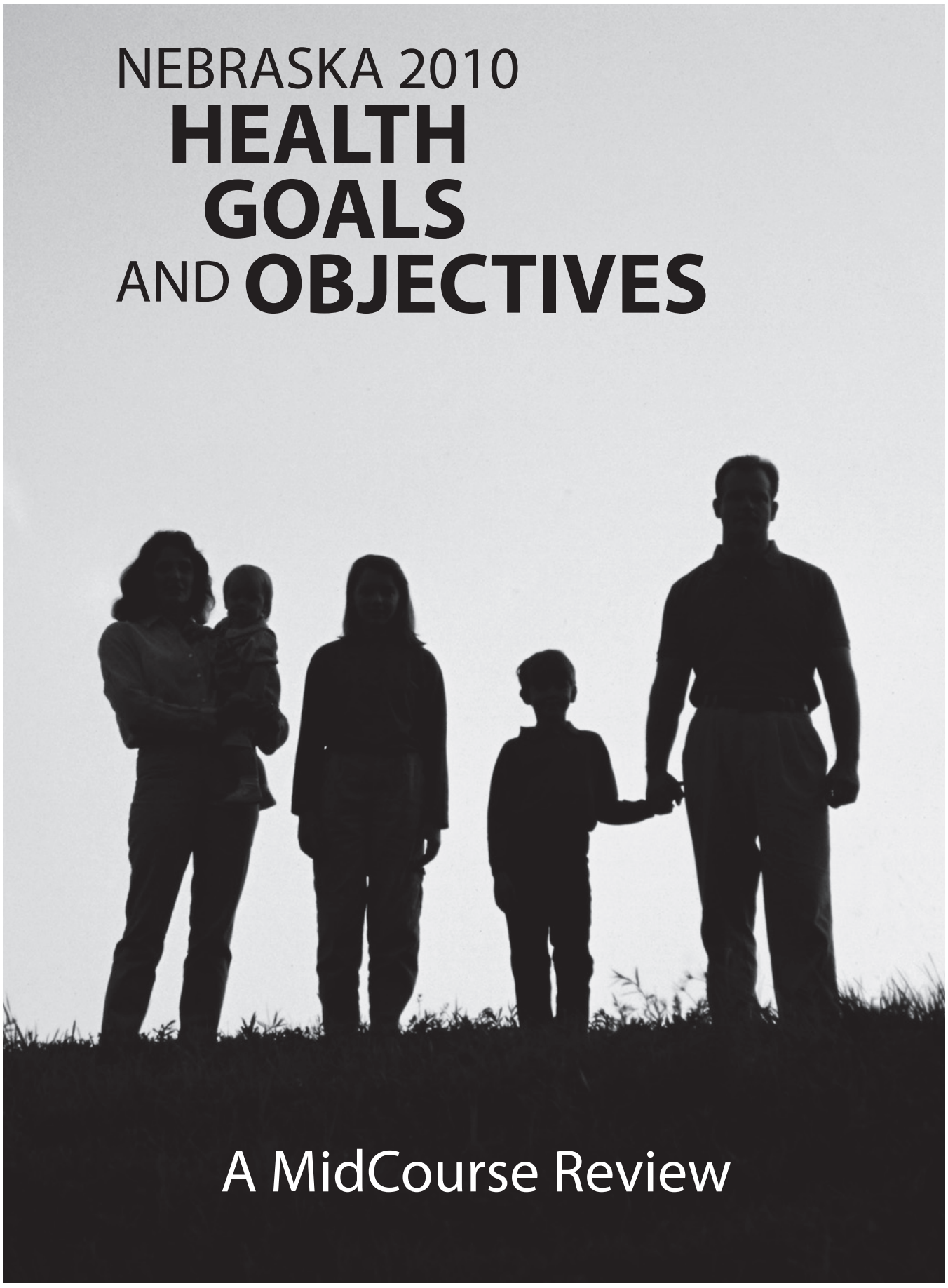
NEBRASKA 2010 HEALTH GOALS AND OBJECTIVES



A MidCourse Review

NEBRASKA 2010 HEALTH GOALS AND OBJECTIVES: A MidCourse Review

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INTRODUCTION

Healthy People 2010 is a nationwide health promotion and disease prevention initiative that is committed to improving the health of all people in the United States during the first decade of the 21st century. Healthy People is designed to achieve two overarching goals:

- increase quality and years of healthy life, and
- eliminate health disparities in the United States.

It builds on Healthy People 2000 and a previous set of national health objectives for 1990.

The *Nebraska 2010 Health Goals and Objectives* report, issued in May 2002, outlines a set of health goals and objectives for the state that are to be achieved by 2010. This initiative shares the national goals of eliminating health disparities and increasing quality and years of healthy life for all people in Nebraska.

The current document, *Nebraska 2010 Health Goals and Objectives: A MidCourse Review*, summarizes the progress that has been made over the past five years in meeting the health goals and objectives set for the state. It also compares Nebraska's accomplishments in meeting these objectives with advancements made nationwide.

HIGHLIGHTS

A great deal of progress has been made in Nebraska in helping individuals of all ages to increase life expectancy and improve their quality of life. Important gains have also been made in reducing health disparities among different segments of the population. These include differences that occur by gender, race and ethnicity, education and income, disability, or rural vs. urban residence. However, much work remains before these disparities can be totally eliminated.

For some health focus areas, improvements in health status or prevalence of risk behaviors are needed "across the board". While there may also be health disparities in these areas, recent trends or current health status indicators show that all segments of the population could benefit from improvement.

Summary of Progress in Nebraska

Twenty-four priority areas, containing a total of 203 objectives and sub-objectives, were identified for Nebraska for 2010 (Table I). Of the 203 objectives, 17 percent have already been achieved and new targets will be set for 2010. For 40 percent of the Nebraska objectives, progress was made toward the targeted rates. Thus, positive results were noted for 57 percent of the State's 2010 objectives.

However, there are also a number of objectives where no progress was made or the situation continued to worsen. Rates moved away from their targets for 25 percent of Nebraska objectives, while no change occurred for 8 percent of the total. Current information was not available for 11 percent of Nebraska objectives, so progress could not be assessed for them.

Table I
Summary of Progress on Nebraska 2010 Health Goals and Objectives
By Priority Area (including sub-objectives)

Priority Area	# of Objectives	PROGRESS				
		Objective Met	Progress Toward Target	Moving Away from Target	Mixed or No Change	Cannot Assess
Access to Quality Health Care	7	--	3	4	--	--
Arthritis, Osteoporosis and Chronic Back Conditions	2	--	--	1	1	--
Cancer	15	2	9	--	4	--
Diabetes	7	2	2	1	2	--
Disability and Secondary Conditions	1	--	--	--	--	1
Educational and Community-Based Programs	1	--	--	--	--	1
Environmental Health	8	6	1	--	1	--
Family Planning	10	--	2	4	--	4
Food Safety	6	2	3	--	--	1
Heart Disease and Stroke	11	1	2	5	--	3
HIV	6	--	5	--	--	1
Immunization and Infectious Diseases	28	14	5	6	1	2
Injury and Violence Prevention	23	1	11	8	1	2
Maternal, Infant, and Child Health	18	--	11	5	2	--
Mental Health	2	--	1	1	--	--
Nutrition and Overweight	3	--	--	2	--	1
Occupational Safety and Health	2	1	1	--	--	--
Oral Health	8	1	2	1	--	4
Physical Activity and Fitness	5	1	2	2	--	--
Respiratory Diseases	9	2	5	2	--	--
Sexually Transmitted Diseases	8	--	3	4	1	--

Table I continued						
		PROGRESS				
Priority Area	# of Objectives	Objective Met	Progress Toward Target	Moving Away from Target	Mixed or No Change	Cannot Assess
Substance Abuse	11	--	5	4	2	--
Tobacco Use	9	--	8	--	1	--
Vision and Hearing	3	1	--	--	--	2
NEBRASKA OBJECTIVES						
Number	203	34	81	50	16	22
Percent	100%	17%	40%	25%	8%	11%
NATIONAL OBJECTIVES						
Number	467	29	138	57	57	186*
Percent	100%	6%	30%	12%	12%	40%
*Includes 28 national objectives dropped at midcourse.						

Comparison to National Healthy People 2010 Results

In comparison, there were 467 national objectives originally identified for the U.S. Healthy People 2010 initiative (not including sub-objectives). Of these, 40 percent could not be assessed because data were not available or for other reasons. Six percent of national objectives were met at mid-course and progress was noted for 30 percent. For 12 percent, current data showed movement away from the 2010 target rates or revealed no change from the baseline.

Progress on Selected Specific 2010 Objectives in Nebraska

All of the 2010 objectives that have been achieved so far for the total population in Nebraska are listed in Table II-a. However, due to the large number of objectives for which progress was made (but targets not reached), not all of them are listed in this table. The objectives showing the strongest improvement were selected for inclusion in Table II-a. The same method was used in selecting objectives moving away from the targets set for 2010.

TABLE II-a Selected Nebraska 2010 Objectives Achieved, Showing Progress, or Moving Away from Target Rates by Focus Area--Total Population		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Access to Quality Health Care		
		Adults aged 18-64 with health insurance coverage Adults with specific source of ongoing health care Adults who, in last 12 months, could not see doctor due to potential cost of health care
Cancer		
Prostate cancer death rate Women aged 40+ who had a mammogram in past 2 years	Overall cancer death rate Lung cancer death rate Breast cancer death rate Cervical cancer death rate Colorectal cancer death rate Lymphoma death rate Adults aged 50+ who ever had sigmoidoscopy or colonscopy	

TABLE II-a continued		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Diabetes		
Adults with diabetes who had hemoglobin A1C test at least twice in past year Adults with diabetes who had dilated eye exam in past year	Adults with diabetes who perform self blood glucose monitoring at least once a day	Prevalence of clinically-diagnosed diabetes among adults
Environmental Health		
All 6 outdoor air quality objectives		
Family Planning		
	Teen pregnancy rate	High school students who reported they never had sexual intercourse
Food Safety		
Outbreaks of infection by food-borne bacteria (E. coli and Salmonella)		
Heart Disease and Stroke		
Coronary heart disease death rate	Stroke death rate	Prevalence of high blood pressure among adults Prevalence of elevated blood cholesterol levels among adults
HIV		
	Overall rate of new AIDS cases	
Immunization and Infectious Diseases		
Incidence of hepatitis A Reported cases of 8 out of 10 vaccine-preventable diseases Vaccination rates for children aged 19 to 35 months for Hib disease, hepatitis B, MMR, polio, and 4:3:1:3:3 series of vaccines	Adults aged 65+ ever vaccinated against pneumonia	
Injury and Violence Prevention		
Death rate due to work-related injuries among farmers Rate of non-fatal injuries caused by motor vehicle crashes	Firearm-related death rates Motor vehicle crash death rates Homicide rates Work-related injury death rates Children under age 5 years buckled into child restraint when riding in motor vehicle	Death rate due to falls
Maternal, Infant and Child Health		
Newborn infants screened for hearing loss by age one month	Healthy full-term infants put down to sleep on their backs Mothers breastfeeding their infants during the early postpartum period Death rates among children, adolescents, and young adults aged 5 through 24 years	Death rate for children aged 1 through 4 years
Mental Health		
	Suicide rate	Suicide attempts requiring medical attention among high school students
Nutrition and Overweight		
		Obesity among adults and adolescents
Oral Health		
Six- to eight-year-olds with untreated dental cavities	Adults aged 65 - 74 who have all their teeth removed	

TABLE II-a continued		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Physical Activity and Fitness		
Adults who achieved recommended physical activity level (moderate and/or vigorous exercise)	Adults participating in no leisure-time physical activity Adults participating in vigorous physical activity for at least 20 minutes 3+ times per week	
Respiratory Diseases		
Asthma death rates among children under age 5 and among adults aged 65+	Asthma death rates for children aged 5-14, adolescents and adults aged 15-34, and adults aged 35-64	
Sexually Transmitted Diseases		
	Incidence of gonorrhea	
Substance Abuse		
	Adolescents drinking and driving Adolescents riding with a drinking driver Adolescents binge drinking High school seniors who never drank alcohol Adolescents not using alcohol or any illicit drug in past month	Cirrhosis death rate Death rate due to alcohol-related motor vehicle crashes Binge drinking among adults Current use of marijuana among high school students
Tobacco Use		
	Cigarette smoking among adults All forms of tobacco use among high school students	

Tables II-b through II-e present objectives achieved, objectives showing progress, and objectives moving away from targets for racial and ethnic minority groups in the state. Please keep in mind that data for some objectives are not available by race or ethnicity for Nebraska (e.g., Youth Risk Behavior Survey data), so fewer objectives are generally shown in these tables than in Table II-a, which lists findings for the total population of the state.

Detailed information for all of the 203 objectives and sub-objectives identified for Nebraska for 2010 can be found in the Results and Discussion section of this report.

Overall Population

No **access to quality health care** objectives achieved or made substantial progress toward the target rates set for 2010 in Nebraska (Table II-a). Instead, fewer adults aged 18 to 64 years had health care coverage or reported a specific source of ongoing care, compared to the baseline. More adults also reported that, in the last 12 months, they were unable to see a doctor due to potential cost of health care.

However, two Nebraska 2010 **cancer** objectives have already been achieved: reducing the prostate cancer death rate and increasing the proportion of women aged 40 and older who had a mammogram in the past 2 years to screen for breast cancer. Several other cancer-related objectives have shown improvement. The overall cancer death rate is down, as are deaths due to lung cancer, breast cancer, cervical cancer, colorectal cancer, and lymphoma. The proportion of adults aged 50 and older who ever had a sigmoidoscopy or colonoscopy to check for colorectal cancer has also increased from the baseline.

Although the prevalence of clinically-diagnosed **diabetes** among adults has increased considerably in Nebraska, three diabetes-management objectives have shown improvement. The proportion of adults with diabetes who had a hemoglobin A1C test at least twice in the past year and the proportion who had a dilated eye exam in the past year both increased enough to reach the target rates set for 2010. In addition, the proportion of adults with diabetes who perform self blood glucose monitoring at least once a day also rose, but did not yet reach the objective set for 2010.

In the **Environmental Health** focus area, all six outdoor air quality objectives adopted for Nebraska were achieved. In the **Food Safety** area, no outbreaks of infection by two food-borne bacteria (E. coli and Salmonella) were reported in 2005, reaching the target rate of zero set for each by 2010.

Although **heart disease** is still the leading cause of death in Nebraska, the overall coronary heart disease death rate has decreased considerably and is now lower than the target rate for 2010. The overall mortality rate for **stroke** declined substantially in Nebraska and has nearly reached the 2010 rate. However, the proportion of adults with high blood pressure increased in Nebraska, as did the proportion of adults with high blood cholesterol levels.

A number of objectives were achieved in the **Immunization and Infectious Diseases** focus area. The incidence of hepatitis A was down and the number of reported cases of eight out of ten vaccine-preventable diseases decreased to zero in 2005, attaining the targets set for 2010. Vaccination rates for children 19 to 35 months of age reached the objectives set for Hib disease, hepatitis B, measles-mumps-rubella, polio, and the 4:3:1:3:3 series of recommended vaccines for this age group. Although the target rate was not achieved, improvement was noted in the proportion of adults aged 65 and older who were ever vaccinated against pneumonia.

The rate of non-fatal injuries caused by motor vehicle crashes decreased enough to meet the Nebraska 2010 target rate. Work-related injury deaths among farmers also met the 2010 objective for the state. Several **Injury and Violence Prevention** objectives showed progress toward the target rates set for them. Firearm-related death rates declined, as did death rates due to motor vehicle crashes, homicides, and work-related injuries. A greater proportion of children under age 5 years were buckled into child restraints when riding in motor vehicles. On the other hand, the death rate due to falls increased from the baseline rate.

In 2005, the proportion of newborn infants screened for hearing loss by age one month reached 99 percent, exceeding the 2010 objective for Nebraska. **Maternal, Infant and Child Health** objectives making progress toward 2010 target rates included: the proportion of healthy full-term infants put down to sleep on their backs; the proportion of mothers breastfeeding their infants during the early postpartum period; and death rates among children, adolescents, and young adults aged 5 through 24 years. However, the death rate for children aged 1 through 4 years rose from the baseline.

In the **Mental Health** focus area, some progress has been achieved in reducing suicide rates but, among high school students, the rate of suicide attempts requiring medical attention was up from the baseline.

Prevalence of **obesity** among adults and among adolescents continued to rise in Nebraska as it did nationwide. Progress was noted, however, in the proportion of adults who reported participation in recommended levels of **physical activity**.

Asthma death rates decreased in all age groups in Nebraska, with the state's 2010 target rates being achieved for children under age 5 years and for adults aged 65 and older.

Progress was made toward five objectives for reducing **substance abuse** among adolescents in Nebraska: drinking and driving, riding with a drinking driver, binge drinking, current use of alcohol or any illicit drug, and increasing the proportion of high school seniors who never drank alcohol. However, movement away from the 2010 objectives occurred for current use of marijuana among high school students, binge drinking among adults, alcohol-related motor vehicle death rates, and cirrhosis death rates.

Prevalence of all forms of **tobacco use** tracked declined for high school students in Nebraska: cigarettes, spit tobacco, cigars, and bidis. The proportion of adults who reported they currently smoke cigarettes was also down slightly.

African American Population

Progress toward the Nebraska 2010 objectives among African Americans in the state is summarized in Table II-b.

TABLE II-b
Selected Nebraska 2010 Objectives Achieved, Showing Progress, or Moving Away from Target Rates
by Focus Area--African American Population

Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Access to Quality Health Care		
	Proportional racial/ethnic representation among primary care physicians	Adults aged 18-64 with health insurance coverage Adults who, in last 12 months, could not see doctor due to potential cost of health care
Cancer		
Women aged 40+ who had a mammogram in past 2 years	Overall cancer death rate Colorectal cancer death rate Prostate cancer death rate Women aged 18+ who had Pap test in past 3 years	Lung cancer death rate Breast cancer death rate
Diabetes		
Adults with diabetes who had hemoglobin A1C test at least twice in past year Adults with diabetes who had dilated eye exam in past year Adults with diabetes who had foot exam by health professional in past year Adults with diabetes who perform self blood glucose monitoring at least once a day		Prevalence of clinically-diagnosed diabetes among adults
Heart Disease and Stroke		
	Coronary heart disease death rate Stroke death rate	Prevalence of high blood pressure among adults Prevalence of elevated blood cholesterol levels among adults Cholesterol screening in past 5 years
HIV		
		Rate of new AIDS cases
Injury and Violence Prevention		
Motor vehicle fatality rate	Firearm-related death rate Unintentional injury death rate Homicide rate	
Maternal, Infant and Child Health		
	Child and adolescent death rates: aged 1-4, 10-14, and 15-19	Low birth weight rate
Mental Health		
Suicide rate		
Nutrition and Overweight		
		Obesity among adults
Physical Activity and Fitness		
		No leisure-time physical activity among adults
Respiratory Diseases		
		Chronic obstructive pulmonary disease (COPD) death rate

TABLE II-b continued		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Sexually Transmitted Diseases		
		Incidence of gonorrhea
Substance Abuse		
	Cirrhosis death rate	

As was the case for adult Nebraskans overall and for most other racial/ethnic groups, the proportion of African American adults who had health insurance decreased, while the proportion who were unable to see a physician due to potential cost increased from the baseline. However, progress was achieved for one **Access to Quality Health Care** objective. The proportion of primary care physicians who are African American rose.

Substantial progress was noted for African Americans in Nebraska in the **Cancer** focus area. The proportion of African American women aged 40 and older who had a mammogram in the past 2 years reached the target rate for 2010. The proportion of African American women aged 18 and older who had a Pap test in the past 3 years also increased, but has not yet achieved the 2010 target rate. In addition, the overall cancer death rate decreased as did the colorectal cancer and prostate cancer death rates for this population group. On the other hand, death rates due to lung cancer and breast cancer among African Americans increased from the baseline.

Although the prevalence of clinically-diagnosed **diabetes** among adults increased among African American adults, excellent progress was made in improving diabetes management. All four of the diabetes management objectives tracked in Nebraska for 2010 have already been achieved among African American adults.

Progress was made in reducing coronary **heart disease and stroke** death rates among African Americans in Nebraska. However, prevalence of high blood pressure and elevated blood cholesterol levels were up among this population group, as they were among adult Nebraskans overall.

The motor vehicle fatality rate among African Americans met the 2010 objective for this group. Progress was also made toward achieving three other **Injury and Violence Prevention** objectives: reducing firearm-related death rates, unintentional injury death rates, and homicide rates among this population group. In addition, the suicide rate among African Americans in Nebraska (in the **Mental Health** focus area) decreased enough to meet the 2010 objective for reducing these deaths.

In the **Maternal, Infant and Child Health** focus area, child and adolescent death rates declined for three age groups of African American children. Low birth weight rates, however, increased from the baseline.

The prevalence of **obesity** among adult African Americans increased as did the proportion of adults who reported not participating in any leisure-time **physical activity**.

Other objectives where rates for African Americans were moving away from the targets set for 2010 include: chronic obstructive pulmonary disease (COPD) death rates, the rate of new AIDS cases, and the incidence of gonorrhea.

Native American Population

Table II-c summarizes progress for Nebraska 2010 health goals and objectives among Native Americans in the state.

TABLE II-c Selected Nebraska 2010 Objectives Achieved, Showing Progress, or Moving Away from Target Rates by Focus Area--Native American Population		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Access to Quality Health Care		
		Adults aged 18-64 with health insurance coverage
Cancer		
	Overall cancer death rate	Lung cancer death rate
Diabetes		
Adults with diabetes who had hemoglobin A1C test at least twice in past year Adults with diabetes who had dilated eye exam in past year Adults with diabetes who had foot exam by health professional in past year Adults with diabetes who perform self blood glucose monitoring at least once a day		
Family Planning		
		Births occurring within 24 months of previous birth
Heart Disease and Stroke		
	Coronary heart disease death rate Stroke death rate	
Injury and Violence Prevention		
	Firearm-related death rate	Unintentional injury death rate Motor vehicle fatality rate Homicide rate
Maternal, Infant and Child Health		
	Adolescent (aged 10-14) death rate Young adult (aged 20-24) death rate Abstinence from smoking during pregnancy	Infant mortality rate
Mental Health		
	Suicide rate	
Respiratory Diseases		
		Chronic obstructive pulmonary disease (COPD) death rate
Sexually Transmitted Diseases		
		Incidence of gonorrhea
Substance Abuse		
		Death rate due to alcohol-related motor vehicle crashes Cirrhosis death rate

As noted above for African Americans and for adult Nebraskans overall, the proportion of Native Americans aged 18-64 who had **health insurance** has declined.

Progress was made in reducing the overall **cancer** death rate for Native Americans in Nebraska. However, the mortality rate due to lung cancer increased from the baseline for this population group.

Excellent progress was made among Native Americans in improving **diabetes** care management. Target rates were achieved for all four diabetes management objectives: hemoglobin A1C testing at least twice a year; dilated eye exam in past year; foot examination by health professional in past year; and self blood glucose monitoring at least once a day. Of all the population groups studied and the population overall, only African Americans and Native Americans achieved target rates for 2010 for all four diabetes management objectives.

In the **Heart Disease and Stroke** focus area, both the coronary heart disease death rate and the stroke death rate decreased substantially among Native Americans.

Of the **Injury and Violence Prevention** objectives, the firearm-related death rate moved downward for this population group. However, the unintentional injury death rate, the motor vehicle fatality rate, and the homicide rate for Native Americans in Nebraska all increased from the baseline.

Three **Maternal, Infant and Child Health** 2010 objectives showed improvement for Native Americans in the state. The death rates for adolescents aged 10 to 14 and for young adults aged 20 to 24 were both down. The proportion of Native American mothers who abstained from smoking during pregnancy increased. On the other hand, the infant mortality rate for this population group increased, compared to the previous five-year period. The proportion of births occurring within 24 months of a previous birth (a **Family Planning** objective) also rose for Native Americans.

One **Mental Health** objective made progress toward the target rate for 2010. The suicide rate for the Native American population decreased from the previous five-year rate.

In the **Respiratory Disease** focus area, the death rate due to chronic obstructive pulmonary disease (COPD) increased for Native Americans.

In the **Sexually Transmitted Diseases** area, the incidence of gonorrhea moved upward.

Two **Substance Abuse** objectives for Native Americans also showed movement away from the target rates for 2010. The mortality rate due to alcohol-related motor vehicle crashes and the cirrhosis mortality rate both increased for this population group.

Asian American Population

Progress toward 2010 objectives for Asian Americans in Nebraska is outlined in Table II-d. As seen with other population groups in Nebraska, the proportion of Asian American adults who had **health insurance coverage** has decreased from the baseline.

TABLE II-d
Selected Nebraska 2010 Objectives Achieved, Showing Progress, or Moving Away from Target Rates
by Focus Area--Asian American Population

Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Access to Quality Health Care		
		Adults aged 18-64 with health insurance coverage
Cancer		
		Lung cancer death rate
Diabetes		
		Diabetes death rate
Heart Disease and Stroke		
Prevalence of high blood pressure among adults		Coronary heart disease death rate Stroke death rate
Injury and Violence Prevention		
		Motor vehicle crash death rates Unintentional injury death rate
Maternal, Infant and Child Health		
Infant mortality rate		Low birth weight rate

TABLE II-d continued		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Nutrition and Overweight		
Obesity among adults		
Respiratory Diseases		
Chronic obstructive pulmonary disease (COPD) death rate		
Sexually Transmitted Diseases		
		Incidence of gonorrhea

The lung **cancer** death rate and the **diabetes** death rate were both up for Asian Americans in Nebraska.

Death rates due to coronary **heart disease and stroke** also increased for Asian Americans, although the prevalence of high blood pressure in this population group met the target rate for 2010.

In the **Injury and Violence Prevention** focus area, the unintentional injury death rate and the motor vehicle crash death rate each increased from the baseline for Asian Americans.

Asian Americans were the only racial/ethnic group in Nebraska to meet the 2010 objective for reducing the **infant mortality** rate. However, the low birth weight rate for Asian American infants increased somewhat from the previous five-year period.

Asian Americans were the only racial/ethnic group in Nebraska to achieve the target rate for prevalence of **obesity** among adults. In the **Respiratory Diseases** focus area, the rate of deaths due to chronic obstructive pulmonary disease (COPD) among Asian Americans met the targeted rate for 2010.

In the **Sexually Transmitted Diseases** focus area, the incidence of gonorrhea increased among Asian Americans, as it did among African Americans and Native Americans in Nebraska.

Hispanic American Population

Table II-e presents selected 2010 objectives achieved, showing progress, or moving away from target rates for Hispanic Americans in Nebraska.

TABLE II-e Selected Nebraska 2010 Objectives Achieved, Showing Progress, or Moving Away from Target Rates by Focus Area--Hispanic American Population		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
Access to Quality Health Care		
	Proportional racial/ethnic representation among primary care physicians	Adults aged 18-64 with health insurance coverage Adults who, in last 12 months, could not see doctor due to potential cost of care
Cancer		
Breast cancer death rate	Colorectal cancer death rate Women aged 40+ who had a mammogram in past 2 years	Lung cancer death rate
Diabetes		
Adults with diabetes who had hemoglobin A1C test at least twice in past year		Diabetes death rate
Heart Disease and Stroke		
Coronary heart disease death rate Prevalence of high blood pressure among adults Prevalence of elevated blood cholesterol levels among adults		Cholesterol screening in past 5 years

TABLE II-e continued		
Objectives Achieved	Objectives Showing Progress	Objectives Moving Away from Targets
HIV		
	Rate of new AIDS cases	
Injury and Violence Prevention		
	Firearm-related death rate Adults who always/nearly always wear seatbelts Homicide rates	
Maternal, Infant and Child Health		
Death rate among children and adolescents aged 10-14	Infant mortality rate Death rate among adolescents aged 15-19 Death rate among young adults aged 20-24 Adequate prenatal care (Kotelchuk) Healthy full-term infants put down to sleep on their backs	
Mental Health		
Suicide rate		
Nutrition and Overweight		
		Obesity among adults
Physical Activity and Fitness		
		No leisure-time physical activity
Respiratory Diseases		
		Chronic obstructive pulmonary disease (COPD) death rate
Substance Abuse		
	Binge drinking among adults	Cirrhosis death rate
Tobacco Use		
	Cigarette smoking among adults	

In the **Access to Quality Health Care** focus area, Hispanic Nebraskans showed progress in increasing the proportion of primary care physicians who are Hispanic. However, as was the case for African Americans, Native Americans, and Asian Americans in the state, fewer Hispanic American adults had health insurance and a greater proportion reported an instance when they could not see a doctor for needed health care due to cost.

The 2010 objective for reducing breast **cancer** deaths was achieved for Hispanic American women in Nebraska. Progress was also made in increasing the proportion of Hispanic women aged 40 and older who had a mammogram in the past two years. The colorectal cancer death rate was down from the baseline for Hispanics in Nebraska. However, lung cancer deaths were up for this group.

The proportion of Hispanic American adults with **diabetes** who had a hemoglobin A1C test at least twice in the past year achieved the target rate set for 2010 in Nebraska. However, the diabetes death rate for Hispanic Americans in Nebraska increased somewhat from the previous five-year period.

Three 2010 objectives in the **Heart Disease and Stroke** focus area were achieved for Hispanic Americans in Nebraska. The coronary heart disease death rate decreased enough to meet the target rate for this group. Prevalence of high blood pressure and prevalence of elevated blood cholesterol among Hispanic Americans also reached the targeted rates for these objectives. However, the proportion of adults who had their cholesterol levels tested in the past five years decreased from the baseline.

Progress was made in reducing the rate of new **AIDS** cases among the Hispanic population in Nebraska.

Three **Injury and Violence Prevention** objectives also showed progress. The rate of firearm-related deaths decreased, as did the homicide rate among Hispanic Americans in Nebraska. The proportion of Hispanic adults who reported that they always or nearly always wear their seatbelts when riding in a motor vehicle increased from the baseline rate.

One **Maternal, Infant and Child Health** objective has already been achieved for Hispanic Americans in Nebraska. The death rate among children and adolescents aged 10 to 14 years decreased enough to reach the target rate for 2010. Progress was also noted in reducing the infant mortality rate and death rates for adolescents aged 15 to 19 and for young adults aged 20 to 24 years. The proportion of pregnant women receiving adequate prenatal care, as measured by the Kotelchuk Index, increased from the baseline. The proportion of healthy full-term infants put down to sleep on their backs also rose, reducing the prevalence of one risk factor for Sudden Infant Death Syndrome (SIDS).

One **Mental Health** objective, reducing the suicide rate, was also reached for Hispanic Nebraskans. Progress was made toward one 2010 **Substance Abuse** objective—reducing the prevalence of binge drinking among Hispanic American adults. Prevalence of cigarette **smoking** among adults also decreased from the baseline.

Four other 2010 objectives showed movement away from their respective target rates. As it did for the overall population and for whites and African Americans in Nebraska, the prevalence of **obesity** among adults increased from the baseline rate for Hispanic Americans. The proportion of Hispanic adults who reported no leisure-time **physical activity** also rose. In addition, death rates due to chronic obstructive pulmonary disease (COPD) and to cirrhosis increased from baseline levels.

Use of This Report

Eliminating health disparities and increasing the quality and years of healthy life for all people in Nebraska will require continued commitment to monitoring progress toward Healthy People 2010 objectives. This Nebraska 2010 MidCourse Review should be helpful in evaluating whether or not unfavorable trends are being reversed and desired rates of improvement are being made. Results of this evaluation, together with other relevant information, can then be used to confirm that current strategies are “on-target” or to point out a need for fine-tuning or developing new interventions to improve the health of all people in Nebraska and meet the targets adopted for 2010.

DATA CONSIDERATIONS

Data Sources

The original national objectives and baseline data relating to them were taken from *Healthy People 2010—Volumes I and II (Second Edition)* and from *Tracking Healthy People 2010*. Current national data were taken from DATA2010, an interactive database hosted on the Centers for Disease Control and Prevention's Wonder system. It contains the most recent monitoring data for Healthy People 2010. In this report, the September 2006 update was used.

For Nebraska, the data sources in the May 2002 state report (*Nebraska 2010 Health Goals and Objectives)* were used whenever possible. New data sources were adopted for only five of Nebraska's 203 objectives, generally because the original sources no longer provided the needed information. For the most part, Nebraska data have been compiled from Vital Statistics data, surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS), and other Nebraska Health and Human Services System program data. Data sources are listed on tables and charts. Background information is taken from the current literature, reference sources, and government websites. A listing of references used is found at the end of this report.

Changes

Midway through the decade, the U.S. Department of Health and Human Services conducted a midcourse review to assess the status of the national 2010 objectives. Data trends are assessed, new science and available data are considered, and objectives are revised (if appropriate) to ensure that they are current, accurate, and relevant to public health priorities. A number of revisions were made at the national level. All of these changes have been incorporated in national data in tables, charts and narratives in this report. Wherever appropriate, revisions were also made to Nebraska objectives and data.

Five new objectives (or sub-objectives) have been added for Nebraska. Two objectives concerning knowledge of the warning signs of heart disease and stroke were established for Nebraska. Other new objectives for the state deal with prevalence of obesity and overweight among children aged 6 to 11 years, adolescent smoking of bidis, and vaccination of young children with pneumococcal conjugate vaccine.

For 17 objectives or sub-objectives, no target rates had been set in the May 2002 report due to unavailability of baseline data. Target rates for 2010 have now been adopted for these objectives and noted in the current report's tables as "Target rate set in 2006".

For 34 Nebraska 2010 objectives, the original target rate has already been met. For these objectives, revised target rates have been set and are listed in the Table A in the Appendix. For objectives already seeking a reduction in rates to zero, no revisions have been made to the original target.

Other changes in the data for the current report include minor revisions to baseline data or definitions. Changing from the Ninth Revision of the International Classification of Diseases (ICD-9) used in the 2002 report to the Tenth Revision (ICD-10) for this report may have made minor differences in a few baseline rates. For a few other objectives, minor changes in definitions (particularly for survey data) were made and are noted in the tables. In all of these situations, the same definitions have been used for baseline, trend and current data in order to maintain consistency, where possible.

Although Nebraska hospital discharge data have been collected for 1999 through 2005, data for 2004 and 2005 have been underreported and would not be reliable for some uses. Thus, trends for objectives based on hospital discharge data will only include the years 1999 through 2003.

Data for Racial and Ethnic Minority Population Groups

One of the two overarching goals for Healthy People 2010 is to eliminate health disparities among population groups. In the past, comprehensive data by race and ethnic origin has not been readily available. However, since the 2002 Nebraska report was published, additional data have become available by race and ethnic origin for a number of objectives. The new data have been added to tables and target rates have been set for these objectives. Charts have been prepared and discussion of trends and disparities included in the narrative, whenever possible.

Trends

Linear regression has been used to draw trend lines shown in the graphs in this report. Please keep in mind that, since they are based on a linear model, these trend lines may not be particularly useful for indicators where major changes in the slope of the line (i.e., direction of the trend) have occurred. In cases like this, selecting a different time period might have resulted in a very different trend line being drawn. For indicators with wide variability in rates over time or those with few data points, no formal trend lines have been drawn.

Results and Discussion

ACCESS TO HEALTH CARE

Healthy People 2010 Goal

The national Healthy People 2010 goal for access to care is to improve access to comprehensive, high-quality health care services.

Background

Everyone needs to have access to high-quality health care services in order to eliminate health disparities and increase the quality and years of healthy life for all Americans. In recent years, major changes in the structure of the U.S. health care system have occurred. Rising health care costs, changes in payment and health care delivery systems, and Medicaid reform are all having an impact on health care consumers, particularly on vulnerable and at-risk populations.

Lack of a health care plan or inadequate insurance coverage prevents many people from getting needed care because they are financially unable to pay for services without the help of insurance. Persons with health insurance are generally more likely to have a primary care provider and to have received appropriate preventive care, such as early prenatal care, immunizations, or health screening tests.

Progress Toward Healthy People 2010 Objectives

National

According to a June 2006 review of national trends in the Access to Health Care priority area, few objectives showed progress on a large scale in improving access to care overall. In general, relative health disparities among population groups have also remained much the same.

Nebraska

In Nebraska, progress was noted toward three of seven Access to Health Care objectives (or sub-objectives). The proportions of primary care physicians who are African Americans or Hispanic Americans increased between 1999 and 2006. The hospitalization rates for pediatric asthma and for immunization-preventable pneumonia or influenza among elderly Nebraskans (aged 65 and older) decreased from the 1999 baseline.

However, Nebraska rates for four of the Access to Health Care objectives moved further away from their respective 2010 target rates. The proportion of adults under 65 years of age who had health insurance coverage decreased. A smaller proportion of Nebraska adults reported having a specific source of ongoing health care in 2005, compared to the 1997-1998 baseline. More Nebraskans also stated that there had been a time in the past 12 months when they needed to see a doctor but could not due to potential cost of care. Hospitalizations for uncontrolled diabetes among adults 18 to 64 years of age were also up between 1999 and 2003.

Health Insurance

Both Nebraska and the nation have established an objective of increasing to 100 percent the proportion of adults under age 65 who have health insurance coverage (Table 1). The current Nebraska rate (86 percent in 2005) is only slightly higher than the national rate of 84 percent in 2004.

Table 1
Nebraska 2010 Health Goals and Objectives
Access to Quality Health Services

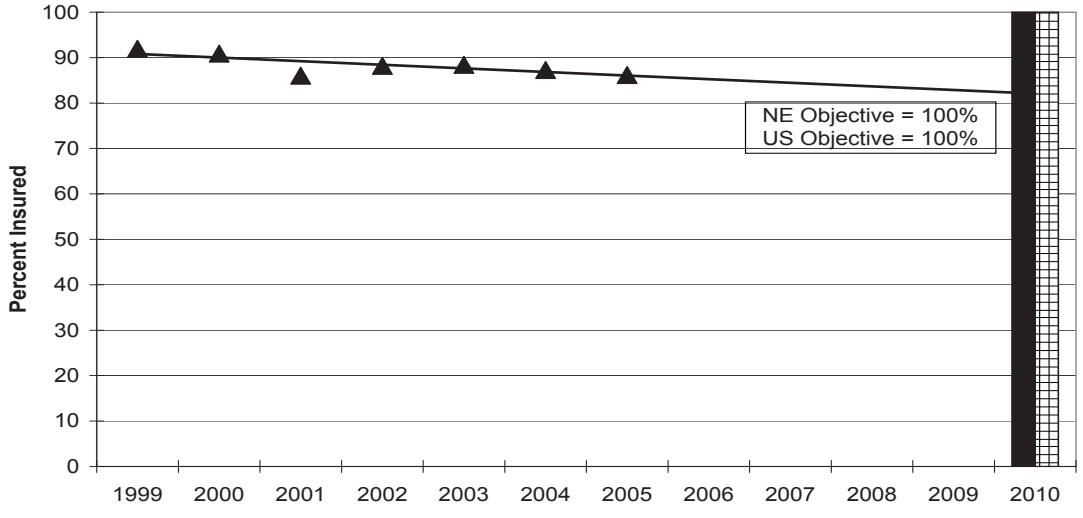
Objective		UNITED STATES Baseline Year	Baseline Rate	Current Year	Current Rate	U.S. 2010 Objective	NEBRASKA Baseline Year	Baseline Rate	Current Year	Current Rate	NE 2010 Objective
#1-1	Percent of persons under age 65 years with health insurance	1997	83%	2004	84%	100%	1999	90%	2005	86%	100%
	White	1997	84%	2004	84%	100%	1994-1998	90%	2001-2005	88%	100%
	African American	1997	80%	2004	82%	100%	1994-1998	88%	2001-2005	79%	100%
	Native American	1997	62%	2004	65%	100%	1994-1998	70%	2001-2005	67%	100%
	Asian American	1997	81%	--	--	100%	1994-1998	91%	2001-2005	84%	100%
	Asian	--	--	2004	83%	100%	--	--	--	--	--
	Native Hawaiian/Pacific Islander	--	--	2004	90%	100%	--	--	--	--	--
	Hispanic American	1997	66%	2004	66%	100%	1994-1998	82%	2001-2005	55%	100%
#1-4c	Percent of adults with specific source of ongoing care. (Have "one particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health").	1998	85%	2004	84%	96%	1997-1998	89%	2005	85%	98%
	White	1998	86%	2004	84%	96%	Data		2001-2005	86%	98%
	African American	1998	84%	2004	84%	96%			2001-2005	81%	98%
	Native American	1998	79%	2004	81%	96%	Not		2001-2005	64%	98%
	Asian American	1998	82%	2004	81%*	96%			2001-2005	73%	98%
	Asian	1998	82%	2004	84%	96%	Available		--	--	--
	Native Hawaiian/Pacjfjc Islander	--	--	2004	82%	96%			--	--	--
	Hispanic American	1998	76%	2004	72%	96%			2001-2005	53%	98%
#1-6	Percent of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members. (Was "a time in the past 12 months when you needed to see a doctor but could not because of the cost").	1996	12%	1999	11%	7%	1999	7%	2005	11%	4%
	White	1996	12%	1999	11%	7%	1994-1998	7%	2001-2005	10%	4%
	African American	1996	10%	1999	8%	7%	1994-1998	7%	2001-2005	19%	4%
	Native American	1996	19%	1999	10%	7%	1994-1998	NA	2001-2005	20%	4%
	Asian American	1996	12%	1999	11%	7%	1994-1998	NA	2001-2005	14%	4%
	Hispanic American	1996	16%	1999	12%	7%	1994-1998	17%	2001-2005	19%	4%
#1-8	Racial and ethnic representation in health professions										
	Primary care physicians--African American as % of total	1996-1997	7.0	2004	6.5	13.0	1999	0.9	2006	1.2	4.4
	Primary care physicians--Native American as % of total	1996-1997	0.7	2004	0.6	1.0	1999	0.3	2006	0.3	1.3
	Primary care physicians--Asian American as % of total	1996-1997	16.0	2004	20.0	4.0	1999	4.8	2006	4.9	4.8
	Primary care physicians--Hispanic American as % of total	1996-1997	5.9	2004	6.5	12.0	1999	1.2	2006	1.7	5.5
	NOTE: Although Objective 1-8 has set targets for increasing the proportion of primary care physicians in racial and ethnic minority groups, the intent is not to decrease the number of minority physicians in currently "over-represented" population groups (i.e., Asian Americans).										
#1-9a	Hospitalizations for pediatric asthma (age <18 years) /10,000 Data by race/ethnicity unavailable	1996	23.0	2003	22.6	17.3	1999	10.5	2003	9.8	7.9*
#1-9b	Hospitalizations for uncontrolled diabetes (age 18-64 years) /10,000 Data by race/ethnicity unavailable	1996	7.2	2003	7.8	5.4	1999	3.7	2003	4.7	2.8
#1-9c	Hospitalizations for immunization-preventable pneumonia or influenza (age 65 + years) /10,000 Data by race/ethnicity unavailable	1996	10.6	2003	9.7	8.0	1999	22.1	2003	20.2	16.0

NA = Not Available *Target rate set in 2006 for Nebraska.

Table 1 continued		
Data Sources:		Additional Notes:
#1-1	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Percent of persons under age 65 years who report coverage by any type of public or private health insurance. Includes children under age 18 years. Percent of persons age 18-64 years who report coverage by any type of public or private health insurance.
#1-4c	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Percent of persons aged 18 years and older who report having a source of ongoing primary care. Same as U.S.
#1-6	U.S.--Medical Expenditure Panel Survey, AHRQ. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Percent of families that report that at least one family member had difficulty or delay in obtaining health care or did not receive needed health care (includes financial and other access reasons). Percent of adults aged 18 and older who report there was a time in the past 12 months "when you needed to see a doctor but could not because of the cost." (Includes financial reasons only and respondent only).
#1-8	U.S.--AAMC Data Book, Association of American Medical Colleges Nebraska--Health Professions Tracking Center, University of Nebraska Medical Center. U.S. Census Bureau.	Number of medical degrees awarded by accredited allopathic medical schools by race or ethnicity as a percent of all medical degrees awarded. Percent of all primary care physicians (General/Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, General Surgery, and Psychiatry) who are members of each racial or ethnic group.
#1-9a	U.S.--Healthcare Cost and Utilization Project (HCUP), AHRQ. Nebraska -- Nebraska Hospital Discharge Data, HHSS.	Number of hospitalizations among persons under age 18 years with asthma (ICD-9 code 493) as principal diagnosis per 10,000 persons under age 18 years. Same as U.S.
#1-9b	U.S.--Healthcare Cost and Utilization Project (HCUP), AHRQ. Nebraska -- Nebraska Hospital Discharge Data, HHSS.	Number of hospitalizations among persons aged 18 to 64 years with uncontrolled diabetes (ICD-9 codes 250.02-250.03, 250.10-250.13,250.20-250.23, 250.30-250.33) as principal diagnosis per 10,000 persons aged 18 to 64 years. Same as U.S.
#1-9c	U.S.--Healthcare Cost and Utilization Project (HCUP), AHRQ. Nebraska -- Nebraska Hospital Discharge Data, HHSS.	Number of hospitalizations among persons aged 65 years and older with preventable pneumonia or influenza (ICD-9 481, 487) as principal diagnosis per 10,000 persons aged 65 years and older. Same as U.S.

The insured rate for adults nationwide has increased by only one percentage point in 2004, compared to the 1997 baseline. In Nebraska, however, the proportion of adults under age 65 has decreased from 90 percent in 1999 to 86 percent in 2005, according to BRFSS data (Figure 1).

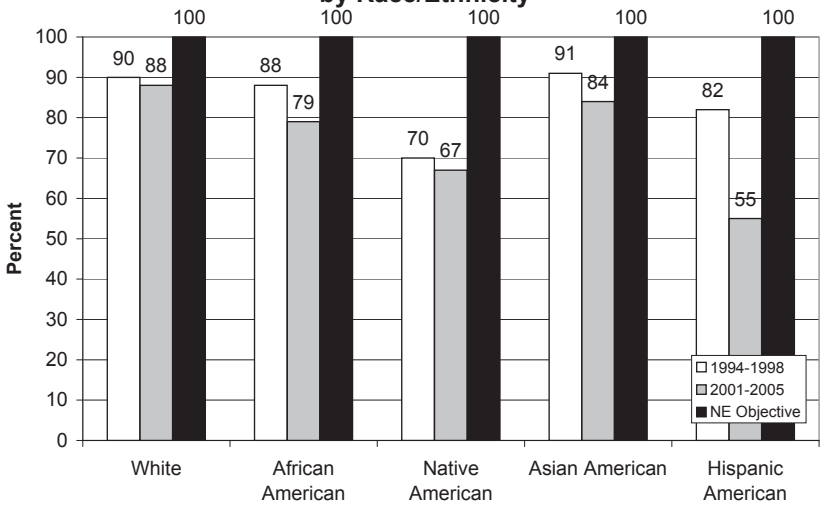
Figure 1
Adults in Nebraska (Aged 18-64) with Health Insurance



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Health insurance coverage rates declined for persons in each racial/ethnic group in Nebraska between 1994-1998 and 2001-2005 (Figure 2). All four racial/ethnic minority groups also experienced lower rates of insurance coverage than whites in Nebraska. Hispanic Americans in the state were least likely to have health insurance coverage (55 percent in 2001-2005). They also showed the greatest decrease in the insured rate from 1994-1998 to 2001-2005.

Figure 2
Adults in Nebraska (Aged 18-64) with Health Insurance by Race/Ethnicity



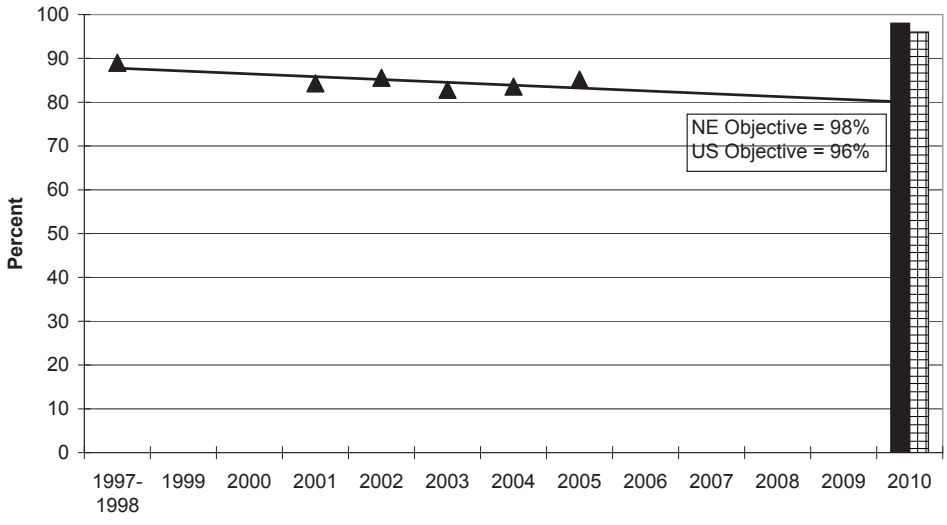
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010

Source of Ongoing Primary Care

Another Nebraska 2010 objective is to increase to at least 98 percent the proportion of adults who have a specific source of ongoing primary care. Nationwide, 84 percent reported having such a source in 2004. In Nebraska, 85 percent of adults in 2005 said they have a particular clinic, health center, doctor's office, or other place they usually go if they are sick or need advice about their health (Table 1).

In Nebraska, this proportion declined from 89 percent in 1997-1998 to the current 85 percent (Figure 3).

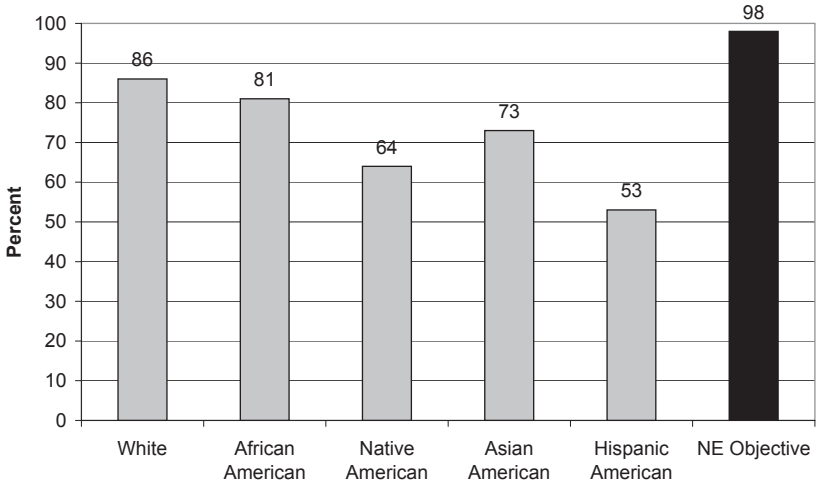
Figure 3
Adults in Nebraska with a Personal Health Care Provider



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Racial and ethnic minorities in the state were less likely to report having a personal health care provider than white Nebraskans (Figure 4). Little more than one-half of Hispanic American adults (53 percent) and less than two-thirds of Native Americans (64 percent) had a specific source of health care, compared to 86 percent of whites in the state. Smaller proportions of Asian Americans (73 percent) and African Americans (81 percent) also reported having a personal health care provider, compared to white Nebraskans.

Figure 4
Adults in Nebraska with a Personal Health Care Provider by Race/Ethnicity (2001-2005)*

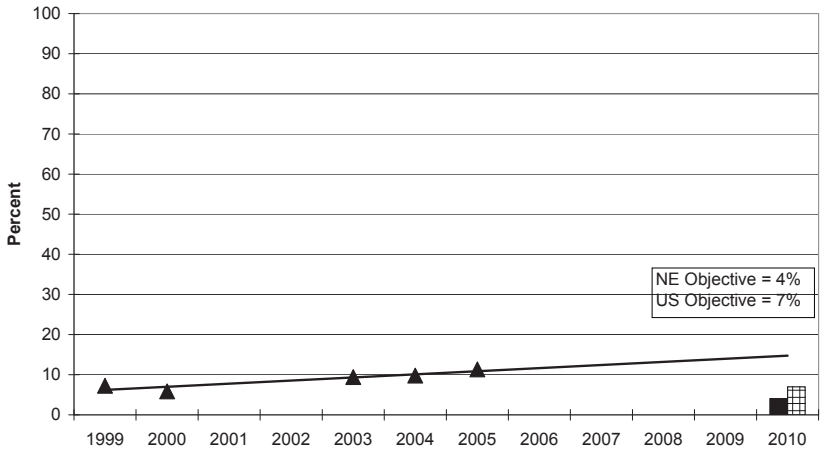


*Trend data are unavailable.
SOURCE: Nebraska HHSS, BRFSS.

Unable to See Doctor due to Cost

Reducing to no more than 4 percent the proportion of persons who are unable to see a doctor for needed medical care due to potential cost is another 2010 objective for Nebraska (Table 1). Eleven percent of adult Nebraskans in 2005 reported that, at least once in the past 12 months, potential cost of health care kept them from visiting a physician when they needed to see one.
Although nationwide rates did not change much from the baseline (decreasing from 12 percent to 11 percent), in Nebraska the proportion of adults who couldn't get needed medical care because of cost rose from 7 percent in 1999 to 11 percent in 2005 (Figure 5).

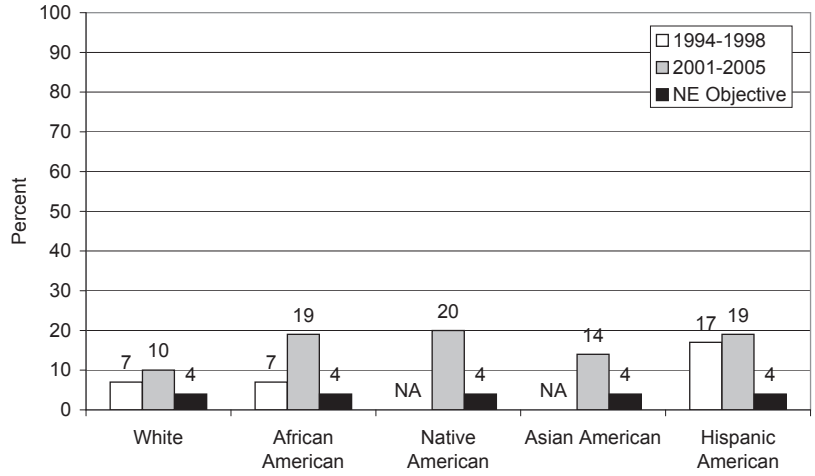
Figure 5
Adults in Nebraska Who Could Not See Doctor Due to Cost



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Proportions of adults who couldn't afford to get health care also increased for each racial/ethnic group (for which trends were available) in Nebraska (Figure 6). For African Americans, the rate increased the most, rising from 7 percent in 1994-1998 to 19 percent in 2001-2005.

Figure 6
Adults in Nebraska Who Could Not See Doctor Due to Cost by Race/Ethnicity



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

All four racial/ethnic minority groups were also more likely than whites in Nebraska to be unable to see a physician due to cost in 2001-2005. About twice the proportion of Native Americans (20 percent), African Americans (19 percent), and Hispanic Americans (19 percent) in the state reported that cost prevented them from receiving care in the past 12 months, compared to only 10 percent of white Nebraskans.

Racial/Ethnic Representation in Health Professions

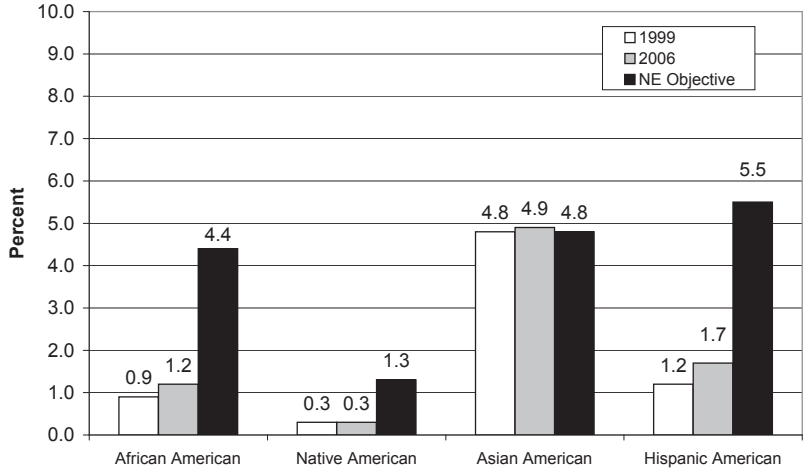
Increasing the number of health care providers from certain racial and ethnic groups has been found to be an effective means of increasing access to care for underserved people, particularly for low-income and racial and ethnic minority populations.

To address this access-to-care issue, one of Nebraska's Healthy People 2010 objectives is to increase the numbers of primary care physicians in active practice who are members of racial or ethnic minority groups so that, by 2010, the proportions of physicians in these groups are representative of their share of the state's population.

National data represent the proportion of medical degrees awarded by accredited medical schools in the United States by race or ethnicity and thus are not strictly comparable to Nebraska data. However, 2004 U.S. data shows increases for Asian Americans and Hispanic Americans and a decrease for African Americans, compared to 1996-1997 data.

In Nebraska, the proportions of primary care physicians in active practice in 2006 (Figure 7) increased somewhat for African Americans (to 1.2 percent) and for Hispanic Americans (to 1.7 percent). However, these percentages fall far short in comparison to the proportions of the state's population that these groups represent.

Figure 7
Percent of All Nebraska Primary Care Physicians*
by Race and Ethnic Origin



*Physician specialties include: General/Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, General Surgery, and Psychiatry.
SOURCE: UNMC Health Professions Tracking Center.

Hospitalizations for Ambulatory-Care-Sensitive Conditions

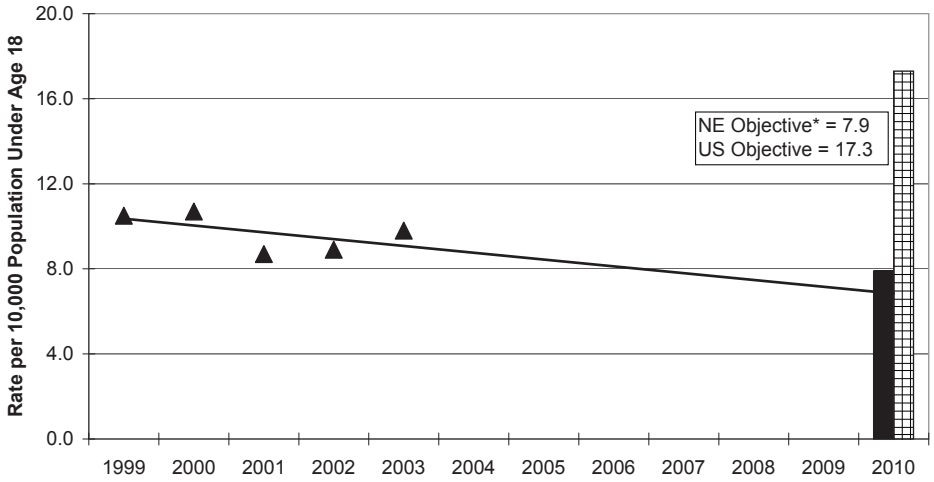
Ambulatory-care-sensitive medical conditions are responsive to high-quality primary care health services. High hospital admission rates for ambulatory-care-sensitive conditions indicate limited access to primary care and/or receipt of low-quality primary care services. The following three conditions are all diagnoses for which hospitalization generally could be avoided by provision of appropriate primary care and preventive services.

Pediatric Asthma

In Nebraska, no target hospitalization rate was originally set as a Healthy People 2010 objective. At that time, asthma death rates were fairly high and it was difficult to determine what direction asthma hospitalization rates should go to improve health. If asthma deaths were occurring because patients were not receiving hospital care when needed, then it might be advisable to target a higher hospitalization rate as a means of reducing asthma deaths. However, asthma deaths have since begun decreasing in Nebraska and a 25 percent reduction in the baseline hospitalization rate for pediatric asthma has been targeted for 2010 (7.9 hospitalizations per 10,000 children under age 18 years).

Nationwide, the rate of hospitalization for asthma among children under age 18 years has decreased slightly to 22.6 per 10,000 population in 2003. In Nebraska, the hospitalization rate is much lower (9.8 per 10,000 in 2003), but has also decreased somewhat (- 7 percent) (Figure 8).

Figure 8
Hospitalizations for Pediatric Asthma
(Age <18 Years) in Nebraska

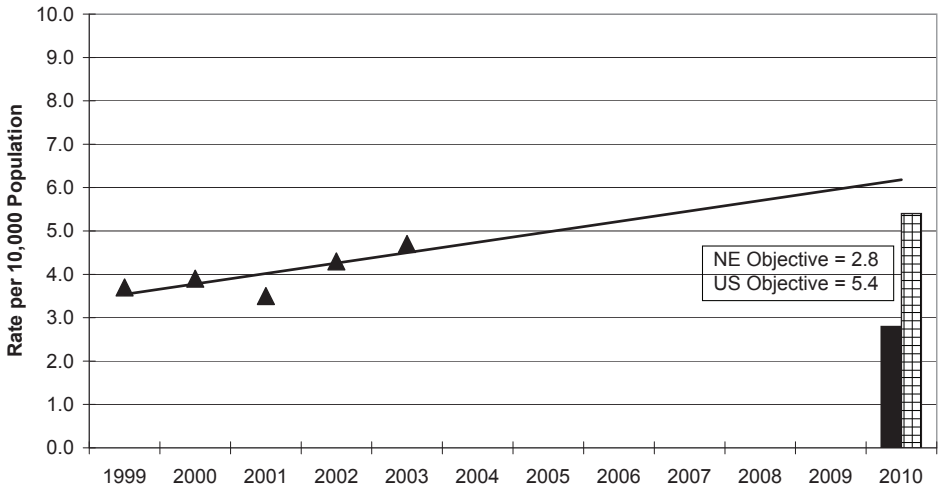


*Nebraska objective set in 2006.
Source: NE HHSS, Nebraska Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Uncontrolled Diabetes

The 2010 objective is to reduce hospitalizations for uncontrolled diabetes among adults aged 18 to 64 to no more than 2.8 per 10,000 population. The current Nebraska rate for this condition (4.7 per 10,000 in 2003) is much lower than the national rate of 7.8. Hospitalizations for uncontrolled diabetes in this age group increased by 27 percent from the baseline in Nebraska, but by only 8 percent nationwide (Figure 9).

Figure 9
Hospitalizations for Uncontrolled Diabetes
Adults Aged 18-64 in Nebraska

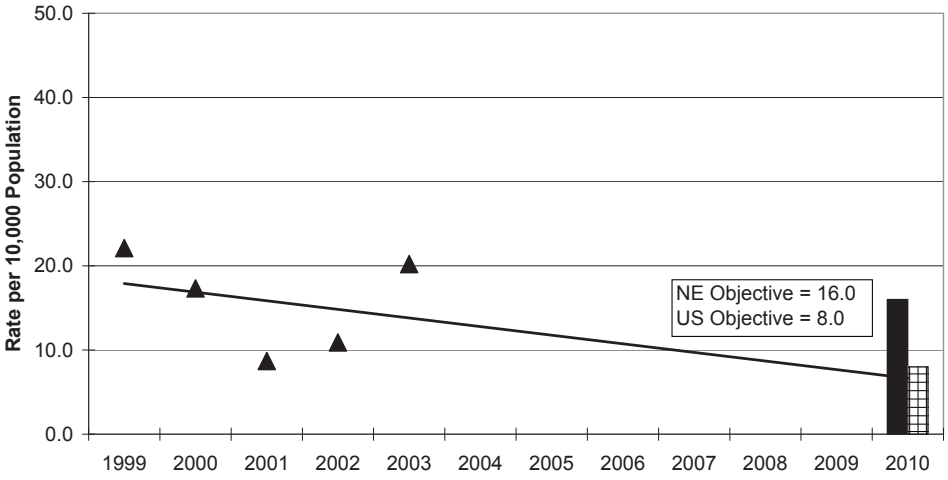


SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Immunization-Preventable Influenza or Pneumonia

The Nebraska 2010 objective for hospitalizations due to immunization-preventable pneumonia or influenza among the elderly (aged 65 and older) is no more than 16.0 per 10,000 population. The 2003 Nebraska rate (20.2) is more than double the nationwide rate of 9.7 and represents a decrease of 9 percent from the baseline of 22.1 (Figure 10).

Figure 10
Hospitalizations for Immunization-Preventable Pneumonia or Influenza (Adults Aged 65+ in Nebraska)



SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

ARTHRITIS, OSTEOPOROSIS, AND CHRONIC BACK CONDITIONS

Healthy People 2010 Goal

The national Healthy People 2010 goal is to prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions.

Background

While arthritis and related conditions are seldom a cause of death, they are very prevalent in the United States. A substantial increase is expected in the overall number of cases of arthritis and osteoporosis as the aging baby-boomers approach the peak years for incidence of these conditions. According to the National Institute of Arthritis and Musculoskeletal and Skin Diseases, arthritis and other rheumatic conditions affected about 43 million Americans in 2004. By 2030, it is estimated that 67 million Americans will be affected by arthritis.

Arthritis and related conditions impose a heavy toll on society in terms of loss of time from productive activities and in health care costs. Arthritis is now the leading cause of disability in the United States and ranks second only to heart disease as a cause of work disability. It also limits everyday activities and adversely affects the physical and mental health of the people who have it. Total U.S. cost for arthritis and other rheumatic conditions was estimated at $127 billion in 2003.

Osteoporosis is responsible for more than 1.5 million fractures each year in the United States. Health care costs attributable to this condition are estimated at $14 billion annually.

Progress Toward Healthy People 2010 Objectives

National

Only two of the national Healthy People 2010 objectives in this priority area were also adopted by Nebraska.

The definition of the indicator measuring prevalence of activity limitation due to arthritis has changed and a new national baseline established in 2002, making progress difficult to measure (Table 2). In 2004, 39 percent of adults with doctor-diagnosed arthritis experienced limitation in activity due to arthritis or joint symptoms, compared to 36 percent in 2002.

Between 1998 and 2002, there was almost no change in the nationwide rate of hospitalizations for vertebral fractures associated with osteoporosis among adults aged 65 and older.

Nebraska

In Nebraska, there was very little change in prevalence of activity limitation due to arthritis in 2005, compared to the 2001 baseline. The trend in hospitalizations for vertebral fractures associated with osteoporosis among elderly Nebraskans generally increased slightly from the baseline.

Table 2
Nebraska 2010 Health Goals and Objectives
Arthritis, Osteoporosis, and Chronic Back Conditions

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#2-2	Percent of adults aged 18+ with doctor-diagnosed arthritis who experience limitation in activity due to arthritis or joint symptoms	2002	36	2004	39	33	2001	23	2005	22	35
	White	2002	34	2004	38	33	Data Not Available By Race/Ethnicity		2001-2005	21	35
	African American	2002	45	2004	45	33			2001-2005	30	35
	Native American	2002	NA	2004	42	33			2001-2005	32	35
	Asian American	2002	39*	2004	30*	33			2001-2005	7	35
	Hispanic American	2002	40	2004	47	33			2001-2005	18	35
#2-10	Hospitalizations for vertebral fractures associated with osteoporosis (age 65 + years)/10,000 population Data by race/ethnicity currently unavailable in Nebraska	1998	17.5	2002	17.4	14	1999	18.7	2003	17.9	15.0

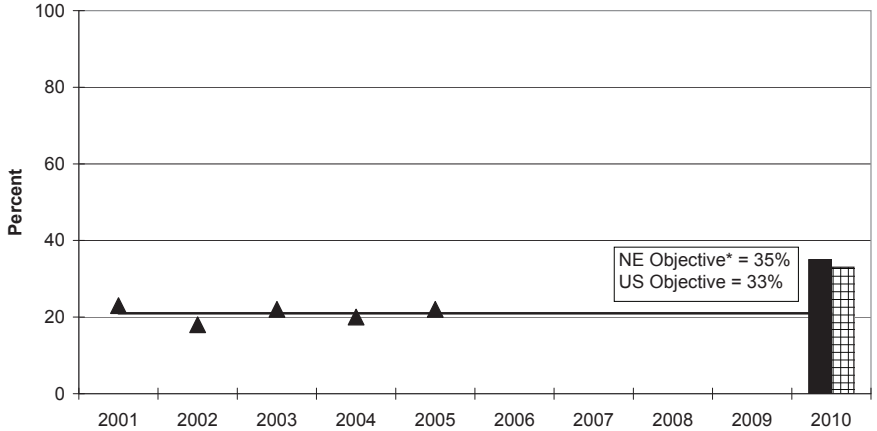
*Asian only. NA = Not Available

Data Sources:		Additional Notes:
#2-2	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	As a percent of adults aged 18 or older who have doctor-diagnosed arthritis. CHANGE IN DATA COLLECTED. As a percent of adults aged 18 or older who have doctor-diagnosed arthritis ("yes" to question "Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?"). Respondents with doctor-diagnosed arthritis were than asked, "Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms?"
#2-10	U.S.--National Hospital Discharge Survey, CDC. Nebraska--Hospital Discharge data, HHSS.	Number of discharges from short-stay hospitals for vertebral fractures (ICD-9 codes 805.0, 805.2, 805.4, or 805.8 in any listed diagnostic field). These codes selected the vertebral fractures most likely to be due to osteoporosis but excluding open vertebral fractures and those with spinal cord involvement, which are usually due to severe trauma. Same as U.S.

Activity Limitation due to Arthritis

In 2005, the proportion of Nebraska adults with doctor-diagnosed arthritis who experienced activity limitations due to arthritis or joint symptoms (22 percent) had changed very little from the 2001 baseline of 23 percent (Figure 11).

Figure 11
Activity Limitations Due to Arthritis/Joint Symptoms Among Nebraska Adults Aged 18+ with Doctor-Diagnosed Arthritis

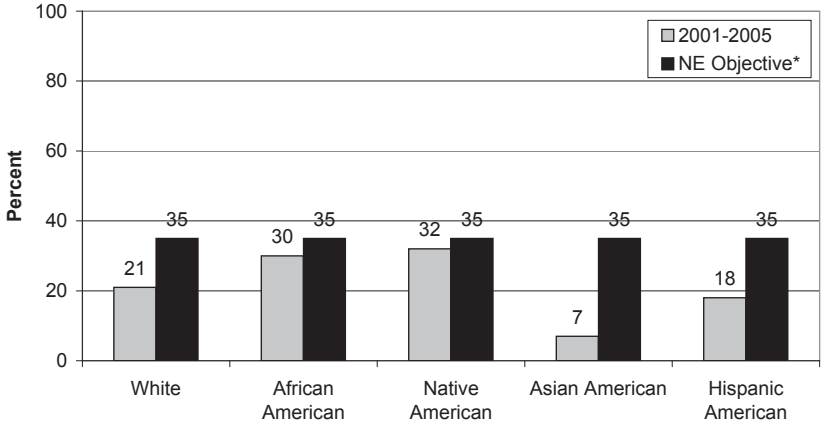


*Change in data collected. Original Nebraska objective met and will be revised.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Originally, Nebraska established an objective of reducing to 35 percent the proportion of adults who had activity limitations due to arthritis. However, the definition used has changed and the new baseline rate (from 2001) is substantially lower, necessitating a change in the Nebraska target rate. Applying a 12 percent reduction to the 2005 rate of 22 percent results in a new overall target of 19 percent for 2010 (Appendix, Table A).

Native Americans (32 percent) and African Americans (30 percent) were much more likely than whites (21 percent), Hispanic Americans (18 percent) or Asian Americans (7 percent) in Nebraska to report being limited in their activities by arthritis or joint symptoms (Figure 12).

Figure 12
Activity Limitations Due to Arthritis/Joint Symptoms Among Nebraska Adults Aged 18+ with Doctor-Diagnosed Arthritis by Race/Ethnicity



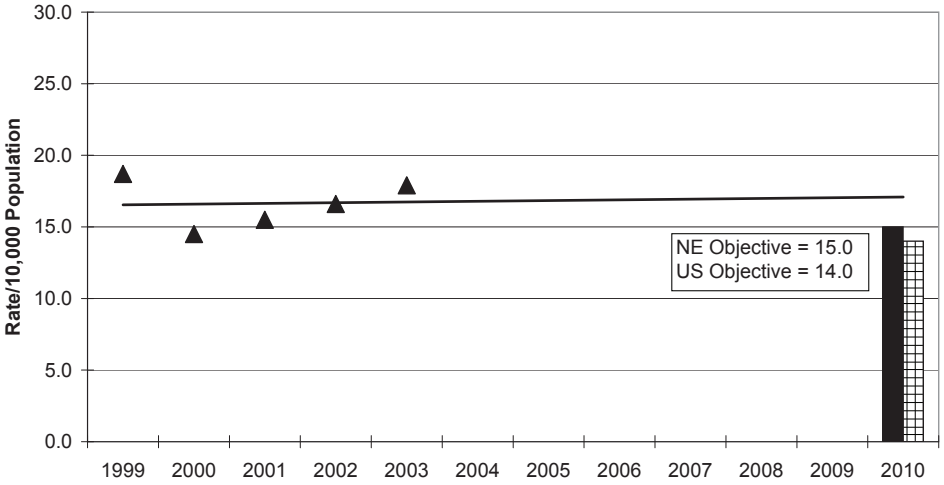
*Nebraska objectives will be revised.
SOURCE: Nebraska HHSS, BRFSS.

Hospitalizations due to Osteoporosis-Related Vertebral Fractures

Vertebral (spinal) fractures are the most frequently occurring fractures caused by osteoporosis. For persons with osteoporosis, normal daily activities can put enough stress on the spine to cause fractures in these bones.

Nebraska's objective is to reduce the rate of hospitalizations due to these fractures among adults aged 65 and older to no more than 15.0 per 10,000 population (Figure 13). Starting in 2000, this rate increased to 17.9 hospitalizations per 10,000 in 2003.

Figure 13
Hospitalizations for Vertebral Fractures
Associated with Osteoporosis (Nebraskans Aged 65+)



SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

CANCER

Healthy People 2010 Goal

The national Healthy People 2010 goal for cancer is to reduce the number of new cases as well as the illness, disability, and deaths caused by cancer.

Background

Cancer is second only to heart disease as a leading cause of death in the United States and in Nebraska. According to the American Cancer Society, nearly 1.4 million Americans will be diagnosed with cancer and 564,830 persons will die from cancer in 2006. In Nebraska, it is estimated that 8,450 people will receive a diagnosis of cancer and 3,410 Nebraskans die as a result of this disease.

Five-year relative survival rates may vary widely by type of cancer, but have generally been improving. For persons diagnosed with cancer in 1995-2001, the likelihood of a person just diagnosed with cancer being alive in five years is 65 percent as great as the chance of persons without cancer.

The National Institutes of Health estimate that overall costs of cancer in 2004 were $189.8 billion. In addition to health expenditures for cancer, this figure includes costs of lost productivity due to illness and premature death resulting from cancer.

Progress Toward Healthy People 2010 Objectives

National

A 2005 cancer trends report from the National Cancer Institute reports that the United States is making progress toward a number of cancer-related Healthy People 2010 targets. Death rates for all cancers combined and for the four most common cancers (lung, colorectal, breast, and prostate) continue to decline. The rate of cancer incidence has been fairly stable since the mid-1990's.

Screening rates for cervical cancer are high and have remained stable since 1998. The use of mammograms to screen for breast cancer among women aged 40 and older is high and continues to edge upward. On the other hand, screening for colorectal cancer is much less common, despite its proven effectiveness. However, the proportion of adults aged 50 and older who ever had a sigmoidoscopy has increased from the baseline rate.

Nebraska

In Nebraska, two cancer objectives for 2010 have already been achieved: reducing the rate of prostate cancer deaths and increasing the proportion of women aged 40 and older who had a mammogram in the last two years (Table 3).

Table 3
Nebraska 2010 Health Goals and Objectives
Cancer

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#3-1	Overall cancer death rate	1999	200.8	2003	190.1	158.6	1998	186.0	2004	173.5	147.0
	White	1999	197.9	2003	188.5	158.6	1994-1998	187.5	2000-2004	180.7	147.0
	African American	1999	252.5	2003	233.3	158.6	1994-1998	263.7	2000-2004	255.2	147.0
	Native American	1999	134.8	2003	119.3	158.6	1994-1998	216.7	2000-2004	201.9	147.0
	Asian American	1999	123.0	2003	113.5	158.6	1994-1998	107.8	2000-2004	137.3	85.2
	Hispanic American	1999	134.8	2003	126.6	158.6	1994-1998	91.2	2000-2004	117.8	72.0
#3-2	Lung cancer death rate	1999	55.5	2003	54.1	43.3	1998	50.1	2004	47.5	39.0
	White	1999	55.4	2003	54.5	43.3	1994-1998	50.3	2000-2004	48.5	39.0
	African American	1999	64.8	2003	60.8	43.3	1994-1998	69.6	2000-2004	81.5	39.0
	Native American	1999	36.3	2003	31.3	43.3	1994-1998	55.5	2000-2004	60.1	39.0
	Asian American	1999	27.9	2003	26.9	43.3	1994-1998	17.0	2000-2004	41.1	13.3
	Hispanic American	1999	25.0	2003	23.2	43.3	1994-1998	13.7	2000-2004	24.6	10.7
#3-3	Breast cancer death rate (females)	1999	26.6	2003	25.3	21.3	1998	25.9	2004	23.8	20.7
	White	1999	26.0	2003	24.7	21.3	1994-1998	28.4	2000-2004	23.4	20.7
	African American	1999	35.1	2003	34.0	21.3	1994-1998	36.4	2000-2004	41.3	20.7
	Native American	1999	15.5	2003	14.0	21.3	1994-1998	*	2000-2004	32.8	20.7
	Asian American	1999	12.7	2003	12.6	21.3	1994-1998	*	2000-2004	*	20.7
	Hispanic American	1999	16.4	2003	16.1	21.3	1994-1998	15.0	2000-2004	9.7	12.0
#3-4	Cervical cancer death rate (females)	1999	2.8	2003	2.5	2.0	1998	3.1	2004	2.3	2.0
	White	1999	2.6	2003	2.2	2.0	1994-1998	2.7	2000-2004	2.0	2.0
	African American	1999	5.4	2003	4.7	2.0	1994-1998	3.9	2000-2004	*	2.0
	Native American	1999	NA	2003	2.7	2.0	1994-1998	0.0	2000-2004	*	0.0
	Asian American	1999	2.6	2003	2.4	2.0	1994-1998	*	2000-2004	*	2.0
	Hispanic American	1999	3.6	2003	3.0	2.0	1994-1998	*	2000-2004	4.7	2.0
#3-5	Colorectal cancer death rate	1999	20.9	2003	19.1	13.7	1998	21.6	2004	18.3	14.3
	White	1999	20.4	2003	18.6	13.7	1994-1998	22.2	2000-2004	20.2	14.3
	African American	1999	28.4	2003	26.4	13.7	1994-1998	32.6	2000-2004	28.0	14.3
	Native American	1999	13.4	2003	11.8	13.7	1994-1998	29.7	2000-2004	*	14.3
	Asian American	1999	12.0	2003	12.1	13.7	1994-1998	*	2000-2004	16.1	14.3
	Hispanic American	1999	14.3	2003	13.4	13.7	1994-1998	16.9	2000-2004	15.0	14.3
#3-6	Oropharyngeal cancer death rate	1999	2.7	2003	2.6	2.4	1998	1.6	2004	1.6	1.4
	White	1999	2.5	2003	2.5	2.4	1994-1998	2.1	2000-2004	2.1	1.4
	African American	1999	4.3	2003	3.8	2.4	1994-1998	5.0	2000-2004	2.0	1.4
	Native American	1999	2.0	2003	1.9	2.4	1994-1998	*	2000-2004	*	1.4
	Asian American	1999	2.3	2003	2.3	2.4	1994-1998	*	2000-2004	*	1.4
	Hispanic American	1999	1.9	2003	1.7	2.4	1994-1998	*	2000-2004	*	1.4
#3-7	Prostate cancer death rate (males)	1999	31.3	2003	26.5	28.2	1998	28.8	2004	24.1	25.9
	White	1999	28.7	2003	24.4	28.2	1994-1998	29.8	2000-2004	25.4	25.9
	African American	1999	69.0	2003	57.4	28.2	1994-1998	58.0	2000-2004	48.8	25.9
	Native American	1999	16.7	2003	17.8	28.2	1994-1998	*	2000-2004	*	25.9
	Asian American	1999	13.9	2003	10.9	28.2	1994-1998	0.0	2000-2004	*	0.0
	Hispanic American	1999	23.0	2003	20.2	28.2	1994-1998	8.8	2000-2004	*	8.0
#3-8	Melanoma death rate	1999	2.6	2003	2.7	2.3	1998	2.7	2004	2.8	2.4
	White	1999	3.0	2003	3.0	2.3	1994-1998	2.7	2000-2004	2.9	2.4
	African American	1999	0.4	2003	0.4	2.3	1994-1998	*	2000-2004	0.0	2.4
	Native American	1999	NA	2003	NA	2.3	1994-1998	0.0	2000-2004	*	0.0
	Asian American	1999	0.4	2003	0.4	2.3	1994-1998	0.0	2000-2004	*	0.0
	Hispanic American	1999	0.8	2003	0.8	2.3	1994-1998	*	2000-2004	*	2.4

Table 3 continued

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
# --	Lymphoma death rate	1990-1997	9.0	2000-2003	8.2		1998	8.9	2004	7.6	6.2
	White	1990-1997	9.4	2000-2003	8.6	No	1994-1998	8.8	2000-2004	8.4	6.2
	African American	1990-1997	6.4	2000-2003	5.7	Target	1994-1998	13.7	2000-2004	4.8	6.2
	Native American	1990-1997	NA	2000-2003	4.7	Rates	1994-1998	*	2000-2004	*	6.2
	Asian American	1990-1997	NA	2000-2003	5.0	Set	1994-1998	*	2000-2004	*	6.2
	Hispanic American	1990-1997	NA	2000-2003	6.3		1994-1998	6.9	2000-2004	4.8	6.2
# --	Leukemia death rate	1990-1997	7.9	2000-2003	7.5		1998	7.5	2004	7.1	5.2
	White	1990-1997	8.0	2000-2003	7.8	No	1994-1998	7.6	2000-2004	7.9	5.2
	African American	1990-1997	7.2	2000-2003	6.7	Target	1994-1998	8.2	2000-2004	9.2	5.2
	Native American	1990-1997	NA	2000-2003	3.9	Rates	1994-1998	*	2000-2004	0.0	5.2
	Asian American	1990-1997	NA	2000-2003	3.9	Set	1994-1998	*	2000-2004	0.0	5.2
	Hispanic American	1990-1997	NA	2000-2003	5.2		1994-1998	0.0	2000-2004	5.6	0.0
#3-11a	Percent of women who ever received a Pap test (age 18+ with or without uterine cervix)	1998	92	2003	93	97	1999	94	2004	94	98
	White	1998	93	2003	93	97	1994-1998	93	2001-2005	95	98
	African American	1998	94	2003	93	97	1994-1998	93	2001-2005	94	98
	Native American	1998	88	2003	93	97	1994-1998	*	2001-2005	95	98
	Asian American	1998	78**	2003	77**	97	1994-1998	*	2001-2005	78	98
	Hispanic American	1998	85	2003	86	97	1994-1998	93	2001-2005	89	98
#3-11b	Percent of all women who received a Pap test within last 3 years (age 18+ with or without uterine cervix)	1998	79	2003	79	90	1999	80	2004	80	90
	White	1998	79	2003	79	90	1994-1998	77	2001-2005	81	90
	African American	1998	83	2003	83	90	1994-1998	82	2001-2005	86	90
	Native American	1998	72	2003	84	90	1994-1998	*	2001-2005	80	90
	Asian American	1998	67**	2003	68**	90	1994-1998	*	2001-2005	70	90
	Hispanic American	1998	74	2003	75	90	1994-1998	84	2001-2005	83	90
#3-12a	Percent of adults age 50+ who had fecal occult blood test in past 2 years	2000	24	2003	22	33	1999	28	2004	30	50
	White	2000	25	2003	22	33	Data Not Available by Race/Ethnicity		2001-2005	31	50
	African American	2000	21	2003	22	33			2001-2005	36	50
	Native American	2000	26	2003	NA	33			2001-2005	38	50
	Asian American	2000	24**	2003	18**	33			2001-2005	*	50
	Hispanic American	2000	13	2003	15	33			2001-2005	18	50
#3-12b	Percent of adults age 50+ who ever had sigmoidoscopy	1998	37	2003	43	50	1999	35	2004***	46	50
	White	1998	38	2003	44	50	Data Not Available by Race/Ethnicity		2001-2005	42	50
	African American	1998	32	2003	38	50			2001-2005	39	50
	Native American	1998	29	2003	34	50			2001-2005	50	50
	Asian American	1998	35**	2003	31**	50			2001-2005	*	50
	Hispanic American	1998	27	2003	28	50			2001-2005	32	50
#3-13	Percent of women age 40+ who had mammogram within the past 2 years	1998	67	2003	70	70	1999	70	2004	76	75
	White	1998	68	2003	70	70	1994-1998	64	2001-2005	76	75
	African American	1998	66	2003	70	70	1994-1998	68	2001-2005	77	75
	Native American	1998	40	2003	NA	70	1994-1998	*	2001-2005	54	75
	Asian American	1998	60**	2003	58**	70	1994-1998	*	2001-2005	*	75
	Hispanic American	1998	60	2003	62	70	1994-1998	53	2001-2005	71	75

NA = Not Available *Number of deaths or respondents too small to allow rate to be reported. **Asian only. ***Question revised in 2001

Table 3 continued		
Data Sources:		Additional Notes:
#3-1	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 codes 140-208. Same as U.S.
#3-2	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 code 162. Same as U.S.
#3-3	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 code 174. Same as U.S.
#3-4	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 code 180. Same as U.S.
#3-5	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 codes 153, 154. Same as U.S.
#3-6	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 codes 140-149. Same as U.S.
#3-7	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 code 185. Same as U.S.
#3-8	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 code 172. Same as U.S.
#3-xx	U.S.--National Cancer Institute, SEER Cancer Statistics Review, 1975-2003. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 codes 200-202. Same as U.S.
#3-xx	U.S.--National Cancer Institute, SEER Cancer Statistics Review, 1975-2003. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	Age-adjusted to 2000 standard population. ICD-9 codes 204-208. Same as U.S.
#3-11a,b	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	Includes women with or without a uterine cervix. Same as U.S.
#3-12a	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	A fecal occult blood test is referred to as a blood stool test in the NHIS.
#3-12b	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	A sigmoidoscopy is referred to as a proctoscopic examination in the NHIS.
#3-13	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	

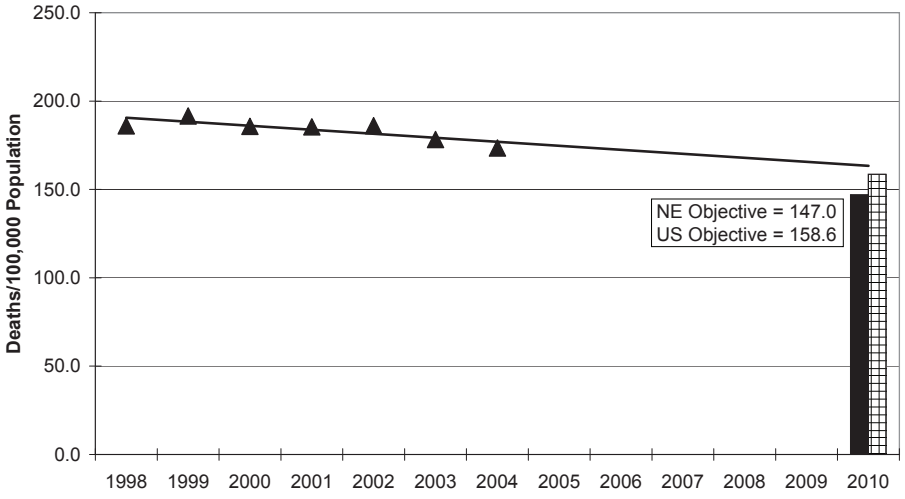
Progress was made toward achieving nine cancer objectives, while rates had not changed from the baseline for four objectives in Nebraska. The overall cancer death rate declined from the 1998 baseline, as did death rates due to lung cancer, breast cancer, cervical cancer, colorectal cancer, lymphoma, and leukemia. The proportion of adults aged 50 and older who had a fecal occult blood test in the past two years increased and so did the proportion of adults in this age group who reported ever having a sigmoidoscopy or colonoscopy. (Both these tests are used to screen for colon cancer.)

No change occurred in the rate of deaths due to cancer of the mouth and throat (oropharyngeal cancer) or in the melanoma death rate. The proportions of women who ever had a Pap test or who had one in the past three years also remained the same, compared to the baseline.

All Cancer Deaths

Although the national cancer mortality objective is set at no more than 158.6 deaths per 100,000 population, the Nebraska objective is to reduce the death rate for all cancers combined to no more than 147.0 deaths per 100,000 population (Figure 14). In Nebraska, the overall cancer death rate was down from 186.0 in 1998 to 173.5 in 2004, a decrease of 7 percent. The current national rate of 190.1 represented a decline of 5 percent from the baseline, but remained higher than the Nebraska rate.

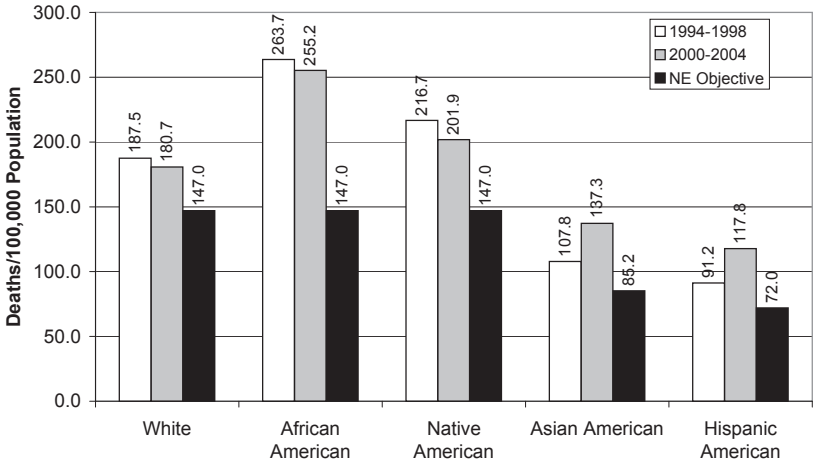
Figure 14
Deaths Due to Cancer in Nebraska (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Some differences were apparent by race and ethnicity in Nebraska (Figure 15). Progress toward the 2010 target was achieved for whites, African Americans, and Native Americans in the state. However, rates for African Americans (255.2) and Native Americans (201.9) were still higher than rates for other racial/ethnic groups.

Figure 15
Deaths Due to Cancer in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)



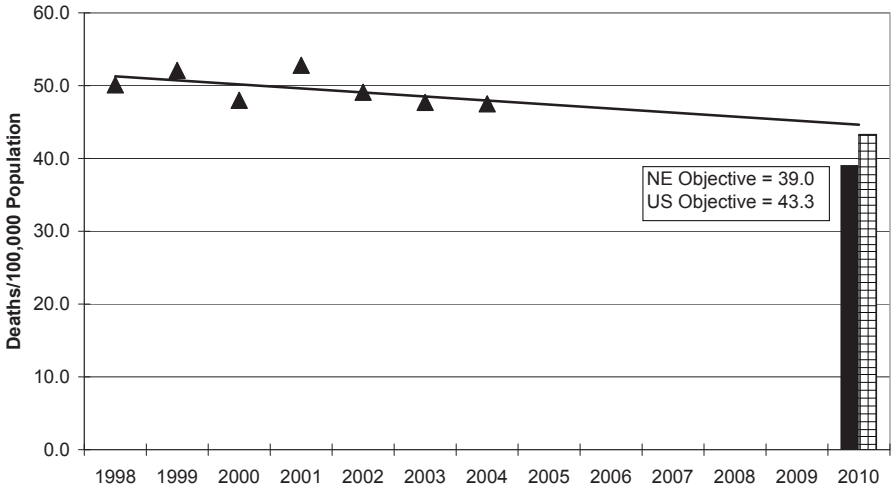
SOURCE: Nebraska HHSS, Vital Statistics.

For Asian Americans and Hispanic Americans in Nebraska, cancer mortality rates rose compared to baseline rates. Cancer death rates increased by 27 percent among Asian Americans (to 137.3) and by 29 percent among Hispanic Americans in Nebraska, reaching 117.8 in 2000-2004.

Lung Cancer Deaths

The target rate for reducing lung cancer deaths is lower for Nebraska (39.0) than for the United States (43.3). The 2004 Nebraska rate of 47.5 lung cancer deaths per 100,000 is also lower than the current national rate of 54.1 (Table 3). Lung cancer death rates have decreased by 5 percent in Nebraska, compared to the 1998 baseline (Figure 16). Nationwide, a decline of less than 3 percent was reported.

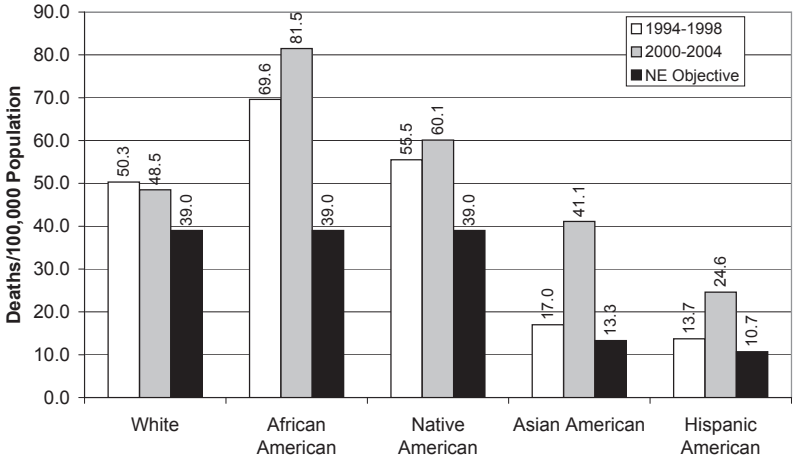
Figure 16
Lung Cancer Mortality in Nebraska (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Although the overall trend in lung cancer death rates is down in Nebraska, the 2000-2004 rates for all racial and ethnic groups except whites in the state are up (Figure 17). Lung cancer deaths for African Americans and Native Americans were already higher than rates for the other groups. The rate for African Americans increased by 17 percent to 81.5 deaths per 100,000, while the rate for Native Americans rose by 8 percent to 60.1. Asian and Hispanic Nebraskans began with lower baseline rates, but showed substantial increases as of 2000-2004 (+142 percent and +80 percent, respectively).

Figure 17
Lung Cancer Mortality in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)

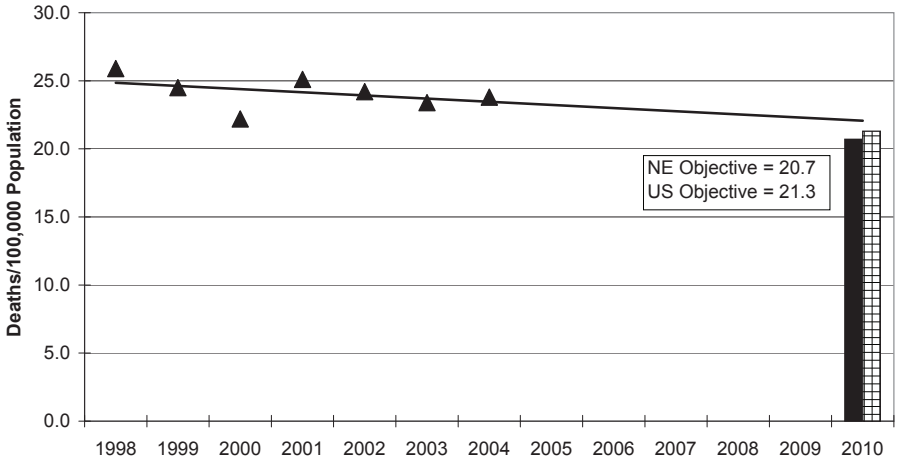


SOURCE: Nebraska HHSS, Vital Statistics.

Breast Cancer Deaths

Another of Nebraska's 2010 health objectives is to reduce mortality due to breast cancer to no more than 20.7 deaths per 100,000 females (Table 3). The national objective is slightly higher, at 21.3. The current U.S. rate (25.3) is also higher than 2004 Nebraska rate of 23.8. Compared to baseline rates, breast cancer mortality declined by 8 percent in Nebraska, while the national mortality rate was down 5 percent. (Figure 18).

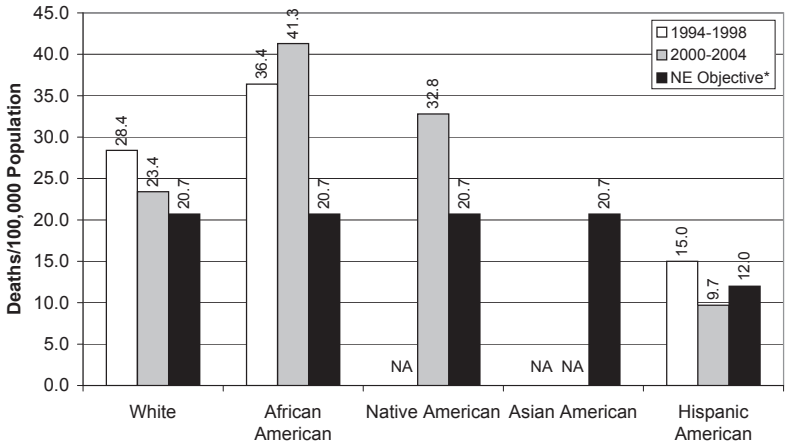
Figure 18
Breast Cancer Mortality in Nebraska (Females)
Age-Adjusted to 2000



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

In 2000-2004, African American women experienced a higher breast cancer death rate (41.3) than other racial/ethnic groups in Nebraska did (Figure 19). This rate represents an increase of 13 percent, compared to the 1994-1998 baseline, and is nearly double the 2010 target rate for this objective.

Figure 19
Breast Cancer Mortality (Nebraska Females)
by Race/Ethnicity (Age-Adjusted to 2000)



*Nebraska objective has been met for Hispanic American females and will be revised.
NA = Not Available. Rates based on fewer than five deaths during period.
SOURCE: Nebraska HHSS, Vital Statistics.

A high breast cancer mortality rate (32.8) was recorded for Native Americans in the state as well in 2000-2004. No baseline rate was reported due to small number of deaths.

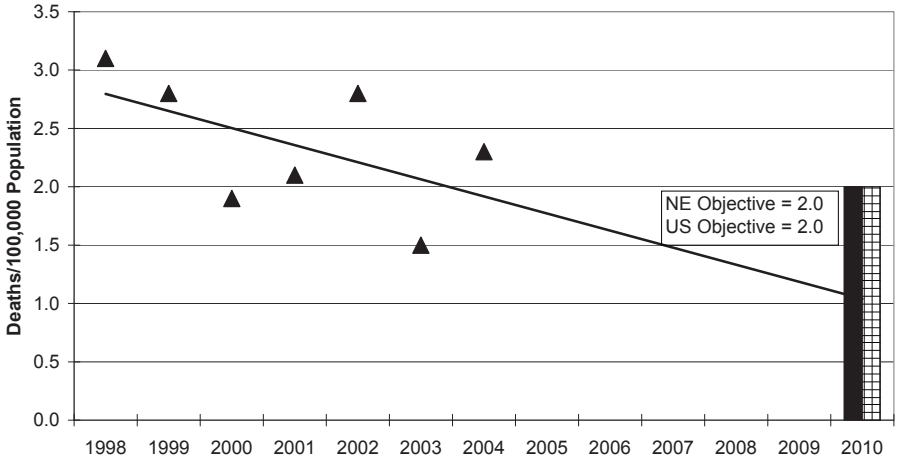
Breast cancer mortality rates declined for white women (-18 percent) and Hispanic women (-35 percent) in Nebraska, compared to the baseline. The breast cancer death rate for Hispanic women in 2000-2004 (9.7) was the lowest for any of the racial/ethnic groups in the state and meets the 2010 objective for this group.

Cervical Cancer Deaths

The Nebraska objective for cervical cancer deaths is identical to the national objective to reduce the rate of these deaths to no more than 2.0 per 100,000 females by the year 2010 (Table 3). Death rates due to cervical

cancer are similar for Nebraska (2.3) and the nation (2.5). These rates have decreased both nationwide (-11 percent) and in Nebraska (-26 percent) (Figure 20).

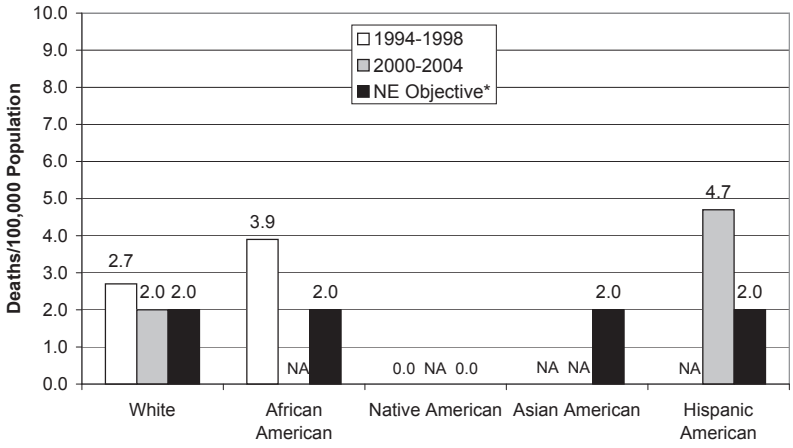
Figure 20
Cervical Cancer Mortality in Nebraska (Females)
Age-Adjusted to 2000



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Due to the relatively small numbers of cervical cancer deaths, trend data by race and ethnic origin are limited for Nebraska (Figure 21).

Figure 21
Cervical Cancer Mortality (Nebraska Females)
by Race/Ethnicity (Age-Adjusted to 2000)

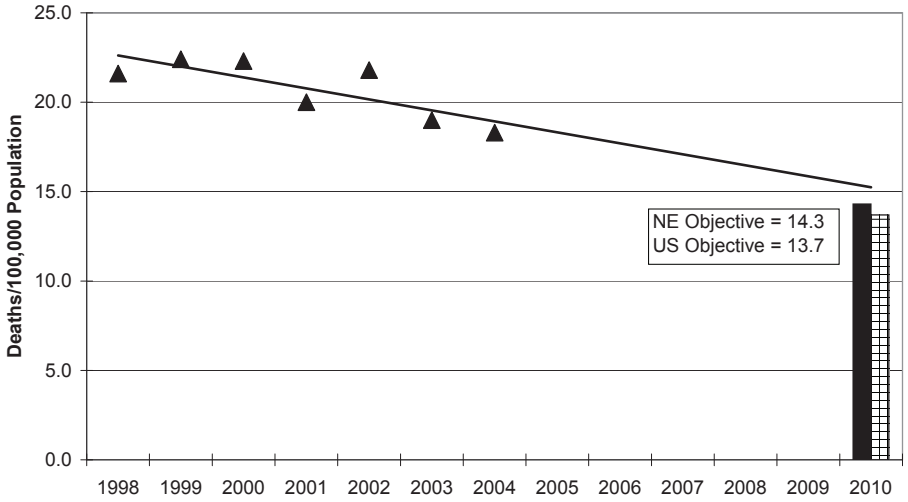


*Nebraska objective has been met for white females and will be revised.
NA = Not Available. Rates based on fewer than five deaths during period.
SOURCE: Nebraska HHSS, Vital Statistics.

Colorectal Cancer Deaths

Colorectal cancer was the second leading cause of cancer deaths in Nebraska, accounting for 357 deaths in 2004. Nebraska has adopted a 2010 objective of reducing colorectal cancer deaths to no more than 14.3 per 100,000 population (Table 3). The national target rate is slightly lower at 13.7. The death rate for this type of cancer in Nebraska decreased by 15 percent from 21.6 in 1998 to 18.3 in 2004 (Figure 22). The U.S. colorectal cancer mortality rate showed slightly less decline (- 9 percent) from the baseline, resulting in the current rate of 19.1 deaths per 100,000.

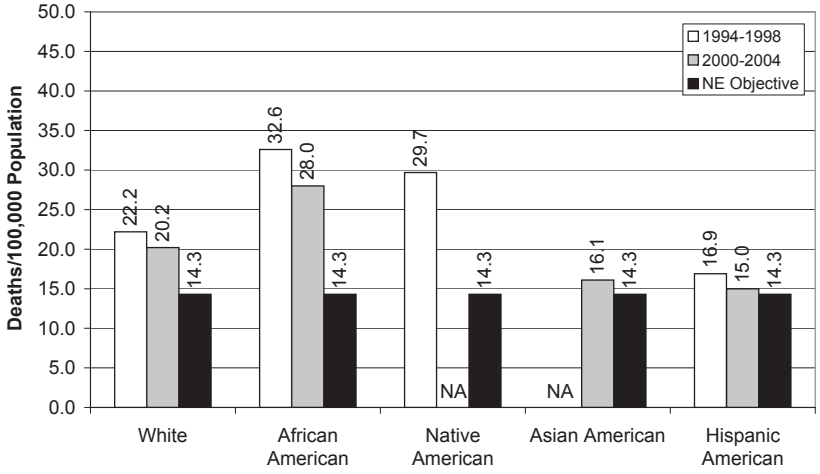
Figure 22
Colorectal Cancer Mortality in Nebraska
(Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

African Americans (28.0 deaths per 100,000) experienced the highest colorectal cancer mortality rate of any major racial/ethnic group in Nebraska in 2000-2004, although this rate represents a decrease of 14.1 percent from 1994-1998 (Figure 23). White (-9 percent) and Hispanic (-13 percent) Nebraskans also recorded lower death rates from this type of cancer in 2000-2004, compared to baseline rates. Trend data were not available for Native Americans and Asian Americans in the state due to small numbers of deaths.

Figure 23
Colorectal Cancer Mortality in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)

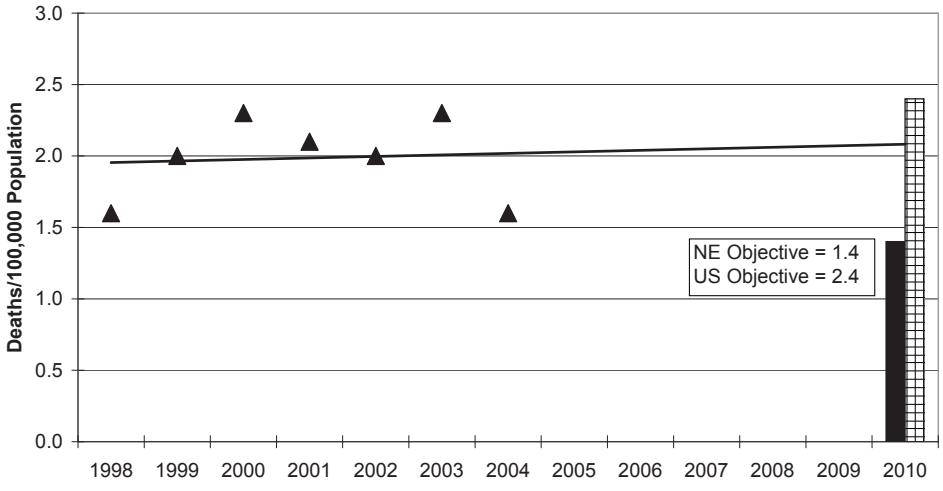


NA = Not Available. Rates based on fewer than five deaths during period.
SOURCE: Nebraska HHSS, Vital Statistics.

Oropharyngeal Cancer Deaths

Nebraska has targeted a reduction in oropharyngeal cancer death rates to no more than 1.4 deaths per 100,000 population by 2010 (Table 3). The national target is higher, at 2.4. Nebraska deaths due to cancers of the mouth and throat have varied somewhat since 1998, but the overall trend has been stable (Figure 24). In 2004, there were 1.6 deaths per 100,000 in the state, compared to 2.6 nationwide.

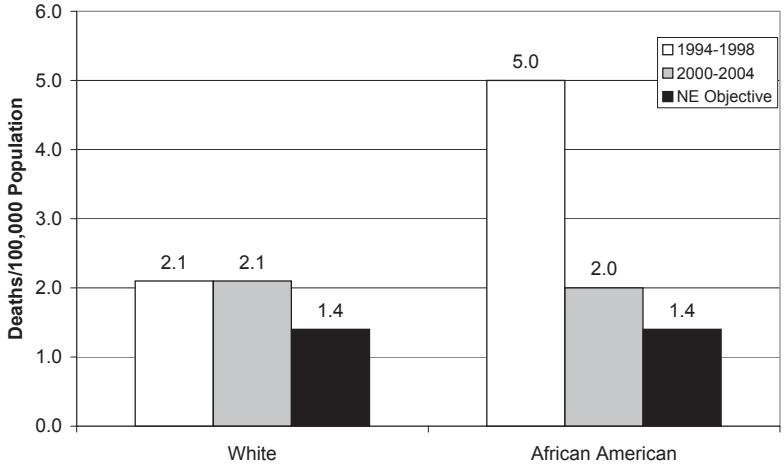
Figure 24
Deaths Due to Cancer of Oral Cavity/Pharynx in Nebraska
(Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Due to the relatively small number of deaths from this cause in Nebraska, data are only available for whites and African Americans. The death rate among African Americans decreased from 5.0 in 1994-1998 to 2.0 in 2000-2004 (Figure 25). Among white Nebraskans, the rate stayed the same at 2.1 deaths per 100,000 population.

Figure 25
Deaths Due to Oropharyngeal Cancer in Nebraska
by Race/Ethnicity (Age-Adjusted to 2000)

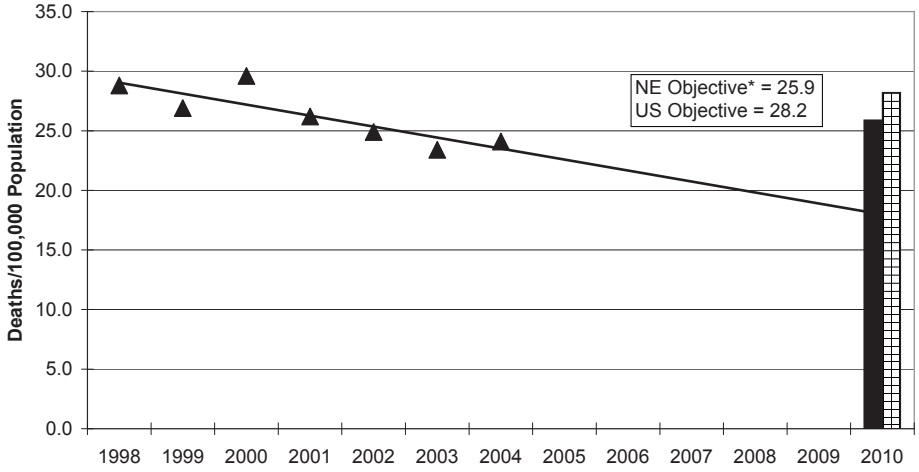


NOTE: Rates for Native Americans, Asian Americans, and Hispanic Americans were based on fewer than 5 deaths during these periods and are not reported here.
SOURCE: Nebraska HHSS, Vital Statistics.

Prostate Cancer Deaths

Another objective adopted by Nebraska was to reduce the prostate cancer death rate to no more than 25.9 per 100,000 men by 2010. The U.S. target rate was somewhat higher at 28.2 (Table 3). Death rates for prostate cancer declined enough, both in Nebraska (- 16 percent) and in the United States (- 15 percent), that these objectives were met (Figure 26). A new target rate of no more than 21.7 deaths per 100,000 will be set for Nebraska (a further reduction of 10 percent from the 2004 rate). (Appendix, Table A)

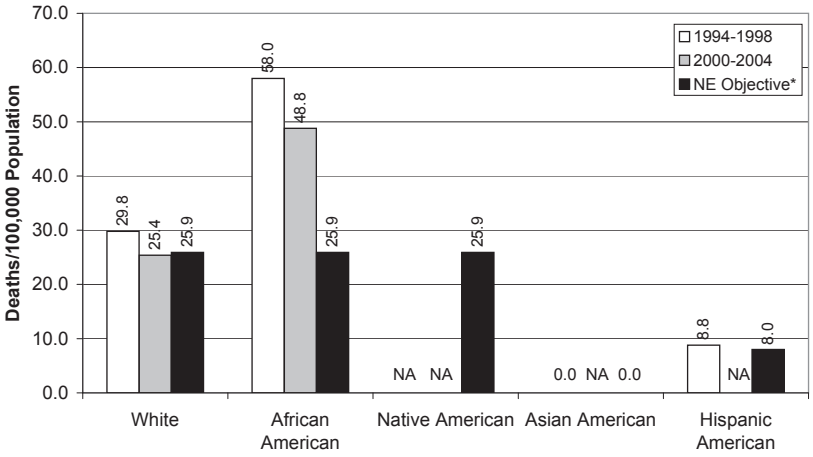
Figure 26
Prostate Cancer Mortality in Nebraska (Males)
Age-Adjusted to 2000



*Nebraska objective has been met and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

White (- 15 percent) and African American (- 16 percent) men in the state both achieved reductions in mortality due to prostate cancer (Figure 27). However, the current death rate was still nearly double among African American men (48.8), compared to white men (25.4) in 2000-2004. This rate for African Americans does not achieve the 2010 target for prostate cancer deaths. The 2000-2004 rate for white men (25.4) did reach the target rate and a new objective of 21.7 deaths/100,000 has been set (Appendix, Table A). Trends in prostate cancer mortality for other racial/ethnic groups are not available due to small numbers of deaths.

Figure 27
Prostate Cancer Mortality--Nebraska Males
by Race/Ethnicity (Age-Adjusted to 2000)

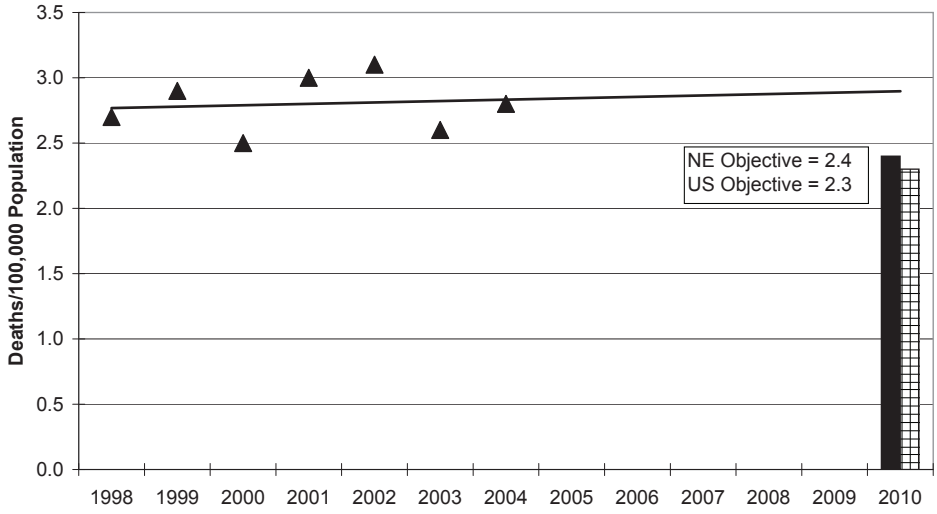


*The Nebraska objective has been met for white males and will be revised.
NA = Not Available. Rates based on fewer than five deaths during period.
SOURCE: Nebraska HHSS, Vital Statistics.

Melanoma Deaths

Nebraska and the nation have set similar target rates for reducing deaths due to melanoma (2.4 and 2.3 deaths per 100,000 population, respectively) (Table 3). There has been very little change in death rates at either the state or the national level. Although there has been some variation in Nebraska rates since 1998, the 2000-2004 rate (2.8) is up only very slightly from the baseline rate of 2.7 (Figure 28).

Figure 28
Melanoma Mortality in Nebraska (Age-Adjusted to 2000)



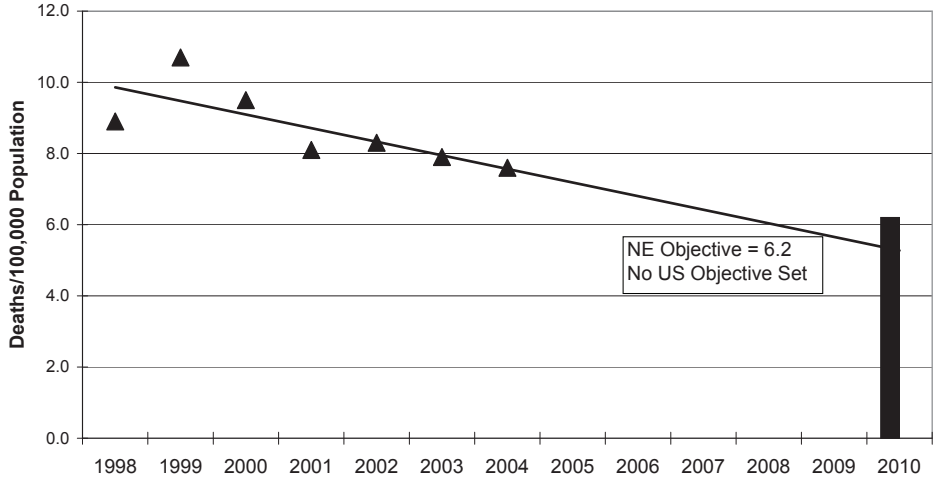
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Incidence and mortality rates due to melanoma are generally higher for white persons than for persons of other races. Since there are few cases of melanoma among these groups, trend data are unavailable for racial and ethnic groups other than white persons in the state.

Lymphoma Deaths

Although no national objective has been set for reducing lymphoma deaths, Nebraska has set a target rate of no more than 6.2 deaths per 100,000 population due to this kind of cancer for the year 2010 (Table 3). In Nebraska, lymphoma deaths were down by 15 percent in 2004 (7.6 deaths/100,000), compared to 1998 (8.9) (Figure 29). The current U.S. rate is a little higher (8.2) and represents a decrease of 9 percent from the national baseline.

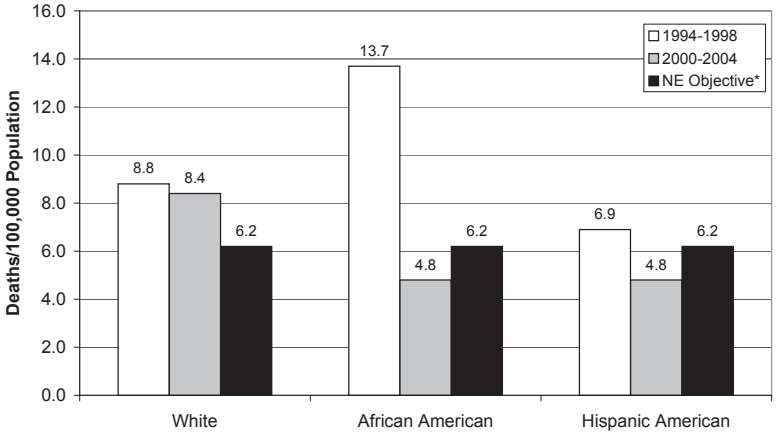
Figure 29
Lymphoma Mortality in Nebraska
Age-Adjusted to 2000



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

All three racial/ethnic groups for which trend data are available experienced decreases in death rates due to lymphoma in 2000-2004 (Figure 30). For white Nebraskans, mortality was down by 5 percent from 1994-1998, resulting in the highest current rate of the three groups (8.4). The lymphoma death rate among African Americans in the state dropped by 65 percent to 4.8 deaths per 100,000. Hispanic deaths due to lymphoma declined by 44 percent to 4.8 in 2000-2004. Death rates for African and Hispanic Americans both reached the target rate of no more than 6.2 deaths per 100,000 population. The revised target rates for these two groups have been set at no more than 3.4 deaths per 100,000 (a further decrease of 30 percent) (Appendix, Table A).

Figure 30
Lymphoma Mortality in Nebraska
by Race/Ethnicity (Age-Adjusted to 2000)

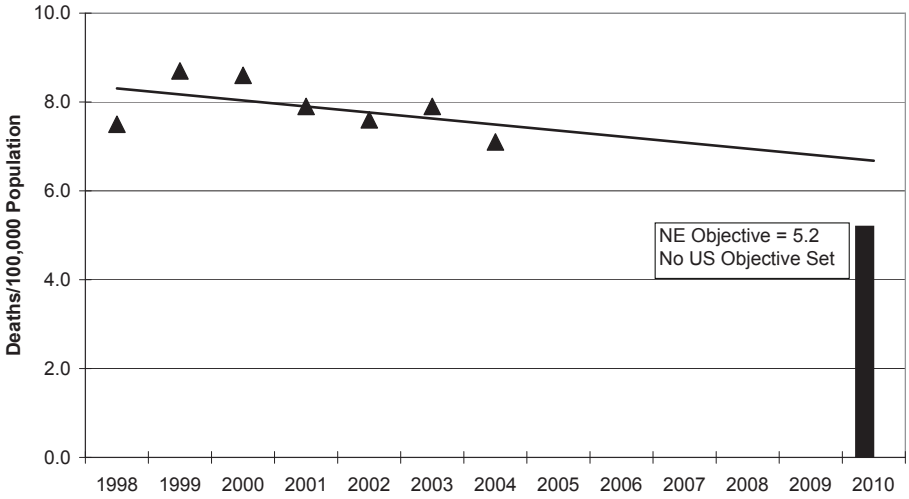


*Nebraska objectives have been met for African Americans and Hispanic Americans and will be revised.
NOTE: Rates for Native Americans and Asian Americans were based on fewer than five deaths during these periods and are not reported here.
SOURCE: Nebraska HHSS, Vital Statistics.

Leukemia Deaths

As is the case with lymphoma, no national objective has been set for reducing leukemia deaths by 2010. Nebraska has set a target rate of no more than 5.2 leukemia deaths per 100,000 by 2010 (Table 3). Death rates for leukemia declined by 5 percent each nationwide and in Nebraska (Figure 31). The 2004 Nebraska rate was 7.1 deaths per 100,000, compared to a current rate of 7.5 for the U.S.

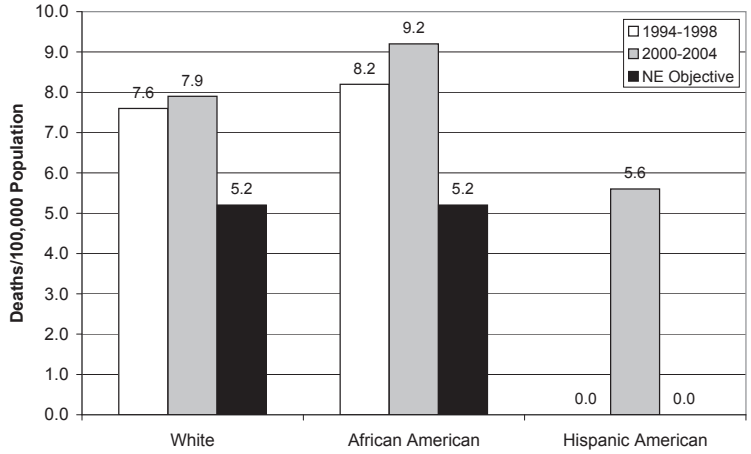
Figure 31
Leukemia Mortality in Nebraska (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

African Americans, Hispanic Americans, and whites in Nebraska all experienced increases in leukemia mortality in 2000-2004, compared to 1994-1998 (Figure 32). The leukemia death rate for African Americans in the state (9.2) was higher than rates for white (7.9) or Hispanic (5.6) Nebraskans in 2000-2004. No leukemia deaths were recorded for Native Americans or Asian Americans during 2000-2004, thus achieving the target rate for 2010. The new target rates for these two groups have been set at zero (Appendix, Table A).

Figure 32
Leukemia Mortality in Nebraska
by Race/Ethnicity (Age-Adjusted to 2000)

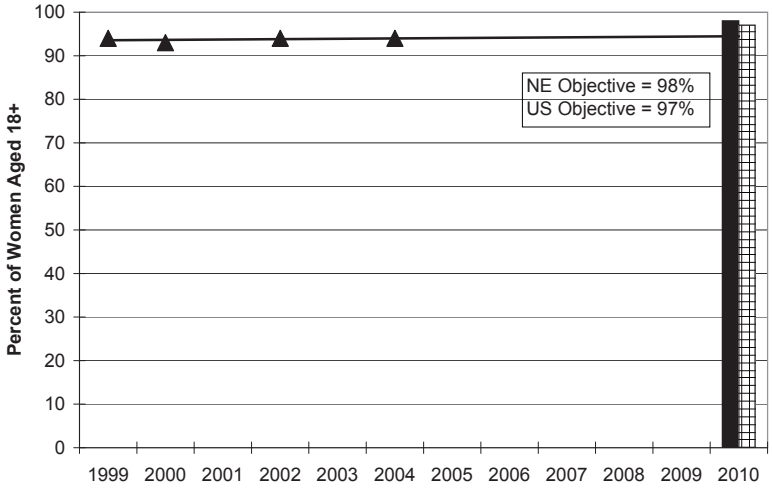


NOTE: Rates for Native Americans and Asian Americans were based on fewer than five deaths during these periods and are not reported here.
SOURCE: Nebraska HHSS, Vital Statistics.

Cervical Cancer Screening (Pap Tests)

An objective related to reducing cervical cancer death rates seeks to increase the proportion of women who have ever received a Pap test. Since the proportion of women who have ever had a Pap smear is already high, the Nebraska target rate for 2010 is 98 percent and the national target rate is 97 percent (Table 3). No change has been noted in Nebraska, where 94 percent of women in 2004 reported ever having this screening (Figure 33). Nationwide, there was an increase of one percentage-point to 93 percent in 2003.

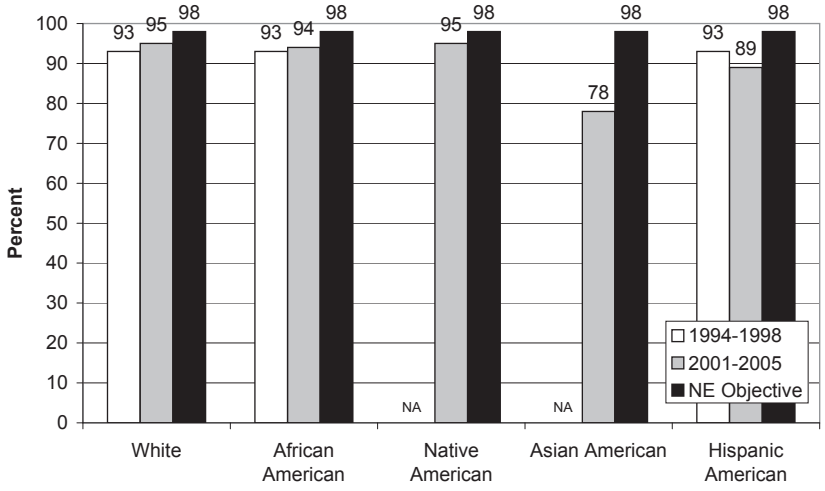
Figure 33
Nebraska Women Aged 18+ Who Ever Had Pap Test



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

In 2001-2005, screening rates were 94 or 95 percent for white, African American and Native American women in Nebraska (Figure 34). The rate was somewhat lower for Hispanic women (89 percent) and much lower for Asian American women (78 percent) in the state.

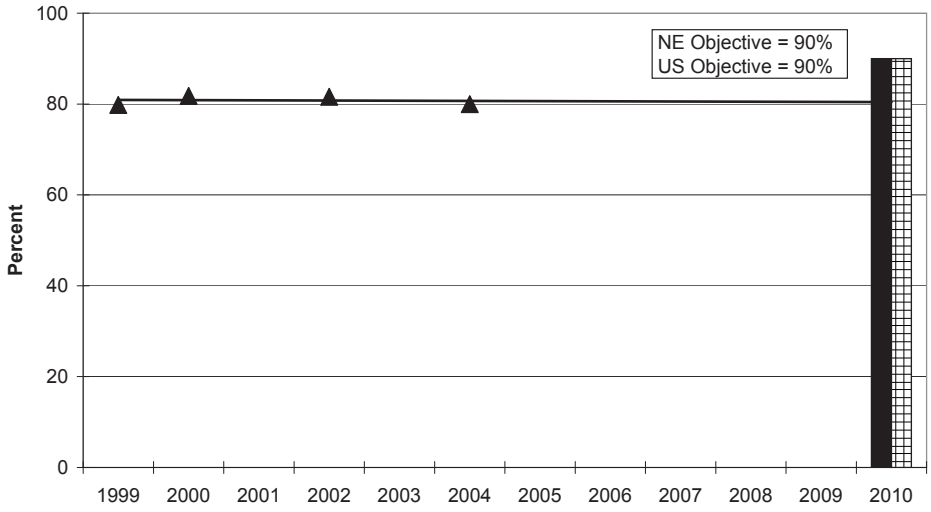
Figure 34
Nebraska Women Aged 18+ Who Ever Had Pap Test by Race/Ethnicity



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

A second objective regarding Pap tests was also adopted nationwide and in Nebraska. It seeks to increase to 90 percent the proportion of women who had this test within the last three years (Table 3). Here again, no change was reported either in the state or the nation (Figure 35). Eighty percent of women in Nebraska and 79 percent in the U.S. stated they had a Pap test within the past three years.

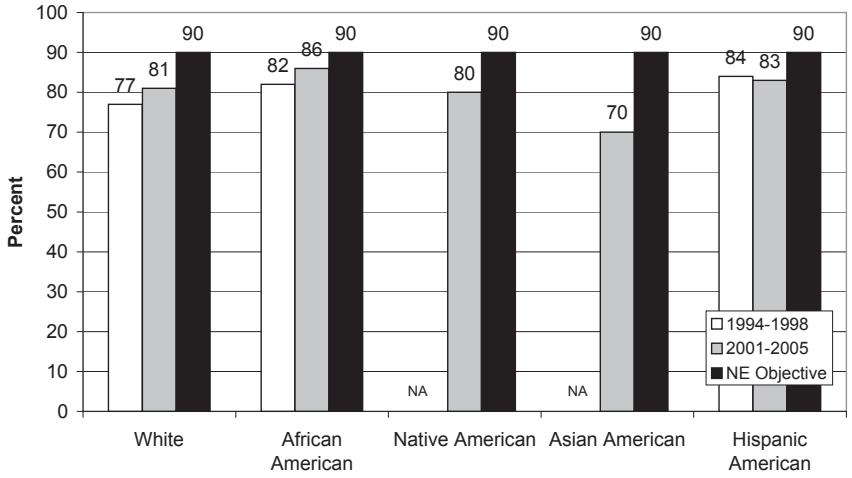
Figure 35
Nebraska Women Aged 18+ Who Had Pap Test in Last 3 Years



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

In 2001-2005, three-year screening rates increased by 5 percent for white and African American women in the state, while the rate for Hispanic American women was down slightly from 1994-1998 (Figure 36). As was the case with the proportion of Asian American women who ever had a Pap test, the proportion of these women who were screened in the last three years (70 percent) was substantially lower than the rates reported for other racial/ethnic groups.

Figure 36
Nebraska Women Age 18+ Who Had Pap Test in Past 3 Years by Race/Ethnicity



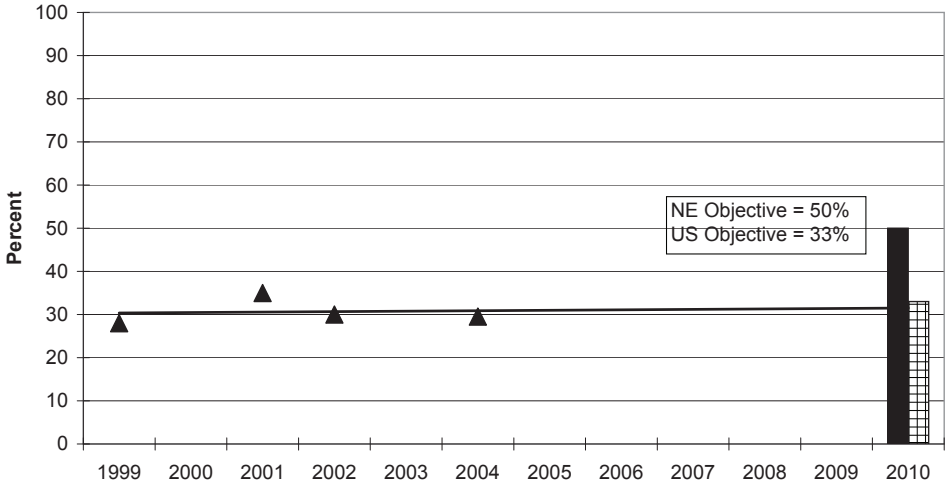
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS. BRFSS.

Colorectal Cancer Screening

A 2010 objective tied to colorectal cancer deaths aims to increase the proportion of adults aged 50 and older who had a fecal occult blood test (FOBT) in the past two years. This test checks for blood in the stools, which could indicate precancerous polyps or cancer. In Nebraska, the target rate is at least 50 percent of persons in this age group (Table 3), while the national target is much lower (33 percent).

The proportion of adults in this age group who had this screening is quite low. By 2004, the Nebraska screening rate had increased only slightly to 30 percent (Figure 37), compared to a national rate of 22 percent in 2002.

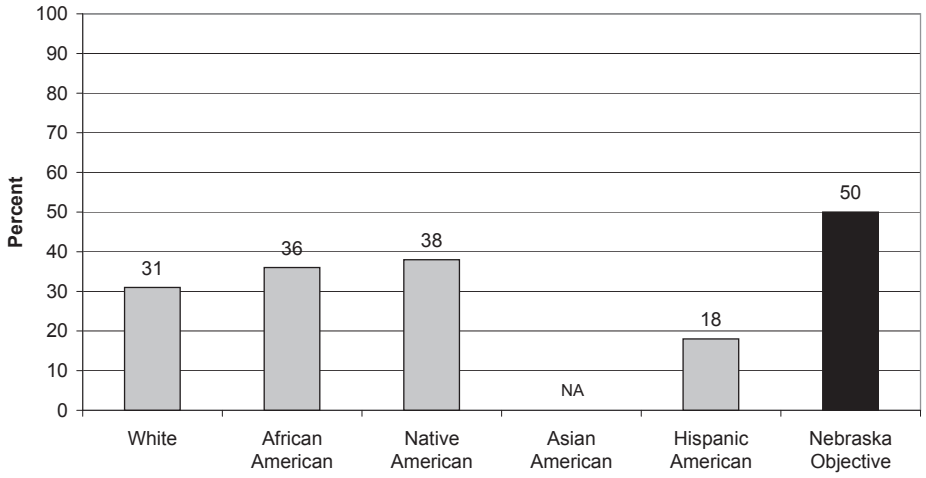
Figure 37
Nebraska Adults Aged 50+ Who Had Fecal Occult Blood Test in Past 2 Years



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010

In 2001-2005, the proportion of adults who had a FOBT in the last two years was higher among Native Americans (38 percent) and African Americans (36 percent) than among whites (31 percent) in Nebraska (Figure 38). Only 18 percent of Hispanic Nebraskans said they had an FOBT within the past two years.

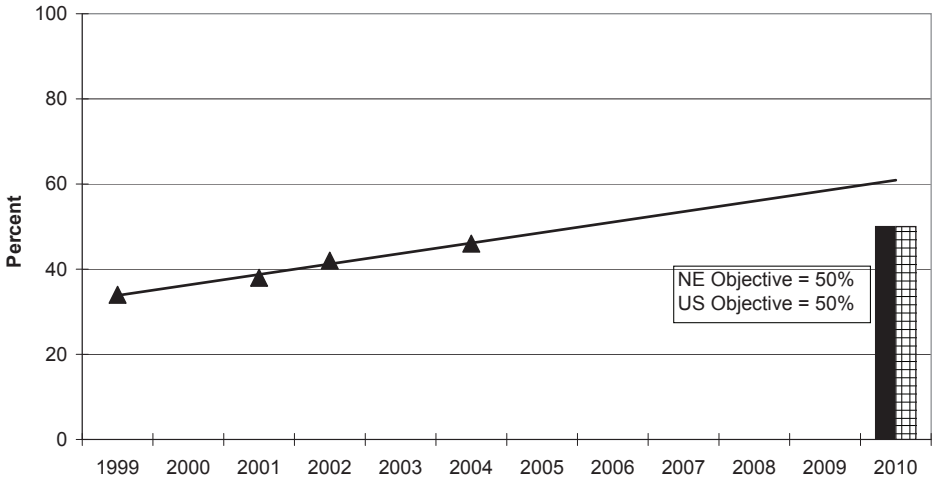
Figure 38
Nebraska Adults Aged 50+ Who Had Fecal Occult Blood Test in Past 2 Years by Race/Ethnicity (2001-2005)



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Another method of screening for colorectal cancer is the sigmoidoscopy or colonoscopy. The 2010 objective (both national and Nebraska) for this test is to increase to at least 50 percent the proportion of adults aged 50 and older who ever had a sigmoidoscopy or colonoscopy (Table 3). Progress has been made in Nebraska and nationwide in increasing this screening rate (Figure 39). In 2004, 46 percent of Nebraskans in this age group reported ever having one of these tests. For the United States overall in 2003, 43 percent of adults 50 and older said they ever had a sigmoidoscopy or colonoscopy.

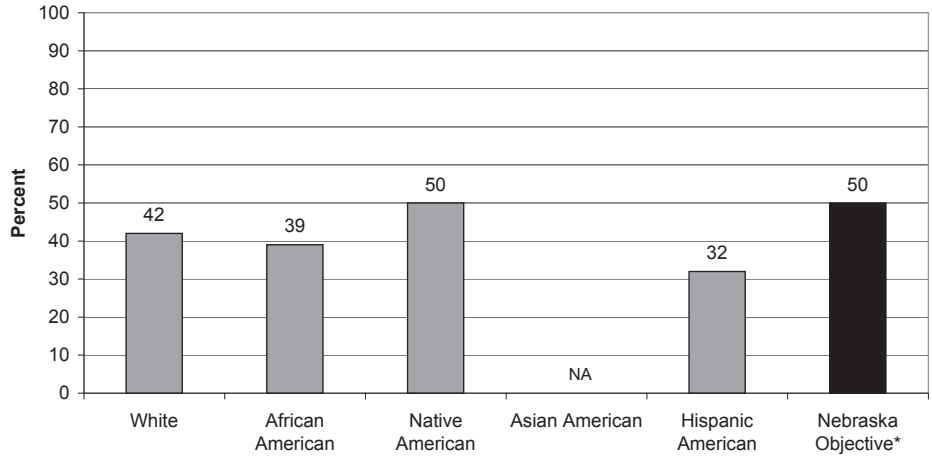
Figure 39
Nebraska Adults Aged 50+ Who Ever Had Sigmoidoscopy or Colonoscopy



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010

Hispanic Americans (32 percent) were the racial/ethnic group in Nebraska least likely to report ever having this screening for colorectal cancer (Figure 40). One-half of Native Americans (50 percent) in this age group ever had a colonoscopy or sigmoidoscopy, thus achieving the 2010 target rate. A 20 percent increase in screening has been targeted for Native Americans, setting the new objective at 60 percent for 2010 (Appendix, Table A).

Figure 40
Nebraska Adults Aged 50+ Who Ever Had Sigmoidoscopy or Colonoscopy by Race/Ethnicity (2001-2005)



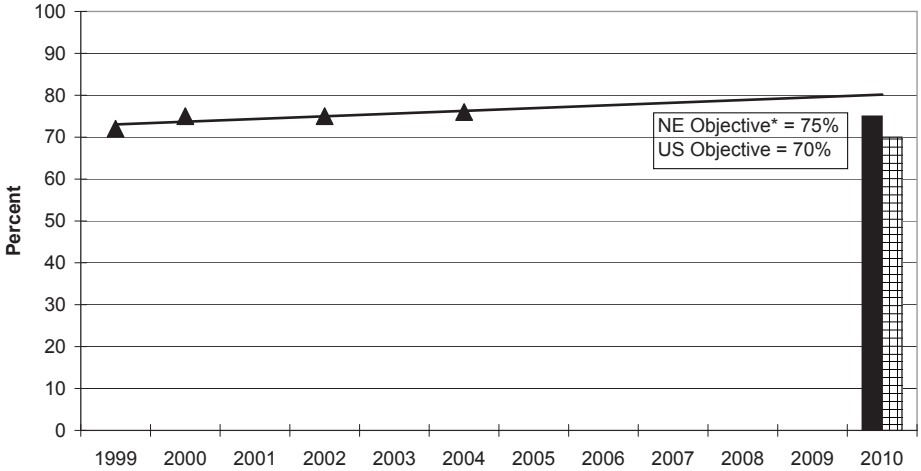
*Nebraska objective has been met for Native Americans and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Among white adults age 50 and older, 42 percent had this testing done, as did 39 percent of African Americans in Nebraska. (Trend data are unavailable for this type of screening.)

Breast Cancer Screening

An objective linked to breast cancer death rates seeks to increase the proportion of women aged 40 and older who have had a mammogram in the past two years. For Nebraska, the target is 75 percent or greater, while a target of at least 70 percent has been set nationwide (Table 3). This objective has been reached, both in Nebraska and in the U.S. overall. In the U.S., 70 percent of women in this age group had this test in the targeted time period, thus reaching the national objective. In 2004, 76 percent of Nebraska women aged 40 and older reported having a mammogram within the last two years. This represents an increase of 9 percent from the 1999 baseline of 70 percent (Figure 41). A new target screening rate of 82 percent will be set for Nebraska for 2010 (a further increase of 8.5 percent applied to the 2004 rate).

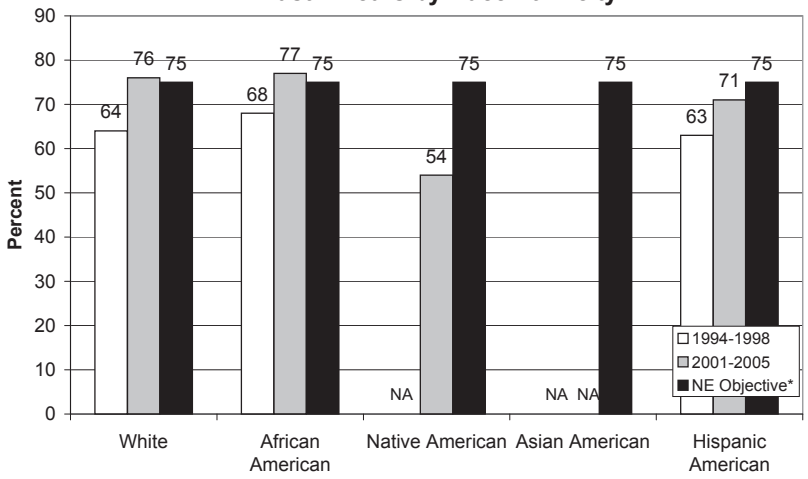
Figure 41
Nebraska Women Aged 40+ Who Had Mammogram in Past 2 Years



*Nebraska objective has been met and will be revised.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

All three racial/ethnic groups in Nebraska (for whom trend data are available) posted increases in screening rates in 2001-2005 (Figure 42). African American (77 percent) and white (76 percent) women met the target rate of at least 75 percent. Hispanic women in the state achieved an increase of more than one-third (+34 percent) in the proportion who had a mammogram in the last two years. However, the 2001-2005 rate of 71 percent still does not meet the target for 2010. The rate for Native Americans was much lower (54 percent screened in the past two years) and also does not reach the 2010 target rate.

Figure 42
Nebraska Women Aged 40+ Who Had Mammogram in Past 2 Years by Race/Ethnicity



*Nebraska objectives for whites and African Americans have been met and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

DIABETES

Healthy People 2010 Goal

The national Healthy People 2010 goal for diabetes is to reduce the disease burden and economic costs of diabetes and improve the quality of life for all persons who have or are at risk for diabetes.

Background

As of 2005, an estimated 20.8 million people in the United States (7.0 percent of the population) have diabetes. Of these, 6.2 million have the disease, but have not been diagnosed and are unaware they have diabetes. In addition to the 20.8 million Americans who currently have this condition, an estimated 54 million adults are at high risk for developing diabetes. They have pre-diabetes; that is, their blood sugar is elevated but not high enough for them to be classified as having diabetes.

The number of newly-diagnosed cases of diabetes has risen rapidly in the United States, with an estimated 1.5 million new cases developing in 2005. With obesity on the increase, it is likely that the number of cases will continue this strong upward trend.

Each year, more than 13,000 children and adolescents are diagnosed with type 1 diabetes. However, incidence of type 2 diabetes (a disease usually diagnosed in adults aged 40 or older) has risen substantially among U.S. children and adolescents in the last twenty years. Obesity and insufficient physical activity are thought to be important factors in the growing prevalence of diabetes among children and youth.

Diabetes was the sixth leading underlying cause of death in 2004 in Nebraska and the nation, accounting for 395 deaths in the state and more than 73,000 deaths nationwide. Diabetes was also listed as a contributing factor for more than 224,000 U.S. deaths. The total cost of diabetes in the United States was estimated to be about $132 billion in 2002.

Progress Toward Healthy People 2010 Objectives

National

According to a 2006 review of progress toward Healthy People 2010 diabetes objectives, incidence and prevalence of diabetes have both increased substantially, compared to the baseline. The rate of diabetes-related deaths in the overall population has risen slightly since 1999.

On the positive side, lower-extremity amputations have been decreasing from the baseline rate. In addition, use of preventive services that are aimed at avoiding complications, such as glycosylated hemoglobin tests, dilated eye exams, and self blood-glucose monitoring, has increased.

Nebraska

In Nebraska, the original 2010 objectives for two diabetes management services were met. The proportion of adults with diabetes who had a glycosylated hemoglobin (A1C) test at least twice in the past year surpassed the target rate of 50 percent. In addition the proportion who had a dilated eye exam in the past year exceeded the target rate of 75 percent.

Progress was made toward two more diabetes objectives. Hospitalization rates for lower extremity amputations among persons with diabetes decreased from the baseline. The proportion of persons with diabetes who perform self blood-glucose monitoring at least once a day also increased from the 1999 rate.

Very little change was evident in the diabetes death rate or in the proportion of adults with diabetes who had a foot exam in the past twelve months.

One measure showed definite movement away from the 2010 objective. Overall prevalence of clinically-diagnosed diabetes among adults in Nebraska increased by 70 percent in 2005, compared to the 1999 rate.

Prevalence of Diabetes

Both Nebraska and the nation have established an objective of decreasing the proportion of adults who have ever been told by a doctor or other health professional that they have diabetes to no more than 25 cases per 1,000 (Table 4). The current Nebraska rate (73 per 1,000) is 35 percent higher than the U.S. rate (52 per 1,000) and nearly triple the target rate for this objective.

Table 4
Nebraska 2010 Health Goals and Objectives
Diabetes

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#5-3	Overall prevalence rate of clinically diagnosed diabetes per 1,000 population aged 18+	1997	40	2004	52	25	1999	43	2005	73	25
	White	1997	36	2004	47	25	1994-1998	50	2001-2005	62	25
	African American	1997	74	2004	83	25	1994-1998	110	2001-2005	123	25
	Native American	1997	84	2004	108	25	1994-1998	NA	2001-2005	157	25
	Asian American	1997	32*	2004	56*	25	1994-1998	NA	2001-2005	32	25
	Hispanic American	1997	61	2004	76	25	1994-1998	NA	2001-2005	65	25
#5-5	Diabetes death rate per 100,000 population	1999	77	2003	78	46.0	1998	70.3	2004	69.8	25.0
	White	1999	71	2003	72	46.0	1994-1998	65.0	2000-2004	70.2	25.0
	African American	1999	135	2003	136	46.0	1994-1998	160.8	2000-2004	162.8	25.0
	Native American	1999	121	2003	109	46.0	1994-1998	261.9	2000-2004	260.9	25.0
	Asian American	1999	62	2003	58	46.0	1994-1998	27.2	2000-2004	51.8	25.0
	Hispanic American	1999	101	2003	96	46.0	1994-1998	92.2	2000-2004	109.3	25.0
#5-10	Hospitalizations for lower extremity amputations per 1,000 persons with diabetes Data not available by race/ethnicity for Nebraska	1997-1999	6.6	2003	4.8	2.9	1999	17.3	2003	16.0 (per 100,000 pop.)	11.5
#5-12	Percent of persons w/diabetes who had glycosylated hemoglobin measurement at least twice in past year (age 18+)	2000	66	2004	65	65	1999	27	2005	65	50
	White	2000	67	2004	67	65	Data Not Available by Race/Ethnicity		2001-2005	72	50
	African American	2000	--	2004	--	65			2001-2005	75	50
	Native American	2000	60	2004	69	65			2001-2005	93	50
	Asian American	2000	64	2004	73	65			2001-2005	NA	50
	Hispanic American	2000	69	2004	58	65			2001-2005	56	50
#5-13	Percent of adults w/diabetes who had dilated eye exam in past year (age 18+)	1998	49	1999	61	76	1999	61	2005	76	75
	White	1998	51	1999	60	76	Data Not Available by Race/Ethnicity		2001-2005	75	75
	African American	1998	44	1999	66	76			2001-2005	79	75
	Native American	1998	NA	1999	NA	76			2001-2005	82	75
	Asian American	1998	NA	1999	NA	76			2001-2005	NA	75
	Hispanic American	1998	42	1999	61	76			2001-2005	68	75

Table 4 continued

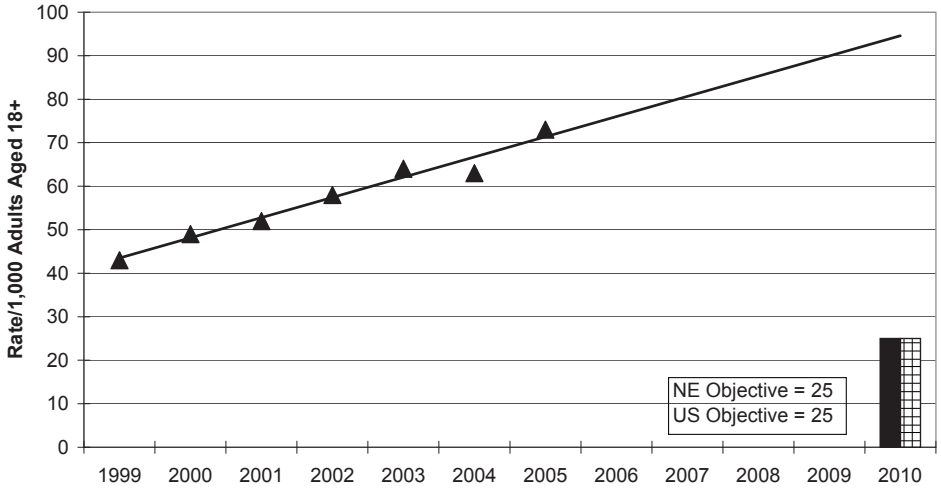
		UNITED STATES					NEBRASKA			
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#5-14	Percent of adults w/diabetes who had foot exam in past year (age 18+)	1998	68	2004	67	91	1999	69	2005	68	80
	White	1998	69	2004	66	91	Data Not Available by Race/Ethnicity		2001-2005	70	80
	African American	1998	68	2004	NA	91			2001-2005	84	80
	Native American	1998	51	2004	72	91			2001-2005	84	80
	Asian American	1998	62	2004	56	91			2001-2005	NA	80
	Hispanic American	1998	68	2004	62	91			2001-2005	67	80
#5-17	Percent of adults w/diabetes who perform self blood glucose monitoring at least once a day (age 18+)	1998	43	2004	61	61	1999	51	2005	58	65
	White	1998	44	2004	61	61	Data Not Available by Race/Ethnicity		2001-2005	62	65
	African American	1998	41	2004	NA	61			2001-2005	71	65
	Native American	1998	54	2004	66	61			2001-2005	81	65
	Asian American	1998	30	2004	44	61			2001-2005	NA	65
	Hispanic American	1998	36	2004	52	61			2001-2005	56	65

*Asian only. NA = Not Available

Data Sources:		Additional Notes:
#5-3	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	All ages. Adults aged 18 and older interviewed. Ever been told by a doctor/health professional that they (or child) havediabetes or sugar diabetes. For females, does not include those for whom diabetes was diagnosed during pregnancy (gestational diabetes). Adults aged 18 and older. Ever been told by a doctor or health professional that they have diabetes.
#5-5	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	Deaths due to diabetes (ICD-9 code 250) reported as the underlying or multiple cause of death (I.e., all mentions of diabetes on the death certificate). Age-adjusted to 2000 standard population. Same as U.S.
#5-10	U.S.--National Hospital Discharge Survey, NHIS, CDC. Nebraska--Hospital Discharge data, HHSS.	Hospital discharges among U.S. civilian population with diabetes (ICD-9 code 250) as any listed diagnosis and amputation of the lower limb (ICD-9 procedure code 84.1) as any listed procedure. No amputations due to trauma are included. Denominator--persons reporting ever been diagnosed with diabetes. Hospital discharges same as U.S., but denominator is total population.
#5-12	U.S.--BRFSS,CDC. Nebraska--BRFSS, HHSS.	Persons aged 18 and older reporting ever been diagnosed with diabetes and report that a doctor, nurse, or other health professional has checked the respondent's glycosylated hemoglobin two or more times in past year. Same as U.S.
#5-13	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Persons aged 18 and older reporting ever been diagnosed with diabetes and report that they had a dilated eye examination in the past year. Similar question.
#5-14	U.S.--BRFSS,CDC. Nebraska--BRFSS, HHSS.	Persons aged 18 and older reporting ever been diagnosed with diabetes and report having seen a health professional for diabetes and have had their feet checked for any sores or irritations. Same as U.S.
#5-17	U.S.--BRFSS,CDC. Nebraska--BRFSS, HHSS.	Persons aged 18 and older reporting ever been diagnosed with diabetes and report that they check their blood for glucose or sugar themselves or have a family member or friend (excludes health professionals) at least once a day. Same as U.S.

Self-reported prevalence of diabetes among adults in Nebraska has risen steadily since 1999 (Figure 43). The 2005 rate of 73 per 1,000 is 70 percent higher than the 1999 rate of 43 for the state. The current national prevalence rate of 52 was also up from its baseline, but the increase was less sharp (30 percent).

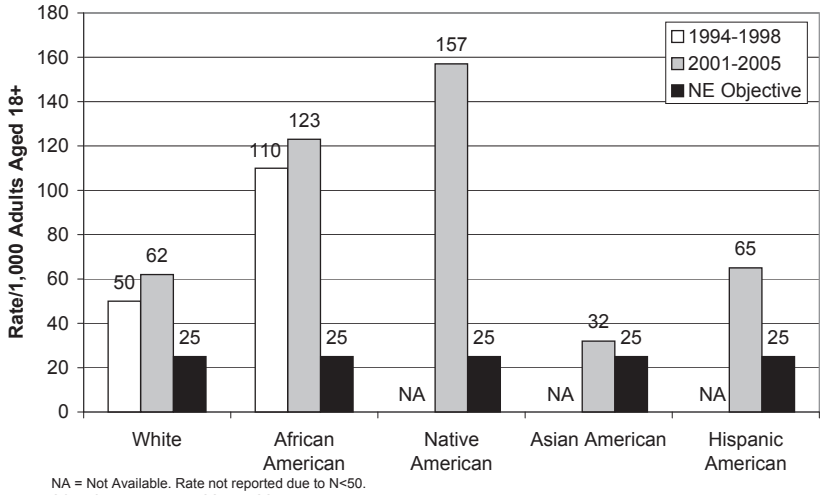
Figure 43
Prevalence of Diagnosed Diabetes
Among Nebraska Adults Aged 18+



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Diabetes prevalence rates for Native Americans (157 cases per 1,000) and African Americans (123 per 1,000) were much higher than rates for other racial/ethnic groups in Nebraska in 2001-2005 (Figure 44). Prevalence estimates for Hispanic (65) and white (62) Nebraskans were roughly one-half as high as rates for Native Americans and African Americans, but twice as high as the prevalence among Asian Americans (32).

Figure 44
Prevalence of Diagnosed Diabetes
Among Nebraska Adults Aged 18+ by Race/Ethnicity



NA = Not Available. Rate not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

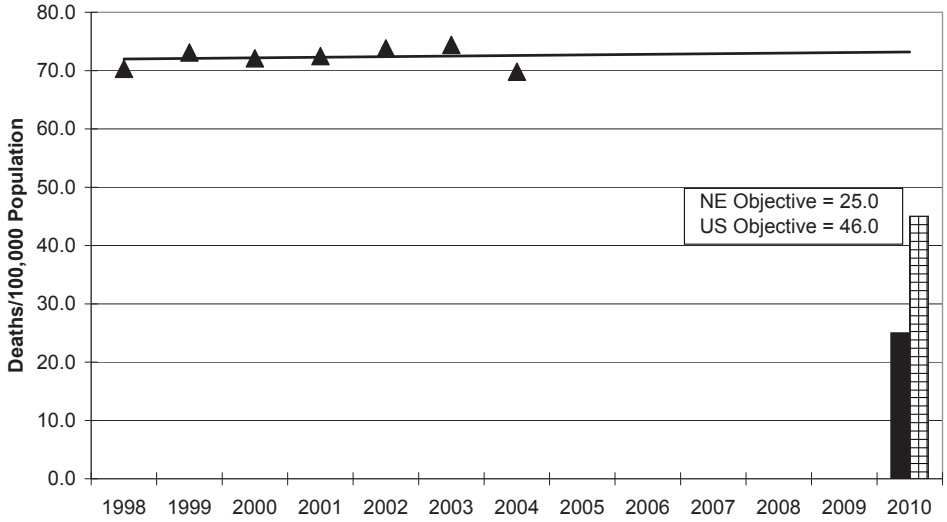
Diabetes prevalence rates were up for white Nebraskans (+ 24 percent) and for African Americans (+ 12 percent) in the state, compared to the 1994-1998 baseline. Trend data are not available for Native Americans, Asian Americans, and Hispanic Americans in Nebraska.

Diabetes-Related Deaths

Diabetes deaths, as measured here, include those deaths where diabetes is listed as the underlying or contributing cause of deaths (i.e., all mentions of diabetes on the death certificate). A reduction in diabetes-related deaths to no more than 25.0 per 100,000 population has been targeted for Nebraska for 2010

(Table 4). The U.S. objective is much higher (46.0 per 100,000). Current mortality rates for the U.S. (78 per 100,000) and for Nebraska (69.8) did not come close to achieving either of these targets (Figure 45). Very little change was apparent in either case (+ 1 percent nationwide and -1 percent for the state).

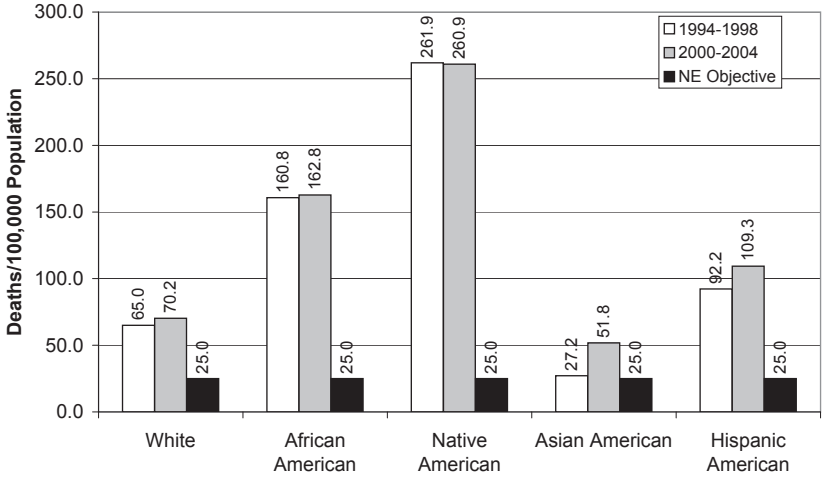
Figure 45
Diabetes-Related Deaths in Nebraska (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Native Americans in Nebraska (260.9) experienced a much higher diabetes-related death rate than Native Americans nationwide (136). Diabetes mortality was also much higher for this group than for any other racial/ethnic group in Nebraska (Figure 46). However, mortality rates had not increased for Native Americans, compared to their 1994-1998 baseline.

Figure 46
Diabetes-Related Deaths in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics.

The 2000-2004 diabetes mortality rate for African Americans in Nebraska (162.8) was 20 percent higher than the corresponding national rate (136). It was also higher than the rates for other racial/ethnic groups in the state, except Native Americans. Still, the rate of increase from the baseline was very low (+1 percent).

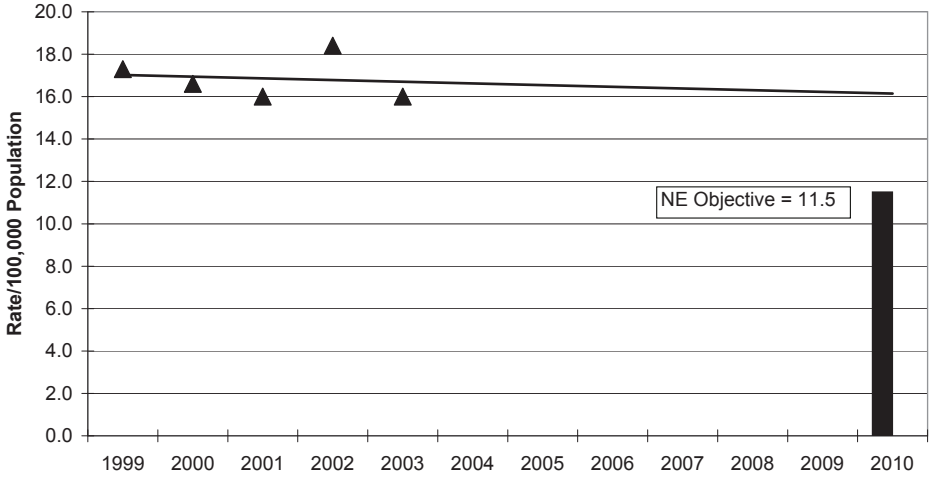
The diabetes-related mortality rate for Hispanic Nebraskans (109.3) rose by 19 percent in 2000-2004, compared to the 1994-1998 rate. This rate was 56 percent higher than the current rate for white Nebraskans (70.2) and more than double the rate for Asian Americans (51.8) in the state. Although the death rate for diabetes was lowest for Asian Nebraskans, this rate increased by 90 percent in 2000-2004, compared to the 1994-1998 baseline. For white Nebraskans, the diabetes-related death rate was up 8 percent from the baseline.

Hospitalizations for Lower-Extremity Amputations

Vascular disease often develops in persons with diabetes and may block blood flow to the feet and legs, making them more prone to infection. Damage to the nerves is another complication of diabetes that can lead to amputation of the lower extremities. Loss of sensation in the feet and legs makes it difficult to notice blisters, small cuts, or other irritations that may become infected and eventually lead to amputation. Persons with diabetes should regularly check their feet for sores and irritations and for signs of poor circulation. Health care providers should also make examining the feet of patients with diabetes a regular practice.

Nebraska and the U.S. have both set objectives to reduce the rate of hospitalizations for amputations of feet and/or legs. In Nebraska, a target rate of no more than 11.5 hospitalizations for this cause has been set (Figure 47). The national objective is not comparable because rates are figured differently. (See "Additional Notes" in Table 4 for further information.) However, reductions were achieved in these hospitalizations both nationwide and in Nebraska. A decrease of 8 percent in hospitalizations for lower extremity amputations occurred in Nebraska in 2003, compared to the 1999 baseline. In 2003, the rate of hospitalizations for these amputations was 16.0 per 100,000 population.

Figure 47
Hospitalizations for Lower Extremity Amputations Related to Diabetes in Nebraska



SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Diabetes Management Practices

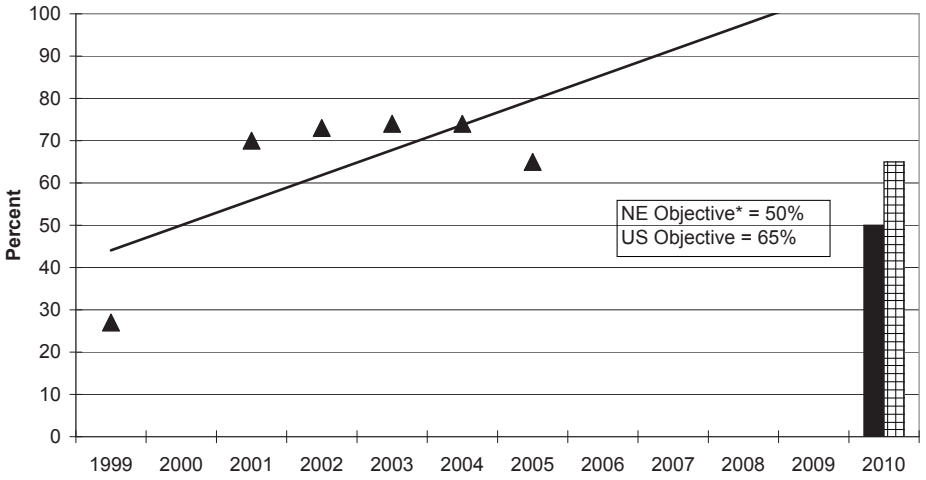
Glycosylated Hemoglobin (A1C) Testing

The American Diabetes Association (ADA) recommends that hemoglobin A1C (glycosylated hemoglobin) be measured at least twice a year to monitor how well blood glucose levels for persons with diabetes have been controlled during this time.

The Nebraska 2010 objective is to increase the proportion of persons with diabetes who have an A1C measurement at least twice in the past year to at least 50 percent (Table 4). The national objective is higher, at 65 percent.

The proportion who had this test two or more times in the last year was 65 percent, both in Nebraska and nationwide, achieving both the state and national target rates for this objective (Figure 48). A new overall target rate of at least 75 percent (an increase of 15 percent) has been set for Nebraska for the year 2010.

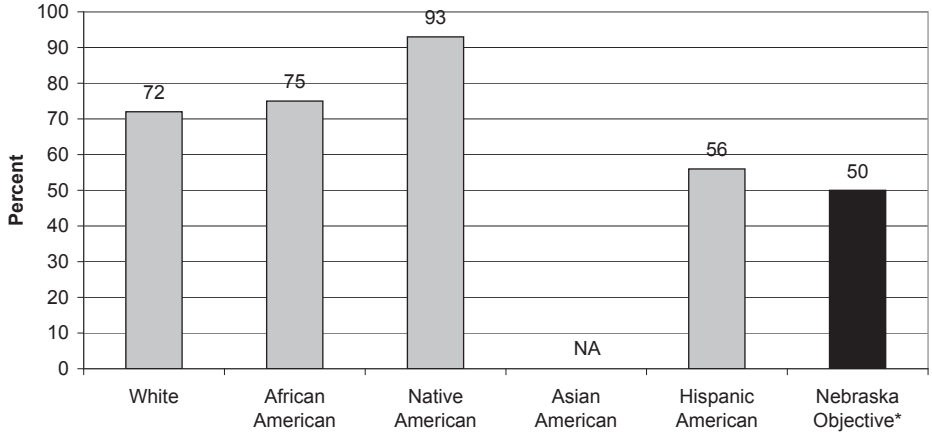
Figure 48
Nebraska Adults Aged 18+ with Diabetes
Who Had Hemoglobin A1C Test at Least Twice in Past Year



*Nebraska objective has been met and will be revised.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Nebraska's original target rate of 50 percent was reached by each racial/ethnic group in the state, except Asian Americans for whom current data were unavailable (Figure 49). However, Hispanic Americans (with 56 percent reporting A1C testing at least twice in the last year) had this measurement done much less frequently than the other groups in 2001-2005. The same revised target rate of 75 percent has been set for all five racial/ethnic groups in Nebraska.

Figure 49
Had Hemoglobin A1C Test At Least Twice in Past Year
Nebraska Adults Aged 18+ with Diabetes by Race/Ethnicity
(2001-2005)



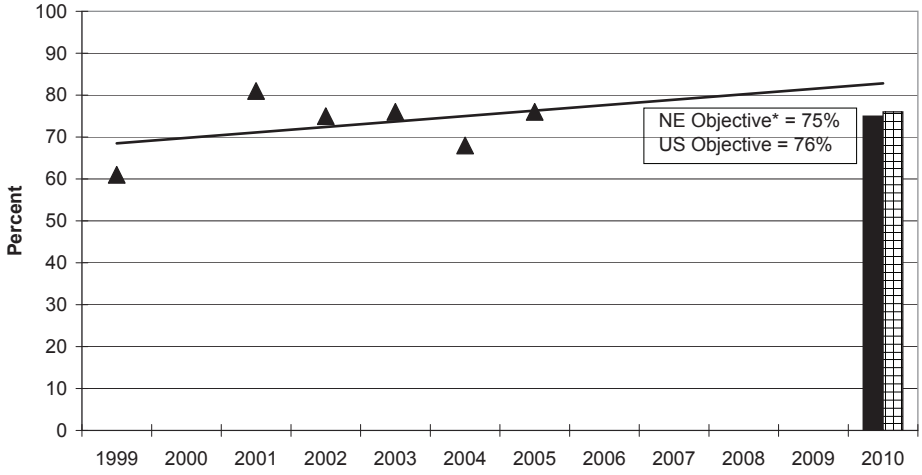
*Nebraska objective has been met for all racial/ethnic groups and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Dilated Eye Examinations

The ADA recommends that a comprehensive dilated eye and visual examination should be performed annually by an eye doctor for: all patients aged twelve and over who have had diabetes for at least five years; all patients over age 30 with diabetes; and any patient with diabetes who has visual symptoms and/or abnormalities.

Nebraska has adopted an objective to increase the proportion of persons with diabetes who had a dilated eye exam in the past year to at least 75 percent (Table 4). The U.S target rate is 76 percent and has not yet been reached. The objective was achieved in Nebraska with a 2001-2005 rate of 76 percent (Figure 50). A new target rate of at least 84 percent (an increase of 10 percent from the current rate) will be used for Nebraska for 2010 (Appendix, Table A).

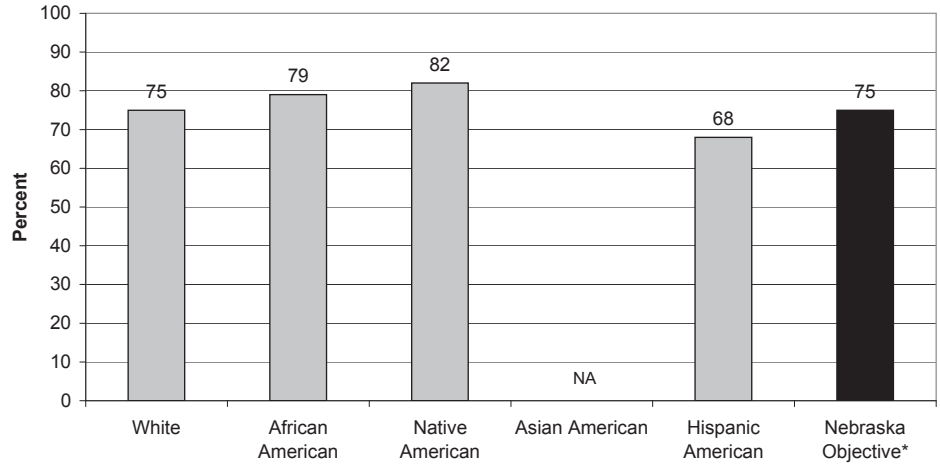
Figure 50
Adults Aged 18+ with Diabetes Who Had Dilated Eye Exam in Past Year



*Nebraska objective has been met and will be revised.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

In 2001-2005, Hispanic Nebraskans with diabetes were less likely than Nebraskans in other racial/ethnic groups to report having a dilated eye exam in the past year (Figure 51). About two-thirds of the Hispanic American adults with this disease (68 percent) stated they had this exam in the last 12 months. At least three-fourths of the Native Americans (82 percent), African Americans (79 percent), and whites (75 percent) with diabetes said they had a dilated eye exam in the past year. The current rates for these three racial groups meet the 2010 objective of at least 75 percent receiving dilated eye exams. The revised Nebraska objective (84 percent) will also be adopted for these groups (Appendix, Table A).

Figure 51
Nebraska Adults Aged 18+ with Diabetes Who Had Dilated Eye Exam in Past Year by Race/Ethnicity (2001-2005)



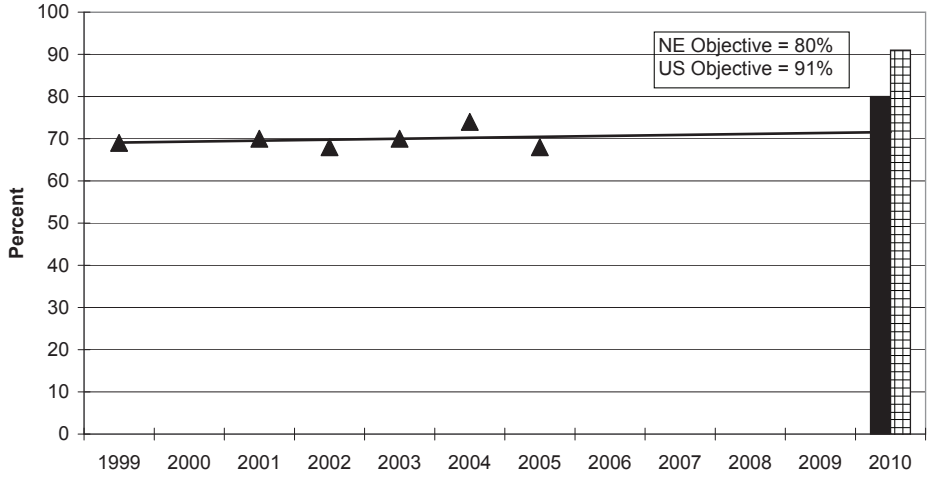
*Nebraska objective has been met for whites, African Americans, and Native Americans and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Foot Examination

The Centers for Disease Control and Prevention (CDC) recommend that persons with diabetes have their feet examined for sores or irritations every time they visit their physician (which should be four or more times per year).

Nebraska's 2010 objective is to increase to at least 80 percent the proportion of persons with diabetes who had their feet checked by a health professional in the past year for any sores or irritations (Table 4). For the United States, the target is higher (91 percent). Only about two-thirds of the adults with diabetes reported having their feet checked by a health professional in the last year (68 percent in Nebraska in 2005, 67 percent nationwide in 2004). These overall rates had shown little improvement from the baseline (Figure 52).

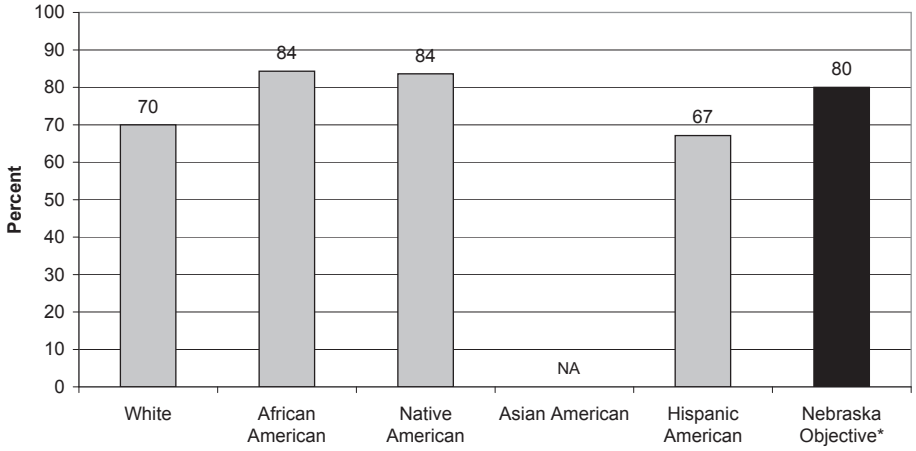
Figure 52
Nebraska Adults Aged 18+ with Diabetes Who Had Foot Exam in Past Year



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

However, African Americans (84 percent) and Native Americans (84 percent) with diabetes in Nebraska both achieved the objective of at least 80 percent of adults with diabetes getting a foot exam in the past year (Figure 53). They were more likely than white (71 percent) or Hispanic (67 percent) Nebraskans to say they had their feet examined by a health professional in the last year. Thus, a revised objective of at least 91 percent has been set for African Americans and Native Americans in Nebraska (Appendix, Table A).

Figure 53
Nebraska Adults Aged 18+ with Diabetes Who Had Foot Exam in Past Year by Race/Ethnicity (2001-2005)



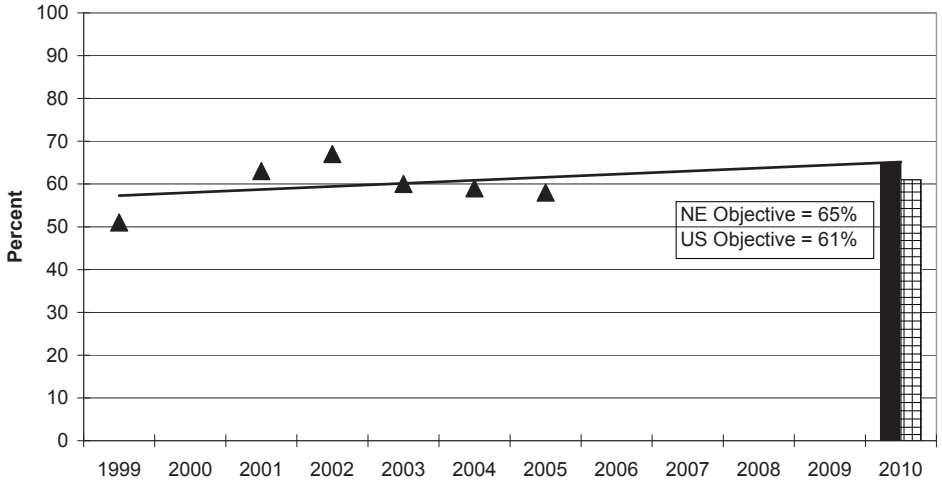
*Nebraska objective has been met for African Americans and Native Americans and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Daily Self Blood Glucose Monitoring

Research has emphasized the importance of frequent testing of blood sugar levels and adjustments to insulin administered based on blood sugar readings. This tighter control of blood sugar levels cuts the risk of complications due to diabetes substantially.

A Nebraska 2010 objective has been adopted that seeks to increase to 65 percent the proportion of adults with diabetes who perform self blood glucose monitoring at least once per day (Table 4). For the U.S., the target rate is 61 percent. Nationwide, the proportion of adults who do this testing on a daily basis increased from 43 percent in 1998 to 61 percent in 2004, thus attaining this objective. In Nebraska, less progress was made with this proportion increasing by 12 percent from the baseline to 58 percent in 2005 (Figure 54).

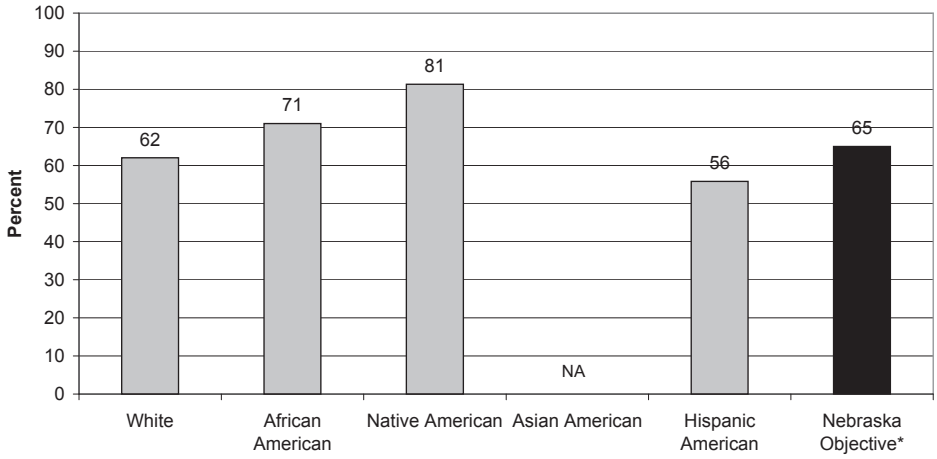
Figure 54
Nebraska Adults Aged 18+ with Diabetes
Who Check Blood Sugar at Least Once a Day



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

In 2001-2005, Native Americans (81 percent) and African Americans (71 percent) were more likely than white (62 percent) or Hispanic (56 percent) Nebraskans to say they test their blood sugar at least once per day (Figure 55). Of these groups, only the Native Americans and African Americans met the Nebraska 2010 objective for increasing the proportion of adults who perform daily testing. Revised target rates have been established for African Americans (75 percent) and Native Americans (85 percent) in Nebraska for 2010 (Appendix, Table A).

Figure 55
Nebraska Adults Aged 18+ with Diabetes Who Check Blood Sugar at Least Once a Day by Race/Ethnicity (2001-2005)



*Nebraska objective has been met for African Americans and Native Americans and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

DISABILITY AND SECONDARY CONDITIONS

Healthy People 2010 Goal

The national Healthy People 2010 goal is to promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities.

Background

One in five community-dwelling adults in the United States reports some type of disability. Disability may result from a wide range of conditions. People with disabilities include persons who have physical, cognitive, or sensory impairments that are either present at birth or acquired (resulting from an illness or injury that has long-term consequences). Children and adults with disabilities and their families face special challenges related to maintaining health, productivity, independence, and quality of life.

Persons with disabilities are more likely to have: self-reported fair to poor health, serious psychological distress, more other health problems, and lower income/fewer resources.

Total costs associated with disabilities are estimated to be more than $300 billion per year in the United States, with costs about evenly divided between costs of direct medical care and costs of lost productivity.

Progress Toward Healthy People 2010 Objectives

National

A 2006 national progress review found mixed results. Although there have been improvements, one of the difficulties faced for objectives in this focus area is the lack of data to measure progress. For the objectives with currently available data, improvements were noted in: the proportion of children with disabilities who report sadness or depression; inclusion of children and youth with disabilities in regular education programs; and the proportion of adults aged 22 and older who are in congregate care.

On the other hand, a greater proportion of adults with disabilities reported negative feelings that interfered with their activities, compared to the baseline rate. Employment parity for persons aged 18 to 64 with disabilities also worsened.

Nebraska

Only one objective in the Disability and Secondary Conditions focus area was adopted for Nebraska. Lack of available data prevented identification of other objectives that could be tracked.

In the 2001-2002 Nebraska BRFSS, adults were defined as having a disability if they report being “limited in any way in any activities because of physical, mental, or emotional problems” or have “any health problem that requires [them] to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?” These adults with a disability were asked for how many days in the past month they felt sad, blue, or depressed. On average, Nebraska adults with a disability reported 6.9 days when they were sad or depressed, compared to 2.1 days for persons who did not have a disability (Table 5). Based on these survey results, the 2010 target rate for this objective was set at an average of no more than two days in the past month when persons with disabilities were sad, blue, or depressed.

Table 5
Nebraska 2010 Health Goals and Objectives
Disability and Secondary Conditions

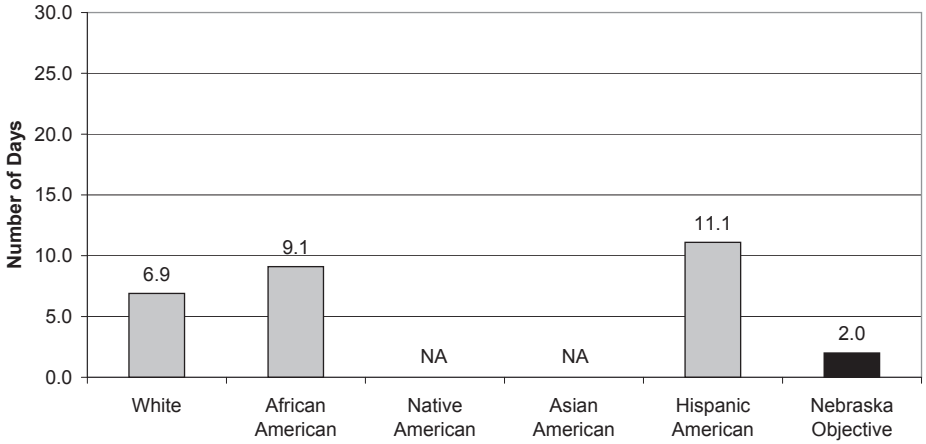
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#6-3	Percent of adults age 18+ with disabilities who report feelings of sadness, unhappiness, or depression that prevent them from being active.	1997	28	2004	30	7	2001-2002	6.9 days			2 days*
	White	1997	28	2004	30	7	2001-2002	6.9 days	Newer		2 days*
	African American	1997	31	2004	30	7	2001-2002	9.1 days	Data Not		2 days*
	Native American	1997	22	2003	39	7	2001-2002	NA	Available		2 days*
	Asian American	1997	30	2004	32	7	2001-2002	NA			2 days*
	Hispanic American	1997	40	2004	36	7	2001-2002	11.1 days			2 days*

*Target rate set in 2006 in Nebraska. NA = Not Available

Data Sources:		Additional Notes:
#6-3	U.S.--National Health Interview Survey (NHIS), CDC.	Adults are defined as having a disability if a "yes" response is obtained to any of a series of limitation or special equipment questions, including questions about: needing help with personal care needs (such as eating, bathing, dressing, or getting around in the home) or routine needs (such as everyday household chores, doing necessary business, shopping, or getting around for other purposes); being unable to work at a job or business or limited in the kind or amount of work they can do; having difficulty walking without special equipment; having difficulty remembering or because of confusion; any other limitations in activities because of physical, mental or emotional problems ; or requiring special equipment such as a cane, wheelchair, special bed or telephone. An adult is considered to have feelings that prevent them from being active if he/she answered the feelings interfered "a lot" or "some" with their life or activities. Adults are defined as having a disability if they report being "limited in any way in any activities because of physical, mental, or emotional problems" or have "any health problem that requires [them] to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?" Nebraska data are not strictly comparable to U.S. data. Adults with disability were asked for about how many days (during the past 30 days) they felt sad, blue, or depressed (but were not asked how much they interfered with their life or activities). Number reported is the average (mean) number of days in the past month.
	Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	

Hispanic American (11.1 days) and African American (9.1 days) adults with disabilities reported greater average numbers of days in the past month when they felt sad or depressed, compared to white adults with disabilities (6.9 days) (Figure 56). Data are unavailable for Native Americans and Asian Americans in Nebraska.

Figure 56
Average Number of Days in Past Month That Nebraska Adults with Disabilities Reported Feeling Sad, Blue, or Depressed by Race/Ethnicity (2001-2002)



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Trend data are not available for this objective.

EDUCATIONAL AND COMMUNITY-BASED PROGRAMS

Healthy People 2010 Goal

The national Healthy People 2010 goal is to increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

Background

Failure to complete high school tends to have a negative effect on the health of persons who have dropped out of school. Dropping out frequently results in diminished or, at least, delayed employment opportunities and thus a greater likelihood of living in poverty, which is associated with poor health status.

Dropping out of school is linked with multiple social and health problems during adolescence. Teenagers who have quit school are more likely than other teens to be delinquent, have substance abuse problems, incur intentional or unintentional injuries, or have (or cause) an unintended pregnancy.

Progress Toward 2010 Healthy People Objectives

National

A 2004 national review of progress in the Educational and Community-Based Programs area was difficult to complete due to lack of current data. For those objectives with current data available, results varied.

One objective was shared with Nebraska—the proportion of persons aged 18 to 24 who had completed high school. This rate had increased as of 2001, but did not achieve the 2010 target rate.

Nebraska

The Nebraska high school completion rate has historically been higher than the national average. The 1997-1999 Nebraska baseline rate was 91.5 percent, compared to 85 percent nationwide in 1998 (Table 6). However, the data source used changed in 2002 to the American Community Survey. Since then, reported rates have decreased in Nebraska to 82.0 percent in 2003 and 84.0 percent in 2005 (Figure 57). Thus, trend data may be unreliable.

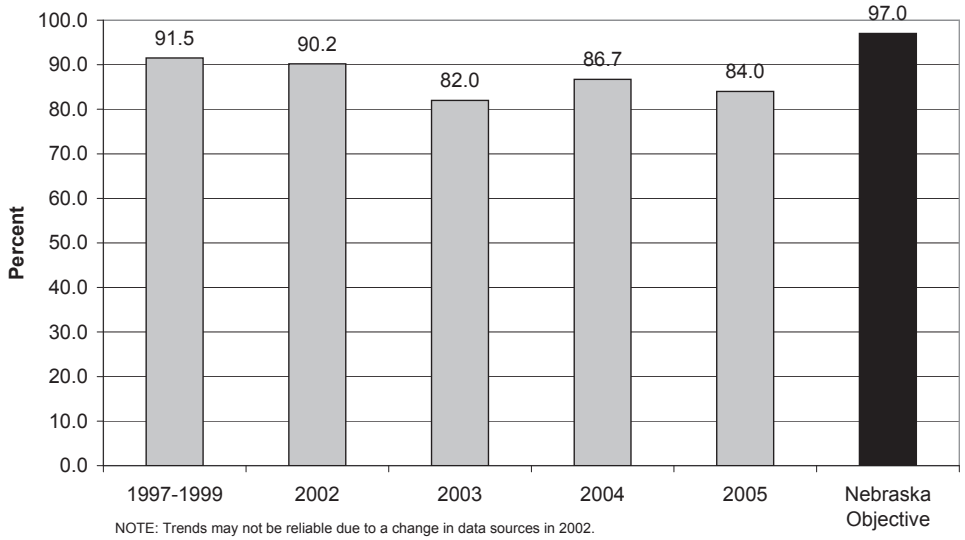
Table 6
Nebraska 2010 Health Goals and Objectives
Educational and Community-Based Programs

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#7-1	Rate of high school completion (percent of persons aged 18 to 24 who had completed high school)	1998	85	2001	87	90	1997-1999	91.5	2005	84	97
	White, non-Hispanic	1998	90	2001	91	90	Data Not Available by Race or Ethnic Origin		Data Not Available by Race or Ethnic Origin		
	African American, non-Hispanic	1998	81	2001	86	90					
	Native American	1998	NA	2001	NA	90					
	Asian American	1998	94	2001	96	90					
	Hispanic American	1998	63	2001	66	90					

NA = Not Available

Data Sources:		Additional Notes:
#7-1	U.S.--Current Population Survey, U.S. Dept. of Commerce, U.S. Bureau of the Census. Nebraska--1997-1999 Current Population Survey, U.S. Bureau of the Census. 2002-2005: American Community Survey, U.S. Bureau of the Census.	Percent of persons aged 18 to 24 not currently enrolled in high school who report receiving high school diploma or the equivalent, such as a General Education Development certificate (GED). Same as U.S. However, comparison of data between baseline and 2002-2005 may not be valid due to change in data source.

Figure 57
Nebraskans Aged 18-24 Who Have Completed High School



NOTE: Trends may not be reliable due to a change in data sources in 2002.
SOURCE: 1997-1999 Current Population Survey, U.S. Census. 2002-2005 American Community Survey, U.S. Census.

Nebraska high school completion rates are not available by race or ethnic origin. Nationally, however, the rate for Hispanic Americans in 2001 (66 percent) was considerably lower than rates for persons of other races or ethnicities (Table 6). African Americans (86 percent), whites (91 percent), and Asian Americans (96 percent) all were more likely to have finished high school than Hispanic Americans. Data were unavailable for Native Americans nationwide.

ENVIRONMENTAL HEALTH

Healthy People 2010 Goal

The national Healthy People 2010 goal is to promote health for all through a healthy environment.

Background

Exposures to hazardous agents in the air, water, soil, and food and to physical hazards in the environment are major contributors to illness, disability, and death worldwide. It is estimated that poor environmental quality is responsible for about 25 percent of all preventable ill-health in the world.

Air pollution continues to be a problem in the United States, causing premature death, cancer, and long-term damage to respiratory and cardiovascular systems. It is estimated that the annual health costs of human exposure to all outdoor air pollutants from all sources range from $40 billion to $50 billion. Approximately 50,000 to 120,000 premature deaths annually are associated with exposure to air pollutants.

While most drinking water is very safe, occasional violations of pollution standards are of concern because of the large number of people that can be exposed to toxic chemicals or microbiological contaminants.

Lead poisoning is another environmental issue. Lead is highly toxic, especially to young children. At high levels, it can lead to coma, convulsions, and death. Even at lower levels, adverse effects may occur such as decreased intelligence and changes in behavior. The adverse effects of lead are persistent, resulting in below average test scores on standardized tests, even 15 to 20 years after childhood exposure.

Progress Toward Healthy People 2010 Objectives

National

With respect to outdoor air quality in 2004, the national 2010 objective of zero percent exposure to harmful air pollutants has been achieved for nitrogen dioxide and lead. Progress has been made in reducing the percent of the population exposed to ozone, particulate matter, carbon monoxide, and sulfur dioxide.

Data has not been available for reviewing many of the national water quality objectives.

The proportion of children aged one to six years with elevated blood lead levels has declined from the 1991-1994 baseline.

Nebraska

Outdoor Air Quality

In Nebraska, all six of the outdoor air quality objectives have met. The proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's standards for harmful air pollutants has been maintained at zero percent (Table 7). This includes: ozone, particulate matter, carbon monoxide, nitrogen dioxide, sulfur dioxide, and lead.

Table 7
Nebraska 2010 Health Goals and Objectives
Environmental Health

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#8-1	Percent of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for harmful air pollutants										
	a. Ozone	1997	43	2004	39	0	1999	0	2004	0	0
	b. Particulate matter, 10 um or less in diameter	1997	12	2004	10	0	1999	0	2004	0	0
	c. Carbon monoxide	1997	20	2004	7	0	1999	0	2004	0	0
	d. Nitrogen dioxide	1997	5	2004	0	0	1999	0	2004	*	0
	e. Sulfur dioxide	1997	2	2004	1	0	1999	0	2004	0	0
	f. Lead	1997	<1	2004	0	0	1999	0	2004	*	0
#8-5	Proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act	1995	84	2003	90%	95	1996-2000 (nitrate levels 10 ppm or less)	>99	2000-2004	99	>99
#8-11	Percent of children aged 1 to 6 years who have blood lead levels exceeding 10 ug/dL	1991-1994	4.4	2002	1.6%	0	1998	7	2002-2004	3.3	0

*Monitoring of nitrogen dioxide was discontinued in Nebraska due to consistently low levels. Lead monitoring at active sites in Nebraska was discontinued in October 2002.

Data Sources:		Additional Notes:
#8-1	U.S.--Aerometric Information Retrieval System (AIRS), Environmental Protection Agency, OAR. Nebraska--Department of Environmental Quality. Nebraska Air Quality Report 2003-2004.	Percent of residents living in nonattainment areas that exceed the National Ambient Air Quality (NAAQ) Standards for that pollutant. When an area is designated as nonattainment, it retains this status for three years, regardless of annual changes in air quality. Nonattainment areas may also include jurisdictions in which the sources of the pollutants are located, even if that jurisdiction meets all NAAQ standards.
#8-5	U.S.--Potable Water Surveillance System (PWSS) and Safe Drinking Water Information System (SDWIS), EPA. Nebraska--Public Health Assurance, Drinking Water Program, HHSS.	Percent of persons served by community water systems that do not have violations of the Safe Drinking Water Act. Limited to violations related to Maximum Contaminant Levels for specific contaminants. Percent of population served by community water systems with nitrate levels of 10 parts per million or less.
#8-11	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC. Nebraska--Public Health Assurance, HHSS.	

Nationwide, the target rate of zero percent of the population exposed to individual air pollutants has been met only for nitrogen dioxide and lead, although improvement was noted for the other four pollutants being tracked.

Nitrates in the Drinking Water Supply

One Nebraska objective in the Environmental Health focus area addresses water quality. It seeks to keep at >99 percent the proportion of persons served by community water systems who receive a drinking water supply that contains nitrate levels of 10 parts per million or less. Excessive nitrates in drinking water can cause methemoglobinemia in infants, a condition that interferes with the oxygen-carrying function of red blood cells, resulting in "blue babies". In 2000-2004, this proportion (99 percent) had not changed appreciably from the 1996-2000 rate. This objective was not tracked for the U.S.

Blood Lead Levels

The U.S. and Nebraska objectives targeting reductions in the proportion of children aged one to six years who have blood lead levels of 10 micrograms per deciliter have both been set at zero. Both the state and the nation showed progress in reducing the proportion of children in the age group with elevated blood lead levels, but neither achieved the target rate. In Nebraska, the rate decreased from 7 percent in 1998 to 3.3 percent in 2002-2004.

FAMILY PLANNING

Healthy People 2010 Goal

The national Healthy People goal for 2010 is to improve pregnancy planning and spacing and prevent unintended pregnancy.

Background

Despite technology that would allow couples to have considerable control over their fertility, about one-half of all pregnancies in the United States are currently unintended. Family planning efforts can aid in achieving planned, wanted pregnancies and preventing unintended pregnancies.

Unintended pregnancies are those not wanted at the time of conception or not wanted at all. Many teen pregnancies are unintended. Consequences of unintended pregnancy can be serious and costly. Socially, the costs can be measured in unintended births, reduced educational attainment and employment opportunity, greater welfare dependency, and increased potential for child abuse and neglect. Medically, unintended pregnancy is serious in terms of a lost opportunity to prepare for a healthy pregnancy, an increased chance of infant and maternal illness, and the possibility of abortion.

Progress Toward Healthy People 2010 Objectives

National

Of the ten Family Planning objectives and sub-objectives shared by Nebraska and the nation, two sub-objectives were met for the U.S. The proportion of sexually active high school students (males and females) who used condoms the last time they had sexual intercourse increased enough to meet the 2010 target rates.

Improvement was noted for five objectives or sub-objectives. The teen pregnancy rate was down nationwide. The proportion of high school students (males and females) who had never engaged in sexual intercourse increased, as did the proportion of each gender who had not engaged in intercourse before age 15 years.

On the other hand, the proportion of births that occurred within 24 months of a previous birth increased. The proportion of females of childbearing age (15 to 44 years) who would be at risk for unintended pregnancy but used contraception decreased. Current data were unavailable to assess progress in decreasing the proportion of pregnancies that are unintended.

Nebraska

In Nebraska, none of the Family Planning objectives have been met so far. Progress was made toward two objectives/sub-objectives. The teen pregnancy rate decreased and the proportion of sexually active male high school students who used condoms the last time they had sexual intercourse increased from the baseline.

However, movement away from the 2010 target rates occurred for four of the ten Family Planning objectives. The proportion of births occurring within 24 months of a previous birth increased slightly. Smaller proportions of male and female high school students reported that they had never had sexual intercourse, while fewer female high school students stated that their partner used a condom the last time they had intercourse.

Data are unavailable to assess progress in decreasing the proportion of pregnancies that are unintended. Nebraska data are also unavailable to track the proportion of high school students who did not have sexual intercourse before age 15 years. Due to a change in survey methodology, current data on proportion of females of childbearing age who would be at risk for unintended pregnancy but used contraception are not comparable to the baseline prevalence estimates.

Intended Pregnancies

The first Family Planning objective seeks to increase the proportion of pregnancies that are intended to at least 70 percent nationwide and to at least 80 percent in Nebraska (Table 8). In 1995, an estimated 51 percent of pregnancies in the U.S. were intended, while 63 percent of pregnancies in Nebraska in 1999 were intended. Unfortunately, more recent data are unavailable to assess progress toward the national and state objectives.

Table 8
Nebraska 2010 Health Goals and Objectives
Family Planning

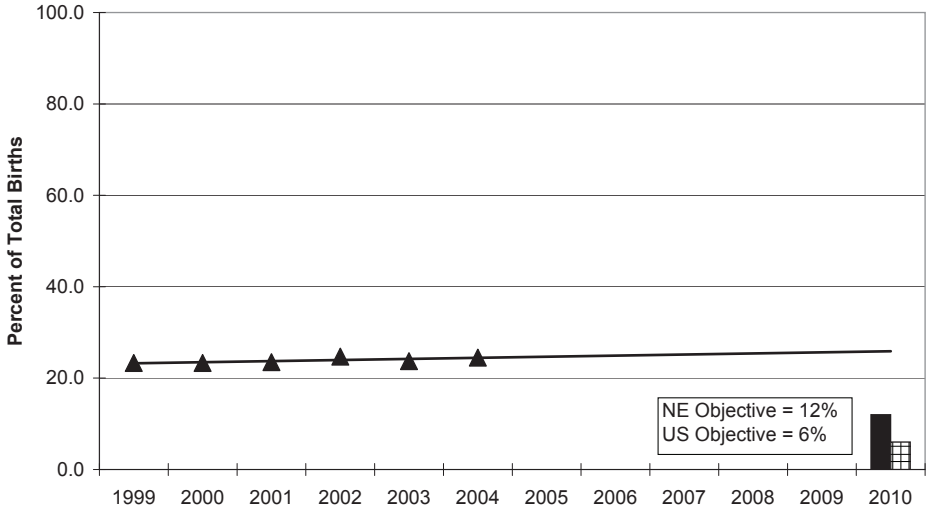
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#9-1	Percent of pregnancies that are intended (women aged 15-44 years) Data not available by race or ethnicity	1995	51	No New Data Available		70	1999	63	Data Not Available		80
#9-2	Percent of births occurring within 24 months of a previous birth	1995	11	2002	18	6	1999	23.3	2004	24.5	12.0
	White	1995	10	2002	18	6	1999	22.8	2004	24.1	12.0
	African American	1995	14	2002	19	6	1999	27.0	2004	28.7	12.0
	Native American	1995	NA	2002	NA	6	1999	31.8	2004	39.6	12.0
	Asian American	1995	NA	2002	NA	6	1999	27.2	2004	23.0	12.0
	Hispanic American	1995	14	2002	17	6	1999	24.8	2004	22.1	12.0
#9-3	Percent of females aged 15-44 at risk of unintended pregnancy (and their partners) who use contraception Data not available by race or ethnicity in Nebraska	1995	93	2002	89	100	1999	86.1	2004	87.5	95
#9-7	Rate of pregnancy/1,000 females aged 15-17 years (live births + fetal deaths + abortions) Data not available by race or ethnicity in Nebraska	1996	67		54	43	1999	27.5	2004	23.7	18
#9-8	Percent of adolescents in grades 9-12 who have never engaged in sexual intercourse before age 15 years										
	9-8a. Females	1995	81	2002	87	88	1999	88	Data Not Available		92
	9-8b. Males	1995	79	2002	85	88	1999	85			92
	Data not available by race or ethnicity										
#9-9	Percent of adolescents in grades 9-12 who have never engaged in sexual intercourse										
	9-9a. Females	1995	62	2002	70	75	1999	62	2005	59	75
	9-9b. Males	1995	57	2002	68	75	1999	62	2005	59	75
	Data not available by race or ethnicity										
#9-10	Percent of sexually active, unmarried adolescents aged 15-17 years in grades 9-12 who used condoms at last intercourse										
	9-10e. Females	1995	39	2002	56	49	1999	59	2005	56	75
	9-10f. Males	1995	70	2002	84	79	1999	63	2005	67	83

Table 8 continued		
Data Sources:		Additional Notes:
#9-1	U.S.--National Survey of Family Growth, CDC; National Vital Statistics System (NVSS), CDC; Abortion Provider Survey, The Alan Guttmacher Institute; Abortion Surveillance Data, CDC. Nebraska--BRFSS Family Planning Module, HHSS.	Intended pregnancies include births that were wanted at the time of conception (I.e., those resulting from pregnancies that happened at the "right" time, later than wanted, or those answering "didn't care"). All pregnancies ending in induced abortion are considered unintended pregnancies. Women aged 18 to 44 who were currently pregnant or had been pregnant within the past five years were asked how they felt about becoming pregnant just before their last or current pregnancy. Those who reported they wanted to be pregnant then or sooner were considered to have an intended pregnancy.
#9-2	U.S.--National Survey of Family Growth, CDC. Nebraska--Vital Statistics, HHSS.	Percent of females aged 15 to 44 years whose most recent live birth occurred within 24 months of a previous live birth. Percent of females giving birth whose most recent live birth occurred within 24 months of a previous live birth.
#9-3	U.S.--National Survey of Family Growth, CDC. Nebraska--BRFSS, HHSS.	Percent of "at-risk" females currently using a method of contraception other than withdrawal. "At-risk" females are those who had intercourse in the three months prior to the survey who were not pregnant, nor seeking pregnancy, not post-partum, nor (themselves or partner) surgically or nonsurgically sterile. Unintended pregnancies are those not wanted at the time of conception or not wanted at all. CHANGE IN DATA. In 1999, rate is percent of "at-risk" females (age 18-44) currently using a method of contraception. "At-risk" females excludes women who were not sexually active, who wanted to become pregnant, who had a same-sex partner, or who had a hysterectomy. In 2002, the definition changed. Questions were asked of non-pregnant women aged 18-44 and men aged 18-59. "At-risk" excludes females who had a hysterectomy, had a same-sex partner, who want a pregnancy, or who were not sexually active. It also excludes male respondents whose partner is now pregnant or who want a pregnancy.
#9-7	U.S.--National Survey of Family Growth, CDC; National Vital Statistics System (NVSS), CDC; Abortion Provider Survey, The Alan Guttmacher Institute; Abortion Surveillance Data, CDC. Nebraska--Vital Statistics, HHSS.	
#9-8	U.S.--National Survey of Family Growth, CDC. Nebraska--Youth Risk Behavior Surveillance System (YRBS), HHSS.	
#9-9	U.S.--National Survey of Family Growth, CDC. Nebraska--Youth Risk Behavior Surveillance System (YRBS), HHSS.	
#9-10	U.S.--National Survey of Family Growth, CDC. Nebraska--Youth Risk Behavior Surveillance System (YRBS), HHSS.	"Sexually active" is defined as having sexual intercourse in the three months prior to the interview. "Sexually active" is defined as having sexual intercourse in the three months prior to the interview.

Time Interval Between Births

Another Family Planning objective is to reduce the proportion of mothers whose most recent live birth occurred within 24 months of a previous live birth to no more than 6 percent in the U.S. overall and to no more than 12 percent in Nebraska. Nationwide, the proportion of births spaced this closely increased by 64 percent, from 11 percent in 1995 to 18 percent in 2002. In Nebraska, nearly one-fourth (24.5 percent) of all mothers' most recent birth occurred within 24 months of a previous birth in 2004. However, this rate increased only slightly compared to the 1999 baseline (Figure 58).

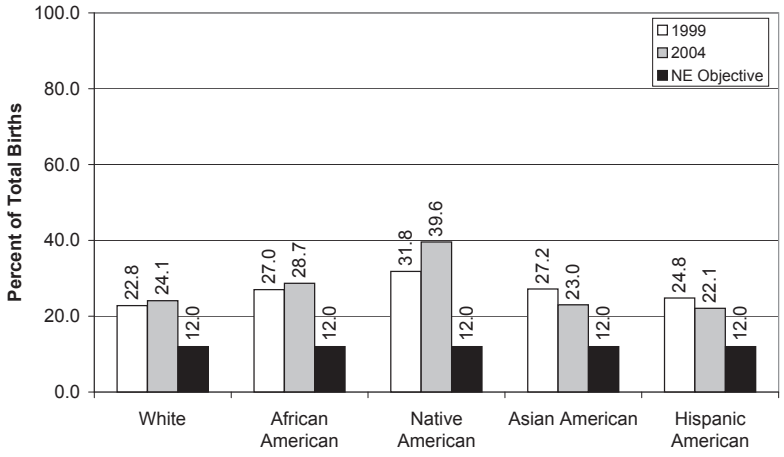
Figure 58
Nebraska Births Occurring Within 24 Months of Previous Birth



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

In Nebraska, the proportion of mothers with their most recent birth occurring within 24 months of a previous birth was highest among Native Americans in 2003 (39.6 percent). This rate had also increased by 25 percent from the 1999 rate (Figure 59). African Americans also recorded a slightly higher rate (28.7 percent) than the average for all mothers. Among Asian Americans (23.0 percent) and Hispanic Americans (22.1 percent), current rates were down somewhat from the baseline and were lower than rates for mothers in the other racial/ethnic groups.

Figure 59
Nebraska Births Occurring within 24 Months of Previous Birth by Race/Ethnicity



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Contraceptive Use Among Females of Childbearing Age

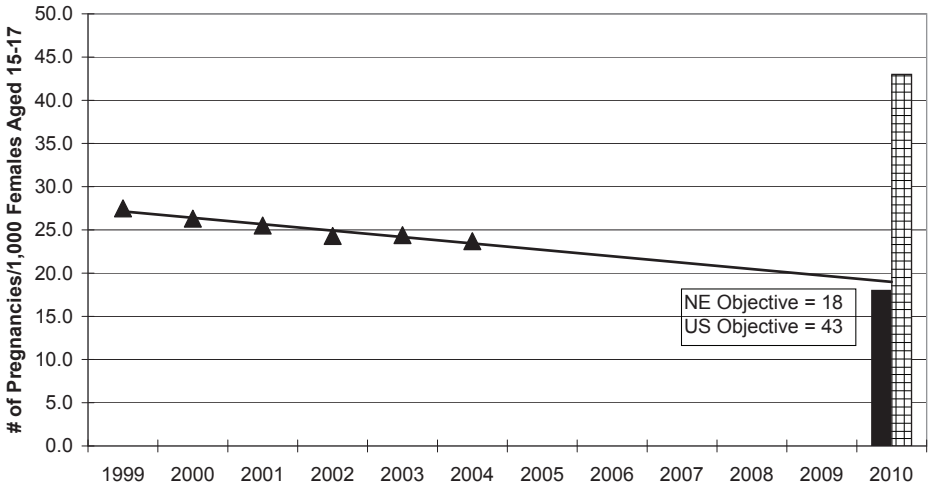
Nebraska and the nation have both established an objective that aims to increase the proportion of females aged 15 to 44 who would be at risk of unintended pregnancy but use contraception. The U.S. target rate is 100 percent, while the Nebraska target rate is 95 percent (Table 8). Definitions and data collection differ between the state and the U.S., so data are not necessarily comparable, although current rates are similar. Nationally, the proportion of adult females (or their partners) using contraception decreased from 93 percent in 1995 to 89 percent in 2002.

In Nebraska, the 1999 baseline is not comparable to 2004 data, due to a 2002 change in the categories of respondents asked this question and the definition of "at-risk". Currently, the BRFSS questions are asked of non-pregnant women aged 18 to 44 years and men aged 18 to 59 years. The definition of "at-risk" excludes women who had a hysterectomy, had a same-sex partner, who want a pregnancy, or who were not sexually active. It also excludes male respondents whose partner is now pregnant or who want a pregnancy. Based on these criteria, 87.5 percent of at-risk respondents used contraception to avoid unintended pregnancy in 2004.

Teen Pregnancy

A target rate of no more than 18 pregnancies per 1,000 females aged 15 to 17 years has been set for Nebraska. For the U.S., the target rate is no more than 43 pregnancies per 1,000 in this age group. Teen pregnancy rates have declined nationwide and in Nebraska. In the U.S., the 2004 rate of 54 pregnancies per 1,000 females in this age group represents a decrease of 19 percent from the 1996 baseline. In Nebraska, the 2004 rate (23.7 per 1,000) is less than one-half the national rate and was down 14 percent from the 1999 baseline (Figure 60).

Figure 60
Rate of Pregnancies* Among Nebraska Females
Aged 15-17 Years



*Number of pregnancies = Live births + Fetal deaths + Abortions
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Sexual Intercourse Among Adolescents

Three objectives regarding sexual behavior among adolescents have been adopted nationwide and in Nebraska. The first of these seeks to increase the proportion of high school students who have not engaged in sexual intercourse before the age of 15 years. The U.S. target is at least 88 percent for both genders, while the Nebraska target rate is at least 92 percent for males and for females (Table 8).

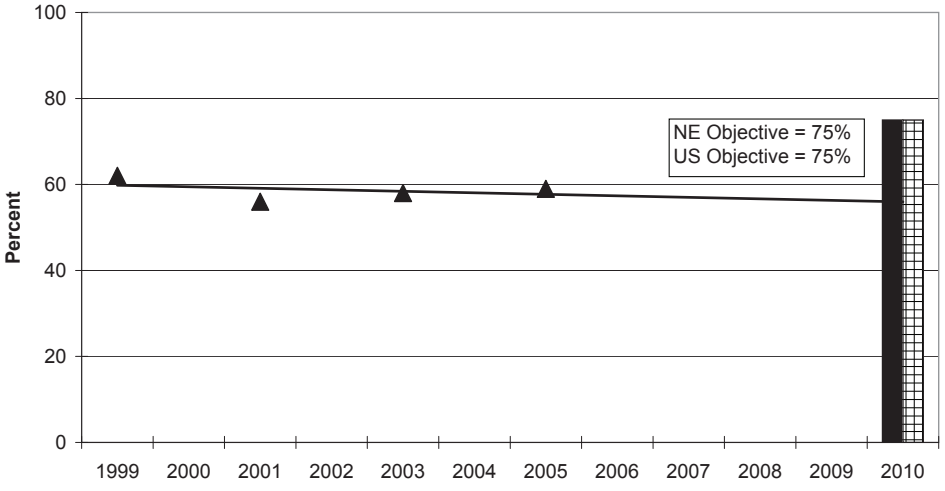
Nationwide, the proportion of females who have not had sexual intercourse before this age rose from 81 percent in 1995 to 87 percent in 2002. Among male high school students, this rate also increased (from 79 percent in 1995 to 85 percent in 2002. In Nebraska, no current data are available to assess progress. However, the 1999 baseline rates (88 percent of high school girls and 85 percent of high school boys) are similar to the 2002 national rates.

A related 2010 objective, established for the U.S. and for Nebraska, is to increase to 75 percent the proportion of high school students (males and females) who have never engaged in sexual intercourse. Nationally, progress was made toward this objective for both male and female students. Among females,

the proportion who had never had sexual intercourse increased from 62 percent in 1995 to 70 percent in 2002. For male high school students, the proportion was up 19 percent (from 57 percent in 1995 to 68 percent in 2002).

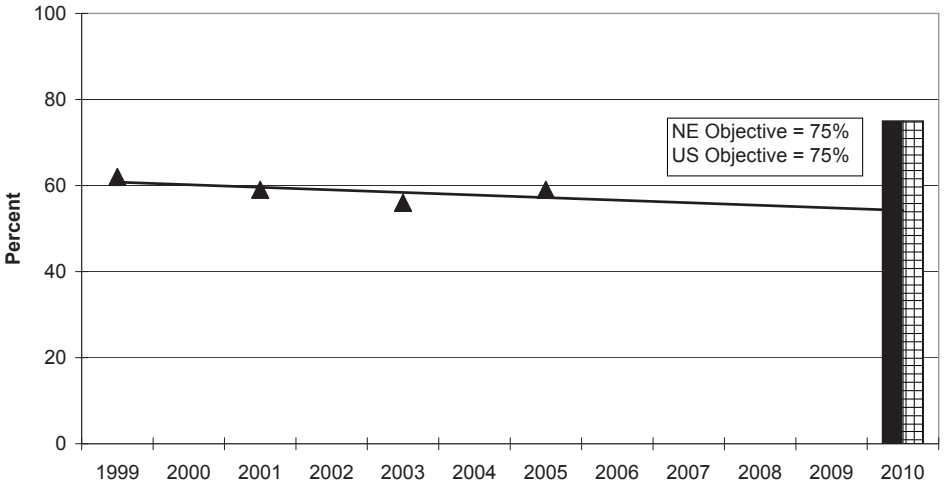
In Nebraska, the trend was negative for both male and female high school students (Figures 61 and 62). For both genders in 1999, 62 percent reported they had never engaged in sexual intercourse. The proportion was lower in each of the three YRBS studies conducted after that, with a 2004 prevalence estimate of 59 percent each for males and females.

Figure 61
Nebraska Adolescent Females (Grades 9-12)
Who Never Engaged in Sexual Intercourse



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

Figure 62
Nebraska Adolescent Males (Grades 9-12)
Who Never Engaged in Sexual Intercourse



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

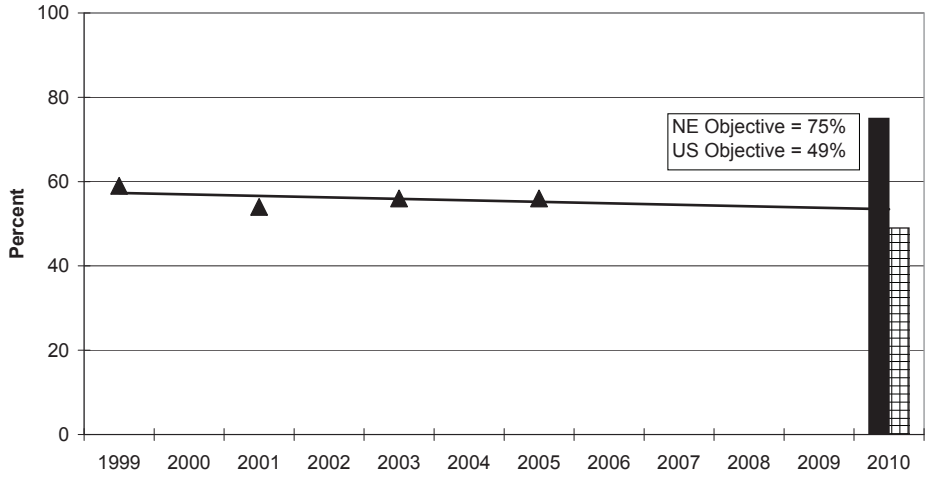
Condom Use Among Sexually Active Adolescents

The third objective related to adolescent sexual behavior tracks the proportion of sexually active, unmarried high school students who used condoms the last time they had sexual intercourse. For female

students, the U.S. objective is to increase the prevalence of condom use to at least 49 percent, while for males the target rate is at least 79 percent (Table 8). For Nebraska, the target rates are at least 75 percent for female high school students and at least 83 percent for male students. Progress was made nationwide, with both of the U.S. objectives met as of 2002. In 2002, 56 percent of high school girls and 84 percent of high school boys who were sexually active reported using condoms the last time they had intercourse.

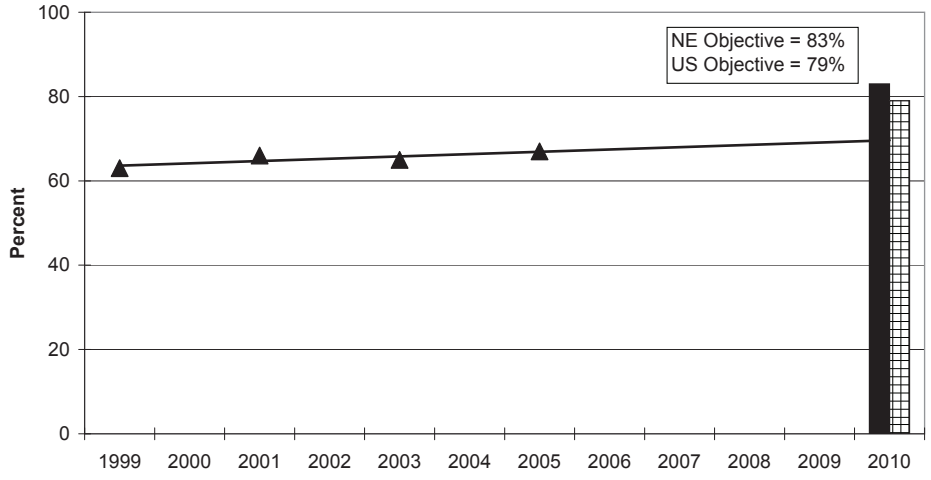
In Nebraska, the proportion of girls who reported that their partner used condoms the last time they had intercourse actually decreased somewhat from 59 percent in 1999 to 56 percent in 2005 (Figure 63). Among high school boys, however, the proportion using condoms at last intercourse increased from 63 percent in 1999 to 67 percent in 2005 (Figure 64).

Figure 63
Nebraska Adolescent Females* Aged 15-17 Years
Who Used Condoms at Last Sexual Intercourse



*Sexually active, unmarried adolescents.
SOURCE: Nebraska HHSS, Behavioral Risk Factor Suvey. U.S. DHHS, Healthy People 2010.

Figure 64
Nebraska Adolescent Males* Aged 15-17 Years
Who Used Condoms at Last Sexual Intercourse



*Sexually active, unmarried adolescents.
SOURCE: Nebraska HHSS, Youth Risk Behavior Survey.

FOOD SAFETY

Healthy People 2010 Goal

The national Healthy People 2010 goal for food safety is to reduce food-borne illness.

Background

Food supplies in the United States are generally maintained as such high levels of safety that food safety is rarely a public issue, except when outbreaks of food-borne illness occur. However, the problem is ongoing and affects many Americans each year. Food-borne infections are estimated to cause approximately 76 million illnesses each year in this country, resulting in 325,000 hospitalizations and 5,000 deaths annually. Costs of food-borne illnesses in the United States are estimated to be about $23 billion each year.

Progress Toward Healthy People 2010 Objectives

National

Of all infections caused by the key food-borne pathogens tracked by Healthy People 2010, *Campylobacter* and *Salmonella* species combined account for the majority of cases in the United States. Incidence of *Campylobacter* infections decreased substantially, nearly reaching the 2010 target rate in 2003. For Salmonella, however, the rate was up slightly. Incidence rates for *E. coli* and *Listeria* infections declined from the 1997 baseline.

The number of outbreaks of infection with *E. coli* increased nationwide. However, the number of *Salmonella* outbreaks was down in 2002. As noted in the Progress Review for this focus area, it is necessary to keep in mind that increases in the number of outbreaks of food-borne infections could reflect enhanced reporting of smaller outbreaks, not an actual increase in outbreak frequency.

Nebraska

In Nebraska, the two objectives related to food-borne disease outbreaks were achieved in 2005. Progress was made in reducing the incidence of infection for three of the four food-borne pathogens tracked here. For the remaining pathogen, there were less than five cases reported in 2005, so the rate could not be reported.

Incidence of Infection by Four Food-borne Pathogens

Nebraska's 2010 objectives address incidence of four food-borne pathogens: *Campylobacter* species, *E. coli* O157:H7, *Listeria monocytogenes*, and *Salmonella* species. Target rates for Nebraska are similar to those adopted nationwide (Table 9).

Table 9
Nebraska 2010 Health Goals and Objectives
Food Safety

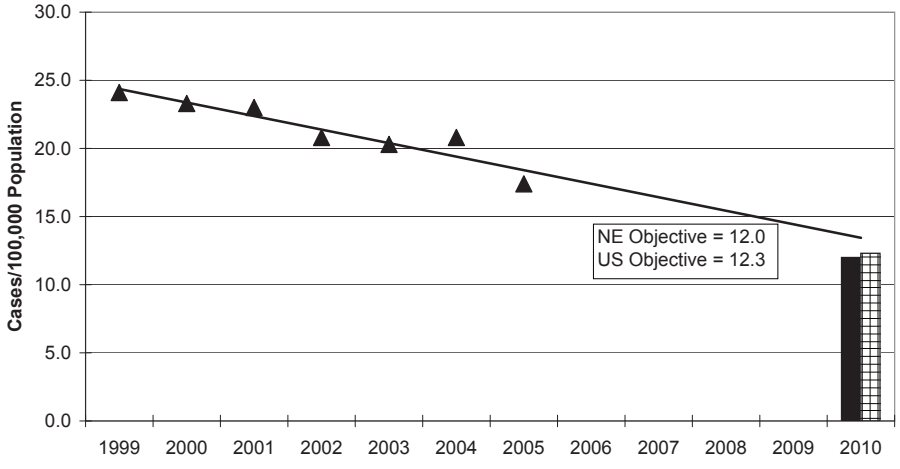
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#10-1	Cases of infection caused by food-borne pathogens per 100,000 population										
	a. Campylobacter species	1997	24.6	2003	12.6	12.3	1999	24.1	2005	17.4	12.0
	b. E. coli 0157:H7	1997	2.1	2003	1.1	1.0	1999	9.5	2005	2.9	1.0
	c. Listeria monocytogenes	1997	0.47	2003	0.33	0.24	1999	0.3	2005	*	0.2
	d. Salmonella species	1997	13.6	2003	14.4	6.8	1999	12.8	2005	12.0	6.4
#10-2	Number of outbreaks of infection by food-borne bacteria										
	a. E. coli 0157:H7	1997	22	2002	38	11	1999	1	2005	0	0
	b. Salmonella serotype Enteriditis	1997	44	2002	29	22	1999	0	2005	0	0

*Rate based on fewer than 5 cases during the year.

Data Sources:		Additional Notes:
#10-1	U.S.--Foodborne Disease Active Surveillance Network (FoodNet), CDC. Nebraska--Public Health Assurance, Environmental, Disease, and Vector Surveillance, HHSS.	Rate based on numbers of culture-confirmed cases of illness caused by these organisms. Population-based surveillance data on these cases of food-borne illness from more than 300 participating clinic laboratories.
#10-2	U.S.--Foodborne Disease Outbreak Surveillance System, CDC. Nebraska--Public Health Assurance, Environmental, Disease, and Vector Surveillance, HHSS.	A foodborne disease outbreak is defined as the occurrence of two or more cases of a similar illness resulting from the ingestion of a common food. These outbreaks are generally reported to CDC by state and local health departments, but may also be received from federal agencies or private physicians.

In Nebraska, progress was made in reducing incidence of infection by three of these four pathogens. For *Campylobacter*, incidence decreased steadily from 24.1 cases per 100,000 population in 1999 to 17.4 in 2005 (Figure 65). The current rate is still higher than the 2003 national rate and is 45 percent higher than the target rate of no more than 12.0 cases per 100,000 by 2010.

Figure 65
Cases of Infection Caused by Food-Borne Pathogens in Nebraska (Campylobacter species)

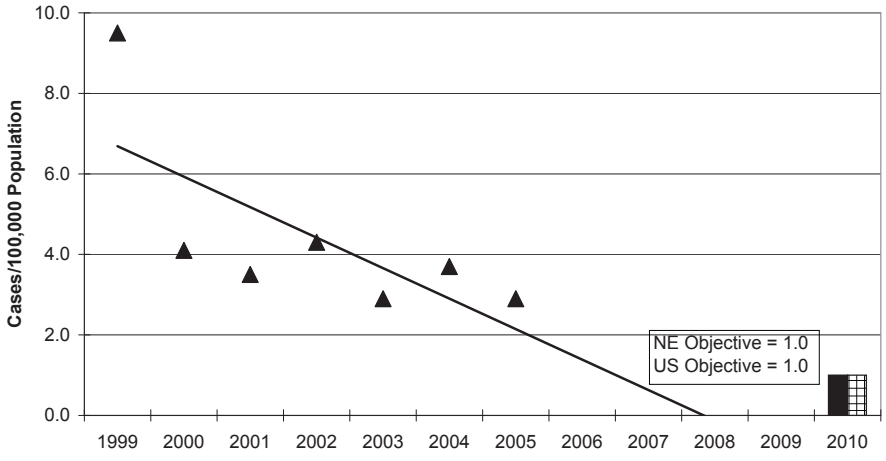


SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance. U.S. DHHS, Healthy People 2010.

E. coli incidence in Nebraska dropped sharply in 2000, after a high of 9.5 cases per 100,000 in 1999 (Figure 66). Rates have varied somewhat since then, but have trended gradually downward to 2.9 cases per 100,000

in 2005. However, this rate is still higher than the 2003 U.S. rate of 1.1 and the Nebraska 2010 objective of no more than 1.0 cases of *E. coli* infection per 100,000 population.

Figure 66
Cases of Infection Caused by Food-Borne Pathogens in Nebraska (E. coli O157:H7)

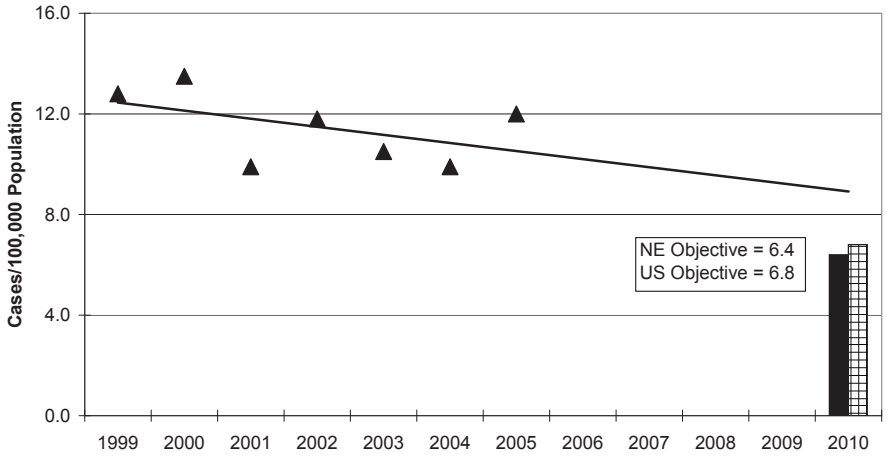


SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance. U.S. DHHS, Healthy People 2010.

There were fewer than five reported cases of *Listeria monocytogenes* infection in Nebraska in 2005; thus, a current rate cannot be reported here. The 1999 baseline rate of 0.3 cases per 100,000 is only slightly higher than the 2010 target rate of 0.2.

Incidence of *Salmonella* infection in 2005 (12.0 cases per 100,000) has decreased slightly since the 1999 baseline of 12.8 (Figure 67). The 2005 rate is lower than the national rate, but is still 88 percent higher than Nebraska's objective of no more than 6.4 cases of *Salmonella* infection per 100,000 population by 2010.

Figure 67
Cases of Infection Caused by Food-Borne Pathogens in Nebraska (Salmonella species)



SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance. U.S. DHHS, Healthy People 2010.

Outbreaks of Food-Borne Infection

Nebraska has set objectives of reducing the number of food-borne disease outbreaks due to *E. coli* O157: H7 and *Salmonella* serotype Enteriditis to zero by 2010. These objectives have both been achieved in 2005. Of course, it will be necessary to maintain the number of outbreaks at this level in future years.

HEART DISEASE AND STROKE

Healthy People 2010 Goals

The national Healthy People 2010 goals for Heart Disease and Stroke are aimed at improvements in cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and strokes; and the prevention of recurrent cardiovascular events.

Background

Cardiovascular disease (CVD) includes a wide variety of heart and blood vessel diseases, of which coronary heart disease and stroke are the principal components. The American Heart Association estimates that 71.3 million Americans currently have one or more types of CVD. An estimated 13.2 million persons have coronary heart disease and 5.5 million have had a stroke.

CVD is the leading cause of death and disability in the United States today. CVD was the underlying cause of 37.3 percent of all deaths in 2003. If deaths in which CVD was a contributing cause are included, CVD accounted for 58 percent of deaths in 2002. CVD claims more live each year than the next four leading causes of death combined (i.e., cancer, chronic lower respiratory diseases, accidents, and diabetes).

The estimated direct and indirect costs of CVD in the United States for 2006 are $403.1 billion.

Progress Toward Healthy People 2010 Objectives

National

Progress has been made in reducing deaths due to coronary heart disease and stroke. Hospitalizations due to congestive heart failure among persons 65 and older are down slightly. The proportion of adults who have elevated blood cholesterol levels has also decreased overall and has reached the target rate. In addition, more adults report having their cholesterol level checked in the last five years.

On the other hand, the proportion of adults who have high blood pressure has increased and the proportion who have had a blood pressure check in the past two years has remained stable.

Data are now available to measure the proportion of adults who know the early warning signs of heart attack and stroke and the importance of accessing rapid emergency care.

Nebraska

One of the objectives in the Heart Disease and Stroke focus area has already been met in Nebraska. The overall coronary heart disease death rate has decreased considerably and is now lower than the target rate for 2010. However, only white and Hispanic Nebraskans reached the target rates for 2010. New target rates will be set for 2010.

Progress was made toward the 2010 targets for two Heart Disease and Stroke objectives in Nebraska. The overall mortality rate for stroke declined substantially and has nearly reached the 2010 target rate in 2005. Whites, African Americans, and Native Americans in the state all achieved reductions in mortality due to stroke, but none met the target rate.

Progress was also made in increasing the proportion of adults who had their blood cholesterol level checked in the past five years.

Movement away from the target rates was noted for five objectives in this focus area. Hospitalization rates for congestive heart failure were up in all three age groups of persons 65 and older. The proportion of adults with high blood pressure increased, as did the proportion of adults with high blood cholesterol levels.

Data were unavailable for the proportion of adults who had their blood pressure checked in the last two years. Only baseline data were available for the two new indicators measuring awareness of the early warning symptoms of a heart attack or stroke.

Coronary Heart Disease Deaths

Nebraska established an objective of reducing the coronary heart disease death rate to no more than 121.5 deaths per 100,000 population by 2010 (Table 10). The 2004 rate of 112.1 represents a decrease of 26 percent from the 1998 baseline and achieves the 2010 objective (Figure 68). The current Nebraska rate is 35 percent lower than the 2003 U.S. rate of 172. A revised objective of no more than 84.0 coronary heart disease deaths per 100,000 has been set for 2010 (a further decrease of 25 percent) (Appendix, Table A).

Table 10
Nebraska 2010 Health Goals and Objectives
Heart Disease and Stroke

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#12-1	Coronary heart disease death rate per 100,000	1999	203	2003	172	162	1998	151.9	2004	112.1	121.5
	White	1999	200	2003	170	162	1994-1998	168.4	2000-2004	120.2	121.5
	African American	1999	248	2003	220	162	1994-1998	210.5	2000-2004	130.7	121.5
	Native American	1999	148	2003	120	162	1994-1998	290.0	2000-2004	165.9	121.5
	Asian American	1999	124	2003	99	162	1994-1998	32.5	2000-2004	49.4	26.0
	Hispanic American	1999	169	2003	139	162	1994-1998	87.0	2000-2004	69.5	69.6
#12-2	Percent of adults (age 20+) who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 9-1-1.	2001	46	No New Data Available		50%	2003	10%	No New Data Available. Objective Added in 2006.		50
#12-6	Hospitalizations with congestive heart failure as the principal diagnosis per 1,000 population										
	a. Age 65 to 74 years	1997	13.2	1999	12.3	6.5	1999	7.2	2003	8.3	3.5
	b. Age 75 to 84 years	1997	26.7	1999	27.1	13.5	1999	16.7	2003	18.3	8.4
	c. Age 85 years and older	1997	52.7	1999	50.4	26.5	1999	31.8	2003	35.0	15.9
#12-7	Stroke death rate	1999	62	2003	53	50	1998	60.4	2004	48.0	47.4
	White	1999	60	2003	51	50	1994-1998	59.2	2000-2004	53.2	47.4
	African American	1999	82	2003	74	50	1994-1998	99.8	2000-2004	87.0	47.4
	Native American	1999	48	2003	35	50	1994-1998	75.2	2000-2004	55.2	47.4
	Asian American	1999	53	2003	45	50	1994-1998	41.7	2000-2004	47.8	32.7
	Hispanic American	1999	47	2003	40	50	1994-1998	28.4	2000-2004	28.8	22.3
#12-8	Percent of adults (age 20+) who are aware of the early warning symptoms and signs of a stroke and the importance of accessing rapid emergency care by calling 9-1-1.	2001	78%	No New Data Available		83%	2003	19%	No New Data Available. Objective Added in 2006.		50
#12-9	Percent of adults w/high blood pressure (age 18+)--among those who ever had it checked	1988-94	26	2002	30	14	1999	22	2005	25	16
	White	1988-94	27	2002	NA	14	1995-1999	22	2001-2005	24	16
	African American	1988-94	40	2002	NA	14	1995-1999	30	2001-2005	35	16
	Native American	1988-94	NA	2002	NA	14	1995-1999	NA	2001-2005	22	16
	Asian American	1988-94	NA	2002	NA	14	1995-1999	NA	2001-2005	12	16
	Hispanic American	1988-94	NA	2002	NA	14	1995-1999	19	2001-2005	13	16

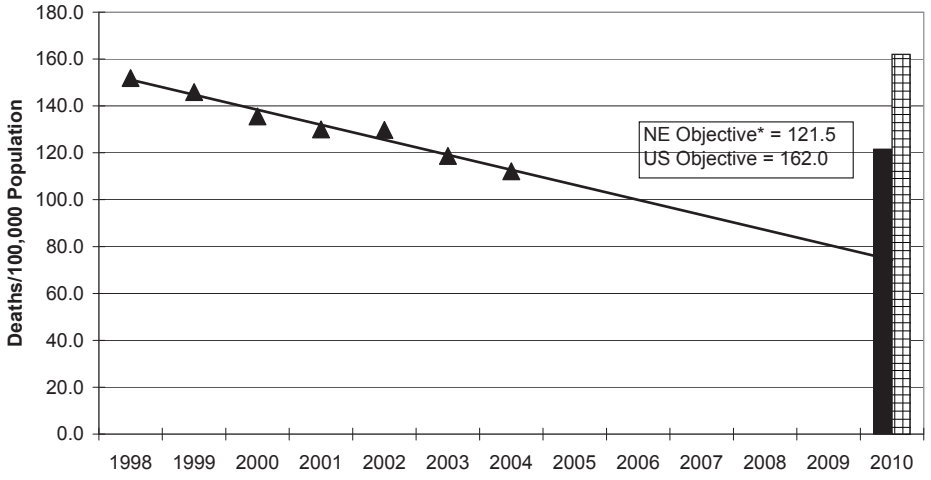
Table 10 continued

Objective		UNITED STATES Baseline Year	Baseline Rate	Current Year	Current Rate	U.S. 2010 Objective	NEBRASKA Baseline Year	Baseline Rate	Current Year	Current Rate	NE 2010 Objective
#12-12	Percent of adults who had BP check in past 2 years (and can state if it is high or low)--age 18+	1998	90	2003	90	95	1999	95			97
	White	1998	90	2003	90	95	1995-1999	93			97
	African American	1998	92	2003	82	95	1995-1999	96	No New Data Available		97
	Native American	1998	89	2003	89	95	1995-1999	NA			97
	Asian American	1998	86	2003	87*	95	1995-1999	NA			97
	Hispanic American	1998	84	2003	83	95	1995-1999	92			97
#12-14	Percent of adults (age 18+) with high blood cholesterol levels	1988-94	21	2002	17	17	1999	27	2005	35	17
	White	1988-94	21	2002	18**	17	1995-1999	29	2001-2005	31	17
	African American	1988-94	19	2002	16**	17	1995-1999	22	2001-2005	25	17
	Native American	1988-94	NA	2002	NA	17	1995-1999	NA	2001-2005	27	17
	Asian American	1988-94	NA	2002	NA	17	1995-1999	NA	2001-2005	23	17
	Hispanic American	1988-94	NA	2002	16	17	1995-1999	29	2001-2005	17	17
#12-15	Percent of adults (age 18+) who had blood cholesterol level checked in last 5 years	1998	67	2003	73	80	1999	67	2005	71	80
	White	1998	67	2003	73	80	1995-1999	64	2001-2005	68	80
	African American	1998	67	2003	75	80	1995-1999	64	2001-2005	57	80
	Native American	1998	58	2003	68	80	1995-1999	NA	2001-2005	52	80
	Asian American	1998	68	2003	75*	80	1995-1999	NA	2001-2005	49	80
	Hispanic American	1998	59	2003	68	80	1995-1999	56	2001-2005	32	80

*Asian only. **Non-Hispanic. NA = Not Available

Data Sources:		Additional Notes:
#12-1	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes 402,410-414,429.2. Age-adjusted to 2000 standard. Same as U.S.
#12-2	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	Adults aged 18+years. Percent of respondents who correctly identified all five of the following signs or symptoms of a heart attack: chest pain or discomfort; shortness of breath; pain or discomfort in the arms or shoulder; feeling weak, lightheaded or faint; and pain or discomfort in jaw, neck, or back.
#12-6	U.S.--National Hospital Discharge Survey, CDC. Nebraska--Hospital Discharge data, HHSS.	ICD-9-CM code 428.0 as principal diagnosis. Same as U.S.
#12-7	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes 430-438. Age-adjusted to 2000 standard. Same as U.S.
#12-8	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	Adults aged 18+years. Percent of respondents who correctly identified all five of the following signs or symptoms of stroke: sudden numbness or weakness of the face, arm, or leg, especially on one side; sudden confusion or trouble speaking; sudden trouble walking, dizziness, or loss of balance; sudden trouble seeing in one or both eyes; and severe headache with no known cause.
#12-9	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC. Nebraska--BRFSS, HHSS.	Adults aged 20 and older. Definition of high blood pressure: either (a) have a measurement of systolic blood pressure >140 mmHg or diastolic blood pressure >90 mmHg or (b) report they are taking high blood pressure medicine. Self-reported.
#12-12	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	An adult was considered able to state their blood pressure level if they responded high, low, normal, or borderline when asked. Self-reported.
#12-14	U.S.--NHANES, CDC. Nebraska--BRFSS, HHSS.	Measured. Adults aged 20 and older with total blood cholesterol >240 mg/dL. Self-reported. Among adults who ever had their blood cholesterol level checked, percent who were told it was high by a doctor or other health professional.
#12-15	U.S.--NHIS, CDC. Nebraska--BRFSS, HHSS.	Self-reported. Self-reported.

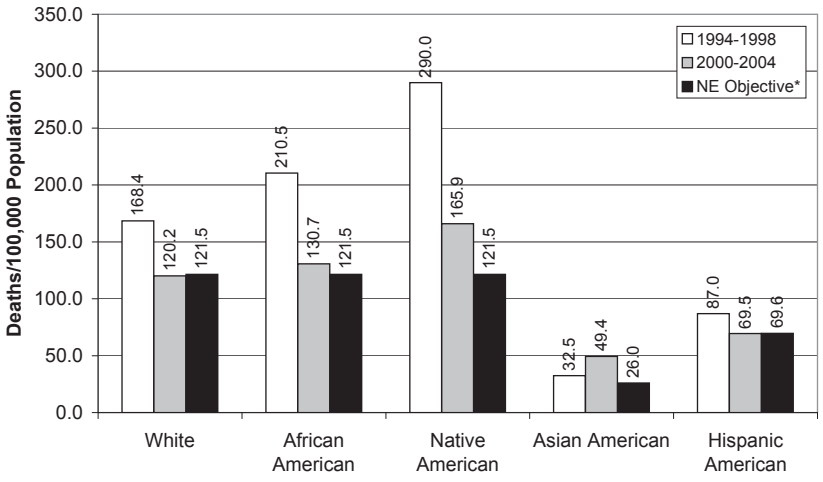
Figure 68
Deaths Due to Coronary Heart Disease in Nebraska
(Age-Adjusted to 2000)



*Nebraska objective has been met and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Each racial/ethnic group in Nebraska except Asian Americans achieved reductions in mortality due to coronary heart disease (Figure 69). For Asian Americans, the death rate increased by 52 percent to 49.4 per 100,000 population (the lowest rate of the five racial/ethnic groups).

Figure 69
Deaths Due to Coronary Heart Disease in Nebraska
by Race/Ethnicity (Age-Adjusted to 2000)



*Nebraska objectives have been met for whites and Hispanic Americans and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics.

Although the coronary heart disease death rate for Native Americans decreased by 43 percent from the baseline, this group still recorded the highest death rate in 2000-2004 (165.9). The death rate for African Americans in the state also decreased substantially (-38 percent), but the current rate of 130.7 still did not meet the target rate of 121.5. Rates for white (120.2) and Hispanic (69.5) Nebraskans also had declined from the 1994-1998 baseline. For these two groups, current rates did achieve the rates targeted for them for 2010. Revised target rates, reflecting increases of 25 percent each, have been adopted for whites (90.0) and Hispanic Americans (52.0) in the state (Appendix, Table A).

Warning Signs of Heart Attack

In Nebraska, the 2003 Behavioral Risk Factor Surveillance System included, for the first time, questions asking adult respondents to identify signs or symptoms of a heart attack. Correctly identifying all of the following five signs or symptoms constituted "awareness": chest pain or discomfort; shortness of breath; pain or discomfort in the arms or shoulder; feeling weak, lightheaded or faint; pain or discomfort in jaw, neck, or back. Only 10 percent of adults aged 18 and older were able to correctly identify all five signs or symptoms of heart attack. The 2010 objective for Nebraska is to increase this proportion to 50 percent.

Hospitalizations for Congestive Heart Failure

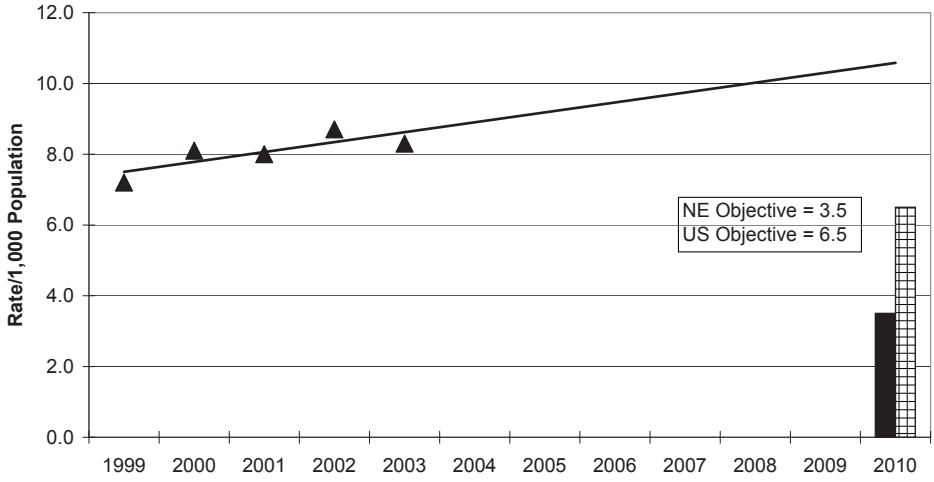
Congestive heart failure (CHF) is a serious condition in which the heart cannot pump enough blood through the body. It develops over time as the pumping action of the heart gets weaker. As the heart becomes weaker, blood and fluid can back up in the lungs and fluid can build up in the feet, ankles, and legs. People with CHF often experience fatigue and shortness of breath.

The National Institutes of Health estimate that 5 million Americans have CHF and the number is increasing. It is most common among people aged 65 and older and is the most frequent cause of hospitalizations among older people.

In Nebraska and the U.S., the 2010 objectives seek to reduce the rate of hospitalizations for CHF by about 50 percent (Table 10). Hospitalization rates for this diagnosis in Nebraska continue to be lower than the corresponding national rates for each of the three age categories.

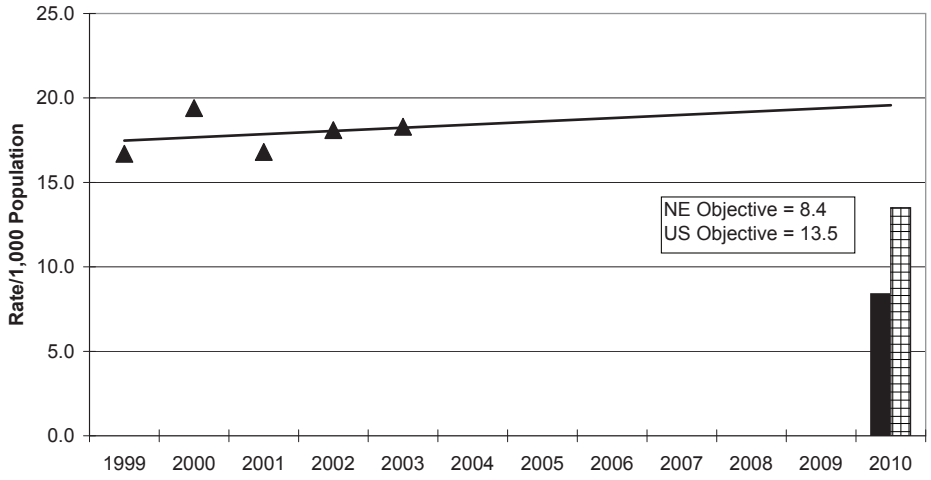
In 2003, there were 8.3 hospitalizations for CHF per 100,000 population among adults aged 65 to 74 in Nebraska, up 15 percent from the 1999 baseline of 7.2 (Figure 70). The rates of hospitalization for this condition were higher for Nebraskans aged 75 to 84 (18.3) and for those 85 and older (35.0). Both of the older age groups experienced increases of about 10 percent from the 1999 baseline (Figure 71 and 72). None of the three age groups achieved the targeted reduction in hospitalization rates for CHF. Nationwide, rates decreased for persons aged 65 to 74 and for those aged 85 and older, but are still far from meeting the target rates.

Figure 70
Hospitalizations for Congestive Heart Failure*
(Nebraskans Aged 65 - 74 Years)



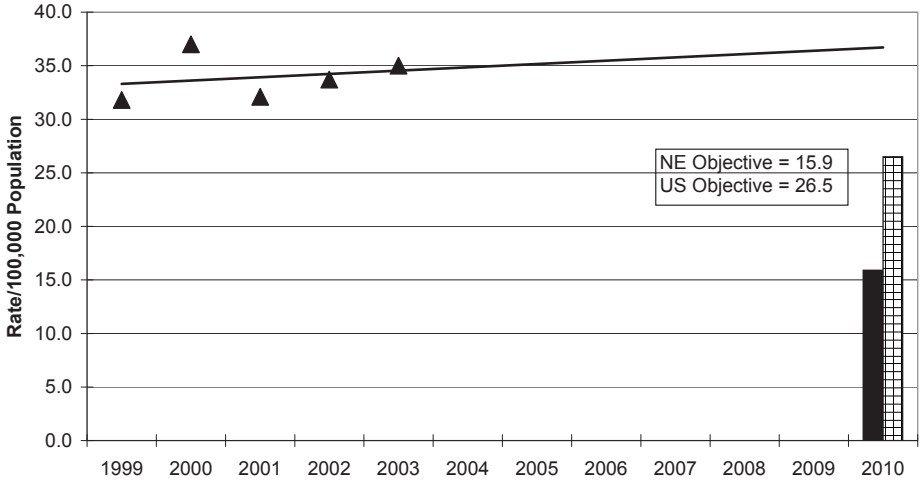
*As principal diagnosis.
SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Figure 71
Hospitalizations for Congestive Heart Failure*
(Nebraskans Aged 75 - 84 Years)



*As principal diagnosis.
SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Figure 72
Hospitalizations for Congestive Heart Failure*
(Nebraskans Aged 85+ Years)



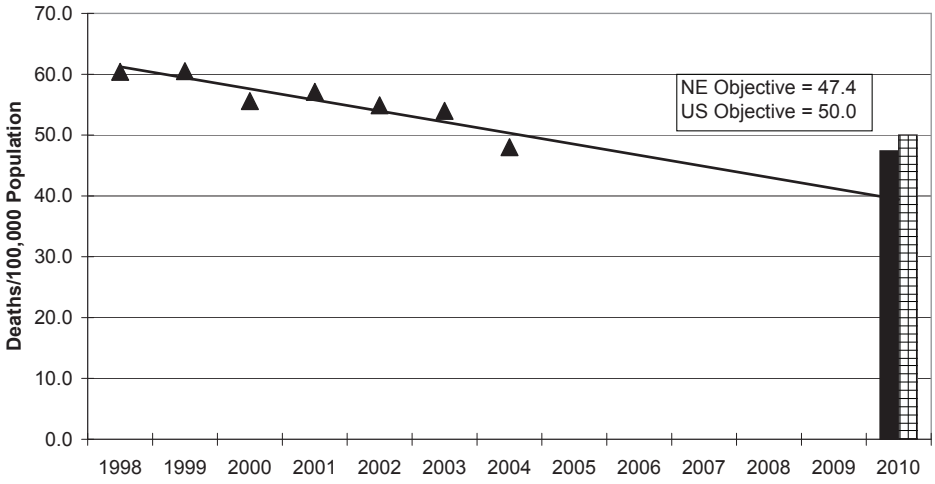
*As principal diagnosis.
SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Stroke Deaths

A nationwide objective of reducing death rates due to stroke to no more than 50 per 100,000 by 2010 has been adopted (Table 10). In Nebraska, the target rate is slightly lower (47.4 per 100,000 population) for the state overall and for whites, African Americans, and Native Americans. Lower target rates were set for Asian Americans and Hispanic Americans in Nebraska, since their baseline rates were lower.

The current stroke mortality rate in Nebraska was 48.0 deaths per 100,000 in 2004, down 21 percent from the 1998 baseline of 60.4 (Figure 73). This current rate nearly achieves the 2010 target rate for the state. Nationwide, the 2003 stroke death rate has declined by 15 percent from the baseline, but is higher (53 per 100,000) than the Nebraska rate and does not achieve the 2010 objective.

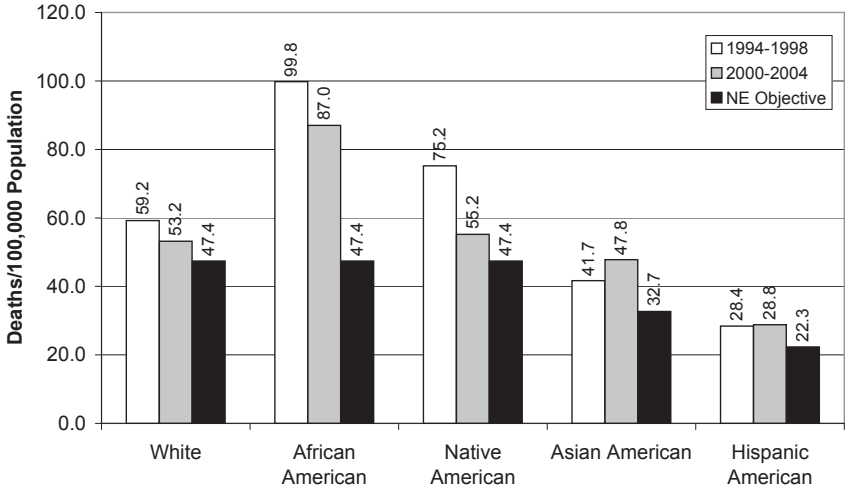
Figure 73
Deaths Due to Stroke in Nebraska
(Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Although stroke mortality decreased in Nebraska, not all racial or ethnic groups experienced improvement in these rates (Figure 74). While Hispanic Nebraskans recorded the lowest mortality rates for this cause of death (28.8), the 2000-2004 rate was up very slightly from 1994-1998. In comparison to the other groups, Asian Americans also had fairly low mortality due to stroke. However, the death rate for this group rose by 15 percent to 47.8 per 100,000.

Figure 74
Deaths Due to Stroke in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics.

The current stroke mortality rate for African Americans in Nebraska (87.0) was down 13 percent from the baseline. However, this rate is far higher than the rates for other racial/ethnic groups in the state. Native Americans also reported good progress in reducing stroke deaths by 27 percent. The current rate (55.2) is still 16 percent higher than the target rate for 2010. The 2000-2004 stroke mortality rate for white Nebraskans (53.2) represents a decrease of 10 percent.

Warning Signs of Stroke

As with the earlier objective concerning warning signs of heart attack, the 2003 Nebraska Behavioral Risk Factor Surveillance System included, for the first time, questions asking adult respondents to identify signs of stroke. Correctly identifying all of the following five signs or symptoms constituted "awareness": sudden numbness or weakness of the face, arm, or leg, especially on one side; sudden confusion or trouble speaking; sudden trouble walking, dizziness, or loss of balance; sudden trouble seeing in one or both eyes; and severe headache with no known cause.

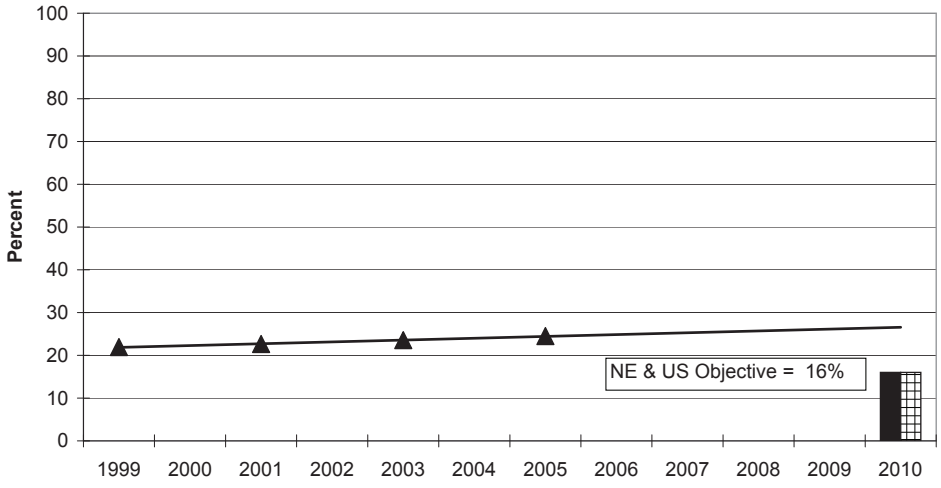
Only 19 percent of adults aged 18 and older were able to correctly identify all five signs or symptoms of stroke. The 2010 objective for Nebraska is to increase this proportion to 50 percent.

High Blood Pressure

One of the cardiovascular disease risk-reduction objectives for Nebraska is to reduce the prevalence of high blood pressure (also known as hypertension) in adults aged 18 and older (who ever had it checked) to no more than 16 percent by 2010 (Table 10). The U.S. objective is 14 percent.

Unfortunately, prevalence of high blood pressure in adults rose in Nebraska (Figure 75) and nationwide. In Nebraska, the proportion increased from 22 percent in 1999 to 25 percent in 2005. Nationally, prevalence reached 30 percent in 2002, compared to a 1988-1994 rate of 26 percent.

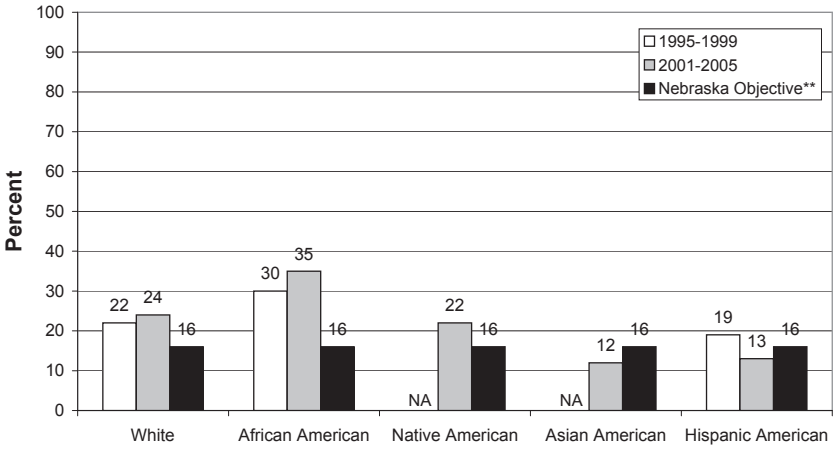
Figure 75
Nebraska Adults Aged 18+ Who Were Ever Told Their Blood Pressure Was High*



*By a doctor or other health professional
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

In 2001-2005, more than one-third of African American adults in Nebraska (35 percent) had been told by a health professional that they had high blood pressure (Figure 76). This prevalence rate is up 17 percent from the 1995-1999 baseline. For white Nebraskans, prevalence increased (by 9 percent) to 24 percent in 2001-2005. Among Native Americans, 22 percent currently reported having hypertension.

Figure 76
Nebraska Adults Ever Told Their Blood Pressure Was High*
by Race/Ethnicity



*By doctor or other health professional.
**Nebraska objectives have been met for Asian and Hispanic Americans and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

BRFSS data show a decrease in high blood pressure prevalence for Hispanics from 19 percent to the current 13 percent. Twelve percent of Asian Americans stated that they had high blood pressure. Both of these groups met the Nebraska 2010 objective of no more than 16 percent of adults with hypertension. Since the original 2010 targets have been reached for these two groups, a revised target rate of 10 percent has been set for both Asian and Hispanic Americans in Nebraska (Appendix, Table A).

A second objective was adopted in Nebraska for hypertension. This objective aims to increase the proportion of adults who reported having their blood pressure checked in the past two years to at least 97 percent by 2010 (Table 10). The national objective is to increase this rate to at least 95 percent. No new data are available for Nebraska. U.S. data show no change in the rate compared to baseline.

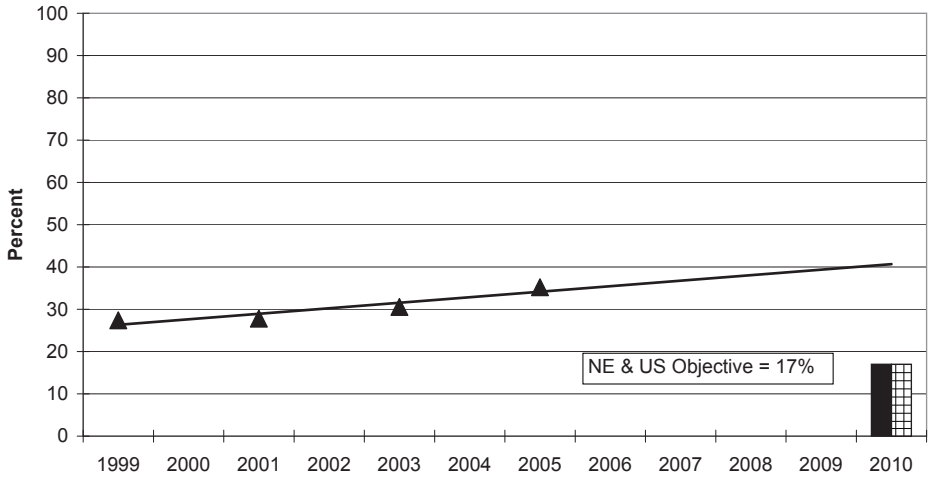
Cholesterol Levels

Both Nebraska and the nation have set 2010 objectives to reduce the prevalence of elevated blood cholesterol levels among adults to no more than 17 percent. Prevalence has declined for the U.S., but not for Nebraska. However, some of this difference in progress achieved is probably attributable to differences in data sources used.

Nationally, the proportion of people with high cholesterol has decreased from 21 percent in 1988-1994 to 17 percent in 2002, based on actual measurement of blood cholesterol levels among adults participating in the National Health and Nutrition Examination Survey. Thus, the U.S. objective has been achieved.

The Nebraska data source is the Behavioral Risk Factor Surveillance System. This survey asks respondents who ever had their blood cholesterol level checked if they had been told by a doctor or other health professional that it was high. Based on this self-reported data, Nebraska recorded an increase in the proportion of adults with elevated blood cholesterol from the baseline of 27 percent in 1999 to 35 percent in 2005 (Figure 77). This current rate is more than double the targeted rate of 17 percent.

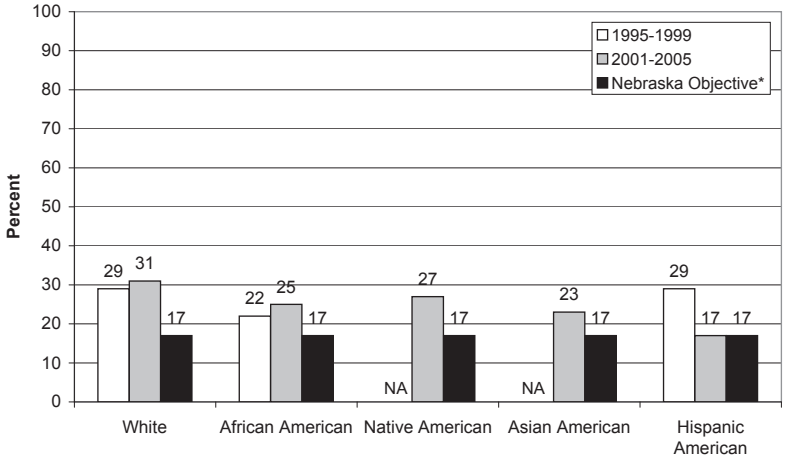
Figure 77
Nebraska Adults Aged 18+ with High Blood Cholesterol Levels*



*Among those who ever had it checked.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Both African American and white adults in Nebraska experienced increases in prevalence of elevated cholesterol (Figure 78). Nearly one-third of white Nebraskans (31 percent) reported having high cholesterol in 2001-2005, compared to 27 percent of Native Americans, 25 percent of African Americans, and 23 percent of Asian Americans. Among Hispanic Nebraskans, only 17 percent said they had ever been told their cholesterol was high, thus achieving the 2010 target rate. A revised target rate of 13 percent has been adopted for Hispanic Americans in the state (Appendix, Table A).

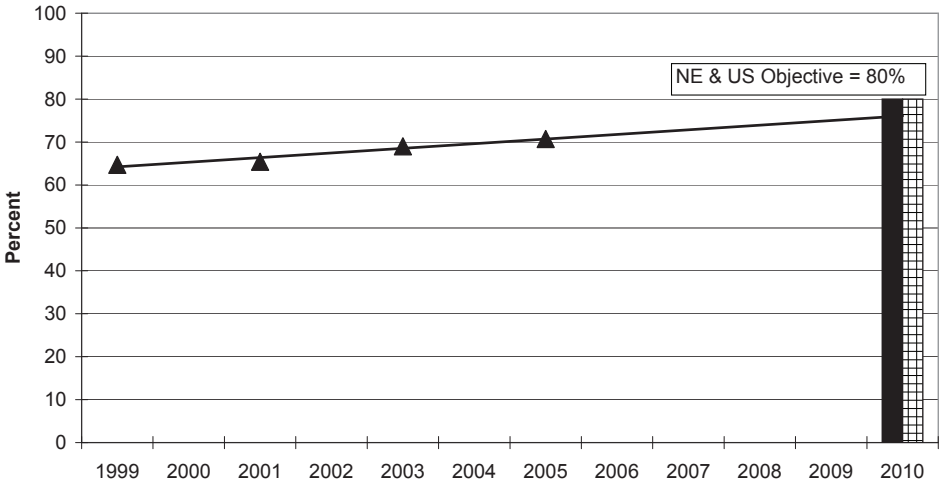
Figure 78
Nebraska Adults with High Blood Cholesterol Levels by Race/Ethnicity



*Nebraska objective has been met for Hispanic Americans and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

A second objective seeks to increase the proportion of adults who have had their blood cholesterol level checked in the past five years to at least 80 percent by the year 2010 (Table 10). Nationwide, the rate has increased from 67 percent in 1998 to 73 percent in 2003. The proportion of Nebraskans who had their cholesterol checked in the last five years increased from 67 percent in 1999 to 71 percent in 2005 (Figure 79).

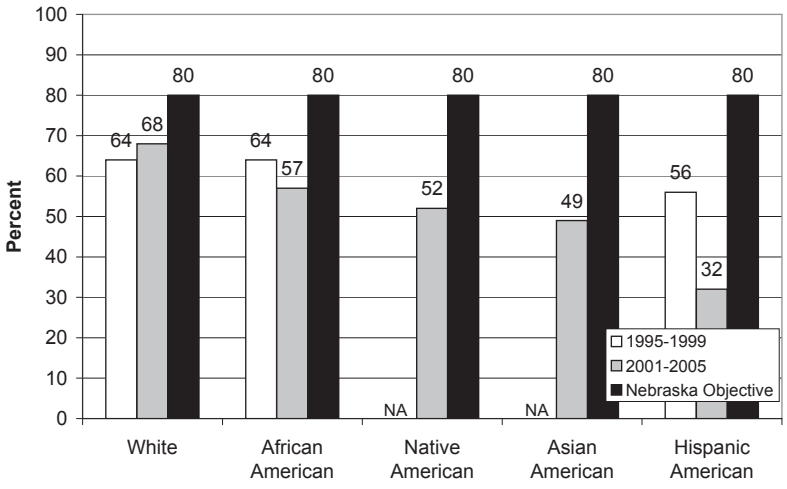
Figure 79
Nebraska Adults Aged 18+ Who Had Blood Cholesterol Level Checked in Last 5 Years



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

White Nebraskans were more likely than other racial or ethnic groups in the state to have cholesterol screening in the last five years (Figure 80). Two-thirds of white residents (68 percent) reported this testing in 2001-2005, up from 64 percent in 1995-1999. Among African Americans, 57 percent had their cholesterol level checked during this time period, down from 64 percent in 1995-1999. About one-half of Native Americans (52 percent) and Asian Americans (49 percent) stated they had a cholesterol check in the past five years. Only one-third of Hispanic Americans in the 2001-2005 survey (32 percent) had this testing done so recently, compared to 56 percent in 1995-1999.

Figure 80
Nebraska Adults Aged 18+ Who Had Cholesterol Level Checked in Last 5 Years by Race/Ethnicity



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

HIV

Healthy People 2010 Goal

The national Healthy People 2010 goal is to prevent HIV infection and its related illness and death.

Background

During the mid-to-late 1990's, advances in treatment slowed the progression of HIV infection to AIDS and led to dramatic decreases in AIDS deaths in the United States. Although the decline in AIDS deaths continues (8 percent decrease from 2000 through 2004), the number of AIDS diagnoses increased 8 percent during that period. Better treatments have also led to an increase in the number of Americans who are living with AIDS.

According to the National Center for Health Statistics, an estimated 40,000 people in the United States are newly infected with HIV each year. Approximately 1,039,000 to 1,185,000 Americans were living with HIV at the end of 2003, with 24 percent to 27 percent of them undiagnosed and unaware that they are infected with HIV.

At the end of 2004, 944,305 cumulative cases of AIDS (acquired immunodeficiency syndrome) and 529,113 deaths caused by HIV/AIDS had been reported to the Centers for Disease Control and Prevention. In Nebraska, there have been 1,394 cumulative cases of AIDS and 722 deaths due to HIV/AIDS reported as of December 31, 2005.

Racial and ethnic minorities in the United States are disproportionately affected by HIV/AIDS. In 2002, nearly 70 percent of all newly-diagnosed cases of HIV and AIDS occurred among these population groups. African Americans were ten times more likely and Hispanic Americans nearly three times more likely to die from AIDS than white Americans in 2001.

The total lifetime cost of this illness for Americans newly-diagnosed with HIV in 2002 is estimated to be $36.4 billion, of which more than 80 percent is related to losses in productivity.

Progress Toward Healthy People 2010 Objectives

National

Progress was made toward five of the seven national HIV objectives shared by Nebraska, although none of the target rates for 2010 were achieved. The overall rate of new AIDS cases decreased, as did the numbers of new AIDS cases among men who had sex with men, persons who inject drugs, and men who had sex with men/injected drugs. The proportion of unmarried women whose sexual partners used condoms increased.

New data were not available for the other two national HIV objectives.

Nebraska

In Nebraska, progress was achieved toward all five of the 2010 objectives for which new data were available. None of the target rates for 2010 were reached however. Current data were unavailable for the proportion of sexually active adults who use condoms.

New AIDS Cases in Nebraska

An objective of reducing the rate of new AIDS cases to no more than 1.0 per 100,000 population has been adopted nationwide and in Nebraska (Table 11). The U.S. objective is specific to persons aged 13 and older, while the Nebraska objective is not limited to persons in this age group.

Table 11
Nebraska 2010 Health Goals and Objectives
HIV

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#13-1	New AIDS cases/100,000 population--age 13+	1998	19.5	2003	17.6	1.0	2000	4.8	2004	4.0	1.0
	White, non-Hispanic	1998	8.5	2003	7.2	1.0	2000	2.7	2004	1.6	1.0
	African American, non-Hispanic	1998	82.9	2003	74.6	1.0	2000	27.8	2004	34.8	1.0
	Native American	1998	9.4	2003	10.3	1.0	2000	NA	2004	NA	1.0
	Asian American	1998	4.3	2003	4.7	1.0	2000	NA	2004	NA	1.0
	Hispanic American	1998	33.0	2003	26.4	1.0	2000	18.0	2004	10.8	1.0
#13-2	New AIDS cases--men age 13+ who had sex with men Data not available by race or ethnicity	1998	17,847	2003	17,774	13,385	2000	32	2004	23	21
#13-3	New AIDS cases--females and males who inject drugs Data not available by race or ethnicity	1998	12,099	2003	9,091	9,075	2000	13	2004	7	6
#13-4	New AIDS cases--men age 13+ who had sex with men and who inject drugs Data not available by race or ethnicity	1998	2,122	2003	1,830	1,592	2000	5	2004	4	1
#13-5	# of new cases of HIV/AIDS diagnosed among adults and adolescents aged 13+	Developmental		Developmental			2000	104 reported new cases	2004	94	50
	White, non-Hispanic								2004	38	
	African American, non-Hispanic								2004	34	
	Native American								2004	<4	
	Asian American								2004	4	
	Hispanic American								2004	15	
#13-6	Percent of sexually active persons who use condoms Data not available by race or ethnicity						1997	20	No New Data Available		50
	a. Unmarried females aged 18-44	1995	23	2002	31	50					
	White	1995	23	2002	30	50					
	African American	1995	22	2002	33	50					
	Hispanic American	1995	17	2002	25	50					
	b. Unmarried males aged 18-44	2002	42	2002	42	54					
	White	2002	39	2002	39	54					
	African American	2002	51	2002	51	54					
	Hispanic American	2002	37	2002	37	54					

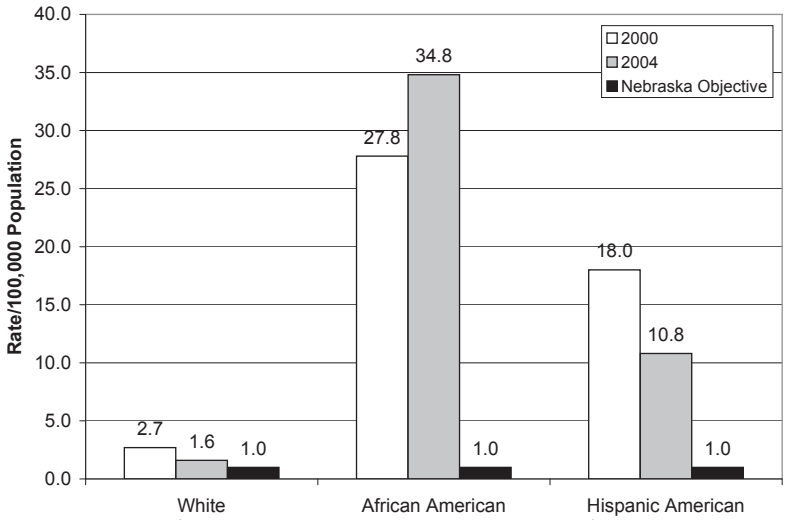
Data Sources:		Additional Notes:
#13-1,13-2, 13-3, 13-4, 13-5	U.S.--HIV/AIDS Surveillance System, CDC. Nebraska--HIV/AIDS Surveillance Program, HHSS.	Not limited to persons aged 13 or older.
#13-6	U.S--National Survey of Family Growth, CDC. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Data currently limited to females aged 18 to 44 years who are unmarried and sexually active. Sexual Behavior Module not used in Nebraska since 1997.

The 2004 Nebraska rate of 4.0 new cases per 100,000 is much lower than the 2003 national rate of 17.6. The current Nebraska rate decreased by 17 percent from 4.8 new cases per 100,000 in 2000, while the U.S. rate was down 10 percent from the 1998 baseline of 19.5.

The 2004 new AIDS case rate for African Americans in Nebraska (34.8) was nearly 22 times as high as the rate for white Nebraskans (1.6) and 3 times as high as the rate for Hispanic persons (10.8) in the state (Figure 81). In addition, the rate for African Americans rose by 25 percent from the 2000 rate of 27.8.

The 2004 new case rate for Hispanic Nebraskans (10.8) was nearly seven times as high as the rate for white Nebraskans (1.6), but the rate for Hispanics dropped by 40 percent since 2000. The rate for whites was down 41 percent from the baseline.

Figure 81
New AIDS Cases in Nebraska by Race/Ethnicity*



*Rates not reported for Native Americans and Asian Americans due to small numbers of new cases.
SOURCE: Nebraska HHSS, HIV/AIDS Surveillance Program.

New AIDS Cases in Nebraska by Mode of Exposure

Numbers of new AIDS cases were down for each of three exposure categories shown in Table 11, both nationwide and in Nebraska. However, the target numbers set for 2010 were not achieved for any of the objectives, state or national.

In Nebraska, the number of new AIDS cases reported for men who had sex with men was 23 in 2004, down 28 percent from 2000 and nearly meeting the target of no more than 21 new cases.

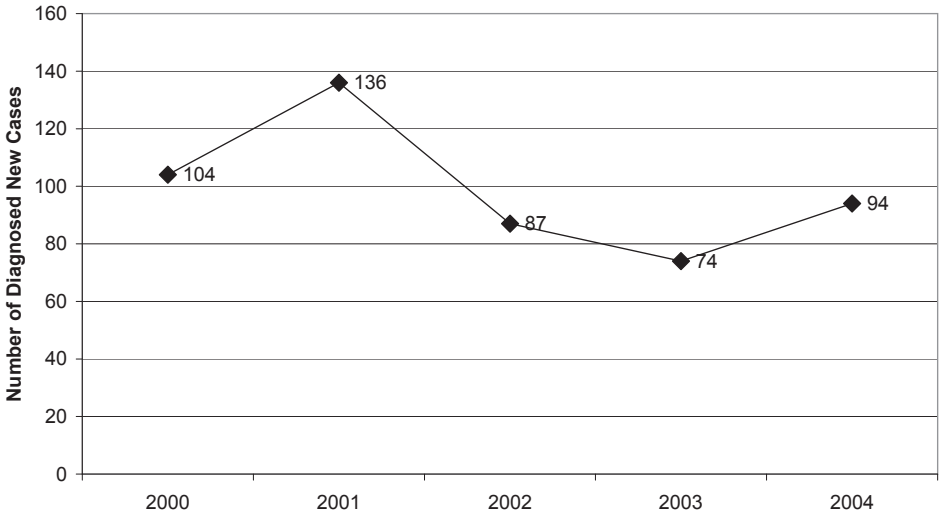
The number of new AIDS cases reported for persons who injected drugs also declined in Nebraska (from 13 in 2000 to 7 in 2004) and came very close to the target rate of no more than 6 new cases.

The baseline number of new cases for men who had sex with men and injected drugs was quite small (5 cases), but also showed a decrease in 2004.

New Cases of HIV/AIDS in Nebraska

Data for this objective are not yet available for the U.S., due to incomplete reporting of new cases of HIV. However, number of new cases of HIV/AIDS diagnosed among Nebraskans is available. In 2000, 104 new cases were reported. In 2004, the number of reported cases decreased to 94 for the year (Figure 82).

Figure 82
Number of Diagnosed HIV/AIDS Cases in Nebraska



SOURCE: Nebraska HHSS, HIV/AIDS Surveillance Program.

Condom Use by Sexually Active Adults

Nebraska adopted an objective to increase to 50 percent the proportion of sexually active unmarried adults who use condoms. In 1997, 20 percent of these adults surveyed in the BRFSS reported using condoms. However, no new data are available to assess progress toward this 2010 objective.

Nationwide, a similar objective was adopted with a target rate of at least 50 percent for unmarried women and at least 54 percent for unmarried men. The proportion of women who reported that their sexual partner used condoms increased from 23 percent in 1995 to 31 percent in 2002. Among males, in 2002, 42 percent stated they used condoms.

IMMUNIZATION AND INFECTIOUS DISEASES

Healthy People 2010 Goal

The Healthy People 2010 goal is to prevent disease, death, and disability from infectious diseases.

Background

Great progress has been made in the United States in reducing the incidence of infectious disease and its effects. The widespread use of vaccines has proven very effective in decreasing the incidence of many of these diseases. In general, 90 percent of the individuals vaccinated will not contract the disease for which they have received vaccine. A variety of antibiotic drugs are also available to combat the effects of many infectious diseases and have been instrumental in reducing death and illness due to these organisms.

However, infectious diseases remain an important cause of illness and death in the United States and the world. New infectious agents continue to be identified for which new treatments must be devised. The emergence of strains of organisms that are resistant to antimicrobials that were previously effective in treating the illnesses caused by them has become a problem. In addition, the possibility of bioterrorist attacks has arisen as a potential threat to the health of Americans and people worldwide. The need to address these issues may have an impact on achievement of the immunization and infectious disease objectives set for 2010.

Progress Toward Healthy People 2010 Objectives

National

Substantial progress was noted in this focus area. An indication of the success of immunization efforts is the reductions in incidence of several vaccine-preventable diseases—including measles, mumps, polio, rubella, and tetanus. No indigenous cases of diphtheria or polio were reported nationwide in 2003.

The rate of new hepatitis A cases met the 2010 objective, due in large part to increasing use of the hepatitis A vaccine licensed in 1995. New case rates for hepatitis B, hepatitis C, and tuberculosis have also declined from the baseline.

The proportion of children aged 19 through 35 months who received the appropriate number of doses of four of the universally-recommended vaccines (*Haemophilus influenzae* type b [Hib], hepatitis B, measles-mumps-rubella [MMR], and polio) met the U.S. objectives of at least 90 percent for each. The proportion of children receiving varicella (chicken pox) vaccine nearly doubled to 85 percent by 2003. The proportion of children receiving four doses of pneumococcal conjugate vaccine also increased from the baseline.

In addition, the proportion of adults aged 65 and older who were ever vaccinated against pneumonia rose to 57 percent in 2004.

Nebraska

Nebraska has also made notable progress toward its 2010 immunization and infectious disease objectives (Table 12). Fourteen of the 28 individual objectives established for the state have already been met, based on most current data available. No cases of eight of the ten vaccine-preventable diseases listed in Objective #14-1 were reported in 2005, thus meeting their 2010 objectives.

Table 12
Nebraska 2010 Health Goals and Objectives
Immunization and Infectious Diseases

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#14-1	Cases of indigenous cases of vaccine-preventable disease										
	a. congenital rubella syndrome	1998	7	2003	1	0	1999	0	2005	0	0
	b. diphtheria	1998	1	2003	0	0	1999	0	2005	0	0
	c. Hib disease	1998	163	2003	259	0	1999	0	2005	0	0
	d. hepatitis B	1997	708	2003	141	7	1999	22	2005	48	2
	e. measles	1998	74	2003	32	0	1999	0	2005	0	0
	f. mumps	1998	666	2003	222	0	1999	0	2005	0	0
	g. pertussis	1998	3,417	2003	3,719	2,000	1999	14	2005	286	8
	h. polio	1998	0	2003	0	0	1999	0	2005	0	0
	I. rubella	1998	364	2003	7	0	1999	103	2005	0	0
	j. tetanus	1998	14	2003	6	0	1999	0	2005	0	0
#14-2	Cases of chronic hepatitis B virus infections in infants and young children under age two (perinatal infections)	1995	1,682	2002	876	400	1999	1	2005	3	0
#14-3	Rate of new hepatitis B cases per 100,000 population (adults age 18 +)						1999	1.7	2005	1.7	0.3
	a. Age 19 to 24 years	1997	18.5	2003	8.8	1.8	2000	3.4	2005	*	0.3
	b. Age 25 to 39 years	1997	20.5	2003	14.3	5.2	2000	6.2	2005	1.7	0.3
	c. Age 40 years and older	1997	14.7	2003	7.3	3.7	2000	1.9	2005	1.9	0.3
#14-6	Rate of new hepatitis A cases per 100,000 population	1997	11.2	2003	2.6	4.3	1999	3.2	2005	1.1	1.5
#14-9	Rate of new hepatitis C cases per 100,000 population	1996	2.5	2003	1.6	1.0	1999	0.1	2005	*	0.0
#14-11	Rate of new cases of tuberculosis per 100,000 population	1998	6.8	2005	4.8	1.0	1999	1.1	2005	2.0	0.5
#14-12	Percent of all tuberculosis patients who complete curative therapy within 12 months	1996	74%	2000	80%	90%	1999	83%	2005	71%	96%
#14-22	Percent of children aged 19 through 35 months who received universally recommended vaccines										
	a. 4 doses diphtheria-tetanus-pertussis (DTP) vaccine	1998	84	2003	85	90.0	1999	86.8	2004	84.4	90.0
	b. 3 doses Hib vaccine	1998	93	2003	94	90.0	1999	93.4	2004	95.3	90.0
	c. 3 doses hepatitis B vaccine	1998	87	2003	92	90.0	1999	92.9	2004	93.7	90.0
	d. 1 dose measles-mumps-rubella (MMR) vaccine	1998	92	2003	93	90.0	1999	91.8	2004	92.7	90.0
	e. 3 doses polio vaccine	1998	91	2003	92	90.0	1999	91.7	2004	93.4	90.0
	f. 1 dose varicella (chicken pox) vaccine	1998	43	2003	85	90.0	1999	58.4	2004	82.2	90.0
	g. 4 doses pneumococcal conjugate vaccine	2002	20	2003	30	90.0	1999	NA	2004	75.5	90.0
#14-24	Percent of children aged 19 through 35 months who have received the recommended vaccines (4 DTP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B)	1998	73	2002	75	80	1999	79.8	2004	82.3	80
	White	1998	74	2002	77	80	1999	80.1	2004	82.5	80
	African American	1998	66	2002	69	80	1999	NA	2004	NA	80
	Native American	1998	65	2002	62	80	1999	NA	2004	NA	80
	Asian American	1998	73	2002	79**	80	1999	NA	2004	NA	80
	Hispanic American	1998	69	2002	73	80	1999	NA	2004	NA	80
#14-29a	Percent of adults aged 65+ who were vaccinated against influenza in the past 12 months	1998	64	2004	65	90	1999	69	2005	73	90
	White	1998	65	2004	66	90			2001-2005	73	90
	African American	1998	46	2004	46	90			2001-2005	56	90
	Native American	1998	NA	2004	76	90			2001-2005	56	90
	Asian American	1998	67**	2004	58**	90			2001-2005	NA	90
	Hispanic American	1998	51	2004	55	90			2001-2005	61	90

Table 12 continued

Objective		UNITED STATES Baseline Year	Rate	Current Year	Rate	U.S. 2010 Objective	NEBRASKA Baseline Year	Rate	Current Year	Rate	NE 2010 Objective
#14-29b	Percent of adults aged 65+ who were ever vaccinated against pneumococcal disease (pneumonia)	1998	46	2004	57	90	1999	55	2005	68	90
	White	1998	48	2004	59	90			2001-2005	65	90
	African American	1998	26	2004	39	90			2001-2005	54	90
	Native American	1998	NA	2004	44	90			2001-2005	65	90
	Asian American	1998	36**	2004	35**	90			2001-2005	NA	90
	Hispanic American	1998	23	2004	34	90			2001-2005	48	90

*Rate not reported due to <5 cases during this period. **Asian only. NA = Not Available

Data Sources:		Additional Notes:
#14-1	U.S.--National Notifiable Disease Surveillance System, CDC; National Congenital Rubella Syndrome Registry, CDC; Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs, CDC.	
	a. Congenital rubella syndrome	Children under age one year.
	b. Diphtheria	Persons under age 35 years.
	c. Hib disease	Children under age five years.
	d. Hepatitis B	Persons aged 2 to 18 years.
	e. Measles	All ages.
	f. Mumps	All ages.
	g. Pertussis	Children under age seven years.
	h. Polio	All ages.
	i. Rubella	All ages.
	j. Tetanus	Persons under age 35 years.
	k. Varicella (chicken pox)	Aged 17 years and under.
	Nebraska--Communicable Disease Division, HHSS.	All ages.
#14-2	U.S.--Perinatal Hepatitis B Prevention Program, CDC; National Vital Statistics System, CDC. Nebraska--Communicable Disease Division, HHSS.	Estimated.
#14-3	U.S.--National Notifiable Disease Surveillance System, CDC; Sentinel Counties Study of Viral Hepatitis, CDC. Nebraska--Communicable Disease Division, HHSS.	Estimated.
#14-6	U.S.--National Notifiable Disease Surveillance System, CDC. Nebraska--Communicable Disease Division, HHSS.	Number of new symptomatic cases in past 12 months.
#14-9	U.S.--Sentinel Counties Study of Viral Hepatitis, CDC. Nebraska--Communicable Disease Division, HHSS.	Estimated.
#14-11	U.S.--National TB Surveillance System, CDC. Nebraska--Communicable Disease Division, HHSS.	Number of confirmed new cases reported to CDC by local health departments.
#14-12	U.S.--National TB Surveillance System, CDC. Nebraska--Communicable Disease Division, HHSS.	Percent of persons with confirmed new cases of tuberculosis who were alive at diagnosis, with an initial drug regimen of one or more drugs prescribed, who did not die during therapy, and who completed curative therapy within 12 months of diagnosis. Same as U.S.
#14-22	U.S.--National Immunization Survey, CDC. Nebraska--National Immunization Survey, CDC.	Data from nationwide telephone sample survey of households with age-eligible children and from records of vaccination providers are combined to provide estimate of vaccination coverage levels. Individual state data.
#14-24	U.S.--National Immunization Survey, CDC. Nebraska--National Immunization Survey, CDC.	Data from nationwide telephone sample survey of households with age-eligible children and from records of vaccination providers are combined to provide estimate of vaccination coverage levels. Individual state data.
#14-29	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	

As it did nationwide, the rate of new hepatitis A cases in Nebraska declined and met the 2010 target rate. The proportion of children aged 19 through 35 months who received the appropriate number of doses of four of the universally-recommended vaccines (Hib, hepatitis B, MMR, and polio) met the U.S. objectives of at least 90 percent for each. The proportion of children in this age group who received the recommended series of vaccines (4 DTP, 3 polio, 1 MMR, 3 Hib, and 3 hepatitis B) rose to 82.3 percent, exceeding the 2010 target rate of 80 percent.

Progress was also made in Nebraska toward 2010 objectives for the rate of new hepatitis B cases among 25- to 39-year-olds and for vaccination rates for chickenpox and pneumococcal conjugate vaccine among children aged 19 to 35 months. The proportion of adults aged 65 and older receiving a flu shot in the past 12 months and the proportion who were ever vaccinated against pneumonia also increased from the 1999 baseline rate.

On the other hand, the number of indigenous cases of two vaccine-preventable diseases (hepatitis B and pertussis) were up compared to the baseline. The number of cases of perinatal hepatitis B infections in Nebraska also rose, although the number remained small. Incidence of tuberculosis increased, while the proportion of tuberculosis patients completing curative therapy within twelve months decreased. In addition, the proportion of children aged 19 to 35 months who had received the recommended four-dose series of diphtheria-tetanus-pertussis vaccinations was down slightly in 2004.

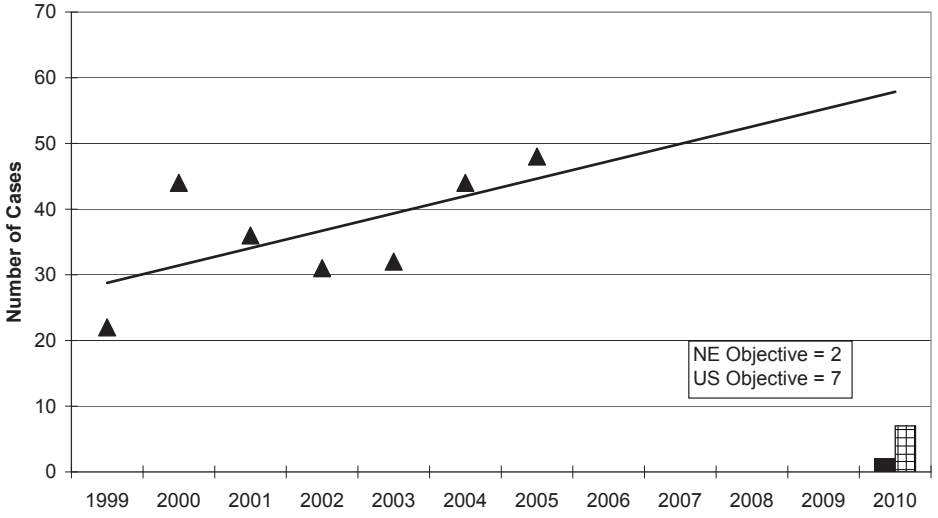
Data to assess progress were unavailable for two objectives.

Incidence of Vaccine-Preventable Disease

The incidence of many vaccine-preventable diseases continues to be low in Nebraska. As of 2005, there have been no reported cases of congenital rubella syndrome, diphtheria, measles, or polio for more than ten years. Only one case each of Hib disease, rubella, or tetanus has occurred in the state since the 1999 baseline. Five cases of mumps were reported in 2000-2002, but there have been none since. The objective for each of these diseases is zero new cases per year in Nebraska, as it is nationwide.

The number of indigenous cases of hepatitis B has ranged from 22 cases in 1999 to 48 in 2005 (Figure 83), with a generally upward trend. The objective for 2010 is to reduce this number to no more than two cases.

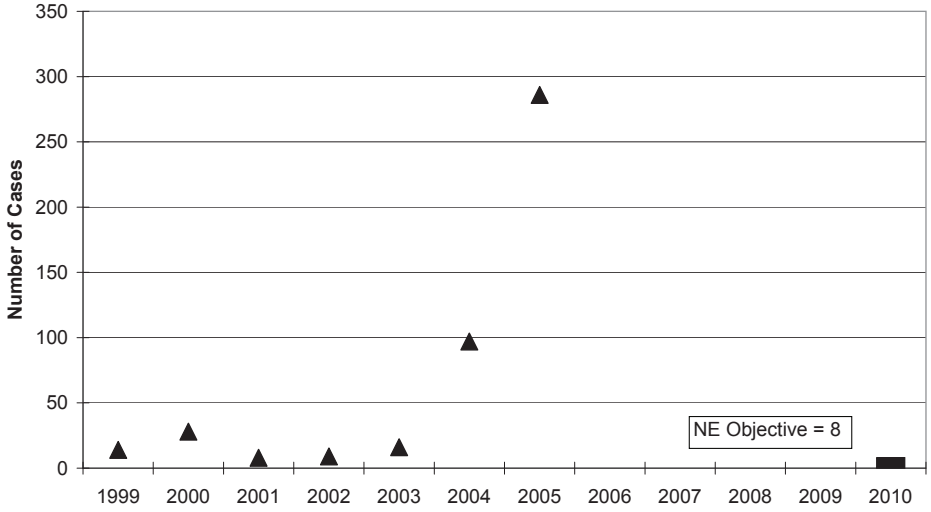
Figure 83
Indigenous Cases of Hepatitis B Reported in Nebraska



SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance. U.S. DHHS, Healthy People 2010.

The number of pertussis (whooping cough) cases was fairly low from 1999 through 2003, ranging between 8 and 28 cases (Figure 84). However, the number of cases increased sharply in 2004 to 97 cases and continued to climb to 286 cases in 2005. Nebraska's objective is to reduce the number of new cases to no more than 8 per year by 2010.

Figure 84
Indigenous Cases of Pertussis Reported in Nebraska



SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance.

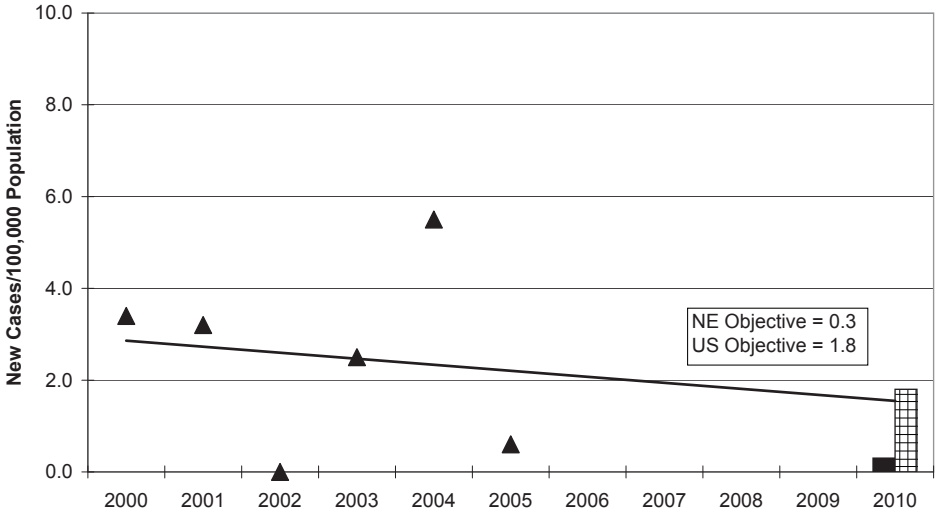
Incidence of Hepatitis B

Nationwide, an objective has been set to reduce the number of perinatal hepatitis B infections by more than 75 percent (to no more than 400 cases) by 2010. As of 2002, a reduction of 48 percent had been achieved. In Nebraska, the objective is to reduce the number of perinatal cases of hepatitis B to zero (Table 12). Since 1999, the number of new cases has remained fairly steady at one to three cases per year.

Objectives have also been adopted that seek to reduce the incidence of new cases of hepatitis B among persons 18 and older nationwide and in Nebraska. U.S. target rates are much higher than those for Nebraska, due to higher baseline rates. As of 2003, national rates had decreased by about 50 percent for persons aged 19 to 24 and for those aged 40 and older. For Americans aged 25 to 39, incidence of hepatitis B was down 30 percent from the 1997 baseline.

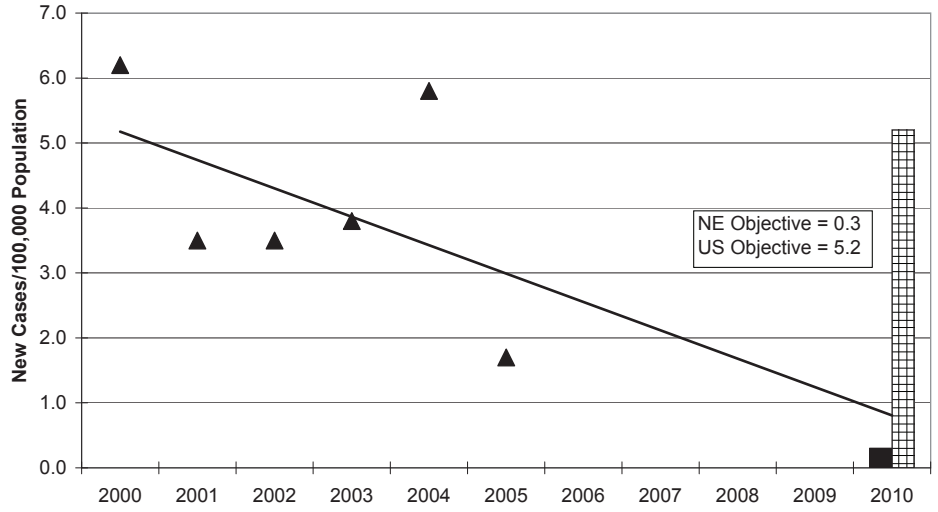
The Nebraska objective is to lower hepatitis B incidence among adults to no more than 0.3 cases per 100,000 population. For adults aged 19 to 24, rates have varied somewhat (Figure 85), but the trend is generally decreasing. Among 25- to 39-year-olds (Figure 86), the rate has declined more sharply to 1.7 cases per 100,000 in 2005. For Nebraskans aged 40 and older, there has been little change in rates (Figure 87). None of these age groups achieved the target rate for 2010.

Figure 85
New Hepatitis B Cases (Nebraskans Aged 19-24 Years)



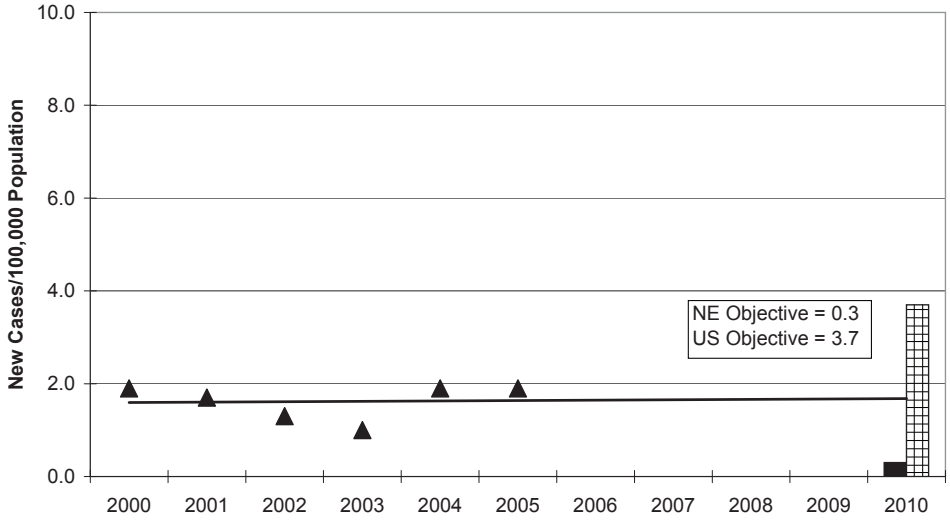
SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance. U.S. DHHS, Healthy People 2010.

Figure 86
New Hepatitis B Cases (Nebraskans Aged 25-39 Years)



SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance. U.S. DHHS, Healthy People 2010.

Figure 87
New Hepatitis B Cases (Nebraskans Aged 40+)

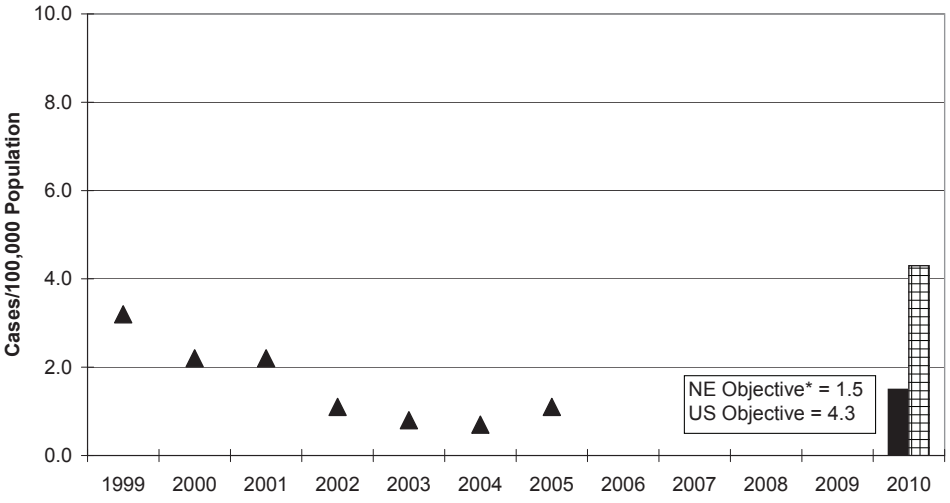


SOURCE: Nebraska HHSS, Environmental, Disease and Vector Surveillance. U.S. DHHS, Healthy People 2010.

Incidence of Hepatitis A and Hepatitis C

As with hepatitis B incidence objectives, the Nebraska target rate for hepatitis A incidence (1.5 new cases per 100,000 population) is substantially lower than the national target (4.3 per 100,000). However, in both instances, the 2010 objective for reducing these rates has been reached (Table 12). In the U.S., the 2003 rate dropped by 77 percent to 2.6. In Nebraska, the 2005 rate was 1.1 (down 66 percent from the 1999 rate) (Figure 88). A revised Nebraska target rate has been set, seeking to reduce incidence of hepatitis A to no more than 0.6 new cases per 100,000 population (Appendix, Table A).

Figure 88
New Hepatitis A Cases in Nebraska



*Nebraska objective has been met and will be revised.
SOURCE: Nebraska HHSS, Environmental, Disease, and Vector Surveillance. U.S. DHHS, Healthy People 2010.

The Nebraska objective for hepatitis C is to reduce the rate of new cases per 100,000 population to zero (Table 12), while the national objective is to lower this rate to no more than 1.0 by 2010. The 2003 U.S. rate (1.6) dropped by 36 percent from the 1996 baseline, but has not achieved the target rate. In Nebraska, the number of new cases has been down for the last three years, but rates cannot be reported because the number of cases is so small.

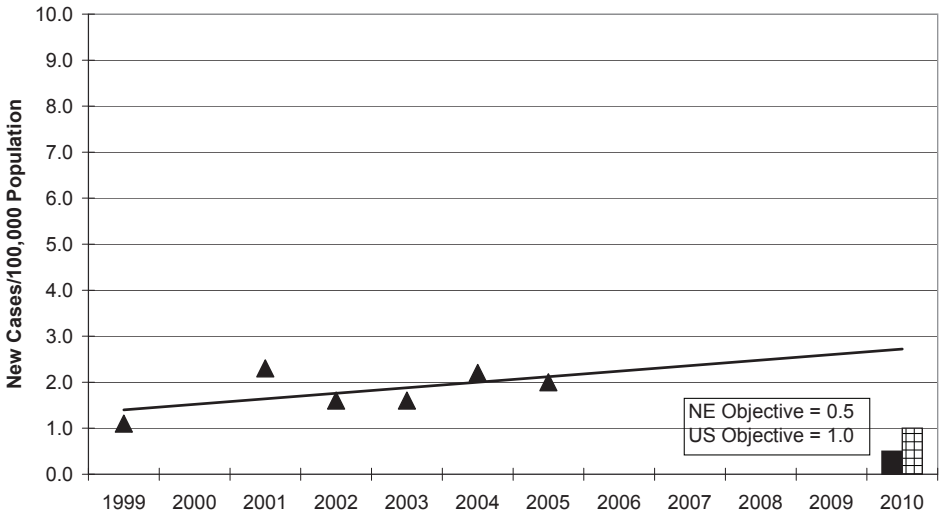
Tuberculosis (TB)

Tuberculosis (TB) is a chronic bacterial infection, usually infecting the lungs and spread through the air. More than 14,000 active cases of TB were reported in the United States in 2005. In addition to those with active TB, an estimated 10 to 15 million people have latent TB.

With appropriate antibiotic treatment, TB can be cured in most people. Treatment usually combines several different antibiotics that are given for at least six months. People who do not take all the required medication can become ill again and spread TB to others. In addition, when patients do not follow their treatment regimen, drug-resistant TB can develop. The occurrence of drug-resistant TB, including extensively drug-resistant cases, has been increasing.

A national 2010 objective has been established to reduce incidence of new cases of tuberculosis to no more than 1.0 per 100,000 population. In Nebraska, the target rate has been set at no more than 0.5 cases per 100,000 (Table 12). In 2005, the national TB case rate was 4.8 cases per 100,000—the lowest since reporting began in 1953. However, incidence appears to be leveling off. On the other hand, Nebraska reported an increase in incidence of TB from 1.1 new cases per 100,000 in 1999 to 2.0 in 2005 (Figure 89).

Figure 89
New Tuberculosis Cases Reported in Nebraska

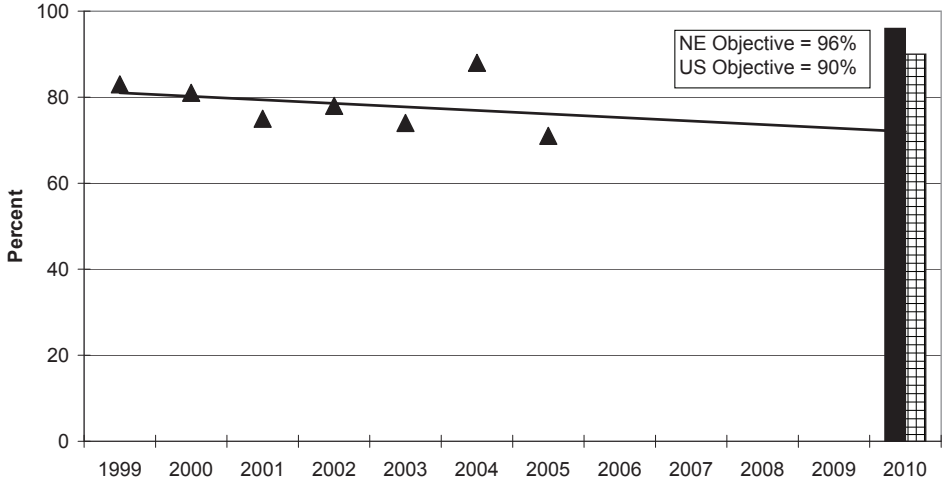


SOURCE: Nebraska HHSS, Communicable Disease.

Since it is important that persons with TB complete their therapy regimen, a national 2010 objective has been set to increase the proportion that complete curative therapy within 12 months to at least 90 percent. Progress was made nationwide with 80 percent of TB patients in 2000 completing therapy within 12 months, compared to 74 percent in 1996.

In Nebraska, the target rate is 96 percent. Nebraska data differ from national data in that it does not include treatment lasting for up to 12 months. The trend has been generally downward from the baseline reading of 83 percent in 1999. In 2005, only 71 percent of persons being treated for TB were known to have completed their course of treatment (Figure 90). Part of this decline is due to the mobility of many of Nebraska's foreign-born patients who move before completion of therapy and cannot be accounted for.

Figure 90
Nebraska Tuberculosis Patients Completing Curative Therapy within 12 Months



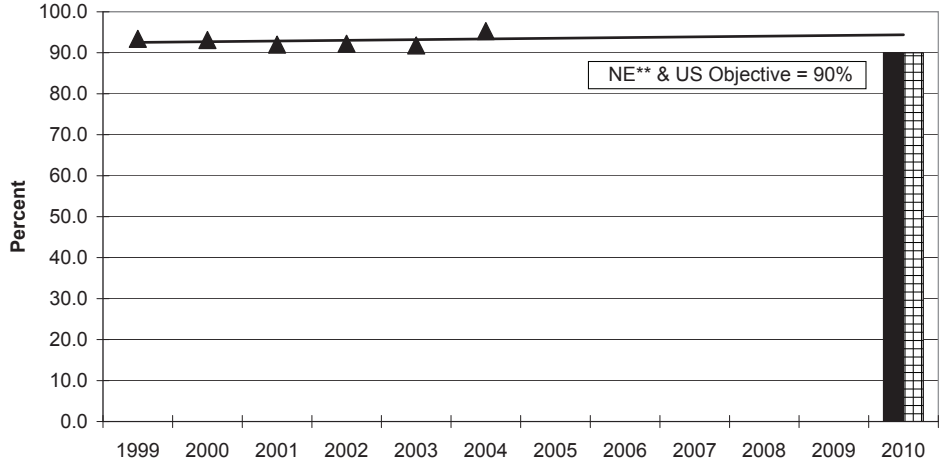
SOURCE: Nebraska HHSS, Tuberculosis Program. U.S. DHHS, Healthy People 2010.

Childhood Immunization Levels

Vaccination coverage levels of 90 percent are generally sufficient to prevent circulation of viruses and bacteria that cause vaccine-preventable diseases. Therefore, Nebraska and the nation have both created objectives seeking to increase to at least 90 percent the proportion of children aged 19 through 35 months who have received the appropriate number of doses of seven recommended vaccines (Table 12).

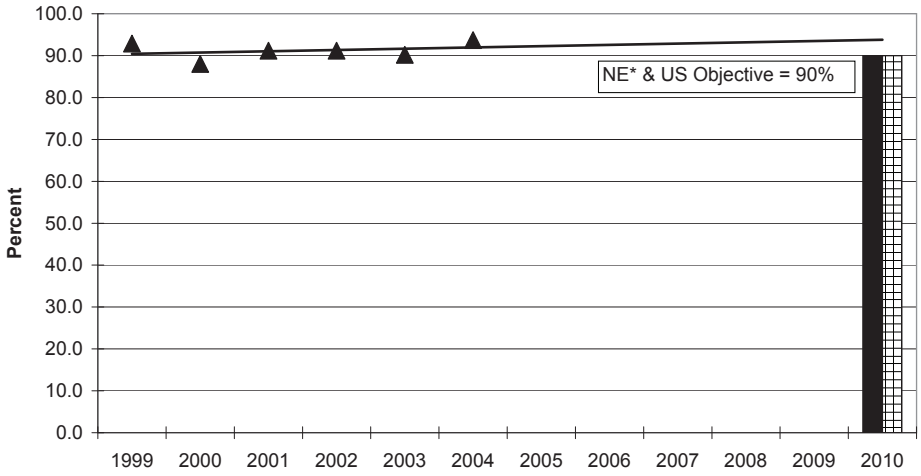
Vaccination rates of at least 90 percent have been achieved, meeting the 2010 objectives, for four of the seven recommended vaccines nationwide and in Nebraska: Hib, hepatitis B, measles-mumps-rubella (MMR), and polio (Figures 91 through 94). Rates for each of these vaccines in Nebraska have been stable since 1999.

Figure 91
Vaccination Rates among Nebraska Children 19-35 Months of Age (3+ Doses of Hib* Vaccine)



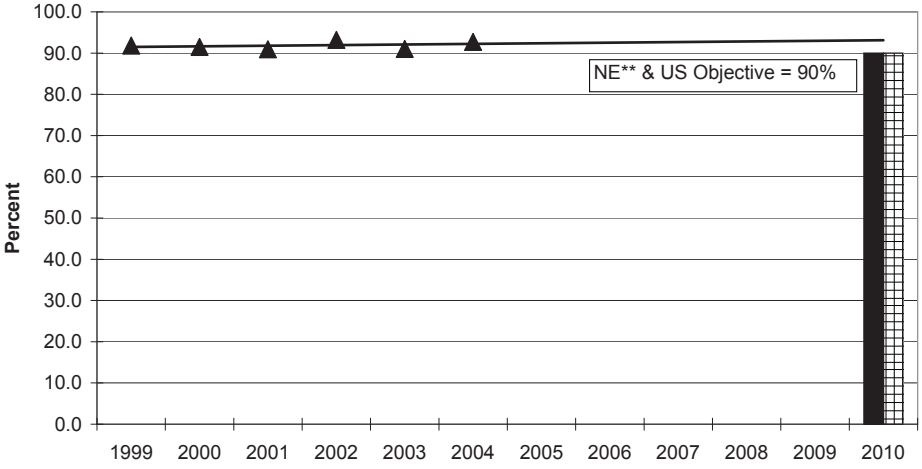
**Haemophilus influenzae type b*
***Nebraska objective has been met but will remain at 90 percent.
SOURCE: Nebraska data-National Immunization Survey, U.S. DHHS Healthy People 2010

Figure 92
Vaccination Rates among Nebraska Children 19-35 Months of Age (3+ Doses of Hepatitis B Vaccine)



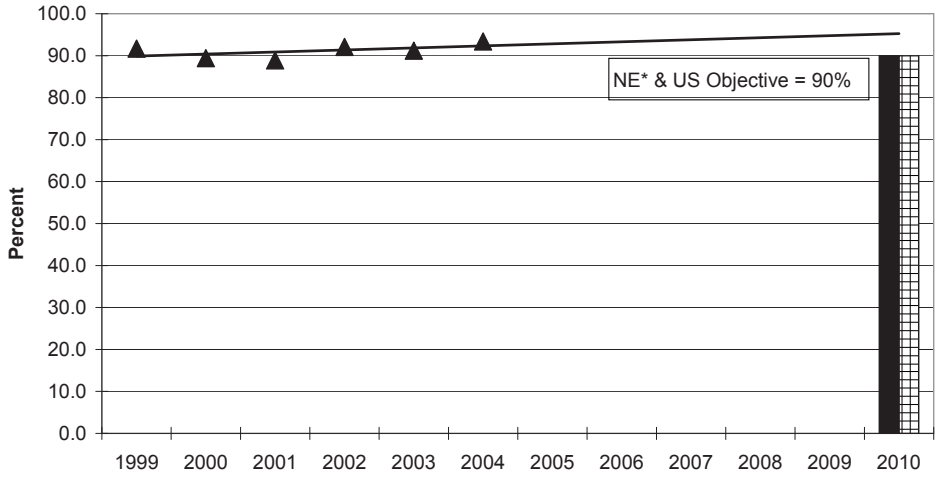
*Nebraska objective has been met but will remain at 90 percent.
SOURCE: Nebraska data-National Immunization Survey. U.S. DHHS, Healthy People 2010.

Figure 93
Vaccination Rates among Nebraska Children 19-35 Months of Age (1+ Doses of Measles/Mumps/Rubella Vaccine)



*Measles-Mumps-Rubella Vaccine
**Nebraska objective has been met, but will remain at 90 percent.
SOURCE: Nebraska data-National Immunization Survey. U.S. DHHS, Healthy People 2010.

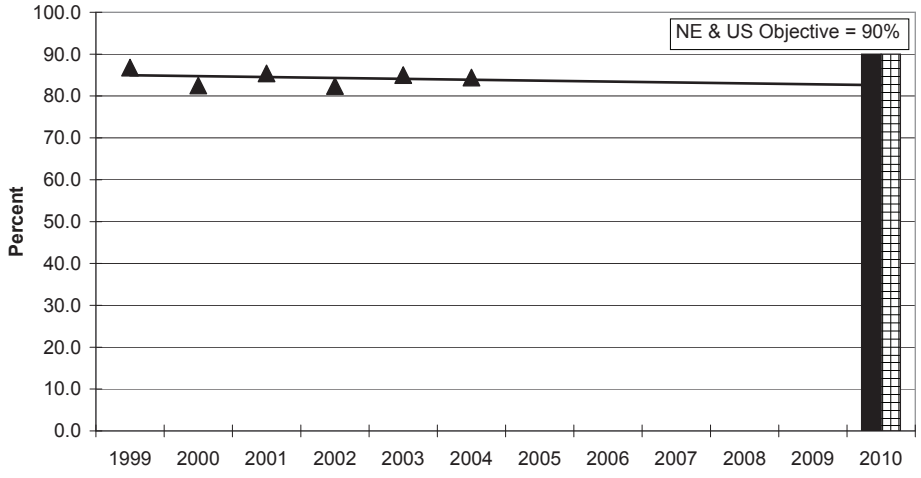
Figure 94
Vaccination Rates among Nebraska Children 19-35 Months of Age (3+ Doses of Polio Vaccine)



*Nebraska objective has been met but will remain at 90 percent.
SOURCE: Nebraska data-National Immunization Survey. U.S. DHHS, Healthy People 2010.

For diphtheria-tetanus-pertussis (DTP) vaccine, the national rate has remained steady, with 85 percent coverage in 2003. In Nebraska, the vaccination rate has dropped somewhat from 86.8 percent in 1999 to 84.4 percent in 2004 (Figure 95).

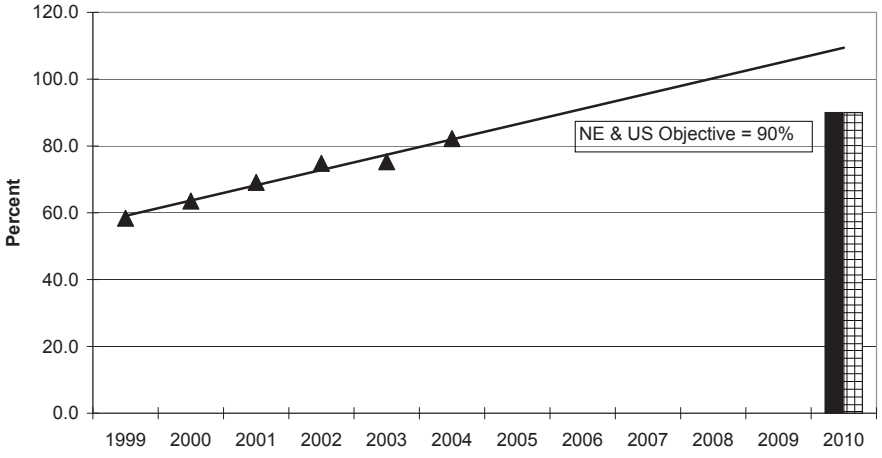
Figure 95
Vaccination Rates among Nebraska Children 19-35 Months of Age (4+ Doses of DTP* Vaccine)



*Diphtheria, Tetanus, Pertussis
SOURCE: Nebraska data-National Immunization Survey, CDC. U.S. DHHS, Healthy People 2010.

The vaccination rate for varicella (chicken pox) has risen sharply in the United States and in Nebraska, surpassing 80 percent in each case. In Nebraska, coverage among children aged 19 to 35 months increased from 58.4 percent in 1999 to 82.2 percent in 2004 (Figure 96).

Figure 96
Vaccination Rates among Nebraska Children 19-35 Months of Age - 1+ Doses of Varicella (Chickenpox) Vaccine*

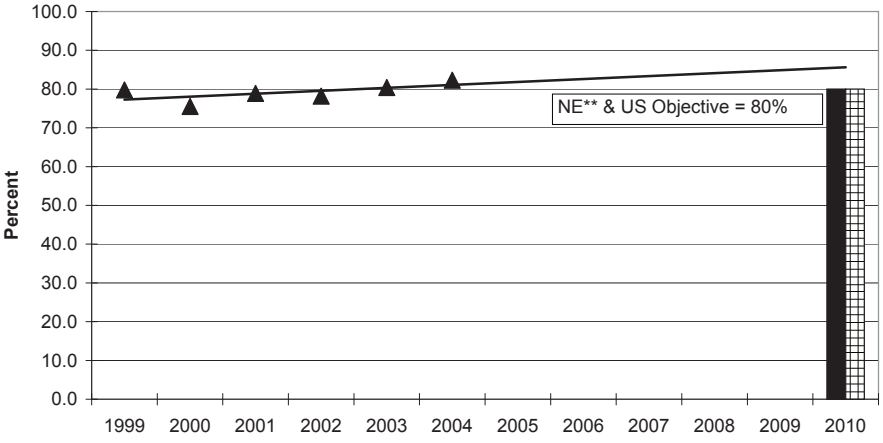


*At or after first birthday.
SOURCE: Nebraska data-National Immunization Survey. U.S. DHHS, Healthy People 2010.

Rates for pneumococcal conjugate vaccine (a newer vaccine) reached 30 percent nationwide in 2003. In Nebraska, the 2004 coverage rate for this vaccine was 75.5 percent.

Another 2010 objective for the state and the nation seeks to increase coverage to at least 80 percent for the 4:3:1:3:3 vaccine series among children aged 19 to 35 months. This series includes: 4 or more doses of DTP vaccine, 3 or more doses of poliovirus vaccine, 1 or more doses of MMR (or measles-containing) vaccine, 3 or more doses of Hib vaccine, and 3 or more doses of hepatitis B vaccine. Although the U.S. rate has risen two percentage points to 75 percent in 2002, this current rate does not meet the 2010 target (Table 12). In Nebraska, however, the 2004 rate of 82.3 percent does achieve the 2010 objective of at least 80 percent (Figure 97).

Figure 97
Vaccination Rates among Nebraska Children 19-35 Months of Age (4:3:1:3:3 Series of Vaccines*)



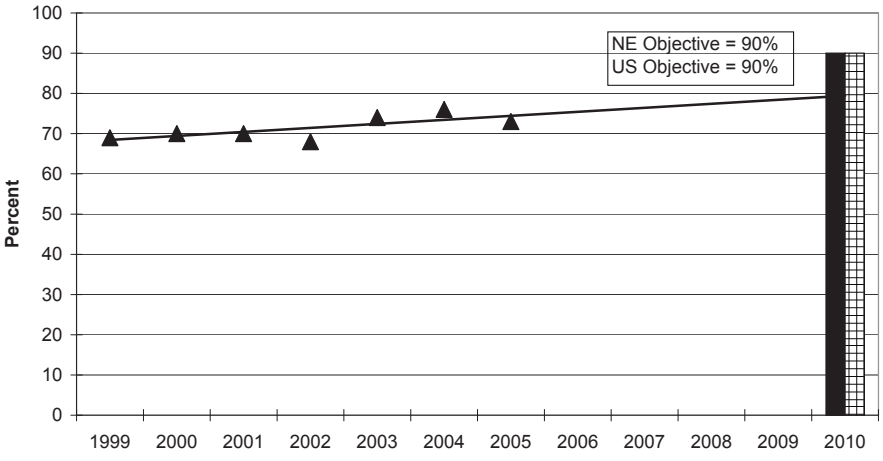
*4+ doses of DTP, 3+ poliovirus, 1+ MMR (or measles-containing vaccine), 3+ Hib, and 3+ Hepatitis B vaccine
**Nebraska objective has been met but will remain at 80 percent.
SOURCE: Nebraska data-National Immunization Survey. U.S. DHHS, Healthy People 2010.

Adult Immunizations for Influenza and Pneumonia

Immunizations against influenza and pneumococcal disease can prevent serious illness and death. Pneumonia and influenza deaths combined constitute the sixth leading cause of death in the United States. In Nebraska, there were 5 deaths due to influenza and 342 deaths due to pneumonia in 2004.

An objective has been adopted, both in Nebraska and nationwide, to increase the proportion of adults aged 65 and older who were vaccinated against influenza in the past 12 months to at least 90 percent. Slight progress was made in the U.S. overall, with the vaccination rate reaching 65 percent in 2004 (Table 12). In Nebraska, 2005 BRFSS data show that 73 percent of adults in this age group had a flu shot in the past 12 months, up from 69 percent in 1999 (Figure 98).

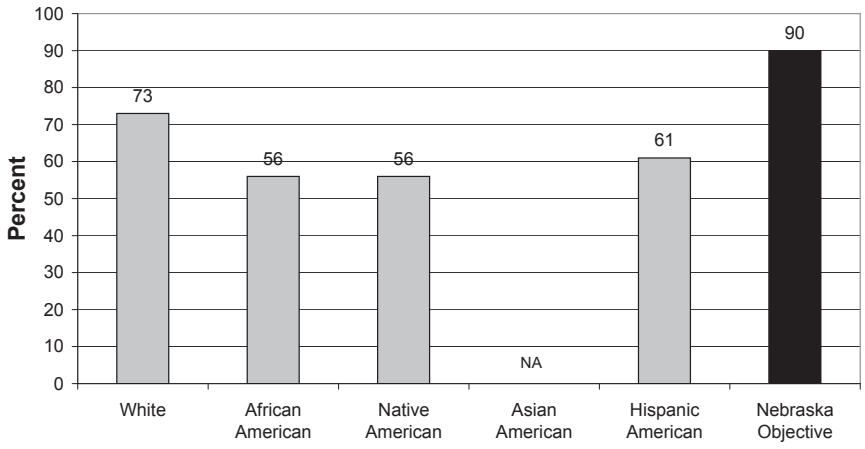
Figure 98
Nebraska Adults Aged 65+ Who Had Flu Shot in Past 12 Months



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

The proportion of adults aged 65 and older who reported having a flu shot in the past 12 months was highest among white Nebraskans (73 percent) in 2001-2005 (Figure 99). Six out of ten Hispanic Nebraskans (61 percent) had a flu shot during the year, as did 56 percent each of African Americans and Native Americans. Data were unavailable for Asian Americans in the state.

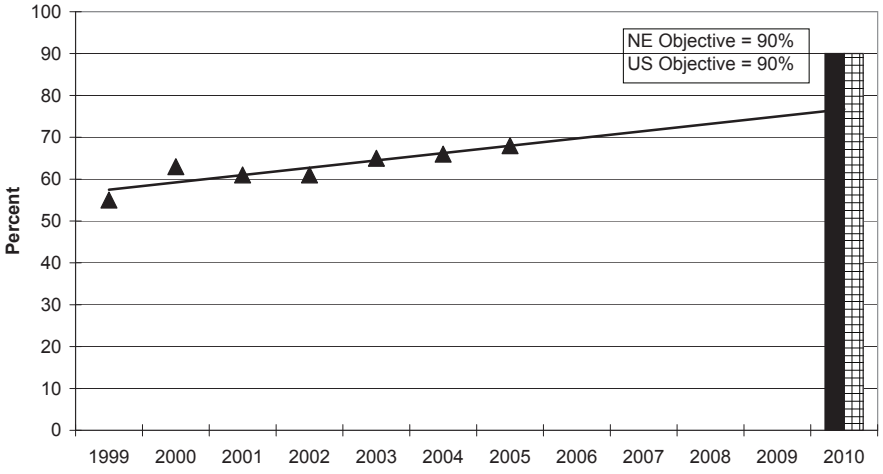
Figure 99
Nebraskans Aged 65+ Who Had a Flu Shot in the Past 12 Months by Race/Ethnicity (2001-2005)



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

A similar objective has been set for increasing to 90 percent the proportion of adults aged 65 and older who ever had a pneumococcal disease (pneumonia) vaccination (Table 12). Pneumonia vaccination rates were up nationwide, moving from 46 percent in 1998 to 57 percent in 2004. In Nebraska, rates also improved. More than two-thirds of Nebraskans in this age group in 2005 reported ever having this "shot" (68 percent), compared to 55 percent in 1999 (Figure 100).

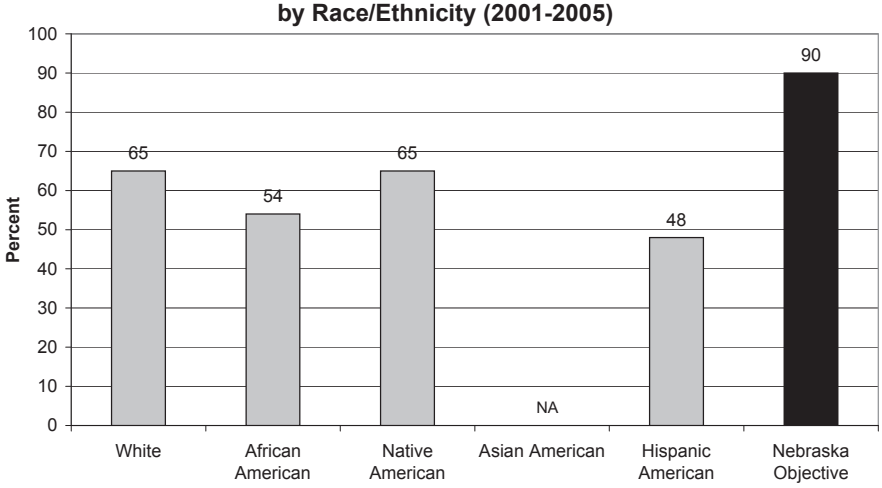
Figure 100
Nebraskans Aged 65+ Who Ever Had a Pneumonia Shot



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

The proportion of persons who ever had a pneumonia vaccination varied by race and ethnic origin (Figure 101). Among whites and Native Americans in the state, 65 percent of BRFSS respondents aged 65 and older said they ever had this preventive measure. Among African Americans (54 percent) and Hispanic Americans (48 percent), a smaller proportion reported having a pneumonia shot.

Figure 101
Nebraska Adults Aged 65+ Who Ever Had a Pneumonia Shot by Race/Ethnicity (2001-2005)



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

INJURY AND VIOLENCE PREVENTION

Healthy People 2010 Goal

The goal of the Injury and Violence Prevention objectives is to reduce injuries, disabilities, and deaths due to unintentional injuries and violence.

Background

According to the National Center for Health Statistics, injuries (both intentional and unintentional) were the cause of 164,000 deaths in the United States in 2004. Injuries resulted in 2.8 million (inpatient) hospitalizations, 41.3 million visits to hospital emergency departments, and 105.3 million physician office visits in 2004.

Two-thirds of all injury deaths in the United States are due to unintentional injuries (i.e., those resulting from motor vehicle crashes, falls, residential fires, poisoning, and drowning, etc.). However, violent and abusive behaviors (such as suicides, homicides, assaults, child abuse and neglect, and domestic violence) are responsible for nearly all of the remaining one-third of injury deaths. In Nebraska, there were 741 unintentional injury deaths, 166 suicides, and 39 homicides in 2004.

The lifetime cost of injuries occurring in a single year in the United States is $406 billion, including medical expenses and productivity losses, according to 2006 estimates from the Centers for Disease Control and Prevention.

Progress Toward Healthy People 2010 Objectives

National

Of the 23 Injury and Violence Prevention objectives shared by Nebraska and the nation, only two have already been met for the United States. The rate of domestic assaults and the rate of rapes or attempted rapes in the U.S. have each achieved their target rates.

Progress has been shown for 10 of the 23 objectives nationwide. Hospitalizations for nonfatal spinal cord injuries and for hip fractures among persons aged 65 and older (both males and females) have declined. The rate of non-fatal injuries due to motor vehicle crashes is down somewhat and the death rate due to drowning has decreased from the baseline. A greater proportion of American adults use seatbelts and more children under age five years are always buckled into a child restraint when riding in a motor vehicle. The rate of children under age 18 who are victims of abuse or neglect has decreased slightly since 1998. The rate of physical assaults (simple and aggravated) has declined and the proportion of high-school students who carried weapons on school property is also down.

No change was evident in motor vehicle fatality rates, deaths due to residential fires, firearm-related death rates, or homicide rates in the United States. The proportion of high-school students who engaged in physical fighting in the past year also remained steady.

Movement away from the national target rates for 2010 occurred for five objectives. Death rates due to poisoning, falls, and all unintentional injuries had all increased, compared to their baseline rates. Hospitalization rates for nonfatal head injuries rose, as did the rate of hospital emergency room visits for nonfatal poisonings.

Current data were unavailable to assess progress for one 2010 objective.

Nebraska

In Nebraska, only one Injury and Violence Prevention objective (reducing the rate of non-fatal injuries caused by motor vehicle crashes) has been achieved.

However, progress has been made in 11 of the 23 objectives shared by the U.S. Hospitalization rates were down for nonfatal spinal cord injuries and for hip fractures among elderly persons (both men and women).

Firearm-related death rates decreased in Nebraska, as did death rates due to motor vehicle crashes and homicides. The proportion of adults who reported always or nearly always wearing their seatbelts rose. The proportion of children under five years of age who were always buckled into a child restraint when riding in a motor vehicle increased, compared to the baseline. The rate of physical assaults reported in Nebraska was down in 2005 and fewer high-school students engaged in physical fighting or carrying a weapon on school property.

On the other hand, the death rate due to residential fires remained nearly steady. The rate of children under age 18 who are victims of maltreatment increased from the 1999 baseline. The rate of rapes or attempted rapes occurring in Nebraska edged upward. Death rates due to poisoning, falls, drowning, and unintentional injuries overall also rose. The rate of hospital emergency room visits for nonfatal poisonings was up somewhat, as was the hospitalization rate for nonfatal head injuries in the state.

Current data were unavailable to assess progress on two Nebraska objectives.

Hospitalizations for Nonfatal Head and Spinal Cord Injuries

One of the Injury and Violence Prevention objectives for 2010 is to reduce the rate of hospitalizations for nonfatal head injuries to no more than 45.0 per 100,000 population nationwide and to no more than 25.5 per 100,000 in Nebraska (Table 13). In the U.S., the rate increased to 66.0 in 2001, while the rate rose by 10 percent in Nebraska to 41.7 in 2003 (Figure 102).

Table 13
Nebraska 2010 Health Goals and Objectives
Injury and Violence Prevention

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#15-1	Hospitalizations for nonfatal head injuries/100,000 population Data not available by race or ethnicity	1998	60.6	2001	66.0	45.0	1999	37.9	2003	41.7	25.5
#15-2	Hospitalizations for nonfatal spinal cord injuries per 100,000 population Data not available by race or ethnicity	1998	4.5	2001	3.7	2.4	1999	3.8	2003	2.5	2.0
#15-3	Firearm-related death rate per 100,000 population	1999	10.3	2003	10.3	3.6	1998	9.5	2004	6.7	3.4
	White	1999	9.1	2003	9.0	3.6	1994-1998	8.6	2000-2004	7.5	3.4
	African American	1999	18.4	2003	19.0	3.6	1994-1998	26.8	2000-2004	17.9	3.4
	Native American	1999	9.3	2003	8.2	3.6	1994-1998	10.8	2000-2004	8.5	3.4
	Asian American	1999	3.7	2003	3.2	3.6	1994-1998	*	2000-2004	8.6	3.4
	Hispanic American	1999	8.2	2003	7.8	3.6	1994-1998	10.9	2000-2004	6.4	3.4
#15-7	Hospital emergency room visits for nonfatal poisonings per 100,000 population Data not available by race or ethnicity	1997	348.3	2004	520.0	292.0	1999	130.4	2003	136.7	104.0

Table 13 continued

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#15-8	Poisoning death rate per 100,000 population	1999	7.1	2003	9.9	1.5	1998	1.6	2004	2.6	1.5
	White	1999	7.2	2003	10.6	1.5			2000-2004	2.2	1.5
	African American	1999	8.1	2003	8.7	1.5			2000-2004	3.7	1.5
	Native American	1999	7.5	2003	10.3	1.5	Data Not Available		2000-2004	11.3	1.5
	Asian American	1999	1.6	2003	1.9	1.5			2000-2004	0.0	0.0
	Hispanic American	1999	5.9	2003	6.1	1.5			2000-2004	2.9	1.5
#15-13	Unintentional injury death rate per 100,000 population	1999	35.3	2003	37.3	17.1	1998	38.8	2004	39.3	19.4
	White	1999	35.2	2003	38.2	17.1	1994-1998	36.0	2000-2004	37.9	19.4
	African American	1999	40.1	2003	36.1	17.1	1994-1998	30.3	2000-2004	25.2	19.4
	Native American	1999	55.8	2003	56.4	17.1	1994-1998	76.9	2000-2004	92.6	19.4
	Asian American	1999	17.2	2003	18.0	17.1	1994-1998	15.0	2000-2004	34.6	7.5
	Hispanic American	1999	30.6	2003	30.6	17.1	1994-1998	33.8	2000-2004	34.9	19.4
#15-15a	Death rate due to motor vehicle crashes per 100,000 population	1999	14.7	2003	14.8	8.0	1998	20.5	2004	16.6	12.0
		1999	14.8	2003	15.1	8.0	1994-1998	17.7	2000-2004	16.8	12.0
	White	1999	15.6	2003	14.7	8.0	1994-1998	12.6	2000-2004	9.7	12.0
	African American	1999	26.9	2003	27.1	8.0	1994-1998	34.2	2000-2004	43.8	12.0
	Native American	1999	8.1	2003	8.3	8.0	1994-1998	6.3	2000-2004	14.9	4.0
	Asian American	1999	13.9	2003	14.8	8.0	1994-1998	20.0	2000-2004	17.4	12.0
	Hispanic American										
#15-17	Rate of non-fatal injuries caused by motor vehicle crashes per 100,000 population	1998	1181	2001	1,065	933	1999	1792.0	2004	1219.6	1415.0
	Data not available by race/ethnicity										
#15-19	Percent of adults aged 18+ who "always" or "nearly always" used safety belts when riding in or driving a motor vehicle	1998	69	2002	75	92	1997	77	2002	81	92
	White	1998	NA	2002	NA	92	1993-1997	77	2002	81	92
	African American	1998	NA	2002	NA	92	1993-1997	77	2002	80	92
	Native American	1998	NA	2002	NA	92	1993-1997	NA	2002	71	92
	Asian American	1998	NA	2002	NA	92	1993-1997	NA	2002	87	92
	Hispanic American	1998	NA	2002	NA	92	1993-1997	70	2002	84	92
#15-20	Percent of adults aged 18+ who reported that their oldest child <5 years always used a child restraint when riding in a motor vehicle	1998	92	2002	95	100	1999	56	2004	88	100
	Data not available by race/ethnicity										
#15-23	Percent of adults aged 18+ who reported that their oldest child aged 5 to 15 years "always" wore a bike helmet when riding a bicycle during the past year	1998	69	No New Data Available		76	1999	24	No New Data Available		50
	Data not available by race/ethnicity										
#15-25	Death rate due to residential fires per 100,000 population	1999	1.2	2003	1.2	0.2	1998	1.0	2004	0.9	0.2
		1999	1.0	2003	1.1	0.2	1994-1998	1.0	2000-2004	1.0	0.2
	White	1999	3.0	2003	2.4	0.2	1994-1998	*	2000-2004	0.7	0.2
	African American	1999	2.1	2003	1.2	0.2	1994-1998	*	2000-2004	*	0.2
	Native American	1999	0.3	2003	0.3	0.2	1994-1998	0.0	2000-2004	0.0	0.0
	Asian American	1999	0.7	2003	0.6	0.2	1994-1998	1.1	2000-2004	1.7	0.2
	Hispanic American										
#15-27	Death rate due to falls per 100,000 population	1999	4.8	2003	5.9	3.3	1998	6.9	2004	8.5	3.5
	White	1999	5	2003	6.1	3.3	1994-1998	7.5	2000-2004	7.7	3.5
	African American	1999	3.4	2003	3.4	3.3	1994-1998	*	2000-2004	3.6	3.5
	Native American	1999	5.2	2003	6.4	3.3	1994-1998	*	2000-2004	*	3.5
	Asian American	1999	3.5	2003	4.2	3.3	1994-1998	*	2000-2004	*	3.5
	Hispanic American	1999	4.1	2003	4.2	3.3	1994-1998	*	2000-2004	3.1	3.5

Table 13 continued

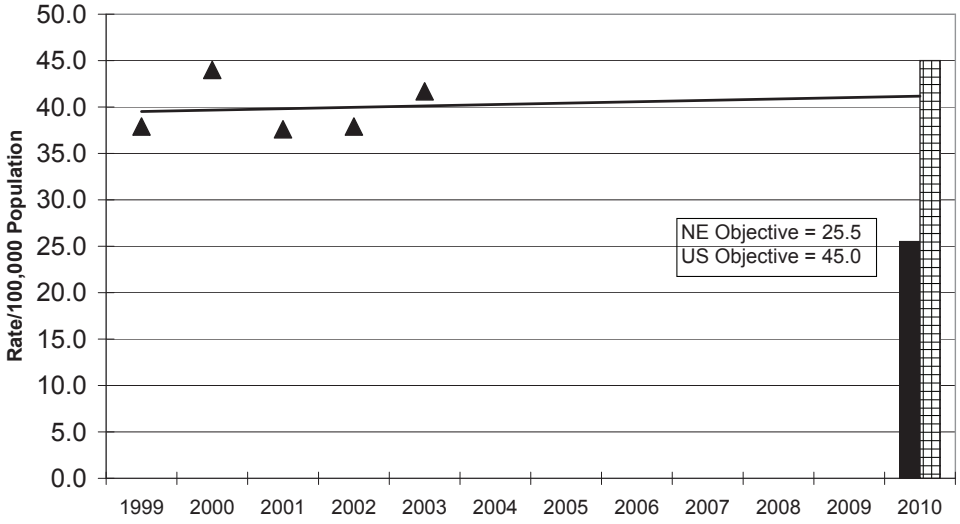
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#15-28	Hospitalizations for hip fractures among adults aged 65 + per 100,000 population										
	a. Females aged 65 years and older	1998	1055.8	2001	1029.2	416.0	1999	1113.7	2003	1032.4	839.2
	b. Males aged 65 years and older	1998	592.7	2001	484.2	474.0	1999	520.9	2003	503.4	387.8
#15-29	Death rate due to drowning per 100,000 population	1999	1.5	2003	1.2	0.7	1998	0.8	2004	1.4	0.5
	White	1999	1.4	2003	1.2	0.7	1994-1998	0.8	2000-2004	1.0	0.5
	African American	1999	1.9	2003	1.4	0.7	1994-1998	1.7	2000-2004	*	0.5
	Native American	1999	2.9	2003	2.4	0.7	1994-1998	*	2000-2004	*	0.5
	Asian American	1999	1.1	2003	1.2	0.7	1994-1998	*	2000-2004	*	0.5
	Hispanic American	1999	1.2	2003	1.1	0.7	1994-1998	2.3	2000-2004	1.1	0.5
#15-32	Homicide death rate per 100,000 population	1999	6.0	2003	6.0	2.8	1998	3.3	2004	2.2	2.0
	White	1999	3.8	2003	3.7	2.8	1994-1998	2.2	2000-2004	2.1	2.0
	African American	1999	20.1	2003	21.0	2.8	1994-1998	26.7	2000-2004	20.3	2.0
	Native American	1999	9.1	2003	7.3	2.8	1994-1998	9.1	2000-2004	11.9	2.0
	Asian American	1999	3.0	2003	2.9	2.8	1994-1998	*	2000-2004	*	2.0
	Hispanic American	1999	7.6	2003	7.7	2.8	1994-1998	8.0	2000-2004	6.6	2.0
#15-33	Rate of children under age 18 years who are victims of maltreatment per 1,000 children Data not currently available by race or ethnicity	1998	12.6	2001	12.4	10.1	1999	6.9	2004	11.3	6.8
#15-34	Rate of physical assaults per 1,000 persons aged 12 years or older by current or former intimate partners	1998	4.4	2001	2.6	3.3	1999	3.6	Data Not Available		2.7
#15-35	Rate of rapes or attempted rapes per 1,000 persons aged 12 years or older	1998	0.8	2001	0.7	0.7	1999	0.3	2005	0.4	0.2
#15-37	Rate of physical assaults (simple and aggravated) per 1,000 persons	1998	31.1	2001	21.8	13.6	1999	12.1	2005	11.5	6.0
#15-38	Percent of adolescents in grades 9-12 who engaged in physical fighting in the past 12 months Data not available by race or ethnicity	1999	36	2005	36	32	1999	30	2005	29	25
#15-39	Percent of adolescents in grades 9-12 who carried weapons on school property in the past 30 days Data not available by race or ethnicity	1999	6.9	2003	6.1	4.9	1999	5.1	2005	4.8	3.5

*Rate based on fewer than 5 deaths over the five-year period. NA = Not Available

Data Sources:		Additional Notes:
#15-1	U.S.--National Hospital Discharge Survey, CDC. Nebraska--Hospital Discharge data, HHSS.	ICD-9-CM codes 800-801, 803-804, 850-854, 870-873, or 925 as principal diagnosis. Same as U.S.
#15-2	U.S.--National Hospital Discharge Survey, CDC. Nebraska--Hospital Discharge data, HHSS.	ICD-9-CM codes 806 or 952 as principal diagnosis. Same as U.S.
#15-3	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E922, E955.0-E955.4, E965.0-E965.4, E970, E985.0-E985.4. Age-adjusted to 2000 standard. Same as U.S.
#15-7	U.S.--National Hospital Ambulatory Medical Care Survey, CDC. Nebraska--Hospital Discharge data, HHSS.	ICD-9-CM codes E850-E869, E950-E952, E962, E972, E980-E982. All emergency room visits related to poisoning regardless of intent (unintentional, intentional, or undetermined).
#15-8	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E850-869, E950-E952, E962, E972, E980-E982. Age-adjusted to 2000 standard. Same as U.S.
#15-13	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E800-869, E880-E929. Age-adjusted to 2000 standard. Same as U.S.

Table 13 continued		
Data Sources:		Additional Notes:
#15-15a	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E810-E819. Age-adjusted to 2000 standard. Same as U.S.
#15-17	U.S.--General Estimates System, Dept. of Transportation (DOT), National Highway Traffic Safety Administration (NHTSA). Nebraska--Nebraska Office of Highway Safety, Dept. of Motor Vehicles.	Data taken from a nationally representative sample of police-reported motor vehicle crashes.
#15-19	U.S.--National Occupant Protection Use Survey, DOT, NHTSA. Nebraska--BRFSS, HHSS.	Observational data collected at intersections, highway ramps, and parking lots.
#15-20	U.S.--National Occupant Protection Use Survey, DOT, NHTSA. Nebraska--HHSS, Safe Kids Nebraska Program, "Nebraska Child Passenger Safety Report, 1999-2004."	Observational data collected at intersections, highway ramps, and parking lots. CHANGE IN DATA SOURCE. BASELINE CHANGED. Observational data.
#15-23	U.S.--National Bike Helmet Survey, Consumer Product Safety Commission. B178 Nebraska--BRFSS, HHSS.	Children aged 1 - 15. In households where the oldest child is aged 5 to 15 years, adult respondent reports whether oldest child always, nearly always, sometimes, seldom or never wore a bicycle helmet when riding a bicycle during the past year. As a percent of households with children aged 5 to 15 who ever ride bicycles.
#15-25	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E890-E899. Unintentional fire-related injury deaths. Age-adjusted to 2000 standard. Same as U.S.
#15-27	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E880-E886, E888. Age-adjusted to 2000 standard. Same as U.S.
#15-28	U.S.--National Hospital Discharge Survey, CDC. Nebraska--Hospital Discharge data, HHSS.	ICD-9-CM code 820 as principal diagnosis. Same as U.S.
#15-29	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E830, E832, E910. Age-adjusted to 2000 standard. Same as U.S.
#15-32	U.S.--National Vital Statistics System, CDC. FBI Uniform Crime Reports, U.S. Dept. of Justice. Nebraska--Vital Statistics, HHSS.	ICD-9 codes E960- E969. Age-adjusted to 2000 standard. Same as U.S.
#15-33	U.S.--National Child Abuse and Neglect Data System (NCANDS), Administration for Children and Families, DHHS. Nebraska--Protection and Safety Division, HHSS.	Children found to be victims of maltreatment by State child welfare agencies. Maltreatment is defined as an act or failure to act by a parent, caretaker, other person as defined by state law which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act that presents an imminent risk of serious harm. Same as U.S.
#15-34	U.S.--National Crime Victimization Survey, U.S. Dept. of Justice, Bureau of Justice Statistics. Nebraska--Nebraska Commission on Law Enforcement and Justice, "Crime in Nebraska" reports.	Number of persons aged 12 years or older who report being threatened or assaulted by current or former spouse, boyfriend, or girlfriend. Nebraska data includes assaults for all ages. Data incomplete due to non-reporting by a law enforcement agency in Douglas County.
#15-35	U.S.--National Crime Victimization Survey, U.S. Dept. of Justice, Bureau of Justice Statistics. Nebraska--Nebraska Commission on Law Enforcement and Justice, "Crime in Nebraska" reports.	Number of persons aged 12 years or older who report being raped or a victim of an attempted rape. Includes females and males. Same as U.S.
#15-37	U.S.--National Crime Victimization Survey, U.S. Dept. of Justice, Bureau of Justice Statistics. Nebraska--Nebraska Commission on Law Enforcement and Justice, "Crime in Nebraska" reports.	Number of persons aged 12 years or older who report being physically assaulted. Nebraska data includes assaults for all ages.
#15-38	U.S.--Youth Risk Behavior Surveillance System (YRBS), CDC. Nebraska--YRBS, HHSS.	Number of students who report being in a physical fight at least once during the 12 months preceding the survey. Same as U.S.
#15-39	U.S.--Youth Risk Behavior Surveillance System (YRBS), CDC. Nebraska--YRBS, HHSS.	Number of students who report carrying a weapon on school property at least 1 day in the 30 days preceding the survey. Same as U.S.

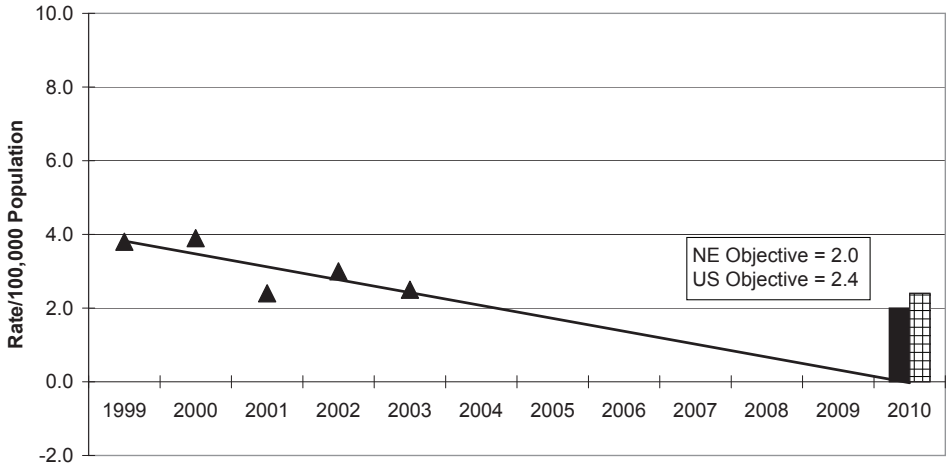
Figure 102
Hospitalizations for Non-Fatal Head Injuries in Nebraska



SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People.

A related objective seeks to lower the rate of hospitalizations for nonfatal spinal cord injuries to no more than 2.4 per 100,000 population nationally and to no more than 2.0 in Nebraska. The U.S. rate declined (by 18 percent) to 3.7 in 2001. In Nebraska, the current rate of 2.5 represents a decrease of 34 percent from the baseline (Figure 103).

Figure 103
Hospitalizations for Non-Fatal Spinal Cord Injuries in Nebraska

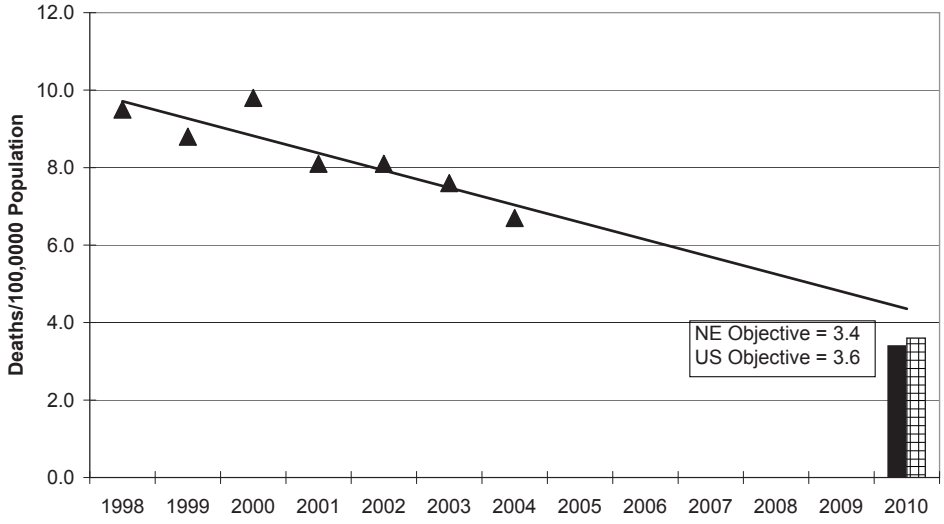


SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Firearm-Related Deaths

An objective targeting a reduction in firearm-related death rates has been adopted nationwide and in Nebraska (Table 13). Although no progress was shown in the U.S. death rate, a reduction of 29 percent was achieved in Nebraska by 2004 (Figure 104). The current rate for the state is 6.7, compared to a target rate of no more than 3.4 deaths per 100,000. A total of 118 firearm-related deaths were recorded in 2004.

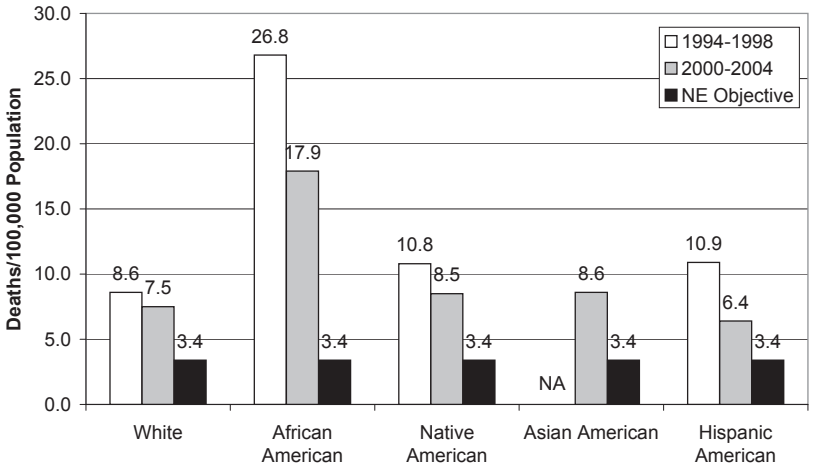
Figure 104
Firearm-Related Deaths in Nebraska (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

In Nebraska, 2000-2004 rates of firearm-related deaths were down for each racial and ethnic group for which trend data are available (Figure 105). Although the rate for African Americans decreased by one-third in 2000-2004 to 17.9 deaths per 100,000, this rate is more than double the rate for each of the other racial or ethnic groups.

Figure 105
Firearm-Related Deaths in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)

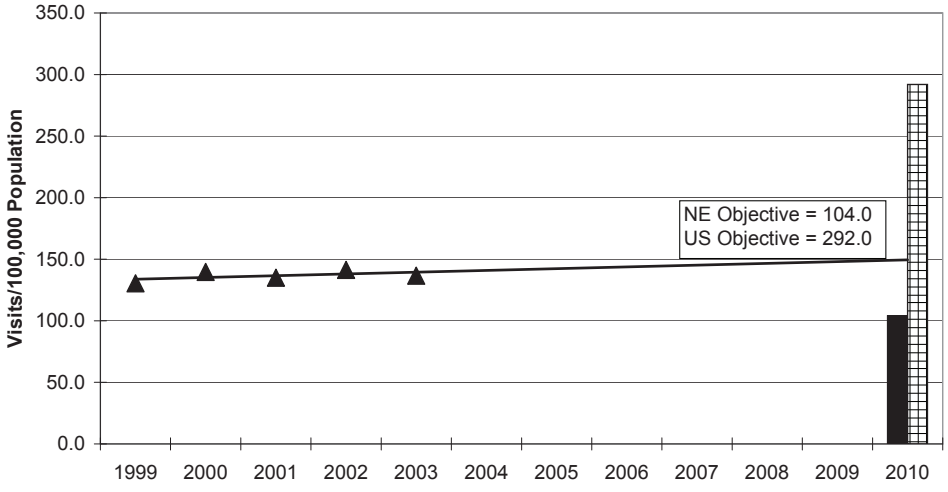


NA = Not Available. Rate not reported due to <5 deaths during period.
SOURCE: Nebraska HHSS, Vital Statistics.

Poisonings

A national 2010 objective has been set to reduce the rate of hospital emergency room visits due to nonfatal poisonings to no more than 292.0 visits per 100,000 population (Table 13). In Nebraska, a much lower target rate of no more than 104.0 visits per 100,000 has been adopted. The U.S. rate moved away from the objective, increasing the rate by 49 percent to 520.0 in 2004. In Nebraska, a small rise in emergency room visits resulted in a 2003 rate of 136.7 per 100,000 (Figure 106).

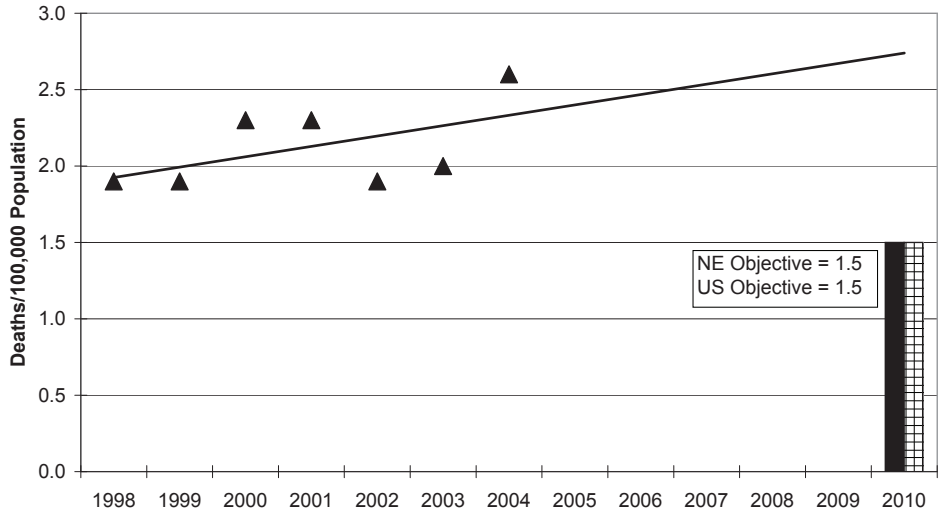
Figure 106
Nebraska Hospital Emergency Room Visits for Non-Fatal Poisonings



SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Although the same 2010 target rate of no more than 1.5 poisoning deaths per 100,000 population has been established for Nebraska and the nation (Table 13), the current U.S. rate (9.9 in 2003) is much higher than the rate for the state (2.6 in 2004). Poisoning death rates increased both for the U.S. (+39 percent) and for Nebraska (+ 62 percent) (Figure 107). A total of 45 poisoning deaths were recorded in the state in 2004.

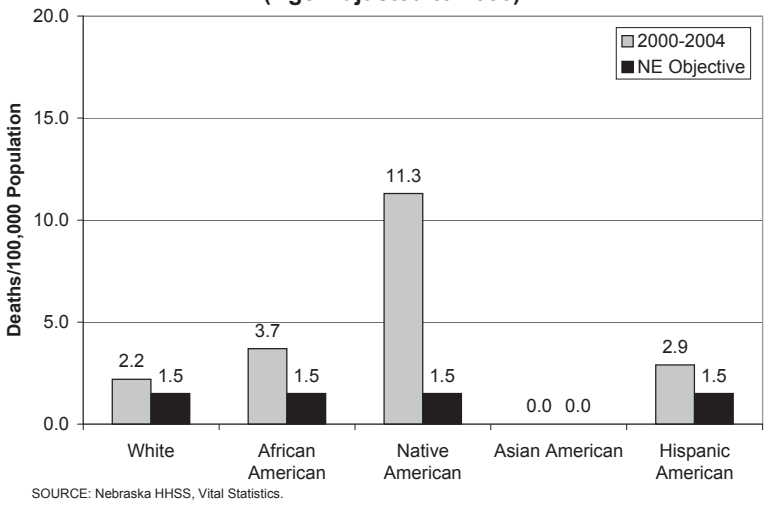
Figure 107
Deaths Due to Poisoning in Nebraska (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Death rates due to poisoning showed some variation by race and ethnic origin (Figure 108). However, it is important to note that the number of deaths for Native Americans, in particular, was small for the five-year period 2000-2004.

Figure 108
Deaths Due to Poisoning in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)

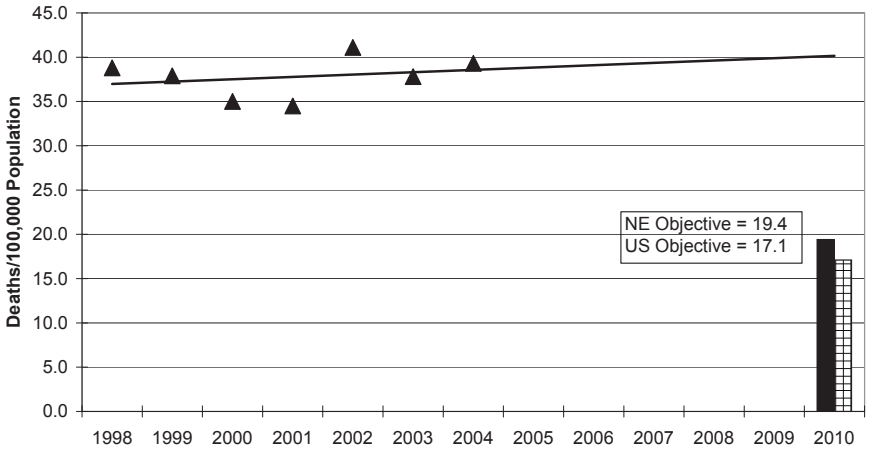


SOURCE: Nebraska HHSS, Vital Statistics.

Unintentional Injury Deaths

Both Nebraska and the nation have adopted objectives to reduce the rate of unintentional injury deaths by the year 2010 (Table 13). The Nebraska target rate of no more than 19.4 deaths per 100,000 is slightly higher than the U.S. target (17.1 per 100,000). The current U.S. unintentional injury mortality rate (37.3) and the Nebraska one (39.3) both represent small increases from their baselines (Figure 109). Each of these rates is more than double their respective 2010 target rates. There were 741 unintentional injury deaths in Nebraska in 2004.

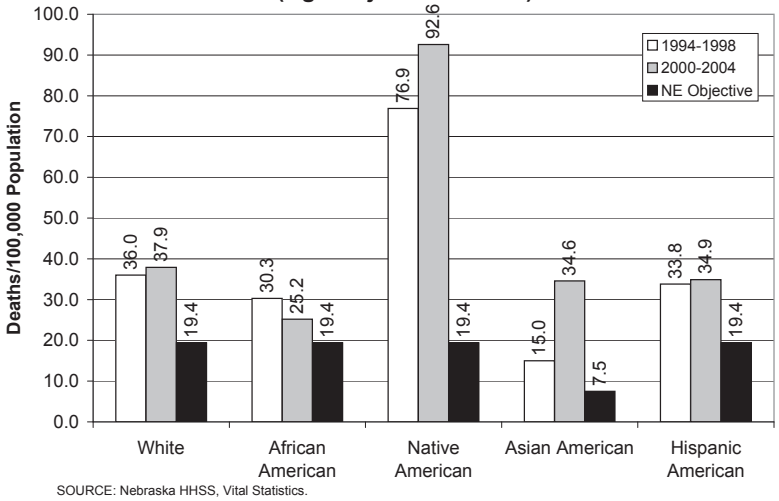
Figure 109
Deaths Due to Unintentional Injuries in Nebraska
(Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

The unintentional injury death rate for Native Americans (92.6) was more than double the rates for other racial or ethnic groups in Nebraska in 2000-2004 (Figure 110). Death rates for each of these groups, except African Americans, increased from the 1994-1998 baseline. The current rate for African Americans (25.2) was down 17 percent from the baseline and was also the lowest rate recorded for any racial/ethnic group in the state in 2000-2004.

Figure 110
Unintentional Injury Deaths in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)

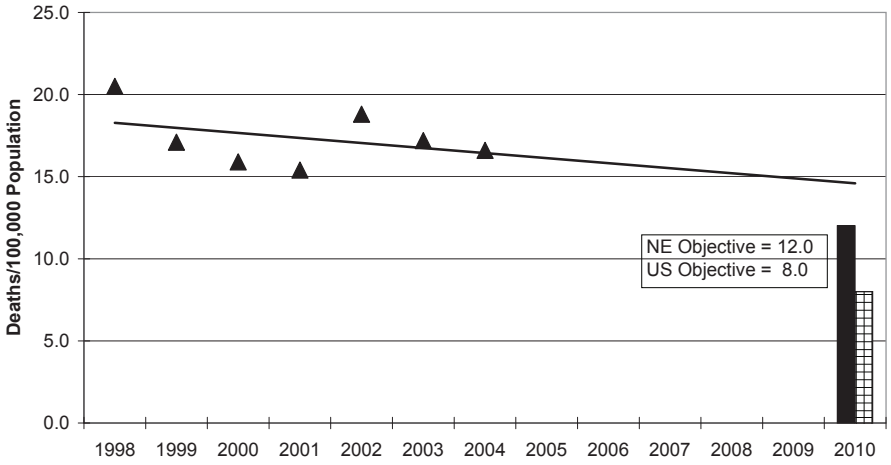


SOURCE: Nebraska HHSS, Vital Statistics.

Injuries and Deaths due to Motor Vehicle Crashes

The 2010 objective for reducing motor vehicle crash deaths was 50 percent in higher in Nebraska (12.0 deaths per 100,000) than nationwide (8.0 per 100,000), due to a higher baseline death rate (Table 13). The U.S. rate remained stable, with 14.8 deaths per 100,000 in 2003. In Nebraska, however, a decrease of 19 percent was achieved, bringing the current rate down to 16.6 (Figure 111). There were 282 motor vehicle fatalities in the state in 2004.

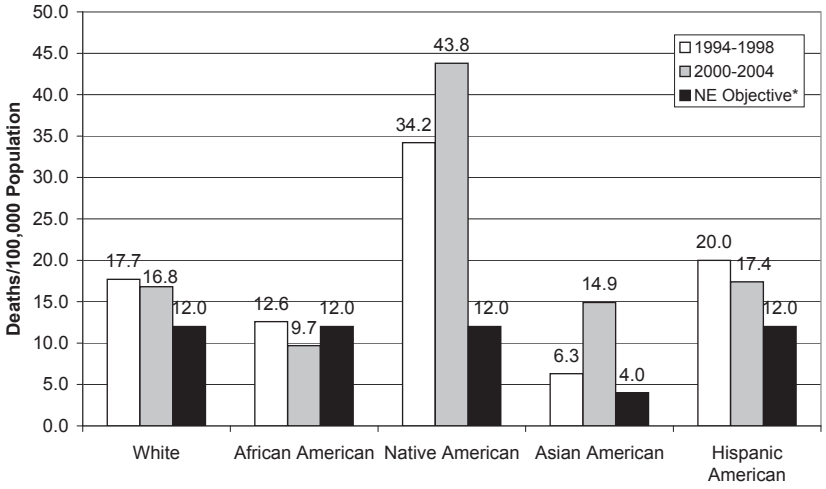
Figure 111
Deaths Due to Motor Vehicle Crashes in Nebraska
(Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

As with all unintentional injuries combined, the current motor vehicle death rate for Native Americans in Nebraska (43.8 in 2000-2004) was more than double the rate for each of the other racial/ethnic groups listed (Figure 112). In addition, the current rate rose by 28 percent from the baseline. Asian Americans also experienced an increase in motor vehicle fatality rates, although the 2000-2004 rate (14.9) was lower than rates for all other groups except African Americans. African Americans, with 9.7 deaths per 100,000, were the only group in the state to achieve the 2010 target rate set for them (12.0) in 2000-2004. A revised objective of no more than 8.0 motor vehicle deaths per 100,000 has been set for African Americans, matching the current U.S. 2010 objective (Appendix, Table A).

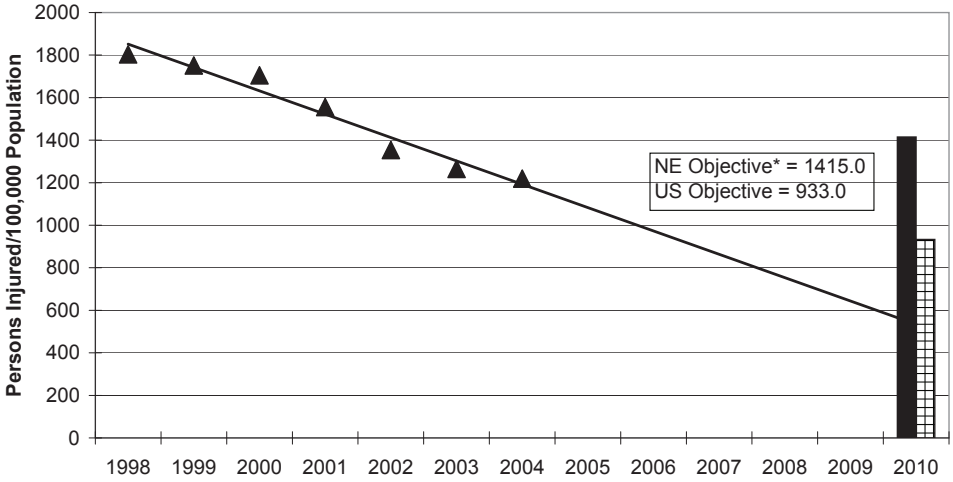
Figure 112
Deaths Due to Motor Vehicle Crashes in Nebraska
by Race/Ethnicity (Age-Adjusted to 2000)



*Nebraska objective has been met for African Americans and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Another 2010 objective adopted in Nebraska and nationwide seeks to reduce the rate of non-fatal injuries caused by motor vehicle crashes. The U.S. target rate is no more than 933 of these injuries per 100,000 population (Table 13), while the Nebraska target is much higher (1,415). The current national rate (1,065 per 100,000) represents a decrease of 10 percent, but does not achieve the target rate. The 2004 Nebraska rate (1,219.6) is higher than the national rate, but it also represents a decline in the nonfatal motor vehicle crash injury rate (down 32 percent) since 1999 (Figure 113). It also meets the Nebraska 2010 objective. A revised target rate, matching the current U.S. target, has been adopted for motor vehicle crash injuries (no more than 933.0 per 100,000 population). (Appendix, Table A).

Figure 113
Persons Injured Due to Motor Vehicle Crashes in Nebraska
(Crude Rate/100,000 Population)



*Nebraska objective has been met and will be revised.
SOURCE: NE Office of Highway Safety, Dept. of Roads. U.S. Census estimates. U.S. DHHS, Healthy People 2010.

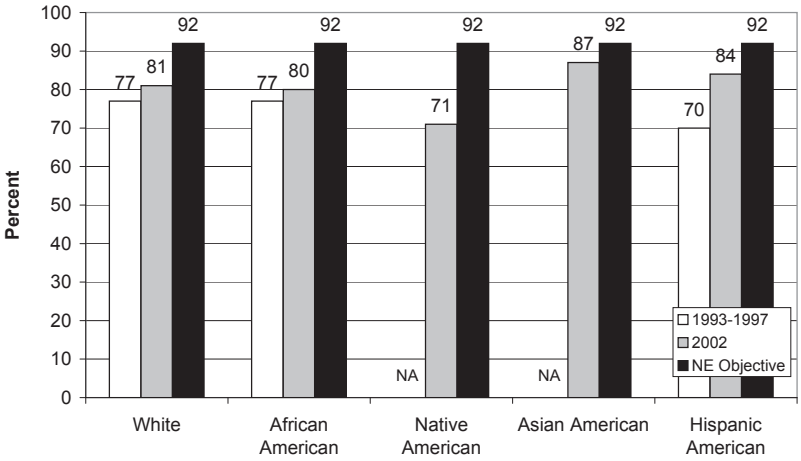
Use of Seatbelts, Child Restraints, and Bicycle Helmets

Another objective related to motor vehicle deaths and injuries tracks progress in increasing to at least 92 percent the proportion of adults aged 18 and older who always or nearly always use seatbelts when riding in or driving a motor vehicle. The same target rate has been adopted in Nebraska and the United States. The

U.S. rate increased from the 1998 baseline of 69 percent to 75 percent in 2002 (Table 13). In Nebraska, the proportion of adults using seatbelts this consistently rose from 77 percent in 1997 to 81 percent in 2002.

Native Americans in Nebraska reported the smallest proportion of adults always or nearly always using seatbelts (71 percent), while Asian Americans (87 percent) were most likely to use seatbelts when riding in or driving a motor vehicle (Figure 114).

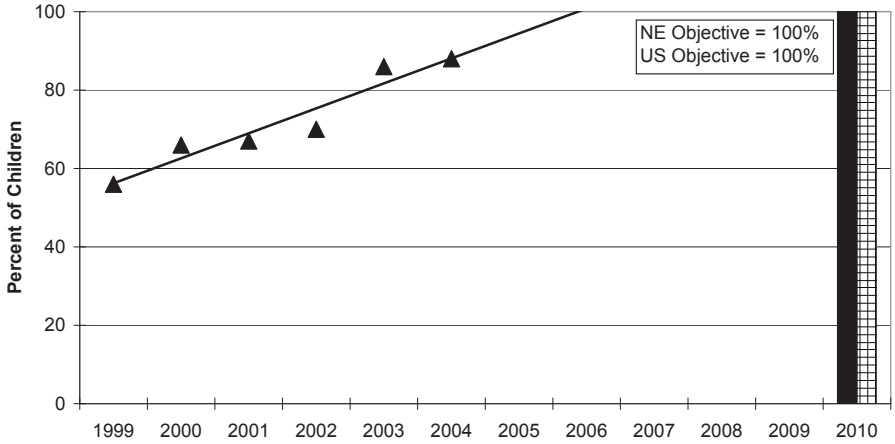
Figure 114
Nebraska Adults Aged 18+ Who "Always" or "Nearly Always" Use Seatbelts by Race/Ethnicity



NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Nebraska and the nation have both established objectives to increase to 100 percent the proportion of children using child restraints while riding in a motor vehicle (as a percent of those required by law at that time). Different data sources are used for Nebraska and the U.S., but both show progress (Table 13). An observational study conducted in Nebraska found that the proportion increased from only 56 percent in 1999 to 88 percent in 2004 (Figure 115).

Figure 115
Nebraska Children Using Child Restraint While Riding in Motor Vehicle (as % of Those Required by Law at That Time*)



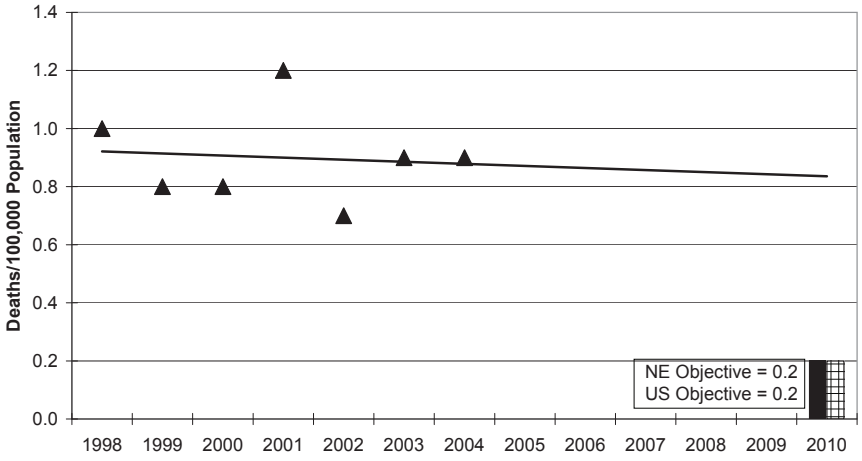
*Required by law: 1999, <4 years or age; 2000-2001, < 5 years of age and <40 lbs.; 2002-2004, <6 years of age.
SOURCE: Nebraska HHSS, Safe Kids Nebraska Program, "Nebraska Child Passenger Safety Report 1999-2004". US DHHS, Healthy People2010

Year 2010 objectives were adopted, both nationwide and in Nebraska, to increase the proportion of children who wear bicycle helmets when riding bikes. However, no new data are available to assess progress toward these objectives.

Residential Fire Deaths

An objective has been set to reduce the death rate due to residential fires to no more than 0.2 deaths per 100,000 population by 2010 for Nebraska and the U.S. (Table 13). The U.S. rate remained steady at 1.2 deaths per 100,000, while the Nebraska rate edged downward very slightly to 0.9 (Figure 116). There were 15 deaths due to residential fires in the state in 2004.

Figure 116
Deaths Due to Residential Fires in Nebraska
(Age-Adjusted to 2000)

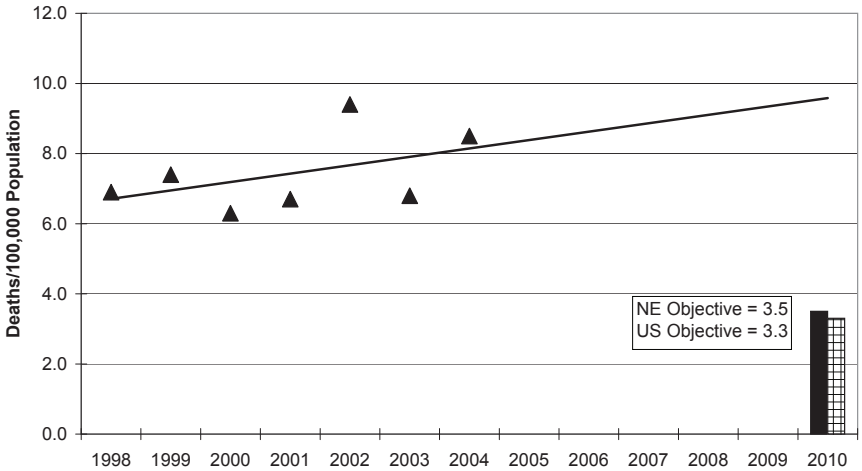


SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Deaths due to Falls

Nebraska and the nation have adopted similar objectives for reducing the death rate due to falls (no more than 3.5 and 3.3 deaths per 100,000 population respectively) (Table 13). However, rates increased by 23 percent at both the state and national levels (Figure 117). There were 172 deaths due to falls in 2004 in Nebraska rate, resulting in a rate of 8.5 per 100,000, compared to 5.9 for the U.S.

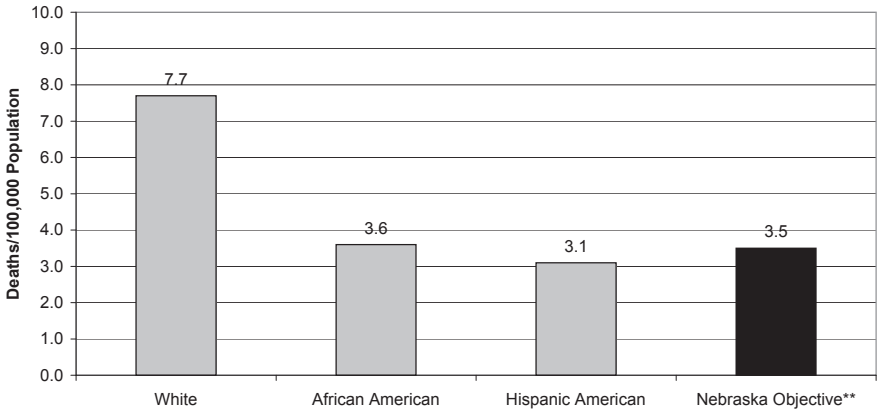
Figure 117
Deaths Due to Falls (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

White Nebraskans experienced the highest death rates due to falls (7.7) in 2000-2004, more than double the rates for African Americans (3.6) and Hispanic Americans (3.1) in the state (Figure 118). The rate for Hispanic Nebraskans met the 2010 target rate of no more than 3.5 deaths per 100,000. A revised objective has been set to reduce deaths due to falls among Hispanic Americans in the state to no more than 2.8 per 100,000 (a further decrease of 10 percent) (Appendix, Table A).

Figure 118
Deaths due to Falls in Nebraska in 2000-2004
by Race/Ethnicity* (Age-Adjusted to 2000)



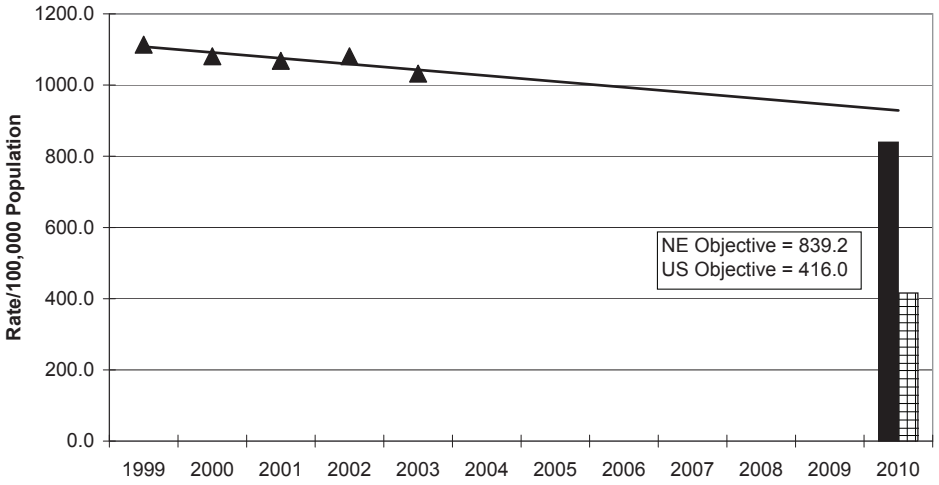
*Rates not reported for Native Americans and Asian Americans due to fewer than five deaths each over the five-year period.
**Nebraska objective has been met for Hispanic Americans and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics.

Hospitalizations for Hip Fractures

A related objective seeks to lower the hospitalization rate for hip fractures among adults aged 65 and older. Since these rates have typically been higher for women in this age group, Nebraska has set a target of no more than 839.2 hospitalizations per 100,000 females and a target of no more than 387.8 hospitalizations per 100,000 males by 2010. The national targets for men (474.0) and women (416.0) aged 65 and older are similar to each other (Table 13).

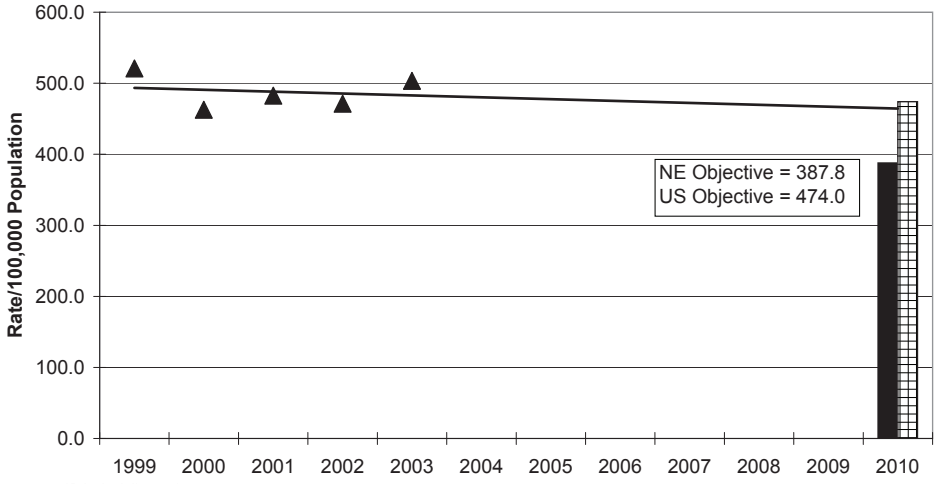
Hospitalizations for hip fractures among the elderly are down for the U.S., with the rate for males (484.2) approaching the 2010 target. For females, however, the current rate (1029.2) has a long way to go before reaching the target. In Nebraska, the hospitalization rate for hip fractures among women in this age range decreased by 7 percent from the 1999 baseline to 1032.4 in 2003 (Figure 119). For men aged 65 and older, this rate declined by only 3 percent to 503.4 (Figure 120).

Figure 119
Hospitalizations for Hip Fracture*
Among Nebraska Women Aged 65+



*Principal diagnosis.
SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Figure 120
Hospitalizations for Hip Fracture*
Among Nebraska Men Aged 65+



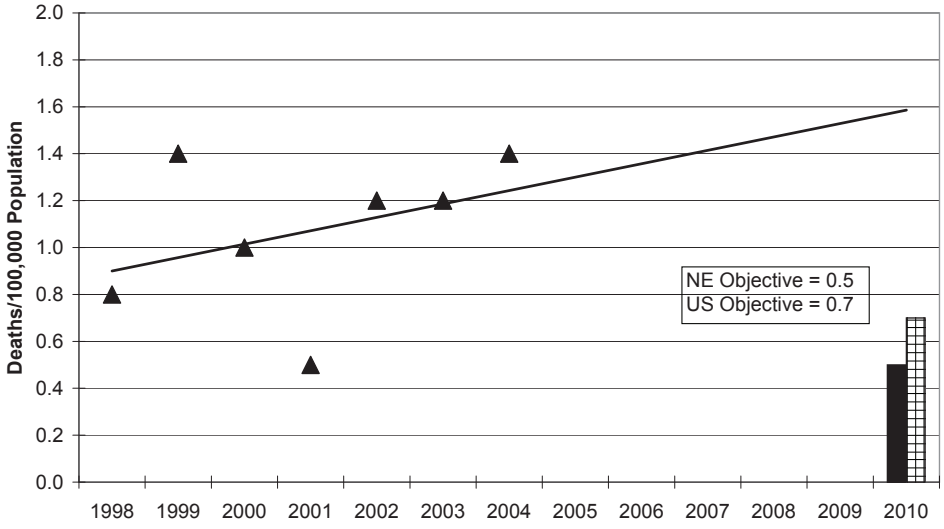
*Principal diagnosis.
SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Drowning Deaths

The Nebraska objective regarding drowning deaths is to reduce the mortality rate to no more than 0.5 deaths per 100,000 population by 2010. This is slightly lower than the U.S. target rate of 0.7. National drowning deaths have decreased somewhat, moving from a 1999 baseline rate of 1.5 to the 2003 rate of 1.2 (Table 13).

In Nebraska, annual rates have been variable due to the small number of deaths from this cause each year, although the overall trend is upward (Figure 121). A total of 25 persons drowned in the state in 2004.

Figure 121
Deaths Due to Drowning in Nebraska (Age-Adjusted to 2000)

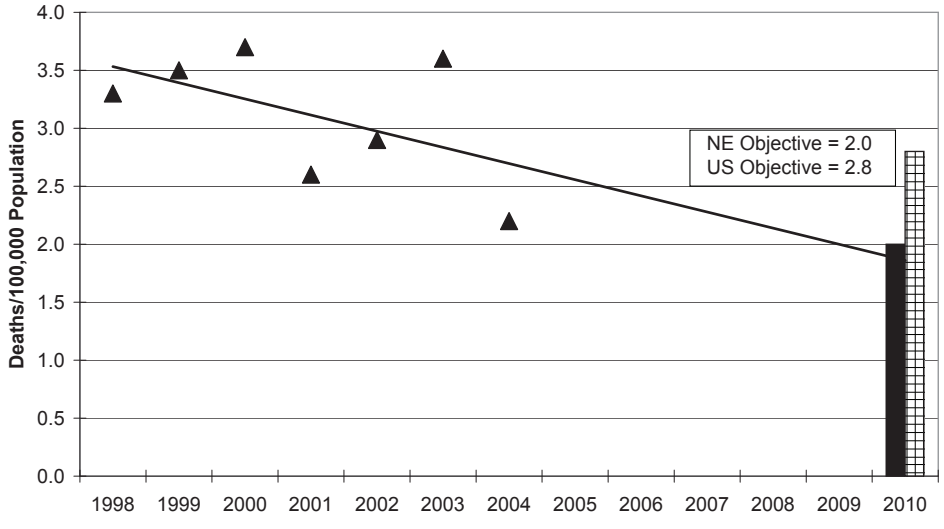


SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Homicides

One of the Nebraska 2010 objectives in the Injury and Violence Prevention focus area is to reduce the homicide rate to no more than 2.0 homicides per 100,000 population (Table 13). This target is lower than the national objective (2.8), based on a lower baseline for the state. No change was noted in the national homicide rate (6.0 in 2003). In Nebraska, however, the homicide rate dropped by one-third between 1998 and 2004 (Figure 122). The 2004 rate was 2.2 homicides per 100,000 population, just 10 percent higher than the targeted rate for 2010. There were 38 homicides in Nebraska in 2004.

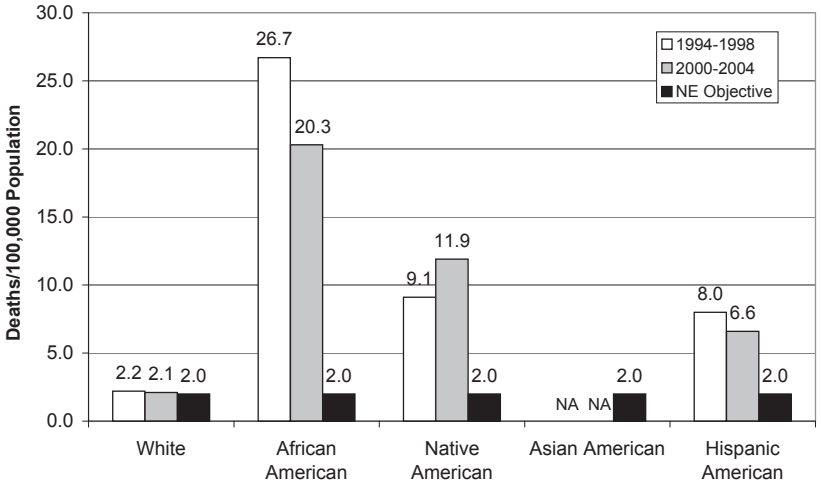
Figure 122
Homicides in Nebraska (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Homicide rates in Nebraska differed by race and ethnic origin in 2000-2004, although progress was achieved in reducing rates for nearly all groups (Figure 123). The current rate for African Americans (20.3) represents a decrease of 24 percent from the 1994-1998 rate of 26.7. Still, the rate for this group is the highest of any in the state and nearly ten times the rate for white Nebraskans (2.1).

Figure 123
Homicides in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)



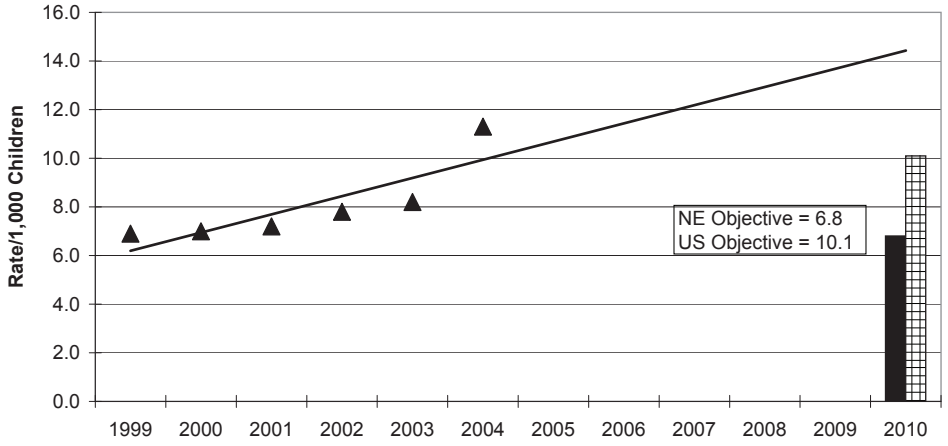
NA = Not Available. Fewer than five deaths reported during five-year period.
SOURCE: Nebraska HHSS, Vital Statistics.

The homicide rate for Native Americans rose by 31 percent to 11.9 in 2000-2004. This rate is more than five times the rate for whites in Nebraska. Among Hispanic Nebraskans, the homicide rate (6.6) was down 17 percent in 2000-2004. However, this rate is about triple the rate for white residents.

Child Abuse and Neglect

Another Nebraska objective related to violence prevention is to reduce the incidence of child abuse and neglect to no more than 6.8 substantiated cases per 1,000 children under 18 years of age (Table 13). The U.S. objective is to reduce this rate to no more than 10.1 per 1,000 by 2010.
Nationwide, the rate of children who are victims of maltreatment has decreased very slightly from 12.6 in 1998 to 12.4 in 2001. In Nebraska, the rate has been increasing from the 1999 baseline of 6.9 substantiated cases per 1,000 children. In 2004, the rate was 11.3, up 64 percent from 1999 (Figure 124). Two factors have probably contributed to a sharp rise in the number of substantiated cases in Nebraska in 2004. In that fiscal year, Nebraska's governor designated money to fund public service announcements to encourage reporting of child abuse or neglect. It is believed that this campaign has contributed to the increased number of reports of child abuse and neglect recorded in 2004. In addition, Nebraska fully implemented a new "intake tool" during 2003. This new tool has an increased focus on risk in addition to maltreatment, which has most likely contributed to more reports being accepted for investigation.

Figure 124
Rate* of Child Abuse/Neglect
Among Nebraska Children Aged 0-17 Years



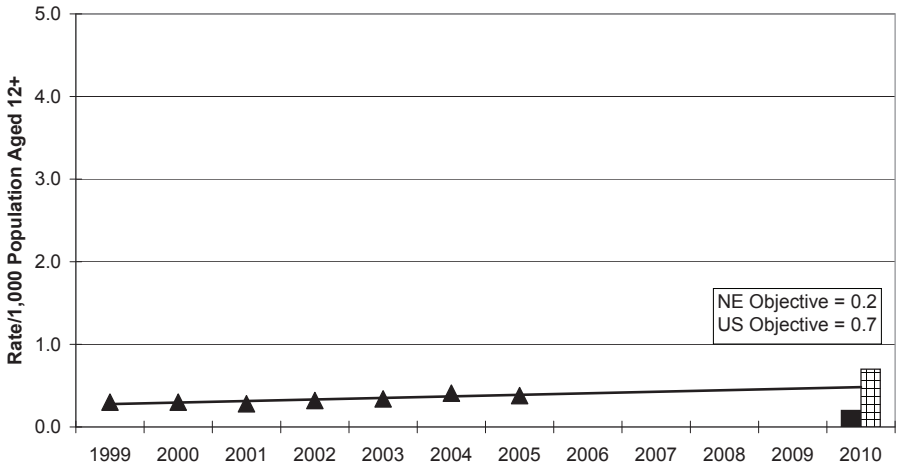
*Rate = # of children aged 0-17 years involved in substantiated cases of child abuse/neglect in current year/ # of children aged 0-17 years in population in current year.
SOURCE: Nebraska HHSS Office of Protection and Safety, "Child Abuse or Neglect Annual Report, CY 2004". U.S. Census Estimates for individual years 1999 through 2004.

Domestic Violence, Rapes, and Physical Assaults

Domestic violence generally refers to threats or physical assaults on persons by current or former spouses, boyfriends, girlfriends, or intimate partners. Nationwide, an objective was set to reduce the rate of physical assaults by current or former "intimate partners" to no more than 3.3 per 1,000 persons aged 12 and older (Table 13). In Nebraska, this objective seeks to reduce the rate of domestic assaults to no more than 2.7 per 1,000 persons (all ages). The U.S. rate of domestic violence declined from 4.4 in 1998 to 2.6 in 2001, thus meeting the 2010 objective. In Nebraska, the baseline rate was 3.6 domestic assaults per 1,000 in 1999. However, no current data are available to assess progress toward the state objective.

Another violence-related objective adopted by Nebraska and the nation is a reduction in the incidence of rapes and attempted rapes. In the U.S., a target rate of no more than 0.7 rapes/attempted rapes per 1,000 persons aged 12 years and older was set. The U.S. rate decreased from 0.8 per 1,000 in 1998 to 0.7 in 2001 and therefore achieved the target rate for 2010. In Nebraska, a lower objective was set for 2010 (0.2 rapes/attempted rapes per 1,000) since the 1999 baseline was 0.3. In 2005, the rate edged upward to 0.4 (Figure 125).

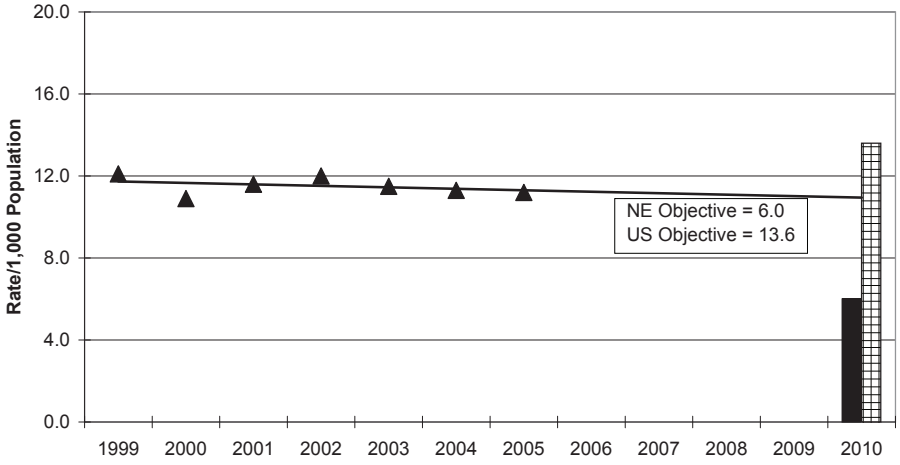
Figure 125
Rapes or Attempted Rapes in Nebraska
(Persons Aged 12 and Older)



SOURCE: Nebraska Commission on Law Enforcement and Justice, "Crime in Nebraska" reports. U.S. DHHS, Healthy People 2010.

A 2010 objective has also been established for reducing the incidence of physical assaults (both simple and aggravated). The national objective seeks to lower this rate to no more than 13.6 per 1,000 population, while Nebraska's target is to reduce this rate to no more than 6.0 by 2010 (Table 13). The U.S. rate dropped by 30 percent to 21.8 assaults per 1,000 in 2001, while the Nebraska rate decreased by only 5 percent to 11.5 (Figure 126). Neither the state nor the nation is close to achieving their 2010 target rates.

Figure 126
Simple and Aggravated Physical Assaults
in Nebraska (per 1,000 Population)

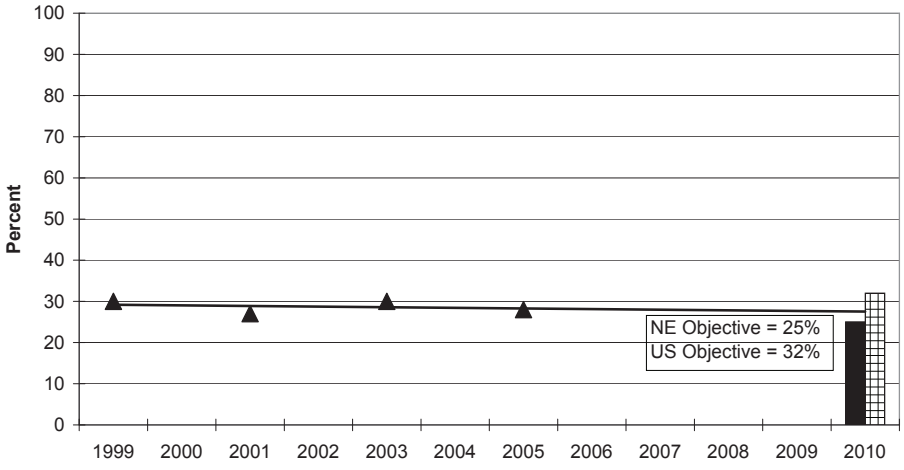


SOURCE: Nebraska Commission on Law Enforcement and Justice. U.S. DHHS, Healthy People 2010.

Physical Fighting and Weapon-Carrying among Adolescents

One of the youth risk behaviors targeted for reduction is the prevalence of physical fighting among high-school students. In Nebraska, the objective has been set to reduce the proportion of youth who participated in physical fighting in the 12 months preceding the survey to no more than 25 percent. The national target rate is no more than 32 percent by 2010 (Table 13). According to the Youth Risk Behavior Survey, there was no change in prevalence of physical fighting nationwide between 1999 and 2005 (36 percent each). In Nebraska, prevalence decreased by one percentage point from 30 percent in 1999 to 29 percent in 2005 (Figure 127).

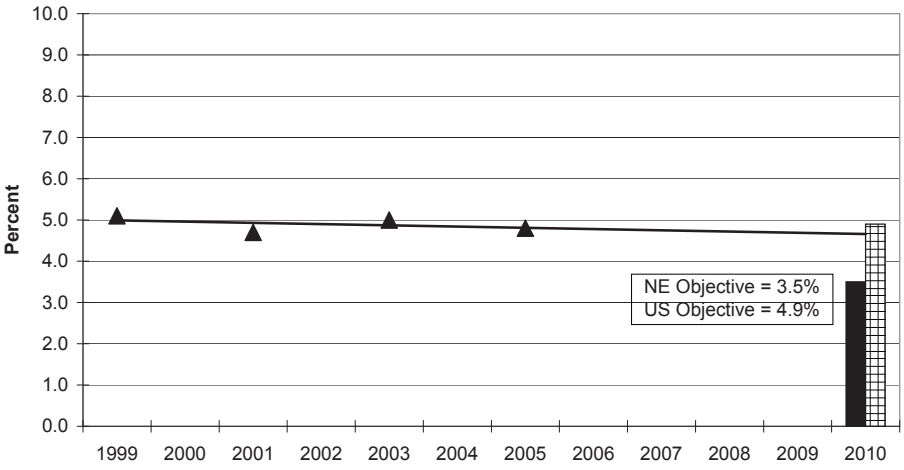
Figure 127
Adolescents (Grades 9-12) Who Engaged in Physical Fighting in the Past 12 Months



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

The prevalence of weapon-carrying on school property among high-school students is another violence-related youth risk behavior selected for reduction. The Nebraska objective is to decrease the proportion of adolescents who carried a weapon on school property on at least one of the 30 days preceding the survey to no more than 3.5 percent by 2010. The U.S. objective is to reduce prevalence to 4.9 percent of adolescents (Table 13). Progress was made nationwide and in Nebraska, with prevalence decreasing by 12 percent in the U.S. to a 2003 rate of 6.1 percent. In the state, prevalence declined by 6 percent to 4.8 percent of adolescents in 2005 (Figure 128).

Figure 128
Nebraska Adolescents (Grades 9-12) Who Carried Weapon on School Property in Past Month



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

MATERNAL, INFANT AND CHILD HEALTH

Healthy People 2010 Goal

The goal of the Maternal, Infant and Child Health objectives is to improve the health and wellbeing of women, infants, children, and families throughout the nation.

Background

The health of mothers, infants and children is of critical importance since they represent a substantial proportion of the population of the United States. Their health is also important as a predictor of the health of the next generation of Americans. In the United States each year, approximately six million women become pregnant. While most women have a normal term pregnancy and deliver a normal infant, not all women experience a safe and healthy pregnancy. Racial and ethnic disparities persist in pregnancy-related deaths, preterm births, infant mortality, and prenatal care rates.

Progress Toward the Healthy People 2010 Objectives

National

Progress was made nationwide for 14 of 18 Maternal, Infant, and Child Health (MCH) objectives shared by Nebraska and the U.S. One of these objectives was achieved nationwide. The proportion of babies who are put down to sleep on their backs doubled from the baseline rate and reached the target rate of 70 percent in 2004.

Infant mortality rates and death rates for children and adolescents in 4 age groups (ages 1 through 19 years) decreased overall. The proportion of women receiving prenatal care was up slightly, as was the proportion of women abstaining from cigarette smoking during pregnancy. More mothers breastfed their babies in the early postpartum period and at age six months. The rate of occurrence of spina bifida and other neural tube defects declined slightly, compared to the baseline.

For two of the shared objectives, current rates showed movement away from their targets. The death rate for young adults (aged 20 to 24 years) increased. The rate of low weight births continued to rise, while no improvement was seen in the proportion of very low weight births. No new data were available to assess the trend in proportion of pregnancies begun with an optimum folic acid level.

It is also necessary to keep in mind that while improvement was achieved in many of these maternal, infant, and child objectives, significant disparities still exist for racial and ethnic minority groups.

Nebraska

Progress was made in Nebraska for 11 of the 18 MCH objectives shared with the nation. The infant mortality rate and the neonatal mortality rate both declined somewhat, compared to the baseline. Death rates were also down from children, adolescents, and young adults in 4 age groups (aged 5 to 24 years). The proportion of healthy full-term infants who are put down to sleep on their backs increased, as did the proportion of pregnancies begun with an optimal folic acid level. More women also abstained from smoking cigarettes during pregnancy and more mothers reported breastfeeding their babies.

On the other hand, movement away from the 2010 target rates was noted for five MCH objectives. The death rate for children aged one to four years increased. Slightly fewer women began receiving prenatal care in the first trimester of pregnancy or received “early and adequate” prenatal care. The rate of low

weight births increased somewhat in Nebraska and the incidence of spinal bifida rose slightly, compared to the 1999 rate.

As was the case nationwide, no improvement was seen in the proportion of very low weight births in Nebraska. The postneonatal death rate (for babies between the ages of 28 days and one year) also remained steady.

Please keep in mind that, although progress was seen in several MCH objectives in Nebraska, racial and ethnic disparities still exist in many of these measures.

Infant Mortality

One of the 2010 MCH objectives for both Nebraska and the United States is to reduce the infant mortality rate to no more than 4.5 infant deaths per 1,000 live births (Table 14). The U.S. rate decreased from 7.2 in 1998 to 6.8 in 2003, while the Nebraska rate also declined somewhat from 6.8 in 1999 to 6.6 in 2004 (Figure 129).

Table 14
Nebraska 2010 Health Goals and Objectives
Maternal, Infant, and Child Health

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#16-1c	Infant mortality rate per 1,000 live births	1998	7.2	2003	6.8	4.5	1999	6.8	2004	6.6	4.5
	White	1998	6.0	2003	5.7	4.5	1995-1999	7.0	2000-2004	5.9	4.5
	African American	1998	13.8	2003	13.5	4.5	1995-1999	16.4	2000-2004	16.9	4.5
	Native American	1998	9.3	2003	8.7	4.5	1995-1999	9.4	2000-2004	14.4	4.5
	Asian American	1998	5.5	2003	4.8	4.5	1995-1999	6.1	2000-2004	3.5	4.5
	Hispanic American	1998	5.8	2003	5.6	4.5	1995-1999	9.1	2000-2004	6.9	4.5
#16-1d	Neonatal death rate (within first 28 days of life) per 1,000 live births	1998	4.8	2003	4.6	2.9	1999	4.5	2004	4.2	2.9
	White	1998	4.0	2003	3.9	2.9	1995-1999	4.8	2000-2004	4.1	2.9
	African American	1998	9.4	2003	9.2	2.9	1995-1999	11.2	2000-2004	11.3	2.9
	Native American	1998	5.0	2003	4.5	2.9	1995-1999	4.7	2000-2004	6.0	2.9
	Asian American	1998	3.9	2003	3.4	2.9	1995-1999	4.7	2000-2004	2.1	2.9
	Hispanic American	1998	3.9	2003	3.9	2.9	1995-1999	6.3	2000-2004	4.8	2.9
#16-1e	Postneonatal death rate (between 28 days and one year) per 1,000 live births	1998	2.4	2003	2.2	1.2	1999	2.3	2004	2.4	1.2
	White	1998	2.0	2003	1.9	1.2	1995-1999	2.2	2000-2004	1.8	1.2
	African American	1998	4.4	2003	4.3	1.2	1995-1999	5.2	2000-2004	5.6	1.2
	Native American	1998	4.4	2003	4.2	1.2	1995-1999	4.7	2000-2004	8.3	1.2
	Asian American	1998	1.7	2003	1.4	1.2	1995-1999	1.4	2000-2004	1.4	1.2
	Hispanic American	1998	1.9	2003	1.7	1.2	1995-1999	2.7	2000-2004	2.1	1.2
#16-2a	Child death rate (children aged one to four years) per 100,000	1998	34.1	2003	31.5	20.0	1998	32.3	2004	38.4	17.4
	White	1998	30.2	2003	28.5	20.0	1994-1998	33.4	2000-2004	33.9	17.4
	African American	1998	55.8	2003	46.8	20.0	1994-1998	89.9	2000-2004	64.0	17.4
	Native American	1998	48.2	2003	50.3	20.0	1994-1998	*	2000-2004	*	17.4
	Asian American	1998	20.1	2003	22.5	20.0	1994-1998	0.0	2000-2004	*	0.0
	Hispanic American	1998	29.4	2003	30.2	20.0	1994-1998	42.1	2000-2004	41.4	17.4

Table 14 continued

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#16-2b	Child death rate (children aged five to nine years) per 100,000	1998	17.2	2003	14.7	13.0	1998	18.8	2004	16.6	13.1
	White	1998	15.4	2003	13.7	13.0	1994-1998	16.4	2000-2004	17.2	13.1
	African American	1998	26.4	2003	19.7	13.0	1994-1998	33.4	2000-2004	37.3	13.1
	Native American	1998	17.3	2003	20.1	13.0	1994-1998	*	2000-2004	*	13.1
	Asian American	1998	13.1	2003	10.6	13.0	1994-1998	0.0	2000-2004	*	0.0
	Hispanic American	1998	14.7	2003	14.0	13.0	1994-1998	11.3	2000-2004	18.1	7.9
#16-3a	Adolescent death rate (aged 10-14 years) per 100,000	1998	21.5	2003	19.1	16.5	1998	23.7	2004	21.2	18.0
	White	1998	20.2	2003	17.8	16.5	1994-1998	23.7	2000-2004	20.4	18.0
	African American	1998	28.5	2003	25.7	16.5	1994-1998	37.2	2000-2004	25.0	18.0
	Native American	1998	23.8	2003	26.9	16.5	1994-1998	58.8	2000-2004	22.8	18.0
	Asian American	1998	18.1	2003	15.6	16.5	1994-1998	0.0	2000-2004	0.0	0.0
	Hispanic American	1998	17.6	2003	17.3	16.5	1994-1998	24.2	2000-2004	14.0	18.0
#16-3b	Adolescent death rate (aged 15-19 years) per 100,000	1998	69.5	2003	66.4	38.0	1998	74.0	2004	67.1	41.7
	White	1998	65.9	2003	64.7	38.0	1994-1998	69.9	2000-2004	64.8	41.7
	African American	1998	95.6	2003	80.0	38.0	1994-1998	140.3	2000-2004	128.1	41.7
	Native American	1998	79.7	2003	96.9	38.0	1994-1998	116.4	2000-2004	132.5	41.7
	Asian American	1998	38.1	2003	38.5	38.0	1994-1998	*	2000-2004	*	41.7
	Hispanic American	1998	62.1	2003	67.2	38.0	1994-1998	96.6	2000-2004	65.8	41.7
#16-3c	Young adult death rate (aged 20-24 years) per 100,000	1998	92.7	2003	96.4	41.5	1998	78.9	2004	70.9	40.6
	White	1998	83.2	2003	89.4	41.5	1994-1998	75.8	2000-2004	76.8	40.6
	African American	1998	158.3	2003	147.3	41.5	1994-1998	131.3	2000-2004	139.1	40.6
	Native American	1998	127.6	2003	121.0	41.5	1994-1998	180.0	2000-2004	121.2	40.6
	Asian American	1998	41.6	2003	46.6	41.5	1994-1998	*	2000-2004	*	40.6
	Hispanic American	1998	84.4	2003	85.7	41.5	1994-1998	129.6	2000-2004	64.3	40.6
#16-6a	Percent of pregnant women who begin prenatal care in the first trimester of pregnancy	1998	83	2003	84	90	1999	84.2	2004	82.7	90
	White	1998	85	2003	86	90	1999	85.4	2004	84.0	90
	African American	1998	73	2003	76	90	1999	73.8	2004	72.2	90
	Native American	1998	69	2003	71	90	1999	66.7	2004	69.2	90
	Asian American	1998	83	2003	85	90	1999	82.7	2004	84.5	90
	Hispanic American	1998	74	2003	77	90	1999	68.5	2004	70.7	90
#16-6b	Percent of pregnant women who receive early and adequate prenatal care (as measured by the Kotelchuck Index)	1998	74	2003	75	90	1999	73.8	2004	71.2	90
	White	1998	76	2003	77	90	1999	74.9	2004	72.4	90
	African American	1998	67	2003	69	90	1999	65.0	2004	62.6	90
	Native American	1998	57	2003	60	90	1999	52.9	2004	51.9	90
	Asian American	1998	74	2003	75	90	1999	73.2	2004	69.5	90
	Hispanic American	1998	66	2003	69	90	1999	58.3	2004	63.5	90
#16-10a	Rate of low weight births per 100 live births (%)	1998	7.6	2003	7.9	5.0	1999	6.7	2004	7.1	5.0
	White	1998	6.5	2003	6.9	5.0	1994-1998	6.1	2000-2004	6.6	5.0
	African American	1998	13.0	2003	13.4	5.0	1994-1998	12.0	2000-2004	12.5	5.0
	Native American	1998	6.8	2003	7.4	5.0	1994-1998	5.8	2000-2004	6.7	5.0
	Asian American	1998	7.4	2003	7.8	5.0	1994-1998	7.4	2000-2004	7.8	5.0
	Hispanic American	1998	6.4	2003	6.7	5.0	1994-1998	6.3	2000-2004	6.2	5.0

Table 14 continued

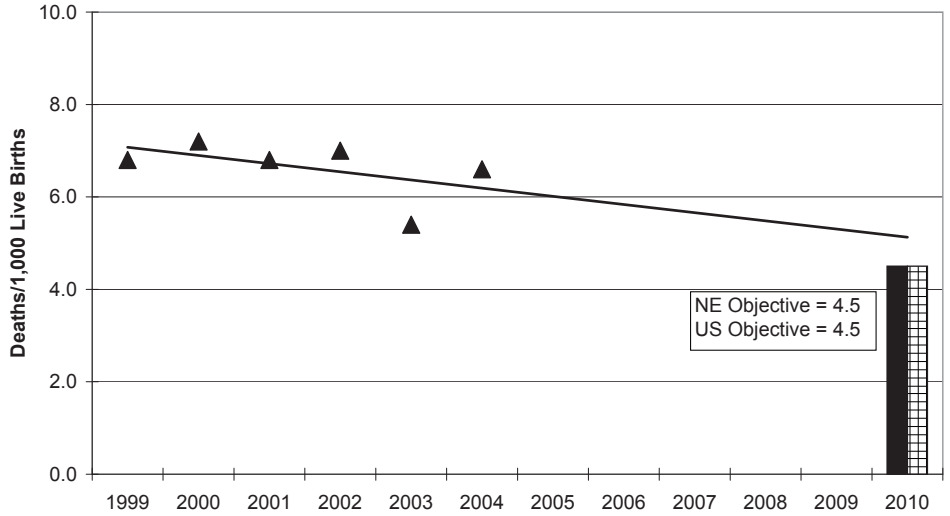
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#16-10b	Rate of very low weight births per 100 live births (%)	1998	1.4	2003	1.4	0.9	1999	1.2	2004	1.2	0.9
	White	1998	1.1	2003	1.2	0.9	1994-1998	1.1	2000-2004	1.2	0.9
	African American	1998	3.1	2003	3.1	0.9	1994-1998	2.6	2000-2004	2.8	0.9
	Native American	1998	1.2	2003	1.3	0.9	1994-1998	0.7	2000-2004	1.1	0.5
	Asian American	1998	1.1	2003	1.1	0.9	1994-1998	1.0	2000-2004	1.2	0.9
	Hispanic American	1998	1.1	2003	1.2	0.9	1994-1998	1.0	2000-2004	1.0	0.9
#16-13	Percent of healthy full-term infants who are put down to sleep on their backs	1996	35	2004	70	70	1999	58	2003	69	70
	White, non-Hispanic	1996	37	2004	72	70	1999	61	2003	72	70
	African American, non-Hispanic	1996	18	2004	60	70	1999	33	2003	NA	70
	Native American	1996	NA	2004	NA	70	1999	52	2003	NA	70
	Asian American	1996	NA	2004	NA	70	1999	68	2003	69	70
	Hispanic American	1996	28	2004	67	70	1999	47	2003	61	70
#16-15	Rate of occurrence of spina bifida and other neural tube defects per 10,000 live births and stillborn cases	1996	6	2000	5	3	1999	4.2	2004	4.5	2.3
	Data currently not available by race or ethnicity										
#16-16	Percent of pregnancies begun with an optimum folic acid level (I.e., consumption of at least 400 ug of folic acid each day from fortified foods or dietary supplements by nonpregnant women aged 15 to 44 years)	1991-94	21%	No New Data Available		80%	2000	46%	2001-2003	50%	80%
	White								2001-2003	53%	80%
	African American								2001-2003	34%	80%
	Native American								2001-2003	47%	80%
	Asian American								2001-2003	32%	80%
	Hispanic American								2001-2003	32%	80%
#16-17c	Percent of women who abstained from cigarette smoking during pregnancy	1998	87	2003	89	99	1999	84.9	2004	87.2	98.0
	White	1998	86	2003	88	99	1994-1998	82.9	2000-2004	85.8	98.0
	African American	1998	90	2003	92	99	1994-1998	83.4	2000-2004	84.7	98.0
	Native American	1998	80	2003	82	99	1994-1998	65.2	2000-2004	70.5	98.0
	Asian American	1998	97	2003	98	99	1994-1998	94.8	2000-2004	96.1	98.0
	Hispanic American	1998	96	2003	97	99	1994-1998	93.7	2000-2004	95.9	98.0
#16-19a	Percent of mothers who breastfeed their babies in early postpartum period	1998	64	2003	68	75	1998	68	2003	74	80
	Low-income	1998	53	2003	NA	75	1998	52	2003	67	80
#16-19b	Percent of mothers who breastfeed their babies at age six months	1998	29	2003	33	50	1998	31	2003	31	50
	Low-Income	1998	19	2003	NA	50	1998	15	2003	22	50

*Fewer than five deaths during the five-year period. NA = Not Available

Data Sources:		Additional Notes;
#16-1c	U.S.--National Vital Statistics System (NVSS), CDC. Nebraska--Vital Statistics, HHSS.	Deaths of infants under age one year. Same as U.S.
#16-1d,e	U.S.--National Vital Statistics System (NVSS), CDC. Nebraska--Vital Statistics, HHSS.	
#16-2,16-3	U.S.--National Vital Statistics System (NVSS), CDC. Nebraska--Vital Statistics, HHSS.	

Table 14 continued		
#16-6a, 6b	U.S.--National Vital Statistics System (NVSS), CDC. Nebraska--Vital Statistics, HHSS.	Using the Adequacy of Prenatal Care Utilization Index (APNCU), i.e., Kotelchuck Index. Combines the month of pregnancy when prenatal care began with the number of prenatal visits. Rates can be classified as intensive, adequate, intermediate, or less than adequate. For this objective, adequate prenatal care is defined as a score of either "adequate" or "intensive use." Same as U.S.
#16-10a	U.S.--National Vital Statistics System (NVSS), CDC. Nebraska--Vital Statistics, HHSS.	Low weight births = live births with birth weights of less than 2,500 grams (5.5 lbs.). Same as U.S.
#16-10b	U.S.--National Vital Statistics System (NVSS), CDC. Nebraska--Vital Statistics, HHSS.	Very low weight births = live births with birth weights of less than 1,500 grams (3 lbs. 4 oz.). Same as U.S.
#16-13	U.S.--National Infant Sleep Position Study, NIH, NICHD. Nebraska--Pregnancy Risk Assessment Monitoring System (PRAMS).	Infants (less than eight months of age) put down to sleep on their backs. Infants (aged 60 days to 9 months) put down to sleep on their backs.
#16-15	U.S.--National Birth Defects Prevention Network, CDC. Nebraska--Birth Defects Registry, Vital Statistics, HHSS.	Number of live births and fetal deaths of 20 or more weeks gestation diagnosed with spina bifida and other neural tube defects (ICD-9 codes 740-742.0).
#16-16	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC. Nebraska--BRFSS, HHS.	Percent of non-pregnant females aged 15 to 44 years who report consuming an average of 400 micrograms of folic acid daily over the past month. Only folic acid intake from dietary supplements is included. Percent of females aged 18 to 44 years who report taking vitamin pills or supplements containing folic acid, combined with data on how frequently they take these pills or supplements.
#16-17c	U.S.--National Vital Statistics System (NVSS), CDC. Nebraska--Vital Statistics, HHSS.	Percent of women having live births reporting abstaining from cigarette smoking during pregnancy. Same as U.S.
#16-19a	U.S.--Mothers' Survey, Abbott Laboratories, Inc., Ross Products Division. Nebraska--Mothers' Survey, Abbott Laboratories, Inc., Ross Products Division. Low-income mothers--WIC, Family Health Division, HHSS.	Percent of mothers with infants aged one to two months who indicate that breast milk was at least one of the types of milk their infant was fed in the hospital. Early postpartum breastfeeding is defined as breastfeeding a newborn infant before being discharged from the hospital. Same as U.S.
#16-19b	U.S.--Mothers' Survey, Abbott Laboratories, Inc., Ross Products Division. Nebraska--Mothers' Survey, Abbott Laboratories, Inc., Ross Products Division. Low-income mothers--WIC, Family Health Division, HHSS.	Percent of mothers who indicate that breast milk is at least one of the types of milk their infant was fed six months after delivery. Same as U.S.

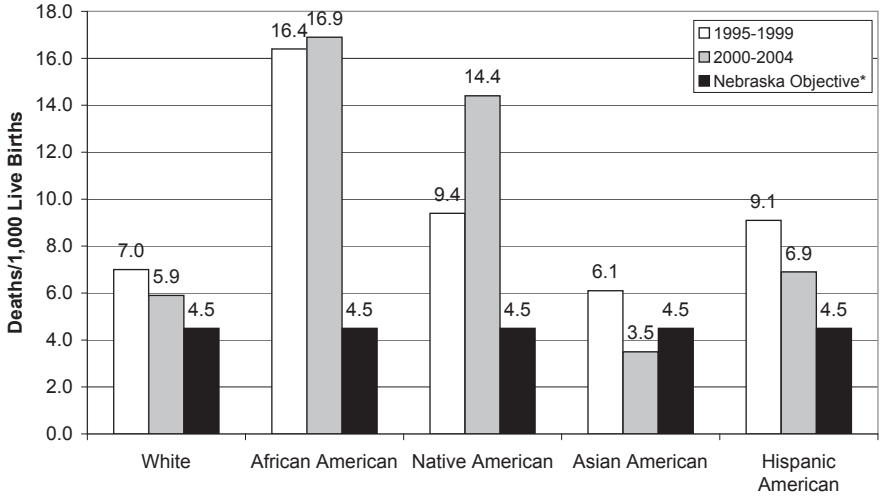
Figure 129
Infant Mortality in Nebraska



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

In Nebraska, the infant mortality rates for African Americans and Native Americans increased from their 1994-1999 baselines (Figure 130). The 2000-2004 rate for African Americans (16.9 deaths per 1,000 live births) was 2.9 times as high as the current rate for white infants (5.9). For Native Americans, the 2000-2004 rate (14.4) was 2.4 times the rate for white babies. Infant mortality rates decreased for Hispanic Americans, whites, and Asian Americans in the state. Asian Americans reported the lowest rate (3.5 infant deaths per 1,000 live births) and were the only group to achieve the 2010 objective. A revised target rate of no more than 2.5 infant deaths per 1,000 live births has been set for Asian Americans (Appendix, Table A).

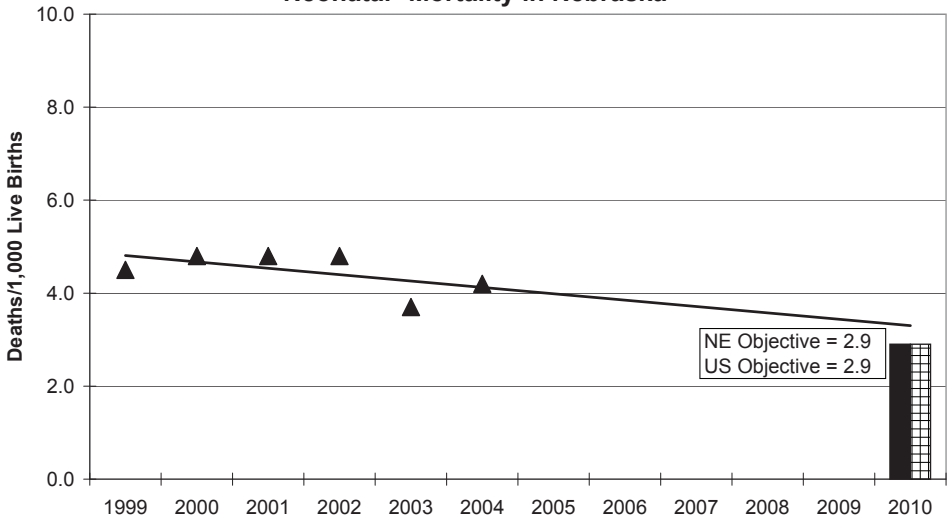
Figure 130
Infant Mortality in Nebraska by Race/Ethnicity



*Nebraska objective has been met for Asian Americans and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics.

Neonatal deaths occur within the first 28 days of life. The 2010 objective (both nationwide and in Nebraska) is to reduce the neonatal death rate to no more than 2.9 deaths per 1,000 live births (Table 14). Modest reductions in this rate were achieved in the U.S. and in Nebraska, with the 2004 Nebraska rate (4.2) somewhat lower than the 2003 U.S. one (4.6) (Figure 131).

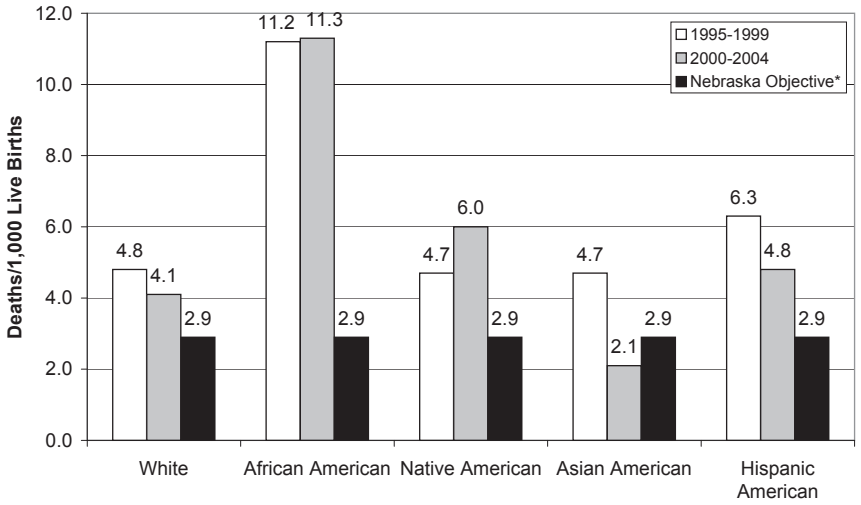
Figure 131
Neonatal* Mortality in Nebraska



*Neonatal deaths occur during the first 28 days of life.
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

The neonatal mortality rate was by far the highest for African American infants (11.3 in 2000-2004) in Nebraska (Figure 132). The rate for Native American infants increased somewhat to 6.0 in 2000-2004 and was higher than the rates for all groups except African Americans. For Hispanic American babies, the neonatal death rate (4.8 in 2000-2004) was also higher than the white rate (4.1) and the rate for Asian American babies (2.1). Asian Americans were the only group to reach the target rate for 2010. The revised objective for Asian Americans in Nebraska seeks to further reduce the neonatal mortality rate to no more than 1.2 per 1,000 live births by 2010 (Appendix, Table A).

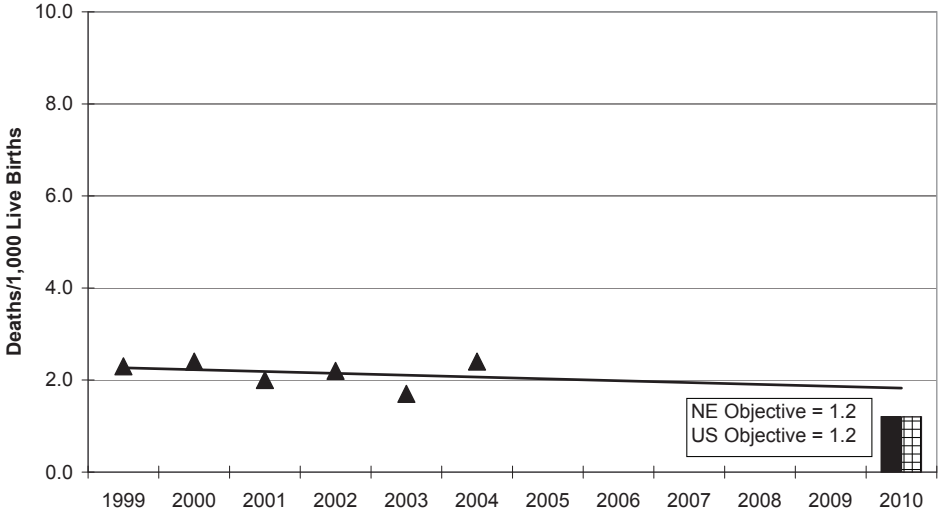
Figure 132
Neonatal Mortality in Nebraska by Race/Ethnicity



*Nebraska objective has been met for Asian Americans and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics.

Postneonatal deaths are those occurring among infants between the ages of 28 days and one year. The U.S. and the Nebraska objectives are the same—to reduce this rate to no more than 1.2 postneonatal deaths per 1,000 live births by 2010 (Table 14). The U.S. rate decreased slightly (from 2.4 in 1998 to 2.2 in 2004), while the Nebraska rate remained nearly steady, edging upward from 2.3 in 1999 to 2.4 in 2005 (Figure 133).

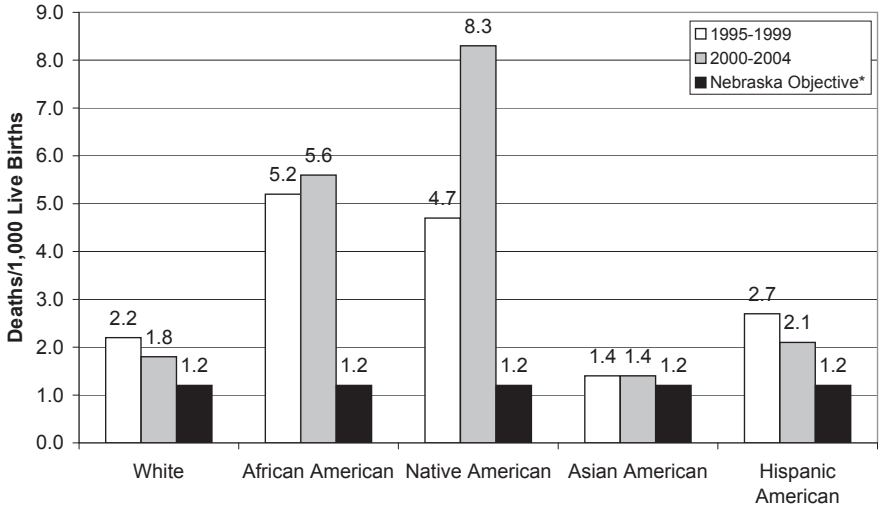
Figure 133
Postneonatal* Mortality in Nebraska



*Postneonatal deaths occur between the 29th day of life and the first birthday.
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Postneonatal mortality rates increased for both African Americans and Native Americans in Nebraska (Figure 134). The 2000-2004 rate for Native American infants (8.3) was more than four times as high as the current rates for Hispanic Americans (2.1), whites (1.8), and Asian Americans (1.4). The current rate for African American babies (5.6) was more than triple the rates for white and Asian American babies.

Figure 134
Postneonatal Mortality in Nebraska by Race/Ethnicity

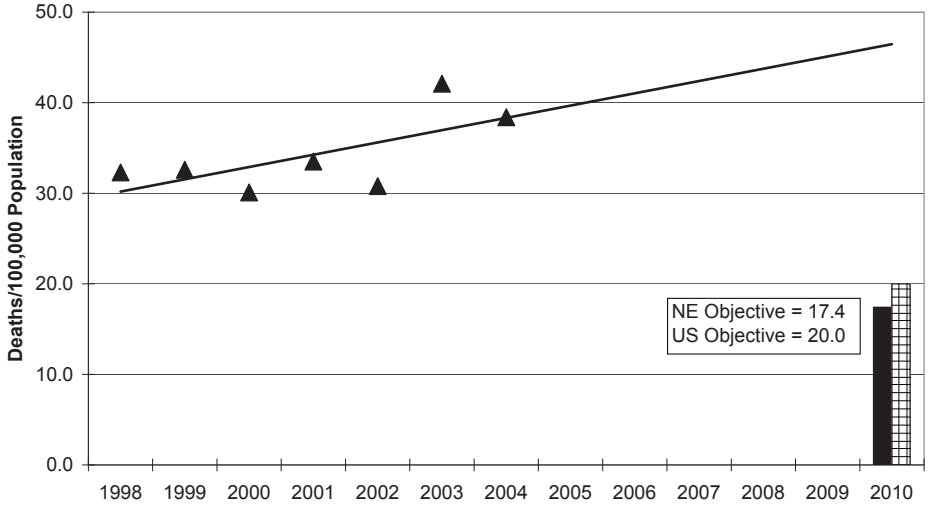


SOURCE: Nebraska HHSS, Vital Statistics.

Child, Adolescent and Young Adult Death Rates

Child and adolescent mortality rates in the United States and in Nebraska have generally declined over the past two decades. However, this trend does not hold true for all age groups. The Nebraska objective for mortality among young children (aged 1 to 4 years) is to reduce deaths to no more than 17.4 per 100,000 children in this age group. Instead, the state's mortality rate has increased by 19 percent from the 1988 baseline to 38.4 per 100,000 children in 2004 (Figure 135), although the national rate has declined. The current Nebraska rate is higher than the 2003 U.S. rate of 31.5.

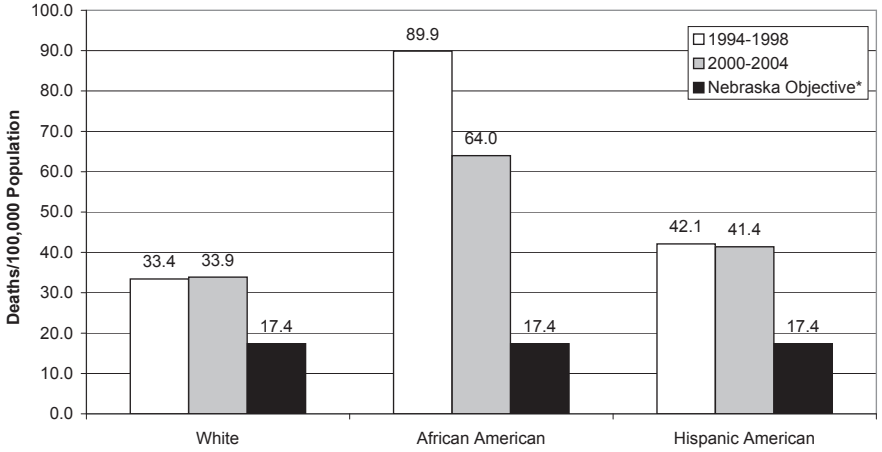
Figure 135
Death Rates - Children Aged 1-4 Years in Nebraska



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Death rates for children one to four years of age differ by race and ethnic origin (Figure 136). Although the rate for young African American children in the state has declined by 29 percent since 1994-1998, the 2000-2004 rate (64.0 deaths per 100,000) is 1.9 times as high as the rate for white children in this age group (33.9) and 1.6 times as high as the rate for Hispanic children (41.4) in Nebraska.

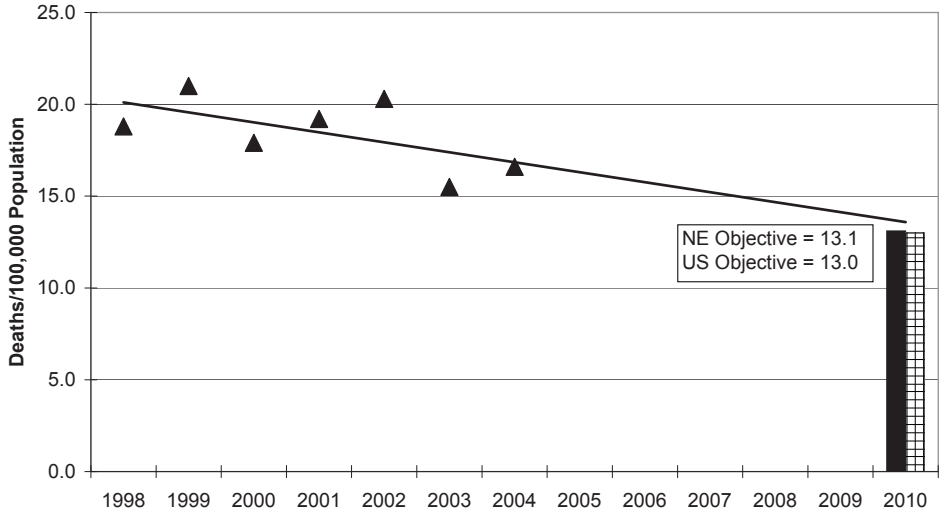
Figure 136
Death Rates - Children Aged 1-4 in Nebraska by Race/Ethnicity*



*Rates are not reported here for Native Americans and Asian Americans. Fewer than five deaths occurred for each group during these five-year periods.
SOURCE: Nebraska HHSS, Vital Statistics.

For children aged five to nine years, the Nebraska objective is to reduce deaths to no more than 13.1 per 100,000 children in this age group. Mortality rates in the state and the U.S. were both down from the 1998 rates. The current Nebraska rate (16.6 in 2004) represents a decrease of 12 percent from the 1998 baseline of 18.8 (Figure 137). However, the state rate is still higher than the national rate of 14.7 deaths per 100,000 children aged 5 to 9 years.

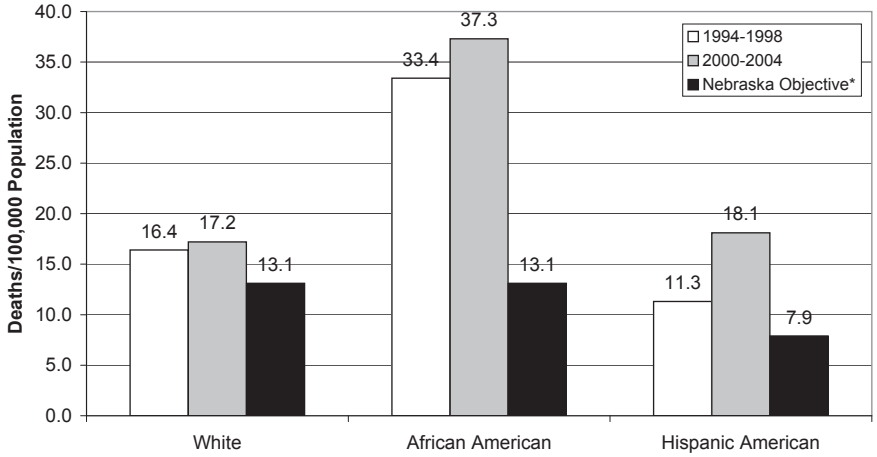
Figure 137
Death Rates - Children Aged 5-9 Years in Nebraska



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

As with children aged one to four, the mortality rate for children aged five to nine was much higher among African Americans in Nebraska (37.3) in 2000-2004 than among Hispanic Americans (18.1) or whites (17.2) in the state (Figure 138).

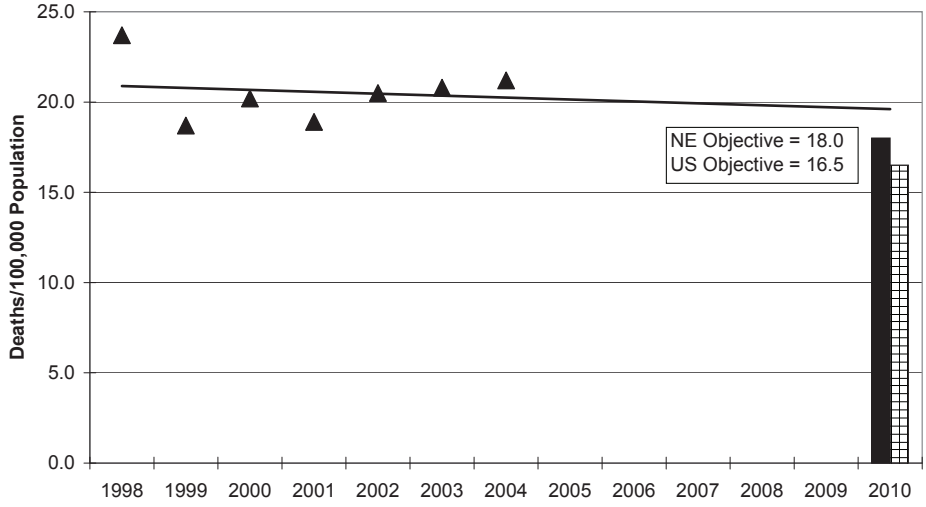
Figure 138
Death Rates - Children Aged 5-9 in Nebraska
by Race/Ethnicity*



*Rates are not reported here for Native Americans and Asian Americans. Fewer than five deaths occurred for each group during these five-year periods.
SOURCE: Nebraska HHSS, Vital Statistics.

Death rates for adolescents aged 10 to 14 years declined for Nebraska and the nation. In Nebraska, the objective is to reduce deaths to no more than 18.0 per 100,000 people in this age group. The 2004 rate of 21.2 is down 11 percent from the 1988 rate of 23.7 (Figure 139). Still, the Nebraska rate is higher than the 2003 U.S. rate of 19.1 deaths per 100,000.

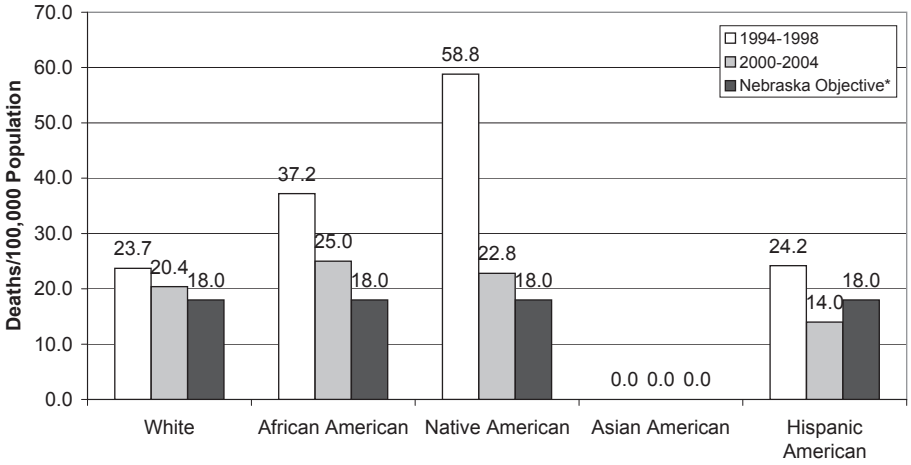
Figure 139
Death Rates - Children Aged 10 - 14 Years in Nebraska



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Unlike the mortality rates for the two younger age groups (children 1 to 4 years and children 5 to 9 years) in Nebraska, 2000-2004 mortality rates for adolescents aged 10 to 14 years varied only moderately by race or ethnic origin (Figure 140). Substantial reductions occurred in rates for Native Americans (22.8) and African Americans (25.0) in the current period, bringing mortality rates near the rate for white adolescents (20.4) in the state. For Hispanic adolescents, the current rate of 14.0 represents a 42 percent reduction from the baseline and meets the 2010 objective for this group. The death rate for Asian Americans in this age group remained at zero, thus achieving their 2010 objective. A revised target rate of no more than 9.8 adolescent deaths per 100,000 has been adopted for Hispanic Americans in the state (Appendix, Table A). For Asian Americans, the target rate will remain at zero.

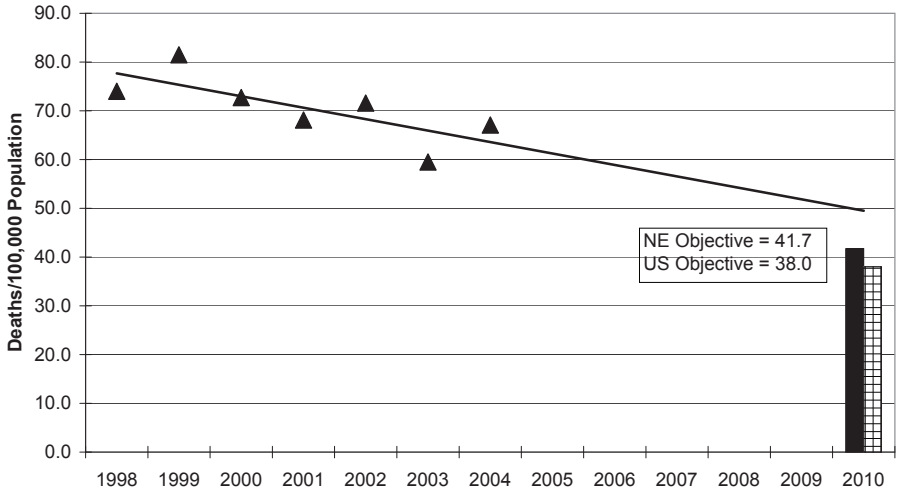
Figure 140
Death Rates - Children Aged 10-14 in Nebraska
by Race/Ethnicity



*Nebraska objectives have been met for Asian and Hispanic Americans. Objective will be revised for Hispanic Americans.
SOURCE: Nebraska HHSS, Vital Statistics.

For adolescents aged 15 to 19 years, the Nebraska objective is to reduce deaths to no more than 41.7 per 100,000 population in this age group by 2010, while the national target rate is 38.0 deaths per 100,000. Death rates decreased somewhat in the U.S. and in Nebraska (Figure 141), with the current rates very similar (66.4 nationwide and 67.1 in Nebraska).

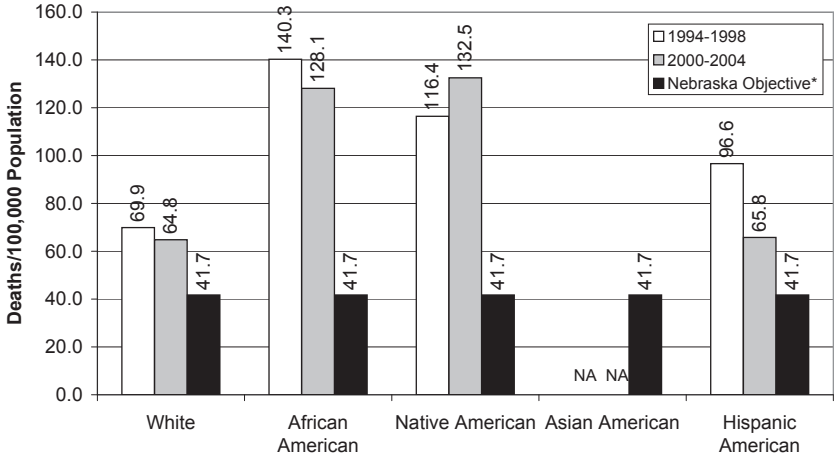
Figure 141
Death Rates - Adolescents Aged 15-19 Years in Nebraska



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

In 2000-2004, death rates for 15- to 19-year-olds in Nebraska were nearly twice as high for African Americans (128.1) and Native Americans (132.5) as for white (64.8) and Hispanic American (65.8) adolescents (Figure 142).

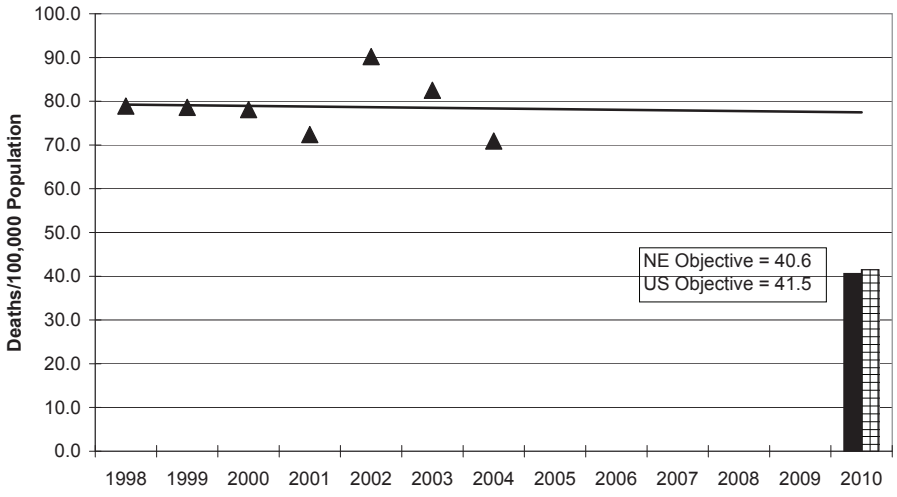
Figure 142
Death Rates - Adolescents Aged 15-19 in Nebraska
by Race/Ethnicity



NA = Not Available. Rate not reported due to fewer than five deaths during five-year period.
SOURCE: Nebraska HHSS, Vital Statistics.

For young adults aged 20 to 24 years, the 2010 objective is to reduce deaths to no more than 41.5 per 100,000 nationwide and to no more than 40.6 per 100,000 in Nebraska (Table 14). In the U.S., the current rate of 96.4 deaths per 100,000 represents a slight increase from the 1998 rate (92.7) for young adults and is more than double the 2010 objective. In Nebraska, the 2004 rate (70.9) is much lower than the national rate and the trend is slightly downward from the baseline rate (78.9) (Figure 143).

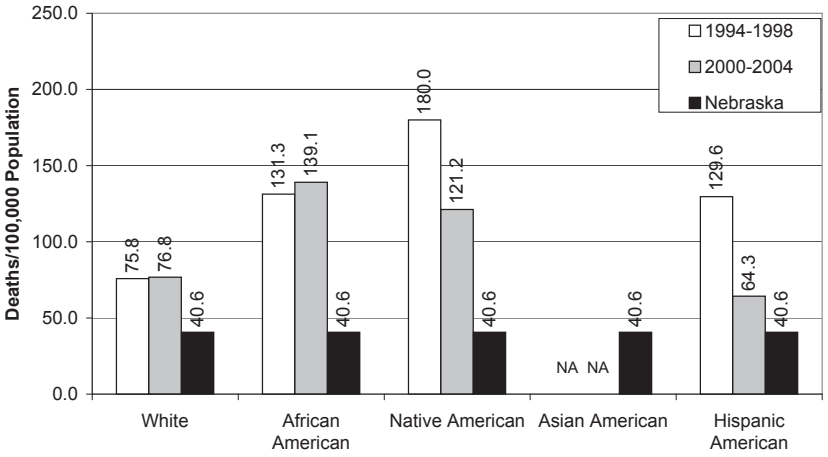
Figure 143
Death Rates - Young Adults Aged 20 - 24 Years in Nebraska



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

In 2000-2004, the death rate for African American young adults (139.1) is much higher than the rate for white persons aged 20 to 24 years (76.8). Both African American and white young adults experienced slight increases, compared to 1994-1998 rates (Figure 144). Death rates for Native Americans in this age group decreased by one-third from the baseline, but the 2000-2004 rate (121.2) was still much higher than the rate for whites. The 2000-2004 death rate for Hispanic American young adults (64.3) was down 50 percent from 1994-1998 and was the lowest of the four racial/ethnic groups for which rates were reported.

Figure 144
Death Rates - Young Adults Aged 20-24 in Nebraska
by Race/Ethnicity

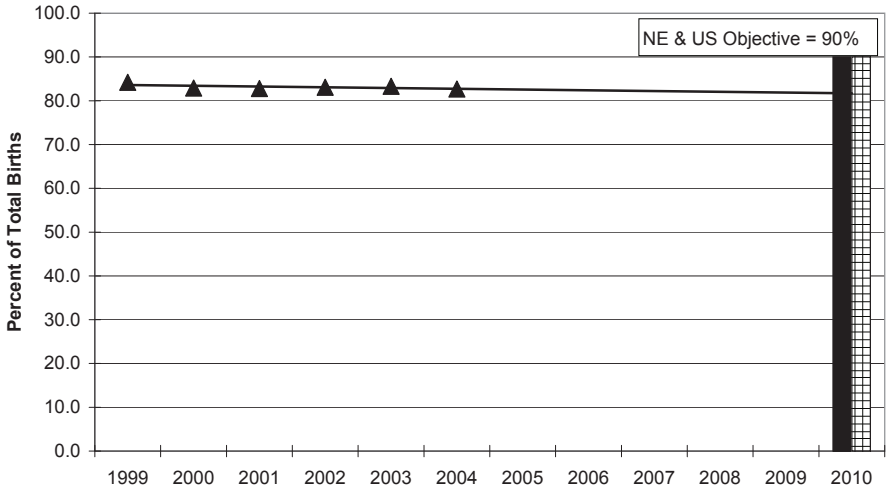


NA = Not Available. Data reported due to fewer than five deaths during the five-year period.
SOURCE: Nebraska HHSS, Vital Statistics.

Prenatal Care

Nebraska and the U.S. have both adopted a 2010 objective to increase to at least 90 percent the proportion of pregnant women who began receiving prenatal care in the first three months of pregnancy (Table 14). Not much progress has been made toward this objective at either the state or the national level. In the U.S., 84 percent of pregnant women in 2003 got first trimester prenatal care, up one percentage point from the 1998 baseline. In Nebraska, there was slight movement away from the target rate with 82.7 percent of mothers receiving first trimester care in 2004, compared to 84.2 percent in 1999 (Figure 145).

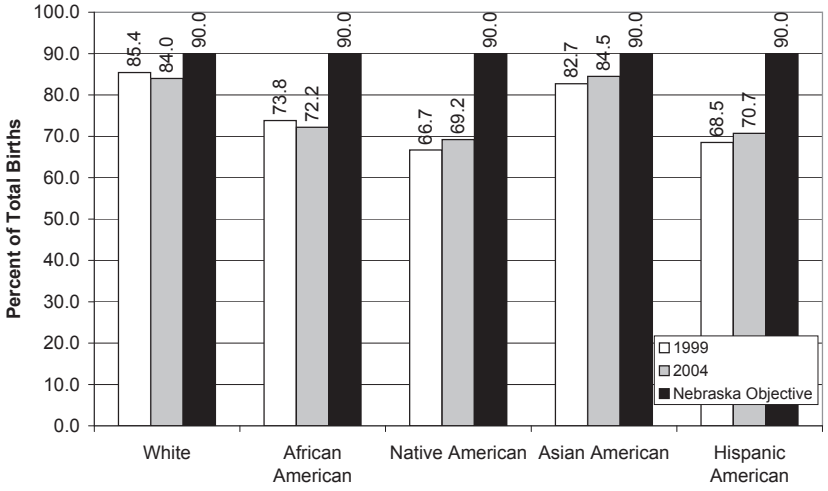
Figure 145
First Trimester Prenatal Care in Nebraska



SOURCE: Nebraska HHSS, Vital Statistics. U. S. DHHS, Healthy People 2010.

Some improvement was noted in first trimester prenatal care rates for Native Americans, Asian Americans, and Hispanic Americans in Nebraska in 2004, compared to 1999 baseline rates (Figure 146). However, slight decreases in the proportion of pregnant women receiving first trimester care were evident for white and African American women in the state. In 2004, Asian American (84.5 percent) and white (84.0 percent) women in Nebraska were much more likely to begin receiving prenatal care in the first three months of pregnancy than Native American (69.2 percent), Hispanic American (70.7 percent), or African American (72.2 percent) women.

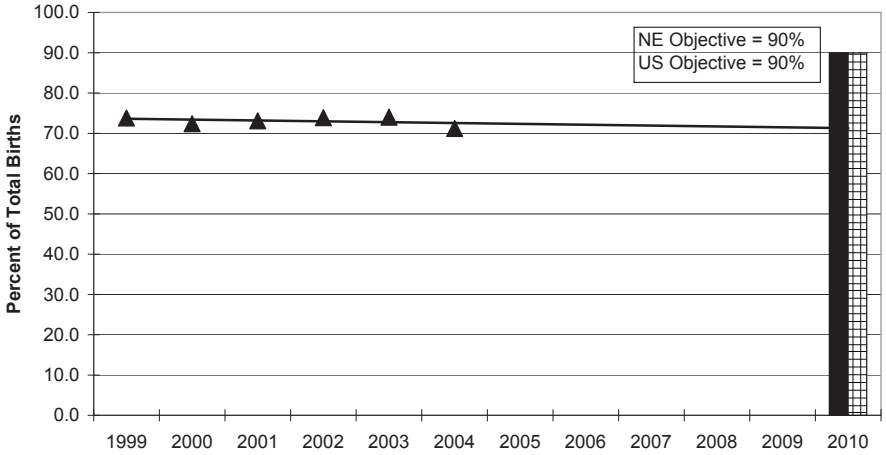
Figure 146
First Trimester Prenatal Care in Nebraska by Race/Ethnicity



SOURCE: Nebraska HHSS, Vital Statistics.

The Kotelchuk Index is used to track the proportion of women receiving "early and adequate" prenatal care. This method takes into account the month of pregnancy when prenatal care began along with the number of prenatal visits. As with the first trimester prenatal care objective, both the U.S. and Nebraska have set a target rate of at least 90 percent of pregnant women receiving "early and adequate" prenatal care (Table 14). Nationwide, the proportion of women getting this care was 75 percent in 2003, up one percentage point from 1998. In Nebraska, only 71.2 percent received early and adequate prenatal care in 2004. This rate was down slightly from the 1999 baseline of 73.8 percent (Figure 147).

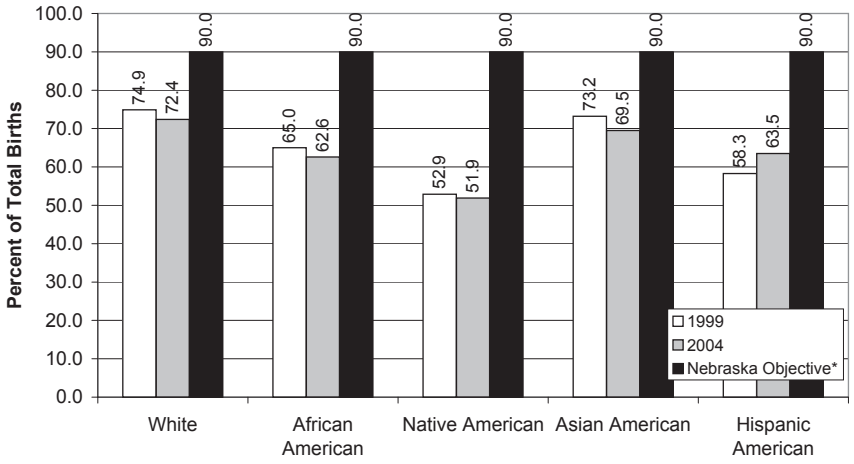
Figure 147
Mothers Receiving Early and Adequate* Prenatal Care in Nebraska



*Based on Adequacy of Prenatal Care Utilization Index (Kotelchuk Index).
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Looking at "early and adequate" prenatal care rates by race and ethnic origin in 2004, the proportion of Nebraska women getting this level of care declined for each group except Hispanic women (Figure 148). Among Hispanic mothers, the rate increased from 58.3 percent in 1999 to 63.5 percent in 2004. The proportion of women receiving early and adequate prenatal care was highest among white (72.4 percent) and Asian American (69.5 percent) women in the state, while little more than one-half of Native American mothers (51.9 percent) reported this level of care in 2004.

Figure 148
Mothers Receiving Early and Adequate* Prenatal Care in Nebraska by Race/Ethnicity



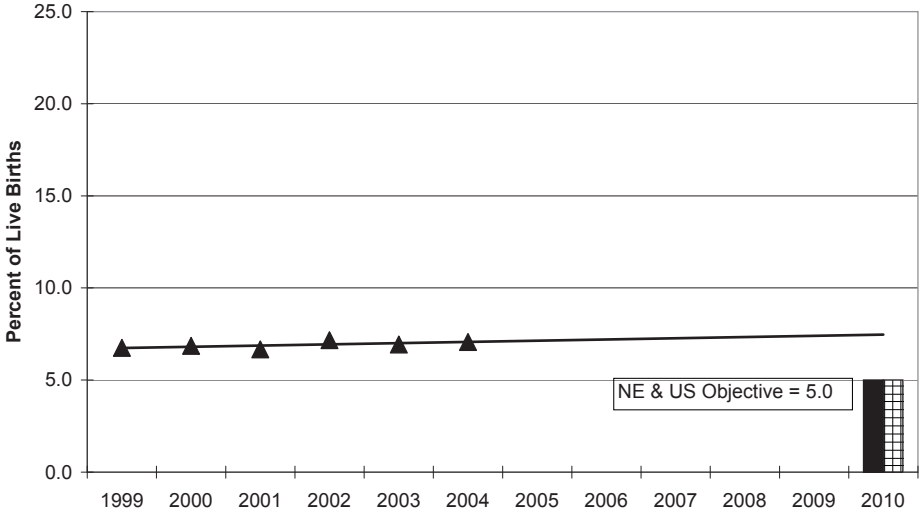
*Based on Adequacy of Prenatal Care Utilization Index (Kotelchuk Index).
SOURCE: Nebraska HHSS, Vital Statistics.

Incidence of Low and Very Low Weight Births

Infants weighing less than 2,500 grams (i.e., 5 pounds 8 ounces) are considered low birth weight (LBW) babies, while those weighing less than 1,500 grams (i.e., 3 pounds 5 ounces) are termed very low birth weight (VLBW) babies.

One of the MCH objectives for Nebraska and the U.S. is to reduce the proportion of low birth weight infants to no more than 5.0 percent by 2010. Unfortunately, the rate of low weight births showed no improvement from the baseline, either nationwide or in Nebraska. The U.S. rate increased slightly, from 7.6 percent in 1998 to 7.9 percent in 2003 (Table 14). In Nebraska, the rate was somewhat lower, but increased from 6.7 percent in 1999 to 7.1 percent in 2004 (Figure 149).

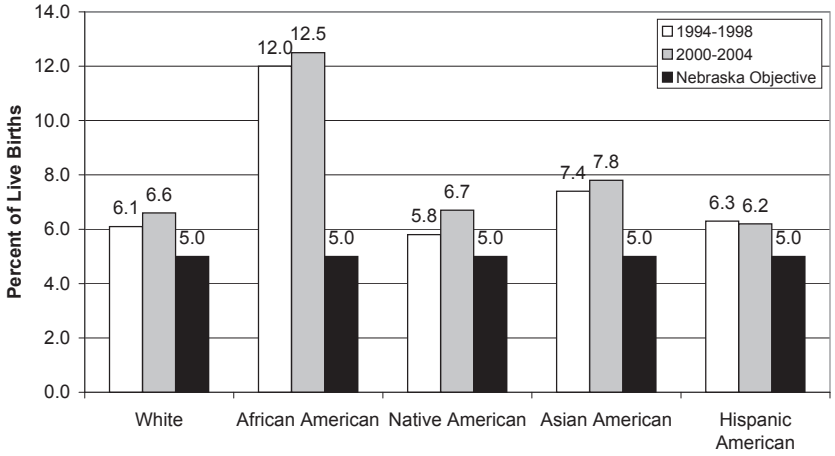
Figure 149
Prevalence of Low Weight* Births in Nebraska



*Low Birth Weight = < 2,500 grams
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Prevalence of low weight births rose for every racial or ethnic group in Nebraska except Hispanic Americans, where the rate remained nearly steady at 6.2 percent in 2000-2004 (Figure 150). The LBW rate continued to be by far the highest for African Americans (12.5 percent in 2004).

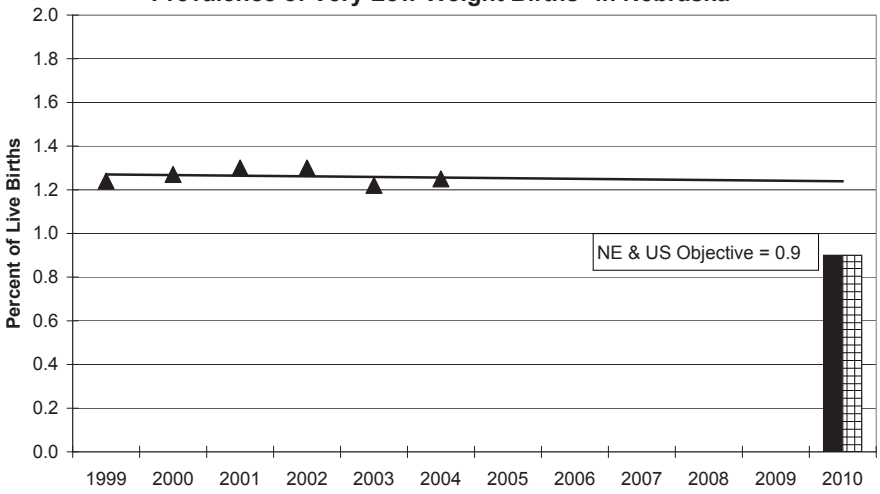
Figure 150
Prevalence of Low Weight* Births in Nebraska
by Race/Ethnicity



*Low Birth Weight = < 2,500 grams
SOURCE: Nebraska HHSS, Vital Statistics.

A related objective seeks to reduce the prevalence of very low weight births to no more than 0.9 percent by 2010, both in the U.S. and in Nebraska (Table 14). No change was seen in the VLBW rate either nationally (1.4 percent) or in Nebraska (1.2 percent) (Figure 151).

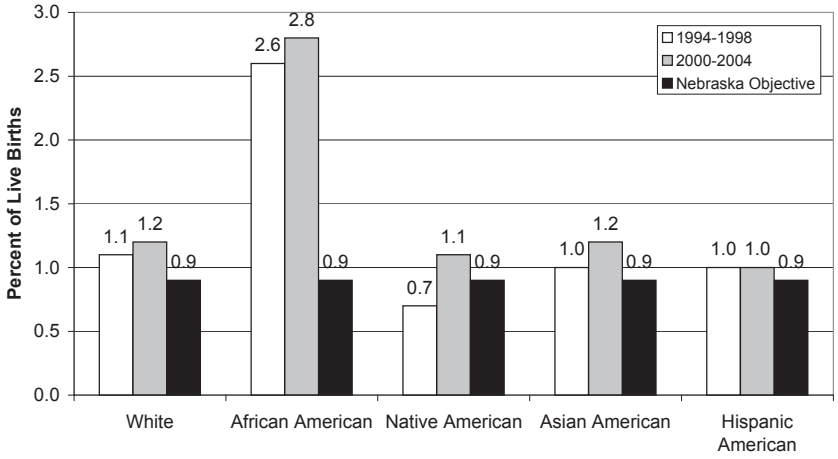
Figure 151
Prevalence of Very Low Weight Births* in Nebraska



*Very Low Birth Weight = < 1,500 grams
SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

The VLBW rate was more than twice as high for African Americans (2.8 percent in 2000-2004) as for any other racial/ethnic group in the state (Figure 152). Rates for other groups ranged from 1.0 percent for Hispanic Americans to 1.2 percent for white and Asian Americans in Nebraska.

Figure 152
Prevalence of Very Low Weight Births* in Nebraska
by Race/Ethnicity



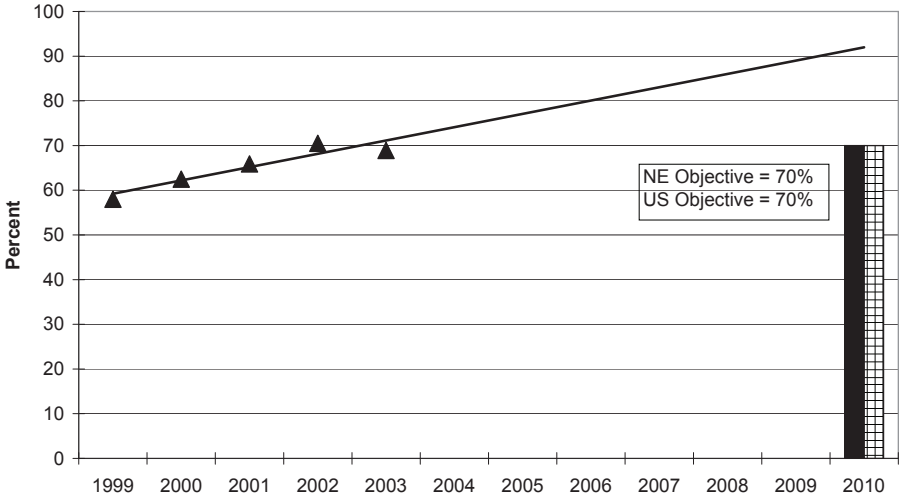
*Very Low Birth Weight = < 1,500 grams
SOURCE: Nebraska HHSS, Vital Statistics.

Prevalence of Back-Sleeping Among Infants

Each year in the United States, more than 4,500 infants die suddenly of no obvious cause. Half of these sudden, unexplained infant deaths are due to sudden infant death syndrome (SIDS), the leading cause of all deaths among infants aged one to twelve months. Based on research studies regarding SIDS and sleep position, the American Academy of Pediatrics currently recommends that caregivers place infants on their backs to sleep to reduce the risk of SIDS. In 1994, the National Institute of Child Health and Human Development and the Maternal and Child Health Bureau instituted the "Back to Sleep" campaign to educate parents and physicians. Since that time, SIDS deaths have decreased significantly.

Both Nebraska and the nation have established an objective to increase the proportion of healthy full-term infants who are put down to sleep on their backs to at least 70 percent by the year 2010 (Table 14). In the U.S., the rate doubled from 35 percent in 1996 to 70 percent in 2004, thus meeting this objective. In Nebraska, the rate increased from 58 percent in 1999 to 69 percent in 2003, nearly achieving the target rate (Figure 153).

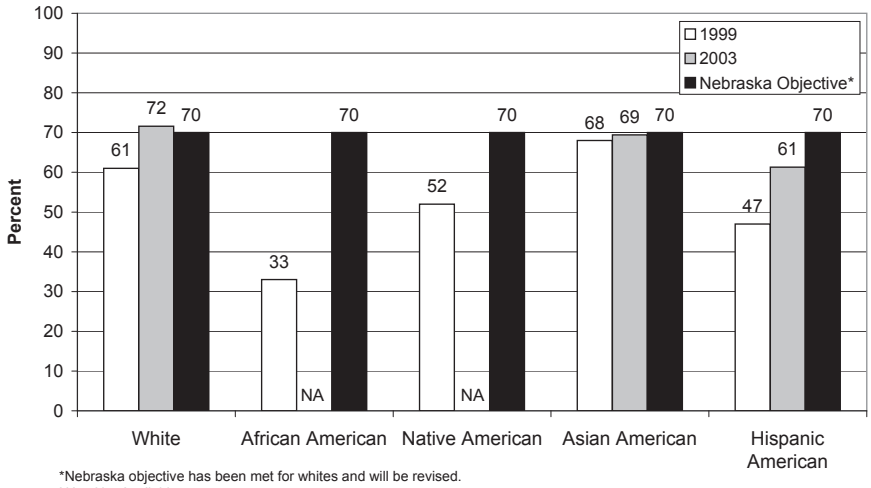
Figure 153
Healthy Full-Term Infants Put Down to Sleep on Their Backs



SOURCE: Nebraska HHSS, PRAMS Surveillance. U.S. DHHS, Healthy People 2010.

For the three racial/ethnic groups with current Nebraska data available, increases occurred in the proportions of infants put down to sleep on their backs (Figure 154). In 2003, PRAMS data indicate that 72 percent of white infants were laid down to sleep in this position, thus reaching the targeted rate for 2010. A revised target rate of at least 80 percent has been adopted for white babies (Appendix, Table A).

Figure 154
Healthy Full-Term Infants Put Down to Sleep on Their Backs by Race/Ethnicity



*Nebraska objective has been met for whites and will be revised.
NA = Not Available
SOURCE: Nebraska HHSS, PRAMS Surveillance.

Among Hispanic American babies, the rate rose from 47 percent in 1999 to 61 percent in 2003. For Asian American infants, 69 percent were put down to sleep on their backs in 2003, up one percentage point from the 1999 baseline. No new data were available for African American or Native American babies in Nebraska.

Incidence of Spina Bifida and Neural Tube Defects

Spina bifida and anencephaly are two of the serious birth defects that occur when the fetal neural tube fails to close fully, interrupting the development of the central nervous system. Research has shown that about 50 percent of neural tube defects may be prevented by increasing the consumption of folic acid to optimal levels from one month before conception through the first three months of pregnancy.

An objective seeking to reduce the incidence of spina bifida and other neural tube defects has been adopted in Nebraska and nationwide (Table 14). The national objective is to reduce this rate to no more than 3 of these defects per 10,000 live births and stillborn cases, while the Nebraska target is a little lower (2.3 per 10,000). Incidence was down in the U.S. from 6 in 1996 to 5 in 2000. In Nebraska, the rates were lower, but the rate of occurrence increased slightly from 4.2 in 1999 to 4.5 in 2004.

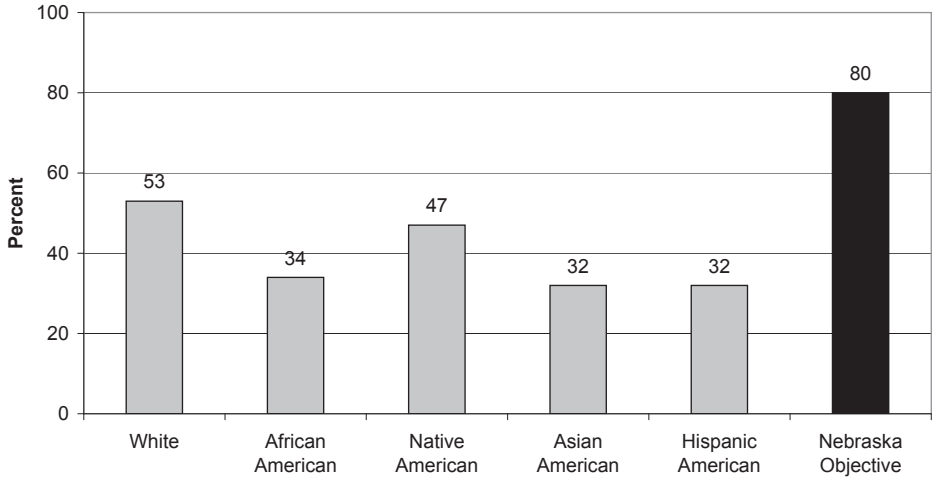
Pregnancies Begun with Optimal Folic Acid Level

The National Folic Acid Campaign seeks to educate Americans about the need for taking folic acid to prevent neural tube birth defects and thus promote its use by women of childbearing age. Both Nebraska and the U.S. have set a 2010 objective of increasing to at least 80 percent the proportion of pregnancies begun with an optimal folic acid level (Table 14). National data come from the 1991-1994 National Health and Nutrition Examination Survey. This study found that only 21 percent of non-pregnant women aged 15 to 44 years reported consuming an average of 400 micrograms of folic acid daily over the month preceding the survey. (This study included only folic acid intake from dietary supplements). Unfortunately, no more recent data are available nationwide.

In Nebraska, the BRFSS began collecting data on folic acid intake through vitamin pills or supplements in 2000. This study found that 46 percent of women aged 18 to 44 years were taking either a multivitamin or another supplement containing folic acid on a daily basis. Thus, they were assumed to be getting the optimal level of folic acid through dietary supplements. In 2001-2003, this proportion had risen to 50 percent of women in this age group.

More than one-half of white women in Nebraska (53 percent) reported getting the optimal level of folic acid through dietary supplements in 2001-2003 (Figure 155). Among Native American women, 47 percent received the optimal level. Only about one-third of women aged 18 to 44 in the other three racial/ethnic groups indicated they were getting an optimal level of folic acid.

Figure 155
Daily Consumption of Optimum Level of Folic Acid
Nebraska Women Aged 18-44 by Race/Ethnicity (2001-2003)

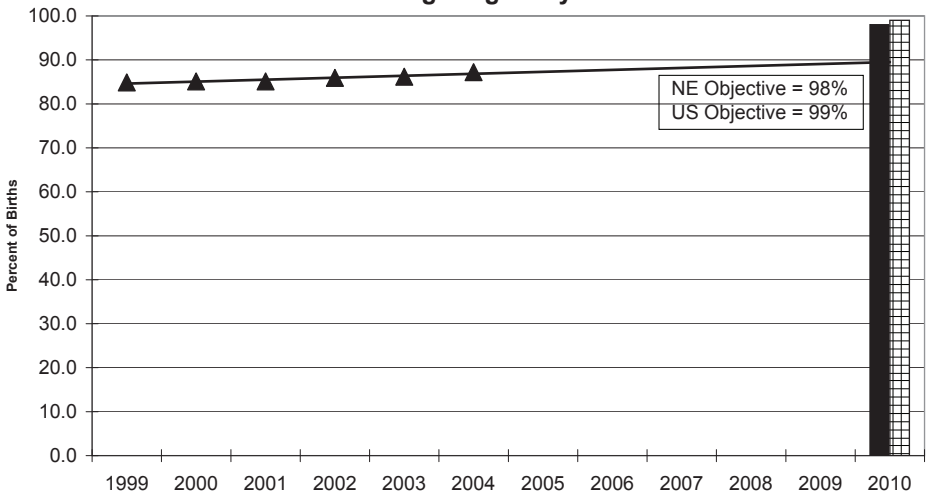


SOURCE: Nebraska HHSS, BRFSS.

Cigarette Smoking During Pregnancy

Nebraska and the U.S. have also adopted an objective of increasing the proportion of women who abstain from cigarette smoking during pregnancy. The U.S. target rate is at least 99 percent, while the target for Nebraska is at least 98 percent (Table 14). Abstinence rates have risen nationally and in Nebraska. In the U.S., 89 percent of women having live births in 2003 reported abstaining from cigarette smoking during their pregnancy, compared to 87 percent in 1998. In Nebraska, the abstinence rate increased from 84.9 percent in 1999 to 87.2 percent in 2004 (Figure 156).

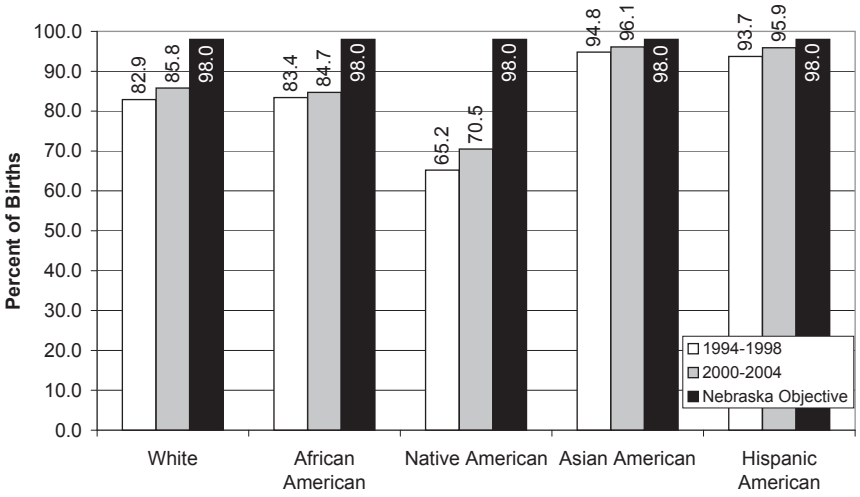
Figure 156
Percent of Women Who Abstained from Smoking During Pregnancy



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Smoking abstinence rates increased for pregnant women in each racial/ethnic group in Nebraska for 2000-2004 compared to the 1994-1998 baseline (Figure 157). The highest abstinence rates were recorded for Asian American (96.1 percent) and Hispanic American (95.9 percent) women, while the rate was lowest for Native American women (70.5 percent).

Figure 157
Percent of Nebraska Women Who Abstained from Smoking During Pregnancy by Race/Ethnicity



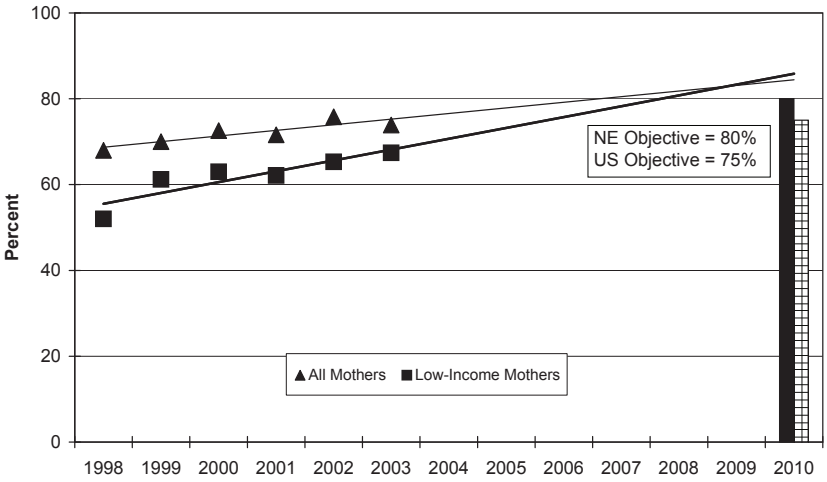
SOURCE: Nebraska HHSS, Vital Statistics.

Breastfeeding

Increasing the proportion of mothers who breastfeed their babies is another objective Nebraska shares with the nation. To meet the 2010 objective, 75 percent of mothers nationwide would need to be breastfeeding their infants in the early postpartum period (Table 14). In Nebraska, the target rate is 80 percent. A second objective is to increase the proportion of mothers who are still breastfeeding their babies at age six months to at least 50 percent (both in Nebraska and the U.S.).

According to the Ross Laboratories Mothers Survey, the proportion of mothers breastfeeding their infants in the early postpartum period (i.e., before being discharged from the hospital) has risen in the U.S. and in Nebraska. In 2003, about two-thirds of mothers nationwide (68 percent) breastfed their newborn infant in the hospital, compared to 64 percent in 1998. In Nebraska, the proportion rose from 68 percent in 1998 to 74 percent in 2003 (Figure 158).

Figure 158
Proportion of Nebraska Mothers Initiating Breastfeeding

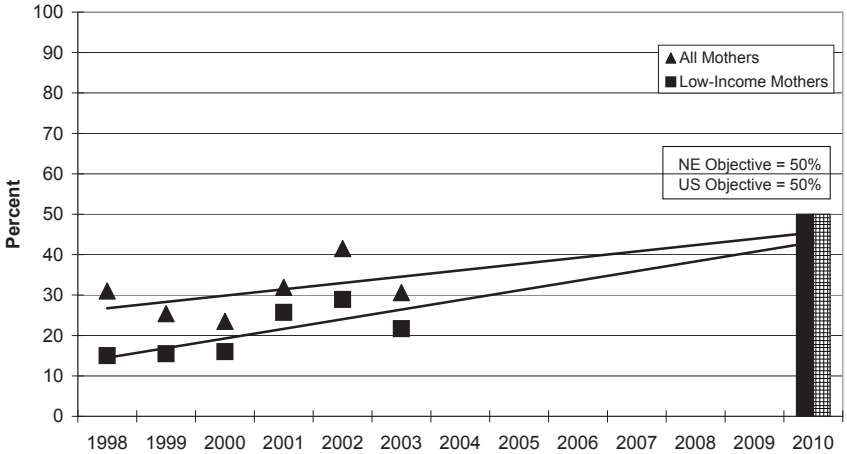


SOURCE: All mothers--Mothers Survey, Ross Products Division, Abbott Laboratories. Low-income mothers--WIC, Family Health Division, Nebraska HHSS. U.S. DHHS, Healthy People 2010.

Among low-income women participating in the WIC program in Nebraska, a substantial increase in prevalence of breastfeeding in the early postpartum period occurred. Two-thirds of these women (67 percent) breastfed their infants in 2003, compared to only 52 percent in 1998.

The proportion of mothers who were still breastfeeding their babies when they were six months of age is much lower than the proportion who started breastfeeding them in the hospital. In 2003, only one-third of mothers nationwide (33 percent) were breastfeeding at six months, although this represents an increase from 1998 (29 percent). In Nebraska, the trend in the proportion of mothers still breastfeeding at six months was generally upward between 1998 and 2003 (31 percent). Among low-income women in the WIC program, the proportion increased from 15 percent in 1998 to 22 percent in 2003 (Figure 159).

Figure 159
Proportion of Nebraska Mothers Still Breastfeeding When Infant Is 6 Months of Age



SOURCE: All mothers--Mothers Survey, Ross Products Division, Abbott Laboratories. Low-income mothers--WIC, Family Health Division, Nebraska HHSS. U.S. DHHS, Healthy People 2010.

MENTAL HEALTH AND MENTAL DISORDERS

Healthy People 2010 Goal

The goal of the Mental Health and Mental Disorders objectives is to improve mental health and ensure access to appropriate, high-quality mental health services.

Background

Mental illness ranks first among illnesses that cause disability in the United States, Canada, and Western Europe. Of $1 trillion spent on health care in the United States in 1997, $71 billion was expended for the direct costs of treating mental illness.

Depressive illness, including major depression, bipolar disorder, and dysthymia, is the most common of mental illnesses, affecting nearly 21 million American adults each year. Suicide is the ninth leading cause of death in Nebraska and the second leading cause of death for persons aged 15 to 34 years. In 2004, there were 166 suicides reported in Nebraska.

Progress Toward Healthy People 2010 Objectives

National

Two of the national mental health objectives for 2010 are shared by Nebraska. The rate of suicides in the United States increased slightly between 1999 and 2003. The current rate is more than double the 2010 objective. The proportion of adolescents who made a suicide attempt requiring medical attention in the past 12 months declined between 1999 and 2005.

Nebraska

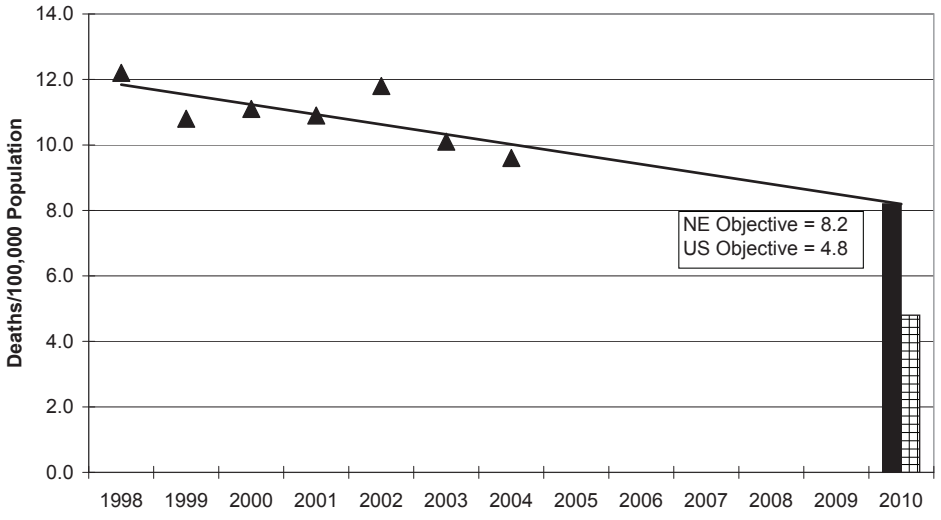
In Nebraska, the suicide rate decreased substantially over the seven-year period from 1998 to 2004. On the other hand, a greater proportion of high-school students made suicide attempts that required medical attention in 2005, compared to 1999.

Suicides

This U.S. objective is to reduce the deaths due to suicide to no more than 4.8 deaths per 100,000 population by 2010 (Table 15). In Nebraska, the target rate is higher, at 8.2 deaths per 100,000. National data show a slight increase in the suicide rate, from 10.5 in 1999 to 10.8 in 2003. In Nebraska, a decrease of 22 percent was achieved in suicides, moving from 12.2 deaths per 100,000 in 1998 to 9.5 in 2004 (Figure 160).

Table 15 Nebraska 2010 Health Goals and Objectives Mental Health and Mental Disorders											
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#18-1	Suicide rate per 100,000 population	1999	10.5	2003	10.8	4.8	1998	12.2	2004	9.5	8.2
	White	1999	11.3	2003	11.8	4.8	1994-1998	11.5	2000-2004	11.0	8.2
	African American	1999	5.6	2003	5.2	4.8	1994-1998	8.3	2000-2004	4.6	8.2
	Native American	1999	10.1	2003	10.0	4.8	1994-1998	10.6	2000-2004	9.1	8.2
	Asian American	1999	6.0	2003	5.6	4.8	1994-1998	3.2	2000-2004	7.9	2.1
	Hispanic American	1999	5.9	2003	5.6	4.8	1994-1998	7.0	2000-2004	4.2	4.7
#18-2	Percent of adolescents in grades 9-12 who made a suicide attempt requiring medical attention in the past 12 months Data by race/ethnicity currently unavailable in Nebraska	1999	2.6	2005	2.3	1.0	1999	1.6	2005	3.2	1.0
Data Sources:				Additional Notes:							
#18-1	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.			ICD-9 codes E950-E959. Age-adjusted to 2000 standard. Suicides may be undercounted due to difficulty in determining suicidal intent by coroner or medical examiner. Same as U.S.							
#18-2	U.S.--Youth Risk Behavior Surveillance System (YRBS), CDC. Nebraska--YRBS, HHSS.										

Figure 160
Suicide Rates in Nebraska (Age-Adjusted to 2000)

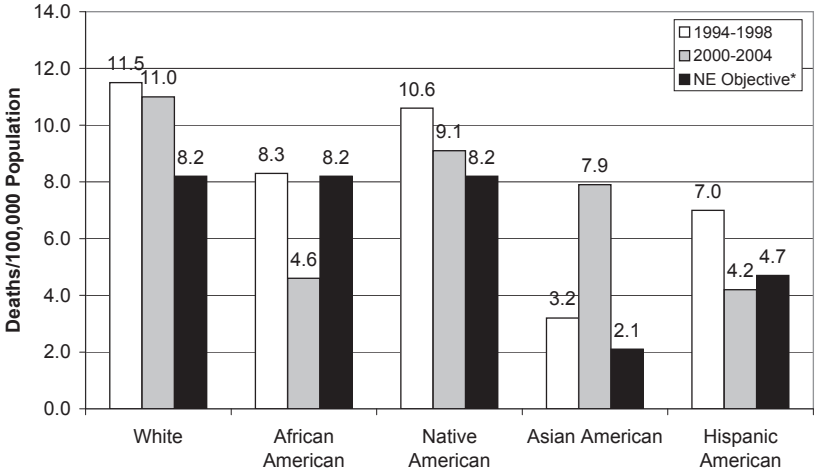


SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

Suicide rates were down for each racial and ethnic group except Asian Americans in Nebraska. For Asian Americans, the 2000-2004 suicide rate (7.9) was more than double the 1994-1998 rate (3.2); however, rates were based on small numbers of deaths.

Although the rate had decreased from the baseline (11.5), the suicide rate was highest for white Nebraskans (11.0) in 2000-2004 (Figure 161). The rate was second highest for Native Americans (9.1), although their rate had also declined. The lowest suicide rates were reported for African Americans (4.6) and Hispanic Americans (4.2) in the state and, in fact, met the 2010 objectives for these groups. Revised objectives of no more than 3.2 suicides per 100,000 for African Americans and no more than 2.9 suicides per 100,000 for Hispanic Americans have been set for 2010 (Appendix, Table A).

Figure 161
Suicide Rates in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)



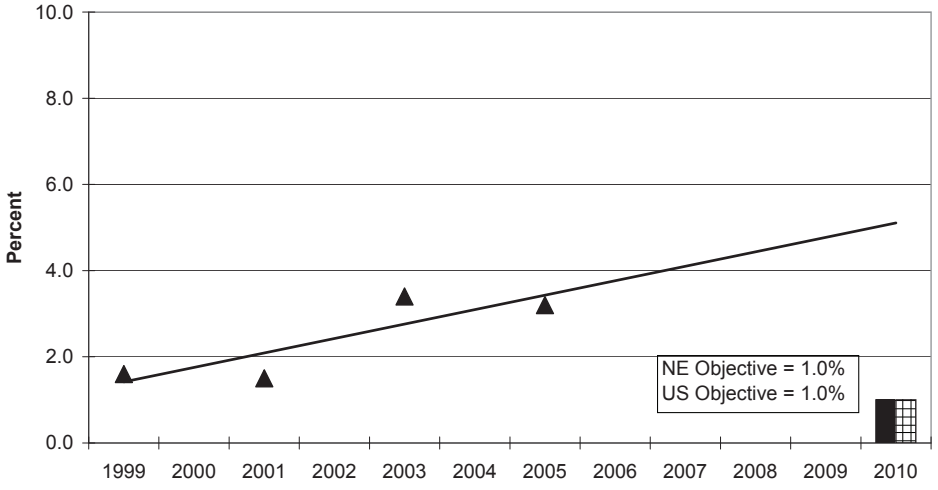
*Nebraska objectives for African Americans and Hispanic Americans have been met and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics.

Suicide Attempts Requiring Medical Attention

Nebraska and the nation share an objective seeking to reduce the proportion of adolescents making suicide attempts requiring medical attention in the past 12 months to no more than 1.0 percent by 2010 (Table 15).

In the U.S., the proportion of high-school students making these serious suicide attempts decreased from 2.6 percent in 1999 to 2.3 percent in 2005. However, in Nebraska, the proportion doubled. In 2005, 3.2 percent of high-school students in the state made suicide attempts requiring medical attention in the past 12 months, compared to 1.6 percent in 1999 (Figure 162).

Figure 162
Nebraska Adolescents (Grades 9-12) Who Made Suicide Attempt Requiring Medical Attention in Past 12 Months



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

NUTRITION AND OVERWEIGHT

Healthy People 2010 Goal

The goal of the Nutrition and Overweight objectives is to promote health and reduce chronic disease associated with diet and weight.

Background

The prevalence of overweight and obesity among adults, adolescents, and children has risen considerably over the past two decades in the United States and in Nebraska. Being overweight or obese often results in a variety of health problems and has been linked to increased risk of death. However, estimates of the number of obesity-related deaths in the United States each year have varied, due in part to the difficulty of separating out the health effects of co-existing conditions or risk factors.

Being overweight or obese substantially raises the risk of illness from: heart disease and stroke; high blood pressure; elevated blood cholesterol levels; type 2 diabetes; endometrial, breast, prostate, and colon cancers; gallbladder disease; arthritis; sleep disturbances; and breathing problems. Obese persons (both children and adults) may also suffer from social stigmatization, discrimination, and lowered self-esteem.

Progress Toward Healthy People 2010 Objectives

National

Three of the national objectives and sub-objectives in the Nutrition and Overweight focus area are shared by Nebraska: reducing prevalence of obesity among adults and reducing the prevalence of overweight and obesity among children aged 6 to 11 years and among adolescents aged 12 to 19. Movement away from the targets established for these rates has occurred in all three of the objectives nationwide.

Nebraska

In Nebraska, prevalence of obesity also increased among adults. Among adolescents aged 12 to 19, prevalence of overweight or obesity also rose. Current data are unavailable to assess progress for children aged 6 to 11 years.

Obesity among Adults

The Nebraska objective for reducing the prevalence of obesity among adults is identical to the national one: to lower the proportion of adults who are obese (i.e., who have a Body Mass Index [BMI] of 30 or greater) to no more than 15 percent by 2010 (Table 16).

Table 16
Nebraska 2010 Health Goals and Objectives
Nutrition and Overweight

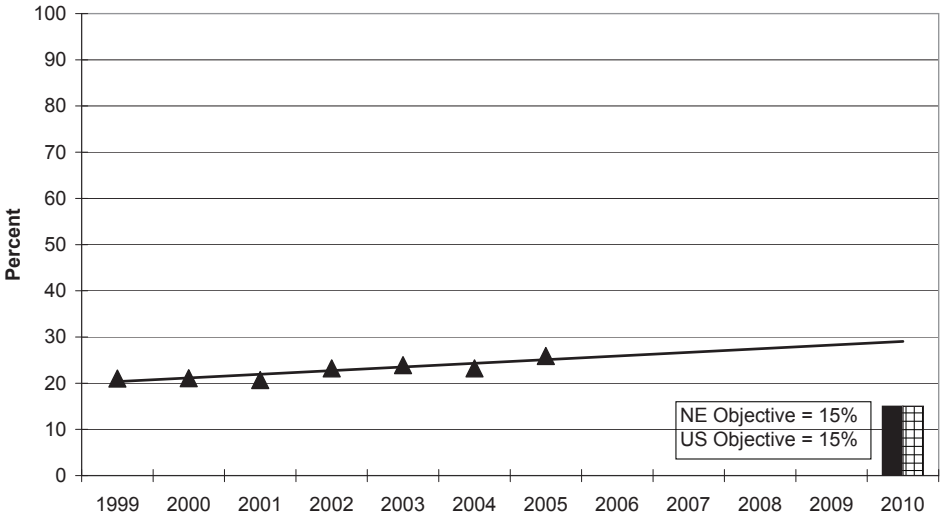
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#19-2	Percent of adults aged 18+ who reported height and weight that placed them in the "obese" category according to the Body Mass Index	1988-94	23	2002	30	15	1999	21	2005	26	15
	White, non-Hispanic	1988-94	22	2002	30	15	1994-1998	16	2001-2005	23	15
	African American, non-Hispanic	1988-94	30	2002	39	15	1994-1998	30	2001-2005	35	15
	Native American	1988-94	NA	2002	NA	15	1994-1998	NA	2001-2005	40	15
	Asian American	1988-94	NA	2002	NA	15	1994-1998	NA	2001-2005	12	15
	Hispanic American	1988-94	NA	2002	31	15	1994-1998	21	2001-2005	25	15
#19-3	Percent of children and adolescents who are overweight or obese										
	19-3a--Aged 6 - 11 years	1988-94	11	2002	16	5	2002-2003	15.6	Data Not Available		5*
	Data not available by age and race combined										
	19-3b--Aged 12 - 19 years	1988-94	11	2002	16	5	1999	6	2005	11	3
	White, non-Hispanic	1988-94	11	2002	14	5					
	African American, non-Hispanic	1988-94	13	2002	21	5	Data Not Available		Data Not Available		
	Native American	1988-94	NA	2002	NA	5					
	Asian American	1988-94	NA	2002	NA	5					
	Hispanic American	1988-94	NA	2002	23	5					

*Objective added in 2006. NA = Not Available

Data Sources:		Additional Notes:
#19-2	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC. Nebraska--BRFSS, HHSS.	Adults aged 20 and older. Body Mass Index (BMI) = 30 or greater. Adults aged 18 and older. Body Mass Index (BMI) = 30 or greater.
#19-3a, 3b	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC. Nebraska--(3a) "Overweight Among Nebraska Youth--2002/2003 Academic School Year", HHSS. (3b) Youth Risk Behavior Survey, HHSS.	"Overweight or obese" is defined here as at or above the gender- or age-specific 95th percentile of Body Mass Index, based on the revised CDC Growth Charts for the United States. NEW DATA SOURCE. Same as U.S. Same as U.S.

In the U.S., 30 percent of adults participating in the National Health and Nutrition Examination Survey (NHANES) were found to have weights and heights that placed them in the obese category. This represents a 30 percent increase from the 1998-1994 baseline of 23 percent. In Nebraska, prevalence of obesity has risen steadily (Figure 163). In 2005, 26 percent of participants in the BRFSS self-reported heights and weights that indicated they were obese. The current rate is 24 percent higher than the 1999 baseline rate of 21 percent.

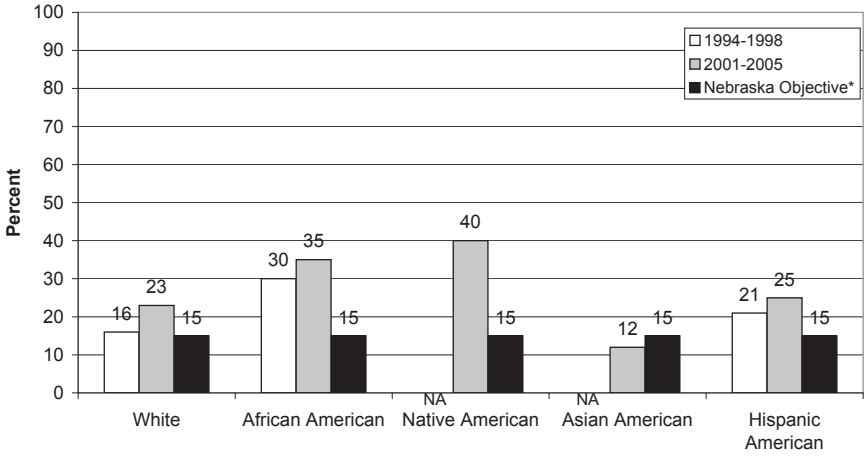
Figure 163
Prevalence of Obesity* Among Nebraska Adults Aged 18+



*Adults are classified as "obese" if they have a Body Mass Index (BMI) reading of 30 or greater.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Prevalence of obesity varied by racial and ethnic group in Nebraska (Figure 164). Asian Americans in the state were the only group to achieve the 2010 target rate for obesity with only 12 percent of adults classified as obese in 2001-2005, based on BMI. A revised objective seeking to further reduce the prevalence of obesity to no more than 10 percent has been set for Asian Americans in Nebraska (Appendix, Table A).

Figure 164
Prevalence of Obesity* Among Nebraska Adults Aged 18+
by Race/Ethnicity



*Nebraska objective for Asian Americans has been met and will be revised.
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

For each of the other racial or ethnic groups in the state (where trends were available), prevalence increased in 2001-2005. Although trend data are not available for them, Native Americans reported the greatest proportion of adults who were obese in 2001-2005 (40 percent). For African Americans, prevalence of obesity rose to 35 percent in the current period, an increase of 17 percent over the 1994-1998 baseline. One-fourth of Hispanic American adults in Nebraska (25 percent) were categorized as obese in 2001-2005, up 19 percent from 1994-1998. White Nebraskans reported a 30 percent increase in the prevalence of obesity, with 23 percent of these adults falling into this category.

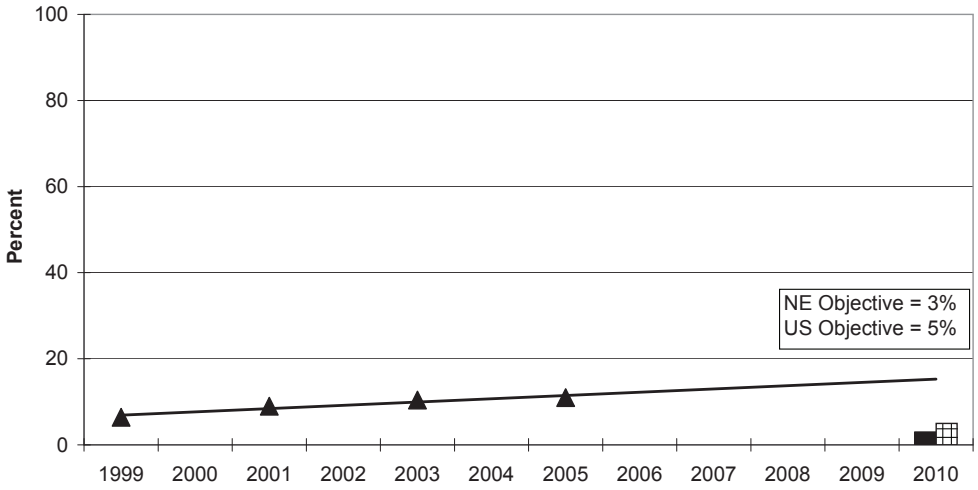
Prevalence of Overweight or Obesity in Adolescents and Children

For children aged 6 to 11 years, reducing the rate of overweight or obesity to no more than 5 percent has been set as the objective for 2010 in Nebraska and the U.S. (Table 16). The U.S. rate of overweight/obesity increased from the 1988-1994 baseline of 11 percent to 16 percent in 2002. In Nebraska, the only data currently available is taken from a 2002-2003 special study of schoolchildren. According to this study, 15.6 percent of 6- to 11-year-olds in the state were overweight or obese.

Among adolescents aged 12 to 19 years of age in the United States, the rates match those of younger children. Sixteen percent of adolescents were overweight or obese in 2002, according to NHANES. This represents an increase of 45 percent from the 1988-1994 rate of 11 percent. The current prevalence rate is triple the national objective of no more than 5 percent overweight or obesity among adolescents.

In Nebraska, a lower 2010 objective of no more than 3 percent has been set for adolescents aged 12 to 19 years. This target rate is based on a 6 percent prevalence of overweight or obesity in 1999, according to the YRBS. However, the YRBS found that 11 percent of youth in this age group were overweight or obese in 2005 (Figure 165). This current prevalence is more than triple the state's objective.

Figure 165
Nebraska Adolescents (Grades 9-12) Who Are Overweight*



*At or above the gender- or age-specific 95th percentile of Body Mass Index, based on revised CDC Growth Charts for the United States.
SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

OCCUPATIONAL SAFETY AND HEALTH

Healthy People 2010 Goal

The goal of the Occupational Safety and Health objectives is to promote the health and safety of people at work through prevention and early intervention.

Background

Work-related injuries and illnesses are defined as any injuries or illnesses incurred by persons engaged in work-related activities while on or off the worksite. Over the long term, workplace safety has improved with occupational injury death rates decreasing.

According to a 2005 review of the literature, there are an estimated 55,000 occupational deaths (due to injuries or illness) annually in the United States. In 2004, the U.S. Bureau of Labor Statistics reported 5,764 deaths that were the result of work-related injuries. An estimated 3.8 million work-related disabling injuries also occur each year in this country. Estimates of costs related to these injuries and deaths range between $128 billion and $155 billion per year in the United States.

Progress Toward National Objectives

Nebraska and the U.S. have both adopted objectives to reduce the death rate due to work-related injuries to no more than 3.2 per 100,000 workers aged 16 years and older by 2010 (Table 17). The U.S. rate decreased to 4.0 in 2003 from the 1998 baseline of 4.5. In Nebraska, work-related injury death rates also declined from 7.5 in 1998 to 4.4 deaths per 100,000 workers in 2004.

Table 17
Nebraska 2010 Health Goals and Objectives
Occupational Safety and Health

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#20-1	Death rate due to work-related injuries (deaths per 100,000 workers aged 16 years & older)	1998	4.5	2003	4.0	3.2	1998	7.5	2004	4.4	3.2
	White, non-Hispanic	1998	4.5	2003	4.0	3.2			2000-2004	4.5	3.2
	African American, non-Hispanic	1998	4.0	2003	3.7	3.2			2000-2004	*	3.2
	Hispanic American	1998	5.2	2003	4.5	3.2			2000-2004	5.4	3.2
	e. Agriculture, forestry, and fishing	1998	23.3	2002	22.7	16.3	1998	17.8	2000-2004	11.5	11.9
	Data not available by race or ethnicity						(Farm-related fatalities in Nebraska)				

*Rate based on fewer than five deaths over the five-year period.

Data Sources:		Additional Notes:
#20-1	U.S.--U.S. Census of Fatal Occupational Injuries, Department of Labor. Current Population Survey. Nebraska--Vital Statistics, HHSS, Regulation & Licensure; 2000 U.S. Census. Nebraska Databook.	CFOI uses multiple data sources, including death certificates, worker's compensation reports, police reports, medical examiner records, and newspaper records to identify and verify work-related fatalities. The number of workers is reported by CPS, including full-time and part-time workers and is averaged over the calendar year to account for seasonal and other variation. Farm-related mortality rates are figured against 2000 total farm population for Nebraska. Crude rates. Number of workers determined using labor force participation rates from Nebraska Databook.

Looking specifically at work-related injury deaths in agriculture, forestry, and fishing in the U.S., the 2002 rate was 22.7 deaths per 100,000 workers in these industries. This current rate was down 3 percent from 1998 but was 39 percent higher than the national objective of 16.3 for these industries.

In Nebraska, only workers in agriculture were included for these statistics. The 2000-2004 rate for farm deaths was 11.5 per 100,000, a drop of 35 percent from 1998. This rate meets the state's objective of no more than 11.9 deaths per 100,000 workers. A revised objective, seeking to reduce this rate to no more than 8.0, has been established for farm workers in Nebraska (Appendix, Table A).

ORAL HEALTH

Healthy People 2010 Goal

The national Healthy People 2010 Oral Health goals are to prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services.

Background

Millions of people nationwide experience dental cavities or periodontal disease. Many more have lost all their teeth. Early tooth loss caused by dental decay in children can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school and reduced self-esteem. Children may also develop permanent disabilities that effect their ability to learn and grow.

Untreated dental decay in older persons can lead to pain, abscesses, and eventual loss of teeth. Periodontal disease is a leading cause of bleeding, pain, infection, tooth mobility and tooth loss. Even when missing teeth are replaced with dentures, there may be limitations in speech, ability to chew, and overall quality of life.

Dental disease is one of the most preventable of health problems. Proper dental hygiene and good eating habits, combined with regular professional dental care, decrease the risk of developing cavities and periodontal disease.

Progress Toward Healthy People 2010 Objectives

National

Nebraska and the U.S. share eight Healthy People 2010 oral health objectives. One of these objectives has already been met. The proportion of older Americans who had all their teeth extracted has decreased enough to achieve the target rate.

Nationally, six of the eight objectives showed progress toward their target rates. The proportions of children in two age groups (6-8 years and 15+ years) with untreated dental decay declined and a greater proportion of eight-year-olds had received dental sealants on their molar teeth. The proportion of adults aged 35 to 44 who had never lost a permanent tooth to decay or periodontal disease increased. More Americans were served by community water systems with optimal levels of fluoridation.

Movement away from the 2010 targets was reported for two objectives nationwide. Slightly more 2- to 4-year-olds had untreated dental decay, compared to the baseline rate. The percentage of 14-year-olds who had received dental sealants on their molar teeth was also down compared to the previous period.

Nebraska

In Nebraska, the proportion of six- to eight-year-olds who had untreated cavities met the 2010 objective.

Progress was also made toward achievement of two oral health objectives. The proportion of adults aged 35 to 44 who have never had a permanent tooth extracted because of cavities or periodontal disease increased, while the proportion of older Nebraskans who had all their teeth removed decreased.

On the other hand, the proportion of Nebraska's population served by community water systems providing optimal levels of fluoride is down slightly from the baseline.

Data are unavailable to assess progress toward four Nebraska objectives.

Untreated Dental Decay Among Children

Current data are available for only one of the three age groups for which Nebraska 2010 objectives have been established. A 2005 survey of third-graders in public and private schools throughout the state was conducted by trained screeners to check for untreated cavities. Results of this survey showed 17 percent of these children with untreated decay, thus meeting the 2010 objective of no more than 21 percent (Table 18). A revised objective has been set which aims to reduce the proportion of children in this age group with untreated dental decay to more than 15 percent (Appendix, Table A).

Table 18
Nebraska 2010 Health Goals and Objectives
Oral Health

		UNITED STATES				NEBRASKA			
		Baseline	Current	U.S. 2010	Baseline	Current	NE 2010
Objective		Year Rate	Year Rate	Objective	Year Rate	Year Rate	Objective
#21-2	Proportion of children with untreated dental decay in primary and permanent teeth.						
	a. Children aged 2 to 4 years	1988-1994 16	2002 17	9	1999 21	No New Data Available	5
	b. Children aged 6 to 8 years	1988-1994 29	2002 27	21		2005 17	21*
	c. Adolescents aged 15 years	1988-1994 20	2002 18	15		No New Data Available	15*
#21-3	Percent of adults aged 35-44 years who have never had a permanent tooth extracted because of dental caries or periodontal disease	1988-94 30	2002 38	40	1999 64 (See "Additional Notes" below).	2005 72	75
#21-4	Percent of adults aged 65-74 years who have had all their permanent teeth extracted	1997 29	2004 21	22	1999 24	2005 18	17
#21-8	Percent of children who have received dental sealants on their molar teeth				1998 11	2005 12	50
	a. Children aged 8 years	1988-1994 23	2002 31	50	(Medicaid recipients aged 6 - 16 years)	2005 45	50
	b. Children aged 14 years	1988-1994 24	2002 20	55		No New Data Available	55*
#21-9	Percent of population served by community water systems with optimally fluoridated water.	1992 62	2002 67	75	1999 70	2004 67.5	80

*Target rate set in 2006 for Nebraska.

Data Sources:		Additional Notes:
#21-2a	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC; Oral Health Survey of Native Americans, 1999, Indian Health Service; California Oral Health Needs Assessment of Children, 1993-1994, Dental Health Foundation. Nebraska--Nebraska Dental Health Program, HHSS.	Percent of children with a clinical diagnosis of dental decay in at least one tooth that has not been restored. #21-2a--Percent of children aged zero to five screened in Head Start or day care centers.
#21-2b	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC; Oral Health Survey of Native Americans, 1999, Indian Health Service; California Oral Health Needs Assessment of Children, 1993-1994, Dental Health Foundation; Hawaii Children's Oral Health Assessment, 1999, State of Hawaii Department of Health. Nebraska--Open Mouth Survey of Third Graders, 2005. Dept. of Regulation and Licensure, HHSS.	Percent of children with a clinical diagnosis of dental decay in at least one tooth that has not been restored. Percent of children in third grade in public and private schools found by trained screeners to have untreated dental decay.
#21-2c	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC; Oral Health Survey of Native Americans, 1999, Indian Health Service; California Oral Health Needs Assessment of Children, 1993-1994, Dental Health Foundation. Nebraska--Nebraska Dental Health Program, HHSS.	Percent of children with a clinical diagnosis of dental decay in at least one tooth that has not been restored. No data available.

Table 18 continued		
Data Sources:		Additional Notes:
#21-3	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC; Oral Health Survey of Native Americans, 1999, Indian Health Service. Nebraska--BRFSS, HHSS.	Clinical confirmation of at least 28 natural teeth, exclusive of third molars, is used as a proxy measure. Self-reported. BRFSS respondents were asked how many of their permanent teeth have been removed because of tooth decay or gum disease.
#21-4	U.S.--National Health Interview Survey (NHIS), CDC: Oral Health Survey of Native Americans, 1999, Indian Health Service. Nebraska--BRFSS, HHSS.	 Self-reported.
#21-8	U.S.--National Health and Nutrition Examination Survey (NHANES), CDC; Oral Health Survey of Native Americans, 1999, Indian Health Service, Hawaii Children's Oral Health Assessment, 1999 State of Hawaii Department of Health. Nebraska--Nebraska Medicaid Program, HHSS. 1998 and 2005 data. Nebraska (#21-8a)--Open Mouth Survey of Third Graders, 2005. Dept. of Regulation and Licensure, HHSS.	Percent of children with a clinical confirmation of dental sealants applied to one or more permanent molars. Percent of children aged 6-16 years who are Medicaid recipients who have had dental sealants applied to one or more permanent molars. Percent of children in third grade in public and private schools found by trained screeners to have a dental sealant on one or more permanent molars.
#21-9	U.S.--CDC Fluoridation Census, CDC. Nebraska--Nebraska Dental Health Program, HHSS.	Optimal water concentration of fluoride is specific for geographic areas, based on their mean daily temperature. Percent is based on information from local water systems on the number of people served by the fluoridated water system. Same as U.S.

The national objective for this age group (6- to 8-year-olds) was the same as Nebraska's original 2010 objective (21 percent). The 2002 U.S. rate of 27 percent was much higher than the corresponding Nebraska rate of 17 percent, but had improved somewhat from the 1988-1994 baseline of 29 percent.

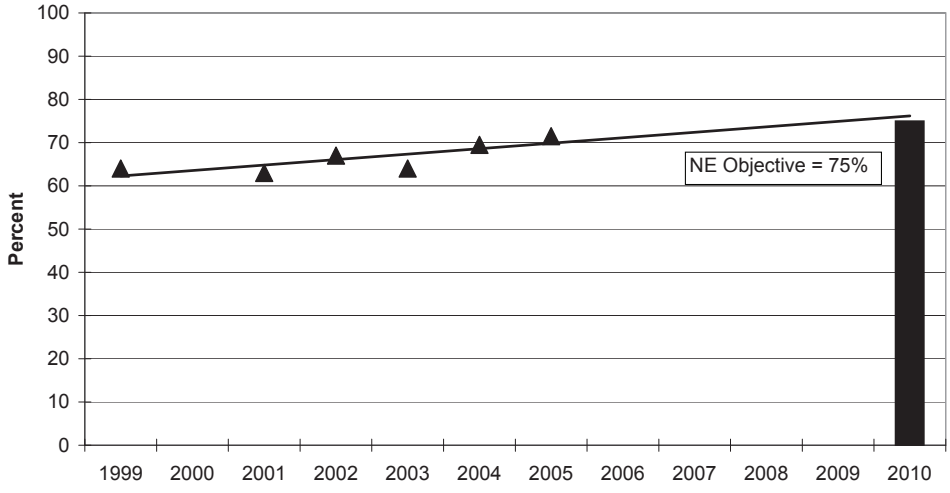
For two- to four-year-olds in Nebraska, children aged zero to five years in Head Start and daycare centers were screened for untreated cavities in 1999. At that time, 21 percent of children with untreated dental decay, compared to the 2010 objective of reducing this proportion to no more than 5 percent. More recent data are unavailable.

Tooth Loss Among Adults

One of the Healthy People 2010 objectives concerned with tooth loss seeks to increase the proportion of adults aged 35 to 44 years who have never had a permanent tooth extracted because of dental caries or periodontal disease. Methods of data collection differed between Nebraska and the U.S. National data reflect clinical confirmation of at least 28 natural teeth, while Nebraska data are self-reported by BRFSS respondents. The baseline and target rates are much lower for the U.S. The national objective is to increase this proportion to at least 40 percent by 2010. The 2002 U.S. rate of 38 percent represents an increase of 27 percent from the 1988-1994 baseline.

In Nebraska, a target rate of at least 75 percent of persons in this age group with no permanent tooth loss due to decay or periodontal disease was adopted. Progress was also made in Nebraska (Figure 166), with this proportion increasing to 72 percent in 2005, compared to 64 percent in 1999 (an increase of 12 percent).

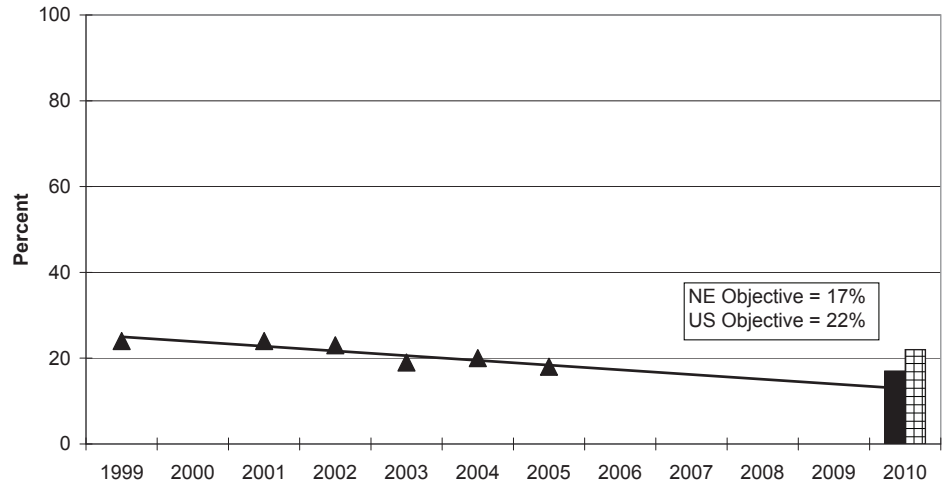
Figure 166
Nebraska Adults Aged 35-44 Who Never Had a Permanent Tooth Extracted Due to Cavities or Periodontal Disease



SOURCE: Nebraska HHSS, BRFSS.

A second objective related to tooth loss tracks the proportion of older adults (aged 65 to 74 years) who have had all their permanent teeth extracted. The national objective is to reduce this rate to no more than 22 percent by 2010 (Table 18). This U.S. objective was achieved in 2004 when the rate reached 21 percent. In Nebraska the target rate was set at 17 percent. In 2005, 18 percent of adults aged 65 to 74 reported that they had lost all of their permanent teeth (Figure 167). This rate represents a decrease of 25 percent from 1999 and is within one percentage point of achieving the 2010 target rate.

Figure 167
Nebraska Adults Aged 65-74 Who Had All Their Permanent Teeth Extracted



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Dental Sealants

Another objective concerning children's dental health seeks to increase the proportions of 8-year-olds and 14-year-olds who have had dental sealants applied to one or more permanent molar teeth. The U.S. and Nebraska target rates for 2010 are the same: at least 50 percent of 8-year-olds and at least 55 percent of 14-year-olds (Table 18).

In the U.S. overall, the proportion of 8-year-olds with dental sealants on their molar teeth increased by more than one-third from the 1988-1994 baseline of 23 percent to the 2002 rate of 31 percent. Among older children (aged 14 years), however, the proportion who had received dental sealants declined from 24 percent in 1988-1994 to 20 percent in 2002.

In Nebraska, available data on use of dental sealants are incomplete. For all Medicaid recipients aged 6 to 16 years, the proportion of children with sealants on their molar teeth increased only slightly from 11 percent in 1988 to 12 percent in 2005. A 2005 screening of children in third grade in public and private schools in the state found that 45 percent of these children had a dental sealant applied to one or more permanent molar teeth.

Fluoridated Water Systems

The final 2010 oral health objective for Nebraska is to increase to 80 percent the proportion of people served by community water systems with optimal levels of fluoride. A slightly lower target rate of 75 percent has been established nationwide.

In the U.S., the proportion of the population receiving optimally fluoridated water increased by 8 percent, moving from 62 percent in 1992 to 67 percent in 2002. In Nebraska, the proportion of persons served by community water systems supplying optimal levels of fluoride in the drinking water decreased slightly from 70 percent in 1999 to 67.5 percent in 2004. (The decrease can be attributed primarily to changes in relative population served by the systems, rather than to systems no longer fluoridating their water supplies.)

PHYSICAL ACTIVITY AND FITNESS

Healthy People 2010 Goal

The goal of the Physical Activity and Fitness objectives is to improve health, fitness, and quality of life for all Americans through daily physical activity.

Background

Regular physical activity is important at all stages of life for maintaining health, enhancing quality of life, and preventing premature death. On average, physically active people outlive those who are inactive.

For good health, it is recommended that people engage in at least 30 minutes of moderate-intensity physical activity (such as brisk walking) on five or more days per week OR engage in vigorous physical activity for at least 20 minutes on three or more days per week.

For those who do not currently participate in any leisure-time physical activity, beginning to exercise at any level of intensity or for even small periods of time is preferable to continuing to get no exercise at all. For anyone just starting to exercise, experts agree that it is best to begin with "small steps"—starting out slowly and gradually increasing the frequency and duration of physical activity—as the key to successful behavior change.

Progress Toward Healthy People 2010 Objectives

National

Despite worsening national trends in prevalence of overweight and obesity, there has been little or no positive change over the last decade in the status of most objectives for Physical Activity and Fitness. No change occurred in the proportion of adults who did not participate in any leisure-time activity or in the proportion of adolescents who engaged in moderate physical activity. Slight movement away from the 2010 objectives was noted for the proportion of adults who engaged in recommended levels of moderate or vigorous physical activity and for the proportion of adolescents who engaged in vigorous physical activity.

Nebraska

Please note that national and state prevalence estimates of physical activity levels among adults are not comparable, due to differences in questions and interviewing methods. For adolescents, the same data source was used for Nebraska and U.S. estimates.

In Nebraska, the proportion of adults who met the recommended activity level (moderate and/or vigorous) achieved the 2010 objective. However, a change in definitions occurred since the 2010 objectives were set. The current Nebraska rate would not meet the corresponding national 2010 objective. Still, movement toward two of the five 2010 objectives shared by Nebraska and the U.S. was noted. Fewer adults reported that they did not participate in any leisure-time physical activity and more adults engaged in vigorous physical activity for at least 20 minutes per day three or more times per week.

For adolescents, the proportion who engaged in moderate physical activity for at least 30 minutes five or more days a week was down by one percentage point from the baseline. Prevalence of vigorous physical activity among adolescents was down four percentage points in 2003.

No Leisure-Time Physical Activity

One of Nebraska's 2010 objectives is to reduce the proportion of adults who do not engage in any leisure-time physical activity to no more than 15 percent (Table 19). Progress was made toward this objective (Figure 168). In 1999, 28 percent of adult Nebraskans reported no physical activity in their leisure hours. By 2005, this proportion had decreased to 24 percent.

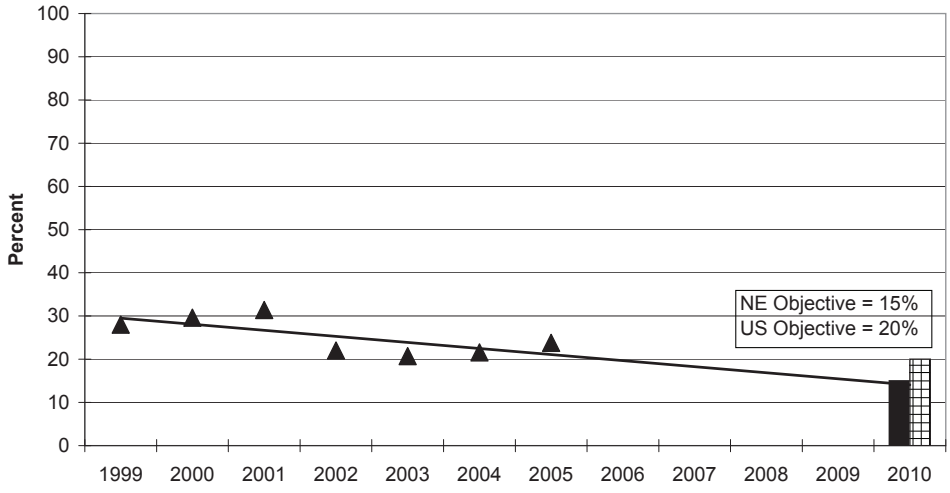
Table 19
Nebraska 2010 Health Goals and Objectives
Physical Activity and Fitness

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#22-1	Percent of adults aged 18+ who engaged in no leisure-time physical activity in the past month	1997	40	2005	40	20	1999	28	2005	24	15
	White	1997	38	2005	38	20	1994-1998	24	2001-2005	23	15
	African American	1997	52	2005	54	20	1994-1998	27	2001-2005	34	15
	Native American	1997	46	2005	42	20	1994-1998	NA	2001-2005	29	15
	Asian American	1997	42	--	--	20	1994-1998	NA	2001-2005	26	15
	Asian only	1997	42	2005	41	20					
	Hispanic American	1997	54	2005	56	20	1994-1998	28	2001-2005	44	15
#22-2	Percent of adults aged 18+ who engaged in moderate physical activity in the past month for at least 30 minutes per day 5 or more days per week or vigorous physical activity for at least 20 minutes per day 3 or more days per week	1997	32	2005	30	50	2001	34	2005	47	30
	White	1997	33	2005	32	50			2001-2005	42	30
	African American	1997	24	2005	21	50			2001-2005	27	30
	Native American	1997	27	2005	27	50			2001-2005	36	30
	Asian American	1997	27	--	--	50			2001-2005	35	30
	Asian only	1997	27	2005	28	50					
	Hispanic American	1997	23	2005	20	50			2001-2005	25	30
#22-3	Percent of adults aged 18+ who engaged in vigorous physical activity in the past month that promotes development and maintenance of cardiorespiratory fitness for at least 20 minutes per day 3 or more days per week	1997	23	2005	22	30	2001	16	2005	25	30
	White	1997	24	2005	23	30			2001-2005	21	30
	African American	1997	17	2005	16	30			2001-2005	20	30
	Native American	1997	20	2005	17	30			2001-2005	19	30
	Asian American	1997	17	--	--	30			2001-2005	24	30
	Asian only	1997	16	2005	17	30					
	Hispanic American	1997	16	2005	13	30			2001-2005	16	30
#22-6	Percent of adolescents in grades 9-12 who engage in moderate physical activity for at least 30 minutes per day five or more days per week Data not available by race or ethnicity	1999	27	2005	27	35	1999	28	2003	27	35
#22-7	Percent of adolescents in grades 9-12 who engaged in vigorous physical activity that promotes respiratory fitness on three or more days per week for 20 or more minutes per occasion Data not available by race or ethnicity	1999	65	2005	64	85	1999	69	2003	65	85

Data Sources:		Additional Notes:
#22-1	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	Adults are classified as not engaging in leisure time physical activity if they answer "never" or "unable to do this type of activity" to both the vigorous and moderate physical activity questions. National and state estimates are not comparable due to difference in questions and in interview method. Neither survey accounts for physical activity that is required for their jobs.

Table 19 continued		
Data Sources:		Additional Notes:
#22-2	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	Adults are classified as participating in light or moderate physical activity if they answer 5 to 28 times per week and 30 to 720 minutes for each time they do this type of activity. Not comparable to national estimates; see #22-1 above.
#22-3	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--BRFSS, HHSS.	Adults are classified as participating in vigorous physical activity if they answer 3 to 28 times per week and 20 to 720 minutes for each time they do this type of activity. Not comparable to national estimates; see #22-1 above.
#22-6	U.S.--Youth Risk Behavior Surveillance System (YRBS), CDC. Nebraska--Youth Risk Behavior Surveillance System (YRBS). HHSS.	"Moderate" physical activity is defined as physical activity that did not make them sweat or breathe hard. Examples given are: fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors. Same as U.S.
#22-7	U.S.--Youth Risk Behavior Surveillance System (YRBS), CDC. Nebraska--Youth Risk Behavior Surveillance System (YRBS). HHSS.	"Vigorous" physical activity is defined as physical activity that made them sweat or breathe hard. Examples given are: basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities. Same as U.S.

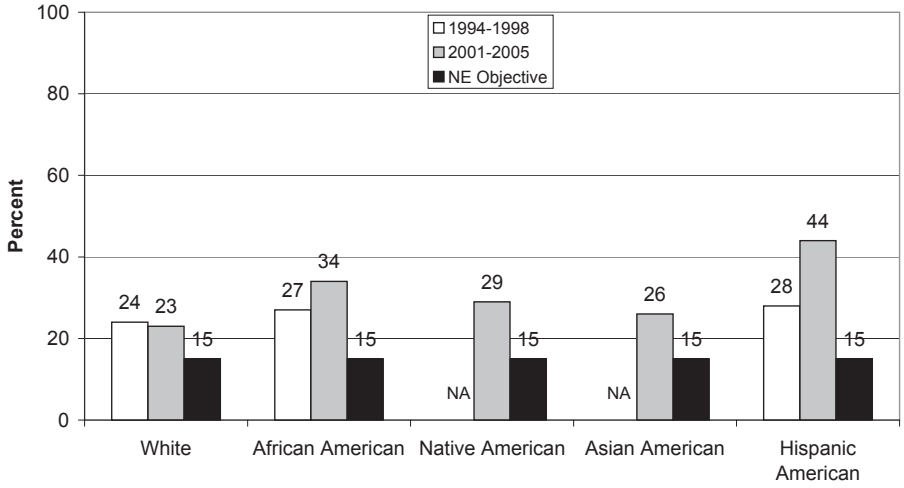
Figure 168
No Leisure-Time Physical Activity in Past Month
Nebraska Adults Aged 18+



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

In 2001-2005, Hispanic Americans (44 percent) in the state were more likely than adults in other racial/ethnic groups to say they had participated in no leisure-time physical activity (Figure 169). This rate had also increased substantially from 28 percent in 1994-1998. About one-third of African American adults (34 percent) in 2001-2005 reported no physical activity in their leisure time, up from 27 percent in 1994-1998. Prevalence of physical inactivity among white Nebraskans was lower (23 percent in 2001-2005) and had edged downward one percentage point from the 1994-1998 baseline. Rates for Native Americans (29 percent) and Asian Americans (26 percent) in the state fell between the lower rate for whites and the higher rates for Hispanics and African Americans.

Figure 169
No Leisure-Time Physical Activity in Past Month
Nebraska Adults Age 18+ by Race/Ethnicity



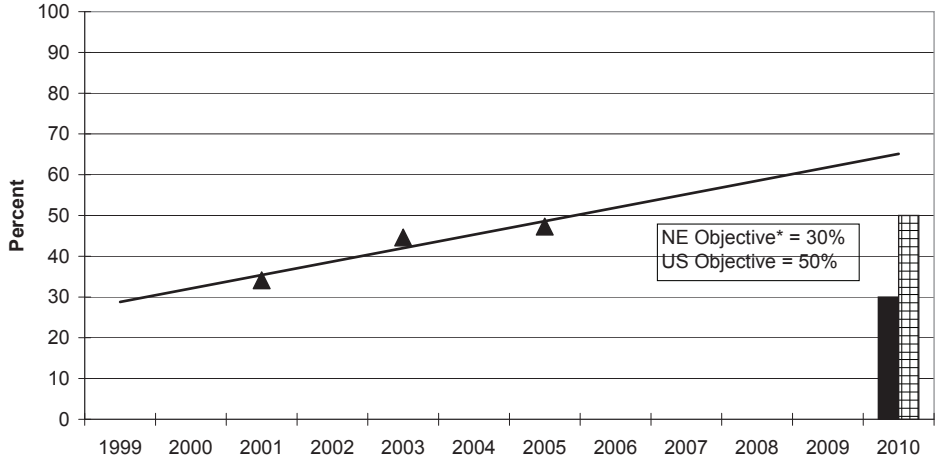
SOURCE: Nebraska HHSS, BRFSS.

Moderate and/or Vigorous Physical Activity

One of the original national 2010 objectives regarding moderate physical activity has been modified to include vigorous physical activity as well. In this way, it measures prevalence of "recommended" physical activity. Wording of the Nebraska objective has also been changed to match the national one and a new baseline set. In Nebraska, this objective seeks to increase to 30 percent or more the proportion of adults who engaged in moderate physical activity (in the past month) for at least 30 minutes per day 5 or more days per week OR vigorous physical activity for at least 20 minutes per day 3 or more days per week (Table 19).

Prevalence of "recommended" physical activity in Nebraska rose from 34 percent in 2001 to 47 percent of adults in 2005 (Figure 170), thus meeting the target rate for the state. However, it does not meet the national target of at least 50 percent.

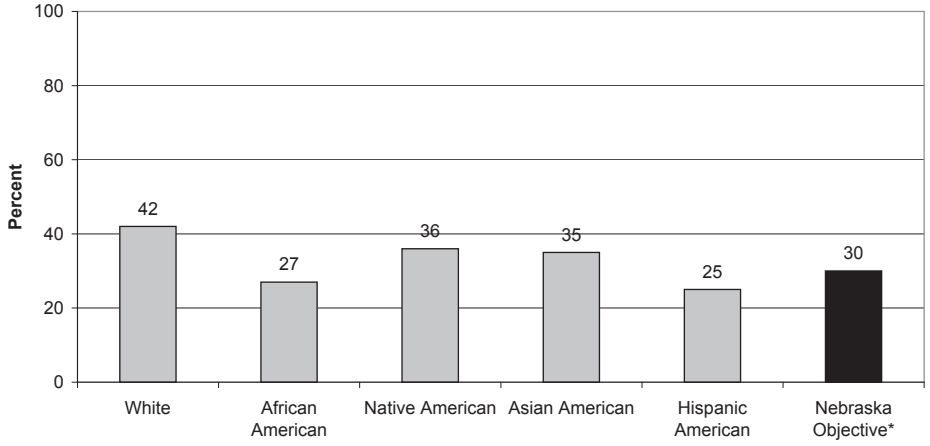
Figure 170
Participation in Moderate or Vigorous Physical Activity
in Past Month (Nebraska Adults Aged 18+)



*Nebraska objective has been met and will be revised.
SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

By race/ethnicity, white Nebraskans (42 percent) were the group most likely to report participating in recommended levels of physical activity in 2001-2005 (Figure 171). Native Americans (36 percent) and Asian Americans (35 percent) were somewhat less likely to engage in moderate or vigorous activity, while African Americans (27 percent) and Hispanic Americans (25 percent) were the groups least likely to participate at this level. Only African Americans and Hispanic Americans did not meet the original Nebraska 2010 target rate. A new Nebraska target rate of at least 50 percent, matching the U.S. target, has been established for adult participation in this level of physical activity for each of these groups (Appendix, Table A).

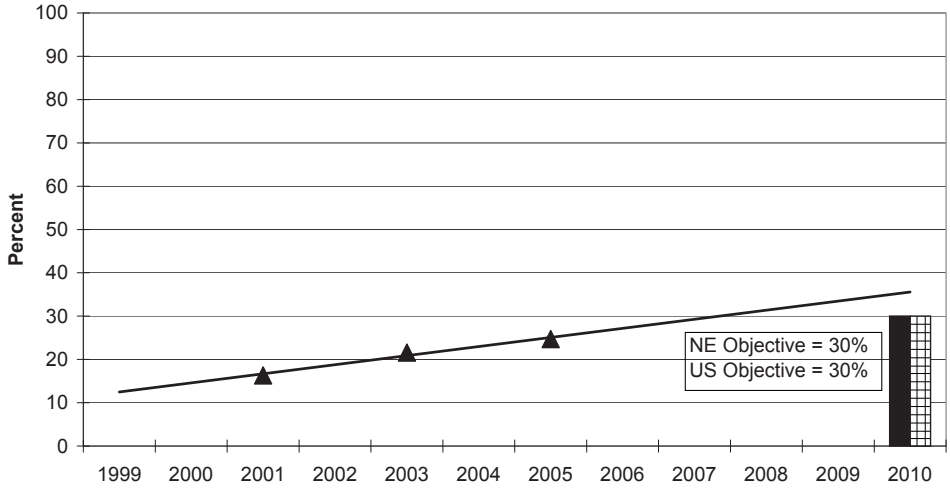
Figure 171
Participation in Moderate/Vigorous Physical Activity in Past Month (Nebraska Adults Aged 18+) by Race/Ethnicity (2001-2005)



*Nebraska objectives for whites, Native Americans, and Asian Americans have been met and will be revised.
SOURCE: Nebraska HHSS, BRFSS.

A third physical activity objective has been set to increase to at least 30 percent the proportion of adults who engaged in vigorous physical activity for at least 20 minutes per day three or more days per week (in the past month). The same target rate has been adopted for the U.S. and for Nebraska. In Nebraska, prevalence of vigorous physical activity increased from 16 percent in 2001 to 25 percent in 2005 (Figure 172).

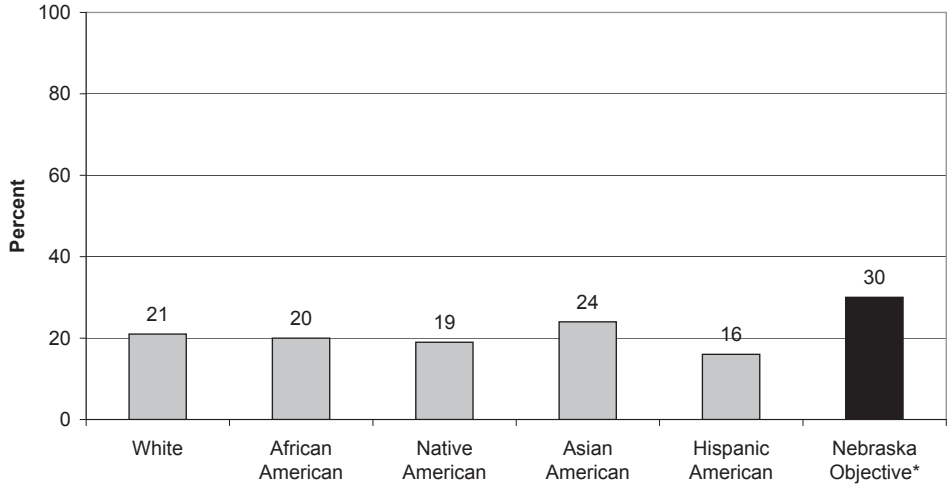
Figure 172
Participation in Vigorous Physical Activity in Past Month (Nebraska Adults Aged 18+)



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

In 2000-2004, participation rates for vigorous physical activity varied from a low of 16 percent for Hispanic Americans in the state to a high of 24 percent for Asian Americans (Figure 173). No trend data are available by race/ethnic origin.

Figure 173
Participation in Vigorous Physical Activity
Nebraska Adults 18+ by Race/Ethnicity (2001-2005)

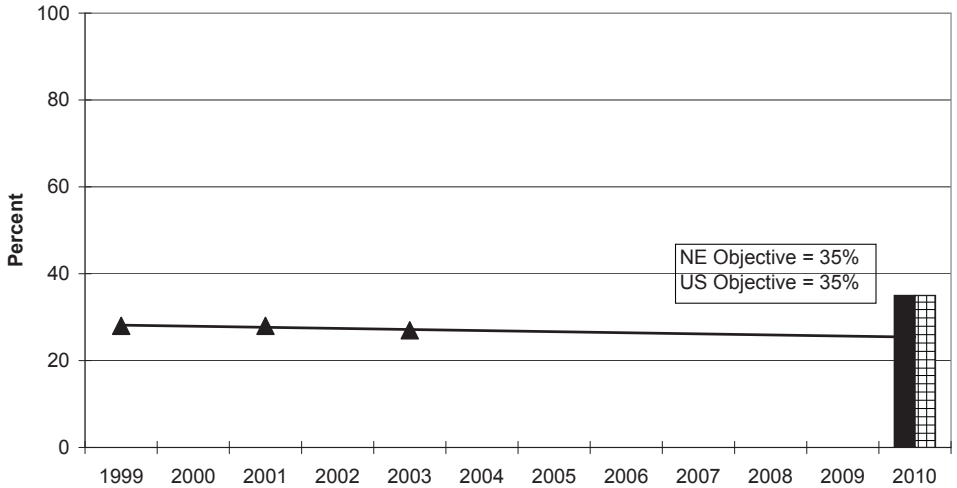


SOURCE: Nebraska HHSS, BRFSS.

Physical Activity Among Adolescents

The Youth Risk Behavior Survey collects data on prevalence of moderate and vigorous physical activity among high-school students in the U.S. and in Nebraska. One of the related 2010 objectives seeks to increase to at least 35 percent the proportion of high-school students who participate in moderate physical activity for at least 30 minutes per day 5 or more days per week (Table 19). No change was seen in the U.S. rates, with 27 percent of adolescents taking part in this level of activity in 1999 and in 2005. Very little change was noted in Nebraska, with a decline of one percentage point occurring between 1999 (28 percent) and 2003 (27 percent) (Figure 174).

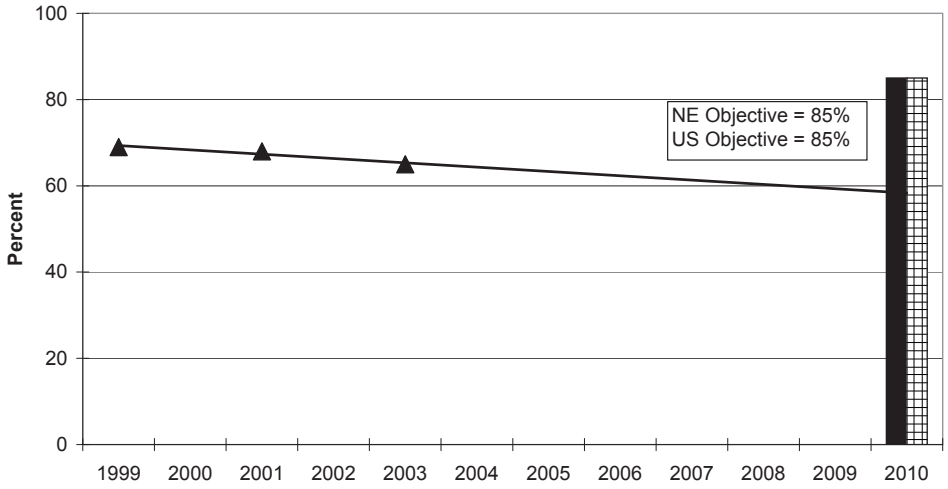
Figure 174
Nebraska Adolescents (Grades 9-12) Participating in Moderate Physical Activity in Past Week



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

A second physical activity objective for adolescents tracks prevalence of vigorous physical activity among high school students. Both the U.S. and Nebraska have adopted a target rate of at least 85 percent of high-school students engaging in vigorous physical activity that promotes respiratory fitness on at least 3 days per week for 20 or more minutes per occasion (Table 19). Prevalence of this level of activity has decreased slightly on the national level, moving from 65 percent in 1999 to 64 percent in 2005. In Nebraska, prevalence declined from 69 percent in 1999 to 65 percent in 2003 (Figure 175).

Figure 175
Nebraska Adolescents (Grades 9-12) Participating in Vigorous Physical Activity in Past Week



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

RESPIRATORY DISEASES

Healthy People 2010 Goal

The national Healthy People 2010 goal for respiratory diseases is to promote respiratory health through better prevention, detection, treatment, and education.

Background

Chronic respiratory diseases include asthma and chronic obstructive pulmonary disease (chronic bronchitis and emphysema). According to the National Center for Health Statistics, chronic respiratory diseases afflict approximately 3.6 million children and 22 million adults in the United States. These diseases are responsible for 20 million physician and outpatient visits, 3.5 million hospital emergency room visits, 1.2 million hospitalizations, and 124,000 deaths annually.

Progress Toward Healthy People 2010 Objectives

National

Progress was made in decreasing U.S. death rates due to asthma for all age groups except children under age five years, where an increase was noted. Hospitalizations for asthma remained steady for persons aged 5 to 64 years, but increased for children under 5 years of age and persons aged 65 and older. Deaths due to chronic obstructive pulmonary disease (COPD) were down slightly for persons aged 45 and older.

Nebraska

In Nebraska, death rates for asthma declined enough for children under age five years and for adults aged 65 and older to meet the 2010 objectives for these two age groups.

Reductions were also achieved in asthma deaths for the remaining three age groups (children aged 5 to 14 years, adolescents and adults aged 15 to 34, and adults aged 35 to 64). The trend in hospitalization rates due to asthma was down somewhat for Nebraskans aged 5 to 64 years, but increased for young children and elderly adults. Death rates due to COPD were down slightly among adults aged 45 and older.

Asthma Deaths

Asthma mortality rates are generally lowest for young children (under five years of age) and highest for adults aged 65 and older, so different 2010 objectives were established for the five age groups shown in Table 20.

Table 20
Nebraska 2010 Health Goals and Objectives
Respiratory Diseases

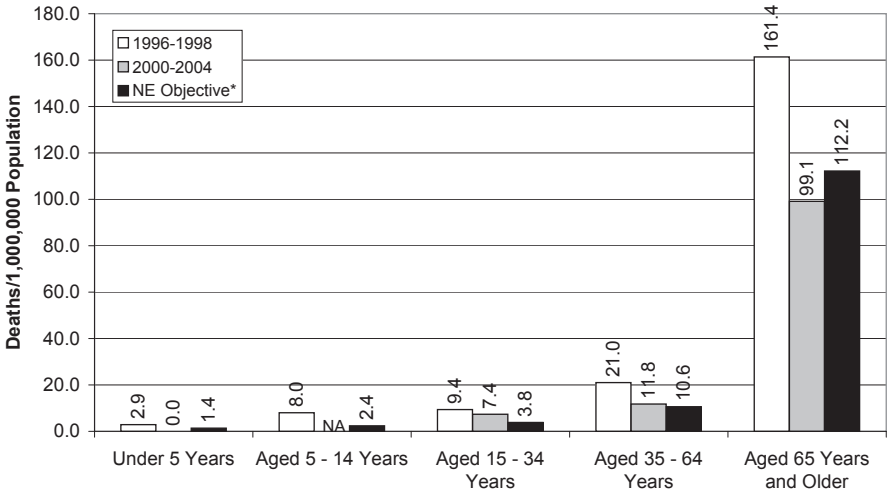
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#24-1	Death rate due to asthma (Rate per million)										
	a. Children under age five years	1999	1.7	2003	2.2	0.9	1996-1998	2.9	2000-2004	0.0	1.4
	White	1999	NA	2003	1.3	0.9	Data Not Available by Race/Ethnicity		2000-2004	0.0	1.4
	African American	1999	8.1	2003	7.8	0.9			2000-2004	0.0	1.4
	Native American	1999	NA	2003	NA	0.9			2000-2004	0.0	1.4
	Asian American	1999	NA	2003	NA	0.9			2000-2004	0.0	1.4
	Hispanic American	1999	NA	2003	NA	0.9			2000-2004	0.0	1.4
	b. Children aged 5 to 14	1999	3.1	2003	2.7	0.9	1996-1998	8.0	2000-2004	*	2.4
	White	1999	1.9	2003	1.5	0.9	Data Not Available by Race/Ethnicity		2000-2004	0.0	2.4
	African American	1999	9.9	2003	8.8	0.9			2000-2004	*	2.4
	Native American	1999	NA	2003	NA	0.9			2000-2004	0.0	2.4
	Asian American	1999	NA	2003	NA	0.9			2000-2004	0.0	2.4
	Hispanic American	1999	NA	2003	NA	0.9			2000-2004	0.0	2.4
	c. Adolescents and adults aged 15 to 34	1999	5.6	2003	4.7	1.9	1996-1998	9.4	2000-2004	7.4	3.8
	White	1999	3.7	2003	3.3	1.9	Data Not Available by Race/Ethnicity		2000-2004	5.4	3.8
	African American	1999	17.8	2003	14.0	1.9			2000-2004	49.9	3.8
	Native American	1999	NA	2003	NA	1.9			2000-2004	0.0	3.8
	Asian American	1999	NA	2003	NA	1.9			2000-2004	0.0	3.8
	Hispanic American	1999	2.8	2003	2.6	1.9			2000-2004	*	3.8
	d. Adults aged 35 to 64 years	1999	15.5	2003	14.2	8.0	1996-1998	21.0	2000-2004	11.8	10.6
	White	1999	11.7	2003	10.7	8.0	Data Not Available by Race/Ethnicity		2000-2004	10.9	10.6
	African American	1999	44.7	2003	39.8	8.0			2000-2004	43.2	10.6
	Native American	1999	NA	2003	20.5	8.0			2000-2004	0.0	10.6
	Asian/Pacific Islander	1999	11.8	2003	10.9	8.0			2000-2004	0.0	10.6
	Hispanic American	1999	14.0	2003	11.2	8.0			2000-2004	*	10.6
	e. Adults aged 65 years and older	1999	69.5	2003	54.4	47.0	1996-1998	161.4	2000-2004	99.1	112.2
	White	1999	64.4	2003	51.0	47.0	Data Not Available by Race/Ethnicity		2000-2004	95.4	112.2
	African American	1999	110.3	2003	82.4	47.0			2000-2004	216.4	112.2
	Native American	1999	NA	2003	NA	47.0			2000-2004	*	112.2
	Asian/Pacific Islander	1999	116.6	2003	73.7	47.0			2000-2004	*	112.2
	Hispanic American	1999	81.4	2003	52.5	47.0			2000-2004	*	112.2
#24-2	Hospitalizations for asthma										
	a. Age < five years	1998	45.6	2002	59.0	25.0	1999	14.8	2003	18.2	8.1**
	b. Age 5-64 years	1998	12.5	2002	12.4	7.7	1999	5.9	2003	5.9	3.7**
	c. Age 65 years and older	1998	17.7	2002	22.4	11.0	1999	12.2	2003	14.4	7.6**
#24-10	Death rate due to chronic obstructive pulmonary disease (COPD) among adults aged 45 years and older (per 100,000 population)	1999	123.9	2003	118.7	62.3	1998	121.8	2004	119.3	60.0
	White	1999	134.0	2003	125.4	62.3	1994-1998	119.4	2000-2004	130.4	60.0
	African American	1999	91.7	2003	76.1	62.3	1994-1998	126.6	2000-2004	136.0	60.0
	Native American	1999	98.3	2003	83.6	62.3	1994-1998	114.4	2000-2004	195.9	60.0
	Asian American	1999	55.1	2003	40.3	62.3	1994-1998	68.0	2000-2004	39.1	60.0
	Hispanic American	1999	65.9	2003	53.4	62.3	1994-1998	28.7	2000-2004	47.8	15.0

NA = Not Available *Rates based on fewer than 5 deaths. ** Target rate set in 2006 for Nebraska.

Data Sources:		Additional Notes:
#24-1	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	ICD-9 code = 493. Same as U.S.
#24-2	U.S.--National Hospital Discharge Survey, CDC. Nebraska--Hospital Discharge data, HHSS.	Asthma (ICD-9 code = 493) as the principal diagnosis. Same as U.S.
#24-10	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS, Regulation & Licensure.	ICD-9 code = 490-496. Age-adjusted to 2000 population. Same as U.S.

Both the U.S. and Nebraska target rates for children under age five represent reductions of about one-half from the baseline. The U.S. asthma death rate for these young children increased to 2.2 deaths per million in 2003. In contrast, there were no deaths due to asthma for this age group in Nebraska for 2000-2004 (Figure 176). Thus, the state's 2010 objective of no more than 1.4 asthma deaths per million children under age five was achieved. A revised target of zero asthma deaths for this age group has been set (Appendix, Table A).

Figure 176
Nebraska Deaths Due to Asthma by Age Group (Crude Rates)



*Nebraska objectives for children under five years of age and adults aged 65 and older have been met and will be revised.
NA = Not Available. Fewer than five deaths reported for this period.
SOURCE: Nebraska HHSS, Vital Statistics.

Reductions of 70 percent in the asthma death rate for children aged 5 to 14 years were established for Nebraska and the nation (Table 20). Since Nebraska's baseline rate was more than double the U.S. baseline for this age group, Nebraska's 2010 objective of no more than 2.4 deaths per million is higher than the national target of 0.9. Nationally, a decrease of 13 percent was recorded in the asthma death rate for this age group. In Nebraska, a much greater reduction was achieved, with the 2000-2004 death rate based on fewer than 5 deaths (and thus not reported here). A revised Nebraska target rate of 0.9 deaths per million, matching the U.S. target for this group, has been adopted (Appendix, Table A).

For adolescents and young adults aged 15 to 34, ambitious reductions (66 percent nationwide and 60 percent in Nebraska) in asthma death rates were targeted. Since Nebraska's baseline death rate was much higher than the U.S. rate, the 2010 objective for the state (3.8 deaths per million) is double the national objective (1.9). Compared to the baseline rate, the 2003 U.S. rate was down 16 percent to 4.7 deaths per million. The 2000-2004 Nebraska rate declined 27 percent to 7.4 (Figure 176).

The asthma death rate for African Americans aged 15 to 34 (49.9 deaths per million) in Nebraska was nearly 10 times as high as the rate for white adolescents and young adults (5.4).

For adults aged 35 to 64, the 2010 objectives for Nebraska (10.6) and the U.S. (8.0) represent a decrease of about 50 percent from the baseline rates. The 2003 U.S. rate (14.2) was down 8 percent, while the current Nebraska mortality rate decreased by 44 percent from 1996-1998.

For this age group too, African Americans experienced a much higher asthma death rate (43.2 deaths per million) than did whites (10.9) in Nebraska in 2000-2004 (Table 20). No deaths due to asthma were reported in this five-year-period for Native Americans or Asian Americans.

Asthma deaths are considerably higher for adults aged 65 and older than for persons in the younger age groups (Figure 176). In addition, asthma mortality for this age group has been much higher in Nebraska than in the U.S. overall. Thus, the Nebraska 2010 objective was set at 112.2 deaths per million, compared to 47.0 per million for the U.S. Reductions in asthma deaths for these older adults were achieved nationwide (down 22 percent) and in Nebraska (down 39 percent). In fact, the 2000-2004 rate for Nebraska (99.1) was low enough to reach the 2010 objective for asthma deaths for adults aged 65 and older.

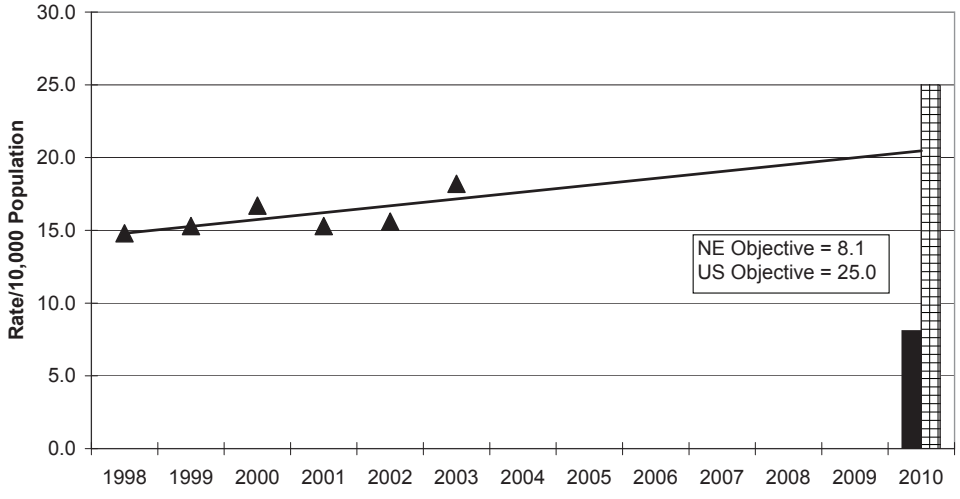
As with the two younger age groups, the asthma death rate for African Americans 65 years of age and older (216.4) was much higher than the rate for white Nebraskans (95.4). Although the asthma death rate for white residents met the 2010 objective, the rate for African Americans in the state did not (Table 20). A revised Nebraska target rate of no more than 47.0 deaths per million has been set for whites and overall to match the U.S. target (Appendix, Table A).

Hospitalizations for Asthma

In Nebraska, no target hospitalization rates for asthma were originally set for 2010. Given the high asthma death rates that were occurring at the time the original objectives were being formulated, it was difficult to determine what direction asthma hospitalization rates should be taking. (Nebraska hospitalization rates were much lower than U.S. rates for children under age five and somewhat lower for older asthma patients.) If asthma deaths were occurring because patients were not being hospitalized when their condition warranted it, it might have been advisable to aim for an increase in hospitalizations as a possible means of reducing deaths due to asthma.

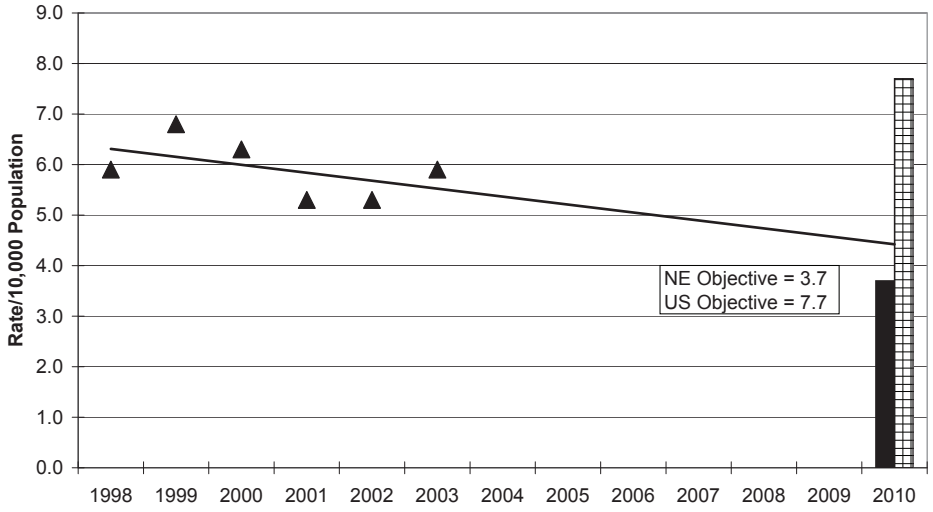
Now that more recent data are available, it is apparent that asthma mortality rates have been decreasing, while hospitalization rates for this disease have increased for children under age five and for older Nebraskans (aged 65 and older) (See Figures 177, 178, and 179). For Nebraskans aged 5 to 64 years, the trend in hospitalization rates was downward somewhat from the baseline. Based on these findings, modest decreases from the 1999 asthma hospitalization rates have been targeted for 2010.

Figure 177
Hospitalizations for Asthma in Nebraska
(Children Under Age 5 Years)



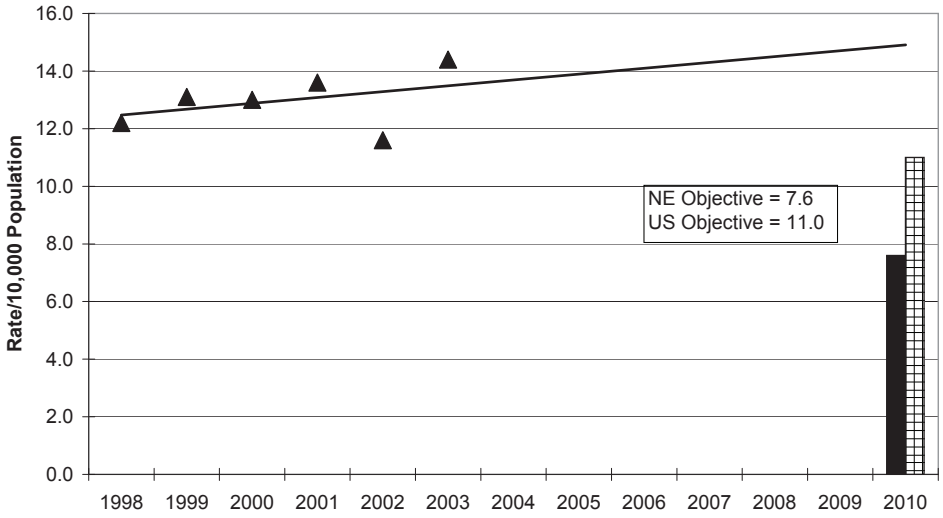
SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Figure 178
Hospitalizations for Asthma in Nebraska (Age 5-64 Years)



SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

Figure 179
Hospitalizations for Asthma in Nebraska (Adults Aged 65+)



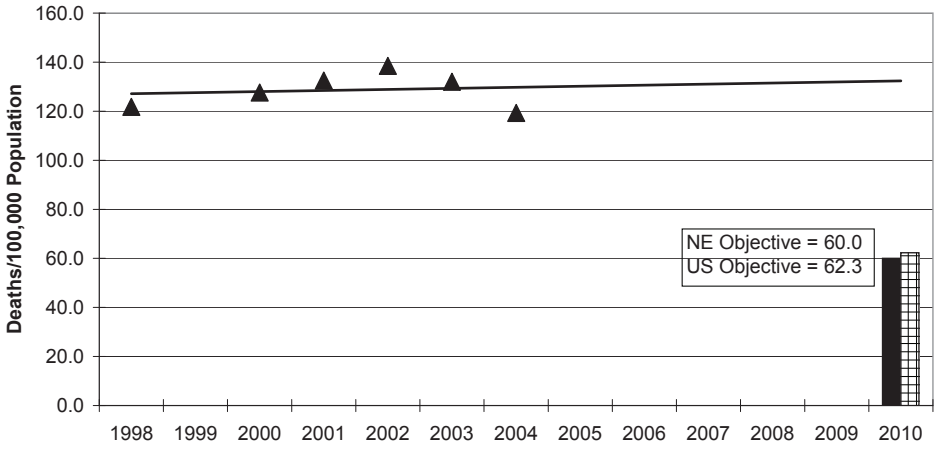
SOURCE: Nebraska HHSS, Hospital Discharge data. U.S. DHHS, Healthy People 2010.

The U.S. asthma hospitalization rate for children under five years of age was up 29 percent in 2002 to 59.0 per 10,000 (Table 20). This rate is much higher than the 2003 Nebraska rate of 18.2 for these young children, although this rate had increased since 1999. As in Nebraska, the national rate of hospitalizations for adults 65 and older (22.4) represented an increase from the baseline, while hospitalizations for Americans aged 5 to 64 held nearly steady at 12.4 in 2002.

Deaths Due to Chronic Obstructive Pulmonary Disease (COPD)

Another 2010 objective in the Respiratory Diseases focus area seeks to reduce the rate of deaths due to COPD among adults aged 45 years and older by about one-half. So far, not much progress has been made toward the national target rate (no more than 62.3 deaths per 100,000) or the Nebraska one (no more than 60.0 deaths per 100,000) (Figure 180). The current U.S. rate (118.7 in 2003) and the 2004 Nebraska rate (119.3) are very similar.

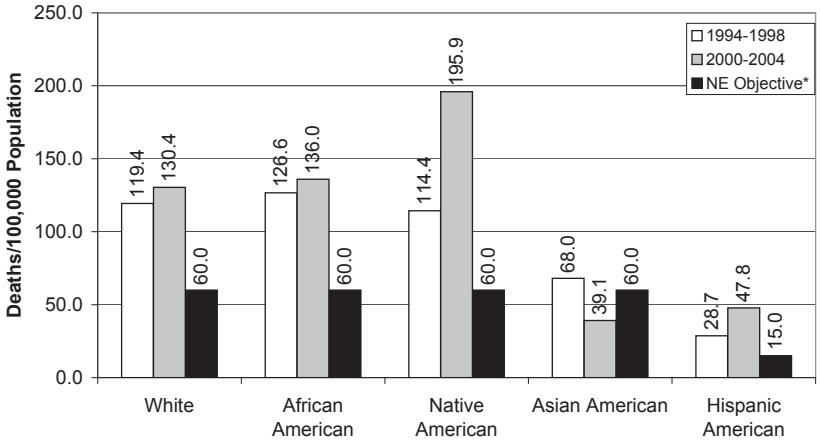
Figure 180
Deaths Due to Chronic Obstructive Pulmonary Disease (COPD) Among Nebraskans Age 45 and Older (Age-Adjusted to 2000)



SOURCE: NE HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

The 2000-2004 COPD death rate for Native Americans (195.9) was much higher than rates for other racial/ethnic groups in Nebraska (Figure 181). This rate also represents an increase of 71 percent over the 1994-1998 rate. In 2000-2004, African Americans (136.0), whites (130.4), and Hispanic Americans (47.8) in the state all experienced rising death rates due to COPD, compared to the baseline. However, the rate for Hispanic Americans was considerably lower than the current rates for all other racial/ethnic groups, except Asian Americans (39.1).

Figure 181
Deaths Due to Chronic Obstructive Pulmonary Disease (COPD) Among Nebraska Aged 45+ by Race/Ethnicity (Age-Adjusted to 2000)



*Nebraska objective for Asian Americans has been met and will be revised.
SOURCE: Nebraska HHSS, Vital Statistics.

Asian Americans were the only group to record a decrease in COPD mortality in 2000-2004 and also meet their 2010 objective. A revised target rate of no more than 27.4 COPD deaths per 100,000 has been set for this age/population group (Appendix, Table A).

SEXUALLY TRANSMITTED DISEASES

Healthy People 2010 Goal

The goal of the Healthy People 2010 objectives for Sexually Transmitted Diseases is to promote responsible sexual behaviors, strengthen community capacity, and increase access to high quality services to prevent sexually transmitted diseases and their complications.

Background

Sexually transmitted diseases (STD's) remain a major public health challenge in the United States. Although progress has been made in preventing, diagnosing, and treating some STD's, the Centers for Disease Control and Prevention estimate that 19 million new infections occur each year. Nearly one-half of these infections are among young people aged 15 to 24. More than 65 million people in the United States are currently living with an incurable STD.

STD's are also the cause of many harmful and often irreversible complications, such as reproductive health problems, fetal and perinatal health problems, and cancer. In addition to the physical and psychological consequences of STD's, these diseases also result in direct medical costs of up to $14.1 billion annually in the United States.

Progress Toward Healthy People 2010 Objectives

National

Since the late 1990's, the objectives for primary/secondary syphilis and responsible sexual behavior among adolescents have shown improvement. In fact, the 2005 rate for one of the sub-objectives for adolescent sexual behavior (use of condoms) reached the 2010 target rate. The incidence of gonorrhea has declined slightly.

Incidence of chlamydia infections, on the other hand, has been increasing, for both males and females. However, to some degree, this increase may reflect expanded screening and more sensitive diagnostic tests.

Nebraska

Progress has also occurred in Nebraska, compared to the 1999 baselines. Incidence of gonorrhea has declined. Prevalence of responsible sexual behavior among high-school students has shown some improvement.

However, incidence of chlamydia infections has increased in Nebraska, as it did nationwide, for both males and females, with expanded screening and improved testing methods probably accounting for some of this increase. The rate of new primary and secondary syphilis cases has remained nearly steady.

Chlamydia Infections

Chlamydia remains the most commonly reported infectious disease in the United States, with more than 976,000 diagnosed cases in 2005 and reported cases are increasing. Even so, most cases go undiagnosed. It is estimated that there are approximately 2.8 million total new cases in this country each year.

Three Healthy People 2010 sub-objectives address rising rates of diagnosed Chlamydia infection. Both Nebraska and the U.S. have target rates of no more than 3.0 percent of adolescents and young adults (aged 15 to 24 years) testing positive for Chlamydia infection among females attending family planning clinics, females attending STD clinics, and males attending STD clinics (Table 21).

Table 21
Nebraska 2010 Health Goals and Objectives
Sexually Transmitted Diseases

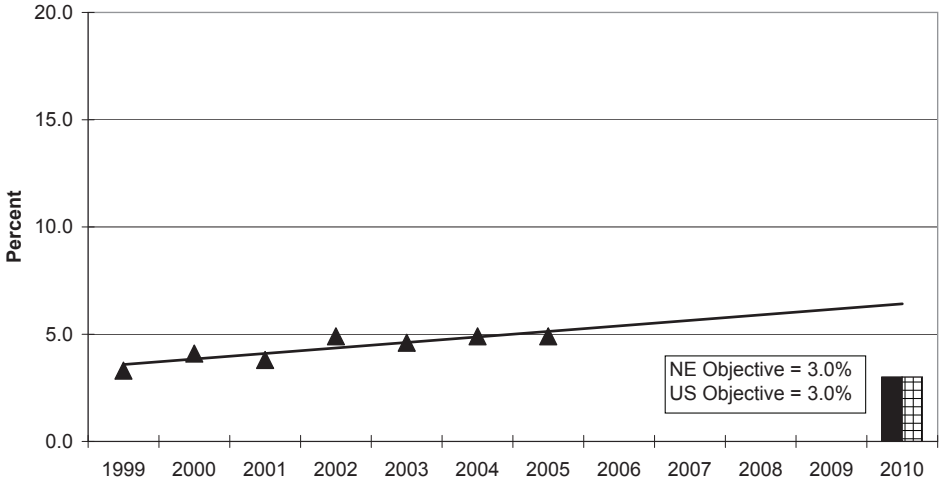
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#25-1	Percent of adolescents and young adults aged 15 to 24 with Chlamydia trachomatis infections										
	a. Females attending family planning clinics	1997	5.0	2004	6.9	3.0	1999	3.3	2005	4.9	3.0
	b. Females attending STD clinics	1997	12.2	2004	15.3	3.0	1999	7.0	2005	15.4	3.0
	c. Males attending STD clinics	1997	15.7	2004	20.2	3.0	1999	11.8	2005	15.6	3.0
#25-2a	Rate of new gonorrhea cases per 100,000 population	1997	122	2004	114	19.0	1999	88.4	2005	66.3	17.0
	White (non-Hispanic)	1997	26	2004	33	19.0	1995-1999	17.1	2001-2005	27.0	17.0
	African American (non-Hispanic)	1997	809	2004	630	19.0	1995-1999	994.2	2001-2005	1136.8	17.0
	Native American	1997	97	2004	118	19.0	1995-1999	131.7	2001-2005	142.7	17.0
	Asian American	1997	19	2004	21	19.0	1995-1999	17.1	2001-2005	21.0	17.0
	Hispanic American	1997	65	2004	71	19.0	1995-1999	67.6	2001-2005	64.8	17.0
#25-3	Rate of new primary and secondary syphilis cases per 100,000 population	1997	3.2	2004	2.7	0.2	1999	0.4	2005	0.3	0.2
	White (non-Hispanic)	1997	0.5	2004	1.6	0.2	1995-1999	0.1	2001-2005	0.2	0.1
	African American (non-Hispanic)	1997	22.0	2004	9.0	0.2	1995-1999	6.1	2001-2005	3.2	0.2
	Native American	1997	2.0	2004	3.2	0.2	1995-1999	*	2001-2005	0.0	0.2
	Asian American	1997	0.3	2004	1.2	0.2	1995-1999	0.0	2001-2005	*	0.0
	Hispanic American	1997	1.6	2004	3.2	0.2	1995-1999	1.5	2001-2005	*	0.2
#25-11	Percent of adolescents in grades 9-12 who abstain from sexual intercourse or use condoms if currently sexually active	1999	85	NA		95	1999	135	NA		
	-- had never had intercourse	1999	50	2005	53	56	1999	62	2005	59	65**
	-- had intercourse but not in the past three months	1999	27	2005	27	30	1999	12	2005	27	35**
	-- were sexually active and used a condom at last intercourse	1999	58	2005	66	65	1999	61	2005	62	70**

*Rate based on fewer than 5 cases. **New target rates set in 2006 for Nebraska due to change in data collected. NA = Not Available

Data Sources:		Additional Notes:
#25-1	U.S.--STD Surveillance System (STDSS), CDC. Nebraska--Communicable Diseases Division, STD Program, HHSS.	Percent of positive Chlamydia tests among persons attending specific clinics in past 12 months (as a percent of all tests administered for this disease). Same as U.S.
#25-2	U.S.--STD Surveillance System (STDSS), CDC. Nebraska--Communicable Diseases Division, STD Program, HHSS.	In most instances, if age or race/ethnicity was not specified, cases were allocated according to the distribution of cases for which these variables were specified. Same as U.S.
#25-3	U.S.--STD Surveillance System (STDSS), CDC. Nebraska--Communicable Diseases Division, STD Program, HHSS.	In most instances, if age or race/ethnicity was not specified, cases were allocated according to the distribution of cases for which these variables were specified. Same as U.S.
#25-11	U.S.--Youth Risk Behavior Surveillance System (YRBS), CDC. Nebraska--Youth Risk Behavior Surveillance System (YRBS), HHSS.	

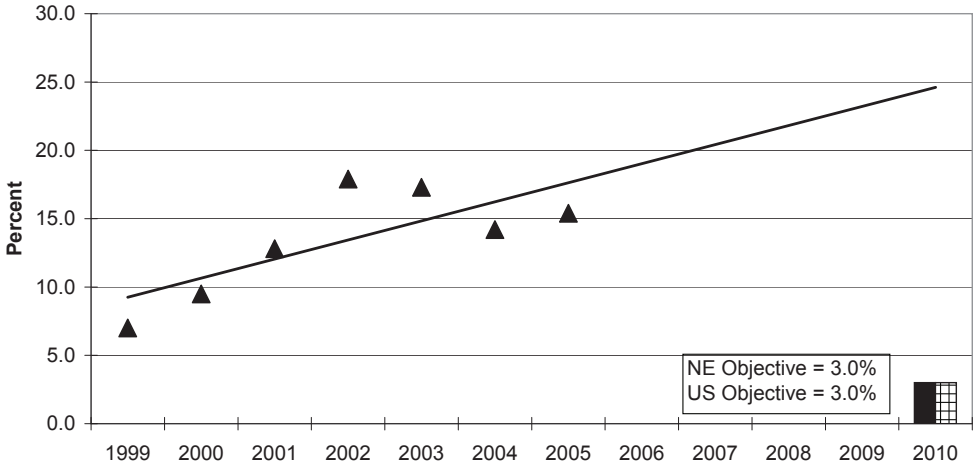
Current rates are similar for Nebraska and the nation, with increases occurring for each of these sub-objectives (Figures 182, 183, and 184). The proportion of persons testing positive for Chlamydia is particularly high in STD clinics for both males and females. In Nebraska in 2005, the percent positive rate was 15.4 for females and 15.6—more than five times the rate targeted for 2010.

Figure 182
Proportion of Females Aged 15-24 Years Attending Family Planning Clinics Who Had Chlamydia Infection



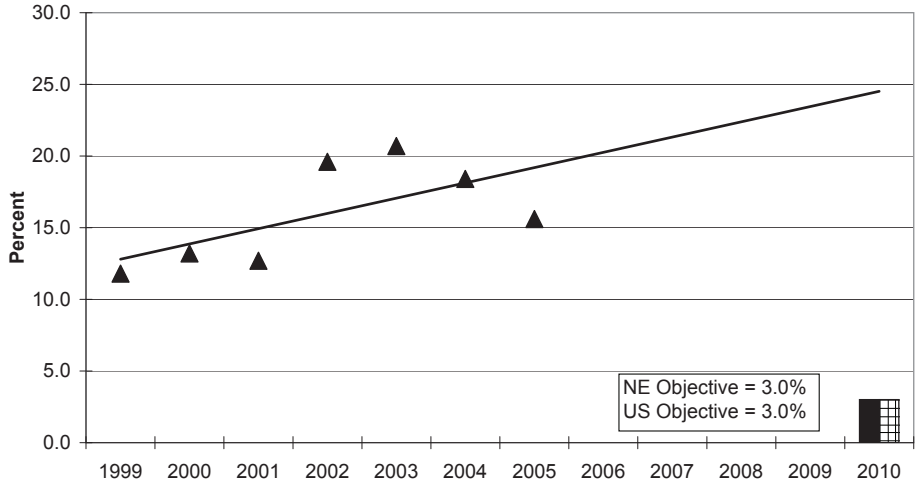
SOURCE: Nebraska HHSS, Communicable Disease. U.S. DHHS, Healthy People 2010.

Figure 183
Proportion of Females Aged 15-24 Years Attending STD Clinics Who Had Chlamydia Infection



SOURCE: Nebraska HHSS, Communicable Disease. U.S. DHHS, Healthy People 2010.

Figure 184
Proportion of Males Aged 15-24 Years Attending STD Clinics Who Had Chlamydia Infection



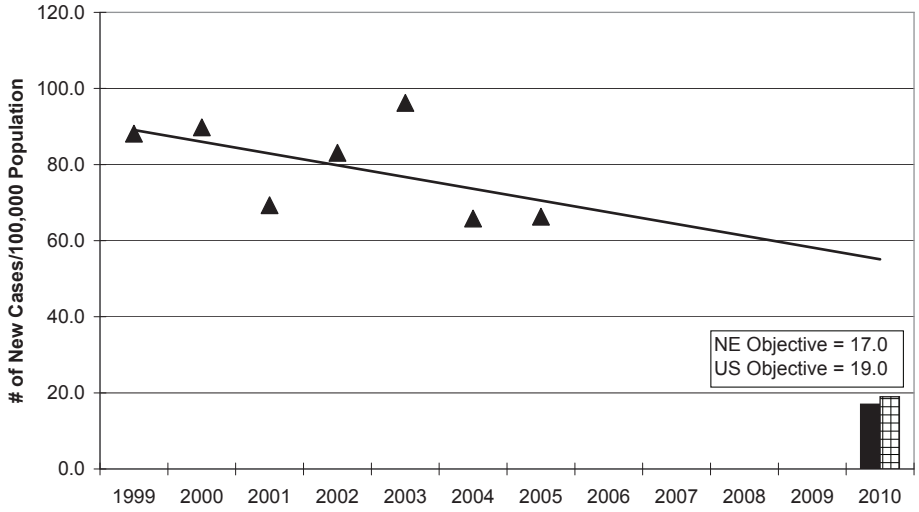
SOURCE: Nebraska HHSS, Communicable Disease. U.S. DHHS, Healthy People 2010.

Incidence of Gonorrhea

Gonorrhea is the second most commonly reported infectious disease in the United States, with nearly 340,000 cases reported in 2005. Although reported incidence of gonorrhea declined sharply between 1975 and 1997, rates have leveled off in recent years. Gonorrhea is currently under-diagnosed and under-reported by about 50 percent in the U.S.

Reductions of more than 80 percent in incidence of gonorrhea were targeted for the U.S. and for Nebraska (Table 21). The U.S. objective is to reduce incidence of this STD to no more than 19.0 by 2010, while the Nebraska objective is to lower it to no more than 17.0. The 2004 incidence rate for the U.S. is 114 new cases per 100,000, down only 7 percent from the 1997 baseline. In Nebraska, a reduction of 25 percent in reported incidence of gonorrhea was achieved (Figure 185). Since the state's baseline rate (88.4) was already below the national baseline (122), the 2005 rate of 66.3 is much lower than the current U.S. rate.

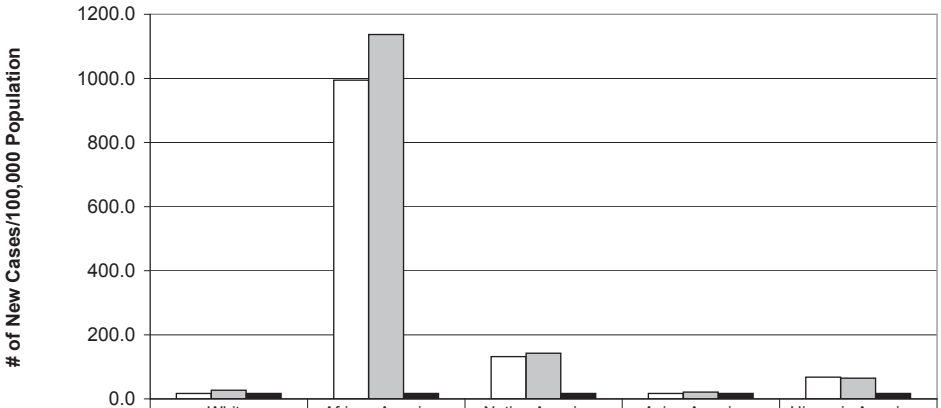
Figure 185
Incidence of Gonorrhea* in Nebraska



*Reported new cases.
SOURCE: Nebraska HHSS, Communicable Diseases. U.S. DHHS, Healthy People 2010.

Incidence of gonorrhea among African Americans (1,136.8 new cases per 100,000 population) was 42 times as high as the rate for whites (27.0) and 54 times as high as the rate for Asian Americans (21.0) in Nebraska in 2001-2005 (Figure 186). In addition, incidence of this STD continued to rise among African Americans, increasing by 14 percent from the 1994-1999 rate for this group.

Figure 186
Incidence of Gonorrhea* in Nebraska by Race/Ethnicity



	White	African American	Native American	Asian American	Hispanic American
1995-1999	17.1	994.2	131.7	17.1	67.6
2001-2005	27.0	1136.8	142.7	21.0	64.8
NE Objective	17.0	17.0	17.0	17.0	17.0

*Reported new cases.
SOURCE: Nebraska HHSS, Communicable Disease. U.S. DHHS, Healthy People 2010.

It is important to note that incidence of gonorrhea also rose for every other racial/ethnic group in the state except Hispanic Americans in 2001-2005. For Native Americans, incidence was up 8 percent from the 1995-1999 baseline. The current rate of 142.7 was more than 5 times the rate for whites (27.0) and nearly 7 times as high as the rate for Asian Americans (21.0) in 2001-2005.

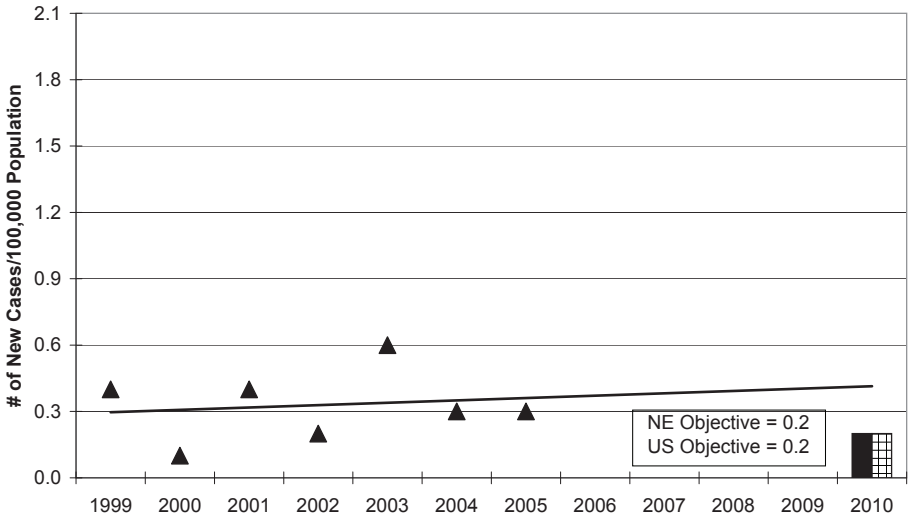
Although incidence rates for Asian Americans and whites were fairly low, both of these groups also experienced increases in gonorrhea rates in 2001-2005 (23 percent and 58 percent, respectively). For Hispanic Nebraskans, the current rate of 64.8 percent represents a decrease of 4 percent from the previous five-year period.

Incidence of Primary and Secondary Syphilis

According to CDC, incidence of primary and secondary syphilis decreased throughout the 1990's, reaching an all-time national low in 2000. However, since then the syphilis rate in the U.S. has been increasing, with the rate for males up 70 percent over the past five years.

The 2010 objective adopted by Nebraska and the U.S. is to reduce the incidence of primary and secondary syphilis to no more than 0.2 cases per 100,000 population (Table 21). The current national rate of 2.7 per 100,000 is much higher than the target rate, despite a modest decrease from the 1997 baseline (3.2). In Nebraska, the 2005 rate of 0.3 is near the 2010 target rate (Figure 187) but the trend has remained nearly steady since the 1999 baseline.

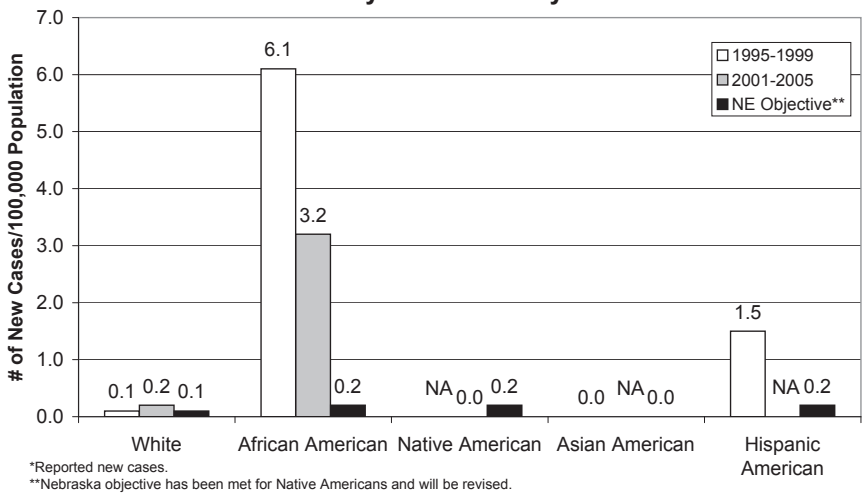
Figure 187
Incidence of Primary and Secondary Syphilis* in Nebraska



*Reported new cases.
SOURCE: Nebraska HHSS, Communicable Diseases. U.S. DHHS, Healthy People 2010.

Incidence of primary and secondary syphilis remains highest for African Americans in Nebraska (Figure 188) at 3.2 new cases per 100,000 in 2001-2005. However, this rate represents a decrease of 48 percent from the 1994-1999 baseline of 6.1.

Figure 188
Incidence of Primary and Secondary Syphilis* in Nebraska by Race/Ethnicity

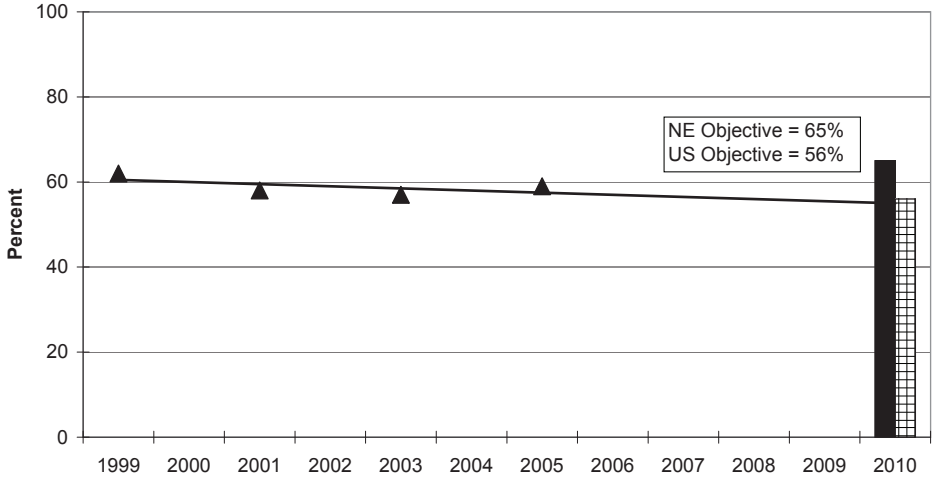


*Reported new cases.
**Nebraska objective has been met for Native Americans and will be revised.
NA = Not Available. Fewer than five reported cases in the time period.
SOURCE: Nebraska HHSS, Communicable Disease.

"Responsible" Sexual Behavior Among Adolescents

Three sub-objectives are being tracked as components of "responsible" sexual behavior among high school students. The first sub-objective seeks to increase the proportion of adolescents in grades 9 through 12 who have never had sexual intercourse. The U.S. target rate is 56 percent, while the Nebraska target is 65 percent or more (Table 21). Some progress was made nationwide, with the proportion of students not engaging in intercourse increasing from 50 percent in 1999 to 53 percent in 2005. In Nebraska, fewer adolescents in the 2005 study (59 percent) reported they had never had sexual intercourse, compared to 62 percent to 1999 (Figure 189).

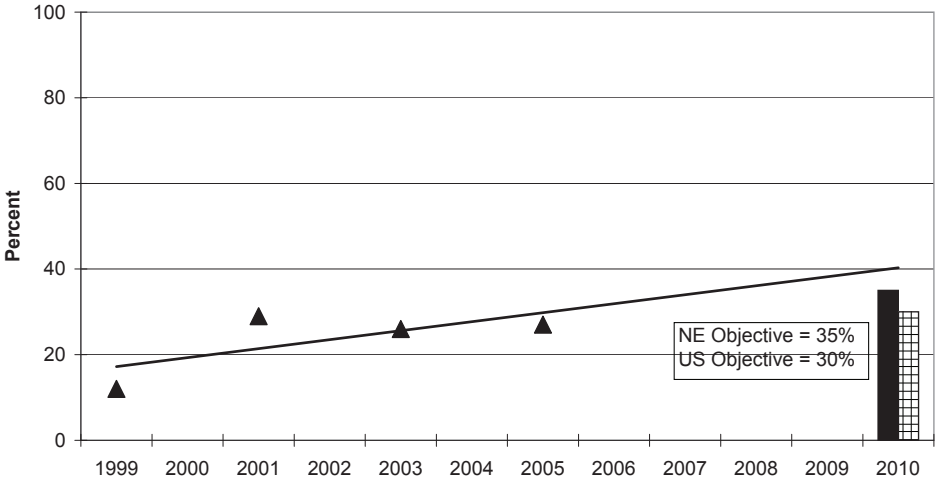
Figure 189
Nebraska Adolescents (Grades 9-12)
Who Never Had Sexual Intercourse



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

The second component of "responsible" sexual behavior targets an increase in the proportion of teens who ever had sexual intercourse, but abstained from it for the last three months. The U.S. objective is 30 percent or more and the Nebraska objective is set 35 percent or more (Table 21). Nationally, the 2005 rate had not changed from the 1999 baseline of 27 percent. In Nebraska, however, the proportion of high school students who had previously been sexually active but abstained from intercourse for the last three months more than doubled, moving from 12 percent in 1999 to 27 percent in 2005 (Figure 190).

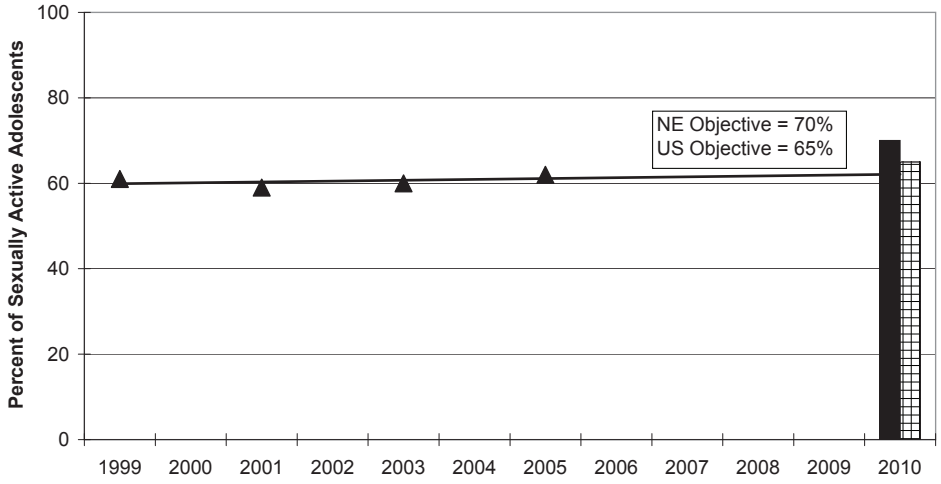
Figure 190
Nebraska High School Students Who Ever Had
Sexual Intercourse But Abstained in Past Three Months



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

The third objective related to "responsible" sexual behavior seeks to increase the proportion of sexually active high school students who used a condom the last time they had sexual intercourse. The national target rate of at least 65 percent was achieved in 2005, with 66 percent of sexually active students reporting this behavior (Table 21). For Nebraska, a target rate of at least 70 percent was set for 2010. Only slight progress was noted for this objective statewide, with the proportion of these teens using a condom at last intercourse increasing only one percentage point to 62 percent in 2005 (Figure 191).

Figure 191
Sexually Active Nebraska Adolescents (Grades 9-12)
Who Used Condom at Last Sexual Intercourse



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

SUBSTANCE ABUSE

Healthy People 2010 Goal

The national Healthy People 2010 goal is to reduce substance abuse in order to protect the health, safety and quality of life for all, especially children.

Background

The annual toll of deaths, illnesses, and injuries due to the use and abuse of alcohol and illicit drugs is a serious and preventable public health problem in the United States. Nationwide, there are approximately 75,000 deaths attributable to excessive alcohol use each year, making this the third-leading lifestyle-related cause of death for the nation. In 2003, there were more than 2 million hospitalizations and over 4 million emergency room visits for alcohol-related conditions. According to the National Institute on Alcohol Abuse and Alcoholism, the economic costs of alcohol abuse in the United States were estimated at $184.6 billion in 1998. This estimate includes costs of health care, potential productivity losses, and costs associated with crime and accidents.

The abuse of illicit drugs has also had a profound effect on the health of Americans, accounting for at least 20,000 deaths annually. Drug abuse contributed to deaths reported for causes such as overdose, suicide, homicide, child abuse, motor vehicle injuries, pneumonia, HIV/AIDS, and hepatitis.

A study completed for the Office of National Drug Control Policy found that, in 2002, the economic cost of drug abuse (illicit drugs only) in the United States was an estimated $180.9 billion. This figure includes health care costs, costs of addressing drug-related crime, and the loss of potential productivity from disability, death and withdrawal from the legitimate workforce.

Progress Toward Healthy People 2010 Objectives

National

Progress toward the 2010 targets was shown for a number of Substance Abuse objectives. Of the nine national objectives (or sub-objectives) shared with Nebraska, one was achieved nationwide. The proportion of high-school students who reported riding with a driver who had been drinking alcohol (28 percent) decreased enough to meet this objective (30 percent).

Seven other objectives made at least some progress toward the target rates set for them. U.S. death rates due to alcohol-related motor vehicle crashes and to cirrhosis were down slightly in the current year. Improvements were noted among adolescents in four substance-abuse-related behaviors, while the proportion of adults reporting binge drinking in the past 30 days was very slightly lower than the baseline rate.

No change was seen in the proportion of high-school students who had not used alcohol or any illicit drug in the past month. Although this was not listed as a national Healthy People 2010 objective, the proportion of high-school students who reported drinking and driving in the past month was considerably lower in 2005, compared to 1999.

Nebraska

In Nebraska, progress was made for five of eleven 2010 Substance Abuse objectives—all of them related to adolescent behaviors. The proportions of high-school students reporting drinking and driving, riding with

a driver who had been drinking, and binge drinking were all down, while the proportion of high-school seniors who never drank alcoholic beverages was up. In addition, more high-school students said they had not used alcohol or any illicit drug in the past 30 days.

Prevalence of adults engaging in drinking and driving remained unchanged, compared to the baseline.

On the negative side, more adults reported binge drinking in the past month. The proportion of adolescents in grades 9 through 12 who used marijuana in the past 30 days was also up somewhat. Death rates due to alcohol-related motor vehicle crashes increased, as did mortality due to cirrhosis.

Alcohol-Related Motor Vehicle Crash Deaths

One of Nebraska's 2010 objectives in the Substance Abuse focus area is to reduce alcohol-related motor vehicle fatalities to no more than 4.0 deaths per 100,000 population (Table 22). The U.S. objective is a little higher, at 4.8 per 100,000. Nationwide, the rate decreased very slightly from 5.3 in 1998 to 5.2 in 2002. In Nebraska, the death rate from alcohol-related motor vehicle crashes was higher than the U.S. rate and increased from 5.6 in 1998 to 6.6 in 2004 (Figure 192).

Table 22
Nebraska 2010 Health Goals and Objectives
Substance Abuse

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#26-1a	Death rate due to alcohol-related motor vehicle crashes/100,000	1998	5.3	2002	5.2	4.8	1998	5.6	2004	6.6	4.0
	White	1995	6.0			4.8	1994-1998	7.4	2000-2004	7.1	4.0
	African American	1995	6.4			4.8	1994-1998	5.3	2000-2004	4.1	4.0
	Native American	1995	19.2	No New Data Available		4.8	1994-1998	14.3	2000-2004	18.4	4.0
	Asian American	1995	2.4			4.8	1994-1998	*	2000-2004	6.2	4.0
	Hispanic American	1995	NA			4.8	1994-1998	8.4	2000-2004	7.3	4.0
#26-2	Death rate due to cirrhosis per 100,000 population	1999	9.6	2003	9.3	3.2	1998	5.4	2004	6.4	3.0
	White	1999	9.6	2003	9.5	3.2	1994-1998	4.9	2000-2004	5.8	3.0
	African American	1999	10.1	2003	8.4	3.2	1994-1998	11.6	2000-2004	6.3	3.0
	Native American	1999	24.8	2003	22.6	3.2	1994-1998	71.0	2000-2004	80.7	3.0
	Asian American	1999	3.7	2003	3.0	3.2	1994-1998	2.0	2000-2004	*	1.2
	Hispanic American	1999	16.1	2003	14.7	3.2	1994-1998	12.1	2000-2004	14.4	3.0
#26-6	Percent of adolescents in grades 9-12 who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol Data not available by race or ethnicity.	1999	33	2005	28	30	1999	46	2005	36	30
#26-9c	Percent of high school seniors who never drank alcoholic beverages Data not available by race or ethnicity.	1998	19	2004	23	29	1999	14	2005	21	29
#26-9d	Percent of high school seniors who never used any illicit drug Data not available by race or ethnicity.	1998	46	2004	49	56	1999	60	2005	62	75
#26-10a	Percent of adolescents in grades 9-12 who had not used alcohol or any illicit drug in the past 30 days Data not available by race or ethnicity.	2002	78	2003	78	91	1999	41	2005	52	60
#26-10b	Percent of adolescents in grades 9-12 reporting use of marijuana in the past 30 days Data not available by race or ethnicity.	2002	8.2	2005	7.9	0.7	1999	16	2005	18	5

Table 22 continued

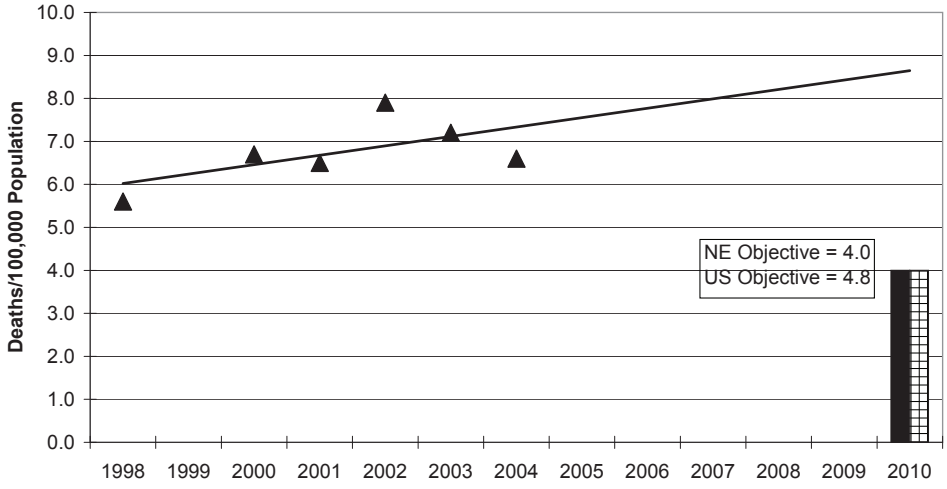
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#26-11c	Percent of adults aged 18+ who engaged in binge drinking of alcoholic beverages in the past month	2002	24.3	2003	24.0	13.4	1999	14	2005	17	6
	White	1998	17.2	2003	25.0	13.4	1994-1998	16	2001-2005	17	6
	African American	1998	13.3	2003	21.2	13.4	1994-1998	9	2001-2005	11	6
	Native American	1998	NA	2003	30.0	13.4	1994-1998	NA	2001-2005	22	6
	Asian American	1998	10.1	2003	13.0	13.4	1994-1998	NA	2001-2005	13	6
	Hispanic American	1998	17.2	2003	26.6	13.4	1994-1998	21	2001-2005	14	6
#26-11d	Percent of adolescents in grades 9-12 who engaged in binge drinking during the past 30 days Data not available by race or ethnicity.	2002	10.7	2003	10.6	3.1	1999	41	2005	30	25
#26-xx	Percent of adults aged 18+ who engaged in "drinking and driving" in the past month	--	--	--	--	--	1999	3	2004	3	1
	White								2002-2004	4	1
	African American								2002-2004	3	1
	Native American								2002-2004	3	1
	Asian American								2002-2004	2	1
	Hispanic American								2002-2004	2	1
#26-xx	Percent of adolescents in grades 9-12 who reported "drinking and driving" in the past 30 days Data not available by race or ethnicity.	1999	13.1	2005	9.9	--	1999	26	2005	17	10

*Rate based on fewer than five deaths. NA = Not Available

Data Sources:		Additional Notes:
#26-1a	U.S.--Fatality Analysis Reporting System (FARS), Dept. of Transportation (DOT), National Highway Traffic Safety Administration (NHTSA); General Estimates System (GES), DOT.	A fatal crash is alcohol-related if either a driver or non-motorist has a measurable or estimated blood alcohol concentration (BAC) of 0.01 g/dL or above. Only deaths that occur within 30 days of the motor vehicle crash are included. FARS data are obtained from state documents, including police crash reports, death certificates (ICD-9 E810-E819), vehicle registration files, and hospital medical reports. Age-adjusted to 2000 standard.
	Nebraska--Vital Statistics, HHSS; Office of Highway Safety, Dept. of Motor Vehicles	ICD-9 E810-E819. Age-adjusted to 2000 standard.
#26-2	U.S.--National Vital Statistics System, CDC. Nebraska--Vital Statistics, HHSS.	ICD-9 code 571. Age-adjusted to 2000 standard. ICD-9 code 571. Age-adjusted to 2000 standard.
#26-6	U.S.--Youth Risk Behavior Surveillance System, CDC. Nebraska--Youth Risk Behavior Surveillance System, HHSS.	Self-reported. Self-reported.
#26-9c	U.S.--Monitoring the Future Study, National Institutes of Health, National Institute of Drug Abuse. National Survey on Drug Use and Health, SAMHSA. Nebraska--Youth Risk Behavior Surveillance System, HHSS.	Students in private and public schools in the U.S. in attendance on the day of the survey administration. Self-reported.
#26-9d	U.S.--Monitoring the Future Study, National Institutes of Health, National Institute of Drug Abuse. National Survey on Drug Use and Health, SAMHSA. Nebraska--Youth Risk Behavior Surveillance System, HHSS.	Students in private and public schools in the U.S. in attendance on the day of the survey administration. Use of any illicit drug includes any use of marijuana ("weed" or "pot", or hashish), LSD ("acid"), other hallucinogens, ("psychedelics like mescaline, peyote, psilocybin, PCP"), cocaine ("coke," "crack,""rock"), heroin, narcotics other than heroin, stimulants, barbiturates, or tranquilizers not taken under a doctor's orders. Self-reported.
#26-10a	U.S.--National Survey on Drug Use and Health, SAMHSA. Nebraska--Youth Risk Behavior Surveillance System, HHSS.	Alcohol or illicit drug use by adolescents aged 12 to 17 years is defined as using at least one of the following substances in the past month: alcohol, marijuana or hashish, cocaine (including "crack"), inhalants, hallucinogens (including PCP and LSD), heroin, or any nonmedical use of analgesics, tranquilizers, stimulants, or sedatives. Self-reported. High school students grades 9-12.
#26-10b	U.S.--National Survey on Drug Use and Health, SAMHSA. Nebraska--Youth Risk Behavior Surveillance System, HHSS.	Self-reported. Adolescents aged 12 to 17. Self-reported. High school students grades 9-12.

Table 22 continued		
Data Sources:		Additional Notes:
#26-11c	U.S.--National Survey on Drug Use and Health, SAMHSA. Nebraska--BRFSS, HHSS.	Self-reported. Binge drinking is defined as drinking 5 or more alcoholic beverages at the same time or within a couple of hours of each other during the past 30 days. Same as U.S.
#26-11d	U.S.--National Survey on Drug Use and Health, SAMHSA. Nebraska--Youth Risk Behavior Surveillance System, HHSS.	Self-reported. Binge drinking is defined as drinking 5 or more alcoholic beverages at the same time or within a couple of hours of each other during the past 30 days. Adolescents aged 12 to 17 years. Same as U.S., except for high school students grades 9-12.
#26-xx	U.S.--Youth Risk Behavior Surveillance System, CDC. Nebraska--Youth Risk Behavior Surveillance System, HHSS. BRFSS.	Self-reported. Self-reported.

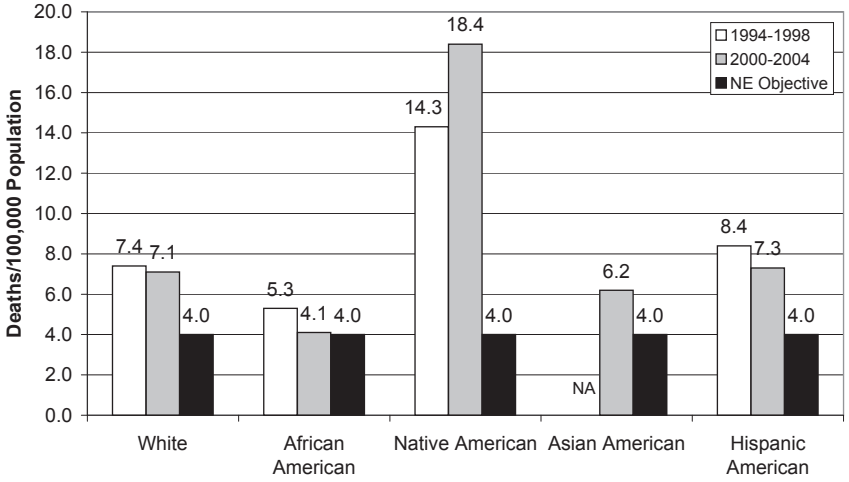
Figure 192
Alcohol-Related Motor Vehicle Death Rates in Nebraska
(Crude Rates)



SOURCE: Nebraska Dept. of Roads, Highway Safety Division. Population estimates--NE HHSS. U.S. DHHS, Healthy People 2010.

Native Americans in Nebraska experienced the highest mortality due to alcohol-related motor vehicle crashes of any racial/ethnic group in the state (18.4 in 2000-2004). This current rate also represents an increase from the 1994-1998 baseline of 14.3 deaths per 100,000 (Figure 193). Other racial/ethnic groups reported modest decreases in these fatality rates. Rates were lowest for African Americans (4.1 in 2000-2004).

Figure 193
Alcohol-Related Motor Vehicle Death Rates in Nebraska by Race/Ethnicity (Crude Rates)

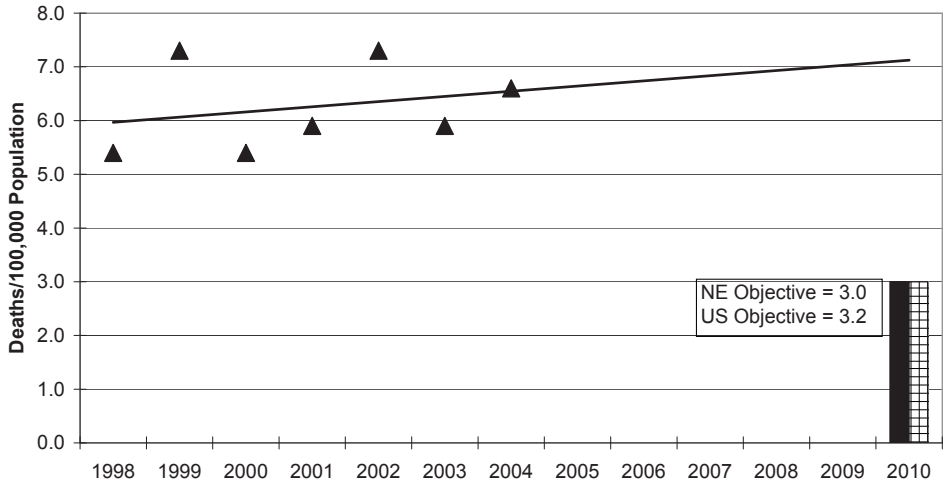


NA = Not Available. Rates based on fewer than five deaths during period.
SOURCE: Nebraska Dept. of Roads, Highway Safety Division. Population estimates--NE HHSS.

Deaths Due to Cirrhosis

Another objective related to alcohol abuse is to reduce the age-adjusted cirrhosis mortality rate to no more than 3.0 in Nebraska and to no more than 3.2 in the U.S. (Table 22). Although the cirrhosis death rate declined somewhat nationally (from 9.6 in 1999 to 9.3 in 2003), it remained higher than the Nebraska rate and much higher than the 2010 objective. In Nebraska, cirrhosis mortality rose from 5.4 deaths per 100,000 in 1998 to 6.4 in 2004, an increase of 19 percent (Figure 194).

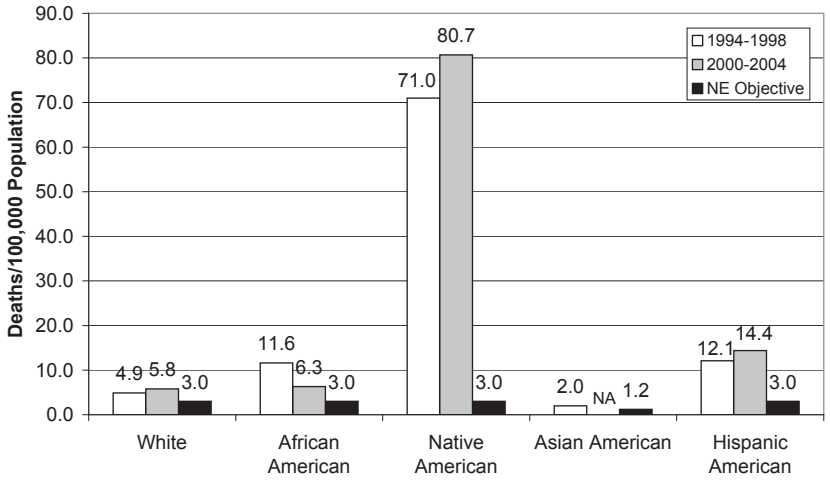
Figure 194
Deaths Due to Cirrhosis (Age-Adjusted to 2000)



SOURCE: Nebraska HHSS, Vital Statistics. U.S. DHHS, Healthy People 2010.

The rate of cirrhosis deaths was by far the highest for Native Americans in the state (Figure 195). In 2000-2004, there were 80.7 deaths per 100,000 population—a rate nearly 14 times as high as the rate for whites (5.8). The rate for Native Americans had also risen 14 percent from 1994-1998. Current cirrhosis mortality rates for Hispanic Americans (14.4) and whites (5.8) also increased, while the rate for African Americans (6.3) in Nebraska was down 46 percent.

Figure 195
Deaths Due to Cirrhosis in Nebraska by Race/Ethnicity
(Age-Adjusted to 2000)

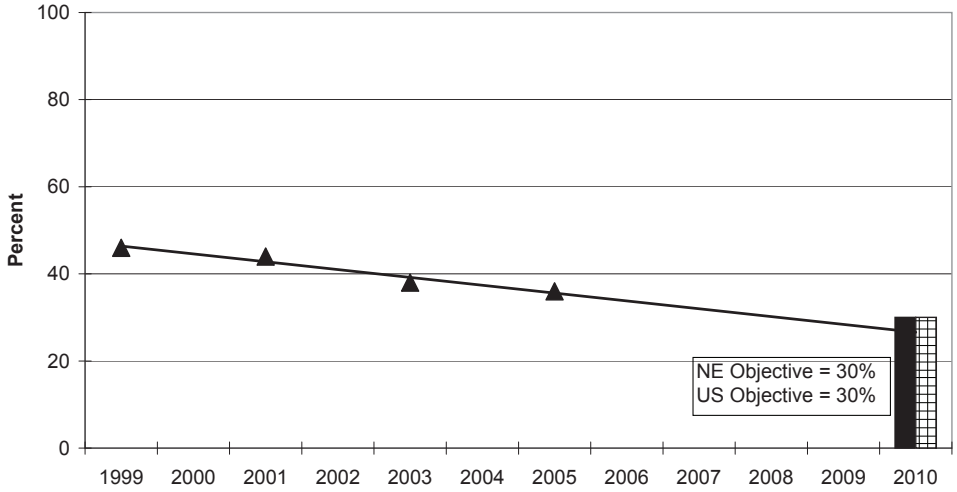


NA = Not Available. Fewer than five deaths reported during the period.
SOURCE: Nebraska HHSS, Vital Statistics.

Riding with a Driver Who Has Been Drinking Alcohol

Another substance abuse objective is to reduce to no more than 30 percent the prevalence of adolescents riding with a driver who had been drinking alcohol, both nationally and in Nebraska (Table 22). This target was reached in the U.S., with 28 percent of high-school students responding to the 2005 YRBS reporting this behavior in the past 30 days. In Nebraska, the 2005 rate was higher (36 percent), but reflects a decrease of 22 percent from the 1999 rate of 46 percent (Figure 196).

Figure 196
Nebraska Adolescents (Grades 9-12) Who Rode with Driver
Who Had Been Drinking (Past 30 Days)



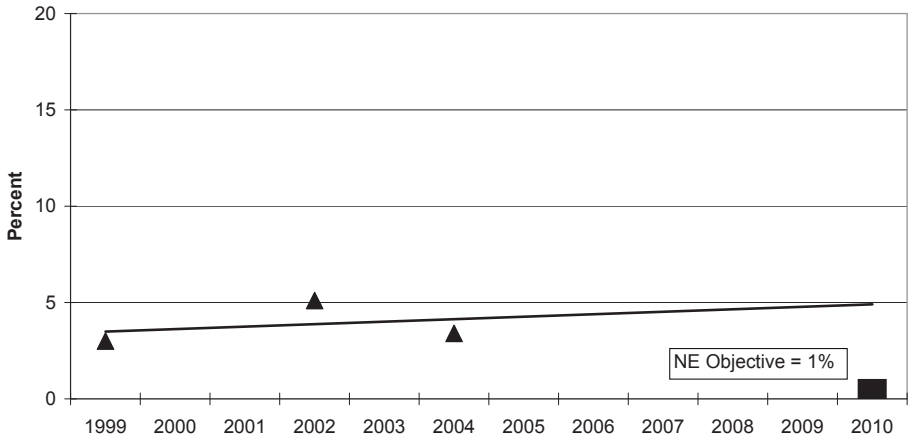
SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

Drinking and Driving

Prevalence of "drinking and driving" is a substance-abuse-related behavior targeted for reduction among Nebraska adults, but not in the national 2010 Healthy People objectives (Table 22). In Nebraska, the intent is to reduce to no more than one percent the proportion of adults who engaged in "drinking and driving" in the past month. Three percent of respondents to the BRFSS reported this behavior, both in 1999 and in 2004 (Figure 197). There was little variation in the "drinking and driving" rates by race or ethnicity of

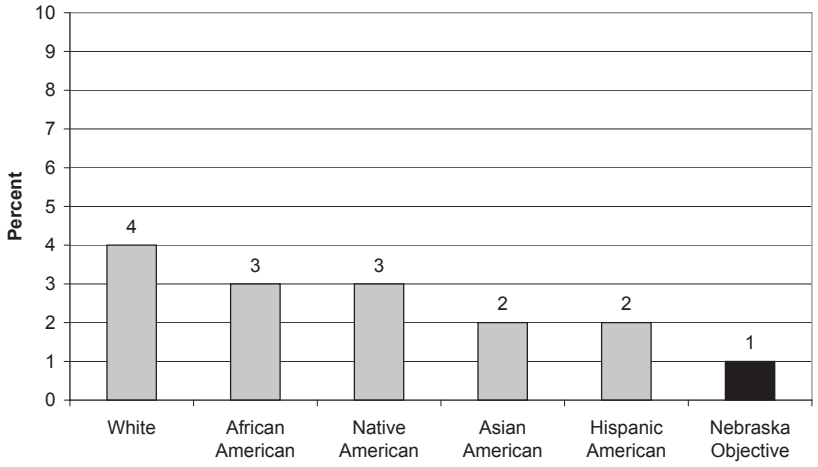
survey respondents, with rates ranging from 2 percent for Asian Americans and Hispanic Americans in the state to 4 percent for white Nebraskans (Figure 198).

Figure 197
Nebraska Adults Aged 18+ Who Engaged in Drinking and Driving in Past 30 Days



NOTE: No U.S. Objective has been set.
SOURCE: Nebraska HHSS, BRFSS.

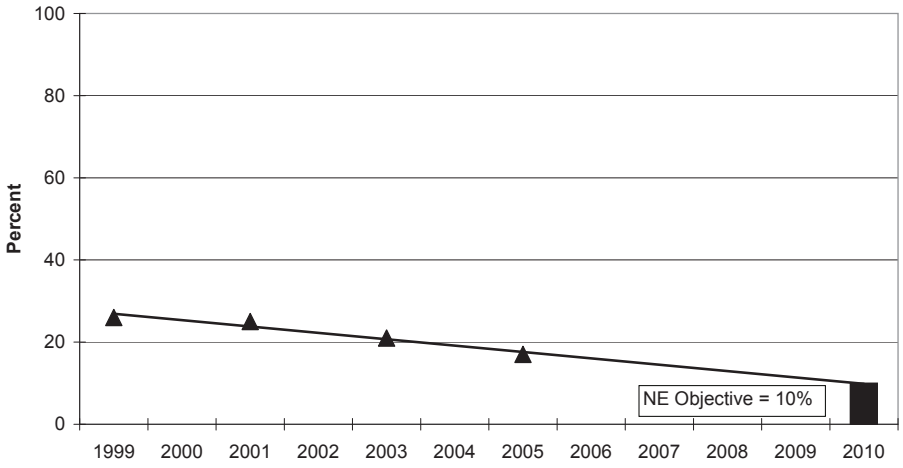
Figure 198
Nebraska Adults Aged 18+ Who Engaged in Drinking and Driving in Past Month by Race/Ethnicity (2001-2005)



SOURCE: Nebraska HHSS, BRFSS.

A related objective adopted in Nebraska (but not nationwide) seeks to reduce the prevalence of drinking and driving in the past 30 days by high-school students to no more than 10 percent by the year 2010 (Table 22). Although an adolescent "drinking and driving" objective was not established for the U.S., results from the YRBS show a decrease in this behavior from 13.1 percent of respondents in 1999 to 9.9 percent in 2005. In Nebraska, prevalence of drinking and driving among high school students (17 percent) was higher than nationwide. However, the current rate represents a decrease of 35 percent from the 1999 one (26 percent) (Figure 199).

Figure 199
Nebraska Adolescents (Grades 9-12) Who Reported Driving After Drinking Alcohol (Past 30 Days)

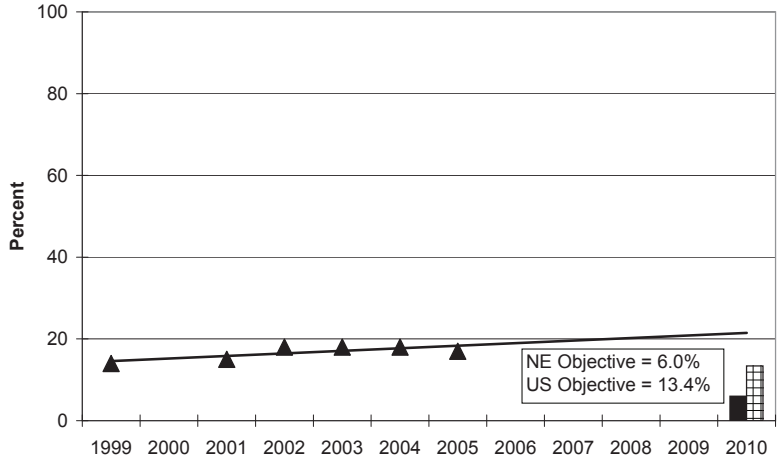


SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

Binge Drinking

Binge drinking is defined here as drinking 5 or more alcoholic beverages at the same time or within a couple of hours of each other during the past 30 days. For adults, the objective is to reduce the proportion participating in binge drinking to no more than 13.4 percent in the U.S. (Table 22). Nationwide prevalence of adult binge drinking decreased slightly from 24.3 percent in 2002 to 24.0 percent the following year. In Nebraska, a lower target rate of no more than 6 percent was set. Based on self-reported BRFSS data, prevalence of binge drinking among adults in the state increased from 14 percent in 1999 to 17 percent in 2005 (Figure 200).

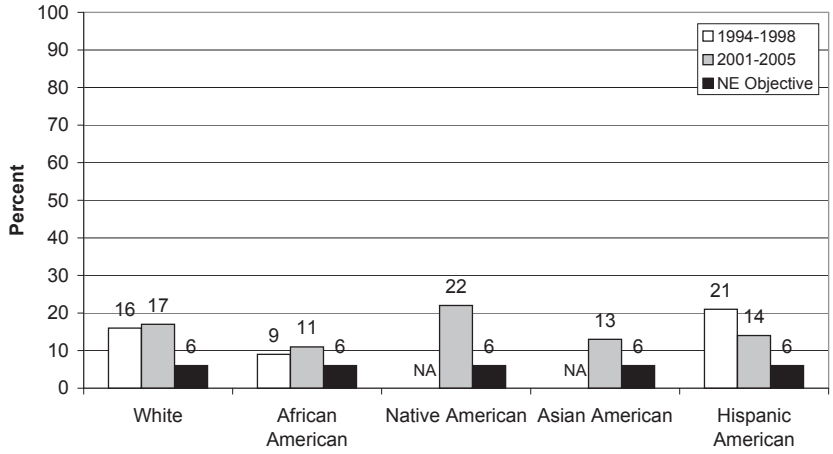
Figure 200
Nebraska Adults Aged 18+ Who Engaged in Binge Drinking in Past 30 Days



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Prevalence of binge drinking among Nebraska adults was highest among Native Americans (22 percent), followed by white Nebraskans (17 percent) in 2001-2005 (Figure 201). Prevalence edged upward for whites and African Americans compared to 1994-1998 rates, although African Americans reported the lowest rate of the five racial/ethnic groups (11 percent in 2001-2005). Prevalence of binge drinking declined for Hispanic Americans, moving from 21 percent in 1994-1998 to 14 percent in 2001-2005.

Figure 201
Nebraska Adults Aged 18+ Who Engaged in Binge Drinking in Past Month by Race/Ethnicity

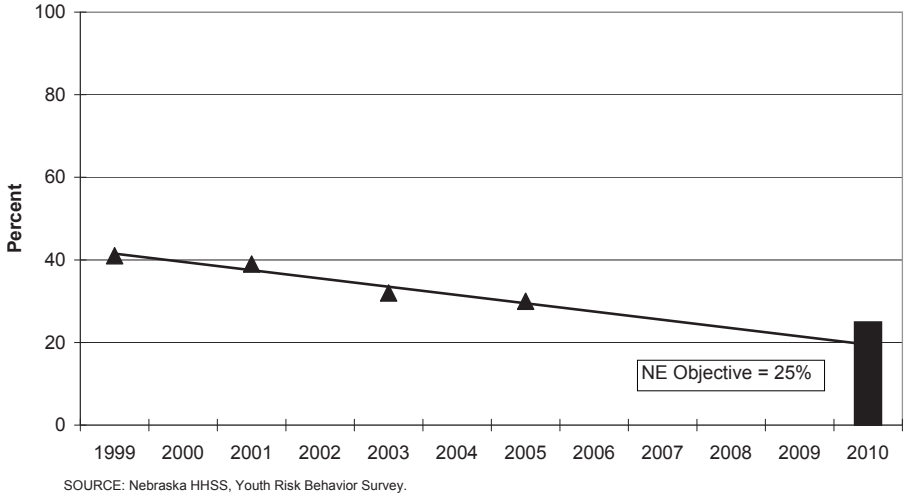


NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Another similar objective is to reduce the prevalence of binge drinking in the past month among high school students (Table 22). As in some of the other substance abuse objectives, rates and objectives differ substantially between Nebraska and the nation, since data sources are not the same. The U.S. objective is to reduce the proportion of high school students engaging in binge drinking to no more than 3.1 percent by 2010. Very little change occurred between the 2002 national baseline of 10.7 percent and 2003 current rate of 10.6 in 2004.

In Nebraska, the 2010 target rate was established at no more than 25 percent of high-school students binge drinking in the past 30 days (Figure 202). Progress was made toward achieving this objective, with prevalence declining from 41 percent in 1999 to 30 percent in 2005—a decrease of 27 percent.

Figure 202
Nebraska Adolescents (Grades 9-12) Who Engaged in Binge Drinking in Past 30 Days



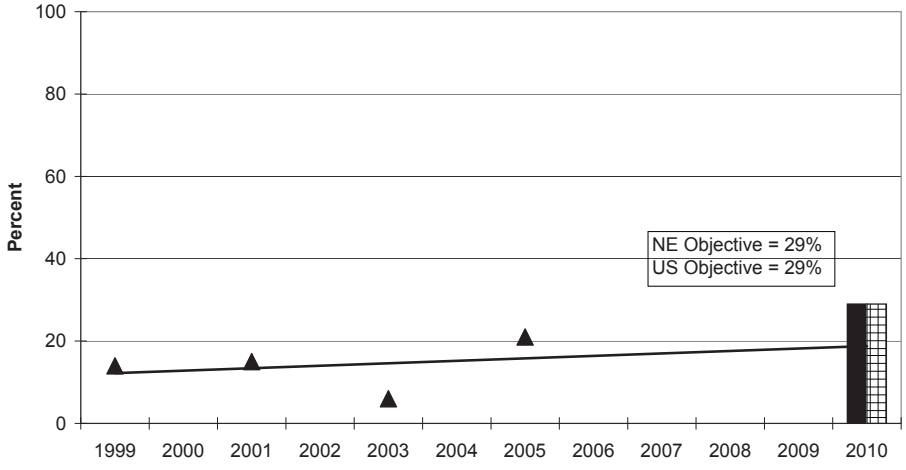
SOURCE: Nebraska HHSS, Youth Risk Behavior Survey.

Other Substance Abuse Among Adolescents

Another substance abuse objective for the adolescent population (in the U.S. and in Nebraska) is to increase to at least 29 percent the proportion of high-school seniors who never drank alcoholic beverages

(Table 22). Improvement was noted nationwide and in Nebraska. In the U.S., the proportion increased from 19 in 1998 to 23 percent in 2004, according to the Monitoring the Future Study. In Nebraska, 21 percent of high-school seniors in the 2005 YRBS reported never having drunk alcoholic beverages, up 50 percent from the 1999 rate of 14 percent (Figure 203).

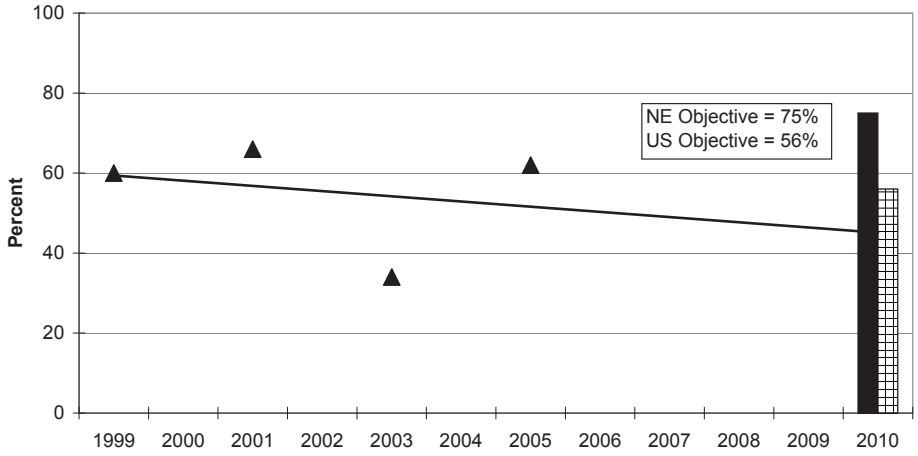
Figure 203
Nebraska High School Seniors
Who Never Drank Alcoholic Beverages



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

A similar objective was adopted nationwide and in Nebraska for illicit drug use. For the U.S., the objective aims to increase the proportion of high-school seniors who never used any illicit drug to at least 56 percent by 2010 (Table 22). The U.S. rate rose somewhat, from 46 percent in 1998 to 49 percent in 2004. For Nebraska, a target rate of at least 75 percent was established. The proportion of high-school seniors in the state who never used an illicit drug was higher than the national rate (62 percent in 2005), but no clear trend in prevalence could be determined (Figure 204). (Please note that the U.S. and Nebraska data sources are different.)

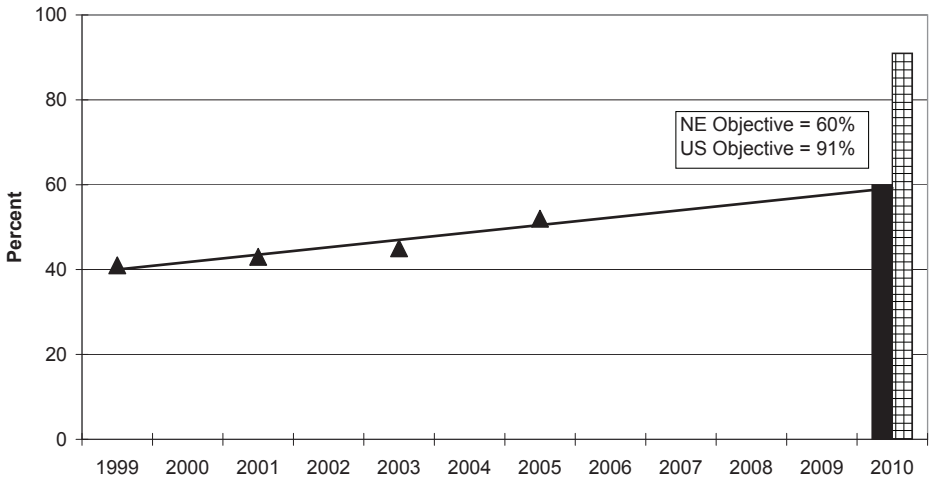
Figure 204
Nebraska High School Seniors
Who Never Used Any Illicit Drug



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

A related objective tracks the proportion of adolescents in grades 9 through 12 who had not used alcohol or any illicit drug in the past 30 days. The U.S. objective is to increase this proportion to at least 91 percent by 2010 (Table 22). The U.S. baseline was established in 2002 at 78 percent and did not change in 2003 (the most recent data available). For Nebraska, the target rate is much lower (60 percent), using a different data source. An increase of 27 percent occurred in the proportion of these not using alcohol or any illicit drug in the past month, moving from 41 percent in 1999 to 52 percent in 2005 (Figure 205).

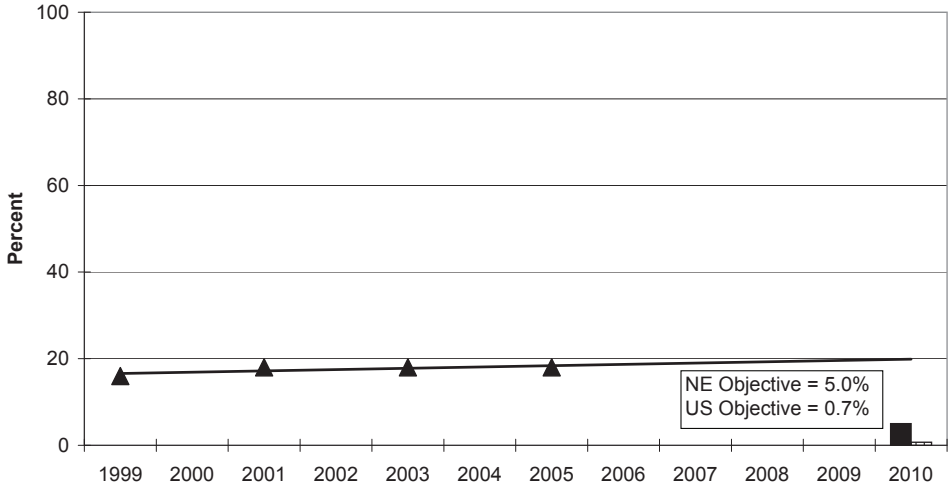
Figure 205
Nebraska High School Students Who Did Not Use Alcohol or Illicit Drugs in Past 30 Days



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

For marijuana use, the national objective is to reduce to no more than 0.7 percent the proportion of high-school students using marijuana in the past 30 days (Table 22). Nationwide, there was a slight reduction in prevalence from 8.2 percent in 2002 to 7.9 percent in 2005, based on the National Household Survey on Drug Abuse. In Nebraska, the intent is to reduce this rate to no more than 5 percent by 2010. However, YRBS results show an increase in prevalence from 16 percent of high-school students using marijuana in 1999 to 18 percent in 2005 (Figure 206).

Figure 206
Nebraska Adolescents (Grades 9-12) Who Used Marijuana in Past 30 Days



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

TOBACCO USE

Healthy People 2010 Goals

The goal of the Tobacco Use objectives is to reduce the illness, disability, and death that are related to tobacco use and to exposure to environmental tobacco smoke.

Background

Tobacco use remains the single most preventable cause of disease and death in the United States today. Cigarette smoking is responsible for approximately 438,000 deaths annually—about 20 percent of all deaths in this country. Most of these deaths are due to cancer, cardiovascular disease, or respiratory disease. On average, adults who smoke cigarettes die 14 years earlier than nonsmokers.

Other forms of tobacco are not safe alternatives to smoking cigarettes. Cigar smoking and pipe smoking increase the risk of dying from cancers of the lung, esophagus, larynx, and oral cavity. Smokeless ("spit") tobacco includes oral forms of tobacco, primarily snuff and chewing tobacco products. Smokeless tobacco use is the single most important risk for oral cancers (cancers of the lip, mouth, tongue, and throat).

Secondhand smoke is responsible for an estimated 3,000 lung cancer deaths annually in nonsmokers and an estimated 35,000 deaths due to cardiovascular disease.

For 1997–2001, cigarette smoking was estimated to be responsible for $167 billion in annual health–related economic losses in the United States ($75 billion in direct medical costs, and $92 billion in lost productivity), or about $3,702 per adult smoker. In Nebraska, cigarette smoking cost approximately $858 million for medical care of people with smoking-related illness and for lost wages and productivity in 2002.

Progress Toward Healthy People 2010 Objectives

National

Progress was made nationwide toward target rates for eight of the nine Tobacco Use objectives (or sub-objectives) adopted by Nebraska and the U.S. Prevalence rates for cigarette smoking, smokeless tobacco use, and cigar smoking among adults all showed at least modest decreases. Adolescent use of any tobacco product was down, as was use of most individual tobacco products. (Only use of smokeless tobacco among high-school students remained steady). There were also fewer households with children under five years of age where someone had smoked in the past month.

Nebraska

Progress was also noted for eight of the nine 2010 Tobacco Use objectives in Nebraska. Fewer adults reported smoking cigarettes or cigars. Among high-school students, reductions were seen in all forms of tobacco use (five sub-objectives). In addition, there were fewer Nebraska households with children under age five where someone had smoked in the past month.

No progress was made in reducing the proportion of men who currently used smokeless tobacco.

Cigarette Smoking—Adults

Nebraska and the nation have established a 2010 objective of reducing prevalence of cigarette smoking to no more than 12 percent among adults (Table 23). Nationwide, the proportion of adults who currently smoked cigarettes decreased from 24 percent in 1998 to 21 percent in 2005. In Nebraska, 21 percent

of adults also reported that they were current smokers in 2005. This rate represents a decrease of two percentage points from 1999 (Figure 207).

Table 23
Nebraska 2010 Health Goals and Objectives
Tobacco Use

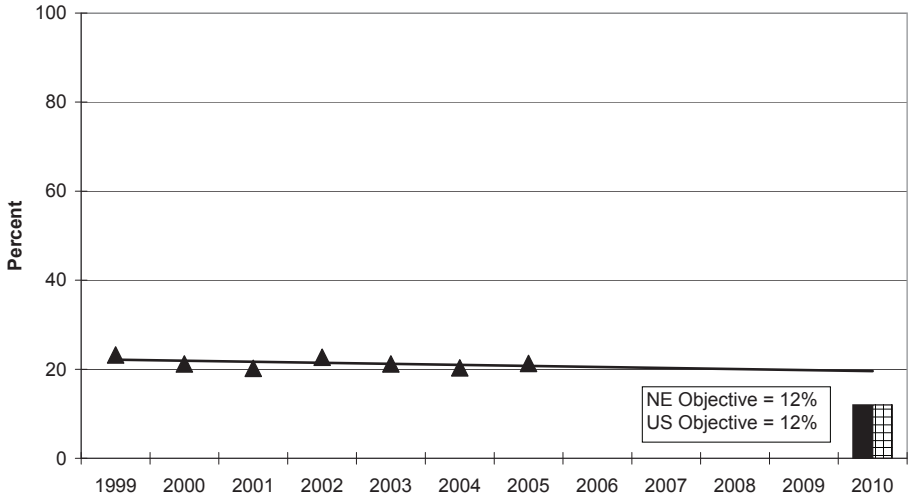
		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#27-1a	Percent of adults aged 18+ who currently smoke cigarettes	1998	24	2005	21	12	1999	23	2005	21	12
	White	1998	25	2005	21	12	1994-1998	21	2001-2005	21	12
	African American	1998	25	2005	21	12	1994-1998	27	2001-2005	26	12
	Native American	1998	35	2005	25	12	1994-1998	NA	2001-2005	47	12
	Asian American	1998	13*	2005	13*	12	1994-1998	NA	2001-2005	22	12
	Hispanic American	1998	19	2005	15	12	1994-1998	25	2001-2005	18	12
#27-1b	Percent of males aged 18+ who currently use smokeless tobacco	1998	4.9	2005	4.5	0.4	1999	9	2004	9	4
	White	1998	2.9	2005	2.6	0.4	Data not available by race/ethnicity		2000-2004	8	4
	African American	1998	1.1	2005	1.3	0.4			2000-2004	3	4
	Native American	1998	NA	2005	NA	0.4			2000-2004	11	4
	Asian American	1998	NA	2005	NA	0.4			2000-2004	3	4
	Hispanic American	1998	0.5	2005	NA	0.4			2000-2004	1	4
#27-1c	Percent of adults aged 18+ who currently smoke cigars	1998	2.4	2005	2.2	1.2	1998	5	2004	3	2
	White	1998	2.6	2005	2.4	1.2	Data not available by race/ethnicity		2000-2004	5	2
	African American	1998	1.9	2005	1.4	1.2			2000-2004	6	2
	Native American	1998	NA	2005	NA	1.2			2000-2004	10	2
	Asian American	1998	NA	2005	NA	1.2			2000-2004	5	2
	Hispanic American	1998	1.3	2005	1.6	1.2			2000-2004	2	2
#27-2a	Percent of adolescents in grades 9-12 who used tobacco products (cigarettes, spit tobacco, or cigars) in the past month Data not available by race or ethnicity	1999	40	2005	28	21	1999	44	2005	28	21
#27-2b	Percent of adolescents in grades 9-12 who smoked cigarettes in the past month Data not available by race or ethnicity	1999	35	2005	23	16	1999	37	2005	22	15
#27-2c	Percent of adolescents in grades 9-12 who used spit tobacco in the past month Data not available by race or ethnicity	1999	8	2005	8	1	1999	12	2005	9	6
#27-2d	Percent of adolescents in grades 9-12 who smoked cigars in the past month Data not available by race or ethnicity	1999	18	2005	14	8	1999	20	2005	17	10
#27-2e	Percent of adolescents in grades 9-12 who smoked bidis in the past month Data not available by race or ethnicity		4	2002	3	2	1999	20	2003	18	10
#27-9	Percent of households with children under five years of age where someone had smoked during the past month Data not available by race or ethnicity	1998	20	2005	8	6	1999	28	2000	21	10

*Asian only. NA = Not Available

Data Sources:		Additional Notes:
#27-1a	U.S.--National Health Interview Survey (NHIS), CDC.	Percent of adults aged 18 and older who have smoked at least 100 cigarettes in their lifetime and who now report smoking cigarettes everyday or some days.
	Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS	Same as U.S.
#27-1b	U.S.--National Health Interview Survey (NHIS), CDC.	Percent of adult males aged 18 and older who have used snuff or chewing tobacco at least 20 times in their lifetime and who now use it everyday or some days.
	Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Percent of adult males aged 18 and older who report that they "currently use any smokeless tobacco products such as chewing tobacco or snuff."

Table 23 continued		
Data Sources:		Additional Notes:
#27-1c	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Percent of adults aged 18 and older who have smoked at least 50 cigars in their lifetime and who now smoke cigars everyday or some days. Percent of adults aged 18 and older who "ever smoked a cigar, even just a few puffs" and last smoked a cigar within the past month.
#27-2a,2b,	U.S.--Youth Risk Behavior Surveillance System (YRBS), CDC.	Self-reported.
2c, 2d	Nebraska--Youth Risk Behavior Survey (YRBS).	Self-reported.
#27-2e	U.S.--National Youth Tobacco Survey, American Legacy Foundation and CDC. Nebraska--Youth Risk Behavior Survey (YRBS).	Self-reported. Self-reported.
#27-9	U.S.--National Health Interview Survey (NHIS), CDC. Nebraska--Behavioral Risk Factor Surveillance System (BRFSS), HHSS.	Percent of children aged six and under living in households where a household resident smoked inside the home at least four days per week. Cigarette, cigar, and pipe smoking are all counted. Percent of households with children under five years of age where someone (the respondent or anyone else) has smoked cigarettes, cigars, or pipes anywhere inside your home in the past 30 days.

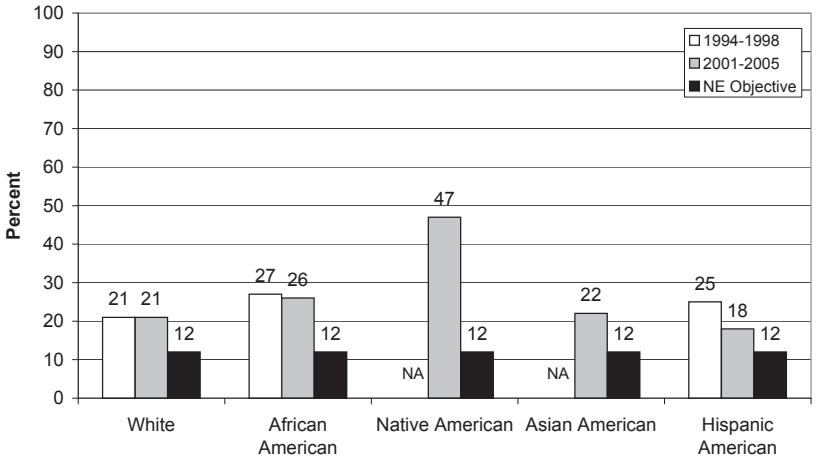
Figure 207
Nebraska Adults Age 18+ Who Currently Smoke Cigarettes



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Native American adults reported by far the largest proportion of current smokers (47 percent) of any racial/ethnic group in Nebraska in 2001-2005 (Figure 208). Smoking prevalence among African American adults (26 percent) was somewhat higher than the rates for Asian Americans (22 percent), whites (21 percent), and Hispanic Americans (18 percent). However, the rate for African Americans was down one percentage point from the 1994-1998 baseline. For Hispanic Nebraskans, a substantial decrease in the smoking rate was recorded, with prevalence declining from 25 percent in 1994-1998 to the current 18 percent.

Figure 208
Nebraska Adults Aged 18+ Who Currently Smoke Cigarettes by Race/Ethnicity



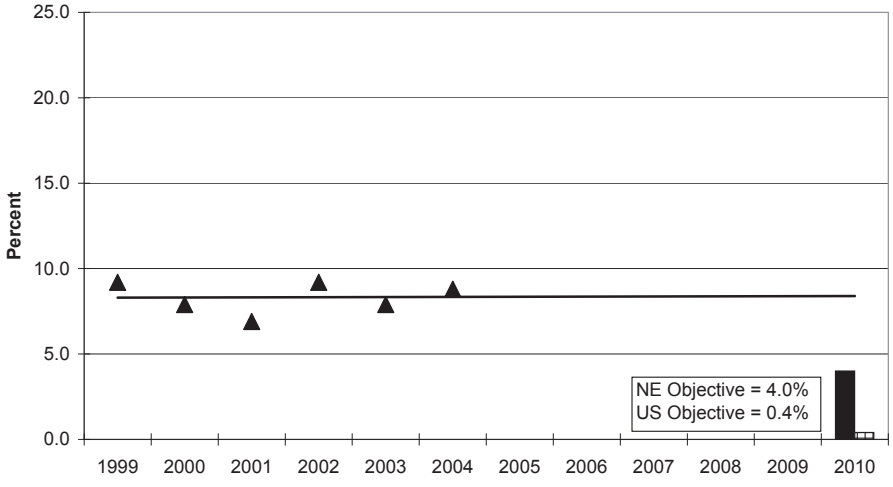
NA = Not Available. Data not reported due to N<50.
SOURCE: Nebraska HHSS, BRFSS.

Smokeless Tobacco Use—Adult Males

Another objective for Nebraska and the nation is to reduce the proportion of men who currently use smokeless tobacco. A target rate of no more than 0.4 percent of adult males using this form of tobacco was set for the U.S., while a higher target rate (4 percent) has been established for Nebraska (Table 23).

A small decrease in prevalence of smokeless tobacco use among men was achieved nationwide, with the 2005 rate (4.5 percent) down 8 percent from the 1998 rate of 4.9 percent. In Nebraska, prevalence remained steady at 9 percent (Figure 209).

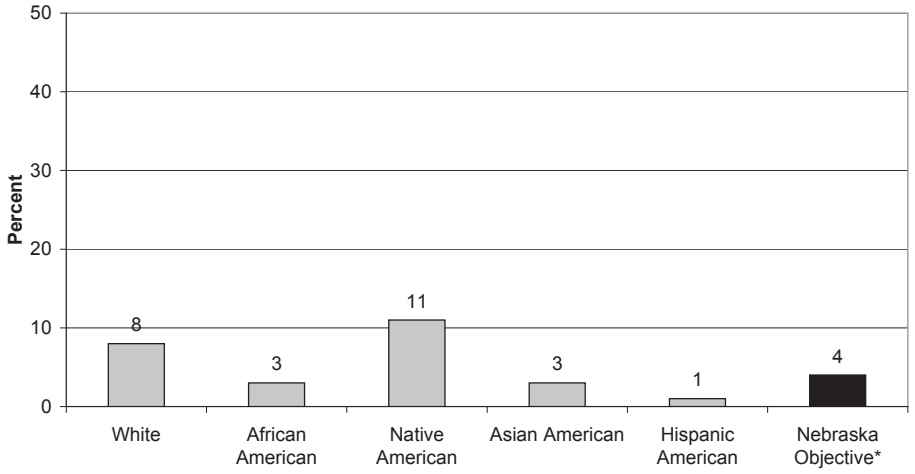
Figure 209
Nebraska Men Aged 18+ Who Currently Use Smokeless Tobacco



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Native American (11 percent) and white (8 percent) men in Nebraska were more likely than men in other racial/ethnic groups to say they currently use smokeless tobacco (Figure 210). Rates for African Americans, Asian Americans, and Hispanic Americans in the state ranged from 1 percent to 3 percent of men. Thus, the 2010 objective was achieved for men in these three racial/ethnic groups. A revised objective, matching the U.S. target of no more than 0.4 percent of men using smokeless tobacco, has been adopted for Nebraska men in these population groups (Appendix, Table A).

Figure 210
Nebraska Men Aged 18+ Who Currently Use Smokeless Tobacco by Race/Ethnicity (2000-2004)



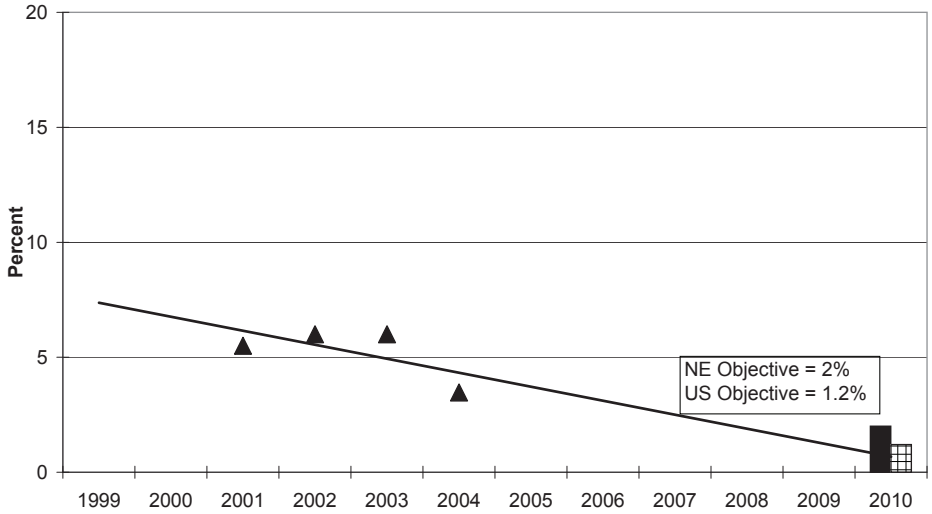
*Nebraska objective met for African Americans, Asian Americans, and Hispanic Americans and will be revised.
SOURCE: Nebraska HHSS, BRFSS.

Cigar Smoking—Adults

Reducing the proportion of adults who currently smoke cigars is another tobacco-related objective shared by Nebraska and the U.S. A target rate of no more than 1.2 percent has been established for the nation, while a target of no more than 2 percent was set for Nebraska (Table 23).

A slight decrease in the proportion of adults who are current cigar-smokers was achieved nationwide, with a rate of 2.2 percent reported for 2005. In Nebraska, prevalence declined from 5 percent in 1998 to 3 percent in 2004 (Figure 211).

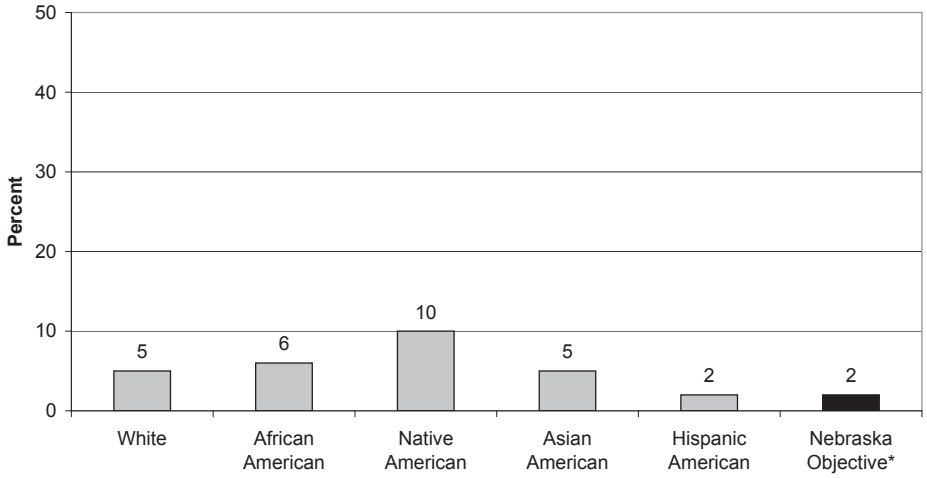
Figure 211
Nebraska Adults Aged 18+ Who Currently Smoke Cigars



SOURCE: Nebraska HHSS, BRFSS. U.S. DHHS, Healthy People 2010.

Some differences were noted in prevalence of current cigar smoking by race/ethnic origin in Nebraska (Figure 212). The rate was highest for Native Americans (10 percent in 2000-2004). Hispanic Americans (2 percent) were the only group meeting the 2010 objective. For them, the 2010 target rate has been revised to no more than 1.2 percent prevalence of cigar smoking (Appendix, Table A).

Figure 212
Nebraska Adults Aged 18+ Who Currently Smoke Cigars by Race/Ethnicity (2000-2004)

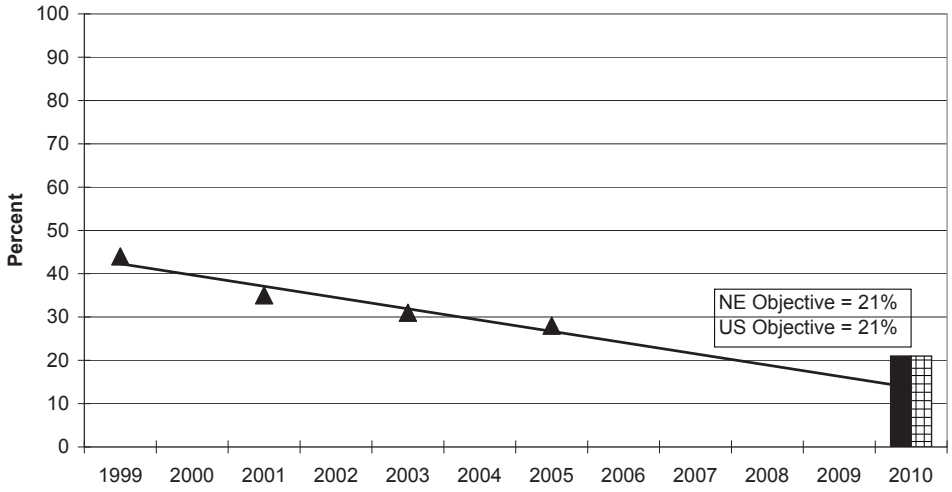


*Nebraska objective met for Hispanic Americans and will be revised.
SOURCE: Nebraska HHSS, BRFSS.

Current Adolescent Use of Any Tobacco Product

One of the objectives in this focus area seeks to reduce the proportion of adolescents in grades 9 through 12 who used any tobacco product (cigarettes, spit tobacco, or cigars) in the past month to no more than 21 percent by 2010 (both nationwide and in Nebraska) (Table 23). The U.S. rate declined from 40 percent of high-school students using any tobacco in 1999 to 28 percent in 2005. In Nebraska, a greater reduction was achieved with this rate decreasing from 44 percent in 1999 to 28 percent in 2005 (Figure 213).

Figure 213
Nebraska Adolescents (Grades 9-12) Who Used Tobacco Products in Past Month

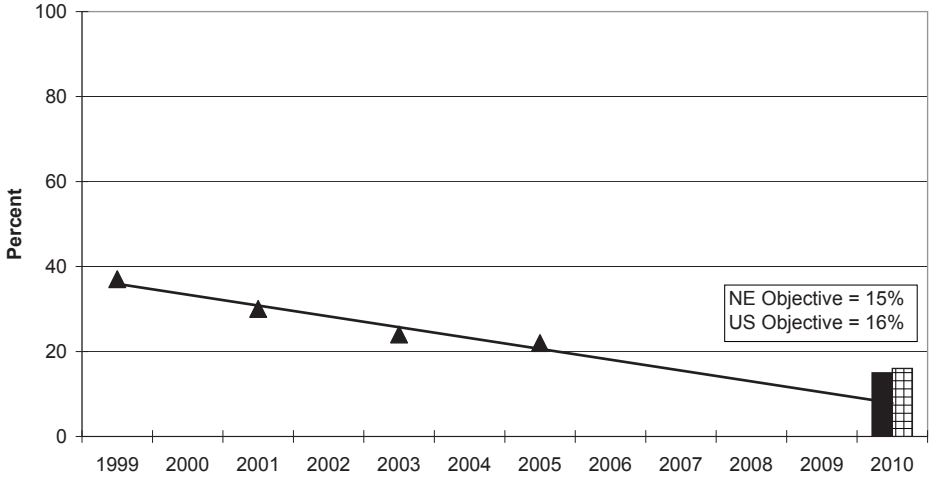


SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

Current Cigarette Smoking—Adolescents

Another tobacco-related objective established for Nebraska is to reduce the proportion of high-school students who smoked cigarettes in the past month to no more than 15 percent. The U.S. objective is to lower this rate to no more than 16 percent by 2010 (Table 23). Smoking prevalence among adolescents decreased in Nebraska and nationwide. The U.S. rate dropped from 35 percent in 1999 to 23 percent in 2005. In Nebraska, prevalence declined even more from 37 percent in 1999 to 22 percent in 2005 (Figure 214).

Figure 214
Nebraska Adolescents (Grades 9-12) Who Smoked Cigarettes in Past Month

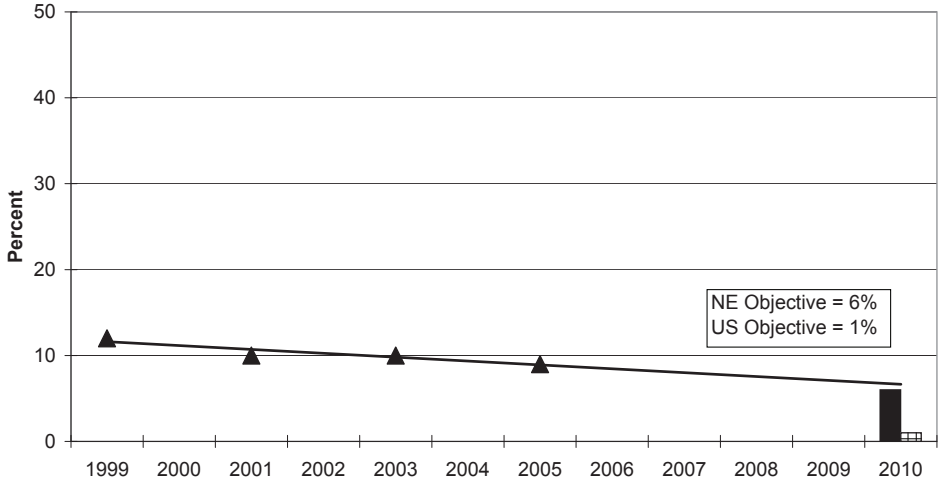


SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

Smokeless ("Spit") Tobacco Use—Adolescents

Reducing the proportion of high-school students who used spit tobacco in the past month to no more than one percent by 2010 is one of the national Tobacco Use objectives (Table 23). The Nebraska target rate is set at no more than 6 percent. There was no change in the U.S. rate between 1999 and 2005 (8 percent each year). Prevalence of spit tobacco use among adolescents did decrease in Nebraska from 12 percent in 1999 to 9 percent in 2005 (Figure 215).

Figure 215
Nebraska Adolescents (Grades 9-12) Who Used Smokeless Tobacco in the Past Month

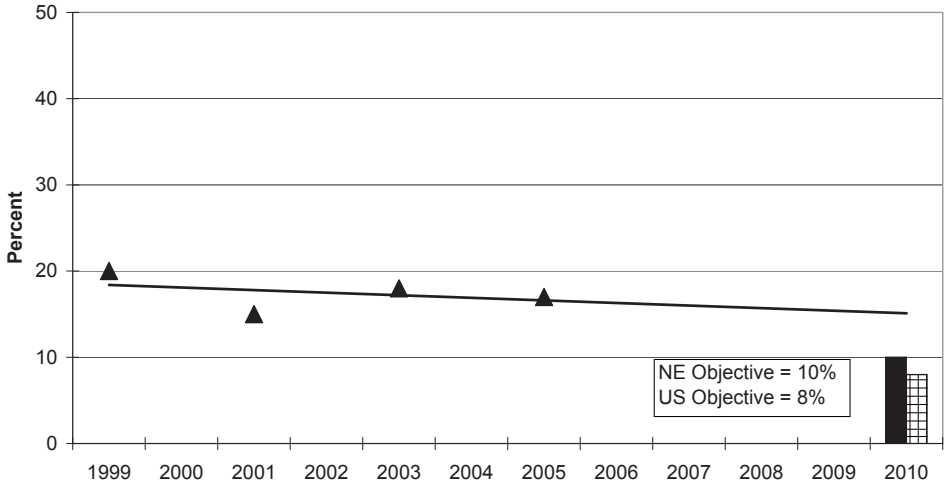


SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

Current Cigar Smoking—Adolescents

In the U.S., an objective to reduce prevalence of cigar smoking in the past month to no more than 8 percent among adolescents has been adopted (Table 23). For Nebraska, the target rate has been set at 10 percent. Progress was made in the U.S. and in Nebraska. The nationwide rate decreased from 18 percent in 1999 to 14 percent in 2005, while prevalence in Nebraska declined from 20 percent in 1999 to 17 percent in 2005 (Figure 216).

Figure 216
Nebraska Adolescents (Grades 9-12) Who Smoked Cigars in Past Month



SOURCE: Nebraska HHSS, Youth Risk Behavior Survey. U.S. DHHS, Healthy People 2010.

Current Bidi Smoking—Adolescents

Nebraska and the nation have each established objectives seeking to reduce prevalence of bidi smoking among high-school students. (Bidis are small, thin, flavored cigarettes imported from India or southeast Asia). The U.S. objective is to lower the proportion of students smoking bidis in the past month to no more than 2 percent (Table 23). In Nebraska, the target rate is 10 percent or less.

Nationwide, the rate was down by one percentage point between 2000 (4 percent) and 2002 (3 percent). In Nebraska, a small decrease in prevalence occurred (from 20 percent in 1999 to 18 percent in 2003).

Smoking in Households with Young Children

One of the 2010 Tobacco Use objectives tracks progress in reducing exposure of young children to environmental tobacco smoke (ETS), also called "secondhand smoke". The U.S. objective aims to reduce to no more than 6 percent the proportion of children under age six where a household resident smoked inside the home at least four days per week. A substantial reduction was achieved in this measure—from 20 percent of children in 1998 to 8 percent in 2005.

In Nebraska, this objective intends to reduce to no more than 10 percent the proportion of households with children under five years of age where someone has smoked cigarettes, cigars, or pipes anywhere inside the home in the past 30 days. Only two years of data are available from the Nebraska BRFSS. However, results show a decrease from 28 percent in 1999 to 21 percent in 2000.

VISION AND HEARING

Healthy People 2010 Goal

The national Healthy People 2010 goals are to improve the visual and hearing health of the nation through prevention, early detection, treatment, and rehabilitation.

Background

Of the five senses, people probably depend most on vision and hearing to give them the cues they need for performing the basic activities of daily life. These two senses allow people to stay oriented and to move about within their environment. They also provide the means for discerning language and are very important to most work and recreational activities and allow people to interact more fully with each other and their environment.

An estimated 28 million people in the United States are deaf or hard of hearing. The age of a child when hearing impairment is diagnosed is crucial to the development of the child's speech, language, cognitive, and psychosocial abilities. The Early Hearing Detection and Intervention Program (EHDI), a component of the National Center for Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention, recommends that all children be screened for hearing loss by one month of age. EHDI further states that all infants who screen positive for hearing loss should be referred for audiological evaluation. Infants with confirmed hearing loss should then be referred for a comprehensive medical evaluation and intervention programs to address the hearing loss.

Progress Toward Healthy People 2010 Objectives

Only one of the national objectives from the Vision and Hearing focus area has been adopted by Nebraska, due to unavailability of data. This three-part objective seeks to increase the proportions of:

- newborns who are screened for hearing loss by age one month;
- infants with possible hearing loss who have audiologic evaluation by age three months; and
- infants with confirmed hearing loss who are enrolled in intervention services by age six months.

Newborn Screening for Hearing Loss

Nationwide, the proportion of infants receiving screening for hearing loss by age one month increased from 66 percent in 2001 to 83 percent in 2002. This rate falls short of the U.S. target rate of at least 90 percent infants receiving this screening by one month of age (Table 24).

Table 24
Nebraska 2010 Health Goals and Objectives
Vision and Hearing

		UNITED STATES					NEBRASKA				
		Baseline		Current		U.S. 2010	Baseline		Current		NE 2010
Objective		Year	Rate	Year	Rate	Objective	Year	Rate	Year	Rate	Objective
#28-11	Percent of newborns who are screened for hearing loss by age one month, have audiologic evaluation by age three months, and are enrolled in appropriate intervention services by age six months						2000	36			95
	a. Screening for hearing loss before age 1 month	2001	66	2002	83	90			2005	99	95*
	b. Receipt of audiologic evaluation before age 3 months among infants with possible hearing loss	2001	56	2002	52	70			2005	48	70*
	c. Enrollment of infants with confirmed hearing loss for intervention services before age 6 months	2001	57	2002	43	85			2005	52	85*

*Target rates (matching U.S. objectives) set in 2006 for Nebraska.

Data Sources:		Additional Notes:
#28-11	U.S.--State-based Early Hearing Detection and Intervention (EHDI) Program Network, CDC. Nebraska--Nebraska Early Hearing Detection and Intervention (EHDI) Program, HHSS.	More detailed data available for 2005.

In Nebraska, a target rate of 95 percent of newborns screened by age one month was established. In 2005, 99 percent of newborns were screened, achieving this part of the 2010 objective. This objective has been revised upward to 99 percent of infants receiving this screening by age one month (Appendix, Table A).

Audiologic Evaluation for Infants with Possible Hearing Loss

This part of the objective aims to increase to at least 70 percent the proportion of infants with possible hearing loss who receive an audiologic evaluation by age three months. Both Nebraska and the U.S. have adopted this target rate.

The U.S. rate decreased somewhat from 56 percent in 2001 to 52 percent in 2002. In Nebraska, 48 percent of infants with possible hearing loss were given an audiologic evaluation by three months of age in 2005.

Enrollment of Infants with Hearing Loss in Intervention Services

The third part of this objective tracks the proportion of children with confirmed hearing loss who are enrolled in intervention services by the time they are six months old. A target rate of at least 85 percent has been established for the U.S. and for Nebraska.

The proportion of these children enrolled for intervention services by age six months decreased nationwide from 57 percent in 2001 to 43 percent in 2002. In Nebraska, more than one-half of these infants with confirmed hearing loss (52 percent) were enrolled to receive interventions by age six months.

Appendix

TABLE A

Table A Nebraska 2010 Objectives Already Met and Revised Objectives Established						
Focus Area/Objective		Original NE 2010 Objective	NE Baseline Rate	NE Current Rate	Revised NE 2010 Objective	Current US 2010 Objective
ARTHRITIS, OSTEOPOROSIS, AND CHRONIC BACK CONDITIONS						
#2-2	Percent of adults aged 18+ with doctor-diagnosed arthritis who experience limitation in activity due to arthritis or joint symptoms	35%	23%	22%	19%	33%
CANCER						
#3-3	Breast cancer death rate/100,000 females Hispanic Americans	12.0	15.0	9.7	7.8	21.3
#3-4	Cervical cancer death rate/100,000 females White females	2.0	2.7	2.0	1.5	2.0
#3-7	Prostate cancer death rate/100,000 population White males	25.9 25.9	28.8 29.8	24.1 25.4	21.7 21.7	28.2 28.2
#3-8	Melanoma death rate/100,000 population African Americans	2.4	*	0.0	0.0	2.3
# --	Lymphoma death rate/100,000 population African Americans Hispanic Americans	6.2 6.2	13.7 6.9	4.8 4.8	3.4 3.4	No Target Rates Set
# --	Leukemia death rate/100,000 population Native Americans Asian Americans	5.2 5.2	* *	0.0 0.0	0.0 0.0	No Target Rates Set
#3-12b	Percent of adults aged 50+ who ever had sigmoidoscopy or colonoscopy Native Americans	50%	NA	50%	60%	50%
#3-13	Percent of women age 40+ who had mammogram within the past 2 years White African Americans	75% 75% 75%	70% 64% 68%	76% 76% 77%	82% 82% 82%	70% 70% 70%
DIABETES						
#5-12	Percent of persons with diabetes who had glycosylated hemoglobin measurement at least twice in past year (age 18+) White African Americans Native Americans Hispanic Americans	50% 50% 50% 50% 50%	27% NA NA NA NA	65% 72% 75% 93% 56%	75% 75% 75% 75% 75%	65% 65% 65% 65% 65%
#5-13	Percent of adults w/diabetes who had dilated eye exam in past year (age 18+) White African Americans Native Americans	75% 75% 75% 75%	61% NA NA NA	76% 75% 79% 82%	84% 84% 84% 84%	76% 76% 76% 76%
#5-14	Percent of adults w/diabetes who had foot exam in past year (age 18+) African Americans Native Americans	80% 80%	NA NA	84% 84%	91% 91%	91% 91%
#5-17	Percent of adults w/diabetes who perform self-blood glucose monitoring at least once a day (age 18+) African Americans Native Americans	65% 65%	NA NA	71% 81%	75% 85%	61% 61%

Table A continued						
Focus Area/Objective		Original NE 2010 Objective	NE Baseline Rate	NE Current Rate	Revised NE 2010 Objective	Current US 2010 Objective
HEART DISEASE AND STROKE						
#12-1	Coronary heart disease death rate per 100,000 White Hispanic Americans	121.5 121.5 69.6	151.9 168.4 87.0	112.1 120.2 69.5	84.0 90.0 52.0	162.0 162.0 162.0
#12-9	Percent of adults (age 18+) with high blood pressure--among those who ever had it checked Asian Americans Hispanic Americans	 16% 16%	 NA 19%	 12% 13%	 10% 10%	 14% 14%
#12-14	Percent of adults (age 18+) with high blood cholesterol--among those who ever had it checked Hispanic Americans	 17%	 29%	 17%	 17%	 13%
IMMUNIZATION AND INFECTIOUS DISEASES						
#14-6	Rate of new hepatitis A cases per 100,000 population	1.5	3.2	1.1	0.6	4.3
INJURY AND VIOLENCE PREVENTION						
#15-15a	Death rate due to motor vehicle crashes per 100,000 population African Americans	 12.0	 12.6	 9.7	 8.0	 8.0
#15-17	Rate of non-fatal injuries caused by motor vehicle crashes per 100,000 population	1415.0	1792.0	1219.6	933.0	933.0
#15-27	Death rate due to falls per 100,000 population Hispanic Americans	 3.5	 NA	 3.1	 2.8	 3.3
MATERNAL, INFANT, AND CHILD HEALTH						
#16-1c	Infant mortality rate per 1,000 live births Asian Americans	 4.5	 6.1	 3.5	 2.5	 4.5
#16-1d	Neonatal death rate (within first 28 days of life) per 1,000 live births Asian Americans	 2.9	 4.7	 2.1	 1.2	 2.9
#16-3a	Adolescent death rate (aged 10-14 years) per 100,000 Hispanic Americans	 18.0	 24.2	 14.0	 9.8	 16.5
#16-13	Percent of health full-term infants who are put down to sleep on their backs White, non-Hispanic	 70%	 61%	 72%	 80%	 70%
MENTAL HEALTH AND MENTAL DISORDERS						
#18-1	Suicide rate per 100,000 population African Americans Hispanic Americans	 8.2 4.7	 8.3 7.0	 4.6 4.2	 3.2 2.9	 4.8 4.8
NUTRITION AND OVERWEIGHT						
#19-2	Percent of adults aged 18+ who reported height and weight that placed them in the "obese" category according to the Body Mass Index Asian Americans	 15%	 NA	 12%	 10%	 15%
OCCUPATIONAL SAFETY AND HEALTH						
#20-1e	Death rate due to work-related injuries (deaths per 100,000 workers aged 16 years and older) Agriculture, forestry, and fishing In Nebraska, farming only	 11.9	 17.8	 11.5	 8.0	 16.3
ORAL HEALTH						
#21-2b	Proportion of children with untreated dental decay in primary and permanent teeth b. Children aged 6 to 8 years	 21%	 NA	 17%	 15%	 21%

Table A continued						
Focus Area/Objective		Original NE 2010 Objective	NE Baseline Rate	NE Current Rate	Revised NE 2010 Objective	Current US 2010 Objective
PHYSICAL ACTIVITY AND FITNESS						
#22-2	Percent of adults aged 18+ who engaged in moderate physical activity in the past month for at least 30 minutes per day 5 or more days per week or vigorous physical activity for at least 20 minutes per day 3 or more days per week	30%	34%	47%	50%	50%
	Whites	30%	NA	42%	50%	50%
	Native Americans	30%	NA	36%	50%	50%
	Asian Americans	30%	NA	35%	50%	50%
RESPIRATORY DISEASES						
#24-1	Death rate due to asthma (rate per million)					
	a. Children under age 5 years	1.4	2.9	0.0	0.0	0.9
	b. Children aged 5 to 14 years	2.4	8.0	<2.4	0.9	0.9
	c. Adolescents and adults aged 15 to 34 years					
	Native Americans	3.8	NA	0.0	0.0	1.9
	Asian Americans	3.8	NA	0.0	0.0	1.9
	d. Adults aged 35 to 64 years					
	Native Americans	10.6	NA	0.0	0.0	8.0
	Asian Americans	10.6	NA	0.0	0.0	8.0
	e. Adults aged 65 years and older	112.2	161.4	99.1	47.0	47.0
	Whites	112.2	NA	95.4	47.0	47.0
#24-10	Death rate due to chronic obstructive pulmonary disease (COPD) among adults aged 45 years and older (per 100,000 population)					
	Asian Americans	60.0	68.0	39.1	27.4	62.3
SEXUALLY TRANSMITTED DISEASES						
#25-3	Rate of new primary and secondary syphilis cases per 100,000 population					
	Native Americans	0.2	NA	0.0	0.0	0.2
TOBACCO USE						
#27-1b	Percent of males aged 18+ who currently use smokeless tobacco					
	African Americans	4%	NA	3%	0.4%	0.4%
	Native Americans	4%	NA	3%	0.4%	0.4%
	Hispanic Americans	4%	NA	1%	0.4%	0.4%
#27-1c	Percent of adults aged 18+ who currently smoke cigars					
	Hispanic Americans	2%	NA	2%	1.2%	1.2%
VISION AND HEARING						
#28-11a	Percent of newborns who are screened for hearing loss by age one month	95%	NA	99%	99%	90%

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