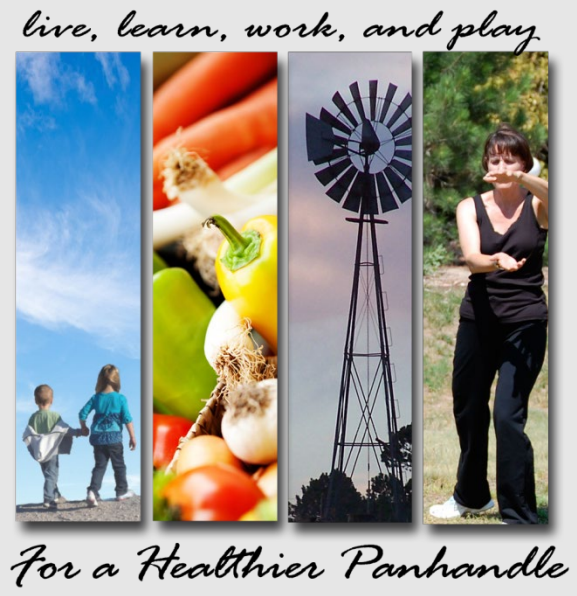
2023

Community Health Assessment

of the

Nebraska Panhandle

Approved by PPHD Board of Health February 8, 2024



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IN COLLABORATION WITH

Rural Nebraska Healthcare Network
Scotts Bluff County Health Department
Box Butte General Hospital
Chadron Community Hospital
Gordon Memorial Hospital
Kimball Health Services
Morrill County Community Hospital
Perkins County Health Services
Regional West Garden County
Regional West Medical Center
Sidney Regional Medical Center
Panhandle Partnership
Panhandle Area Development District
Nebraska Department of Health and Human Services

FOR MORE INFORMATION

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LETTER FROM THE DIRECTOR

The Community Health Assessment is a crucial initiative, completed every three years, enabling us better to understand our residents' health needs and challenges. It is a comprehensive process that involves data collection, analysis, and community engagement to identify key health issues, disparities, and opportunities for improvement.

Our dedicated team of professionals has been working diligently to gather and analyze a wide range of data related to the health of our community. This data includes information on demographics, health behaviors, access to healthcare services, environmental factors, and much more. Through surveys, interviews, and focus groups with community members and stakeholders, we have gained valuable insights into our residents' unique health concerns and priorities. Special attention is given to outreach efforts to ensure that the assessment is inclusive and reflects the diverse perspectives within our community.

With the data collection and analysis phases complete, we work closely with our community partners to develop a Community Health Improvement Plan (CHIP). This plan will outline actionable strategies and interventions to address health issues and disparities. It will serve as a roadmap for our community's health improvement efforts in the coming years.

I want to express my gratitude to all the individuals and organizations actively involved in this process. Our area hospitals, schools, law enforcement, businesses, Panhandle Partnership, and the rest of the local public health system complete this process together. Your input and collaboration have been invaluable, and I am confident that together, we can make significant strides in improving the health and well-being of our community.

Thank you once again for your commitment to the health and vitality of our Panhandle Community. We are working together to improve the health, safety, and quality of life for all who live, learn, work, and play in the Panhandle.

Sincerely,

Kimberly A. Engel

Health Director
Panhandle Public Health District

Contents

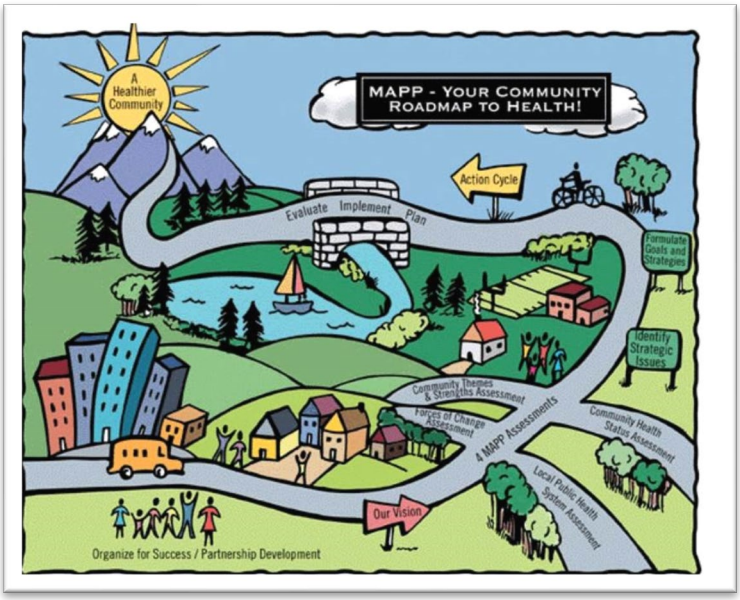
INTRODUCTION

Panhandle Public Health District (PPHD) is accredited by the Public Health Accreditation Board (PHAB), which requires the health department to conduct a comprehensive Nebraska Panhandle Community Health Assessment (CHA) every five years. However, Internal Revenue Service (IRS) regulations require tax-exempt hospitals to conduct a CHA every three years. In 2014, PPHD made the decision to collaborate with hospitals on the CHA process by syncing the health department process with the hospital process, meaning that PPHD completes a CHA every three years, in tandem with area hospitals. Thus, PPHD now facilitates a joint CHA and planning process with the eight hospitals in the Nebraska Panhandle and one in Perkins County, all of which are members of the Rural Nebraska Healthcare Network (RNHN).

The purpose of the CHA process is to describe the current health status of the community, identify and prioritize health issues, better understand the range of factors that can impact health, and identify assets and resources that can be mobilized to improve the health of the community.

OVERVIEW OF MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, has been used for the CHA and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011, and continued to be used for this round of the CHA and CHIP. MAPP emphasizes the partnership with all sectors of the public health system to evaluate the health status of the region it serves, identify priority areas, and develop plans for implementation.



The MAPP model has six key phases:

1. Organize for success/Partnership development
2. Visioning
3. Four MAPP assessments
    a. Community Health Status Assessment
    b. Community Themes and Strengths Assessment (CTSA)
    c. Forces of Change Assessment
    d. Local Public Health System Assessment
4. Identify Strategic Issues
5. Formulate Goals and Strategies
6. Take Action (plan, implement, and evaluate)

This document contains information for phases one through four. Phases five and six can be found in the 2021-2023 Panhandle Community Health Improvement Plan (CHIP).

MAPP PHASE 1: ORGANIZE FOR SUCCESS/PARTNERSHIP DEVELOPMENT

A MAPP Steering Committee was formed in 2014, made up of representatives from each of the nine RNHN hospitals (see list of members on page 10). Committee members provide guidance throughout the MAPP process and are charged with reviewing data and progress on the chosen priority areas, using quality improvement to modify implementation plans as needed, and sharing results with stakeholders.

LOCAL PUBLIC HEALTH SYSTEM COLLABORATIVE INFRASTRUCTURES

The Panhandle region enjoys a robust, well-established collaborative infrastructure, which provides the foundation for the local public health system communication and engagement process. This infrastructure includes:

- **Rural Nebraska Healthcare Network** (RNHN) which includes nine hospitals in the region, all rural health clinics, and assisted living/nursing homes that are a part of the RNHN member systems, including the Trauma Network. See page 10 for a list of RNHN members.
- **Public health partnerships** including collaborative work groups such as the Panhandle Regional Medical Response System (PRMRS) and Panhandle Worksite Wellness Council (PWWC), as well as the two public health Boards of Health (PPHD and SBCHD), which include elected officials.
- The **Panhandle Partnership** is a large, not-for-profit organization which promotes collective impact through planning and partnership. This inclusive, membership-based organization has and continues to be an integral part of the regional assessment and planning process. See page 11 for a list of Panhandle Partnership members.

MAPP STEERING COMMITTEE MEMBERS

Community Action Partnership of Western Nebraska	Betsy Vidlak
Rural Nebraska Health Care Network	Boni Carrell
Regional West Garden County	Bradley Howell
Gordon Memorial Health Services	Amanda Kehn
Box Butte General Hospital	Lori Mazanec Dan Newhoff
Sidney Regional Medical Center	Evie Parsons Tammy Meier
Chadron Community Hospital	Nathan Hough
Western Community Health Resources/ Chadron Community Hospital	Sandy Montague-Roes
Perkins County Health Services	Neil Hilton Rhonda Theiler
Panhandle Public Health District	Kim Engel Jessica Davies Megan Barhafer Sara Williamson Tabi Prochazka
Regional West Medical Center	Joanne Krieg Julie Franklin
Scotts Bluff County Health Department	Paulette Schnell
Kimball Health Services	Laura Bateman Kerry Ferguson
Educational Service Unit 13	Nicole Johnson
Morrill County Community Hospital	Robin Stuart
Panhandle Partnership	Faith Mills
Health in Disproportionately Affected Communities	Martin Vargas

RURAL NEBRASKA HEALTHCARE NETWORK MEMBERS

Chadron Community Hospital	Nathan Hough
Sidney Regional Medical Center	Jason Petik
Perkins County Health Services	Neil Hilton
Regional West Medical Center	Mel McNea
Kimball Health Services	Ken Hunter
Box Butte General Hospital	Lori Mazanec
Morrill County Community Hospital	Robin Stuart
Gordon Memorial Hospital	Megan Heath
Regional West Garden County	Bradley Howell

PANHANDLE PARTNERSHIP MEMBERS

Aging Office of Western Nebraska

Banisters Leadership Academy

Bayard Public Schools

Box Butte General Hospital

CAPstone Child Advocacy Center

CASA of Scotts Bluff County

Central Plains Center for Services

Chadron Public Schools

Chadron State College

Chappell Community Development

Cindy Osborne

MENTOR Nebraska

Mobius Communications

Monument Prevention Coalition

Nebraska Children's Home Society

Nebraska Commission for the Deaf & Hard of Hearing

Nebraska Department of Labor

Panhandle Trails Intercity Public Transit

Region 1 Behavioral Health Authority

Region 1 Office of Human Development

Region 22 Emergency Management

Roger Wess

Scotts Bluff County Cooperative Ministry Council

Scottsbluff Public Schools

Shawna & David Ricshling

Cirrus House

City of Gering Administration

City of Scottsbluff

Civic Nebraska

Community Action Health Center

Department of Health and Human Services

Disability Rights Nebraska

Educational Service Unit 13

Empowering Families

Gering Public Schools/Foundation

Guardian Light Family Services

Nebraska Foster & Adoptive Parent Association

Nebraska Foster Care Review Office

Nebraska Panhandle Area Health Ed Center

Nebraska Safety Council

Nebraska SHIP- Local Assistance for Nebraska with Medicare

Snow-Redfern Foundation

Snowy Peak Community Services

The DOVES Program

United Way of Western Nebraska

UNL Panhandle Extension Center

UNMC Monroe Meyer

Valley Youth Connections

Western Community Health Resources/Chadron Community Hospital

Healthy Blue Nebraska

Housing Partners of Western Nebraska

Immigrant Legal Center

Inclusive Communities

Independence Rising

Joan Cromer

Julie Eckland

Katie Samples Dean

Kimberly Dreyer

Legal Aid of Nebraska

Lutheran Family Services

Mediation West

Nebraska Total Care

Northwest Community Action Partnership

Options in Psychology

OutNebraska

Panhandle Area Development District

Panhandle Equality

Panhandle Public Health District

Western Nebraska Community College

Brain Injury Alliance

Valor Counseling and Support

Scotts bluff Diversion/JAC

MAPP PHASE 2: VISIONING

The MAPP Visioning process took place in February at the kick-off event for the 2023 Community Health Assessment. See Appendix A for the meeting work product (including details on the process) and see the next page for the full Vision.

2023 VISION

If we could align our resources, what would our vision for a safer and healthier Panhandle be?

Incentivizing wellness & mental well being	Access to Safe, Decent, Affordable Housing	Increase Social Connectedness	Workforce development & sustainability	Optimizing Health Systems Collaboration to serve the area	Robust system to address Behavioral Health	Community Equity	Advocacy to address access for patients	Resource accessibility	Safe Built Environments	ACE Prevention
• Incentivizing wellness & mental well being	• Affordable Housing • Enforcing codes on rental properties • Remove stigma	• Accessibility to activities • Increased social (inclusive) connectedness • Informal Social Gatherings & Supports	• Adult classes not part of college degree • Workforce development increase people +$ • Access to affordable childcare to allow for greater workforce • Alternate education	• Show casing wellness & mental well being • Streamline referral process • Affordable easy access including atypical setting (vaccinations & screenings • Healthcare systems - referrals and collaboration • Collaborative data sharing Mco's , hospitals, PH. • Access to Telehealth	• Mental health prevention Early peer detection/professional resources • Access & investigation of Behavioral health resources • Streamline referral process • Mental Health Providers • Substance misuse - accessibility, stigma, red tape/penalties • Remove stigma • Universal MH screening starting pre k- K • Education on vaping, drugs & Alcohol (resources & outcomes) • CCBHC Community BH Clinics • Substance Abuse treatment • Access to Telehealth	• Written translation resources • Safe and Inclusive welcoming communities • Culturally inclusive medical & Community Service • Full employment and housing for minority families • Healthcare Literacy • Identify individual community needs	• Healthcare access (stay healthy) Cost associated with insurance • Assistance for those that do not meet income guidelines • Policy on dentists taking insurance • Advocate for insurance co. to cover MH services • Access to Telehealth	• Increased Food Security • Widespread distribution of resources • Resource access SHIPP, MCD, Economic • Easy to understand resource guideassistance	• Ensure safe walking accessibility • Community recreation "safe space" • Improved city infrastructure	• ACE Reduction Parental Education Collaboration

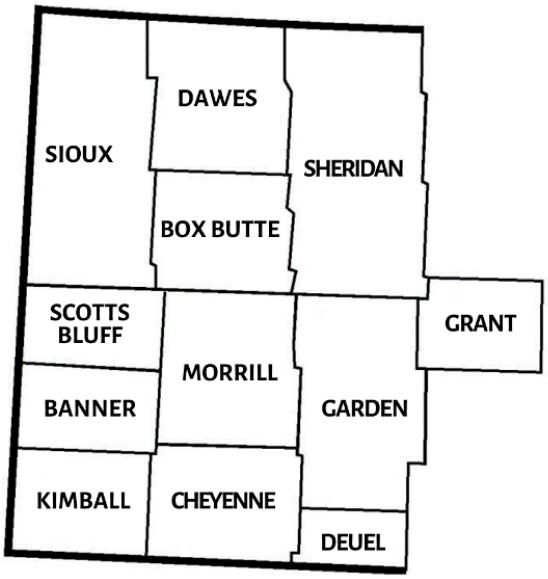
MAPP PHASE 3: FOUR MAPP ASSESSMENTS

COMMUNITY HEALTH STATUS ASSESSMENT

COMMUNITY PROFILE

The Nebraska Panhandle is a rural region on the high plains, surrounded by neighbors of Wyoming to the west, Colorado to the south, and South Dakota to the north. Its agricultural backbone perhaps has insulated it from historical economic downturns but has likely also contributed to out-migration as fewer opportunities have been available compared to larger cities for young adults with diverse professional trades. Population consolidation continues, wages remain lower than the state and national averages, and the median age continues to increase as the baby boomers age, birth rate stabilizes, and out-migration of youth continues. The unique bluffs, escarpments, and open space are some of the most treasured assets in the region which lay the foundation for tourist and historic attractions.

The geographic Nebraska Panhandle consists of the counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Grant, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux. The Panhandle Public Health District (PPHD) service area additionally consists of Grant County, for a total of 12 counties covered. Throughout this document, the PPHD service area will be referred to as the Panhandle.



PPHD Service Area Quick Facts:
Population: 83,841*
Unemployment rate: 3.19%
Total land area: 14,963 square miles

Source: *2020 Census Count; 2016-2020 American Community Survey

POPULATION

While the population of Nebraska has been slowly but steadily increasing over the past 60 years, the Panhandle's population peaked in the 1960s. In recent years communities have noted an increase in interest in their communities but the lack of housing among other challenges has prevented potential growth.

Figure 1: Nebraska Population, 1910-2020, data from the decennial census, prepared by Megan Barhafer.

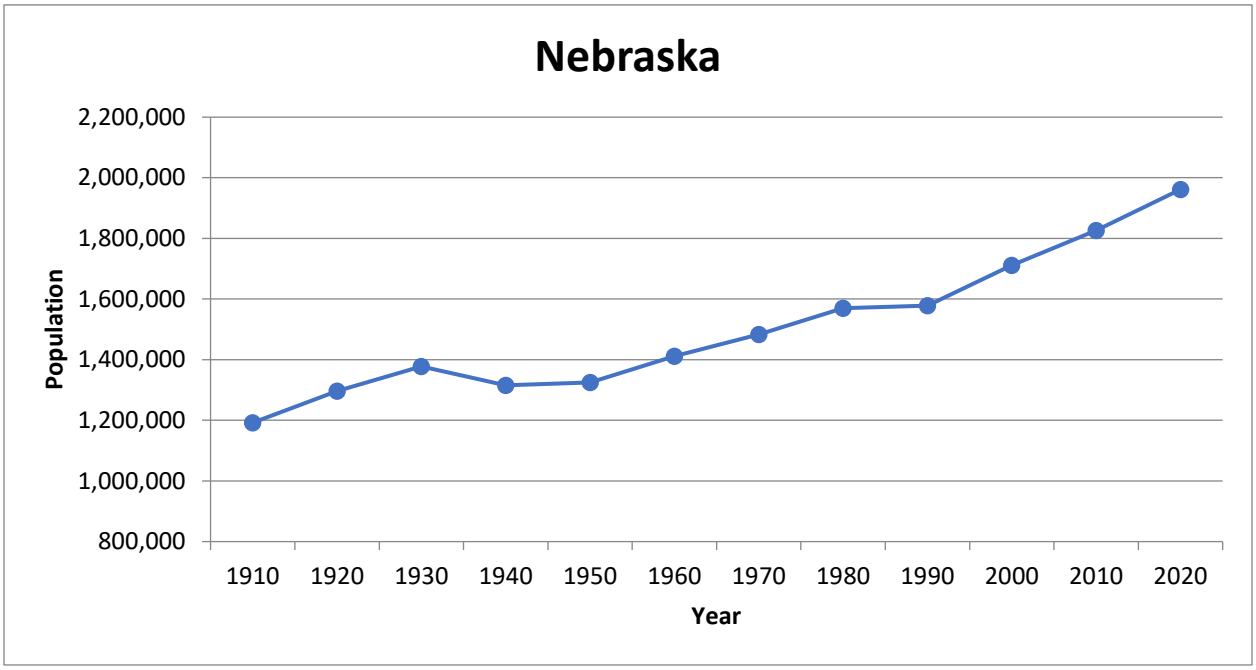
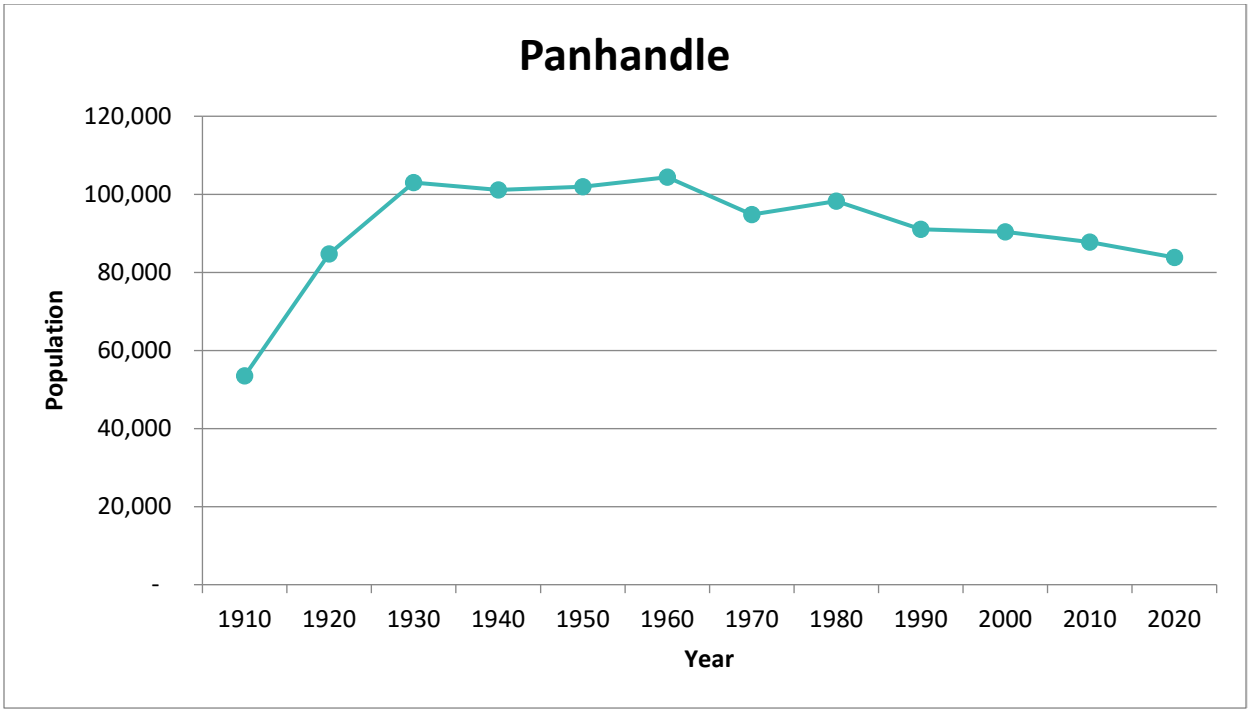
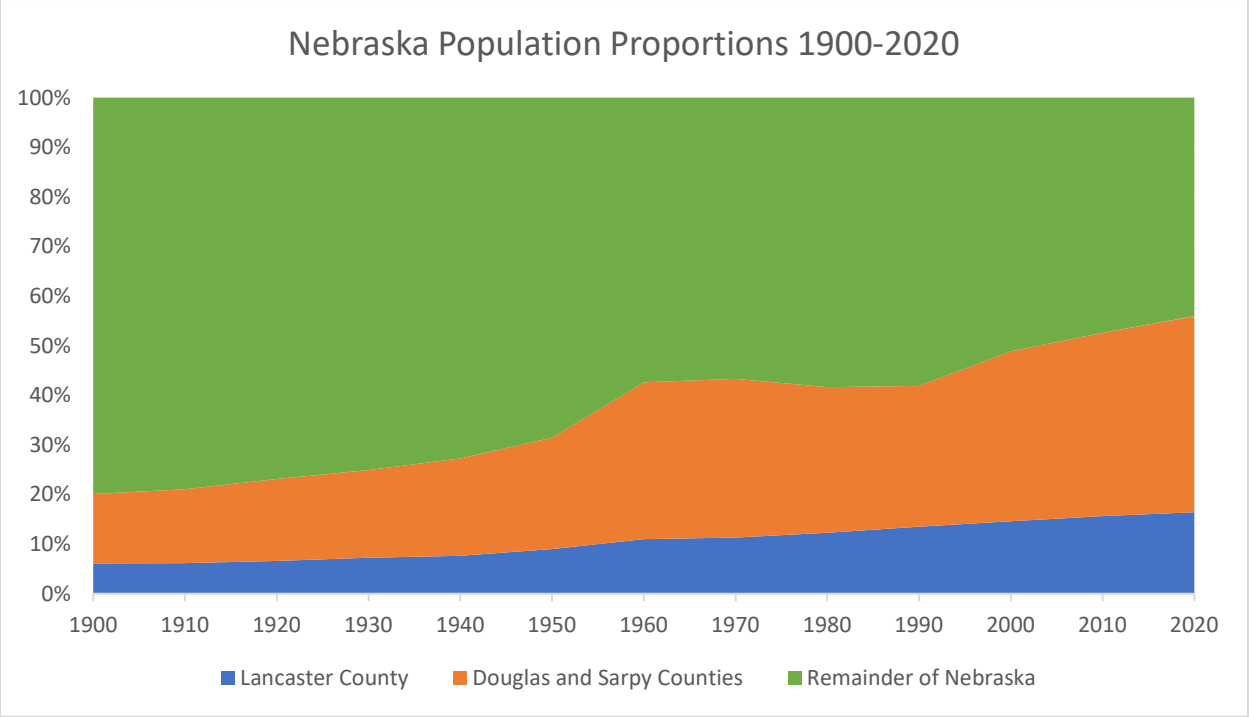


Figure 2: Panhandle Population, 1910-2020, data from the decennial census, prepared by Megan Barhafer



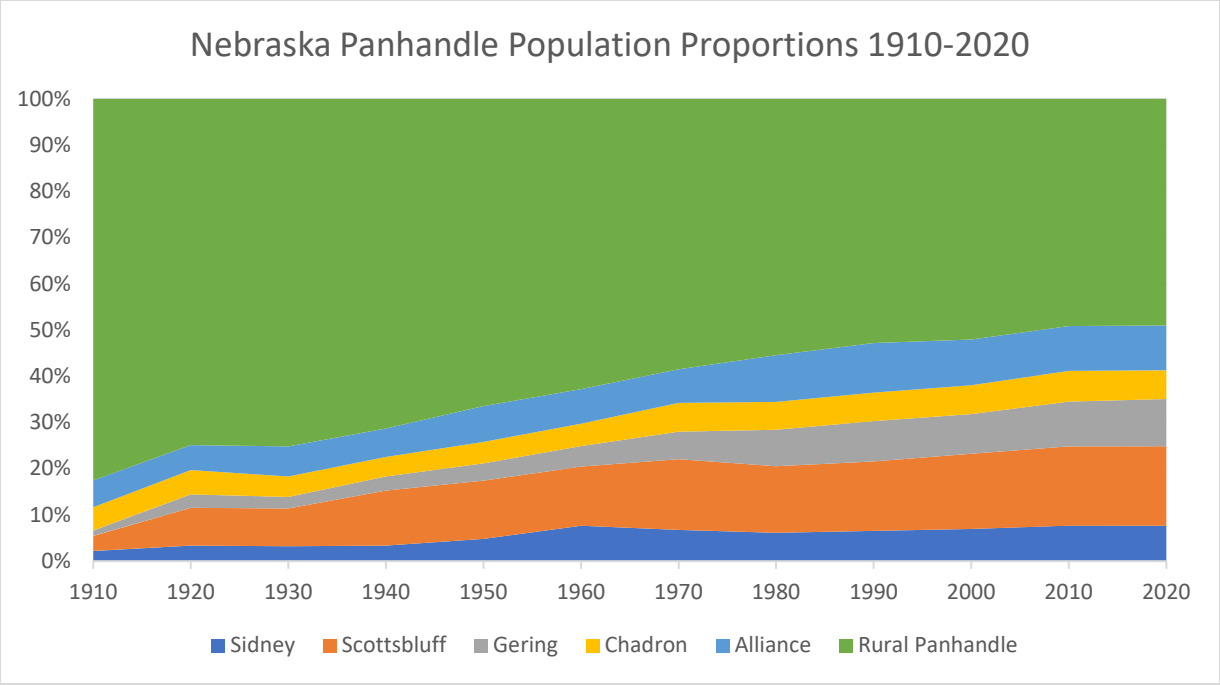
Nebraska's population growth has been concentrated almost entirely in the metropolitan counties of Douglas, Sarpy, and Lancaster in the eastern part of the state. These counties are home to the Omaha metropolitan area and the state capital metropolitan area of Lincoln.

Figure 3: Nebraska Population, Omaha and Lincoln metro areas and rest of state



Source: U.S. Decennial Census

Figure 4: Nebraska Panhandle Population Consolidation: 1910-2020

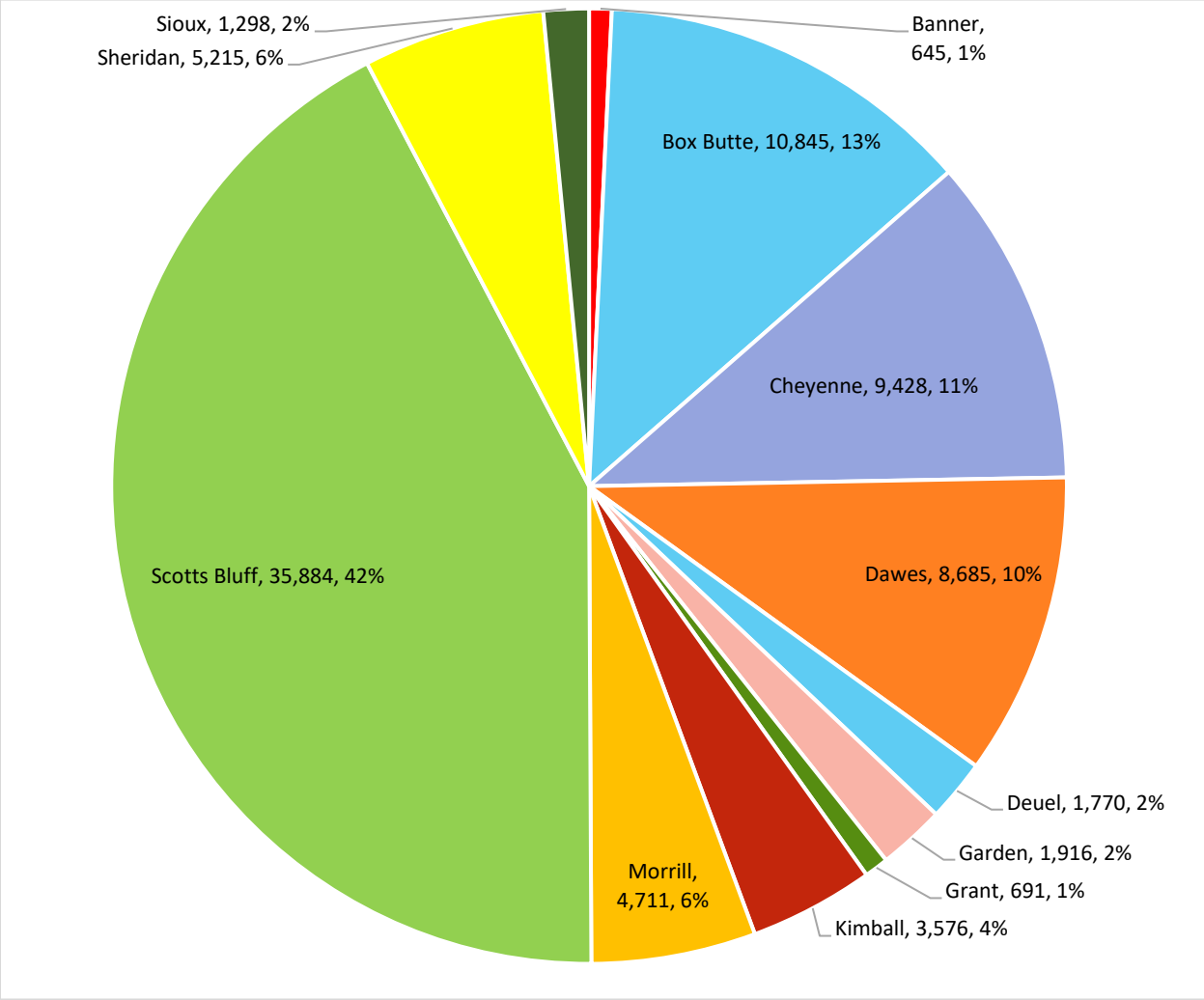


Source: U.S. Decennial Census

Population consolidation away from rural areas is not new, is a global phenomenon, and has also been occurring within our region. The emergence of the service and innovation-based economy and decrease of farm employment practically ensures this pattern will continue. For this reason, communities should not undertake frantic efforts to stop population loss but rather measured strategies that aim to steadily improve the quality of life and opportunities for their citizens. The Panhandle may see a slight increase in population due to emigration from large cities which started during the 2020 Pandemic. Communities should still focus on steadily improving quality and ensuring that housing is appropriate to meet the needs of the community as people age.

Seventy-six percent of the Panhandle's population is concentrated in the 4 'trade counties' of Scotts Bluff, Box Butte, Cheyenne, and Dawes. These counties are home to the cities that draw from large areas that tend to have more amenities, retail, and services. Many of the 'rural counties' also boast communities with excellent local services. However, in rural counties, travel time, available labor, and lower levels of public revenue hinder economic growth. Collaborative economic development groups in these areas work to close these gaps.

Figure 5: Panhandle Population by County, Count and Percentage



Source: 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District.

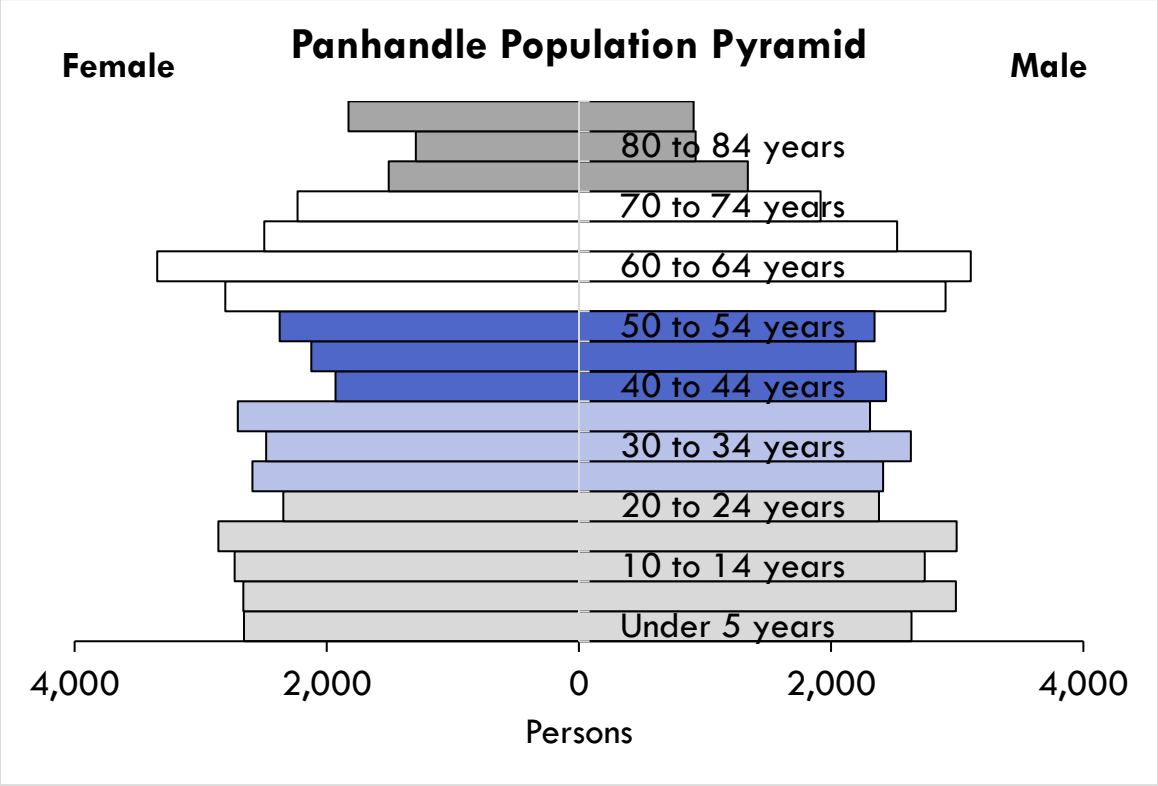
POPULATION PROJECTIONS

Figure 6: Panhandle Population by Sex and 5-Year Age Group

	Both Sexes		Male	Female
	Estimate	Percent	Estimate	Estimate
Total Population	84,664		41695	42969
Under 5 years	5294	6.1%	2637	2657
5 to 9 years	5651	6.5%	2989	2662
10 to 14 years	5473	6.3%	2742	2731
15 to 19 years	5855	6.7%	2995	2860
20 to 24 years	4724	5.4%	2379	2345
25 to 29 years	5002	5.7%	2412	2590
30 to 34 years	5113	5.9%	2632	2481
35 to 39 years	5014	5.8%	2308	2706
40 to 44 years	4367	5.0%	2436	1931
45 to 49 years	4318	5.0%	2195	2123
50 to 54 years	4718	5.4%	2344	2374
55 to 59 years	5712	6.6%	2907	2805
60 to 64 years	6452	7.4%	3107	3345
65 to 69 years	5019	5.8%	2523	2496
70 to 74 years	4148	4.8%	1916	2232
75 to 79 years	2848	3.3%	1339	1509
80 to 84 years	2219	2.6%	925	1294
85 years and over	2737	3.1%	909	1828

Source: 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District

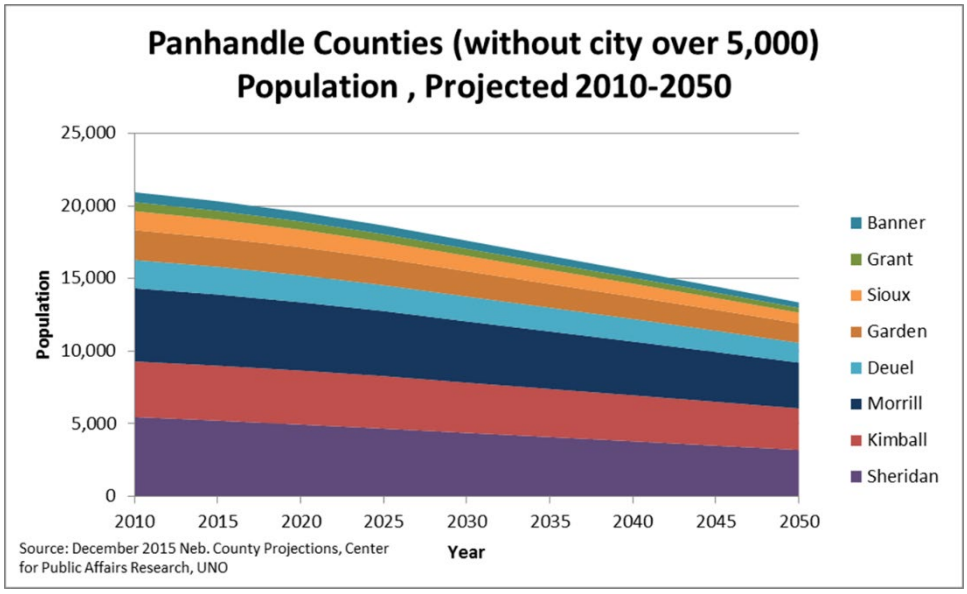
Figure 7: Panhandle Population Pyramid

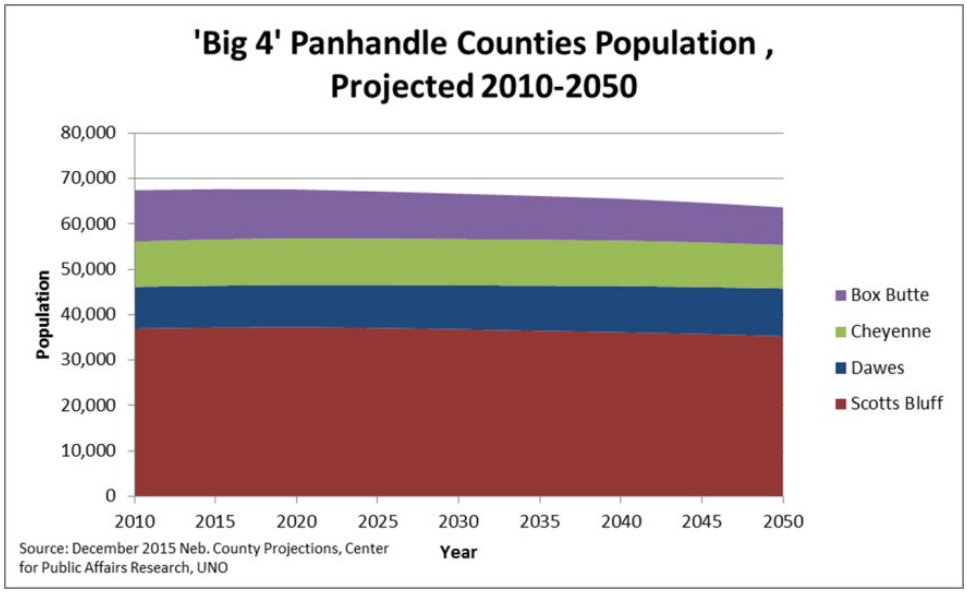


Source: 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District.

Population projections for the Panhandle counties show a slight growth or steady population in Cheyenne, Scotts Bluff and Dawes Counties and a decline in all other counties through 2030.

Figure 8: Panhandle projected populations by county





AGING

Aging patterns in a population have impacts on the workforce availability, overall health of the population, housing, and business succession.

The population pyramid from the 2016-2020 American Community Survey Estimates shows the general age makeup of the Nebraska Panhandle. In the global population pyramid, you see the graph as a true triangle. When the graph displays this way, it means that the population is growing, and older generations are producing larger newer generations. With a more rectangular shape, older generations are being replaced with newer generations of about the same size resulting in a constant population. The population pyramid for the PPHD service area shows a more rectangular shape, leaning toward being an inverted triangle. The shape of this pyramid illuminates the shrinking and aging population in the region. This pattern is projected to continue.

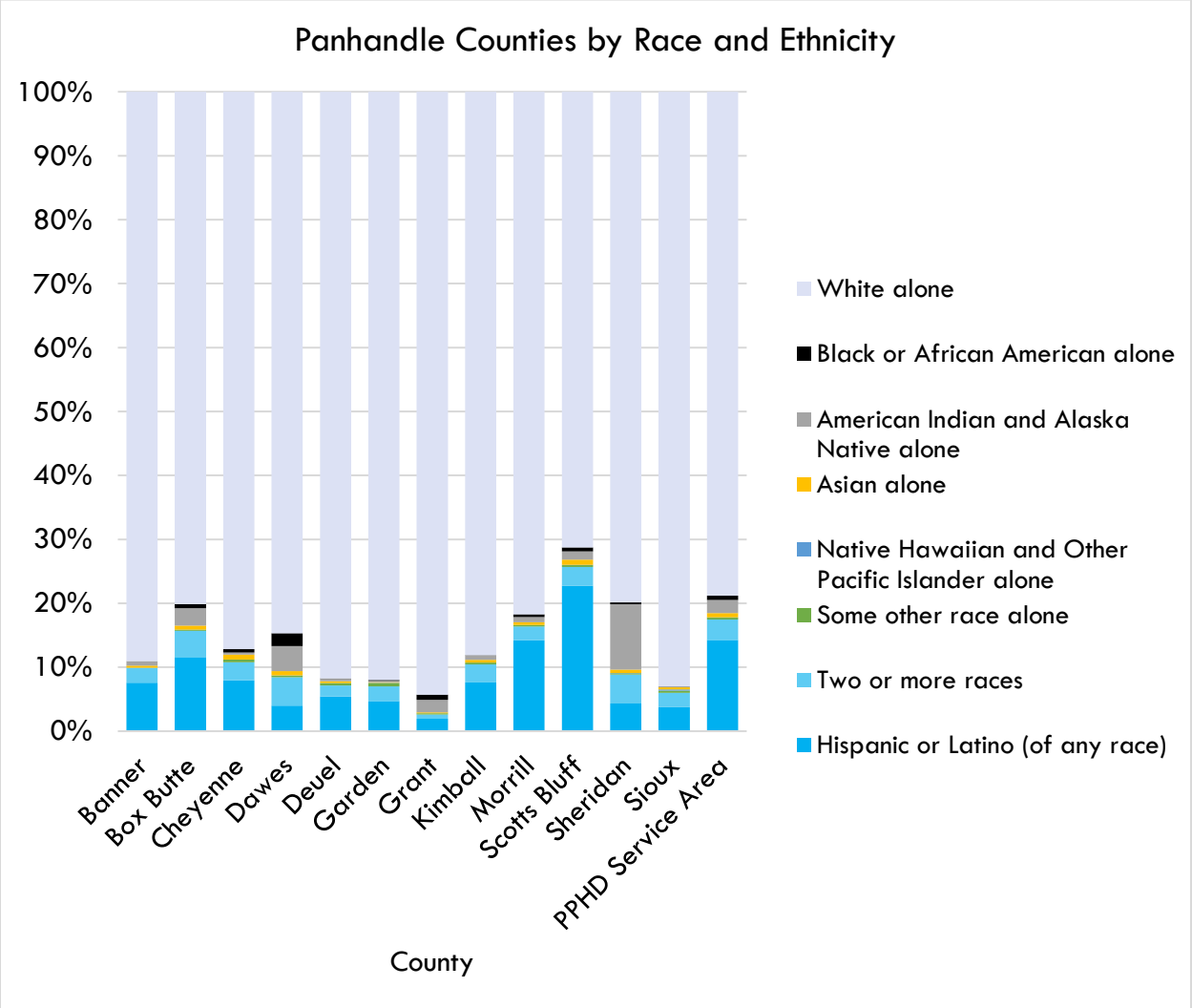
A shrinking and aging population explains at least a portion of the workforce challenges the region has experienced in the past few years. Workforce availability will be explored more in depth in a future section. Businesses are also vulnerable without a sufficient base of new workers who are positioned to step into ownership or management roles. Housing is affected by an aging population who lacks the proper housing infrastructure for aging friendly homes because they then stay in homes that are much larger than they need which could be available to families (including multi-generational). The overall health of the region is also affected by an aging population because while age is not a disease it does put you at higher risk for heart conditions, cancer, and falls among other morbidities.

RACE AND ETHNICITY

Racial demographic patterns reveal social patterns. Health and economic disparities in America have long existed along racial and ethnic lines. The data presented in this section helps PPHD understand which disparities exist and whether they are improving or worsening. In 2022, an in-depth look at disparities was completed and 5 priorities to address health equity were identified.

In the Nebraska Panhandle, the majority race is non-Hispanic White, some communities are 15 to 30 percent Hispanic and Latino and some have American Indian communities that account for up to 10 percent of the population. Scotts Bluff and Morrill counties show higher Hispanic populations while Sheridan County shows an almost 10% American Indian population. Many Hispanic families have been in the area for multiple generations.

Figure 9: Panhandle Counties by Race and Ethnicity



Source: 2020 Census. Prepared by Megan Barhafer, Panhandle Public Health District

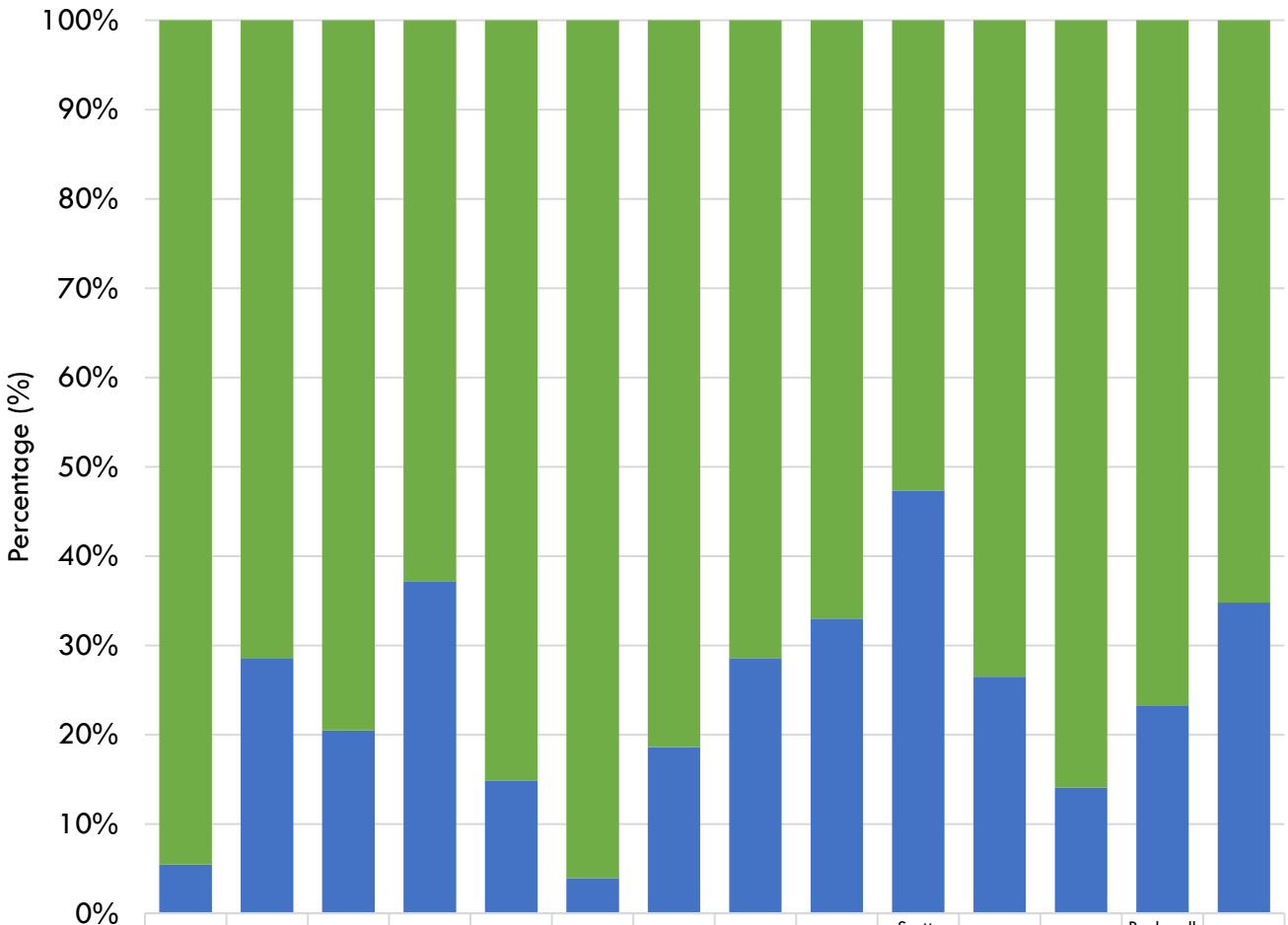
Like the rest of Nebraska, younger generations of new Nebraskans born to Hispanic or Latino families is the driver behind the growth of Hispanic or Latino populations in the region. However, unlike other parts of Nebraska, the Panhandle's Hispanic population is largely US-born and has been for decades. New generations of Nebraskans born to Hispanic families in the Panhandle are often second, third, or fourth-generation Americans. Despite a large portion of the population being native, the percentage of the population who chooses to speak another language at home indicates that while people in our community may be able to speak English, their preferred language may be something else. Our numbers are still lower than state or national averages but language access has come up as an important consideration in access to care in the recent Minority Health Assessment completed in 2022.

Figure 10: English language proficiency, language spoken at home, compared between Panhandle counties and the United States. ACS 2016-2020 data.

	United States	Nebraska	Banner Co.	Box Butte Co.	Cheyenne Co.	Dawes Co.	Deuel Co.
Speak English less than "very well"	8.2%	5.2%	3.3%	3.0%	0.2%	1.5%	1.4%
Speak a language other than English at home	21.5%	11.8%	7.0%	8.2%	2.6%	4.3%	1.8%
	Garden Co.	**Grant Co.**	**Kimball Co.**	**Morrill Co.**	**Scotts Bluff Co.**	**Sheridan Co.**	**Sioux Co.**
Speak English less than "very well"	1.7%	0.0%	1.4%	2.2%	2.9%	1.0%	2.9%
Speak a language other than English at home	4.6%	0.2%	2.7%	8.5%	12.3%	4.1%	3.4%

The population in younger age groups of the region is more diverse than that of the general population. Figure 11 shows the proportion of children under 5 who identified as People of Color compared to those children under 5 identified as White only.

Figure 11: Panhandle Population Age 5 and Under by Race/Ethnicity



	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Grant	Kimball	Morrill	Scotts Bluff	Sheridan	Sioux	Panhandle	Nebraska
White alone	95%	72%	80%	63%	85%	96%	81%	71%	67%	53%	74%	86%	77%	65%
Minority	5%	28%	20%	37%	15%	4%	19%	29%	33%	47%	26%	14%	23%	35%

Source: 2016-2020 American Community Survey 5-Year Estimates.
Prepared by Megan Barhafer, Panhandle Public Health District

ECONOMY

Economic health is an important preventive factor for community health and wellness. A diverse economic base that can withstand changing markets and one that can accommodate different skillsets and training needs of the people that might grow up in an area or who might be changing careers in an area is critical to a community's resilience.[1]

The Nebraska Panhandle has Its roots in a strong agricultural economy and has fared well in economic downturns, maintaining unemployment rates often much lower than the nation. Wages and professional opportunities, however, are concentrated in larger communities (Scottsbluff, Gering, Sidney, Alliance, Chadron). These wages and opportunities often remain less appealing than those offered in the front range, despite the lower cost of living in the Panhandle. A reason cited frequently is the lack of benefits/quality of benefits available to employees in the Panhandle.

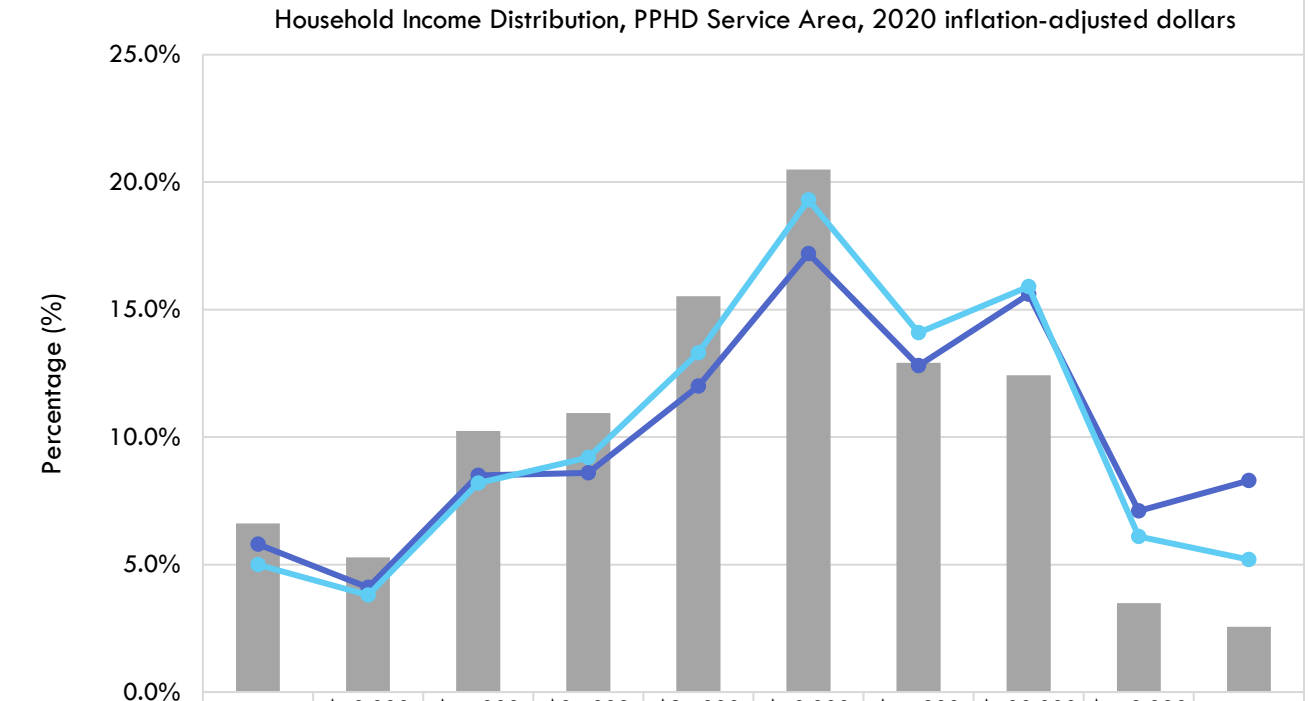
INCOME

Average wages are well below the average for both Nebraska and the nation. The state median household income is $63,015. None of the Panhandle counties recorded a higher median income in the most recent estimates. While the costs of living expenses are generally lower in the Panhandle, wages are also low and are a noted problem by citizens and community leaders across the region. This is made worse by inflated housing costs and limited housing availability.

Incomes in the Panhandle are lower than they are nationally or statewide. Maintaining a large middle-income population is important because income disparities are detrimental for a community. The distribution graph shows that the number of middle-income families in the Panhandle is like the number of middle-income families nationally and statewide. Unfortunately, the number of lower income families is higher, and the number of higher income families is lower. Fewer professional, science, and technology-based jobs likely lead to this outcome.

[1] (Pinderhughes, Davis and Willams 2015)

Figure 12: Household Income Distribution, Panhandle, 2020 Inflation-Adjusted Dollars



	Less than $10,000	$10,000 to $14,999	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 to $99,999	$100,000 to $149,999	$150,000 to $199,999	$200,000 or more
PPHD	6.6%	5.3%	10.2%	10.9%	15.5%	20.5%	12.9%	12.4%	3.5%	2.6%
United States	5.8%	4.1%	8.5%	8.6%	12.0%	17.2%	12.8%	15.6%	7.1%	8.3%
Nebraska	5.0%	3.8%	8.2%	9.2%	13.3%	19.3%	14.1%	15.9%	6.1%	5.2%

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates; Table Dp03. Prepared By Megan Barhafer, Panhandle Public Health District.

Median household income is a helpful measure of where our middle class is situated in the Panhandle. In most counties, the median household income has increased. This means that incomes are getting stronger despite inflation. When household incomes are decreasing, the incomes are failing to keep up with inflation.

Figure 13: Median Household Income, Panhandle

County	2010	2020	Change
Banner County	$40,553	$53,864	32.82%
Box Butte County	$52,864	$61,904	17.10%
Cheyenne County	$58,923	$52,270	-11.29%
Dawes County	$41,593	$49,379	18.72%
Deuel County	$44,226	$48,958	10.70%
Garden County	$39,242	$42,076	7.22%
Grant County	$46,741	$43,625	-6.67%
Kimball County	$50,014	$48,056	-3.91%
Morrill County	$44,903	$46,903	4.45%
Scotts Bluff County	$46,435	$53,433	15.07%
Sheridan County	$40,011	$45,543	13.83%
Sioux County	$50,462	$47,422	-6.02%
Nebraska	**$58,743**	**$63,015**	7.27%
United States	**$61,805**	**$64,994**	5.16%

Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates; 2016-2020 American Community Survey 5-Year Estimates; Bureau of labor statistics CPI inflation calculator, all numbers are in 2020 inflation-adjusted numbers. Prepared by Megan Barhafer, Panhandle Public Health District

Per capita income is an average measure of the amount of income each individual person would have if it were divided equally. This gives an idea of the general wealth circulating in the area and the strength of the economy.

Figure 14: Per Capita Income in the past 12 months, Panhandle, 2020 Inflation-Adjusted Dollars

County	Per capita income ($)
Banner County	30,628
Box Butte County	29,447
Cheyenne County	30,145
Dawes County	25,380
Deuel County	27,998
Garden County	33,689
Grant County	23,806
Kimball County	26,528
Morrill County	25,492
Scotts Bluff County	28,770
Sheridan County	30,173
Sioux County	25,398
Nebraska	33,205
United States	35,384

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates; Bureau of labor statistics CPI inflation calculator. Prepared by Megan Barhafer, Panhandle Public Health District

EMPLOYMENT AND WORKFORCE

The Panhandle has had a similar unemployment rate to the state over time and has had lower unemployment rates compared to the nation over time. The moderate rate of unemployment during the recession years shows evidence of the region's resilience to external market pressures. In 2020, Nebraska's overall unemployment rate rose to the same level as in 2010 (recession marker) but the Panhandle's unemployment rate remains at similar historic levels and remains lower than the state and national rates.

Figure 15: Panhandle Unemployment Rate (%), 2000-2020 12-Month Average

County	2000	2008	2010	2016	2018	2020
Banner County	3.0	2.5	4.4	3.4	3.4	2.9
Box Butte County	3.9	3.7	5.0	3.6	2.8	4.6
Cheyenne County	2.3	2.8	3.6	2.8	2.8	4.3
Dawes County	3.0	2.9	4.0	2.9	2.7	2.7
Deuel County	3.0	2.9	3.9	2.6	3.0	3.1
Garden County	2.6	3.0	4.1	3.3	2.3	3.5
Grant County	2.3	2.9	3.8	2.2	2.6	1.9
Kimball County	2.5	3.4	4.7	4.1	2.6	3.5
Morrill County	3.5	3.1	4.1	3.2	2.7	3.5
Scotts Bluff County	4.0	3.7	5.5	3.5	3.2	4.1
Sheridan County	2.9	2.7	3.5	2.9	2.6	2.3
Sioux County	1.9	3.4	3.7	2.7	2.6	2.2
Panhandle	**3.4**	**3.4**	**4.7**	**3.3**	**2.9**	**3.2**
Nebraska	**2.8**	**3.3**	**4.6**	**3.2**	**2.8**	**4.5**
United States	**4.0**	**5.8**	**9.6**	**4.9**	**3.9**	**5.4**

Source: Bureau of Labor Statistics, Prepared by Megan Barhafer, Panhandle Public Health District.

LABOR FORCE

While unemployment can give us a quick glance as to the percentage of people out of work in an area, it does not account for the rate of people who are underemployed or who are working multiple jobs to make ends meet. In an economic downturn, someone who is self-employed or working multiple jobs could lose a significant amount of their work and still not technically be unemployed. Unemployment also does not account for size of the labor force which has decreased consistently since 2000.

The Labor force numbers are based on people living in that county who are either working or actively looking for work. The labor force has decreased in all the Panhandle Counties. Banner, Box Butte, Cheyenne, Deuel, and Sheridan counties all had large decreases in their labor force from 2000 to 2020. This sharp decrease in labor force is a trend that continued through the recession and has continued even while the national economy has recovered.

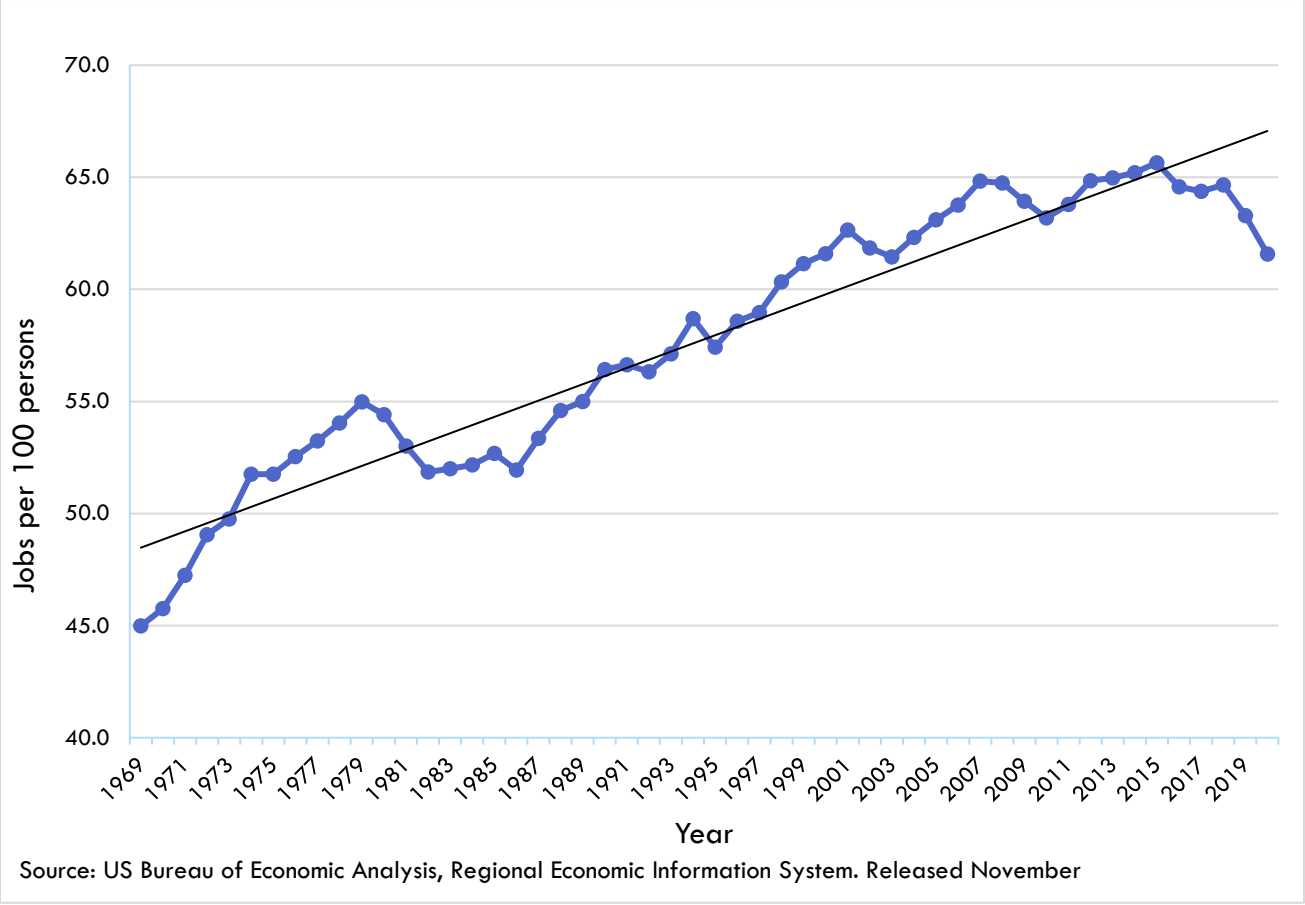
Figure 16: Panhandle Labor Force, 2000-2020

County	2000	2010	2020	Change 2000-2020
Banner County	428	413	392	-8.3%
Box Butte County	6,422	5,852	5,403	-15.9%
Cheyenne County	5,655	5,558	4,287	-24.2%
Dawes County	5,062	5,499	4,985	-1.5%
Deuel County	1,175	1,031	967	-17.7%
Garden County	1,217	1,266	1,082	-11.1%
Grant County	439	373	420	-4.4%
Kimball County	2,198	2,124	1986	-9.6%
Morrill County	2,798	2,650	2639	-5.7%
Scotts Bluff County	18,775	19,200	18279	-2.6%
Sheridan County	3,295	2,821	2734	-17.0%
Sioux County	802	835	767	-4.4%
Panhandle	**47,827**	**47,249**	43941	-9.0%
Nebraska	**944,986**	**993,400**	1044541	10.5%
United States	**143,893,664**	**155,539,411**	165902838	15.3%

Source: Bureau of Labor Statistics. Prepared by Megan Barhafer, Panhandle Public Health District.

Historically, the number of jobs available per 100 persons has increased while wages continue to remain below the national and state averages. This increase in available jobs over the past 50 years is considered a symptom of a declining population.

Figure 17: Jobs per 100 persons, 1969-2020, Panhandle



Source: US Bureau of Economic Analysis, Regional Economic Information System. Released November

Figure 18: Jobs per 100 Persons, 2008-2020, Panhandle

2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
64.8	63.9	63.2	63.8	64.8	65.0	65.2	65.6	64.6	64.4	64.7	63.3	61.6

Source: US Bureau of Economic Analysis, Regional Economic Information System. Released November 2020. Prepared by Megan Barhafer Panhandle Public Health District

POVERTY

Poverty in the Panhandle is generally higher than in the rest of the state and nearby metro areas. The college student population in Dawes County skews that poverty rate. Six other Panhandle counties had estimated poverty rates over the state average by the most recent estimates.

CHILDHOOD POVERTY

Particularly high poverty rates exist for children under 18. Half of the counties have childhood poverty rates higher than that of the latest state estimate. Sheridan County has the highest rate at 35.9%. The table is ranked from the county with the highest rate of poverty to the county with the lowest rate of poverty. More children in poverty means more children growing up with

potential obstacles to career, educational, and health care opportunities and has implications for the mental health of the region.

Figure 19: Percent of All Population with Income in Past 12-Months Below Poverty Line, Panhandle

County	%
Sheridan County	19.0%
Grant County	17.4%
Dawes County	13.1%
Scotts Bluff County	13.0%
Box Butte County	12.8%
Kimball County	12.0%
Cheyenne County	11.0%
Morrill County	9.7%
Garden County	8.6%
Deuel County	8.2%
Sioux County	8.1%
Banner County	3.4%
Panhandle	**12.6%**
Nebraska	**10.4%**
United States	**12.8%**

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District

Figure 20: Percent of Children Under 18 With Income in Past 12 Months Below Poverty Line, Panhandle

County	Percent
Sheridan County	**35.9%**
Grant County	**18.5%**
Scotts Bluff County	**15.0%**
Dawes County	**14.6%**
Kimball County	**12.8%**
Cheyenne County	**11.8%**
Box Butte County	**10.2%**
Morrill County	**10.2%**
Sioux County	**8.0%**
Garden County	**7.2%**
Deuel County	**6.6%**
Banner County	**4.5%**
Panhandle	**14.4%**
Nebraska	**12.2%**

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District

RACE AND POVERTY

Racial disparities in income levels have long been documented in the United States. The Panhandle is not immune to these disparities. The table below shows the distribution between the White population and the non-White populations in the region. The American Indian communities and Hispanic/Latino communities both experience poverty at a higher rate than the White communities in the region.

Figure 21: Percent of all Population with Income in past 12 Months Below Poverty Level, by Race and Ethnicity, Panhandle

County	White Alone	American Indian alone	Two or more races	Hispanic or Latino origin (of any race)	White alone, not Hispanic or Latino
Banner County	3.6%	-	0.0%	27.9%	1.7%
Box Butte County	12.3%	53.4%	16.1%	16.1%	11.6%
Cheyenne County	10.4%	65.5%	18.5%	9.7%	10.6%
Dawes County	10.3%	26.4%	47.7%	56.0%	9.4%
Deuel County	8.5%	0.0%	5.3%	7.2%	8.5%
Garden County	8.5%	0.0%	35.7%	0.0%	12.0%
Grant County	17.0%	0.0%	57.1%	0.0%	17.0%
Kimball County	11.1%	72.6%	1.6%	26.2%	9.2%
Morrill County	10.1%	0.0%	3.5%	25.3%	6.7%
Scotts Bluff County	13.2%	22.2%	6.0%	18.8%	10.7%
Sheridan County	14.0%	46.5%	28.8%	58.7%	13.2%
Sioux County	7.7%	0.0%	0.0%	24.1%	7.7%
Panhandle	11.9%	37.1%	14.0%	20.6%	10.5%
Nebraska	9.0%	24.9%	15.5%	18.4%	8.1%

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District

POVERTY BY EDUCATIONAL ATTAINMENT

The rate of poverty among people with lower educational attainment in the Panhandle can be attributed to the availability of jobs for non-bachelor degree levels of education. The region's 33% poverty rate for those with a high school degree or less is lower than big cities such as Denver (37.5%), Rapid City (53.6%), or Omaha (36.6%). Across the state and regionally, poverty rates do decrease as people attain higher levels of education. This is a challenging measure because people with access to higher education often come from families who started off at a higher level of education.[2]

[2] (Fry 2021)

Figure 22: Percent of Population in Poverty by Educational Attainment, Population 25+, Panhandle

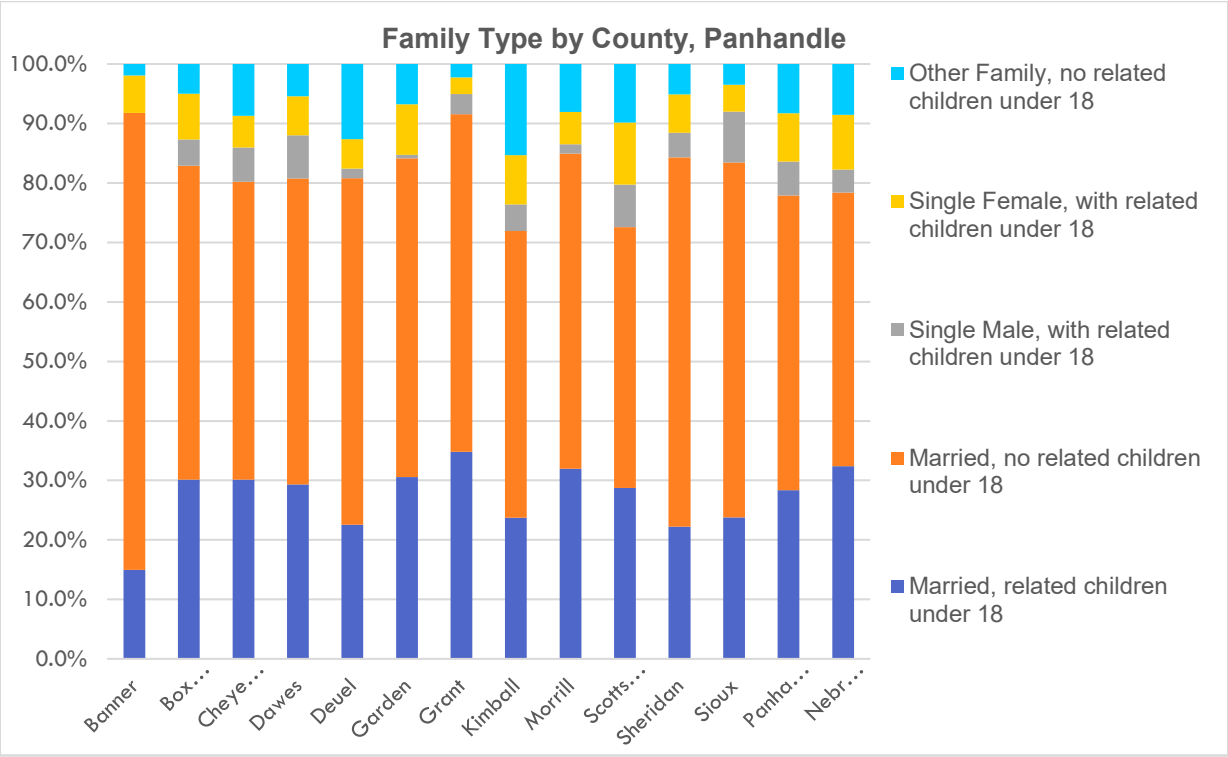
	Less than high school	High school graduate	Some college, associate degree	Bachelor's degree or higher
Banner County	0.00%	7.20%	1.80%	0.00%
Box Butte County	14.60%	16.50%	10.80%	0.60%
Cheyenne County	15.80%	14.40%	8.50%	4.10%
Dawes County	9.50%	5.00%	10.00%	1.40%
Deuel County	15.90%	8.70%	7.00%	2.60%
Garden County	22.20%	15.20%	4.30%	3.60%
Grant County	54.50%	16.20%	17.60%	7.50%
Kimball County	19.80%	13.90%	6.40%	8.20%
Morrill County	16.90%	14.20%	7.50%	2.70%
Scotts Bluff County	25.20%	13.00%	11.10%	4.60%
Sheridan County	31.70%	15.90%	7.40%	7.30%
Sioux County	17.10%	12.50%	6.00%	1.80%
Panhandle	20.27%	12.73%	8.20%	3.70%
Nebraska	21%	11%	8%	3%

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District

POVERTY BY FAMILY TYPE

Most families in the Panhandle do not have children under 18 years of age. Single parent families with children make up about 14% of all Panhandle families. The highest rates of single parent families with children occur in Kimball, Morrill, and Scotts Bluff Counties, with the highest rates of married families occurring in the more rural counties of Banner, Deuel, Garden, and Sioux. This has implications for housing needs in the region as well as childcare.

Figure 23: Family Type by County, Panhandle

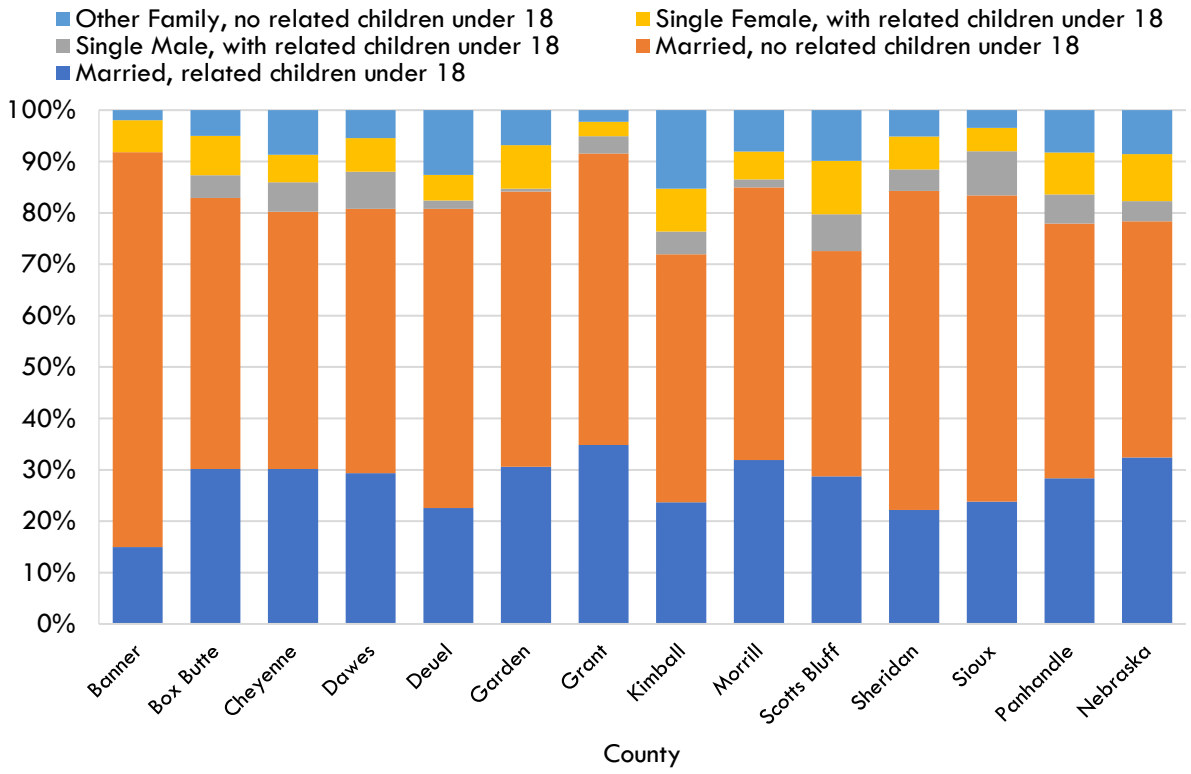


	Single Female, with related children under 18	Single Male, with related children under 18	Married, related children under 18	Married, no related children present	Other family, no related children present
Banner County	6.3%	0%	15.0%	76.8%	1.9%
Box Butte County	7.7%	4.4%	30.1%	52.8%	5.0%
Cheyenne County	5.4%	5.7%	30.1%	50.1%	8.7%
Dawes County	6.6%	7.2%	29.3%	51.4%	5.4%
Deuel County	5.0%	1.6%	22.6%	58.3%	12.6%
Garden County	8.5%	0.6%	30.6%	53.6%	6.8%
Grant County	2.8%	3.4%	34.8%	56.7%	2.2%
Kimball County	8.3%	4.5%	23.7%	48.2%	15.3%
Morrill County	5.4%	1.6%	31.9%	53.0%	8.0%
Scotts Bluff County	10.4%	7.1%	28.7%	43.9%	9.9%
Sheridan County	6.4%	4.1%	22.2%	62.1%	5.1%
Sioux County	4.5%	8.6%	23.8%	59.6%	3.5%
Panhandle	**8.2%**	**5.7%**	**28.4%**	**49.5%**	**8.3%**
Nebraska	**9.2%**	**3.9%**	**32.4%**	**46.0%**	**8.5%**

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates; Table B11003. Prepared By Megan Barhafer, Panhandle Public Health District

The graph below shows families who have an income at or below the poverty level by type of family. Most families who live in poverty have children under 18 years of age. Single female headed families with children make up over 40% of all families in the Panhandle with an income level below the poverty line. Families with children experience a greater strain making ends meet, particularly if a household only has one income to contribute.

Figure 24: Poverty by Family Type, Panhandle



	Total number of households	Number of households below poverty line	Percentage of households below poverty line				
			Married, related children under 18	Married, no related children under 18	Single Male, with related children under 18	Single Female, with related children under 18	Other Family, no related children under 18
Banner County	207	5	0.0%	0.0%	0.0%	100.0%	0.0%
Box Butte County	2,962	264	13.6%	29.2%	14.4%	39.4%	3.4%
Cheyenne County	2,373	172	1.7%	33.1%	22.7%	34.3%	8.1%
Dawes County	2,065	184	21.7%	4.3%	6.5%	58.2%	9.2%
Deuel County	563	27	29.6%	11.1%	0.0%	44.4%	14.8%
Garden County	530	41	7.3%	56.1%	7.3%	14.6%	14.6%
Grant County	178	18	44.4%	27.8%	0.0%	27.8%	0.0%
Kimball County	987	80	7.5%	16.3%	17.5%	38.8%	20%
Morrill County	1,143	57	24.6%	33.3%	1.8%	28.1%	12.3%
Scotts Bluff County	9,386	888	11.5%	19.1%	12.4%	43.0%	14.0%
Sheridan County	1,446	134	50.0%	0.0%	3.0%	47.0%	2.7%
Sioux County	374	13	38.5%	30.8%	0.0%	7.7%	23.1%
Panhandle	**22214**	**1883**	**15.5%**	**20.1%**	**11.7%**	**41.9%**	**10.6%**
Nebraska	**488,849**	**32,413**	**21.2%**	**15.5%**	**8.7%**	**47.2%**	**7.5%**

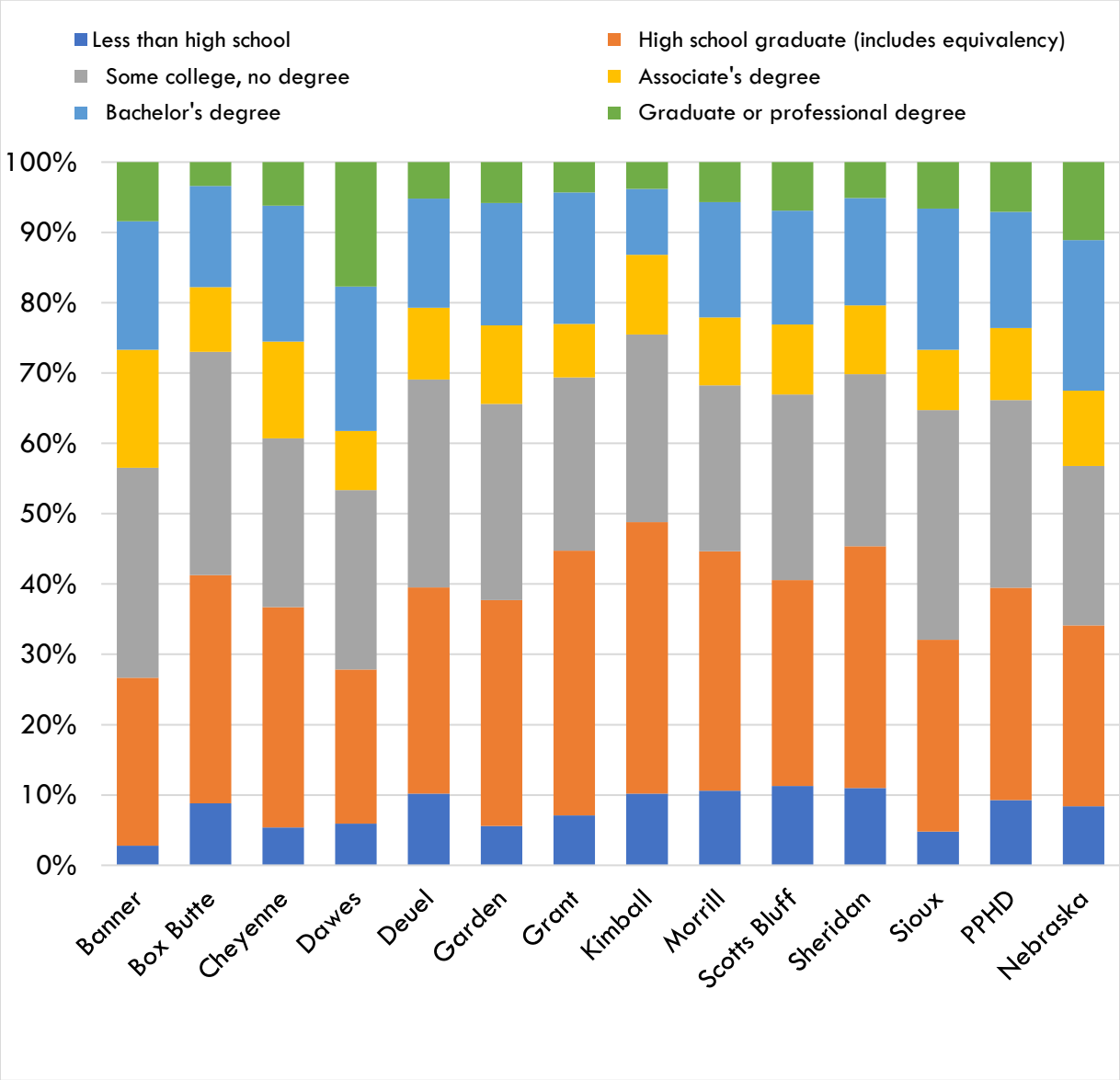
Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-year Estimates. Prepared By Megan Barhafer, Panhandle Public Health District.

EDUCATION

EDUCATIONAL ATTAINMENT

The Panhandle area has a lower level of educational attainment than the state average. Many of the jobs available in the region are in agriculture, transportation, and manufacturing and do not require a bachelor's degree. Dawes County is the exception where the presence of Chadron State College likely increases the percentage of the population with advanced degrees.

Figure 25: Educational Attainment, Panhandle, Population 25 Years and Over



Source: 2016-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District.

The 4-year graduation rate across the state of Nebraska for the 2021-2022 school year was 87%. Of public schools in the Educational Service Unit (ESU) 13 service area in the Panhandle, several have an average graduation rate below the state graduation rate: Alliance and Minatare Public Schools.

The table below shows the graduation rate in each school district over the past 7 years. The final column shows the school's average graduation rate over the same period.

Figure 26: 4-Year Graduation Rate, Panhandle Public Schools and Nebraska

	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	Avg.
Alliance Public Schools	89%	84%	83%	81%	83%	84%	85%	84%
Banner County Public Schools	NA	NA	NA	NA	NA	NA	NA	NA
Bayard Public Schools	100%	88%	100%	89%	83%	97%	90%	92%
Bridgeport Public Schools	89%	87%	92%	98%	94%	87%	94%	92%
Chadron Public Schools	90%	95%	96%	92%	97%	93%	95%	94%
Crawford Public Schools	94%	92%	86%	94%	100%	79%	94%	91%
Creek Valley Schools	91%	95%	87%	NA	100%	81%	88%	90%
Garden County Schools	100%	100%	100%	96%	96%	100%	89%	97%
Gering Public Schools	88%	87%	91%	91%	87%	88%	91%	89%
Gordon-Rushville Public Schools	92%	91%	94%	97%	98%	92%	80%	92%
Hay Springs Public Schools	100%	83%	92%	NA	NA	79%	91%	89%
Hemingford Public Schools	88%	97%	89%	96%	100%	100%	94%	95%
Hyannis Area Schools	100%	100%	100%	87%	NA	85%	100%	95%
Kimball Public Schools	98%	94%	89%	92%	85%	100%	85%	92%
Leyton Public Schools	100%	100%	100%	92%	93%	85%	93%	95%
Minatare Public Schools	NA	93%	100%	93%	86%	85%	60%	86%
Mitchell Public Schools	95%	95%	92%	86%	91%	93%	93%	92%
Morrill Public Schools	83%	90%	96%	96%	89%	97%	86%	91%
Potter-Dix Public Schools	93%	85%	NA	94%	NA	94%	NA	92%
Scottsbluff Public Schools	92%	91%	91%	91%	88%	85%	86%	89%
Sidney Public Schools	97%	95%	89%	97%	90%	91%	97%	94%
Sioux County Public Schools	NA	NA	NA	NA	NA	NA	100%	100%

Source: Nebraska Department of Education. Prepared by Megan Barhafer, Panhandle Public Health District.

EARLY CHILDHOOD EDUCATION

The number of children 5 and under with all available parents working used to be less in Panhandle counties when compared to the state of Nebraska. However, the 2016-2020 American Community Survey data shows that the Panhandle's rate of families with all available parents working has increased despite having a low number of childcare facilities.

Figure 27: Children 5 and Under with all Available Parents Working, Panhandle & Nebraska

	2008-2012		2012-2016		2016-2020	
	#	%	#	%	#	%
Banner County	25	30%	37	59%	54	71%
Box Butte County	406	52%	569	74%	633	85%
Cheyenne County	550	75%	528	68%	580	81%
Dawes County	396	75%	433	70%	554	83%
Deuel County	63	71%	94	83%	102	85%
Garden County	142	100%	101	92%	56	64%
Grant County	27	75%	22	49%	43	73%
Kimball County	162	61%	227	76%	118	79%
Morrill County	193	59%	205	79%	266	81%
Scotts Bluff County	2,170	73%	1,973	69%	2099	81%
Sheridan County	208	60%	210	80%	285	75%
Sioux County	42	59%	83	82%	78	51%
Panhandle	4384	69%	4482	71%	4868	80%
Nebraska	**112,004**	**74%**	**110,101**	**72%**	**172929**	**78%**

Source: U.S. Census Bureau, 2012, 2016, 2020 American Community Survey 5-Year Estimates. Prepared By Megan Barhafer, Panhandle Public Health District

There are three head start and early head start grantees that serve Panhandle counties: Northwest Community Action Partnership, Migrant and Seasonal Head Start, and Educational Service Unit (ESU) 13. These grantees served a total of 628 children in the 2021/2022 year. Sioux, Banner, and Grant Counties are not served by any head start or early head start programs. The Migrant and Seasonal Head Start program in Scottsbluff has seen the starkest decreases in their enrollment. The program has cited declining numbers of seasonal workers as the primary reason for this drop.

Figure 28: Panhandle Children Served by Head Start/Early Head Start

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Northwest Community Action Partnership	258	258	258	258	247	270	246	264	304
Migrant and Seasonal Head Start	46	65	65	65	49	33	54	31	38
Educational Service Unit 13	350	350	350	350	316	316	316	286	286
Total Served	**654**	**673**	**673**	**673**	**612**	**619**	**616**	**581**	**628**

There are 118 licensed childcare facilities in the Panhandle. This number has dropped since 2019. The table below shows total capacity. However, just because a facility is licensed to serve that many children doesn't mean that they have the staffing capacity to actually serve them. 628 spots are available through Head Start or Early Head Start and 3594 children are served through licensed childcare facilities.

Figure 29: Licensed Childcare and Preschool Programs in Nebraska Panhandle, as of March 2023

	Number of Facilities	Total Capacity
Banner County	0	0
Box Butte County	16	266
Cheyenne County	8	625
Dawes County	18	301
Deuel County	3	59
Garden County	3	84
Grant County	1	16
Kimball County	3	32
Morrill County	8	201
Scotts Bluff County	49	1,858
Sheridan County	9	152
Sioux County	0	0
Panhandle	**118**	**3,594**

Source: Roster Of Licensed Childcare And Preschool Programs In Nebraska, Nebraska DHHS. Prepared By Megan Barhafer, Panhandle Public Health District

GAPS IN EARLY CHILDCARE

Childcare is cited as a contributing factor to overall economic health of a region both in terms of providing opportunities for parents to send their children somewhere while they work and in terms of early brain development for the child.[3]

ROOTED IN RELATIONSHIPS

As of June 2023, four counties implemented Rooted in Relationships (RiR) programs. Scotts Bluff acts as the Community Collaborative Hub for this work, where there is one cohort. Additional statistics for this program can be found in Figure 30.

[3] (First Five Nebraska 2023)

Sixpence Child Care Partnership Grants provide funding to grantees/contractors to offer support, coaching, training, and resources to childcare programs serving infants and toddlers. Partners in Sixpence Sprouting Success (the Child Care Partnership program in the Panhandle) must be willing to serve children enrolled in childcare subsidy and must strive to serve at-risk children for at least 50% of their roster. There are 19 programs engaged with Sixpence coaches and of these programs, 12 have received a step up to quality rating of 3 or higher. Eight new programs will participate in this program starting in July. This program is in Dawes, Box Butte, Scotts Bluff, Morrill, and Kimball Counties.

Figure 30: Impact of Rooted Relationships in the Panhandle as of 6/30/2023

Programs engaged with coaches	5
Number of families served directly	111
Number of children served directly	120
Programs starting in July 2023	5

Source: Rooted In Relationships program coordinator. Prepared By Megan Barhafer, Panhandle Public Health District

HOUSING

AGE OF HOUSING

The age of housing stock is related to population growth and employment growth. There is less new housing stock in the Panhandle compared to Nebraska.

Figure 31: Housing Age by Year Built, Panhandle Counties

	2014 or later	2010 to 2013	2000 to 2009	1990 to 1999	1980 to 1989	1970 to 1979	1960 to 1969	1950 to 1959	1940 to 1949	1939 or earlier
Banner County	0.50%	0.80%	4.90%	7.00%	7.60%	15.40%	6.50%	22.10%	9.40%	25.80%
Box Butte County	0.30%	2.80%	5.80%	4.40%	8.60%	25.30%	6.50%	7.30%	6.80%	32.20%
Cheyenne County	3.30%	0.70%	8.00%	8.00%	6.10%	10.50%	7.40%	20.90%	10.30%	24.80%
Dawes County	2.30%	0.50%	6.30%	4.10%	5.90%	15.20%	10.20%	9.60%	7.70%	38.10%
Deuel County	0.00%	2.00%	1.40%	2.90%	4.40%	8.70%	13.20%	15.10%	13.40%	39.00%
Garden County	0.40%	1.70%	8.80%	4.00%	6.90%	7.90%	9.60%	13.60%	11.70%	35.30%
Grant County	4.60%	3.60%	7.50%	8.40%	10.30%	4.80%	17.50%	11.10%	7.00%	25.20%
Kimball County	0.40%	0.00%	4.30%	8.10%	3.40%	10.40%	15.50%	16.50%	11.00%	30.40%
Morrill County	0.40%	1.00%	3.60%	4.50%	7.30%	20.70%	10.00%	7.20%	10.80%	34.50%
Scotts Bluff County	1.30%	1.30%	7.20%	6.30%	7.00%	23.00%	14.20%	13.30%	9.40%	17.10%
Sheridan County	0.00%	0.10%	4.20%	5.60%	5.80%	12.90%	9.20%	13.60%	8.10%	40.50%
Sioux County	1.40%	2.20%	4.30%	7.90%	7.90%	9.20%	5.30%	4.10%	6.80%	50.90%
Panhandle	1.28%	1.24%	6.29%	5.89%	6.73%	18.30%	11.12%	12.82%	9.15%	27.17%
Nebraska	3.60%	2.60%	11.10%	11.60%	9.40%	15.80%	11.10%	9.50%	4.80%	20.10%

Source: U.S. Census Bureau, 2015-2020 American Community Survey 5-Year Estimates. Prepared By Megan Barhafer, Panhandle Public Health District.

Housing stock built before 1979 is more common in rural areas such as the Panhandle. Lead in residential paints was banned in 1978, which means houses built in 1978 or earlier are more likely to contain lead-based paint, which can lead to lead poisoning in children. It is more common for low-income peoples or people of color to live in older housing, due to affordability, which contributes to disproportionate lead poisoning in these populations.

Lead poisoning is highly toxic to young children under the age of six and interferes with brain and organ development. The negative impacts of lead poisoning are irreversible. There are methods of lead abatement that can prevent these impacts.

Figure 32: Pre-1979 Housing Stock, Panhandle Counties

Banner County	79.20%
Box Butte County	78.10%
Cheyenne County	73.90%
Dawes County	80.80%
Deuel County	89.40%
Garden County	78.10%
Grant County	65.60%
Kimball County	83.80%
Morrill County	83.20%
Scotts Bluff County	77.00%
Sheridan County	84.30%
Sioux County	76.30%
Panhandle	78.56%
Nebraska	61.30%

Source: U.S. Census Bureau, 2015-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District

HOUSING TENURE

The majority of housing in the Panhandle is owner-occupied, with higher percentages of owner-occupied housing units compared to the overall state of Nebraska. Dawes County's percentage of owner-occupied housing units is 63.5%, due to the renting college population in the Chadron community. However, Sioux County and Sheridan County both experience lower rates of home ownership as well and do not have a college community. Garden County has the highest percentage of owner-occupied housing units, at 80.4%.

Figure 33: Housing Tenure, Panhandle Communities

	Occupied housing units	Owner-occupied	Renter-occupied
Banner County	234	69.20%	30.80%
Box Butte County	4,601	71.20%	28.80%
Cheyenne County	4,403	66.00%	34.00%
Dawes County	3,555	63.50%	36.50%
Deuel County	823	78.40%	21.60%
Garden County	929	76.50%	23.50%
Grant County	297	69.00%	31.00%
Kimball County	1,612	69.00%	31.00%
Morrill County	1,969	75.20%	24.80%
Scotts Bluff County	14,657	66.70%	33.30%
Sheridan County	2,312	64.80%	35.20%
Sioux County	530	62.30%	37.70%
Nebraska	766,663	66.20%	33.80%

Source: U.S. Census Bureau, 2015-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District

EXCESSIVE HOUSING COST BURDEN

Housing costs that exceed 30% of household income are typically viewed as an indicator of housing affordability problems. Across Panhandle counties, there are significantly more renters than owners at lower income levels for whom housing costs are 30% or more of their household incomes. Dawes County has the highest rate of renter-occupied households with income less than $20,000 whose housing costs make up more than 30% of their household income. This is likely related to the large college population in the Chadron area. Banner, Garden, Grant, and Sioux counties have the lowest rates of renter-occupied households with income less than $20,000 whose housing costs make up more than 30% of their household income. Sheridan and Grant Counties have higher rates of owner-occupied housing units with housing costs making up more than 30% of their household income compared to renter-occupied units. This may be related to less rental units being available in these communities.

Figure 34: Housing Tenure, Panhandle Communities

	Less than $20,000	$20,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 or more
Banner County					
Owner-occupied	3.7%	5.6%	0%	2.5%	1.2%
Renter-occupied	9.7%	0.0%	6.9%	0.0%	0.0%
Box Butte County					
Owner-occupied	6.6%	2.2%	2.1%	2.9%	0.9%
Renter-occupied	19.6%	14.3%	1.5%	0.0%	0.0%
Cheyenne County					
Owner-occupied	9.9%	2.8%	3.6%	1.7%	1.9%
Renter-occupied	18.4%	16.5%	1.7%	0.0%	0.0%
Dawes County					
Owner-occupied	6.5%	1.5%	2.5%	0.7%	0.8%
Renter-occupied	26.0%	7.9%	0.0%	1.4%	0.0%
Deuel County					
Owner-occupied	2.7%	3.9%	2.4%	0.7%	0.5%
Renter-occupied	14.6%	9.0%	0.0%	0.0%	0.0%
Garden County					
Owner-occupied	7.5%	8.4%	2.3%	0.0%	0.0%
Renter-occupied	9.6%	9.6%	0.0%	0.0%	0.0%
Grant County					
Owner-occupied	18.5%	3.4%	4.4%	1.5%	0.0%
Renter-occupied	0.0%	10.9%	0.0%	0.0%	0.0%
Kimball County					
Owner-occupied	5.6%	6.6%	3.6%	2.2%	2.7%
Renter-occupied	24.4%	5.0%	2.2%	0.0%	0.0%
Morrill County					
Owner-occupied	3.9%	3.8%	1.4%	1.7%	0.5%
Renter-occupied	17.8%	8.0%	0.0%	0.0%	0.0%
Scotts Bluff County					
Owner-occupied	8.9%	3.8%	5.0%	2.5%	1.2%
Renter-occupied	21.0%	14.9%	3.7%	2.8%	0.0%
Sheridan County					
Owner-occupied	10.6%	3.3%	2.2%	0.0%	0.6%
Renter-occupied	11.4%	6.8%	2.1%	0.0%	0.0%
Sioux County					
Owner-occupied	4.5%	2.3%	6.6%	4.0%	6.6%
Renter-occupied	5.0%	0.0%	0.0%	0.0%	0.0%
Nebraska					
Owner-occupied	**5.3%**	**4.2%**	**3.2%**	**2.7%**	**1.5%**
Renter-occupied	**17.6%**	**13.7%**	**5.1%**	**1.7%**	**0.2%**

Source: U.S. Census Bureau, 2015-2020 American Community Survey 5-Year Estimates. Prepared by Megan Barhafer, Panhandle Public Health District.

CHILD WELFARE

CHILD MALTREATMENT

In 2019, seven of the eleven Panhandle counties (Banner, Box Butte, Cheyenne, Dawes, Scotts Bluff, Sheridan, Sioux) had a child maltreatment rate higher than that of the state of Nebraska (6.5 per 1,000 children). The rate of child maltreatment in Panhandle communities can vary widely year-to-year due to small county numbers, but the rate showed a large peak in 2019. The effects of the pandemic have yet to be seen as it relates to child maltreatment rates.

Figure 35: Child Maltreatment Rate* (Per 1,000 Children), Panhandle Counties

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Banner County	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	11.9
Box Butte County	7.0	14.4	7.8	3.5	3.8	2.1	2.5	9.8	6.1	11.8
Cheyenne County	5.5	6.7	6.9	3.2	3.3	4.1	2.1	3.0	7.0	7.2
Dawes County	16.0	12.0	17.5	7.8	5.4	4.3	4.3	3.9	9.3	11.9
Deuel County	2.5	21.8	4.7	9.6	2.5	2.5	2.6	10.2	2.5	2.6
Garden County	0.0	5.3	17.1	0.0	0.0	0.0	8.2	8.0	8.0	2.6
Grant County	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kimball County	7.0	15.5	19.7	14.8	8.5	0.0	6.1	5.0	6.2	4.9
Morrill County	8.2	7.4	13.4	7.6	6.7	7.6	5.1	9.6	4.5	5.7
Scotts Bluff County	17.9	21.8	17.0	6.9	9.4	10.5	9.7	8.9	5.8	7.7
Sheridan County	3.9	12.3	5.8	6.0	5.9	6.9	1.7	11.9	5.1	8.3
Sioux County	0.0	0.0	3.3	0.0	0.0	0.0	8.0	0.0	0.0	15.0
Nebraska	**11.2**	**11.4**	**9.3**	**6.2**	**5.5**	**7.9**	**7.9**	**7.6**	**6.7**	**6.5**

*Number of Substantiated Victims Of Child Maltreatment. Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Data dashboard (2020). Prepared By Megan Barhafer, Panhandle Public Health District

The rate of state wards (per 1,000 children) in some Panhandle counties has consistently remained higher than that of the state of Nebraska. Scotts Bluff County has a consistently high rate of state wards and Garden County has had very high rates since 2017. Five other counties also rose above the state rate in 2019.

Figure 36: State Wards, Rate per 1,000 Children, Panhandle Counties

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Banner County	0.0	6.7	0.0	13.8	12.4	12.3	5.7	5.7	0.0
Box Butte County	11.2	10.6	5.6	4.5	4.5	4.9	4.4	4.0	9.4
Cheyenne County	17.6	12.6	10.9	11.4	11.1	13.3	13.9	18.1	14.8
Dawes County	14.2	9.4	7.2	11.4	5.6	9.2	12.2	16.8	18.4
Deuel County	21.8	16.4	16.8	12.3	9.9	10.3	20.3	17.3	15.8
Garden County	5.3	11.4	12.1	5.9	5.7	16.4	26.6	39.8	33.9
Grant County	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Kimball County	32.2	26.6	16.0	18.3	17.5	13.4	8.8	10.0	12.3
Morrill County	9.9	7.5	8.4	5.1	3.4	6.0	9.6	11.8	12.3
Scotts Bluff County	28.2	22.6	21.2	17.9	18.4	22.2	24.0	25.1	22.9
Sheridan County	9.0	10.0	7.7	14.3	15.5	11.0	11.0	6.8	4.1
Sioux County	0.0	3.3	10.0	0.0	0.0	0.0	0.0	4.5	15.5
Nebraska	**21.2**	**20.0**	**18.2**	**16.1**	**14.4**	**15.2**	**15.0**	**13.3**	**12.4**

Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared By Megan Barhafer, Panhandle Public Health District

Removal from the home is a traumatic event for a child, with lasting impacts. To keep more children in the home with their parents, some children are involved in the child welfare system on a non-court basis. This means they stay in the home and may not have a substantiated incident of child maltreatment but are able to receive services as a measure to prevent potential future incidents of child maltreatment. In the Panhandle, Box Butte, Cheyenne, Dawes, Deuel, Garden and Sheridan counties had higher rates of children with non-court welfare involvement in 2019 when compared to that of the state.

Figure 37: Children with Non-Court Child Welfare Involvement, 2013, 2016-2019 Panhandle Counties

	2013	2016	2017	2018	2019
Banner County	0.0	0.0	0.0	0.0	0.0
Box Butte County	7.4	3.4	5.0	10.5	10.7
Cheyenne County	11.7	7.6	7.6	10.6	8.0
Dawes County	12.6	0.6	0.6	5.0	9.9
Deuel County	16.8	7.4	0.0	19.8	7.9
Garden County	6.0	16.3	13.3	13.3	28.6
Grant County	0.0	0.0	0.0	0.0	0.0
Kimball County	30.8	14.2	1.2	8.7	4.9
Morrill County	12.6	10.0	8.6	0.9	0.0
Scotts Bluff County	22.0	7.4	3.2	6.0	4.9
Sheridan County	19.6	3.4	0.8	5.1	10.8
Sioux County	0.0	0.0	0.0	0.0	0.0
Nebraska	**9.4**	**6.0**	**6.9**	**10.1**	**6.7**

Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared by Megan Barhafer, Panhandle Public Health District

GENERAL HEALTH STATUS

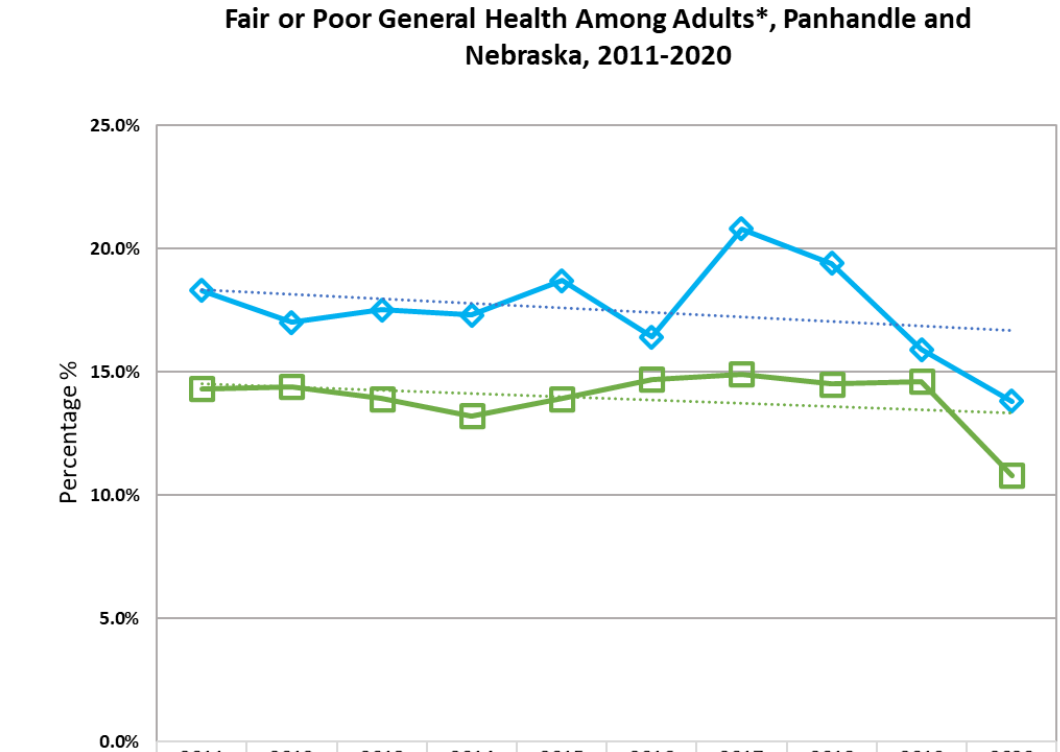
The Behavioral Risk Factors Surveillance System (BRFSS) is collected each year. Some questions are asked every other year. PPHD applied trend lines to all of the graphs this cycle to better measure the overall picture of health for each indicator. The trends tell an important story that helps to average out the effects of a survey in a small community.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.[1] PPHD did a minority health report in 2022, but, due to the pandemic race and ethnicity data was not available. This report contains race and ethnicity data averaged over 5 years. Due to the small population of the Panhandle, estimates for racial and ethnic minority groups are often not as reliable as they are in larger communities. PPHD uses these numbers as a way to prioritize our efforts.

HEALTH-RELATED QUALITY OF LIFE

The percentage of adults who report their general health as fair or poor in the Panhandle has been increasing over the years until 2018. It saw a decrease of 5.6% over 2019 & 2020. Compared to the Panhandle, the historical percentage of Nebraska is seen to be lower, while the percentage remained relatively even from 2011-2019 in Nebraska, it had a decrease in 2020 of 3.8%.

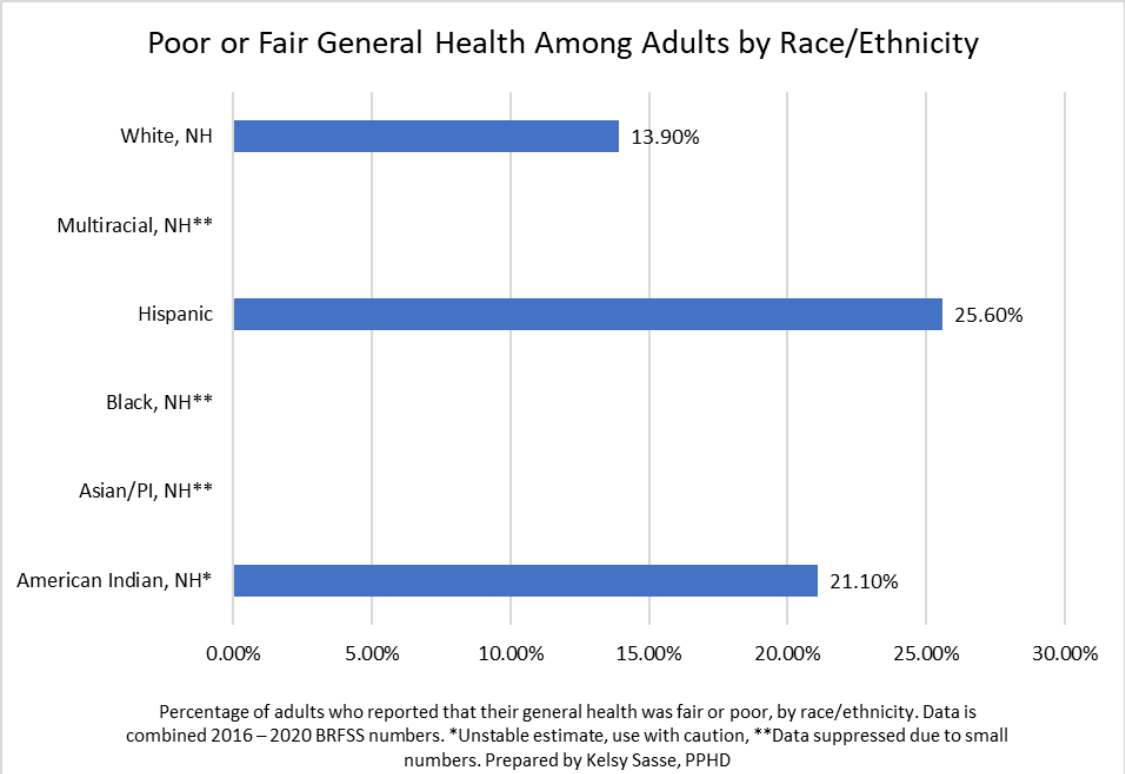
Figure 38: Fair or Poor General Health Among Adults



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	18.3%	17.0%	17.5%	17.3%	18.7%	16.4%	20.8%	19.4%	15.9%	13.8%
Nebraska	14.3%	14.4%	13.9%	13.2%	13.9%	14.7%	14.9%	14.5%	14.6%	10.8%

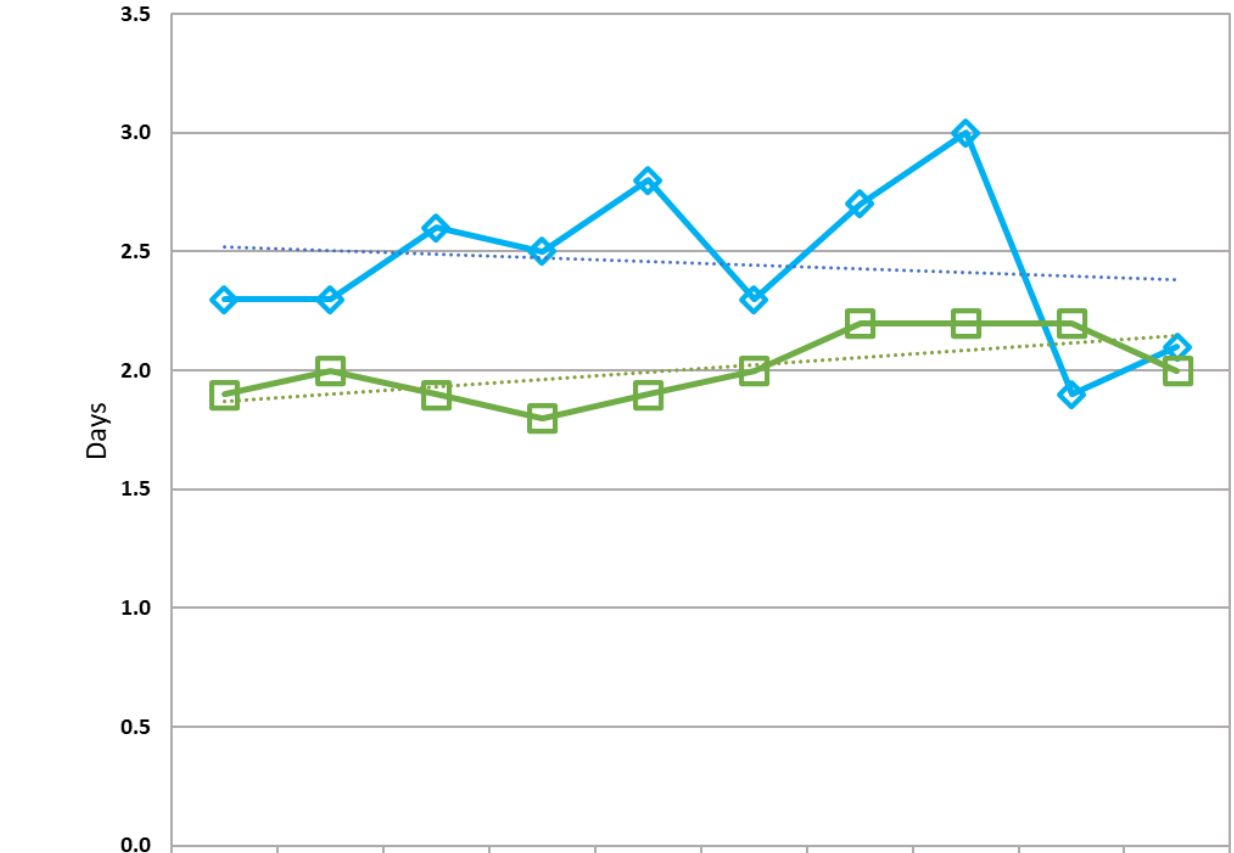
*Percentage of adults 18 and older who reported their general health is fair or poor. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 39: Fair or Poor General Health Among Adults by Race/Ethnicity



The average number of days that physical and mental health limited the usual activities of Panhandle adults in the past 30 days, has been decreasing generally over time. Nebraska's have been increasing over time. Compared to the Panhandle, Nebraska's numbers have been lower until 2019 when the Panhandle's numbers dipped below Nebraska's. Hispanic and Native American Panhandle residents indicated the highest rate of poor or fair general health.

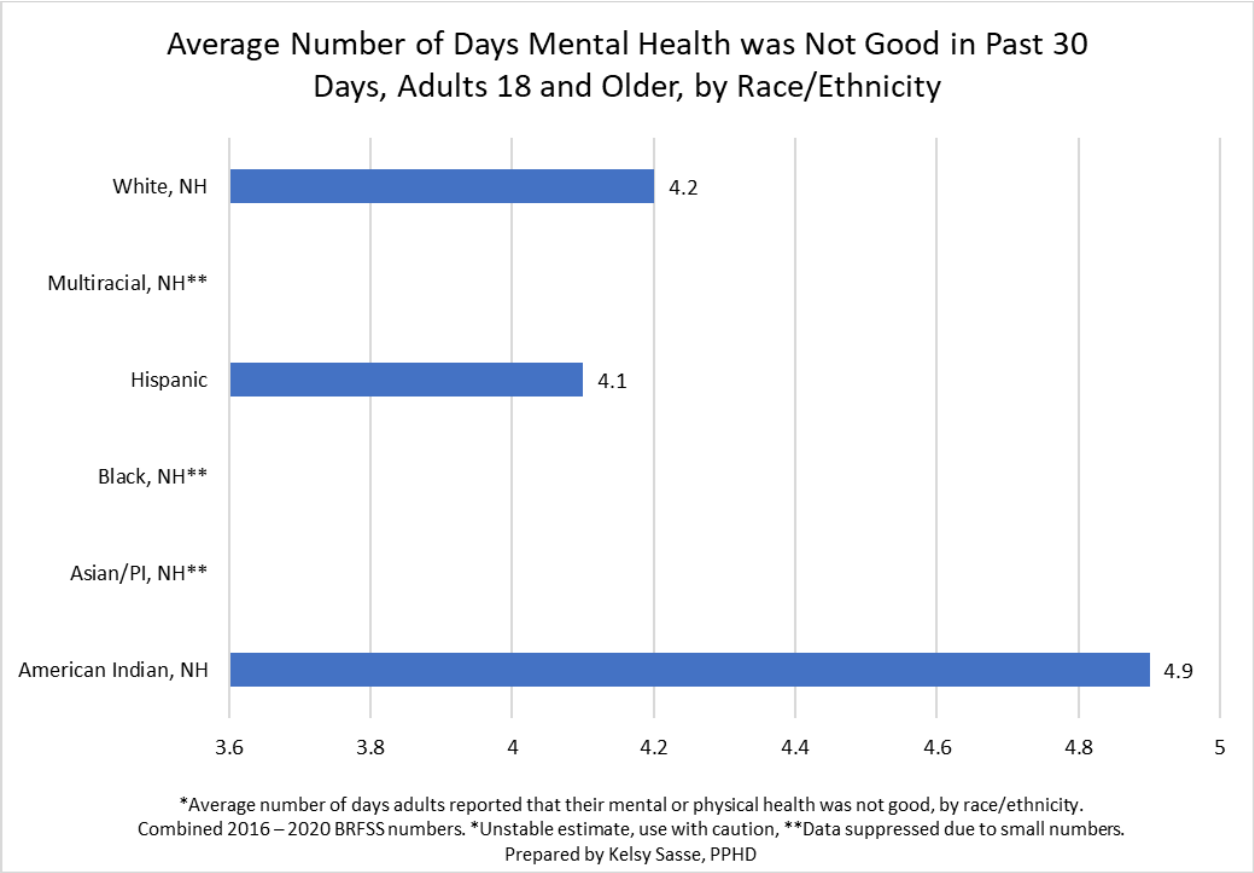
Figure 40: Average Number of Days Physical and Mental Health were not Good During the Past 30 Days



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	2.3	2.3	2.6	2.5	2.8	2.3	2.7	3.0	1.9	2.1
Nebraska	1.9	2.0	1.9	1.8	1.9	2.0	2.2	2.2	2.2	2.0

*Average number of days during the previous 30 that adults 18 or older report (1) their physical health (illness and injury) was not good and (2) their mental health (including stress, depression and emotions) was not good. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 41: Average Number of Days Physical and Mental Health were not Good During the Past 30 Days by Race/Ethnicity



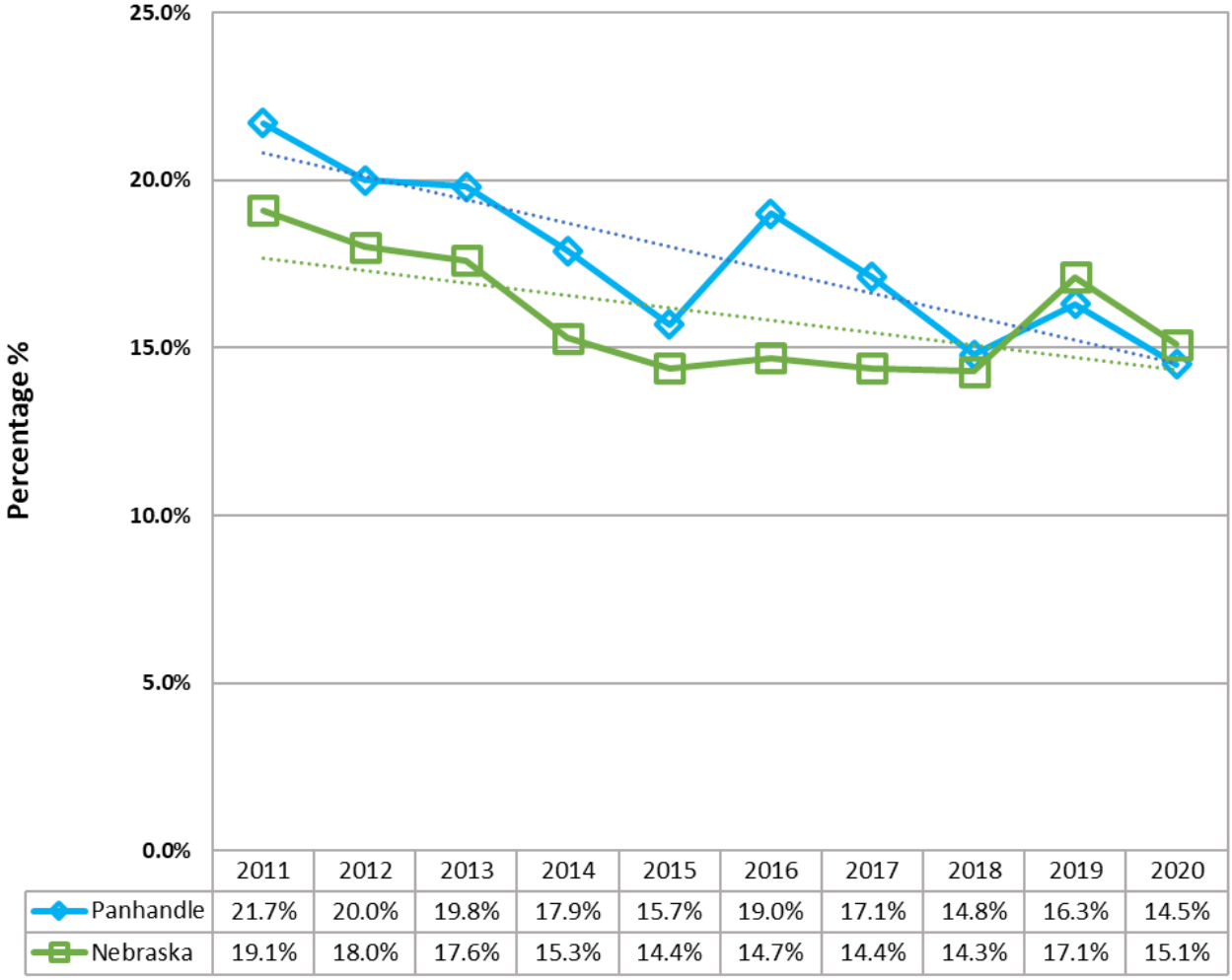
American Indian residents of the Panhandle have the highest average number of days with poor mental or physical health. On average they have an extra day per month of poor mental or physical health than Hispanic and White residents.

HEALTHCARE ACCESS AND UTILIZATION

HEALTHCARE COVERAGE

The percentage of adults who report they do not have health care coverage has decreased over the years both across the state and in the Panhandle. Compared to Nebraska, the Panhandle had a higher percentage until 2018 when the percentages became similar.

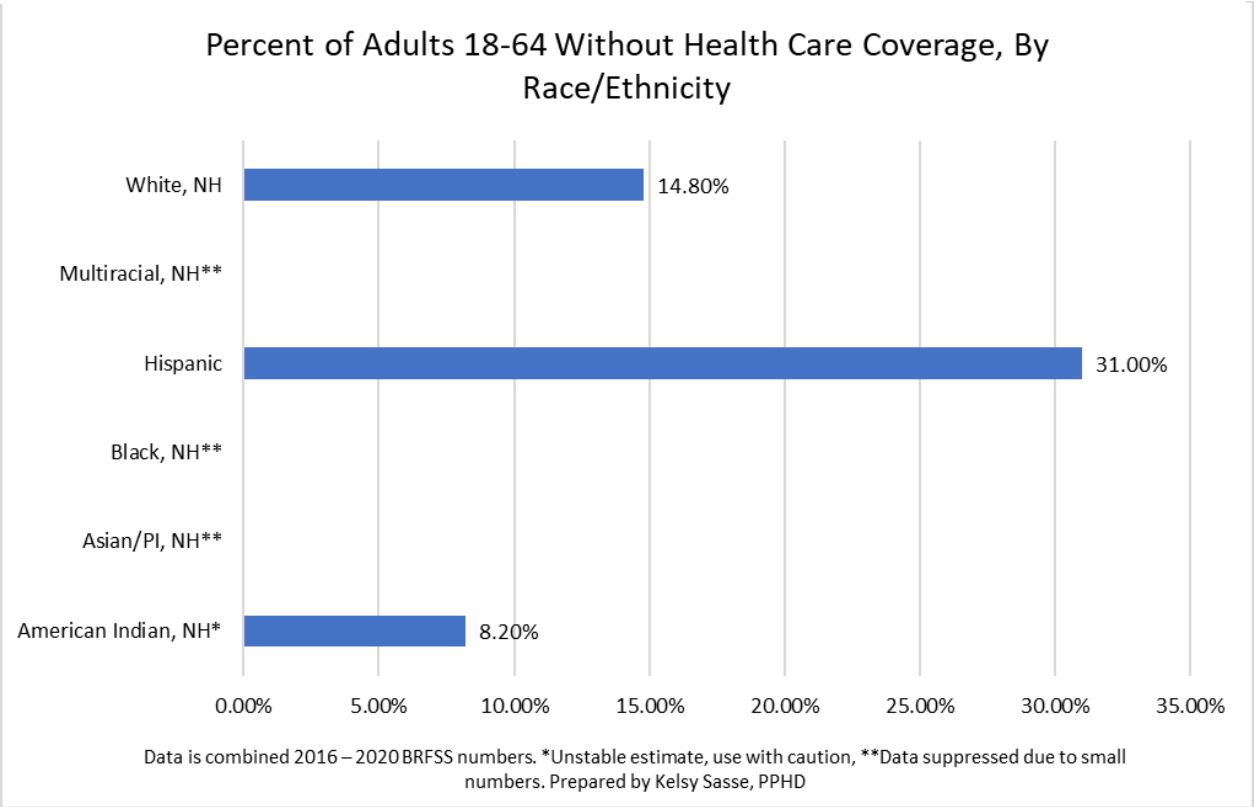
Figure 42: No Health Care Coverage Among Adults 18-64 Years Old



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	21.7%	20.0%	19.8%	17.9%	15.7%	19.0%	17.1%	14.8%	16.3%	14.5%
Nebraska	19.1%	18.0%	17.6%	15.3%	14.4%	14.7%	14.4%	14.3%	17.1%	15.1%

*Percentage of adults 18-64 years old who report that they do not have any kind of health care coverage. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 43: No Health Care Coverage Among Adults 18-64 Years by Race/Ethnicity



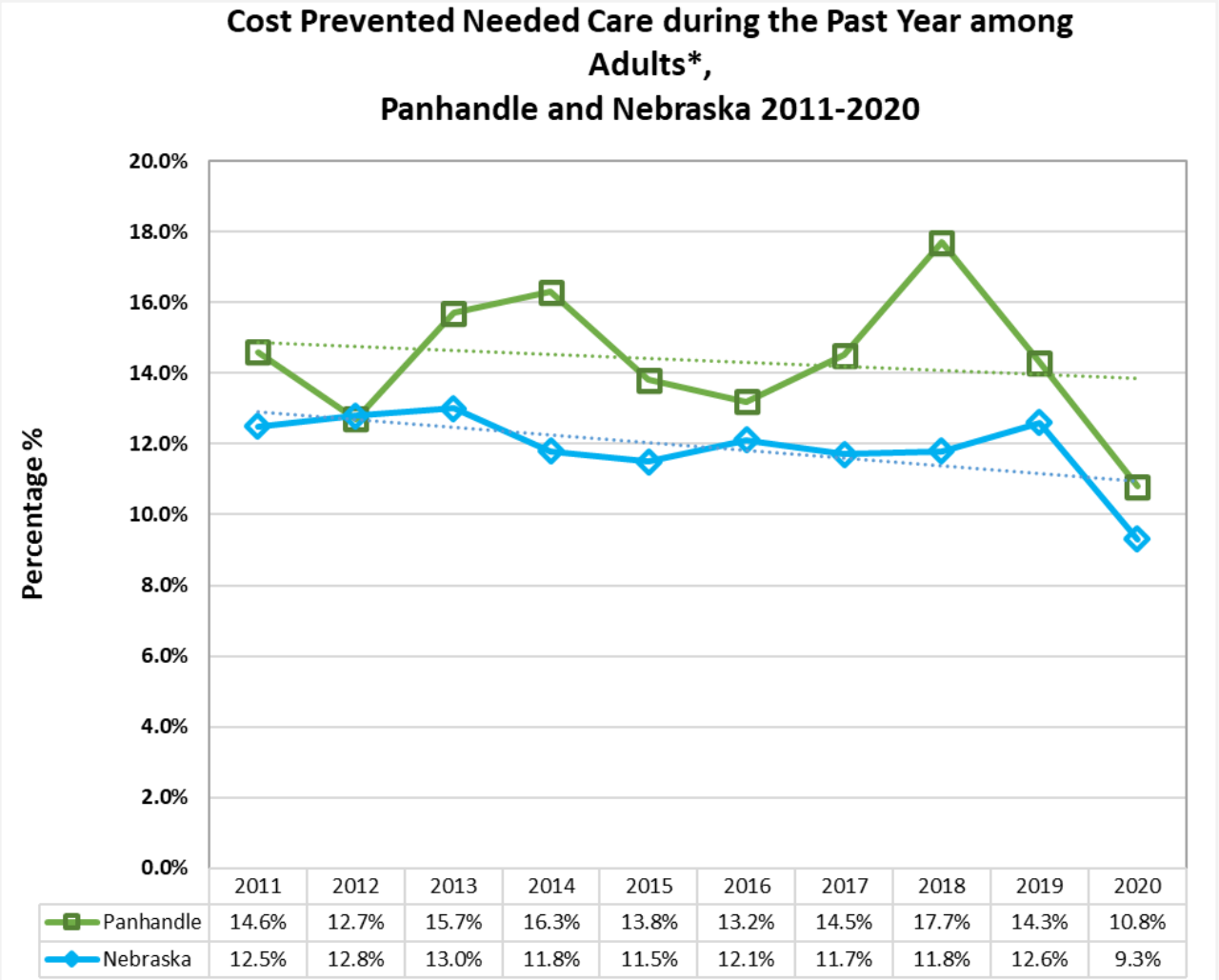
Hispanic residents of the Panhandle have the highest rate of no healthcare coverage. They are more than twice as likely to be without coverage than White Panhandle residents and more than three times as likely as American Indian residents. Most American Indian residents in the Panhandle have access to healthcare coverage through the Indian Health Services program which could explain their higher rates of coverage.

BARRIERS TO HEALTHCARE

COST AS A BARRIER TO CARE

The percentage of Panhandle adults who report they are unable to seek medical care due to cost has decreased over the years after hitting its highest point in 2018. The Panhandle had a higher percentage over the years, especially in 2013, 2014 and 2018 when compared to the state.

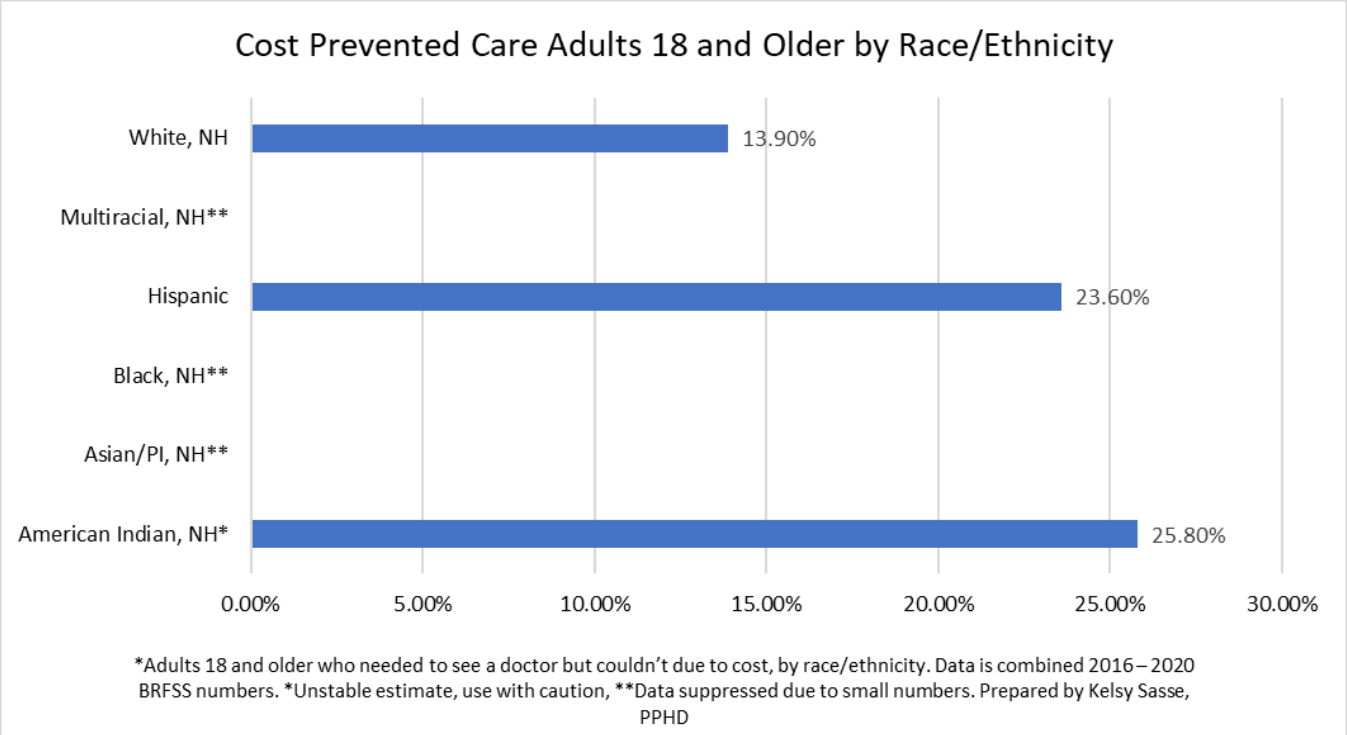
Figure 44: Cost Prevented Needed Care During the Past Year Among Adults



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	14.6%	12.7%	15.7%	16.3%	13.8%	13.2%	14.5%	17.7%	14.3%	10.8%
Nebraska	12.5%	12.8%	13.0%	11.8%	11.5%	12.1%	11.7%	11.8%	12.6%	9.3%

*Percentage of adults who report that they do not have any kind of health care coverage. Data from 2011-2020 Nebraska Behavioral Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public health District.

Figure 45: Cost Prevented Needed Care During the Past Year Among Adults by Race/Ethnicity

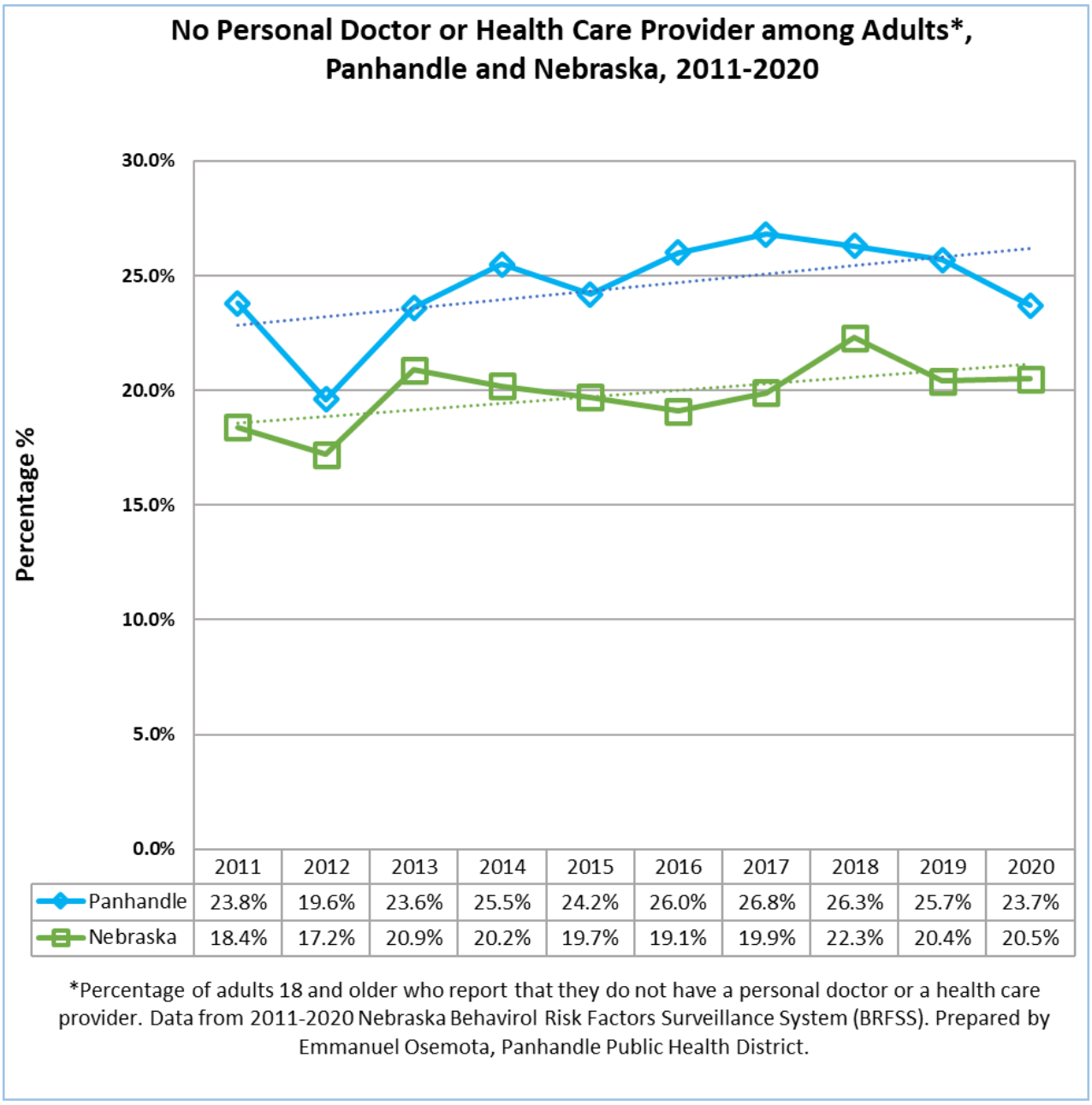


American Indian residents of the Panhandle are most likely to have not been able to see a doctor due to cost in the past year.

LACK OF PERSONAL HEALTHCARE PROVIDER

The Panhandle has an increasing number of adults who don't have a personal doctor or health care provider. Some statements made in the community health survey indicate that part of this problem is due to the high turnover of providers at some of the facilities. The percentage of adults without personal doctors in the Panhandle has remained higher than in Nebraska.

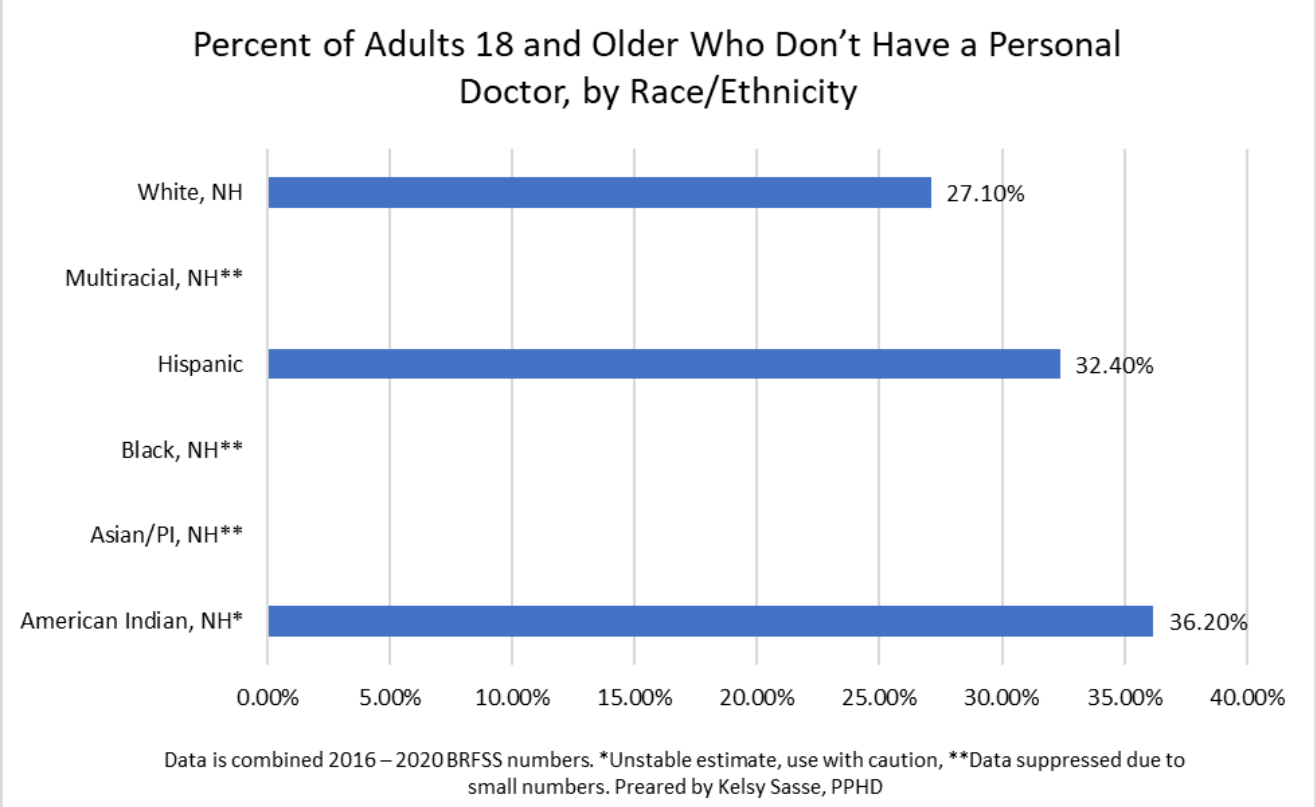
Figure 46: No Personal Doctor or Health Care Provider among Adults



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	23.8%	19.6%	23.6%	25.5%	24.2%	26.0%	26.8%	26.3%	25.7%	23.7%
Nebraska	18.4%	17.2%	20.9%	20.2%	19.7%	19.1%	19.9%	22.3%	20.4%	20.5%

*Percentage of adults 18 and older who report that they do not have a personal doctor or a health care provider. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 47: No Personal Doctor or Health Care Provider among Adults by Race/Ethnicity



American Indian residents of the Panhandle are most likely not to have a personal doctor, followed by Hispanic residents.

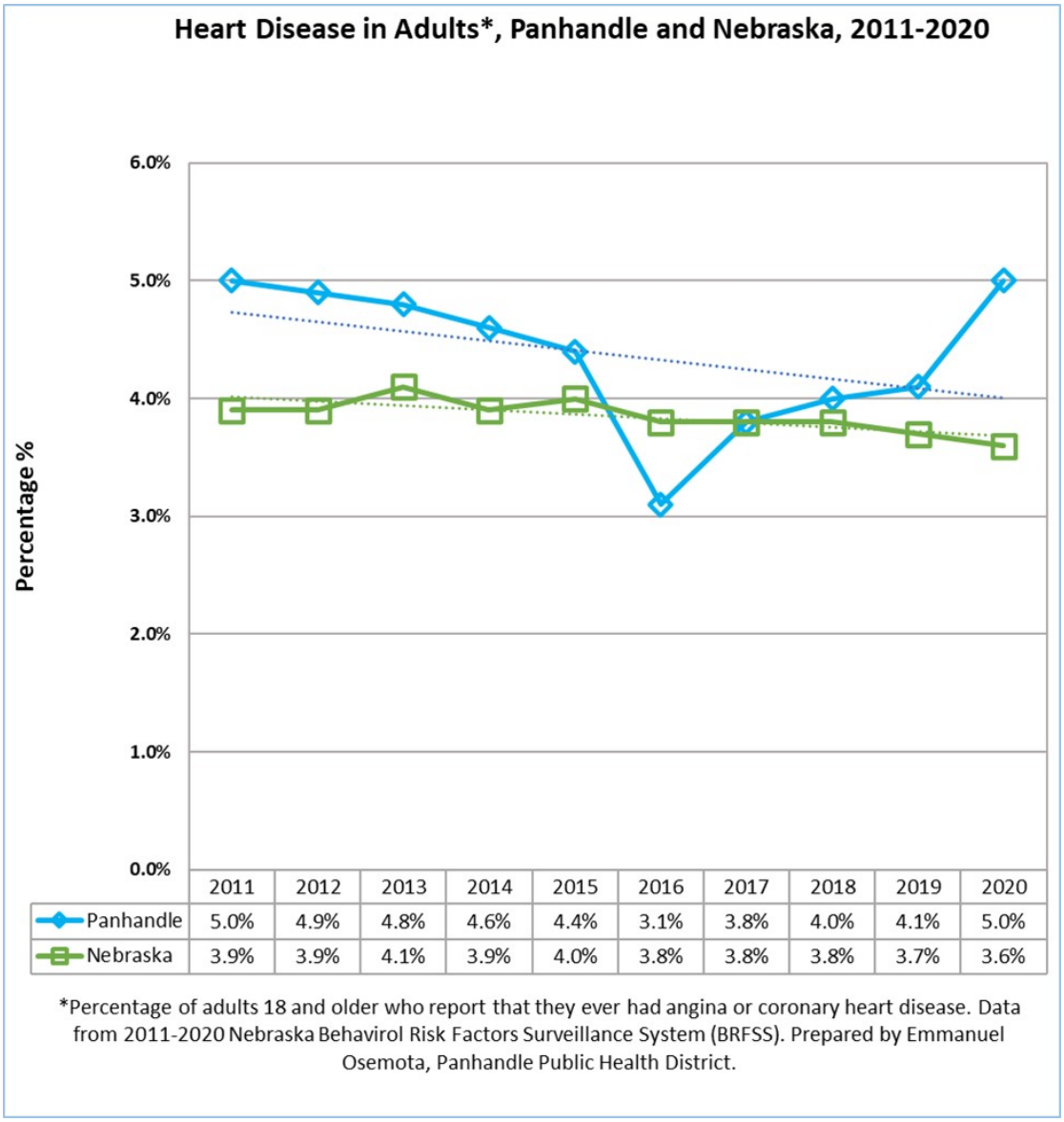
CHRONIC DISEASE

CARDIOVASCULAR DISEASE

Heart disease is the leading cause of death across the world and the United States. In the United States, one person dies every 37 seconds from heart disease.[4]

The trend in heart disease rates has been decreasing over time in the Panhandle and across the state. However, after a dip in 2016 there has been an upward trend in heart disease rates. As for Nebraska, the percentage rate has decreased and was seen to have the lowest rate in 2020.

Figure 48: Heart Disease in Adults



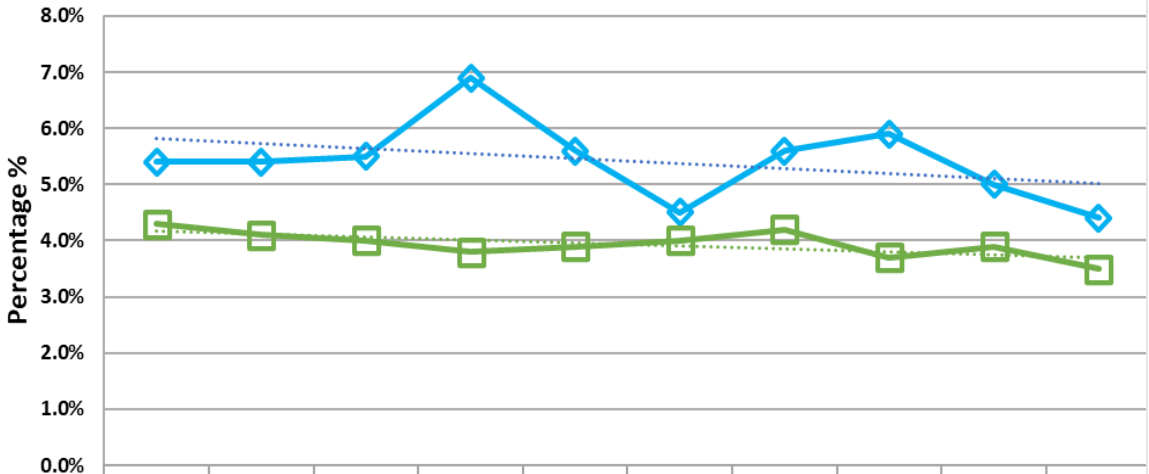
Compared to Nebraska, the Panhandle has had higher rates in every year except 2016 and 2017.

[4] (CDC 2020)

HEART ATTACKS

The percentage of adults with a heart attack has decreased in Nebraska and the Panhandle. Nebraska's heart attack rates have been historically lower than in the Panhandle.

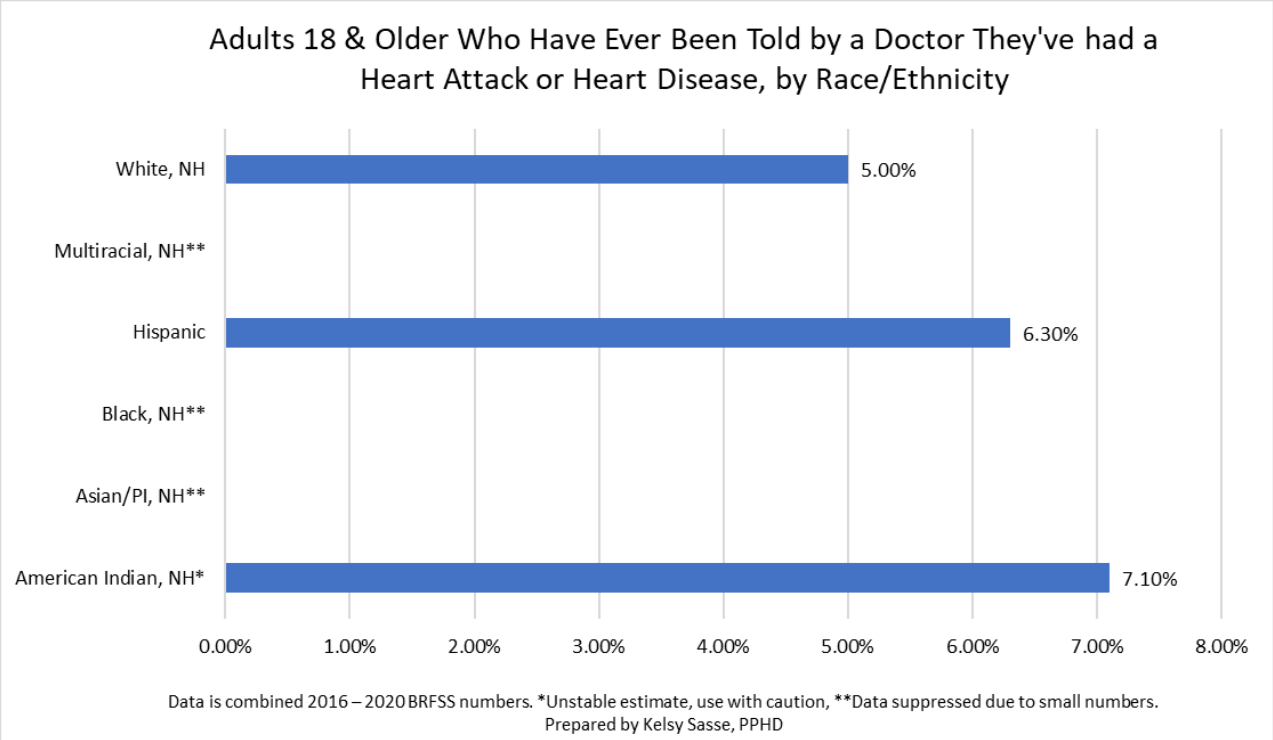
Figure 49: Heart Attacks in Adults, Panhandle and Nebraska



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	5.4%	5.4%	5.5%	6.9%	5.6%	4.5%	5.6%	5.9%	5.0%	4.4%
Nebraska	4.3%	4.1%	4.0%	3.8%	3.9%	4.0%	4.2%	3.7%	3.9%	3.5%

*Percentage of adults 18 and older who report that they have ever been told by a doctor, nurse or other health professional that they had a heart attack. Data from 2011-2020 Nebraska Behavioral Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health Distict.

Figure 50: Heart Attacks in Adults by Race/Ethnicity



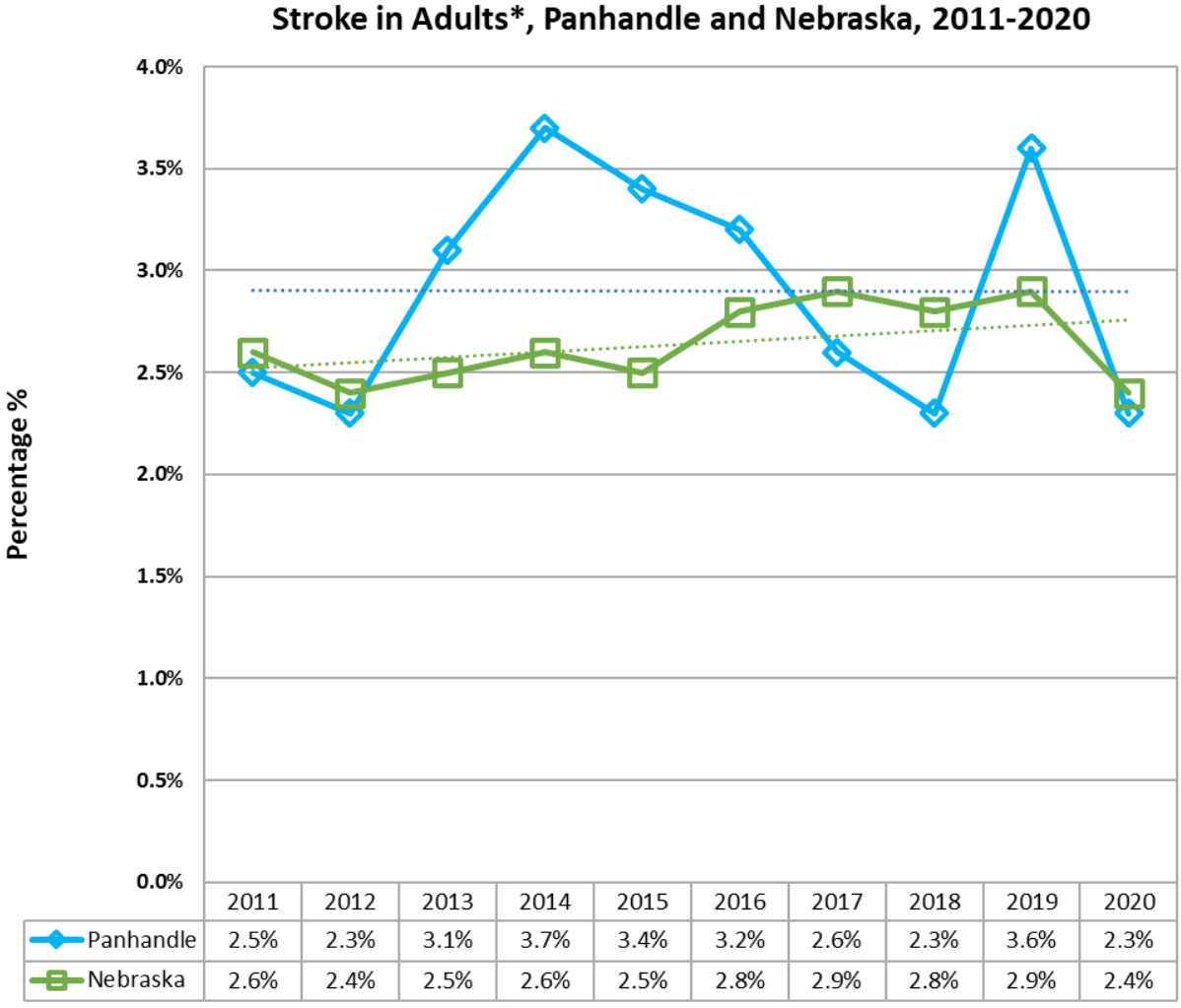
American Indian residents of the Panhandle are most likely to have had a heart attack or been diagnosed with heart disease.

STROKE

Stroke is a type of heart disease where blood supply to a part of the brain is blocked, or when a blood vessel in the brain bursts. This leads to brain damage and can cause severe disability or even death.[5]

The rate of Panhandle adults who report they ever had a stroke has been going up and down, with 2014 having the highest and 2020 having the lowest rates. This fluctuation has resulted in a stable trend in the rates over time. As for Nebraska, it has an increasing trend in the rates, with 2020 having the lowest rate.

Figure 51: Stroke in Adults

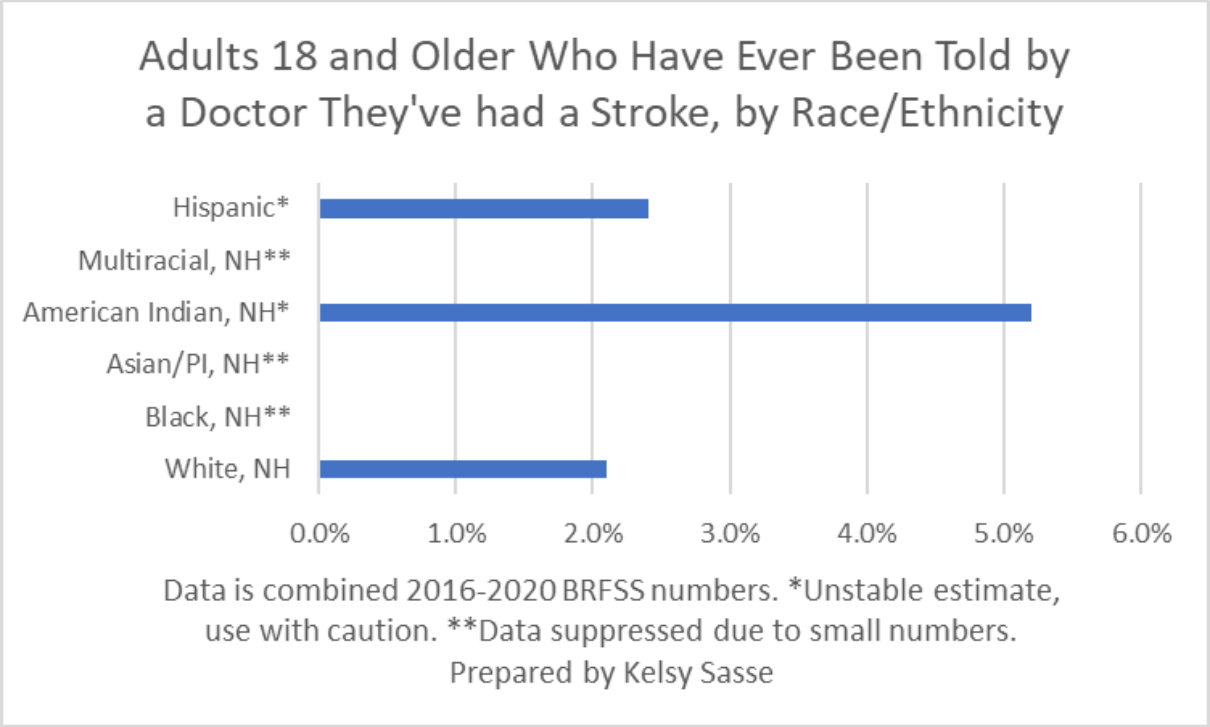


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	2.5%	2.3%	3.1%	3.7%	3.4%	3.2%	2.6%	2.3%	3.6%	2.3%
Nebraska	2.6%	2.4%	2.5%	2.6%	2.5%	2.8%	2.9%	2.8%	2.9%	2.4%

*Percentage of adults 18 and older who report they were ever told that they had a stroke. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

[5] (CDC 2020)

Figure 52: Stroke in Adults by Race/Ethnicity



American Indian Panhandle residents are most likely to have had a stroke. Hispanic Panhandle residents are slightly more likely than White residents.

CLINICAL RISK FACTORS FOR HEART DISEASE

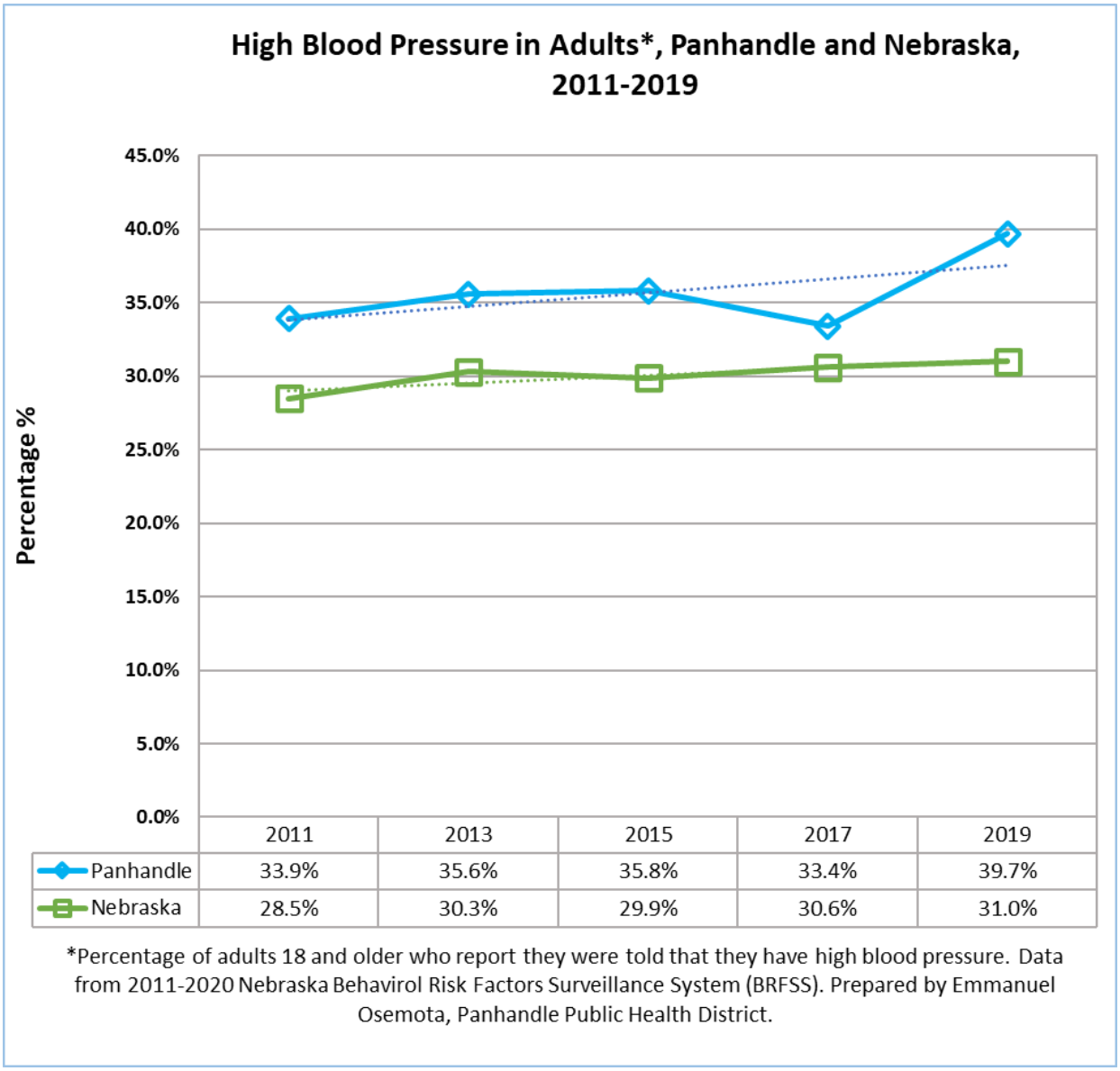
HIGH BLOODO PRESSURE (HYPERTENSION)

High blood pressure (hypertension) is a risk factor for heart disease. Almost half of US adults have high blood pressure and only about 25% of these people have their high blood pressure under control.[6]

The percentage of adults who report having high blood pressure has generally increased over time and 2019 was seen to have the highest rates in both the Panhandle and Nebraska as a whole. Compared to Nebraska, the Panhandle has higher rates.

[6] (CDC 2020)

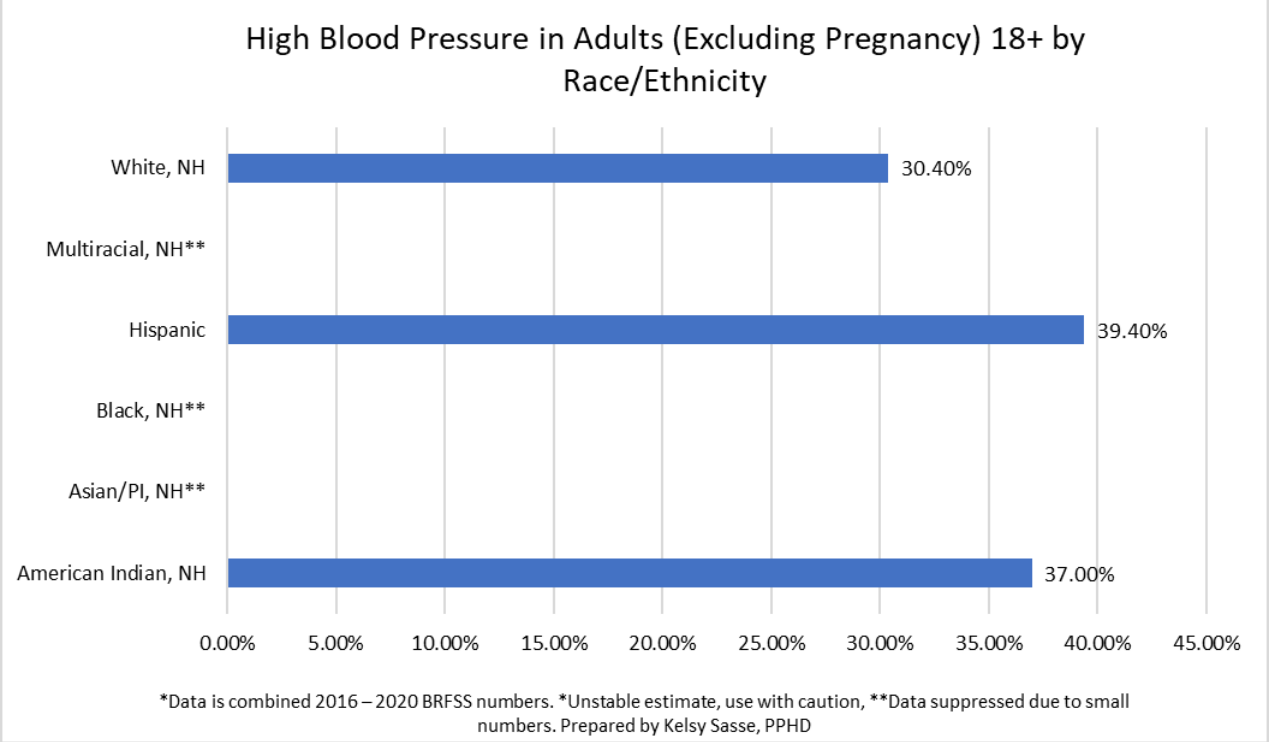
Figure 53: High Blood Pressure in Adults



	2011	2013	2015	2017	2019
Panhandle	33.9%	35.6%	35.8%	33.4%	39.7%
Nebraska	28.5%	30.3%	29.9%	30.6%	31.0%

*Percentage of adults 18 and older who report they were told that they have high blood pressure. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 54: High Blood Pressure in Adults by Race/Ethnicity



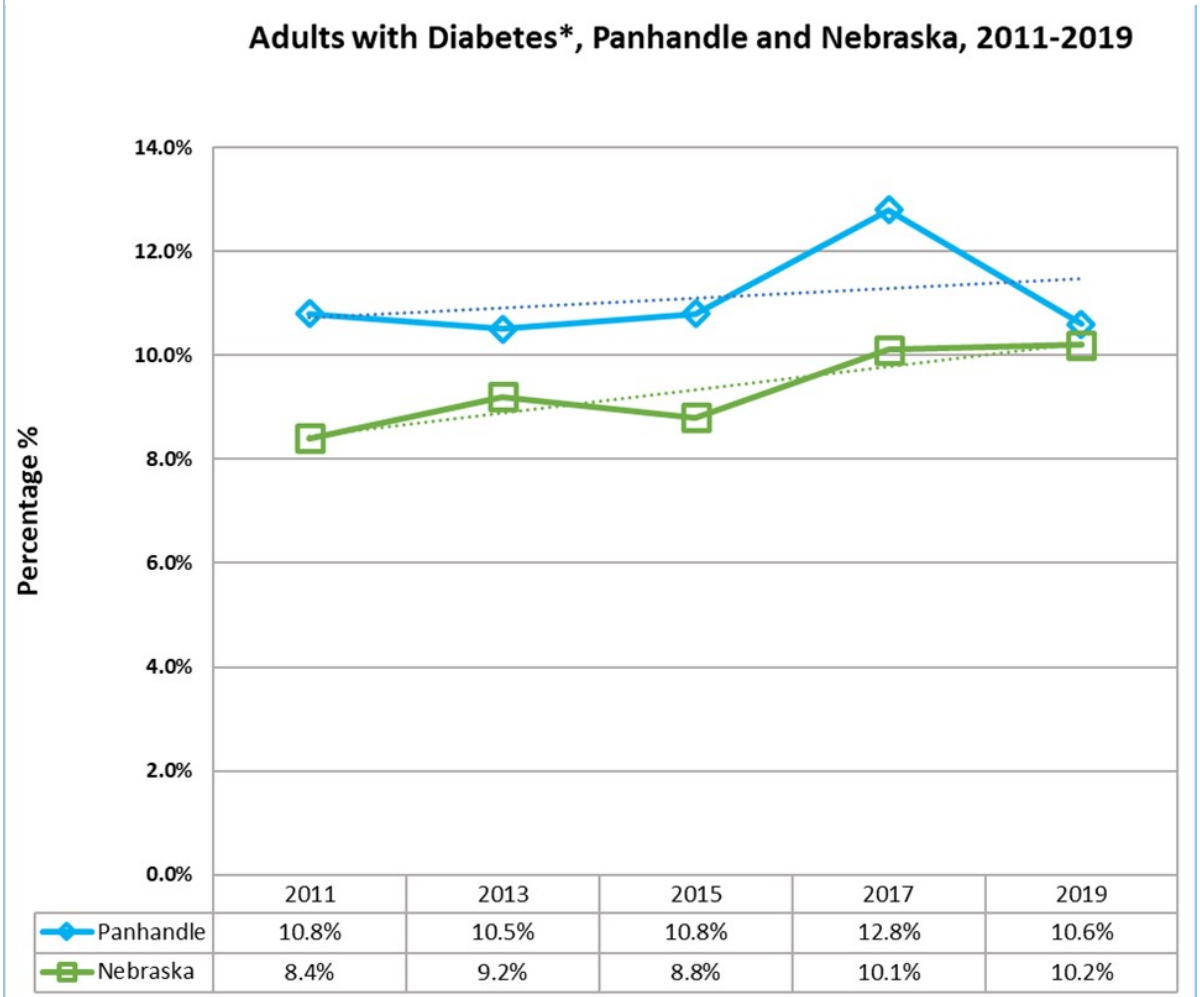
Hispanic residents of the Panhandle are most likely to have ever been told they have high blood pressure. American Indian residents are also more likely than White residents to have been told they have high blood pressure.

Several programs offered in the Panhandle benefit those with high blood pressure. The National Diabetes Prevention Program is an appropriate program for those with high blood pressure and helps participants develop a healthy diet and exercise habits. Living Well, a chronic-disease self-management program, can help people manage medications, deal with stress from a chronic condition, and eat well and exercise.

DIABETES

Diabetes is a chronic illness in which blood glucose levels are above normal. There are two types of diabetes: type 1 and type 2. Type 1 diabetes, often referred to as juvenile-onset diabetes, occurs when the body cannot produce its own insulin, and makes up 5-10% of diagnosed diabetes cases. Type 2 diabetes, also known as adult-onset diabetes, makes up 90-95% of diagnosed diabetes cases. Gestational diabetes is a form of diabetes that occurs in pregnant women, but often disappears when pregnancy ends.[7]

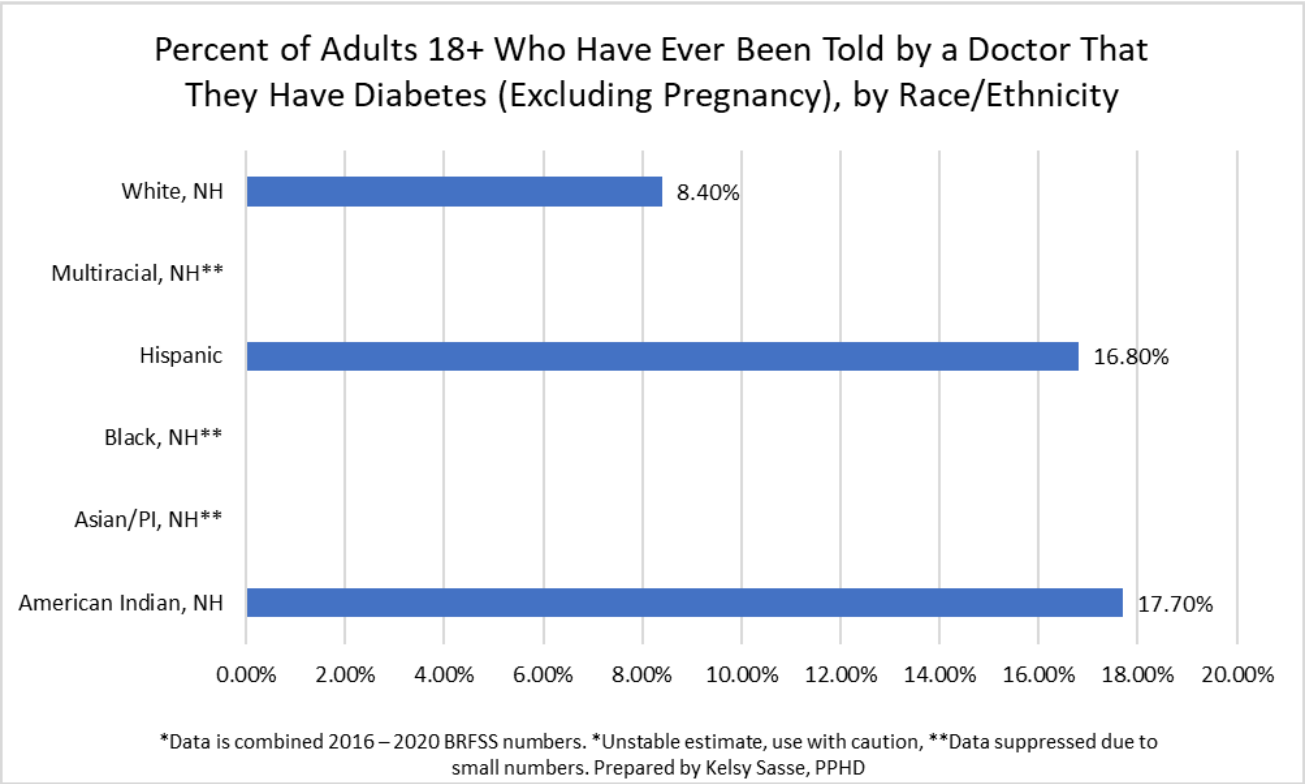
Figure 55: Adults with Diabetes



The rate of diabetes in adults has increased in Nebraska and in the Panhandle over time. Promisingly, in the Panhandle it has decreased between 2017 and 2019. More data is needed to see whether this trend will continue. Even though the Panhandle had a decrease in the most recent year, it still has higher rates than Nebraska.

[7] (CDC 2020)

Figure 56: Adults with Diabetes by Race/Ethnicity



American Indian residents and Hispanic residents of the Panhandle are most likely to have ever been told they have diabetes. Both groups are about twice as likely as White residents to have been told they have diabetes.

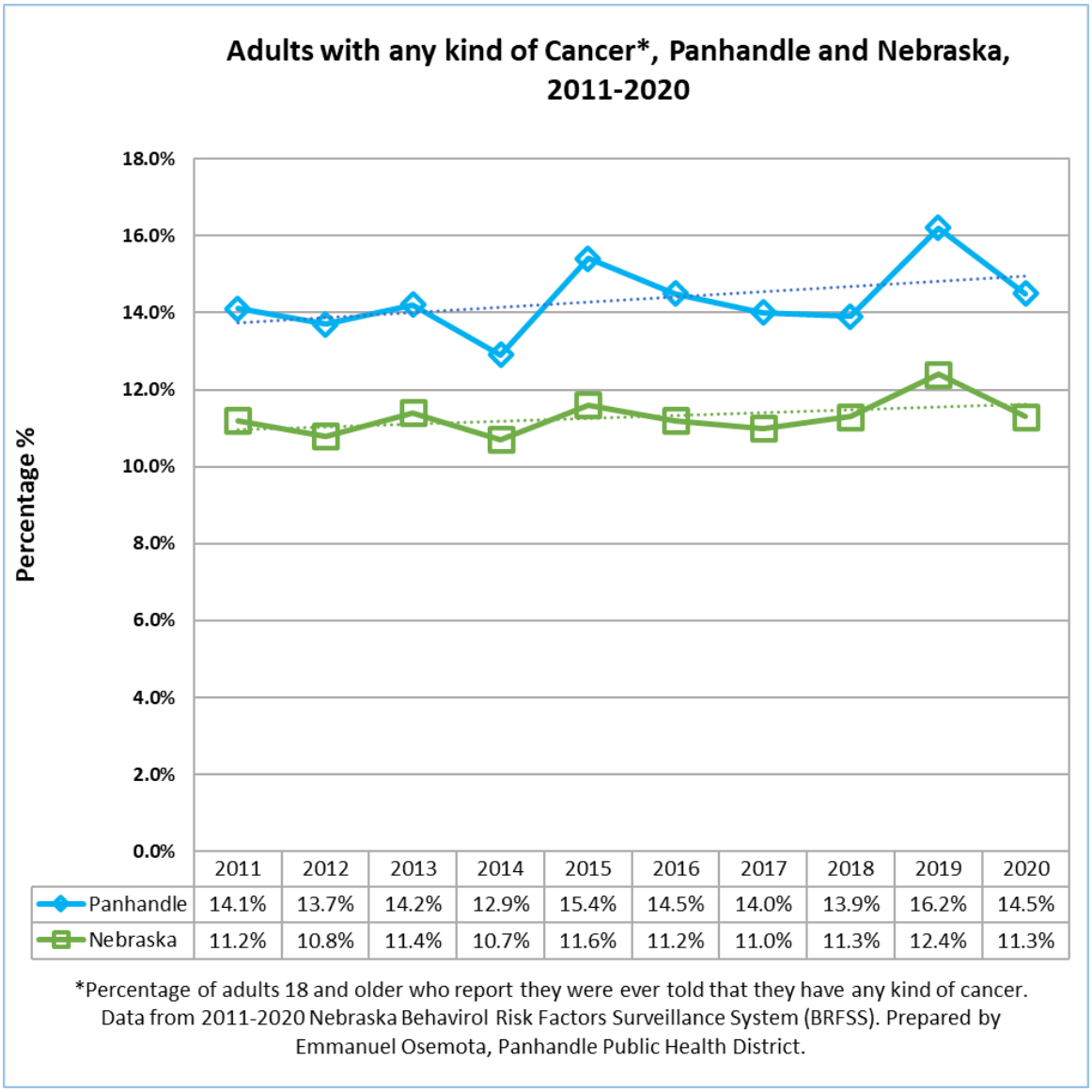
The National Diabetes Prevention Program in the Panhandle aims to decrease the number of adults who develop type 2 diabetes through diet and exercise.

CANCER

"Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues".[8] Cancer spreads throughout the body through the blood and lymph system. Cancer is not only one disease—there are more than 100 types of cancers.

The percentage of adults who were ever told they have any kind of cancer has been slightly increasing since 2011 for both the Panhandle and Nebraska. The Panhandle has a higher percentage every year and is increasing at a greater rate.

Figure 57: Adults with any kind of Cancer

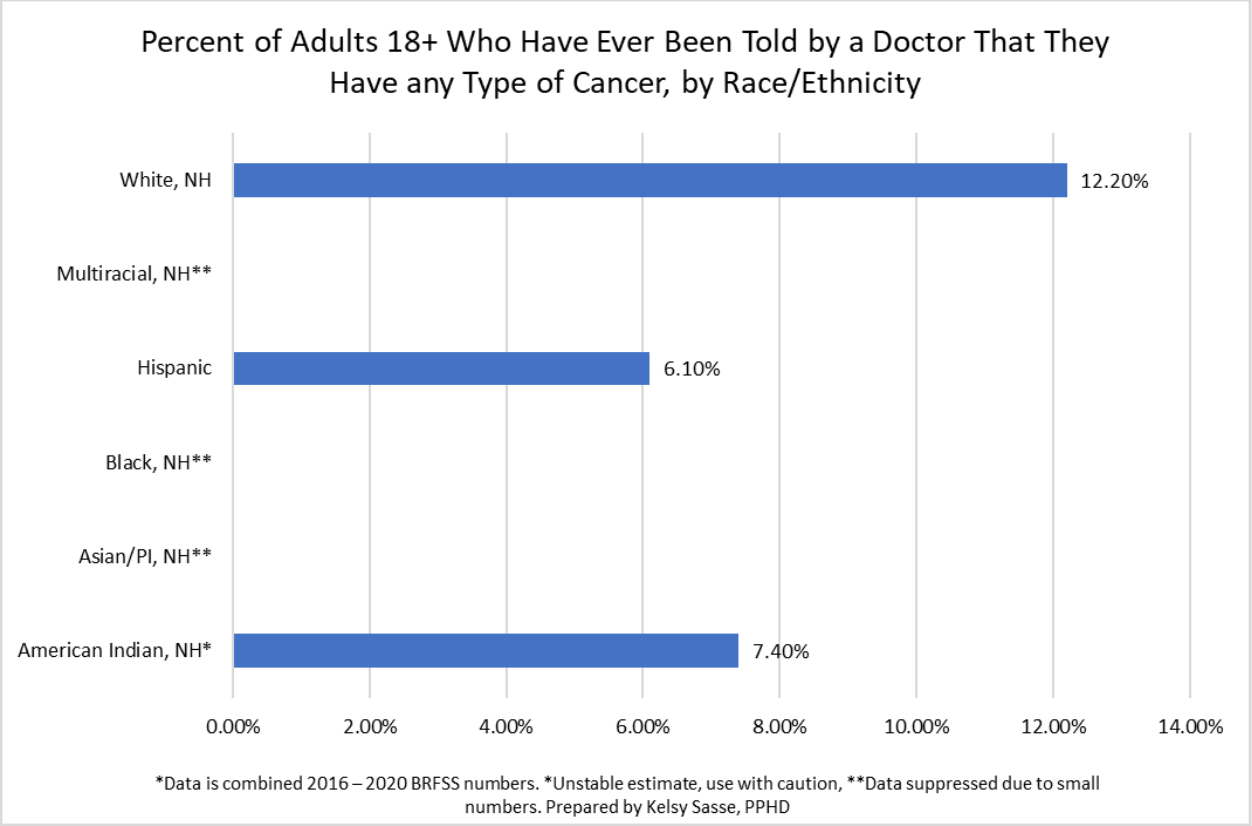


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	14.1%	13.7%	14.2%	12.9%	15.4%	14.5%	14.0%	13.9%	16.2%	14.5%
Nebraska	11.2%	10.8%	11.4%	10.7%	11.6%	11.2%	11.0%	11.3%	12.4%	11.3%

*Percentage of adults 18 and older who report they were ever told that they have any kind of cancer. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

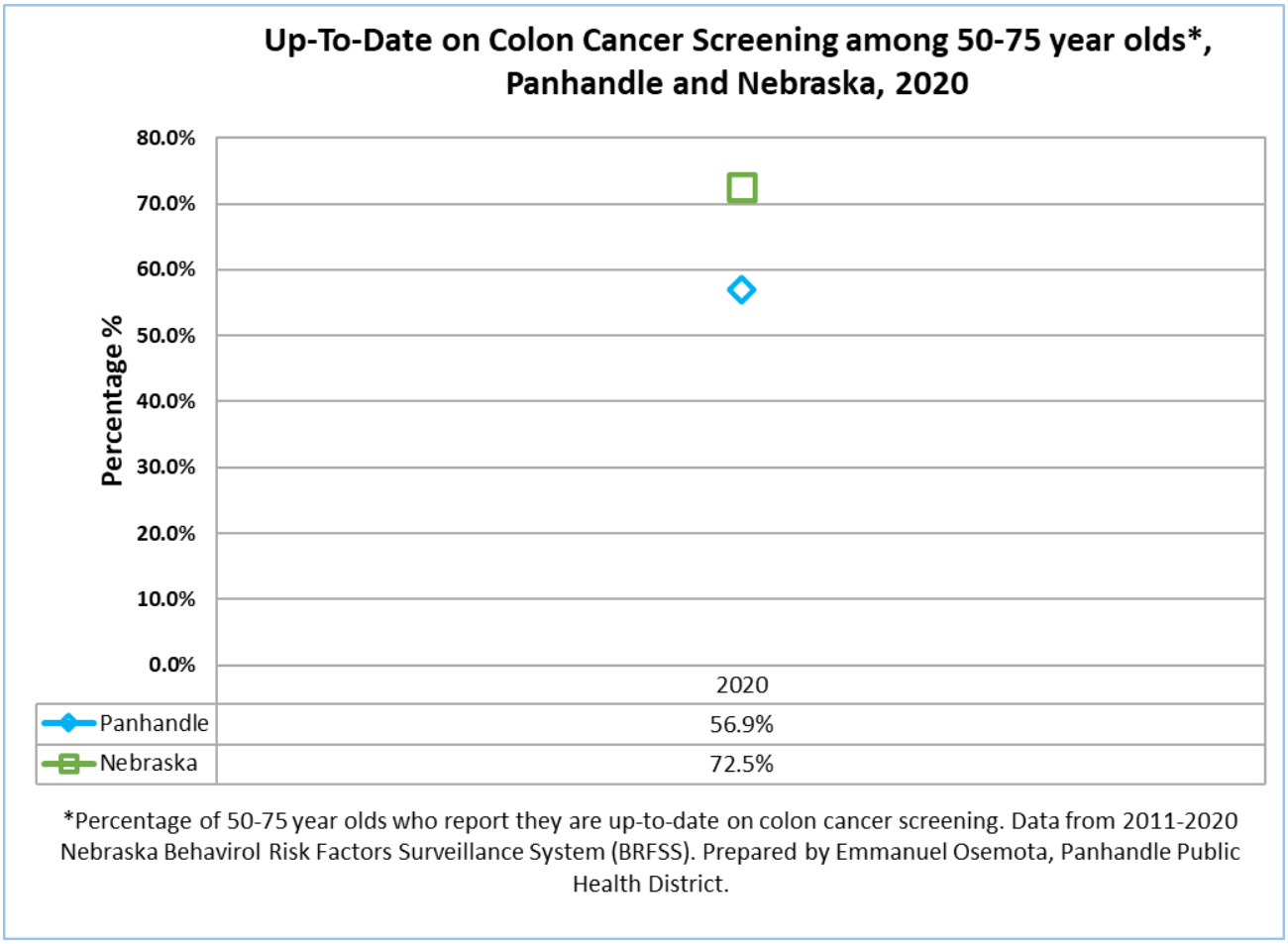
[8] (CDC 2020)

Figure 58: Adults with any kind of Cancer by Race/Ethnicity



White residents of the Panhandle are most likely to have ever been told they have cancer.

Figure 59: Adults Up-To-Date on Colon Cancer Screenings

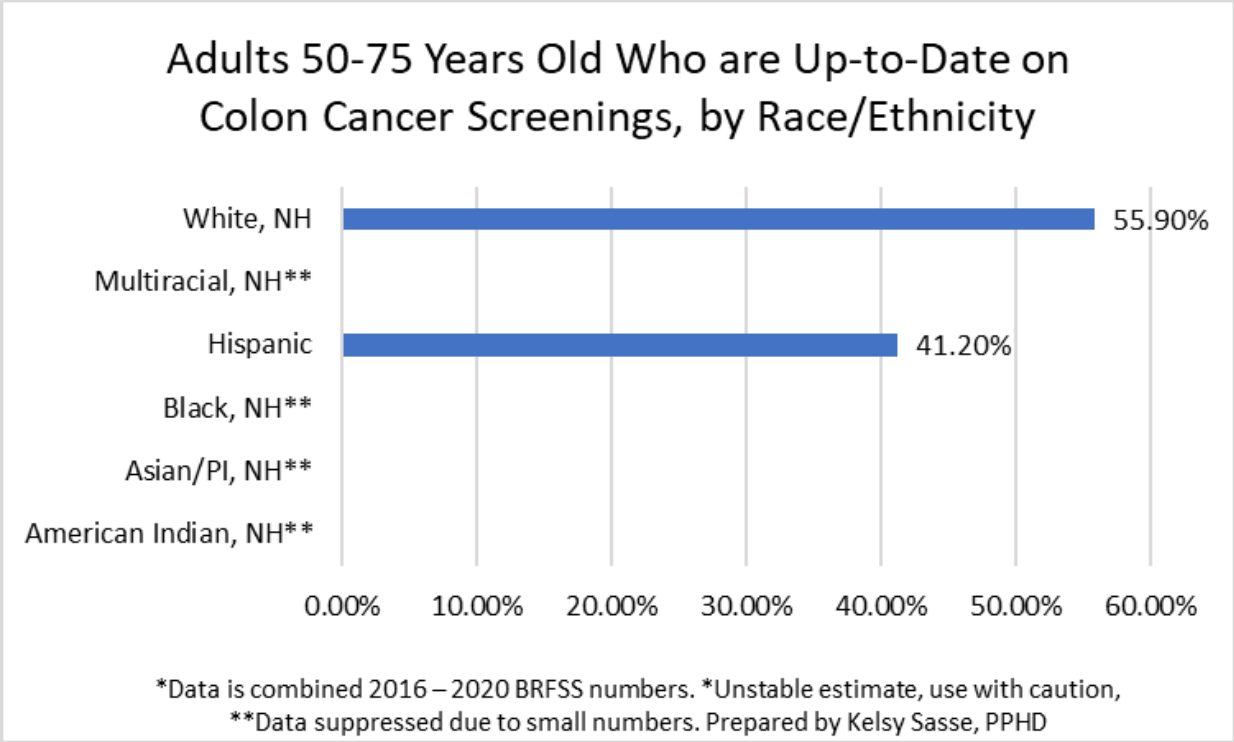


*Percentage of 50-75 year olds who report they are up-to-date on colon cancer screening. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

COLON CANCER SCREENING

The percentage of adults 50-75 years old who report being up to date on colon cancer screening is much lower in the Panhandle compared to Nebraska in the most recent year.

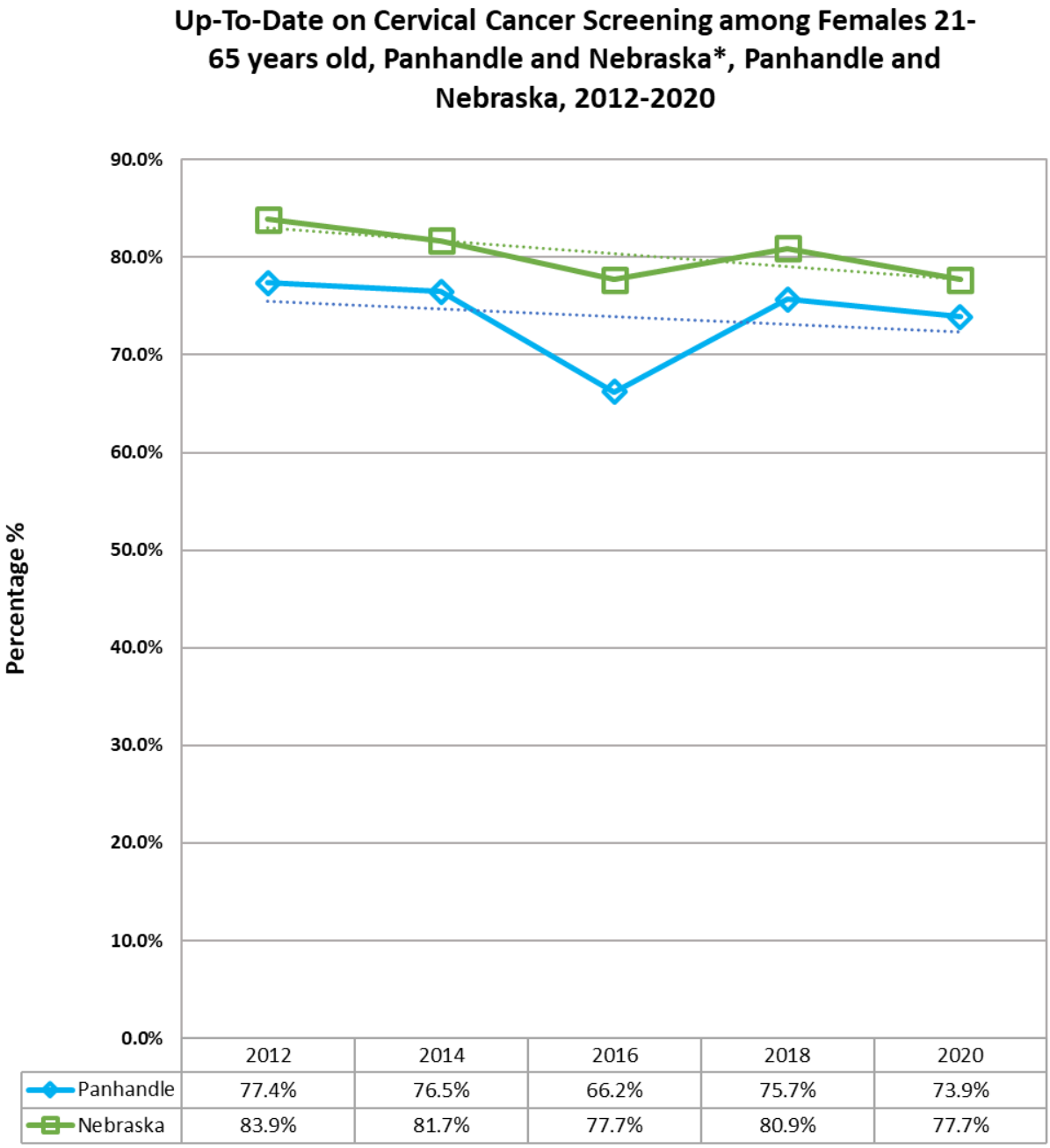
Figure 60: Adults Up-To-Date on Colon Cancer Screenings by Race/Ethnicity



The White residents of the Panhandle have the highest reported percentage of colon cancer screening among adults aged 50-75 across different race/ethnicity populations in the area.

CERVICAL CANCER SCREENING

Figure 61: Up-To-Date on Cervical Cancer Screening

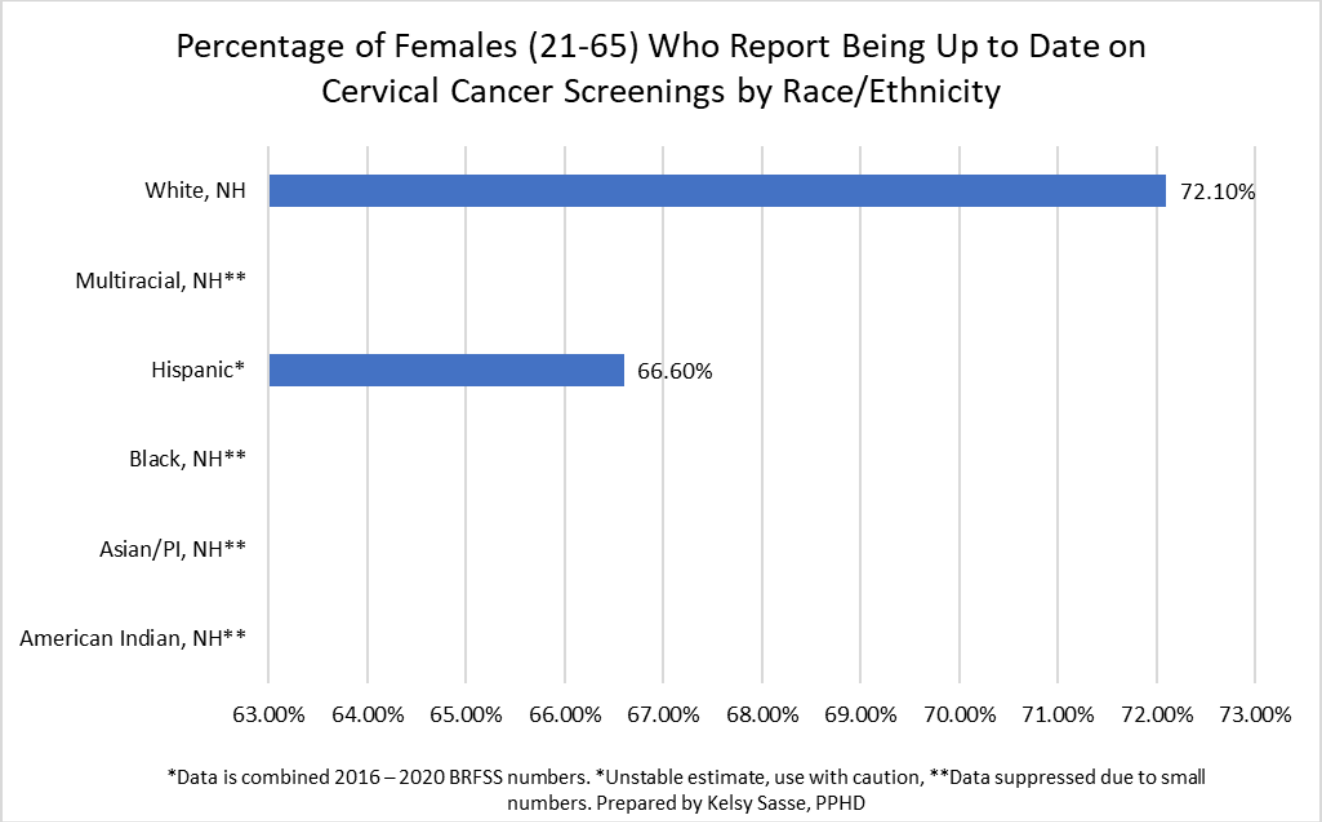


	2012	2014	2016	2018	2020
Panhandle	77.4%	76.5%	66.2%	75.7%	73.9%
Nebraska	83.9%	81.7%	77.7%	80.9%	77.7%

*Percentage of females 21-65 years old who report they are up-to-date on cervical cancer screening. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

The percentage of females 21-65 years old that are up to date on cervical cancer screening is also lower in the Panhandle when compared to Nebraska. Both geographies are decreasing over time with less people getting cervical cancer screenings.

Figure 62: Up-To-Date on Cervical Cancer Screening by Race/Ethnicity



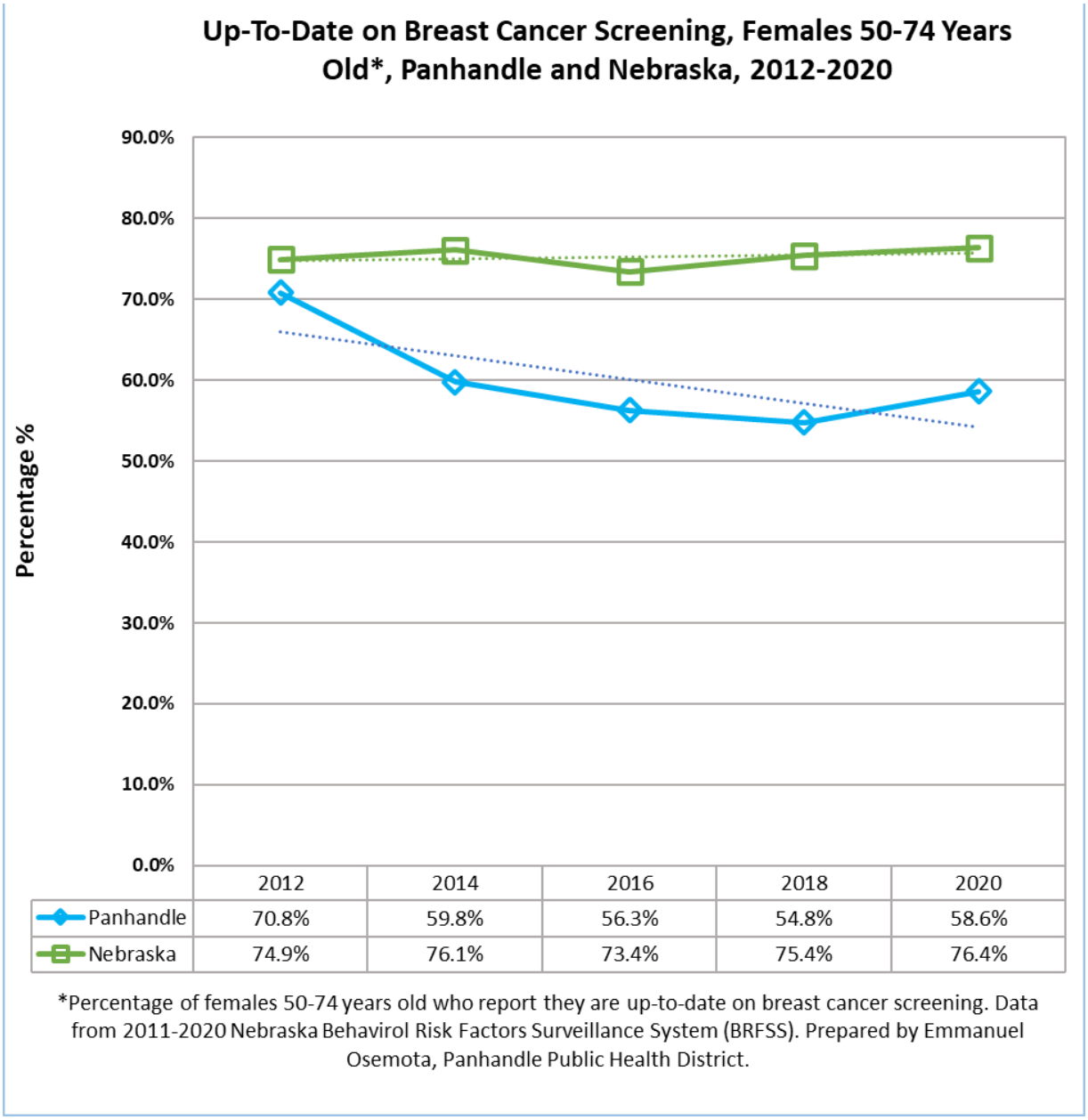
The percentage of females 21-65 years old that are up to date on cervical cancer screening is similar amongst White and Hispanic populations in the Panhandle. However, the White Panhandle residents have a slightly higher rate of cervical cancer screening than the Hispanic Panhandle residents.

Across different race/ethnicity populations in the area, the White Panhandle residents exhibit a higher reported percentage of females aged 21-65 who are up to date on cervical cancer screening.

BREAST CANCER SCREENING

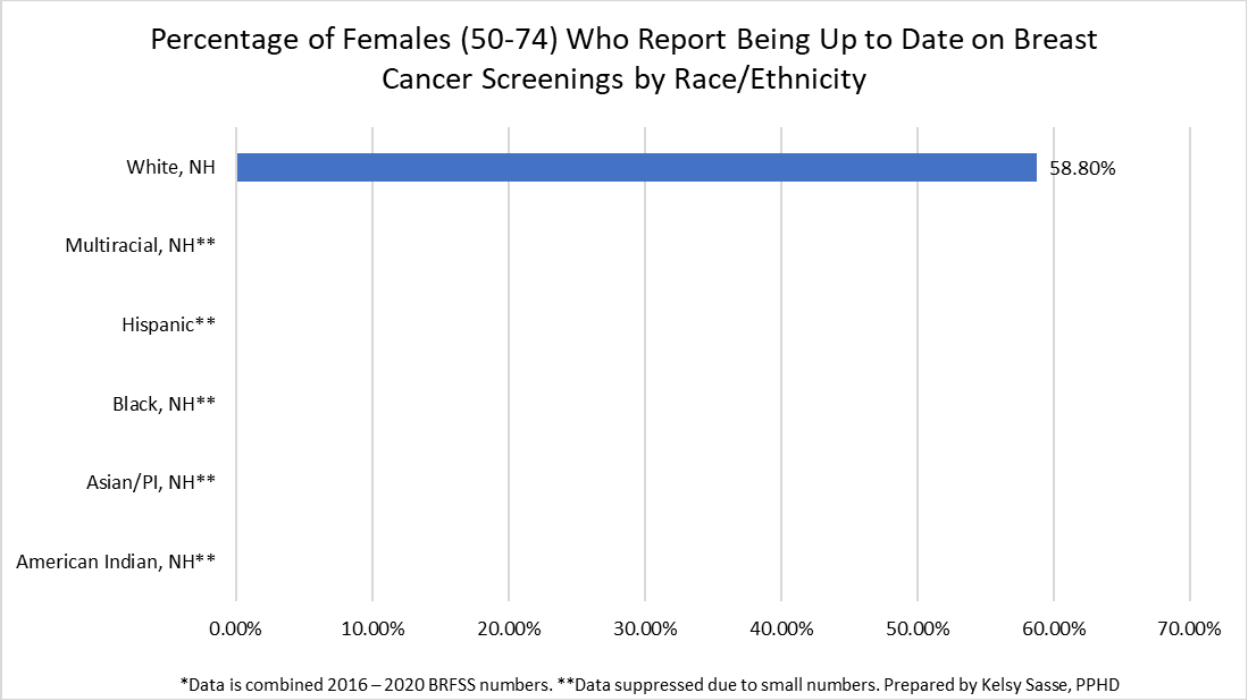
The percentage of females aged 50-74 who report being up to date on their breast cancer screening in the Panhandle has decreased while Nebraska had a small increase over time. The Panhandle had a slight increase in 2020 which is still 12% lower than 2012. Nebraska remained at an almost even percentage rate over the years, with the most recent year having the highest rate. The chronic disease prevention work group has been focused on increasing the rates of breast cancer screenings, so it is promising to see a reversal of the trend despite not being even with the state yet.

Figure 63: Up-To-Date on Breast Cancer Screening



*Percentage of females 50-74 years old who report they are up-to-date on breast cancer screening. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 64: Up-To-Date on Breast Cancer Screening by Race/Ethnicity



The Percentage of females 50-74 years old who report having a breast cancer screening, by race/ethnicity is highest amongst White Panhandle residents compared to other demography residents in the Panhandle region of Nebraska.

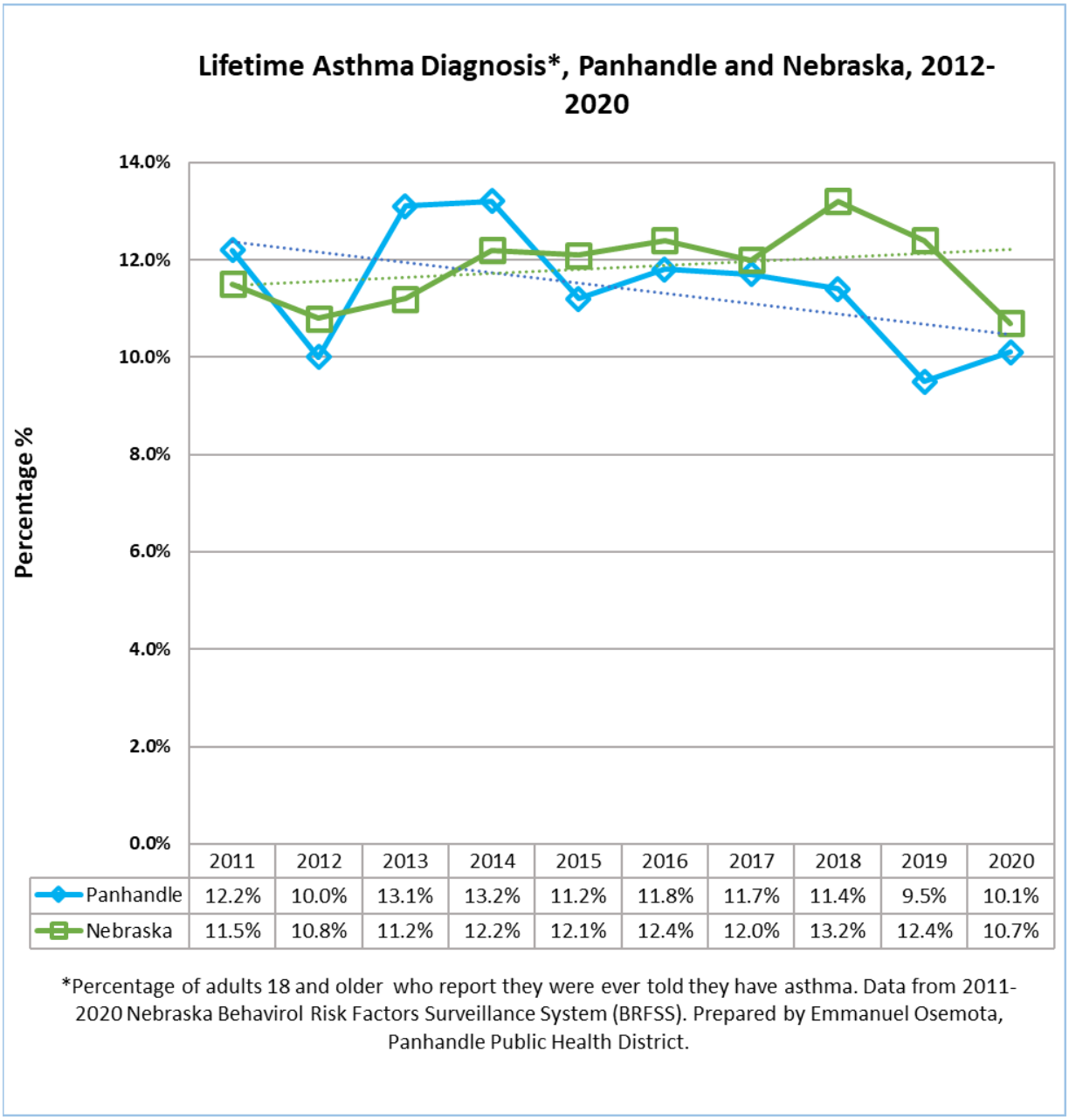
ASTHMA

Asthma is a disease that affects the lungs, causing repeated episodes of breathlessness, wheezing, nighttime or early morning coughing, and chest tightness. It can be controlled through medication and avoiding triggers.[9]

The percentage of adults who have ever been diagnosed with asthma (lifetime asthma diagnosis) has decreased from 2011-2020, with the Panhandle having the lowest percentage in 2019. Compared to Nebraska, the Panhandle has had a slightly lower percentage in most years.

[9] (CDC 2020)

Figure 65: Lifetime Asthma Diagnosis in Adults

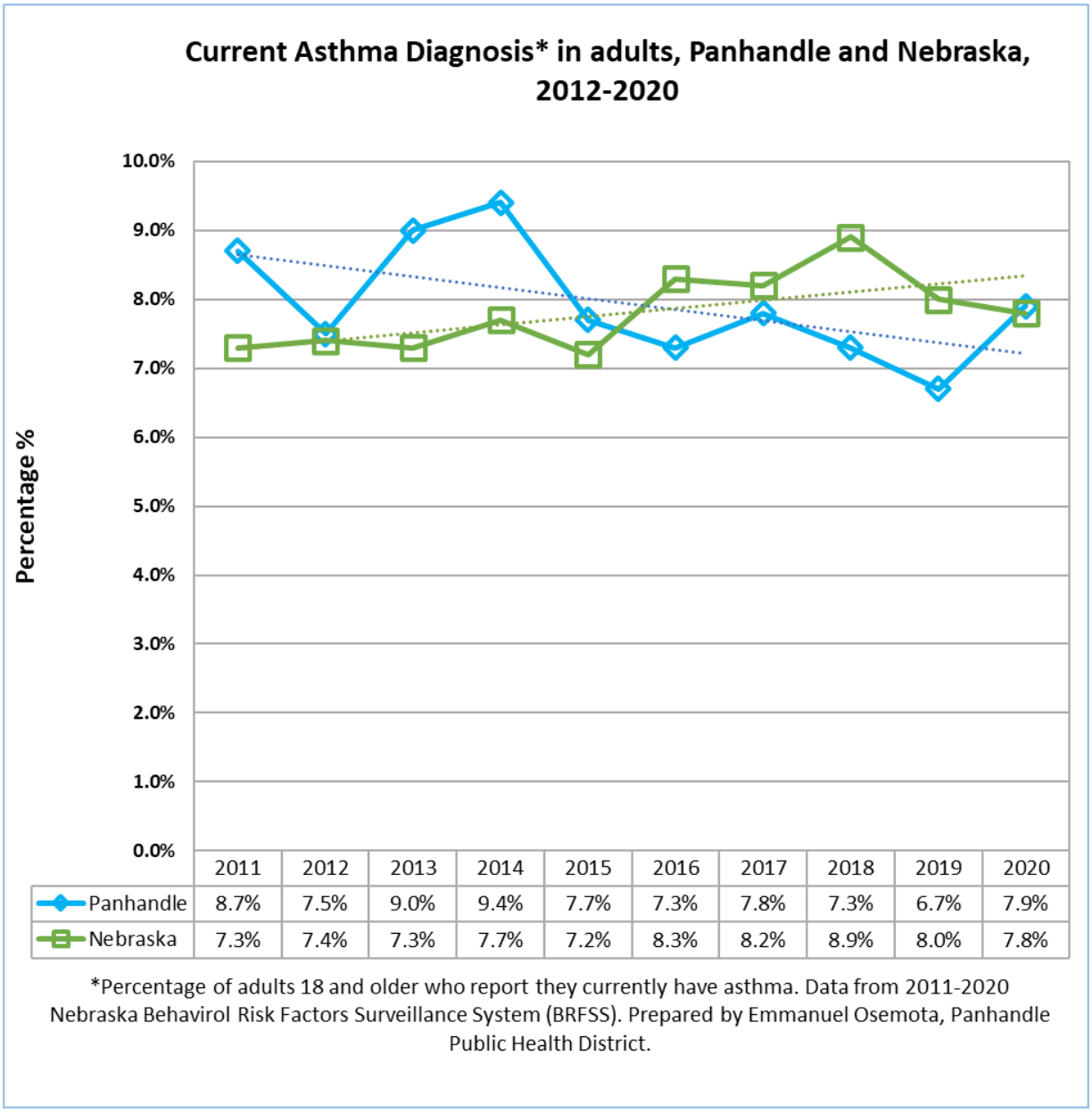


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	12.2%	10.0%	13.1%	13.2%	11.2%	11.8%	11.7%	11.4%	9.5%	10.1%
Nebraska	11.5%	10.8%	11.2%	12.2%	12.1%	12.4%	12.0%	13.2%	12.4%	10.7%

*Percentage of adults 18 and older who report they were ever told they have asthma. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

The percentage of adults who currently have asthma decreased the most in 2019 and then it had a slight increase in 2020 in the Panhandle, while in Nebraska it has slightly decreased from 2019. There were not any significant changes year to year in both states. The rates of asthma in the Panhandle are highest among the Native American population.

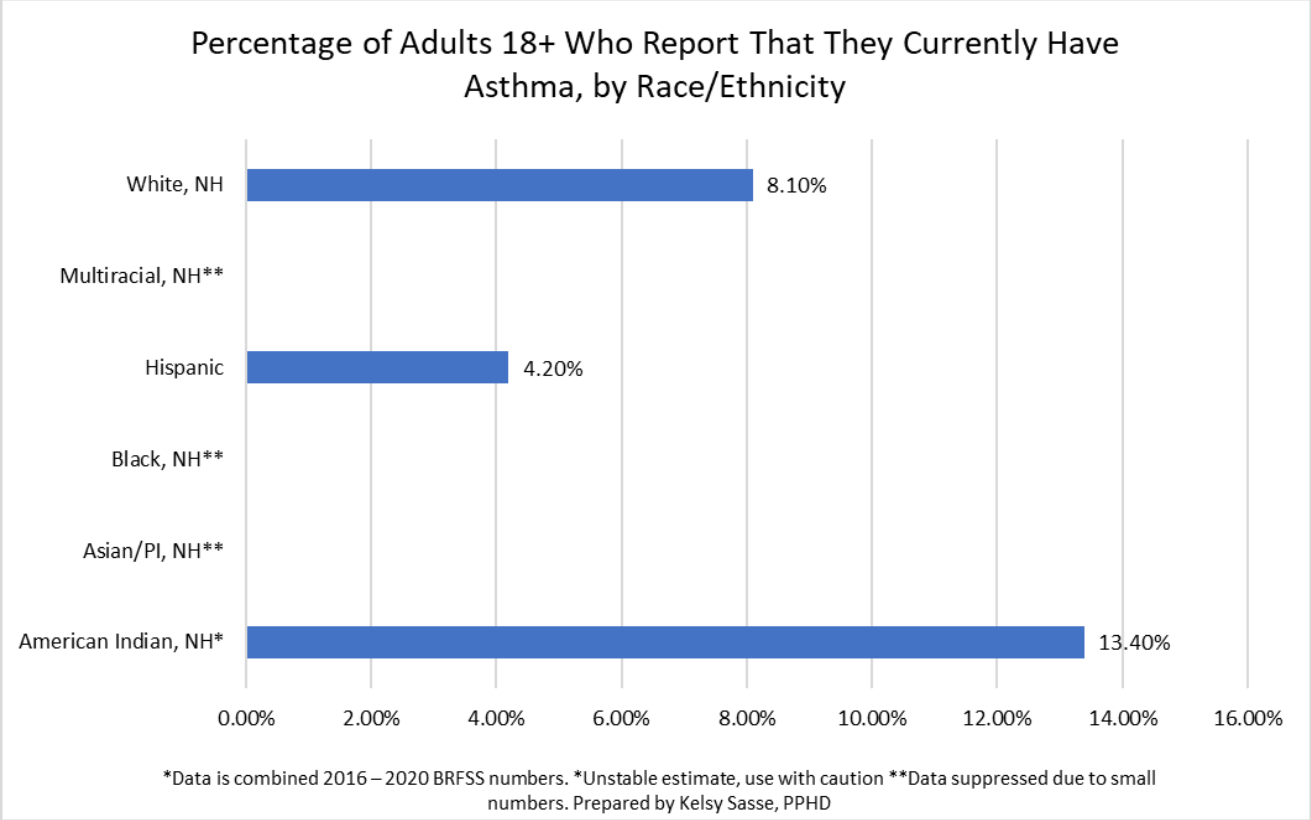
Figure 66: Current Asthma Diagnosis in Adults



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	8.7%	7.5%	9.0%	9.4%	7.7%	7.3%	7.8%	7.3%	6.7%	7.9%
Nebraska	7.3%	7.4%	7.3%	7.7%	7.2%	8.3%	8.2%	8.9%	8.0%	7.8%

*Percentage of adults 18 and older who report they currently have asthma. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 67: Current Asthma Diagnosis in Adults, by Race/Ethnicity



The Percentage of adults 18 or older who report they currently have asthma by race/ethnicity indicates that American Indian residents of the Nebraska Panhandle have a higher rate of asthma than White residents and Hispanic residents.

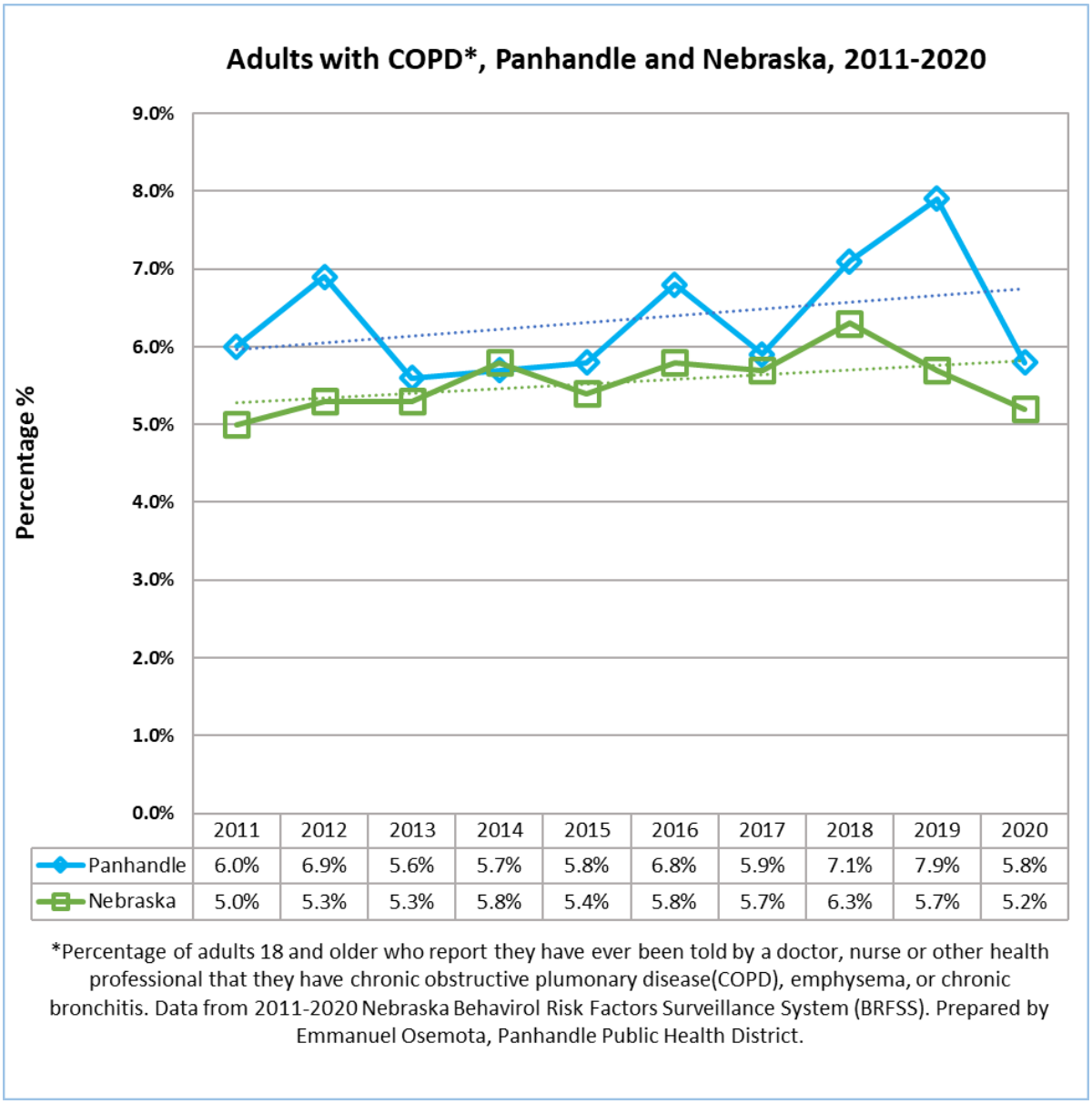
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease (COPD) is a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis.[10]

Nearly 16 million Americans are diagnosed with COPD, although the actual number with the disease may be higher. There is no cure for COPD, but it is treatable.

[10] (Burden 2023)

Figure 68: Adults with COPD



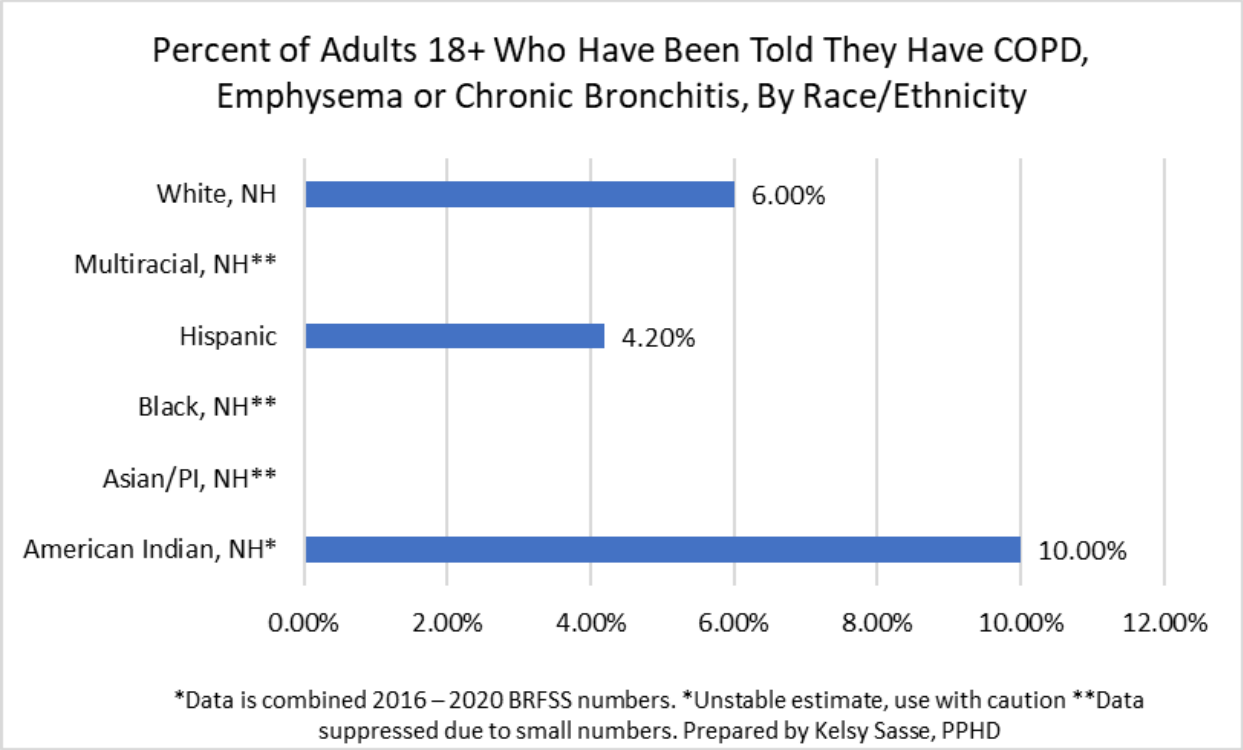
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	6.0%	6.9%	5.6%	5.7%	5.8%	6.8%	5.9%	7.1%	7.9%	5.8%
Nebraska	5.0%	5.3%	5.3%	5.8%	5.4%	5.8%	5.7%	6.3%	5.7%	5.2%

*Percentage of adults 18 and older who report they have ever been told by a doctor, nurse or other health professional that they have chronic obstructive plumonary disease(COPD), emphysema, or chronic bronchitis. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

The percentage of adults with COPD in the Panhandle have been increasing since 2011. In most of the years, Nebraska has had slightly lower rates than Panhandle.

One risk factor for COPD is age, with people aged 65 and older at higher risk for the disease. The Panhandle has a larger population of older adults when compared to the overall state of Nebraska, which may contribute to the higher rates of COPD in the region.

Figure 69: Adults with COPD by Race/Ethnicity



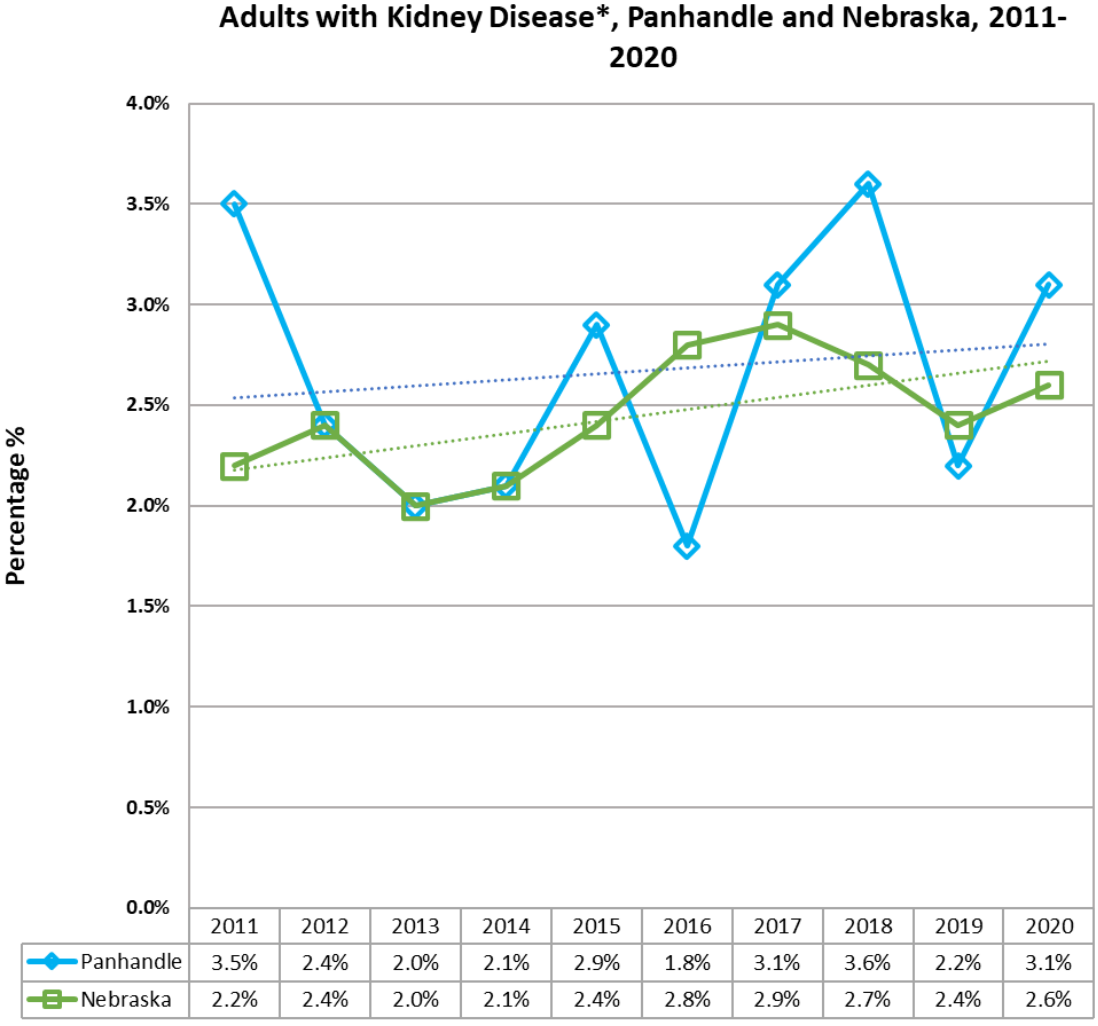
Among adults aged 18 or older who report being diagnosed with COPD, the highest percentage is observed among American Indian residents, followed by White residents. On the other hand, Hispanic residents have the lowest reported percentage in this regard.

KIDNEY DISEASE

Kidney disease means that your kidneys are damaged, and you are unable to filter blood the way that you should. This damage to your kidneys can cause waste to build up in your body, among other things. Kidney disease may lead to kidney failure, which is only treatable with dialysis or a kidney transplant. More than 30 million American adults may have chronic kidney disease. Risk factors for kidney disease include diabetes, high blood pressure, heart disease, and family history of kidney failure.[11]

The percentage of adults who have been diagnosed with kidney disease has increased in the Panhandle and in Nebraska. The Panhandle generally has higher rates than the rates across the state.

Figure 70: Adults with Kidney Disease

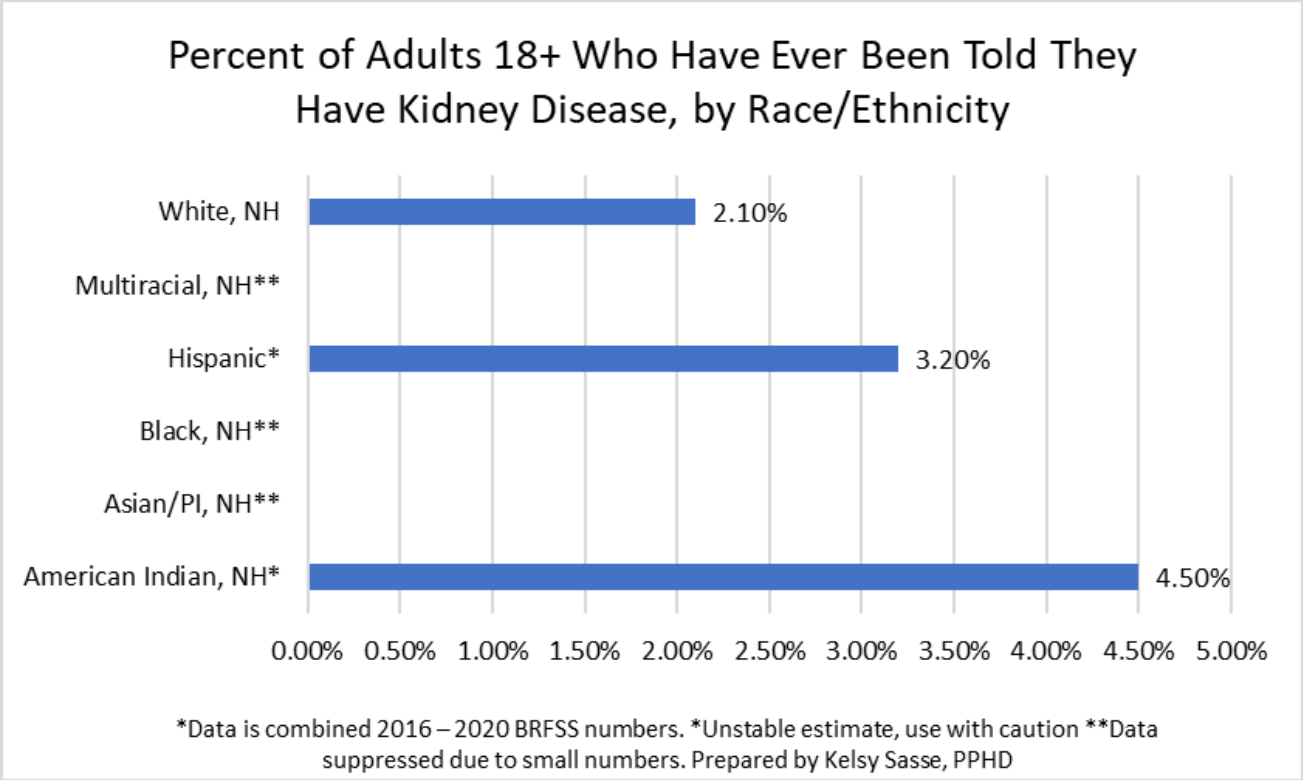


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	3.5%	2.4%	2.0%	2.1%	2.9%	1.8%	3.1%	3.6%	2.2%	3.1%
Nebraska	2.2%	2.4%	2.0%	2.1%	2.4%	2.8%	2.9%	2.7%	2.4%	2.6%

*Percentage of adults 18 and older who report they were ever told they have kidney disease. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

[11] (National Institute of Diabetes and Digestive and Kidney Diseases 2017)

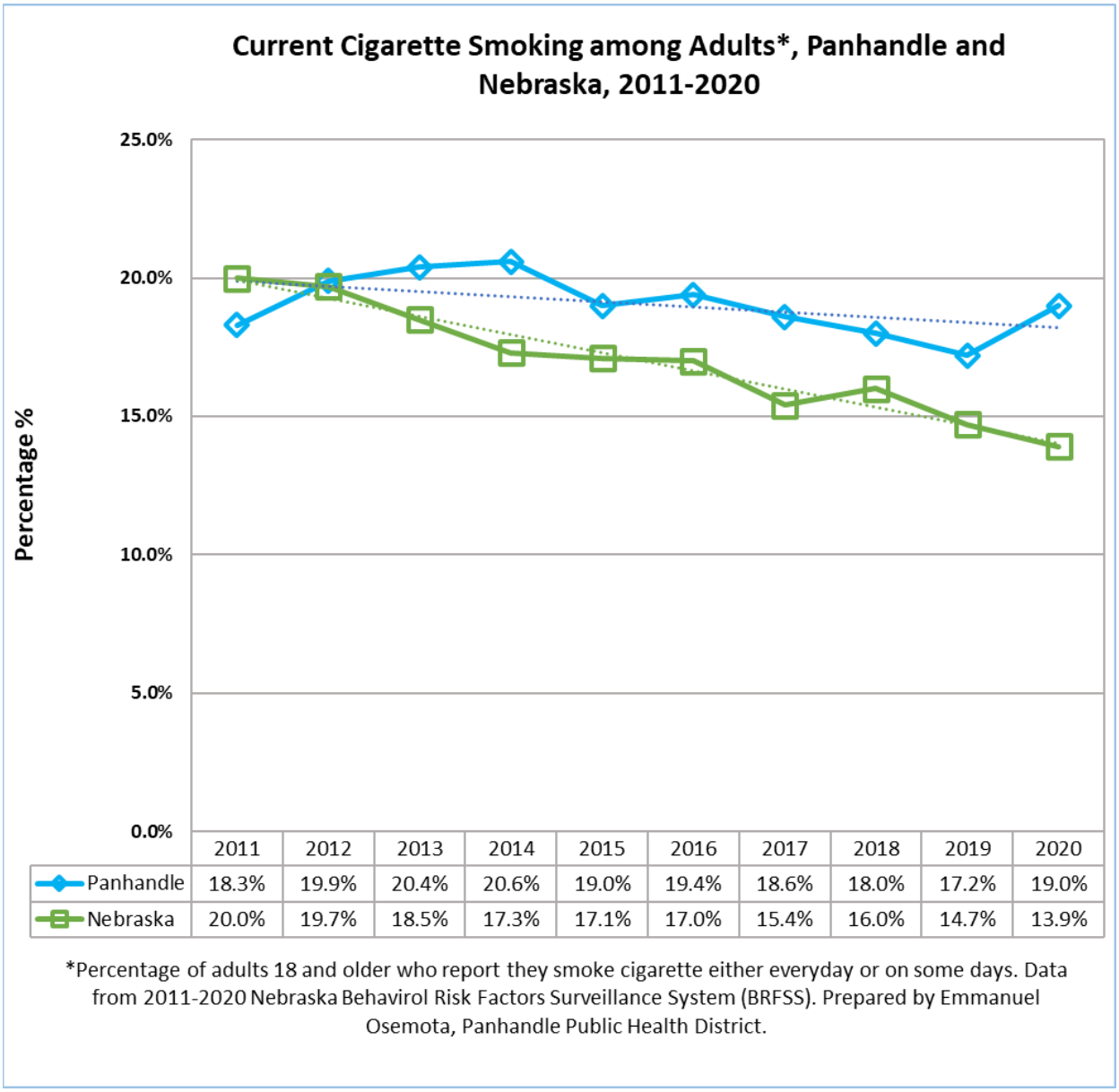
Figure 71: Adults with Kidney Disease by Race/Ethnicity



Among adults aged 18 or older, the highest reported percentage of individuals who have been diagnosed with kidney disease is found among American Indian and Multiracial residents of the Nebraska Panhandle. Conversely, the White resident population exhibits the lowest rate in this regard.

ADULT TOBACCO USE

Figure 72: Current Cigarette Smoking Among Adults



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	18.3%	19.9%	20.4%	20.6%	19.0%	19.4%	18.6%	18.0%	17.2%	19.0%
Nebraska	20.0%	19.7%	18.5%	17.3%	17.1%	17.0%	15.4%	16.0%	14.7%	13.9%

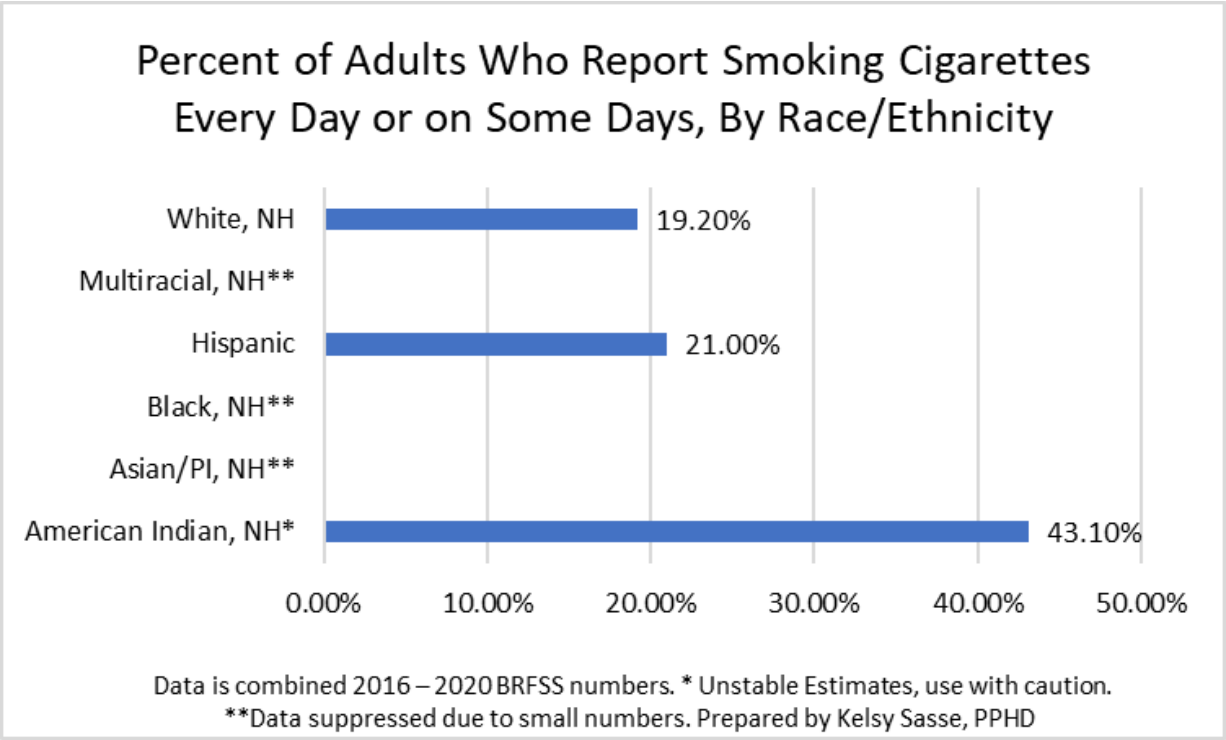
*Percentage of adults 18 and older who report they smoke cigarette either everyday or on some days. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Tobacco use is the top cause of preventable death, disease, and disability in the United States. Smoking-related illness costs the US over $300 billion each year, including $170 billion in direct medical costs.[12]

The percentage of adults who report smoking has decreased in Nebraska while it has slightly increased in the Panhandle from 2011-2020. The Panhandle generally has experienced higher rates of tobacco use than across the state.

[12] (CDC 2021)

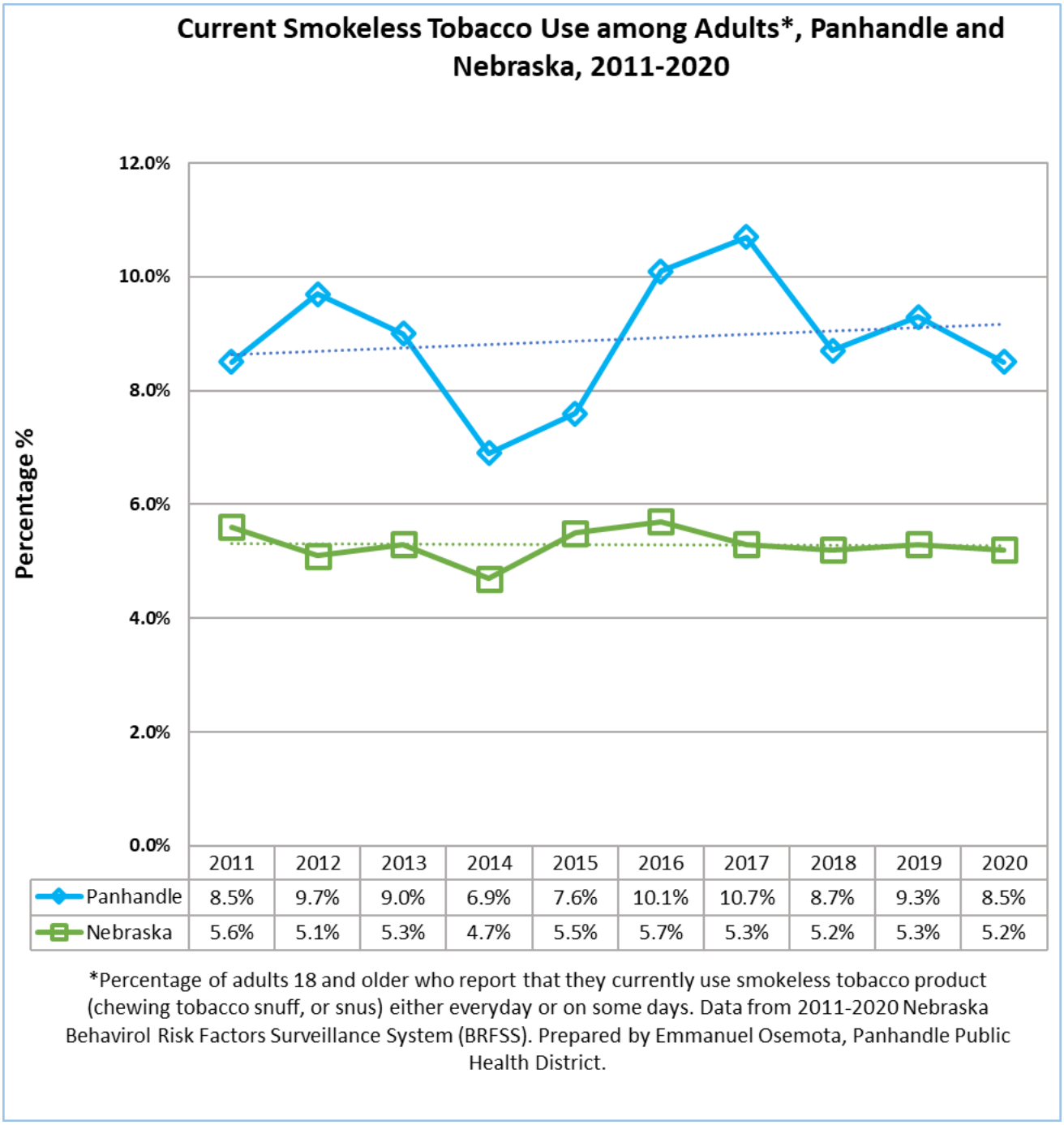
Figure 73: Current Cigarette Smoking Among Adults by Race/Ethnicity



The Percentage of adults 18 or older who report that they are currently smoking either every day or some days by race/ethnicity is highest amongst the American Indian residents of the Nebraska Panhandle.

ADULT SMOKELESS TOBACCO USE

Figure 74: Current Smokeless Tobacco Use Among Adults



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	8.5%	9.7%	9.0%	6.9%	7.6%	10.1%	10.7%	8.7%	9.3%	8.5%
Nebraska	5.6%	5.1%	5.3%	4.7%	5.5%	5.7%	5.3%	5.2%	5.3%	5.2%

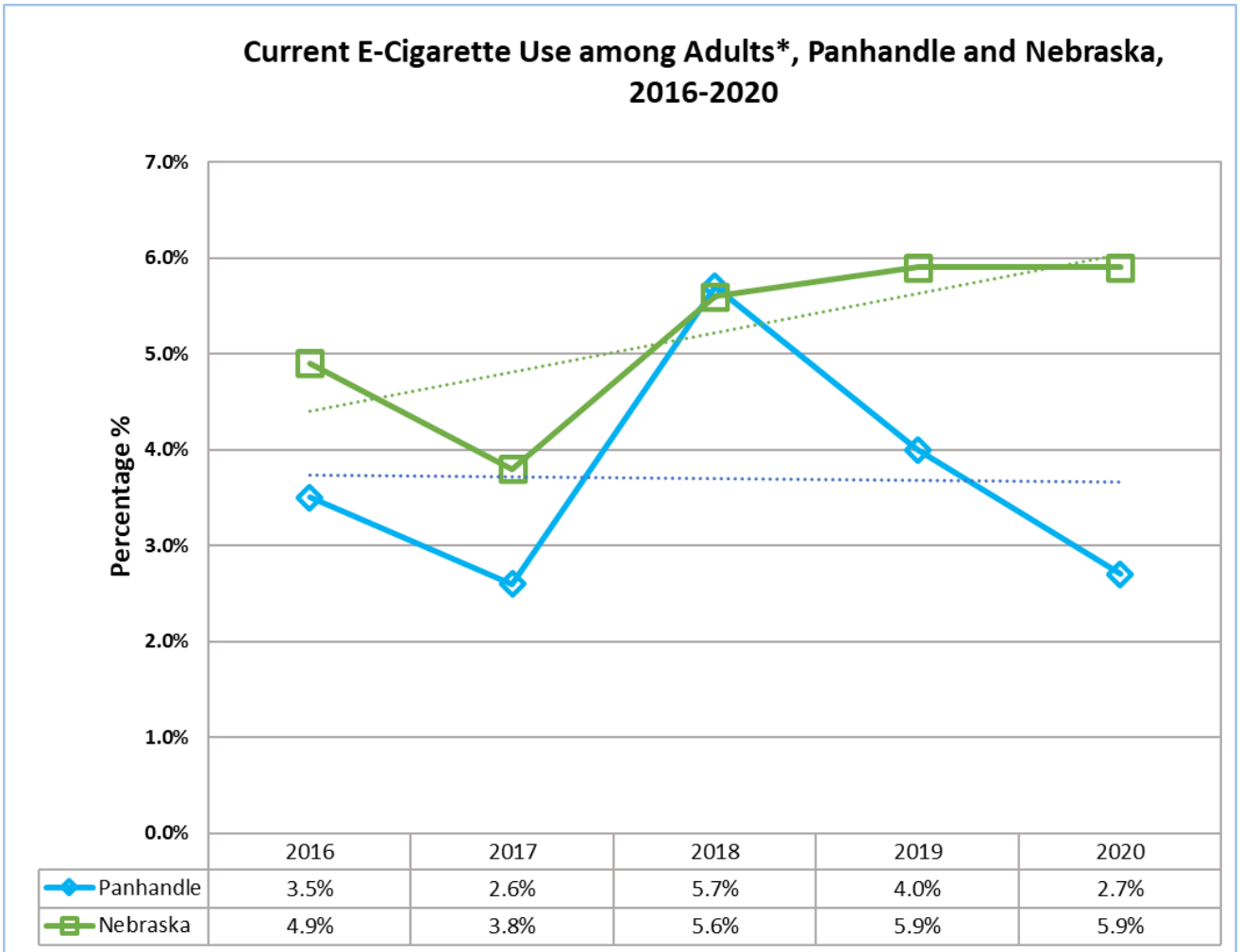
*Percentage of adults 18 and older who report that they currently use smokeless tobacco product (chewing tobacco snuff, or snus) either everyday or on some days. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Current smokeless tobacco (chew, snuff, snus) usage among adults has remained about the same in both states in the most recent year when compared to 2011. The Panhandle has consistently had higher rates of smokeless tobacco usage compared with the State.

ADULT E-CIGARETTE USE

Data on adult e-cigarette use has only been collected since 2016. Since 2016, the trend of Panhandle adults who report current use of e-cigarettes has remained stable, while trends across the state show increasing rates.

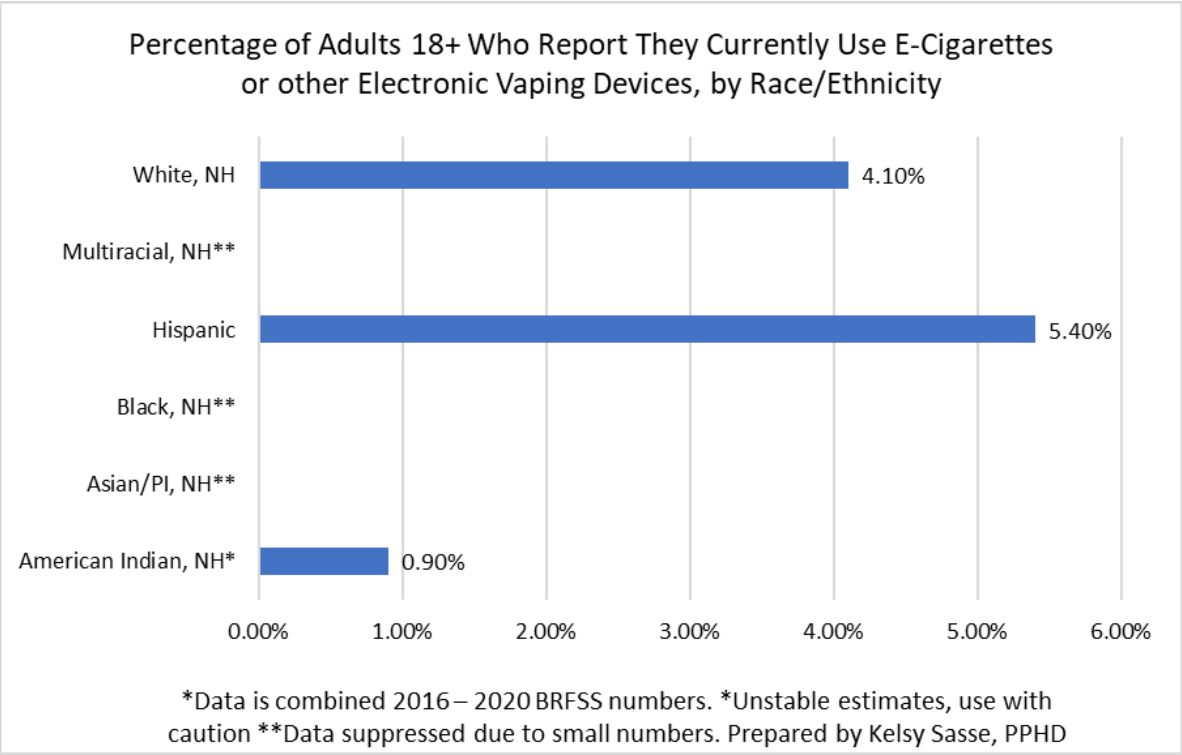
Figure 75: Current E-Cigarette Use Tobacco Use Among Adults



*Percentage of adults 18 and older who report that they currently use an e-cigarette or other electronic "vaping" products either everyday or on some days. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

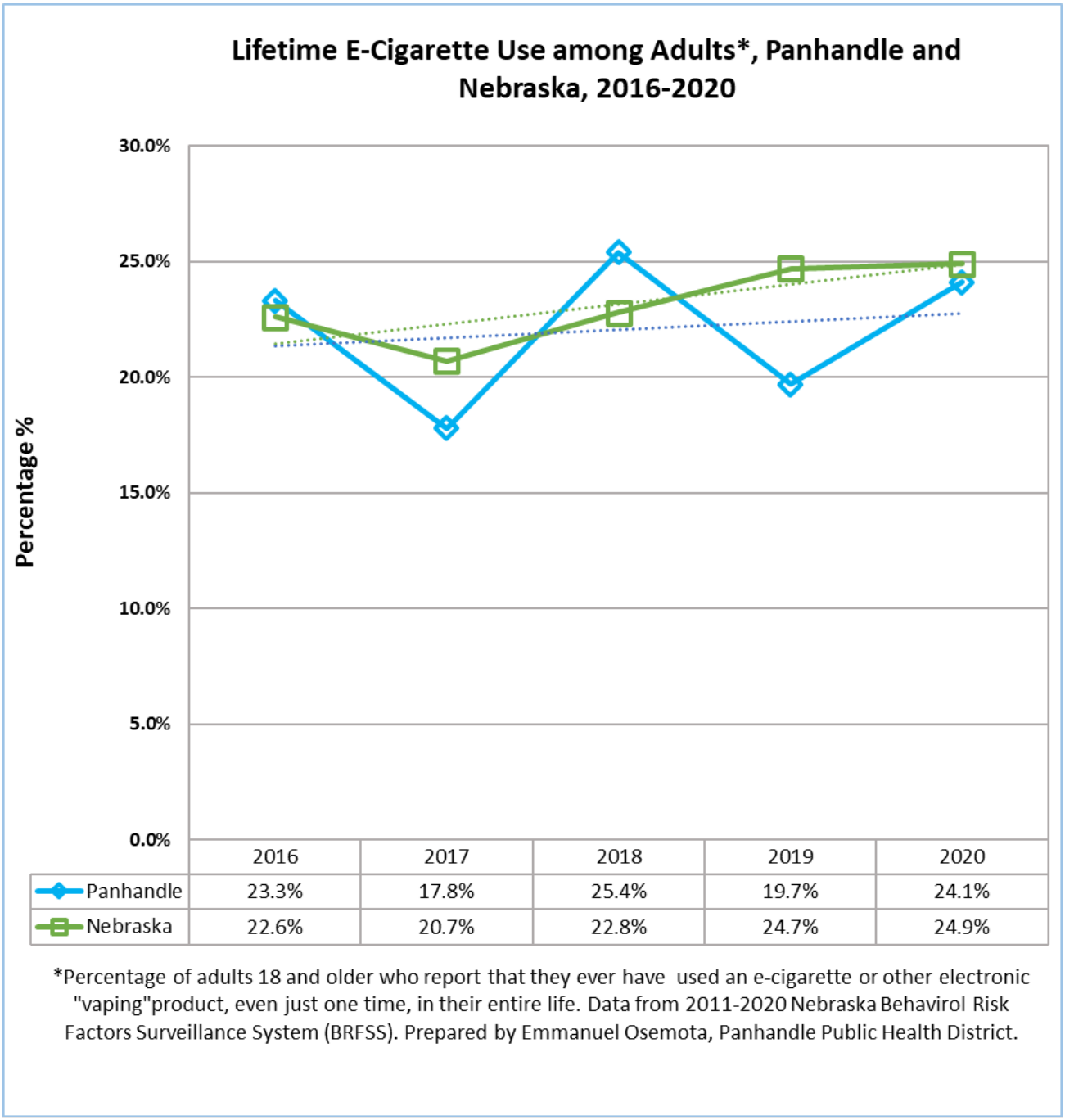
Lifetime e-cigarette use indicates the percentage of adults who have ever used an e-cigarette. The percentage of Panhandle adults who have ever used e-cigarettes is slightly higher than the state. Both rates are increasing.

Figure 76: Current E-Cigarette Use Among Adults by Race/Ethnicity



Among adults aged 18 or older, the highest reported percentage of individuals who currently use e-cigarettes or other electronic "vaping" products, either daily or occasionally, is found among Hispanic residents of the Nebraska Panhandle. Conversely, the lowest rate is observed among the American Indian and Multiracial resident population.

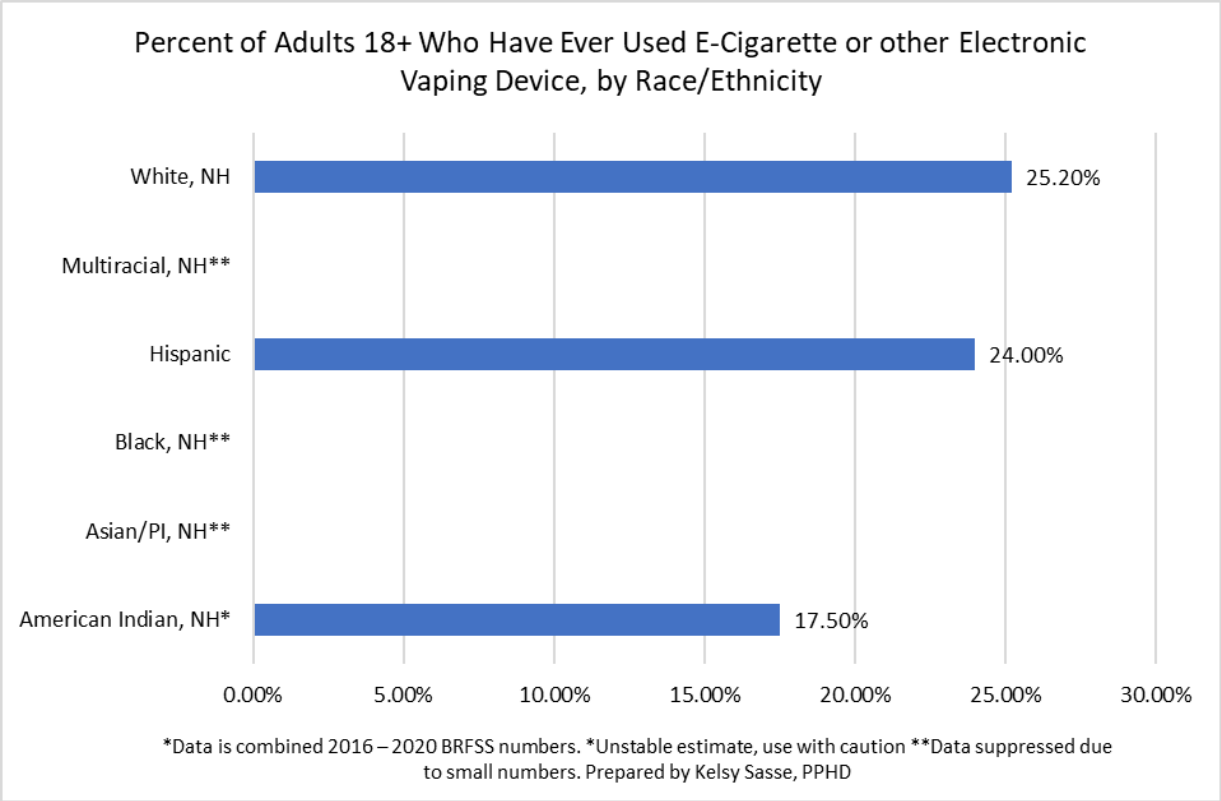
Figure 77: Adult Lifetime E-Cigarette Use



	2016	2017	2018	2019	2020
Panhandle	23.3%	17.8%	25.4%	19.7%	24.1%
Nebraska	22.6%	20.7%	22.8%	24.7%	24.9%

*Percentage of adults 18 and older who report that they ever have used an e-cigarette or other electronic "vaping"product, even just one time, in their entire life. Data from 2011-2020 Nebraska Behavirol Risk Factors Surveillance System (BRFSS). Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 78: Adult Lifetime E-Cigarette Use by Race/Ethnicity



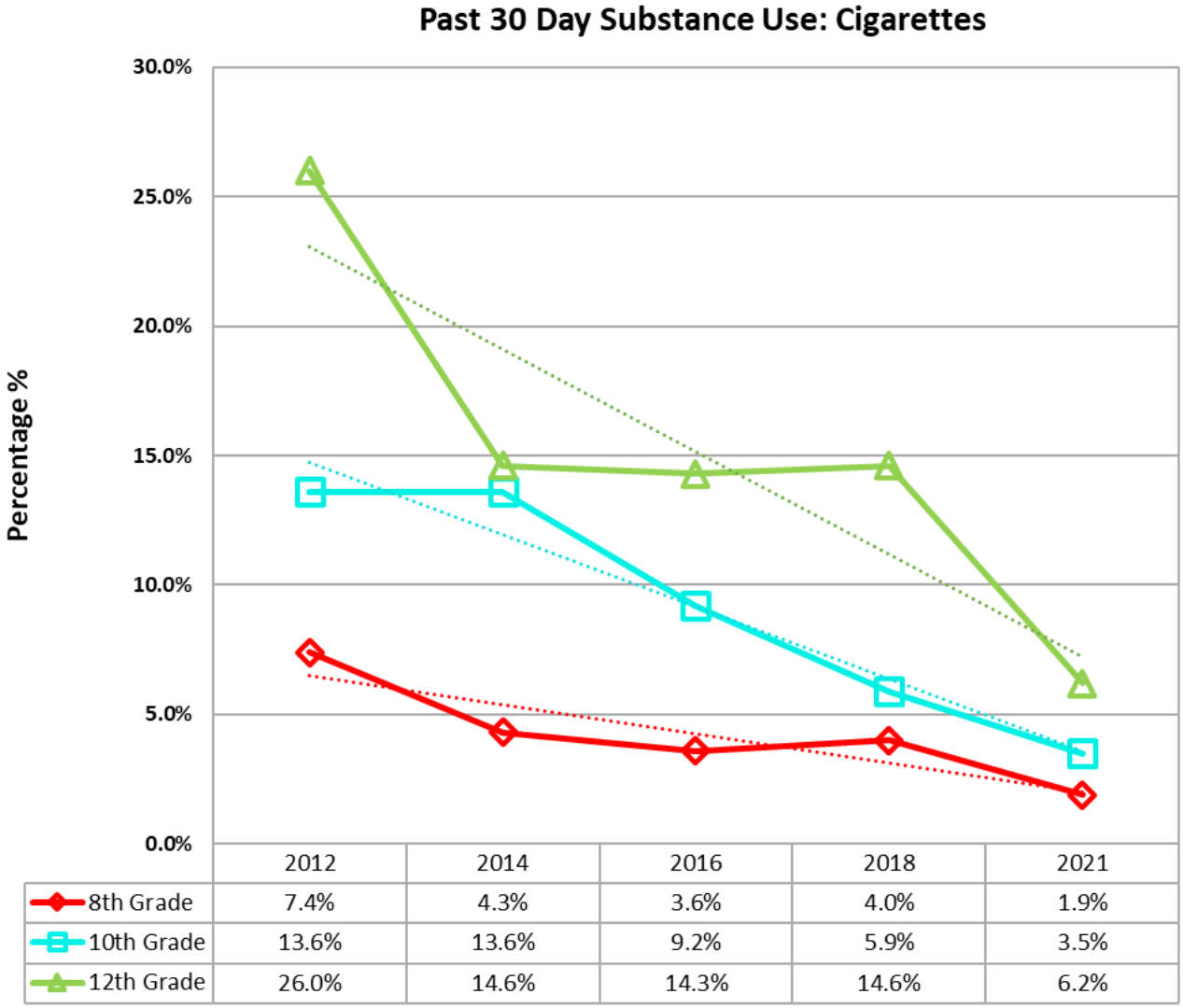
The Percentage of adults 18 or older who report that they ever have use an e-cigarette or other electronic "vaping" product, even just one time, in their entire life by race/ethnicity is highest amongst the White and Hispanic residents of the Nebraska Panhandle, while the lowest rate is the American Indian resident population.

YOUTH TOBACCO USE

CIGARETTE USE

Both current cigarette use (past 30 days) and lifetime cigarette use have been trending downward in Panhandle youth since 2012. This is true for all grade levels.

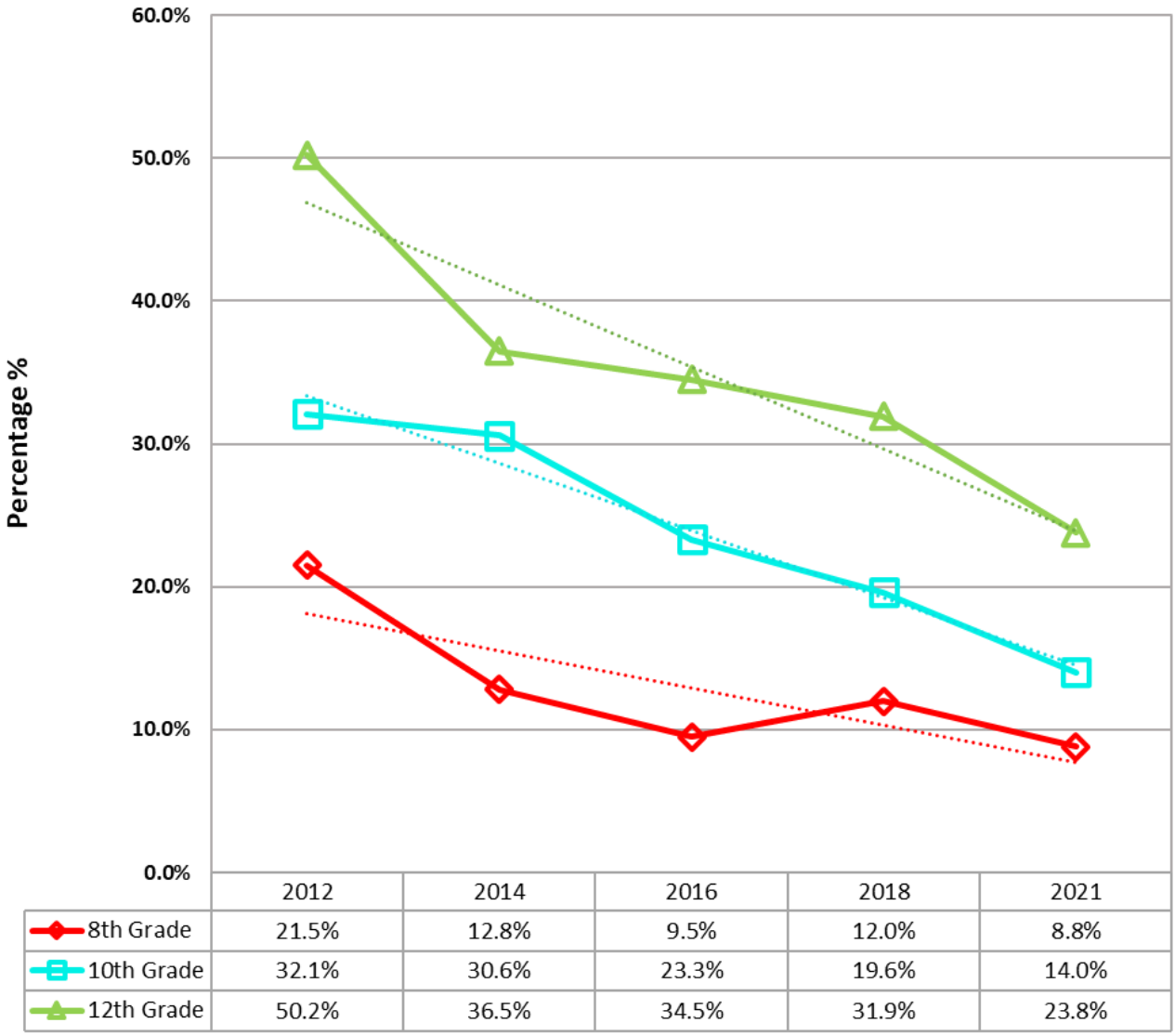
Figure 79: Past 30 Day Cigarette Use Among Youth



	2012	2014	2016	2018	2021
8th Grade	7.4%	4.3%	3.6%	4.0%	1.9%
10th Grade	13.6%	13.6%	9.2%	5.9%	3.5%
12th Grade	26.0%	14.6%	14.3%	14.6%	6.2%

*Percentage who reported using cigarettes one or more times in the past 30 days. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 80: Lifetime Cigarette Use Among Youth



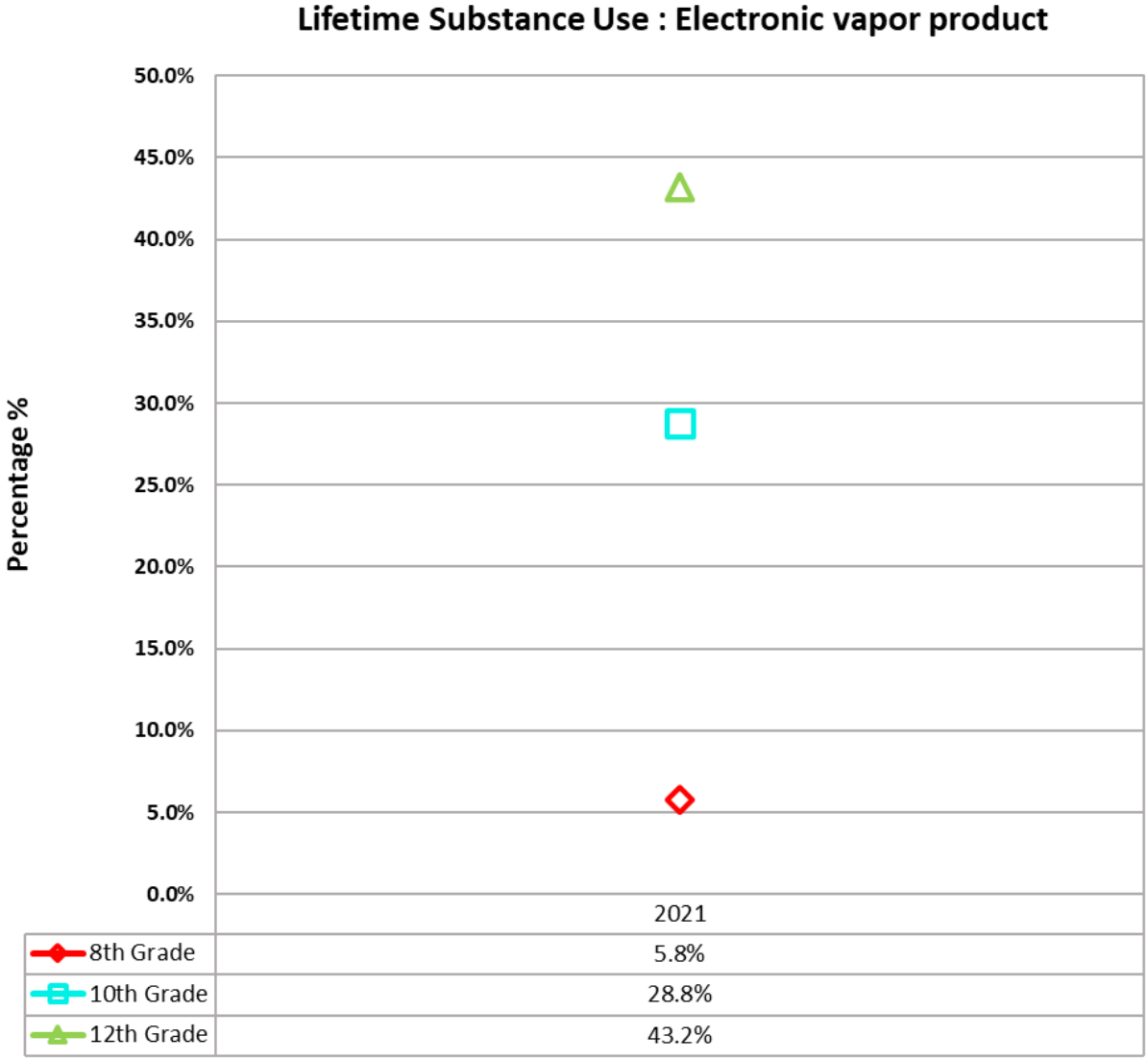
	2012	2014	2016	2018	2021
8th Grade	21.5%	12.8%	9.5%	12.0%	8.8%
10th Grade	32.1%	30.6%	23.3%	19.6%	14.0%
12th Grade	50.2%	36.5%	34.5%	31.9%	23.8%

*Percentage who reported using cigarettes one or more times in their life. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

E-CIGARETTE USE

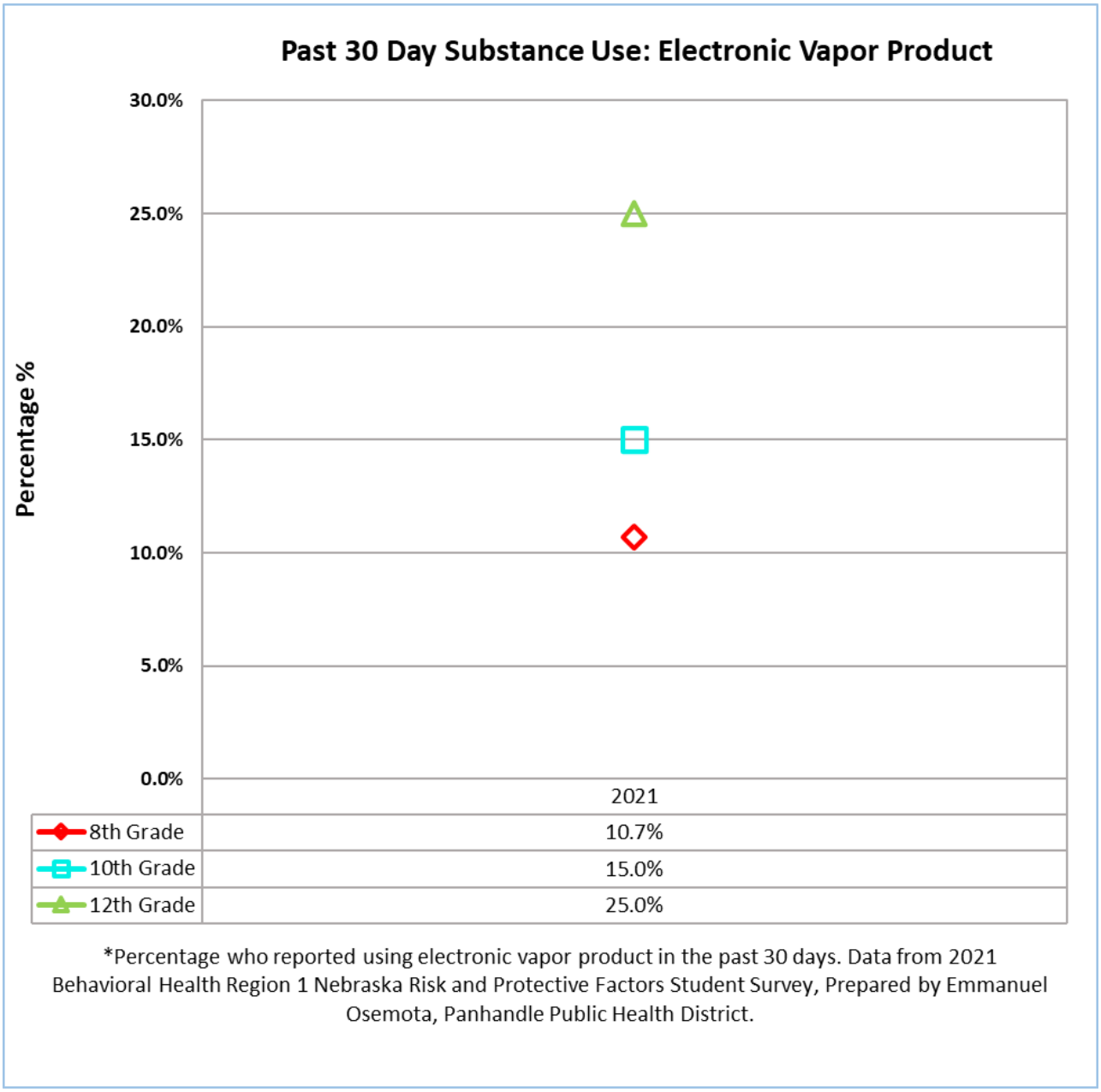
Only 2021 data exists for E-Cigarette usage among youth. The use of e-cigarettes among youth is highest for 12th graders and lowest for 8th graders.
While the lifetime usage of e-cigarettes is only 5.8% for 8th graders, the numbers are almost double in the past 30 days usage.

Figure 81: Electronic Vapor Use Among Youth in 2021, Lifetime



*Percentage who reported using electronic vapor at least once in their lifetime. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 82: Electronic Vapor Use Among Youth in 2021, Last 30 Days

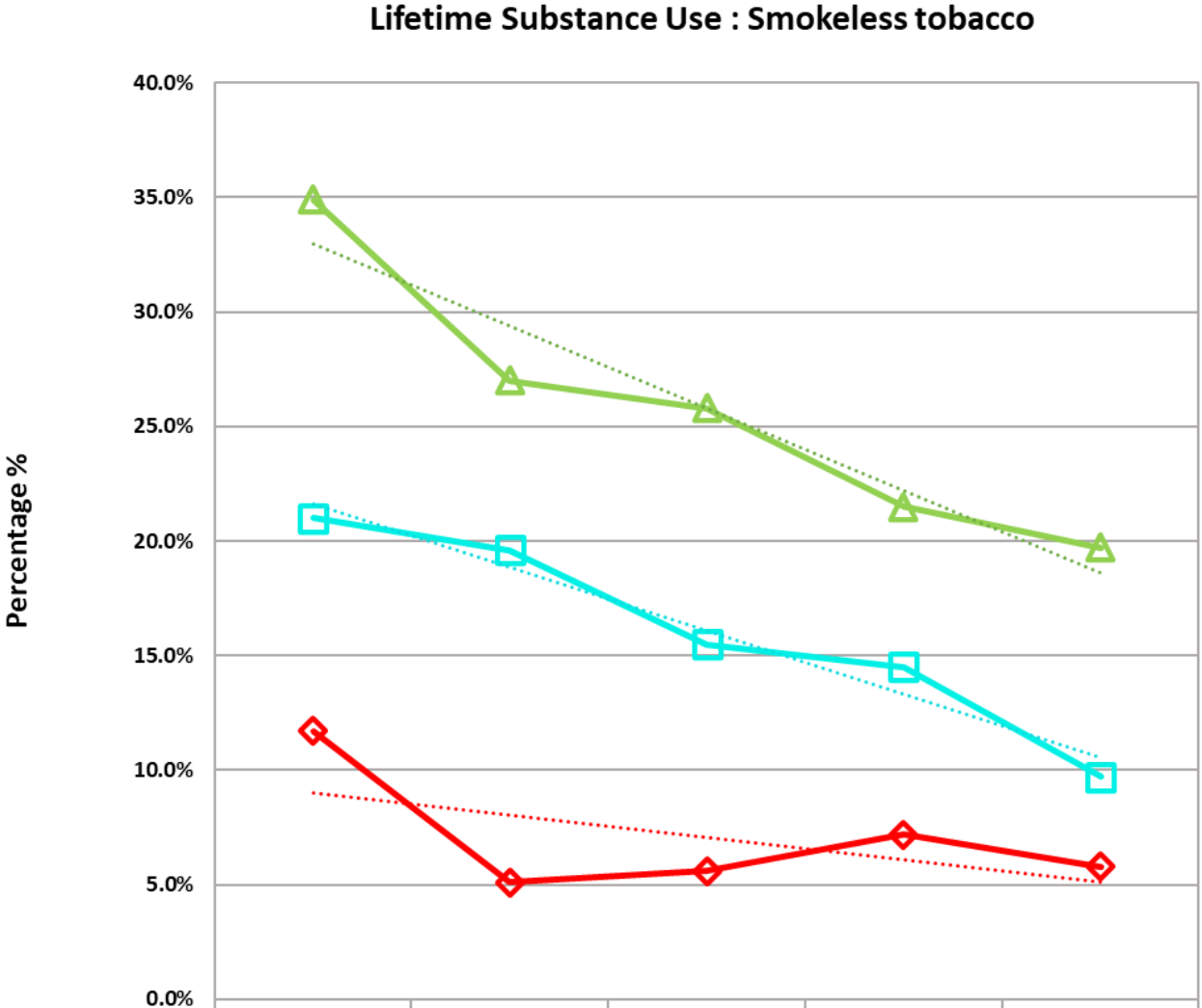


*Percentage who reported using electronic vapor product in the past 30 days. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

SMOKELESS TOBACCO

The percentage of youth who have ever used smokeless tobacco (chew, snuff, plug, dipping tobacco or chewing tobacco) has gone downward from 2012-2021. Lifetime usage is down by half among 8th and 12th graders. In both lifetime usage and past 30 days usage there was a slight increase in 2018 among 8th graders but it has gone down since then.

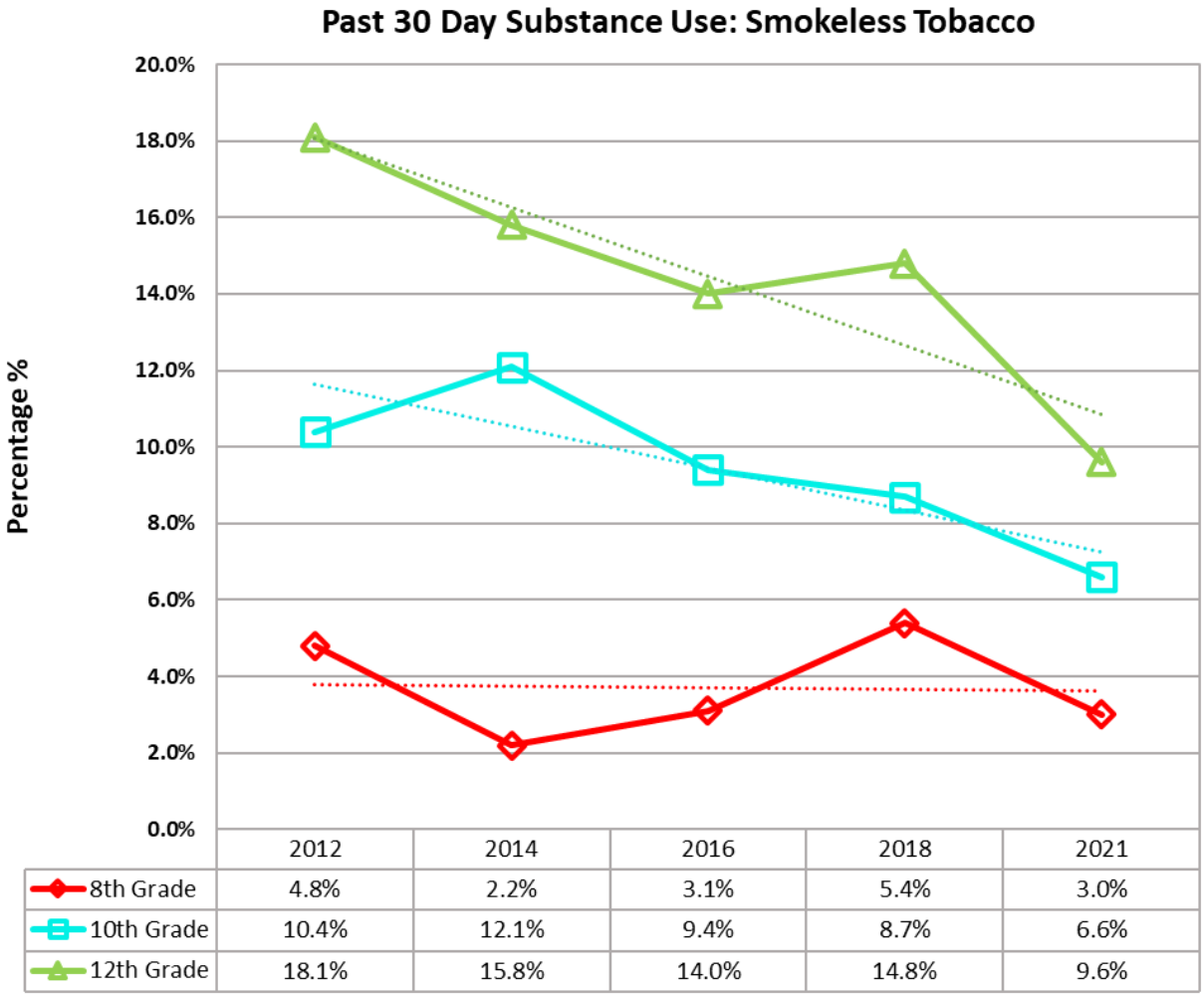
Figure 83: Lifetime Smokeless Tobacco Use Among Youth



	2012	2014	2016	2018	2021
8th Grade	11.7%	5.1%	5.6%	7.2%	5.8%
10th Grade	21.0%	19.6%	15.5%	14.5%	9.7%
12th Grade	34.9%	27.0%	25.8%	21.5%	19.7%

*Percentage who reported using smokeless tobacco at least once in their lifetime. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 84: Past 30-Day Smokeless Tobacco Use Among Youth



	2012	2014	2016	2018	2021
8th Grade	4.8%	2.2%	3.1%	5.4%	3.0%
10th Grade	10.4%	12.1%	9.4%	8.7%	6.6%
12th Grade	18.1%	15.8%	14.0%	14.8%	9.6%

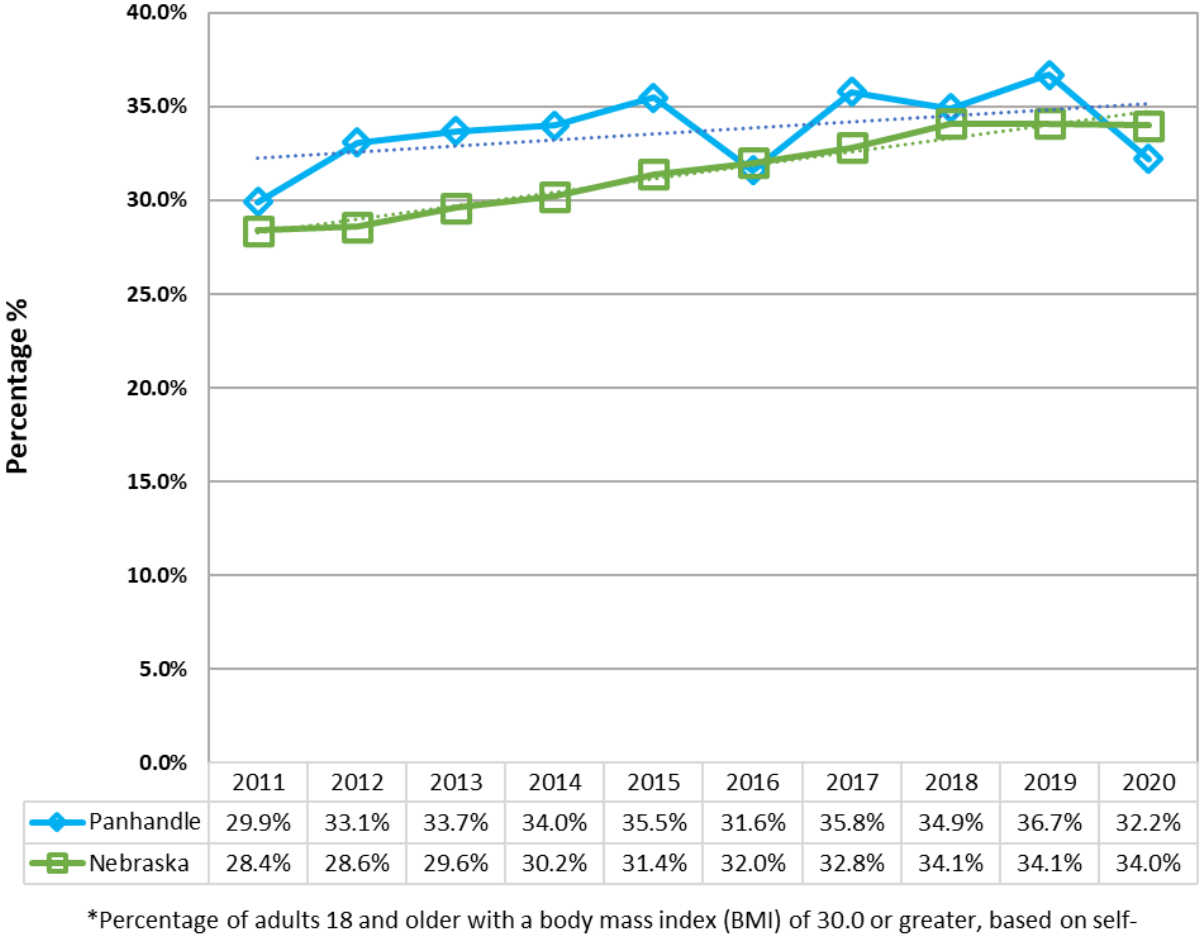
*Percentage who reported using smokeless tobacco one or more times in the past 30 days. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

OBESITY

Adult obesity is defined as a BMI (Body Mass Index) of 30 or higher. Heart disease, stroke, type 2 diabetes, and some cancers are related to obesity.[13]

Obesity among adults has grown since 2011 in both states. The percentage of Panhandle adults with obesity is slightly higher than the overall percentage of Nebraska adults with obesity.

Figure 85: Obesity Among Adults

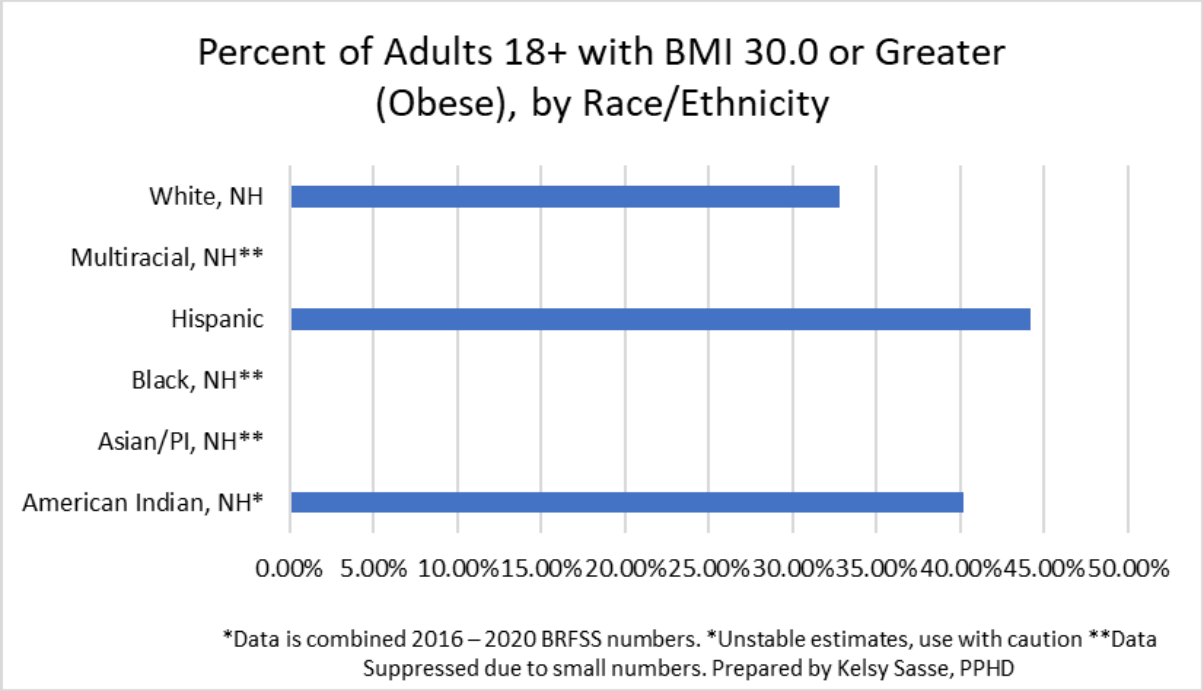


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	29.9%	33.1%	33.7%	34.0%	35.5%	31.6%	35.8%	34.9%	36.7%	32.2%
Nebraska	28.4%	28.6%	29.6%	30.2%	31.4%	32.0%	32.8%	34.1%	34.1%	34.0%

*Percentage of adults 18 and older with a body mass index (BMI) of 30.0 or greater, based on self-reported height and weight. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

[13] (CDC 2022)

Figure 86: Obesity Among Adults by Race/Ethnicity



The Percentage of adults 18 or older with a body mass index (BMI) of 30 or greater based on self-reported height and weight race/ethnicity is similar amongst the different race/ethnicity population in the Panhandle of Nebraska, with the Hispanic resident population having a slightly higher rate.

NUTRITION

Adults are recommended to consume between 2 and 3 cups of vegetables per day and between1 and 2 cups of fruit per day. The Panhandle and the state had very similar rates of vegetable consumption. 39.5% of Nebraska adults report consuming fruits less than one time per day, which is slightly higher than the rate in the Panhandle.

Figure 87: Adults Consuming Vegetables Less than 1 time per day

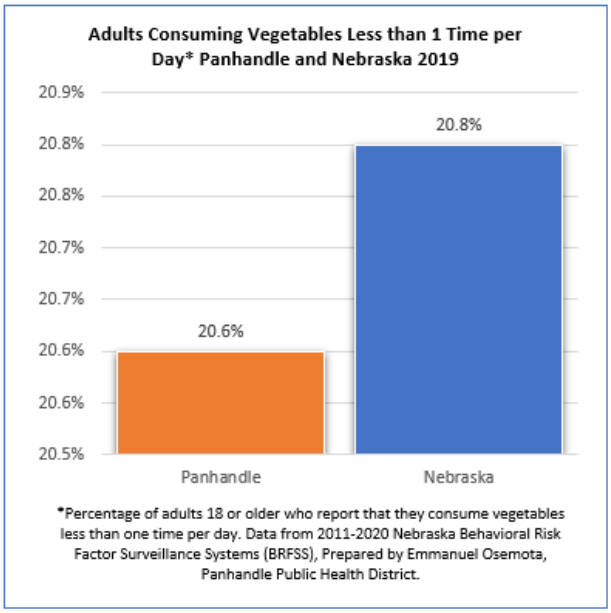
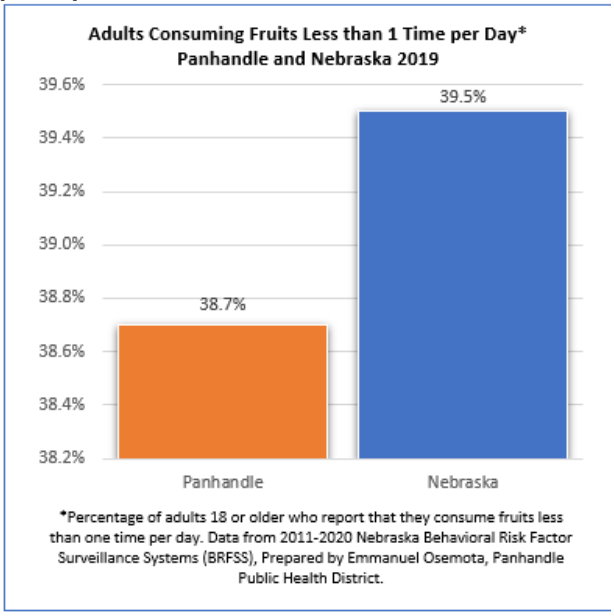
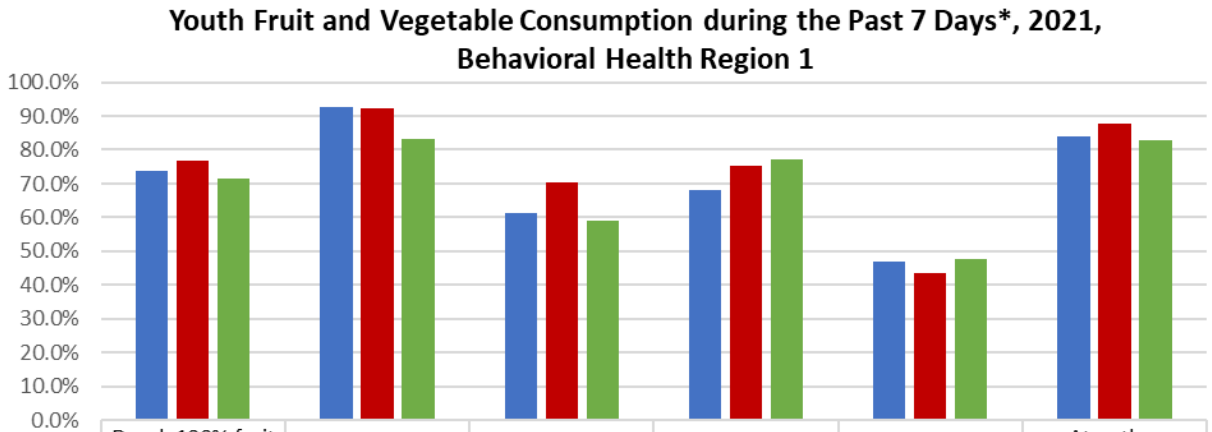


Figure 88: Adults Consuming Fruits less than 1 time per day



Youth in grades 8th through 12th grade are recommended to consume 1 1/2-2 cups of fruit per day, and 2 1/2 to 3 cups of vegetables per day. A survey of youth fruit and vegetable consumption in 2021 found that the majority of youths ate a fruit or vegetable one or more times in the past week.

Figure 89: Youth Fruit and Vegetable Consumption



	Drank 100% fruit juice	Ate fruit	Ate green salad	Ate potatoes	Ate carrots	Ate other vegetables
8th	73.8%	92.7%	61.3%	68.0%	47.1%	84.0%
10th	76.7%	92.4%	70.2%	75.2%	43.4%	87.7%
12th	71.6%	83.3%	59.0%	77.1%	47.8%	82.8%

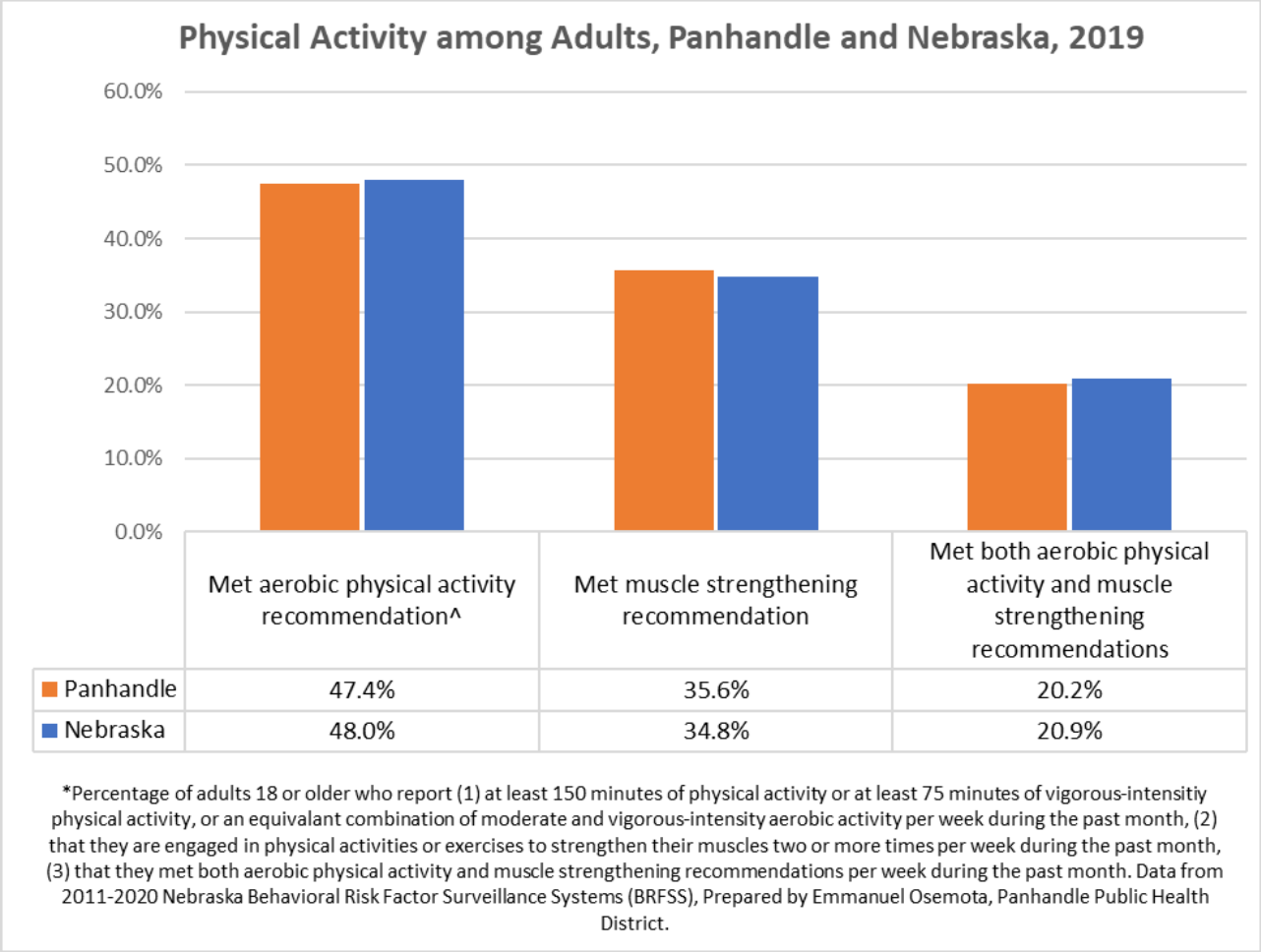
*Percentage who reported consuming the indicated drink or food one or more times during the past 7 days. Data from the Nebraska Risk and Protective Factors Student Survey; Prepared by Emmanuel Osemota, Panhandle Public Health District.

PHYSICAL ACTIVITY

ADULTS

In 2019, 47.4% of Panhandle adults met aerobic physical activity recommendations, 35.6% met muscle strengthening recommendations and 20.2% met both aerobic physical activity and muscle strengthening recommendations. The percentages in the Panhandle aren't much different from the percentages in Nebraska. The percent of individuals meeting both aerobic physical activity and muscle strengthening recommendations (at least 150 minutes of moderate-intensity physical activity, or at least 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate and vigorous intensity activity per week, is lowest among the American Indian population in the Panhandle.

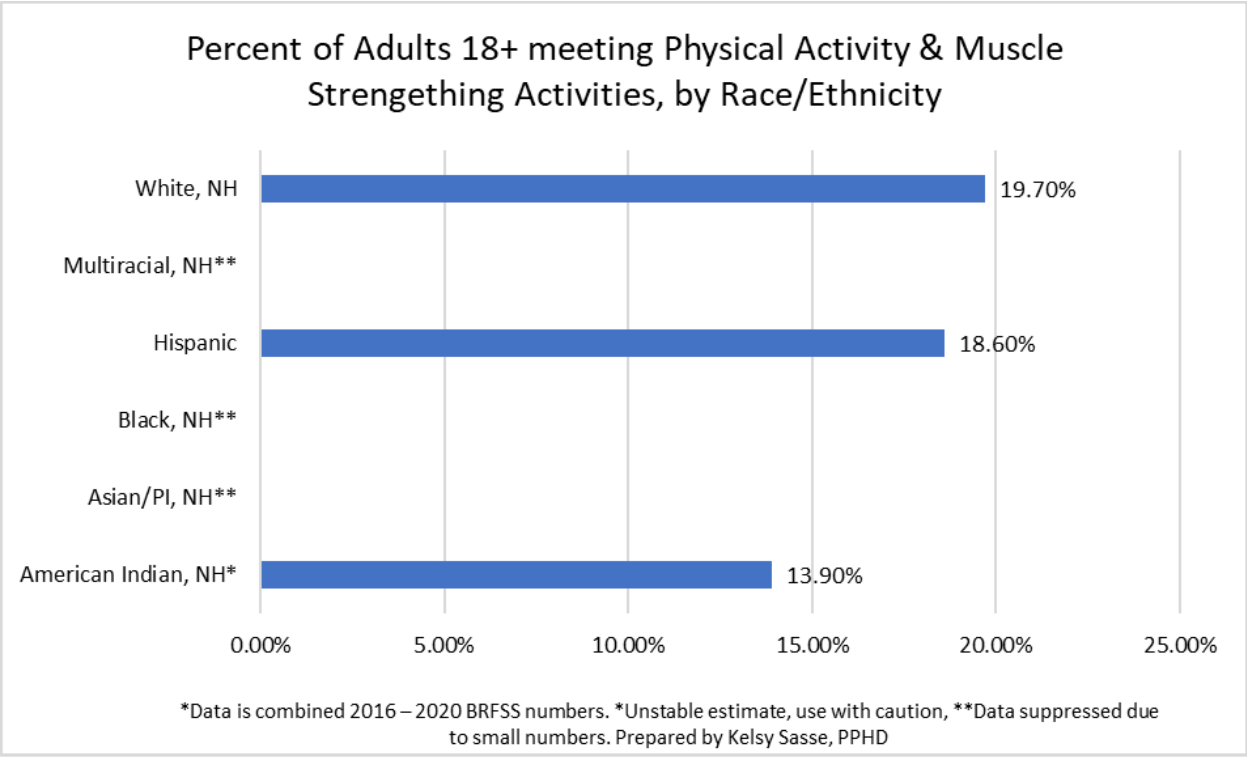
Figure 90: Physical Activity Among Adults



	Met aerobic physical activity recommendation^	Met muscle strengthening recommendation	Met both aerobic physical activity and muscle strengthening recommendations
Panhandle	47.4%	35.6%	20.2%
Nebraska	48.0%	34.8%	20.9%

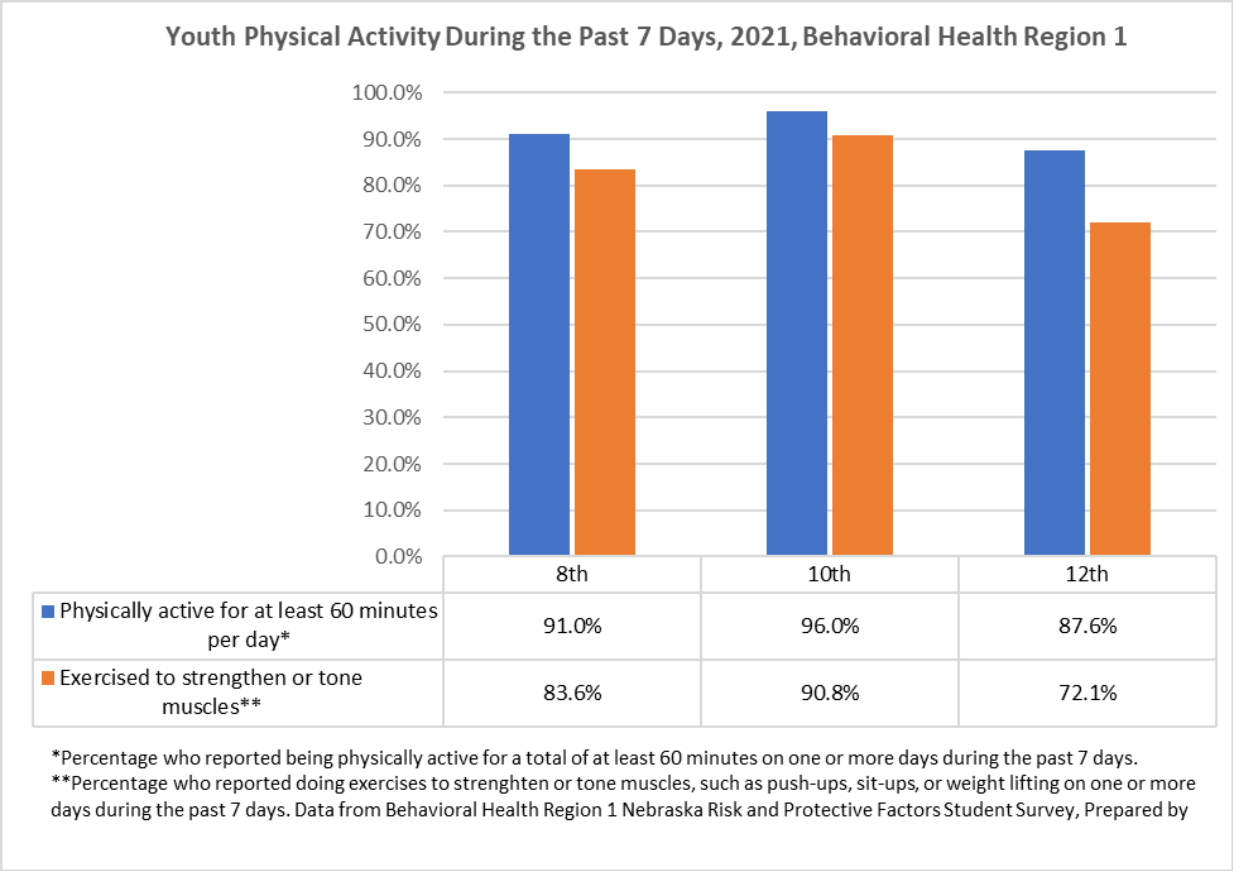
*Percentage of adults 18 or older who report (1) at least 150 minutes of physical activity or at least 75 minutes of vigorous-intensitiy physical activity, or an equivalant combination of moderate and vigorous-intensity aerobic activity per week during the past month, (2) that they are engaged in physical activities or exercises to strengthen their muscles two or more times per week during the past month, (3) that they met both aerobic physical activity and muscle strengthening recommendations per week during the past month. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 91: Physical Activity Among Adults by Race/Ethnicity



YOUTH

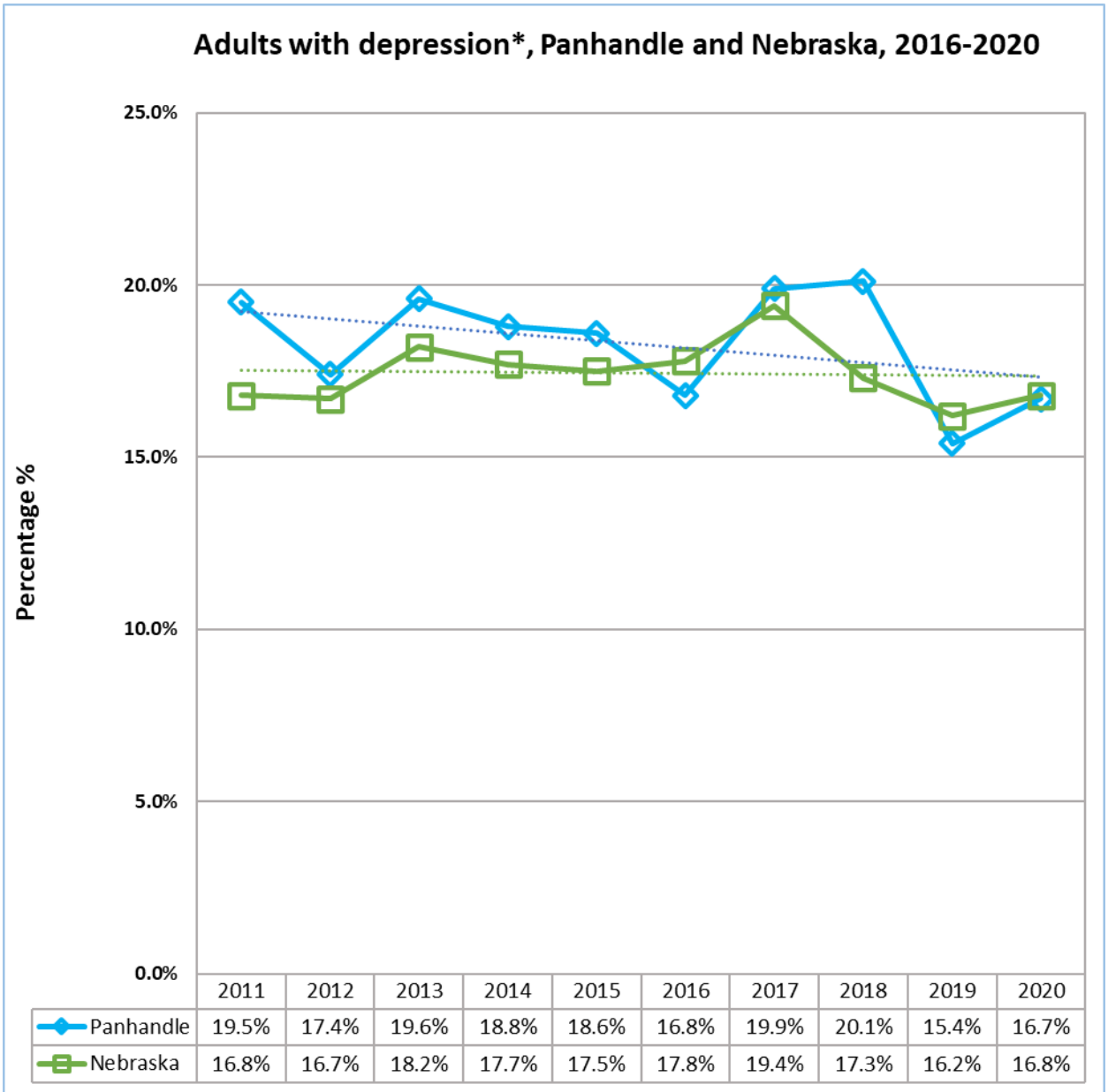
Figure 92: Youth Physical Activity



The majority of Panhandle youth report being physically active for at least 60 minutes per day, and that they regularly exercise to strengthen or tone muscles. The percentages of both physical activity and strength exercise are lower among 12th graders when compared to the younger students.

MENTAL HEALTH

Figure 93: Adults with Depression



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	19.5%	17.4%	19.6%	18.8%	18.6%	16.8%	19.9%	20.1%	15.4%	16.7%
Nebraska	16.8%	16.7%	18.2%	17.7%	17.5%	17.8%	19.4%	17.3%	16.2%	16.8%

*Percentage of adults 18 and older who report that they have ever told by a doctor, nurse or other health professional that they have a depressive disorder. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

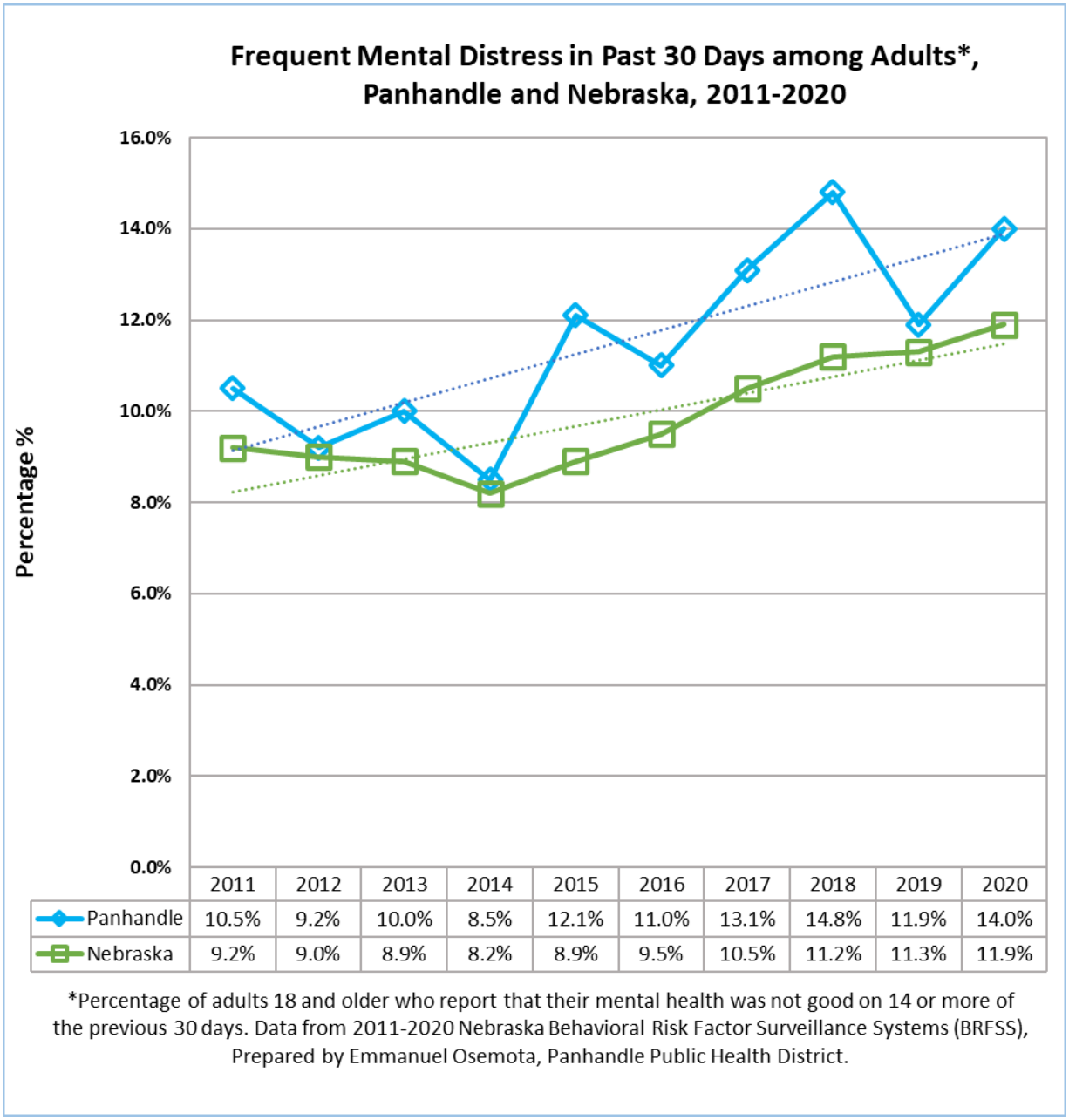
"A mental illness is a condition that affects a person's thinking, feeling, behavior or mood. These conditions deeply impact day-to-day living and may also affect the ability to relate to others."[14]

[14] (National Alliance on Mental Illness 2020)

Approximately 1 in 5 US adults experience mental illness, and 50% of all lifetime mental illness begins by age 14.

The percentage of Panhandle adults who have ever been diagnosed with depression has had slight ups and downs over the years. There is an overall decrease in the Panhandle and the state percentages have remained constant.

Figure 94: Adult Frequent Mental Distress



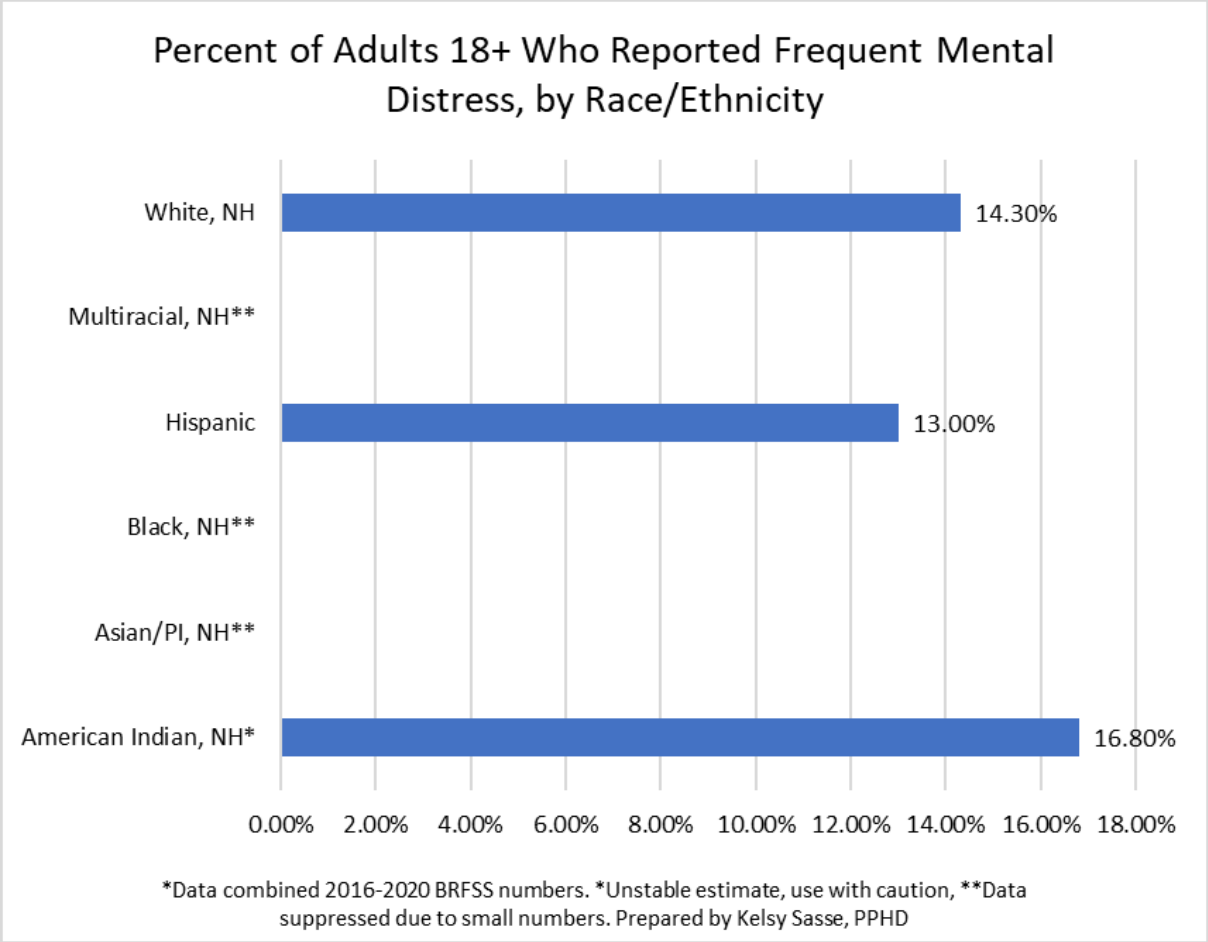
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	10.5%	9.2%	10.0%	8.5%	12.1%	11.0%	13.1%	14.8%	11.9%	14.0%
Nebraska	9.2%	9.0%	8.9%	8.2%	8.9%	9.5%	10.5%	11.2%	11.3%	11.9%

*Percentage of adults 18 and older who report that their mental health was not good on 14 or more of the previous 30 days. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

The percentage of adults in the Panhandle who experienced frequent mental distress has been higher than the state, historically. In both states the percentage has gone upwards, the Panhandle saw the highest uptick in 2018 while Nebraska saw the highest percentage in 2020. The rate of

individuals who reported that their stress, depression, or problems with emotions were not good on 14 or more of the previous 30 days (defined as frequent mental distress) was highest among the American Indian population.

Figure 95: Adult Frequent Mental Distress by Race/Ethnicity



SUBSTANCE ABUSE

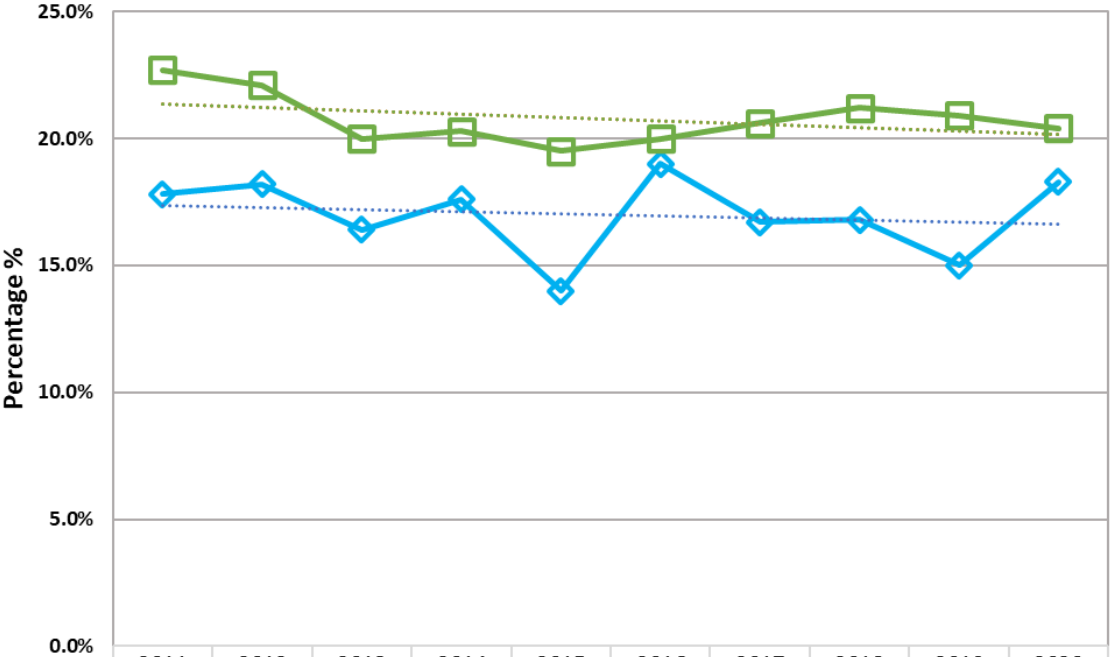
ALCOHOL

Misuse of alcohol includes underage drinking and binge drinking. Binge drinking is drinking 5 or more drinks on one occasion for men or 4 or more drinks on one occasion for women. Misuse of alcohol can contribute to increased health problems, such as injuries, violence, liver diseases, and cancer.[15]

BINGE DRINKING

The percentage of binge drinking among adults is higher across the state when compared to the Panhandle. Both are decreasing slightly over time. This rate is highest in the Panhandle among the American Indian population.

Figure 96: Adult Binge Drinking

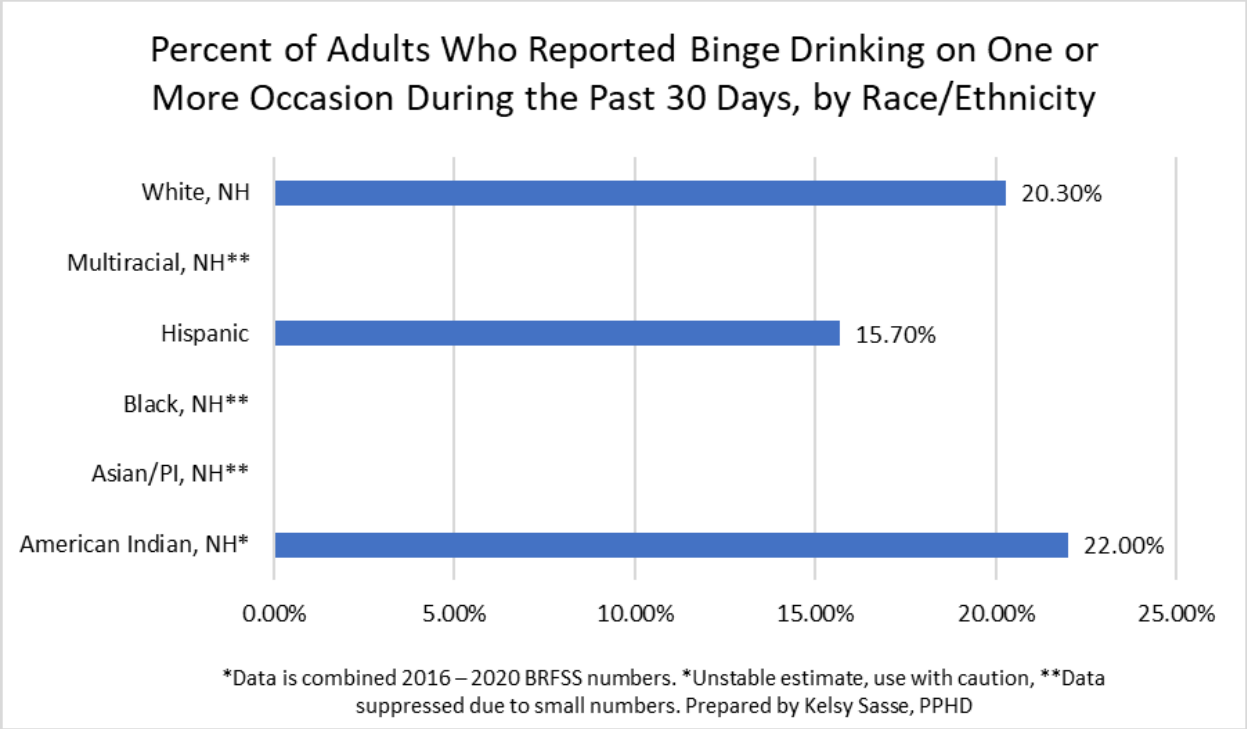


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	17.8%	18.2%	16.4%	17.6%	14.0%	19.0%	16.7%	16.8%	15.0%	18.3%
Nebraska	22.7%	22.1%	20.0%	20.3%	19.5%	20.0%	20.6%	21.2%	20.9%	20.4%

*Percentage of adults 18 and older who report having five or more alcoholic drinks for men/four or more alcoholic drinks for women on at least one occasion during the 30 days. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

[15] (CDC 2019)

Figure 97: Adult Binge Drinking by Race/Ethnicity



ALCOHOL IMPAIRED DRIVING

Adults who report alcohol-impaired driving is fairly low across the state of Nebraska, and historically lower in the Panhandle. The rate of individuals self-reporting alcohol impaired driving is highest among the white population in the Panhandle Region.

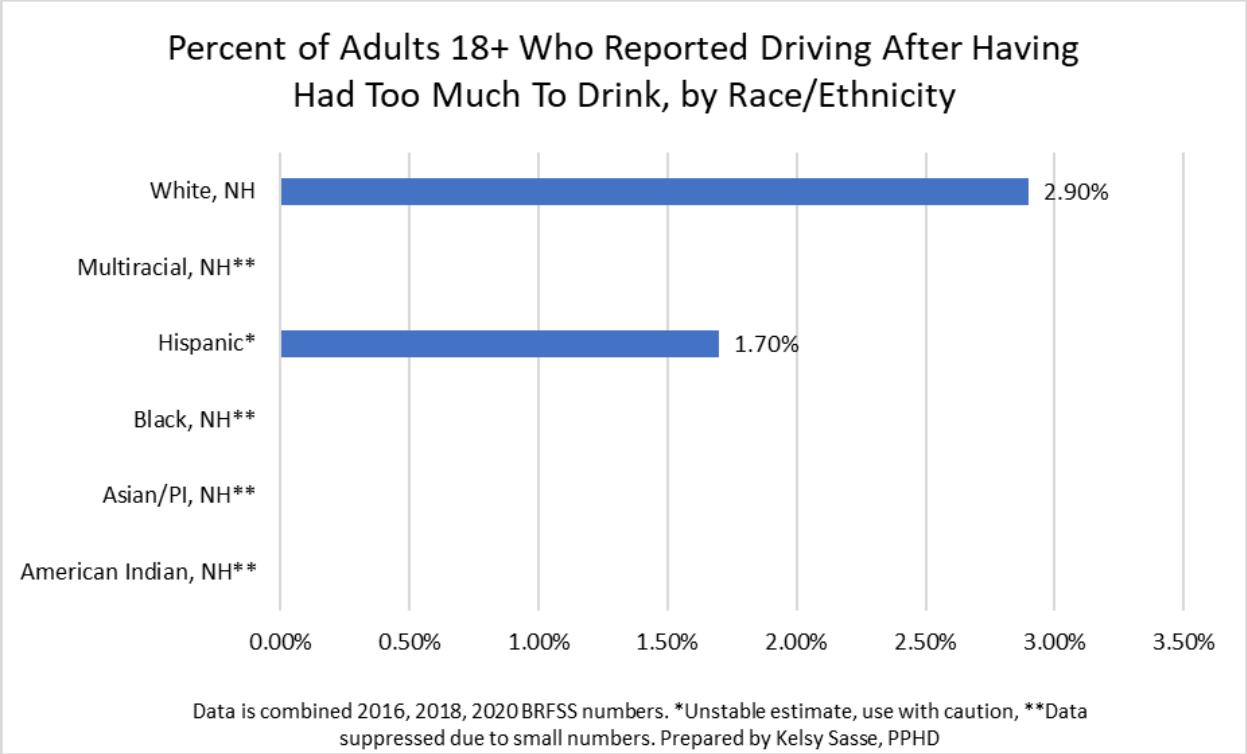
Alcohol-Impaired Driving among Adults*, Panhandle and Nebraska, 2012-2018

Figure 98: Adult Alcohol Impaired Driving

	2012	2014	2016	2018	2020
Panhandle	2.5%	2.5%	2.6%	2.2%	2.6%
Nebraska	3.4%	2.5%	3.4%	3.0%	2.5%

*Percentage of adults 18 and older who report driving after having had perhaps too much to drink during the past 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 99: Adult Alcohol Impaired Driving by Race/Ethnicity

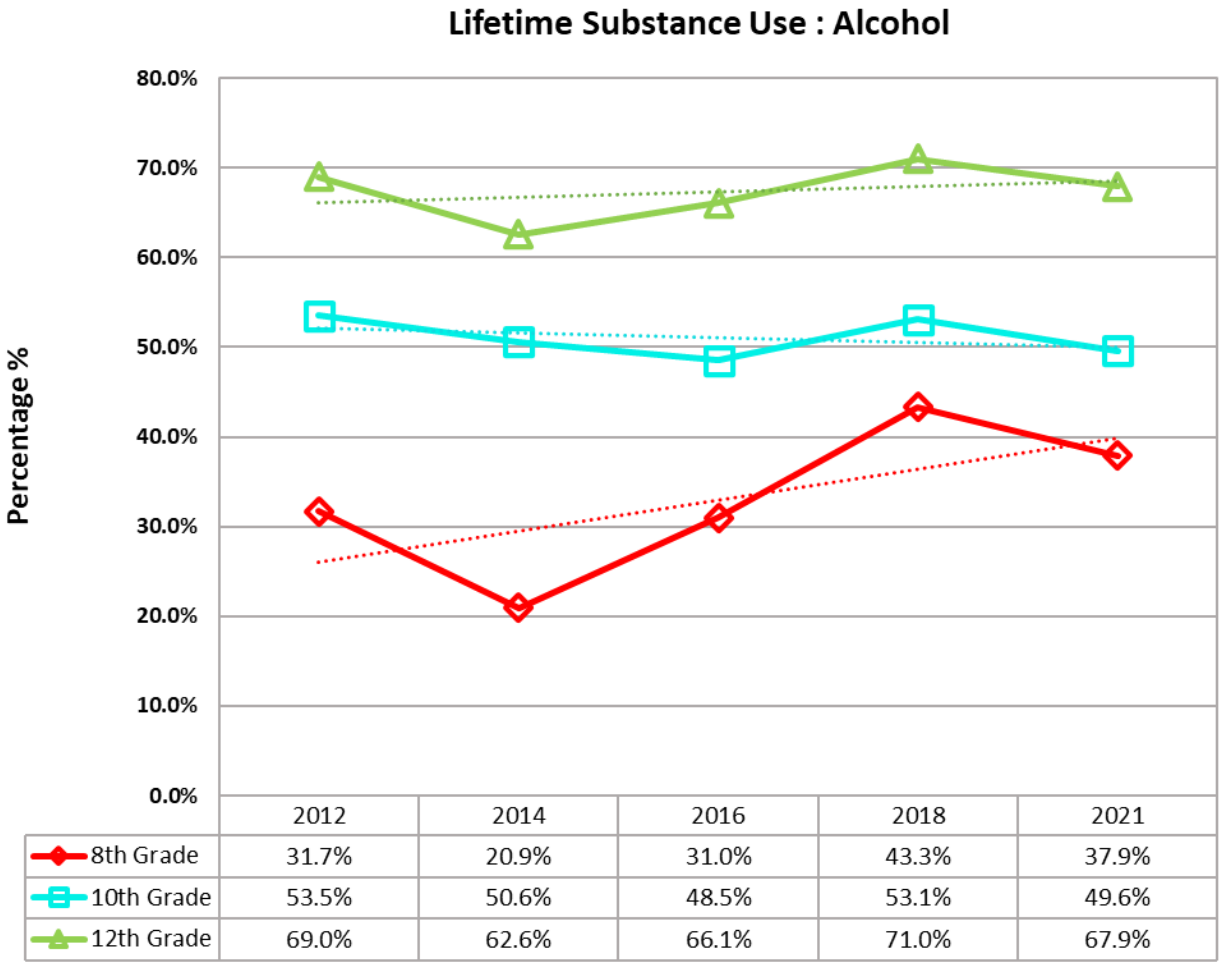


YOUTH ALCOHOL USE

The proportion of Panhandle youth who report they have ever tried alcohol (lifetime use) has decreased slightly in 10th and 12th graders over time, but slightly increased from 2014 to 2018 among 8th graders.

Youth lifetime usage and past 30 days alcohol usage have gone up among 8th graders. Both lifetime and past 30 days alcohol usage is highest among 12th graders compared to younger grades.

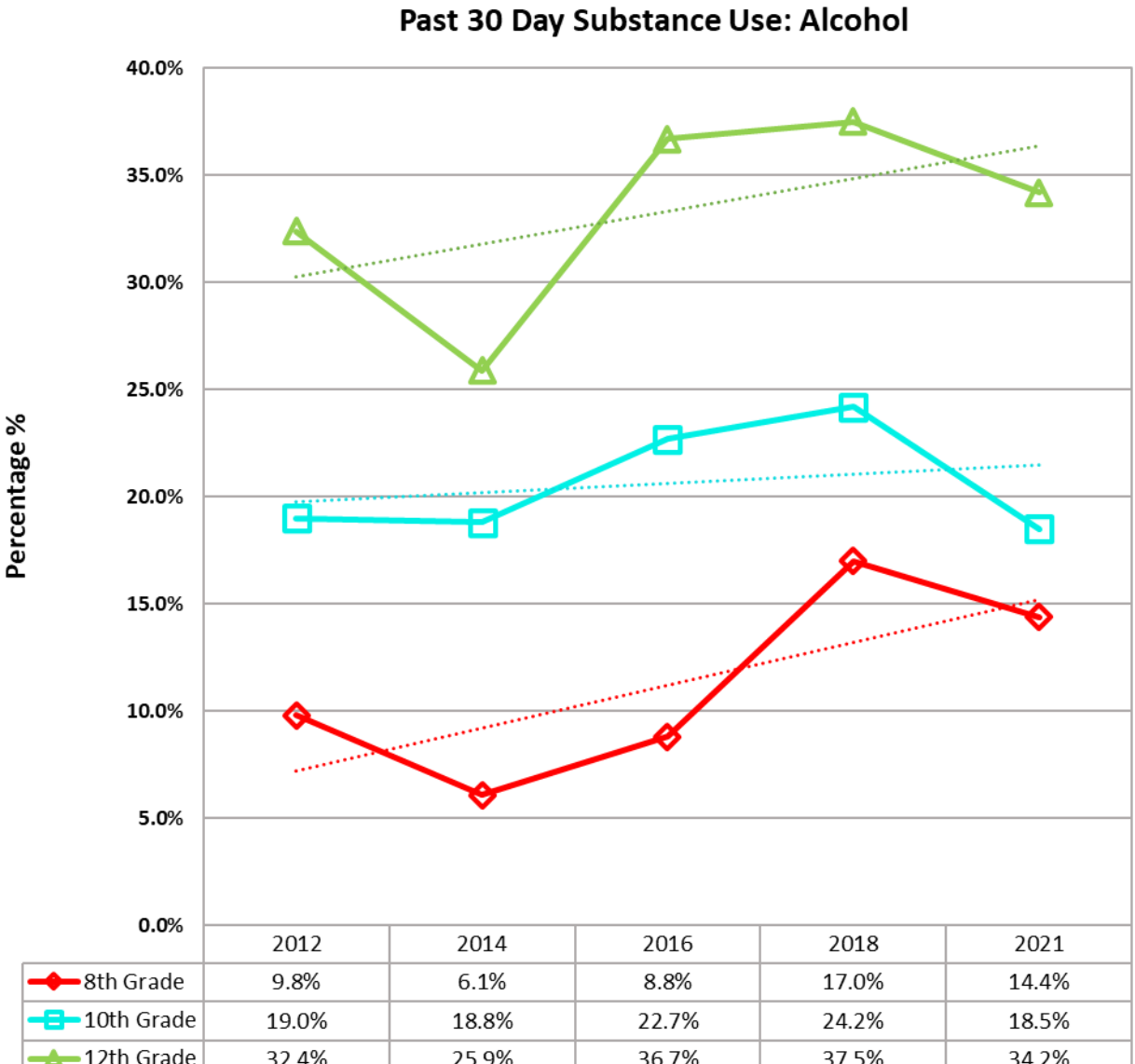
Figure 100: Youth Lifetime Alcohol Use



	2012	2014	2016	2018	2021
8th Grade	31.7%	20.9%	31.0%	43.3%	37.9%
10th Grade	53.5%	50.6%	48.5%	53.1%	49.6%
12th Grade	69.0%	62.6%	66.1%	71.0%	67.9%

*Percentage who reported consuming alcohol one or more times in their life. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 101: Youth Current Alcohol Use

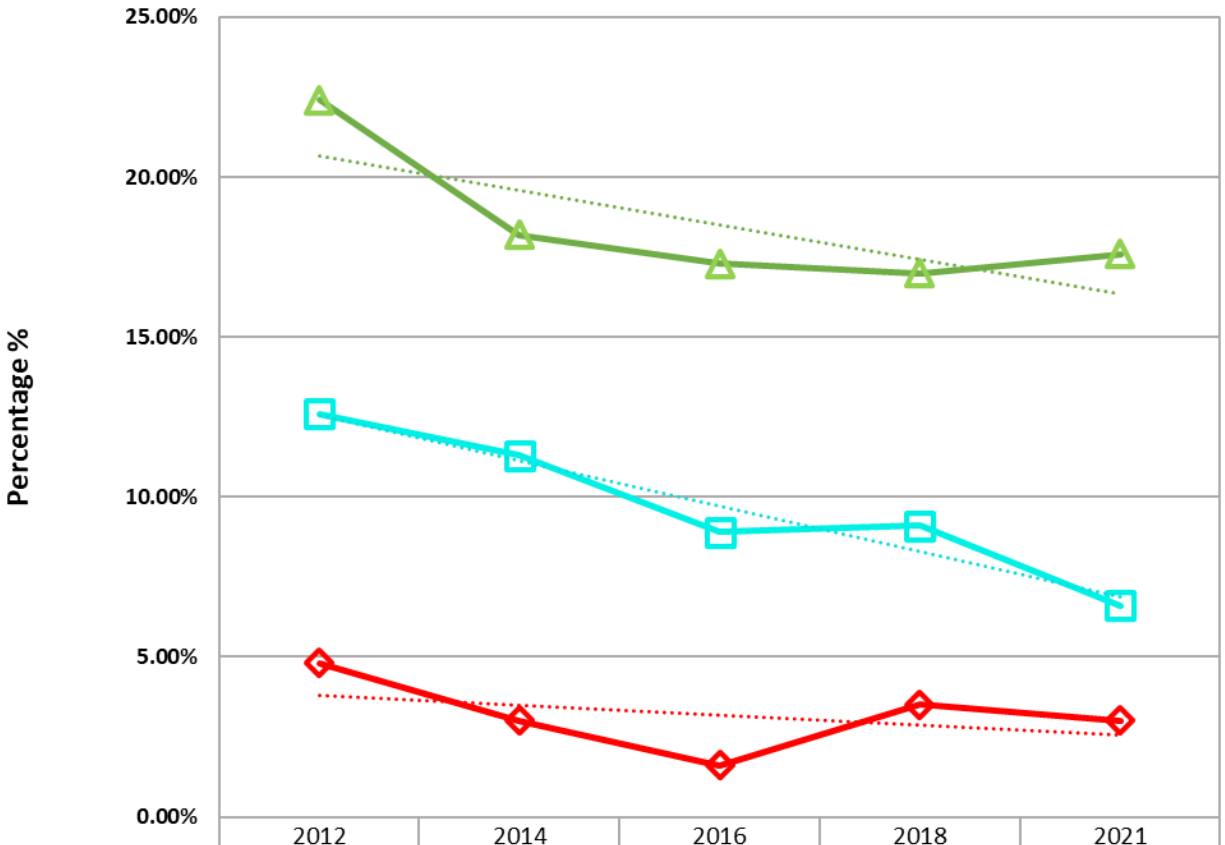


	2012	2014	2016	2018	2021
8th Grade	9.8%	6.1%	8.8%	17.0%	14.4%
10th Grade	19.0%	18.8%	22.7%	24.2%	18.5%
12th Grade	32.4%	25.9%	36.7%	37.5%	34.2%

*Percentage who reported consuming alcohol one or more times in the past 30 days. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

Binge drinking among youth has decreased over the years except among 8th graders who have remained relatively even, with a very small percentage reporting they binge drink. The change in percentage is most noticeable among 10th graders from 12.60% in 2012 to 6.60% in 2021.

Figure 102: Youth Binge Drinking



	2012	2014	2016	2018	2021
8th Grade	4.80%	3.00%	1.60%	3.50%	3.00%
10th Grade	12.60%	11.30%	8.90%	9.10%	6.60%
12th Grade	22.4%	18.2%	17.3%	17.0%	17.6%

*Percentage who reported consuming 4 drinks or more in a row within a couple hours in the past 30 days. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

MARIJUANA

The percentage of adults who report using marijuana in the past 30 days has increased over time. Panhandle rates of usage are slightly lower than statewide rates. When comparing rates across racial/ethnic groups, White Panhandle residents have higher rates of marijuana usage.

Figure 103: Adult Marijuana Use Past 30 Days

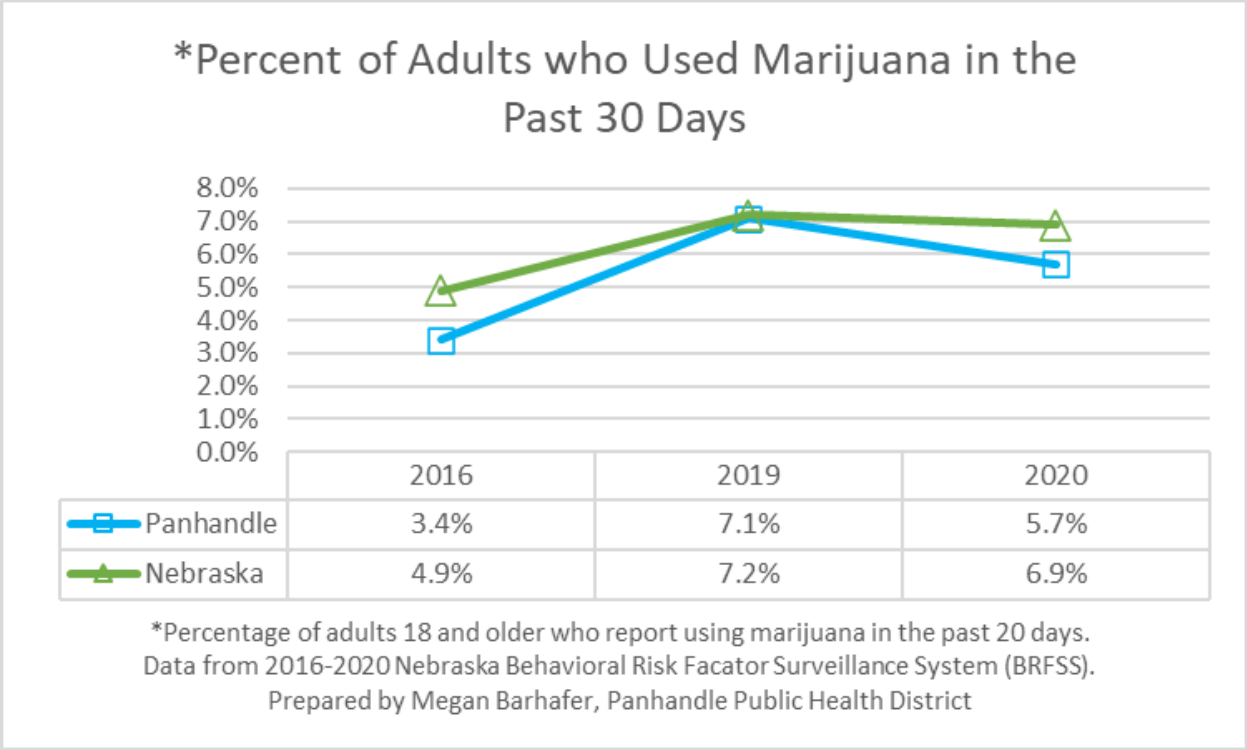
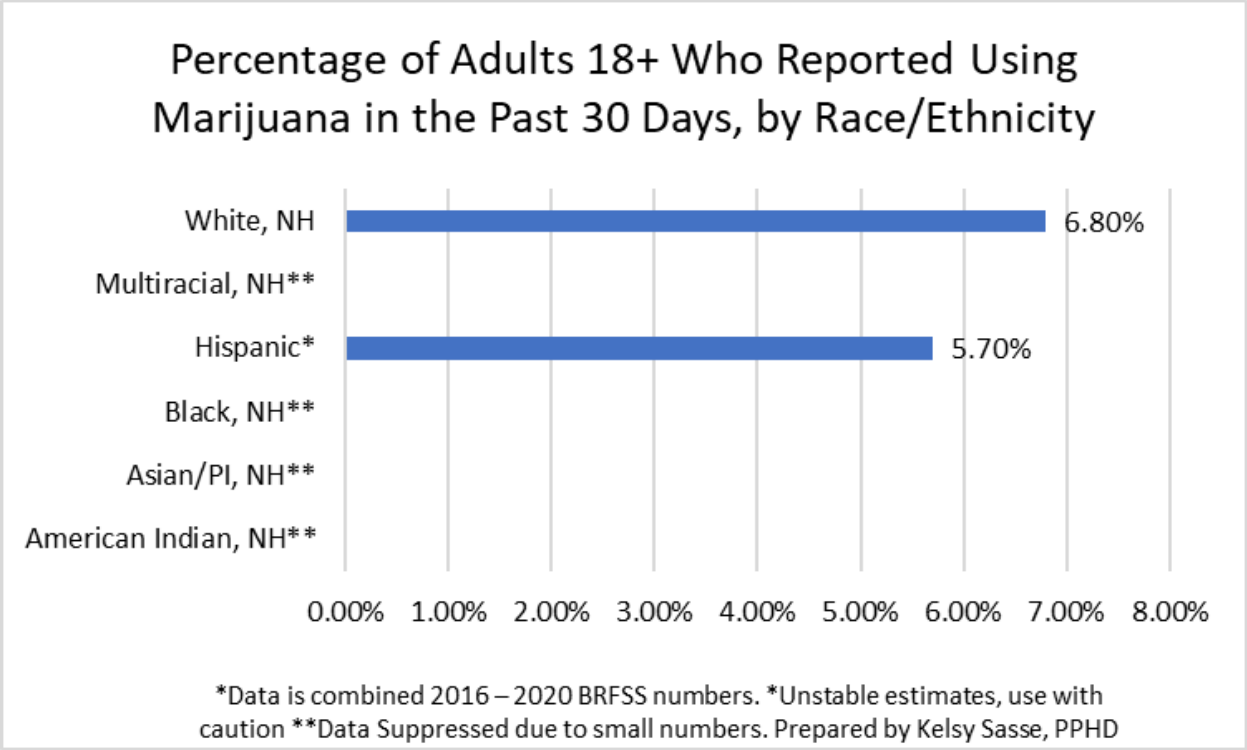


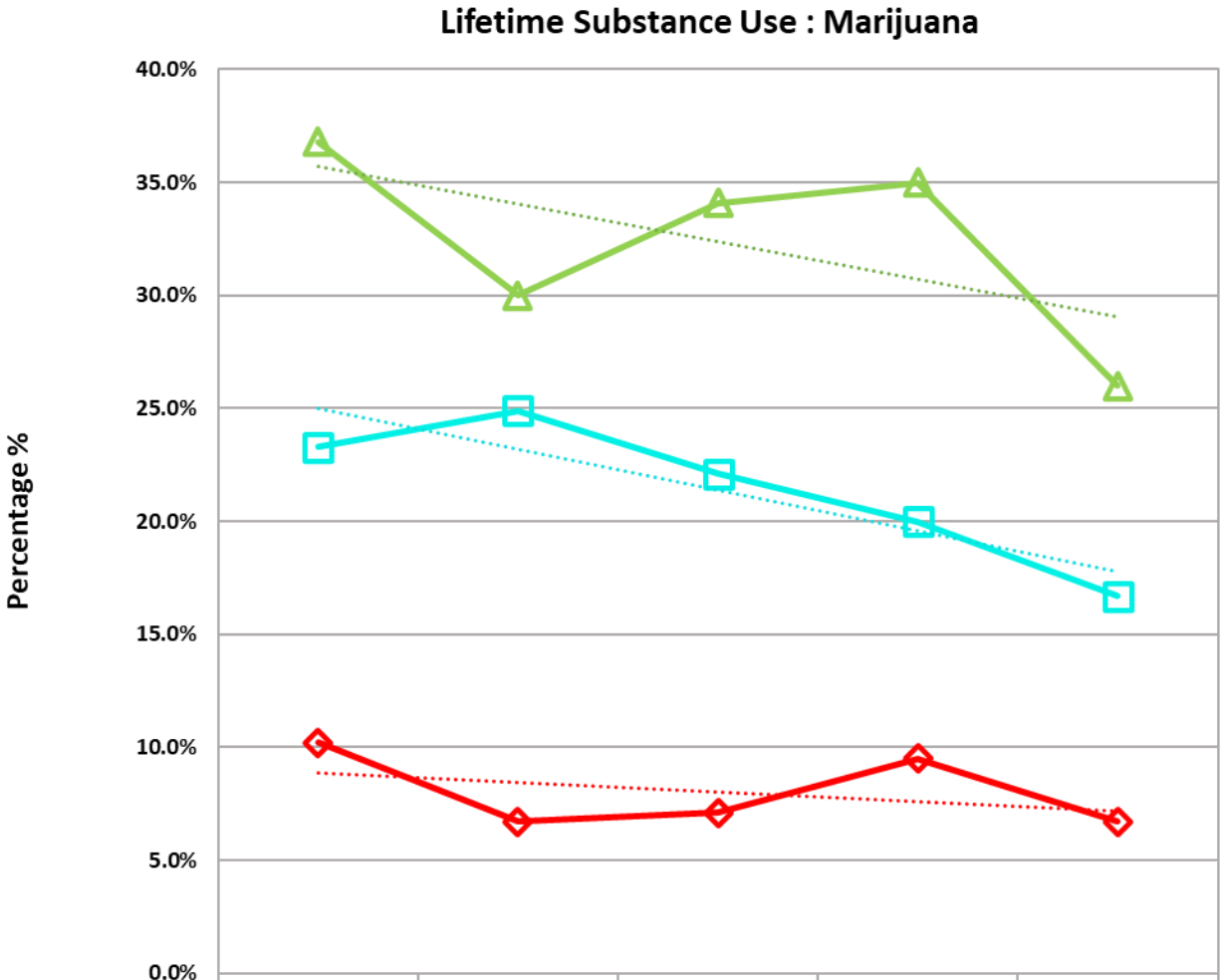
Figure 104: Adult Marijuana Use Past 30 Days by Race/Ethnicity



YOUTH MARIJUANA USE

The percentage of youth who report ever using marijuana or using it in the past 30 days have decreased among all youth.

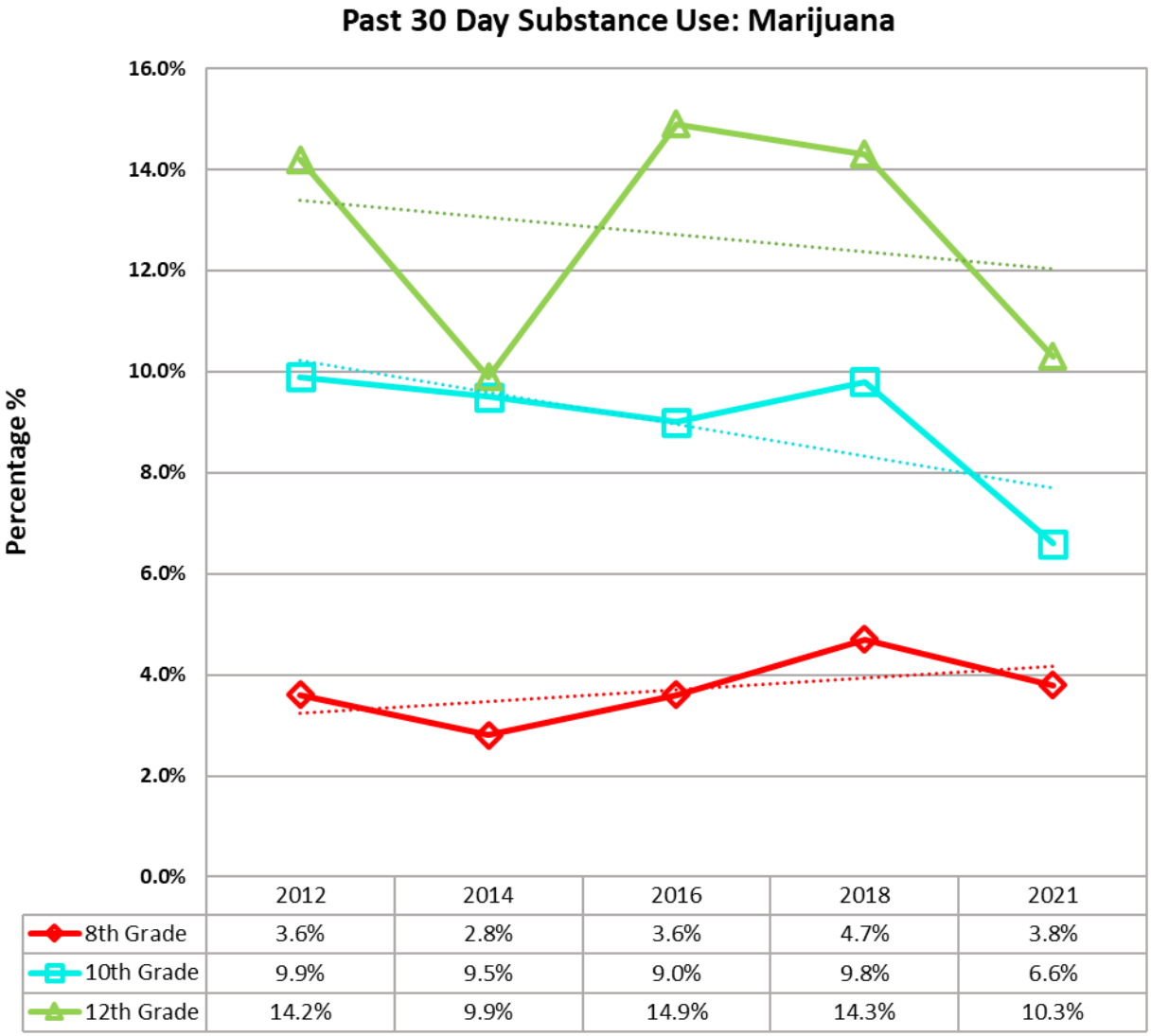
Figure 105: Youth Lifetime Marijuana Use



	2012	2014	2016	2018	2021
8th Grade	10.2%	6.7%	7.1%	9.5%	6.7%
10th Grade	23.3%	24.9%	22.1%	20.0%	16.7%
12th Grade	36.8%	30.0%	34.1%	35.0%	26.0%

*Percentage who reported using marijuana one or more times in their lifetime. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 106: Youth Current Marijuana Use



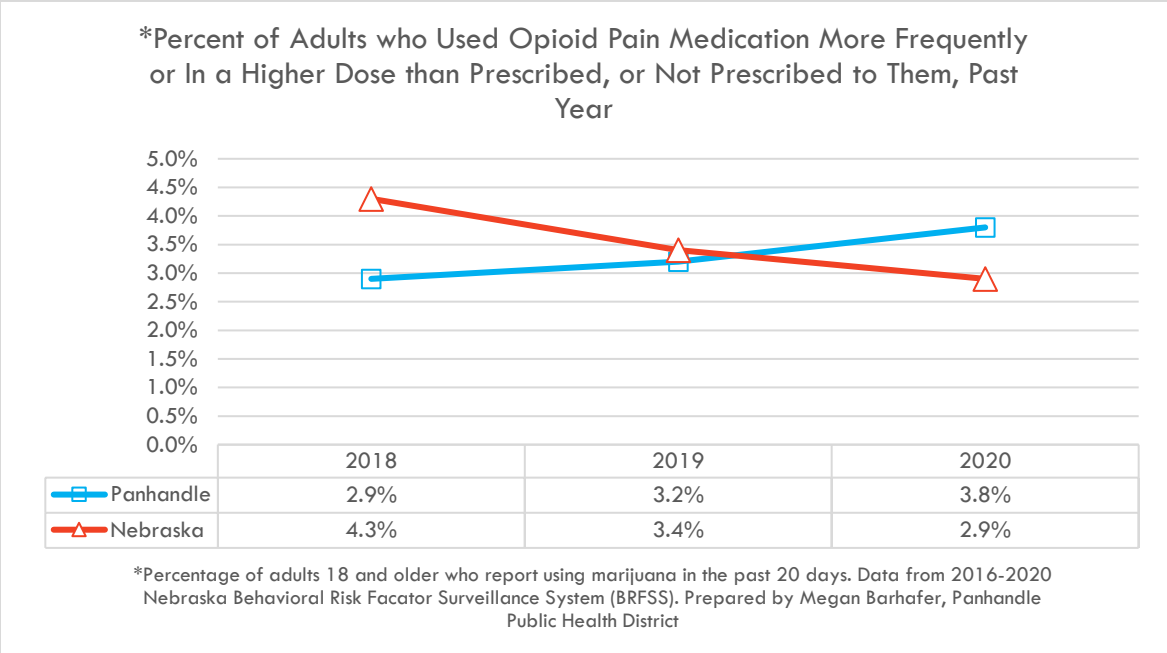
	2012	2014	2016	2018	2021
8th Grade	3.6%	2.8%	3.6%	4.7%	3.8%
10th Grade	9.9%	9.5%	9.0%	9.8%	6.6%
12th Grade	14.2%	9.9%	14.9%	14.3%	10.3%

*Percentage who reported using marijuana one or more times in the past 30 days. Data from 2021 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District.

OPIOID AND PRESCRIPTION DRUGS

The state of Nebraska has not seen the bulk of Opioid Overdose deaths, but the state has been proactive in working to decrease opioid addiction.[16] Statewide rates of Opioid misuse have decreased over time. Panhandle rates of Opioid misuse have slightly increased since 2018. Rates of misuse among Hispanic residents are higher than among White residents.

Figure 107: Opioid Pain Misuse by Adults



*Percentage of adults 18 and older who report using marijuana in the past 20 days. Data from 2016-2020 Nebraska Behavioral Risk Facator Surveillance System (BRFSS). Prepared by Megan Barhafer, Panhandle Public Health District

[16] (DHHS 2023)

Figure 108: Opioid Pain Misuse by Adults by Race/Ethnicity

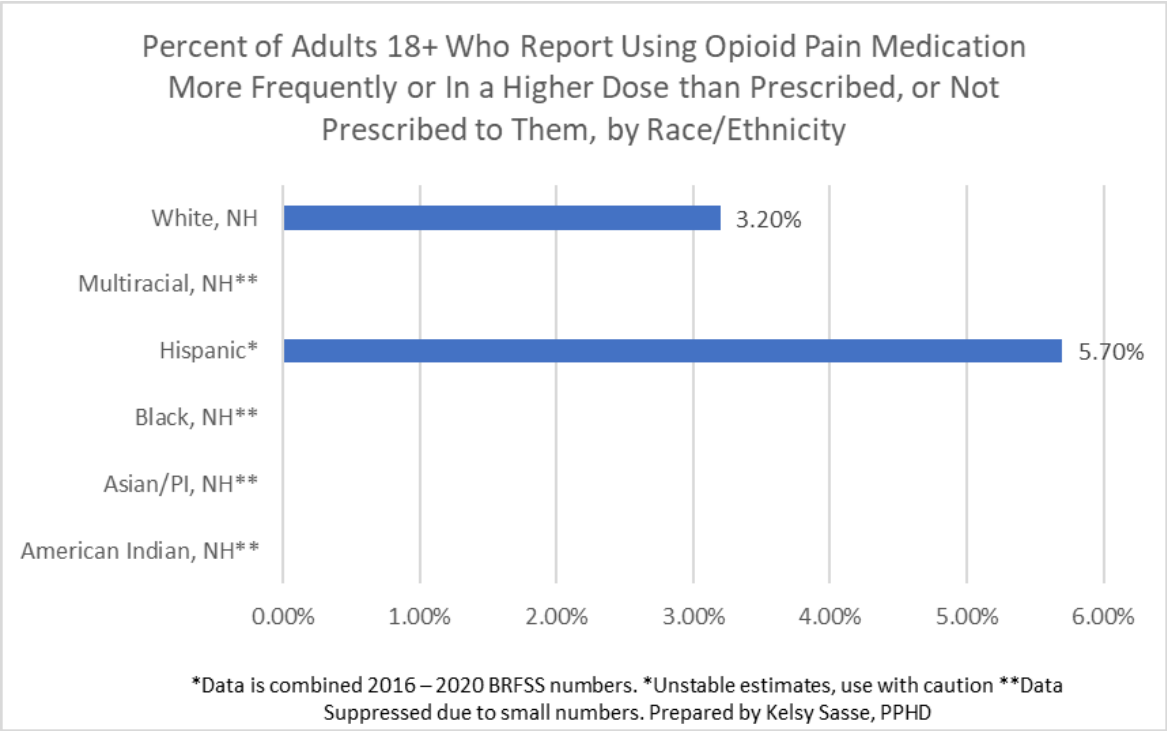
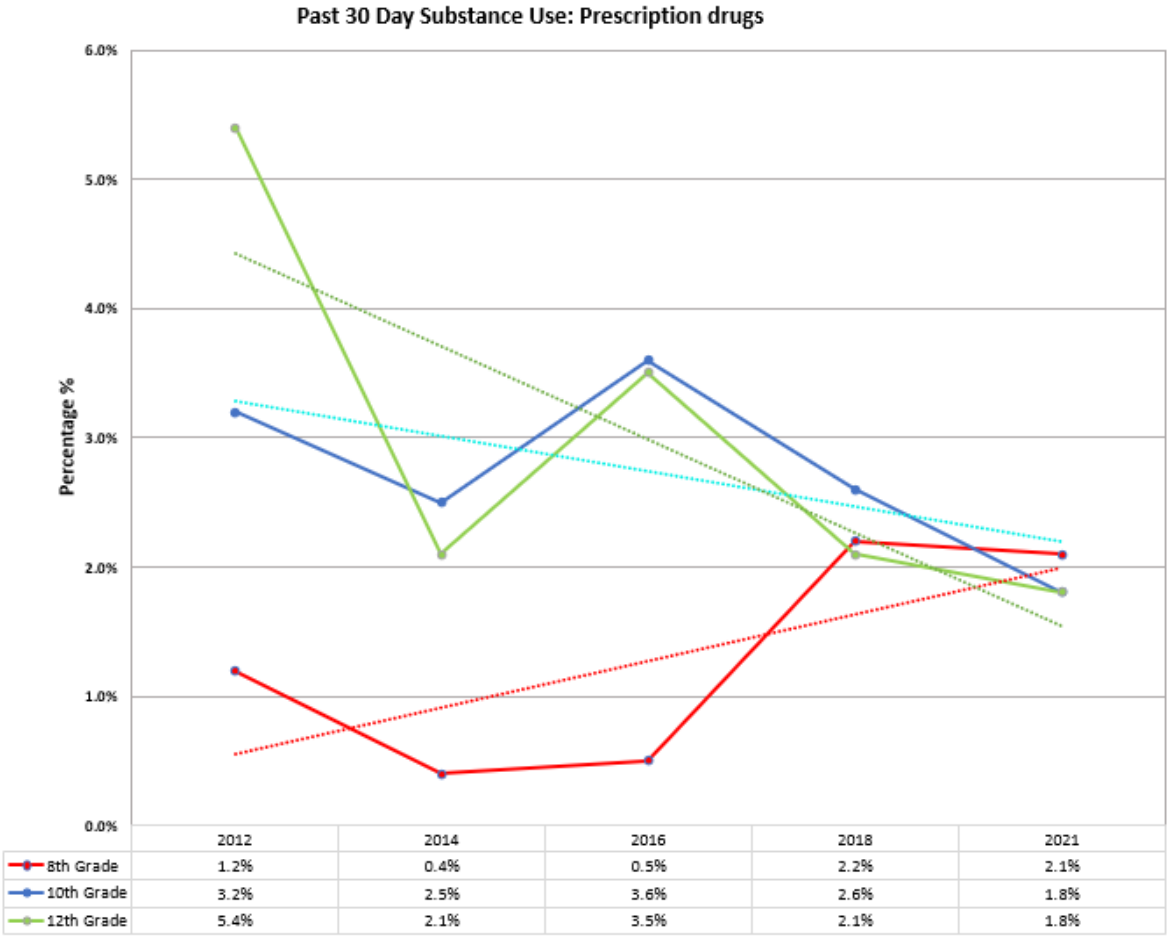


Figure 109: Youth Prescription Drug Use



	2012	2014	2016	2018	2021
8th Grade	1.2%	0.4%	0.5%	2.2%	2.1%
10th Grade	3.2%	2.5%	3.6%	2.6%	1.8%
12th Grade	5.4%	2.1%	3.5%	2.1%	1.8%

*Percentage who report using prescription drugs in the past 30 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey, Prepared by Emmanuel Osemota, Panhandle Public Health District

INJURY

MOTOR VEHICLE CRASHES

There were 1,376 motor vehicle crashes in the Panhandle in 2020, resulting in 554 injured individuals and 26 deaths. The rate of Panhandle adults that always wear a seatbelt is consistently lower than the broader state of Nebraska, by approximately 12 points. The rate of seatbelt use (always wear a seatbelt while riding or driving in a car) is highest among the American Indian population.

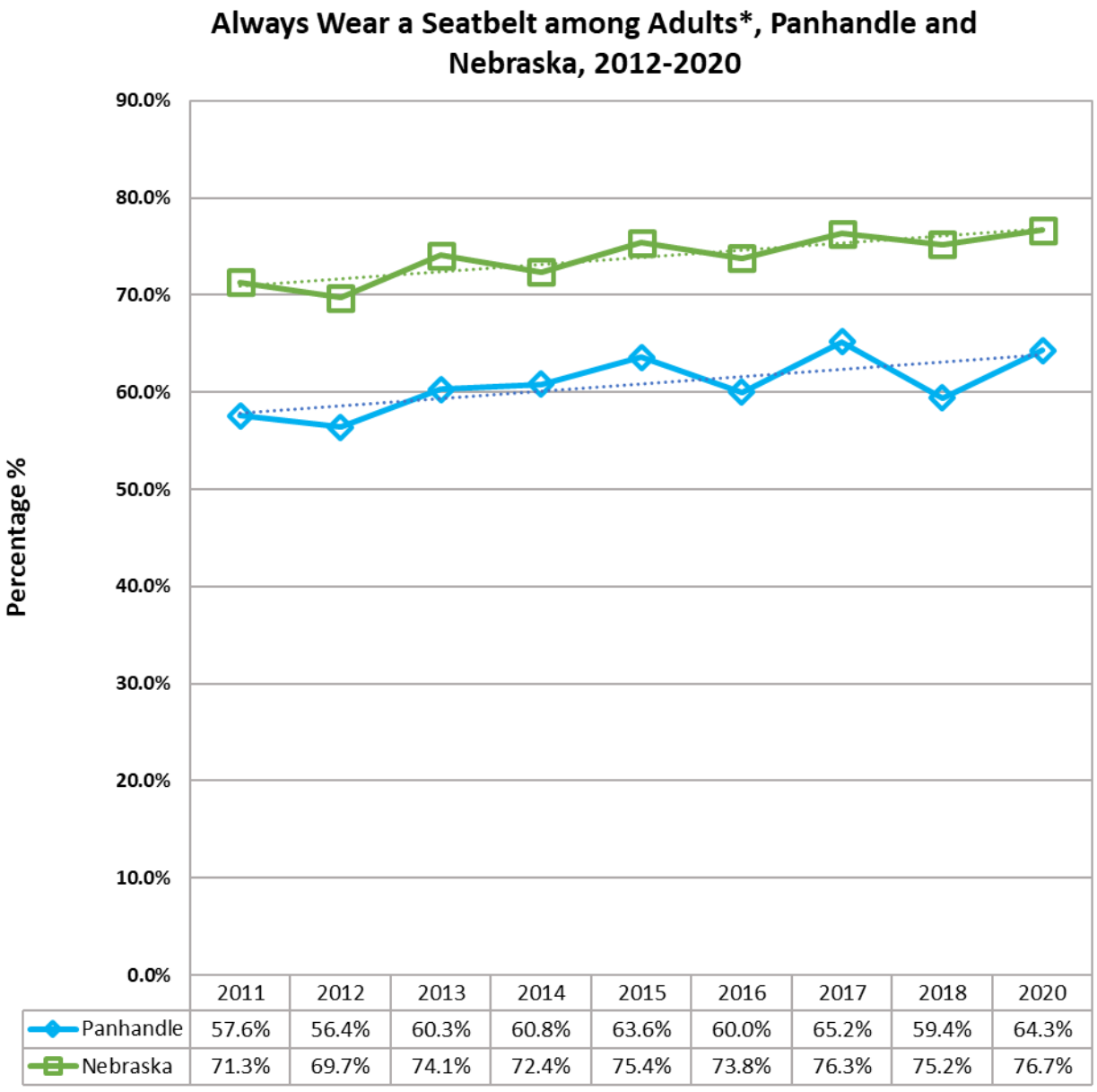
Figure 110: Panhandle Motor Vehicle Crash Data by County, 2020

County	Crashes				Persons killed and injured	
	Total	Fatal	Injury	PDO*	Killed	Injury
Banner	24	1	6	17	1	7
Box Butte	142	1	40	101	1	65
Cheyenne	157	4	35	118	4	48
Dawes	121	1	28	92	1	33
Deuel	50	3	10	37	4	15
Garden	34	1	5	28	1	12
Grant	4	1	2	1	1	2
Kimball	76	3	19	54	4	33
Morrill	71	2	20	49	2	27
Scotts Bluff	595	6	192	397	7	277
Sheridan	79	0	22	57	0	31
Sioux	23	0	4	19	0	4
Panhandle	**1,376**	**23**	**383**	**970**	**26**	**554**
Nebraska	**29,418**	**217**	**9,847**	**19,354**	**233**	**14,100**

*PDO = Property Damage Only

Source: 2019 Nebraska Traffic Crash Facts Annual Report

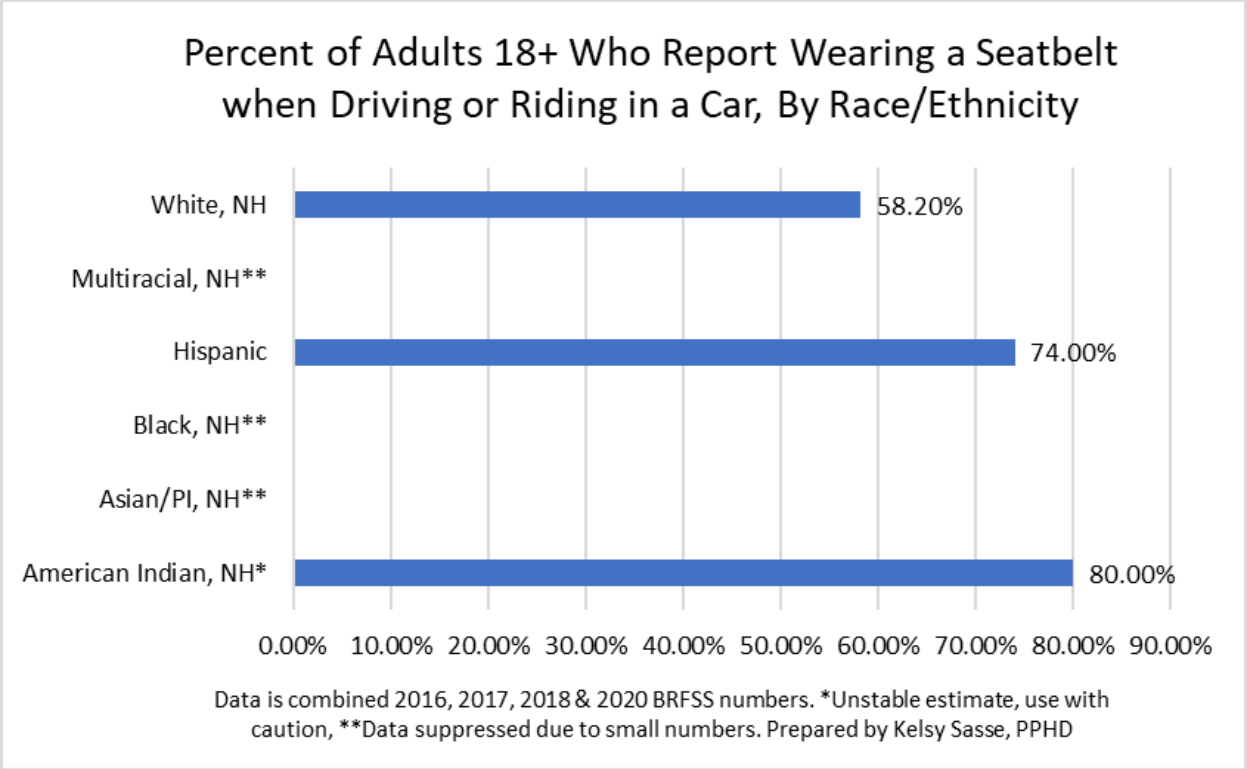
Figure 111: Adults Seatbelt Usage



	2011	2012	2013	2014	2015	2016	2017	2018	2020
Panhandle	57.6%	56.4%	60.3%	60.8%	63.6%	60.0%	65.2%	59.4%	64.3%
Nebraska	71.3%	69.7%	74.1%	72.4%	75.4%	73.8%	76.3%	75.2%	76.7%

*Percentage of adults 18 or older who report that they always use a seatbelt when driving or riding in a car. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

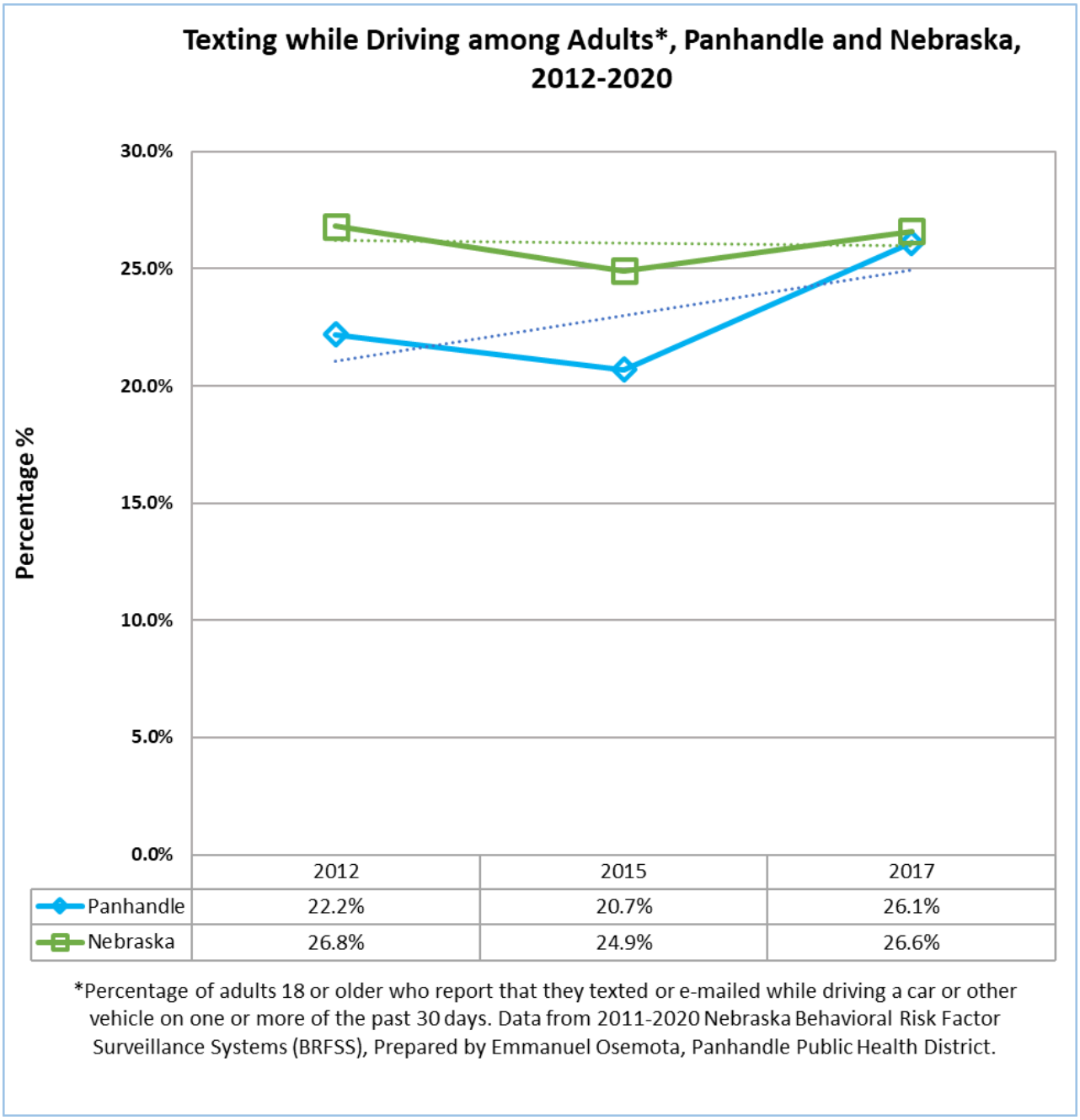
Figure 112: Adults Seatbelt Usage by Race/Ethnicity



Distracted Driving

The rate of Panhandle adults that report they text while driving was lower than that of the overall state of Nebraska but has increased in recent years to be at approximately the same rate. The percentage of adults who report talking on a cell phone while driving is very high in both the state and the Panhandle. The rates of texting while driving have increased in the Panhandle bringing the region's rates almost equal with the state's. This rate is highest among the White population in the Panhandle.

Figure 113: Adult Texting While Driving



*Percentage of adults 18 or older who report that they texted or e-mailed while driving a car or other vehicle on one or more of the past 30 days. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 114: Adult Texting While Driving by Race/Ethnicity

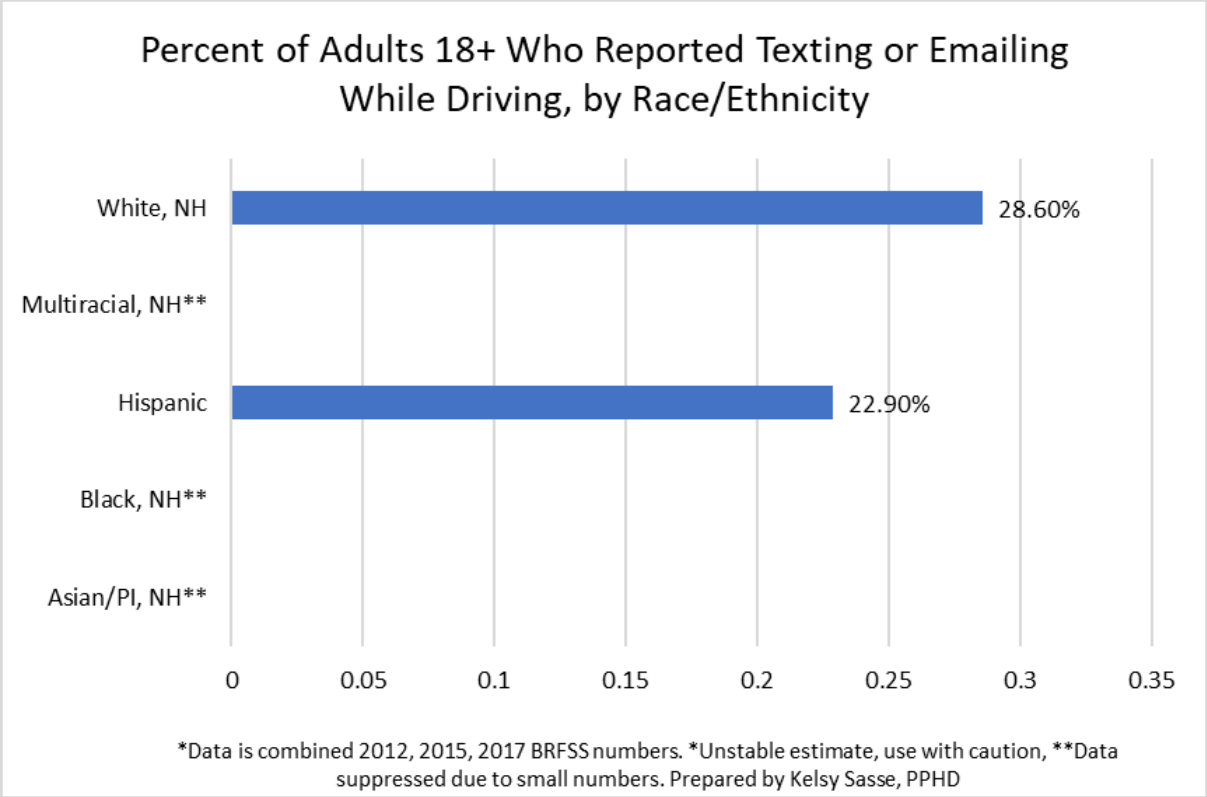
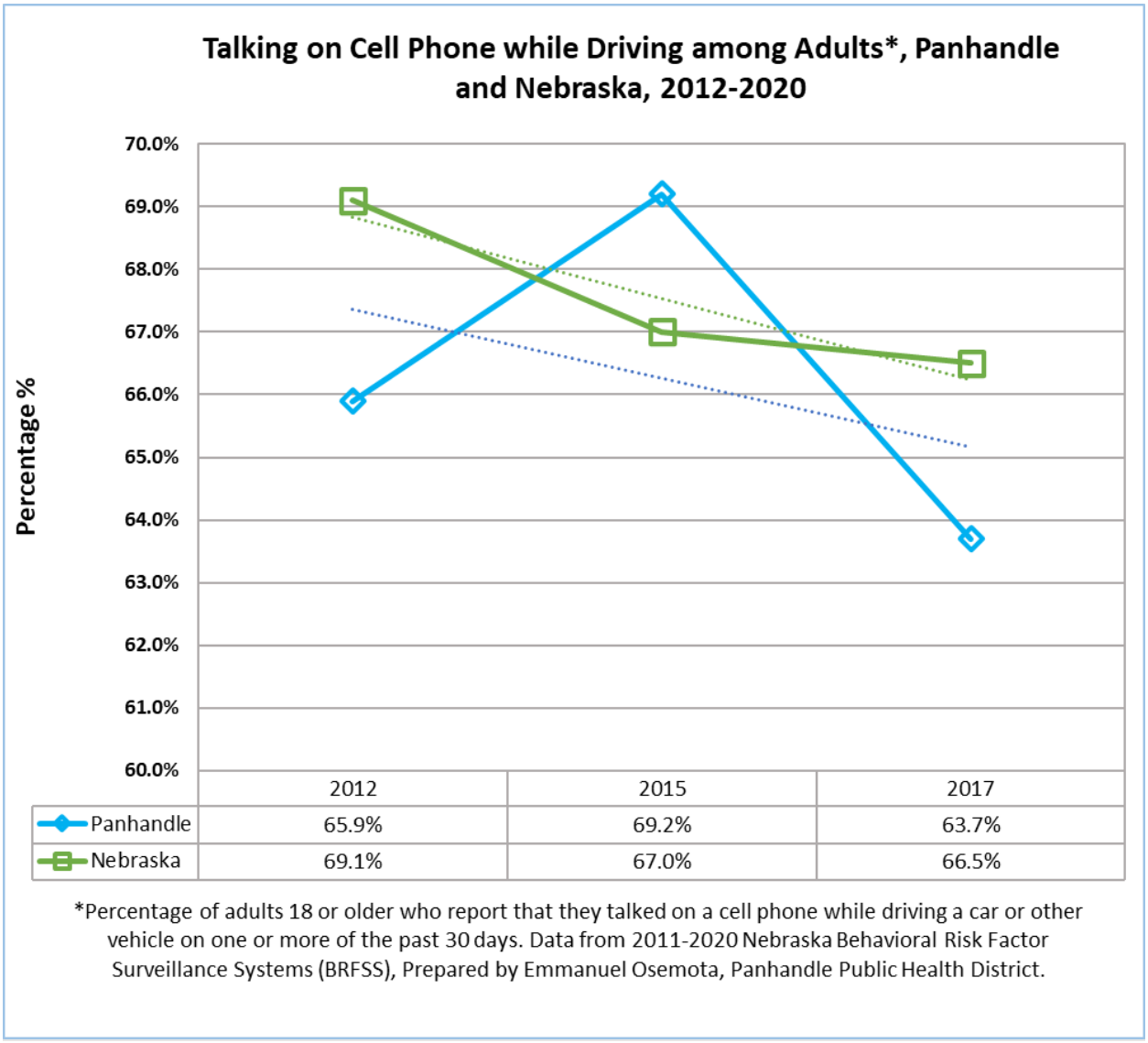


Figure 115: Adult Talking on Cell Phone While Driving



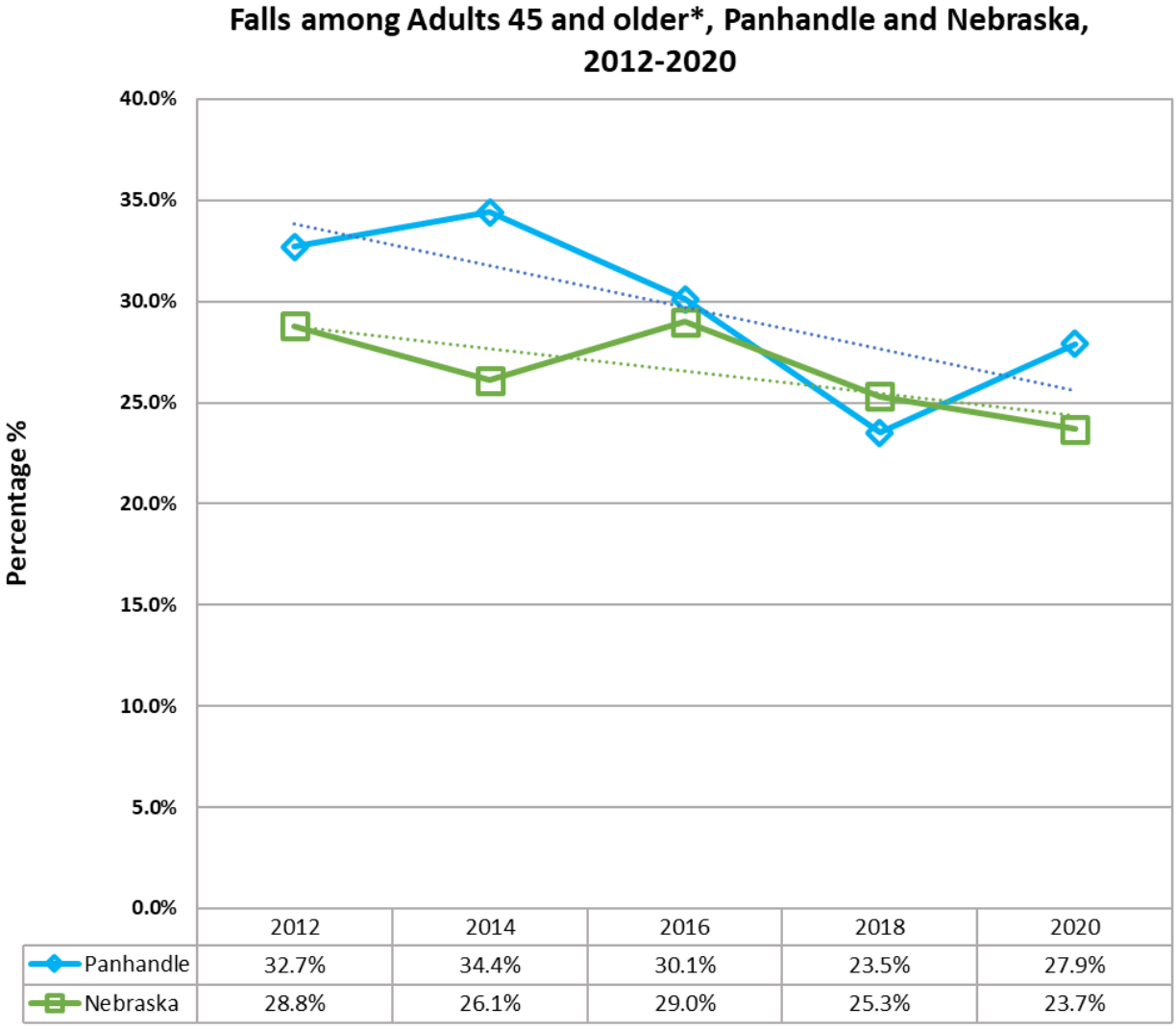
	2012	2015	2017
Panhandle	65.9%	69.2%	63.7%
Nebraska	69.1%	67.0%	66.5%

*Percentage of adults 18 or older who report that they talked on a cell phone while driving a car or other vehicle on one or more of the past 30 days. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

FALLS

The percentage of adults 45 and older who experienced a fall in the past year decreased in both the Panhandle and across the state. The Panhandle had its lowest percentage in 2018 but it has increased in 2020. This percent is highest among the White population in the Panhandle.

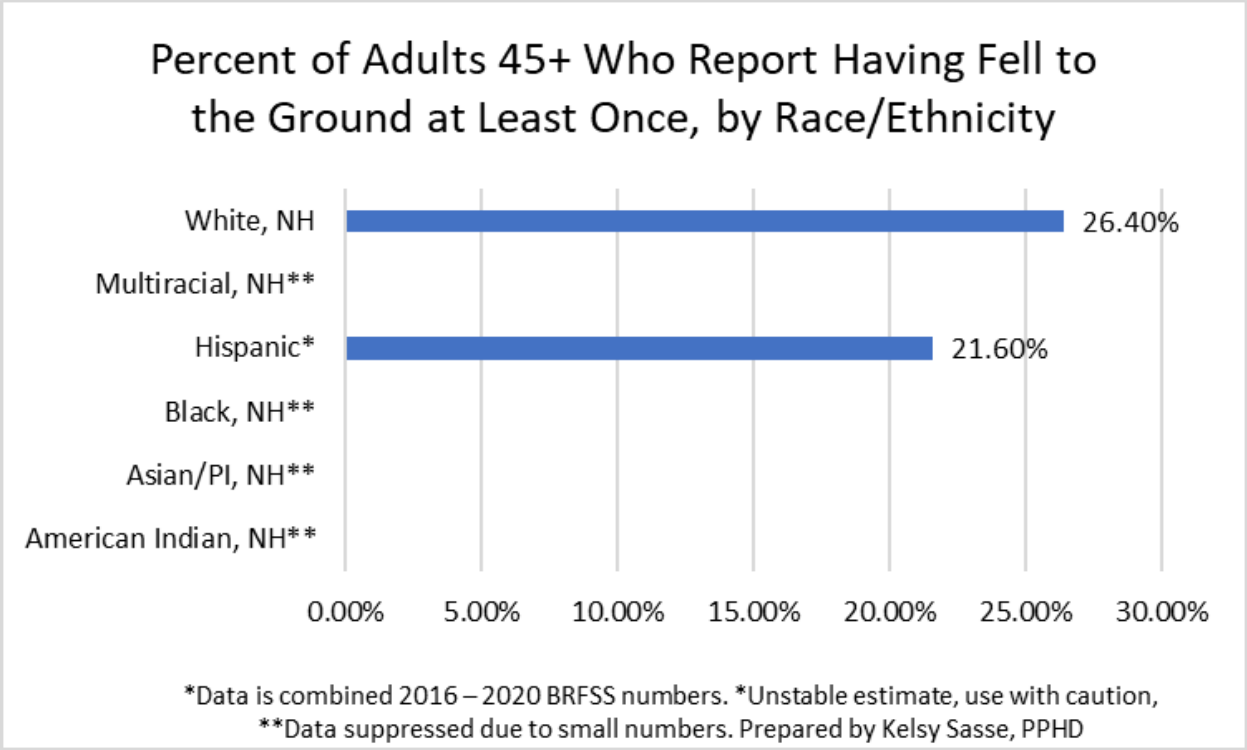
Figure 116: Falls Among Adults 45+



	2012	2014	2016	2018	2020
Panhandle	32.7%	34.4%	30.1%	23.5%	27.9%
Nebraska	28.8%	26.1%	29.0%	25.3%	23.7%

*Percentage of adults 45 or older who report that they fell to the ground or another lower level one or more times during the past 12 months. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

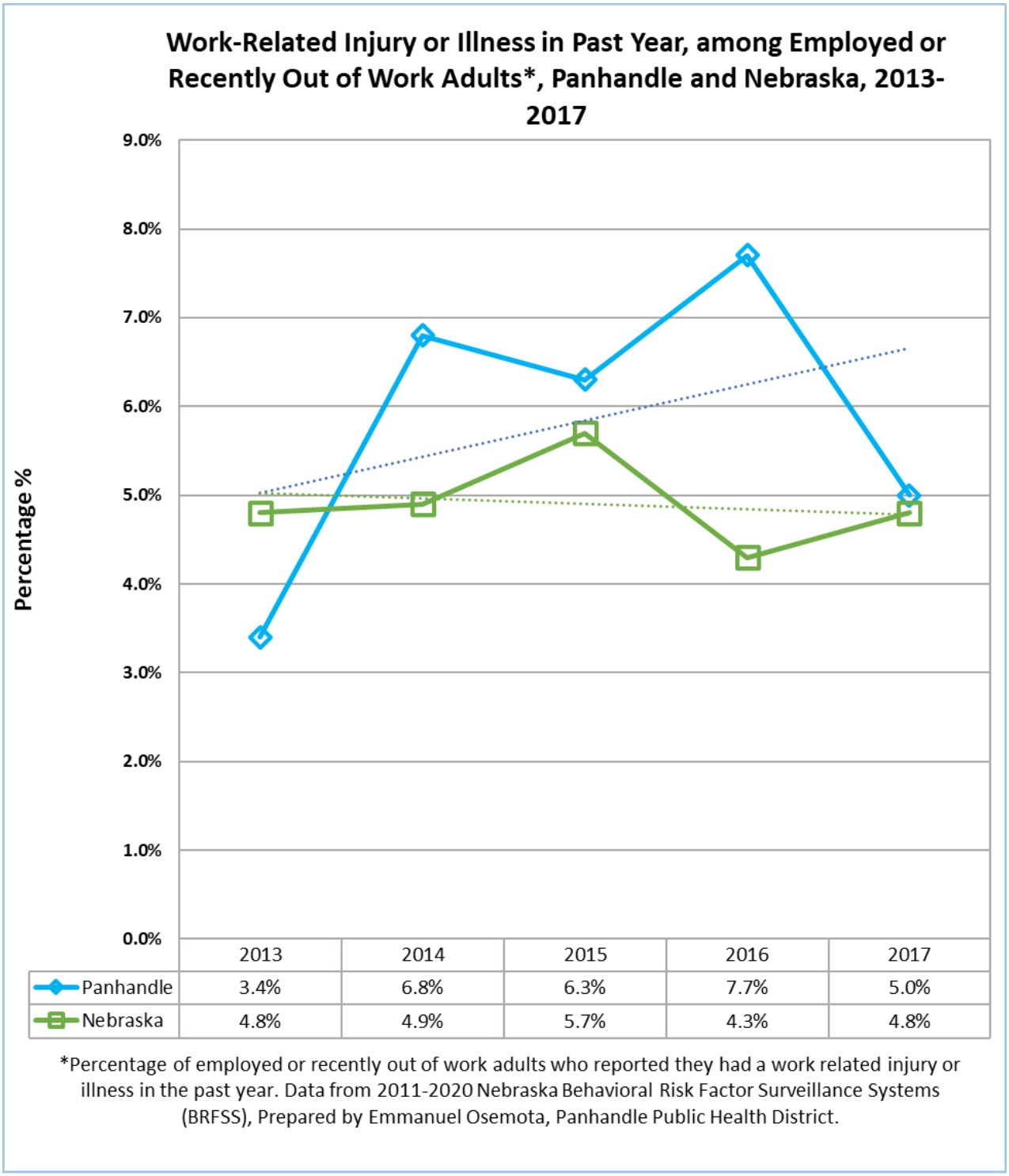
Figure 117: Falls Among Adults 45+ by Race/Ethnicity



WORK RELATED INJURIES

The percentage of Nebraska adults who experienced a work-related injury in the past year has remained relatively even over the years. The Panhandle had been increasing in rates of work-related injuries over time and is slightly more than Nebraska's. The percent of individuals who reported being injured while performing their job or that a doctor or medical professional told them they have a work-related injury or illness is highest among the Hispanic population in the Panhandle.

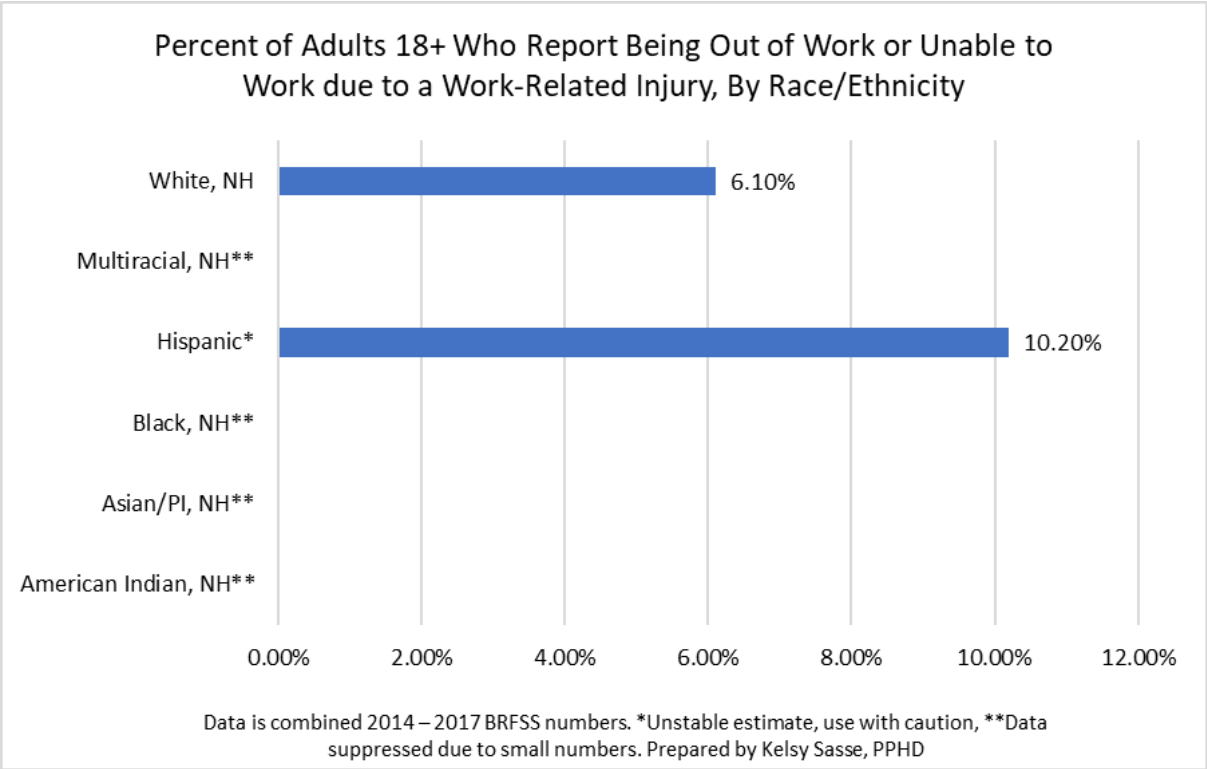
Figure 118: Work-Related Injury or Illness



	2013	2014	2015	2016	2017
Panhandle	3.4%	6.8%	6.3%	7.7%	5.0%
Nebraska	4.8%	4.9%	5.7%	4.3%	4.8%

*Percentage of employed or recently out of work adults who reported they had a work related injury or illness in the past year. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

Figure 119: Work-Related Injury or Illness by Race/Ethnicity

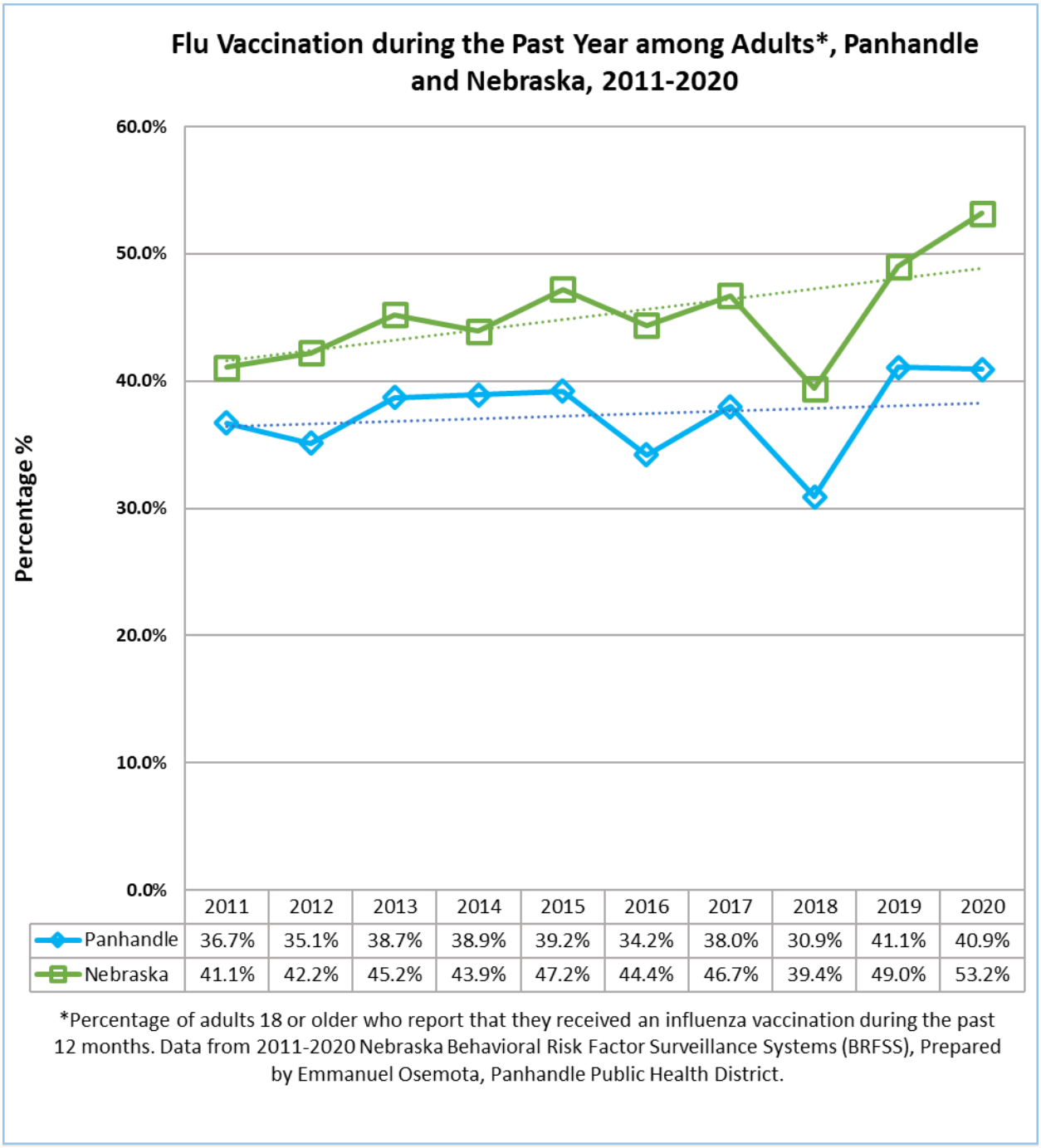


IMMUNIZATIONS

A large portion of infectious diseases have been eradicated or controlled by vaccination. However, a rising movement supporting anti-vaccination has led to under-immunized children, adolescents, and adults in the United States, leaving them susceptible to many vaccine preventable diseases.[17]

[17] (Common Questions About Vaccines 2023)

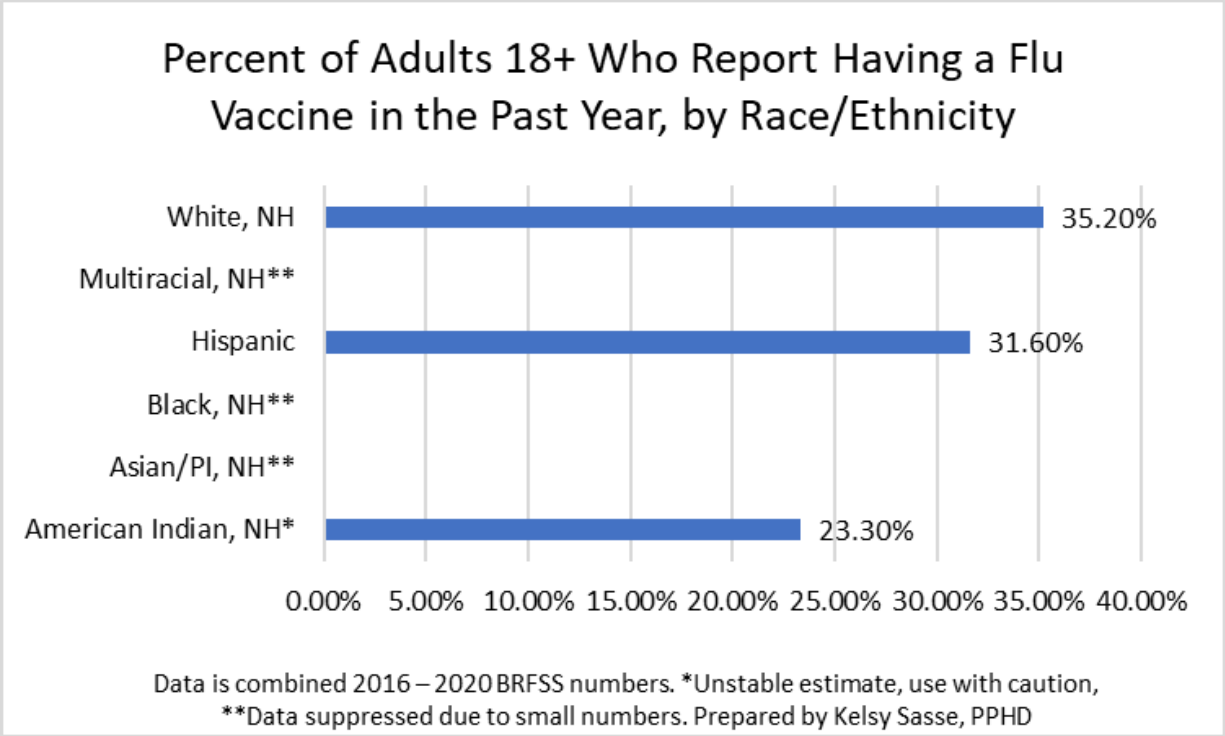
Figure 120: Flu Vaccination during Past Year



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	36.7%	35.1%	38.7%	38.9%	39.2%	34.2%	38.0%	30.9%	41.1%	40.9%
Nebraska	41.1%	42.2%	45.2%	43.9%	47.2%	44.4%	46.7%	39.4%	49.0%	53.2%

*Percentage of adults 18 or older who report that they received an influenza vaccination during the past 12 months. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

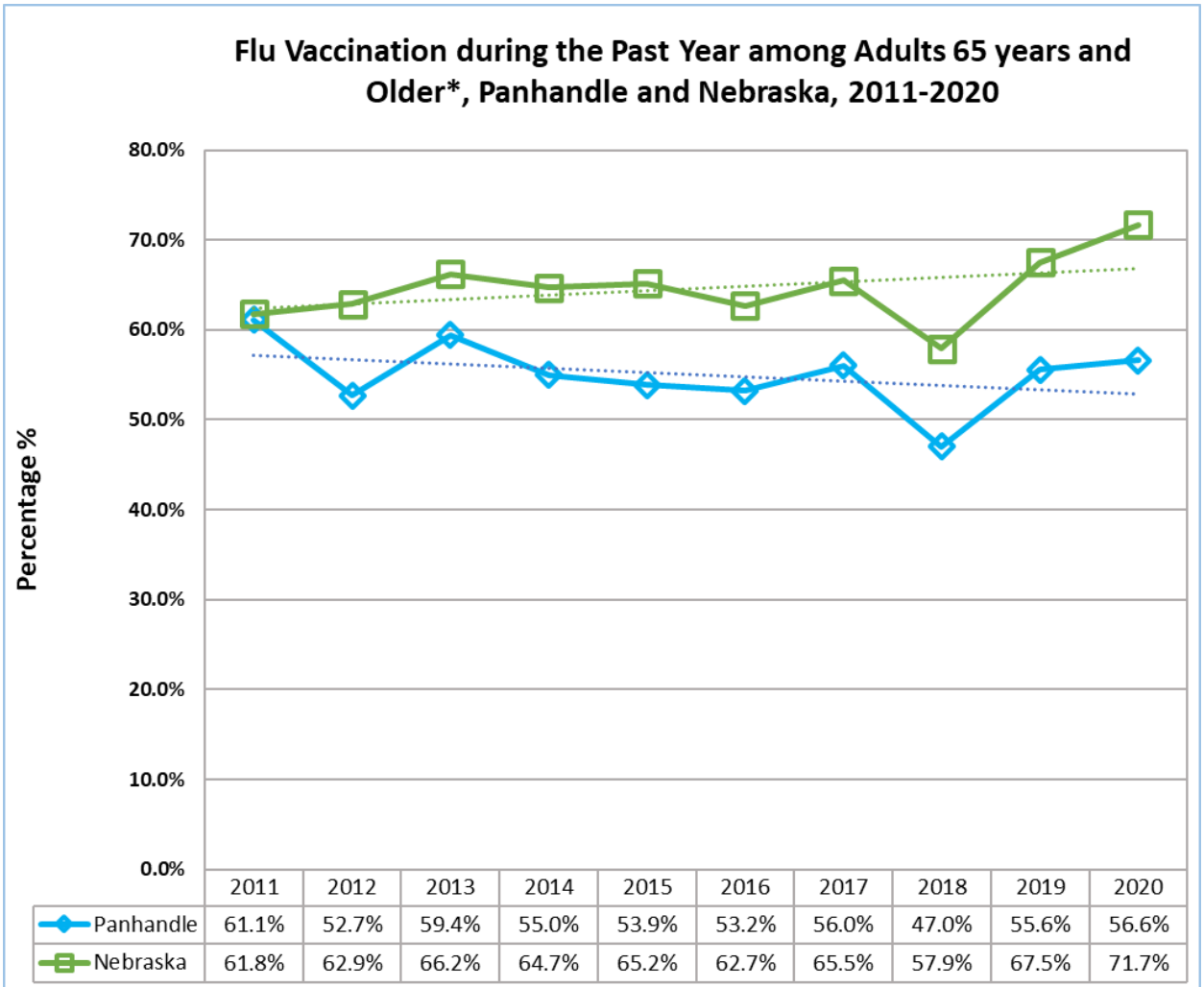
Figure 121: Flu Vaccination during Past Year by Race/Ethnicity



INFLUENZA VACCINATION

The percentage of adults that report having a flu vaccination during the past year has been increasing since 2011 in both the Panhandle and in the state, with Nebraska having the highest rate in 2020. Rates are lower across the Panhandle than in the state as whole. The percentage of individuals who report they had received a flu vaccine in the past 12 months is lowest among the American Indian population.

Figure 122: Flu Vaccination During Past Year Adults 65+



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Panhandle	61.1%	52.7%	59.4%	55.0%	53.9%	53.2%	56.0%	47.0%	55.6%	56.6%
Nebraska	61.8%	62.9%	66.2%	64.7%	65.2%	62.7%	65.5%	57.9%	67.5%	71.7%

*Percentage of adults 65 or older who report that they received an influenza vaccination during the past 12 months. Data from 2011-2020 Nebraska Behavioral Risk Factor Surveillance Systems (BRFSS), Prepared by Emmanuel Osemota, Panhandle Public Health District.

The flu vaccination is highly recommended for people in vulnerable populations (children, pregnant people, and elderly people). The percentage of adults 65 years and older that received a flu vaccination in the past year is much higher than the percentage of all adults. However, the Panhandle has seen a decrease in the percentage over the years while Nebraska had a huge increase by almost 10%.

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

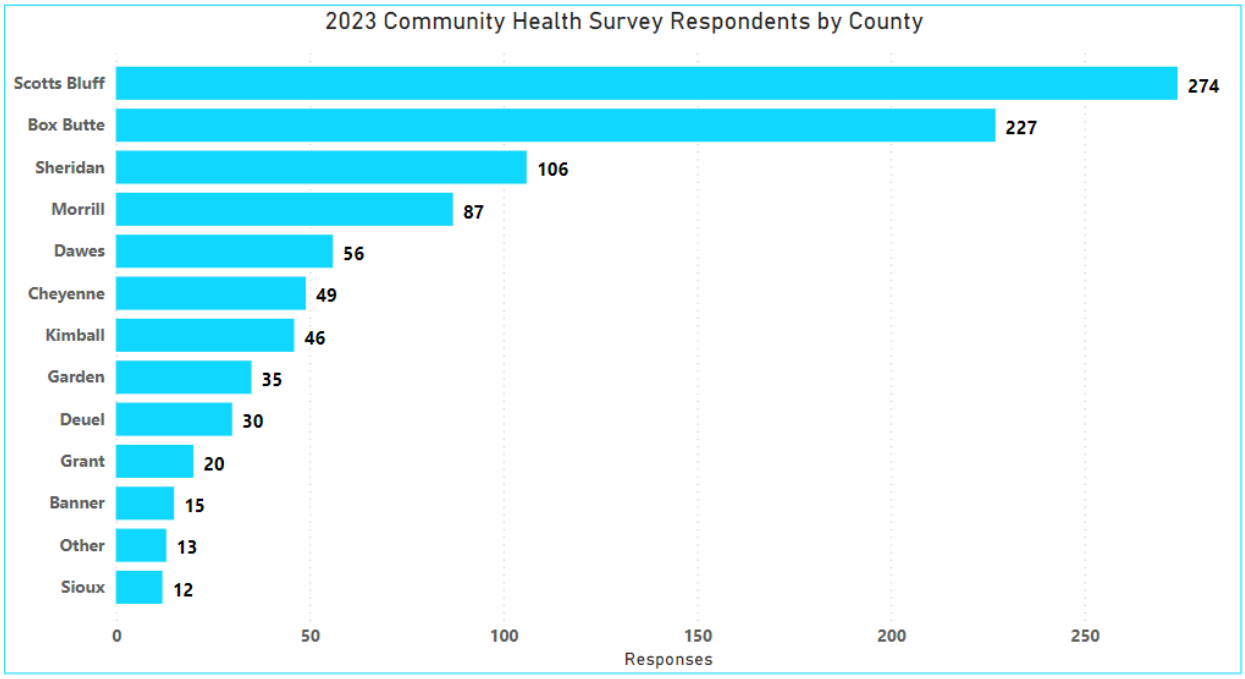
The Community Themes and Strengths Assessment was done through a community-wide survey. The top concerns of community members are captured in this survey.

COMMUNITY HEALTH SURVEY

The Community Health Survey was distributed to Panhandle residents in November of 2022 via paper and electronic survey. See Appendix B for a copy of the survey. Paper copies of the survey were distributed by hospitals. The electronic copy was administered using Qualtrics, and shared online by mailers, PPHD website, social media, and email by PPHD, local hospitals, and other community organizations. Counts and percentages from the survey responses were calculated using Power BI.

1,186 Panhandle community members from a variety of backgrounds responded to the Community Health Survey.

Figure 123: 2023 Community Health Survey Respondents by County



Original Question: 73. County of Residence:
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Figure 124: 2023 Community Health Survey Selected Demographic Information, N = 949

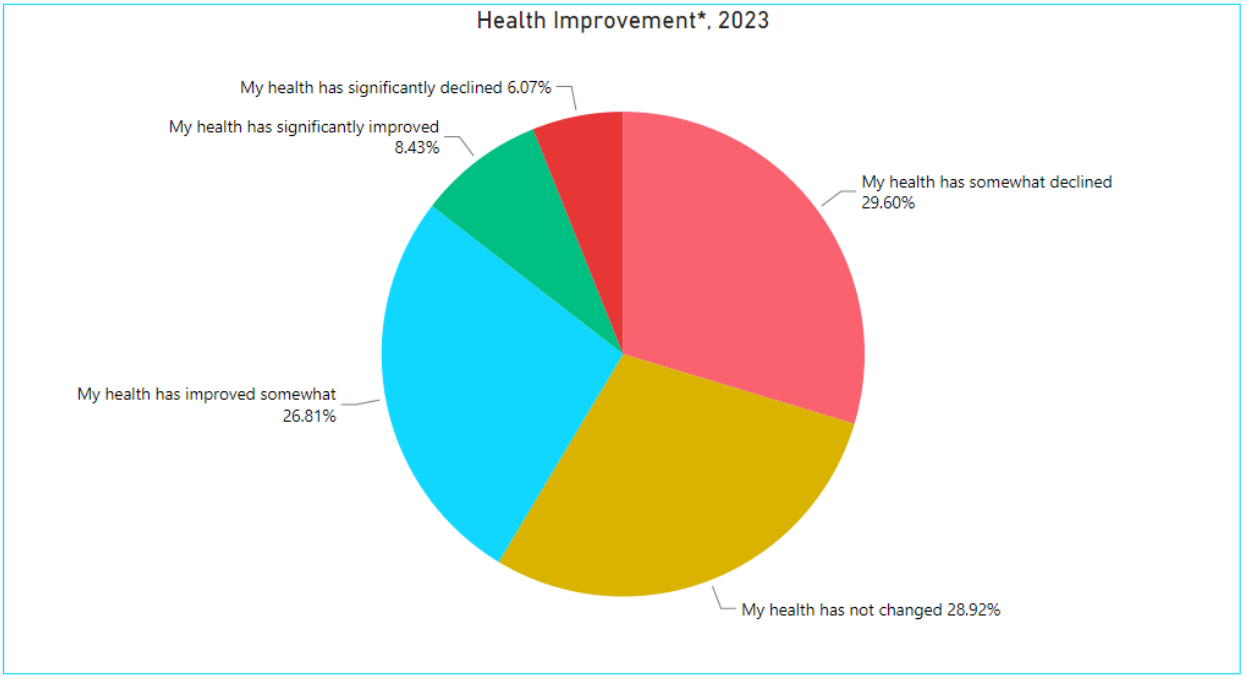
	#	%
Gender identity		
Male	235	26%
Female	670	74%
Highest level of education		
Less than high school graduate	31	3.2%
High school diploma or GED	223	23.4%
Associates or Technical Degree	187	19.7%
College degree or higher	473	49.8%
Decline to answer	16	1.6%
Other	19	2%
Race/Ethnicity		
White	821	86%
Black or African American	30	3.1%
Asian	9	0.9%
Native Hawaiian or Other Pacific Islander	5	0.5%
American Indian or Alaska Native	19	2%
Decline to answer	59	3.1%
Other	27	.2%
Two or more races	24	2.5%
Hispanic/Latino	197	23.4%

	#	%
Marital Status		
Married/Partnered	634	68%
Divorced	132	14%
Never Married	99	10.5%
Decline to answer	14	1.4%
Other	67	7.2%
Household income		
Less than $20,000	48	5.1%
$20,000 to $29,999	104	11%
$30,000 to $49,999	204	21.5%
$50,000 to $74,999	206	21.7%
$75,000 to $99,999	148	15.5%
Over $100,000	176	18.5%
Decline to answer	63	7.2%
Age		
Under 18	3	.3%
18-25	97	10.2%
26-39	302	31.7%
40-54	252	26.4%
55-64	172	18%
65-80	120	12.6%
Over 80	8	.8%

Demographic information for the respondents to the 2023 Community Health Survey can be found in the table above. The respondents were primarily female (74%). The population distribution skews older than the general population with 58% older than 39. In the general population, only 49% are older than 39. Most respondents were married or partnered (69.6%). Most respondents were White (86%), and 23.4% indicated they were Hispanic or Latino. Survey respondents had a higher income than the general population with only 37.5% making less than $50,000. In the general population 60% make less than $50,000.

HEALTH IMPROVEMENT

Figure 125: Health Improvement

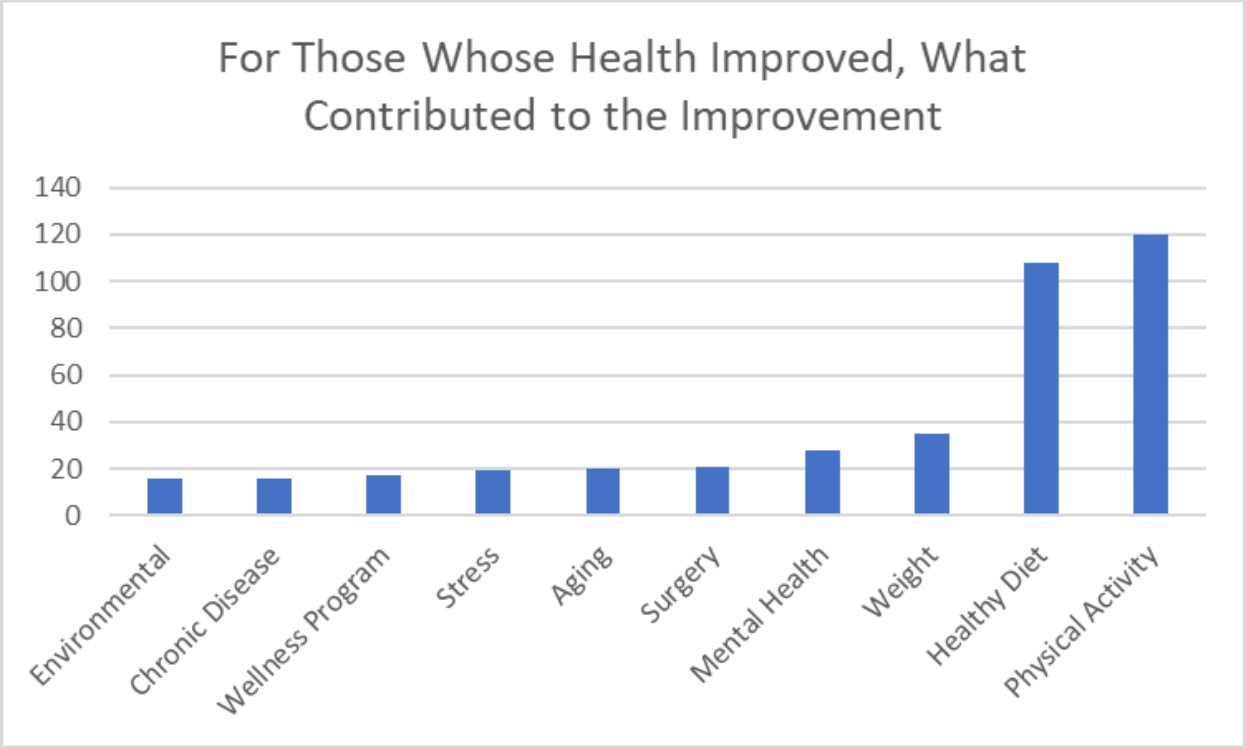


*Original question: Has your health improved in the last 3 years?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

The Panhandle community's health condition in the last 3 years is split evenly between their health declining, staying the same and improving. 29.60% of respondents stated that their health has somewhat declined and 6.07% have noted that their health has significantly declined for a total of 35.67% whose health declined. 28.92% have not seen any change in their health. 26.81% of them have stated that their health has somewhat improved and 8.43% of them have seen significant health improvement for a total of 37.35%.

The survey followed up the question of how their health condition was changing by asking about what they thought contributed to the change.

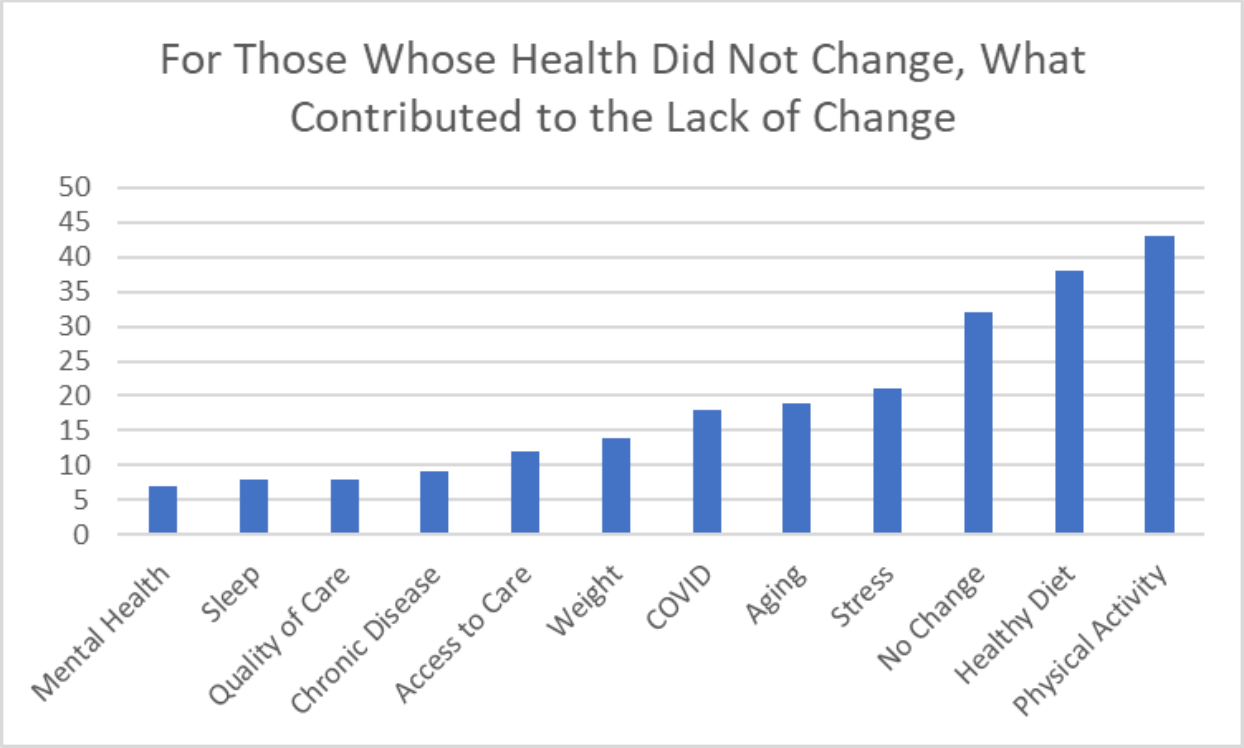
Figure 126: Health Improvement Contributors



Source: 2023 PPHD Community Health Survey. Prepared By Megan Barhafer, Panhandle Public Health District.

Most responses for those whose health improved mentioned that they thought the improvement was due to their diet or physical activity levels. The top 10 responses are shown in the graph.

Figure 127: Health Contributors Lack of Change

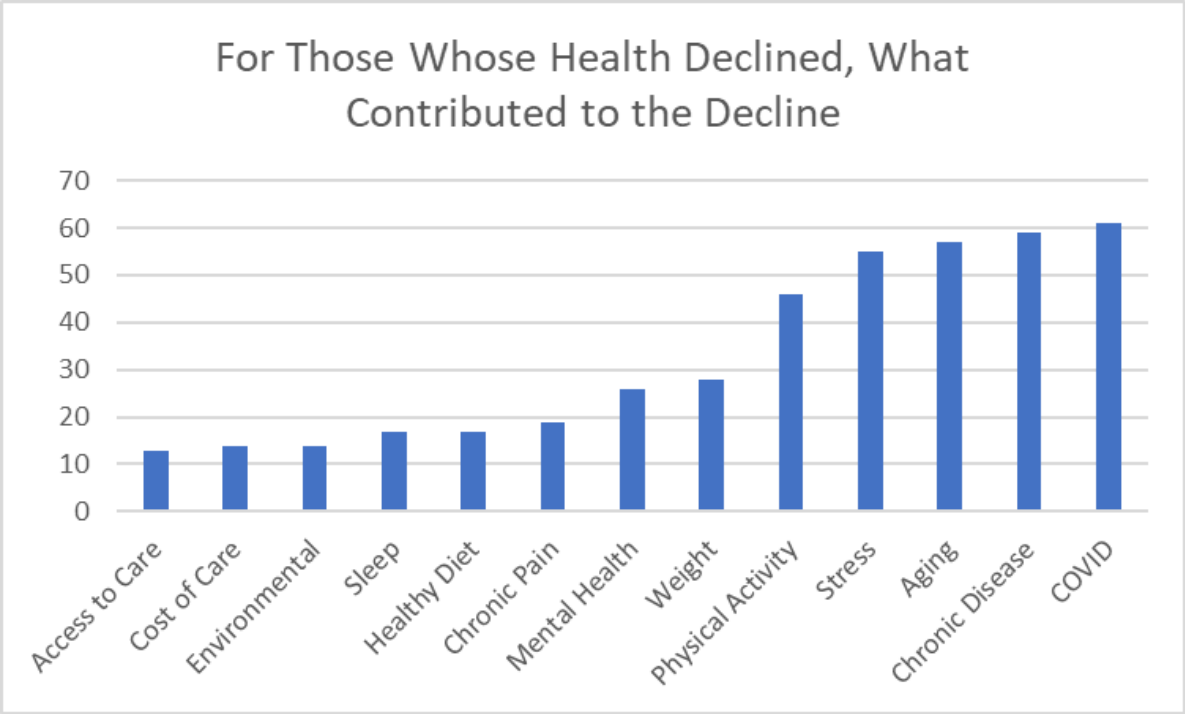


Source: 2023 PPHD Community Health Survey. Prepared By Megan Barhafer, Panhandle Public Health District.

Most responses for those whose health stayed the same mentioned that they thought the improvement was due to their diet or physical activity levels. The spread of responses is much more even among this group. The top 12 responses are shown in the graph.

Among those who said their health had worsened, COVID, chronic disease, aging, stress, and physical activity ranked in the top 5 responses at similar rates.

Figure 128: Health Contributors Decline



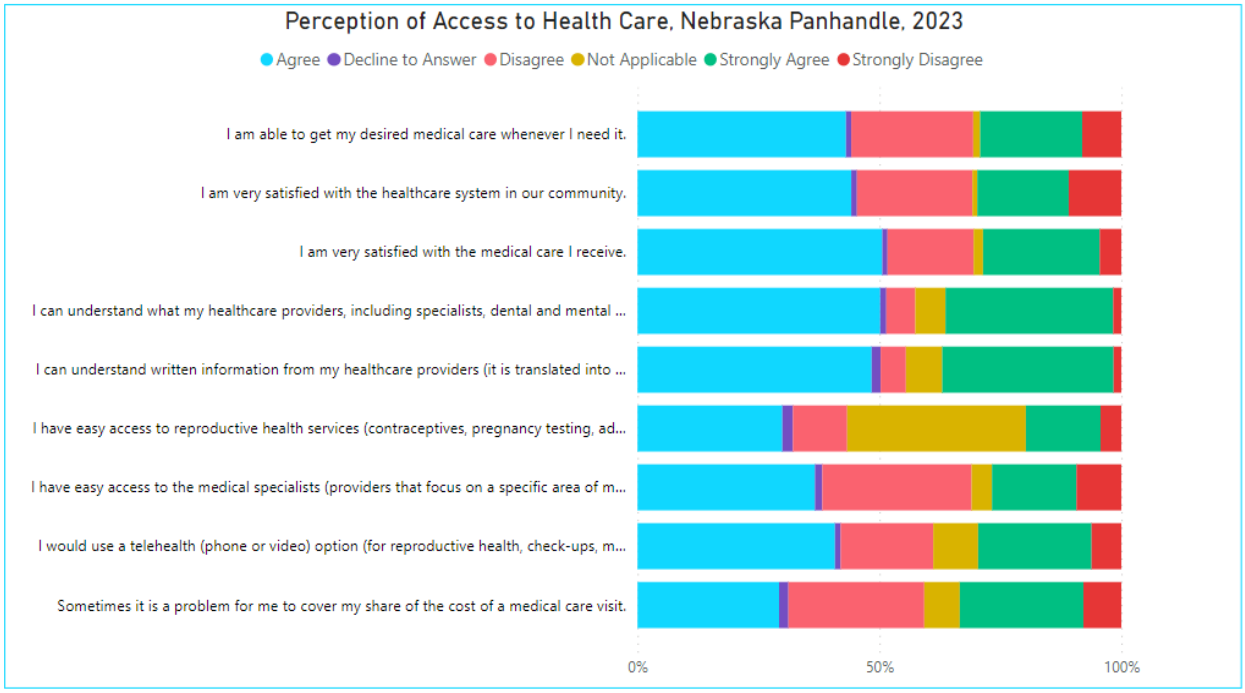
Source: 2023 PPHD Community Health Survey. Prepared By Megan Barhafer, Panhandle Public Health District.

Respondents were then asked to describe what they thought would improve their health. Diet and Physical Activity filtered to the top of the list as important factors.

ACCESS TO CARE

The following section includes responses to questions about access to care in the Panhandle. Most respondents agree they are satisfied with the health care system, can access medical care, understand what their healthcare providers are saying to them, are able to get their desired medical care whenever they need it. Of all the surveyed members, 29% of them agree and 26% of them disagree with the statement that sometimes it is a problem for them to cover their share of the cost of a medical care visit.

Figure 129: Perception of Access to Health Care



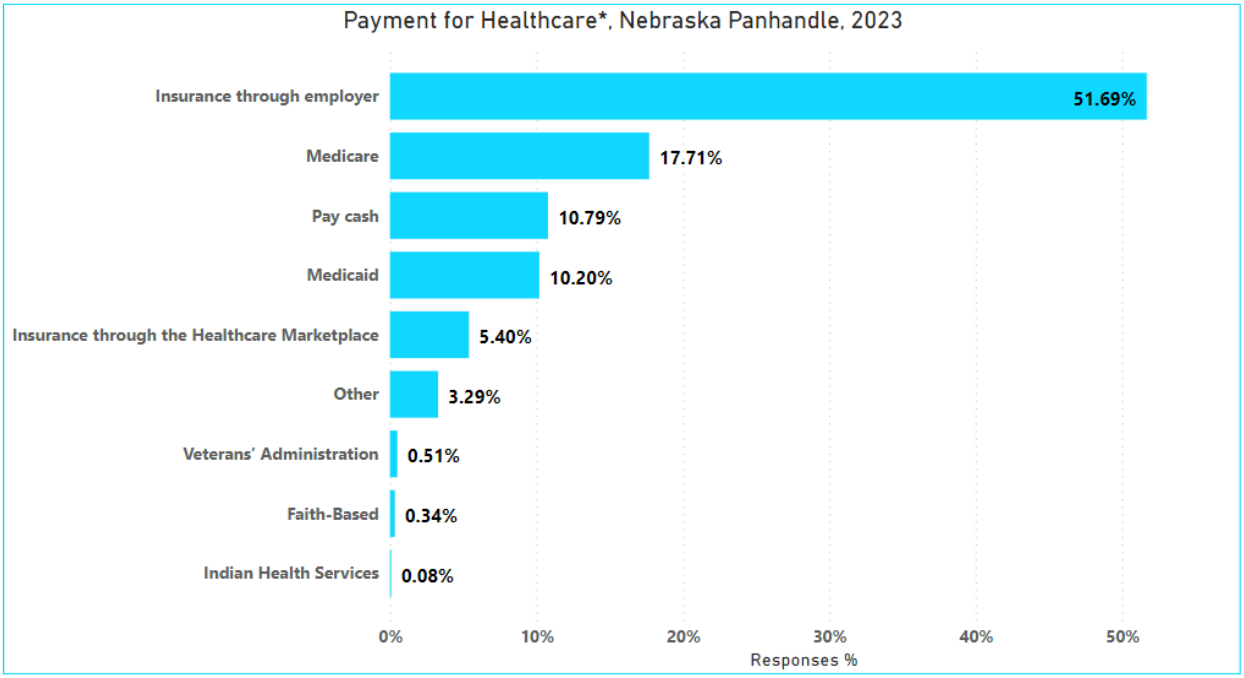
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Statement	Agree	Not Applicable	Strongly Agree	Disagree	Strongly Disagree	Decline to Answer
I am able to get my desired medical care whenever I need it.	43.00%	1.00%	21.00%	25.00%	8.00%	1.00%
I am very satisfied with the healthcare system in our community.	44.00%	1.00%	19.00%	24.00%	11.00%	1.00%
I am very satisfied with the medical care I receive.	51.00%	2.00%	24.00%	18.00%	4.00%	1.00%
I can understand what my healthcare providers, including specialists, dental and mental health, are saying to me and act on that information (there is an interpreter available to me if necessary)?	50.00%	6.00%	35.00%	6.00%	2.00%	1.00%
I can understand written information from my healthcare providers (it is translated into another language if necessary)?	48.00%	8.00%	35.00%	5.00%	2.00%	2.00%
I have easy access to reproductive health services (contraceptives, pregnancy testing, adoption counseling, infertility services, etc.)	30.00%	37.00%	15.00%	11.00%	4.00%	2.00%
I have easy access to medical specialists (providers that focus on a specific area of medicine that I need).	37.00%	4.00%	17.00%	31.00%	9.00%	2.00%
I would use a telehealth (phone or video) option (for reproductive health, check-ups, mental health visits, or other medical needs, not including surgery)	41.00%	9.00%	23.00%	19.00%	6.00%	1.00%
Sometimes it is a problem for me to cover my share of the cost of a medical care visit.	29.00%	7.00%	26.00%	28.00%	8.00%	2.00%

PAYMENT FOR HEALTHCARE

Paying for Healthcare with insurance through an employer is the most common answer among the Panhandle Community members surveyed, followed by Medicare, Cash, and Medicaid.

Figure 130: Payment for Healthcare

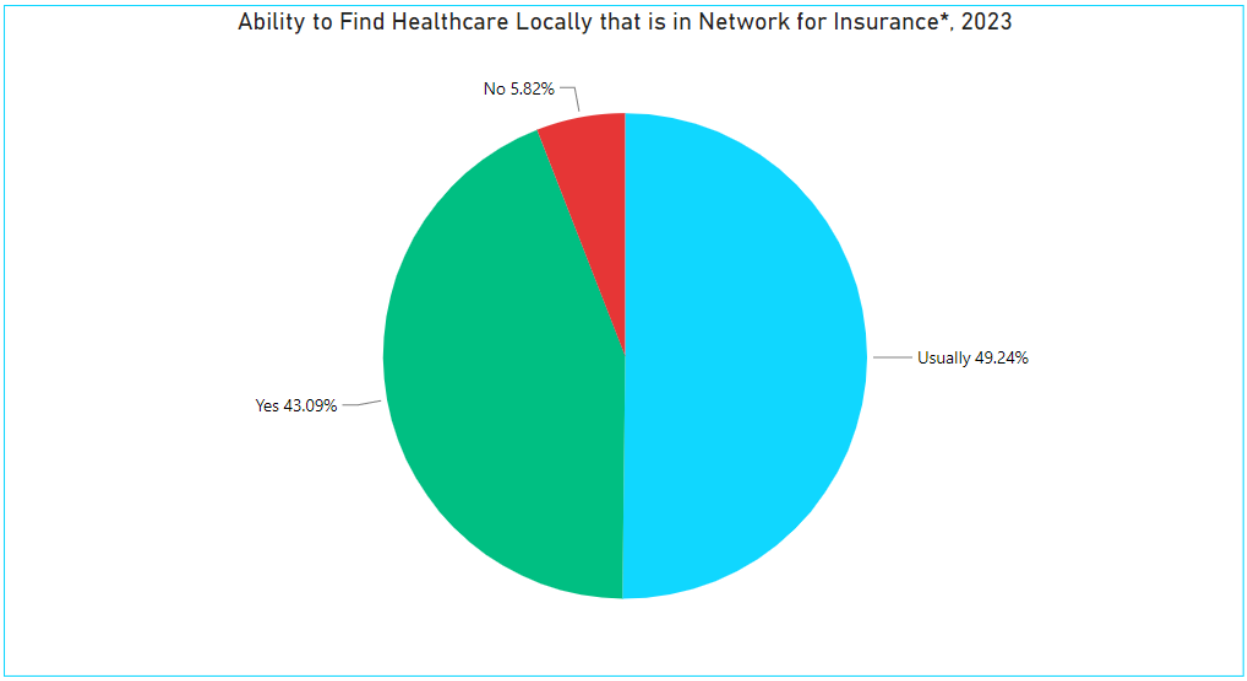


Original Question: How do you pay for health care?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

IN NETWORK HEALTHCARE

43% of the Panhandle Community members surveyed say that they can find local healthcare that is in the network for their insurance, 49% are "usually able to" find one and 6% "aren't able to" find a local healthcare that is in the network of their insurance.

Figure 131: Ability to find Healthcare Locally that is in Network for Insurance

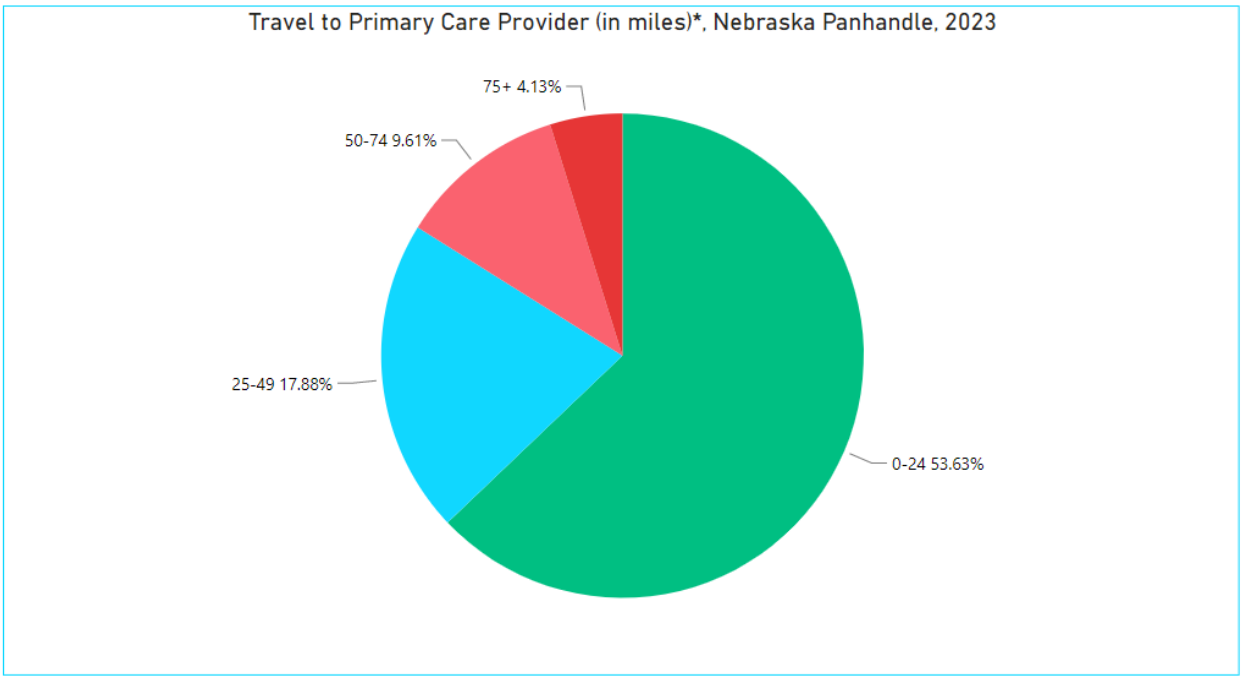


*Original question: Are you able to find healthcare locally that is in your network for insurance?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

PRIMARY CARE

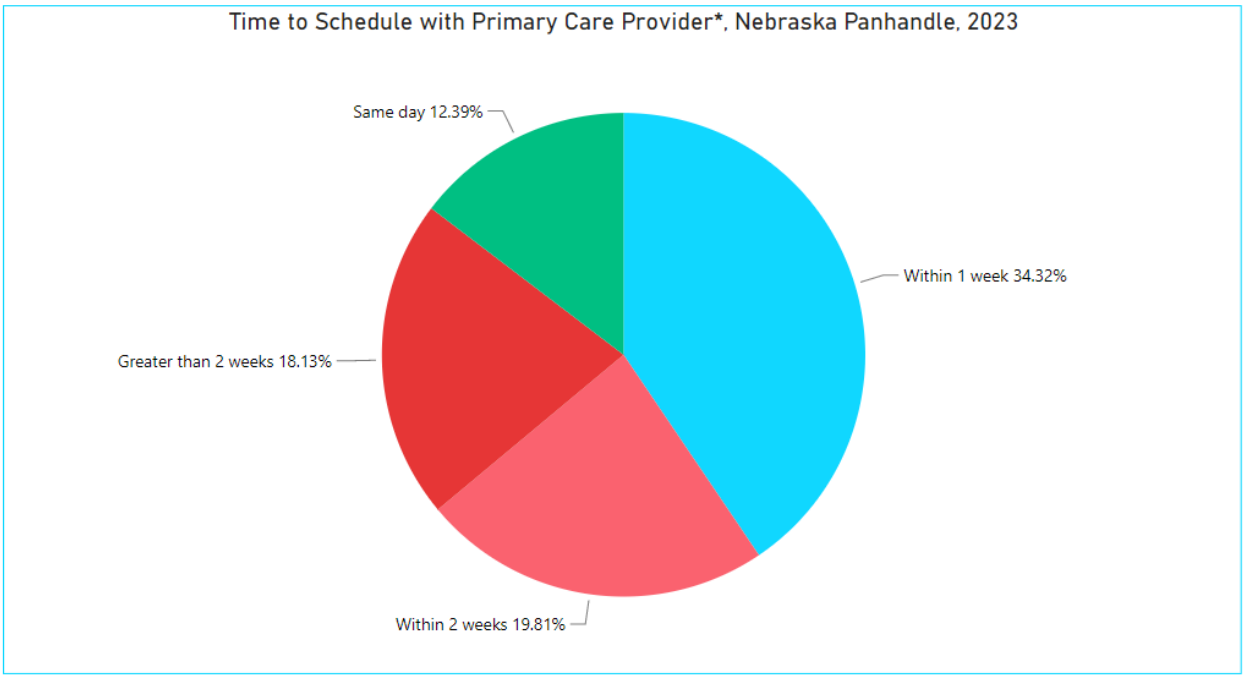
More than half (53.63%) of the surveyed Panhandle Community members said that they had to travel between 0-24 miles to see their primary care provider, 17.88% had to travel between 25-49 miles, 9.61% had to travel between 50-74 miles and only 4.13% had to travel for over 75 miles to see their primary care provider.

Figure 132: Travel to Primary Care Provider



*Original question: How far do you travel for your primary care provider? (in miles)
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Figure 133: Time to Schedule with Primary Care Provider



*Original question: How long, from the time you call to make an appointment, do you have to wait to see your primary care provider?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

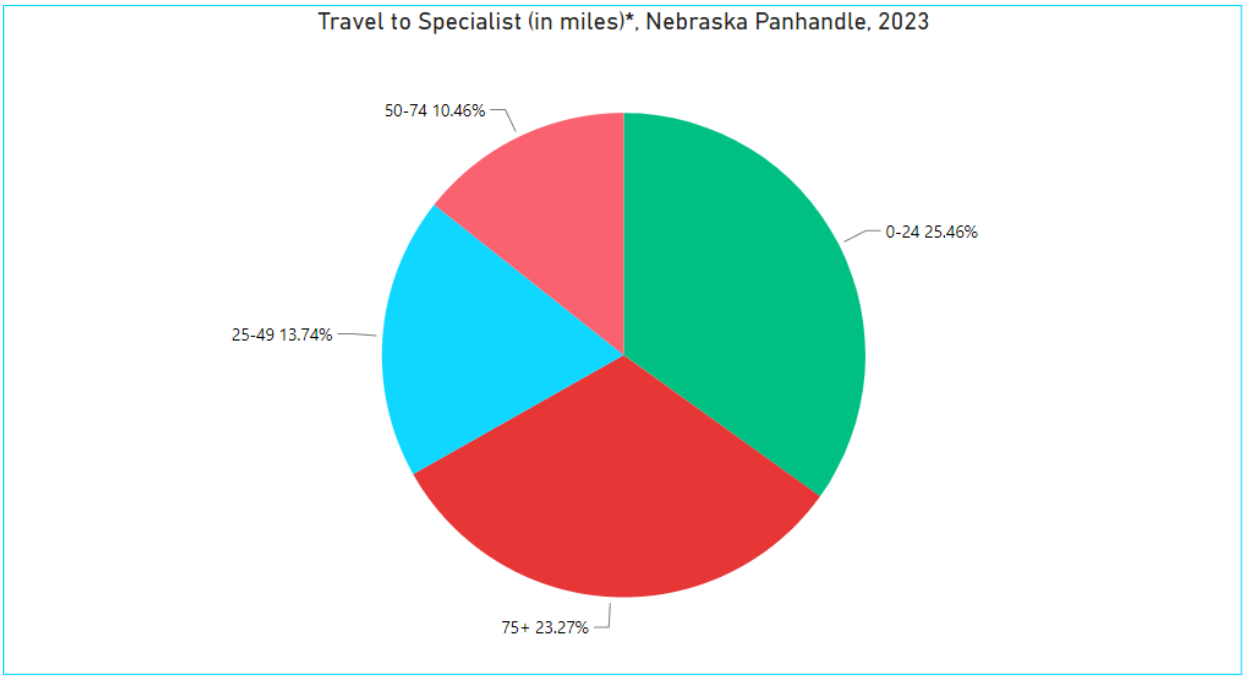
Of all the surveyed Panhandle Community members, only 12.39% got to see their primary care provider on the day of appointment, 34.32% could see their primary care provider within a week, 19.81% within 2 weeks and 18.13% had to wait for more than 2 weeks to see their primary care provider.

SPECIALTY CARE

25.46% of the surveyed Panhandle Community members said that they travel between 0-24 miles to see their specialist, 13.74% travel between 25-49 miles, 10.46% travel between 50-74 miles and 23.27% of the surveyed members travel for more than 75 miles to see their specialist.

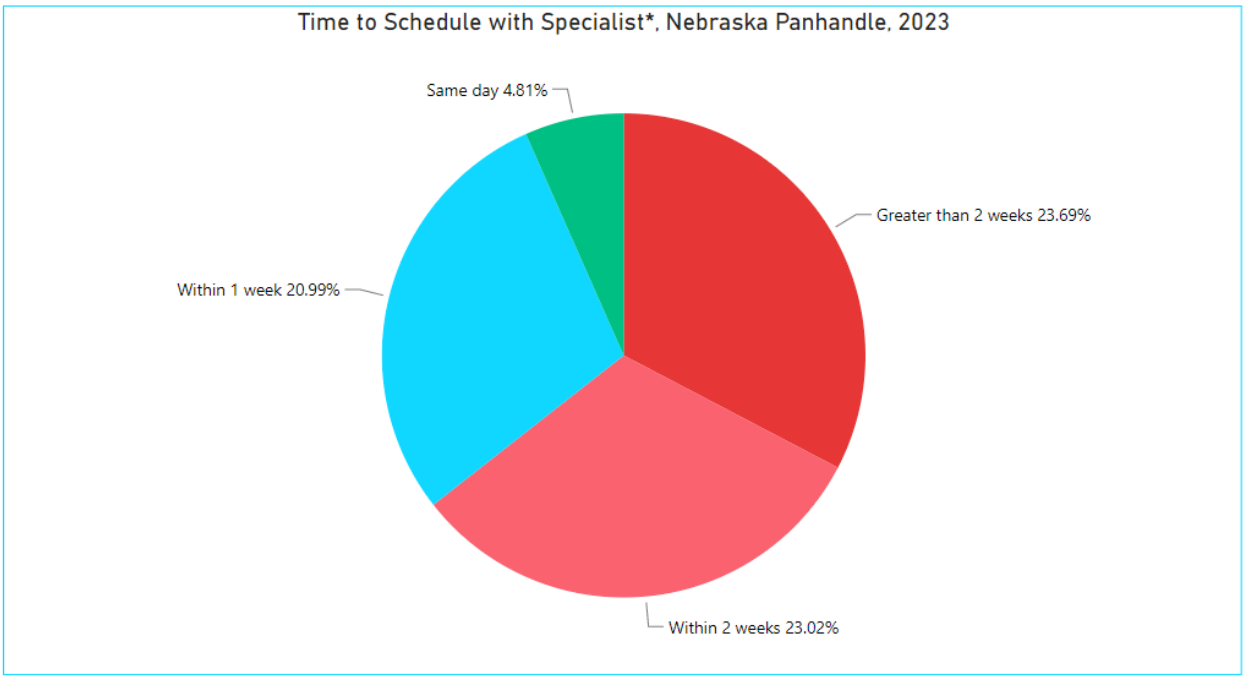
Only a few (4.81%) of the surveyed Panhandle Community members said that they can see their specialist on the day of appointment, 20.99% of them got to see their specialist within one week, 23.02% were able to see their specialist within 2 weeks and 23.69% of them had to wait for more than 2 weeks to see their specialist.

Figure 134: Travel to see Specialist



*Original question: How far do you travel for your specialist? (in miles)
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Figure 135: Time to Schedule with Specialist

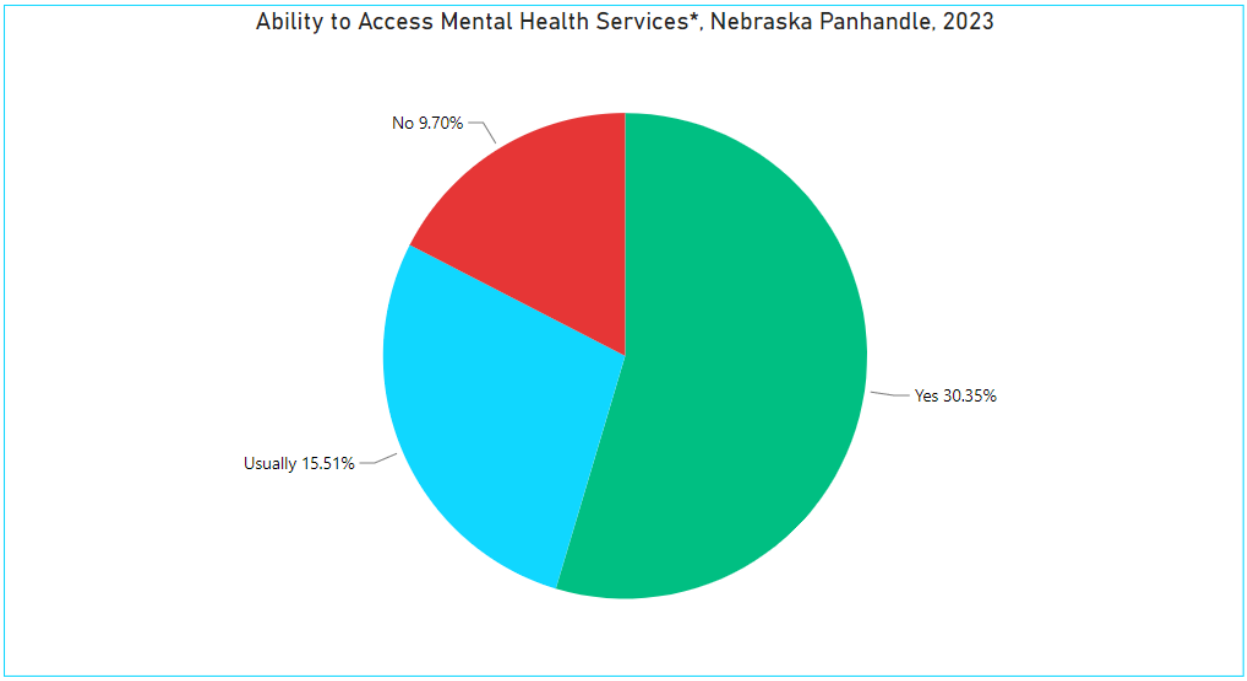


*Original question: How long, from the time you call to make an appointment, are you able to see your specialist?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

MENTAL HEALTH SERVICES

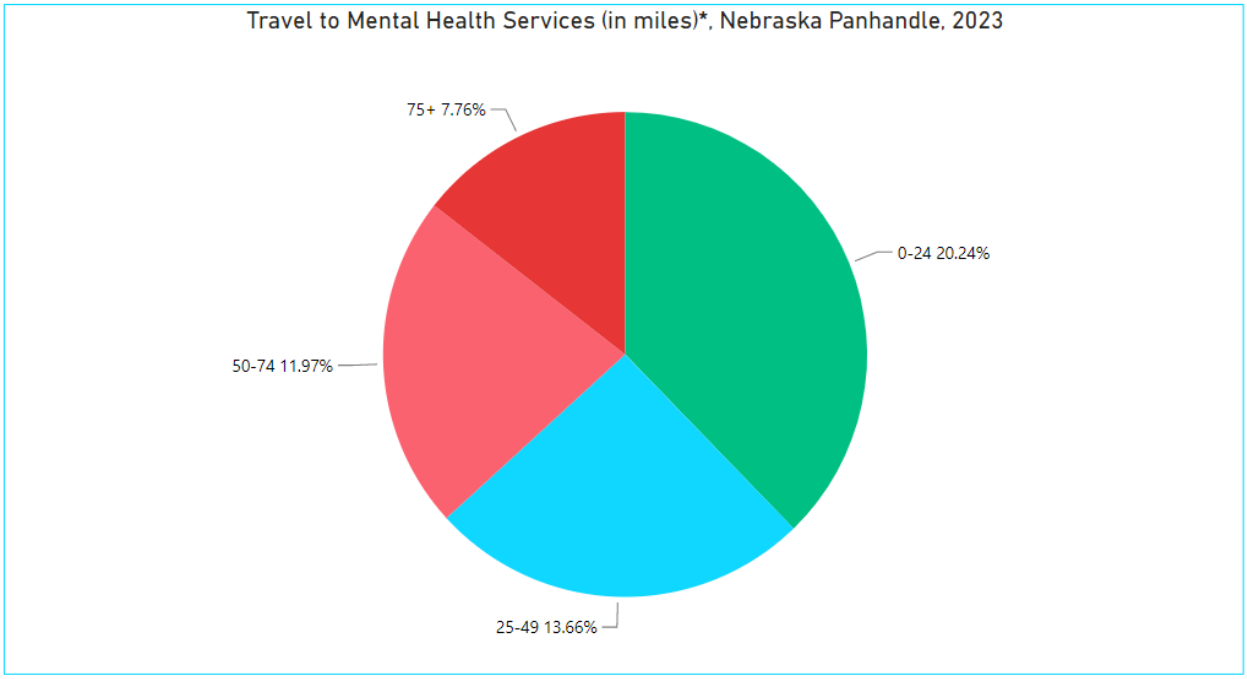
30.35% of the surveyed Panhandle Community members said that they have been able to access mental health services, including telehealth services, locally for themselves or a family member in the last year, 15.51% of the member said that they were usually able to access mental health services and 9.70% said that they weren't able to find any mental health services locally for themselves or a family member in the last year.

Figure 136: Ability to Access Mental Health Services



*Original question: Have you been able to access mental health services, including telehealth services, locally for yourself or a family member in the last year?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

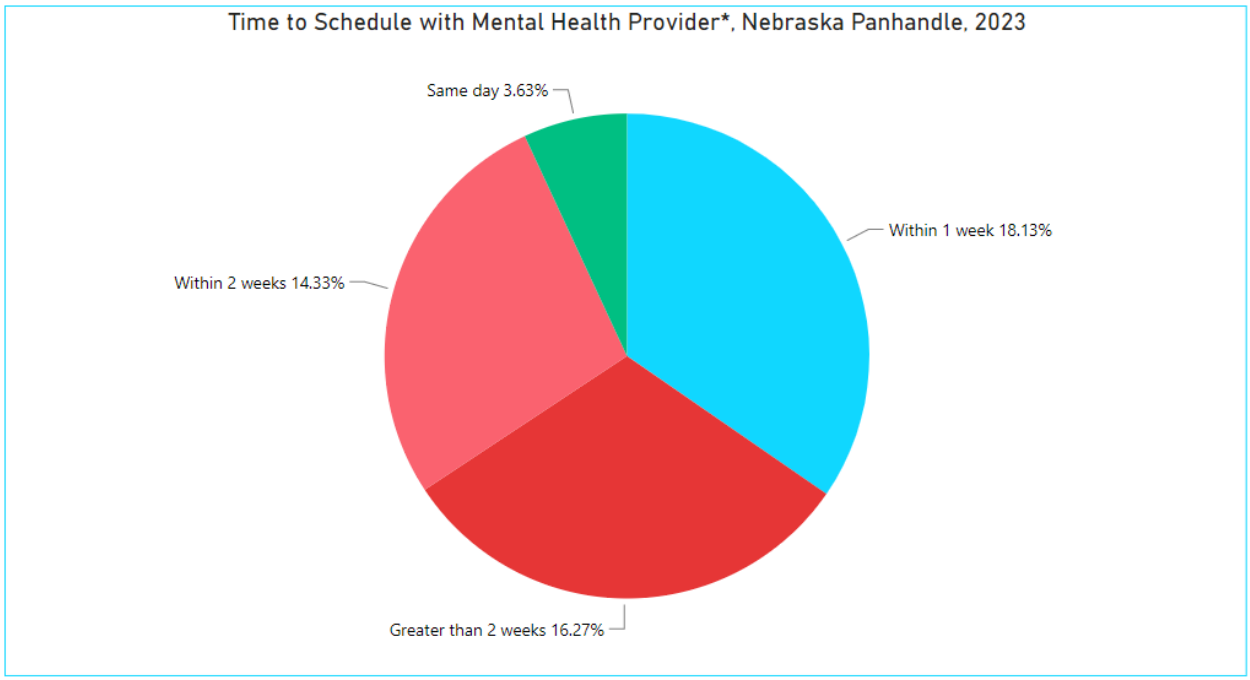
Figure 137: Travel to Mental Health Services



*Original question: How far have you or a family member had to travel for access to mental health services, including telehealth mental health services? (in miles)
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

20.24% of the surveyed Panhandle Community members said that they had to travel only between 0-24 miles to access mental health services, 13.66% said that they had to travel between 25-49 miles, 11.97% said that they travelled between 50-74 miles and 7.76% said that they travelled for over 75 miles to access mental health services.

Figure 138: Time to Schedule with Mental Health Provider

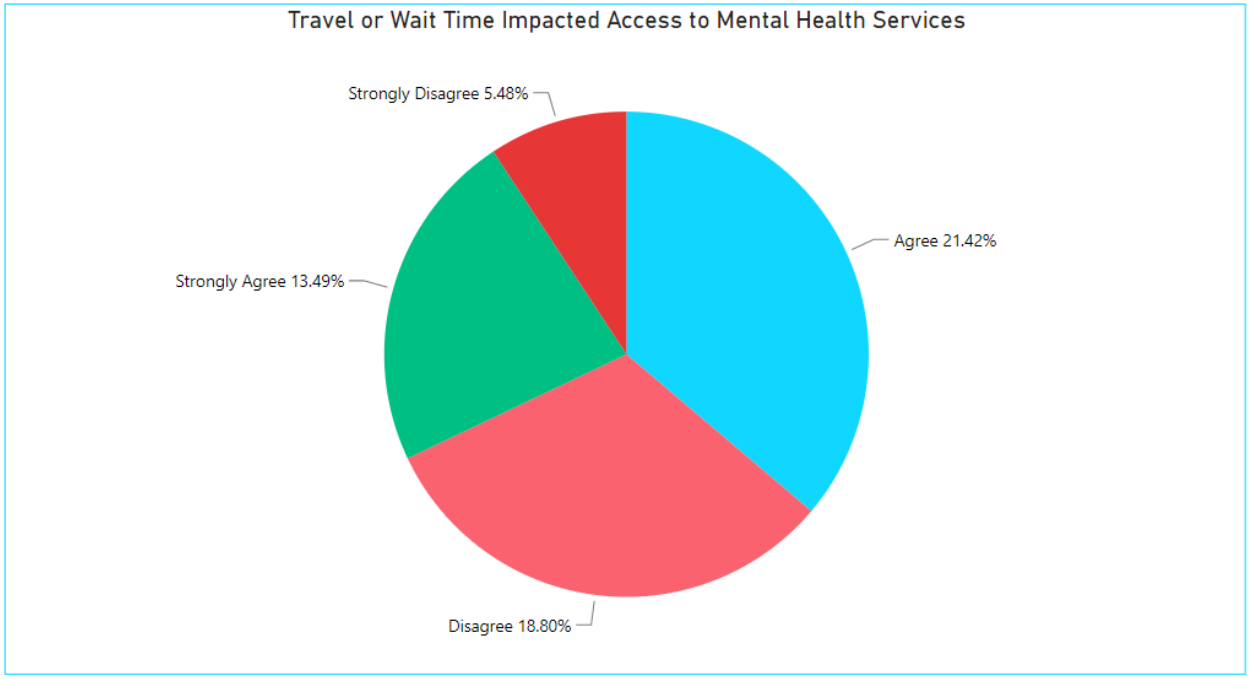


*Original question: How long, from the time you call to make an appointment, do you have to wait to see a mental health provider?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Of all the surveyed Panhandle Community members, only 3.63% said that they were able to see a mental health provider on the same day as they made the appointment, 18.13% were able to see a mental health provider within a week of appointment, 14.33% were able to see a mental health provider within 2 weeks and for most (16.27%) of them it took more than 2 weeks to see a mental health provider.

IMPACT OF TRAVEL OR WAIT TIME ON ACCESS TO MENTAL HEALTH SERVICES

Figure 139: Travel or Wait Time Impacted Access to Mental Health Services



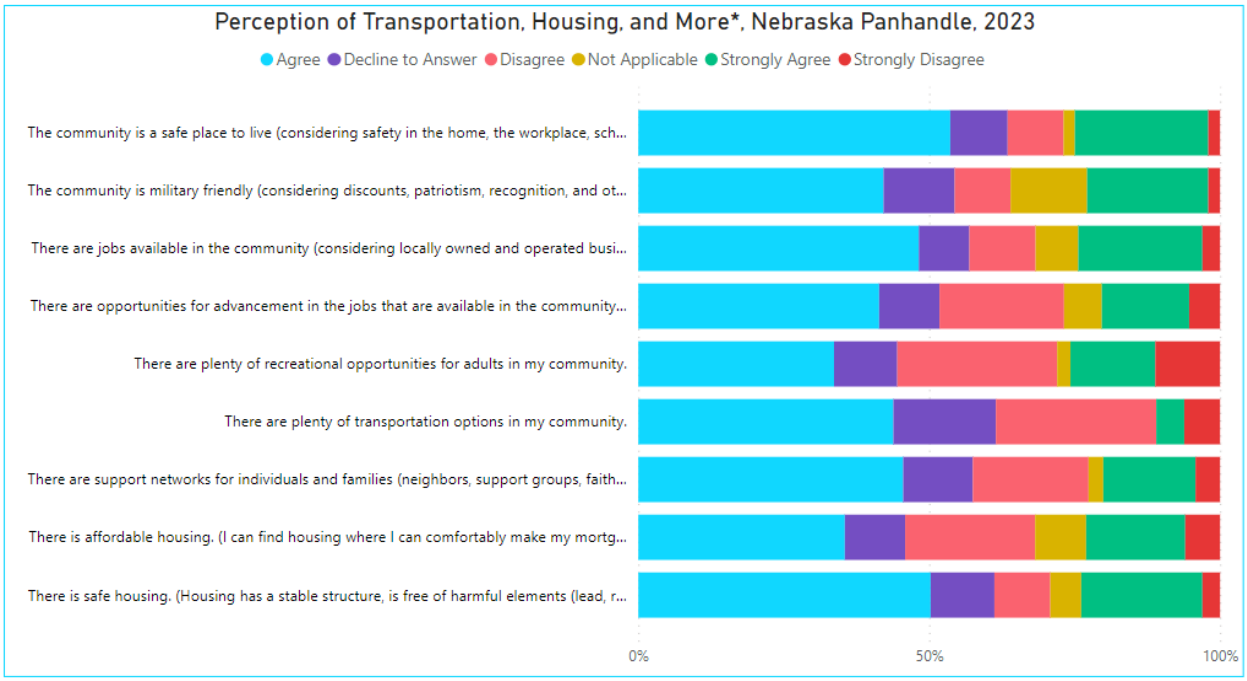
Original Question: The distance I must travel to see a mental health professional has resulted in me not seeking help.
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

34.91% of the surveyed Panhandle Community members agree with the statement that the distance they must travel to see a mental health professional has resulted in them not seeking help and only 24.28% of the members disagree with the statement, which is a cause for concern.

TRANSPORTATION, HOUSING, AND MORE

The following section includes responses to questions about transportation, housing, employment, and more in the Panhandle. Most respondents agree with all the statements below while some of them disagree with the statements that there are plenty of recreational opportunities for adults and there are plenty of transportation options in their community.

Figure 140: Perception of Transportation, Housing, and More



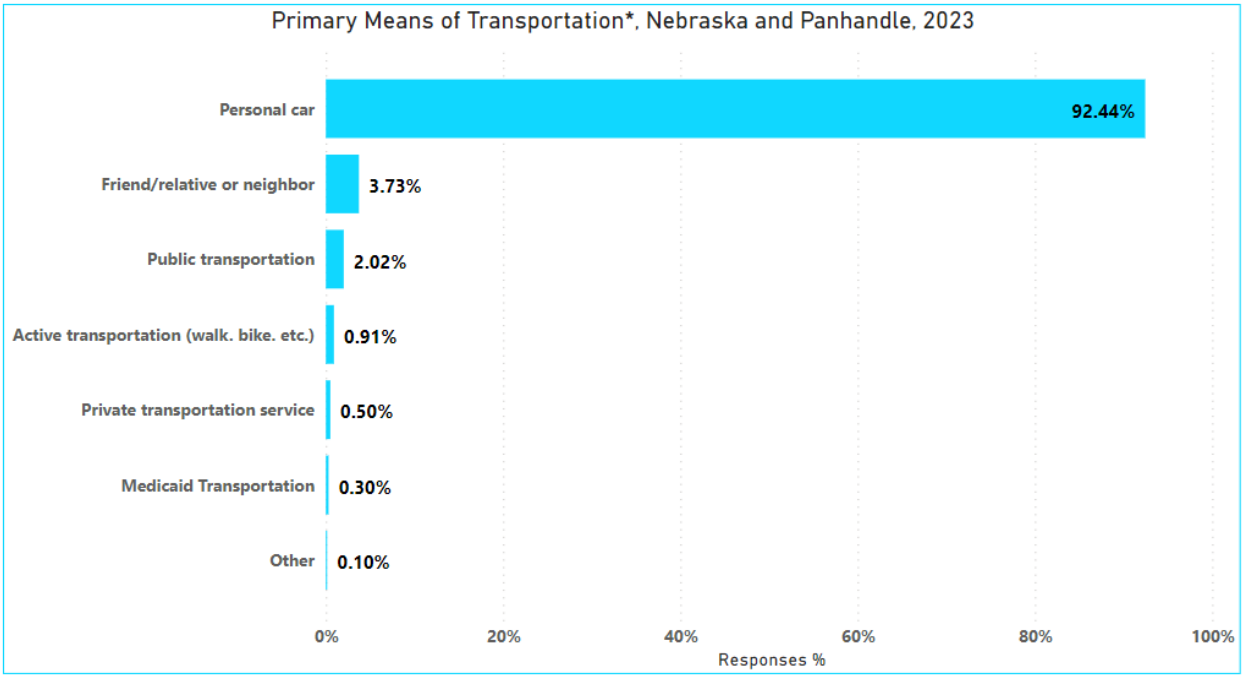
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Decline to Answer	Not Applicable
The community is a safe place to live (considering safety in the home, the workplace, schools, playgrounds, parks, and shopping areas).	23.00%	54.00%	10.00%	2.00%	10.00%	1.00%
The community is military friendly (considering discounts, patriotism, recognition, and other local resources such as housing support and mental health).	21.00%	42.00%	10.00%	2.00%	12.00%	13.00%
There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, etc.).	21.00%	48.00%	11.00%	3.00%	9.00%	8.00%
There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities).	15.00%	42.00%	21.00%	5.00%	10.00%	6.00%

There are plenty of recreational opportunities for adults in my community.	15.00%	34.00%	27.00%	11.00%	11.00%	2.00%
There are plenty of transportation options in my community.	5.00%	44.00%	28.00%	6.00%	17.00%	0.00%
There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.	16.00%	46.00%	20.00%	4.00%	11.00%	3.00%
There is affordable housing. (I can find housing where I can comfortably make my mortgage or rent payment each month)	17.00%	35.00%	22.00%	6.00%	10.00%	10.00%
There is safe housing. (Housing has a stable structure, is free of harmful elements (lead, radon, etc.), has utilities that function, etc.)	21.00%	50.00%	10.00%	3.00%	11.00%	5.00%

92.44% of the surveyed Panhandle Community members have said that they use their personal car as their primary means of transport, 3.73% have chosen friend, relative or neighbor and 2.02% have chosen public transportation as their primary means of transport.

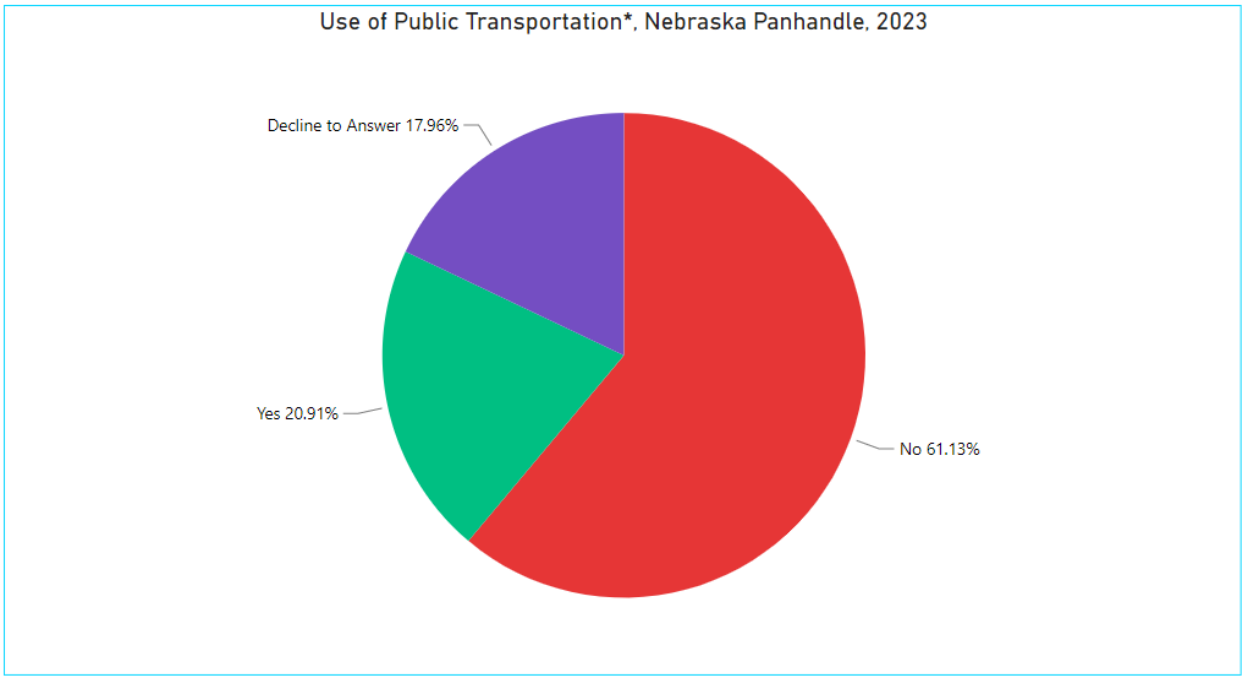
Figure 141: Primary Means of Transportation



Original Question: What is your primary means of transportation?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

PUBLIC TRANSPORTATION

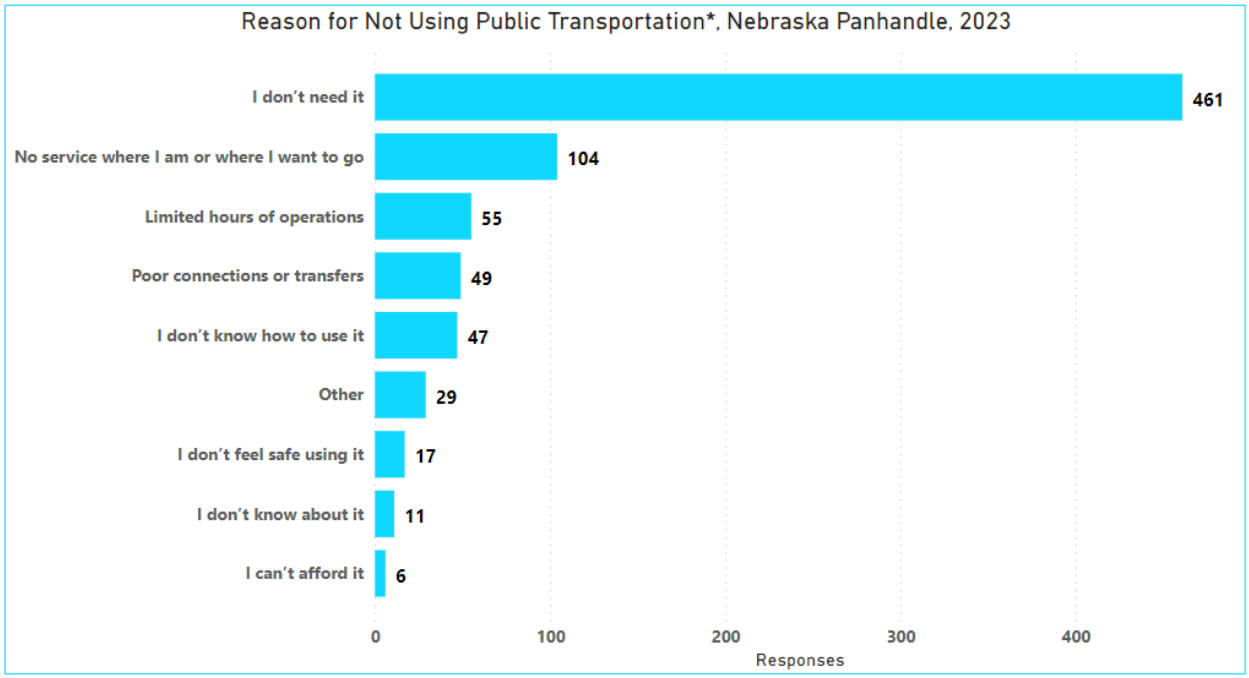
Figure 142: Use of Public Transportation



Original Question: Do you use public transportation?
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Most of the surveyed respondents (61.13%) have said that they do not use public transportation, 20.91% have said that they use public transportation.

Figure 143: Reasons for Not Using Public Transportation



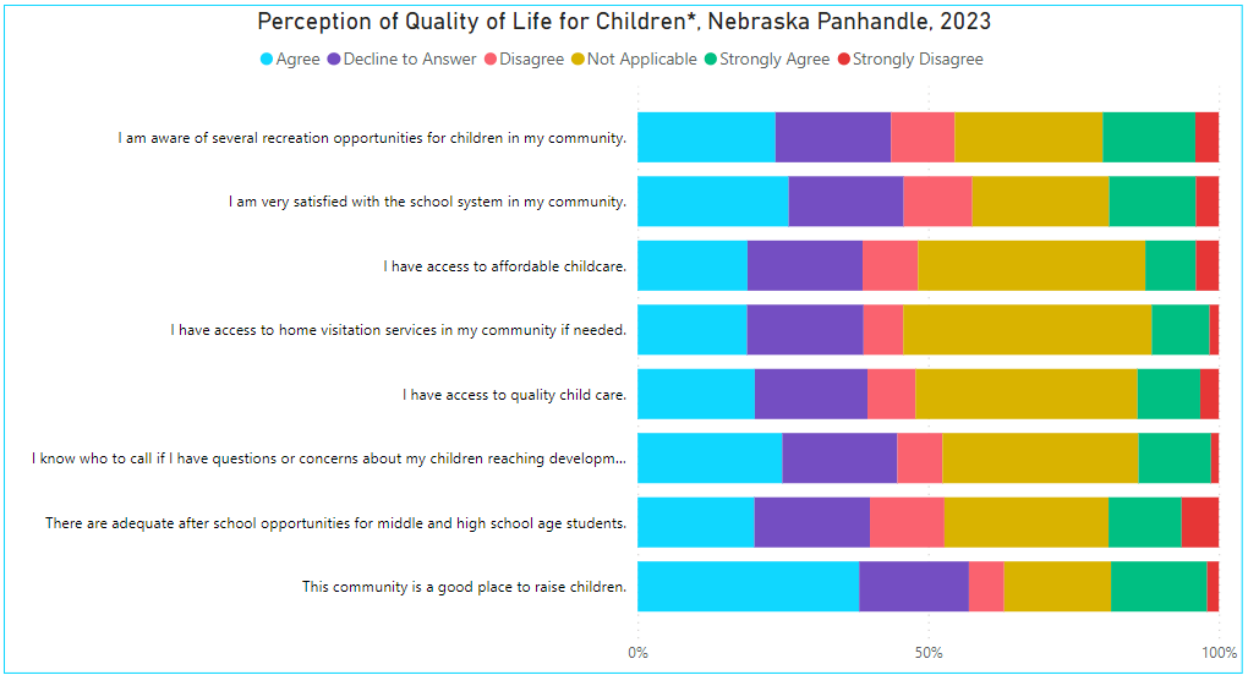
Original Question: If no, why not? (check all that apply)
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Most (461) have said that they do not need public transportation, 104 have said that they have no service where they are or where they want to go.

QUALITY OF LIFE FOR CHILDREN

The following section includes responses to questions about children, childcare, and education in the Panhandle. Only respondents with children in their care responded to these questions, therefore the "Not Applicable" bars are larger than seen in other charts. Many people agree the communities are a good place to raise children and there are good school systems.

Figure 144: Perception of Quality of Life for Children



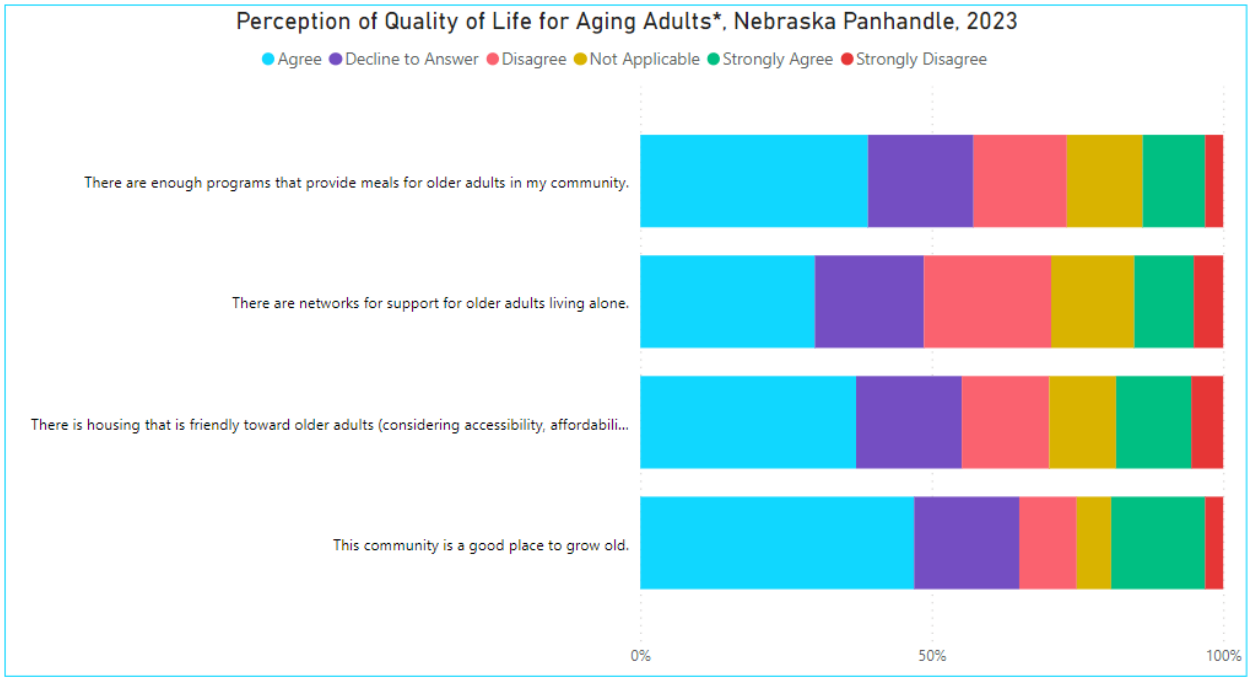
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Statement	Not Applicable	Agree	Decline to Answer	Strongly Agree	Disagree	Strongly Disagree
I am aware of several recreation opportunities for children in my community.	25.00%	24.00%	20.00%	16.00%	11.00%	4.00%
I am very satisfied with the school system in my community.	24.00%	25.00%	20.00%	15.00%	12.00%	4.00%
I have access to affordable childcare.	38.00%	19.00%	20.00%	9.00%	10.00%	4.00%
I have access to home visitation services in my community if needed.	43.00%	19.00%	20.00%	9.00%	7.00%	2.00%
I have access to quality child care.	38.00%	20.00%	19.00%	11.00%	8.00%	4.00%
I know who to call if I have questions or concerns about my children reaching developmental milestones.	34.00%	25.00%	20.00%	12.00%	8.00%	1.00%
There are adequate after school opportunities for middle and high school age students.	28.00%	20.00%	20.00%	13.00%	13.00%	6.00%
This community is a good place to raise children.	18.00%	38.00%	19.00%	17.00%	6.00%	2.00%

QUALITY OF LIFE FOR AGING ADULTS

The following section includes responses to questions about older adults in the Panhandle. Overall, respondents ranked items about quality of life for older adults on the positive side. The majority felt the community is a good place to grow old (63% agreed or strongly agreed).

Figure 145: Perception of Quality of Life for Aging Adults



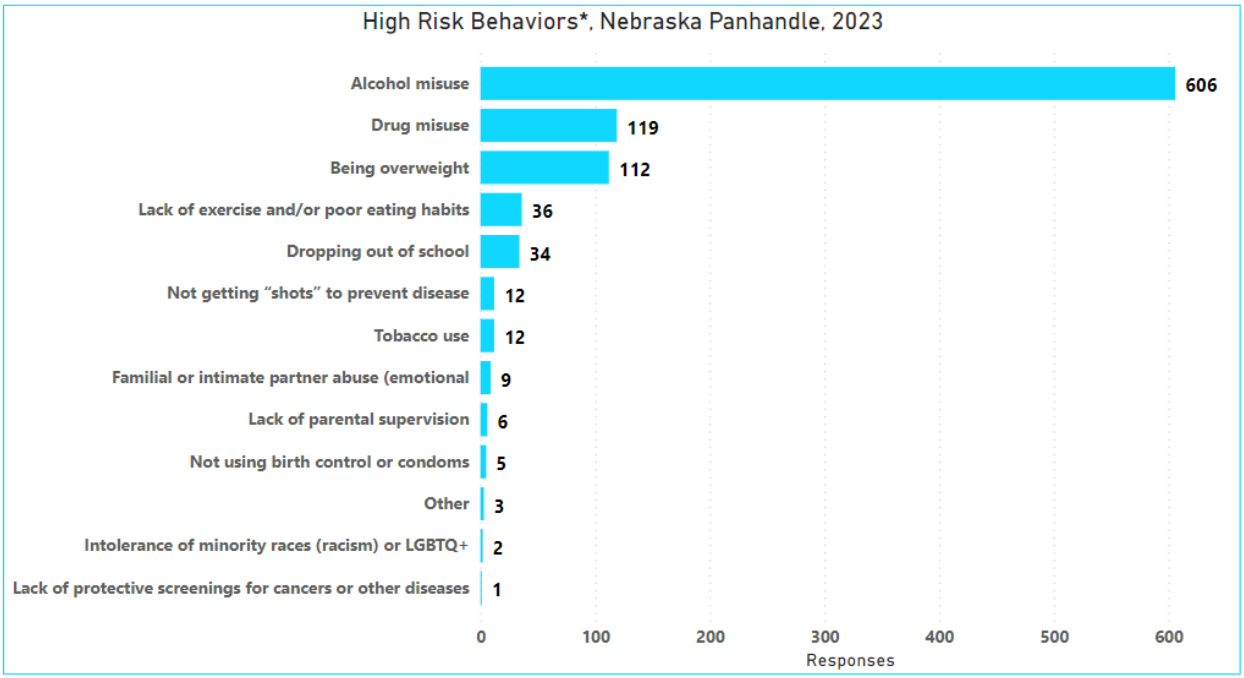
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

Statement	Agree	Disagree	Decline to Answer	Strongly Agree	Not Applicable	Strongly Disagree
There are enough programs that provide meals for older adults in my community.	39.04 %	16.02%	18.13%	10.71%	12.98%	3.12%
There are networks for support for older adults living alone.	29.93 %	21.84%	18.72%	10.20%	14.25%	5.06%
There is housing that is friendly toward older adults (considering accessibility, affordability, and safety).	37.02 %	15.00%	18.13%	12.90%	11.47%	5.48%
This community is a good place to grow old.	46.97 %	9.87%	18.04%	16.10%	5.90%	3.12%

TOP RISKY BEHAVIORS

The Community Health Survey asked respondents to rank the three most risky behaviors in the community. The top three risky behaviors were alcohol misuse, drug misuse, and being overweight, followed by poor eating habits, and lack of exercise.

Figure 146: 2023 Panhandle Biggest Risky Behaviors

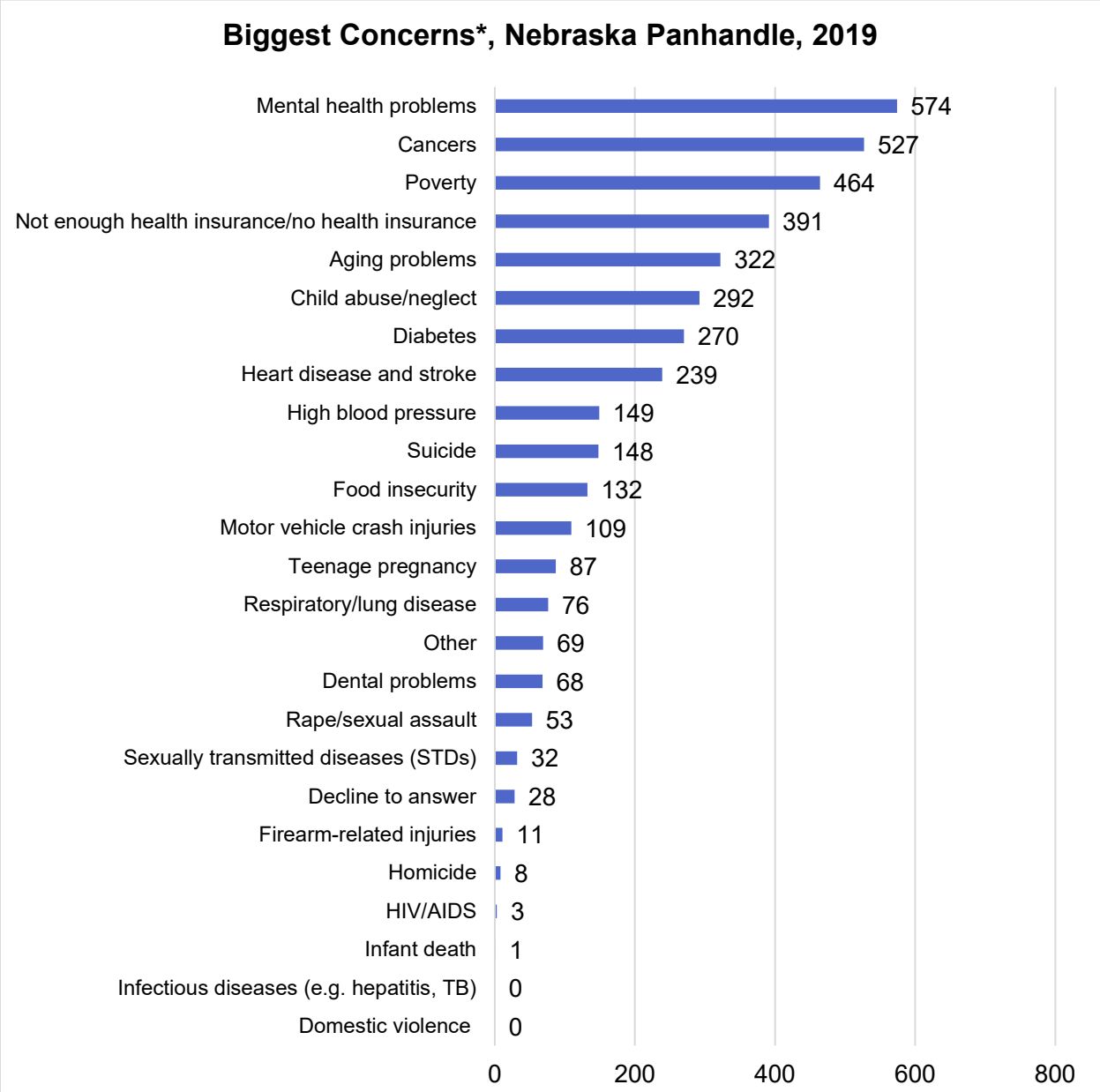


Original Question: 69. In the following list, what do you think are the 3 most impactful "high risk behaviors" in our community? (those behaviors that have the greatest impact on overall community health and wellness). Check only 3:
Data from 2023 Panhandle Public Health District Community Survey. Prepared by Emmanuel Osemota.

BIGGEST CONCERNS

The Community Health Survey asked respondents to rate their three biggest concerns in the community. The top three concerns rated were mental health problems, cancers, and poverty, followed by not enough health insurance/underinsurance, aging problems, and child abuse/neglect. As with risky behaviors, the 2017 survey elicited similar results. The top three concerns from the 2017 survey were poverty, mental health problems, and cancers, followed by not enough health insurance/underinsurance, aging problems, and child abuse/neglect.

Figure 147: 2023 Panhandle Biggest Concerns



*Original Question: In the following list, what do you think are the 3 biggest concerns in our community? (concertns that have the greatest impact on overall community health). Check only 3. Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

FORCES OF CHANGE ASSESSMENT

The Forces of Change assessment was completed in February 2023. See Appendix A for the meeting work product (including details on the process), and see the next page for the full Forces of Change assessment.

Horizon

- Simplifying the referral process
- Universal electronic health records
- Fully subsidized child care
- 1-year paid family leave, including for adopted children
- Equal pay for all
- Universal pricing for medical care and medications regardless of insurance availability
- Reducing paperwork for resources/services
- Enforcement for landlords to maintain housing standards/quality including non-Section 8
- Education reform related to cost of specialized fields
- Behavioral health/wellness center in every community
- Detox center access in the Panhandle instead of jails
- Access to sharps containers for safe disposal
- Regular youth social activities
- Regular senior activities
- Support group identification in the referral process
- Access to specialized all-pediatric care (out of state)
- Insurance companies become nonprofits
- Expand needle exchange programs and naloxone access
- Mentoring programs that is outside school systems, pool of qualified background checked volunteers
- Expanded post-natal care and support - resources, screenings, breastfeeding, letting moms bring small children to work to continue BF
- Everyone has access to employment training - exposure to trades skills in high school
- Removal of financial guidelines and admission requirements requirements to receive/maintain services - ie Healthy Families to all new parents instead of screener eligibility
- Crisis stabilization unit with detox (one stop shop for assessment, wrap around services, meet ST need and address LT strategies)
- Free post-secondary education
- Places for youth and seniors to connect that are quality, well-maintained locations, intergenerational learning and sharing
- Support for families that have older adults needing senior/expanded care that is affordable - trauma of losing family assets to pay for senior care, depletes family assets
- Paying clients for their time to learn the skills they need - ie paid for an hour of homeownership courses
- Inclusive communities - community equity and connectedness
- Peer learning programs
- Employer provided housing, also provides transportation to/from work
- Expanded concierge clinics
- Lifestyle medicine - more diverse approach to handling chronic conditions, all encompassing
- Teleportation
- Major health insurance restructuring
- Local shuttle services also contract to help employers get employees to/from work
- Remove state borders impacting insurance coverages/providers
- Remove barriers (like during covid - laws, policies, credentialing, access to telehealth) that allow providers to provide care in a more expanded area/capacity
- Better approach to elderly care - handling death of a loved one, home health resources, 24/7 CNAs, AFFORDABLE

Emerging

- Tele-Health
- Diversity, Equity, and Inclusion
- Real Data -Race, ethnicity, age, language
- Asking identifiers
- Continues glucose meters - early prevention
- Community Rec Center - Resources -Social interaction
- Integrated Behavioral Health Clinic - everything in one place
- Continue to promote healthy eating
- Nutrition shortcuts
- Active collaboration - 5K's
- Peer support
- Partnering / Collaboration
- Welcoming community conference
- More classes/education offered
- Businesses, school , community partnership to help address childcare needs
- Law enforcement & community health collaboration
- Training Resources for emotional awareness to caregiver/teachers
- Walking/biking lanes
- Inclusive Parks (age appropriate, ADA)
- MAT Programs
- detention center reintegration program/resource availability
- LOSS Team
- Rural resilience/communicating with agriculture community in stress
- 988 - Suicide Hotline
- Double up food program
- Cultural sensitivity training LGBTQ+
- Restorative Justice
- Housing First
- Centralized information
- No Wrong Door
- Utilizing expertise of people with lived experiences
- Utilize faith based communities
- After school programming
- Harness viral social media
- Medical Interpretation
- Remote Work
- wellness incentives (gym memberships)
- Behavioral Health/ meditation
- De-emphasis on getting 4 year degree
- Renewed interest in FFA, Ag, 4H
- Desire to learn a different language
- Canning, DIY, Sustainability
- Upstream

Established

- Question, Persuade, Refer
- Situation Table
- Panhandle Partnership
- Youth Mental Health First Aid
- Absence of services
- Traveling to next city/state for in-personal care
- Sweep it under the rug
- Professional Partner Program
  - Youth Transitional Services (similar to PPP but 16-18)
- Healthy Families
- Collaboration
- Community Supports
- In and out of the system (Mental Health/Substance Abuse)
- Training Academy
- Common Cause: unified recognition & want to address
- Don't have support for homeless population
- Recidivism
- Unite us - United way
- Western Nebraska HealthCare Alliance
- Rural response hotline - 988
- Behavioral Health Education Center of Nebraska
- Asking about social determinants
- National Diabetes Prevention
- Panhandle Collaborative Spirit
- Regional Hospital have services
- More established diverse population
- Tying insurance to employment
- Panhandle organization employers
- In-person work
- Virtual meetings
- High copays
- Employers recognizing their roll in a happy employee. Access to health care etc.
- Youth sports
- Not every community has established organizations
- Access to supports like food stamps, housing, etc.
- Local Public Health systems
- Strategies to improve walkability and active living
- Youth diversion program
- Worksite Wellness
- Tobacco Free Policies
- Hope squad
- Prevention Coalition
- Previous data to rely on - data driven decisions
- Use evidence based strategies
- secondary education
- Treating symptoms instead of causes
- Things get piloted in Eastern NE and don't make their way out west

Disappearing

- Safe Sex/Sex Education (needs resuscitated)
- Vaccines (needs resuscitated)
- BMI (outdated/replaced)
- Parental discipline (outdated)
- Work ethic/Company loyalty
- Traditional Families/Lack of positive role models
- Social media - disappearance of social experiences
- Expert opinions (disappearing)
- Problem solving abilities
- Time Outside (needs resuscitated)
- Trust/Wrong information
- Libraries
- Expectations for our youth
- Shame/Exclusion ("out")
- In-person communication
- Sense of community - rootedness
- Job recruitment ("out") and quality of life "in"
- 1st time home buyers (disappearing)
- Local media / journalism
- Meeting in person/networking (needs resuscitated)
- Funding to go to in-person events
- Punitive towards behavioral health (needs to be let go)
- 9-5 work week / 5 days / at the office
- separation of medical and mental health treatments (let go of the idea that they're separate)
- family care doctors (needs resuscitated)
- Feeling safe - media, worldly
- The word "traditional" needs to go away
- Traditions and religion (needs resuscitated)
- In-person group fitness needs resuscitated
- Prioritizing health (needs resuscitated)
- Recycling (needs resuscitated)

Undertow

- Silos that don't communicate
  - Schools, hospitals, foster care, Juvenile Justice
  - No Central Intake
  - Control Mindset
- Bias & Stigma- Scared Straight approach, access to services in certain areas, Medicaid population, Mental Health Substance Misuse Stigma Treatment (more so for men)
- Clarification of Continuance of Care
- Gatekeepers to care- Barriers/red tape
- Lack of sustainable funding
- Institutional Mistrust
- Reluctance to change
- Political will- "don't rock the boat"
- Agendas & perspective
- Trends of Consolidation- Lost local considerations & perspectives
- Competition for scarce resources
- Make less here for same jobs than would be made elsewhere
- Expectations
- Problem focused rather than solution focused
- Conspiracy theories- Misinformation & Social Media
- Inaccessible communication-
  - written & verbal (brail, multilingual, Sign-language)
- Racism
- Cultural understanding of healthcare services
- Political Polarization
- Cost of education - student loans
- Big Pharma- Cost of medication
- wait lists
- Passing the buck - reimbursement
- Insurance dictated care
- Access to quality affordable childcare- getting people to work
  - willingness to explore flexible options
- Small workforce
- Discomfort asking hard questions
  - Mental Health
- Rural & Remote Nature of the Panhandle
- Zero Sum Mentality
  - Lack of a "greater good" mentality
- Generational Poverty
- Lack of lived experience in decision making processes
- Service Cliff- Loss of services if circumstances change

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The MAPP process typically includes an assessment called the Local Public Health System Assessment (LPHSA). In 2022, MAPP 2.0 was made available and a new tool for assessing partner capacity was made available. It is called the Community Partner Assessment (CPA). The CPA was completed in the Spring of 2023. A summary of the results can be found in Appendix C.

The Community Partner Assessment was distributed as a survey through the Panhandle Partnership, MAPP, and Work Groups email lists. Questions in the Community Partner Assessment were designed to assess strengths and gaps in the participating agency's capacity. This method of assessing the public health system was much smoother than it was during the last cycle. The partners gave good feedback on the ease of use but gave a recommendation for it to be shorter next time.

MAPP PHASE 4: IDENTIFY STRATEGIC ISSUES

A prioritization process to identify strategic issues to focus on in the Community Health Improvement Plan (CHIP) was completed through a modified consensus workshop in April 2023. 25 people attended the meeting.

The agenda was as follows: Introductions, Data Presentation, Prioritization Consensus Workshop, Conclusion.

The presentation presented included the results of the survey distributed to the community and the results of the community partner assessment. After going through the presentation, attendees made a list of three themes that emerged to them based on that data and the data from the kick-off in February. Attendees then worked with their tables to narrow the ideas down and sort ideas into 4 categories: Highly Urgent/Resources Available, Highly Urgent/Limited Resources, Less Urgent/Resources Available, and Less Urgent/Limited Resources. As a large group, we worked together to come to a consensus on where each of the top ideas fell onto that same grid. The list of attendees from this meeting can be found in Appendix D.

The top priority areas in the Highly Urgent/Resources Available and Highly Urgent/Resources Limited categories are below:

- Resources for Aging Individuals
- Workforce Capacity
- Housing
- Childcare
- Access to Care/Cost of Care
- Built Environment
- Access to Dental Care
- Utilization/Level of Care
- Access to Mental Health Care

We then voted on the top three ideas because so many fell into the Highly urgent categories. Final priority areas for the 2021-2023 CHIP are:

Priority Area 1:	Community Education • Considering how we might educate our communities in a way that prepares all of us to act together.
Priority Area 2:	Affordable Housing
Priority Area 3:	Childhood Care & Education
Priority Area 4:	Access to Mental Health Services • Mental Health & Substance Use Disorder Treatment
Priority Area 5:	Cultural Awareness and Support


CULTURAL AWARENESS AND SUPPORT
Create a culture of belonging, trust, and engagement
CHILDCARE
Quality and accessible early childcare and programs for older children
AFFORDABLE HOUSING
Increase the availability of affordable housing that would easily fit in family income at all levels
STRATEGIC PRIORITIES PLANNING FOR HEALTH 2023
COMMUNITY EDUCATION
Educating the community in a way that builds community capacity and readiness for health improving activities
ACCESS TO MENTAL HEALTH SERVICES
Making mental health & substance use disorder treatment available and accessible by increasing ease/timeliness, accessibility to mental health resources and providers
Panhandle
Public Health District

APPENDICES

2023 Community Health Assessment
Visioning & Forces of Change

Completed February 8, 2023

The Forces of Change assessment and Visioning process were completed during the kickoff meeting in April 2023. 58 people attended the meeting.

The agenda was as follows:

- Introductions
- Review the data
- Visioning
- Forces of Change
- Regroup and Review
- Conclusion

Megan Barhafer (PPHD) provided a short presentation of health outcome and risk factor data and selected Census data.

Megan led the group in a Technology of Participation Consensus Workshop to develop the vision for the next three years. The group answered the question "If we could align our resources, what would our vision for a safer and healthier Panhandle be?". The group also considered the following Resources:

- Energy
- Policies
- Non-profits
- Community Efforts
- Alignment of Infrastructure

The group then completed the Forces of Change Assessment in several groups where they could add on to each other's work. Megan led the group through a review of the Wave process and format. The Wave process is a Technology of Participation process that focuses on five areas:

- Horizon: Which new ideas are pushing or needing to become accepted trends and practices?
- Emerging: Which trends and practices are picking up momentum and acceptance?
- Established: Which trends and practices are mainstream or standard operating procedures?
- Disappearing: Which trends and practices are concepts whose variability is overtly questioned or not needed?
- Undertow: What are the deep patterns that cause trouble, even amid success?

The attendees were split into 5 groups and each group went through each section of the waves model adding context and ideas. Each group worked on one section at a time and when they were done the group rotated their list so that subsequent groups could add on.

The remaining pages include the participant list.

Participant List:

Name:	Organization:
Megan Barhafer	Panhandle Public Health District
Kelsy Sasse	Panhandle Public Health District
Amanda Mcclaren	Panhandle Public Health District
Martin Vargas	Regional West Medical Center
Kim Engel	Panhandle Public Health District
Nicole Berosek	Panhandle Public Health District
Kalyn Tissue	ESU 13
Renee Miller	ESU 13
Robin Stuart	Morrill County Community Hospital
Melissa Schaub	Community health
Jessica Davies	Panhandle Public Health District
Sandy Montague-Roes	Western Community Health Resources
Nici Johnson	ESU 13
Lori Reifschneider	Community Health
Daniel Bennett	Civic Nebraska
Janelle Visser	Panhandle Public Health District
Marie Parker	PPHD Board of Health
Emily Timm	Panhandle Public Health District
Evie Blackburn	Sidney Regional Medical Center
Sam Fisher	ESU 13
Tabi Prochazka	Panhandle Public Health District
Sara Williamson	Panhandle Public Health District
Laura Bateman	Kimball Health Services
Kerry Ferguson	Kimball Health Services
Angie Luppen	ESU 13
Amanda Kehn	Gordon Memorial Hospital
Theresa Thomas	Community Health
Tina Cook	Community Health
Kendra Dean	Cirrus House
Jonnie Kusek	Panhandle Trails
Erin Sorenson	Panhandle Public Health District
Kristin Maag	Scottsbluff Diversion
Kristen Rose	Sidney Regional Medical Center
Sam Hahn	Sidney Regional Medical Center
Penny Parker	Nebraska Total Care
Don Lease	Community Member
Faith Mills	Panhandle Partnership
Lisa Simmons	Region 1 Behavioral Health
Kym Fries	Region 1 Behavioral Health
Bailey Kling	Region 1 Behavioral Health
Heather Brown	Region 1 Behavioral Health
Jeralee Wangler	State of Nebraska
Liz MacDonald	Panhandle Public Health District
Paulette Schnell	Community Health
Beverly Yax	UNMC
Dez Brandt	Panhandle Public Health District
Kendra Lauruhn	Panhandle Public Health District
Bonnie Carrell	Regional West Medical Center

Name:	Organization:
Dan Newhoff	Box Butte General Hospital
Ashley Ahrens	University of Nebraska - Lincoln
Georgia Ryer	School Diversion
Aimee Wheeler	Scotts Bluff Public Schools
Rosanna Kirk	Gordon Memorial Hospital
Dawn Ferrell	ESU 13
Gloria Kennedy	United Health Care
Sandy Preston	Community Health
Melinda Pearson	Kimball Health Services
Michael-Lawrence Dunn	Recovery Corps

APPENDIX B: 2022 COMMUNITY HEALTH SURVEY

2022 Community Health Survey

Please take about 15 minutes to complete this short survey. The purpose of this survey is to get your input about the health of your community. The Panhandle Public Health District, area hospitals, and economic development will use your responses to help identify the most pressing concerns. There are several required questions in order for you to be able to move on to the drawing portion of the survey. The survey will prompt you if you skip a required question.

1a. Has your health improved in the last 3 years? - this question is required

- o My health has significantly declined (1)
- o My health has somewhat declined (2)
- o My health has not changed (3)
- o My health has improved somewhat (4)
- o My health has significantly improved (5)

1b. What has been the biggest contributor to an improvement or decline in your health over the past 3 years? - this question is required

_____

1c. What do you think would make the biggest difference in improving your health or your family's health over the next 3 years? - this question is required

_____

Please indicate your level of agreement with each of the following statements:

	Strongly Disagree (1)	Disagree (2)	Agree (4)	Strongly Agree (5)	Not Applicable (6)
2. I am very satisfied with the healthcare system in our community. (1)	o	o	o	o	o
3. I am able to get my desired medical care whenever I need it. (2)	o	o	o	o	o
4. I am very satisfied with the medical care I receive. (3)	o	o	o	o	o
5. Sometimes it is a problem for me to cover my share of the cost of a medical care visit. (4)	o	o	o	o	o
6. I have easy access to the medical specialists (providers that focus on a specific area of medicine that I need). (5)	o	o	o	o	o
7. I have easy access to reproductive health services (contraceptives, pregnancy testing,	o	o	o	o	o

adoption counseling, infertility services, etc.) (6)					
8. I would use a telehealth (phone or video) option (for reproductive health, check-ups, mental health visits, or other medical needs, not including surgery) (7)	o	o	o	o	o
9. I can understand what my healthcare providers, including specialists, dental and mental health, are saying to me and act on that information (there is an interpreter available to me if necessary)? (8)	o	o	o	o	o
10. I can understand written information from my healthcare providers (it is translated into another language if necessary)? (9)	o	o	o	o	o

11. How do you pay for your health care? (Check all that apply)

1. Pay cash (no insurance) (1)
2. Private Health insurance (through employer) (2)
3. Through the Healthcare Marketplace (3)
4. Faith-Based (4)
5. Medicaid (5)
6. Medicare (6)
7. Veterans' Administration (7)
8. Indian Health Services (8)
9. Other (10)

Display This Question:

If 11. How do you pay for your health care? (Check all that apply) = 10

11b. If you responded "Other" to Question 11 (How do you pay for your health care?), please specify:

_____

12. Are you able to find healthcare locally that is in network for your insurance?

o No (1)

- o Usually (2)
- o Yes (3)

Q22 Please indicate your level of agreement with each of the following statements:

	Strongly Disagree (1)	Disagree (2)	Agree (4)	Strongly Agree (5)	Not Applicable (6)
13. There is safe housing. (Housing has a stable structure, is free of harmful elements (lead, radon, etc.), has utilities that function, etc.) (1)	o	o	o	o	o
14. There is affordable housing. (I can find housing where I can comfortably make my mortgage or rent payment each month) (2)	o	o	o	o	o
15. There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, etc.). (3)	o	o	o	o	o
16. There are opportunities	o	o	o	o	o

for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities). (4)					
17. The community is a safe place to live (considering safety in the home, the workplace, schools, playgrounds, parks, and shopping areas). (5)	o	o	o	o	o
18. There are plenty of recreational opportunities for adults in my community. (6)	o	o	o	o	o
19. There are support networks for individuals and families (neighbors, support groups, faith community outreach,	o	o	o	o	o

agencies, and organizations) during times of stress and need. (7)					
20. The community is military friendly (considering discounts, patriotism, recognition, and other local resources such as housing support and mental health). (8)	o	o	o	o	o
21. I believe that I can individually and collectively make the community a better place to live. (9)	o	o	o	o	o
22. I can be my authentic self in my community. (10)	o	o	o	o	o
23. Written communicatio n in my community is available in a language I understand. (11)	o	o	o	o	o

Page Break

Q17 **The following questions are about mental health care access in the community**

Q70 Please indicate your level of agreement for the following statements:

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)	Not Applicable (5)
24. It is easy to find mental health providers in my community. (1)	o	o	o	o	o
25. My family supports me seeing a mental health professional. (2)	o	o	o	o	o
26. I am satisfied with the types of mental health services available in my community (traditional therapists, telehealth, addiction recovery, overnight	o	o	o	o	o

facilities, etc.) (3)					
27. It is easy for me to schedule appointments with mental health providers that fit into my schedule. (4)	o	o	o	o	o
28. The distance I must travel to see a mental health professional has resulted in me not seeking help. (5)	o	o	o	o	o
29. I feel comfortable with the idea of seeking help from a mental health professional if I need it. (6)	o	o	o	o	o
30. I can find a mental health professional who is respectful of my cultural beliefs. (7)	o	o	o	o	o
31. I can find a mental health professional that communicates in a	o	o	o	o	o

language I understand or uses an interpreter who speaks a language I understand. (8)					
32. I believe that seeking mental health resources is for anyone, not just people who are in crisis. (9)	o	o	o	o	o

Q18 33. Have you been able to access mental health services, including telehealth services, locally for yourself or a family member in the last year?

- o No (1)
- o Usually (2)
- o Yes (3)
- o Not applicable (4)

Q71 34. How long, from the time you call to make an appointment, do you have to wait to see a mental health provider?

- o Same day (2)
- o Within 1 week (3)
- o Within 2 weeks (5)
- o Greater than 2 weeks (6)
- o Not Applicable (4)

Q19 35. How far have you or a family member had to travel for access to mental health services, including telehealth mental health services? (in miles)

- o 0-24 (1)
- o 25-49 (2)

- o 50-74 (3)
- o 75+ (4)
- o Not applicable (5)

Q20 36. Do you have affordable, reliable transportation to get to your or your family's mental health appointments?

- o No (1)
- o Yes (3)
- o Not applicable (4)

Page Break

Q7 **The following questions are about your primary care provider:**

Q8 37a. What clinic/hospital/health system do you go to for your primary care provider (the doctor you usually go to for medical care)?

_____

Q72 37b. What clinic/hospital/health system do you go to for your family's primary care provider (if different than above)?

_____

Q10 38. How long, from the time you call to make an appointment, do you have to wait to see your primary care provider?

- o Same day (1)
- o Within 1 week (2)
- o Within 2 weeks (3)
- o Greater than 2 weeks (4)

- o Not applicable (5)

Q9 39. How far do you travel for your primary care provider? (in miles)

- o 0-24 (1)
- o 25-49 (2)
- o 50-74 (3)
- o 75+ (4)
- o Not applicable (5)

Q11 40. Do you have affordable, reliable transportation to take you to your primary care provider?

- o Yes (4)
- o No (5)
- o Not Applicable (6)

Page Break

Q12 **The following questions are about any specialists you may see:**

Q13 41a. What clinic/hospital/health system do you go to for your specialist?

_____

Q73 41b. What clinic/hospital/health system do you go to, for a specialist to see your family members (if different than above)?

_____

Q15 42. How long, from the time you call to make an appointment, are you able to see your specialist?

- o Same day (1)
- o Within 1 week (2)
- o Within 2 weeks (3)
- o Greater than 2 weeks (4)
- o Not applicable (5)

Q14 43. How far do you travel for your specialist? (in miles)

- o 0-24 (1)
- o 25-49 (2)
- o 50-74 (3)
- o 75+ (4)
- o Not applicable (5)

Q16 44. Do you have affordable, reliable transportation to get to your or your family's specialist?

- o No (4)
- o Yes (5)
- o Not Applicable (6)

Page Break

Q74 **The following questions are about your dental care provider:**

Q75 45a. What dental clinic do you see for routine care?

_____

Q76 45b. Can everyone in your family see the same dentist?

_____

Q80 46. How do you pay for your dental care? (Check all that apply)

1. Pay cash (no insurance) (1)
2. Private Health insurance (through employer) (2)
3. Through the Healthcare Marketplace (3)
4. Faith-Based (4)
5. Medicaid (5)
6. Medicare (6)
7. Veterans' Administration (7)
8. Indian Health Services (8)
9. I can't afford dental care (11)
10. Other (10)

Q77 47. How long, from the time you call to make an appointment, are you able to see your dentist?

- Same day (1)
- Within 1 week (2)
- Within 2 weeks (3)
- Greater than 2 weeks (4)
- Not applicable (5)

Q78 48. How far do you travel for your dental care? (in miles)

- 0-24 (1)
- 25-49 (2)
- 50-74 (3)
- 75+ (4)
- Not applicable (5)

Q79 49. Do you have affordable, reliable transportation to get to your or your family's dental clinic?

- No (4)
- Yes (5)
- Not Applicable (6)

Page Break

Q86 The following questions are about reproductive services:

Q82 50a. What are the 3 most important reproductive health services to make available in the Panhandle (check 3 boxes)?

11. Education and presentations (1)
12. Contraceptives (2)
13. Pregnancy counseling (3)
14. Adoption counseling (4)
15. Basic infertility services (5)
16. Pre-conception health services (health education, reproductive life plan) (6)
17. Testing and treatment for sexually infectious diseases (7)
18. Cervical cancer and breast cancer screening (8)

Q84 50b. What prevents you from accessing reproductive health services (select all that apply)?

19. Cost of services (1)
20. Hours or days of operation (2)
21. Language - no interpreter or language line (3)
22. Privacy concerns (4)
23. Location of services (5)
24. No barriers (6)
25. Other (7)

Q85 If you selected other in question 50b. please write in your answer here:

_____

Page Break

Q87 The following questions are about transportation in your community

Q88 51. There are plenty of transportation options in my community.

- o Strongly disagree (1)
- o Disagree (2)
- o Agree (3)
- o Strongly Agree (4)

Q23 52. What is your primary means of transportation? (Check all that apply).

26. Personal car (1)
27. Friend, relative, or neighbor (2)
28. Private transportation service (3)
29. Active transportation (walk, bike, etc.) (4)
30. Public transportation (5)
31. Medicaid Transportation (6)
32. Other (7)

Q24 If you responded "Other" to question 52 (What is your primary means of transportation?), please specify:

_____

_____

_____

_____

_____

Q25 53. If you don't drive a car, why not? (Check all that apply).

33. Can't drive due to a medical/physical condition (1)
34. Can't afford a car (2)
35. Can't afford gas/insurance (3)
36. Lost driver's license (4)
37. No need, everything I need I can access without a car (5)
38. Other (6)

Q26 If you responded "Other" to question 53 (If you don't drive a car, why not?), please specify:

_____

_____

_____

_____

_____

Q27 54. Do you use public transportation?

- o Yes (1)
- o No (2)

Q89 55a. If yes, which public transit service do you use and what was your experience?

_____

Q28 55b. If no, why not? (Check all that apply).

39. No service where I am or where I want to go (1)
40. Poor connections or transfers (2)
41. I don't know how to use it (3)
42. Limited hours of operations (4)
43. I don't feel safe using it (5)
44. I can't afford it (6)
45. I don't know about it (7)
46. I don't need it (8)
47. Other (9)

Q29 If you responded "Other" to question 55b, please specify:

_____

_____

_____

_____

_____

Page Break

Q30 **The following questions are about raising children in your community. Please only respond if you currently have a child that resides with you for whom you provide care. If you do not have children, please mark "Not Applicable".**

Q31 **Please indicate your level of agreement with each of the following statements:**

	Strongly Disagree (1)	Disagree (2)	Agree (4)	Strongly Agree (5)	Not Applicable (6)
55. This community is a good place to raise children. (1)	o	o	o	o	o
56. I have access to quality child care. (2)	o	o	o	o	o
57. I have access to affordable childcare. (3)	o	o	o	o	o
58. I have access to home visitation services in	o	o	o	o	o

my community if needed. (4)					
59. I know who to call if I have questions or concerns about my children reaching developmental milestones. (5)	o	o	o	o	o
60. I am very satisfied with the school system in my community. (6)	o	o	o	o	o
61. There are adequate after school opportunities for middle and high school age students. (7)	o	o	o	o	o
62. I am aware of several recreation opportunities for children in my community. (8)	o	o	o	o	o

Page Break

Q34 **The following questions are about older adults in your community. Please only fill this section out if you are an older adult, work with older adults, or are helping a family member who is an older adult navigate these things.**

Q35 **Please indicate your level of agreement with each of the following statements:**

	Strongly Disagree (1)	Disagree (2)	Agree (4)	Strongly Agree (5)	Not Applicable (6)
63. This community is a good place to grow old. (1)	o	o	o	o	o
64. There is housing that is friendly toward older adults (considering accessibility, affordability, and safety). (2)	o	o	o	o	o
65. There are enough programs that provide meals for older adults in my community. (3)	o	o	o	o	o
66. There are networks for support for older adults living alone. (4)	o	o	o	o	o
67. There are activities for	o	o	o	o	o

older adults in my community. (5)	

Page Break

Q36 68. The following questions are about your experiences as a child. If you are currently under the age of 18, think of your present or past. If you are an adult, think of when you were younger than 18. These questions are called Adverse Childhood Experiences, people who answer yes to these experiences have a higher risk for poor health outcomes. This data supports If you need resources or assistance relating to anything in the following questions, please call 988

	Yes (1)	No (2)	Decline to Answer (3)
Did you live with anyone who was depressed, mentally ill, or suicidal? (1)	o	o	o
Did you live with anyone who was a problem drinker or an alcoholic? (2)	o	o	o
Did you live with anyone who used illegal street drugs or who abused prescription medications? (3)	o	o	o
Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility? (4)	o	o	o

Were your parents separated or divorced? (5)	o	o	o
Did parents or adults in your home slap, hit, kick, punch, or beat each other up? (6)	o	o	o
Did a parent or adult in your home hit, beat, kick, or physically hurt you in any way? Do not include spanking. (7)	o	o	o
Did a parent or adult in your home swear at you, insult you, or put you down? (8)	o	o	o
Did an adult or anyone at least 5 years older than you touch you in sexual way? (9)	o	o	o
Did an adult or anyone at least 5 years older than you try to make you touch them in sexual way? (10)	o	o	o

Page Break

Q36 **The following questions are about high-risk behaviors and health problems in your community. The first section will ask about high risk behaviors (those behaviors that have the greatest impact on overall community health) and the second section will ask about health problems (concerns that have the greatest impact on overall community health).**

Q37 69. In the following list, what do you think are the 3 most impactful “high risk behaviors” in our community? (those behaviors that have the greatest impact on overall community health and wellness). Check only 3:

48. Alcohol misuse (1)
49. Being overweight (2)
50. Dropping out of school (3)
51. Drug misuse (4)
52. Lack of exercise and/or poor eating habits (5)
53. Lack of parental supervision (6)
54. Not getting “shots” to prevent disease (7)
55. Familial or intimate partner abuse (emotional, sexual, physical) (14)
56. Intolerance of minority races (racism) or LGBTQ+ (8)
57. Tobacco use (9)
58. Not using birth control or condoms (10)
59. Not using seat belts and/or child safety seats (11)
60. Lack of protective screenings for cancers or other diseases (12)
61. Other (13)

Q38 If you responded "Other" to question 69, please specify:

_____

_____

_____

_____

_____

Q39 70. Please rank what you believe to be the top 3 topic areas from greatest health concern in our area to least health concern in our area? (1= least health concern, 3 = greatest health concern)

- o Aging related concerns (falling, dementia, hearing/vision loss) (1) _____
- o Chronic disease (diabetes, cancers, heart disease, etc.) (2) _____
- o Mental Illness (depression, anxiety, schizophrenia, suicidal ideation) (4) _____
- o Substance Addictions and Overdoses (alcoholism, prescription drugs, overdoses, illegal substances) (3) _____
- o Injuries due to Violence (domestic, sexual, homicide etc.) (5) _____
- o Health decisions (eating habits, exercise habits, smoking, etc.) (6) _____
- o Infectious diseases (COVID, flu, HIV/AIDS, Monkey pox, Sexually transmitted infections) (7) _____
- o Workplace injuries (8) _____

- o Access to care (cost, transportation, culturally appropriate services, language) (9) _____
- o Vehicular injuries (10) _____
- o Safe Housing (affordable housing, housing that is free of dangerous toxins, etc.) (11) _____
- o Lack of community resources (places to exercise, gather, get medical care, food access etc.) (12) _____
- o Other: Please list the rank (1-3) and then also list what "other" is for you (13) _____

Q42 71. Are there emerging issues in the community that you think need to be focused on, that may not be in the above lists?

_____

_____

_____

_____

_____

Page Break

Q45 **Please provide the following information about yourself. It will be used for demographic purposes only. Keep in mind you will NOT be identified in any way with your answers.**

Q46 72. Zip code:

_____

Q47 73. County of residence:

▼ Banner (1) ... Other (13)

Q48 If you selected other in question 73, please write in your answer:

_____

Q49 74. What is your gender?

_____

Q57 75. Age:

- o Under 18 years (1)
- o 18-25 years (2)
- o 26-39 years (3)
- o 40-54 years (4)
- o 55-64 years (5)
- o 65-80 years (6)
- o Over 80 years (7)

Q55 76. Race:

62. White (1)
63. Black or African American (2)
64. Asian (3)
65. Native Hawaiian or Other Pacific Islander (4)
66. American Indian or Alaska Native (5)
67. Decline to answer (6)
68. Other (7)

Q90 If you responded "Other" to question 76, please specify:

_____

Q61 77. Are you Hispanic or Latino/a/x (you can mark both if applicable)?

69. Yes (1)
70. No - please indicate your ethnicity in the following question (2)
71. Decline to answer (3)

Q54 If you responded "No" to question 77, please specify your ethnicity here:

_____

Q53 78. Highest level of education:

- o Less than high school graduate (1)
- o High school diploma or GED (2)
- o Associates or Technical Degree (3)
- o College degree or higher (4)
- o Decline to answer (5)
- o Other (6)

Q60 79. Household Income:

- o Less than $20,000 (1)
- o $20,000 to $29,999 (2)
- o $30,000 to $49,999 (3)
- o $50,000 to $74,999 (4)
- o $75,000 to $99,999 (5)
- o Over $100,000 (6)
- o Decline to answer (7)

Q58 80. Marital Status:

- o Married/Partnered (1)
- o Divorced (2)
- o Never married (3)
- o Separated (4)
- o Widowed (5)

- o Decline to answer (6)
- o Other (7)

Q59 If you responded "Other" to question 80, please specify:

_____

Q91 81. Do you have children under the age of 18 living with you?

- o Yes (1)
- o No (2)
- o Decline to Answer (3)

Q62 82. Military status (Check all that apply):

- o I served or currently serve in the military (1)
- o My husband, wife, or significant other served or currently serves in the military (2)
- o My child served or currently serves in the military (3)
- o My parent served or currently serve in the military (4)
- o My brother/sister served or currently serves in the military (5)
- o None of the above (6)
- o Other (7)

Q63 If you responded "Other" to question 82, please specify:

_____

End of Block: Default Question Block

Start of Block: Block 2

Q92 Would you like to be directed to the separate survey to enter your name for a raffle? - Your entrance in the raffle will not be linked to your survey answers in any way.

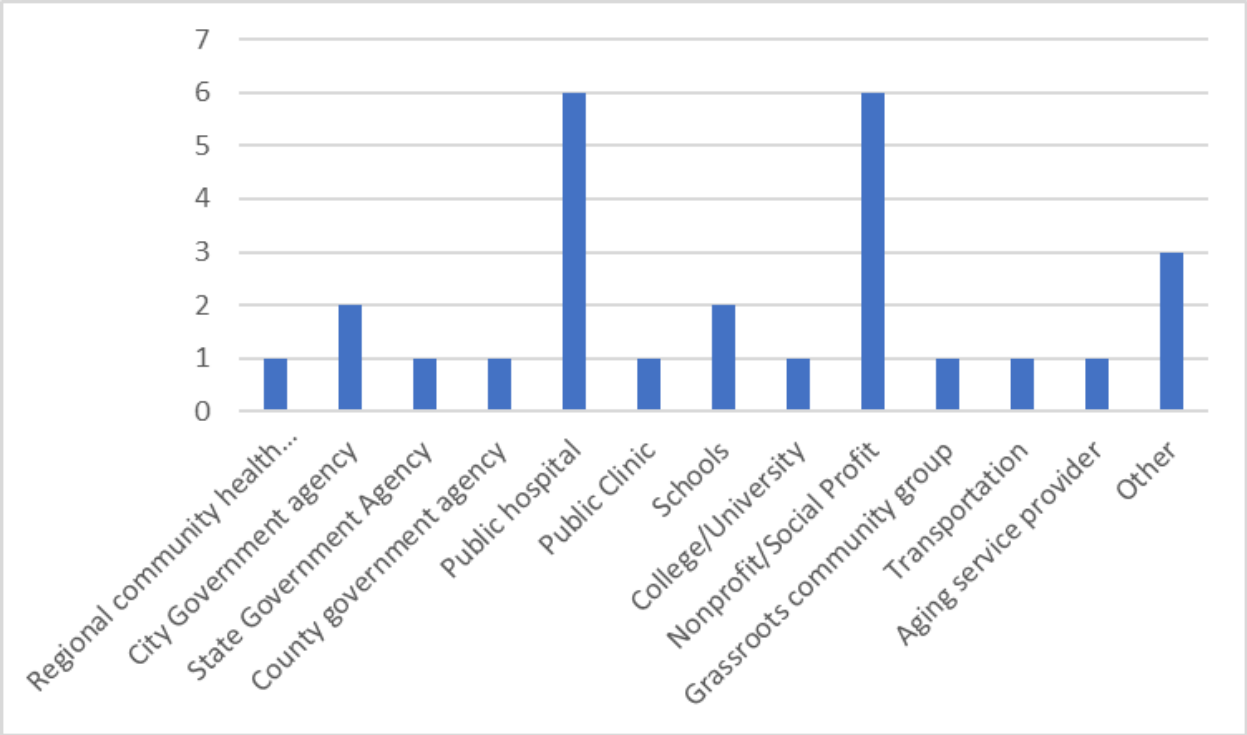
- o Yes (1)
- o No (2)

End of Block: Block 2

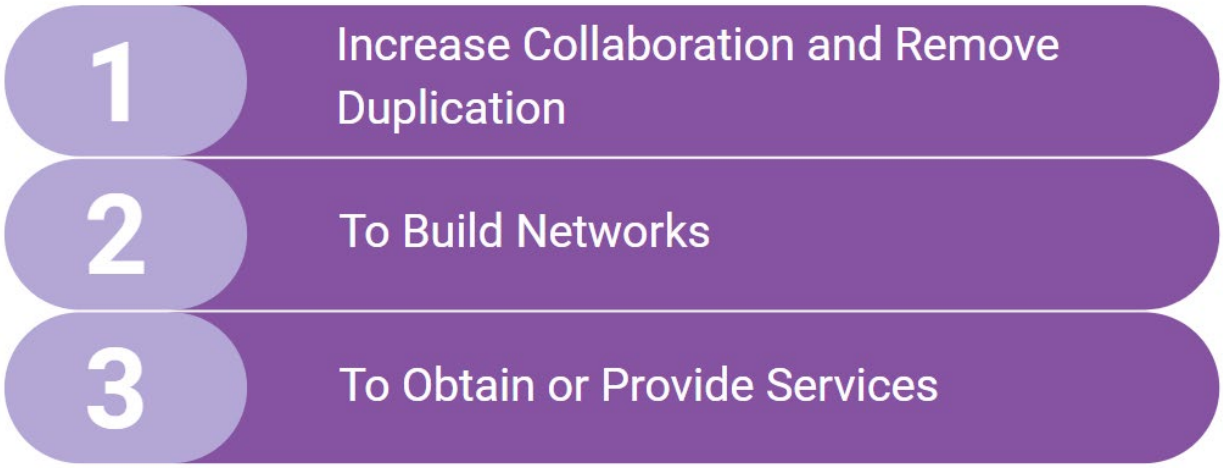
Thank you for taking the time to respond to this survey. Your responses will help us identify where we need to focus work to improve health in the Panhandle

APPENDIX C: LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT SUMMARY OF RESULTS

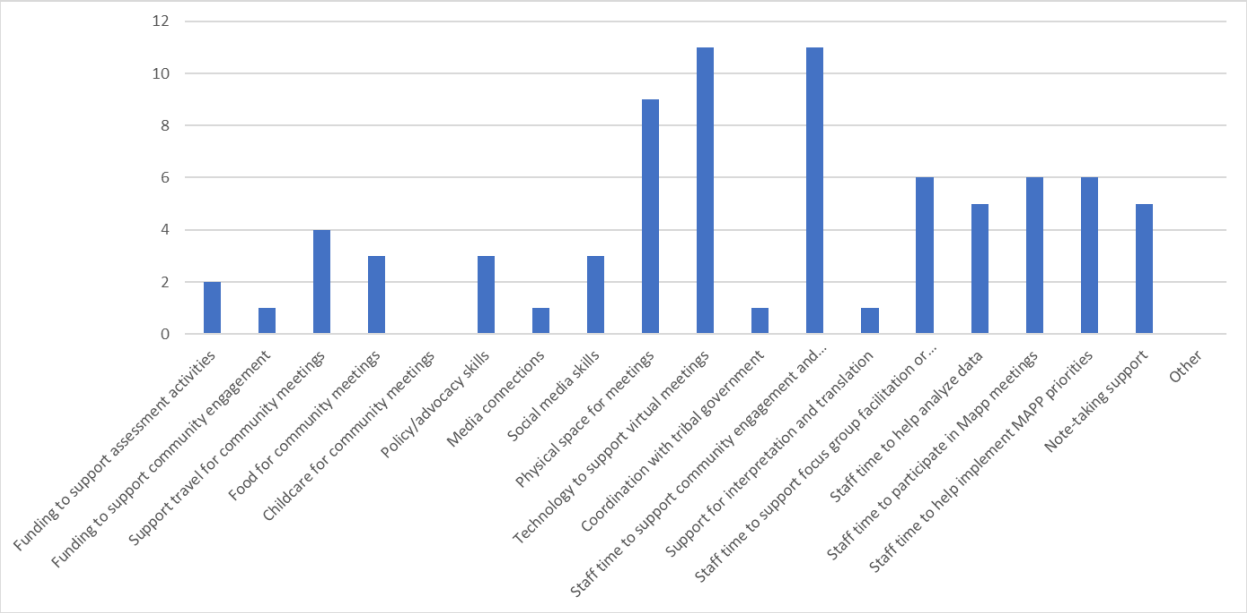
Organizations who participated in the assessment



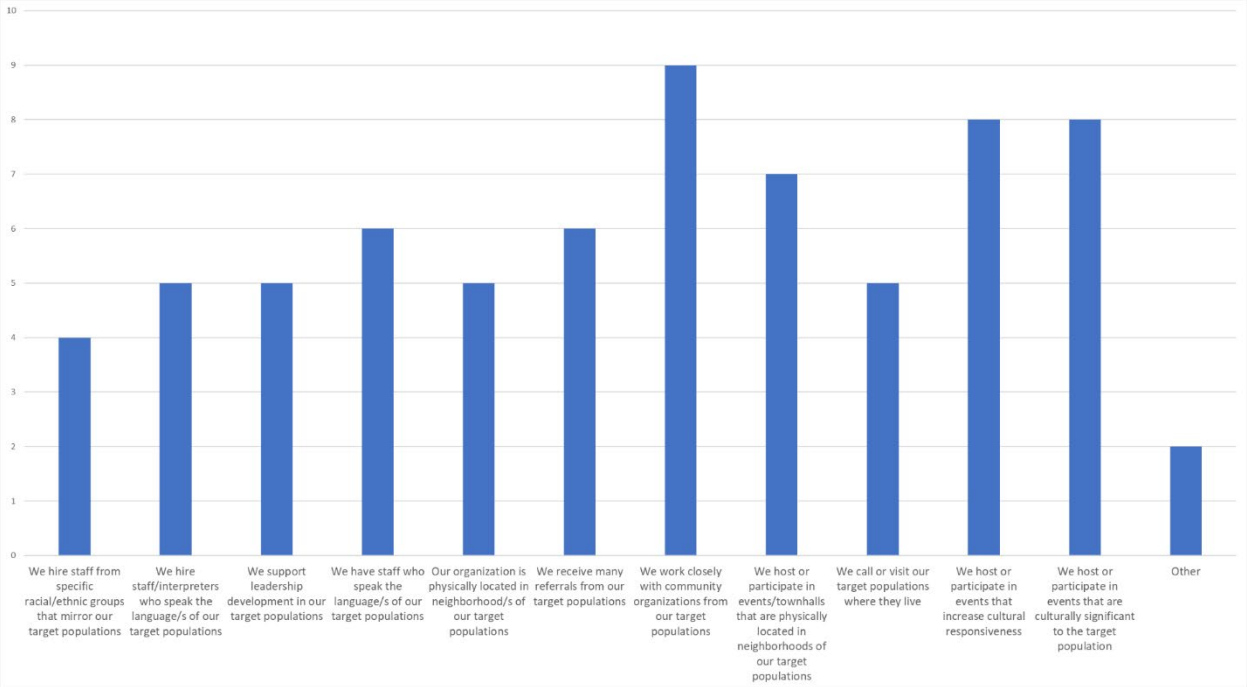
Top 3 interests in participating in Community Health Improvement



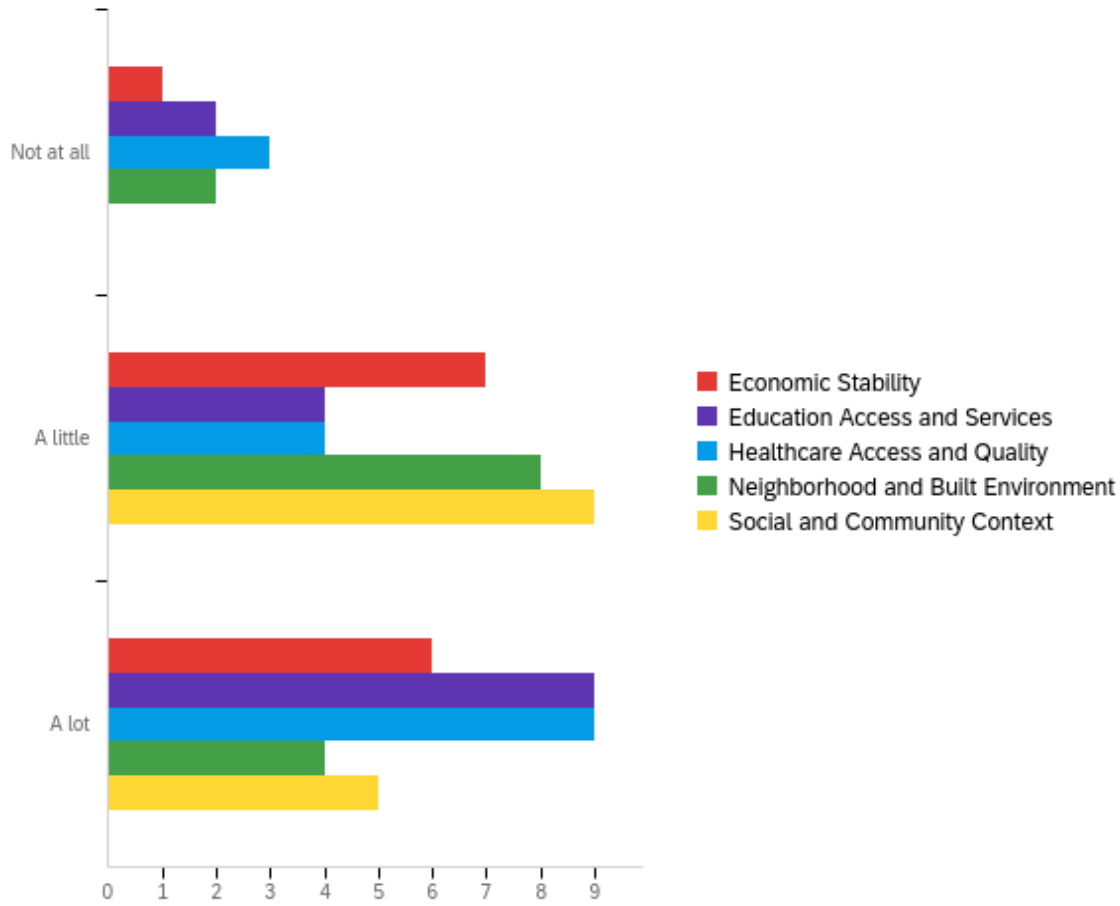
Organizations indicated they might be willing to support community health improvement in these areas



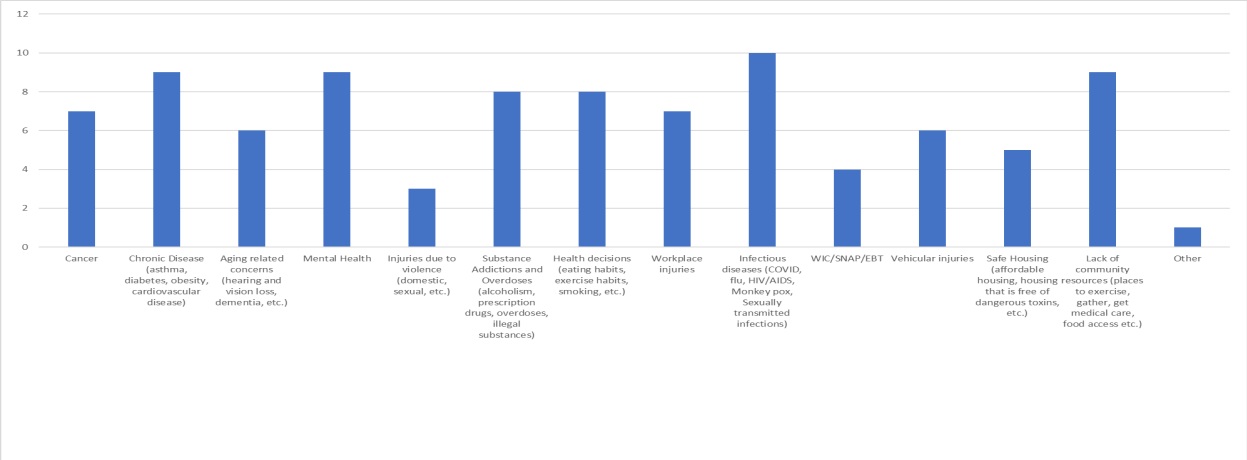
How partners most commonly engage with the community.



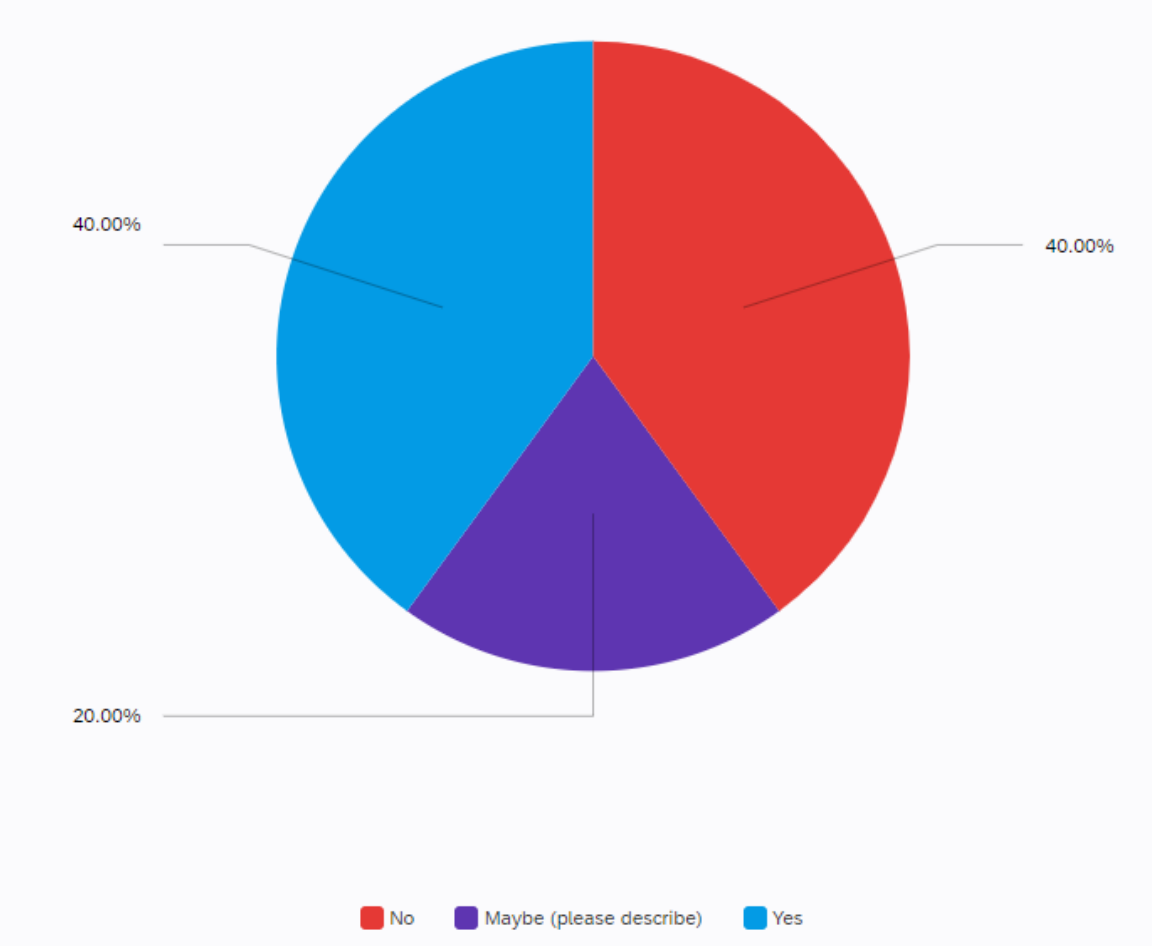
Organizational focus on social determinants of health.



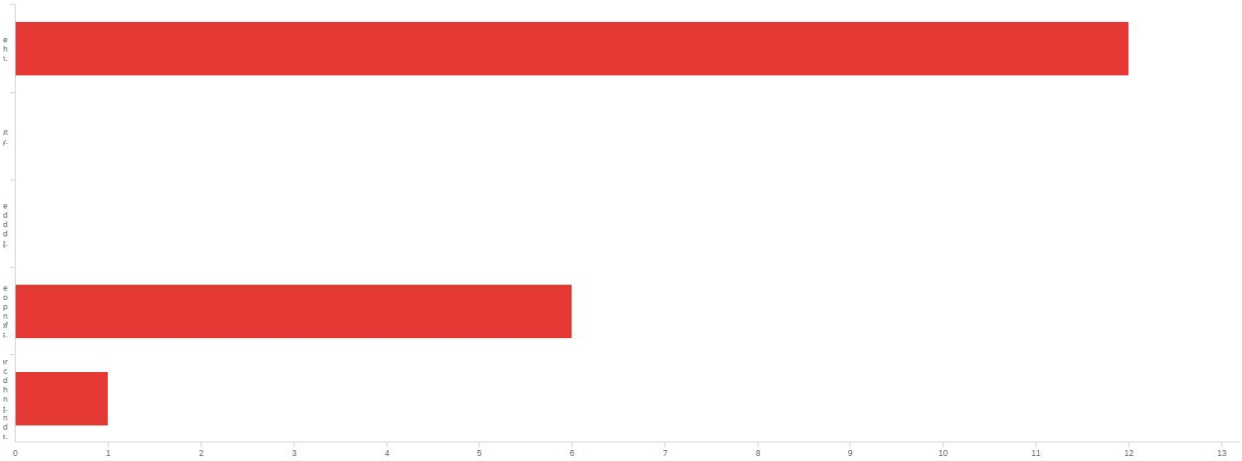
Areas of community health that organizations work on



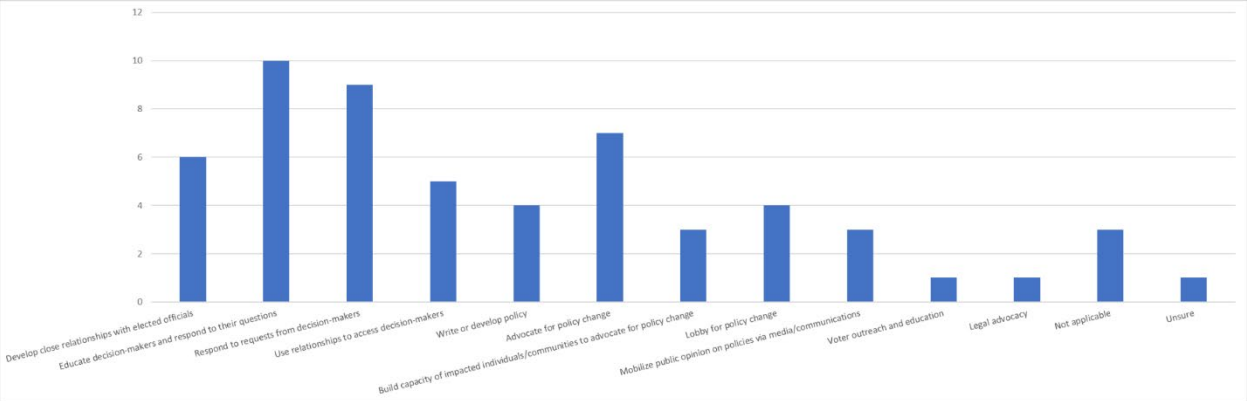
Capacity to meet the needs of clients



Community-engagement practices used by organizations



Type of Policy and Advocacy work done by organization



Themes of Note for partners participating in the survey:

- Many organizations do not conduct assessments
- Many do not have a shared equity or health equity statement
- Strengths are mostly in Communication & Education and Community Engagement & Partnership
- Many want to grow in Coalition Building, and Inside-Outside Strategies
- Institutions such as schools and hospitals have materials in Spanish
- Would prefer to connect via Zoom
- Organizational reach expands to all parts of the area including youth to adult, minority, and low-income
- Need a good amount of time ahead of a meeting to make sure it is on their schedules (at least 2 weeks)
- Indication that there is a lack of staff and time to focus on community health initiatives

APPENDIX D: PRIORITIZATION MEETING ATTENDEE LIST

Name:	**Organization:**
Megan Barhafer	Panhandle Public Health District
Kelsy Sasse	Panhandle Public Health District
Robin Stuart	Morrill County Community Hospital
Karri Garcia	Cirrus House
Gloria Kennedy	United Healthcare
Sandy Montague-Roes	WCHR
Jenn Ernest	Morrill County Community Hospital
Kim Engel	Panhandle Public Health District
Marissa Peterson	Panhandle Public Health District
Kristin Maag	Scotts Bluff Diversion
Daniel Bennett	Civic Nebraska
Jenny Nixon	Nebraska Extension
Erin Sorenson	Panhandle Public Health District
Amanda McClaren	Panhandle Public Health District
Janelle Visser	Panhandle Public Health District
Jessica Davies	Panhandle Public Health District
Sue McManigal	Hometown Medical Group - Kimball
Keri Foster	Hometown Medical Group - Kimball
Greg DeWeese	Hometown Medical Group - Kimball
Jonnie Kusek	Open Plains Transit
Penny Parker	Nebraska Total Care
Kelsy Sasse	Panhandle Public Health District
Melissa Schaub	Regional West Medical Center – Community Health
Paulette Schnell	Regional West Medical Center – Community Health
Amanda Kehn	Gordon Memorial Hospital
Audrey Rochleau	Healthy Blue
Kristine Anderson	Morrill County Community Hosptial