Community Health Needs Assessment

2019

Banner Health

Ogallala Community Hospital

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) has requirements that nonprofit hospitals must satisfy to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by the ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt implementation strategies to address the identified needs for the community at least once every three years. As part of the CHNA, each hospital is required to collect input from individuals in the community, including public health experts as well as residents, representatives or leaders of low-income, minority, and medically underserved populations.

As part of the process for evaluating community need, a Banner Health CHNA Steering Committee was formed. This committee, which was commissioned to guide the CHNA process, was comprised of professionals from a variety of disciplines across the organization. This steering committee has provided guidance in all aspects of the CHNA process, including development of the process, prioritization of the significant health needs identified and development of the implementation strategies, anticipated outcomes, and related measures. A list of the steering committee members can be found in Appendix B.

Beginning in early 2019, Banner Health conducted an assessment for the health needs of residents of Ogallala and Nebraska as well as those in its primary service area (PSA). For the purposes of this report, the primary service area is defined as the area where the top 75 percent of patients for the respective facility originate from. The CHNA process undertaken and described in this report was conducted in compliance with federal requirements.

Headquartered in Phoenix, Arizona, Banner Health is one of the nation's largest nonprofit health care systems and is guided by our nonprofit mission: "Making health care easier, so life can be better." This mission serves as the cornerstone of operations at our 28 acute care facilities located in small and large, rural and urban communities spanning 6 western states. Collectively, these facilities serve an incredibly diverse patient population and provide more than $113M annually in charity care – treatment without expectation of being paid. As a nonprofit organization, we reinvest revenues to add new hospital beds, enhance patient care and support services, expand treatment technologies, and maintain equipment and facilities. Furthermore, we subsidize medical education costs for hundreds of physicians in our residency training programs in Phoenix and Tucson, Arizona and Greeley, Colorado.

With organizational oversight from a 13-member board of directors and guidance from both clinical and non-clinical system and facility leaders, our more than 50,000 employees work tirelessly to provide excellent care to patients in Banner Health hospitals, urgent cares, clinics, surgery centers, home care, and other care settings.

While we have the experience and expertise to provide primary care, hospital care, outpatient services, imaging centers, rehabilitation services, long-term acute care and home care to patients facing virtually any health conditions, we also provide an array of core services and specialized services. Some of our core services include: cancer care, emergency care, heart care, maternity services, neurosciences, orthopedics,

pediatrics and surgical care. Specialized services include behavioral health, burn care, high-risk obstetrics, Level 1 Trauma care, organ and bone marrow transplantation and medical toxicology. We also participate in a multitude of local, national and global research initiatives, including those spearheaded by researchers at our three Banner- University Medical Centers, Banner Alzheimer's Institute and Banner Sun Health Research Institute.

Ultimately, our unwavering commitment to the health and well-being of our communities has earned accolades from an array of industry organizations, including distinction as a Top 5 Large Health System three out of the five past years by Truven Health Analytics (formerly Thomas Reuters) and one of the nation's Top 10 Integrated Health Systems according to SDI and Modern Healthcare Magazine. Banner Alzheimer's Institute has also garnered international recognition for its groundbreaking Alzheimer's Prevention Initiative, brain imaging research and patient care programs. Further, Banner Health, which is the second largest private employer in both Arizona and Northern Colorado, continues to be recognized as one of the "Best Places to Work" by Becker's Hospital Review.

In the spirit of the organization's continued commitment to providing excellent patient care, Banner Health conducted a thorough, system wide Community Health Needs Assessment (CHNA) within established guidelines for each of its hospital and healthcare facilities with the following goals at the heart of the endeavor:

- Effectively define the current community programs and services provided by the facility.
- Assess the total impact of existing programs and services on the community.
- Identify the current health needs of the surrounding population.
- Determine any health needs that are not being met by those programs and services, and/or ways to increase access to needed services.
- Provide a plan for future programs and services that will meet and/or continue to meet the community's needs.

The CHNA results have been presented to the leadership team and board members to ensure alignment with the system-wide priorities and long-term strategic plan. The CHNA process facilitates an ongoing focus on collaboration with governmental, nonprofit and other health-related organizations to ensure that members of the community will have greater access to needed health care resources.

Banner Health has a strong history of dedication to community and of providing care to underserved populations. The CHNA process continues to help identify additional opportunities to better care for populations within the community who have special and / or unmet needs; this has only strengthened our commitment to improving the health of the communities we serve.

For Ogallala Community Hospital's leadership team, this has resulted in an ongoing commitment to continue working closely with community and healthcare leaders who have provided solid insight into the specific and unique needs of the community since the previous cycle. In addition, after accomplishing measurable changes from the actions taken in the previous CHNAs, we have an improved foundation to

work from. United in the goal of ensuring that community health needs are met now, and, in the future, these leaders will remain involved in ongoing efforts to continuously assess health needs and subsequent services.

INTRODUCTION

PURPOSE OF THE CHNA REPORT

The purpose of this CHNA is to identify and prioritize significant health needs of the community served by Ogallala Community Hospital (OCH). The priorities identified in this report help to guide the hospital's ongoing community health improvement programs and community benefit activities. This CHNA report meets requirements of the ACA that nonprofit hospitals conduct a CHNA at least once every three years.

Ogallala Community Hospital is dedicated to enhancing the health of the communities it serves. The findings from this CHNA report serve as a foundation for understanding the health needs found in the community and will inform the implementation strategies selected. This report complies with federal tax requirements set forth in Internal Revenue Code Section 501(r) requiring hospital facilities owned and operated by an organization described in Internal Revenue Code Section 501(c)(3) to conduct a CHNA at least once every three years. Regarding the CHNA, the ACA specifically requires nonprofit hospitals to:

1. Collect and take into account input from public health experts, community leaders, and representatives of high need populations – this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions;
2. Identify and prioritize community health needs;
3. Document a separate CHNA for each individual hospital; and,
4. Make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an implementation strategy that describes how the hospital will address the identified significant community health needs.

This is the third cycle for Banner Health, with the second cycle completed in 2016. Feedback on the previous CHNA and Implementation Strategy will be addressed later in the report.

This CHNA report was adopted by the Banner Health's board on December 6, 2019.

This report is widely available to the public on the hospital's website bannerhealth.com, and a paper copy is available for inspection upon request at CHNA.CommunityFeedback@bannerhealth.com

Written comments on this report can be submitted by email to:
CHNA.CommunityFeedback@bannerhealth.com

ABOUT OGALLALA COMMUNITY HOSPITAL

Ogallala Community Hospital is an 18-bed critical care access hospital located within western Nebraska, in Keith County. The hospital was opened in 1952 to serve the community and has never strayed from the community focus, constantly striving to live the Banner Health mission of, "Making health care easier, so life can be better".

Ogallala Community Hospital (OCH) is committed to providing a wide range of quality care, based on the needs of the community, including the following services:

- Infusion Therapy
- Medical Imaging
- Orthopedics
- Surgery
- Women's Services

The staff of 13 physicians provides personalized care complemented by leading technology from Banner Health resources directed at preventing, diagnosing, and treating illnesses. On an annual basis, Ogallala Community Hospital health care professionals render care to nearly – 20,000 outpatients, 2,000 inpatients, and over 3,000 patients in the Emergency Department (ED). The staff also welcomes an average of 50 newborns into the world each year.

Ogallala Community Hospital opened the Specialty Clinic and Infusion Center on April 11, 2014. The new construction includes seven exam rooms, a nurses' station, two procedure rooms, a Telehealth / consultation room, support areas, and five bays for infusion and cancer care.

To help meet the needs of uninsured and underinsured community members, Ogallala Community Hospital follows the Banner Health process for financial assistance, including financial assistance and payment arrangements. A strong relationship with the community is a very important consideration for Banner Health. Giving back to the people we serve through financial assistance is just one example of our commitment. In 2018, Ogallala Community Hospital reported $1,218,000 in Charity Care, while it wrote off an additional $1,198,000 in Bad Debt, on uncontrollable money owed to the facility.

DEFINITION OF COMMUNITY

Ogallala Community Hospital is located, in the South Platte River Valley in western Nebraska. U.S. Highway 30, U.S. Highway 26 and Nebraska Highway 61 all intersect in Ogallala. The South Platte River flows through town and the North River flows through Lake McConaughy, located 9 miles north of Ogallala.

DESCRIPTION OF COMMUNITY

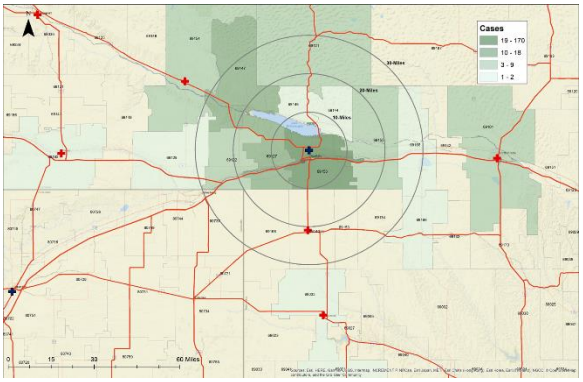
Primary Service Area

The Primary Service Area (PSA) is determined based on where the top 75 percent of patients for the respective facility originate from. In Table 1 the top ~75 percent of the Ogallala Community Hospital PSA is listed.

Table 1. Primary Service Area

Zip	County	%	Cumulative
69153	Keith County	64.2%	64.2%
69127	Keith County	6.8%	71.0%
69147	Garden County	6.8%	77.8%

Source: McKesson, 2018



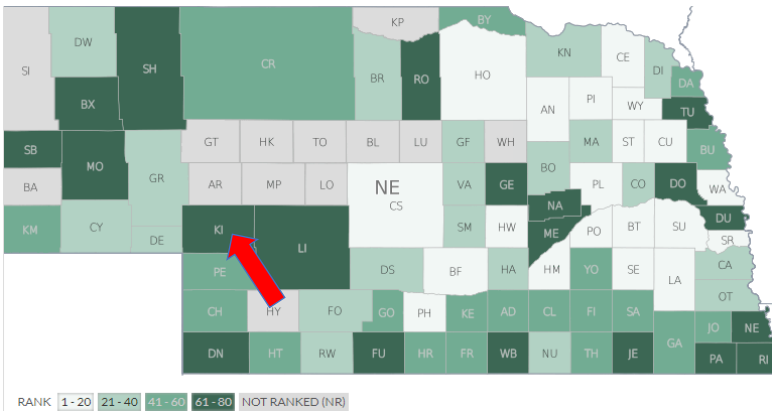
Source: Banner Strategy and Planning

Hospital Inpatient Discharges and Map

Ogallala Community Hospital's Inpatient Origin by Zip Code data informs the primary service area. For the 2019 CHNA report the data derives from the 2018 calendar year and is determined by the top 3 contiguous quartiles, equaling 75 percent of total discharges. The town of Ogallala accounted for 64 percent of Ogallala Community Hospital's inpatient discharges in 2018. An additional 7 percent of discharges came from Brule and Lewellen respectively.

Health Outcomes Ranking and Map

2019 Nebraska County Health Outcomes Rankings: Keith County ranked #67 of 80 participating counties, a significant increase in the health outcome ranking of 2016 (#75 of 79 participating counties). The health outcomes determine how healthy a county is by measuring how



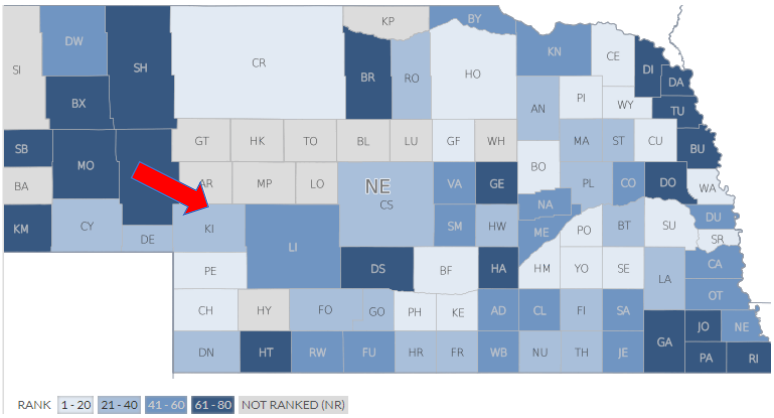
Source: County Health Rankings and Roadmaps, 2018

people feel while they are alive and how long they live. Health outcomes are influenced by health factors, which are thus influenced by programs and policies in place at the local, state, and federal levels. Health outcomes indicate whether health improvement plans are working. Listed below are the two areas that the study looked at when determining health outcomes:

- Length of Life: measuring premature death and life expectancy.
- Quality of Life: measures of low birthweight and those who rated their physical and mental health as poor. (County Health Rankings, 2019)

Health Factors Ranking and Map

2019 Nebraska County Health Factors Rankings: Keith County ranked #39 of 80 participating counties, a slight decrease from the 2016 health factors ranking (#41 of 79 counties). Health factors represent things that can be modified to improve the length and quality of life and are predictors for how healthy communities can be in the future. While there are many factors, from education to the environment in which a person lives, this study focused on the following four factors:



Source: County Health Rankings and Roadmaps, 2018

- Health Behaviors: rates of alcohol and drug abuse, diet and exercise, sexual activity, and tobacco use.
- Clinical Care: showing the details of access to quality of health care.
- Social and Economic Factors: rating education, employment, income, family and social support, and community safety.
- Physical Environment: measuring air and water quality, as well as housing and transit. (County Health Rankings, 2019)

COMMUNITY DEMOGRAPHICS

Table 2 provides the specific age, gender distribution, and data on key socio-economic drivers of health status of the population in Ogallala Community Hospital primary service area compared to Keith County and the state of Nebraska.

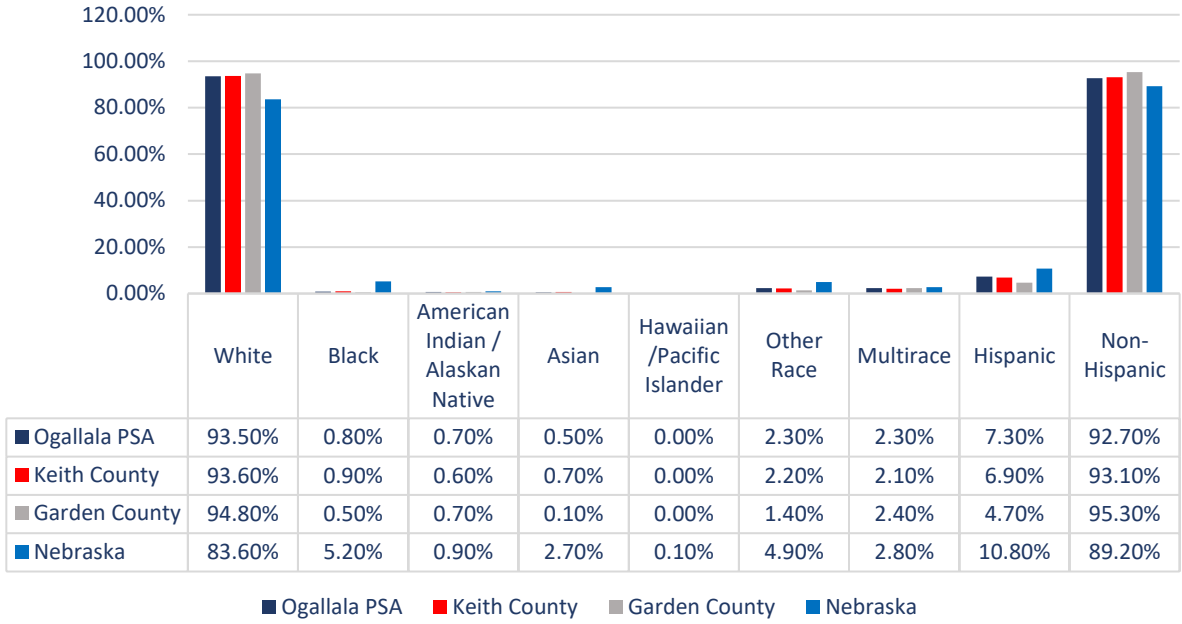
Table 2. Community Demographics				
	Ogallala Community Hospital PSA	**Keith County**	**Garden County**	**Nebraska**
Population: estimated 2018	8,186	9,027	3,104	1,926,218
Gender				
• Male	50.1%	50.2%	52.2%	49.9%
• Female	49.9%	49.8%	47.7%	50.1%
Age				
• 0 to 9 years	10.9%	10.4%	10.6%	13.8%
• 10 to 19 years	11.4%	11.6%	10.2%	13.7%
• 20 to 34 years	15.1%	15.1%	13.5%	20.4%
• 35 to 64 years	37.1%	37.9%	39.0%	36.5%
• 65 to 84 years	21.9%	22.1%	22.2%	13.3%
• 85 years and over	3.5%	2.9%	4.3%	2.3%
Social & Economic Factors				
• No HS diploma	7.9%	8.1%	5.6%	9.2%
• Median Household Income	$46,800	$47,900	$55,228	$61,800
• Unemployment	3.0%	2.6%	1.7%	2.5%

Source: Advisory Board 2019

Race/Ethnicity (PSA, County and State)

Garden County, where 7 percent of OCH's patients derive from has the largest white population, followed by Keith County (93.6%), the PSA (93.5%) than the state (84%).

Chart A. Race / Ethnicity, 2019



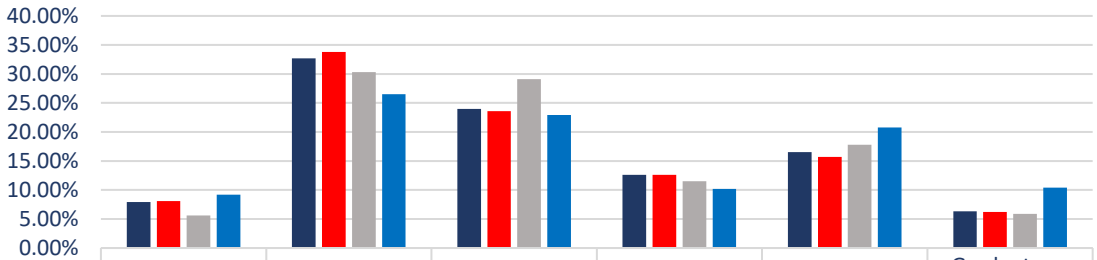
	White	Black	American Indian / Alaskan Native	Asian	Hawaiian /Pacific Islander	Other Race	Multirace	Hispanic	Non-Hispanic
Ogallala PSA	93.50%	0.80%	0.70%	0.50%	0.00%	2.30%	2.30%	7.30%	92.70%
Keith County	93.60%	0.90%	0.60%	0.70%	0.00%	2.20%	2.10%	6.90%	93.10%
Garden County	94.80%	0.50%	0.70%	0.10%	0.00%	1.40%	2.40%	4.70%	95.30%
Nebraska	83.60%	5.20%	0.90%	2.70%	0.10%	4.90%	2.80%	10.80%	89.20%

Sources: Crimson, Advisory Board, 2019

Educational Attainment (PSA, County and State)

OCHs primary service area has a larger population of high school graduates than the state by 6 percent. However, the primary service area and counties both have a smaller population of those who have completed a post-secondary education compared to the state.

Chart B. Educational Attainment*, 2019



	No HS Diploma	HS graduate	College no diploma	Associate degree	Bachelor's degree	Graduate or prof school degree
Ogallala PSA	7.90%	32.70%	24.00%	12.60%	16.50%	6.30%
Keith County	8.10%	33.80%	23.60%	12.60%	15.70%	6.20%
Garden County	5.60%	30.30%	29.10%	11.50%	17.80%	5.90%
Nebraska	9.20%	26.50%	22.90%	10.20%	20.80%	10.40%

Ogallala PSA Keith County Garden County Nebraska

**Over the Age of 25; Sources: Crimson, Advisory Board, 2019*

Insurance Coverage Estimates for PSA and State of Nebraska Populations

The charts below indicate the PSA has a significantly smaller percentage of the population covered by private insurance, 55 percent, in comparison to the state, 64 percent. The PSAs population utilizes Medicare and Medicaid 10 percent more so than the state population. Both of these differences can be attributed to the unemployment rate, higher in the PSA than that of the state, median income, lower in the PSA than the state, and the age of the population, the PSA has a larger population of those 65+ in comparison to the state.

Chart C. OCH PSA

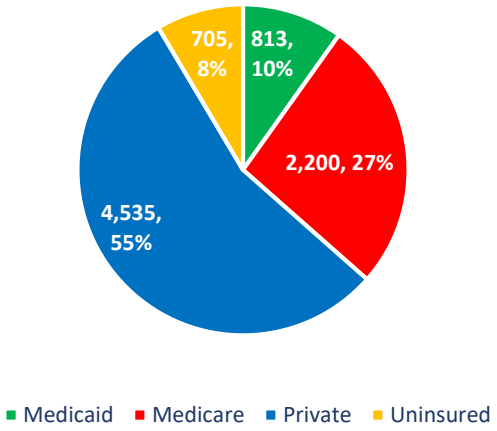
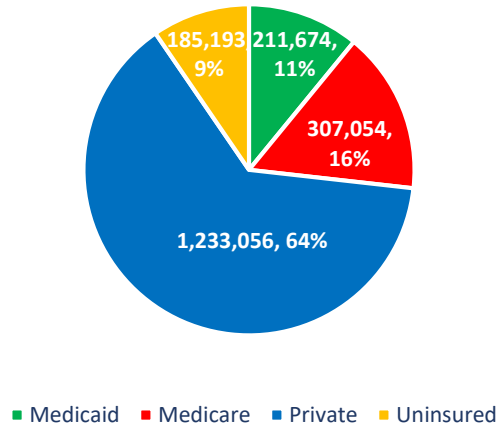


Chart D. Nebraska

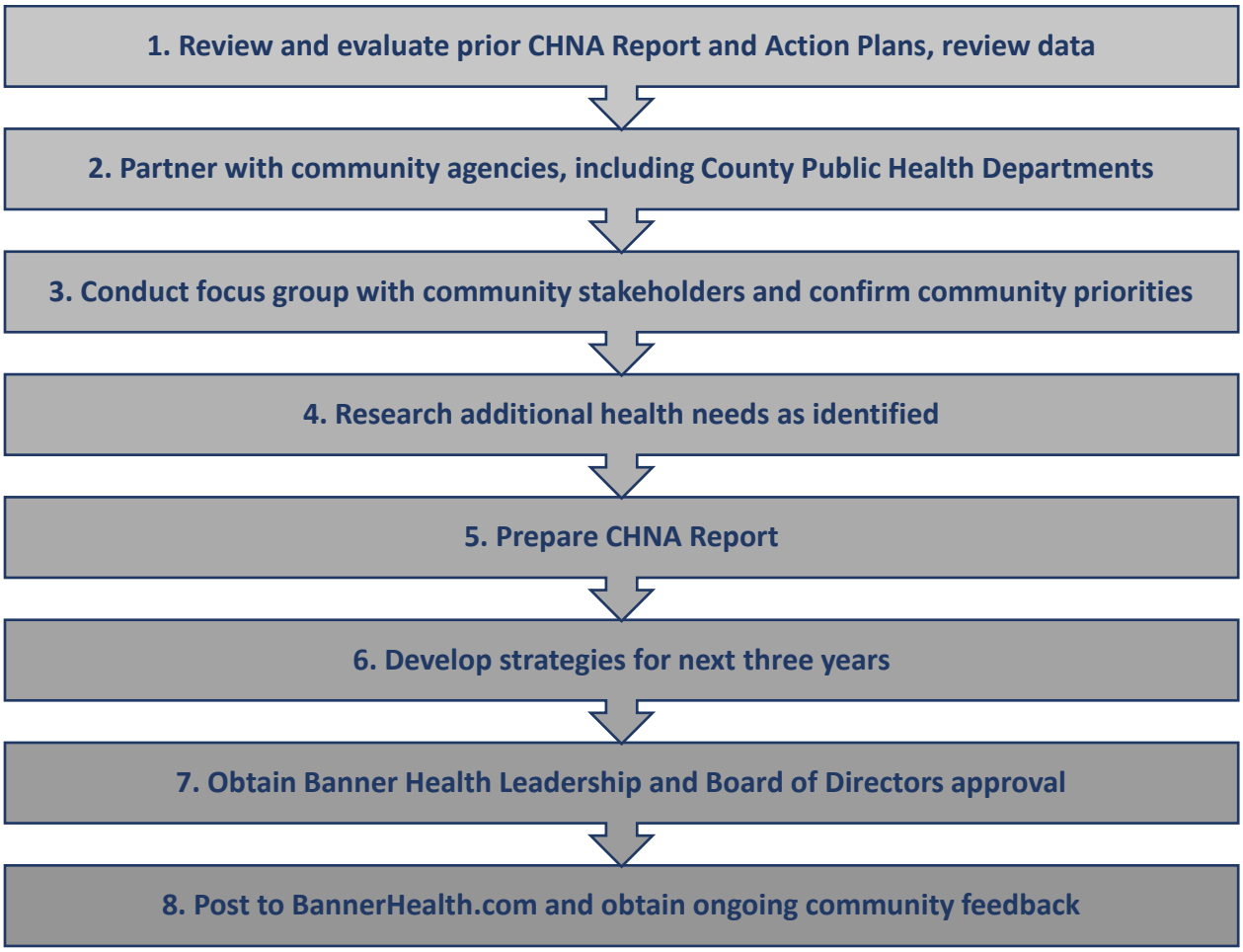


Source: 2017-18 Nebraska State Data, Truven

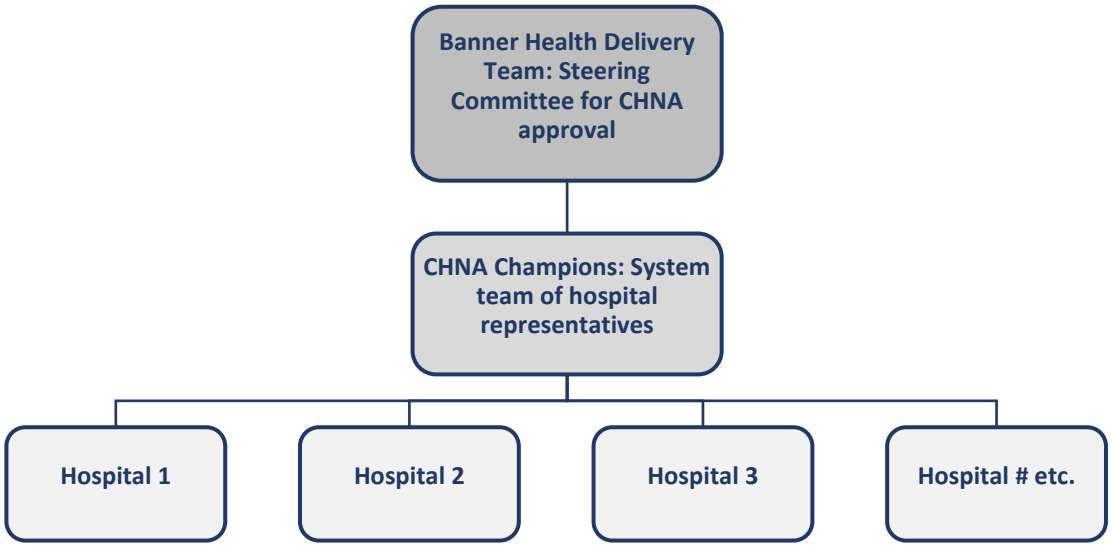
PROCESS AND METHODS USED TO CONDUCT THE CHNA

Ogallala Community Hospital's process for conducting Community Health Needs Assessments (CHNAs) involve a leveraged multi-phased approach to understanding gaps in services provided to its community, as well as existing community resources. In addition, a focused approach to understanding unmet needs especially for those within underserved, uninsured and minority populations included a detailed data analysis of national, state and local data sources is conducted, including obtaining input from leaders within the community.

Ogallala Community Hospital's eight step process based on experience from previous CHNA cycles is demonstrated below. The process involves continuous review and evaluation of our CHNAs from previous cycles, through both the action plans and reports developed. Through each cycle Banner Health and Ogallala Community Hospital has been able to provide consistent data to monitor population trends.



BANNER HEALTH CHNA ORGANIZATIONAL STRUCTURE



PRIMARY DATA / SOURCES

Primary data, or new data, consists of data that is obtained via direct means. For Banner, by providing health care to patients, primary data is created by providing that service, such as inpatient / outpatient counts, visit cost, etc. For the CHNA report, primary data was also collected directly from the community, through stakeholder meetings.

The primary data for the Community Health Needs Assessment originated from Cerner (Banner's Electronic Medical Record) and McKesson (Banner's Cost Accounting / Decision Support Tool). These data sources were used to identify the health services currently being accessed by the community at Banner locations and provides indicators for diagnosis-based health needs of our community. This data was also used to identify the primary services areas and inform the Steering Committee (Appendix C) and facility champions on what the next steps of research and focus group facilitation needed to entail.

SECONDARY DATA / SOURCES

Secondary data includes publicly available health statistics and demographic data. With input from stakeholders, champions, and the steering committee, additional health indicators of special interest were investigated. Comparisons of data sources were made to the county, state, and PSA if possible.

Data analytics were employed to identify demographics, socioeconomic factors, and health trends in the PSA, county, and state. Data reviewed included information around demographics, population growth,

health insurance coverage, hospital services utilization, primary and chronic health concerns, risk factors and existing community resources. Several sources of data were consulted to present the most comprehensive picture of Ogallala Community Hospital's PSA's health status and outcomes. Appendix B has the data sources listed.

DATA LIMITATIONS AND INFORMATION GAPS

Although the data sources provide an abundance of information and insight, data gaps still exist, including determining the most appropriate depth and breadth of analyses to apply. Additional gaps include:

Table 3. Data Limitations and Information Gaps

Data Type	Data Limitations and Data Gaps
Primary Data	• Data not available on all topics to evaluate health needs within each race / ethnicity by age-gender specific subgroups. • Limited data is available on diabetes prevalence and health risk and lifestyle behaviors (e.g. nutrition, exercise) in children.
Secondary Data	• Data not available on all topics to evaluate health needs within each race / ethnicity by age-gender specific subgroups. • Limitations on County Level data for mortality statistics, specific incidence rates, and racial/ethnic breakdowns • Since Nebraska has such small numbers for certain conditions it is difficult to compare data at a national level. • Public transportation is based on commuter data. • Garden County did not report data for the County Health Rankings.

COMMUNITY INPUT

Once gaps in access to health services were identified through data analytics, as explained above, Banner Health system representatives worked with Ogallala Community Hospital's leadership to identify those impacted by a lack of health-related services. The gaps identified were used to drive the conversation in facilitating Community Stakeholder Focus Groups. Focus group participants involved PSA community leaders, community focused programs, and community members, all of which represented the uninsured, underserved, and / or minority populations. These focus groups (through a facilitated conversation) reviewed and validated the data, providing additional health concerns and feedback on the underlying issues for identified health concerns. A list of the organizations that participated in the focus groups can

be found under Appendix C and a list of materials presented to the group can be found under Appendix D.

Prioritization of Community Health Needs

To be considered a health need the following criteria was taken into consideration:

- The county had a health outcome or factor rate worse than the state / national rate
- The county demonstrated a worsening trend when compared to state / national data in recent years
- The county indicated an apparent health disparity
- The health outcome or factor was mentioned in the focus group
- The health need aligned with Banner Health's mission and strategic priorities

Building on Banner Health's past two CHNAs, our steering committee and facility champions worked with Banner Health corporate planners to prioritize health needs for Cycle 3 of the CHNA. Facility stakeholders, community members, and public health professionals were among major external entities involved in identifying health needs, which were then brought to the steering committee. Both Banner Health internal members, and external entities were strategically selected for their respective understanding of community perspectives, community-based health engagement, and health care expertise.

Using the previous CHNAs as a tool, the steering committee reviewed and compared the health needs identified in 2019 to the previous health needs. The group narrowed the community health needs to three. It was determined that Banner Health, as a health system would continue to address the same health needs from Cycle 2, the 2016 CHNA, due to the continued impact these health needs have on the overall health of the community. These needs and the strategies to address the needs align with the short- and long-term goals the health system has, specific strategies can be tailored to the regions Banner Health serves, and the health needs can address many health areas within each of them. The graphic below lists the three health needs and the areas addressed by the strategies and tactics.

Access to Care	Chronic Disease Management	Behavioral Health
•Affordability of care •Uninsured and underinsured •Healthcare provider shortages •Transportation barriers	•High prevalence of: heart disease, diabetes, and cancer •Obesity and other factors contributing to chronic disease •Health literacy	•Opioid Epidemic •Vaping •Substance abuse •Mental health resources and access

DESCRIPTION OF PRIORITIZED COMMUNITY HEALTH NEEDS

Banner Health has a strong history of dedication to its community and of providing care to the underserved populations. The CHNA process continues to help identify additional opportunities to better care for populations within the community who have special and / or unmet needs; this has only strengthened our commitment to improving the health of the communities we serve. The following statements summarize each of the areas of priority for Ogallala Community Hospital and are based on data and information gathered through the CHNA process.

PRIORITY #1: ACCESS TO CARE

Access to care is a critical component to the health and wellbeing of community members. Often individuals without insurance, and even those who are underinsured, experience greater difficulty readily accessing health care services, particularly preventative and maintenance health care. This can be very costly, both to the individuals and the health care system. Focus group participants overwhelmingly felt that access to care is an important issue for the community.

Low-income populations are known to suffer at a disproportionate rate to a variety of chronic ailments, delay medical care, and have a shorter life expectancy compared to those living above the poverty level (Elliott, Beattie, Kaitfors, 2001). Understanding income and its correlation to access to care, primarily through access to health insurance, is necessary to understand the environmental factors that influence a person's health. Research supports the correlation between income and health, compared to high-income Americans, those with low-incomes have higher rates of heart disease, diabetes, stroke, and other chronic conditions (Khullar, Dhruv, Chokshi, 2018).

Table 4 breaks down the percentage of the community living in various states below federal poverty levels. Over a quarter of Garden County's population, and nearly a third of Keith County's population lives at 200 percent below the federal poverty level.

Table 4. Percentage Below Federal Poverty Level (FPL) 2013 – 2017

	Garden County	Keith County	Nebraska	US
Population Below FPL				
50%	5.42%	5.89%	5.07%	6.48%
100%	11.69%	13.06%	11.98%	14.58%
185%	23.43%	28.4%	27.09%	30.11%

200%	26.11%	32.56%	29.92%	32.75%
Children Below FPL				
100%	10.51%	20.95%	15.59%	20.31%
200%	21.59%	42.76%	37.99%	42.24%

Source: U. S. Census Bureau, American Community Survey, 5-Year Estimates, 2013 – 2017

A Health Professional Shortage Area is a designation indicating a health care shortage in primary, dental, and / or mental health. In the US 23.3 percent of the population is living in an area affected by a HPSA, which is low compared to Garden County, and high when compared to Nebraska and Keith county (Garden Co.: 98.2%; Keith C.:0%; Nebraska: 0.06%). The designation of an HPSA is an indicator for access and health status issues (HHS, February 2019). This indicates a huge variance in service area availability.

Table 5 shows the ratio of the population to primary care physicians. You can see that Garden County has the largest discrepancy of patients to provider when compared to Keith County and the state, which aligns with the health need recognized through a HPSA.

Table 5. Ratio of Population to Primary Care Physicians

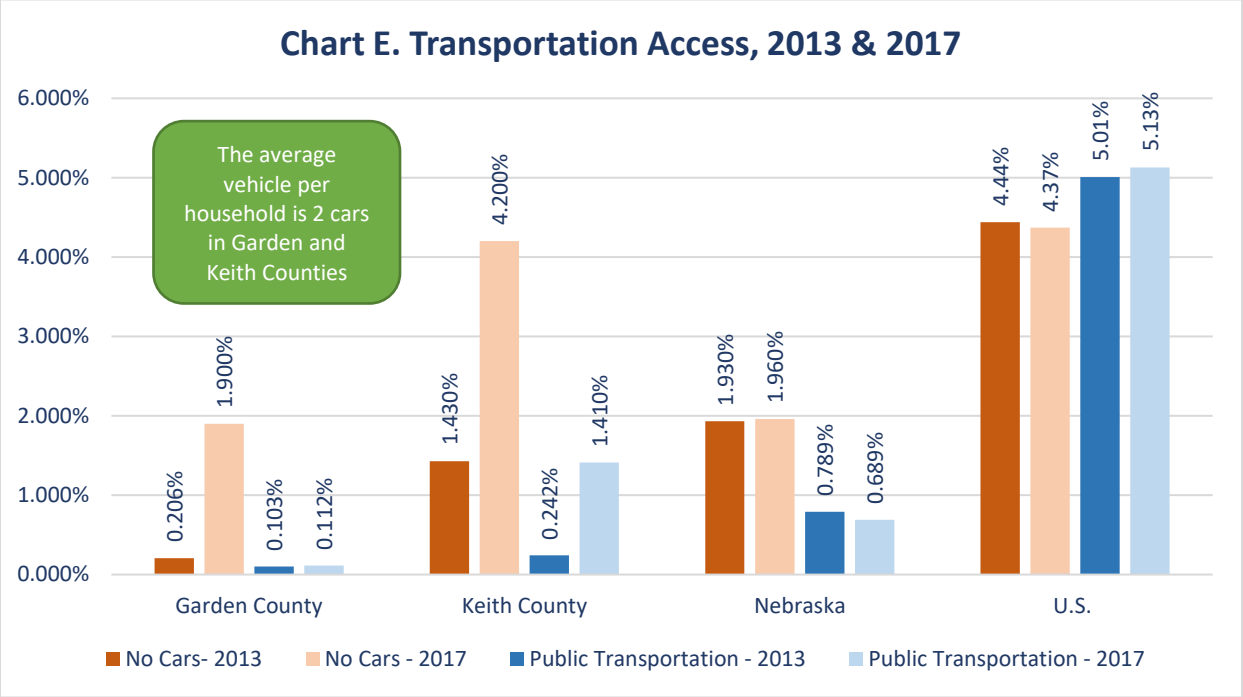
	Garden County	Keith County	Overall in Nebraska
2017	1,910:1	1,620:1	1,330:1
2018	1,920:1	1,610:1	1,340:1
2019	1,930:1	1,150:1	1,320:1

County Health Rankings, 2017-2019

Transportation barriers are often associated as a barrier to healthcare access – including missed appointments, delayed care, and missed / delayed medication use. These results lead to poor health management, and to poor health outcomes (Syed, Gerber, Sharp, 2013).

Less than 1 percent of Garden County had no car in 2013, that increased significantly by 2017, where 1.9 percent of the population had no car. In Keith County, the percentage of the population who did not have a car tripled from 2013 to 2017. This represents a deteriorating rate of access to transportation for these residents (Refer to Chart E). Public Transportation in Garden and Keith County is not available at a county wide level. Garden County is designated as a nonmetro completely rural county, while Keith County is designated as a nonmetro-urban community (USDA, 2019). Transportation barriers listed above and in

Chart E can have a significant impact on a persons mobility, due to the lack of alternative transportation options in rural and urban environments.



Source; Census Bureau, American Community Survey, 5-Year Estimates, 2013-2017

PRIORITY #2: CHRONIC DISEASE MANAGEMENT

Chronic diseases such as cancer, diabetes, and heart disease affect the health and quality of life of Keith and Garden County residents, but they are also major drivers in health care costs. In 2016, Cancer was the leading cause of death in Nebraska with heart disease a close second. Lung cancer and colorectal cancer were the leading causes of death for men, while lung and breast cancer were for women (Nebraska Division of Public Health 2016).

In Table 6 you can see that Cancer and Heart Disease have different prevalence's in Keith and Garden County respectively. Cancer is the leading cause of premature death in Keith County, and Heart Disease is the leading cause of premature death in Garden County.

Table 6. Chronic Disease Mortality Rates, 2013-17

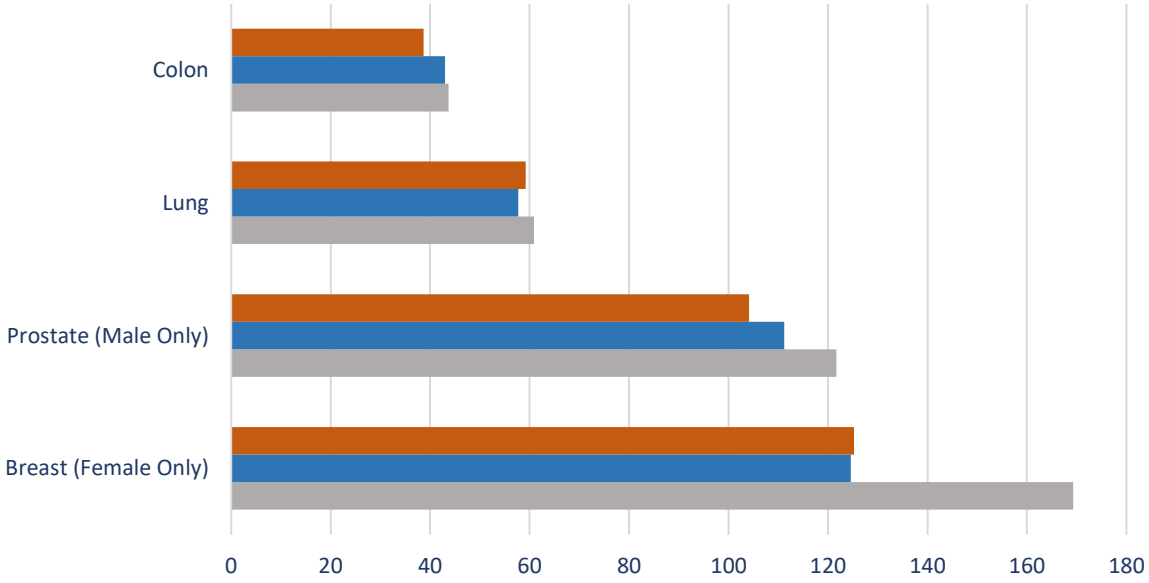
	Keith County	Garden County	Nebraska
Heart Disease	145.2	166.4	149.3

Cancer	165.9	131.3	152.6
Diabetes	*Data suppressed (<20 Deaths)*		25.0
Influenza / Pneumonia			16.1

Source: Cares Engagement Network, 2019

Cancer, has the highest cause of mortality in Nebraska and Keith County, while Heart Diseases has a larger effect on Garden County. There are four prevalent cancer groups in Nebraska and Keith County (data for Garden County is suppressed, meaning there are three or fewer incidences to report), colon, lung, prostate, and breast. Chart F shows the breakdown by incidence for Keith County, Nebraska, and the U.S.

Chart F. Cancer Incidences, 2012-2016



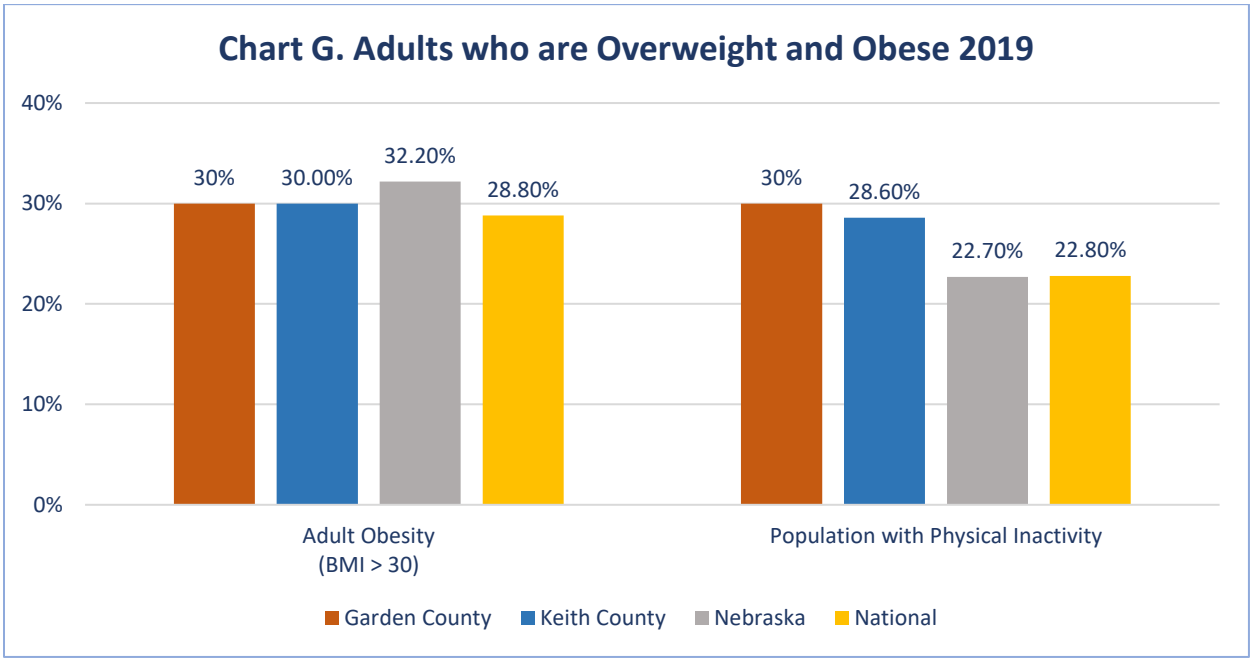
	Breast (Female Only)	Prostate (Male Only)	Lung	Colon
US (Both Sexes)	125.2	104.1	59.2	38.7
Nebraska	124.6	111.2	57.7	43
Keith County (Both Sexes)	169.3	121.7	60.9	43.7

Source: National Cancer Institute, 2016

Obesity can be an indicator for chronic diseases down the road, factors that can be attributed to obesity are both genetic and community environmental factors, such as physical inactivity and food access (CDC, 2017). Obesity is defined as having a Body Mass Index (BMI) score greater than 30 (BMI > 30.0), while being overweight, a precursor to obesity, is defined as having a BMI from 25 to 30 (CDC, 2015). Body Mass

Index is determined by a person's height and weight and is a standard measure for determining if a person is underweight, overweight, has a normal weight, or is obese.

Chart G shows the populations national, state, and county trends of obesity and physical inactivity prevalence. Nearly one third of the adult populations in Keith and Garden County are obese, lower when compared to the state. Both counties have a higher prevalence of physical inactivity compared to state and national data (County Health Rankings, 2019).



Source: County Health Rankings, 2019

PRIORITY #3: BEHAVIORAL HEALTH (SUBSTANCE ABUSE / DEPRESSION / BEHAVIORAL HEALTH)

Behavioral Health encompasses both mental health conditions, such as depression and anxiety disorder; and substance abuse issues, including opioid addiction, alcohol, illicit drugs, and tobacco. According to Substance Abuse and Mental Health Services Administration in 2018 47.6 million U.S. adults experienced mental illness, representing 1 in 4 adults or 19.1 percent of the adult population in the U.S (SAMHSA, 2019). A limitation in understanding the behavioral health needs in Keith and Garden County as well as Nebraska is the lack of up to date data, most data is 3+ years old. This limitation impacts the ability for health professionals to understand the size and type of behavioral health needs within the communities.

Table 7 provides the ratio of the population to mental health care providers for Keith County, the state, and the U.S., Garden County was not reported. Based on data from the County Health Rankings Keith County has a behavioral health provider demand, this aligns with focus group input – community members continue to identify lack of behavioral health services as a need in their community.

Table 7. Access to Mental Health Care Providers in 2019			
	Keith County	**Nebraska**	**US**
Ratio of Population to Mental Health Providers	730:1	400:1	310:1

Source: County Health Rankings, 2019

Nearly 14 percent of Garden County residents (13.8%) report their health as fair or poor compared to Keith County at 14.8 percent, both counties have lower reports of overall health compared to the national average of 15.7 percent and higher compared to the state average of 12 percent (CARES Engagement Network 2019). In 2014 Suicide was the 11th leading cause of death in Nebraska and has been increasing steadily since 2009. For youth in Nebraska, one in seven report having seriously considered suicide in the past year, and one in eleven reported having attempted suicide in the past year (Nebraska DHHS, 2016).

Both Keith and Garden County have large populations of residents age 65 and older, it is anticipated that the aged populations will continue to grow disproportionately within the counties when compared with other age groups and the states projected growth. The elderly are at an increased risk of developing depression related to risk factors often experienced by older adults, such as chronic medical conditions and decreased mobility which can result in social isolation.

In Keith and Garden County 19 percent and 18 percent of the population, respectively, report binge or heavy drinking, this is lower than the state average of 21 percent and higher when compared to the national rate of 13 percent (County Health Rankings 2019). In 2015, around 22.7 percent of youth in Nebraska reported consuming alcohol within the last month (Nebraska DHHS, 2016). In 2019 over one third, 35 percent, of fatal motor vehicle accidents involved alcohol.

In Nebraska it is difficult to understand the impact the opioid epidemic is having across the state due to the lack of data for each county and age of data publicly reported. The National Institute of Health indicates that in 2017 the drug overdose rate for Nebraska was 8.1 per 100,000 persons, nearly 2/3rds less than the national average. However, based on the differences in state reporting and NIH standards, the majority of opioid associated deaths were not included for Nebraska because the data did not meet the standards for reporting (NIH, 2019). It is estimated that 2/3rds of drug overdose deaths involve an opioid (CDC, January 2019). In regard to opioid prescriptions, Nebraska is slightly below the national average, writing 56.6 opioid prescriptions per 100 persons compared to the national rate of 58.7 per 100 persons (NIH, 2019).

Lung disease as the result of vaping is a rising health concern, specifically its effects on the health and health behaviors of youth, as of November there are currently over 2,000 confirmed and probable cases, not including cases that are under investigation. Vaping has affected 36 states, resulted in nearly 50 deaths, and the numbers continue to rise (CDC, September 2019). Characteristics that factor into an adolescent smoking include, older age (High School aged), being male, being white (compared to Black

and Hispanic adolescents), lacking college plans, having parents who are not college educated, and experiencing highly stressful events (HHS, 2019).

NEEDS IDENTIFIED BUT NOT PRIORITIZED

Focus Group participants identified e-cigarette use, specifically youth and their utilization of the e-tobacco product, as a health priority. Since vaping falls into the priority of substance abuse / behavioral health, it was decided not to focus on at this time.

2016 CHNA Follow Up and Review

Feedback on Preceding CHNA / Implementation Strategy

In the focus groups the facilitators referred to the cycle 2 CHNAs significant areas. Specific feedback on the impact the strategies developed to address the health need is included in Table 8 below. In addition, the link to the 2016 report was posted on the Bannerhealth.com website and made widely available to the public. Over the past three years little feedback via the email address has been collected, but the account has been monitored.

In order to comply with the regulations, feedback from cycle 3 will be solicited and stored going forward. Comments can be sent to CHNA.CommunityFeedback@bannerhealth.com

Impact of Actions Taken Since Preceding CHNA

Table 8 indicates what actions have been taken on the cycle 2 CHNA action plan in creating impact in the Ogallala Community Hospital PSA.

Table 8. Implementation Strategies 2016 for Ogallala Community Hospital Primary Service Area

Significant Need #1: Access to Care
Strategy #1: Increase use of Banner Urgent Care facilities and improve access to primary care services
Impacts of Strategy: • We have collaborated with other local healthcare resources to align patients with services. • We offer educational materials and links to community resources related to the insurance marketplace • OCH continues to offer and participate in free health activities such as screenings and blood drives. • We continue to promote MyBanner, our online patient portal.
Significant Health Need #2: Chronic Disease (Diabetes / Heart Disease)
Strategy #1: Increase personal management of Chronic Disease
Impacts of Strategy: • We have 3D mammography now in place. • We promote our Chronic Disease webpage on the facility website to increase the educational opportunities and resource awareness.
Significant Need #3: Behavioral health (Mental Health & Substance Abuse)
Strategy #1: Increase identification of behavioral health needs and access to early interventions
Impacts of Strategy: • We are using Banner Health's depression screening tool in primary care provider clinics and pediatric provider clinics within Banner Medical Group • We promote our Behavioral Health webpage with resources and information for Mental Health and Substance Abuse.

APPENDIX A. RESOURCES POTENTIALLY AVAILABLE TO ADDRESS NEEDS

Listed below are available resources in the community to address the three priority needs:

Name of Organization	Phone Number	Address	Priority Area
Heartland Counseling	(308) 284-6767		BH / SA
Ogallala Counseling	(308) 284-6519		BH / SA
Health & Human Services	(308) 284-8080		Other
Camelot Transportation	(888) 452-3194		AC
Handi Bus	(308) 284-6400	411 East 2nd Street, Ogallala, NE 69153	AC
Banner Medical Group	(308) 284-3645	2601 N Spruce Street, Ogallala, NE 69153	CD
Family Medical Center	(308) 284-8421	221 East 10th, Ogallala, NE 69153	CD
Vitality Chiropractic Lifestyle Center	(308) 284-9858	10 North Sprucet Street, Ogallala, NE 69153	CD

APPENDIX B. LIST OF DATA SOURCES

PRIMARY AND SECONDARY DATA SOURCES

The primary data sources that were utilized to access primary service information and health trends include:

Advisory Board (2019) Primary Service Area Demographic Data.

Cares Engagement Network. (2019) Keith and Garden County Community Health Needs Assessment Report.

County Health Rankings and Roadmaps. (2019) Nebraska Health Outcomes and Factors.

Elliott, M. K. Beattie, S. E. Kaitfors. (May 2001) Health needs of people living below poverty level. Family Medicine; 33(5): 361–366.

Health and Human Services – Office of Population Affairs. (April 2019) Adolescents and Tobacco: Risk and Protective Factors

Health and Human Services – Health Resources and Services Administration (February 2019) Health Professional Shortage Area.

Khullar, Dhruv and Chokshi, Dave A. (October 2018) Health, Income, & Poverty: Where We Are & What Could Help. Health Affairs – Health Policy Brief the Culture of Health.

McKesson. (2018) Primary Service Area Data Set.

Nebraska Department of Health & Human Services. (2016) State Health Assessment: Nebraska.

Nebraska Division of Public Health. (2016) Nebraska 2016 Vital Statistics Report.

National Cancer Institute. (2016) State Cancer Profiles Nebraska- Incidence.

National Center for Disease Control and Prevention – Division of Nutrition, Physical Activity, and Obesity. (May 2015) Healthy Weight – Assessing Your Weight Body Mass Index.

National Center for Disease Control and Prevention – Division of Nutrition, Physical Activity, and Obesity. (2017). Adult Obesity Causes and Consequences.

National Center for Disease Control and Prevention – Morbidity and Mortality Weekly Report. (January 2019) Drug and Opioid Involved Overdose Deaths 2014 -2017.

National Center for Disease Control and Prevention – Smoking & Tobacco Use. (November 2019) Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products.

Substance Abuse and Mental Health Services Administration - Center for Behavioral Health Statistics and Quality. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health.

Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: transportation barriers to health care access. *Journal of community health*

Truven. (2018) Nebraska State Data.

U.S. Census Bureau. (2017) American Community Survey

U. S. Department of Agriculture – Economic Research Service (2019) Atlas of Rural and Small-Town America, Rural -Urban Continuum Code.

FOCUS GROUPS

Date	Time	Location
Monday, June 24th, 2019	12:00 PM	Mid Plains Community College
Tuesday, October 8th, 2019		

FOCUS GROUP DEMOGRAPHICS

Characteristics	Number
Gender	
Male	4
Female	3
Identifies at LGBTQ+	
Race/Ethnicity	
White	7
Marital Status	
Married	5
Widowed, separated, or, divorced	
Never married	2
Employment	
Full-time	6
Part-time	1

APPENDIX C. STEERING COMMITTEE AND STAKEHOLDERS

STEERING COMMITTEE

Banner Health CHNA Steering Committee, in collaboration with Ogallala Community Hospital's leadership team and Banner Health's Strategic Planning and Alignment department were instrumental in both the development of the CHNA process and the continuation of Banner Health's commitment to providing services that meet community health needs.

Steering Committee Member	Title
Darin Anderson	Chief of Staff
Derek Anderson	AVP HR Community Delivery
Ramanjit Dhaliwal	AVP Division Chief Medical Officer Arizona Region
Phyllis Doulaveris	SVP Patient Care Services / CNO
Kip Edwards	VP Facilities Services
Anthony Frank	VP Financial Operations Care Delivery
Russell Funk	CEO Pharmaceutical Services
Larry Goldberg	President University Medicine Division
Margo Karsten	President Western Division / CEO Northern Colorado
Becky Kuhn	Chief Operating Officer
Patrick Rankin	CEO Banner Medical Group
Lynn Rosenbach	VP Post-Acute Services
Joan Thiel	VP Ambulatory Services

CHNA Facility-Based Champions

A working team of CHNA champions from each of Banner Health's 28 Hospitals meets on a monthly basis to review the ongoing progress on community stakeholder meetings, report creation, and action plan implementation. This group consists of membership made up of CEOs, CNOs, COOs, facility directors, quality management personnel, and other clinical stakeholders.

Stakeholders

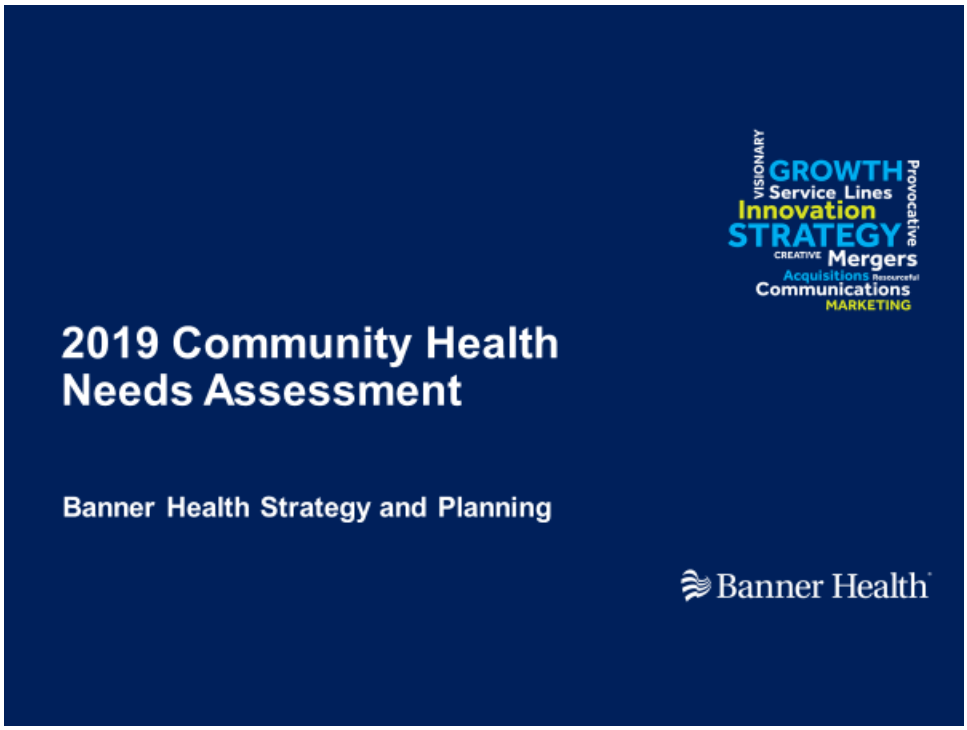
This list, while not exhaustive, identifies individuals/ organizations external to Banner Health that represent the underserved, uninsured, and minority populations. Stakeholders were identified based on their role in the public health realm of the hospital's surrounding community. These stakeholders are individuals/ organizations with whom we are collaborating, or hope to do, around improving our communities. Each stakeholder is vested in the overall health of the community and brought forth a unique perspective with regards to the population's health needs. This list does not include all the individuals and organizations that have participated in the focus groups.

Name	Organization	Area of Expertise
Mike Apple	Ogallala Public School	School/Youth
Dr. Wong	Ogallala Community Hospital	Medical
Shelly McQuillan	Ogallala Community Hospital	Social Work in Community
Father Brian Ernest	St. Luke's Catholic Church	Spiritual
Linda Baldwin	Ogallala Community Hospital	Medical
Mary Wilson	Keith County Area Development	
	Sandhill's Crisis Intervention Program (SCIP)	Social Work
	Bridge of Hope Child Advocacy Center	
Region II - Robin	APS/CPS	
	Food Pantry	Access to Food
Peggy Rogers	Indian Hills Nursing Home	Aging
	Keith County Senior Center	Aging

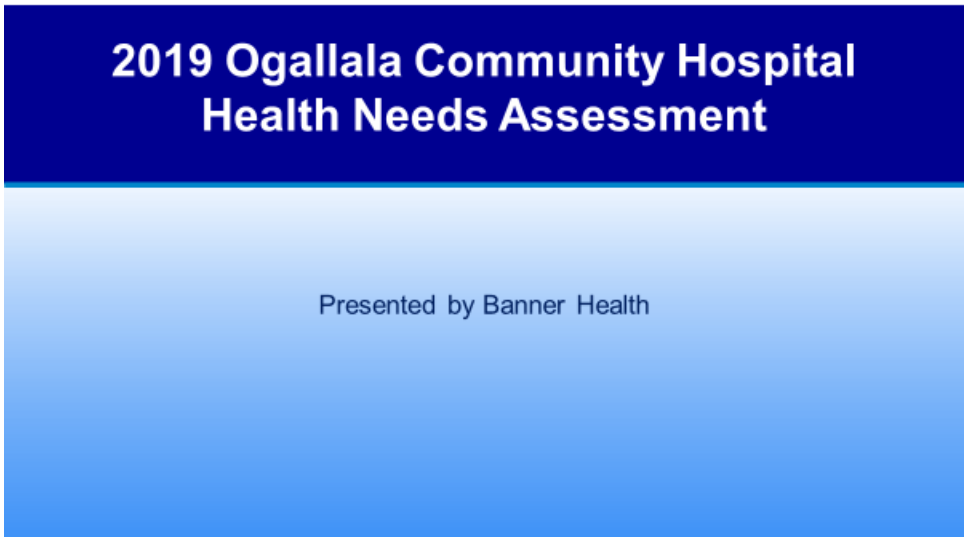
Name	Organization	Area of Expertise
	NE Respite Network	
Karla Scott	Ogallala Chamber of Commerce	Business
	Ogallala Women's Resource Center	Social Work
	WIC (Women, Infant, Children)	Public Health / Social Work
	Southwest NE Public Health Department	Public Health
	Welcov Assisted Living	
	West Central District Health	Public Health
Laura Nielson	Ogallala Housing	
	West Central	
	Ogallala Village	
Carol Packard, PA	Family Medical Center	Medical
	Regional West Home Health & Hospice	
Amy Richards	Rooted in Relationships	Social Work
James Herman - Chief	Ogallala Police Department	Safety
	Ogallala Head Start	Education

APPENDIX D. MATERIALS USED IN FOCUS GROUP

Slides used for focus groups



Banner Health



Banner at a Glance

- 28 Acute Care and Critical Access Hospitals
- Behavioral Hospital
- Banner Health Network
- Banner Network Colorado
- Banner Medical Group and Banner – University Medical Group with nearly 2,000 physicians and advanced practitioners and more than 200 Banner Health Centers and Clinics
- Banner Home Care and Hospice
- Outpatient Surgery
- Urgent Care
- Banner – University Medicine division
- $7 billion in revenue in 2015
- AA- bond rating
- $746 million in community benefits, including $62.9 million in charity, 2015

Banner Health

Community Health Needs Assessment Purpose

- Gather input and feedback from community leaders that represent the community
- Validate and/or identify significant areas of healthcare need within the community
- Promote collaborative partnerships
- Identify opportunities to engage with the community in addressing potential areas of need
- Requirement of the Patient Protection and ACA

Banner Health

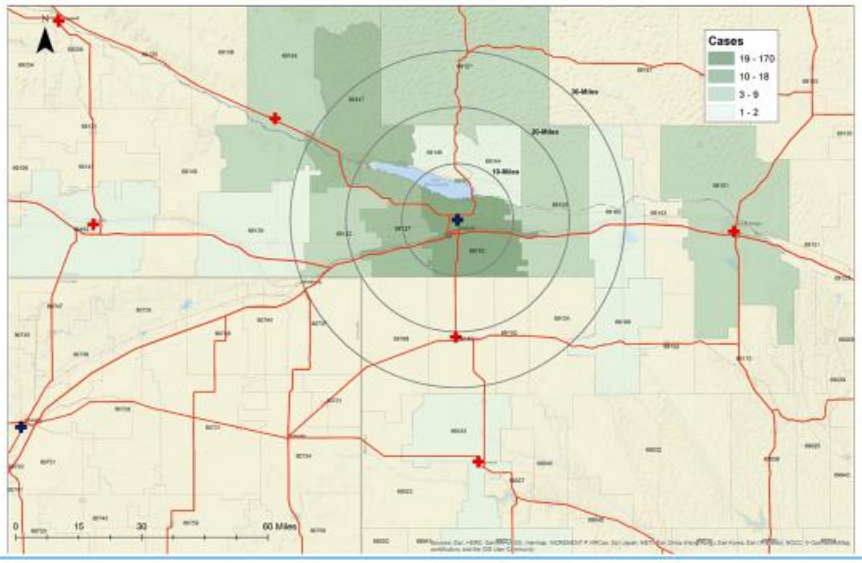
2018 OCH Community Benefit

Facility:	Bad Debt:	Charity Care:	2018 Community Benefit:
OCH	$1,198,000	$1,218,000	$2,416,000

Source: Banner Financials December 2018 - Unaudited

OCH - Inpatient Origin by Zip Code

January 1, 2018 through December 31, 2018 (Top 3 contiguous quartiles = 75% of total discharges)



Source: Banner Strategy and Planning

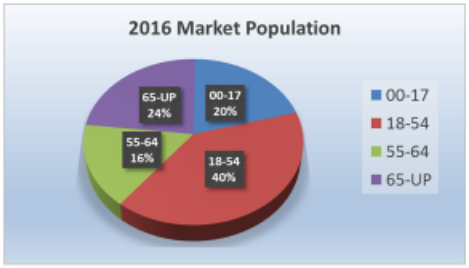
OCH 2017 Demographic Snapshot – Keith County

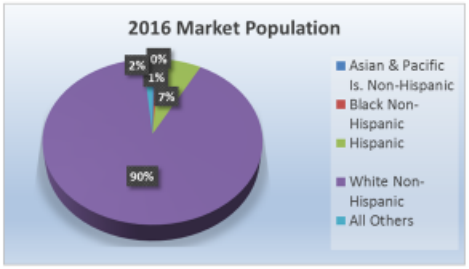
2016 Truven Health Analytics, Inc

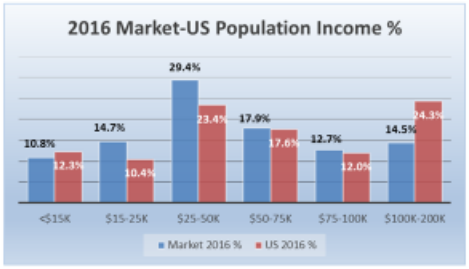
Banner Health

Keith County, Nebraska

Population and Gender	Market 2016 Population	Market 2016 % of Total	Market 2021 Population	Market 2021 % of Total	Market Population % Change
Female Population	3,915	50.2%	3,885	50.2%	(0.8)%
Male Population	3,891	49.8%	3,861	49.8%	(0.8)%
Total	7,806	100.0%	7,746	100.0%	(0.8)%







Source: Truven Health Analytics, Inc

Banner Health

County Health Rankings

Health Outcomes

- Health outcomes in the *County Health Rankings* represent how healthy a county is. They measured two types of health outcomes: how long people live (mortality) and how people feel while alive (morbidity).

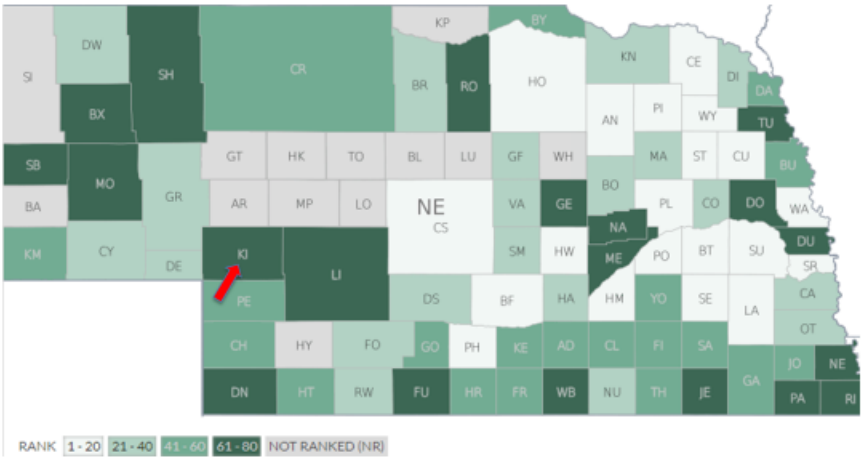
Health Factors

- Health factors in the *County Health Rankings* represent what influences the health of a county. They measured four types of health factors: health behaviors, clinical care, social and economic, and physical environment factors. In turn, each of these factors is based on several measures.

Source: www.countyhealthrankings.org

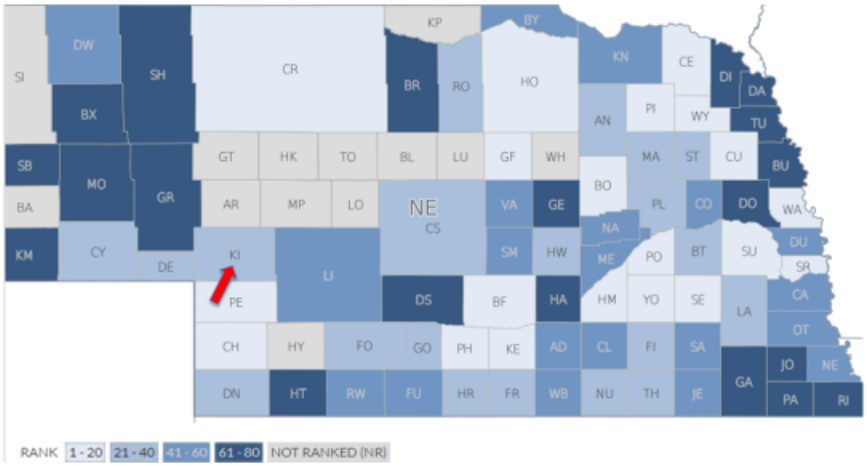
Banner Health

2018 Nebraska County Health Outcomes Rankings
Keith County #76 of 80 ranked



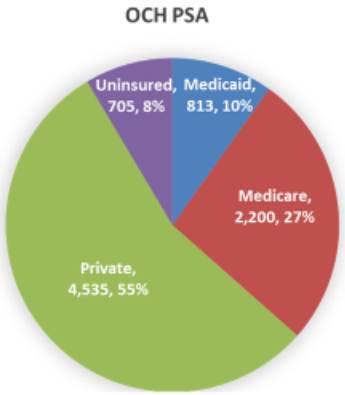
Source: http://www.countyhealthrankings.org/app/nebraska/2018/rankings/keith/county/

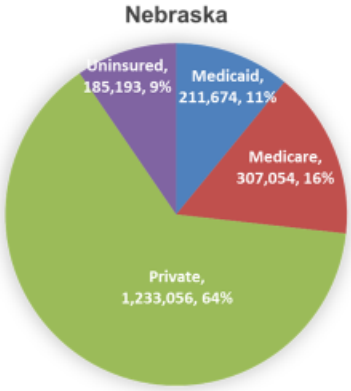
2018 Nebraska County Health Factors Rankings
Keith County #30 of 80 ranked



Source: http://www.countyhealthrankings.org/app/Nebraska/2018/rankings/Keith/county

2019 Insurance Estimates = Top 75% Patient Origin*





PSA/Top 75% Patient Origin Zip Codes:
69127, 69147, 69153, 69154

*Patient Origin Source: 2017 State Data
Insurance Estimates Source: Truven

2018 County Health Rankings

- Keith County ranks 76 out of 80 Nebraska Counties in Health Outcomes
- Adult smoking and adult obesity are areas of improvement to explore, compared to national benchmark
- Preventable hospital stays and mammography screening are areas of improvement compared to national and state measures

Source: www.countyhealthrankings.org

	Keith County	Rank of 80	Top U.S. Performers	Nebraska
Health Outcomes		76		
Length of Life		55		
Premature death	7,400		5,300	6,000
Quality of life		76		
Poor or fair health**	15%		12%	14%
Poor physical health days**	3.1		3.0	3.2
Poor mental health days**	3.0		3.1	3.1
Low birth weight	9%		6.0%	6%
Health Factors		30		
Health Behaviors		15		
Adult Smoking**	16%		14%	14%
Adult Obesity	28%		26%	31%
Food Environment Index	8.0		8.6	8.1
Physical Inactivity	28%		20%	23%
Access to exercise opportunities	81%		91%	83%
Excessive Drinking**	19%		13%	21%
Alcohol impaired driving deaths	13%		13%	37%
Sexually transmitted infections	73.9		145.1	422.9
Teen births	31		15	25
Clinical Care		49		
Uninsured	9%		6%	9%
Primary Care Physicians	1,610:1		1,030:1	1,340:1
Dentists	1,600:1		1,280:1	1,360:1
Mental Health Providers	620:1		330:1	420:1
Preventable Hospital Stays	64		35	48
Diabetic Monitoring	86%		91%	87%
Mammography Screening	49%		71%	62%

Area of Strength
Area of Concern

Source: http://www.countyhealthrankings.org/app/nebraska/2018/rankings/keith/county/

** Data should not be compared to prior years

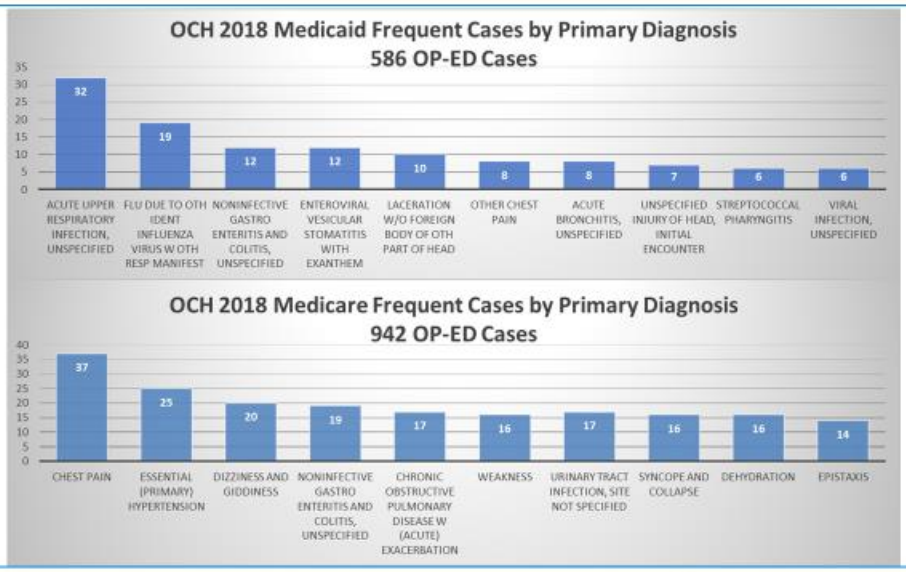
	Keith County	Rank of 80	U.S. Benchmark	Nebraska
Social & Economic Factors		47		
High School Graduation	92%		95%	87%
Some College	73%		72%	71%
Unemployment	3.1%		3.2%	3.2%
Children in Poverty	19%		12%	14%
Income Inequality	4.5		3.7	4.3
Children in Single-parent households	37%		20%	29%
Social Associations	22.3		22.1	13.9
Violent crimes	77		62	267
Injury Deaths	72		55	58
Physical Environment		10		
Air pollution-particulate matter	7.2		6.7	8.2
Drinking water violations	No		No	
Severe housing problems	8%		9%	13%
Driving alone to work	78%		72%	81%
Long commute-driving alone	15%		15%	18%

Area of Strength
Area of Concern

Source: http://www.countyhealthrankings.org/app/nebraska/2018/rankings/keith/county/

** Data should not be compared to prior years

Outpatient ED Visits Frequent Diagnosis



Source: Banner McKesson 2018 Full year

2019 Community Feedback

1. Behavioral Health
   Vaping/Substance Abuse
   Synthetic Pain Medications (Fentanyl, Morphine, etc)
2. Access to Care
3. Chronic Disease

2016 Prioritized Community Health Needs

1. Behavioral Health

Both mental health and substance abuse

- Perception is there's little else to in small towns but drink and do drugs
- Children exposed to behaviors in homes
- Treatment in small town a stigma, perceived judgment prevents seeking treatment
- Limited resources
- Forced into ED for treatment or jail
- Transport issues to larger communities with resources to treat
- Tele-health and gap services opportunities exist

2016 Prioritized Community Health Needs

2. Access to Care

Understanding what is covered

- Costs are driving decision-making, if they can't afford care, won't seek
- Delayed care often means more costs associated with care
- Medicaid had not expanded under ACA
- Long wait times for care and higher physician turnover rates talking toll on community
- Lack of after hours care
- No Urgent Care alternative forces higher ED use/costs

2016 Prioritized Community Health Needs

3. Chronic Disease

Includes cancer, heart disease, diabetes and obesity

- High drivers of health costs
- Ranked 75th of 80 counties in NE for poor health
- Decreasing physical activity and increasing adult obesity trends
- Ease of access to unhealthy foods
- Education needed to improve quality food preparation and consumption
- Need more screening education efforts

2016 Top Needs Not Being Met

From 2016 - IMPORTANT ISSUES DISCUSSED BUT NOT PRIORITIZED: The following were brought up in by the CAC but not something they felt could be addressed at this time:

Transportation: This is becoming more significant as people can't get a ride home from hospital if they are outside city limits. They may also have appointments outside the county and can't get to them. While there is a handi-bus outside the city limits which helps people to schedule appointments and shopping, it is not a long term solution as the schedule is limited. Due to increasing support for the handi-bus, it was thought that services may be expanding and the need was going to be addressed.

Senior Services: An aging population affects the need for access to care, preventative care and mental health services. If this was focused on in the future, it could possibly reduce medical costs later on. Lack of long range planning and end of life directives are something that could be impacted by simple education and outreach. Because services for this would require a capital investment, it was not something the CAC felt they could have an impact on.

Tobacco Use: Smokeless tobacco is becoming an issue as well as e-cigarettes. Children drinking vapor liquid was mentioned as increasing the number of calls to poison control. Because this is a newer trend, the group wanted to wait and see data in the next cycle of CHNA. Also, the rates of smoking decreased since the previous CHNA and the group agreed it should not be prioritized.

2016 Previous Actions Taken

Access to Care
- Promoted participation in MyBanner (online patient portal)
- Offered educational materials and links to community resources related to the insurance marketplace
- Promoted internal and external community resources that support preventative and maintenance care via the facility website
- Hired 2 new providers for the community

Chronic Disease
- Developed a Chronic Disease webpage on the facility website to increase on-line educational opportunities and resource awareness
- Expanded Diabetic Education and Nutrition programs
- Provided health screenings and educational materials

Behavioral Health
- Created a webpage with information and resources related to Mental Health and Substance Abuse
- Provider to provider telephone consults

Smoking/Tobacco Use
- Partnered with the State Quit Line to build the Proactive Referral into the Banner Medical Group clinic workflows
- Supported a Tobacco Free campus

Obesity/Nutrition
- Sponsorships focused on wellness, healthy eating
- Online education, support and recipes

Next Steps…

- Behavioral Health
  - Vaping/Substance Abuse
  - Synthetic Pain Medications, Fentanyl/Morphine
- Access to Care
- Chronic Disease