MercyOne Oakland Medical Center is pleased to share with you our 2020 Community Health Needs Assessment. MercyOne is committed to transforming the health of those living within the communities served. This report is a tangible representation of our continued commitment to that goal.

MercyOne Oakland partnered with the Elkhorn Logan Valley Public Health Department to complete the community health needs assessment. MercyOne Oakland Medical Center opted to follow the principles of National Association of County and City Health Officials (NACCHO) Mobilizing for Action through Planning Partnerships (MAPP) process. It is a community-driven strategic planning process for improving community health. As a result, this report includes community thoughts from online survey respondents and 50 community stakeholders.

This wealth of quantitative and qualitative data allowed us to fulfill our commitment to the community by prioritizing their needs in the assessment. The CHNA Team would like to thank everyone who was involved in development of this assessment. We would also like to thank you for reading this report, and your interest and commitment to improving the health of the communities.
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April 26, 2020

Dear Partners and Citizens of Burt and Cuming Counties,

Every three years MercyOne Oakland Medical Center partners with Elkhorn Logan Valley Public Health Department and other community stakeholders to conduct a community health needs assessment. The public in the area was surveyed using a detailed questionnaire. A research firm compiled the results of the survey and combined them with pieces of data specific to the service area. With this information, a group of public health stakeholders gathered to discuss and share concerns, identify strengths of our communities, and to identify priorities that we can work on together to improve the health status of the people in the communities we serve. The top three priority areas identified by the data and subsequent community group were healthy foods and physical activity which will impact the prevalence of chronic disease, mental health and prevention of mental health issues, and healthcare provider shortage.

This wealth of quantitative and qualitative data allowed us to fulfill our commitment to the community by prioritizing their needs in our assessment. We would like to recognize the many providers, agencies, and community partners that are committed to improving the health of our communities. MercyOne Oakland Medical Center would like to thank everyone who was involved in the development of this assessment. We would also like to thank you for reading this report, and your interest and commitment to improving the health of the communities.

Sincerely,

Rob Stowe
Executive Director Rural Hospital Operations
Executive Summary

Community Health Needs Assessment

The Affordable Care Act and the Health Care Education Affordability Reconciliation Act, both enacted in March 2010, mandate tax-exempt hospital organizations to conduct a Community Health Needs Assessment every three years, beginning in 2011. Once again, MercyOne Oakland Medical Center collaborated with Elkhorn Logan Valley Public Health to complete the Community Health Needs Assessment. The CHNA Planning Team elected to utilize the National Association of Counties and Cities Health Officials (NACCHO), Mobilizing for Action through Planning and Partnerships (MAPP) community-driven strategic planning process to complete their community health needs assessment. Data was gathered from the counties of Burt and Cuming counties. After reviewing the information and the data available, the following three needs were identified for the Oakland area: Access to Care, Mental Health Access and Prevention, and Chronic Disease Management and Prevention. The community health needs assessment is not designed to be an exhaustive list of the area’s health concerns. Rather this document represents the three-year health concern priorities and is the starting point from what must be done to achieve measurable progress for the health of area residents. The Community Health Improvement Plan is a supporting document that includes actionable performance measures keyed to the four identified areas of need.

MercyOne Oakland Medical Center's mission is to serve with fidelity to the Gospel as a compassionate, healing ministry of Jesus Christ to transform the health of our communities. MercyOne Oakland Medical Center is dedicated to serving and benefitting our community by continuing our healing ministry and promoting the wellbeing of people in our community. The community, in turn, supports MercyOne Oakland through serving on our boards, volunteering for special hospital events and providing generous philanthropy. Together, we are continuing to serve the MercyOne Oakland mission by living the values of justice, compassion, integrity, reverence, commitment to the poor, excellence, and stewardship.

MercyOne Oakland Medical Center is a nonprofit, community-based health care facility that is classified as a critical access hospital in Oakland, Nebraska. MercyOne Oakland Medical Center and its associated clinics are committed to providing quality health care to the residents of Burt and surrounding counties by offering a broad spectrum of services and programs enhanced by caring professionals which include cardiology and vascular care, general surgery, lab, sleep medicine, diabetic education, family medicine, emergency care, imaging and radiology, and physical therapy and rehabilitation. MercyOne Oakland Medical Center is owned by MercyOne Siouxland Medical Center, a member of Trinity Health, Livonia, Michigan. MercyOne Oakland Medical Center is a member of the Nebraska Hospital Association. The owned affiliate clinics include MercyOne Oakland Family Medicine, MercyOne Tekemah Family Medicine, and MercyOne Lyons Family Medicine.

MercyOne Oakland Medical Center and ELVD recognize that by including members from many organizations throughout the community, we can accomplish more than what could be done by any one organization alone. The purpose of the community health needs assessment and improvement planning is to align efforts of these various organizations to move forward in
improving the health of the community in a strategic manner.

What follows is the result of the community’s collaborated effort and planning to address health concerns in a way that combines resources and energy to make a measurable impact on the health issues in the area and that there are many assets within the area that will aid in the accomplishment of these efforts. In the spirit of holding true to the ‘community-driven’ intent of this process, community engagement was an overarching concept encompassing the Community Health Needs Assessment, and the subsequent formation of the Community Health Improvement Plan. As such, community engagement is discussed under: 1). the Follow-Up and Monitoring section of this plan; and 2). the Detailed Plans for Priority Areas and Strategies work plan tables.

Supplementary Recognitions

In addition, the Midtown Health Center, Inc. (the local, Federally-Qualified Health Center), has to satisfy requirements for their ongoing federal funding. As such, they periodically assess the needs of the community that they serve to validate the necessity of their services based upon data that is available. For this reason, Midtown Health Center helped to inform the development and implementation of the survey, as well as the community stakeholder process in order to achieve their data needs. Continued success of the Midtown Health Center is a vital necessity in the for the community residents as a major provider of healthcare to the uninsured and underinsured populations in the area.

The Ponca Tribe of Nebraska—particularly the Tribal clinic located in Norfolk, NE, serves as a major partner in the community health needs assessment process. Because many Tribal members reside within the health district, collaborating to improve the health of the Native American population is an important consideration when choosing culturally-appropriate strategies and outcomes.

Finally, due to the national momentum to achieve clinical transformation in the nation, neighboring health districts are collaborating across jurisdictional lines to align their Community Health Improvement Plan priorities, goals and outcomes. This is due to the geographical reach of the rural hospital systems and their satellite medical clinics located in neighboring health department jurisdictions. To that end, ELVPHD included input and participation from the following neighbors—

- Three Rivers District Health Department
  - Memorial Community Hospital & Health System—Blair, NE (operates a medical clinic in Tekamah, NE).
  - Franciscan Care Services—West Point, NE (operates family medicine clinics in Hooper and Scribner, NE).

- North Central District Health Department
  - Faith Regional Health Services/Faith Regional Physician Services—Norfolk, NE (operates family medicine clinics in Pierce and Neligh NE, as well as holds an Affiliate Partnership with Niobrara Valley Hospital, Niobrara, NE).
• Northeast Nebraska Public Health Department
  o Faith Regional Physician Services—Norfolk, NE (operates family medicine clinics in Wakefield, Wayne and Laurel, NE).
  o Pender Community Hospital—Pender, NE (operates family medicine clinics in Bancroft and Beemer, NE).

Hospital and Local Public Health Collaborations

Some of the major drivers in continuing a high level of collaboration between the health department and the hospitals include:

1. Nebraska State Statutes: Nebraska Statutes (under 71-1628.04) provides guidance on the roles public health departments must play and provides the following four (of the ten) required public health essential services, which fit into the public health role in the Community Health Improvement Plan.

   ...Each local public health department shall include the essential elements in carrying out the core public health functions, to the extent applicable, within its geographically-defined community, and to the extent funds are available. The essential elements include, but are not limited to, (a) monitoring health status to identify community health problems, (b) diagnosing and investigating health problems and health hazards in the community, (c) informing, educating, and empowering people about health issues, (d) mobilizing community partnerships to identify and solve health problems...

2. The Patient Protection and Affordable Care Act Impact on Hospitals: The historic passage of the Patient Protection and Affordable Care Act (PPACA) called on non-profit hospitals to increase their accountability to the communities they served. PPACA created a new Internal Revenue Code Section 501(r), which clarified certain responsibilities for tax-exempt hospitals. Although tax exempt hospitals had long been required to disclose their community benefits, PPACA added several new requirements. Section 501(r) required a tax-exempt hospital to:
   - Conduct a community health needs assessment every three years
     o The assessment must continue to take into account input from persons who represent the broad interests of the community served, especially those of public health
   - Develop an implementation plan and strategy that addresses how a hospital plans to meet EACH of the health care needs identified by the assessment
     o This plan must continue to be adopted by each hospital’s governing body of the organization, and must continue to include an explanation for any assessment findings not being addressed in the plan
   - Widely publicize assessment results
As mentioned earlier, this requirement affects the MercyOne Oakland Medical Center in the ELVPHD service area. The Public Health Accreditation Board (PHAB) only requires public health departments to conduct a comprehensive community health needs assessment at a minimum of every five years, or more often at the discretion of each public health department. Because of ELVPHD’s continued desire to collaborate with the hospitals within its jurisdiction, ELVPHD has committed to continue to conduct their community health assessment every three years, on the same rotation as the hospitals.

3. Redefinition of Hospital Community Benefit: Hospitals have been providing community benefits for many years in a variety of ways. In return, hospitals receive a variety of local, state, and federal tax exemptions. The activities listed under “community benefit” are reported on the hospital’s IRS 990 report.

Community benefit was recently defined by the IRS as “the promotion of health for a class of persons sufficiently large so the community as a whole benefits.” Simply put, community benefit is composed of programs and services designed to address identified needs and improve community health. To qualify as community benefit, initiatives must respond to an identified community need and meet at least one of the following criteria:

- Improve access to healthcare services
- Enhance health of the community
- Advance medical or health knowledge
- Relieve or reduce the burden of government or other community efforts

4. Public Health Accreditation Board (PHAB) Requirements: In July of 2011, the PHAB released the first public health standards for the launch of national public health department accreditation. All local health departments pursuing voluntary public health accreditation must have completed a CHA and CHIP. Since the time that the first standards were developed, PHAB Version 1.5 has been released and includes standards that are required of participating local health departments. Relevant standards include:

- Participate in, or lead, a collaborative process resulting in a comprehensive community health assessment
- Collect and maintain reliable, comparable and valid data that provide information on conditions of public health importance and on the health status of the population
- Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public’s health
- Provide and use the results of the health data analysis to develop recommendations regarding public health policy, processes, programs or interventions
Community Description and Demographic Data

The community served is predominantly the primary service area of Burt and Cuming counties in Nebraska. This service area was chosen as the community to assess because those served by MercyOne Oakland Medical Center and its owned affiliates of MercyOne Oakland Family Medicine, MercyOne Tekemah Family Medicine, and MercyOne Lyons Family Medicine reside in the two counties of Burt and Cuming.

Community and demographic data was analyzed for these two counties to get an understanding of who the constituents were that are being served by this plan, and to understand how the constituents compared to the rest of the state of Nebraska. Sources used were the Behavioral Risk Surveillance Survey (BRSS), County Health Rankings, American Community Survey/U.S. Census Bureau, Centers for Disease Control, Nebraska Crime Commission, Nebraska Department of Education, and the U.S. Bureau of Labor Statistics to assess the health status of the region and identify emerging issues, trends, and changes from the prior Community Health and Needs Assessment. Further demographic details are included in the subsequent sections.

Additionally, this community health status assessment reviewed the responses to the community health survey distributed across the region to determine Community Themes and Strengths. The survey assessed perceptions of important health issues, including well-being and quality of life. It also asked about the assets available in communities. This survey was available in English and Spanish, both in print and online. Print copies were distributed through the ELVHD and their partners. Additionally, ELVPHD posted the survey link on the ELVPHD website and Facebook.
Population Demographics

Nebraska’s rural population is decreasing while the urban population is increasing. Nebraska’s population in the 2018 Census was estimated at 1,929,268. This count was up 5.6% from the 2010 Census and consistent with the national increase of 6.0% during the same period. Growth has occurred in all four of the urban counties of Nebraska. Conversely according to the US Census, Burt and Cuming counties experienced a decrease in population between 2010 and 2016 as demonstrated below. The overall census of Burt County in 2016 was 6,546 and 9,016 in Cuming County.

Race and Ethnicity

The largest group by race in both Burt (95.1%) and Cuming (97.3%) counties was classified as white according to the 2017 U.S. Census. In the state of Nebraska, there was a significant Hispanic growth rate, between 2005 and 2014. The Latino population growth rate was more than five times higher than the overall population growth rate within Nebraska (55% vs. 10%). Hispanics represented 5.6% of the total population in Nebraska in 2000, 9.2% in 2010, and 10.4% in 2015. It is estimated that by 2025 the Hispanics will make up nearly a quarter of Nebraska’s population (23.4%). Hispanics in Nebraska are from a variety of countries, but Mexico is the primary country of origin (76%).
The percent of Hispanic residents in Burt County was 3% and 10% in Cuming County which were lower than the current percentage for Nebraska of 11%. Moreover, Burt and Cuming counties border two Indian Reservations, Winnebago and Omaha. The Ponca Tribe is a landless tribe with members residing within the service area. The American Indian/Alaskan Native population of Burt was 2.3% and .5% in Cuming.

According to the 2017 data from the United States Census, the residents of Burt and Cuming counties were identified by the following racial groups:

<table>
<thead>
<tr>
<th>Race</th>
<th>Burt</th>
<th>Cuming</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>95.1%</td>
<td>97.3%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>.6%</td>
<td>.4%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>2.3%</td>
<td>.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>.4%</td>
<td>.5%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>.1%</td>
<td>.1%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>1.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>3%</td>
<td>10.6%</td>
</tr>
<tr>
<td>White alone, not Hispanic or Latino</td>
<td>92.9%</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Age Demographics

Residents under the age of 18 comprised 22.3% of the Burt County population and 24.4% of Cuming County. Individuals over the age of 65 made up 23.6% of Burt County and 21.9% of Cuming County. The percent of the population over 65 was significantly higher in Burt and Cuming county when compared to the state average of 15%. The census of Burt County in 2016 was 6,546 and 9,016 in Cuming County.

Economic Status

The median household incomes were $50,174 in Burt County and $50,734 in Cuming County in 2018 which were lower than the overall median income of $56,675. Also, in 2018, the unemployment rates were 3.2% (Burt), 2.5% (Cuming), and 2.8% (Nebraska).

A significant number of children were found to be living in poverty in both counties (15% in Burt and 12% in Cuming). Fourteen percent of the children in Nebraska lived in poverty in 2018. It is significant to note that 29% of children in Nebraska live in single-parent households as compared to 14% in Burt county and 28% in Cuming county.
Educational Level

The high school graduation rates with Burt (96%) and Cuming (99%) counties ranked higher than the overall state of Nebraska (89%). Overall, a majority of the residents had completed some college courses (69-70%) which was similar to the overall population of Nebraska (71%). However, the population with bachelor's degrees in Burt (19%) and Cuming (21%) counties was significantly lower than the overall Nebraska rate (30%).
Health Outcomes

According to the County Health Rankings data for Nebraska for 2019, Burt County ranked 55th and Cuming County ranked 24th in the Overall Ranking in Health Outcomes out of 66 reported counties in Nebraska. Burt county ranked 60th and Cuming ranked 9th in the Ranking of Overall Health Factors among counties within the 79 counties reported in the state of Nebraska. The two leading causes of death in Burt and Cuming counties were heart disease and cancer which were consistent with the overall state of Nebraska.

Leading Causes of Death

<table>
<thead>
<tr>
<th>Leading Types of Chronic Disease</th>
<th>Burt</th>
<th>Cuming</th>
<th>Macilson</th>
<th>Stanton</th>
<th>Nebraska</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>153.2</td>
<td>165.6</td>
<td>194.2</td>
<td>139.9</td>
<td>143</td>
</tr>
<tr>
<td>Cancer</td>
<td>181.1</td>
<td>139.6</td>
<td>144.9</td>
<td>114.2</td>
<td>154.8</td>
</tr>
<tr>
<td>Chronic Lung Disease</td>
<td>49.7</td>
<td>26.9</td>
<td>46</td>
<td>32.6</td>
<td>44.7</td>
</tr>
<tr>
<td>Accidents</td>
<td>60.6</td>
<td>42</td>
<td>41.7</td>
<td>25.3</td>
<td>37.2</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>44.4</td>
<td>23.8</td>
<td>31.7</td>
<td>36.6</td>
<td>33.6</td>
</tr>
<tr>
<td>Diabetes</td>
<td>21.9</td>
<td>15.2</td>
<td>24</td>
<td>9.7</td>
<td>21.6</td>
</tr>
<tr>
<td>Alzheimer's Disease</td>
<td>21.6</td>
<td>11.5</td>
<td>42.7</td>
<td>72.3</td>
<td>23.7</td>
</tr>
</tbody>
</table>


Leading Types of Chronic Disease

Four out of five of the leading causes of death in Nebraska were chronic diseases, including heart disease, cancer, chronic lung disease and cerebrovascular disease. In addition to diabetes, these chronic diseases were the most common, costly and preventable of all health problems in the U.S. Furthermore, deaths by chronic disease comprised nearly 50% of the Years of Potential Life Lost (YPLL) among Nebraskans. Most of these leading types of chronic disease are generally preventable through a healthy lifestyle that includes healthy eating and active living, not smoking and limiting alcohol consumption.
Overweight/Obesity

According to the 2018 County Health Rankings, about 1 in 3 adults in the two counties of Burt and Cuming were considered obese (Body Mass Index [BMI] = 30+), slightly higher than the state (31%).
Heart Disease

Heart disease is one of the top two leading causes of death in Burt and Cuming counties and across the state. Leading a healthy lifestyle, including active living, healthy eating, not smoking and limiting alcohol use, and/or managing other medical conditions, high cholesterol, high blood pressure, or diabetes, reduces the risk of heart-related diseases, including heart attack and stroke. In Nebraska, non-Hispanic, White (81.1/100,000), African American (93.9/100,000), and Native American (94.6/100,000) populations have a higher rate of death due to heart disease than the state (77.4/100,000).

Heart Disease Indicators, ELVPHD District: Heart Disease Indicators

<table>
<thead>
<tr>
<th></th>
<th>NE</th>
<th>Region overall</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever told they have high blood pressure (excluding pregnancy)</td>
<td>30%</td>
<td>32%</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Currently taking blood pressure medication, among those ever told they have high BP</td>
<td>78%</td>
<td>81%</td>
<td>86%</td>
<td>76%</td>
</tr>
<tr>
<td>Ever told they have high cholesterol, among those who have ever had it checked</td>
<td>32%</td>
<td>34%</td>
<td>36%</td>
<td>33%</td>
</tr>
</tbody>
</table>
Cancer

Cancer is one of the leading causes of death in the area and across the state. Notably, the incidence of cancer of any type was three times higher in the area for Hispanics and non-Whites compared to Non-Hispanic, Whites.
Vaping and the use of e-cigarettes is on the rise especially for youth. Based on the state's data for 2017, 36% of the youth use e-cigarettes.

**Leading Causes of Injury**

Deaths by injury comprised approximately 20% of the total YPLL among Nebraskans.

<table>
<thead>
<tr>
<th>Leading causes of death by injury in Nebraska (2009-2013)</th>
<th>Leading causes of hospitalizations due to injury in Nebraska (2009-2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Motor vehicle crashes</td>
<td>1. Unintentional falls</td>
</tr>
<tr>
<td>2. Suicide</td>
<td>2. Unintentional injuries due to motor vehicle traffic</td>
</tr>
<tr>
<td>4. Unintentional poisoning</td>
<td></td>
</tr>
</tbody>
</table>

According to the Behavioral Risk Factor Surveillance System (BRFSS) 2018, nearly 70% of adults in the local district health region talked on a cell phone while driving in the past 30 days, slightly surpassing the state rate of 68%. Additionally, 4% of adults in the region reported driving under the influence of alcohol in the past 30 days, higher than the state rate (3%). Other risky behaviors while driving a vehicle in the local district health region did not surpass the state average; however, 1 in 5 ELVPHD adults reported texting while driving a vehicle, 2 in 3 ELVPHD adults did not always wear a seatbelt when driving or riding in a car.
**Data Collection and Analysis**

Primary data was collected through community-level health surveys administered online and through regular mail in February 2019. Patrons in Burt and Cuming were invited to take the survey by means of any of the following routes—public press releases, radio public service announcements, Chamber of Commerce newsletters, through employers and area businesses, senior citizen centers, social media posts, and distribution of paper flyers. The data was then analyzed by a consultant group from the University of Nebraska Medical Center College of Public Health. The results of the survey can be found in the Appendix.

During the implementation of the Community Health Needs Assessment, ELVPHD and MercyOne Oakland Medical Center began planning for the next step in the process which was the Community Health Improvement Plan Stakeholder Town Hall Meetings. A planning meeting was conducted and a partnership plan for collaboratively hosting the focus groups was formed.

Approximately 100 individuals/agencies were identified by the collaborative partners as key stakeholders in the public health system. Three weeks prior to the scheduled event, an invitation e-mail was sent to all of the identified potential participants for the event. Those interested in participating were invited to register via the online registration portal on the ELVPHD website. A hyperlink was provided to the invitees for ease and convenience.

In addition, preliminary data findings were also distributed to the public at-large by press release and by posting a preliminary data findings brief on the ELVPHD website. The public was invited to provide input on the preliminary data and to attend the focus groups as well.

Prior to the meetings, the planning team met—including four ELVPHD staff, UNMC College of Public Health as the contracted facilitators, as well as the Nebraska Association of Local Health Directors—the agency that was contracted for the data collection, analysis and reporting. Together, these partners created tools and ancillary materials to be used on the days of the events. Such items included:

- Robert Wood Johnson County Health Rankings
- Community Health Survey Results data brief
- Demographics of ELVPHD handout
- Leading Causes of Death handout
- Years of Potential Life Lost handout
- Results of ELVPHD Streets, Trails and Sidewalks survey

Also prepared prior for these events was the expanded Data Gallery Stations prepared by Nebraska Association of Local Health Directors. The aim of the Data Gallery Walk was to summarize trends in data and differences between the counties served by ELVPHD and the rest of the state of Nebraska. These data sources are compared to the Community Health Needs Assessment survey data.
The next step in the process commenced with the gathering of approximately 50 community stakeholders for Burt and Cuming counties at a one-day town hall meeting in West Point, NE on May 1, 2019. To launch the planning process, meeting participants were asked to contribute to a discussion about Forces of Change, which is a type of environmental scan. In small groups, participants began to identify trends, events, and factors occurring in their communities, state, nation, and world that could either help them achieve their vision for health in the region or prevent them from achieving it. The conversation focused on forces from the following categories: social, economic, political, environmental, technological, scientific, legal, and ethical. Full details regarding those discussions are included later in this document. As a group, participants then identified the common themes among the forces. The overarching themes of the forces were as follows:

- **Rural sustainability and opportunities** (aging, decreasing population, etc.)
- **Health care** (stretched, expensive, complex, not accessible, mental health, pharmaceuticals, hospital sustainability, preventative, etc.)
- **Insurance** (expensive, changes to payment, uninsured)
- **Political** (legislative, taxes, environment, etc.)
- **Mental health concerns** (high suicide, opioid crisis, lack of service providers, stigma)
- **Violence**
- **Economic stability**
- **Demographic/Generation gap** (health care – expectation of quick service for younger people and longer visits with older people)
- **Education** (as a tool/vehicle for change)
- **Environmental issues** (natural disasters, flooding, water quality)

**Stakeholders Data Review**

The next phase of planning involved a review of community health data prepared by the Nebraska Association of Local Health Directors (NALHD) by the stakeholders of Burt and Cuming counties at the town hall meeting on May 1, 2019.

Data analyzed included the following data sources:

- The results of the community level health surveys completed by residents of Burt and Cuming counties.
- Other sources of primary and secondary data.

The format of the town hall meeting follows.
Community Health Improvement Plan Stakeholder Town Hall Meeting

Process: The objectives of the Community Health Improvement Plan Stakeholder/Focus Groups were:

- To identify the trends, factors and events that influence the health and quality of life in our communities and/or the work of the public health system
- To prioritize (based on data) focus areas in which to concentrate efforts
- To develop logical, evidence-based action steps towards each priority area
- To instill community ownership of and commitment to the ongoing process of creating healthy communities

In small groups, the 50 participants reviewed sections of the data and identified what stood out in the report in order to begin to name the issues that needed collective community attention over the next three years.

After additional discussion with the full group, participants identified a list of potential priorities based on the review of data.

The agenda for this community meeting held on May 1, 2019 was outlined as follows:

- Welcome, Introductions, and Context
- Identifying Forces of Change
- Data Gallery Walk and Large Group Discussions—Nebraska Association of Local Health Directors, presented a summary of community health-related data compiled from a variety of surveys and other sources. These Data Gallery stations framed the discussion of potential priorities for community planning and action. Persons interested in obtaining a complete copy of the data report were encouraged to request a copy of the report via the Data Request Form.
- Selecting Top Priorities—Once potential priorities were agreed upon, each participant reviewed them through a criteria matrix to help them begin to focus on the most important health-related issues on which to focus for the next three years. Participants were then given two stickers to place on their top priorities. The overall top priorities were moved forward for consideration and merging for the regional health priorities. The criteria for selection included:
  1). Size in terms of the number of people affected
  2). Seriousness in terms of the number of deaths, disabilities, hospitalizations
  3). Trends—the problem is getting worse, not better
  4). Equity—looking at whether some groups were affected more (i.e. health disparities)
  5). Interventions—the existence of proven strategies in which to replicate
  6). Values in terms of the community caring about the issue
  7). Resources and opportunities to build on current work
  8). Impact in terms of the ability to strike the issue from a policy, system, or environmental angle to achieve the greatest impact.
**Small Group Discussions: Defining Priorities & Brainstorming Key Strategies**—discussion exercises to come to consensus around evidence-based strategies that could be employed to improve community health and well-being in regard to each priority focus area.

**Closing Conversation and Next Steps**

A detailed summary outlining the discussion at each focus group is included.

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**Potential priorities developed from the West Point Town Hall:**  
*Burt and Cuming Counties*

- Recruiting specialized healthcare workforce
- Promoting healthy lifestyles—food and activity
- Eliminating stigma associated with poverty and mental health
- Education through inspiration and motivation
- Focus on mental health as prevention (across the life course, especially kids)
- Focus on environmental (prevention and mitigation)
- Recruitment and resources for mental health providers
- Funding for public health needs (collaborative strategies, insurance)
- Creating strong system of collaboration/network
- Study effectiveness of current work/quality improvement systems
- Response to shifting demographics (cultural, age, etc.)
- Substance abuse
- Innovation in payment system
- Rural sustainability (helping rural thrive)
- Safe driving practices

After the potential priorities were listed for each group, the facilitators led the group through a process of narrowing down the original menu. The intent of this narrowing process was to ensure that efforts aren’t spread too thin, but rather, are isolated to no more than 4-5 strategic issues so that meaningful progress could be made on each one without diluting the efforts. To that end, the ending discussion concluded with the following priorities as the top three from the event.

Please note that chronic disease control was listed as a given top priority for each group. This was intended to include:

1. Aspects of built community environments (such as Complete Streets, Walkable Communities, and community trail systems)
2. Clinical transformation initiatives to build the infrastructure to help connect health system leadership, system caregivers, and community-based organizations to optimize health outcomes at the population level
3. Continued momentum of the obesity prevention through focus on increased fruits and vegetables consumption and physical activity rates.

With that in mind, the top three choices noted below are to be interpreted as “in addition to” the chronic disease focus area noted above.
Top three priorities developed from the West Point Town Hall:
(Burt and Cuming Counties)

- Healthy foods and physical activity (25 votes)—This will be merged with the chronic disease priority already mentioned.
- Mental health and prevention of mental health issues (18 votes)
- Healthcare provider shortage (10 votes)—includes specialized and mental health

The last step was that participants broke into small groups to define the priorities, note the root causes, and begin to identify potential strategies to implement. Details regarding those discussions are noted.

Participation: On May 1, 2019, the Burt and Cuming County stakeholder focus group was convened at the Nielsen Community Center in West Point, Ne. The attendance totaled 50 participants, including the staff of ELVPHD and partner hospitals, as well as the facilitators and data presenters.

The total attendance was up significantly (approximately 12%). Pre-registrations showed an additional 7 participants that had planned on attending but did not attend. The increase in participation was assumed to be from the personalized email approach (ELVPHD staff sent personal email invitations one-by-one to invitees) and the ease of the online registration process rather than having to RSVP by way of phone call or postcard.

Meeting participation reflected diversity, including the following sectors:

- Economic Development
- Chamber of Commerce
- Financial Institution
- Hospital/clinic workers
- ELVPHD Board of Health
- Trails Committee Members
- Long Term Care
- Medical Response Systems
- Nebraska DHHS
- Veteran Service Officer
- UNL County Extension
- Elected Officials
- Juvenile Diversion
- League of Human Dignity
- Norfolk Safe Communities
- Behavioral Health
- Hospital Board Members
- Nebraska See to Learn Program
- Public Health Liaison/Advocate
- School Nurses and School Administrators
- Center for Rural Affairs
- Cuming County Public Power District
- Law Enforcement
- Institutes of Higher Education
- Community-Based Organizations
- City employees
- Nebraska Bicycling Alliance
- Area Agency on Aging
- Ponca Tribe of Nebraska
- Federally-Qualified Health Center
- Norfolk Family Coalition
- Neighboring Local Public Health Departments
Phase 5 Formulate Goals and Strategies

The completion of the Community Health Needs Assessment in the Oakland area fulfilled phases 1-4 of the MAPP process. Phase 5 of the MAPP process involved the development of the Implementation Strategy, which is a supporting document that includes actionable performance measures keyed to the identified areas of need.

The recommended goals and strategies that were developed from the brainstorming activity were then provided to both the ELVPHD and the MercyOne Oakland Medical Center. Each entity then selected which areas of need they would focus on and finalized their strategies based on the recommendations from the focus group. Final strategies were then presented to the general public via web page postings for open comments.

Phase 6 Action Cycle

- Over the next three years both the hospital and the district health department along with many community partners will implement their identified strategies to make a positive impact on the health and well-being for the residents in Burt and Cuming counties. The priority areas to be addressed by MercyOne Oakland Medical Center were identified through the ranking process during the Strategic Issue Gallery Walk discussed earlier that was then followed by consensus building during the same community meeting. This prioritization process took place during the town hall meeting. The criteria for selection included the following:
  1. Size in terms of the number of people affected
  2. Seriousness in terms of the number of deaths, disabilities, hospitalizations
  3. Trends—the problem is getting worse, not better
  4. Equity—looking at whether some groups were affected more (i.e. health disparities)
  5. Interventions—the existence of proven strategies in which to replicate
  6. Values in terms of the community caring about the issue
  7. Resources and opportunities to build on current work
  8. Impact in terms of the ability to strike the issue from a policy, system, or environmental angle to achieve the greatest impact.

The top three priorities were determined as:

1. Healthy foods and physical activity which will impact the prevalence of chronic disease
2. Mental health and prevention of mental health issues
3. Healthcare provider shortage (includes specialized and mental health)
Community Health Improvement Progress

Since the prior Community Health Needs Assessment and Improvement Plan, the following improvements have been achieved.

**Priority Area 1: Obesity:**

MercyOne recognized the need for a local exercise opportunity for the community. A Stepping Class at the MercyOne Oakland cafeteria was held for community participation. The purpose of the class was to promote physical activity to increase strength and decrease the risk for falls. Diabetic teaching on medications, dosing insulin, and diabetic diets are reviewed and taught to members of the community. Health fairs were held at the Tekamah-Herman elementary school to educate students on health eating and the importance of exercise to stay healthy. Continued efforts are needed to decrease the rate of obesity in the community.

**Priority Area 2: Access to Care:**

An additional physician was added to the MercyOne staff who practiced at MercyOne at both the Oakland and Tekamah locations. Adding another primary care physician provided greater convenience and access to needed primary care in Burt County. Nursing staff from MercyOne Oakland Medical Center provided blood pressure checks monthly at the area Senior Citizen Centers. MercyOne Medical Center hosted an influenza clinic and delivered flu shots for people in the community. The Health Coach at the MercyOne Medical Clinics contacted patients to ensure that all questions were answered after being discharged from the hospital or the emergency department. The health coach also arranged for Annual Wellness Visits to promote a healthier community.

**Priority Area 3: Cancer Prevention and Screening:**

Color Me Healthy was the MercyOne Oakland's community education at the Burt County Fair. The education included information about the importance of yearly health exams and other health screenings. Community Forums were held and to encourage the public to come and ask questions about their health needs and the services that are available in the community. This forum is hosted by local family practice providers and specialty outpatient providers that come to MercyOne for cardiology, podiatry, urology and surgery. Education is provided on how to maintain and improve one's health. The public is invited to become involved with helping Burt County become a healthier community.

MercyOne Oakland Medical Center took an active role in the Relay for Life. This organization raised awareness and money to help those with cancer and to aid in cancer research. The
community was educated on the importance of cancer prevention screenings such as mammography.

**Priority Area 4: Standard Motor Vehicle Safety:**

A Child Car Seat Safety Check was held at the local public school. Car seats were inspected and instruction on proper ways to secure the car seat was provided. Two faulty care seats were replaced that day. At the local county fair, a simulation was used to educate the local community members on the effects of impaired driving due to alcohol use. Coaches, parents, and local student athletes were educated by the physician assistant on safety and the signs, symptoms, and proper handling of concussions.

**Available to the Community**

A draft copy of this CHNA was made available to the public at [https://www.mercyone.org/oakland/about-us/community-benefit/](https://www.mercyone.org/oakland/about-us/community-benefit/) to solicit public comment. Copies of the final CHNA are currently available from the MercyOne Oakland Medical Center's Business Office. Alternately, the public may go to the MercyOne Oakland website at [https://www.mercyone.org/oakland/about-us/community-benefit/](https://www.mercyone.org/oakland/about-us/community-benefit/) to review or print the CHNA. Written comments may be submitted to the following link [https://www.mercyone.org/Oakland/for-patients/contact-us](https://www.mercyone.org/Oakland/for-patients/contact-us). Comments on the prior CHNA were solicited on the hospital's website by clicking on the "contact us" link. No written comments were received by MercyOne Oakland Medical Center related to the prior CHNA. The prior CHNA is also available at the hospital and on the website.
Forces

Overarching Themes

- Mental health (high suicide, lack of providers – affects a lot of areas)
- Insurance coverage – increasing deductibles or even no insurance
- Flooding – infrastructure, wells, mold, stress
- Pharmaceuticals – opioid crisis, medication safety, legalization of marijuana, violence in the workplace (for providers)
- Healthcare and hospital sustainability
- Opening of Costco plant in Fremont (influx of workers, housing needs, language, traffic, healthcare needs)
- Access to a healthy lifestyle – migrant populations, insurance costs, noncompliance
- Aging population
- Legislative taxing decision – impacts
- Obesity and diabetes
- Violence – gun access and everything going on the world
- Government (generally – where will Medicaid go in the future, repeal of ACA?, healthcare of the future)
- Lack of appropriately trained workforce and volunteers
- Small towns continuing to shrink (keeping people here); fewer farmers
- Communication (prevalence/dominance of technology, how to share information that is true/real, tech use to keep you healthy, telehealth)
- Divisive political climate
- Health is really trendy right now (making healthy cool)

- Rural sustainability and opportunities (aging, decreasing population, etc.)
- Healthcare [stretched, expensive, complex, not accessible] – (mental health, insurance, pharmaceuticals, hospital sustainability, preventive, etc.)
- Insurance (expensive, changes to payment, uninsured)
- Political (legislative taxes, environment, etc.)
- Mental health concerns (high suicide, opioid crisis, lack of service providers, stigma)
- Violence
- Economic stability affects a lot of these forces
- Demographic / Generation gap (healthcare – expectation of quick service for younger people and longer visits with older folks)
- Education (as a tool / vehicle for change)
- Environmental issues (natural disasters, flooding, water)
• Access to rural
• Influx of young professionals and their families
• Affordable housing
• Long term care threats (emerging) – threatened because of reimbursement issues
• Water quality – drinking and recreational use
• Parents being on their phones all the time – what does that do to kids? (Technology abuse)
• Mental health concerns – especially related to flooding
• Economic impact of flooding – especially related to infrastructure
• 2020 national, state, local elections
• Safety – texting and driving; impaired driving
• Basic physical health
• Education (as a tool / vehicle for change)

DATA REVIEW

The next phase of planning involved a review of community health data prepared by the Nebraska Association of Local Health Directors (NALHD). In small groups, participants reviewed sections of the data and identified what stood out in the report in order to begin to name the issues that need collective community attention over the next three years.
After additional discussion with the full group, participants identified a list of potential priorities based on the review of data and the themes that emerged from the forces of change discussion. The results follow.

**Potential Priorities**

- Recruiting specialized healthcare workforce
- Promoting healthy lifestyles—food and activity
- Eliminating stigma associated with poverty and mental health
- Education through inspiration and motivation
- Focus on mental health as prevention (across the life course, esp. kids)
- Focus on environmental (prevention and mitigation)
- Recruitment and resources for mental health providers
- Funding for public health needs (collaborative strategies, insurance)
- Creating strong system of collaboration/network
- Study effectiveness of current work/quality improvement systems
- Response to shifting demographics (cultural, age, etc.)
- Substance abuse
- Innovation in payment system
- Rural sustainability (helping rural thrive)
- Safe driving practices
PRIORITIZATION

Once potential priorities were agreed upon, each participant reviewed them through a criteria matrix to help them begin to focus on the most important health-related issues on which to focus for the next three years. Participants were then given two stickers to place on their top priorities. The overall top priorities were moved forward for consideration and merging for the regional health priorities.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>Many people affected</td>
</tr>
<tr>
<td>Seriousness</td>
<td>Many deaths, disabilities, hospitalizations</td>
</tr>
<tr>
<td>Trends</td>
<td>Getting worse, not better</td>
</tr>
<tr>
<td>Equity</td>
<td>Some groups affected more</td>
</tr>
<tr>
<td>Intervention</td>
<td>Proven strategies exist</td>
</tr>
<tr>
<td>Values</td>
<td>Our community cares about this</td>
</tr>
<tr>
<td>Resources</td>
<td>Builds on current work</td>
</tr>
</tbody>
</table>

What priorities should we focus on collectively to have the most impact over the next 3 years?

- Promote healthy lifestyle – food and physical activity (25 Votes)
- Focus on mental health as prevention – eliminate stigma, across life course (18 Votes)
- Recruit healthcare workforce – specialized and mental health (10 Votes)
- Innovate payment systems (5 Votes)
- Address substance abuse (3 Votes)
- Strengthen economic stability (3 Votes)
- Create system of collaboration (3 Votes)
- Address safe driving practices (1 Vote)
- Enhance rural sustainability (1 Vote)
- Respond to shifting demographics (1 Vote)
- Focus on environmental preparedness and mitigation (1 Vote)
Chosen Priorities of Group:

Individuals and Organizations Interested in Strategy Development for these Health Issues:

**Promote Healthy Lifestyle**
- Kevin Black
- Jody Woldt
- Hannah Guenther (NE Extension)
- Sandra Renner
- Delaney Brudigam
- Shelly Green
- Mary Lauritzen
- Crystal Hunke (Dinklage Medical Clinic)
- Linda Munderloh
- Lindsay Shelton

**Mental Health as Prevention**
- Dennis Colsden
- Jerry Wordekemper
- Norbert Holtz
- Karsten Schuetze (CCED)
- Laura Gamble
- (MercyOne)
- Dara Schlecht (SFMH)
- Michaela Flick (SFMH)
- Nicki White
- John Ross (Board of County Supervisors)
- Sara Cameron (ELVPHD)

**Recruit Healthcare Workforce**
- Addisen Johnson
- Elisabeth Linder (Oakland Heights)
- Amie Clausen (Oakland Heights)
- Stasia Stokely
- Dan Frink (MercyOne)
- Carol Kampschneider (SFMH)

**Walkable Communities**
- Tina Biteghe
- Steve Sill (County Board)
- Casey Koch
- Melanie Thompson (ELVPHD)
- Kay Eierman

DEFINING PRIORITIES AND STRATEGY IDEATION
Finally, participants broke into small groups to define the priorities, note root causes, and begin to identify potential strategies to implement. This information provides a starting point for action planning for each of the priorities that is moved forward into the final Community Health Improvement Plan.

**Priority Area: Walkable Communities**

<table>
<thead>
<tr>
<th>Define the priority</th>
<th>Systems and beliefs holding this problem in place</th>
<th>Key strategies (what, who, when, how, why)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Some trails</td>
<td>Policy and government Buy In</td>
</tr>
<tr>
<td>Accessible</td>
<td>Sidewalks</td>
<td>Marketing</td>
</tr>
<tr>
<td>Connectivity</td>
<td>No policy to create priorities</td>
<td>Funding (state)</td>
</tr>
<tr>
<td>Outdoors</td>
<td>Funds</td>
<td>Planning, Engagement and public buy-in</td>
</tr>
<tr>
<td>Mental health</td>
<td>Lack of government involvement</td>
<td>Park Board, health department,</td>
</tr>
<tr>
<td>Committee work</td>
<td></td>
<td>city council investment-financial resources</td>
</tr>
<tr>
<td>Amenities for families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

30
Priority Area: Healthy Lifestyles (food and physical activity)

Define the priority
Educate the community about a healthy lifestyle in locations convenient to them to increase community participation

Systems and beliefs holding this problem in place
Quick fix, commitment
try to fix the problem and not prevent it
No incentive
Cost
Time
System of misinformation
Marketing media
Limited options in rural areas
Lack of education/confusion about available resources
Seasonal limitations to activities and food
Lack of cooking skills
Lack of knowledge of exercise routines
Economics/demographic difference

Key strategies (what, who, when, how, why)
Community outreach program to education population at sites they frequent (grocery stores, schools, churches).
Fitness program – what can be done at home with no equipment or with a friend/group
Credible links on community sites/Facebook (nutrition—fad diets, activity, chronic disease management)
Create a community cohort to direct program—bring in partners
Educate on health lifestyle can lead to physical, financial, mental well-being
Health literacy

Priority Area Mental Health as Prevention

Define the priority
Figure out how to measure this. How will we know our outcomes/impact? (# of providers?)
Break the stigma

Systems and beliefs holding this problem in place
$$ economic
Healthy lifestyle expensive for prevention
Treatment expensive and limited stigma

Key strategies (what, who, when, how, why)
Education – who; why; your population, (when) in schools, (how), teachers, guidance counselors, peer support groups
Coping strategies – prevent medical issues, prevent suicide, prevent incarceration
Create a crisis center – use resources wisely; quick evaluation +prioritization + appropriate treatment
Priority Area: Recruit Health Care Workforce

Define the priority
Shortage of professions, docs to CNAs and mid-level professionals (see a PA quicker)
Lack of mental health providers, inpatient
Community support lacking

Systems and beliefs holding this problem in place
Small town living
Limited amenities
24/7/365 days a year wages

Key strategies (what, who, when, how, why)
Promote – school ratios, cost of living, community involvement, support systems (EME, Firefighter, neighbors)
Public transportation
Family opportunities – work, church, sports, school
Loan repayment and housing options provided by business
Pro-active in schools to go into certain areas

Priority Area: Primary Care and Community Linkages

Define the priority
Mechanism to help assure people get the healthcare they need and can afford through strong connection of care and communication methods

Systems and beliefs holding this problem in place
lack of partnering with local health departments
patients don’t understand care coordination
Lack of care coordination and linkages
Competition among health systems

Key strategies (what, who, when, how, why)
Train workforce on care coordination process including targeted interviewing
Identify appropriate care coordinators based on the complexity of patient need
Health systems and local health departments identify resources and gaps and leveraging resources
Assist with Medicare and Medicaid drug plans
Use evidence-based practices
RECOMMENDATIONS

The Office of Public Health Practice offers these recommendations as next steps for your Community Health Improvement Plan work.

- Merge the priorities into one Regional Health Improvement Plan with specific county-level strategies noted.
- Complete an action planning process to develop key strategies for the next three years. Strategy development should include:
  - Clear definition of the problem that exists in the region (complete additional data analysis as necessary);
  - Discussion of root causes of the problem(s);
  - Identification of strategies to help overcome the root causes; and
  - Individuals and organizations that will take the lead and/or be involved in implementation.
- Clearly delineate specific roles and work plans for partners who will be involved.
- Establish an implementation structure for the overarching plan that outlines who will do what (related to overall coordination), how often the full group will meet, how often subgroups will meet, reporting of activities, etc.
- Send the final draft plan to all participants for review and further refinement, input, and engagement.
Thinking about your physical health, which includes physical illness and injury, on how many days in the past 30 days was your physical health not good?

Would you say that in general, your health is.....?
Where do you get most of your medical care? (Please select one option)

- Primary Care Provider: 100.00%
- Urgent Care: 0.00%
- Hospital/Emergency Room: 0.00%
- Sliding fee or reduced fee: 0.00%
- Tribal Health Clinic: 0.00%
- Veterans Clinic/Hospital: 0.00%
- I do not seek medical care: 0.00%

How often do you have a regular visit at the…?

- Primary care provider: 1.5
- Eye doctor: 2.0
- Dentist: 2.0
- Specialist: 3.0

Weighted Average
Within the past 5 years

More than 5 years ago

Never

I don’t know

When was your most recent cholesterol screening?

When were you most recently tested for any of the following?

Weighted Average

Blood pressure

Diseases of the eye

Osteoporosis

Diabetes

HIV/AIDS

Sexually transmitted...
Which of the following problems have stopped you from getting a health screening or other health care services, including prescription drugs?

Answer Choices

1. I don’t know where to go for a health screening/services 2.72%
2. I couldn’t get an appointment 1.36%
3. Health care provider has limited office hours 2.04%
4. My doctor hasn’t recommended I get a health screening 8.16%
5. I can’t pay for health screenings/services 13.61%
6. My health insurance doesn’t cover health screenings/services 5.44%
7. My deductible or co-payment is too high 10.88%
8. Hospitals or Doctor won’t take my insurance or medical assistance 0%
9. I don’t trust the health care providers in my area 1.36%
10. Health care services aren’t close to where I live 2.04%
11. Language/interpretive services not provided 0%
12. I don’t have time to get a health screening/services 6.8%
13. Transportation related concerns such as no car, can’t afford transportation, etc. 2.04%
14. Other Reason 8.16%
15. None 53.74%
## 2019 County Health Rankings for the 79 Ranked Counties in Nebraska

<table>
<thead>
<tr>
<th>County</th>
<th>Health Outcomes</th>
<th>Health Factors</th>
<th>County</th>
<th>Health Outcomes</th>
<th>Health Factors</th>
<th>County</th>
<th>Health Outcomes</th>
<th>Health Factors</th>
<th>County</th>
<th>Health Outcomes</th>
<th>Health Factors</th>
</tr>
</thead>
</table>
### Compare Counties
#### 2019 Rankings

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Nebraska</th>
<th>Burt (BU), NE</th>
<th>Cuming (CU), NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Life</td>
<td>75</td>
<td>75</td>
<td>70</td>
</tr>
<tr>
<td>Premature death</td>
<td>6,100</td>
<td>7,600</td>
<td>31</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>29</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Poor or fair health</td>
<td>14%</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>Poor physical health days</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Poor mental health days</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>7%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Health Factors</td>
<td>60</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Health Behaviors</td>
<td>37</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Adult smoking</td>
<td>17%</td>
<td>17%</td>
<td>14%</td>
</tr>
<tr>
<td>Adult obesity**</td>
<td>31%</td>
<td>33%</td>
<td>34%</td>
</tr>
<tr>
<td>Food environment index**</td>
<td>8.1</td>
<td>8.6</td>
<td>8.6</td>
</tr>
<tr>
<td>Physical inactivity**</td>
<td>22%</td>
<td>30%</td>
<td>27%</td>
</tr>
<tr>
<td>Access to exercise opportunities</td>
<td>84%</td>
<td>47%</td>
<td>72%</td>
</tr>
<tr>
<td>Excessive drinking</td>
<td>21%</td>
<td>19%</td>
<td>20%</td>
</tr>
<tr>
<td>Alcohol-impaired driving deaths</td>
<td>35%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Sexually transmitted infections**</td>
<td>432.3</td>
<td>197.4</td>
<td>186.5</td>
</tr>
<tr>
<td>Teen births</td>
<td>23</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>50</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Uninsured</td>
<td>10%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>Primary care physicians</td>
<td>1,320.1</td>
<td>1,540.1</td>
<td>1,500.1</td>
</tr>
<tr>
<td>Dentists</td>
<td>1,320.1</td>
<td>3,270.1</td>
<td>1,870.1</td>
</tr>
<tr>
<td>Mental health providers</td>
<td>400.1</td>
<td>6,540.1</td>
<td>1,130.1</td>
</tr>
<tr>
<td>Preventable hospital stays</td>
<td>3,630</td>
<td>3,070</td>
<td>2,510</td>
</tr>
<tr>
<td>Mammography screening</td>
<td>45%</td>
<td>49%</td>
<td>55%</td>
</tr>
<tr>
<td>Flu vaccinations</td>
<td>47%</td>
<td>20%</td>
<td>26%</td>
</tr>
<tr>
<td>Social &amp; Economic factors</td>
<td>65</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>High school graduation</td>
<td>85%</td>
<td>62%</td>
<td>98%</td>
</tr>
<tr>
<td>Some college</td>
<td>71%</td>
<td>69%</td>
<td>68%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>2.9%</td>
<td>3.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Children in poverty</td>
<td>14%</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Income inequality</td>
<td>4.2</td>
<td>4.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Children in single-parent households</td>
<td>26%</td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td>Social associations</td>
<td>14.0</td>
<td>29.0</td>
<td>21.1</td>
</tr>
<tr>
<td>Violent crime**</td>
<td>286</td>
<td>82</td>
<td>32</td>
</tr>
<tr>
<td>Injury deaths</td>
<td>58</td>
<td>64</td>
<td>58</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>55</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>Air pollution - particulate matter</td>
<td>7.5</td>
<td>8.0</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>Nebraska</td>
<td>Burt (BU), NE</td>
<td>Cuming (CU), NE</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------</td>
<td>---------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Drinking water violations</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Severe housing problems</td>
<td>13%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Driving alone to work</td>
<td>82%</td>
<td>62%</td>
<td>76%</td>
</tr>
<tr>
<td>Long commute - driving alone</td>
<td>18%</td>
<td>31%</td>
<td>16%</td>
</tr>
</tbody>
</table>

** Compare across states with caution
Note: Blank values reflect unreliable or missing data
## QuickFacts

**Cumming County, Nebraska; Burt County, Nebraska; United States**

QuickFacts provides statistics for all states and counties, and for cities and towns with a population of 5,000 or more.

### Table

<table>
<thead>
<tr>
<th>ALL TOPICS</th>
<th>Cumming County, Nebraska</th>
<th>Burt County, Nebraska</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEOPLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population estimates, July 1, 2018 (V2018)</td>
<td>9,940</td>
<td>6,488</td>
<td>327,167,434</td>
</tr>
<tr>
<td>Population estimates base, April 1, 2010 (V2018)</td>
<td>9,139</td>
<td>6,854</td>
<td>308,795,105</td>
</tr>
<tr>
<td>Population, percent change - April 1, 2010 (estimates base) to July 1, 2018 (V2018)</td>
<td>-2.2%</td>
<td>-5.4%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Population, Census, April 1, 2010</td>
<td>9,139</td>
<td>6,854</td>
<td>308,745,520</td>
</tr>
<tr>
<td><strong>Age and Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons under 5 years, percent</td>
<td>6.2%</td>
<td>5.2%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Persons under 18 years, percent</td>
<td>24.4%</td>
<td>22.9%</td>
<td>22.8%</td>
</tr>
<tr>
<td>Persons 65 years and over, percent</td>
<td>21.0%</td>
<td>23.8%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Female persons, percent</td>
<td>49.7%</td>
<td>50.6%</td>
<td>53.9%</td>
</tr>
<tr>
<td><strong>Race and Hispanic Origin</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White alone, percent</td>
<td>97.3%</td>
<td>95.1%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Black or African American alone, percent</td>
<td>0.4%</td>
<td>0.6%</td>
<td>13.4%</td>
</tr>
<tr>
<td>American Indian and Alaska Native alone, percent</td>
<td>0.6%</td>
<td>2.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Asian alone, percent</td>
<td>0.5%</td>
<td>0.4%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander alone, percent</td>
<td>0.1%</td>
<td>0.1%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Two or More Races, percent</td>
<td>1.1%</td>
<td>1.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Hispanic or Latino, percent</td>
<td>10.6%</td>
<td>3.0%</td>
<td>16.1%</td>
</tr>
<tr>
<td>White alone, not Hispanic or Latino, percent</td>
<td>87.7%</td>
<td>92.9%</td>
<td>63.7%</td>
</tr>
<tr>
<td><strong>Population Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans, 2013-2017</td>
<td>513</td>
<td>483</td>
<td>18,939,219</td>
</tr>
<tr>
<td>Foreign-born persons, percent, 2013-2017</td>
<td>5.1%</td>
<td>1.5%</td>
<td>13.4%</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing units, July 1, 2018 (V2018)</td>
<td>4,257</td>
<td>3,487</td>
<td>138,537,078</td>
</tr>
<tr>
<td>Owner-occupied housing units, 2013-2017</td>
<td>66.1%</td>
<td>7.8%</td>
<td>63.8%</td>
</tr>
<tr>
<td>Median value of owner-occupied housing units, 2013-2017</td>
<td>$113,200</td>
<td>$91,600</td>
<td>$103,500</td>
</tr>
<tr>
<td>Median monthly owner cost with a mortgage, 2013-2017</td>
<td>$1,022</td>
<td>$1,055</td>
<td>$1,515</td>
</tr>
<tr>
<td>Median monthly owner cost without a mortgage, 2013-2017</td>
<td>$430</td>
<td>$485</td>
<td>$474</td>
</tr>
<tr>
<td>Median gross rent, 2013-2017</td>
<td>$562</td>
<td>$613</td>
<td>$982</td>
</tr>
<tr>
<td>Building permits, 2017</td>
<td>16</td>
<td>4</td>
<td>1,281,597</td>
</tr>
<tr>
<td><strong>Families &amp; Living Arrangements</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons per household, 2012-2017</td>
<td>2.35</td>
<td>2.23</td>
<td>2.63</td>
</tr>
<tr>
<td>Living in same house 1 year ago, percent of persons age 1 year, 2013-2017</td>
<td>90.5%</td>
<td>89.1%</td>
<td>45.4%</td>
</tr>
<tr>
<td>Language other than English spoken at home, percent of persons age 5 years, 2013-2017</td>
<td>0.2%</td>
<td>2.7%</td>
<td>21.3%</td>
</tr>
<tr>
<td><strong>Computer and Internet Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Households with a computer, percent, 2013-2017</td>
<td>78.2%</td>
<td>76.5%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Households with a broadband internet subscription, percent, 2013-2017</td>
<td>65.3%</td>
<td>64.9%</td>
<td>78.1%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate or higher, percent of persons age 25 years, 2013-2017</td>
<td>87.1%</td>
<td>90.9%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Bachelor's degree or higher, percent of persons age 25 years, 2013-2017</td>
<td>21.2%</td>
<td>19.1%</td>
<td>30.9%</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>With a disability, percent, 2013-2017</td>
<td>6.1%</td>
<td>6.6%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Persons without health insurance, under age 65 years, percent</td>
<td>12.6%</td>
<td>11.0%</td>
<td>12.2%</td>
</tr>
</tbody>
</table>

https://www.census.gov/quickfacts/fact/table/cumingcountynebraska,burctountynebraska,unitedstates/
<table>
<thead>
<tr>
<th>Economy</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In civilian labor force, total, percent of population age 16 years+, 2013-2017</td>
<td>69.8%</td>
<td>59.8%</td>
<td>63.0%</td>
</tr>
<tr>
<td>In civilian labor force, female, percent of population age 16 years+, 2013-2017</td>
<td>60.9%</td>
<td>56.9%</td>
<td>58.2%</td>
</tr>
<tr>
<td>Total accommodation and food services sales, 2012 ($1,000) (c)</td>
<td>15,446</td>
<td>2,756</td>
<td>708,159,568</td>
</tr>
<tr>
<td>Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)</td>
<td>40,851</td>
<td>12,912</td>
<td>2,040,461,023</td>
</tr>
<tr>
<td>Total manufacturers shipments, 2012 ($1,000) (c)</td>
<td>245,806</td>
<td>22,223</td>
<td>5,696,729,632</td>
</tr>
<tr>
<td>Total merchandise sales, 2012 ($1,000) (c)</td>
<td>220,549</td>
<td>127,977</td>
<td>5,208,023,478</td>
</tr>
<tr>
<td>Total retail sales, 2012 ($1,000) (c)</td>
<td>205,974</td>
<td>33,813</td>
<td>4,019,821,871</td>
</tr>
<tr>
<td>Total retail sales per capita, 2012 (c)</td>
<td>522.704</td>
<td>55.078</td>
<td>513.443</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean travel time to work (minutes), workers age 16 years+, 2013-2017</td>
<td>15.4</td>
<td>22.4</td>
<td>26.4</td>
</tr>
<tr>
<td>Income &amp; Poverty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per capita income in past 12 months (in 2017 dollars), 2013-2017</td>
<td>$28,762</td>
<td>$26,421</td>
<td>$31,177</td>
</tr>
<tr>
<td>Persons in poverty, percent</td>
<td>▶ 8.3%</td>
<td>▶ 11.5%</td>
<td>▶ 12.3%</td>
</tr>
</tbody>
</table>

**BUSINESSES**

<table>
<thead>
<tr>
<th>Businesses</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total employer estabishments, 2016</td>
<td>358</td>
<td>296</td>
<td>7,597,843</td>
</tr>
<tr>
<td>Total employment, 2016</td>
<td>2,603</td>
<td>1,166</td>
<td>120,752,238</td>
</tr>
<tr>
<td>Total annual payroll, 2016 ($1,000)</td>
<td>94,785</td>
<td>42,155</td>
<td>6,435,142,055</td>
</tr>
<tr>
<td>Total employment, percent change, 2015-2016</td>
<td>-0.4%</td>
<td>-0.6%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Total nonemployer establishments, 2016</td>
<td>745</td>
<td>519</td>
<td>24,813,048</td>
</tr>
<tr>
<td>All firms, 2012</td>
<td>903</td>
<td>709</td>
<td>7,600,306</td>
</tr>
<tr>
<td>Man-owned firms, 2012</td>
<td>489</td>
<td>459</td>
<td>1,484,597</td>
</tr>
<tr>
<td>Women-owned firms, 2012</td>
<td>195</td>
<td>170</td>
<td>9,678,397</td>
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<tr>
<td>Minority-owned firms, 2012</td>
<td>47</td>
<td>F</td>
<td>7,952,306</td>
</tr>
<tr>
<td>Nonminority-owned firms, 2012</td>
<td>818</td>
<td>742</td>
<td>18,987,918</td>
</tr>
<tr>
<td>Veteran-owned firms, 2012</td>
<td>55</td>
<td>125</td>
<td>2,521,682</td>
</tr>
<tr>
<td>Nonveteran-owned firms, 2012</td>
<td>779</td>
<td>598</td>
<td>24,070,685</td>
</tr>
</tbody>
</table>

**GEOGRAPHY**

<table>
<thead>
<tr>
<th>Geography</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Population per square mile, 2010</td>
<td>16.0</td>
<td>14.0</td>
<td>87.4</td>
</tr>
<tr>
<td>Land area in square miles, 2010</td>
<td>570,62</td>
<td>491,98</td>
<td>3,531,905,43</td>
</tr>
<tr>
<td>FIPS Code</td>
<td>31039</td>
<td>31021</td>
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</tbody>
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https://www.census.gov/quickfacts/fact/table/cumingcountynebraska,burctountynebraska,...  6/12/2019