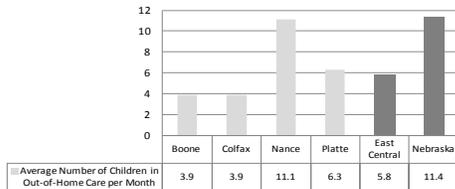
Related Information

- 20% of our youth drank alcohol at home with their parents permission compared to 16.8% in the state.
- According to the Local Public Health System Assessment there is a lack of education on underage drinking
- There is a lack of parenting education attendance

Child Welfare

Children in Out-of-Home Care

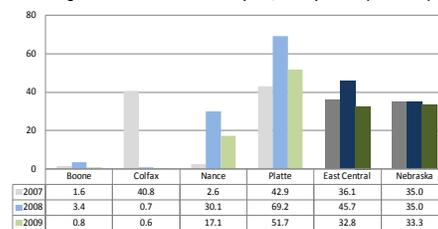
Figure 4: Average Number of Children per Month in Out-of-Home Care (2009)



- Out-of-home care includes foster care, group homes, and other residential care facilities

Juvenile Arrests

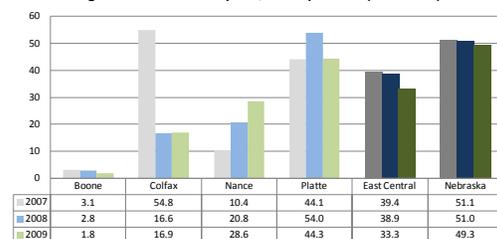
Figure 6: Total Juvenile Arrests per 1,000 Population (2007-2009)



- High rates of juvenile arrests in Platte County compared to the other counties in the district and the state

Arrests

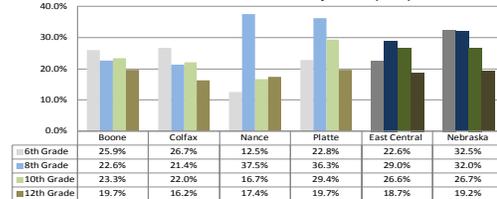
Figure 5: Total Arrests per 1,000 Population (2007-2009)



- High rate of arrests in Platte County compared to the other counties in the district

Bullying

Figure 7. Percent of Youth Reporting Being Bullied at School in the Past 12 Months by Grade (2010)



- High rates of 8th, 10th, and 12th grade students in Platte County report being bullied in Platte County as compared to the district and state

Access to Day Care

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean
Boone	1.9%	15.1%	34.0%	49.1%	0.0%	3.3
Colfax	2.5%	24.6%	38.5%	26.2%	8.2%	3.1
Nance	2.6%	7.9%	21.1%	57.9%	10.5%	3.7
Platte	1.9%	9.4%	43.4%	36.6%	8.7%	3.4
Hispanic	3.8%	24.0%	27.9%	29.8%	14.4%	3.3
Non-Hispanic	1.6%	11.0%	42.9%	38.5%	6.0%	3.4
East Central	2.1%	13.8%	39.3%	37.0%	7.7%	3.4

• Over 10% of survey participants from Platte County report not having access to safe and affordable day care, with over 40% being neutral

Health Needs and Priorities for Platte County

Community Health Needs and Priorities	Rationale for Selection
➤ Crime	<ul style="list-style-type: none"> High perception of the increase in gang activity and the impact of gangs on schools and child safety. High rates of arrests for the adult population. High rates of arrests and drug law violations for the juvenile population.
➤ Mental Health Services	<ul style="list-style-type: none"> High rate of patients to the Good Neighbor Community Health Center with mental health issues secondary to the primary purpose for their health visit. High rates of hospitalizations for self-inflicted injuries.
➤ Rape and Forced Sexual Intercourse	<ul style="list-style-type: none"> High reported cases of rape. High rates of self-reported forced sexual intercourse by youth district-wide.
➤ Recreation Opportunities	<ul style="list-style-type: none"> Low perceived availability of recreation opportunities.
➤ Satisfaction with and Access to Health Care	<ul style="list-style-type: none"> Relatively low satisfaction and perceived access to health care among participants in the <i>Community Health Survey</i>.
➤ Teen Pregnancy	<ul style="list-style-type: none"> High rates of teen pregnancy, notably among the Hispanic population.
➤ Underage Alcohol and Marijuana Use	<ul style="list-style-type: none"> Alcohol was the top perceived risky behavior in the county. High rates of marijuana use, binge drinking, and driving under the influence.



Community Driven

- Mobilizing and engaging the community
- Partnerships to strengthen the community
- Planning driven by the community
- Action with and by the community



The Next Step

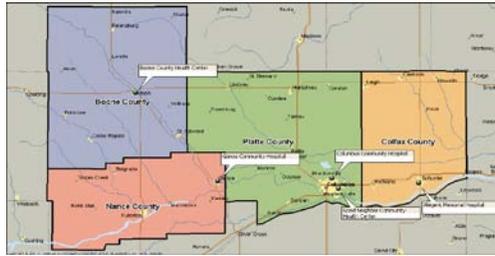
- Platte County Next Steps:
 - Develop a Community Health Improvement Plan
 - March 2nd at Columbus Community Hospital
 - Select between 4-8 areas to work on as a Community
 - Engage the Community to put resources behind the top priorities
 - Look for outside resources to invest in the top priorities
 - Agencies integrate the CHIP into their strategic plans

Appendix 2 - Comprehensive Community Assessment-County Presentations

2011 Comprehensive Community Assessment: Selected Results for Platte County



The East Central Health District



Community and District Wide Project

- Alegent Health Memorial Hospital in Schuyler
- American Red Cross
- ARC of Platte County
- Board Member and medical user of the Community Health Center
- Boone County Hospital
- Catholic Charities
- Center for Survivors
- Central Community College
- The Child Well-Being Initiative
- City of Columbus Parks and Recreation Department
- Columbus Chamber of Commerce
- Columbus Community Hospital
- Columbus Family Practice (Private Medical Clinic)
- Columbus Public Library
- Columbus Public Schools
- Connect Columbus
- Crisis Navigators
- Department of Health and Human Services
- East Central District Health Department
- ESU #7
- First United Methodist Church
- Genoa Community Hospital
- Good Neighbor Community Health Center
- Greystone Manufacturing
- Harold Stevens Accounting
- Local Board of Health public minded citizen
- Loup Public Power
- Meadows Behavioral Health
- Platte County Emergency Management
- Platte Valley Diversion
- Quality of Life Center Committee
- Rainbow Center - Mental Health Center
- Sertoma Service Club
- Time 4 Change
- United Way of Columbus
- Village of Duncan
- The YMCA

Comprehensive Community Health Needs Assessment CHNA



- Assessment took about 18 months to complete
- Will be repeated every three years
- Available to the public – will soon be posted on ECDHD website, CCH website, Columbus Telegram website in Columbus

What are the Top Health Problems in our area?



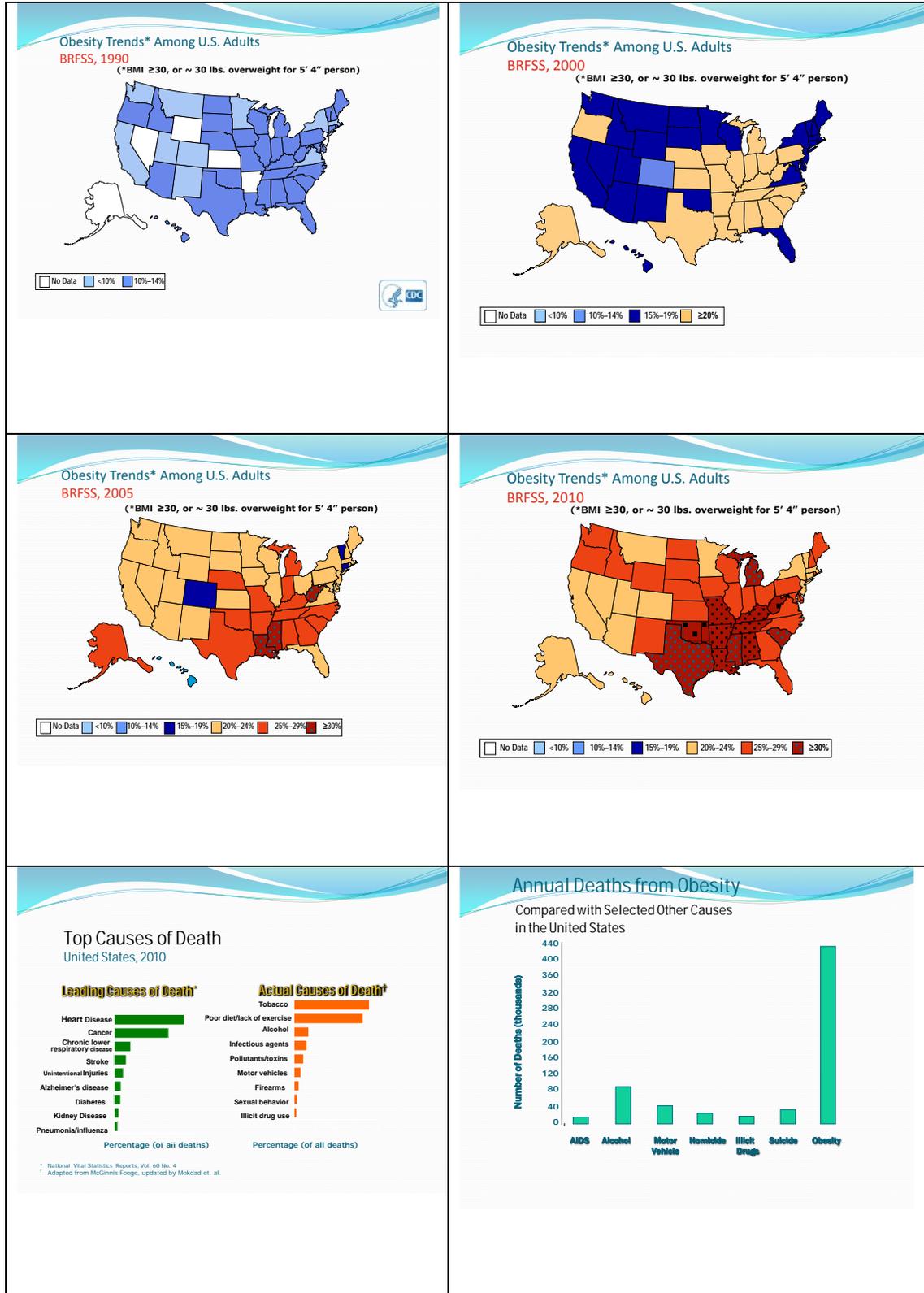
What is in the CHNA?



- 30 Sources of data.
- Nearly 500 Written Surveys
- Nearly 500 Telephone Surveys
- Six Focus Groups
- Other Community Surveys
- National Surveys:
- BRFSS Census
- YRBS Youth Protective

<h3>What's in the final product?</h3> <ul style="list-style-type: none"> • 260 Pages of Data • Profile of the District as a Whole • Profile of each individual County • Identification of the top problems for the District • Identification of the top problems for the Counties 	<h3>Some Data included in the CHNA</h3> <ul style="list-style-type: none"> • Description of Health Resources • Community Profile (Population/Education) • Access to Health Care / Quality of Life • Mental Health • Physical Health (Various conditions) • Health Risk Factors • Social Programs and Crime 																						
<h3>Top 5 Perceived Health Problems Telephone Survey</h3> <table border="0"> <tr> <td>1. Overweight and Obesity</td> <td>1. Overweight and Obesity</td> </tr> <tr> <td>2. Cancer</td> <td>2. Alcohol Abuse</td> </tr> <tr> <td>3. Alcohol Abuse</td> <td>3. Cancer</td> </tr> <tr> <td>4. Distracted Driving</td> <td>4. Drug Abuse</td> </tr> <tr> <td>5. Drug Abuse</td> <td>5. Health care (Access/Cost)</td> </tr> </table>	1. Overweight and Obesity	1. Overweight and Obesity	2. Cancer	2. Alcohol Abuse	3. Alcohol Abuse	3. Cancer	4. Distracted Driving	4. Drug Abuse	5. Drug Abuse	5. Health care (Access/Cost)	<h3>Obesity</h3> <p>Figure 3: Percent of Population Identified as Obese</p> <table border="1"> <thead> <tr> <th></th> <th>2007</th> <th>2008</th> <th>2009</th> </tr> </thead> <tbody> <tr> <td>East Central District</td> <td>28.7%</td> <td>27.0%</td> <td>32.3%</td> </tr> <tr> <td>Nebraska</td> <td>26.1%</td> <td>27.7%</td> <td>27.9%</td> </tr> </tbody> </table> <p>• Higher rates of obesity in the district compared to the state</p>		2007	2008	2009	East Central District	28.7%	27.0%	32.3%	Nebraska	26.1%	27.7%	27.9%
1. Overweight and Obesity	1. Overweight and Obesity																						
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Appendix 2 - Comprehensive Community Assessment-County Presentations



**Top 5 Perceived Health Problems
Written Survey**

Table 8	Top Five Perceived Health Problems: Platte County and East Central Total	
	Platte	East Central
1st	Cancer	Cancer
2nd	Diabetes	Teenage Pregnancy
3rd	Teen Pregnancy	Diabetes
4th	Heart Disease and Stroke	Aging Problems
5th	Aging Problems	Heart Disease and Stroke

**Maternal and Child Health
Births to Teenage Mothers**

Table 11	Teen Births as Percent of Total Births (2005-2009)		
	Total Live Births	Number of Teen Births	Teen Births as % of Total Live Births
Boone	298	20	6.7%
Colfax	1,046	140	13.4%
Nance	206	6	2.9%
Platte	2,427	247	10.2%
East Central	3,977	413	10.4%
Nebraska Total	133,723	11,165	8.4%

• High rate of births to teen mothers in Colfax and Platte Counties

Top Problems in the District

- Cancer
- Teen Pregnancy
- Drug and Alcohol Use
- Obesity
- Mental Health Services
- Health Professional Shortages
- Aging Population

Health Needs and Priorities for Platte County

Table 16: Community Health Needs and Priorities for Platte County	
Community Health Needs and Priorities	Rationale for Selection
> Crime	<ul style="list-style-type: none"> • High perception of the increase in gang activity and the impact of gangs on schools and child safety. • High rates of arrests for the adult population. • High rates of arrests and drug law violations for the juvenile population.
> Mental Health Services	<ul style="list-style-type: none"> • High rate of patients to the Good Neighbor Community Health Center with mental health issues secondary to the primary purpose for their health visit. • High rates of hospitalizations for self-inflicted injuries.
> Rape and Forced Sexual Intercourse	<ul style="list-style-type: none"> • High reported cases of rape. • High rates of self-reported forced sexual intercourse by youth district-wide.
> Recreation Opportunities	<ul style="list-style-type: none"> • Low perceived availability of recreation opportunities.
> Satisfaction with and Access to Health Care	<ul style="list-style-type: none"> • Relatively low satisfaction and perceived access to health care among participants in the <i>Community Health Survey</i>.
> Teen Pregnancy	<ul style="list-style-type: none"> • High rates of teen pregnancy, notably among the Hispanic population.
> Underage Alcohol and Marijuana Use	<ul style="list-style-type: none"> • Alcohol was the top perceived risky behavior in the county. • High rates of marijuana use, binge drinking, and driving under the influence.



Community Driven

- Mobilizing and engaging the community
- Partnerships to strengthen the community
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The Next Step

- Platte County Next Steps:
 - Develop a Community Health Improvement Plan
 - March 2nd at Columbus Community Hospital
 - Select between 4-8 areas to work on as a Community
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 - Look for outside resources to invest in the top priorities
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Appendix 2 - Comprehensive Community Assessment-County Presentations



Focus Question:

Based on the results of our community assessment, what will we choose to focus on over the next three years to improve the health of all who live, work and play in Boone County and how will we mobilize our efforts?

Session Objectives:

- Choose priority areas of focus
- Mobilize around our priorities
- Identify outcomes, goals and objectives
- Design an organizational structure to support activities over the next three years

Process Guidelines:

- Test assumptions and inferences
- Share all relevant information
- Hear and be heard
- Share the air
- Use specific examples and agree on what important words mean
- Electronics off (or in silent mode)

Questions for Data Presentation:

- What surprises you in the information shared?
- What DOESN'T surprise you? (Yep, you expected this...)
- What else stands out for you from the presentation? Patterns/relationships?
- How should this information inform our task today?

Rank Order the Strategic Issues

1=Top priority – Most important
2=Next important
3=Next important
and so forth....

Appendix 2 - Comprehensive Community Assessment-County Presentations



Focus Question:

Based on the results of our community assessment, what will we choose to focus on over the next three years to improve the health of all who live, work and play in Colfax County and how will we mobilize our efforts?

Session Objectives:

- Choose priority areas of focus
- Mobilize around our priorities
- Identify outcomes, goals and objectives
- Design an organizational structure to support activities over the next three years

Process Guidelines:

- Test assumptions and inferences
- Share all relevant information
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Questions for Data Presentation:

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Rank Order the Strategic Issues

1=Top priority – Most important
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and so forth....

Appendix 2 - Comprehensive Community Assessment-County Presentations

2011 Comprehensive Community Assessment:
Selected Results for Nance County



Comprehensive Community Health Needs Assessment
CHNA

- Assessment took about 18 months to complete
- Will be repeated every three years
- Available to the public – the assessment is posted on ECDHD website, Alegent website, Columbus Telegram website



What is in the CHNA?



- 30 Sources of data.
- Nearly 500 Written Surveys
- Nearly 500 Telephone Surveys
- Six Focus Groups
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- National Surveys:
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What's in the final product?

- 260 Pages of Data
- Profile of the District as a Whole
- Profile of each individual County
- Identification of the top problems for the District
- Identification of the top problems for the Counties

Some Data included in the CHNA

- Description of Health Resources
- Community Profile (Population/Education)
- Access to Health Care / Quality of Life
- Mental Health
- Physical Health (Various conditions)
- Health Risk Factors
- Social Programs and Crime

The East Central Health District



Appendix 2 - Comprehensive Community Assessment-County Presentations

What are the Top Health Problems in our area?



2000 to 2010 Population Change

Table 1	2000-2010 Population Change		
	2000	2010	Percent Change
Boone	6,259	5,505	-12.0%
Colfax	10,441	10,515	+0.7%
Nance	4,038	3,735	-7.5%
Platte	31,662	32,327	+2.1%
East Central	52,400	51,992	-0.8%

- Population losses in Boone and Nance Counties
- Population growth in Colfax and Platte Counties

Hispanic/Latino Population

Table 2	2010 Hispanic/Latino Population	
	2010 Hispanic/Latino Population	Percent of Total Population
Boone	65	1.2%
Colfax	4,315	41.0%
Nance	65	1.7%
Platte	4,452	13.8%
East Central	8,897	17.1%

•Hispanic/Latino population concentrated primarily in Platte and Colfax Counties (i.e., the cities of Columbus and Schuyler)

2010 Age Distribution

Figure 1: 2010 Age Distribution: District, State, and National Comparisons



	Under 5	5 to 14	15 to 24	25 to 34	35 to 44	45 to 54	55 to 64	Over 65
East Central District	7.0%	14.0%	12.0%	13.7%	13.5%	13.5%	13.0%	15.0%
Nebraska	6.5%	13.3%	14.3%	13.3%	13.3%	14.4%	13.8%	13.1%
United States	7.2%	13.4%	12.5%	13.5%	13.0%	14.1%	13.6%	15.6%

•The over 65 age group contains the highest percentage of the population in the East Central District

2010 Age Distribution*

Table 2.7	Boone	Colfax	Nance	Platte	East Central
Under 5	6.1%	9.3%	6.2%	7.4%	7.6%
5 to 14	12.9%	15.2%	13.5%	14.6%	14.5%
15 to 24	11.3%	13.5%	10.2%	12.3%	12.3%
25 to 34	8.7%	12.9%	10.4%	12.0%	11.7%
35 to 44	10.5%	11.8%	9.9%	11.7%	11.5%
45 to 54	16.3%	13.6%	16.0%	15.2%	15.1%
55 to 64	13.1%	10.0%	14.9%	11.9%	11.9%
Over 65	21.2%	13.6%	19.1%	14.8%	15.5%

Percent of Population from 2000-2010

Chart Title



	Under 5	5 to 14	15 to 24	25 to 34	35 to 44	45 to 54	55 to 64	Over 65
Boone County	3.4%	-21.4%	3.7%	-2.2%	-10.9%	12.5%	41.0%	1.9%
Colfax County	29.2%	-5.0%	-4.3%	2.4%	-22.9%	24.8%	29.9%	-15.8%
Nance County	0.0%	-13.9%	-23.5%	11.8%	-16.9%	26.3%	73.3%	-3.0%
Platte County	1.4%	-21.4%	-4.3%	1.7%	-25.5%	14.4%	41.7%	6.5%
East Central District	7.2%	-13.4%	-4.2%	3.1%	-26.5%	23.4%	42.8%	9.7%

Appendix 2 - Comprehensive Community Assessment-County Presentations

Female Householder No Husband Present Families

	Female Householder No Husband Present Families as a Percent of Total Families (2000)	Female Householder No Husband Present Families as a Percent of Total Families (2010)
Boone	7.2%	8.0%
Colfax	10.1%	11.2%
Nance	8.0%	9.8%
Platte	10.9%	12.4%
East Central	18.1%	11.5%

- Increases for every county in the East Central District in the percentage of female householder no husband present families as a percent of total families from 2000 to 2010
- Second lowest rate of female householder no husband present families is in Nance County

Income

	Per Capita Income	Median Household Income
Boone	\$22,360	\$43,891
Colfax	\$18,384	\$45,919
Nance	\$19,678	\$40,729
Platte	\$23,085	\$48,359
East Central	\$21,837	\$46,892
Nebraska	\$24,568	\$47,995
United States	\$27,041	\$51,425

- Nance County has the lowest median household income in the district
- The district as a whole has a lower per capita and median household income compared to the state and nation

Percent of Population in Poverty

	Per Capita Income	Median Household Income	Percent Families with Related Children under 18 below Poverty	Percent of Individuals below Poverty
Boone	\$22,360	\$43,891	4.9%	7.4%
Colfax	\$18,384	\$45,919	8.9%	11.0%
Nance	\$19,678	\$40,729	7.9%	11.4%
Platte	\$23,085	\$48,359	9.0%	7.8%
East Central	\$21,837	\$46,892	8.5%	8.6%

- Nance has the lowest median household income in the district and the highest percent of individuals below poverty

Poverty by Race/Ethnicity

	White (non-Hispanic)	Hispanic/Latino	American Indian	Two or More Races
Boone	7.3%	36.0%	-	-
Colfax	4.8%	20.1%	0.0%	67.6%
Nance	11.3%	23.7%	55.0%	0.0%
Platte	7.2%	14.0%	31.5%	16.5%
East Central	7.2%	17.3%	32.9%	32.4%

Medicaid Eligibles

	Number of Medicaid Eligibles	Medicaid Eligibles as a Percent of the Total Population
Boone	462	8.5
Colfax	1,322	12.8%
Nance	454	13.1%
Platte	2,962	9.1%
East Central	5,200	10.1%
Nebraska	206,725	11.5%

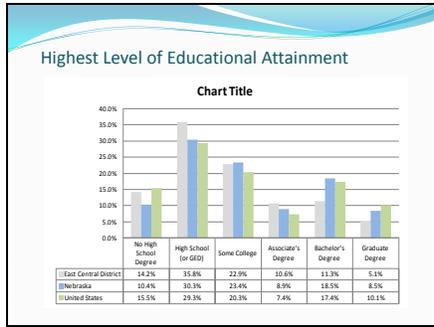
- Nance and Colfax Counties have higher percentages of Medicaid eligible individuals in the district
- Nance and Colfax Counties have rates that are higher than the district and state

Selected School Districts Data

School District	Free and Reduced Lunch	English Language Learners	Special Education	School Mobility Rate	Graduation Rate	Enrollment
Fullerton Public Schools	37.9%	0.0%	11.7%	11.1%	unavailable	325
Twin River Public Schools	32.2%	0.0%	13.3%	10.6%	unavailable	503
East Central District Total	48.9%	13.4%	14.2%	12.3%	90.8%	8,650
State of Nebraska Total	42.6%	6.7%	15.2%	12.1%	90.0%	298,177

- Though Nance County does not have high rates of students receiving free and reduced lunches, the district does have higher than the state average for these rates

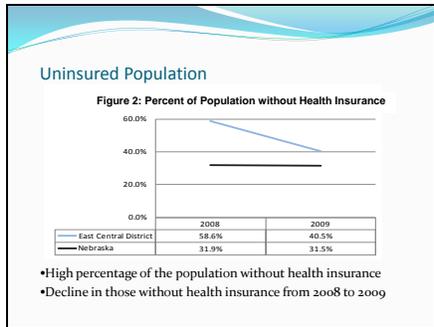
Appendix 2 - Comprehensive Community Assessment-County Presentations



Education Levels Attained

Table 2.14 Highest Level of Educational Attainment - Individuals over 25 (2009)¹⁸

	Boone	Colfax	Nance	Platte	East Central
No High School Degree	7.8%	30.0%	15.8%	10.5%	14.2%
High School (or GED/Equivalent)	41.5%	31.6%	38.5%	35.7%	35.8%
Some College	23.0%	20.9%	24.0%	23.3%	22.9%
Associate's Degree	11.8%	7.3%	9.1%	11.6%	10.6%
Bachelor's Degree	11.4%	6.7%	9.7%	12.9%	11.3%
Graduate or Professional Degree	4.5%	3.5%	2.9%	6.0%	5.1%



Satisfaction with Quality of Life

Table 7 I am satisfied with the quality of life in our community (considering my sense of safety and well-being).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean
Boone	0.0%	0.0%	1.8%	87.9%	30.4%	4.3
Colfax	3.2%	20.2%	16.1%	50.0%	10.5%	3.4
Nance	0.0%	2.6%	15.4%	51.3%	30.8%	4.1
Platte	0.4%	7.5%	25.8%	56.9%	9.4%	3.7
Hispanic	1.0%	7.6%	28.2%	40.5%	14.6%	3.7
Non-Hispanic	0.8%	5.4%	40.9%	51.2%	1.6%	3.7
East Central	1.0%	9.5%	19.8%	56.0%	13.8%	3.7

- Survey participants from Boone and Nance were more satisfied with the quality of life in their community compared to survey participants from Colfax and Platte

Table 2.16 Federally Designated Health Professional Shortages (2008)¹⁹

	Boone	Colfax	Nance	Platte	East Central
Primary Care			√		partial
Mental Health	√	√	√	√	√
Dental Health		√			partial

Table 2.18 Persons Served per Health Professional (2010)¹⁸

	Boone	Colfax	Nance	Platte	East Central
Physicians	681	9,989	-	1,002	1,245
FM/GP	778	4,995	-	3,207	2,687
Internal Medicine	-	-	-	32,072	51,057
Pediatrics	5,446	-	-	-	10,691
OB/GYN	-	-	-	-	8,018
Psychiatrists	-	-	-	32,072	51,057
Dentists	1,815	4,995	3,350	2,138	2,431
Pharmacists	778	1,998	1,775	1,234	1,276
Physical Therapists	2,723	4,995	3,550	1,782	2,220
Physician Assistants	1,089	4,995	1,775	4,582	3,191
Nurse Practitioners	-	3,330	-	4,582	5,106
RNs	91	145	111	134	127
LPNs	127	217	127	229	199

Appendix 2 - Comprehensive Community Assessment-County Presentations

Written Survey Participants Able to Get Care

Table 2.20 I am able to get medical care whenever I need it.¹⁵

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean (1-5 scale)
Boone	0.0%	3.6%	7.1%	73.2%	16.1%	4.0
Colfax	1.6%	6.5%	14.6%	48.8%	28.5%	4.0
Nance	2.6%	5.3%	2.6%	81.6%	7.9%	3.9
Platte	0.7%	9.7%	13.1%	67.5%	9.0%	3.7
Hispanic	1.9%	12.5%	18.3%	51.0%	16.3%	3.7
Non-Hispanic	0.8%	6.7%	10.0%	68.2%	14.3%	3.8
East Central	1.0%	7.8%	12.0%	64.5%	14.6%	3.8

Support Networks

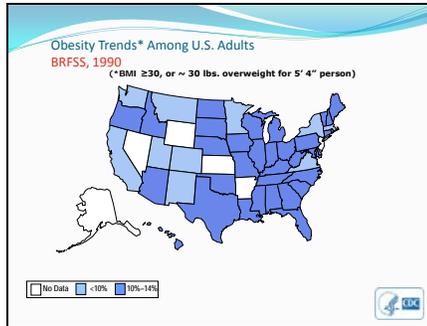
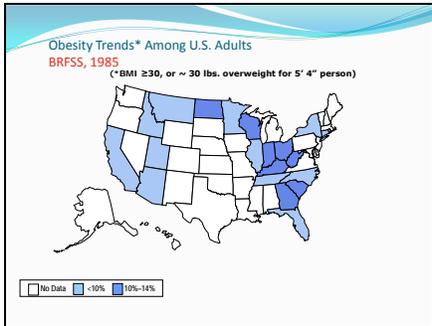
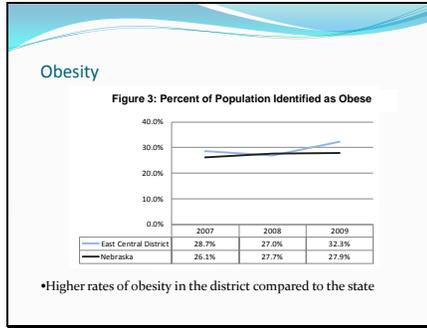
Table 14 There are support networks for individuals and families (neighbors, support groups, faith community, outreach, agencies, and organizations) during times of stress and need.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean
Boone	0.0%	5.4%	17.9%	73.2%	3.9%	3.8
Colfax	8.1%	12.1%	20.2%	51.6%	8.1%	3.4
Nance	0.0%	10.3%	15.4%	64.1%	10.3%	3.7
Platte	0.7%	11.2%	25.8%	57.7%	4.5%	3.5
Hispanic	5.8%	16.3%	28.8%	41.3%	7.7%	3.3
Non-Hispanic	1.8%	9.4%	21.0%	62.8%	5.4%	3.6
East Central	2.5%	10.7%	22.6%	58.4%	5.8%	3.5

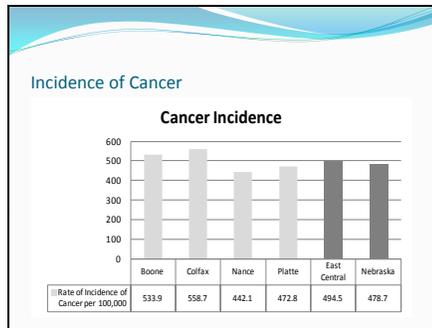
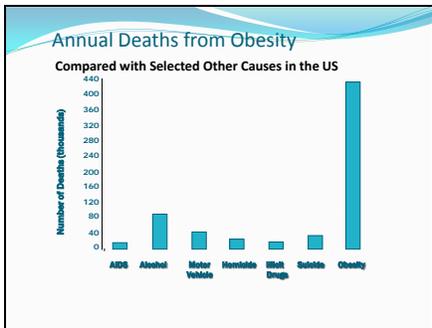
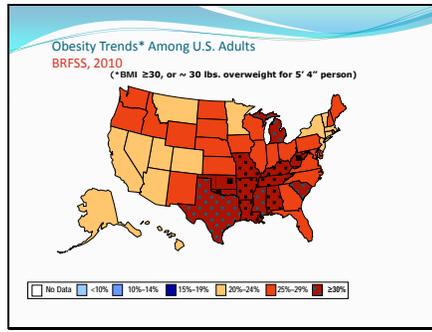
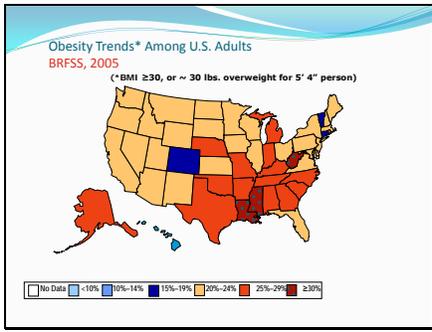
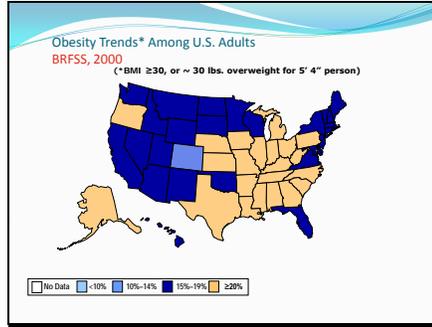
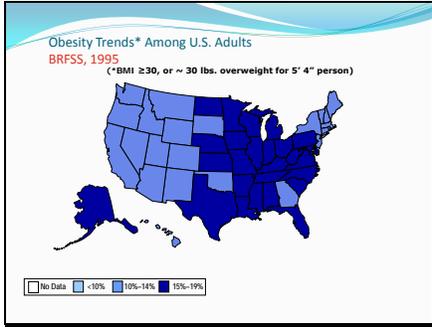
•Over 74% of survey participants from Nance County report having a support network in their community

Top 5 Perceived Health Problems Telephone Survey – Looking at the District

East Central District	State of Nebraska
1. Overweight and Obesity	1. Overweight and Obesity
2. Cancer	2. Alcohol Abuse
3. Alcohol Abuse	3. Cancer
4. Distracted Driving	4. Drug Abuse
5. Drug Abuse	5. Health care (Access/Cost)



Appendix 2 - Comprehensive Community Assessment-County Presentations



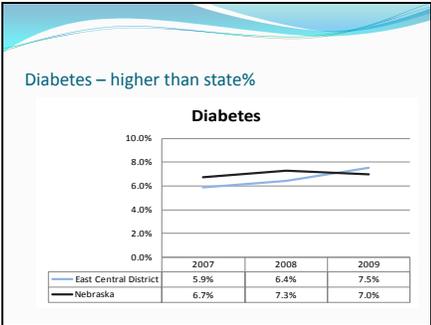
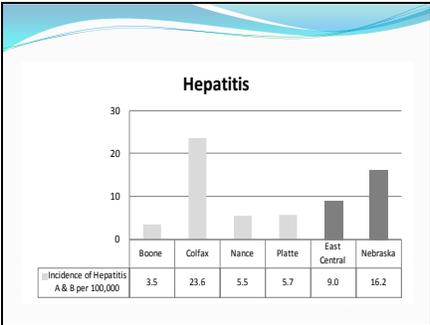
Appendix 2 - Comprehensive Community Assessment-County Presentations

Incidence of Cancer by Type

- Nance has a higher incidence of Breast Cancer than the other three counties in the district and higher than the state of Nebraska
- Rate of colorectal cancer is higher than the state of Nebraska
- Prostate Cancer in Nance is lowest in the district and slightly above the state of Nebraska (may be related to aging population)
- Nance has the highest rate of Lymphoma and is higher than the district and state of Nebraska average

Poorer rate of Cancer Screening

	East Central District	Nebraska
Had a colonoscopy in past ten years (50+) [2009]	48.4%	50.1%
Had a prostate specific antigen (PSA) in past two years (males 50+) [2009]	66.4%	62.4%
Had a digital rectal exam (DRE) in past two years (males 50+) [2009]	44.1%	51.5%
Mammogram screening in past year (women 40+) [2008]	46.4%	54.5%
Clinical breast exam (CBE) in past year (women 40+) [2008]	54.4%	63.0%
Had PAP test in past three years [2008]	71.4%	77.9%



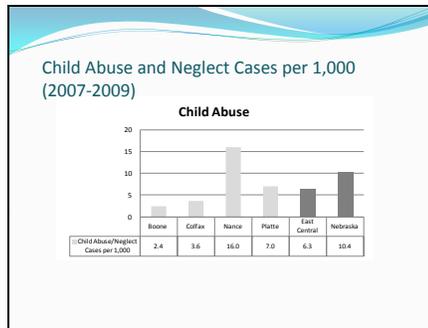
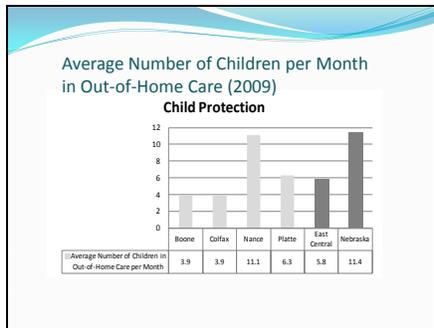
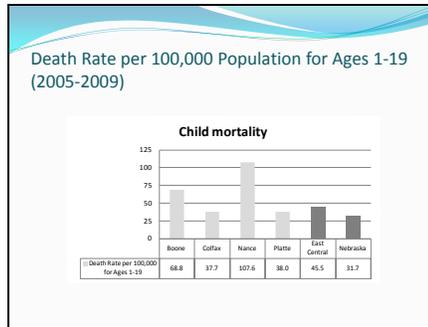
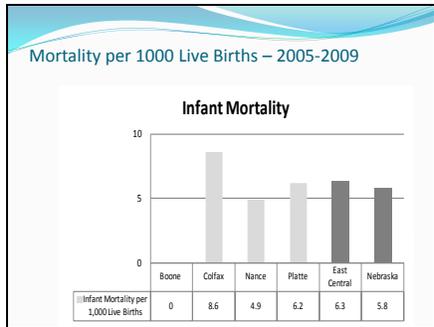
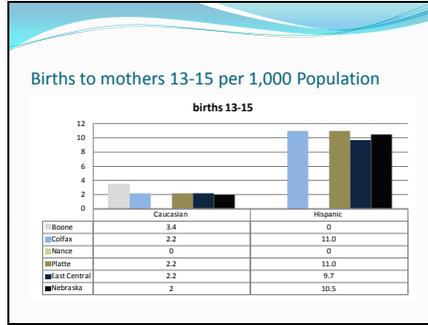
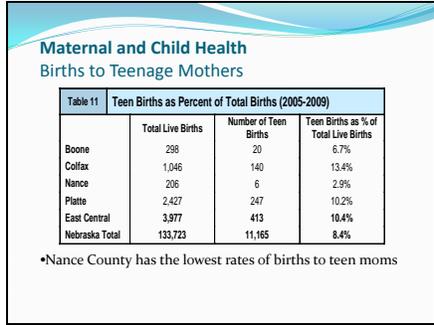
Top 5 Perceived Health Problems – Nance Written Survey

	Top Five Perceived Health Problems			
	Nance	East Central	Hispanic	Non-Hispanic
1st	Cancer	Cancer	Teenage Pregnancy	Cancer
2nd	Heart Disease & Stroke	Teenage Pregnancy	Diabetes	Heart Disease and Stroke
3rd	Aging Problems	Diabetes	Cancer	Aging Problems
4th	Diabetes	Aging Problems	Child Abuse/Neglect	Diabetes
5th	Affordable and Safe Housing	Heart Disease and Stroke	High Blood Pressure	Teenage Pregnancy

Top 5 Perceived Risky Behaviors

	Top Five Perceived Risky Behaviors by County and Ethnicity ¹⁵	
	Nance	East Central
1st	Alcohol Abuse	Alcohol Abuse
2nd	Tobacco Use	Drug Abuse
3rd	Lack of Exercise	Being Overweight
4th	Being Overweight	Tobacco Use
5th	Not Using Seat Belts	Lack of Exercise

Appendix 2 - Comprehensive Community Assessment-County Presentations



Appendix 2 - Comprehensive Community Assessment-County Presentations

Teen Sexual Activity

- Compared to 2001, more youth in grades 9-12 were more sexually active in 2010.
- Youth in the East Central District in 2010 were also more sexually active than youth in the State.
- 9th and 10th graders in the District were more sexually active than the state average.
- Of youth that were sexually active in 2010
 - 13.0% used no method to prevent pregnancy
 - 6.9% used withdrawal
 - Condoms at 55.3% were the most commonly used

Forced Sexual Intercourse

	9th Grade	10th Grade	11th Grade	12th Grade	Overall
East Central District 2001	4.5%	4.4%	7.4%	6.1%	5.6%
East Central District 2010	8.8%	7.4%	13.0%	11.8%	10.4%
Nebraska 2010	6.3%	6.6%	7.9%	10.0%	7.5%

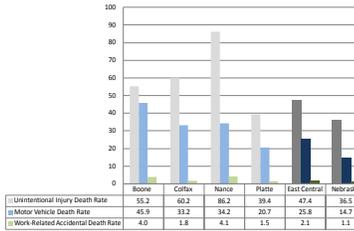
- The rate of teens reporting being forced to have sexual intercourse nearly doubled from 2001 to 2010
- Higher rates of teens reporting being forced to have sexual intercourse in the district compared to the state

Access to Day Care

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean
Boone	1.9%	15.1%	34.0%	49.1%	0.0%	3.3
Collax	2.5%	24.6%	38.5%	26.2%	8.2%	3.1
Nance	2.6%	7.9%	21.1%	57.9%	10.5%	3.7
Platte	1.9%	9.4%	43.4%	36.6%	8.7%	3.4
Hispanic	3.8%	24.0%	27.9%	29.9%	14.4%	3.3
Non-Hispanic	1.6%	11.0%	42.9%	38.5%	6.0%	3.4
East Central	2.1%	13.8%	39.3%	37.0%	7.7%	3.4

- Over 10% of survey participants from Nance County report not having access to safe and affordable day care, with over 20% being neutral

Accidental Deaths

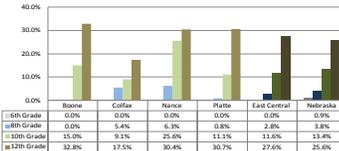


Activities for Children

- There are adequate after school programs for elementary children - 21.0% Disagree
- There are adequate after school opportunities for middle and high school age students - 23.7% Disagree
- There are plenty of non-sports related activities for children in my community - 52.7% Disagree

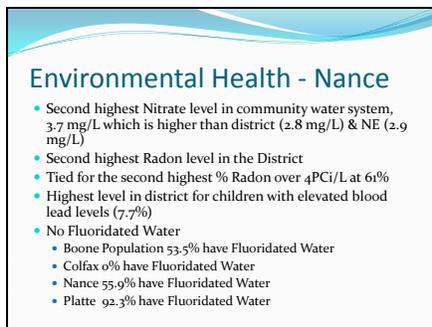
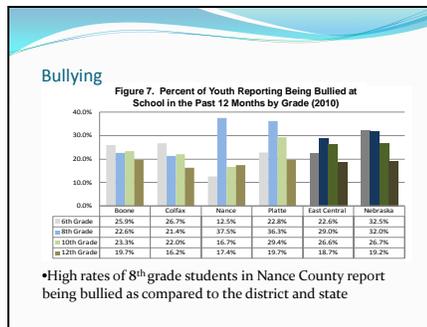
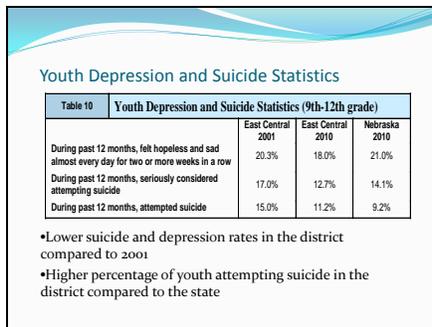
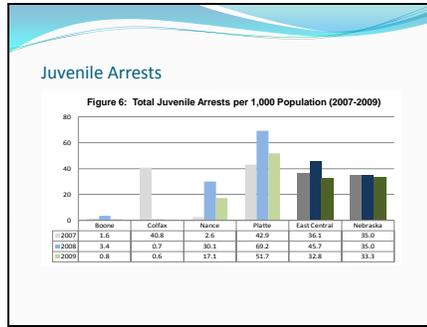
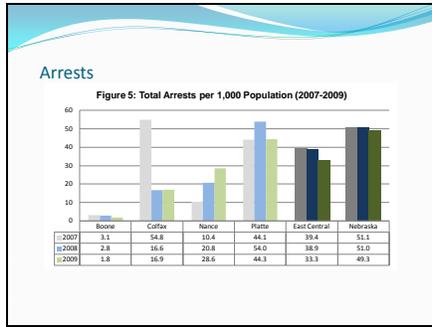
Underage Binge Drinking

Figure 8: 30-Day Binge Drinking (5 or More Drinks) by Grade (2010)



- Binge drinking rates in 8th, 10th and 12th graders in Nance County are higher than the East Central and Nebraska averages

Appendix 2 - Comprehensive Community Assessment-County Presentations



Appendix 2 - Comprehensive Community Assessment-County Presentations

Health Needs and Priorities for Nance County

Table 3.36: Community Health Needs and Priorities for Nance County

Community Health Needs and Priorities	Rationale for Selection
> Accidental Death	<ul style="list-style-type: none"> High rates of unintentional injury, motor vehicle, and work-related accidental deaths.
> Aging Population	<ul style="list-style-type: none"> The number three perceived health problem in the county. High percentage of the population over 65. High percentage of the over 65 population in a nursing home or long-term care. Other health issues such as cancer and heart disease was likely due at least in part to the aging population.
> Birth Defects	<ul style="list-style-type: none"> High rates of birth defects.
> Cancer	<ul style="list-style-type: none"> Cancer was the top perceived health problem in the county. High rates of death due to cancer. High rates of incidence of and deaths due to breast and colorectal cancer.
> Child and Adolescent Mortality	<ul style="list-style-type: none"> High rates of child and adolescent mortality.
> Child Protection and Safety	<ul style="list-style-type: none"> High monthly average number of children in out-of-home care. High rates of child abuse and neglect cases.
> Heart Disease and Stroke	<ul style="list-style-type: none"> High rates of death due to coronary heart disease and stroke.
> Pulmonary Disease	<ul style="list-style-type: none"> High rates of hospitalization for asthma. High rates of death due to chronic lung disease.
> Radon Levels	<ul style="list-style-type: none"> Over three-fifths of homes have Radon levels over 4 pCi/L.
> Underage and Adult Alcohol and Tobacco Use	<ul style="list-style-type: none"> Alcohol was the top perceived risky behavior in the county. High rates of lifetime tobacco use, 30-day alcohol use, 30-day binge drinking, 30-day tobacco use for the underage population. High percentage of youth reporting having rode with a drunk driver. High rates of hospitalization for and deaths due to alcohol and tobacco-related diseases.

Appendix 3. CHIP Strategic Planning Grid Instructions

Tips for completing the CHIP Strategic Planning Grid:

Goals vs Objectives /Success Indicators: What is the difference and what do you want? In many situations people use words goals, objectives, and success indicator as interchangeable. Yet, in the context of goal setting, the difference between goals and objectives has an important practical meaning. Good goals feed into SMART success indicators and objectives.

The goal should answer the question: *What results do we want to see in the community as a result of our actions in this area?*

An example of a goal might be: *I will lose weight.*

Current Baseline or Data to support the need for the goal: Fill this is with data that supports the need for change.

An example might be: *Current BMI is 30, I do not exercise at all, my doctor recommends I lose 20 pounds, I weigh 200 pounds.*

The success indicator should be SMART and tell us if we achieve our goal, it is more specific than the goal and should be based in some part on the current baseline or data. SMART means:

- **Specific** (straightforward and strategic)
- **Measurable** (tied to measurable outcomes)
- **Achievable** (realistically able to be worked toward)
- **Realistic** (aligned with resources)
- **Timely** (with completion timelines).

An example of a SMART success indicator might be: *I will lose 20 pounds dropping from 200 to 180 pounds by December 31st, 2012.*

Current Resources list here known resources that could help you achieve your goal. Some questions here might be: What do we have in place already in this community to address this issue? What conditions make success possible? What community resources are available? What skills are available in the community? Who has the knowledge you need?

An example of current resources might be: *I have a scale, the YMCA has exercise equipment, the park has walking trails. My friend Jayne walks every Saturday.*

GAP analysis: Fill this in by answering the question; What resources do we need that we do not have now?

An example of GAP analysis might be: *I do not know the cost of the YMCA or the hours they are open, I am not sure how much I should lose in a week or how to start on a diet when I have diabetes.*

The Objectives identify the specifics. Moving from a success indicator to an objective requires getting even more specific. Objectives have only one purpose to serve your main goal. They may be something significant that your group will need to achieve before you can reach your goals. Objectives should set up the practical side of achieving the success indicator and your goal. Some questions around setting these

Appendix 3. CHIP Strategic Planning Grid Instructions

can include: What conditions should you provide? Which resources should you collect? Which skills should you develop? What knowledge should you acquire? Formulate the answers to these questions as your objectives in writing. These should have some challenge and not just be something you need to do (Should not be an Action Step). If the objective or any subsequent action step does not work to help achieving your goal, change or replace it so that it does. All objectives should also be SMART.

Examples of SMART Objectives might be: *I will sign up for a membership at the YMCA by the end of March 2012. I am committed to attending the YMCA three times per week. AND/OR I will schedule time on my calendar to walk every Saturday and keep track of how often I go and how far I walk. By December 31st, I will have walked 40 times and covered 80 miles.*

Fill out the form as much as you can. Decide as well on when the sub-committee will meet next to work on these issues and begin to think about what agency or group and who the person might be to lead the community or sub-committee.

Action Steps: While this is a three year plan it is helpful to get the details down for what you should do in the first year, you can go beyond the first year as your group plans.

Time Line: In what time period should this be done? The end of the plan should be approximately December 31st, 2014.

Responsibility: List the lead agency that will complete that step.

Budget: As the plan develops it is nice to put a cost to each action step, this helps to keep the plan from being a wish.

Comments/Progress: As the team meets it is nice to evaluate where we are on the plan.

CHIP Strategic Planning Grid: Platte County CHIP--Access to Care

Goal 1: Improve access to comprehensive, quality health care services.

Current Baseline or Data to support the need for the goal: High percentage of uninsured 40.5% compared to 31.5% for the state, 52% of residents see a physician in the past 12 months compared to 58% for the state.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
Increase the percent of persons who visited a doctor in the Past 12 Months from 52% to the state average of 58%	Columbus Community Hospital. CCH has a medical service gap analysis. Primary Care and Specialty Providers in area. FQHC at Health Department. Nurse Triage Line	Public Transportation is limited to take individuals to medical appointments. Limited financial resources and volunteers for patient transportation. Education is lacking for patients on what is available for services. A greater percentage of the 18-64 year old without health care coverage than the state.	HP-CA 4 Objective 1 Reduce the death rate from cancer of the uterine cervix. <u>EBI</u> <i>The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer</i> HP-CA 3 <u>Objective 2</u> Reduce the female breast cancer death rate. <i>USPSTF recommends biennial</i>	1.1 Explore and plan for the implementation of a free PAP smear screening day or week in Columbus with collaboration from area healthcare providers. 1.2 Implement a free PAP smear screening event in Columbus. 1.3 Explore with UNMC how Platte County and UNMC could collaborate on cancer management. 2.1 Look for funding to increase the number of women who are low income and uninsured that have mammograms.	1.1 By January 31, 2012. 1.2 By January 31, 2013. 1.3 By June of 2013. 2.1 By December 31, 2012 apply for one funding opportunity.	1.1 Platte County Access to Healthcare Group with CCH staff leading project. 1.2 Platte County Access to Healthcare Group with CCH staff leading project. 1.3 Platte County Access to Healthcare Group 2.1 CCH will be the lead on applying for the grant funding.	1. January is Cervical Cancer Awareness Month. Many clinics nationwide offer free pap smear clinics often with one or more of the following criteria; 1) low income, 2) uninsured women and/or 3) Woman who have not had a Pap smear in the last three years. The (USPSTF) recommends PAP screening women ages 21 to 65 years every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years 2.1 Grant funding is available from the Susan G. Koman foundation.

Appendix 4. ECDHD District CHIP Plans

		<p>Residents in the East Central District consistently see a doctor less than the average for all of Nebraska.</p> <p>Compared to the state, the East Central district has a notably higher rate of residents without health insurance.</p> <p>Area Nursing homes are at capacity.</p> <p>Of the 20 NE health districts, ECDHD district ranked 17th in the percentage of individuals reporting good to excellent health in 2009, in addition minorities in ECDHD rank last in the state in this indicator.</p>	<p><i>screening mammography for women aged 50 to 74 years.</i></p> <p>HP AHS-6 <u>Objective 3</u></p> <p>Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.</p>	<p>3.1 Explore the feasibility of starting a transportation program for patients who have transportation as a barrier to care.</p> <p>3.2 Explore other disease health screening opportunities to increase access to health care and develop a plan to address early screening. CCH already holds a “tune up for life”</p> <p>3.3 Facilitate communication opportunities between providers and patients to increase access to care by supporting Nurse Triage Line and Medical Resources Guide.</p> <p>3.4 Implement a home monitoring program for</p>	<p>3.1 By December 31, 2012.</p> <p>3.2 Ongoing</p> <p>3.3 Triage line is Ongoing, Medical Resource Guide by June of 2013.</p> <p>3.4 By</p>	<p>3.1 CCH will be the lead on exploring options.</p> <p>3.2 CCH will be the lead on the tune up for life and on exploring options for more screenings.</p> <p>3.3 CCH will continue to work with St. Elizabeth’s on Triage. CCH is the lead for the medical resource guide with all area providers.</p> <p>3.4 CCH home health</p>	<p>3.1 Explore CCH paid program or a program operated by volunteers.</p> <p>3.2 Continue with Tune up for Life and the prevention screenings done at this annual event.</p> <p>3.3 Currently providing this new service to all area local providers for a small fee.</p>
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Appendix 4. ECDHD District CHIP Plans

		Health Professional shortages exist in ENT, Ophthalmology, and General Surgery.	<p>patients receiving home health services.</p> <p>3.5 Provide community screening and information day regarding diabetes.</p> <p>3.6 Provide support to help the FQHC in serving uninsured patients (such as diabetes) to keep patients from using the emergency room for care.</p> <p>3.7 Explore forming a geriatric assessment team to complete patient testing and evaluation for best setting for patients.</p>	<p>December 31, 2013</p> <p>3.5 Annually in October.</p> <p>3.6 Work with GNCHC to maintain ongoing case-management services and provide needed medications and services to patients.</p> <p>3.7 By June of 2013.</p>	<p>lead.</p> <p>3.5 CCH will be the lead on the Diabetes awareness day.</p> <p>3.6 CCH working with GNCHC.</p> <p>3.7 Dr. Zadina office, CCH and consultation with Pender hospital.</p>	<p>3.6 Current % of patients with A1c below 9 is 70% improved over 2011 when 65% had A1c < 9.</p> <p>3.7 Dr. Timm has been doing this in Pender for a number of years and it is very beneficial for families.</p>
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CHIP Strategic Planning Grid: Platte County CHIP – Adult Obesity

Goal 1: Promote Healthy Weight and Reduce Chronic Disease Risk

Current Baseline or Data to support the need for the goal: The most current statistics, 2009, indicate that 32.3% of the population in the ECDHD is obese.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
<p>To decrease the percent of population defined as obese from 32.3% to 30.0% by January 2015.</p>	<p>PACE – Physical Activity Comes Easy – program for businesses and individuals to increase activity. Includes power point and activity tracker log.</p> <p>Area Dietitians</p> <p>Columbus has bike and walking trails.</p> <p>Aquatic Center</p> <p>Columbus Family Y</p> <p>Local adult sports teams</p> <p>ChooseMyPlate.gov</p> <p>CAHRA (Columbus Area Human Resources Association).</p> <p>Choose to Lose</p>	<p>No community wide worksite wellness plan.</p> <p>The local Y is aging, pool is out of order.</p> <p>Low incidence of people walking for goods and supplies, no stores in residential areas.</p>	<p>HP2020-NWS-09</p> <p><u>Objective 1</u></p> <p>Reduce the proportion of adults who are considered obese.</p>	<p><u>Objective 1</u></p> <p>1.1 Meet with local HR people monthly to develop a worksite wellness plan that is user friendly and can be packaged and ready for business use.</p>	<p><u>Objective 1</u></p> <p>1.1 By 12/31/2013 have a worksite wellness plan for Platte County and three businesses or worksites will adopt an employee worksite p.a. & nutrition program.</p>	<p><u>Objective 1</u></p> <p>1.1 CCH-Occupational Health and Cardiac Rehab</p>	<p><u>Objective 1</u></p> <p>1.1 Funding - In-kind CCH?</p>
				<p>1.2 Include the Chamber of Commerce in the development of the worksite wellness plan.</p>	<p>1.2 By 12/31/2012</p>	<p>1.2 CCH-Occupational Health and Cardiac Rehab</p>	<p>1.2 Funding - In-kind CCH?</p>
				<p><i>1.3 Evidenced Based: CDC Community Guide: Worksite Health Promotion:</i></p>	<p>1.3 Plan implemented with parameters by 03/31/2014.</p>	<p>1.3 CCH-Occupational Health and Cardiac Rehab</p>	<p>1.3 Funding - In-kind CCH and/or combination of business. Look for funding opportunities. Possible workforce challenge – using Columbus days, Downtown Runaround, etc.</p>

				<p><i>Assessment of Health Risks with Feedback to Change Employees' Health includes assessment of health habits & risk factors; and provision of feedback in the form of educational messages and counseling. PACE was based off of an evidenced based program.</i></p>				<p>Workforce/rotary/etc challenge at downtown runaround.</p>
			<p><u>Objective 2</u> Grow the coalition and gather resources for public distribution.</p>	<p><u>Objective 2</u> 2.1 Have coalitions members invite other community agencies and individuals to join coalition</p> <p>2.2 Gather together some of the resources available on physical activity</p>	<p><u>Objective 2</u> 2.1 Coalition will grow by ten members by December 31,2015</p> <p>2.2 Handout created by September 30, 2012.</p>	<p><u>Objective 2</u> 2.1 Platte County CHIP Obesity Prevention Coalition.</p> <p>2.2 Platte County CHIP Obesity Prevention Coalition.</p>	<p><u>Objective 2</u> 2.1 In-kind by representative agencies with CCH as lead agency.</p> <p>2.2 In-kind by representative agencies.</p>	

Appendix 4. ECDHD District CHIP Plans

				<p>and nutrition and create folder with menu of services offered.</p> <p>2.3 Create a letter to businesses regarding nutrition and physical activity services offered.</p> <p>2.4 Present to the CAHRA group & provide community resources.</p> <p>2.5 Explore regular nutrition and physical activity articles/messages in paper and/or on website.</p>	<p>2.3 Letter created by September 30, 2012.</p> <p>2.4 By October 2012 CCH will have talked to the CAHRA group.</p> <p>2.5 By November 2012, the group will have developed a series of 12 messages to be posted on ECDHD/CCH website.</p>	<p>2.3 Platte County CHIP Obesity Prevention Coalition.</p> <p>2.4 Platte County CHIP Obesity Prevention Coalition.</p> <p>2.5 Platte County CHIP Obesity Prevention Coalition – perhaps Holly Wrath.</p>	<p>2.3 In-kind by representative agencies with CCH as lead agency.</p> <p>2.4 In-kind by representative agencies .</p> <p>2.5 In-kind by representative agencies.</p>
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CHIP Strategic Planning Grid: Platte County CHIP--Child Obesity

Goal 1: Promote Healthy Weight and reduce chronic disease risk

Current Baseline or Data to support the need for the goal: 15.4% (look up reference 19) of the youth in ECDHD are overweight.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
<p>To decrease the percentage of overweight youth from 15.4% to the state average of 13.7%</p>	<p>Obesity Consortium-which became the CHIP Obesity prevention group.</p> <p>Shape Down at CCH</p> <p>Skate Center (old wishbones)</p> <p>T4C</p> <p>YMCA</p> <p>All Platte County Schools</p> <p>NAP SACC program for day care</p> <p>Lana the Iguana program for day care</p> <p>Fuel Up to Play 60 - 4K for schools to apply for.</p> <p>Local sports teams unattached to schools.</p> <p>Boy Scouts</p> <p>Girl Scouts</p> <p>Dance Studios</p> <p>Heartland Athletics</p>	<p>Some counties are able to pull BMI levels from area schools - Platte is not able to do this at this time.</p> <p>Affordable weight loss programs for overweight or obese children.</p> <p>Columbus Family Y is the main facility for children's physical activity, Y at this time is ageing and is without a swimming pool.</p> <p>Youth activities cost and this may be a deterrent for</p>	<p>HP2020-NWS-10</p> <p><u>Objective 1</u></p> <p>Reduce the proportion of children and adolescents who are considered obese.</p>	<p><u>Objective 1</u></p> <p>1.1 Contact all school nurses in Platte County to see if they can help collect data.</p> <p>1.2 Contact select schools in Platte County regarding measurement of Weight/Height of third graders to assess for BMI baseline.</p>	<p><u>Objective 1</u></p> <p>By 12/31/2012 have a BMI average for third graders in Platte County.</p>	<p><u>Objective 1</u></p> <p>ECDHD – School Surveillance Nurse</p>	<p><u>Objective 1</u></p> <p>Funding - In-kind by ECDHD</p>
			<p>NWS-17</p> <p><u>Objective 2</u></p> <p>Reduce consumption of calories from solid fats and added sugars in the population age 2-5 years.</p>	<p><u>Objective 2</u></p> <p>2.1 Incorporate NAP SACC <i>Evidenced Based</i> - into daycare centers in Platte County.</p>	<p><u>Objective 2</u></p> <p>2.1 By 12/31/2013 we will reach 20 in home daycare providers and 5 centers.</p>	<p><u>Objective 2</u></p> <p>Kaise Recek with ECDHD.</p>	<p><u>Objective 2</u></p> <p>ECDHD \$50,000 in funding for this project.</p>

		families.	<p>PA-6 <u>Objective 3</u> Increase regularly scheduled elementary school recess in the United States</p>	<p><u>Objective 3</u> 3.1 Create a handout on why recess time is important to health. 3.2 Meet with the administration of three schools to champion the cause of increasing recess time.</p>	<p><u>Objective 3</u> 3.1 Handout created by November 1, 2012 3.2 By December 31, 2012 contact at least three schools and work out commitments.</p>	<p><u>Objective 3</u> 3.1 Platte County CHIP Obesity Prevention Coalition. 3.2 Coalition volunteers. ECDHD Health Director R. Rayman and Doug Moore will approach CPS.</p>	<p><u>Objective 3</u> 3.1 In-kind by representative agencies. 3.2 In-kind by representative agencies.</p>
			<p>PA-15 <u>Objective 4</u> Enhance access to and availability of physical activity opportunities. <i>Evidenced Based - Creation of or enhancing... access to places for physical activity... including building exercise facilities.-CDC</i></p>	<p><u>Objective4</u> 4.1 Research funding opportunities to impact childhood obesity. Goal is to implement CATCH – <i>Evidenced Based - Coordinated Approach to Child Health</i> to reduce obesity rates 4.2 Implement any funded programs</p>	<p><u>Objective 4</u> 4.1 By December 31, 2012 will have applied for at least one funding opportunity. 4.2 According to the grant timeline.</p>	<p><u>Objective 4</u> 4.1 ECDHD will look for and write a grant application. 4.2 ECDHD as</p>	<p><u>Objective 4</u> 4.1 In-kind by ECDHD. Grant was applied for in late spring 2012. 4.2 Application was funded for one year by BCBS for \$18,000.</p>

Appendix 4. ECDHD District CHIP Plans

			<p><i>Community Guide</i></p>	<p>4.3 Explore with city leaders the possibility of a new facility for physical activity opportunities for the community.</p> <p><u>Objective 5</u> 5.1 Create a Healthy Futures Columbus website with information on the site about healthy eating and activity.</p>	<p>4.3 By December 31, 2015</p> <p><u>Objective 5</u></p>	<p>lead and members of coalition.</p> <p>4.3 Chamber Quality of Life Task force. Joe M or Rebecca R will keep the coalition posted of progress.</p> <p><u>Objective 5</u> June 30, 2015</p>	<p>4.3 Study Funded by multiple agencies</p> <p><u>Objective 5</u></p>
			<p>Nebraska State Plan Partners in Health</p> <p><u>Objective 5</u> Increase fruit and vegetable consumption</p>				

CHIP Strategic Planning Grid: Platte County CHIP- Family Support /Child Well Being

Goal 1: To improve the stability, health and well-being of women, infants, children and families through the effective use of community resources.

Current Baseline or Data to support the need for the goal: Average per capita income for the district is \$21,837 and the state average \$24,568 and National is \$27,041, Median income is \$46,892 for the ECDHD district compared to the NE state at \$47,995. Percent of families in the district living in poverty is 7) Colfax County has 11% of individuals in poverty compared to 8.6% for district.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
At least three different community agencies will have adopted interventions to improve family support by December 2015.	211 Service Local Churches Connect Columbus Child Well Being Healthy Families NE Early Development Network Early Head Start Planning Region Team NAP SACC YFC (Youth For Christ) CNCS Kids Program	Lack of coordination and information communication. Cultural differences Difficulty in public transportation. Buy-in from parents. Lack of male parenting education.	HP <u>Objective 1</u> Increase the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting.	1.1 Improve parenting and family support by implementing PIWI program. 1.2 Improve parenting and family support by implementing PCIT program. 1.3 Train and Implement child care providers in Evidenced based practices using the Pyramid model. 1.4 Develop a plan to reach children not served in daycare centers - identify other community partners	1.1 By December of 2013, complete at least one PIWI parenting group. 1.2 By December of 2013 serve at least 16 families. 1.3 By December of 2014 at least one training completed. 1.4 By December 2014.	1.1 CCH, ECDHD and PIWI leadership and work group. 1.2 ECDHD BH clinic and Meadows Therapy. 1.3 Child Well Being Group PIWI trained members. 1.4 Child Well Being Members.	1.1 PIWI is Parents Interacting With Infants. Funding from a grant by Nebraska Children’s Foundation awarded to United Way for Child Well Being Group. 1.2 PCIT is Parent Child Interaction Therapy. Funding from a grant by Nebraska Children’s Foundation awarded to United Way for Child Well Being Group. 1.3 The first PIWI training has occurred. 1.4 Possible development of positive parenting messages through brief messages at exit contact points.

Appendix 6. ECDHD District CHIP Plans

	<p>Mothers & Babies</p> <p>Personal Support Svs.</p> <p>PCIT (Parent Child Inter Active Therapy)</p>			<p>who work with young children.</p> <p>1.5 Develop or Obtain information sheets for the families of young children (birth to age three) on positive parenting communication that can be distributed at day care centers and physician clinics that serve children from Platte County</p>	<p>1.5 By December 2013 information sheets will be available to clinics and/daycares.</p>	<p>1.5 Child Well Being Group, GNCHC, WIC, Daycares.</p>	<p>1.5 May keep track of how many handouts distributed or how many children receive handouts. Be great to get policy changes at daycares or clinics making handing out social-emotional materials</p>
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CHIP Strategic Planning Grid: Platte County CHIP- Youth Substance Abuse

Goal 1: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children in grades 6-12.

Current Baseline or Data to support the need for the goal: Percent of 12th graders driving under the influence of alcohol in the past 12 months for Platte is 23.7%, district is 21.6%, while state is 20.1%. Percent of 12th graders who reported riding in a car in the past 30 days with someone who had been drinking alcohol: Platte 33.0%, ECDHD 33.5% and State is 25.7%. Percent of 30 day marijuana use by 10th graders: Platte 9.8%, ECDHD 8.7% and State 8.0%.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE	RESPONSIBILITY	BUDGET COMMENTS/PROGRESS
<p>To decrease the percent of 12th graders who report past 30 day alcohol impaired driving from 23.7% to 18.7% or by 5% overall.</p>	<p>Back to Basics coalition with current SPF SIG funding.</p> <p>Youth for Christ</p> <p>D.A.R.E program</p> <p>T4C-Time for Change</p> <p>YMCA</p> <p>Columbus Public Library</p> <p>Faith-based Youth groups.</p> <p>Columbus Skate and Hockey Center</p> <p>Columbus Schools</p>	<p>Representation from: business sector, school sector, mental health sector, media, youth and parents</p> <p>Continued funding, main funding will be ending Sept 2012</p> <p>Sustainability</p>	<p>HP 2020 SA 1</p> <p><u>Objective 1</u></p> <p>Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol</p>	<p><u>Objective 1.1</u></p> <p>Perform the <i>Evidence Based Strategy</i> of compliance checks with collaboration from Platte County Sheriff's Department and Columbus Police Department.</p> <p><u>Objective 1.2</u></p> <p>Implement <i>Evidence Based</i> mass media campaigns focusing on consequences; health, social, and legal, of alcohol impaired driving.</p>	<p><u>Objective 1.1</u></p> <p>By Sept 30, 2014 seven checks will be performed.</p> <p><u>Objective 1.2</u></p> <p>By Sept 30, 2014 provide community education through the use of: 3 billboards; print media two times per year; Facebook and Back to BASICS website.</p>	<p><u>Objective 1.1</u></p> <p>ECDHD Columbus Police Department Platte County Sheriff's Department</p> <p><u>Objective 1.2</u></p> <p>ECDHD program staff B. Preister and K. Recek</p>	<p><u>Objective 1.1</u></p> <p>Grant funding \$ CCH In-kind \$</p> <p><u>Objective 1.2</u></p> <p>Grant funding \$ 6,400.00 CCH In-kind \$ 1,500.00 Region 4 Block Grant \$ 1,449.00 Region 4 Mini-Grant \$ 250.00</p>

Appendix 6. ECDHD District CHIP Plans

	<p>B-D Behlen ADM</p> <p>Medical Community</p>		<p>HP 2020 SA1</p>	<p><u>Objective 1.3</u> Collaborate with law enforcement implement <i>Evidence Based</i> sobriety checkpoints.</p> <p><u>Objective 1.4</u> Partner with schools to strengthen their youth prevention activities such as Students Against Destructive Decisions (SADD) group. <i>Evidence Based</i></p> <p><u>Objective 1.5</u> Conduct <i>Evidence Based (SAMHSA)</i> Responsible Beverage Server Training (TIPS) targeting “carry out” liquor establishments to reduce youth access.</p>	<p><u>Objective 1.3</u> By Sept 30, 2014 Sobriety checkpoints will be conducted three times.</p> <p><u>Objective 1.4</u> By Sept 30, 2014 partner with two schools in Platte County to strengthen or support youth prevention activities such as SADD.</p> <p><u>Objective 1.5</u> By Sept 30, 2014 conduct TIPS training to reach six businesses.</p> <p><u>Objective 2.1</u></p>	<p><u>Objective 1.3</u> Law enforcement ECDHD program staff B Preister</p> <p><u>Objective 1.4</u> ECDHD program staff B Preister</p> <p><u>Objective 1.5</u> TIPS trainers: Zyweic, Black, Gragert, Preister and Jensen.</p> <p><u>Objective 2.1</u> ECDHD program staff B. Preister</p>	<p><u>Objective 1.3</u> Grant funding \$ 3,890.00 CCH In-kind \$ 2,000.00</p> <p><u>Objective 1.4</u> Grant funding \$ 1,750.00 CCH In-kind \$ 1,175.00</p> <p><u>Objective 1.5</u> Grant funding \$ 3,100.00 CCH In-kind \$ 1,700.00 Region 4 Block Grant \$ 500.00</p> <p><u>Objective 2.1</u> Grant funding \$ 6,400.00</p>
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Appendix 6. ECDHD District CHIP Plans

<p>By 2015, reduce the number of 12th graders who report riding with someone under the influence of alcohol in the past 30 days from 33% to 30% or by 3% overall.</p> <p>By 2015, reduce the number of 10th graders who report past 30 day use of marijuana from 9.8% in Platte County to 8% or 1.8% decreased overall .</p> <p>By 2015 secure coalition participation</p>			<p><u>Objective 2</u> Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol</p> <p>HP2020 SA2.2 <u>Objective 3</u> Increase the proportion of at risk adolescents aged 12 to 17 years who, in the past year, refrained from</p>	<p><u>Objective 2.1</u> Implement <i>Evidence Based</i> mass media campaigns focusing on consequences; health, social, and legal, of alcohol impaired driving.</p> <p><u>Objective 2.2</u> Partner with schools to strengthen their youth prevention activities such as Students Against Destructive Decisions (SADD) group. <i>Evidence Based</i></p> <p><u>Objective 3.1</u> Partner with schools to strengthen their youth prevention activities such as Students Against Destructive Decisions (SADD) group. <i>Evidence Based</i></p>	<p>By Sept 30, 2014 provide community education through the use of: 3 billboards; print media two times per year; Facebook and Back to BASICS website.</p> <p><u>Objective 2.2</u> By Sept 30, 2014 partner with two schools in Platte County to strengthen or support youth prevention activities such as SADD.</p> <p><u>Objective 3.1</u> By Sept 30, 2014 provide community education through the use of: 3 billboards; Facebook and Back to BASICS website.</p>	<p>and K. Recek</p> <p><u>Objective 2.2</u> ECDHD program staff B Preister</p> <p><u>Objective 3.1</u> ECDHD program staff B Preister</p>	<p>CCH In-kind \$ 1,500.00 Region 4 Block Grant \$ 1,449.00 Region 4 Mini-Grant \$ 250.00</p> <p><u>Objective 2.2</u> Grant funding \$ 1,750.00 CCH In-kind \$ 1,175.00</p> <p><u>Objective 3.1</u> Grant funding \$ 1,750.00 CCH In-kind \$ 1,175.00</p>
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Appendix 6. ECDHD District CHIP Plans

<p>from the following sectors: youth (under 18), parents, business community, media, schools, youth-serving organizations, law enforcement, religious or fraternal organizations, civic and volunteer groups, healthcare/public health, state or local government, and other organizations involved in reducing substance abuse.</p>			<p>using marijuana for the first time</p> <p><u>Objective 4</u> Expand the reach of the coalition via presentations and education to thereby gain support and community awareness of Back to BASICS.</p>	<p><u>Objective 4.1</u> Request current members to invite one quest per quarter.</p> <p><u>Objective 4.2</u> Provide coalition presentations a minimum of two times per year (e.g. School presentations, business, or service organizations).</p> <p><u>Objective 4.3</u> Inform the general public of upcoming meetings (e.g. Chamber of Commerce communication, community media).</p>	<p><u>Objective 4.1</u> By September 30, 2014 expand coalition participation to include youth and media.</p> <p><u>Objective 4.2</u> By September 30, 2014 provide four presentations within Platte County.</p> <p><u>Objective 4.3</u> By September 30, 2014 provide the general public with information on upcoming meeting through a minimum of four sources.</p>	<p><u>Objective 4.1</u> Platte County Back to BASICS coalition.</p> <p><u>Objective 4.2</u> Platte County Back to BASICS coalition.</p> <p><u>Objective 4.3</u> Platte County Back to BASICS coalition.</p>	<p><u>Objective 4.1</u> No funding needed.</p> <p><u>Objective 4.2</u> No funding needed.</p> <p><u>Objective 4.3</u> No funding needed.</p>
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CHIP Strategic Planning Grid: Platte County CHIP-- Mental Health

Goal 1: Improve mental health through prevention and by ensuring access to appropriate, quality, mental health services

Current Baseline or Data to support the need for the goal: While the mental health is statistically better than the state of Nebraska as far as percent of population having ten or more days when their mental health was bad 9.7% for district and 10.5% for state, and while the area has a lower suicide mortality rate at 5.1 individuals compared to the state average of 10.5 per 100,000 the district does have a slightly higher rate of self-inflicted injury at 77 per 100,000 compared to 74 per 100,000. Mental health was identified as one of the top three needs in the district in the written survey by 14% of those who took the survey and ranked ninth out of a total of 24 items.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
Platte County will improve the mental health system by December of 2014 by adding at least one service or one new provider in the community.	Law enforcement	No pre-EPC beds in Platte County	1. Reduce the suicide rate	1.1 Initiate a new respite service.	1.1 By July 31, 2012	1.1 Rainbow Center with Regional Service Center support.	1.1 New respite service was up and running by July 1 st , 2012.
	Crisis Navigators	No local detox bed in Platte County		1.2 Law Enforcement training in mental health issues.	1.2 By December 31, 2012.	1.2 Update from County Attorney office regarding law enforcement issues for EPC and pre-EPC.	1.2 Arrangements have already been made.
	Local Mental Health Providers including private therapists, the GNCHC behavioral health program and Catholic Charities which has out-patient and in-patient services.	No pre-EPC assessment, action steps, resources or services available.		1.3 Evaluate prospects for “skyping” between subjects in crisis. Example law enforcement skyping with mental health professionals to assist in the determination of EPC.	1.3 By December 31, 2013.	1.3 Platte County Mental CHIP group.	1.3 Group is unsure of the feasibility and liability of doing this.
	School Authorities	No pre- EPC current protocols, policies or process.					
	DHHS	No differentiation of adult and child process/ program	2. Reduce the	2.1 Continue to have	2.1 Ongoing	2.1 ECDHD GNCHC	
	Neighbors looking out after others						

Appendix 6. ECDHD District CHIP Plans

	<p>Resources from distant community mental health providers.</p>	<p>Lack of funding</p> <p>Lack of follow-through</p> <p>No consequences when clients do not follow-through.</p>	<p>proportion of persons who experience major depressive episodes (MDE). See USPSTF information below.</p> <p>3. Increase the proportion of adults with mental health disorders who receive treatment. <i>Evidenced Based The USPSTF recommends screening adults for depression when depression care supports are in place.</i></p> <p>4. Increase the proportion of persons with co-occurring substance</p>	<p>medical patients complete a mental health screen prior to medical visits.</p> <p>2.2 Promote National depression screenings in Platte County.</p> <p>3.1 Continue to have Platte County Mental health CHIP group meet on a regular basis (bi-monthly) to monitor services and increase communication between providers, community agencies and law enforcement.</p> <p>3.2 Look for grants or funding sources to look for community providers.</p> <p>4.1 Explore local options for detoxification processes.</p>	<p>through 2014.</p> <p>2.2 Provide for community screening avenues by October of 2013.</p> <p>3.1 Group will meet bi-monthly in even months.</p> <p>3.2 Ongoing have applied for at least one new funding opportunity by December of 2014.</p> <p>4.1 December of 2013.</p>	<p>will provide data to the group on a semi-annual basis.</p> <p>2.2 Platte County Mental CHIP group.</p> <p>3.1 Platte County Mental CHIP group.</p> <p>3.2 Platte County Mental CHIP group.</p> <p>4.1 Need time to explore medical detox with hospital and other agencies that provide in-patient services.</p>	
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Appendix 6. ECDHD District CHIP Plans

			<p>abuse and mental disorders who receive treatment for both disorders.</p> <p>5. Identify gaps and needs in Platte County.</p>	<p>5.1 Continue to have Platte County Mental health CHIP group meet on a regular basis (bi-monthly) to discuss gaps and needs.</p>	<p>5.1 Ongoing the group will show discussion in the minutes.</p>	<p>5.1 Dru Keating is the secretary of the group.</p>	
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CHIP Strategic Planning Grid: Boone County CHIP- Cancer

Goal 1: To increase awareness of cancer prevention education and screenings in Boone to aid in decreasing overall cancer rates.

Current Baseline or Data to support the need for the goal: Incidence of cancer per 100,000 population in Boone County is 533.9 compared to the district at 494.5 and state of 478.7. Incidence of cancer by type per 100,000 population include: Lung Cancer Boone 60.6, district 56.5, state 65.6; Breast Cancer Boone 138.6, district 127.1, state 123.2; Colorectal Cancer Boone 67.1, district 63.9, state 56.2; Prostate Cancer Boone 255.0, district 209.6, state 158.9; Lymphoma Boone 22.0, district 20.1, state 20.4. Deaths due to cancer per 100,000 population: Boone 235.1, district 171.1, state 174.0.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE	RESPONSIBILITY	BUDGET COMMENTS/PROGRESS
To decrease the incidence of colon cancer per 100,000 population from 67.1 to 65.0.	Boone County Health Center Colon Cancer FOBT (Fecal Occult Blood Test) kits available from ECDHD Boone Central School Past superintendent Dick Stephens School Involvement Substance Abuse Prevention Program of ECDHD		<u>HP 2020 C16</u> Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines	<u>Objective 1.1</u> Partner with a Boone County Pharmacy and provide FOBT kits during March and April of each year. <u>Objective 1.2</u> Utilize newspaper in Boone County to increase awareness of Colon Cancer.	<u>Objective 1.1</u> By Feb. 1, 2013 secure one pharmacy to partner with on FOBT kit distribution. <u>Objective 1.2</u> By April of each year ECDHD will submit one ad and one article to local newspaper regarding colon cancer screening and/or where to obtain free colon cancer kits.	<u>Objective 1.1</u> ECDHD staff Kaise Recek <u>Objective 1.2</u> ECDHD staff Kaise Recek	<u>Objective 1.1</u> ECDHD funds from NE Colon Cancer Program \$200 <u>Objective 1.2</u> ECDHD funds from NE Colon Cancer Program \$200
To decrease the incidence of lung cancer from 60.6 to 58.6.			<u>HP 2020 C-2</u> Reduce the lung cancer death rate	<u>Objective 2.1</u> Increase awareness of radon and the need for testing to aid in preventing lung cancer from radon.	<u>Objective 2.1</u> By February of each year submit one article and one ad into Boone County newspaper to increase awareness of	<u>Objective 2.1</u> ECDHD staff Kaise Recek	<u>Objective 2.1</u> NE DHHS Radon Risk Awareness Funding for 2013 and possibly 2014 for amount of \$200.00 New grant may need to cover

Appendix 6. ECDHD District CHIP Plans

<p>To increase the use of protection against sunburns to aid in decreasing melanoma.</p>			<p><u>HP 2020 C-20</u> Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn</p>	<p><u>Objective 3.1</u> Educate outside pool users of benefits of protecting oneself from the sunburn.</p>	<p>radon risks. <u>Objective 3.1</u> POOL COOL funds in 2010, 2011 and 2012 have been used to purchase lifeguard and/or public umbrellas and UV wrist bans. Aluminum signs have been provided to Albion pool to encourage sun protection. Annually, communication with Albion pool will occur reminding staff/city of these sun protection resources.</p>	<p><u>Objective 3.1</u> ECDHD staff Kaise Recek</p>	<p>costs of media. <u>Objective 3.1</u> Items already purchased. Staff time from ECDHD to communicate with Albion pool/city offices.</p>
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CHIP Strategic Planning Grid: Boone County CHIP--Bullying

Goal 1: Decrease bullying rates in 6th and 12th grade students in Boone County

Current Baseline or Data to support the need for the goal: 25.9% of youth in 6th grade in Boone County report being bullied at school in the past 12 months; this the district average of 6th graders being bullied is 22.6%. 19.7% of 12th graders in Boone County report being bullied at school as compared to the district rate of 18.7% and state average of 19.2%

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE	RESPONSIBILITY	BUDGET	COMMENTS/PROGRESS
Reduce percentages of 6 th grade youth reporting being bullied at school over the last 12 months to less than the district average of 22.6% and 12 th grade bullying rate of 19.7% to be below the district average of 18.7%.	YRBS <ul style="list-style-type: none"> • Community resources: • School Counselors • Parents • Clergy • Local Mental Health professionals • Teachers • Youth for Christ? 	(Needed Resources) What are the school policies Action steps taken by school personnel when bullying is reported. Others who might be interested in cause Would Youth for Christ provide antibullying speaker to Boone County?	Re-enforce that the school's policies and procedures are followed each and every time that an incident is reported, based on the presumption that they have anti-bullying policies and procedures. Accountability to those that know about the situation. Make	Create a support program created by peers and staff (been there/survived that) Assist in bringing speakers on the topic to visit the schools/organizations Involve parents through PTOs and/or booster clubs	By December 31, 2014 By Dec. 2014 By Dec. 2014	Coalition will engage the schools and other organizations to facilitate this program. Coalition Coalition	No budget needed immediately but will be for speakers	

Appendix 6. ECDHD District CHIP Plans

			<p>education available to staff/students/parents on the negative effect of bullying</p> <p>Ensure that other youth organizations are encouraging anti-bullying practices (4-H, Teammates, Girl Scouts, Boy Scouts, sports clubs/teams, youth groups)</p> <p>Recruit partners</p>					
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CHIP Strategic Planning Grid: Boone County CHIP – Childhood Obesity

Goal 1: Promote Healthy Weight and Reduce Chronic Disease Risk

Current Baseline or Data to support the need for the goal: 15.4% (look up reference 19) of the youth in ECDHD are overweight.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
<p>To decrease the percentage of overweight youth from 15.4% to the state average of 13.7%</p>	<p>NAP SACC program for day care</p> <p>Fuel Up to Play 60 - 4K for schools to apply for. Funding comes and goes for Nebraska Schools.</p> <p>Boone County School District.</p> <p>Hospital has a daycare center.</p>	<p>Some counties are able to pull BMI levels from area schools – Boone is not able to do this at this time.</p> <p>No day care providers in Boone County know about NAP SACC program.</p> <p>No Achieve or CATCH programs operating in Boone County.</p> <p>No weight loss programs targeted for overweight or obese children.</p>	<p>HP2020-NWS-10</p> <p><u>Objective 1</u></p> <p>Reduce the proportion of children and adolescents who are considered obese.</p> <p>NWS-17</p> <p><u>Objective 2</u></p> <p>Reduce consumption of calories from solid fats and added sugars in the population age 2-5 years.</p>	<p><u>Objective 1</u></p> <p>1.1 Contact all school nurses in Boone County to see if they can help collect data.</p> <p>1.2 Contact select schools in Boone County regarding measurement of Weight/Height of third graders to assess for BMI baseline.</p>	<p><u>Objective 1</u></p> <p>By 12/31/2012 have a BMI average for third graders in Boone County.</p>	<p><u>Objective 1</u></p> <p>ECDHD – School Surveillance Nurse</p>	<p><u>Objective 1</u></p> <p>Funding - In-kind by ECDHD</p>
				<p><u>Objective 2</u></p> <p>2.1 Obtain and provide material from NAP SACC to local daycare providers.</p> <p>2.2 Hospital will communicate with NAP SACC coordinator on a quarterly basis.</p> <p>2.3 Incorporate NAP SACC <i>Evidenced Based</i> - into daycare centers in Boone County.</p>	<p><u>Objective 2</u></p> <p>2.1 By 12/31/2012 daycare providers will have material</p> <p>2.2 Ongoing</p> <p>2.3 By 06/15/2013 we will reach 5 in home daycare providers.</p>	<p><u>Objective 2</u></p> <p>2.1 Nicole Levander Boone County Hospital and Kaise Recek with ECDHD.</p> <p>2.2 Nicole Levander Boone County Hospital and Kaise Recek with ECDHD.</p> <p>2.3 Kaise Recek with ECDHD.</p>	<p><u>Objective 2</u></p> <p>No funding required</p> <p>2.3 ECDHD has \$50,000 in funding for this project for the district implementation.</p>

CHIP Strategic Planning Grid: Boone County CHIP-Youth Substance Abuse

Goal 1: Reduce youth substance abuse and access among 6th – 12th graders in Boone County.

Current Baseline or Data to support the need for the goal: Percent of 12th graders driving under the influence of alcohol in the past 12 months for Boone is 32.8%, district is 21.6%, while state is 20.1%. Percent of 12th graders who reported riding in a car in the past 30 days with someone who had been drinking alcohol: Boone 6th graders 37.0%, 8th graders 29%, 10th graders 26.7%, 12th graders 37.7%; District average for 6th grade is 23%, 8th grade 23.2%, 10th grade 26.4%, 12th grade 33.5%; state average 6th grade 19.6%, 8th grade 21.4%, 10th grade 23.3%, 12th grade 25.7%. Thirty day alcohol use for youth in Boone County as 10th graders is 21.7%, 12th graders 47.5%. This compares to the district 10th grade level of 20.6% and 12th grade level of 33.4%. State results for 30 day alcohol use is 21% for 10th graders and 34.7% for 12th graders.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE	RESPONSIBILITY	BUDGET COMMENTS/PROGRESS
<p>By June 2015, decrease by 10% the percent of 10th and 12th graders who report impaired driving from 32.8% in 12th graders to 29.52%.</p>	<p>Why Am I Tempted (WAIT) Training (Boone Central & St. Mikes)</p> <p>Back To BASICS</p> <p>TEAM MATES</p> <p>Law enforcement (Boone Central)</p> <p>Businesses through financial donations for after prom parties</p> <p>REACH (Boone Central)</p>	<p>Faith Based</p> <p>Law enforcement</p> <p>Parents</p> <p>Local Coalition members</p> <p>Incentives for non-athletes do abstain from substance abuse</p> <p>School accountability for alcohol/drug offences</p> <p>Medicine Take Back Events have not been held in Boone</p>	<p>HP 2020 SA</p> <p><u>Objective 1</u></p> <p>Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol</p>	<p><u>Objective 1.1</u></p> <p>Perform the <i>Evidence Based Strategy</i> of compliance checks with collaboration from Boone County Sheriff’s Department. .</p>	<p><u>Objective 1.1</u></p> <p>By Sept 30, 2014 one check will be performed.</p>	<p><u>Objective 1.1</u></p> <p>Boone County Sheriff’s Department</p>	<p><u>Objective 1.1</u></p> <p>Grant funding \$ Boone County Medical Clinic</p> <p><u>Objective 1.2</u></p> <p>Grant funding \$6,400 Boone County Medical Clinic Region 4 Block Grant \$ 1,449.00 Region 4 Mini-Grant \$ 250.00</p>
				<p><u>Objective 1.2</u></p> <p>Implement <i>Evidence Based</i> mass media campaigns focusing on consequences; health, social, and legal, of alcohol impaired driving.</p>	<p><u>Objective 1.2</u></p> <p>By Sept 30, 2014 provide community education through the use of: billboards; print media; Facebook and Back to BASICS website.</p>	<p><u>Objective 1.2</u></p> <p>ECDHD program staff B. Preister and K. Recek</p>	
				<p><u>Objective 1.3</u></p>	<p><u>Objective 1.3</u></p>	<p><u>Objective 1.3</u></p>	

Appendix 6. ECDHD District CHIP Plans

				<p><u>Objective 1.3</u> Collaborate with law enforcement implement <i>Evidence Based</i> sobriety checkpoints.</p> <p><u>Objective 1.4</u> Partner with schools to strengthen their youth prevention activities such as Students Against Destructive Decisions (SADD) group. <i>Evidence Based</i></p> <p><u>Objective 1.5</u> Conduct <i>Evidence Based (SAMHSA)</i> Responsible Beverage Server Training (TIPS) targeting “carry out” liquor establishments to reduce youth access</p>	<p>By Sept 30, 2014 Sobriety checkpoints will be conducted one time.</p> <p><u>Objective 1.4</u> By Sept 30, 2014 partner with one school in Boone County to strengthen or support youth prevention activities such as SADD.</p> <p><u>Objective 1.5</u> By Sept 30, 2014 conduct TIPS training to reach one business.</p>	<p>Law enforcement ECDHD program staff B Preister</p> <p><u>Objective 1.4</u> ECDHD program staff B Preister</p> <p><u>Objective 1.5</u> TIPS trainers: Zyweic, Black, Gragert, Preister and Jensen.</p>	<p><u>Objective 1.3</u> Grant funding \$ 3,890.00 Boone County Medical Clinic</p> <p><u>Objective 1.4</u> Grant funding \$ 1,750.00 Boone County Medical Clinic</p> <p><u>Objective 1.5</u> Grant funding \$ 3,100.00 Boone County Medical Clinic Region 4 Block Grant \$ 500.00</p>
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Appendix 6. ECDHD District CHIP Plans

<p>2. By June 2015, decrease the percent of 10th and 12th graders who report riding in a vehicle in the past 30 days driven by someone who had been drinking alcohol from 26.7% in 10th graders to _____% and 37.7% in 12th graders to _____%.</p>			<p>HP 2020 SA 1</p> <p><u>Objective 2</u> Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol</p>	<p><u>Objective 2.1</u> Perform the <i>Evidence Based Strategy</i> of compliance checks with collaboration from Boone County Sheriff's Department and Albion Police Department.</p> <p><u>Objective 2.2</u> Implement <i>Evidence Based</i> mass media campaigns focusing on consequences; health, social, and legal, of alcohol impaired driving.</p> <p><u>Objective 2.3</u> Collaborate with law enforcement implement <i>Evidence Based</i> sobriety checkpoints.</p>	<p><u>Objective 2.1</u> By Sept 30, 2014 one check will be performed.</p> <p><u>Objective 2.2</u> By Sept 30, 2014 provide community education through the use of: billboards; print media; Facebook and Back to BASICS website.</p> <p><u>Objective 2.3</u> By Sept 30, 2014 Sobriety checkpoints will be conducted one time.</p>	<p><u>Objective 2.1</u> ECDHD Boone County Law Enforcement</p> <p><u>Objective 2.2</u> ECDHD program staff B. Preister and K. Recek</p> <p><u>Objective 2.3</u> Law enforcement ECDHD program staff B Preister</p>	<p><u>Objective 2.1</u> Grant funding \$</p> <p><u>Objective 2.2</u> Grant funding \$ 6,400.00 Region 4 Block Grant \$ 1,449.00 Region 4 Mini-Grant \$ 250.00 Boone County Medical Center</p> <p><u>Objective 2.3</u> Grant funding \$ 3,890.00 CCH In-kind \$ 2,000.00</p>
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Appendix 6. ECDHD District CHIP Plans

<p>3. Reduce the number of 12th graders in Boone County who report past 30-day alcohol use from 47.5% to 43.5% by July 2015.</p>			<p><u>HP 202 SA 2.1</u> Increase the proportion of at risk adolescents aged 12 to 17 years who, in the past year,</p>	<p><u>Objective 2.4</u> Partner with schools to strengthen their youth prevention activities such as Students Against Destructive Decisions (SADD) group. <i>Evidence Based</i></p> <p><u>Objective 2.5</u> Conduct <i>Evidence Based (SAMHSA)</i> Responsible Beverage Server Training (TIPS) targeting “carry out” liquor establishments to reduce youth access.</p> <p><u>Objective 3.1</u> Partner with schools to strengthen their youth prevention activities such as Students Against Destructive Decisions (SADD) group. <i>Evidence Based</i></p>	<p><u>Objective 2.4</u> By Sept 30, 2014 partner with one school in Boone County to strengthen or support youth prevention activities such as SADD.</p> <p><u>Objective 2.5</u> By Sept 30, 2014 conduct TIPS training to reach six businesses.</p> <p><u>Objective 3.1</u> By Sept 30, 2014 provide community education through the use of: billboards; Facebook and Back to BASICS website.</p>	<p><u>Objective 2.4</u> ECDHD program staff B Preister</p> <p><u>Objective 2.5</u> TIPS trainers: Zyweic, Black, Gragert, Preister and Jensen.</p> <p><u>Objective 3.1</u> ECDHD program staff B Preister</p>	<p><u>Objective 2.4</u> Grant funding \$ 1,750.00 Boone County Medical Clinic</p> <p><u>Objective 2.5</u> Grant funding \$ 3,100.00 Boone County Medical Center Region 4 Block Grant \$ 500.00</p> <p><u>Objective 3.1</u> Grant funding \$ 1,750.00 Boone County Medical Clinic</p>
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Appendix 6. ECDHD District CHIP Plans

<p>I don't think the group can feasibly decrease each year 4% do you? I didn't list each each by 4% but it is their plan and we could do that.</p> <p>4. By Dec. 2015 to provide a safe and secure method for community members to properly dispose of unwanted and unused medications.</p> <p>5. By 2015 Investigate additional community</p>			<p>refrained from using alcohol for the first time</p> <p><u>HP 2020 SA 19</u> Reduce the past-year nonmedical use of prescription drugs</p>	<p><u>Objective 4.1</u> Partner with local law enforcement and community agencies to provide a medicine take back event.</p> <p><u>Objective 4.2</u> Collaborate with local law enforcement to provide a med take back unit in county.</p> <p><u>Objective 5.1</u> Build community interest in preventing youth substance abuse.</p>	<p><u>Objective 4.1</u> By September 2013 provide one take back event in Boone County.</p> <p><u>Objective 4.2</u> By September 2013 purchase a med take back unit and secure location for unit.</p> <p><u>Objective 5.1</u> Four agencies will be approached by April 2013.</p>	<p><u>Objective 4.1</u> ECDHD staff B. Preister Boone County Sheriff's Department</p> <p><u>Objective 4.2</u> ECDHD staff B. Preister Boone County Sheriff's Department</p> <p><u>Objective 5.1</u> ECDHD staff</p>	<p><u>Objective 4.1</u> Grant funds</p> <p><u>Objective 4.2</u> Purchased with grant funds from previous year</p> <p><u>Objective 5.1</u> Grant funds cover time of ECDHD</p>
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Appendix 6. ECDHD District CHIP Plans

<p>resources/teens/agencies to partner on substance abuse prevention and maximize resources with Back to BASICs.</p>			<p><u>Objective 5</u> Increase the proportion of adolescents (and community members) who disapprove of substance abuse</p>	<p><u>Objective 5.2</u> Hold focus group with Boone County youth to determine their views on problem areas as well as activities.</p>	<p><u>Objective 5.2</u> One focus group will be held by April 2013.</p>	<p>B.Preister, Boone County Schools and community <u>Objective 5.2</u> ECDHD staff B. Preister and Boone County Schools</p>	<p>staff <u>Objective 5.2</u> Grant funds cover cost of ECDHD staff time</p>
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CHIP Strategic Planning Grid: Boone County CHIP-- Mental Health

Goal 1: Improve mental health through prevention and by ensuring access to appropriate, quality, mental health services

Current Baseline or Data to support the need for the goal: While Boone County has a mental health therapist the county has no regular psychiatric support services. While the mental health is statistically better than the state of Nebraska as far as percent of population having ten or more days when their mental health was bad 9.7% for district and 10.5% for state, and while the area has a lower suicide mortality rate at 5.1 individuals compared to the state average of 10.5 per 100,000 the district does have a slightly higher rate of self-inflicted injury at 77 per 100,000 compared to 74 per 100,000. Mental health was identified as one of the top three needs in the district in the written survey by 14% of those who took the survey and ranked ninth out of a total of 24 items.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
Boone County will improve the mental health system by December of 2014 by adding at least one service or one new provider in the community.	Boone County Hospital - Gina Baker.	Lack of recourses for mental health from patients.	1. Increase the proportion of adults with mental health disorders who receive treatment. <i>Evidenced Based The USPSTF recommends screening adults for depression when depression care supports are in place.</i>	1.1 Boone County Mental health CHIP group meet on a regular basis (bi-monthly or quarterly) to monitor services and increase communication between Boone County Hospital, Mental Health providers, and ECDHD.	1.1 Group will meet regularly and minutes will be kept of the meetings.	1.1 Boone County Hospital and ECDHD.	
	Local providers.	Lack of dedicated mental health funding sources.		1.2 Add in other community agencies such as law enforcement.	1.2 Ongoing	1.2 Boone County Mental CHIP group.	
	School Authorities	Ms. Baker is not full-time.		1.3 Look for grants or funding sources to look	1.3 Have applied for at least one	1.3 Boone County Mental Health CHIP	
	Resources from distant community mental health providers.	Lack of follow-through					
		No consequences when clients do not follow-through.					

Appendix 6. ECDHD District CHIP Plans

				for community providers. 1.4 Explore ECDHD and Boone County options for BH support.	new funding opportunity by December of 2015. 1.4 December of 2013.	Group 1.4 Boone County Administrator and ECDHD Administrator.	1.4 Vic Lee was going to set up meeting with Medical Staff and R. Rayman was going to explore capacity for ECDHD to go to Boone County to provide support.
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CHIP Strategic Planning Grid: Colfax County CHIP – Childhood Obesity

Goal 1: Promote Healthy Weight and reduce chronic disease risk

Current Baseline or Data to support the need for the goal: 15.4% (look up reference 19) of the youth in ECDHD are overweight.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
<p>HP NWS 10</p> <p>By 2015 reduce childhood obesity by 1% in the district from 15.4% to 14.4%</p>	<p>Alegent Health Weight Management Team</p> <p>Resource Center School Systems</p> <p>ECDHD</p> <p>Renee Sayer/CAPSTONE project</p> <p>Healthy Families in Omaha at One World and Charles Drew</p> <p>Exercise Science PA at Alegent</p> <p>Cargill Volunteers</p> <p>Cargill Learning Center</p> <p>Clarkson Kindergarten Teacher – Wes Pokorny – garden in school; Mr. Harlan Hammernick –</p>	<p>No weight loss program in Colfax</p> <p>Cargill does not have resources</p> <p>Lots of fried foods in cafeterias</p>	<p>NWS-17</p> <p><u>Objective 1</u></p> <p>Reduce consumption of calories from solid fats and added sugars in the population age 2-5 years.</p>	<p><u>Objective 1</u></p> <p>1.1 Incorporate NAP SACC <i>Evidenced Based</i> - into daycare centers in Colfax County.</p>	<p><u>Objective 1</u></p> <p>1.1 By 12/31/2013 we will reach 5 in home daycare providers and 1 centers.</p>	<p><u>Objective 1</u></p> <p>1.1 Kaise Recek with ECDHD.</p>	<p><u>Objective 1</u></p> <p>Funding - In-kind by ECDHD</p>
			<p>PA-6</p> <p><u>Objective 2</u></p> <p>Increase regularly scheduled elementary school recess in the United States</p>	<p><u>Objective 2</u></p> <p>2.1 Talk to schools about more recess.</p> <p>2.2 Assess the level of recess in schools.</p>	<p><u>Objective 2</u></p> <p>2.1 By March 31, 2013 contact at least one school and work out commitments.</p> <p>2.2 By November 2013 assess the level of recess in schools in Colfax County.</p> <p><u>Objective 3</u></p>	<p><u>Objective 2</u></p> <p>2.1 Colfax County CHIP Obesity Prevention Coalition.</p> <p>2.2 Jeanine Emmanuel with Alegent Creighton</p>	<p><u>Objective 2</u></p> <p>3.1 In-kind by ECDHD</p>

Appendix 6. ECDHD District CHIP Plans

	<p>principal FFA teacher and high school students</p> <p>Tori Oehlich – RN with Schuyler Schools NRD (Natural Resources District)</p>		<p>Nebraska State Plan Partners in Health</p> <p><u>Objective 4</u> 4.1. Research and implement Healthy Families at Alegent Creighton</p> <p>HP PA-3 <u>Objective 5</u> Explore with Colfax Community Schools and FFA implementing</p>	<p><u>Objective 3</u> 3.1 Research funding opportunities to impact childhood obesity. Goal is to obtain funding dedicated to Colfax County.</p> <p><u>Objective 4</u> 4.1 Increase proportion of physician offices that refer families to Healthy Families class.</p> <p><u>Objective 5</u> 5.1 Increase fruit and vegetable recognition and consumption in students.</p>	<p>3.1 By October 31, 2012 ECDHD Intern will have completed a list of potential funding opportunities.</p> <p><u>Objective 4</u> 4.1 By Dec. 2013, implement at least one Healthy Families class at Alegent.</p> <p><u>Objective 5</u> 5.1 By November 2013 speak with and secure one teacher to take part in gardens in classrooms.</p>	<p><u>Objective 3</u> 3.1 Ralph Ovonen</p> <p><u>Objective 4</u> 4.1 Renee Sayer</p> <p>Colfax County CHIP Obesity Prevention Coalition.</p> <p><u>Objective 5</u> 5.1 Wes Pokorny</p>	<p>3.2 In-kind by representative agencies.</p> <p><u>Objective 5</u></p> <p><u>Objective 5</u> 5.1</p>
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Appendix 6. ECDHD District CHIP Plans

			<p>fruit and vegetables gardens (in tubs) in schools other than Clarkson.</p> <p><u>Objective 6</u> Reduce the proportion of children and adolescents who are considered obese.</p>	<p><u>Objective 6</u> 6.1 Offer educational material at Schuyler Resource Center.</p>	<p><u>Objective 6</u> 6.1 By Jan 2013 ECDHD will provide Lana the Iguana curricula to the Colfax Community Center for use in daycare centers.</p>	<p><u>Objective 6</u> 6.1 Roberta Miksch</p>	<p><u>Objective 6</u></p>
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CHIP Strategic Planning Grid: Colfax County CHIP—Family Support for Children living in Poverty

Goal 1: To improve the health and well-being of women, infants, children and families.

Current Baseline or Data to support the need for the goal: 1) Available EPSDT Visit Data indicates a low incidence of compliance with well child visits at GNCHC only 28.37% of children age 0-11 completed an EPSDT visit between January 1st, 2012 and September 30th, 2012. 2) Out of home placement in Colfax County averages 3.9 children per month. 3) Schuyler Community Schools Kindergarten readiness exams indicate _____ 4) Early Steps to School Success (ESSS) data indicates _____. 5) CNCS Kindergarten readiness exams indicate _____. 6) Average per capita income for the district is \$21,837 and the state average \$24,568 and National is \$27,041, the median household income is also lower Colfax median income is \$45,919, compared to \$46,892 for the ECDHD district and the NE state at \$47,995. Percent of families in the district living in poverty is 7) Colfax County has 11% of individuals in poverty compared to 8.6% for district.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET COMMENTS PROGRESS
Increase readiness for school from _____% to _____% by December 31, 2012. Reduce out of home placement from the average of 3.9 children per month to 3.5 per month by	Save the Children Child Well Being Healthy Families NE Early Development Network Early Head Start Planning Region Team NAP SACC YFC (Youth For Christ)	Most resources are focused on Schuyler and not on Leigh Clarkson Howells North Colfax County Lack of coordination. No mental health services in Colfax County.	HP <u>Objective 1</u> Increase the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting.	1.1 Establish a baseline for EPSDT at Alegent Health Clinics in Colfax County by December of 2013, present EPSDT data to group every six months. 1.2 Develop or Obtain information sheets for the families of young children (birth to age three) on positive parenting communication that	1.1 By December of 2013, at Alegent clinics. 1.2 By December 2013 information sheets will be available to clinics and/daycares.	1.1 Alegent Health Clinics Electronic Medical Record System. 1.2 Colfax County Support for families group with help from Child Well Being Group.	1.1 GNCHC will provide data to group every six months on EPSDT rates for children 0-11 unable to break-down further easily. 1.2 In the first three years of life there are 10 different EPSDT screenings recommended to include newborn, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months,

Appendix 6. ECDHD District CHIP Plans

<p>December 31, 2015.</p> <p>Increase Well Child Visits in medical clinics from 28% to ____%.</p>	<p>CNCS Kids Program</p> <p>Mothers & Babies</p> <p>Personal Support Svs.</p> <p>PCIT (Parent Child Inter Active Therapy)</p>	<p>No Parenting Classes</p> <p>Need to see what other data is out there</p>		<p>can be distributed at day care centers and physician clinics that serve children from Colfax County</p> <p>1.3 Have clinics in Colfax and at GNCHC agree to provide written linguistically and culturally appropriate social/emotional information or activities at EPSDT visits with all children birth to age 2.</p> <p>1.4 Train ____ people from Colfax County in PIWI which is a part of Pyramid model.</p> <p>1.5 Offer one to two PIWI sessions in Colfax County every year.</p>	<p>1.3 January of 2014 MOUs will be signed and information sheets distributed to at least three sources.</p> <p>1.4 By December 31, 2012. Training will be held and sign-up sheet will show ____ people attended.</p> <p>1.5 By June of 2013 hold at least one 6-8 week PIWI session in Colfax County.</p> <p>1.6 By December of 2015 complete four PIWI sessions in Colfax County.</p>	<p>1.3 Colfax County Support for families group.</p> <p>1.4 Child Well Being Group will provide training resources for both the pyramid model and PIWI.</p> <p>1.5 Participants of Group that signed up for PIWI training.</p>	<p>2 years and 3 years. Need to determine who would pay for information sheets?- Child Well Being Coalition?</p> <p>1.3 May keep track of how many handouts distributed or how many children receive handouts. Be great to get policy changes at daycares or clinics making handing out social-emotional materials</p> <p>1.4 Training for PIWI will help provide the base for the Pyramid Model (evidence-based teaching Practices) that promote children’s social emotional development and are effective in addressing challenging behavior.</p> <p>1.5</p>
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CHIP Strategic Planning Grid: Nance County CHIP – Youth Substance Abuse

Goal 1: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children in grades 6-12.

Current Baseline or Data to support the need for the goal: Data from Community Health Needs Assessment, December 2011. Alcohol was the top perceived risky behavior in the county. Rates of 30 day alcohol use for Nance 10th graders 41.7% while district was 20.6% and state 21%. 12th grade rates for Nance are 34.8%, district 33.4%, state 34.7%. Percent of youth who have driven under the influence in 10th grade Nance County 16.7% while district is 5.3% and state is 5.1%. Youth reporting riding in a car in the past 30 days driven by someone who had been drinking alcohol... Nance County 6th grade results 21.4%, district 23.0% state 19.6%; 10th grade Nance 41.7%, district 26.4%, state 23.3%; 12th grade Nance 56.5%, district 33.5%, state 25.7%. Lifetime tobacco use for Nance 10th graders 66.7%, district 32.7%, state 32.4%; 12th grade Nance 56.5%, district 50%, state 49.3% Hospitalization for alcohol related diseases in Nance was 471, district 446.5 and state 434.8 while tobacco related diseases were 390.2 for Nance, district 277.5 and state 255.5.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE	RESPONSIBILITY	BUDGET COMMENTS/PROGRESS	
By June 2015, increase awareness of youth substance abuse to Nance County through a variety of methods.	Student Opposed to Drugs and Alcohol (SODA) for high school students	Key partners at the table – law enforcement and others.	Educate community on youth substance abuse statistics from recent CHNA of Dec 2011.	<u>Objective 1.1</u> Determine interest level of local law enforcement and schools in collaborating with ECDHD and Nance County regarding reducing substance abuse.	<u>Objective 1.1</u> By Dec. 31, 2012, assessment of interest on collaboration will be made.	<u>Objective 1.1</u> ECDHD staff B. Preister will contact local law enforcement. Amanda will contact schools.	<u>Objective 1.1</u> No funding necessary.	
	Back to BASICS (red ribbon week supplies for instance)	Responsible Beverage Server Training though trainers exist in the four county local health department district.		<u>Objective 1.2</u> Provide a ‘town hall’ event in which the community is invited to hear substance abuse data and to engage public in combating substance abuse.	<u>Objective 1.2</u> By March 2013, one town hall meeting will be conducted to share youth substance abuse data from CHNA with Nance County community members.	<u>Objective 1.2</u> ECDHD program staff B. Preister, Amanda, Abigail, Alicia and Kristie	<u>Objective 1.2</u> No funding needed.	
	Alcoholics Anonymous – every Monday in Genoa	Lack of education for elementary students						
	Probation (Fullerton)	Not sure of services in						
	Law Enforcement – local and state						Region 4 Block Grant \$ 1,449.00 Region 4 Mini-Grant \$ 250.00	

Appendix 6. ECDHD District CHIP Plans

<p>By June 2015, decrease the rate of riding in a vehicle with someone who has been drinking will decrease from 56.5% in 12th graders to 52.5% and from 41.7% in 10th graders to 37.7%.</p> <p>Percent of youth who have driven under the influence will</p>	<p>patrol as well as outside agencies (Columbus Police Department) DARE?</p>	<p>Fullerton (AA, e.g.)</p>	<p>HP 2020 SA <u>Objective 1</u> Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.</p> <p>HP 2020 SA <u>Objective 3</u> Reduce the proportion of</p>	<p><u>Objective 1.3</u> Implement <i>Evidence Based</i> mass media campaigns focusing on consequences; health, social, and legal, of alcohol impaired driving.</p> <p><u>Objective 2.1</u> Implement <i>Evidence Based</i> mass media campaigns focusing on consequences; health, social, and legal, of alcohol impaired driving.</p> <p><u>Objective 2.2</u> Provide education material at three agencies new to the table since the CHIP meeting in Aug 2012.</p> <p><u>Objective 3.1</u> Provide education to the community to increase awareness of</p>	<p><u>Objective 1.3</u> By Sept 30, 2014 provide community education through the use of: billboards; print media, Facebook and Back to BASICS website.</p> <p><u>Objective 2.1</u> By Sept 30, 2014 provide community education through the use of: billboards; Print media; Facebook and Back to BASICS website.</p> <p><u>Objective 2.2</u> By December 31, 2012 display education in three agencies.</p> <p><u>Objective 3.1</u> By Sept 30, 2014 provide community education through the</p>	<p><u>Objective 1.3</u> ECDHD program staff B Preister, Abigail with Genoa Community Hospital</p> <p><u>Objective 2.1</u> ECDHD program staff B. Preister and K. Recek</p> <p><u>Objective 2.2</u> B Preister Kristie</p> <p><u>Objective 3.1</u> ECDHD program staff B Preister</p>	<p><u>Objective 1.3</u> Region 4 Block Grant \$ 1,449.00 Region 4 Mini-Grant \$ 250.00</p> <p><u>Objective 2.1</u> Region 4 Block Grant \$ 1,449.00 Region 4 Mini-Grant \$ 250.00</p> <p><u>Objective 2.2</u> Prevention education material already purchased</p> <p><u>Objective 3.1</u> Grant funds with ECDHD</p>
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Appendix 6. ECDHD District CHIP Plans

<p>decrease from 16.7% in 10th graders to 12.7% in 10th graders and from 13.0% in 12th graders to 9% in 12th graders.</p> <p>Rate of 30 day usage will decrease in 10th grade from 41.7% to 37.7% and from 34.8% in 12th graders to 30.8%.</p>			<p>adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.</p> <p>HP2020 SA4 Increase the proportion of adolescents who perceive great risk associated with substance abuse</p>	<p>substance abuse.</p> <p><u>Objective 4.2</u> Provide education to the community to increase awareness of substance abuse</p>	<p>use of: billboards; print media, Facebook and Back to BASICS website.</p> <p><u>Objective 4.1</u> By Sept 30, 2014 provide community education through the use of: billboards; print media, Facebook and Back to BASICS website.</p>	<p><u>Objective 4.1</u> B Preister</p>	<p><u>Objective 4.1</u> Grant funds with ECDHD</p>
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CHIP Strategic Planning Grid: Nance County CHIP- Lack of Participation in Health Care

Goal 1: To increase the rate of Nance County residents who participate in prevention health care activities.

Current Baseline or Data to support the need for the goal: High rates for hospitalization for asthma; high rates of death due to chronic lung disease; high instances of death due to cancer, high rates of incidence of and deaths due to breast and colorectal cancer. Low percent of residents who receive immunizations for pneumonia.

SUCCESS INDICATOR (SMART)	CURRENT RESOURCES	GAP ANALYSIS	OBJECTIVE	ACTION STEPS	TIME LINE DELIVERABLE	RESPONSIBILITY	BUDGET C COMMENTS PROGRESS
In 2013, increase the number of percent of Nance County residents over 65 years of age immunized for pneumonia from 65.1% to 69%.	Genoa Hospital Fullerton Medical Clinic, Fullerton Long Term Care Transportation is available through Genoa Community Hospital.	Culture of non-prevention among some residents in Nance County. Transportation. Inadequate community communication leading to a lack of knowledge. County with the fewest health professionals. Lack of childcare.	<i>Objective 1</i> Increase the percentage of adults age 65 and over who are vaccinated against pneumococcal disease. <i>HP 2020 IID-13.1</i> <i>Increase the percentage of non-institutionalized adults age 65 and over who are vaccinated against pneumococcal disease.</i>	1.1 Work to increase community awareness about pneumonia and the availability of pneumococcal vaccines by creating a press release at least annually. 1.2 Educate the community in variety of ways about why it is important to get your pneumonia vaccine. 1.2.1 Provide information at Senior toe-nail clinics about pneumococcal vaccines. 1.2.2 Distribute information about pneumococcal vaccines at Fullerton and Genoa Senior Centers to get education information out. 1.2.3 Check for billing	By January 31, yearly a press release will be completed. At least three education sessions completed per year.	Staff at Genoa Community Hospital. Staff at Genoa Community Hospital. Staff at Genoa Community Hospital. Staff at Genoa Community Hospital. Staff at Genoa	Work at having two papers in Nance County run the information as a news story. Staff will keep track of education opportunities. Senior toe-nail clinics are popular events and well attended. Visiting Senior Centers is targeted way to reach those

Appendix 6. ECDHD District CHIP Plans

<p>To increase the community participation</p>			<p><i>Objective 2</i> Increase the access for preventative care services.</p> <p><i>Healthy People 2020</i> AHS-7 <i>Increase the proportion of persons who receive appropriate evidence-based clinical preventive care.</i></p>	<p>regulations for pneumonia shots to see about holding clinics or other mass clinics.</p> <p>2.1 Provide lung age screening to the community at no charge as part of health fair or community preventative screening event.</p> <p>2.2 Provide Free FOBT kits to screen for colon cancer to individuals age 50 years and over.</p> <p>2.3 Provide transportation to Nance County residents to Genoa Memorial Hospital.</p>	<p>By October 31, 2013</p> <p>Between January of 2013 and October of 2014.</p> <p>Ongoing</p>	<p>Community Hospital.</p> <p>GNCHC Nursing Quality Manager who is a Respiratory Therapist in collaboration with ECDHD.</p> <p>Genoa Clinic and Genoa Hospital in collaboration with East Central District Health Department.</p> <p>Abigail</p>	<p>over 65 years.</p> <p>ECDHD will provide lung age at no charge unless clients are charged a fee for screening. Great way to promote discussion about Asthma or Chronic Pulmonary Disease. ECDHD will provide FOBT kits at no charge to the clinic and hospital.</p>
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