Community Medical Center

3307 Bill Schock Blvd., Falls City, NE 68355 www.cmcfc.org

Community Health Needs Assessment

&

Implementation Strategy

2025 - 2028

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I. Executive Summary

Community Medical Center (CMC) is a 501(c)(3) not-for-profit critical access hospital located in Falls City, NE. CMC conducted a Community Health Needs Assessment (CHNA) to provide direction for health outreach activities for the three years beginning August 1, 2025. This CHNA was created in partnership with the Southeast District Health Department (SEDHD), other area hospitals, community members, governmental representatives, local medical staff, and the College of Public Health at University of Nebraska Medical Center. Developmental processes included community survey, community meetings, demographic review, analysis of county health data, expert review, and governing board review.

Top priorities include:

1. Improving access to behavioral health services
2. Reducing transportation barriers
3. Increasing availability or sustainability of support infrastructure, including:
    - Affordable quality housing
    - Recreational/fitness opportunities
    - Childcare
    - Social services navigation
    - Emergency services

The first two align with the regional priorities of the five-county health district and CMC will work independently and in partnership with the health district and other partners. The third priority is primarily local but will also utilize partnerships with schools, government, churches, volunteer organizations, economic development, and interested citizens.

II. 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.

III. Process Used

CMC completes a Community Health Needs Assessment every three years, as stipulated for tax-exempt hospitals under the Affordable Care Act and Internal Revenue Service Section 501(r)(3). While CMC produces a CHNA specifically for itself and service area, CMC has found that collaboration with hospitals and health organizations in neighboring counties, under the umbrella of the health department, helps maximize resources and facilitate natural partnerships to address common issues. This collaboration is an essential component of CMC's assessment and planning process.

This health assessment commenced with pre-planning with the health department in 2023 and 2024, selection of the UNMC College of Public Health to assist with data analysis and community facilitation in 2024, a survey of community members in 2024, a stakeholder meeting open to all community members and representatives from key community organizations in late 2024, synthesis of findings in 2024 and 2025, and final prioritization in 2025. CMC administration was tasked with developing and presenting a strategic response plan to address priorities locally, and a collaborative set of specific regional goals was developed by all parties at the health district level. Regular reporting on progress with priorities and strategies from the previous CHNA occurred on a regular basis through the CMC Governing Board and the Board's Community and Planning Committee, chaired by a local physician. Progress towards community goals was part of CEO performance evaluation at CMC.

The findings, priorities and implementation plan were approved by the Governing Board of Community Medical Center on July 31, 2025. Implementation strategies may be modified or adjusted as necessary should community circumstances change or organizational capacity change. The public may download a copy of this document from the hospital's website or may ask for a copy in person. Copies are delivered to the City of Falls City, Richardson County Board, the Southeast Health District, the Nebraska Hospital Association, and the tertiary hospitals acting as partners for CMC under critical access network agreements.

IV. Community Description

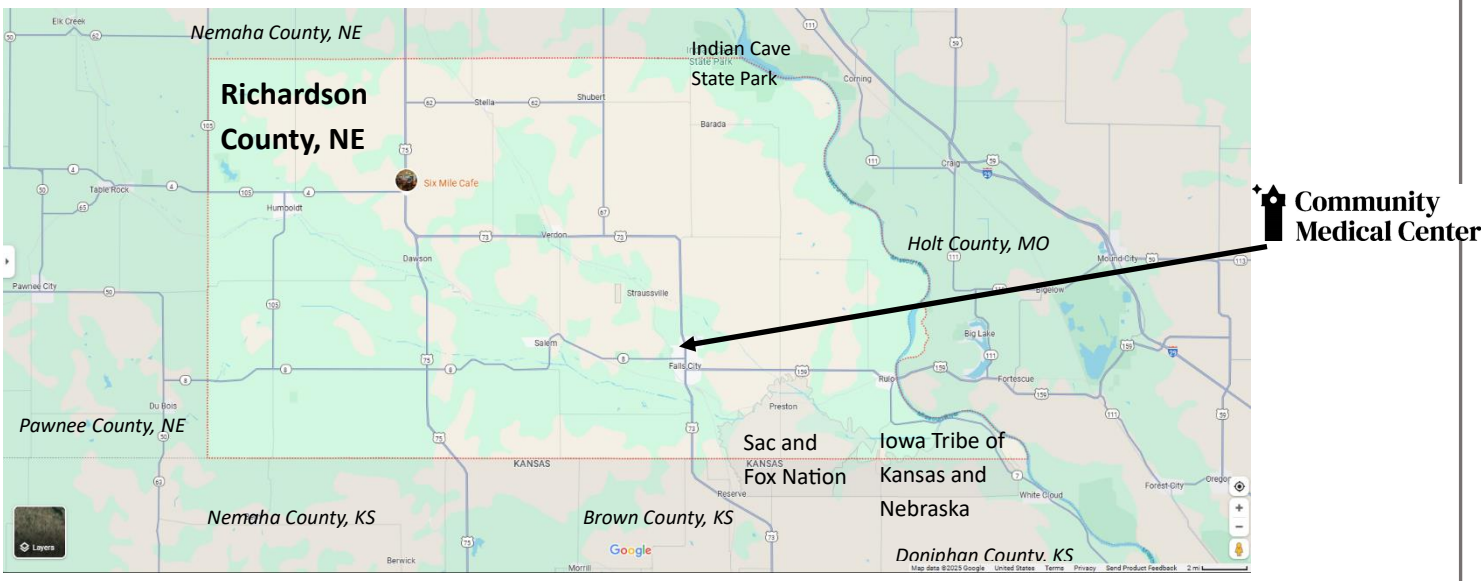
Community Medical Center primarily serves the residents of Richardson County, Nebraska, including the communities of Falls City, Humboldt, Verdon, Rulo, Salem, Dawson, Schubert, and Stella. Collectively, patients from these areas represented 94.1% of CMC outpatients and 93.1% of CMC inpatients. CMC also serves as a secondary health provider for residents of communities that border or are near Richardson County, including Reserve, KS; Big Lake, MO; and Craig, MO. CMC is the only hospital operating in Richardson County.

Community Medical Center Patients by Residence, 2023

	Outpatient	Acute
Falls City	**72.5%**	**75.7%**
Rest of Richardson County	**21.7%**	**17.5%**
Kansas	4.0%	3.2%
Missouri	1.0%	2.1%
Other Nebraska	0.8%	1.6%
Iowa	0.0%	0.0%
Other	0.0%	0.0%
Total	100.0%	100.0%

	Outpatient	Acute
Percentage from Richardson County:	**94.2%**	**93.1%**

Richardson County is in the southeast corner of Nebraska. The County had a population of 7,871 in the 2020 Census, down from 8,363 in 2010 (-5.9%). The two largest communities are Falls City (4,009) and Humboldt (850). Falls City, where Community Medical Center is located, is the county seat. Two tribal reservations are partially located in Richardson County—Sac and Fox Nation and the Iowa Tribe of Kansas and Nebraska.

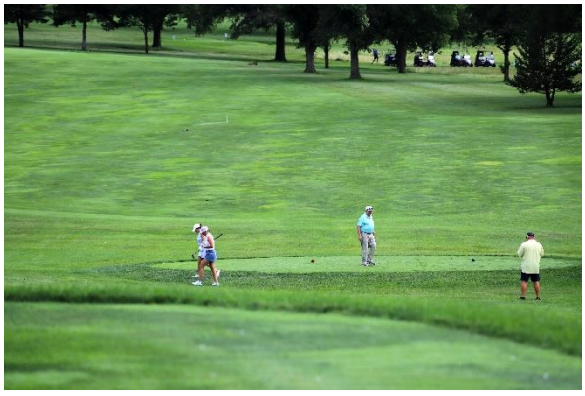


Community Description (*continued*)

In the 2020 Census, persons 65 and over represented 24.2% of population, while persons 18 and under made up 21.7%. Those identifying as white only ethnicity represented 90.9% of population, with American Indian at 2.9%, two or more races 5.2%, Black or African American 0.3%, and Asian 0.5%. Interestingly, the percentage of residents reporting heritage of two or more races more than doubled from 2010. Hispanic or Latino background, alone or included with another category, represented 2.0% of population in 2010. English was the language primarily spoken in 98.8% of households in the county, compared to a state rate of 87.5%.

Compared to Nebraska as a whole, Richardson County has a smaller proportion of those under 18 and a significantly higher proportion of those 65 and older. 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 to the state but a lower rate of those with bachelor's degrees or higher. Richardson County's rate of persons with disabilities 17.0% was higher than the state's (12.7%). Poverty levels were only slightly higher than statewide (10.6% vs 10.5%), but median household income is significantly lower ($55,578 vs $74,590). County employment rate (58.2%) was lower than Nebraska's statewide (66.8%). Monthly rental rates were lower in the County compared to the state ($692 vs $1,042) while home ownership rates were higher (74.5% vs 66.3%). 52.0% of homes had a value of under $100,000, compared to just 13.3% statewide. 7.9% of residents did not have health care coverage, compared to 6.1% statewide.

Additional discussion of community demographic and socio-economic status may be found in pages 35-50 of Appendix A.



V. Findings

Survey

A survey of community members was completed in September of 2024, resulting in 157 responses. A breakdown of respondent demographics and socio-economic characteristics can be found on pages 7-8 of Appendix A. The response rate in Richardson County was the highest of any of the five counties in the health district, hopefully suggesting strong community interest and engagement. Key survey results included a strong sense of the important role that access to health services plays in overall health; a focus on behavioral health, including mental health and substance abuse; a desire to address unhealthy lifestyles and lack of access to recreational and fitness options; and concern for cancer incidence and mortality.

Focus Group

A focus group of 11 individuals met in October of 2024, facilitated by researchers from the UNMC College of Public Health, and representing the hospital, the health department, school district, government, clinicians, parent groups, and patients. They reviewed survey and external data, discussed needs, and refined focus. The top five priorities were identified as 1) affordable housing, 2) mental health workforce expansion, 3) community recreation center, 4) childcare, and 5) expanded EMS/emergency transportation capacity. See pages 15-19 of Appendix A for notes on the discussion.

External Data

Richardson County's life expectancy was slightly lower than Nebraska's (77.8 vs 78.4) but in line with national (77.6). Top three causes of death over three years matched the state's: heart disease, cancer, and chronic lower respiratory disease. Hypertension and hypertensive renal disease were the fifth leading cause of death in the county, while not in the state's top 10. A higher proportion of county residents reported their health as fair or poor, their overall health as not good at least half of the time, and their mental health as not good at least half of the time. The rate of adequate pre-natal care was lower in the county (70.6%) than in the rest of the district and statewide.

As a positive, fewer residents reported not having a doctor or health care provider than statewide (9.1% vs 17.1%). It should be noted that Richardson County is a federally designated health professional shortage area for primary care and mental health, and a state designated shortage area for both those areas and for dentistry and pharmacy.

Healthy literacy was slightly lower but in line with the state, while the area had a higher proportion of residents with BMIs of 30.0+ (39.4% vs 35.3%) and a higher rate of physical

inactivity (29.5% vs 24.7%). Cancer rates (14.8% vs 11.0%) and diabetes rates (14.1% vs 10.8%) were higher than state averages.

Please see pages 51-90 of Appendix A for additional findings and discussion.

VI. Priorities

1. **Improve access to behavioral health services**
   This is consistent with survey and focus group concerns, combining those dealing with mental health and drug and alcohol abuse. Richardson County is a state and federally designated shortage area for mental health. This is a consistent issue from past CHNAs, and though great strides have been made in recent years, more work is clearly needed.

2. **Reduce transportation barriers**
   Lack of access to reliable transportation affects ability to receive physical and mental health services, to maintain employment, to maintain social connections, and to leverage various services. This is especially pronounced in rural communities. Some transportation services are provided by Southeast Nebraska Community Action (SENCA) and the hospital, but gaps remain. Reducing those gaps may help residents become more able to address their health and economic vulnerabilities.

3. **Increase availability or sustainability of support infrastructure, including:**
   - **Affordable quality housing**—*home values and rental rates are relatively low, but housing remains a concern, affecting families and businesses*
   - **Recreational/fitness opportunities**—*a consistent issue for the community focus group, supported by obesity and inactivity rates*
   - **Childcare**—*CMC recently took over operation of the only day care center in the city based on community need, underscored by this prioritization*
   - **Social services navigation**—*considered hand-in-hand with behavioral health, since behavioral health issues may coincide with and be exacerbated by non-medical factors like insurance coverage, food insecurity, housing, transportation, and assistance. Programs may be available, but various barriers may affect the ability to access them.*
   - **Emergency services**—*declining and aging populations are impacting the ability of volunteer-based community response organizations. Similarly, changing governmental funding priorities impacts the ability of local government to establish critical emergency infrastructure. Community health and resilience require an ability to prepare for and respond to emergencies—both small and large in scale.*

VII. Implementation Plan

1. **Improve access to behavioral health services**
    a. Continue to provide assistance to school district and behavioral health agency to support expanded counseling services
        i. As needed, consider expanding hospital- and clinic-based counseling to augment availability
        ii. Determine the feasibility of group counseling and treatments
    b. Increase awareness of Medication Assisted Treatment and other substance abuse services and support groups
    c. Work with SEDHD on regional gap identification and plan (see Appendix B)

2. **Reduce transportation barriers**
    a. Work with organizations and volunteers to coordinate additional transportation services
    b. Sponsor adult driver's education training
    c. Work with SEDHD on regional gap identification and plan (see Appendix B)

3. **Increase availability or sustainability of support infrastructure, including:**
    a. Affordable quality housing
        i. Conduct senior living market analysis
        ii. Work with city and economic development to renew community housing study
        iii. Explore innovative partnerships to connect workers and families to housing and to housing assistance opportunities
        iv. Support efforts of agencies and organizations that help fix or refurbish housing to maintain quality
    b. Recreational/fitness opportunities
        i. Support efforts in Falls City and other area communities to provide sustainable recreation and fitness opportunities, both through public and private means
        ii. Establish, promote and grow small-group wellness activities
        iii. Continue to develop hospital campus trail and community walking routes
        iv. Advocate for smart recreational and fitness facilities
    c. Childcare
        i. Support community childcare providers and programs
        ii. Continue to develop capacity in the Community Kids Center, likely in partnership with Sixpence and Falls City Public Schools

d. **Social services navigation**
    i. Expand social services and community health worker offerings
    ii. Support similar programs in other agencies and organizations and coordinate efforts as practical
    iii. Provide awareness and education about key services and collaboratively support navigation assistance
e. **Emergency services**
    i. Increase planning and training of hospital and medical community with schools, emergency management, fire, police, churches, government, and ambulance squads
    ii. Support volunteer ambulance squads, including recruitment, training, and equipment needs
    iii. As practical, expand emergency transfer capacity of hospital to augment existing services

VIII. Communication Plan

a. **Initial dissemination** (by end of September, 2025)
    i. Place downloadable pdf on CMC website
    ii. Announcement in local media and on social media
    iii. Print copies for those requesting in person
    iv. Mail or deliver to:
        1. Falls City Mayor & Council
        2. Falls City Administrator & Recreation Director
        3. Humboldt Mayor & Council
        4. Richardson County Board
        5. Richardson County Emergency Manager
        6. Nebraska Hospital Association
        7. Southeast District Health Department
        8. CAH Network tertiary hospitals (HHA, CHI, Mosaic)
b. **Ongoing**
    i. Maintain downloadable link on hospital website
    ii. Have copies on hand in case requested
c. **Oversight and Progress Tracking**
    i. Quarterly reporting to CMC Community and Planning Committee
    ii. Quarterly summary and annual presentation to CMC Governing Board
    iii. Regular meetings with SEDHD implementation task force

IX Review of Progress on Previous Community Health Needs Assessment (2022-2025)

1 Increase Access to Fitness and Wellness Opportunities

Initiative	Description	Partners	Progress
1.1	Explore potential for combined early childhood/ fitness/ recreation center.	FCSH, FCPS, EDGE, City	•Visited multiples sites & explored with architects but was rejected by city council •Turned towards other avenues to utilize existing infrastructure (especially auditorium)
1.2	Add/expand walking trail to hospital campus.	Landscaping (Scholl's), FC Rotary and private donors	•Expanded trail; •created more ADA-friendly grades at main entrance drive; •added benches; •public usage increased
1.3	Sponsor/encourage regular weekly fitness activities.	CMC, FC Parks & Rec,	•City absorbed CMC basketball night as part of expanded auditorium use; •started Spin class; •yoga, water aerobics, and crochet groups sponsored and/or housed by hospital
1.4	Sponsor teams to support recreation.	Schools, parks and rec	CMC sponsored multiple youth teams
1.5	Sponsor events and challenges.	Chamber of commerce, CMC Foundation, parks & rec	CMC sponsored or partnered on several fun runs, including providing facilities, staff, insurance
1.6	Evaluate medically-directed weight loss programs.	Medical Staff	•Began offering GLP-1 coverage to staff; •allow use of facility for private GLP-1 administration by clinician

2 Increase Access to Behavioral Health Resources

Initiative	Description	Partners	Progress
2.1	Provide subsidies & financial support to increase availability of behavioral health services.	Blue Valley, FCPS, Six Pence	Provided over $40,000 in assistance each year
2.2	Expand behavioral health offerings in hospital clinics.	Providers	•Added part-time licensed clinical social worker and pediatric psychologist; •Now offer two psychiatric APRNs including telehealth; •Offer MAT •Started esketamine (Spravato) program for patients with treatment-resistant depression; •Started providing services to RC Jail inmates
2.3	Explore (and add if feasible) adult focused structured outpatient services.		Placed on hold to focus on esketamine and community health worker programs
2.4	Continue to implement opioid best practice recommendations.		•Offer MAT (medication-assisted treatment of opioids); •House medication disposal receptacle; •Created controlled substance diversion team

3 Strengthen social support coordination and emergency services

Initiative	Description	Partners	Progress
3.1	Provide subsidy to FCVAS to support on-call availability, especially for transfers.	FCVAS	Provided supplies and staff to allow FCVAS to provide ALS-billable services and long-distance transfers
3.2	Recruit & train CMC staff to driver role, and establish rotation. As able, expand to other businesses.	FCVAS.	Attempted, but only minimally successful; squad membership requirements proved challenging to adapt to a rotational system like that proposed
3.3	Increase hours for hospital-based social work in hospital.		Very successful; added part-time LCSW and three FT community health workers
3.4	Offer medical triage line to support after hours needs.	External service	Now offering;
3.5	Enhance awareness/coordination among social service providers	SENCA, Churches, Primary Care	Strong partnership with SENCA and community health workers; especially important as state agencies have cut local in-person support in rural areas
3.6	Explore feasibility of additional transportation support for medical services, especially behavioral health.	SENCA	•Added transport van •Emphasized SENCA is primary option while CMC's is for unplanned situations

4. Increase use of preventative services and early detection screenings

Initiative	Description	Partners	Progress
4.1	Increase communication to patients regarding recommended screenings, diabetic precautions, etc, using written, electronic and verbal methods.		•Lung cancer screenings now at 25% of eligible, with CMC receiving award from American Cancer Society •Participated in multi-hospital collaborative •Mammography & Colon Screenings up but below top-performing targets •Diabetic foot exams and HeA1c testing showed significant improvement
4.2	Provide education to community members around recommended screenings.		Limited additional advertising; produced several videos, but completion and airing have been delayed
4.3	Increase use of chronic care management, transitions of care management and remote patient monitoring, as appropriate.		Reviewed proposals, but after discussions with med staff and community committee did not implement; have set parameters that any potential program must show both clinical benefit and cost reduction for patients
4.4	Provide access to home Radon testing for community members.	SEDHD	•Continuing to provide kits, but rate of usage slowed from prior period •Participated in study that showed that smoking rates alone cannot explain the increased lung cancer rates in high-radon rural counties like ours

Appendix A: Attach SEDHD 2024-2025 Community Health Assessment

Appendix B: Attach SEDHD 2025 Community Health Improvement Plan

Appendix A

2024-2025 COMMUNITY HEALTH ASSESSMENT

Southeast District Health Department

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INTRODUCTION

In partnership with the Southeast District Health Department (SEDHD), a team from the University of Nebraska Medical Center (UNMC) conducted and prepared this 2024-2025 Community Health Assessment (CHA) for the five counties within the Southeast Health District (Johnson, Nemaha, Otoe, Pawnee, and Richardson Counties). This assessment was completed in partnership with the district's six nonprofit hospitals; Johnson County Hospital, Nemaha County Hospital, CHI St. Mary's, Syracuse Area Health, Pawnee County Memorial Hospital, and Community Medical Center in Falls City; as well as various other community partners and agencies. This assessment provides the foundation for the development of the Community Health Improvement Plan (CHIP) and serves as a reference document for the six hospitals to support their strategic planning initiatives, and it can be used to develop the Community Health Needs Assessments (CHNAs). Lastly, this assessment provides data and information that can be used to inform and educate interested community partners and stakeholders about the health status of the population in the Southeast Health District.

The CHA process is a collaborative effort and aims to serve as a single source of data for community partners, stakeholders, and organizations. The primary objective of this assessment is to describe the health status of the population, identify areas for health improvement, and outline the health priorities of the communities within the health department's jurisdiction. To provide continuous and up-to-date data, this assessment will be updated every three years. Subsequent revisions to this assessment should evaluate progress towards the current health priorities and identify new priorities that reflect the changes in health conditions and problems within our communities.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND METHODS

The process of identifying the high priority health needs in the five-county area of the SEDHD was multi-dimensional and involved several steps. A concerted effort was made to identify major health challenges from individuals through a community survey and focus group interviews with some representatives from organizations who represented vulnerable populations. A secondary data analysis using multiple data sources was also conducted. The ultimate goal was to select 3-5 high priority needs. The major steps in the process are summarized below:

1. Convene a planning group that includes staff from the SEDHD, the hospital administrators from the six hospitals in the region, and the COPH to identify the breadth, scope, and timing of the process.

2. Collect and analyze secondary health data that assesses population characteristics, personal risk factors, social drivers of health such as food insecurity, prevalence of

chronic and mental health conditions, and health outcomes such as life expectancy and mortality rates. Using a variety of data sources (e.g., the U.S. Census data, the Behavioral Health Risk Factor Surveillance System, the County Health Rankings from the University of Wisconsin, the Nebraska Crime Commission, the Nebraska Department of Education, and the Nebraska Department of Health and Human Services).

3. Conduct a survey of adults in the five county region to identify the most important health problems, the changes needed to improve the health of family and friends, the strengths of the current health system, and the quality of life in their communities (e.g., satisfaction with the health care system, a good community to grow old and raise children, economic opportunities, and a safe place to live).

4. Organize focus group interviews in each community with a hospital to review the results of the survey and the secondary data analysis and recommend high priority health needs in each of the hospital service areas.

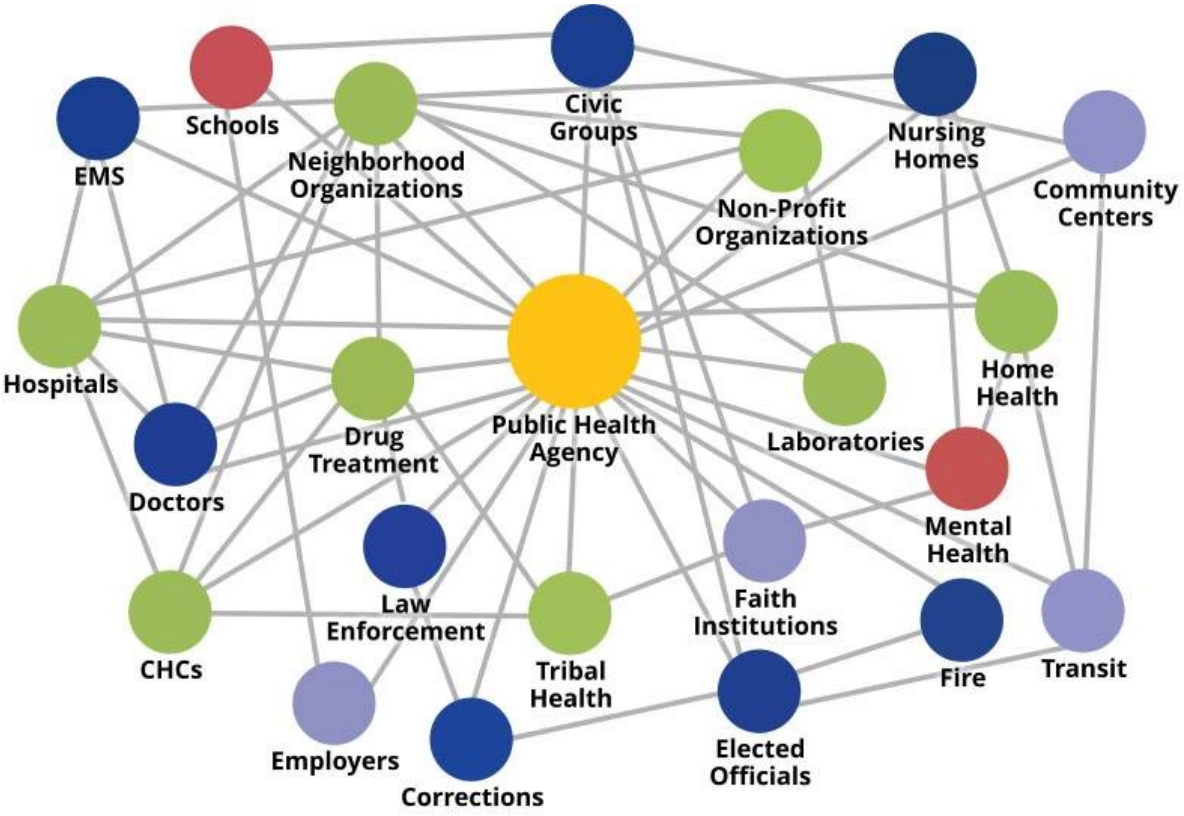
5. Review all the information (i.e., the survey results, the secondary data analysis, and the priorities recommended by each of the six focus groups) to determine three to five health priorities for the district.

COMMUNITY HEALTH AND THE PUBLIC HEALTH SYSTEM

To address a broad array of community health issues, it is essential to create collaborative partnerships among many community-based organizations. Some of these issues include access to health care services, public safety and welfare, crime, substance use, poverty, obesity, diabetes, adolescent and child health, chronic diseases, and various other epidemiological challenges.

Improving the health of a community requires a collaborative effort among diverse community agencies and goes beyond efforts typically undertaken by hospitals and the local public health department. Figure 1 shows the public health network and interdisciplinary relationships needed between public, private and non-profit agencies that effectively address the community's health needs.

Figure 1. The Public Health System



Source: Centers for Disease Control and Prevention, 2018

COMMUNITY HEALTH COLLABORATORS

There were several individuals and organizations involved in the CHA process. The overall planning process and the scope of the plan were developed by the SEDHD and the six hospitals in the region because each of these hospitals is using the findings from the CHA as the foundation for their Community Health Needs Assessments (CHNAs) which is a requirement for all nonprofit hospitals under the Affordable Care Act. The following hospitals were key members of the planning group.

- Johnson County Hospital
- Nemaha County Hospital
- CHI Health St Mary's (Otoe County
- Syracuse Area Health (Otoe County)
- Pawnee County Memorial Hospital
- Community Medical Center (Richardson County)

Consultants Contracted

The SEDHD contracted and worked closely with the College of Public Health (COPH) at the University of Nebraska Medical Center.

Contributing Organizations

The SEDHD also worked with each hospital to identify other community-based organizations that identify health challenges for vulnerable populations and help to devise intervention strategies to address the high priority challenges. These organizations are listed below.

Nemaha County

- City Council, City of Auburn
- Community Member
  Nemaha County Veteran Service Officer
- Community Member, Retired Physician

Otoe County

- Nebraska City Public Schools
- School Nurse in Syracuse
- Superintendent in Palmyra/Bennet Public Schools
- Nebraska City News Press
- City Administrator in Syracuse
- Nebraska City Police Department
- Lewis and Clark Center
- Heartland Workers Center, Nebraska City
- Juvenile Diversion and Central Navigation, Nebraska City
- The Faith Community
- Mission Field Treatment Center, Nebraska City
- Senior Center, Syracuse
- Nursing Home, Syracuse

Pawnee County

- Pawnee County Sheriff's Office
- Pawnee County Public Schools
- Member of the School Board
- John and Pawnee County Emergency Management Agency
- Alphia Pet Food Company
- State Bank of TR
- Pawnee City Librarian
- Pawnee City Veterinary Clinic

One of the important requirements of PHAB accreditation is to demonstrate the involvement of

other organizations representing sectors other than governmental public health and community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes. In addition to the six hospitals in the SEDHD jurisdiction, there were many community organizations such as the public schools, various churches representing the faith community, a school nurse, law enforcement, and the Heartland Workers Center that emphasizes the rights of Hispanics and other foreign workers. All of these organizations were involved in the focus group interviews where health challenges for vulnerable populations were discussed at length.

The SEDHD also used the results of the community survey to seek input from racial/ethnic minorities and other underserved populations. For example, 7% of the Otoe County survey respondents were from minority population groups, about 8% had household incomes of less than $30,000, and about 25% had household incomes of less than $50,000. The characteristics of the survey respondents are summarized in Table 1.

COMMUNITY HEALTH SURVEY

As part of the CHA process, 393 residents within the SEDHD completed the community health survey in August and September of 2024. The survey findings provide valuable information about community members within the SEDHD. The survey is also used as a tool to gauge residents' perceptions on the quality of life in their community, personal health, and behaviors that may impact the health of their community.

Table 1 shows the demographic characteristics of survey participants in each of the 5 counties represented in the Southeast district. The results of the survey are calculated by county and presented as part of the data packets given to focus group participants.

Table 1. Community Health Survey Results - Respondent Demographics

	Johnson	Nemaha	Otoe	Pawnee	Richardson
Total Respondents	**20**	**57**	**110**	**49**	**157**
Race					
White Non-Hispanic or Latino	87.5%	91.8%	93.0%	95.9%	97.3%
Hispanic or Latino	0.0%	2.0%	3.0%	0.0%	0.0%
African American	6.3%	0.0%	0.0%	0.0%	0.0%
American Indian/Alaska Native	0.0%	0.0%	0.0%	0.0%	0.7%
Asian	0.0%	0.0%	1.0%	0.0%	0.0%
Native Hawaiian/ Other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%
Two or more races	0.0%	2.0%	3.0%	2.0%	1.3%
Prefer not to answer	6.3%	4.1%	0.0%	2.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.7%
Gender					
Male	12.5%	12.2%	16.0%	22.5%	7.4%
Female	81.3%	85.7%	83.0%	73.5%	92.0%
Prefer not to answer	6.3%	2.0%	1.0%	2.0%	0.7%
Age					
Under 18	0.0%	0.0%	0.0%	0.0%	0.0%

Table 1. Community Health Survey Results - Respondent Demographics					
	Johnson	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
18 - 24	0.0%	2.1%	6.0%	6.1%	4.8%
25 - 34	33.3%	21.3%	18.0%	16.3%	21.8%
35 - 44	20.0%	36.2%	18.0%	14.3%	17.7%
45 - 54	20.0%	8.5%	26.0%	18.4%	16.3%
55 - 64	6.7%	17.0%	14.0%	20.4%	25.2%
65 or over	20.0%	10.6%	18.0%	22.5%	14.3%
Prefer not to answer	0.0%	0.0%	0.0%	2.0%	0.0%
Yearly Household Income					
Less than $15,000	6.25%	2.0%	1.0%	2.0%	0.7%
$15,000 - $29,999	0.0%	8.2%	7.0%	10.2%	5.4%
$30,000 - $49,999	31.3%	8.2%	16.0%	14.3%	12.1%
$50,000 - $74,999	18.8%	10.2%	10.0%	20.4%	19.5%
$75,000 - $99,999	12.5%	14.3%	22.0%	8.2%	19.5%
$100,000 - $149,999	12.5%	30.6%	14.0%	12.2%	20.8%
$150,000 or more	18.75%	18.4%	22.0%	8.2%	13.4%
Prefer not to answer	0.0%	0.0%	0.0%	24.5%	8.7%
Educational Attainment					
Less than high school degree	0.0%	0.0%	1.0%	2.0%	0.7%
High school degree or equivalent	18.8%	4.1%	9.0%	20.4%	10.7%
Some college but no degree	12.5%	12.2%	15.0%	10.2%	22.2%
Associate degree	12.5%	14.3%	21.0%	20.4%	29.5%
Bachelor's degree	12.5%	44.9%	36.0%	18.4%	21.5%
Graduate degree	43.75%	20.4%	17.0%	18.4%	13.4%
Other	0.0%	2.0%	0.0%	2.0%	1.3%
Prefer not to answer	0.0%	2.0%	1.0%	8.2%	0.7%

FOCUS GROUPS

As a part of the 2024-2025 CHA and CHIP process, UNMC facilitated six in person focus groups within the SEDHD region. The focus group schedule included:

- October 1, 2024 - Richardson County, Falls City, NE
- October 1, 2024 - Johnson County, Tecumseh, NE
- October 3, 2024 - Nemaha County, Auburn, NE
- October 3, 2024 - Pawnee County, Pawnee City, NE
- October 10, 2024 - Otoe County, Syracuse, NE
- October 10, 2024 - Otoe County, Nebraska City, NE

Focus group participants included community members, stakeholders, and leaders from local businesses, schools, social service agencies, hospitals, local government, economic development, and police within the corresponding counties of the health district. Participants of the focus groups were recruited by partnering hospitals (CHI Health, Community Medical Center, Pawnee County Memorial Hospital, Syracuse Area Health, and Nemaha County Hospital). All focus groups were facilitated by UNMC researchers. Table 2 shows the number of participants in each focus group.

Table 2. Community Focus Groups Location and Number of Participants

Location	Number of Participants
Falls City (Richardson)	11
Tecumseh (Johnson)	10
Auburn (Nemaha)	10
Pawnee City (Pawnee)	15
Syracuse (Otoe)	17
Nebraska City (Otoe)	16

The focus groups lasted approximately ninety (90) minutes. In each of the focus groups, participants were given a packet of information specific to their respective county, created by UNMC and reviewed by SEDHD, that consisted of data from secondary sources such as BRFSS, County Health Rankings and Roadmaps, American Community Survey/US Census Bureau, and the Nebraska Department of Education to provide a broad overview of the county's health status.

Focus group participants also reviewed selected survey response data from the community health survey which was administered by SEDHD and their partners in the five-county area. Specifically, the group considered responses from survey questions 12, 13, and 14 which asked about the most important health factors, health concerns and what is needed to improve the community's health. After providing dedicated time for individual review, the UNMC facilitator asked the group to share and discuss their thoughts about these survey questions, the data, the strengths within the county, and the opportunities that exist in the county. After this discussion, the UNMC facilitator listed the opportunities discussed by the group on a white board and asked the group to use markers to vote for their top three priorities to determine which of the opportunities identified should be the focus moving forward.

FOCUS GROUP HIGHLIGHTS

This section highlights the emerging themes from the six focus groups.

- ***Strengths*** identified were quality healthcare; community pride among residents; availability of long-term care in the community (other communities had this as an opportunity instead of a strength); collaboration among public-private entities; good schools; strong police presence; strong community resources (pools, libraries, parks, and recreation programs, etc.).

- ***Areas of opportunity included*** increasing access to mental health; raising awareness of what kinds of services were available in each community; access to affordable housing; finding ways to keep people in the community (prevent community outmigration); child and adult daycare services; improve availability of transportation, especially for healthcare related needs; developing a community wellness center or for those communities that have one, expanding use of the wellness center/wellness services; consider adding weight management to community services/wellness center; expanding EMS services to mitigate overreliance on volunteer staffing; maximize telehealth services; expand availability of LTC in the community; Improve health literacy/Increase education on health behaviors such as substance abuse, social media use, vaping, etc.; activate the religious community as a resource; improve access to healthy foods; improve overall healthcare staffing.

- ***Themes on Priorities*** identified from the areas of opportunity across the six focus groups (priorities mentioned in two or more of the groups) included:

    - Access to affordable housing
    - Increasing mental health providers/services

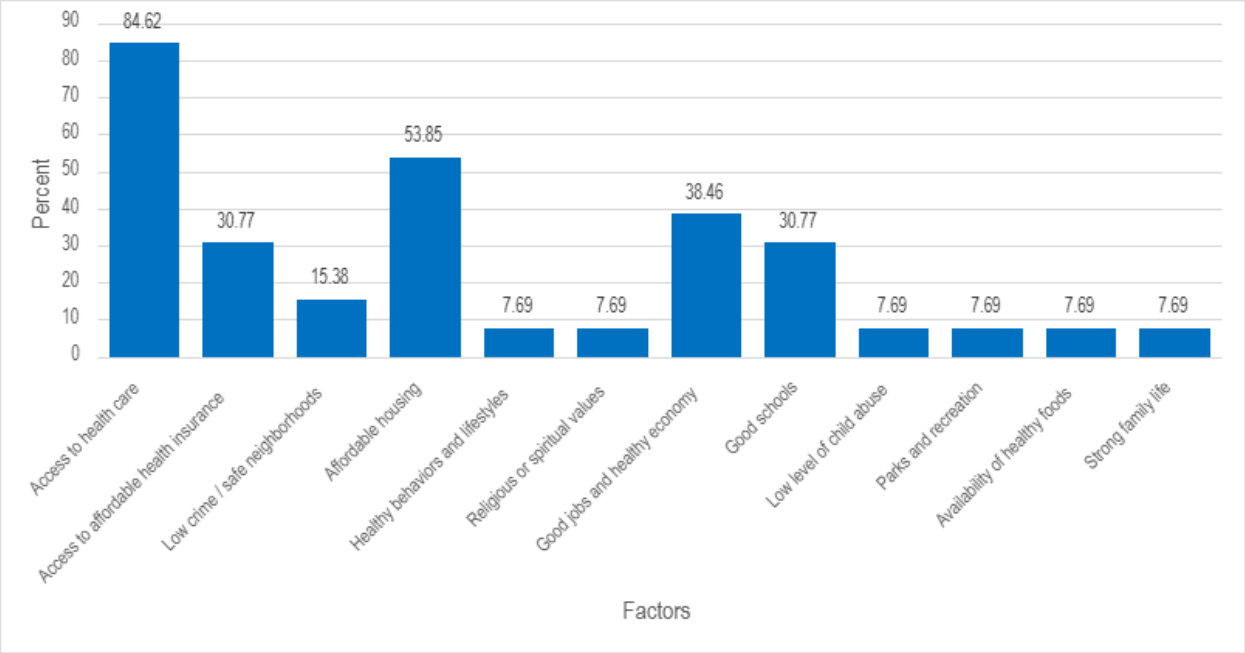
- Leverage telehealth to improve access (mental health often given as an example)
- Improve availability of transportation, especially for healthcare related needs
- Expanding EMS services to mitigate overreliance on volunteer staffing
- Expand/stabilize the healthcare workforce in general
- Increase child and adult day care programs (after school programs were mentioned)

FOCUS GROUP DETAILS

Johnson County Focus Group (10 Participants)

The data packets were provided and reviewed by the focus group members. Data packets included results for Survey Questions Q12-14:

Q12: In the following list, what do you think are the three (3) most important factors for a "Healthy Community" (Those factors which most improve the quality of life in a community)

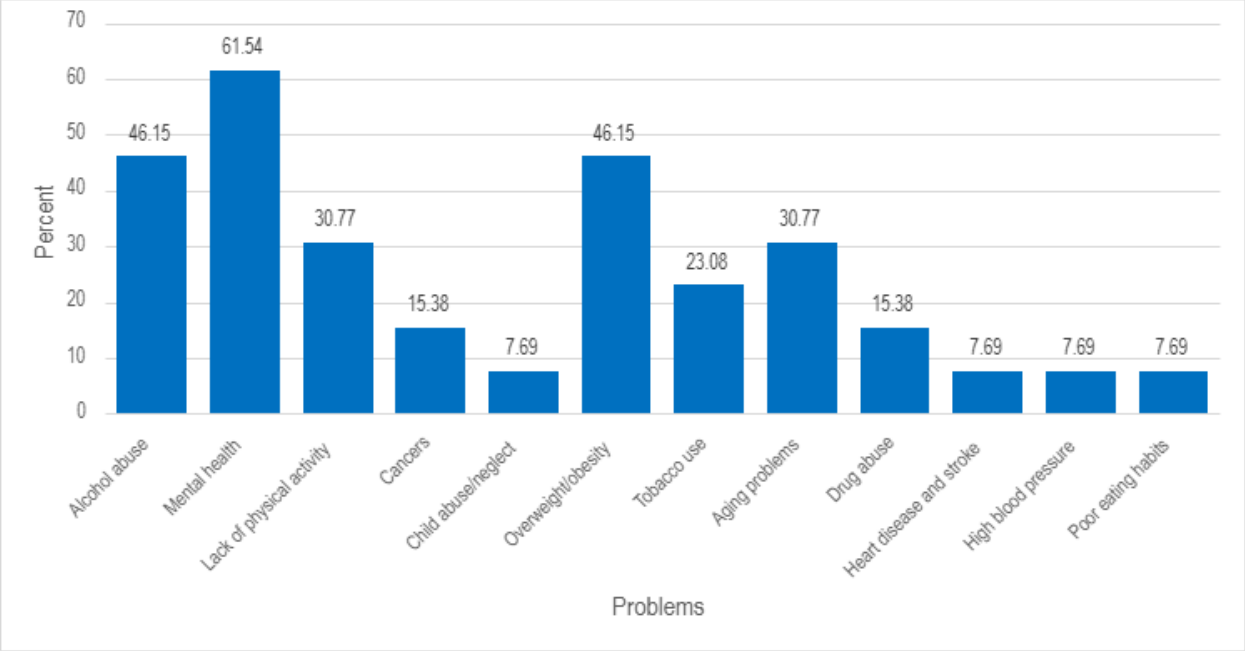


Top 5 Responses:

- Access to health care
- Affordable housing
- Good jobs and a healthy economy

- Good schools
- Access to good health insurance

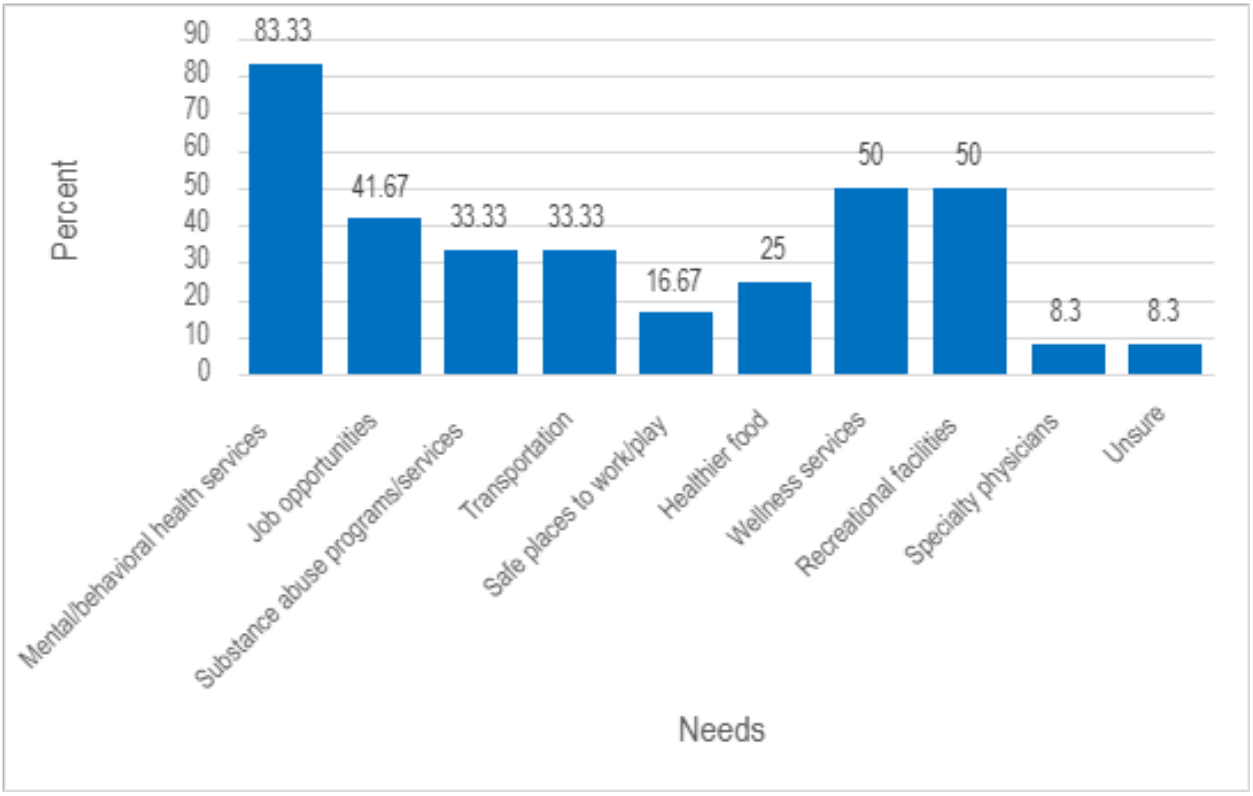
Q13: In the following list, what do you think are the three (3) most important "Health Problems" in your community? (Those factors which have the greatest impact on overall community health)



Top 5 Responses:

- Mental health
- Alcohol abuse
- Overweight/obesity
- Lack of physical activity
- Aging problems

Q14: What is needed to improve the health of your family and neighbors? (Select all that apply)



Top 3 Responses:

- Mental/behavioral health services
- Wellness services
- Recreational facilities

The results from these three questions were then discussed in the focus group.

Survey Q12. What are the most important factors for a healthy community? Does this seem right or are there other factors you would prioritize? "This pretty strongly reflects Johnson County." Others agreed. One participant stated we need to make sure to highlight that while there are opportunities to think about, we need to make sure that people understand what an incredible area we live in and how lucky we are. That idea can get lost when all we are focusing on is the opportunities.

Survey Q13. What are the most important health problems in the community? Does this seem right or are there other health problems you would prioritize? "I don't understand how aging is a problem. That just happens." "It is more about the health problems gaining brings." "For me, a lot of these run together. For example, lack of activity ties to obesity." People supported the list

identified in the survey.

Survey Q14. What is needed to improve the health of your family and neighbors? Are there things other than what is identified that you would add? "We are taking some baby steps now, but there isn't anything we can take off the list." "When the service is there, you must be willing to reach out for it. There is accountability on the person. There are a lot of things available if you have the self-initiative to take advantage of it." We do not have LTC. They are being "shipped out." Staffing shortages; for example, strong EMS but shortages of staffing and dependence on volunteer systems resulting in longer response times." "Childcare is an issue."

What other strengths would you identify?

- We are recruiting a lot of primary care providers, and they are very busy
- We have added pediatric providers
- We have implemented a transfer system
- We just implemented paramedics
- More activities for kids through parks and rec including wellness

Opportunities?

- Survey result – wouldn't raise children here (group thought this might be related to school quality or childcare) – 4 votes. (The group would like to reword this to recruitment/retention of young people/families)
- Community mental health services (e.g., AA, grief support) (combined) – 3 votes
- Collaboration between hospital and health department – zero votes
- Community paramedicine programs (e.g., home health) – zero votes
- Awareness of services (might add to the community welcome packet) – 4 votes
- Increasing services for mental health specifically in the 18-65 age group (combined) – 2 votes
- Availability of housing/affordable housing – 5 votes
- Community outmigration (added as a recommendation when the two mental health topics were combined)

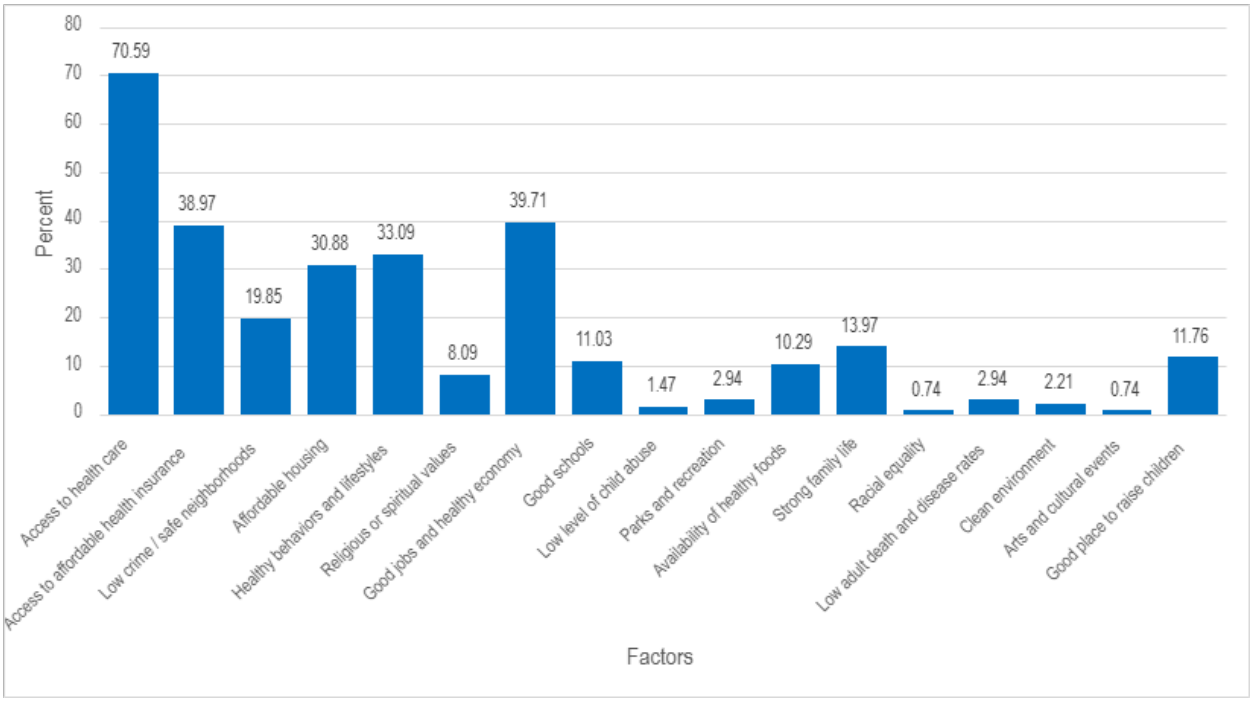
Top Priorities identified by the group

1. Housing
2. Awareness of services
3. Community member recruitment/retention
4. Mental health providers/services

Richardson County Focus Group (11 Participants)

The data packets were provided and reviewed by the focus group members. Data packets included results for Survey Questions Q12-14:

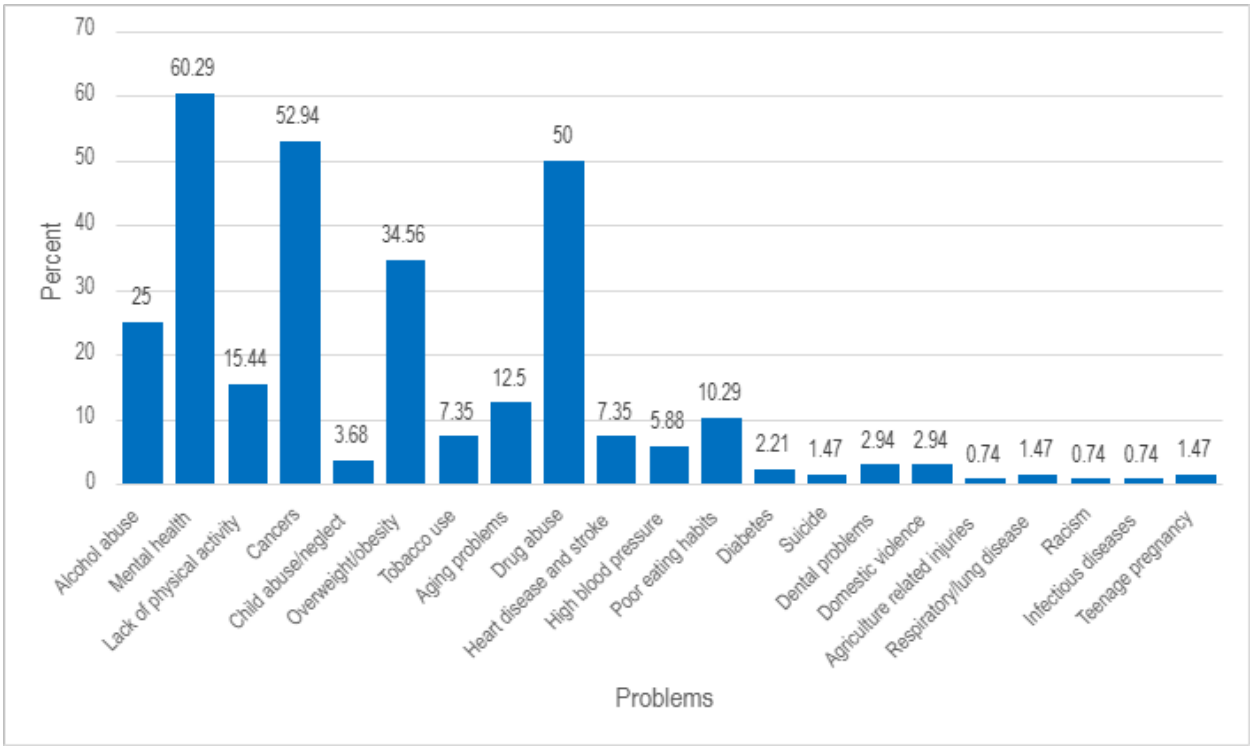
Q12: In the following list, what do you think are the three (3) most important factors for a "Healthy Community" (Those factors which most improve the quality of life in a community)



Top 5 Responses:

- Access to health care
- Good jobs and a healthy economy
- Access to affordable health insurance
- Healthy behaviors and lifestyles
- Affordable housing

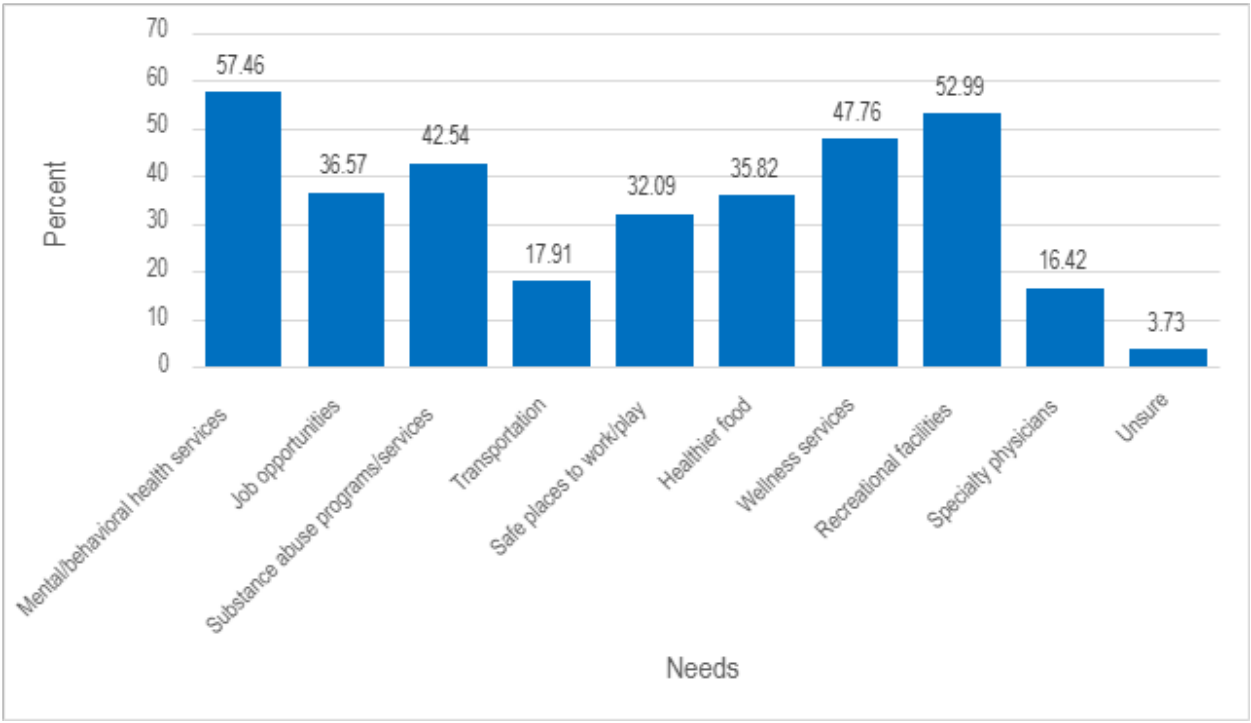
Q13: In the following list, what do you think are the three (3) most important "Health Problems" in your community? (Those factors which have the greatest impact on overall community health)



Top 5 Responses:

- Mental health
- Cancers
- Drug abuse
- Overweight/obesity
- Alcohol abuse

Q14: What is needed to improve the health of your family and neighbors? (Select all that apply)



Top 3 Responses:

- Mental/behavioral health services
- Recreational facilities
- Wellness services

The results from these three questions were then discussed in the focus group.

Survey Q12. What are the most important factors for a healthy community? Does this seem right or are there other factors you would prioritize? "For many people, it seems like access to healthcare and access to insurance are interrelated, but I guess that isn't entirely the case." "Affordable housing is complicated as well. Sometimes we have the reverse bell curve here." "Affordable family housing is a big one. We have no place for low-income families." "When we talk about access to care, we may have access to doctors, but we don't have access to things like dental and vision for low-income families." "Since the pandemic, supporting mental health and stability…work together to address mental health."

Survey Q13. What are the most important health problems in the community? Does this seem right or are there other health problems you would prioritize? "Noting that drug abuse was mentioned at twice the rate that alcohol abuse is, does the group feel this is accurate?" "I see tons

of kids that are in that slot, 18-25 age, but there are a lot of people in town that I didn't know." "I don't know if drugs are abused at a higher level, but they are more visible." "I think they (drugs and alcohol) are pretty comparable." Others agreed. Recategorize as substance abuse. On a separate topic, one member was surprised to see diabetes, HBP so low. If you were going to rank 3-4 problems, what would they be? Mental health, substance abuse. One member agreed these two are priorities as well as Cancer. While obesity is mentioned, a lot of the things that go with it are not. The one not mentioned is SDOH and this should be captured. Transportation was later mentioned which is related to SDOH.

Survey Q14. What is needed to improve the health of your family and neighbors? Are there things other than what is identified that you would add? No additional comments from the group.

What other strengths would you identify?

- Hospital with high patient satisfaction
- Hospital expanded mental health outreach, transportation
- Strong family practice clinics
- Access to mental health facilities
- Some access to mental health through the schools
- Senior and worker focused on low-cost housing
- Community health workers to help with things like finding housing, services, etc.
- New walking trails, water aerobics, etc. have grown
- Expanded recreational activities for both adults and kids
- Data reflects that it is a safe community, schools are good, etc.

Opportunities?

- Community rec center - 4
- Expand community health workers - 2
- Affordable housing - 5
- Expand emergency services – reliance on limited volunteers - 4
- Expand transportation - 2
- Childcare - 4
- Job Corp focused on 18–25-year-old population/engagement and retention - 1
- Mental Health workforce expansion - 5

Top Priorities identified

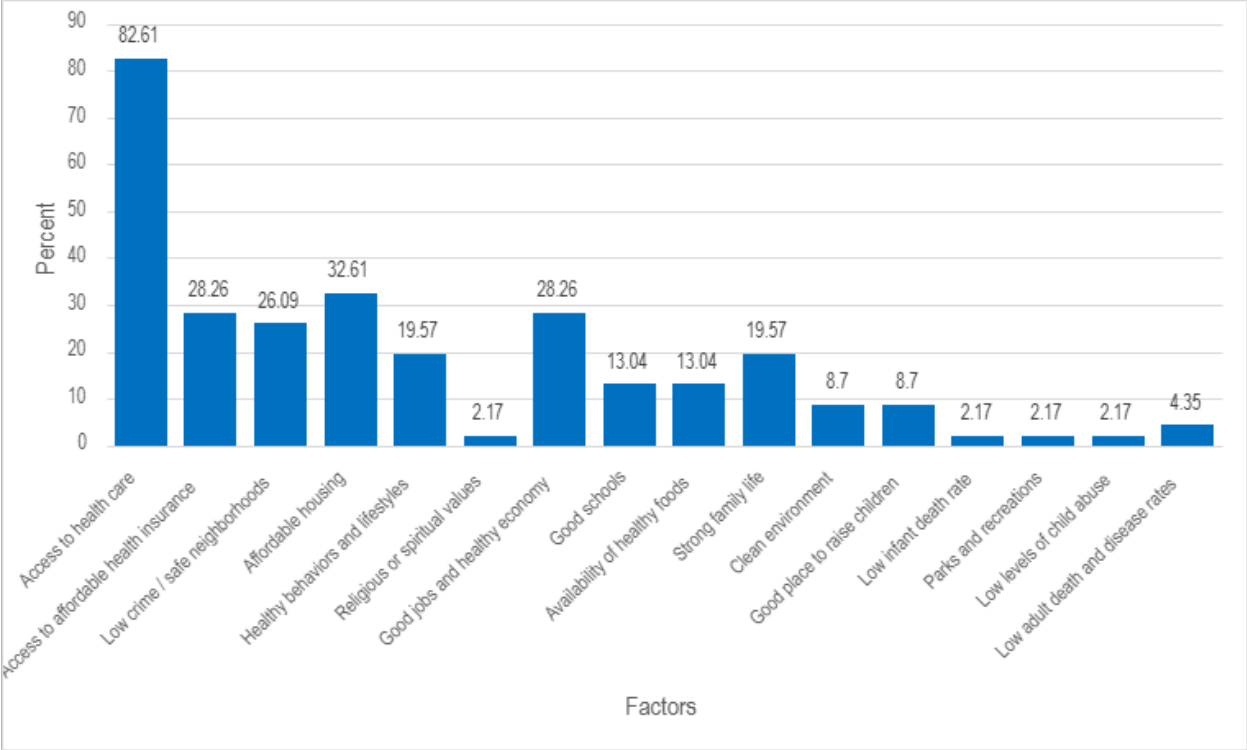
1. Affordable housing
2. Mental health workforce expansion
3. Community rec center
4. Childcare

5. Expand EMS services

Pawnee County (15 Participants)

The data packets were provided and reviewed by the focus group members. Data packets included results for Survey Questions Q12-14:

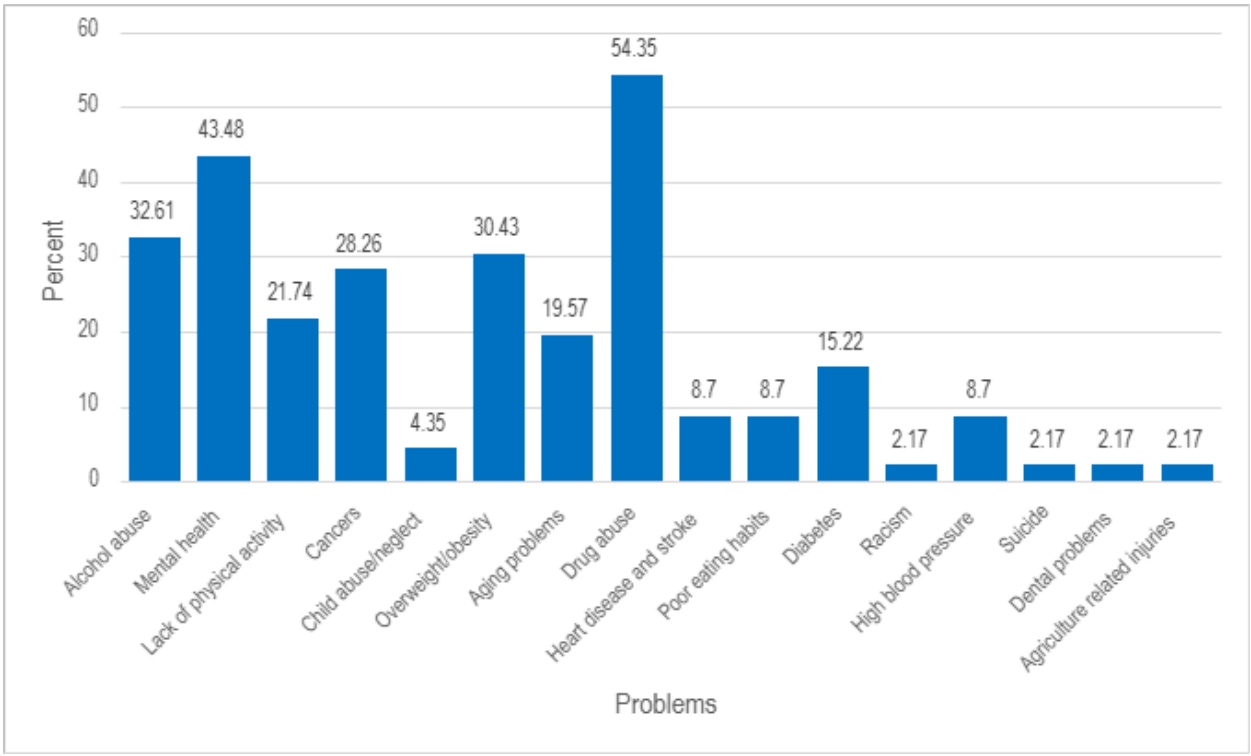
Q12: In the following list, what do you think are the three (3) most important factors for a "Healthy Community" (Those factors which most improve the quality of life in a community)



Top 5 Responses:

- Access to health care
- Affordable housing
- Access to affordable health insurance
- Good jobs and a healthy economy
- Low crime/safe neighborhoods

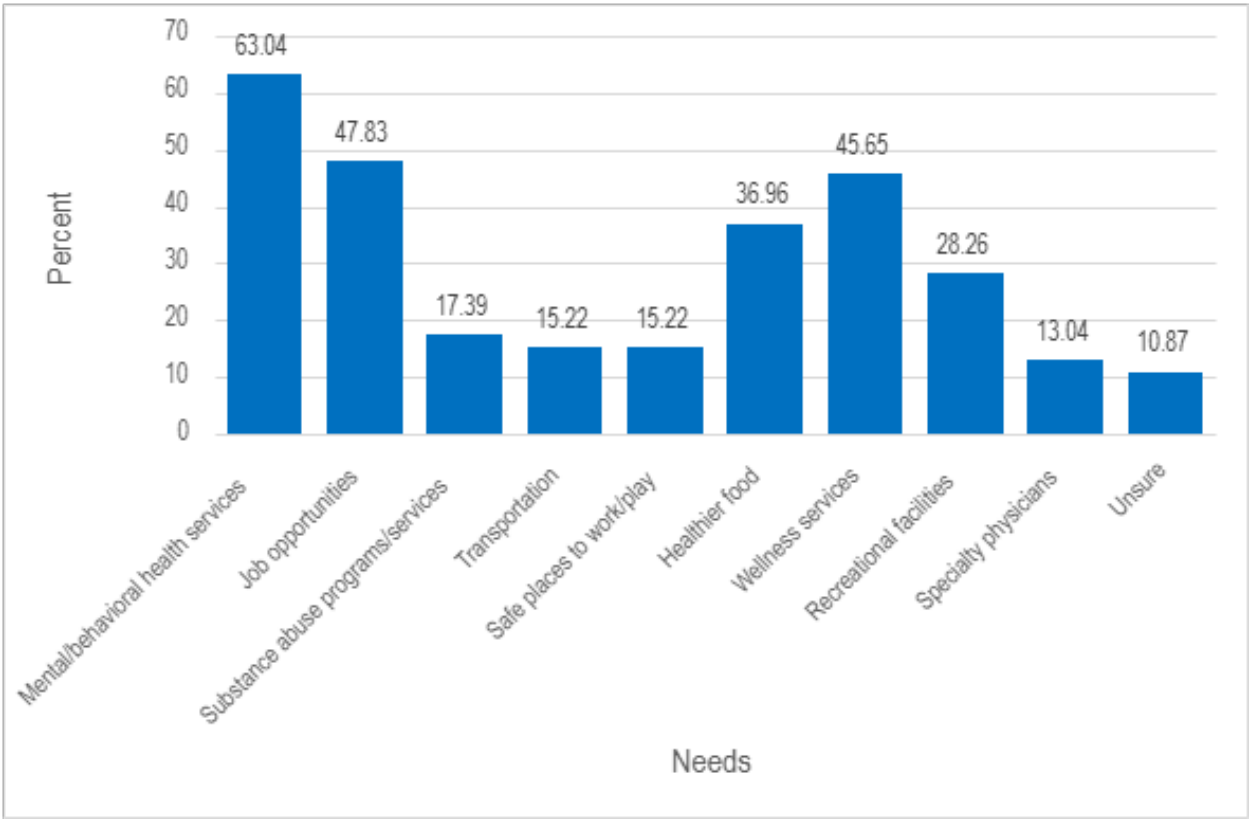
Q13: In the following list, what do you think are the three (3) most important "Health Problems" in your community? (Those factors which have the greatest impact on overall community health)



Top 5 Responses:

- Drug abuse
- Mental health
- Alcohol abuse
- Overweight/obesity
- Cancers

Q14: What is needed to improve the health of your family and neighbors? (Select all that apply)



Top 3 Responses:

- Mental/behavioral health services
- Job opportunities
- Wellness services

The results from these three questions were then discussed in the focus group.

Survey Q12. What are the most important factors for a healthy community? Does this seem right or are there other factors you would prioritize? “I am a little concerned religious/spiritual values are so low.” “Not a lot of people go to church anymore.” “I think this is skewed because it shows more of the concerns of 65 plus than people in my age group. We are more concerned about safety and security.” “I don’t know how expensive it would be…but, could we have volunteers that help with transportation.”

Survey Q13. What are the most important health problems in the community? Does this seem right or are there other health problems you would prioritize? “I have a different take on this than

most people would. We have had no end to issues with EPC (emergency protective custody). In my experience, we have many more problems with alcohol than with drugs (e.g., domestic violence, DUIs). Although this is changing with the younger generations, for example, drug rings, but you see less of the effects of drugs than alcohol. One of the reasons is they have enough money to live in an area like Pawnee County than somewhere else. "After the opioid crisis was shut down, meth became the drug of choice because it is cheap and easily accessed." "From an E.R. perspective, this list nails it." "From a school perspective, we see mental health issues younger and younger. This follows them through their lives."

Survey Q14. What is needed to improve the health of your family and neighbors? Are there things other than what is identified that you would add? "There may be an education issue, but we have problems with people getting a headache and going to the ER. Availability of walk-in clinics would be helpful." "Telehealth would be helpful." "If you can establish a relationship with a healthcare provider long-term, it would be helpful." "A wellness center available for the public would be helpful." "More access to mental health." "Incentives to bring more healthcare professionals to the area." Difficulty retaining specialists like ENT, Pulmonology, etc. It is difficult to retain younger people unless they were originally from here because there are no social life opportunities.

What other strengths would you identify?

- New emergency manager
- Strong police force
- Nice healthcare system/patient experience
- Highschool recruitment programs for example, CNA program, ride along, shadowing

Opportunities?

- Telehealth/walk in care (option to get better access to medications/extended hours) – 10 votes
- Wellness Center – 4 votes
- Transportation/ride share – 10 votes
- Recruit and retain specialists and healthcare workers – 4 votes
- Affordable or free community weight management program – 9 votes

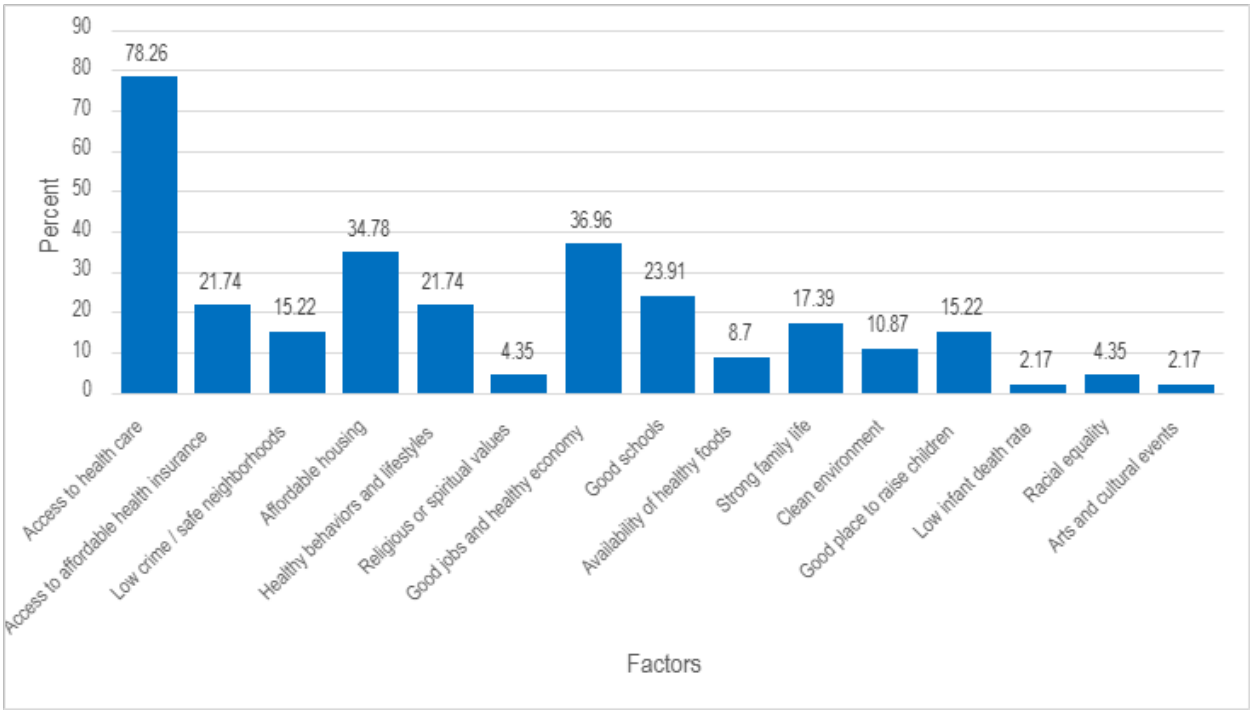
Top Priorities identified

1. Telehealth/walk in care
2. Transportation
3. Weight management program – could decide to combine with the wellness center

Nemaha County (10 Participants)

The data packets were provided and reviewed by the focus group members. Data packets included results for Survey Questions Q12-14:

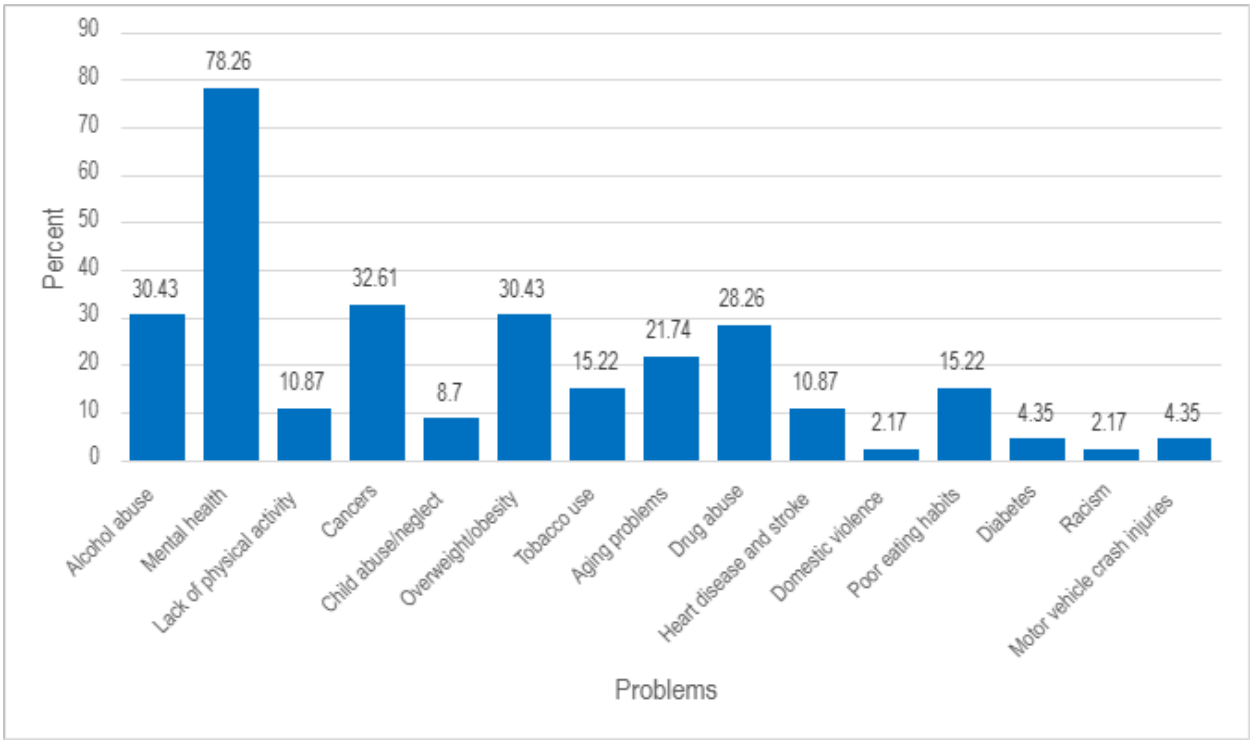
Q12: In the following list, what do you think are the three (3) most important factors for a "Healthy Community" (Those factors which most improve the quality of life in a community)



Top 6 Responses:

- Access to health care
- Good jobs and a healthy economy
- Affordable housing
- Good schools
- Access to affordable health insurance
- Healthy behaviors and lifestyles

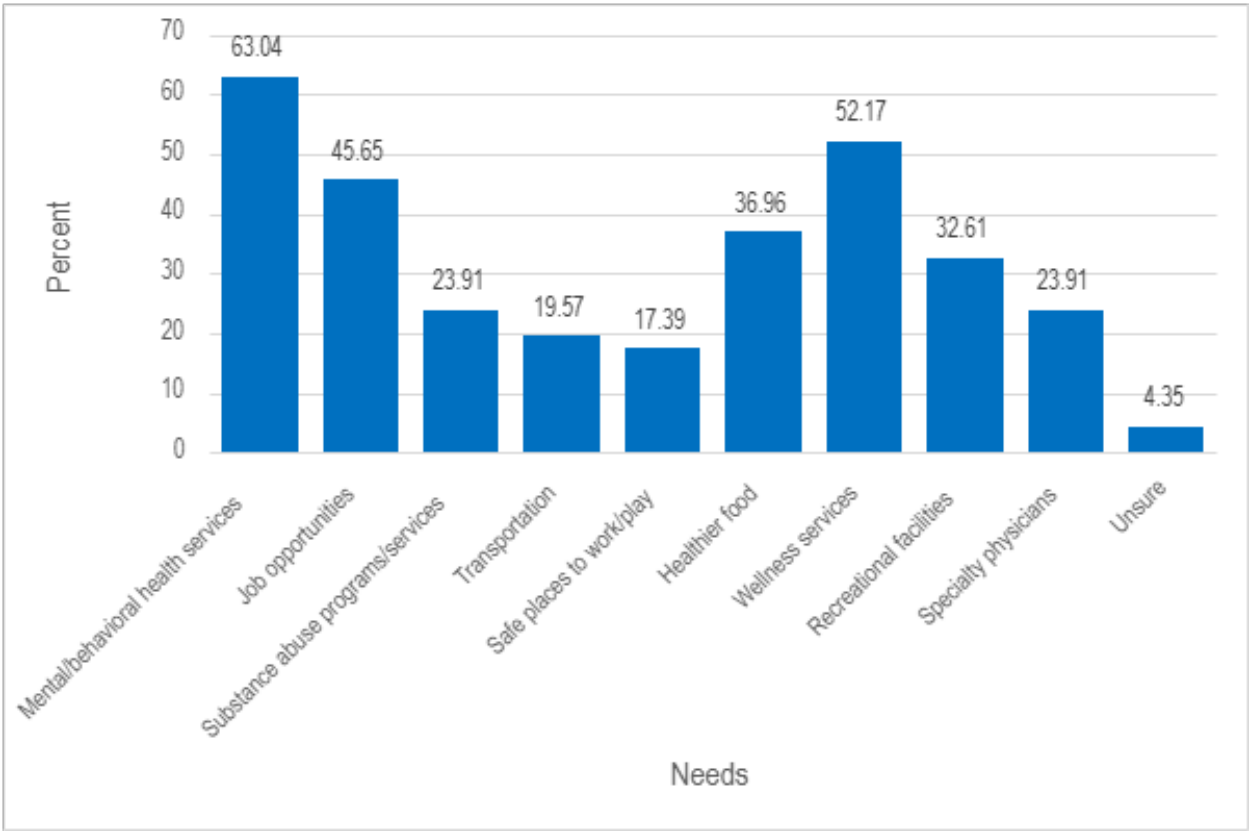
Q13: In the following list, what do you think are the three (3) most important "Health Problems" in your community? (Those factors which have the greatest impact on overall community health)



Top 5 Responses:

- Mental health
- Cancers
- Alcohol abuse
- Overweight/obesity
- Drug abuse

Q14: What is needed to improve the health of your family and neighbors? (Select all that apply)



Top 3 Responses:

- Mental/behavioral health services
- Wellness services
- Job opportunities

The results from these three questions were then discussed in the focus group.

Survey Q12. What are the most important factors for a healthy community? Does this seem right or are there other factors you would prioritize? “I think these are correct if not necessarily in the right order. These are the basic ones of any community.”

Survey Q13. What are the most important health problems in the community? Does this seem right or are there other health problems you would prioritize? “I was surprised to see how many people said mental health was a problem.” Others agreed that they were surprised as well and wondered if this was skewed because of age. Another group member pointed out that this has

been a trend. It was mentioned that this shows progression because mental health would not have been mentioned due to stigma 20 years ago. Other problems we might want to include are affordable housing and the availability of assisted living.

Survey Q14. What is needed to improve the health of your family and neighbors? Are there things other than what is identified that you would add? "I was surprised to see that wellness services were ranked so high in addressing the problems." "I see mental health services, but a lot of people don't realize that we have Blue Valley in Auburn. Has there been any thought about having a separate building?" Discussion in the group continued about how to raise awareness about services, e.g., Blue Valley, pediatric mental health, etc. One group member mentioned "some people are more reactive than proactive about their mental health, which contributes to the awareness problem." "I'd like more information on wellness services"

What other strengths would you identify?

- Great healthcare coverage with the potential exception of mental health
- Availability of LTC
- Good working relationships/integration of health services

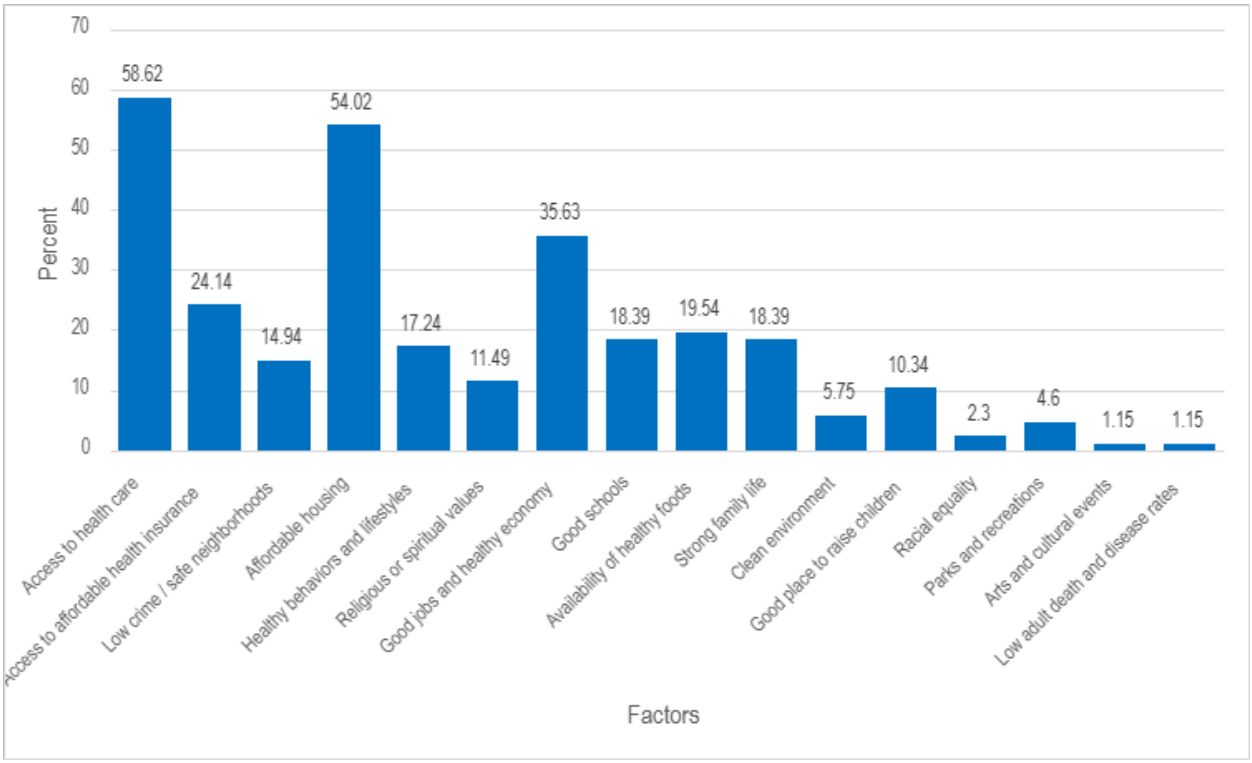
Opportunities?

- Availability/Awareness of services/Telehealth for mental health and substance abuse
- Availability of EMS
- Collaboration between wellness centers/health dept/hospital
- (The group discussed, combined areas, and just kept all three as priorities.)

Otoe County (CHI St. Mary's) (16 Participants)

The data packets were provided and reviewed by the focus group members. Data packets included results for Survey Questions Q12-14:

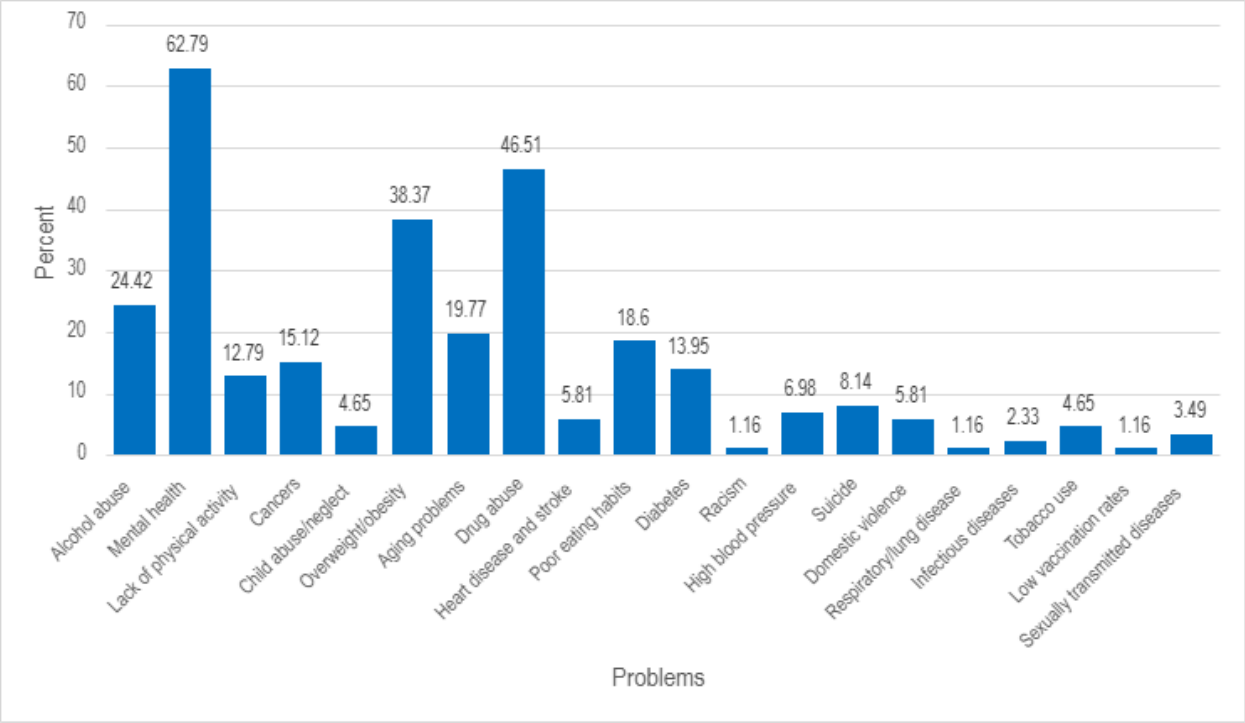
Q12: In the following list, what do you think are the three (3) most important factors for a "Healthy Community" (Those factors which most improve the quality of life in a community)



Top 5 Responses:

- Access to health care
- Affordable housing
- Good jobs and a healthy economy
- Access to affordable health insurance
- Availability of healthy foods

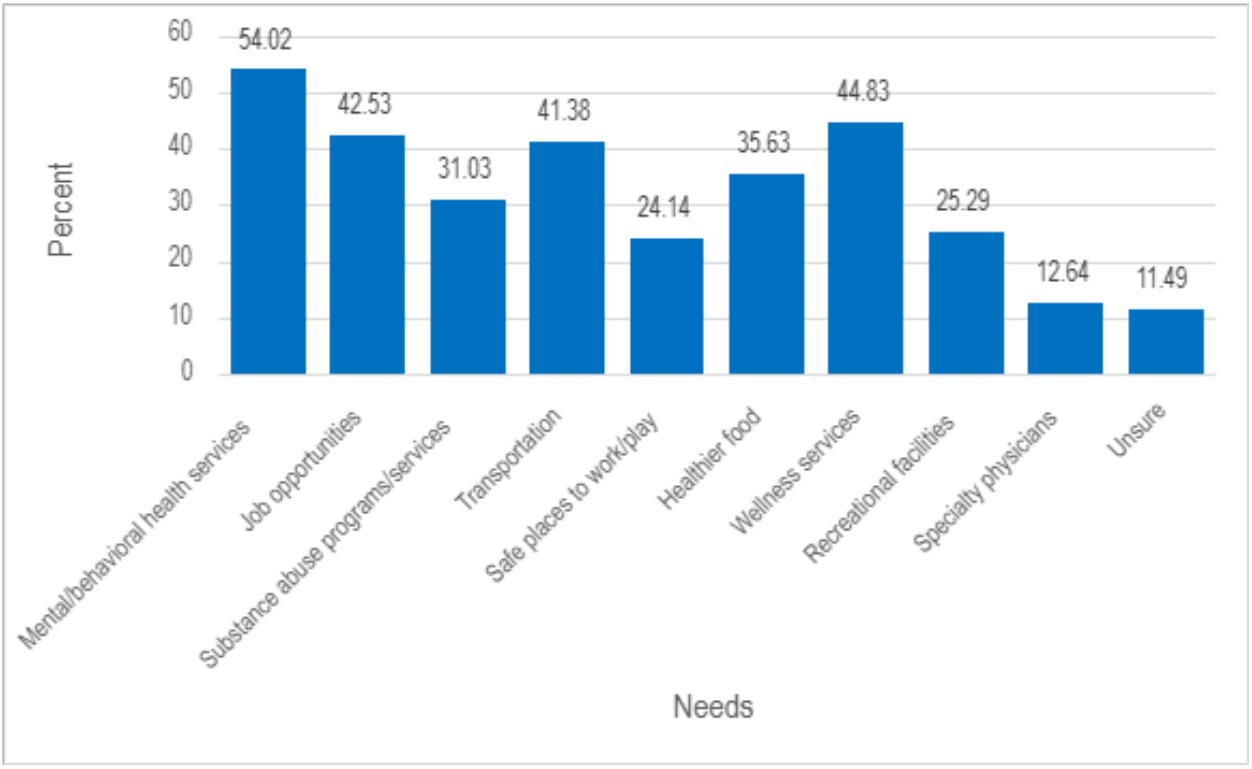
Q13: In the following list, what do you think are the three (3) most important "Health Problems" in your community? (Those factors which have the greatest impact on overall community health)



Top 5 Responses:

- Mental health
- Drug abuse
- Overweight/obesity
- Alcohol abuse
- Aging problems (e.g., arthritis, hearing/vision loss, etc.)

Q14: What is needed to improve the health of your family and neighbors? (Select all that apply)



Top 3 Responses:

- Mental/behavioral health services
- Wellness services
- Job opportunities

The results from these three questions were then discussed in the focus group.

Survey Q12. What are the most important factors for a healthy community? Does this seem right or are there other factors you would prioritize? The group did not mention anything in reply – they moved ahead to opportunities.

Survey Q13. What are the most important health problems in the community? Does this seem right or are there other health problems you would prioritize? "I have noticed there is an increase in incidence of asthma and there is an increase in e-cigarettes. Are these related?" "Alcohol use is also up. Every gas station is a mini casino. We need to limit liquor license applications. I personally feel like the church needs to lead in this area. But the door is already open, so I guess at this point it is education." "There is a lack of dental providers that accept Medicaid." "Gambling is a problem." "At one time, Otoe county had the highest percent of gambling in the

state." "When COVID shut us down, it showed the lack of internet access, and this is a problem for kids trying to get their homework done."

Survey Q14. What is needed to improve the health of your family and neighbors? Are there things other than what is identified that you would add? "Transportation is a big deal in our community. For them to get to here (hospital) and for them to get to grocery stores, get children to school, get to work is a challenge. I just heard this week that patients could not get to the hospital." "There is a group called 'small beginnings' that is trying to help with transportation at least to and from the hospital. I just met with them last week. Sometimes in Nebraska City, police or EMS will come to take people home." "The hospital also sometimes pays for transportation for patients." "Another example is blue rivers – they transport to Lincoln and Omaha – but the hours are a problem." The group went on to talk about access to healthy food. There is a community kitchen that is available to the community.

What other strengths would you identify?

- Excellent hospitals
- Access to specialists locally
- Good collaboration across healthcare entities, across EMS/Police/Fire, etc.
- Engaged community – e.g., volunteering
- People who truly care

Opportunities?

- Transportation - 13
- Access to healthy foods/using the community kitchen to make things ahead - 5
- Education on substance use - 9
- Dentists that accept Medicaid - 2
- The high percentage of gambling - 0
- Internet access - 0
- Home care/respite care - 0
- Long term care - 0
- Activate religious community as a resource - 7
- Child and adult care - 5
- Housing - 1
- Immunization clinic – 1

Top priorities identified

1. Transportation
2. Education on substance use
3. Activate religious community as a resource
4. Access to healthy foods

5. Child and adult care

Otoe County (Syracuse) (17 participants)

The data packets were provided and reviewed by the focus group members. Data packets included results for Survey Questions Q12-14. The data for Otoe County is shared in the prior section.

The results from these three questions were then discussed in the focus group.

Survey Q12. What are the most important factors for a healthy community? Does this seem right or are there other factors you would prioritize? "Top 4 were pretty expected for me. I was surprised that 5 (access to healthy foods) was listed." No other comments were offered.

Survey Q13. What are the most important health problems in the community? Does this seem right or are there other health problems you would prioritize? "I think there is a direct relationship between overweight, substance abuse and mental health." "E-cigarette use has gone up significantly. I was disappointed to see a vape shop come into town. Is there an education piece/health literacy need?" No other health problems were mentioned by the group.

Survey Q14. What is needed to improve the health of your family and neighbors? Are there things other than what is identified that you would add? "If you look at mental health providers, it is 850 to 1. Maybe we could up that to 2 or 3. That person will have too much to do." "We have one mental health provider at the hospital." "Is police/EMS availability a problem?" "My personal experience is that there is a problem with an individual in the community who they will no longer pick up because they don't have mental health providers available." "I used to work at Boys Town. They don't listen to healthcare providers, teachers, police, etc., but they will listen to other kids. We need to find people who have gone through the same things to serve as resources." "Transportation. The van is not for them. We could add another driver to this area. We are waiting on buses. We have ordered them but can't get them. We need transportation that is wheelchair accessible. Our buses are very busy in Nebraska City." "Day care and after school programming for children." "The baby boomers are aging. They want to stay in their homes but that is not always possible. Then they show up in the E.D. because they can't take care of them anymore and they don't have a plan." "We have good LTC availability, but the regulatory environment is difficult. For example, the new R.N. rule." "Staffing is an issue for us in LTC and assisted living." "Staffing is a problem everywhere. We don't have enough staffing in home health." "Volunteering will die. We have an issue relying on volunteering for EMS. Soon, we will not have paramedic level available because no one wants to go through that training for a volunteer position." "We had a mental health patient in the hospital over the weekend, first had a problem with finding a facility that would accept them, and then when we did, didn't have any

EMS available to transport them."

What other strengths would you identify?

- People indicate they want to live in the community
- LTC availability – Good Sam
- Good chief for EMS
- People care
- Strong hospital, strong health system, collaborative
- School system
- Collaboration between hospital and schools – e.g., pathfinders – getting students interested in healthcare
- You can get a lot of healthcare here for the size of the community
- Good community trust

Opportunities?

- Transportation – specifically wheelchair accessible - 4
- Health literacy (e.g., vaping, mental health, social media) - 10
- Day care/ after school programs - 11
- More mental health providers - 10
- Home health, LTC, assisted living staffing - 1
- Staffing issue in EMS/reliance on volunteers – 7 (the group decided to combine the staffing categories into "health care staffing" in general after further discussion)

Top Priorities Identified

1. Day Care/after school programs
2. More mental health providers
3. Health literacy
4. Healthcare staffing
5. Transportation

The group discussed whether to also add transportation at length and decided to include it.

Description of Secondary Data Sources

Secondary Data Analysis

The purpose of the secondary data analysis is to identify the health-related factors that influence both the length of life and the quality of life. This analysis involves examining data on social and economic factors (e.g., education, employment, and income levels), access to clinical care services, and positive or negative changes in health behaviors (e.g., diet and exercise, alcohol and drug use, cancer screenings). The goal is to present a picture of the health and quality of life for people living in the SEDHD region and the impact on health outcomes.

Table 3. Frequently Cited Data Sources

Behavioral Risk Factor Surveillance System (BRFSS)	The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect data from all 50 states, making it the largest continuously conducted health survey system in the world. Each year, more than 400,000 U.S. adult residents are surveyed regarding their health-related risk behaviors, chronic health conditions, and usage of preventive services. The survey is conducted by the Centers for Disease Control and Prevention. The most recent BRFSS data consists of about 250 Nebraska residents in the SEDHD region.
County Health Rankings & Roadmaps (CHR&R)	County Health Rankings & Roadmaps (CHR&R) provide local-level data that depict how people from one county to another rank on a range of factors that determine overall health. These factors include measures such as unemployment, education, community safety, diet and exercise, violent crimes, premature deaths, and ratio of population to healthcare providers.
Nebraska Incident-Based Reporting System	Annual counts on arrests (adult and juvenile) by type submitted voluntarily by local and state-level police departments and compiled and reported by the Nebraska Crime Commission
Nebraska Department of Health and Human Services (DHHS)	A wide array of data on mortality rates, health professional shortage areas, and other areas. Note that all mortality data are age-adjusted.
Nebraska Risk and Protective Factor	The NRPFSS is a substance abuse-related survey of Nebraska students in grades 8, 10, and 12 conducted by the Nebraska

Table 3. Frequently Cited Data Sources	
Student Survey (NRPFSS)	Department of Education and the Nebraska Department of Health and Human Services. NRPFSS is the only school-based public health survey that generates local and regional estimates for topics related to alcohol, tobacco, delinquent behaviors, bullying, and risk and protective measures that predispose youth toward or protect them against problem behaviors like delinquency, school dropout, violence, and teen pregnancy
U.S. Census American Community Survey (ACS)	Every year, the U.S. Census Bureau contacts over 3.5 million households across the county to participate in the ACS. The ACS covers a broad range of topics about social, economic, housing, and demographic characteristics to provide annual estimates.
U.S. Department of Health and Human Services	Provided age-adjusted mortality rates for various causes of death in the counties comprising the Southeast District as well as information relevant to health professional shortage areas across Nebraska.
Nebraska Risk and Protective Factor Student Survey (NRPFSS)	The NRPFSS is a substance abuse-related survey of Nebraska students in grades 8, 10, and 12 conducted by the Nebraska Department of Education and the Nebraska Department of Health and Human Services. NRPFSS is the only school-based public health survey that generates local and regional estimates for topics related to alcohol, tobacco, delinquent behaviors, bullying, and risk and protective measures that predispose youth toward or protect them against problem behaviors like delinquency, school dropout, violence, and teen pregnancy
U.S. Census American Community Survey (ACS)	Every year, the U.S. Census Bureau contacts over 3.5 million households across the county to participate in the ACS. The ACS covers a broad range of topics about social, economic, housing, and demographic characteristics to provide annual estimates.
U.S. Department of Health and Human Services	Provided age-adjusted mortality rates for various causes of death in the counties comprising the Southeast District as well as information relevant to health professional shortage areas across Nebraska.

DEMOGRAPHICS

This section describes the overall demographics for the five counties that represent the SEDHD. Demographics are statistics that describe populations and their characteristics, and they can help provide a better understanding of the health needs in communities and serve as a guide in planning future investments and services.

Total Population

Table 4 and Table 5 present total population statistics for the five counties within the SEDHD. Table 4 summarizes total population and population density; the total population is 38,691 from the 2020 census. Table 5 depicts the change in population; according to the 2020 census the population decreased by 1.7% – from 2010 to 2020.

Table 4. Total Population and Population Density

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
United States	331,449,281	3,532,068.58	93.8
Nebraska	1,961,504	76,823.79	25.5
Southeast	38,691	2,381.97	16.2
Johnson	5,290	376.05	14.1
Nemaha	7,074	407.38	17.4
Otoe	15,912	615.63	25.8
Pawnee	2,544	431.07	5.9
Richardson	7,871	551.84	14.3

Source: U.S. Census Bureau, 2021 – Nebraska 2020 Census

Table 5. Change in Total Population				
	Total Population, 2010 Census	**Total Population, 2020 Census**	**Total Population Change, 2010-2020**	**Percent Population Change, 2000-2010**
United States	307,745,539	331,449,281	23,703,742	7.7%
Nebraska	1,826,341	1,961,504	135,163	7.4%
Southeast	39,341	38,691	-650	-1.7%
Johnson	5,217	5,290	73	1.4%
Nemaha	7,248	7,074	-174	-2.4%
Otoe	15,740	15,912	172	1.1%
Pawnee	2,773	2,544	-229	-8.3%
Richardson	8,363	7,871	-492	-5.9%

Source: U.S. Census Bureau, 2021 – Nebraska 2020 Census

Population Characteristics

The following section presents demographic data for the SEDHD. Understanding population characteristics provides crucial insights into the district's composition and needs, which allows better-informed decision-making in areas like healthcare, community development, government policy, and business strategy.

Table 6 and Table 7 depict age demographics of the Southeast District and counties. Overall, the Southeast District has a lower percentage of the population under the age of 18 (22.5%) and a higher percentage of the population aged 65+ (21.4%) compared to the Nebraska and the US populations. Table 8 presents the population by gender. Overall, the counties are split evenly between male and female, with Johnson County's statistics skewing toward a higher male population.

Table 6. Under 18 Population			
Report Area	**Total Population**	**Population Age 0-17**	**Percent Population Age 0-17**
United States	331,449,281	73,106,000	22.1%
Nebraska	1,961,504	485,377	24.7%
Southeast	38,691	8,707	22.5%
Johnson	5,290	964	18.2%
Nemaha	7,074	1,632	23.1%
Otoe	15,912	3,852	24.2%
Pawnee	2,544	559	22.0%
Richardson	7,871	1,700	21.6%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 7. Total Population by Age Groups, Percent								
Report Area	**Age 0-4**	**Age 5-14**	**Age 15-24**	**Age 25-34**	**Age 35-44**	**Age 45-54**	**Age 55-64**	**Age 65+**
United States	5.5%	12.3%	13.3%	13.6%	13.2%	12.1%	12.6%	17.3%
Nebraska	6.2%	13.7%	14.1%	12.8%	13.4%	11.0%	11.9%	17.0%
Southeast	5.6%	12.8%	12.3%	10.7%	12.1%	11.0%	14.3%	21.4%
Johnson	4.5%	11.1%	12.1%	13.4%	14.5%	12.3%	13.4%	18.7%
Nemaha	5.8%	12.1%	16.5%	10.8%	11.8%	9.9%	12.9%	20.3%
Otoe	5.7%	14.2%	11.4%	10.3%	12.4%	11.6%	14.0%	20.3%
Pawnee	7.0%	13.2%	9.6%	8.5%	11.0%	8.1%	14.3%	28.4%
Richardson	5.3%	11.4%	11.1%	10.0%	10.5%	10.8%	16.8%	24.2%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 8 describes the total population by gender for each county; Johnson County has a larger percentage of males (61%) as compared to females (39%).

Table 8. Total Population by Gender		
Report Area	**Male**	**Female**
United States	49.6%	50.4%
Nebraska	50.2%	49.8%
Johnson	60.6%	39.4%
Nemaha	51.2%	48.8%
Otoe	51.5%	48.5%
Pawnee	48.6%	51.4%
Richardson	50.7%	49.3%

Table 9 and Table 10 show the Southeast District's race and ethnicity statistics. Overall, the population is primarily white (89.4%) and non-Hispanic (94%) with percentages far exceeding both Nebraska and US race and ethnicity percentages. However, Johnson and Otoe counties have larger Hispanic populations compared to the rest of the district, 10.3% and 8.5%, respectively.

Table 9. Population by Race

	White	Black	Asian	Native American / Alaska Native	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Races
United States	60.9%	12.2%	5.9%	1.0%	0.2%	7.3%	12.5%
Nebraska	78.4%	4.7%	2.5%	1.0%	0.1%	4.4%	8.9%
Southeast	89.4%	1.6%	0.2%	0.9%	0.0%	2.7%	5.3%
Johnson	82.2%	5.5%	0.8%	1.5%	0.0%	5.1%	4.9%
Nemaha	91.6%	1.6%	0.4%	0.5%	0.0%	1.0%	5.0%
Otoe	88.5%	0.7%	0.1%	0.3%	0.0%	4.2%	6.2%
Pawnee	95.2%	0.2%	0.0%	0.0%	0.0%	0.4%	4.2%
Richardson	92.1%	1.1%	0.1%	2.3%	0.0%	0.1%	4.4%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 10. Population by Ethnicity					
Report Area	**Total Population**	**Hispanic or Latino Population**	**Percent Population Hispanic or Latino**	**Non-Hispanic Population**	**Percent Population Non-Hispanic**
United States	333,287,562	63,553,639	19.1%	269,733,923	80.9%
Nebraska	1,967,923	241,898	12.3%	1,726,025	87.7%
Southeast	38,711	2,336	6.0%	36,375	94.0%
Johnson	5,294	545	10.3%	4,749	89.7%
Nemaha	7,019	214	3.0%	6,805	97.0%
Otoe	15,995	1,355	8.5%	14,640	91.5%
Pawnee	2,553	53	2.1%	2,500	97.9%
Richardson	7,850	169	2.2%	7,681	97.8%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Languages Spoken within the SEDHD

Based on a report from the Office of Health Disparities and Health Equity in DHHS, there are many languages that are spoken in Nebraska, including Spanish, Vietnamese, and Arabic. The languages spoken in each of the five counties that are part of the SEDHD are summarized below.

- **Johnson County** – Spanish (378), Korean (5), Chinese (12), Tagalog (2), Other Asian Languages (49), and Other Languages (1); It was estimated that 166 people speak English "less than very well".
- **Nemaha County** – Spanish (106), French (8), Russian (18), Indo-European Languages (2), Korean (3) Chinese (2), and Tagalog (44); It was estimated that 54 people speak English "less than very well".
- **Otoe County** – Spanish (810), French (2), German (2), Russian (2), Indo-European Languages (20), Korean (33), Chinese (7), Arabic (6), and Other Languages (33); It was estimated that 465 people speak English "less than very well".
- **Pawnee County** – Spanish (30), German (164); Russian (4), Indo-European Languages (4), and Other Languages (9); It was estimated that 46 people speak English "less than very well".

- **Richardson County** – Spanish (34), French (3), German (5), Russian (11), Indo-European Languages (15), Korean (12), Other Languages (2); It was estimated that 28 people speak English "less than very well".

Veteran Population Characteristics

Table 11 presents demographic data on the veteran population within the Southeast District.

Table 11. Veteran Population Demographics by County					
	Johnson	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
Period of Service					
Gulf War (9/2001 or later) veterans	33.9%	18.3%	22.0%	15.4%	11.3%
Gulf War (8/1990 to 8/2001) veterans	18.2%	11.3%	17.0%	6.0%	14.0%
Vietnam era veterans	24.3%	28.2%	38.4%	50.0%	32.1%
Korean War veterans	6.5%	15.7%	5.4%	21.4%	18.0%
World War II veterans	2.7%	0.9%	1.2%	1.6%	0.8%
Sex					
Male	94.2%	84.0%	89.3%	93.4%	95.5%
Female	5.8%	16.0%	10.7%	6.6%	4.5%
Age					
18 to 34 years	15.8%	1.2%	12.4%	5.5%	1.3%
35 to 54 years	19.2%	14.6%	18.5%	16.5%	20.0%
55 to 64 years	15.4%	27.1%	25.3%	15.4%	20.2%
65 to 74 years	16.8%	25.5%	21.3%	34.6%	11.5%
75 years and over	32.9%	31.7%	22.6%	28.0%	46.9%
Race And Hispanic or Latino Original					
White alone	90.8%	96.5%	96.3%	97.8%	94.7%
Black or African American alone	3.1%	1.9%	0.0%	0.0%	2.8%
Asian alone	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian and					

Table 11. Veteran Population Demographics by County					
	Johnson	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
Other Pacific Islander alone	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone	0.0%	0.0%	0.0%	0.0%	0.0%
Two or more races	6.2%	1.6%	3.7%	2.2%	2.5%
Hispanic or Latino (of any race)	2.1%	1.6%	0.0%	0.0%	2.6%
White alone, not Hispanic or Latino	88.7%	94.9%	96.3%	97.8%	92.1%
Educational Attainment					
Less than high school graduate	4.6%	1.6%	0.3%	3.3%	5.5%
High school graduate (includes equivalency)	47.0%	50.6%	38.1%	59.9%	47.4%
Some college or associate's degree	19.2%	29.7%	43.6%	24.2%	28.9%
Bachelor's degree or higher	29.2%	18.1%	18.0%	12.6%	18.1%
Employment Status					
Labor force participation rate	63.3%	77.3%	93.4%	55.9%	78.2%
Unemployment rate	0.0%	8.4%	0.0%	0.0%	0.0%
Poverty Status in The Past 12 Months					
Income in the past 12 months below poverty level	2.4%	11.8%	12.0%	8.0%	14.1%
Disability Status					
With any disability	38.0%	41.5%	34.3%	42.5%	35.7%
Without a disability	62.0%	58.5%	65.7%	57.5%	64.3%
Service-Connected Disability (Estimate)					
Has a service-connected	60	88	335	79	201

Table 11. Veteran Population Demographics by County					
	Johnson	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
disability rating:					
0 percent	0	0	1	0	0
10 or 20 percent	38	5	149	33	90
30 or 40 percent	2	36	40	27	35
50 or 60 percent	14	10	33	6	18
70 percent or higher	6	10	93	9	38
Rating not reported	0	27	19	4	20

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Social Factors

This section presents demographic data on social factors for the counties in the SEDHD. Social factors are important because they provide crucial insights into the broader social context of a given population. These factors often explain behaviors, attitudes, disparities, and access to care opportunities.

Table 12, Table 13, and Table 14 present data on household structures within the SEDHD. Households primarily comprise married couples. In single-parent households, the householder is primarily female across all counties. Johnson, Otoe, and Pawnee have higher percentages of single-parent households than both the Southeast District and the state while Nemaha and Richardson counties are both below.

Table 12. Number of Married Couple Family Households with Children Under 18

Southeast	Johnson	Nemaha	Otoe	Pawnee	Richardson
2,690	243	446	1,235	178	588

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 13. Composition of Single Parent Households with Children Under 18

	Southeast	Johnson	Nemaha	Otoe	Pawnee	Richardson
Male householder, no spouse present, family household	251	52	5	105	23	66
Female householder, no spouse present, family household	627	81	95	280	40	131

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 14. Single Parent Family Households with Children Under 18 as a Percent of Total Family Households with Children Under 18						
Nebraska	**Southeast**	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
21.2%	15.47%	31.8%	14.4%	22.4%	24.1%	7.6%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 15 and Table 16 present educational attainment levels for the Southeast District and each county. Approximately one third (35.4%) of residents in the Southeast District have a high school diploma or equivalent, which is greater than the state percentage (25.1%). Around one sixth (16.6%) of the population in the Southeast District has a bachelor's degree or higher, which is lower than the state percentage (22.6%). High school graduation rates remain strong across the Southeast District where most of the rates across all five counties mostly exceed the state's graduation rates.

Table 15. Highest Level of Educational Attainment – Individuals over 25, 2024 (5-year estimates)							
	Nebraska	**Southeast**	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
Less than 9th grade	3.3%	3.2%	3.8%	3.2%	3.0%	7.9%	1.7%
9th to 12th grade, no diploma	3.9%	5.7%	6.8%	6.6%	4.1%	6.2%	7.0%
High school graduate (or GED/ equivalent)	25.1%	35.4%	41.6%	29.4%	32.3%	40.1%	40.6%
Some college, no degree	21.6%	20.7%	18.6%	20.6%	22.3%	16.3%	20.3%
Associate degree	11.5%	11.1%	10.3%	9.8%	12.7%	9.1%	9.9%
Bachelor's degree	22.6%	16.6%	12.0%	21.0%	17.7%	12.7%	15.3%
Graduate or professional degree	12.1%	7.5%	7.0%	9.5%	8.0%	7.7%	5.1%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 16. Public High School Graduation Rates			
	2019	2020	2021
Nebraska	89%	89%	87%
Johnson	86%	90%	-
Nemaha	92%	94%	92%
Otoe	92%	88%	87%
Pawnee	90%	100%	-
Richardson	89%	93%	92%

Source: County Health Rankings, 2024

Table 17, Table 18, and Table 19 present crime statistics for the Southeast District and the counties. In 2023, there were 52 juvenile arrests and 770 adult arrests in the Southeast District. Richardson County had the most juvenile arrests (30) in 2023. However, Otoe County had the largest number of arrests during the 2019-2023 five-year period. Richardson and Otoe counties had the highest numbers of adult arrests in 2023 with 357 and 293, respectively. Larceny, simple assault, drug abuse, and driving under the influence remain the most prevalent arrest types year over year. However, overall arrests for both juvenile and adult populations in 2023 show a decline from previous years.

Table 17. Total Juvenile Arrest by County					
	2019	2020	2021	2022	2023
Johnson	3	11	1	4	-
Pawnee	-	4	-	1	2
Richardson	13	15	17	26	30
Nemaha	19	8	7	3	3
Otoe	35	32	70	32	17
Southeast	70	70	95	66	52

Source: Nebraska Crime Commission, 2024

Table 18. Total Adult Arrests by County					
	2019	2020	2021	2022	2023
Johnson	78	116	50	61	12
Pawnee	7	36	5	8	13
Richardson	290	284	369	413	357
Nemaha	179	184	138	93	95
Otoe	404	349	634	480	293
Southeast	958	969	1,196	1,055	770

Source: Nebraska Crime Commission, 2024

Table 19. Total Arrests in the Southeast District by Type					
	2019	2020	2021	2022	2023
Criminal Homicide	0	1	0	1	0
Forcible Rape	6	3	3	1	2
Robbery	1	3	0	1	0
Aggravated Assault	36	26	26	20	14
Burglary	15	10	9	7	4
Larceny	73	56	35	44	72
Motor Vehicle Theft	5	6	3	4	0
Simple Assault	130	97	120	105	69
Arson	2	1	0	0	0
Forgery/Counterfeit	1	2	9	2	4
Fraud	11	6	12	14	1
Embezzlement	1	0	0	1	0
Stolen Property	5	11	3	2	5
Vandalism	14	15	22	21	16
Weapons	27	17	28	18	18
Sex Offense	1	1	3	1	0
Drug Abuse	176	246	329	241	177
Offense against kids	3	8	5	12	9
Driving Under the Influence	102	103	144	161	113
Liquor Laws	65	53	40	37	35
Disorderly Conduct	29	38	23	13	19
All other Offenses	318	333	469	415	262
Curfew (Juvenile)	2	1	6	0	2
Runaway (Juvenile)	0	0	0	0	0

Source: Nebraska Crime Commission, 2024

Economic Factors

Economic factors are important demographics to understand as they directly influence the size and composition of a population, impacting key aspects of the economy in each community. These factors often influence the ability of individuals and families to access various types of health care services and contribute to the general well-being of a population.

Table 20, Table 21, and Table 22 present income, unemployment, and poverty economic characteristics for the Southeast District. Overall, both median household income and per capita income are lower across all five counties compared to Nebraska and the US. Otoe County is the exception with a median household income of $73,031 compared to Nebraska at $69,597. Nemaha County has the highest unemployment rate at 6.4% while Johnson County is the only county that has a lower unemployment rate (1.4%) than the state (2.3%). Pawnee and Nemaha Counties have the highest percentage of residents in poverty within the Southeast District, 13.3% and 15.3%, respectively. Both exceed the state's poverty rate (11.2%) and the US's poverty rate (12.6%). Likewise, Otoe (14.3%), Pawnee (16.5%), and Nemaha (15.7%) Counties have the highest percentage of residents under 18 years of age in poverty, exceeding the state (13.8%).

Table 20. Median and Per Capita Income, 2024 (5-year estimates)

	United States	Nebraska	Johnson	Nemaha	Otoe	Pawnee	Richardson
Median household income	$74,755	$69,597	$64,352	$57,196	$73,031	$55,833	$50,321
Per capita income	$41,804	$38,997	$28,046	$36,367	$36,817	$29,091	$32,336

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 21. Unemployment Rate, 2024 (5-year estimates)

United States	Nebraska	Johnson	Nemaha	Otoe	Pawnee	Richardson
4.3%	2.3%	1.4%	6.4%	3.2%	2.4%	4.7%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 22. Poverty Rate, 2024 (5-year estimates)							
	United States	**Nebraska**	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
All people	12.6%	11.2%	6.1%	15.3%	11.4%	13.3%	10.9%
Under 18 years	16.3%	13.8%	6.4%	15.7%	14.3%	16.5%	13.7%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

Table 23 and Table 24 present data on economic factors related to children within the Southeast District. Overall, childcare costs for a household with two children as a percentage or median household income is comparable to the state. The percentage of children enrolled in Medicaid and CHIP programs has stayed consistent year after year for each county. Otoe County consistently has the lowest percentage (35.98%-39.91%). All Counties have seen a gradual rise in enrollment from 2020 to 2023.

The percentage of households participating in the Supplemental Nutrition Assistance Program (SNAP) varies across the counties. Johnson, Otoe, and Pawnee Counties have lower percentages than the state (8.5%) while Nemaha and Richardson Counties have slightly higher percentages (Table 25). This table also shows the percentage of individuals in Nebraska and the five-county area with food insecurity between 2018 and 2022. During this period, there was generally an upward trend for both the state and the five counties. In 2022, the percentage in the state was 13.6%. Both Nemaha and Pawnee Counties had significantly higher percentages at 15.7% and 15.0%, respectively.

Table 23. Average Childcare Costs for a Household with Two Children as a Percent of Median Household Income, 2024 (Estimates 2022 & 2023)					
Nebraska	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
28%	29%	28%	25%	31%	31%

Source: County Health Rankings, 2024 – Estimates 2022 & 2023

Table 24. Percent of Children Enrolled in Medicaid and CHIP, 2020-2023 *						
	Nebraska	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
2020	--	41.79%	41.17%%	35.98%	48.60%	48.12%
2021	--	40.87%	42.58%	38.06%	50.69%	49.88%
2022	--	41.79%	43.50%	38.95%	48.92%	51.39%
2023	--	40.10%	44.73%	39.91%	50.41%	50.60%

*Note: The 2023 percentages are estimated from the 2022 percentages.
Source: Nebraska Department of Health and Human Services, personal communication, December 2024.

Table 25: Food Insecurity Challenges in Nebraska					
Percentage of People Participating in the Supplemental Nutrition Assistance Program 2018 -2022					
Nebraska	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
8.5%	8.4%	10.5%	5.9%	6.6%	9.0%

Percentage of Food Insecurity Among Individuals, 2018-2022						
	Nebraska	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
2018	12.3%	12.3%	12.4%%	12.2%	12.7%	13.1%
2019	12.3%	12.3%	12.4%%	12.2%	12.7%	13.1%
2020	12.3%	12.3%	12.4%%	12.2%	12.7%	13.1%
2021	12.3%	12.3%	12.4%%	12.2%	12.7%	13.1%
2022	12.3%	12.3%	12.4%%	12.2%	12.7%	13.1%

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018 – 2022 American Community Survey 5-year estimates and Feeding America – Estimates, 2018-2022

HEALTH OUTCOMES

Health outcomes refer to the health consequences resulting from the treatment of a health condition or access to the healthcare delivery system. Through a community lens, health outcomes inform us how long people live on average within a community setting, and the amount of physical and mental experiences people have while living in that community. Health outcomes are determined by several factors, such as employment, health insurance status, affordable housing, and access to quality medical services. By comparing health outcomes across communities, we can gain a better understanding of inequities and what health factors interact to influence these differences in health outcomes.

Length of Life

Length of life is a commonly used metric when determining overall health outcomes. Length of life is the measure of time between birth and death. We use this metric to determine how long people live and what may have led to early deaths. By investigating length of life among communities, we can better understand differences in overall health outcomes and then work to change how long people live by improving the community-level factors that influence health outcomes.

Table 26 shows the average life expectancy in the Southeast District. During the period 2019-2021, average life expectancy was lower in four of the five counties in the Southeast District as compared to the Nebraska rate of 78.4 years. The lowest rate of life expectancy was in Nemaha County (75.9 years and the highest one was in Otoe County (79.2 years).

Table 27 shows the leading causes of death during the period 2019-2021. The leading cause of death in Nebraska and each of the five counties in Southeast Nebraska is heart disease followed by cancer.as the second leading cause of death. Chronic lower respiratory disease is the third leading cause of death in Nebraska and three of the five counties. The fourth and fifth leading causes in Nebraska are accidents and adverse events followed by cerebrovascular disease. These causes are reflective in the counties although there is some variation. In three of the five counties in the Southeast District, hypertension and hypertensive renal disease is the fourth leading cause of death in Otoe, Pawnee, and Richardson Counties. Many of the deaths are preventable and related to personal lifestyle factors (e.g., eating more nutritious foods and regular exercise).

Table 26. Life Expectancy by County, 2019-2021

	United States	Nebraska	Johnson	Nemaha	Otoe	Pawnee	Richardson
Life Expectancy (years)	77.6	78.4	77.6	75.9	79.2	76.2	77.8

Source: County Health Rankings, 2024 – Estimates 2019-2021

Table 27. Leading Causes of Death for Persons < Age 75, 2019-2021					
Nebraska	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
Cancer	Cancer	Cancer	Cancer	Cancer	Cancer
Chronic Lower Respiratory Disease	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Disease	Cerebrovascular Disease	Accidents & Adverse Events	Chronic Lower Respiratory Diseases
Accidents & Adverse Events	Cerebrovascular Disease	Accidents & Adverse Events	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Cerebrovascular Disease
Cerebrovascular Disease	Accidents & Adverse Events	Alzheimer's Disease	Hypertension & Hypertensive Renal Disease	Hypertension & Hypertensive Renal Disease	Hypertension & Hypertensive Renal Disease
Alzheimer's Disease	Suicide & Self-Inflicted Injury	Cerebrovascular Disease	Alzheimer's Disease	Cerebrovascular Disease	Diabetes Mellitus
Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus	Accidents & Adverse Events	Suicide & Self-Inflicted Injury	Accidents & Adverse Events
Suicide & Self-Inflicted Injury	Alzheimer's Disease	Hypertension & Hypertensive Renal Disease	Diabetes Mellitus	Diabetes Mellitus	Pneumonitis due to Solids & Liquids
Chronic Liver Disease & Cirrhosis	Septicemia	Septicemia	Parkinson's Disease	Nephritis & Nephrosis	Pneumonia
Pneumonia	Pneumonia	Chronic Liver Disease & Cirrhosis	Chronic Liver Disease & Cirrhosis	Parkinson's Disease	Chronic Liver Disease & Cirrhosis

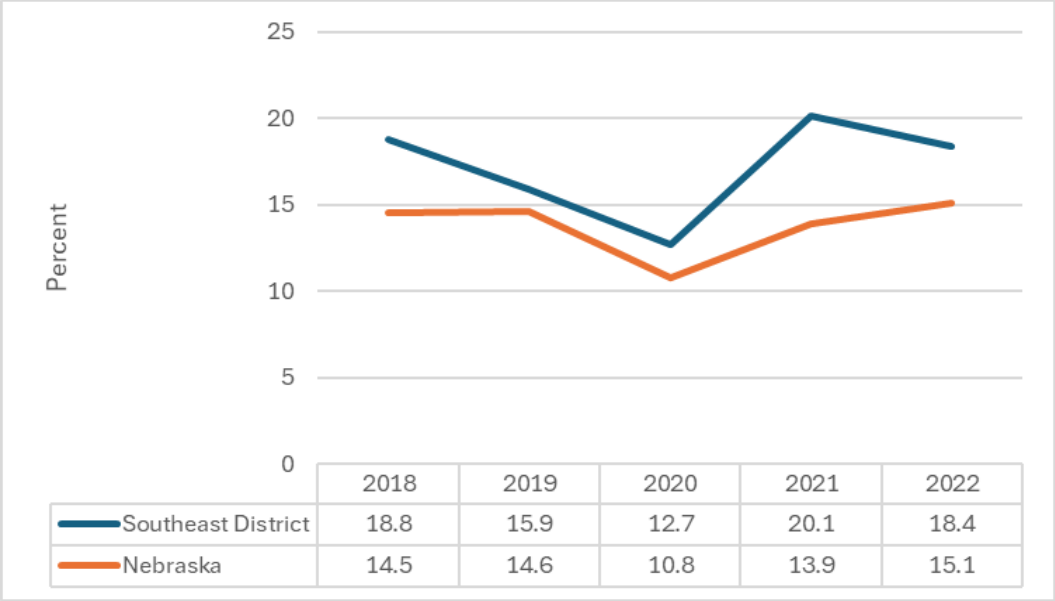
Quality of Life

Quality of life represents the overall well-being of a community and emphasizes the importance of physical, mental, social, and emotional health throughout life. Using quality of life as an indicator of health outcomes can help communities understand how their residents perceive their health and whether they are satisfied with their health status. It will also help them identify longitudinal patterns and inequities that may exist between groups of people and aid in identifying risk factors and policies to address these risks.

Overall Health

Figures 2 shows the percentage of adults reporting their general health as fair or poor. In comparison with the state average, the Southeast District had a higher percentage of people who indicated they had fair or poor general health. The same pattern was observed when the percentage of adults aged 18 and over reported that their physical health was not good on 14 or more of the past 30 days (Figure 3). However, the opposite trend was generally observed when people were surveyed about their mental health. During the period 2018-2022, the percentage of people in the Southeast District as compared to the state had a lower percentage of people reporting that their mental health was not good on 14 or more days of the past 30 days (Figure 4). The exception to this trend was in 2022 when it was almost 3% above the state rate. This indicator should be carefully observed to see if it was a one-year aberration or a new trend moving in a negative direction.

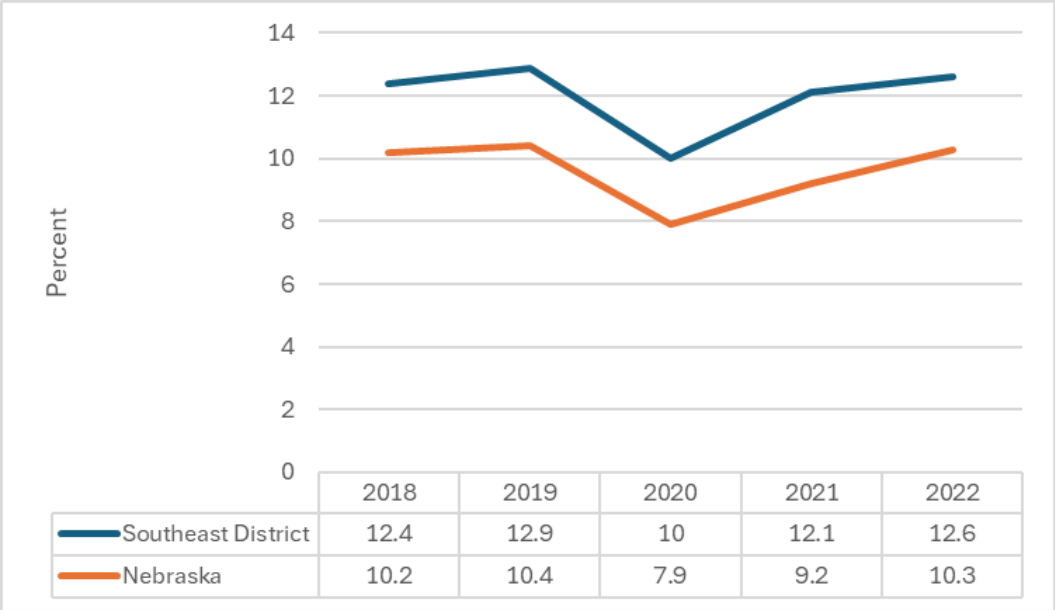
Figure 2. Percent of Adults Aged 18 and Over Reporting General Health as Fair or Poor



	2018	2019	2020	2021	2022
Southeast District	18.8	15.9	12.7	20.1	18.4
Nebraska	14.5	14.6	10.8	13.9	15.1

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022
* Response options: Excellent, very good, good, fair, poor.

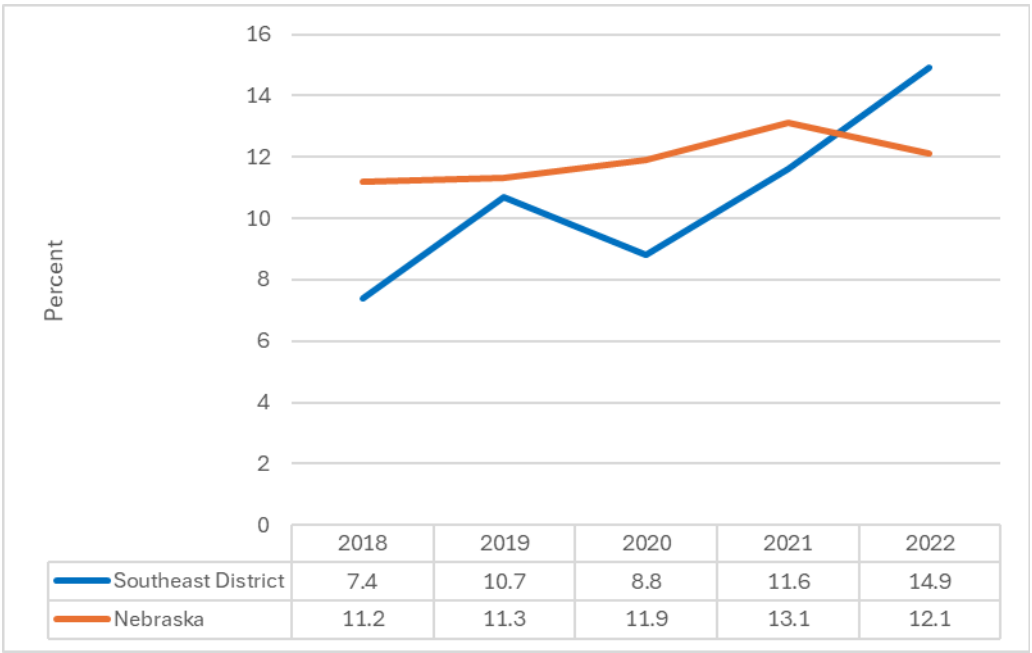
Figure 3. Percent of Adults Aged 18 and Over Reporting Physical Health Was Not Good on 14+ of the Past 30 Days



	2018	2019	2020	2021	2022
Southeast District	12.4	12.9	10	12.1	12.6
Nebraska	10.2	10.4	7.9	9.2	10.3

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Figure 4. Percent of Adults Aged 18 and Over Reporting Mental Health Was Not Good on 14+ of the Past 30 Days



	2018	2019	2020	2021	2022
Southeast District	7.4	10.7	8.8	11.6	14.9
Nebraska	11.2	11.3	11.9	13.1	12.1

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Results of the Community Survey

The community survey also asked respondents about their satisfaction with their quality of life. The responses varied considerably by county. In Nemaha County, 63% of the respondents indicated that they either strongly agreed or somewhat agreed with their satisfaction with the quality of life in their community. Fifty-seven percent of the respondents in Otoe strongly agreed or somewhat agreed followed by Richardson County at 55%, Pawnee County with 52% and Johnson County at 46%.

When they were asked about the economic opportunities in the community, 45% of the respondents indicated that they either strongly agreed or somewhat agreed about the economic opportunities. Otoe County had the second highest percentage at 43% followed by Richardson County at 34%, Johnson County at 31%, and Pawnee County at 29%.

The survey asked about the safety of their community. In Nemaha County, 78% of the survey participants reported that their community was a safe place to live. The respective percentages for Richardson, Otoe, Pawnee, and Johnson Counties were 73%, 64%, 63%, and 62%.

Maternal and Child Health

This section provides data of various maternal and infant health metrics, including data on births, prenatal care, breastfeeding, infant mortality, and other topics. Understanding maternal and child statistics and outcomes is a vital component of the strength of a community and is of utmost importance to mitigate risk factors, especially those risk factors that are easily preventable such as prenatal visits.

Table 28 displays the trends in births across the Southeast District from 2018 to 2022. For most of the counties, births have been increasing although there was a significant drop in both Nemaha and Pawnee Counties. in 2021 and 2022.

Table 28. Women With Births in the Previous 12 Months

	2018	2019	2020	2021	2022
Southeast District	480	471	413	388	464
Johnson	51	50	60	54	56
Nemaha	87	67	41	32	46
Otoe	237	228	192	199	255

Table 28. Women With Births in the Previous 12 Months					
	2018	**2019**	**2020**	**2021**	**2022**
Pawnee	33	31	30	8	4
Richardson	72	95	84	95	103

Source: U.S. Census Bureau, 2024 – Demographic and Housing Estimates, 2018-2022 American Community Survey 5-year estimates

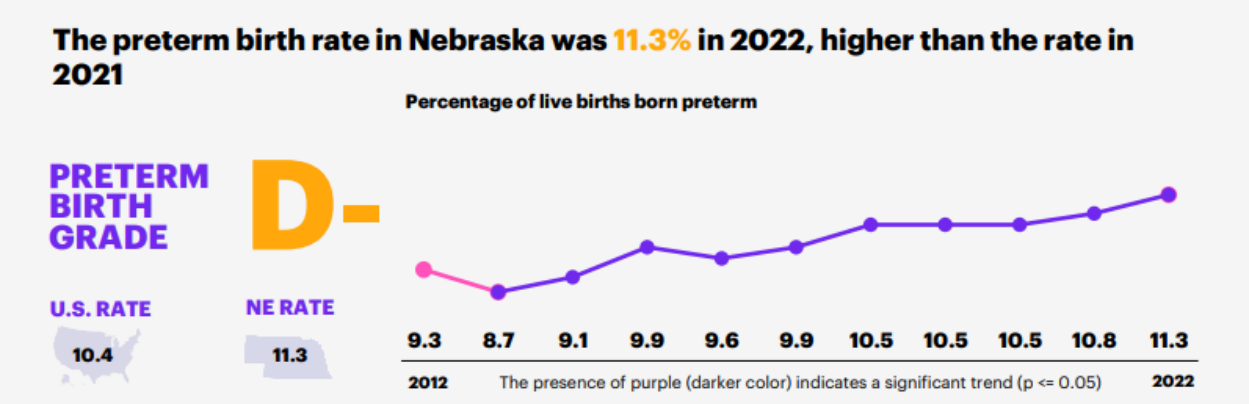
Table 29 portrays the percentage of adequate prenatal care by county. This is defined as the percent of women who received care prior to the fifth month and more than 80% of the appropriate number of prenatal visits for the infant's gestational age. Most counties from 2019 to 2022 are close to reaching the 80% threshold with Otoe and Nemaha exceeding it. Richardson and Pawnee counties saw a dip into the 60% range, but this drop is due to the COVID-19 pandemic.

Table 29. Percentage of Women Receiving Adequate Prenatal Care				
	2019	**2020**	**2021**	**2022**
Johnson	76.5%	81.8%	81.6%	76.3%
Nemaha	85.7%	79.2%	76.9%	82.4%
Otoe	77.7%	76.6%	83.7%	77.5%
Pawnee	75.7%	87.0%	61.5%	76.0%
Richardson	75.0%	67.8%	62.5%	70.6%

Source: National Center for Health Statistics, final natality data. Retrieved December 13, 2024, from www.marchofdimes.org/peristat

Table 30 shows the percentage of premature births in Nebraska. County level information was not available. Preterm labor has been trending up in the state.

Table 30. Preterm Birth Rate in Nebraska



Source: March of Dimes 2023 Report Card for Nebraska
https://npqic.org/file_download/inline/69a3623d-87d7-4c81-a7d2-ff362e70fc93

In 2023, 1 in 13 babies (8.0% of live births) were low birthweight in Nebraska. Table 31 shows the 3-year average low birth weight by county.

Table 31 Low Birth Weight by County, 2020-2023 Average	
County	**Percent LBW**
Johnson	**
Nemaha	6.9
Otoe	7.7
Pawnee	11.1
Richardson	8.6

Source: National Center for Health Statistics, final natality data. Retrieved December 13, 2024, from www.marchofdimes.org/peristat

Table 32 presents the percentage of Women, Infants, and Children (WIC) beneficiaries that have ever breastfed, exclusively breastfed, and continued to breastfeed their infants up to one year of age.

Table 32. WIC Breastfeeding Prevalence												
	Nebraska		Johnson		Nemaha		Otoe		Pawnee		Richardson	
	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023
Ever Breastfed	27,672	28,394	50	54	60	68	107	105	21	17	36	47
Exclusively Breastfed-1 Week	3,171	3,201	12	19	11	12	16	20	2	2	6	8
Exclusively Breastfed-3 month	1,739	1,777	1	5	8	7	6	12	1	0	2	2
Exclusively Breastfed-6 month	939	1,066	0	3	7	2	2	3	1	0	2	2
12 Month	987	1,146	2	0	4	4	7	6	0	1	1	1

Source: Family Health Services, personal communication, September 2024

HEALTH FACTORS

Health factors are behaviors, access to clinical care services, physical environment, and social and economic factors that influence how well and how long people live. Positive changes in these factors can help people to live a longer, healthier, and more fulfilling life and improve the future health of a community. No single health factor fully determines or carries such weight that if improved upon it would drastically change the outlook of those living in a community. It is a conglomeration of health factors intersecting one another that creates the picture of overall community health.

Clinical Care

Clinical care is another component under the umbrella of Health Factors (Figure 5). Clinical care involves the direct medical treatment or testing of patients. Access to high quality and affordable clinical care is critical to prevent and control medical conditions. Access to health care services results in fewer premature deaths and a longer life expectancy.

Insurance Coverage

Lack of health insurance coverage is one of the most significant barriers to accessing necessary healthcare and in maintaining financial economic security in the long-term. Uninsured individuals often face more serious health consequences and events and are less likely to seek out and receive preventive care.

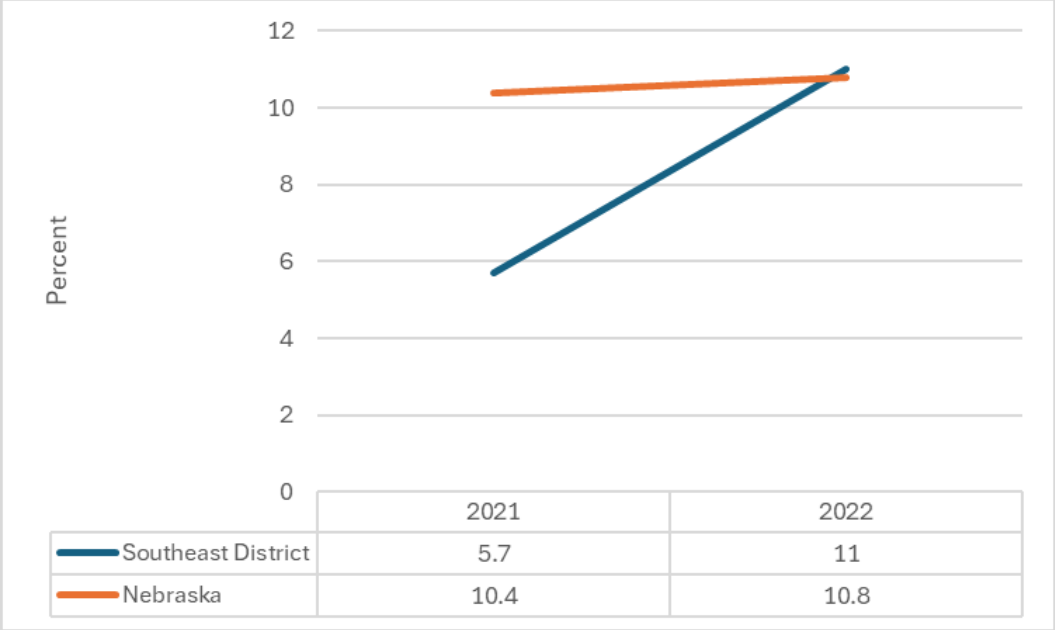
Table 33 shows the total percentage of uninsured adults and individuals under age 19. Nemaha, Pawnee, and Richardson Counties have higher percentages than the state for uninsured adults. Only Richardson County has a slightly higher rate of uninsured individuals under the age of 19 compared to the state.

Table 33. Uninsured in Nebraska, Percent					
Nebraska	**Johnson**	**Nemaha**	**Otoe**	**Pawnee**	**Richardson**
Individuals 19 and Under					
4.6%	1.3%	3.4%	1.2%	1%	4.9%
Total Uninsured (All Ages)					
6.7%	5.7%	8.9%	5.4%	12.3%	9.7%

Source: U.S. Census Bureau, 2022 – Demographic and Housing Estimates, 2018-2022 American Community survey 5-year estimates

Figure 5 depicts the percentage of adults aged 18-46 who reported that they have no health care coverage. The Southeast District has seen a sharp increase from 5.7% in 2021 to 11% in 2022.

Figure 5. Percent of Adults Ages 18 to 64 Reporting They Have No Health Care Coverage



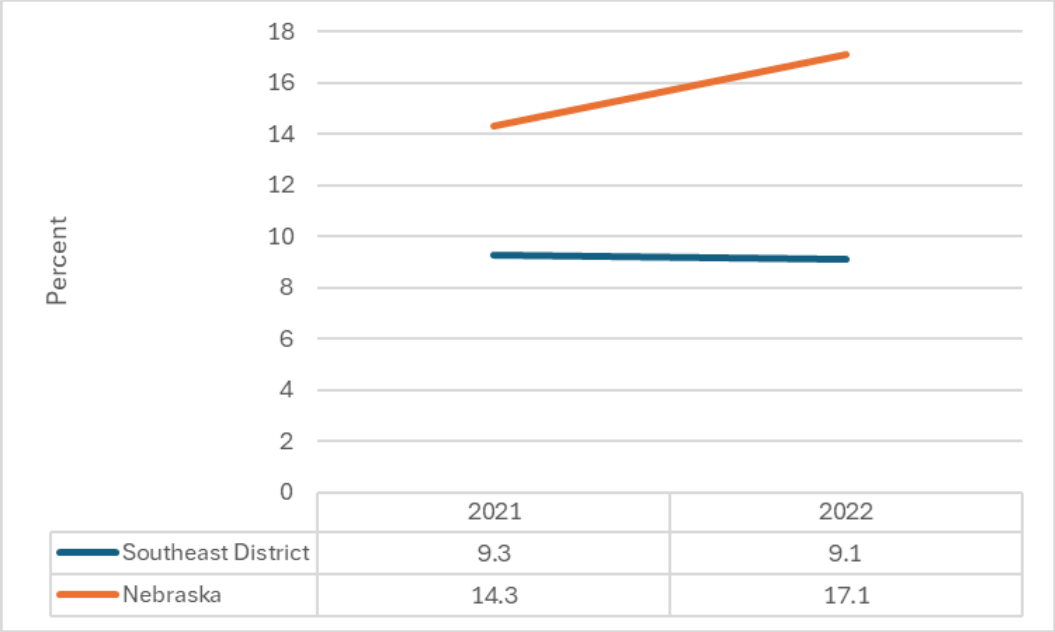
Source: Nebraska Behavioral Risk Factor Surveillance System, 2022

Access to Health Care

In many instances, access to health care is hindered not only by inadequate health insurance coverage, but also local care options, and a usual source of care. Having access to care allows individuals to enter the healthcare system, find care easily and locally, pay for care, and get their health care needs met, all within their local community.

Figure 6, Figure 7, and Figure 8 depict Southeast District adults reporting on access to health care. The Southeast District has seen no change in adults reporting they have no personal doctor or health care provider. In contrast, there has been a sharp increase in those reporting that they needed to see a doctor but could not due to cost. Lastly, the percentage of adults reporting a routine checkup in the past year has remained relatively steady.

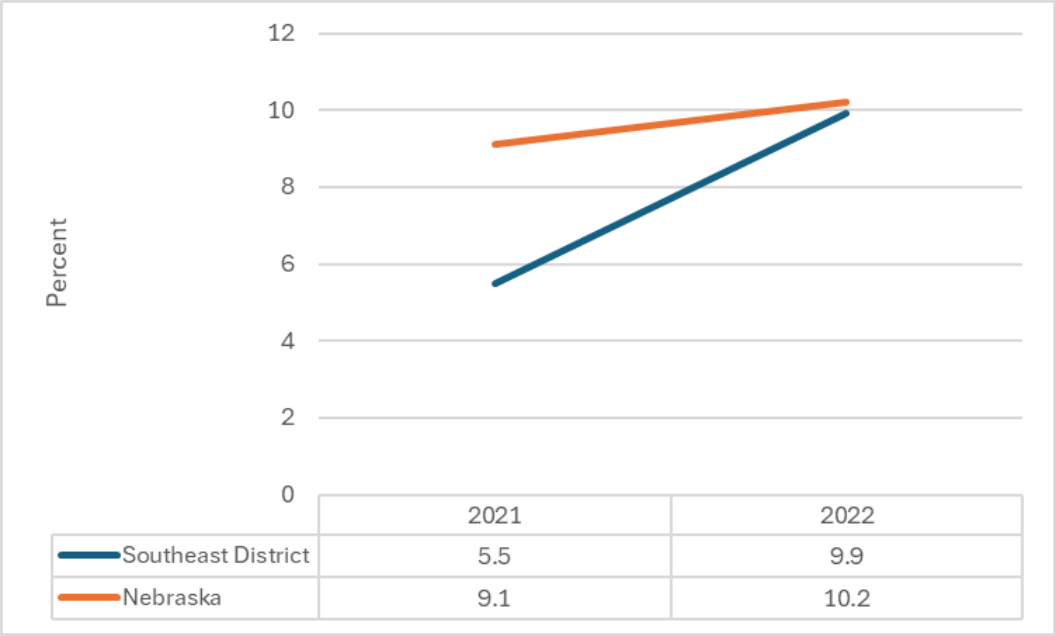
Figure 6. Percent of Adults Aged 18 and Over Reporting They Have No Personal Doctor or Health Care Provider



	2021	2022
Southeast District	9.3	9.1
Nebraska	14.3	17.1

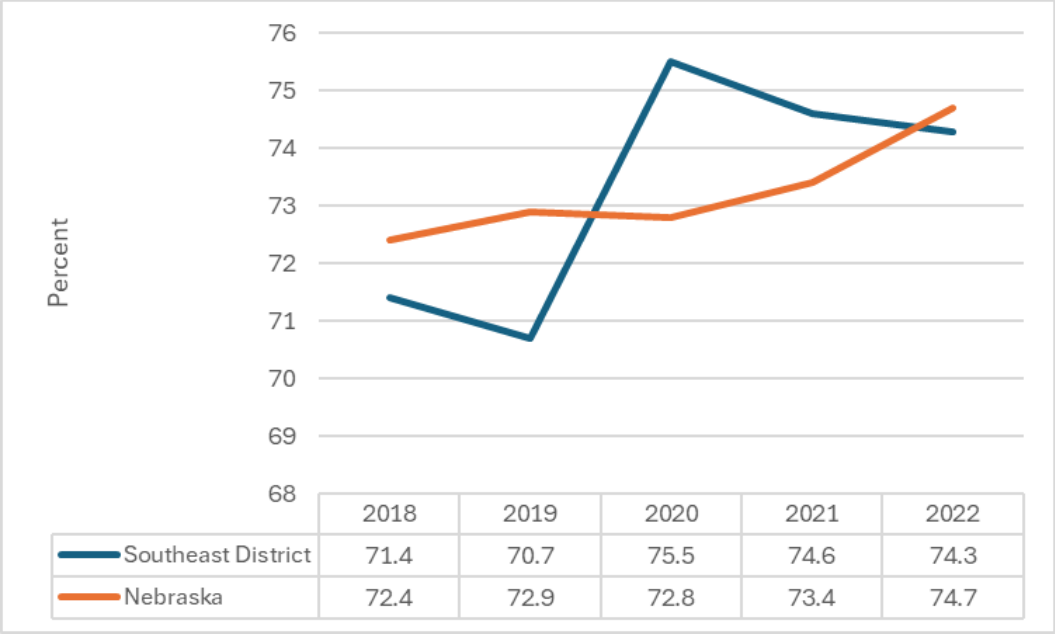
Source: Nebraska Behavioral Risk Factor Surveillance System, 2022

Figure 7. Percent of Adults Ages 18 and Over Reporting They Needed to See a Doctor but Could Not Due to Cost in Past Year



Source: Nebraska Behavioral Risk Factor Surveillance System, 2022

Figure 8. Percent of Adults Ages 18 and over Reporting They Had a Routine Checkup in Past Year



Source: Nebraska Behavioral Risk Factor Surveillance System, 2022

Health Professionals

Access to health care requires not only financial coverage but also access to providers. Nationally, many counties lack a sufficient number of providers to meet the needs of their community. The shortage includes primary and specialty care physicians as well as mental health and dental health providers.

Table 34 and Table 35 present Federal and state Designated Health Professional Shortages in the Southeast District. Nemaha, Pawnee, and Richardson Counties are designated shortage areas for primary care. Nemaha and Pawnee Counties are also designated shortage areas for dental health. Additionally, the entire Southeast District is a designated mental health shortage area. All counties within the district are full or partial shortage areas for general surgery, internal medicine, pediatrics, obstetrics and gynecology, and psychiatrics. Physical therapy is the only health profession in which the Southeast District did not have a full or partial professional shortage are designation.

Table 34. Federal Designated Health Professional Shortages

	Johnson	Nemaha	Otoe	Pawnee	Richardson	SEDHD Region
Primary Care		X		X	X	X
Mental Health	X	X	X	X	X	X
Dental Health		X		X		X

Source: U.S. Health and Human Services Health Resources and Services Administration, 2024

Table 35. State or Federal Designated Health Professional Shortages

	Johnson	Nemaha	Otoe	Pawnee	Richardson	SEDHD Region
Family Medicine	X	X		X	X	Partial
General Surgery	X	X	X	X	X	Total
Internal Medicine	X	X	X	X	X	Total
Pediatrics	X	X	X	X	X	Total
Obstetrics and Gynecology	X	X	X	X	X	Total
General Psychiatry	X	X	X	X	X	Total
General Dentistry		X		Partial	X	Partial
Pharmacy	X	X		X	X	Partial
Occupational Therapy		X				Partial
Physical Therapy						

Source: Nebraska Department of Health and Human Services Office of Rural Health, 2024

Table 36 displays the ratio of population to primary care physicians, midlevel primary care providers, dentists, and mental health providers. Text highlighted in red indicates health professions for which there is a higher number of people served per health care professional as compared to the state.

Table 36. Ratio of Population to Health Care Providers

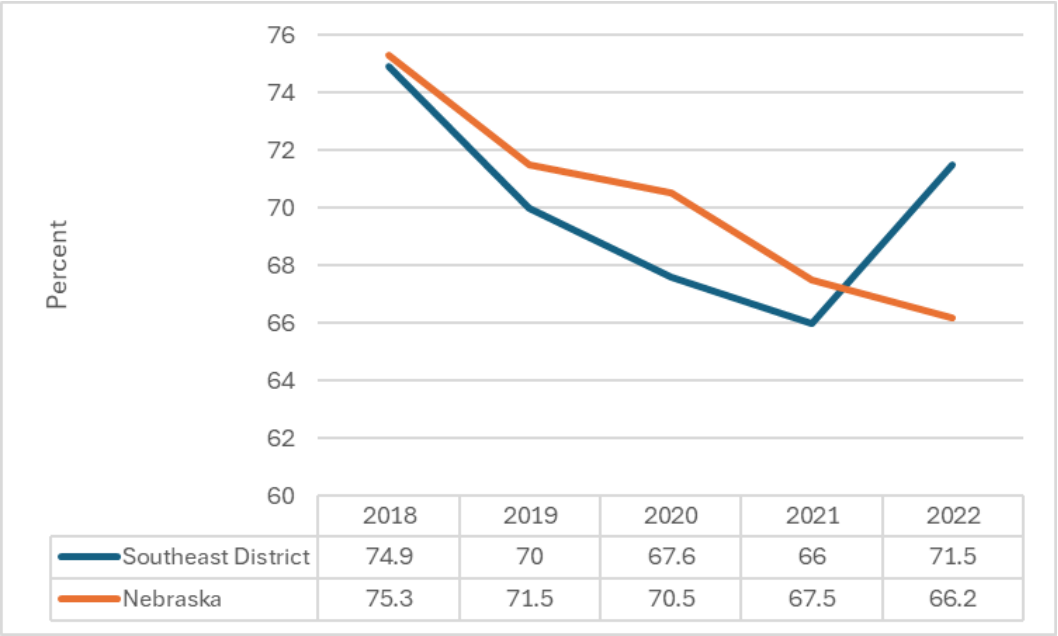
	Johnson	Nemaha	Otoe	Pawnee	Richardson	Nebraska
Primary Care Physician	5,320:1	1,180:1	1,330:1	2,550:1	1,940:1	1,340:1
Midlevel Primary Care Providers*	660:1	2,350:1	1,160:1	630:1	700:1	630:1
Dentists	5,290:1	2,350:1	1,800:1	840:1	2,570:1	1,220:1
Mental Health Providers	5,290:1	2,350:1	850:1	2,530:1	960:1	310:1

Source: County Health Rankings, 2024
* Midlevel primary care providers include nurse practitioners, physician assistants, and clinical nurse specialists

Health Literacy

Health literacy is a health factor that can affect a person's ability to make healthy decisions, receive necessary care, and manage their overall health. Figure 9, Figure 10, and Figure 11 depict health literacy issues. Overall, a slightly smaller percentage of Southeast District adults found it very easy to get needed medical advice or information compared to the state. However, there was a sharp increase in this number from 2021 to 2022 in which the percentage surpassed the state by 5.3%. A smaller percentage reported it was very easy to understand information provided by medical professionals compared to the state. And a parallel downward trend was found between the Southeast District and the state reporting that it is very easy to understand written health information, with the Southeast District reporting lower percentages.

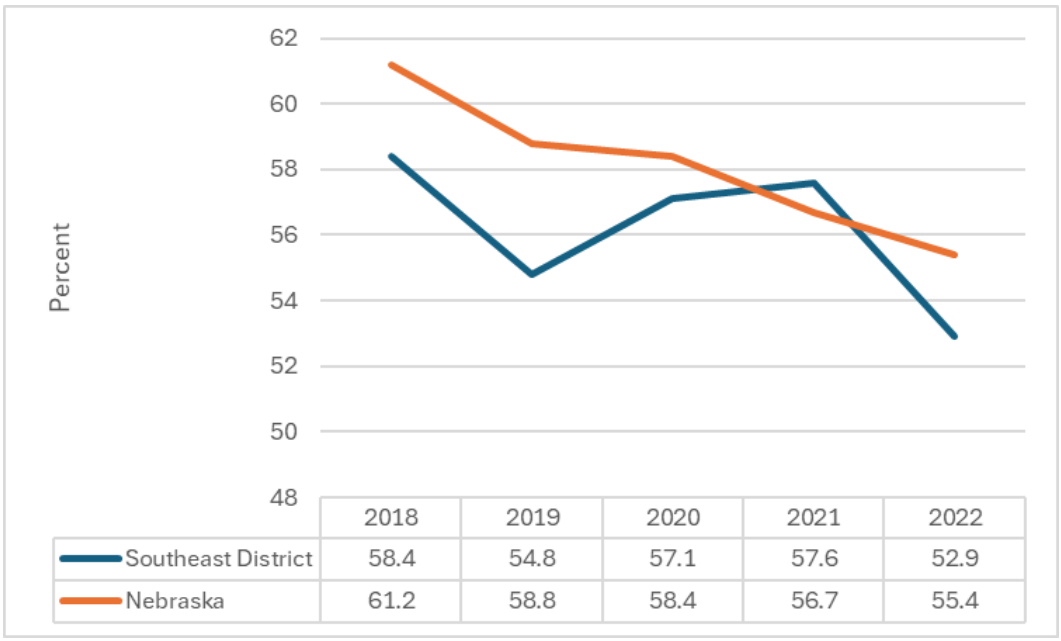
Figure 9. Very Easy to Get Needed Advice or Information About Health or Medical Topics



	2018	2019	2020	2021	2022
Southeast District	74.9	70	67.6	66	71.5
Nebraska	75.3	71.5	70.5	67.5	66.2

Source: Nebraska Behavioral Risk Factor Surveillance System, 2022

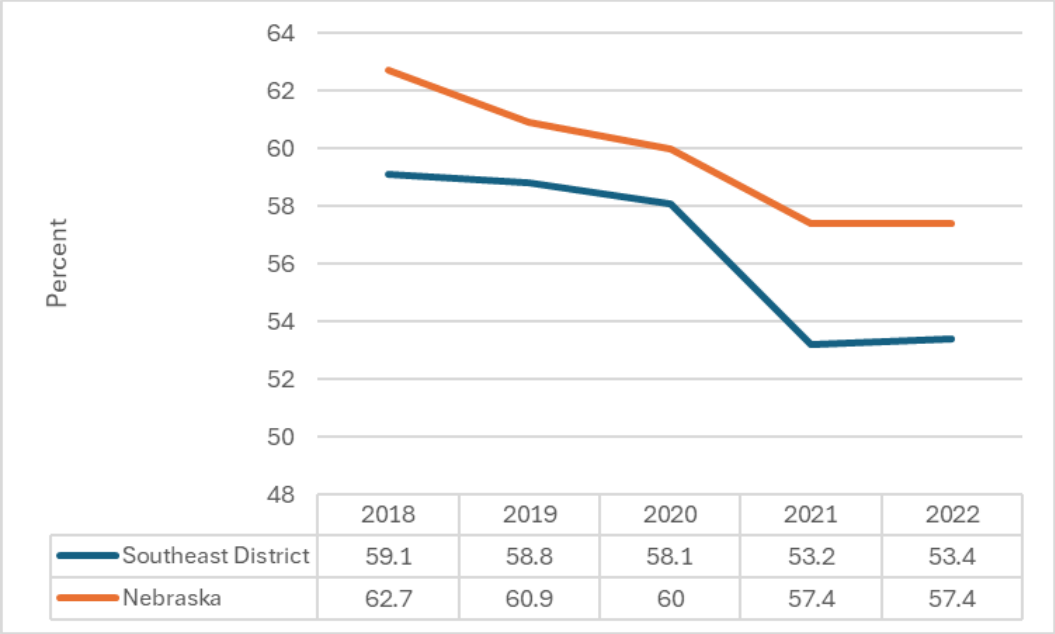
Figure 10. Very Easy to Understand Information that Medical Professions Tell You



	2018	2019	2020	2021	2022
Southeast District	58.4	54.8	57.1	57.6	52.9
Nebraska	61.2	58.8	58.4	56.7	55.4

Source: Nebraska Behavioral Risk Factor Surveillance System, 2022

Figure 11. Very Easy to Understand Written Health Information



	2018	2019	2020	2021	2022
Southeast District	59.1	58.8	58.1	53.2	53.4
Nebraska	62.7	60.9	60	57.4	57.4

Source: Nebraska Behavioral Risk Factor Surveillance System, 2022

Health Behaviors

Health behaviors are health-related practices, such as diet, exercise, and tobacco use, which can either improve or damage the health of individuals within a community. Health behaviors are highly determined by the individuals' choices people make in their community. For example, if most people follow positive health behaviors, they will not only become healthier as individuals, but workers in the community are more likely to be more productive and the community more economically vibrant.

Diet & Exercise

The environments in which people live, learn, work, and play affect access to healthy food and opportunities for physical activity. Along with genetic factors and personal choices, these community environments related to diet and exercise influence the risk of obesity.

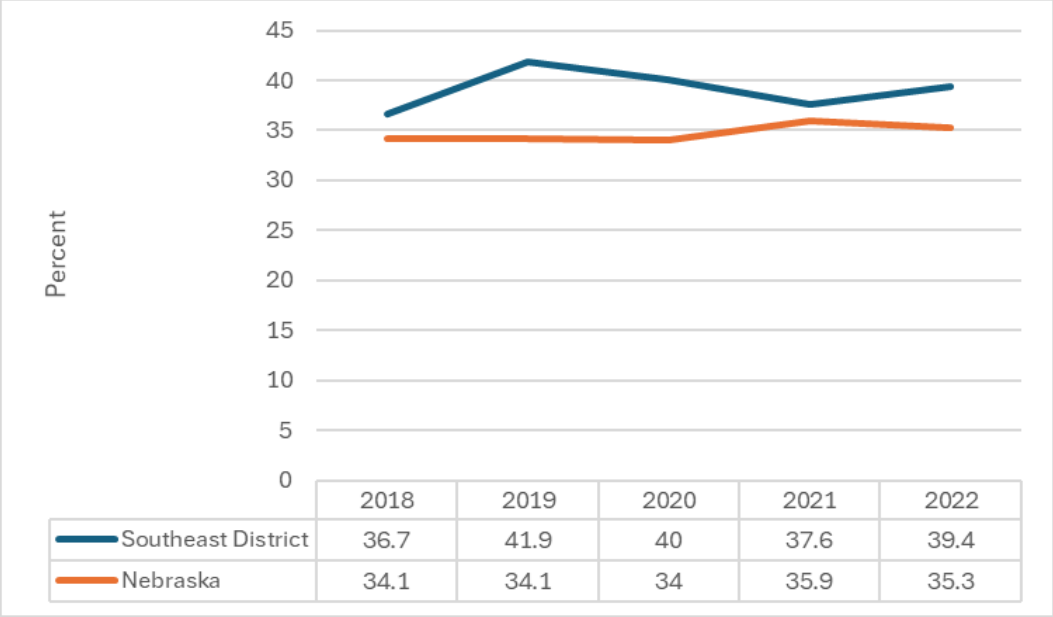
Obesity

Adult obesity is a chronic condition that is a precursor and cause of a myriad of chronic conditions including hypertension, heart disease, type 2 diabetes, breathing problems, chronic inflammation, mental illness, and cancer. Obesity is considered one of the most important health factors since it is often a direct product of the environment and personal choices individuals make in their communities. Furthermore, obese individuals often face stigma and discrimination

in communities, further cementing the importance of this risk factor.

Figure12 shows the percentage of adults that report a body mass index (BMI) of 30.0 or greater. The Southeast District reports a higher percentage of the population with 30 BMI compared to Nebraska.

Figure 12. Percentage of Adults 18 and Older with a BMI of 30.0 or Greater*



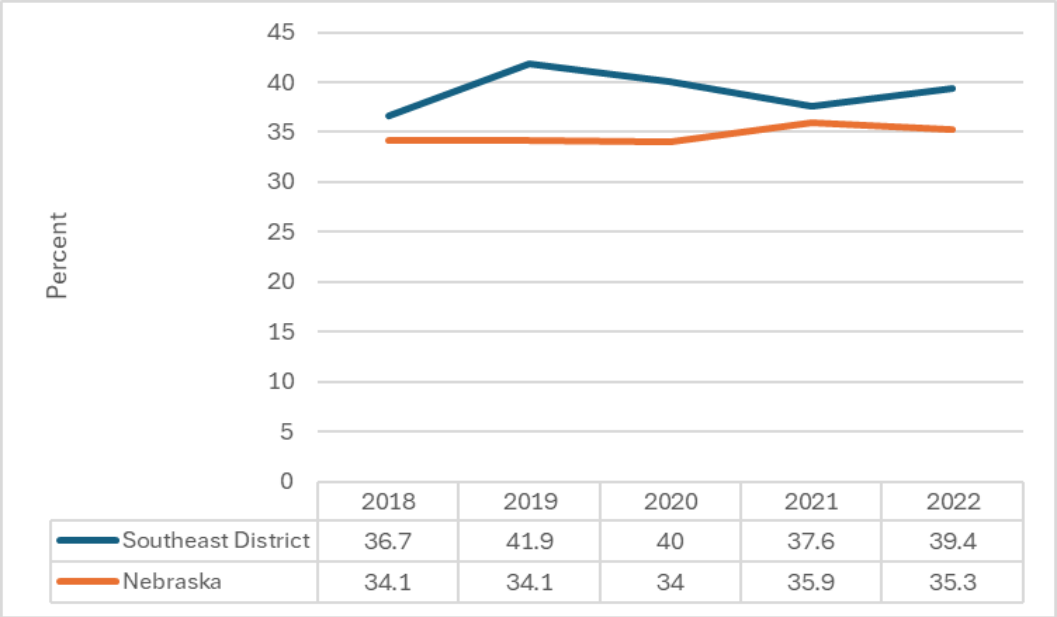
	2018	2019	2020	2021	2022
Southeast District	36.7	41.9	40	37.6	39.4
Nebraska	34.1	34.1	34	35.9	35.3

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022
* Based on self-reported height and weight

Physical Activity

Physical inactivity is linked to increased risk of health conditions such as Type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and shortened life expectancy. Conversely, healthy amounts of physical activity are associated with improved sleep, cognitive ability, musculoskeletal health, and reduced risk of dementia. Figures 13 through 17 depict physical activity trends among Southeast District adults. In general, compared to the state, adults indicated having less time devoted to leisure-time physical activity and tend not to meet recommendations for muscle strengthening or combination of aerobic and muscle-strengthening physical activities.

Figure 13. Percentage of Adults 18 and Older with a BMI of 30.0 or Greater*



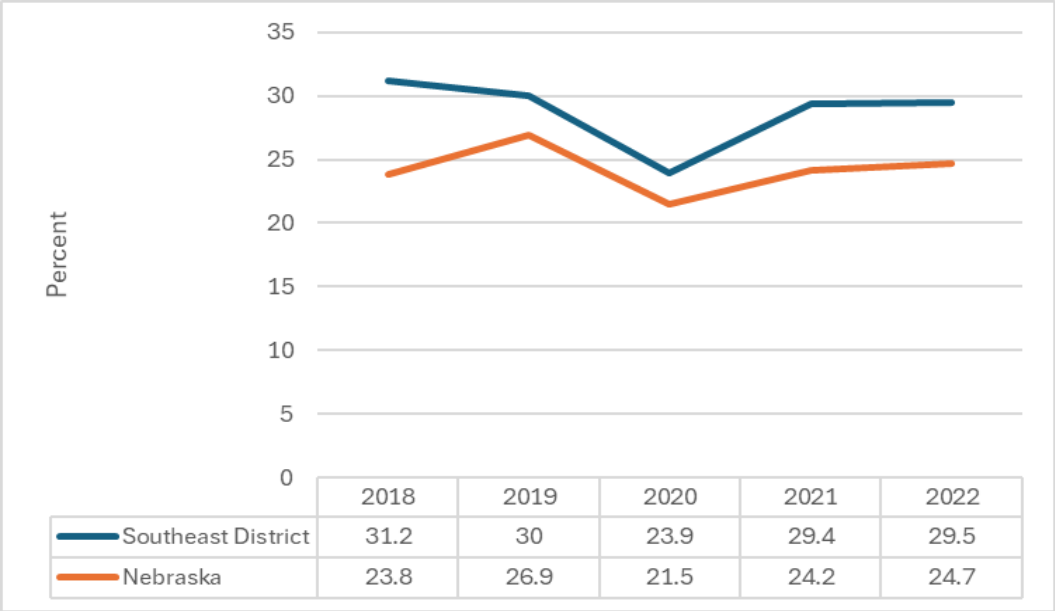
	2018	2019	2020	2021	2022
Southeast District	36.7	41.9	40	37.6	39.4
Nebraska	34.1	34.1	34	35.9	35.3

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022
* Based on self-reported height and weight

Physical Activity

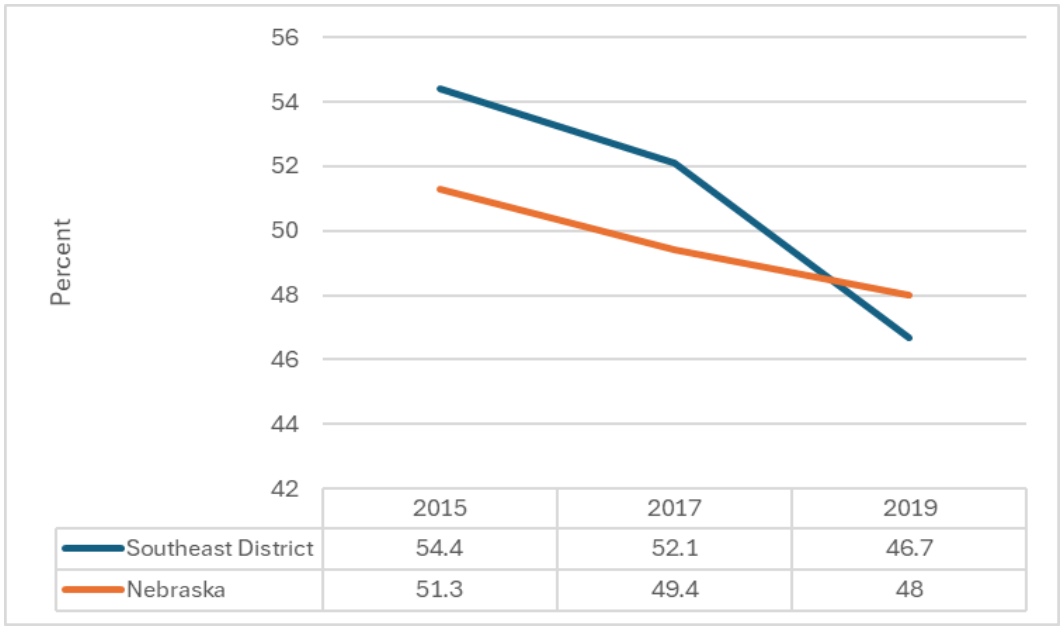
Physical inactivity is linked to increased risk of health conditions such as Type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and shortened life expectancy. Conversely, healthy amounts of physical activity are associated with improved sleep, cognitive ability, musculoskeletal health, and reduced risk of dementia. Figures 14 through 17 depict physical activity trends among Southeast District adults. In general, compared to the state, adults indicated having less time devoted to leisure-time physical activity and tend not to meet recommendations for muscle strengthening or combination of aerobic and muscle-strengthening physical activities.

Figure 14. Percentage of Adults 18 and Older Who Report No Leisure-Time Physical Activity in past 30 Days*



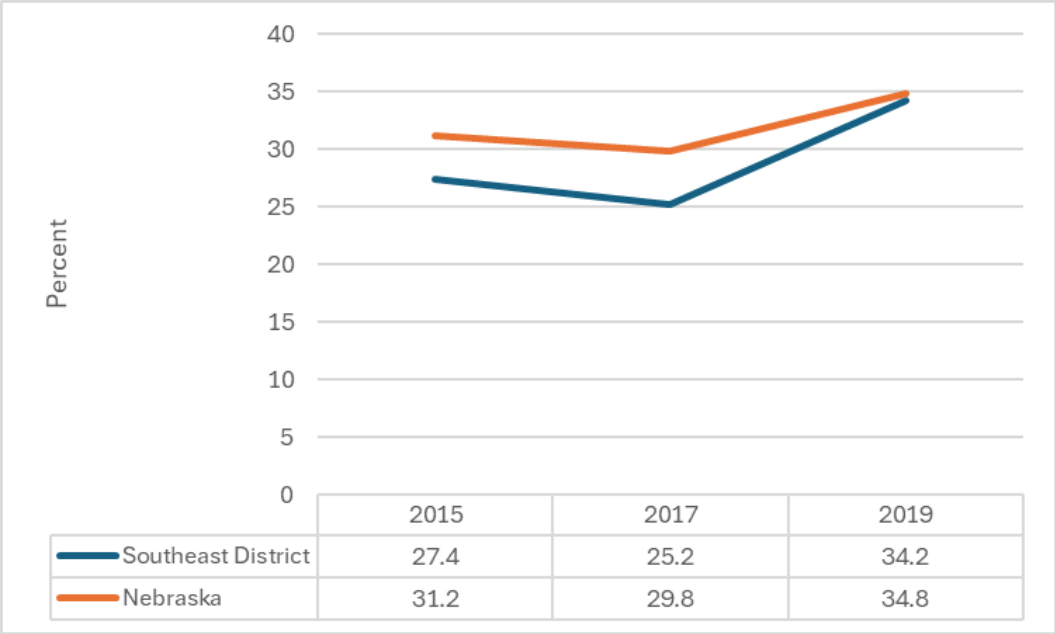
Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022
* Percentage of adults 18 and older who report no physical activity or exercise (such as running, calisthenics, golf, gardening or walking for exercise) other than their regular job during the past month.

Figure 15. Percentage of Adults 18 and Older that Met Aerobic Physical Activity Recommendation*



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2015-2019
* Percentage of adults 18 and older who report no physical activity or exercise (such as running, calisthenics, golf, gardening or walking for exercise) other than their regular job during the past month.

Figure 16. Percentage of Adults 18 and Older that Met Muscle Strengthening Recommendation*

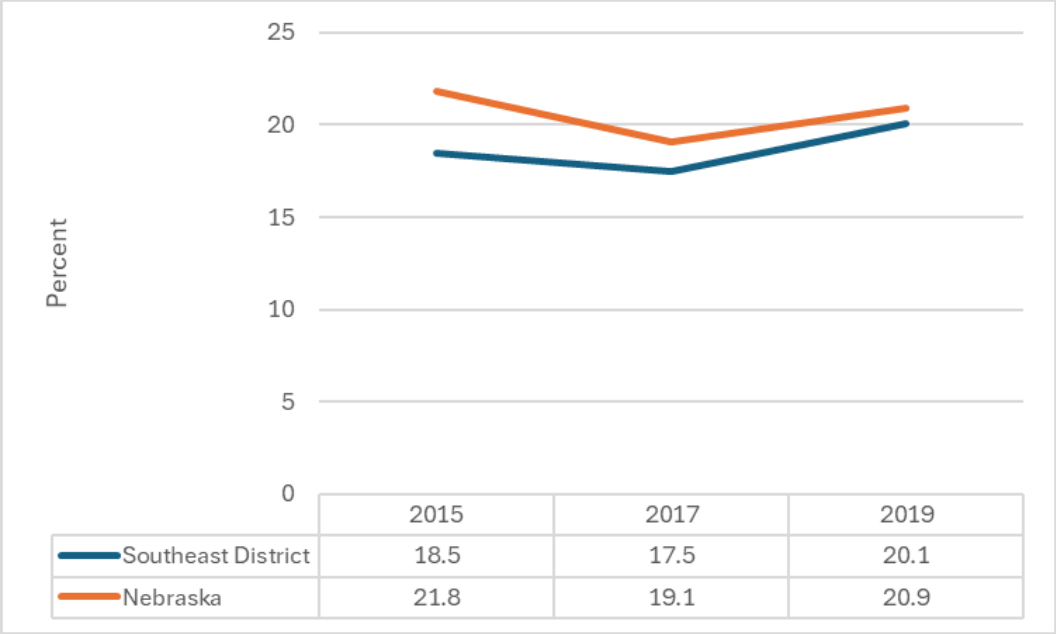


	2015	2017	2019
Southeast District	27.4	25.2	34.2
Nebraska	31.2	29.8	34.8

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2015-2019

* Percentage of adults 18 and older who report that they engaged in physical activities or exercises to strengthen their muscles two or more times per week during the past month.

Figure 17. Percentage of Adults 18 and Older that Met Both Aerobic Physical Activity and Muscle Strengthening Recommendation*



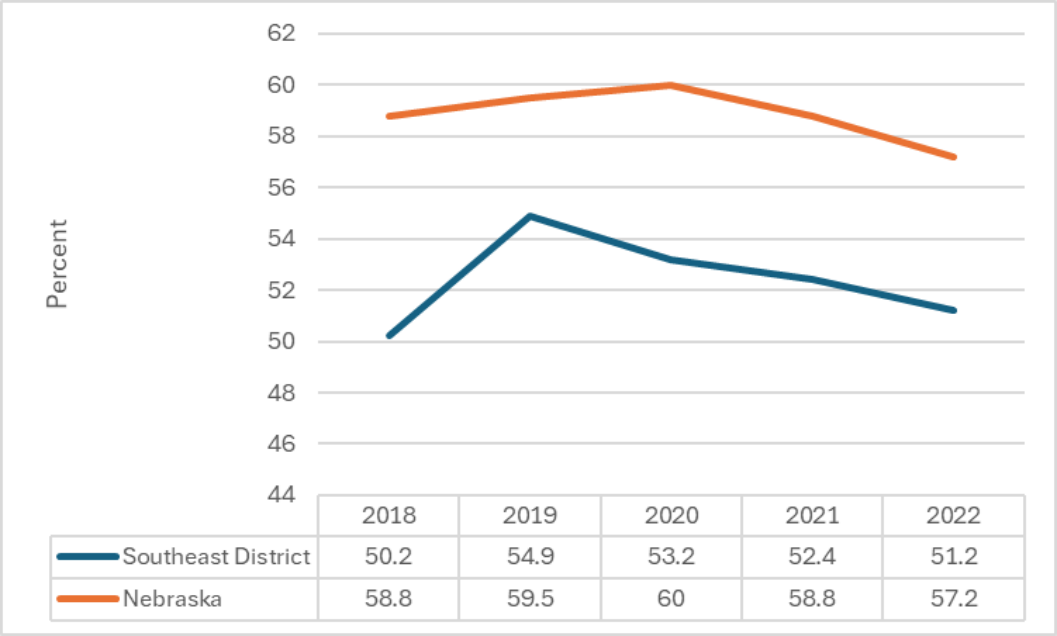
Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2015-2019
* Percentage of adults 18 and older who report at least 150 minutes of moderate-intensity physical activity, or at least 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity per week during the past month and that they engaged in physical activities or exercises to strengthen their muscles two or more times per week during the past month.

Alcohol Use

When consumed in excess, alcohol is harmful to the health and well-being of those that drink as well as their families, friends, and communities. Excessive alcohol use refers to both the amount and the frequency of alcohol consumed.

Figures 18 through 20 present information on adult alcohol consumption. In general, respondents in the Southeast District reported lower rates than the state for consuming any alcohol, binge drinking, or heavy drinking within the past 30 days, although there were slight increases in 2021.

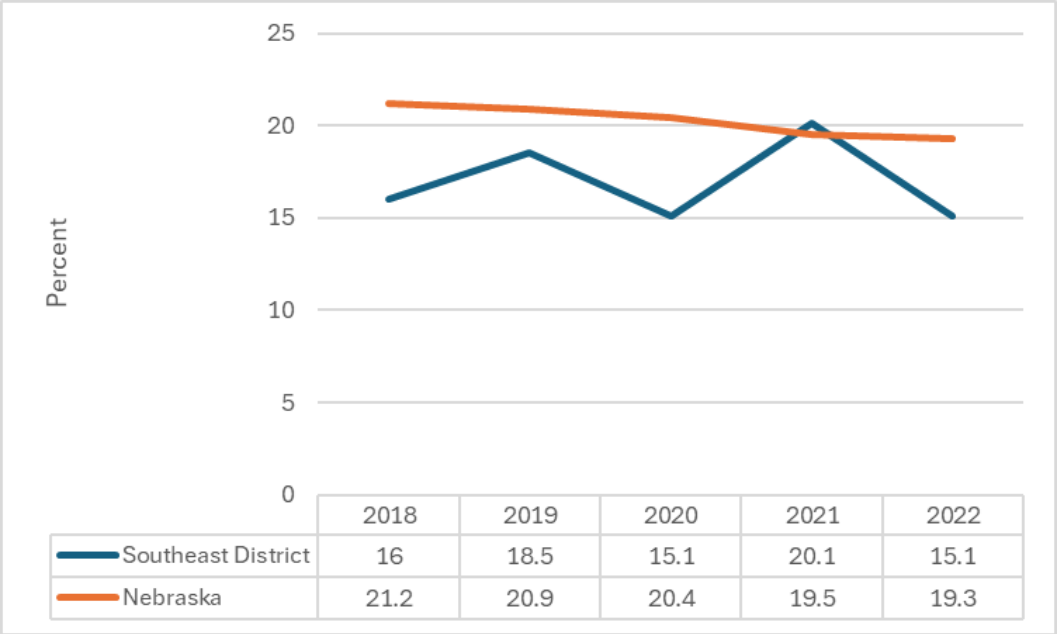
Figure 18. Percentage of Adults 18 and Older Who Report Having Any Alcohol Consumption in past 30 Days



	2018	2019	2020	2021	2022
Southeast District	50.2	54.9	53.2	52.4	51.2
Nebraska	58.8	59.5	60	58.8	57.2

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

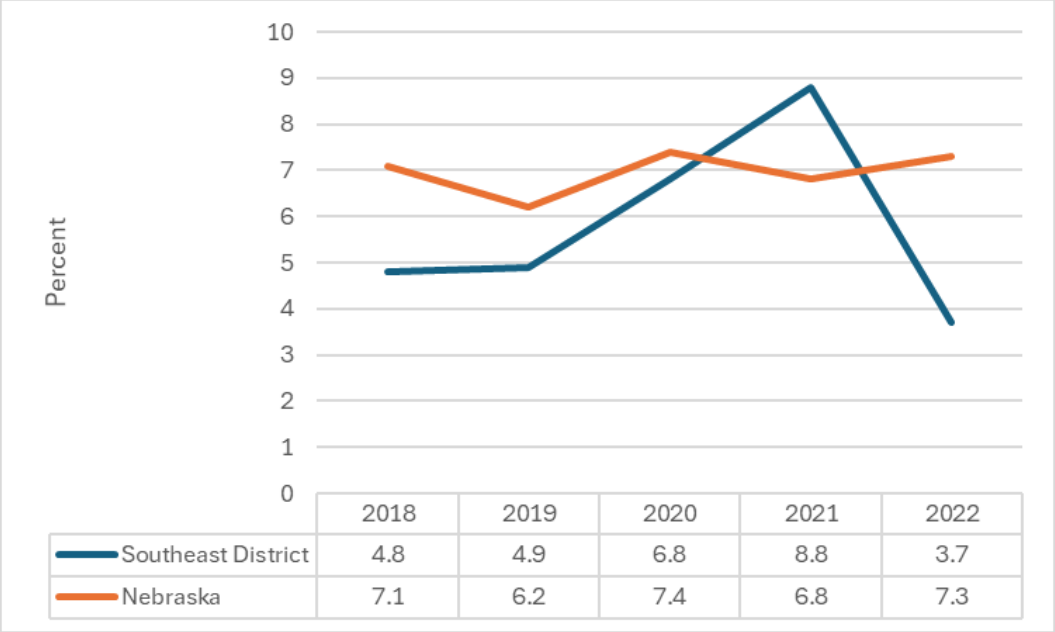
Figure 19. Percentage of Adults 18 and Older Who Report Having Binge Drank in past 30 Days*



	2018	2019	2020	2021	2022
Southeast District	16	18.5	15.1	20.1	15.1
Nebraska	21.2	20.9	20.4	19.5	19.3

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022
*Binge drinking defined as five or more alcoholic drinks for men/four or more alcoholic drinks for women on at least one occasion

Figure 20. Percentage of Adults 18 and Older Who Report Heavy Drinking in past 30 Days*



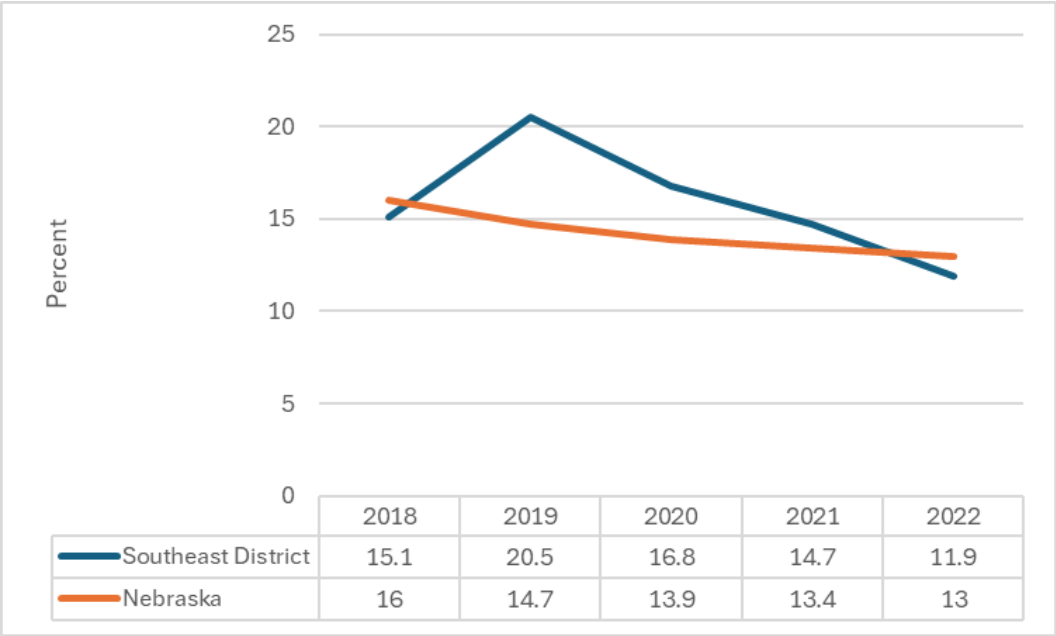
	2018	2019	2020	2021	2022
Southeast District	4.8	4.9	6.8	8.8	3.7
Nebraska	7.1	6.2	7.4	6.8	7.3

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022
* Heavy drinking defined as drinking more than 60 alcoholic drinks (an average of more than two drinks per day) during the past 30 days for men and drinking more than 30 alcoholic drinks (an average of more than one drink per day) for women.

Tobacco

Figures 21 through 23 were below the state average in 2022 adult tobacco use. The Southeast District has seen a decline in the percentage of adults reporting current cigarette use, and a greater decline than the state. Although there was also a decline in smokeless tobacco products, the Southeast District continues to use smokeless tobacco at much higher rates than the state. Also, both for the state and the Southeast District there has been a sharp increase in the use of vaping products.

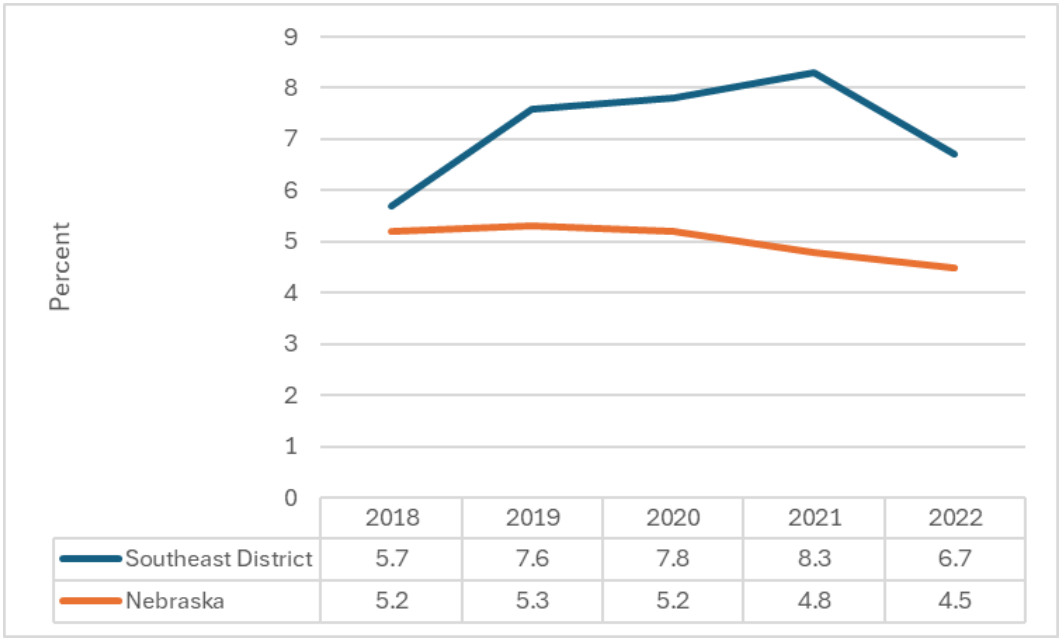
Figure 21. Percentage of Adults 18 and Older Who Report that They Currently Smoke Cigarettes



	2018	2019	2020	2021	2022
Southeast District	15.1	20.5	16.8	14.7	11.9
Nebraska	16	14.7	13.9	13.4	13

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

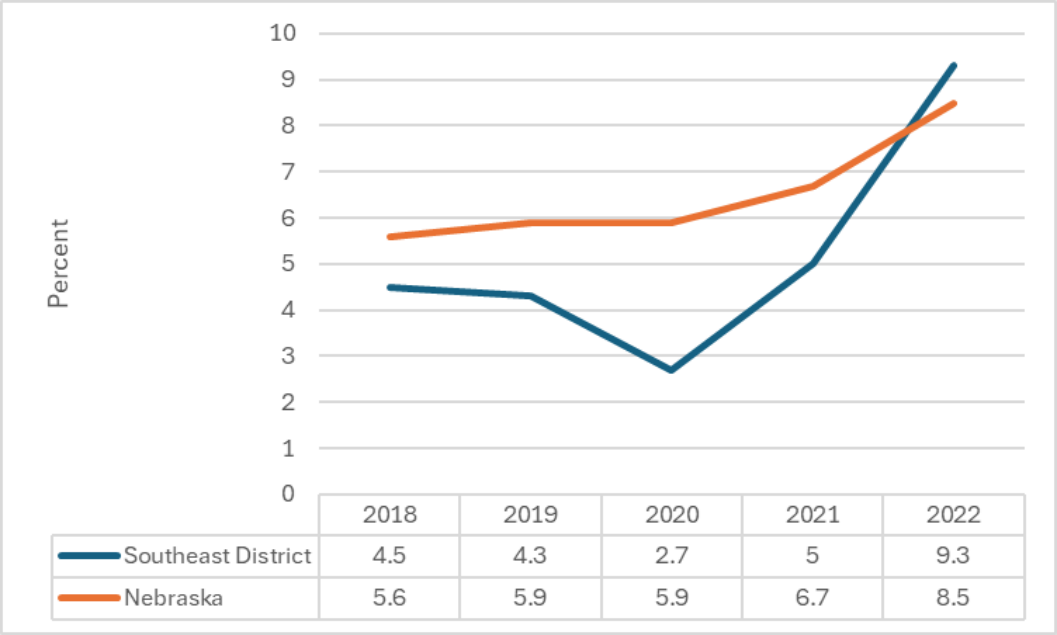
Figure 22. Percentage of Adults 18 and Older Who Report that They Currently Use Smokeless Tobacco Products



	2018	2019	2020	2021	2022
Southeast District	5.7	7.6	7.8	8.3	6.7
Nebraska	5.2	5.3	5.2	4.8	4.5

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Figure 23. Percentage of Adults 18 and Older Who Report that They Currently Use E-cigarettes or Other Electronic "Vaping" Products



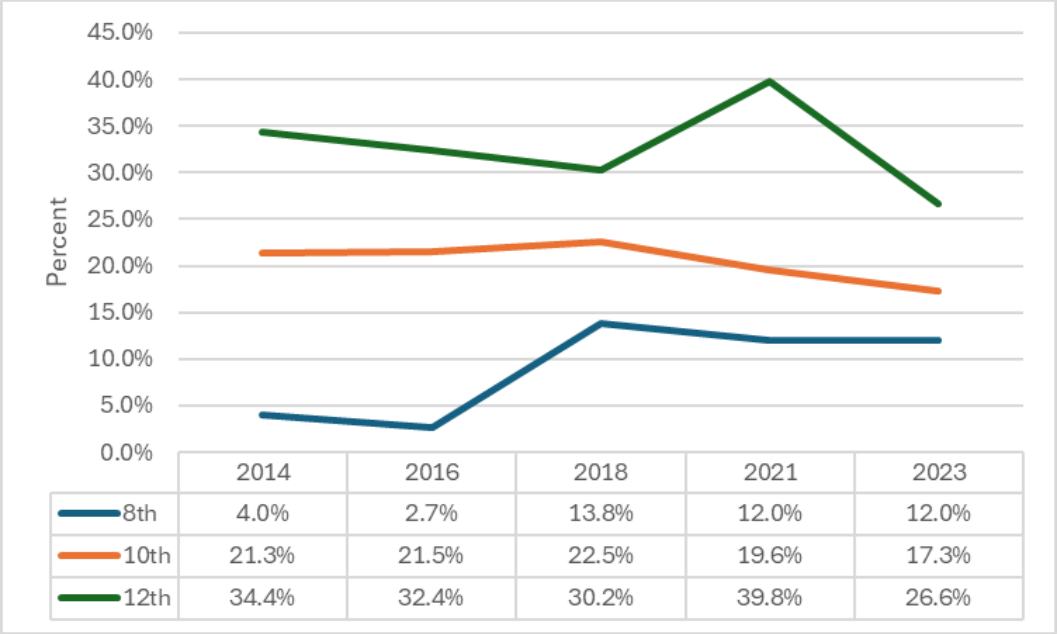
	2018	2019	2020	2021	2022
Southeast District	4.5	4.3	2.7	5	9.3
Nebraska	5.6	5.9	5.9	6.7	8.5

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Youth Alcohol, Tobacco & Drug Use

Figures 24 through 29 present data regarding youth alcohol, tobacco, and drug use. Prescription drug misuse and illicit drug use also have substantial health, economic, and social consequences within a community. Overall alcohol use and binge drinking have stayed steady over time, with a sharp increase in 2021. Youth cigarette and smokeless tobacco usage declined among all grade levels. Interestingly, marijuana usage has stayed constant among 8th graders, but the use has declined for both 10th and 12th graders. Similarly, prescription drug use has increased among 8th graders but declined for 10th and 12th graders.

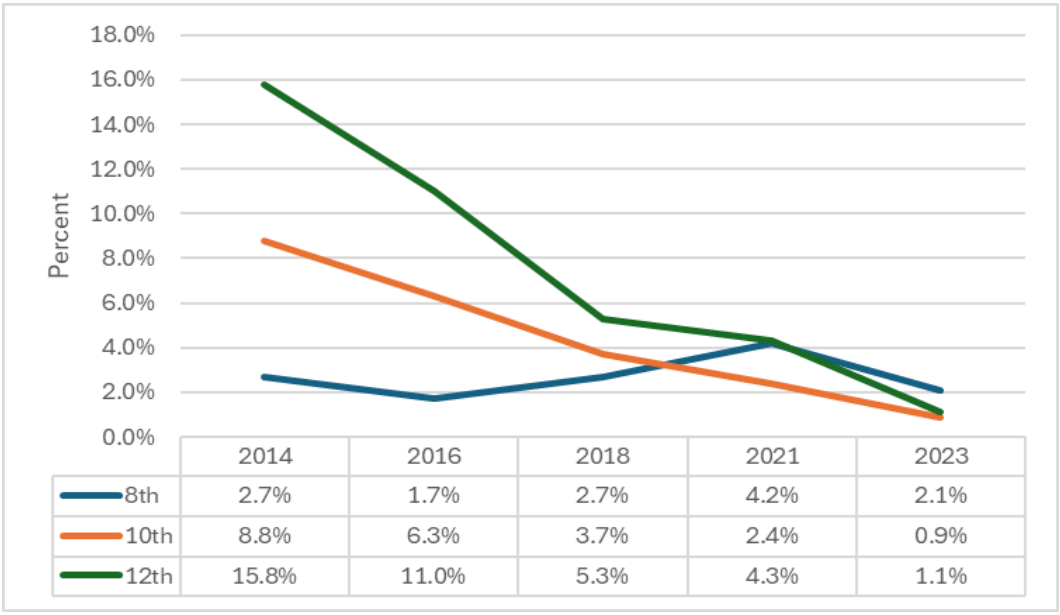
Figure 24. Past 30-Day Alcohol Use Among 8th, 10th, and 12th Graders



	2014	2016	2018	2021	2023
8th	4.0%	2.7%	13.8%	12.0%	12.0%
10th	21.3%	21.5%	22.5%	19.6%	17.3%
12th	34.4%	32.4%	30.2%	39.8%	26.6%

Source: Nebraska Risk and Protective Factor Student Survey, 2023

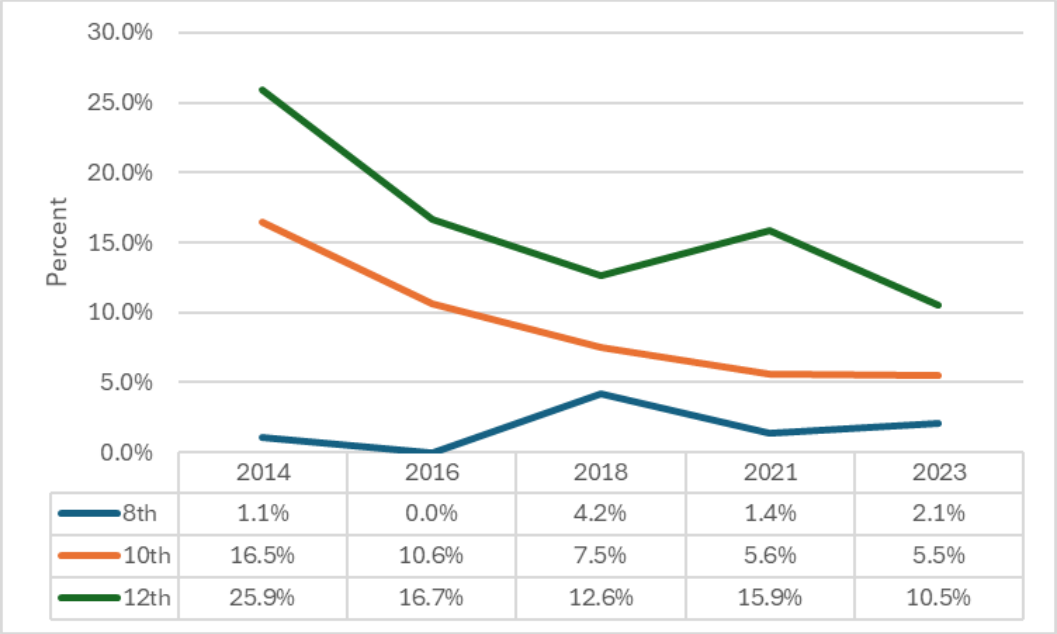
Figure 25. Past 30-Day Binge Drinking* Among 8th, 10th, and 12th Graders



	2014	2016	2018	2021	2023
8th	2.7%	1.7%	2.7%	4.2%	2.1%
10th	8.8%	6.3%	3.7%	2.4%	0.9%
12th	15.8%	11.0%	5.3%	4.3%	1.1%

Source: Nebraska Risk and Protective Factor Student Survey, 2023

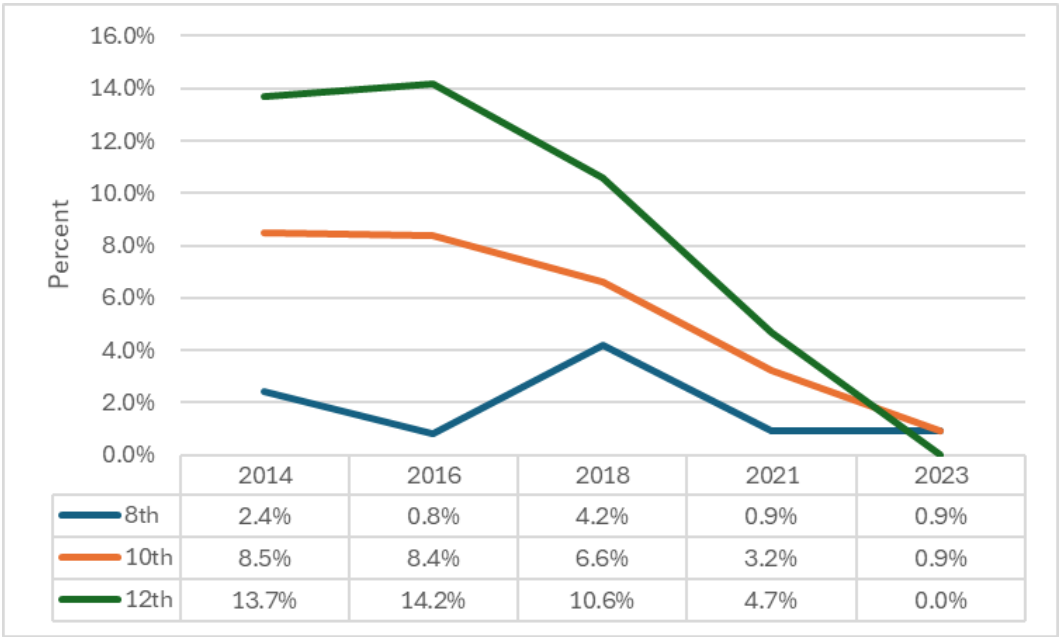
Figure 26. Past 30-Day Cigarette Use Among 8th, 10th, and 12th Graders



	2014	2016	2018	2021	2023
8th	1.1%	0.0%	4.2%	1.4%	2.1%
10th	16.5%	10.6%	7.5%	5.6%	5.5%
12th	25.9%	16.7%	12.6%	15.9%	10.5%

Source: Nebraska Risk and Protective Factor Student Survey, 2023

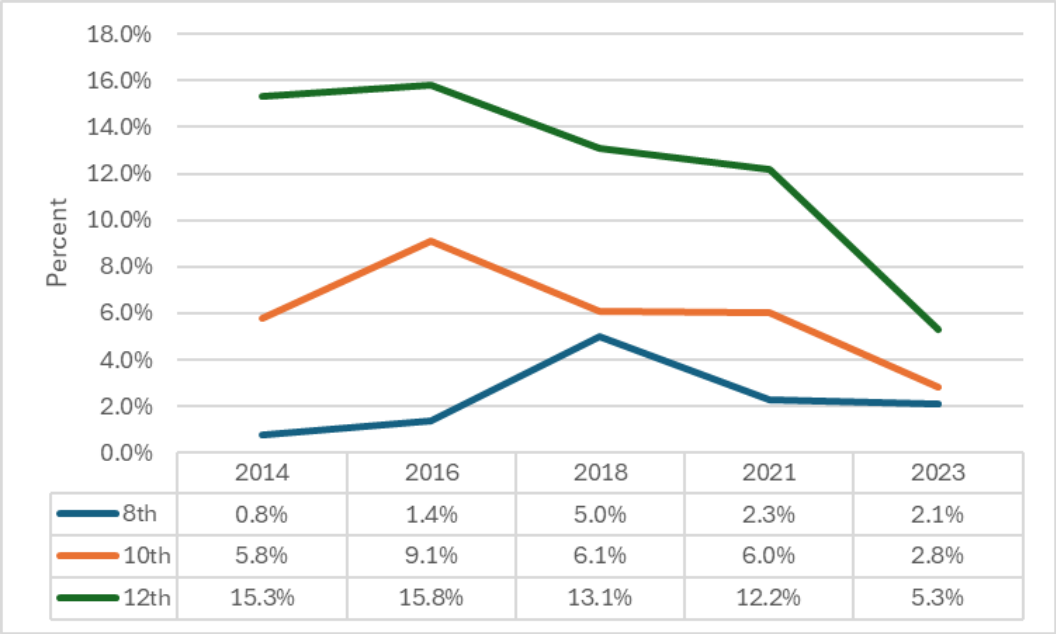
Figure 27. Past 30-Day Smokeless Tobacco Use Among 8th, 10th, and 12th Graders



	2014	2016	2018	2021	2023
8th	2.4%	0.8%	4.2%	0.9%	0.9%
10th	8.5%	8.4%	6.6%	3.2%	0.9%
12th	13.7%	14.2%	10.6%	4.7%	0.0%

Source: Nebraska Risk and Protective Factor Student Survey, 2022

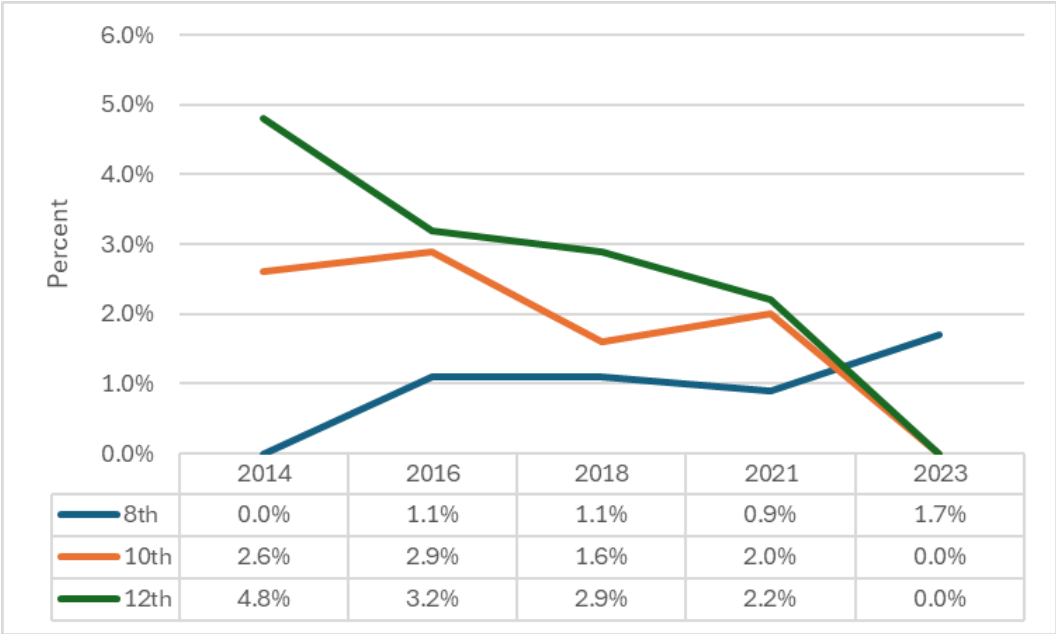
Figure 28. Past 30-Day Marijuana Use Among 8th, 10th, and 12th Graders



	2014	2016	2018	2021	2023
8th	0.8%	1.4%	5.0%	2.3%	2.1%
10th	5.8%	9.1%	6.1%	6.0%	2.8%
12th	15.3%	15.8%	13.1%	12.2%	5.3%

Source: Nebraska Risk and Protective Factor Student Survey, 2023

Figure 29. Past 30-Day Prescription Drug Use (Not Prescribed by a Doctor) Among 8th, 10th, and 12th Graders



	2014	2016	2018	2021	2023
8th	0.0%	1.1%	1.1%	0.9%	1.7%
10th	2.6%	2.9%	1.6%	2.0%	0.0%
12th	4.8%	3.2%	2.9%	2.2%	0.0%

Source: Nebraska Risk and Protective Factor Student Survey, 2023

Accidental Deaths

Accidental deaths include motor vehicle accidents, falls, drug poisoning, fires and burns, drownings, suffocations, work-related accidents, and similar unintentional injuries. Table 37 presents unintentional injury morality rates for the Southeast District. In general, the Southeast District has slightly more accidents and adverse effects resulting in death than the state, although the rates in Richardson County are slightly lower.

Table 37. Accidents and Adverse Effects Age-Adjusted Mortality Rate (2018-2022)			
County	**Deaths per 100,000**	**Average Annual Count**	**Recent Trend**
Nebraska	42	889	rising
Johnson	46.8	3	-
Nemaha	52.1	5	-
Otoe	47.9	9	-
Pawnee	-	3 or fewer	-
Richardson	41.8	4	-

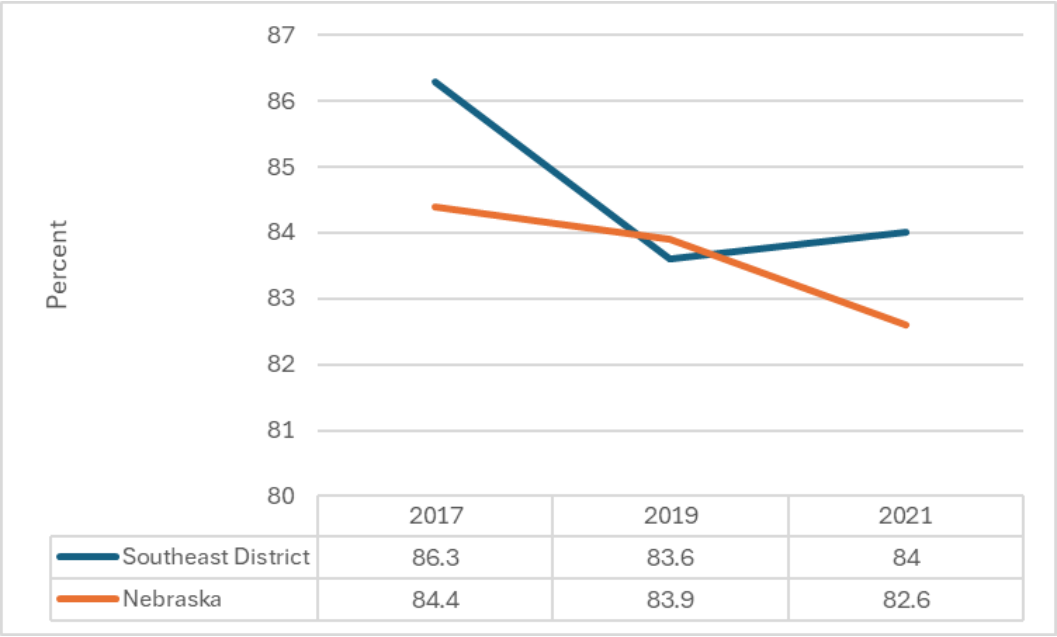
Source: National Institute on Minority Health and Health Disparities, 2024 – Estimates, 2018-2022

Preventive Health

Accessing preventive health care is a crucial health factor to maintain health and prevent diseases. Prevention involves engaging in regular checkups, screening for cancer and other diseases, vaccinations, and healthy lifestyle choices. These actions lead to early detection of potential health issues, fewer premature deaths, and a longer, healthier life.

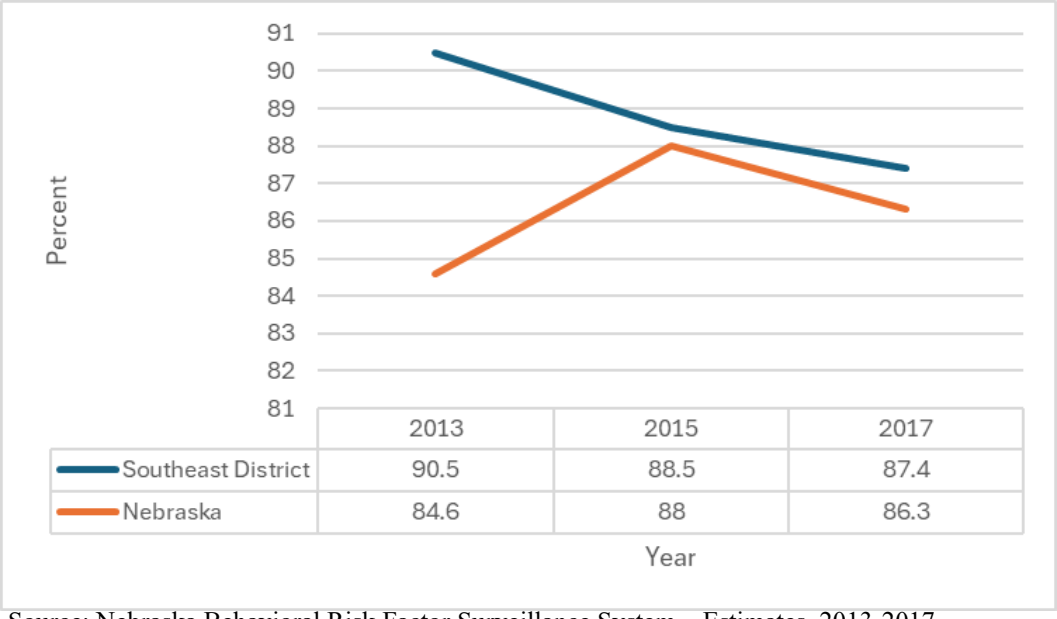
Figures 30-34 illustrate the percentage of Southeast District adults who have completed various health screenings within recommended time frames. Southeast District adults tend to have higher completion rates for blood pressure and cholesterol screenings but lower completion rates for cancer screenings (i.e., colon, breast, and cervical cancer screenings).

Figure 30. Percentage of Adults 18 and Older Who Report Having Had Their Blood Pressure Checked During the Past 12 Months



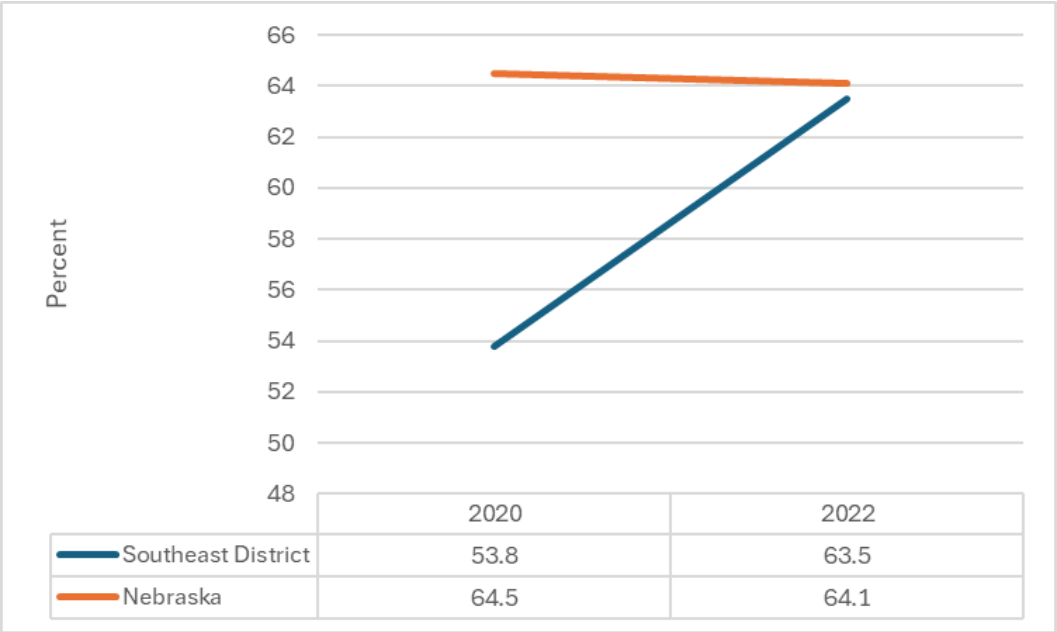
Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2013-2017

Figure 31. Percentage of Adults 18 and Older Who Report Having Had Their Blood Cholesterol Checked During the Past Five Years



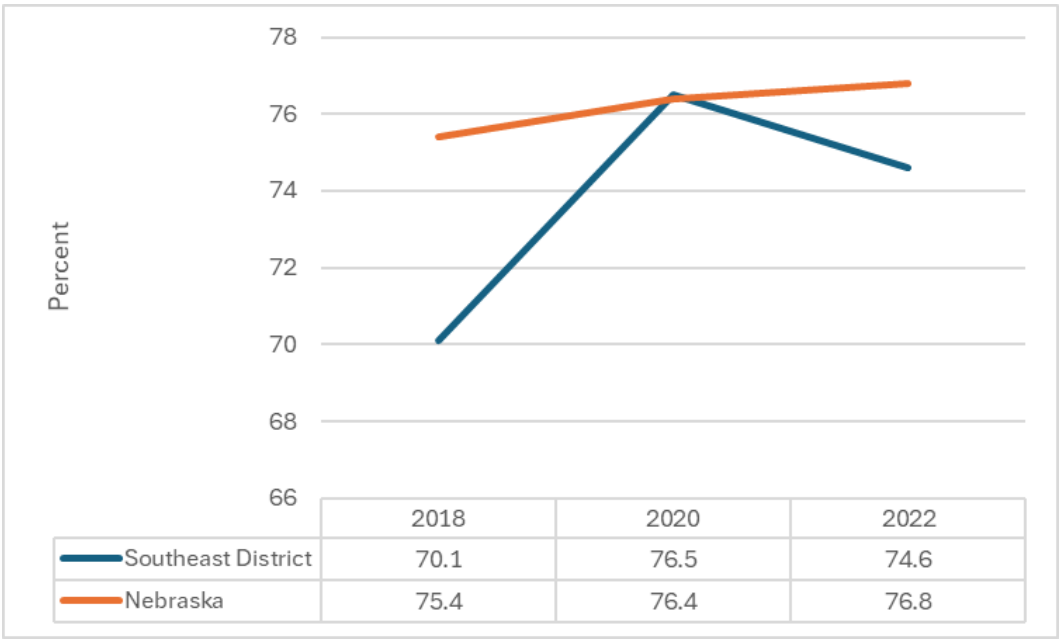
Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2013-2017

Figure 32. Percentage of Adults 45–75 Years Old Who Report Up to Date on Colon Cancer Screening*



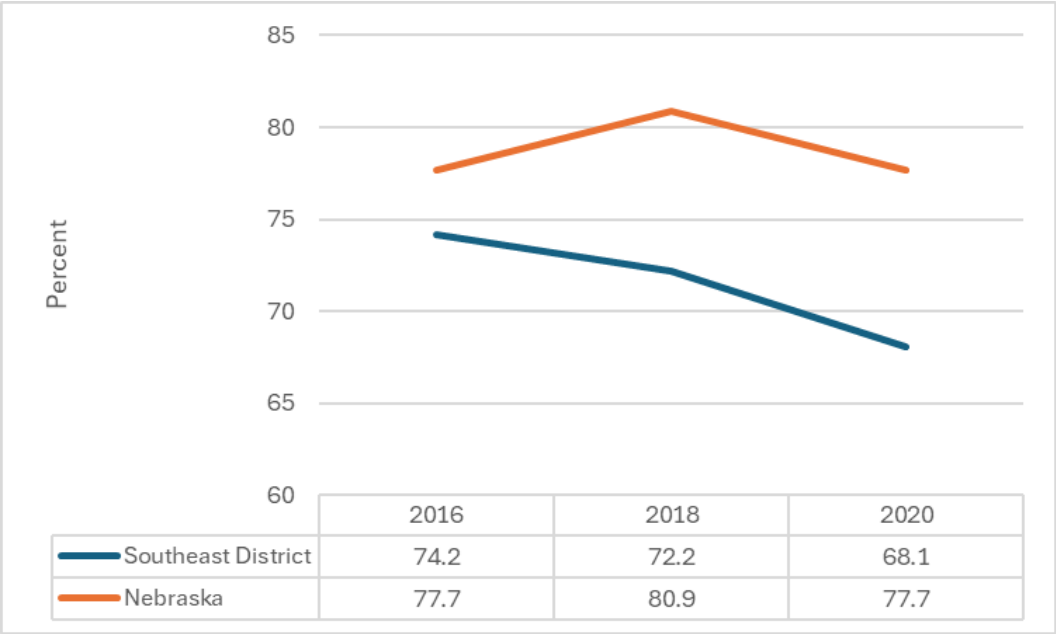
Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2020-2022
*Note: Up to date is determined from a blood stool test in the past year, a stool DNA test in the past 3 years, a sigmoidoscopy in the past 5 years, a virtual colonoscopy in the past 5 years, or a colonoscopy in the past 10 years

Figure 33. Percentage of Females 50-74 Years Old Who Report Having Had a Mammogram During the Past Two Years



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Figure 34. Percentage of Females 21-65 years Old Without a Hysterectomy Who Report Having had a Pap Test During the Past Three Years



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2016-2022

CHRONIC DISEASES

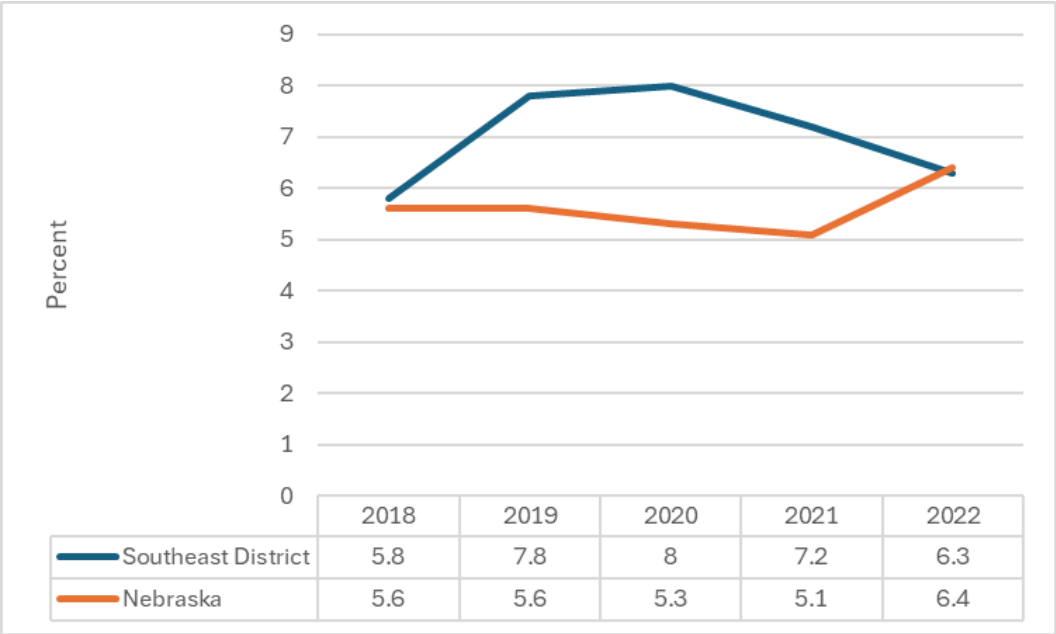
Chronic diseases are the leading cause of illness, disability, and death in the United States and contribute to several negative health outcomes including a decrease in life expectancy, a lower quality of life, and higher health care costs. Many chronic diseases are due to personal risk factors and poor health behaviors such as not eating nutritious foods, excessive alcohol and tobacco use, physical inactivity, and risky behaviors. Many chronic diseases are preventable by addressing these risk factors through preventive screenings, patient education and more effectively using community resources to implement evidence-based intervention strategies. The chronic diseases included are:

- Heart disease
- Stroke
- Blood pressure and cholesterol
- Mental health
- Cancer
- Diabetes
- Respiratory disease

Heart Disease

Figure 35 presents BRFSS response data on heart disease within the Southeast District. In 2022, 6.3% of respondents indicated that they have ever been told they had a heart attack or coronary artery disease, which is slightly below the state percentage. Table 38 displays heart disease, age-adjusted, mortality rates for each county as compared to the state. Only Otoe County has lower mortality rates than the state; all counties except Pawnee County have a relatively stable trend rate.

Figure 35. Percent of Adults Ages 18 and Older Ever Told They Had a Heart Attack or Coronary Heart Disease



	2018	2019	2020	2021	2022
Southeast District	5.8	7.8	8	7.2	6.3
Nebraska	5.6	5.6	5.3	5.1	6.4

Source: National Institute on Minority Health and Health Disparities, 2024 – Estimates, 2018-2022

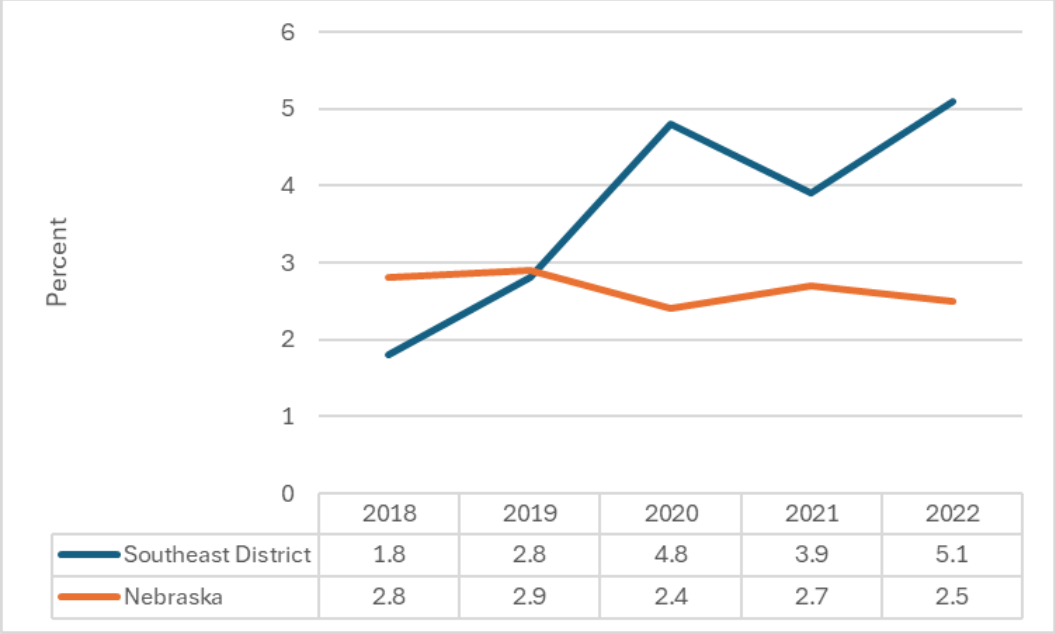
Table 38. Heart Disease Age-Adjusted Mortality Rate (2018-2022)			
County	**Deaths per 100,000**	**Average Annual Count**	**Recent Trend**
Nebraska	149.8	3,638	stable
Johnson	195.6	16	stable
Nemaha	152.1	17	-
Otoe	135.4	37	stable
Pawnee	206.1	12	rising
Richardson	156.8	25	stable

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Stroke

Figure 36 presents data on the percentage of people that have ever been told they have had a stroke within the Southeast District. In 2022, 5.1% of respondents indicated that they have ever been told they had a stroke in the Southeast District, which is considerably higher than the state percentage of 2.5%.

Figure 36. Percent of Adults Ages 18 and Older Ever Told They Had a Stroke



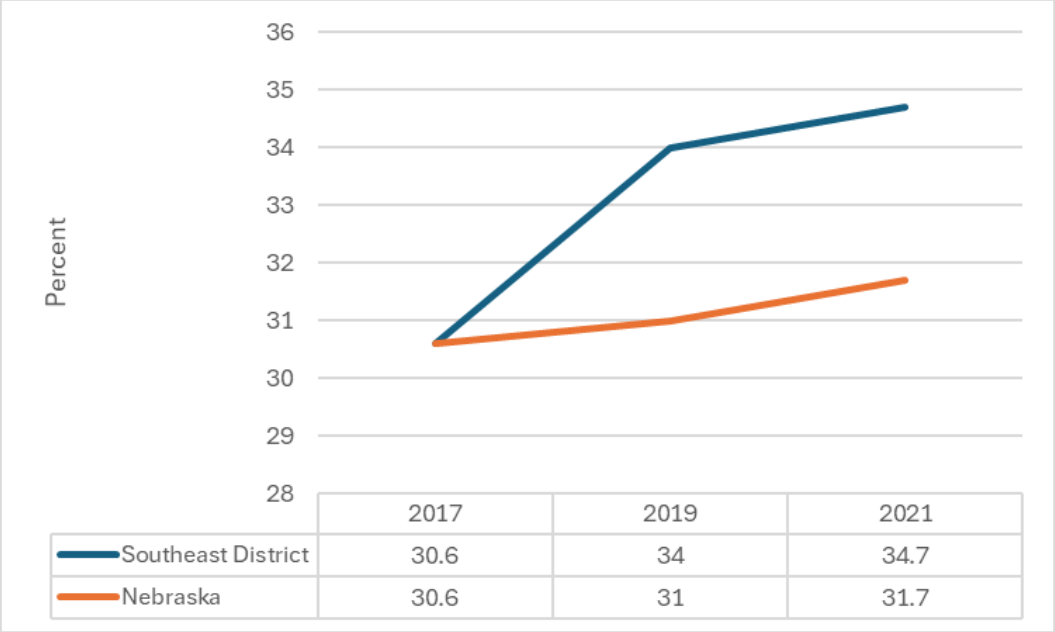
Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

High Blood Pressure & Cholesterol

Figure 37 shows the percentage of people who have ever been told they have high blood pressure within the Southeast District and Nebraska. In 2021, 34.7% of respondents indicated that they had been told they had high blood pressure, a slightly higher rate than the state percentage at 31.7%. Figure 38 reveals the percentage of people who have ever been told that their blood cholesterol is high. In 2021, 40.5% of respondents indicated that they have high cholesterol levels, a slightly higher rate than the state at 34.8%.

Table 39 displays cerebrovascular diseases, age-adjusted, mortality rates for each county as compared to the state. All counties in the Southeast District have higher mortality rates than the State.

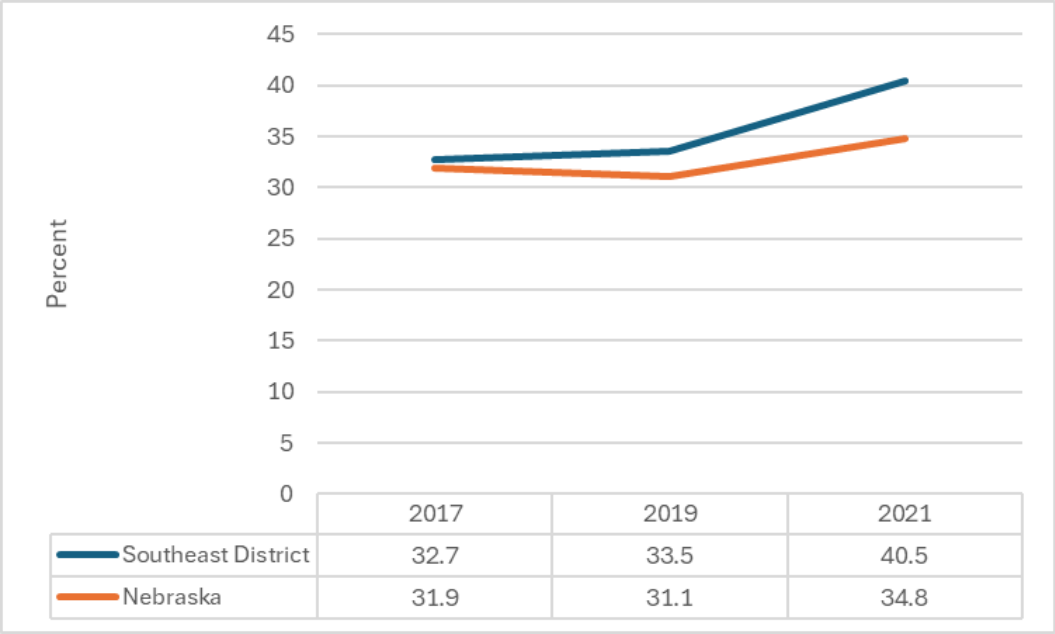
Figure 37. Percentage of Adults 18 and Older Who Report that They Have Ever Been Told They Have Blood Pressure*



	2017	2019	2021
Southeast District	30.6	34	34.7
Nebraska	30.6	31	31.7

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2017-2021
* Excluding pregnancy

Figure 38. Percentage of Adults 18 and Older Who Report that They Have Ever Been Told They Have Ever Been Told that Their Blood Cholesterol is High



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2017-2021

Table 39. Cerebrovascular Diseases Age-Adjusted Mortality Rate (2018-2022)			
County	**Deaths per 100,000**	**Average Annual Count**	**Recent Trend**
Nebraska	34.2	825	stable
Johnson	44.3	4	-
Nemaha	35.2	4	-
Otoe	41.9	11	stable
Pawnee	-	3 or fewer	-
Richardson	37.2	6	-

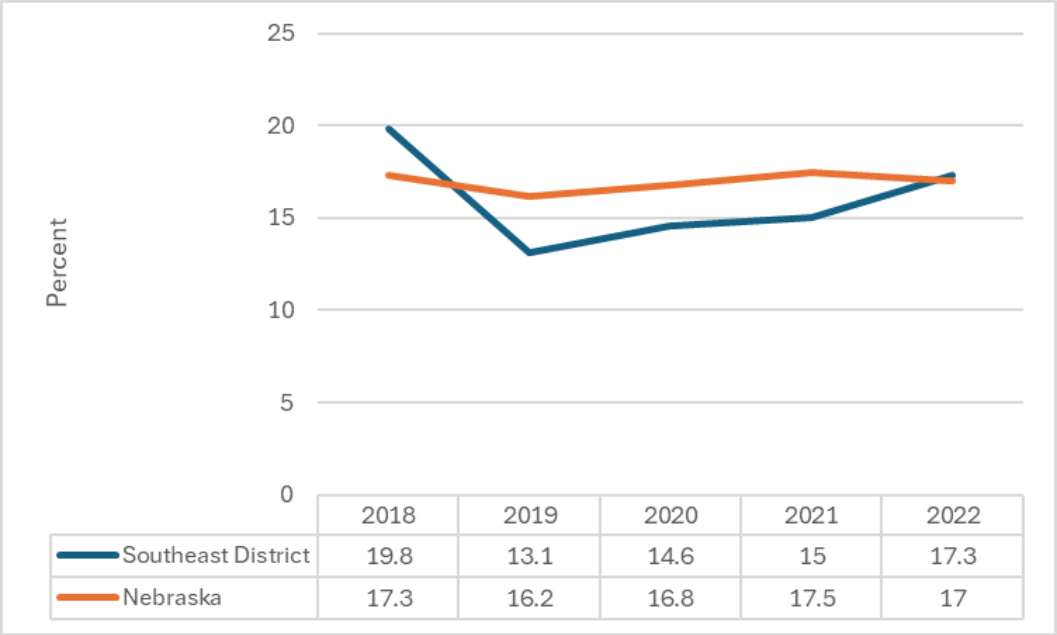
Source: National Institute on Minority Health and Health Disparities, 2024 – Estimates, 2018-2022

Mental Health

Figure 39 presents BRFSS response data on mental health condition of depression, within the Southeast District. In 2022, 17.3% of respondents indicated that they have depression, which is about the same as the state percentage at 17%. Figure 40 presents percentages of Southeast District youth who reported anxiety, depression, and suicide in 2023 among 8th, 10th, and 12th grade students. Depression is the most reported mental health disease and 8th grade students appear to be the most at risk across all mental health categories.

Table 40 displays mental health, specifically suicide and self-inflicted injury, age-adjusted, mortality rates for each county as compared to the state. All counties in the Southeast District have too few instances to make a true comparison.

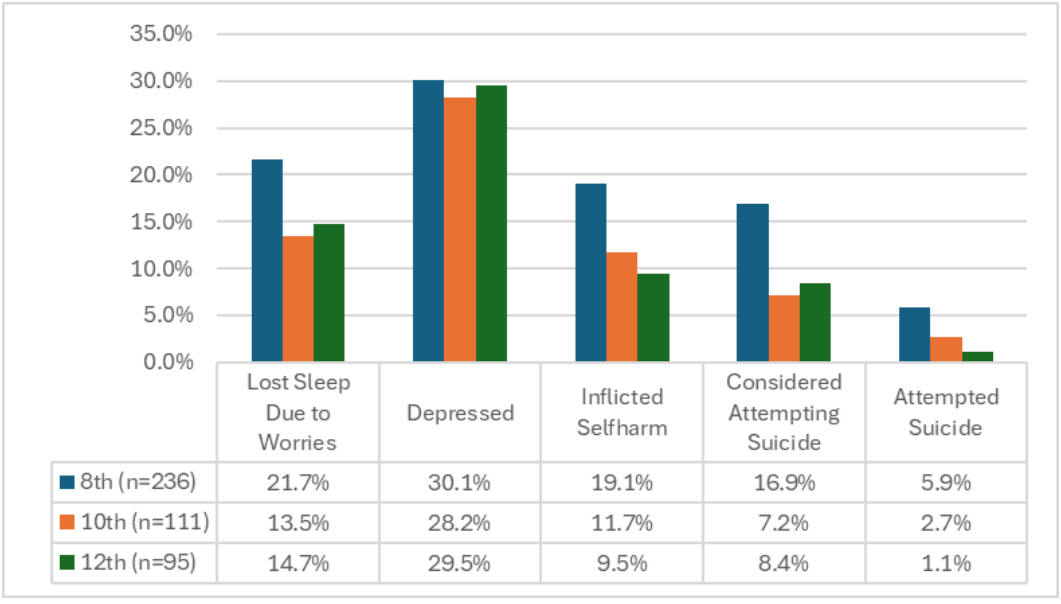
Figure 39. Percentage of Adults 18 and Older Who Report that They have Depression



	2018	2019	2020	2021	2022
Southeast District	19.8	13.1	14.6	15	17.3
Nebraska	17.3	16.2	16.8	17.5	17

Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022
* Includes depression, major depression, dysthymia, or minor depression

Figure 40. Percentage Reporting Anxiety, Depression, and Suicide During Past 12 Months Among 8th, 10th, and 12th Grade Students, 2023



	Lost Sleep Due to Worries	Depressed	Inflicted Selfharm	Considered Attempting Suicide	Attempted Suicide
8th (n=236)	21.7%	30.1%	19.1%	16.9%	5.9%
10th (n=111)	13.5%	28.2%	11.7%	7.2%	2.7%
12th (n=95)	14.7%	29.5%	9.5%	8.4%	1.1%

Source: Nebraska Risk and Protective Factor Student Survey, 2023

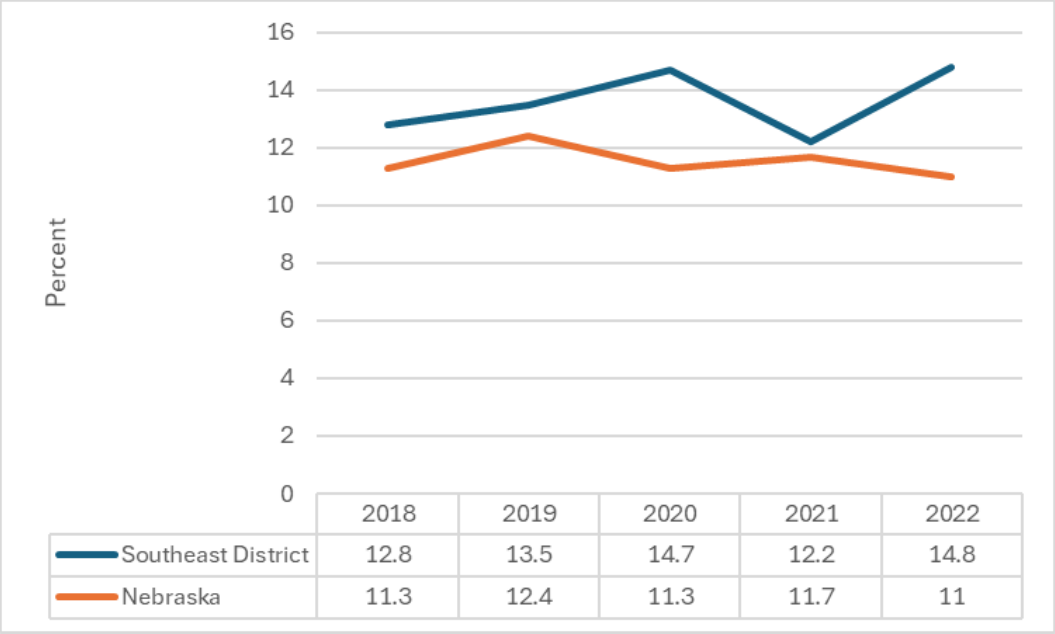
Table 40. Suicide and Self-Inflicted Injury Age-Adjusted Mortality Rate (2018-2022)			
County	**Deaths per 100,000**	**Average Annual Count**	**Recent Trend**
Nebraska	14.9	291	rising
Johnson	-	3 or fewer	-
Nemaha	-	3 or fewer	-
Otoe	-	3 or fewer	-
Pawnee	-	3 or fewer	-
Richardson	-	3 or fewer	-

Source: National Institute on Minority Health and Health Disparities, 2024 – Estimates, 2018-2022

Cancer

Figure 41 shows the percentage of people in the Southeast District and Nebraska who have ever been told they have cancer. In 2022, 14.8% of respondents indicated that they have ever been told they had any form of cancer, higher than the state percentage at 11%. Table 41 displays cancer, age-adjusted, mortality rates for each county as compared to the state. All counties in the Southeast District have higher mortality rates than the state, and only Richardson County has falling rates.

Figure 41. Percent of Adults Ever Told They Have Cancer (any form)



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

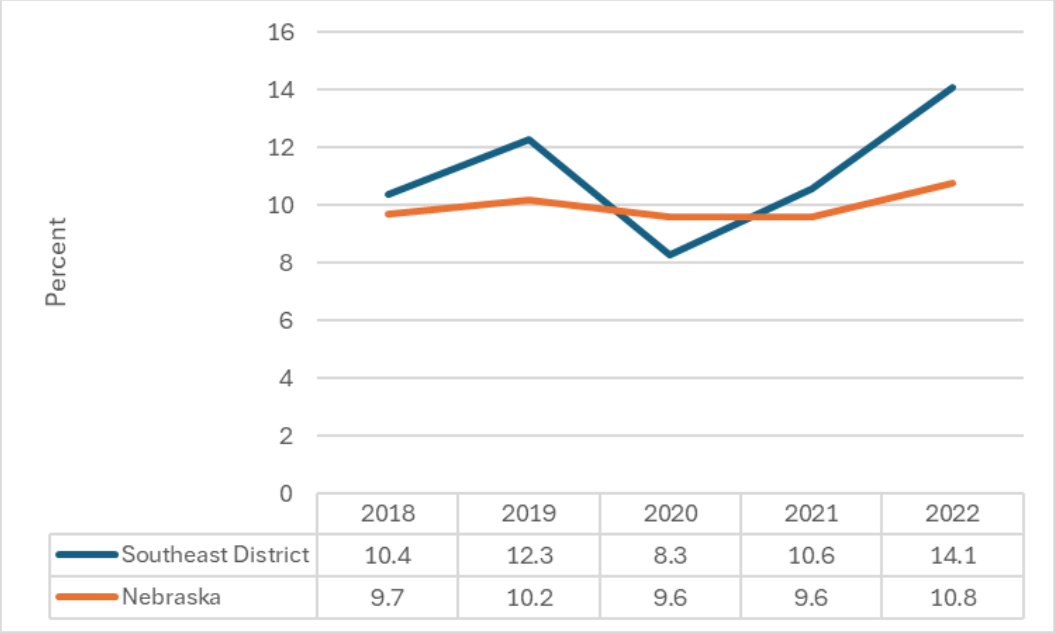
Table 41. Cancer Age-Adjusted Mortality Rate (2018-2022)			
County	**Deaths per 100,000**	**Average Annual Count**	**Recent Trend**
Nebraska	147.6	3,521	falling
Johnson	162.7	12	-
Nemaha	182.3	19	stable
Otoe	151.5	37	stable
Pawnee	156.9	8	-
Richardson	166.5	24	falling

Source: National Institute on Minority Health and Health Disparities, 2024 – Estimates, 2018-2022

Diabetes

Figure 42 presents data on diabetes within the Southeast District. In 2022, 14.1% of respondents indicated that they have ever been told they had diabetes, higher than the state percentage at 10.8%. Table 42 displays diabetes, age-adjusted, mortality rates for each county as compared to the state. All counties have such few data points that they are not comparable. Otoe and Richardson Counties have higher rates than the state.

Figure 42. Percentage of Adults 18 and Older Who Report that They Have Ever Been Told that They Have Diabetes (Excluding Pregnancy)



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

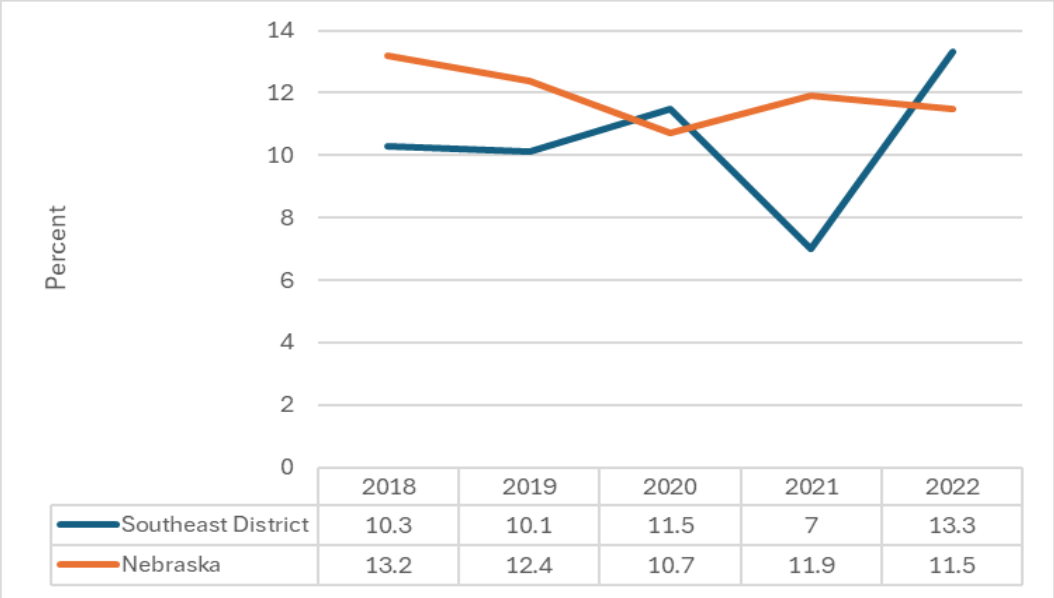
Table 42. Diabetes Age-Adjusted Mortality Rate (2018-2022)			
County	**Deaths per 100,000**	**Average Annual Count**	**Recent Trend**
Nebraska	24.4	576	rising
Johnson	-	3 or fewer	-
Nemaha	-	3 or fewer	-
Otoe	26.9	6	-
Pawnee	-	3 or fewer	-
Richardson	38.7	5	-

Source: National Institute on Minority Health and Health Disparities, 2024 – Estimates, 2018-2022

Respiratory Disease

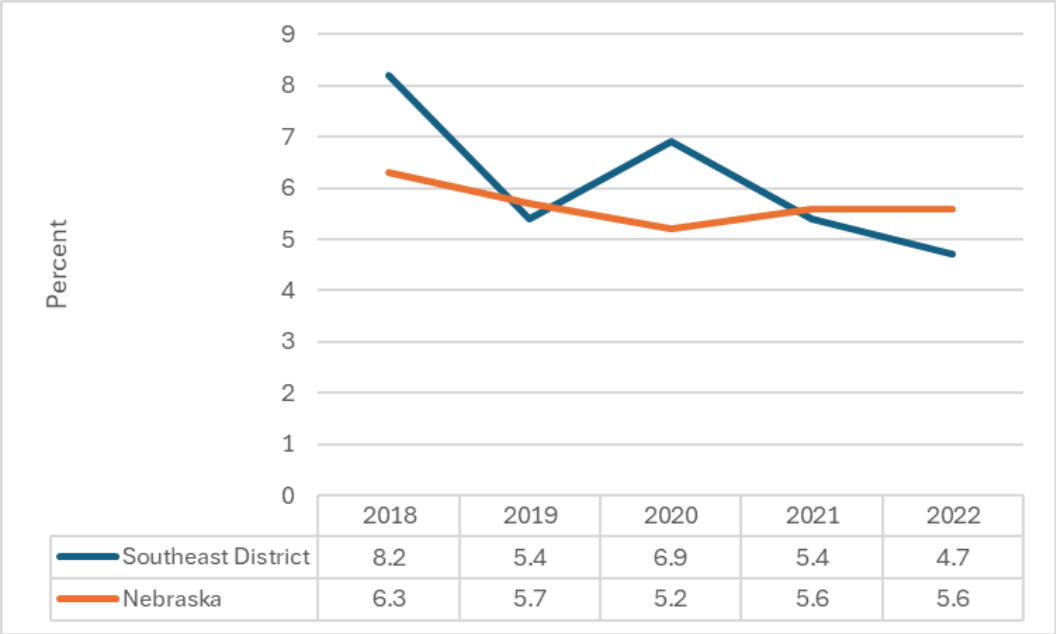
Figure 43 presents data on various respiratory diseases (e.g., asthma), within the Southeast District and Nebraska. In 2022, 13.3% of respondents indicated that they have been told they had asthma, slightly higher than the state percentage at 11.5%. Figure 44 presents data on COPD within the Southeast District. In 2022, 4.7% of respondents indicated that they have ever been told they had COPD, slightly lower than the state percentage at 5.6%. Table 43 displays respiratory diseases, age-adjusted, mortality rates for each county as compared to the state. All counties, except Otoe County, have higher mortality rates than the state, with Richardson and Nemaha Counties far exceeding the state rate.

Figure 43. Percentage of Adults 18 and Older Who Report that They Currently Have Asthma



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Figure 44. Percentage of Adults Ages 18 and Older Ever Told They Have Chronic Obstructive Pulmonary Disease



Source: Nebraska Behavioral Risk Factor Surveillance System – Estimates, 2018-2022

Table 43. Chronic Lower Respiratory Disease Age-Adjusted Mortality Rate (2018-2022)			
County	**Deaths per 100,000**	**Average Annual Count**	**Recent Trend**
Nebraska	43.1	1,042	falling
Johnson	49.1	4	-
Nemaha	61.8	7	-
Otoe	42.6	11	-
Pawnee	-	3 or fewer	-
Richardson	64.9	10	-

Source: National Institute on Minority Health and Health Disparities, 2024 – Estimates, 2018-2022

SUMMARY AND CONCLUSIONS

The Southeast District has both strengths and weaknesses when examining the factors that influence health outcomes, including both the length of life and the quality of life in their communities. Some of the major strengths and weaknesses are listed below.

Strengths

- Unemployment rates are low in most counties.
- There has been some success in recruiting primary care professionals, and there are strong hospitals.
- Long-term care facilities are available in four of the five counties.
- Most people feel they live in a safe community.
- Mental health status is generally better than state averages.
- The percentage of adults that do not have a personal doctor or health care provider is substantially lower in the Southeast District as compared to the state (9.1% vs. 17.1% in 2022).

Weaknesses

- Overall, the population declined from 2010 to 2020 by 1.7%.
- The poverty rate varies, but it is above the state average in three of the five counties in the Southeast District.
- Based on the focus group discussions, some of the major challenges in the Southeast District were (1) lack of affordable housing, (2) shortage of health professionals, particularly mental health professionals and EMS volunteers.
- A strong perception that behavioral health issues are a major problem.
- Overall physical health issues are worse in the Southeast District as compared to state averages, but it could be due to a larger older population.
- The adult obesity rate is significantly above the state average (e.g., 39% versus 35% in 2022).
- No leisure time physical activity is also worse than the state average.
- There is an upward trend in the number of adults using e-cigarettes.
- The cancer screening rates for colon and breast cancer are below the state rates.
- For most years, the number of adults in the Southeast District who have ever been told they have high blood pressure or diabetes are generally above the state averages.

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Pawnee County Memorial Hospital
John Werner, Chief Executive Officer

Community Medical Center
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REFERENCES

Centers for Disease Control and Prevention. (2018). *The public health system and the 10 essential public health services.* Retrieved from https://www.cdc.gov/public-health-gateway/php/about/?CDC_AAref_Val=https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

National Center for Health Statistics, final natality data. Retrieved from https://www.marchofdimes.org/peristats/assets/s3/reports/documents/March-of-Dimes-2024-Full-Report-Card.pdf

Nebraska Crime Commission. (2024). *Arrest and offense data.* Retrieved from https://ncc.nebraska.gov/data-and-reports

Nebraska Department of Health and Human Services. (2024). *Nebraska behavioral risk factor and surveillance system*. Retrieved from https://dhhs.ne.gov/Pages/BRFSS.aspx

Nebraska Department of Health and Human Services. (2023). Nebraska risk and protective factor student survey – Southeast District Health Department report. Retrieved from https://bosr.unl.edu/projects/sharp/nrpfss/health-department-level-data .

Nebraska Department of Health and Human Services-Nebraska Office of Rural Health. (2019). *State shortage areas.* Retrieved from https://dhhs.ne.gov/Pages/Rural-Health.aspx

University of Wisconsin Population Health Institute County Health Rankings and Roadmaps. (2024). *Health data.* Retrieved from https://www.countyhealthrankings.org/health-data

U.S. Health and Human Services National Institutes of Health. (2024). Health outcomes. Retrieved from https://hdpulse.nimhd.nih.gov/data-portal/home

U.S. Health and Human Services. (2024). Health professions shortage areas. *Health Resources and Services Administration.* Retrieved from https://data.hrsa.gov/tools/shortage-area/

U.S. Census Bureau. (2021). *2020 Population and Housing State Data.* Retrieved from https://www.census.gov/library/visualizations/interactive/2020-population-and-housing-state-data.html

U.S. Census Bureau. (2024). *American Community Survey Data.* Retrieved from https://www.census.gov/programs-surveys/acs/data.html

Appendix B

Southeast District Health Department

2025 Community Health Improvement Plan

June 2025

Table of Contents

Acknowledgements

The SEDHD wants to thank all the people and organizations who participated in the planning process which included the development of the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP). It was a lengthy process that began in June of 2024 and ended in June of 2025. We want to specifically acknowledge the CEOs and staff from the Johnson County Hospital in Tecumseh, the Nemaha County Hospital in Auburn, The Pawnee County Memorial in Pawnee City, The Community Medical Center in Falls City, CHI Health St. Mary's in Nebraska City, and Syracuse Area Health in Syracuse.

Introduction

In June of 2024, the Southeast District Health Department (SEDHD) in conjunction with the six hospitals in the district (the Johnson County Hospital, the Nemaha County Hospital, the Pawnee County Memorial Hospital, the Community Medical Center in Falls City, CHI St. Mary's in Nebraska City, and the Syracuse Area Health) and other health care providers, city officials, and nonprofit organizations began developing a Community Health Assessment (CHA). The purpose of the CHA is to describe the health status of the population, including health disparities and at-risk populations, barriers and gaps limiting access to health care services, the strengths and weaknesses of the current health system, and the resources that are currently available to address the challenges and improve health outcomes and the quality of life for those living in the five counties of the SEDHD. The CHA was completed in March of 2025, and it will be used by the nonprofit hospitals to develop their community health needs assessments (CHNAs) and Implementation Plans that are required under the Affordable Care Act. It also serves as a resource for other community partners and is the foundation for setting priorities for the SEDHD.

The purpose of the Community Health Improvement Plan (CHIP) is to set the priorities for the SEDHD and develop an implementation/action plan for addressing the priority needs. The action plan includes broad goals, specific objectives to achieve the goals, and activities that will be undertaken. It also includes a time limit, the roles of the SEDHD and its partners, and expected outcomes to monitor progress.

Overview of the Process for Setting Priorities

The process for setting priorities involved several steps. First, the SEDHD scheduled a meeting on March 18, 2025, to begin the process of establishing priorities. Invitations were sent to the six hospitals in the district, and they were encouraged to invite additional community partners. A total of 14 people attended the meeting, including representatives from all of the six hospitals in the district and staff from the SEDHD. The meeting was facilitated by staff from the College of Public Health at the University of Nebraska Medical Center.

At the meeting, some background information about the CHA process was explained and key findings from the CHA were reviewed. The key findings were based on a community perception survey from individuals in each county, including the strengths and weaknesses of the local health system and the major health challenges in the county. In addition, there was a comprehensive analysis of several secondary data sources (e.g., BRFSS and the County Health Rankings), and focus groups organized by each of the six hospitals. The focus groups discussed the results of the survey in their county and reviewed a summary of

results from the data analysis. After the discussion, each focus group developed a list of major health challenges in their county and then identified 3-5 priority areas for their county.

As a next step, the attendees of the March 18 meeting reviewed these county priorities and discussed other criteria that could also be considered when setting priorities for the entire southeast district. These criteria included:

- Magnitude of the problem – number of people affected
- Severity of the problem – number of premature deaths and impact on the quality of life
- Readiness of communities in the southeast district to address the problem
- Applicable effective interventions
- Resources available and sustainable
- Individual county priorities

High Priority Challenges

During the discussion, the following four health challenges were identified as potential high priorities to improve the health and well-being of people in the southeast district:

- **Improve access to behavioral health services**
- **Reduce transportation barriers**
- Increase child and adult day care services
- Increase wellness and recreational activities

All of the challenges listed were high priorities in either every county or the majority of the counties. After considerable discussion, the group selected the top two issues: (1) improve access to behavioral health services and (2) reduce transportation barriers which are bolded in the list above.

The rationale for this selection was based on several factors. First, the top two issues will most likely require a network-wide approach whereas the approach to child and adult day care challenges and wellness and recreational activities will likely differ between communities and are likely strategies that should be worked on locally. While these are high priorities for all communities, resources and progress vary considerably among the communities.

In addition to a network district-wide approach, access to behavioral health services and transportation barriers affect a large number of people and impacts the quality of life for many people throughout the district. All communities are ready to address these issues,

and there are effective interventions. While resources are an issue, a district-wide approach would increase the likelihood of success as compared to each community attempting to solve the problems separately. A separate approach has been used in the past with only limited success.

Action Plans to Improve Access to Behavioral Health Services and Reduce Transportation Barriers

There was unanimous agreement on the goal – improve access to behavioral health services, and there was some discussion about what barriers and gaps should be addressed first (e.g., availability of behavioral health professionals, the stigma attached to behavioral health, suicide prevention in schools, inadequate insurance coverage, using community health workers, and billing for navigation services). For reducing transportation barriers, potential actions could include creating an Uber or Lyft type company, developing a volunteer network, and exploring grant opportunities. As a result, the group agreed that the first step should be to identify the resources across the district that are currently available, the root causes of the challenges, and the data that are most helpful in defining the issues and at-risk population groups. It would also be helpful to know what programs and strategies (e.g., telehealth and mobile apps) have worked in communities across the state.

This work should be completed in the next six months and then a comprehensive workplan with specific objectives, activities to achieve the objectives, a time limit for completion, the organizations responsible, and performance measures to monitor progress.

SEDHD Workplan

Goal 1: Improve access to behavioral health services
Objective 1: By December 31, 2025, develop an asset map of the resources currently available in the SEDHD region
Activities to Meet the Objective

Activity	Target Completion Date	Staff Responsible	Expected Outcome
1. Develop an asset map of the behavioral health services available	July 1, 2025	SEDHD and the six hospitals in the region	Inventory of behavioral health services
2. Assess the gaps in behavioral health services	September 1, 2025	SEDHD and the six hospitals in the region	Gaps in services (e.g., workforce shortages) identified
3. Prepare a report that highlights gaps in services and includes recommendations	September 30, 2025	SEDHD	Report completed and disseminated

Objective 2: By December 31, 2025, collect and analyze the data related to the prevalence of behavioral health problems in the SEDHD region and identify best practices for expanding access to behavioral health services

1. Analyze available data (e.g., BRFSS)	September 1, 2025	SEDHD	Data analyzed
2. Contact other LHDs, hospitals, and others to identify best practice strategies	October 1, 2025	SEDHD	Interviews completed and best practices identified
3. Report prepared which includes recommendations and best practices	November 1, 2025	SEDHD	Report completed and disseminated

Goal 2: Reduce transportation barriers
Objective 1: By December 31, 2025, develop an asset map of the transportation resources currently available in the SEDHD region

1. Develop an asset map of current transportation resources	**July 15, 2025**	**SEDHD and six hospitals in region**	**Inventory of transportation resources**
2. Assess the transportation resource gaps	**September 1, 2025**	**SEDHD and six hospitals in the region**	**Gaps in Services identified**
3. Prepare a report that highlight gaps and includes recommendations	**September 30, 2025**	**SEDHD**	**Report prepared and disseminated**

Objective 2: By December 31, 2025, identify best practices for reducing transportation barriers in the SEDHD region

1. Contact other LHDs, hospitals, and others to identify best practice strategies	**September 1, 2025**	**SEDHD**	**Information collected**
2. Prepare a report outlining best practices	**September 30, 2025**	**SEDHD**	**Report prepared and disseminated**

Next Steps

Staff from the SEDHD, representatives from the six hospitals in the region, and other partners will review the workplan, modify it where appropriate, and approve the first stage of the action plan. Once the activities are completed, the plan will be updated to include additional activities that are essential to achieve the two main goals by the Fall of 2027.