COMMUNITY MEDICAL CENTER
FALLS CITY, NEBRASKA
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Community Health Needs Assessment

AND

Implementation Strategy

2018

Community Health Needs Assessment
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Executive Summary

Community Medical Center, Inc., a 501(c)3 not-for-profit hospital, located in Falls City, Nebraska, conducted a Community Health Needs Assessment for 2018 with input from medical staff, government, law enforcement, churches, health department, other care providers, and community members. The top three priorities identified were:

- **Behavioral Health**: increasing support and care levels for those with mental health and substance abuse issues;
- **Fitness and Obesity:** promoting fitness and reducing the prevalence of obesity;
- **Chronic Diseases and Cancer:** Improving tools, education and systems to prevent cancers and chronic diseases, and to aid in their early detection and management.

Other prominent concerns meriting attention include lack of access or insecure access to health care, including emergency services, maternal and newborn needs, and home care; the inability of individuals, families and businesses to afford care, including medications; and the need for more education and support to community members, families and care givers for end-of-life decisions.

Community Medical Center has developed strategies to address these needs, involving hospital personnel, medical staff, community members and other health and governmental agencies. These strategies may be modified over time. Progress will be reviewed by the Board of Directors and its Community and Planning Committee and will be reported in summary to the community through the hospital's annual community report or other appropriate methods.

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Purpose

The purpose of CMC's Community Health Needs Assessment is to:

1. Identify areas of high need impacting the health of community members.
2. Develop a rational prioritization with input from community members to focus outreach efforts and resources.
3. Establish cooperative relationships among hospital, community members, government, churches, agencies and other interested parties for community health improvement.
4. Comply with section 501(r) of the Internal Revenue Code for not-for-profit hospitals.

Process Used

CMC last completed a community health needs assessment (CHNA) in its 2015 fiscal year. That CHNA, while specific to Community Medical Center (CMC), was done in conjunction with the Southeast District Health Department and the five other hospitals located in the district. These entities collaborated because of similar populations and needs across the five counties and in order to maximize resources and efforts when addressing common issues.

Due to the timing of its fiscal year, CMC's previous CHNA was completed a year ahead of those of the health department and other facilities in our region. The 2018 Assessment, while designed to satisfy fully the purposes previously described, is intended for one year of use, rather than the three years of previous CHNAs. Another CHNA will be completed within 12 months. This will place CMC within the same three-year cycle as the other entities and is intended to facilitate cooperation and reduce duplication of effort.

The process used to complete the 2018 CHNA involved pre-planning with the health department and UNMC College of Public Health; review of available data regarding health status indicators in the county; use of internal and external experts; a stakeholder meeting open to all community members and involving representatives from government, schools, medical staff, and law enforcement; review of progress on priorities established in the previous plan; prioritization of needs identified; and development of a strategic plan to respond to priorities.

The plan was reviewed by the Community and Planning Committee of the Community Medical Center Board of Directors on July 16, 2018. The Assessment and Implementation Strategy were adopted by the Community Medical Center Board of Directors at a regular meeting on July 26, 2018. The document will be posted to the CMC website prior to July 31, 2018 and made available as described in the communication plan.

Further information about the meetings held to develop this assessment can be found in Appendix A.

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Community Description

The primary and secondary service area of Community Medical Center is best defined by the geographic boundaries of Richardson County, Nebraska, with additional consideration given to those residing just outside of county boundaries, but for whom Community Medical Center is the closest hospital facility. This is consistent with both the purpose for the organization found in its articles of incorporation and the principle geographic distribution of its patients.

The first purpose for the organization of CMC as a not for profit corporation in Nebraska, found in its articles of incorporation, is, “To operate as a non-profit corporation for the purpose of providing a Community Hospital for Falls City, Nebraska.” Falls City is the County Seat and largest town in Richardson, County. Zip code analysis shows that for the most recent time period, 76% of inpatients and 88% of outpatients served at CMC were from Richardson County.

Unique Inpatients by County of Residence

County of Residence	% of Total
Richardson County, Nebraska	75.9%
Brown County, Kansas	6.2%
Nemaha County, Kansas	2.1%
Nemaha County, Nebraska	1.9%
Page County, Iowa	1.8%
Lancaster County, Nebraska	1.6%
Doniphan County, Kansas	1.2%
Johnson County, Nebraska	0.9%
Pawnee County, Kansas	0.7%
Holt County, Missouri	0.7%
All other locations	7.0%

Unique Outpatients by County of Residence

County of Residence	% of Total
Richardson County, Nebraska	87.5%
Brown County, Kansas	3.7%
Nemaha County, Nebraska	1.4%
Nemaha County, Kansas	1.1%
Holt County, Missouri	1.1%
Pawnee County, Kansas	0.8%
Page County, Iowa	0.5%
Doniphan County, Kansas	0.5%
Lancaster County, Nebraska	0.3%
Atchison County, Missouri	0.3%
All other locations	2.7%

Richardson County is in the southeast corner of Nebraska, bounded by Missouri on the East and Kansas on the South. Richardson County was estimated to have a population of 7,969 in 2017 by the U.S. Census Bureau, down from 8,363 in 2010 (a 4.7% decline). Two communities have over 200 residents: Falls City (county seat) 4,214 and Humboldt, 862. Other communities include Dawson, Verdon, Stella, Shubert, Salem, Rulo, Barada and Preston. A portion of the Reservation of the Iowa Tribe of Kansas and Nebraska is in Richardson County.

Community Description (*continued*)

Persons under 18 years comprised 21.1%, while those 65 and older made up 24.4%. Those identifying as of white ethnicity represented 93.7%, with American Indian at 3.1%, two or more races 2.4%, Black or African American 0.4%, and Asian 0.4%. Hispanic or Latino background, alone or included with another category, represented 2.0%. English is the language primarily spoken in the home of 98.5% of households.

High school graduates or higher represented 91.0% of the population 25 and older, with 19.1% having a bachelor's degree or higher by that age. Among those under the age of 65, 8.4% reported having a disability and 10.5% lacked health insurance. Persons in poverty represented 12.4% of the population. Median household income was $45,929, while per capita income was $26,638. These are lower than the state figures of $54,384 per household and $28,596 per capita. Approximately 1 in 5 (19%) of Richardson County children live in poverty, compared to 14% for the state. 49% of county school children qualify for free or reduced price lunches. The Bureau of Labor Statistics showed an unemployment rate of 3.0% in March of 2018, ranging from 2.7% to 4.1% over the past 3 years.

Compared to Nebraska as a whole, Richardson County has a smaller proportion of those under 18 (21.1% to 24.4%) and a significantly higher proportion of those 65 and older (24.4% to 15.4%). Richardson County had a smaller proportion of traditionally minority races, except for American Indians, for which it has over twice Nebraska's proportion. Richardson County has a very similar proportion of high school graduates but a lower rate of those with bachelor's degrees or higher (19.1% to 30.0%). Richardson County's rates were slightly higher for persons with a disability (8.4% to 7.5%) and persons in poverty (12.4% to 11.4%). Richardson County residents were more likely than the state average to be without health insurance (10.5% to 9.9%), representing 14% of adults and 7% of children.

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Findings

Richardson County shows a higher rate of premature death, measured by lost years of life before age 75 than the nation and state. Residents report slightly higher rates of poor physical or mental health than in the state. The percent of babies born with low birth weight is lower than the state average. This has improved (dropped) over the past decade, as maternal fetal health has been a clinical target for hospital and doctors in past years. Previously, Richardson County had been worse than the state average. Rates of early elective deliveries and rates of babies born with low APGAR scores have also improved significantly according to internal measures.

	Richardson County	Error Margin	Top U.S. Performers	Nebraska
Premature death	8,200	5,700-10,700	5,300	6,000
Poor or fair health	15%	14-15%	12%	14%
Poor physical health days	3.3	3.1-3.4	3	3.2
Poor mental health days	3.3	3.1-3.4	3.1	3.2
Low birthweight	5%	3-6%	6%	7%
Premature age-adjusted mortality	380	310-450	270	310
Frequent physical distress	10%	10-11%	9%	9%
Frequent mental distress	11%	10-11%	10%	10%

Data from County Health Rankings 2018

As shown on the following table, diabetes rates are slightly above state average, as is the smoking rate. Adult obesity and physical inactivity are significantly higher than the state, perhaps affected by the low access to exercise opportunities. Sexually transmitted disease rates were relatively low. Food insecurity and limited access to healthy foods were also poorer than state average.

	Richardson County	Error Margin	Top U.S. Performers	Nebraska
Diabetes prevalence	11%	9-13%	8%	9%
Adult smoking	19%	18-20%	14%	17%
Adult obesity	38%	34-43%	26%	31%
Food environment index	7.1		8.6	8.1
Physical inactivity	31%	28-35%	20%	23%
Access to exercise opportunities	39%		91%	83%
Excessive drinking	19%	18-19%	13%	21%
Alcohol-impaired driving deaths	40%	15-62%	13%	37%
Sexually transmitted infections	73.8		145.1	422.9
Teen births	25	18-34	15	25
Food insecurity	14%		10%	12%
Limited access to healthy foods	12%		2%	6%
Drug overdose deaths - modeled	18-19.9		8-11.9	6.4
Insufficient sleep	30%	29-31%	27%	30%

Findings (*continued*)

Richardson County has much poorer ratios of population to physicians, dentists and mental health providers than the state and nation. Preventable hospital stays have decreased but are still above state average. Diabetes monitoring and mammography screening rates are low. Other reports indicate colon cancer screening rates are also low. Richardson County is in a high radon area.

	Richardson County	Error Margin	Top U.S. Performers	Nebraska
Uninsured	12%	10-13%	6%	9%
Primary care physicians	4,050:1		1,030:1	1,340:1
Dentists	2,690:1		1,280:1	1,360:1
Mental health providers	1,340:1		330:1	420:1
Preventable hospital stays	62	49-75	35	48
Diabetes monitoring	83%	70-96%	91%	87%
Mammography screening	43%	31-54%	71%	62%
Uninsured adults	14%	11-16%	7%	11%
Uninsured children	7%	5-9%	3%	5%
Health care costs	$10,666			$9,334
Other primary care providers	1,151:1		782:1	988:1

Data from County Health Rankings

Nearly one in five county children lives in poverty. More children than average in the state qualify for free or reduced price school lunches. Violent crime rates are very low, though deaths from injuries are higher than average.

	Richardson County	Error Margin	Top U.S. Performers	Nebraska
Children in poverty	19%	13-25%	12%	14%
Violent crime	47		62	267
Injury deaths	76	52-108	55	58
Disconnected youth			10%	9%

Data from County Health Rankings

Heart disease and chronic obstructive pulmonary disease represent leading causes of death, with lung cancer, stroke, dementia, heart attacks, colon cancer, hypertension, Alzheimers, and prostate cancer also among the top ten causes of death. The following table shows the leading causes of death from 1999 to 2016 for Richardson County, from the records of the Centers for Disease Control. Of particular note are the large number diseases that could be prevented or would not be fatal if well-managed and the number of cancers that would be treatable if detected early.

Findings (*continued*)

Top 20 Reported Causes of Death for Richardson County, 1999 to 2016, Centers for Disease Control

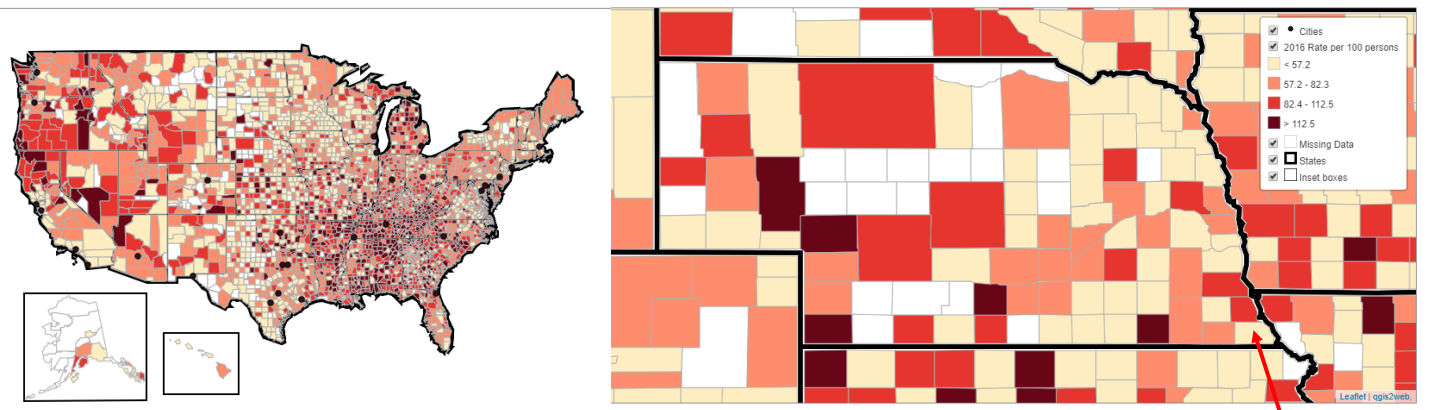
		Deaths	% of Total
1	I25.1 (Atherosclerotic heart disease)	202	12.4%
2	J44.9 (Chronic obstructive pulmonary disease, unspecified)	153	9.4%
3	C34.9 (Bronchus or lung, unspecified - Malignant neoplasms)	127	7.8%
4	R99 (Other ill-defined and unspecified causes of mortality)	116	7.1%
5	I64 (Stroke, not specified as hemorrhage or infarction)	97	6.0%
6	F03 (Unspecified dementia)	95	5.8%
7	I21.9 (Acute myocardial infarction, unspecified)	74	4.5%
8	C18.9 (Colon, unspecified - Malignant neoplasms)	55	3.4%
9	I10 (Essential (primary) hypertension)	46	2.8%
10	G30.9 (Alzheimer's disease, unspecified)	41	2.5%
11	C61 (Malignant neoplasm of prostate)	38	2.3%
12	J18.9 (Pneumonia, unspecified)	35	2.1%
13	C50.9 (Breast, unspecified - Malignant neoplasms)	33	2.0%
14t	I35.0 (Aortic (valve) stenosis)	31	1.9%
14t	N19 (Unspecified renal failure)	31	1.9%
16	I42.9 (Cardiomyopathy, unspecified)	30	1.8%
17	I50.0 (Congestive heart failure)	29	1.8%
18	C25.9 (Pancreas, unspecified - Malignant neoplasms)	28	1.7%
19t	C80 (Malignant neoplasm without specification of site)	27	1.7%
19t	E11.9 (Non-insulin-dependent diabetes mellitus, without complications)	27	1.7%
21	G20 (Parkinson's disease)	25	1.5%
22t	I48 (Atrial fibrillation and flutter)	22	1.4%
22t	I70.9 (Generalized and unspecified atherosclerosis)	22	1.4%
24	I51.6 (Cardiovascular disease, unspecified)	20	1.2%
25t	I46.9 (Cardiac arrest, unspecified)	19	1.2%
25t	I61.9 (Intracerebral hemorrhage, unspecified)	19	1.2%

Substance abuse is very concerning to citizens and leaders. A community behavioral health assessment in 2016 found significant gaps in screening, treating and supporting those with substance abuse disorders. Law enforcement and medical staff agree that these issues are problematic. Richardson County had the highest rate of drug overdoses in the state in 2014. Methamphetamines are a problem, with opioids increasing significantly as a concern in re-

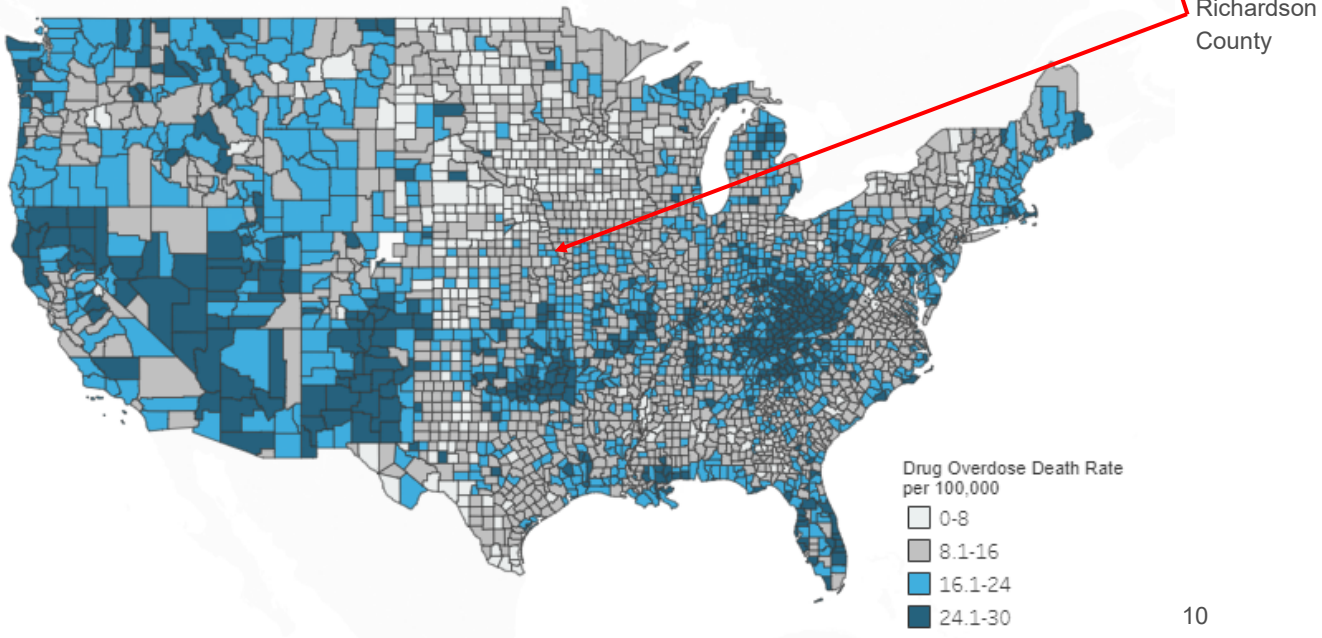
Findings (*continued*)

cent years. Interestingly, state and CDC data show only 51.2 opioid prescriptions per 100 persons in Richardson County in 2016, well below the state and national averages. Medical staff noted that because we border two other states, patients can sometimes “shop” for additional prescriptions across state lines, which would not be reflected. Even more than opioids, the group noted that alcohol and methamphetamines are still probably our largest drug concern. This would be consistent with the following maps. The first shows Richardson County’s rate of opioid prescriptions compared to nation and state. It is one of the lowest. The second shows drug overdose fatality rate, where Richardson County had the highest rate in Nebraska and was in the second highest tier nationally. It was also noted that, since Richardson County’s drug overdose rate (including all drugs) in 2016 was the highest in Nebraska,

Opioid Prescribing Rates (Richardson County 51.2)



Fatal Drug Overdose Rates (Richardson County 18.1- 20.0)



Priorities

Based on data reviewed and discussion among various stakeholders, the following priorities were established:

- **Behavioral Health**. Richardson County needs additional behavioral health resources, formal and informal. This includes improving screening tools and sensitivity to these issues among public and clinicians, increased availability of counseling and support services, better coordination among concerned parties, and finding funding and efficiencies so such services can be affordable and self-sustaining. Substance abuse efforts should include reducing the likelihood of abuse or addiction, increasing the availability of treatment options, and providing ongoing support to those in recovery.
- **Fitness and Obesity.** Obesity levels in Richardson County must be reduced to avoid the disabling health issues that impact health and functioning. We should support efforts to increase healthy activity levels and improve eating habits at all ages and economic levels. Efforts that leverage existing cultural and peer support systems are especially attractive for increasing the effectiveness and durability of improvements.
- **Chronic Diseases and Cancer:** We will improve use of screening tools and other methods for early detection of disease. We will provide education, tools and support to those with chronic diseases to improve management and avoid complications and maintain quality of life. We believe such efforts are best done in collaboration among patients, family and community supports, and clinicians.

Other prominent concerns, outside the top three priorities but still meriting attention, include lack of access or insecure access to health care, such as emergency services, maternal and newborn needs, and home care; the inability of individuals, families and businesses to afford care, especially medications; and the need for more education and support to community members, families and care givers for end-of-life decisions.

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Implementation Strategy

The following strategies represent planned activities, efforts and outcomes. As with any plan, this implementation strategy may require adjustment as circumstances, opportunities, information and available resources change.

Health Area	Goals/Objectives	Key Activities	Key Parties	Hospital Contribution	Impact
Behavioral Health	**1. Improve availability of counseling and support for mental health and substance abuse.**	Subsidize community and school-based counseling.	Falls City Public School District, Blue Valley Behavioral Health	$20,000 to $35,000 annually, depending on need	**Reduce time to next available appointment. Reduce ratio of population to mental health practitioners.**
		Assist those pursuing behavioral health professional practices in Richardson County.	Area Health Education Center	$500-$2,500	
		Increase availability and awareness of AA and NA groups.	Ministerial Association	Limited	
		Explore increasing ability to provide counseling in jail.		Uncertain, would likely require subsidy up to $5,000	
	2. Reduce incidence of substance abuse and addiction.	Implement PDMP in hospital and clinics.	Family Practice, Family Medicine, CMC ED	Programming and process re-engineering time	**Reduce number of patients on chronic doses and high doses of pain medication. Reduce rate of death from alcohol and drug overdose.**
		Expand pain clinic availability.	CMC, Medical staff	Increase in cost ($50,000) likely offset by increased revenue.	
		Implement tapering program for those on chronic opioids.	Medical Staff, Pharmacies, UNMC	Likely limited	
		Reduce unused prescriptions from community homes.	CMC, Pharmacies, SEDHD	Grant funding	
		Explore starting drug-assisted treatment program.	CMC, Medical staff, outside expertise	If implemented, would likely require $40,000 investment and $20,000 subsidy	
		Support school-based programs, such as education and after-event safe activities.	School districts	$500 to $2,500	

Implementation Strategy (*continued*)

Health Area	Goals/Objectives	Key Activities	Key Parties	Hospital Contribution	Impact
Behavioral Health (continued)	**3. Improve mental health of community members.**	Increase use of screening tools for mental health issues by medical clinics.	Family Practice, Family Medicine, CMC ED	Programming and process re-engineering time	**Increase the rate of patients identified with behavioral health needs, closer to national average. Reduce rate of suicide.**
		Provide suicide prevention training to clinicians and community.	Medical staff, ministerial assoc., Blue Valley	Limited	
		Implement Assertive Community Teams.	CMC, Blue Valley, Law Enforcement, Ministerial Assoc.	Staff coordinating and follow-through time	
		Implement Community Health Line to help identify and refer behavioral needs	CMC, Medical staff, Mosaic Community Health Line	Cost shown under chronic disease plan	
Health Area	**Goals/Objectives**	**Key Activities**	**Key Parties**	**Hospital Contribution**	**Impact**
Fitness & Obesity	**1. Increase activity level of area adults and children.**	Support efforts to increase availability of parks, gyms, trails and other fitness resources.	FC Rec Board, FC Parks Dept., Schools, Civic Clubs	$500 to $7,500	**Increase the number of participants in regular fitness activities.**
		Support youth teams.	FC Rec Board	$500 to $1,000	
		Assist with training resources for athletes.	Schools, PTRS	$2,000 to $12,000	
		Publicize fitness efforts, including social media	CMC	Limited	
		Organize and support fun runs and other fitness events.	FC Rec Board, CMC, Others	Staff time, liability insurance, $500 in direct subsidies	
	2. Support healthy eating initiatives in community.	Create Healthy Eating Guide for Falls City	CMC, Restaurant Owners, Chamber of Commerce	Significant Staff time and $250 in printing	**Reduce food insecurity and improve access to healthy foods.**
		Support afterschool or summer lunch programs	Schools	$1,000 - $5,000	
		Support Meals on Wheels	Senior Center	Staff Time	
		Further explore groups vulnerable to insufficient nutrition.	SEDHD, SENCA, Ministerial Assoc.	Uncertain	
		Support healthy cooking clubs and demos	TBD	TBD	

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Implementation Strategy

Health Area	Goals/Objectives	Key Activities	Key Parties	Hospital Contribution	Impact
Prevention & Management of Cancer and Chronic Disease	**1. Reduce incidence of preventable cancers and diseases.**	Test more homes for Radon	CMC, SEDHD	$250 to 500	**Increase number of participants.**
		Support tobacco cessation efforts	CMC, SEDHD	TBD	
		Summer sun awareness and protection program	CMC, Chamber of Commerce	Staff Time; $100 for materials	
		Concussion awareness and prevention program	CMC, Medical Staff, Schools, outside experts	TBD; purchased testing equipment; staff time	
	2. Increase use of early cancer detection screenings.	Colorectal Cancer Screen Promotion	CMC, Clinics, SEDHD, American Cancer Soc.	Staff and clinic time; $250 to $1,000 advertising	**Increase screening rates to national benchmarks.**
		Explore cost reduction options for colonoscopy	CMC, legal	TBD	
		Breast Cancer Screen Promotion	CMC, Clinics, SEDHD, American Cancer Soc.	Staff and clinic time; $250 to $1,000 advertising	
		Develop algorithm for proper use (if any) of Fecal Occult Blood Tests	CMC, Clinics, SEDHD, American Cancer Soc.		
	3. Support management of chronic diseases to prevent hospitalizations, emergency visits, and other complications.	Population health module and follow-up.	CMC, Clinic	$25,000 to $75,000 for ongoing module and staff time; partially offset by revenues	**Reduce readmissions and unnecessary hospitalizations. Increase use of Community Line and decrease use of Emergency Department.**
		Community Health Worker Program.	CMC	TBD; grant funding initially	
		Diabetic Education Program.	CMC	$10,000 to $20,000	
		Care Coordination Programs.	CMC, Clinics	$50,000 to 75,000 in staff costs; partial offset from revenues	
		Community Health Line.	Mosaic Community Health Line	Subsidized by Mosaic; $2,500 to $7,500 from CMC	
		Patient Centered Medical Home	Clinics	Incorporated into existing operations	

Implementation Strategy (*continued*)

Health Area	Goals/Objectives	Key Activities	Key Parties	Hospital Contribution	Impact
Other	**1. Support dignity at end-of-life by encouraging meaningful conversations.**	Implement the Conversation Project community-wide.	CMC and Steering Committee, Medical staff, ministerial association.	Staff time;$100 to $500 to support meetings, meals and materials	**Increase use of hospice. Reduce tertiary transfers of terminal patients.**
		Support education efforts regarding end-of-life care documents.	CMC, Home Health, Nursing Homes, Hospice, Senior Center	$100 to $500	
	2. Increase or maintain access to key services.	Partner with FC Volunteer Ambulance Squad to maintain squad availability.	CMC, FCVAS	Some investment, up to $25,000. Stipend for call $15,000 to 25,000. Training events.	**Ensure availability of emergency services and hard-to-find health professions.**
		Encourage those looking to practice Richardson County in key health professions.	CMC, Area Health Education Centers, Schools	$10,000 to $20,000	

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Communication Plan

This document will be posted to the Community Medical Center website at www.cmcfc.org under the Community tab. Copies will be sent to all the stakeholder organizations represented in our planning and focus meetings. Copies will also be sent to county, city and township government offices, community libraries, newspaper, radio, and television news media. Press releases will accompany those sent to media outlets, and staff will be made available for interviews as requested. Free printed copies will be available in CMC's administration department for anyone requesting a copy.

Progress will be summarized in CMC's annual community report. Ongoing reports will be made to the Planning and Community Committee of the CMC Board of Directors, with reports made as requested to the full Board.

Appendix A: Notes on Meetings and Participants

Pre-planning and Preliminary Analysis Meetings

Meeting Dates

February 27, 2018
May 29, 2018

Participants

Marty Fattig—President and CEO, Nemaha County Hospital
Ruth Stephens—President and CEO, Pawnee County Memorial Hospital
Ryan Larsen—CEO, Community Medical Center, Falls City
Diane Newman—President and CEO, Johnson County Hospital
Arli Boustead—Healthier Communities Coordinator, CHI Health
Kevin Cluskey—Executive Director, Southeast District Health Department
Grant Brueggemann—Preparedness Manager & Epidemiologist, Southeast District Health Department
Traci Reuter—Health Communities Coordinator, CHI Health St. Mary's
Amanda Drier—Program Coordinator, Growing Great Kids, Southeast District Health Department
Mustapha Barry—Graduate Student, UNMC College of Public Health
Michaela Frenzel—Graduate Student, UNMC College of Public Health
Brandon Grimm—Director, Office of Public Health Practice, UNMC College of Public Health
Vicky McNealy—Executive Director, Southeast Nebraska Community Action (SENCA)
Sandy Morrissey—Prevention Director, Region V Systems

Meeting Summary

Discussed previous health needs assessments, surveys, focus groups and data sources. Reviewed progress and barriers. Explored improvements for data collection, sensitivity to underserved populations, and content. Discussed preliminary results from initial data gathering. Established timeline and goals for next community health needs assessment cycle.

Appendix A (*continued*)

Richardson County Community Focus Group for Issue Prioritization

Meeting Date

May 21, 2018

Participants

Allan Tramp—Physician, Board Member, School Board President, Ambulance Squad Director
Kurt Forsyth—Director of Physician and Practice Services, Community Medical Center
Ryan Larsen—CEO, Community Medical Center, Falls City
Gayle Keller—Nurse Practitioner, Family Practice and Mental Health
Steve Severin—Board Member, Veterinarian
Nicole Mason—Board Member, Attorney
Nancy Tuma—Pastor, First Presbyterian Church; Sponsor Falls City Diaper Closet
Jina Santo—Clinic Manager
Lyle McCann—Richardson County Sheriff's Office
Betsy Coolidge—Recorder
Grant Brueggemann—Preparedness Manager & Epidemiologist, Southeast District Health Department
Joe Froeschl—Counselor, Blue Valley Behavioral Health, Chamber of Commerce Board (Participated in discussions, but unable to attend meeting)

Summary

Welcome - Ryan Larsen, CEO, welcomed everyone to the group. Introductions were held.

Purpose of the Meeting – Ryan told the group the purpose of this community meeting was to review the 2015 CHNA, discuss data related to the current health needs of Richardson County residents, explore trends and options, and agree to a prioritization of health needs in the community as of 2018.

Schedule – Discussed the schedule for this CHNA and implementation plan. Another, more in-depth CHNA will occur later in the year (but part of the next fiscal year), which will build upon and expand the work done for the 2018 CHNA.

Service Area Definition – The group agreed with administration's analysis that Richardson County was the most rational service area for this assessment, with some consideration as practical given to those living in surrounding states and counties for whom CMC is the closest medical facility.

Service Area Characteristics – Reviewed handouts delineating the demographics and health characteristics of Richardson County.

Appendix A (*continued*)

Previous CHNA - Reviewed a summary of the 2015 CHNA and response plan. Ryan distributed a summary of efforts. Group felt that 2 of the 3 priorities showed improvement. The third (obesity) showed activity by the hospital and community, but could not determine that significant improvement had occurred. CHNA progress now reported to the governing board or committee on a regular basis. Board members read material and discussed community outreach ideas as part of previous strategic plan, and the group felt that the 2015 CHNA showed more concrete progress due to the increased focus and accountability.

Current Needs and Priorities- Group reviewed data regarding health indicators in Richardson County, including those from County Health Rankings. Reviewed additional material regarding cancer rates and screening rates. Felt that screening rates are still too low. Reviewed material regarding drug overdose trends and opioid prescription rates for the county. Group agreed that drug use, including alcohol, is problematic and growing. Support resources are limited and not well-publicized.

After discussion, the group reached consensus that top priorities include behavioral health (including substance abuse), fitness and obesity, and cancer and chronic diseases. Other concerns include access to care, emergency services, home health, cost of care, medication affordability, understanding how to discuss and plan for end-of-life wishes. Will look for more information for future discussions to explore whether displaced youth, sex trafficking, and inadequate nutrition should be identified as areas of significant concern for Richardson County.

Adjourn – The meeting adjourned somewhat abruptly, due to a tornado warning. The group, however, agreed that the conclusions reached reflected the needs of the community and a basis for action.

Appendix B: Summary of 2015 CHNA and Response Plan Progress

Community Health Needs Assessment 2015
Regarding Richardson County, Nebraska
For Use by Community Medical Center, Inc.,
Located in Falls City, Nebraska

A Community Health Needs Assessment (CHNA) has been conducted on behalf of Community Medical Center, Inc. (CMC), a not-for-profit, Critical Access Hospital, located in Falls City, Nebraska. This assessment and strategic response plan have been reviewed by CMC administration and adopted by the CMC Board of Directors. Though this document has been adopted by CMC, it is also part of a larger effort by the Southeast (Nebraska) Health District, Southeast Nebraska Community Action (SENCA), and five other hospitals in the district to create a comprehensive regional health assessment and plan. It is believed that significant alignment will exist in the health need priorities within each of the five counties (with some county-level variation), such that a comprehensive regional plan may be adopted to impact identified health issues on a larger scale with greater combined resources.

Creation of this assessment involved cooperation between the Health Department, SENCA, Community Medical Center, local government, other health care providers and organizations and interested citizens. Quantitative and qualitative measures were used, with input from individuals with medical and public health expertise. Tools included public health data, health research studies from outside entities, a survey of community perception, and a facilitated discussion meeting of experts, representatives of community organizations, and community members.

A community meeting was held on April 15, 2015 at the Grand Weaver Hotel in Falls City. Attendees included representatives of the Southeast Nebraska Health District, Southeast Nebraska Community Action, Community Medical Center, County Government, Various City and Township Governments, Law Enforcement, Education, Ministerial Association, Blue Valley Behavioral Health, Long-Term Care, Six Pence, Fitness and Wellness, Peru State College, Chamber of Commerce, and Concerned Citizens. The meeting was facilitated by Kevin Cluskey, Director of the Southeast Nebraska Health District. Copies of the agenda and attendees are included as Appendix A. A collection of statistical information regarding health outcomes, environment, health behaviors, cancer incidence, and other factors is included in Appendix B. The survey tool is included as Appendix C. A summary of survey results is shown as Appendix D. Notes from the meeting, including insights on the data collected and participant concerns and ideas are found in Appendix E.

Through the process, three priority issues were identified and agreed upon. These are:

1. **Substance Abuse**—We are concerned with drug and alcohol abuse among adults and youth. Of special concern is abuse of prescription drugs. Substance abuse affects individuals' and families' health, mental health, financial situations, self-reliance, social support, spirituality and criminal status. It is a multifaceted problem that greatly impacts our community.
2. **Fitness & Obesity**—We are concerned about high levels of obesity and inactivity in our community. This results in health issues that multiply over time. We are concerned about lack of access to fitness and healthy eating options. We are also concerned about increasing technology dependence that reduces activity and social supports and about cultural and social norms that may not emphasize fitness, activity, healthy eating and maintaining healthy weights. Poor finances, lack of access to necessary medical and social supports, as well as cultural stigma, may also prevent those in greatest need from receiving necessary interventions.
3. **Cancer**—The community is concerned about the prevalence of cancer and what can be done to reduce risks (behavioral, social, genetic & environmental), improve early detection, ensure access to treatment, and support individuals and families affected.

Appendix B (*continued*)

CMC's Strategic Response Plan to 2015 CHNA

The following initiatives were approved by the Community Medical Center Board in July 2015, as part of CMC's 2015 fiscal year. These plans may be updated as progress is made or new information becomes available. It is intended that CMC's plan will roll into the broader regional plan being developed in conjunction with the Health Department. Initiatives developed regionally will also be applicable in Richardson County.

1. **Substance Abuse**
   a. Increase behavioral health resources available in the community.
      i. Continue to provide financial assistance to BVBH to ensure adequate counseling resources
      ii. Add a licensed drug and alcohol counselor at least 2 days per week in community
      iii. Offer or support additional group support programs in Richardson County
   b. Coordinate management and practices among area medical practices, dental practices, pharmacies, etc.
      i. Provide education to physicians, practitioners and other professionals regarding best practices
      ii. Support development of regional or state standards for reporting, tracking and communicating
   c. Engage concerned parties, including local law enforcement, schools, ministerial association, and others to sup port those trying to reduce substance abuse in the community.
      i. Support the efforts of local schools regarding prevention of drug and alcohol abuse
      ii. Support efforts to create social and activity sites as alternatives to drug and alcohol pressures
   d. Ensure availability of resources to monitor related health issues, such as pain management and communicable diseases.
      i. Seek credible pain management professionals willing to offer practice hours in community
      ii. Increase testing and communication regarding Hepatitis C
      iii. Ensure hospital and medical staff are trained to identify and discuss signs of substance abuse
2. **Fitness and Obesity**
   a. Support grassroots efforts to develop sustainable activity support groups
   b. Support youth activities to encourage development of good fitness habits
   c. Support availability of healthy eating options in schools, institutions, restaurants and homes
   d. Implement practice support tools to help physicians and practitioners manage the care of patients at high risk of complications related to obesity and poor fitness, including those with Type 2 Diabetes
   e. Work with government and interested entities to increase availability of facilities and/or programs to support healthy activity levels
3. **Cancer**
   a. Launch campaign to increase awareness of appropriate cancer risk factors, prevention recommendations, and screening options
      i. Partner with media, medical professionals and community organizations to raise awareness
      ii. Increase the rate of colorectal screening and mammogram screening to at least the national median by 2020
   b. Promote smoking and tobacco-use cessation efforts
   c. Partner with the Health Department to test 100-200 county homes for unhealthy Radon levels by 2017

Appendix B (*continued*)

Report on Community Health Response Activities 2015 to 2018

Tactic	Response Area	Progress
Blue Valley Financial Support	Behavioral Health	Added LDAC
Monroe-Meyer Collaboration	Behavioral Health	Started Clinic
School District Counselor Financial Support	Behavioral Health	Added Counselor
Independent Behavioral Health Assessment	Behavioral Health	Conducted
Implement Community Teams	Behavioral Health	Steering Committee
Additional Counseling Resources	Behavioral Health	Yes
Increase Use of Assessment Tools	Behavioral Health	Results lagging
Pain Management Resources	Behavioral Health	Added clinic
Encourage Support Groups	Behavioral Health	Some, but still lagging
Explore Suboxone Clinic	Behavioral Health	Still analyzing
Explore Narcan Distribution	Behavioral Health	Still analyzing
Implement PDMP	Behavioral Health	Poor adoption
Other Prescription Efforts	Behavioral Health	Low
Police & Sheriff Cooperative Efforts	Behavioral Health	In development; lagging
Rx Take-Back Box	Behavioral Health	Complete
Suicide Risk Training	Behavioral Health	In development
Explore Adult Group Psych Programs	Behavioral Health	Analysis said not feasible
Increase Fun Run Events	Fitness & Obesity	Doubled
Community Open Gym	Fitness & Obesity	Yes, successful
Community Walking Groups	Fitness & Obesity	Yes, but not successful
Fitness Social Media Campaign	Fitness & Obesity	Yes, low utilization
Additional Trainers in Schools	Fitness & Obesity	Yes, modest initial program
Support Community Efforts	Fitness & Obesity	Supported successful JC's sand volleyball court; supported new splash pad
Increase Colorectal Screens	Cancer	Poor results
Increase Breast Cancer Screens	Cancer	Some improvement
Offer Sun Safety Material	Cancer	Distributed at civic events
Added dermatology Clinic	Cancer	Successfully added
Support Humboldt Cancer Memorial	Cancer	Supported; built
Radon Home Testing & Remediation	Cancer	Distributed several hundred kits & held remediation class; SEDHD helped con tractor certify
Implement Population Health Outreach	Chronic Disease	Initial phase complete
Partner w/UNMC & SEHD on Cardiac Care	Chronic Disease	Grant funded
Diabetic Education	Chronic Disease	Ongoing program
End of Life Conversation Project	End-of-Life	Stage 1 complete
Transfer partnership with FCVAS	Emergency	Implemented successfully
Good Beginnings	Newborn	Providing free visits
Eliminate Early Elective Deliveries	Newborn	Successfully accomplished
Car seat Safety Evaluations	Newborn	Provide certified teachers
Increase Breastfeeding Support	Newborn	Honored for improvement
Support Area Health Students	Health Professions	3 scholarships per year; Plus significant stipends to assist med students