2025 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT

Identification and assessment of the health needs of the primary and secondary service areas served by Faith Regional Health Services. Submitted in fiscal year ended December 31, 2025, to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) and to satisfy the requirements set forth in IRS Notice 2011-52 and the Affordable Care Act for hospital facilities owned and operated by an organization described in Code section 501(c)(3).

Adopted by Board Resolution on December 23, 2025

To Our Residents in Northeast Nebraska:

Faith Regional Health Services welcomes you to review the 2025 Community Health Needs Assessment (CHNA) as we strive to meet the health and medical needs in the communities we serve. All not-for-profit hospitals are required to develop this report in compliance with the Affordable Care Act.

The CHNA identifies health and medical needs specific to our service area and provides a plan to indicate how FRHS will respond to such needs. This document suggests areas where other area organizations and agencies might work with us to achieve desired improvements. Faith Regional is committed to meeting our obligations to deliver medical services efficiently.

We do not have adequate resources to solve all the problems identified in the survey that was conducted in our service area. Some issues are beyond the mission of the hospital, and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. The CHNA is a working plan that allows multiple agencies to collaboratively bring the best each has to offer to address the more pressing needs in our area. This report will guide our actions and the efforts of others to make needed health and medical improvements.

As you read through the CHNA, please think about how you can help to improve the health and medical services our area needs. We all live and work in communities throughout Northeast Nebraska, and by working together, our collective efforts can make living here healthier.

Thank You

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Executive Summary

Faith Regional Health Services – ("FRHS" or "Hospital") – is organized as a not-for- profit hospital system. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "community benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures FRHS identifies and responds to the primary health needs of its residents. FRHS partnered with the Elkhorn Logan Valley Public Health Department to complete a joint Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). A shared plan helps to ensure that progress on the identified priorities are approached in unison, while considering the various contributions of all partners, and offers a thorough analysis of the current programs and resources, as well as the existing gaps in the current programs, activities and services. This partnership allows for the following:

- Conduct community health needs survey and provide Hospital with survey results;
- Provide Hospital with information required to complete IRS-990h schedule;
- Produce necessary information from Public Health Departments' Community Health Improvement Plans for Hospital to issue an assessment of community health needs and document its response to those needs.

This community health improvement plan was developed through a collaborative process led by the Elkhorn Logan Valley Public Health Department (ELVPHD) involving a wide variety of local community partners and stakeholders. It serves to describe the priority health issues identified through the community health assessment process and outlines the work plan developed to address those issues. Individuals and organizations involved in the effort thus far have committed to continue their participation as workgroup members to strategically implement work plan action items. A tracking system will be developed to document activities completed by all participating workgroup partners, and periodic progress updates for each priority health issue.

Plan Ownership

There are many reasons why Faith Regional Health Services (FRHS) chose to partner with the Elkhorn Logan Valley Public Health Department (ELVPHD) and its respective district hospitals to complete the joint Community Health Needs Assessment (CHNA). First, Madison County is the largest populated county in the FRHS primary and secondary service area. Second, to improve overall community health requires the assistance of multiple partners. Third, all the area hospitals are now required to complete both a Community Health Needs Assessment and Community Health Improvement Plan to meet IRS requirements to maintain their non-profit status.

The non-profit partnering hospitals include:

1. Franciscan Healthcare—West Point, NE
2. Faith Regional Health Services—Norfolk, NE

In addition, the Midtown Health Center, Inc. (the local, Federally Qualified Health Center), must satisfy requirements for their ongoing federal funding. Continued success of the Midtown Health Center is a vital necessity in the ELVPHD District as a major provider of healthcare to the uninsured and underinsured populations in the area. The Northeast Nebraska Area Agency on Aging (NENAAA) uniquely represents and oversees programs to address the health and well-being of aging residents in the district. The agency provides direct programming to assist elders in the area, and oversees the senior citizen centers, which provide a range of services to assist the aging population locally.

DETERMINING HEALTH PRIORITIES

HOW DID WE GET HERE?

The Community Health Assessment and Community Health Improvement Plan were developed through a community-driven strategic planning process called Mobilizing for Action through Planning and Partnership 2.0 (MAPP). The MAPP process commenced in December 2024 and took approximately eight months to complete.

Elkhorn Logan Valley Public Health Department (ELVPHD) guided the processes and incorporated representatives of varying organizations throughout the health district.

The Community Health Assessment (CHA) was completed by obtaining and reviewing health data for the community. The Community Health Improvement Plan details strategic issues noted throughout the assessment process, and outlines goals and strategies to address identified health priority areas.

The full data report from the CHA related to the health of the Elkhorn Logan Valley Public Health Department service area referenced throughout this document can be found on the ELVPHD website: www.elvphd.ne.gov.

PURPOSE

We recognize that by including members from many organizations throughout the community, we can accomplish more than what could be done by any one organization alone. The purpose of the Community Health Improvement Plan (CHIP) is to align efforts of these various organizations to move forward in improving the health of the community in a strategic manner. Community partnership also serves to create a broader representation of community perspectives and shared ownership of the efforts aimed to address identified priority health issues. What follows is the result of the community's collaborative effort and planning to address health concerns in a way that combines resources and energy to make a measurable impact on the health issues of the Elkhorn Logan Valley Public Health Department district.

PROCESS

The CHA incorporates a broad range of both qualitative and quantitative data. The secondary quantitative data were pulled from national, state, and local sources on MySidewalk; these allow for trend analysis and comparisons to both state and national levels.

Qualitative data was sourced from the CHA data gathered in February-May 2025 and from Community Partner/Stakeholder Input gathered in August 2025.

During June 2025, ELVPHD assembled the Community Health Assessment data report. This full data report was shared with partners and stakeholders in August 2025, who provided input on the CHIP priorities and potential strategies via an online surveying process. The sectors representing stakeholder input on the CHIP priorities and strategies included: hospitals and healthcare (both medical and behavioral health), long-term care facilities, government, schools, college, organizations representing the aging population, organizations representing those with health disparities, the faith community, law enforcement, organizations and groups representing minority populations, community-based organizations, and ELVPHD board members and staff.

ELVPHD, then, utilized that input to further refine the goals, objectives, and strategies for the CHIP based upon the partner and stakeholder input. Additionally, partners and stakeholders who indicated their intent to participate in ELVPHD's Health Improvement Coalition will meet throughout the period of this CHIP to provide continued input, assist with implementation action plans, and ensure progress is being made to obtain goals. ELVPHD will be the lead agency in convening the Health Improvement Coalition meetings and measuring progress for annual reporting on the priorities, strategies and activities defined in the CHIP.

PRIORITY 1: *Mental Health*

Goal: Improve access to and utilization of mental health services to support overall well-being

PROCESS OF SELECTING MENTAL HEALTH AS A PRIORITY SELECTION:

The CHA responses (1,376 total respondents) of the general public reflected that mental health was the top health concern among residents of the district. Additionally, the stakeholder/partner engagement input also identified mental health as the top concern; therefore, mental health was deemed priority 1 for the Community Health Improvement Plan, as not only was it the top health concern from the general public, but also from collaborative partners.

DATA SUPPORTING MENTAL HEALTH AS A PRIORITY:

Mental Health Primary Data from the CHA:

Of the 1,376 responses which were gathered during the Community Health Assessment phase, there were several questions pertaining specifically to mental health, social determinants of health, and/or substance use/abuse. The results of several of these questions reflected that the data supported mental health as a priority.

19% of individuals indicated that their mental health was not good for 6 or more days out of the past 30 days.

53% of individuals indicated that mental health (depression, anxiety, stress, suicide) was their highest health concern.

42% of respondents indicated that their own or a family member's health status has caused additional stress.

49% of respondents indicated that over the past 2 weeks they have felt down, stressed, anxious, depressed or hopeless on several days or more.

Mental Health Secondary Data for the ELVPHD health district:

All four counties of the ELVPHD service area (Burt, Cuming, Stanton and Madison counties) are considered behavioral health professional shortage areas as per the Health Resources and Services Administration.

Depression rates in the district are similar to Nebraska overall with 17.4% of ELVPHD service area residents noted as having been diagnosed with depression, as compared to

17.7% of Nebraskans as per the CDC BRFSS PLACES, 2022.

Secondary data from the CDC BRFSS PLACES, 2022, also indicates that ELVPHD residents have a slightly higher percentage of those who are indicated as having "poor mental health" at 14.3% versus the State average of 14.1%.

Substance Use/Abuse Primary Data from the CHA:

Of the 1,376 responses gathered during the CHA phase, 12.7% of respondents indicated that they have experienced additional stress due to their own or a family member's alcohol or drug use in the past 6 months.

34% of CHA respondents indicated that drug and/or alcohol abuse was a top health concern for the community.

Social Determinants of Health Primary Data from the CHA:

Social determinants of health (SDOH) are contributing factors which affect the ability of people to access health care (including mental health services) and achieve positive health outcomes. Data from the CHA indicated that 12.9% of individuals were unable to pick up medications and/or attend doctor appointments due to financial hardship.

Social Determinants of Health Secondary Data for the ELVPHD health district:

Several data points from the US Census Bureau 5-year review from 2019-2023 indicates the following social determinants challenges for the service area with regard to poverty levels, disabilities and educational attainment:

10.9% of ELVPHD's population lives below the poverty level as compared to 10.3% of Nebraskans overall.

12.5% of the population is indicated as living with a disability as compared to 12.1% for Nebraska overall. Notably, Burt county in the ELVPHD service area indicates that 17.9% of the population is living with a disability.

Mental Health Assets & Resources:

Healthcare providers, hospitals, behavioral health agencies, public health, schools and community-based organization

PRIORITY 2: *Cancer Prevention*

Goal: Increase access to and utilization of preventative cancer screening

PROCESS OF SELECTING CANCER PREVENTION AS A PRIORITY SELECTION:

The CHA responses (1,376 total respondents) of the general public reflected that cancer was the second most prevalent health concern among residents of the district. Additionally, the stakeholder/partner engagement input also identified cancer prevention was a main concern.

DATA SUPPORTING CANCER PREVENTION AS A PRIORITY:

Cancer-Related Primary Data from the CHA:

Of the 1,376 responses which were gathered during the Community Health Assessment phase, there were several questions pertaining specifically to cancer prevalence, screening, and cancer-prevention lifestyle factors. The results of several of these questions reflected that the data supported cancer prevention as a priority.

50% of individuals indicated that cancer was a health condition of the highest concern in their community (ranked the #2 concern of survey respondents).

41.4% of women aged 40-74 had not completed a mammogram in the past 2 years.

23% of women aged 21-65 had not completed a cervical (pap) screening in more than 3 years.

18% of respondents indicated that they either cannot afford health insurance, or they have health insurance but their deductible or co-pay is too high, which is a barrier to accessing timely, preventative health care.

Cancer-Related Secondary Data for the ELVPHD health district:

Routine medical care is an important consideration for the prevention of cancer. According to the CDC BRFSS PLACES 2022, 73.4% of adults in the ELVPHD health district had a doctor check-up in the past year, which is lower than the State of Nebraska's percentage of 74.1%.

Additionally, the CDC BRFSS PLACES (2022) data also showed lower rates of preventative care utilization in the district for mammography, cervical screening and colorectal screening as follows:

73.5% of women (aged 50-74) in the ELVPHD district had received a timely mammogram as compared with 75.2% for Nebraska overall.

Cervical Screening (pap) rates were indicated at 80.5% for women 21-65 in the ELVPHD service area as compared with 81.5% for women in the same age group in Nebraska.

Colorectal screening also was lower for the district (adults aged 50-75) at 61.6% as compared with 62.8% for all Nebraskans.

Lifestyle factors also are important to prevention of cancer and other chronic diseases. The following secondary data reflects areas of concern with regard to lifestyle-related factors in the district:

40.1% of ELVPHD district adults are obese as compared to 37.2% for Nebraska overall.

27.4% of adults in the district fall into the category of being physically inactive compared to 25.2% for Nebraska.

The ELVPHD service area has an 8.9% incidence of cancer (excluding skin cancers) among adults as compared with 8.0% for Nebraskans overall.

Cancer Prevention Assets & Resources:

Healthcare providers, hospitals, public health and community-based organizations.

PRIORITY 3: *Chronic Disease*

Goal: Promote preventative lifestyle choices to prevent and/or manage chronic disease

PROCESS OF SELECTING CHRONIC DISEASE AS A PRIORITY SELECTION:

The CHA responses (1,376 total respondents) of the general public reflected that chronic disease/obesity was the third most prevalent health concern among residents of the district. Additionally, the stakeholder/partner engagement input also identified that chronic disease was a primary concern.

DATA SUPPORTING CHRONIC DISEASE AS A PRIORITY:

Chronic Disease-Related Primary Data from the CHA:

Of the 1,376 responses which were gathered during the Community Health Assessment phase, there were several questions pertaining specifically to chronic disease/ obesity prevalence and chronic disease risk factors. The results of several of these questions reflected that the data supported chronic disease management and prevention as a priority.

47% of individuals indicated that overweight/obesity was a condition of the highest concern in their community (ranked the #3 concern of survey respondents) and an additional 35% of individuals indicated that diabetes/ prediabetes and heart disease were of highest concern.

70% of respondents obtain less than the recommended weekly 150 minutes of physical activity for adults.

57% indicated they consume one or less servings of fruit in an average day and 47% indicated they consume one or less servings of vegetables in an average day.

42% of individuals indicated they have additional stress due to their own or a family member's health status, indicating that chronic disease not only affects physical health, but also causes mental health concerns as well.

Chronic Disease and Obesity Secondary Data for the ELVPHD health district:

There are many lifestyle risk factors which contribute to chronic disease and obesity and managing/improving lifestyle choices are a key factor to influencing chronic disease improvement. Secondary data which supports room-for-improvement with regard to lifestyle risk factors includes:

15.2% of health district residents regularly smoke tobacco as compared to 14.2% for Nebraska overall, CDC BRFSS PLACES 2022.

27.4% of adults in the district fall into the category of being physically inactive compared to 25.2% for Nebraska, CDC BRFSS PLACES, 2022.

40.1% of ELVPHD district adults are obese as compared to 37.2% for Nebraska overall, CDC BRFSS PLACES, 2022.

Specific chronic disease related secondary data for the health district also highlighted the following areas in which residents of the district were more negatively affected by specific chronic diseases (according to CDC BRFSS PLACES 2021, 2022):

12.6% of ELVPHD district were categorized as having "poor physical health" as compared to 11.4% for Nebraska.

12.0% of adults in the district have been diagnosed with diabetes as compared to 10.9% for all Nebraskans.

7.9% of district residents are indicated as having coronary heart disease compared with 6.8% in Nebraska overall and 3.7% of ELVPHD adult residents have suffered from a stroke compared to 3.2% in Nebraska.

Finally, high blood pressure affects 34.5% in the health district compared to 30.4% among all Nebraskans.

Chronic Disease & Obesity Assets & Resources:

Healthcare providers, hospitals, public health, public environment including trails and parks that support outdoor physical activity, and community-based organizations.

PARTNERS & STAKEHOLDERS

Partners, stakeholders and community members who have agreed to support the CHIP and input received during the partner/stakeholder engagement process.

Partner/Stakeholder Entity	Sector(s) Represented
Faith Regional Health Services	Healthcare, Hospital, Mental Health
Franciscan Healthcare	Healthcare, Hospital, Mental Health
Midtown Health Center	Healthcare, Mental Health, Dental
Northeast Nebraska Area Agency on Aging	Aging/Elder Care
Ponca Tribe of Nebraska	Minority Health, Healthcare, Transportation
Northern Nebraska Area Health Education Center	Healthcare, Healthcare Career Support
Our Savior Lutheran Church	Faith-Based Community
Northeast Community College	School, Healthcare Career Support
Oakland-Craig Public Schools	School
Rural Region One Medical Response System	Emergency Preparedness
Norfolk Fire Division	Fire/Rescue, Government
Colonial Haven	Long-Term Care
Wesley Center	Childcare
Little Lambs Preschool & Daycare	Childcare
Westside Daycare	Childcare
ELVPHD Board of Directors	Community Members, County Government
Northeast Nebraska Community Action Partnership	Community-Based Organization
Norfolk Area Chamber of Commerce	Community-Based Organization
Oakland Heights (LTC/AL)	Aging/Elder Care
Norfolk Police Division	Law Enforcement
St. John's Early Learning Center	Faith-Based Community & Childcare

The community partners noted above contributed to providing insight and input in the creation of the Community Health Improvement Plan during August 2025 via an online survey tool. Input was gathered by sharing the Community Health Assessment (CHA) data with the partners/stakeholders, and soliciting their feedback and input on the main data/themes of the CHA, as well as requesting their input on other potential priority areas, external factors affecting health, community strengths which would support CHIP priority areas, and perceptions of emerging issues affecting health. The results of the community partner/stakeholder input process yielded the following results regarding the top 3 health concerns identified in the CHA data:

Mental Health: 100% of stakeholders affirmed Mental Health as a CHIP priority

Cancer Prevention: 89% of stakeholders affirmed Cancer Prevention as a CHIP priority

Chronic Disease: 94% of stakeholders affirmed Chronic Disease as a CHIP priority

Other potential priority areas that were suggested by the partners/stakeholders:

Substance Abuse Prevention – Workplan activities concerning substance abuse prevention was incorporated within Objective 4 of the mental health priority area as substance abuse/misuse is statistically significant as a co-occurring disorder.

Keeping Seniors Active – Workplan activities regarding the importance of keeping the senior/elderly population active and engaged is incorporated within Objective 2 of the Chronic Disease priority.

External Factors Affecting Health:

Partners and stakeholders provided input on the external factors which may affect the health of our communities. Following are the common themes for external factors in influencing health from the input of the partners/stakeholders:

- **Environmental:** Including where and how people live, contaminants including those contributing to water and air quality, and built-environment resources available to support healthy lifestyles.
- **Technology:** Including how people interact in a tech-driven society and use of artificial intelligence (AI) as it pertains to healthcare and societal factors.
- **Economic:** Including housing affordability concerns, the ability to afford healthy foods, as well as affordability concerns regarding healthcare and mental healthcare.
- **Societal Factors:** Including uncertainty of funding availability/stability for social and healthcare related programs, as well as misinformation regarding various healthcare topics often proliferated via social technology platforms.

Community Assets and Strengths:

Partners and stakeholders provided input on the community assets and strengths which contribute to health improvement and leveraging the assets and strengths to accomplish the goals, strategies, and activities within the CHIP in an effort to improve health.

- **Robust community engagement:** Community members in the area are often highly engaged in endeavors to improve their local communities and support programs that focus on health and overall well-being.
- **Partner engagement:** Many local organizations are available to assist with supporting shared goals to improve health and make a difference in the CHIP priority areas. Although each community agency may have a differing focus, often there are opportunities to align with other agencies.
- **Quality healthcare resources:** There are many quality healthcare resources available to assist people with health improvement.

Emerging Health-Related Issues:

Partners and stakeholders were asked if there were additional emerging issues that should be kept in view and considered over the next several years. Those issues included:

- **Environmental:** As policy and funding resources change, environmental issues may receive less attention and surveillance in the future.
- **Artificial Intelligence (AI) and the use of technology:** Technological changes and AI incorporation is a highly evolving factor for which the effect on health is unknown at this time.

WORK PLAN

The remaining pages in this document outline the work plan for each issue identified by community partners as priority health areas through this planning process.

The work plan contains goals, objectives, strategies, activities, measures, timelines, and partners for each priority health area.

Over the course of the next three years, workgroup (Health Improvement Coalition) members will commit resources and efforts to activities as outlined in the work plan. This section is meant to be a flexible, responsive component of the community health improvement plan. As such, it will periodically be reviewed and updated to ensure the elements reflect workgroup progress and needs of our community.

Efforts and results of this workgroup will be tracked by the Elkhorn Logan Valley Public Health Department. ELVPHD will coordinate workgroup meetings to create an environment of collaboration. Each meeting, progress will be shared, and a comprehensive annual report will be made each year to document progress. It is each facility's responsibility to report organization specific progress made to ELVPHD.

PRIORITY 1: Mental/Behavioral Health

GOAL: Improve access to and utilization of mental health services to support overall well-being.

OBJECTIVE 1	OUTCOME MEASURES
By December 31 2028, reduce the prevalence of individuals reporting frequent mental health distress by .5%.	14.3% of ELVPHD adults (ages 18+) indicated their mental health was not good 14 or more days in the past month compared with 14.1% of Nebraskans overall. *Source: CDC BRFSS PLACES 2022 FREQUENT MENTAL DISTRESS*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Increase the number of mental health providers in the district.	Continue recruitment of behavioral health providers in the area and opportunities for training, and introduction to behavioral health as focus area for students.	Number of behavioral health providers in the district Number of training and/or career path opportunity awareness events	December 2028 December 2028	Healthcare Area Health Education Center Schools
Baseline: 112 total mental/behavioral healthcare providers (2024) UNMC Nebraska Medical Nebraska Behavioral Health Workforce Dashboard				

OBJECTIVE 2	OUTCOME MEASURES
By December 31 2028, increase the percentage of individuals indicating a social determinants of health concern that are connected to and/or referred to a resource to address their concern to 97%.	*At least 97% of social determinants of health concerns reflected on intake forms are addressed via resource and/or referral.* *Source: ELVPHD SDOH Tracking*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Improve social determinants of health engagement	For individuals indicating any SDOH concern, connect individuals with resources and/or referrals to appropriate services.	Number of SDOH concerns by topic Number of referrals provided by topic	Quarterly	Public Health Healthcare Community referral agencies
2. Improve mental health-specific social determinants of health engagement	For individuals indicating a mental health-specific SDOH concern, connect individuals with resources and/or referrals to appropriate mental health resources and/or referrals.	Number of mental health SDOH concerns at intake Number of mental health referrals / resources provided.	Quarterly	Public Health Mental health providers and service organizations
Baseline: 174 SDOH concerns indicated on intake forms (164 follow-up with – 94%) 26 Mental/Behavioral health SDOH concerns indicated (26 followed-up with – 100%). Source: ELVPHD internal tracking of SDOH for ELVPHD clientele				

OBJECTIVE 3	OUTCOME MEASURES
Increase the number of individuals accessing Credible Mind as a mental health and overall well-being platform by 10% annually (for a 40% increase over baseline levels by December 31, 2028).	Each calendar year, increase usage of Credible Mind by 10% over the prior year's user level. *Source: Credible Mind user statistics for the ELVPHD platform*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Promote and support the Credible Mind mental health and well-being electronic platform.	Incorporate multi-modal media strategies to promote the Credible Mind platform including: social media, class-based promotion and school-based promotion	Number of promotional efforts implemented	Quarterly	Schools Service Organizations Media platforms
Baseline: 1,262 Credible Mind platform users during 2025. Source: Credible Mind user statistics for the ELVPHD Credible Mind platform.				

OBJECTIVE 4	OUTCOME MEASURES
Increase students' understanding of the risks associated with substance use in the district by an average of 0.25 points annually for alcohol, vaping, and illegal substances, through substance abuse prevention education, by December 31, 2028.	Increase students' understanding of the risks of substance use and misuse by an average of 0.25 points across all categories surveyed on internal student surveys, and by 0.25% on NRPFSS results. *Source: NRPFSS (Nebraska Risk and Protective Factor Student Survey)*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Promote and implement substance use / misuse messaging among youth	Conduct messaging and education geared toward youth on substance use / misuse prevention	Number of students provided annual education	Annually by the academic year	Schools Organizations serving youth
Baseline: Wrong or Very Wrong for Use Of (8th grade students): Vapes (93.9%), Marijuana (97.3%), Prescription Drug Misuse (97.3%), Other Illegal Drugs (98.4%), Alcohol Once or Twice Per Month (85.2%). Source: NRPFSS 2023 (the NRPFSS is conducted every 2 years)				

PRIORITY 2: Cancer Prevention

GOAL: Increase access to and utilization of preventative cancer screening

OBJECTIVE 1	OUTCOME MEASURES
Increase the percentage of women receiving mammography screening to 74.5% (an increase of 1%) by December 31, 2028.	73.5% of women in the health district (aged 50-74) have had a mammogram in the past 2 years as compared with 75.2% in Nebraska overall. *Source: CDC BRFSS Places, 2022*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Promote mammography screening for women according to screening guidelines	Educational campaign targeted to increasing importance of screening and guidelines	Social media post reach and additional promotional endeavors implemented	Annually	Healthcare Mammography centers
2. Implement reminder / recall systems for completion of mammography for women past the 2-year timely screening timeframe	Implement mammography reminder system for clients indicating they are due / overdue for mammography (women aged 40-74).	Number of reminders sent	Quarterly	
3. Complete case management / barrier reduction for women experiencing educational needs or difficulties in completing mammography timely	Provide barrier reduction / case management services to reduce barriers to screening	Number of women which receive barrier reduction / case management services	Annually	Healthcare clinics Community service organizations for barrier reduction services (such as transportation)
Baseline: 73.5% of women in the health district (aged 50-74) have had a mammogram in the past 2 years as compared with 75.2% in Nebraska overall. Source: CDC BRFSS Places, 2022				

OBJECTIVE 2

Increase the percentage of women receiving cervical (pap) screening to 81% (an increase of .5%) by December 31, 2028.

OUTCOME MEASURES

80.5% of women in the health district (aged 21-64) have had a cervical (pap) screening in the past 3 years as compared with 81.5% in Nebraska overall.

Source: CDC BRFSS Places, 2020

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1 Promote cervical (pap) screening for women according to screening guidelines	Educational campaign targeted to increasing importance of screening and guidelines	Social media post reach and additional promotional endeavors implemented	Annually	Healthcare
2 Implement reminder / recall systems for completion of mammography for women past the 2-year timely screening timeframe	ELVPHD to implement cervical (pap) reminder system for clients indicating they are due / overdue for cervical (pap) screening (women aged 21-64).	Number of reminders sent	Quarterly	
3. Complete case management / barrier reduction for women experiencing educational needs or difficulties in completing cervical (pap) screening timely	Provide barrier reduction / case management services to reduce barriers to screening	Number of women which receive barrier reduction / case management services	Annually	Healthcare clinics Community service organizations for barrier reduction services (such as transportation)
Baseline: 80.5% of women in the health district (aged 21-64) have had a cervical (pap) screening in the past 3 years as compared with 81.5% in Nebraska overall. Source: CDC BRFSS Places, 2020				

OBJECTIVE 3

Increase the percentage of people (aged 50-75) completing colorectal cancer screening to 62.5% by December 31, 2028.

OUTCOME MEASURES

61.6% of people in the health district (aged 50-75) have had a timely colorectal cancer screening as compared to 62.8% in Nebraska overall.

Source: CDC BRFSS Places, 2022

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1 Promote colorectal cancer screening according to screening guidelines	Educational campaign targeted to increasing importance of screening and guidelines	Social media post reach and additional promotional endeavors implemented	Annually	Healthcare
2. Promote use of FIT screening kits as an annual screening for people ages 45-75	Distribute FIT kits and follow-up to boost return rates and follow-up with next steps for positive kits	Number of kits distributed Number of kits returned	Quarterly	DHHS FIT kit program

		Tracking and follow-up of positive kit results		
Baseline: 61.6%% of people in the health district (aged 50-75) have had timely colorectal cancer screening as compared with 62.8% of Nebraskans overall Source: CDC BRFSS Places, 2022				

OBJECTIVE 4	OUTCOME MEASURES
Increase the number of homeowners testing their home for radon by December 31, 2028, by 10% over baseline annually.	124 radon test kits were distributed by ELVPHD in 2024 and the target is to increase the number of radon kits distributed by 10% annually (136 kit target for the years of 2026, 2027 and 2028). *Source: ELVPHD internal tracking of radon home test kits distributed & returned*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1 Promote distribution of radon test kits to increase number of homes tested for radon	Educational campaign targeted to increasing importance of radon screening and mitigation	Number of kits distributed	Annually	Area events Media platforms
2. Implement reminder systems for return of radon test kits to the lab for testing	Reminder activities conducted to boost return rates of radon home test kits	Number of kits returned Tracking and follow-up of high radon level results	Annually	Radon test kit provider
Baseline: 124 radon test kits distributed in the district (2024) and 82 test kits returned to lab (66% return rate). Source: ELVPHD internal tracking of radon home test kits distributed and returned				

OBJECTIVE 5	OUTCOME MEASURES
Increase the percentage of HPV vaccines administered each year in the health district by 1% over baseline by December 31, 2028.	Increase percentage of adolescents (aged 13-17 years) who have received all recommended doses of HPV vaccine to 68.4% (2023 baseline was 67.4%). *Source: America's Health Rankings (2023): www.americashealthrankings.org*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Promote HPV vaccination and provide opportunities for HPV vaccine in-office and at off-site events	HPV educational messaging and reminder/recall for adolescents for 2nd dose of HPV vaccine	Number of HPV vaccines administered	Annually	Media platforms
Baseline: 67.4% of adolescents (ages 13-17) had received both recommended doses of HPV vaccine in 2023. 67 HPV vaccines provided by ELVPHD in the past year (baseline). Source: *America's Health Rankings (2023): www.americashealthrankings.org and ELVPHD electronic health record.*				

PRIORITY 3: Chronic Disease

GOAL: Promote preventative lifestyle choices to prevent and/or manage chronic disease

OBJECTIVE 1	OUTCOME MEASURES
Provide evidence-based healthy lifestyle programming aimed at improving nutrition levels by increasing fruit and vegetable intake by at least .85 combined cups per day from baseline to final session.	During 2024, baseline average number of combined fruits and vegetables cups consumed per day was an average of 3.47 cups. Increase the average number cups of fruits and vegetables combined by .85 cups or more as of the final session. *Source: ELVPHD Qualtrics data tracking nutrition intake for evidence-based nutrition programs.*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Provide evidence-based programming to improve nutrition	Implement evidence-based programs to increase fruit and vegetable consumption (including assistance with policy development)	Fruit and vegetable intake at baseline and final session	Quarterly	Evidence-based program providers or hosts (healthcare and/or service organizations)
2.Promote healthy nutrition messaging aimed making healthier nutrition choices	Social media campaign and other messaging to increase healthy choices including fruit and vegetable consumption	Social media tracking for promotion of healthy nutrition and/or promotion of evidence-based programs to improve nutrition	Quarterly	Media platforms
Baseline: Fruit and vegetable combined intake reflected an average combined consumption of 3.47 cups per day (2024). 47% of ELVPHD Community Health Assessment participants consumed 1 or less servings of vegetables per day (2025). 57% of ELVPHD Community Health Assessment participants consumed 1 or less servings of fruit per day (2025). Source: ELVPHD Qualtrics baseline statistics for nutrition levels (2024).				

OBJECTIVE 2	OUTCOME MEASURES
Increase the percentage of adults who report participating in at least 150 minutes or more of physical activity weekly by 2% by December 31, 2028.	30% of Community Health Assessment (2025) participants report getting at least 150 minutes or more of physical activity weekly and average number of physical activity minutes per week was 114 minutes (ELVPHD Qualtrics 2024) *Source: ELVPHD Community Health Assessment (2025) & Qualtrics (2024)*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1. Provide evidence-based programming to increase physical activity levels	Implement evidence-based programs to increase physical activity and promote physical activity options in the district (including assistance with policy development and/or built-environment initiatives)	Physical activity minutes at baseline and final session	Quarterly	Evidence-based program providers or hosts (healthcare and/or service organizations)
2.Promote physical activity messaging to increase physical activity levels to 150 minutes or more weekly	Social media campaign and other messaging to increase physical activity levels	Social media tracking for promotion of physical activity	Quarterly	Media platforms
Baseline: 30% of ELVPHD Community Health Assessment participants reported 150 minutes or more of physical activity weekly (2025). 114 minutes of physical activity on average at baseline – ELVPHD Qualtrics (2024) Source: ELVPHD Qualtrics baseline statistics for physical activity levels (2024)				

OBJECTIVE 3	OUTCOME MEASURES
Reduce obesity levels among adults in the health district by 1% by December 31, 2028.	Obesity levels were at 40.1% of adults in the district as compared with 37.2% of Nebraskans overall. *Source: BRFSS Places, 2022*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1.Implement evidence-based programming targeted to reducing weight from overweight and/or obesity levels	Program implementation to include programs such as NDPP (National Diabetes Prevention Program), DSMES (Diabetes Self-Management Education and Support), health coaching and worksite wellness-based programs focusing on lifestyle choices including weight reduction/management.	Number of programs implemented by type and number of individuals served Baseline and final session weights tracked for pounds lost and BMI level	Annually	Healthcare Evidence-based program providers or host sites (healthcare and/or service organizations)
2. Promote messaging to encourage healthy lifestyle choices which are in support of weight reduction and/or weight management.	Social media campaign and other messaging to increase physical activity levels	Social media tracking for promotion of healthy lifestyle choices messages	Quarterly	Media platforms
Baseline: 40.1% obesity levels in the health district as compared to 37.2% for Nebraska overall. Source: BRFSS Places, 2022				

OBJECTIVE 4	OUTCOME MEASURES
Increase the percentage of adults participating in preventative medical services by .5% and increase the percentage of children (grades K-8) indicating they have a dental home by 1% by December 31, 2028.	73.4% of health district adults participated in a medical provider check-up in the past year as compared with 74.1% of Nebraskans overall and baseline grades K-8 children indicating they have a dental home is 58.7% (2023). *Source: BRFSS Places, 2022 and ELVPHD Dental Tracking statistics for dental home, 2023*

STRATEGY	ACTIVITY	PROCESS MEASURES	TIMELINE	PARTNERS
1.Connect individuals to preventative medical services and provider resources / referrals for medical home for those experiencing SDOH concerns regarding insurance and/or financials concerns	Provide opportunities for individuals throughout the health district to receive preventative services (such as immunizations, blood pressure checks and health coaching) in accessible locations and provide referrals resources to individuals served who do not have a medical home	Number of preventative services provided by type (immunizations, evidence-based programs) SDOH referrals for those experiencing SDOH hardships	Quarterly	Healthcare providers for referrals
2. Connect children to preventative dental services and provider resources / referral for establishing a dental home	Provide opportunities for children to receive dental services (screenings, fluoride varnish, sealants) and connect those without a dental home via resources / referral to establish a home dental provider	Number of preventative services provided by type Dental home referrals for those without a current dental home	Quarterly	Community sites (childcare / schools / WIC / other) for preventative services Dental providers for referrals
Baseline: 73.4% of ELVPHD service area individuals participating in a medical provider check-up in the past year and 58.7% of children in grades K-8 indicated they have a dental home (baseline – 2023) Source: BRFSS Places, 2022 and ELVPHD Dental Tracking statistics for dental home, 2023				