Regional West Medical Center

2015-2017

Community Health Needs Assessment
and Health Improvement Plan

Regional West Health Services

Scotts Bluff County Health Department

Panhandle Public Health District

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Letter from the CEO

We, at Regional West, are proud of our longstanding tradition of not only providing quality health care but also reaching out to the community to address local and regional health care needs and concerns. Doing so is our both mission and the basis of our growth from a small community hospital to a regional referral center.

We are now required by the Patient Protection and Affordable Care Act to conduct a community needs assessment to determine unmet health care needs in the community.

For the past year, we have worked collaboratively with the Scotts Bluff County Health Department, focus groups, community boards, advisory groups, and area residents to discuss and review local health initiatives, resources, and gaps in health care. This assessment involves the collection of data to steer our efforts to address pressing health issues.

A task force of staff from Regional West and Scotts Bluff County Health department ranked the unmet needs based on data analysis and the recommendations of the individuals and organizations who participated in the assessment. Two issues were identified as top priorities: chronic disease and injury prevention. The task force has developed a three-year plan for implementation and interventions to address these local needs.

Regional West is committed to improving the health of our community by continually working with community partners to address the health needs of Scotts Bluff County and regional residents. We hope that the end result of this assessment and the goals it establishes helps to improve the lives of those we are privileged to serve.

John Mentgen FACHE
President & CEO
Regional West Health Services

About Regional West Medical Center

Regional West Health Services in Scottsbluff, Neb., is the parent company of Regional West Medical Center, a 182-bed regional referral center and one of three Level II Trauma Centers in the state. The trauma program includes Air Link air ambulance services, which is fully accredited by The Commission on Accreditation of Medical Transport Systems (CAMTS).

As the region's only tertiary referral medical center, Regional West offers care that spans more than 32 medical specialties provided by over 28 physician clinics. With nearly 300 providers, and over 2,000 employees, Regional West provides comprehensive and innovative health care services for the people of western Nebraska and the neighboring states of Colorado, South Dakota, and Wyoming.

Regional West Health Services includes

- Regional West Medical Center—182-bed regional referral center and a Level II Trauma Center
- Regional West Physicians Clinic—Western Nebraska's and central eastern Wyoming's largest multispecialty medical and surgical group.
- Regional West Garden County, Oshkosh—A 10-bed acute care hospital, health care clinic, and 40-bed intermediate care facility that serves residents in the southeastern Nebraska panhandle region.
- Regional West Laboratory Services—Offers a full range of laboratory services 24/7, including reference laboratory services, to health care providers throughout Nebraska, Wyoming, South Dakota, Iowa and Idaho. It is accredited by the Commission on Laboratory Accreditation of the College of American Pathologists (CAP).
- Regional Care, Inc. (RCI)—Based in Scottsbluff, RCI is one of the nation's premier independent third-party administrators; providing cost, medical, and claims management for clients throughout the United States.
- The Village at Regional West—A full-service retirement community located adjacent to Regional West Medical Center and offering both independent and assisted living apartments for persons age 55-plus with 100 units for residents.
- Regional West Foundation—A 501(c)(3) non-profit organization developed to enhance the services, programs, and projects of Regional West Health Services through donations, planned giving and fundraising efforts.

Regional West is an active leader in the Rural Nebraska Healthcare Network (RNHN) and supports the following Critical Access Hospitals in Nebraska:

- Regional West Garden County—Oshkosh
- Chadron Community Hospital—Chadron
- Gordon Memorial Health Services—Gordon
- Kimball Health Services—Kimball

- Box Butte General Hospital—Alliance
- Morrill County Community Hospital—Bridgeport
- Perkins County Health Services—Grant
- Sidney Regional Medical Center—Sidney

Award Winning Care

- The Joint Commission—Full accreditation by the Joint Commission demonstrates our commitment to providing the very best for our patients–quality, safety, and innovation.
- American College of Surgeons Commission on Cancer—The only program in Nebraska, and one of a limited number of U.S. hospitals, to receive four consecutive Outstanding Achievement Awards from the American College of Surgeons Commission on Cancer.
- Bariatric Surgery Center of Excellence—Regional West is a designated Bariatric Surgery Center of Excellence, making our medical center one of two Nebraska hospitals to be so recognized.
- Commission on Accreditation of Rehabilitation Facilities (CARF)—Regional West's Acute Rehabilitation Unit and Stroke Care program are both certified by the Commission on Accreditation of Rehabilitation Facilities.
- AACVPR Certified—Regional West's AACVPR certified cardiovascular rehabilitation program is recognized as a leader in the field of cardiovascular rehabilitation by offering the most advanced practices available.
- Level II Trauma Center -Regional West is one of just three Level II Trauma Centers in Nebraska, as verified by the American College of Surgeons Committee on Trauma and designated by the State of Nebraska Health and Human Services Department.

Mobilizing for Action through Planning and Partnerships (MAPP)

Regional West Medical Center (RWMC) participated with other hospitals in the Rural Nebraska Healthcare Network (RNHN) in a joint planning process facilitated by Panhandle Public Health District (PPHD). Mobilizing for Action through Planning and Partnerships (MAPP) is a partnership-based framework to conduct a community health needs assessment and develop a community health improvement plan. MAPP emphasizes the partnership with all sectors of the public health system to evaluate the health status of the region it serves, identify priority areas, and develop plans for implementation

MAPP consists of four assessments:

1. Community Themes and Strengths Assessment: focus groups addressing the community concerns about what is important, how quality of life is perceived, and the assets that exist that can be used to improve community health
2. Local Public Health System Assessment: identifies the components, activities, competencies, and capacities of the public health system and how the essential services are being provided
3. Forces of Change Assessment: identifies what is occurring, or might occur, that affects the health of the community; the opportunities and threats factors that are currently at play
4. Community Health Status Assessment: identifies priority community health and quality of life issues; economic data provided by Panhandle Area Development District and health data provided by Panhandle Public Health District

MAPP was used in 2011 to conduct the Regional Community Health Assessment and the priorities chosen for the 2012-2017 Regional Community Health Improvement Plan are:

- Healthy Living: Healthy Eating, Active Living, Breastfeeding
- Mental and Emotional Well Being
- Cancer Prevention: Primary Prevention, Early Detection
- Injury and Violence Prevention

The hospitals in the RNHN and PPHD partnered to complete the MAPP process again in 2014 and will continue to do so every three years. These participants make up the MAPP Steering Committee. The Steering Committee will be charged with reviewing data and progress on the chosen priorities, using quality improvement to modify implementation plans as needed, and sharing results with stakeholders.

Prioritization Process

In April 2014, the hospitals came together in an initial meeting to discuss the MAPP framework and review current data. The group reviewed the elements of the 2011 CHA and 2012 CHIP. As part of the work with the hospitals, all affirmed the regional priorities, and acknowledged that their own chosen priorities will impact the regional priorities. Participants also completed the *Forces of Change Assessment.* The resulting work product is available in Appendix A.

RWMC hosted focus groups for residents of the service area in May 2014 as part of the *Community Themes and Strengths Assessment*. These focus groups were targeted at the community at-large served by the hospital. The focus groups centered on community themes and strengths, including how participants view the community, the health and service needs of the community, and how residents receive health care information. A summary of the Focus Group notes is available in Appendix B.

A stakeholder meeting was held in June to establish vision for Scotts Bluff County. Participants included representatives from the hospital, public health, public school system, law enforcement, fire department, non-profit and service organizations, economic development, media, faith-based community, City of Scottsbluff, and local businesses. Over the course of the meeting, as part of the *Community Health Status Assessment,* participants were presented with health data relevant to the Panhandle, socioeconomic data specific to Scotts Bluff County, leading causes of death for the Panhandle compared to the State of Nebraska, the impact of Adverse Childhood Experiences (ACE), and Child Well Being Data. Presenters also gave an outline of the MAPP process, and the current priority areas of the Panhandle Community Health Improvement Plan. The resulting work product is available in Appendix C.

Participants were then led through a consensus workshop focusing on the question "What do we see in place in 3-5 years as a result of our collective action?" The elements of the vision include:

- Educational Opportunities
- Socially Conscious Environment
- Quality Services Across the Life Span
- Better Sense of Community
- Economic Development
- Active Living
- Healthy Eating Environment
- Equal, Affordable Access to Healthcare
- Access to Dependable Transportation
- Shift to Preventative Care Model

The results of the focus groups, stakeholder meeting, and health data was presented to a smaller committee of RWMC staff in September 2014 to determine priority areas. Participants reviewed the socioeconomic and health data presented during the stakeholder meetings. Based on the information presented, the participants scored the data based on the availability of data, the percentage of the population affected, the resources available to the hospital and within the community to address the issue, and the seriousness of the issue. The prioritization matrix is available in Appendix D. The priority areas identified are:

- Cardiovascular
- Tobacco Use
- Nutrition/Physical Activity
- Cancer
- Child well being
- Accidental Injury
- Family support

These areas then were grouped into two main categories:

PRIORITY HEALTH AREA	GOAL
1. Prevention and Reduction of Chronic diseases	
A. Cardiovascular	Promote health and reduce chronic disease risk through the prevention and control of hypertension.
B. Cancer	Reduce the number of new cases, as well as the illness, disability and death caused by cancer by reducing the use of tobacco product and increasing preventive screenings and intervention measures.
C. Diabetes	Decrease the number of people over the age of 18 with Diabetes.
2. Injury due to Unintentional Injuries and Violence	
A. Unintentional injuries	Prevent unintentional injuries and reduce their consequences through education.
B. Injuries caused by violence	Prevent injuries caused by violence through early intervention.

Implementation Plan

Priory Area #1: Prevent and reduce the burden of chronic diseases among residents of those living in Scotts Bluff County.

According to the Nebraska Physical Activity and Nutrition State Plan 2011-2016,[3] " chronic diseases – such as cancer, diabetes, heart disease and stroke – are among the most common, costly, and preventable of all health problems in Nebraska and throughout the United States.

Priory Area #1A: Cardiovascular

Goal: Promote health and reduce cardiovascular risk through the prevention and control of hypertension.

Objective 1A.1 **By July 31, 2017, increase the number of adults 18 and older who have had their blood pressure taken in the past year by 10%.**

Indicators	Site	Baseline 2014	Target 2017	Data Source
Adults over the age of 18 who have had their blood pressure checked in the past year.	**State**	84.6%	93.06%	NE BRFSS, 2014
	SBC	83.7%	92.07%	NE BRFSS, 2014

Strategies for Cardiovascular: Hypertension		Key Partners	Specific Actions to Achieve Strategies
# 1	Improve the availably to have blood pressures checked in Scotts Bluff County	Pharmacy, health care providers, and public health	Community Health will offer blood pressure screening at 8 or more events each year. Coordinate with the pharmacy and physician offices to provide blood pressure checks.
#2	Provide education regarding hypertension management to healthcare providers	Regional West Physicians Clinic, hospital staff, and pharmacy.	Provide training to healthcare providers regarding prevention and management of hypertension utilizing evidence based practices like the Million Hearts Program.
#3	Provide education regarding hypertension to the community.	Pharmacy, workplaces, schools, public health and health providers.	Give at least five community presentations per year regarding hypertension.

Priory Area #1B: Cancer

Goal: Reduce the number of new cases, as well as the illness, disability and death caused by cancer by reducing the use of tobacco products in all ages.

Objective 1B.1 By July 31, 2017, decrease the proportion of Panhandle adults (18 years and older) who currently smoke cigarettes by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Adults who currently smoke cigarettes	**SBC**	22.2%	19.98%	NE BRFSS, 2014

Objective 1B.2 By July 31, 2017, decrease the proportion of Panhandle adult men (18 years and older) who currently use smokeless tobacco by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Adults who currently use smokeless tobacco	**SBC**	5.3%	4.77%	NE BRFSS, 2014

Strategies for Cancer Prevention: Primary Prevention-Tobacco		Key Partners	Specific Actions to Achieve Strategies
#1	Support comprehensive tobacco free and other evidence-based tobacco control policies.	Hospital, city, government, public health	Enforce tobacco free campuses on all Regional West Health Services Properties
#2	Reduce the number of people who use tobacco products in Scotts Bluff County.	Hospital, Nebraska Quit Line, Public Health	Promote the Nebraska Quit Line and provide education through outreach programs and events.
#3	Clinician counseling and interventions to prevent tobacco use and tobacco-caused disease.	Hospital and physicians	Clinicians to ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Clinicians implementing as part of Meaningful Use.

Priory Area #1B: Cancer

Goal: Reduce the number of new cases, as well as the illness, disability and death caused by cancer by increasing preventive screenings and intervention measures.

Objective 1B.3 By July 31, 2017, increase the proportion of Scotts Bluff County women aged 50 to 74 years old who are up-to-date on their breast cancer screening by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Women ages 50-74 who had a mammogram within the past 2 years	**SBC**	55.0%	60.5%	NE BRFSS, 2014

Objective1B.4 By July 31, 2017, increase the proportion of Scotts Bluff County women aged 21 to 65 years old who are up-to-date on their cervical cancer screening by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Women ages 21-65 who had a pap smear within the past 3 years	**SBC**	76.2%	83.8%	NE BRFSS, 2014

Objective 1B.5 By July 31, 2017, increase the proportion of Scotts Bluff County adults aged 50 to 75 years old who are up-to-date on their colorectal cancer screening by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Adult ages 50-75 who are up-to-date on their colorectal cancer screening	**SBC**	51.8%	56.98%	NE BRFSS, 2014

Objective 1B.6 By July 31, 2017, increases the proportion of Scotts Bluff adolescents who have the HPV series by 10%.

Indicators	Site	Baseline 2012	Target 2017	Data Source
Increase the number of adolescents who have the HPV series.	**SBC**	Female >1 dose 59% Males >1 dose 14.2%	Female >1 dose 65% Males >1 dose 15.7%	MMWR [19]

Strategies for Cancer Prevention: Early Detection		Key Partners	Specific Actions to Achieve Strategies
#1	Send patients client reminders that they are due or overdue for cancer screening.	Health Care Providers and Public Health	Utilize the patient portal reminders for colonoscopy, cervical cancer screening and mammography.
#2	Offer one-on-one education to help people overcome barriers to cancer screening.	Health Care Providers and Public Health	Utilize the patient portal and EMMI programs to provide education and reminders for colonoscopy, cervical cancer screening and mammography. Distribute coupons for FOBT kits to patients to promote state program.
#3	Use small media (i.e. videos and printed communication) to promote cancer screening.	Health Care Providers and Public Health	Attend health fairs and community events to promote EMMI programs and educational information regarding colonoscopy, cervical cancer screening and mammography.
#4	Reduce financial barriers to cancer screening.	Public Health, CAPWN, Health Care Providers	Implement the Welcome to Medicare program for qualified patients. Educate RWHS employees regarding insurance preventive benefits. Most screening is a covered benefit under approved health insurance policies requiring no copay or deductible, free FOBT kits available, Title X
#5	Reduce access barriers to cancer screening.	Health Care Providers	Extend Breast Health Center Hours for evening and walk-in access. Increase access to care for screening at RWPC.

Priory Area #1C: Diabetes

Goal: Decrease the number of people over the age of 18 with Diabetes.

Objective 1C.1 By July 31, 2017, decrease the proportion of people in Scotts Bluff County who have been told they had diabetes (excluding pregnancy) by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Proportion of people who have been told that they have diabetes (excluding pregnancy)	**State**	9.2	8.28	NE BRFSS, 2014
	SBC	14.1	12.69	NE BRFSS, 2014

Strategies for Diabetes		Key Partners	Specific Actions to Achieve strategies
#1	Assess and promote health foods, including fruits, vegetable and water in the facility for our employees, patients, and visitors.	State of Nebraska, public health	Assess cafeteria options through site assessment of healthy foods through 1422 state funding and increase healthy options. Assess vending machine options through site assessment of healthy foods through 1422 state funding and increase healthy options.
#2	Offer Evidence Based Practice community programs to prevent diabetes	State of Nebraska, public health	Promotion and implementation of the National Diabetic Prevention Program to employees and community.

Priory Area #2: Prevent and reduce unintentional injuries and those from violence for those living in Scotts Bluff County.

According to Healthy People 2020, "unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages."[16] Unintentional injuries accounted for 5.5% of deaths in the Panhandle in 2009 and were considered the fifth leading cause of death that year.[11] In addition to their immediate impacts, injuries and violence can result in premature death, disabilities, poor mental health, high medical costs, and lost productivity.[16]

This is a broad issue with multiple risk factors and a range of consequences which makes it a challenge to entirely address. Therefore, to make the most impact, RWMC developed strategies that focus on strengthening and implementing policies and programs, community engagement and education to enhance the safety of the community.

Priory Area #2A Unintentional Injuries

Goal: Decrease the number of unintentional injuries and their consequences for those who live in Scotts Bluff County.

Objective 2A.1 By July 31, 2017, reduce the number of falls among Scotts Bluff County adults 45 years and older that resulted in injury by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Those who were injured due to a fall in the past year, age 45 years and older	**SBC**	34.5%	31%	NE BRFSS, 2014

Objective 2A.2. By July 31, 2017, reduce crude death rates from unintentional injury by 10%.

Indicators	Site	Baseline 2007-2012	Target 2017	Data Source
Crude death rate from unintentional injury	**NE**	35.68	Not Available	NDH Crude Death Rates by Cause, 2007-2012
	Panhandle	48.03	43.23	NDH of Health Crude Death Rates by Cause, 2007-2012

Strategies for Unintentional injuries		Key Partners	Specific Actions to Achieve strategies
#1	Community Campaigns to educate families about safety issues.	State of Nebraska, public health, schools, local organizations	Attend community events to promote Injury prevention. Coordinate a Kid's Safety Safari with all listed partners to educate youth on varied safety issues specific to the area
#2	Promote and strengthen policies and programs to prevent falls, especially among older adults.	Public health, EMS, community organizations	Offer Evidence Based Practice community programs to prevent unintentional injuries- specifically the "Stepping On" Program

Priory Area #2B Injuries due to violence

Goal: Decrease the number of injuries due to violence and their consequences for those who live in Scotts Bluff County.

Objective 2B.1 By July 31 2017, reduce the number of simple domestic violence complaints by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Simple Domestic violence complaints (rate)	**NE**	26.4	Not Available	NDH Child Well Being Data 2014
	SBC	38.8	34.92	NDH Child Well Being Data 2014

Objective 2B.2 By July 31 2017, reduce the number Children experiencing abuse and neglect by 10%.

Indicators	Site	Baseline 2014	Target 2017	Data Source
Child Abuse/Neglect Substantiated Reports to the Nebraska Department of Health and Human Services	**SBC**	84 Cases	75 Cases	Stat of Nebraska Child Abuse and Neglect Statistical Report 2014

Strategies for injuries from violence		Key Partners	Specific Actions to Achieve strategies
#1	Increase referral to evidence base home visitation services for families with high stressors	Physicians clinics and public health	Establish referral process to Healthy Families America and Early Head Start
#2	Provide individuals and families with support needed to maintain positive mental and emotional well-being.	Public health, schools, health care providers and community organizations	Provide space, referrals and financial support for evidence based programs such as Circle of Security Parenting. Participate in community committees to promote family positive mental and emotional well-being such as the System of Care for Children 0-8

Conclusion:

The Community Health Improvement Plan (CHIP) serves as a roadmap for a continuous health improvement process for Regional West Medical Services. It is not intended to be an exhaustive list. Beyond what is included in the CHIP, it is expected that initiatives and efforts that are currently ongoing will continue. Progress of the work will be evaluated on an ongoing basis to identify areas for possible improvement or revision. We would like to thank Panhandle Public Health District and The Rural Nebraska Healthcare Network for their assistance in the completion of this report.

References:

1. Panhandle Area Development District. (2014). *Panhandle snapshot*. Retrieved from http://www.nepadd.com/Panhandle_Snapshot_2014.pdf

2. U.S. Census Bureau. (2010, April 1). *State & County Quickfacts: Scotts Bluff County, NE.* Retrieved March 25, 2014, from http://quickfacts.census.gov.

3. Nebraska Department of Health & Human Services, Division of Public Health Behavioral Risk Factors Surveillance System Summary Table, 2014 Retrieved on Oct. 15,2015 from http://dhhs.ne.gov/publichealth/Pages/brfss_reports.aspx

4. Nebraska Department of Health & Human Services, Division of Public Health Child and Family Services Table 1.7, 2014 Child Abuse and Neglect Substantiated cases by county. Retrieved on Oct. 15,2015 from http://dhhs.ne.gov/cfs,

5. Trust for America's Health & Robert Wood Johnson Foundation. (2014). The *State of Obesity: Better Policies for a Healthier America*. Retrieved on Oct. 15,2015, 15,2015,from http://healthyamericans.org/assets/files/TFAH-2014-ObesityReport-Fnl10.9.pdf

6. Lean, M.E. (2000). Obesity: burdens of illness and strategies for prevention or management. *Drugs Today*, *36*(11), 773-84. PMID: 12845336

7. Lehnert, T., Sonntag, D., Konnopka, A., Riedel-Heller, S., & Konig, H. (2013). Economic costs of overweight and obesity. *Best Practice & Research Clinical Endocrinology & Metabolism, 27*(2), 105-115. DOI: http://dx.doi.org/10.1016/j.beem.2013.01.002

8. Moreno, M.A., Furtner., F. & Rivara, F.P. (2011). Breastfeeding as obesity prevention. *Archives of Pediatrics and Adolescent Medicine, 165*(8), 772. doi:10.1001/archpediatrics.2011.140

9. National Institute of Mental Health. (n.d). Statistics. Retrieved on March 10, 2015, from http://www.nimh.nih.gov/health/statistics/index.shtml

10. World Health Organization. (2002). Facts: self-directed violence. Retrieved from: http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/selfdirectedviolfacts.pdf?ua=1

11. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. (2014, December 24). Suicide: consequences. Retrieved March 12, 2015, from http://www.cdc.gov/violenceprevention/suicide/consequences.html

12. Panhandle Public Health District & Scotts Bluff County Health Department. (2011). Nebraska Panhandle Community Health Assessment. Retrieved from: http://www.pphd.org/ProgramData/CHIP/Community%20Health%20Assessment2011.pdf

13. Inset, T. (2013, January 24). Assessing the State of America's Mental Health System, Testimony before the Committee on Health, Education, Labor, and Pensions United States Senate. Retrieved from: http://www.help.senate.gov/imo/media/doc/Insel.pdf.

14. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. (2014, December 23). Suicide: risk and protective factors. Retrieved March 12, 2015, from http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

15. U.S. Department of Health and Human Services, Substance Abuse and mental Health Services Administration. (2009). Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. Retrieved from: http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf

16. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. (2014, May 13). ACE Study. Retrieved on March 13, 2015, from http://www.cdc.gov/violenceprevention/acestudy/

17. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020. (2014). Injury and violence prevention. Retrieved on March 13, 2015, from https://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention

18. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020. (2014). Cancer. Retrieved on March 13, 2015, from https://www.healthypeople.gov/2020/topics-objectives/topic/cancer

19. Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention. (2014, August 25). Cancer prevention. Retrieved on March 13, 2015, from http://www.cdc.gov/cancer/dcpc/prevention/

20. Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion, (2011) *National and State Vaccination Coverage Among Adolescents Aged 13–17 Years — United States, 2011.* Retrieved on July 2, 2015, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6134a3.htm?s_cid=mm6134a3_x

Glossary:

BRFSS – Behavioral Risk Factor Surveillance System

CAPWN – Community Action Partnership of Western Nebraska

COS – Circle of Security

DHHS – Department of Health and Human Services

ESU – Educational Service Unit

EWM – Every Woman Matters

FOBT – Fecal Occult Blood Test

NDPP – National Diabetes Prevention Program

NRPFSS – Nebraska Risk and Protective Factor Student Survey

SBC – Scotts Bluff County

SOC – Systems of Care

USPSTF – United States Preventive Services Task Force

YRBS – Youth Risk Factor Survey

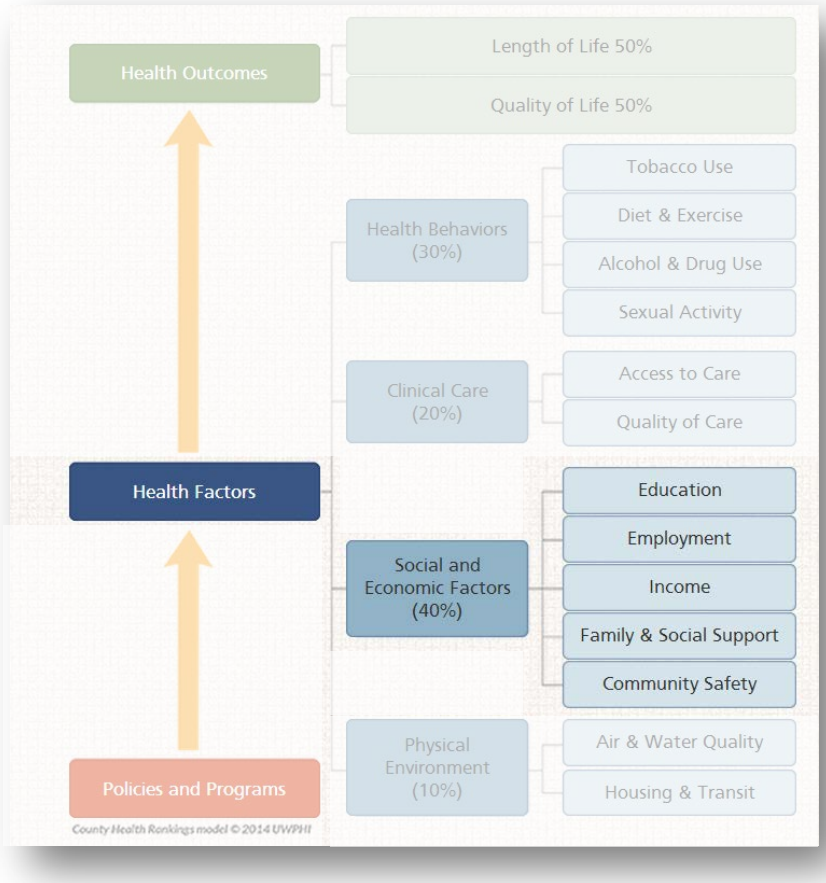
Appendix

Appendix A: Social and Economic Data

Overview

Social and Economic Factors in Population Health

Some of the biggest predictors of health in an individual's life come from social and economic factors. This section addresses what social and economic factors of health such as education, income, and social support look like in the Nebraska Panhandle and what the data indicate about the health of Panhandle citizens.



Key Trends and Patterns

Stable or slightly growing population

Population consolidation in the region has actually contributed to stable or slightly positive change in population in Scotts Bluff County in recent years. With almost 40% of the region's population, Scotts Bluff County and particularly the North Platte River valley communities are positioned to cultivate and attract new economic opportunities. Planning how all of the county's communities can work together to build a strong economic and social fabric will be important in continuing positive economic and population trends.

Increase in older age groups

Another trend that continues is the general aging of the population through both outmigration of youth and aging of the still large baby boom cohorts. In-migration of older populations and aging of current residents evokes conversations of mobility, business succession, health care needs, and engagement of retired persons, to name a few.

Stark social and economic contrasts between minority and majority populations

Hispanic origin and American Indian populations in Scotts Bluff County have much lower median incomes and levels of educational attainment than the majority population (white, non-Hispanic). Even though income disparities exist by race in the county, Scotts Bluff County minority populations generally

have higher median incomes than those of other counties in the Panhandle. Across the region, attention should be made to promote economic and social parity among different races.

Relatively high rates of poverty

While the rate of poverty in Scotts Bluff County is a little lower than in the region, it is generally more prevalent in the Nebraska Panhandle than in other parts of the state, with an overall rate around 15% for the region and 14% for the county. Minority populations and single parent households have particularly high rates. Poverty can have significant health consequences by posing barriers to quality nutrition, health care, child care, education, and living environments among other things.

Low unemployment, large middle class, good base of skilled positions

Strong health, agricultural, and transportation industries have kept unemployment low in the Scotts Bluff County. Many opportunities also exist for people with less advanced levels of educational attainment. These opportunities are reflected in the region's large proportion of households in middle income brackets. However, wages lag behind the state and other nearby markets due to fewer opportunities for high skilled and professional workers. Pursuing identified target industries which typically have higher skilled job opportunities and promoting entrepreneurship to grow local talent could be ways to grow wealth in the county and region as a whole.

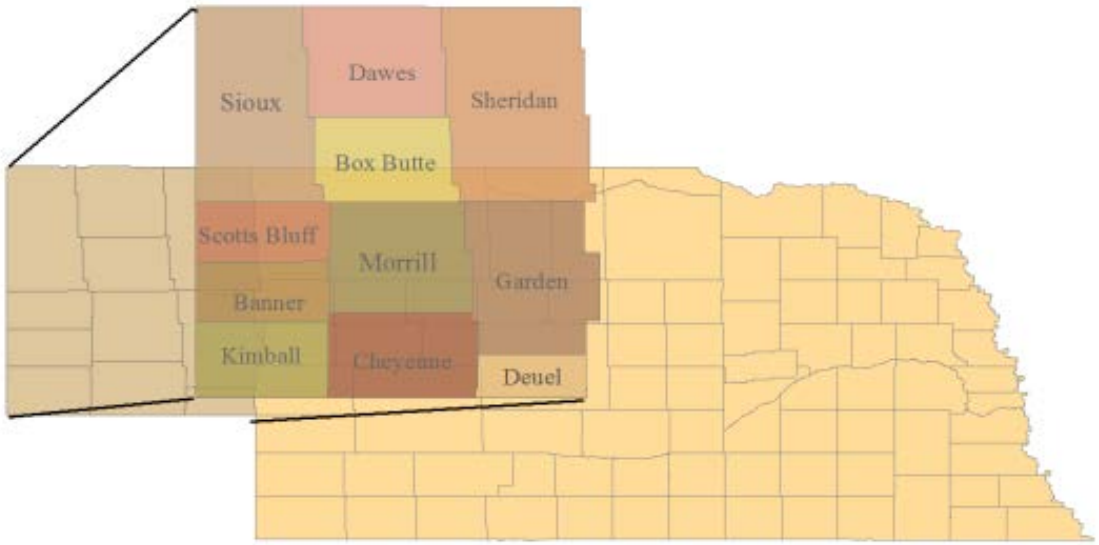
Basics

Scotts Bluff County is most defined by the string of communities which line the banks of the North Platte River and Highways 92 and 26 in western Nebraska. Each of these communities takes pride in their unique identity and contributes in varying ways to the vitality of the region. Due to this higher concentration of communities, the county is the most populous in the Nebraska Panhandle, accounting for over 40% of the region's population. The North Platte Valley (also known simply as 'The Valley') is also one of the major trade, service, and retail hubs in the region and draws from a very large area for these amenities and economic opportunities, not the least of which is access to quality health care and good professional jobs at Regional West Medical Center. The unique bluffs, escarpments, and open space are some of the most treasured assets in the county and lay the foundation for tourist and historic attractions.

Scotts Bluff County is a part of the larger regional community of the Nebraska Panhandle which also consists of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Sheridan, and Sioux counties.

Quick Facts for 11 Panhandle Counties:

Population (2012)	36,835
Population change (2000-2010)	+0.1%
Incorporated municipalities	10
Unemployment Rate (July 2014)	4.2%
Total Land Area	746 sq. miles



Population

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

Figure 1: Nebraska Population 1930-2010

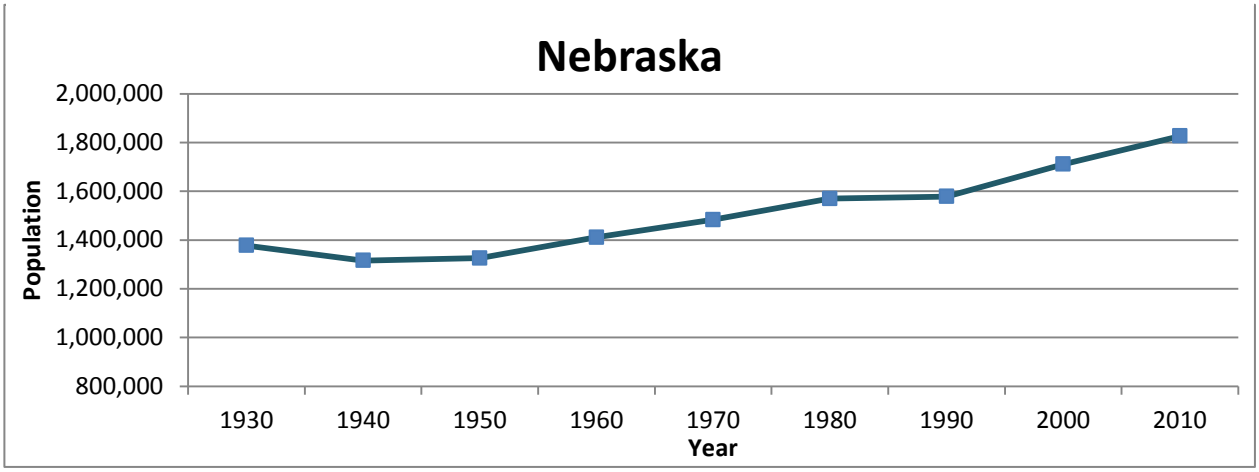


Figure 2: Nebraska Panhandle population 1930-2010

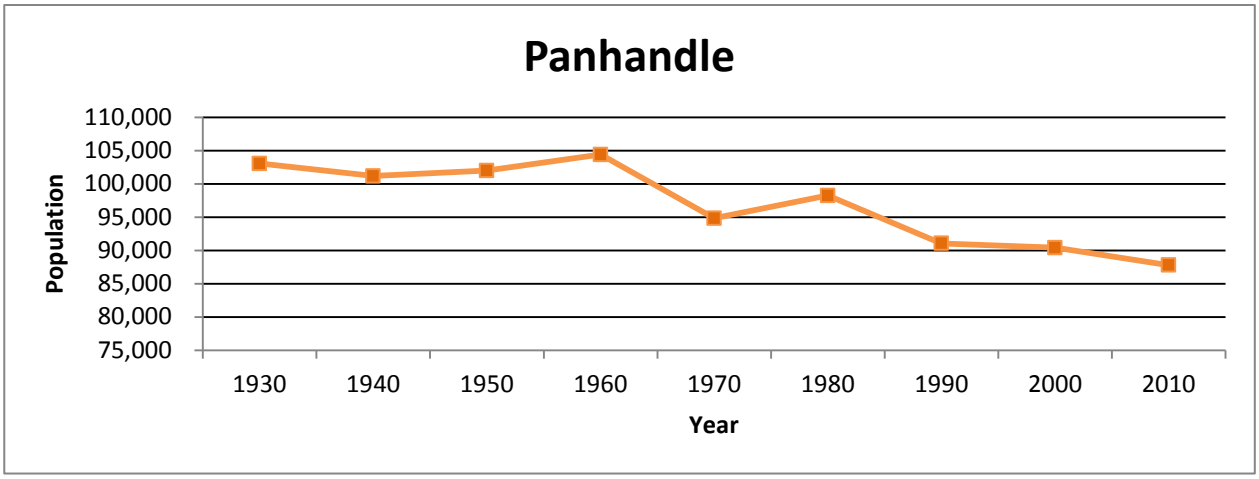


Figure 3: Scotts Bluff County population 1930-2010

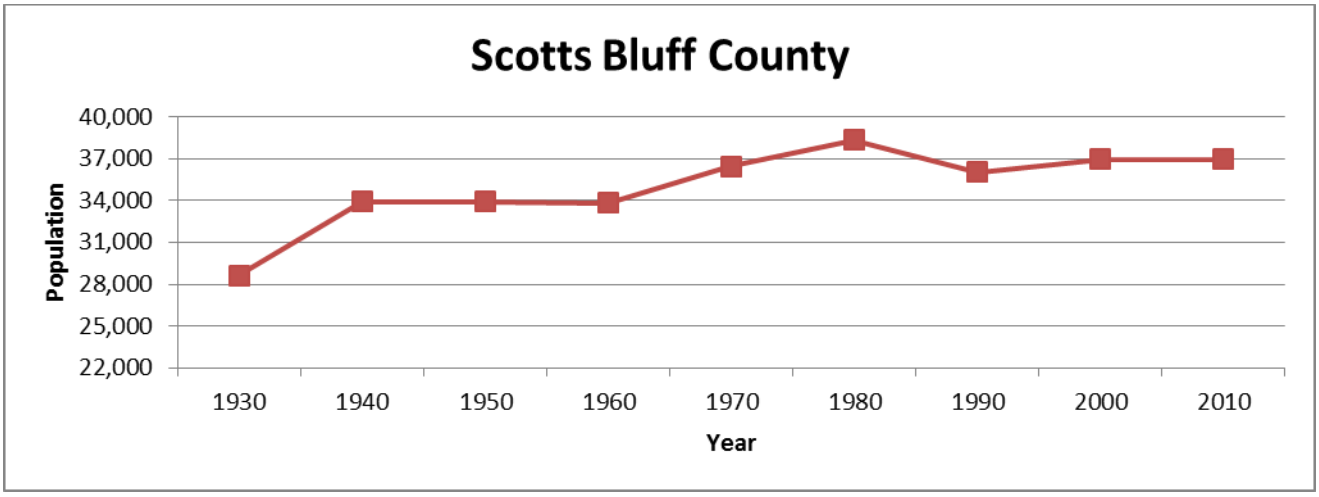


Figure 4: Metropolitan share of Nebraska population

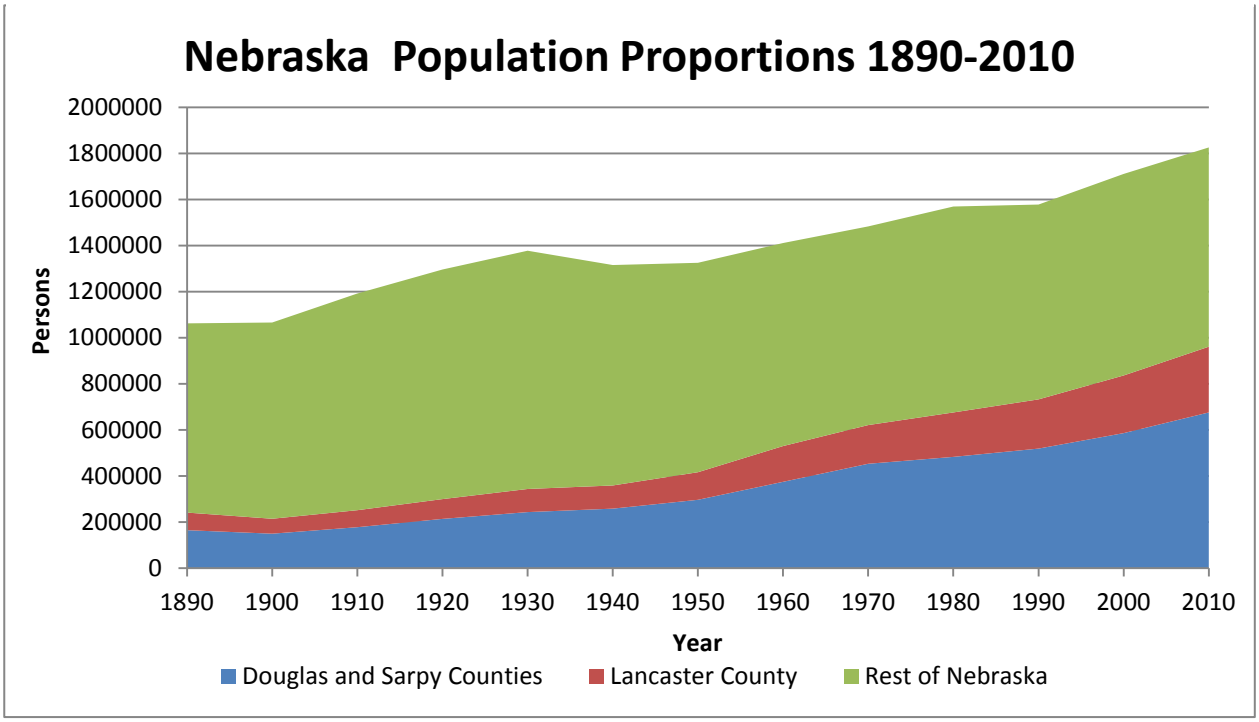


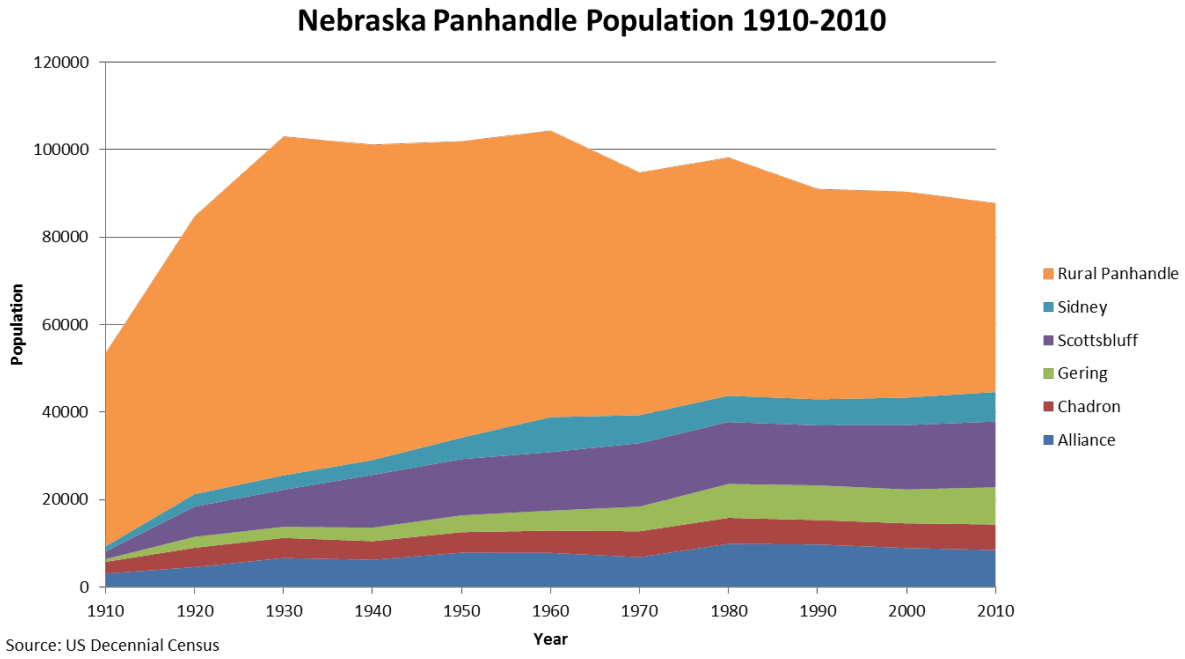
Figure 4 shows how Nebraska's population growth has been concentrated almost entirely in the metropolitan counties of Douglas, Sarpy, and Lancaster in the eastern part of the state. These counties are home to the Omaha metropolitan area and the state capital metropolitan area of Lincoln.

What does a declining population mean for our region?

- Decreased political influence in the state
- Impacted share of resources
- Threat of decreased vitality
- Need to reassess infrastructure needs vs. capacity

However, population consolidation away from rural areas is not new, is a global phenomenon, and as Figure 45 shows, has also been occurring within our region. The emergence of the service and innovation based economy and decrease of farm employment practically ensures this pattern will continue into the future. For this reason, communities should not undertake frantic efforts to stop population loss but rather measured strategies which aim to steadily improve quality of life and opportunities for their citizens. What the Panhandle lacks in critical mass of resources and people, it must make up for in creative solutions and the strengthening of partnerships to build a collective impact.

Figure 5: Panhandle population consolidation

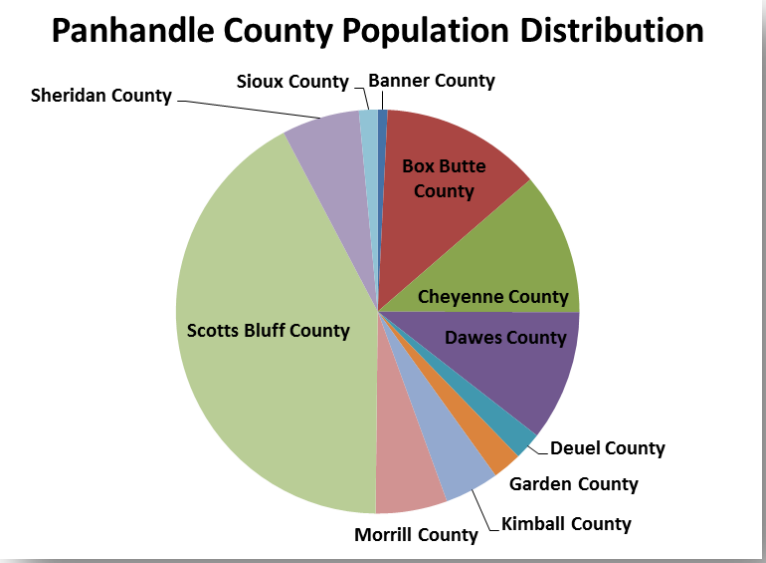


Source: US Decennial Census

Table 1: County and Panhandle population and change 2000-2010

	Banner County	Box Butte County	Cheyenne County	Dawes County	Deuel County	Garden County	Kimball County	Morrill County	Scotts Bluff County	Sheridan County	Sioux County	Panhandle	% Change 2000-2010
2000	819	12,158	9,830	9,060	2,098	2,292	4,089	5,440	36,951	6,198	1,475	90410	
2010	690	11,308	9,998	9,182	1,941	2,057	3,821	5,042	36,970	5,469	1,311	87789	
Net Change	-129	-850	168	122	-157	-235	-268	-398	19	-729	-164	-2621	-2.9

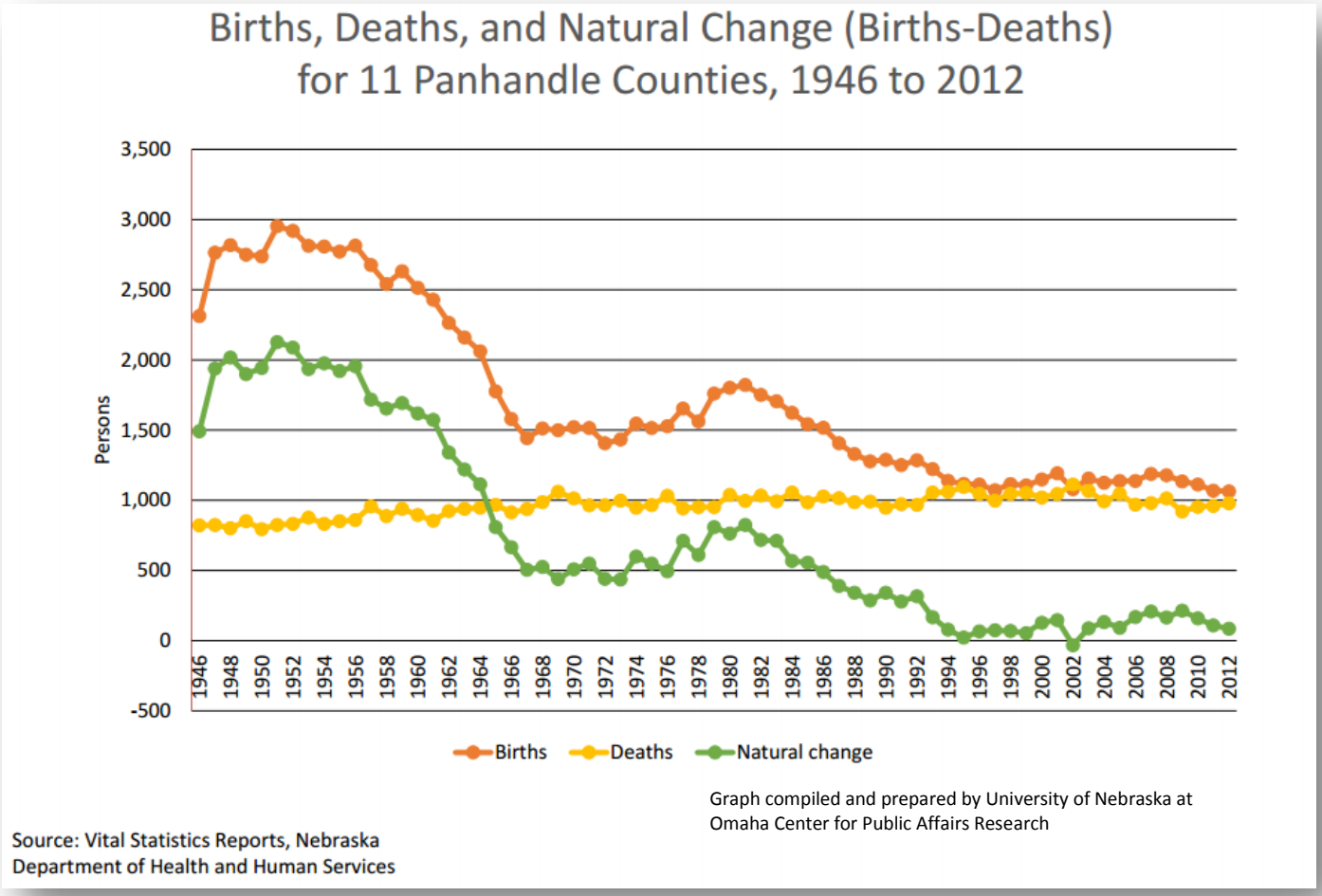
Figure 6: Panhandle population distribution by county



As Figure 6 emphasizes, 77% of the panhandle's population is concentrated in the 4 'trade counties' of Scotts Bluff, Box Butte, Cheyenne, and Dawes, with Scotts Bluff making up over 40% of the Panhandle's population. Scottsbluff, Gering, and Terrytown make up two thirds of the county population but other communities in the North Platte Valley are an integral part of the vitality of the Scottsbluff-Gering economic hub. These smaller communities each take pride in their unique identity and boast quality businesses, lifestyle, and a smaller town living environment. However, travel time, lack of available labor, and lower levels of public revenue pose obstacles for economic growth and community vitality of smaller communities in Scotts Bluff County and across the region.

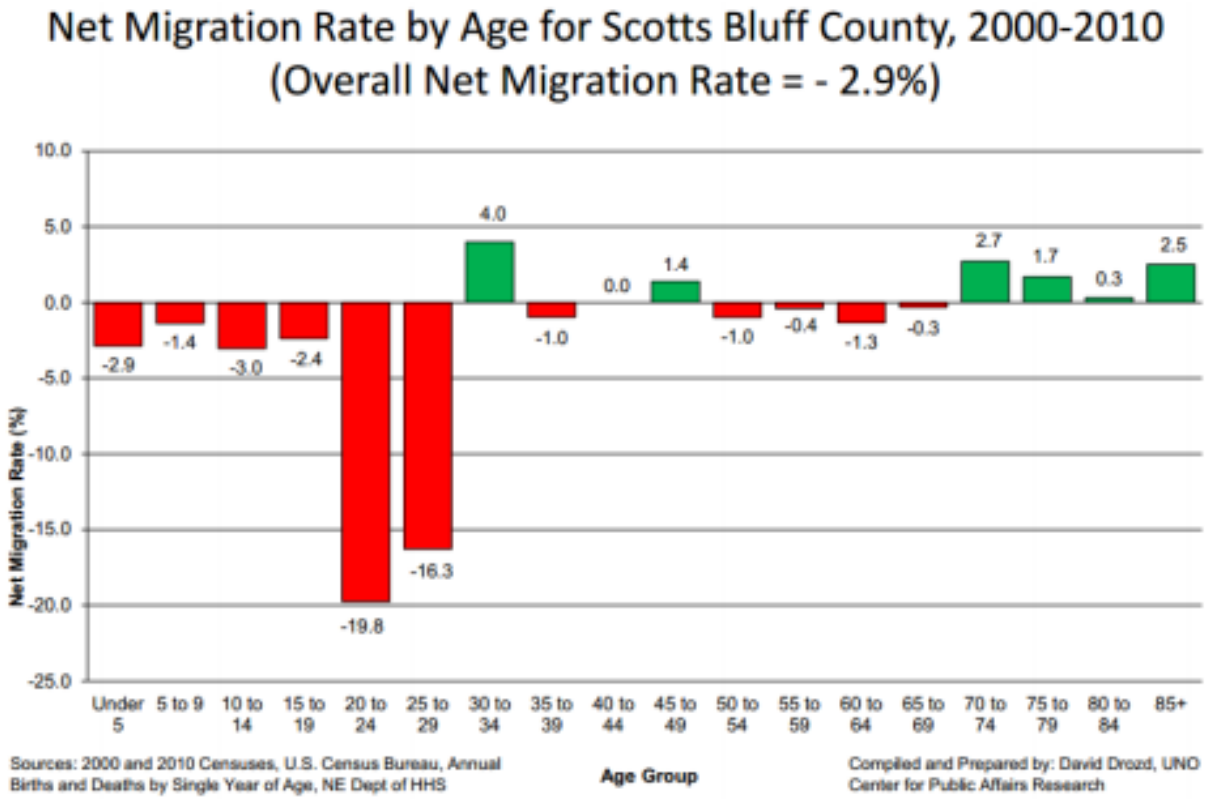
The graph in figure 7 shows that natural change has leveled out around zero and in coming years, deaths are projected to exceed births. Because of years of youth outmigration and a decrease in White Non-Hispanic/Latino family size, births are lower and population gains will likely come primarily from in migration and natural increase in the Hispanic/Latino population. The region also has had around 15,000 children under the age of 18 for several years and so the prospect of young adult population would also rely on in-migration.

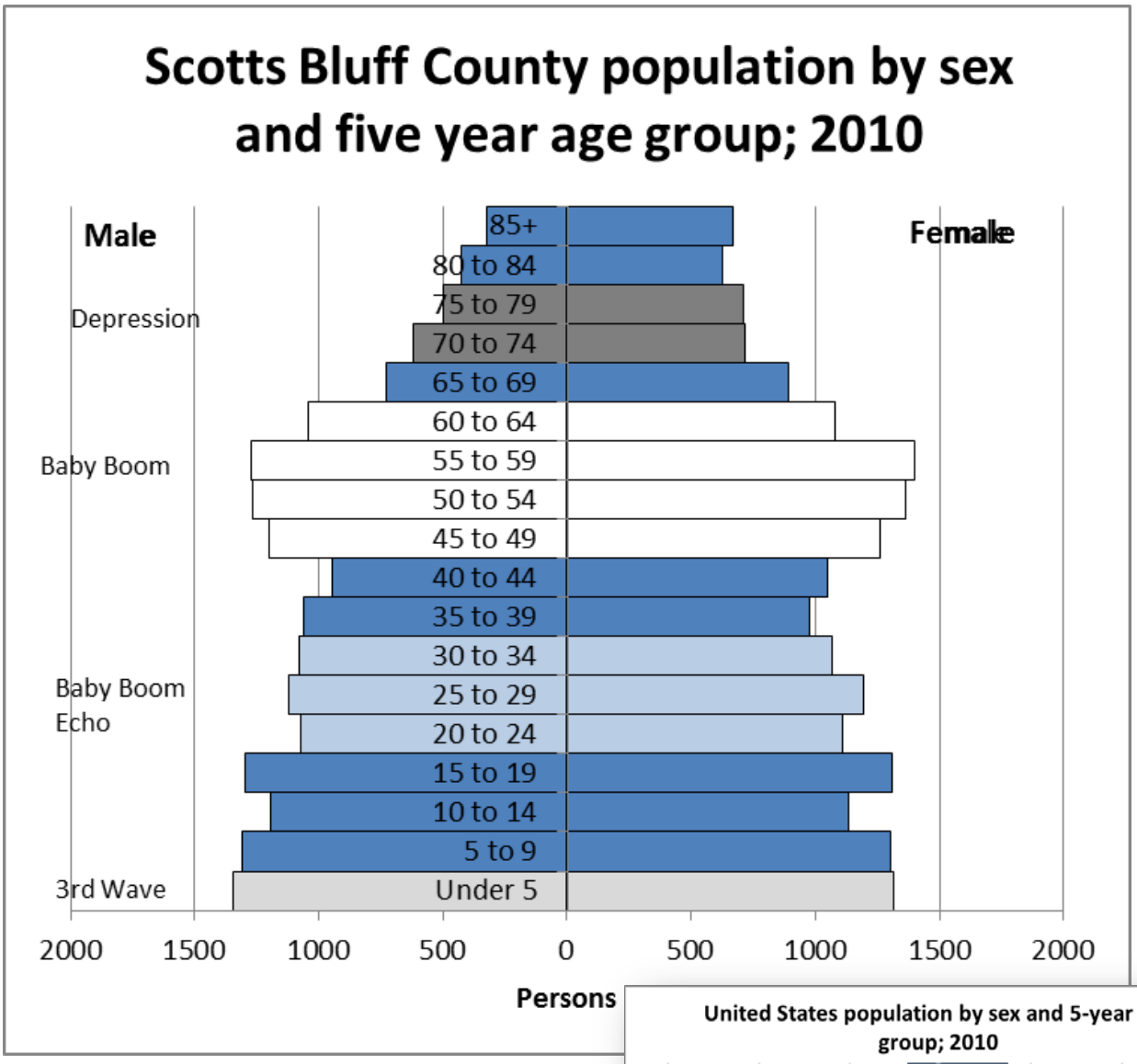
Figure 7: Births, deaths, and Natural Change for 11 Panhandle counties

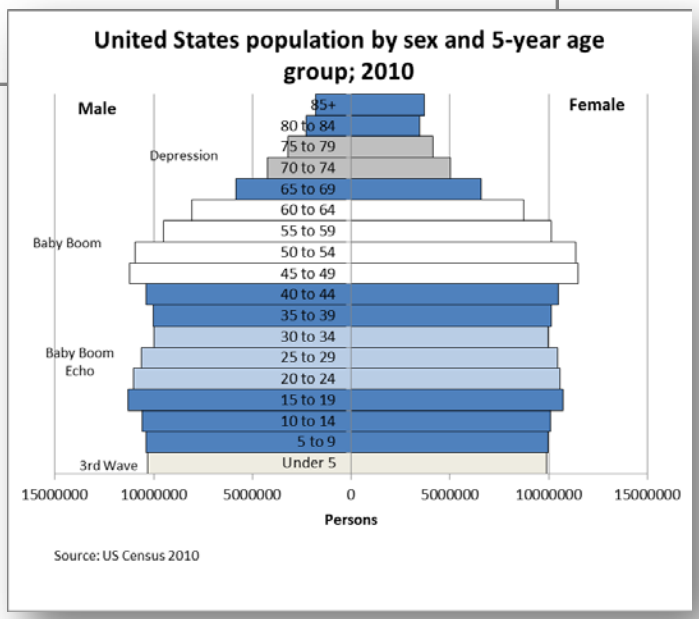


Migration patterns show the out-migration for young adults as the economic, educational, and social opportunities of metropolitan and other areas draw them away. In Scotts Bluff County and across the Panhandle, some in migration occurs for age groups in their mid-20s to 30s, as people either find job opportunities or come back to raise their family in their home town. However, it is still not enough to make up for the outmigration of people in their late teens and early twenties. Notable in Scotts Bluff's county's migration patterns is in-migration for older populations potentially moving in from elsewhere in the region to be near to medical facilities, amenities, and family.

Figure 8: Net migration rates for Scotts Bluff County 2000-2010







The population pyramid from 2010 shows the general age make-up of Scott Bluff County with a still strongly pronounced baby boom generation. While the county does have some thinning in the baby boom echo generation, it is not as pronounced as the rest of the region and the base of Scotts Bluff County's pyramid (young age groups) actually flairs out as opposed to being a 'straight trunk' indicating more children and

potentially a higher rate of new births in the county.

Race

Race patterns in a population are important to assess because they reveal social patterns. Social issues tend to follow the lines of certain social classes and families, and families have tended to follow race lines. With this understanding we can see social and economic patterns for certain segments of the population.

In the Scotts Bluff County, the majority race is non-Hispanic white but Hispanic persons make up over 20% of its population, one of the higher Hispanic/Latino population rates in the state and 40% higher than the statewide rate.

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

Figure 9: Race composition in the 11 panhandle counties

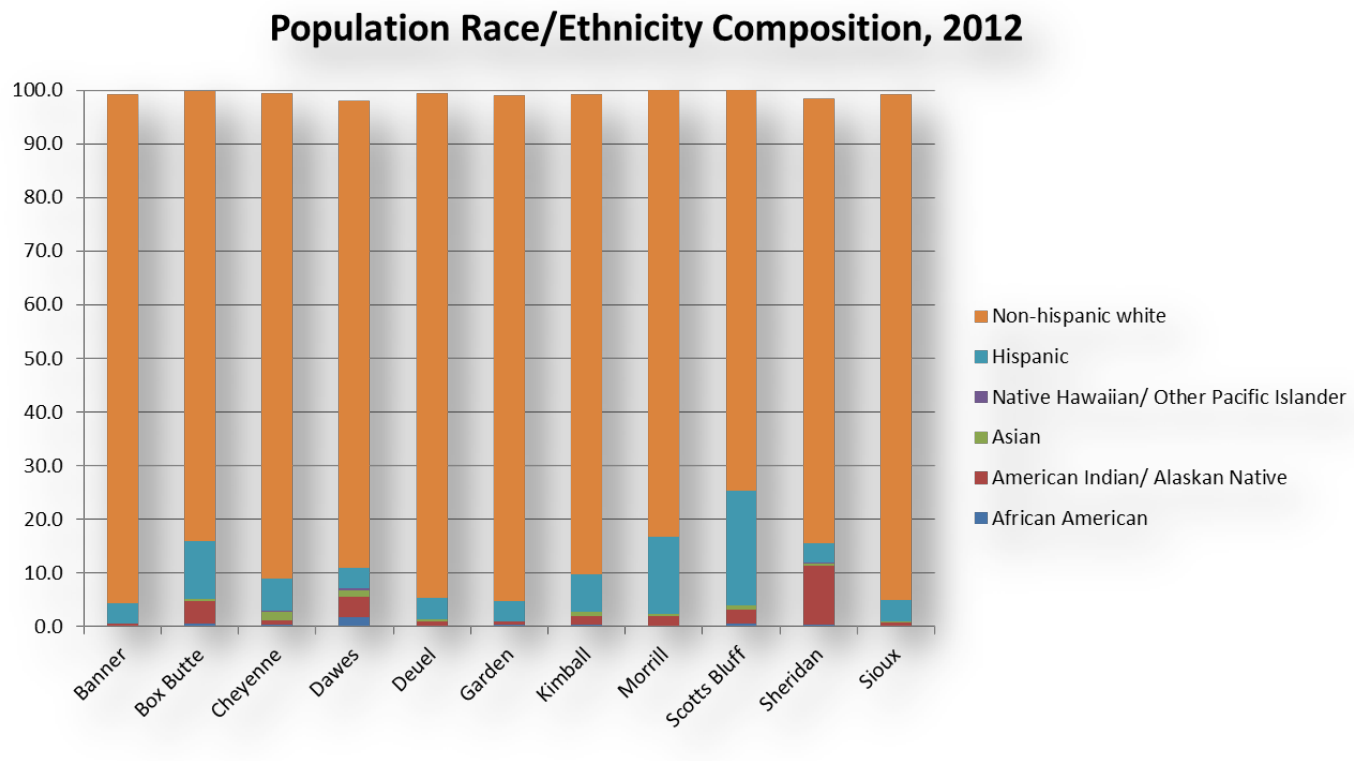


Table 2: Percent not proficient in English by County

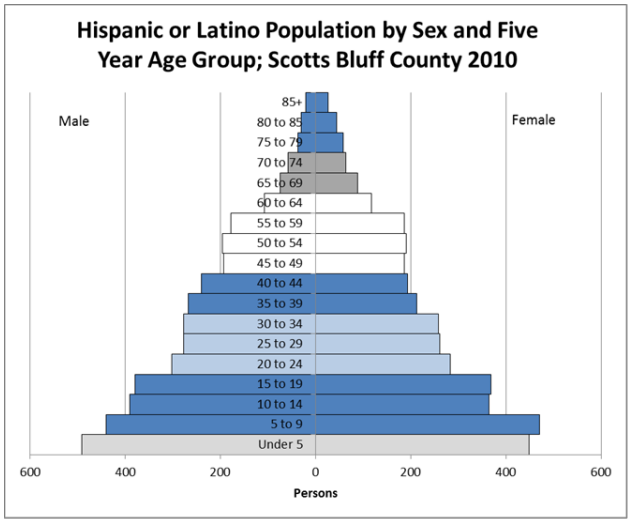
	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Kimball	Morrill	Scotts Bluff	Sheridan	Sioux
% not proficient in English	0.0	0.8	0.1	0.6	0.6	0.0	0.7	1.2	1.8	0.7	0.3

Table 3: Panhandle foreign born rates

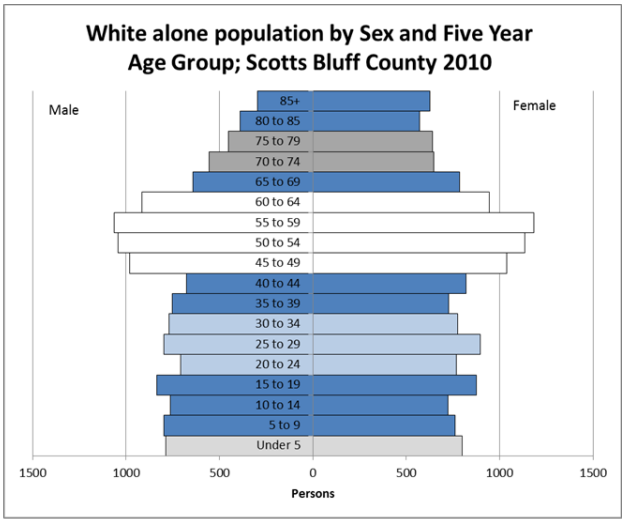
County	Percent Foreign Born
Banner County	5.8%
Box Butte County	2.1%
Cheyenne County	3.0%
Dawes County	2.6%
Deuel County	1.4%
Garden County	0.9%
Kimball County	2.6%
Morrill County	4.7%
Scotts Bluff County	4.0%
Sheridan County	1.3%
Sioux County	1.0%
Colfax County	21.0%
Dawson County	18.4%

The foreign born rates in the Panhandle particularly show that the region's minority populations are mostly US citizens. This is different from Colfax and Dawson Counties, (home to Schuyler and Lexington, respectively); whose high Latino populations also include a high number of foreign born citizens. While language and other issues that come with a high foreign born population are not as prevalent in Scotts Bluff County, a stark contrast still exists in economic measures between minority and majority populations, as indicated below by rates of higher education and income. Hispanic or Latino households in Scotts Bluff County made an estimated median income of $0.57 per every $1.00 of Non-Hispanic White median household income in 2012.

Figure 10: Comparison between Hispanic/Latino and White alone races in Scott Bluff County



Average Family Size 2010:	3.54
Median Age 2012:	24.5
Bachelor Degree or Higher 2012:	2.6%
Median HH Income 2012:	33,634



Average Family Size 2010:	2.85
Median Age 2012:	44.8
Bachelor Degree or Higher 2012:	24.3%
Median HH Income 2012:	58,630

Economy

Economic health is the driving force for opportunities and prosperity in a community. While it is not the only indicator of well-being, quality economic opportunities contribute heavily to the quality of income and the access to education and health care. Thriving local and regional economies also contribute to the vibrancy of communities and provide a base for shared investments in things like infrastructure, law enforcement, public spaces, and maintaining positive neighborhood environments.

Scotts Bluff County has its roots in a strong agricultural economy and has fared well in economic downturns, maintaining unemployment rates often much lower than the nation. Many major industries in the county, though not technically agricultural, support or are supported by agriculture. Top industries in the county are biomedical, manufacturing, and transportation/logistics, which reflects some of the largest employers. Despite low unemployment, wages and professional opportunities lag behind the state and nation as the region has struggled to compete with the metropolitan areas' pool of talent and innovation.

Table 4: Unemployment rates

County	Labor Force	Employed	Unemployed	Unemployment Rate (%)
Banner County, NE	372	352	20	5.4
Box Butte County, NE	5,529	5,287	242	4.4
Cheyenne County, NE	5,124	4,972	152	3.0
Dawes County, NE	4,807	4,612	195	4.1
Deuel County, NE	1,253	1,213	40	3.2
Garden County, NE	1,146	1,108	38	3.3
Kimball County, NE	2,059	1,982	77	3.7
Morrill County, NE	2,873	2,795	78	2.7
Scotts Bluff County, NE	19,213	18,391	822	4.3
Sheridan County, NE	3,074	2,971	103	3.4
Sioux County, NE	749	721	28	3.7
Goshen County, WY	6,479	6,116	363	5.6
REGION	**52,678**	**50,520**	**2,158**	**4.1**

Nebraska	3.7%
United States	6.7%

Employment and Workforce

Scotts Bluff County has a similar unemployment rate (4.3%) to the region (4.1%) and slightly higher than Nebraska (3.7%). Local, regional, and state unemployment is low compared to the nation (6.7%).

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

Figure 12: Jobs per 100 persons 1969 to 2011

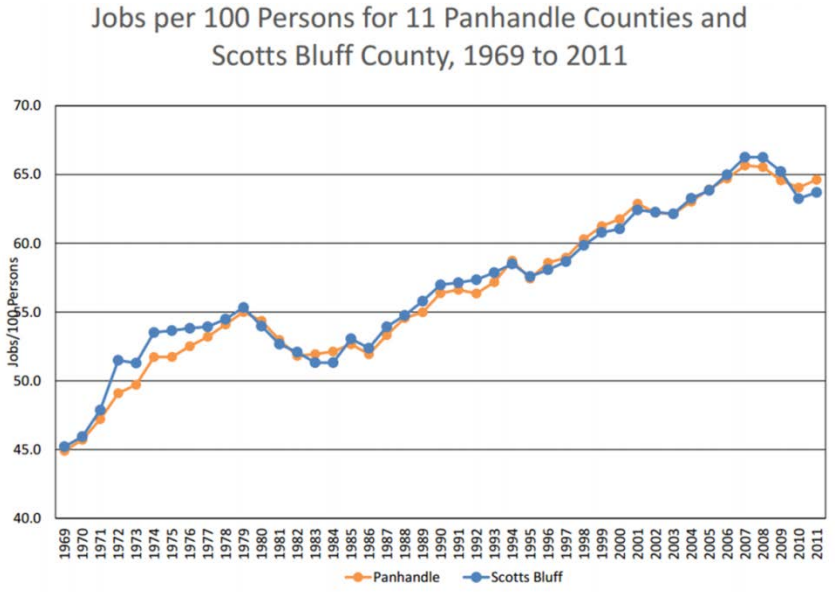
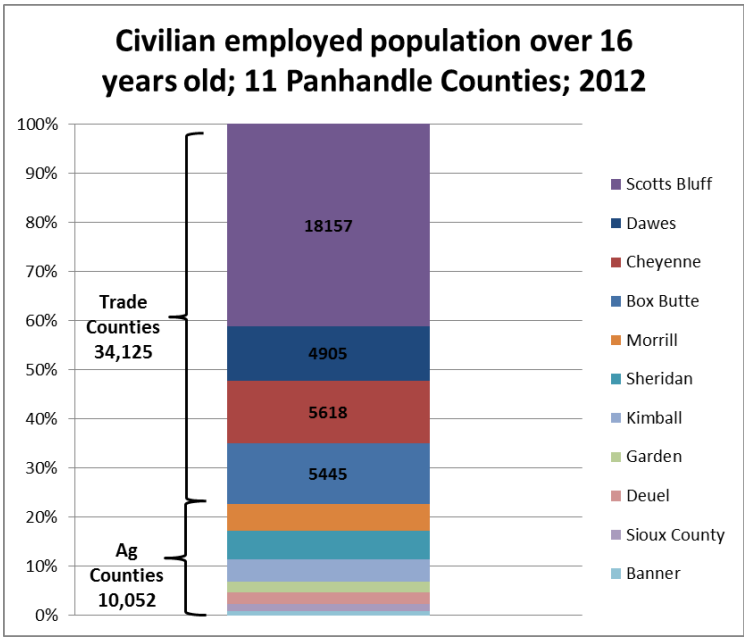


Figure 11: Employed population by county, 2012



Educational Attainment

Lower levels of educational attainment in the panhandle reflect the fact that many of the jobs available in agriculture, transportation, and manufacturing do not require the bachelor's degree statistical benchmark. Scotts Bluff County's rate of those 25 and older with a high school diploma or higher is below the state rate and is the second lowest number of the 11 Panhandle counties.

Table 5: Educational attainment by Panhandle county

	Population 25 or older	Bachelor Degree or Higher		High School Diploma or Higher	
	Estimate	Estimate	Percent	Estimate	Percent
Banner County	514	107	20.8%	473	92.0%
Box Butte County	7,585	1329	17.5%	6784	89.4%
Cheyenne County	7,029	1775	25.3%	6558	93.3%
Dawes County	5,604	2021	36.1%	5141	91.7%
Deuel County	1,432	248	17.3%	1334	93.2%
Garden County	1,612	314	19.5%	1481	91.9%
Kimball County	2,757	478	17.3%	2397	86.9%
Morrill County	3,477	720	20.7%	2977	85.6%
Scotts Bluff County	24,458	4996	20.4%	21174	86.6%
Sheridan County	3,910	794	20.3%	3496	89.4%
Sioux County	914	239	26.1%	843	92.2%
Panhandle	59292	13021	22.0%	52658	88.8%
Nebraska			28.1%		90.4%
United States			28.5%		85.7%

Income

Scotts Bluff County's income statistics show higher incomes than in the more agricultural counties of the region but lower income among other Panhandle trade hubs such as Box Butte, Dawes, and Cheyenne Counties, though it does show a higher relative income for married couple families. Income statistics often reflect the types of jobs available in an area. Raising income levels in the county should begin with sticking to outlined strategies which target higher paying industries and positions.

Table 6: Median Income by county, 2011

	Household Income (dollars)	Family Income (dollars)	Married couple Family Income (dollars)	Non-Family Income (dollars)
Cheyenne County	50,143	62,392	72,907	31,860
Box Butte County	44,118	56,011	62,104	25,826
Kimball County	43,191	53,381	59,583	26,429
Sioux County	42,386	53,036	55,227	25,217
Morrill County	42,075	48,019	51,917	25,901
Scotts Bluff County	40,939	51,487	62,075	23,397
Deuel County	37,500	51,210	55,208	19,524
Dawes County	36,396	52,273	56,356	20,692
Garden County	35,861	46,979	57,721	21,658
Sheridan County	34,588	44,184	51,395	22,433
Banner County	27,167	42,361	42,361	19,531

Income distribution in Scotts Bluff County shows a lot of households in the middle of the spectrum. Maintaining this large middle income population is important, as too much of a gulf between the low and high income earners is detrimental for a community. Many of the jobs associated with the medical center, manufacturing, transportation, and finance contribute to Scotts Bluff county's healthy middle incomes. The county has a slightly higher percentage (20%) of its households in the $50,000-74,999 bracket as the Omaha area, but it has a lower percentage in the $75,000-$149,000 brackets and more in the under $35,000 brackets. More professional, creative, science, and technology based jobs could lead to higher numbers of people in the higher income brackets.

Table 7: Household income distribution

	Panhandle	
	Estimate	Percent
Total households	36674	
Less than $25,000	10495	28.6%
$25,000 to $74,999	17552	47.9%
$75,000 or more	8627	23.5%

Figure 13: Household income distribution Scotts Bluff County, 2012

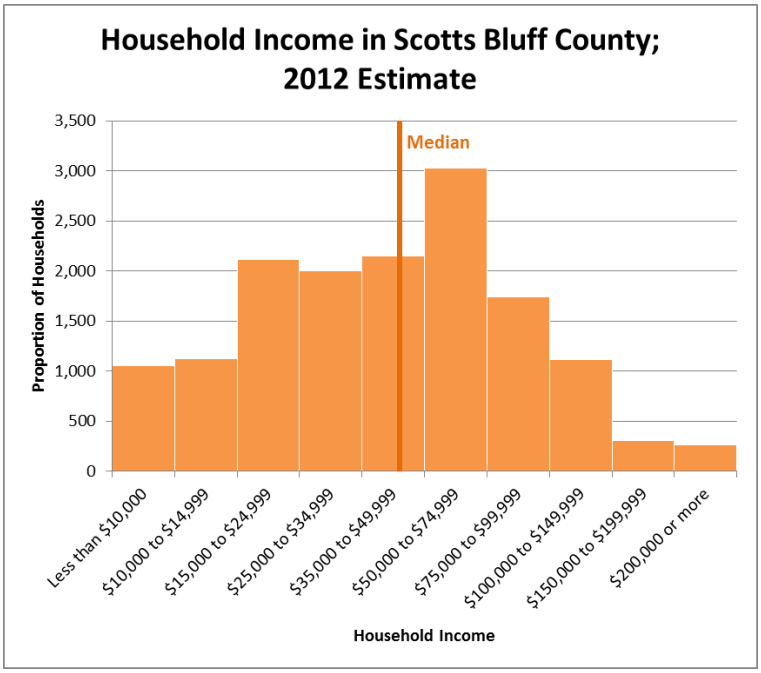


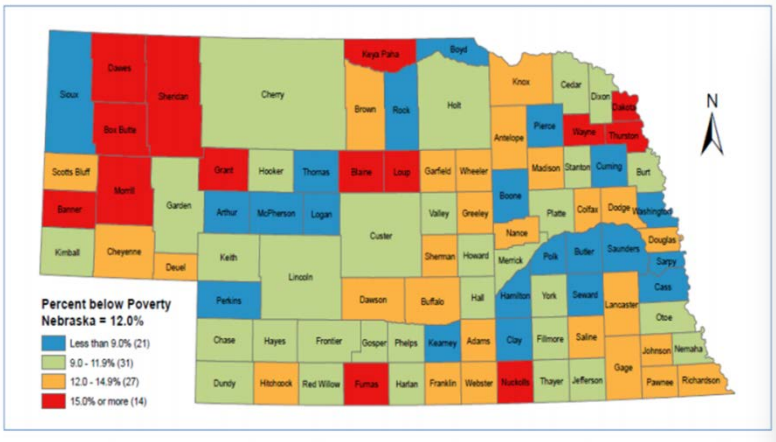
Table 8: Household income

	Household Income	Per Capita Income	Total Households
Banner County	27,167	19,877	309
Box Butte County	44,118	24,389	4,849
Cheyenne County	50,143	27,296	4,438
Dawes County	36,396	20,345	3,772
Deuel County	37,500	24,821	854
Garden County	35,861	24,923	869
Kimball County	43,191	25,304	1,681
Morrill County	42,075	21,881	2,084
Scotts Bluff County	40,939	22,345	14,886
Sheridan County	34,588	22,576	2,373
Sioux County	42,386	31,635	559
Nebraska	50,695	26,113	715,703
Wyoming	56,380	28,952	219,628
South Dakota	48,010	24,925	318,466
Colorado	57,685	30,816	1,941,193

Poverty

Poverty in the Panhandle is generally higher than in the rest of the state and nearby metro areas. Scotts Bluff County's poverty rate (14.7%) is right around the regional rate and higher than the state rate of 12%.

Figure 14: Percent below poverty by county



County	Below Poverty
Dawes	24.7%
Banner	17.8%
Sheridan	17.6%
Box Butte	16.6%
Morrill	15.2%
Scotts Bluff	14.7%
Cheyenne	12.9%
Deuel	12.5%
Kimball	11.2%
Garden	10.1%
Sioux County	8.9%
Panhandle	15.5%

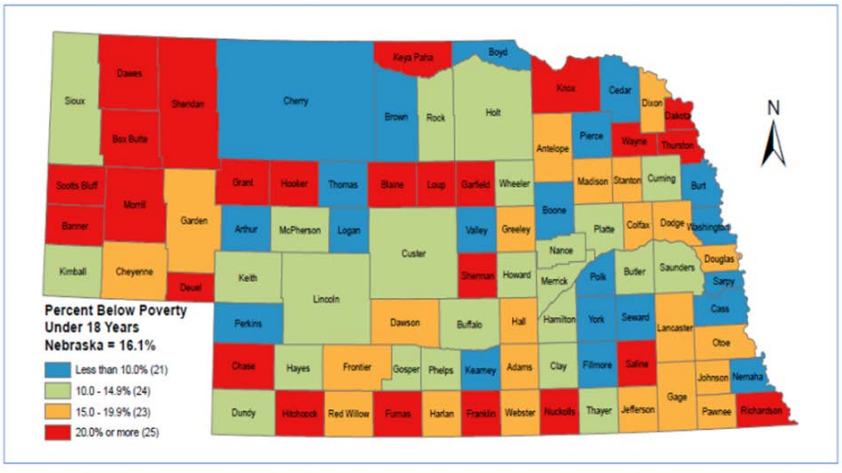
By race, the rate of poverty is high among basically all races except White and Asian. In Scotts Bluff County, the two largest minority groups, Hispanic or Latino and American Indian, had poverty rates of 21% and over 50%, respectively. As was stated before, economic disparities in race represent patterns in economic, social, family, and educational environments. Identifying among which populations (by geography, age, race, etc.) certain patterns exist can help to narrow down which factors are leading to certain social and economic outcomes.

Table 9: Poverty by Race

	One race	White	Black or African American	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Some other race	Two or more races	Hispanic or Latino origin (of any race)	White alone, not Hispanic or Latino
Banner County	18.0%	18.0%	-	-	-	-	0.0%	0.0%	0.0%	18.2%
Box Butte County	16.3%	13.6%	0.0%	34.4%	2.3%	-	66.7%	30.0%	60.2%	11.1%
Cheyenne County	12.8%	13.1%	25.0%	11.8%	0.0%	-	0.0%	14.7%	41.4%	11.4%
Dawes County	24.8%	24.0%	78.0%	24.4%	19.5%	-	0.0%	17.6%	62.1%	22.7%
Deuel County	12.1%	12.2%	0.0%	-	-	-	0.0%	38.7%	10.0%	12.2%
Garden County	10.2%	10.2%	-	0.0%	0.0%	0.0%	-	0.0%	8.6%	10.3%
Kimball County	11.4%	11.6%	0.0%	0.0%	23.5%	-	0.0%	0.0%	39.3%	9.8%
Morrill County	15.5%	15.4%	-	14.7%	0.0%	0.0%	29.8%	2.7%	15.3%	15.5%
Scotts Bluff County	14.6%	13.0%	45.7%	50.3%	8.9%	0.0%	36.2%	18.3%	21.1%	12.0%
Sheridan County	15.5%	14.0%	100.0%	29.0%	36.4%	-	37.5%	56.7%	5.7%	14.3%
Sioux County	8.8%	8.8%	-	-	0.0%	-	0.0%	18.2%	20.0%	8.9%
Panhandle	15.4%	14.2%	54.8%	33.1%	8.6%	0.0%	40.3%	24.3%	26.6%	13.1%
Nebraska	12.2%	10.5%	32.5%	38.2%	16.0%	25.3%	24.3%	25.0%	25.4%	9.4%
United States	14.8%	12.1%	26.5%	27.8%	12.1%	18.7%	26.1%	19.4%	24.1%	10.3%

Particularly high poverty rates exist in the region for children under 18 years of age, with Scotts Bluff County having a rate of 22.3%. Box Butte County has the highest rate at 31.7% and Sioux County has the lowest at just over 10% of children under 18 below poverty. More children in poverty could mean more children growing up with potential obstacles to career, educational, and health care opportunities and threatens the overall prosperity of a community.

Figure 15: Poverty for children under 18 years, 2011



County	Below Poverty
Box Butte	31.7%
Morrill	27.0%
Banner	25.5%
Sheridan	23.3%
Dawes	22.4%
Scotts Bluff	22.3%
Deuel	20.9%
Cheyenne	15.7%
Garden	15.1%
Kimball	14.6%
Sioux	10.5%
Panhandle	22.7%

The Panhandle's lower rate of poverty among people with lower educational attainment likely reflects the good paying jobs available for non-bachelor degree levels of education. Our region's 33% poverty rate for those with a high school degree or less is drastically lower than big cities such as Denver (50%), Rapid City (43%), or Chicago (52%). Table 4 also gives credence to the benefit of higher education in being financially stable, with fewer than 4% of those with a bachelor's degree or higher being below the poverty level.

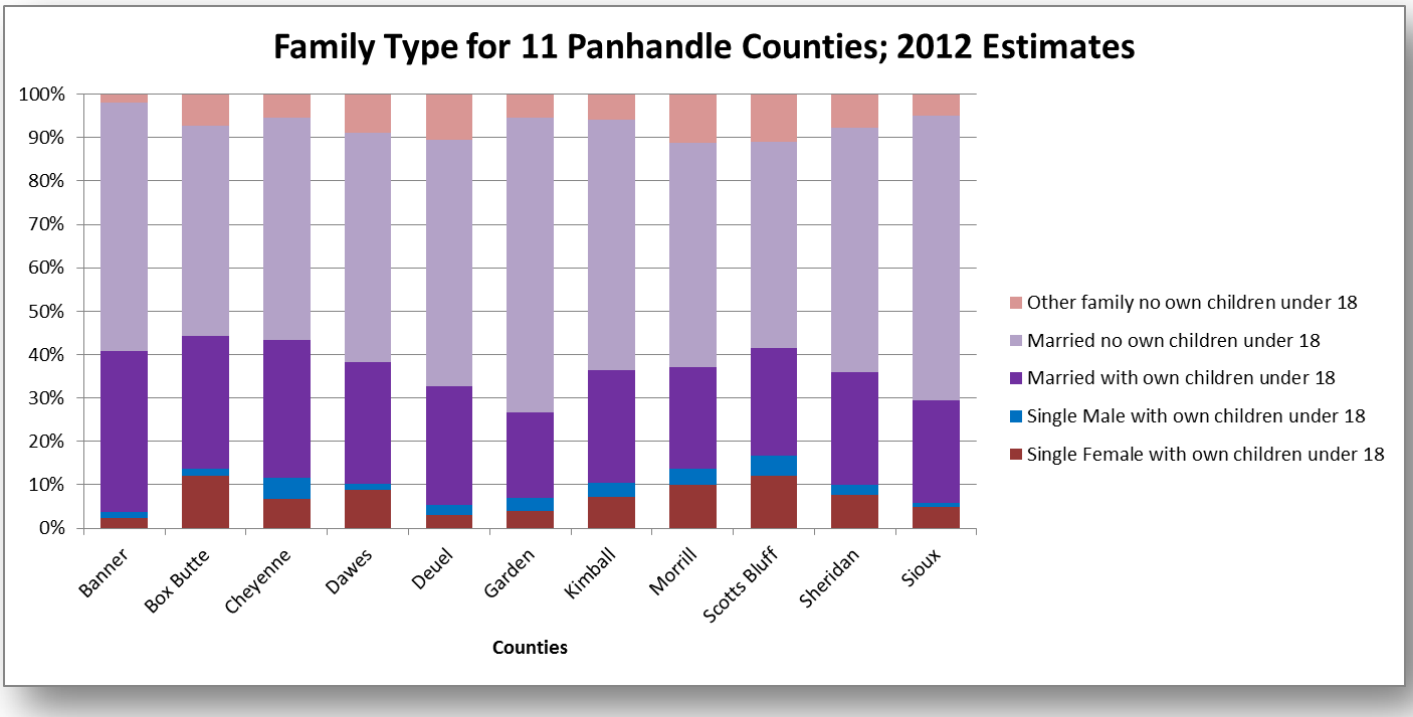
Table 10: Educational attainment and poverty

	Panhandle	Nebraska	United States
	Percent below poverty level	Percent below poverty level	Percent below poverty level
EDUCATIONAL ATTAINMENT			
Population 25 years and over	10.8%	8.8%	11.4%
Less than high school graduate	22.8%	23.1%	26.5%
High school graduate (includes equivalency)	11.1%	10.3%	13.1%
Some college, associate's degree	11.3%	8.4%	9.6%
Bachelor's degree or higher	3.9%	3.3%	4.1%

Family Type

Most families in the Panhandle do not have children under 18 years of age and counties with older while single parent families with children make up about 13.7% of all Scott Bluff County families. Highest rates of single parent families with children occur in Box Butte, Dawes, Morrill, and Scotts Bluff Counties with highest rates of married families occurring in the more rural counties of Banner, Deuel, Garden, and Sioux.

Figure 16: Family type for 11 Panhandle Counties



Poverty by Family Type

When looking at the families with income at or below poverty, we find that 78% of families in poverty are families with children under 18 years of age. Single female headed families with children are particularly prevalent among families in poverty, making up 45% of all families in the Panhandle and 57% of families in Scotts Bluff County with income below poverty.

Figure 17: Poverty by family type

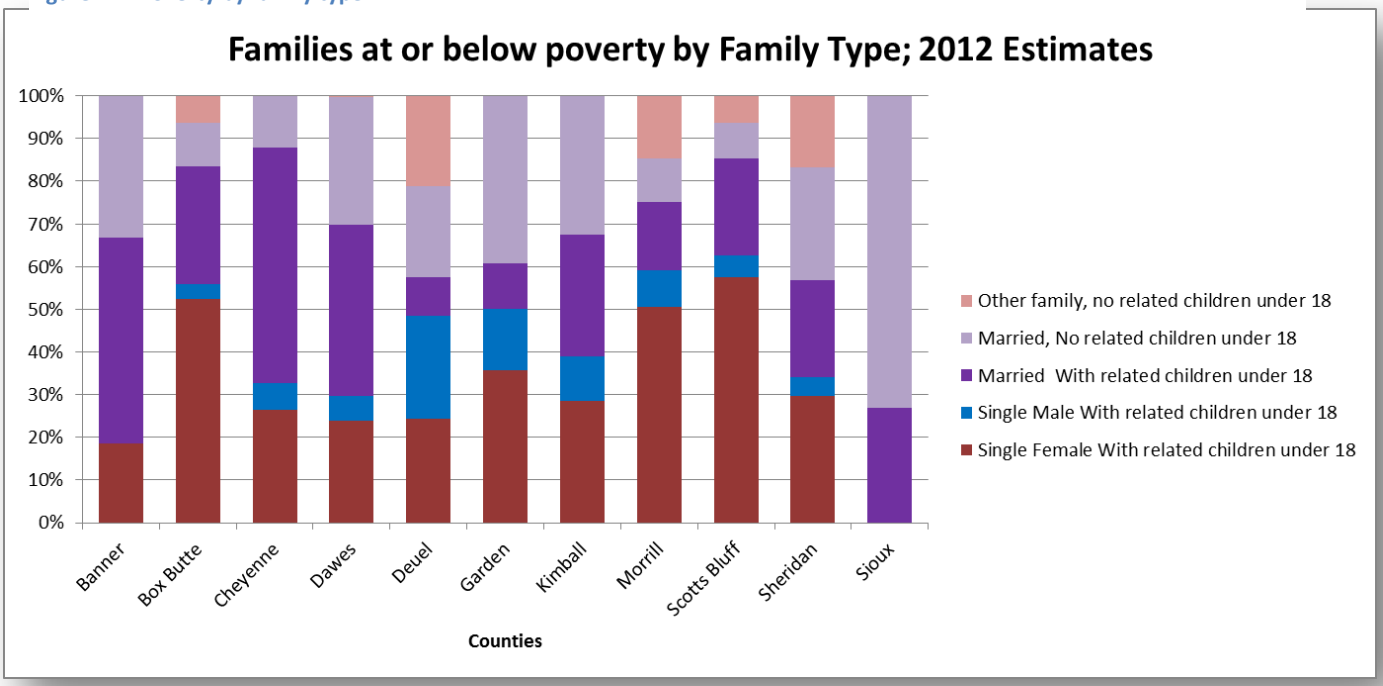


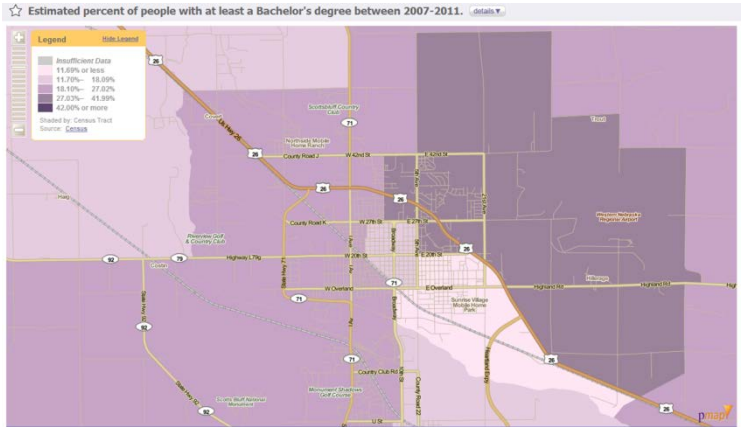
Table 11: Poverty by family type, counts

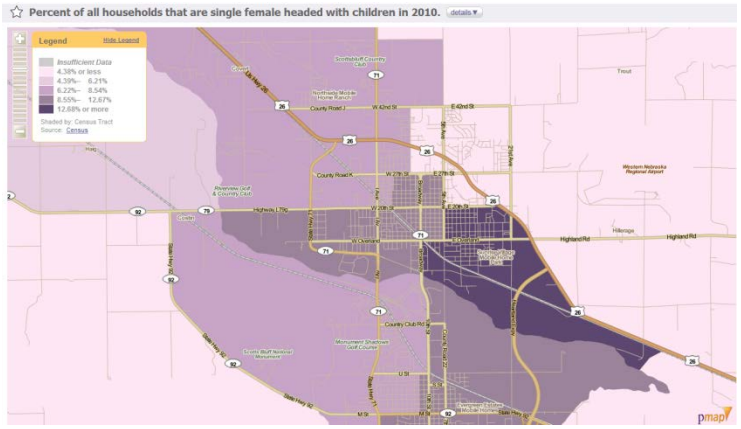
	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Kimball	Morrill	Scottsbluff	Sheridan	Sioux
Total families income below poverty in last 12 months:	27	509	224	310	33	28	95	164	1,075	232	26
Married, No related children under 18	9	52	27	93	7	11	31	17	92	61	19
Married With related children under 18	13	141	124	124	3	3	27	26	243	53	7
Single Male With related children under 18	0	17	14	18	8	4	10	14	54	10	0
Single Female With related children under	5	267	59	74	8	10	27	83	619	69	0
Other family, no related children under 18	0	32	0	1	7	0	0	24	67	39	0

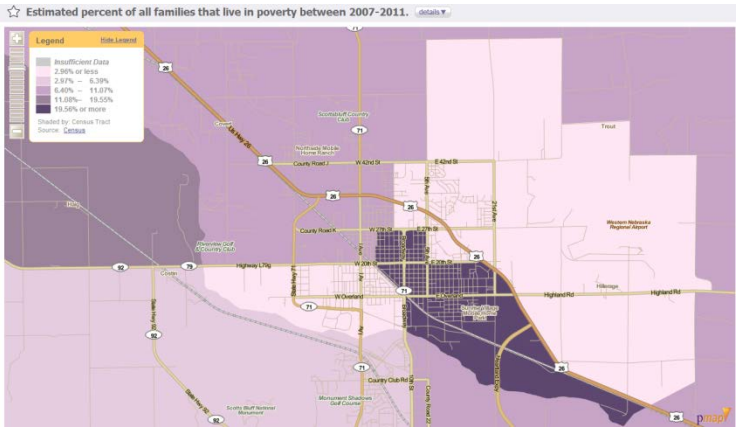
Correlation of factors and social environments

Economic and social factors that affect health do not exist independent of one another but are interrelated. For example, families headed by single parents not only run a higher risk of inadequate social support for children but also potentially bear a greater financial burden. The correlation of these factors points to solutions which touch multiple aspects of a person's life.

The correlation of social and economic factors also manifests itself geographically with those having lower incomes often locating in neighborhoods with lower cost housing. The images on this page show the southeastern census tract of Scottsbluff having the highest rates of poverty and single female headed households and also the lowest rate of educational attainment. These maps not only affirm the interrelation of social and economic health factors but also show the environmental implications of this correlation. Having a positive neighborhood and school environment is also important for personal health in developing positive developmental assets as well as physical health (Franzini et al. 2009).







Moving Forward

An individual's economic and social well-being directly affects his or her health. While Scotts Bluff County has some social and economic indicators that are worse than the state and surrounding regions, the positive is that many of the issues, while complex, are patterned and can be strategically addressed to have the greatest positive impact. As the largest population and economic hub in the region, the county has some important assets from which to build in both the development of economic opportunities and strong social support. Strong partnerships among educational, governmental, non-profit, and business communities and policies that promote financial and social stability for all citizens of the Nebraska Panhandle will drive sustainable, regional wellness.

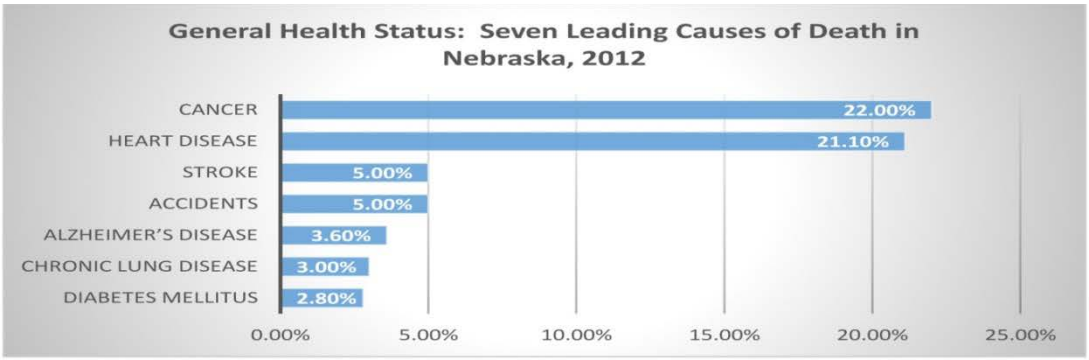
Appendix B: Health Data

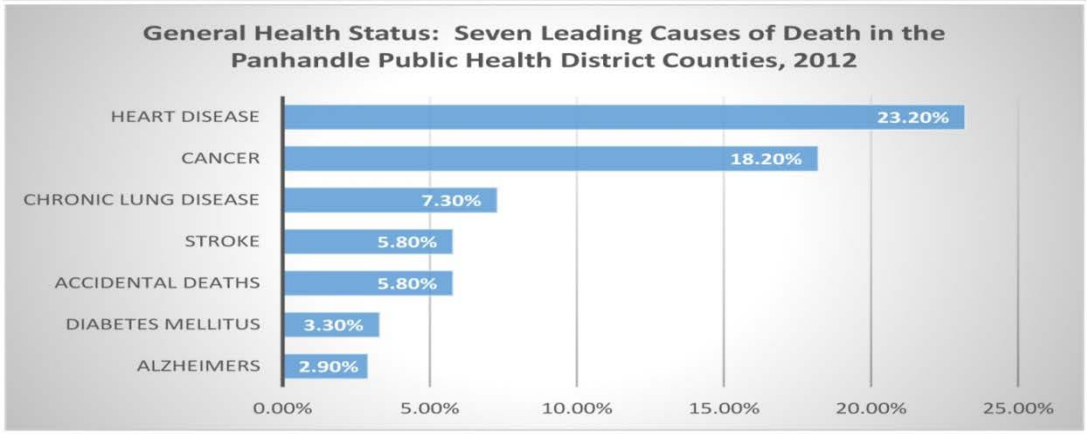
Overview

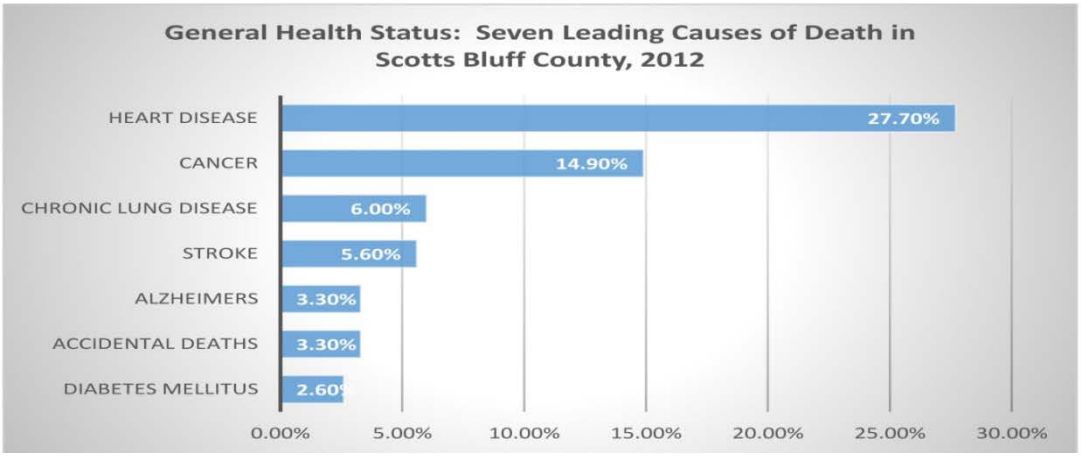
According to vital statistics data, cancer was the leading cause of death in Nebraska in 2012, followed by heart disease, as indicated in the figure below. In the ten counties represented by Panhandle Public Health District, the leading cause of death that year was heart disease followed by cancer. Although in a slightly different order, the top seven leading causes of death are the same for both the Panhandle and the State.

By determining priorities and strategies at a local level that align with a regional or statewide priorities and efforts, a stronger impact on health outcomes can be made.

Figure 18: General Health Status – Leading Causes of Death







Health Status

Behavioral Risk Factors Surveillance System

Each year Panhandle Public Health District and Scotts Bluff County Health Department working with the State of Nebraska, contracts the University of Nebraska Medical Center to conduct a telephonic survey to gather self-reported health data. This survey, the Behavioral Risk Factor Surveillance System (BRFSS), is done nationally and is coordinated with each of the states through the Centers for Disease Control and Prevention.

This survey is a great resource for public health planning efforts. It paints the picture of the region and allows for comparison to state and national data.

The following table represents BRFSS data used for Scotts Bluff County to determine their priority areas. BRFSS data is not available on a county-by-county level, but with similar populations, industries, and resources across the region, the data is a good representation of the health of any county in the Panhandle.

Table 12: BRFSS Data, Scotts Bluff County and Panhandle, 2011-2013

	2011			2012			2013		
	SCB	Comb	Neb	SCB	Comb	Neb	SCB	Comb	Neb
General Health Status									
General health fair or poor	19.0	18.4	14.3	20.5	17.0	14.4	20.2	17.6	13.9
Physical health not good on 14 or more of the past 30 days	12.9	12.1	9.6	14.0	11.8	9.8	17.3	14.7	9.2
Mental health not good on 14 or more of the past 30 days	11.1	10.6	9.2	10.8	9.3	9.0	9.4	10.0	8.9
Health Care Access									
No health care coverage	11.1	21.7	19.1	10.8	20.0	18.0	9.4	19.8	17.6
No personal health care doctor or health care provider, 18-64 yr old	22.5	23.8	18.4	24.4	19.7	17.2	26.1	23.6	20.9
Needed to see a doctor but could not due to cost in past year	15.7	14.7	12.5	12.1	12.8	12.8	20.1	15.7	13.0
Had a routine checkup in past year	55.9	53.6	57.7	54.5	56.4	60.4	54.8	56.5	61.6
Visited a dentist or dental clinic for any reason in the past year	-	-	-	58.9	59.9	67.6	-	-	-
Cardiovascular									
Ever told they had a heart attack	4.5	5.5	4.3	6.3	5.5	4.1	6.7	5.6	4.0
Ever told they had coronary heart disease	4.6	5.0	3.9	4.1	5.0	3.9	5.5	5.6	4.0
Ever told they had a stroke	2.3	2.6	2.6	1.8	2.3	2.4	2.6	3.1	2.5
Had blood pressure checked in last year	-	-	-	-	-	-	83.7	86.5	84.6
Ever told they have high blood pressure (excluding pregnancy)	32.1	33.8	28.5	-	-	-	37.8	35.6	30.3
Had cholesterol checked in past 5 years	65.3	68.1	71.8	-	-	-	70.9	72.9	74.0
Ever told they have high cholesterol, among those checked	37.8	40.2	38.3	-	-	-	39.3	36.5	37.4
Tobacco									
Current cigarette smoking	17.4	18.3	20.0	20.9	20.1	19.7	23.0	20.5	18.5
Attempted to quit smoking in past year, among current smokers	59.5	57.5	55.6	71.5	61.2	57.1	63.3	62.9	57.1
Current smokeless tobacco use	6.6	8.5	5.6	6.7	9.7	5.1	6.5	8.9	5.3
Cancer									
Ever told they had skin cancer	6.9	7.5	5.6	7.5	7.7	5.6	7.7	7.6	5.9
ever told they have cancer, other than skin cancer	7.8	8.3	6.6	8.9	7.5	6.5	8.7	8.2	6.8
Ever told they had cancer (in any form)	13.1	13.9	11.2	14.8	13.7	10.8	14.3	14.2	11.4
Up-to-date on colon cancer screenings, 50-75 years old	-	-	-	53.9	57.7	61.1	52.1	52.0	62.8
Nutrition/Physical Activity									
Ever told they had diabetes (excluding pregnancy)	11.3	10.8	8.4	12.8	10.4	8.1	11.4	10.5	9.2
Obese (BMI =30+)	34.1	29.9	28.4	39.6	33.4	28.6	37.8	33.8	29.6
Overweight or Oobese (BMI=25+)	66.5	65.2	64.9	72.9	70.3	65.0	71.0	68.3	65.5
Consumed fruits less than 1 time per day	39.8	41.4	40.1	-	-	-	42.1	42.1	39.7
Consumed vegetables less than 1 time per day	24.6	23.7	26.2	-	-	-	23.4	24.0	23.3
Currently have activity limitations due to arthritis, among those told they have arthritis	49.1	52.2	45.2	-	-	-	49.0	45.1	42.4
No leisure time physical activity in the past 30 days	25.7	31.9	26.3	21.7	20.7	21.0	28.7	29.5	25.3
Mental Well Being									
Ever told they had depression	21.2	19.6	16.8	17.0	17.5	16.7	20.2	19.6	18.2
Alcohol									
Any alcohol consumption in the last 30 days	53.0	56.2	61.8	53.6	56.4	61.3	50.4	55.0	57.5
Binge drank in the past 30 days	18.0	18.8	22.7	18.3	21.4	22.1	16.4	18.8	20.0
Heavy drinking in the past 30 days	6.0	5.3	7.5	8.0	10.3	7.2	5.5	6.3	6.8
Injury									
Always wear a seatbelt when driving or riding in a car	57.6	55.9	71.3	56.2	53.9	69.7	60.4	58.4	74.1
Texted while driving in past 30 days	-	-	-	22.5	23.4	26.8	-	-	-
Talked on a cell phone while driving in the past 30 days	-	-	-	65.6	66.0	69.1	-	-	-
Had a fall in past year, aged 45 years and older	-	-	-	32.8	34.9	28.8	-	-	-
Injured due to a fall in past year, age 45 years and older	-	-	-	12.1	13.5	9.9	-	-	-
Accessibility									
Occupied housing units with no vehicle available	6.7	5.1	5.7	6.4	5.2	5.8	-	-	-
Economic Health									
Individuals with Income Below Poverty	14.7	15.5	12.0	15.1	15.4	12.4	-	-	-
HH Income	$0.67	-	$0.73	$0.72	-	$0.72	-	-	-
Median Income	$40,939	-	$50,695	$43,113	-	$51,381	-	-	-
Family Support									
Children Under 18 years below poverty	22.3	22.7	16.1	23.3	24.1	16.7	-	-	-
Single Parent with own Children under 18 years of age	17.4	13.7	13.0	16.6	13.4	13.1	-	-	-
Single parent families with children under 18 years below poverty as percentage of all families in poverty	63.5	49.8	56.8	62.6	50.3	56.6	-	-	-
Educational Attainment									
Percent 25 years or older with High School Diploma or Higher	86.6	88.8	90.4	86.6	88.8	91.2	-	-	-
Percent 25 or older with associate degree or higher	29.6	31.4	37.0	29.8	31.2	37.5	-	-	-
Percent 25 or older with Bachelor's Degree or Higher	20.4	22.0	28.1	20.4	22.0	28.1	-	-	-
Unemployment									
Unemployment (July 2014)			4.5			4.0	4.6	4.4	4.0
Elderly									
Population 65 years and older	16.7	17.6	13.5	16.7	17.0	13.5	-	-	-

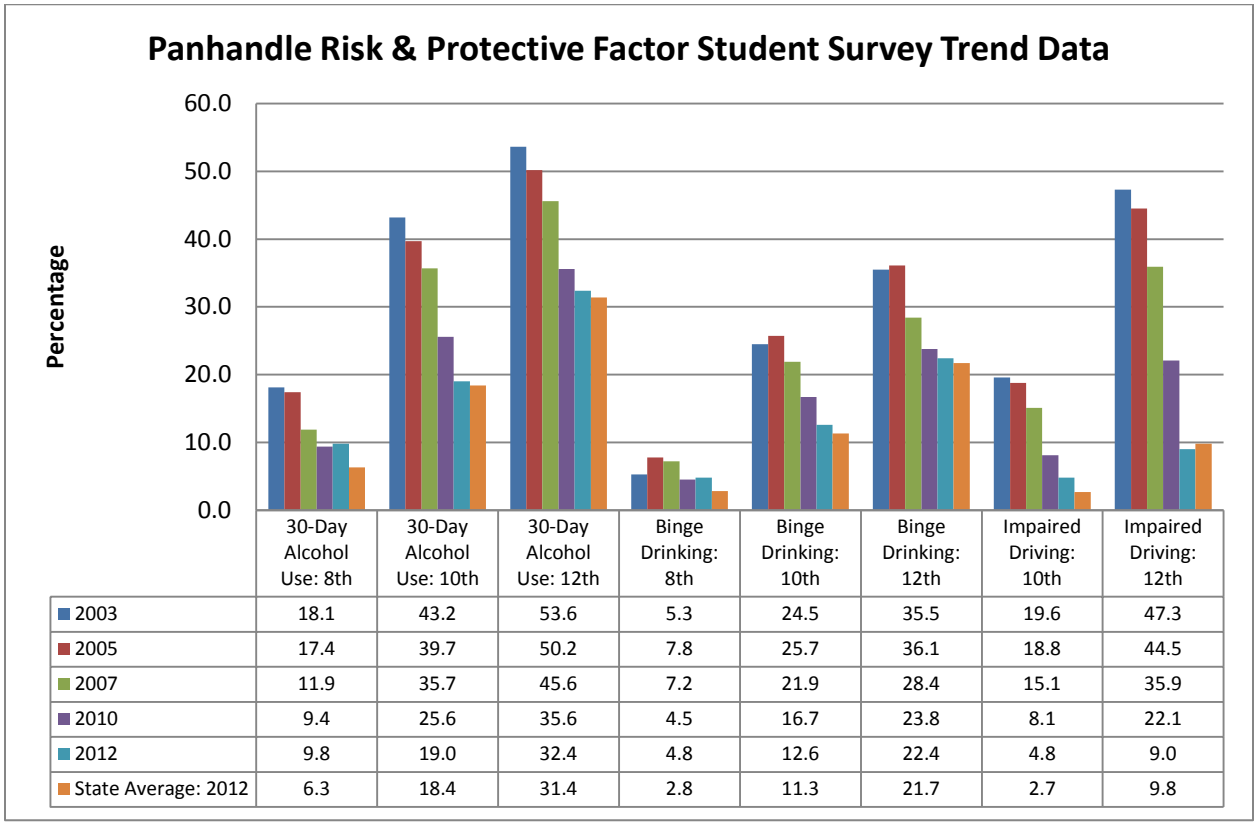
There has been progress in the percentage of adults that have health insurance. Factors that can influence this include a rebounding economy, decreasing unemployment, and the elements of the Affordable Care Act, such as adult children remaining on their parents' health insurance until age 26.

Unfortunately, the percentage of adults reporting they are overweight or obese continues to increase, following state and national trends. About one-third of residents have not had any leisure-time physical activity in the last 30 days. Tobacco use continues to decline, but about 1 in 5 adults still smokes. Alcohol use, binge drinking and heaving drinking are all below the state average, but still impact factors such as accidental injury. Seat belt use is far below the state average.

Youth Risk Factors

The Nebraska Risk and Protective Factors Student Survey (NRPFSS) is a biennial survey of students in grades 6, 8, 10, and 12. This is a survey that schools can choose to administer the survey to receive local information on topics such as substance use/abuse and other risky behaviors. These behaviors can have negative effects on rates of crime, teen pregnancy, high school completion, all of which can negatively affect socioeconomic status and health outcomes later in life. Although the data for the Panhandle is aggregated, a general downward trend is shown for all grades in the risk behaviors of alcohol use, binge drinking, and impaired driving. A positive impact is being made through the efforts of schools, retailers, law enforcement, and community organizations to prevent youth alcohol use.

Figure 19: Panhandle Nebraska Risk and Protective Factors Survey



	30-Day Alcohol Use: 8th	30-Day Alcohol Use: 10th	30-Day Alcohol Use: 12th	Binge Drinking: 8th	Binge Drinking: 10th	Binge Drinking: 12th	Impaired Driving: 10th	Impaired Driving: 12th
2003	18.1	43.2	53.6	5.3	24.5	35.5	19.6	47.3
2005	17.4	39.7	50.2	7.8	25.7	36.1	18.8	44.5
2007	11.9	35.7	45.6	7.2	21.9	28.4	15.1	35.9
2010	9.4	25.6	35.6	4.5	16.7	23.8	8.1	22.1
2012	9.8	19.0	32.4	4.8	12.6	22.4	4.8	9.0
State Average: 2012	6.3	18.4	31.4	2.8	11.3	21.7	2.7	9.8

Injury

Injury data that has been tracked over time is injury deaths due to falls, motor vehicle crashes and suicides. All of these categories are higher than the state crude rate for the same cause.

Figure 20: Injury Crude Death Rates, 2007-2012

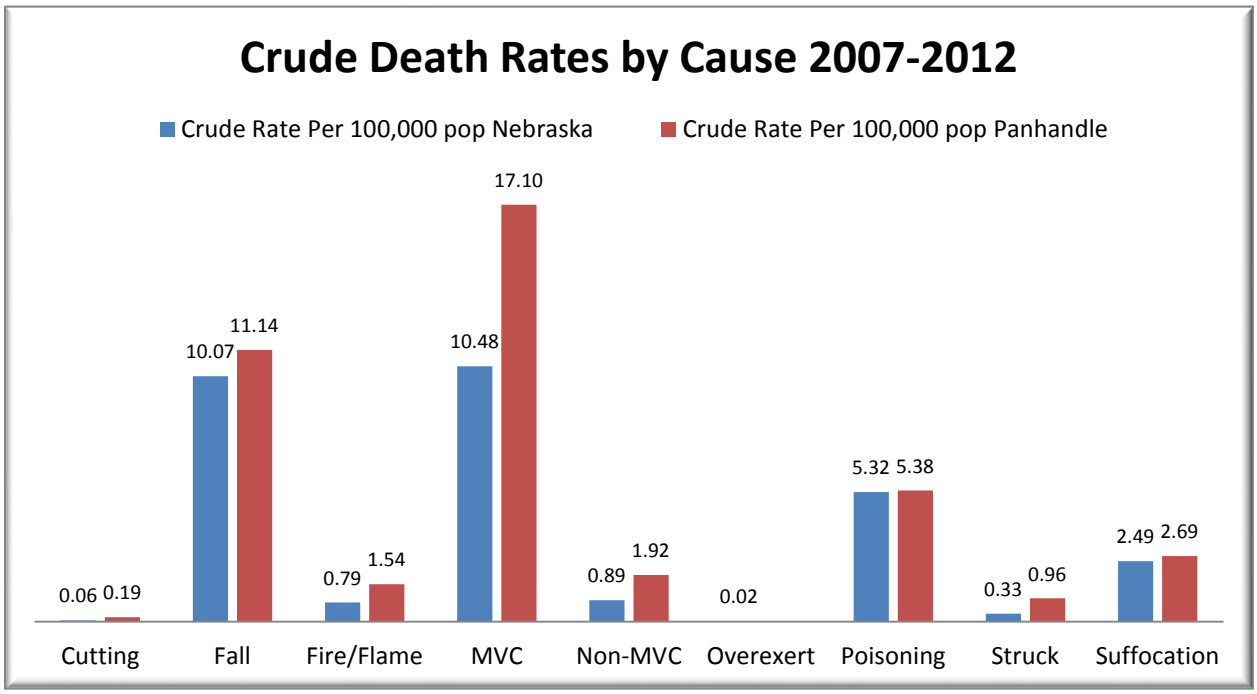
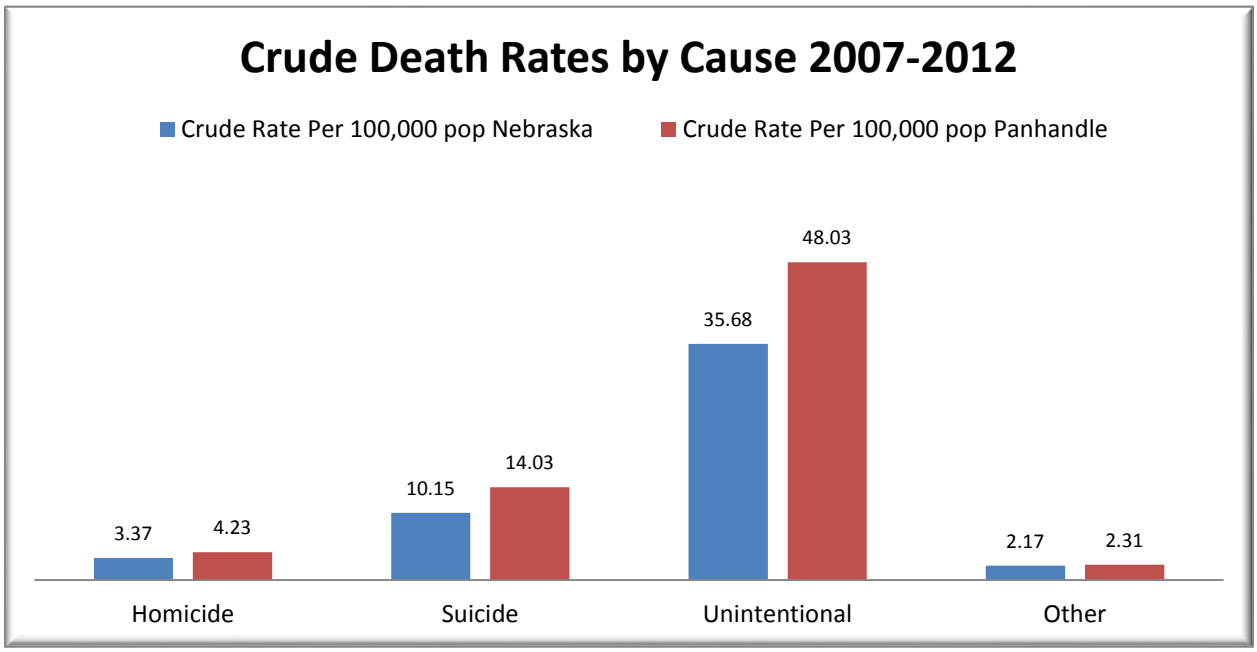


Figure 21: Crude Death Rates by Cause, 2007-2012



Child Well Being

Child Well Being is measured by taking into account child welfare, abuse, and neglect rates, juvenile crime rates, economic factors, educational attainment, adult health behaviors and health outcomes, pregnancy outcomes and social welfare reports. Nebraska conducts an annual evaluation of several indicators of child wellbeing as part of an assessment for home visitation programs.

Table 13: Child Well Being Data, July 2014

Scotts Bluff County

	Factor	Indicator	County	State
1.	Child Welfare	CA/N Reports (rate)	66.8	29.9
2.	Child Welfare	CA/N reports, substantiated (rate)	15.2	6.9
3.	Child Welfare	Out of home Care (rate)	13.7	11.8
4.	Crime	Juvenile Arrests (rate)	35.6	26.2
5.	Crime	Juvenile Drug Arrests (rate)	5.5	2.8
6.	Crime	Juvenile DUI (rate)	0.2	0.3
7.	Crime	Juvenile Violent Crime Arrests (rate)	0.1	0.5
8.	Economic	Poverty, All ages (%)	15.7%	12.6
9.	Economic	Unemployment (%)	4.9%	4.4%
10.	Education	Education less than 9th Grade (%)	4.8%	4.1%
11.	Health Behaviors	Adult Smoking (%)	20.0%	18.0%
12.	Health Behaviors	Binge Drinking (%)	12.0%	19.0%
13.	Health Behaviors	Chlamydia Infections (rate)	213.0	305.0
14.	Health Behaviors	Inadequate Prenatal Care (%)	16.5%	14.3%
15.	Health Behaviors	No Prenatal Care (%)	1.0%	0.7%
16.	Health Behaviors	Births to Teens (% teen births)	12.9%	7.6%
17.	Pregnancy Outcomes	Low Birth Weight (%)	8.2%	6.9%
18.	Pregnancy Outcomes	Very Low Birth Weight (%)	1.3%	1.2%
19.	Pregnancy Outcomes	Prematurity (%)	12.8%	11.2%
20.	Pregnancy Outcomes	Infant Mortality(rate)	7.4	5.7
21.	Health Outcomes	Poor/Fair Health (%; self-reported)	15.0%	12.0%
22.	Health Outcomes	Poor Mental Health Days (mean)	3.5	2.7
23.	Health Outcomes	Poor Physical Health Days (Mean)	3.7	2.9
24.	Health Outcomes	Premature Death (YPLL)	7,281.0	5,904.0
25.	Social Welfare	Aggravated Domestic Violence Complaints (rate)	3.1	2.6
26.	Social Welfare	Domestic violence Crisis Line Calls (rate)	30.9	25.7
27.	Social Welfare	Simple Domestic violence Complaints (rate)	38.8	26.4
28.	Social Welfare	Single Parent Household (%)	42.0%	27.0%

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

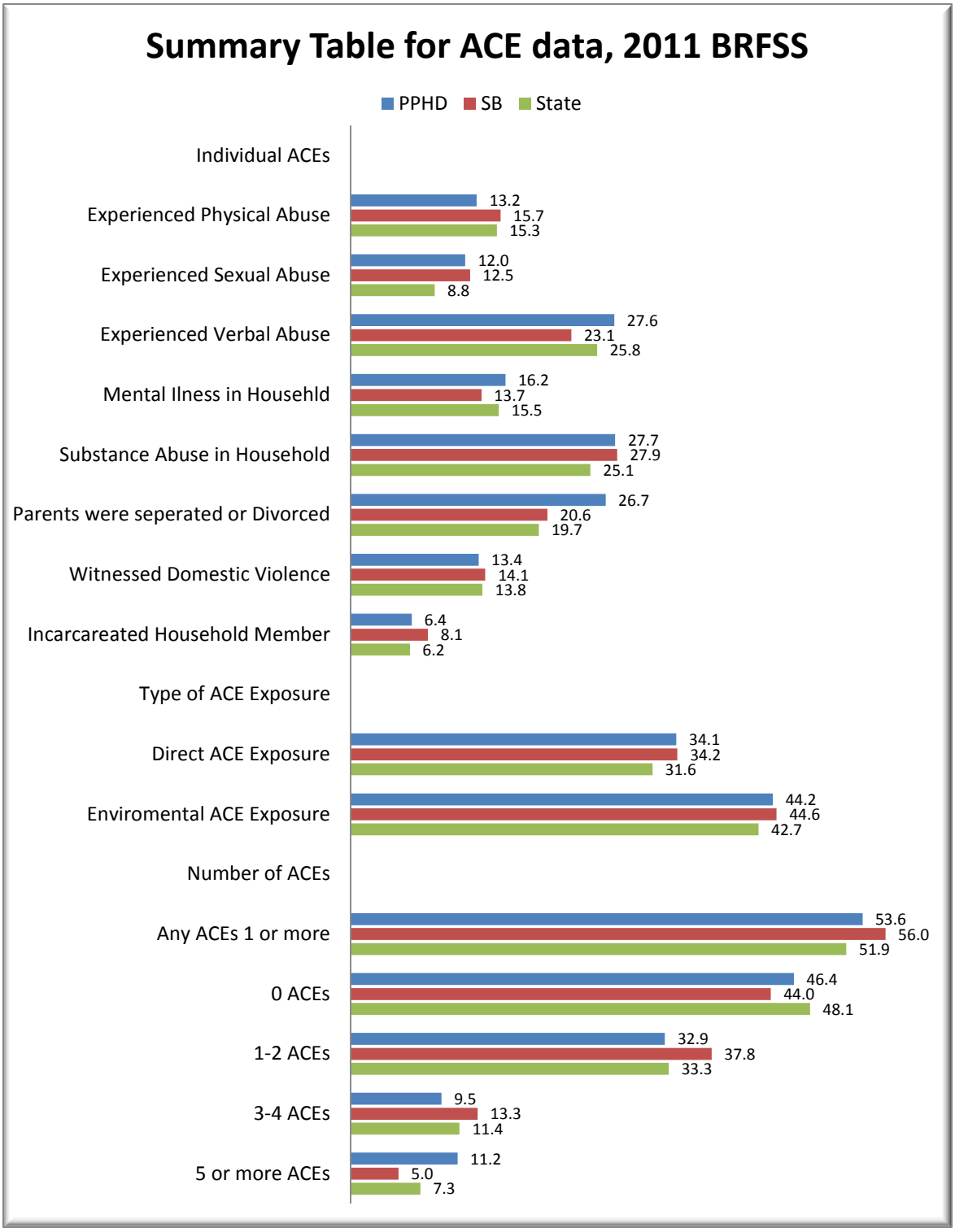
More than 17,000 Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than100 conference and workshop presentations have been made.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.

Adverse Childhood Experiences, Nebraska, 2010–2011

Nebraska's Behavioral Risk Factor Surveillance System (BRFSS) data from 2010 and 2011 were analyzed to evaluate associations between adverse childhood experiences (ACEs) and adverse health outcomes and behaviors during adulthood. Statistically significant associations were demonstrated between the number of ACEs and tobacco use, obesity, reporting poor general health, arthritis, cardiovascular disease, COPD, depression, diabetes, and disability. In addition, we demonstrated associations between individual ACEs and multiple adverse health outcomes. These findings highlight the need to detect and intervene in the lives of children affected by ACEs before they develop adverse health outcomes.

Figure 22: Adverse Childhood Experiences

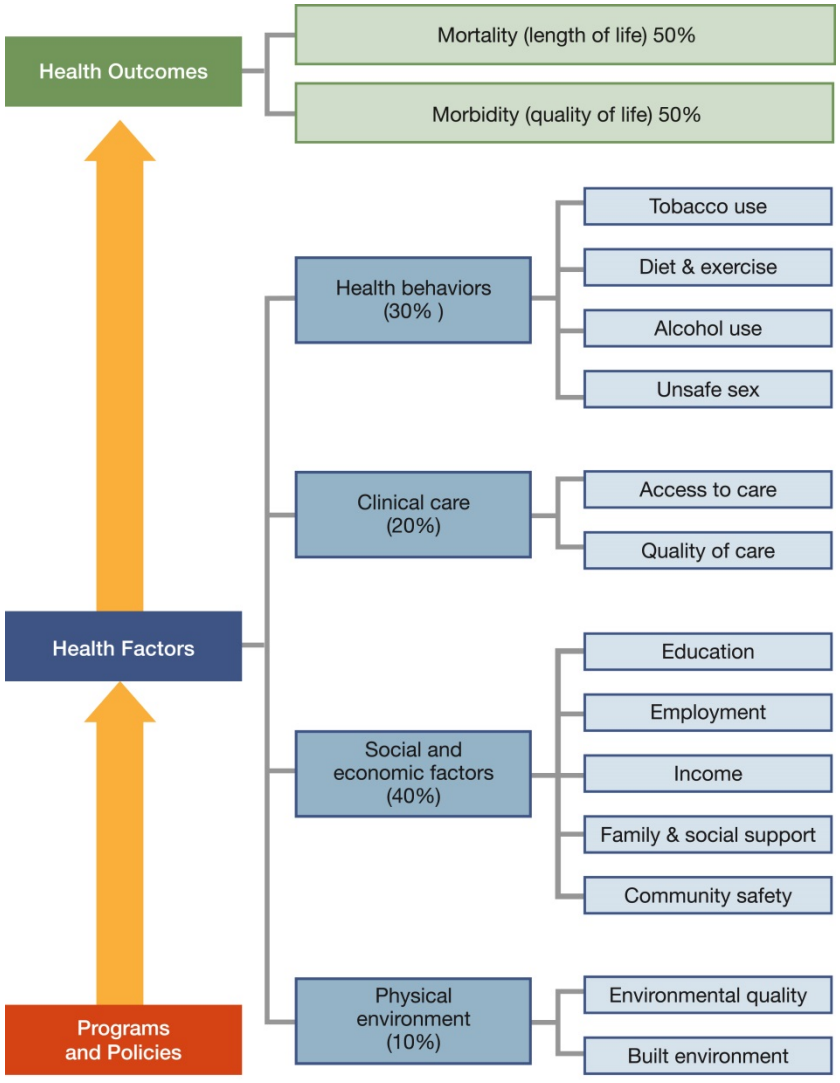


Appendix C: County Health Rankings

The Robert Wood Johnson Foundation releases an annual ranking of each county in each state of the nation. In Nebraska, 79 of the 93 counties are ranked due several with very small populations that cannot be fairly ranked. The score is made up of two main categories: 50% health outcomes, including length of life and quality of life; and 50% health factors including health behaviors, clinical care, social and economic factors, and the physical environment.

This model shows that it takes more than just exercise and good nutrition to be considered healthy. Where we live, our environment, education, medical care and the behavioral choices we make count just as much as how long we live.

Figure 23: County Health Rankings Model



County Health Rankings model ©2010 UWPHI

In 2014 Scotts Bluff County was ranked 70th in the state in health outcomes and 73rd in health factors.

Figure 24: 2014 Health Outcomes Rankings

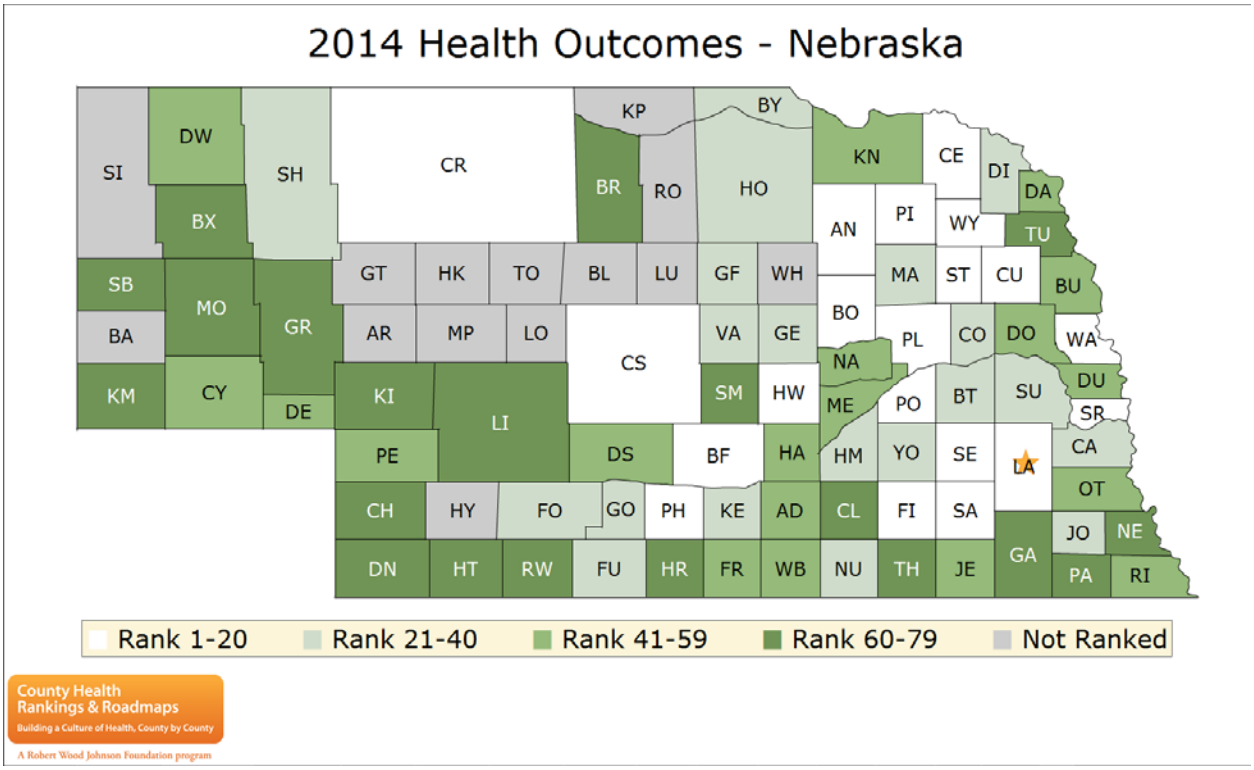


Figure 25: 2014 Health Factors Rankings

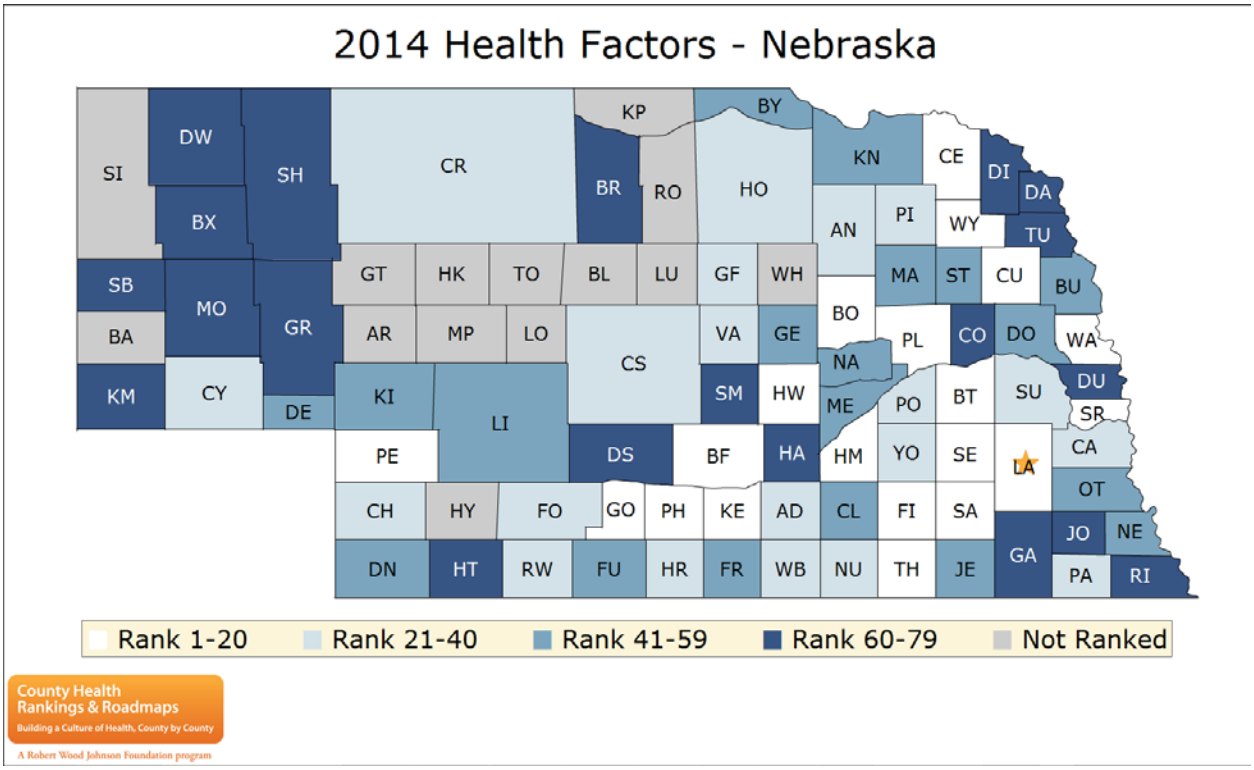


Table 14: Scotts Bluff County Health Rankings, 2014

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

Scotts Bluff (SB)

	Scotts Bluff County	Error Margin	Top U.S. Performers*	Nebraska	Rank (of 79)
Health Outcomes					70
Length of Life					60
Premature death	7,281	6,315-8,247	5,317	5,904	
Quality of Life					77
Poor or fair health	14%	13-16%	10%	12%	
Poor physical health days	3.9	3.4-4.4	2.5	2.9	
Poor mental health days	3.9	3.3-4.4	2.4	2.7	
Low birthweight	7.4%	6.6-8.3%	6.0%	7.0%	
Health Factors					73
Health Behaviors					58
Adult smoking	18%	16-20%	14%	18%	
Adult obesity	32%	30-35%	25%	29%	
Food environment index	7.7		8.7	8.1	
Physical inactivity	27%	25-29%	21%	25%	
Access to exercise opportunities	59%		85%	75%	
Excessive drinking	11%	9-13%	10%	20%	
Alcohol-impaired driving deaths	45%		14%	36%	
Sexually transmitted infections	316		123	368	
Teen births	58	53-63	20	33	
Clinical Care					30
Uninsured	15%	14-17%	11%	13%	
Primary care physicians	1,323:1		1,051:1	1,404:1	
Dentists	1,760:1		1,392:1	1,493:1	
Mental health providers	616:1		521:1	560:1	
Preventable hospital stays	56	50-63	46	64	
Diabetic screening	83%	75-91%	90%	85%	
Mammography screening	57%	49-64%	71%	62%	
Social & Economic Factors					77
High school graduation	80%			85%	
Some college	60%	54-65%	70%	69%	
Unemployment	4.5%		4.4%	3.9%	
Children in poverty	25%	19-31%	13%	17%	
Inadequate social support	21%	19-23%	14%	17%	
Children in single-parent households	39%	32-47%	20%	28%	
Violent crime	167		64	271	
Injury deaths	74	62-87	49	54	
Physical Environment					77
Air pollution - particulate matter	13.6		9.5	12.1	
Drinking water violations	18%		0%	10%	
Severe housing problems	16%	13-18%	9%	13%	
Driving alone to work	82%	79-84%	71%	80%	
Long commute - driving alone	11%	9-12%	15%	17%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2014

Appendix D: Forces of Change Assessment

What factors, trends, and events are or will be influencing the health and safety in our Panhandle community and or the work of the Public Health System?									
Prevention Funding Decreasing	**Chronic Disease**	**Injury and Violence Prevention**	**Access**	**Demographics**	**Policy Decisions Affecting the Cost of Care**	**Societal Mentality**	**Economy**	**Making the Easy Choice Healthy**	**Political Unrest**
• Prevention funding decreasing	• Childhood obesity and diabetes mellitus • Increased electronics = decreased activity • Increase in chronic disease, obesity, diabetes, heart disease	• Legalization of marijuana increases crime rate • Increase in drug use (Colorado legalizes drug use) • Child safety concerns • Increase in child abuse • Food safety • Increase in distracted driving	• Need more access to patient education and support • New additions to healthcare facilities • Mental health access • Transitioning elderly into long-term care, access • Far distance, frontier community	• Aging population • High number of children in poverty • Young people leaving • Minority/language cultural • Far distance, frontier community • Declining and more transient population • Cheyenne County growing population, meeting needs	• Wellness in Nebraska Act • Nebraska not expanding Medicaid • Reducing Critical Access Hospital (CAH) legislation (within 15-30 miles) • Sky-rocketing costs to provide healthcare • Confusion on healthcare insurance rates and ratings • Increased deductibles, increased out of pocket, insurance changes • Aging population and diminishing resources through Medicare • Healthcare reform, Medicaid expansion, ACA • Reduction of CAH-cost reimbursement decreases	• Faith-based services decreasing • Personal accountability, who is responsible? • Instant gratification culture • Change in family and community structure • Ease of access to social government support • Wellness readiness – lack of community acceptance	• Middle class being squeezed • Depressed economy (nationally and in Nebraska) • Lack of quality jobs • Economic development • Climate – fires, drought, wind • Education issues	• Food industry making small steps, NuVal • Increased focus for active lifestyle • Bountiful baskets	• Elected officials quick to change, turnover • Political climate is challenging

Appendix E: Focus Group Summary

Regional West Medical Center hosted two focus groups for residents of the service on May 19 and 22, 2014. The following is a summary of the discussions:

Factors contributing to quality of life (Strengths)

Friendly - Participants described their community as positive, friendly and a great location to raise kids. There is a small town atmosphere which can have both positive and negative implications.

Outdoor Activities – The area is rich with history and has an abundance of outdoor activity such as hiking, climbing, biking, fishing and hunting. There has been improvement in the parks and expansion of walking trails.

Health care services–Most of the participants receive their care locally at RWMC, the VA, Quick Care or CAPWN. It was recognized that RWMC just hired a Spanish interpreter and has expanded service for the elderly. Care is also sought in Denver, Fort Collins and Cheyenne for specialists not available here. People receive health information from their physician, pharmacist, nurses, and reliable web sites.

Other services – Participants felt there was an array of services for lower income families.

Employment opportunities - Participants felt the area was an agriculture based economy that is conservative in nature, but open to change. There is great potential for growth.

Local commerce – The area is viewed as a hub for the rest of the panhandle. People present felt there are adequate shopping options. Mall has lost businesses, but just recently is going through a concentrated effort of expansion. There is a great selection of Mexican restaurants.

Safety of the community – Residents identified safety as strength in the community.

School system – participants felt that the schools are improving and felt encouraged with the expanding skill set available at the high school. The recent remodeling of the middle school was noted. Western Nebraska Community College provides for a college education at a low cost.

Art and culture – The Midwest theater was mentioned many times as an asset to the community. It was recognized that there are many community events and celebrations available throughout the year.

Acceptance of differences – People of other races that have moved here have been accepted. People are friendly to outsiders.

Factors reducing quality of life (Weaknesses)

Transportation –this has been a major concern expressed in other community planning sessions. Transportation for medical appointments, shopping, and getting to work have all been identified.

Crime – Participants noted there is an increase in crime and drug use, especially meth.

Health care services – Some participants did not know that Urgent Care is a part of RWMC and that they have access to the electronic medical record from the physician's clinic. There was a concern voiced about not always knowing what is available at RWMC. Specialists come and go. Members discussed the lack of knowledge in the community regarding the concept of a medical home the changes in healthcare and navigating the new insurance changes.

Schools - There is a concern that the school lunch programs are not meeting healthy food and quantity standards

Employment - There is a lack of jobs that provide livable wages. We need more jobs to keep people here and bring more people in.

Child care – There are not enough daycares and preschools.

Awareness of services available – A need identified is a good source for what is available in the community. Increased awareness of tornado shelter and preparedness education is also needed.

Poverty – A concern was expressed about resources for the homeless.

Other services – The recent closing of the detox service is a loss to the community.

Acceptance of differences – Some perceived that people did not want the meat packing plant because of the increased diversity that would result. There is a lack of interaction between elderly and young people.

Civic engagement- members compared the community to a lung, it expands to a certain point and then businesses and people move away. It seems to cycle around and never grows past a certain point. Leaders need to take risks to grow.

Air quality – It was expressed in both groups that the sugar beet factory affects the air quality.

Youth activities – Need to be more activities for the tween age of young people. Need more after school programs and activities for kids and teens.

Appendix F: RWMC Stakeholder Meeting Work Product

What do we see in place in 3-5 years as a result of our collective action?									
Educational Opportunities	**Socially Conscious Environment**	**Quality Services Across the Life Span**	**Better Sense of Community**	**Economic Development**	**Active Living**	**Healthy Eating Environment**	**Equal, Affordable Access to Healthcare**	**Access to Dependable Transportation**	**Shift to Preventative Care Model**
• Modern high quality educational opportunities • Educated workforce • Community kitchen teaching opportunity	• Higher quality "greenspaces" • Clean neighborhoods • Equal opportunity for pro-social involvement for youth • Community garden • Everyone has smoke-free campuses	• Family center for women and children • Quality, affordable daycare • Reduction in child abuse • Senior citizen needs met • More resources for seniors Policies about follow-up care or discharge from prison, hospital	• Decision-maker demographics reflect demographics of community • One-stop local community resource center • Equal opportunity for pro-social involvement for youth • Free internet, countywide "hot spots" • Respect for all cultures	• Economic development, new industry • New wave of entrepreneurs • Aquaculture • Private/public partnership, for-profit/non-profit partnership • Housing – affordable rental, purchase • Increase in average household income • Young business people taking over existing businesses	• Bike lanes on main streets and roads • Bike trails, walking trails • More accessible fitness • Easier to make the right healthy active choice!!! • Access to healthy activities • Smoke-free campuses, areas	• Access to healthy foods and activities • Easier to make the right healthy food choice!!! • Aquaculture (plants/fish growing cycle) • All food vendors will adopt "healthy food choice system" such as NuVal • Community gardens	• Equal access to healthcare • Access to mental health and addiction services • Affordable access to mental healthcare • Family center for women and children	• Public transportation • Increased access to public transportation • More reliable air service	• Different delivery of healthcare that focuses on population management not acute episodic

Appendix G: RWMC Prioritization Matrix

Criteria	Weight	Scoring Values	General Health Status	Health Care Access	Cardiovascular	Tobacco Use	Cancer	Nutrition/Physical Activity	Mental Well Being	Alcohol	Child Well Being	Accidental Injury	Accessibilty	Economic Health	Family Support	Educational Attainment	Unemployment
Available Data: Is measurable data available?	1	0, 1, 2, 3, 4 0: no data 1: perceptual / anecdotal 2: perceptions and counts 3: perceptions and baseline 4: perceptions and trend	4	4	4	4	4	4	3	4	4	4	3	4	4	4	4
Population Affected: What percentage of the population does this health issue affect?	2	1, 2, 3, 4, 5, 6, 7, 8, 9, 10 1 - 2: Less than 1% 3 - 4: 1.0 - 9.9% 5 - 7: 10 - 24.9% 8 - 10: 25% or greater	6	7	10	6	6	10	6	4	4	5	3	6	7	5.5	3
Resources Available: Does the community hospital and do the community partners have the knowledge, skill, materials and equipment needed to address this health issue?	3	0, 1, 2, 3, 4 0: no hospital or community resources 1: minimal hospital resources 2: minimal hospital and community resources 3: adequate resources from one organization (partner or hospital) 4: adquate community resources	3	3.5	3.5	2	4	3.5	2.75	2	3	3	2	3	3.5	3.5	3
Significance / Importance: What is the seriousness of this issue? Urgency - high death rate - hospitalization - premature death rate - economic burden - impact on others?	3	1, 2, 3, 4, 5, 6, 7, 8, 9, 10 1 - 2: Not serious / little impact 3 - 5: Moderate - illness 6 - 8: Serious - some death, impact 9 - 10: Very serious - high death	3	4	8	7	7	6.5	5	6	7	6	3	7	6	6	5
		Total Score	34	40.5	58.5	43	49	54	38.25	36	42	41	24	46	46.5	43.5	34