



Community Health Assessment 2021 Report

For more information:

<https://cdhd.ne.gov/>

Contact:

Central District Health Department
Teresa Anderson, Health Director
Grand Island NE
308-385-5175

Prepared by Nebraska Association of Local Health Directors
For Central District Health Department

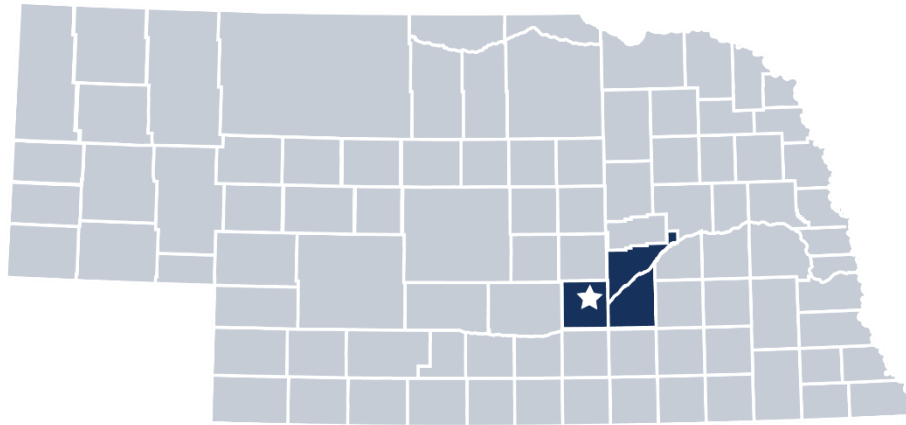
Contents

Introduction	4
Community Health Assessment Methods	6
District Overview & Health Equity	8
Literacy and Language Barriers.....	8
Veterans.....	9
Disability.....	9
Aging	11
Socially Vulnerable Populations.....	11
Population Demographics.....	12
Race and Ethnicity.....	13
Median Age	15
School District Profiles	18
Socio-Economic Status	21
Economics	21
Educational Level	25
Health Outcomes	26
Leading Causes of Death.....	26
Leading Types of Chronic Disease.....	28
Overweight/Obesity.....	28
Physical Activity and Nutrition.....	29
Diabetes	32
Heart Disease	34
Cancer	34
Tobacco and Nicotine Product Usage.....	36
Radon Risk.....	40
Leading Causes of Injury	40
Motor Vehicle Behaviors.....	41
Behavioral/Mental Health and Related Risk Factors	42
Suicide Risk.....	44
Adverse Childhood Experiences.....	45
Substance Use Disorders.....	47
Alcohol Use	47

Maternal and Child Health.....	49
Healthcare Access and Utilization.....	50
Healthcare Insurance Coverage	50
Health Care and Prevention Assets.....	54
Access for Aging Populations:	54
Access for Veteran Populations:	54
Preventative Screenings.....	55
Barriers to Accessing Health Care	58
Community Themes and Strengths.....	58
Health Summary: CDHD District	59
Appendices.....	61
Appendix A: List of Tables	62
Appendix B: List of Figures.....	63
Appendix C: Demographics of Community Survey Respondents (2021) compared to CDHD Census ...	65
Appendix C: Community Survey Responses by Overall, Hispanic and Non-White	66
Appendix D: Resource Inventory Survey, August 2021	70
Appendix D: References.....	76

Introduction

Central District Health Department (CDHD) serves 78,432ⁱ people within a three-county district comprised of Hall, Hamilton, and Merrick counties in central Nebraska. CDHD was formed in 2002 as a result of State legislation that applied Tobacco Master Settlement funds to organize local health departments statewide. The mission of CDHD is to protect and improve the health and wellbeing of our community.



As Chief Health Strategist—who convenes stakeholders that investigate and take action to make meaningful progress on complex health community issuesⁱⁱ—for this three-county district, CDHD conducts a community health assessment (CHA) and community health improvement plan (CHIP) every three years. The CHA is a process of gathering and interpreting information from multiple and diverse sources in order to develop a deeper understanding of the health and wellbeing of a community/jurisdiction. The CHA process describes the current health status of the community, identifies and prioritizes health issues, and develops a better understanding of the range of factors that influence and impact health. Data were gathered from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings and Roadmaps (CHRR), American Community Survey/US Census Bureau, Centers for Disease Control and Prevention (CDC), Nebraska Department of Transportation, Nebraska Department of Education, and the US Bureau of Labor Statistics. This assessment identifies leading causes and emerging issues that impact community health and quality of life, including the leading causes of mortality and morbidity, the general health status of community members, disparities in health outcomes, the access and availability of behavioral and health care, etc.

Main partners who take the lead role in providing healthcare for the communities within CDHD region and play an important role in the development of this assessment include:

CHI Health Saint Francis, located in Grand Island, Hall County, is a regional referral center, with more than 100 physicians and 1,100 employees working together to build a healthier community. The goal of CHI Health Saint Francis is to provide patients with high-quality medical care close to home, where they can be supported by their family, friends, and community. In 2018, the CHI Health Regional Cancer Center became a QOPI Certified Practice. Services provided by CHI Health Saint Francis include behavioral care, breast cancer care, cancer care, diabetes education, emergency and trauma, general surgery, heart care, home care, imaging

maternity center, neurosurgery, nursing, orthopedics, pediatrics, primary care, rehabilitation care, respiratory care, sleep disorders, and wound and ostomy center.

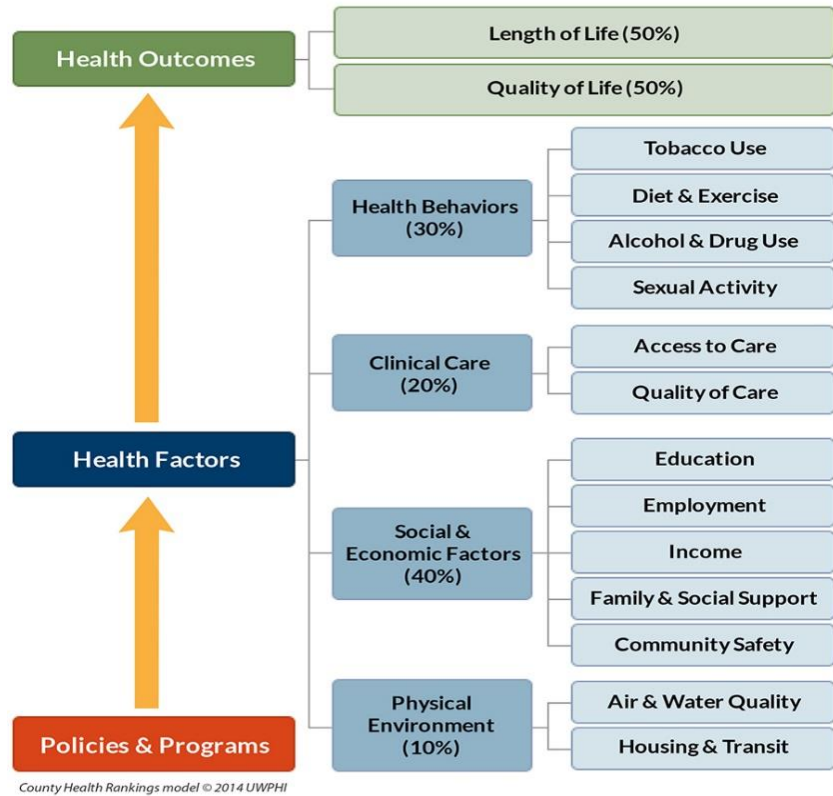
Grand Island Regional Medical Center is an acute care hospital located in Grand Island, Hall County, that aims to bring additional patients and health care talent to the area. Grand Island Regional Medical Center is a locally owned and organized nonprofit organization, offering a broad range of specialties and services including a maternity center and a variety of surgical, medical, clinical, and emergency services. The hospital opened its doors in August 2020 and is accredited by the Center for Improvement in Healthcare Quality (CIHQ).

Merrick Medical Center-Bryan Health, formerly Litzenberg Memorial County Hospital, promotes and provides personalized, compassionate, and quality healthcare services for the people in Merrick County and the surrounding area. Merrick Medical Center-Bryan Health is located in Central City, Merrick County, and is a critical access hospital with 25 licensed beds and two physician clinics. On July 1, 2017, Bryan Health, a non-profit, Nebraska owned health system partnered with the former Litzenberg Memorial County Hospital to establish Merrick Medical Center-Bryan Health. Merrick Medical Center-Bryan Health provides health care services, fitness and wellness programs, telehealth technology and works with community partners to make health a commitment.

Memorial Community Health is a Critical Access Hospital in Aurora, Hamilton County, which offers residents a diverse, modern health care system that includes three family practice clinics, an acute hospital, outpatient specialty and diagnostic services, independent and assisted living facilities, and a nursing home. Memorial Community Health is fully licensed by the State of Nebraska and approved by Medicare and Medicaid which sets and oversees the standards of quality for health care institutions; while also being members of the American Hospital Association, the Nebraska Hospital Association, the Nebraska Nursing Home Association, and the Nebraska Assisted Living Association. Memorial Community Health is a not-for-profit organization and is entirely dependent upon revenue from patient services, resident care, and philanthropy.

County Health Rankings and Roadmaps (CHRR), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin, provides reliable local data and evidence to communities to help them identify opportunities to improve their health. The CHRR model was used as the lens for this community health assessment.

Figure 1. County Health Rankings and Roadmaps Framework



Community Health Assessment Methods

This community health assessment gathered data from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings, American Community Survey/US Census Bureau, Centers for Disease Control, Nebraska Department of Education, and so on to assess the health status of the CDHD region to identify emerging issues and trends, when possible, and to gauge big changes from the previous 2019 Community Health Improvement Plan priorities.

At the beginning of 2020, local health departments in Nebraska began the response to a global pandemic resulting from a novel virus, Coronavirus 2019. While eager to know the impact of COVID-19 on population health, this data was not available at the time of this community health assessment. In efforts to learn more about the impact of COVID-19 on communities in the CDHD area, CDHD launched a 5-question survey. The survey was developed by the Nebraska Association of Local Health Directors (NALHD) as an open-ended survey design intended to allow respondents to tell LHDs their experience related to their health and the health of their community to identify emerging issues in the community. The NALHD made the survey accessible to all LHDs across Nebraska to identify statewide impact and trends. The survey is intended to be initially launched during the community health assessment and released more frequently throughout the community health improvement process to keep current on emerging issues in the community; however, results discussed throughout this report are from the initial launch in June 2021. This survey will assist CDHD by highlighting community themes and strengths that may not be identified solely with the use of secondary data sources. The survey assessed experiences of community members related to major health issues for them or their family, what it means to be healthy, top health concerns, and ways to be healthy in their community and was made available in

English, Spanish, Somali and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey online when waiting for appointments. In all, 665 responses were collected (see Appendix D for a table of respondent demographics).

Additionally, a resource inventory survey was launched to partners of CDHD in August 2021 as a way to provide insight into available medical resources, resources that help people prevent and manage personal health risks, and resources that help people thrive. In all, 15 responses were collected. Respondents self-identified from the following sectors: 20% non-profit, 20% hospitals, 13% Federally Qualified Health Centers, and 6% from each of the following sectors: business, faith-based organizations, health departments, higher education/academic institutions, law enforcement/judicial systems, and medical clinics.

Finally in June 2021, 35 partners participated in a focused discussion to identify forces that impact health in communities within the CDHD area as part of this community health assessment. The results follow:

Economic	<ul style="list-style-type: none"> • Businesses impacted by COVID-19 • Poverty rate • Healthcare worker shortage • Jobs/workers not returning to jobs • Online shopping impacts small brick/mortar businesses • Employers' expansion of remote working and other flexibility that wasn't an option before COVID
Environmental	<ul style="list-style-type: none"> • Housing shortage • Flood recovery • Access to clean water
Legal/Political	<ul style="list-style-type: none"> • Political concerns regarding safety/masks • Medicaid expansion • Vaccines turned very political • Issues (COVID, other) were politicized (for good/bad) and dealing with social perceptions as the after effect
Social/Family	<ul style="list-style-type: none"> • Lower volume of employees returning to work • Primarily women choosing to stay home instead of going back to a lower paying job • Increase in depression related to social distancing/isolation • Everyone (age, generational) impacted by stress/is under stress
Technological/Scientific	<ul style="list-style-type: none"> • Tele-health access for those without internet • Navigating technology • Telehealth potential was more clearly demonstrated than before (+) <p><i>Trend</i> toward expanding broadband... more internet</p> <ul style="list-style-type: none"> • Flipside: still need to help many folks navigate using tech
Other...	<ul style="list-style-type: none"> • Additional hospital/second hospital • Employment • Migration changes • Workforce not returning... women not reentering workforce • Stress for folks of all ages • Job losses • Impact of new • Reluctance to get usual care... staying home hurts local rural business • High achieving children may have had easier time than those who struggle. Teachers had to <u>adapt</u> daily. • Stressful year for everyone in GI and across the state • Summer school attendance is higher than any other year • Students playing catch up • Teachers and families learned to manage and to adapt • Schools found ways to meet needs of kid... academic and basic (food) <p><i>Trends:</i> Increasing obesity rates for child and adults Alcohol consumption and alcoholism increasing Growing population overall and more diverse</p>

District Overview & Health Equity

Central District Health Department (CDHD), headquartered in Hall County, serves 78,432ⁱⁱⁱ people within a three-county district comprised of Hall, Hamilton, and Merrick counties in the central part of Nebraska. Main economic drivers in CDHD include agriculture/forestry/fishing/hunting, health care/social assistance and manufacturing^{iv}.

Quick Facts for CDHD Region:^v

Population (2020): **79,992**¹
Population Change (2010-2019): **5.7%**
Unemployment Rate: **3.2%**^{vi}
Total Land Area (2010): **1,574 square miles**

While Hall County is classified as a metropolitan statistical area, Hamilton and Merrick counties are classified as rural counties by the Federal Office of Rural Health Policy^{vii}. Rurality is associated with a number of negative health outcomes, specifically higher premature mortality rates, infant mortality rates, and age-adjusted death rates. Rurality is also associated with a number of negative health behaviors that contribute to chronic disease and death, such as unhealthy diets and limitations in meeting moderate or vigorous physical activity recommendations.^{viii} These data paint a stark picture of health disparities given one factor, geography. Additionally, it is important to understand that there are disparities related to race and ethnicity independent from geography, and there are disparities related to geography independent from race and ethnicity. When disparities from independent factors overlap, such as race/ethnicity overlapping with geography, the result is a dual disparity resulting in some of the poorest health statuses seen in the nation.^{ix} Other obstacles that can impede someone from achieving their full health potential include literacy/language barriers, military status, disability, age, social vulnerability, and key social and economic factors (like poverty and income-level, housing, education status, etc.). These obstacles are described in detail below for the CDHD area; however, race/ethnicity data for many of these factors are limited.

Literacy and Language Barriers

Literacy and primary language must be taken into account in all health contexts. It is estimated that only 1 in 10 American adults have the skills needed to use health information that is routinely available in health care facilities, retail outlets, and the media.^x *“Being able to read does not necessarily mean one will be health literate, however, the lack of basic literacy skills does mean that patients almost certainly will have difficulty reading and understanding basic health information.”*^{xi} Basic literacy and health literacy levels are also factors associated with health disparities.

Language barriers also contribute to health disparities and exacerbate difficulties understanding and acting on health information.^{xii} The CDHD district is home to multiple immigrant populations and residents whose second language is English, with concentrations from Mexico, Somali, and Arabic nations and smaller populations from other areas.

¹ US Census data was updated with 2020 data where applicable in this report. Note: granular Census data is not available from US Census Bureau until later 2021.

Table 1 summarizes the health literacy indicators within the CDHD district. Nearly 1 in 2 adults in the CDHD district reported that written health information and verbal health information given by medical professionals is not easy to understand.

Table 1. Health Literacy Indicators, CDHD District

Health Literacy Indicators ^{xiii}	CDHD Region
Very easy to get needed advice or information about health or medical topics	70%
Written health information very easy to understand	57%
Very easy to understand information that medical professions tell you	56%

Veterans

Overall, CDHD district Veteran’s population is consistent with the state (see Table 2). Although the US Department of Veteran Affairs (VA) assists Veterans in accessing health care and other services, eligibility status for these services depends greatly upon the branch of service, time served, and discharge status. Even when Veterans access services, challenges still exist for health care professionals to effectively understand and treat health issues in Veterans due to complex military histories and medical needs. Unlike previous generations, many younger Veterans experienced frequent deployments to multiple conflict areas, exposure to explosions in close proximity and longer tours of duty.^{xiv}

Table 2. Veteran Status, CDHD District

Veteran Status ^{xv}	% Veterans (age 18+)
Hall County	5%
Hamilton County	7%
Merrick County	7%
CDHD District	6%
Nebraska	6%

Disability

In the US, one in four adults reported having a disability that impacts their major life activities. Women, non-Hispanic American Indians/Alaska Natives and adults with lower income experience disabilities more than other groups. Mobility disability is the most common type of disability followed closely by cognition, independent living, hearing, vision, and self-care. Adults aged 65 and older who experience disability are more likely to have health insurance, a primary doctor and receive routine health check-ups in the past year compared to adults under 65 years of age with disabilities.^{xvi}

Figure 2. Disability types among adults in Nebraska^{xvii}

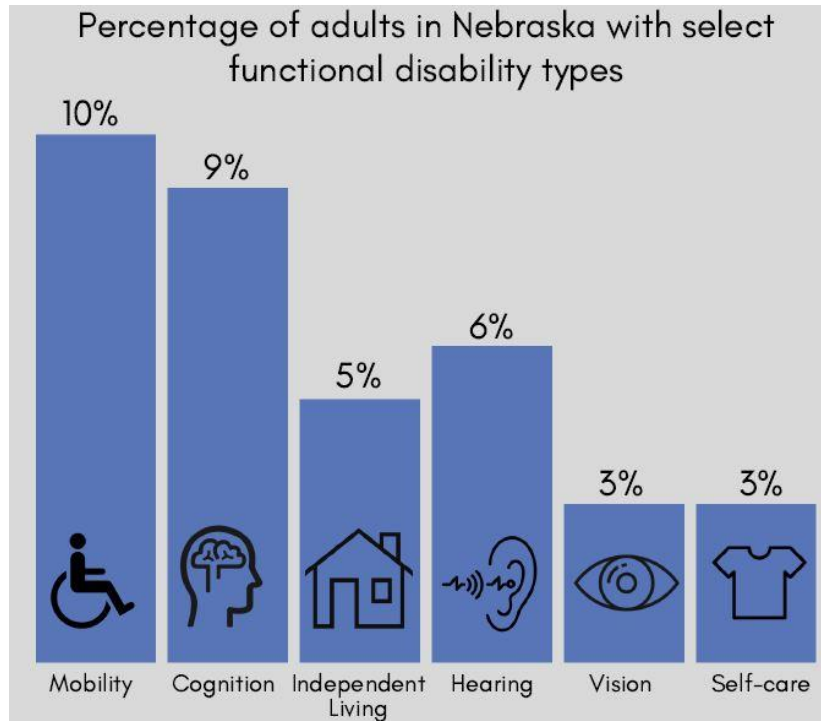
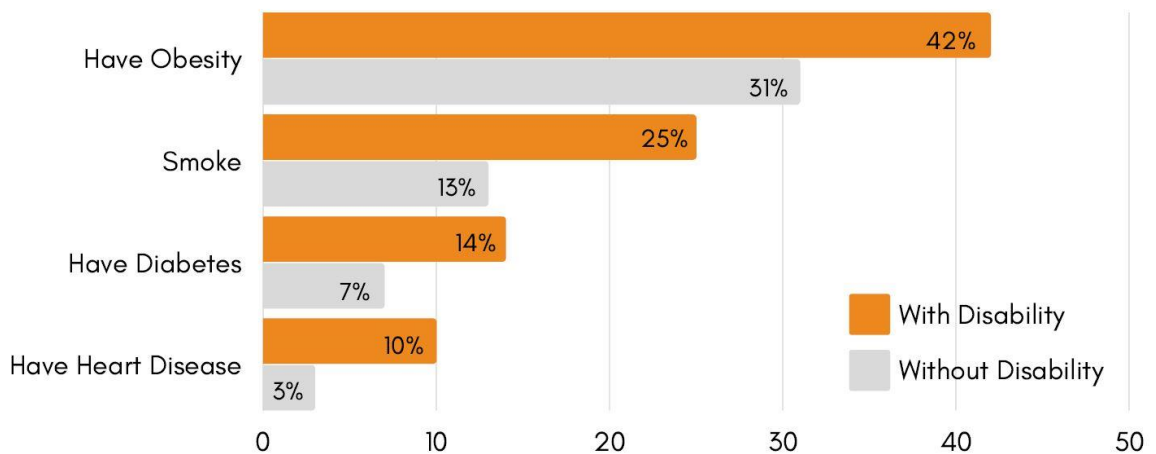


Figure 3. Disability and Health Disparities among adults in Nebraska^{xviii}

Adults with disabilities in **Nebraska** experience health disparities and are more likely to...¹



Visit dhds.cdc.gov for more disability and health data across the United States.

In the CDHD district, over 1 in 12 adults under age 65 reported having a disability (12.3% Merrick, 5.4% Hamilton, and 8.7% Hall)^{xix}. Disabilities become more common as people age. Care coordination and better access to health care services are key to better health by helping people with disabilities adopt healthy behaviors.

Aging

Currently, 16% of the US population is aged 65 and older. This number is expected to grow over the next 40 years to 25%.^{xx} As Americans age, many older adults aged 65 and older make rural living their home. Older adults typically reside in rural areas in part due to the attractiveness of the scenic and recreation amenities available in rural communities and due to younger people moving out of rural areas, essentially leaving an older generation behind.^{xxi} Older adults have a higher risk of developing chronic diseases and illnesses, including dementia, heart disease, diabetes, arthritis, and cancer. These diseases and illnesses tend to be the leading causes of death and disability in the state and nation and leading drivers of health care costs.^{xxii} In the US, more than 25% of older adults were considered “high-need”, meaning they were managing three or more chronic conditions or required help with basic tasks of everyday living.^{xxiii}

In the CDHD area, almost 1 in 5 people are 65 years or older, slightly higher than the state rate (16%). Alzheimer’s Disease is a more commonly known disease among the older adult population. In Hall County, the adult population that experience Alzheimer’s Disease (43.5/100,000) is over two times the rate of the state (23.7/100,000 population, respectively) and four times more than adults in Hamilton and Merrick counties (18.3 and 16.6/100,000 population, respectively)^{xxiv}. The ability to remain active, healthy and independent as long as possible is key for older adults to live a quality, long life.

Socially Vulnerable Populations

Certain factors, such as gender, age, income level, education level, housing conditions, limited English proficiency, disability, limited transportation and so on, can influence personal health risk of disease, illness, and risk of being seriously affected by an emergency (i.e. flooding, tornadoes, and infectious disease outbreaks). People at higher risk of being seriously affected by the aforementioned public health outcomes and emergencies are considered socially vulnerable. The Centers for Disease Control and Prevention established a Social Vulnerability Index (SVI) as a tool to provide information to community stakeholders in effort to better prepare communities for response to these public health outcomes and emergencies with the overall goal of decreasing both human suffering and economic loss.

The SVI produces a vulnerability score of populations within each US Census tract among four main themes and a score for each theme. Themes include: **socioeconomic status**, such as poverty level, employment status, income level and high school diploma; **household composition and disability**, such as aged 65 and older, aged 17 and younger, single-parent households and disabilities among age 5 and older; **minority status and language**, such as race/ethnicity and English proficiency; **housing type and transportation**, such as mobile homes/multi-level structures, crowding, and lack of transportation. For the CDHD area, the CDC produces an overall SVI score and a SVI score by theme for each county (see Table 3 for results). Hall County has the highest vulnerability out of all counties within the CDHD area, which is not a surprise given the population characteristics illustrated in upcoming sections of this report. Community stakeholders can use the SVI as a snapshot into where the most vulnerable communities reside and assist with honing in on areas of focus to help reduce risk of public health outcomes and emergencies.

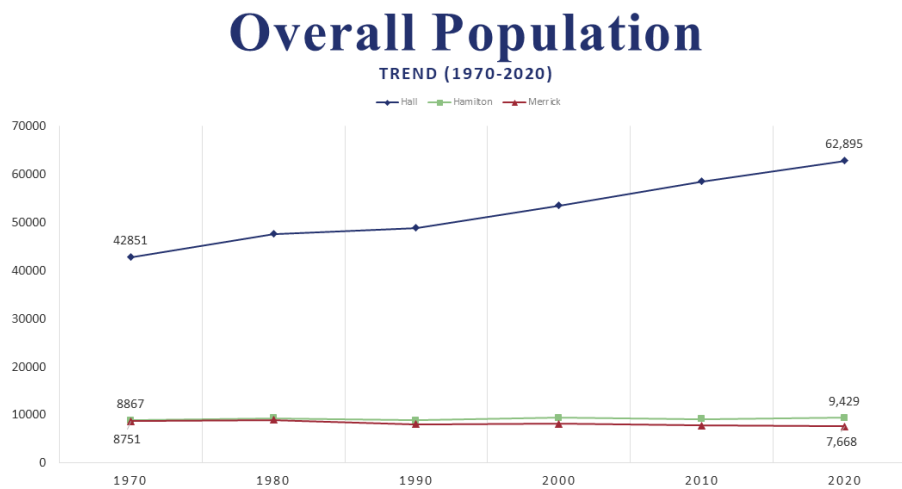
Table 3. Social Vulnerability Index, CDHD District

Social Vulnerability Index			
	Hall County	Hamilton County	Merrick County
Overall Score	0.6701	0.0089	0.1975
Socioeconomic Status	0.4455	0.0194	0.1086
Household Composition and Disability	0.7163	0.2865	0.3114
Minority Status and Language	0.8838	0.0675	0.2165
Housing Type and Transportation	0.5909	0.0185	0.5587
<i>Scale: lowest vulnerability = 0.0 highest vulnerability = 1.0</i>			

Population Demographics

Overall, Nebraska’s rural population is decreasing while the urban population is increasing. Nebraska’s population in the 2019 Census was estimated at 1,934,408. This count was up 5.9% from the 2010 Census and consistent with the national increase of 6.3% during the same period. Growth has occurred in all four of the urban counties of Nebraska. Conversely according to the US Census, all counties within the CDHD district experienced an increase in population (ranging from 2% to 5% increase) between 2010 and 2019 except for Merrick County, which experienced a 1.3% decrease in population. Over a 50-year period (see Figure 4), population in the CDHD area has trended upward in Hall County and remained relatively flat (or a slight downward trend) for Hamilton and Merrick counties.

Figure 4. Overall Population Trend, CDHD (1970-2019)



Source: Decennial Censuses, US Census Bureau; Prepared by UNO Center for Public Affairs Research, Aug 12, 2021

Race and Ethnicity

Nebraska has a high Hispanic growth rate. Between 2005 and 2014, the Latino population growth rate was more than five times higher than the overall population growth rate in Nebraska (55% vs. 10%).^{xxv} Hispanics represented 5.6% of the total population in Nebraska in 2000, 9.2% in 2010, and 11.4% in 2019, and 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%). According to the Center for Public Affairs Research at the University of Nebraska-Omaha, populations over time in Nebraska increased in racial/ethnic diversity resulting in positive net migration in Nebraska as of late (see Figure 5). In the future, as the children of today grow up and have children of their own, racial/ethnic diversity is expected to increase (see Figure 6).

Figure 5. Net migration over time, Nebraska (1920-2019)

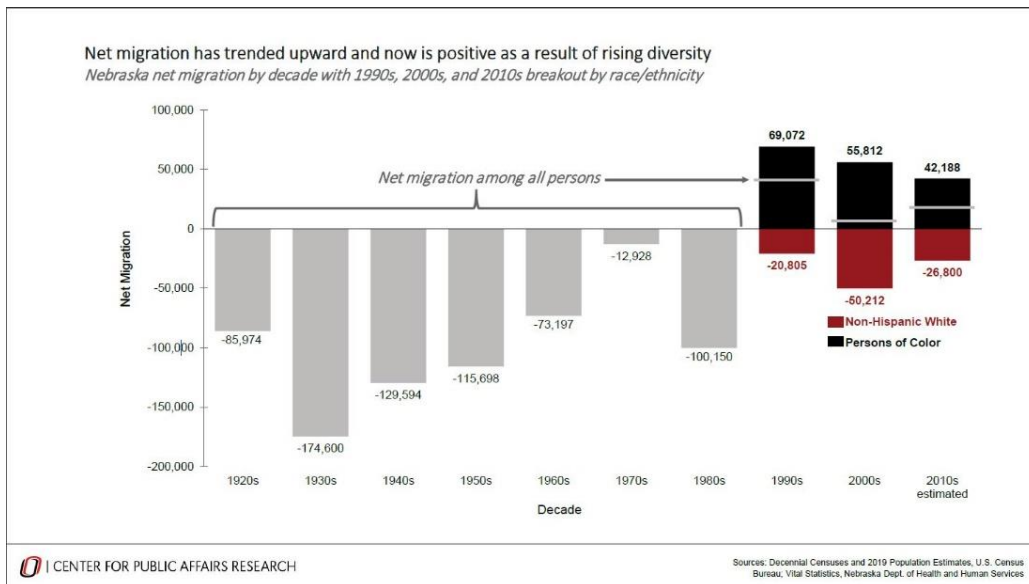
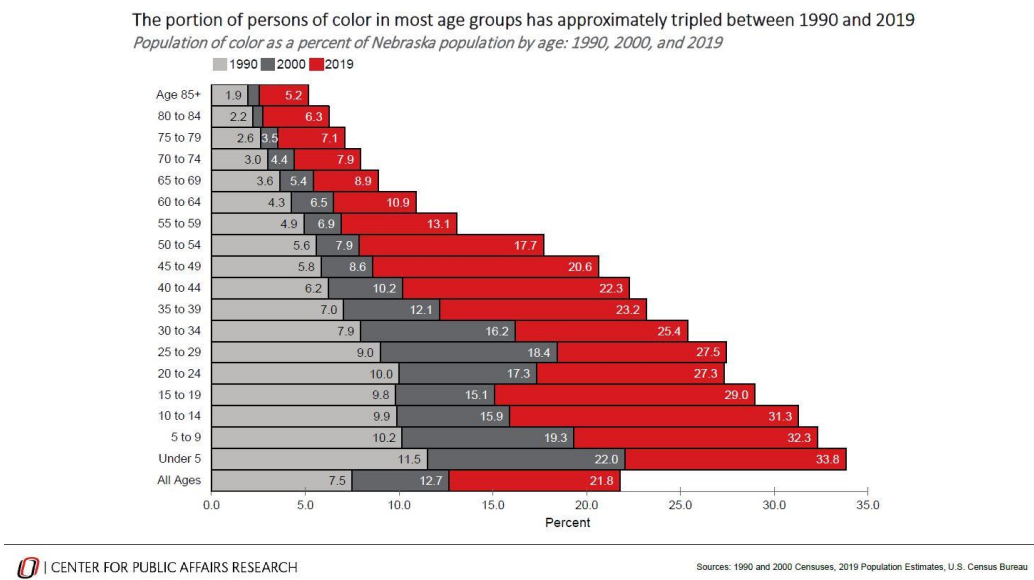


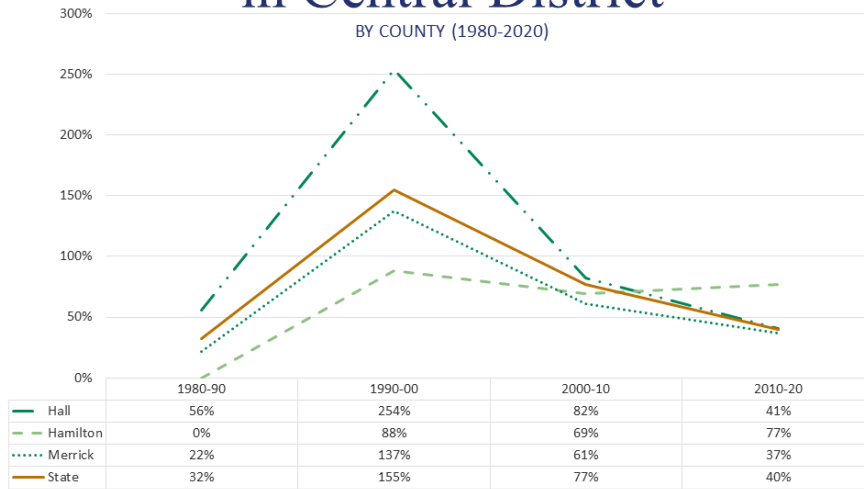
Figure 6. Persons of color by age group, Nebraska (1990-2019)



According to the 2020 County Health Rankings in the CDHD district, Hispanics represented 12%, consistent with the state (11%)^{xxvi}. Among counties within the CDHD district, the Hispanic/Latino percent population change over the last 30 years mimicked the state trend peaking between 1990 and 2000 ending with a downward trend in 2020, except for Hamilton County. Hamilton County experienced a slight upward trend in Hispanic/Latino percent population change between 1980-2020 (see Figure 7).

Figure 7. Hispanic/Latino % population change, by county in CDHD

Hispanic/Latino Population Change in Central District



Source: Decennial Censuses, US Census Bureau; Prepared by David Drozd, UNO Center for Public Affairs Research, Aug 13, 2021

According to the County Health Rankings and Roadmaps, most of the Hispanic population within the CDHD district resides in Hall County (29%). Within Hall County, the Grand Island Public Schools District had the highest English Language Learners (17%) of all school districts within CDHD area. The percent of Hispanic residents in the other two counties was as follows: Hamilton, 4%; Merrick, 5%. Additionally, race by county is similar to ethnicity by county in that Hall County was home to more racially diverse residents (7.1%) than Hamilton and Merrick counties (1.1% and 2.2%, respectively) and is similar to the state (9.2%) (see Figure 8).

Figure 8. Hispanic Origin, CDHD District

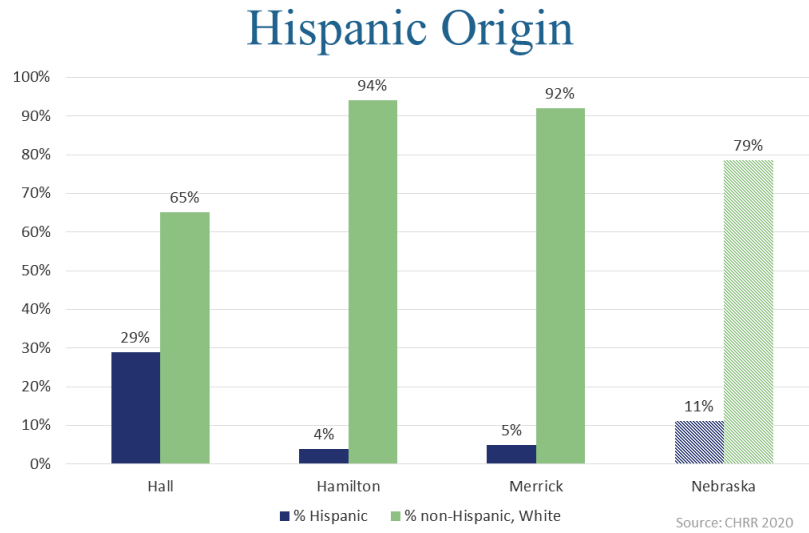
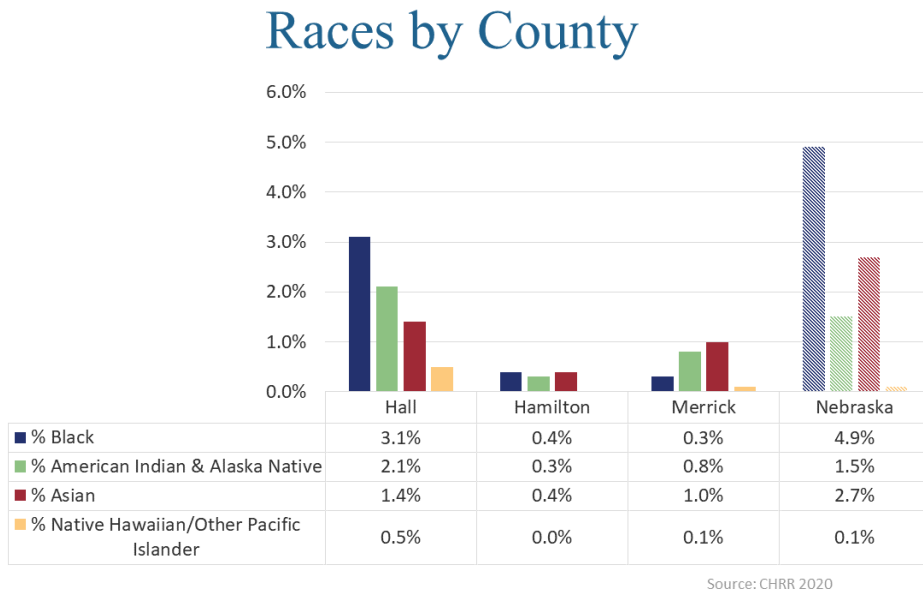


Figure 9. Races by County, CDHD District



Median Age

The median age in the CDHD district was 40 years in 2019, a little older than the average in Nebraska (36 years). Merrick County had the oldest median age of the counties within the CDHD area, almost eight years older than the state.

Figure 10. Age Distribution, Hall County

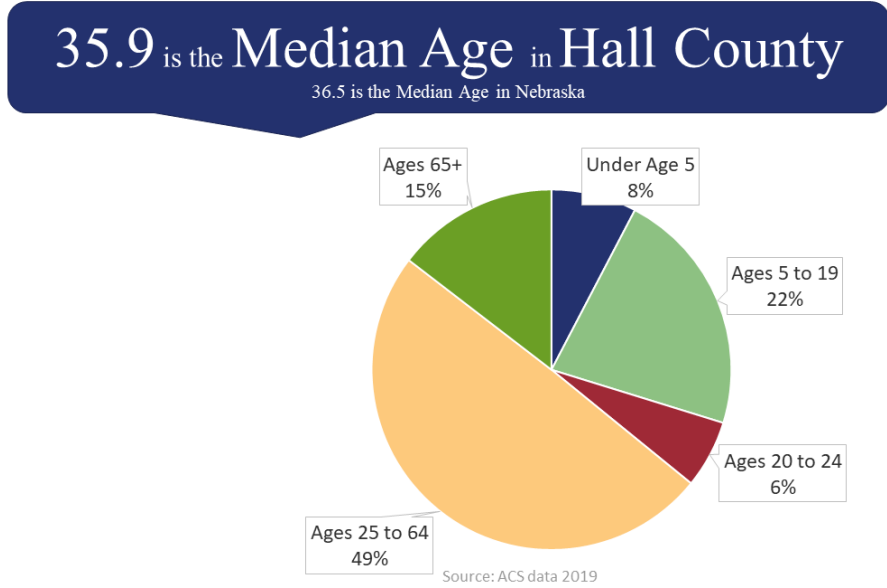


Figure 11. Age Distribution, Hamilton County

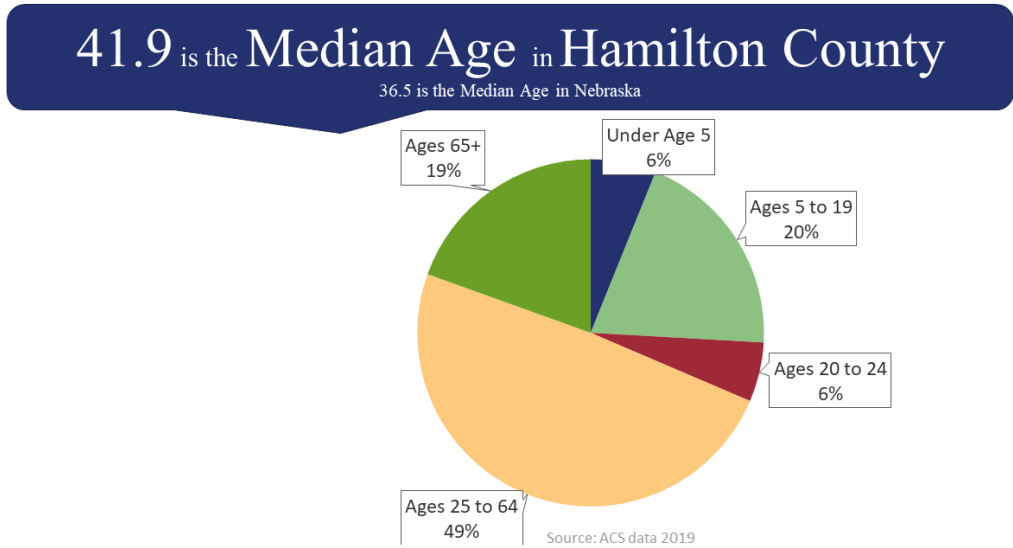
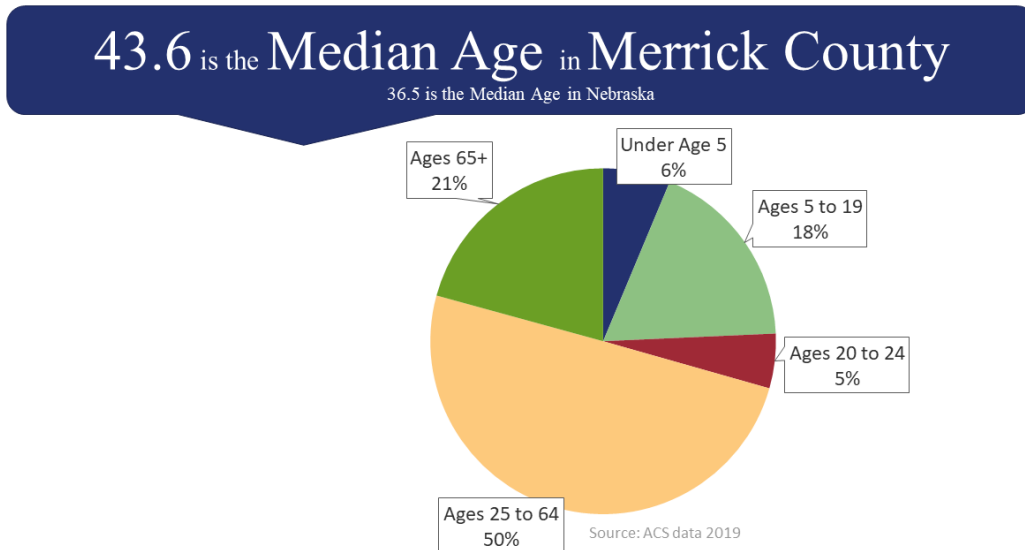
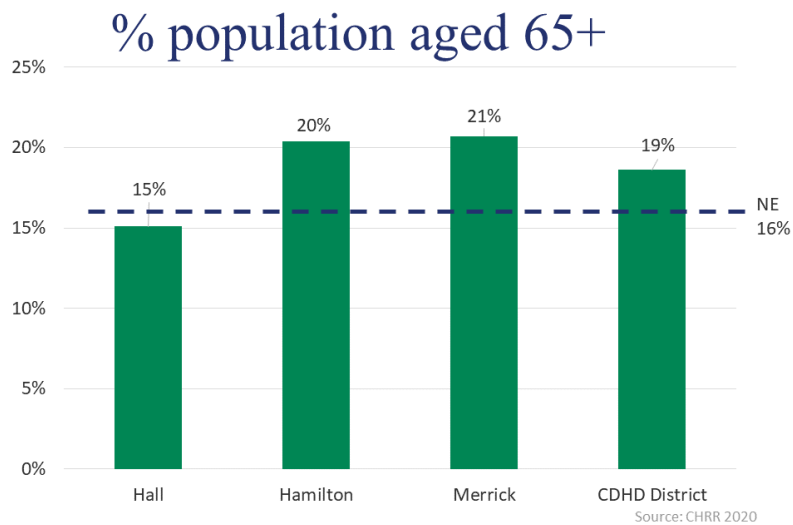


Figure 12. Age Distribution, Merrick County



Roughly 1 in 5 adults in Hamilton and Merrick counties were 65 years and older, and nearly 1 in 6 adults in Hall County were 65 years and older. The percentage of adults aged 65 years and older across the CDHD district (19%) was higher than the state (16%).

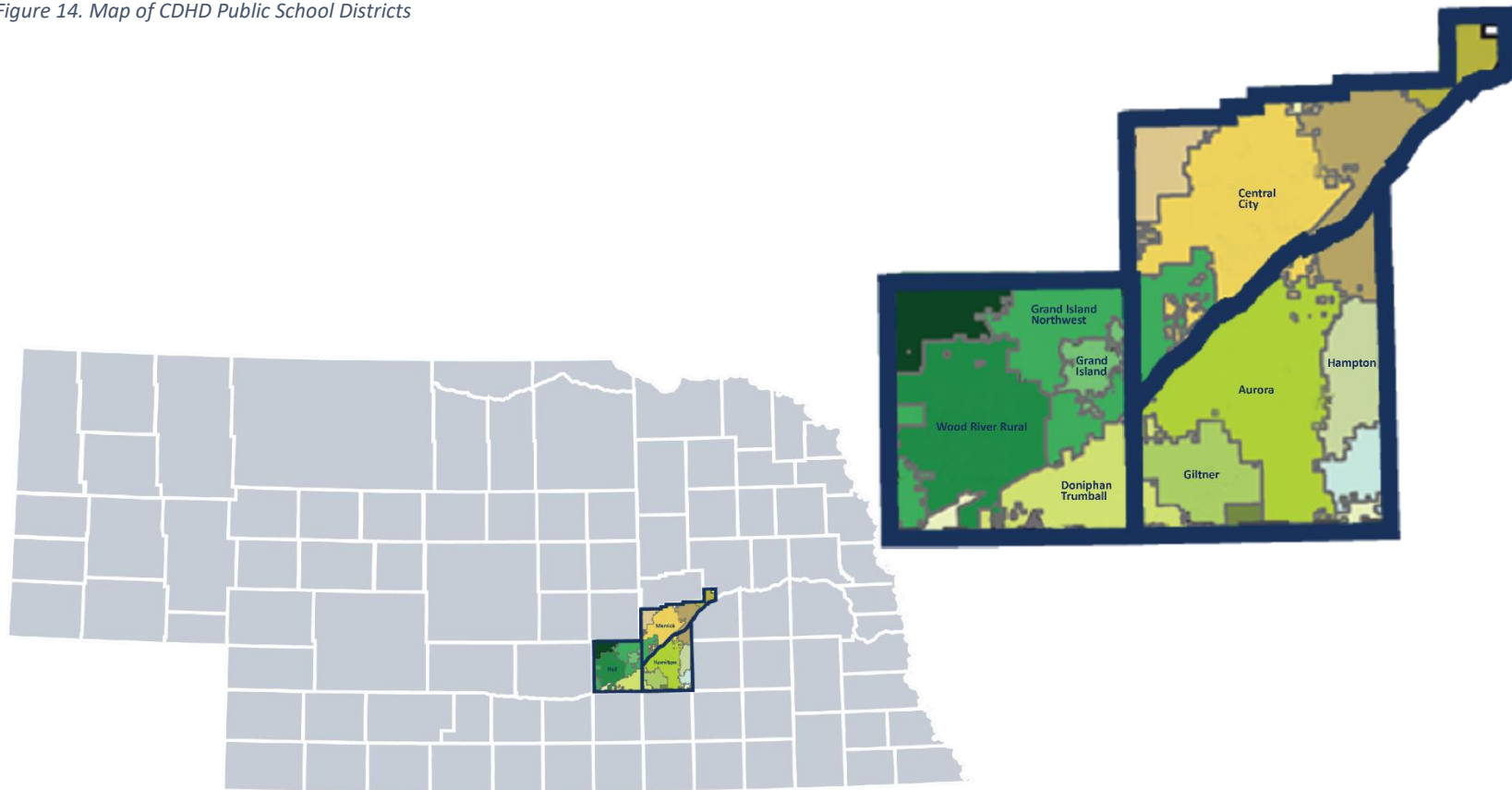
Figure 13. Percent Population Aged 65+, CDHD District



School District Profiles

School-related data can provide a timely picture of the cultural and socio-economic shifts in a community that influence health factors and health outcomes at a population level. Figure 14 illustrates the location of public-school districts within the CDHD district.

Figure 14. Map of CDHD Public School Districts



The following tables highlight key community-level indicators for each county and related public school districts:

Table 4. Public School District Profile--Hall County

Hall County Public School Districts Profile (2018-2019) ^{xxvii}						
		Doniphan-Trumbull	Grand Island Northwest	Wood River	Grand Island Public Schools	State of Nebraska
Student Characteristics	Enrollment	460	1,574	512	10,070	329,290
	Graduation rate	93%	99%	90%	83%	88%
	College-Going rate	81%	76%	80%	61%	*
	% Receiving free/reduced lunch	24%	29%	49%	65%	46%
	% English language learners	*	1%	5%	17%	7%
	% Students in special education	12%	11%	13%	16%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in language arts	Cancelled due to COVID-19				Cancelled due to COVID-19
	% Proficient in math					
	% Proficient in science					

Quick Facts for Hall County:^{xxviii}

Population (2020): **62,895**
 Population Change (2010-2019): **4.7%**
 % children under 18: **28%**
 Median Household Income: **\$57,371**
 % total population in poverty: **10%**
 % children living in poverty:^{xxix} **14%**
 Unemployment Rate: **2.8%**^{xxx}
 Race/Ethnicity--
 % Hispanic: **29%**
 % non-Hispanic, White: **65%**
 % non-Hispanic, other races: **6%**

Table 5. Public School District Profile--Hamilton County

Hamilton County Public School Districts Profile (2018-2019) ^{xxxii}					
		Aurora	Hampton	Giltner	State of Nebraska
Student Characteristics	Enrollment	1283	177	222	329,290
	Graduation rate	92%	*	94%	88%
	College-Going rate	77%	87%	89%	*
	% Receiving free/reduced lunch	36%	28%	27%	46%
	% English language learners	*	*	*	7%
	% Students in special education	16%	24%	17%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in language arts	Cancelled due to COVID-19			Cancelled due to COVID-19
	% Proficient in math				
	% Proficient in science				

Quick Facts for Hamilton County:^{xxxii}

Population (2020): **9,429**
 Population Change (2010-2019): **2.3%**
 % children under 18: **24%**
 Median Household Income: **\$68,236**
 % total population in poverty: **7%**
 % children living in poverty:^{xxxiii} **8%**
 Unemployment Rate: **2.8%**^{xxxiv}
 Race/Ethnicity--
 % Hispanic: **4%**
 % non-Hispanic, White: **94%**
 % non-Hispanic, other races: **2%**

Table 6. Public School District Profile--Merrick County

Merrick County Public School Districts Profile (2018-2019) ^{xxxv}			
		Central City	State of Nebraska
Student Characteristics	Enrollment	767	329,290
	Graduation rate	95%	88%
	College-Going rate	71%	*
	% Receiving free/reduced lunch	46%	46%
	% English language learners	*	7%
	% Students in special education	17%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in language arts	Cancelled due to COVID-19	Cancelled due to COVID-19
	% Proficient in math		
	% Proficient in science		

Quick Facts for Merrick County:^{xxxvi}

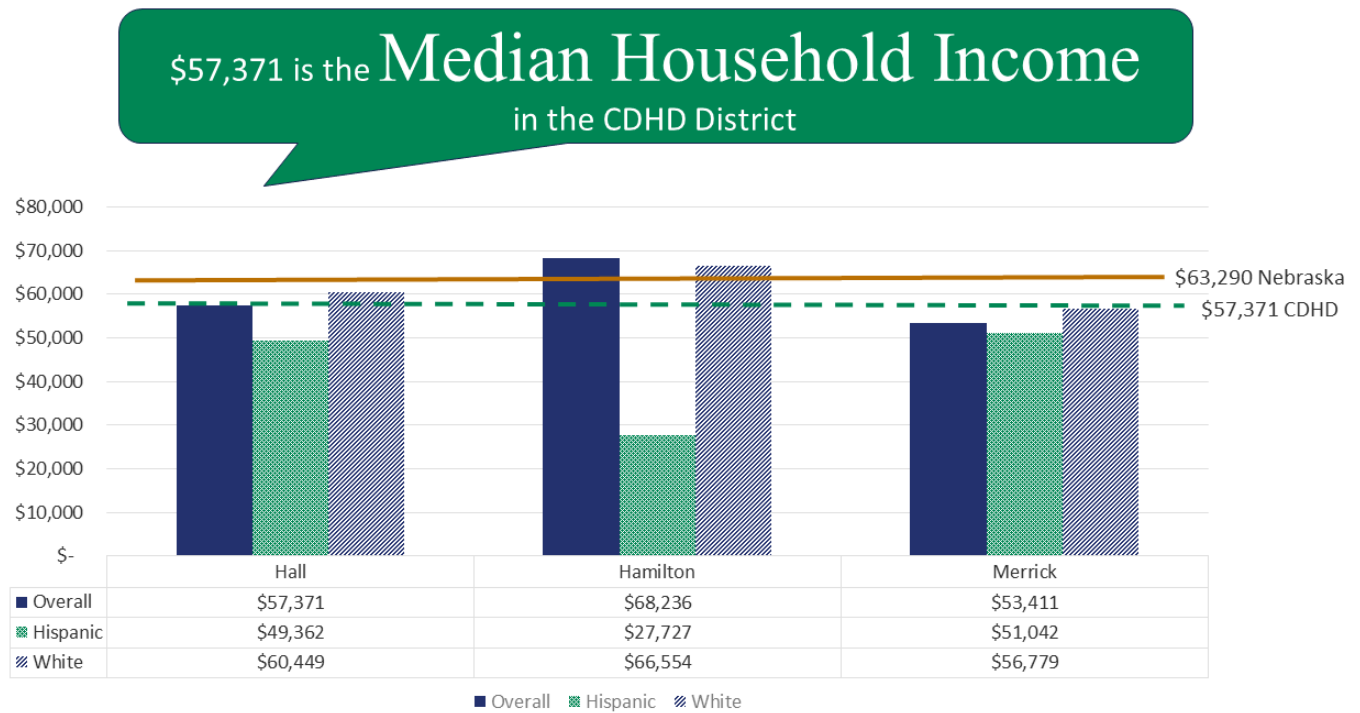
Population (2020): **7,668**
 Population Change (2010-2019): **-1.3%**
 % children under 18: **22%**
 Median Household Income: **\$53,411**
 % total population in poverty: **11%**
 % children living in poverty:^{xxxvii} **14%**
 Unemployment Rate: **2.7%**^{xxxviii}
 Race/Ethnicity--
 % Hispanic: **5%**
 % non-Hispanic, White: **92%**
 % non-Hispanic, other races: **3%**

Socio-Economic Status

Economics

According to the 2020 County Health Rankings, the median household income for Nebraska was \$63,290 with the median household income for CDHD region coming in a little less than the state at \$57,371. Notably, Hamilton County was the only county in the CDHD area with a median household income (\$68,236) higher than the state and the largest income gap between Hispanic and non-Hispanic, White households (a difference of \$38,827) of any county within CDHD district.

Figure 15. Median Household Income, CDHD District



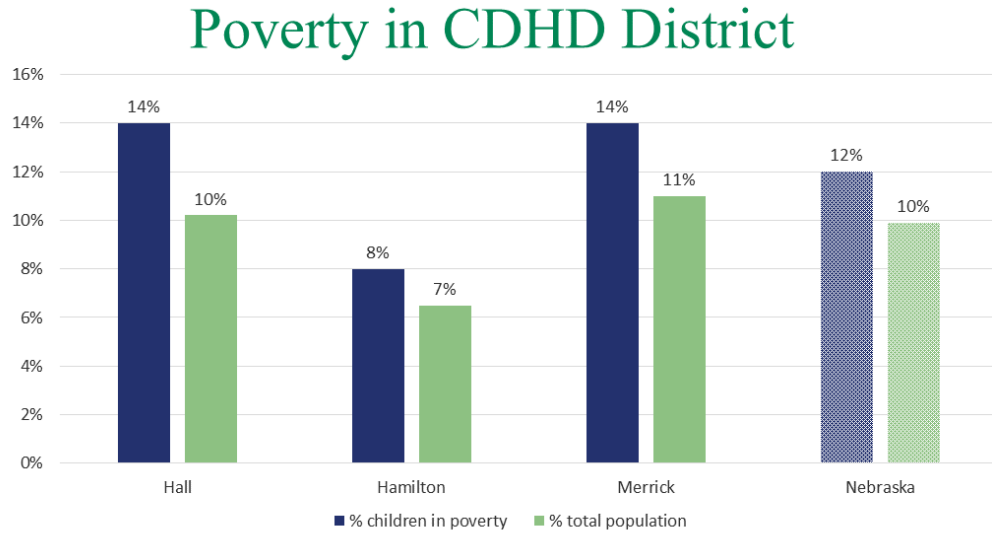
Source: CHRR 2020

Nearly 1 in 5 children were from single family homes across the CDHD region, which was similar to the state average of 21%.^{xxxix} Twelve percent (12%) of children were living in poverty across all counties within the CDHD region, which is same as the state rate of 12%.^{xl} Also the same as the state, CDHD regional unemployment rate was 2.8%.^{xli} Despite the low unemployment rate across the CDHD region, families still struggled to make ends meet.

Table 7. Economic Indicators, CDHD District

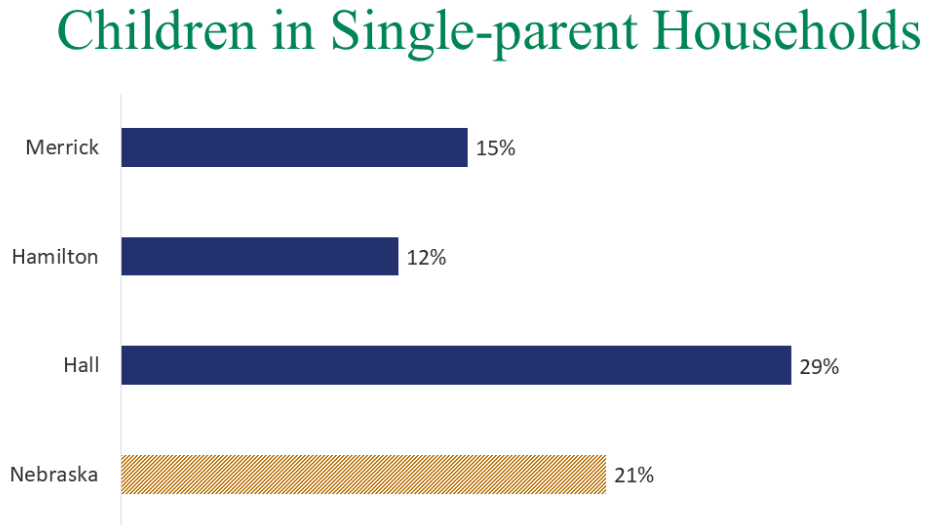
Economic Indicators	CDHD region	Nebraska
Median Household Income ^{xlii}	\$57,371	\$63,290
Children in Single-parent Households ^{xliii}	19%	21%
Percentage of children under age 18 in poverty ^{xliiv}	12%	12%
Unemployment ^{xliv}	2.8%	2.8%

Figure 16. Poverty, CDHD District



Sources: Total population: ACS 2015-2019; Children: County Health Rankings 2020

Figure 17. Children in Single-Parent Households, CDHD District



Source: County Health Rankings 2020

Figure 18. Average Residential Value, CDHD District

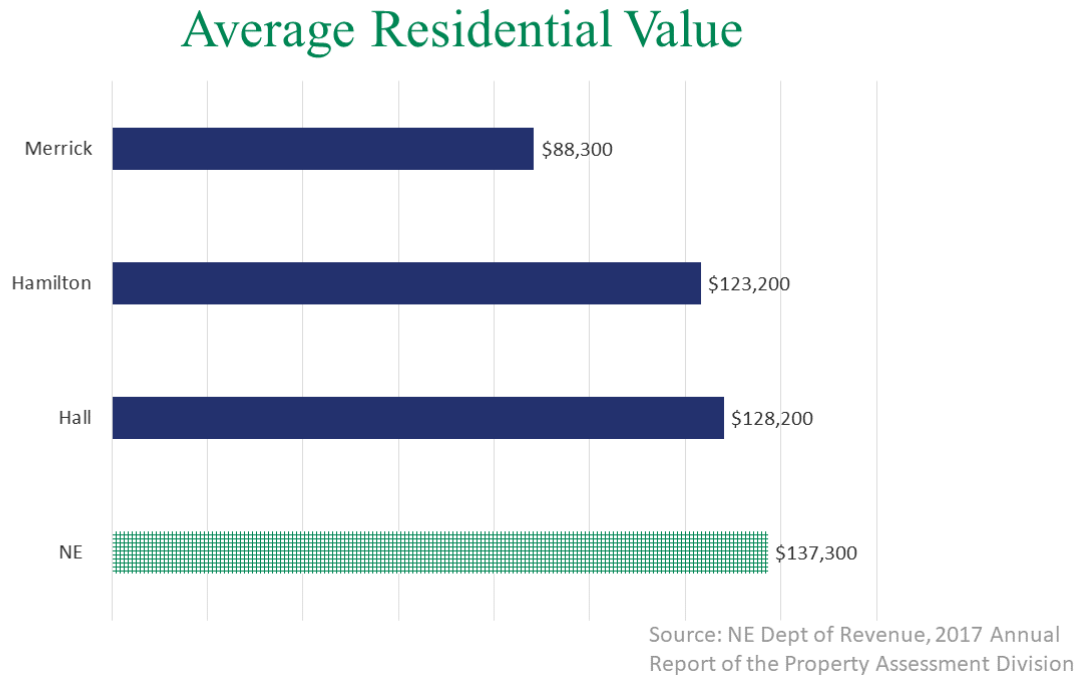


Figure 19. Percentage of Homes Occupied by Owner, CDHD District

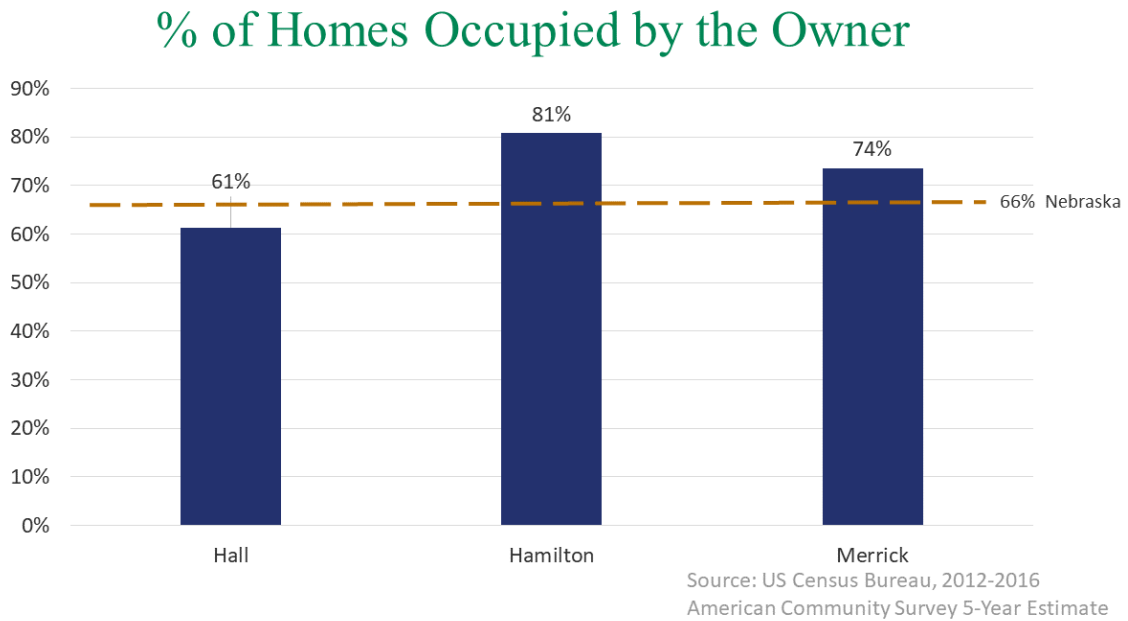
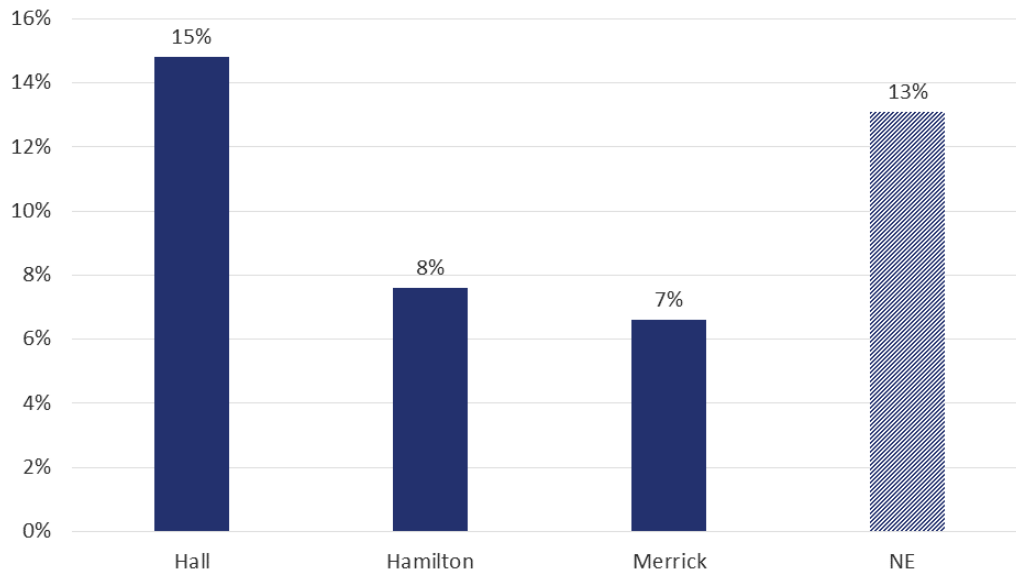


Figure 20. Percentage of Households with Severe Housing Problems, CDHD District

% of Households with Severe Housing Problems



Source: US Dept of Housing and Urban Development, Comprehensive Housing Affordability Strategy, 2018

Housing problems as an indicator is designed to understand the housing needs of low-income households and other vulnerable populations. Figure 20 above is based on the percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities.

Educational Level

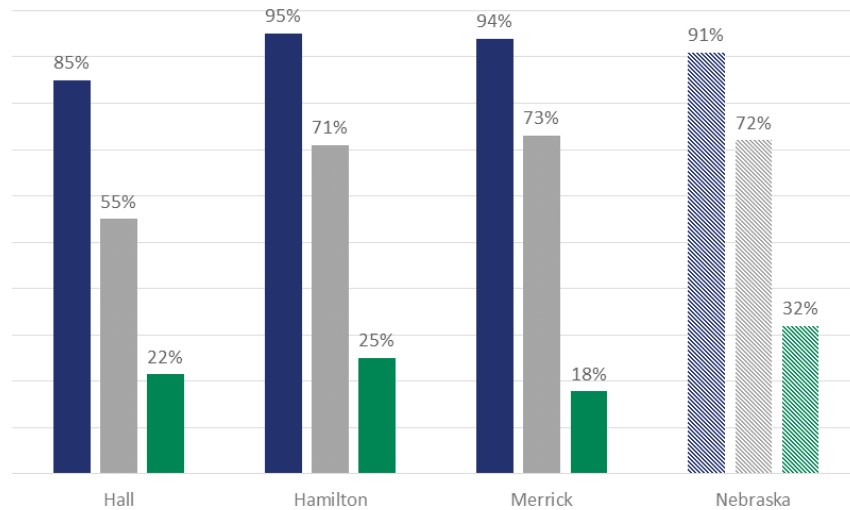
In terms of educational attainment, available data indicate that the CDHD region has a similar high school completion rate (91%) as the state (91%). The Central District region had a slightly lower rate for adults who had some college (counties within the CDHD district range from 55% to 73%) than the state (72%). The state and national averages (32% and 30% respectively) for those who had completed a bachelor's degree was higher than the average for all counties in the CDHD region (range from 18% to 25%).

Table 8. Education Indicators, CDHD District

Education Indicators	CDHD region	Nebraska
High school graduation rate ^{xlvi}	91%	91%
Some college ^{xlvii}	66%	72%
Bachelor's degree or higher, percent of persons age 25+ ^{xlviii}	21%	32%

Figure 21. Education Levels, CDHD District

Education in CDHD District



■ High School Completion Rate* ■ Some college ■ Bachelor's Degree+
 *High School Completion Rate = Percentage of adults ages 25 and over with a high school diploma or equivalent.
 Sources: High School Completion and Some College: County Health Rankings 2020; Bachelor's Degree: ACS 2019 5-year estimates

Health Outcomes

The aforementioned social and economic factors, along with health behaviors, clinical care, and physical environment—otherwise known as modifiable health factors, directly impact how well and how long an individual lives. Furthermore, health outcomes (quality and length of life) are compounded by the presence or the absence of policies and programs that promote health and longevity.

Leading Causes of Death

Across the CDHD district, cancer and heart disease were the leading causes of death, similar to state and national trends.

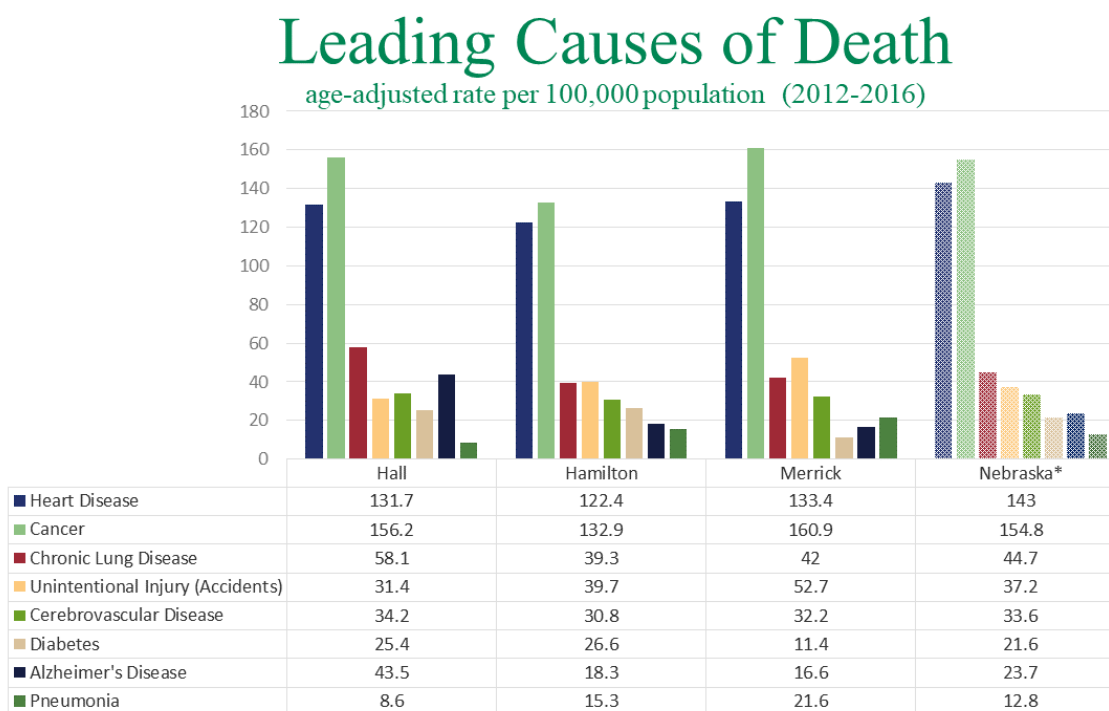
Table 9. Leading Causes of Death, Nebraska & US

Leading Causes of Death	
Nebraska ^{xlix}	United States ^l
1. Cancer	1. Heart disease
2. Heart disease	2. Cancer
3. Chronic lung diseases	3. Accidents (unintentional injuries)
4. Accidents	4. Chronic lower respiratory diseases
5. Cerebrovascular diseases	5. Stroke (cerebrovascular diseases)

Figure 22 illustrates the leading causes of death by county within the CDHD region.^{li} In most cases, counties within the CDHD region have higher rates of death due to cancer, accidents and diabetes than does the state. Of particular note, Merrick County experienced almost twice the death rate

(52.7/100,000 population) due to accidents/unintentional injuries than the state (37.2/100,000 population) and Hall County experienced two times the death rate (43.5/100,000 population) due to Alzheimer’s Disease than the state (23.7/100,000 population). The death rate due to heart disease for counties in CDHD was lower than the state. The death rate in Hall County due to chronic lung disease and stroke (58.1 and 34.2/100,000 population, respectively) were slightly higher than the state (44.7 and 33.6/100,000 population). Most all of these leading causes of death can be influenced by a healthy lifestyle and evidence-based public health strategies that include healthy eating and active living, not smoking, wearing a seatbelt, and limiting alcohol consumption by way of programs that help people prevent and manage personal health risks and policies that help people thrive in their communities.

Figure 22. Leading Causes of Death, CDHD District

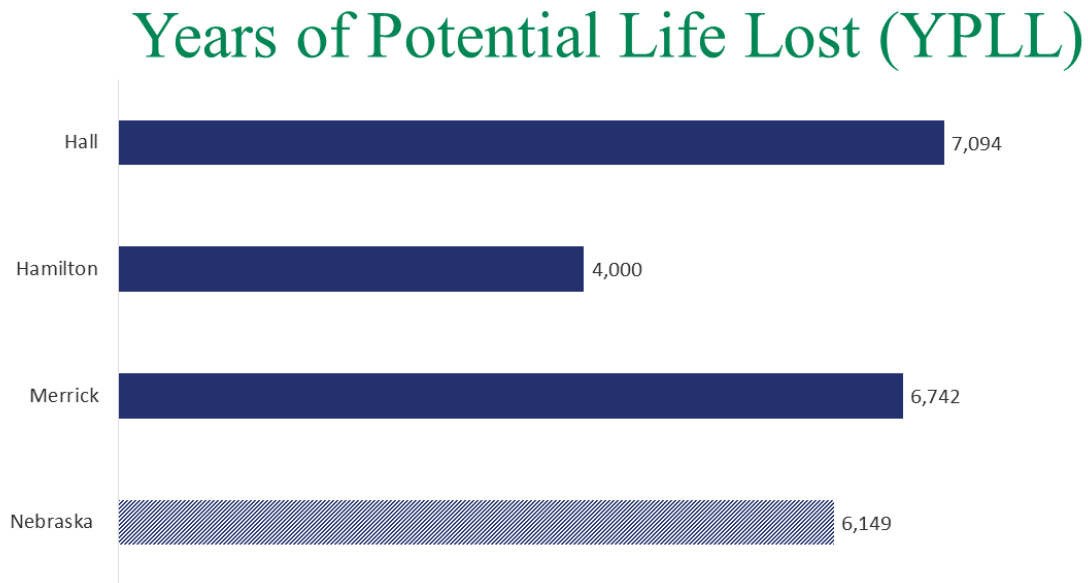


*Nebraska rates (age-adjusted to 2000 US population) Source: NEDHHS Vital Statistics Report 2016

An indicator that helps communities focus on prevention is the Years of Potential Life Lost (YPLL), which is a measurement of premature death (mortality). YPLL is an estimate of the average years a person would have lived if he/she had not died prematurely—typically before the age of 75. YPLL emphasizes deaths of younger persons, whereas statistics that include all mortality are dominated by deaths of the elderly.^{lii} Figure 23^{liii} illustrates the average Years of Potential Life Lost for each county within the CDHD region compared to the state.

Hall and Merrick counties had a higher YPLL than the state, which may be due to having had higher rates of death by cancer, chronic lung disease, accidents/unintentional injuries, and diabetes than the state.

Figure 23. Years of Potential Life Lost (YPLL), CDHD District



Source: County Health Rankings 2020

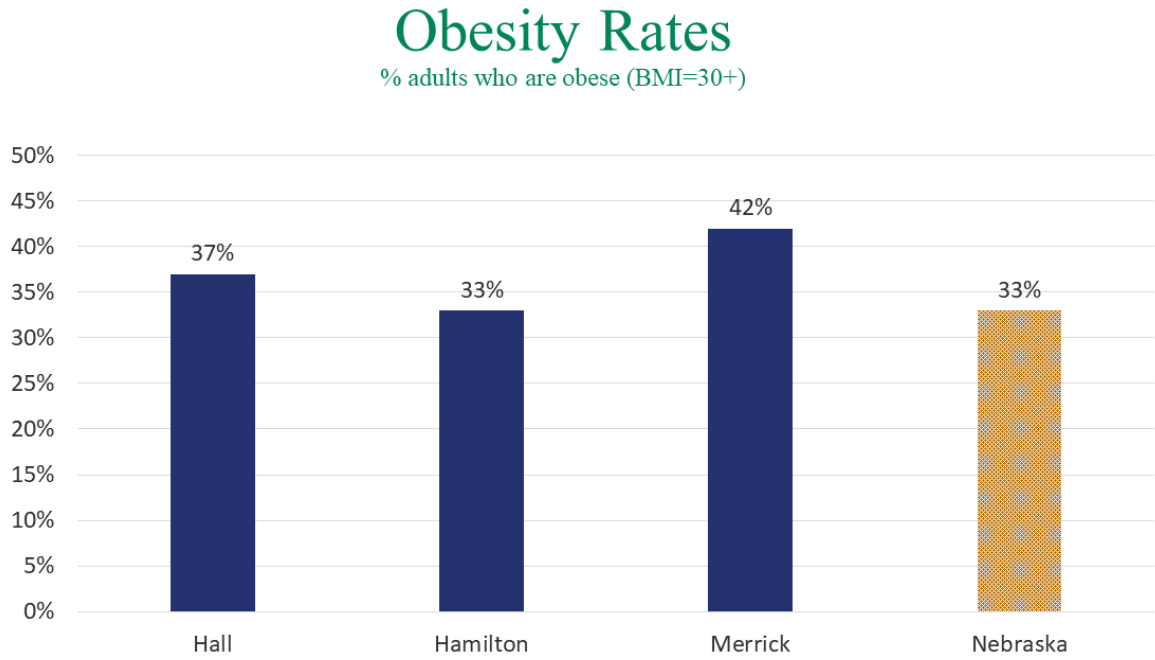
Leading Types of Chronic Disease

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.^{lv} Furthermore, deaths by chronic disease comprised nearly 50% of the Years of Potential Life Lost (YPLL) among Nebraskans.^{lv} 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 rooted in the social and economic factors by which an individual lives.

Overweight/Obesity

According to the 2020 County Health Rankings, nearly 1 in 3 (28%) adults in the CDHD district were considered obese (Body Mass Index [BMI] = 30+), slightly lower than the state (33%). According to the Nebraska BRFSS (2011-2019), 72% of adults in the CDHD district reported being overweight or obese (BMI = 25+), slightly higher than the state (67%), with rates higher among males than females (78% and 65%, respectively).

Figure 24. Obesity Rates, CDHD District



Source: County Health Rankings 2020

Table 10. Overweight/Obesity Rates, CDHD District

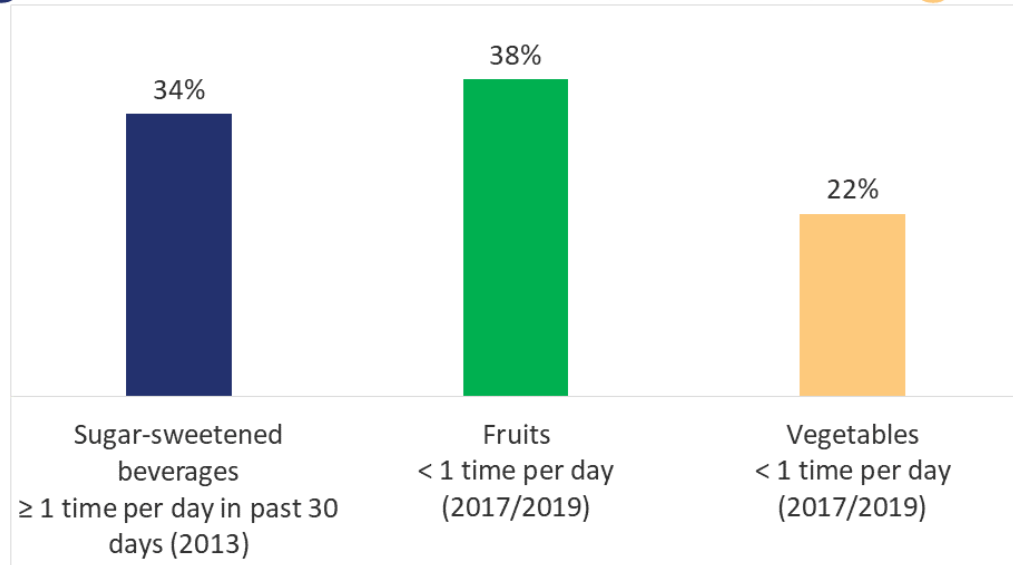
Overweight/Obesity Rates ^{1vi} (BRFSS, 2011-2019)	Overweight or Obese (BMI = 25+)	Obese (BMI = 30+)
Nebraska	67%	31%
CDHD District	72%	35%
Men	78%	36%
Women	65%	35%

Physical Activity and Nutrition

According to the Nebraska BRFSS, healthy eating and active living was not a routine behavior for many adults in the CDHD district. Nearly 40% of adults in this area reported consuming fruits less than 1 time per day and about 1 in 4 adults consumed vegetables less than 1 time per day.

Figure 25. Nutrition Behaviors, CDHD District

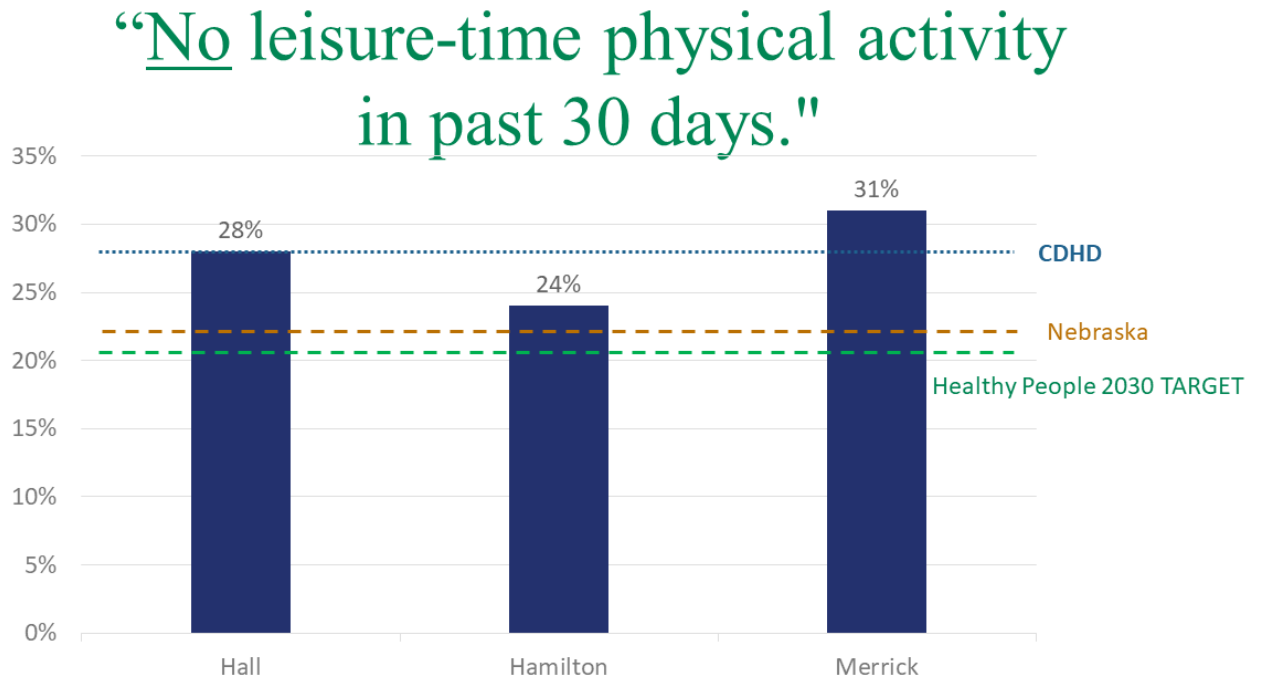
How often adults in CDHD consume Sugar-sweetened Drinks, Fruits, Vegetables



Source: BRFSS 2011-2019

Despite the majority of adults (85%)^{vii} in the CDHD region indicating that they had access to safe places to walk in their neighborhoods, roughly 1 in 3 adults reported no leisure-time physical activity in the past 30 days. Also of concern, the 2012 to 2017 trendline indicates that the percentage of CDHD residents reporting no leisure-time physical activity is increasing. As affirmation to the above indicators related to nutrition, non-White, Hispanic respondents to the CDHD Community Survey identified challenges getting healthy and affordable food as one of top three health concerns.

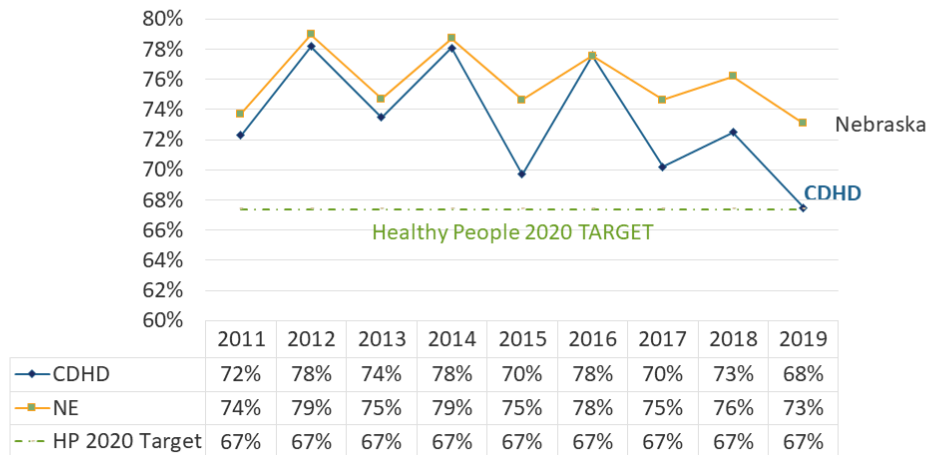
Figure 26. Physical Activity—No Leisure-Time, CDHD District



Source: CHRR 2020

Figure 27. Physical Activity—At Least Some Leisure-Time, CDHD District

Reported At Least Some Leisure-time Physical Activity in Past 30 Days

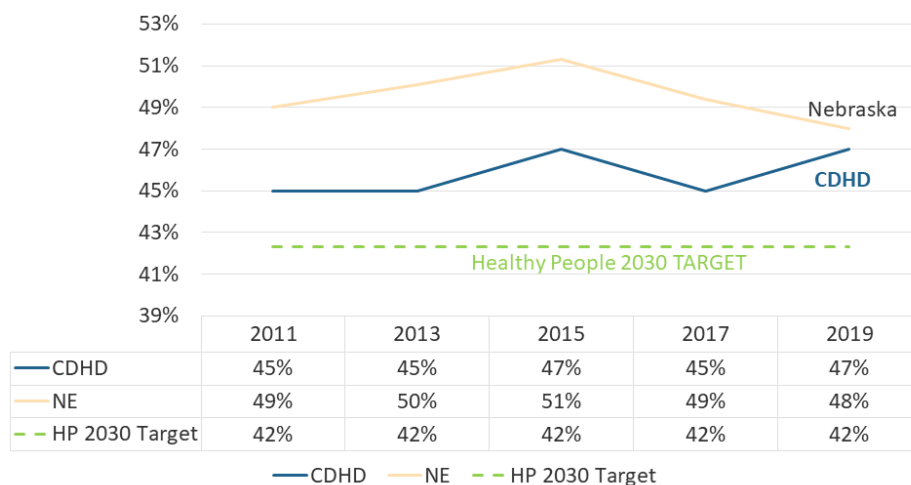


Source: BRFSS 2011-2019

Nearly 50% of people in the CDHD region did not meet the aerobic physical activity recommendations (at least 150 minutes of moderate-intensity physical activity per week—such as brisk walking or 75 minutes of vigorous physical activity per week). Safe community environments, such as walking paths, sidewalks, and walking/biking trails to move throughout the area, encourage residents to engage in healthy eating and active living, which are key to preventing chronic disease. As affirmation to the above indicators related to physical activity, respondents to the CDHD Community Survey identified getting enough exercise as one of the top three health concerns.

Figure 28. Physical Activity—Met Recommendations, CDHD District

Met Aerobic Physical Activity Recommendation

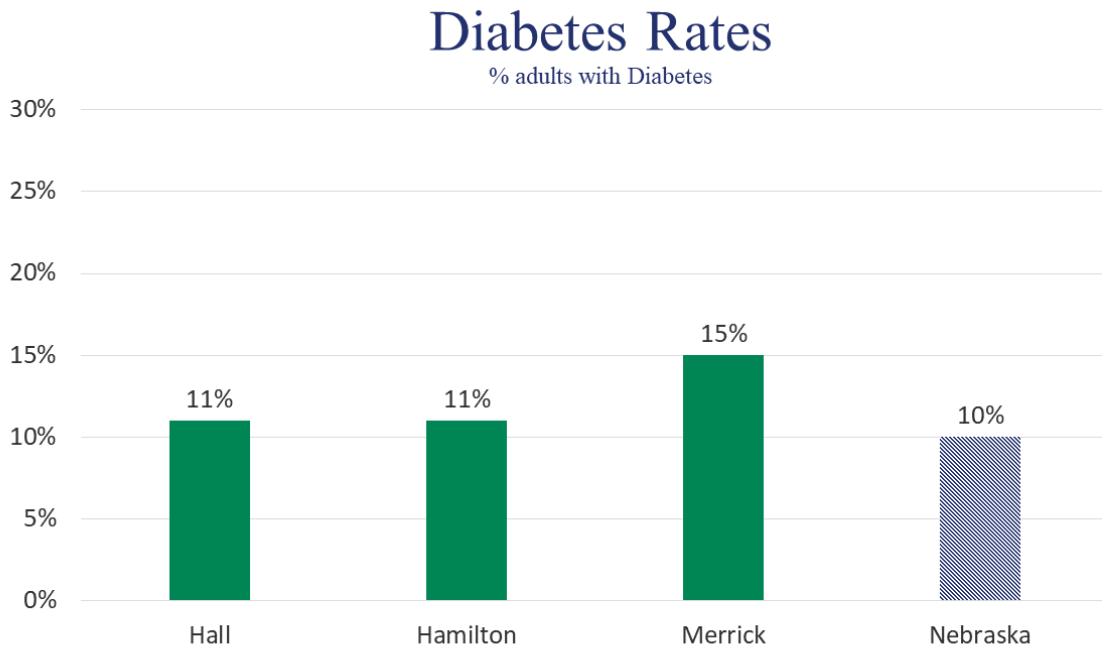


Source: BRFSS 2011-2019

Diabetes

Diabetes is a chronic disease that impacts how a body gets energy from food. Diabetes is the 7th leading cause of death in the US with more than 88 million US adults diagnosed with diabetes. Over the past 20 years, the number of adults diagnosed with diabetes has more than doubled. Overweight/obesity and age are factors that impact the risk of diabetes.^{lviii} Often times, diabetes and heart disease are co-occurring. A person with diabetes is 2 times more likely to have heart disease or stroke, the leading causes of death.^{lix} Generally, diabetes rates in CDHD region are similar to the state rate, except for Merrick County which experienced a slightly higher diabetes rate than the other counties within CDHD perhaps due to a higher proportion of an aging population in this county.

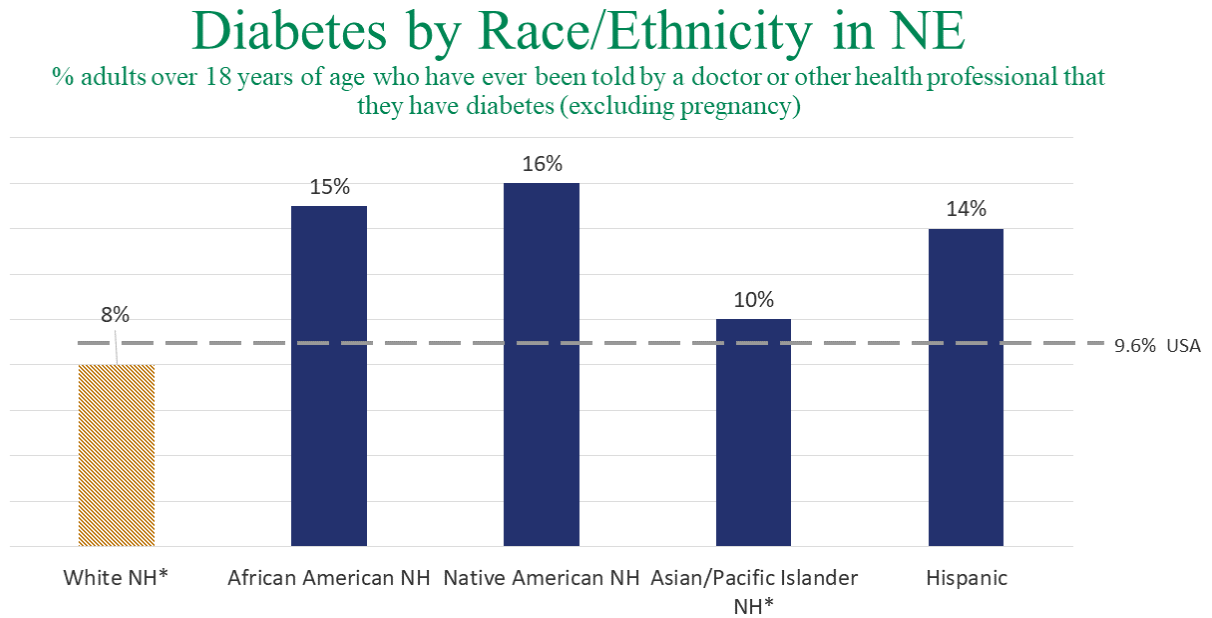
Figure 29. Diabetes rates—by county, CDHD District



Source: County Health Rankings 2020

Diabetes data broken down among race/ethnicity is not available by county, diabetes rates among racial/ethnic populations is available at the state level. There are dramatic gaps between racial/ethnic populations when looking at the state diabetes rates. Notably, African American/Black (15%), American Indian/Alaskan Native (16%), and Hispanic (14%) populations experience almost 2 times the rates of diabetes compared to non-Hispanic, Whites (see Figure 30). As affirmation to the above prevalence and factors contributing to diabetes, respondents to the CDHD Community Survey identified diabetes as one of the top three health concerns.

Figure 30. Diabetes rates—by race and ethnicity, Nebraska



Source: NeDHHS, Office of Health Disparities and Health Equity, diabetes Dashboard

Heart Disease

Heart disease is one of the top two leading causes of death in the CDHD district 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, such as 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).^{ix}

Table 11. Heart Disease Indicators, CDHD District

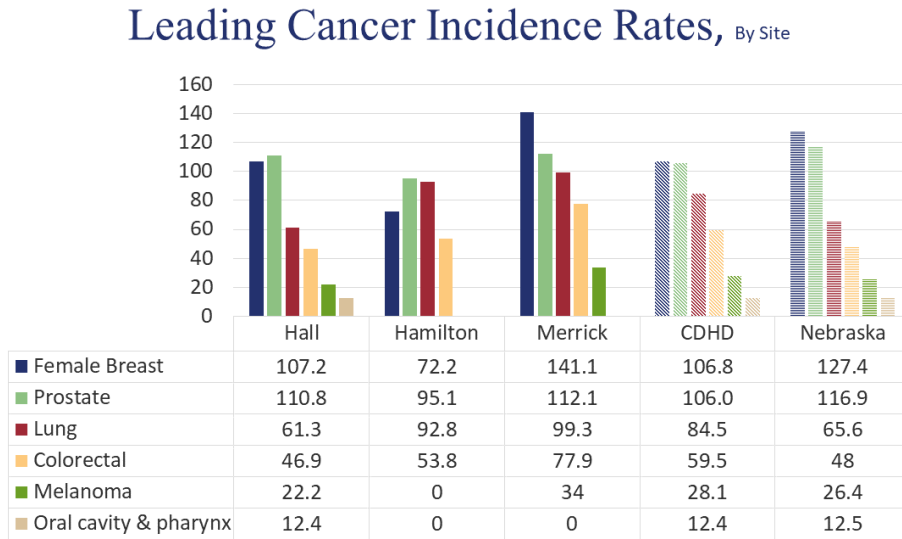
Heart Disease Indicators ^{ixi}	NE	CDHD Region		
		Overall	Female	Male
Ever told they have high blood pressure (excluding pregnancy)	30%	33%	30%	35%
Currently taking blood pressure medication, among those ever told they have high BP	78%	77%	86%	72%
Ever told they have high cholesterol, among those who have ever had it checked	32%	30%	30%	30%

Cancer

Cancer is a leading cause of death in the CDHD district and across the state. In the CDHD region, female breast cancer was the leading type of cancer diagnosed (106.8/100,000 population), which was lower than the state (127.4/100,000 population, respectively). Prostate cancer followed as a close second for CDHD district (106.0/100,000 population) and was lower than the state (116.9/100,000 population,

respectively). Notably, Merrick County residents experience more cancer than their counterparts in Hall or Hamilton counties and the state.

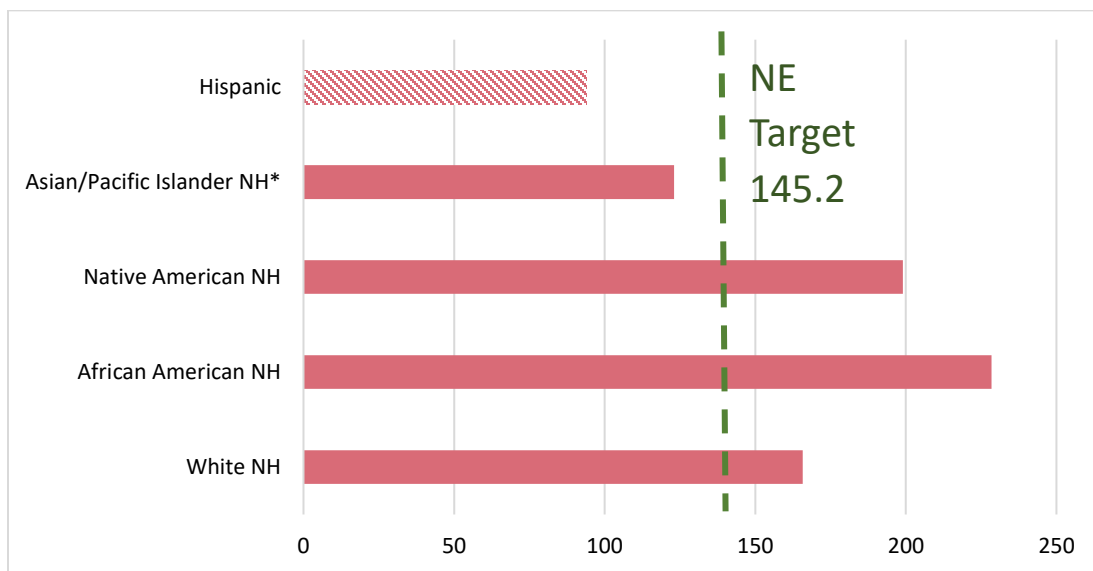
Figure 31. Cancer Incidence Rates, CDHD District



Source: State Cancer Profiles, 2013-2017

Cancer mortality rates are on the decline in the CDHD district, state, and nation.^{lxii} Despite this trend, cancer remained one of the top two leading causes of death in the CDHD district through 2017. Cancer mortality data by race and ethnicity was not readily available for the CDHD district. Native Americans, African Americans, and Whites across Nebraska had cancer mortality rates in excess of the state target of 145.2/100,000 population (see Figure 29). More information is needed about the cause of cancer incidence and death rates in the CDHD area.

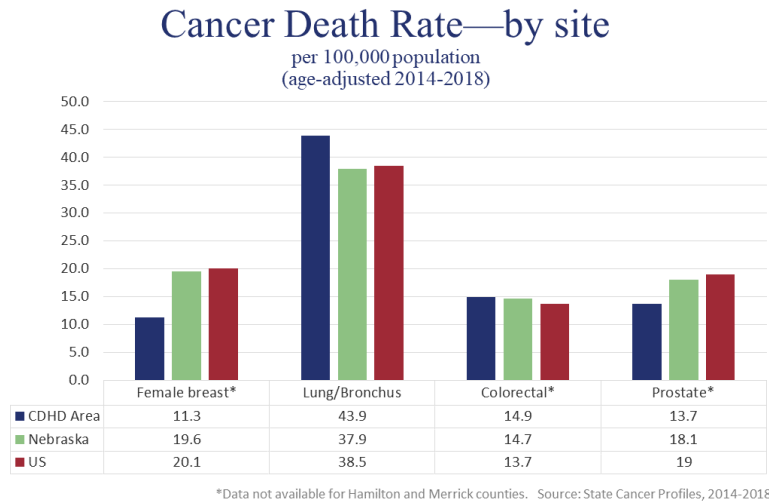
Figure 32. Cancer Mortality Rates--Nebraska Racial/Ethnic Comparison (per 100,000 population)



*NH = Non-Hispanic

Although cancer mortality data by county was not readily available, lung (and bronchus) cancer was the leading type of cancer that resulted in death in the CDHD district (see Figure 33).^{lxiii} Tobacco smoking remains the leading cause of lung cancer, responsible for about 80% of lung cancer deaths. Other causes include exposure to secondhand smoke and radon.^{lxiv}

Figure 33. Leading Cancer Death Rates in CDHD (per 100,000 population)



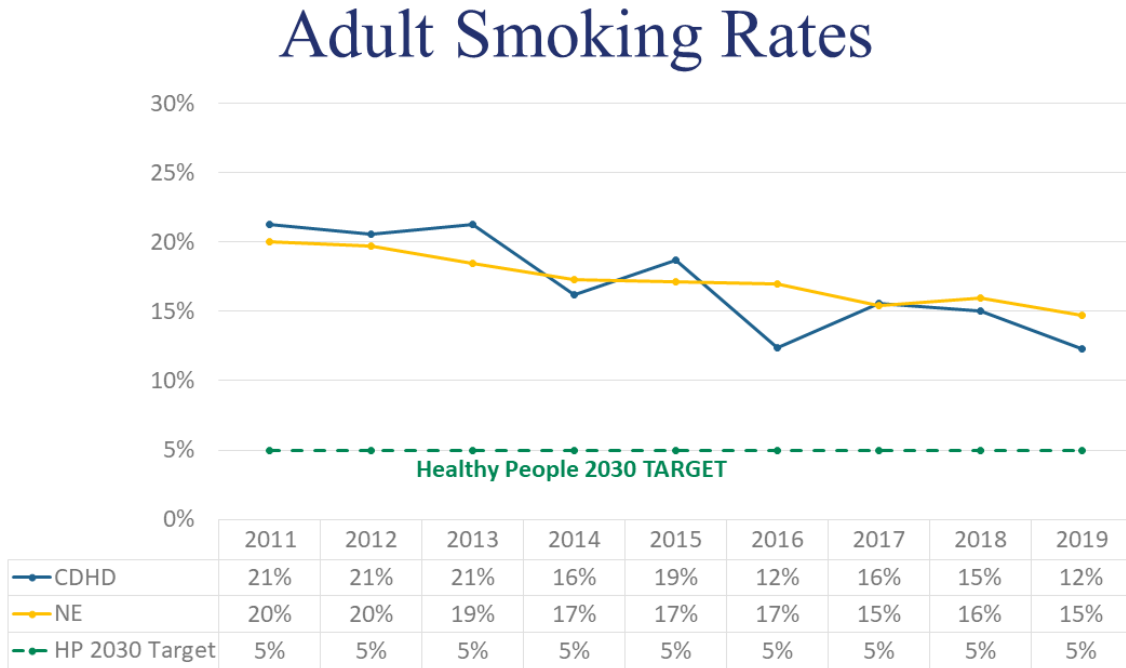
As affirmation to the above prevalence and factors contributing to cancer, respondents to the CDHD Community Survey identified cancer as one of the top three health concerns.

Tobacco and Nicotine Product Usage

Cigarette smoking is the leading cause of preventable disease and death in the US. According to the CDC, the smoking rate among adults in the US has dropped from 20.9% in 2005 to 14% in 2019.^{lxv}

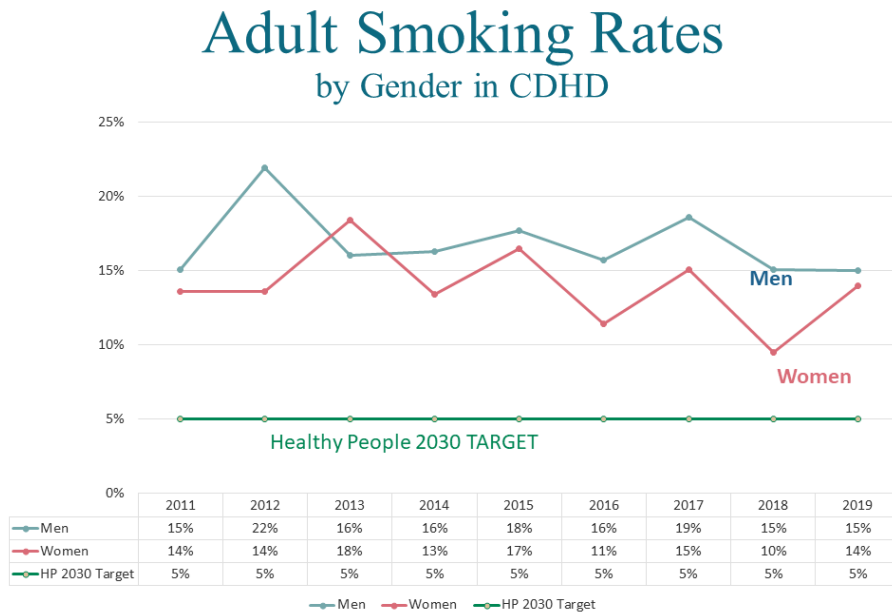
According to the Nebraska BRFSS (2011-2019), the smoking rate among adults in the CDHD region and in the state has trended downward (see Figure 31), yet the adult smoking rate is higher than the Healthy People 2030 target of 5%. Smoking rates among male adults in the CDHD region was higher than female adults (see Figure 35).

Figure 34. Adult Smoking Rates, CDHD District



Source: BRFSS 2011-2019

Figure 35. Adult Smoking Rates by Gender, CDHD District



Source: BRFSS 2011-2019

While Nebraska has a clean indoor air ordinance prohibiting smoking in all government and private workplaces, schools, childcare facilities, restaurants, bars, casinos/gaming establishments, retail stores and recreational/cultural facilities, tobacco products are relatively easy to access and inexpensive. Nebraska’s tobacco tax is \$0.64 per pack, \$1.18 lower than the national average, ranking Nebraska 42nd in the US for its cigarette tax^{lxvi}.

Even though cigarette smoking (otherwise known as combustible tobacco cigarette) was trending downwards in the CDHD district, e-cigarette usage was growing among CDHD adults. According to the 2019 NE BRFSS, 1 in 5 adults in the CDHD district used e-cigarettes just slightly under the state rate of 25%. E-cigarettes are devices that heat liquid solution to produce an aerosol that is inhaled. E-cigarettes contain varying amounts of nicotine depending on the type of e-cigarette; and although considered less harmful to individual health than inhaling smoke from combustible tobacco, still deliver harmful chemicals. E-cigarettes can be addictive due to the nicotine content.^{lxvii}

The most commonly used tobacco product among youth was e-cigarettes, and e-cigarette usage among youth increased more than any other age group in recent years (see Figures 36, 37 and 38). E-cigarettes are marketed to youth with strategies that have been heavily regulated to reduce youth consumption of combustible cigarettes, i.e. kid-friendly flavors, scholarship opportunities for school, online/mobile and TV ads.^{lxviii} CDHD district has experienced marked increases in e-cigarette use among youth. According to the Nebraska Risk and Protective Factor Surveillance Survey (NPRFSS) in 2018, the current e-cigarette usage rate among CDHD youth in 12th grade is 35.3% (see Figure 39) and nearly half of all 12th graders who responded to the NPRFSS survey reported ever using e-cigarettes.

Figure 36. E-Cigarette Use Rate-- Youth, Nebraska

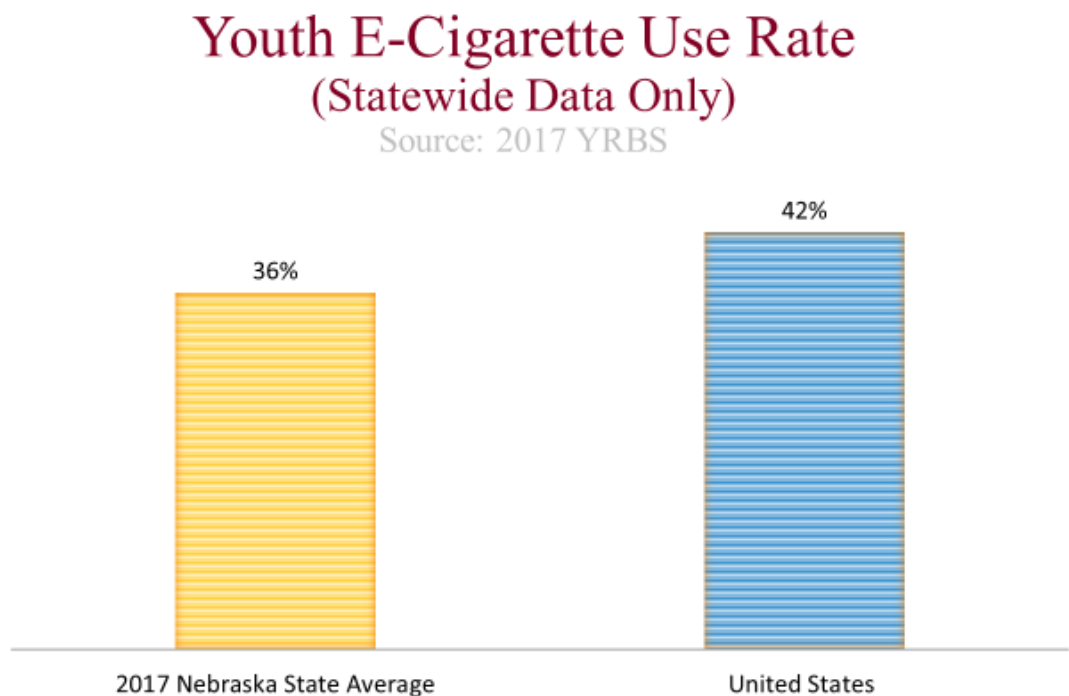


Figure 37. E-Cigarette Use Rate--Youth, Nebraska

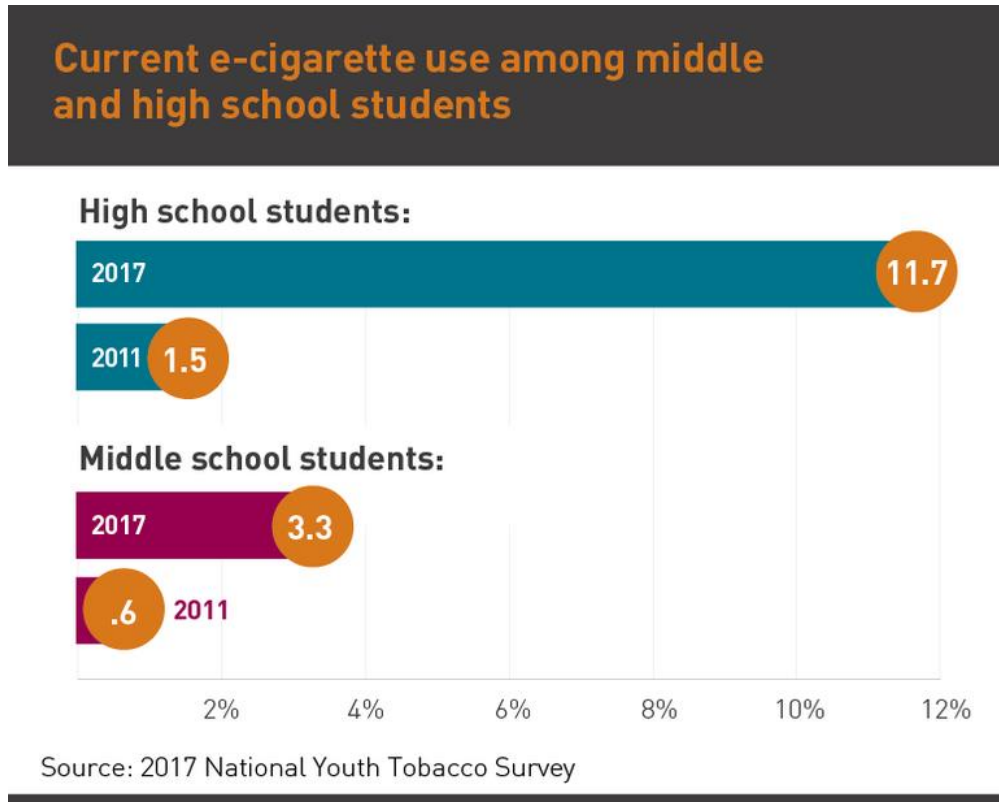


Figure 38. Tobacco Use—Other Tobacco Product Use Rate, Nebraska

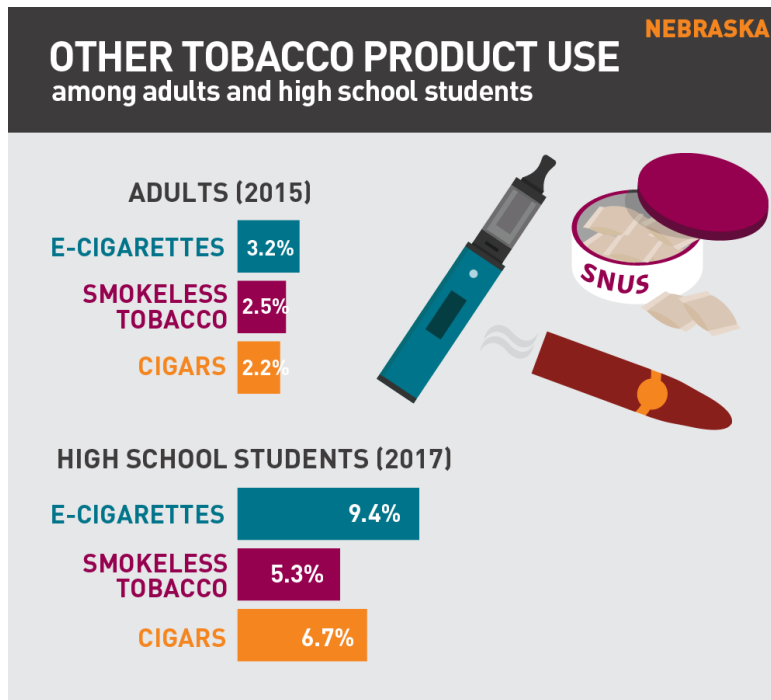
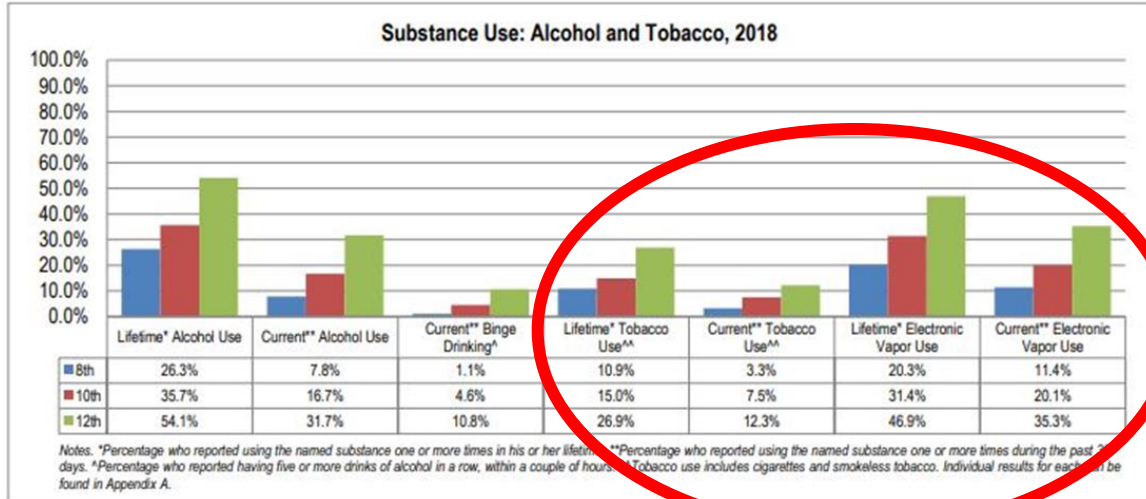


Figure 39. Tobacco and Alcohol Use Rate—Youth, CDHD District

Alcohol and Tobacco Use of Youth in CDHD District Grades 8, 10 and 12



Source: 2018 results from Nebraska Risk and Protective Factor Student Survey

Radon Risk

The second-leading cause of lung cancer, behind smoking, is breathing radon gas, a naturally-occurring, radioactive, colorless and odorless gas. Homes, schools, and workplaces are where most radon exposure occurs. Nebraska has a high statewide average radon level at 6.3 pCi/L, ranking it third across the US. Over half of the radon tests in the state were above the Environmental Protection Agency’s recommended action level of >4.0 pCi/L. At least 70 of 93 Nebraska counties had an average radon level greater than 4.0 pCi/L, including Hamilton County.^{lxix}

Leading Causes of Injury

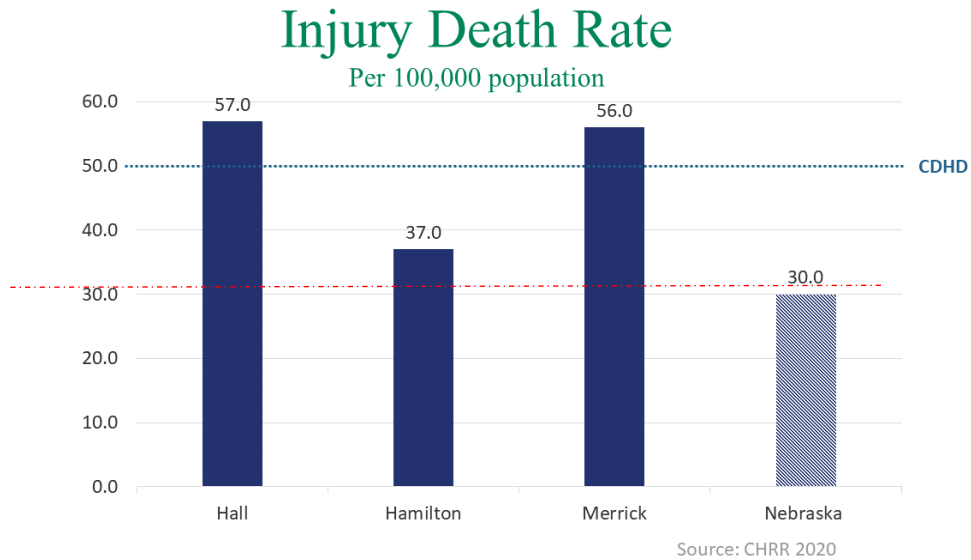
Deaths by injury comprised approximately 20% of the total YPLL among Nebraskans.^{lxx}

Table 12. Leading causes of injury, Nebraska

Leading causes of <i>death</i> by injury in Nebraska (2009-2013)	Leading causes of <i>hospitalizations</i> due to injury in Nebraska (2009-2013)
<ol style="list-style-type: none"> 1. Motor vehicle crashes 2. Suicide 3. Unintentional falls 4. Unintentional poisoning 	<ol style="list-style-type: none"> 1. Unintentional falls 2. Unintentional injuries due to motor vehicle traffic 3. Self-inflicted injuries

In the CDHD district, all counties experienced higher rates of death by injury than the state. Of particular note, the death by injury rate in Hall and Merrick counties was nearly double than the state (see Figure 40^{lxxi}).

Figure 40. Injury Death Rate, CDHD District



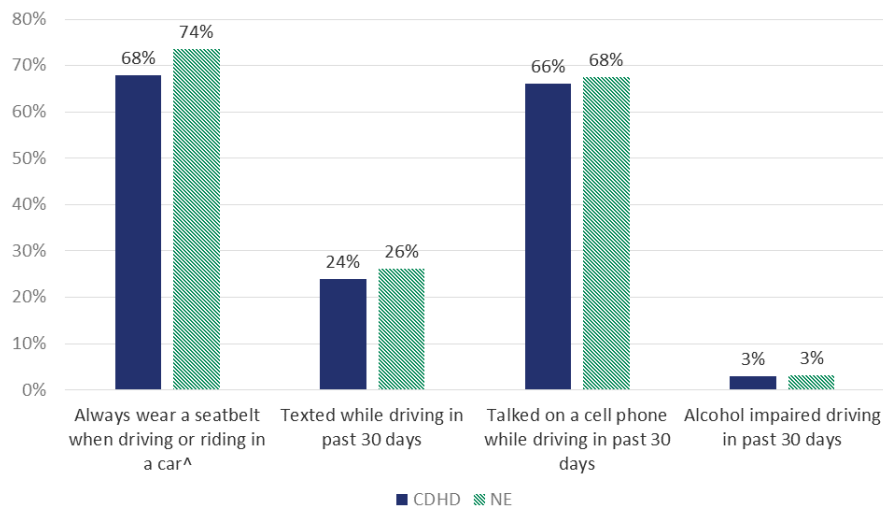
Motor Vehicle Behaviors

According to the Behavioral Risk Factor Surveillance System (BRFSS) 2019, 2 out of 3 adults in the CDHD district talked on a cell phone while driving in the past 30 days, similar to the state rate of 68%. Additionally, 3% of adults in the CDHD district reported driving under the influence of alcohol in the past 30 days, similar to the state rate (3%). Other risky behaviors while driving a vehicle in the CDHD district did not surpass the state average; however, 1 in 4 CDHD district adults reported texting while driving a vehicle, 1 in 3 CDHD adults did not always wear a seatbelt when driving or riding in a car.

Figure 41. Motor Vehicular Behavior Indicators, CDHD District

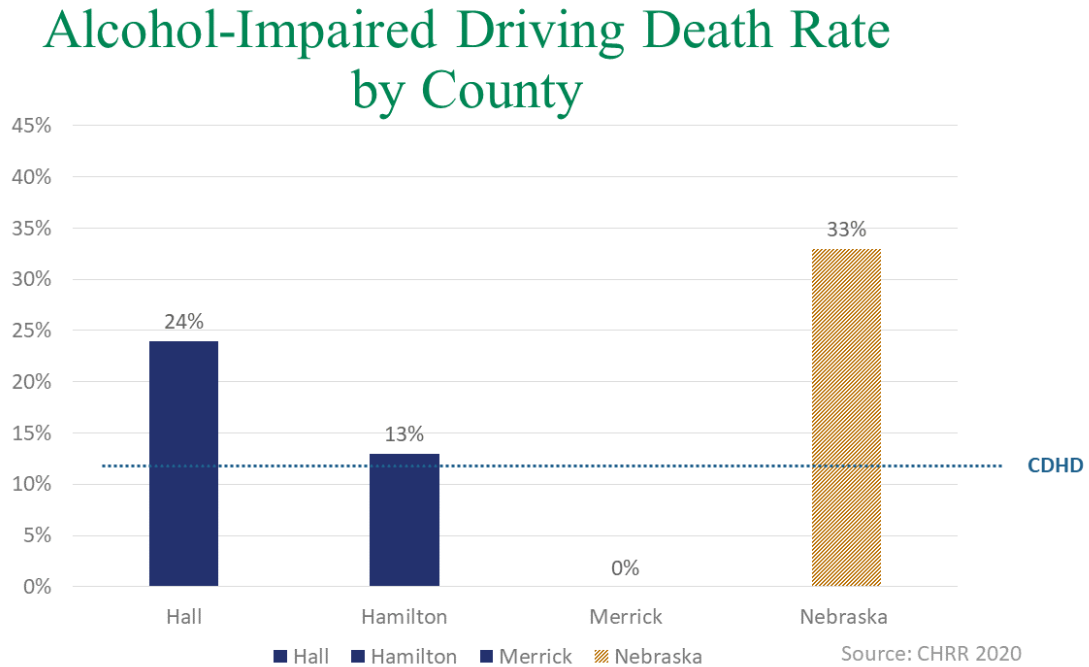
Motor Vehicular Behavior Indicators

NE BRFSS (2011-2019)



The death rate caused by alcohol-impaired driving in the CDHD district (12%) was lower than the state rate (33%)^{lxxii}.

Figure 42. Alcohol-Impaired Driving Death Rate, by County CDHD District



Behavioral/Mental Health and Related Risk Factors

Mental health impacts a person’s ability to maintain good physical health and vice versa. Mental health is strongly associated with the risk, prevalence, progression, outcome, treatment and recovery of chronic diseases, including diabetes, heart disease and cancer. Good mental health is essential for a person to live a healthy and productive life.^{lxxiii}

According to the Nebraska Behavioral Health Needs Assessment in 2016, mental health illness was a common health problem in Nebraska. One in five Nebraskans reported any mental illness—defined as any diagnosable mental, behavioral or emotional disorder other than substance use disorder. Nebraska’s rate is similar to the US rate (18.13%). Concerning, although less common, 4%-7% of Nebraskans reported having serious thoughts of suicide, a major depressive episode, or serious mental illness—defined as a mental disorder causing significant interference with one or more major life activity.

Table 13 below summarizes the 2011-2019 BRFSS data regarding mental health indicators for Nebraska and the CDHD district. Women fared worse than men. Compared to the state, as a whole, CDHD is relatively aligned across all five indicators.

Table 13. Mental Health problem indicators in CDHD District

Mental Health Indicators

	Ever told they have depression (%)	Average days mental health was not good in past 30 days	Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	Average days poor physical or mental health limited usual activities in past 30 days	Poor physical or mental health limited usual activities on 14 or more of the past 30 days
<i>Nebraska</i>	18%	3.2	10%	2.0	6%
CDHD District	18%	3.2	10%	2	6%
<i>Male</i>	12%	2.5	9%	1.9	6%
<i>Female</i>	23%	2.5	12%	2.1	5%

Source: BRFSS 2011-2019

Table 14. Mental Health problem indicators in CDHD District by County

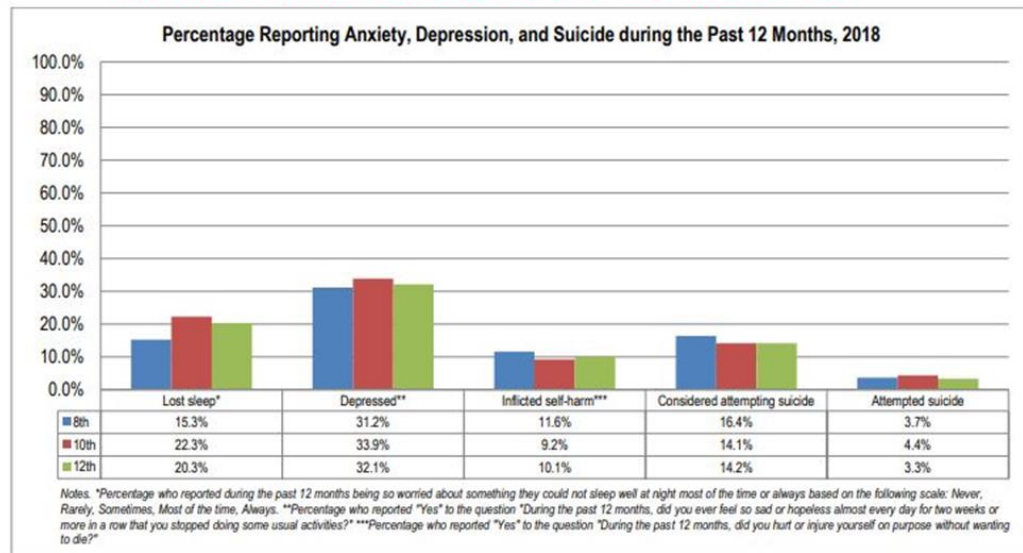
Mental Health Indicators	Average number of mentally unhealthy days in the past 30 days	Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)
<i>Nebraska</i>	3.6 <small>(CHRR 2020)</small>	10% <small>(BRFSS 2011-2019)</small>
CDHD District	2.8 <small>(CHRR 2020)</small>	10% <small>(BRFSS 2011-2019)</small>
<i>Hall County</i> <small>(CHRR 2020)</small>	3.8	12.0%
<i>Hamilton County</i> <small>(CHRR 2020)</small>	3.5	11.0%
<i>Merrick County</i> <small>(CHRR 2020)</small>	3.8	12.0%

Approximately 1 in 4 Nebraska high school youth reported feeling depressed compared to nearly 1 in 3 youth nationwide (24.1% vs 29.9%). Female students had a significantly higher rate of depression (31.4% vs. 17.1%), of considering a suicide attempt (18.0% vs. 11.3%) and of making a suicide plan

(17.0% vs. 9.8%) compared to male students.^{lxxiv} According to the NRPFSS 2018 in the CDHD, nearly 1 in 3 high school youth reported feeling depressed and 14% considered attempting suicide (see Figure 43).

Figure 43. Mental Health indicators for Youth, CDHD District

Mental Health of Youth in CDHD District Grades 8, 10 and 12

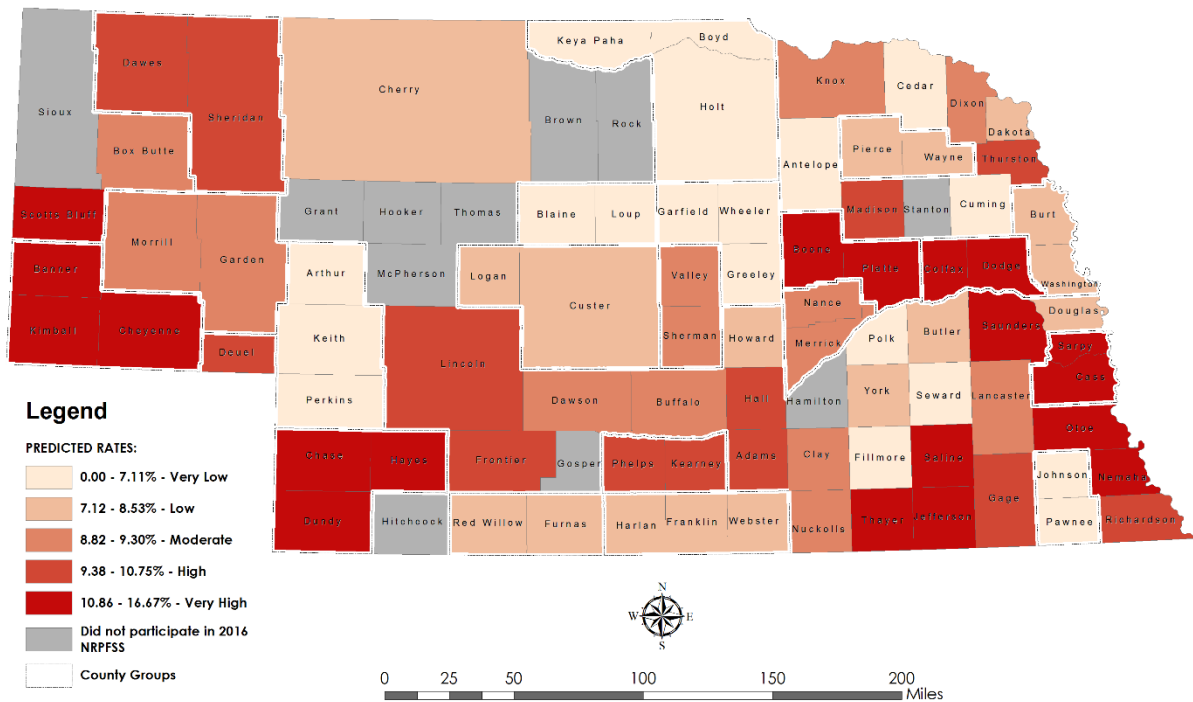


Source: 2018 results from Nebraska Risk and Protective Factor Student Survey

Suicide Risk

In Nebraska, the rate of suicide across all ages was similar to the rate of suicide for the US (13.05 vs. 13.42—per 100,000 population). Suicide is the 9th leading cause of death in Nebraska, and the second leading cause of death for ages 10-34.^{lxxv} Hall County was at higher risk for youth suicide ideation and attempts. Figure 44 shows this risk for each county across the state based on the average responses to two questions on the Nebraska Risk and Protective Factors Surveillance System in 2016: 1) “During the past 12 months did you ever seriously consider attempting suicide?” and 2) “During the past 12 months, did you actually attempt suicide?”

Figure 44. Risk level for youth suicide ideation and attempts by county based on the 2016 results from the Nebraska Risk and Protective Factors Surveillance System

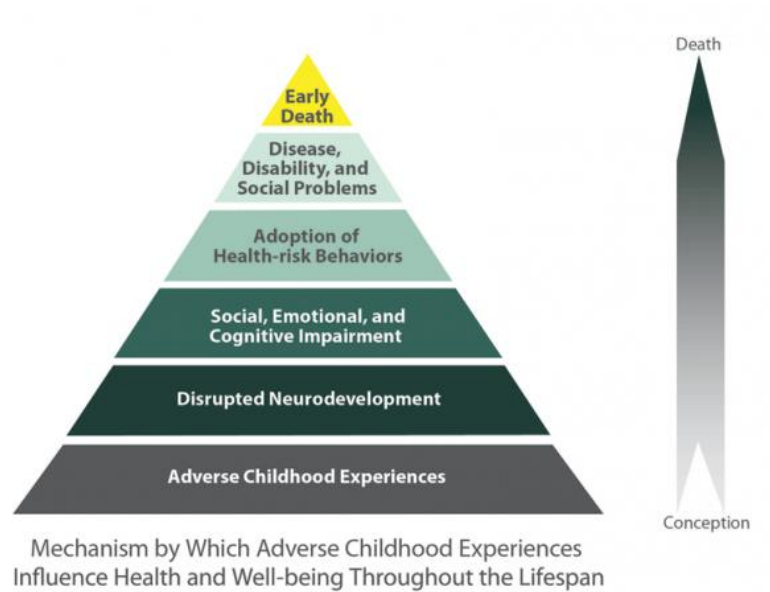


Veterans are at higher risk for several negative behavioral health outcomes – most alarmingly, suicide. Data from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) show that veteran families are also impacted. Statewide, when compared to other demographic groups, Nebraska's Veteran spouses and partners report having more poor mental health days and are more likely to have been told that they have depression.^{lxxvi}

Adverse Childhood Experiences

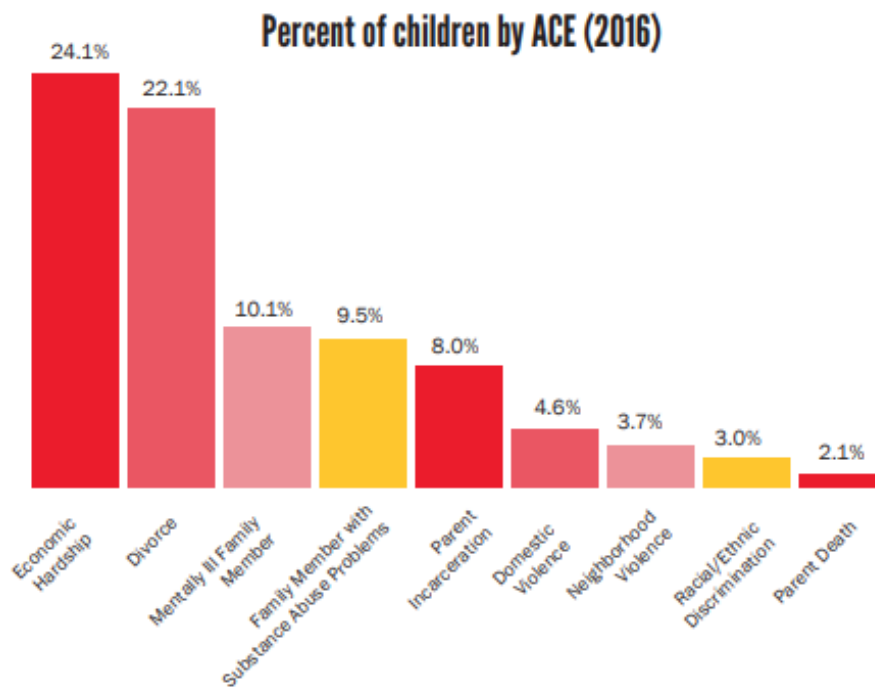
Adverse childhood experiences (ACEs) are one of the most accurate predictors of lifelong health and well-being.^{lxxvii} ACEs are stressful or traumatic events that occur before age 18^{lxxviii} and can include things such as a child experiencing abuse and neglect; family effects of struggling to get by financially; seeing/hearing violence in the home; witnessing and/or being the target of neighborhood violence; living with anyone mentally ill, suicidal, or depressed; living with anyone with alcohol or drug problems; or experiencing parents who are divorced/separated or serving jail time.^{lxxix} The landmark Kaiser ACE study showed dramatic links between ACEs and the leading causes of death, risky behaviors, mental health and serious illness.^{lxxx} Figure 45 demonstrates the ACE Pyramid, used as the conceptual framework for the Kaiser Study.^{lxxx}

Figure 45. Adverse Childhood Experiences Pyramid



The last time Nebraska implemented the ACEs module of the BRFSS was in 2010 and 2011. At that time, roughly 30% of children experienced one to two ACEs. Around 10% of children experienced three to four ACEs and about 5% experienced 5+ ACEs^{lxxxii}. Figure 46 illustrates the percent of children by ACE category in Nebraska.^{lxxxiii}

Figure 46. Percent of children by ACE category in Nebraska



Resilience is the ability to adapt to stressful or traumatic events, such as ACEs. Resilience is not a genetic factor but more of a learned behavior. Resilience can be cultivated in anyone.^{lxxxiv} Children who experience protective family routines and habits, such as limited screen time, no TV/screen time in bedrooms, parents who have met all or most of the child’s friends, and parents who participate in a child’s extracurricular activities^{lxxxv}, are less likely to experience ACEs.^{lxxxvi} Community-based strategies to provide safe, stable, nurturing relationships and environments to increase resilience and to reduce ACEs can include:

Program based^{lxxxvii}:

- Home visiting programs for pregnant women and families with newborns
- Parenting training programs
- Intimate partner violence prevention programs
- Social support for parents
- Teen pregnancy prevention and parent support programs for teens
- Treatment for mental illness and substance abuse
- High quality, affordable childcare
- Sufficient income support for low-income families

System/Policy based^{lxxxviii}:

- Increase awareness of ACEs and their impact on health within both the professional and public spaces
- Increase capacity of health care providers to assess for the presence of ACEs and appropriate response
- Enhance capacity of communities to prevent and respond to ACEs through investment in evidence-based prevention programming, trauma interventions, and increased access to needed mental health and substance abuse services
- Increased funding for ACE-specific surveys in order to increase their utility and scope

Substance Use Disorders

Like mental health, substance use disorders are among the top causes of disability in the US and can make daily activities hard to accomplish.^{lxxxix} Furthermore, substance use and addiction can advance the development of mental illness due to the effects of substances in changing the brain in ways that make a person more likely to develop a mental illness. Likewise, mental illness can lead to drug use and substance use disorders.^{xc}

Alcohol Use

Alcohol is the third-leading preventable cause of death in the US following tobacco and nutrition/physical activity. In 2019, 1 in 5 Nebraska adults binge drank or drank heavily (21.9%), a stark difference when compared to Utah (12%)—the state with the lowest prevalence of binge/heavy drinking. Excessive alcohol consumption, in either the form of binge drinking (more than 4 drinks on one occasion for men or more than 3 drinks on one occasion for women) or heavy drinking (drinking more than 14 drinks per week for men or more than 7 drinks per week for women), is associated with an increased risk of many health problems, including short-term risks that can increase the chances for accidents/unintentional injuries, violence, alcohol poisoning, and long-term risks that can increase the

chances for heart disease, stroke, liver disease, cancers, alcohol dependence, and more.^{xcii} The Nebraska BRFSS survey in 2019 indicated 17% of adults in the CDHD region reported binge drinking in the past 30 days, and nearly 5% of adults in the CDHD region reported heavy drinking in the past 30 days, both of which were similar to the US averages (17% and 6% respectively).

Figure 47. Alcohol Use, CDHD District, State and Nation

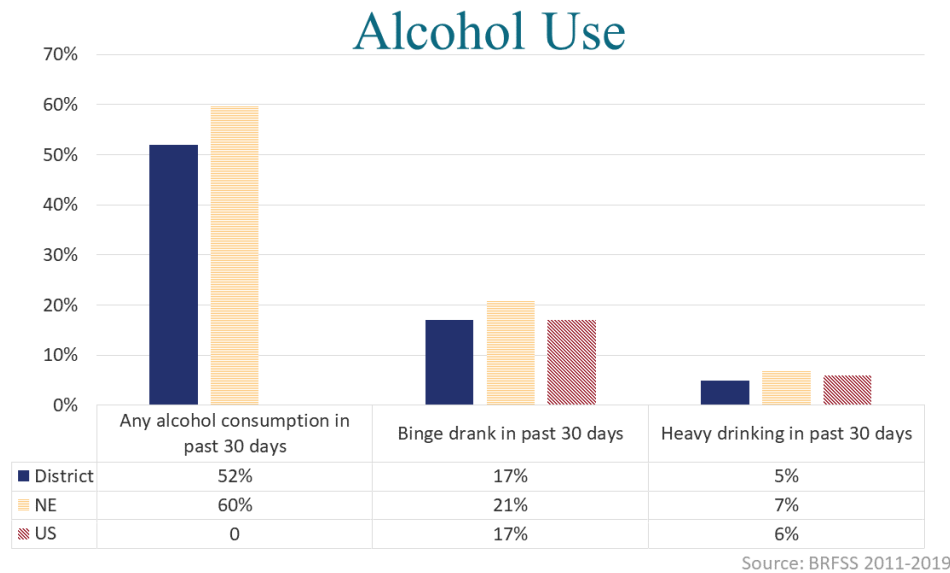
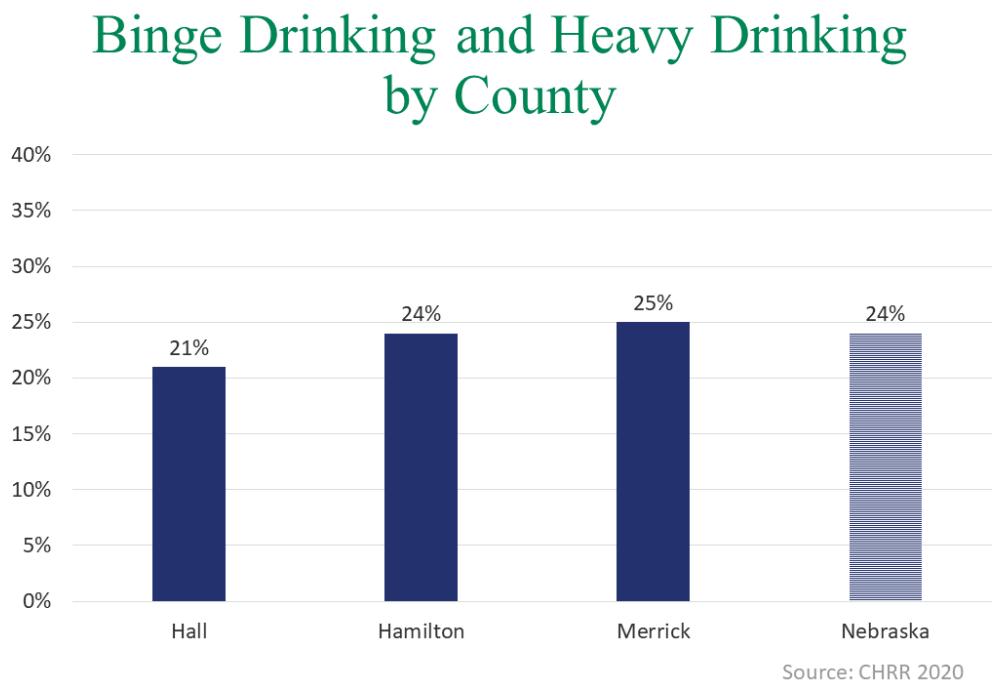


Figure 48. Binge and Heavy Drinking, by County in CDHD District



In general, excessive drinking is higher among men than women, younger adults (ages 18-44) compared to older adults (ages 45+), adults who graduated from high school compared to those who did not, and

among adults with higher income levels (>\$75K). In addition, Hawaiian/Pacific Islander, Hispanic, and white adults have a higher prevalence of excessive drinking that Asian and black adults.

Maternal and Child Health

Infant mortality (death of an infant before his/her first birthday) is an indicator of maternal and child health within a community. More importantly, this indicator is a marker of overall health of a community due to the associations between the causes of infant death and other factors that are likely to influence health—such as social and economic factors, general living conditions and other quality of life factors.^{xcii} The infant mortality rate (the number of infant deaths per 1,000 live births in the same year) in the US was 5.7 in 2018.^{xciii}

Nebraska fairs a little bit better than the US with an infant mortality rate of 6.^{xciv} Figure 49 illustrates the stark differences between counties across the CDHD district regarding infant mortality.^{xcv} Hall and Hamilton counties’ infant mortality rates were higher than the state rate and nearly 1.5 times higher than Merrick County.

Figure 49. Infant Mortality Rate, CDHD District

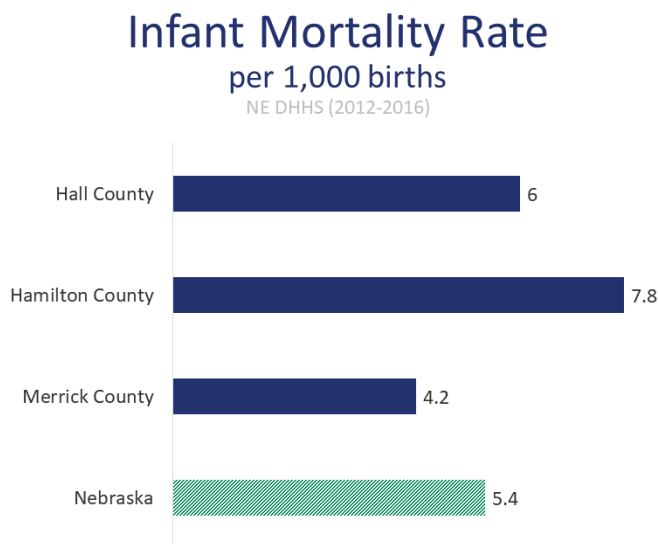


Table 15 provides an overview of the birth statistics and other maternal and child health indicators. Notably, the overall birth rate (15.7/1,000) and teen birth rate (38/1,000) in Hall County was higher than other counties in the CDHD district and state rate.

Table 15. Maternal and Child Health Indicators, CDHD District

Maternal and Child Health Indicators	Hall	Hamilton	Merrick	CDHD District	NE
Birth rate ^{xcvi}	15.7	12.8	12.5	13.7	13.9
Teen birth rate ^{xcvii}	38	9	20	22	25
Low birthweight ^{xcviii}	7%	5%	6%	6%	7%

Healthcare Access and Utilization

Healthcare Insurance Coverage

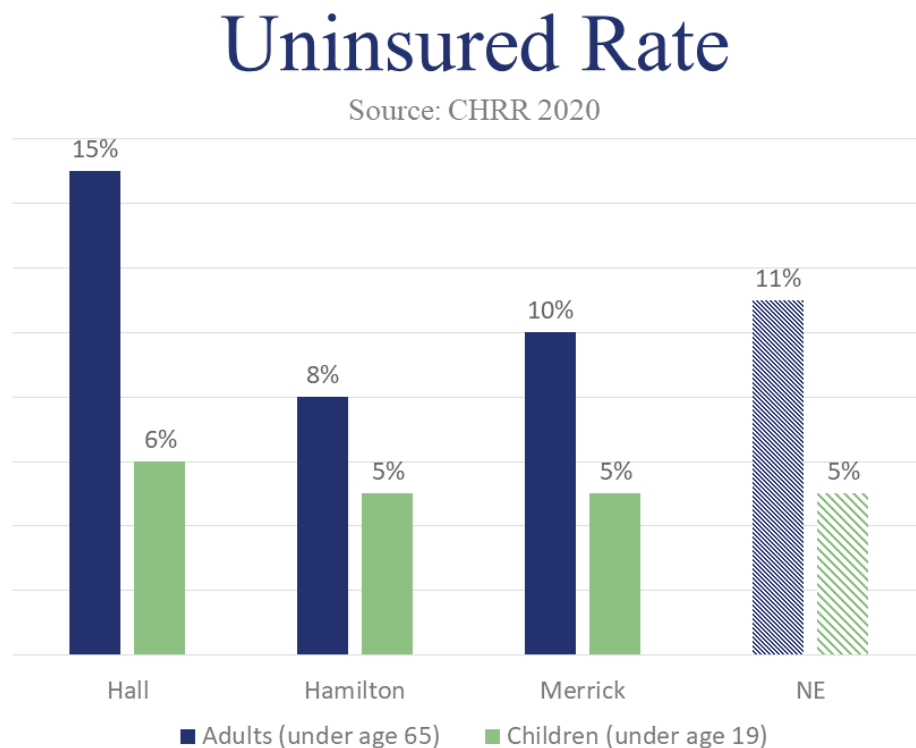
According to the Nebraska BRFSS (see Table 16), one in five adults aged 18-64 in the CDHD district did not have health care coverage.

Table 16. Health Care Access Indicators, CDHD District

Health Care Access Indicators ^{xcix} (BRFSS, 2011-2019)	NE	CDHD Region		
		Overall	Male	Female
No health care coverage, 18-64-year olds	16%	20%	21%	19%

To provide a county snapshot for uninsured among the population under the age of 65, the latest County Health Rankings (see Figure 50) reported that more adults under the age of 65 (15%) and under age 19 (6%) in Hall County were uninsured than the state average (11% and 5%, respectively).

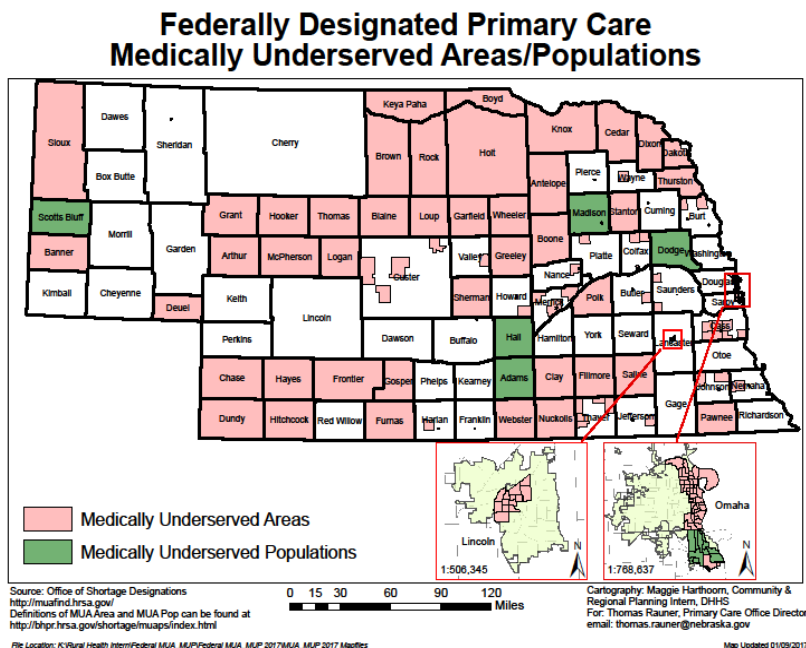
Figure 50. Uninsured Rates, CDHD District



While lack of health insurance, cost of health care services, and age of clientele may be contributing factors of not accessing health care, health professional shortages can compound the issue. About 3 of 4 adults in CDHD district had a personal doctor or healthcare provider.^c According to the Health Resources and Services Administration (HRSA), some areas within CDHD were designated as Medically Underserved Areas (MUA). MUAs are “counties, a group of counties or civil divisions, or a group of

urban census tracts in which residents have a shortage of personal health services.” The following map (Figure 51) illustrates the federal health professional shortage area for primary care across the state in 2018.

Figure 51. Primary Care, Federally Designated Medically Underserved Areas/Populations

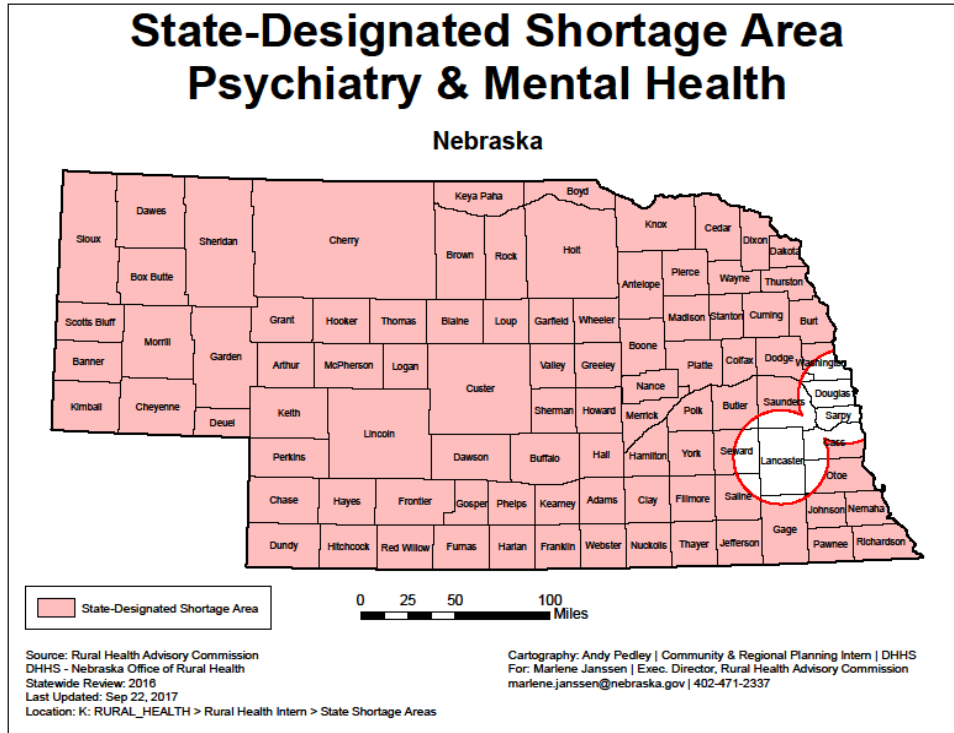


Notably, all of Hall County and parts of Merrick County were designated as MUA/MUPs for primary care. To help ease this provider shortage problem, Physician’s Assistants (PA-Cs) and Nurse Practitioners (APRNs) were utilized in many primary care clinics in the CDHD region, and the Northern Nebraska Area Health Education Center (AHEC) worked with healthcare agencies to place students on training paths to be healthcare providers.

Generally, emergency rooms and primary care offices are the most common place where people with behavioral health needs seek care. Often clinicians in these settings do not have the resources and/or training to appropriately respond to behavioral health needs. Overall, 66% of primary care providers report that they are unable to respond to people with behavioral health needs due to a shortage of mental health providers and to insurance barriers.^{ci}

Most counties in the state are designated as mental health professional shortage areas (see Figure 52). In the Central District Health Department district, there were an average of 1,731 people for every one mental health provider (range: 280:1 to 3,878:1), and nearly four times as many people to mental health provider as the state average (362:1).^{cii} According to the 2016 Nebraska Behavioral Health Needs Assessment, only 47% of adults in Nebraska with any mental illness received treatment. Additionally, only 43% of youth in Nebraska with depression received treatment. Furthermore, 11% of persons aged 12 or older in Nebraska with illicit drug dependence or abuse received treatment. In addition to CDHD’s known mental health professional shortage area designation, access to behavioral health care may be further complicated by other barriers, including lack of insurance coverage and stigma often associated with mental illness.^{ciii}

Figure 52. Mental Health Care, State-Designated Shortage Areas



In other health professional care, including dentistry and pharmacy, counties within CDHD were designated as shortage areas. Figures 53, 54, and Table 17 illustrate these shortages.

Figure 53. Dentistry, State-Designated Shortage Areas

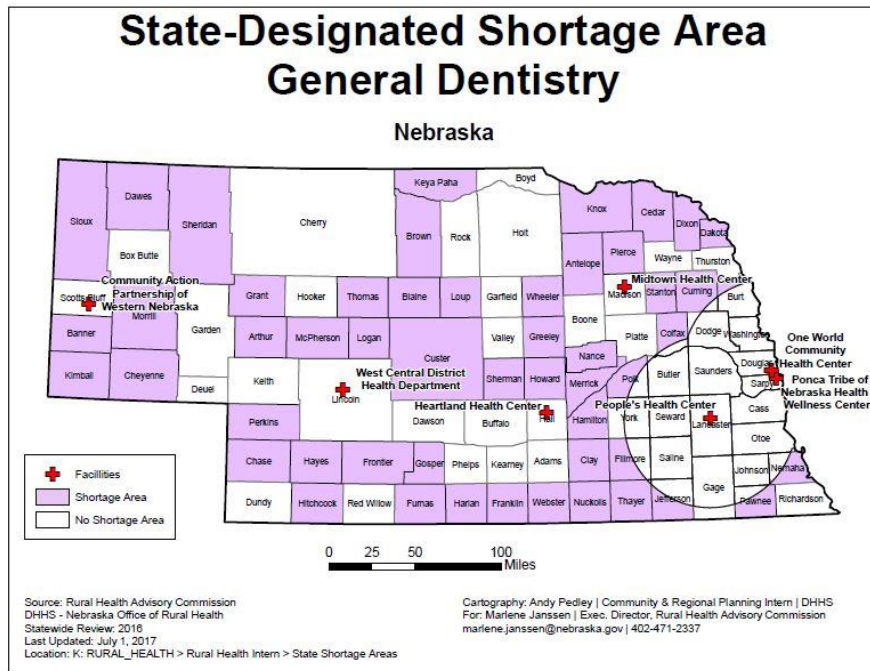
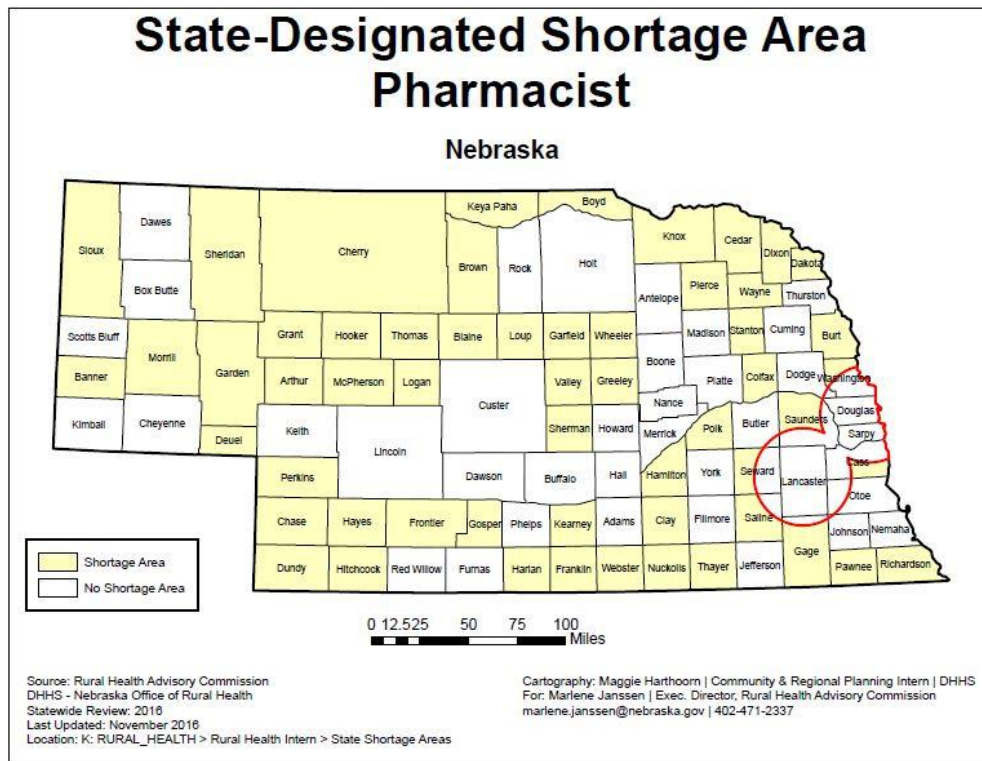


Figure 54. Pharmacist, State-Designated Shortage Areas



Stark disparities exist between counties when looking at population per provider type in the CDHD area. Merrick County has a significantly higher population per provider ratio for mental health (3,878:1) and primary care providers (3,867:1) than the state (362:1 and 1,330:1, respectively) as shown in Table 17.

Table 17. Ratio of Population per Type of Provider, CDHD District

Ratio of Population : Type of Provider (2020)

	NE	Hall	Hamilton	Merrick
Primary care physicians	1330:1	1621:1	1160:1	3867:1
Dentists	1272:1	1180:1	1865:1	1939:1
Mental health providers	362:1	280:1	1036:1	3878:1

Source: CHRR 2020

Although Hall County has a lower provider per population ratio among dental and mental health services compared to the state and other counties within CDHD, comments from respondents to the resource

inventory survey (n=15 partners in the CDHD area) included: Medicaid is not accepted at all dentist providers or specialty care providers; under/uninsured patients lack access to quality and routine care; patients not established with a mental health provider are offered only telehealth appointments with long waitlists for in person appointments and for those residents in the CDHD area with severe mental health problems lack the appropriate access to care; more substance abuse services are needed. Furthermore, bilingual/interpretation services offered among these providers may need enhanced to effectively serve and reach the growing minority population in this area.

Health Care and Prevention Assets

In the CDHD district, health care providers and services include four hospitals, namely CHI Health Saint Francis, Grand Island Regional Medical Center in Hall County, Memorial Community Health Inc. in Hamilton County, and Merrick Medical Center-Bryan Health in Merrick County. The area also has one Federally Qualified Health Center (FQHC; Heartland Health Center in Hall County). There are several medical clinics providing primary care and prevention services. Medical clinics in the CDHD district operate during traditional business hours (from 8:00am to 5:00pm, Monday through Friday, and Saturday mornings). Providers offering specialty services travel to these medical clinics from outside of the CDHD district and hold office hours from weekly to once monthly at select medical clinics/hospitals. Additionally, CDHD district has is home to several dental clinics as well as Heartland Health Center's dental clinic. Dental clinics are present in each county. Professional and Volunteer Emergency Medical Services are located throughout each county.

Access for Aging Populations:

Multiple assisted living and long-term care facilities are available in the CDHD district offering around the clock assistance and/or nursing care for residents. Home-health services are available in the CDHD district. Senior Centers are active in each county. The area is served by Midlands Area on Aging.

Central District Health Department offers several preventative programs s including Every Woman Matters, Diabetes Prevention Program and Living Well with Diabetes.

The Social Services for Aged and Disabled Adult Program (SSAD) provides services to individuals who are aged, blind, or disabled and need assistance in remaining as independent as possible. Eligibility is based on the client's income as well as their need for the requested service. The SSAD program provides services to clients who do not qualify for Medicaid or are ineligible to receive assistance from other programs. Services provided include: Chore services, Adult day care, Home delivered meals, Congregate meals, Homemaker services, and Transportation.

Access for Veteran Populations:

Multiple agencies in the CDHD district offer services for Veterans and their families. The Grand Island VA Medical Center provides inpatient, outpatient, and home visitation services. VA services also include a Community Living Center. The Community Living Center is a 65-bed facility providing extended care, rehabilitation, geriatric care, palliative care, respite care, supportive/restorative and long-term care, and general nursing home care. Each county has a Veterans Services Officer. Other support services for Veterans and their families are offered by agencies such as the Central Nebraska Community Action Partnership, local churches, local Veterans of Foreign Wars (VFW) posts, American Legions, County Veteran Service Officers and the Department of Labor.

Central District Health Department staff and partners have been trained in the No Wrong Door training, a day-long deep dive into military culture and life where participants learn about military experiences and how they influence emotions and behaviors by hearing from Veterans, their families, and experts in the field.

Preventative Screenings

Nearly 40% of adults in the CDHD district did not receive a routine checkup in the past year.

Table 18. Preventative Health Screening Indicators, CDHD District

Preventative Health Screening Indicators ^{civ} (BRFSS, 2011-2019)	NE	CDHD Region		
		Overall	Male	Female
Preventative Screenings				
Heart Disease				
Had cholesterol checked in past 5 years	84%	86%	85%	87%
Cancer				
Up to date on colon cancer screening, 50-75-year olds	65%	63%	61%	65%
Up to date on breast cancer screening, overall female 50-74-year olds	75%			74%
Up to date on cervical cancer screening, female 21-65-year olds	81%			82%
Routine Checkups				
Had a routine checkup in past year	65%	62%	56%	68%

The rate of adult population in the recommended age groups across the CDHD district who received appropriate preventative screenings such as breast, cervical and colon cancer screenings was similar to the state rate. While the majority of adults in the recommended age groups across the CDHD district received appropriate preventative screenings, the trend over a seven-year period was downward. Breast cancer was the second leading cause of death by type of cancer in the CDHD district, yet only 74% of CDHD area adults aged 50-75 years of age received this particular screening. Of particular note, about half of women ages 65-74, Medicare enrollees, are up-to-date on breast cancer screening. Breast cancer screening is a covered preventative measure by Medicare. About two-thirds of adults in CDHD area were up-to-date on their recommended colon cancer screening, and about 80% of women were up-to-date on recommended cervical cancer screenings.

Figure 55. Colon Cancer Screening Rates, CDHD District

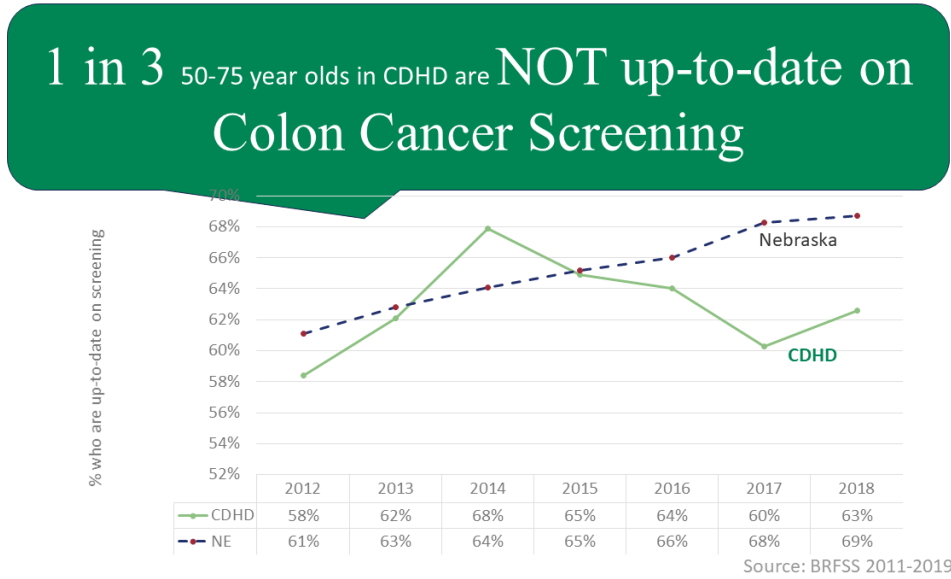


Figure 56. Breast Cancer Screening Rates adult population ages 50-75, CDHD District

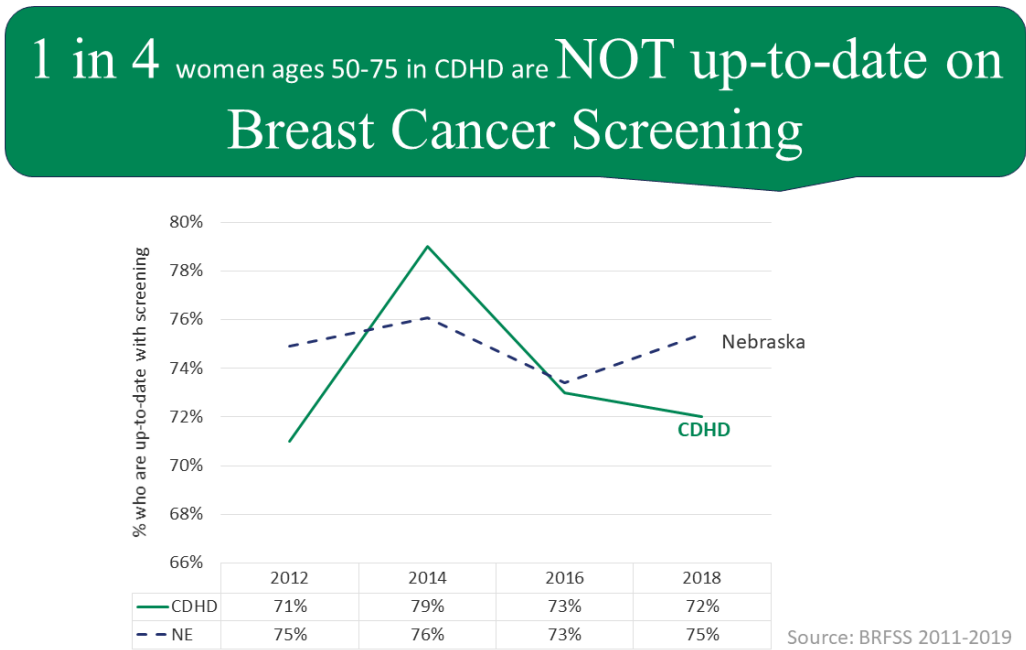


Figure 57. Breast Cancer Screening Rates among Medicare population ages 65-74, CDHD District

1 in 2 women ages 65-74 in CDHD are **NOT** up-to-date on Breast Cancer Screening

Source: CHRR 2020

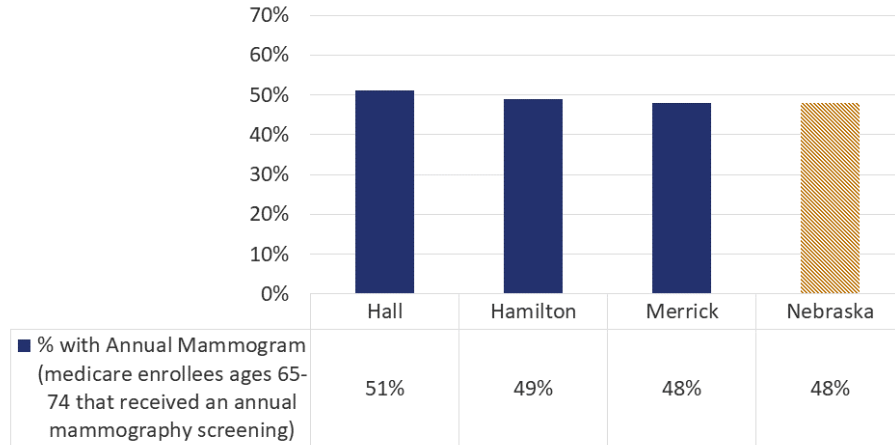
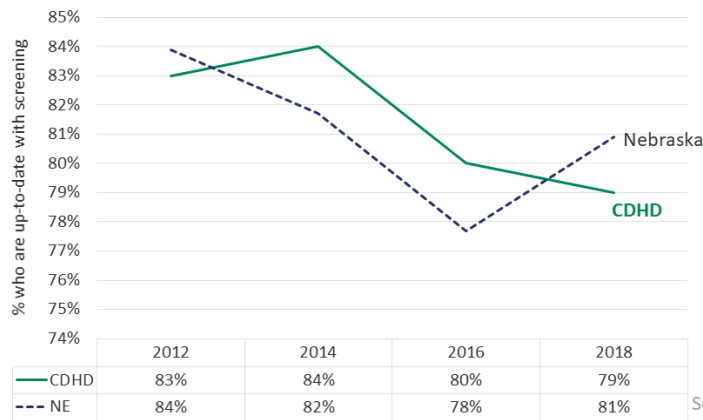


Figure 58. Cervical Cancer Screening Rates, CDHD District

1 in 5 women aged 21-65 in CDHD are **NOT** up-to-date on Cervical Cancer Screening



Source: BRFS 2011-2019

Barriers to Accessing Health Care

Accessing health care is complicated by multiple factors, such as the ability to travel to care locations, location and number of healthcare providers, types and costs of services offered, insurance coverage, etc. Cost of healthcare services can be a barrier to care for CDHD residents. Surpassing the state rate, about 1.5 in 10 adults aged 18-64 needed to see a doctor but could not due to cost within the past year, and 1 in 5 adults aged 18-64 had no health care coverage.^{cv} Though data are not available for CDHD by race/ethnicity, Hispanics had the highest uninsured rates of any racial or ethnic group across the state (57.7%)^{cvi} and nation.^{cvi} In the US, Medicare provides universal health coverage to adults 65 and older; however, cost-sharing and premium contributions continue to be a serious burden for many.^{cvi}

Table 19. Access to Care Indicators, CDHD District

Access to Care Indicators ^{cix} (BRFSS, 2011-2019)	CDHD Region	NE
Needed to see a doctor but could NOT due to cost in past year	14%	12%
No personal doctor or health care provider	22%	20%
No health care coverage, 18-64-year olds	20%	16%

Healthcare professional shortages is another barrier to care for CDHD residents. Nearly 1 in 5 adults in the CDHD district report not having a personal doctor or health care provider. Furthermore, across the state, nearly 1 in 2 Hispanics and 65% of Native Americans reported not having a personal doctor or health care provider.^{cx}

As affirmation to the above barriers contributing to inability to access health care, respondents to the CDHD Community Survey identified access to affordable and quality healthcare as a major health-related worry and as a way to make neighborhoods healthier.

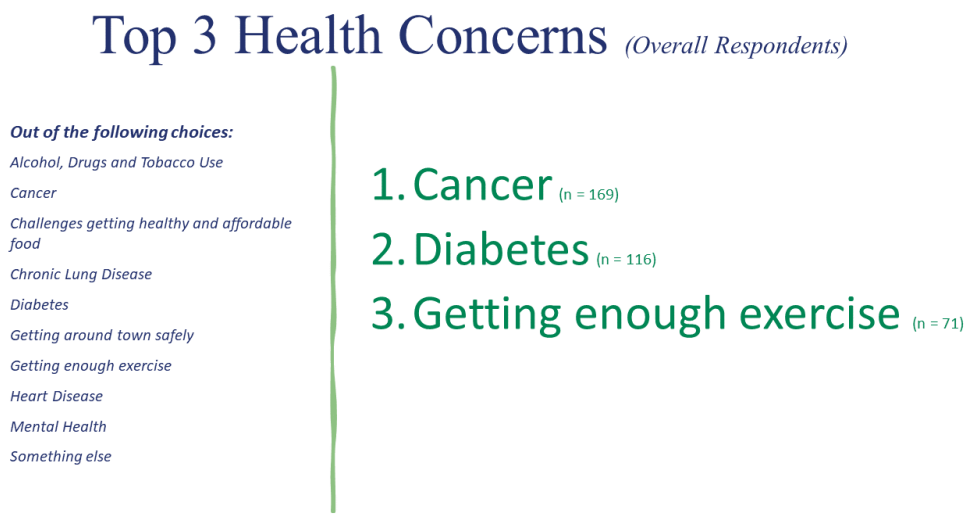
Community Themes and Strengths

Central District Health Department launched a 5-question survey, developed by the Nebraska Association of Local Health Directors (NALHD), to learn more about the impact of COVID-19 on communities in the CDHD area and to assess community health related to things people do to be healthy, top health concerns, and major health issues. This open-ended survey design, intended to allow respondents to tell LHDs their experience related to their health and the health of their community, provides insight into to emerging issues in the community. The survey was made available in English, Spanish, Somali, and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey while waiting for appointments.

There were 665 responses (see Appendix C for full details on the demographics of survey respondents and summary of responses), of which most survey respondents self-identified as non-Hispanic, White women between ages 30-64. While not representative of the population of the region, as a whole, many of the survey responses are consistent with other data collected as part of this Community Health Assessment. Survey findings are also consistent with anecdotal input from key stakeholders (from the

priority setting meetings) who are connected to many of the diverse community groups not directly represented in survey responses. The survey revealed the following:

Figure 59. Top 3 Health Concerns, Community Survey Respondents



(Source: Community Health Survey—CDHD area)

When looking at the survey data by ethnicity and race, Hispanic and non-White respondents listed the same top two concerns as in Figure 59; however, the third concern was challenges getting healthy and affordable food. Even given the low response to the resource inventory survey, partners identified the need to increase the availability of bilingual/interpretation for services and programs to ultimately enhance and improve the health of all residents within the CDHD area.

Health Summary: CDHD District

The majority of the adult population within the CDHD district reported their general health was good or better in the BRFSS between 2011-2019. However, nearly 1 in 10 people within the CDHD district indicated they experienced frequent mental distress. Table 20 summarizes the general health of the adult population within the CDHD district.

Table 20. General Health Indicators, CDHD District

General Health Indicators ^{cx1}	CDHD District	NE
General health fair or poor	17%	14%
Average number of days physical health was not good in past 30 days	3.3	3.1
Physical health was not good on 14 or more of the past 30 days	10%	10%
Average number of days mental health was not good in past 30 days	3.2	3.2
Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	10%	10%

Average days poor physical or mental health limited usual activities in past 30 days	2.0	1.9
Poor physical or mental health limited usual activities on 14 or more of the past 30 days	6%	6%

Similar to the state, the CDHD district experienced shortages in primary care, dental, and mental health professionals, further reducing access to needed health services. The Years of Potential Life Lost (YPLL), a measurement of preventable deaths, in the CDHD district surpassed the state rate. More specifically, Hall and Merrick counties' YPLL rate was higher than the state rate. Multiple factors impact how well and how long we live. Things like education, availability of jobs, access to healthy foods, social connectedness, and housing conditions all impact our health outcomes. Conditions in which we live, work, and play have an enormous impact on our health, long before we ever see a doctor. It is imperative to build a culture of health where getting healthy, staying healthy, and making sure our kids grow up healthy are top priorities.

Appendices

Appendix A: List of Tables

Table 1. Health Literacy Indicators, CDHD District.....	9
Table 2. Veteran Status, CDHD District.....	9
Table 3. Social Vulnerability Index, CDHD District.....	12
Table 4. Public School District Profile--Hall County.....	19
Table 5. Public School District Profile--Hamilton County.....	20
Table 6. Public School District Profile--Merrick County.....	21
Table 7. Economic Indicators, CDHD District.....	22
Table 8. Education Indicators, CDHD District.....	25
Table 9. Leading Causes of Death, Nebraska & US.....	26
Table 10. Overweight/Obesity Rates, CDHD District.....	29
Table 11. Heart Disease Indicators, CDHD District.....	34
Table 12. Leading causes of injury, Nebraska.....	40
Table 13. Mental Health problem indicators in CDHD District.....	43
Table 14. Mental Health problem indicators in CDHD District by County.....	43
Table 15. Maternal and Child Health Indicators, CDHD District.....	49
Table 16. Health Care Access Indicators, CDHD District.....	50
Table 17. Ratio of Population per Type of Provider, CDHD District.....	53
Table 18. Preventative Health Screening Indicators, CDHD District.....	55
Table 19. Access to Care Indicators, CDHD District.....	58
Table 20. General Health Indicators, CDHD District.....	59

Appendix B: List of Figures

Figure 1. County Health Rankings and Roadmaps Framework.....	5
Figure 2. Disability types among adults in Nebraska	10
Figure 3. Disability and Health Disparities among adults in Nebraska	10
Figure 4. Overall Population Trend, CDHD (1970-2019)	12
Figure 5. Net migration over time, Nebraska (1920-2019).....	13
Figure 6. Persons of color by age group, Nebraska (1990-2019).....	13
Figure 7. Hispanic/Latino % population change, by county in CDHD	14
Figure 8. Hispanic Origin, CDHD District	15
Figure 9. Races by County, CDHD District	15
Figure 10. Age Distribution, Hall County.....	16
Figure 11. Age Distribution, Hamilton County	16
Figure 12. Age Distribution, Merrick County	17
Figure 13. Percent Population Aged 65+, CDHD District	17
Figure 14. Map of CDHD Public School Districts	18
Figure 15. Median Household Income, CDHD District.....	22
Figure 16. Poverty, CDHD District	23
Figure 17. Children in Single-Parent Households, CDHD District.....	23
Figure 18. Average Residential Value, CDHD District.....	24
Figure 19. Percentage of Homes Occupied by Owner, CDHD District	24
Figure 20. Percentage of Households with Severe Housing Problems, CDHD District	24
Figure 21. Education Levels, CDHD District.....	26
Figure 22. Leading Causes of Death, CDHD District	27
Figure 23. Years of Potential Life Lost (YPLL), CDHD District	28
Figure 24. Obesity Rates, CDHD District	29
Figure 25. Nutrition Behaviors, CDHD District	30
Figure 26. Physical Activity—No Leisure-Time, CDHD District.....	31
Figure 27. Physical Activity—At Least Some Leisure-Time, CDHD District	31
Figure 28. Physical Activity—Met Recommendations, CDHD District	32
Figure 29. Diabetes rates—by county, CDHD District.....	33
Figure 30. Diabetes rates—by race and ethnicity, Nebraska.....	34
Figure 31. Cancer Incidence Rates, CDHD District	35
Figure 32. Cancer Mortality Rates--Nebraska Racial/Ethnic Comparison (per 100,000 population)	35
Figure 33. Leading Cancer Death Rates in CDHD (per 100,000 population).....	36
Figure 34. Adult Smoking Rates, CDHD District	37
Figure 35. Adult Smoking Rates by Gender, CDHD District.....	37
Figure 36. E-Cigarette Use Rate-- Youth, Nebraska	38
Figure 37. E-Cigarette Use Rate--Youth, Nebraska	39
Figure 38. Tobacco Use—Other Tobacco Product Use Rate, Nebraska	39
Figure 39. Tobacco and Alcohol Use Rate—Youth, CDHD District.....	40
Figure 40. Injury Death Rate, CDHD District	41
Figure 41. Motor Vehicular Behavior Indicators, CDHD District.....	41
Figure 42. Alcohol-Impaired Driving Death Rate, by County CDHD District	42
Figure 43. Mental Health indicators for Youth, CDHD District	44

Figure 44. Risk level for youth suicide ideation and attempts by county based on the 2016 results from the Nebraska Risk and Protective Factors Surveillance System	45
Figure 45. Adverse Childhood Experiences Pyramid	46
Figure 46. Percent of children by ACE category in Nebraska.....	46
Figure 47. Alcohol Use, CDHD District, State and Nation	48
Figure 48. Binge and Heavy Drinking, by County in CDHD District	48
Figure 49. Infant Mortality Rate, CDHD District.....	49
Figure 50. Uninsured Rates, CDHD District	50
Figure 51. Primary Care, Federally Designated Medically Underserved Areas/Populations.....	51
Figure 52. Mental Health Care, State-Designated Shortage Areas.....	52
Figure 53. Dentistry, State-Designated Shortage Areas	52
Figure 54. Pharmacist, State-Designated Shortage Areas	53
Figure 55. Colon Cancer Screening Rates, CDHD District.....	56
Figure 56. Breast Cancer Screening Rates adult population ages 50-75, CDHD District	56
Figure 57. Breast Cancer Screening Rates among Medicare population ages 65-74, CDHD District	57
Figure 58. Cervical Cancer Screening Rates, CDHD District	57
Figure 59. Top 3 Health Concerns, Community Survey Respondents	59

Appendix C: Demographics of Community Survey Respondents (2021) compared to CDHD Census

		CDHD Overall Population (US Census 2019)	CDHD Survey Respondents (N = 665)	
Gender	Female	50%	71%	470
	Male	50%	27%	178
	No Response	-	2.5%	17
Age	Under 20	27%	3%	20
	20-29	11%	10%	69
	30-39	12%	24%	159
	40-49	11%	21.5%	143
	50-64	21%	27%	178
	65-74	10%	9%	60
	75+	8%	2%	11
	No Response	-	4%	25
Hispanic/Latino	Yes	13%	23%	152
	No	84%	75%	498
	No Response	-	2%	15
Race	American Indian or Alaska Native	1.1%	0.6%	4
	Asian	0.9%	0.5%	3
	Black/African American	1.6%	9%	59
	Native Hawaiian/Pacific Islander	0.3%	0.1%	1
	White	94.3%	76%	505
	Other	1.3%	11%	71
	No response	-	3%	22

Appendix C: Community Survey Responses by Overall, Hispanic and Non-White

Community Survey Summary: Overall respondents

LAST MAJOR HEALTH ISSUE EXPERIENCED (BY SELF OR BY FAMILY)

Community members identified many health issues. Highlights included:

- **COVID-19:** 139 responses including self or family sick from or death from COVID-19
- **Cancer:** 64 responses including self or family diagnosed with or death from Cancer
- **Cardiovascular Disease:** 68 responses including cholesterol, heart, high blood pressure, stroke
- **Surgery:** 60 responses related to knee, heart, back, shoulder, gallbladder, foot, hip and eye
- **Respiratory:** 34 responses related to sinus infection, RSV, bronchitis, pneumonia, flu
- **Diabetes:** 29 responses including self or family diagnosed or at-risk for diabetes
- **Mental Health:** 26 responses including depression, anxiety, and struggles in general and related to COVID-19 and postpartum
- **Suicide:** 4 responses
- **None:** 208 responses
- Other responses include burns, arthritis, osteoporosis, birth, broken/torn ligaments and bones, hip issues, kidney problems and stones, dental work, falls, accidents, stitches

HEALTH-RELATED WORRIES (FOR SELF OR FOR FAMILY)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 146 responses including self or family sick from or death from COVID-19
- **Access to affordable and quality healthcare:** 109 responses including ability to cover costs, available healthcare facilities and staff to take care of loved ones, not having insurance, lack of access to emergency services, availability of health care resources, being able to see the doctor when needed, best care, insurance not covering things, being able to pay the doctor bills and/or pay for medications
- **Cancer:** 62 responses mentioned for either self or family diagnosed or death from Cancer
- **Maintaining healthy life:** 34 responses including staying health, general health, healthy now
- **Mental Health:** 32 responses including suicide, suffering from loss of family members to suicide, stress, depression, anxiety
- **Diabetes:** 28 responses mentioned self or family diagnosed or at risk
- **Aging:** 21 responses including aging in place, caring for aging parents, affordable aging care/long-term care, memory and mobility as we age, aging well
- **Cardiovascular Disease:** 19 responses including cholesterol, heart, high blood pressure
- **None:** 78 responses

HEALTHY PERSONS

Community members identified several actions that make them healthier. Highlights included:

- **Healthy eating:** 138 responses including drink water, eat healthy/healthier, homemade food, watch what I eat, fat-free meals, make fruits and vegetables available at home, track my foods, cook healthy meals at home, diet
- **Active living:** 190 responses including work out, exercise, walk, swim, play soccer with family, job requires a lot of walking/lifting, staying/keep active
- **Clinical Care:** 17 responses including visit doctor, follow doctor's instructions, take vitamins/supplements
- **Non-Pharmaceutical Interventions and vaccination:** 10 responses including clean, hand washing, mask, vaccinated
- **Mental Health:** 27 responses including see a therapist regularly, take care of yourself, worry storage, read more often, church/faith
- **Nothing:** 5 responses

HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

Community members identified several actions that would make their neighborhood healthier.

Highlights included:

- **Active Living:** 72 responses including access to walking paths, better and more sidewalks, more recreation parks, community centers where families can meet for recreational activities, outdoor space, green areas
- **Healthy Eating:** 22 responses including better access to affordable healthier food options for kids and families, healthier restaurants, bigger grocery store, farmer's markets
- **Environmental Health:** 45 responses including less farm chemicals sprayed and in water/food sources, clean communities, city-wide trash pick up, more trees/green space, water quality issues
- **COVID-19:** 45 responses including cleaning, vaccinations, stay healthy and maintain distance from others, everyone wear mask
- **Substance Free:** 13 responses including alcohol, drug and tobacco free, complexes be better at being tobacco free, no drug deals in neighborhoods
- **Safety:** 8 responses including more security, neighborhood watch, protection, police surveillance, mall security
- **Healthcare:** 8 responses including free/affordable healthcare, more community health services
- **Neighborhood/Neighbors:** 8 responses including communicate with neighbors when things like drug deals and molesting minors is happening in the neighborhood, take care of each other, good neighborhood relationships
- **Nothing:** 45 responses

Community Survey Summary: *Hispanic respondents*

LAST MAJOR HEALTH ISSUE EXPERIENCED (BY SELF OR BY FAMILY)

Community members identified many health issues. Highlights included:

- **COVID-19:** 38 responses included respondent or family member sick from or died from COVID-19
- **Diabetes:** 10 responses including diagnosed with diabetes
- **Cardiovascular Disease:** 7 responses including heart problems, heart attack and stroke
- **Cancer:** 4 responses including diagnosed with or death from Cancer
- **None:** 43 responses

HEALTH-RELATED WORRIES (FOR SELF OR FOR FAMILY)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 31 responses including self or family sick from or death from COVID-19
- **Access to affordable and quality healthcare:** 22 responses including proper care after surgery, hard to find a good doctor, impossible to switch to a different doctor in the same clinic, no health insurance, cost of doctors/care and medications
- **Cancer:** 12 responses mentioned for either self or family diagnosed or death from Cancer
- **Maintaining healthy life:** 6 responses including staying healthy
- **Children's Health:** 6 responses including concerned about the health and well-being of their children
- **None:** 78 responses

HEALTHY PERSONS

Community members identified several actions that make them healthier. Highlights included:

- **Healthy eating:** 71 responses including drink water, eat healthy/healthier, homemade food, watch what I eat, fat-free meals, make fruits and vegetables available at home, track my foods, cook healthy meals at home, diet
- **Active living:** 58 responses including work out, exercise, walk, swim, play soccer with family, job requires a lot of walking/lifting, staying/keep active
- **Clinical Care:** 8 responses including visit doctor, follow doctor’s instructions, take vitamins/supplements
- **Non-Pharmaceutical Interventions:** 6 responses including clean, hand washing, mask, vaccinated
- **Mental Health:** 11 responses including protect me, read more often, organized, take care of us, go to church/faith, relaxation techniques, meditation, spend more time with family/kids

HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

Community members identified several actions that would make their neighborhood healthier.

Highlights included:

- **Active Living:** 29 responses. Comments included access to walking paths safe from animals and traffic, more recreation parks, community centers where families can meet for recreational activities and learn crafts, art, having places to go to near by to exercise regularly, have place to exercise, access to bike trails, outdoor space, green areas...for kids to play, better sidewalks...
- **Healthy Eating:** 13 responses. Comments included children and healthy eating, make more homemade food, accessible food market, healthier restaurants, eat healthy, education about healthy eating
- **Environmental Health:** 17 responses. Comments included clean street, less noise, less trash, tree naturalization care, keep the community clean, street pavement creating lagoon, air quality tests (powder coat/welding co) in neighborhood, landlords keep properties maintained and listen to renters when issues arise, less crowded housing
- **COVID-19:** 16 responses. Comments included cleaning, vaccinations, get the shot, stay healthy and maintain distance from others, everyone wear mask
- **Safety:** 7 responses. Comments included more security, neighborhood watch, protection, police surveillance, drug free
- **Access to Healthcare:** 3 responses. Comments included free/affordable healthcare, more community health services
- **Neighborhood/Neighbors:** 3 responses including communicate with neighbors when things like drug deals and molesting minors is happening in the neighborhood, take care of each other, good neighborhood relationships

Community Survey Summary: Non-White respondents

LAST MAJOR HEALTH ISSUE EXPERIENCED (BY SELF OR BY FAMILY)

Community members identified many health issues. Highlights included:

- **COVID-19:** 30 responses including sick from or death from COVID-19
- **Diabetes:** 7 responses including diagnosed or at-risk for diabetes
- **Cardiovascular Disease:** 7 responses including cholesterol, heart, high blood pressure, stroke
- **Brain-related:** 5 responses including migraine, amnesia, cognitive memory loss, seizure
- **Cold/Flu:** 5 responses
- **Cancer:** 3 responses including diagnosed with or death from Cancer
- **None:** 54 responses

HEALTH-RELATED WORRIES (FOR SELF OR FOR FAMILY)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 45 responses including self or family sick from or death from COVID-19

- **Access to affordable and quality healthcare:** 10 responses including being able to afford doctors' visits or bills, unsure of where to go or how to pay for care for chronic conditions or acute issues, not having health coverage or money to pay for healthcare
- **Cancer:** 11 responses mentioned for either self or family diagnosed or death from Cancer
- **None:** 17 responses

HEALTHY PERSONS

Community members identified several actions that make them healthier. Highlights included:

- **Healthy Eating:** 53 responses including eat healthy, good nutrition, eat homemade food, watch my diet, drink water
- **Active Living:** 38 responses including exercise, walk, go to the gym, workout
- **Self-Care:** 14 responses including faith/church, protect me, take multi-vitamins, meditation, listen to music, spend time with family/people, go to park
- **Non-Pharmaceutical Interventions:** 9 responses including wear masks, wash hands

HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

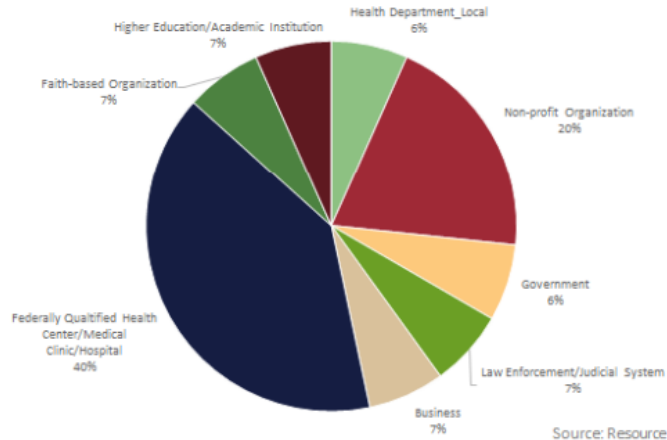
Community members identified several actions that would make their neighborhoods healthier.

Highlights included:

- **Non-Pharmaceutical Interventions and Vaccinations:** 41 responses including wear masks, clean/hygiene, get vaccinated, wash hands
- **Active Living:** 22 responses including more parks/green space for children, practice more sports, fishing, community centers for family fun
- **Environmental Health:** 19 responses including less noise, fix streets where water stands, clean community, air quality
- **Access to Healthcare:** 6 responses including education to know where to go for services, community health services/events, affordable healthcare
- **Substance free:** 5 responses including no drugs or smoking
- **None:** 14 responses

Resource Inventory Survey

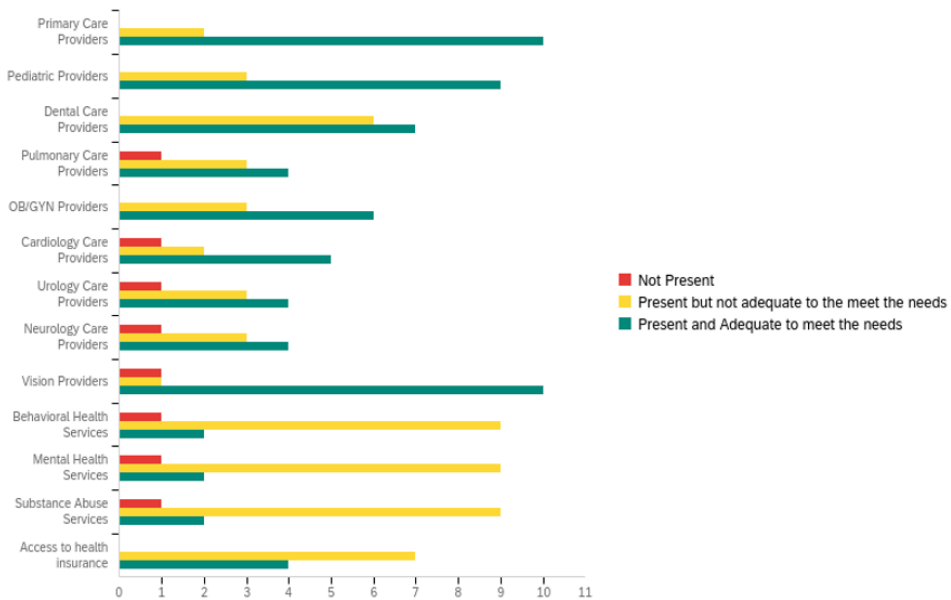
Resource Inventory Survey Respondents by Sector (N = 15)



Source: Resource Inventory Survey—CDHD area

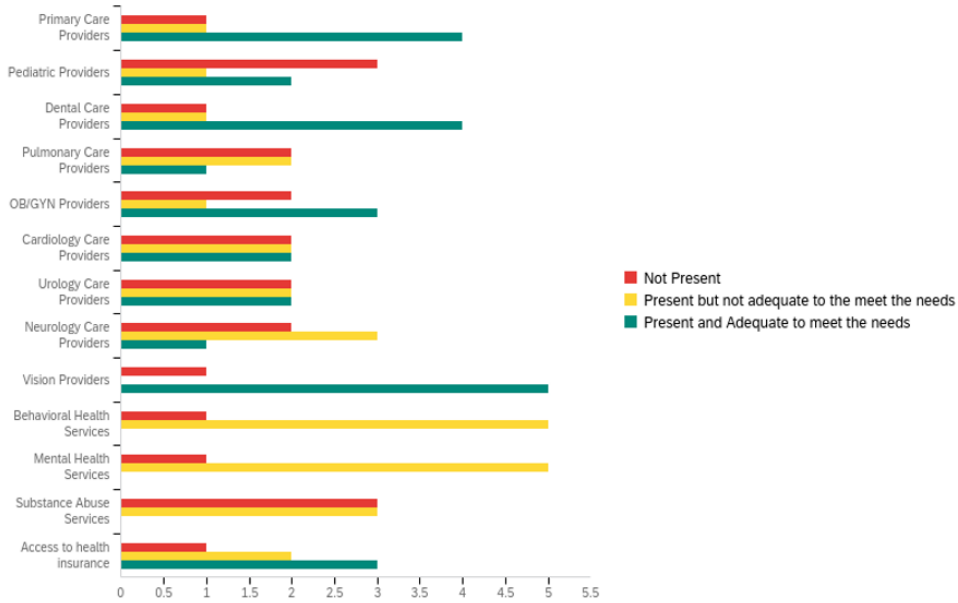
Q3#1 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - Hall County

Availability of medical resource/service in Hall County



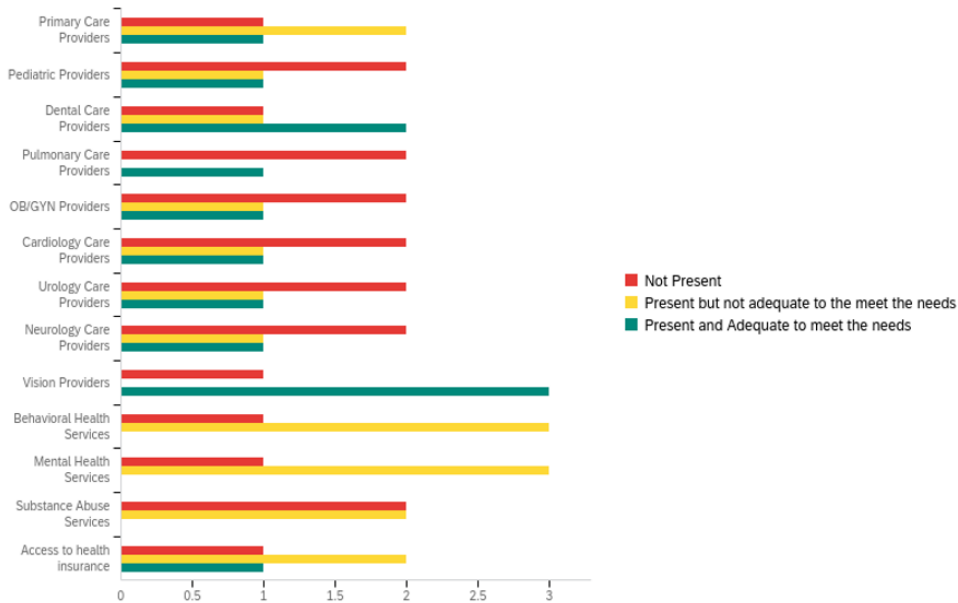
Q3#2 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - Hamilton County

Availability of medical resouces/services in Hamilton County

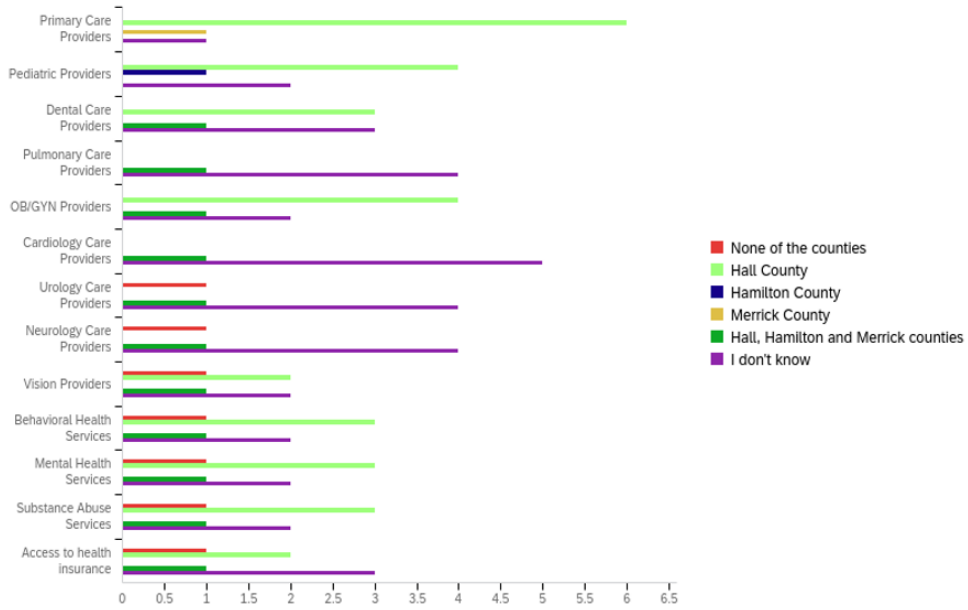


Q3#3 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - Merrick County

Availability of medical resources/services in Merrick County

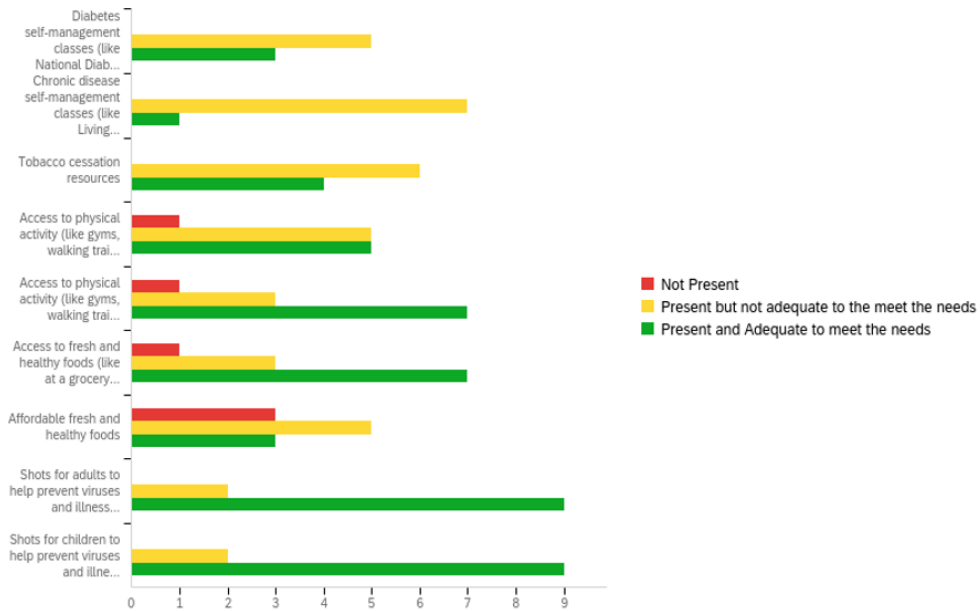


Q3#4 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - In which county is the resource/service available in other lanugages (by way of intrepreation services or bilingual translation)?



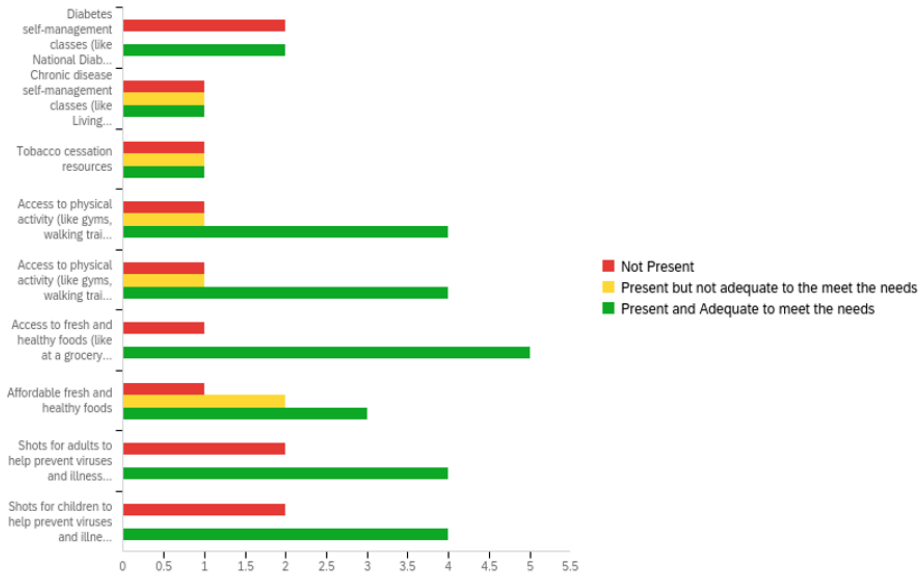
Q21#1 - Below is a list of resources/services to help people prevent and manage personal health risks. Pl... - Hall County

Availability of resources/services in Hall County to help people prevent and manage personal health risks



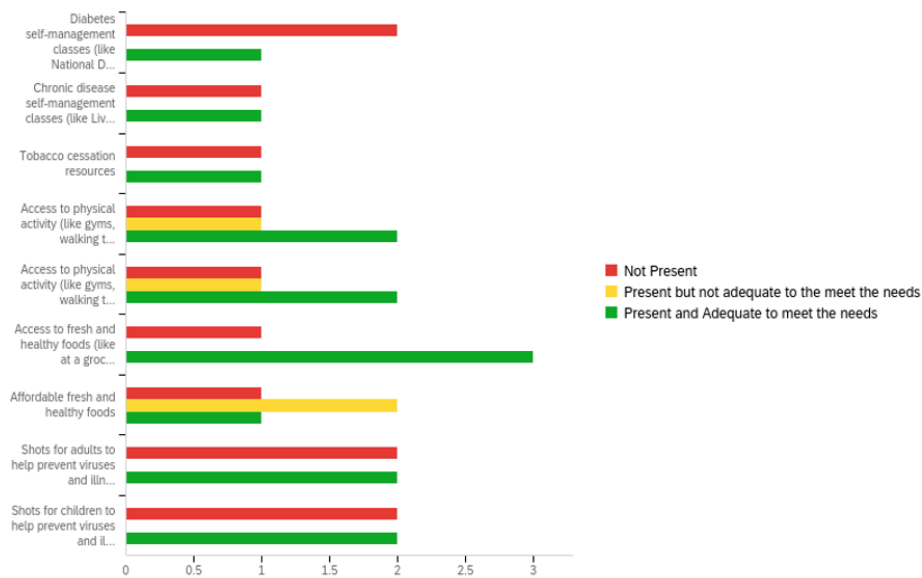
Q21#2 - Below is a list of resources/services to help people prevent and manage personal health risks. Pl... - Hamilton County

Availability of resources/services in Hamilton County to help people prevent and manage personal health risks

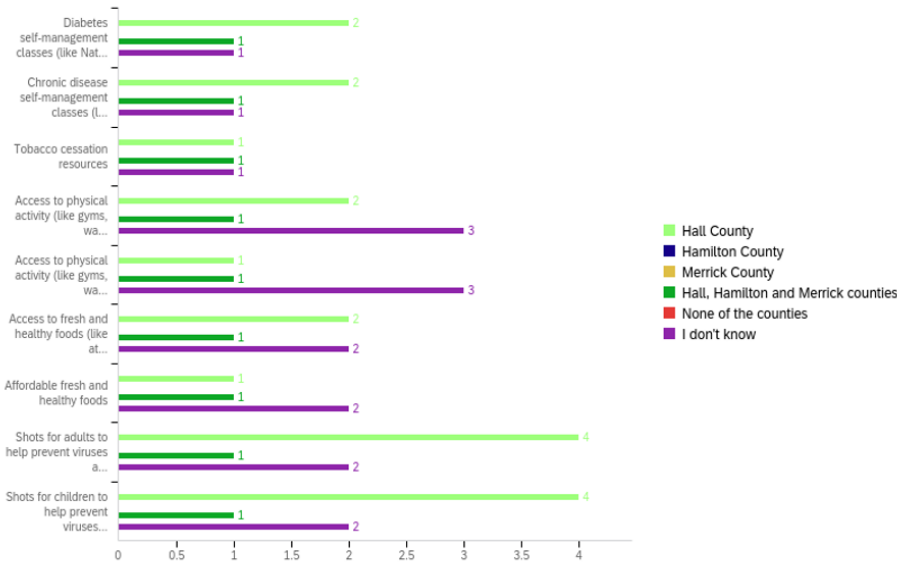


Q21#3 - Below is a list of resources/services to help people prevent and manage personal health risks. Pl... - Merrick County

Availability of resources/services in Merrick County to help people prevent and manage personal health risks

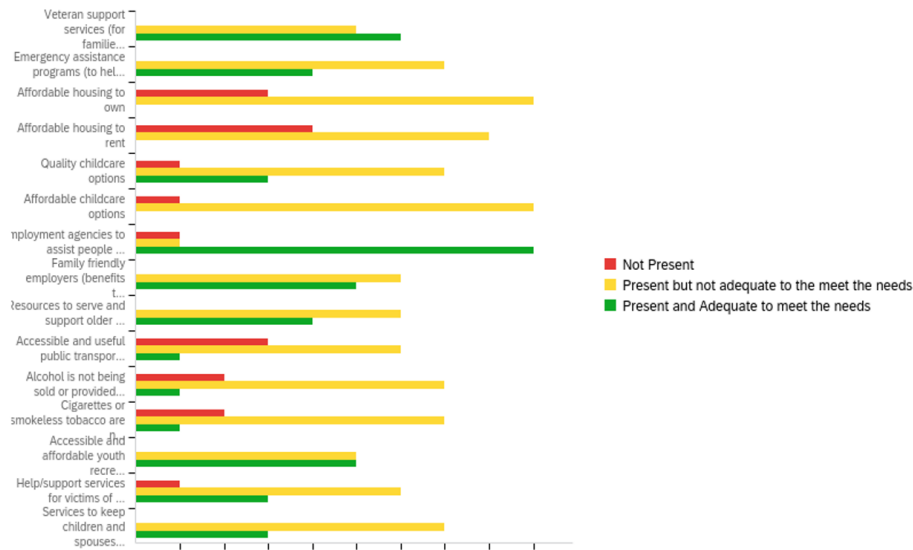


Q21#4 - Below is a list of resources/services to help people prevent and manage personal health risks. In which county is the resource/service available in other languages (by way of interpretation services or bilingual translation)?



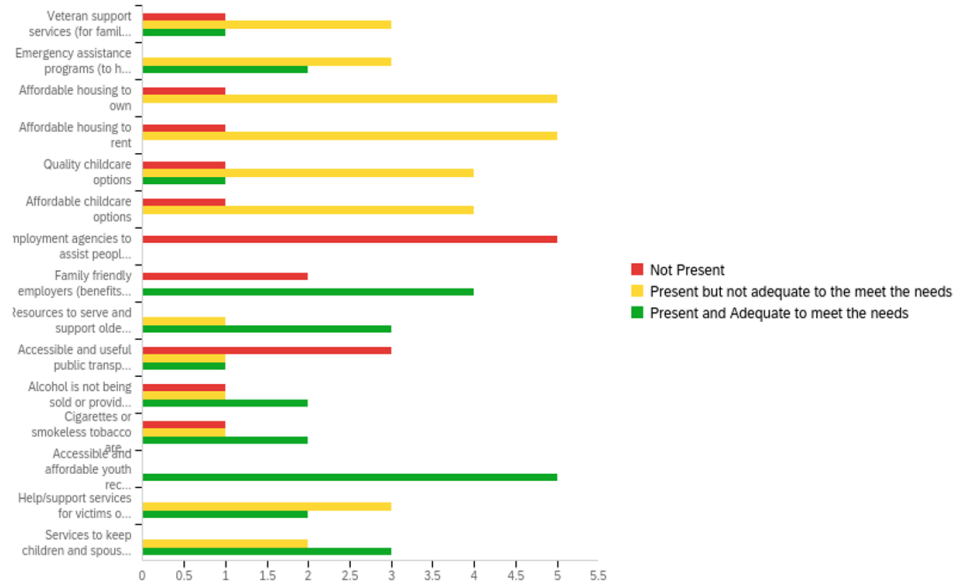
Q22#1 - Below is a list of resources/services that help people thrive within the Central District Health... - Hall County

Availability of resources/services in Hall County that help people thrive within their community



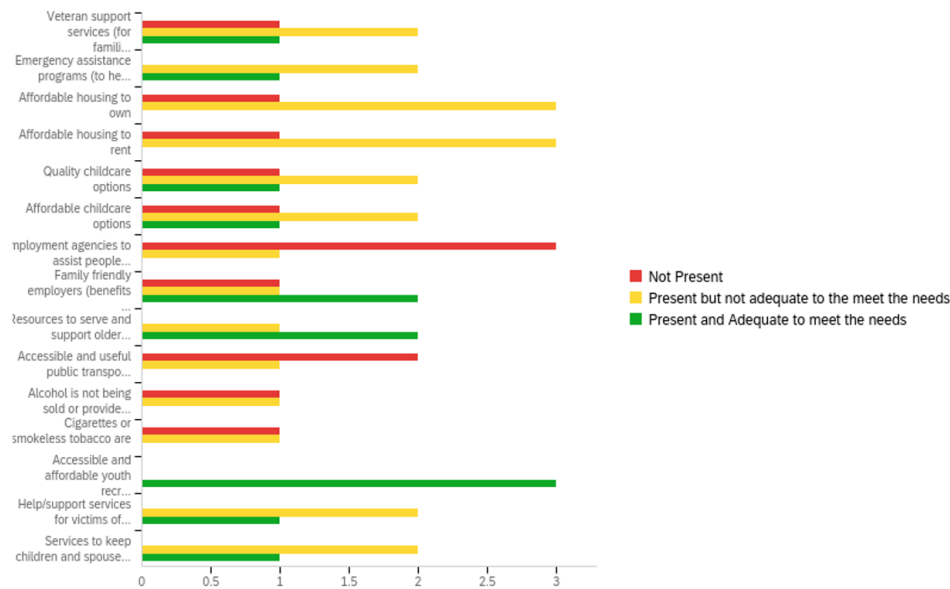
Q22#2 - Below is a list of resources/services that help people thrive within the Central District Health... - Hamilton County

Availability of resources/services in Hamilton County to help people thrive within their community



Q22#3 - Below is a list of resources/services that help people thrive within the Central District Health... - Merrick County

Availability of resources/services in Merrick County to help people thrive within their community



Appendix D: References

- i US Census Bureau, 2015-2019 American Community Survey 5-year estimates
- ii Public Health Foundation. Becoming a Community Chief Health Strategist. Retrieved 10/17/2018 at http://www.phf.org/consulting/Pages/Becoming_the_Community_Chief_Health_Strategist.aspx
- iii US Census Bureau, 2015-2019 American Community Survey 5-year estimates
- iv DataUSA, Hall, Hamilton and Merrick counties retrieved August 2021 from [Data USA](#)
- v US Census Bureau, Quick Facts, 2019
- vi County Health Rankings and Roadmaps, 2020
- vii US DHHS, HRSA, Rural Health Information Hub. 2019. Am I rural tool
- viii Bennett, KJ, Olatosi, B, Probst, JC. 2008. Health Disparities—A Rural-Urban Chartbook. 2008. South Carolina Rural Health Research Center.
- ix Meit, M., Knudson, A., Gilbert, T., Yu, A. T. C., Tanenbaum, E., Ormson, E., & Popat, M. S. (2014). The 2014 update of the rural-urban chartbook. *Rural Health Reform Policy Research Center*.
- x US Dept of Education. National Center for Health Statistics. (2006). The health literacy of America's adults: Results from the 2003 national assessment of adult literacy.
- xi Indian Health Service Health Literacy Workgroup. (2017, July 17). *Indian Health Service: White Paper on Health Literacy*. page 2
- xii USDHHS, Office of Minority Health. Profile: Hispanic/Latino Americans. 2019
- xiii Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- xiv Ross, P. T., Ravindranath, D., Clay, M., & Lypson, M. L. (2015). A Greater Mission: Understanding Military Culture as a Tool for Serving Those Who Have Served. *Journal of graduate medical education*, 7(4), 519–522. doi:10.4300/JGME-D-14-00568.1
- xv US Census Bureau, 2015-2019 American Community Survey 5-year estimates
- xvi CDC, Press Release: 1 in 4 US adults live with a disability, August 16, 2018
- xvii CDC, National Center on Birth Defects and Developmental Disabilities, Disability and Health State Profile Data: Adults 18+ years of age, June 28, 2021 <https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/nebraska.html>
- xviii CDC, National Center on Birth Defects and Developmental Disabilities, Disability and Health State Profile Data: Adults 18+ years of age, June 28, 2021 <https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/nebraska.html>
- xix US Census Bureau, 2015-2019 American Community Survey 5-year estimates
- xx CDC, National Center for Chronic Disease Prevention and Health Promotion, Promoting Health for Older Adults, retrieved from [Promoting Health for Older Adults | CDC](#)
- xxi US Department of Agriculture, Rural Aging Occurs in Different Places for Very Different Reasons retrieved from [Rural Aging Occurs in Different Places for Very Different Reasons | USDA](#)
- xxii CDC, National Center for Chronic Disease Prevention and Health Promotion, Promoting Health for Older Adults, retrieved from [Promoting Health for Older Adults | CDC](#)
- xxiii The Commonwealth Fund, 2017, Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries
- xxiv Nebraska DHHS, 2016, Vital Statistics Report
- xxv University of Nebraska Omaha, Office of Latino/Latin American Studies, “Latinos and the Economic Downturn in Nebraska”, July 2016 <https://www.unomaha.edu/college-of-arts-and-sciences/ollas/files/pdfs/publications-presentations/report-latinos-and-the-economic-downturn-2016.pdf>, page 1
- xxvi County Health Rankings and Roadmaps, 2020
- xxvii Nebraska Department of Education, Nebraska Education Profile, 2018-2019
- xxviii US Census Bureau, Quickfacts, 2019
- xxix County Health Rankings and Roadmaps, 2020
- xxx Nebraska Legislative Research Office, (2018), Nebraska Counties at-a-glance research report
- xxxi Nebraska Department of Education, Nebraska Education Profile, 2018-2019
- xxxii US Census Bureau, Quickfacts, 2019
- xxxiii County Health Rankings and Roadmaps, 2020
- xxxiv Nebraska Legislative Research Office, (2018), Nebraska Counties at-a-glance research report
- xxxv Nebraska Department of Education, Nebraska Education Profile, 2018-2019
- xxxvi US Census Bureau, Quickfacts, 2019
- xxxvii County Health Rankings and Roadmaps, 2020
- xxxviii Nebraska Legislative Research Office, (2018), Nebraska Counties at-a-glance research report
- xxxix County Health Rankings and Roadmaps, 2020
- xl County Health Rankings and Roadmaps, 2020
- xli Nebraska Legislative Research Office, (2018), Nebraska Counties at-a-glance research report

-
- xlii County Health Rankings and Roadmaps, 2020
- xliii County Health Rankings and Roadmaps, 2020
- xliv County Health Rankings and Roadmaps, 2020
- xlv Nebraska Legislative Research Office, (2018), Nebraska Counties at-a-glance research report
- xlvi County Health Rankings and Roadmaps, 2020
- xlvii County Health Rankings and Roadmaps, 2020
- xlviii US Census Bureau, 2015-2019 American Community Survey 5-year estimates
- xlix Nebraska DHHS, 2016, Vital Statistics Report
- ¹ Heron, M. Deaths: Leading Causes for 2016. National Vital Statistics Reports; vol 67 no 6. Hyattsville, MD: National Center for Health Statistics, 2018.
- ⁱⁱ Nebraska DHHS, 2016, Vital Statistics Report
- ⁱⁱⁱ County Health Rankings and Roadmaps, 2020
- ⁱⁱⁱⁱ County Health Rankings and Roadmaps, 2020
- ^{lv} Nebraska DHHS, Chronic Disease Surveillance Report, 2011
- ^{lv} Nebraska DHHS, Injury in Nebraska Report 2009-2013
- ^{lvi} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^{lvii} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^{lviii} Centers for Disease Control and Prevention, Diabetes basics-quick facts, retrieved from: <https://www.cdc.gov/diabetes/basics/quick-facts.html>
- ^{lix} Centers for Disease Control and Prevention, Diabetes and Your Heart, retrieved from: <https://www.cdc.gov/diabetes/library/features/diabetes-and-heart.html>
- ^{lx} Nebraska DHHS, Office of Health Disparities and Health Equity, Heart Disease and Stroke Dashboard
- ^{lxi} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^{lxii} National Cancer Institute, State Cancer Profiles, Mortality by Nebraska County all cancer sites, all races/ethnicity, all ages, all genders from [State Cancer Profiles > Death Rates Table](#)
- ^{lxiii} National Cancer Institute, State Cancer Profiles 2014-2018
- ^{lxiv} American Cancer Society, 2019, What causes non-small cell lung cancer?
- ^{lxv} CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2019, Current cigarette smoking among adults in the United States.
- ^{lxvi} Truth Initiative, 2020, Tobacco use in Nebraska 2020
- ^{lxvii} Truth Initiative, 2018, E-cigarettes: Facts, stats and regulations
- ^{lxviii} Truth Initiative, 2018, E-cigarettes: Facts, stats and regulations
- ^{lxix} Nebraska DHHS, Radon Data 2013
- ^{lxx} Nebraska DHHS, Injury in Nebraska Report 2009-2013
- ^{lxxi} Nebraska DHHS, Nebraska 2016 Vital Statistics Report
- ^{lxxii} County Health Rankings and Roadmaps, 2020
- ^{lxxiii} CDC, Office of Disease Prevention and Health Promotion, Healthy People 2020: Mental health: Overview and Impact
- ^{lxxiv} Watanabe-Galloway, S., et al. 2016. Nebraska Behavioral Health Needs Assessment. University of Nebraska Medical Center, Omaha, NE.
- ^{lxxv} American Foundation for Suicide Prevention. Suicide: Nebraska 2016 facts and figures.
- ^{lxxvi} NALHD, VetSET: <http://nalhd.org/our-work/vetset/building-military-cultural-competence.html>
- ^{lxxvii} CDC. Adverse Childhood Experiences: looking at how ACEs affect our lives and society.
- ^{lxxviii} US Department of Health and Human Services. (2018) Adverse Childhood Experiences. Retrieved 1/23/19 from <https://www.childwelfare.gov/topics/preventing/preventionmonth/resources/ace/>
- ^{lxxix} ACEs Connection. 2017 Nebraska fact sheet.
- ^{lxxx} CDC, Adverse Childhood Experiences: looking at how ACEs affect our lives and society.
- ^{lxxxi} CDC, 2019, CDC-Kaiser ACE Study.
- ^{lxxxii} Safranek, T., Buss, B., Yeoman, K. 2012 Nebraska ACE Study Findings, p. 11-12
- ^{lxxxiii} Voices for Children in Nebraska, The Kids Count in Nebraska 2017 Report, Page 37
- ^{lxxxiv} American Psychological Association, 2019, The road to resilience.
- ^{lxxxv} Data Resource Center for Child & Adolescent Health, 2016, National Survey of Children's Health: Indicator 6.28.
- ^{lxxxvi} America's Health Rankings, 2018, Public Health Impact: Adverse Childhood Experiences
- ^{lxxxvii} America's Health Rankings, 2018, Public Health Impact: Adverse Childhood Experiences
- ^{lxxxviii} America's Health Rankings, 2018, Public Health Impact: Adverse Childhood Experiences
- ^{lxxxix} SAMHSA, 2019, Substance Abuse and Mental Illness Prevention
- ^{xc} NIH, National Institutes on drug abuse, Comorbidity: Substance use disorders and other mental illnesses, August 2018
- ^{xci} America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, Accessed 2021

-
- ^{xcii} Reidpath DD, Allotey P. Infant mortality rate as an indicator of population health. *Journal of Epidemiology & Community Health* 2003; **57**:344-346.
- ^{xciii} CDC, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, 2020, Infant Mortality
- ^{xciv} County Health Rankings and Roadmaps, 2020
- ^{xcv} Nebraska DHHS, Vital Statistics Report, 2016: Infant Death Rate by Place of Residence, 2012-2016
- ^{xcvi} Nebraska DHHS, Vital Statistics Report, 2016: The number of resident live births per 1,000 population
- ^{xcvii} County Health Rankings and Roadmaps, 2020
- ^{xcviii} County Health Rankings and Roadmaps, 2020
- ^{xcix} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^c Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^{ci} Alliance for Health Policy, 2017, *The Sourcebook: Essentials of Health Policy*. Chapter 8-Mental Health and Substance Abuse.
- ^{cii} County Health Rankings and Roadmaps, 2020
- ^{ciii} Alliance for Health Policy, 2017, *The Sourcebook: Essentials of Health Policy*. Chapter 8-Mental Health and Substance Abuse
- ^{civ} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^{cv} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^{cvi} Nebraska DHHS, Office of Health Disparities and Health Equity, Access to Health Services Dashboard
- ^{cvi} USDHHS, Office of Minority Health. 2019. Profile: Hispanic/Latino Americans.
- ^{cvi} The Commonwealth Fund. 2017. Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries.
- ^{cix} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined
- ^{cx} Nebraska DHHS, Office of Health Disparities and Health Equity, Access to Health Services Dashboard
- ^{cx} Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2019 combined