Mobilizing for Action Through Planning and Partnerships In Sarpy and Cass Counties

Building a Healthier Community for the Year 2010

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Sarpy/Cass
Department of Health & Wellness

Dear Sarpy and Cass communities,

In March of 2007 we launched a project that will have long term effects for the entire public health system in our area. Mobilizing for Action through Planning and Partnerships (MAPP) is a dynamic process developed by the Centers for Disease Control and Prevention and the National Association of City and County Health Officials that helps communities prioritize public health issues and identify resources for addressing them. Community ownership is the fundamental component of MAPP.

We are pleased to be able to present this report as outcome of our project so far. After working through the visioning process, gathering data, conducting community surveys, and determining where our healthcare needs are….we are now busy formulating our action plans. MAPP groups will continue to meet every 3-4 months to keep everyone on track and constantly renew and revitalize the mission of creating the best public health system for Sarpy and Cass counties.

It has been so encouraging for me to witness the many partners who have come together to work side by side and give true meaning to the phrase "public health system", with the emphasis on system, rather than department. We have had energetic participation from our local school districts, law enforcement, county boards, city governments, healthcare institutions (both medical and behavioral), and the community at large. This has been a great opportunity for our health department to engage the many partners in our area and work toward common goals. I am personally thankful to all who took time to be involved with the MAPP process. The hours spent in meaningful discussions and data collection are reflected in this report. And, we should be proud of our accomplishments thus far.

This report is not a final one. The mission to establish and consistently evaluate the public health system in our area is an ongoing process and will continue. We welcome additional participation from groups and/or individuals at any time and, in fact, we will seek an even broader segment of our constituency to work towards identifying and solving local health problems.

Again, my very sincere thanks to all MAPP participants. Your gifts of time and talent are much appreciated and will definitely make a difference to your community. I look forward to continuing partnerships with all of you as we move forward. Thank you also to our great facilitator, Whitney Shipley, and the staff of the Sarpy/Cass Health Department, especially Amy Seys and Erin Ponec, for bringing us this far.

Sincerely,
Dianne Kelly, Director
Sarpy/Cass Department of Health and Wellness

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Introduction

The overall mission of the Sarpy/Cass Department of Health and Wellness is to improve the lives of the citizens it serves by promoting the health of the community through

- Preventing disease
- Developing partnerships
- Establishing policies
- Providing health education
- Improving the delivery of healthcare services

The Department was established in 2001 to assure that the Ten Essential Public Health Services established through the Centers for Disease Control and Prevention's National Public Health Performance Standards Program (Table 1.) were guaranteed delivery to the residents of Sarpy and Cass Counties. The Department is governed by a board comprised of representatives from both counties that meets monthly at the Department's offices in Papillion. Meetings are scheduled for the fourth Monday evening of each month and are open to the public.

Prior to the establishment of the Sarpy/Cass Department of Health and Wellness, a comprehensive public health system did not exist in these counties. Various components of the Ten Essential Public Health Services were provided in or to residents of Sarpy and Cass counties, but service was fragmented and lacked coordination and collaboration toward public health outcomes.

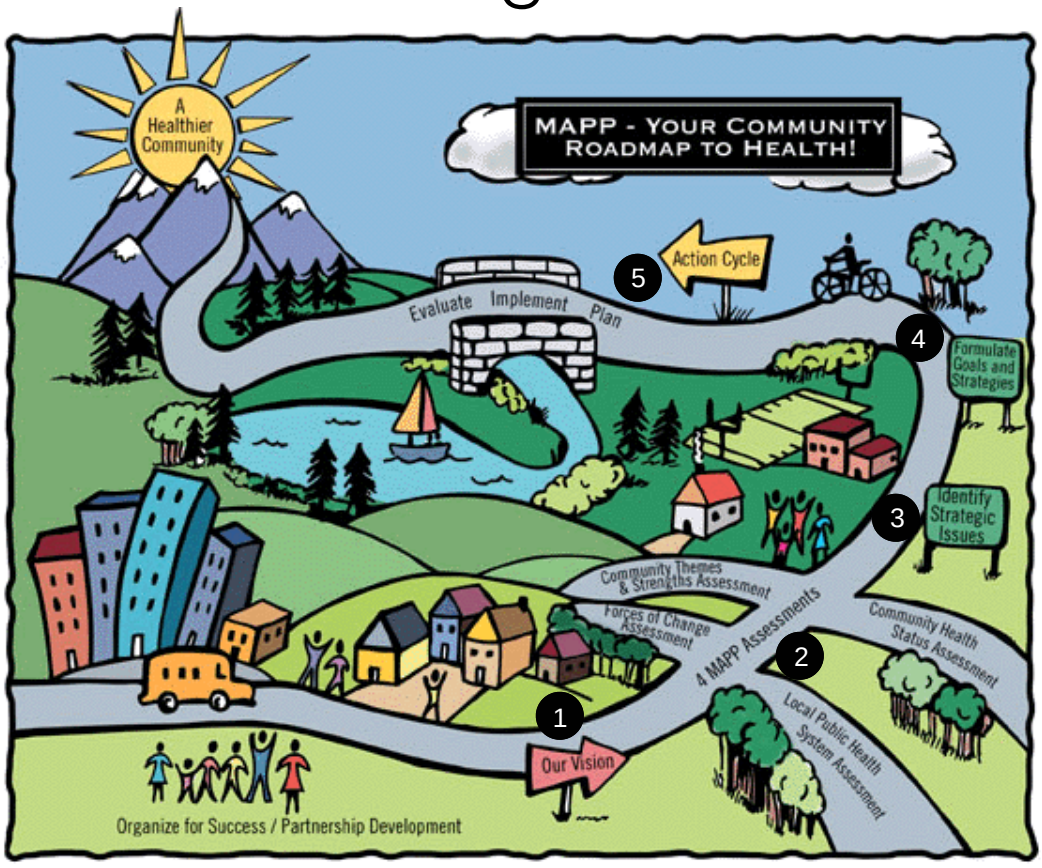
The initial years of operation have focused on development of the Department's basic infrastructure including the hiring of a director and staff, establishing an office, developing policies and initiating public health programs. Extensive time has been spent educating stakeholders on the roles, responsibilities, and core functions of public health and developing the partnerships that will sustain continued progress toward positive public health outcomes for Sarpy and Cass Counties.

The *Mobilizing for Action Through Planning and Partnerships* program is a community-driven planning initiative intended to foster common understanding and group processes toward the furtherance of public health outcomes. The ultimate goal of our work together in this process is to develop community ownership and success in the provision of the Essential Public Health Services.

Table 1. The CDC's National Public Health Performance Standards Ten Essential Public Health Services

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable
8. Assure competent public and personal healthcare workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

Planning Process



1 VISION - Deciding what we collectively want to see in place in 3 years (workshop)

2 ASSESSMENT - Examination of the relevant data that will reveal our current status relative to our vision and suggest factors that should be incorporated in our plans.

COMMUNITY THEMES AND STRENGTHS - What is important to our community? How is quality of life perceived here? What assets do we have to work with? (survey)

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT - What are the activities, competencies, and capacities of our local public health system? (assessment tool, meeting)

COMMUNITY HEALTH STATUS ASSESSMENT - Analysis of current data to answer, "What does the health status of our community look like?" (data review & analysis)

FORCES OF CHANGE ASSESSMENT - Identifying what is occurring or might occur that affects the health of our community? (workshop)

3 STRATEGIC ISSUES - Identifying which issues the assessment data suggest are in need of community action (focus groups)

4 GOALS & STRATEGIES - Articulating what future state it is we're working towards and what strategies we feel will be most productive in getting us there (workshop)

5 ACTION CYCLE - Quarterly cycles of planning, implementing our plans, and then evaluating our progress and revising before beginning a new cycle (workshops)

Vision

On March 19, 2007 approximately 40 residents convened at offices of the Sarpy/Cass Department of Health and Wellness to craft a vision for the future of the health of their community. The group participated in a consensus workshop designed to produce a collective answer to the question, "What do we want our community to look like in three years as a result of our efforts to build a healthy community?". Participants brainstormed individually, then in small groups, and after large-group discussion collectively identified the following as the vision that would guide the community's health planning initiative.

It is our vision that, in three years, the Sarpy and Cass Community…

...will have achieved a reduction in high risk behavior

...will feature "hot spots" for public health

...will be preventing injuries through education

...will have strong families—beginning to end

...will be a community that promotes healthy neighborhoods

...will feature easy access to healthy living

...will feature community-driven programming

Ideas generated in support of this vision that may, in addition to new ideas, be discussed in later stages of planning included the following:

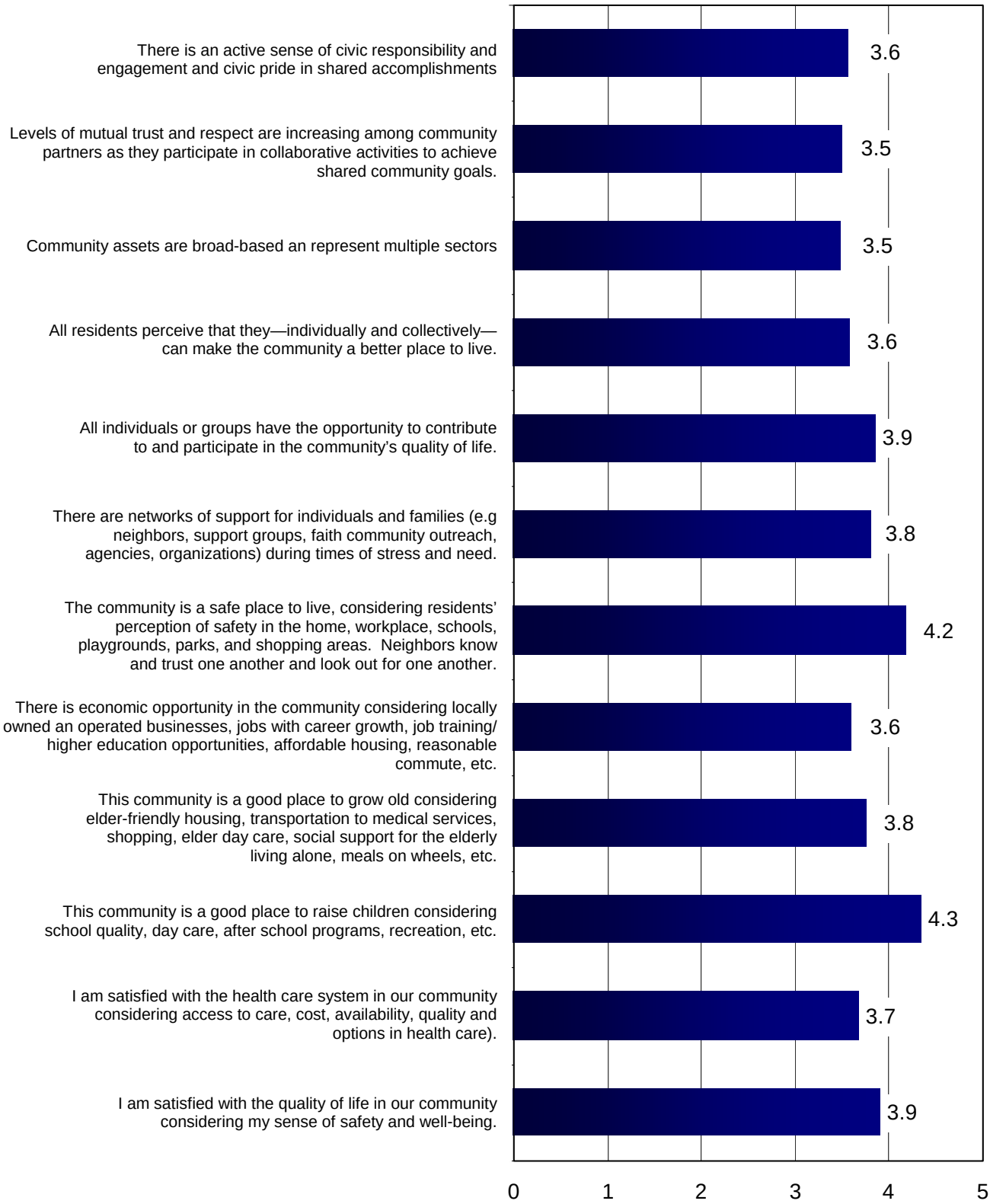
- Create a community challenge to generate recognition of the importance of health
- Create a Community Wellness Foundation
- Develop intergenerational activities and centers
- Develop community activities and youth programs
- Develop a community health report card
- Emphasize healthy eating for life, the importance of an eating plan, and rally around these
- Develop and/or promote nutrition and exercise programs
- Increase affordable access to physical and mental health services for rural residents
- Increase access to prenatal care through education
- Create a list of and advertise all Sarpy and Cass community services, including all health services
- Build bike trails in Cass County, walkways to mall
- Fix sidewalks
- Promote parks and recreation
- Promote fitness through walking trails and community centers
- Develop community centers with low-cost activities
- Increase transportation services
- Raise community awareness
- Found a viable volunteer network, including seniors
- Implement community policing programs like Crime-Free Multi-Housing, Crime Prevention Through Environmental Design, and Neighborhood Watch
- Deliver meals to rural areas
- Create a community garden
- Promote neighborhood programs
- Raise achievement scores in schools
- Promote healthy functioning families
- Promote parental involvement
- Create a bike safety program
- Hold car seat safety checks and provide correct car seats
- Reduce fatality and injury accidents
- Work to decrease incidents of sexually-transmitted diseases and teen pregnancies and alcohol and tobacco sales to minors
- Work for a smoke-free community
- Reduce drug and alcohol use, including methamphetamines

Community Themes and Strengths Assessment

Building a Healthier Community for the Year 2010

A community survey published by the National Association of City and County Health Officials and featured in the "Achieving Healthier Communities through MAPP, A User's Handbook" was distributed by MAPP committee members throughout Sarpy and Cass Counties over a period of three months with an effort to achieve diversity in representation as much as possible. Three hundred and forty-seven (347) survey responses were returned by September 1, 2007. Compiled results of those 347 surveys are reported here.

On a scale of agreement from 1 to 5 (with 1 being low and 5 being high), responses indicated the following average levels of agreement with the statements listed below.



Asked about their opinion of the **top three factors important to having a healthy community**, respondents indicated their priorities as follows:

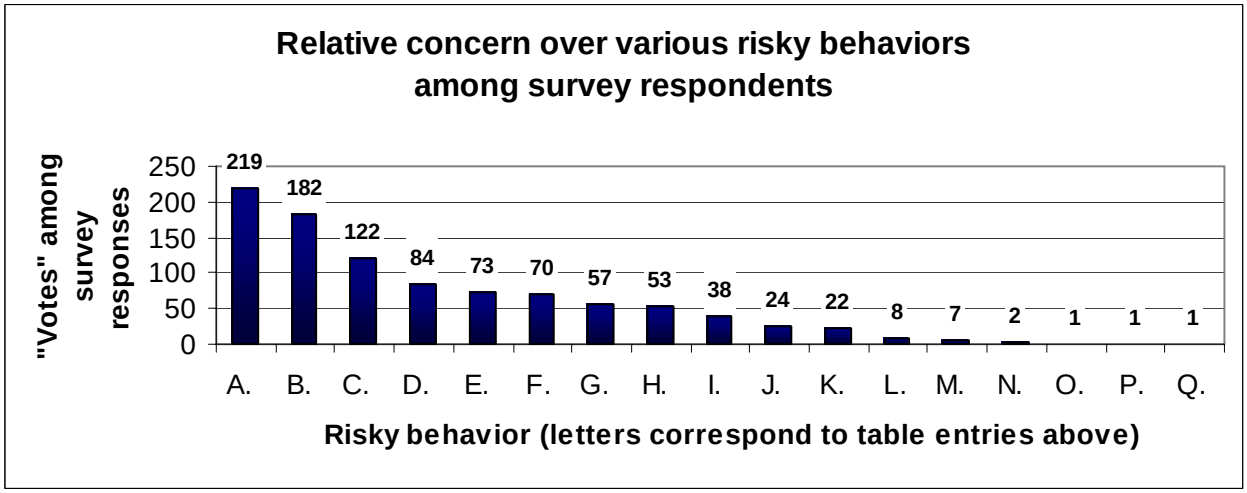
Health Factor	# of Responses
Low crime/safe neighborhoods	209
Good schools	168
Good place to raise children	161
Good jobs and healthy economy	85
Strong family life	74
Religious or spiritual values	62
Access to health care	49
Healthy behaviors and lifestyles	47
Affordable housing	39
Clean environment	36
Parks and recreation	19
Low level of child abuse	11
Excellent race relations	10
Arts and cultural events	9
Low adult death and disease rates	3
Low infant deaths	1
Prevention of child abuse	1
Health insurance for all	1
Lower real estate taxes	1
Transportation	0

Asked about their opinion of the **top three health problems** in their community, respondents indicated the following:

Health Problem	# of Responses
Cancers	123
Aging problems	103
Heart disease and stroke	91
Domestic violence	87
Child abuse or neglect	84
Motor vehicle crash injuries	71
Mental health problems	70
Teenage pregnancy	53
Sexually transmitted diseases	50
High blood pressure	45
Diabetes	37
Suicide	28
Respiratory/lung disease	17
Fire-arm related injuries	13
Infectious disease	11
Homicide	9
Rape/sexual assault	8
HIV/AIDS	6
Infant death	4
Illegal drugs	4
Teen drinking and drugs	4
Dental problems	3
Farming-related injuries	2
Abortion clinic	2
Obesity	2
Alcohol-related illnesses	2
Lack of prenatal and abstinence education	2
Allergies	1
Bullying	1

Asked about their opinion of the **top three high-risk behaviors** in their community, respondents identified the following as the risky behaviors of

Risky Behaviors	# of Responses
A. Alcohol abuse	219
B. Drug abuse	182
C. Being overweight	122
D. Lack of exercise	84
E. Tobacco use	73
F. Unsafe sex	70
G. Not using seat belts/child safety seats	57
H. Poor eating habits	53
I. Dropped out of school	38
J. Racism	24
K. Not using birth control	22
L. Extramarital and premarital sex	8
M. Not getting immunizations	7
N. Using cell phones while driving	2
O. Student grades—communication failure b/w teachers & parents	1
P. Using "artificial" birth control	1
Q. Gambling	1



Local Public Health System Performance Assessment

Building a Healthier Community for the Year 2010

Sarpy/Cass
Department of Health & Wellness

Executive Summary

The National Public Health Performance Standards Program is a collaborative effort of seven national partners:

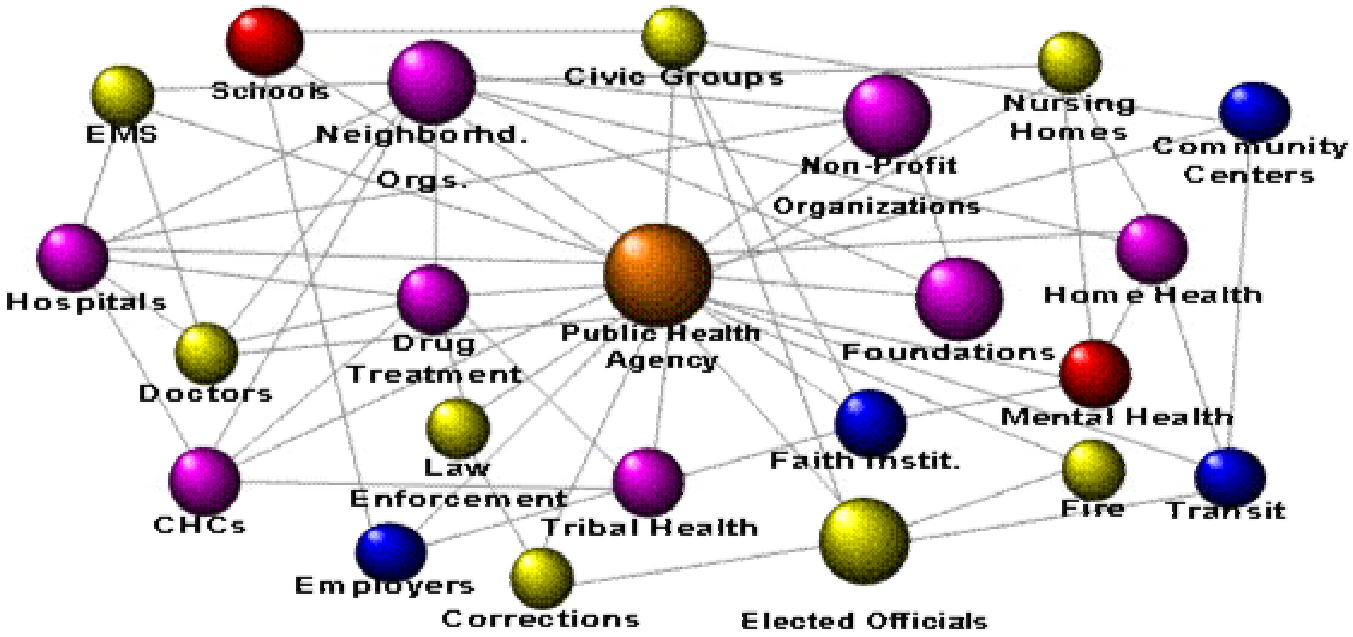
- Centers for Disease Control and Prevention, Office of Public Health Practice
- Association of State and Territorial Health Officials
- American Public Health Association
- National Association of County and City Health Officials
- National Association of Local Boards of Health
- National Network of Public Health Institutes
- Public Health Foundation

The instrument is based on the framework of the ten Essential Public Health Services—the spectrum of public health activities that should collectively be provided in any jurisdiction by the collective effort of its public health system partners.

It is important to note that the ***Local Public Health System*** is not one agency, but rather an array of agencies that each have a stake in one or more aspects of community health (Figure 1, p. 13). It is the collective efforts of these agencies, working together, that are measured in this assessment. Where relevant, the assessment makes the distinction between the local public health ***system*** and the local health ***department***, which serves simply as one of the key agencies making up the system. The reader should take note of the distinction when interpreting the results of this assessment.

The purpose of undertaking the assessment is to strengthen and improve the collective efforts of the local public health system. The audience for the assessment results is the local public health system—the collection of organizations or entities that contribute to the health or well-being of the Sarpy/Cass community. Partners may use the results of this assessment as an indicator of the extent to which the system is effectively providing the ten Essential Services. Through exploration of diverse perspectives and a heightened understanding of each organization's contributions, system partners can reveal the interconnectedness of their activities and how the public health system can be strengthened through their collective efforts. For this reason, the MAPP Committee may find the results of the assessment to be effective in revealing gaps in services that may warrant further attention by the MAPP process.

Local Public Health System



Local Public Health System Illustration, CDC, http://www.cdc.gov/od/ocphp/nphpsp/

Local Public Health System Partners currently participating in the Sarpy and Cass County MAPP planning initiative (recruitment is ongoing):

- City of LaVista
- City of Bellevue
- City of Papillion
- City of Gretna
- Cass County Board of Commissioners
- Sarpy County Board of Commissioners
- Sarpy Chamber of Commerce
- Plattsmouth Schools
- Papillion Public Schools
- Bellevue Public Schools
- St. Columbkille School
- South Sarpy School District
- Sarpy/Douglas Extension Office
- Sarpy County Community Services
- Sarpy County Tobacco Coalition
- Nebraska Medical Center
- Midlands Hospital
- UNO Department of Gerontology
- One World Community Health Center
- Sarpy County Head Start
- Sarpy County Sheriff's Office
- Bellevue Police Department
- Cass County Emergency Services
- Papillion Times
- Residents at large from both Sarpy and Cass Counties
- Region 6
- NE HHS Office of Minority Affairs
- Offutt AFB Strategic Command

Process

The assessment questions were organized into ten sections, each representing one of the ten Essential Public Health Services. For each question respondents were asked to indicate the level of progress they felt the system had made toward the optimal state of each performance standard by choosing from among the following five levels of progress: no, minimal, moderate, significant, and optimal. With the exception of the questions regarding community collaboration (which were answered by the MAPP Committee as a whole), the assessment was completed by an ad hoc subcommittee that convened specifically for the purpose of completing the assessment.

Assessment Responses

Five different responses were possible for each question—'no', 'minimal', 'moderate', 'significant' and 'optimal'. The answers represent the extent to which the local public health ***system*** demonstrates the competencies listed in each assessment statement with 'no' representing 'not at all' and 'optimal' indicating that the local system fully demonstrates the competencies as described in the statement. Note that the expectation is for ***local*** demonstration of the competency described; full credit was not awarded for questions where activities described were performed at the state level.

Essential Service 1: Monitor Health Status to Identify Community Health Problems

	No	Minimal	Moderate	Significant	Optimal
Has the LPHS conducted a community health Assessment?			•		
• Is the community health assessment updated at least every 3 years?		•			
• Are data from the assessment compared to data from other representative areas or populations?				•	
• Are data used to track trends over time?				•	
• Does the LPHS use data from community health assessments to monitor progress toward health-related objectives?			•		
Does the LPHS compile data from the community health assessments into a Community Health Profile (CHP)? Do CHP data elements include:				•	
• Community demographic characteristics?					•
• Community socioeconomic characteristics?					•
• Health resource availability data?					•
• Quality of life data for the community?					•
• Behavioral risk factors for the community?				•	
• Community environmental health indicators?					•
• Social and mental health data?			•		
• Maternal and child health data?					•
• Death, illness, and/or injury data?					•
• Communicable disease data?					•
• Sentinel events data for the community?					•
• Has the LPHS identified the individuals or organizations responsible for contributing data and/or resources to produce the CHP?					•
• Does each contributor of data have access to the completed CHP?					•
Is community-wide use of community health assessment or CHP data promoted?			•		
• Is a media strategy in place to promote community-wide use of the CHP?			•		
• Is the information easily accessible by the general public?				•	
• Do the organizations in the LPHS use the CHP to inform health policy and planning decisions?		•			

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS use state-of-the-art technology to support health profile databases?			•		
• Is technology used to make community health data available electronically?					•
Does the LPHS have access to geocoded health data?					•
• Does the LPHS use geographic information systems (GIS)?		•			
Does the LPHS use computer-generated graphics to identify trends and/or compare data by relevant categories (i.e. race, gender, age group)?				•	
Does the LPHS maintain and/or contribute to one or more population health registries?				•	
• Are their standards for data collection?				•	
• Are there established processes for reporting health events to the registry or registries?				•	
In the past year, has the LPHS used information from one or more population health registries?				•	

Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards in the Community

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS operate or participate in surveillance systems designed to monitor the health problems and identify health threats				•	
• Is the system integrated with national and/or state surveillance systems?			•		
• Is the system compliant with national and/or state health information exchange guidelines?				•	
• Does the LPHS use the surveillance system(s) to monitor changes in the occurrence of health problems and hazards?			•		
Do community health professionals submit reportable disease information in a timely manner to the state or LPHS?				•	
Does the LPHS have necessary resources to support health problem and health hazard surveillance and investigation activities?		•			
• Does the LPHS use information technology for surveillance activities (e.g., geographic information systems, work processing, spreadsheets, database analysis, and graphics presentation software)?				•	
• Does the LPHS have (or have access to) Masters or Doctoral level epidemiologists and/or statisticians to assess, investigate and analyze public health threats and threat hazards?			•		
Does the LPHS maintain written protocols for implementing a program of case finding, contact tracing, source identification, and containment for communicable diseases or toxic exposures? Are protocols in place for:				•	
• Animal control?				•	
• Vector control?				•	
• Exposure to food-borne illness?					•
• Exposure to water-borne illness?					•
• Excessive lead levels?			•		
• Exposure to asbestos?			•		
• Exposure to other toxic chemicals?			•		
• Communicable diseases?					•

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS have current epidemiological case investigation protocols to guide immediate investigations of public health emergencies? Do these protocols address:			•		
• Infectious disease outbreaks?					•
• Environmental health hazards and emergencies?				•	
• Chemical threat and incidents?				•	
• Biological agent threats?				•	
• Radiological threats?				•	
• Large-scale natural disasters?				•	
• Intentional incidents?				•	
Has the LPHS designated an individual to serve as an Emergency Response Coordinator within the jurisdiction?					•
• Does the individual coordinate with the local health department's emergency response personnel?					•
• Does the individual coordinate with community leaders?				•	
Can LPHS personnel rapidly respond to natural and unintentional disasters?				•	
• Does the LPHS maintain a current roster of personnel with the technical expertise to respond to natural and intentional emergencies and disasters?				•	
• Does the LPHS have access to response personnel within one hour?				•	
• Does the LPHS have capacity to mobilize sufficient numbers of trained professionals in an emergency (i.e., surge capacity)?				•	
• Does the LPHS have capacity to mobilize volunteers during a disaster?				•	
Does the LPHS evaluate public health emergency response incidents for effectiveness and opportunities for improvement (i.e., After Action Reports)?				•	
• Are findings incorporated into emergency plans?				•	
Does the LPHS maintain ready access to laboratories capable of meeting routine diagnostic and surveillance needs?				•	

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS have ready access to laboratory services to support investigations of public health threats, hazards, and emergencies?				•	
• Does the LPHS have access to laboratory services to support these investigations within four hours of notification?			•		
• Does the LPHS have access to at least one microbiology laboratory within four hours of notification?				•	
Does the LPHS utilize only laboratories that are licensed and/or credentialed?					•
Does the LPHS maintain current guidelines or protocols for handling laboratory samples?					•

Essential Service 3: Inform, Educate, and Empower Individuals and Communities about Health Issues

Does the LPHS provide the general public, policymakers, and public and private stakeholders with information on community health?					•
• Does the LPHS provide information on community health status (e.g., heart disease rates, cancer rates, environmental risks)?				•	
• Does the LPHS provide information on community health needs, such as those identified by members of the community or through a needs assessment tool such as APEXPH or MAPP, including prevention and risk (e.g., smoking, obesity, etc.)?				•	
Does the LPHS plan and conduct health education and/or health promotion campaigns?				•	
• Are these campaigns based on sound theory, evidence of effectiveness, and/or best practice?				•	
• Are campaigns designed to support healthy behavior among individuals and their communities?				•	
• Are campaigns tailored for populations with higher risk if negative health outcomes?		•			

	No	Minimal	Moderate	Significant	Optimal
Have LPHS organizations developed health communication plans?				•	
• Do LPHS organizations work collaboratively to link the communications plans? Do the communications plans:			•		
⇒ Include policies and procedures for creating, sharing, and disseminating information with partners and key stakeholders?				•	
⇒ Identify different sectors of the population in order to create targeted public health messages for various audiences?			•		
⇒ Provide guidance for developing content and materials appropriate to the type of dissemination channel?			•		
⇒ Provide guidance for creating targeted public health messages using various channels?			•		
Does the LPHS establish and utilize relationships with the media?				•	
• Does the LPHS have policies and procedures in place to route all media inquiries appropriately?				•	
• Does the LPHS have a mechanism in place to document and respond to public inquiries?				•	
• Does the LPHS coordinate with local media to develop information or features on health issues?			•		
Has the LPHS identified and designated individuals such as public health information officers to provide important health information and answers to public and media inquiries?				•	
• Are designated spokespersons adequately trained in providing accurate, timely, and appropriate information on public health issues for different audiences?			•		
• Does the LPHS have policies and procedures in place to coordinate responses and public announcements related to public health issues?			•		
Has the LPHS developed emergency communications plan(s) that can be adapted to different types of emergencies (i.e., disease outbreaks, natural disasters, bioterrorism)? Does the plan include:				•	
• Procedures of inter-agency coordination of plans dependent upon the type of emergency (i.e., use of the plans to create a unified emergency communications plan)?				•	

	No	Minimal	Moderate	Significant	Optimal
• Established lines of authority, reporting, and responsibilities for emergency communications teams in accordance with the National Incident Management System (NIMS)?					•
• Procedures for alerting communities, including special populations, about possible health threats or disease outbreaks?			•		
• Guidelines for providing necessary, appropriate information from emergency operation center situation reports, health alerts, and meeting notices to stakeholders, partners, and the community?				•	
Does the LPHS have resources to ensure rapid communications response?				•	
• Does the LPHS have the technological capacity (e.g. telephone, electronic, and print) to respond to communication needs)?				•	
• Have staff to develop or adapt emergency communications materials and to provide communications for all stakeholders and partners in the event of an emergency?				•	
Does the LPHS provide crisis and emergency communications training for new and current staff?			•		
Does the LPHS have policies and procedures in place to ensure rapid, mobile response by public information officers?				•	
• Does the LPHS maintain a directory of emergency contact information for media liaisons, partners, stakeholders, and public information officers?				•	
• Does the LPHS provide communication "Go-Kits" to assist in public information officer response?			•		

Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS have a process for identifying key constituents?		•			
• Are key constituents identified for population-based health in general (e.g., improved health and quality of life at the community level)?		•			
• Are key constituents identified for specific health concerns (e.g., a particular health theme, disease, risk factor, life stage need)?		•			
• Does the LPHS maintain a list of the names and contact information for individuals and groups for constituency building?			•		
• Is there a protocol and/or suggested approach for contact potential constituents?			•		
Does the LPHS encourage participation of constituents in improving community health?			•		
• Does the LPHS encourage constituents from the community-at-large to identify community issues and themes through a variety of means (e.g., using on-line resources, community/town hall meetings, ballot votes, community surveys, focus groups)?		•			
• Does the LPHS provide opportunities for volunteers to help in community health improvements?			•		
⇒ If so, does the LPHS have mechanisms to recruit and retain volunteers?		•			
⇒ Does the LPHS publicize these volunteer opportunities?		•			
Does the LPHS maintain a current directory of organizations that comprise the LPHS?		•			
• Is the directory accessible to the public? Does it contain information on the following:		•			
⇒ The local governmental public health agency?		•			
⇒ The local governing entity (e.g., board of health)?	•				
⇒ Other governmental entities (e.g., state agencies)	•				
⇒ Hospitals?		•			

	No	Minimal	Moderate	Significant	Optimal
⇒ Managed care organizations?	•				
⇒ Primary care clinics and physicians?	•				
⇒ Social service providers?	•				
⇒ Civic organizations?	•				
⇒ Professional organizations?	•				
⇒ Local businesses and employers?	•				
⇒ Neighborhood organizations?	•				
⇒ Faith institutions?		•			
⇒ Transportation providers?	•				
⇒ Educational institutions?		•			
⇒ Public safety and emergency response organizations?		•			
⇒ Environmental or environmental health agencies?	•				
⇒ Non-profit organizations/advocacy groups?	•				
⇒ Local officials who impact policy and fiscal decisions?		•			
⇒ Other community organizations?	•				
Does the LPHS use communications strategies to strengthen organizational linkages and/or to inform community constituents about public health issues and services?		•			
• If so, are there any mechanisms or events to facilitate communication among organizations?		•			
⇒ If so, is there an established frequency for these communications?		•			
• Are there any mechanisms to facilitate communication with the community-at-large?		•			
⇒ If so, is there an established frequency for holding these events and or reviewing these communication mechanisms?	•				
How much of this LPHS Model Standard is achieved by the local system collectively?		•			
• What percent of the answer reported above is the direct contribution of the local public health agency?		•			

	No	Minimal	Moderate	Significant	Optimal
Do partnerships exist in the community to assure coordination of public health activities? If so, is there coordination to provide:		•			
• A comprehensive approach to improving community health?		•			
• Health promotion services?		•			
• Disease prevention services?		•			
Does the LPHS assure the establishment of a broad-based community health improvement committee? If so, does this committee:		•			
• Participate in the community assessment process?		•			
• Participate in the implementation of a community health improvement process?		•			
• Monitor progress toward prioritized goals?		•			
• Leverage community resources?		•			
• Meet at least four times per year?			•		
Does the LPHS assess the effectiveness of community partnerships developed to improve community health? If so, does the assessment include:		•			
• Process measures?		•			
• Outcome measures?		•			
How much of this LPHS Model Standards is achieved by the local public health system collectively?		•			
• What percent of the answer reported above is the direct contribution of the local public health agency?		•			

Essential Service 5: Develop Policies and Plans that Support Individual and Community Health Efforts

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS include a governmental local public health presence (i.e. local health department) to assure the provision of Essential Public Health Services to the community? Does the local health department:					•
• Maintain current documentation describing its mission?					•
• Maintain current documentation describing its statutory, chartered, and/ or legal responsibilities?					•
• Assess its functions against the operational definition of a functional local health department?					•
Does the LPHS assure the availability of resources for the local health department's contributions to the Essential Public Health Services? Do resources for the local health department include:					•
• Availability of legal counsel on issues related to the provision of Essential Public Health Services?					•
• Funding for mandated public health programs?					•
• Funding for needed public health programs, as identified by the community?					•
• The personnel required to deliver Essential Public Health Services, including and designated local health official?					•
• The facilities, equipment, and supplies required to deliver Essential Public Health Services?					•
Does the local board of health or other governing entity conduct oversight for the local health department?					•
• Has this local board of health or other governing entity completed the National Public Health Performance Standards Program Local Public Health Governance Performance Assessment Instrument?					•
Does the LHD work with the state public health agency and other state partners to assure the provision of public health services?					•
• Have state partners completed the National Public Health Performance Standards Program State Public Health System Performance Assessment Instrument with input from the local level?					•

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS contribute to the development of public health policies?					•
• Does the LPHS engage constituents and identifying and analyzing issues?					•
• Does the LPHS advocate for prevention and protection policies for those in the community who bear a disproportionate risk for mortality or morbidity?		•			
• Within the past year, has the LPHS been involved in activities that influenced or informed the public health policy process?			•		
Does the LPHS alert policymakers and the public of public health impacts from current and/or proposed policies?					•
Does the LPHS review public health policies at least every three to five years?	•				
• Do reviews include assessment of outcomes and/or consequences?	•				
• Do reviews include examination of potential community health impact of other policy areas (e.g. fiscal, social, environmental)?	•				
• Does the review process include community constituents, including those affected by the policy?	•				
Has the LPHS established a community health improvement process (e.g. MAPP, PACE EH)?					•
• Did the community health improvement process use an established tool such as MAPP or PACE-EH?					•
Is there broad participation in the community health improvement process? Does the process include:			•		
• Information from community health assessments?					•
• Issues and themes identified by the community?					•
• Identification of community assets and resources?					•
• Prioritization of community health issues?					•
• Development of measurable health objectives?					•
• Does the process result in the development of a community health improvement plan?					•
⇒ Is the community health improvement plan linked to a state health improvement plan?					•

	No	Minimal	Moderate	Significant	Optimal
Do governmental public health entities within your LPHS have the authority to enforce laws, regulations, or ordinances related to the public's health?					•
• Does a document (paper or electronic) exist that identifies the roles and responsibilities of each governmental entity with enforcement authority?					•
• Do governmental entities with enforcement authority provide their staff who engage in or support enforcement activities, with formal training on compliance and enforcement?					•
Is the local health department or governmental public health entity empowered through laws and regulations to implement necessary community interventions in the event of a public health emergency?					•
• Does this entity's authority include the power to implement quarantine and isolation?					•
• Does this entity's authority include the power to implement mass immunization and dispensing clinics?					•
Does the LPHS assure that all enforcement activities are conducted in accordance with applicable laws, regulations, and ordinances?					•
• Does the LPHS have the appropriate power and ability to prevent, detect, manage, and contain emergency health threats?				•	
• Does the LPHS conduct enforcement activities within the time frame stipulated in laws, regulations, or ordinances?				•	
• Does the LPHS conduct enforcement activities in compliance with due process and civil rights protections?					•
Does the LPHS provide information about public health laws, regulations, and ordinances to the individuals and organizations who are required to comply with them?					•
• Is dissemination of this information integrated with other public health activities (e.g. health education, communicable disease control, health assessment, and planning)?					•
In the past 5 years, has the LPHS assessed the compliance of institutions and businesses in the community (e.g., schools, food establishments, etc.) with laws, regulations, and ordinances designed to ensure the public's health?	•				
• Did the assessment include input from the regulated institutions regarding their perceived difficulties with compliance?	•				
• Did the assessment examine the extent of their resistance or support for enforcement activities by regulated institutions and businesses?	•				
• Did the assessment include input from key stakeholders?	•				

Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS identify any populations who may experience barriers to personal health services?			•		
Has the LPHS identified the personal health service needs of populations in its jurisdiction?			•		
• Have personal health service needs been identified for populations who may experience barriers to care?			•		
Has the LPHS assessed the extent to which personal health services in its jurisdiction are available to populations who may experience barriers to care?			•		
• Has the LPHS assessed the extent to which personal health services are utilized by populations who may experience barriers to care?			•		
Does the LPHS link populations to needed personal health services?			•		
Does the LPHS provide assistance to vulnerable populations in accessing needed health services? Does this assistance include:		•			
• Culturally and linguistically appropriate staff to assist population groups in obtaining personal health services?	•				
• Culturally and linguistically appropriate materials?		•			
• Transportation services for those with special needs?			•		
Does the LPHS have initiatives to enroll eligible individuals in public benefit programs such as Medicaid, and/or other medical or prescription assistance programs?		•			
Does the LPHS coordinate the delivery of personal health and social services to optimize access to services to populations who may encounter barriers to care? Are services targeting the same populations:		•			
• Co-located to optimize access?		•			
• Coordinated among providers to optimize access?		•			

Essential Service 8: Assure a Competent Public and Personal Care Workforce

	No	Minimal	Moderate	Significant	Optimal
Within the past three years, has an assessment of the LPHS workforce been conducted?	•				
Whether or not a formal assessment has been conducted, have shortfalls and/or gaps within the LPHS been identified?	unknown				
• Were gaps related to workforce composition identified?					
• Were gaps related to workforce size identified?					
• Were gaps related to workforce skills and/or experience identified?					
• Were recruitment and retention shortfalls identified?					
• Is this knowledge used to develop plans to address workforce gaps?					
• Have the organizations within the LPHS implemented plans for correction?					
• Is there a formal process to evaluate the effectiveness of plans to address workforce gaps?					
Were the results of the workforce assessment and/or gap analysis disseminated for use in LPHS organizations' strategic or operational plans?	unknown				
• Was this information provided to community leaders?					
• Was this information provided to governing bodies?					
• Was this information provided to public agencies?					
• Was this information provided to elected officials?					
Are organizations within the LPHS aware of guidelines and/or licensure certification requirements for personnel contributing to the Essential Public Health Services?					•
• Are organizations within the LPHS in compliance with guidelines and/or licensure/certification requirements for personnel contributing to the Essential Public Health Services					•
Have organizations within the LPHS developed written job standards and/or position descriptions for all personnel contributing to the Essential Public Health Services?					•

	No	Minimal	Moderate	Significant	Optimal
Do organizations within the LPHS conduct annual performance evaluations?			•		
Does the LHD develop written job standards and/or position titles for all personnel?					•
• Are job standards and/or position descriptions reviewed periodically?					•
Does the LPHS identify education and training needs so as to encourage opportunities for workforce development?			•		
• Distance learning technology?	•				
• National, state, local, and regional conferences?			•		
• Staff cross-training?	•				
• Coaching, mentoring, and modeling?			•		
• Does the LPHS provide refresher courses for key public health issues (e.g., HIPAA, non-discrimination, and emergency preparedness)?			•		
Does the LPHS provide opportunities for all personnel to develop core public health competencies? Do these training opportunities include:	•				
• An understanding of the Essential Public Health Services?	•				
• An understanding of the multiple determinants of health to develop more effective public health interventions?	•				
• Cultural competencies to interact with colleagues and community members?	•				
Are incentives provided to the workforce to participate in educational and training experiences?			•		
• Does the LHD have dedicated resources for training and education?					•
Are there opportunities for interaction between staff of LPHS organizations and faculty from academic and research institutions, particularly those connected with schools of public health?					•
Do organizations within the LPHS promote the development of leadership skills? Is leadership skill development promoted by:					•
• Encouraging potential leaders to attend formal leadership training?			•		
• Mentoring personnel in middle management/supervisory positions?			•		

	No	Minimal	Moderate	Significant	Optimal
• Promoting leadership at all levels within organizations that comprise the LPHS?		•			
• Establishing financial resources to support leadership development on an ongoing basis?		•			
Do organizations within the LPHS promote collaborative leadership through the creation of a shared vision and participatory decision-making?		•			
• Across LPHS organizations, are there established communication mechanisms that encourage informed participation in decision-making (e.g. forums, list serve)?			•		
Does the LPHS provide leadership opportunities for individuals and/or organizations in areas where their expertise or experience can provide insight, direction, or resources?	•				
Does the LPHS recruit and retain new leaders who are representative of the population diversity within their community?		•			
• Does the LPHS provide opportunities to develop community leadership through coaching and mentoring?		•			

Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

	No	Minimal	Moderate	Significant	Optimal
In the past three years, has the LPHS evaluated population-based health services?				•	
Are established criteria used to evaluate population-based health services?	•				
• Does the evaluation determine the extent to which program goals are achieved for population-based health services?	•				

	No	Minimal	Moderate	Significant	Optimal
Does the LPHS assess community satisfaction with population-based health services? Does the assessment:		•			
• Gather input from residents representing a cross-section of the community?		•			
• Determine if residents' needs are being met, including those groups at increased risk of negative health outcomes?		•			
• Determine residents' satisfaction with the responsiveness to their complaints or concerns regarding population-based health services?		•			
• Identify areas where population-based health services can be improved?		•			
Does the LPHS identify gaps in the provision of population-based health services?		•			
Do organizations within the LPHS use the results of population-based health services evaluation in the development of their strategic and operational plans?		•			
In the past three years, have organizations within the LPHS evaluated personal health services for the community? Were the following assessed:					•
• Access to personal health services?					•
• The quality of personal health services?					•
• The effectiveness of personal health services?					•
Are specific personal health services in the community evaluated against established standards (e.g. JCAHO, State licensure, HEDIS)?					•
Does the LPHS assess client satisfaction with personal health services?	•				
• Were surveyed clients representative of past, current, and potential users of services?	•				
Do organizations within the LPHS use information technology to assure quality of personal health services?					•
• Do organizations use electronic health records?	•				
• Is information technology used to facilitate communication among providers?					

	No	Minimal	Moderate	Significant	Optimal
Do organizations within the LPHS use the results of the evaluation in the development of their strategic and operational plans?					•
• Has the LPHS identified community organizations or entities that contribute to the delivery of the Essential Public Health Services?			•		
Is an evaluation of the LPHS conducted every three to five years? Does the evaluation:	•				
• Assess the comprehensiveness of LPHS activities?	•				
• Use established standards (e.g., National Public Health Performance Standards Program)	•				
Do LPHS entities participate in the evaluation of the LPHS?	•				
Has the partnership assessment been conducted that evaluates the relationships among organizations that comprise the LPHS (e.g., the NPHPSP or an evaluation of a partnership within the MAPP process)?			•		
• Is the exchange of information among the organizations in the LPHS assessed?	•				
• Are linkage mechanisms among the providers of population-based services and personal health services assessed (e.g., referral systems, memoranda of understanding)?			•		
• Is the use of resources (e.g., staff, communications systems) to support the coordination among LPHS organizations assessed?	•				
Does the LPHS use results from the evaluation process to guide community health improvements? Are the results from the evaluation process used:			•		
• To refine existing community health programs?			•		
• To establish new community health programs?			•		
• To redirect resources?			•		
• To inform the community health improvement process?			•		

(as a result of the MAPP process)

Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems

	No	Minimal	Moderate	Significant	Optimal
Do LPHS organizations encourage staff to develop new solutions to health problems in the community?			•		
• Do LPHS organizations provide time and/or resources for staff to pilot test or conduct studies to determine new solutions?	•				
During the past two years, have LPHS organizations proposed to research organizations one or more public health issues for inclusion in their research agenda?			•		
Do LPHS organizations identify and stay current with best practices developed by other public health agencies or organizations?		•			
Do LPHS organizations encourage community participation in the development or implementation of research?	•				
Does the LPHS develop relationships with institutions of higher learning and/or research organizations?			•		
Does the LPHS partner with at least one institution of higher learning and/or research organization to conduct research related to the public's health?					•
Does the LPHS encourage collaboration between the academic and practice communities?					•
Does the LPHS have access to researchers (either on staff or through other arrangements)?					•
Is there access to resources to facilitate research within the LPHS?					•
Does the LPHS disseminate findings from their research?					•
Does the LPHS evaluate its research activities?	•				

Summary

It bears mentioning here that prior to beginning the MAPP initiative, the Sarpy and Cass County community lacked a collaborative initiative that featured such a diverse array of partners convened for the purpose of joint planning. While several smaller partnerships exist in the area that focus on specific problems, it does not appear that such a broad-scope, large-scale planning initiative had been undertaken at the county level.

The effects of this were manifested in two recurring themes that appeared throughout the Local Public Health System Assessment process. First, participants were often not confident that the answers they provided were entirely accurate because they didn't feel overly familiar with the extent of services and practices among system partners, particularly those not yet involved in the process. Therefore, it is very possible that scores will rise over time not only as a result of growth in competency, but also in growth in the strength of the relationship among system partners. In addition, the assessment process itself revealed opportunities to invite new partners to the process—a process that will be ongoing as planning continues.

The strongest performance was recorded in the essential service of developing policies and plans that support individual and community health efforts, suggesting that the way is clear for continued growth of both the local public health department and its collaborative efforts with community partners.

Weakest performance was seen where answers required evidence of an established comprehensive community health partnership, since a partnership of this type did not exist in the Sarpy/Cass community prior to the start of this project. Fortunately, it is anticipated that many of the assessment items that were scored low due to lack of information (workforce development questions, for example) will undoubtedly score higher in the future simply due to the enhanced communication brought on by the MAPP project.

Community Health Status Assessment

Building a Healthier Community for the Year 2010

Sarpy/Cass
Department of Health & Wellness

Introduction

One of the primary limitations revealed to the MAPP Committee as a result of reviewing available health status data was the lack of easily-accessible, relevant, current and specific data for county-level planning in the state. While Nebraska's State Association of City and County Health Officials is currently working with the Nebraska Department of Health and Human Services to improve this situation, their efforts provide no immediate solution for districts currently engaged in MAPP Planning.

For the purposes of interpreting the data included here, the following assumptions must be understood:

- At this time, most local health departments in the state of Nebraska have limited, if any, capacity to independently collect county-level health status data for their constituents. This is largely because most of the districts—like the Sarpy/Cass Department of Health and Wellness—are only five years old and are still in the process of developing full capacity to perform the data assessment function. As mentioned above, the State Association of City and County Health Officials is currently working with the Department of Health and Human Services to enhance the availability of local districts to obtain local data.

- In the meantime, the only health status data available for some counties (including Sarpy and Cass Counties) is data collected by the state health agency—the Nebraska Department of Health and Human Services (DHHS). Furthermore, state data does not always contain fields that allow it to be further broken down by county. Therefore, *it is not always possible to obtain county-level data for a desired health statistic.*

- State-level data (data *not* broken down by county) is only minimally useful for the purposes of a local planning initiative like MAPP.

- Data included here in this Community Health Status Assessment represent that data for which county-specific data was available. It should be noted that this creates unavoidable bias in the data and prevents many trends in performance—including positive ones—from being revealed.

- THEREFORE, IT SHOULD BE NOTED THAT IT IS NOT POSSIBLE TO COMPLETE AS COMPREHENSIVE A HEALTH STATUS ASSESSMENT AS DESIRED AT THIS TIME GIVEN THE CURRENT LIMITATIONS ON AVAILABLE DATA.

- Data included in this chapter, then, should be considered objective data points collected on the basis of their availability and not because they represent any particular positive or negative health status for Sarpy or Cass Counties. Where available, state averages are included for comparison; however, differences between local and state figures are significant only where specifically noted.

General Population Data

Sarpy County

Race & Ethnicity

- Racial and ethnic minority residents made up 13.3% of the population of Sarpy County in 2004 compared to 14.3% statewide. (2004 census est.)
- Hispanic Americans accounted for 5.1% of the total population while Asian Americans accounted for 2.2% (2004 census est.)

Family Status

- The proportion of single-parent families in this area has increased since 1990. 12.7% of the county households were single-parent families, compared to an average of 12.4% for Nebraska. (2004 census est.)
- The number of single-parent families was disproportionately higher for African Americans (17.1%), Native Americans (17.2%), Hispanic Americans (16.1%), Asian Americans (10.5%) than it was among Caucasians (8.7%)
- 297 children were in foster care in Sarpy County in 2005 (Source: 2006 Kids Count Report)

Cass County

Race & Ethnicity

- Racial and ethnic minority residents made up 3.5% of the population of Cass County in 2004 compared to 14.3% statewide. (2004 census est.)
- Hispanic Americans accounted for 1.5% of the county's total population in 2004 (2004 census est.)

Family Status

- The proportion of single-parent families in the county has increased since 1990. 11.0% of Cass County households were single-parent families, compared to an average of 12.4% for Nebraska. (2004 census est.)
- 34 children were in foster care in Cass County in 2005 (Source: 2006 Kids Count Report)

General Population Data (continued)

	Sarpy County	Cass County
Age		
	• 7.4% of residents are aged 65+, lower than the state average of 13.3% (2004 census est.) • 29.3% of county residents were under the age of 18, higher than the state average of 25.5% (2004 census est.)	• 12.3% of residents are aged 65+, slightly lower than the statewide proportion of 13.3 (2004 census est.) • 26.9% of county residents are under the age of 18, slightly higher than the state average of 25.5% (2004 census est.)
Education		
	• 6.7% of county residents aged 25 years or older have less than a high school education, compared to 13.4% statewide. (Source: DHHS) • The proportion of county residents aged 25 years or older that had not completed high school was higher among Hispanic Americans (19.7%), Agina Americans (20.1%) and Native Americans (15.4%) than it was among Caucasians (6.1%) (Source: DHHS) • The proportion of seventh– to twelfth-graders in the county who dropped out of school during the 2003-2004 school year was 0.6%, compared to 1.9% statewide. (Source: DHHS) • 75 dropouts in 2004-2005 school year. (Source: 2006 Kids Count Report)	• 10.6% of county residents aged 25 years or older have less than a high school education, compared to 13.4% statewide. Among Hispanic Americans, the proportion that had not completed high school was higher—20.0% in Cass County and 53.4% in Nebraska. (Source: DHHS) • The proportion of seventh– to twelfth-graders in Cass County who dropped out of school during the 2003-2004 school year .2%, compared to 1.9% statewide. (Source: DHHS) • 22 dropouts in 2004-2005 school year. (Source: 2006 Kids Count Report)

General Population Data (continued)

Sarpy County

Social Indicators

- 5.0% of Sarpy County residents lived below the federally-defined poverty level in 2002, well below the average of 10.0% for the state. (Source: DHHS)
- Between 2004 and 2005, there was a 12% increase in the number of Sarpy County families receiving food stamps, compared to a 5% increase statewide. (Source: United Way)
- Between 2004 and 2005, there was a 6% increase in the number of Sarpy County families receiving Women, Infants, and Children (WIC) assistance, compared to a 22% decrease statewide. (Source: United Way)
- Between 2004 and 2005, there was a 2% increase in the number of Sarpy County families receiving financial assistance, compared to 2% decrease statewide. (Source: United Way)

Cass County

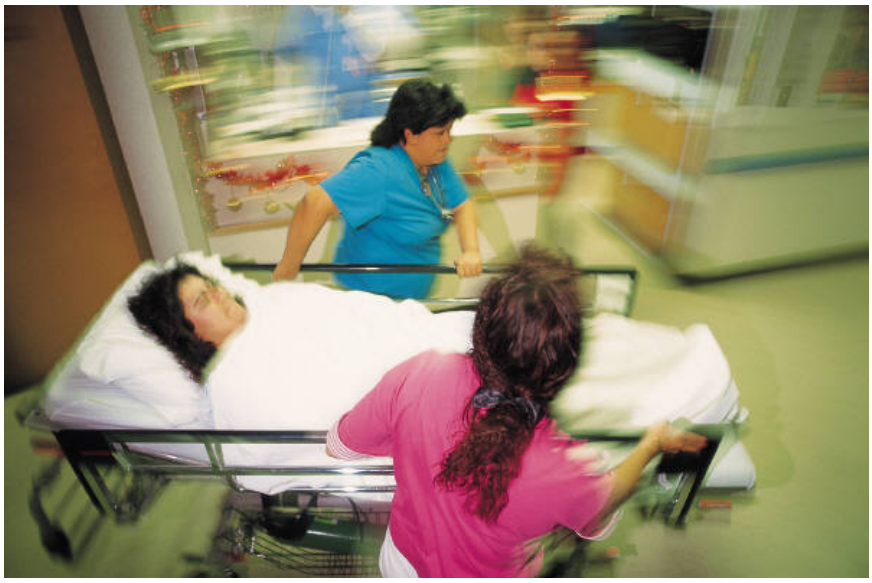
- 6.7% of Cass County residents lived below the federally-defined poverty level in 2002, well below the average of 10.0% for the state. (Source: DHHS)
- Between 2004 and 2005, there was a 3% increase in the number of Cass County families receiving food stamps, compared to a 5% increase statewide. (Source: United Way)
- Between 2004 and 2005, there was a 7% increase in the number of Cass County families receiving Women, Infants, and Children (WIC) assistance, compared to a 5% decrease statewide. (Source: United Way)
- Between 2004 and 2005, there was a 4% decrease in the number of Cass County families receiving financial assistance, compared to 2% decrease statewide. (Source: United Way)

General Population Data (continued)

Sarpy County	Cass County
Social Indicators, continued	
• The number of children enrolled in the free/subsidized school lunch program during the 2005 school year was 3,049. (Source: Kids Count 2006 Report)	• The number of children enrolled in the free/subsidized school lunch program during the 2005 school year was 911. (Source: Kids Count 2006 Report)
• The number of children enrolled in the summer food program in 2005 was 289. (Source: Kids Count 2006 Report)	• No children in Cass County were enrolled in the summer food program in 2005. (Source: Kids Count 2006 Report)
• The percent of working mothers that had children under the age of six was 70% in 2005 (Source: 2006 Kids Count Report)	• The percent of working mothers that had children under the age of six was 74% in 2005 (Source: 2006 Kids Count Report)
• The percent of minority children living in poverty in 2005 was 8% (Source: 2006 Kids Count Report)	• The percent of minority children living in poverty in 2005 was 5% (Source: 206 Kids Count Report)
• The percent of children under the age of five living in poverty in 2005 was 12% (Source: 2006 Kids Count Report)	• The percent of children under the age of five living in poverty in 2005 was 7% (Source: 2006 Kids Count Report)

Financial Access to Healthcare

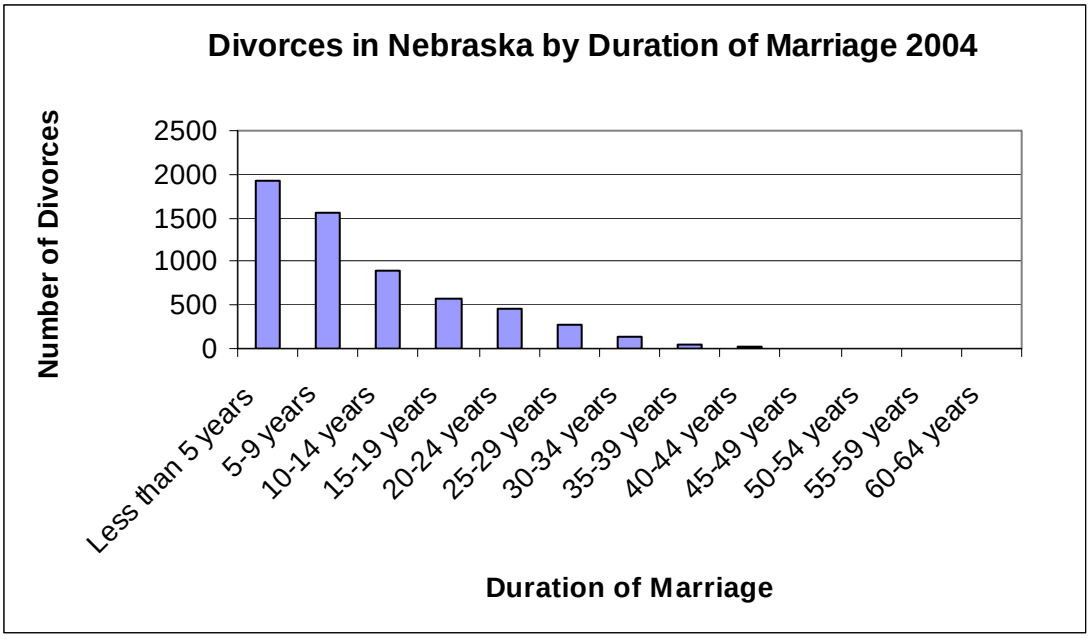
	Sarpy County	Cass County
Medicaid		
	• Between 2004 and 2005, there was a 2% increase in the number of Sarpy County families receiving Medicaid, compared to 0.6% decrease statewide. (Source: United Way)	• Between 2004 and 2005, there was a 4% decrease in the number of Cass County families receiving Medicaid, compared to 0.6% decrease statewide. (Source: United Way)
Insurance		
	• 96.5% of Sarpy County residents who were aged 64 or under in 2004 held health insurance; 3.5% were uninsured. (Source: UNMC College of Public Health)	• (Comparable data not available for Cass County due to insufficient sample size)



Marriage and Family Indicators

Sarpy County	Cass County
Teen Births	
• 5.3% of live births were to teen mothers in Sarpy County in 2004, less than the 2004 statewide average of 8.7%. (Source: UNMC College of Public Health)	• 5.1% of live births were to teen mothers in Cass County in 2004, less than the 2004 statewide average of 8.7%. (Source: College of Public Health)
Births to Unmarried Women	
• The rate* of births to unmarried women in Sarpy County was 189.8 in 2004, compared to 302.2 statewide. (Source: UNMC College of Public Health, *rate = number per 1000 births)	• The rate* of births to unmarried women in Cass County was 256.7 in 2004, compared to 302.2 statewide (Source: UNMC College of Public Health, *rate = number per 1000 births)

Divorces by Duration of Marriage Statewide, 2004
(Source: Nebraska Vital Statistics Report 2004)



Leading Causes of Death

Deaths Due to Select Chronic Diseases, 2004
(Source: 2004 Nebraska Vital Statistics Report)

	Sarpy County	Cass County*	Nebraska
Hypertension and Hypertensive Renal Disease	2.2	15.6	10.0
Heart Disease	101.5	198.7	213.9
Diabetes	4.4	23.4	22.6
Chronic Lung Disease	22.1	39.0	40.2

**The fact that the incident rate, but not the death rate, is high for cancer in Cass County may be indication that patients are contracting treatable, survivable forms of cancer and/or are obtaining adequate treatment.*

Accidental Deaths by Principal and Other Cause, 2004
(Source: 2004 Nebraska Vital Statistics Report)

	Sarpy County	Cass County
All Accidents	44	6
Motor Vehicle	11	2
Farm	0	0
Fall	6	3
Drowning	3	0
Fire	0	0
All Others	24	1

Deaths Due to Chronic Disease

(Source: 2004 Nebraska DHHS Vital Statistics Report)

Sarpy County	Cass County
Hypertension and Hypertensive Renal Disease Deaths	
• The crude rate* of deaths of Sarpy County residents due to hypertension and hypertensive renal disease was 2.2 in 2004, compared to the statewide rate of 10.0 the same year.	• The crude rate of deaths of Cass County residents due to hypertension and hypertensive renal disease was 15.6 in 2004, compared to the statewide rate of 10.0 the same year.
Heart Disease Deaths	
• The crude rate of deaths of Sarpy County residents due to heart disease was 101.5 in 2004, compared to the state-wide rate of 213.9 for the same year.	• The crude rate of deaths of Cass County residents due to heart disease was 198.7 in 2004, compared to the state-wide rate of 213.9 for the same year.
Diabetes Deaths	
• The crude rate of deaths of Sarpy County residents due to diabetes was 4.4 in 2004, compared to the statewide rate of 22.6 for the same year.	• The crude rate of deaths of Cass County residents due to diabetes was 23.4 in 2004, compared to the statewide rate of 22.6 for the same year.
Cancer Deaths	
• The crude rate of deaths of Sarpy County residents due to cancer was 100 in 2004, lower than the statewide rate of 187.0 for the same year.	• The crude rate of deaths of Cass County residents due to cancer was 229.8 in 2004, higher that the statewide rate of 187.0 for the same year.

* Crude Rate = unadjusted number of an event per 1,000 residents of the population

Deaths Due to Chronic Disease

(Source: 2004 Nebraska DHHS Vital Statistics Report)

	Sarpy County	Cass County
Chronic Lung Disease		
	• The crude rate of deaths of Sarpy County residents due to chronic lung disease was 22.1 in 2004, compared to the statewide rate of 40.2 the same year.	• The crude rate of deaths of Cass County residents due to chronic lung disease was 39.0 in 2004, compared to the statewide rate of 40.2 the same year.
Cerebrovascular Disease		
	• In 2004, 30 deaths occurred in Sarpy Co. residents due to cerebrovascular disease—an age-adjusted rate of 44.6 cases per 100,000 residents. This is slightly less than the state rate of 48.9 in 2004.	• In 2004, 15 deaths occurred in Cass Co. residents due to cerebrovascular disease—an age-adjusted rate of 58.4 cases per 100,000 residents. This is greater than the state rate of 48.9 in 2004.
Alzheimer's Disease		
	• In 2004, 9 deaths occurred in Sarpy Co. residents due to Alzheimer's Disease—an age-adjusted rate of 15.8 cases per 100,000 residents. This is considerably less than the state rate of 22.1 in 2004.	• In 2004, 9 deaths occurred in Cass Co. residents due to Alzheimer's Disease—an age-adjusted rate of 36.8 cases per 100,000 residents. This is considerably greater than the state rate of 22.1 in 2004.

Cancer

Sarpy County

Cancer Deaths

- Crude rate of cancer deaths in Sarpy County was 100 in 2004, indicating that there were 100 deaths per 100,000 county residents. This was considerably less than the state rate of 187.1 for the same year. (Source: Nebraska Vital Statistics Report 2004)

Cancer Incidence

- 461 incidents of cancer were diagnosed in Sarpy County in 2004—a rate of 459.9 cases per 100,000 residents. This was not significantly different than the state rate of 462.1 in the same year. (Source: Nebraska DHHS Cancer Registry 2004)

Cass County

Cancer Deaths

- Crude rate of cancer deaths in Cass County was 229.8 in 2004, indicating that there were 229.8 deaths per 100,000 county residents. This was higher than the state rate of 187.1 for the same year. (Source: Nebraska Vital Statistics Report 2004)

Cancer Incidence

- 153 incidents of cancer were diagnosed in Cass County in 2004—a rate of 572.4 cases per 100,000 residents. This was significantly higher than the state rate of 462.1 in the same year. (Source: Nebraska DHHS Cancer Registry 2004)

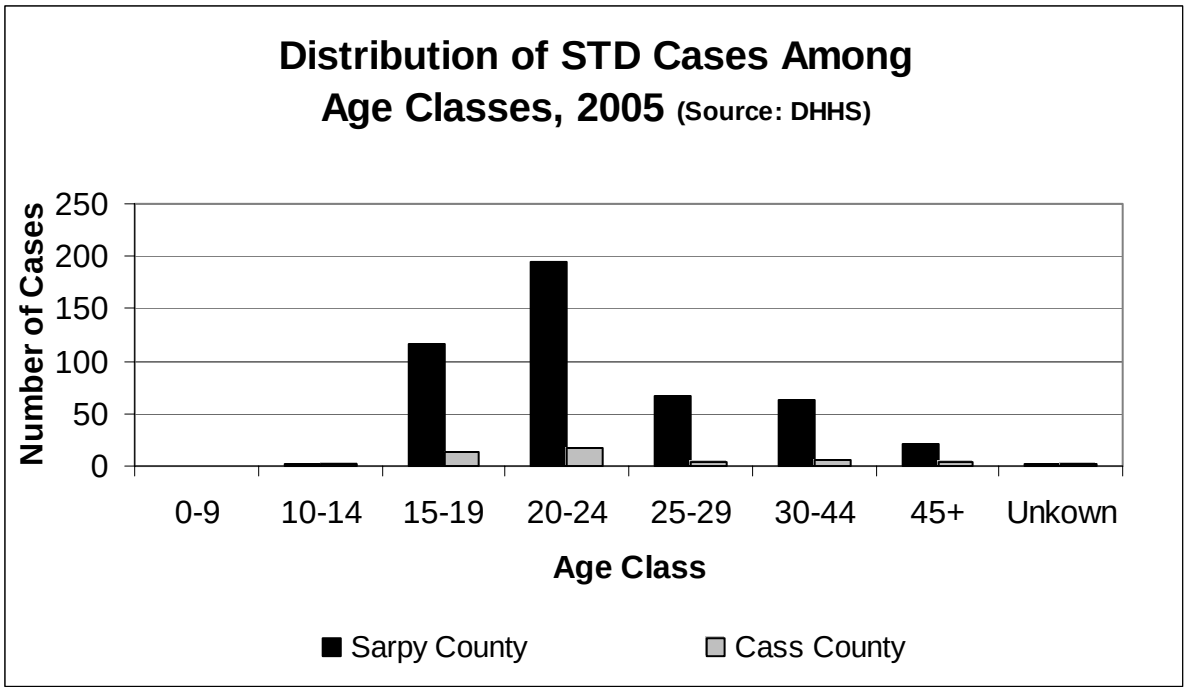
Child Welfare Indicators

Sarpy County	Cass County
Substantiated Reports of Child Abuse	
• In 2004, 224 children were involved in substantiated reports of child abuse or neglect, a rate of 5.5 per 1,000 children age 0-18 living in Sarpy County in 2004 (Source: 2004 DHHS Child Abuse or Neglect Report). This is considerably lower than the statewide, unduplicated rate of 10.4 during the same time period.	• In 2004, 81 children were involved in substantiated reports of child abuse or neglect, a rate of 11.4 per 1,000 children age 0-18 living in Cass County in 2004 (Source: 2004 DHHS Child Abuse or Neglect Report) This is slightly higher than the statewide, unduplicated rate of 10.4 during the same time period.

	Sarpy County	Cass County	Nebraska
Types of Abuse or Neglect in Substantiated Cases (Source: 2004 DHHS Child Abuse or Neglect Annual Report)			
Abuse	47	29	1343
Neglect	206	109	6121
Sexual Abuse	37	3	441
% of County Children Involved in Reports	4.6%	1.7%	

Sexually-Transmitted Diseases

	Sarpy County	Cass County
Diagnoses	• 465 individuals (342 per 100,000 population) were diagnosed with chlamydia, gonorrhea, genital herpes, and/or syphilis in 2005. The state rate for the same year was 425 per 100,000. (Source: Nebraska DHHS)	• 48 individuals (187 per 100,000 population) were diagnosed with chlamydia, gonorrhea, genital herpes, and/or syphilis in 2005. The state rate for the same year was 425 per 100,000. (Source: Nebraska DHHS)



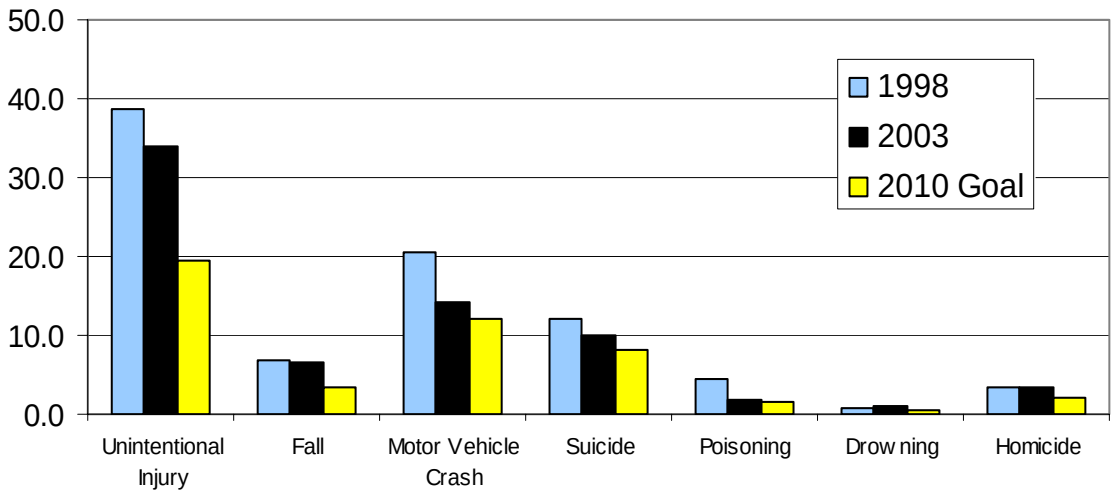
Injuries*

(*Injury data are not available by county. Statements below are based on statewide data)

Summary (Source: Nebraska DHHS 2005 "Injury in Nebraska" report)

- From 199-2003, injuries overall, including intentional and unintentional injuries, were the fourth leading cause of death in Nebraska.
- More years of potential life were lost due to injury than to any other cause of death (e.g. disease)
- Motor vehicle crashes were the leading cause of injury death from 1999-2003; suicide was the second.
- Native Americans had a significantly higher rate of injury death due to motor vehicle crashes than the state rate.
- Suicide was the leading cause of injury death for individuals age 25-64 years. Males were more likely to die from suicide while females were more likely to be hospitalized for suicide attempts.
- Homicide was the leading cause of injury death for infants under one year of age; deaths were most commonly related to abuse.

Nebraska 2010 Health Goal for injuries and most recent rates



Injuries to Children

Unintentional injury deaths for children by cause and age, 1999-2003
(Source: Nebraska Department of Health and Human Services)

Sarpy County

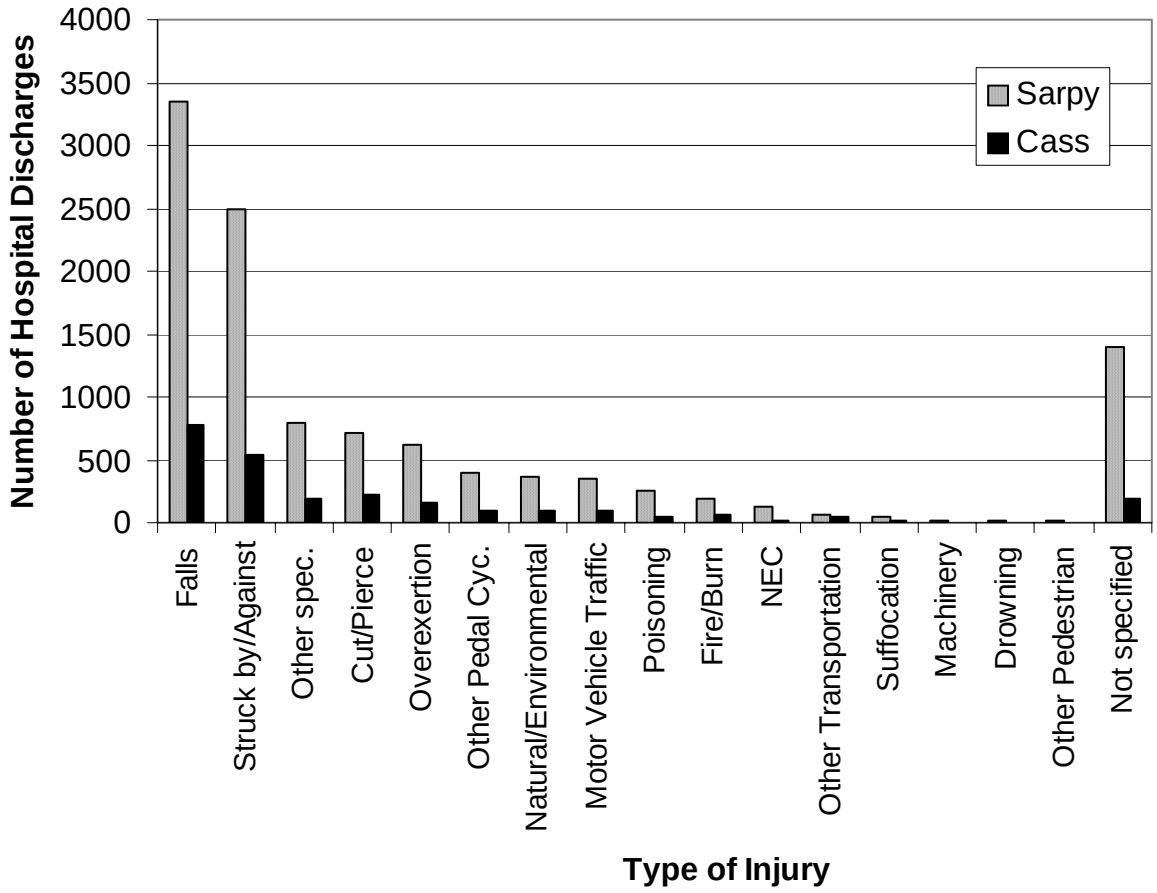
Cause	Age 0-4		5-9		10-14		Total	
	N	% of deaths	N	% of deaths	N	% of deaths	N	% of deaths
Drowning	1	33.3					1	14.3
Fall			1	100			1	14.3
Fire/Flame					1	33.3	1	14.3
Motor Vehicle Traffic	1	33.3					1	14.3
Other Pedestrian	1	33.3					1	14.3
Suffocation					2	66.7	2	28.6
TOTAL	3	100	1	100	3	100	7	100

Cass County

Cause	Age 0-4		5-9		10-14		Total	
	N	% of deaths	N	% of deaths	N	% of deaths	N	% of deaths
Drowning			1				1	25
Fall								
Fire/Flame			2				2	50
Motor Vehicle Traffic					1		1	25
Other Pedestrian								
Suffocation								
TOTAL	NA		3		1		4	100

Injury

Unintentional injury hospital discharges by cause for children 0-14, 1999-2003
(Source: Nebraska Department of Health and Human Services)



The most common type of fall injury in both counties for all age classes was the type incurred by falling from one level to another. The second most common type of fall was that incurred by slipping, tripping, or stumbling on the same level. The most common location for falls in both counties was the home, followed by public buildings and places of recreation and sport.

Youth Substance Abuse

(Source: 2005 Nebraska Risk and Protective Factor Student Survey)

Percentage of Students Surveyed Who Reported Using Alcohol, Tobacco, or Other Drugs in the last 30 Days

	Grade 8		Grade 10		Grade 12	
	Sarpy-Cass	State	Sarpy-Cass	State	Sarpy-Cass	State
alcohol	11.7	13.9	26.4	31.6	44.1	47.2
cigarettes	3.4	6.9	12.8	15.3	22.1	26.1
chewing tobacco	0.4	3.1	5.6	9.1	9.7	12.9
any drug	12.6	12.6	20.2	19.6	29.5	24.3
marijuana	2.0	3.2	9.7	9.4	17.2	13.6
prescription drugs	3.7	3.8	7.2	6.2	7.6	7.4
performance enhancers	0.5	0.8	2.6	3.4	7.0	5.8
inhalants	6.7	5.7	3.9	3.9	1.6	2.2
cocaine	0.2	0.4	0.6	1.0	0.9	1.5
hallucinogens	0.7	0.4	0.6	0.9	1.4	1.2
methamphetamines	0	0.4	0.0	0.9	0.7	1.1
steroids	0	0.4	0.3	0.7	0.7	0.7
other drugs	1,8	1.6	2.3	3.1	4.5	3.3

Behavioral Health

(Source: Region 6 Behavioral Health)

Emergency Protective Custody (EPC) by County, 2006

	Number of EPCs	2006 Population Estimate	EPCs as a Proportion of Pop.
Sarpy County	164	142,637	0.11%
Cass County	16	25,963	0.06%
Sarpy and Cass Counties Combined	180	168,600	0.11%
Region 6*	1044	716,818	0.15%

**Behavioral Health Region 6 includes Douglas, Sarpy, Cass, Dodge, & Washington Counties.*

Emergency Protective Custody (EPC) occurs when any peace officer immediately takes into custody any individual believed to be a mentally ill dangerous person if certain harm is likely to occur before mental health board proceedings can be commences. The person taken into custody is to be placed in a private or government hospital or a mental health center, or in a jail.

Admissions to the Spring Center* by County, July 2006—March 2007

	Number of Admissions	2006 Population Estimate	Adm. as Proportion of Pop.
Sarpy County	58	142,637	0.04%
Cass County	7	25,963	0.03%
Sarpy and Cass Counties Combined	65	168,600	0.04%
Region 6	731	716,818	0.10%

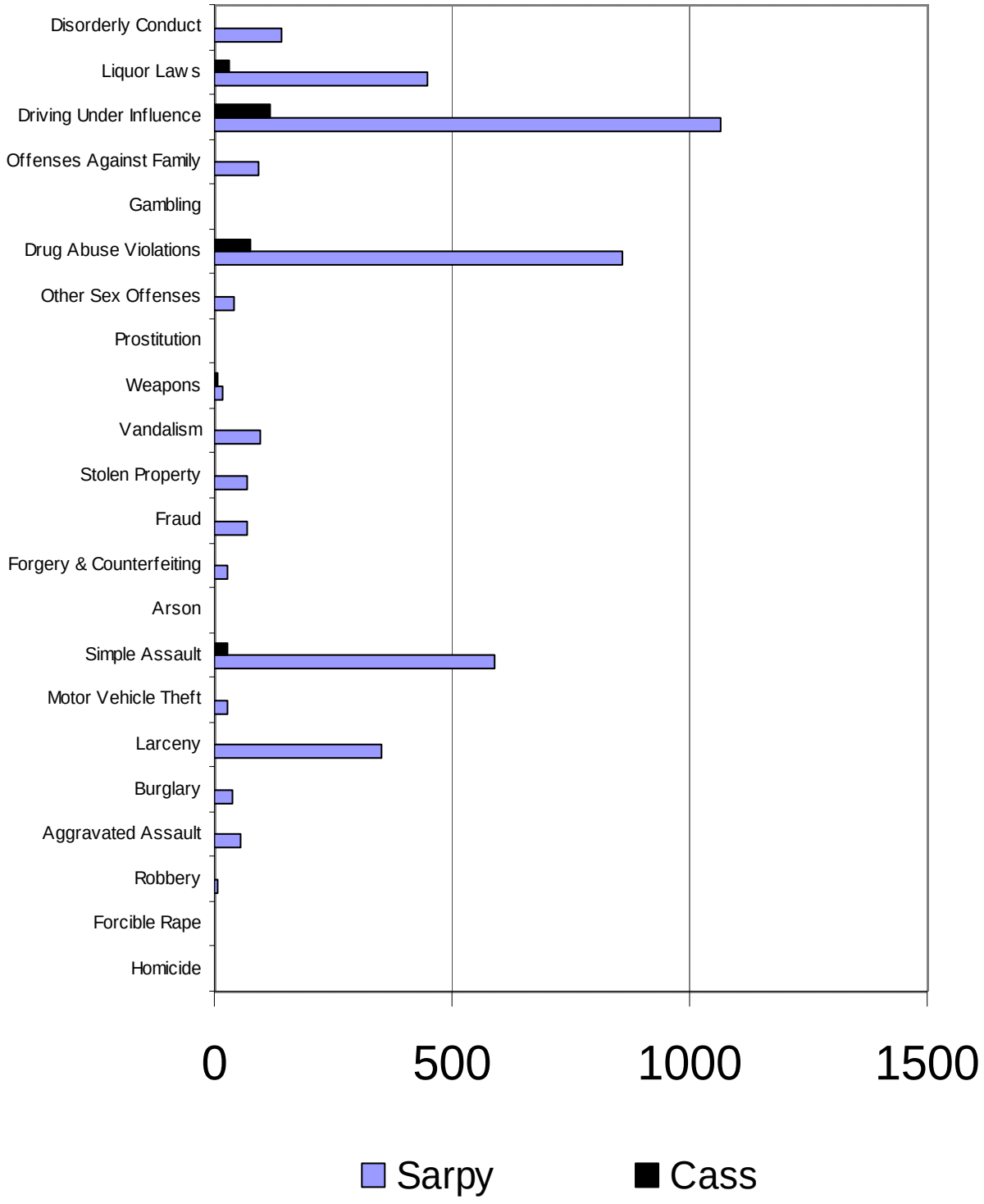
**The Spring Center is a 10-bed voluntary psychiatric crisis stabilization program serving adults, age 19 and over, from the Region 6 area who are motivated to receive help for currently experienced crisis mental health systems..*

Birth Statistics

Sarpy County	Cass County
Low Birth Weight	
• From 2000-2004, 774 infants were born weighing less than 2500 grams (68.1 for every 1,000 live births). This is comparable, and even slightly less, than the state rate of 69.4 for the same time period. (Source: 2004 Nebraska DHHS Vital Statistics Report)	• From 2000-2004, 105 infants were born weighing less than 2500 grams (65.3 for every 1,000 live births). This is considerably less than the state rate of 69.4 for the same time period. (Source: 2004 Nebraska DHHS Vital Statistics Report)
Births to Adolescents	
• 5.3% of live births were to adolescent mothers in Sarpy County in 2004, less than the 2004 statewide average of 8.7%. (Source: UNMC College of Public Health)	• 5.1% of live births were to adolescent mothers in Cass County in 2004, less than the 2004 statewide average of 8.7%. (Source: UNMC College of Public Health)
Birth Defects	
• From 2000-2004, 485 infants (4.2% of total number of infants born) were born with birth defects. This is slightly greater than the state average of 3.9% over the same time period. (Source: 2004 Nebraska DHHS Vital Statistics Report)	• From 2000-2004, 68 infants (4.2% of total number of infants born) were born with birth defects. This is slightly greater than the state average of 3.9% over the same time period. (Source: 2004 Nebraska DHHS Vital Statistics Report)
Neonate and Infant Mortality	
• In 2004, 12 neonates and 15 infants died in Sarpy County, resulting in neonate and infant death rates of 5.1 and 6.3 per 1,000 live births, respectively. State rates for the same year were 4.2 and 6.6. (Source: 2004 Nebraska DHHS Vital Statistics Report)	• In 2004, 5 neonates and 3 infants died in Cass County, resulting in neonate and infant death rates of 3.1 and 9.0 per 1,000 live births, respectively. State rates for the same year were 4.2 and 6.6) (Source: 2004 Nebraska DHHS Vital Statistics Report)

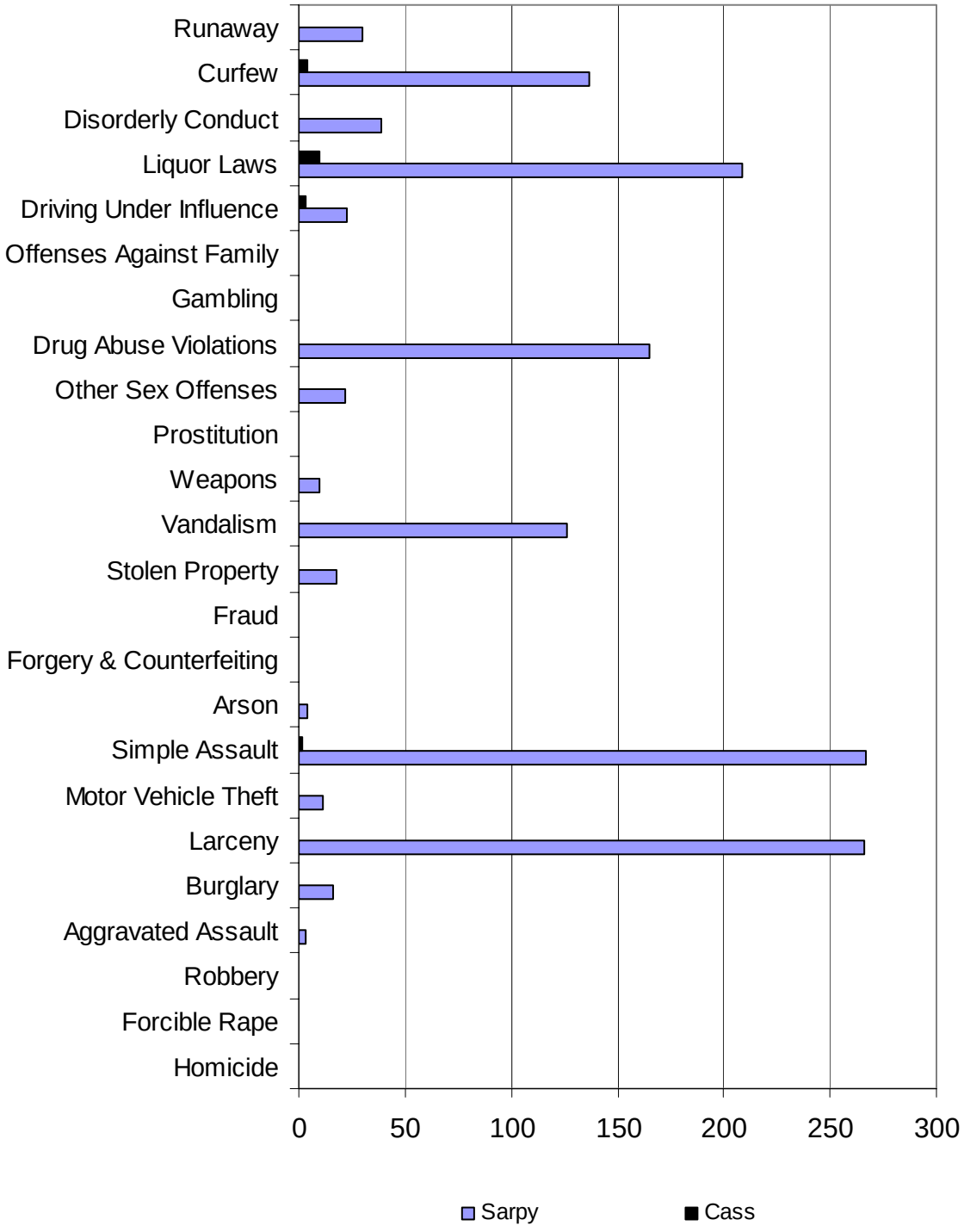
Adult Criminal Activity

2005 Crime Data for Select Offenses (Source: Nebraska Crime Commission)



Juvenile Criminal Activity

2005 Crime Data for Select Offenses (Source: Nebraska Crime Commission)



Top Calls for Police Service

Bellevue (Source: 2006 Summary Data, Bellevue PD)

- Citizen Assist (12,399)
- Housewatches (6287)
- Courtesy Citations (5117)
- Warning Citations (5078)
- Citation, Non Accident Non-Hazard (2103)

Papillion (Source: 2005 Annual Report, Papillion PD)

High Risk

- Disturbance (181)
- Open Door (140)
- Domestic Violence (130)
- Emergency Protective Custody (91)
- Remove a Subject (47)

Moderate Risk

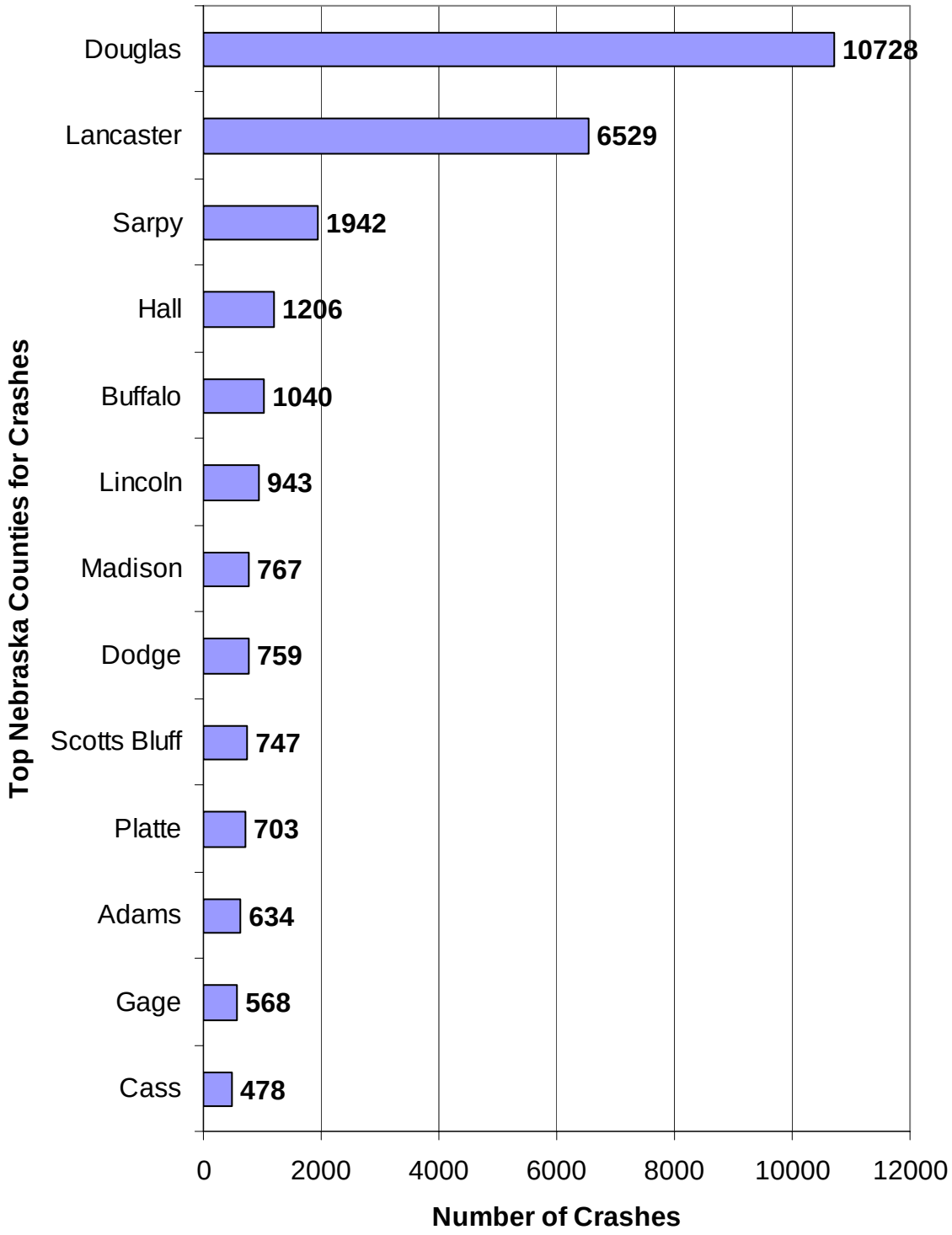
- Suspicious Activity (843)
- 911 Hangup/911 Wrong Number (601)
- Check Location (405)
- Check Well Being (183)
- Business Alarm (159)
- Residential Alarm (89)
- Personal Injury Accidents (69)

Routine

- Vehicle Parking Complaint (558)
- Property Damage Accident (463)
- Larceny/Theft Report (324)
- City Ordinance Violation (310)
- Juvenile Complaints (201)
- Loud Noise Complaint (163)
- Vehicle Lockout (121)
- Reckless Endangerment (155)

Nebraska Traffic Accidents, 2005

(Source: Nebraska Department of Roads)



Forces of Change Assessment

Building a Healthier Community for the Year 2010

Sarpy/Cass
Department of Health & Wellness

Forces of Change Assessment

The MAPP Planning Committee met July 30, 2007 to identify, through focused conversation, the forces of change currently at work in Sarpy and Cass Counties, Nebraska. Participants answered the question, "What factors are currently at work in our community that might influence its health and quality of life and our efforts to achieve our vision for a strong, healthy Sarpy/Cass community.

The following factors were identified as forces of change currently at work in the Sarpy/Cass community:

NEUTRAL OBSERVATIONS

- **Residents have a more favorable orientation toward projects than concepts**. There is a tendency for people to be more interested in a subject when it is presented in the context of a project rather than a concept. Planners should take this into consideration when developing social marketing strategies for initiatives developed through the MAPP project.
- **Sanitary Improvement Districts affect organization patterns among residents**. The fact is that true "neighborhoods" don't exist in some parts of the community. Instead, populations are organized into Sanitary Improvement Districts. Although the fact that residents of the same improvement district do associate with one another may present the opportunity for these areas to be treated like neighborhoods for the purpose of our work, planners need to remain conscious of the fact that residents in these districts often suffer from 'identity crises' in that they may send their children to one municipality to school, work in a different municipality, and shop in yet a third municipality. It is possible that because of this, it might be especially hard to create a cohesive sense of community among residents living in sanitary improvement districts.

OPPORTUNITIES

- **Increasing immigrant population** increases the diversity of our population.
- **Transportation within our community is improving** as more roads become paved and existing urban roads have lanes added.
- **New hospital** will present increased opportunities for residents to access health care within our community.
- **Plenty of tax revenue**

THREATS

- **Family dynamics have changed and continue to change over time**. The definition of 'normal' family has changed and it is no longer prudent to assume that nuclear families are the predominant family form in our community. Divorce is prevalent and atypical family structures result, which place strain on children and parents and raise mental health issues that may need to be addressed.
- **Access to alcohol, tobacco, and drugs is easy**.
- **Our shortage of geriatric specialists** makes it difficult to meet the health care needs of our aging population.
- **There is an increase in the number of uninsured and underinsured** residents in our population.
- **Both Sarpy and Cass Counties are short on mental health care facilities**.
- **Not everyone wants to get to know their neighbors**. Some residents are territorial.
- **The rapid population growth** in our community puts pressure on existing resources
- **The learning community initiative** underway among metro area schools (includes Sarpy County) places a strain on the school community and diverts resources from other initiatives.
- **Increased growth results in increased demand for law enforcement.**
- **Lack of availability of current, relevant, specific data** makes it difficult to make data-driven decisions regarding programming.
- **Poverty rates are likely increasing**

The observations made as part of the Forces of Change Assessment will be discussed and considered when the MAPP Planning Committee meets to identify issues to target with action during the next phase of the planning cycle.

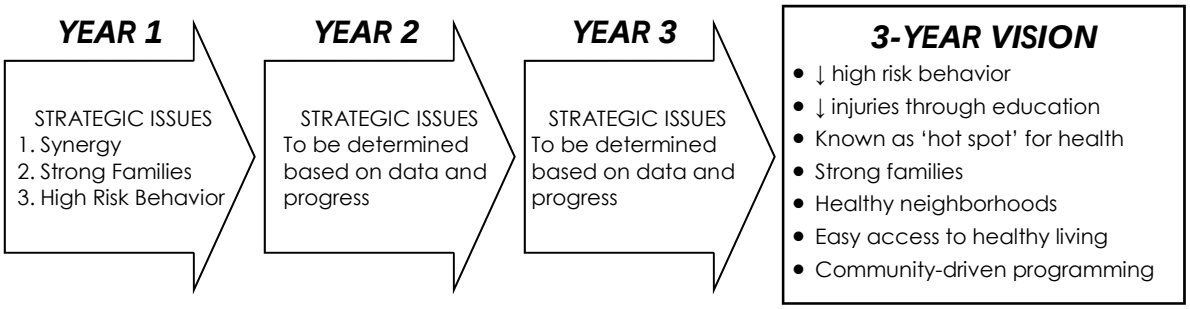
Strategic Issues

After developing the vision and reviewing the data associated with the four community assessments, the MAPP Committee identified the following issues for their focus in 2008:

1. ***Increasing the capacity for positive community health outcomes by building synergy among existing and future partners, their missions, and their capabilities***. The MAPP process has introduced to one another, in many cases for the first time, key community partners from a variety of focus areas across the Sarpy and Cass communities that have incomplete knowledge of each other and/or the organizations they represent. As a result, committee members placed a priority on spending the first year researching what successful programs, services, and capabilities already exist in the Sarpy and Cass communities relative to their vision.

2. ***Strengthening Families*** The MAPP Committee felt that many of the issues identified during the community assessments stemmed from a decline in the strength of family. For this reason, the group identified strengthening families as one of its key issues to target in its first year of collaborative work.

3. ***Lowering High-Risk Behaviors*** In addition to family issues, engagement in high-risk behaviors appeared to the committee to be a root cause for many of the issues identified in one or more of the community assessment process.



Year 1 Projects

Project	Objective	Team Members	Completion Date
Services Database	Develop comprehensive understanding of existing services and projects in Sarpy and Cass Counties	Amy Seys Gail Garnett Tim Gilligan Diana Failla Crystal Fuller	December 2007
Provide access to healthy living by increasing transportation opportunities	Identify existing public transportation opportunities and develop and implement strategies for expanding opportunities	Crystal Fuller Rebecca Horner Sara Roberts Julie Chytil	March 2008
Promoting Internet Safety	Develop and implement internet safety campaign in partnership with local schools	Amy Seys Mary Kay Steyskal Lisa Sanford Brad Conner Demetria Geralds	September 2008
Community Action Program to Minimize Youth Risk Behavior	Expand Gretna's successful community action program to at least one additional community	Dianna Failla Jona Beck Jane Nielsen Tim Gilligan Russ Zeeb Rene Lust Brenda Carlisle	September 2008
Defining and promoting strong families	Expanding successfully faith-based programs outside the churches	Anita Belsky Paul Cook Julie Masters Nancy Reissig	September 2008