



2000 – 2010 Community Report

Mission

The mission of the Buffalo County Community PARTNERS is to assess, promote and strengthen the HEALTH of Buffalo County. HEALTH, as defined by the World Health Organization, and endorsed by the PARTNERS as their definition for HEALTH is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.

Vision

The vision of the Buffalo County Community Partners is that everyone from all corners of Buffalo County work together to improve the quality of life of those who live in and work in this community.

In so doing, our community focuses its time and resources on the things we value as a community, including:

Nature & the Environment . . .

- We support the conservative use of our valuable natural resources.
- We support the development of and preservation of appropriate parks and other recreational areas and activities in the county.
- We support the use and continuing development of alternative sources of energy.
- We maintain clean air and water.
- The pride we have in our community moves us to maintain our community in a way that is visually appealing. High quality, dependable and accessible transportation is available to all.

Strong Sense of Community . . .

- We live in a safe environment.
- We take responsibility for our health.
- We support and help our neighbors in their time of need.
- We encourage one another to be involved in our community.
- We appreciate cultural and age diversity and view it as an asset.
- We appreciate the family unit and see the community as an extended family.
- We support the availability of safe, affordable housing for our residents.
- We believe prevention and supportive services are integral to improving the quality of life in Buffalo County.

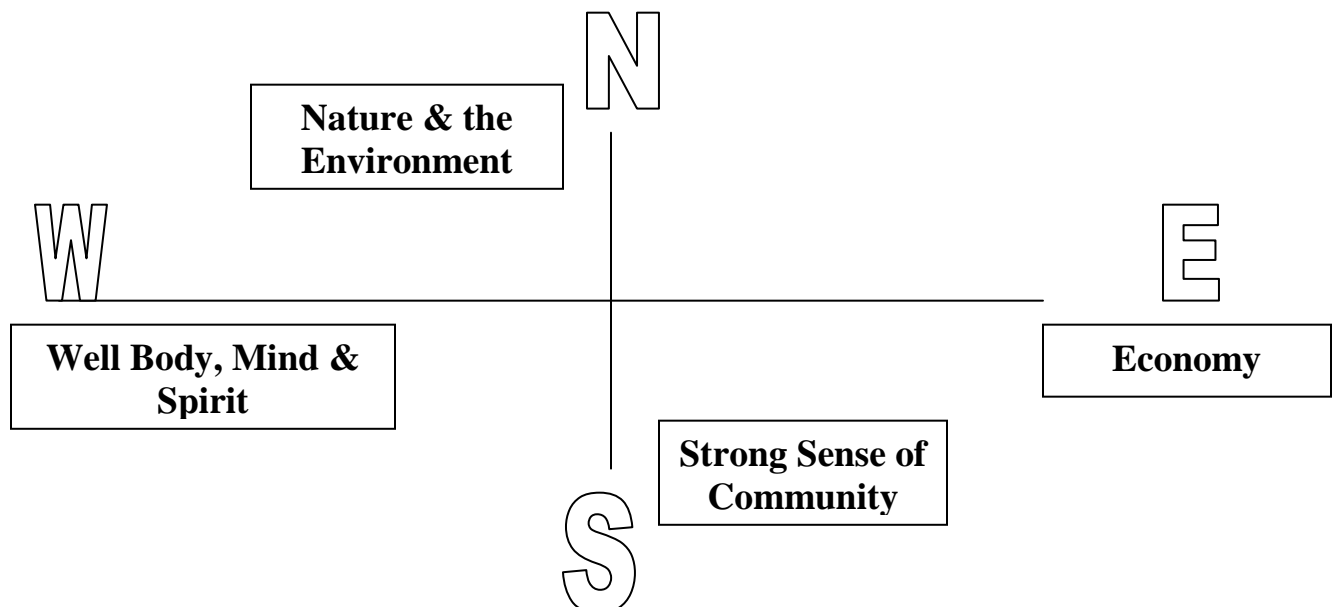
Well Body, Mind and Spirit . . .

- All of our residents have access to affordable health care.
- Our health system supports the health of body, mind and spirit.
- Our local health and human services delivery system is well coordinated.
- Health and human services delivery has the full continuum of high quality services locally -- from predictive to prevention and wellness through treatment and aftercare.
- Our health and human services delivery system recognizes and actively seeks to provide services to those at the highest risk, including seniors, children and those economically disadvantaged.
- Our educational system is coordinated and emphasizes life-long learning.
- A familiarity and appreciation of the arts is key to the culture of Buffalo County.
- We support the ongoing technology upgrades necessary to educate our community.
- We believe in active community involvement in the educational process -- from program development through instruction and evaluation.
- Our educational system provides families instruction in positive health behaviors as well as the opportunity for students to apply good health practices.
- The media plays an active role in delivering broad-based community information.
- The educational environment incorporates the understanding of living and working in a culturally diverse environment.

The Economy . . .

- We value and seek diversity of employment.
- We actively seek a local economy that provides jobs, which pay a livable wage.
- We economically support our community's vision through individual and organizational philanthropic involvement.

Elements of Partners Vision – Quadrant Divisions



OVERVIEW & PURPOSE

History (1994-2001)

Our community health status improvement initiative, Buffalo County Community Partners, is a countywide effort located in central Nebraska. Kearney is the county seat and comprises 28,195 of the 41,000 people who live in Buffalo County. The Partners draw upon old fashioned grassroots problem solving, as well as looking to the latest in community architecture, to knit our community together into a creative, future-oriented, inviting place to live and work. Our initiative began in the Fall of 1994 with a countywide assessment. From that assessment fifteen priority health goals emerged in 1996 for attainment by 2001. Since 1996, over 250 community volunteers have worked together in new and creative ways to work toward attainment of the 15 priority health goals. As of 2001, 53% of those goals were attained: these include coordinated public transportation system, Alzheimer's units, assisted living units, infant and older adult immunizations, and reduced teen pregnancy.

2000 – 2001 Countywide Re-Assessment

In 2000-2001, the Partners conducted a countywide re-assessment to determine which priority health goals have been attained and to determine if new emerging priority health areas needed attention. In 2000 and 2001 the Partners conducted Behavioral Risk Factor Surveys for adults, minority and youth in Buffalo County. (Survey results are available on our web site and by contacting the Partners office.) They also reviewed Buffalo County outcome indicator information related to morbidity and mortality from the Nebraska Health and Human Services System (Latest data available was 1997.) To secure the qualitative data the Partners conducted a focus group process called Mini-Town Hall Meetings in eight of the eleven Buffalo County communities networking with 500 residents including youth and minorities.

What the Partners heard community members share with other community members in the Mini-Town Hall meetings were concerns that closely reflected the other data gathered in the behavioral risk factor surveys and outcome indicator review. All eight Buffalo County communities determined that "Stress on the Family Unit" is a top priority health issue for their families and communities. Other areas that the communities stated are top concerns were issues around youth, elderly and economic growth in rural communities.

Contained in this document are health priorities identified by Buffalo County residents during the 2000 – 2001 reassessment.

In reviewing the countywide re-assessment data, the Buffalo County Community Partners identified 125 community issue areas. In order for Buffalo County residents to make a true impact in the overall health status, the Partners needed to focus on priority areas. This document identifies 10 priority health goal areas. The Partners understand that there are other prime issue areas that were not defined as priority areas. By researching inter-related issues, they are proposing that the community work together to strive to impact these 10 priority health goals to make a greater impact on the health of our residents. There are also indicators identified in this report that will be monitored, since they also can impact the overall health of Buffalo County residents. The Partners have organized the re-assessment data in the form of goals and indicators to assist the community in working together around like issues to make a positive impact on creating a healthier community over the next 10 years.

Definitions of Document Terminology

Goals: Goals are broadly stated outcomes to be attained by the end of the year 2010. **Indicators:** Indicators are measurements designed, developed and researched by the community members utilized for trending purposes to alert the community to a potential emergency health concern. **Targets:** Targets are the optimal standard to shoot for by 2010, but any movement toward the target is considered attainment of a goal. Five different target-setting methods were used for the national Healthy People 2010 objectives and the Partners adopted the same methodology: 1) "Better than best" rate achieved by any population group 2) %(percent) improvement from current rate 3) "Total coverage" or "complete elimination" for targets like "100% access to health insurance" 4) Consistent with another national program, could also be state or local program 5) Retain a past Healthy People

2000 target. Quality of Life Index: A Quality of Life Index is an aggregate index made up of baseline goal and indicator data that is monitored on an annual basis to measure overall impact on quality of life.

2002-2010 Action Plan

For each of the Priority Health Goals specific action plans will be developed by Buffalo County residents. The Priority Health Goals and Indicators will provide a snapshot of health for the county and assist in tracking and communicating progress locally and nationally.

The Priority Health Goals and Indicators are intended to help county residents more easily understand the importance of health and its inter-relationship to families, income, and education. Developing action plans, strategies and policies to address one or more of these Goals and Indicators can have a profound effect on increasing the quality of life and the years of healthy life, reducing stress on the family and eliminating health disparities and as an end result create a healthier community and healthier residents.

The Partners release this document and all data to the community to be adopted by businesses, organizations, schools any many others. Business groups may use the goals and indicators to assess their health promotion programs for employees. Schools may use this information to educate students about local trends and issues. Youth may select an issue area of their greatest concern to organize a local community effort. Advocacy groups may refer to the goals and indicators to strengthen their position related to a specific issue with the media, the public, and political figures. The media can use this to report on what's happening in the community. Politicians can use this as a focus area for future legislation and as a tracking tool to demonstrate their accomplishments.

The Partners most important use of this report will be to facilitate broad community efforts to create an overall healthier Buffalo County.

This document was prepared by the Buffalo County Community Partners Planning and Measurement Committee and approved by the Buffalo County Community Partners Board of Directors. For more information regarding this document and the information contained herein, please contact the staff at the Partner office:

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Buffalo County Community Partners

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Nature and the Environment

LEAD LEVELS IN CHILDREN GOAL – GOAL MOVING TOWARD TARGET

GOAL: Reduce the percent of children aged 1-5 years with blood lead levels (BLLs) > 9ug/dL.

Baseline: 6.2% (9 children) of Buffalo County children tested (146 children tested) aged 1-5 years reported with BLLs > 9ug/dL (*Source: Meridel Funk, 1996-1997 NHHSS Data*)

Target: 0% BLLs

Comparison Data: U.S. 4.4% (1996) Healthy People 2010 Target 0%
 NE 7% (1997) Nebraska 2010 Target 0%
(Source: Nebraska 2010 Health Goals & objectives, page 106)

Measurement Updates:

2000: 1.3% (6 children) of Buffalo County children tested (462 children tested) aged 1-5 years reported with BLLs>9ug/dL. (*Source: Meridel Funk, 1998-2000 NHHSS Data*)

Comparison Data: NE 5.2%

2005: 1.9% of “other counties” (314 children tested) aged 1-6 years reported with elevated blood lead levels (EBLL) equal to 10+ micrograms/dL.
(Source: Meridel Funk, 2001- 2005 NHHSS Data)

Comparison Data: NE 2.1%

Rationale: Although considerable progress has been made in reducing BLLs in the Nation’s children, lead poisoning remains a preventable environmental problem in the United States. Culturally and linguistically appropriate information is needed alerting persons to the dangers of lead poisonings.
(Source: Healthy People 2010 page 8-22)

Nature and the Environment

AIR QUALITY GOAL

SMOKE FREE RESTAURANTS - GOAL TARGET ATTAINED

GOAL: Increase percent of smoke free restaurants in Buffalo County

Baseline: 47.7% (*Source: 2001 Guide to Smoke Free Restaurants in Buffalo County and 2001 McLeod USA Web site yp.mcleodusea.com*). The definition of restaurant is not limited to formal sitting but also includes lounges, fast food establishments and other food services.

Target: 100%

Comparison Data: Hall County: 45% (2001)
(*Source: Hall County Tobacco Free Coalition*)

Measurement Updates:

2005: 79.2% (*Source: 2005 Guide to Smoke Free Restaurants in Buffalo County*).

Comparison Data: Hall County: 53% (2003)

2007: 77% (*Source 2007 Guide to Smoke Free Restaurants in Buffalo County*).

Comparison Data: Grand Island (in Hall County): 100% (2008)
(*Source: Hall County Tobacco Free Coalition*)

2009: 100% (*Source: Through Nebraska law, all restaurants went smoke-free on June 1, 2009. (June 2009, Nebraska Legislature passed a state wide Clean Indoor Air Act to implement 100% smoke free bars and restaurants.)*)

Comparison Data: 100% State of Nebraska (2009)

AIR QUALITY GOAL (Continued)

WORKSITE WELLNESS - GOAL MOVING TOWARD TARGET

GOAL: Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas

Baseline: 72% (41 of 57 businesses) of worksites with 50 or more employees had formal smoking policies that prohibited or limited it to separately ventilated areas in 2003. *The definition of workplace is extended from the traditional business worksite, to schools, nursing homes and public buildings. (Phone survey of Buffalo County Worksites, Summer 2003)*

Target: 100%

Comparison Data: U.S. 69% (1998-1999) Healthy People 2010 Target: 100%
(Source: *Healthy People 2010, page 27*)

Measurement Updates:

2008: 82.14% (46 of 56 businesses) have formal, written policies prohibiting or limiting smoking to separately ventilated areas (*Phone survey of Buffalo County Worksites with 50 or more employees, Winter 2008*).

Comparison Data: U.S. 77% (2003) (*Source: CDC DATA2010*)

Rationale: Poor air quality contributes to respiratory illness, cardiovascular disease, and cancer. Exposure to ETS (Environmental Tobacco Smoke), or second hand smoke, among nonsmokers is widespread. Home and workplace environments are major sources of exposure. A total of 15 million children are estimated to have been exposed to secondhand smoke in their homes in 1996. ETS increases the risk of heart disease and respiratory infections in children and is responsible for an estimated 3,000 cancer deaths of adult smokers. (*Healthy People 2010 page 41*)

Nature and the Environment

INDICATORS

Water Quality Indicator

Baseline: 94.9% of Buffalo County residents served by community water systems that meet standards (*Source: Buffalo County Health Profile '97*)

Target: 98%

Desired Trend: Increase

Comparison Data: U.S. 85% (1995) Healthy People 2010 Target: 95%
NE 99% (1996-2000) Nebraska 2010 Target: 99%
(*Source: Nebraska 2010 Goals & Objectives, page 32*)

Measurement Updates:

2000: 100% of Buffalo County residents served by community water systems that meet standards. (*Source: Meridel Funk, NHHSS*)

Comparison Data: U.S. 99.4% (2003) Healthy People 2010 Target: 95%
NE 99.8% (2004) Nebraska 2010 Target: 99%

Recycling Indicator

Baseline: 22,481,250 Lbs. Solid Waste Recycled in Kearney Landfill
80,908,000 Lbs. of solid waste deposited in Kearney Landfill
(*Source: City of Kearney, Waste Management, 2000*)

Target: Better than the best

Desired Trend: Increase

Measurement Updates:

2002: 22,481,250 Lbs. Solid Waste Recycled in Kearney Landfill
136,000,000 Lbs. of solid waste deposited in Kearney Landfill
(*Source: City of Kearney, Waste Management, 2002*)

2004: 23,101,750 Lbs. Solid Waste Recycled in Kearney Landfill
82,516,000 Lbs. of solid waste deposited in Kearney Landfill
(*Source: City of Kearney, Waste Management, 2004*)

2006: 23,308,500 Lbs. Solid Waste Recycled in Kearney Landfill
91,100,000 Lbs. of solid waste deposited in Kearney Landfill
(*Source: City of Kearney, Waste Management, 2006*)

2008: 23,250,000 Lbs Solid Waste Recycled in Kearney Landfill
105,042,000 Lbs. Solid Waste deposited in Kearney Landfill
(*Source: City of Kearney, Waste Management, 2009*)

Nature and the Environment INDICATORS (Continued)

Land Quality Indicator

Baseline: 192,900 acres of corn for grain harvested with average yield of 149.6 bushels ranking Buffalo County as 3rd in the state. (Source: *Buffalo County Extension Service, NE Ag Stats Service, 2000*)

Target: 200 bushels per acre

Desired Trend: Increase average yield per acre harvested

Measurement Updates:

2001: 176,700 acres of corn for grain harvested with average yield of 167.2 bushels ranking Buffalo County as 6th in the state. (Source: *Bob Scriven, Buffalo County Extension Services, Aug. 2001*)

2003: 170,400 acres of corn for grain harvested with average yield of 186.5 bushels ranking Buffalo County as 5th in the state.
(Source: http://www.nass.usda.gov:81/ipedbcnty/c_NEcrops.htm; Brent Plugge, *Buffalo County Extension Services, Jan. 2005*)

2006: 178,800 acres of corn for grain harvested with average yield of 179.8 bushels ranking Buffalo County as 6th in the state.
(Source: http://www.nass.usda.gov:81/ipedbcnty/c_NEcrops.htm; Brent Plugge, *Buffalo County Extension Services, June 2007*)

2008: 197,200 acres of corn for grain harvested with average yield of 173 bushels ranking Buffalo County as 17th in the state.
(Source: http://www.nass.usda.gov/Charts_and_Maps/Crops_County/Data/index.asp; Brent Plugge, *Buffalo County Extension Services, November 2009*)

Toxic Chemical Releases Indicator

Baseline: 0% of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health based standards for harmful air pollutants. (1999)
(Source: *EPA, 1999 TRI*)

Target: No Change

Desired Trend: Stable

Comparison Data: NE 0% (1999) Nebraska 2010 Target: 0%
(Source: *Nebraska 2010 Goals & Objectives, page 106*)

Measurement Updates:

2000: 0% of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health based standards for harmful air pollutants. (Source: *EPA, 2000*)

2004: 0% of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health based standards for harmful air pollutants. (Source: *Jim Yeggy, NDEQ, 2004 email: Jim.Yeggy@NDEQ.State.NE.US*)

2006: 0% of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health based standards for harmful air pollutants. (Source Jim Yeggy, *NDEQ*, 2006 email: *Jim.Yeggy@NDEQ.State.NE.US*)

A Strong Sense of Community

ACCESS TO HEALTH CARE GOAL

GOAL: To improve access to health care and decrease health disparities in Buffalo County.

Health Care Insurance -- GOAL MOVING AWAY FROM TARGETS

Baseline: 90% of Buffalo County residents report having health care insurance. (*ABRFS '00*)

Target: 100% Access to Health Care by increasing use of Kids Connection, CHIP or other health access opportunities.

Comparison Data: Residents having health care insurance (ABRFS)
U.S. 83% (1997) Healthy People 2010 Target 100%
NE 90% (1994-1998) Nebraska 2010 Target 100%

Measurement Updates:

2003: 89% of Buffalo County residents report having health care insurance. (*ABRFS '03*)

2007: 86% of Buffalo County residents report having health care insurance. (*ABRFS '07*)

Comparison Data: U.S. 83.6 % (2007)
NE 87.6% (2004-2008) (*Source: Meridel Funk, NHHSS*)

MINORITY Baseline: 51.4% of the surveyed minority population in Buffalo County has health insurance coverage. (*Source: 2006 Minority Behavioral Risk Factor Survey MBRFS*)

Target: 100% Access to Health Care

Comparison Data: U.S.
NE 54.5% (2007-2008) (*Source: Meridel Funk, NHHSS*)

Measurement Updates:

2009: 48.8% of surveyed minority population in Buffalo County has health insurance coverage. (*Source: 2009 Buffalo County Minority Behavioral Risk Factor Survey, MBRFS*)

Health Disparities - GOAL MOVING AWAY FROM TARGETS

Baseline: 39% of Hispanic Americans state that race/ethnic origin is a barrier to receiving health care in Nebraska. (*Source: Buffalo County Health Profile '97*)

Target: Decrease Perceived Barriers to Health Care

Measurement Updates:

2004: 42.9% of Hispanic Americans state that race/ethnic origin is a barrier to receiving health care in Nebraska (*Source: Minority BRFS '04*)

Comparison Data: U.S. 66% (1997) Healthy People 2010 Target 0%
NE 82% (1994-1998) Nebraska 2010 Target 0%
(Source: Nebraska 2010 Goals & Objectives, page 32)

2009: 53.7% of those surveyed in the Minority BRFSS agreed or strongly agreed that racial or ethnic origin is a barrier to receiving health care services in their community.
(Source: Minority BRFSS '09)

Comparison Data: U.S.
NE 3.1% of Hispanic Americans (2008) (Source: Meridel Funk, NHHSS)

Rationale: Access to quality care is important to eliminate health disparities and increase the quality and years of life of healthy life for all Americans. Major changes in the structure of the U.S. health care system, including the increasing influence of market forces, changes in payment and delivery systems, and welfare reform, have significant implication for vulnerable and at-risk populations. In light of these system changes, Federal, State and local public health agencies must redouble their efforts to address access barriers and reduce disparities for these populations. (Source: Healthy People 2010 page 1-3/1-5)

A Strong Sense of Community

SAFETY GOAL

MOTOR VEHICLE RESTRAINTS - GOAL MEETING TARGET

GOAL: Increase percent of 9-12 graders who report using seat belt “always, most of the time, or sometimes” when riding in a car driven by someone else.

Baseline: 76.4% of 9-12th graders in Buffalo County report using the seat belt “always, most of the time, or sometimes” when riding in a car driven by someone else. (*YBRFS 2000*)

Target: 80%

Desired Trend: Increase

Measurement Updates:

2003: 79.9% of 9-12th graders in Buffalo County report using the seat belt “always, most of the time, or sometimes” when riding in a car driven by someone else. (*YBRFS 2003*)

Comparison Data: U.S. 81% (1998) Healthy People 2010 Target (NA)
NE 79% (1997) Nebraska 2010 Target (NA)
(*Source: Meridel Funk, NHHSS*)

2007: 80.9% of 9-12th graders in Buffalo County report using the seat belt “always, most of the time, or sometimes” when riding in a car driven by someone else. (*YBRFS 2007*)

Comparison Data: U.S. 88.9% (2007)
NE 84.1% (2005) (*Source: Meridel Funk, NHHSS*)

2009: 82.7% of 9-12th graders in Buffalo County report using the seat belt “always, most of the time, or sometimes” when riding in a car driven by someone else. (*YBRFS 2009*)

Comparison Data: U.S. Data will be released Summer 2010.
NE Not Available

Rationale: The risk of injury is so great that most persons sustain a significant injury at some time during their lives. Nevertheless, this widespread human damage too often is taken for granted, in the erroneous belief that injuries happen by chance and are the result of an unpreventable “accident”. In fact, many injuries are not “accidents,” or random, uncontrollable acts of fate; rather, most injuries are predictable and preventable. In 1997, 149,691 Americans died from injuries due to a variety of causes such as motor vehicle crashes, firearms, poisonings, suffocation, falls, fires and drowning. In 1997, injuries accounted for 20 percent more years of potential life lost than cancer did. (Healthy People 2010 pg 15-3/15-4)

SAFETY GOAL (continued)

Fall Prevention in Older Adults - GOAL MEETING TARGET

GOAL: Reduce hospital trauma admissions due to falls in older adults, 60 years and older.

Baseline: Buffalo County adults 60 years and older admitted to Good Samaritan Emergency Room for falls 42/1,000 population in 2003.
(GSHS HIM Dept, Emergency Dept. and Planning Dept.)

Target: 5% less than baseline

Desired Trend: Decrease

Comparison Data: N/A

Measurement Updates:

2006: Buffalo County adults 60 years and older admitted to Good Samaritan Emergency Room for falls 31/1,000 population in 2006.
(GSHS HIM Dept, Emergency Dept, and Planning Dept.)

IMPORTANT UPDATE: (2010)

Due to unforeseen circumstances, the data is not available in 2010 to note progress toward goal. The following data was collected by GSH Planning Department to document decrease in falls in older adults.

2007	15.58 / 1000	(108 falls in GSH ED*/6931 population)
2008	16.30/1000	(117 falls / 7178 pop)
2009	17.83 / 1000	(133 falls / 7458 pop)
2010	12.52 / 1000	(98 falls / 7825 pop)

*Sought care at GSH ED for injuries related to a fall / U.S. Bureau census estimate by county

Rationale: The number one trauma admission in Buffalo County is from falls in people over the age of 65 years. A fall is defined as; Fall on same level from slipping, tripping or stumbling, fall on same level from collision, pushing, shoving by or with another person, accidental fall from one level to another, accidental fall on or from stairs or steps, accidental fall on or from ladders or scaffolding, accidental fall from or out of building or other structure, accidental fall into hole or other opening in surface or other and unspecified accidental fall.

According to the CDC Injury Fact Book for 2000-2001, "Every hour an older adult dies as a result of a fall". The Emergency Nurses Association states that 85% of falls occur in the home and about 5% result in fractures. Source: National ENCARE.

The most common fall-related injuries are fractures of the spine, hip or forearm caused by osteoporosis and these injuries cost over \$75-\$100 billion each year. One out of every three persons 65 years or older fall each year. 50% of the people hospitalized for a fall do not recover. Studies show that a woman who has fallen twice and does not exercise is more likely to fall again compared to a woman who has fallen twice, but begins exercising. Her risk of falling is decreased by almost half.

Exercise is important because it can strengthen bones, muscles and the heart. Tai Chi, a martial arts form that enhances balance and body awareness through slow, graceful, and precise body movements, can significantly cut the risk of falls among older people and may be beneficial in maintaining gains made by people age 70 and older who undergo other types of balance and strength training. The news comes in two reports appearing in the May 1996 issues of the Journal of American Geriatrics Society. One study found that older people taking part in a 15-week Tai Chi program reduced their risk of falling by 47.5%.

A Strong Sense of Community

INDICATORS

Child Abuse Indicator

Baseline: 9.4/ 1,000 children involved in substantiated cases of child abuse in Nebraska 21 county Central Service area, which includes Buffalo County. (*NHSSS, 1999*)

Target: Lower than baseline

Desired Trend: Decrease

Comparison Data: U.S. 13.9/ 1,000 (1999) Healthy People 2010 Target 11.1
NE 19.1/ 1,000 (1999) Nebraska 2010 Target 15.3
(*Source: Meridel Funk, NHHSS*)

Measurement Updates:

2001: 8.7/ 1,000 children involved in substantiated cases of child abuse in Nebraska 21 county Central Service area, which includes Buffalo County. (*Source: NHSSS, 2001*)

Comparison Data: U.S. 12.2/ 1,000 (2000)
NE 12.7 / 1,000 (2001)
(*Source: Meridel Funk, NHHSS*)

2003: 10.3/ 1,000 children involved in substantiated cases of child abuse in Nebraska 21 county Central Service area, which includes Buffalo County. (*Source: Buffalo County Health Profile, 2003*)

Comparison Data: U.S. 12.3/ 1,000 (2002)
NE 6.4/ 1,000 (2003)
(*Source: Meridel Funk, NHHSS*)

2005: 8.9/ 1,000 children involved in substantiated cases of child abuse in Nebraska 21 county Central Service area, which includes Buffalo County. (*Source: Meridel Funk, NHHSS, 2005*)

Comparison Data: U.S. 12.1/ 1,000 (2005)
NE 6.4/ 1,000 (2003)
(*Source: Meridel Funk, NHHSS*)

2006: 7.2/ 1,000 children involved in substantiated cases of child abuse in Nebraska 21 county Central Service area, which includes Buffalo County. (*Source: Meridel Funk, NHHSS, 2006*)

Comparison Data: U.S. 12.1/ 1,000 (2006)
NE 13.8/ 1,000 (2006)
(*Source: Meridel Funk, NHHSS*)

2008: 19.42/1,000 children involved in substantiated cases of child abuse in Nebraska 21 county Central Service area, which includes Buffalo County. (Based on 29% of 44,936 Buffalo County residents being 19 or younger.) (*Source: Meridel Funk, NHHSS, 2008*)

Comparison Data: U.S.
NE 6.53/1,000 (2008) (*Source: Meridel Funk, NHHSS*)

Economy

TRANSPORTATION GOAL

GOAL: Expand affordable public transportation services, i.e. R.Y.D.E., to meet unmet needs of Buffalo County residents

Baseline: 55,280 riders in 2001 (*Source: RYDE 2001*)

Estimated Baseline: 5,015 (estimated) riders turned away from services (*Source: RYDE 2001*)

Target: Decrease unmet needs

Comparison Data: (NA)

Measurement Updates:

2002: 67,389 riders

3,120 riders turned away from services (*Source: RYDE 2002*)

2003: 88,274 riders

176 riders turned away from services (*Source: RYDE 2003*)

2004: 90,845 riders

272 riders turned away from services (*Source: RYDE 2004*)

2007: 90,440 riders

470 riders turned away from services (*Source: RYDE 2007*)

2008: 90,668 riders

520 riders turned away from services (*Source: RYDE 2008*)

Rationale: Reliable public transportation is essential for a community to access services, build relationships and conduct commerce. As a community, we recognize only by addressing these important civic infrastructure issues will health and quality of life be enhanced. Elderly, disabled, and low income can be particularly disadvantaged by the lack of access to reliable public transportation. As a community we can track the number of riders turned away from services through the R.Y.D.E. system, but as a community we also acknowledge that we have a number of residents that are not being tracked in 'riders turned away from services', which would include rural residents and school children. In 2004, Kearney started a Walking School Bus that is meeting the needs of some Kearney youth.

Economy INDICATORS (continued)

Children Living in Poverty Indicator

Baseline: 12.3% of children (18 and younger) living in poverty (*U.S. Census, 1997 Estimates*)

Target: Better than the best

Desired Trend: Decrease

Comparison Data: U.S. 19.9% (1997) Target (NA)
NE 12.6% (1997) Target (NA)
(*Source: U.S. Census, 1997 Estimates*)

Measurement Updates:

1999: 12.3% of children (18 and younger) living in poverty. (*Source: U.S. Census, 1999*)

Comparison Data: U.S. 17.1% (1999)
NE 12.5% (1999) (*Source: U.S. Census, 1999*)

2002: 11.6% of children (17 and younger) living in poverty. (*U.S. Census, 2002*)

Comparison Data: U.S. 16.7% (2002)
NE 12.3% (2002) (*Source: U.S. Census, 2002 Estimates*)

2004: 12.4% of children (17 and younger) living in poverty (*Source: US Census, 2004*)

Comparison Data: U.S. 18.4% (2004)
NE 13.1% (2004) (*Source: U.S. Census Estimates, 2004*)

2006: 11.6% of children (18 and younger) living in poverty (*Source: US Census, 2005-2007 Estimates*)

Comparison Data: U.S. 14.9% (2006)
NE 13.0% (2006) (*Source: US Census Estimates, 2006*)

2008: 13.1 % of children (18 and younger) living in poverty (*Source: US Census Bureau 2008*)

Comparison Data: U.S. 18.2% (2008)
NE 14.2% (2008) (*Source: US Census Bureau 2008*)

Livable Wage Indicator

Baseline: _____% of businesses paying their workforce a Livable Wage of \$7.85 or more per hour. The Livable Wage is based on research conducted for a single male working a 40 hour week in Kearney. (*Percent to be established by the Kearney Area Housing and Homeless Coalition by end of 2002*)

Target: 80% of Buffalo County businesses pay a livable wage

Desired Trend: Increase employers offering a livable wage

Economy INDICATORS (continued)

Unemployment Rates Indicator

Baseline: 2.6% Unemployment rate for Buffalo County (*2001 Woods & Poole*)

Target: Better than the best

Desired Trend: Decrease

Comparison Data: U.S. 3.9% (2001) Target (NA)
NE 2.6% (2001) Target (NA)
(*Source: Woods & Poole, 2001*)

Measurement Updates:

2002: 2.6% Unemployment rate (*Woods & Poole, 2008*)

Comparison Data: U.S. 4.9%
NE 2.8%
(*Source: Woods & Poole, 2002*)

2004: 2.9% Unemployment rate (*Woods & Poole, 2008*)

Comparison Data: U.S. 5.5%
NE 3.9%
(*Source: Woods & Poole, 2007*)

2005: 2.8% Unemployment rate (*Woods & Poole, 2008*)

Comparison Data: U.S. 5.1%
NE 3.8%
(*Source: Woods & Poole, 2007*)

2007: 2.2% Unemployment rate (*Woods & Poole, 2008*)

Comparison Data: U.S. 4.1%
NE 2.5%
(*Source: Woods & Poole, 2007*)

Economy INDICATORS (continued)

Buffalo County Population Indicator

Baseline: 41,000 - Buffalo County Population (*Source: Woods & Poole, 2001*)

Target: 2.5% growth

Desired Trend: Increase

Measurement Updates:

2002: 43,150 – Buffalo County Population
(*Source: Woods & Poole, 2002*)

2004: 43,660 – Buffalo County Population
(*Source: Woods & Poole, 2004*)

2006: 44,150- Buffalo County Population
(*Source: Woods & Poole, 2006*)

2008: 45,310- Buffalo County Population
(*Source: Woods & Poole, 2008*)

Well Body, Mind and Spirit

STRESS ON THE FAMILY UNIT GOAL

GOAL: Reduce stress on the family unit by impacting factors related to stress in the family such as substance abuse (tobacco, alcohol and other drug use) and the status of mental health.

SUBSTANCE ABUSE

Youth Tobacco Use GOAL MEETING TARGET

Baseline: 24.8% - 9-12th graders regularly smoke at least 1 cigarette daily for past 30days
(YBRFS 2000)

Target: 15%

Measurement Updates:

2003: 15.1% 9-12th graders regularly smoke at least 1 cigarette daily for past 30 days (YBRFS 2003)

Comparison Data: U.S. 36% (1999) Healthy People 2010 Target 16%
NE 37% (1999) Nebraska 2010 Target 15%
(Source: Nebraska 2010 Goals & Objectives, page 344)

2007: 11% 9-12th graders regularly smoke at least 1 cigarette daily for past 30 days (YBRFS 2007)

Comparison Data: U.S. 8.1% (2007)
NE 9.6% (2005)
(Source: Meridel Funk, DHHS)

2009: 11.2% 9-12th graders regularly smoke at least 1 cigarette daily for past 30 days
(YBRFS 2009)

Comparison Data: U.S. Data will be released Summer 2010
NE Not Available
(Source: Meridel Funk, NHHSS)

Adult Tobacco Use – GOAL MOVING TOWARD TARGET

Baseline: 18% adults 18 years and older smoke regularly or casually in past 30 days.
(ABRFS 2000)

Target: 12%

Comparison Data: U.S. 24% (1998) Healthy People 2010 Target 12%
NE 23% (1999) Nebraska 2010 Target 12%
(Source: Nebraska 2010 Goals & Objectives, page 344)

Measurement Updates:

2003: 17% adults 18 years and older smoke regularly or casually in past 30 days. (ABRFS 2003)

Comparison Data: U.S. 22% (2003) Healthy People 2010 Target 12%
NE 21% (2003) Nebraska 2010 Target 12%
(Source: *Nebraska 2010 Goals & Objectives*, page 344)

2007: 13% adults 18 years and older smoke regularly or casually in past 30 days. (*ABRFS 2003*)

Comparison Data: U.S. 19.8% (2007)
NE 19.9% (2007) (Source: *Meridel Funk, DHHS*)

STRESS ON THE FAMILY UNIT GOAL (continued)

Youth Alcohol Use – GOAL MOVING TOWARD TARGET

Baseline: 38.7% - 9-12th graders engaged in binge drinking (5 or more drinks in a row within a couple of hours) in past 30 days (*YBRFS 2000*)

Target: 22.5%

Measurement Updates:

2003: 32.6% 9-12th graders engaged in binge drinking (5 or more drinks in a row within a couple of hours) in past 30 days. (*YBRFS 2003*).

Comparison Data: U.S. 7.7% (1998) Healthy People 2010 Target 2%
NE 41% (1999) Nebraska 2010 Target 25%
(*Source: Nebraska 2010 Goals & Objectives, page 332*)

2007: 20.8% 9-12th graders engaged in binge drinking (5 or more drinks in a row within a couple of hours) in past 30 days. (*YBRFS 2007*).

Comparison Data: U.S. 26.0% (2007)
NE 29.8% (2005) (*Source: Meridel Funk, DHSS*)

2009: 21.9% 9-12th graders engaged in binge drinking (5 or more drinks in a row within a couple of hours) in past 30 days. (*YBRFS 2009*).

Comparison Data: U.S. Data will be released Summer 2010
NE Not Available

Adult Alcohol Use DATA NOT AVAILABLE TO DETERMINE GOAL STATUS

Baseline: 5.2 % adults 18 years and older engaged in drinking and driving (*ABRFS '00*)

Target: 1%

Comparison Data: NE 3% (1999) Nebraska 2010 Target 1%
(*Source: Nebraska 2010 Goals & Objectives, page 332*)

Measurement Updates:

2004: 2.7 % adults 18 years and older engaged in drinking and driving (*ABRFS '03*)

Comparison Data: NE 5% (2002)
(*Source: Nebraska 2010 Goals & Objectives, page 332*)

2007: NO SIMILAR QUESTION ON 2007 ABRFS FOR BUFFALO COUNTY OR NEBRASKA
WILL BE IN 2010 SURVEY

STRESS ON THE FAMILY UNIT GOAL (continued)

Illegal Drug Use by Youth – GOAL MOVING TOWARD TARGET

Baseline: 14.2% 9-12th graders report using marijuana in past 30 days (*YBRFS'00*)

Target: 5%

Measurement Updates:

2003: 13.3% 9-12th graders report using marijuana in past 30 days. (*YBRFS 2003*)

Comparison Data: U.S. 9.4% (1998) Healthy People 2010 Target 0.7%
NE 16% (1999) Nebraska 2010 Target 5%
(*Source: Nebraska 2010 Goals & Objectives, page 332*)

2007: 10.7% 9-12th graders report using marijuana in past 30 days. (*YBRFS 2007*)

Comparison Data: U.S. 19.7% (2007)
NE 17.5% (2005)
(*Source: Meridel Funk, NHHSS*)

2009: 10.8% 9-12th graders report using marijuana in past 30 days. (*YBRFS 2009*)

Comparison Data: U.S. Data will be released Summer 2010
NE Not Available

Illegal Drug Use Access – GOAL MOVING TOWARD TARGET

Baseline: 22.9 % 9-12th graders who have been offered, sold, or given illegal drugs on school property (*YBRFS '00*)

Target: Lower than Nebraska

Measurement Updates:

2003: 19.3% 9-12th graders who have been offered, sold or given illegal drugs on school property. (*YBRFS 2003*)

Comparison Data: NE 17% (1999) Nebraska 2010 Target (NA)
(*Source: Meridel Funk, NHHSS*)

2007: 18.5% 9-12th graders who have been offered, sold or given illegal drugs on school property. (*YBRFS 2007*)

Comparison Data: NE 3.1% (2005) (*Source: Meridel Funk, NHHSS*)

2009: 16.2% 9-12th graders who have been offered, sold or given illegal drugs on school property. (*YBRFS 2009*)

Comparison Data: NE Not Available

Rationale: Smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung diseases – all leading causes of death. Smoking during pregnancy can result in miscarriages, premature delivery, and sudden infant death syndrome. Other health effects of smoking result from injuries and environmental damage caused by fires. (Healthy People 2010 pg 31)

Alcohol and illicit drug use are associated with child and spousal abuse; sexually transmitted diseases, including HIV infection; teen pregnancy; school failure; motor vehicle crashes; escalation of health care costs; low worker productivity; and homelessness. Alcohol and illicit drug use also can result in substantial disruptions in family, work and personal life causing stress on the family unit. Alcohol abuse alone is associated with motor vehicle crashes, homicides, suicides, and drowning – leading causes of death among youth. Long-term heavy drinking can lead to heart disease, cancer, alcohol-related liver disease, and pancreatitis. Alcohol use during pregnancy is known to cause fetal alcohol syndrome, a leading cause of preventable mental retardation. (Source: Healthy People 2010 page 33)

STRESS ON THE FAMILY UNIT GOAL (continued)

MENTAL HEALTH

Youth Depression – GOAL NOT ATTAINED

Baseline: 22% 9-12th graders feel sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities. (*YBRFS 2000*)

Target: 12%

Measurement Updates:

2003: 19.7% 9-12th graders feel sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities. (*YBRFS 2003*)

Comparison Data: NE 23% (1999) Nebraska 2010 Target (NA)
(*Source: Meridel Funk, NHHSS*)

2007: 21.2% 9-12th graders feel sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities. (*YBRFS 2007*)

Comparison Data: NE 25.1% (2005) (*Source: Meridel Funk, NHHSS*)

2009: 21.4% 9-12th graders feel sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities. (*YBRFS 2009*)

Comparison Data: NE Not Available

Youth Suicide – GOAL MOVING TOWARD TARGET

Baseline: 15.3% 9-12th graders report seriously considering attempting suicide. (*YBRFS 2000*)

Target: 5%

Measurement Updates:

2003: 14% 9-12th graders report seriously considering attempting suicide. (*YBRFS 2003*)

Comparison Data: NE 17% (1999) Nebraska 2010 Target (NA)
(*Source: Meridel Funk, NHHSS*)

2007: 14% 9-12th graders report seriously considering attempting suicide. (*YBRFS 2007*)

Comparison Data: NE 16.5% (2005) (*Source: Meridel Funk, NHHSS*)

2009: 13.1% 9-12th graders report seriously considering attempting suicide. (*YBRFS 2009*)

Comparison Data: NE Not Available

STRESS ON THE FAMILY UNIT GOAL (continued)

Adult Depression – GOAL NOT MEETING TARGET

Baseline: 34% 18 and older females report one or more days of depression in past 30 days.
(*ABRFS 2000*)

Target: 30%

Comparison Data: (NA)

Measurement Updates:

2003: 39% 18 and older females report one or more days of depression in past 30 days.
(*ABRFS 2003*)

2007: 31% 18 and older females report one or more days of depression in past 30 days.
(*ABRFS 2007*)

Rationale: Approximately 20% of the U.S. population is affected by mental illness during a given year; no one is immune. Of all mental illnesses, depression is the most common disorder. Mental health is sometimes thought of as simply the absence of a mental illness but is actually much broader. Mental health is a state of successful mental functioning, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and one's contribution to society.

A person with a depressive disorder is often unable to fulfill the daily responsibilities of being a spouse, partner, or parent. The misunderstanding of mental illness and the associated stigmatization prevent many persons with depression from seeking professional help. Many people will be incapacitated for weeks or months because their depression goes untreated.

Depression is also associated with other medical conditions, such as heart disease, cancer and diabetes as well as anxiety and eating disorders. Depression has also been associated with alcohol and illicit drug abuse. An estimated 8 million persons aged 15-24 years had co-existing mental and substance disorders within the past year. The total estimated direct and indirect cost of mental illness in the United States in 1996 was \$150 billion. (*Source: Healthy People 2010 page 36/37*)

Well Body, Mind and Spirit

REDUCE OBESITY AND OVERWEIGHT GOAL

GOAL: Reduce obesity and overweight by increasing positive health behaviors relative to physical exercise and nutrition.

NEW BASELINE & TARGET?

	Girls				Boys			
	2000	2003	2007	2009	2000	2003	2007	2009
At risk of becoming overweight	11%	13%	11%	11%	15%	14%	14%	13%
Overweight	2%	7%	7%	8%	8%	13%	13%	14%

Students were asked to record their height and weight. From these data their Body Mass Index was calculated. Based on the 2000 NCHS/CDC Growth Charts, students were identified as “at risk of becoming overweight” (gender and age-specific body mass index at or above the 85th percentile and below the 95th percentile) and as “overweight” (gender and age-specific body mass index greater than or equal to the 95th percentile).

YOUTH PHYSICAL EXERCISE

Baseline: 22.9% 9-12 graders engaged in 20 minutes of Physical activity daily for past 7 days
(YBRFS 2000)

Target: 85%

Measurement Updates:

2003: 25.2% 9-12th graders engaged in 20 minutes of physical activity daily for past 7 days.
(YBRFS 2003)

Comparison Data: U.S. 65% (1999) Healthy People 2010 Target 85%
NE 69% (1999) Nebraska 2010 Target 85%
(Source: Nebraska 2010 Goals & Objectives, page 288)

2007: 26.1% 9-12th graders engaged in 20 minutes of physical activity daily for past 7 days.
(YBRFS 2007)

Changed to: “Were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/ day on 5 or more days during 7 says before survey.”

Comparison Data: U.S. 34.7% (2007)
NE 40.8% (2007) (Source: Meridel Funk, NHHSS)

2009: 25.2% 9-12th graders engaged in 20 minutes of physical activity daily for past 7 days.
(YBRFS 2009)

**Changed to: “On how many of the past 7 days did you exercise or participate in physical*

*activity for at least 20 minutes that made you swear and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing or similar aerobic activities?”**

Comparison Data: U.S.
NE ___% (2009) (Source: Meridel Funk, NHHSS)

REDUCE OBESITY AND OVERWEIGHT GOAL (continued)

ADULT PHYSICAL EXERCISE – GOAL MOVING TOWARD TARGET

Baseline: 23.3% 18 yrs and older are inactive (*ABRFS 2000*)

Target: 15%

Comparison Data: U.S. 40% (1997) Healthy People 2010 Target 20%
NE 27% (1997) Nebraska 2010 Target 15%
(Source: *Healthy People 2010, page 281*)

Measurement Updates:

2003: 16% 18 yrs and older are inactive (*ABRFS 2003*)

Comparison Data: U.S. 24% (2003) Healthy People 2010 Target 20%
NE 25% (2003) Nebraska 2010 Target 15%
(Source: *Meridel Funk, NHHSS*)

2007: 11% 18 yrs and older are inactive (*ABRFS 2007*)

Comparison Data: U.S. 50.5% (2007) (*Adults who are inactive*)
NE 48.0% (2007) (*Adults who are inactive*)
(Source: *Meridel Funk, NHHSS*)

ADULT NUTRITION – DATA NOT AVAILABLE

Baseline: 19% of adults consume 5 or more daily servings of fruits and vegetables. (*ABRFS 2000*)

Target: 25%

Measurement Updates:

2003: 23% of adults consume 5 or more daily servings of fruits and vegetables. (*ABRFS 2003*)

2007: QUESTION IS INCONSISTENT- 2007 RESPONSES ARE "4-5 TIMES A DAY" AND "MORE THAN 5 TIMES"

YOUTH NUTRITION – CHANGE GOAL TO BMI?

Baseline: 2.8% of 9-12th graders consume fruit and 1.2% consume vegetables 4 times or more daily (*YBRFS 2000*)

Target: 25%

Measurement Updates:

2003: 1.8% of 9-12th graders consume fruit and 1.2% consume vegetables 4 times or more daily. (*YBRFS 2003*)

2007: 2.7% of 9-12th graders consume fruit and 1.9% consume vegetables 4 times or more daily. (*YBRFS 2007*)

REDUCE OBESITY AND OVERWEIGHT GOAL (continued)

OVERWEIGHT AND OBESE – GOAL MOVING AWAY FROM TARGET

Baseline: 55.7% adults 18 years and older are overweight and obese as measured by the Body Mass Index (BMI) (*ABRFS 2000*)

Target: 30%

Comparison Data: U.S. 55% (1999) Healthy People 2010 Target (NA)
 NE 58% (1999) Nebraska 2010 Target (NA)
(Source: Meridel Funk, NHHSS)

Measurement Updates:

2003: 59.7% adults 18 years and older are overweight and obese as measured by the Body Mass Index (BMI) (*ABRFS 2003*)

Comparison Data: U.S. 59% (2003)
 NE 60% (2003) (*Source: Meridel Funk, NHHSS*)

2007: 62% adults 18 years and older are overweight and obese as measured by the Body Mass Index (BMI) (*ABRFS 2007*)

Comparison Data: U.S. 63.0% (2007)
 NE 64.7% (2007) (*Source: Meridel Funk, NHHSS*)

Rationale: When a body mass index (BMI) cut-point of 25 is used, nearly 55 percent of the U.S. adult population was defined as overweight or obese in 1988-94, compared to 46 percent in 1976-80. In particular, the proportion of adults defined as obese by a BMI 30 or greater has increased from 14.5 percent to 22.5 percent. A similar increase in overweight and obesity also has been observed in children above age 6 years in both genders and in all population groups.

Being overweight is a major risk factor for a number of diseases. Dietary factors contribute substantially to the burden of preventable illness and premature death in the United States. They are associated with 5 of the 10 leading causes of death: coronary heart disease, some types of cancer, stroke, noninsulin-dependent diabetes mellitus, and atherosclerosis. We recognize that many of the habits that lead to obesity later in life are established during childhood. Buffalo County Community Health Partners are committed to identifying environmental strategies that address the early life habits that lead to obesity. (Source: Healthy People 2000).

Well Body, Mind and Spirit

HEALTH & SPIRITUALITY GOAL – GOAL ATTAINED

GOAL: Increase awareness of spirituality's effect on health and healing.

Baseline: 79% of Buffalo County residents surveyed reported that they were a spiritual person and spirituality had a positive impact on their health. (ABRFS 2003)

Target: Increase in baseline

Measurement Updates:

2007: 86% of Buffalo County residents surveyed reported that they were a spiritual person and spirituality had a positive impact on their health. (ABRFS 2007)

Rationale: Whether celebrating the festival of lights of Hanukkah or the light of Christ at Christmas or Kwanzaa this holiday season, frequently attending religious services adds spark to improving healthy behaviors and increases chances for living longer by as much as 33%, found a 28-year- long study published in the American Journal of Public Health.

The researchers suggested further investigation is needed to learn what mechanisms might contribute to impacting health behaviors and social connections. These might include spiritual/religious/philosophical tenets, such as viewing one's body with respect; relational aspects, such as supportive friendships and community; cognitive aspects such as a stronger sense of coherence, meaning, or sense of control; and psychological, such as enhanced coping skills or potentially increased self-esteem stemming from religious beliefs or practices.

For instance, other mental health studies have revealed the role of positive religious coping in reducing psychological distress and reducing one's risk for depression. In addition, in more than 800 studies that have examined the relationship between religious involvement and some indicator of mental or social health, the large majority found that religious involvement is associated with lower rates of alcohol or drug abuse, less depression and anxiety, greater hope and optimism, more self-esteem, greater purpose and meaning in life, greater well-being and life-satisfaction, and more stable marriages. (Source: *International Center for the Integration of Health and Spirituality*)

Well Body, Mind and Spirit

INFANT MORTALITY AND POST NEONATAL INFANT MORTALITY GOAL

GOAL: Reduce Infant Mortality and Post Neonatal Infant Mortality.

(Neonatal is defined as 0-28 days after birth and Post Neonatal is 28 – 365 days)

INFANT MORTALITY – MOVING TOWARD TARGET

Baseline: 8.5/ 1,000 live births result in infant mortality in Buffalo County.

(Source: Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009)

Target: 4.5/ 1,000 live births

Comparison Data: U.S. 7.2 (1997) Healthy People 2010 Target 4.5
 NE 7.3 (1997) Nebraska 2010 Target 4.5

(Source: Buffalo County Health Profile, 1997)

Measurement Updates (Based on a 3-year moving average):

2001: 5.6/ 1,000 live births result in infant mortality in Buffalo County.

(Moving average for 1999-2001)

(Source: Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009)

Comparison Data: U.S. 6.9 (2000)
 NE 6.8 (2001)

2002: 5.6/1,000 live births result in infant mortality in Buffalo County.

(Moving average for 2000-2002)

(Source: Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009)

2003: 6.0/ 1,000 live births result in infant mortality in Buffalo County.

(Moving average for 2001-2003)

(Source: Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009)

Comparison Data: U.S. 7.0 (2003)
 NE 5.4 (2003)

2004: 7.4/1,000 live births result in infant mortality in Buffalo County.

(Moving average for 2002-2004)

(Source: Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009)

2005: 7.3/ 1,000 live births result in infant mortality in Buffalo County.
(Moving average for 2003-2005)
(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 6.76 (2005)
NE 5.60 (2005)

2006: 6.7/ 1,000 live births result in infant mortality in Buffalo County
(Moving average for 2004-2006)
(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 6.87 (2006)
NE 5.50 (2006) (Source: *Meridel Funk, NHHSS*)

2007: 5.0/1,000 live births result in infant mortality in Buffalo County
(Moving average for 2005-2007)
(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 6.69 (2007) (Source: *Center for Disease Control (CDC) Web site*)
NE 6.8 (2007) (Source: *Meridel Funk. NHHSS*)

INFANT MORTALITY AND POST NEONATAL INFANT MORTALITY GOAL (Continued)

POST NEONATAL INFANT MORTALITY – MOVING TOWARD TARGET

Baseline: 3.4/ 1,000 live births result in Post Neonatal Infant Mortality

(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Target: 1.5/ 1,000 live births

Comparison Data: U.S. 2.5 (1997) Healthy People 2010 Target 1.5
 NE 2.5 (1997) Nebraska 2010 Target 1.2
(Source: *Buffalo County Health Profile, 1997*)

Measurement Updates (Based on a 3-year moving average):

2001: 1.1/ 1,000 live births result in Post Neonatal Infant Mortality in Buffalo County.
(Moving average for 1999-2001)

(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 2.3 (2000)
 NE 2.0 (2001)

2002: 1.1/1,000 live births result in Post Neonatal Infant Mortality in Buffalo County.
(Moving average for 2000-2002)

(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

2003: 1.1/1,000 live births result in Post Neonatal Infant Mortality in Buffalo County.
(Moving average for 2001-2003)

(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 2.3 (2003)
 NE 3.7 (2003) (Source: *Meridel Funk, NHHSS*)

2004: 1.6/1,000 live births result in Post Neonatal Infant Mortality in Buffalo County.
(Moving average for 2002-2004)

(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

2005: 1.6/ 1,000 live births result in Post Neonatal Infant Mortality in Buffalo County.
(Moving average for 2003-2005)

(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 2.26 (2005)
 NE 2.30 (2005) (Source: *Meridel Funk, NHHSS*)

2006: 1.6/ 1,000 live births result in Post Neonatal Infant Mortality in Buffalo County.
(Moving average for 2004-2006)
(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 2.34 (2005)
NE 2.00 (2005) (Source: *Meridel Funk, NHHSS*)

2007: 2.0/1,000 live births result in Post Neonatal Infant Mortality in Buffalo County.
(Moving average for 2005-2007)
(Source: *Nebraska Vital Statistics Reports, 1998-2007, Nebraska DHHS, Meridel Funk, Dec. 2009*)

Comparison Data: U.S. 2.24 (2006) (Source: *Center for Disease Control (CDC) Web site*)
NE 1.9 (2007) (Source: *Meridel Funk, NHHSS*)

Rationale: Infant death is an important measure of a nation's health and a worldwide indicator of health status and social well-being. As of 1995, the US infant mortality rates ranked 25th among industrialized nations. In the past decade, critical measures of increased risk of infant death, such as new cases of low birth weight and very low birth weight, have actually increased in the United States. In addition, the disparity in infant mortality rates between whites and specific racial and ethnic groups persists. Although the overall infant mortality rate has reached record low levels, the rate for African Americans remains twice that of whites. In Buffalo County we have seen a higher rate than the U.S. with white infant mortality at a higher rate than specific racial or ethnic groups. (Source: *Healthy People 2010 page 16-3*)

Well Body, Mind and Spirit

INDICATORS

School Health Indicator

Baseline: 96.13% of students attend school on a regular basis. (*Source: Nebraska Schools Web Site: includes all K-12 class 2 & 3 schools and private schools, 2000-2001.*)

Target: 98%

Desired Trend: Increase

Comparison Data: NE 94.98% (2000-2001)

Measurement Updates:

2001-2002: 96.13%

Comparison Data: NE 95.06% (2001-2002)

2003-2004: 96.10%

Comparison Data: NE 95.02% (2003-2004)

2005-2006: 96.13%

Comparison Data: NE 94.94% (2005-2006)

2006-2007: 93.94%

Comparison Data: NE 94.77% (2006-2007)

2007-2008: 95.29%

Comparison Data: NE 94.71% (2007-2008)

2008-2009: 96.23%

Comparison Data: NE 94.84% (2008-2009)

Well Body, Mind and Spirit INDICATORS (continued)

Teen Sexual Activity Indicator

Baseline: 62.3% 9-12th graders are not sexually active (*YBRFS'00*)

Target: 70%

Desired Trend: Increase

Measurement Updates:

2003: 58.6% 9-12th graders are not sexually active. (*YBRFS 2003*)

Comparison Data: U.S. Females 62% (1995) Healthy People 2010 Target 75%
U.S. Males 57% (1995) Healthy People 2010 Target 75%
NE (NA)
(*Source: Healthy People 2010, pages 9-21*)

2007: 61.2% 9-12th graders are not sexually active. (*YBRFS 2007*)

Comparison Data: U.S. 65.0% (Females & Males)
NE 69.5% (Females & Males) (*Source: Meridel Funk, NHHSS*)

2009: 57.7% 9-12th graders are not sexually active. (*YBRFS 2009*)

Comparison Data: U.S. Data will be released Summer 2010
NE ____% (2009) (*Source: Meridel Funk, NHHSS*)

Injuries & Death Indicator

Baseline: 19.3/ 100,000 rate of deaths by motor vehicle (*Source: Buffalo County Community Health Profile 1997*)

Target: 12

Desired Trend: Decrease

Comparison Data: U.S. 15.6 (1998) Healthy People 2010 Target 9.2
NE 20.5 (1998) Nebraska 2010 Target 12
(*Source: Nebraska 2010 Goals & Objectives, page 203*)

Measurement Updates:

2000: 20.3/ 100,000 rate of deaths by motor vehicle.
(*Source: Buffalo County Community Health Profile 2000*)

Comparison Data: U.S. 15.7 (2000)
NE 15.5 (2001)
(*Source: Meridel Funk, NHHSS*)

2003: 17.8/ 100,000 rate of deaths by motor vehicle.
(*Source: Buffalo County Community Health Profile 2003*)

Comparison Data: U.S. 15.7 (2003)
NE 16.8 (2003)
(*Source: Meridel Funk, NHHSS*)

2006: 17.9/ 100,000 rate of deaths by motor vehicle. (2002-2006) (*Source: Meridel Funk, NHHSS*)

Comparison Data: U.S. 14.6 (2002-2006)
NE 16.5 (2002-2006)

Well Body, Mind and Spirit INDICATORS (continued)

Injuries & Death Indicator

Baseline: 4.0/ 100,000 rate of deaths by homicide.
(*Buffalo County Community Health Profile 1997*)

Target: 3.0

Desired Trend: Decrease

Comparison Data: U.S. 6.5 (1998) Healthy People 2010 Target 3.0
NE 3.3 (1998) Nebraska 2010 Target 2.0
(*Source: Nebraska 2010 Goals & Objectives, page 204*)

Measurement Updates:

2000: 1.7/ 100,000 rate of deaths by homicide.
(*Source: Buffalo County Community Health Profile 2000*)

Comparison Data: U.S. 6.1 (2000)
NE 2.6 (2001)

2003: 0.9/ 100,000 rate of deaths by homicide.
(*Source: Buffalo County Community Health Profile 2003*)

Comparison Data: U.S. 6.1 (2003)
NE 3.3 (2003)

2006: 0.0/ 100,000 rate of deaths by homicide (2002-2006) (*Source: Meridel Funk, NHHSS*)

Comparison Data: U.S. 6.1 (2006)
NE 2.9 (2002-2006) (*Source: Meridel Funk, NHHSS*)

KEY

- ABRFS – Buffalo County Adult Behavior Risk Factor Survey
- BCHP – Buffalo County Health Profile provided by Nebraska Health & Human Services System
- BCTFC – Buffalo County Tobacco Free Coalition
- NNHHSSS – Nebraska Health and Human Services System
- MTHM – Mini-Town Hall Meeting Results
- MBRFS – Buffalo County Minority Behavior Risk Factor Survey
- (NA) – Data Not Available
- RYDE – Reach Your Destination Easily (Public Transportation System in Buffalo County)
- W&P – Woods and Poole Economic, Inc.
- YBRFS - Buffalo County Youth Behavior Risk Factor Survey