2018
Lexington Regional Health Center
Comprehensive
Community Health Needs Assessment

LEXINGTON REGIONAL HEALTH CENTER
Your Community. Your Health. Your Care.

Report prepared by Kim Matthews in collaboration
with Lexington Regional Health Center

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Letter from the desk of Leslie Marsh, Lexington Regional Health Center C. E. O.

Greetings, Community Members.

As part of the Patient Protection and Affordable Care act, Lexington Regional Health Center (LRHC) is exempt from conducting a community health needs assessment (CHNA). Nonetheless, LRHC conducted a very through CHNA. Based on the Two Rivers Public Health Department's 2012 Community Health Improvement Plan, the LHRC CHNA helps us to determine unmet health needs in the community. Good data analysis translates into better patient care and quality service delivery. Since inception in 1976, LHRC's mission has focused on meeting the unique needs of Lexington and our surrounding communities:

> *Our mission is to optimize the health of our patients, and community, through innovation and excellence in care, education and service.*

A robust CHNA helps to identify both the causes of those challenges and the availability of local resources to address them. A systematic, ongoing CHNA process also can strengthen bonds between the community and the hospital, enhance community investment and meaningful support for both the physical campus and the hospital's mission statement, and simultaneously foster increased willingness for future collaboration.

In an environment of fiscal scarcity, it is vitally important to be proactively mindful of how our resources are being utilized. That is why LHRC committed to partnering with the University of Nebraska-Lincoln, other key stakeholders, and the CHNA author, to ensure that we captured the 'voice' of our community. Hospital staff, providers, patients, and community members provided their input. Together, we identified the unique health challenges faced by our diverse rural town.

The primary strength of our CHNA is the use of Social Determinants of Health (SDOH) as the primary framework by which we examined all of our data: focus groups, photovoice images and transcripts, the UNL community health survey, and Robert Woods Foundation's 2017 County Health Rankings data (just to name a few). SDOH are the foundational drivers of overall health (and are explained in more detail in Sections I & II). LRHC understands the importance of these SDOH and is moving away from a disease management model toward community health.

The salient questions are no longer confined to the bricks and mortar, as well as the people who deliver care in that structure. Our new mental model, for example, must consider nutrition, activity, social support networks, emotional health, transportation, economic circumstances, and diverse cultural attitudes towards all aspects of community life.

The issues identified in the CHNA are not new to the LHRC administration and staff. We have a solid history of impacting, and improving, the health of our service area.

Recent focus group efforts initiated by LRHC have identified a set of gaps in the community's current understanding of many aspects of health care. Transcripts reveal a host of potential action areas:

- Respondents noted an inability to navigate the insurance requirements including co-payments, prior-authorization requirements and areas of coverage;
- Respondents have difficulty understanding the pharmaceutical industry from obtaining prescriptions to the role of the pharmacist;
- Respondents described a host of information challenges concerning chronic care management including not understanding the actual disease process or the providers' direct instructions or the role of different layers of the health care system;
- And, respondents with limited income face a daunting gauntlet of direct impediments to receiving the right care at the right time from the right providers.

When systematically developed and implemented, with active engagement by all stakeholders, the CHNA process is a powerful tool to develop partnerships and initiate evidence-based interventions that address prioritized community health needs. These CHNA efforts will drive strategic planning, the recruitment of specialists and other staff, community partnerships, and resource allocation.

As you read our community health narrative, keep in mind that LHRC serves 14% of the primary patients, and 4% of the secondary, of Dawson County. To improve the overall status of the dramatic rural health challenges facing our service area outlined in this report, hospitals in Cozad and Gothenburg also need to reach deeper into their communities to engage our new, and old, residents.

The LHRC community impact includes an 82% reduction in readmissions, as well as a 70% reduction in harm resulting in a cost savings of $206,526. Of the 9.4% of Dawson County residents with diabetes, our staff is managing 28% of these patients. Since July 2017, we have seen a 5% improvement of in A1C management of these folks.

We hope that our CHNA provides you with a clear picture of the community health in Lexington, and the surrounding communities.

If you have any questions, please feel free to reach out to lmarsh@lexhc.org.

Sincerely,

Leslie Marsh

Leslie Marsh
CEO, Lexington Regional Health Center

Introduction

Lexington Regional Health Center: Community Health Needs Assessment

The Lexington Regional Health Center (LHRC) Community Health Needs Assessment (CHNA) was conducted in lieu of the upcoming Two River Public Health Department's (Two Rivers) Community Health Needs Assessment. The new leadership at Two Rivers recently opted to forgo the Mobilizing for Action through Planning and Partnerships (MAPP) collaborative process for a more informal and less time taxing route. Beginning in mid-March, 2018, Two Rivers is holding town halls and focus groups to gather community input across their service area. Two Rivers is not holding any formal planning sessions with the local hospitals in their service area, nor are they conducting any collaborative analysis of the feedback collected. The Two Rivers CHNA will be released in the summer 2018.

Under prior administrations, Two Rivers adhered to a collaborative public health delivery model and partnered with LRHC extensively. In 2011 - 2013, Two Rivers coordinated the MAPP process and published a community health needs assessment (CHNA). LRHC participated in the entire MAPP process with the Two River's staff. The Two Rivers CHNA was then used by LRHC, and the other local hospitals in the district, to assist in strategic planning. Two Rivers has not released another CHNA since that time. Therefore, the LRHC leadership produced this report to provide their team, as well as other regional hospitals, a tool to use for strategic planning and service delivery.

The LHRC CHNA builds on the Two Rivers' 2012 Community Health Improvement Plan that incorporated the MAPP process mentioned above. The LHRC CHNA contains three sections. The first section describes Lexington Regional Health Center's capacity and location in the public health system in Nebraska. Section II paints a portrait of community health in Dawson County and the surrounding areas. The third section is an in-depth discussion of the major health needs of the LRHC service area and provides a closer look at Lexington's unique cultural dynamics. The discussions are put into context through LRHC's extensive efforts to address community health needs through planning, partnership, research, and executing evidence-based programming. The voices from the photovoice project and focus groups bring to life the broad cross section of demographic and public health data.

In April 2017, LRHC began partnering with University of Nebraska – Lincoln Minority Health Disparities Initiative (MHDI) to train their staff in the collection of formal qualitative data. MHDI lead the LRHC work group through an abbreviated needs assessment process to identify the top four community health needs and to conduct focus groups on these issues in their local service area. The LRHC work group defined four health priority areas:

- Chronic Conditions;
- Prenatal Care;

- Mental Health; and
- Workplace Injuries.

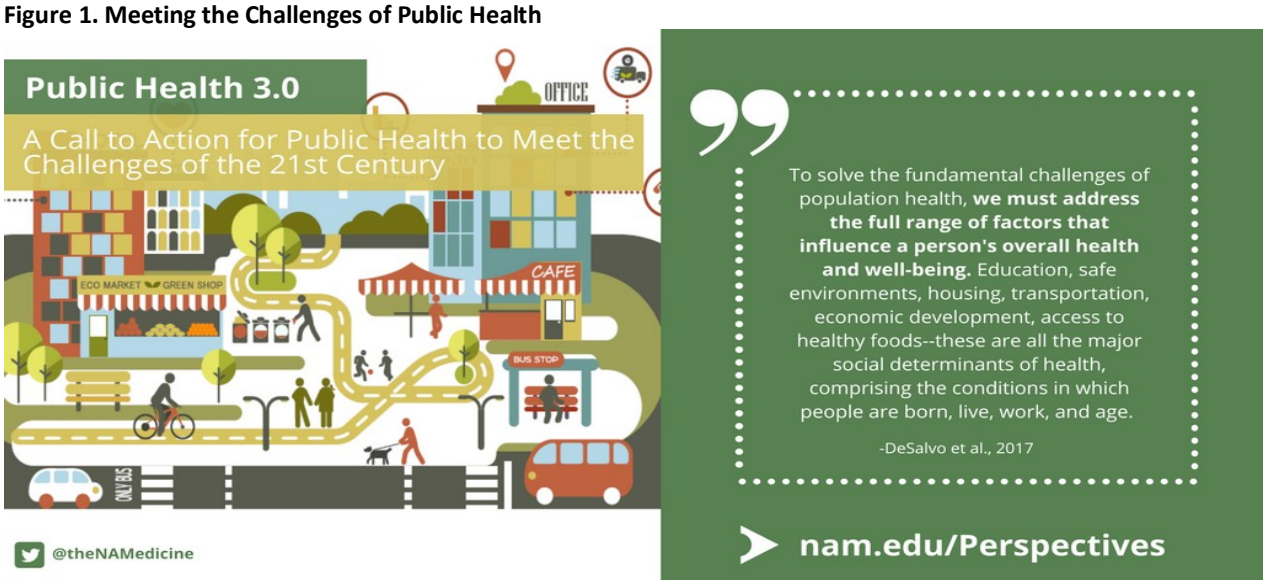
These priority areas align with the community needs revealed in the local public health data analyzed in Sections II & III of this report. The workgroup also defined six common themes that were prevalent across the priority areas:

- access to care,
- economics,
- education,
- health insurance,
- local health care resources, and
- stigma.

These six common themes were expanded during the coding of the focus group transcripts (see Section III). The challenges and successes of the numerous focus groups conducted by hospital staff - across industries, consumers, and language - is discussed in more detail in Section III. The author assembled this assessment of public health and community well-being under the provision of the Lexington Regional Health Center leadership, based largely upon data collected through Social Determinants of Health (SDOH) framework, as well as built upon the Two Rivers' 2012 Community Health Improvement Plan.

Community Health and the Local Public Health System

Figure 1. Meeting the Challenges of Public Health



(Source: National Academy of Medicine)

The national dialogue on community health is recognizing the relationships between an individual's ability to maintain health/well-being and the social determinants of health. Social

Determinants of Health (SDOH) are complex, integrated, and overlapping social structures and economic systems that influence individual and community health, including social and physical environments and health services.[1] Identification of SDOH is rooted in a "social production of health" approach, which precludes simple causal attributions for large health trends such type 2 diabetes, obesity, and other related health conditions.[2] Rather, SDOH research consistently illustrates correlations between population health and various measures of social and economic status, showing that social arrangements account for a considerable fraction of population health[3], and supporting that a person's health depends on their income, food security, housing, employment, ethnicity, safety of their community, and accessibility to health care, among other factors. These issues are of local and global concern, drawing the attention of organizations such World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC).

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education			Quality of care
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

(Source: The Kaiser Family Foundation)

[1] Control C for D, (CDC) P, others. Establishing a holistic framework to reduce inequities in HIV, viral hepatitis, STDs, and tuberculosis in the United States. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control Retrieved from: http://www cdc gov/socialdeterminants. 2010; Burris S. Law in a social determinants strategy: a public health law research perspective. Public health reports. 2011;126(Suppl 3):22–7.

[2] Sharpe TT, Harrison KM, Dean HD. Summary of CDC consultation to address social determinants of health for prevention of disparities in HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis. Public Health Reports. 2010;125(Suppl 4):Marmot M, Friel S, Bell R, Houweling TA, Taylor S, Health C on SD of, et al. Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet. 2008;372(9650):1661–9; Marmot M. Social determinants of health inequalities. The Lancet. 2005;365(9464):1099–104

[3] Sharpe TT, et. al.; Marmot M.

Planning and Partnerships

"Change is something LRHC is not afraid of. In order to be a viable health care facility in the future we need to adapt and find ways to care for our community and area."
Leslie Marsh, LRHC CEO, 2018.

Planning

Building on the Two Rivers' 2012 Community Health Improvement Plan, the LRHC CHNA utilized a similar framework to synthesize and organize data (since the 2011 Two Rivers data collection) as put forth by the four essential building blocks of the MAPP process:

1. *The Community Health Status Assessment* identifies community health and quality of life issues. Questions answered by this assessment include: "How healthy are our residents?" and "What does the health status of our community look like?" The LHRC CHNA contains a comprehensive data collection process. It includes public health data collected by Nebraska DHHS and the Robert Woods Johnson Foundation, as well as data from the Adult Risk Behavior Factors Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS), among other data sources.
2. *The Community Themes and Strengths Assessment* provides a deep understanding of the issues that residents feel is important by answering questions such as: "What is important to our community?" "How is quality of life perceived in our community" and "What assets do we have that can be used to improve community health?" This assessment includes focus groups and the surveying of a small population of Somali residents.
3. *The Forces of Change Assessment* focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This answer such questions as: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?"
4. *The Local Public Health System Assessment* focuses on all of the organizations and entities (or lack thereof) that contribute to the public health. The LPHSA answers questions such as: "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?" This section will provide a more in-depth look at the extensive focus group data and discuss opportunities to address the identified gaps.[4]

[4] The description of the four MAPP assessments was based heavily on that found in East Central District Health Department *Comprehensive Community Health Needs Assessment 2015;* The report was prepared by Schmeekle Research in conjunction with the East Central District Health Department.

(Photo credit: Paul Pack Jr. 2017)

Unlike a traditional MAPP report, these four essential building blocks are not broken out into their own subsection and/or tables. Instead, these questions were asked throughout the data collection process and the results are clear in the comprehensive nature of Section III.

Partnerships

As shown in Section II, LRHC is located in Lexington; a rural agriculture industry town (est. pop. 10K) that has experienced a steep demographic shift in the past two decades. The opening of a corporate meat packing plant began to change the face of Lexington in the late 1980s. Soon after, LRHC began addressing the challenges of providing care to a population that speaks several different languages and holds a myriad of different cultural beliefs about health.

The LRHC staff reflects the diverse face of Lexington. LRHC was one of the first Nebraska rural hospital/clinic to employ a Latino community health worker. Community Health Workers (CHW) are trusted, knowledgeable frontline health personnel who typically come from the communities that they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes.[5]

In 2010, LRHC beginning evolving into an institution that would no longer be defined by its bricks and mortar. On the local level, LRHC partnered with the local community foundation, city and school systems, to launch the Community Fitness Initiative (CFI), a childhood obesity prevention program. Sporting events and outdoor living opportunities embraced an afterschool program that taught kids about making smart food choices. The community garden is now under LRHC management with all staff kicking in to grow fresh produce for the local food pantry. Providers have held sport clinics and been on-site to provide medical care during athletic events. LRHC also sponsors the high school's Impact Program to promote safety of athletes and to prevent concussions. LRHC has hosted several community health fairs in partnership with other public health organizations, as well as high school students who produced campaigns to educate their peers about important health topics.

[5] CHW definition provided by Minnesota Community Health Worker Alliance: http://mnchwalliance.org/who-are-chws/definition/.

On a regional, state, and national level, the LRHC CEO stays on the cutting edge of service delivery by serving on a variety of councils and boards that include (just to name a few):

- Nebraska Hospital Association (District IV Chair/Medicaid Reform Issue Strategy Group/Policy Development Committee/NHA Board Member);
- University of Nebraska Medical Center (Public Health Advisory Council);
- Dawson County Council of Economic Development (President/board member);
- Federal Office of Rural Health's Funded Technical Assistance Service Center;
- Regional Health Equity Council;
- Nebraska State Office of Minority Health;
- National Rural Health Associate (Critical Access Hospital Leadership Team);

LRHC leadership listens closely to the input from their staff. For example, Hispanic and Somali CHWs have worked side-by-side with trained healthcare staff to deliver culturally appropriate educational workshops on diabetes, obesity, prenatal care, and the importance of wellness checks. LRHC staff are also working diligently with the school system to bring more mental health services to students and their families. The CHWs facilitated a Photovoice project amongst Hispanic and Somali community members; the insights garnered from this community endeavor influenced the formation of a patient support group and changed how Somali leadership viewed community organizing on health issues. The Community Health Workers and Interpreters are important members of the LRHC integrated care teams.

LRHC has partnered with Nebraska University researchers, from across campuses, to conduct numerous studies. Their latest endeavors have included testing a cell phone app that provided an additional layer of support to prenatal patients and the conducting of a community health survey of Lexington residents. The innovation of the survey is discussed in more detail in Section II. LRHC also supports and encourages individual providers in their own research interests. One such provider-driven study has lifted a curtain to complexities of the informal health networks that many people employ before engaging in the formal healthcare system.

The LHRA CHNA explores these complex relationships with the communities that they serve while providing a comprehensive portrait of the triumphs and challenges of keeping rural populations healthy.

Section I. Lexington Regional Health Center & Community Health

History

The story of the Lexington hospital goes back to the year 1925, when Mrs. Neva Richards, a practical nurse living in Lexington, established a small hospital in her home. The hospital was enlarged by a small addition within the first two years. This addition was able to accommodate approximately 10 patients. The first caesarean section ever done in Lexington, Nebraska was performed at this hospital in 1927. In 1928, Mrs. Richards closed her hospital, and Miss Julia Prasch and Miss Ann Gelhaar, opened the City General Hospital. They maintained this hospital until 1936, when the Community Hospital was opened.

The Lexington Community Hospital was built in 1936 at a cost of $18,458. Later, a second story was added to the porch at a cost of $1,500. The contents of the original building were valued at $3,599, a part of which was donated. Addison Sutton and L.J. Stewart had the foresight, vision and devotion to complete the hospital. They developed the idea of selling stock to build the hospital and sold 164 shares for $100 each. A loan of $5,000 was used to pay for the remaining balance and was paid off in 1944.

(Photo Credit: Dawson County Historical Society)

The Tri-County Hospital was opened September 1, 1976 with a capacity for 40 beds. The hospital (then valued at $3.3 million) is located on a 14-acre site and is operated by a board whose members were elected from the hospital district which includes eastern Dawson and northern Gosper Counties. The hospital was originally constructed as a single-level, 40-bed hospital with the ability to accommodate up to 80 beds as expansion became necessary. Facilities included a two-bed cardiac care unit/intensive care unit, radiology department, laboratory, respiratory therapy, physical therapy, pharmacy, social services and a hospice program.

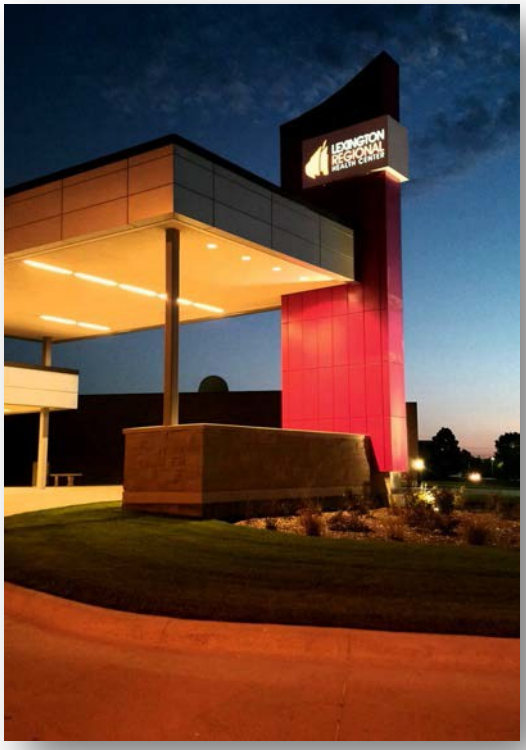
(Photo credits: Paul Pack Jr. 2017)

Tri-County Hospital expanded its services and offerings to the community, becoming much more than a hospital that treated inpatients. Physical therapy, radiology and outpatient services all grew substantially. Tri-County Hospital wasn't representative of the service area; actually, two counties joined together to create their own hospital district. The hospital underwent a name and branding change to reflect these changes and growth and became Lexington Regional Health Center on September 1, 2011. Leslie Marsh, CEO, said the Board of Directors took the lead on selecting the name they felt would better represent how the hospital delivers services. The name Lexington Regional Health Center aptly describes the service area, scope of available services and the philosophy on patient care.

Resource Overview

Since 1976, Lexington Regional Health Center has had the honor to serve the needs of the area and we will continue to do so with the help of our Board of Directors, administration, staff, community partners and patients. Lexington Regional continues to provide high-quality, cost-effective healthcare, offer state-of-the-art technology and recruit healthcare professionals. These advancements will progress the health care opportunities available to those in our community and surrounding areas by providing additional services to ensure everyone has access to superior care close to home.

A strong local hospital is vital to a community's economic well-being, and Lexington Regional is no different. The economic impact continues to increase as new opportunities arise and Lexington Regional continues to make progressive changes in the future. Lexington Regional Health Center is a political subdivision, now 25-bed critical access hospital offering inpatient, outpatient, surgical, emergency and obstetric services. The hospital is operated by a five-member board whose members are elected by the hospital district.



(Photo credits: LHRC, 2017)

Lexington Regional expanded its services with the opening of a walk-in Urgent Care in September 2011 bringing in a high definition television for surgical procedures and offering more minimally invasive procedures. Urgent Care was added to Lexington Regional's array of services so that people would have access to non-emergency medical attention after regular doctors' hours. It also provides a less costly alternative to a typical Emergency Room visit.

In May 2013, Lexington Regional starting offering on-site emergency room coverage 24 hours a day, 7 days per week. Lexington Regional's success is based on its commitment to quality physician leadership allowing physicians to provide evidence-based care in a cost-effective manner. The positive impact has been seen in Lexington Regional's most recent overall ratings of the Emergency Department.

Lexington Regional Health Center decided to embark on a journey to undergo a major renovation and construction project, due to the rapid changes in medical technology and ever-evolving patient expectations. The existing facility was inefficient and insufficient to meet the

community's current and future health needs. Rising health care costs are still a national concern, so the need for cost containment was a major component in deciding the scale and scope of the project.

In order to fund this project, Lexington Regional and the Board of Directors worked diligently to find the best options for the community. To help fund the $25 million project, Lexington Regional was able to partner with a local financial institution, Great Western Bank, and the United States Department of Agriculture's Rural Development Direct Loan Program and utilization of state and federal new market tax credits and funded depreciation to help fund the project. While the hospital district has the statutory taxing authority, it remains committed to not levying any tax as a result of the project. Additionally, hospital charges for patients were not directly increased by this construction and renovation project. The facility renovations will serve as the foundation for community health services in the foreseeable future.

In April of 2014, Lexington Regional Health Center broke ground on the facility's major construction and renovation project. All aspects of the patient and visitor experience were enhanced through a complete transformation of the dining area, renovation of all patient rooms to private rooms and the construction of a new Outpatient Services Center. The Outpatient Services Center includes: 16 exam rooms to serve as a central location for all visiting specialists, three new operating rooms with state-of-the art technology, two endoscopy procedure rooms, nine pre and post operation recovery rooms, four post-surgery rooms, telemedicine capabilities and an expanded and comfortable waiting room for family and friends. The project added an additional 31,000 square feet, with more than 23,000 existing square footage that was renovated. The project also included major upgrades to the mechanical, electrical and air-handling systems. Additionally, the front entrance and main lobby were renovated. These changes allowed the hospital to meet its core mission of providing high- quality, accessible and cost-effective health care.

Across the nation, the health care delivery system is becoming more integrated. Health care providers, private clinics, and hospitals work closely with one another to coordinate care. In July 2014, Lexington Regional Health Center opened Family Medicine Specialists, the hospital-owned clinic, and began employing their own providers to offer primary care for the community. Family Medicine Specialists has since been designated as a Rural Health Clinic. Lexington Regional is also currently engaged in recruitment efforts to secure additional providers. At the time, there were ten full-time providers on staff. Two orthopedic surgeons and an urologist was added to their growing list of visiting specialists.

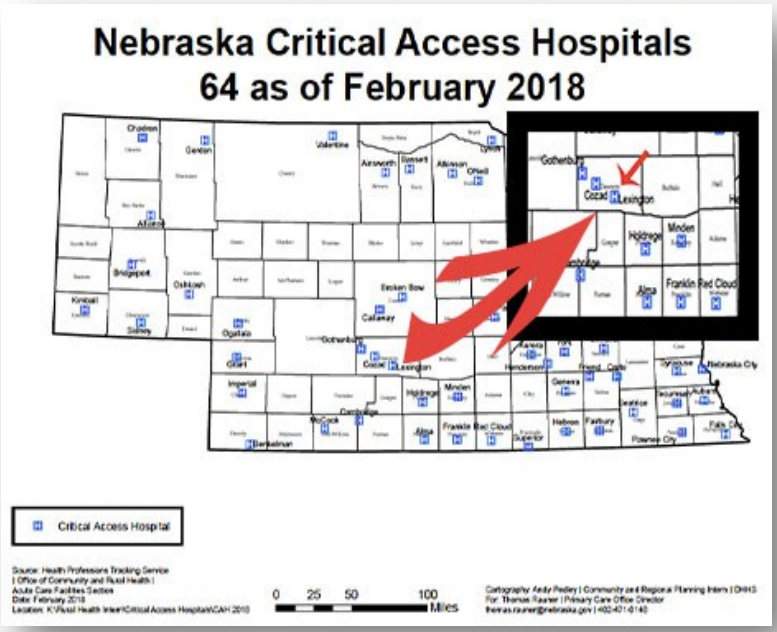
In March 2016, Lexington Regional expanded services to the Elwood community and opened a Rural Health Clinic. Lexington Regional has diligently worked to expand the orthopedic service line, which includes the prestigious Rural Partners of Medicine (RPM). Lexington recruited two orthopedic surgeons, began an orthopedic clinic and is expanding the sports medicine offerings as well. In addition, Lexington Regional has recently recruited an urologist and spine surgeon.

Resource Inventory

Service Area

Lexington Region Health Center (LHRC) has a broad reach across central Nebraska. LHRC targets residents in the counties of Dawson, Phelps, and Gosper. The rural critical access hospital is located in Lexington, the seat of Dawson County. As the demographics in Section II reveal, Lexington is very diverse with a large Hispanic community and a growing Somalian population.

Figure 3. Nebraska Critical Access Hospitals, 2018



(Source: Health Professionals Tracking Services)

Dawson County has three critical access hospitals within a short distance from each other. All of the hospitals are located on the Interstate 80 corridor whereas Phelps and Gosper struggle with service deserts. LHRC has addressed the healthcare shortage by opening a clinic in Elwood (Gosper County) and recently acquiring the Bertrand Clinic (Phelps County). More data on access to health care and shortages of health care professionals is available in Section II & III.

Lexington Regional Health Center serves 14% of the primary market share, and 4% of the secondary, of Dawson County residents in need of health care. The other two critical hospitals in Cozad and Gothenburg are facing the same health disparities discussed in this CHNA.

<u>Cozad Community Hospital</u>

The Cozad Community Hospital (CCH) is part of the Cozad Community Health System. CCH is a general medical and surgical Critical Assess Facility with 20 staffed beds and emergency room services. CCH was built in 1952 and was remodeled most recently from 1995 to 1996. There are five staffed physicians and one nurse practitioner, as part of the total of 130 employees. CCH provides specialists and specialized services (i.e. MRI, etc.) on a rotating/mobile service schedule.

Gothenburg Health

Gothenburg Health (GH) is a Critical Assess Facility with 12 licensed beds/4 nursery beds and emergency room services. GH was built in 1969 and underwent remodeling/updating in 2004, 2011, and 2014 – with final phase to be completed in 2018. The GH staff of 154 employees includes 4 medical staff, an advanced practice nurse, a physician assistance, a general surgeon, and an OB/GYN, as well as twenty courtesy medical staff.

Location of LRHC Core Direct Service Area in the Public Health System

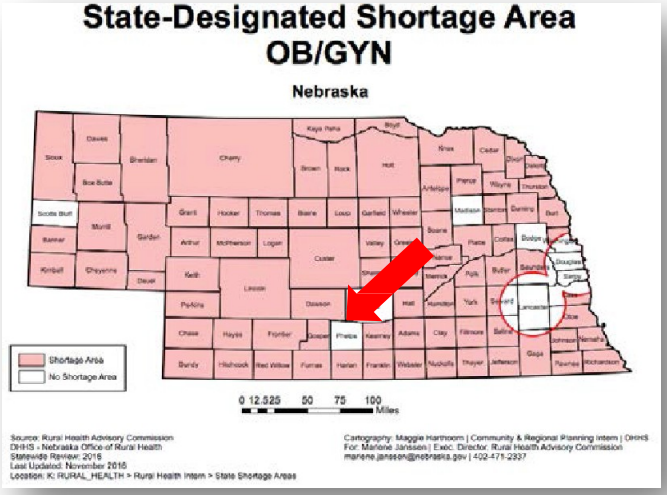
The Lexington Regional Health Center's (LHRC) provides direct services in three rural counties: Dawson, Gosper, and Phelps. LHRC facilities are located in state-designated healthcare shortage areas. All three counties lack adequate psychiatry and mental health services (see Figure 4).

Figure 4. Shortage Area: Psych & Mental Health, 2017

(Source: Rural Health Advisory Commission)

Gosper and Phelps Counties need more family practices to meet their needs. Only Phelps County has an adequate amount of practicing OB/GYN physicians. Therefore, residents of these counties face many barriers to obtaining healthcare such as long wait times for appointments or traveling long distances to see specialists. Many patients simply go without the proper care.

Figure 5. Shortage Area: OB/GYN, 2016



(Source: Rural Health Advisory Commission)

Intercepting state agencies to ensure continuity of patient care is challenging. Dawson and Gosper Counties are in the same state regions for most human services whereas Phelps County is located in a different region (see Figure 6).

Figure 6: State Service Regions, 2018

State Agencies Service Areas	Dawson County	Gosper County	Phelps County
Behavioral Health Regions	Region 2	Region 2	Region 3
Child & Family Services	Western Service Area	Western Service Area	Central Service Area
Healthcare Coalitions	Tri-Cities Medical Response	Tri-Cities Medical Response	Tri-Cities Medical Response
Local Health Department	Two Rivers	Two Rivers	Two Rivers
Nebraska Area Agencies on Aging	West Central NE Area Agency on Aging	West Central NE Area Agency on Aging	South Central NE Area Agency on Aging

(Source: Nebraska Department of Health & Human Services)

Community Focus Areas

The LHRC CHNA builds on the 2012 Community Health Improvement Plan produced by the previous leadership at Two Rivers Public Health Department. In lieu of no other active community organizing to produce the next CHNA, LHRC spearheaded the planning process beginning in mid-2017. At the first meeting, core LHRC leadership (staff & administration) discussed the most community beneficial evaluation framework with a representative from Two Rivers, as well as a consultant (the author) from University of Nebraska-Lincoln's Minority Health Disparities Initiative (MHDI). Two Rivers offered to assist LHRC in the process as they were not ready to commit to producing the CHNA for their service area. The LHRC CHNA Leadership decided to conduct an internal review of their progress addressing the strategic issues identified by the MAPP Process reported in the 2012 Community Improvement Plan.

Two Rivers Public Health Department: 2012 Community Improvement Plan

According to Two Rivers' 2012 Community Improvement Plan Executive Summary (see Appendix B), the Community Health Improvement Plan process (CHIP) for Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney, and Phelps Counties began in October 2011. The first step was the formation of steering committee with local representation from Good Samaritan Hospital, Kearney County Health Services, Lexington Regional Health Center, Phelps Memorial Health Center, and the Two Rivers Public Health Department's Board of the Health and staff. The steering committees chose the Mobilizing for Action through Planning and Partnerships (MAPP) as the framework to complete these four assessments: the Local Public Health System Assessment; Community Themes and Strengths; Force of Change; and Community Health Status.

The steering committees used the following tools to produce the three strategic issues that were forwarded to the Action Groups (from late-2011 to mid-2012):

- Community Themes and Strength Surveys were conducted to better understand issues facing Two Rivers District residents by asking the questions:
    - "What is Import to our community?"
    - "How is the quality of life perceived in our community?"
    - "What assets do we have that can be used to improve community health?
- National Public Health Performance Standards Program (NPHPSP) developed by Centers for Disease Control and Prevention; the assessment finds were used to develop plans for district-wide interagency collaboration (one of three of the strategic issues).
- Forces of Change assessment was completed by the steering committee in the first meeting.
- Supplementary qualitative and quantitative data to enhance the understanding of the assessment results.

The following strategic issues identified: (1) access to care/Mental and Behavioral Health; (1) District Wide Interagency Collaboration; and (3) Life Style Choices and Personal Accountability. See Appendix C: 2012 Community Health Plan for more information.

2018 Community Health Needs Assessment Process

LHRC Leadership Team, in collaboration with MHDI, started the CHNA planning process by defining their service areas as Dawson, Gosper, and Phelps counties – with a special emphasis on the Lexington minority communities. Next, the Leadership Team reviewed the Two Rivers' 2012 Community Health Improvement Plan (see Appendix B), as well as a wide spectrum of qualitative/quantitative data. The Leadership Team decided to refine the Two Rivers' 2012 strategic issues into four target focus areas:

- Chronic Conditions
    - Related 2012 Community Health Improvement strategic issues: Access to Care/District-Wide Interagency Collaboration/Life-Style Choices & Personal Accountability
- Mental Health
    - Related 2012 Community Health Improvement strategic issues: Access to Care/District-Wide Interagency Collaboration/Life-Style Choices & Personal Accountability
- Prenatal Care
    - Related 2012 Community Health Improvement strategic issues: Access to Care/District-Wide Interagency Collaboration/Life-Style Choices & Personal Accountability
- Workplace Injuries
    - Related 2012 Community Health Improvement strategic issues: Access to Care/District-Wide Interagency Collaboration/Life-Style Choices & Personal Accountability

The LHRC Leadership Team then conducted an internal audit of the four target focus areas. The internal audit used the three strategic issues areas identified in the Two Rivers' report as the framework for analysis.

Internal Service Audit: Lexington Regional Health Center

Overall, LHRC had established an 82% reduction in readmissions, as well as a 70% reduction in harm resulting in a cost savings of $206,526. The internal service audit also found that LHRC has had successfully impacted all three strategic issues from the 2012 Community Health Improvement Plan as follows:

Chronic Conditions

Of the 9.4% of Dawson County residents with diabetes, our staff is managing 28% of this population. Since July 2017, we have seen a 5% improvement of in A1C management in our patients.

The LHRC developed the Medically Managed Program (MMP). MMP is designed to provide our chronic disease patients with the tools to manage all aspects their health condition. Patients are referred to the LHRC MMP by their primary care provider. Patients are then screened to determine if they qualify for the program. Qualification is based on specific evidence-based inclusion criteria. The specific chronic disease groups incorporated into the MMP includes: cardiac health, lung health, smoking cessation, neuro health, diabetes health, chronic pain, cancer health, weight management and fall risk (general aging). Inclusion criteria targets the most common chronic diseases affecting populations nationally as well as locally. Individuals are able to qualify for multiple disease groups based on their screening results.

The strategy of the MMP is designed to focus on optimizing each individual's 'well-being'. In order to achieve program goals for each patient, the LHRC medical team focuses on all components of patient care including: physical, mental, emotional and social aspects. The LHRC MMP uses medical and evidence-based practices and each treatment plan is customized to meet every patient's individual needs. Patients regularly engage with medical professionals from across the LHRC campus. Each patient/medical professional encounter emphasizes accountability and incorporates outcomes measures.

Mental Health

The LHRC mental health staff provide health services from diagnosis to treatment. LHRC has mental health professionals available to patients through our outpatient clinics, as well as consults are available in both Emergency Room and Inpatient settings. A certified Psychiatric Nurse Practitioner provides medication management for LHRC patients with mental health conditions. LRHC has three licensed staff members facilitating individual, couple, and family counseling using evidence-based practices. A wide range of patients are served from youth to elderly. Common practice areas include depression, anxiety, schizophrenia, post-traumatic stress disorder (PTSD), mood/bipolar disorders, and attention deficit hyperactivity disorder/Oppositional Defiant Disorder (ADHD/ODD), as well as life changes and pre/post adoption counseling.

Prenatal Care

The treatment plan for prenatal care at Lexington Regional Health Center works with expecting mothers throughout their pregnancy and delivery. The treatment plans consist of: (a) regularly scheduled provider visits, (b) education through the hospital, and (c) community outreach.

Provider Visits

We encourage patients to see a provider throughout their pregnancy starting in the first trimester and increase frequency of visits until delivery. Our two medical doctors, physician assistant and six nurse practitioners provide the patient with comprehensive prenatal care until week 36. At that time, the patient starts to meet with our doctors only. Patients with high risk pregnancies are scheduled with the visiting OB/GYN specialist practices. Our OB/GYN specialist serves in our clinic once a week. Our treatment plan provides optimal care to the mothers delivering at LRHC. Every two weeks, our doctors rotate being on-call to deliver babies, as well as tend to any issues that may surface for expecting moms. Throughout their term, our patients are provided tours of the delivery rooms and kept up-to-date with other available resources.

Other Available LHRC Resources

We have full-time interpreters who speak Spanish, Somali, and Arabic, as well as a computerized interpreter service that speaks several different language and dialects. We have a Spanish community health worker that provides supportive care, during the pregnancy and postpartum.

The LRHC social workers are available to assess needs upon provider referral.

A certified lactation consultant facilitates group classes for all expecting mothers prior to delivery. Classes are also available in Spanish, as well as interpreter services are provided as needed. Our consultants also meet with the expecting mothers in the hospital and post-delivery, as needed.

The hospital holds childbirth classes every 2nd and 4th Thursday of the month from 4-7pm. These classes are available one-on-one or small group. These classes are offered in Spanish, Somali and English. The childbirth course instructors have a bachelor's degree nursing and are currently working towards becoming certified childbirth educators. The instructors may also very well be our patients' labor and/or post-partum nurse.

Workplace Injuries

Workplace injury care is provided through the standard services provided by the clinic, hospital, and physical therapy departments. The LHRC staff also works hard to maintain strong state-wide interagency collaborations to ensure patients receive the best care possible.

LHRC Staff Driven Focus Groups

The internal audit revealed that LHRC was improving their health care delivery system and that was having a positive impact on their patients. Yet, the LHRC Leadership Team duly noted that there were still important issues that needed to be addressed. The LHRC Leadership Team opted to conduct focus groups for more insight into three strategic areas. The LHRC Leadership Team reached out for technical assistance from University of Nebraska-Lincoln's Minority Health Disparities Initiative (MHDI). Over the course of four meetings, MHDI facilitated the process of identifying/recruiting focus group participants, creating the focus group questionnaires, and training LHRC staff members to conduct the focus groups in Lexington.

To create the focus group questions, the LHRC Leadership Team established Expert Action Teams to create a set of questions for these four focus areas. The Expert Action Team recruited and utilized the expertise of the LHRC staff, as well as community collaborators. Each Expert Action Team was assigned one of the following four focus areas:

- Chronic Conditions,
- Mental Health,
- Prenatal Care,
- and Workplace Injuries.

The Expert Action Team brought their set of questions back to the table. Facilitated by MHDI, the Leadership Team identified common themes across the four sets of questions. Collaboratively, the Team revised the questionnaires to be consistent across all four focus areas. All focus group questions were developed within LHRC and no outside survey tools inspired the final questionnaires.

LHRC staff successfully recruited a wide variety of participants: (a) who access the healthcare system (workplace injury, prenatal care, and chronic conditions); (b) healthcare providers/administrators; and (c) community health stakeholders. The survey included a diverse representation that reflected the community's demographics (Caucasian, Somali, and

Hispanic). Section III provides a comprehensive discussion of these four areas, as well as how LHRC is currently addressing the challenges. See Appendix A for more information, including the data analysis of the focus group transcripts.

LHRC/MHDI Collaboration: Community Health Survey

There are no community health data resources specific to Lexington, Nebraska. All available community health data is at county level. Community demographics in Lexington, a very diverse community, are much different than those found in Cozad and Gothenburg (90% or higher Caucasian populations). Thus, a community health survey in Lexington was needed to better understand the issues and challenges facing Lexington residents. Lexington Regional Health Center (LHRC) partnered with MHDI to conduct such a survey.

With the financial support of the Rural Futures Institute, MHDI put together an interdisciplinary research team to develop the questionnaire. Researchers came together from Sociology, Communications, Public Health, and Family/Children with specializations in refugee/immigrants (migration), trust, and epidemiology. The community health survey questionnaire adapted measurements from the National Health Interview Survey, acculturation scales, and immigrant trauma/trust tools. The questionnaire was heavily influenced by the Photovoice project and MHDI over two-year relationship with the Lexington community.

LHRC/MHDI conducted a cross-sectional survey of 325 adult Lexington residents (19 years or older) using respondent-driven sampling (RDS). RDS is an enhanced, peer-referral sampling strategy designed for hard-to-reach populations. It has been widely adopted by both the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) for prevalence and population estimation. RDS works by providing incentives to survey participants so as to recruit eligible members from their own social networks. LHRC community health workers teamed with the MHDI research team to recruit and administer 325 surveys. Surprising, the survey goal of 325 participants was completed within 10 hectic days. The questionnaire had 140 questions on demographics, attitudes, knowledge, trust, community/personal health, stress and self-care. The interviewers used laptops to administer the survey. The administration sites were rotated between LHRC, the Somali Community Center, and a Hispanic church.

LHRC/MHDI Collaboration: Looking Past Skin

The success of the survey is partly due to the Photovoice project conducted prior to the survey. LHRC community health workers and interpreters recruited community members to tell their stories through photos. LHRC community health workers and interpreters were trained in facilitating the Photovoice process. Community members for the Latino and Somali community worked together for 10 weeks contributing their images and stories. Many of the participants sought other community members for their stories. Therefore, by the time that the community health survey was conducted, many community members were already aware of upcoming

research opportunity. See Appendix D for more information about the project and the resulting art exhibits.

(Photo Credit: Shukri, 2017)

(Photo Credit: M. & E., 2017)

(Photo Credit: Maria, 20 7)

Section II. Demographic and Public Health Data

Service Area Snapshot

This report is comprised of a wide range of data including LHRC driven surveys conducted to better understand Lexington. Most available community health data is reported at county level or by public health department service area. The focus of the CHNA is on Lexington and Dawson County, with information on Gosper and Phelps Counties when available and/or pertinent. Lexington is very diverse. Therefore, more dialogue and resources are needed to better service these populations.

Demographics

Lexington, Nebraska is considered a rural community, and is located in the central part of the state, in Dawson County. According to the United States Census Bureau population estimates, Lexington's population as of July 1, 2016 was 10,004. Lexington has seen an influx of minority populations throughout the past two decades, which included significant immigrant and refugee populations such as the Somali, Central Americans, and Karen. Schuyler is the only community in Nebraska to see a demographic flip in their population; it is located about 167 miles northeast of Lexington. Phelps and Gosper Counties are predominantly white communities that reflect the demographic composition of the majority of other rural counties across the State.

Figure 7. Racial and Ethnic Demographics, 2017

U.S. Census Data	Dawson County	Gosper County	Phelps County	Nebraska	Lexington, NE
White Alone, percent	90.2%	97.1%	97.4%	88.9%	81.1%
Black or African American Alone, percent	5.3%	0.8%	0.4%	5.0%	10.8%
Asian Alone, percent	1.1%	0.4%	0.4%	2.5%	1.3%
Native Hawaiian and Other Pacific Islander Alone, percent	0.2%	0.0%	0.0%	0.1%	0.0%
Two or More Races, percent	1.2%	1.4%	1.0%	2.1%	1.0%
Hispanic or Latino, percent	33.0%	5.4%	5.6%	10.7%	61.4%
White Alone, not Hispanic or Latino, percent	60.1%	91.8%	92.4%	79.6%	27.3%

(Source: U.S. Census)

Social Determinants of Health

Social Determinants of Health (SDOH) is the primary of the frameworks of analysis used by LHRC to be understand the community health needs of our service area. SDOH are complex, integrated, and overlapping social structures and economic systems that influence individual and community health, including the condition of social/physical environments and the availability/affordability of health services. [1] Understanding the impact of SDOH is rooted in a "social production of health" approach, which precludes simple causal attributions for large health trends such type 2 diabetes and obesity.[2] Digging deeper, SDOH research consistently illustrates correlations between population health and various measures of social and economic status, showing that social arrangements account for a considerable fraction of population health,[3] and supporting that a person's health depends on their income, food security, housing, employment, ethnicity, safety of their community, and accessibility to health care, among other factors. These issues are of global concern, drawing the attention of international organizations such as World Health Organization (WHO)[4], as well as domestic agencies like Centers for Disease Control and Prevention (CDC).[5]

A growing body of literature substantiates broadening our future investigations beyond the SDOH directive into 'informal systems of health care', i.e. how people take care of themselves before engaging the health care system; communities disadvantaged by multiple SDOH tend to take their health into their own hands by developing informal systems of health care. The scholarship confirms our rural stakeholders' suspicions: many Latino communities in the United States have sophisticated informal systems of health care.[6] Unfortunately, the bulk of discussion on informal health systems emerges from scholars working in developing countries such as India and Africa (where unlicensed practitioners account for up to 60% of rural health care).[7] A glaring omission in the current public health literature is the lack of systematic research on the informal systems of health care established by communities disadvantaged due to rapidly changing social conditions in industrialized nations. In later 2018, LHRC will engage in

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[1] The Centers for Disease Control and Prevention, (CDC) P, others. Establishing a holistic framework to reduce inequities in HIV, viral hepatitis, STDs, and tuberculosis in the United States. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control Retrieved from: http://www cdc gov/socialdeterminants. 2010; Burris S. Law in a social determinants strategy: a public health law research perspective. Public health reports. 2011;126(Suppl 3):22–7.

[2] Sharpe TT, Harrison KM, Dean HD. Summary of CDC consultation to address social determinants of health for prevention of disparities in HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis. Public Health Reports. 2010;125(Suppl 4):11–5; Marmot M, Friel S, Bell R, Houweling TA, Taylor S, Health C on SD of, et al. Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet. 2008;372(9650):1661–9; Marmot M. Social determinants of health inequalities. The Lancet. 2005;365(9464):1099–104.

[3] Sharpe, TT et. al.; Marmot, M.

[4] Marmot, M. et. al.

[5] CDC

[6] Brown SA, Garcia AA, Kouzekanani K, Hanis CL. Culturally competent diabetes self-management education for Mexican Americans the starr county border health initiative. Diabetes care. 2002;25(2):259–68; McGlade MS, Saha S, Dahlstrom ME. The Latina paradox: an opportunity for restructuring prenatal care delivery. American Journal of Public Health. 2004;94(12):2062–5; Tafur MM, Crowe TK, Torres E. A review of curanderismo and healing practices among Mexicans and Mexican Americans. Occupational Therapy International. 2009;16(1):82–8.

[7] Peters DH, Garg A, Bloom G, Walker DG, Brieger WR, Hafizur Rahman M. Poverty and access to health care in developing countries. Annals of the New York Academy of Sciences. 2008;1136(1):161–71; Rifat M, Rusen ID, Islam MA, Enarson DA, Ahmed F, Ahmed SM, et al. Why are tuberculosis patients not treated earlier? A study of informal health practitioners in Bangladesh. The International Journal of Tuberculosis and Lung Disease. 2011;15(5):647–51; Sudhinaraset M, Ingram M, Lofthouse HK, Montagu D. What is the role of informal healthcare providers in developing countries? A systematic review. PloS one. 2013;8(2):e54978

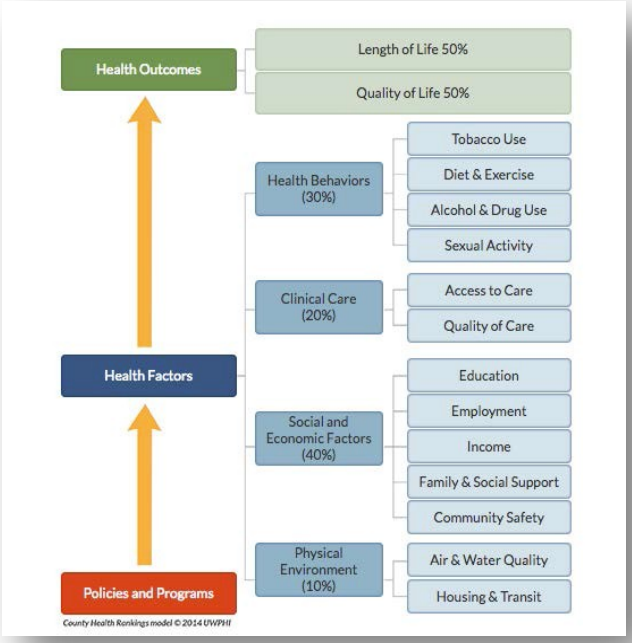
transdisciplinary collaborations to better understand the interrelationships between SDOH and informal systems of health care in rural communities with diverse populations.

County Health Rankings

In the Robert Woods Foundation's County Health Rankings & Roadmaps (2017), Dawson County ranks near the bottom of all counties in Nebraska (#64 out of 78 ranked counties) for health outcomes and drops down the list even further for health factors (#72 out of 78 ranked counties). Gosper and Phelps Counties rank much higher than Dawson County. Gosper County ranks #39 out of 78 ranked counties in health outcomes and #20 out of 78 ranked counties in health factors. Phelps County ranks near the top of the list: #15 out of 78 ranked counties in health outcomes, and #7 out of 78 ranked counties in health outcomes. (For more information, see Section III, Subsection – County Rankings: Health Outcomes & Factors.)

The purpose of Robert Woods Johnson Foundation's County Health Rankings & Roadmaps, 2017, is to help make communities healthier places to live, learn, work and play. The Rankings are based on a model of population health that emphasizes that many factors contribute to the health of any one person in a community (see Figure 8). In the case of the LHRC service area, the health outcomes and factors of Dawson County are ranked as dire compared to its neighboring counties. Yet, a review of the data found in Section II will also show that Dawson, Gosper, and Phelps Counties have a lot more in common than these rankings reveal.

Figure 8. County Health Rankings Model, 2014



(Source: Robert Woods Johnson Foundation)

Economic Stability

Dawson, Gosper and Phelps Counties are rural counties located in central Nebraska. All three counties depend on agriculture business. Several large employers are housed in Lexington (Dawson County); these employers include Tyson Fresh Meats, Orthman Manufacturing and Walmart. Gosper County has experienced population declines since that turn of the 20th century, whereas Dawson and Phelps counties are still experiencing benchmarks of growth. Dawson County experienced a 22.2% growth spurt at beginning of the 21st century (U.S. Census). Since 2010, all three counties have experienced population loss while the state of Nebraska grew by 5.1% (see Figure 9).

Figure 9. Population & Population Changes, 2017 estimate

U.S. Census Data	Dawson County	Gosper County	Phelps County	Nebraska
Population (2017 estimate)	23,709	2,028	9,060	1,920,076
% of Pop. Change since 2010	-2.5%	-0.8%	-1.4%	5.1%
Pop. Per Square Mile (2017 est.)	-2.5%	-0.8%	-1.4%	5.1%

(Source: U.S. Census)

Median household income and the average per capital income is about $10K less in Lexington than the rest of Nebraska. Lexington's median household income and average per capita income is approximately $5K less than its resident county of Dawson. Median household income in Dawson and Phelps Counties are approximately 9% less than the State, whereas Gosper County median household income is 12% higher. Dawson County's average per capita income is 8% lower than the state. Lexington's poverty rate is 7.7% higher than the rest of the county and 9% higher than the State. Dawson County is experiencing a poverty rate equal to the State, whereas both Phelps and Gosper counties are about 3% lower (see Figure 10).

U.S. Census Data	Dawson County	Gosper County	Phelps County	Nebraska	Lexington, NE
Median Household Income (in 2016 dollars), 2012 - 2016	$49,943.00	$60,711.00	$51,264.00	$54,384.00	$44,834.00
Average Per Capita Income in past 12 months (in 2016 dollars), 2012 - 2016	$24,042.00	$29,393.00	$27,882.00	$28,596.00	$18,296.00
Persons in poverty, percent	12.7%	9.8%	9.2%	11.4%	20.4%

(Source: U.S. Census)

According to the U.S. Census, despite higher poverty and lower income rates, Lexington employs 6% more labor force than the State average of 69.7%. More people (16 years+) in Dawson (71.1%) and Gosper (72%) counties are working then the State average (69.7%) whereas Phelps County has 3.9% less civilians in the workforce. For the most part, the distribution of firm ownership reflects that found in the rest of the state. Minority-owned firms

are underrepresented in the LHRC service area. Lexington houses 86% of the minority-owned firms identified in Dawson County (see Figure 11).

Figure 11. Labor Force & Firms, 2012-2016

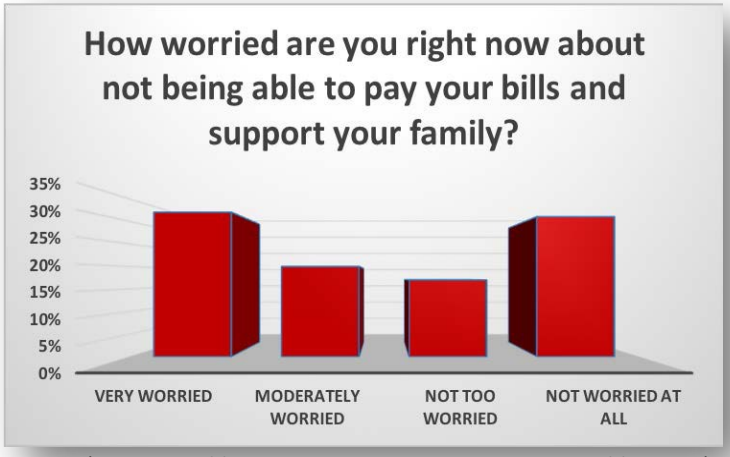
U.S. Census Data	Dawson County	Gosper County	Phelps County	Nebraska	Lexington, NE
In Civilian Labor Force, total, percent of population age 16 years+, 2012 - 2016	71.1%	72.0%	65.8%	69.7%	75.7%
All Firms, 2012	1,894	254	866	164,089	644
Men-owned Firms, 2012	969	117	419	83,696	297
Women-owned Firms, 2012	503	68	275	51,936	221
Minority-owned Firms, 2012	161	NA	NA	14,571	139
Nonminority-owned Firms, 2012	1,650	245	811	144,122	450

(Source: U.S. Census)

HealthVoiceVision Lexington Community Health Survey

Most of the 300+ Lexington residents who completed the Survey are very to moderately worried about paying the cost of living (see Figures 12).

Figure 12. Worried About Bills, 2017

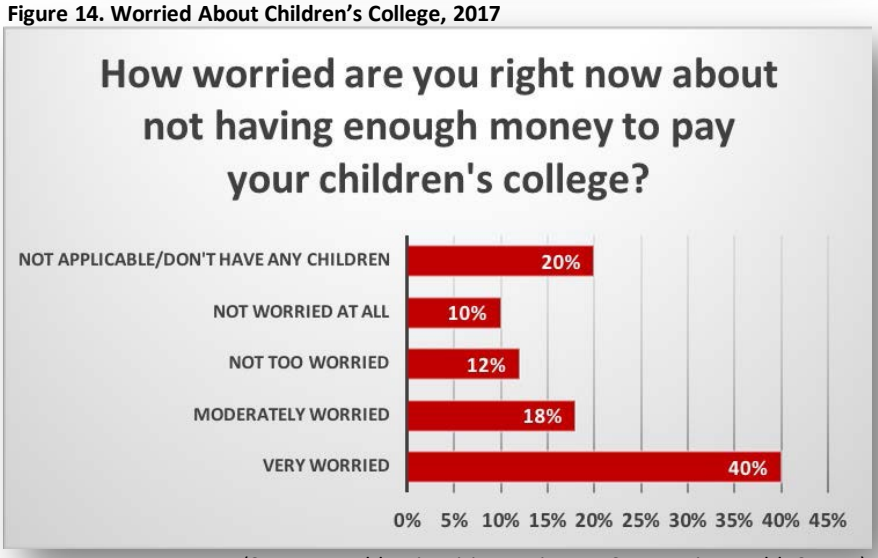


(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 13. Worried About Normal Monthly Bills, 2017

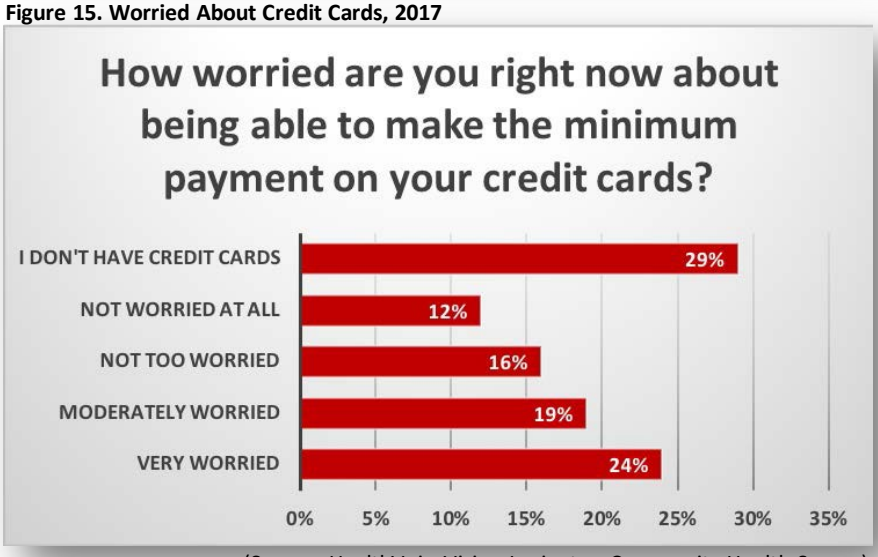
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 14. Worried About Children's College, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 15. Worried About Credit Cards, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 16. Worried About Serious illness, 2017

(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 17. Worried About Housing Costs, 2017

(Source: HealthVoiceVision Lexington Community Health Survey)

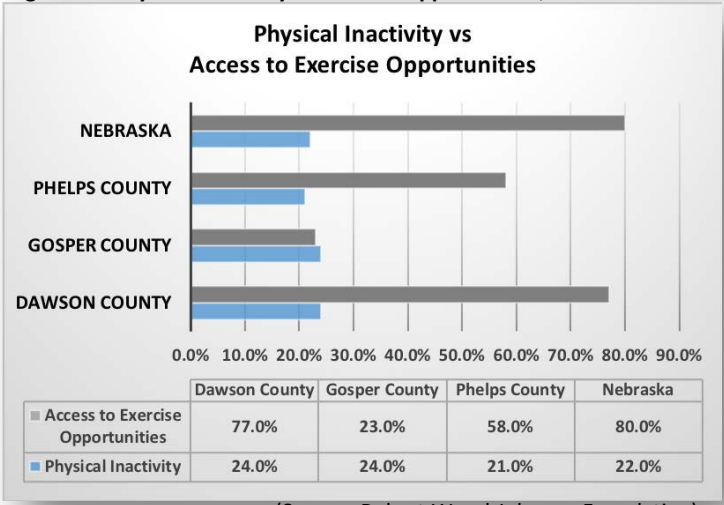
Neighborhood and Physical Environment

Dawson, Phelps and Gosper Counties are located in Central Nebraska. The winters are colder than the United States average while the summers hot and humid. According to Sperling's Best Places, Dawson County scores 40 out of 100, where a higher score indicates a more comfortable year-around climate. Lexington is the seat of Dawson County. Lexington has limited walkability and the town is split by a heavily used set of train tracks. There is no public transportation. According to Dawson Area Development, the County has high air quality (93.4 out of 100), but relatively low water quality (40 out of 100). Dawson, Gosper and Phelps counties consist of prairies that are relatively flat, dry land, which serves well for industrial development, as well as crop and livestock production.

Figure 18. Physical Environment Rankings, 2018

A Robert Woods Foundation Project: County Health Rankings & Roadmaps - 2018				
	Nebraska	Dawson County	Gosper County	Phelps County
Physical Environment Ranking		32 out of 78	8 out of 78	16 out of 78
Air Pollution - particulate matter	8.2	7.8	7.6	8
Drinking water violations	NA	No	No	No
Severe housing problems	13%	15%	3%	7%
Driving alone to work	81%	75%	80%	81%
Long commute - driving alone	18%	16%	21%	14%

Figure 19. Physical Inactivity & Exercise Opportunities, 2018



	Dawson County	Gosper County	Phelps County	Nebraska
Access to Exercise Opportunities	77.0%	23.0%	58.0%	80.0%
Physical Inactivity	24.0%	24.0%	21.0%	22.0%

(Source: Robert Wood Johnson Foundation)

Housing

According Dawson County Nebraska Housing Study (2014), the adjusted housing vacancy rate for the Dawson County Are Communities, total, is an estimated 4.2 percent, which includes an adjusted owner housing vacancy rate of 3.2 percent and adjusted rental housing vacancy rate of 6 percent. The Housing Study concluded that Dawson County Area has a major owner housing vacancy deficiency and a slight renter housing vacancy deficiency. An Adjusted Housing Vacancy Rate includes only vacant units that are available for rent or purchase, meeting current housing code and having modern amenities. Lexington is experiencing a housing "vacancy deficiency" with an estimated 2.4 percent adjusted rental housing vacancy and 1.5 percent adjusted owner housing vacancy rate. Rentals are turning over quickly which creates a high demand for additional rental units. The report recommends developing a total of 248 owner

and 170 housing units by 2019. Also, there are little or no temporary housing/emergency shelters that exit in Dawson County. The Workforce Housing Needs Survey also identified the following issues:

- Of the 249 homeowners and 61 renters how took the survey, 58 participants were not satisfied with their current housing situation; reasons included their home being too small, in need of substantial updating and being too far from their place of employment.
- Some of the barriers identified when obtaining affordable owner housing are:
    - Costs of utilities
    - Real estate taxes
    - Excessive housing prices
    - Homeowners insurance
    - A lack of sufficient homes for sale.
- The most common barriers when obtaining affordable rental housing are:
    - High cost of rent and utilities
    - A lack of decent rental units at an affordable price range.

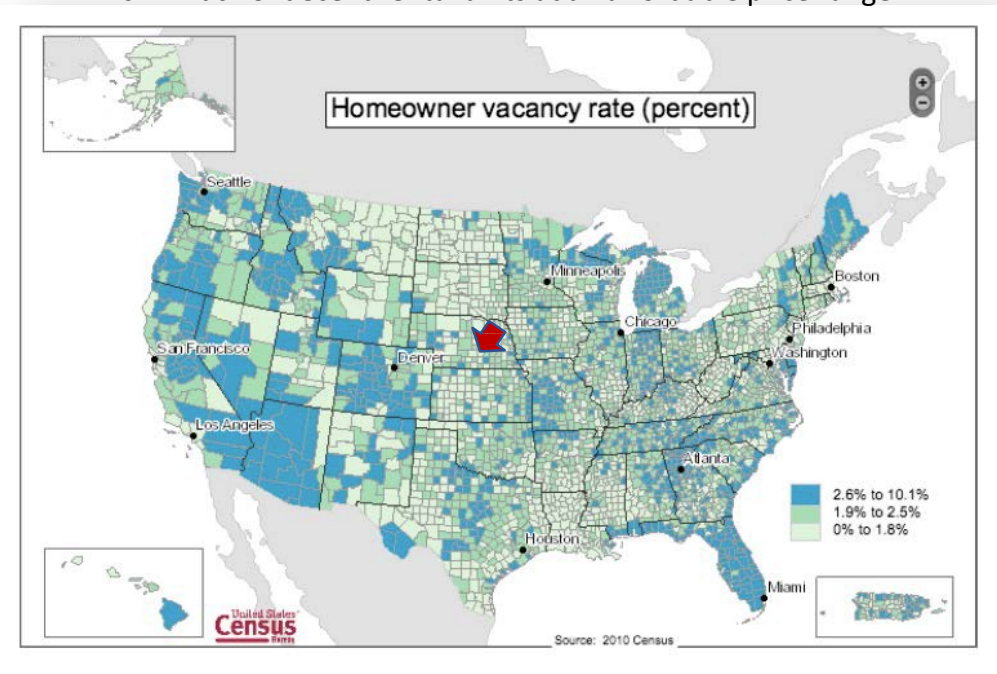


Figure 20. Homeowner Vacancy Rate, 2010 (Source: U.S. Census)

The Housing Structural Condition Survey for Dawson County identified 437 total housing structures in "poor" or "salvage" condition, and 1506 structures in "fair". Several participants at Lexington 'Listening Sessions', hosted by Study authors, cited overcrowding in existing rental units. During the PhotoVoice (PV) sessions facilitated by the CHNA author, many of PV participants cited overcrowding due a lack of affordable rental housing, as well as a reluctance by some landlords to rent immigrants/refugees. Due to the lack and variety of available housing

types, several people employed in Dawson County choose to live in other towns, such as Kearney and North Platte.

Education

Lexington High School (LHS) students come from 32 nations and speak 20 languages. LHS student body population: 76% of students live in poverty, 18% are English Language Learners, 21% are 1st generation immigrants or refuges, and 13% are homeless. Yet, LHS has high attendance (95%) and many students graduate on time (91%). However, rapidly changing demographics represent a particular stress on rural communities' infrastructures. Lexington residents are more likely to be foreign born (36.9%/6.3% NE), speak English as a second language (67.6%/10.5% NE), and have poor education backgrounds (high school diplomas: 55.2%/90.7% NE) than in the rest of Dawson County, as well as Gosper and Phelps counties.

Figure 21. Percentage of Diplomas & Degrees, 2012-2016

U.S. Census Data 2012 - 2016	Nebraska	Dawson County	Gosper County	Phelps County	Lexington
High school graduate or higher, percentage of persons age 25 years+	90.7%	75.9%	93.1%	93.1%	55.2%
Bachelor's degrees or higher, percent of persons age 25 years+	30.0%	15.2%	20.9%	23.3%	8.4%

(Source: U.S. Census)

High school graduates (26 years+) in Gosper and Phelps Counties (93.1%) is slightly higher than State average, whereas Dawson County is 14.8% lower (see Figure 21). There are 20.7% less High school graduates (26 years+) in Lexington than the rest of Dawson County. Lexington lags behind the state by a staggering 35.5%. Compared to the rest of Nebraska, all three counties have less residents, 26 years or older, with bachelor's degrees or higher. Lexington has 21.6% less residents (26 years+) with a higher education than the State. The active resumes in the Nebraska workforce system shows an even larger education gap (see Figure 22) between Dawson County and the state of Nebraska than represented by the U.S. Census data.

Figure 22. Dawson County: Ranking of Education Level, 2017

Rank	Minimum Education Level	Potential Candidates	Percentage
1	Less than High School	8,090	40.72%
2	High School Diploma or Equivalent	4,038	20.33%
3	1 to 3 Years at College or a Technical or Vocational School	5,107	25.71%
4	Vocational School Certificate	390	1.96%
5	Associate Degree	761	3.83%
6	Bachelor's Degree	1,154	5.81%
7	Master's Degree	264	1.33%
8	Doctorate Degree	31	.16%
9	Specialized Degree (e.g., MD, DDS)	32	.16%

Candidate Source: Individuals with active resumes in the workforce system.

(Source: Nebraska Workforce Development)

Adult Education Opportunities in Lexington

Nebraska Extension in Dawson County provides education in the following program areas: community environment; community vitality initiative; cropping & water systems; food, nutrition, & health; beef systems; and the learning child. All of these programs are informative only and none grant certificates for completion.

Central Community College – Lexington provides certificate, diploma, and degrees programs, as well as other important opportunities like English as a Second Language courses and GED classes and testing. First aid courses (CPR/AED) and EMT training can also be obtained thru CCC – Lexington.

Food

The entire LHRC service area is experiencing food insecurity, whereas half of Dawson county and all of Lexington are considered food deserts. Dawson County has a lower rate of food insecurity (8.9%) while having a much larger percentage of population likely to be income eligible for Federal Nutrition Assistance than Gosper and Phelps counties (see Figure 23). The Roberts Wood Johnson Foundation's County Health Rankings & Roadmaps reports that 21% of Gosper County and 12% of Dawson County residents have limited access to healthy foods. In comparison to the only 6% of Nebraska residents, and a low 4% of Phelps County's population, has limited access to healthy foods.

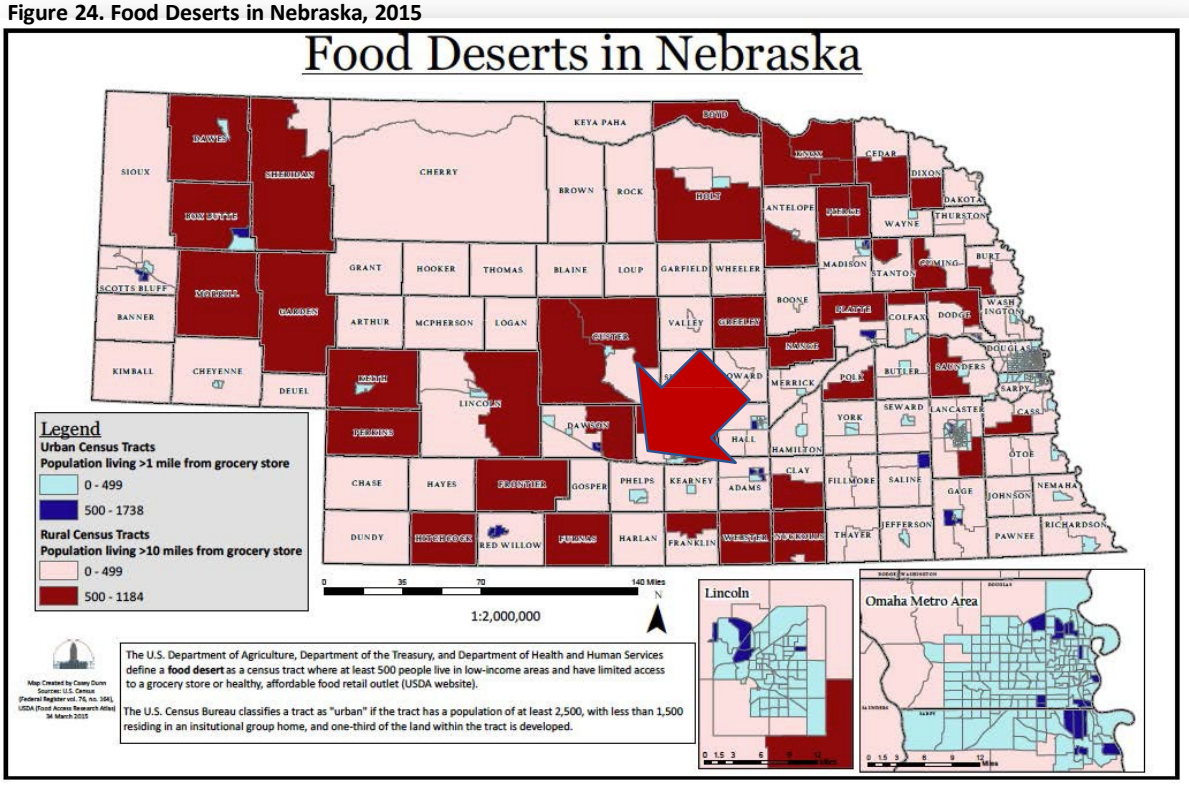
Figure 23. Likely Eligible for Federal Nutrition Assistance, 2018

	Feeding America: Map the Meal Gap 2018	Nebraska	Dawson County	Gosper County	Phelps County
Likely Income Eligibility for Federal Nutrition Assistance	**Food Insecurity Rate**	11.9%	8.7%	12.3%	10.6%
	% below 130% poverty *(SNAP, WIC, free school meals, CFSP, TEFAP)*	43.6%	62.0%	31.0%	39.0%
	% between 130% & 185% poverty *(WIC, reduced priced school meals)*	12.2%	23.0%	19.0%	20.0%
	% above 185% poverty *(charitable response, i.e. food banks/pantries)*	44.2%	16.0%	50.0%	41.0%

(Source: Feeding America)

Most of the population in Gosper, Phelps, and the west half of Dawson County are not considered low-income and live within 10 miles of a grocery store with health, affordable food options. Lexington and the east half of Dawson County are considered food deserts. Food deserts are census tracts with more than 500 low-income people who do not have access to a grocery outlet with affordable, healthy food options - more than one mile for urban and more than ten miles for rural (see Figure 24).

Figure 24. Food Deserts in Nebraska, 2015



(Source: United States Department of Agriculture/U.S. Census)

Health Care System

According to the Nebraska Rural Health Information Hub (2017), eight percent of Nebraska families living in rural areas lack health insurance. The Robert Wood Johnson Foundation's County Rankings and Roadmaps shows LHRC service area to have more uninsured residents living in counties with health care professional shortages (see Figures 25 & 26). Nebraska State data (see Figures 4 & 5 in Section I) reflects the same results found by the Robert Wood Johnson Foundation.

Figure 25. Healthcare Overview, 2018

Robert Woods Johnson Foundation: County Health Rankings & Roadmaps, 2018	Nebraska	Dawson County	Gosper County	Phelps County
Health Care Costs	$9,334	$9,461	$8,971	$9,844
Primary Care Physicians	1,340 to 1	1,840 to 1	1,970 to 1	1,330 to 1
Other Primary Care Providers	988 to 1	1,576 to 1	1,970 to 0	842 to 1
Dentists	1,360 to 1	1,690 to 1	1,970 to 1	1,850 to 1
Mental Health Providers	420 to 1	1,070 to 1	1,970 to 1	710 to 1
Preventable Hospital Stays *(Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees)*	48	66	NA	63

(Source: Robert Wood Johnson Foundation)

Figure 26. Uninsured, 2018

Robert Woods Johnson Foundation: County Health Rankings & Roadmaps, 2018	Nebraska	Dawson County	Gosper County	Phelps County
Uninsured	9.0%	16.0%	9.0%	8.0%
Uninsured Adults	11.0%	19.0%	9.0%	8.0%
Uninsured Children	5.0%	9.0%	8.0%	6.0%

(Source: Robert Wood Johnson Foundation)

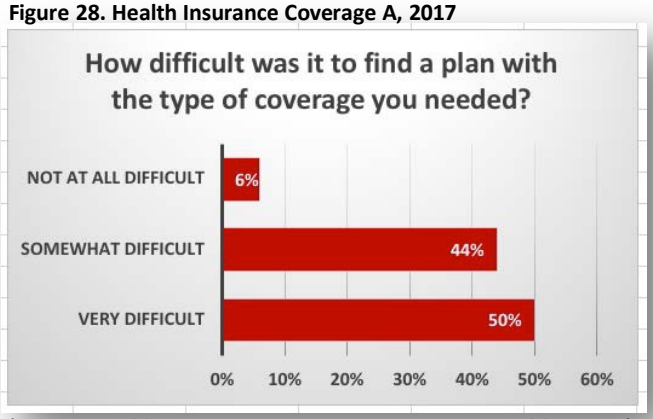
Of the 316 residents that participated in community health survey, 38% of the respondents have no health insurance, of any kind. Lexington has 22% more residents without health insurance than the rest of Dawson County (16%) and 29% more than the State's uninsured rate of 9%. The following tables and graphs is the other relevant data for the discussion of community health in Lexington (see Figures 27-29).

Figure 27. Health Insurance Plans, 2017

Lexington Community Health Survey, 2017		
Question	**Yes**	**No**
During the past 3 years, did you try to purchase health insurance directly, that is, not through any employer, union or government?	**9%**	**91%**
Was a plan purchased…	**50%**	**50%**

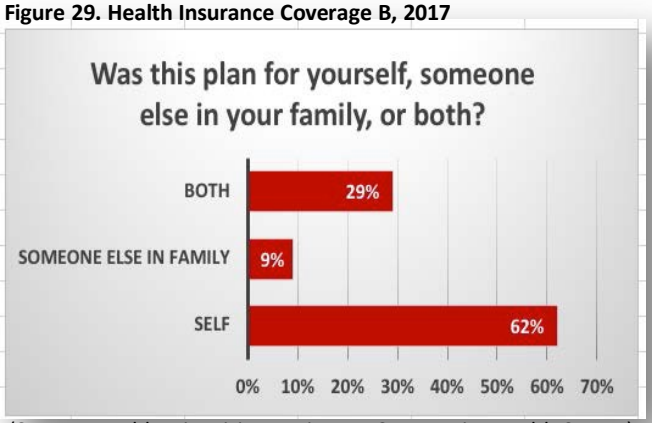
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 28. Health Insurance Coverage A, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 29. Health Insurance Coverage B, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 30. General Health Care Access, 2017

Lexington Community Health Survey, 2017		
During the past 12 months, did you change the place to which you usually go for health care?	**13%**	**87%**
Was this change for a reason related to health insurance?	**23%**	**77%**
During the past 12 months, were you able to find a general document or provider who could see you?	**8%**	**92%**
During the past 12 months, were you able to find a general doctor or provider who could see you (*out of the 8% who responded 'yes' to the*	**54%**	**46%**
During the past 12 months, were you told by a doctor's office or clinic that they would not accept your healthcare coverage?	7%	93%
During the past 12 months, were you told by a doctor's office or clinic that they would not accept you as a new patient?	**5%**	**95%**
Have you looked into purchasing health insurance coverage through healthcare.gov or the Nebraska health insurance marketplace?	17%	83%

(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 31. Health Care Satisfaction, 2017

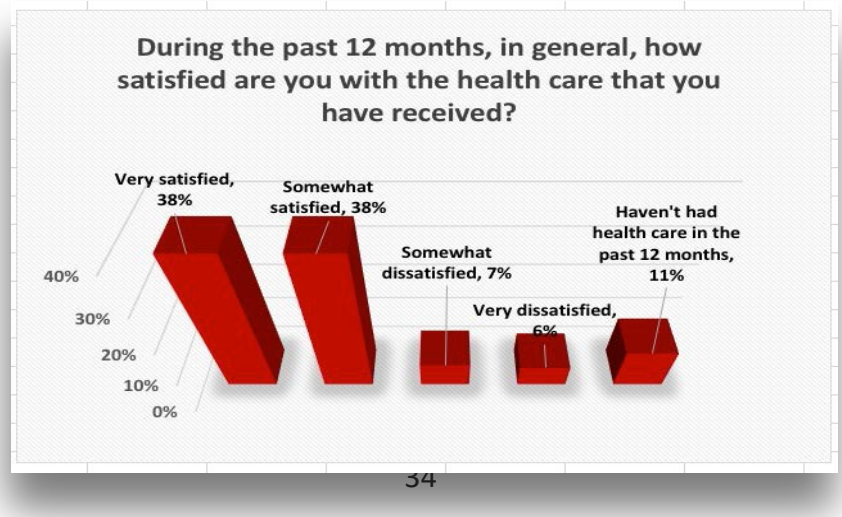


Figure 32. Health Care Delays, 2017

Lexington Community Health Survey, 2017		
Q: Have you delayed health getting care for any of the following reasons in the past 12 months?	Yes	No
You couldn't get through on the telephone…	13%	87%
You couldn't get an appointment soon enough…	15%	85%
Once you got there, you have to wait too long to see the doctor…	19%	81%
You didn't have transportation…	12%	88%
You couldn't afford the doctor's visit…	24%	86%
You needed an interpreter and one wasn't available…	11%	89%
You weren't able to get the time off work…	14%	86%
You were afraid to find out what is wrong with you…	14%	86%
You were afraid that your employer would discover your medical condition…	8%	92%
You were afraid of losing your job…	10%	90%
You were unable to get childcare…	8%	92%

(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 33. Health Care Affordability, 2017

Lexington Community Health Survey, 2017		
Q: During the past 12 months, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?	**Yes**	**No**
Prescription Medicine	22%	78%
Mental Health Care or Counseling	15%	85%
Dental Care	25%	75%
Eyeglasses	21%	79%
To See a Specialist	17%	83%
Follow-up Care	18%	82%
During the past 12 months, were any of the following true?	**Yes**	**No**
You skipped medication doses to save money…	16%	84%
You took less medicine to save money…	15%	85%
You asked your doctor for a lower cost medication to save money…	20%	80%
You bought prescription drugs from another country to save money…	11%	89%
You used alternative therapies to save money…	11%	89%

(Source: HealthVoiceVision Lexington Community Health Survey)

Community and Social Context

Most of the community and social context data overlaps with data presented in both Sections II & III. How can it not be? Community and social context is about our relationships with each other and the systems that we have to engage for quality of life. Therefore, the data listed here is not listed any other place in the survey. Yet, it worth noting when attempting to put the big picture together of then impact of SDOH on the service area, as well as the challenges, and rewards, the administration and staff at LHRC.

Figure 34. Overall Community Health, 2017

Robert Woods Johnson Foundation: County Health Rankings & Roadmaps, 2018	Nebraska	Dawson County	Gosper County	Phelps County
Social Associations *(number of membership associations per 10K population)*	13.9	18.8	20.3	29.0
Preventable Hospital Stays *(Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees)*	48	66	NA	63
Poor or Fair Health	14%	16%	12%	13%
Poor Physical Health Days *(in the past 30 days)*	3.2	3.3	2.7	2.8
Poor Mental Health Days *(in the past 30 days)*	3.2	3.0	2.8	3.0
Low Birthweight	7%	6%	12%	6%

(Source: Robert Wood Johnson Foundation)

Figure 35. Children in Poverty & Income Inequality, 2017

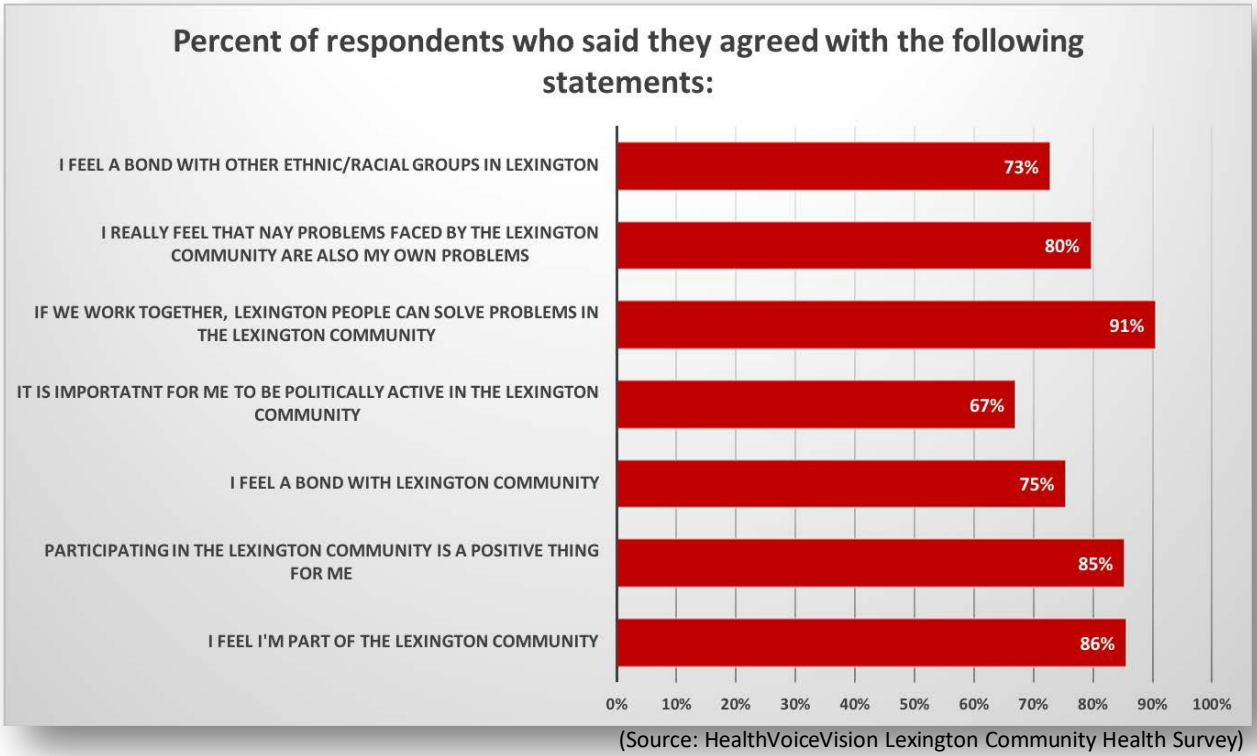
Robert Woods Johnson Foundation: County Health Rankings & Roadmaps, 2018	Nebraska	Dawson County	Gosper County	Phelps County
Children in Poverty	14%	17%	17%	12%
Children in Single-Parent Households	29%	27%	17%	19%
Income Inequality *(Ratio of household incomes at the 80th percentile to income at the 20th percentile)*	4.3	3.7	3.4	3.9

(Source: Robert Wood Johnson Foundation)

HealthVoiceVision Lexington Community Health Survey

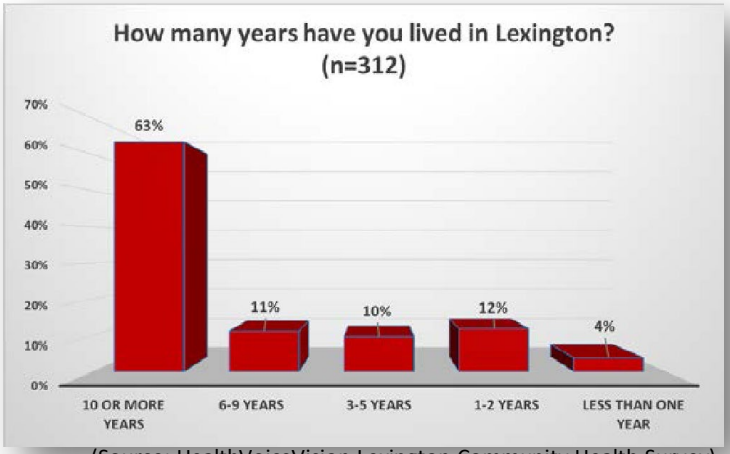
More than 95% of the respondents for the Lexington Community Health Survey were refugees, immigrants, and/or considered minorities as per the U.S. Census.

Figure 36. Community Bond, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 37. Years in Lexington, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

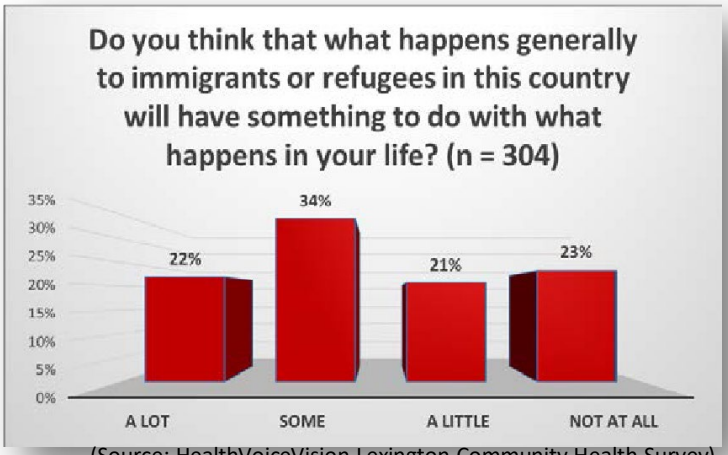
Figure 38. Happiness with Job, 2017

(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 39. Physical Fitness, 2017

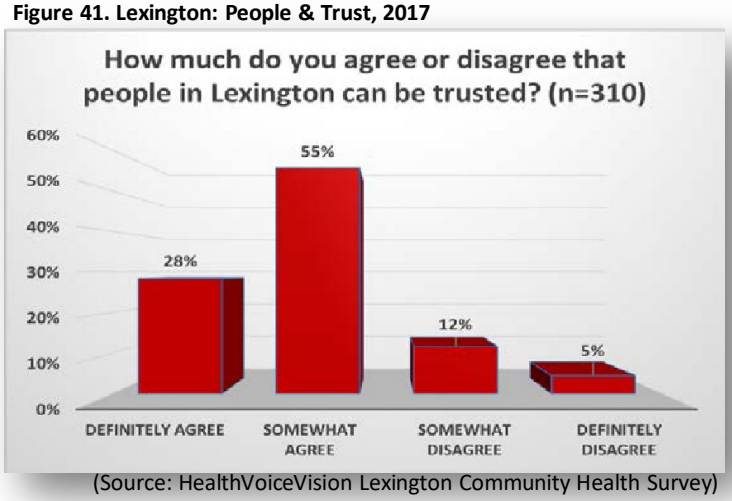
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 40. Immigrants/Refugees National, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 41. Lexington: People & Trust, 2017

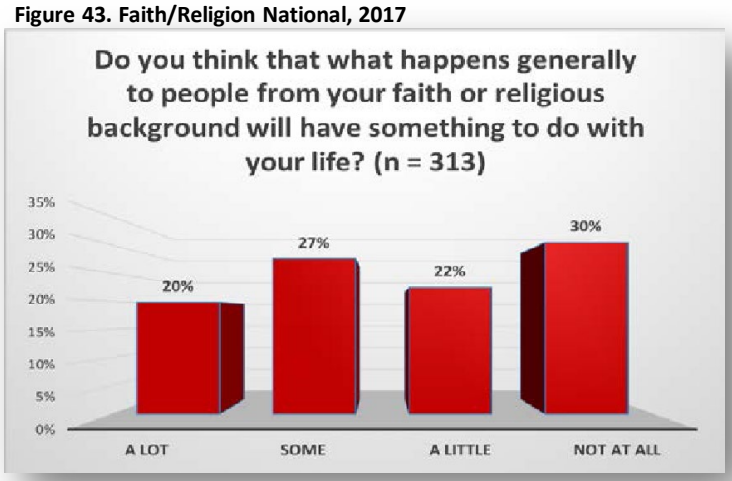


(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 42. Personal Happiness, 2017

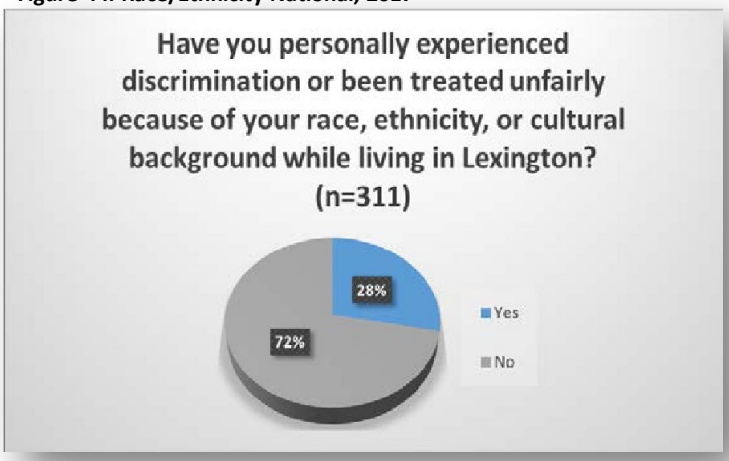
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 43. Faith/Religion National, 2017



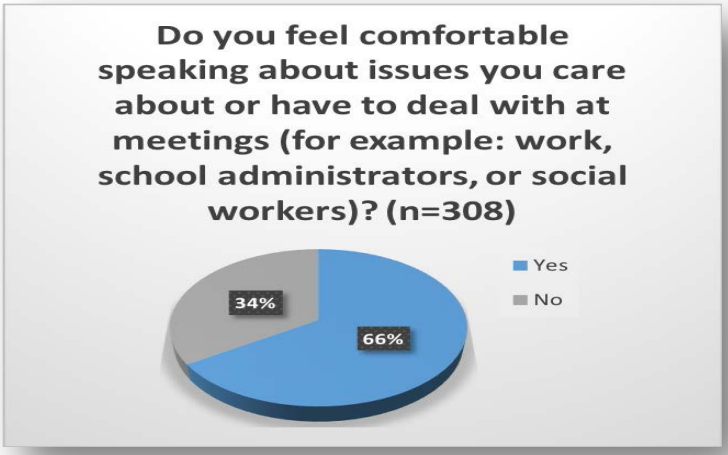
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 44. Race/Ethnicity National, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 45. Comfort Speaking in Public, 2017



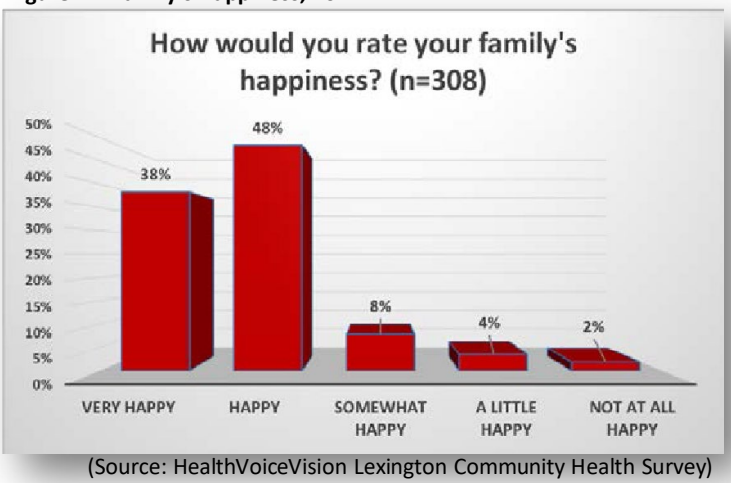
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 45. Fear of Harassment: Citizenship, 2017

Lexington Community Health Survey: Have you ever avoided any of the following because fear of possible harassment (or worse) about citizenship:	Yes	No
Talking with school teachers or school officials	18%	82%
Talking to police or reporting crime	22%	78%
Renewing or applying for a driver's license	19%	81%
Using public transportation like the bus	17%	83%
Driving a car	18%	82%
Traveling by airplane or picking up family at the airport	16%	84%
Visiting a doctor or clinic	17%	83%
Smoking cigarettes or drinking alcohol	12%	88%
Going to the grocery store or running daily errands	14%	86%
Going to a community event	15%	85%
Meetings with community support workers (social services, etc	16%	84%
Community health fairs	16%	84%
Meetings and events at your cultural center	16%	84%
Eating out at certain restaurants	18%	82%

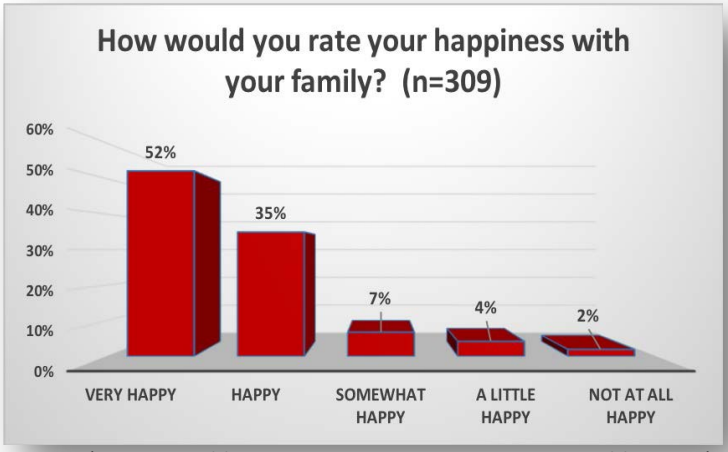
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 47. Family's Happiness, 2017



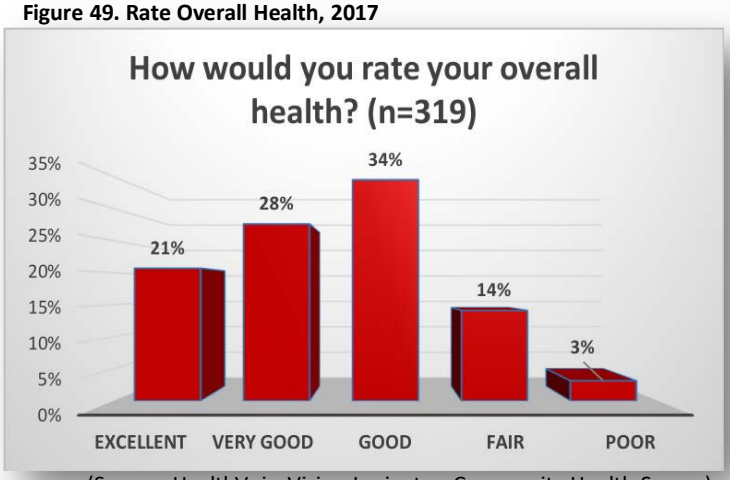
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 48. Happiness with Your Family, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 49. Rate Overall Health, 2017



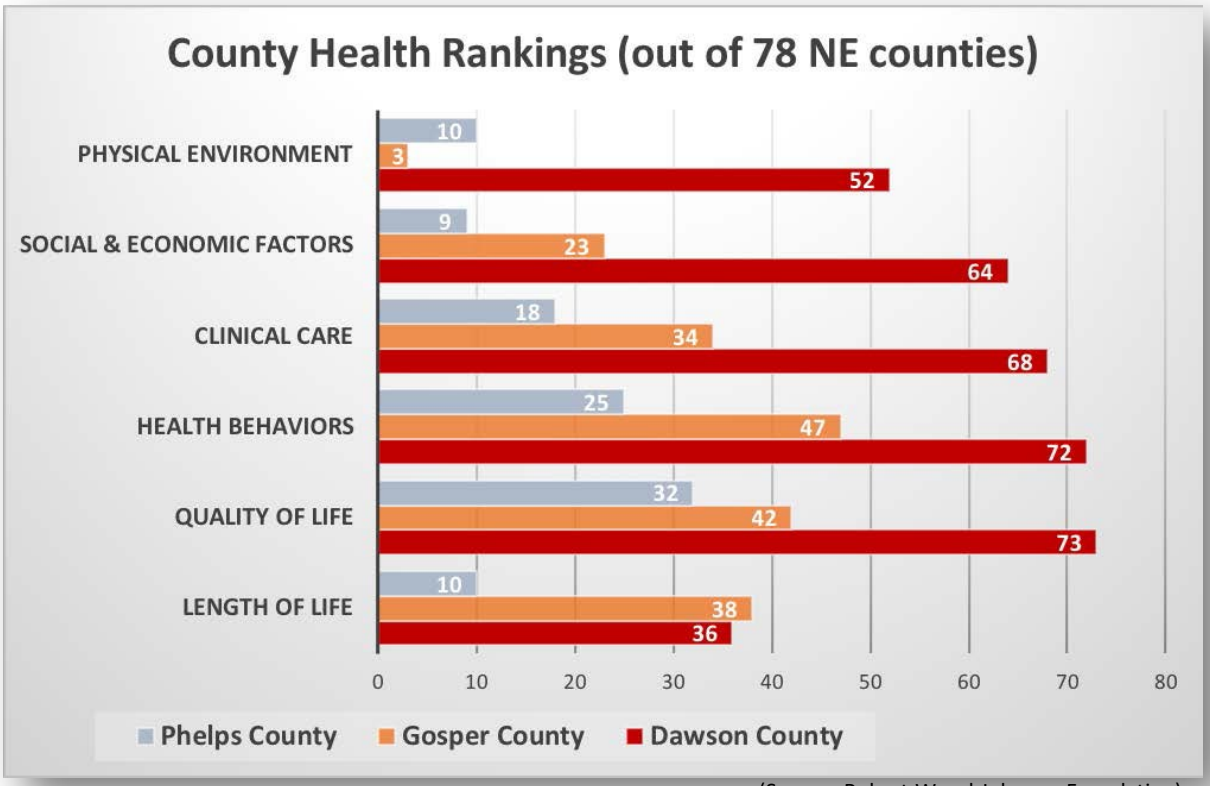
(Source: HealthVoiceVision Lexington Community Health Survey)

Health Outcomes

The Robert Woods Johnson Foundation's County Health Rankings ranks Dawson County as one of the lowest in the State for Health Behaviors and Quality of Life (see Figure 50). Yet, the Lexington Community Health Survey participants showed that they trusted their community and were generally happy (see Figures 36 - 49).

Life in rural Nebraska is more complex than the data in Section I & II illustrates. In Section II, we begin to address the sophistication of the challenges facing the folks living in the LHRC service area. Focus groups, Photovoice, and examples of how the staff at LHRC are tackling their patients' problems, give a voice to the statistics found here.

Figure 50. County Overall Factor Health Rankings, 2018



(Source: Robert Wood Johnson Foundation)

Figure 51. Overall Health Outcomes, 2018

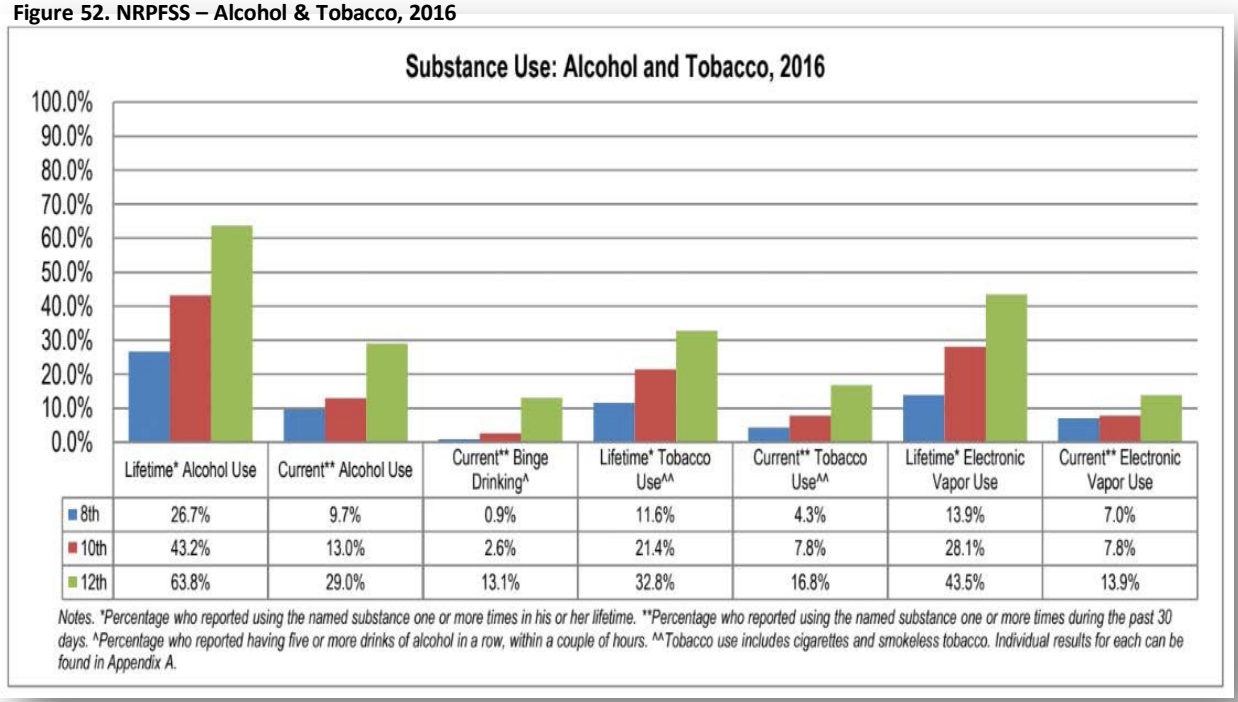
Robert Woods Johnson Foundation: County Health Rankings & Roadmaps, 2018	Dawson County	Gosper County	Phelps County
Premature Deaths	240	NA	77
Years of Potential Life Lost *(to premature deaths)*	6613	NA	4892
Adult Smokers	17%	14%	15%
Adult Excessive Drinking	19%	19%	18%
Alcohol Impaired Driving Deaths	22%	2 out of the 3 driving deaths	4 out of the 7 driving deaths

(Source: Robert Wood Johnson Foundation)

Dawson County Youth: Nebraska Risk and Protective Factor Student Survey Results for 2016

The Nebraska Risk and Protective Factor Student Survey (NRPFSS), 2016, for Dawson County is sponsored by the Nebraska Department of Health and Human Services: Division of Behavioral Health and administered by the Bureau of Sociological Research: University of Nebraska-Lincoln. Some of this data could be categorized under different headings. For the sake of clean analysis, it was decided to mirror most of the data tables found in the report.

Figure 52. NRPFSS – Alcohol & Tobacco, 2016

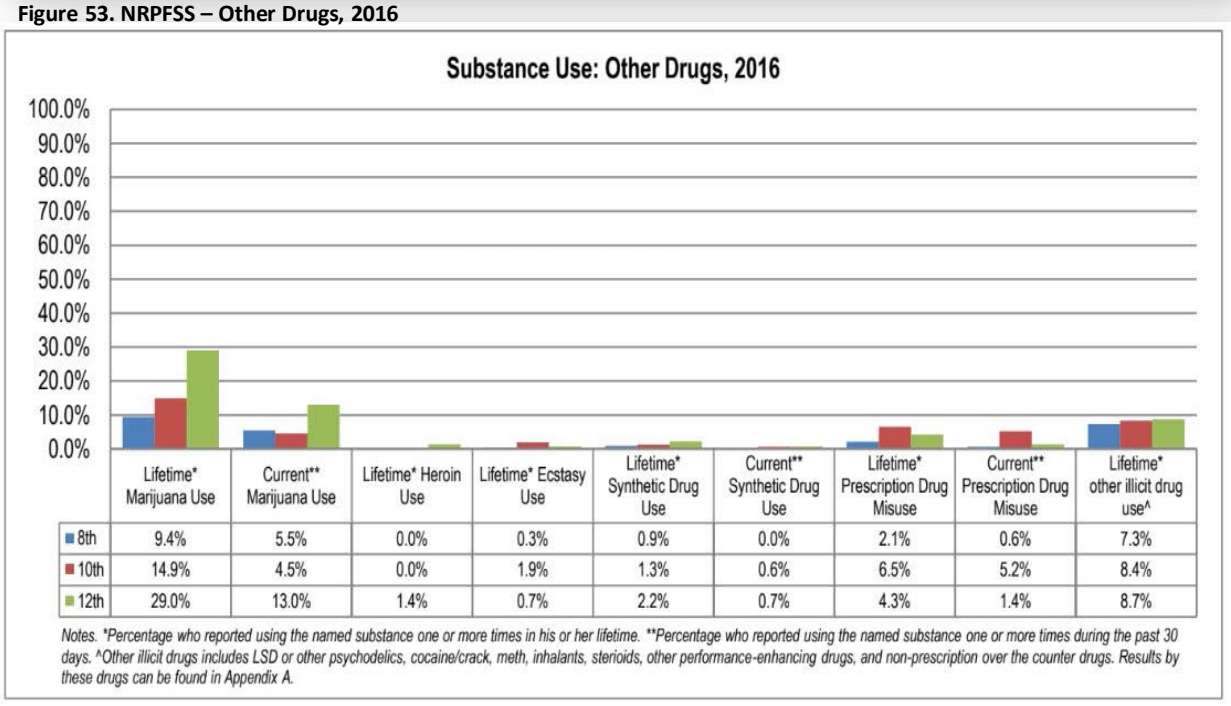


	Lifetime* Alcohol Use	Current** Alcohol Use	Current** Binge Drinking^	Lifetime* Tobacco Use^^	Current** Tobacco Use^^	Lifetime* Electronic Vapor Use	Current** Electronic Vapor Use
8th	26.7%	9.7%	0.9%	11.6%	4.3%	13.9%	7.0%
10th	43.2%	13.0%	2.6%	21.4%	7.8%	28.1%	7.8%
12th	63.8%	29.0%	13.1%	32.8%	16.8%	43.5%	13.9%

*Notes. *Percentage who reported using the named substance one or more times in his or her lifetime. **Percentage who reported using the named substance one or more times during the past 30 days. ^Percentage who reported having five or more drinks of alcohol in a row, within a couple of hours. ^^Tobacco use includes cigarettes and smokeless tobacco. Individual results for each can be found in Appendix A.*

(Source: Nebraska Department of Health and Human Services)

Figure 53. NRPFSS – Other Drugs, 2016

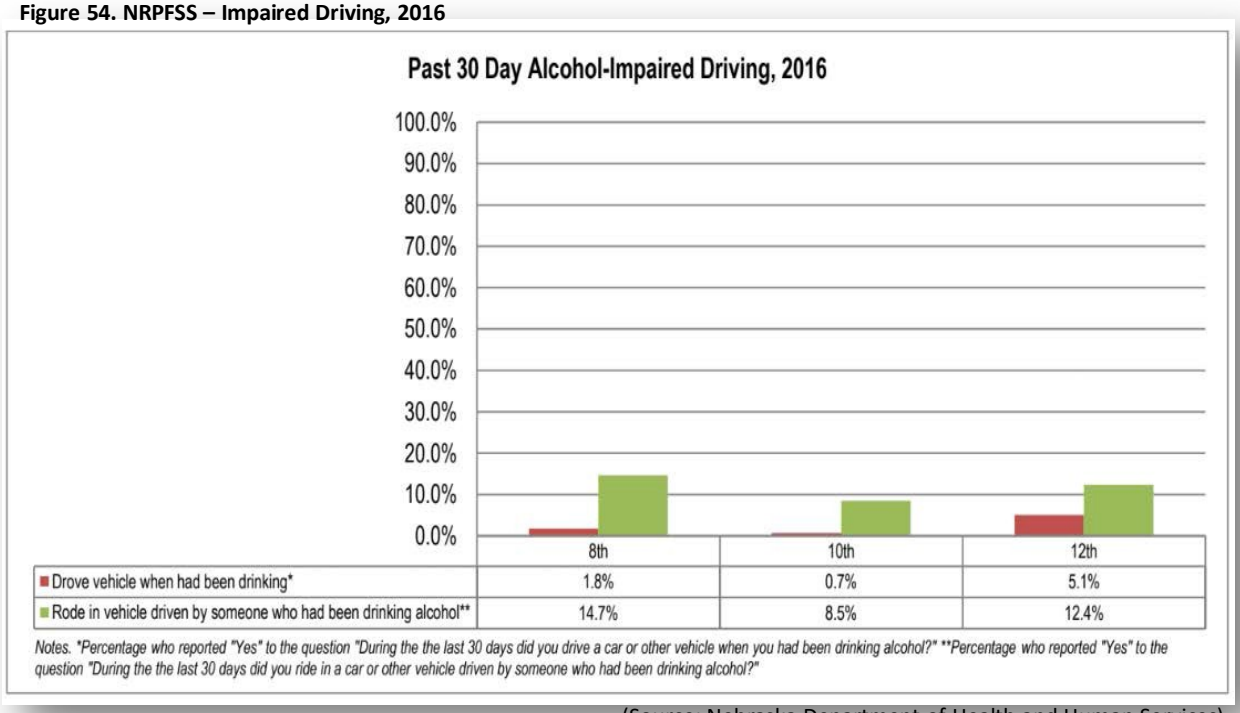


	Lifetime* Marijuana Use	Current** Marijuana Use	Lifetime* Heroin Use	Lifetime* Ecstasy Use	Lifetime* Synthetic Drug Use	Current** Synthetic Drug Use	Lifetime* Prescription Drug Misuse	Current** Prescription Drug Misuse	Lifetime* other illicit drug use^
8th	9.4%	5.5%	0.0%	0.3%	0.9%	0.0%	2.1%	0.6%	7.3%
10th	14.9%	4.5%	0.0%	1.9%	1.3%	0.6%	6.5%	5.2%	8.4%
12th	29.0%	13.0%	1.4%	0.7%	2.2%	0.7%	4.3%	1.4%	8.7%

*Notes. *Percentage who reported using the named substance one or more times in his or her lifetime. **Percentage who reported using the named substance one or more times during the past 30 days. ^Other illicit drugs includes LSD or other psychodelics, cocaine/crack, meth, inhalants, sterioids, other performance-enhancing drugs, and non-prescription over the counter drugs. Results by these drugs can be found in Appendix A.*

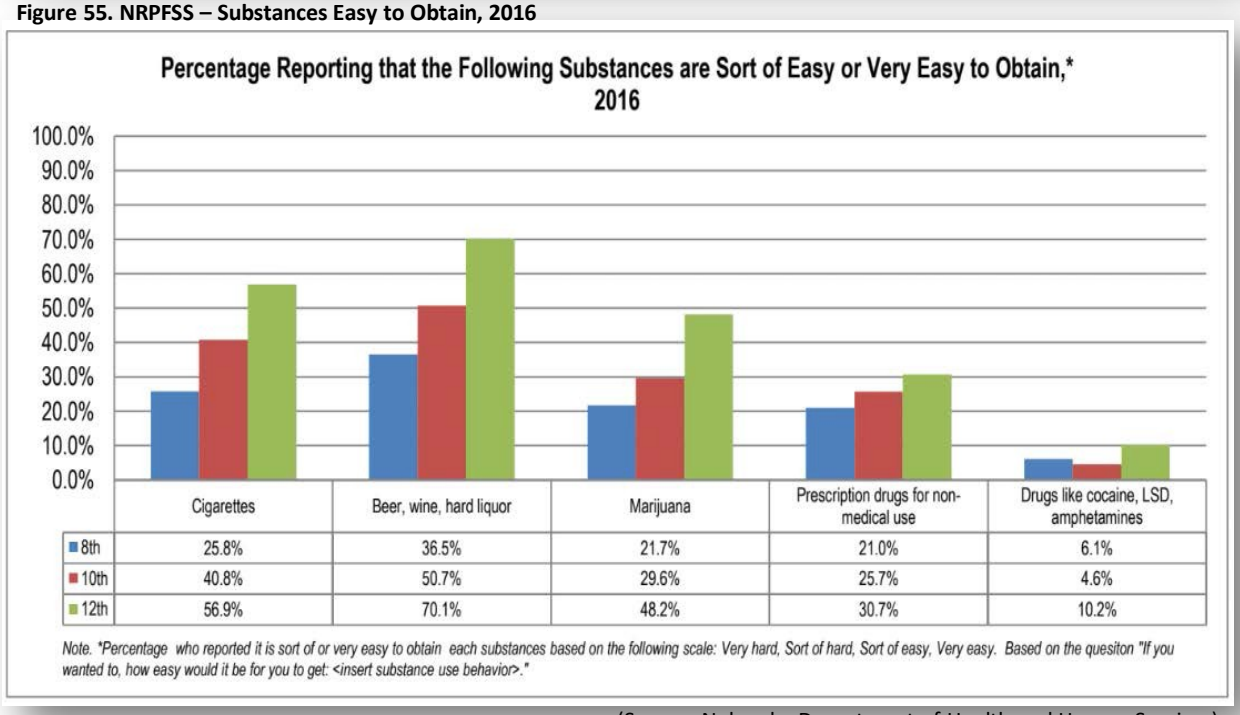
(Source: Nebraska Department of Health and Human Services)

Figure 54. NRPFSS – Impaired Driving, 2016



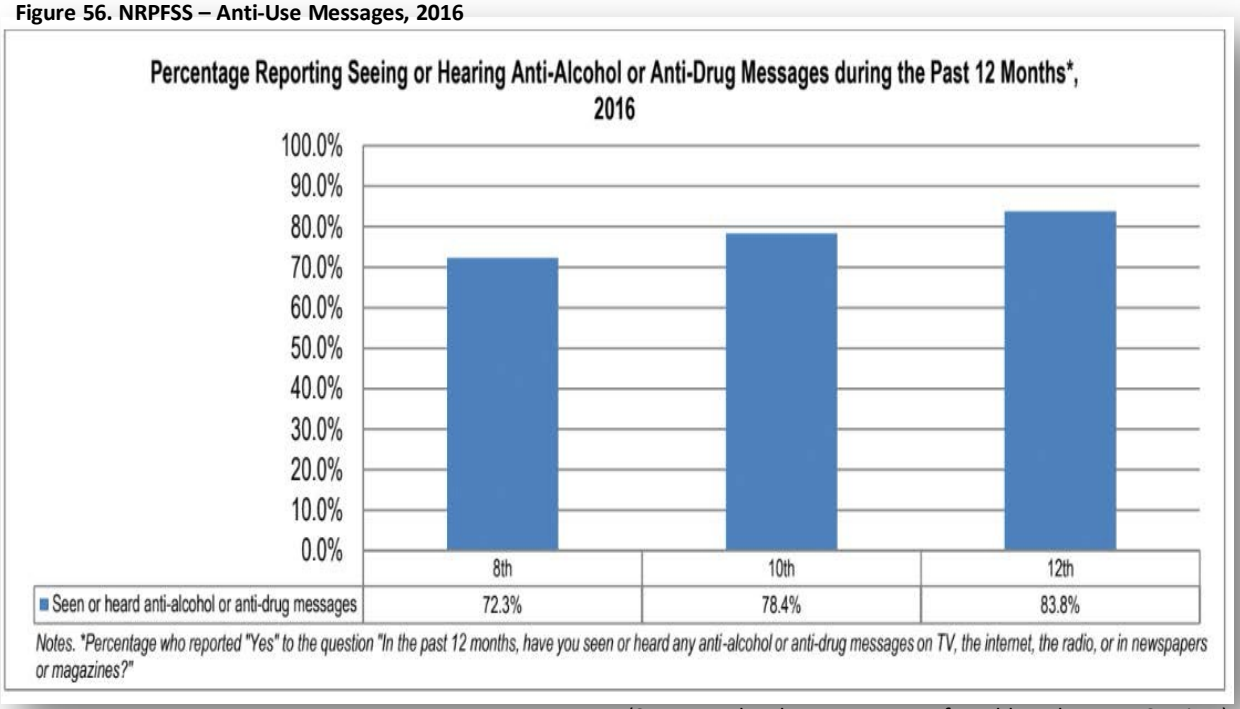
(Source: Nebraska Department of Health and Human Services)

Figure 55. NRPFSS – Substances Easy to Obtain, 2016



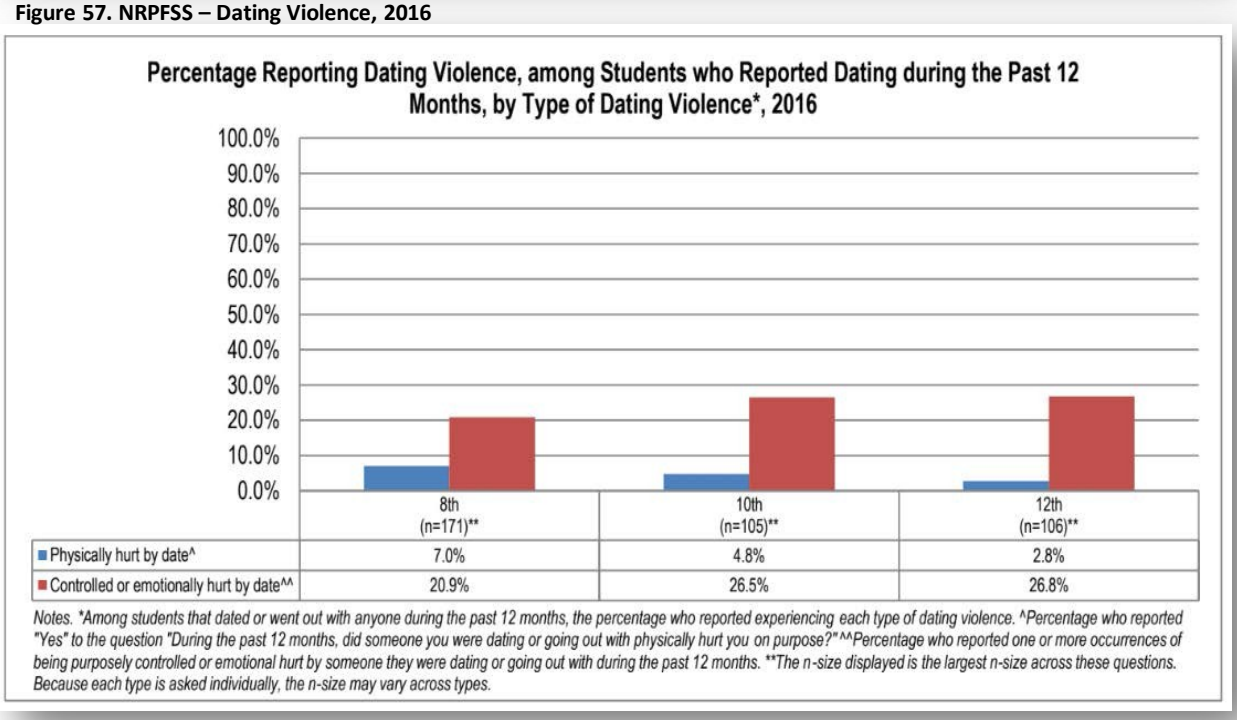
(Source: Nebraska Department of Health and Human Services)

Figure 56. NRPFSS – Anti-Use Messages, 2016



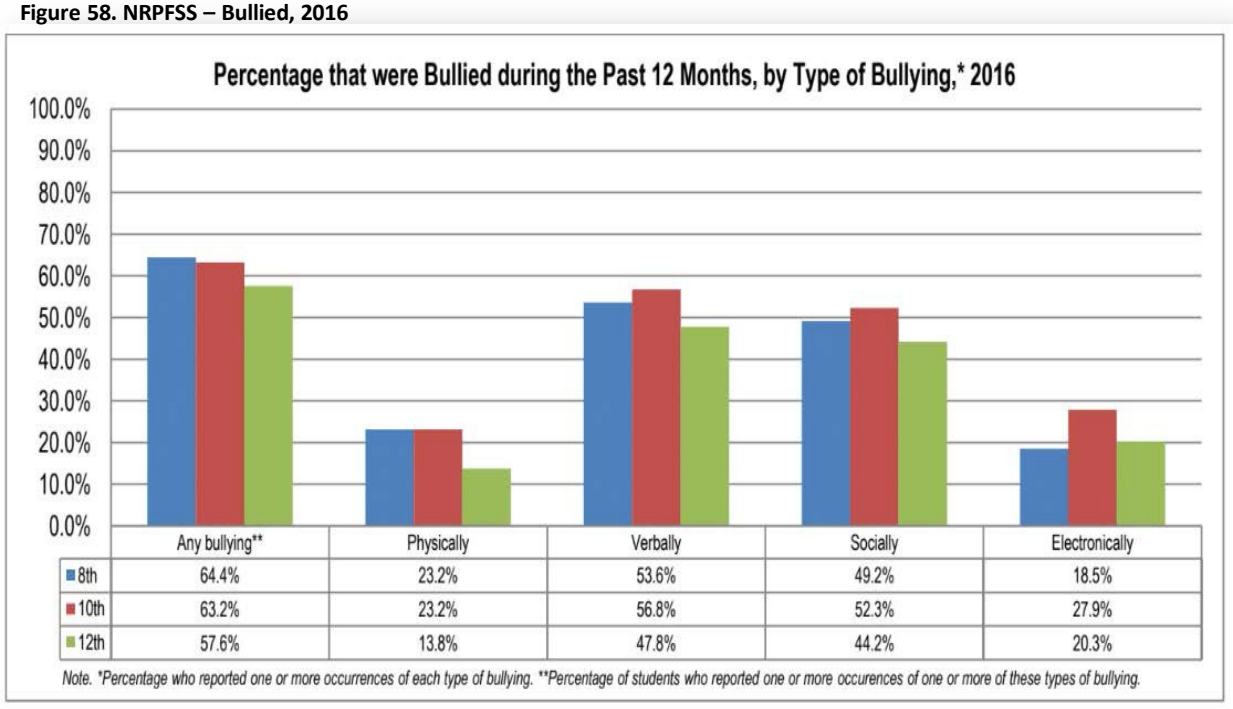
(Source: Nebraska Department of Health and Human Services)

Figure 57. NRPFSS – Dating Violence, 2016



(Source: Nebraska Department of Health and Human Services)

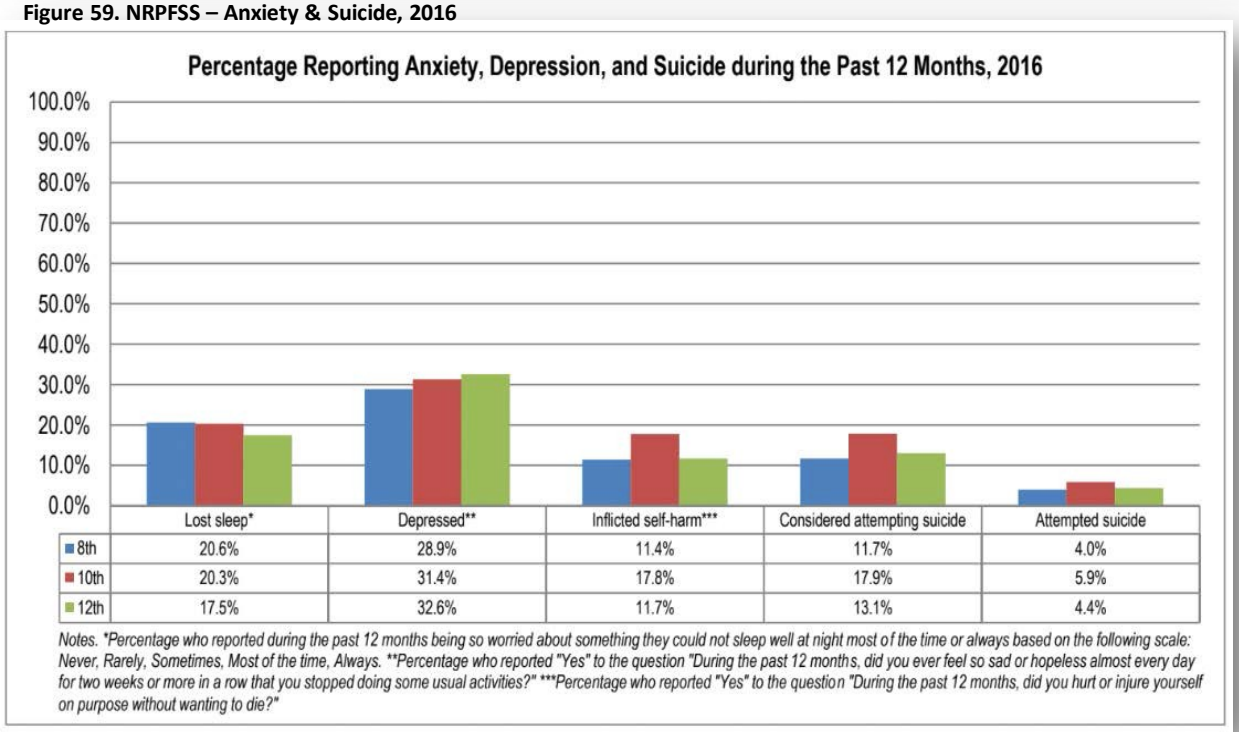
Figure 58. NRPFSS – Bullied, 2016



	Any bullying**	Physically	Verbally	Socially	Electronically
8th	64.4%	23.2%	53.6%	49.2%	18.5%
10th	63.2%	23.2%	56.8%	52.3%	27.9%
12th	57.6%	13.8%	47.8%	44.2%	20.3%

(Source: Nebraska Department of Health and Human Services)

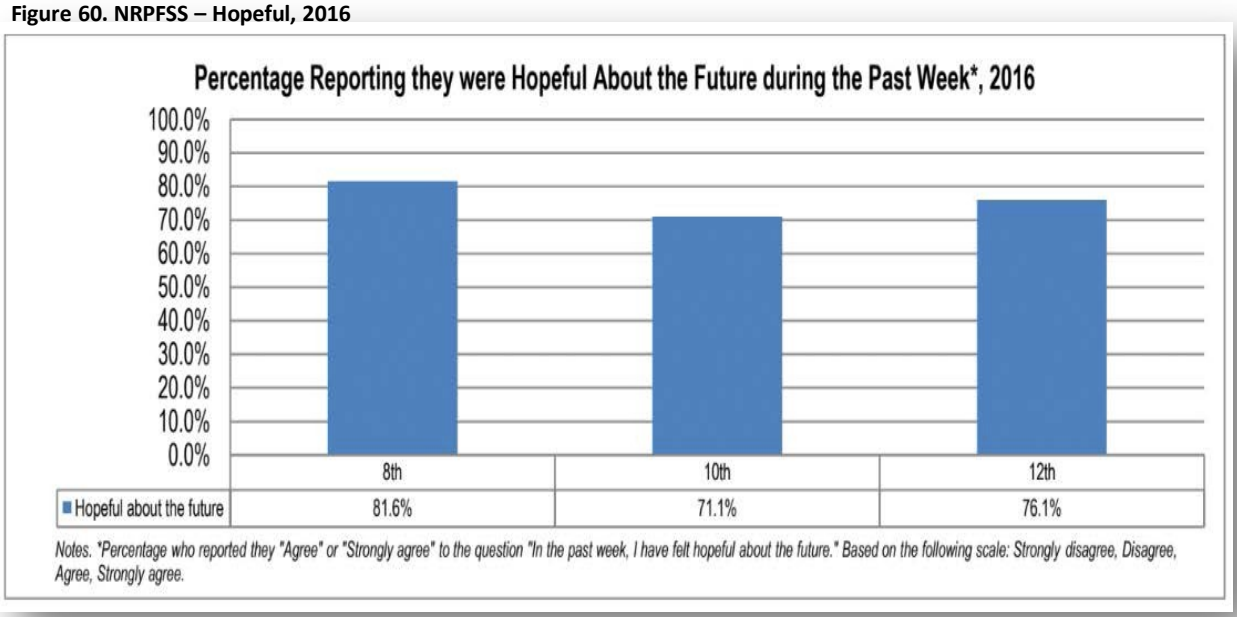
Figure 59. NRPFSS – Anxiety & Suicide, 2016



	Lost sleep*	Depressed**	Inflicted self-harm***	Considered attempting suicide	Attempted suicide
8th	20.6%	28.9%	11.4%	11.7%	4.0%
10th	20.3%	31.4%	17.8%	17.9%	5.9%
12th	17.5%	32.6%	11.7%	13.1%	4.4%

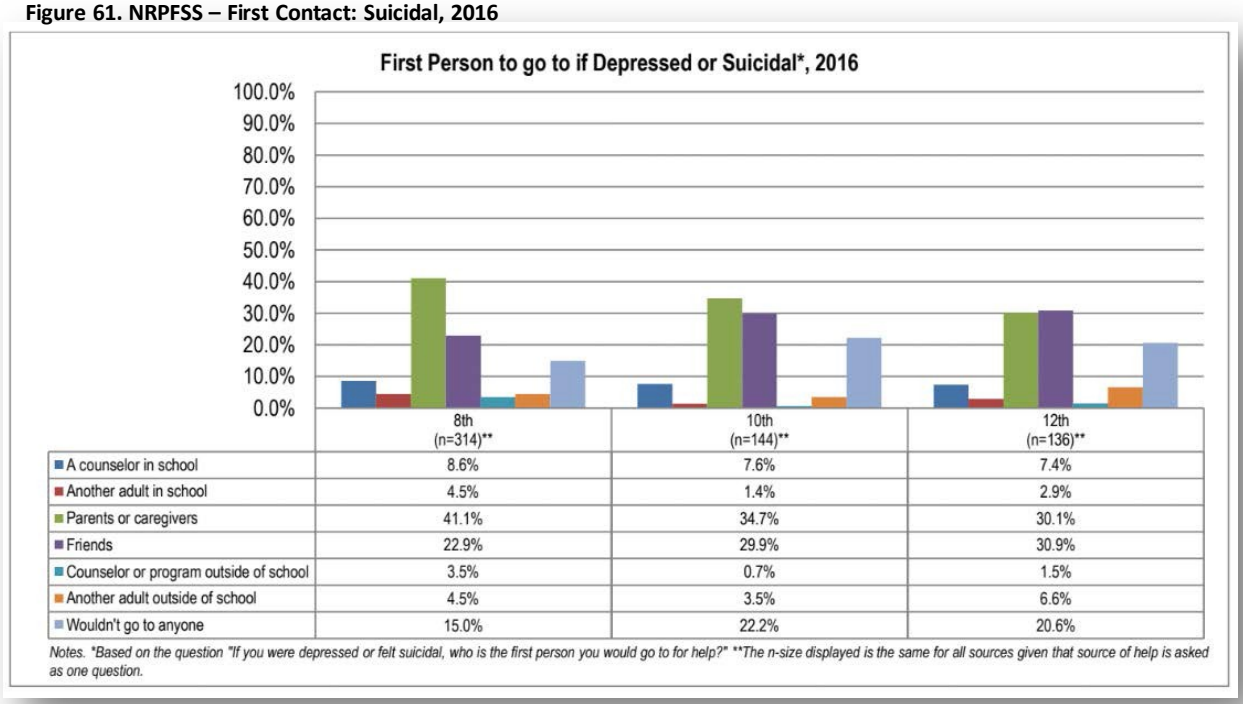
(Source: Nebraska Department of Health and Human Services)

Figure 60. NRPFSS – Hopeful, 2016



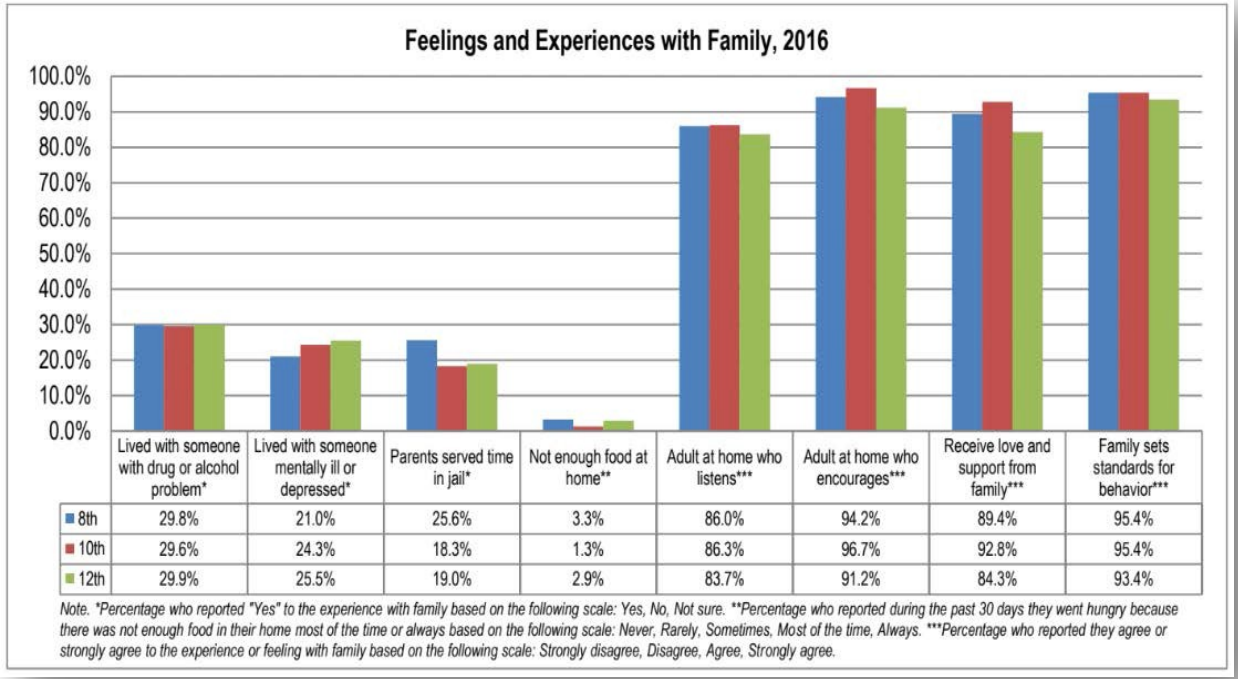
(Source: Nebraska Department of Health and Human Services)

Figure 61. NRPFSS – First Contact: Suicidal, 2016



(Source: Nebraska Department of Health and Human Services)

Figure 62. NRPFSS – Experiences with Family, 2016

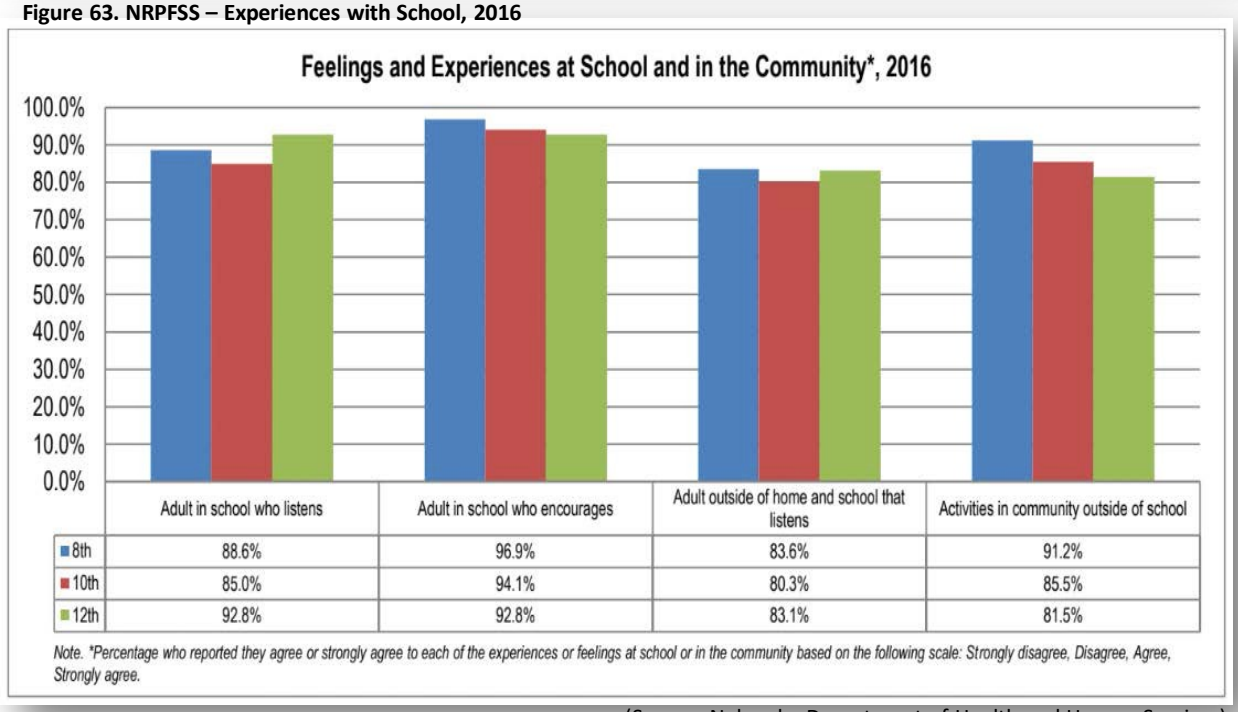


	Lived with someone with drug or alcohol problem*	Lived with someone mentally ill or depressed*	Parents served time in jail*	Not enough food at home**	Adult at home who listens***	Adult at home who encourages***	Receive love and support from family***	Family sets standards for behavior***
8th	29.8%	21.0%	25.6%	3.3%	86.0%	94.2%	89.4%	95.4%
10th	29.6%	24.3%	18.3%	1.3%	86.3%	96.7%	92.8%	95.4%
12th	29.9%	25.5%	19.0%	2.9%	83.7%	91.2%	84.3%	93.4%

*Note. *Percentage who reported "Yes" to the experience with family based on the following scale: Yes, No, Not sure. **Percentage who reported during the past 30 days they went hungry because there was not enough food in their home most of the time or always based on the following scale: Never, Rarely, Sometimes, Most of the time, Always. ***Percentage who reported they agree or strongly agree to the experience or feeling with family based on the following scale: Strongly disagree, Disagree, Agree, Strongly agree.*

(Source: Nebraska Department of Health and Human Services)

Figure 63. NRPFSS – Experiences with School, 2016



	Adult in school who listens	Adult in school who encourages	Adult outside of home and school that listens	Activities in community outside of school
8th	88.6%	96.9%	83.6%	91.2%
10th	85.0%	94.1%	80.3%	85.5%
12th	92.8%	92.8%	83.1%	81.5%

*Note. *Percentage who reported they agree or strongly agree to each of the experiences or feelings at school or in the community based on the following scale: Strongly disagree, Disagree, Agree, Strongly agree.*

(Source: Nebraska Department of Health and Human Services)

Obesity

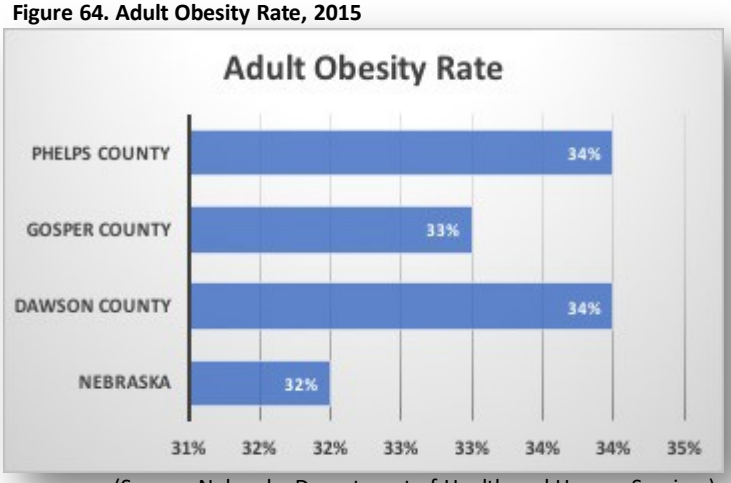
Nebraska

In Nebraska, the 2011-2014 Behavioral Risk Factor Surveillance System (BRFSS) and minority oversample BRFSS results indicate that nearly 30% of Nebraska adult residents had a body mass index (BMI) greater than 30. On average, adult American Indians (42.1%) were more likely to be obese than African Americans (35.9%), Hispanics (32.8%), and Asians (13.8%), compared to non-Hispanic White residents (28.7%).

Obesity rates are also a concern for the State of Nebraska, especially among children and adolescents. According to the National Survey of Children's Health (2017), as of 2012, nearly 30% of Nebraska youth ages 10-17 were overweight or obese (BMI at or above 85th percentile). Additionally, according to the 2015 Nebraska Youth Risk Behavior Survey (YRBS), almost one-third of students (30%) in grades 9-12 perceived themselves as slightly or very overweight. Female students were more likely to feel that they were slightly or very overweight, at 35.6%. The number of high school students (18%) who reported high-risk weight loss methods during the past 30 days, such as fasting, taking diet pills, vomiting or taking laxatives, also showed cause for concern and a need for healthier alternatives.

One of the greatest disparities in obesity among minority populations in Nebraska is found in Hispanic youth (Ramos et al., 2013). The National Survey of Children's Health (2017) data indicated large disparities among minority populations. Fifty percent of Nebraska's Hispanic children and 43% of African American children ages 10-17 were overweight or obese, compared to only 26% of non-Hispanic White children (Data Resource Center for Child & Adolescent Health, 2017). Studies have shown that children who become overweight during adolescence are more likely to remain overweight into adulthood. Addressing these issues during the earlier stages in a child's life creates the potential for long-term impact on mental and physical health outcomes.

Figure 64. Adult Obesity Rate, 2015



(Source: Nebraska Department of Health and Human Services)

Lexington

The obesity epidemic has and continues to be a public health concern for our country and for the community of Lexington, Nebraska. Lexington Public Schools has seen an increase in obesity rates among their students in recent years. Data from Lexington Public Schools from 2017 indicates that 48.4% of students are overweight or obese (at or above the 85% Body Mass Index [BMI] percentile for gender and age). Within age and gender categories, rates vary between 33% (11th grade girls) and 75% (8th grade boys).

As Lexington has seen the minority population increase in the community, especially among the Hispanic population, they have also seen increases in BMI rates in the student populations. Hispanic students in the Lexington School District made up approximately 2,214 students during the 2014-2015 school year. This number has steadily increased since 2011 (Nebraska Department of Education, 2016). Various community needs assessments have been conducted in Lexington, and the community has identified childhood obesity as a priority for the city. These assessments have included partners such as the Lexington Public Schools, Lexington Regional Hospital, Plum Creek Medical Group, and other stakeholders.

Diabetes

According to the American Diabetes Association, people with diabetes have medical expenses approximately 2.3 times higher than those who do have diabetes.

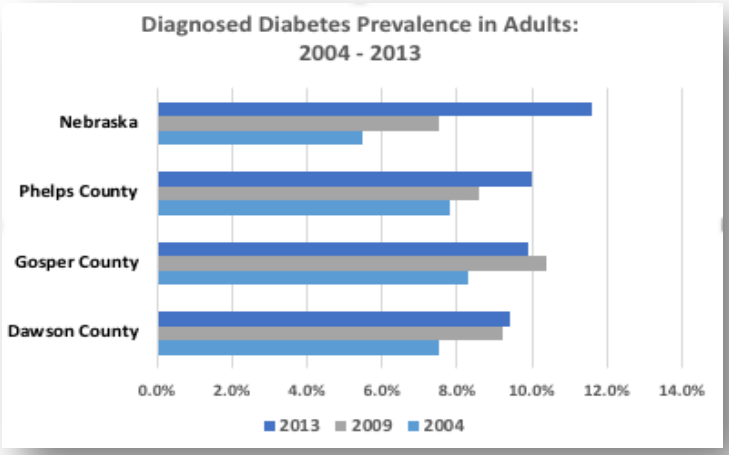
Nebraska

During the 5-year period from 2011 to 2014, American Indians had the highest death rate due to diabetes mellitus (67.9/100,000), which was 3.3 times the rate for non-Hispanic Whites (20.4/100,000). African Americans had a rate of 50.4/100,000, which was 2.5 times the rate for non-Hispanic Whites. Hispanics had a rate of 28.9/100,000, which was 1.4 times the rate for non-Hispanic Whites.

LHRC Service Area

All three counties in the LHRC service area had a higher prevalence of adults with diabetes until 2013 (see Figure 65). Since 2009, Dawson, Gosper, and Phelps Counties has remained steady with approximately 9 - 10% of the adult population who were diagnosed with diabetes. Rates of diabetes in these counties were higher than the State until 2013 when Nebraska experienced a dramatic spike (11.6% - up from 7.5% in 2009). The HealthVoiceVision Lexington Community Health Survey suggests that these county numbers may be misleading.

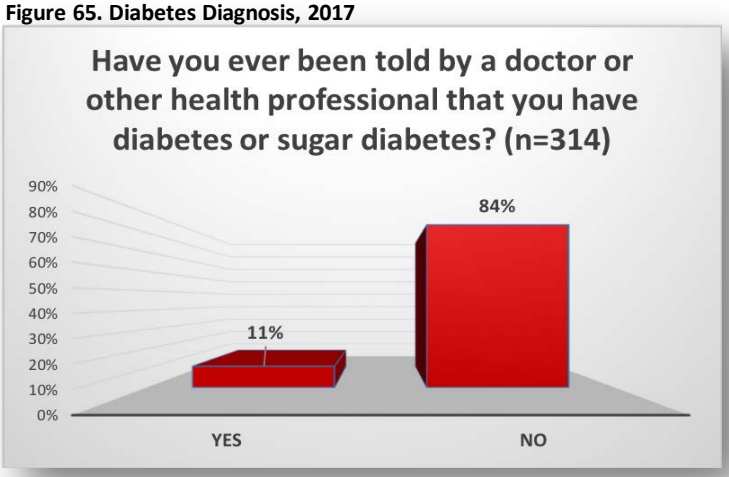
Figure 64. Diabetes Prevalence in Adults, 2004-2013



(Source: U.S. Census)

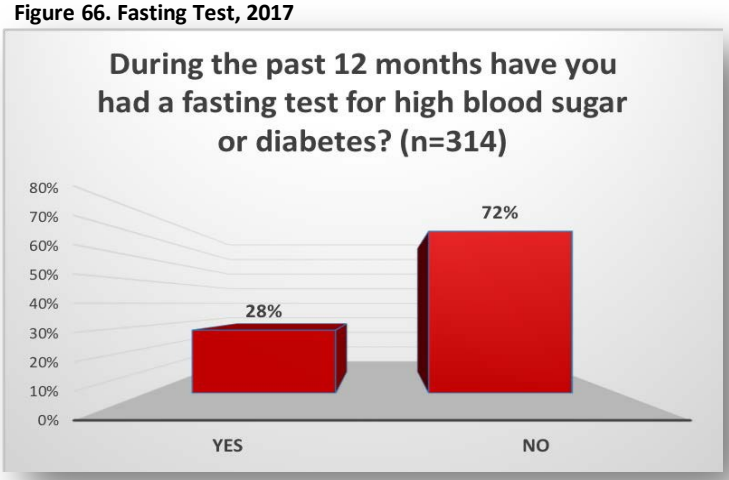
HealthVoiceVision Lexington Community Health Survey

Figure 65. Diabetes Diagnosis, 2017



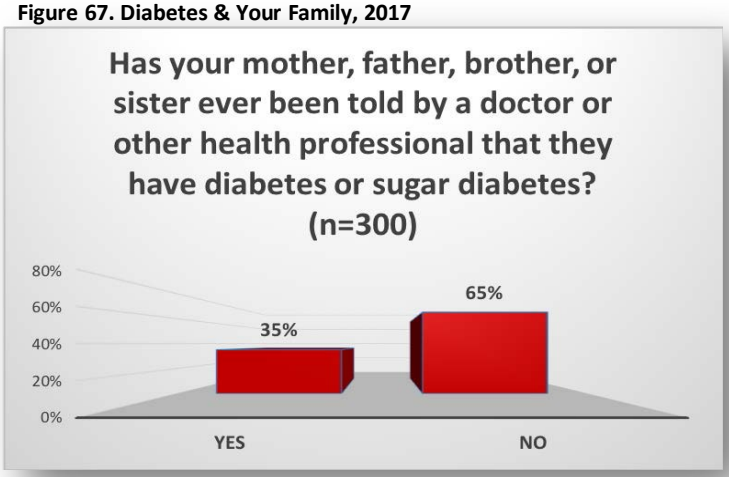
(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 66. Fasting Test, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Figure 67. Diabetes & Your Family, 2017



(Source: HealthVoiceVision Lexington Community Health Survey)

Section III: Community Health Needs and Priorities

Data & Analysis

The LHRC service area community health needs and priorities are based upon the data collected from a wide variety of sources. Most of these studies were introduced in the two preceding sections. The following discussion introduces some new data, as well as more unpublished data from HealthVoiceVision Lexington Community Health Survey. The selected health priorities and strategies was the work of the LRHC administration and staff in partnership with the University of Nebraska-Lincoln's Minority Health Disparities Initiative, local area agencies, and stakeholders.

As previously stated, the LRHC focus groups consisted of community stakeholders, health providers, and health consumers. The ten focus groups were conducted in English or Spanish. All of the focus group audios were transcribed into English. The LHRC focus groups concentrated on four health priority areas: (1) Chronic Health Conditions, (2) Mental Health, (3) Prenatal Care, and (4) Workplace Injuries. The author of this report analyzed the transcripts using the following code system:

- Anxiety/Stress
- Access to Health Care
- Culture
- Economic/Money
- Education
- Evaluation & Follow-up
- Health Insurance
- Language
- Resources to Self-Care
- Self-Care
- Stigma
- Trust

The code system will be used to reveal the discovery, and other pertinent information, for each of the four health priority areas. The health priority areas aren't ranked. Instead, the health priorities are merely listed in alphabetical order. Other CHNAs across the state consider some of the code system items health priorities in their own right, e.g. health insurance and education.

LRHC is interested in obtaining more insight in the interrelationships between the health priorities and Social Determinants of Health (SODH). By utilizing the SDOH framework, the

common factors contributing to all of the health priorities are better identified, and thus, can be more effectively addressed in the LHRC Implementation Strategy.

The purpose of a CHNA is to act as a reference guide for development and execution of the LRHC Implementation Strategy. Therefore, the author embedded the qualitative data report for the LRHC focus groups into this section to streamline the comparative analysis process. Planners only need to reference one document versus the negotiation of several resources.

Most of the focus group passages could be used under one or more of the thematic code subgroups. The overlap in focus groups code system can be cross-walked between health priorities, e.g. a support group for long-term work injury (mental health + work injuries) and pregnant patients need more education on postpartum depression (mental health + prenatal care).

Several Social Determinants of Health (SDOH) are discussed in relationship to each of the code systems, as they emerge below. At the beginning of each subsection is a summary of the innovative approaches taken by the committed LHRC teams; there is a special focus on the strategies taken to eliminate, and/or lessen, SDOH barriers to healthcare. The author provides recommendations for any SDOH that have not yet been addressed by the LHRC continuity of care strategies; all author recommendations are based on extensive work with the community and available data.

(Source: HealthVoiceVision Lexington Community Health Survey)

Demographics: Lexington & Dawson County

Dawson County/Lexington Demographics:

Dawson County Population:	23,640
Lexington Population:	10,230

Lexington Racial Demographics[1]

Hispanic or Latino	60%
White	57%
Some Other Race	29%
Black or African American	6%
Two or More Races	3%
American Indian	1%
Asian	Below 1%

Lexington High School Student Membership by Race

Hispanic	76%
White	15%
Black or African American	6%
American Indian/Alaska Native	1%
Asian	1%
Two or More Races	1%

Lexington

Median Age	29.7	
Median Household Income	$44,834	
Individuals Below Poverty	20.4%	(Nebraska Poverty Rate 2016: 11.4%)
High School Graduate or Higher	55.2%	(Nebraska Education Attainment: 90.7%)

Lexington High School Student Membership

Enrollment	877	
Free/Reduced Lunches	74%	(an increase of 39% since 2002/2003)
English Language Learners	19%	
Graduation Rate	90%	

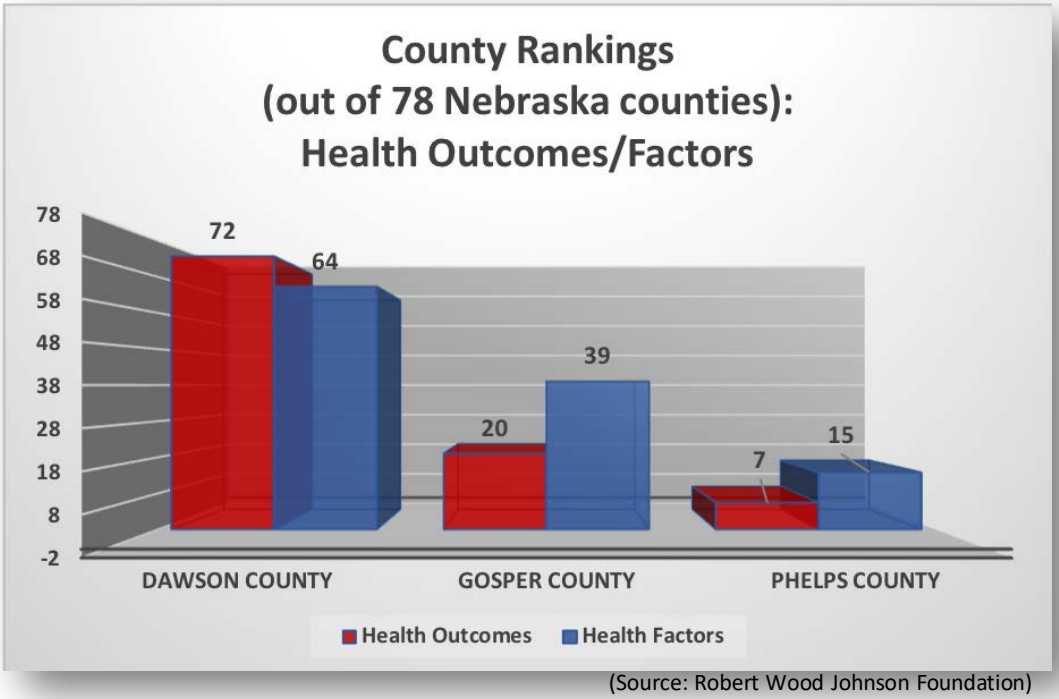
In 2015/2016 school year, 574 Lexington public school students were identified as homeless. The lack of available housing is cited as one of the main reasons so many students are classified homeless.

[1] US Census demographics reflect a residents ethnic and racial identity – thus the demographic percentage breakdowns don't add up (so to speak) to the actual population.

County Rankings: Health Outcomes & Factors

According to the Robert Wood Johnson Foundation's County Rankings & Roadmaps, 2017, Dawson County is ranked very low in both health outcomes (72nd out of 78 counties) and health factors (64th out of 78 counties). Phelps County ranks very high: 7th out of 78 counties for health outcomes and 15th out of 78 counties for health factors. Gosper County rankings are found in-between Phelps and Gosper Counties.

Figure 68. County Rankings: Health Outcomes/Factors



(Source: Robert Wood Johnson Foundation)

Lexington Regional Health Center: Addressing the Challenges NOW

As the data throughout this report, Dawson County is facing some serious challenges due to a myriad of reasons: growing elderly populations, shrinking health care systems, changing demographics, fluctuating agricultural markets, poor transportation systems, and aging house stock. To impact the dramatic rural health challenges facing the LHRC service area, hospitals in Cozad and Gothenburg need to adapt their community outreach strategies to be more effect with the changing demographics. Critical Access hospitals aren't going to have an effective impact without interagency collaborations that focus on improving patient care *everywhere* in Dawson County.

LHRC's health professionals are getting outside of the bricks and mortar to meet high needs patients on the ground, where they live, and where they self-care. Healthcare in today's world is complicated. The LHRC focus groups revealed that health care consumers need assistance in

navigating complex health insurance issues, estate planning, and the financial land fields of trying to afford chronic care.

Lexington Regional Health Center (LHRC) is doing just that: putting the patient first and reorganizing their systems of care to fit the community needs. LHRC efforts are illustrated throughout this report. The steep community partnerships are outlined in Section I. The very fact that LHRC invested their resources into creating a CHRA illustrates their hearts and minds are in the right place.

Since 2010, Leslie Marsh, CEO, has spearheaded the LHRC transformation into a *patient care* facility. Under her tenure, LHRC engaged patient care by adding an Urgent/Primary Care clinic, increasing availability of emergency room services (24 hours/7 days a week), opening a hospital-owned Family Medicine clinic, and completing an overhaul of the Outpatient Services Center. The Outpatient Services Center includes: 16 exam rooms to serve as a central location for all visiting specialists, three new operating rooms with cutting edge technology, two endoscopy procedure rooms, nine pre- and post- operation recovery rooms, four post-surgery rooms, telemedicine capabilities and an expanded and comfortable waiting room for family and friends. Under her strategic direction, LRHC has experienced an 82% percent reduction in readmissions and a 70% percent reduction in harm.

Leslie's resolute leadership, and commitment to excellence, has earned LHRC national recognition. She is the Treasurer for National Health Association, sits on the American Health Association Region 6 Policy Board, and is a member of the National Rural Health Association (NHRA) Board of Trustees and Rural Health Policy Congress, as well as serves as the NHRA Hospital and Health Systems Constituency Group Chair. Marsh has received numerous local, regional and national awards. Of note, Leslie received the 2015 Nebraska Health Achievement in Excellence award and was named one of the 130 *Women to Know in Hospital and Health Systems* by Becker's Hospital Review. As a tireless rural health systems advocate, and a constant champion for her staff, Leslie has spoken across the nation in a wide variety of venues, including testifying to the U.S. Congress about the regulatory burdens that rural health organizations endure.

Again, LHRC serves 14% of the primary patients, and 4% of the secondary, of Dawson County. Their community impact includes an 82% reduction in readmissions, as well as a 70% reduction in harm resulting in a cost savings of $206,526. Of the 9.4% of Dawson County residents with diabetes, the LHRC staff is managing 28% of this population. Since July 2017, this patient cohort has experienced a 5% improvement of in A1C management. XX Leslie

LHRC is in trenches of rural health care and will remain committed to the stellar care of their patients long past Leslie's and her staff's tenure.

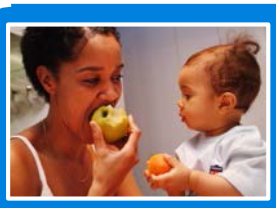
Appendix B:
Two River's 2012
Community Health Improvement Plan

2012

Community Health Improvement Plan

Access to Care and Mental/Behavioral Health

District-Wide Interagency Collaboration



Life-Style Choices & Personal Accountability

Two Rivers Public Health Department

Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney and Phelps Counties

Updated: 5.6.2013

Two Rivers Public Health District

COMMUNITY HEALTH IMPROVEMENT PLAN 2012

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Community Health Improvement Plan process (CHIP) for Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney and Phelps Counties began in October 2011 with the formation of a steering committee with local representatives from Good Samaritan Hospital, Kearney County Health Services, Lexington Regional Health Center, Phelps Memorial Health Center, and the Two Rivers Public Health Department Board of Health and Staff. The goal of this group was to complete a comprehensive assessment of the District. The Mobilizing for Action Through Planning and Partnerships (MAPP) Process was chosen as a framework for the assessment. This process is comprised of four assessments: the Local Public Health System Assessment, Community Themes and Strengths, Forces of Change, and Community Health Status.

The MAPP assessments were completed over the course of four meetings held in various locations throughout the District from February 2012 thru May 2012. Safety, Opportunity, Connectedness and Education were the guiding values identified during the course of the first meeting based on responses by District residents that participated in the Community Themes and Strengths Surveys. From this set of values a common vision was developed by participants to guide planning to improve the health of the district and its residents. Forces of Change working within the District were assessed during the initial meeting and later taken into consideration during the development phase of the CHIP.

During the second meeting, participants identified the strengths and opportunities for improvement in the function and form of the Public Health System as a whole using the National Public Health Performance Standards Program (NPHPSP) developed by the Centers for Disease Control and Prevention. Findings from this assessment were later used in the development of plans for district wide interagency collaboration.

The Community Health Status Assessment was performed by participants during the 3rd meeting in the MAPP Process. Analysis of both qualitative and quantitative data presented during the meeting were performed to identify strategic issues in the district as a whole.

The work product of 4th and final meeting produced three strategic issues for Action Groups to address: **Access to care/Mental and Behavioral Health; District Wide Interagency Collaboration; and Lifestyle Choices and Personal Accountability**. Actions groups were formed to address each identified priority and Initial follow up meeting dates were selected during this time.

Coordinated and collaborative efforts and resources of many organizations and individuals have been utilized in the development of this Community Health Improvement Plan. In order to successfully implement the CHIP community input and participation will be needed to significantly impact these complex health issues.

We welcome your input and participation as we work together to improve the health of the people in Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney and Phelps Counties.

Sincerely,

The MAPP Steering Committee

ACKNOWLEDGMENTS

The mission of Two Rivers Public Health Department is to *assess and monitor the health status of the district and facilitate the linking of resources to assure health promotion, prevention and protection for the people within the District*. In keeping with the mission of the Department the MAPP Steering Committee and the Two Rivers Board of Health would like to acknowledge all those who participated in and contributed to the MAPP process and the development of the Community Health Improvement Plan. We would like to thank the District Residents for their valuable input, without which this plan would not exist. Also, a big Thank You to our Facilitator, Deb Burnight, for all of her hard work to make this process such a success!

A full list of participants in the MAPP Process and the Action Group Members can be found at the end of this document.

MAPP Steering Committee

Connie Linder, Safety Director-
Kearney County Health Services

Dale Gibbs, Director of Outreach Services-
Good Samaritan Hospital

Trisha Sandstedt, Outreach Services Coordinator-
Good Samaritan Hospital

Rhonda Johnson, Public Relations, Foundation and Volunteer Officer - Phelps Memorial Health Center

Pat Samway, Director of Internal and External Affairs -
Lexington Regional Health Center

Patsy Johnson, Phelps Memorial Foundation Member

Dick Pierce, Buffalo County Supervisor and Two Rivers Board of Health Chairman

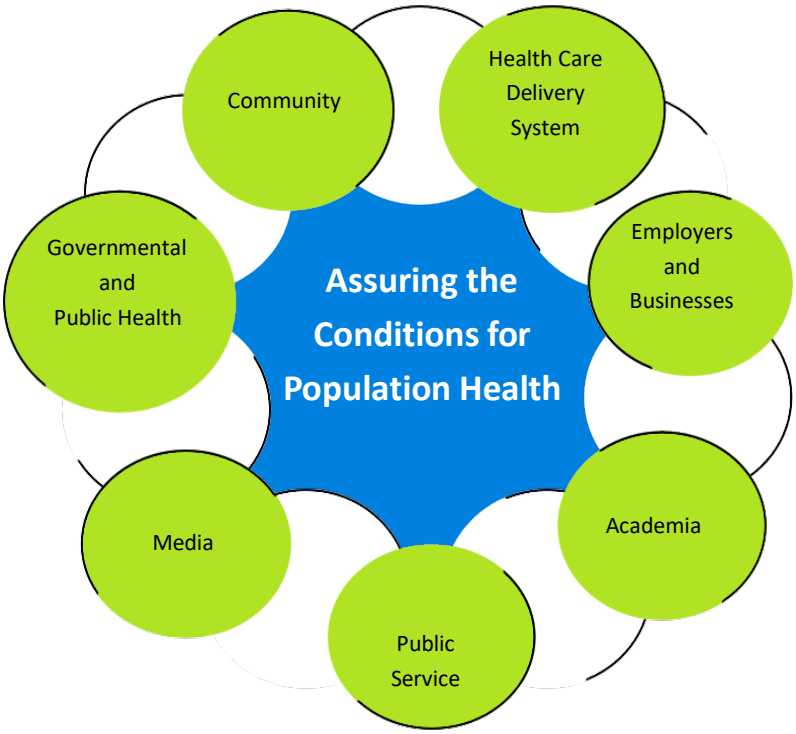
Terry Krohn, Director-
Two Rivers Public Health Department

Marsha Carlson, Public Health Nurse -
Two Rivers Public Health Department

Kim Hayes, Public Health Nurse/Assistant ERC-
Two Rivers Public Health Department

Amy Elwood, Assistant Director/ERC-
Two Rivers Public Health Department

How Do We Build Healthier Communities? BY WORKING TOGETHER !



The Public Health System

VISION

The Vision for the Two Rivers Public Health System was developed using input from District Residents participating in surveys (conducted in Spanish and English), Focus Groups, and Members of the Board of Health. MAPP Participants were guided through a collaborative process to develop a shared community vision to impart what the ideal future looks like in the Two Rivers District. To facilitate the development of the vision the following questions were asked of each group:

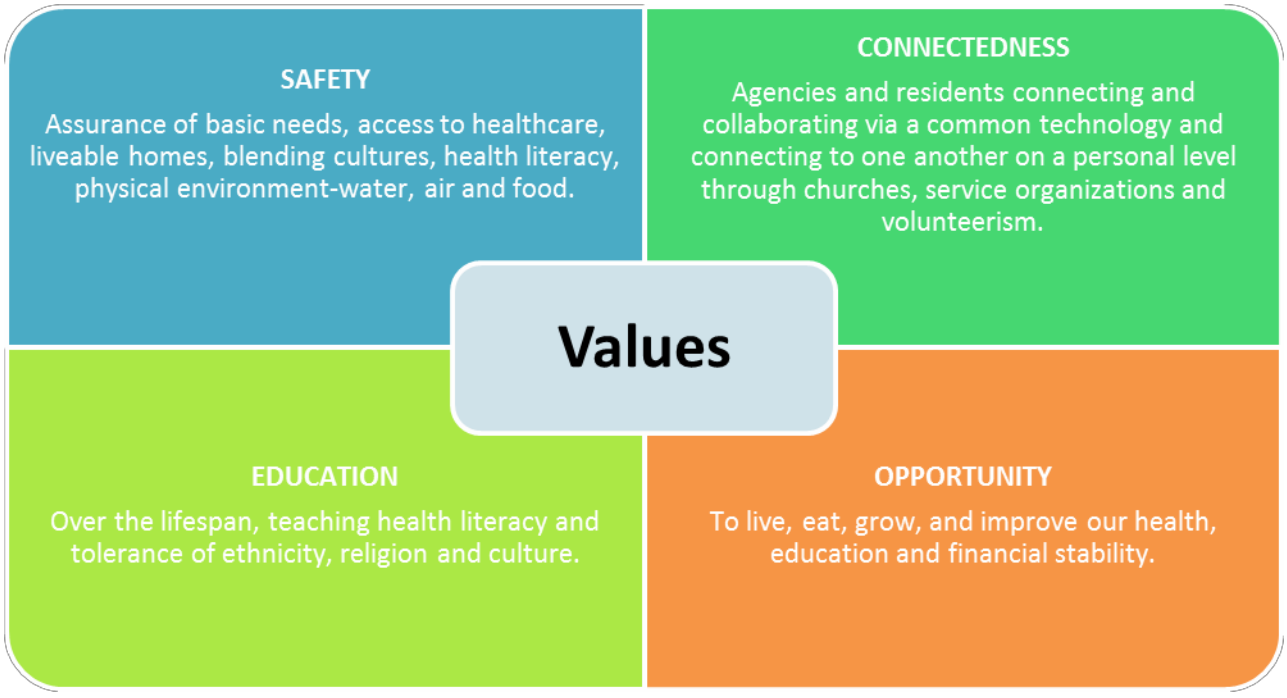
1. *How do you define a healthy community?*
2. *What community values promote a healthy neighborhood?*
3. *What kinds of resources are needed to create a healthy neighborhood?*
4. *Who is responsible for keeping a community healthy?*

Based on responses to these questions, the following Vision Statement was adopted to guide the MAPP Process and development of the CHIP:

"A healthy community assures that the opportunity to obtain optimal health is provided to district residents via interagency collaboration to promote safety, access to care and increased health literacy across the health district."

Values identified during the Visioning Process:

- **Safety**
- **Connectedness**
- **Education**
- **Opportunity**



LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

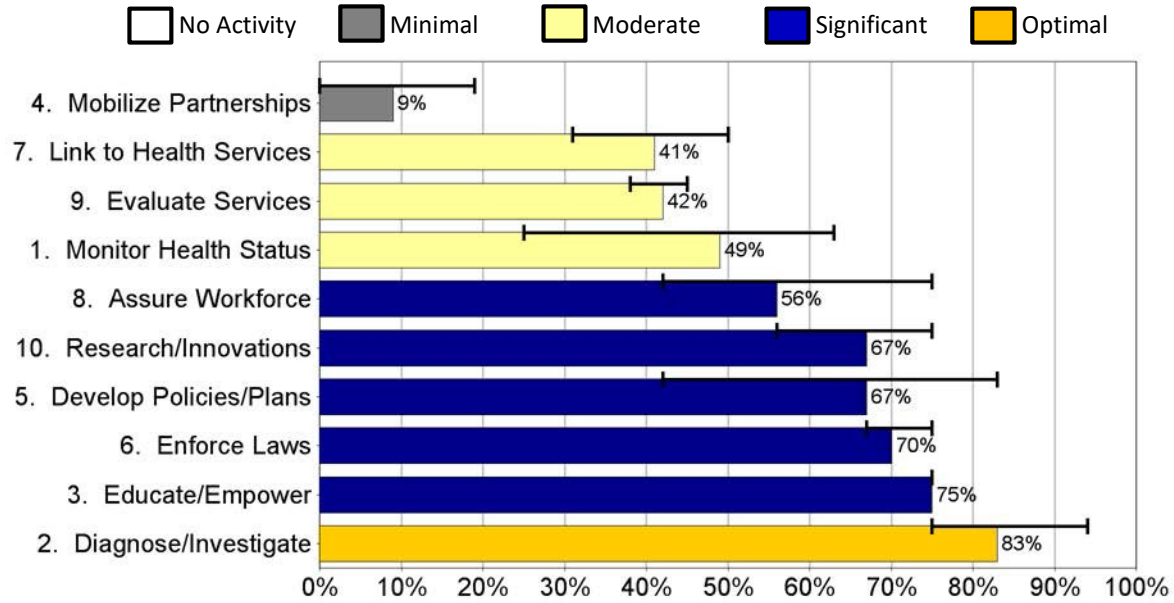
The National Public Health Performance Standards Program (NPHPSP) is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPSP Assessment Instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, respondents evaluate the activity levels of all public, private and voluntary entities that comprise the public health system and contribute to public health within the community. Assessment questions are asked to determine to what degree the Public Health System is providing the 10 Essential Services within the district. MAPP Participants Assessed the performance of the health system and Two Rivers Board of Health completed the Local Public Health Governance Performance Standards Assessment.

10 Essential Services of Public Health

1. *Monitor Health Status*
2. *Identify, Investigate, Control and Prevent Disease/Injury*
3. *Inform, Educate and Empower the Public*
4. *Promote Community Partnerships*
5. *Develop Policies and Plans*
6. *Enforce Public Health Laws and Regulations*
7. *Link People to Health Services*
8. *Maintain a Competent Public Health Workforce*
9. *Evaluate and Improve Programs and Services*
10. *Research*

Pub l i c Health System Performance Scores

The table below provides a quick overview of the system's performance in each of the 10 Essential Public Health Services (EPHS, listed above). Each EPHS score is a composite value determined by the scores given to those activities that contribute to each Essential Service. These scores range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum of 100% (all activities associated with the standards are performed at optimal levels).



To view the full report, go to [www .tworiverspublichealth.com .](http://www.tworiverspublichealth.com)

COMMUNITY HEALTH STATUS ASSESSMENT

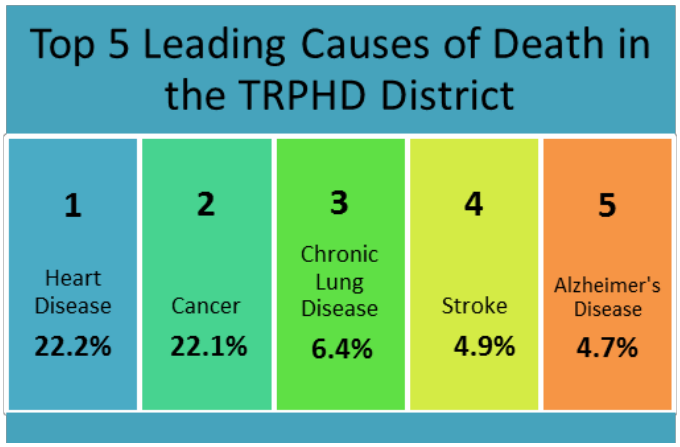
The Community Health Status Assessment identifies priority community health and quality of life issues. Data from a variety of sources were reviewed to compile the most current picture of the Health Status of the District. Sources included the Centers for Disease Control & Prevention, the 2010 U.S. Census Bureau, the 2011 Chronic Disease in Nebraska, Morbidity and Mortality Weekly Report, Nebraska Department of Health and Human Services, and the Nebraska Risk and Protective Factor Student Survey 2010.

The Two Rivers Public Health Department District Health Profile contains a more thorough listing of health status data. To view the full Profile go to: www.tworiverspublichealth.com.

Demographics

2010 Census Bureau reported that the population for the 7 counties in the Two Rivers' District was **94,797** and is comprised of **50.2% females and 49.8% males**.

Although there was overall population growth in the Two Rivers District between 2000 and 2010, 6 out of the 7 counties had a decrease in population. The most populated county, Buffalo, saw an increase of over 9%.



In the Two Rivers District there are:

- 8 hospitals
- 45 medical clinics, specialty clinics, and surgery centers
- 31 long term care and assisted living facilities

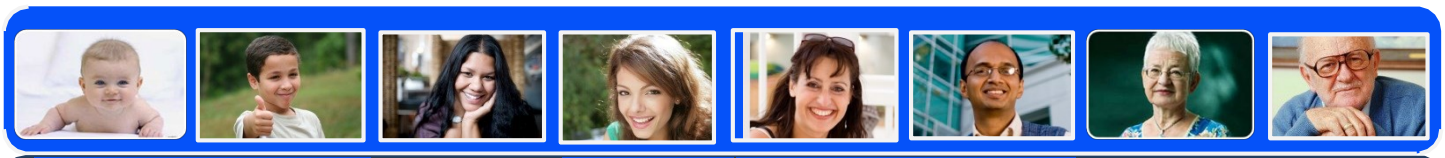
Access to Care

Uninsured Individuals:	12.7%
Medicaid Beneficiaries:	12%
Primary Care Physicians in District:	159
Federally Qualified Health Centers:	None
Mental Health Professional Shortage Area:	Yes

Perceived Health

Self-Reported: 10+ Days in Past Month When Physical Health was Not Good:	11.4%
Self-Reported: 10 + Days in the Past Month When Mental Health was Not Good:	10.5%

Population Distribution



0 -5 Years	6-14Years	15 24Years	25-44Years	45 -64 Years	65-74Years	75 -84Years	85+Years
6,779	12,909	14,717	22,303	24,197	6,780	4,765	2,347

Median Age is 36

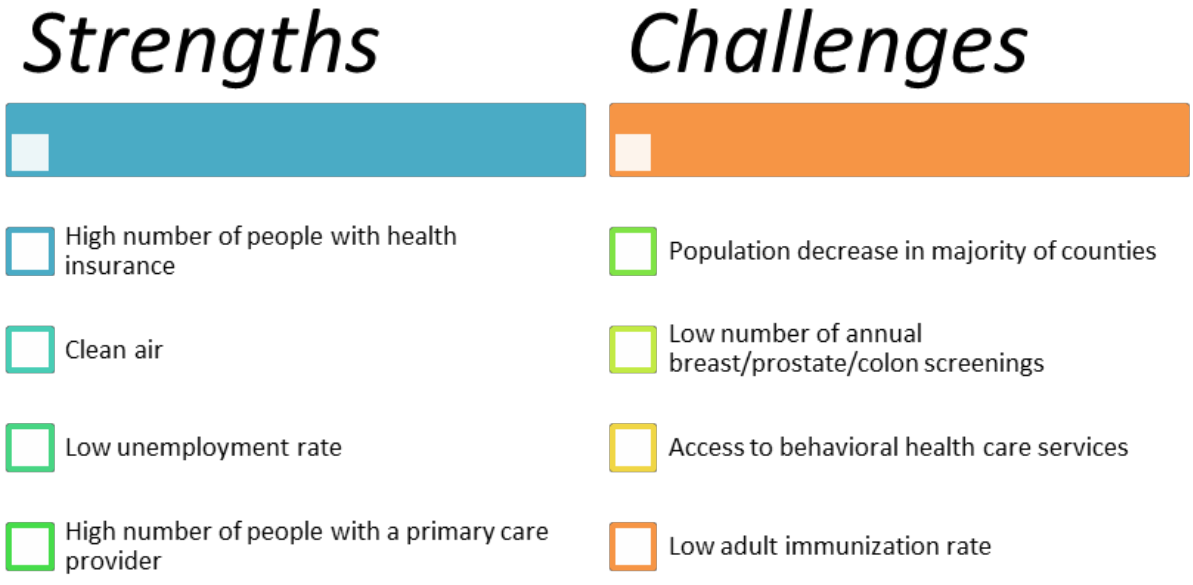
Two Rivers District Demographic Profile: Race and Ethnic Distribution (2010 Data US Census)

White	African American	Asian	American Indian or Alaska Native	Native American or Pacific Islander	Other	Total Population	Hispanic or Latino (Ethnicity)	Non-Hispanic or Latino (Ethnicity)
85,421	1,163	783	406	64	6,960	94,797	11,922	82,875

Demographic Profile: Poverty/Unemployment Distribution (US Census)

Core Indicators	Buffalo	Dawson	Franklin	Gosper	Harlan	Kearney	Phelps	NE
Percent Unemployed (2012 Data) Bureau of Labor	2.7%	4.7%	2.8%	3.8%	2.7%	2.7%	2.9%	3.7%
Percent Below Poverty Level (2009 US Census)	15.8%	14.8%	12%	9.4%	13.1%	9.2%	11%	12.2%
Percent Children Below Poverty Level (2008 US Census)	10.7%	14.1%	15%	12.7%	14.9%	9.9%	11%	11.7%
Median Household Income (2009 US Census)	$45,009	$40,048	$38,510	$49,336	$41,112	$51,165	$46,567	$47,470

After reviewing data for the District, the following **Strengths** and **Challenges** were identified;



COMMUNITY THEMES and STRENGTHS ASSESSMENT

This assessment provides a deep understanding of the issues residents feel are important by answering the questions: *"What is important to our community?"; "How is the quality of life perceived in our community?"; "What assets do we have that can be used to improve community health?"*.

To gather this information, a three part approach was taken. A convenience survey was distributed throughout the Two Rivers' District via email and the websites of multiple partners. A total of 387 community members responded to the survey. Next, a similar telephone survey of 529 district residents was conducted by the University of Nebraska Medical Center. Finally, five focus groups were also conducted in Alma, Elwood, Lexington (2), and Kearney utilizing an abbreviated survey form.

There were eight community domains covered in the surveys:

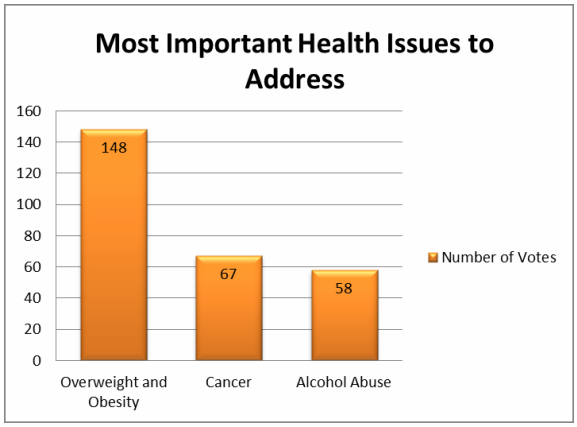
1. **Health care** (availability of general health care services and specialists, quality of hospital care and health care services; asked separately for their community and region)
2. **Supports for raising children** (childcare, schools, after school programs)
3. **Supports for older adults** (housing, meals, transportation, social networks)
4. **Recreational and leisure options** (physical activity, arts/music/culture, leisure time activities for young and middle-age adults)
5. **Jobs and the economy** (job availability, benefits, advancement, overall economy
6. **Housing** (availability and affordability of quality housing)
7. **Safety and security** (safety, crime, trust/support from neighbors)
8. **Social support and civic responsibility** (social support, volunteerism)

Telephone Survey:

The phone survey respondents in the Two Rivers District were more positive than the state overall in five of the eight community domains covered on the survey: **safety and security; social support and civic responsibility; jobs and the economy; supports for raising children; and supports for older adults.** Resident opinions were similar to the rest of state in the other three domains: **healthcare in their community and region; recreational and leisure options; and housing.**

Key Findings:

- When asked to rank order the seriousness of 16 different health issues are in their community, the top three responses included **cancer, overweight and obesity, and high blood pressure**.
- When asked to rank order the impact of 12 different behaviors impact overall health in their community, the top four responses included **talking on a cell phone while driving, texting while driving, tobacco use, and alcohol abuse**.
- When asked in an open-ended question what they see as the single most important health issue or health behavior that needs to be addressed in their community, the top three responses included **overweight and obesity, cancer, and alcohol abuse.** All other responses were at five percent or below.



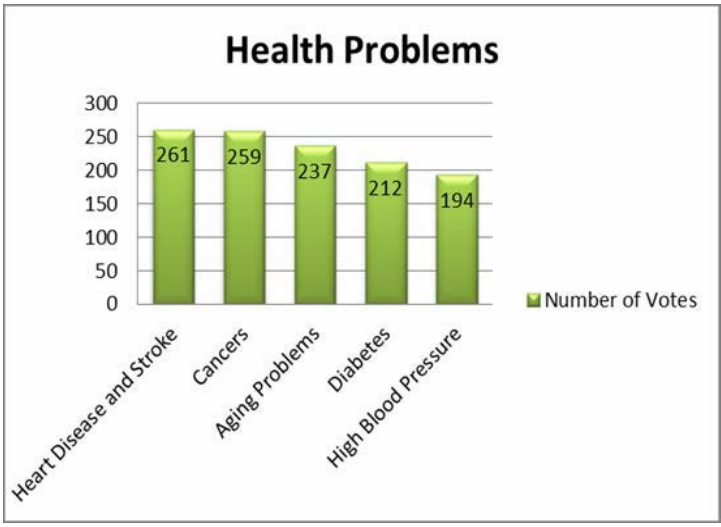
Web -based Survey:

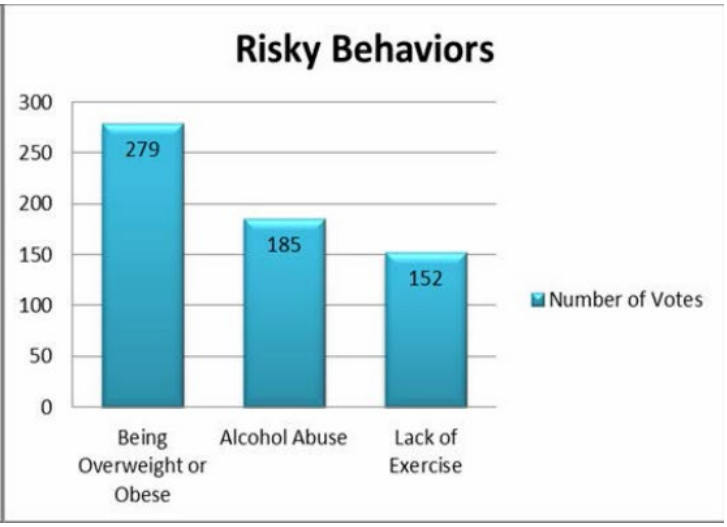
Respondents of this survey generally felt that their communities were safe places to live, provided opportunities, resources, and support that they needed. Most also felt that they were able to see a medical provider in their community when they needed to. However, prevention (e.g., seeing a medical provider when they are not ill) did not seem to be a priority. Low cost physical activity opportunities were identified as being important. Expenses (all types), healthcare, transportation, and housing were identified as issues for the elderly.

Key Findings:

The top 5 most important "Health Problems" (problems that have the greatest impact on overall community health) identified were; **Heart Disease and Stroke, Cancers, Aging Problems, Diabetes, and High Blood Pressure.**

The top 3 most important "Risky Behaviors" (risks that have the greatest impact on the overall community health) identified were; **Being Overweight or Obese, Alcohol Abuse, and Lack of Exercise.**





From the five Health Problems listed above**, cancer and heart disease and stroke** were identified as areas needing to be addressed. Although **obesity** was not listed it was identified by many as a concern.

Common themes identified in both the telephone and web-based surveys were **obese/overweight, cancer, and alcohol abuse.** The Focus Group theme of **Concern about Easy Availability of Unhealthy Food** reinforced responses in the other two surveys related to obese/overweight.

Common themes identified between our local assessment and the State assessment were **obese/ overweight, cancer, high blood pressure, and heart disease.**

Obese/overweight was the most common thread between all of the assessments.

Key Findings identified by Focus Groups:

- They had pride in their communities
- Concern about access to care
- Concern about the easy availability of unhealthy food
- Concern about limited hours of businesses such as grocery stores and pharmacies
- Concern about the limited employment opportunities

FORCES OF CHANGE ASSESSMENT

This assessment focused on the identification of forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operates.

In this workshop, participants were asked to consider the following question: *"What trends, factors and events are or will be influencing the health and quality of life in our communities and/or the work of our public health system?",* and to come to consensus on seven key forces of change. Participants also noted that the health system was moving away from fragmentation and toward collaboration. We are also moving from disease management toward prevention of disease and changing the health care focus from a Physician centered to a patient centered focus.

Di strict Key Forces of Change

- **Increased demand and decreased health resources**
- **Rural to urban population shift**
- **Economic uncertainties**
- **Globalization**
- **Shifts in speed, direction, type and amount of information (Public Relations trends- "shift happens")**
- **Technology and other scientific advances**
- **Changes in family structure**

Changes in family structure

- Changing definition of "family"
- Single families
- Schools expected to teach values

Economic uncertainties

- Healthcare reform
- Economy
- Prevention fundi

Rural to urban population shift

- Brain drain-migration
- Exodus of younger people
- Economics (jobs, aging population, insurance)

Globalization

- Ethnic diversity
- World events, natural disasters
- Mobile society leading to increase in communicable disease

Shifts in speed, direction, type and amount of information

- Technology, social networking
- Public perception

Technology and other scientific advances

- Public perception
- Environmental link to overall health
- Technology gap, affordable technology

Increased demand and decreased health resources

- Aging of the population
- Burden of chronic disease
- Increased obesity rate
- Behavioral Health

PRIORITY ISSUES/ACTION GROUPS

The MAPP Group reviewed all of the data and information from the four assessments: Visioning, Community Themes and Strengths, National Public Health Performance Standards, and the District Health Profile. **Eight strategic issues** were identified as needing to be addressed in order to achieve the Vision:

- **Access to Care**
- **Lifestyle Choices and Personal Accountability**
- **Sustainability**
- **Mental/Behavioral Health**
- **Environmental Issues**
- **Socio-Economic Issues**
- **Effective Education/Public Relations**

The group came to consensus around **four strategic priorities** that will guide the MAPP Action Cycle:

- **District-Wide Interagency Collaboration (for improved coordination of care)**
- **Lifestyle Choices and Personal Accountability**
- **Mental/Behavioral Health**
- **Access to Care**

It was agreed that Access to Care and Mental/Behavioral Health are strategically linked and will be focused on by one Action Group. Effective Education/Public Relations was seen as an overarching issue/tool that would be utilized in reaching the prioritized goals.

A data platform with current baseline and supporting data was developed for each one of the identified priority areas by TRPHD staff. This included data and best practices from Healthy People 2020, the Community Guide, and the State. This information was provided to the three Action Workgroups to aid them in developing an action plan that included a strategic issue goal, long and short term goals and process goals which are detailed in this plan.

Access to Care and Mental/Behavioral Health

- Access to Care

District-Wide Interagency Collaboration

- District Council Development

Lifestyle Choices & Personal Accountability

- Healthy Actions

Access To Care

The MAPP Access to Care Action Group is working to increase access to healthcare in the Two Rivers' District through the use of the telehealth system. Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health - related education, public health and health administration.

Risk Factors:

- In 2009, 10.5% of district residents reported having 10 or more days in the last month as having mental health that was not good.
- Every county in the Two Rivers' District is federally designated as having a mental health professional shortage as of 2008.
- Two Rivers District is a State designated shortage area for health professionals including: Family Practice, General Surgery, Internal Medicine, Pediatrics, OBGYN, Dentists, and Pharmacists.

Impacts:

- **Money and time savings for patients and providers**
- **Early diagnosis and treatment**
- **Decreased use of the emergency room**

This priority issues addresses the National Prevention Strategy of Clinical and Community Preventative Services-prevention focused healthcare and community prevention efforts are available, integrated and mutually reinforcing. It also relates to the Nebraska State Health Improvement Plan Priority Strategic Issue: Improving the integration of public health, behavioral health, environmental health, and health care services.

Goal	Healthy People 2020	Baseline	Source Data
Increase the number of mental/behavioral health specialty and primary care telehealth clinical encounters in the District by 20% by 2016.	Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral by 10% improvement.	222 encounters in 2012 in Two Rivers' District	Nebraska Statewide Telehealth Network (2012)

Impact Objectives:

- Increase the number of mental/behavioral health encounters over telehealth in the Two Rivers' District by 20% by 2016. **Baseline data: 131 encounters in 2012**
- Increase the number of mental/behavioral health encounters provided by *local Behavioral Health professionals* over telehealth to patients located within the Two Rivers' District by 20% in 2016. **Baseline data: 131 encounters in 2012**
- Increase the number of specialty care and primary care encounters provided by local professionals over telehealth in the Two Rivers' District by 20% by 2016. **Baseline data: 91 encounters in 2012**
- Increase the number of sites that provide patient access to telehealth encounters for mental/behavioral health, specialty and primary care by 20% by 2016. **Baseline data: 10 Sites in 2012**

Healthy Actions

Healthy Actions is currently facilitating the creation and the sustainability of community based programs, policies, and environmental change which increase access to health foods, develop and promote active recreational choices, and empower the population to take control of their wellness.

Risk Factors:

- 12.7% of households in Nebraska experienced food insecurity between 2008-2010.
- 11.5% of the districts' population is below 100% of poverty.
- Nebraska has a 35% prevalence of high cholesterol which is more than double the national target of 17%.
- Prevalence of high blood pressure in District adults is 27.4 persons per 100,000 as opposed to the Nebraska rate of 24.8 persons per 1000,000.

This priority issue addresses the National Prevention Strategy of Empowered People-support people in making healthy choices. It also relates to the Nebraska State Health Improvement Plan Priority Strategic Issue: Expand health promotion capacity to delivery public health prevention programs and policies across the lifespan.

Healthy Actions	Healthy People 2020	Baseline	Source Data
Facilitate the creation and sustainability of community based programs, policies, and environmental changes which promote healthy choices	The target of adults at healthy weight is 33.9% of a population	32.6% of population are at a healthy weight in the District	NBRFSS (2009) (Nebraska Behavioral Risk Factor Surveillance System)
Increase access to healthy foods	Persons consume .9 cups of fruits and 1.1 cups of vegetables each day per 1,000 calories daily	21.9% of the District self-reported 5 or more fruit and vegetable servings per day	NBRFSS (2009)
Develop and promote active recreational choices	47.9% of adults engage in moderate intensity physical activity for 30 minutes a day, 5 days a week	47.5% of the District participate in regular activity, and 21.4% reported no physical activity at all	NBRFSS (2009)

Impact Objectives:

- Decrease Body Mass Index (overall in health district)
- Increase fruit and vegetable intake
- Self report of 30 minutes of physical activity 5 days a week per week of at least a moderate intensity

67.4% of district adults are either overweight or obese

District Council Development

Mission:

The Mission of the District Council Development Committee is to facilitate the creation of a district-wide interagency council for the purposes of fostering improved communication and health collaboration.

Problems:

- Mobilizing partnerships within the district received an overall score of 9% in the National Public Health Performance Standards Program (NPHPSP) Assessment. Minimal activity in this area was reported.
- Communication strategies to build awareness of public health received a score of 0 in the NPHPSP. Constituency development received a score of 19%. No formal community partnerships were identified with a score of zero.

Strategic Issues:

Based on the National Public Health Performance Standards Program's Local Public Health System Performance Assessment, actions should be taken to mobilize community partnerships in order to identify and solve health problems. The Nebraska State Health Improvement Plan strategic issue of "Improving the integration of public health, behavioral health, environmental health, and health care services." should also be included in the plan for improvement.

Root Causes Identified by District Stakeholders:

- Lack of funding
- Grant restrictions
- Limited focus of agencies
- Territory issues
- Lack of collective buy-in and collaboration
- Trust issues

Benefits of a District Council:

- **Promotes responsible use of funds**
- **Promotes common vision**
- **Increased awareness of District programs and services**
- **Provides a broader evidence base**

Goals met as of March 2013:

- By January 2013, the committee has formulated a list of potential members and contacted them
- Preliminary By-Laws, Governance Model and suggested council objectives identified
- Create Introduction Packet for potential Council Members

Continuation Phase:

- District Council Development Committee continues to work with initial 3 members of the District Council to support them throughout planning stages
- Committee members are currently working with the UNMC College of Public Health to develop an Effective marketing strategy to secure buy-in for the council

RESOURCES FOR EFFECTIVE ACTION

The following are websites for Promising or Model Practice Programs for assistance when developing programs.

Cancer Control Planet:
http://cancercontrolplanet.cancer.gov

Centers for Disease Control and Prevention:
www.cdc.gov

Community Guide Website-The Guide to Community Preventative Services:
http://www.thecommunityguide.org/index.html

NACCHO Model and Promising Practice Website:
https://eweb.naccho.org/eweb/DynamicPage.aspx?site=naccho&webcode=mpsearch

Nebraska Department of Health and Human Services:
http://dhhs.ne.gov

GET INVOLVED!

We need you to help us make a difference in the health of the people in your community.

MA PP Access to Care Action Group

Contact: Terry Krohn, 308-995-4778

District Council Action Group

Contact: Kim Hayes, 308-995-4778

Healthy Actions Action Group

Contact: Heather Easton, 308-995-4778

For questions concerning the MAPP Process

Contact: Terry Krohn, 308-995-4778

The four MAPP Assessments will be repeated again in the next 4 years.
Please consider being a part of that process!

Assessment Participants

Bertrand Health Clinic:
- Ruby Houck, Nurse Practitioner

Buffalo County Board of Supervisors:
- Dick Pierce, County Supervisor

Buffalo County Community Partners:
- Denise Zwiener, Director
- Jessica Carter
- Jessie Perez, Health HUB Coordinator

Buffalo County Emergency Management:
- Darrin Lewis, Emergency Manager

Buffalo County Juvenile Services:
- Doug Kramer

Central Community College:
- Diana Watson
- Cassie Smith
- Marilyn Hersh
- Marcie Kemnitz, Dean

Central Health Center:
- Laura Urbanec
- Susan Sheppard

Christian Homes:
- Don Bakke, Administrator

Community Action Partnership: of Mid-Nebraska
- Julie Weir, Health Services Director
- Kris Wright, Fiscal Director
- Meredith Collins, Planning Director

Cozad United Way:
- Barbara Fink

Dawson County Emergency Management:
- Brian Woldt, Emergency Manager

Dawson County Transit:
- Barbara Hollenbeck

Department of Health and Human Services:
- Diane Urias
- Josie Rodriguez
- Maria Hines

Elwood Public Schools:
- Gwen Stoll, School Nurse

Family Medical Specialties:
- Sharrise Guthrie

Assessment Participants

Family Practice Associates:
- Janet Steffen

Franklin County Memorial Hospital:
- Lora Rutt
- Sheri Alber

Gibbon Public Schools:
- Kay Bockstadter, School Nurse

Good Samaritan Hospital:
- Bob Smoot
- Dale Gibbs, Director of Outreach Services
- Dana Welsh
- Trish Sandstedt, Outreach Services Coordinator

Good Samaritan Hospital Foundation:
- Lesley La File

Gothenburg Memorial Hospital:
- Myra Gronewold

Harlan County Health Services:
- Jeff Shelton, Chief Executive Officer
- Manny Wolf, Director of Nursing

Harlan County Journal:
- Michelle Janicek

Holdrege Chamber of Commerce:
- Michelle Ehresman

Holdrege Housing Authority:
- Amber Lewis

Kearney County Health Services:
- Connie Linder, Safety Director
- Renee Grams, APRN

Kearney Housing Authority:
- Laurie Jameson

Kearney Public Schools:
- Carol Renner

Lexington Police Department:
- Diane Reiber, Police Sargent
- Tracy Wolf, Police Chief

Lexington Public Schools:
- Bob Ripp, Director of Early Learning Academy
- Cyndi Jaeger, School Nurse

Lexington Regional Health Center:
- Leslie Marsh, Chief Executive Officer
- Pat Samway, Director of Internal/External Affairs
- Tiffany Carlson

Assessment Participants

Marse McCann-Carpenter Dental:
- Marse McCann-Carpenter, DDS

Mosaic:
- Debbie Herbel, Executive Director

Parent Child Center:
- Jennifer Sancksen
- Maria Reyes

Phelps County Supervisors:
- Russ Cruise, County Supervisor

Phelps County Sheriff:
- Delisa Beaudette
- Gene Samuelson, Sheriff

Phelps Memorial Health Center:
- Dorothy Anderson
- Rhonda Johnson, Public Relations, Foundation, and Volunteers Officer
- Sami Bradley, Child Services
- Cindy Jackson
- Mark Harrel, Chief Executive Officer

Phelps Memorial Foundation:
- Patsy Johnson

Phelps Memorial Home Health:
- Lisa Skaggs

Plum Creek Care Center:
- Gayle Rogers, RN/Administrator

Plum Creek Medical Group:
- Chrystal Dowling, Care Coordinator
- Karma Bomberger
- Marian Wehr, Director of Nursing

Region 2 Human Services:
- Shannon Sell

Region 3 Behavioral Health Services:
- Beth Baxter, Regional Administrator
- Kay Gidden
- Tiffany Gressley, Prevention System Coordinator

Sentinel Health Care:
- Crystal Winfield, Director of Operations

South Central Behavioral Services:
- Sally Cox, LIMHP, LADC

Assessment Participants

The S.A.F.E. Center:
- Nikki Gausman

Tri-Cities Medical Response System (TRIMRS):
- Laura Meyers, Consultant

Two Rivers Public Health Department:
- Marsha Carlson , Public Health Nurse
- Heather Easton, Wellness/Environmental Coordinator
- Amy Elwood, Assistant Director/ERC
- Kim Hayes, Public Health Nurse/Assistant ERC
- Terry Krohn, Director
- Kerrey Miller, Surveillance Coordinator
- Farren Nelson, Office Manager

Two Rivers Public Health Department Board of Health:
- Sandy Becker
- Bob Butz
- Jean Rush

United Way of the Kearney Area:
- Dawn Holbin, Accounting Manager

University of Nebraska at Kearney:
- Allan Jenkins, Ph.D. Economics Department
- Brad Plantz, Ph.D.
- John Lakey, Assistant Vice-Chancellor of Business and Finance
- Todd Bartee

University of Kearney Police Department:
- Michelle Hamaker

University of Nebraska at Lincoln Extension:
- Carol Schwarz, MS RD

University of Nebraska Medical Center:
- Kate Nickel, Assistant Professor
- Steve Pitkin, Assistant Dean, UNMC-CON

Vocational Rehabilitation:
- Cassy Kvasnicka, Employment Specialist

YCPO:
- Roxanne Denny-Mickey-YCPO Coordinator

YMCA of the Prairie:
- Jeff Morgan, Chief Executive Officer

Zion Lutheran School:
- Diane Jackson, School Nurse

Action Group Participants

Access To Care:

Good Samaritan Hospital:
- Wanda Kjar, Telehealth Coordinator
- Trish Sandstedt, Outreach Services Coordinator
- Dale Gibbs, Director of Outreach Services

DKG Consultants:
- Dave Glover
- Laura Meyers, Consultant

Franklin County Memorial Hospital:
- Sheri Albers

Phelps Memorial Health Center:
- Mark Harrel, Administrator

Region 3:
- Melinda Farritor
- Beth Baxter, Regional Administrator
- Kay Glidden , BHECN

South Central Behavioral Health Services:
- Greg Mucklow, Counselor
- Sally Cox, Counselor

Two Rivers Public Health Department:
- Terry Krohn, Director
- Robert Butz– Board of Health

School Nurse:
- Patsy Johnson

Recruitment is ongoing for all Action Groups.

District Council Development:

Buffalo County Community Partners:
- Denise Zwiener, Executive Director

Community Action Partnership: of Mid-Nebraska:
- Julie Weir, Health Services Director

Franklin County Memorial Hospital:
- Sheri Alber

Good Samaritan Hospital:
- Trish Sandstedt, Outreach Services Coordinator

Region 3 Behavioral Health:
- Melinda Farritor

TRIMRS:
- Laura Meyers, Consultant

Two Rivers Public Health Department:
- Kim Hayes, Public Health Nurse/Assistant ERC
- Amy Elwood, Assistant Director/ERC

YCPO:
- Roxanne Denny-Mickey-YCPO Coordinator

Healthy Actions:

Buffalo County Emergency Management
- Darrin Lewis, Emergency Manager

Central Community College
- Diana Watson, Regional Coordinator

Holdrege Public Schools
- Abbie Soneson, School Nurse

Kearney Park and Recreation
- Jade Meads, Recreation Coordinator
- Scott Hayden, Park and Recreation Director

Lexington Regional Health Center
- Tiffany Carlson, C.F.I. Coordinator

Community Action Partnership of Mid-Nebraska
- Meredith Collins, Planning Director

Phelps Memorial Health Center
- Sue Keiser, Dietician
- Rhonda Johnson, Public Relations

Two Rivers Public Health Department
- Heather Easton, Wellness/Environmental Coordinator
- Marsha Carlson, Public Health Nurse

UNMC College of Nursing
- Michelle Ellermeier, Instructor

YMCA of the Prairie
- Jeff Morgan, C.E.O

APPENDIX B

ACCESS TO CARE

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DISTRICT WIDE INTERAGENCY COLLABORATION

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LIFE-STYLE CHOICES

Goals met as of March 2018

Life-Style Choices and Personal Accountability

In 2018, Two Rivers Public Health Department began the fourth and final year of the 1422 Grant. As stated previously, the 1422 Grant is funded through the Affordable Care Act to support programs to prevent and control chronic disease. Two Rivers Public Health Department (TRPHD) is continuing to collaborate with the community and with partners to enact policy change, environmental change, and promote active recreational choices.

As part of 1422 Grant activities, TRPHD has partnered with local food retail stores and businesses to increase the offering of healthy food. From the baseline data of healthy food offerings in retail stores gathered in July of 2015, it was determined that both ethnic and convenience stores could be potential partners in healthy retail.

- TRPHD has partnered with 2 ethnic stores in Lexington to increase healthy food retail
    - Teresa's Tortilleria and Bakery
    - Lexington Oriental Market
- TRPHD has partnered with Eaton Corporation in Kearney in order to increase healthy food vending in the onsite cafeteria/micromarket.
- The vending assessment and improvement will be conducted by UNK representative Alexis Malmkar.

Two Rivers PUBLIC HEALTH DEPARTMENT

Life-Style Choices and Personal Accountability

New Grant Funding

2012 Community Health Improvement Plan

APPENDIX B

ACCESS TO CARE

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DISTRICT WIDE INTERAGENCY COLLABORATION

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LIFE-STYLE CHOICES

- Malmkar also completed the vending assessment and improvement on the UNK campus during the third year of the 1422 grant, 2017.

TRPHD continues to promote walking in transportation and community plans in key urban centers; Kearney, and Lexington. Although the Walking Summit in November 14, 2015 generated an enthusiastic response, implementation of policy change and walking initiatives have failed to gain ground in both the Lexington and Kearney communities.

TRPHD is actively promoting classes via the National Diabetes Prevention Program (an evidence-based practice to educate individuals on lifestyle change). To date, three clinics in the district have added National Diabetes Prevention Program to the CDC Registered list.

1. HelpCare Clinic _Kearney
   3015 Avenue A
   Kearney, NE 68847
   308-224-2392
2. Kearney YMCA
   4500 6th Avenue
   Kearney, NE 68845
   308-237-9622
3. Lexington Regional Heath Center
   120 N Erie Street
   Lexington, NE 68850
   308-324-5651

APPENDIX B

ACCESS TO CARE

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DISTRICT WIDE INTERAGENCY COLLABORATION

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LIFE-STYLE CHOICES

The second component of 1422 focuses on interventions to improve at risk quality delivery. Many of the activities focus on the collaboration of partners within the health system to provide better access to care.

Specific activities are team-based care engagement, using community health workers to connect patients to services in the community, and to link resources and life-style change programs. During March 2018 TRPHD was happy to initiate the Community Health Worker Collaborative to enhance the exchange of information among district Community Health Workers (CHWs). The goal of this group is to inform district CHWs of resources, ability to refer, discuss current political and local issues.

District-wide Interagency Collaboration

Two Rivers Public Health Department went through significant staff transitions during 2017. Because of the changes, TRPHD is actively re-engaging partners in the district through interagency collaboration, the forming of new partnerships, and emphasizing a new branding strategy to become more visible in the community. TRPHD continues to take part in a strong partnership with Phelps County COAD, regular attendance to both the Lexington Interagency Meeting and the Community Connections Meeting in Kearney.

Oral Health Expansion Program

Brief History of the Two Rivers Public Health Department's LifeSmiles Dental Health Program

In the past few decades, oral health has become a national priority in the United States. In May 2000, the US Surgeon General issued a significant report titled *Oral Health in America*, which provided an evidence-based argument for the importance of optimal oral care, specifically how diseases and conditions that affect the face, mouth, and teeth are connected to overall health and well-being in all age groups.Good oral health is crucial to overall health. Research has shown that poor oral health is a risk factor for;

- Heart and lung disease
- Dementia
- Diabetes
- Cancer
- Autoimmune diseases
- Premature-low Birth weight babies
- Reduced ability for children to thrive
- Complications with children's education experience

Two Rivers Public Health Department's Dental Health Program originated in 2008 and began with providing access to care to those found at high risk for oral/ dental disease. Early collaboration endeavors began by partnering with WIC and Head Start in Kearney and Lexington.

Two Rivers Public Health Department's Dental Health Program originated in 2008 and began with providing access to care to those found at high risk for oral/ dental disease. Early collaboration endeavors began by partnering with WIC and Head Start in Kearney and Lexington.

The Lifesmiles Dental Health Program's objective is to collaborate with community based groups, healthcare providers, and organizations to provide preventive dental services with goals of improving access to dental care. Program services include; fluoride varnish treatments, silver diamine treatments, antibacterial treatments, dental sealants, oral/ dental screenings, oral cancer screenings, dental prophies, oral health education, referral assistance, and the providing of homecare supplies. Program services also include providing educational in-services and presentations to agencies and organizations as well as participation at outreach community events. Lifesmiles Dental Health Program has utilized NE DHHS- Office of Oral Health and

Dentistry's State Assessments as a guideline for where to focus services as well as using risk assessment to concentrate service delivery where disparities exist. Lifesmiles' program expansion now has evolved to provide preventive dental services in partnership with 8 preschools, 4 Head Starts, 14 schools, 4 WIC clinics. Services were also

APPENDIX B

ACCESS TO CARE

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DISTRICT WIDE INTERAGENCY COLLABORATION

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LIFE-STYLE CHOICES

expanded to include 4 assisted living facilities and 5 long-term care facilities in the Two Rivers Public Health Department Service area.

Update of Oral Health Program Activities

In July of 2017, partnership development meetings occurred with Cozad Care Center and Rehab, Elwood Care Center, Brookdale Senior Living, and Holdrege Memorial Homes to provide preventative services to their residents in both their Assisted Living and Long-term Care facilities. Cozad Care Center was the first site to receive services on August 15th, 2017 followed by Elwood Care Center on August 22nd, 2017 and Holdrege Memorial Homes on August 29th, 2017. Brookdale Senior Living began with service coordination on September 29th, 2017