

This document contains the Table of Contents and Executive Summary of the *Nebraska 2010 Health Goals & Objectives*.

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Nebraska 2010 Health Goals and Objectives

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EXECUTIVE SUMMARY

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 2010 is designed to achieve two overarching goals: to increase quality and years of healthy life and to 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 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.

Like the national initiative, the *Nebraska 2010 Health Goals and Objectives* build on work undertaken in the state during the previous decade. In 1990, the Nebraska Department of Health published a set of disease prevention and health promotion objectives that were patterned after the United States Public Health Service's *Healthy People 2000* report. Over the last ten years, a series of Nebraska reports has tracked progress toward the original set of objectives for the state and identified new objectives to be addressed. The final report, issued in December 2000, summarizes progress made toward achieving the state's year 2000 targets and identifies the areas still needing improvement.

During the last decade, a great deal of progress was made in improving the health of people in Nebraska. For example, death rates for coronary heart disease have declined. Significant progress has been made in diagnosing and treating cancer and in reducing the rate of teen pregnancies. The proportion of preschool children who have received recommended vaccinations has increased dramatically over the past ten years. More children under age five are buckled into car seats or safety restraints when riding in a motor vehicle and more adults report using seatbelts.

Still, diabetes-related deaths continue to rise in Nebraska, particularly for some racial and ethnic minority groups. The prevalence of obesity has reached a new high in the state and more than one-fourth of adults do not participate in any physical activity in their leisure hours. Binge drinking and cigarette smoking rates among adolescents have increased in recent years. Infant mortality and low birth weight rates continue to be much higher for some racial and ethnic minority groups than for white people in the state.

Race and ethnicity are associated with health disparities in Nebraska, as they are nationwide. Eliminating these disparities, one of the two overarching goals for Healthy People 2010, represents a major change from Healthy People 2000 where the intent was to reduce disparities in health status, prevalence of risk factors, and use of

preventive services among population groups. In the Healthy People 2000 initiative, special population targets were established for racial and ethnic minority groups and for other specific groups.

In Healthy People 2010, a single target has been set for each indicator, with no racial or ethnic minority group having a different objective than the overall target rate*. An objective will not be considered achieved unless it is reached for all population groups.

For the *Nebraska 2010 Health Goals and Objectives* to have a positive impact on the health of everyone in the state, it will be necessary to take a “fresh look” at the issues presented in this report and review the factors potentially influencing each objective.

It is important to keep in mind that a variety of interrelated factors impact the health status of the population. The health of each individual is greatly influenced by personal behaviors (or lifestyle), both negative and positive. Many health problems, such as birth defects, diabetes, and coronary heart disease, also have a genetic component that may contribute to differences in the health status of individuals. A healthy physical environment in which to live and work is also essential in maintaining the health of individuals and their communities. Geographic, financial, cultural, and discriminatory barriers may make access to high quality health care difficult and thus negatively affect the health status of the population. Poor socioeconomic conditions such as poverty, unemployment, and lack of education are also generally associated with poor health status.

Eliminating health disparities and increasing the quality and years of healthy life for all people in Nebraska will necessitate a commitment to identifying the underlying causes of higher levels of disease, disability and mortality in racial and ethnic minority communities. Effective strategies that are tailored to the needs of various population groups and communities must be developed to address these causes and programs to implement these strategies put into operation.

Periodic evaluations of progress toward Nebraska’s 2010 objectives will be needed to determine whether or not unfavorable trends are being reversed and desired rates of improvement are being made. Results of these evaluations 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 people in Nebraska and meet the targets adopted for 2010.

*If a racial or ethnic minority group has already achieved a better rate than the overall targeted rate, then the target rate for that group is determined by applying a percent of improvement to be attained by 2010.

HIGHLIGHTS

There are dozens of important objectives delineated in the 24 health focus areas identified in this report and, undoubtedly, many more issues that could be discussed to provide a comprehensive view of the health status of people in Nebraska and the health care system in the state.

These “Highlights” are intended to provide a sampling of some of the many important health issues that must be addressed if we are to make progress in Nebraska toward meeting the two overarching goals of Healthy People 2010:

- Helping individuals of all ages to increase life expectancy and improve their quality of life; and,
- Eliminating 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.

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.

Obesity and physical inactivity are risk factors related to a variety of health problems, such as diabetes, heart disease and stroke, and some types of cancer.

- Prevalence of obesity has risen dramatically in Nebraska and in the United States. Since 1992, the proportion of adults in Nebraska who are obese has risen by about 75 percent. In 1999, 21 percent were classified as obese (based on self-reported height and weight data), compared to only 12 percent in 1992.
- Physical activity and fitness is a related area in which very little or no improvement has occurred in Nebraska in recent years. The proportion of people aged 18 and older who stated that they participated in no leisure-time physical activities in the past month increased from a 1996 low of 23 percent to 27 percent in 1999. Only 20 percent of adults engaged in activities that would be categorized as “regular and sustained” physical activity—up only slightly from the 1992 rate of 18 percent participation.

Tobacco use is the single most preventable cause of disease and death in the United States today. Cigarette smoking is responsible for about one-third of all cancer deaths and one-fifth of all cardiovascular disease deaths. Smoking also contributes substantially to illness and death from respiratory and other diseases.

- Despite the fact that the adverse health effects of smoking have been widely known for nearly 40 years, prevalence of cigarette smoking among adults in Nebraska has changed very little in more than a decade. In 1999, 23 percent of adults currently smoked cigarettes, compared to 24 percent in 1987.
- Unfortunately, tobacco use overall and cigarette smoking in particular are both more common among Nebraska high school students than they are nationally. In 1999, 37 percent of these Nebraska youth reported current use of cigarettes.

Alcohol abuse, particularly among adolescents, is another focus area in which improvement is needed in most population groups. Youth Risk Behavior Survey data, although missing data from some large urban schools, indicate high levels of alcohol use and related risk behaviors among Nebraska teens.

- Nearly one-half (46 percent) of Nebraska high school students in 1999 reported that, in the past 30 days, they had ridden in a motor vehicle with a driver who had been drinking. This proportion is well above the national average of 33 percent.
- Nebraska high school students are also about twice as likely to “drink and drive” as their counterparts nationwide. More than one-fourth of Nebraska teens participating in the Youth Risk Behavior Survey reported drinking and driving in the past month.
- Among high school students in Nebraska, more than 40 percent reported binge drinking during the past month.

Cancer remains the second leading cause of death in Nebraska and the United States, although death rates have fallen over the last ten years. Smoking, diet, and infectious diseases account for about three-fourths of all cancer cases. Regular screening examinations can result in earlier detection and more successful treatment of many cancers

- Colorectal cancer is the second leading cause of cancer deaths in Nebraska.
- Screening rates for colorectal cancer are quite low in Nebraska with only about one-third of adults aged 50 and older reporting ever have a fecal occult blood test (31 percent) or ever having a sigmoidoscopy or proctoscopic exam (35 percent).

People tend to see **unintentional injuries** as happening as a result of unpreventable “accidents,” when in fact most injuries are predictable and preventable.

- Motor vehicle fatalities in Nebraska accounted for 51 percent of all unintentional injury deaths in 1998. The Nebraska motor vehicle fatality rate was higher than the national rate and has risen since 1996, when speed limits in the state were raised.
- Although self-reported usage rates are higher, observational studies show an overall seatbelt usage rate of only 68 percent in Nebraska. Even among children under five years of age, only 66 percent were buckled into a child restraint when riding in a motor vehicle.

Violent and abusive behaviors continue to be major causes of death, injury, disability and stress in Nebraska and the nation.

- Homicide rates in Nebraska have experienced a slight upward trend over the last ten years, with 55 homicides recorded in 1998. Still, the 1998 Nebraska rate was only about one-half the age-adjusted U.S. homicide rate for the same year.
- In Nebraska, 3,475 children were the victims of substantiated cases of child abuse or neglect in 1999.

Asthma is a serious and growing health problem, with the number of persons who have the disease increasing rapidly over the last twenty years.

- In Nebraska, an estimated 112,100 persons have asthma.
- Asthma death rates in the state have increased by 13 percent over the last decade.

- The asthma death rate for African Americans in Nebraska was 5.0 times the rate for whites in 1996-1998.

Mental health is another focus area of importance to all people in Nebraska. It is estimated that, in the past year, one in five adults in the state had a diagnosable mental disorder. One in twenty adults experienced a serious mental illness.

- Suicide is the ninth leading cause of death in Nebraska and the second leading cause of death for persons aged 15 to 34 years.
- Many persons with mental disorders do not seek treatment. One reason may be that the cost of treatment can be prohibitive and many health insurance plans do not provide adequate coverage for mental disorders. The stigma often associated with mental illness also prevents many people from seeking and receiving treatment. In addition, mental health treatment resources may not always be readily available or accessible. In 1999, 88 of Nebraska's 93 counties experienced a shortage of psychiatrists. A total of 66 counties were federally-designated Mental Health Professional Shortage Areas.

Oral health problems include dental caries (tooth decay), periodontal disease, and cancers of the mouth and throat. Tooth decay is the most common chronic childhood disease in the United States, occurring five times as frequently as asthma (the second most common chronic disease among children). Early tooth loss caused by tooth decay can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school, and lowered self-esteem for children.

- In 1999, 21 percent of children aged 0 to 5 years in Head Start and daycare centers in Nebraska had untreated dental decay.
- In 1998, only 11 percent of Medicaid recipients aged 6 to 16 years had dental sealants applied to the chewing surfaces of molar teeth to prevent tooth decay.
- The number of dentists in Nebraska has been decreasing for the past two decades, while the population increased by 6 percent. Currently, 45 of the 93 counties in Nebraska have been designated as dental shortage areas by the State. Sixteen counties have no dentist.

In some of the focus areas included in this report, major disparities in health status and prevalence of risk factors are apparent. For example, racial and ethnic minority groups in Nebraska often experience far higher mortality rates from certain diseases than white people in the state.

Everyone needs to have **access to quality health care** services in order to eliminate health disparities and increase the quality and years of healthy life for all people in Nebraska.

- Having no health insurance or having a health care plan that provides inadequate coverage for needed services, coupled with a lack of financial resources to cover services falling outside insurance coverage, makes it difficult or impossible for many people to get necessary medical care.

- Nearly one of every ten people in Nebraska (all ages) had no health insurance throughout 1999. Native Americans and Hispanic Americans were more likely than persons of other racial or ethnic groups to be uninsured.
- Nebraska has many rural areas that are underserved and have shortages of physicians, midlevel practitioners, mental health professionals, dentists, and other health professionals.
- 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. In Nebraska, racial and ethnic minorities are, for the most part, underrepresented in the primary care physician population.

Although the coronary **heart disease** death rate has declined by 25 percent in Nebraska between 1990 and 1998, it is still the leading cause of death in Nebraska and the nation.

- Both coronary heart disease and stroke death rates are higher for African Americans and Native Americans in Nebraska than for white residents of the state.

The number of newly-diagnosed cases of **diabetes** in the United States has risen at an alarming rate in the past ten years. There has also been a substantial increase in the number of children and adolescents who have developed type 2 diabetes. This rise in new diabetes cases is attributed largely to sharp increases in the prevalence of obesity.

- In Nebraska, diabetes-related death rates have risen steadily over the past ten years.
- Significant disparities exist in diabetes-related death rates for certain racial and ethnic minority groups compared to whites and rates continue to increase. In 1994-1998, the diabetes-related death rate for Native Americans was more than four times as high as the white rate and more than double the national rate for Native Americans.
- For African Americans in the state, the death rate for diabetes-related causes was 2.5 times the corresponding white rate.

In addition to the impact it has on individuals and families, **infant mortality** is an important measure of a population's health and an indicator of social wellbeing.

- A total of 162 infant deaths occurred among Nebraska residents in 1999, resulting in an infant mortality rate of 6.8 per 1,000 live births. Although this rate is slightly lower than the national rate of 7.0, the decline in Nebraska rates has not kept pace with the progress achieved nationally during the 1990's.
- Substantial disparities still exist in infant mortality rates for some racial and ethnic groups in Nebraska. Five-year average rates for African Americans were more than double the rate for white infants—and rates have risen over the last four years from a 1995 low.
- Native Americans and Hispanic Americans in the state also experienced a higher infant mortality rate than whites.
- Disparities in rates of adequate prenatal care (based on the Kotelchuck Index) are also evident by race and ethnicity in Nebraska. Native American, Hispanic American,

and African American mothers were all much less likely than white or Asian American mothers in the state to have received adequate prenatal care.

The problems associated with **teen pregnancy** are well-documented. For example, teenaged mothers are less likely to complete high school or college and are more likely to live in poverty than their peers who are not mothers. Infants born to teenaged mothers are more likely to have low birth weight and are at greater risk of neonatal death and sudden infant death syndrome (SIDS).

- The Nebraska teen pregnancy rate has decreased by nearly 38 percent over the past decade and was significantly lower than the U.S. rate in 1999. Similarly, the teen birth rate was the lowest recorded in the state since 1987.
- Declines in the teen birth rate occurred for all major racial and ethnic groups in the state except Hispanic Americans over the past ten years. Still, birth rates for 15- to 19-year-olds were nearly three times as high for African Americans, Native Americans, and Hispanic Americans as for white adolescents (although three-fourths of all teen births occurred among white teens).

Despite the disease burdens, complications, costs, and the preventable nature of **sexually transmitted diseases** (STDs), they remain a significant health problem in Nebraska and nationwide.

- In Nebraska, two-thirds of all reported STD cases in 1995-1999 occurred among 15- to 24-year-olds.
- Non-Hispanic African Americans were far more likely than any other racial or ethnic group in Nebraska to have a reportable STD. In 1995-1999, the new case rate was 17 times the rate for non-Hispanic white persons in the state.
- Rates for Native Americans and Hispanic Americans in the state were also much higher than the rate for non-Hispanic whites in Nebraska.
- In Nebraska, a total of 1,092 AIDS cases have been reported from 1983 through 2000. Of these persons diagnosed with AIDS, 55 percent have died.
- The AIDS incidence rate for African Americans in 2000 was more than ten times the corresponding rate for white persons in Nebraska. Hispanic Americans in the state experienced a new case rate that was 6.7 times the white rate.

DATA CONSIDERATIONS

Selection of Healthy People 2010 Objectives

Altogether, more than 150 different health objectives have been identified for achievement in Nebraska by 2010. For the most part, they were taken from the national Healthy People 2010 set of objectives. However, a few were included at the request of HHSS staff or other persons or groups who reviewed the proposed list of objectives for Nebraska.

Availability of reliable data for Nebraska was a primary requirement for selection of objectives from the national Healthy People set. Additional objectives that address health issues of importance for Nebraska but for which data are not currently available have been listed in the Appendix to this report. Some of these are considered “developmental” since they need further definition, as well as a source of data.

A draft of the Nebraska Healthy People 2010 objectives, along with comparable current national rates and the national 2010 objectives, was sent out to HHSS staff and interested organizations and parties for review and comment. Their comments have been taken into consideration and revisions to the current document made based on their input.

A revised version of the national Healthy People 2010 objectives (the second edition) was issued after the draft of Nebraska objectives was prepared. These updated national data have been incorporated into the current report, so some changes will be evident when comparing to the draft Nebraska objectives document.

Target-Setting Methods

Five different target-setting methods were used for the national Healthy People 2010 objectives.

- “Better than the best” rate achieved by any population group.
- _____ percent improvement in the current rate.
- “Total coverage” or “complete elimination” (for targets like “100 percent of the population with health insurance”).
- Consistent with _____ (another national program).
- Retain Healthy People 2000 target.

Nebraska targets were also determined using these methods or by adopting the national objective when it appeared reasonable, based on Nebraska trends and current status. In some cases, the “better than the best” method would have resulted in an extremely low (or high) target rate due to one population subgroup’s current rate being much “better” than all other subgroups. In instances where this much “better” rate was based on a very small number of events (e.g., deaths), the “percent improvement” method was used to set a target rate.

Data Sources

The national objectives and data relating to them have been taken from *Healthy People 2010--Volumes I and II (Second Edition)* and from *Tracking Healthy People 2010*.

The greatest share of Nebraska data has been compiled from Vital Statistics data, Nebraska Hospital Information System (NHIS) data, surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS), and other Nebraska Health and Human Services System program data. Data sources are listed on the tables and charts.

Background information is taken from the current literature, reference sources, and Internet websites. A complete listing of references used is found at the end of each section.

Current Health Status Information

The background information presented in this report is not intended to be an exhaustive review of important concepts related to each of the priority areas. Instead, it is intended to briefly discuss some of the factors that impact the health status of people in Nebraska. Taken together with health statistics for the people of Nebraska, it is intended to provide information for use in planning efforts to improve health.

Ideally, all Nebraska data presented in this report would be perfectly comparable to national data. It would also be consistent over time and among population subgroups with regard to data sources, method of collection and time frames. As might be expected, available data do not meet these criteria in every case.

The guiding principle used in preparing this document has generally been toward less (rather than more) restrictive use of data. That is, although data used in assessing current status for Nebraska's 2010 objectives may not be perfectly comparable to national data or perfectly consistent within subgroups, data that are otherwise reliable have been presented and limitations noted in the tables of objectives for each area.

The most recent data available at the time the report was written have generally been used throughout the document to describe current status. However, for mortality data, 1998 data (or multi-year data ending in 1998) have been used to facilitate comparison with national data and to avoid problems in trend data potentially introduced in 1999 by conversion to the new version of the International Classification of Disease (ICD-10). However, the ICD-10 system will be used for future reports (when some trend data from the new classification is available), with adjustments to target rates to be made as necessary.

Mortality rates presented in this report have generally been age-adjusted to the 2000 standard population to allow comparability with U.S. data. Any exceptions have been noted in data tables or charts.

For hospital discharge data, trend data have generally not been presented for Nebraska. Increases in the number and proportion of hospitals submitting discharge data over the five years since data have been available for the state make it difficult to ascertain whether changes noted are due to actual differences in hospitalization patterns or to changes resulting from increased reporting.

Please note that results of the Nebraska Youth Risk Behavior Survey (YRBS) may not be truly representative of the state's students in grades 9 through 12. The survey sample did not include a number of urban schools that chose not to participate in the study.

Trends/Projections

Linear regression has been used to draw trend lines shown in the graphs in this report. These trend lines have served as one of the criteria used in setting Nebraska objectives.

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 slope of the line (i.e., direction of the trend) have occurred. In these cases, selecting a different time period (instead of the ten years used for most indicators) might have resulted in a very different trend line being drawn. In such instances, reference has generally been made to this possibility in the narrative.

For indicators with wide variability in rates over time or those with few data points, no formal trend lines have been drawn.

Future Data Plans

A subset of the objectives chosen for Nebraska will be developed to serve as Leading Health Indicators (LHI) to be tracked on an annual basis. Progress toward all of Nebraska's 2010 objectives will also be evaluated and reported periodically during the coming decade.

Current data are unavailable for several Healthy People 2010 objectives that were proposed for Nebraska. A number of other national 2010 objectives have been proposed as developmental objectives that will need further definition (Appendix). For some of these, methods of collecting data need to be investigated. For others, data collection will begin shortly or is already underway, but data are not yet available for setting objectives. All of these objectives have been selected for future tracking because they are important to the health of people in Nebraska.

As additional data become available for population subgroups, such as racial or ethnic minorities, these data will be added and target rates included for them. As new data sources become available, their potential for providing information for additional

Nebraska objectives will be examined. New objectives may also be added for health issues that emerge over the coming decade.