

July of 2019-June of 2022

NORTHEAST NEBRASKA COMMUNITY HEALTH IMPROVEMENT PLAN

Northeast Nebraska Rural Health Network Core Team

Northeast Nebraska Public Health Department, Pender Community Hospital, and
Providence Medical Center

This report was prepared by RJR Consulting for:

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Executive Summary

Improving population health requires a collaborative effort. The Nebraska Center for Rural Health Research provided the quote found here in their 2017 review of local Community Health Improvement Plans¹ (CHIPs), this document is based on this premise.

“To Make significant progress on these difficult and complex population health needs, the hospital, the Local Health Department, and other partners need to work together to develop a cohesive implementation strategy”.

The Northeast Nebraska Public Health Department (NNPHD), Providence Medical Center and the Pender Community Hospital are collectively known as the Network Core Planning Team. The Network Core Planning Team developed a purpose statement that applies to the work they are doing. *“In rural Nebraska, it’s important that we maximize our resources. That’s why we are working together as partners to measure the health of the area and make a plan that will create a healthier community for all people”.*

The Core Planning Team came together in January of 2018 around the shared interest of assessing their community’s health needs and working to address those needs to improve the health of the service area. This Community Health Improvement Plan (CHIP) is the outcome of those initial efforts completed with the collaborative work of twenty different community agencies reviewing data from the 2019 Northeast Nebraska Rural Health Network Community Health Needs Assessment (CHNA). The CHNA is a community-informed public health assessment that describes the health status of the four counties of Cedar, Dixon, Thurston and Wayne.

This Northeast Nebraska CHIP presents the prioritized health concerns of both the community and all the agencies who worked on the plan. It is not the health departments plan nor is it the Core Planning Team’s plan it is the communities plan. The plan contains two priority areas: Behavioral Health and Obesity. It will take a collaborative effort to reach the goals and objectives laid out in this plan. We hope that if you are not a part of this collaborative, collective impact effort that you will join us in our work.

Acknowledgements

Special thanks to the members of the Core team and members of the CHIP priority area workgroups, who represented the following organizations:

- Nebraska Behavioral Health Network
- Nebraska Extension Office in Thurston
- Northeast Nebraska Behavioral Health Network

¹ David Palm, Li-Wu Chen and Jamie Larson, “An Assessment of the Community Health Needs Assessment and Implementation Plans for Nonprofit Small Rural Hospitals in Nebraska” Research Findings Brief, Nebraska Center for Rural Health Research, August 2017.

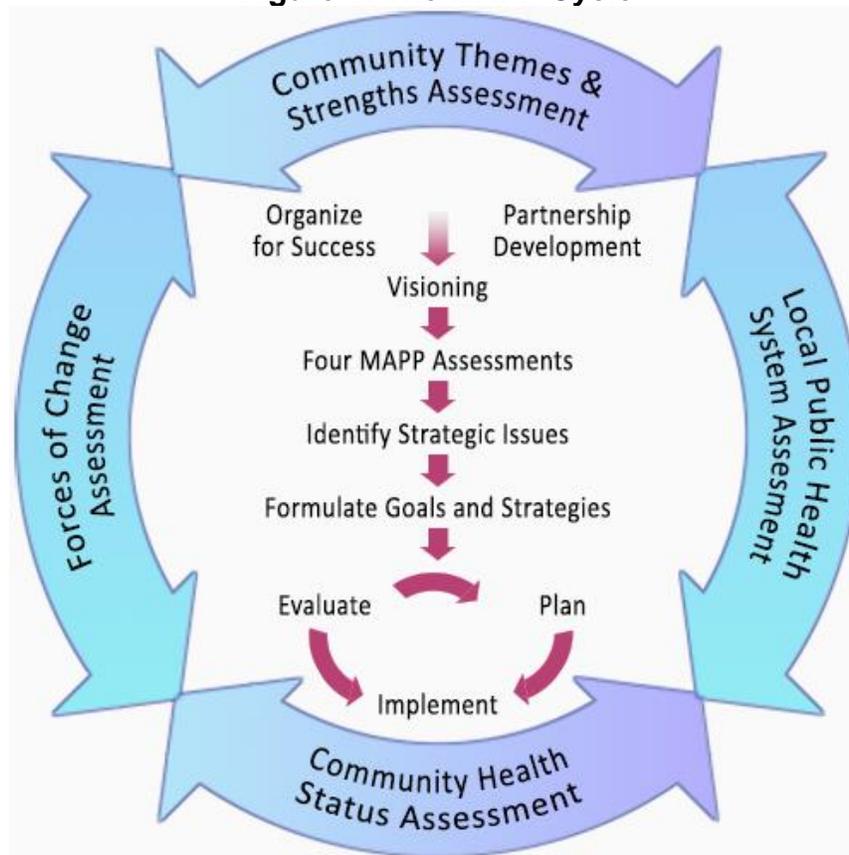
- Northeast Nebraska Community Action Partnership
- Northeast Nebraska Public Health Department
- Pender Community Hospital
- Providence Medical Center
- Wayne State College
- Winnebago Health Department

Development of Work

Framework/Methodology

The Mobilizing for Action through Planning and Partnership (MAPP) framework was chosen for this CHNA. MAPP is the most common planning process used by local health departments and by hospitals to develop CHNA's in Nebraska.² MAPP is a partnership-based framework that was developed by the National Association of County and City Health Officials (NACCHO), in collaboration with the Centers for Disease Control and Prevention (CDC) in 1997. MAPP is a comprehensive approach that includes the collection and analysis of both qualitative and quantitative data.

Figure 1: The MAPP Cycle



² David Palm, Li-Wu Chen and Jamie Larson, "An Assessment of the Community Health Needs Assessment and Implementation Plans for Nonprofit Small Rural Hospitals in Nebraska" Research Findings Brief, Nebraska Center for Rural Health Research, August 2017.

The MAPP process has six key phases, the first three phases are: 1) Organize for success/partnership development; 2) Visioning; and 3) the Four Mapp assessments. The bulk of this work including the MAPP assessments were completed between July of 2018 and March of 2019. The first three phases and the four MAPP assessments are found in the Northeast Nebraska CHNA document.

This document represents a shift from identification of community issues to implementation of a community plan to address these issues. Here, the next three phases (4-6) of MAPP will be discussed. The next phases are: 4) Identify strategic issues; 5) Formulate goals, strategies and an action plan and 6) The action cycle which is continuous cycle comprised of Plan, Implement and Evaluate, this phase will take place until the next CHIP meeting is held (estimated to be held in 2022).

Phase 4: Identify Strategic Issues

Phase four is the identification of strategic issues and this phase was done after the data was compiled and reviewed. The 2019 CHNA was placed on the NNPHD website on April 15th and the general public was notified of its placement through newspaper articles, Facebook and through the partner networks. A community prioritization meeting was scheduled for May 21st which was also advertised by newspaper, where segments of the data was presented via a virtual meeting format. In total, 45 persons other than the facilitator and producers attended the meeting and they represented multiple sectors of the community (see also participation of the community in the CHIP process in this document). The data that was presented at the CHIP meeting was based off the data collected in the Northeast Nebraska Community Health Needs Assessment. Strategic issues were chosen by majority vote of the group assembled at the CHIP meeting; two strategic issues were identified.

Phase 5: Formulate goals, strategies and an action plan

Phase five of the MAPP process began at the CHIP meeting on May 21st when participants by majority vote decided on overarching goals for the two strategic issues. The CHIP meeting attendees also identified some potential objectives for the two CHIP goals which served as a place to start discussions at the next series of CHIP strategic issues priority group meetings which started in August of 2019.

Each of the two CHIP strategic priority groups reviewed the objectives and refined the objective selection to match the groups priorities for change. The CHIP strategic priority groups also looked at current resources as well as current activities to address each of the two strategic issues, goal and chosen objectives.

Once community resources were understood the two groups looked at some evidence-based interventions (EBIs) that have helped other communities achieve similar objectives. An emphasis was made on presenting and reviewing evidence-based interventions that have been proven to be effective rather than just choosing activities the group was familiar with without looking at their effectiveness. In looking at EBI's and

strategies/action steps in general, the groups were encouraged to consider what local support and barriers to implementation might be present using a matrix for scoring. The groups were then encouraged to narrow down potential strategies which may be EBI's or other strategies to address and meet the objectives.

While finalizing objectives, implementation strategies were discussed. The strategic priority workgroups drafted initial action plans complete with marketing strategies and strategic steps that needed to be taken to include additional organizations that need to be involved, who would be responsible for what and developed a proposed timeline for implementation.

Network Core Planning team members were intimately involved in the development of the draft work plans. Those action plans and this report were then ready to be adopted by Core Team organizations. Concurrently, at this juncture, other organizations involved in the strategic planning groups were asked to consider how this CHIP plan could support and inform their work, invited to formally join the network and vote on the action plans as well as to adopt the action plans (at least the strategic area and goal) at their organizational level. The documented adoption both at a community wide and organizational level will help ensure organizational consensus and provide a shared community improvement plan to help to set the stage for community health improvement.

Phase 6: The MAPP Action Cycle

The two strategic areas were selected in May, the overarching goals and objectives were finalized in November. The group will soon be ready for implementation, also known as the action cycle. The action cycle as previously mentioned links three key activities- Planning, Implementation and Evaluation in a continuous cycle.

MAPP phases five and six will add some of the conditions of an additional methodology called collective impact. The practice of collective impact allows it to be customized for local context. The conditions and principles for collective impact dovetail well with the Core Teams planned implementation. Collective impact has some principles of practice that the Core Network Team has agreed upon include:

- Design and implement the initiative with a priority placed on equity.
- Include community members in the collaborative.
- Recruit and co-create with cross-sector partners.
- Use data to continuously learn, adapt, and improve.
- Cultivate leaders with unique system leadership skills.
- Focus on program and system strategies.
- Build a culture that fosters relationships, trust, and respect across participants.
- Customize for local context.

In addition to principles there are also five conditions of collective impact. These conditions are found in the collective impact graphic labeled figure 2.

Figure 2: Conditions of Collective Impact

The 5 Conditions of Collective Impact



The Core Network Team and other priority workgroup members completed an assessment of collective impact readiness in October and have decided to adopt collective impact to move forward in the CHIP process.

Definitions

Definitions enable us to have a common understanding of a word or subject; they allow us to all be on the “same page” when discussing or reading about an issue. Definitions also allow us to be successful by defining what we mean by success. The Network Core Team had a purpose statement they used through the development of the CHIP:

“In rural Nebraska, it’s important that we maximize our resources. That’s why we are working together as partners to measure the health of the area and make a plan that will create a healthier community for all people”.

In order to be on the “same page”, the group needed to define some of the terms in the statement to make sure we understood what we were working toward. During the CHNA and CHIP development the following definitions were adopted by the Northeast Nebraska CHIP workgroups.

Community – The people who live, work and play in Cedar, Dixon, Thurston and Wayne Counties.

Collective Impact – A process that brings people together, in a structured way, to achieve social change.

Health – Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity³

Healthier Community – A healthy community attains high quality, longer lives free of preventable disease, disability, injury and premature death; achieves health equity, eliminates disparities, and improves the health of all groups; creates social and physical environments that promote good health for all; and promotes quality of life, healthy development, and healthy behaviors across all life stages.⁴

Participation in CHIP Process by Community Partners

The health of the community is influenced by many different agencies and community sectors and not just the public health department. The 45 participants who attended the May 21st, 2019 initial CHIP meeting held virtually on Adobe Connect were asked to record what community sector they represented within the Public Health System. The following community sectors were present at the meeting.

- Hospitals
- Health Care Providers
- Federally Qualified Health Center
- Local Public Health Department
- Faith Community
- Academic Institution
- School
- Community not for profit
- Civic group / club
- Chamber of Commerce
- Local business
- Law enforcement
- EMS
- Foundation / philanthropists
- Behavioral Health
- Private citizen
- Hispanic population

³ World Health Organization, 1948 definition of Health found in the preamble

⁴ Healthy People 2020 overarching goals

Previous CHIP Implementation Lessons Learned

Previous Community Health Needs Assessments and Implementation plans have been done by the members of the Network Core Planning team in largely single agency focused efforts. Each agency developed their own implementation plan based on the assessment. In January of 2019, the Network Core Planning Team summarized these past efforts to learn from them and to help avoid potential pitfalls in the implementation of new Community Health Improvement Plans (CHIP's) during 2019-2022. The previous CHIP implementation process did yield some valuable lessons that were used as building blocks for this implementation period.

As discussed in the CHNA, a major factor in implementation rollout and success was unexpected events which required a sustained response from one or more members of the Network Core Team and was cited as a factor in loss of implementation accountability in the previous CHIP. While unexpected events cannot be controlled easily it was felt that better planning could help mitigate their impact. Lessons learned included:

- The need for implementation plans that have goals, objectives, timelines, agency and person responsible and regular evaluation and reporting for accountability.
- Requesting community volunteers to assist in leading CHIP strategic sections so that there is depth in organizational leadership and leadership does not fall on one agency.
- Narrow down the strategic issues to two issues and keep the CHIP objectives that support strategic issues to a reasonable number.
- Focus on some prevention activities within the strategic issues chosen.
- Attention should be paid to how resources will be allocated to support the CHIP strategic issues.

Presentation of CHNA Data

As previously mentioned, the Northeast Nebraska CHNA data was made available to the community on the NPPHD website for review and public comment on April 15th, 2019. The availability of the data was also advertised in local newspapers, Facebook and by Network Core Partners and opportunities for comment were provided. No comments were received.

Formally the data was presented to the community at a meeting that was advertised in the newspapers and open to the public. Selected data from multiple sections of the CHNA were reviewed in Power Point format and copies of the PowerPoint were made available for participant download at the May 21st, 2019 CHIP meeting. The data included in the presentations were on the top issues that were identified as most important to the community through the MAPP assessment process. CHIP meeting participants were also directed to the entire CHNA document as a resource for the meeting and opportunities were given to add issues for discussion.

During the CHIP meeting, six data presentations were made by Core Team Members and following each presentation some questions were asked to gather community input. Participant input was robust in each section with participants identifying insights, concerns and potential impact of the data presented. This discussion is available via the meeting recording (audio and visual), in total 30 opportunities were available for participants to provide input during the meeting. After the presentations ended participants were asked: *In looking at all the data presented today did you gain any new insights?* All of the participants (100% on an electronic poll) indicated that they gained new insights based on the CHNA data. When asked about these insights the following themes were identified:

- The high percentage of children in the community who are obese and overweight.
- The health disparities, poor health outcomes and life expectancy of Thurston County.
- Lack of mental health services and providers.
- The number of children who live in poverty.

Community Identification of Strategic Health Priorities

Community identification of health priorities also known as strategic issues also took place at the May 21st, 2019 CHIP meeting. Stakeholders from throughout the four-county area were present. The community decided it would select priority strategic issues by majority vote. Five areas were identified in the CHNA that were important to the community. These five areas were then voted on for potential strategic issues. The top two issues were then selected as the health priorities that the CHIP would focus on. The votes received are listed below:

1. Behavioral Health (25 votes)
2. Overweight/Obesity (19 votes)
3. Prevention (5 votes)
4. Access to Care (2 votes)
5. Cancer (0 votes)

At the same meeting initial goals were selected and objectives were briefly discussed. Goals were chosen from Healthy People 2020. The goals that were selected for each priority area are listed below:

Strategic Health Priority Area 1: Behavioral Health

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

Strategic Health Priority Area 2: Overweight/Obesity

Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement of maintenance of healthy body weights.

Strategies (MAPP Action Steps)

The finalization of objectives and discussion of possible action steps (strategies to implement the objective) was completed through a series of meetings held by the CHIP priority area workgroups which started in August of 2019. The groups assessed the following criteria when selecting strategies also known in the MAPP process as action steps: 1) Community interest/acceptance of the strategy; 2) Data availability and the ability to monitor the data at set intervals to see if the strategy is working; 3) Resource availability or potential availability including funding and workforce development to implement the strategy; 4) Network Core Team commitment to the strategy; 5) Ability to align with Network Core Team partners strategic plans; 6) Evidence-based intervention; 7) Alignment with National, State or Local initiatives for greater collective impact and 8) Policy or legal barriers to implementation. While the group did not require all eight to be present to choose an intervention the eight factors were reviewed for each potential strategy/action step.

Implementation, Monitoring and Updating the CHIP

The final CHIP as presented here was reviewed by the Network Core Team and will be implemented over the 2019-2022 time period. NNPHD will provide a report for the community and stakeholders on the progress made in implementing the two strategies within their annual report. As strategies are implemented, the Network Core Team will revise the CHIP as needed. Monitoring the implementation will consist of answering these four questions:

- Are we doing the work we said we would do?
- Are we making an impact?
- Are we meeting the needs of the population we serve?
- Are we doing the right things?

Priority Area 1: Behavioral Health

Background CHNA Data

During the CHNA data collection it was clear that the community has less Behavioral Health (BH) services per 100,000 in relationship to the State of Nebraska and is a true shortage area. It was also clear from a review of the electronic surveys, focus groups, Ag survey and other data sets that BH is an area of concern for the community. On the next few pages data from the CHNA is highlighted which aligns with the priority area; additional BH data is available from the NNPHD CHNA.

Behavioral health is a broad term that includes both mental health and substance abuse. Both of these issues were identified by the Northeast Nebraska Rural Health

Network 2018-2019 Community Health Survey (electronic) as causes of “Much” concern for youth by the respondents. When asked the question: “*What is needed to improve the health of your family and neighbors?*” The number one response was Mental Health Services, with 50.35% answering this way. A third response from this same survey identified that Mental Health Services provision was “Very Little” in the service area, as reported by 32.87% of respondents.

The need for more services in this area was also brought up by the Community Focus Groups, the Forces of Change assessment and the Agricultural survey respondents.

Federal health professional shortage areas (HPSAs) are designated by the Health Resources Services Administration (HRSA) as having shortages of primary care, dental care, or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health centers, or state or federal prisons). All of the four counties in the NNPHD have a HPSA designation for mental health. Altogether, Cedar and Thurston counties have three additional designated rural federal HPSA’s specific to facilities. See also Primary Care and Oral Health for more HPSA’s.

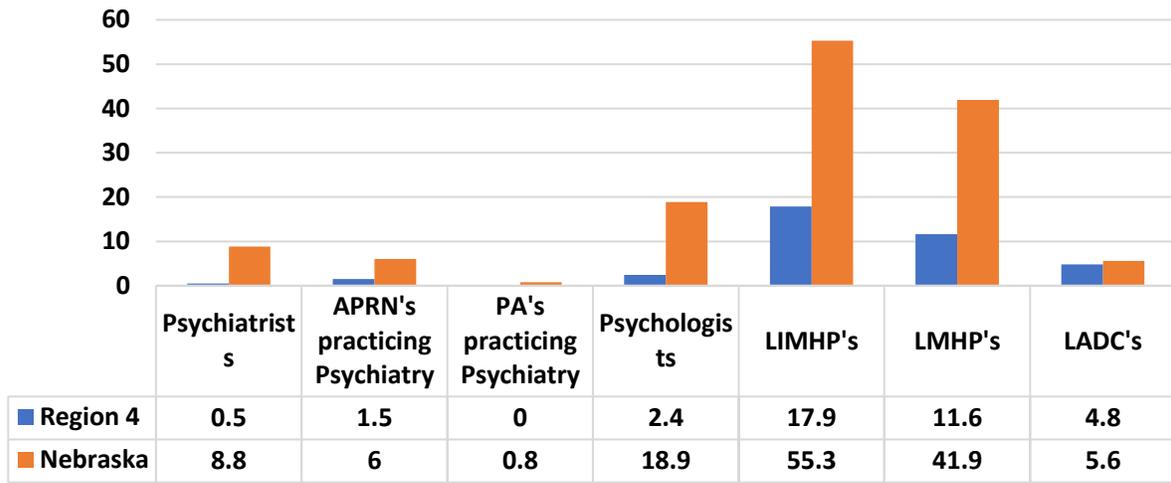
Table 1: Designated Mental Health HPSA’s in the NNPHD area		
HPSA Name	Designation Type	County
Catchment Area 4	Geographic HPSA	All counties
Avera Medical Group - Hartington	Rural Health Clinic	Cedar County
Winnebago PHS Indian Hospital	Indian Health Service Facility	Thurston County
Carl T. Curtis Health Center	Native American/Tribal Facility/Population	Thurston County

(Source: HRSA, HPSA find 2019)

All the counties in the NNPHD service area are part of the Nebraska Region 4 Behavioral Health Regional Service Center district. Region 4 includes the following counties: Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, and Wayne.

The number of providers per 100,000 residents was much lower in Region 4 compared to the state overall. For example, there were only 0.5 psychiatrists per 100,000 residents in Region 4 compared to 8.8 psychiatrists per 100,000 residents for the state overall. The difference was also large for psychologists (2.4 vs. 18.9), LIMHPs (17.9 vs. 55.3), and LMHPs (11.6 vs.41.9).

Figure 3: MH Providers per 100,000 Population



The behavioral health workforce in Region 4 is aging, 70% of LADCs, 60% of the psychologists, and 50% of the psychiatrists actively practicing in Region 4 in 2016 were 56 years or older. This will create workforce shortages when BH providers retire, unless they are replaced.

The University of Nebraska Medical Center, Health Professions Tracking Service (HPTS) tracks data on BH providers by county as well as by region. In total, NNPHD service area has 11 BH providers with only one provider available for BH medication management, a Psychiatrist practicing in Thurston County.

Table 2: Number of BH providers actively practicing in primary locations 2016					
	Cedar	Dixon	Thurston	Wayne	NNPHD
Psychiatrists	0	0	1	0	1
APRN's practicing Psychiatry	0	0	0	0	0
PA's practicing Psychiatry	0	0	0	0	0
Psychologists	0	0	0	0	0
LIMHP's	1	0	1	2	4
LMHP's	0	1	0	3	4
LADC's	0	0	2	0	2
TOTAL	1	1	4	5	11

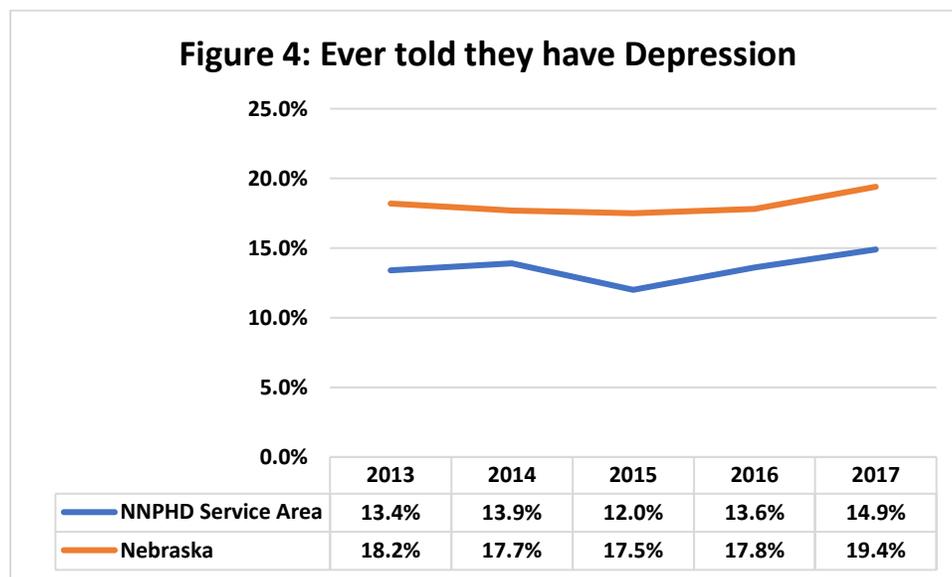
(Source: UNMC Health Professions Tracking Service 2017 Region 4 report)

Providers may also practice in satellite locations. Some providers practice in both primary and satellite locations and the same provider may be counted more than once between tables 2 and 3.

Table 3: Number of providers actively practicing in satellite locations 2016					
	Cedar	Dixon	Thurston	Wayne	TOTAL
Psychiatrists	0	0	1	0	1
APRN's practicing Psychiatry	0	0	0	1	1
PA's practicing Psychiatry	0	0	0	0	0
Psychologists	0	0	0	0	0
LIMHP's	0	0	0	1	1
LMHP's	0	0	0	0	0
LADC's	0	1	0	0	1
TOTAL	0	1	1	2	4

In general, over the past five years, the percentage of adults in the NNPHD service area who experience frequent mental distress was lower or equal to the average for the State of Nebraska. On the chart below, frequent mental distress was rounded to a whole number with Nebraska having 10%, as well as three of the four counties at 10%. The range of Nebraska county averages was 9-16%, of note is Thurston County at 16% at the top of the range for percent of population with frequent mental distress, the next highest counties are at 11%.

Table 4: Individual County BRFSS Results 2016				
	Cedar	Dixon	Thurston	Wayne
% Reporting frequent mental distress	10%	10%	16%	10%



(Source: Behavioral Risk Factor Surveillance System)

The percentage of adults 18 and older who report that they have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder (depression, major depression, dysthymia, or minor depression) is lower in the NNPHD area than in the state of Nebraska, possibly linked to a shortage of providers.

At the May 21st CHIP meeting participants were asked after the data presentation to prioritize what in the presentation concerned them the most, participants could choose more than one. All eleven areas presented received some votes; the percentage of votes received from the group are listed below from area of most concern to least concern:

- Mental Health Stigma – 78.7%
- Lack of MH services to refer to -72.7%
- Fewer BH providers- 63.6%
- Abuse of prescription drugs – 51.5%
- Student bullying – 36.3%
- Youth alcohol use – 36.3%
- Adult binge drinking – 33.3%
- Youth marijuana use – 30.3%
- Youth tobacco use – 21.2%
- Other illegal drugs – 9.09%
- Ease of buying marijuana- 6.06%

Objectives

Community partners continued to meet in summer and fall to begin organizing a community coalition to address this priority issue. Workgroup members discussed and finalized objectives for the obesity priority which will help move partners toward the goal chosen by the group which is the Healthy People 2020 goal to ***Improve behavioral health through prevention and by ensuring access to appropriate, quality mental health services.***

Final objectives agreed upon by the workgroup members to guide the collective work over the next two years includes:

Objective 1: By December 20, 2020, develop a communication plan that includes culturally and linguistically appropriate strategies for residents across the lifespan of the NNPHD service area to promote awareness, training and education events that will define and normalize behavioral health (mental health and substance use) and reduce stigma.

Objective 2: Activate communication plan among partners to reach throughout the NNPHD service area by February 1, 2021.

Objective 3: By January 1, 2021, develop a culturally and linguistically appropriate toolkit of resources and screening materials that will make behavioral health screening a basic component of preventive healthcare services for all ages.

Objective 4: By July 31, 2022, complete a pilot test of the toolkit with two entities (preferably 1 medical and 1 community) to begin the process of integration of

mental wellness screening and referral as a component of receiving other standard preventive healthcare services.

Participation

These four behavioral health objectives were selected and finalized by the priority area workgroup on November 26, 2019 which includes members of the Network Core Planning Team. Planning members include: Northeast Nebraska Behavioral Health Network (Abby Stewart and Susan Boust), Winnebago Health Department (Mona Zuffante), Providence Medical Center (McKayla Thege and Kathy Mohlfeld), Pearl St Counseling (Lin Brummels and Karen Granberg), Pender Community Hospital (Traci Haglund and Katie Peterson), Public-minded Citizens (Melanie Loggins), and Northeast Nebraska Public Health Department (Nicole Hinspeter, Georgina Bernal and Julie Rother).

Priority Area 2: Overweight/Obesity

Background CHNA Data

According to the State of Obesity report, obesity is a harmful, costly and complex health problem with multiple interrelated causes.⁵ This same report goes on to say that low-income communities, rural areas and communities of color are disproportionately affected by obesity. The theme of obesity/overweight was the most common theme noted in all of the MAPP assessments. In the NNPHD district, obesity was chosen as the top issue on the electronic survey, forces of change assessment and the focus group meeting. In addition, the data presented in this section of the health status assessment points to a very real problem in this area for both adults and youth.

On the Northeast Nebraska Rural Health Network 2018-2019 Community Health Survey (electronic survey), 64.44% said that obesity was one of the top five areas that needed to be improved for the community to be healthier; this was the number one answer. This concern about obesity was not just for the community, but also at the individual level. The most common response to the question concerning what health challenges you face, was overweight/obese at 45.49% on the electronic survey. When asked what were the top five “unhealthy behaviors” for youth and adults in the community, three of the top five in each category were related to factors around obesity/overweight. This area is clearly of concern to those who live and work in the service area.

⁵ Robert Wood Johnson Foundation, Trust for America’s Health, *The State of Obesity, 2018*, retrieved from <https://stateofobesity.org/wp-content/uploads/2018/09/stateofobesity2018.pdf>

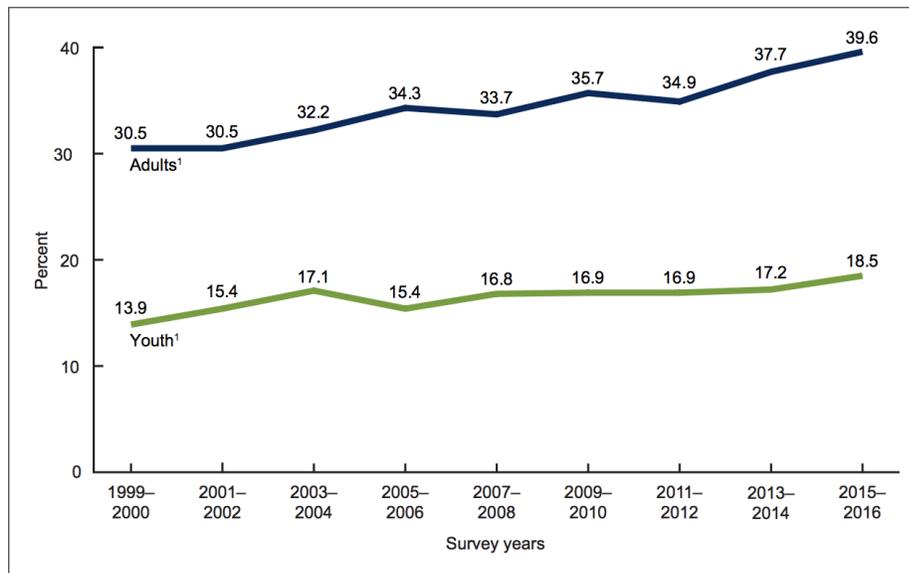
Table 6: The top five "unhealthy behaviors"				
Ranking	Youth	Percent	Adults	Percent
#1	Poor Eating Habits	62.6%	Being Overweight	82%
#2	Alcohol Use	60.7%	Lack of Exercise	76%
#3	Lack of Exercise	52.7%	Alcohol Use	71%
#4	Bullying	45.5%	Poor Eating Habits	69%
#5	Being Overweight	45.3%	Tobacco Use	37%

The electronic Community Health Survey also asked how well services were being provided in the community. On this survey, 37.36% of the 554 respondents felt that as far as services for obesity, the community was providing “very little”.

The graph in figure 6 is from the State of Obesity website⁶ and shows the trend pattern for both adult and childhood obesity and is shown here for comparison with NNPHD data on childhood Body Mass Index (BMI). BMI is a person’s weight divided by height in metric measurement. For children and teens, BMI is age and sex-specific and is often referred to as BMI-for-age. In children, a high amount of body fat can lead to weight-related diseases and other health issues and being underweight can also put one at risk for health issues.

Figure 6: Trends in obesity among adults and youth

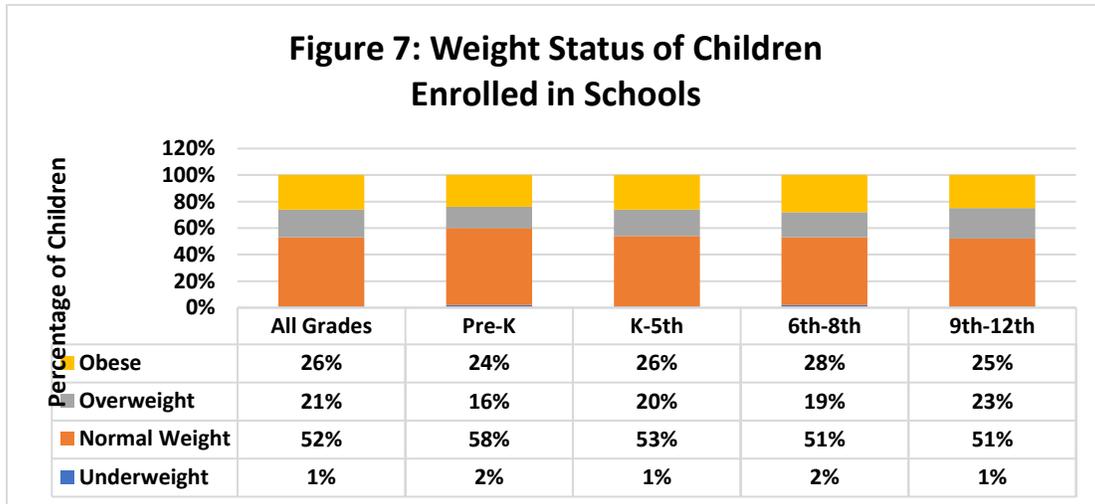
Figure 5. Trends in obesity prevalence among adults aged 20 and over (age adjusted) and youth aged 2–19 years: United States, 1999–2000 through 2015–2016



¹Significant increasing linear trend from 1999–2000 through 2015–2016.
 NOTES: All estimates for adults are age adjusted by the direct method to the 2000 U.S. census population using the age groups 20–39, 40–59, and 60 and over.
 Access data table for Figure 5 at: https://www.cdc.gov/nchs/data/databriefs/db288_table.pdf#5.
 SOURCE: NCHS, National Health and Nutrition Examination Survey, 1999–2016.

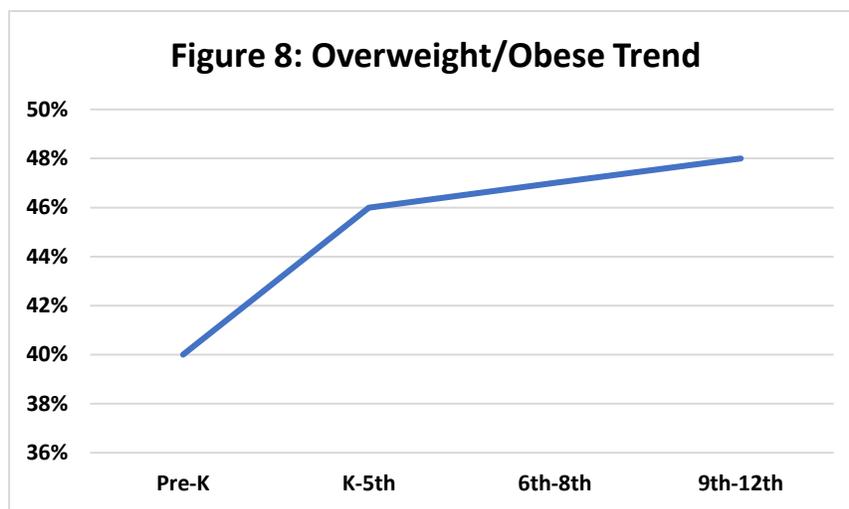
⁶ State of Obesity, Childhood Obesity Trends, *NHANES National Trends*, Retrieved from <https://www.stateofobesity.org/childhood-obesity-trends/> on March 12, 2019

The NNPHD, along with six school partners, collected BMI data on 1,965 unduplicated children in 2018-2019 to get an accurate picture of the levels of obesity and obese/overweight children.



(Source: NNPHD 2018 UNK School BMI data)

The rates on the school BMI data collection were higher for every age group in the service area when compared with the national data. Nationally, 18.4% of 6 to 11-year-olds and 20.6% of 12 to 19-year-olds have obesity. As mentioned, childhood obesity levels tend to rise as children age. The percentage of children enrolled in the grade categories who were overweight or obese ranged from a low of 40% in Pre-K, to a high of 48% in the 9th to 12th grade.

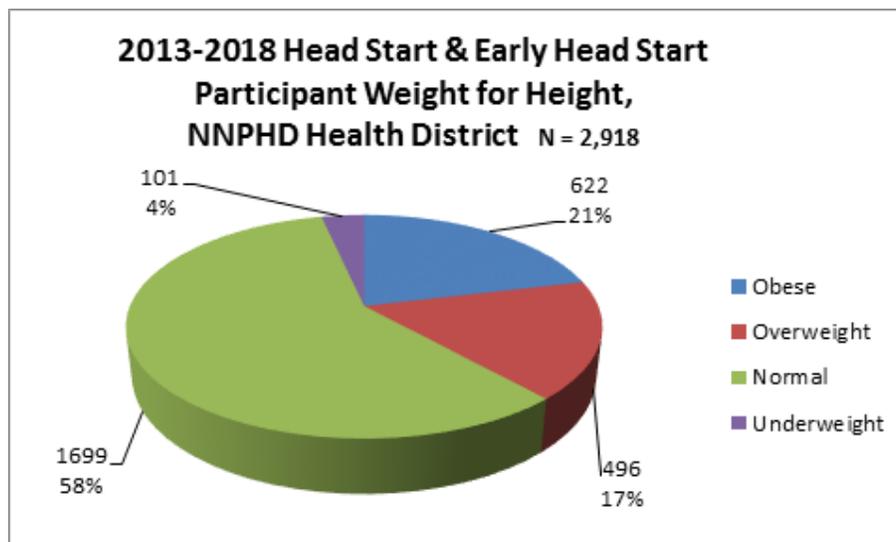


(Source: NNPHD 2018 UNK School BMI Data)

The overall national childhood obesity rate is 18.5%, significantly lower than the rates found in the NNPHD service area BMI data collection, represented in Figures 62-64.

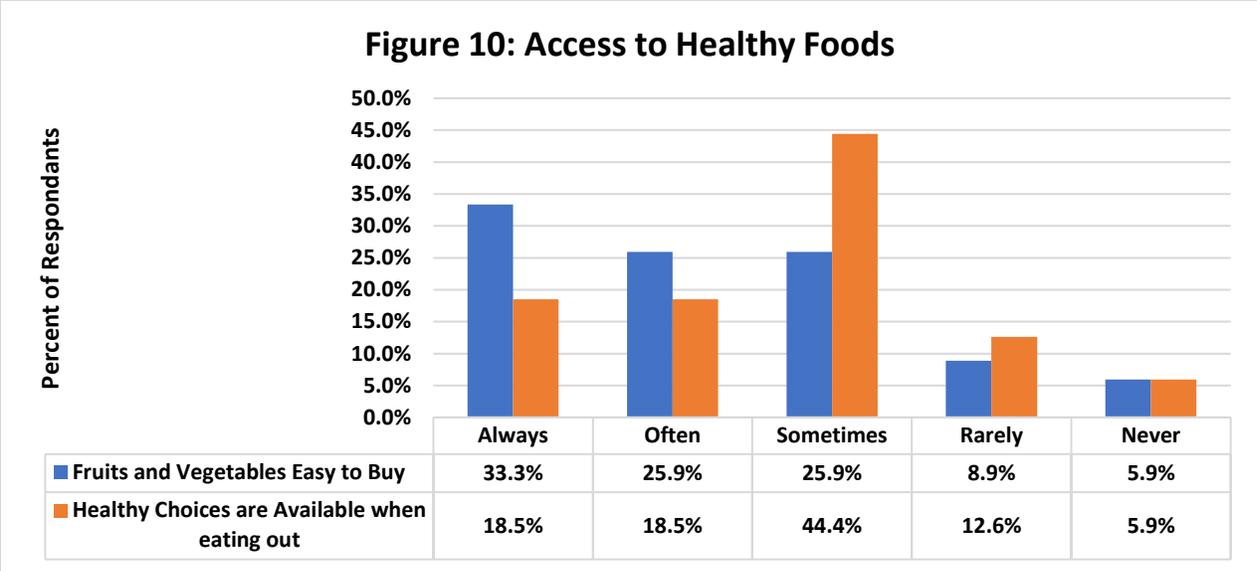
The national rate varies among different age groups and rises as children get older (just as it does in the NNPHD service area).

Also, part of the Northeast Nebraska CHNA, height/weight data was gathered from other local agencies to determine the weight status of children in the NNPHD service area. The graph below is from children under five who participated in local Head Start and Early Head Start programs from 2013-2018 in the Northeast Nebraska area, which contains the four counties in this CHNA. The rate of obesity for his group is 21%, compared to the national average of 13.9% for children age 2-5.



The NNPHD surveyed 135 members of the agricultural population of the four-county district for input on health and safety needs of the community. The majority (59.2%) felt that fruits and vegetables are easy to buy (always/often). When asked about eating out, only 37% felt that they always or often had healthy choices.

On this same Agricultural survey, the number one concern of respondents was to have access to healthier foods & restaurants, chosen by 31% of those who answered the question: “*The most important health or safety need for community is?*” While falling into fourth place on the Northeast Nebraska Rural Health Network 2018-2019 Community Health Survey (electronic) for the question: “*What do you think are the top five areas that need to be improved for your community to make it healthier?*” Again, 31.41% responded that they need healthy choices when eating out.



(Source: NNPHD Agricultural Survey 2018)

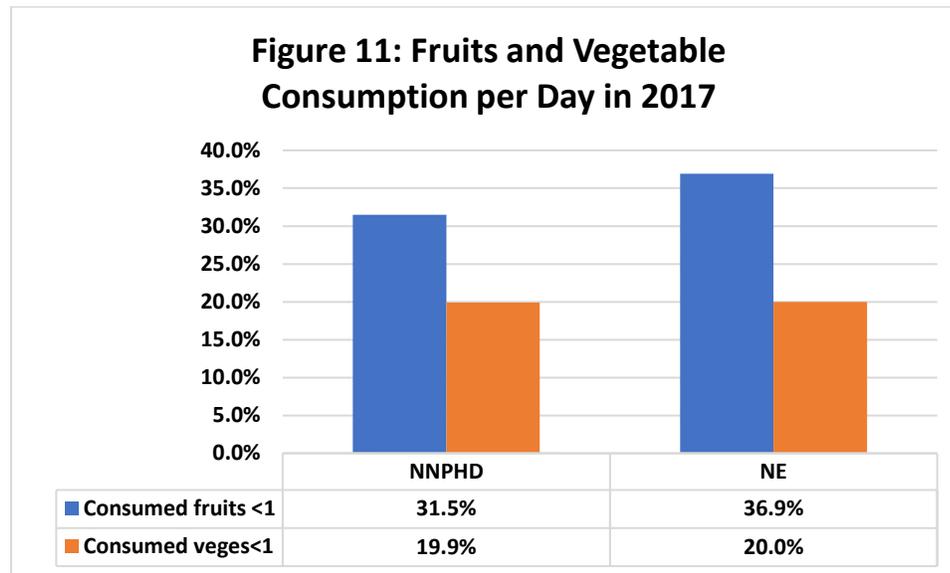
There is strong evidence that residing in a food desert is correlated with a high prevalence of overweight, obesity, and premature death. The County Health Rankings look at the relationship to food access and health.

Limited Access to Healthy Foods is the percentage of the population that is low income and does not live close to a grocery store. Living close to a grocery store is defined differently in rural and non-rural areas; in rural areas, it means living less than ten miles from a grocery store, in urban the rate is less than one mile. "Low income" is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size.

The County Health Rankings have moved from the *Limited Access to Healthy Foods* measure only to the *Food Environment Index*, and the measure now comprises two variables; 1) Limited access to healthy foods with data taken from the USDA Food Environment Atlas and 2) Food insecurity with data from Feeding America which estimates the percentage of the population who did not have access to a reliable source of food. The two variables are scaled from 0 to 10 (zero being the worst value in the nation, and 10 being the best) and averaged to produce the Food Environment Index. In 2016, the U.S average value for counties was 7.0, the Nebraska average was 7.6. Three of the four counties, Thurston (6.4), Cedar (7.3) and Dixon (7.4) ranked below the Nebraska average and Wayne (8.0) ranked above the Nebraska average.

The percentage of adults 18 and older in the NNPHD service area who report consuming fruit less than one time per day during the past month is lower than for the state of Nebraska but not significantly so. The percentage of adults 18 and older who

report consuming vegetables an average of less than one time per day during the past month is very similar to the state of Nebraska.



(Source: Behavioral Risk Factor Surveillance System)

On the Northeast Nebraska Rural Health Network 2018-2019 Community Health Survey (electronic), the percent of respondents who reported eating at least five servings of fruits and vegetables most days of the week was reported at 33.39%

Food insecure households may not know how they will provide for their next meal. As defined by the U.S. Department of Agriculture (USDA), food security refers to the household-level economic and social condition of reliable access to an adequate amount of food for an active, healthy life for all household members. A household is food insecure if, in the previous year, they experienced limited or uncertain availability of nutritionally adequate foods.

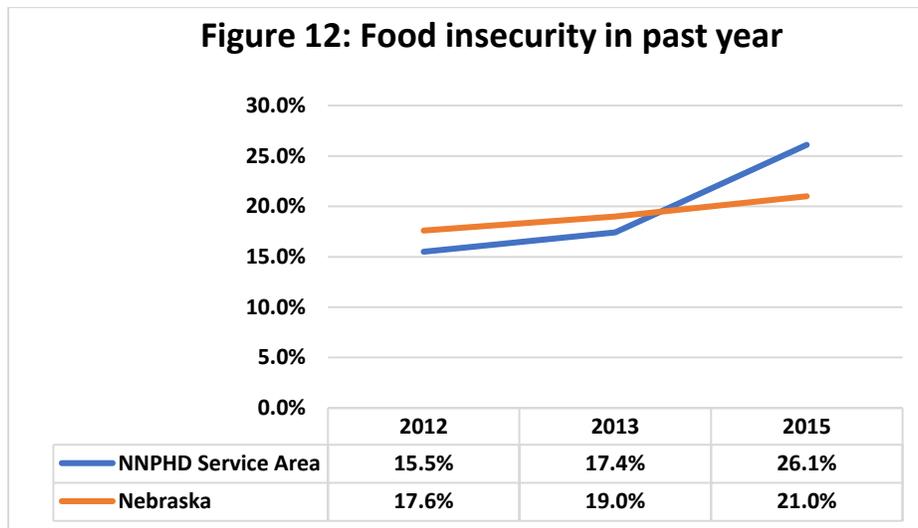
Table 7 : Overall rate of Food Insecurity in NNPHD service area				
	Cedar	Dixon	Thurston	Wayne
Total Population in 2016	8,657	5809	6989	9414
Overall Food Insecurity Rate in 2016	10.7%	10.1%	18.9%	12.5%
Est. Number of Food Insecure Individuals	930	590	1320	1180

(Feeding America, Map the meal, Overall Food Insecurity in Nebraska 2016)

The overall rate of food insecurity in Nebraska is 11.9%. Two of the counties (Thurston and Wayne) in the NNPHD service area have higher overall food insecurity rates than the State of Nebraska.

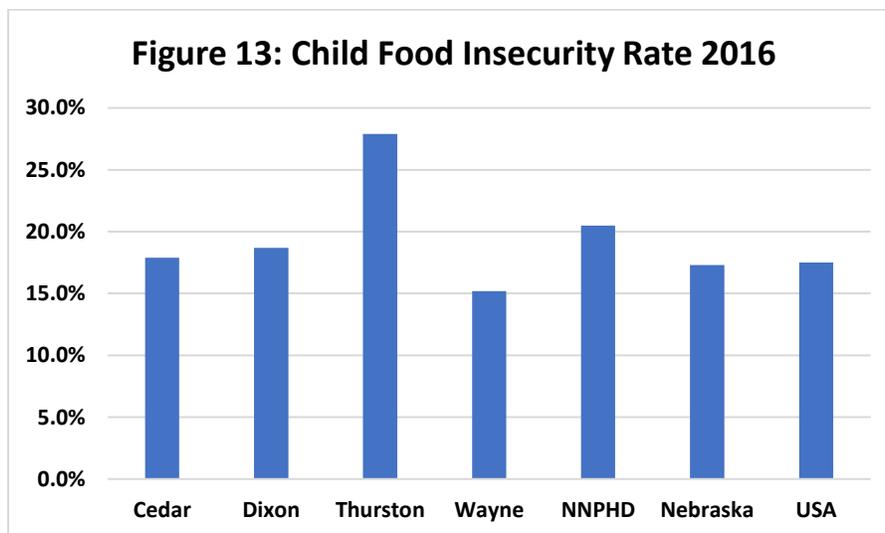
The NNPHD district rate of food insecurity can be assessed as well from the self-reported percentage of adults 18 and older who report that they were always, usually, or

sometimes worried or stressed during the past 12 months about having enough money to buy nutritious meals. The reported food insecurity was below the state of Nebraska for 2012 and 2013 and above the state of Nebraska for 2015.



(Source: Behavioral Risk Factor Surveillance System)

The rate of food insecurity is higher in children than in adults in the NNPHD service area, State of Nebraska and the U.S., as can be seen by Figure 13 below.



(Feeding America, Map the meal, Overall Food Insecurity in Nebraska 2016)

Within the four-county service area, there were a total of 7,921 children in 2016. Of those children, 20.5% or 1,620 were estimated to be food insecure. The Nebraska rate of childhood food insecurity during the same time was 17.3% and the U.S rate was 17.5%. As can be seen by the chart, more than 1 in 4 children in Thurston County are estimated to be food insecure. Not all the children who are food insecure are eligible for federal food assistance. Federal Food assistance for children may include SNAP

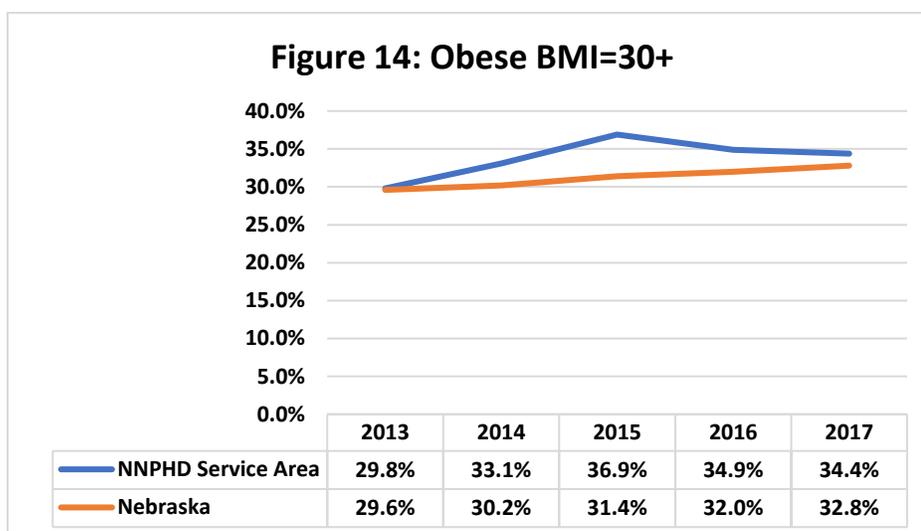
(below 130% of FPL), free school meals (below 130% of FPL), reduced price school meals (below 185% of FPL) and WIC (below 185% of FPL).

Table 8: Child Food Insecurity in NNPHD Service Area in 2016				
	Cedar	Dixon	Thurston	Wayne
Population under 18 years	2,143	1461	2491	1826
Child Food Insecurity Rate	17.9%	18.7%	27.9%	15.2%
Est. Number of Food Insecure Children (FIC)	380	270	690	280
% FIC likely eligible for nutrition assistance	55%	56%	84%	62%

(Feeding America, Map the meal, Child Food Insecurity in Nebraska 2016)

The State of Obesity source lists Nebraska’s 2017 adult obesity rate at 32.8% with 69% of all adults being overweight or obese. Nebraska ranks 10th highest in obesity/overweight rate out of 50 states. The report uses data from the National Health and Nutrition Examination Survey (NHANES) data, which is based on actual physical examinations. Physical exam data from clinics in NNPHD service area was reviewed and shown to be higher than the national NHANES data, however, the data was not able to be verified at the time of this publication.

The BRFSS data presented in the NNPHD tables and individual county data is based on self-reported height and weight. Research has demonstrated that people tend to overestimate their height and underestimate their weight. Therefore, the NHANES data is felt to be a more accurate reflection of overall obesity.⁷ NHANES data is not available for NNPHD or the county level but is mentioned only because of the potential for underreporting the actual levels of obesity and overweight in the service area.



(Source: Behavioral Risk Factor Surveillance System)

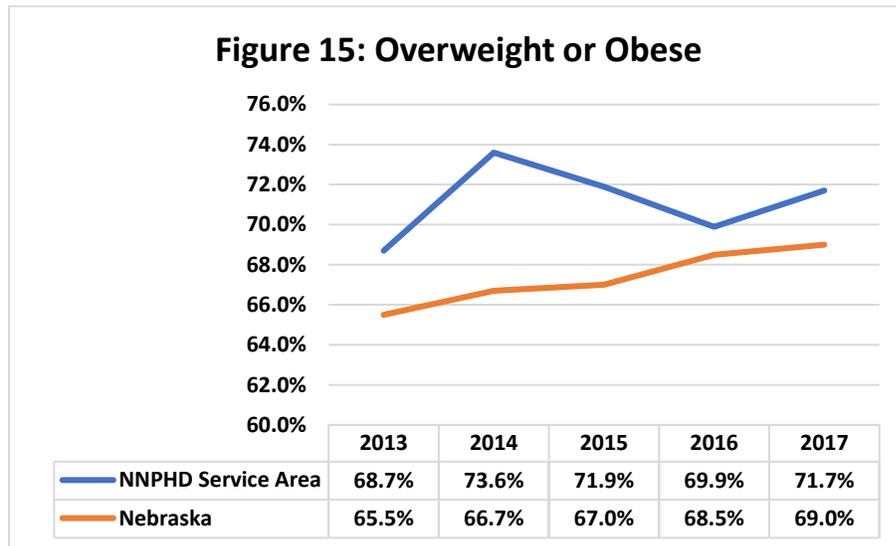
⁷ Ibid

In 2015, the range of percentages of obese in the BRFSS ranged from a low of 26% to a high of 43%. Thurston County had a high of 43% of all adults age 18 and older self-reported heights and weights that made their BMI >30.

Table 9 : 2015 Individual County BRFSS Results				
	Cedar	Dixon	Thurston	Wayne
% Adult obesity	31%	35%	43%	32%

(Source: County Health Rankings 2018)

The NNPHD percentage of adults 18 and older with a body mass index (BMI) of 25.0 or greater, based on self-reported height and weight, from the BRFSS is also reported here, no County specific data was available for this measure.



(Source: Behavioral Risk Factor Surveillance System)

Objectives

Community partners continued to meet in summer and fall to begin organizing a community coalition to address this priority issue. Workgroup members discussed and finalized objectives for the obesity priority which will help move partners toward the goal chosen by the group which is the Healthy People 2020 goal to **Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement of maintenance of healthy body weights.**

Final objectives were agreed upon by the workgroup members in November 2019 which will guide the collective work over the next two years, these include:

Objective 1: Decrease the proportion of youth and adults in the NNPHD service area who are considered overweight or obese by 5 percentage points by December 2025.

Objective 2: Demonstrate a 5% improvement in the proportion of residents aged 18-74 living in the NNPHD district who report healthy food options are available and affordable by December 2023.

Measures from the CHNA which will be used to measure progress toward the objectives and goal are:

- a) *5% increase in the number of people who report healthy food options when eating out, from 37% to 42%. (Northeast NE Community Health Survey)*
- b) *5% increase in the number of people who report fresh fruits and vegetables are easy to buy, from 32% answering “always” to 37%. (NNPHD Blue Ribbon Agricultural Survey)*
- c) *5% decrease in the number of people who report eating an average of less than 1 fruit per day from 32% to 27%. (BRFSS)*
- d) *5% decrease in the number of people who report eating an average of less than 1 vegetable per day, from 20% to 15%. (BRFSS)*
- e) *1-point increase in the Food Environment Index for NNPHD Counties (Cedar – increase from 7.3 to 8.3, Dixon – increase from 7.4 to 8.4, Thurston – increase from 6.4 to 7.4, and Wayne – increase from 8.0 to 9.0). (County Health Rankings & Roadmaps)*

Participation

The workgroup includes members of the Network Core Planning Team. Planning members for the priority area objectives include: Winnebago Health Department (Angela Keller), Providence Medical Center (Jim Frank and Kathy Mohlfeld), Pender Community Hospital (Katie Peterson), Public-minded Citizens (Molly Herman and Alex Blaine Schuetz), Wayne State College (Barbara Engebretsen), Educational Service Unit #1 (Erika Fink), University of Nebraska Medical Center College of Nursing (Christine Eisenhauer) and Northeast Nebraska Public Health Department (Peggy Triggs, Victor Zarate and Julie Rother).