COMMUNITY HEALTH IMPROVEMENT PLAN

Serving the Counties of: Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock

2022-2024

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Approved By: NCDHD Board of Health

NCDHD
North Central District
Health Department

CONTENTS

ACKNOWLEDGEMENTS

The North Central District Health Department would like to recognize the following organizations for their participation in the planning sessions that led to the development of this report:

North Central District Health Department
NCDHD Board of Health
Antelope Memorial Hospital
Avera Creighton Hospital
Avera St. Anthony's Hospital-O'Neill
Brown County Hospital
Cherry County Hospital***
CHI Health Plainview Hospital
Counseling & Enrichment Center
Building Blocks
Region 4 Behavioral Health System
Central Nebraska Community Action Partnership***
Northeast Nebraska Community Action Partnership
Valentine Community School
NorthStar Services***
North Central Community Care Partnership-
Area Substance Abuse Prevention Coalition
Proteus***
Central Nebraska Economic Development
Good Samaritan Society – Atkinson
Niobrara Valley Hospital
Osmond General Hospital
Rock County Hospital
West Holt Memorial Hospital
Indian Health Services***
The Evergreen Assisted Living Facility ***
Cottonwood Villa Assisted Living Facility**
Calvary Bible Church
Brown-Rock-Keya Paha County
O'Neill Public School Board
O'Neill Ministerial Association
West Holt Health Ministries
Legal Aid of Nebraska***
O'Neill Public Schools
Santee Sioux Nation***
University of Nebraska Public Policy Center
O'Neill Chamber of Commerce
ESU 17/ Ainsworth Schools
Holt County Economic Development
Northwest Nebraska Community Action Partnership

***in the 2019-2021 Community Health Assessment, Native Americans, Hispanics, the elderly, and those living in poverty were identified as populations that are disproportionately affected by health risks or poorer health outcomes. NCDHD ensured these populations were represented in the health assessment efforts.

EXECUTIVE SUMMARY

The health of our nation and its people is an especially important topic. Improving and maintaining good health for the entire nation starts with a dedicated public health system that works together at the local level to promote quality of life, health equity, supportive environments, and healthy behaviors across all life stages.

This community health improvement plan was developed through a collaborative process involving a wide variety of local community partners and stakeholders. It serves to describe the priority health issues identified through the community health assessment process and outlines the work plan developed to address those issues.

Individuals and organizations involved in the effort thus far have committed to continue their participation as workgroup members to strategically implement work plan action items. A tracking system will be developed to document activities completed by all participating workgroup partners and periodic progress updates for each priority health issue.

As the public health system serving north-central Nebraska, we are excited to move forward into the implementation phase of our community health improvement efforts, with a focus on building and strengthening the local foundation that will ultimately serve to support good health for our entire nation.

"HEALTH IS A STATE OF COMPLETE PHYSICAL, MENTAL AND SOCIAL WELL-BEING AND NOT MERELY THE ABSENCE OF DISEASE OR INFIRMITY."

-WORLD HEALTH ORGANIZATION, 1948.

DETERMINING HEALTH PRIORITIES

HOW DID WE GET HERE?

The Community Health Assessment and Community Health Improvement Plan were developed through a community-driven strategic planning process called Mobilizing for Action through Planning and Partnership (MAPP). The MAPP process commenced August 2021 and took approximately eight months to complete. North Central District Health Department (NCDHD) guided the processes and incorporated representatives of varying organizations throughout the health district.

The Community Health Assessment (CHA) was completed by obtaining and reviewing health data for the community. The Community Health Improvement Plan details strategic issues noted throughout the assessment process and outlines goals and strategies to address identified health priority areas.

Data related to the health of the North Central District referenced throughout this document can be found on the NCDHD website: [www.ncdhd.ne.gov.](http://www.ncdhd.ne.gov)

PURPOSE

We recognize that by including members from many organizations throughout the community, we can accomplish more than what could be done by any one organization alone. The purpose of the Community Health Improvement Plan is not to create a heavier workload for our partners, but rather, to align efforts of these various organizations to move forward in improving the health of the community in a strategic manner. Community partnership also serves to create a broader representation of community perspectives and engender ownership of the efforts aimed at addressing identified priority health issues.

What follows is the result of the community's collaborated effort and planning to address health concerns in a way that combines resources and energy to make a measurable impact on the health issues of the North Central District community. There are many assets within the North Central District that will aid in the accomplishment of these goals.

PROCESS

Community partners gathered to create a common vision, identify key stakeholders, complete the Forces of Change Assessment, the Community Themes and Strengths Assessment, and the Local Public Health System Assessment. Questions included in the NCDHD resident survey were identified by key stakeholders. The results of all these assessment and surveys were then sent the UNL Public Policy Division to assess. Results of the CHA were then presented to partners at the community prioritization meeting. In groups and individually, participants voted on the health issues of highest concern and impact. The process resulted in two priorities: cardiovascular health and mental health.

On April 21, 2022 partners drafted the CHIP priority goals, objectives, and strategies. Work groups for each priority health issue will meet regularly to implement action plans and ensure progress is being made to obtain goals. NCDHD will assist in convening these meetings and measuring progress with each work plan.

PRIORITY 1:
CARDIOVASCULAR HEALTH

STRATEGIC ISSUE 1: HOW DO WE OPTIMIZE CARDIOVASCULAR HEALTH WITHIN THE HEALTH DISTRICT?

CURRENT SITUATION: CARDIOVASCUALR DISEASE

CARDIOVASCULAR DISEASE

When surveyed, NCDHD community member's health concerns include cancer, heart disease, mental and behavioral health resources, poverty, and quality of life – all issues which have been previously identified as major public health issues. With heart disease being the primary cause of death for NCDHD residents, the workgroup deemed this a worthy cause (see Table at bottom of page).

According to the CDC, heart disease risk factors include high blood pressure, blood cholesterol, diabetes, obesity, lack of exercise, excess alcohol consumption, tobacco use, unhealthy diet, and genetics (Heart Disease Facts, 2021). Per the CDC, diabetes risk factors are family history, age, overweight, lack of physical activity, and history of gestational diabetes.

EMPLOYMENT AND INSURANCE STATUS

Gainful employment can provide income and a sense of purpose and belonging. Employment may often include provision of health care insurance, paid sick leave, and wellness programs that can encourage healthy choices. Employment can have profoundly positive effects on social and emotional well-being and self-efficacy. Unfortunately, those who are unable to find and maintain gainful employment often are more likely to suffer increased stress, high blood pressure, and greater prevalence of heart disease and depression than those with gainful employment (Braveman, Dekker, et al., 2011; RWJF, 2013).

HEALTH BEHAVIORS:

An abundance of research shows that personal health behaviors are strongly linked to chronic disease, mortality, or other outcomes that affect well-being (Berrigan et al., 2003; Hanson & Chen, 2007; Schwarzer, 2008). Cancer, heart disease, diabetes, and other leading causes of death in the United States are strongly associated with unhealthy behaviors that may evolve over a lifetime (Colditz et al., 1992; Keys, 1957; Sasco et al., 2004; Walker et al., 2010). Health professionals play a critical role highlighting behavioral health risks and promoting interventions that encourage communities and individuals to adopt and maintain healthy behaviors across their lifespans.

According to NBRFSS data (2020), 70.5% (n = 749) of NCDHD respondents had a routine checkup in the past year with a healthcare provider, 89.7% (n = 436) had their blood pressure checked in the past year, and among CHA (2021) survey respondents, 92.7% (n = 234) indicated that they had seen a primary care provider once within the previous one to two years, 85.7% (n = 231). Regularly seeing a healthcare provider and screening for common conditions is an important preventative measure.

Maintaining a healthy diet and regular exercise are key predictors of positive health outcomes. An abundance of evidence links obesity with a wide variety of chronic health conditions, including diabetes, heart disease, stroke, hypertension, cancers, and other illnesses (Hu, 2003; Hubbard, 2000; Kelly et al., 2013; Nejat et al., 2010). Obesity and poor exercise habits are major factors causing preventable chronic diseases and deaths among Americans, resulting in substantially increased individual health care costs and social-economic losses. It should be noted that both obesity and lack of exercise are also impacted by environmental conditions (e.g., costs and availability of healthy food) (Cooksey-Stowers et al., 2017; Walker, Keane & Burke, 2010) and workplace or social and community contexts that promote sedentary lifestyles (Bassett et al., 2015; Gaziano, 2010). It is worth highlighting that the prevalence of obesity and its health impacts in the United States is among the highest in the world, and research indicates strong associations between obesity and race, ethnicity, income, and educational status (Kirby et al., 2012; Lee, 2011; Rossen, 2014).

Table 9. *Top Causes of Death in NCDHD 2015-2017 & 2018-2020*

		2015-2017				2018-2020	
Rank	Cause of Death	Deaths	Crude Rate	Rank	Cause of Death	Deaths	Crude Rate
1	Diseases of heart	447	328.8	1	Diseases of heart	392	292.6
2	Malignant neoplasms	321	236.1	2	Malignant neoplasms	300	223.9
3	Chronic lower respiratory diseases	109	80.2	3	Chronic lower respiratory diseases	109	81.4
4	Accidents (unintentional injuries)	93	68.4	4	Alzheimer disease	88	65.7
5	Cerebrovascular diseases	92	67.7	5	Cerebrovascular diseases	77	57.5
6	Diabetes mellitus	64	47.1	6	Accidents (unintentional injuries)	77	57.5
7	Alzheimer disease	58	42.7	7	COVID-19	77	57.5
8	Influenza and pneumonia	52	38.3	8	Diabetes mellitus	66	49.3
9	Nephritis, nephrotic syndrome and nephrosis	28	20.6	9	Influenza & pneumonia	44	32.8
10	Parkinson disease	24	17.7	10	Nephritis, nephrotic syndrome and nephrosis	29	21.6
11	Essential hypertension and	23	16.9	11	Parkinson disease	22	16.4

ASSETS AND RESOURCES: Healthcare providers, hospitals, local public health department, schools, community organizations, community gardens, fitness facilities, long-term care facility activity directors, UNMC APEX Partnership, Indian Health Services, Santee Clinic, and senior centers.

PRIORITY 2: MENTAL HEALTH

STRATEGIC ISSUE 2: HOW DO WE OPTIMIZE MENTAL HEALTH IN THE DISTRICT?

CURRENT SITUATION: MENTAL HEALTH

Of the top concerns identified by NCDHD CHA respondents (n = 242), 58.7% reported mental health as a top concern. Mental health illnesses are very common in the United States, with an estimated 50% of all Americans diagnosed with a mental illness or disorder at some point in their lifetime. Mental illnesses, such as depression, are the third most common cause of hospitalization in the United States for those aged 18-44 years old, and adults living with serious mental illness die on average 25 years earlier than others (CDC, 2019). Depressive illness (including major depression, bipolar disorder, and dysthymia) is the most common mental illness, affecting roughly 21 million Americans each year. Frequent mental distress is the percentage reporting 14 or more poor mental health days. The averaged values across NCDHD counties was 12.1% for frequent mental distress, compared to overall Nebraska values 11.3%, respectively (NBRFSS, 2018). About one third of elderly residents surveyed reported not feeling lonely or disconnected from others (69.6%).

FAMILY SUPPORT

According to the results of the American Community Survey (2019), 15% of children within the NCDHD live in single-parent households, which is associated with adverse mental health outcomes and unhealthy behaviors for children and adults (Balistreri, 2018; Manning, 2015). However, the percentage of children in single-family households in the NCDHD (15.0%) is significantly lower than the US average (25.5%) and the Nebraska average (21.0%). This result is supported by NCDHD student self-reports, with 14% saying they lived with one parent (NRPFSS, 2018). Students living in the NCDHD also largely agreed that they could ask their parents for help with personal problems (85.4%) and that they had an adult who listens to them at home (86.9%).

HEALTH DISPARITIES

The two primary minority populations in NCDHD are American Indians and Hispanics. General health and physical health are worse for American Indians and Hispanics compared to non-Hispanic Whites, while mental health is better for Hispanics and Whites compared to American Indians. Other notable health disparities are health care coverage, diabetes, cigarette use and depression. Hispanics have higher rates of being uninsured, while American Indians have higher rates of diabetes, tobacco use and depression.

HEALTH BEHAVIORS

Alcohol sale and consumption is a widespread fixture of American life. However, excessive use has been linked to a wide range of preventable chronic conditions and acute issues, including a variety of cancers, cardiovascular disorders, and gastrointestinal conditions (Room et al., 2005). Excessive alcohol use is also associated with unintentional and intentional injuries (Chikritzhs & Livingston, 2021; Shield et al., 2012), co-morbidities in mental health (Tembo et al., 2017; Weitzman, 2004), and domestic or relationship aggression and violence (Foran & O'Leary, 2008; Leonard, 2005). Similarly, illegal drug use and addiction is linked to a variety of physical and mental health co-morbidities (Fenton et al., 2012; Jones & McCance-Katz, 2019) and drug overdose related deaths (Lim et al., 2021; Lippold et al., 2019).

SOCIOECONOMIC STATUS

A household's income level determines what types of health-related choices are available. Those with lower levels of income often have lower access to healthy foods, preventative health care, and educational opportunities and are also associated with poorer physical and mental health outcomes (Braveman, Egerter, & Barclay, 2011).A lack of financial resources can make engaging in healthy behaviors difficult, often leading to poor health behaviors and outcomes. Poor physical health and mental health are all more common among people making less money in their household. A lack of health care coverage for lower income populations, more cancer diagnoses, less up-to-date colon cancer screening and higher depression rates were notable inequities identified for low-income people in NCDHD's service area.

ACCESS TO CARE:

The ratio of the population to mental health providers was 1,903 persons per mental health provider, compared to an overall average of 360 people per mental health provider statewide. It should be noted that all counties which compose the NCDHD are designated as health professional shortage areas by the State of Nebraska for at least one if not all primary medical professions; as well as dentistry, pharmacy, and allied health professions (Wehbi et al., 2020). Additionally, every NCDHD county is also a HRSA-designated mental health professional shortage area (HRSA, 2021).

ASSETS AND RESOURCES: Healthcare providers, mental health/behavioral health agencies, hospitals, pharmacies, local public health department, schools, faith/community organizations, law enforcement, and community action agencies.

PARTNERS AND COMMUNITY MEMBERS WHO HAVE AGREED TO SUPPORT CHIP ACTION:

North Central District Health Department
NCDHD Board of Health
Antelope Memorial Hospital
Avera Creighton Hospital
Avera St. Anthony's Hospital-O'Neill
Brown County Hospital
Cherry County Hospital***
CHI Health Plainview Hospital
Counseling & Enrichment Center
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Central Nebraska Community Action Partnership***
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NorthStar Services***
North Central Community Care Partnership-
Area Substance Abuse Prevention Coalition
Proteus***
Central Nebraska Economic Development

Good Samaritan Society – Atkinson

Niobrara Valley Hospital
Osmond General Hospital
Rock County Hospital
West Holt Memorial Hospital
Indian Health Services***
The Evergreen Assisted Living Facility ***
Cottonwood Villa Assisted Living Facility**
Calvary Bible Church
Brown-Rock-Keya Paha County
O'Neill Public School Board
O'Neill Ministerial Association
West Holt Health Ministries
Legal Aid of Nebraska***
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Santee Sioux Nation***
University of Nebraska Public Policy Center
O'Neill Chamber of Commerce
ESU 17/ Ainsworth Schools
Holt County Economic Development
Northwest Nebraska Community Action
Partnership

WORK PLAN

The remaining pages in this document outline the work plan for each issue identified by community partners as priority health areas through this planning process.

The work plan contains goals, objectives, strategies, activities, measures, timelines, and partners for each priority health area.

Over the course of the next three years, workgroup members will commit resources and efforts to activities as outlined in the work plan. This section is meant to be a flexible, responsive component of the community health improvement plan. As such, it will periodically be reviewed and updated to ensure the elements reflect workgroup progress and needs of our community.

PRIORITY 1: CARDIOVASCULAR HEALTH

GOAL: Improve cardiovascular health and reduce deaths from heart disease and stroke

OBJECTIVE 1

Decrease the mortality rates due to heart disease in NCDHD by 1% by 2024.

****Crude rate is defined as number of deaths per 100,000 residents.*

OUTCOME MEASURES

Crude rate of deaths due to heart disease.

Note:

2015-2017 Heart Disease Deaths: 447 Crude Rate: 328.8

2018-2022 Heart Disease Deaths: 392 Crude Rate: 292.6

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Increase amount of CPR/AED/first aid certified instructors and trainees	Promote, advertise, and/or schedule CPR/AED/ first aid trainings	Number of trainers and trainees trained in Basic Life Support	December 2024	Workgroup members/ Hospitals/ Community Colleges
2. Promote blood pressure screenings with appropriate referrals	Promote blood pressure screening at public events, fairs, etc.	Number promotions in community	December 2024	Workgroup member organizations/ UNMC
3. Promote awareness of the risks of abnormal blood pressure values	Create a media campaign to educate public	Number of ads/PSAs/ social media posts	December 2024	NCDHD/ Workgroups members/ media/ UNMC
4. Explore avenues for physical activity in each county	Workgroup will assess physical activity opportunities in each county for all populations	Number physical activity opportunities per county	December 2024	All workgroup member
5. Connect minorities and populations with lowest health indicators with Medicaid awareness and access	Workgroup will identify locations and events to provide Medicaid awareness to populations of need	Number of events/ locations/media releases providing Medicaid education	December 2024	NCDHD & Partners
6. Explore avenues to reach Native American, Hispanic, elderly, and low-income residents in the above strategies	Workgroup will identify avenues to reach disparate populations regarding CPR, blood pressure education and screening, physical activity, and Medicaid education	Number of efforts workgroup made to reach disparate populations, i.e. material in language other than English, etc.	December 2024	All workgroup member organizations

RECOMMENDED POLICY CHANGES

1. Encourage providers to include health literacy and cultural competency into their outreach efforts to address language and literacy barriers.
2. Encourage providers to include blood pressure screens and health fairs and clinics at no cost to address access to care and socioeconomic health disparities.

3. Encourage non-medical partners, i.e. churches, businesses, county court houses, etc., to have blood pressure cuffs and education available for employees and guests.

STATE ALIGNMENT

Pending.

NATIONAL ALIGNMENT

National Prevention Strategy Priorities: Healthy Eating, Active Living
HP2030 PREP-01: Increase the rate of bystander CPR for non-traumatic cardiac arrests
HP2030 PREP-02: Increase the rate of bystander AED for non-traumatic cardiac arrests
HP2030 HDS–1: Improve cardiovascular health in adults
HP2030- HDS-02 Reduce coronary heart disease deaths
HP2030- HDS-04 Reduce the proportion of adults with high blood pressure
HP2030- HDS-05 Increase control of high blood pressure in adults
HP2030 PREP-01 Increase the rate of bystander CPR for non-traumatic cardiac arrests
HP2030-CKD-06 Reduce the proportion of adults with chronic kidney disease who have elevated blood pressure

DETERMINANTS OF HEALTH EQUITY CONSIDERATION

Availability of healthy food; Access to Healthcare services; Transportations Options; Language/ Literacy; Socioeconomic Conditions; Gender; Age.

PRIORITY 2: MENTAL HEALTH

GOAL: IMPROVE MENTAL HEALTH

OBJECTIVE 1

Decrease the number of deaths by suicide in the NCDHD area during the period of 2022- 2024 by 10% from the previous period of 2018-2020, which was 21 deaths.

OUTCOME MEASURES

Number of 2022-2024 deaths by suicide in the NCDHD area as reported by the Nebraska Vitals Record.

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1 Increase Mental Health First Aid Training (MHFA) providers in NCDHD district	Identify NCDHD residents to attend MHFA training of the trainer.	# of new NCDHD residents/ provider trained as a MHFA trainer	December 2024	All workgroup member organizations/ Region 4
2 Provide MHFA trainings in each county	Coordinate one MHFA training in each county	The number of MHFA trainings in each county	December 2024	NCDHD/Mental health providers/ Region 4 Behavioral Health Systems/ Hospitals/ ESU's/ media partners
3 Bring one BCBA (Board Certified Behavior Analyst) to the district	Workgroup will compile a list of requirements for BCBA, identify possibly personnel, funding, and logistics to place BCBA in district	Number of BCBAs in district	December 2024	All workgroup member organizations/ schools/ Region 4
4 Provider peer to peer mental health training to local schools (QPR, Teen MHFA, etc.)	Link schools with peer-to-peer mental health trainings	The number of trainings in each school	December 2024	All workgroup member organizations/ schools/ Region 4
5 Utilize media outlets to increase the awareness of mental health and suicide	Disperse mental health media campaign advertising the National Suicide Prevention Lifeline's 3-digit number (988)	Number of outreach attempts, i.e. fliers dispersed, media releases, social media posts, etc.	December 2024	All workgroup member organizations
6 Explore avenues to reach Native American, Hispanic, elderly, and low-income, and/or other populations of health inequity in the above strategies.	Workgroup will identify avenues to reach disparate populations regarding MHFA trainers, trainees, and in media/ outreach efforts.	Number of efforts workgroup made to reach disparate populations, i.e. material in language other than English, etc.	December 2024	All workgroup member organizations

RECOMMENDED POLICY CHANGES

Encourage policies for providers to implement mental telehealth services to address access to care. Encourage partner organizations to implement health literacy and cultural competency policies to address language and literacy health inequities.

STATE ALIGNMENT

PENDING

NATIONAL ALIGNMENT

HP2030 MHMD-01: Reduce the suicide rate
HP2030- EMC-DO6: Increase the proportion of children and adolescents who get preventive mental health care in school
HP2030 AH-RO9: Increase the proportion of public schools with a counselor, social worker, and psychologists

DETERMINANTS OF HEALTH EQUITY CONSIDERATION

Gender; Age; Lack of Available Health Care; Insurance Status; Lack of Awareness; Social Norms and Attitudes; Socioeconomic conditions; Language/ Literacy Barriers.