LANCASTER COUNTY COMMUNITY HEALTH PROFILE, 2015

Mobilizing for Action through Planning & Partnership

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We welcome comments at https://www.surveymonkey.com/r/SSCKXYR.

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Introduction

This 2015 update to the community profile for Lincoln and Lancaster County is based upon the recent community health assessment utilizing much of the MAPP (Mobilizing for Action through Planning and Partnership) process. This community profile is informed by the four assessments that are part of the MAPP process: Community Health Status Assessment, Community Themes and Strengths, Forces of Change Assessment, and the Community Public Health System Assessment.

This update includes the latest available data, including statistical and survey data for 2014 from several sources as well as qualitative information from surveys and focus groups where appropriate. The data and statistics include a number of health and environmental health indicators as well as the most recent estimates of demographic and social characteristics that influence health. While some things have changed since the last MAPP process was completed in 2012, many of the issues remain the same. The Community Profile summarizes and highlights the results of the MAPP assessments and weighs heavily on data and information gathered for the assessments. The Community Health Improvement Plan (CHIP) is a separate document, which was also updated to reflect actions and improvements that have occurred since 2013 as well as any modifications in goals and objectives. One thing that didn't change were the four priority areas in the CHIP as reflected by the scores of priority health issues completed by the MAPP committees. The four priority areas included in the CHIP are: Access to Care, Chronic Disease Prevention, Behavioral Health, and Injury Prevention. The process for determining the CHIP priorities is discussed in this community profile.

The MAPP process with four community health assessments and the CHIP committees were led by Lincoln-Lancaster County Health Department staff. However, we were fortunate to have broad-based representation from the Department's many community partners and stakeholders as well as participation in the surveys and meetings from members of the general public. There is a MAPP webpage on the Health Department's web site that provides information about the process, including the Vision Statement for the next five years ***("A thriving community where all people are safe and healthy"***), Vision Priorities and Guiding Principles as well as presentations for each of the 2015 meetings and a survey instrument for people to provide feedback on any aspect of MAPP and CHIP. The MAPP webpage is found at http://lincoln.ne.gov/city/health/pde/MAPP.htm.

The Executive Summary that follows highlights some of the health measures and factors that influence personal, public, and environmental health in Lincoln and Lancaster County. More detailed analysis and additional measures are covered in the full report. While reports such as this include the most recent data available at the time, as new data become available some of the statistics become outdated. Therefore, readers are encouraged to search for the latest available data from Vital Statistics, adult (BRFSS) and youth risk behavior (YRBS) surveys, county health rankings, air quality monitoring, food inspection reports and communicable disease data posted on the Health Department's website (http://lincoln.ne.gov/city/health/index.htm).

Executive Summary

In assessing a community's health status, it is important to analyze a host of indicators as well as available historical and/or trend data that give perspective to any one measure. Reviewing information on a range of health status indicators as shown below reveals that many of the health and quality of life measures for Lincoln and Lancaster County are positive. When compared to a select group of peer cities or counties, Lancaster County is frequently ranked near the top of the group for many of the indicators for which there is comparable data. Furthermore, when local indicators are compared to state and national health goals such as the objectives in the Nebraska Healthy People 2020 and Healthy People 2020 documents, the community's measures already are at the objective level or on track to meet the objective by 2020.

Despite the generally favorable outcomes we enjoy as a community, there are other areas where local measures are only average and a few where the local rates are below average when compared to other counties in the state or nation.

In analyzing any particular measure of health it is also important to understand how the data are collected or recorded. Such information is important in assessing current status as well as providing insight into future changes in the measure. Factors that are also known as social determinants of health (the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness) will be discussed in some detail when we have data related to these factors (e.g., poverty data, education, employment history).

The recent 2015 Lincoln Vital Signs report that presented data for a host of demographic, economic, social and health indicators concluded that things look good for Lincoln overall for several health measures. The community collaborative called Prosper Lincoln is working to make improvement and address several key areas that influence health, especially the high level of poverty for children and adults in several census tracts in Lincoln. The annual County Health Rankings yields the same overall assessment—that Lancaster County's health outcomes are relatively good, but some factors influencing health are not as positive. Over the past several years, the county has dropped in the rankings to the second quartile of Nebraska counties (number 24 out of 78 counties, which is just out of the top quartile of counties). There's a mixed picture as Lancaster County ranks high for measures of clinical services and environmental health, yet the county's measures are only average for many other indicators. In fact, Lancaster County's indicators rank below other Nebraska or peer county's rates for smoking, binge drinking, and STDs. The data and results for a host of indicators are summarized here in the Executive Summary, but more detailed information for each topic is provided in the full report.

Demographic Profile

The demographic data utilized in this profile come from a number of U.S. Census Bureau sources, including the 2010 census and data from the 2014 American Community Survey (ACS) or a combination of ACS survey years, especially the 2009-2013 ACS data.

- The annual American Community Survey (ACS) conducted by the U.S. Census Bureau estimates that the 2014 population for Lancaster County was 301,795. The 2014 figure represents an increase of almost 17,000 or a 5.8 percent increase in population in four years when compared to the 2010 Census count of 285,407. Over the decade from 2000 to 2010, the population had increased by 35,116 or 14.8 percent. Looking to the future, there is a projection that the 2010 to 2020 increases will be on par or higher than the growth in the first decade of the new millennium (the 2020 population is projected to be 326,000 or almost 40,000 more people than in 2010). Demographers also expect future population growth over the next several decades with a 2040 projected population of more than 410,000 (the trend series gives a projection of 412,697). Lincoln's 2014 ACS estimated population was 272,996. The 2010 Census counted the City of Lincoln's population as 258,379, which is an increase of 32,798, or 14.5 percent, from 2000 when the population was 225,581. As can be seen, the Lincoln's population represents approximately 90 percent of Lancaster County's population.
- Over the past several decades the minority population of Lincoln and Lancaster County has increased; and minorities now represent nearly 17 percent of the total population in 2015. Over time the county's demographic profile has shown a marked increase in diversity due to both immigration and multi-racial and multi-ethnic marriages. Racial minorities and ethnic populations have grown significantly in numbers since 2000, especially in percentage terms. Persons of Hispanic origin nearly doubled (97.8 percent increase from 8,437 to 16,685) in size from 2000 to 2010 and while the number of Hispanics now approaches 20,000, the rate of increase has slowed down between 2010 and 2014. Hispanics represent the largest group of minority residents in the county as their numbers double the size of both African Americans and Asians. African American and Asian populations have also grown in numbers, especially when people identify themselves as being in more than one race or ethnic group. There are estimates of race and ethnicity from the 2014 ACS, and there is also information in the five-year ACS survey (2009-2013). The 2014 ACS data reveals the racial/ethnic breakdown for Lancaster County as follows:

    - Total Population: 301,795
    - Hispanic or Latino (of any race): 19,918
    - White alone, Non-Hispanic: 248,377
    - Race (includes persons of Hispanic origin who may be of any race)
        - White alone: 266,787
        - Black or African American alone: 11,770
        - American Indian/Alaskan Native alone: 2,716
        - Asian alone: 12,374
        - Native Hawaiian or Pacific Islander: 302
        - Two or more races: 7,847

- Looking at the demographic data by age group, it is also evident that the 60 and older population has increased at a faster percentage rate in the past decade than the overall population. From 2000 to 2010, the county's population aged 62 or older increased by 27 percent versus the overall population growth rate of 14.8 percent. Projections for the next several decades indicate that the higher growth rate in the elderly cohort groups (those 65

and older), both in numbers and as a percent of the total population, will continue as the "baby boomers" (persons born from 1948 to 1964) age in place. To illustrate the growth, 10.9 percent of Lancaster County's population was over 65 in 2010. The 2014 ACS estimate shows that 12.1 percent of the population, or an estimated 36,517 residents were 65 or older. By 2020 it is projected that those 65 and older will represent 14.5 percent of the total population; by 2030, 17.7 percent; and by 2040, 18.2 percent. These population projections are based on the "trend rate" population model for Lancaster County projected by David Drozd and Jerome Deichert from the University of Nebraska Omaha's Center for Public Affairs Research.

- When examining the socioeconomic characteristics of Lincoln and Lancaster County residents, the overall measures for the community seem good based on averages and comparisons with measures for the state. However, in looking at the details it is evident that there are a number of socioeconomic concerns (discussed below) that stand out when examining the data for geographic areas such as census tracts and neighborhoods, as well as when looking at subsets of the population. For instance, despite Nebraska having the lowest unemployment rate in the nation in almost every month in 2015 and Lincoln having had one of the lowest city rates of unemployment for the past several years, wages and incomes in the community aren't high enough for all individuals and families to rise above poverty. [The federal government establishes the income levels that define the poverty rate each year, factoring in the size of families—see the 2015 and 2016 poverty income guidelines.] Poverty estimates for 2013 (when a family of four with an annual income of $23,500 or less would be considered to be at the poverty level) made by the Census Bureau from their Small Area Poverty and Income Estimate (SAIPE) model for Lancaster County indicated that 14.8 percent of the population had family incomes below the poverty level. In comparison, 12.9 percent of families in Nebraska had an income level that was below the poverty threshold. The 2013 Lancaster County poverty rate estimate for children under 18 was 16.7 percent. Both of the local 2013 estimates represent an increase from 2012 when an estimated 13.5 percent of families had incomes below poverty and 15.3 percent of children under 18 lived in households with incomes below poverty. Based on the high poverty rates in families, it is not surprising that data for the 2014-2015 school year revealed that 43.4 percent of students enrolled in the Lincoln Public Schools qualified for free and reduced meals.
- Estimates of median income from the same source (SAIPE) show that the relative position of the county is somewhat volatile from year to year. In 2013, based on the 2009-2013 ACS surveys, the county's median household income of $51,574 was lower than both Nebraska's median household income estimate of $51,672 and the national median household income estimate of $53,046. As for per capita income, the per capita income in Lancaster County ($27,141) was slightly above the per capita in Nebraska ($26,899), but below the national per capita income ($28,155).
- In the 2014-15 school year, Lincoln Public Schools (LPS) had an enrollment of 37,495 students in kindergarten through 12th grade and a grand total of 39,066 students in the LPS system, which includes LPS's preschool programs. As mentioned above, 43.4 percent of these students overall qualified for free or reduced price lunches, but the rates are much higher in some elementary schools. The LPS report also shows that 31.9 percent of students came from ethnically diverse cultures, 14.0 percent had an identified disability, and 6.4 percent participated in the English Language Learner program. A total

of 57 languages other than English were spoken by LPS students. The on-time graduation rate in the Lincoln Public Schools (LPS) dropped to 85.2 percent for the class of 2015 from the 2014 graduation rate of 87.2 percent using the LPS formula (by the State's Department of Education, the four-year graduation rate was 83.2% in 2014 and 82.2% in 2015). LPS has a strategic planning graduation goal of 90 percent by 2016.

- In addition to LPS, there are a significant number of students enrolled in non-public and parochial schools in Lincoln, including kindergarten and pre-school students. At the start of the 2014-2015 school year there were 6,828 students enrolled in the non-public schools in Lincoln. There are also five public elementary and four public high schools in the rest of Lancaster County. The high schools in the county are Waverly, Norris (Hickman), Malcolm and Raymond Central. Norris had a 99.3 percent on-time graduation rate for 2015, which is almost perfect.
- The University of Nebraska's main campus is located in Lincoln, which is also the home of Nebraska Wesleyan, Union College, a branch campus of Doane College as well as Southeast Community College, Kaplan University and several professional schools where students are pursuing degrees or certificates. The 2013 American Community Survey (ACS) estimates that 88,381 students, three years of age and older, are enrolled in schools: 4,674 in nursery/preschool; 45,571 in K-12 grades; 32,930 in undergraduate and 5,656 in graduate college programs.
- The 2009-2013 ACS estimates that 93.8 percent of Lancaster County residents 25 or older have a high school diploma or higher degree, with 36.1 percent of the over-25 population having a bachelor's degree or higher.

Health Status Overview

- In the bulleted information that follows we show Behavioral Risk Factor Surveillance System (BRFSS) survey data for adults (those 18 and older) from 2011 to 2014, and Lancaster County BRFSS survey results are compared to state and national BRFSS results for 2011 to 2014 where available. Overall, on the basis of self-reported responses from the BRFSS surveys for 2014, Lancaster County residents generally have health conditions and engage in risky behaviors at rates that are better than overall rates for Nebraska (2011 to 2014 data for all BRFSS questions are available at this site for both Lancaster County and Nebraska with confidence intervals) and the nation, but not for all:
    - Looking at the latest available data in Table 1 below from 2013 and 2014 BRFSS results, Lancaster County residents indicate that they have a lower prevalence of several conditions than the state and nation (except for asthma and depression), but most differences are not statistically significant:
        - Lower prevalence of high blood pressure
        - Lower rate of elevated cholesterol
        - Smaller percent of persons having had a heart attack
        - Lower percent of respondents having angina or coronary heart disease
        - Lower percent of persons diagnosed with diabetes

Table 1: 2013/2014 BRFSS Data Comparison (Chronic Health Conditions)

Disease/Condition	Lancaster County	Nebraska	US (States & DC)
Hypertension [2013]	25.7%	30.3%	31.4%
Elevated Cholesterol [2013]	35.2%	37.4%	38.4%
Heart Attack History	2.6%	3.8%	4.4%
Angina/CHD	2.8%	3.9%	4.2%
Asthma (Lifetime)	15.0%	12.2%	13.8%
Asthma (Current)	9.7%	7.7%	8.9%
Depression	19.5%	17.7%	19.0%
Diabetes	8.2%	9.2%	10.0%

Adult Risk Behaviors

- Some notable behaviors that are shown to be associated with the chronic health conditions mentioned in Table 1 are mentioned below. Further details about health behaviors will be clarified later, but here are some other 2013 and 2014 BRFSS findings:
    - *2014 Binge Drinking:* Lancaster County residents (23.5%) binge drink more than the state (20.3%) and national (16.0%) levels.
    - *2014 Smoking Status:* A larger percentage of Lancaster County residents are current smokers (18.8%) than the percentage of state (17.4%) and national (18.1%) residents who are current smokers.
    - *2013 Physical Activity:* Adults in Lancaster County (52.9%) engage in at least 150 minutes of physical activity per week more frequently than adults in Nebraska overall (50.1%) and in the nation (50.8%).
    - *2013 Fruit & Vegetable Consumption:* County residents consume vegetables 1 or more times per day (74.3%) less often than the state (76.7%) and the nation (77.1%), as well as consume fruits 1 or more times per day (59.4%) less often than the state (60.3%) and nation (60.8%).
    - *Asthma:* As shown in the table above, the rates for persons who have a lifetime history (15.0%) or currently have asthma (9.7%) are higher than Nebraskans overall (12.2% and 7.7% respectfully) and the U.S. rates (13.8% and 8.9% respectfully).
    - *Depression:* As shown in Table 1, Lancaster County residents have a higher rate (19.5%) of respondents diagnosed with a lifetime diagnosis of depression than the state (17.7%) and the rate is similar to, but slightly above, the national rate for depression (19.0%).
    - *Obesity and Overweight:* The BRFSS relies on self-reported heights and weights rather than actual measurement. Lancaster County BRFSS data for 2014 showed the local rates for overweight and obesity (25.4 percent) are better than the Nebraska rates for obesity (30.3 percent obese), but more county residents fall into the overweight category—37.5% vs. 36.4%. The local rates had the same relative comparison against national rates (35.4 percent overweight, 29.4 percent obese). The Lancaster rate of obesity (25.4%) was lower than Nebraska's obesity rate (30.3%) in 2014, and has been lower in every year from 2011 to 2014. Nevertheless, as is

true everywhere, the long-term obesity trend is negative over the past twenty years and contributes to the chronic health conditions (such as diabetes, heart disease, and cancers) identified above.

Youth Risk Behaviors

Table 2: Lancaster County YRBS Results, 2009 to 2015 (Every Other Year)

Question/Behavior	2009	2011	2013	2015
Lifetime Alcohol Use	66.3%	54.6%	52.5%	50.9%
Current Alcohol Consumption	35.0%	28.0%	24.1%	23.4%
Riding in a car driven by someone who has been drinking	31.6%	23.7%	19.4%	17.4%
Driving a car after consuming alcohol	14.4%	10.1%	5.6%	5.7%
Marijuana Use (Past 30 days)	18.0%	15.9%	16.1%	17.1%
Cocaine Use (Lifetime)	1.4%	4.6%	4.1%	3.4%
Current Smoker	17.6	16.4%	13.3%	12.4%
Ever had Sexual Intercourse	37.0%	31.9%	31.6%	31.3%
Not physically active at least 60 minutes per day on at least 1 day	23.9%	11.0%	12.1%	9.3%
Played video games or used a computer 3 or more hours a day	18.6%	22.1%	31.5%	35.9%
Watched television 3 or more hours a day	22.3%	21.2%	23.3%	19.3%
Involved in a physical fight (past 12 months)	23.0%	25.7%	20.3%	19.4%
Rarely or never use seat belts	8.4%	8.6%	8.4%	4.9%
Texting while driving	Not asked	Not asked	48.5%	49.0%
Bullied on school property (past year)	23.8%	21.5%	21.7%	23.6%
Electronically bullied (past 12 months)	Not asked	15.4%	17.6%	17.9%
Suicide Ideation (past 12 months)	14.2%	12.5%	12.3%	17.5%
Made a plan to commit suicide	11.3%	10.7%	10.2%	13.4%
Attempted suicide (past 12 months)	11.1%	11.0%	9.6%	14.0%

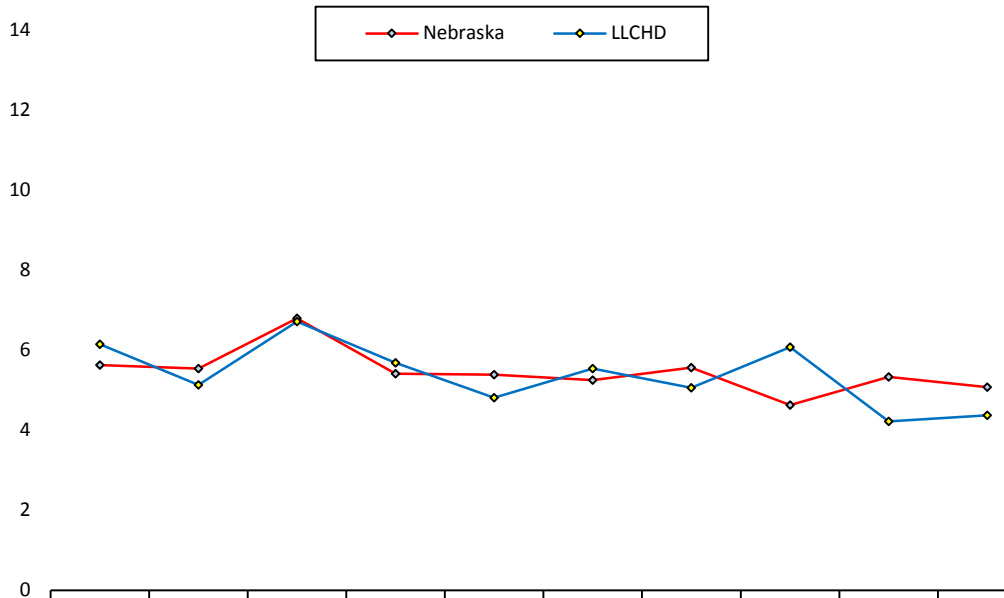
Leading Causes of Death

- In 2014, the order of the leading causes of death was unchanged from previous years as cancer was the leading cause of death (454 – 22.1% of 2,057 deaths) in Lancaster County, followed by heart disease (368), chronic lung disease (127), unintentional injuries (accidents – 105), cerebrovascular disease (93), diabetes (54) and Alzheimer's disease (45). Renal disease (43 in 2014, 50 in 2013) and intentional self-harm (suicide – 46 in 2014, 37 in 2013) were two notable causes of death in 2014due to their increased numbers, especially given the age distribution of the suicide victims (to be discussed later in this profile and as a concern discussed in the CHIP).
    - Among the cancer types in 2014, lung cancer remained the leading cause of cancer deaths (115), followed by colorectal cancer (42). Female breast cancer (36) and prostate (26) cancers were again the leading gender-specific causes of death.
    - While unintentional injuries (accidents) were the fourth leading cause of death overall, based on several years' data unintentional injuries are the leading cause of death for persons ages 1 to 44, and they are second only to cancer in years of potential life lost (YPLL) before the age of 75.
- All of the top ten leading causes of death can be positively impacted by lifestyle changes and prevention efforts with the possible exception of Alzheimer's disease (and that is being researched to see if exercise or mental stimulation delays the onset of disease).
- While suicide deaths are not listed as one of the top ten causes of death overall, the number of suicide deaths in Lancaster County has increased significantly for teens and young adults so there is now a greater focus on suicide prevention in the community and state, which is also discussed in the CHIP Behavioral Health section.

Maternal and Child Health

- ***Overall Births:*** The number of Lancaster County births has been fairly steady since about 2006, with a range of 4,100 to 4,200 births a year. In 2014, the number of births, 4,115, fell below the birth numbers reached in 2010 (4,153), equaled the 2012 births (4,115), and was above the 3,951 births in 2011.
- ***Infant Mortality:*** The infant mortality rate or the number of infants younger than one who die per 1,000 live births has fallen over time, but is somewhat volatile (not stable) on a year-to-year basis. As recently as 2012, the infant mortality rate jumped to 6.1 infant deaths per 1,000 live births from an infant mortality rate of 5.1 infant deaths per 1,000 live births in 2011, reflective of how a small number of infant deaths can significantly affect the infant mortality rate. In 2013, the 17 infant deaths versus 4,030 live births, resulted in an infant mortality rate of 4.2 infant deaths per 1,000 live births. The 2013 rate represented a significant decrease from the 2010-2012 infant mortality rates and it is the lowest we have ever experienced. However, given the volatility of the measure, it should not be a surprise to see that the 2014 infant mortality rate rose slightly to 4.4 infant deaths per 1,000 live births), which is still well below both the **Healthy People 2020** objective of 6.0 infant deaths per 1,000 live births and is below the Nebraska Healthy People 2020 objective of 4.8 infant deaths per 1,000 live births.

Infant Mortality Rate* per 1,000 Live Births, Nebraska and Lincoln-Lancaster County Health Department, 2005-2014**



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	5.6	5.5	6.8	5.4	5.4	5.2	5.6	4.6	5.3	5.1
LLCHD	6.1	5.1	6.7	5.7	4.8	5.5	5.1	6.1	4.2	4.4

*Number of deaths to infants (less than 12 months old) per 1,000 live births
**Lincoln-Lancaster County Health Department encompases Lancaster County
Source: Nebraska Vital Records; National Center for Health Statistics

- ***First Trimester Prenatal Care:*** Starting prenatal care in the first trimester is beneficial for both moms and babies. Prior to 2005 mothers were asked when filling out the birth certificate to indicate when they began prenatal. In 2005, there was a change in the birth certificate and one of the changes was to no longer rely on a mother's memory, but instead to rely on the medical record. Prior to 2005, rates of prenatal care were therefore unreliable and errored on the high side—rates of 85 to 90 percent were seen. Since 2005, prenatal care rates are generally in the seventies. Prenatal care rates for Lancaster County generally hover in a range from 77 to 80 percent, which is relatively good when compared to the Nebraska rates. In 2014, the prenatal care rate was 78.6 percent compared to 71.5 percent for Nebraska. (A chart comparing Lancaster County and Nebraska from 2005 to 2014 is included in the full report.) The highest rate for prenatal care locally was in 2011, at 80.9 percent. The rates for the past three years are lower, but remain above the **Healthy People 2020** objective of 77.9 percent of mothers initiating prenatal care in the first trimester of their pregnancy. Nevertheless, there is room for improvement in the prenatal care rates as, ideally, over 90 percent of women should start prenatal care during the first trimester of any pregnancy.
- ***Ten or more Prenatal Care Visits:*** Overall, there has been an upward trend in the percent of mothers who have had ten or more prenatal care visits prior to their delivery. Race was as significantly associated with receiving at least 10 prenatal visits as was age, with 64.4% of white mothers receiving this suggested number of visits, but only 54% of Blacks, 34.9% of American Indians/Pacific Islanders, 54.1% of Asians and 57% of Other Races receiving the recommended number of prenatal care visits before their delivery.

Hispanic moms had ten or more prenatal visits 52.5 percent of the time. In 2014, only 53 percent of mothers younger than 20 and 55.6 percent of mothers aged 20 to 24 had 10 or more prenatal visits before giving birth. In comparison, 64.8 percent of mothers aged 25 to 29, and 64.7 percent of mothers over 30, had 10 or more prenatal visits prior to delivery.

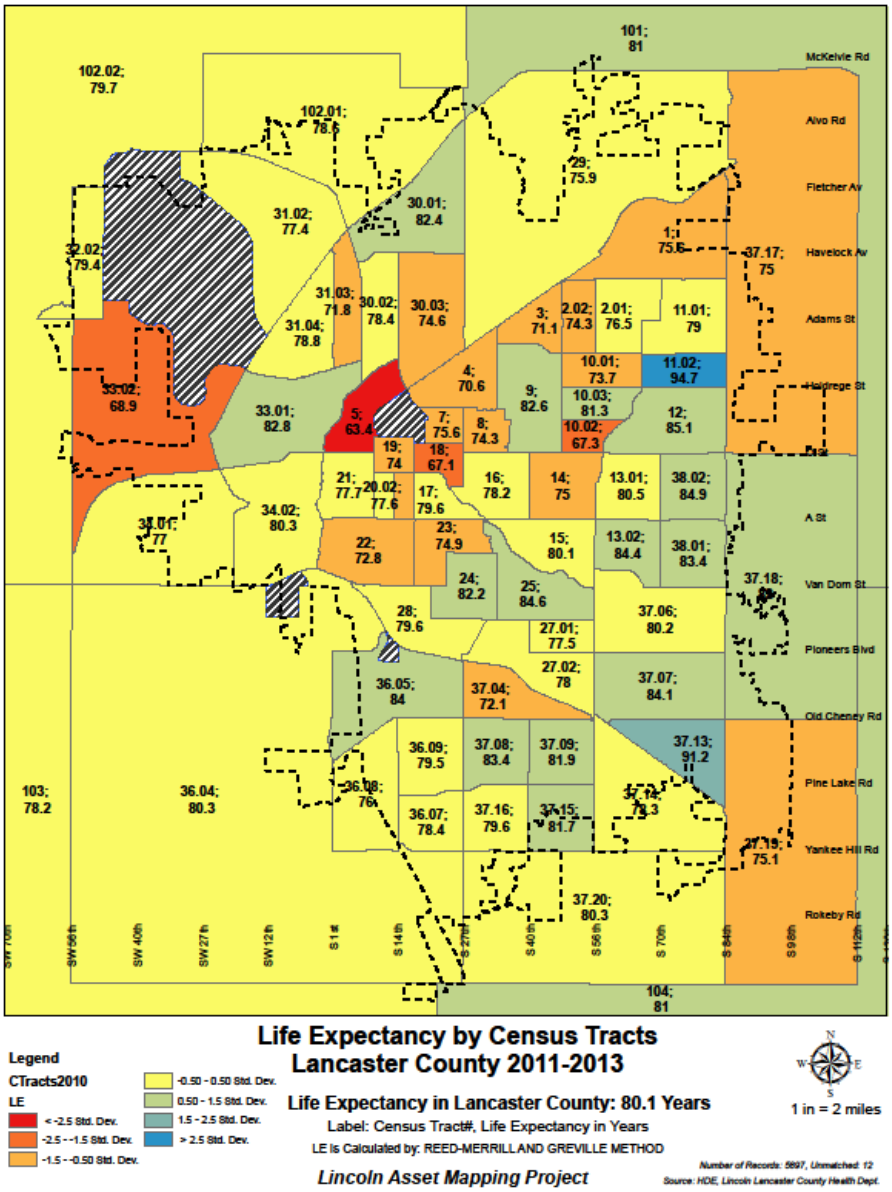
- ***Low Birth Weight (LBW):*** Babies weighing 2500 grams (5.5 pounds) or less are classified as low birth weight (LBW) babies—a measure associated with several negative health outcomes. Of greatest concern, low birth weight is the leading risk factor for infant mortality. The overall rate of LBW babies in Lancaster County dropped to 6.0 percent in 2014 after having been at or near 6.5 percent of births over the previous three years (6.5% in 2011 and 2012, and 6.3% in 2013). The rates for both African American and Asian babies that are born with low birth weights are more volatile than for White babies due to the smaller number of births. The following table provides the differences by mother's race (for the three largest racial groups) over the past five years.

LBW (%) Babies by Year	White Mothers	African American Mothers	Asian Mothers
2014	**5.6%** of 3,362 births	**12.8%** of 187 births	**7.7%** of 196 births
2013	**5.9%** of 3,349 births	**13.7%** of 182 births	**6.3%** of 160 births
2012	**5.8%** of 3,372 births	**17.6%** of 199 births	**3.2%** of 188 births
2011	**6.0%** of 3,310 births	**14.2%** of 176 births	**7.1%** of 155 births
2010	**7.2%** of 3,375 births	**15.2%** of 217 births	**7.5%** of 174 births

- ***Unmarried Mothers:*** In 2014, 30.5 percent of births were to unmarried mothers, which was an increase from 2013 when 29.3 percent of mothers giving birth were unmarried at the time of their delivery. Based on previous comparisons, we expect that the local rate of unmarried mothers will compare favorably to the 2014 rates for both Nebraska and the U.S. as the Nebraska rate is generally 4 to 5 percentage points higher than for the county and national rates have been closer to 40 percent. Age, race and ethnicity were significantly associated with marital status. Mothers younger than 20 were unmarried 91.7% of the time and 63.4% of mothers 20 to 24 years old were unmarried. In contrast, 23.6% of mothers 25-29 years old were unmarried and only 15.8% of mothers 30 years and over were unmarried. By race, White mothers were unmarried 26.8% of the time (up from 25.4%) and Asian mothers were unmarried 14.3% of the time. In contrast, 60.4 percent of Black/African-Americans moms were unmarried when they gave birth, 78.3 percent of American Indian/Pacific Islanders mothers and 54.8 percent of moms of "Other" races were unmarried when they gave birth in 2014. By ethnicity, in 2014 28.5 percent of Non-Hispanic mothers were unmarried when they gave birth while 49.2 percent of Hispanic mothers were unmarried at the time of their delivery.

Geographic Differences

This year there has been a concerted effort to look at health data, and factors contributing to health, at the census tract or neighborhood level. Census tracts are more uniform in size than Zip Code areas although neither type of area designation matches neighborhood designations.



Of the two, census tracts are closer to matching neighborhoods. The map above shows the dramatic differences in life expectancy in the county, especially the vast differences in life expectancy in Census tracts 5 (63.4 years) and 10.2 (67.3 years) versus Census tracts 37.13 (91.2 years) and 11.02 (94.7 years). While the wide variation in the computed life expectancies has drawn a great deal of attention, values aside, the differences in life expectancy across the City is shown by the shading and the actual values are less important. The Health Department and other City agencies produced a series of census tract maps for the Community Health Endowment's "Place Matters" project. Some of the maps and the differences they display (e.g., differences in life expectancy and poverty among census tracts) are discussed in the profile and many more maps are included in Appendix 3.

Environmental Health

Our Environment and Health

The environment impacts our health through the air we breathe, the water we drink, the food we consume, and other environmental exposures, such as toxic materials. In addition to the impacts on health from the natural environment, land use planning decisions can also impact our health by affecting how much pollution is emitted through transportation choices or how close residential housing, schools or older adult living facilities are allowed to locate near environmental hazards, such as railroads, industrial zoning, and hazardous materials pipelines. As the more detailed Environmental Health section in the profile discusses, Lincoln and Lancaster County environmental health indicators are generally good to very good:

- Air quality measures for fine particulate matter and ozone are both meeting the EPA standards, meaning that the air quality in the city and county are not at a level to cause harm to the population. Nevertheless, there are certain days each spring and around the Fourth of July that the air is polluted and the public is warned to stay indoors if they have a respiratory condition. While within standards, the ozone level has risen in the past few years and the EPA will be changing the standard (lowering the acceptable level of ozone) this year so it may be that we will exceed the new standard in future years.
- The quality of water in the Lancaster County is generally good to excellent. That's especially true for all public water systems serving 90 percent of the county's population as the systems usually meet all Safe Water Drinking Act (SWDA) standards for the level of contaminants in the water we drink. The quality of water from private wells is more of an issue.
    - The Lincoln Water System provides drinking water to all residents of Lincoln and has maintained compliance with all SDWA requirements for many years. However, there have been a number of SDWA violations in other community systems in Lancaster County, ranging from inadequate sampling to microbial contamination requiring boil orders. Nevertheless, despite some violations from time to time, there has not been a confirmed outbreak of illness associated with a community water supply in Lancaster County for over 20 years.
    - As for private wells, contamination with bacteria and nitrates are the primary concerns. Local inspections of private wells have found some wells with contamination from *E. coli* bacteria or nitrate levels above the EPA's Maximum Contaminant Levels (MCL) for public water supplies. Over the past decade, several local investigations of gastrointestinal illnesses in families have been associated with private wells that were found to be contaminated with *E. coli* bacteria. In addition, private wells are not fluoridated, which reduces the potentially beneficial effects such as the reduced number of cavities for children.
- There are many possible factors influencing the safety of the food we consume including food production practices, food storage, food preparation and handling. Key factors in the food system, including an increasingly diverse industry; the importation of 60 percent of our produce and 80 percent of our seafood; newly emerging pathogens; and an increasing reliance on food prepared by others for our meals; place every person at risk of foodborne illness. With all of the times for possible contamination of food we consume, it should not be a surprise that as many as 1 in 6 people will contract a foodborne illness in any given year. However, the risks of contracting a foodborne disease are greatly reduced

with the proper training and education of food handlers, when inspection of food by agencies at all stages of production occurs, and when processes and procedures used in restaurants follow the best practices and standards. The Health Department makes food inspection reports and relative ratings available on the City's and Department's web site at http://lincoln.ne.gov/city/health/environ/food-inspections/.

Comparison of Lincoln and Lancaster County Health Measures to Peer Cities/Counties

Until relatively recently community health assessments primarily involved only comparing local data with state and national data where possible. County-to-county comparisons of data related to health outcome have become increasingly available over the past decade. For overall health measures there's also local interest as the goal of local officials is that "Lincoln is the healthiest community in the country." In 2012 and 2014, Gallup-Healthways Well-Being Index has ranked Lincoln as the "healthiest" or "happiest" city in the country, but the rankings for any community vary over time so there have been other years when our local rating is lower, but often in the top quarter of the 188 metropolitan areas.

The process of selecting comparison communities, assigning the appropriate weight to each health statistic and combining measures into a composite score is not an easy task. The first of the efforts was undertaken by DHHS and is known as the Community Health Status Indicators (CHSI) report (http://wwwn.cdc.gov/communityhealth) and the latest version of the CHSI was released in March of this year (2015) with the initial version having been implemented in 2008. Another ranking effort, the ***County Health Rankings*** (CHR) effort by the University of Wisconsin (http://www.countyhealthrankings.org/) has been around since 2010 and it has become the ranking system many public health agencies look to when comparing counties by health outcomes and factors influencing those outcomes.

Comparing counties presents a number of challenges as counties vary significantly in population size and demographics as well as in health and environmental resources, health factors, and health outcomes. The table on the following page displays how Lancaster County's measures compare to measures for Nebraska and the best (top 10 percent) county rates in the nation.

In the full report, the CHSI tool and areas where our community's rates are better than our peers' rates (e.g., most chronic diseases, obesity) as well as areas where our rates are worse (e.g., chlamydia and binge drinking) are detailed. Priority health issues and how they were determined and other background information for the CHIP are also provided in the full report.

County Health Ranking Measure--2015	Lancaster County	Nebraska Overall	National Benchmark*
Premature Death	5,063	5,792	5,200
Poor/fair health	10%	12%	10%
Poor physical health days	2.8	2.9	2.5
Poor mental health days	2.9	2.7	2.3
Low birth weight	6.7%	7.0%	5.9%
Adult smoking	18%	18%	14%
Adult obesity	26%	29%	25%
Food environment index	7.9	7.8	8.9
Physical inactivity	19%	24%	20%
Excessive drinking	20%	20%	10%
Alcohol-impaired driving deaths	22%	35%	14%
Sexually Transmitted Infections (STIs)	431	364	138
Teen birth rate	24	32	20
Uninsured adults	12%	13%	11%
Primary care physicians	1,417:1	1,405:1	1,045:1
Dentists (population to dentist ratio)	1,100:1	1,450:1	1,377:1
Mental health providers	299:1	435:1	386:1
Preventable hospital stays	49	56	41
Diabetic screening	87%	86%	90%
Mammography screening	66.9%	61.8%	70.7%
High school graduation rate**	84%	88%	86%
Some college	76.2%	70.0	71.0
Unemployment rate	3.5%	3.9%	4.0%
Children in poverty	17%	17%	13%
Income inequality	4.4	4.2	3.7
Children in single-parent households	28%	28%	20%
Violent crime rate**	388	264	59
Daily fine particulate matter	9.7	12.1	9.5
Drinking water violations	0%	8%	0%
Severe housing problems	14%	13%	9%
Driving alone to work	81%	81%	71%
Long commute – driving alone	13%	17%	15%

Lancaster compared to others:

	Color	Comment:
Above or equal to NE/ Nat'l benchmark (top 10 %)		
Better than or equal to NE, but not in the top 10 %		Equal or better than NE
Worse than national benchmark		

*Top 10 percent level **Calculations vary nationwide

NE/national compared to Lancaster:

	Color
Better outcome/factor value than Lancaster County	
Equal to or tied value with Lancaster County	
Worse outcome/factor value than Lancaster County	

Other Assessments

While the community profile focuses a great deal on community level health data, as part of the MAPP process we also assessed the local public health system, community themes and strengths, and forces of change. A summary of these assessments is included in the full report and a brief summary is provided here:

- Community Themes and Strengths: We used surveys and focus group to inform us about how people perceive the quality of life in Lincoln and Lancaster County and also to rank health issues they perceive as important. In general, from the surveys we know that most people feel that medical services are good, that Lincoln is a healthy community, and that the community is a safe place to live, has good schools, and has great parks and recreation opportunities, and good housing. While most people feel that jobs in Lincoln are available, advancement is possible and employers are supportive there were some who disagreed. The most disagreement was about affordable child care, public transportation for the elderly and adequate housing and support for the elderly. Our senior focus group participants voiced the same issues while generally agreeing that health care services locally are good. However, they also talked about how their neighborhoods have changed for the worse in terms of services, even being unable to keep churches afloat as well as losing grocery stores.
- Community Public Health System Assessment: We surveyed our partners about their role in providing the ten essential services (ES) of public health and, as in previous surveys most partners educate and inform (ES#3), link people to health services (ES#7), develop policies and plans (ES#4), and develop partnerships (ES#5). When the national local public health performance standards assessment was conducted in 2011, the results showed that our local public health system was functioning at a high level.
- Forces of Change: From brainstorming strengths and weaknesses and discussing community resources as well as events that have had a significant impact on the community we learned a number of perceptions, including: the economy is getting stronger, but wages are not keeping people out of poverty and poverty has expanded beyond the core; development of the Haymarket, Innovation Campus and the joint LPS/SCC Career Academy were mentioned as positives. In addition, the community's foundations and CHE and those programs that prevent disease and promote health were highlighted. As for legislation, the lack of Medicaid expansion, and passage and implementation of the ACA via the Health Marketplace were mentioned. There are more specifics in the full report that follows.

Community Health Profile

Demographic Overview

Lancaster County covers an area of 839 square miles in southeastern Nebraska. The county's population density computes to 360 persons per square mile in 2014 versus 345 persons per square mile in 2013. The Census Bureau reported that Lancaster County's 2010 population was 285,407, an increase of 35,116 from 2000 when the population was 250,291. The 2009-2013 5-year American Community Survey (ACS) data estimated the 2013 Lancaster County population to be 289,873 (145,138 males, 144,735 females) and the 2014 ACS estimate for July 1, 2014, is 301,795.

The City of Lincoln, the county seat, is also the capital city of Nebraska. Lincoln is the second largest city in Nebraska, behind Omaha. Over the decade from 2000 to 2010, the City of Lincoln grew by 14.5 percent; from 225,581 to 258,379. The 2014 ACS estimate for Lincoln's July1, 2014, population was 272,996.

With four post-secondary educational institutions, the community has a lower than average home ownership rate than the state and nation (2014 ACS: Lincoln at 60.1%, NE at 67.0%, U.S. at 64.9%), but higher than average educational attainment than the state and nation (2010 Census: High School/BA - Lincoln 92.7%/35.1%, NE 90%/27.7%, USA 85%/27.9%).

The community boasts over 40 active neighborhood associations, and features a strong Mayor form of municipal governance with an active City Council. Starting in the 1980s, the community welcomed resettlement of refugees from across the world. In the 1980s, the immigrants were mostly from Vietnam, but in more recent decades there have been refugees and immigrants who have moved to Lincoln from Africa, Europe and Russia, the Middle East and the Far East. In addition there has been an influx of Hispanics (mostly from Mexico) over several decades. The community has initiated numerous social support services, and has embraced its newfound diversity, but some challenges remain in meeting the health needs of new Americans and minorities who are unaccustomed to our country's health care system.

Lancaster County's demographic changes since 2000 reflect the increased diversity as shown in the tables below. Over the decade from 2000 to 2010 the minority population increased by 16,481, or by 58.4 percent. In 2014, the minority population represents 17.2 percent of the total population, compared to 11.3 percent of the total 2000 population. Persons of Hispanic origin (who may be of any race) are the largest minority population in the county and their numbers nearly doubled (a 98.7 % increase) from 8,437 in 2000 to 16,685 in 2010. The growth has slowed since 2010, but there has been growth as the estimated size of the Hispanic population in 2014 was 19,918 according to the 2014 ACS.

The following table shows the 2014 distribution of the Lancaster County population when residents indicate one race (race alone, not a combination of races), with a category for two or more races. Persons of Hispanic origin are included in the other six categories so those six categories add to the estimated 2014 county population of 301,795. The last column in the first of the tables below denotes those people who classify themselves as Hispanic (an ethnicity), but

their number (19,918) cannot be added to the other racial categories as that would double count their numbers. The second table shows race categories that are Non-Hispanic (NH) plus a column for the Hispanic population, which add to the total of 301,795.

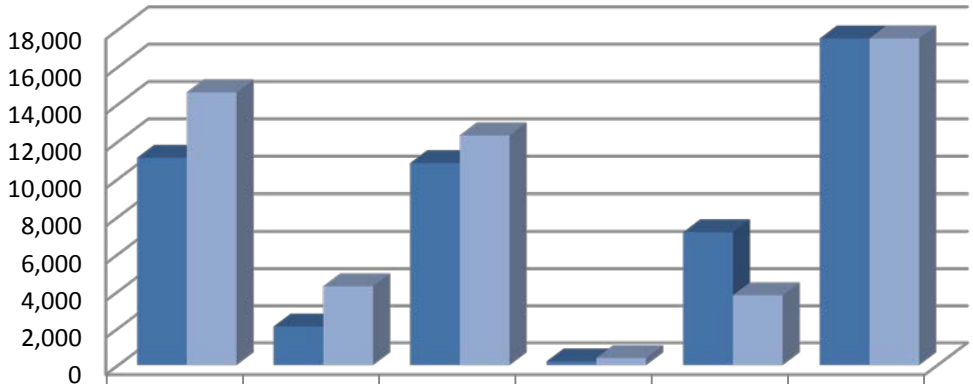
White Alone	Black Alone	American Indian/Alaska Native Alone	Asian Alone	Native Hawaiian/Other Pacific Islander Alone	Two or more Races	Hispanic or Latino (may be any race)
266,787	11,770	2,716	12,374	302	7,847	19,807

White Alone--NH	Black Alone--NH	American Indian/Alaska Native Alone--NH	Asian Alone/PI --NH	Two or more Race--NH	Hispanic or Latino
249,985	11,080	1,769	12,265	6,889	19,807

From a different perspective on the county's racial profile, the table below shows estimates of the racial breakdown for July 1, 2014, for Lancaster County (***Source: Annual Estimates of the Resident Population by Sex, Race Alone or in Combination, and Hispanic Origin for the United States, and Counties: April 1, 2010 to July 1, 2014***). The last column is for persons identifying themselves as Hispanics or Latinos/Latinas who may be of any race, and therefore their numbers are included in the Total Population column to the left. Since people can claim to be of more than one race (another measure of diversity), if you add the numbers in the first column the total would be more than the 301,795 estimated 2014 population. The numbers are shown in the following table for all races while the chart below shows the impact of mixed marriages on the characteristics for the non-White, minority population groups.

2014 ACS Estimate for July 1, 2014	Total Population	Total Non-Hispanic	Total Hispanic
White alone or in combination	274,160	256,497	17,663
Black or African American alone or in combination	16,116	14,983	1,133
American Indian/Alaska Native alone or in combination	5,071	3,452	1,619
Asian alone or in combination	14,327	13,946	431
Native Hawaiian/Pacific Islander alone or in combination	578	455	123

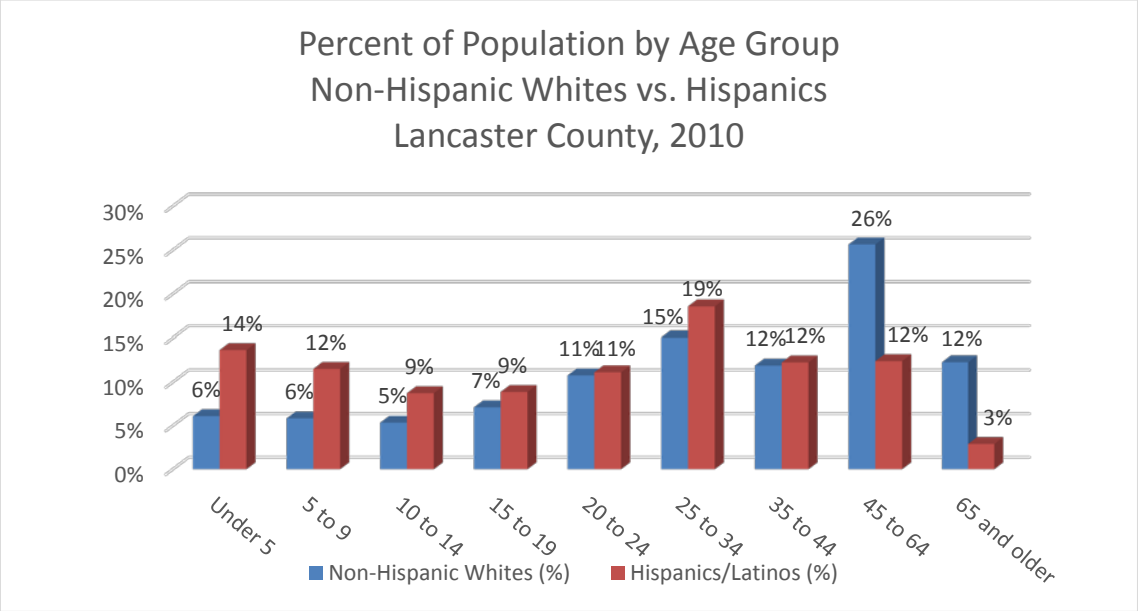
Racial Minorities and Person's of Hispanic Origin (Any Race)
One Race Alone or In Combination
Lancaster County, 2013 (2009-2013 5-Year ACS)



	African-American	AIAN	Asian	NHPI	Other	Hispanic
Alone	11,119	2,085	10,831	197	7,162	17,513
Alone or in combination	14,626	4,259	12,319	380	3,776	17,513

Alone Alone or in combination

Another difference in these two population groups is the age distribution. The 2014 age distribution is not available, but data from the 2010 Census illustrate that the Hispanic population was relatively younger than the White majority population with 34 percent of the total Hispanic population under 15 years of age while only 15 percent of the Hispanic population was 45 or older. By contrast, the White Non-Hispanic population was relatively much older with only 17 percent of the population under 15 years of age while 38 percent of this group was 45 or older.



The following table reflects the general population data by age and gender from the 2014 American Community Survey (ACS) and changes from the 2010 Census.

Population/Age Group	2000 Census	**2010 Census**	Population Change 2000 to 2010	**2014 ACS Estimates**	**Population Change 2010 to 2014**	**Percentage Change 2010 to 2014**
Total Population	250,291	**285,407**	35,116	**301,795**	**16,388**	**5.7%**
Male	125,029	**143,048**	17,981	**150,771**	**7,976**	**5.4%**
Female	125,262	**142,359**	17,097	**151,024**	**8,665**	**6.1%**
Under 5	16,680	**20,171**	3,491	**20,219**	**48**	**0.2%**
18 and Older	191,463	**219,506**	28,043	**232,191**	**12,685**	**5.8%**
Male	95,028	**109,396**	14,368	**115,580**	**6,814**	**6.2%**
Female	96,435	**110,110**	13,675	**116,611**	**6,501**	**5.9%**
62 and Older	30,548	**38,796**	18,248	**44,967**	**6,171**	**15.9%**
65 and Older	26,080	**31,101**	5,021	**36,561**	**5,460**	**17.6%**
Male	10,572	**13,358**	2,786	**16,107**	**2,749**	**20.6%**
Female	15,508	**17,743**	2,235	**20,454**	**2,711**	**15.3%**

There have been some differences and similarities when comparing the 2000 to 2010 growth rate (14%) and the 2010 to 2014 changes (5.7%). The increase in population over the decade 2000-2010 was 14 percent, and the various population sub-groups generally increased at a similar rate. The notable exceptions were the 20.9 percent growth in the population under 5, and the 27.0 percent growth in the population 62 and over. The increase in the under-five age group from 2000 to 2010 was due to the higher birth rates among minorities and the corresponding increase in the non-White population overall. From 2010 to 2014 there has been literally no growth (48 more children and a 0.2 percent growth rate) in the under 5 population, which is a real contrast to the 2000 to 2010 decade's change in the under 5 population numbers.

However, as can be seen, the growth in the elderly (65 and older) cohort that occurred from 2000 to 2010 (5,021) has actually picked up steam as the growth in numbers (5,460) over the last four years exceeds the decade growth in numbers. The growth in the elderly is due to the aging of the "Baby Boomers" or people born between 1948 and 1964. In 2014 the elderly population in Lancaster County represented 12.1 percent of the total population versus 10.9 percent of the population in 2010. By comparison, the elderly population in Nebraska was 14.4 percent of the total population in 2014, up from 13.5 percent of the state's total population in 2010. Nationally, the elderly were 13 percent of the total in 2010 and have increased in numbers to account for 14.5 percent of the population in 2014. While the local rate is below the state and national rates, by 2020 the elderly population is projected to represent 14.5 percent of the total population of Lancaster County.

Lincoln's Homeless Population

The 2015 Homeless Point in Time (PIT) survey revealed that 715 persons were identified as homeless on the night of the count in 550 households. An additional 127 persons were in permanent supportive housing and 58 persons in Rapid Rehousing. Persons in other permanent and permanent supportive housing and rapid rehousing programs are not counted as homeless in the HUD Point in Time Count.

Lincoln Point in Time Count – January 22nd 2015					Not counted homeless for the HUD Point in Time Count			
Emergency Shelter		**Transitional Housing**		**Unsheltered**	**Permanent Housing (PSH & OPH)**		**Rapid Rehousing RRH**	
Households	**Persons**	**Households**	**Persons**	**Persons**	**Households**	**Persons**	**Households**	**Persons**
214	259	283	399	55	113	127	38	58

The 2015 PIT count also indicated an increase in the number of unsheltered homeless on the night of the count by 8 persons. Persons in emergency shelter and transitional housing decreased on the evening of the 2015 PIT count.

The 2015 Homeless Point in Time count data is a single evening's data point that suggests the Lincoln Continuum of Care and member agencies are making significant progress in their work to end homelessness in our community. A single night's count of the homeless is not a definitive measurement of the degree to which homelessness exists in our community and the Lincoln Homeless Coalition and Continuum of Care provide the community with additional data and information on the homeless situation in our community throughout the year including the Annual Homeless Assessment Report which looks at homelessness over the course of year. However, the PIT count is a very good, single point in time assessment of homelessness in Lincoln. (Source: Jeffrey Chambers)

Socio-Economic Characteristics of Households and Families

While some 2010 Census data are used for this section and others below, data and estimates from the most recent American Community Survey (ACS) are also referenced when the comparable 2010 Census data are not available or when the ACS may provide more detailed estimates. Any use of annual and multi-year (e.g., 2009 to 2013) ACS data will be noted as there are some times when the most recent data are more revealing even if the data may be preliminary. Also, the Census Bureau has created an online source of health insurance and poverty information known as SAIPE (Small Area Income and Poverty Estimates) that provides single-year estimates from ACS survey information combined with administrative records, population estimates for a given year and Census data.

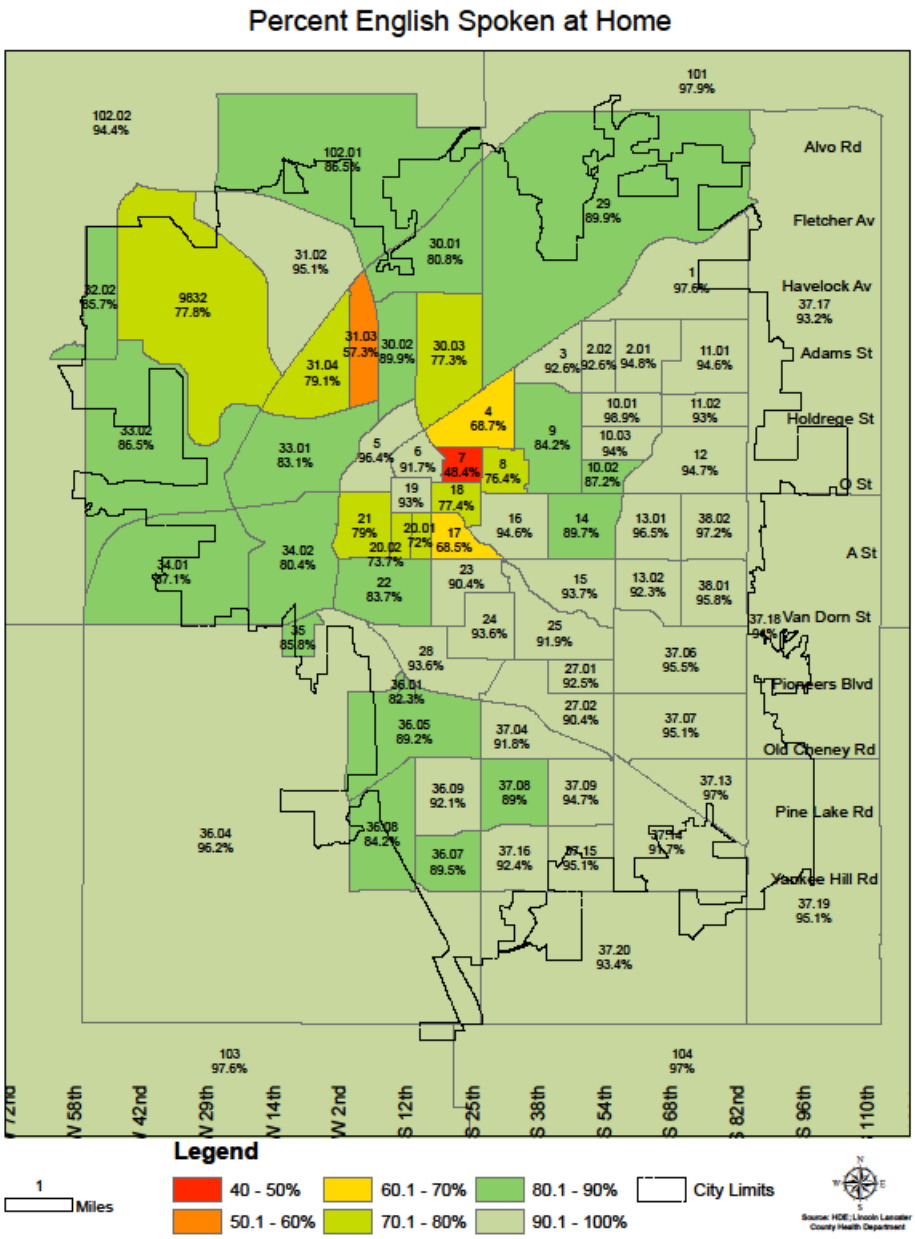
Households and Families: In the 2014 ACS there were an estimated 124,817 total housing units, up from the 120,875 households in the 2010 Census for Lancaster County. Married-couple families made up 59.7 percent of the households in Lancaster County in the 2006-2010 ACS. This figure includes both married-couple families (49 percent) and other families (13 percent). Nonfamily households made up 38.8 percent of all households in Lancaster County in the 2009-2013 ACS. Most of the nonfamily households were people living alone, but some were

composed of people living in households in which no one was related to the householder. The average household size was 2.4 people while the average family size was 2.9 persons.

Employment: Of the population 16 and older, 73.6 percent (2005-2009) and 72.4 percent (2009-2013) of the population were in the civilian labor force, with 70.0 percent (2005-2009) and 67.8 percent (2009-2013) employed. An average of 4.7 percent of the population was unemployed over the five-year period, 2009-2013. The most recent unemployment figure for Lancaster County (October 2015) was 2.2 percent (not seasonally adjusted), which was below Nebraska's unemployment rate of 2.6 percent and the national unemployment rate of 4.8 percent (both rates also not seasonally adjusted). See the Nebraska Department of Labor site, for the latest data--http://neworks.nebraska.gov/analyzer/default.asp.

Income: The median income of households from 2009 to 2013 in Lancaster County was $51,574. Eighty-four percent of the households received earnings and 13.9 percent received retirement income other than Social Security. Twenty-three percent of the households received Social Security. The average annual income from Social Security was $18,527.

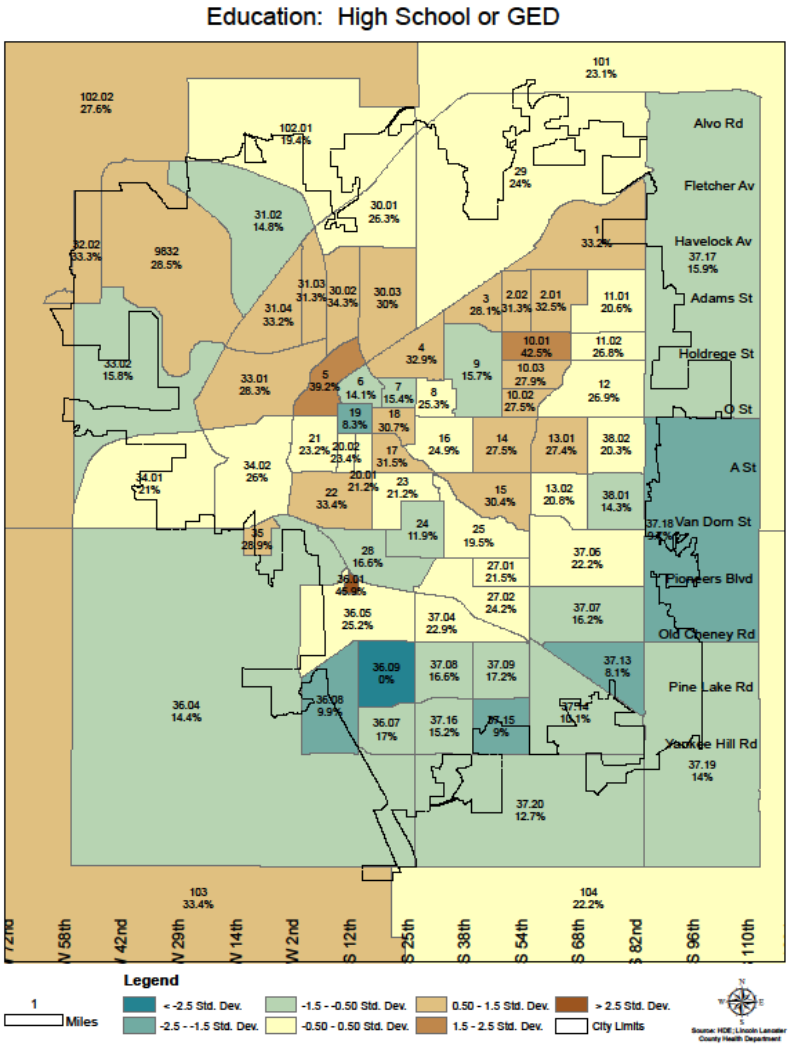
Nativity and Language: In the 2009-2013 ACS, 7.0% of the people in Lancaster County were foreign born, 92.1% of the population was native, including 67.0% who were born in Nebraska. From the 2011-2013 three-year ACS data we know that 11.1% of the population spoke a language other than English at home. Of the 11.1 percent, 37.1 percent spoke Spanish and 62.9 percent spoke some other language; 4.6 percent of all people reported speaking English less than "very well" and 41.5 percent of non-English speakers reported speaking English less than "very well." The map below shows the distribution of the population by language spoken at home.



Education: The 2011-2013 ACS estimated that 93.5 percent of people 25 years and older had at least graduated from high school and 36.7 percent had a bachelor's degree or higher. Seven percent were dropouts; that is, they were not enrolled in school and had not graduated from high school.

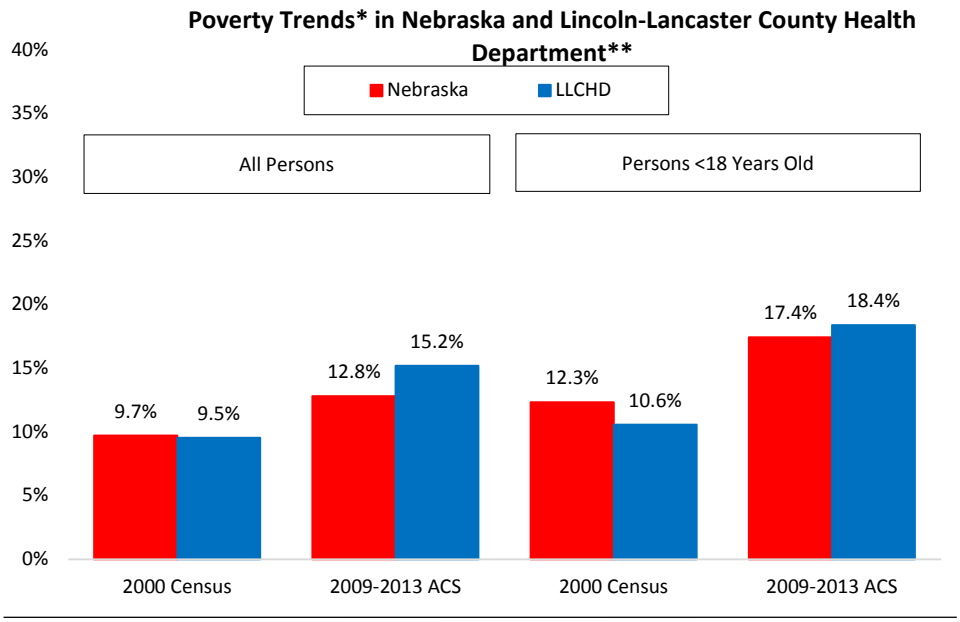
ACS estimates show that the total school enrollment in Lancaster County was 87,000 in 2005-2009 and 89,806 in 2011-2013. Nursery school and kindergarten enrollment was 7,900 (2005-2009) and 8,436 (2011-2013) and elementary or high school enrollment was 39,000 children in 2005-2009 and 42,788 in 2011-2013. College or graduate school enrollment was 40,000 in 2005-2009 and 38,582 in 2011-2013. The following map shows the percent of population by census tract of those who have only a high school diploma or GED. Areas in blue show areas where a

higher percentage of the population has either a bachelor's degree or advanced degree as their highest level of education.

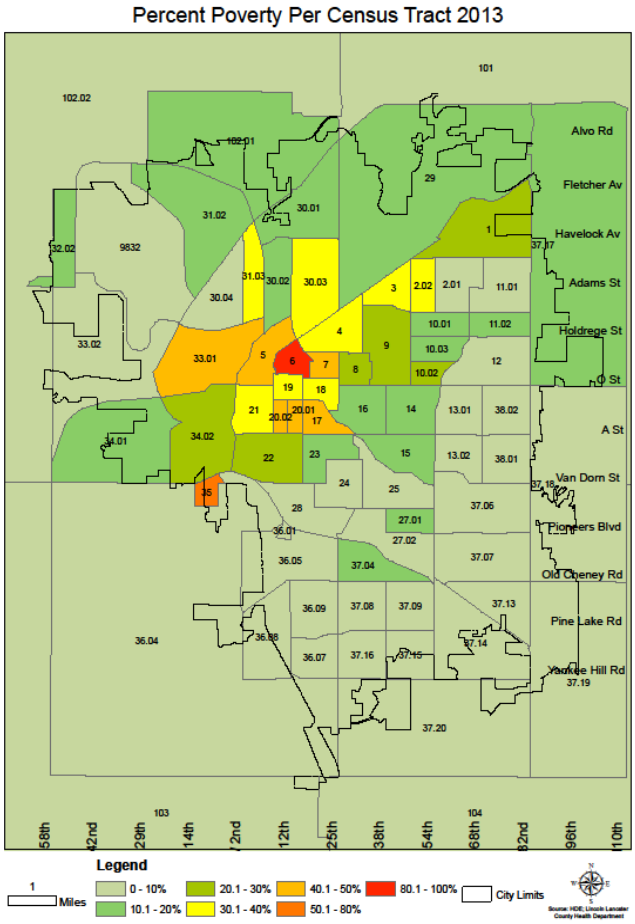


Poverty:

The 2009-2013 ACS estimated that 15.2 percent of people had poverty-level incomes and 9.4 percent of families were living with incomes that fell below the poverty threshold. By age, 18.4 percent of children under 18 were in families with incomes below the poverty level, compared with 5.3 percent of people 65 years old and over. Only 3.8 percent of married couple families had an income below the poverty level, but 33.2 percent of families with a female householder and no husband present had an income below the poverty level. ***Among families with a female householder and no husband present: 40.9 percent of families with children younger than 18 years of age are in poverty, and 57.0 percent of female-headed household families with children younger than 5 years of age are in poverty.*** As is discussed elsewhere in the report and as shown in the map below, the level of poverty and its expansion throughout the community has a significant impact on neighborhoods and the health of residents.



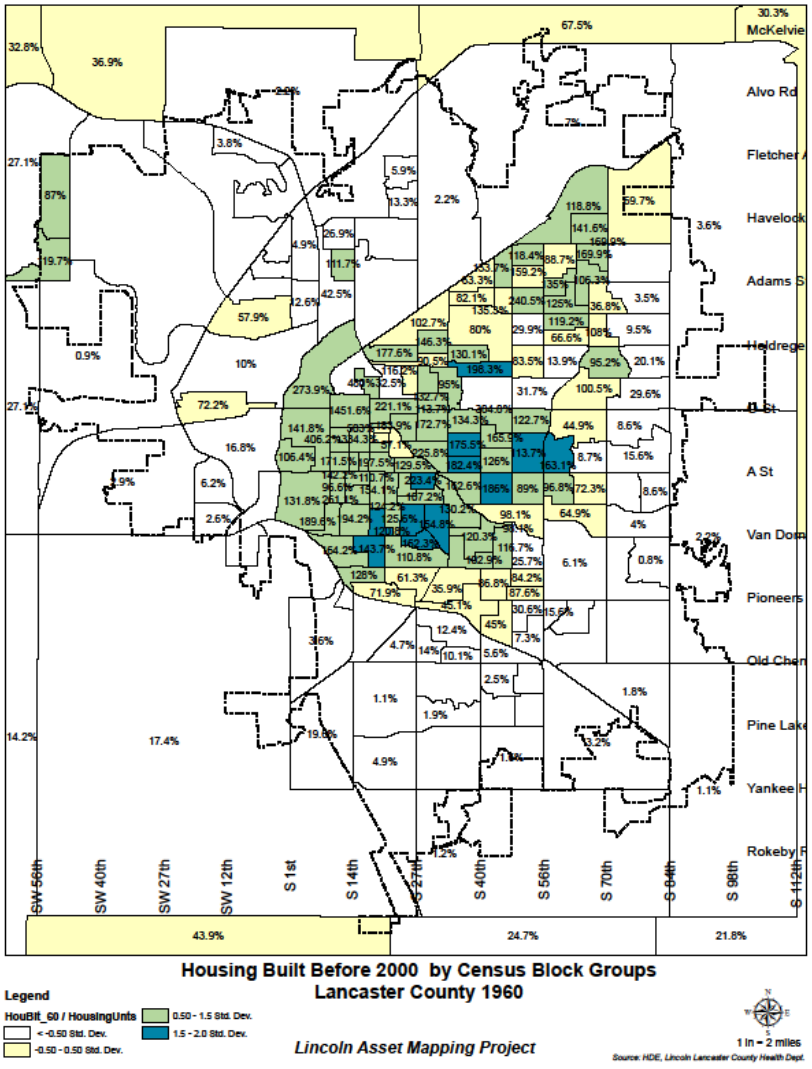
*Percentage below 100% of the federal poverty level
**Lincoln-Lancaster County Health Department encompases Lancaster County

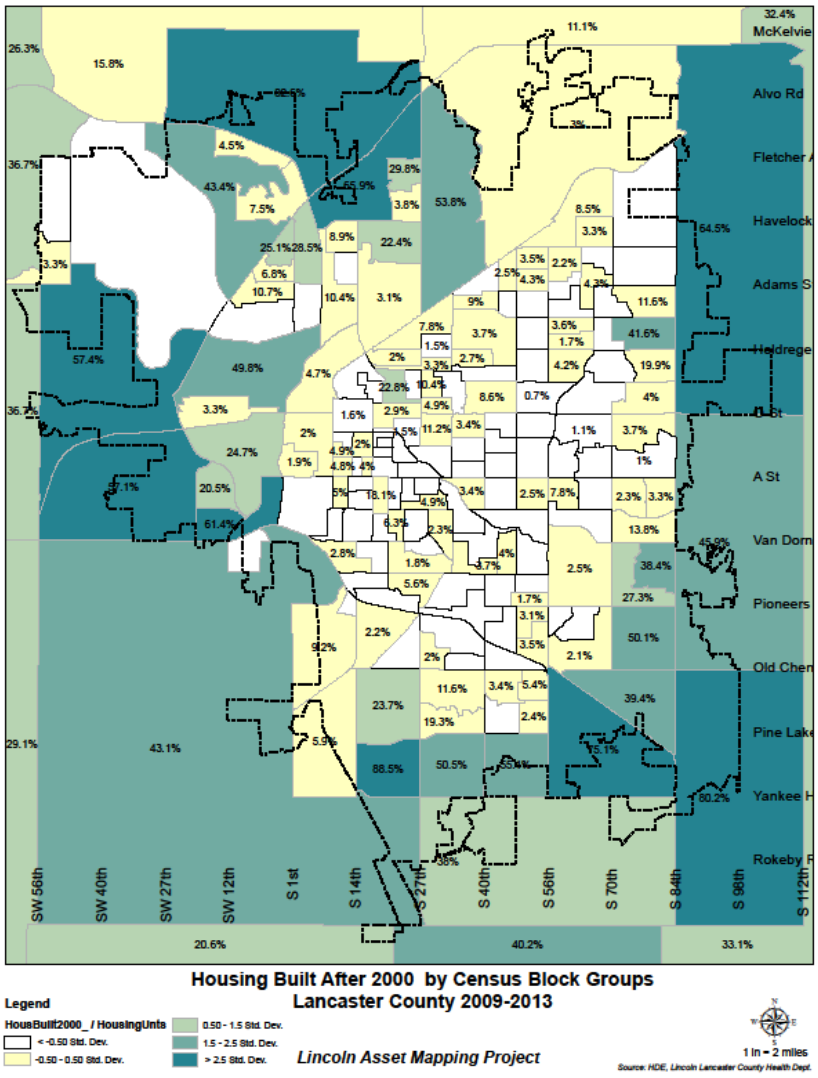


Poverty rates have expanded in each decade since 1980, and in 2013 five census tracts (excluding the tracts with the university and the penitentiary) had poverty rates of 40 percent or more. Maps showing rates and distribution by census tract from 1980 to 2013 are shown in Appendix 3 to detail the spread of poverty throughout the community.

Housing Costs:

The 2009-2013 ACS estimated the median monthly housing costs for mortgaged owners was $1,336, for non-mortgaged owners it was $482; and for renters it was $715. Twenty-three percent of owners with mortgages, ten percent of owners without mortgages, and forty-eight percent of renters in Lancaster County spent 30 percent of more of their household income on housing. The following maps show the areas with the oldest housing (those built prior to 1960) and some of the newest developments (those houses built since 2000). The areas of the City with the oldest housing stock are loosely correlated with the poverty data in the map above, and the maps of poverty from 1980 to 2013 in Appendix 3 are also concentrated in the older sections of Lincoln.





In 2012 and 2013, a BRFSS question was asked about whether individuals had experienced housing insecurity (defined as worried or stressed about having enough money to pay the rent/mortgage) in the past year and 26.8 percent of adults replied "yes" in 2012. The 2013 "yes" response was 25.3 percent of individuals who had experienced housing insecurity.

Health Status Indicators for Lancaster County Adults

There are a number of health status indicators, including both measures of morbidity and mortality. Unfortunately, morbidity measures (incidence or prevalence rates of disease or medical conditions) are less available at the population level. For instance, Vital Statistics birth and death certificate data provide very good information about births and deaths (mortality), but only a limited set of information (e.g., health conditions contributing to the cause of death) about health status (morbidity) between birth and death. So, while Vital Statistics data are a reliable database for maternal and child health data and mortality, they are not as useful for other health status measures. Beyond Vital Statistics, there are many local health indicators or measures available from disease registries, hospital discharge data, and several health behavior surveys.

For most data sources there are several years, or even decades, of data that we can use to analyze any trends present in the data. However, data interpretation is not always easy for the available data sources due to the reliability of the data source or the characteristics (e.g., number of years of data, volatility or trends) of the available measures. For health indicators that are somewhat stable or less volatile (data whose year-to-year changes are minor), data or measures (whether counts, averages or rates) from the latest year, or even from several years ago, can provide us with a pretty good feel for the community's current overall status for that measure. This is not true for other indicators that are based on small numbers of occurrences or are rates based on small samples or number of events (cells); or for those measures that fluctuate due to random variation. For these data series, even the most recent data, and certainly data from prior years, may be of limited value in assessing/estimating the current, true or stable health status. As will be shown in this report, there are several such measures that move up or down with no apparent pattern from year to year—falling in some years, rising in other years with no discernible short-term trend. With relatively smaller populations, data about minorities are often not available or so volatile from year to year that it is often necessary to provide caveats about race and ethnicity data or to combine multiple years of results in order to have enough data to provide a reliable rate or measure. Another group that needs mention is the population with a disability. The estimate is that 17,747 people under the age of 65 have a disability of some kind. While we know the size of the population with a disability, we do not know many of their other characteristics except for children with disabilities, as many individuals in this group function quite well. This is an area for further fact gathering, especially when we can get access to Medicaid data.

Morbidity Information

The sources of information about illnesses, diseases and health conditions include survey results, especially those from the Behavioral Risk Factor Surveillance System (BRFSS), disease registries, hospital discharge data, and reportable disease information from physicians and laboratories. Unfortunately, each source has limitations (e.g., self-reported information, incidence rather than prevalence information). Also, local data are not always available for ambulatory conditions treated in physicians' offices and urgent care centers although those data may be easier to get in the future from insurers and through electronic data interchange systems. Currently only one of Lincoln's community hospitals (CHI St. Elizabeth joined in September and the other CHI hospitals, including the CHI Nebraska Heart are likely to all be joining) is aligned with NEHII (Nebraska Health Information Exchange) or another data clearinghouse for health data.

The following table lists the leading causes for inpatient hospitalizations at the Lincoln hospitals in 2013. The top cause of hospitalization was due to child birth, which is almost always the leading reason for hospital admissions in community hospitals. The second and third causes, circulatory system diseases (such as heart disease) and mental disorders, are also regular causes at the top of most lists of hospitalization across the state although the same order is not true for each of the local hospitals as each specializes to a degree. Of note, Bryan Health admits more patients with mental health diagnoses than does CHI St. Elizabeth.

Leading Causes of Inpatient Hospitalization*,
Lincoln-Lancaster County Health Department, 2013**

Cause	#	%
Pregnancy & Childbirth	3,926	14.4%
Circulatory System Diseases	3,181	11.6%
Mental Disorders	2,531	9.3%
Digestive System Diseases	2,124	7.8%
Respiratory System Diseases	2,045	7.5%
Musculoskeletal System Diseases	1,490	5.5%
Genitourinary System Diseases	973	3.6%
Neoplasms (Cancers)	890	3.3%
Infections & Parasitic Diseases	709	2.6%
Endocrine, Nutritional, Metabolic, Immunologic Disorders	687	2.5%
Injury & Poisoning	513	1.9%
Skin & Subcutaneous Tissue Diseases	457	1.7%
Nervous System & Sense Organ Diseases	379	1.4%
Anemia & Diseases of the Blood and Blood-Forming Organs	272	1.0%
Congenital Anomalies	76	0.3%
All Others	7,062	25.9%
Total	27,315	100.0%

*Based on the general ICD-9-CM categories
**Lincoln-Lancaster County Health Department encompasses Lancaster County
Source: Nebraska Hospital Discharge Data, NDHHS

Self-Reported Health Status

An individual's health status can usually be determined by how that individual rates his/her own health. The BRFSS survey annually asks the question: "Would you say in general your health is Excellent, Very Good, Good, Fair or Poor?" The respondents who answer "excellent," "very good" or "good" generally have their responses added together; and replies of "fair" or "poor" are also combined.

In 2014, 9.0 percent, and in 2013, 11.4 percent of Lancaster County adults indicated that their health was only either fair or poor, comparing favorably to the 13.2 percent (2014) and 13.9 percent (2013) of Nebraska adults and 16.8 or 16.7 percent of adults nationwide who indicated that was their health status in 2014 and 2013 respectively. Minority populations often indicate higher rates of poor health and that is discussed in the section on disparities. See state and national BRFSS data at http://www.cdc.gov/brfss/brfssprevalence/index.html.

Diagnosed Health Conditions

In addition to self-reported health status information, the BRFSS survey asks adult respondents about whether or not they have been diagnosed with or have experienced certain health conditions. The following tables reflect the latest available data, either from 2014 or 2013. With the changes in the 2011 BRFSS sampling (including cell phone numbers in addition to landlines) the combined effects of these methodological changes from 2011 onward results in BRFSS measures that more accurately reflect the true prevalence of risk behaviors and conditions among adults in Lancaster County, the state, and nation. With the 2012, 2013, and 2014 BRFSS data added to the 2011 BRFSS, we can now look for any trends that might be present in the behaviors and health status results from the survey, and those trends and data are shown at other points in this profile. Items in **bold** in the table below indicate statistically significant difference from state results.

2014 BRFSS Results

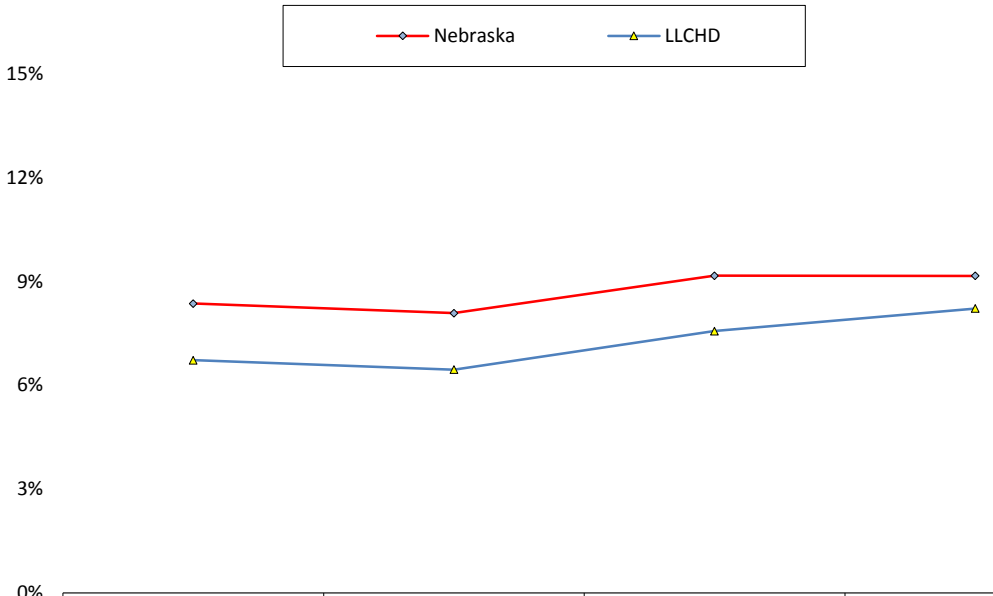
Disease/Condition	2014 LLCHD BRFSS (%)	2014 Nebraska BRFSS (%)	2014 National BRFSS (%)	Estimated Population Affected--Lancaster County
Asthma (Current)	9.7	7.7	8.9	22,512
Asthma (Lifetime)	15.0	12.2	13.8	34,812
Arthritis	**21.1**	24.6	26.0	48,969
Angina or Coronary Heart Disease	2.8	3.9	4.2	6,498
Heart Attack	**2.6**	3.8	4.4	6,034
Stroke	2.0	2.6	3.0	4,642
Diabetes	8.2	9.2	10.0	19,031
High Cholesterol (2013)	35.2	37.4	38.4	81,692
High Blood Pressure (2013)	25.7	30.3	31.4	59,645
Depression	19.5	17.7	19.0	45,256
COPD	6.0	5.8	6.5	13,925
Kidney Disease	1.4	2.1	2.7	3,249
Limited in activities due to physical, mental problems 14+ days	5.7	5.8	NA	13,229
Adults needing special equipment (2013)	6.7	6.8	8.1	15,549
Elderly with all teeth extracted	**8.5**	14.1	16.1	3,104
Had a fall last year, 45+	25.2	26.1	NA	26,694
Injured from a fall last year, 45+	8.5	8.8	NA	9,004

- Asthma: The BRFSS survey asks if respondents have been diagnosed as currently having asthma and they also ask if individuals have ever been told they have asthma. The local rate of persons currently diagnosed with asthma was generally above the comparable

Nebraska rate, but below the national rate. In 2014, residents indicated they had been diagnosed with asthma in their lifetime (15.0%) and currently have asthma (9.7%) at levels above both the state (12.2%, 7.7%) and the nation (13.8%, 8.9%).

- Arthritis: Arthritis is the leading cause of disability in the U.S. In 2014, 21.1 percent of local respondents indicated they have arthritis, which translates to 48,969 adults suffering from the condition. While about one out of every five Lancaster County adults reported being diagnosed with arthritis, the local rate is still below both Nebraska (24.6%) and national (26.0%) rates.
- Angina or coronary heart disease: In 2014, 2.8 percent of adults reported they had angina or coronary artery disease, representing 6,498 people.
- Heart Attack (myocardial infarction): The 2014 BRFSS results indicated 2.6 percent of adults (an estimated 6,034 adults) had a diagnosed heart attack, a statistically significantly lower rate when compared to 3.8% of Nebraska and 4.4% American adults.
- Stroke (cerebrovascular disease): Stroke is the fourth leading cause of death in the county, Nebraska and the nation. Stroke victims often have at least some temporary disability and stroke is one of the major causes of long-term disability. In 2014, the local percentage of adults diagnosed with a stroke was 2.0 percent, which is below the state (2.6%) and national (3.0%) rates.
- Diabetes: Diabetes rates do not include women who have gestational diabetes or those who have been told that they have pre-diabetes or borderline diabetes. In 2014, the BRFSS results for Lancaster County indicated that 8.2 percent of adults had been diagnosed with diabetes, which is lower than the state (9.2%) and national (10.0%) rates. The trend is disturbing as the rates for diabetes are rising everywhere—locally, the 8.2 percent rate in 2014 is up from 6.7% in 2011 and 6.5% in 2012, and the Nebraska rates are higher than the county rates.

Ever told they have Diabetes (excluding pregnancy)*, Adults 18+, Nebraska and Lincoln-Lancaster County Health Department 2011-2014**



	2011	2012	2013	2014
Nebraska	8.4%	8.1%	9.2%	9.2%
LLCHD	6.7%	6.5%	7.6%	8.2%

*Percentage of adults 18 and older who report that they have ever been told by a doctor that they have diabetes (excluding pregnancy)
**Lincoln-Lancaster County Health Department encompases Lancaster County
Source: Behavioral Risk Factor Surveillance System (BRFSS)

- Cholesterol Awareness: In 2013 (the latest available data), the BRFSS survey showed that 35.2 percent of local respondents indicated they have been diagnosed with high cholesterol, a rate that is lower than the overall state and national rates (37.4% and 38.4%, respectively). The majority of those diagnosed with high cholesterol have probably been told to exercise and most have been probably been prescribed a cholesterol-lowering drug (one of the statins) to help prevent cardiovascular disease.
- Blood Pressure Awareness: In 2013 (latest available data), 25.7 percent of Lancaster County residents said they had been diagnosed with high blood pressure, which amounts to over 59,645 residents. Comparable figures for the state and nation were higher as the Nebraska and national percentages were 30.3 percent and 31.4 percent, respectively. Many people are taking anti-hypertensives drugs to keep their blood pressure under control.
- Depression: In 2014, 19.5 percent, or 45,246 people, indicated that they have been told that they had depression in their lifetime. The local rate is not much different than the national rate (19.0%), but above the state rate (17.7%).
- Chronic Obstructive Pulmonary Disease (COPD): In 2014, 6.0 percent of county residents indicate that they have been told at one time or other in their life that they have COPD. COPD is one of the chronic lung diseases that count as the third leading cause of death locally and nationally and smoking is a key factor in the development and

progression of COPD. The local rate is similar to the Nebraska (5.8%) and national (6.5%) rates.

- Kidney Disease: In 2014, 1.4 percent of county adults, representing an estimated 3,249 people, indicated that they had been told they had been diagnosed with kidney disease at some time in their life. The local rate is below the state (2.1%) and national (2.7%) rates
- Limited in Activities: In 2014, 5.7 percent of county adults, or an estimated 13,229 people indicated that they had physical and mental health problems limiting their daily activities for 14 or more days in the past month. The local rate is similar to the state (5.8%) rate.
- Persons needing special equipment: In 2013 (latest available data), an estimated 15,549 adults (6.7% of adults) indicated they had health problems requiring special equipment. The county rate was comparable to the Nebraska rate (6.8%) and below the national rate (8.1%).
- Elderly with all of their teeth extracted: In 2014, the percent of persons 65 and older who have had all of their teeth extracted (8.5%) was statistically significantly lower than Nebraska (14.1%) and national (16.1%) rates, which reflects well on the dental care community as well as the population' access to dental care. The local number of elderly who have lost their teeth was an estimated 3,249 adults based on the responses.
- Persons 45 or older who had a fall in the past year: In 2014, 25.2 percent of Lancaster County residents age 45 or older indicated that they had fallen in the past year. That means that 26,694 people may have fallen at some point during the previous year. The local rate is similar to the Nebraska rate (26.1%).
- Persons 45 or older who were injured from a fall in the past year: In 2014, 8.5 percent of Lancaster County residents age 45 or older indicated that they had been injured from a fall in the past year. That means that 9,004 people sustained an injury from a fall during the previous year. The rate is similar to the Nebraska rate (8.8%). Injury prevention, including injuries from falls, was scored as a high priority concern and is one of the CHIP priority areas.

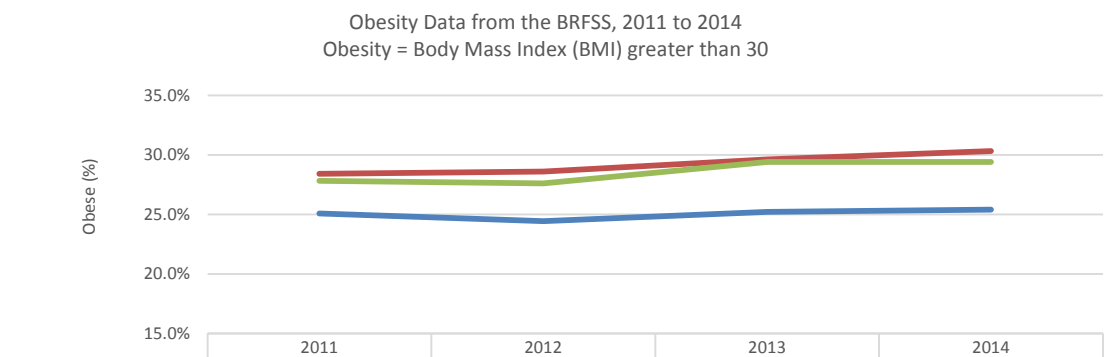
The available evidence suggests that lifestyle factors (e.g., smoking, physical inactivity, alcohol use, diet, BMI) influence the incidence of many of the chronic health conditions (e.g., diabetes, heart disease, cancer) discussed in the health status section. Positive factors such as regular screening (i.e., mammograms, colonoscopies, Pap tests) for cancers (i.e., breast, colorectal and cervical cancers) that can be found and prevented at an early stage are another factor as is access to necessary primary care. Of course, access to care is influenced by having an adequate level of providers and health insurance.

Behavioral Risk Factors (Adults)

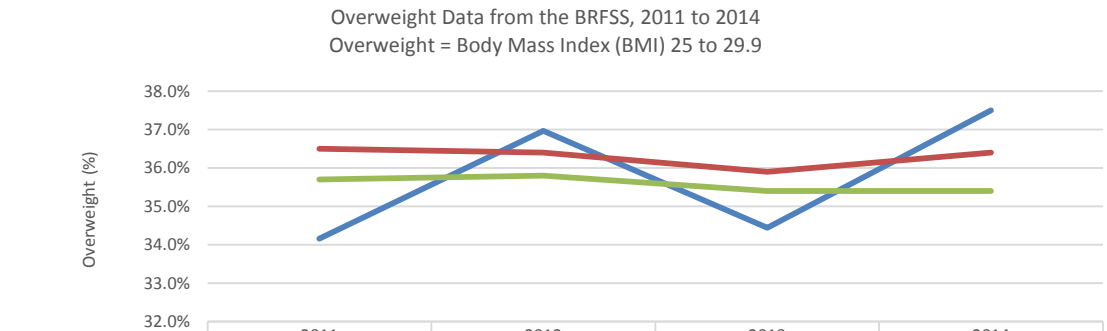
The information below is drawn from the Behavioral Risk Factor Surveillance System (BRFSS), which is a survey of adults, 18 and older. Data from the 2014 BRFSS survey for Lancaster County and Nebraska are available for this report, but national BRFSS data are only preliminary or only posted through 2013. ***While we present data by race and ethnicity here, it must be kept in mind that the data by race/ethnicity has wide confidence intervals for all but the Non-Hispanic Whites due to the small number of respondents that are minorities.*** In the section on

disparities, there's a detailed comparison of 2011 to 2014 combined data to account for the smaller number of minority respondents in any year.

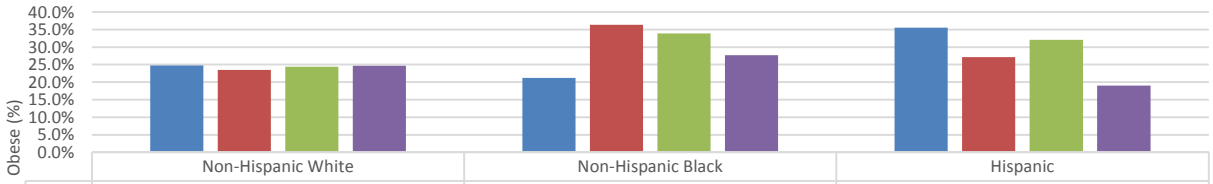
- ***Overweight & Obesity:*** The BRFSS relies on self-reported heights and weights rather than actual measurement. Lancaster County BRFSS data for 2014 showed the local rates for overweight (37.5 percent) and obesity (25.4 percent) when measured by Body Mass Index (BMI) are better than the Nebraska rates for obesity (36.4 percent overweight, 30.3 obese). However, more county residents fall into the overweight category than do state adults—37.5% vs. 36.4%. The same dichotomy exists when local rates are compared to the national rates (35.4 percent overweight, 29.4 percent obese). As shown in the graph below and has been the case since 2011, in 2014 the local rate of obesity (25.4%) was better on a statistically significant basis (95% chance that the difference is true rather than random) than Nebraska's obesity rate (30.3%). As can be seen in the second graph, the Lancaster data in this category (overweight) are somewhat volatile from year to year so even for the entire survey's sample population the data from a single year can be misleading so there is a need to combine several years of data or to utilize techniques such as a moving average to smooth the results. In several sections, and especially when we look at data by race and ethnicity, we show the data for the four years, 2011 to 2014. By race and ethnicity, local rates show that Non-Hispanic Blacks (68.4%) are overweight or obese (BMI 25 or over) more than Non-Hispanic whites (65.4%) and similar to the rate for persons of Hispanic origin (68.3%). Obesity (BMI 30 or over) data show that Non-Hispanic Blacks (34.6%) have significantly higher rates of obesity than Non-Hispanic Whites (25.4%) and are also more likely to be obese than Hispanics (30.7%). [Remember the survey data by race is based on a small number of respondents.]



	2011	2012	2013	2014
Lancaster County	25.1%	24.4%	25.2%	25.4%
Nebraska	28.4%	28.6%	29.6%	30.3%
U.S.	27.8%	27.6%	29.4%	29.4%

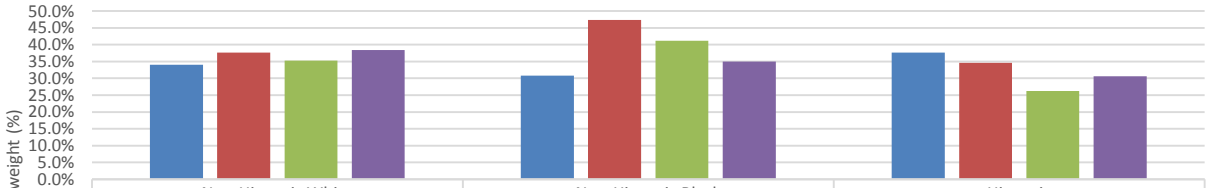


	2011	2012	2013	2014
Lancaster County	34.2%	37.0%	34.4%	37.5%
Nebraska	36.5%	36.4%	35.9%	36.4%
U.S.	35.7%	35.8%	35.4%	35.4%



	Non-Hispanic White	Non-Hispanic Black	Hispanic
2011	24.8%	21.2%	35.5%
2012	23.5%	36.4%	27.1%
2013	24.4%	33.9%	32.1%
2014	24.7%	27.7%	19.0%

2011 2012 2013 2014



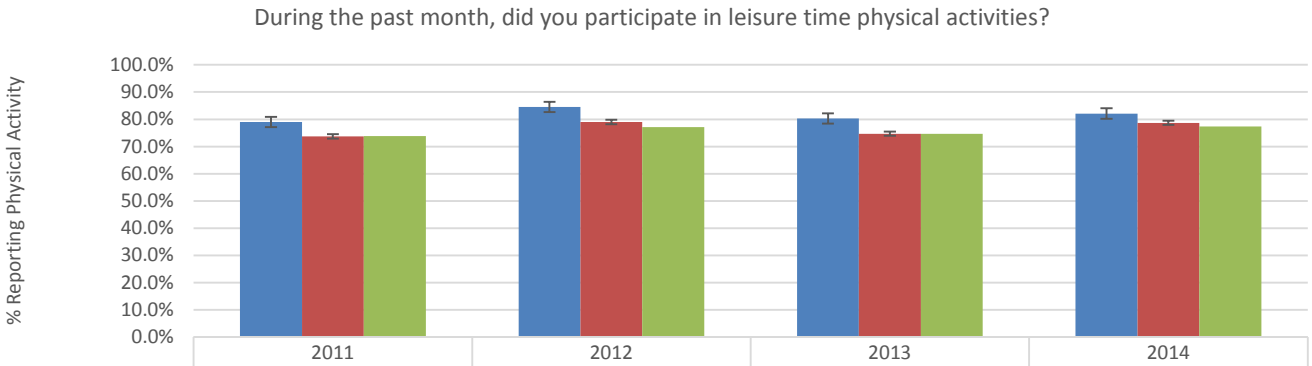
	Non-Hispanic White	Non-Hispanic Black	Hispanic
2011	34.0%	30.8%	37.6%
2012	37.6%	47.3%	34.6%
2013	35.3%	41.2%	26.2%
2014	38.4%	35.0%	30.6%

2011 2012 2013 2014

- ***Fruit & Vegetable Consumption:*** Overall, in 2013 (the latest year the question was asked on the survey) adults consumed fruit 1 or more times per day slightly more often (61.7%) than state respondents (60.3%) or those in the nation (60.8%); and consumed vegetables 1 or more times per day slightly more often (77.6%) than respondents in the state (76.7%) and the nation (77.1%). Non-Hispanic Black adults consumed vegetables 1 or more times per day (45.2%) and fruits 1 or more times per day (31.2%) at rates well below these

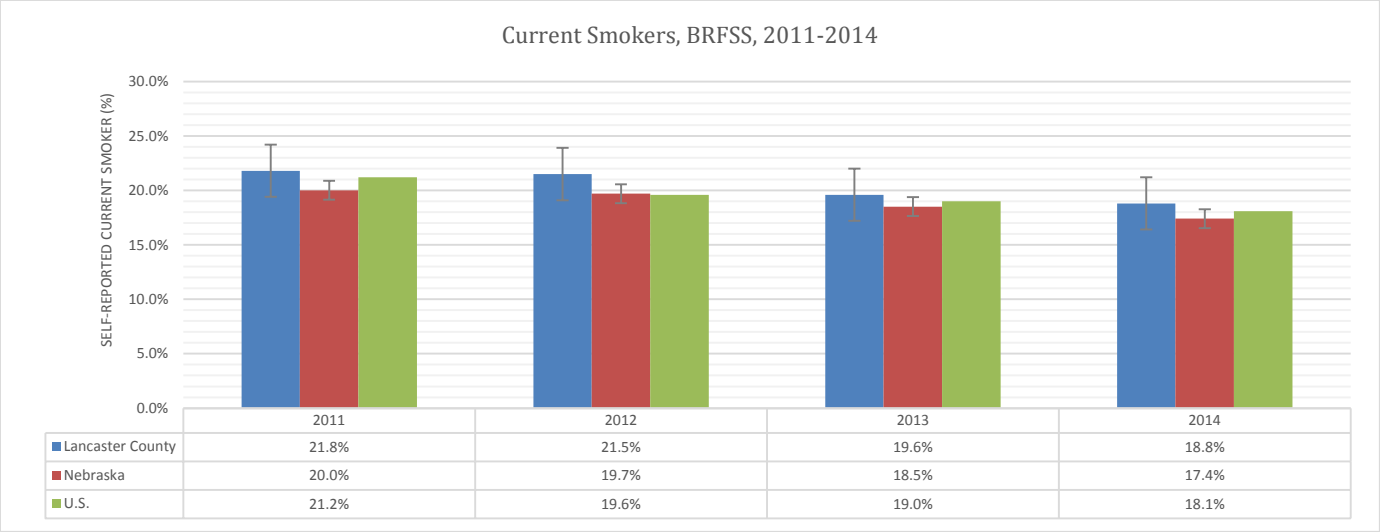
overall rates. Of note, in 2012, 20.4 percent; and, in 2013, 19.6 percent of adults said they had experienced food insecurity (worried that they could not afford nutritious meals) in the past year.

- ***Physical Activity:*** Overall, in 2014 Lancaster County adults participated in leisure time physical activity (82.1%) more often on a statistically significant basis than those in the state (78.7%), and at a rate above that for the nation (77.4%). However, based on a small sample, Hispanics (67.1%) participated in leisure time physical activities at rates well below those of Non-Hispanic Whites (82.1%).

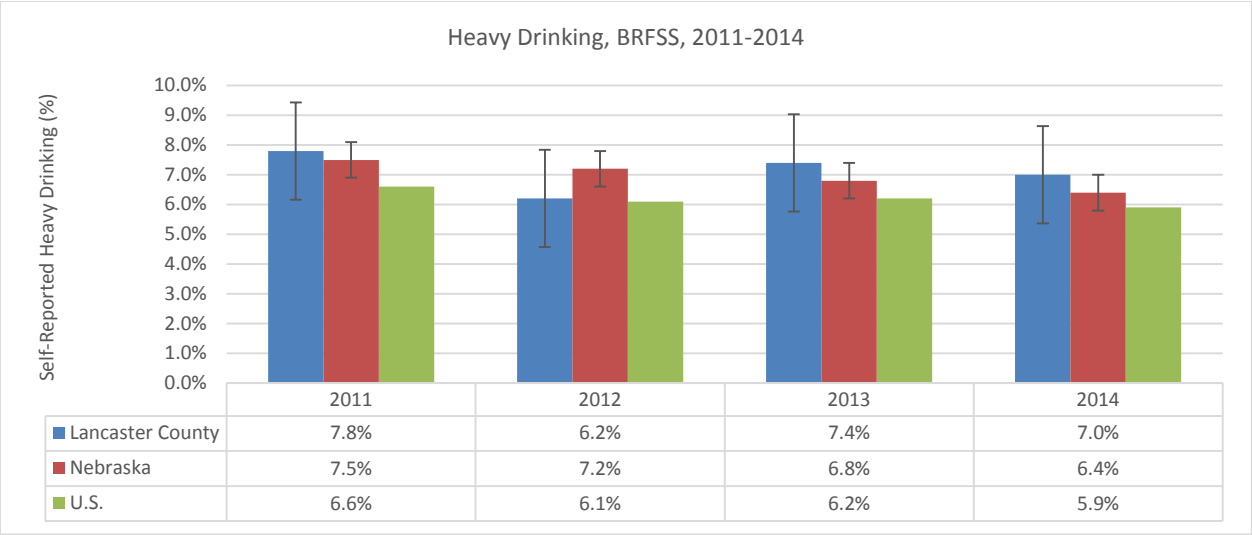


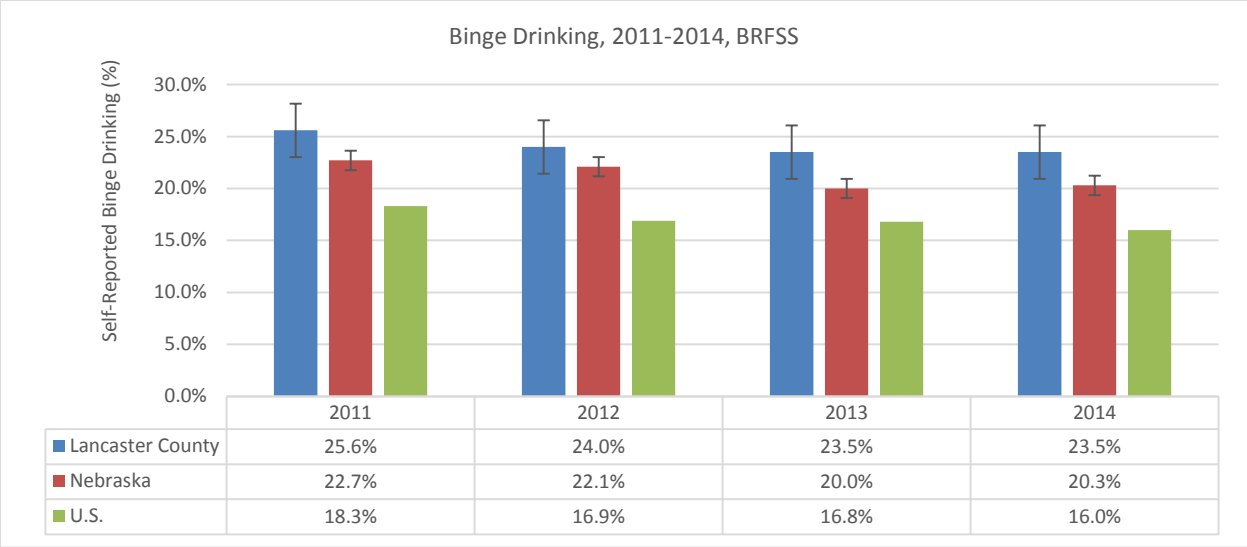
	2011	2012	2013	2014
Lancaster County	79.0%	84.5%	80.3%	82.1%
Nebraska	73.7%	79.0%	74.7%	78.7%
U.S.	73.8%	77.1%	74.7%	77.4%

- ***Smoking:*** In 2014, BRFSS results indicate Lancaster County adult's current smoking rate (18.8%) decreased from the rates in 2011 (21.8 percent), 2012 (21.3 percent) and 2013 (19.2 percent), but the local smoking rate was still greater than the state (17.4%) and national (18.1%) prevalence rates of current smoking. Smoking rates by race and ethnicity reveal that Non-Hispanic Black adults (40.7% in 2013, 31.7% in 2014) are much more likely to be current smokers than Non-Hispanic White adults (18.4% in 2013, 17.9% in 2014) and Hispanic adults (16.7% in 2013, 12.9% in 2014). [The 2014 BRFSS data for Lancaster County indicates that the percent of current smokers fell to 18.8 percent, however that is not a statistically significant difference from the 2013 result (19.2%).]

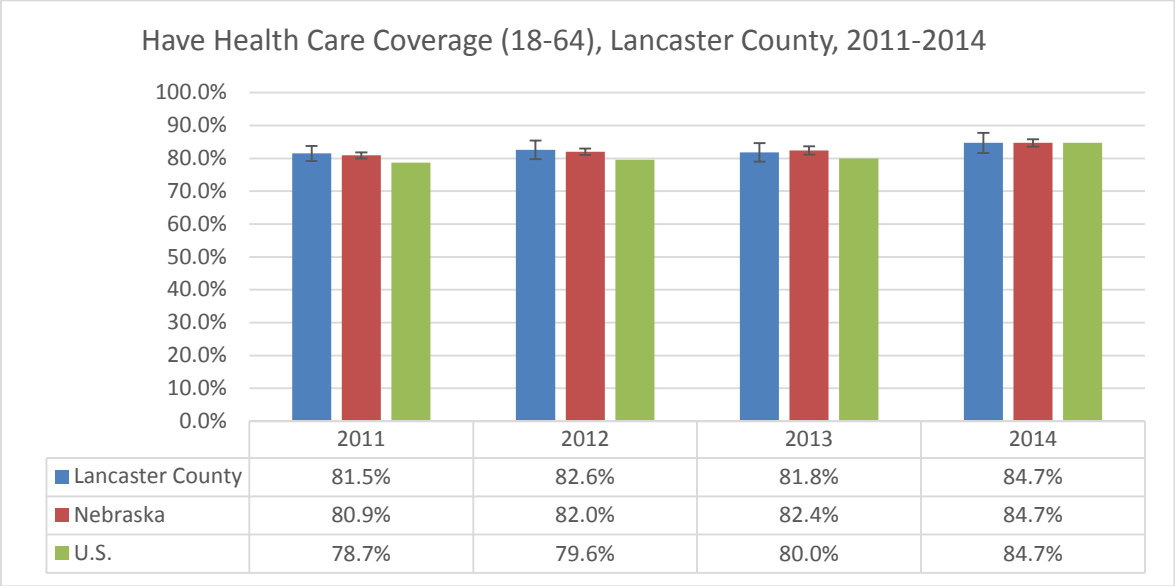


- ***Alcohol:*** The changes in the BRFSS binge drinking rates in 2014 locally and statewide (23.5%, local; 20.3%, state) were not significantly different than those in 2013. In 2013, the local binge drinking rate (23.5%) had decreased slightly from the 2012 rate (24.0 percent), and there was a marked reduction from the 25.6 percent rate in 2011. However, the local 2014 rate remains higher than the state rate (20.3%) and significantly higher than the national rate (16.0%). Binge drinking by race and ethnicity also shows that Non-Hispanic Black adults (32.2%) are more likely to binge drink than Non-Hispanic White adults (24.2%) and Hispanic adults (20.1%). Except in 2012, Lancaster County adults report that they also more likely to be heavy drinkers (regularly consuming 2 or more drinks a day) than Nebraska or U.S. adults.



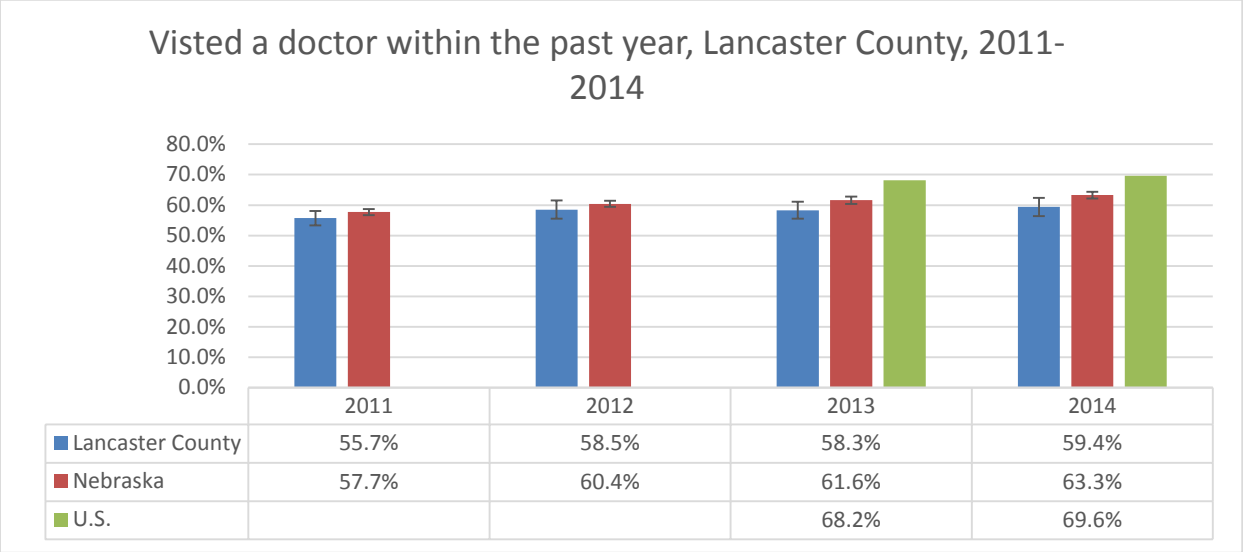


- ***Health Care Coverage:*** In 2013, respondents aged 18 to 64 indicated they did not have health care coverage (18.2%) at a rate higher than the state (17.6%), but lower than the nation (20.0%). Most likely in large part due to the growing impact of the ACA, the local, state, and national rates of reported health care coverage for 18-64 year olds all dropped to 15.3% in 2014. By race and ethnicity, disparities continue to persist as Non-Hispanic White adults aged 18 to 64 (88.8%) reported having health care coverage at a much higher proportion than Non-Hispanic Black adults aged 18 to 64 (62.2%) and Hispanic adults aged 18 to 64 (48.5%).

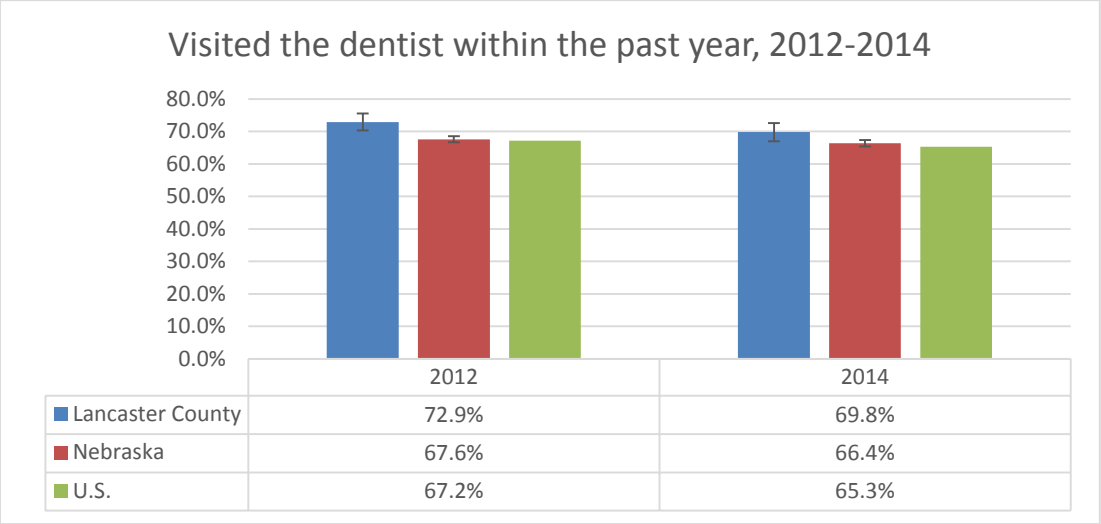


- ***Access to and Utilization of Health Care:*** Based on 2014 BRFSS results, 84.7% of adults have health care coverage and 57.9% of adults indicated they had visited a doctor for a routine checkup within the past year, but 12.5% of adults indicated they couldn't see a doctor in the past year because of cost (a reduction from 13.2% in 2013). The

percentage of adults indicating they couldn't see a doctor in the past year because of cost is slightly higher than the state rate (11.9%), but about the same as the national rate (13.1%). By race and ethnicity, Non-Hispanic White adults (10.6%) reported not being able to see a doctor in the past year due to cost less often than Non-Hispanic Black adults (36.6%) and Hispanic adults (23.8%).

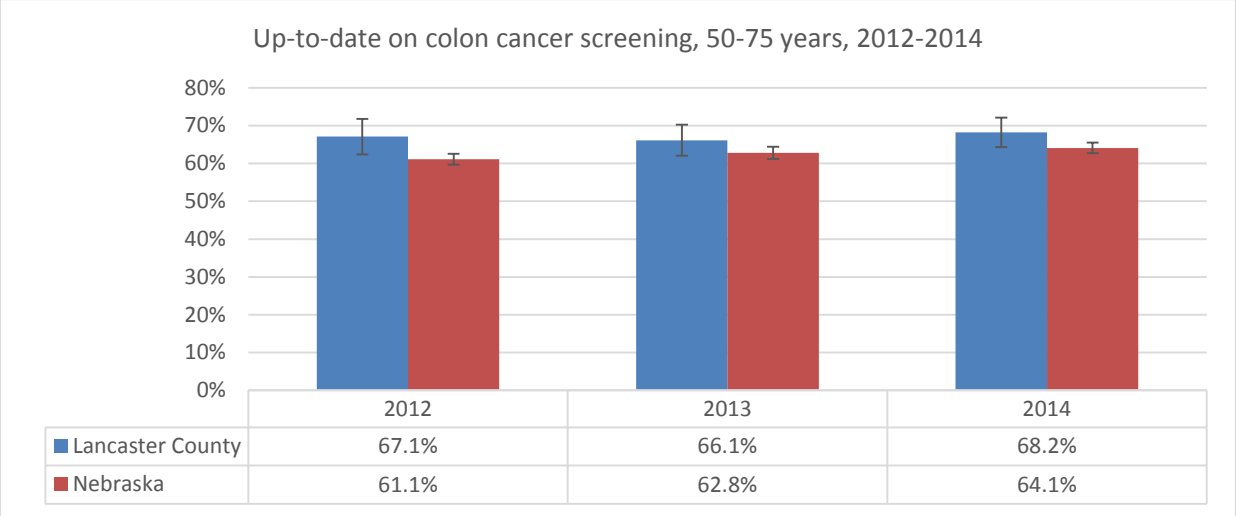


- ***Access to and Utilization of Dental Care:*** In 2013, 69.9 percent of Lancaster County respondents visited a dentist, but 26 percent of residents indicated that they could not afford to seek dental care during the year. Based on the 2014 BRFSS, 69.8% of Lancaster County adults have visited a dentist, dental hygienist or dental clinic within the past year, comparing favorably to statewide and national results, which were 66.4% and 65.3% respectively. While overall Lancaster County dental care access compares favorably, Non-Hispanic White adults (72.4%) are significantly more likely to visit a dentist than Non-Hispanic Black adults (51.8%) and Hispanic adults (52.3%).

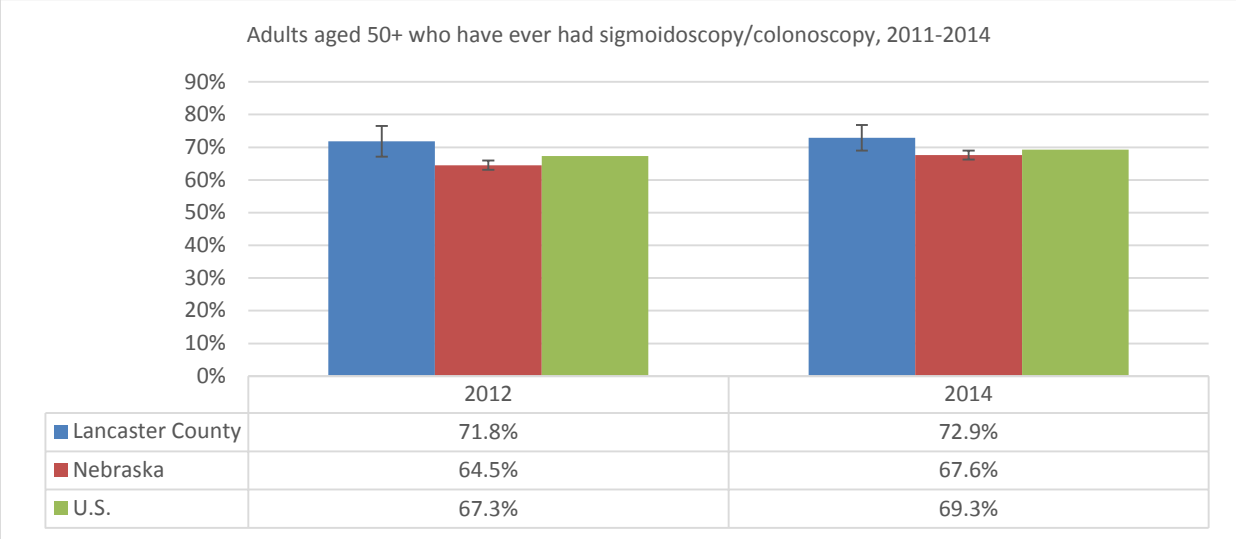


- ***Cancer Screening:*** There is a mixed picture on cancer screening locally. The BRFSS helps to provide insight into the screening being utilized with regard to the following types of cancer:

    - *Colorectal Cancer Screening:* Among persons 50 and older, in 2013, 70.5 percent of this age group reported having a sigmoidoscopy or colonoscopy and 38.0 percent of those who had received a sigmoidoscopy or colonoscopy received it within the past two years. Non-Hispanic White adults (71.9%) and Non-Hispanic Other Race adults (76.3%) reported high rates of colorectal cancer screening, while Non-Hispanic Black adults (34.4%) and Hispanic adults (39.8%) reported a very low rate of colorectal cancer screening. Since colorectal cancer can be prevented when any polyps are found during screening and colorectal cancer is the second leading cause of cancer deaths in Lancaster County, these rates need to be increased, especially those for Blacks and Hispanics.



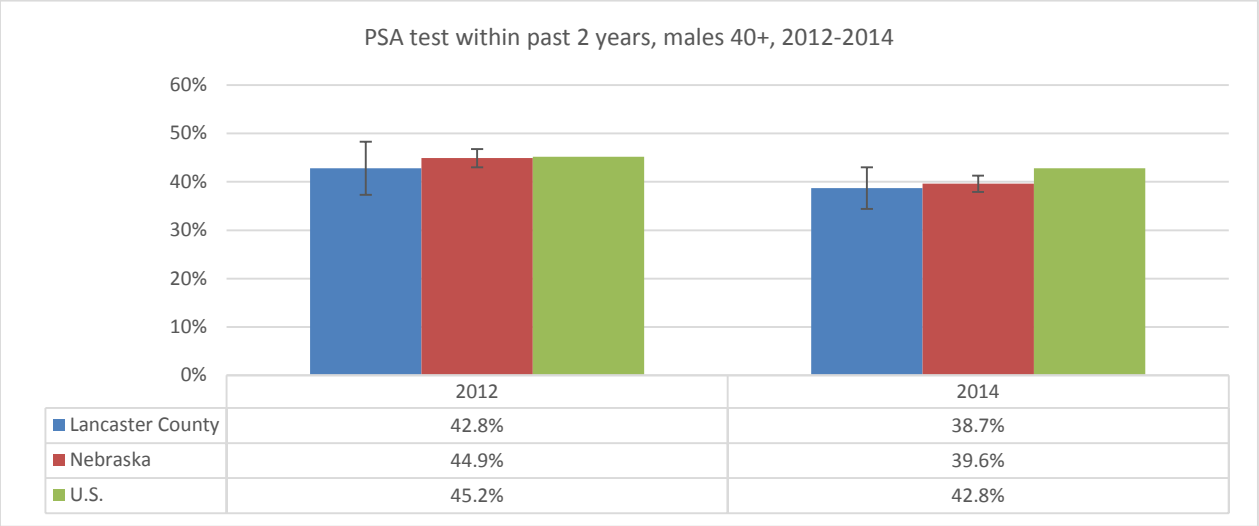
	2012	2013	2014
Lancaster County	67.1%	66.1%	68.2%
Nebraska	61.1%	62.8%	64.1%



	2012	2014
Lancaster County	71.8%	72.9%
Nebraska	64.5%	67.6%
U.S.	67.3%	69.3%

- *Breast Cancer Screening:* The recent changes in recommendations for screening mammograms, which do not recommend routine screening beginning at age 40, mean that we now ask above mammograms for women over 50 and younger than 75. The question is not a core question so it was only asked in the 2012 and 2014 BRFSS surveys. Among women 50 to 74, in 2014 78.5 percent of Lancaster County women were up-to-date on breast cancer screening (had a mammogram within the past two years), slightly better the 76.1 percent rate in Nebraska. Both the local and Nebraska 2014 rates were improvements in the screening rates from 2012, which were 76.9 percent for Lancaster County and 74.9 percent for the state of Nebraska.

- *Prostate Cancer:* In 2012 and 2014 Lancaster County men 40 and older utilized the PSA test (note the PSA test is less in favor these days) for prostate cancer at rates (42.8 percent in 2012, 38.7 percent in 2014) lower than male Nebraskans (44.9 percent in 2012, 39.6 percent in 2014) and men in that age group from across the nation (45.2 percent in 2012, 42.8 percent in 2014).



- *Cervical Cancer Screening:* 2012 BRFSS results indicate that 85.9 percent of local women aged 18 and older had a Pap test within the last three years, while 83.9 percent of Nebraska women had a Pap test. In 2014, a reduced percentage of women ages 18 and above had a Pap test within the past three years (78.2%), which was below the statewide percentage (81.7%), and also below the national percentage (82.6%).

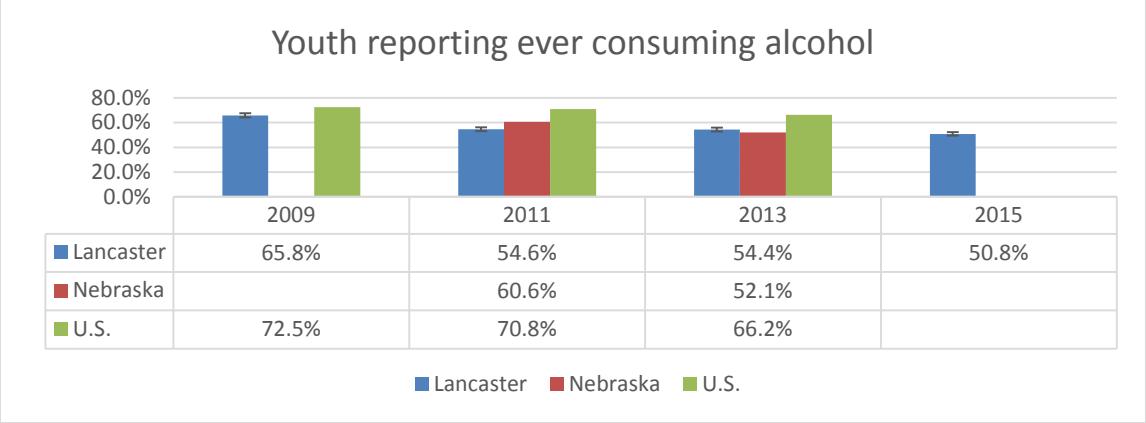
Risky Behaviors by Youths

The Lincoln-Lancaster County Health Department has been conducting the Youth Risk Behavior Surveillance Survey (YRBSS or YRBS) every odd year (biennially) since 1991. The YRBS survey is a paper-based survey that is generally conducted during the spring of odd years (e.g., 2005, 2007, etc.). Our 2011 local YRBS data come from the fall of 2010 as the state tried to reduce the administrative burden on school administrators by combining a number of surveys at

that time. Also, the 2013 local data comes from the fall of 2012 and 2015 local data comes from the fall of 2014 thanks to the CDC approving the change in timing.

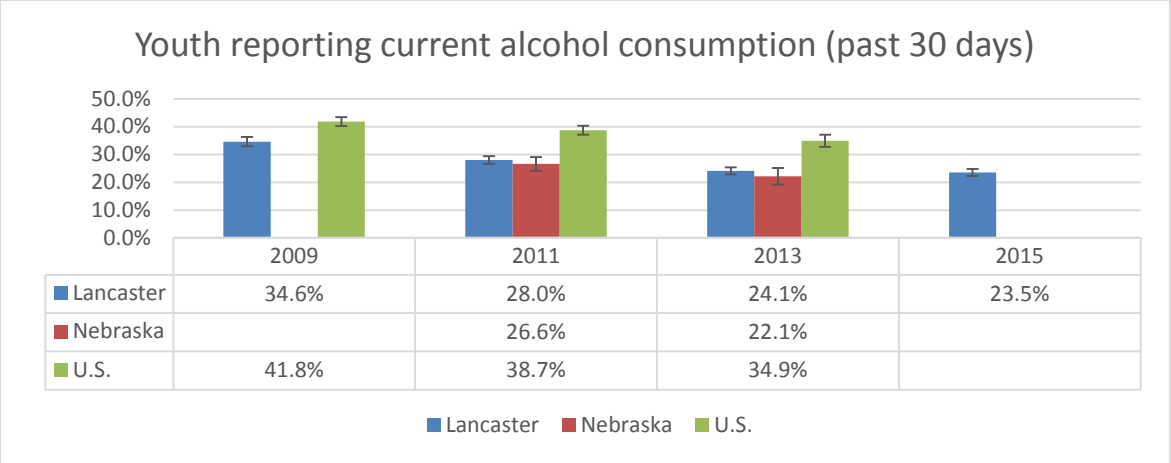
There is an YRBS dashboard posted on the LLCHD website with Lancaster County YRBS data for every year from 2001 to 2015. The dashboard includes graphs by grade to show any differences in behaviors by freshmen and seniors or changes in behaviors from 9th to 12th grade. The YRBS dashboard does not show comparable Nebraska and U.S. data; however, the graphs that follow show national YRBS for 2009, 2011 and 2013. We also show Nebraska's 2011 and 2013 YRBS data for comparison. Unfortunately, due to the low response rates in Nebraska high schools for the years of 2005, 2007 and 2009 the overall response rates did not meet the CDC criteria for weighting, so it is difficult to compare long-term trends between the state and Lancaster County. State and national YRBS 2015 data will be added as soon as they become available. Local YRBS data on selected behaviors are summarized below:

- ***Lifetime Alcohol Use:*** The percent of Lancaster County teens that have had at least one drink in their lifetime decreased from 65.8 percent in 2009 to 54.6 percent in 2011 and 54.4 percent in 2013. The 2015 results showed a drop to 50.8 percent locally and we do not have 2015 results for the state and nation yet. The comparable Nebraska and U.S. rates were 52.1 percent and 66.2 percent in 2013.

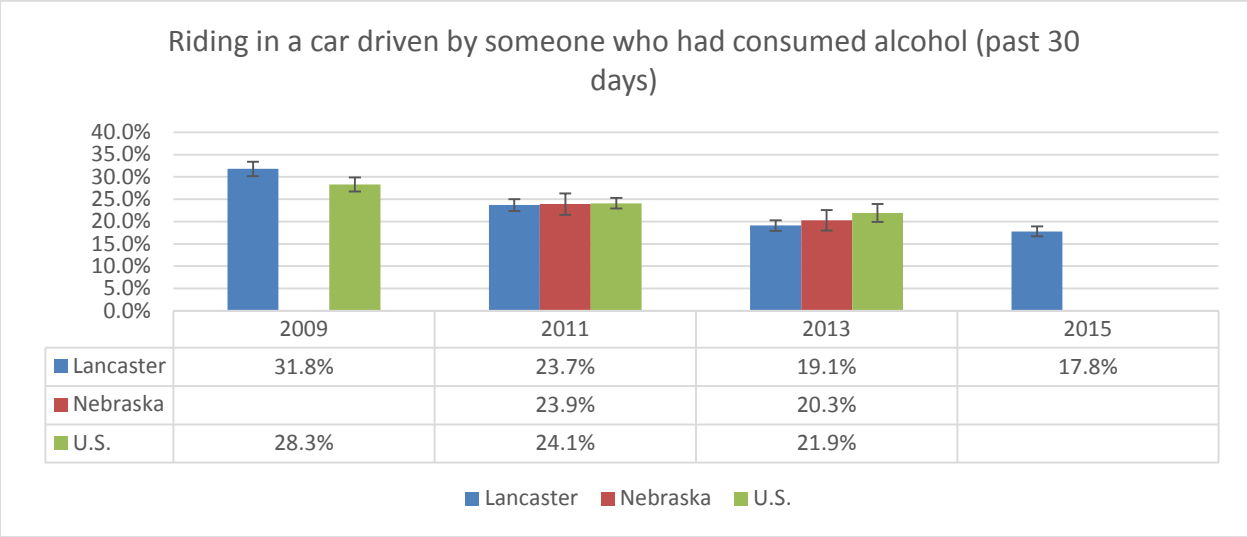


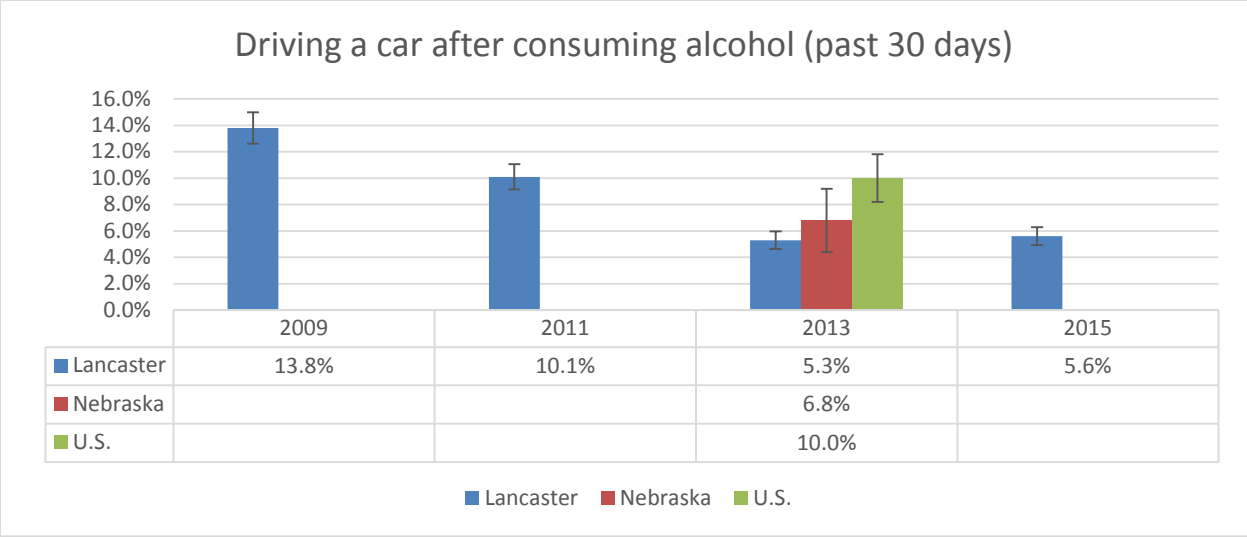
	2009	2011	2013	2015
Lancaster	65.8%	54.6%	54.4%	50.8%
Nebraska		60.6%	52.1%	
U.S.	72.5%	70.8%	66.2%	

- ***Current Alcohol Consumption:*** The rate of current alcohol consumption among high school teens has declined since 2009 (34.6% in 2009, 28.0% in 2011, 24.1% in 2013, and 23.5% in 2015). The reduction in alcohol consumption over time is encouraging and both local and state rates are below the national rates by a fair margin.

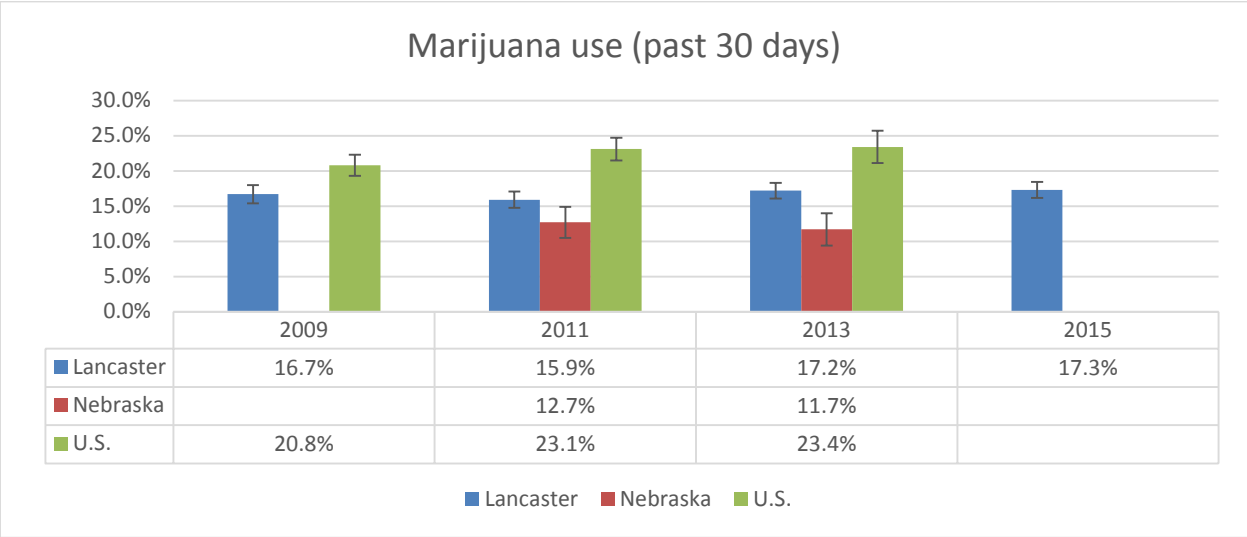


- ***Alcohol & Motor Vehicle Transportation:*** Unfortunately, while there's been improvement from the 19.1 percent rate for 2013, the 2015 results show that 17.8 percent of students still reported riding in a car or other vehicle driven by someone who had been drinking alcohol. The 2013 local rate (19.1%) was slightly better than the 20.3% statewide and 21.9% nationwide rates. Also, while the 2013 results indicated that 5.3 percent of local students reported driving when they had been drinking alcohol (compared to 6.8% statewide and 10.0% nationwide) the trend may have leveled off since the 2015 YRBS rate is slightly above the 2013 rate (5.3%) as 5.6 percent of teens reported driving after drinking in 2015.

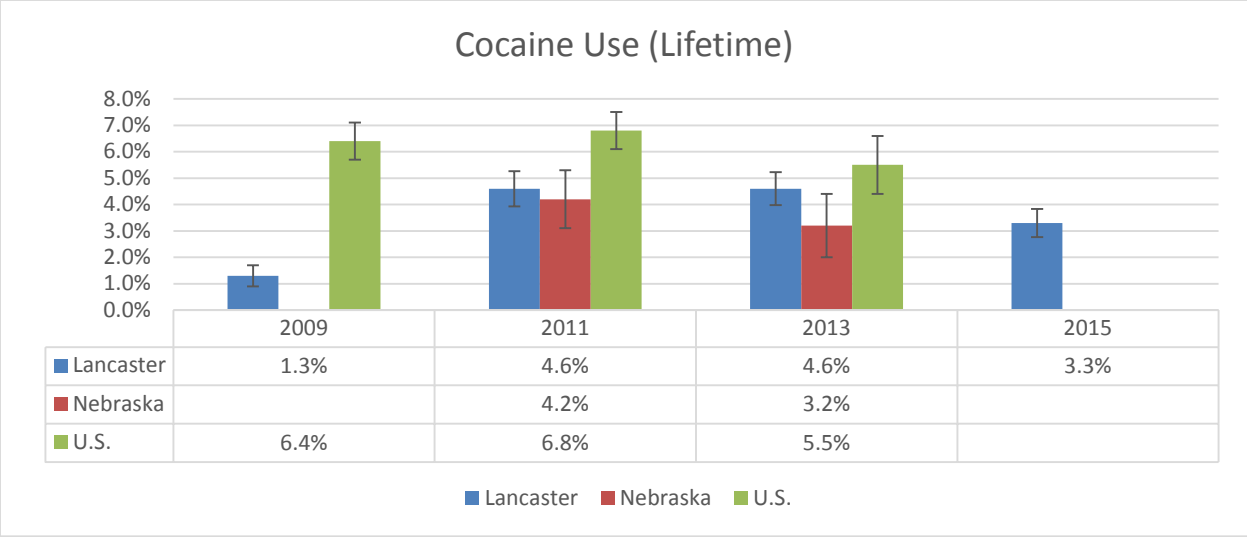




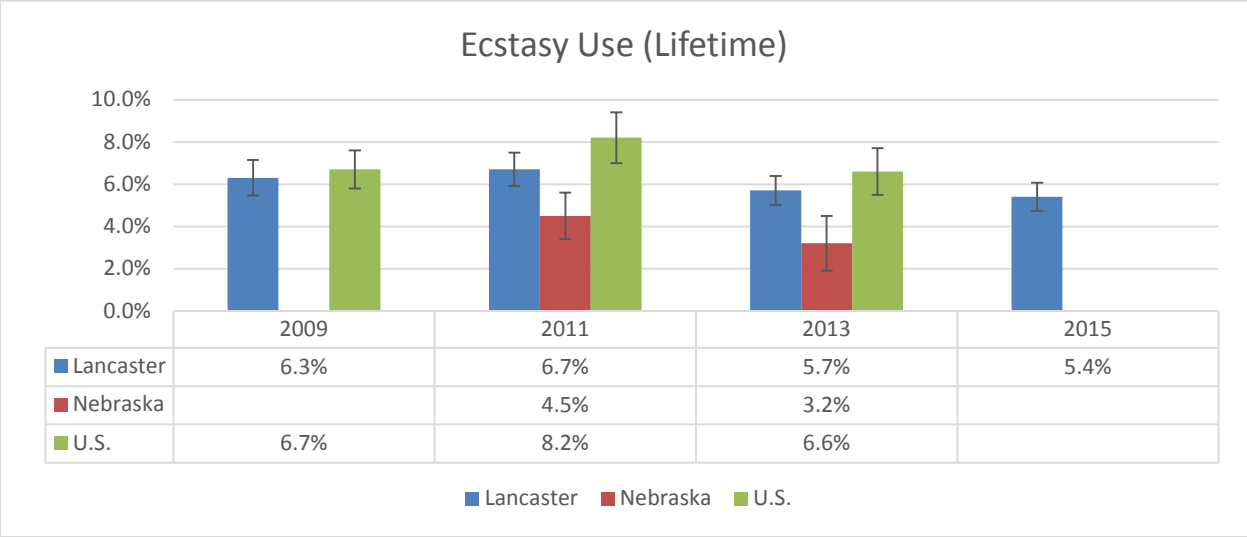
- ***Marijuana Use:*** Marijuana use within the prior 30 days decreased from 16.7 percent of teens that had used marijuana in 2009 to 15.9 percent of youths who reported using it in 2011. In 2013 the rate increased to 17.2 percent, which while still too high, compared favorably to 23.6% statewide and 23.4% nationwide in 2013. The 2015 rate was 17.3 percent, which is essentially unchanged from 2013.



- ***Cocaine Use:*** Although the data on cocaine use has been wildly volatile, the trend has been up. However, the 2015 results decreased to 3.3 percent from the 2013 rate of 4.5% and the similar 2011 rate of 4.6 percent. For comparison, in 2013, the statewide percentage of teens that had ever used cocaine was 3.2%, which is the same statewide percentage for those who had ever used ecstasy. Both the state and local rates are well below the nationwide YRBS rates of cocaine use (5.5%) and ecstasy use (6.6%).



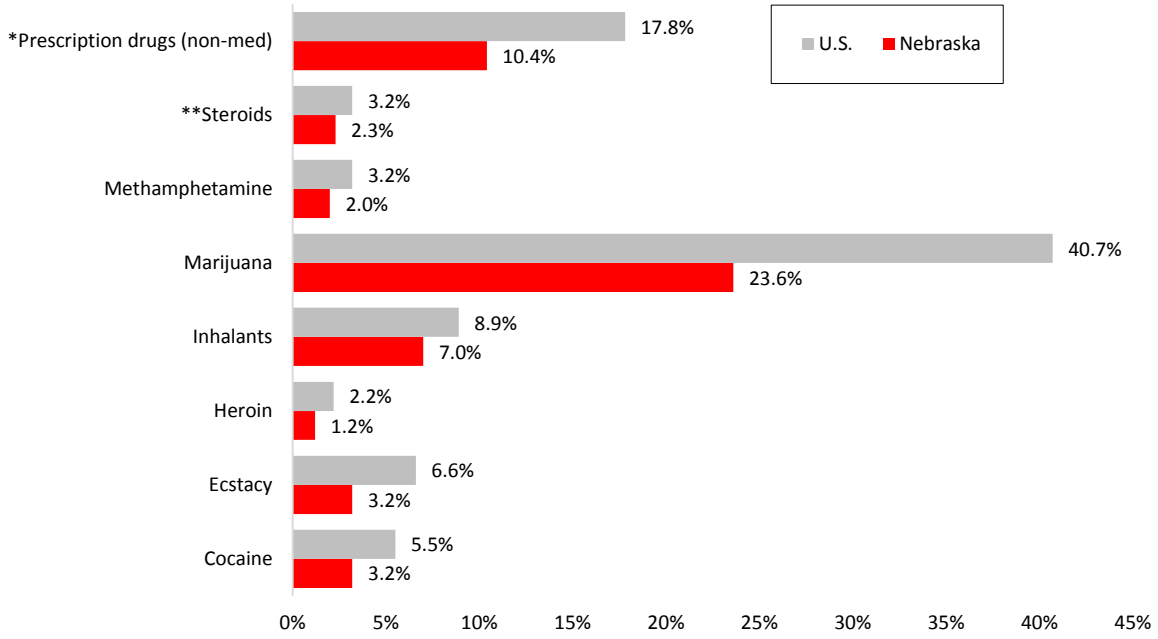
	2009	2011	2013	2015
Lancaster	1.3%	4.6%	4.6%	3.3%
Nebraska		4.2%	3.2%	
U.S.	6.4%	6.8%	5.5%	



	2009	2011	2013	2015
Lancaster	6.3%	6.7%	5.7%	5.4%
Nebraska		4.5%	3.2%	
U.S.	6.7%	8.2%	6.6%	

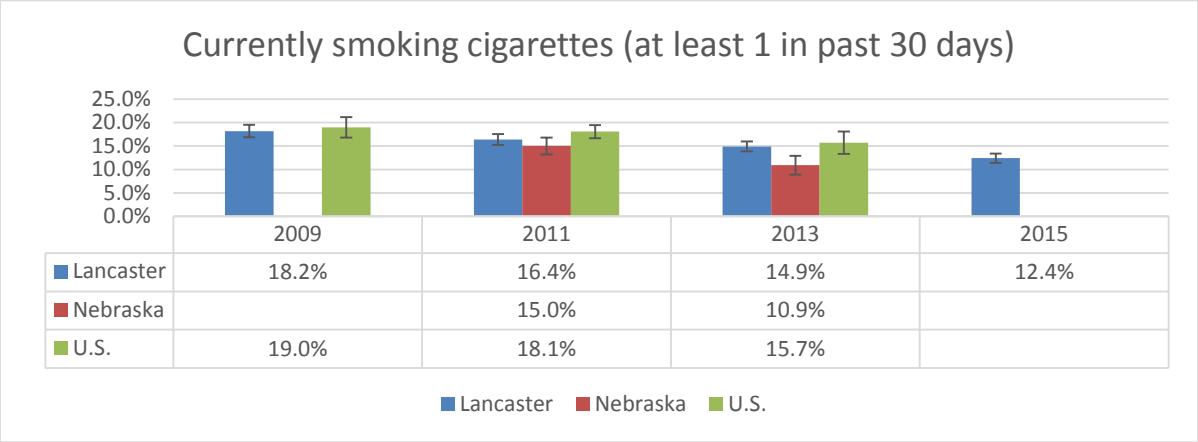
When Nebraska YRBS rates for drugs are compared to national rates as shown in the following graph it is clear that drug use rates are well below national rates. Nevertheless, local rates of drug use as shown above are higher than the state rates overall.

Lifetime Illicit Drug Use among High School Students by Drug Type, Nebraska and U.S., 2013



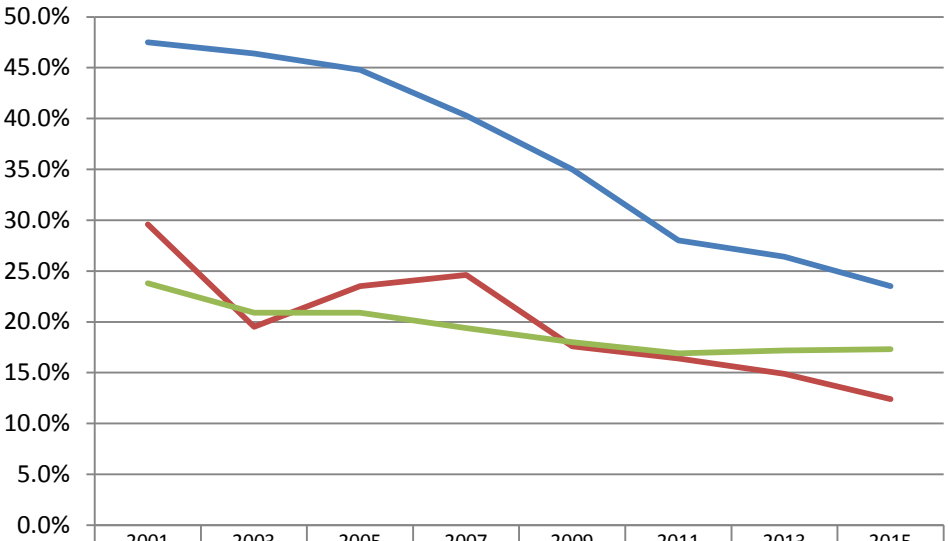
*Taking a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription
**Includes steroid pills or shots taken without a doctor's prescription

- ***Current Tobacco Use:*** The percent of teens who are current smokers dropped to 12.4 percent in 2015 and this is a continuation of a downward trend. As recently as 2009 the rate was 18.2 percent and the smoking rate had decreased to 16.4 percent in 2011 and 14.9 percent in 2013. The comparable statewide and national rates for 2013 were 10.9 percent and 15.7 percent respectively. In 2013, 5.5 percent of teens reported smoking cigarettes on school property during the 30 days before the survey, but this question was not included on the 2015 survey. While we applaud the reduction in smoking rates, there's the possibility that the use of e-cigarettes (electronic cigarettes) may be one of the reasons for the drop.



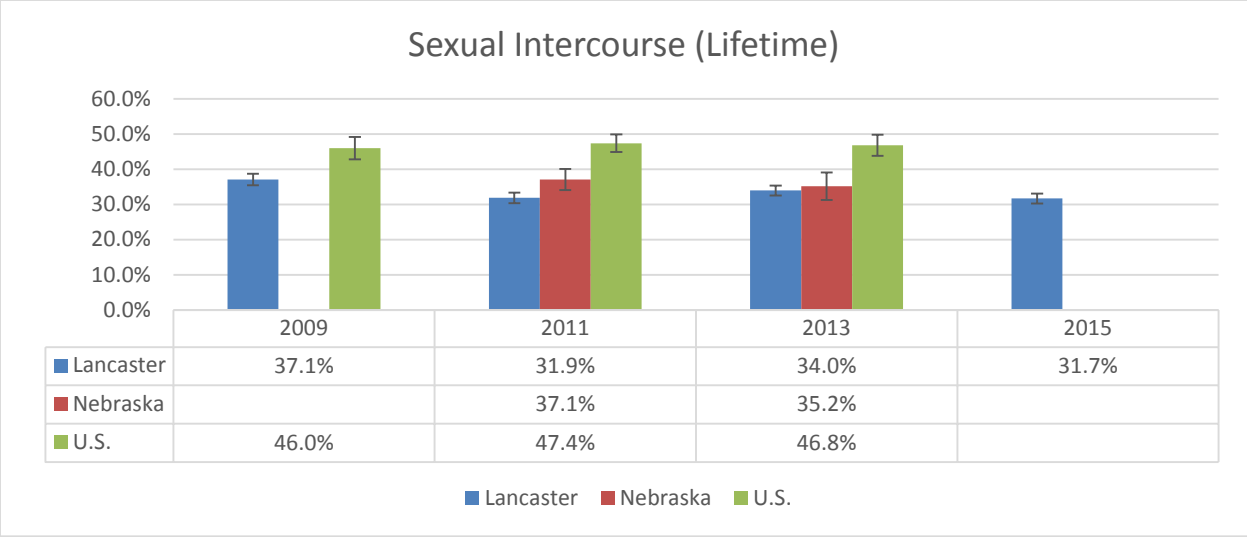
	2009	2011	2013	2015
Lancaster	18.2%	16.4%	14.9%	12.4%
Nebraska		15.0%	10.9%	
U.S.	19.0%	18.1%	15.7%	

The following chart shows the trends from 2001 to 2015 in YRBS results for three risky behaviors (drinking, smoking and using marijuana). As can be seen, the recent rates are well below those 14 years ago.

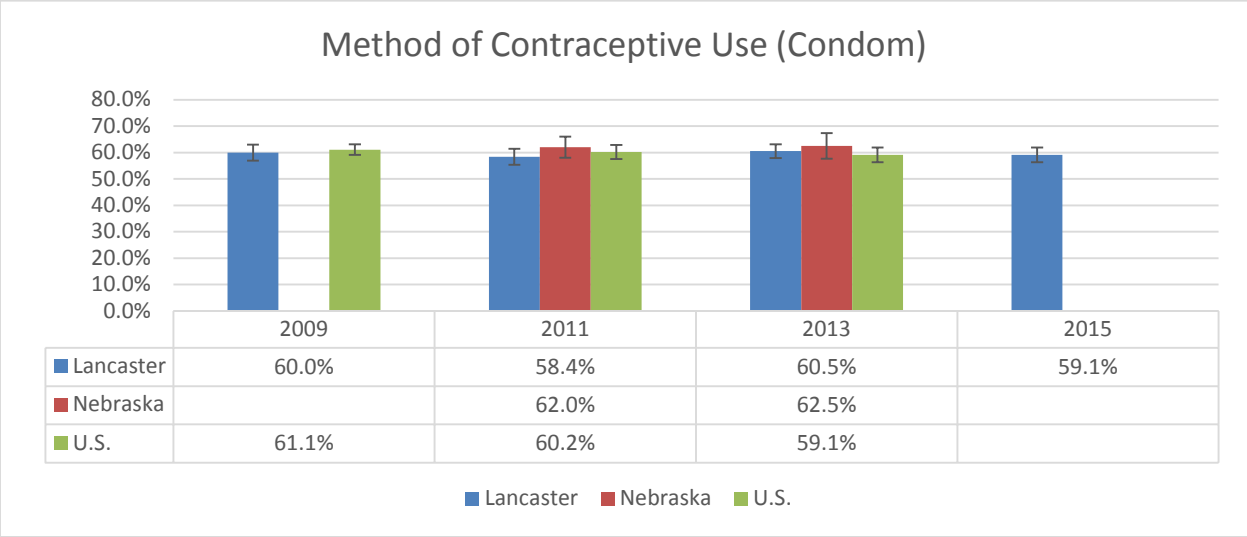


	2001	2003	2005	2007	2009	2011	2013	2015
Current Drinkers	47.5%	46.4%	44.8%	40.3%	35.0%	28.0%	26.4%	23.5%
Current Smokers	29.6%	19.5%	23.5%	24.6%	17.6%	16.4%	14.9%	12.4%
Marijuana Use	23.8%	20.9%	20.9%	19.4%	18.0%	16.9%	17.2%	17.3%

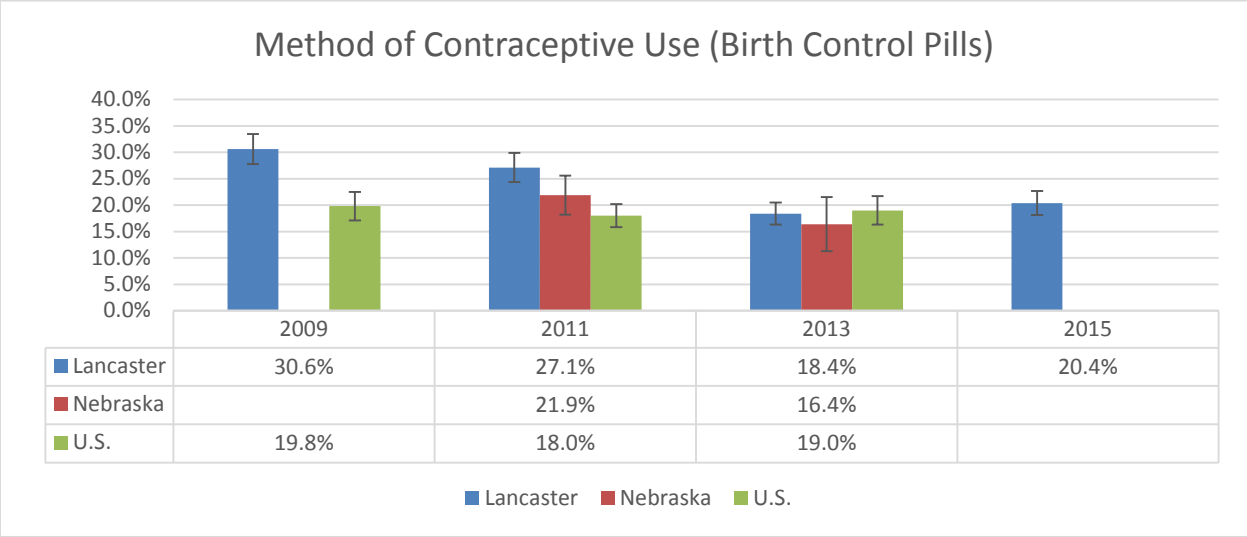
- ***Sexual Activity & Birth Control:*** In 2015 the percent of teens who indicated that they had ever had sexual intercourse was 31.7 percent. Between 2009 and 2013, the percent of teens indicating they had ever had sexual intercourse ranged from 37.1 percent in 2009 to 31.9 percent in 2011, with the 2013 rate in the middle at 34.0 percent. The local 2013 result was below the statewide (35.2%) and national (46.8%) percentages. In 2015, 59.1 percent of students used a condom when having intercourse. In 2013, the rate for those students who did not use a condom when they were having intercourse was reported to be 40.9 percent locally, compared to 37.5 percent statewide and 40.9 percent nationwide. Also in 2013, the percent of those teens not using birth control pills was reported to be 80.6 percent locally compared to 83.6 percent statewide and 81.0 percent nationwide. The 2015 local result was 79.6 percent (20.4 percent used birth control pills).



	2009	2011	2013	2015
Lancaster	37.1%	31.9%	34.0%	31.7%
Nebraska		37.1%	35.2%	
U.S.	46.0%	47.4%	46.8%	

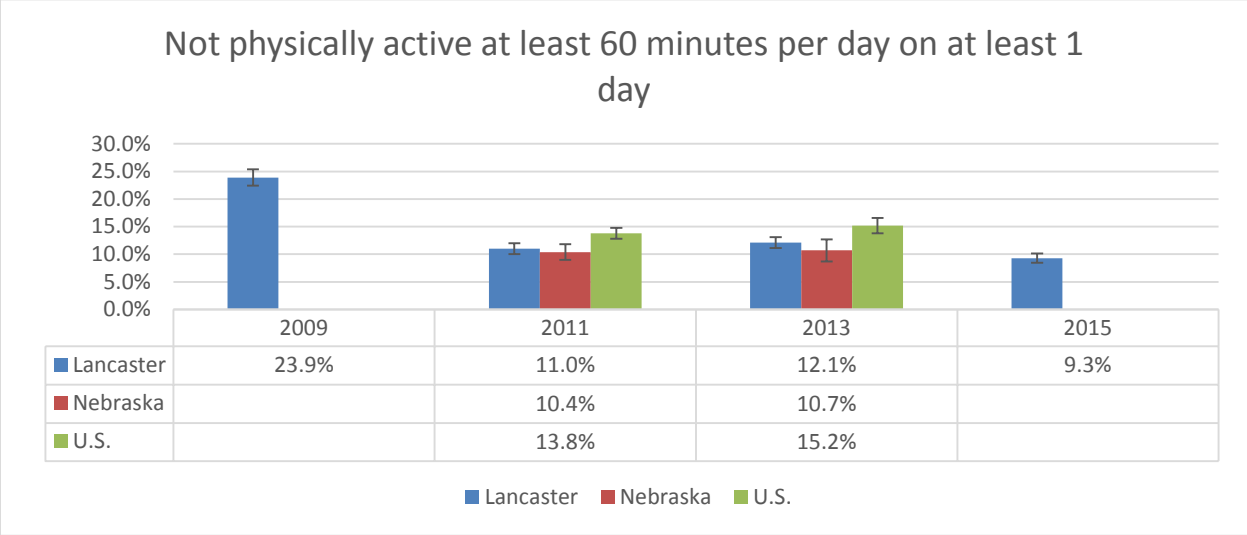


	2009	2011	2013	2015
Lancaster	60.0%	58.4%	60.5%	59.1%
Nebraska		62.0%	62.5%	
U.S.	61.1%	60.2%	59.1%	

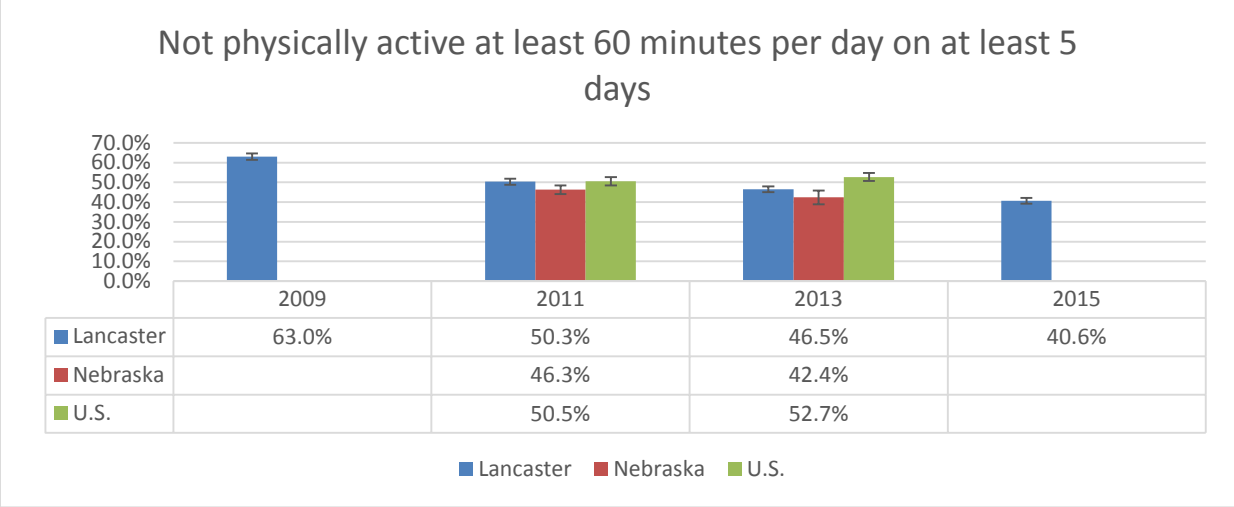


	2009	2011	2013	2015
Lancaster	30.6%	27.1%	18.4%	20.4%
Nebraska		21.9%	16.4%	
U.S.	19.8%	18.0%	19.0%	

- ***Physical Activity:*** As for physical activity, from 2009 to 2011 the percent of teens who had not engaged in vigorous physical activity at least once within the previous week decreased from 23.9 percent to 9.3 percent. In 2013, the percentage who did not participate in at least 60 minutes of physical activity on at least one day was 10.7 percent statewide and 15.2 percent nationwide, while the percentage who did not participate in at least 60 minutes of physical activity per day on five or more days was 42.4 percent statewide and 52.7 percent nationwide. Locally, in 2013 physical inactivity by teens was more common than statewide but less common than nationally as 12.1 percent of U.S. teens reported not participating in at least 60 minutes of physical activity on at least one day, and 46.5 percent reported not participating in at least 60 minutes of physical activity on at least five days during the week. The 2015 results showed an improvement, as the percentage of students who had not engaged in physical activity for 60 minutes or more on at least one day in the past week, dropped to 9.3 percent, and 40.6 percent reported not participating in at least 60 minutes of physical activity for at least five of the days in the past week.

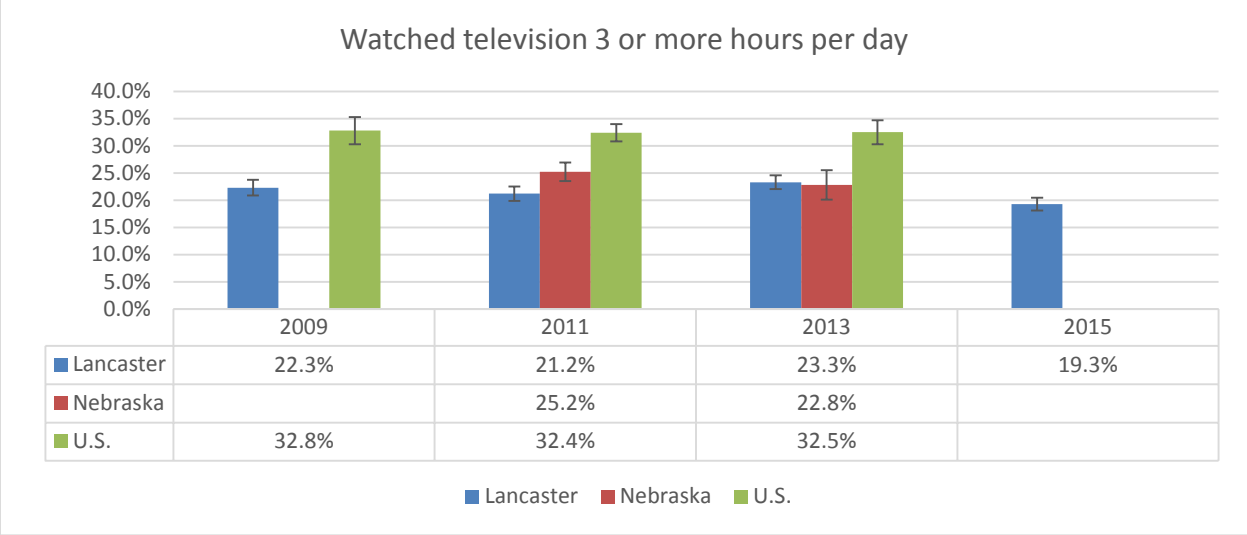


	2009	2011	2013	2015
Lancaster	23.9%	11.0%	12.1%	9.3%
Nebraska		10.4%	10.7%	
U.S.		13.8%	15.2%	



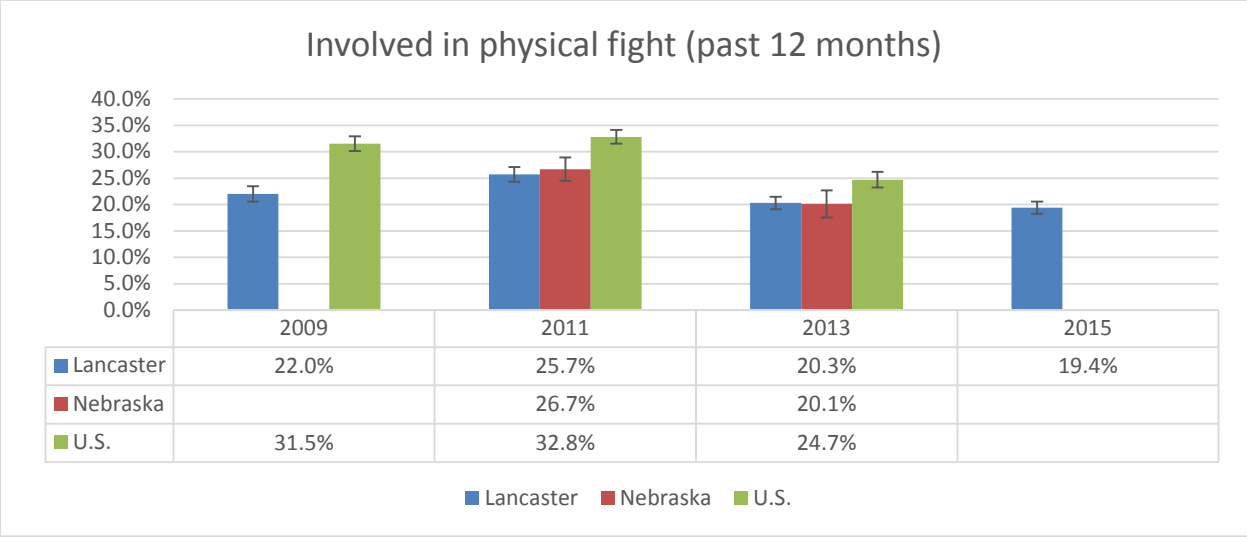
	2009	2011	2013	2015
Lancaster	63.0%	50.3%	46.5%	40.6%
Nebraska		46.3%	42.4%	
U.S.		50.5%	52.7%	

- ***Video Games & Television:*** In 2013, the percentage of teens playing video or computer games three or more hours per day on an average school day was 31.5 percent locally, 28.1 percent statewide and 41.3 percent nationwide. As for TV watching, 23.3 percent of teens locally, 22.8 percent statewide and 32.5 percent nationwide watched television three or more hours per day on an average school day. As for participation in sports, in 2013, 40.1 percent of local teens, 34.8 percent of high school students statewide and 46.0 percent of students nationwide did not play on at least one sports team in the 12 months before the survey. The 2015 results showed an improvement in TV watching (down to 19.3%) and in sports team participation (only 19.3 percent had not participated on a sports team in the past year); however, 35.9 percent of students reported playing video games for three hours or more on a typical school day.

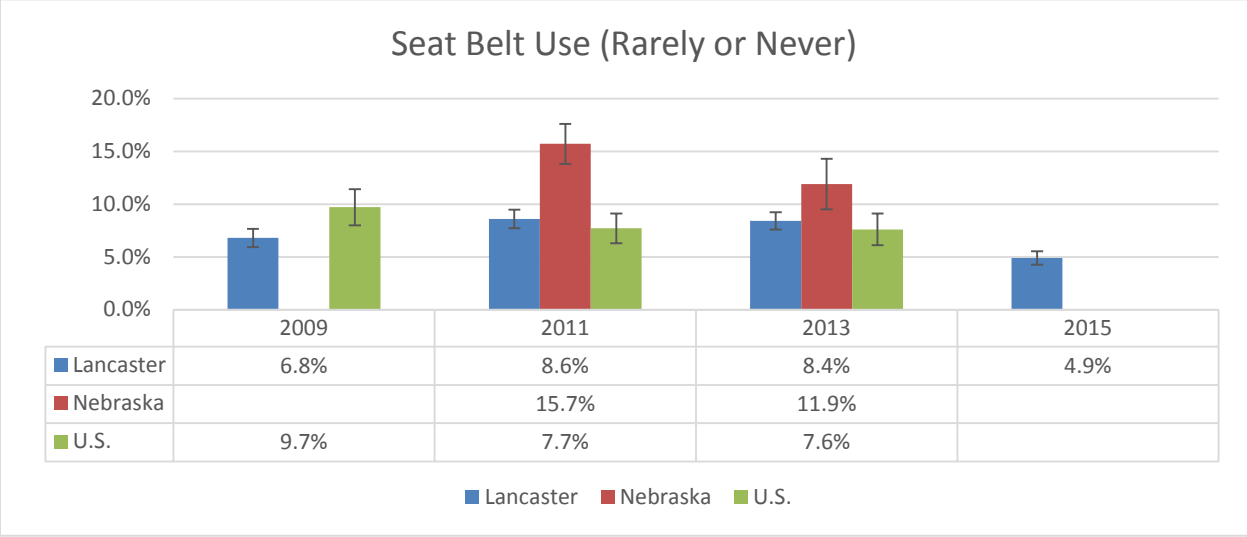


	2009	2011	2013	2015
Lancaster	22.3%	21.2%	23.3%	19.3%
Nebraska		25.2%	22.8%	
U.S.	32.8%	32.4%	32.5%	

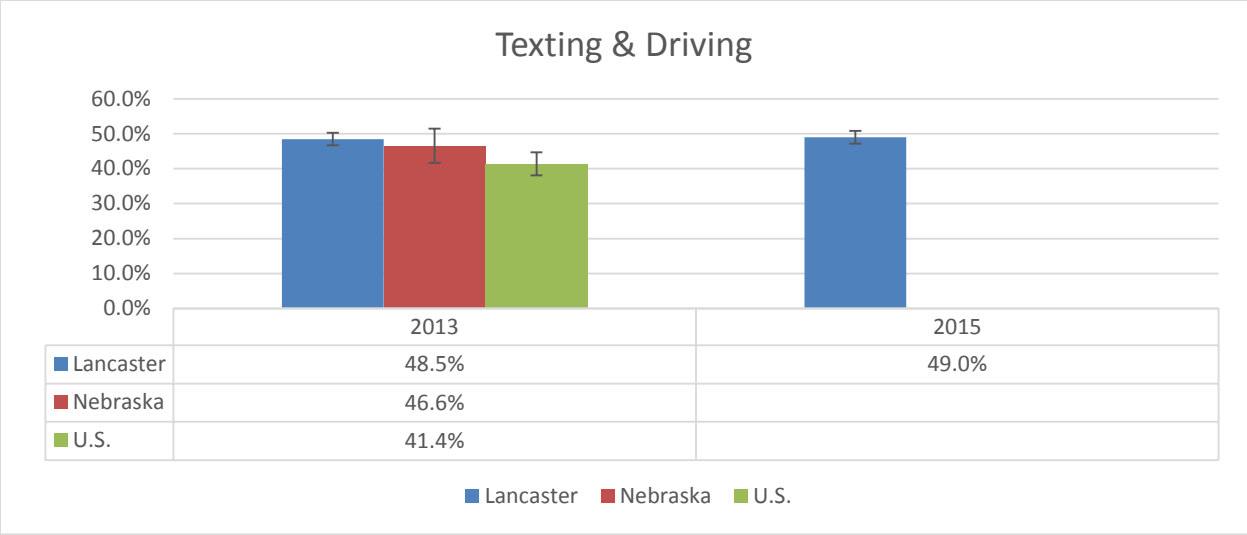
- ***Physical Violence:*** In 2015, the local YRBS results indicated that 19.4 percent of students indicated they had been in a physical fight during the past year, a slight improvement (reduction) over 2013. This is an improvement from 2009 and 2011 rates in the percent of teens indicating they had been in a physical fight within the past 12 months (2009, 22.0%, 2011, 25.7%, and 2013, 20.3%). For comparison, in 2013 those teens reporting being in a physical fight in the 12 months before the survey was 20.1 percent statewide and 24.7 percent nationwide.



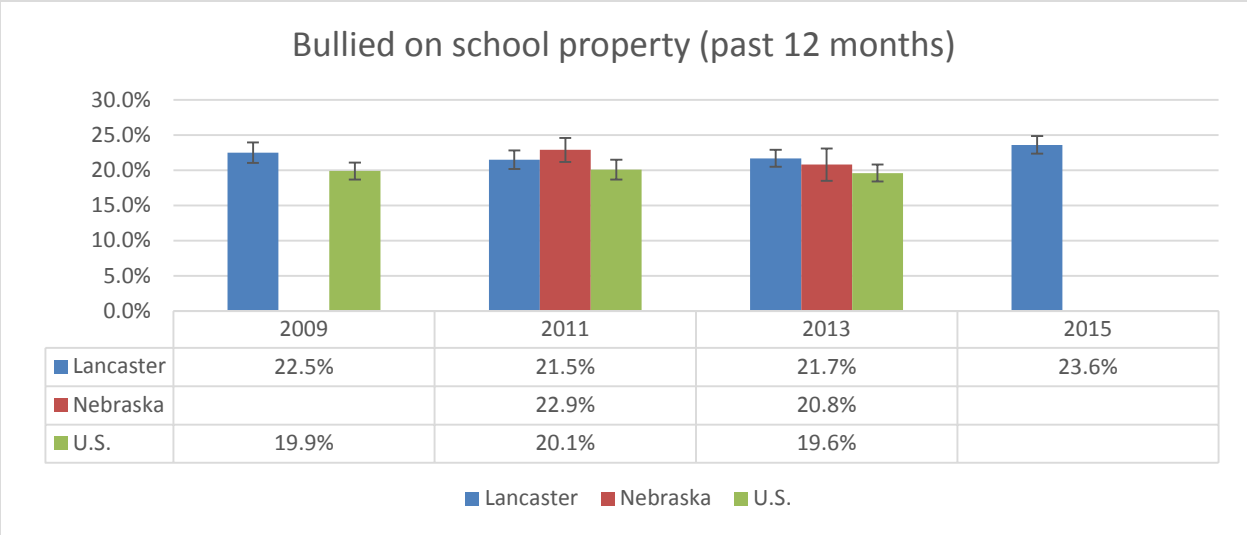
- ***Seatbelt Use:*** In 2015, only 4.9 percent of teens never or rarely wore their seatbelt, which is much improved from the results from 2009 to 2013 (6.8 percent in 2009, 8.6 percent in 2011, and 8.4 percent in 2013). In 2013, 11.9 percent of teens statewide and 7.6 percent of teens in the nation never or rarely wore a seatbelt.

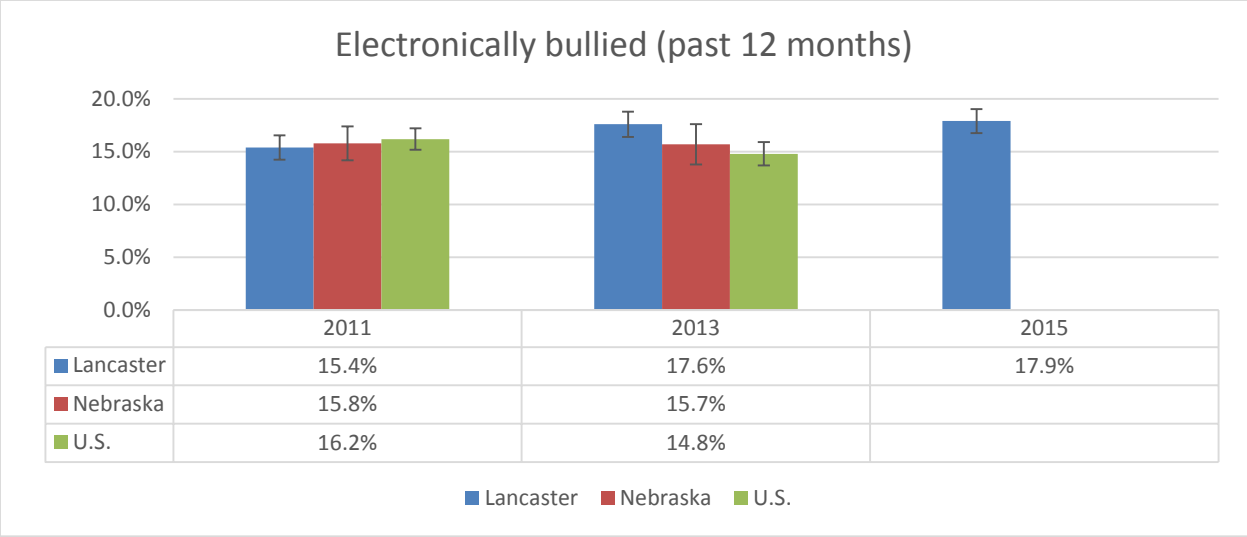


- ***Texting While Driving:*** In 2015, 49 percent of youth in Lancaster County texted or e-mailed while driving. In 2013, 48.5 percent of local students had texted or e-mailed while driving, which compared to 46.6 percent of youth statewide and 41.4 percent of youth nationwide that texted or e-mailed while driving a car or other vehicle. Obviously, this is a concern that relates to injury prevention, one of the CHIP priorities and concerns among those who we surveyed during our assessments.

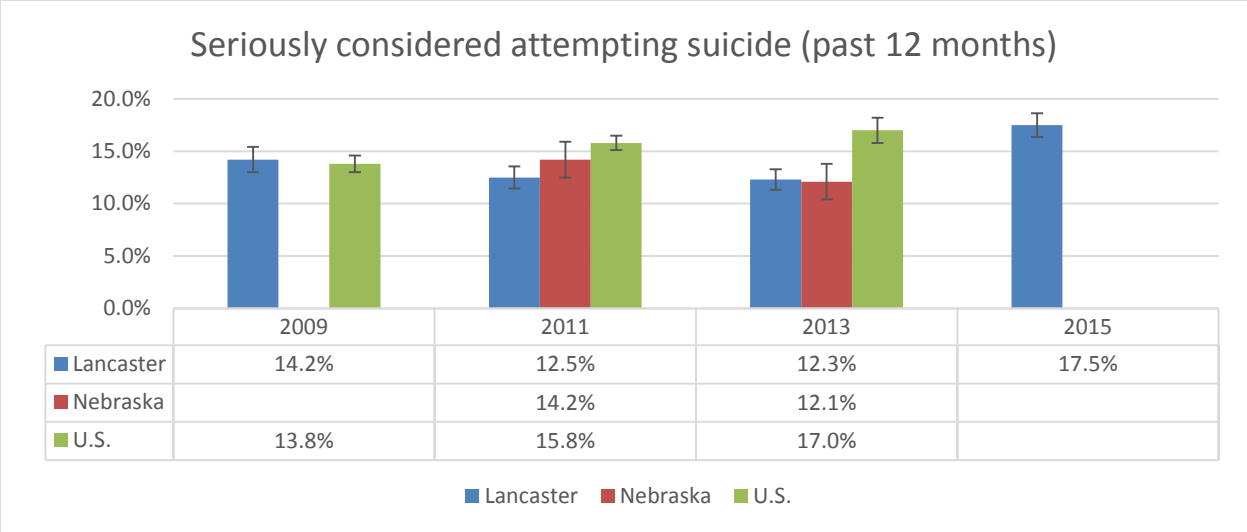


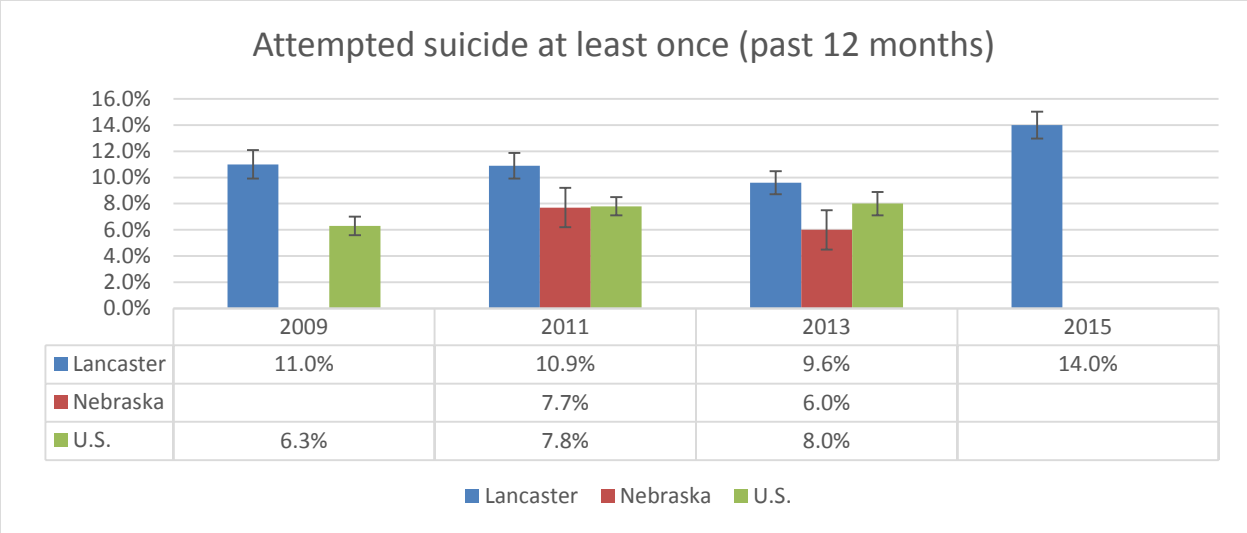
- ***Bullying:*** Statewide and locally, bullying of students remains an ongoing problem. Locally, rates are quite high with 17.6 percent of local teens reporting being electronically bullied in 2013; and the rate rose to 17.9 percent in 2015. Statewide, 15.8 percent and 15.7 percent of teens reported being electronically bullied in 2011 and 2013 respectively, with the national YRBS rate (16.2%) above the local and state rates in 2011, while the local and state rates were above the nationwide rate (14.8%) in 2013. As for teens being bullied on school property; locally, in 2015, 23.6 percent of teens were bullied on school property, which is an increase from the 2013 rate of 21.7 percent of teens being bullied on school property in the last 12 months. Both of these rates, as well as the 2009 and 2011 local YRBS rates and 2011 (22.9%) and 2013 (20.8%) state YRBS rates are higher than the nationwide rates for bullying on school property (19.9% in 2009, 20.1% in 2011, and 19.6% in 2013).





- ***Suicide:*** Locally, 2015 suicide-related issues are concerning as 17.5 percent of teens reported seriously considering attempting suicide. What's more, 13.4 percent of teens reported making a plan on how they would attempt suicide and 14.0 percent reported attempting suicide at least once in the last year. These rates are higher than the 2013 survey results when 12.3 percent of teens seriously considered attempting suicide, 10.2 percent of teens reported making plan to commit suicide, and 9.6 percent of local teens reported attempting suicide at least once in the previous year. For comparison, from 2011 to 2013 YRBS Nebraska suicide-related rates declined slowly, from 14.2 percent in 2011 to 12.1 percent of teens in 2013 who reported seriously considering a suicide attempt during the 12 months before the survey. The 2011 and 2013 YRBS reveals that 10.9 percent considered suicide and 9.8 percent made a plan about how they would attempt suicide; and 7.7 percent and 6.0 percent of teens attempted suicide one or more times, respectively. In 2013, statewide suicide-related issues are slightly lower than national rates, where 17.0 percent of teens were seriously considering attempting suicide, 13.6 percent made a plan about how they would attempt suicide and 8.0 percent attempted suicide one or more times Not factored into these data is the fact that suicides among youth are a locally troubling concern based on recent mortality data discussed elsewhere in this profile.





Morbidity Associated with Other Diseases/Conditions

Cancer Incidence

While we don't have a good estimate for the prevalence of Lancaster County residents who are living with cancer or those who are cancer survivors, new cases of cancer (incidence) are reported to the Nebraska Cancer Registry each year. Cancer registry data include information on children as well as adults. The following table shows cancer incidence over the five-year period from 2008 to 2012 for all cancer sites as well as ten selected cancer sites. (Cancer data are only available through 2012, but there's little change year to year in cases or rates by site.) As the data indicate, there are almost 1,200 new cases of cancer in Lancaster County per year. The most common cancers are female breast, prostate, lung and bronchus, and colon and rectum cancer, with these four sites combined representing just over 52 percent of all new cancer cases.

2008 to 2012 Reported Information (Nebraska Cancer Registry)

Cancer Incidence by Site	5-year total for Lancaster County	Lancaster County Cancer Rate per 100,000	Nebraska Number	Nebraska Cancer Rate per 100,000
All Sites	5,910	**432.9**	45,291	451.9
Lung & Bronchus	738	56.1	5,928	58.9
Female Breast	929	127.8	6,415	122.7
Colon & Rectum	543	**40.1**	4,667	46.1
Prostate	697	**108.7**	5,954	125.7
Urinary Bladder	229	17.6	1,996	19.8
Non-Hodgkin Lymphoma	232	17.4	2,016	20.1
Leukemia	184	13.7	1,325	13.2
Kidney & Renal Pelvis	215	15.2	1,656	16.5
Melanoma	254	18.5	1,781	18.4
Pediatric	56	14.2	503	19.5

All rates in the tables are age-adjusted. When comparing cancer incidence rates from 2008 to 2012, the Lancaster County rates are not significantly higher or lower than state rates except for all cancer sites (432.9 per 100,000), colon and rectum cancer (40.1 per 100,000), and prostate cancer (108.7 per 100,000) where the Lancaster County rate is statistically significantly lower than the Nebraska rate over this period of time (it is highlighted in **bold** font in the table). For cancer mortality it must be kept in mind that cancer is the leading cause of death in Lancaster County. The latest cancer data for Nebraska and some county data can also be searched online at the Cancer Control Planet site.

Communicable Diseases

This section presents a summary of selected communicable diseases reported over the last seven years, and ten years of data from 2005 to 2014 and monthly 2015 disease data are posted on our website. The diseases that are included in the following table are vaccine-preventable and sexually transmitted diseases. The remaining selected communicable diseases include foodborne or waterborne diseases; vector-borne (from an animal or insect) diseases; as well as TB and other diseases that are rare but can have a significant effect on health status.

Reportable Diseases (selected)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Vaccine-Preventable Diseases							
Hepatitis A	9	7	0	1	3	4	1
Hepatitis B (Acute and Chronic)	56	49	44	41	18	23	36
Influenza	12	188	8	55	34	40	37
Mumps	0	2	4	0	0	0	0
Pertussis	24	19	32	2	20	42	167
Sexually-Transmitted Diseases							
AIDS	19	8	12	6	6	9	8

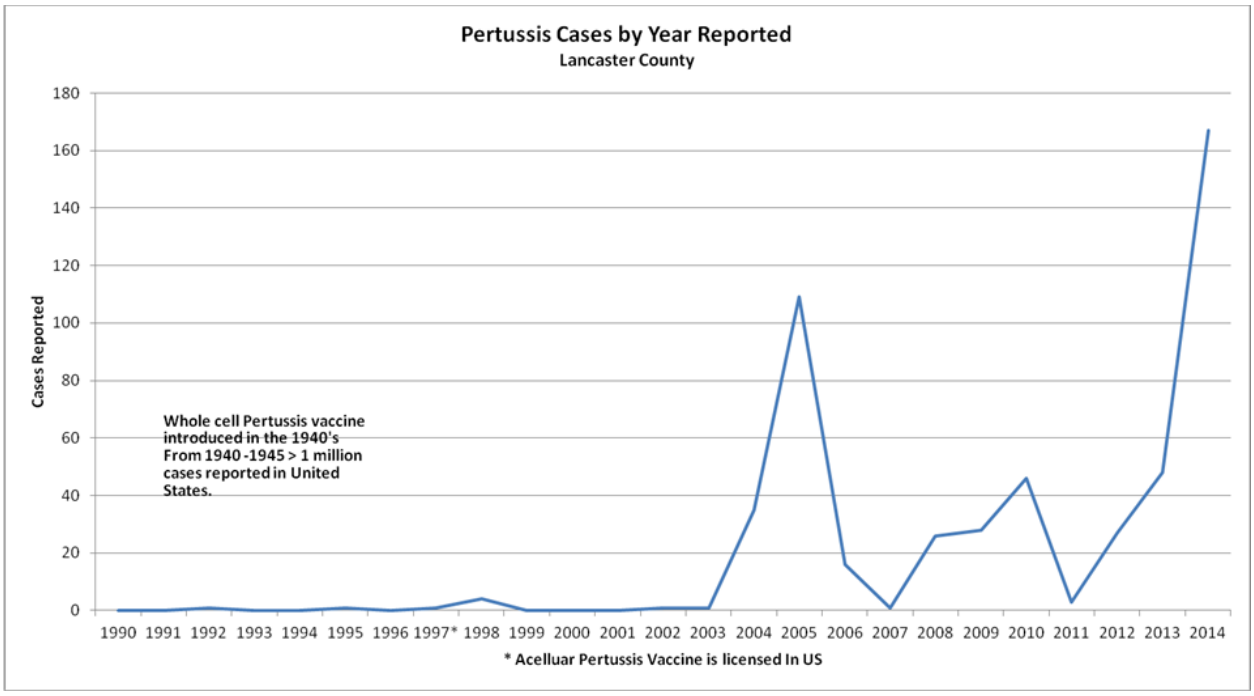
HIV	16	16	21	6	11	7	9
Chlamydia	996	1,108	1,033	1,234	1,346	1,383	1,490
Gonorrhea	353	283	238	251	390	320	299
Herpes Simplex (genital)	197	204	178	202	183	172	169
Syphilis (Primary)	0	0	1	2	0	4	3
Syphilis (Other)	2	10	7	8	10	9	20

Vaccine-Preventable Diseases

The case numbers for these diseases are not very large overall. Please note, in the case of influenza, the numbers are for confirmed cases and do not reflect the true dimensions of the pandemic H1N1 2009 flu outbreak of 2009-2010 or even for regular seasonal flu as providers usually don't report clinically-diagnosed cases once influenza is circulating in the community. Also, notably absent from the list are measles (English measles) and rubella (German measles) since there have been no local cases in recent years. Any case of measles locally would be a sentinel event as measles cases had been virtually eliminated in 2000 in the U.S. due to vaccination until the recent outbreaks associated with visitors to a California theme park. Most children receive a series of MMR (measles, mumps and rubella) shots that provide immunity to 90 percent of those vaccinated.

Of the six diseases listed, increases in pertussis (whooping cough) have been seen in the last several years, especially in the fall and winter of 2014-2015 when we experienced a local outbreak in the community. The chart below shows the rapid uptick in the number of cases and both the spikes in cases in some years (e.g., 2005, 2010, and 2014) and the low number of cases most years.

The increases are largely due either to waning immunity against pertussis (or situations where the vaccinations were not effective as not everyone seroconverts) among teens and adults who have been vaccinated; or, most certainly, those who have not completed the required number of doses. The case numbers continued to rise in early 2015 and the numbers probably understate the number of local cases as some individuals may be asymptomatic or never got diagnosed for a persistent cough. Whooping cough cases pose an especially difficult problem for infants six weeks and younger who cannot be vaccinated and they have a difficult time breathing with the disease. Infants who come down with pertussis generally need to be hospitalized.



Vaccines for hepatitis A and B are now common for younger populations, but older adults are more susceptible to these diseases. Hepatitis A affects the liver and is spread via the fecal-oral route. Small local outbreaks have occurred sporadically in recent years. Having no reported cases of hepatitis A in 2010 was unusual as there are typically a few cases every year. Hepatitis A is generally a self-limiting disease with few long-term repercussions, but it can result in epidemics if food is contaminated by a food handler with the disease; or if a food product such as lettuce is contaminated from the water supply or some other source. Hepatitis B is known to have infected up to a quarter of the world's population, but it is not as common (endemic) in North America. Unlike hepatitis A, hepatitis B is not spread by touch or contact, but is generally transmitted by the exchange of blood or other bodily fluids. Infants can contract hepatitis B from their mothers during childbirth and they need to receive the vaccine within the first 12 hours after birth and undergo a series of vaccinations. Acute cases of hepatitis B are self-limited, but persons with a chronic case of hepatitis B have a high risk of developing cirrhosis or liver cancer.

Sexually Transmitted Diseases

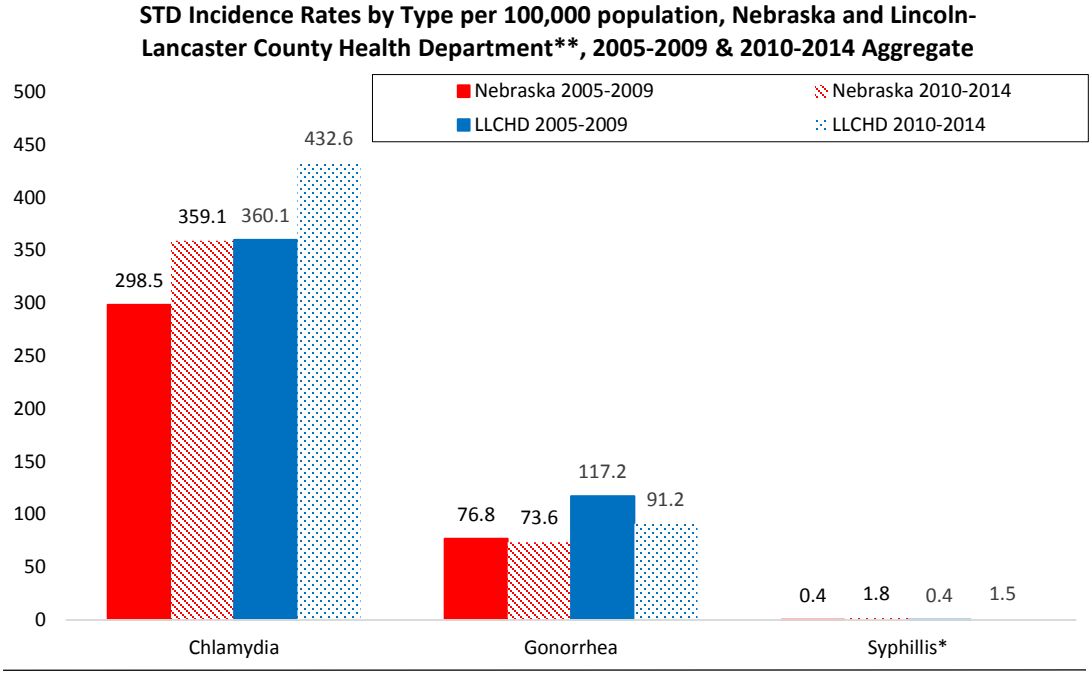
Sexually transmitted diseases may be underreported even though providers are required to report about patients with the disease. The data reported on sexually transmitted infections as shown in the table identifies chlamydia and gonorrhea as the most common sexually transmitted diseases (STDs) in Lancaster County followed by genital herpes. Until the last two years we had not had many cases of primary syphilis, but there were 4 cases in 2013 and 3 in 2014.

Chlamydia and Gonorrhea

Chlamydia affects both men and women and occurs in all age groups, but it is most prevalent in young women. Many people with chlamydia do not show any symptoms, but once chlamydia is

detected it is easily treated. If left untreated, chlamydia can lead to more serious health problems. In Lancaster County, chlamydia cases have been rising steadily for the past several years. The long-term trend of chlamydia rates has been upward as shown in the following graph. Lancaster County rates, while in line with national rates (sometimes a little above or below) have been consistently above the Nebraska rate.

Lincoln and Omaha are more urban than the rest of the state and both have a younger population although the disease is also increasing in numbers among middle aged individuals. Lancaster and Douglas Counties are also where the state's largest colleges and universities are located. When Lancaster County's chlamydia rate is compared to the Douglas County rate as shown in the following graph, our local rate is generally in the range of 60 to 80 percent of the Douglas County rate. While the rates have stabilized or dropped slightly the rates remain high and continue to need attention.



*Includes Primary and Secondary Syphilis
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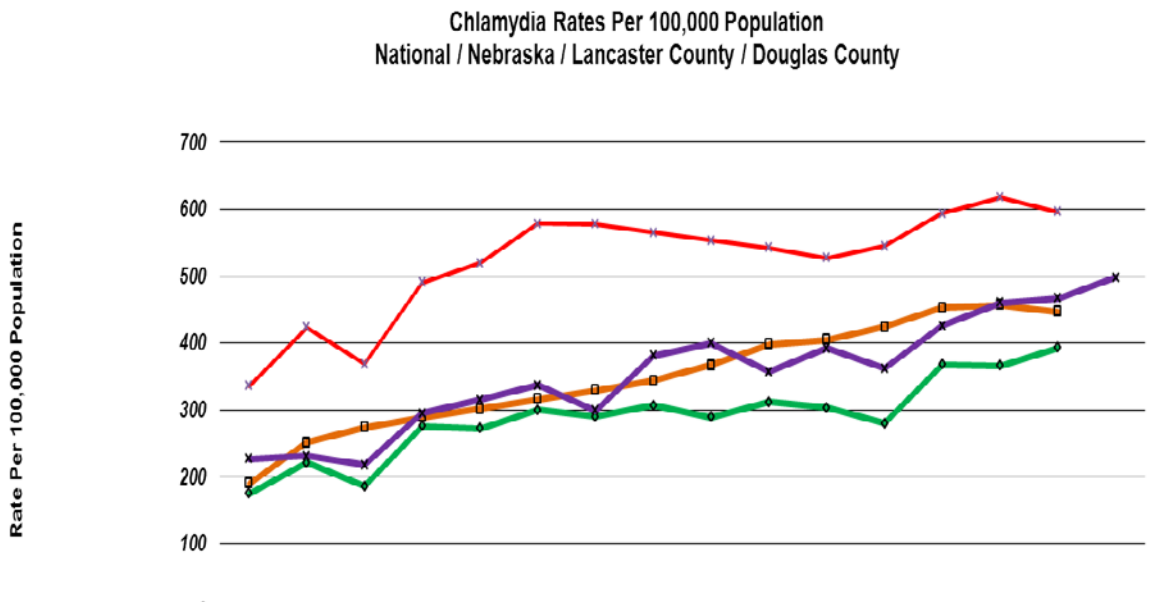
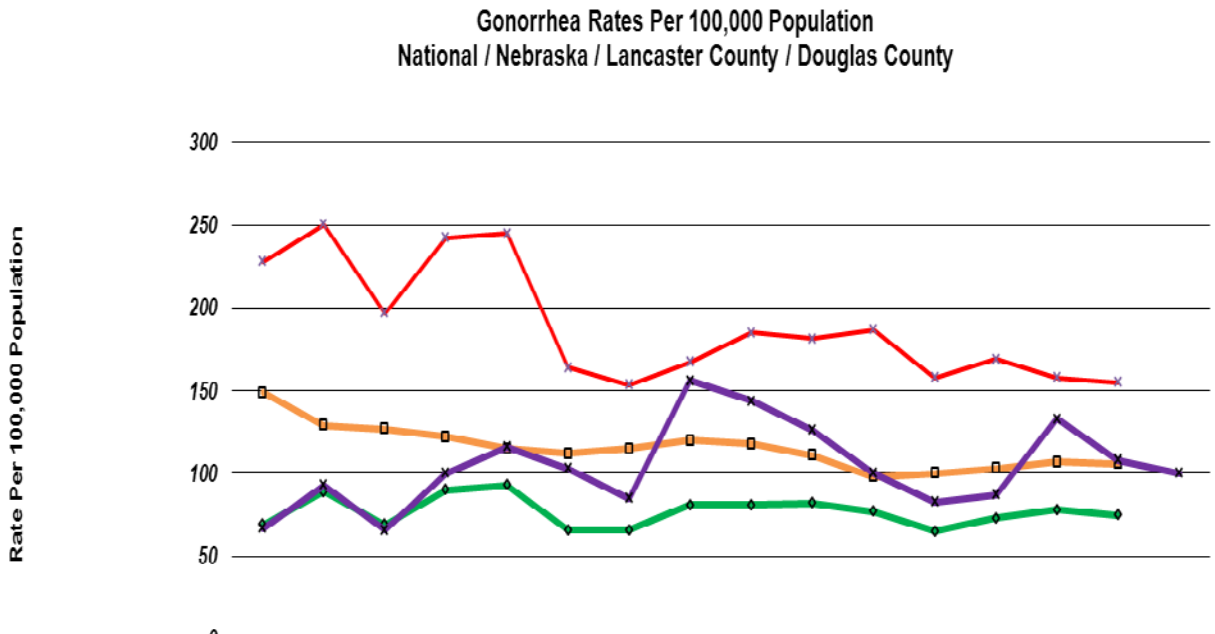


	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
National	190	251	274	289	302	316	329	344	367	398	405	424	453	457	447	
Nebraska	175	221	186	276	272	300	290	307	289	312	303	280	368	366	393	
Lancaster County	227	231	218	295	315	337	299	381	400	357	392	362	426	460	467	498
Douglas Co.	336	423	369	491	520	579	578	565	554	543	528	545	594	618	596	

Gonorrhea is the second most common sexually transmitted disease in the county. As is the case with chlamydia, both men and women may not experience any symptoms; or, if they experience symptoms, they may be mild. When present, symptoms include a painful or burning sensation during urination and both men and women may detect a discharge. In women, symptoms may be mild and the cases may not be quickly diagnosed as symptoms are similar to other conditions such as bladder infections. Women may pass the disease to babies during childbirth. Gonorrhea is treatable with antibiotics, but if untreated can lead to infertility in both men and women.

The data in the table below shows a decline in gonorrhea cases from 2006 to 2010, followed by an upturn to higher rates from 2011 to 2014 although the rates in 2013 and 2014 are below the recent peak in 2012. The graph also shows a much more volatile long-term pattern locally, a fairly stable pattern in Nebraska and a slow decline nationally. When Lancaster and Douglas County rates are compared, Douglas County has higher rates of gonorrhea although the Douglas County rates are showing a gentle decline over time and the Lancaster rates have approached the Douglas County rate in our peak years.



	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
National	149	129	127	122	115	112	115	120	118	111	98	100	103	107	106	
Nebraska	69	89	69	90	93	66	66	81	81	82	77	65	73	78	75	
Lancaster County	67	93	66	100	116	103	85	156	144	126	100	83	87	133	108	100
Douglas Co.	228	250	197	243	245	164	154	167	185	181	187	158	169	158	155	

HIV and AIDS

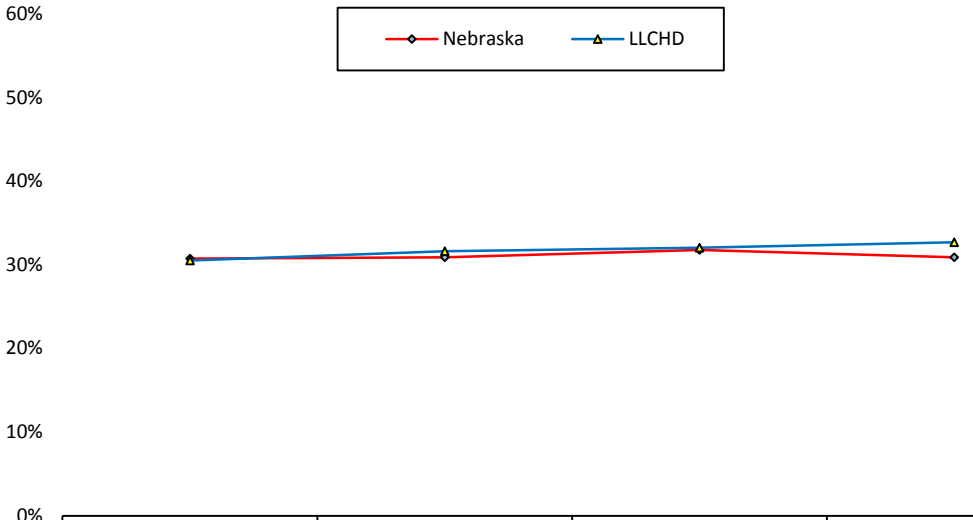
While relatively few in number, cases of Human Immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) cases are of special concern due to the life-threatening nature of AIDS. AIDS is a terminal disease, but anti-retroviral drugs have made it possible for persons with AIDS to live much longer with the disease. HIV is a virus (retrovirus) that causes AIDS. Infection with HIV occurs by the transfer of bodily fluids. The four major routes of transmission are unsafe sex, contaminated needles, breast milk and transmission from an infected mother to her baby at birth.

Most untreated people infected with HIV eventually develop AIDS. Those individuals mostly die from opportunistic infections or malignances associated with the progressive failure of the immune system. HIV progresses to AIDS at a variable rate affected by viral, host, and environmental factors; most will progress to AIDS within ten years of HIV infection.

The first local AIDS case occurred in 1983. HIV did not begin to be reported until 1995, and there was a spike in numbers. In the last several years, the number of both AIDS and HIV cases has generally been less than ten. AIDS cases peaked in 1994 (24) and the most recent peak was in 2004, when there were 14 cases. Most cases are associated with men having sex with men although an equal number of cases have not shown an identifiable link. Heterosexual transmission cases are increasing and cases linked to the use of injectable drug use are still

found. The chart below shows the data for persons who have sought testing for HIV and it is stable to slightly up over the 2010 to 2014 period.

Ever been Tested for HIV (other than blood donations)*, Adults 18 to 64, Nebraska and Lincoln-Lancaster County Health Department, 2011-2014**



	2011	2012	2013	2014
Nebraska	30.8%	30.9%	31.8%	30.9%
LLCHD	30.5%	31.7%	32.0%	32.7%

*Percentage of adults 18-64 year old who report that they have ever been tested for HIV/AIDS other than testing that may have occured during a blood donation
**Lincoln-Lancaster County Health Department encompases Lancaster County

Enteric and Other Communicable Diseases

Enteric Diseases

As a group the enteric diseases listed below are generally contracted through food or water, improper cooking or by poor practices by food preparers or servers. There is more discussion of these diseases in the Environmental Health section. Since most people suffer only short-term discomfort and may not seek medical treatment, it is likely that many cases of enteric disease are not reported, but the CDC estimates (based on a 2011 study) that 1 in 6 people will experience a foodborne disease during the year. These diseases are generally spread through the fecal-oral route, by ingesting contaminated food or drinking contaminated water. Eliminating cross contamination of food during preparation, proper hand washing and cooking or storing food at the proper temperature goes a long way in preventing many enteric diseases. Healthy individuals generally recover from these diseases quickly. However, persons with compromised immune systems, such as the elderly or AIDS patients, may experience severe illness or, possibly death.

Reportable Diseases (selected)	2008	2009	2010	2011	2012	2013	2014
Enteric Diseases (selected)							
Campylobacteriosis	50	46	72	71	37	49	50
Cryptosporidiosis	6	11	17	7	39	12	8
E-coli (Shiga toxin producing)	13	1	5	12	12	5	8
Giardiasis	34	20	43	35	59	54	48
Salmonellosis	27	76	31	31	40	44	41
Shigellosis	3	13	3	4	4	3	18

Campylobacteriosis is an infectious disease caused by a bacteria (genus *Campylobacter)*. One species, *Campylobacter jejuni*, is responsible for most human illness, but other species are responsible for illness in animals. *Campylobacter* is one of the most common causes of diarrheal illness in the U.S. While outbreaks are possible, most numbers of cases are associated with single or isolated case. Eating raw or undercooked chicken or cross-contamination of chicken juices and produce are the usual source of the disease. As the table indicates, in most years there are approximately 50 cases; in 2010 and 2011 the number of cases increased into the low seventies, but the cases were mostly isolated cases rather than an outbreak. The number of cases has dropped back to the normal numbers in 2013 and 2014. See more about campylobacter on the CDC site at http://www.cdc.gov/nczved/divisions/dfbmd/diseases/campylobacter/ .

Cryptosporidiosis and Giardiasis are parasitic diseases caused by protozoan parasites that generally live in water. The human case numbers for these two diseases are relatively few (20 or fewer cases of cryptosporidiosis and about 50 cases of giardiasis), except for 2012 when cases of "crypto" increased to 39 due to an outbreak. Giardiasis also reached a recent high in 2012 (59 cases), and the cases per year are somewhat volatile as they are associated with outdoor activities which vary with the seasons. The number of cases diagnosed in 2013, 2014, and 2015 are back to the normal range of giardiasis case numbers.

Salmonellosis is an infection with *Salmonella* bacteria. There are a number of different species of *Salmonella* and the source may be cattle, chicken, pork, eggs, egg products, milk, reptiles such as turtles, pet rodents or tainted fruits and vegetables. As can be seen, Salmonellosis cases have generally increased from the twenties to the mid-forties, except for the 76 cases due to an outbreak in 2009. The 2012 (40), 2013 (44) and 2014 (41) numbers reflect the current norm. The increased number of cases (76) in 2009 was due to an outbreak of a food-borne illness attributed to raw alfalfa sprouts (sprouts are a frequent source of food-borne illness and outbreaks). While salmonella may cause about a ninth (11 percent) of all foodborne illness cases, salmonellosis is the reason for the highest percentage of hospitalizations (35 percent) and death (28 percent) based on the 2011 CDC study.

In recent years, as shown in the table, the number of local cases of Shigellosis has been few, but there was a local outbreak of cases in 2014 totaling 18, which is the highest number of cases since 2009 when 13 cases were reported. Shigellosis is an infection caused by the bacteria *Shigella.* The usual mode of transmission is directly person-to-person hand-to-mouth, in the setting of poor hygiene among children. *Shigella* can be transmitted through food, including salads (potato, tuna, shrimp, macaroni, and chicken), raw vegetables, milk and dairy products,

and meat. Contamination of these foods is usually through the fecal-oral route. The two most common causes of contamination are water contaminated with fecal material and unsanitary practices by food handlers. Infants, the elderly, and the infirm are susceptible to the severest symptoms of disease, but all humans are susceptible to some degree.

The above table shows that the number of people confirmed to have contracted Shiga-toxin producing *E. coli* has ranged from one case in 2009 to 13 cases in 2008.The most common sources for Shiga toxin are the bacteria *Escherichia coli* (STEC), which includes serotypes O157:H7 and O104:H4. *E. coli* O157:H7 cases are found occasionally, but as can be seen in the table there has been no large outbreaks, rather more sporadic cases from time to time. *E. coli* can be killed by cooking meat to the proper temperature and most of the local cases have been due to undercooked meat. *E. coli* can also be present on produce due to contaminated fields or water supply.

[In reviewing the data for enteric disease, please note that one of the common diseases known for outbreaks, norovirus, is not included. Norovirus is responsible for almost 60 percent of cases of foodborne disease yet it is not a reportable disease except in an outbreak in the community associated with a restaurant, caterer or an outbreak at a school, nursing home, childcare center. The Health Department routinely gets involved in any outbreak associated with a regulated facility; but oftentimes, especially with norovirus cases, there are no laboratory-confirmed cases. Persons infected with the virus usually recover fully within days and, if there's a food establishment, childcare center, school, hospital or nursing home involved the usual outcome is that control measures are put in place (e.g., disinfection of the rooms and equipment, excluding sick staff or isolating attendees) to stop the spread.]

Reportable Diseases (selected)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Other Diseases (selected)							
Hepatitis C (Acute/Chronic)	284	185	181	192	139	240	183
Haemophilus influenzae (invasive)	11	4	6	6	3	1	4
Meningitis, Aseptic	19	25	14	26	10	6	8
Rabies in animals	4	13	6	4	10	4	6
Streptococcal Disease (invasive)	27	49	38	33	28	37	45
Tuberculosis	2	7	5	3	4	3	5
West Nile virus (includes fever plus nueroinvasive disease)	5	1	3	1	13	9	4

As for other diseases that we see in Lancaster County, Hepatitis C is an infectious disease of the liver caused by the hepatitis C virus (HCV). It is spread by blood-to-blood contact. There is no vaccine for hepatitis C. Hepatitis C can progress from an acute infection to become a chronic infection (i.e., a condition lasting longer than six months). Persons with chronic hepatitis C may experience scarring of the liver or liver cancer. Over the last two years the numbers (240 in 2013 and 183 in 2014) are up from 139 cases in 2012, but the recent numbers are on par with those seen from 2008 to 2011. The increase in cases in the last couple of years may reflect the fact that

clinicians are being asked to screen all people born between 1945 and 1970 for Hepatitis C as that birth cohort is most likely to have been exposed to the disease.

Naturally-acquired disease caused by *H. influenzae* seems to occur only in humans. In infants and young children, *H. influenzae* type b (Hib) causes bacteremia, pneumonia, and acute bacterial meningitis. Due to the routine use of the Hib conjugate vaccine in the U.S. since 1990, the incidence of invasive Hib disease has decreased to 1.3/100,000 in children. Locally, due to incomplete vaccination of the population there have been a few cases confirmed each year, with the highest number of cases (11) in 2008.

Invasive streptococcal disease can be severe and sometimes results in life-threatening illness. There have been between 27 and 49 cases found in Lancaster County each of the past seven years. Invasive streptococcal disease occurs when “group A streptococcal (GAS)” bacteria get into parts of the body where bacteria usually are not found, such as the blood, muscle, or the lungs; causing infection. Two of the most severe, but least common, forms of invasive GAS disease are necrotizing fasciitis and Streptococcal Toxic Shock Syndrome. Necrotizing fasciitis (occasionally described by the media as "the flesh-eating bacteria") destroys muscles, fat, and skin tissue. Streptococcal toxic shock syndrome (STSS), causes blood pressure to drop rapidly and organs (e.g., kidney, liver, lungs) to fail.

Tuberculosis (TB or MTB) is a common, and in many cases, a lethal infectious disease caused by various strains of mycobacteria. Tuberculosis usually attacks the lungs but can also affect other parts of the body. It is spread through the air when people who have an active infection cough, sneeze, or otherwise transmit their saliva through the air. Most TB infections in humans result in an asymptomatic, latent infection, and about one in ten latent infections eventually progresses to active disease, which, if left untreated, kills more than 50 percent of its victims. The table shows the active cases of TB confirmed in Lancaster County, where three to five cases have been diagnosed and treated annually over the past several years. Persons with TB are often immigrants to the U.S., but whose TB was latent when they migrated. Family members are the most at risk to contract the disease so spikes in numbers are often due to spread within a family. Treatment regimens generally last for six to nine months and persons with TB are generally monitored to make sure they are taking their medications in order to prevent the TB from becoming resistant to TB drugs.

West Nile virus (WNV) is spread by mosquitoes and infection caused by the virus can result in a potentially serious illness. This is especially true for persons 50 or older. Fortunately, most local cases have been West Nile fever rather than the more serious cases of West Nile Encephalitis or West Nile Meningitis. Experts believe WNV is established as a seasonal epidemic in North America that flares up in the summer and continues into the fall. Locally, after peaking at 129 in 2003, we experienced four cases in 2014 and the highest number (13) of recent cases was in 2012. There have been 6 cases of WNV fever and 2 cases of neuro-invasive WNV in 2015 through October.

Unintentional Injuries

Unintentional injuries, especially falls, are a significant source of morbidity in the county and they are the sixth leading cause of death overall. Unintentional injuries are in fact the leading cause of death for individuals ages 1 to 44. Injuries also may result in either short- or long-term disabilities. All injuries are classified by e-code and Nebraska hospitals are required to submit the data to the Nebraska Department of Health and Human Services (NDHHS). The Nebraska Hospital Association collects the injury data from hospitals and then transfers the information to the NDHHS. Since injury data are mandated these data are likely to be as complete as possible. Hospital discharge data from 2011 through 2013 show that there were 72,630 outpatient visits to hospital emergency rooms (2,010 per month) and 5,509 inpatient admissions (153 per month) to hospitals due to unintentional injuries. This more recent data suggests an increase in the number of outpatient visits to hospital emergency rooms per year, as well as an increase in the rate of inpatient admissions.

The following table shows the distribution of injury-related hospital visits, whether hospital outpatient (ER) visits or inpatient admissions, by age. It should be noted that the range for the age groups differ, with five-year spreads for children and young adults (20-24), but ten-year spreads for persons 25 and older.

2011-2013 Hospital Discharge Data (01/01/2011 through 12/31/2013)

	Age Group												
Total Injuries	**< 1**	**1-4**	**5-9**	**10-14**	**15-19**	**20-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75-84**	**85+**
Outpatient Visits	912	6,608	5,199	5,790	6,689	7,471	12,643	9,527	10,269	9,947	6,652	5,063	3,662
Inpatient Admissions	20	61	38	59	138	217	303	378	566	753	704	1,013	1,259

As shown in the graph below, falls are the reason for most outpatient and inpatient visits by a wide margin. While “Non-Fall” is the second leading reasons for outpatient visits, for a specific cause the next leading reason for outpatient visits from 2011 to 2013, are motor vehicle accidents, followed by poisoning, natural/environmental, fire/burn, with “Struck by, against” being the 6th most likely reason for outpatient visits. Information on the mortality caused by injuries is included in the next section on causes of mortality.

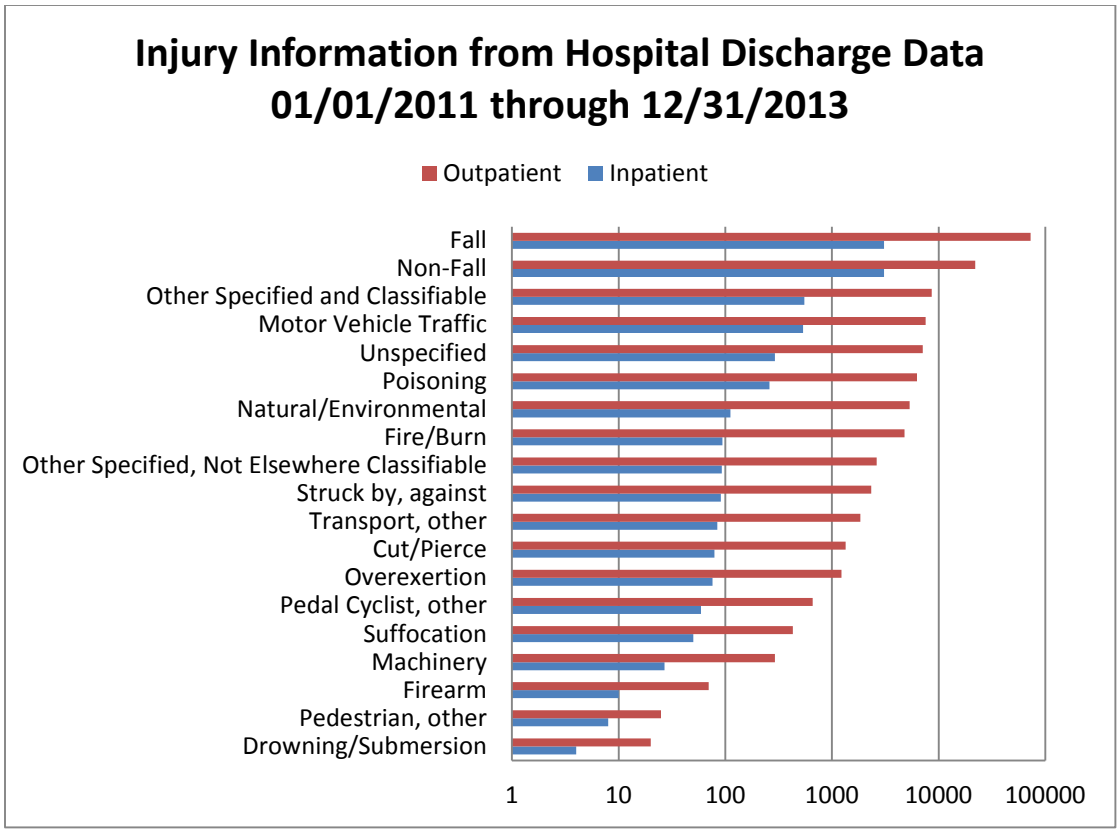


Figure 1: Injury Information from Hospital Discharge Data (01/01/2011 - 12/31/2013)

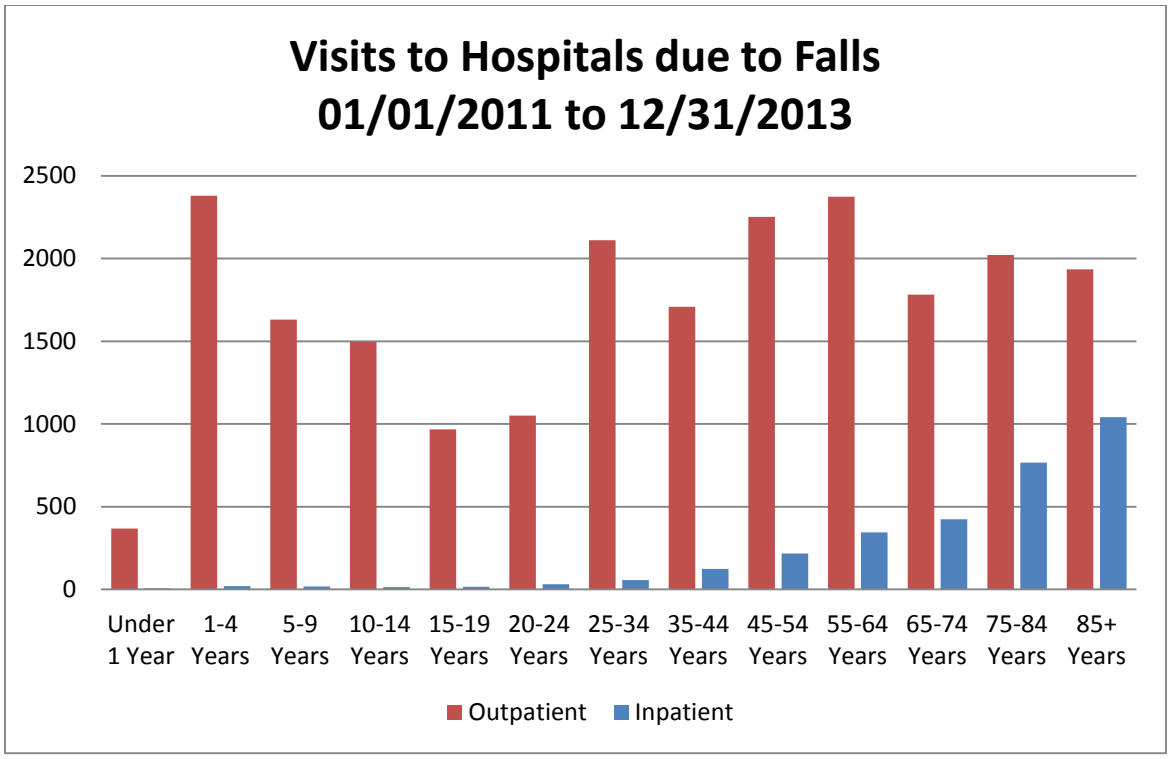


Figure 2: Falls by Age Group & Inpatient versus Outpatient Counts (01/01/2011 – 12/31/2013)

Due to the large number of fall-related outpatient visits and hospital admissions the second chart above shows falls by the age of the person falling, and distinguishes between outpatient visits and inpatient admissions. As can be seen, children 1 to 4 years old are frequently seen in the emergency room for falls and that age group has the highest number of falls. The ratio of inpatient admissions to outpatient visits for falls generally rises with the age of the victim, approaching ten percent for those 45 to 54 and rising to almost 60 percent for persons 85 and older who fall.

Mortality: Leading Causes of Death

The ten leading causes of death in 2005 and 2014 are shown in the following table and the Lincoln-Lancaster County Health Department website has a dashboard with birth and death data, by year from 2005 to 2014. Some of the information used in this section comes from 2013 as that is the latest Nebraska Vital Statistics Report with state data for comparison purposes.

Except for unintentional injuries, the leading causes of death generally increase with age. The average age at death in Lancaster County was 75.3 in 2013, slightly below the average age at death for Nebraska, which was 75.7 years in 2013, a new state record high. By age group, 63.3 percent of deaths in Lancaster County were in the 75 and older population, and 36.5 percent of deaths occurred among those 85 and older. Similarly, 63.1 percent of deaths statewide occurred in those 75 and older, while 37.8 percent of deaths occurred among those 85 and older. There are generally very few deaths in the age group from 1 to 14 and the NDHHS has a child death review team that examines the information about any child death. (Click here to see the Nebraska Child & Maternal Death Review Team Reports).

Leading Causes of Death in Lincoln-Lancaster County Health Department* (2005 vs. 2014)

2005				2014			
Rank	Cause of Death	Number Deaths	% of Total	Rank	Cause of Death	Number Deaths	% of Total
1	Cancer	410	24.1%	1	Cancer	454	22.1%
2	Heart Disease	343	20.2%	2	Heart Disease	380	18.5%
3	Stroke	131	7.7%	3	Chronic Lung	127	6.2%
4	Chronic Lung	96	5.6%	4	Unintentional Injury	105	5.1%
5	Unintentional Injury	78	4.6%	5	Stroke	93	4.5%
6	Diabetes	49	2.9%	6	Diabetes	54	2.6%
7	Alzheimer's	47	2.8%	7	Suicide	46	2.2%
8	Suicide	36	2.1%	8	Alzheimer's	45	2.2%
9	Pneumonia	34	2.0%	9	Renal Disease	43	2.1%
10	Parkinson's	30	1.8%	10	Parkinson's	37	1.8%
	LLCHD Total	1,700			LLCHD Total	2,057	

Source: Nebraska Vital Records

*Lincoln-Lancaster County Health Department encompasses Lancaster County

As can be seen from the data, cancer and heart disease are the top two leading causes of death and that has not changed over the decade. The order of the other causes of death has changed somewhat between 2005 and 2014 except for diabetes (sixth leading cause) and Parkinson's disease (tenth leading cause). Stroke deaths have dropped from the third leading cause of death in 2005 to fifth in 2014 while chronic lung disease and unintentional injury rose from being the fourth and fifth leading causes of death to third and fourth. While suicide and Alzheimer's disease reversed order, the numbers deaths in the bottom five of the ten leading causes of death are always close so the order is not particularly relevant. However, suicide deaths have risen significantly in the last couple of years, especially among teens and young adults after several years where the numbers were lower.

Selected Mortality Causes

As the data from the following table show, the age-adjusted death rates per 100,000 people are generally lower in Lancaster County in comparison the state. The exception is chronic lung disease. In this section the focus will be on certain causes of death of particular interest due to their numbers, their potential to be prevented, and their recent trend or some other salient characteristics.

2013 Age-Adjusted Death Rate per 100,000	**Lancaster County**	**Nebraska**
Deaths due to Cancer	146.5	161.3
Deaths due to Lung Cancer		53.7 M, 34.5 F
Deaths due to Prostate Cancer		21.5 M
Deaths due to Breast Cancer		0.3 M, 21.0 F
Deaths due to Heart Disease	127.8	147.7
Deaths due to Coronary Heart Disease		
Deaths due to Unintentional Injuries	22.9	34.8
Deaths due to Motor Vehicle Crashes		12.5
Deaths due to Chronic Lung Disease	48.8	44.3
Deaths due to Cerebrovascular Disease	33.6	36.2
Deaths due to Diabetes	18.7	21.8
Deaths due to Suicide	11.7	11.6
Deaths due to Homicide		4.2

Cancer (Malignant Neoplasm)

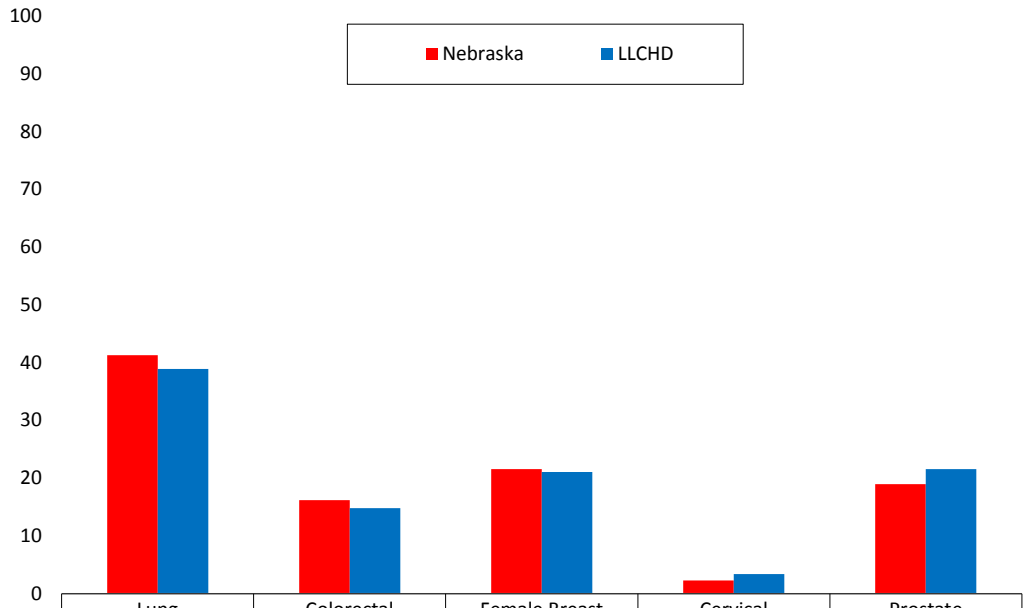
Cancer has been the leading cause of death in Lancaster County since 1999. In 2014, cancers were the cause of death for 454 persons, and over the five-year period, 2009 to 2013, there were 2,111 cancer deaths. Earlier in the report, the incidence of cancer was discussed and there are usually about 1,200 new cases of cancer of all types each year. The following table displays cancer deaths by site over the period 2008 to 2012 (the most recent data from the Nebraska Cancer Registry). As the mortality table shows, lung cancer deaths are the leading cause of cancer deaths, followed by colon cancer, breast and prostate cancer. The mortality rates in **bold**

for all cancer sites (154.3 per 100,000), female breast (15.6 per 100,000) and colon and rectum (14.1 per 100,000) are significantly lower than the Nebraska rates.

2008 to 2012 Reported Information (Nebraska Cancer Registry)

Cancer Mortality by Site	5-year total for Lancaster County	Lancaster County Cancer Rate per 100,000	Nebraska Number	Nebraska Cancer Rate per 100,000
All Sites	2,077	**154.3**	17,034	165.9
Lung & Bronchus	536	40.7	4,463	44.1
Female Breast	120	**15.6**	1,118	19.7
Colon & Rectum	191	**14.1**	1,763	16.9
Prostate	115	21.3	930	22.0
Urinary Bladder	58	4.5	426	4.0
Non-Hodgkin Lymphoma	87	6.6	99	7.3
Leukemia	99	7.3	728	7.1
Kidney & Renal Pelvis	61	4.5	460	4.4
Melanoma	38	2.8	315	3.1
Pediatric	11	2.8	74	2.9

Cancer Death Rates by Type per 100,000 population, Nebraska and Lincoln-Lancaster County Health Department*, 2014



	Lung	Colorectal	Female Breast	Cervical	Prostate
Nebraska	41.3	16.2	21.6	2.3	19.0
LLCHD	38.9	14.8	21.1	3.4	21.6

*Lincoln-Lancaster County Health Department encompases Lancaster County

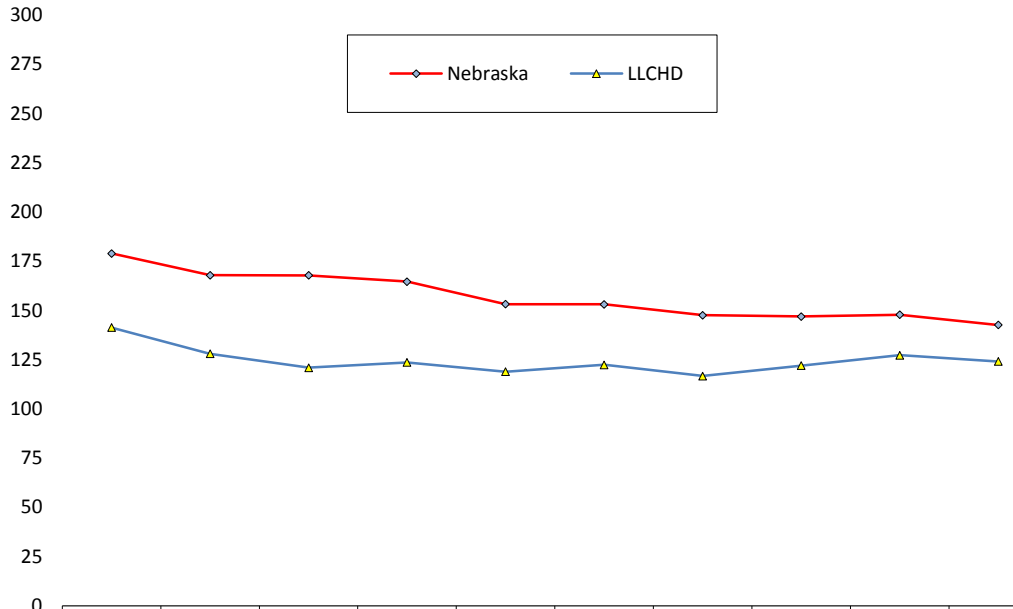
Both Nebraska and Lancaster County rates are close to the average national rates—see http://statecancerprofiles.cancer.gov/index.html.

In addition to cancer mortality, heart disease, stroke and diabetes deaths are areas of interest as heart disease is the second leading cause of death in the county and stroke and diabetes are lower than, but not significantly different than state rates. Also diabetes rates are increasing and there are often times co-morbidities associated with diabetes, including heart disease, even when diabetes is listed as the cause of death. All death rates are age-adjusted so that makes the comparisons with the state more comparable even with our relatively younger population.

Heart Disease

Locally, heart disease is the second leading cause of death for both men and women. Prior to 1999, heart disease had been the leading cause of death in the county. Statewide, in 2009 for the first time, heart disease dropped from the leading cause of death and became the second leading cause of death overall. Since then, cancer has been the leading cause of death in Nebraska overall; however, heart disease remains as the leading cause of death for women in the Nebraska.

Heart Disease Death Rate per 100,000 population (age-adjusted), Nebraska and Lincoln-Lancaster County Health Department*, 2005-2014



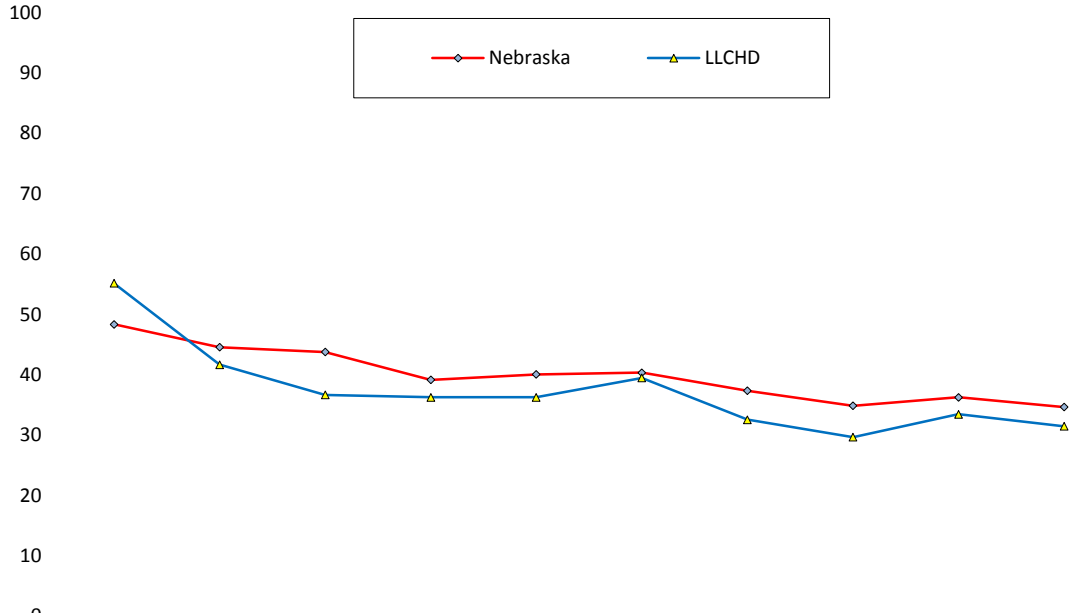
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	179.0	168.0	167.9	164.7	153.3	153.2	147.7	147.0	147.9	142.7
LLCHD	141.4	128.1	121.0	123.7	119.0	122.5	116.8	122.1	127.4	124.2

*Lincoln-Lancaster County Health Department encompases Lancaster County
Source: Nebraska Vital Records; National Center for Health Statistics

Heart disease is the leading cause of death in the U.S. for both men and women. As can be seen by the graph, heart disease death rates have been relatively stable locally in recent years after a decline from 2005. (Longer term declines would be significant if the chart included data back to the 1970s, 1980s or 1990s.) The Nebraska heart disease rate still shows a gentle decline overall, but the rates from 2011 to 2014 are again fairly stable. While the Lancaster County's heart disease death rate has been lower throughout this period, data for the last three years show that the gap is shrinking. Like diabetes and several other chronic diseases, heart disease can be prevented or reduced by changes in life style and by practicing good habits; namely never starting or stopping smoking, individuals knowing their numbers and treating high blood pressure and cholesterol, eating right, exercising and slimming down.

Stroke

Stroke Death Rate per 100,000 population (age-adjusted), Nebraska and Lincoln-Lancaster County Health Department*, 2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	48.4	44.6	43.8	39.2	40.1	40.4	37.4	34.9	36.3	34.7
LLCHD	55.2	41.7	36.7	36.3	36.3	39.5	32.6	29.7	33.5	31.5

*Lincoln-Lancaster County Health Department encompases Lancaster County
Source: Nebraska Vital Records

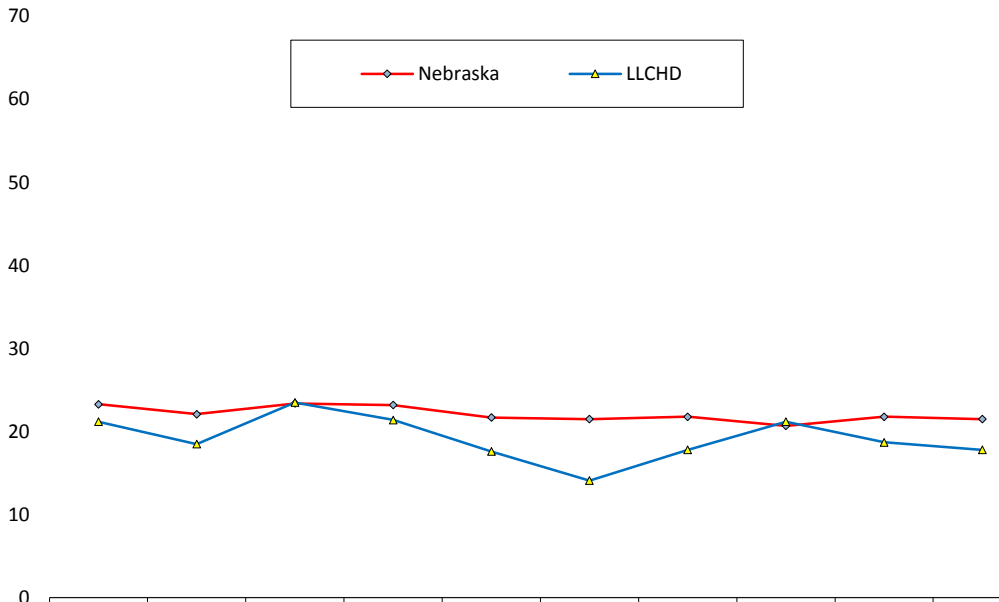
Stroke death rates are much lower than heart disease death rates, but generally the fourth or fifth leading cause of death in Lancaster County and Nebraska and a major cause of adult disability. Stroke is the fifth leading cause of death in the U.S. and about 800,000 people have a stroke each year. As might be expected based on the BRFSS data that showed Lancaster County residents and Nebraskans had experienced similar rates of having been diagnosed with stroke the rates are

very close to one another although Lancaster County rates are slightly lower than the state's rates.

Diabetes

As shown in the following graph the diabetes death rate difference between Lancaster County and the state is small and in two years (2007 and 2012) the rates were the same. The burden of diabetes is growing over time and it is estimated that 86 million Americans have diabetes. Diabetes is associated with obesity rates and as stated above, to a certain extent can be reduced or delayed through changes in lifestyle. Also, with the growing concern about diabetes, the recent focus on preventing childhood obesity is aimed at keeping upcoming generations from contracting the disease as children age into adulthood. Based on 2011-2014 BRFSS data (combined to better reflect accurate rates) Non-Hispanic African Americans (17.3 percent), Non-Hispanic Multiracial populations (11.5 percent), and Hispanics (11.5 percent) have a higher prevalence of diabetes than Non-Hispanic Whites (7.1 percent), and, while we don't have a local rate due to the small sample size, from state and national data we know that Native American rates of diabetes are also higher than for Whites, and that is likely true in Lancaster County for the Native American population.

Diabetes Death Rate per 100,000 population (age-adjusted), Nebraska and Lincoln-Lancaster County Health Department*, 2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	23.3	22.1	23.4	23.2	21.7	21.5	21.8	20.7	21.8	21.5
LLCHD	21.2	18.5	23.5	21.4	17.6	14.1	17.8	21.2	18.7	17.8

*Lincoln-Lancaster County Health Department encompases Lancaster County
Sources: Nebraska Vital Records

Injury-related Deaths

Injury-related deaths include deaths from unintentional injuries, suicides (intentional self-harm) and homicides. In 2013, in Lancaster County there were 66 unintentional injury deaths, 37 suicides (a significant increase) and 6 homicides, for a total of 109 injury-related deaths.

Unintentional injuries (accidents) alone were the sixth leading cause of death overall as of 2010, the fifth leading cause of death overall in 2013 and the fourth leading cause in 2014. As seen below, unintentional injuries ranked second when ranking deaths by Years of Potential Life Lost (YPLL) before 75 over the five years from 2010 to 2014, second only to cancer. On a yearly basis, intentional self-harm (suicide) was second in YPLL in 2013, as suicide was responsible for 1312.5 YPLL before 75 and unintentional deaths (accidental deaths) were responsible for 1177.5 YPLL before 75. Of the 66 deaths in 2013 from unintentional injuries, 19 were related to falls, 13 were related to transport accidents, 1 was a drowning and there were 33 other deaths from all other causes, including poisoning.

As can be seen from the following table for YPLL (Years of Potential Life Lost), All Injury (both unintentional and intentional injuries) represents the second highest number of potential lives lost (15,205) before the age of 75. [YPLL is usually calculated using 75 as the age since life expectancy is now in the seventies, but some reports use 60 or 65, which can change the order of categories as well as the size of the YPLL.]

Leading Causes of Years of Potential Life Lost (Before Age 75), Lincoln-Lancaster County Health Department*, 2010-2014 Combined

Rank	Cause of Death	Total Deaths	Total YPLL	Average YPLL Per Death
-	All Injury	608	15,205	25.0
1	Cancer	2,185	15,703	7.2
2	Unintentional Injury	411	8,738	21.3
3	Heart Disease	1,787	7,915	4.4
4	Suicide	166	5,220	31.4
5	Birth Defects	53	2,844	53.7
6	Chronic Lung Disease	618	2,127	3.4
7	Stroke	470	1,811	3.9
8	Diabetes	258	1,542	6.0
9	Homicide	31	1,248	40.3
10	Pneumonia	113	561	5.0

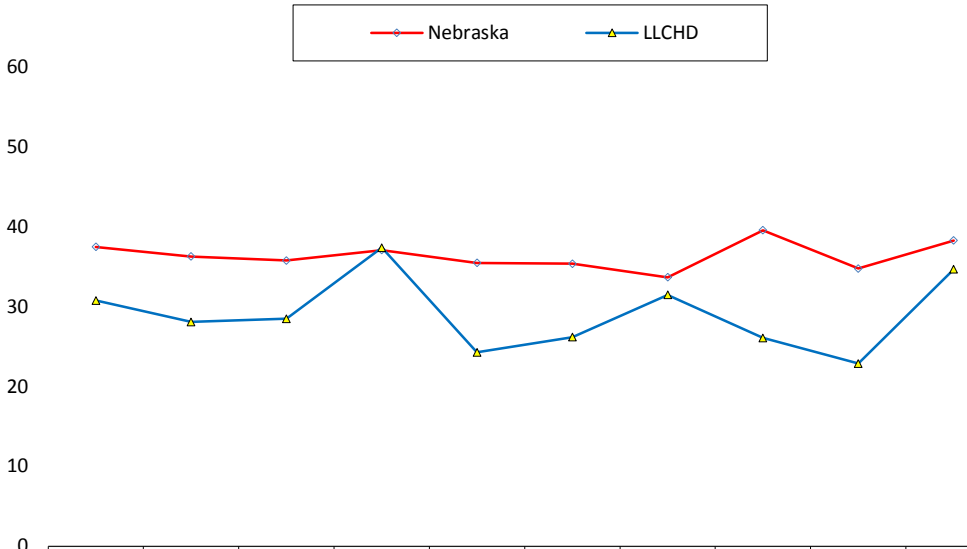
Source: Nebraska Vital Records

*Lincoln-Lancaster County Health Department encompasses Lancaster County

Due to its incidence overall (2,185 deaths over the five years), cancer represents the highest number of YPLL lost (15,708) but only by a slight margin over all injuries (15,205 YPLL from 608 deaths over the five years). However, when looking at the average YPPL per death, injury (25.0 average YPLL per death), unintentional injury (21.3 average YPLL per death), suicide (31.4 average YPLL per death), and homicide (40.3 average YPLL per death) all have an average YPLL per death rate higher than for cancer (7.2 average YPLL per death). The largest average YPLL per death is for birth defects (53.7 YPLL per death) due to the age of the infants and children who die from birth defects.

The graphs that follow show the Lancaster County and Nebraska death rates for unintentional injury and two of the types of unintentional injury deaths, motor vehicle crashes and falls, that are among the largest contributors to unintentional injury deaths. As can be seen, the rate of motor vehicle crash deaths in Lancaster County is generally well below the Nebraska rate. The local death rate for unintentional injuries overall is therefore also below the state rate except in some years where other injury deaths, such as those related to falls are particularly high (see 2008). Note also that the local death rate from falls was higher than the state rate from 2005 to 2009 and since 2010 the local and state rates are close to one another with the local rate being slightly lower.

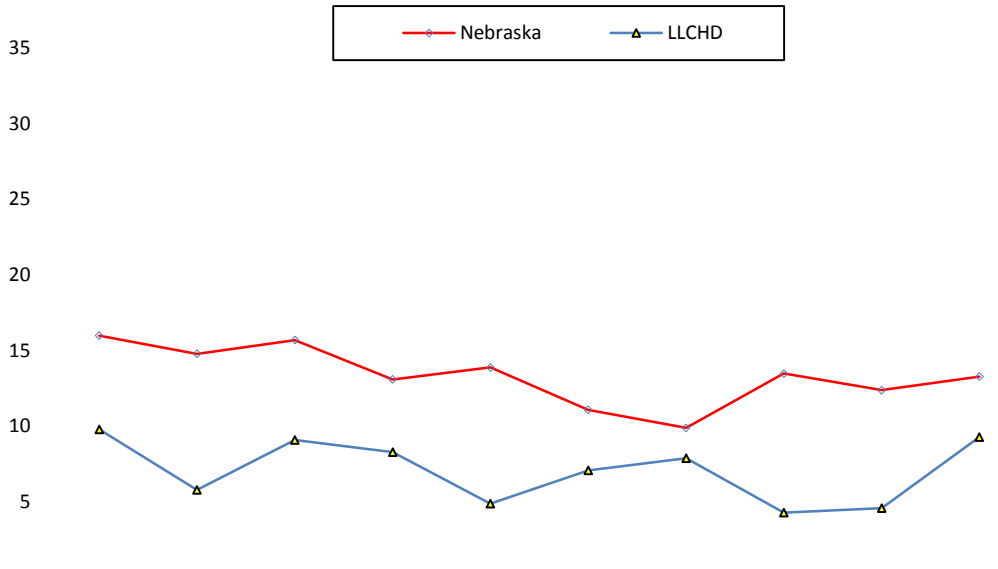
Unintentional Injury Death Rate per 100,000 population (age-adjusted), Nebraska and Lincoln-Lancaster County Health Department*, 2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	37.5	36.3	35.8	37.1	35.5	35.4	33.7	39.6	34.8	38.3
LLCHD	30.8	28.1	28.5	37.4	24.3	26.2	31.5	26.1	22.9	34.7

*Lincoln-Lancaster County Health Department encompases Lancaster County

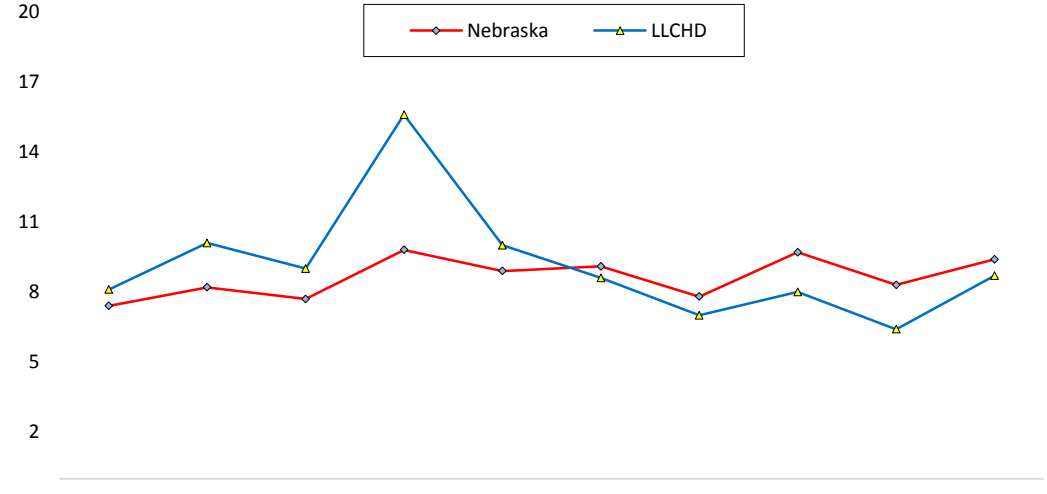
Motor Vehicle Crashes Death Rate per 100,000 (age adjusted), Nebraska and Lincoln-Lancaster County Health Department*, 2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	16.0	14.8	15.7	13.1	13.9	11.1	9.9	13.5	12.4	13.3
LLCHD	9.8	5.8	9.1	8.3	4.9	7.1	7.9	4.3	4.6	9.3

*Lincoln-Lancaster County Health Department encompases Lancaster County

Unintentional Fall Death Rate per 100,000 population (age-adjusted), Nebraska and Lincoln-Lancaster County Health Department*, 2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	7.4	8.2	7.7	9.8	8.9	9.1	7.8	9.7	8.3	9.4
LLCHD	8.1	10.1	9.0	15.6	10.0	8.6	7.0	8.0	6.4	8.7

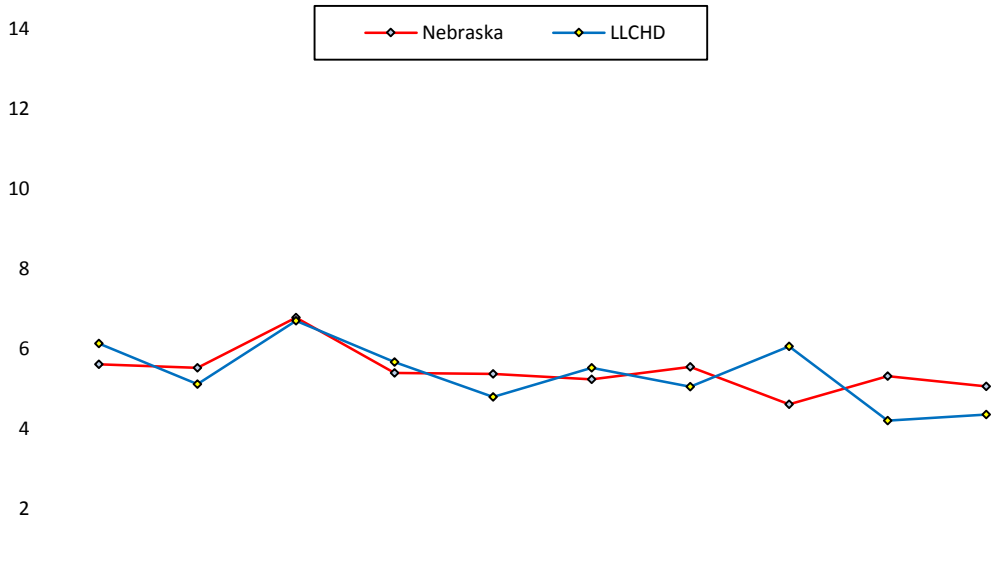
*Lincoln-Lancaster County Health Department encompases Lancaster County

Infant Deaths

The death of a child younger than one year of age is a key measure of the status of maternal and child health in a community. The infant mortality rate (the number of infant deaths per 1000 live births) is often used to compare communities, states and nations. By cause, as was indicated in the above table for leading causes of death, the principal cause of death for children under one is birth defects/congenital anomalies.

The trend in the infant mortality rate for Lancaster County has clearly been positive (a drop in the infant mortality rate) over the last 25 years, from 1984 to 2014, as the infant mortality rate has fallen from the 10+ rate in the nineteen eighties to the recent low of 4.2 in 2013. As shown in the graph below, our local infant death rate doesn't deviate much from the Nebraska rate except for the last three years—the local rate was higher in 2012 and has been lower in 2013 and 2014. The infant mortality rate in 2014 was at 4.4 infant deaths per 1,000 live births. Given the relatively small number of births (on the order of 4,100 per year), the infant mortality rate can be rather volatile year-to-year based on just a few more deaths any year.

Infant Mortality Rate* per 1,000 Live Births, Nebraska and Lincoln-Lancaster County Health Department, 2005-2014**



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	5.6	5.5	6.8	5.4	5.4	5.2	5.6	4.6	5.3	5.1
LLCHD	6.1	5.1	6.7	5.7	4.8	5.5	5.1	6.1	4.2	4.4

*Number of deaths to infants (less than 12 months old) per 1,000 live births
**Lincoln-Lancaster County Health Department encompases Lancaster County
Source: Nebraska Vital Records; National Center for Health Statistics

The ***Healthy People 2020*** objective to reduce the rate of all infant deaths was set at 6.0 infant deaths per 1,000 live births, which would be a 10% improvement from the national baseline of 6.7 infant deaths per 1,000 live births occurring with the first year of life in 2006. The local

infant mortality rate in recent years meet this national Maternal, Infant, and Child Health Healthy People 2020 standard (6.0 infant deaths per 1,000 live births) and also the Nebraska Healthy People 2020 standard of 4.8 infant deaths per 1,000 live births. Of note, racial disparities in the infant mortality rates continue to be a problem even though there has been some improvement over time. In 2013, the infant mortality rate for White babies was 3.9 per 1,000 live births (2012: 4.7 per 1,000 live births), the Black infant mortality rate was 16.5 per 1,000 live births (2012: 25.1 per 1,000 live births).

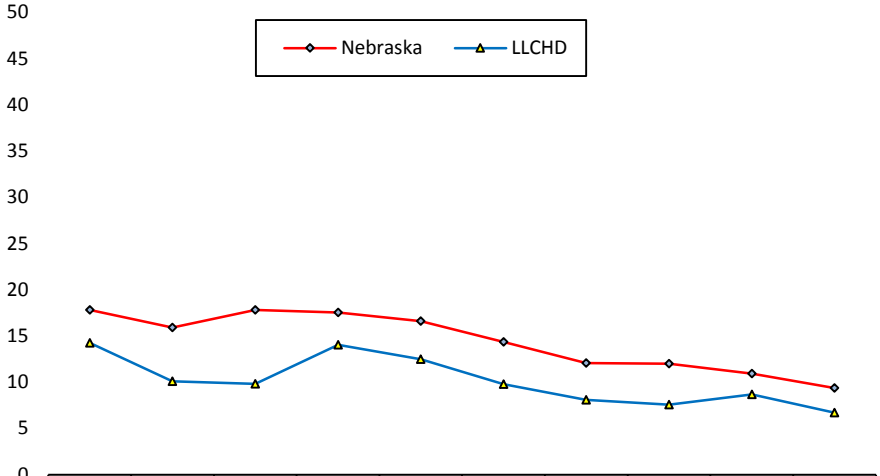
Maternal and Child Health

Vital Records: Birth Data

As was evident in reviewing the leading causes of death, vital statistics data are fairly rich with details related to deaths, but the data from birth certificates are even more informative. Birth certificates contain information related to the pregnancy, birth outcomes and characteristics of the mother and father. In 2005, Nebraska became one of the 31 states to modify its birth and death certificates to comply with the recommended national standards. Perhaps the most significant change in the birth certificate was the way of determining when the expectant mother began prenatal care. Prior to 2005, the information was self-reported by the mother. After the change, the information comes from the medical records completed by the providers.

- ***Births to Teenage Mothers:*** The number of births to teens (mothers under 20) rose slightly from 177 in 2013, to 180 in 2014; which is still down significantly from the 232 teen births in 2012, 198 teen births in 2011, and 241 teen births in 2010. The 2014 births represent a 25.3 percent decrease in birth numbers from 2012, and a 41.7 percent decline from 2003 when there were 309 teen births. The graph below looks at teen moms 15 to 17, and Lancaster County teen birth rates are consistently lower than the state rate.

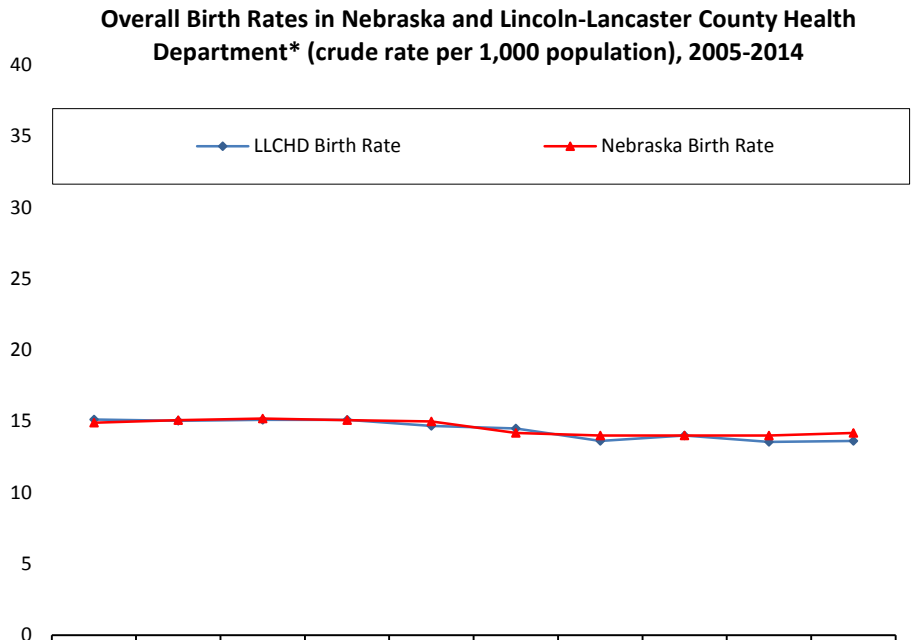
Teen Birth Rate among 15-17 year old females per 1,000 population, Nebraska and Lincoln-Lancaster County Health Department*, 2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	17.8	15.9	17.8	17.5	16.6	14.4	12.1	12.0	10.9	9.4
LLCHD	14.3	10.1	9.8	14.0	12.5	9.8	8.1	7.6	8.7	6.7

*Lincoln-Lancaster County Health Department encompases Lancaster County

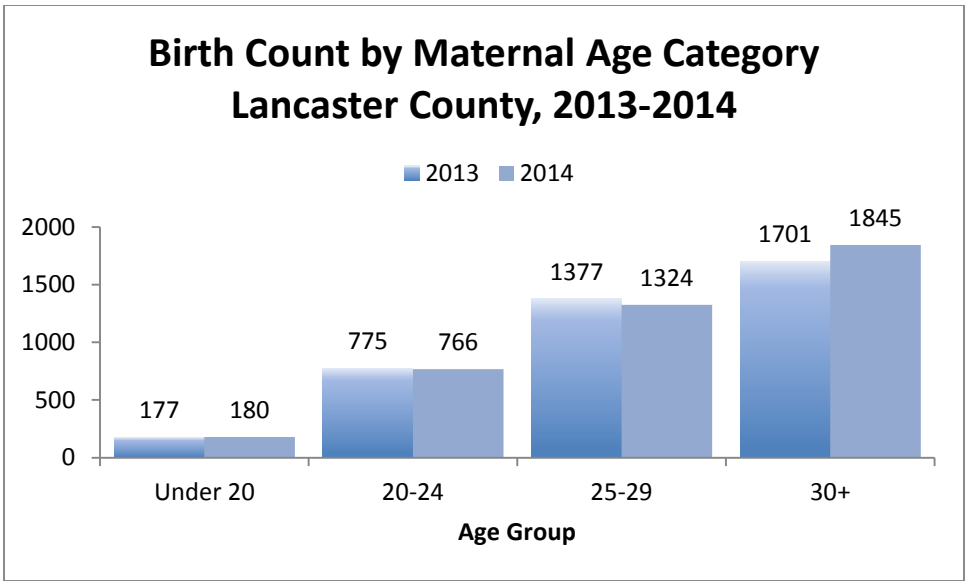
Births Overall: Based on the 2009-2013 ACS estimates 5,215 women in the age group 15 to 50 years old had a birth in the past 12 months, which yields a birth rate of 70 births per 1,000 women of child-bearing age. By age category, 19 per 1,000 women 15 to 19 years old had a birth, 117 per 1,000 women 20 to 34 years old had a birth, and 29 per 1,000 women 35 to 50 years old had a birth. The chart below shows that the Lancaster County birth rate overall is very close to or slightly below the state birth rate from 2005 to 2014 and the trend is down slightly.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
LLCHD Birth Rate	15.1	15.0	15.1	15.1	14.7	14.5	13.6	14.0	13.6	13.6
Nebraska Birth Rate	14.9	15.1	15.2	15.1	15.0	14.2	14.0	14.0	14.0	14.2

*Lincoln-Lancaster County Health Department encompases Lancaster County
Source: Nebraska Vital Records

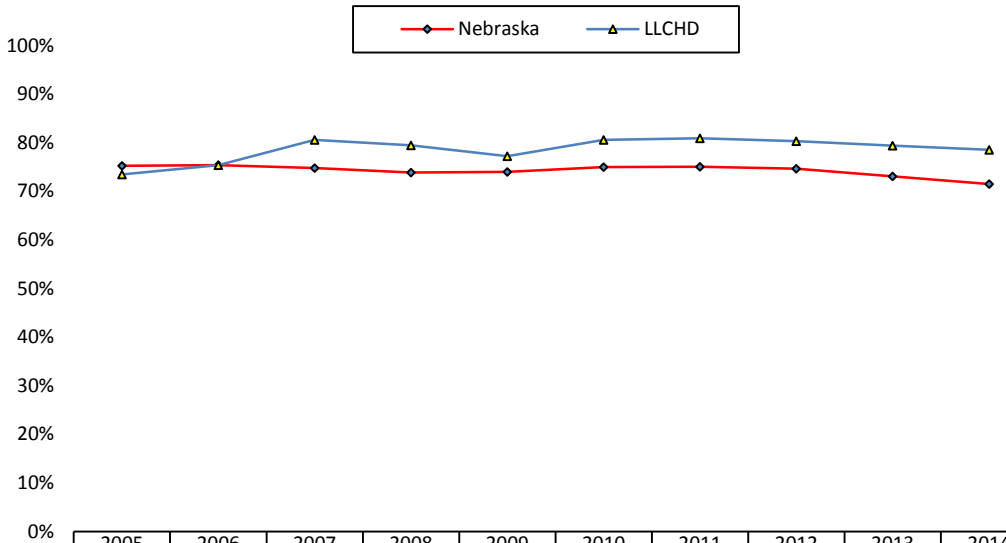
The number of Lancaster County births over this period peaked in 2008 (4,226 births) although the birth rate was at its highest at 15.1 births per 1,000 population in 2005, 2007 and 2008. The number of births to teens (mothers under 20) continues to decline from 309 teen births in 2003, 241 teen births in 2010, 177 teen births in 2013, and 180 teen births in 2014.



Overall Birth Statistics and Trends

Looking at the birth data overall, first trimester prenatal care rates in Lancaster County are higher than in Nebraska as shown in the chart below. However, as discussed below, there are differences in the initiation of prenatal care and the number of prenatal visits, especially by the younger mothers and minority race mothers.

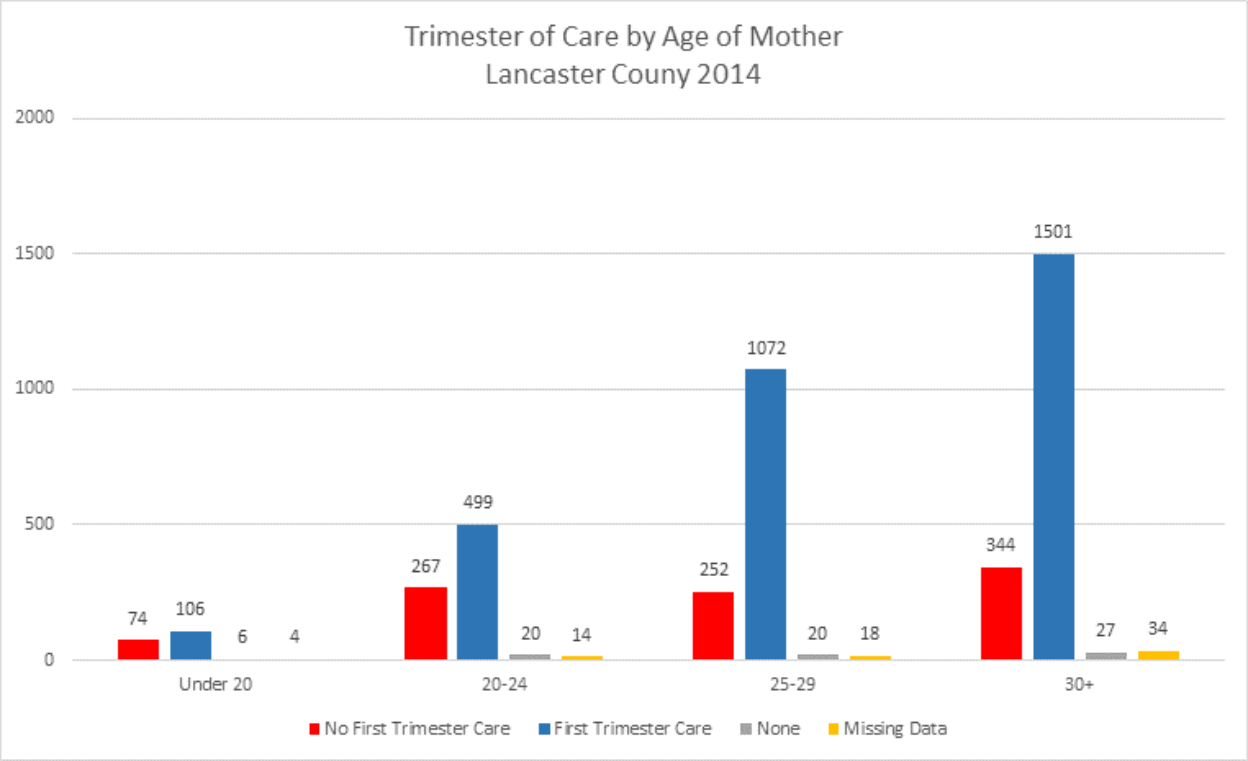
First Trimester Prenatal Care* in Nebraska and Lincoln-Lancaster County Health Department, 2005-2014**



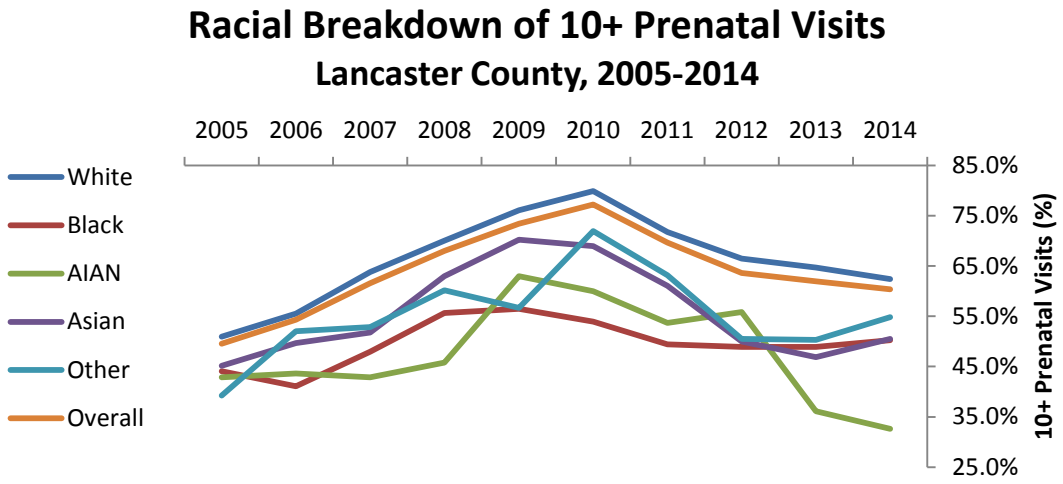
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	75.3%	75.4%	74.8%	73.9%	74.0%	75.0%	75.1%	74.7%	73.1%	71.5%
LLCHD	73.5%	75.4%	80.6%	79.5%	77.2%	80.6%	80.9%	80.4%	79.4%	78.6%

*Percentage of infants born to a woman receiving prenatal care beginning in the first trimester
**Lincoln-Lancaster County Health Department encompases Lancaster County
Source: Nebraska Vital Records

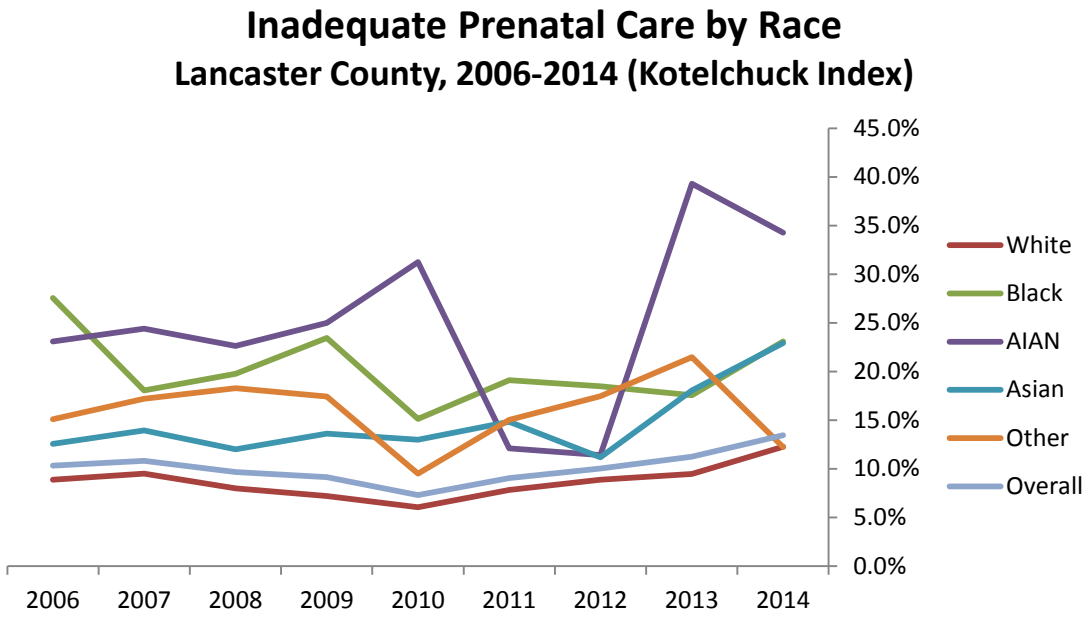
- In 2014, 78.6 percent of mothers were seen for prenatal care during the first trimester of their pregnancy. As age increases, so does the percentage of mothers beginning prenatal care in the first trimester (see chart below). Race is also a factor in when women begin prenatal care, as White women initiate prenatal care in the first trimester (72.8%) of their pregnancy, significantly more often than do Black women (52.2%) and American Indian/Alaskan Native women (47.2%) during their pregnancies.



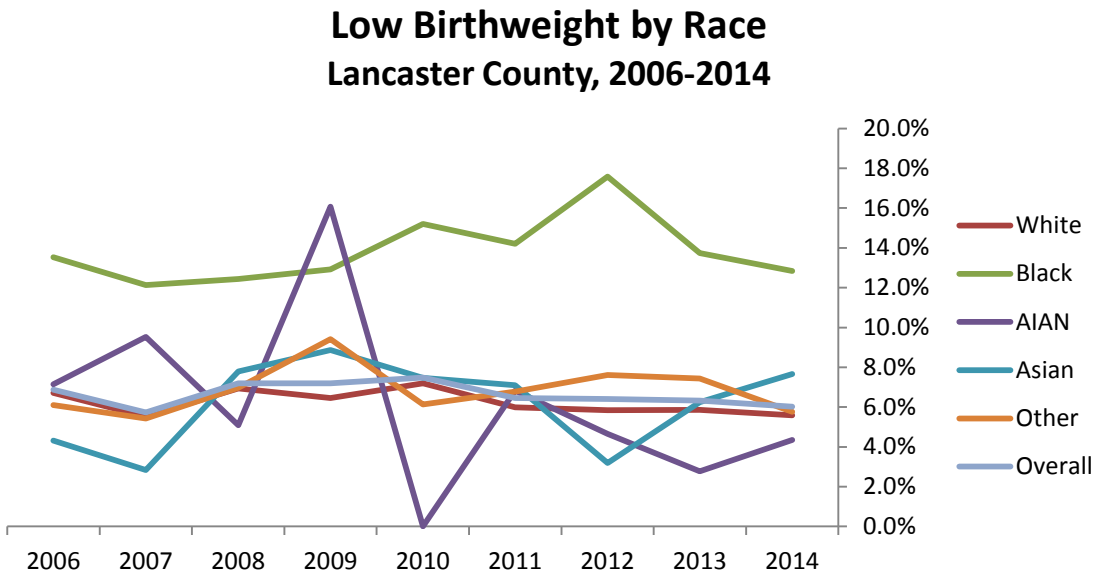
- In 2010, a high of 77.1 percent of expectant mothers had ten or more prenatal care visits. Ten visits are considered the standard. The chart below shows the improvement in this indicator from 2005 to 2010 and subsequent decline to 2014, where only 62.0 percent of mothers had ten or more prenatal visits. By race in 2014, White mothers (62.4%) were most likely to receive ten or more prenatal visits, while Hispanic (50.5%), African American (50.3%), American Indian/Alaskan Native (32.6), or Asian (50.5%) mothers were all significantly less likely to receive 10 or more prenatal visits.



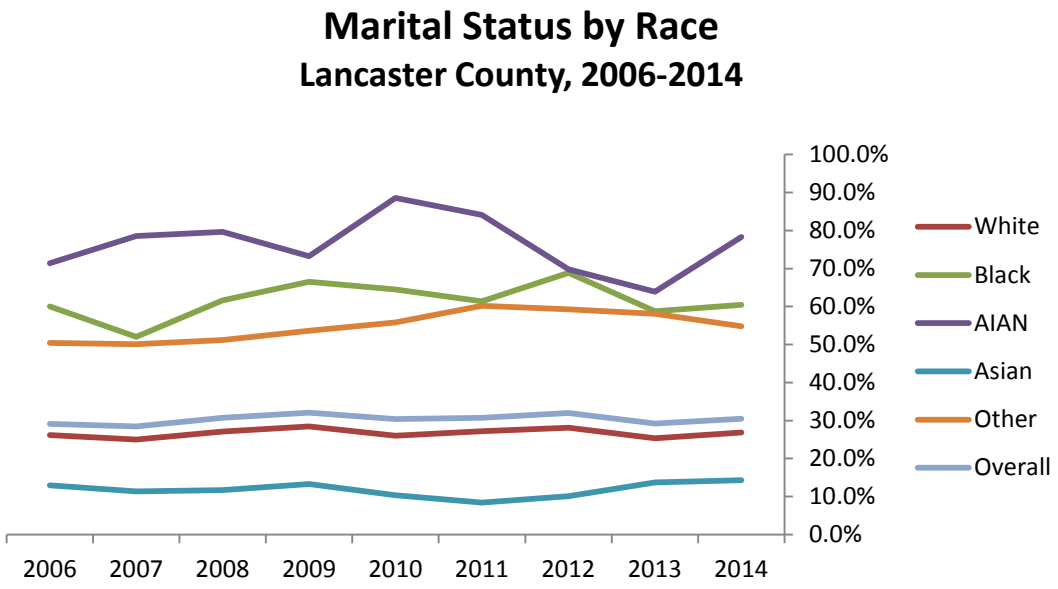
- The Kotelchuck Index (an index used by the Nebraska Department of Health and Human Services) measures adequacy of prenatal care (inadequate, intermediate, adequate, and adequate plus) by using a combination of the following factors: number of prenatal visits, gestation, and trimester prenatal care began. ***It is not a measure of the quality of prenatal care services received.*** In 2014, the percentage of Lancaster County births where the mother was determined to have received inadequate prenatal care by the Kotelchuck Index was 13.4 percent, signifying a steady increase in the number of pregnancies with inadequate prenatal care number of visits since 2010, when the rate was at an 8-year low of 7.3 percent. The mother's race continues to be an issue with utilization of prenatal care, as over the period from 2006 to 2014, White mothers received inadequate prenatal care under 12.5% of the time (low: 6.1%, high: 12.5%), while Black mothers (low: 15.1%, high: 27.6%), American Indian and Alaskan Native mothers (low: 11.4%, high: 39.3%), Asian mothers (low: 11.2%, high: 22.9%) all experienced higher than normal rates of inadequate prenatal care, as depicted by the chart below.



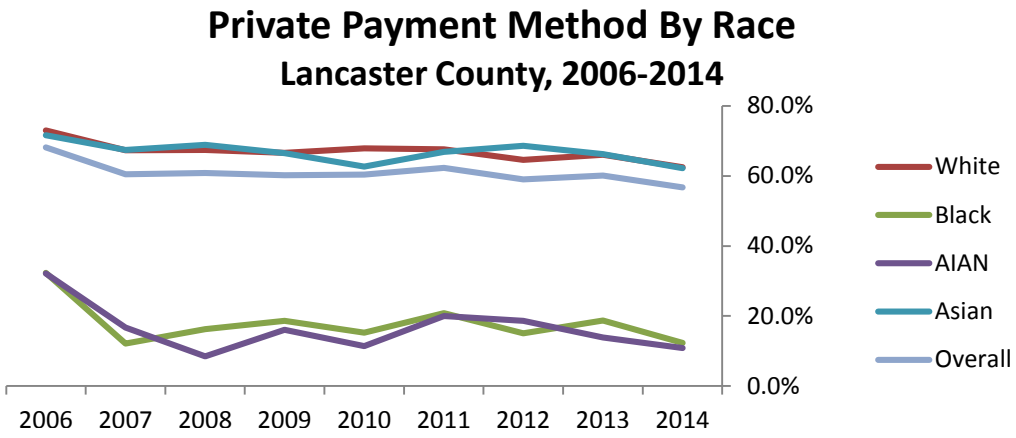
- In 2014, 6.0 percent of babies were born at a weight that classified them as low birth weight (LBW) babies, meaning that their birth weight was below 2500 grams or approximately 5 pounds, 9 ounces. In 2010, when 7.5 percent of babies were considered low birth weight, which was increase from 2008 and 2009 when the LBW rate was 7.2 percent. Although the trend oscillates between 5 to 8 percent for the overall rates, Black infants consistently show a higher LBW rate (12.1% low in 2007 to 17.6% high in 2012). The average overall rate was 6.6 percent from 2006-2014, but the average Black LBW rate was 13.9 percent.



- The long-term trend in the percent of mothers who are unmarried continues to range from 29 to 32 percent. American Indian and Alaskan Native mothers were the most likely to be unmarried, although their unmarried rate is declining slightly (76.3% 2006-2014, 74.6% 2011-2014), followed by Black mothers (61.8% 2006-2014, 62.5% 2011-2014). Asian mothers are the least likely to be unmarried at the time of delivery (11.8% 2006-2014, 11.7% 2011-2014). White mothers also have a low unmarried rate relative to non-Asian minorities and their unmarried rate remains fairly steady (26.7% 2006-2014, 26.9% 2011-2014).

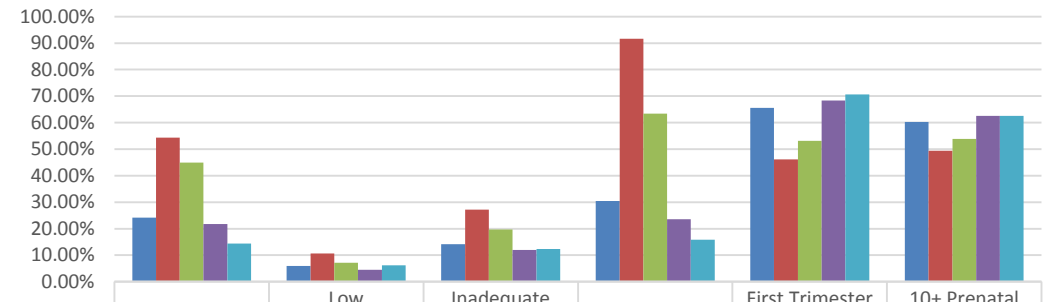


- Medicaid was the primary payer for 33.8 percent of Lancaster County births in 2010, which was below the 2009 rate of 36.2 percent. From 2006 to 2014, the primary payer for 32.8% of births was Medicaid and 60.9% of costs were paid for by Private Insurance. As shown by the following chart, the payment method varied by race, as Black and American Indian/Alaskan Native mothers were much more likely to utilize Medicaid, while White and Asian mothers were much more likely to utilize Private Insurance. There was minimal variation from this mean by race or for the overall rate.



Information by Mother's Age

While the overall rates presented above are generally as good as or better than comparable state and national measures or outcomes, when the data are analyzed by age group, there are some notable differences, especially for those mothers under 20 (teens). The chart below presents the percentage of Lancaster County births with Medicaid as their payment method, low birthweight, inadequate prenatal care based on the Kotelchuck Index, unmarried status, first trimester care and 10 or more prenatal visits, which are all important factors to consider when considering maximizing the likelihood of a positive pregnancy outcome.



	Medicaid	Low Birthweight	Inadequate Prenatal Care	Unmarried	First Trimester Care	10+ Prenatal Visits
All Ages	24.20%	6.00%	14.10%	30.50%	65.60%	60.30%
Under 20	54.40%	10.60%	27.20%	91.70%	46.10%	49.40%
20-24	44.90%	7.20%	19.70%	63.40%	53.10%	53.87%
25-29	21.80%	4.50%	12.00%	23.60%	68.40%	62.50%
30+	14.40%	6.20%	12.40%	15.80%	70.70%	62.50%

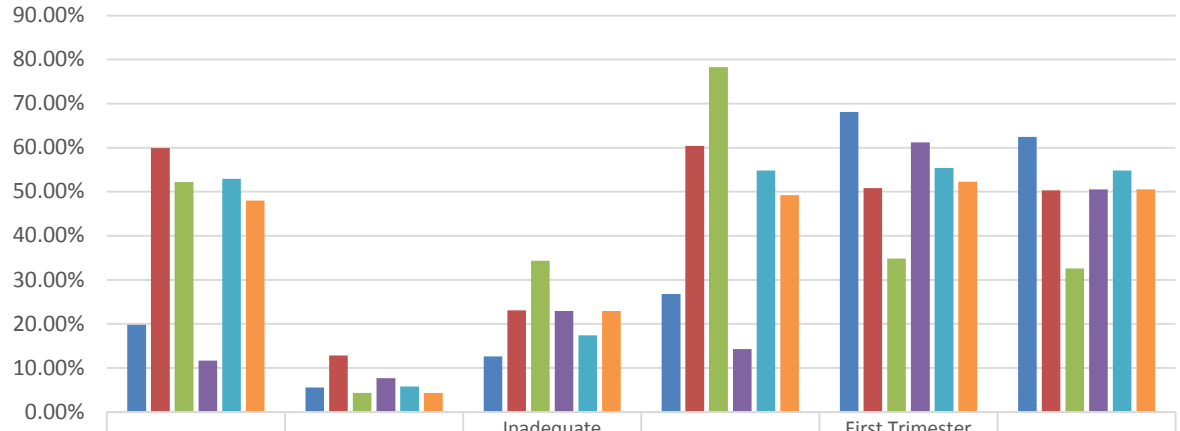
While the trend in unmarried mothers has been steadily increasing over time throughout Nebraska and the nation, the cohort with the highest percentage of unmarried mothers is those under 20. In 2014, 91.7 percent of mothers were unmarried at the time of delivery, which is representative of the increase across all age groups. Also, for this under-20 cohort, 54.4 percent

of the mothers listed Medicaid as the primary payer for medical and hospital costs. These young moms started prenatal care at a later time (only 46.1 percent began care in the first trimester of their pregnancy) and, correspondingly, only 49.4% had made ten or more prenatal visits before their delivery. Applying the Kotelchuck Index to this age group's prenatal care record shows that mothers under 20 are much more likely to fail to receive adequate prenatal care compared to other age groups. Adequate prenatal care increases the chances for a favorable birth outcome so it is not surprising that the rate of LBW babies for these mothers is higher than older moms, but there are also other factors that influence LBW births by teen moms.

The above table also clearly indicates that with increasing age the likelihood the mother is married increases, which is important considering the support a spouse helps provide throughout a pregnancy. The table also reflects mothers under 20 years of age are more likely to utilize Medicaid as their method of payment than other age groups, reflecting a lack of private insurance and/or the financial security to cover the costs. It also suggests a difficult future dealing with the expenses of parenthood.

Information by Mother's Race/Ethnicity

When birth data are examined by the mother's race and/or Hispanic ethnicity for the selected characteristics (marital status, Medicaid utilization, low birthweight, Kotelchuck Index, first trimester care & 10+ prenatal visits) patterns emerge clearly depicting racial and ethnic disparities in our community. There are many underlying factors contributing to these disparities. A general review of the racial disparities is shown below for various birth and maternal child health measures.



	Medicaid	Low Birthweight	Inadequate Prenatal Care	Unmarried	First Trimester Care	10+ Prenatal Visits
White	19.80%	5.60%	12.60%	26.80%	68.10%	62.40%
Black	59.90%	12.80%	23.10%	60.40%	50.80%	50.30%
AIAN	52.20%	4.30%	34.30%	78.30%	34.80%	32.60%
Asian	11.70%	7.70%	22.90%	14.30%	61.20%	50.50%
Other	52.90%	5.80%	17.40%	54.80%	55.40%	54.80%
Hispanic	48.00%	4.30%	22.90%	49.20%	52.30%	50.50%

Reviewing the mother's characteristics by race/ethnicity reveals:

- Overall, 29.2 percent of mothers are unmarried at the time their baby is born, but there are clear distinctions by race. Asian mothers are unmarried least often (14.3%) followed by White mothers (26.8%). In comparison, African American mothers (60.4%), American Indian and Alaskan Native mothers (78.3%) and Hispanic mothers (49.2%) are more likely to be unmarried when they deliver their babies.

- Overall, 6.0 percent of births were LBW births in 2014, which is the second lowest overall rate between 2006 and 2014, behind only the 5.7% LBW births in 2007. While American Indian and Alaskan Native LBW rates vary significantly due to the smaller number of births to this race, all other races' LBW rates are relatively stable. Of particular concern is the continued elevated Black LBW rates of 12.8% in 2014 (2006-2014, 13.9% average).

- The percentage of mothers who received inadequate or no prenatal care as defined by the Kotelchuck Index was 13.4% in 2014. However, White mothers (12.3%) heavily skew this overall rate. The rates of inadequate prenatal care for African American mothers (23.1%), American Indian and Alaskan Native mothers (34.3%), Asian mothers (22.9%) and Hispanic mothers (22.9%) are all elevated when compared to the rate for White mothers.

Environmental Quality

Our Environment and Our Health

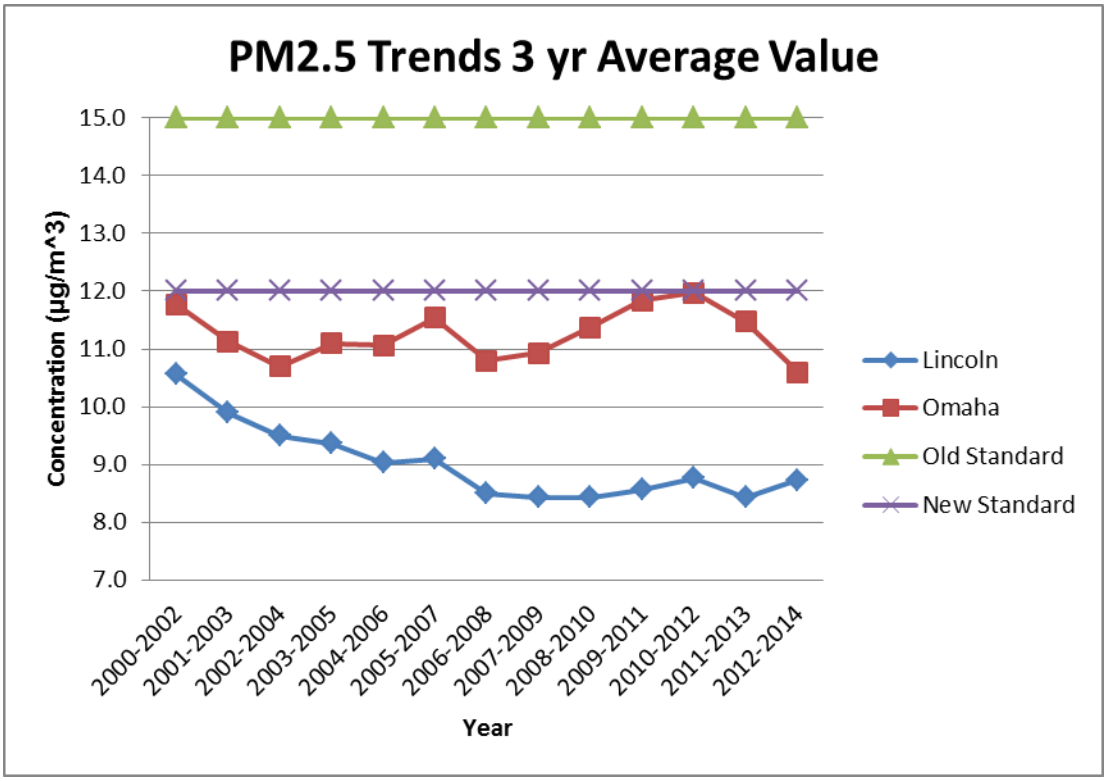
Our environment impacts our health through the air we breathe, the water we drink, the food we consume, and other environmental exposures, such as toxic materials. In addition, land use planning decisions can impact our health by affecting how much pollution is emitted through transportation choices or how close residential housing, schools or older adult living facilities are allowed to locate near environmental hazards, such as railroads, industrial zoning, and hazardous materials pipelines. The Lincoln-Lancaster County Environmental Health Division exists to protect people from the health effects of environmental exposures; and to prevent illness and disease that might be caused by environmental source.

Air Quality

It is generally recognized that air pollution can cause breathing difficulties for people with asthma and Chronic Obstructive Pulmonary Disease (COPD). However, there is also strong evidence that short term exposures to higher levels of air pollution can increase the risk of heart attack, stroke, arrhythmias, and heart failure in people with pre-existing cardiovascular disease. Furthermore, the American Heart Association posts that current science suggests that longer term exposure to air pollution facilitates atherosclerosis and may play a role in high blood pressure, heart failure and diabetes.

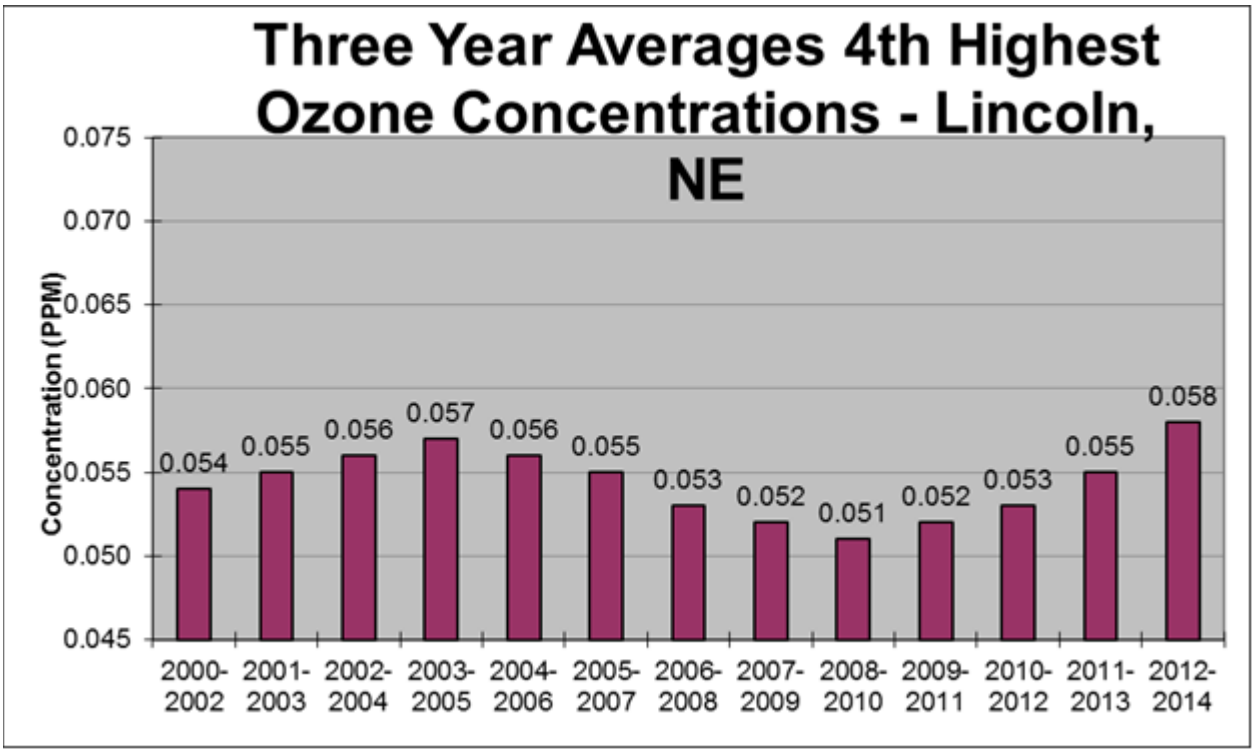
The Clean Air Act is the comprehensive federal law that regulates air emissions from stationary and mobile sources and requires the U.S. Environmental Protection Agency (EPA) to establish National Ambient Air Quality Standards (NAAQS) to protect public health and public welfare and to regulate emissions of hazardous air pollutants. The NAAQS are reviewed every five years to assure they are protective of people's health. EPA establishes air pollution emission requirements for cars and trucks, off road vehicles, equipment and permanent sources of air pollution. EPA and the State of Nebraska have delegated the responsibilities of monitoring air quality, writing permits for new and existing sources of air pollution, providing compliance assistance, inspecting businesses and industry, inventorying air pollution emissions, and enforcing regulations to the Lincoln-Lancaster County Health Department. All such activities are intended to protect people from air pollution, thereby improving community health status.

Air quality in Lincoln and Lancaster County is typically very good, with our entire jurisdiction maintaining compliance with the National Ambient Air Quality Standards. The following graph shows the values for fine particulate matter (PM 2.5) on a three-year average basis and the rates are well below the current standard. Thus, everyone in Lincoln usually breathes air that does not pose a significant risk to their health.



However, several days each year PM 2.5 does exceed levels which are known to impact people's health. PM 2.5 is made up of very small particles less than 2.5 microns in diameter which can go deep into the lungs. In the spring, the most common source of high levels of PM 2.5 from smoke from extremely large grass fires in Kansas' Flint Hills region. These controlled burns are conducted every year, and south winds, which are common in the spring, bring the smoke to Lincoln resulting is multiple hours of poor air quality. And, fireworks in the city of Lincoln on the 4th of July also result in very high levels of PM 2.5. Local burning is closely regulated by the Health Department to prevent health impacts.

Lincoln has also maintained compliance with the current ozone standard, which is a second measure of air quality. Ground level or "bad" ozone is not emitted directly into the air, but is created by chemical reactions between oxides of nitrogen (NOx) and volatile organic compounds (VOC) in the presence of sunlight. Emissions from industrial facilities and electric utilities, motor vehicle exhaust, gasoline vapors, and chemical solvents are some of the major sources of NOx and VOC. Breathing ozone can trigger a variety of health problems, particularly for children, the elderly, and people of all ages who have lung diseases such as asthma. Ground level ozone can also have harmful effects on sensitive vegetation and ecosystems. The chart showing the three-year average ozone concentrations indicates an upward trend, with a 2012-2014 concentration of 0.058 parts per million (58 parts per billion or PPB) for the annual fourth-highest daily maximum 8-hour concentration, averaged over three years. Lincoln's rates, while trending up in recent years, are still below the current standard of 75 PPB (or 0.075 parts per million). In 2015, the EPA is proposing to lower that standard, perhaps somewhere between 65 and 70 PPB. Even with the new standard Lincoln should continue to be in compliance.



Water Quality

Much like air, water is required for human life. Safe uncontaminated water is of utmost importance to the health of every person. Numerous disease-causing organisms and chemical contaminants can be transmitted via water and can have serious health effects. These contaminants may enter the water at the source, during transmission in pipes, and at the point of use.

The Federal Safe Drinking Water Act (SDWA) requires the U.S. EPA to establish regulations intended to protect the public's health. This includes setting maximum contaminant levels (MCLs) for drinking water for microorganisms and chemicals known or suspected to cause acute or chronic human health impacts. Public water supply systems are required to test the water they provide to their community. If violations are identified, the water system is required to notify the public of the violation and provide guidance on what actions they should take, such as boiling their water. In addition, all regulated community water systems must provide their customers a "consumer confidence report" annually, which includes what contaminants were found in their water and how these contaminants might affect their health.

More than 90% of people residing in Lancaster County drink water that is regulated by the Nebraska Department of Health and Human Services under the SDWA. This includes all the residents of Lincoln, Hickman, Waverly, and all villages. In addition, the SDWA applies to Lancaster County Rural Water District (RWD) No. 1, Cass County RWD No. 2 and other "community" systems that serve larger numbers of people.

The City of Lincoln Water System provides drinking water to all residents of the city. The Lincoln Water System has maintained compliance with all SDWA requirements for many years. However, there have been a number of SDWA violations in other community systems in Lancaster County, ranging from inadequate sampling to microbial contamination requiring boil orders. There has not been a confirmed outbreak of illness associated with a community water supply in Lancaster County for over 20 years.

For those persons relying on private wells for their drinking water, contamination with bacteria and nitrates are the primary concerns. Local inspections of private wells have found some wells with contamination from E. coli bacteria or nitrate levels above the EPA MCL for public water supplies. Over the past decade, several local investigations of gastrointestinal illnesses in families have been associated with private wells that were found to be contaminated with E. coli bacteria. In addition, private wells are not fluoridated, thus increasing the risk for dental caries for young children.

Food Safety

Key factors in the food system, including an increasingly diverse industry, importing 60 percent of our produce and 80 percent of our seafood, newly emerging pathogens, and an increasing reliance on food prepared by others for our meals, place every person at risk of foodborne illness. As with many environmental risks, young children, pregnant women, and our growing population of older adults are more susceptible to foodborne illness than the general population. The U.S. Centers for Disease Control and Prevention (CDC) estimates that 1 in 6 people contract a foodborne illness every year, and the USDA estimates that foodborne illness costs around $15 billion each year (http://www.ers.usda.gov/media/1204383/eib-118-summary.pdf). Thus, foodborne illness poses a significant burden of illness and costs to our country and to Lincoln and Lancaster County. Applying CDC estimates to our community, each year approximately 50,000 people contract foodborne illness, 120 are hospitalized and 3 die. This in turn, results in significant medical costs and loss of productivity (lost work and school days).

While more than 250 different foodborne diseases have been described, eight known pathogens account for the vast majority of illnesses, hospitalizations, and deaths.

Table 1. Top five pathogens contributing to foodborne illnesses in the U.S.

Pathogen	Estimated number of illnesses	90% Credible Interval	%
Norovirus	5,461,731	3,227,078–8,309,480	58
***Salmonella*, non-typhoidal**	1,027,561	644,786–1,679,667	11
Clostridium perfringens	965,958	192,316–2,483,309	10
Campylobacter spp.	845,024	337,031–1,611,083	9

Staphylococcus aureus	241,148	72,341–529,417	3
Subtotal			91

(Source: CDC http://www.cdc.gov/foodsafety/facts.html)

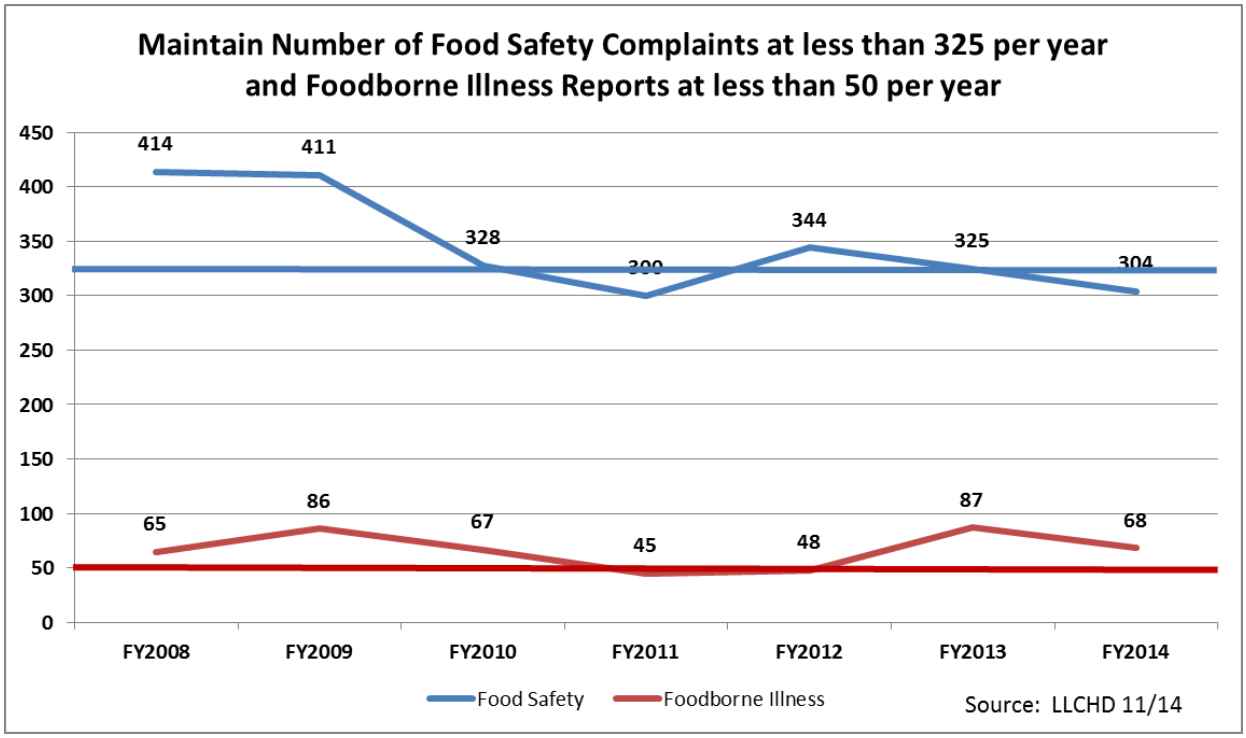
The top five pathogens associated with hospitalizations include: Salmonella, Norovirus, Campylobacter, Toxoplasma, and E. coli 0157:H7. The top five pathogens causing death are: Salmonella, Toxoplasma, Listeria, Norovirus and Campylobacter. (Source: CDC http://www.cdc.gov/foodsafety/facts.html). In addition to microbes, food poisoning can be caused by harmful toxins or chemicals that have contaminated the food, such as botulinum toxin or even pesticides.

Tremendous effort has been made both nationally and locally to reduce this disease burden. The FDA Food Safety Modernization Act of 2011 was the most sweeping reform of our food safety laws in more than 70 years. It aims to ensure the U.S. food supply is safe by shifting the focus from responding to contamination to preventing it. Key aspects of the FSMA include:

- Comprehensive, prevention-based controls across the food supply.
- Science-based standards for the safe production and harvesting of fruits and vegetables.
- Risk-based inspection strategies.
- Significant enhancements on imported food oversight.
- Mandatory recall authority for all food products.
- Strengthening existing collaboration among all food safety agencies – Federal, state, local, territorial, tribal, and foreign – to achieve our public health goals.

The results of the Federal efforts are beginning to be realized, but overall incidence of foodborne illness has not dropped significantly. The following report card for shows the national progress report for 2012, which is the latest available information.

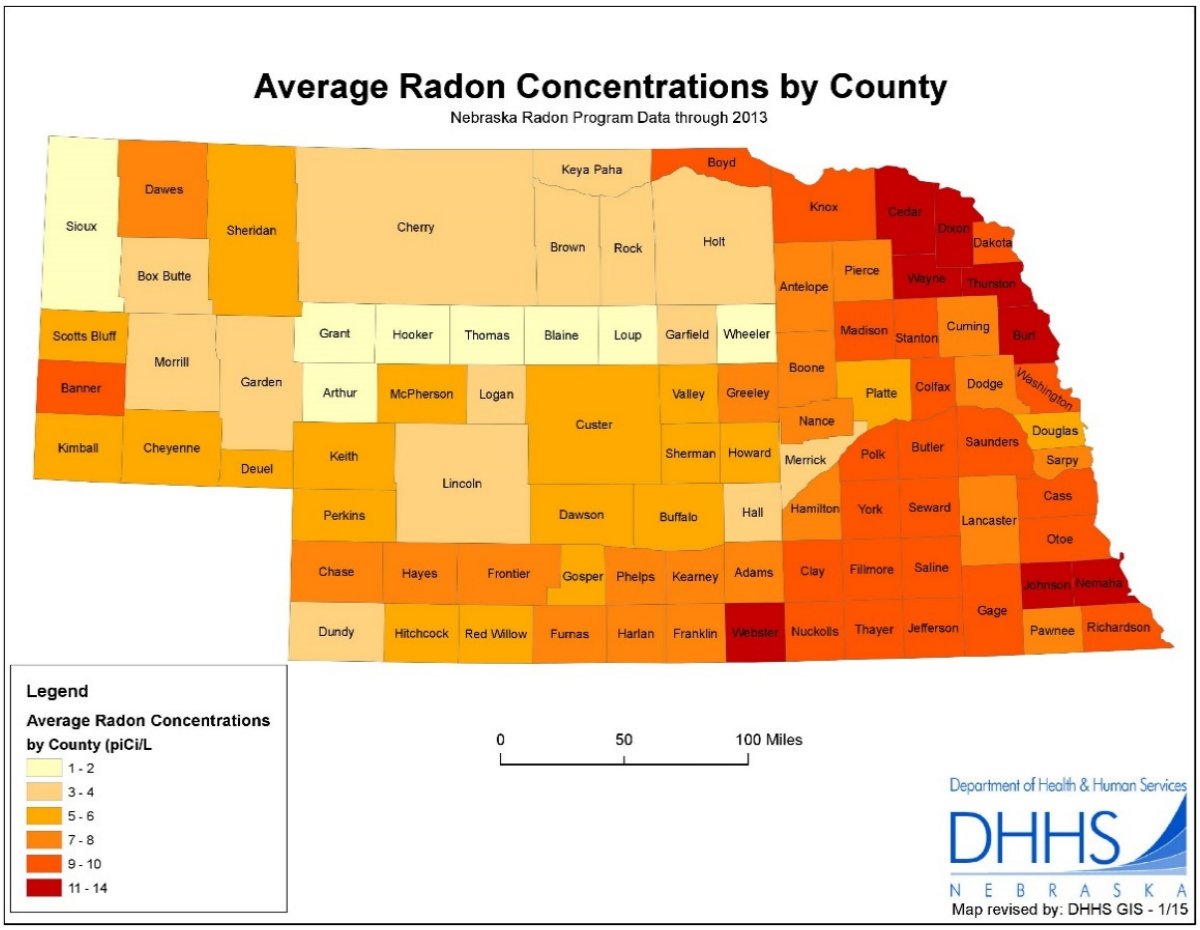
The ability to accurately measure the incidence of foodborne illnesses over time locally is hampered by the fact that the vast majority of foodborne illnesses go unreported to health officials, human testing is typically not performed, and most foodborne illnesses are self-limiting, with symptoms subsiding in a few days. However, one to four outbreaks per year are identified through public reports of possible illnesses due to food. As with the CDC data, the majority of local outbreaks are caused by norovirus. When outbreaks are identified, our multi-faceted Epi Team quickly investigates and implements control measures to stop further spread of disease. LLCHD collaborates with State and Federal officials in multi-jurisdictional outbreaks, such as the nation-wide outbreak of Cyclosporiasis from salads in 2013 and a regional outbreak of Salmonella from sprouts in 2010. Employing new technology, such as Polymerase Chain Reaction (PCR) testing for microbes, and electronic surveys of affected individuals, has sped up investigations, led to rapid identification of the causes of outbreaks, and reduced secondary transmission of illnesses.



LLCHD's Food Safety Program's primary goal is to prevent foodborne illness. Communication and collaboration with the food industry and consumers greatly enhances food safety for our community. The regulatory foundation is the 2009 FDA Food Code. The structural framework for quality assurance is FDA's Retail Program Standards. LLCHD is the only jurisdiction in Nebraska requiring food handler training and food manager certification. LLCHD's Food Safety Team conducts inspections using HACCP (Hazard Analysis and Critical Control Points) principles, focusing on risk factors known to be most associated with foodborne illness. Consultative assistance is offered to assist food establishments in adopting Active Managerial Controls focused on preventing violations known to pose highest risk of foodborne illness. When enforcement is needed, LLCHD uses a progressive approach, issuing enforcement notices in the

field, and taking administrative action as necessary to achieve compliance. These efforts are usually successful in preventing foodborne illness outbreaks.

The physical environment can affect the health of a community. Water and air quality, the built environment and housing standards are all factors that influence the community's health. Another environmental issue to consider is radon, which is the leading cause of lung cancer for non-smokers. Counties in the eastern third of Nebraska have higher rates of radon than the rest of the state. As shown in the map below, Lancaster County's average radon rate based on data from the state's radon program in the 7-8 average range of picocuries per liter (pCi/L).The average reading can be deceiving and radon test results can vary significantly from house to house. However, if a homeowner has test results with an average radon level above 4 picocuries, mitigation to reduce radon levels is recommended.



Health Disparities

In the sections above, some health disparities have been pointed out such as the vast difference in low birth weight (LSW) babies; where teen moms have more LBW babies than moms in their

twenties and African American mothers have a higher percentage of LBW babies than moms of other races and ethnicities. Health disparities are often looked at as differences in health status between the white population and racial/ethnic minorities. However, race and ethnicity, gender, age, disability, social and economic status and geographic location all contribute to an individual's ability to achieve good health. The following description comes from the CDC in discussing school health, but provides an overall context:

> "*Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.*[1] *Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.*
>
> *Health disparities result from multiple factors, including*
>
> - *Poverty*
> - *Environmental threats*
> - *Inadequate access to health care*
> - *Individual and behavioral factors*
> - *Educational inequalities*"

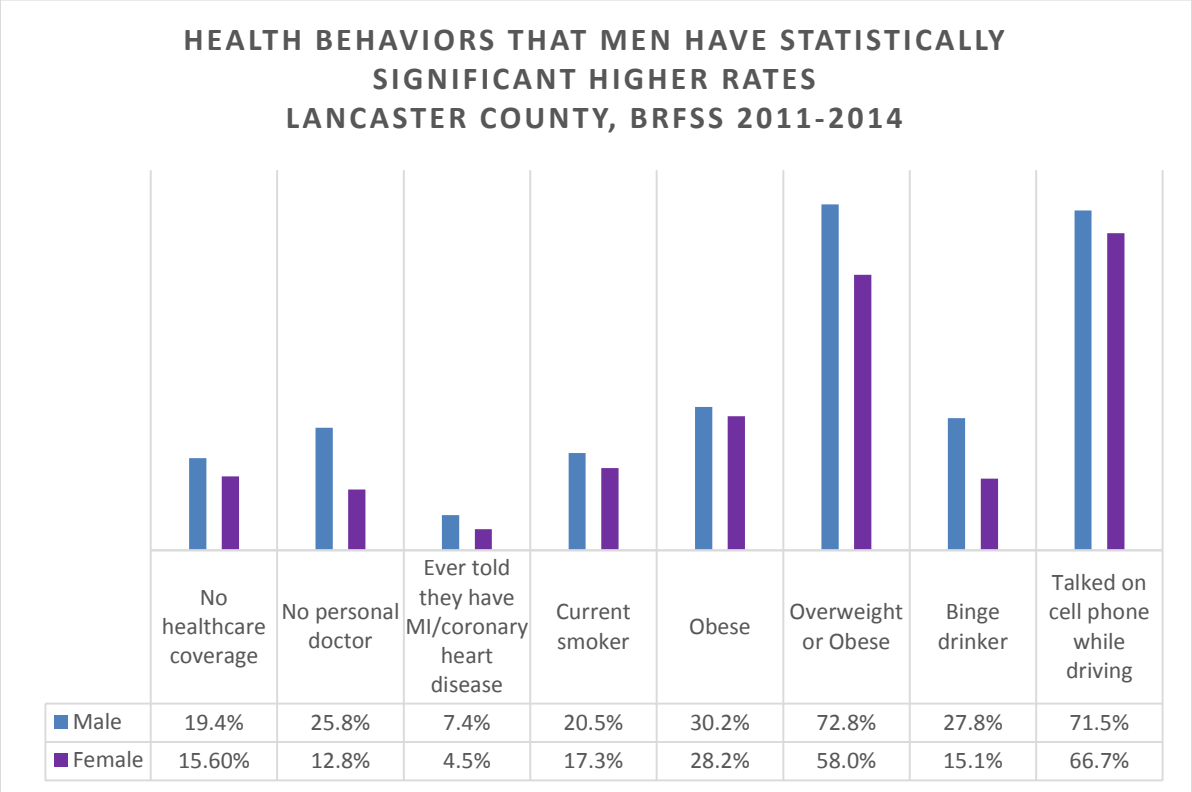
Overall statistics for the community often mask differences among persons of different gender, race/etnicity or age group. Differences are also present when we look at the data about persons with different education, family incomes and neighborhoods. While disparities are often discussed in terms of differencs among race and ethnic groups, having enough data from minority populations, especially from surveys but also from disease registries, is a problem for interpretation and for making any generalizations. In the examples below, when data are presented by race/etnicity several years of data are used or data are combined into an aggregated category such as "minority" or "non-White."

In this section we discuss some of the differences in morbidity, mortality and health behaviors that are apparent in the data we have available for subpopulations (e.g., by gender, by race/ethnicity) or groups of persons by income, education or age group. Differences by census tract are also presented with maps to highlight distinct differencs across the community. It is by no means an exhaustive list of differences, but instead highlights some of the disparities in the community.

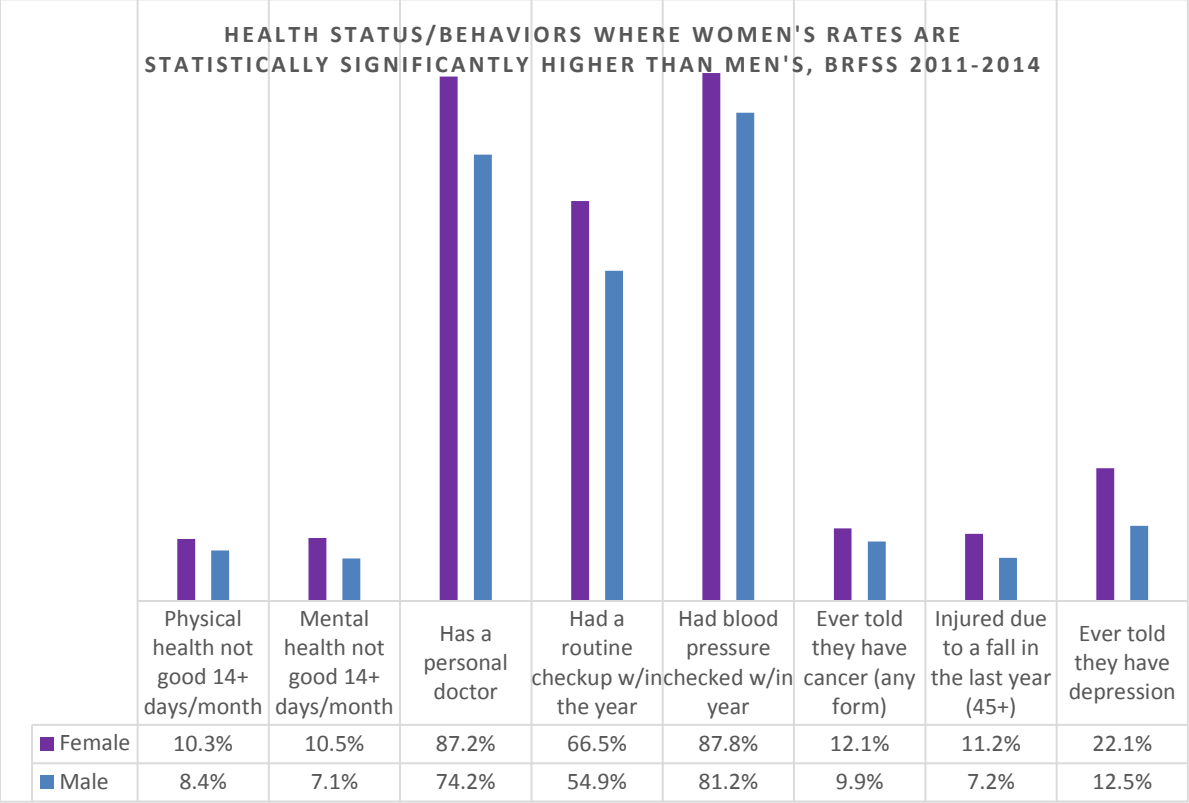
Gender Disparities (Not all would fit the disparity definition)

From examing BRFSS data from 2011 to 2014, there are a host of indicators where the responses of women and men differ significantly, statistically speaking (95% chance that the differences are real and not just random variation). The graphs below show some of the areas where women or men have a statistically significant difference in a positive direction (not always a good direction depending on the question). The caution is that in some cases (e.g., percent of days where physical or mental was not good 14+ days in the last month, ever had cancer, injured due to a fall, ever told they have depression) having a higher response is not good. The two charts can be taken together to reveal a great deal on the 16 measures. For instance, women generally have more health care coverage, see doctors more often, smoke less, are not as likely to be overweight or obese, don't binge drink as much often and are less likely to use their cell phones

while driving. The differences can have an affect on health conditions and at least some of the differences are due to traditional cultural differences between genders.



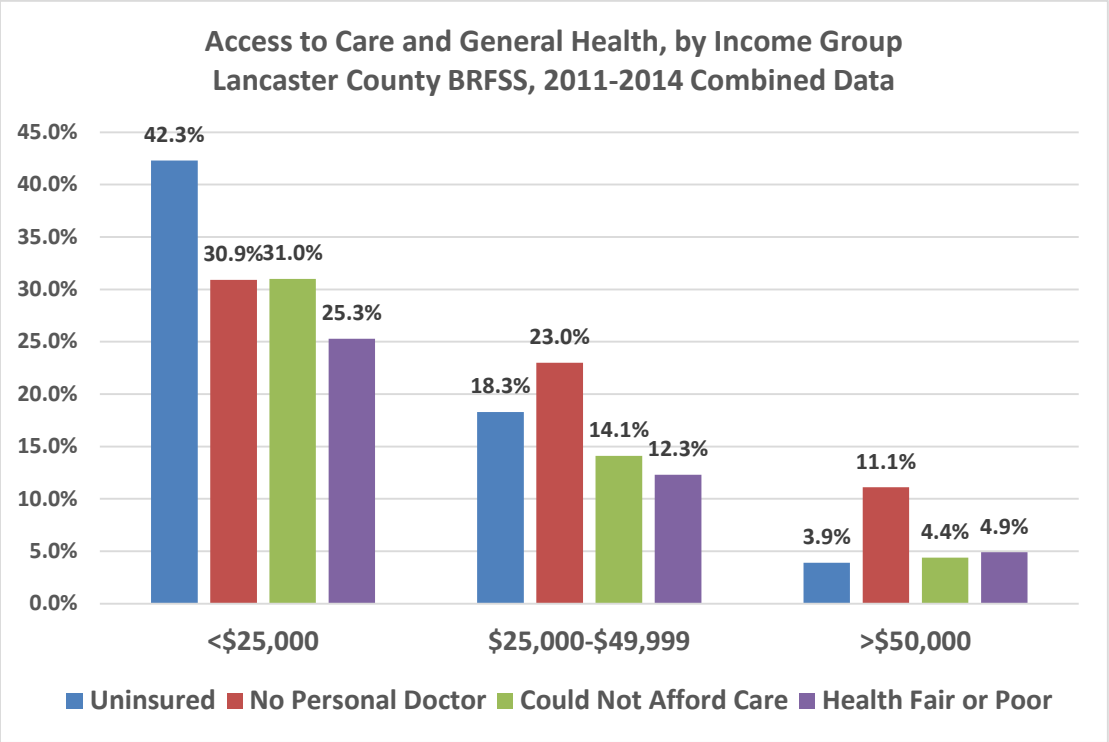
	No healthcare coverage	No personal doctor	Ever told they have MI/coronary heart disease	Current smoker	Obese	Overweight or Obese	Binge drinker	Talked on cell phone while driving
Male	19.4%	25.8%	7.4%	20.5%	30.2%	72.8%	27.8%	71.5%
Female	15.60%	12.8%	4.5%	17.3%	28.2%	58.0%	15.1%	66.7%



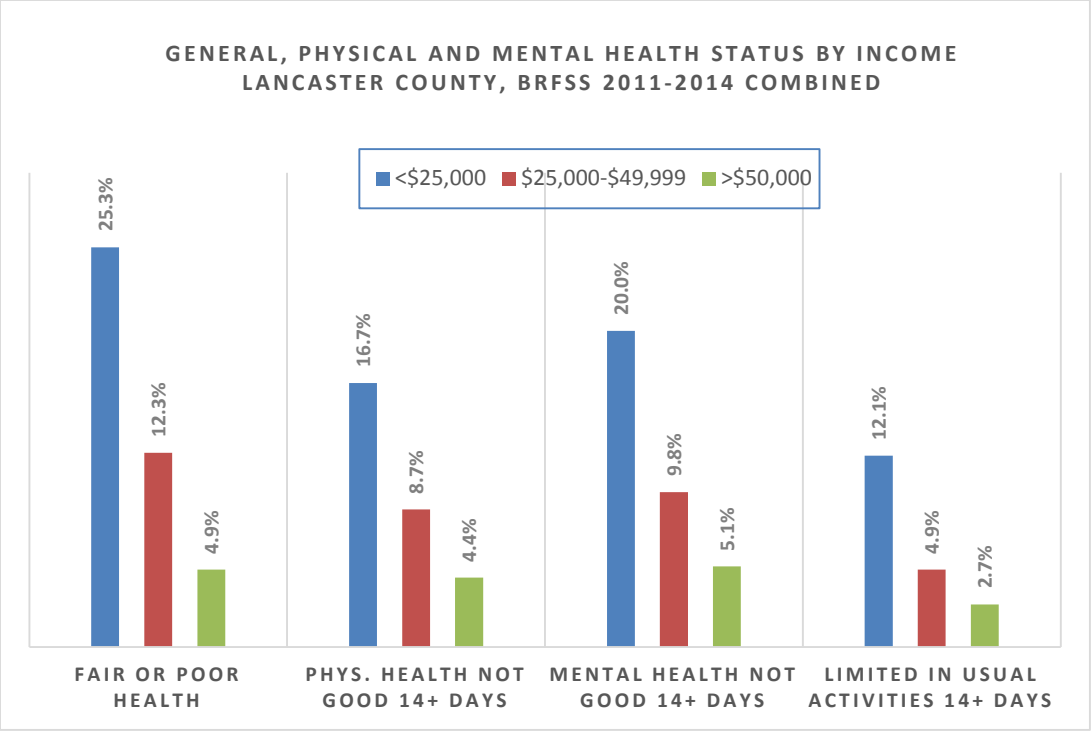
	Physical health not good 14+ days/month	Mental health not good 14+ days/month	Has a personal doctor	Had a routine checkup w/in the year	Had blood pressure checked w/in year	Ever told they have cancer (any form)	Injured due to a fall in the last year (45+)	Ever told they have depression
Female	10.3%	10.5%	87.2%	66.5%	87.8%	12.1%	11.2%	22.1%
Male	8.4%	7.1%	74.2%	54.9%	81.2%	9.9%	7.2%	12.5%

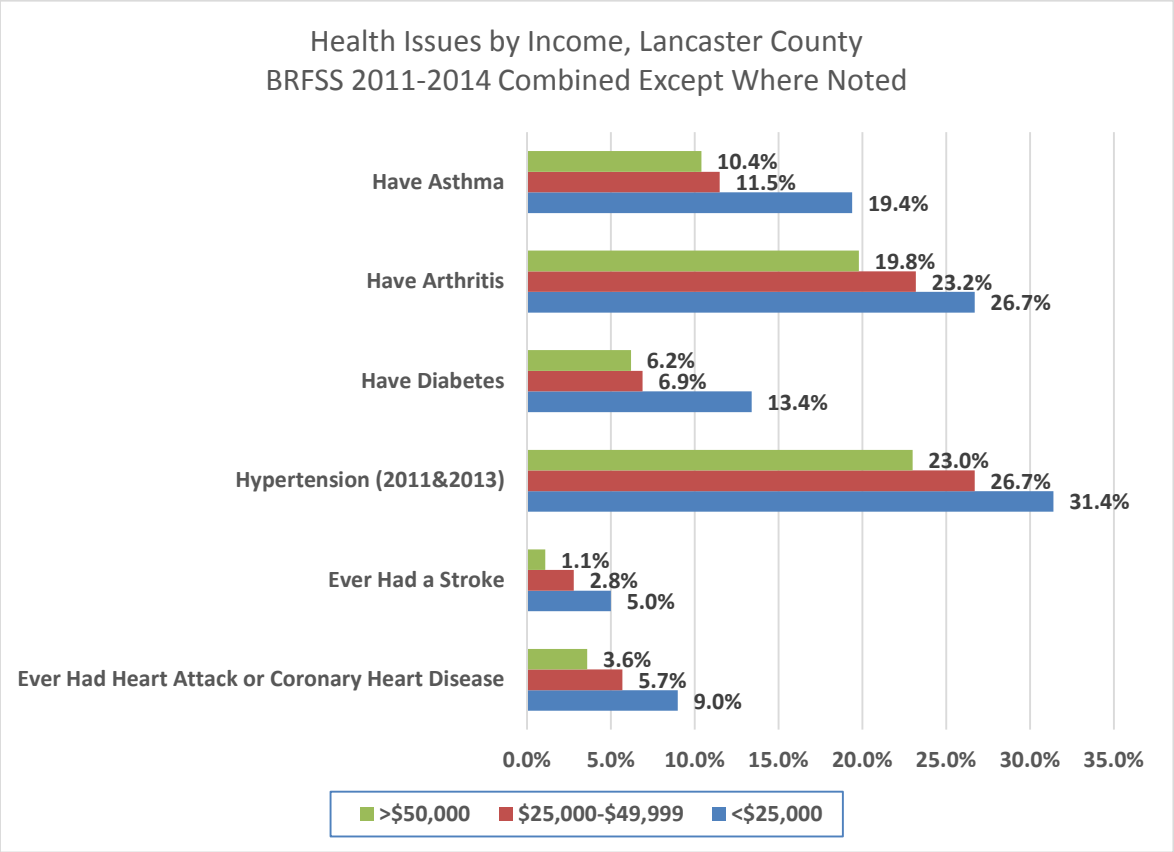
Income Related Disparities

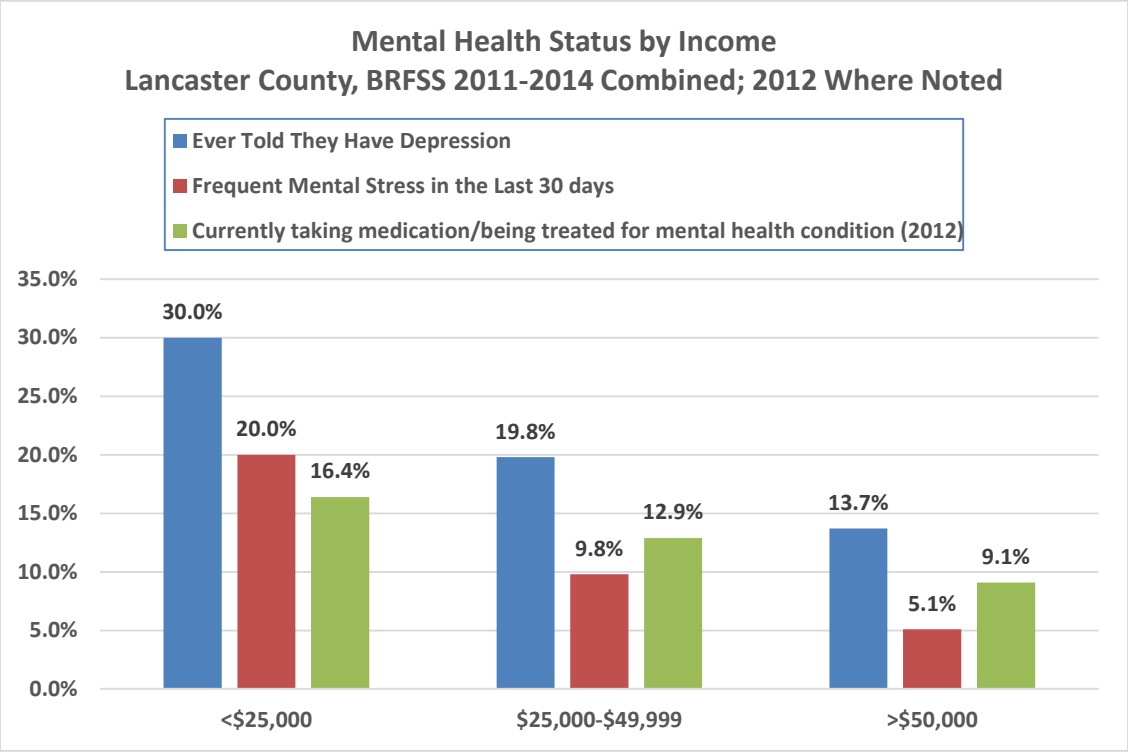
Income and poverty differences may be due to a host of influences (inheritance, education, disability, race, gender, old age, etc.) so looking at the differences by income is a key to understanding other relationships. The first two graphs below show access to health care and general health by income group. As can be seen lower incomes are associated with poor access to healthcare coverage and physicians; and persons with lower incomes are more likely to state that they have only fair or poor health



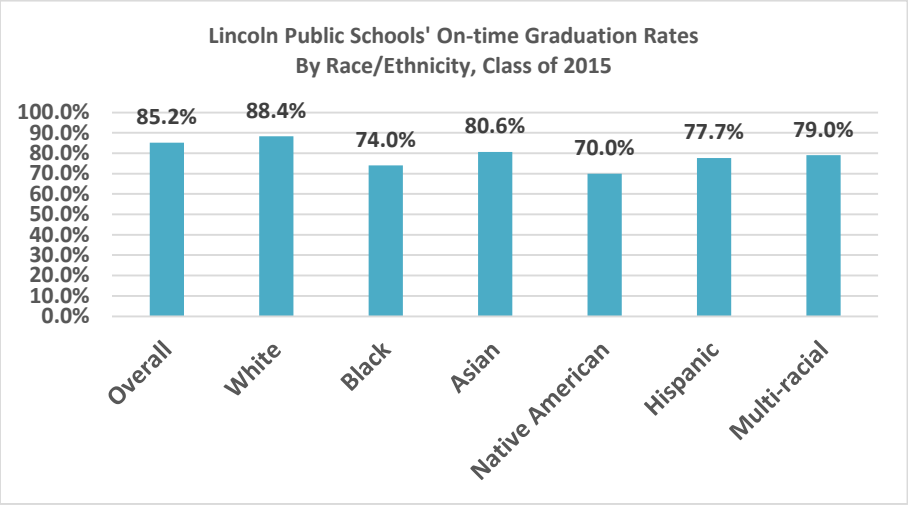
The second and third graphs below show the association between income and various health conditions (asthma, arthritis, diabetes, hypertension, stroke and heart disease) and mental health conditions. Again, the relationship is that persons with lower incomes have the most health problems. Of course, it likely is the other way around—namely, persons with the worst health outcomes probably earn less income due to their conditions. The graph doesn't show cause and effect, only correlation. However, from other information we know that persons with disabilities, minority populations in general, the elderly, and persons without high school degrees are more likely to have low incomes than the general population.


GENERAL, PHYSICAL AND MENTAL HEALTH STATUS BY INCOME
LANCASTER COUNTY, BRFSS 2011-2014 COMBINED
<$25,000
$25,000-$49,999
>$50,000
25.3%
12.3%
4.9%
16.7%
8.7%
4.4%
20.0%
9.8%
5.1%
12.1%
4.9%
2.7%
FAIR OR POOR HEALTH
PHYS. HEALTH NOT GOOD 14+ DAYS
MENTAL HEALTH NOT GOOD 14+ DAYS
LIMITED IN USUAL ACTIVITIES 14+ DAYS


Health Issues by Income, Lancaster County
BRFSS 2011-2014 Combined Except Where Noted
Have Asthma
10.4%
11.5%
19.4%
Have Arthritis
19.8%
23.2%
26.7%
Have Diabetes
6.2%
6.9%
13.4%
Hypertension (2011&2013)
23.0%
26.7%
31.4%
Ever Had a Stroke
1.1%
2.8%
5.0%
Ever Had Heart Attack or Coronary Heart Disease
3.6%
5.7%
9.0%
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
30.0%
35.0%
>$50,000
$25,000-$49,999
<$25,000



As a footnote for this section, generally speaking persons with higher levels of education earn higher incomes or at least have the potential to do so. As we discovered in the earlier sections of the assessment, minorities in general make less money and have higher rates of poverty than Non-Hispanic Whites. The recent article (Lincoln Journal Star, November 21, 2015) on graduation rates in the Lincoln Public Schools presented the on-time graduation rates by race and ethnicity and the following graph displays the results. While it isn't a certainty that those who don't graduate in four years won't eventually graduate or earn their GED, the fact that 11.6 percent of White students, 26 percent of Black students, and 30 percent of Hispanic students don't graduate in four years will likely work against their economic fortune in the future.



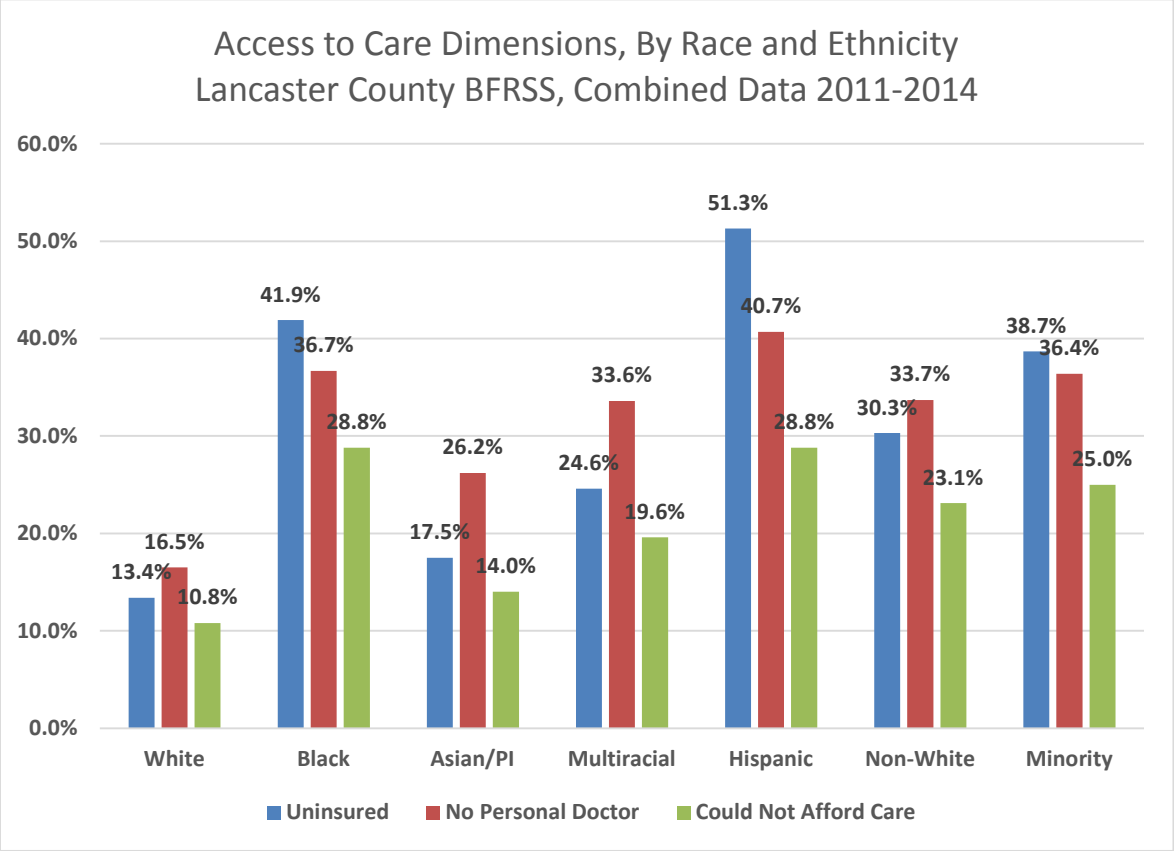
Disparities by Race and Ethnicity

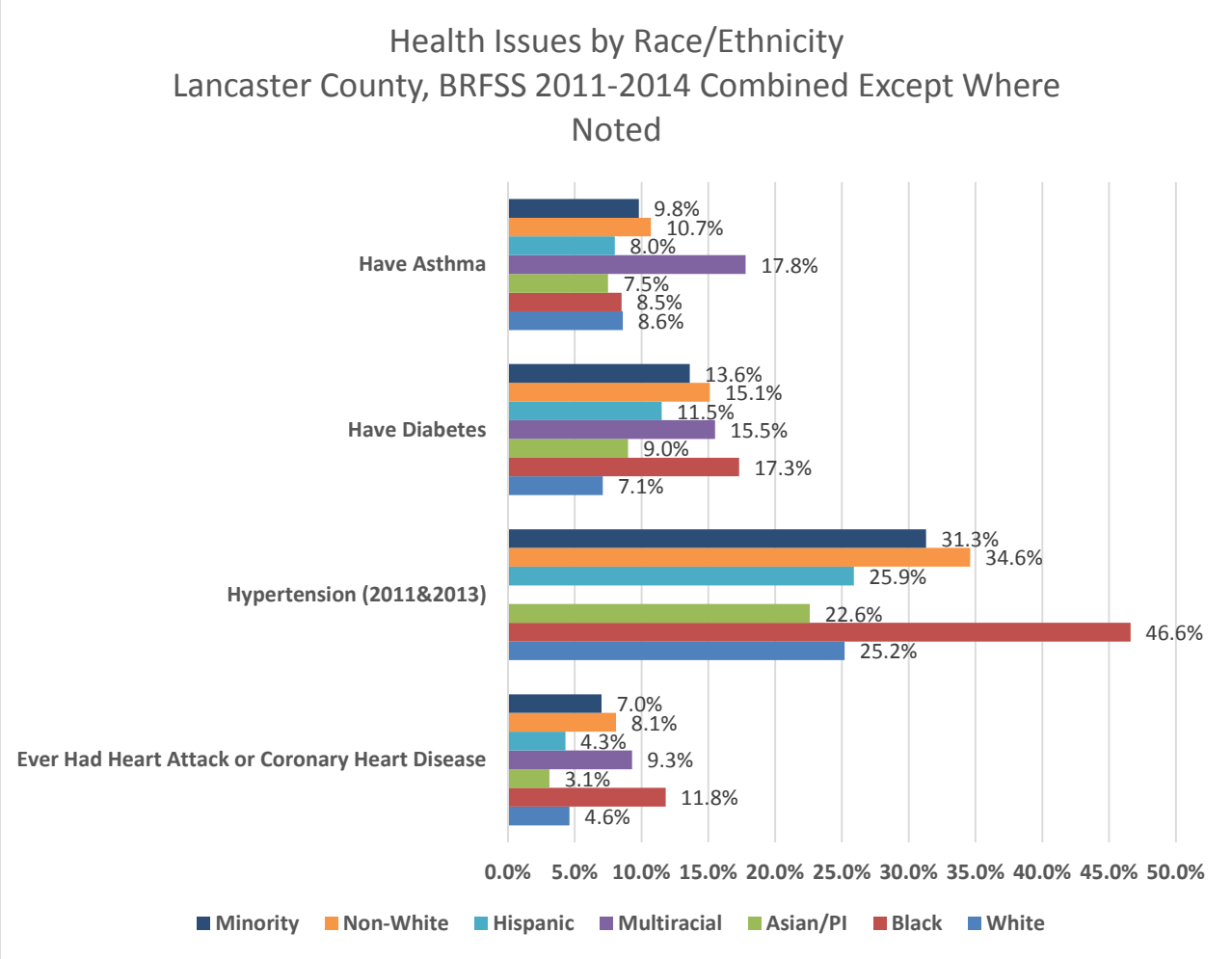
Any single year's BRFSS does not provide a large enough sample of persons from various racial or ethnic groups (there are fewer than 50 respondents to the BRFSS survey each year except for Hispanics) and we often don't have information on race and ethnicity from other sources such as hospital discharge data or insurance claims to say anything meaningful. In the charts that follow, BRFSS data are combined for 2011 to 2014 or any two or three years to increase the sample size and provide comparisons by race and ethnicity. Another way to look at the data is to aggregate all races and Hispanics into a category called "Minority," as shown in the table below. In the table all differences are statistically significant (meaning that there is 95 percent certainty that the differences are real rather than due to random variation) based on 2011-2014 combined BRFSS results.

BRFSS Question	White, Non-Hispanic	Minority
General health fair or poor	9.9%	23.2%
No health care coverage, 18-64	13.4%	38.7%
No personal doctor or health care provider	16.5%	36.4%
Ever told they had a heart attack	2.8%	5.9%
Ever told they have diabetes (excluding pregnancy)	7.1%	13.6%
Current cigarette smoking	19.6%	25.5%
Obese (BMI=30+)	25.1%	32.0%
Consumed vegetables less than 1 time per day	21.9%	29.2%
No leisure time physical activity in the past 30 days	17.5%	26.9%
Symptoms of serious mental health in the last 30 days	1.6%	9.0%
Ever been tested for HIV, 18-64 year olds (excluding blood donation)	31.1%	41.9%
Had any permanent teeth extracted due to tooth decay or gum disease	30.7%	51.1%
Had any permanent teeth extracted due to tooth decay or gum disease, 45-64 year olds	37.6%	66.1%
Get less than 7 hours of sleep per day	31.1%	42.7%
Always or nearly always get help reading health information	8.0%	20.6%
Had a routine checkup in the past year	59.7%	51.5%
Had cholesterol checked in the past 5 years	74.7%	67.7%
Ever told they have skin cancer	6.4%	2.6%
Ever told they have cancer (in any form)	11.3%	7.1%
Up-to-date on colon cancer screening, 50-75 year olds	68.8%	52.9%
Met aerobic physical activity recommendation	54.2%	44.4%
Talked on a cell phone while driving in past 30 days	76.0%	54.7%
Texted while driving in past 30 days	33.4%	16.6%
Any alcohol consumption in the last 30 days	67.4%	48.2%
Binge drank in the past 30 days	24.0%	17.8%
Had a tetanus vaccination since 2005	62.7%	49.4%
Visited a dentist or dental clinic for any reason in the past year	73.5%	58.8%

As can be seen, with a few exceptions highlighted in green, Minority health status or risk behaviors are worse than that for Whites.

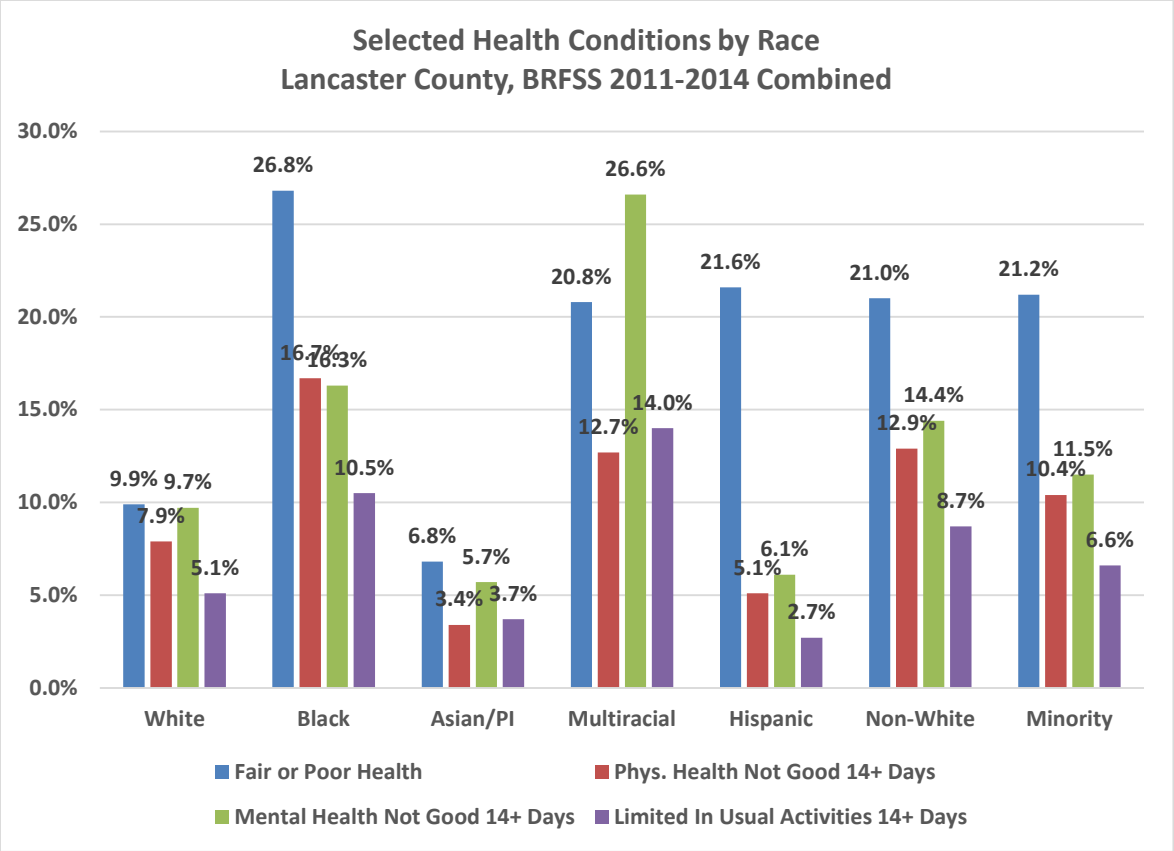
Minority includes Hispanics, but another way to group by race is to aggregate the data for all Non-Whites together (however, this excludes most Hispanics since most classify themselves as White). The following information comes from four years of BRFSS surveys in order to increase the number of non-Whites. Even by combining years there are not have enough Native American respondents to show a rate for them alone (their numbers are included in the Non-White and Minority groups). The following graphs display the differences by race where data are available and also show the categories for Non-Whites and Minority. The graph below shows the access to care issues (uninsured, no personal doctor, and could not afford care) and there is a clear difference—all racial groups have much more limited access by a factor of up to four in terms of being uninsured, and by smaller but real differences for having a personal doctor and being able to afford needed care. In most cases there are twice the access issues for the Minority population when compared to Whites (columns to the right versus the left hand column) and as presented in the table above, the difference is statistically significant.

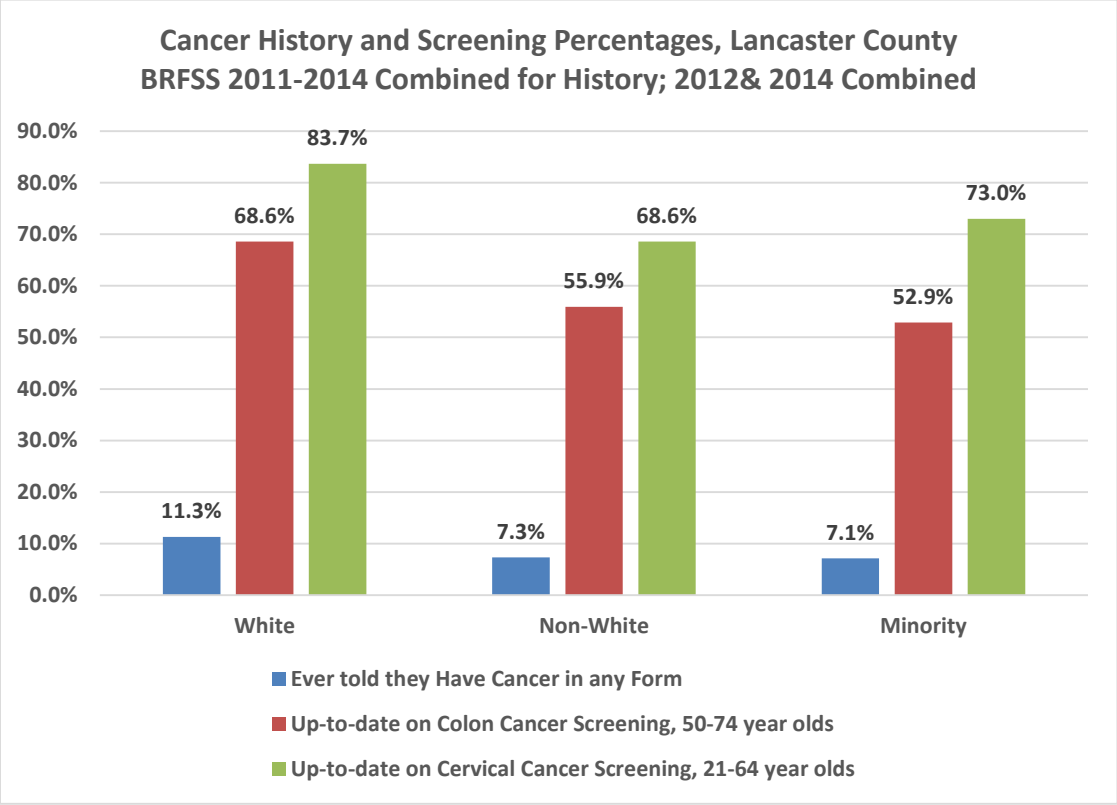




In the chart above, the prevalence of selected chronic conditions is displayed by race. While the Asian population tends to have fewer health issues than other races and ethnicities there are several issues that stand out when compared to Whites-- the Asian population has a higher prevalence of heart disease, hypertension and diabetes.

The first chart below shows the differences by race for fair or poor health, and limitations in physical and/or mental health for 14 or more days in the month. The results show that Blacks, persons who classify themselves as Multiracial as well as the grouped categories of Non-White and Minority have higher rates of fair or poor health. Asians and Hispanics have fewer health or mental health problems for 14 or more days a month than do Whites. When looking at the assessment of personal health, Hispanics answer that their health is only “fair or poor” at a higher rate than Whites, but Asians have a lower rate of fair or poor health than do Whites. The second chart shows the difference in cancer diagnosis and cancer screening rates for Whites, Non-Whites and Minorities. Despite the fact that minorities indicate they have not been told they have cancer, cancer rates for colorectal cancer are higher for African Americans than Whites and it is the third or fourth highest type of cancer for all races and Hispanics. Cervical cancers are often found less often, but at a later stage in women who do not get regular screening.


Selected Health Conditions by Race
Lancaster County, BRFSS 2011-2014 Combined
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
9.9%
7.9%
9.7%
5.1%
26.8%
16.7%
16.3%
10.5%
6.8%
3.4%
5.7%
3.7%
20.8%
12.7%
26.6%
14.0%
21.6%
5.1%
6.1%
2.7%
21.0%
12.9%
14.4%
8.7%
21.2%
10.4%
11.5%
6.6%
White
Black
Asian/PI
Multiracial
Hispanic
Non-White
Minority
Fair or Poor Health
Phys. Health Not Good 14+ Days
Mental Health Not Good 14+ Days
Limited In Usual Activities 14+ Days


Cancer History and Screening Percentages, Lancaster County
BRFSS 2011-2014 Combined for History; 2012& 2014 Combined
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
11.3%
68.6%
83.7%
7.3%
55.9%
68.6%
7.1%
52.9%
73.0%
White
Non-White
Minority
Ever told they Have Cancer in any Form
Up-to-date on Colon Cancer Screening, 50-74 year olds
Up-to-date on Cervical Cancer Screening, 21-64 year olds

Information from the 2012 Nebraska Cancer Registry Report for 2003-2012 that's displayed in the tables below and from the Cancer in Minorities fact sheet for 2002-2011 reveals the following facts about cancer rates by race and ethnicity. During the decade (2002-2011), incidence and mortality rates of cancer (all types) were significantly higher for African Americans in Nebraska than Whites. The incidence and mortality rates of all types of cancers were significantly lower for Asian/Pacific Islanders and Hispanics than Whites. While the Native American incidence rate was significantly lower than that for Whites, they were slightly more likely to die from cancer than Whites.

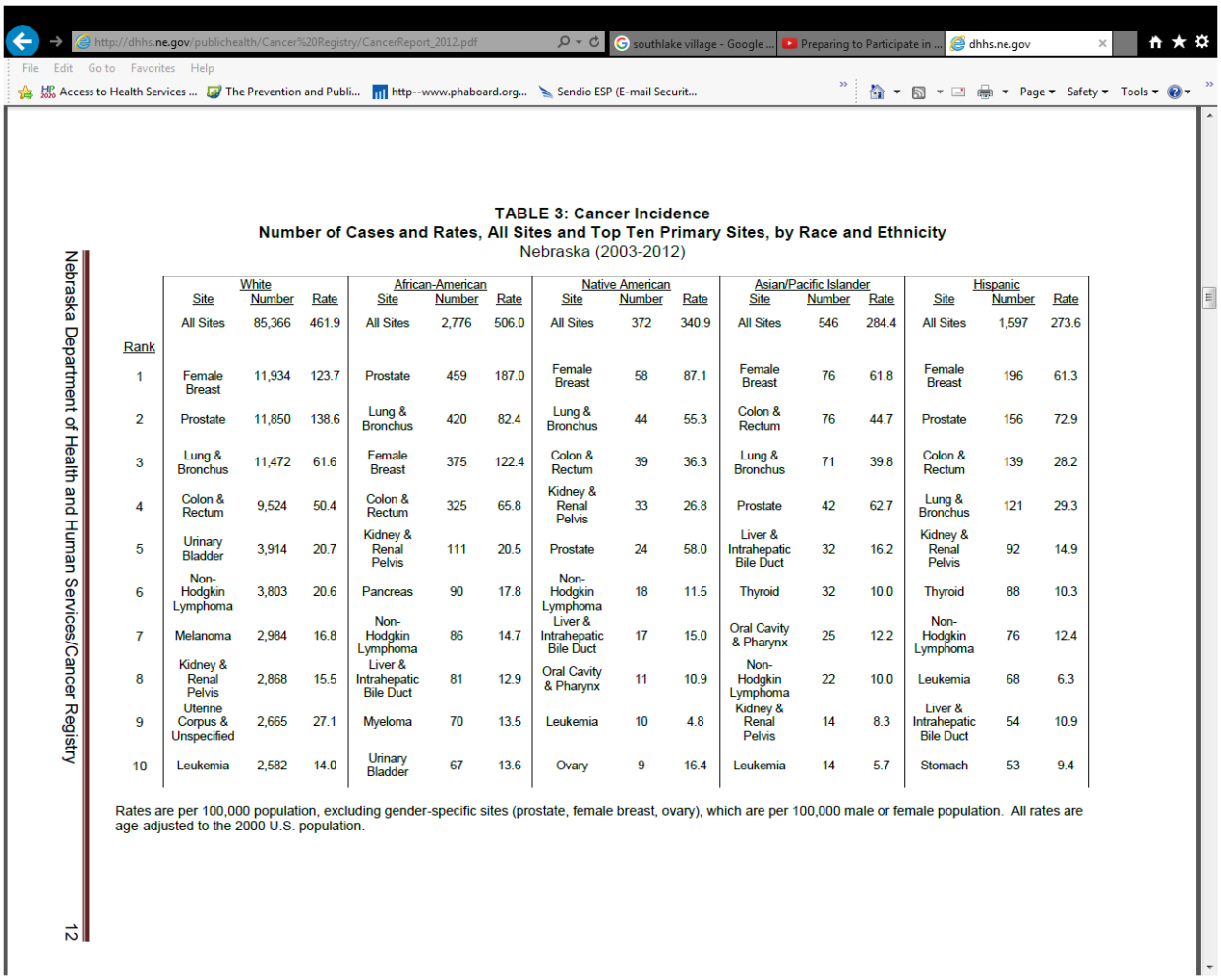


TABLE 3: Cancer Incidence
Number of Cases and Rates, All Sites and Top Ten Primary Sites, by Race and Ethnicity
Nebraska (2003-2012)

	White			African-American			Native American			Asian/Pacific Islander			Hispanic		
	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate
	All Sites	85,366	461.9	All Sites	2,776	506.0	All Sites	372	340.9	All Sites	546	284.4	All Sites	1,597	273.6
Rank															
1	Female Breast	11,934	123.7	Prostate	459	187.0	Female Breast	58	87.1	Female Breast	76	61.8	Female Breast	196	61.3
2	Prostate	11,850	138.6	Lung & Bronchus	420	82.4	Lung & Bronchus	44	55.3	Colon & Rectum	76	44.7	Prostate	156	72.9
3	Lung & Bronchus	11,472	61.6	Female Breast	375	122.4	Colon & Rectum	39	36.3	Lung & Bronchus	71	39.8	Colon & Rectum	139	28.2
4	Colon & Rectum	9,524	50.4	Colon & Rectum	325	65.8	Kidney & Renal Pelvis	33	26.8	Prostate	42	62.7	Lung & Bronchus	121	29.3
5	Urinary Bladder	3,914	20.7	Kidney & Renal Pelvis	111	20.5	Prostate	24	58.0	Liver & Intrahepatic Bile Duct	32	16.2	Kidney & Renal Pelvis	92	14.9
6	Non-Hodgkin Lymphoma	3,803	20.6	Pancreas	90	17.8	Non-Hodgkin Lymphoma	18	11.5	Thyroid	32	10.0	Thyroid	88	10.3
7	Melanoma	2,984	16.8	Non-Hodgkin Lymphoma	86	14.7	Liver & Intrahepatic Bile Duct	17	15.0	Oral Cavity & Pharynx	25	12.2	Non-Hodgkin Lymphoma	76	12.4
8	Kidney & Renal Pelvis	2,868	15.5	Liver & Intrahepatic Bile Duct	81	12.9	Oral Cavity & Pharynx	11	10.9	Non-Hodgkin Lymphoma	22	10.0	Leukemia	68	6.3
9	Uterine Corpus & Unspecified	2,665	27.1	Myeloma	70	13.5	Leukemia	10	4.8	Kidney & Renal Pelvis	14	8.3	Liver & Intrahepatic Bile Duct	54	10.9
10	Leukemia	2,582	14.0	Urinary Bladder	67	13.6	Ovary	9	16.4	Leukemia	14	5.7	Stomach	53	9.4

Rates are per 100,000 population, excluding gender-specific sites (prostate, female breast, ovary), which are per 100,000 male or female population. All rates are age-adjusted to the 2000 U.S. population.

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African-Americans in Nebraska were significantly more likely to be diagnosed with and die from lung, colorectal, prostate, and liver cancers than Whites. Asian/Pacific Islanders and Hispanics in Nebraska were significantly less likely to be diagnosed with female breast, lung, and prostate cancer than Whites. Hispanics also had a significantly lower rate of colorectal cancer than Whites, but they had a significantly higher incidence of stomach cancer. Native Americans had a significantly lower incidence rate of female breast, prostate, non-Hodgkin lymphoma and leukemia than White Nebraskans. Asians, Native Americans and Hispanics all had a significantly

higher incidence of liver cancer; and Native Americans had a significantly higher rate of kidney cancer.

African American women were also significantly more likely to die from female breast cancer than were Whites even though they were slightly less likely to be diagnosed with breast cancer.

TABLE 7: Cancer Mortality
Number of Deaths and Rates, All Sites and Top Ten Primary Sites, by Race and Ethnicity
Nebraska (2003-2012)

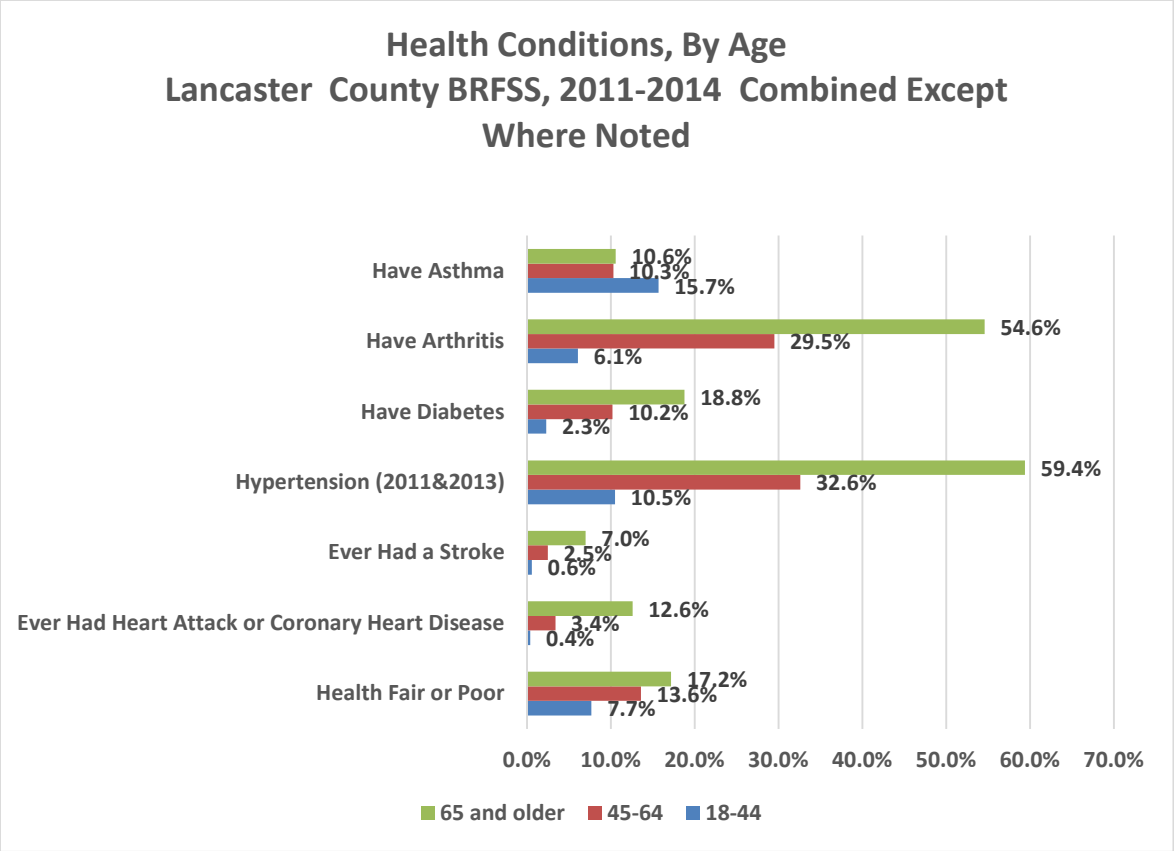
Rank	White Site	White Number	White Rate	African-American Site	African-American Number	African-American Rate	Native American Site	Native American Number	Native American Rate	Asian/Pacific Islander Site	Asian/Pacific Islander Number	Asian/Pacific Islander Rate	Hispanic Site	Hispanic Number	Hispanic Rate
	All Sites	32,332	169.0	All Sites	1,134	231.4	All Sites	156	176.7	All Sites	178	110.5	All Sites	477	105.0
1	Lung & Bronchus	8,518	45.3	Lung & Bronchus	335	69.4	Lung & Bronchus	45	59.1	Lung & Bronchus	42	24.6	Lung & Bronchus	77	19.6
2	Colon & Rectum	3,446	17.6	Colon & Rectum	129	29.1	Colon & Rectum	16	14.4	Liver & Intrahepatic Bile Duct	30	14.0	Female Breast	39	14.9
3	Female Breast	2,204	20.8	Female Breast	85	28.7	Female Breast	11	18.6	Colon & Rectum	17	11.9	Colon & Rectum	37	8.4
4	Pancreas	1,943	10.2	Pancreas	74	15.3	Kidney & Renal Pelvis	8	10.0	Pancreas	11	7.4	Liver & Intrahepatic Bile Duct	33	8.1
5	Prostate	1,797	23.0	Prostate	63	37.8	Ovary	7	13.7	Female Breast	10	9.2	Prostate	26	20.4
6	Leukemia	1,382	7.2	Liver & Intrahepatic Bile Duct	52	8.5	Liver & Intrahepatic Bile Duct	7	5.0	Non-Hodgkin Lymphoma	10	7.1	Stomach	25	4.5
7	Non-Hodgkin Lymphoma	1,336	6.9	Myeloma	40	8.5	Pancreas	7	4.1	Stomach	8	3.3	Kidney & Renal Pelvis	22	4.1
8	Brain & ONS	926	5.1	Esophagus	32	5.9	Prostate	5	10.9	Myeloma	5	3.2	Leukemia	21	3.5
9	Kidney & Renal Pelvis	859	4.5	Leukemia	31	5.7	Oral Cavity & Pharynx	5	8.5	Leukemia	5	2.9	Pancreas	20	5.1
10	Esophagus	840	4.4	Stomach	27	5.0	Stomach	5	4.8	Brain & ONS	5	2.6	Non-Hodgkin Lymphoma	20	4.8

Rates are per 100,000 population, excluding gender-specific sites (prostate, female breast, ovary), which are per 100,000 male or female population. All rates are age-adjusted to the 2000 U.S. population.
Abbreviation: ONS, other nervous system

Nebraska Department of Health and Human Services/Cancer Registry

Disparities by Age

Aging issues ranked high in our surveys and the demographics indicate that the elderly population is growing faster now and will be growing at a higher rate than any other group over the next several decades. The chart below shows the higher rate of poor health and incidence of chronic health issues and disease (except for asthma) starting in the age group 45 to 64, with an acceleration in health issues for persons 65 and older.



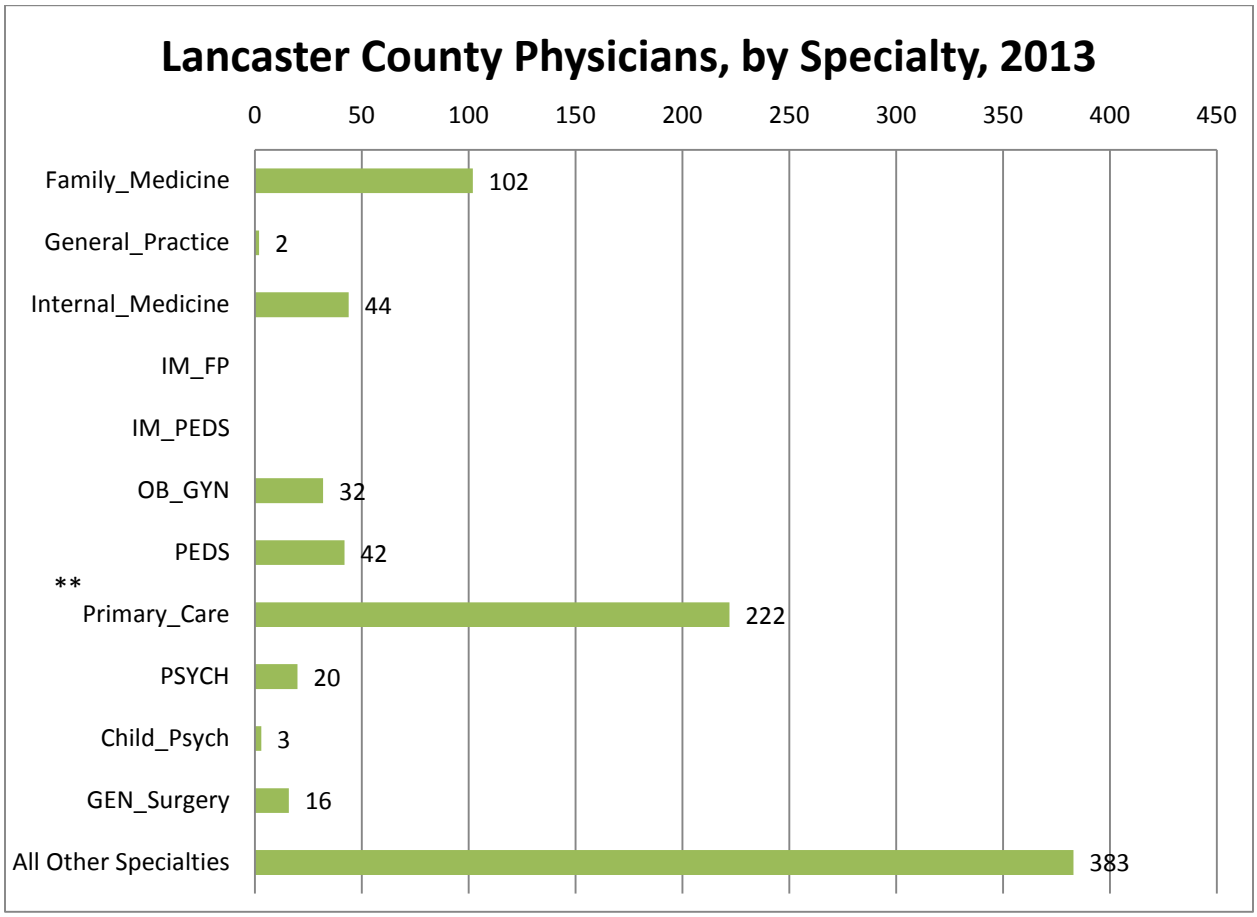
Geographic Disparities

Lincoln has grown over the decades and despite significant rejuvenation, economic development and modernization in the older neighborhoods; in general, health outcomes in those older parts of town are not as good as elsewhere in the community. Earlier in this report maps were presented that showed some of the differences from census tract to census tract (e.g., poverty, housing stock, education, life expectancy), but there are other differences that are displayed in the maps in Appendix 3. GIS maps like these raise a number of issues about what creates the differences in outcomes between and among geographic areas in the community. As can be seen, death rates by disease vary across the community as do obesity rates in schools, behaviors such as smoking and binge drinking, uninsured rates, and a host of maternal and child health measures. The discussion about these geographic disparities is just now taking place thanks to the work of the Community Health Endowment, a number of City departments, and Neighborworks. It is no surprise that there seems to be a strong correlation between several poor health outcomes and the rates of poverty and/or education levels by census tract, but addressing these disparities is not a simple task. It is beyond the scope of this document to address each map or series of maps and the possible causes as well as a proposed list of solutions in each census tract. However, the Community Health Endowment is making it a funding priority for community groups to propose interventions within the census tracts with poor outcomes to address particular health problems found there. As those proposals take shape and interventions/programs progress, in time we should learn a great deal about works and doesn't.

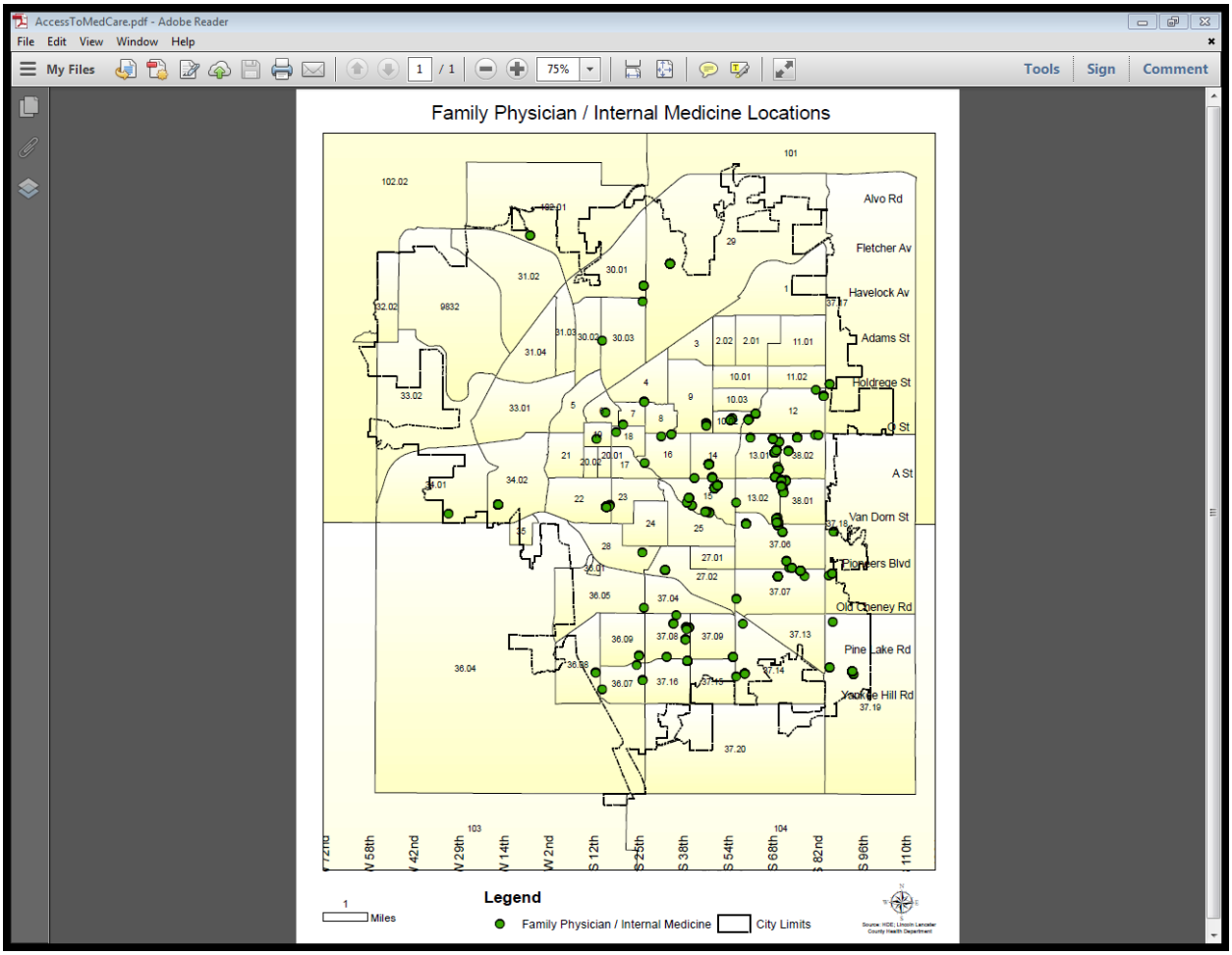
Resources (Assets)

Lancaster County has a number of community assets that contribute to the health of the residents. Most health care providers in the county are located in Lincoln, and distributed unevenly across the community, with fewer providers in northern Lincoln.

Physician numbers are one measure of human resources. As of December 2013, in Lancaster County, the number of physicians is shown in the chart below. As indicated, there were 222 physicians licensed in a primary care specialty (e.g., family and internal medicine, obstetrics, and pediatrics) out of the 644 total physicians. In addition, a total of 39 physicians are listed as practicing psychology, child psychology or general surgery; specialists who generally provide a level of primary care. The remaining 383 licensed doctors are licensed in a sub-specialty licensure category.



Lincoln has a wide range of personal health care providers, mental health providers, physician clinics and other health facilities and medical and dental providers that not only address the needs of the local population, but also residents from throughout southeast Nebraska, northern Kansas and from across the state. The Lincoln-Lancaster County Health Department as well as state agencies provide population health services. Some of the prominent providers, but not all, are listed below:



Primary Care Services

The map above shows the distribution of primary care physicians in the community. As can be seen, the majority of physician offices are located in south and southeast Lincoln. The lack of more services in the north and northeast was a recurrent theme in discussions with the public and in the committee's brainstorming.

People's Health Center, Lincoln's Community Health Center, is a federally qualified health center (FQHC), serving the community's medically-underserved population. As a FQHC, People's Health Center offers their services to all persons according to their ability to pay. The Center provides vital primary care services, dental care and behavioral health services to residents with limited financial resources. Community Health Centers serve as a "medical home" to their patients. The definition of a medical home is the coordination of care from care plans to appointments with specialists. The patient receives consistent care from birth through old age. The medical home serves as a guide to community support services from education to transportation.

Lincoln Medical Education Partnership (LMEP) opened more than 30 years ago to train family medicine physicians in response to a growing need for primary care providers. Now in its fourth

decade, LMEP has evolved into a multi-dimensional organization offering a variety of healthcare programs and services. The Partnership is supported by both local hospital systems. As a residency program with the University Of Nebraska College Of Medicine, the Lincoln Family Medicine Program has positioned itself over the past 33 years as a premier trainer of family medicine physicians. The Lincoln Medical Education Partnership provides a full range of healthcare education and services to people of all ages and backgrounds.

Among other health resources for Lancaster County residents, the Lincoln Veterans Administration Medical Center provides both primary care and behavioral health services on an out-patient basis. Clinic with a Heart and People's City Mission both provide primary care services for the homeless, low-income residents and the uninsured in their free clinics. Both clinics rely on volunteer physicians and medical staff and have limited hours of operation, especially Clinic with a Heart, which generally provides medical, dental, mental health assessments, vision and hearing screening, and physical therapy either by appointment or on certain days and nights. For students at the University of Nebraska-Lincoln, the University Health Center is also a provider of primary care services. In addition, for primary care after normal physician hours and on weekends, several urgent care clinics have opened in Lincoln over the last decade. Primary among them are three LincCare offices, Bryan Urgent Care, People's Quick Care, Heartland Urgent Care, Nebraska Urgent Care Center, and Express Care Clinic.

Ancillary Primary Care Services. The Lancaster County Medical Society (LCMS) helps individuals find a physician who is accepting new patients. LCMS also assists patients find free or low-cost prescription drugs through the Medication Assistance program. The Center for People in Need and LLCHD also provide referral information for individuals needing care.

Population Health

The Lincoln-Lancaster County Health Department is the largest local public health department in Nebraska, providing a wide range of public health services including a limited amount of primary care services. The Health Department offers direct services such as specialized clinic services, immunizations, dental care, WIC, and home visitation. The department addresses the needs of low-income families in general, but also refugees and the community's increasingly diverse minority population.

Among other responsibilities, the Environmental Public Health (EPH) division monitors air and water quality, regulates and issues permits, enforces city ordinances, responds to hazmat spills and other public health emergencies, inspects food establishments and promotes a safe and livable community. The Communicable Disease program works with EPH to investigate any food- and waterborne diseases and outbreaks of disease at facilities such as child care centers; program staff members also investigate and monitor all reportable and infectious diseases in the community such as influenza, sexually transmitted infections, tuberculosis.

The Health Promotion and Outreach division actively promotes healthy lifestyles and addresses the many negative (e.g., smoking, physical inactivity) and positive behaviors (e.g., preventive screening) that influence health. Factors influencing chronic health problems in the community (e.g., diabetes, cancer, heart disease) are a special focus of the program and the many partner

coalitions (e.g., Safe Kids, Crusade against Cancer, Action *Now!* Diabetes Coalition, Partnership for a Healthy Lincoln, Teach a Kid to Fish) that provide health education and prevention efforts.

Hospital Services

Lincoln is a regional center for healthcare, insurance, education, and business. CHI Health St. Elizabeth and Bryan Health (with two campuses) are the general acute care hospitals.

Bryan Health is a not-for-profit, locally owned healthcare organization with two acute-care facilities (the Bryan East Campus with 374 beds; and the Bryan West Campus with 266 licensed beds) and several outpatient clinics. Hospital care services include the areas of cardiology, orthopedics, trauma, neuroscience, mental health, women's health and oncology. Bryan Health employs more than 4,000 staff and they have a statewide network that provides sophisticated mobile diagnostic treatment and services to citizens throughout the region. Based on DRG categories, psychosis accounts for the single largest number of admissions at Bryan Health.

CHI Health St. Elizabeth is a non-profit, faith-based care provider and one of about 70 U.S. healthcare facilities affiliated with Catholic Health Initiatives (CHI). Saint Elizabeth (264 licensed beds) has particular experience in the treatment areas of newborn and pediatric care, women's health, emergency medicine, orthopedics, neuroscience, oncology, rehabilitation and burn and wound care. Obstetric services and newborn care top the list of admissions to St. Elizabeth.

CHI Nebraska Heart is a non-profit hospital affiliated with St. Elizabeth Hospital and Catholic Health Initiatives. Nebraska Heart (63 beds) has a large staff of experienced cardiac-care professionals, including 19 cardiologists, 5 surgeons, 3 anesthesiologists, and more than 500 support staff.

Madonna Rehabilitation Hospital is one of the nation's foremost facilities for medical rehabilitation and research. Madonna Rehabilitation Hospital (79 beds) is more than a local resource as patients are referred from throughout the state and U.S. Madonna specializes in traumatic brain injury, spinal cord injury and pediatric rehabilitation. The professional staff includes a team of highly specialized physiatrists, therapists, rehabilitation nurses and clinicians. They work with the most advanced technology and equipment to help each person achieve the highest level of independence.

Lincoln Surgical Hospital, a for-profit facility licensed for 21 beds, provides state of the art surgical suites and a skilled, professionally staffed alternative for many of the city's best surgeons. Lincoln Surgical Hospital offers surgical service on an outpatient or an inpatient basis.

The Lincoln Regional Center is a 250 bed, Joint Commission-accredited state psychiatric hospital operated by the Nebraska Department of Health and Human Services. The Lincoln Regional Center serves people who need very specialized psychiatric services and provides services to people who, because of mental illness, require a highly structured treatment setting.

With Omaha less than sixty miles to the northeast, county residents needing specialized care such as advanced pediatric services, trauma care and transplants can avail themselves of medical

services provided by physicians and staff at the University of Nebraska Medical Center, Creighton University Medical Center and Children's Hospital and Medical Center.

Built Environment and City Planning

One of the key health promotion efforts is to encourage individuals to become more physically active if they lead a sedentary existence or to maintain their lifestyle if they are active. People may get exercise at work or belong to the YMCA or a gym, but exercising outdoors is the choice of most residents. Therefore, the built environment (e.g., homes, buildings, streets, open spaces, and infrastructure) has received a great deal of attention due to its impact on the likelihood that individuals engage in exercise and physical activity. As we have shown with the data, almost half (46.1 percent; 2013 BRFSS) community residents do not meet the weekly aerobic physical activity recommendation of 150 minutes or more of moderate activity. In addition, the trend in obesity and diabetes rates has been upward over the past several decades. Nevertheless, our local measures of physical activity, obesity and diabetes are better than those for Nebraska and the U.S. Some of the reasons for the better outcomes may be due to the existing built environment in Lincoln, and ongoing planning efforts to maintain an infrastructure in the future that supports healthy living. As was learned in the Community Themes and Strengths assessment, most people perceive that access to parks and recreation in the community is good to excellent. Also, several strengths discussed in the Forces of Change assessment included mention of the 133 miles of multi-use trails for bikers, walkers and pedestrians (bike trail maps from the Great Plains Trails Network), an increase in bike commuting and the fact that health is included in the vision statement and goals of the City Planning Department's 2040 comprehensive plan (LPlan 2040) that addresses issues such as residential density, block lengths, green spaces and parks, zoning and transportation plans including bicycle commuting. Specifically, the plan states the following vision/goals related to healthy living:

- Urban design encourages walking and bicycling which improve environmental and physical health.
- Neighborhoods are friendly to pedestrians, children, bicycles, the elderly and people with disabilities.
- Redevelopment projects consider the use of existing infrastructure and buildings in their design.
- Mixed use communities that integrate a variety of housing types and commercial services and serve a variety of income levels allow people to live, work and shop within walking and biking distance.

As for biking, the City has a Bike Lincoln website with videos ("BikeLincs" and Bike Videos) that encourage bike commuting and address cyclists' needs. Lincoln has just completed a two-way protected bikeway along the south side of N Street known as the "N" Street Cycle Track. It is for the exclusive use of bicyclists. The cycle track will allow for safe bicycle commuting to work in downtown, to the dining, entertainment and sporting events in the Haymarket, and it ties in with the trails network along the Antelope Valley trails so bicyclists can easily connect to the nearby University of Nebraska as well as provide access to and from residential areas throughout Lincoln.

Non-profit Foundations and Health-Focused Coalitions

Over the years, community leaders have created a number of coalitions and foundations whose purpose is to improve the health and quality of life of residents of Lincoln and Lancaster County either as their primary mission or as a high priority goal. At the top of the list of funders is the Community Health Endowment of Lincoln (CHE) whose vision is "…making Lincoln, Nebraska the healthiest community in the nation." As was pointed out at several points in this document, CHE has funded a number of major efforts that have improved access to health, dental and behavioral care. CHE made the four priority issues in the 2013 CHIP their funding priorities that year and they are using the Place Matters mapping project to solicit applications from government and non-profit agencies at address health problems in any neighborhood or census track with poor health outcomes. Another local foundation, the Lincoln Community Foundation, has funded the Lincoln Vital Signs and Prosper Lincoln efforts that focus on ways to improve the quality of life in Lincoln, including addressing the social determinants of health.

Of course, the funders do not deliver the interventions and actions needed to improve access to health and specific health initiatives. That is up to the community's many non-profit and governmental units. Many of the non-profit organizations are part of the Human Services Federation and their membership list is made of many of the people and organizations who contributed to the MAPP community health assessments and that are partners of the Health Department in many efforts. While the contributions of many organizations on the list and others have addressed the four areas (access to care, behavioral health, chronic disease prevention, and injury prevention) highlighted in the CHIP the following have been awarded funds for specific efforts: People's Health Center, Lutheran Family Services, Lancaster County Medical Society, LLCHD, Center for People in Need, Clinic with a Heart, Aging Partners, Keya House, Cornhusker Place, Bryan Health, CHI Health St. Elizabeth, and LPS, among others.

In addition, there are other community partners and coalitions that have helped with the community health improvement efforts: Tobacco Free Nebraska, Partnership for a Healthy Lincoln, Teach a Kid to Fish, Safe Kids Lincoln-Lancaster County and Safe Kids Nebraska, Milk Works, Lancaster Crusade Against Cancer and Lincoln Breast Cancer Coalition, 5-4-3-2-1 Go!, Action *Now*! Community Diabetes Coalition, Work Well as well as others. These are among the many resources in the community.

Comparing Health Measures for Lancaster County with Other Counties throughout the Nation

In recent years there have been several efforts to determine how a county's performance on a number of measures compares to that of other counties within their state or even the 3,141[1]

[1] There are many small-population counties in the nation, and no data are available for 90 counties, including 14 or 15 in Nebraska, so the true number of counties compared is approximately 3,051 or so.

counties or county equivalents in the nation. Such a task would have been formidable without access to uniform data. As more and more data have become available at the county level, a couple of significant efforts have been made in the past decade. The first effort was made by the U.S. Department of Health and Human Services (HSS) with partial funding from the Robert Wood Johnson Foundation (RWJF), which has been improved and updated for 2015--see Community Health Status Indicators (CHSI). The CHSI 2015 data are available online to compare Lancaster County with other counties that they have designated as peer counties (see discussion below).

The second effort, also funded in part by RWJF, comes from the University of Wisconsin Population Health Institute. The County Health Rankings (CHR) website shows state-by-state county health rankings. The rankings can also be used to compare counties with counties in other states since the measures are generally consistent across the country for each year of the CHR. The one caveat is that the indicators have changed from year to year with some new indicators replacing others that had been used for the rankings. CHR continues to be an ongoing project with the 2015 rankings utilizing data for a number of multiple-year composites such as 2006-2012, including single year data from 2011, 2012 or 2013 for some of the key indicators. So, how does Lancaster County stack up or compare to other counties for which data are available?

Before answering that question, it is valuable to discuss some of the methodological characteristics of the two approaches. The original CHSI was not useful due to their use of older measures and the selection of "peer" counties, which were very dissimilar in many ways. The 2015 CHSI does seem to have selected a smaller group of comparison counties that appear to be better matches for Lancaster County. As a matter of fact, LLCHD staff has developed a dashboard application that uses the set of CHSI peer counties to compare the measures that are used in the CHR rankings. See the County Health Rankings dashboard on the Health Department's website.

Community Health Status Indicators (CHSI 2015)

1) Rather than ranking counties per se, the CHSI approach is more of a "report card" that shows the relative status of Lancaster to data for both peer counties and the U.S.

2) Utilizing Census demographic characteristics and data available from the Center for Health Statistics, the researchers established 21 peer counties, including Lancaster County.

3) The CHSI researchers then gathered data for all peer counties and compared Lancaster County data to data for peer counties for a selected set of outcome and behavioral measures (including leading causes of death, birth measures, life expectancy, BRFSS measures, communicable disease, social factors and environmental health data). The comparisons then categorized as being "Better," "Moderate" or "Worse" than the 20 other peer counties.

INDICATOR	BETTER	MODERATE	WORSE
Mortality	• Coronary heart disease deaths • Female life expectancy • Motor vehicle deaths • Unintentional injury (including motor vehicle)	• Alzheimer's disease deaths • Cancer deaths • Chronic kidney disease deaths • Diabetes deaths • Male life expectancy • Stroke deaths	• Chronic lower respiratory disease (CLRD) deaths
Morbidity	• Adult overall health status • Older adult asthma • Syphilis	• Adult diabetes • Adult obesity • Alzheimer's disease/dementia • Cancer • HIV • Older adult depression • Preterm births	• Gonorrhea
Health Care Access and Quality		• Cost barrier to care • Primary care provider access • Uninsured	• Older adult preventable hospitalizations
Health Behaviors		• Adult binge drinking • Adult female routine pap tests • Adult physical inactivity • Teen births	• Adult smoking
Social Factors	• Unemployment	• Children in single-parent households • High housing costs • Inadequate social support • On time high school graduation	• Poverty • Violent crime
Physical Environment	• Access to parks • Annual average PM2.5 concentration • Limited access to healthy food	• Housing stress • Living near highways	

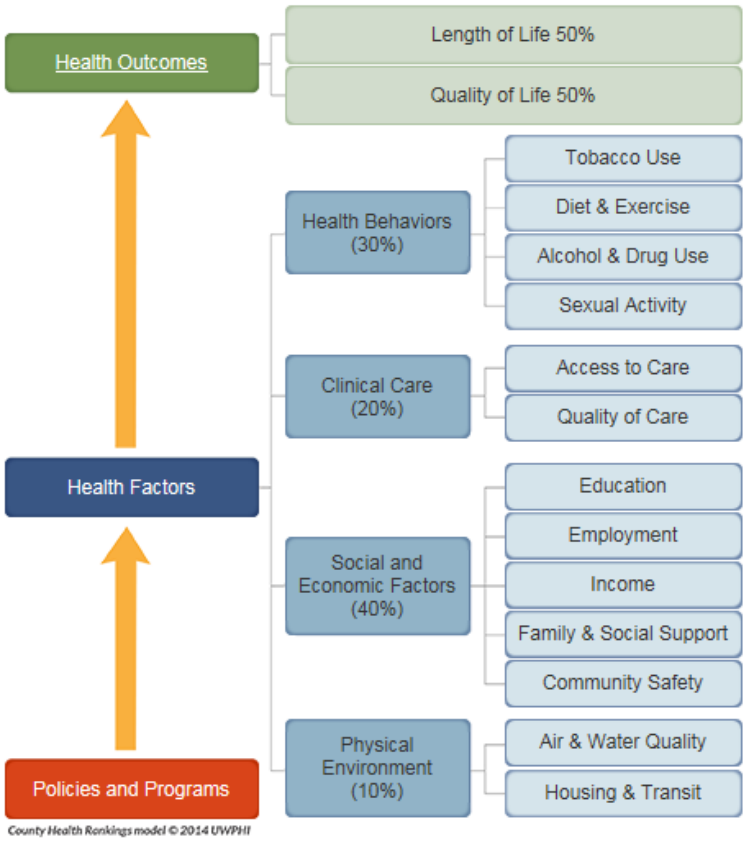
County Health Rankings (CHR)

1) The County Health Rankings employs a methodology that is used to rank counties within a state based on a composite score. They list both ordinal and cardinal ranks of counties (3,051 or so, with 78 or 79 of Nebraska's 93 counties included most years) for which they have available data. The 2015 CHR rankings for Lancaster County are listed as 24th for Health Outcomes with a ranking of 14th for Length of Life and 48th for Quality of Life, the two subcategories for Health Outcomes. Lancaster County is also ranked 24th for Health Factors; and for the subcategories under Health Factors, for Health Behaviors the rank is 21st, for Clinical Care the rank is 6th, for Social and Economic Factors the rank is 49th, and for Physical Environment the rank is 24th. The ranking of 24th for both of the broad categories (Health Outcomes and Health Factors) places Lancaster County in the second quartile of the 78 Nebraska counties that are ranked in the 2015 CHR report.

2) The CHR methodology utilizes z scores and weighting[2] to score each county's data for comparison to other counties within a given state, which is a fairly sophisticated technique, and they use multiple years of data so that volatility is removed and there's also enough data to include smaller counties. The use of z scores allows for a composite value in order to provide rank order.

3) In addition to statewide data for reference, the CHR lists the value that would constitute the top ten percent of counties nationwide. Also, with a few exceptions, the data are comparable across the country for counties so it is possible to compare county-level data with data for counties in other states. (America's Health Rankings ranks the states on health status and shares some of the concepts and measures as the CHR.) However, since

[2] See http://www.countyhealthrankings.org/our-approach for more detailed information but the diagram below gives the weighting.



we do not necessarily utilize the same weighting and cannot compare all data we will not show a numerical (ordinal) rank when comparing Lancaster County with another county or any of its peer counties in the tables and discussions that follows:

County Health Ranking Measure--2015	Lancaster County	Nebraska Overall	National Benchmark*
Premature Death	5,063	5,792	5,200
Poor/fair health	10%	12%	10%
Poor physical health days	2.8	2.9	2.5
Poor mental health days	2.9	2.7	2.3
Low birth weight	6.7%	7.0%	5.9%
Adult smoking	18%	18%	14%
Adult obesity	26%	29%	25%
Food environment index	7.9	7.8	8.9
Physical inactivity	19%	24%	20%
Excessive drinking	20%	20%	10%
Alcohol-impaired driving deaths	22%	35%	14%
STIs	431	364	138
Teen birth rate	24	32	20
Uninsured adults	12%	13%	11%
Primary care physicians	1,417:1	1,405:1	1,045:1
Dentists (population to dentist ratio)	1,100:1	1,450:1	1,377:1
Mental health providers	299:1	435:1	386:1
Preventable hospital stays	49	56	41
Diabetic screening	87%	86%	90%
Mammography screening	66.9%	61.8%	70.7%
High school graduation rate**	84%	88%	86%
Some college	76.2%	70.0	71.0
Unemployment rate	3.5%	3.9%	4.0%
Children in poverty	17%	17%	13%
Income inequality	4.4	4.2	3.7
Children in single-parent households	28%	28%	20%
Violent crime rate**	388	264	59
Daily fine particulate matter	9.7	12.1	9.5
Drinking water violations	0%	8%	0%
Severe housing problems	14%	13%	9%
Driving alone to work	81%	81%	71%
Long commute – driving alone	13%	17%	15%

Shading Legend

Lancaster compared to others:	**Color**	**Comment:**
Above or equal to NE/ Nat'l benchmark (top 10 %)		
Better than or equal to NE, but not in the top 10 %		Equal or better than NE
Worse than national benchmark		May equal NE rate
*Top 10 percent level **Calculations vary nationwide		
NE/national compared to Lancaster:	**Color**	
Better outcome/factor value than Lancaster County		
Equal to or tied value with Lancaster County		
Worse outcome/factor value than Lancaster County		

Community Themes and Strengths Summary

In conducting the Community Themes and Strengths assessment we utilized both online surveys as well as focus groups in 2011, and then again in 2015. In 2011 we posted an online survey and conducted focus groups with a group of African Americans and another with a group of Hispanics/Latinos. Since our survey was just a convenience survey, when the state conducted a random phone survey statewide and offered to sample at least 500 residents of each local health district, the Lincoln-Lancaster Health Department agreed to participate. The results of that survey allow us to not only compare similar questions to the local convenience survey and also to compare local results with the state results. In 2015 we posted another convenience survey online. We also cooperated with the state to conduct a facilitated focus group with Lincoln and Lancaster County residents that we invited to the session. In addition to the larger focus group, we also conducted two smaller focus groups with seniors at a senior center in Lincoln. The reason we wanted to host seniors was due to the responses from the 2011 surveys that found that seniors were not as satisfied with the issues we asked about, namely public transportation, housing for the elderly and other supports for the elderly.

This is a brief summary, but the details of the survey results and focus groups are included in Appendix 4.

The surveys asked about perceptions of the public about various aspects of the community. The results showed that respondents thought that Lincoln/Lancaster County was a healthy or very healthy community, that the community is a safe place to live, work, and play; has quality housing available; has people who pitch in to help in times of need; has excellent schools; and generally has available and safe childcare providers available. The community also has great access to recreational services, arts, music and cultural events; and to a lesser extent has a lot of organized leisure activities for young adults. In all of the areas about recreation; access to arts, music and cultural events; and leisure programs for young adults (despite the good comparison there were a relatively high percent of respondents who disagreed in 2011), the random survey responses results were better than the state results on a statistically significant basis. However, there were a fairly large number of respondents who disagreed in a number of areas—respondents with children feel that childcare is not easily affordable; there are not enough after-school programs for elementary students; and to a lesser extent, not enough after-school opportunities for middle and high school students. When looking at issues for the elderly there was a positive, but less favorable rating overall. However, 15 percent or more from the random survey disagreed about the availability of housing for the elderly, programs that provide meals for the elderly and social networks for the elderly living alone. The most negative response related to transportation options such as public transport. The area with the most negative responses in 2011 related to jobs and the economy, which probably reflected the effects of the recession. In all areas related to jobs (whether there are enough jobs, opportunities for advancement, jobs that are family friendly; and whether the economy is strong) the respondents who disagreed exceeded 25% and the most negative responses were around a third (33%).

As for the responses to the questions about health issues, the rankings differed between the random survey and the convenience surveys. Still, the issues that relate to chronic disease and aging, distracted driving, access to care including behavioral health stand out and are not too

much different than the results of the MAPP committee scoring. Of course, the MAPP committee members had the benefit of data on incidence, prevalence and comparisons to Nebraska data. With the data in hand, suicide, binge drinking and excessive alcohol use, and STDs (chlamydia) were issues that rose in the rankings from the MAPP committee.

Serious Health Issues

Random Sample Survey, 2011	**LLCHD Online Surveys 2011 and 2015**
Cancer	Mental/behavioral health (both 2011 and 2015)
Overweight and obesity	Obesity (2015)
Diabetes	Substance or drug abuse/overdose (both years)
High blood pressure	Health disparities/inequities (both 2011 and 2015)
Heart disease	Diabetes (both 2011 and 2015)
Stroke	Aging problems (both 2011 and 2015)
Aging problems	Heart disease and stroke (both 2011 and 2015)
Teenage pregnancy	Child abuse/neglect (both 2011 and 2015)
Child abuse and neglect	Domestic violence (both 2011 and 2015)
Sexually transmitted diseases (STDs)	Suicide (2015)
Infectious disease	Cancers (both 2011 and 2015)

Behaviors/Issues Impacting Overall Health

Random Sample Survey, 2011	**LLCHD Online Surveys 2011 and 2015**
Talking on a cell phone while driving	Being overweight or obese (both 2011 and 2015)
Texting while driving	Poverty (2015)
Not enough exercise	Alcohol and substance abuse (both 2011 and 2015)
Poor eating habits	Behavioral health issues (2015)
Drunk driving	Physical inactivity (both 2011 and 2015)
Drug abuse	Distracted drivers (texting/using cell phone)
Tobacco use (cigarettes and smokeless)	Access to care (2015)
Alcohol abuse	Child abuse/neglect (2015)
Violence (domestic violence, Fighting, etc.)	Tobacco use/smoking (both 2011 and 2015)
Not getting vaccine ‘shots’ to prevent disease	Not getting vaccinations to prevent disease (2015)
Not using seat belts (or improper use)	Language/cultural barriers (2015)

Single Issue to be Addressed First

Random Sample Survey, 2011	**LLCHD Online Surveys 2011 and 2015**
Overweight and obesity	Mental/behavioral health (both 2011 and 2015)
Cancer	Obesity (2015)

Healthcare-related (quality, access, cost, coverage)	Health disparities/inequities (both 2011 and 2015)
Not enough exercise	Diabetes (both 2011 and 2015)
Unhealthy eating and/or poor nutrition	Aging problems (both 2011 and 2015)
Diabetes	Substance or drug abuse/overdose (both years))
Mental health/or suicide	Child abuse/neglect (both 2011 and 2015)
Distracted driving	Cancer (2011)
Drug abuse	Domestic violence (2011)
Aging population and elderly conditions/needs	High blood pressure (2011)
Drunk driving	Suicide (2011)
Heart disease	Dental problems (2011)

Forces of Change Assessment Summary

The MAPP process includes a Forces of Change Assessment and we conducted a brainstorming session both in 2011 and again in 2015 to gather input about events, trends and factors that shape the background conditions in the community. This big picture look differed somewhat between the two times in which they were conducted and the lists of topics are included in Appendix 2. The following table highlights the forces that were mentioned and were consistent themes.

Community Resources	**Events**
Community Health Endowment funds programs that improve access to care	Development in the Haymarket District including Pinnacle Bank Arena
People's Health Center and Lutheran Family Services	Antelope Valley Project—prevents flooding
Center for People in Need, especially for new residents	Innovation campus and research, but there's now no State Fair
Free clinics such as Clinic with a Heart and People's City Mission clinic	County privatized Community Mental Health--2014
Good cooperation by the Lincoln Hospitals and Lincoln is a planning community	Southeast Community College and LPS created the Career Academy
Lancaster County Medical Society and Health 360	360 Health Care Clinic opening in February 2015
Great parks and trails	**Legislation**
Great schools everywhere in the county	The Affordable Care Act and Health Marketplace
Air and water quality is good	Medicaid expansion legislation failed
Medical homes are available if unknown	Breast feeding in public law passed
UNL and other colleges/universities	Mid-levels can now practice independently
LLCHD and Dental College dental services	**Trends**

Coalitions and non-profits that address child obesity as well as promote active lifestyles	Poverty has spread throughout the community;
"Streets Alive" and "Girls on the Run" are positives	Income inequality seems to be getting wider and poverty is hidden
Background	Economy is improving; skilled worker in demand
Lincoln is growing and with growth travel times across town are long; crime is picking up	Suicide rates are rising among the young
Low unemployment, but also low wages	Increasing diversity of the population
Midwest work ethic	Food insecurity is growing—more need
Work force is educated	Behavioral health is increasingly focused on drugs
Retirees have little savings, need to work longer; their neighborhoods are changing	More global access: good and bad (diseases are brought in by travelers)
North Lincoln (Including NW and NE) has fewer primary care and medical providers	Homeless are often victims of domestic abuse
High rates of free and reduced meals in schools--over 40 percent overall in LPS	Increasing diversity, more languages spoken
Public transportation is lacking, especially for elderly and in evenings/on weekends	Later marriages; delayed child care. It's good that teen births are down.
Low foreclosure rates, good housing but rents are rising and unaffordable for some	Non-profits are asked to do more and there is fatigue
Behavioral health is often more drug prescription than counseling	Wellness is promoted by business
Public services are questioned more	Drug use (K2 and prescription drugs) up

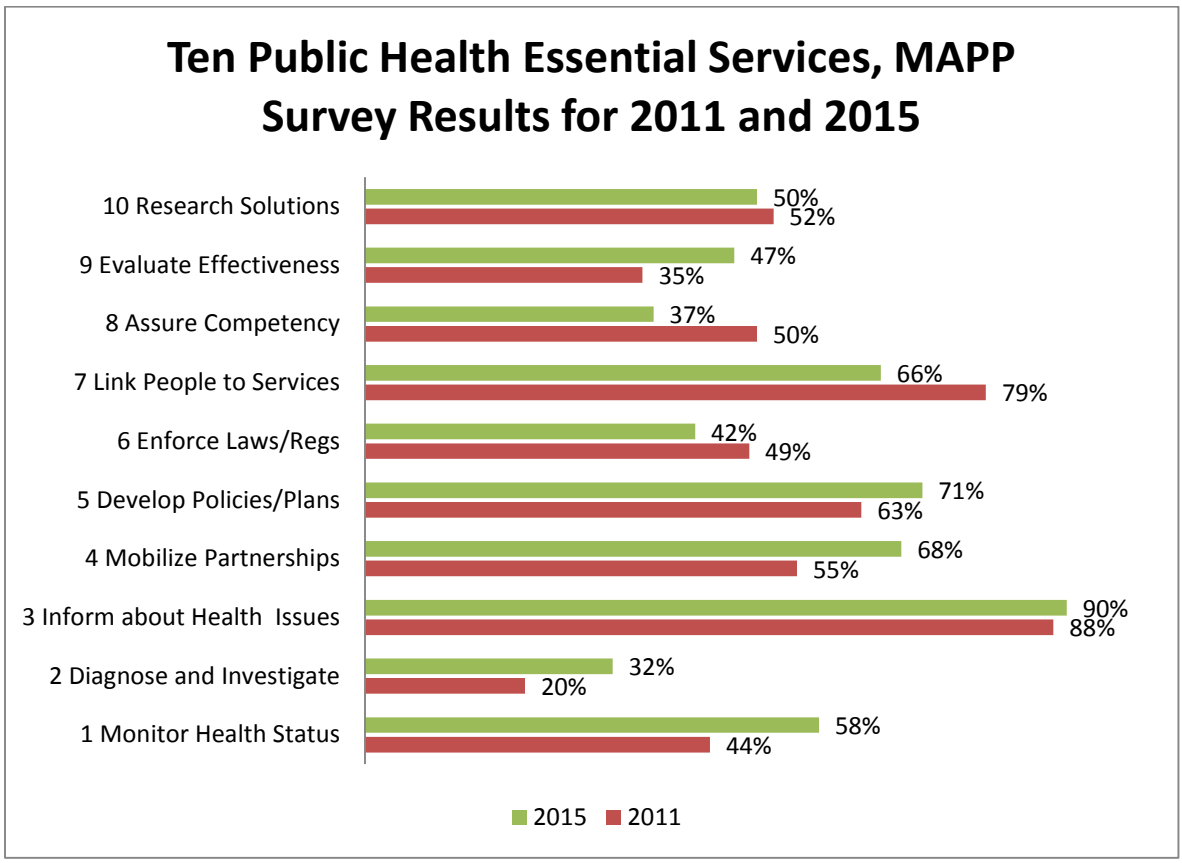
The issues that were focused on are the growth of Lincoln's population now and in the future, and the changing city landscape with development of the Haymarket area, Innovation Park and Antelope Valley project improving infrastructure. On a negative note, some of the development pushed poor people out. Despite the general economic growth, wages are low in the city compared to other cities, and poverty has expanded beyond the core to the North (both Northeast and Northwest). Food insecurity is on the rise due to people's poverty incomes or having just enough money to no longer qualify for SNAP. The lack of legislation to expand Medicaid has also left some people without subsidies from the Affordable Care Act (ACA). The local not-for-profit agencies are doing a great job, but their resources are stretched. The Community Health Endowment has funded a number of efforts in the community to both promote health (Partnership for a Healthy Lincoln, Teach a Kid to Fish) and to increase access to health and dental care (Lancaster County Medical Society, People's Health Center, the Bridge, Clinic with a Heart, LLCHD Dental, the Health Hub). The elderly numbers are growing and many are unprepared for retirement and changes in their life; their neighborhood services are changing and they don't have public transit that fits their needs. LPS and SCC have created a great option to promote career growth for students. Lincoln has great parks and trails and there are more entertainment options due to the building of Pinnacle Bank Arena. There is a growing discussion about government services and whether the private sector could do a better job, yet street repairs,

construction, and public safety are pressing needs as the City expands, which it is in all directions, but mostly to the South, Southeast and lately, to the East/Northeast.

Local Public Health System Assessment Summary

We assessed the local public health system through both a survey of our local health partners as well as conducting the National Local Health Performance Standards assessment. The surveys of our partners have been conducted every five years while we conducted the NPHSP tool in 2011.

The following chart shows the survey results of our local public health system partners conducted in 2011 and 2015. The survey link for 2015 is on our MAPP webpage.



The surveys in 2011 and 2015 asked our partner agencies which of the ten essential services of public health they perform and followed up with specific areas that would be aspects of the essential service to be sure that they actually were performing the essential service that was indicated. As the chart above shows, LLCHD and most of our partners inform about health issues (ES#3) and link people to services (ES#7). The next highest scoring essential services were developing policies and plans (ES#4) and mobilizing partnership (ES#5). Essential services that are primarily provided by the Health Department (ES#1, ES#2 and ES#6) scored lower, as expected. While the results of the survey help understand what our partners do, we also invited

our local public health partners to participate in the Local Public Health Performance Standards assessment.

In August of 2011, LLCHD invited our community partners to assess how we measured up against the Local Public Health System Performance Standards. Over 100 citizens and staff from our partner agencies participated in scoring the performance standards. People were invited to rate performance for the essential service(s) that was most relevant to them. The facilitated assessment took place over a day and a half and the CDC provided results to us on 8/24/2011 as shown below.

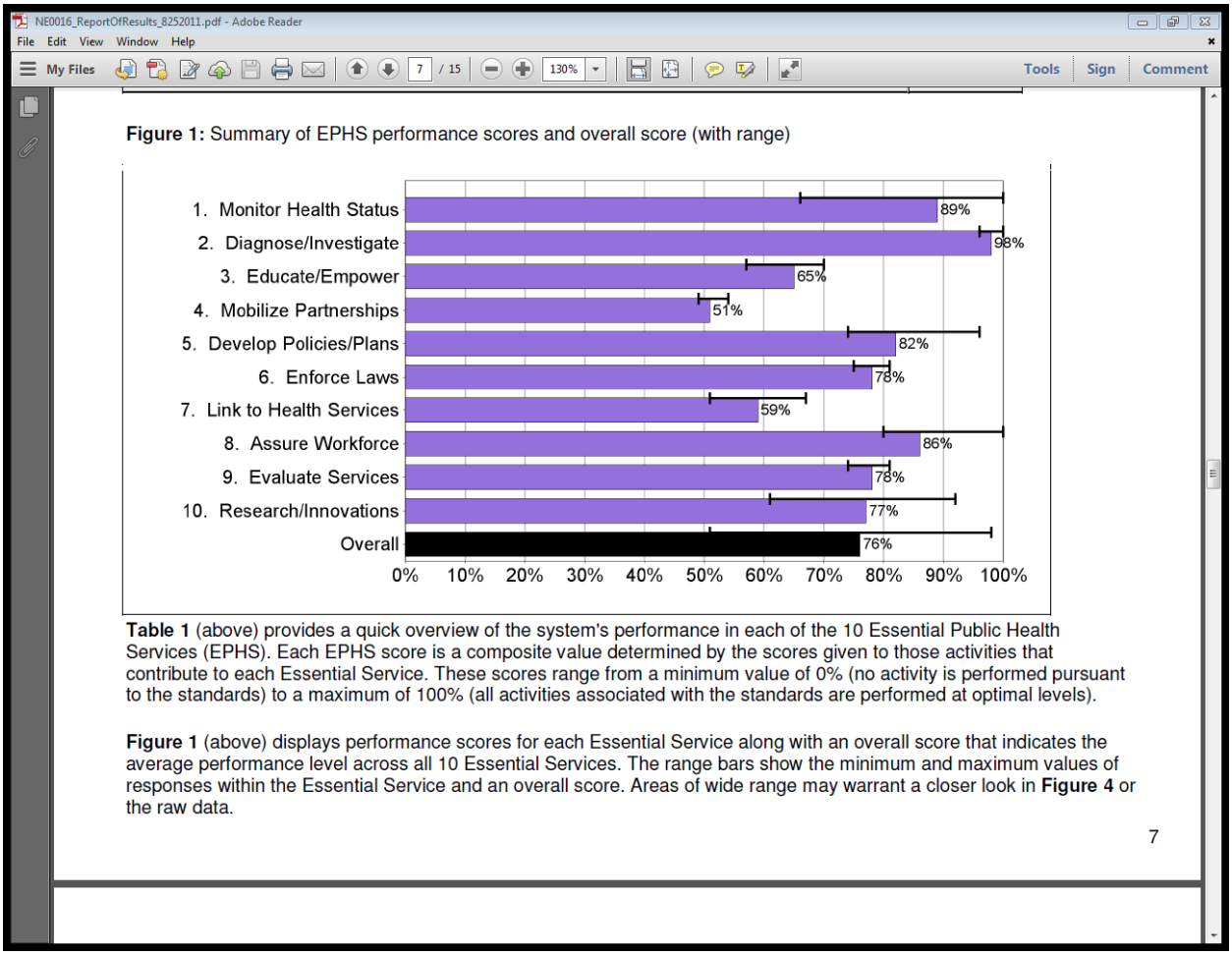


Figure 1: Summary of EPHS performance scores and overall score (with range)

Table 1 (above) provides a quick overview of the system's performance in each of the 10 Essential Public Health Services (EPHS). Each EPHS score is a composite value determined by the scores given to those activities that contribute to each Essential Service. These scores range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum of 100% (all activities associated with the standards are performed at optimal levels).

Figure 1 (above) displays performance scores for each Essential Service along with an overall score that indicates the average performance level across all 10 Essential Services. The range bars show the minimum and maximum values of responses within the Essential Service and an overall score. Areas of wide range may warrant a closer look in **Figure 4** or the raw data.

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Given that the scoring for each performance standard ranged from No Activity (0 percent) to Optimal Performance (75-100 percent) where Significant Performance was scored as 50-74 percent, the results tell us that there is no area where we have only Minimal (1-24 percent) or Moderate (25-49 percent) activity as the lowest mean was 51 percent (ES#4). Nevertheless, there is room for improvement as some of the areas where we scored the lowest on performance are the essential services many of our partners are engaged in (ES#4 and ES#7.

Scoring of Priority Issues

After reviewing the information on health status and the other assessments, the MAPP committee was asked to score the health issues on the basis of seven criteria (the scoring is outlined in Appendix 1). Three of the criteria were based on the latest available data on the burden of the health condition, behavior or problem, the trend, and how the local rates compare to state rates. These three values represented one-third of the weight. The fourth criterion was the based upon the social or economic impact of the problem, which is weighted as one-third. The last three criteria were the capability of the local health department to have an impact on the problem, the capacity of the local health care system, and the political will to address the problem. These last three criteria account for one-third of the weight. Eighty issues were scored overall. The full results are shown in Appendix 1, with the top-scored issues being the following:

Health Issue/Behavior--2015	Score
Diabetes (Black)	***4.33***
STI/STD (Chlamydia)	***3.89***
Diabetes (Overall)	***3.89***
Excessive drinking (adults)	***3.78***
Distracted driving (adults)	***3.78***
Obesity (adults)	***3.78***
Obesity (children)	***3.78***
Mental Illness prevalence	***3.67***
STI/STD (Gonorrhea)	***3.67***
High blood pressure (hypertension)	***3.67***
Inadequate prenatal care	***3.67***
Colorectal cancer screening (50+)	***3.67***
Physical inactivity	***3.67***
Violence/Abuse	***3.67***
Distracted driving (youth)	***3.61***
Binge drinking	***3.56***
Suicide (15-24 year olds)	***3.56***
Falls (elderly)	***3.56***
Food insecurity	***3.56***
Drug abuse (K2)	***3.44***
Heart Disease	***3.44***
Smoking (adults)	***3.44***
Alcohol abuse (youths)	***3.39***
Cavities (dental caries)	***3.39***

Prescription drug abuse	***3.33***
Breast cancer mortality	***3.33***
LBW babies (African Americans)	***3.33***
Child abuse/neglect	***3.33***
Uninsured (health)	***3.28***
Behavioral Health Access	***3.28***
Safety belt use (adults)	***3.28***
Smoking (youths)	***3.28***

As can be seen, the scores are close together and this list is more than the 20 that would constitute one-fourth. However, it is not possible to give much focus to we could not address all 32, let alone 80 issues so the 32 were reviewed for communalities. After much discussion, we prioritized four issues: chronic disease prevention; access to care (including access to dental care and some mental health services; behavioral health issues including substance abuse and suicide; and injury prevention including violence/abuse. These broad categories encompass most of the issues scored high on the list except for STDs (Chlamydia and Gonorrhea), maternal and child health issues (inadequate prenatal care and LBW babies), and food insecurity. However, STDs and food insecurity are the focus of other efforts by the public health and health community; and food insecurity is also a community wide effort of many non-profit agencies.

Therefore, the four broad health issues remain the focus of the Community Health Improvement Plan where strategies, goals and objectives are addressed for each of the areas. The CHIP is a separate document that accompanies this community health assessment.

APPENDICES

Appendix 1. Scoring Criteria to Determine Health Priorities

The 2015 health priorities were scored based on the following criteria and the results of the scoring, with their rank are shown in the table that follows. The issues were grouped to establish the priority health issues for the Community Health Improvement Plan (CHIP):

- Chronic Disease Prevention
- Injury Prevention
- Access to Care (including behavioral health and dental)
- Behavioral Health (including substance abuse, but emphasizing suicide prevention)

Scoring Criteria for Identifying Priority Health Issues

Note: Criteria 1 through 3 are based on data and data trends and account for 1/3rd of the weight.

1 Magnitude (Size) of the Problem
1 = 0-4 % of population (or a rate of < 25 per 100,000);
2 = 5-9 % of population (or a rate of 25-49 per 100,000);
3 = 10-14 % of population (or a rate of 50-99 per 100,000);
4 = 15-24 % of population (or a rate of 100-149 per 100,000);
5 = 25+ % of population (or a rate of > 25 150 per 100,000).

2 Comparison with State (National) Results
1 = numbers/Rates significantly better than state results;
2 = numbers/Rates slightly better than state results;
3 = numbers/Rates same as state results;
4 = numbers/Rates slightly worse than state results;
5 = numbers/Rates significantly worse than state results.

3 Historical Trends
1 = data show significant improvement over the past five to ten years;
2 = data show some improvement over the past five to ten years;
3 = data are stable over the past five to ten years;
4 = data show some deterioration (worsening) over the past five to ten years;
5 = data show rapid deterioration (worsening) over the past five to ten years.

Note: Criteria 4 through 7 are more subjective and were scored via survey. Criteria 4 is 1/3rd of the weight and criteria 5 through 7 make up the final 1/3rd of the score.

4 Economic/Social Impact
1 = low impact on productivity, health care expenditures, academic performance, crime and arrest rates, and overall population health
2 = below average impact on productivity, health care expenditures, academic performance, crime and arrest rates, and overall population health

3 = average impact on productivity, health care expenditures, academic performance, crime and arrest rates, and overall population health
4 = above average impact on productivity, health care expenditures, academic performance, crime and arrest rates, and overall population health
5 = high impact on productivity, health care expenditures, academic performance, crime and arrest rates, and overall population health

5 Changeability
1 = very unlikely that the issue can be changed at the LHD level through evidence-based programs, policies, and practices
2 = somewhat unlikely that the issue can be changed at the LHD level through evidence-based programs, policies, and practices
3 = neither unlikely nor likely that the issue can be changed at the LHD level through evidence-based programs, policies, and practices
4 = somewhat likely that the issue can be changed at the LHD level through evidence-based programs, policies, and practices
5 = very likely that the issue can be changed at the LHD level through evidence-based programs, policies, and practices

6 Capacity of the Local Health System
1 = there is very little capacity among local public health system stakeholders to move forward on this issue
2 = there is little capacity among local public health system stakeholders to move forward on this issue
3 = there is a moderate amount of capacity among local public health system stakeholders to move forward on this issue
4 = there is strong capacity among local public health system stakeholders to move forward on this issue
5 = there is very strong capacity among local public health system stakeholders to move forward on this issue

7 Readiness/Political Will
1 = there is very little willingness among state and community **leaders** to move forward with advocates on this issue
2 = there is little willingness among state and community **leaders** to move forward with advocates on this issue
3 = there is a moderate amount of willingness among state and community **leaders** to move forward with advocates on this issue
4 = there is strong willingness among state and community **leaders** to move forward with advocates on this issue
5 = there is very strong willingness among state and community **leaders** to move forward with advocates on this issue

Scores

Health Issue/Behavior	Size of the local problem	Comparison with state/national rates	Historical Trends	Economic /Social impact	Change-ability	Capacity of the local public health system	Readiness/ political will	Score
Diabetes (Black)	5	3	4	5	4	4	4	***4.33***
STI/STD (Chlamydia)	5	5	5	3	4	4	3	***3.89***
Diabetes (Overall)	2	2	4	5	4	4	4	***3.89***
Excessive drinking (adults)	2	4	3	5	4	3	3	***3.78***
Distracted driving (adults)	3	3	3	5	4	3	3	***3.78***
Obesity (adults)	5	2	3	5	3	3	3	***3.78***
Obesity (children)	3	2	2	5	4	4	4	***3.78***
Mental Illness prevalence	3	3	3	5	3	3	3	***3.67***
STI/STD (Gonorrhea)	4	5	4	3	4	4	3	***3.67***
High blood pressure (hypertension)	5	1	4	4	4	4	3	***3.67***
Inadequate prenatal Care	4	3	4	4	3.5	4	2.5	***3.67***
Colorectal cancer screening (50+)	5	1	3	4	4	4	4	***3.67***
Physical inactivity	4	1	1	5	4	4	4	***3.67***
Violence/Abuse	3	5	3	4	4	3	3	***3.67***
Distracted driving (youth)	5	4	2	4	3.5	3	3	***3.61***
Binge drinking	4	5	1	4	4	3	3	***3.56***
Suicide (15-24 year olds)	1	5	4	4	4	3	3	***3.56***
Falls (elderly)	5	3	3	4	3	3	3	***3.56***
Food insecurity	4	3	2	4	4	4	3	***3.56***
Drug abuse (K2)	1	4	4	4	4	3	3	***3.44***
Heart Disease	1	1	3	5	4	4	3	***3.44***
Smoking (adults)	4	3	2	4	4	3	3	***3.44***
Alcohol abuse (youths)	4	3	1	3.5	4	4	4	***3.39***
Cavities (dental caries)	4	4	4	3	3.5	3	3	***3.39***
Prescription drug abuse	1	3	4	4	4	3	3	***3.33***
Breast cancer mortality	2	4	4	3	4	3	4	***3.33***
LBW babies (African Americans)	3	4	2	4	4	3	2	***3.33***
Child abuse/neglect	1	4	3	4	4	3	3	***3.33***
Uninsured (health)	4	2	3	4	3	3	2.5	***3.28***
Behavioral Health Access	3	1	1	5	4	3	2.5	***3.28***
Safety belt use (adults)	4	2	3	3	4	3.5	4	***3.28***
Smoking (youths)	3	3	1	4	4	3	3.5	***3.28***
Bicycle helmet use	5	1	4	3	4	3	3	***3.22***
Prostate cancer screening	5	1	4	3	4	3	3	***3.22***
Immunization rates (2 year olds)	2	3	3	3	4	4	4	***3.22***
Asthma (current)	3	5	4	3	3	3	2	***3.22***
Drug (Opiate) overdose deaths	1	3	4	3.5	4	3	3	***3.17***
Riding with drunk driver (youth)	4	1	1	4	4	3	3.5	***3.17***
Prematurity	2	3	2	4	3	3.5	3	***3.17***

Oral health access	5	3	3	3	3	3.5	2	***3.17***
Fruit/vegetable consumption	4	3	2	3	4	3.5	3	***3.17***
Alzheimer's disease (mortality)	5	1	4	4	2	2	2	***3.11***
Drinking and driving (adults)	1	4	2	4	3	2.5	3.5	***3.11***
Breastfeeding rate (WIC)	5	2	2	2.5	4	4	3.5	***3.11***
High cholesterol	5	2	2	3	4	3	3	***3.11***
Mammography Rates (50+)	4	2	3	3	4	3	3	***3.11***
Infant mortality (African Americans)	1	4	2	4	4	3	2	***3.11***
Asthma (minorities)	4	3	4	3	3	3	2	***3.11***
Sports injuries (concussions)	2	3	3	3	4	4	3	***3.11***
Sleep deprivation	5	3	3	4	2	2	1	***3.11***
Foodborne illness	1	3	2	3.5	4	4	3	***3.06***
Waterborne illness (Giardia)	1	4	3	3	4	3.5	3	***3.06***
Preparedness (community)	3	2	1	3.5	4	4	3	***3.06***
Breastfeeding rate (NIS)	5	2	1	2.5	4	4	3.5	***3.00***
Uninsured (dental)	4	3	3	3	3	3	2	***3.00***
Poor water quality	1	3	3	3	4	3.5	3	***2.94***
Drug overdoses	1	3	3	3	4	3	3	***2.89***
COPD/chronic lung disease	2	4	4	3	2	3	2	***2.89***
Drowning (youth)	1	3	3	3	4	3	3	***2.89***
LBW babies overall	2	2	1	4	3	3	3	***2.89***
Lung cancer	2	3	3	3	3.5	3	2	***2.83***
Waterborne illness (Crypto)	1	2	3	3	4	3.5	3	***2.83***
Waterborne illness (E-coli Shiga)	1	2	3	3	4	3.5	3	***2.83***
Colorectal cancer mortality	2	1	3	3	4	3	3	***2.78***
Leukemia	1	4	4	3	3	2	2	***2.78***
Teen births	1	1	1	4	4	3	3	***2.78***
Hospital nosocomial infections	3	3	2	3	3	3	2	***2.78***
Preparedness (individual/family)	4	3	3	2.5	2.5	2	2.5	***2.72***
Arthritis	4	1	4	3	2	2	2	***2.67***
Hepatitis C	1	3	3	3	3	3	2	***2.67***
Prostate cancer mortality	1	2	3	3	3	3	3	***2.67***
Air quality (Ozone)	1	3	3	3	2	3	3	***2.67***
Air quality (PM 2.5)	1	3	3	3	2	3	3	***2.67***
Motor vehicle deaths	1	1	1	4	3	3	3	***2.67***
Infant mortality overall	1	2	2	3	4	3	2	***2.56***
Non-Hodgkin Lymphoma	1	2	2	3	3	3	2	***2.44***
Fair or Poor health (self-report)	2	1	1	3	3	3	3	***2.44***
HIV/AIDS	1	2	2	2	4	3	3	***2.33***
Tuberculosis (TB)	1	3	3	2	2	4	2	***2.33***
Compulsive gambling	1	3	3	3	1	1	1	***2.11***

Comparison of Ranked Health Issues—2015 versus 2011

Rank	Health Issue/Behavior 2015	Score
1	Diabetes (Black)	***4.33***

Health Issue/Behavior 2011	Score
Diabetes	***4.06***

2	STI/STD (Chlamydia)	***3.89***
3	Diabetes (Overall)	***3.89***
4	Excessive drinking (adults)	***3.78***
5	Distracted driving (adults)	***3.78***
6	Obesity (adults)	***3.78***
7	Obesity (children)	***3.78***
8	Mental Illness prevalence	***3.67***
9	STI/STD (Gonorrhea)	***3.67***
10	High blood pressure (hypertension)	***3.67***
11	Inadequate prenatal Care	***3.67***
12	Colorectal cancer screening (50+)	***3.67***
13	Physical inactivity	***3.67***
14	Violence/Abuse	***3.67***
15	Distracted driving (youth)	***3.61***
16	Binge drinking	***3.56***
17	Suicide (15-24 year olds)	***3.56***
18	Falls (elderly)	***3.56***
19	Food insecurity	***3.56***
20	Drug abuse (K2)	***3.44***
21	Heart Disease	***3.44***
22	Smoking (adults)	***3.44***
23	Alcohol abuse (youths)	***3.39***
24	Cavities (dental caries)	***3.39***
25	Prescription drug abuse	***3.33***
26	Breast cancer mortality	***3.33***
27	LBW babies (African Americans)	***3.33***
28	Child abuse/neglect	***3.33***
29	Uninsured (health)	***3.28***
30	Behavioral Health Access	***3.28***
31	Safety belt use (adults)	***3.28***
32	Smoking (youths)	***3.28***
33	Bicycle helmet use	***3.22***
34	Prostate cancer screening	***3.22***
35	Immunization rates (2 year olds)	***3.22***
36	Asthma (current)	***3.22***
37	Drug (Opiate) overdose deaths	***3.17***
38	Riding with drunk driver (youth)	***3.17***
39	Prematurity	***3.17***
40	Oral health access	***3.17***
41	Fruit/vegetable consumption	***3.17***
42	Alzheimer's disease (mortality)	***3.11***
43	Drinking and driving (adults)	***3.11***
44	Breastfeeding rate (WIC)	***3.11***

Obesity (adults)	***4.00***
Smoking (youths)	***4.00***
Violence/Abuse	***4.00***
Texting/cell phone use while driving	***4.00***
Fruit/vegetable consumption	***3.94***
Smoking (adults)	***3.89***
High blood pressure (hypertension)	***3.89***
No health insurance	***3.78***
Cavities (dental caries)	***3.78***
Mental Illness	***3.78***
High cholesterol	***3.78***
Obesity (children)	***3.78***
Safety belt use (youth)	***3.67***
Binge drinking	***3.56***
Falls (# outpatient visits--18 months)	***3.56***
Births to teens (% of total births)	***3.56***
Poor parenting practices	***3.56***
Breast cancer (rate per 100,000)	***3.56***
Health disparities (African Americans)	***3.56***
LBW babies	***3.56***
Heart disease (rate per 100,000)	***3.50***
Physical inactivity (Moderate Physical Activity)	***3.44***
Preparedness (community)	***3.44***
Alcohol abuse (adults)*Ever drank alcohol	***3.39***
Drinking and driving (youth)	***3.39***
Immunization rates (recommended)	***3.39***
STIs (STDs): Chlamydia (#)	***3.39***
Alcohol abuse (youths) *Ever used alcohol	***3.33***
Health disparities (minorities)	***3.33***
Illegal drug use: Youth (marijuana)	***3.33***
Inadequate prenatal care (10+ Prenatal Visits)	***3.33***
Low breast feeding rate	***3.33***
Overeating (large portions)	***3.33***
Poor water quality	***3.33***
Suicide (rate per 100,000)	***3.33***
Health disparities (age)	***3.22***
Teen's driving behavior	***3.22***
Prescription drug abuse	***3.22***
Compulsive gambling	***3.22***
Health disparities (Hispanics)	***3.22***
Lung cancer (rate per 100,000)	***3.22***
Mammography rates (50+)	***3.22***
Asthma	***3.11***

45	High cholesterol	***3.11***
46	Mammography Rates (50+)	***3.11***
47	Infant mortality (African Americans)	***3.11***
48	Asthma (minorities)	***3.11***
49	Sports injuries (concussions)	***3.11***
50	Sleep deprivation	***3.11***
51	Foodborne illness	***3.06***
52	Waterborne illness (Giardia)	***3.06***
53	Preparedness (community)	***3.06***
54	Breastfeeding rate (NIS)	***3.00***
55	Uninsured (dental)	***3.00***
56	Poor water quality	***2.94***
57	Drug overdoses	***2.89***
58	COPD/chronic lung disease	***2.89***
59	Drowning (youth)	***2.89***
60	LBW babies overall	***2.89***
61	Lung cancer	***2.83***
62	Waterborne illness (Crypto)	***2.83***
63	Waterborne illness (E-coli Shiga)	***2.83***
64	Colorectal cancer mortality	***2.78***
65	Leukemia	***2.78***
66	Teen births	***2.78***
67	Hospital nosocomial infections	***2.78***
68	Preparedness (individual/family)	***2.72***
69	Arthritis	***2.67***
70	Hepatitis C	***2.67***
71	Prostate cancer mortality	***2.67***
72	Air quality (Ozone)	***2.67***
73	Air quality (PM 2.5)	***2.67***
74	Motor vehicle deaths	***2.67***
75	Infant mortality overall	***2.56***
76	Non-Hodgkin Lymphoma	***2.44***
77	Fair or Poor health (self-report)	***2.44***
78	HIV/AIDS	***2.33***
79	Tuberculosis (TB)	***2.33***
80	Compulsive gambling	***2.11***

COPD/Lung disease (rate per 100,000)	***3.11***
Oral health access	***3.11***
Foodborne illness (#)	***3.11***
Prematurity	***3.06***
Bicycle helmet use	***3.06***
Colorectal cancer screening (50+)	***3.06***
Preparedness (family)	***3.00***
Fair or Poor health (self-report)	***2.94***
Hospital nosocomial infections	***2.94***
Arthritis	***2.89***
Colorectal cancer (rate per 100,000)	***2.89***
Provider's cultural competency	***2.89***
Alzheimer's disease	***2.89***
Elderly's driving behaviors	***2.89***
Infant mortality (2009 rate per 1000 Live Births)	***2.89***
Infant mortality--minorities	***2.89***
Health disparities (gender)	***2.83***
HIV/AIDS (# HIV)	***2.83***
Leukemia/Lymphoma	***2.83***
Sports injuries	***2.83***
Prostate cancer (rate per 100,000)	***2.78***
Motor vehicle deaths (rate per 100,000)	***2.72***
Drowning	***2.67***
Waterborne illness	***2.50***
Bad air quality	***2.50***
Hepatitis B (#)	***2.22***
Poisoning (hospital admissions--18 months)	***2.11***
Tuberculosis	***1.89***

Appendix 2. Forces of Change Assessment

Issues from the Brainstorming Sessions (bulleted items were from 2015 MAPP Committee)

25. Development of the Innovation Campus
26. Antelope Valley/Arena positives
27. Fewer bankruptcies—good Nebraska values
28. Big Ten opportunities (research and reputation)
    - Streets Alive is a positive.
45. Passage of the breastfeeding-in-public law
51. New early child research
1. Increased economic pressures
8. Pressure on the state for funding of the mandates
7. Federal healthcare policy uncertainty
    - Attempted child abduction. Kids are not safe around low-income schools.
38. Brain Drain
17. Lincoln's low unemployment rate
18. Community Health Endowment's existence
21. Great parks/trails
30. Lincoln's strong school system
37. Lincoln is a great planning community
42. Public utility costs are reasonable
    - Antelope Valley stopped flooding which is a positive, but as a negative, it pushed people out.
    - Flexible funding for health (CHE)
    - Protected bike way – bike sharing – Star Tran bike rack
    - Community Health Endowment is a positive.
    - Great recreational opportunities – trails and parks.
    - All schools in Lancaster County are a positive.
    - The long-standing non-profits in Lincoln have stood the test of time.
    - Innovation Campus is a positive.
    - Economic conditions in Lincoln are a positive.
58. Backpack program in 70 schools
68. Good air and water quality
69. Global access
    - Managed care contracts – we will have to do a lot more with these people.
    - Health 360 is a positive
    - Hospitals in Lincoln are active and communicate with each other.

- Independent physicians.
- Hospitals work with their local health department.
- “Girls on the Run” is a positive.
- Almost everyone can get a medical home but awareness and education is still lacking.

16. Education (systems and how to use them)
    - Diversity and new cultures in Lincoln with different needs.
39. Lincoln's well educated and underpaid population
    - Inadequate cross-walks for pedestrians and bicyclists.
    - Travel times across Lincoln are long.
36. Immigration issues
65. Language difficulties (50+ in LPS)
    - Average age in years of town is an impact.
55. 48 % free and reduced lunches (elementary schools)
57. 57% free and reduced for Lincoln High School
    - Working poor and the pressures.
13. Transportation issues (public transportation issues versus multimodal, trails)
54. Generous and ignorant community re homelessness (60 percent transients) most are there for domestic abuse
12. Food distribution/food insecurity
56. Poverty is hidden
    - Primary care in north Lincoln is low.
    - Lack of health care resources in north and northeast Lincoln.
    - Behavioral health services for children
    - Some providers are still back logged (Peoples Health Center)
61. Access to care/medical home
    - With the university, STDs are up.
59. 6500 visits to Mission’s medical clinics; many have had no connection to the Mission or distribution center
47. Suicide rates among the young and old
63. PTSD issues at Cedar’s
31. Child welfare/foster care awareness
    - Affordable Care Act is a positive and a negative.
14. Gaps between systems (child welfare, juvenile justice)
    - Schools are being locked for safety reasons.
    - There is no cross-town public transportation in the evenings and on weekends.
40. Issues related to homelessness
6. Domestic violence
41. Near homeless
48. Easy access to guns
50. Incarceration rates especially among certain populations
60. Entitlement mentality (ER use)
43. Buying local campaign
3. Increased cultural/racial diversity
11. Growth of the City/County’s population
74. In-home and adult day care
35. Strong green movement promotes health

53. Social media changes (impact of Facebook, Twitter, texting, et. al.)
22. Wellness programs (WorkWell and State wellness programs)
64. Less paperwork
62. Behavioral health breakthroughs (no need for hospital care due to meds)
72. Medical technology improvement
73. Mid-level practitioners are increasing
70. Prevention issues—increased personal accountability
    - Increased interest in bikes.
5. Substance abuse increases/awareness
23. More Nebraskans have quit smoking (locally also)
29. More living generations
    - Lincoln is a growing community; however, it is lopsided – south and southeast growing and north is not.
19. Growth issues (gets ugly)
20. Baby boomers are aging/half of elders have little or no savings
75. Dementia increases in the elderly
    - Baby boomers are healthy but there will be fixed incomes when they retire that will result in higher health costs, hunger issues, mental health, and isolation.
2. Increased gas prices
15. Increasing gaps between the haves/have nots
    - Increased poverty outside the core.
9. Longer waiting lists for health care providers
66. Medicare changes (Dr. won't take Medicare)
44. Prescription drug abuse is rising
49. Use of marijuana and K2 like substances (bath soap)
    - Drivers distracted by texting or talking on the phone.
67. Providers don't accept subsidized day care
10. Increases in obesity/childhood obesity; increased awareness
24. Alcohol consumption remains high
46. Prematurity resulting from lack of prenatal care
33. Discussion about public responsibilities and private responsibilities (also tension between private and public sectors)
4. Growing dissatisfaction with government performance
52. Later marriages; delayed childbirth
34. Vulnerable populations are at risk
    - Increased housing costs for rental and private owned.
    - Fatigue in non-profit community – trends going in wrong direction; asking more of our schools; want to cut back on schools.

Appendix 3: GIS Maps

The maps in this section were created both for this document, but also for the "Place Matters" project headed by the Community Health Endowment of Lincoln. The Place Matters project is aimed at defining areas of Lincoln that have better or worse outcomes and factors such as poverty than influence health, and asking for community organizations to help identify the reasons why a neighborhood or census tract has poorer outcomes than the community as a whole. Once the groups have identified the problems in an area they can apply for funds from CHE to address the issue. The hope is that over the next several years, efforts will be made to lessen the disparities in outcomes across the City.

The maps for the Place Matters project involved GIS staff from Health, and Urban Development as well as data from several agencies (Health, Urban Development, Election Commission, Lincoln Public Schools (LPS) and Public Safety). Several of the GIS maps, with attributes, are available online and they differ from the maps included here as the CHE maps are more refined in terms of individual values. This mapping project is ongoing and the Health Department will continue to work on helping to define the levels of health status, and other measures related to health, across the county's geographic areas.

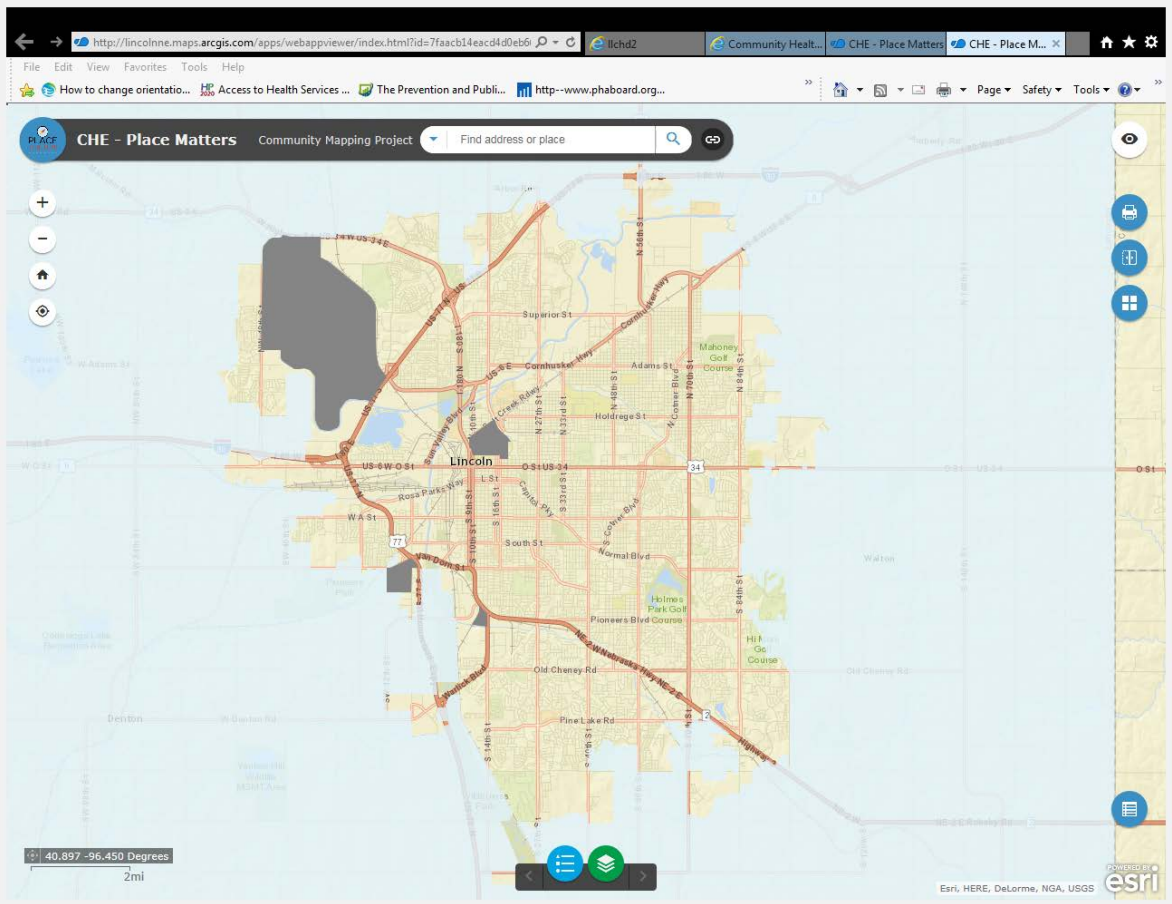
For the maps in this appendix, the data comes from a variety of sources: Census data, facility rosters, Vital Statistics reports (birth and death), LPS (obesity data) and BRFSS (Behavioral Risk Factor Surveillance Survey) data for all adults. In the case of maps utilizing BRFSS data, three years (2011-2013) of data were combined and a methodology was employed to create estimates by census tract. The regular BRFSS survey does not have a large enough sample to present data by census tract so the estimates are based upon the age characteristics of the population living in a given census tract.

As for the legends, the;

- Census data (e.g., poverty rates, education) are generally shown as percentages
- Facility data (i.e., urgent care facilities, hospitals, etc.) show locations
- Vital Statistics, birth data, also show a number of indicators by percentage
- Vital Statistics, mortality data, are shown as rates or calculated values (e.g., life expectancy) based on several years of death certificate information
- Obesity data for schools comes from Lincoln Public Schools
- BRFSS data by census tract are estimated based on three years of BRFSS results, and the data are displayed by standard deviation, where the (mean) midpoint is plus or minus .50; and deviations, either positive or negative from the mean are shown by color with the cooler colors representing a better outcome, and warmer cools representing a worse outcome (the exact color schemes differ from map to map)
- Some of the other maps also use the standard deviation approach but the final maps will use a value for the cutoffs (the mean value will be presented for those census tracts in yellow, the value for one standard deviation above or below will have a value, and so on)

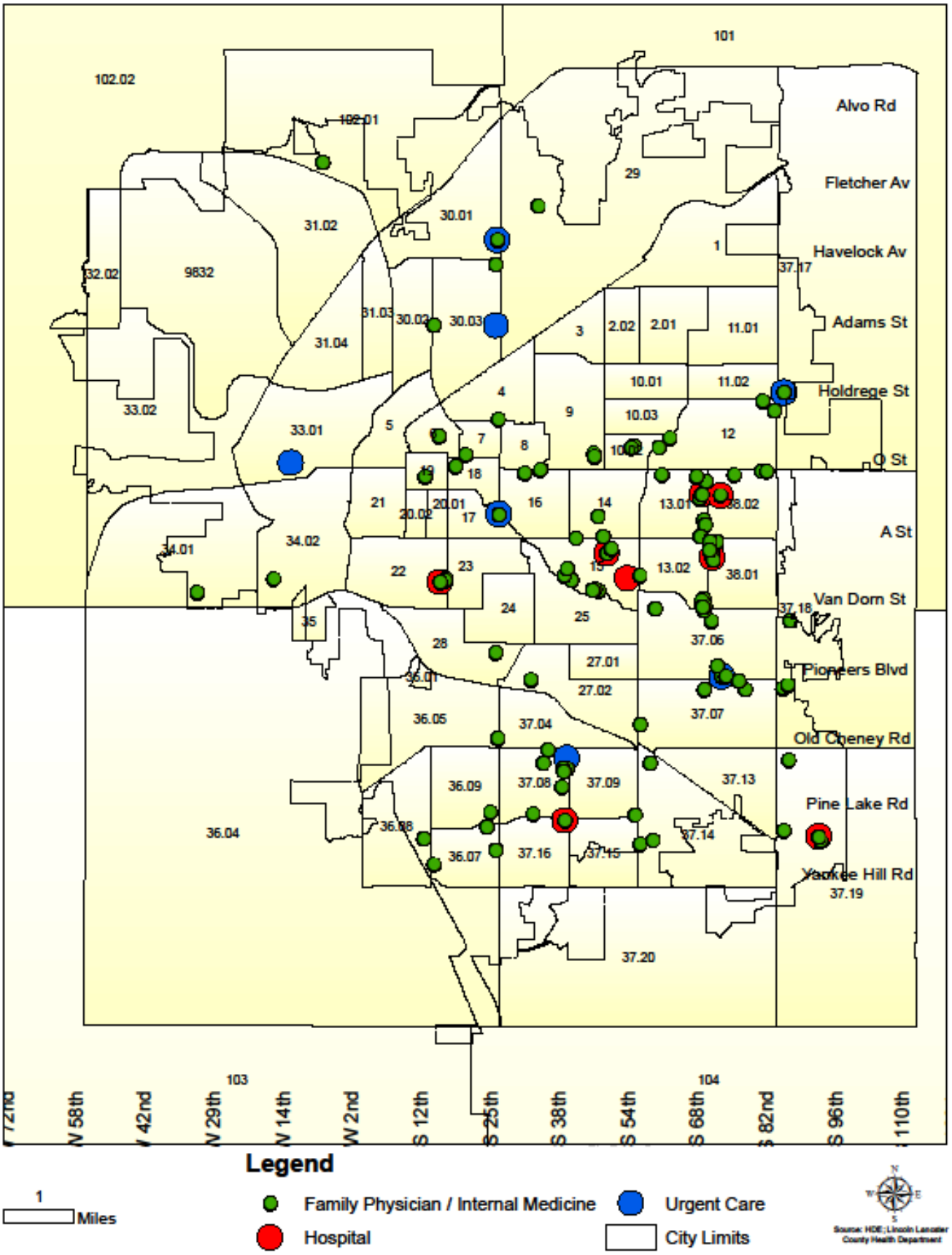
One other note about the maps is that there are four census tracts (6, 35, 36.01, and 9832) that are excluded (e.g., MCH maps), or should be excluded due to their unique

characteristics, when discussing the level of rates. These four census tracts include the University of Nebraska, the Lincoln Airport, the state penitentiary and the Regional Center as shown in the following map. While people do live in those census tracts, the size of the population or other characteristics of the population and the rates are not meaningful in comparison to other census tracts.

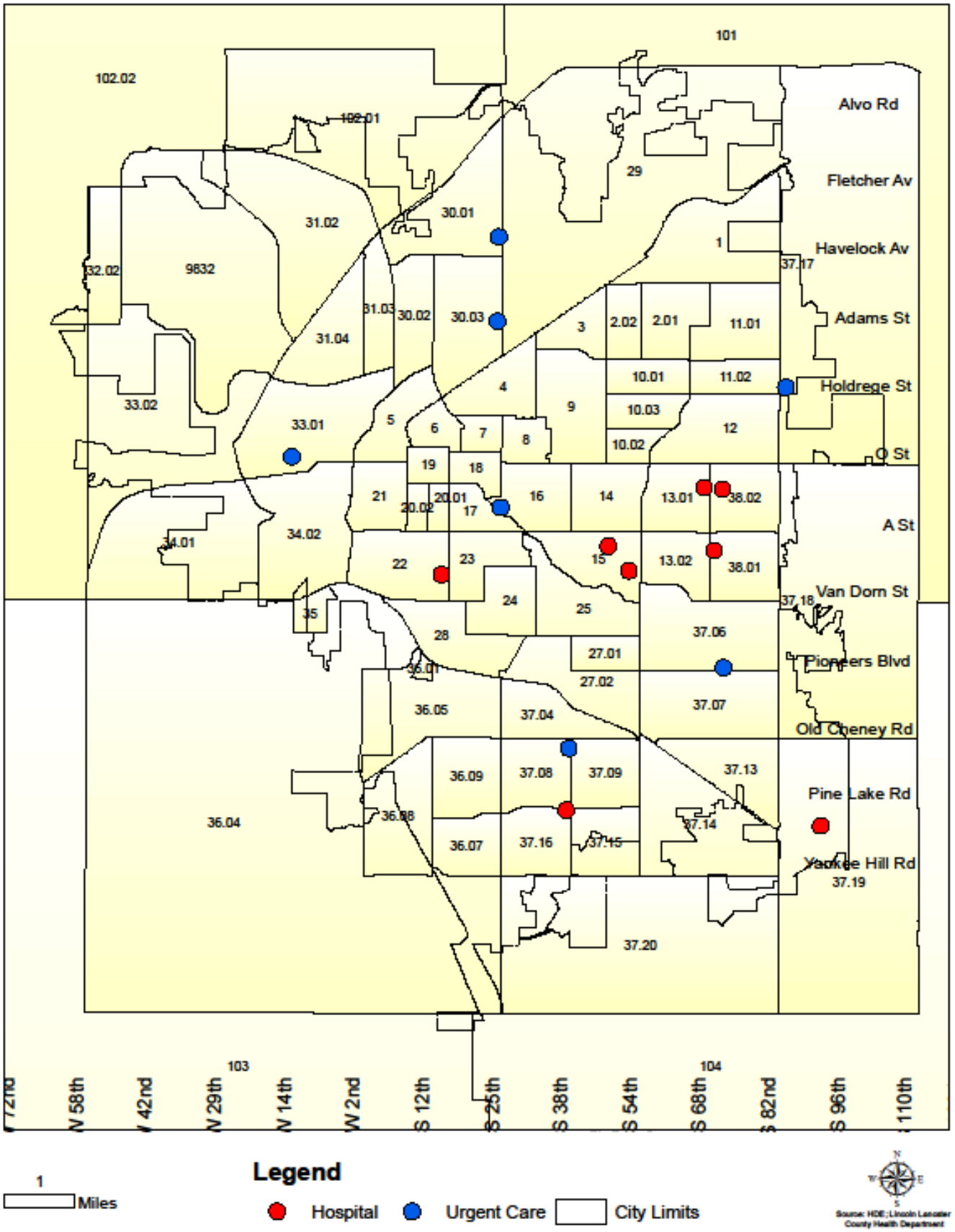


Therefore, in analyzing the data from the following maps, be careful not to draw conclusions based on the shading of these four census tracts when they are not excluded.

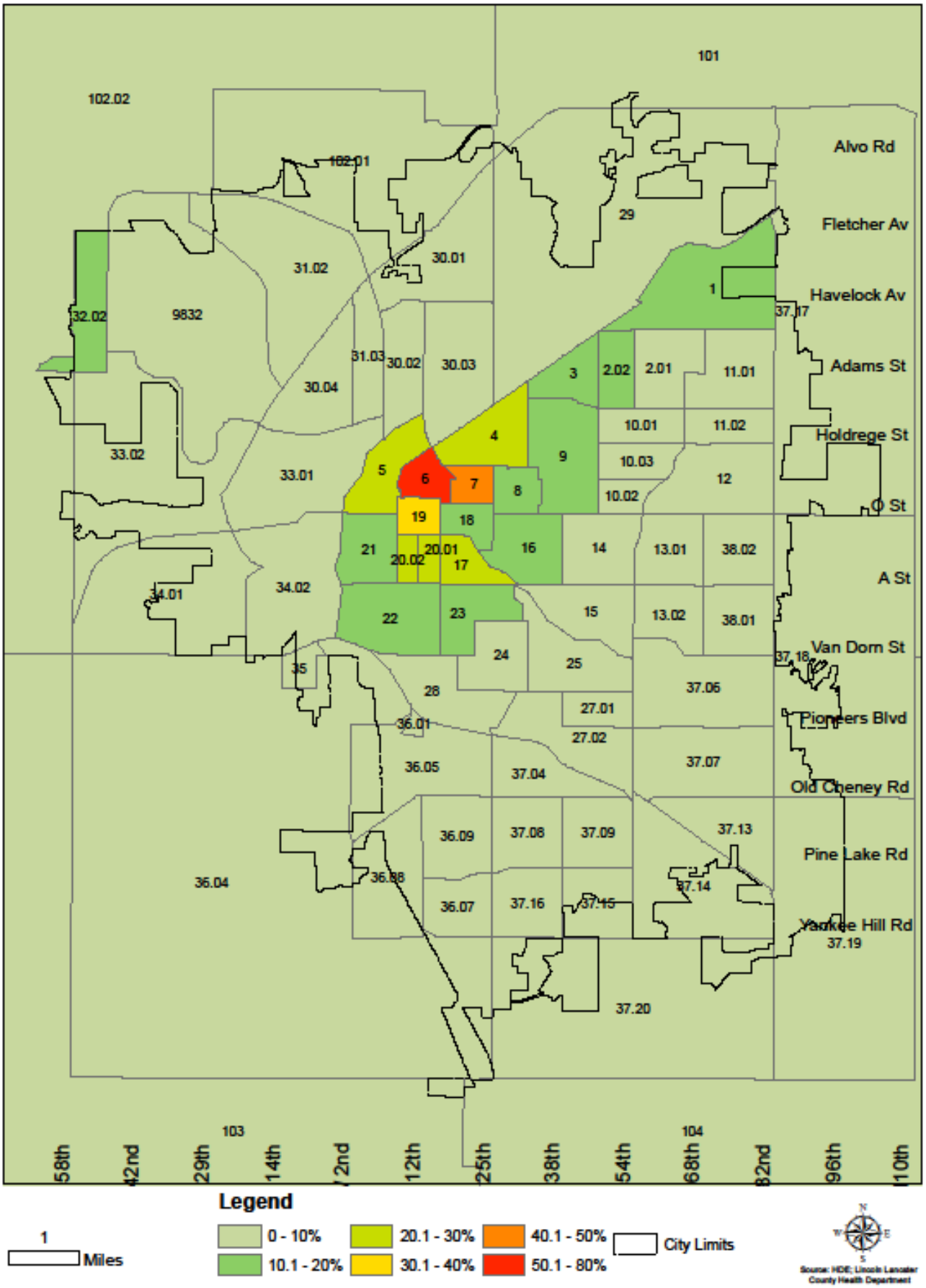
Medical Care Locations



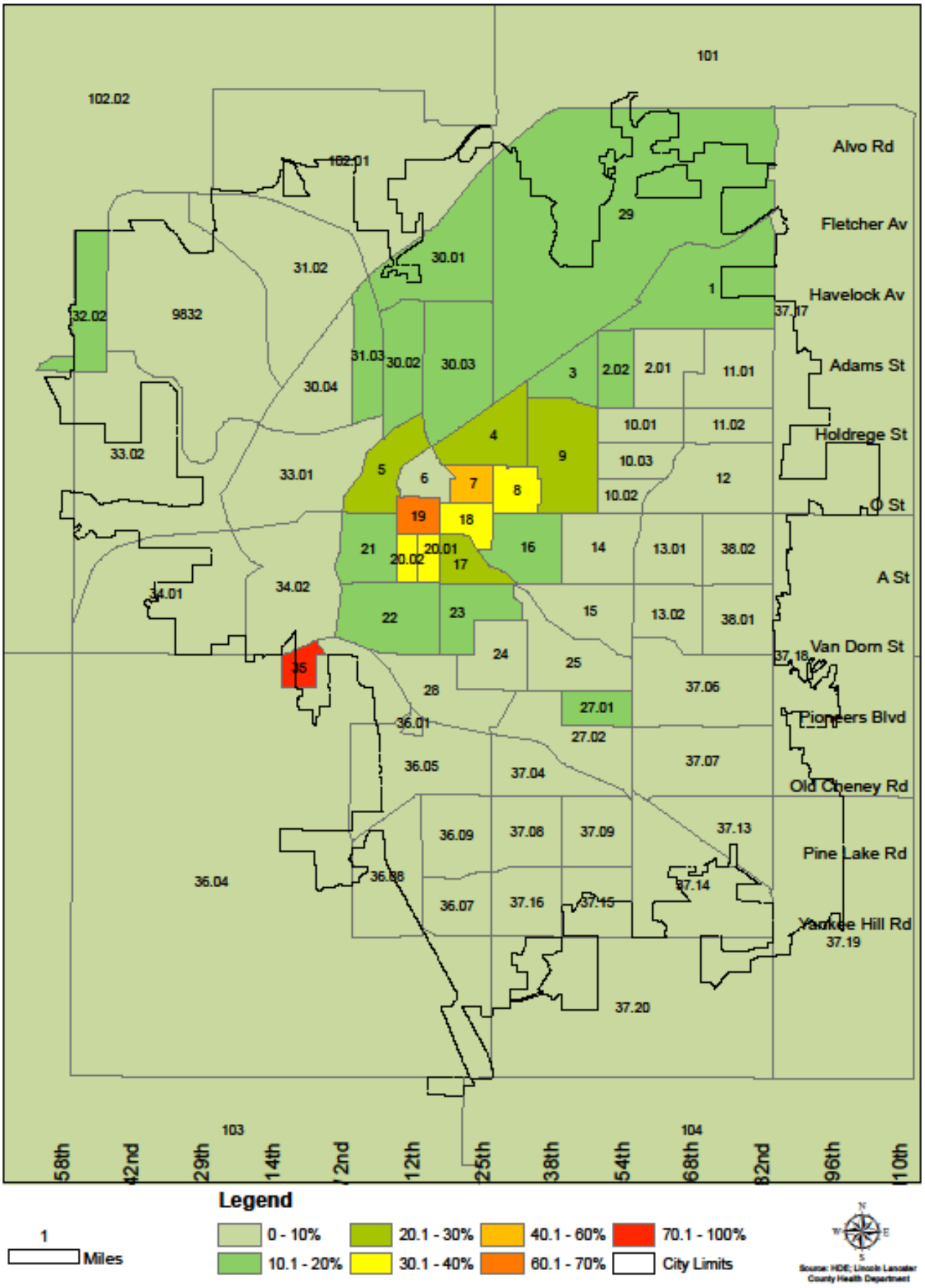
Access To Urgent / Hospital Care



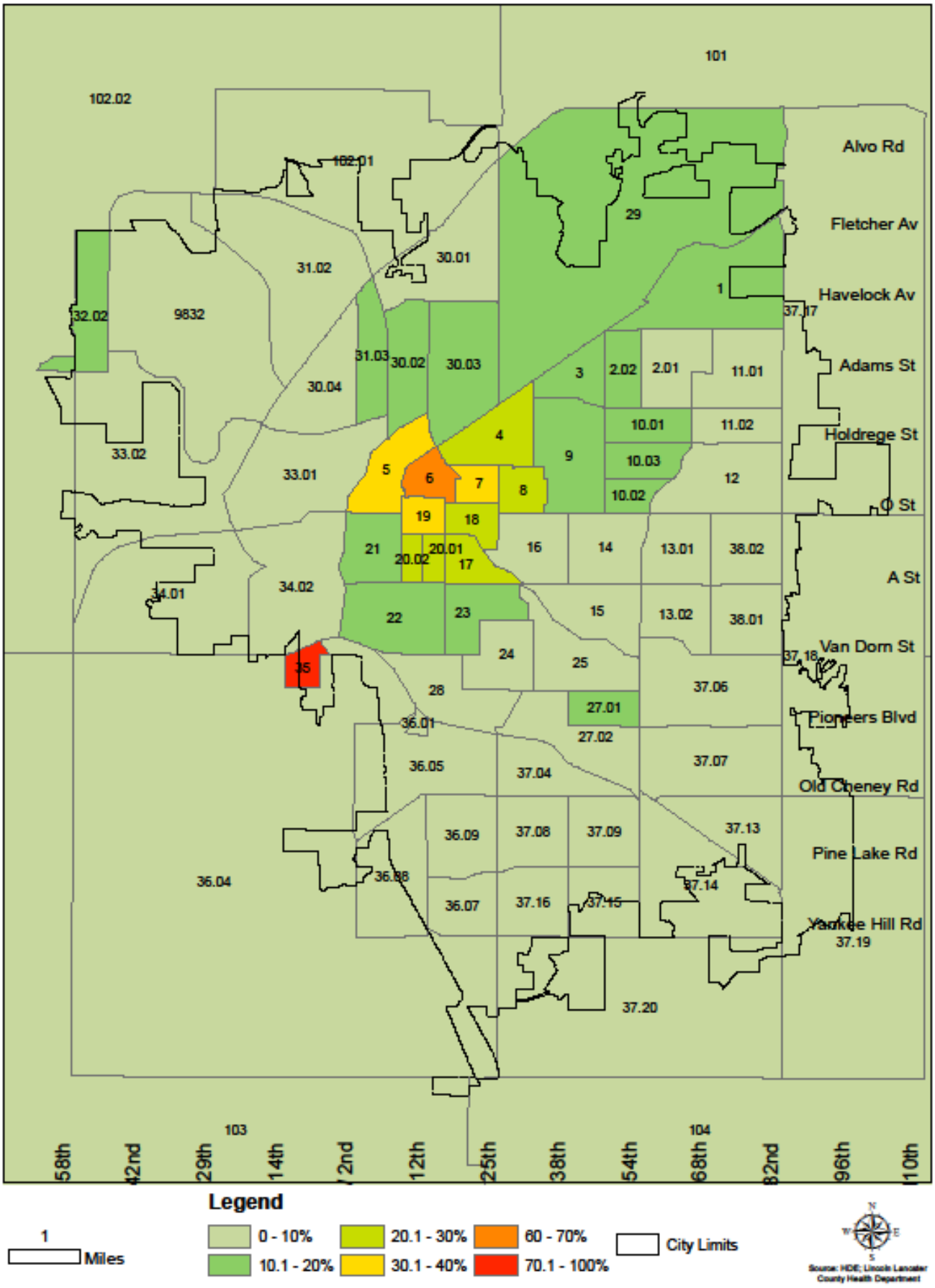
Percent Poverty Per Census Tract 1980



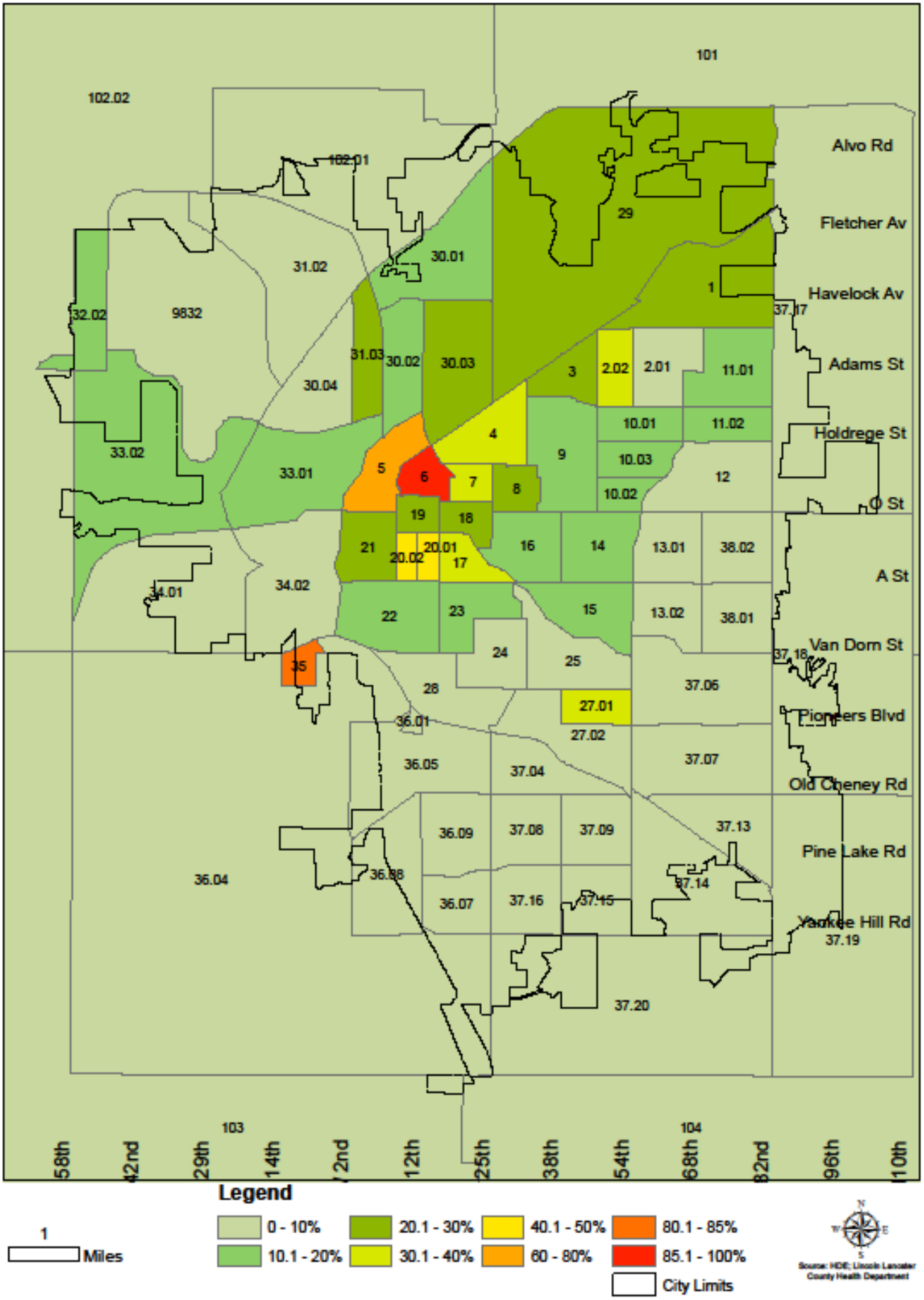
Percent Poverty Per Census Tract 1990



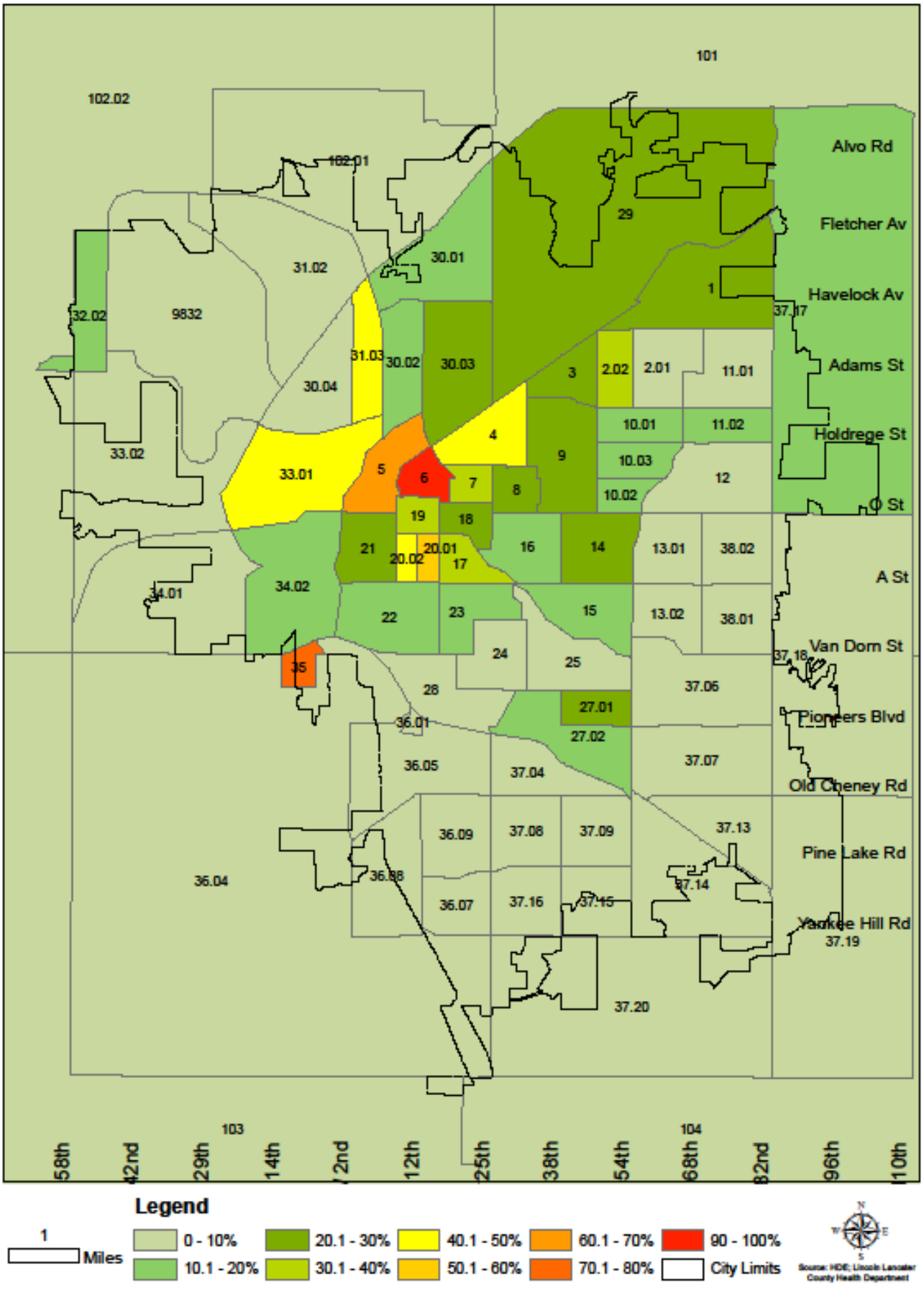
Percent Poverty Per Census Tract 2000



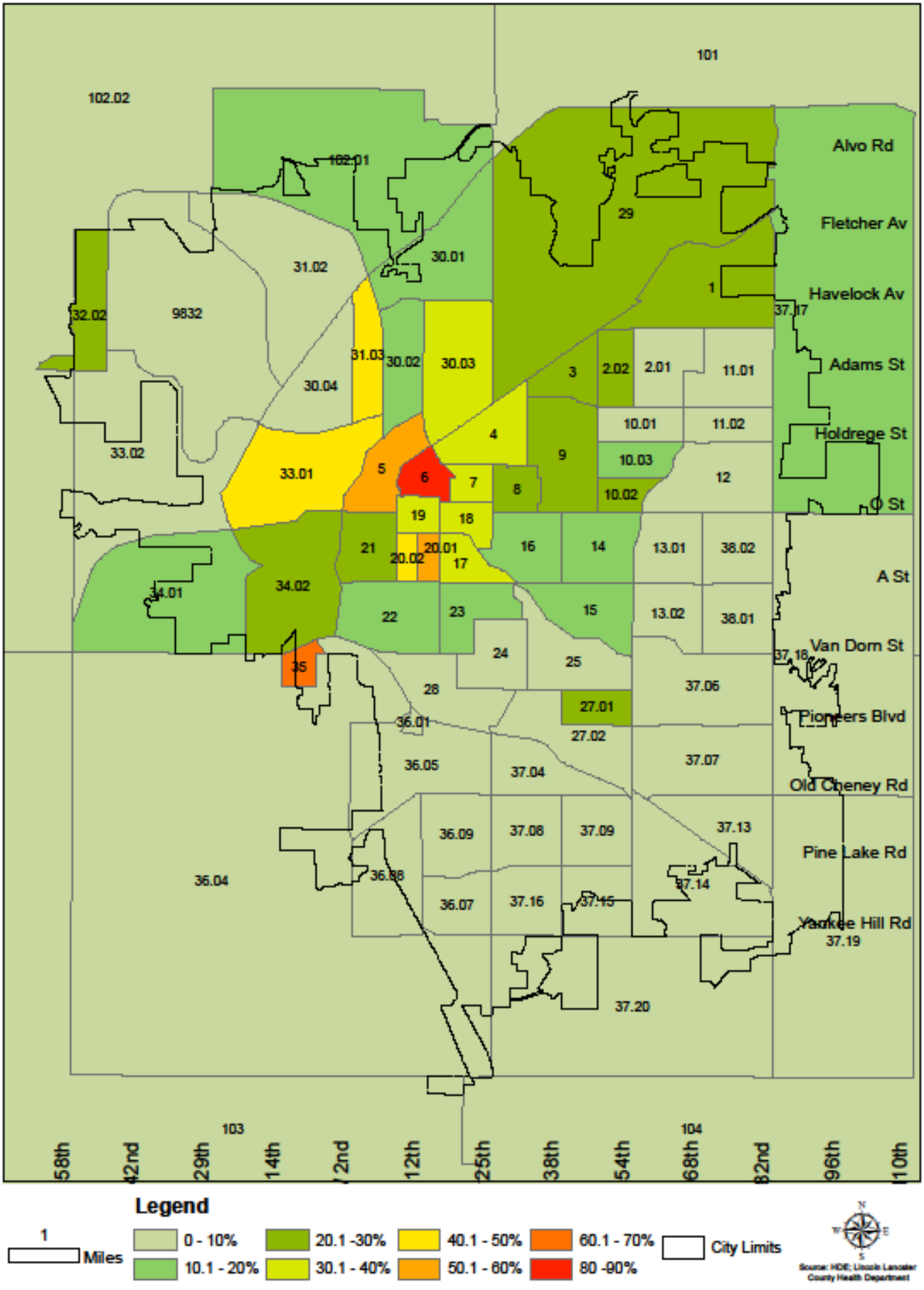
Percent Poverty Per Census Tract 2009



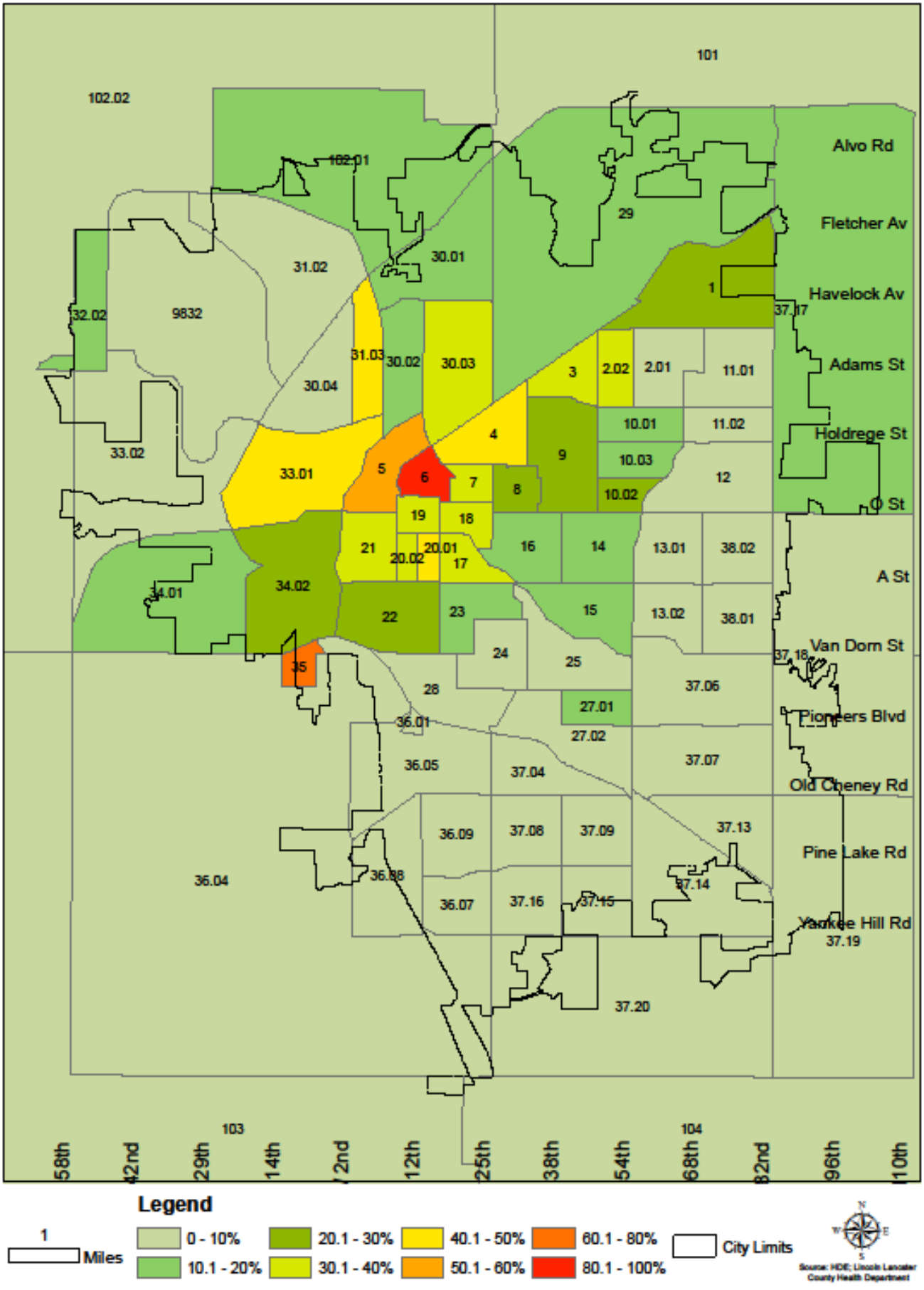
Percent Poverty Per Census Tract 2010



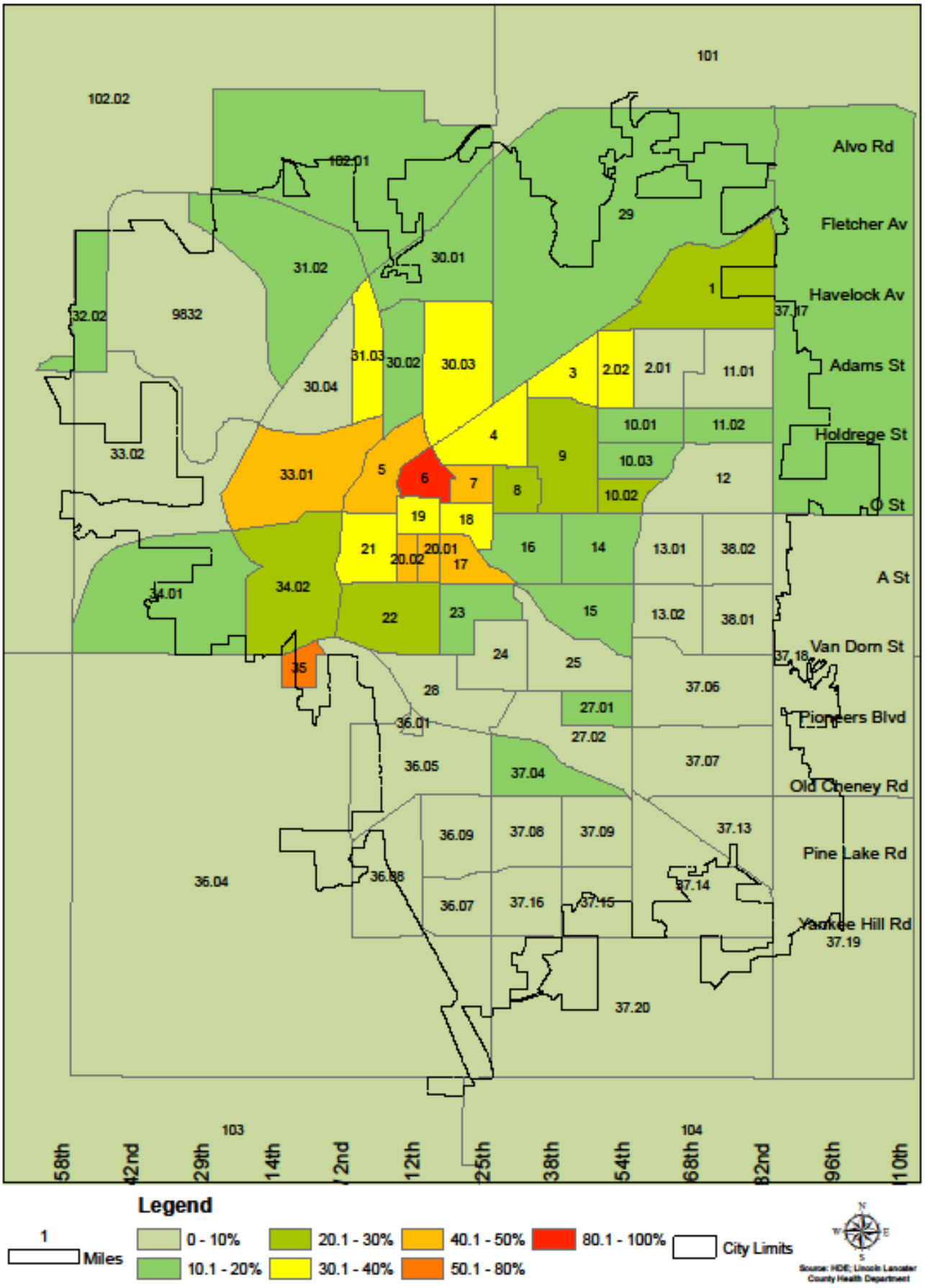
Percent Poverty Per Census Tract 2011

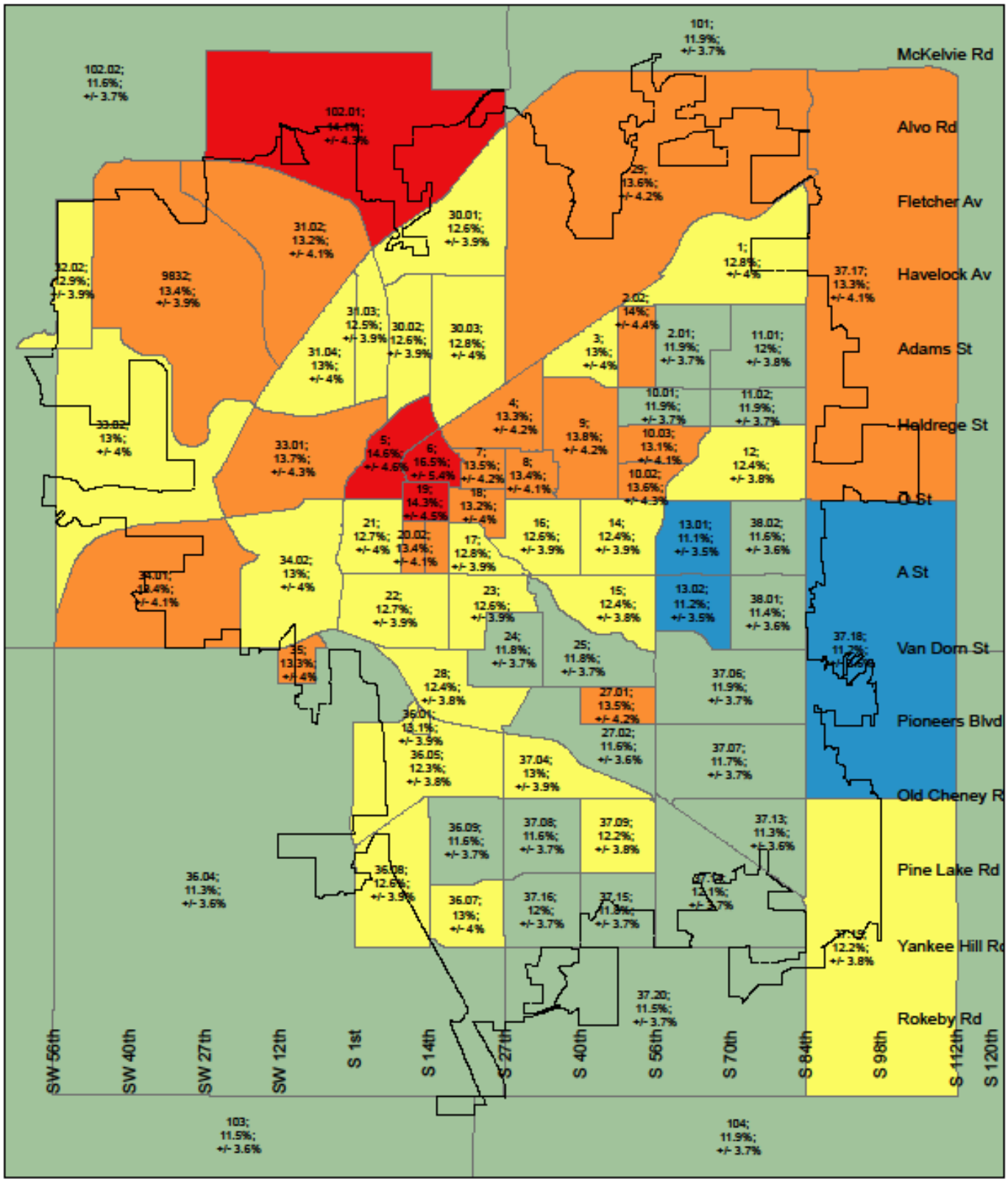


Percent Poverty Per Census Tract 2012



Percent Poverty Per Census Tract 2013





Asthma by Census Tracts
Lancaster County 2011-2013

Label: Census Tract#, Value, 95%CI Margin of Error

Lincoln Asset Mapping Project

Legend

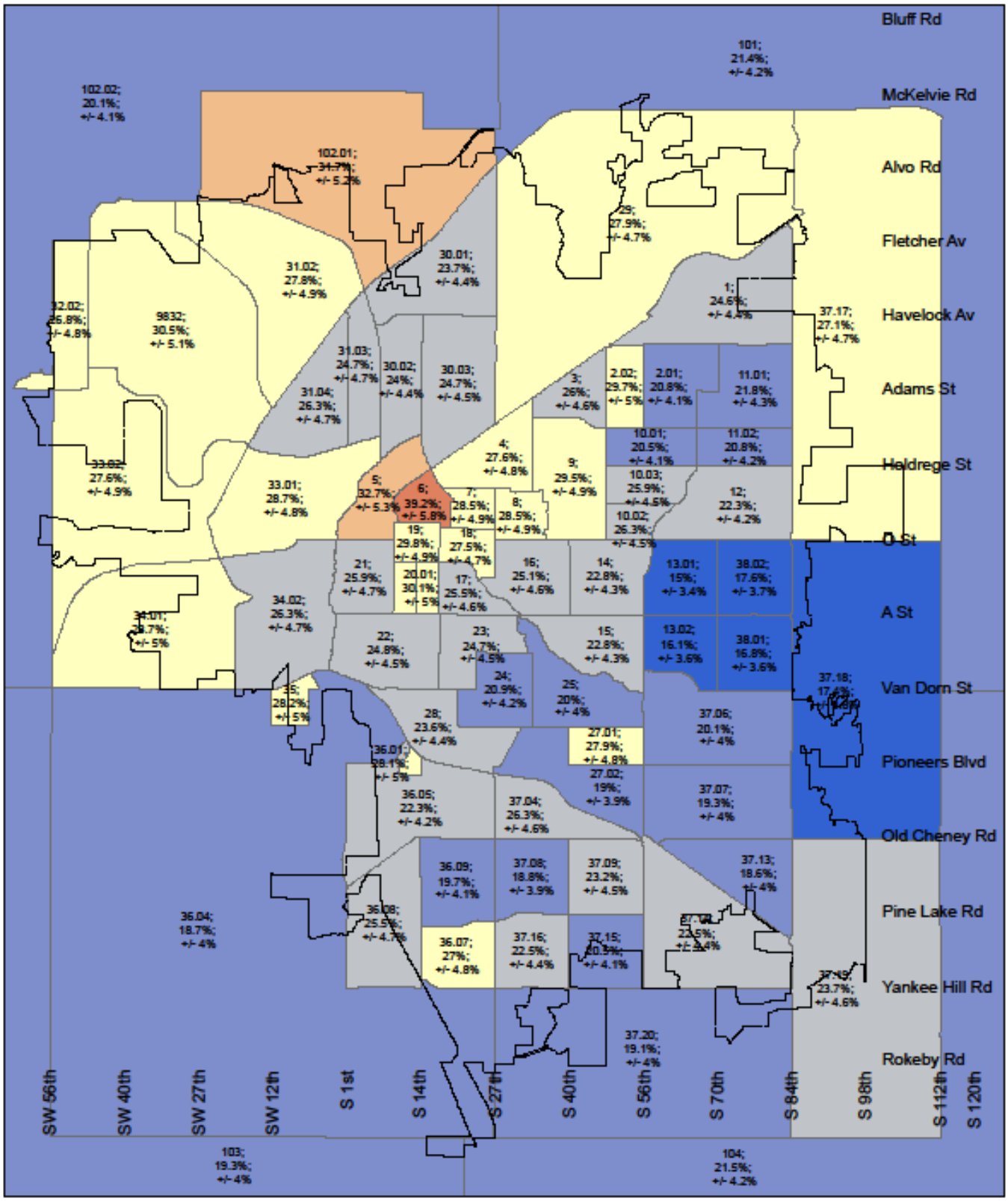
Asthma

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- > 1.5 Std. Dev.

1 In = 2 miles

BRFSS 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Legend

BingeDnk

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Binge Drinking by Census Tracts
Lancaster County 2011-2013

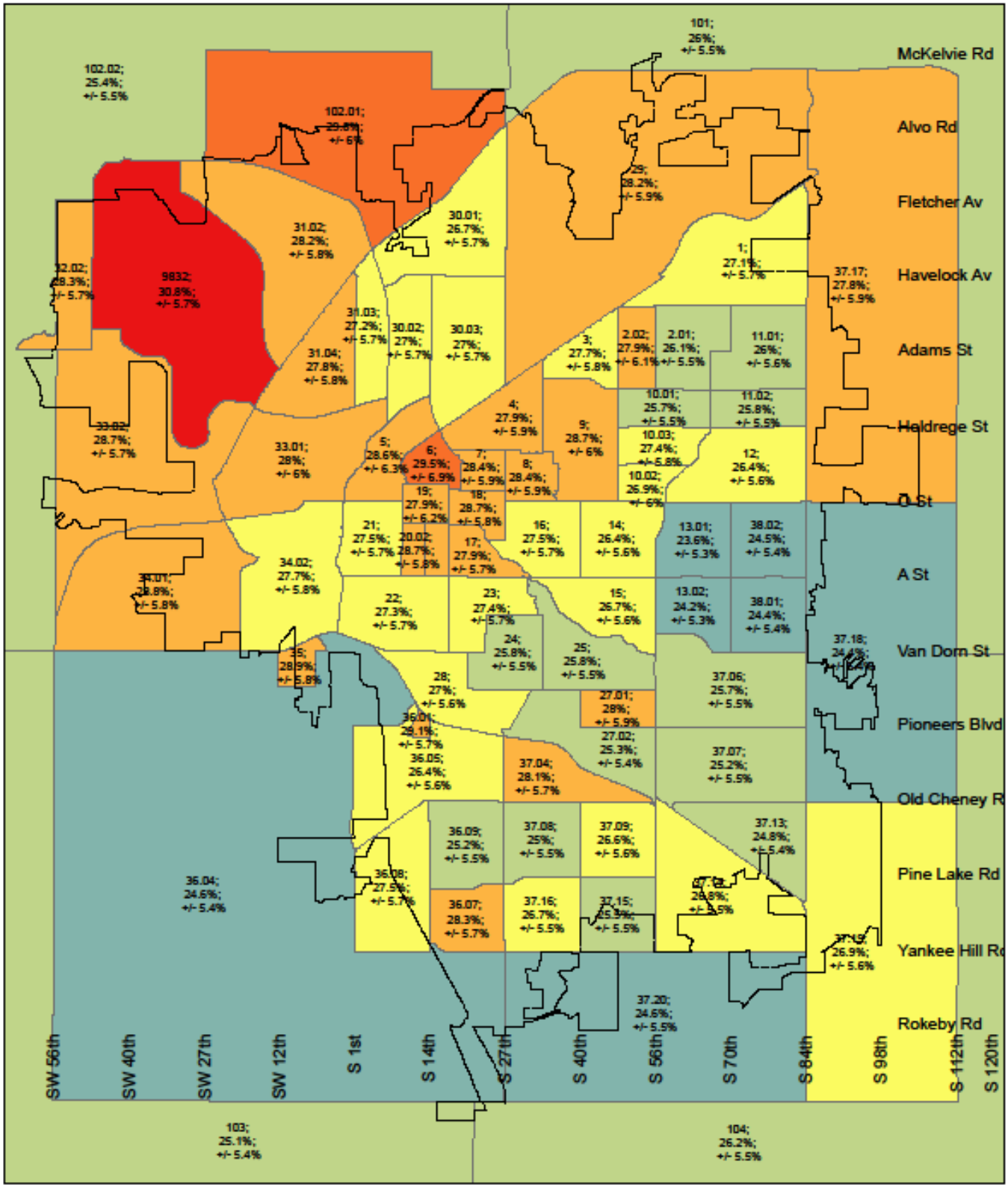
Label: Census Tract#, Value, 95%CI Margin of Error

Lincoln Asset Mapping Project

N W E S

1 in = 2 miles

BRFSS 2011-2013
Source: HDE, Lincoln Lancaster County Health Dept.



Legend

Dentist

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

No Dental Care in Past 1 year by Census Tracts
Lancaster County 2011-2013

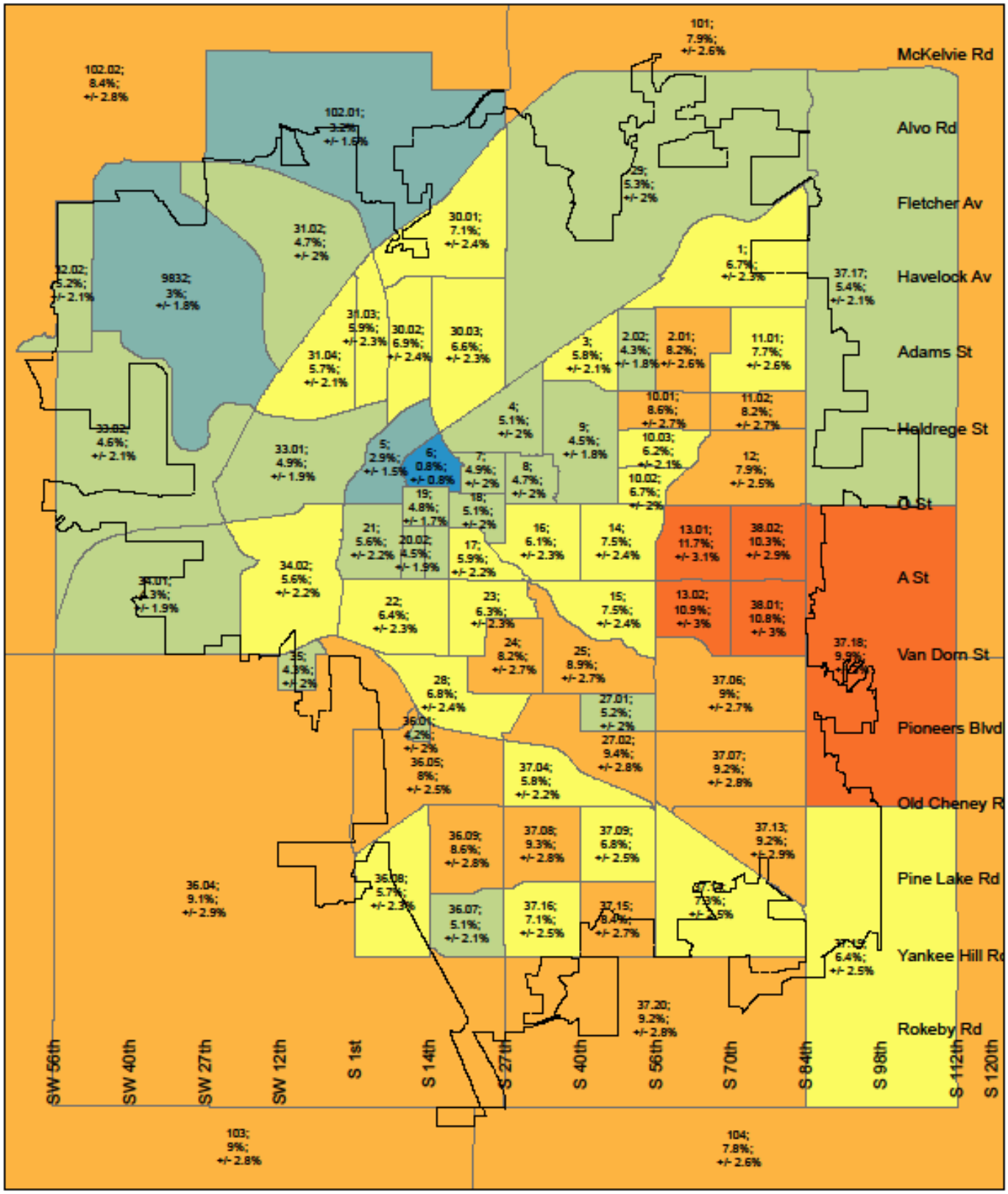
Label: Census Tract#, Value, 95%CI Margin of Error

Lincoln Asset Mapping Project

1 in = 2 miles

BRFSS 2012

Source: HDE, Lincoln Lancaster County Health Dept.



Legend

Diabetes

- < -2.5 Std. Dev.
- -2.5 - -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.4 Std. Dev.

Diabetes by Census Tracts
Lancaster County 2011-2013

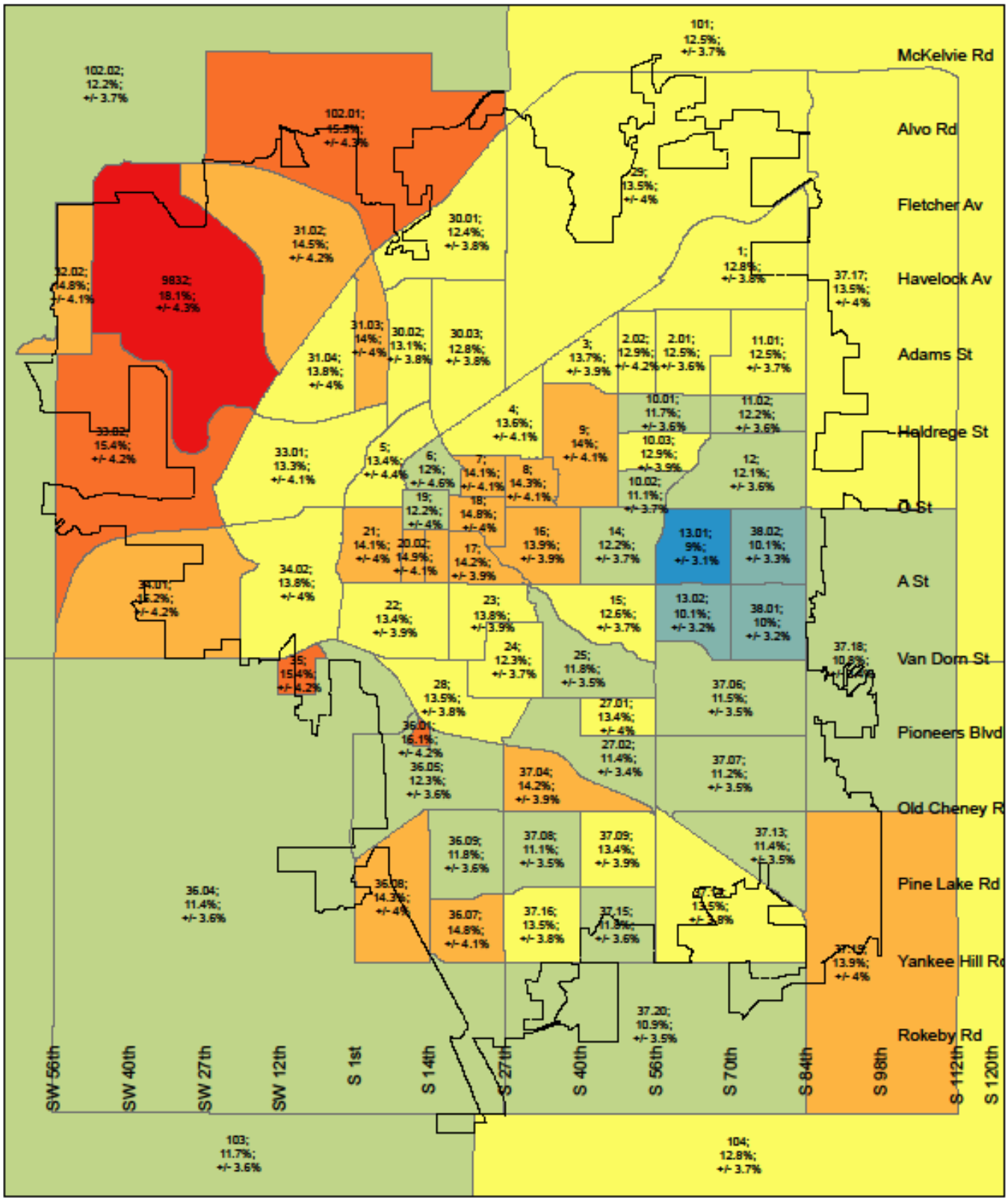
Label: Census Tract#, Value, 95%CI Margin of Error

Lincoln Asset Mapping Project

1 In = 2 miles

BRFSS 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Legend

NoDocCost

- < -2.5 Std. Dev.
- -2.5 - -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

'Could not see the doctor due to cost' by Census Tracts
Lancaster County 2011-2013

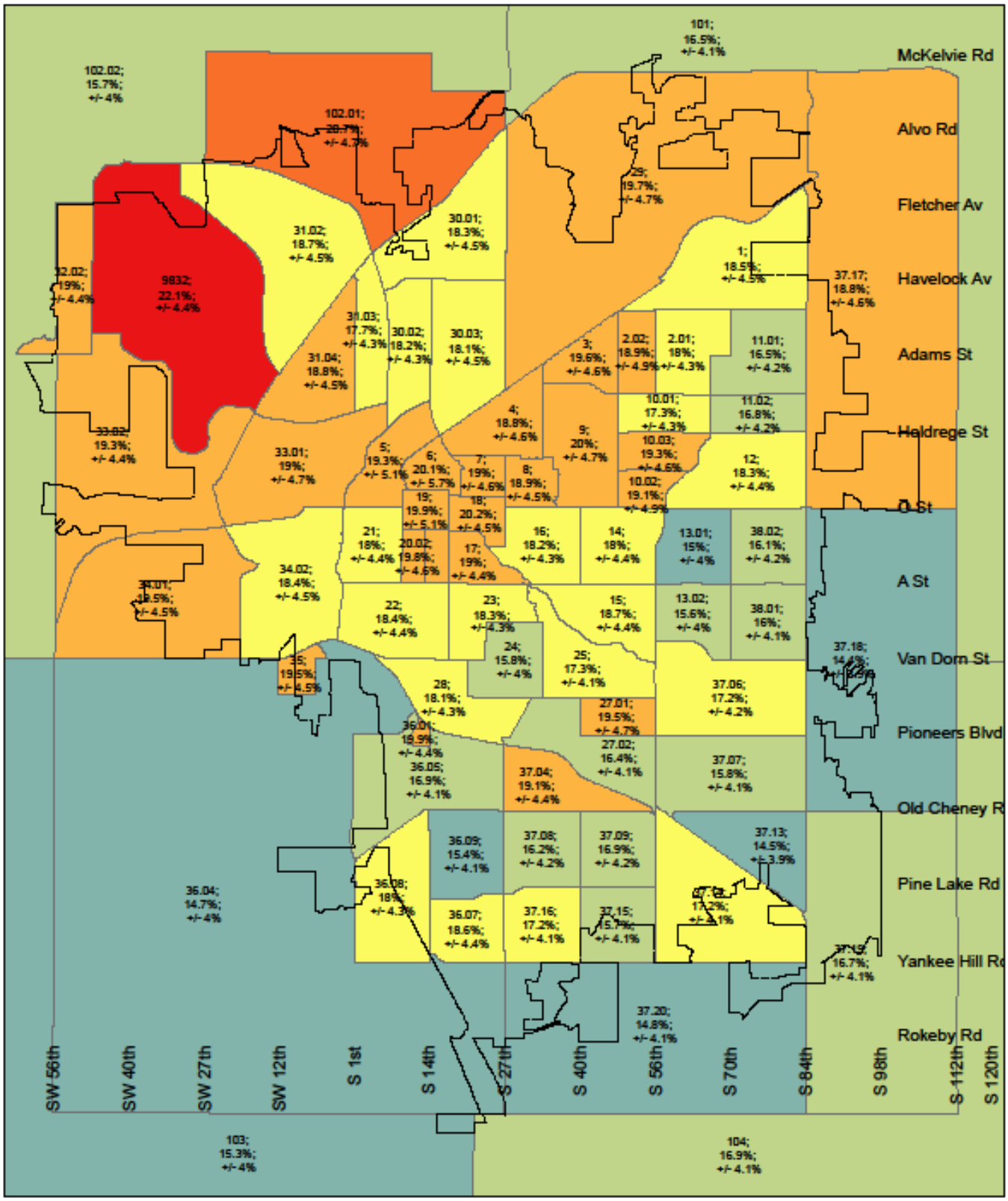
Label: Census Tract#, Value, 95%CI Margin of Error

Lincoln Asset Mapping Project

N W E S

1 in = 2 miles

BRFSS 2011-2013
Source: HDE, Lincoln Lancaster County Health Dept.



Legend

NoHthInsu

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

No Health Care Coverage(18-64 Age Group) by Census Tracts Lancaster County 2011-2013

Label: Census Tract#, Value, 95%CI Margin of Error

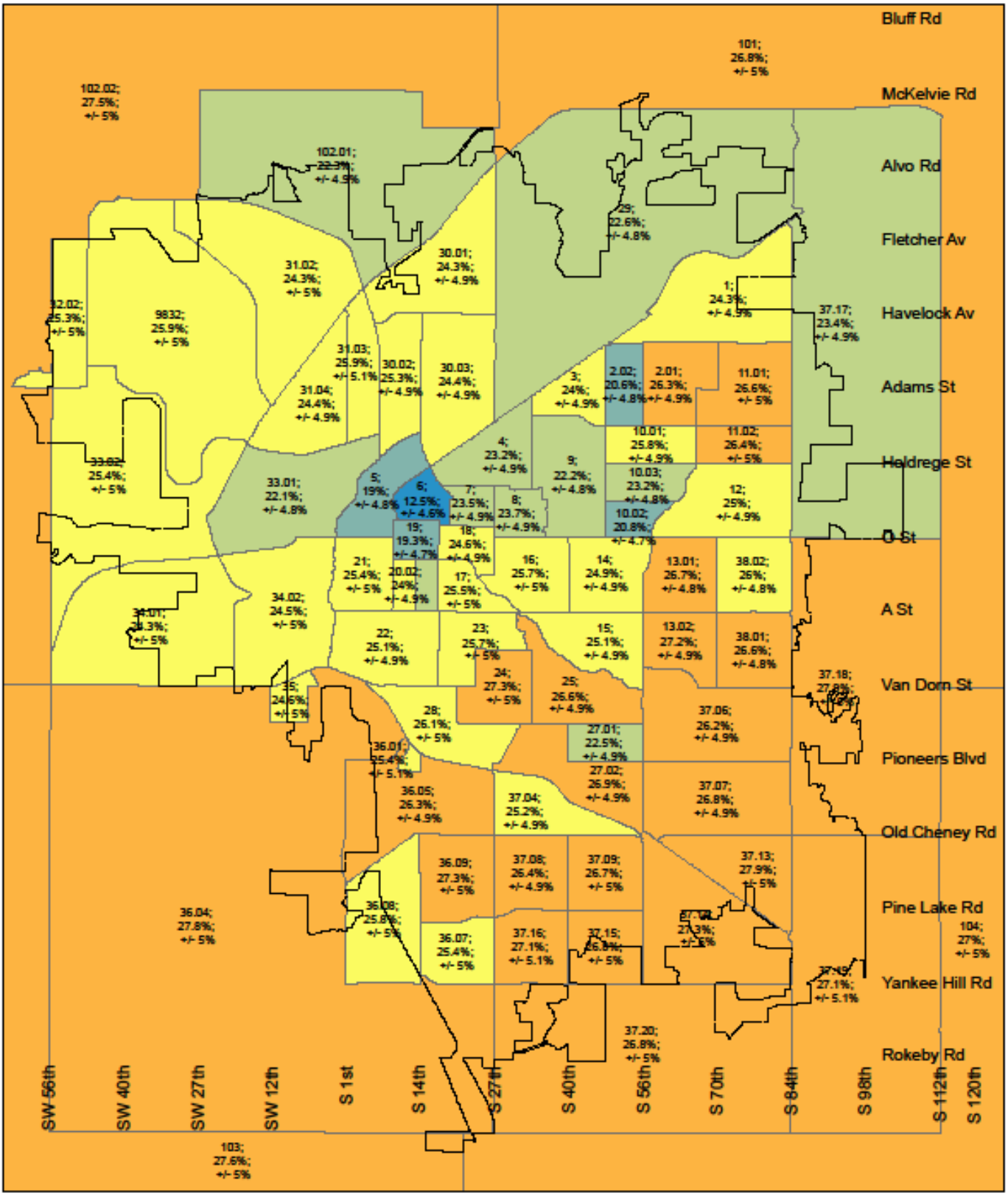
Lincoln Asset Mapping Project

N W E S

1 in = 2 miles

BRFSS 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Obesity by Census Tracts
Lancaster County 2011-2013

Label: Census Tract#, Value, 95%CI Margin of Error

Lincoln Asset Mapping Project

Legend

Obesity

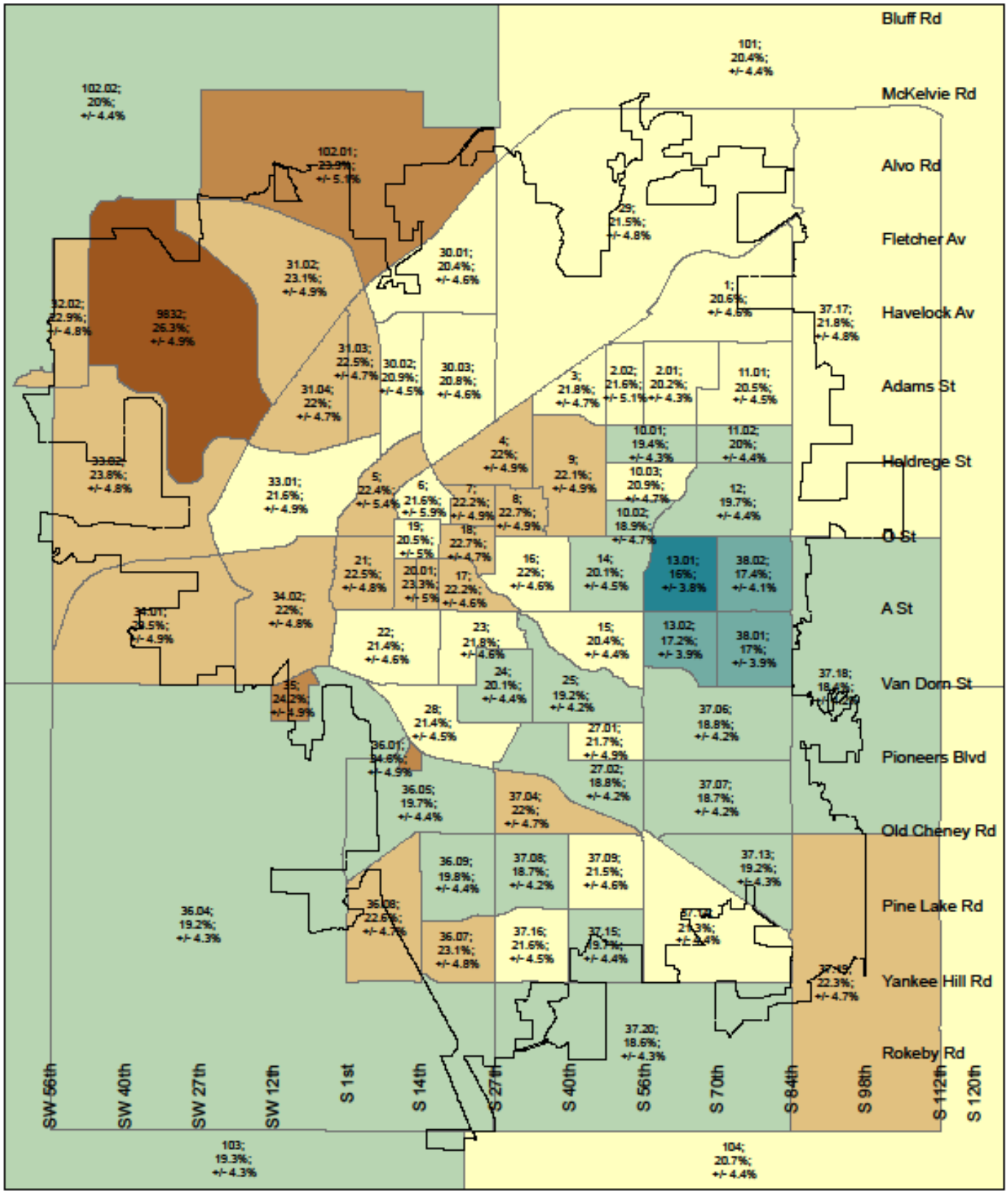
- < -2.5 Std. Dev.
- -2.5 - -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.2 Std. Dev.

N W E S

1 In = 2 miles

BRFSS 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Legend

Smoking

- < -2.5 Std. Dev.
- -2.5 - -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Current Smoking by Census Tracts
Lancaster County 2011-2013

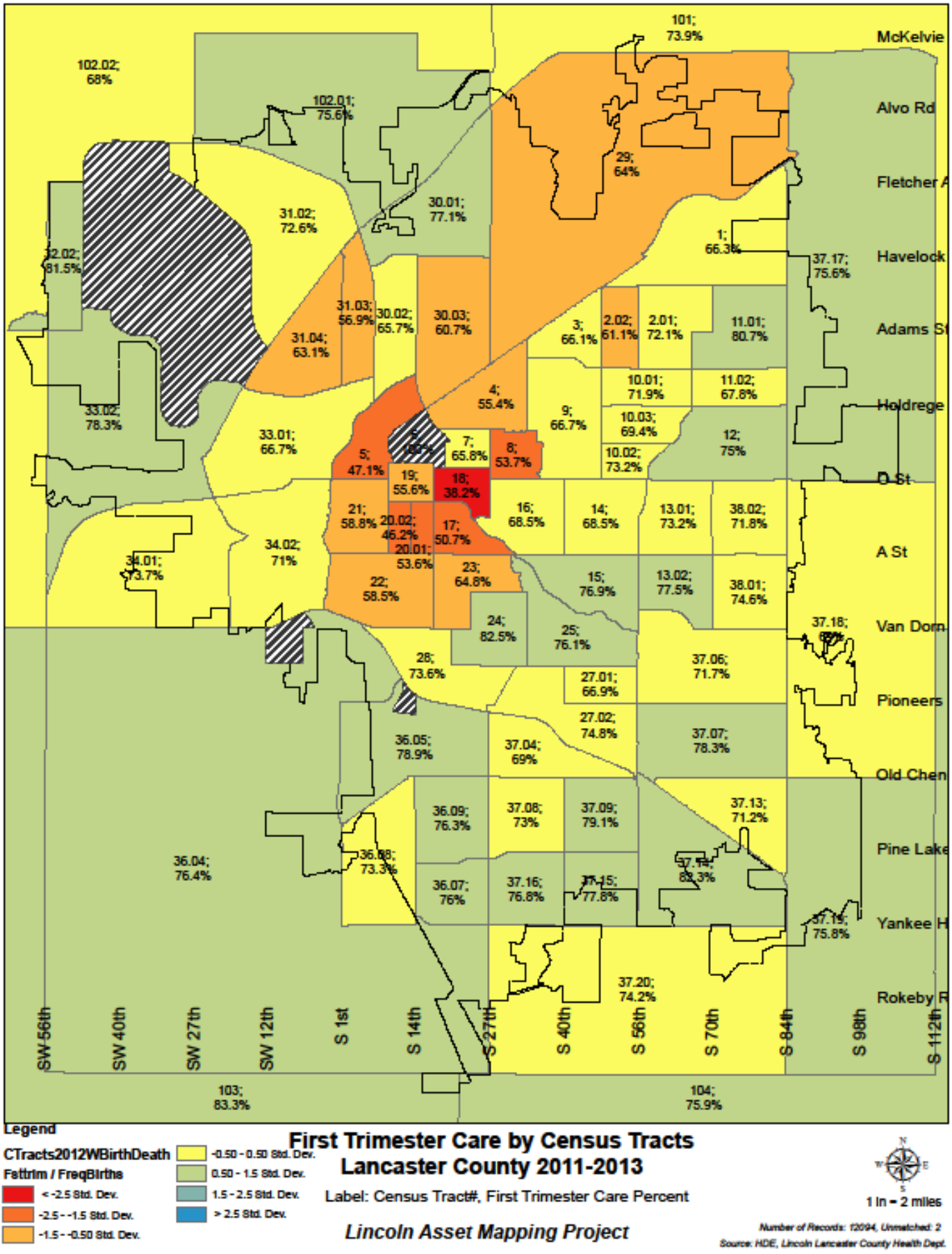
Label: Census Tract#, Value, 95%CI Margin of Error

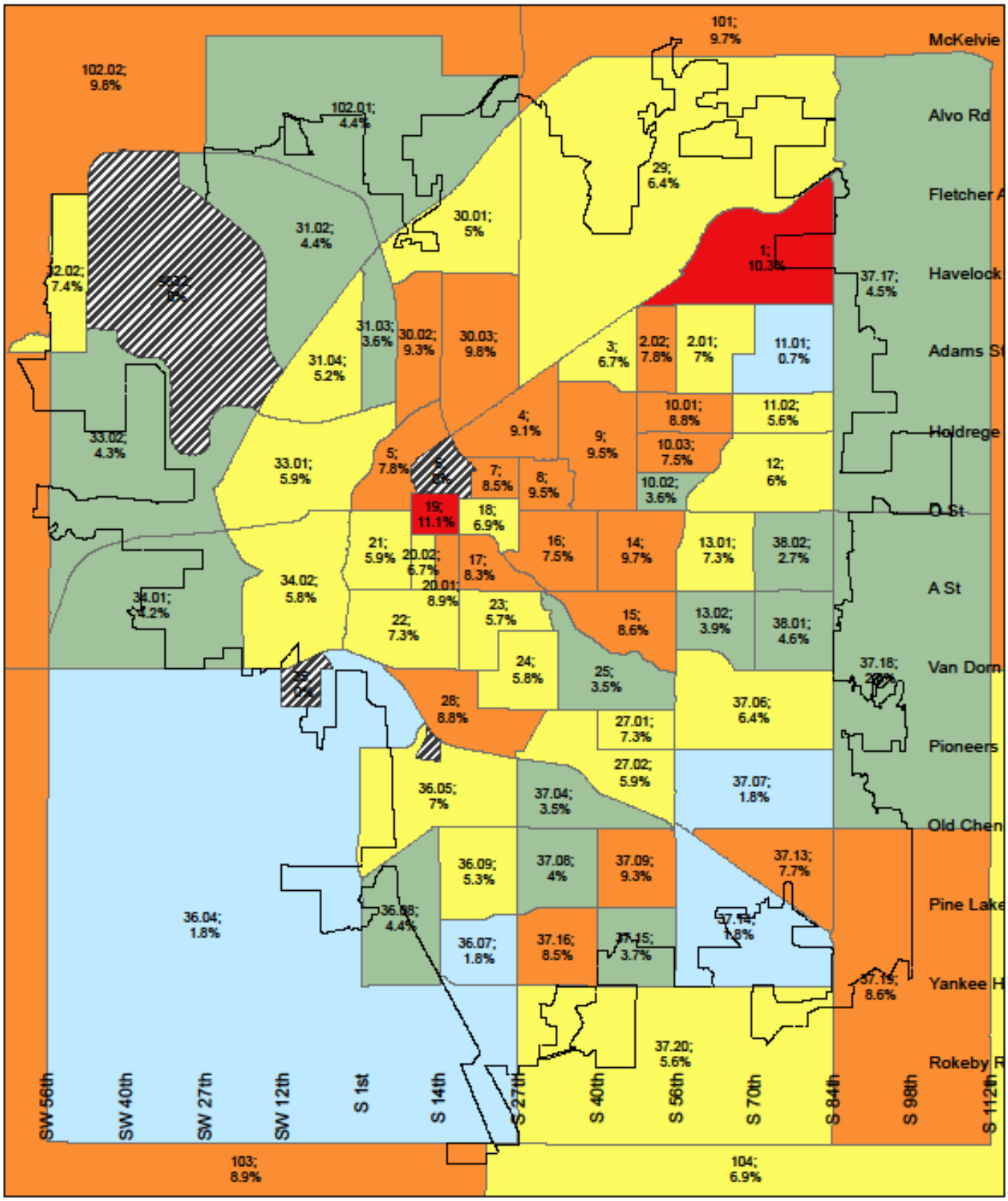
Lincoln Asset Mapping Project

1 In = 2 miles

BRFSS 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.


First Trimester Care by Census Tracts
Lancaster County 2011-2013
Label: Census Tract#, First Trimester Care Percent
Lincoln Asset Mapping Project
Legend
CTracts2012WBirthDeath
Fsttrim / FreqBirths
< -2.5 Std. Dev.
-2.5 - -1.5 Std. Dev.
-1.5 - -0.50 Std. Dev.
-0.50 - 0.50 Std. Dev.
0.50 - 1.5 Std. Dev.
1.5 - 2.5 Std. Dev.
> 2.5 Std. Dev.
1 In = 2 miles
Number of Records: 12094, Unmatched: 2
Source: HDE, Lincoln Lancaster County Health Dept.
McKelvie
Alvo Rd
Fletcher A
Havelock
Adams St
Holdrege
O St
A St
Van Dorn
Pioneers
Old Chen
Pine Lake
Yankee H
Rokeby R
SW 56th
SW 40th
SW 27th
SW 12th
S 1st
S 14th
S 27th
S 40th
S 56th
S 70th
S 84th
S 98th
S 112th
101; 73.9%
102.02; 68%
102.01; 75.6%
29; 64%
30.01; 77.1%
31.02; 72.6%
32.02; 81.5%
1; 66.3%
37.17; 75.6%
31.03; 56.9%
30.02; 65.7%
30.03; 60.7%
31.04; 63.1%
3; 66.1%
2.02; 61.1%
2.01; 72.1%
11.01; 80.7%
4; 55.4%
10.01; 71.9%
11.02; 67.8%
33.02; 78.3%
9; 66.7%
10.03; 69.4%
33.01; 66.7%
7; 65.8%
8; 53.7%
12; 75%
5; 47.1%
19; 55.6%
18; 38.2%
10.02; 73.2%
21; 58.8%
20.02; 46.2%
17; 50.7%
16; 68.5%
14; 68.5%
13.01; 73.2%
38.02; 71.8%
34.02; 71%
20.01; 53.6%
34.01; 73.7%
23; 64.8%
22; 58.5%
15; 76.9%
13.02; 77.5%
38.01; 74.6%
24; 82.5%
25; 76.1%
37.18;
28; 73.6%
37.06; 71.7%
27.01; 66.9%
27.02; 74.8%
37.07; 78.3%
36.05; 78.9%
37.04; 69%
36.09; 76.3%
37.08; 73%
37.09; 79.1%
37.13; 71.2%
36.04; 76.4%
36.07; 76%
37.16; 76.8%
37.15; 77.8%
37.19; 75.8%
37.20; 74.2%
103; 83.3%
104; 75.9%



Legend

CTracts2012WBirthDeath

COUNT_LBW / COUNT_ID

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 1.9 Std. Dev.

Low Birth Weight Births by Census Tracts
Lancaster County 2011-2013

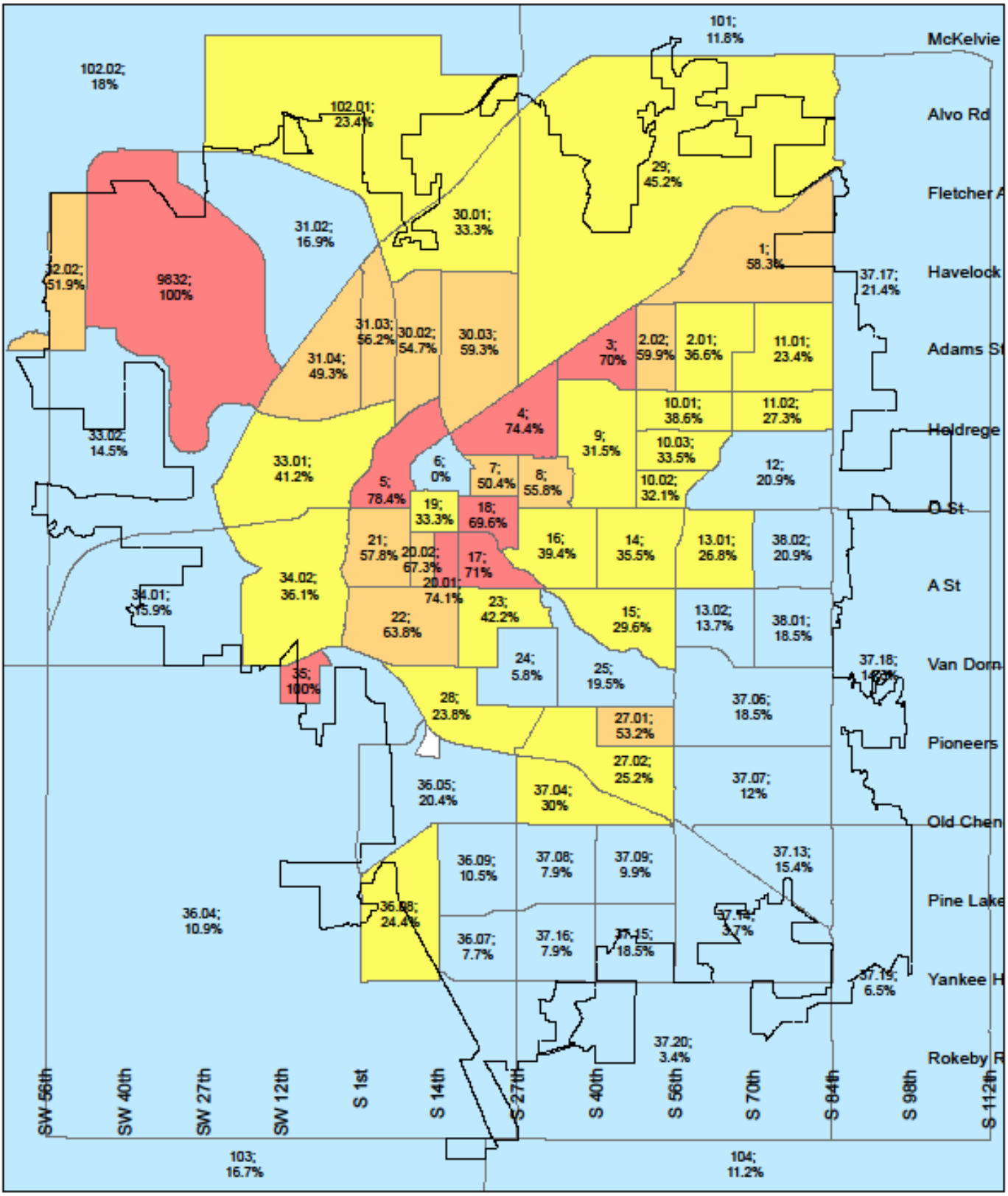
Label: Census Tract#, LBW Births Percent

Lincoln Asset Mapping Project

1 in = 2 miles

Number of Records: 12094, Unmatched: 2

Source: HDE, Lincoln Lancaster County Health Dept.



Medicaid Births by Census Tracts
Lancaster County 2011-2013

Label: Census Tract#, Medicaid Births Percent

Lincoln Asset Mapping Project

Legend

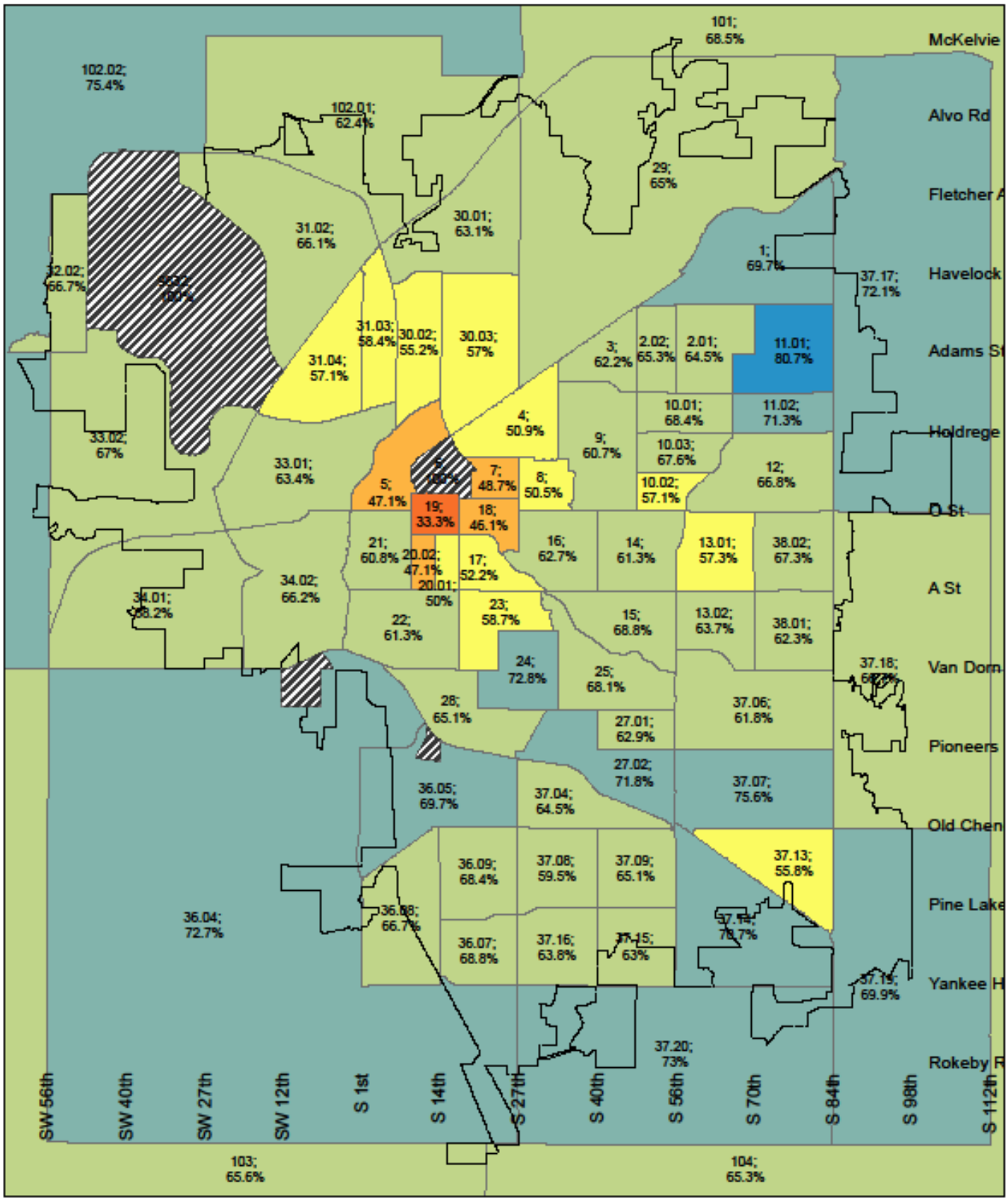
CTracts2012WBirthDeath
COUNT_payo / COUNT_ID

- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- < -0.50 Std. Dev.
- > 1.5 Std. Dev.

N W E S

1 In = 2 miles

Number of Records: 12094, Unmatched: 2
Source: HDE, Lincoln Lancaster County Health Dept.



Legend

CTracts2012WBirthDeath

pertenvisl / FreqBirths

- < -2.5 Std. Dev.
- -2.5 - -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- > 1.5 Std. Dev.

10+ Prenatal Visits by Census Tracts
Lancaster County 2011-2013

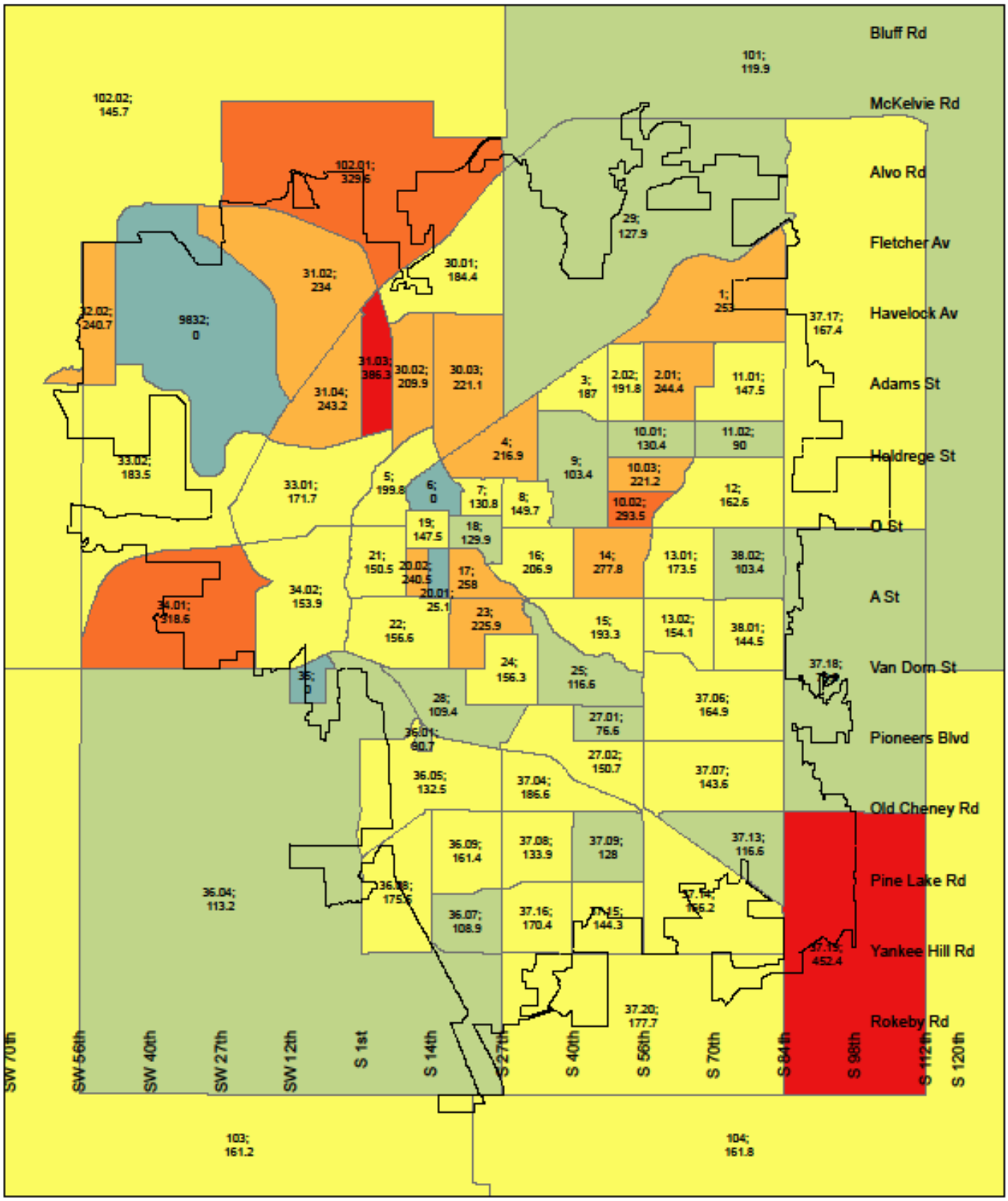
Label: Census Tract#, 10+ Prenatal Visits Percent

Lincoln Asset Mapping Project

1 in = 2 miles

Number of Records: 12094, Unmatched: 2

Source: HDE, Lincoln Lancaster County Health Dept.



Legend

CancerAAR

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Age Adjusted Death Rate for Cancer (All Sites) by Census Tracts
Lancaster County 2011-2013

Label: Census Tract#, Age Adjusted Rate
per 100,000 Population per Year

Lincoln Asset Mapping Project

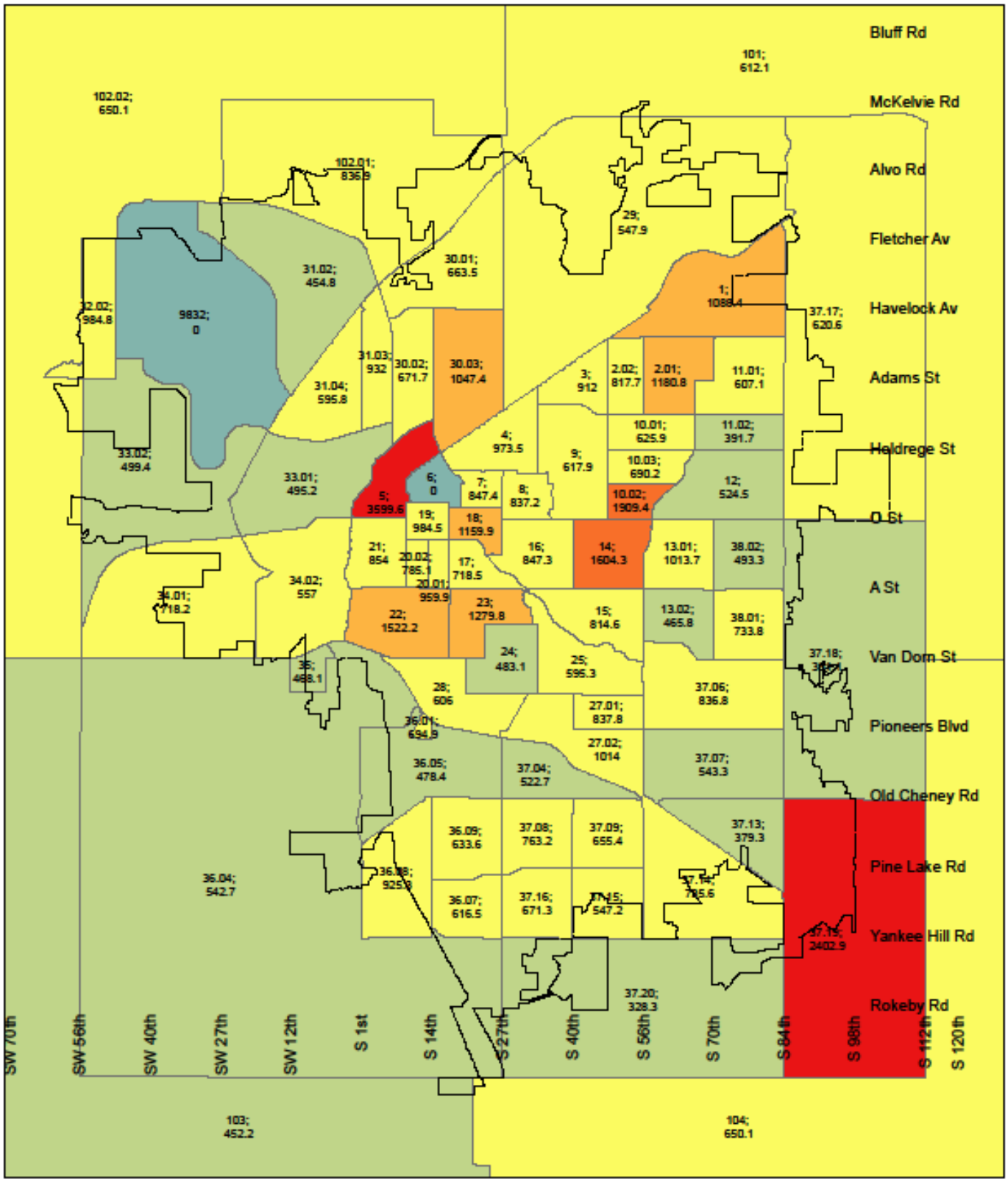
N W E S

1 in = 2 miles

US 2000 Standard Population

Vital Statistics 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Legend

DeathAAR

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Age Adjusted Death Rate (All Causes) by Census Tracts
Lancaster County 2011-2013

Label: Census Tract#, Age Adjusted Rate per 100,000 Population per Year

Lincoln Asset Mapping Project

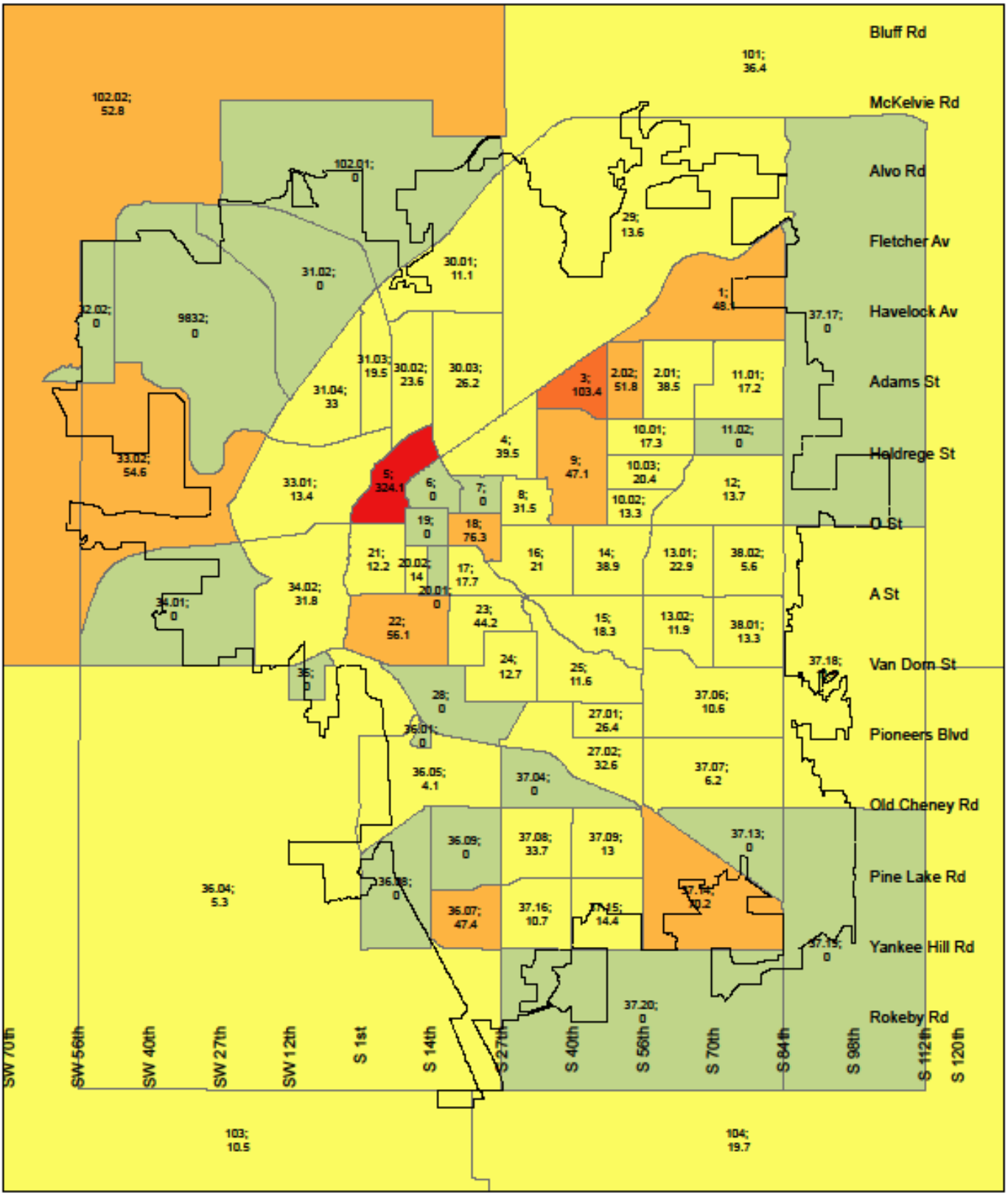
N W E S

1 In = 2 miles

US 2000 Standard Population

Vital Statistics 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Age Adjusted Death Rate for Diabetes by Census Tracts
Lancaster County 2011-2013

Legend

DiabetesAAR

- < -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Label: Census Tract#, Age Adjusted Rate per 100,000 Population per Year

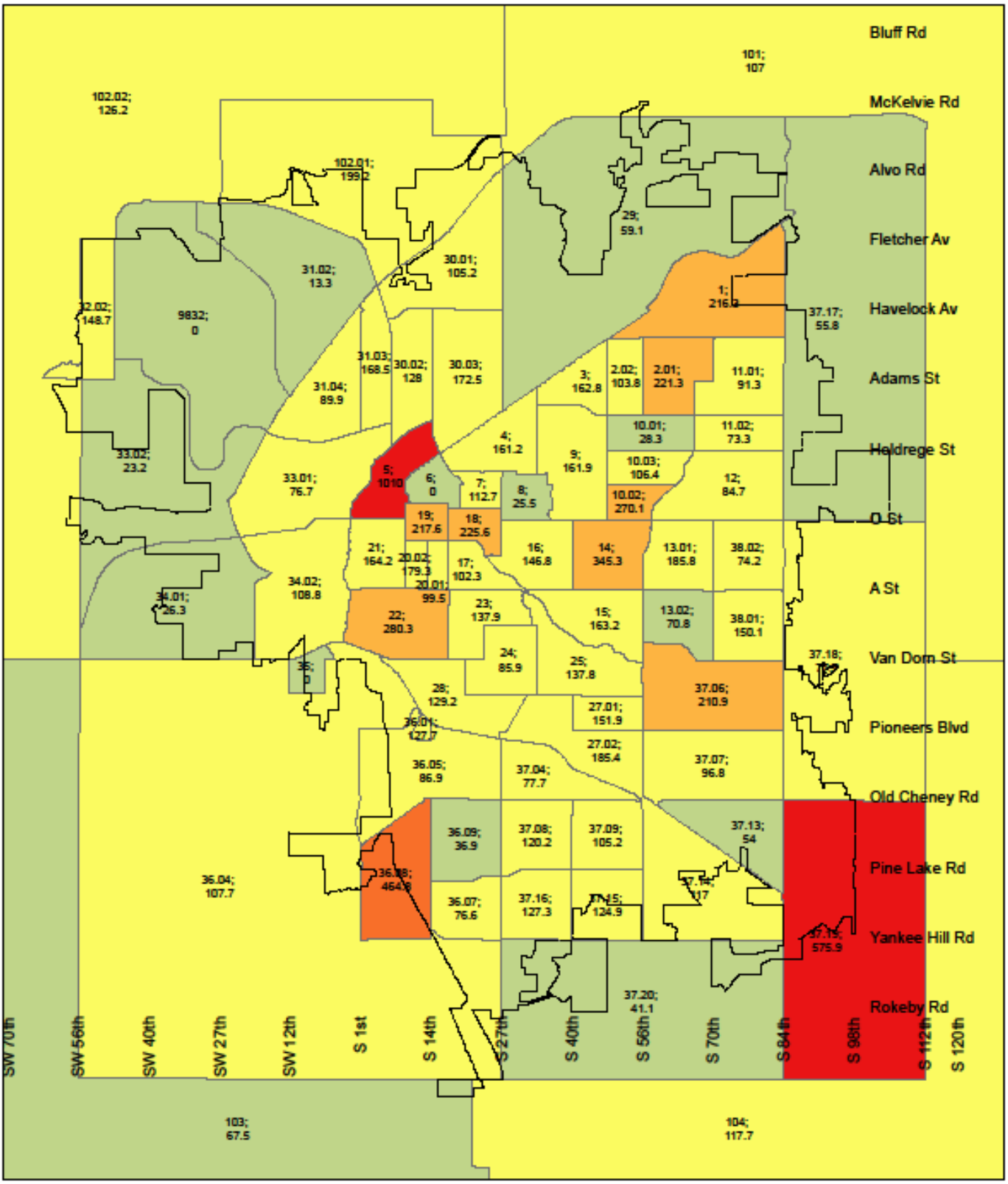
Lincoln Asset Mapping Project

1 In = 2 miles

US 2000 Standard Population

Vital Statistics 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Age Adjusted Death Rate for Heart Disease by Census Tracts
Lancaster County 2011-2013

Legend

HDAAR

- < -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Label: Census Tract#, Age Adjusted Rate per 100,000 Population per Year

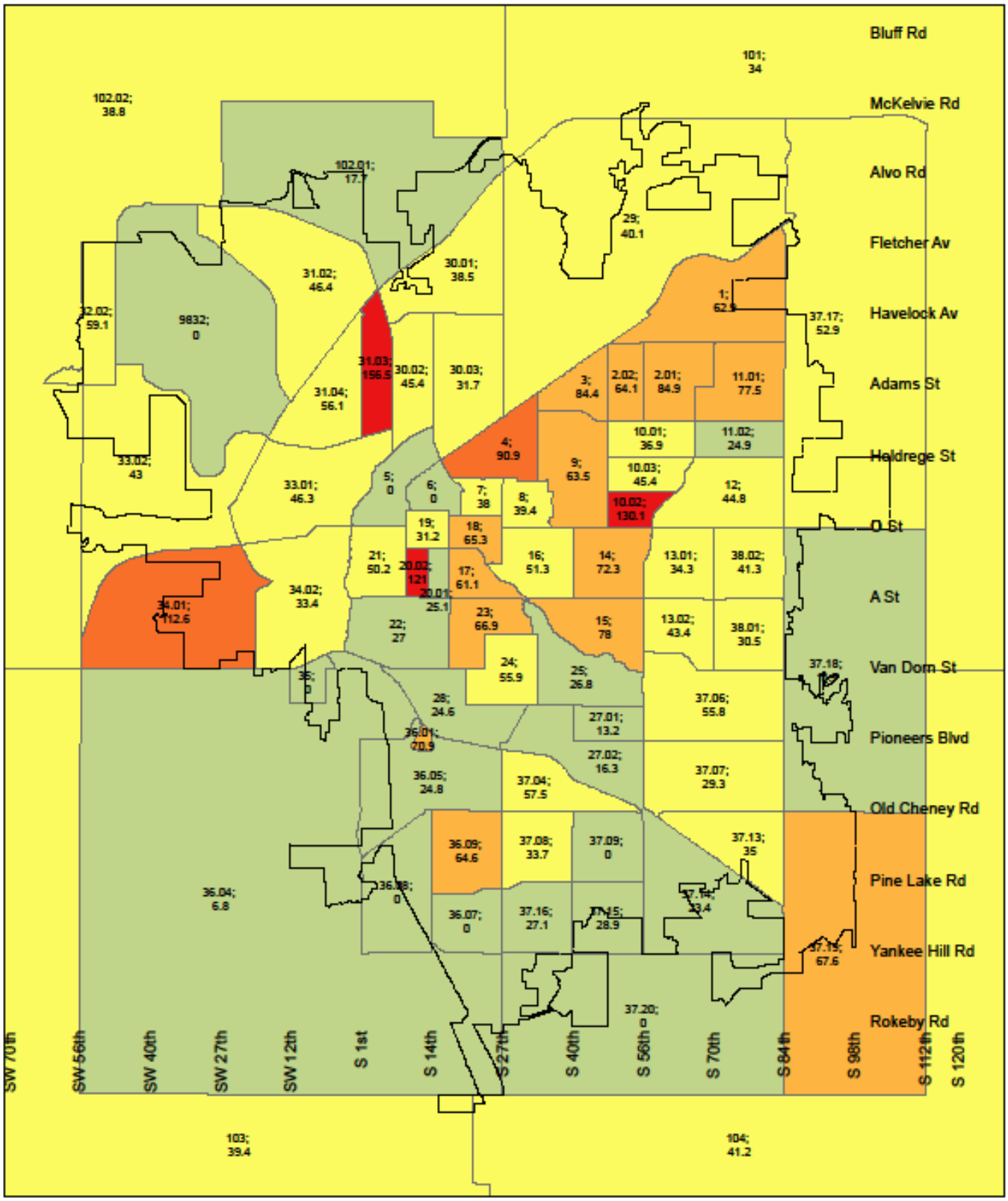
Lincoln Asset Mapping Project

1 in = 2 miles

US 2000 Standard Population

Vital Statistics 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Age Adjusted Death Rate for Lung Cancer by Census Tracts
Lancaster County 2011-2013

Legend

LungCancerAAR
- < -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Label: Census Tract#, Age Adjusted Rate per 100,000 Population per Year

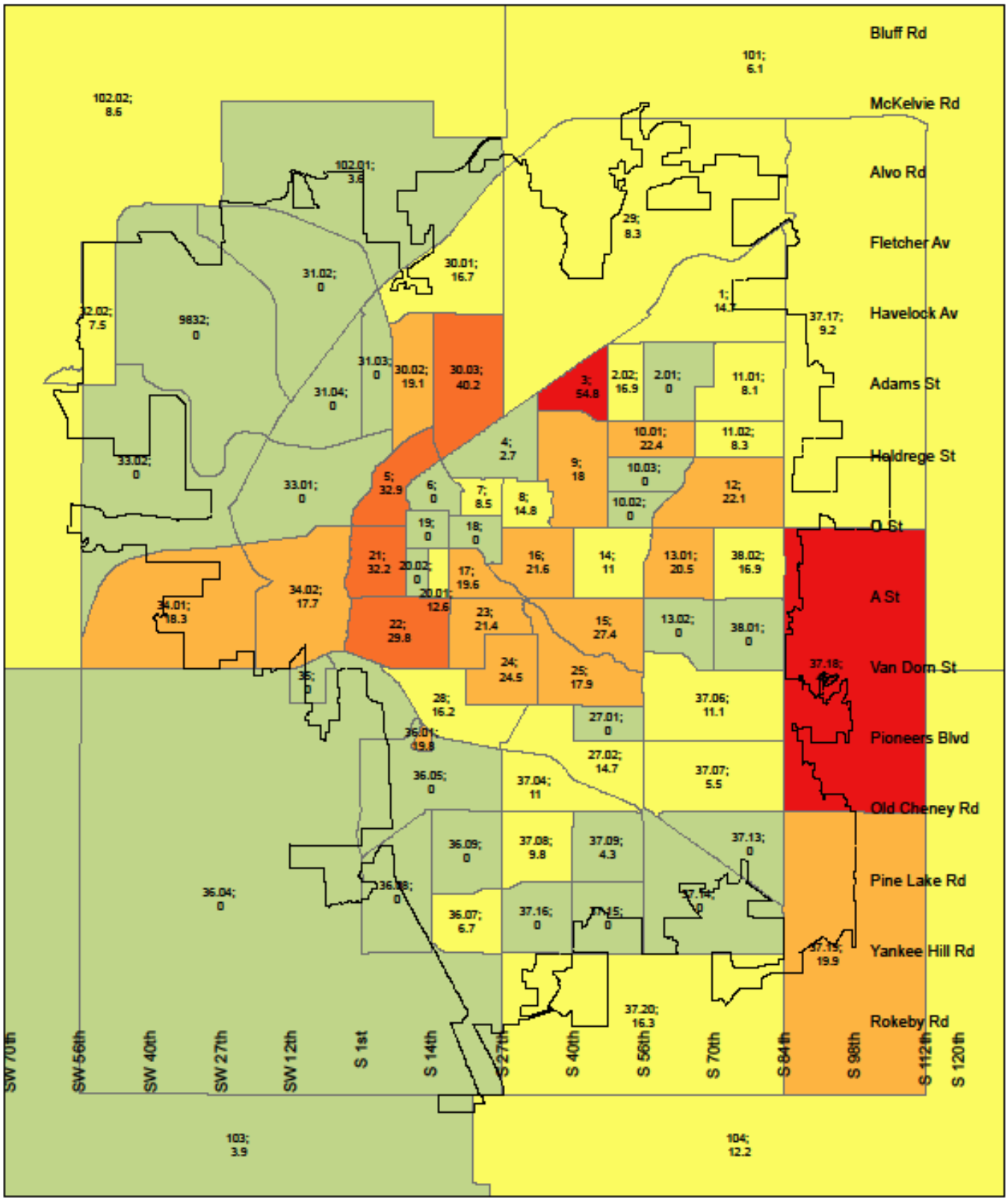
Lincoln Asset Mapping Project

1 in = 2 miles

US 2000 Standard Population

Vital Statistics 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Age Adjusted Death Rate for Suicide by Census Tracts
Lancaster County 2011-2013

Legend

SuicideAAR

- < -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Label: Census Tract#, Age Adjusted Rate per 100,000 Population per Year

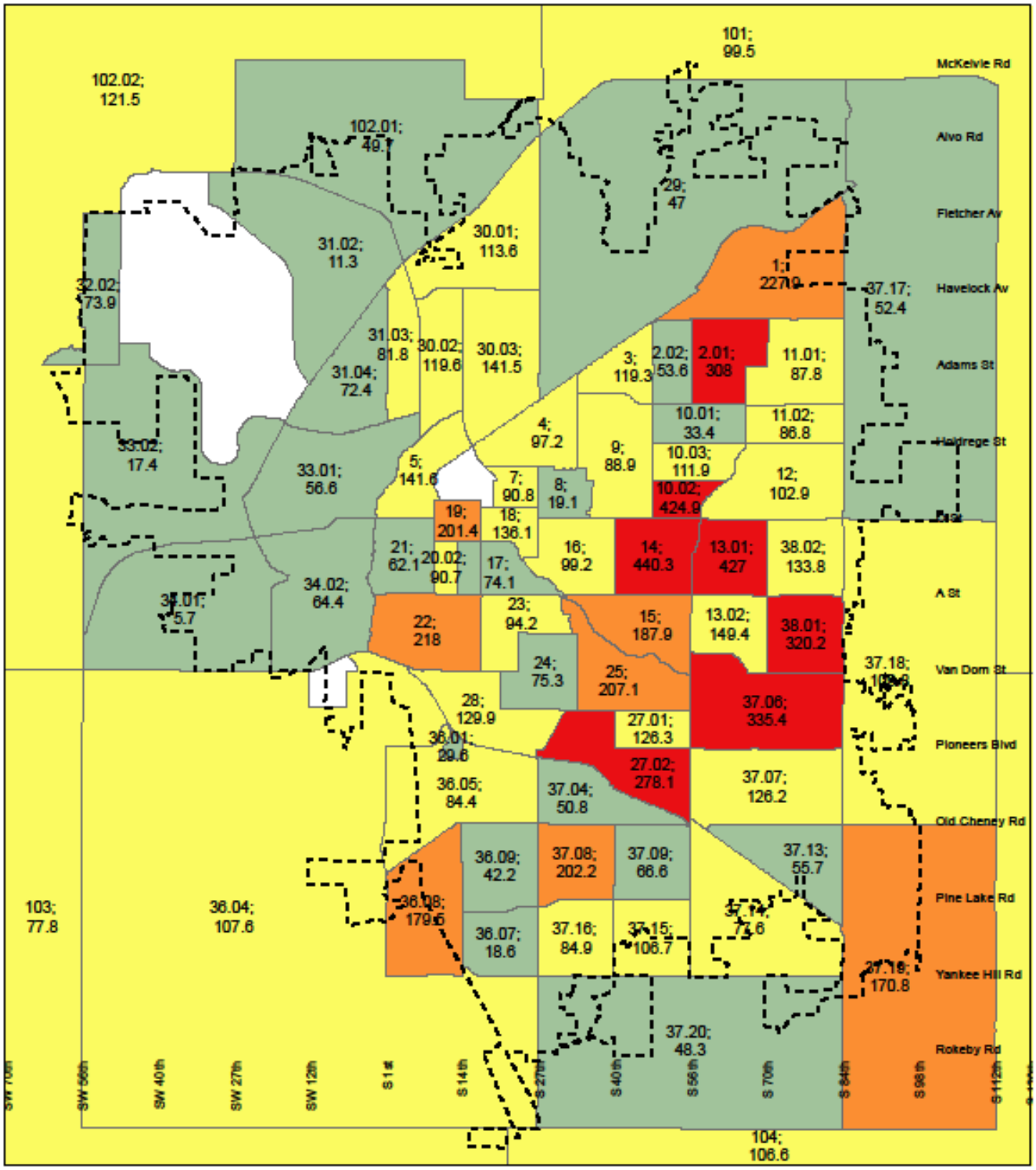
Lincoln Asset Mapping Project

1 in = 2 miles

US 2000 Standard Population

Vital Statistics 2011-2013

Source: HDE, Lincoln Lancaster County Health Dept.



Heart Disease Deaths by Census Tracts
Lancaster County 2011-2013

Label: Census Tract#, Crude Death Rate

Crude Death Rate: Rate per 100,000 Population

Legend

CTracts2010

HeartDisease / D001_Tot__

< -0.50 Std. Dev.

-0.50 - 0.50 Std. Dev.

0.50 - 1.5 Std. Dev.

> 1.5 Std. Dev.

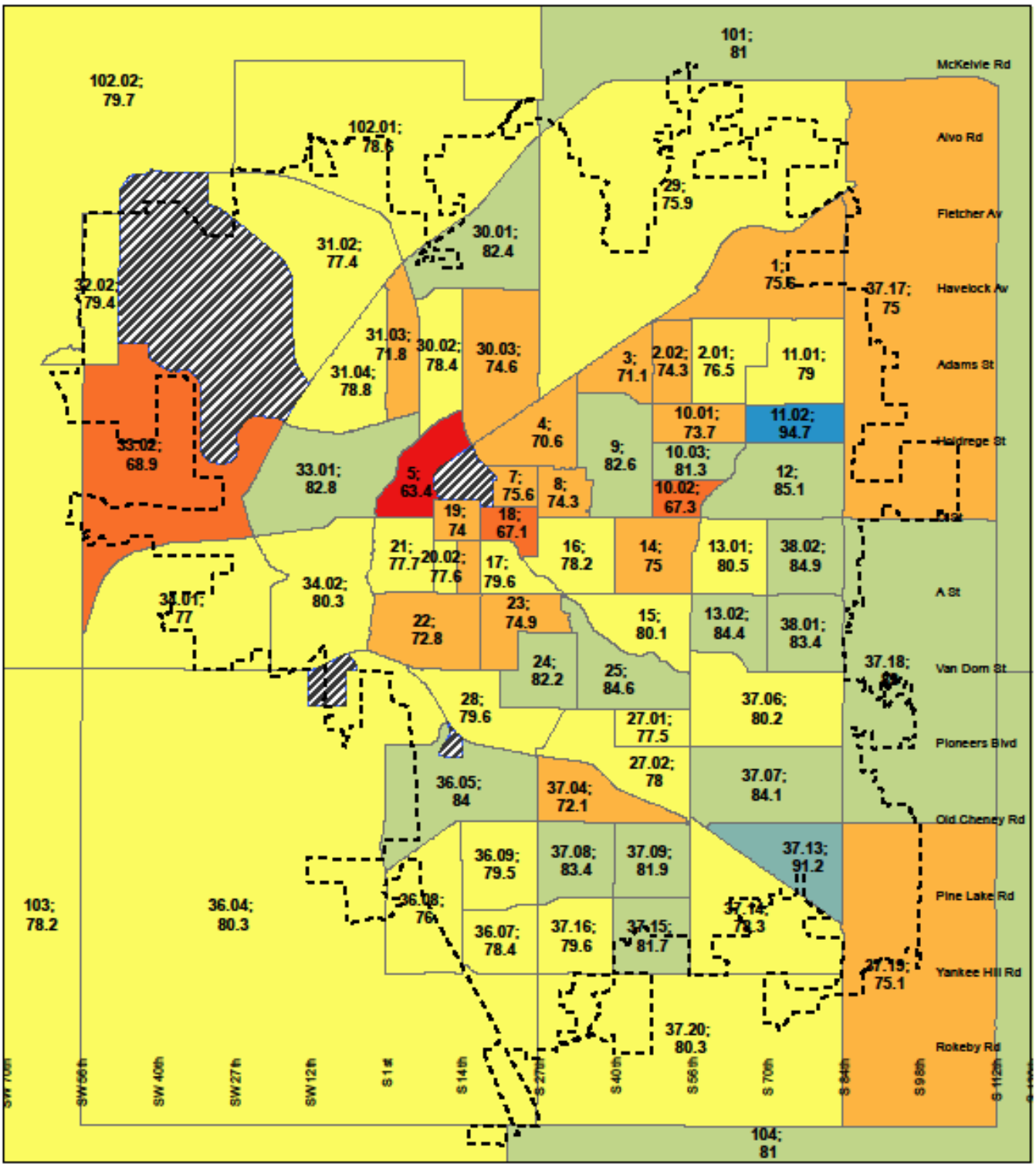
N W E S

1 in = 2 miles

Lincoln Asset Mapping Project

Number of Records: 5897, Unmatched: 12

Source: HDE, Lincoln Lancaster County Health Dept.



Life Expectancy by Census Tracts
Lancaster County 2011-2013

Legend

CTracts2010

LE

- < -2.5 Std. Dev.
- -2.5 - -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.

Life Expectancy in Lancaster County: 80.1 Years

Label: Census Tract#, Life Expectancy in Years

LE is Calculated by: REED-MERRILL AND GREVILLE METHOD

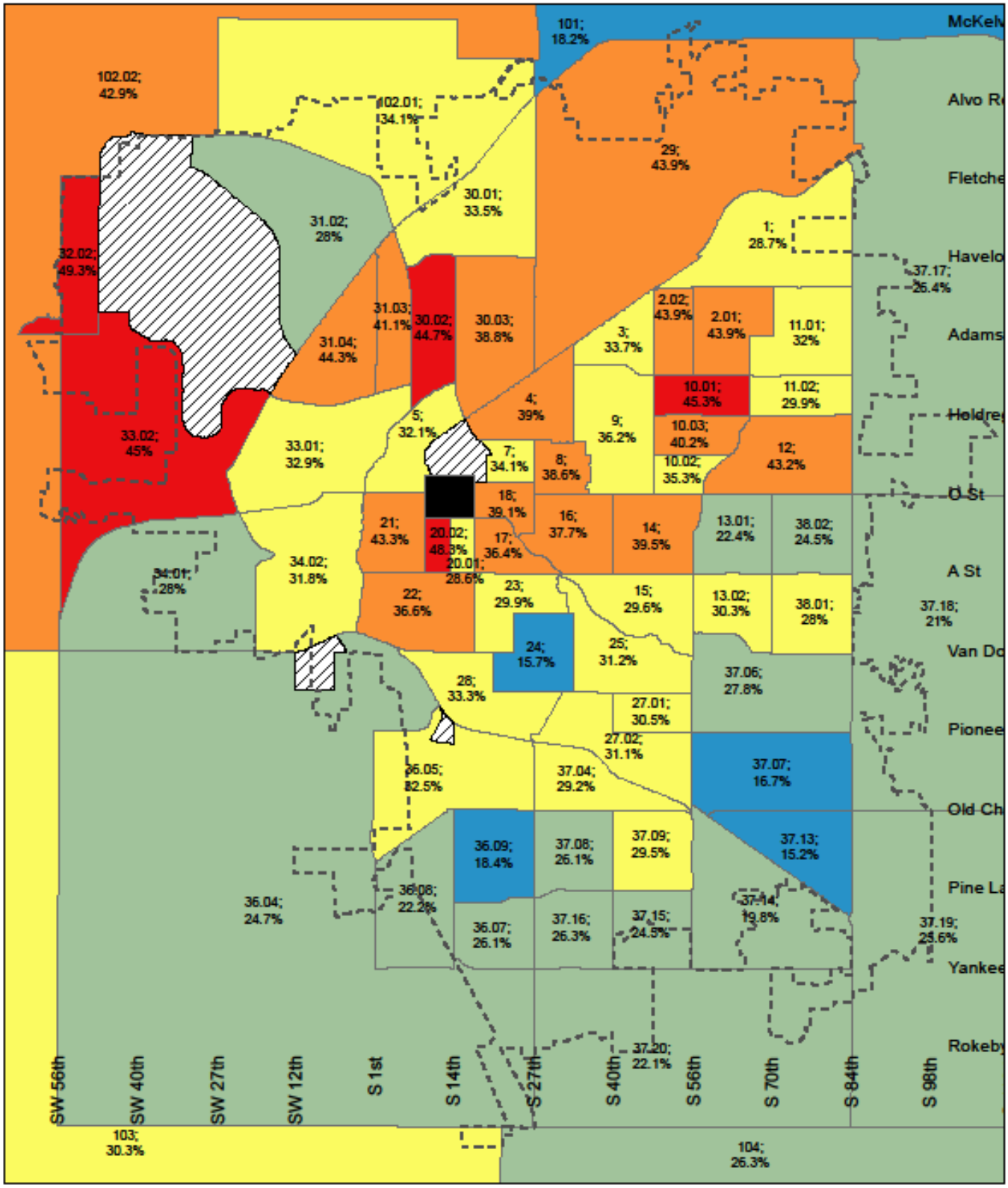
Lincoln Asset Mapping Project

N W E S

1 in = 2 miles

Number of Records: 5897, Unmatched: 12

Source: HDE, Lincoln Lancaster County Health Dept.



Legend

CTracts2010

OwtObs6_8 / Total6_8

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.1 Std. Dev.
- Insufficient Data

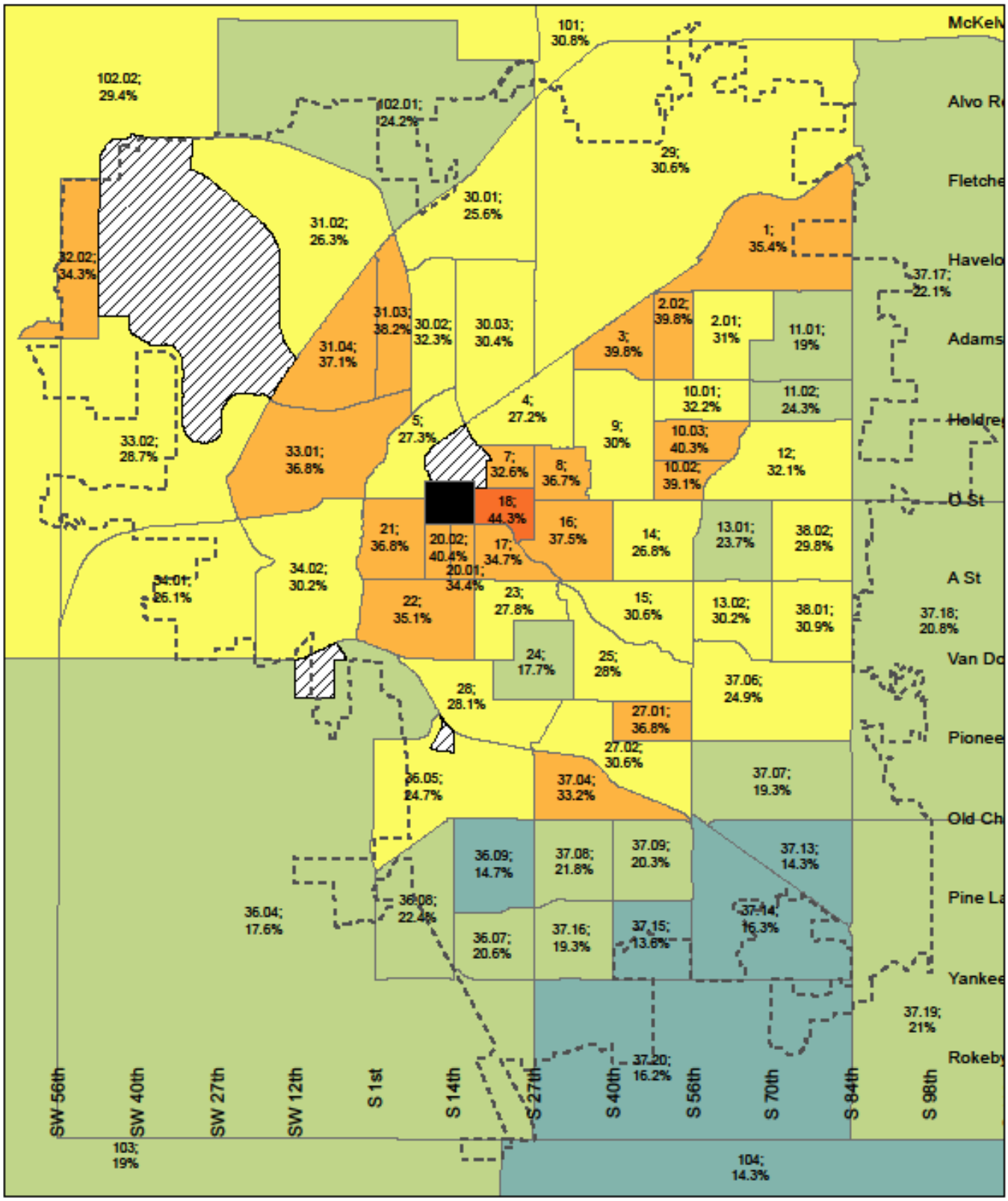
Overweight or Obese in Middle Schools
Lancaster County 2014-2015

Label: Census Tract#, Overweight or Obesity %

Lincoln Asset Mapping Project

1 in = 2 miles

# of Records: 30,421, Matched: 26,216
Data Source: Lincoln Public Schools



Legend

CTracts2010

OwtObsK_5 / TotalK_5

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- 1.5 - 2.5 Std. Dev.
- > 2.5 Std. Dev.
- Insufficient Data

Overweight or Obese in Elementary Schools
Lancaster County 2014-2015

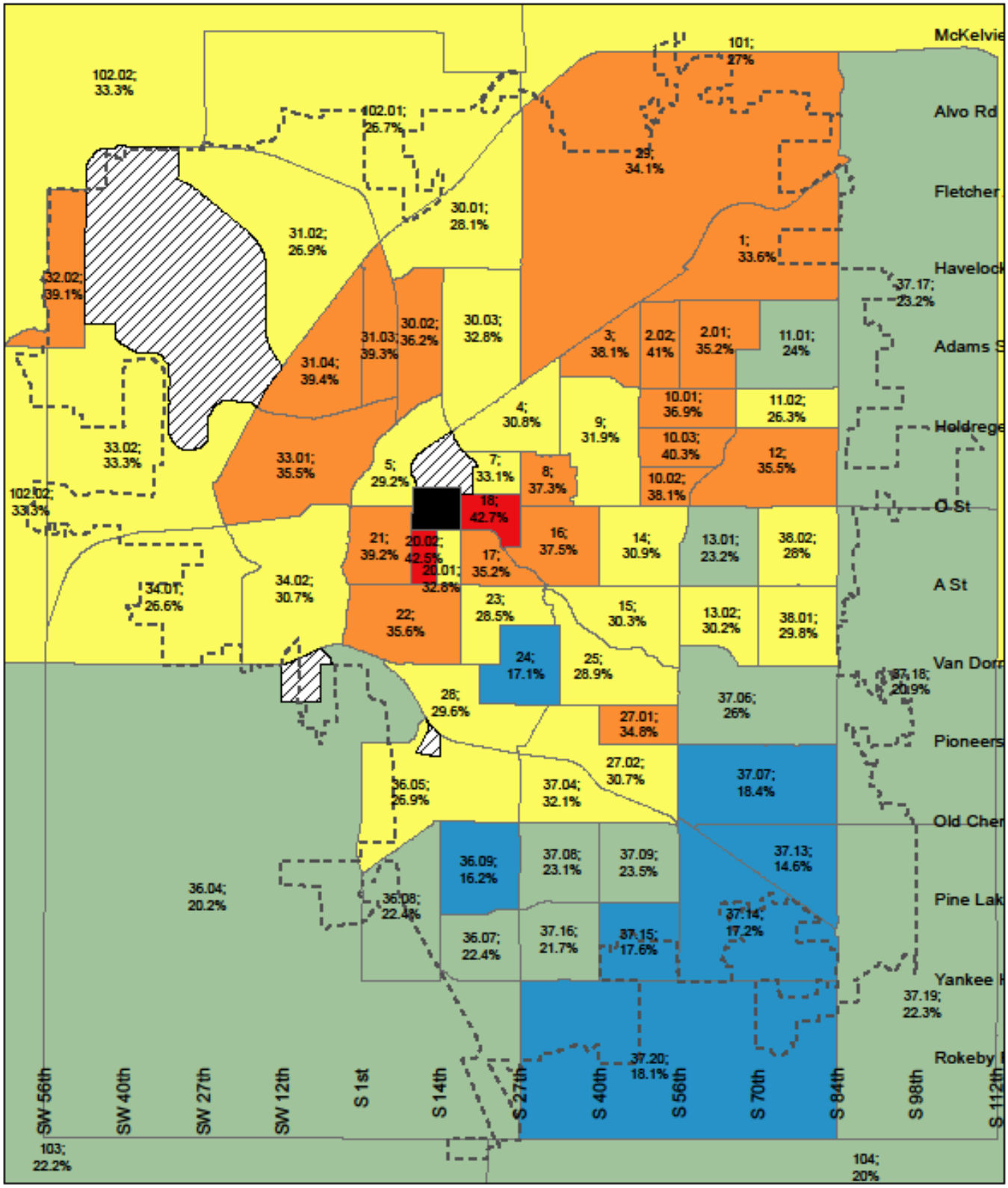
Label: Census Tract#, Overweight or Obesity %

Lincoln Asset Mapping Project

N W E S

1 in = 2 miles

#of Records: 30,421, Matched: 26,216
Data Source: Lincoln Public Schools



Legend

CTracts2010

OwtObs / Total

- < -1.5 Std. Dev.
- -1.5 - -0.50 Std. Dev.
- -0.50 - 0.50 Std. Dev.
- 0.50 - 1.5 Std. Dev.
- > 1.5 Std. Dev.
- Insufficient Data

Overweight or Obese in Elementary & Middle Schools
Lancaster County 2014-2015

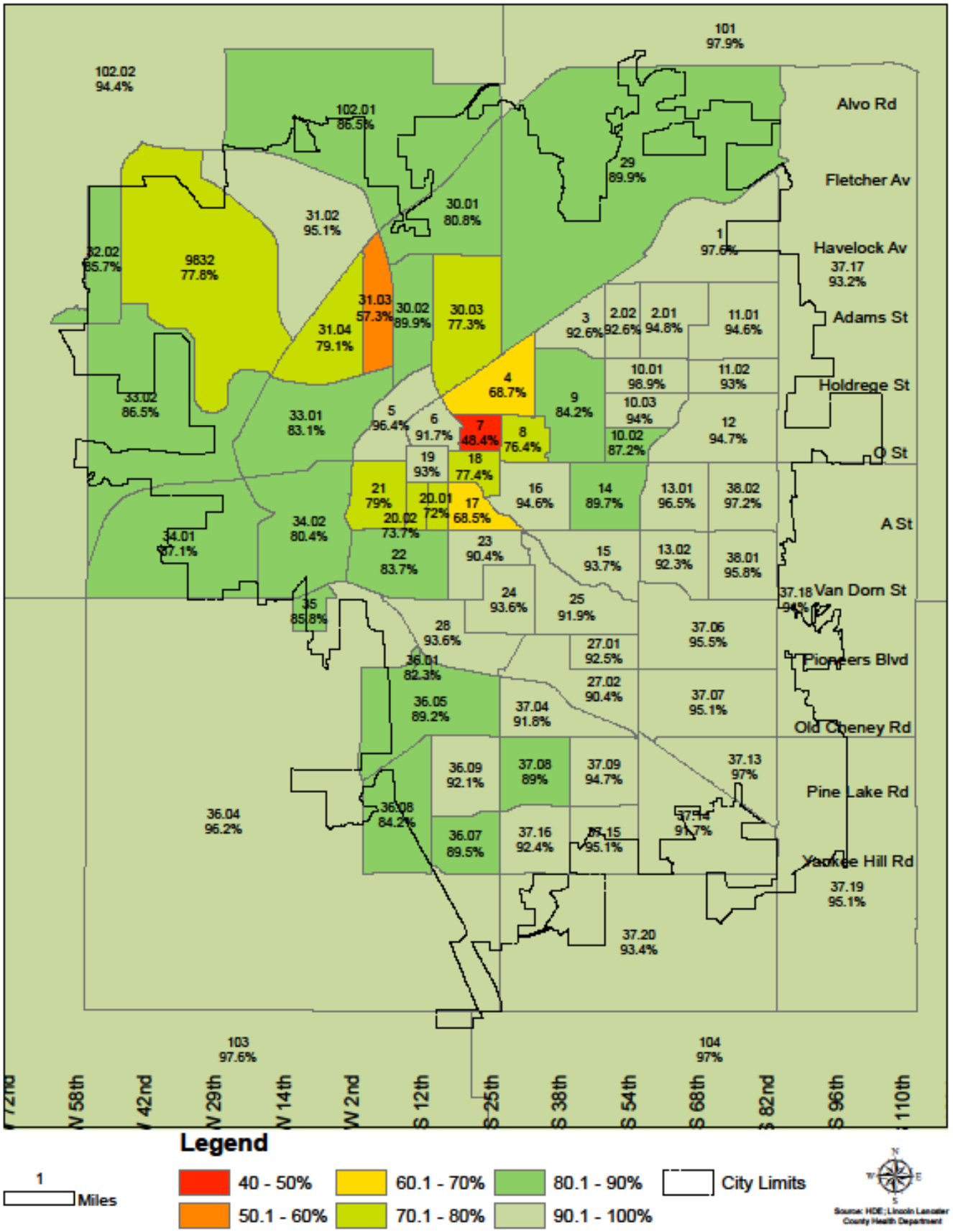
Label: Census Tract#, Overweight or Obesity %

Lincoln Asset Mapping Project

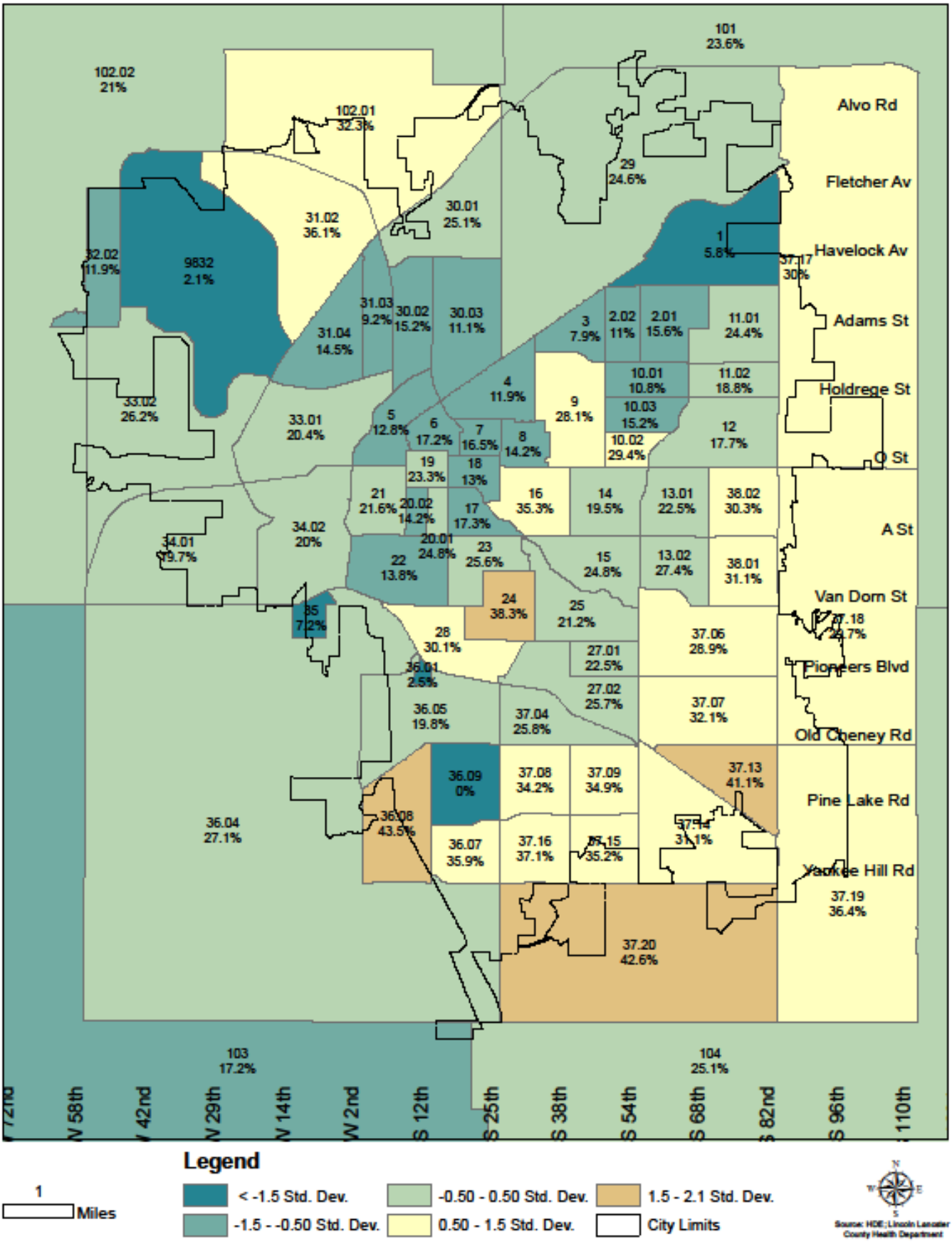
1 in = 2 miles

#of Records: 30,421, Matched: 26,216
Data Source: Lincoln Public Schools

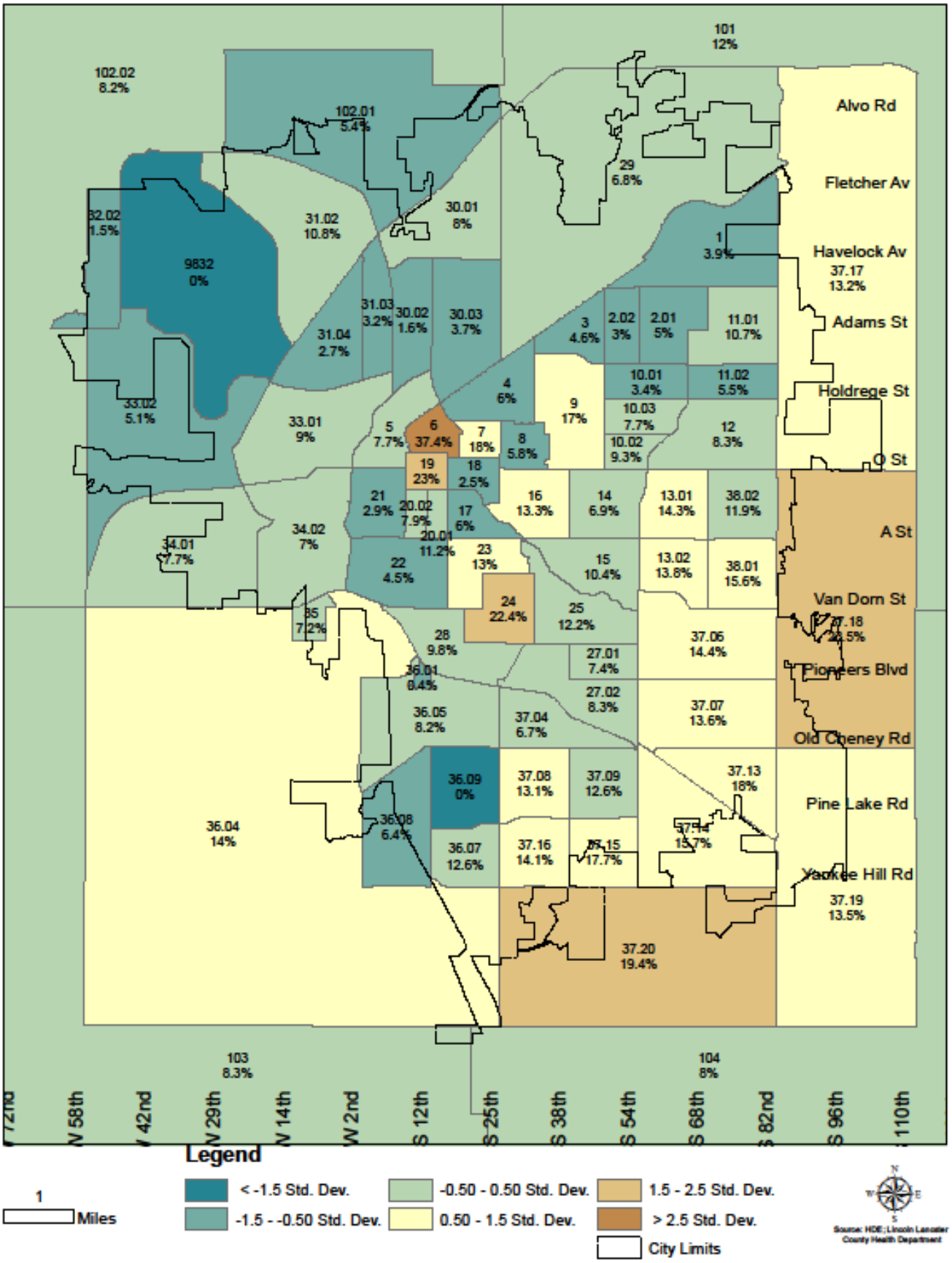
Percent English Spoken at Home



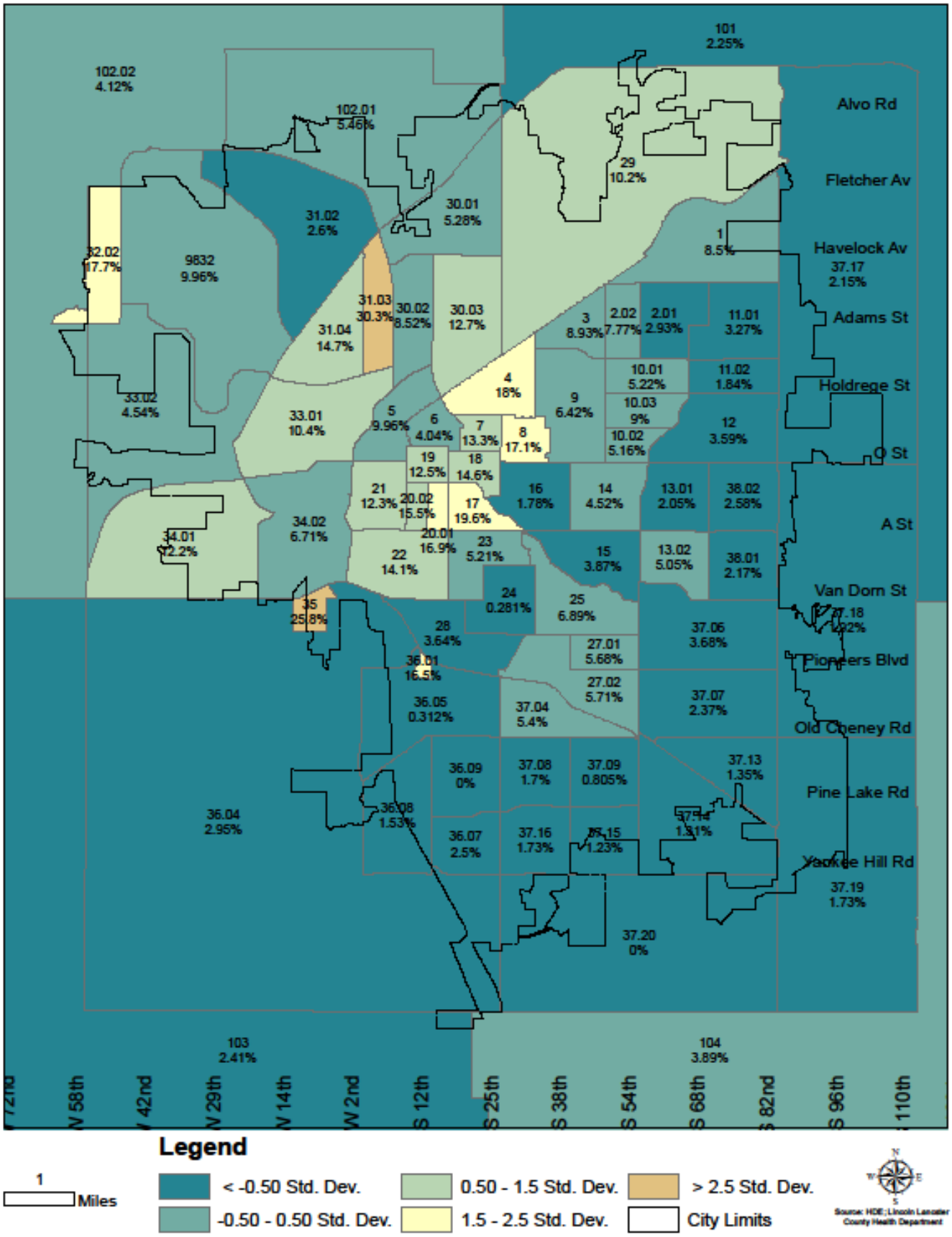
Education: Bachelors Degree



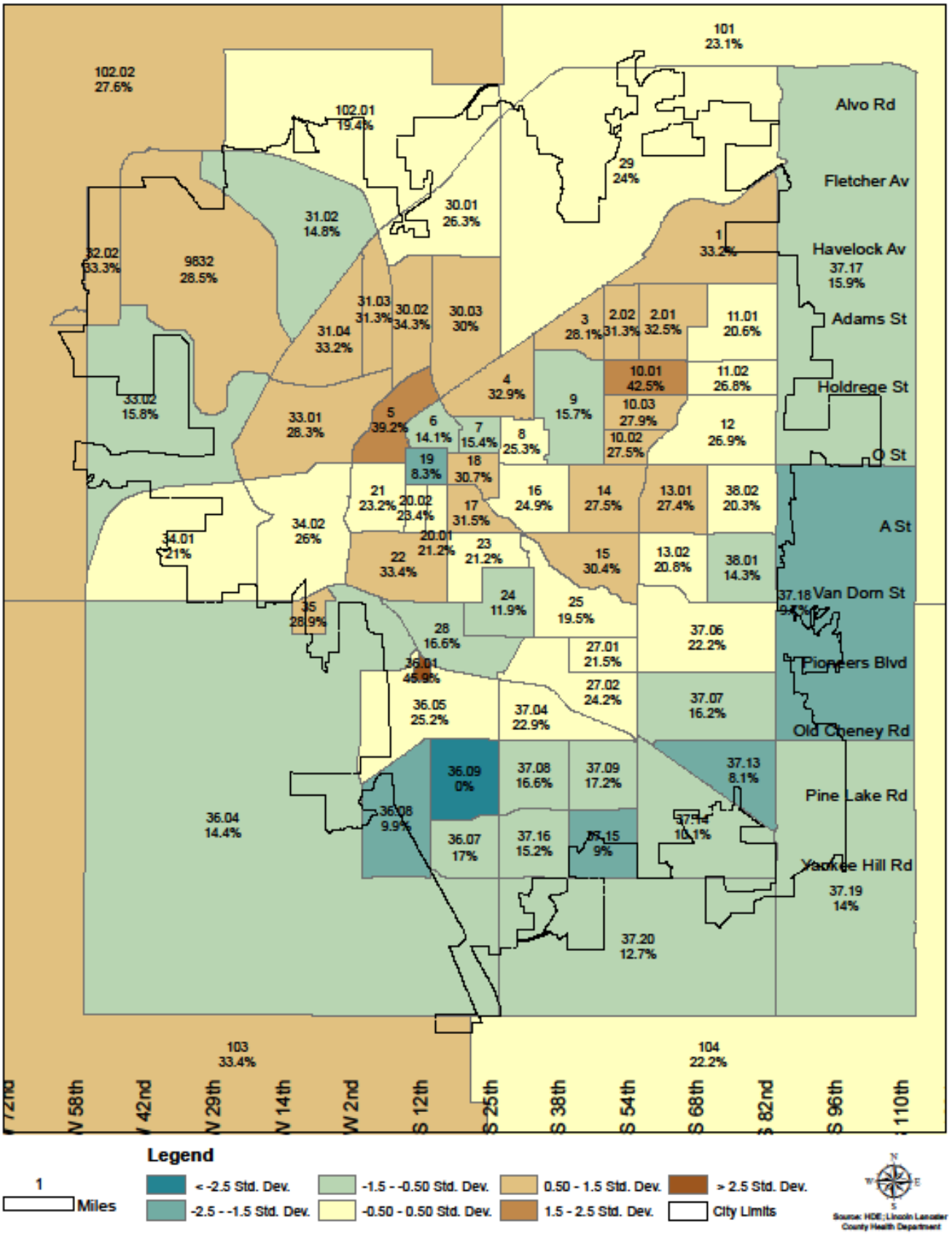
Education: Graduate or Professional Degree



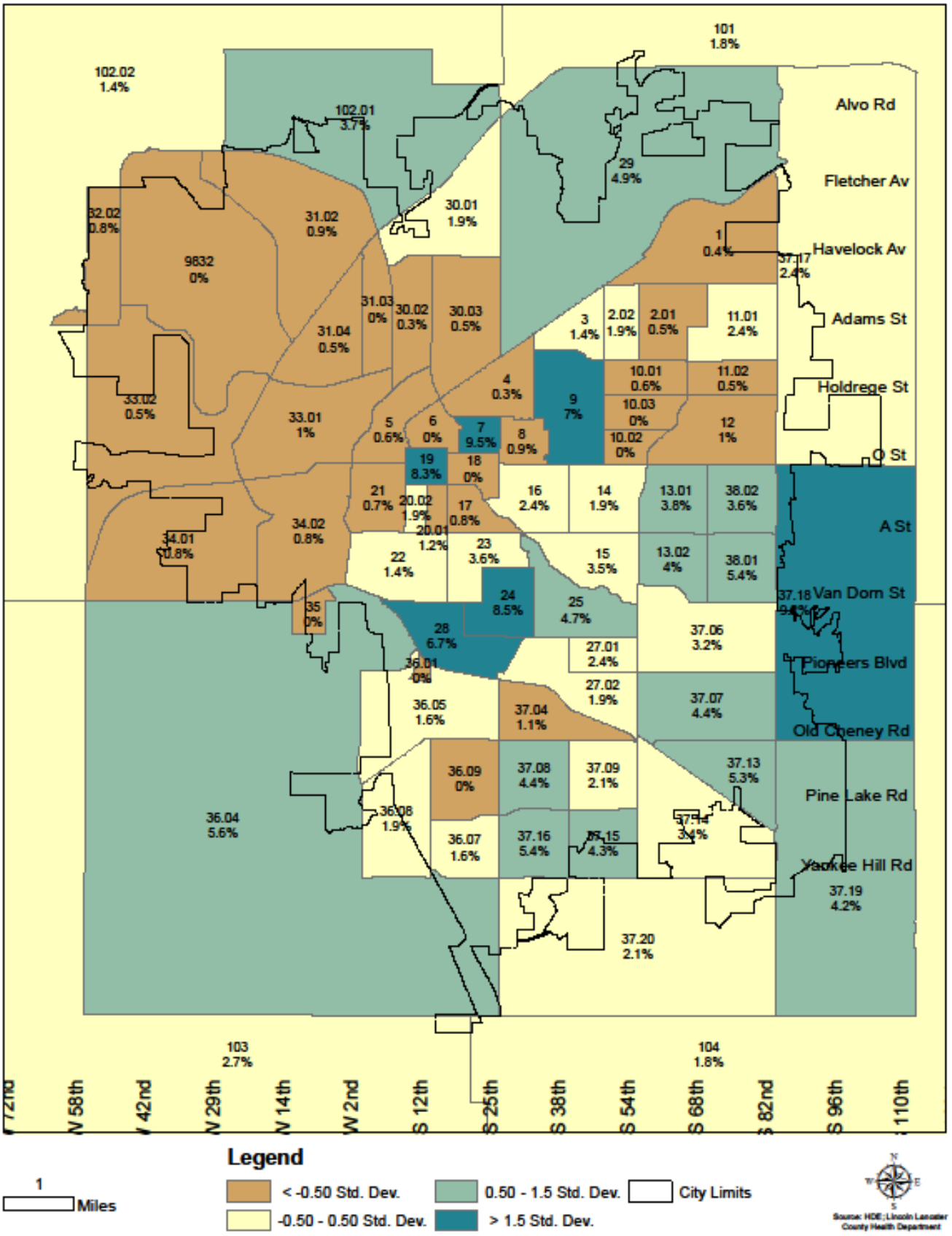
Education: Less than High School



Education: High School or GED



Education: Phd



Appendix 4. Community Themes and Strengths Assessment

Focus Groups

Included are the notes/summaries of the following focus groups:

- June 1, 2015, Focus Group conducted by NDHHS in Lincoln with community members recruited by LLCHD
- September 1, 2015, Focus Groups (2) at the Lake Senior Center with seniors
- March 2011 Focus Group with a church group of African Americans
- January 20, 2011, with a group of Spanish parents

February 2011 invite:

The Lincoln-Lancaster County Health Department wants to hear from you! If you are 18 and a resident of the county, we want to know how you feel about living in Lincoln and Lancaster County. To help us, please complete a voluntary 10-minute survey. You will not be identified and no one will call. If you have previously completed this survey, please do not complete it again but feel free to share the survey link with others.

The survey starts out with some health-related questions; however, its focus is on factors related to the quality of life in our community. The results of this survey along with other information we gather about the community will be used to identify the most pressing health issues that can be addressed through community action.

The link to the survey is http://www.surveymonkey.com/s/6P26FS2, but it's also available on the Health Department's web page (http://health.lincoln.ne.gov) under "What's New".

Your opinion is important! Thank you for taking the time to respond to the survey.

Community Survey Results

Included in this appendix are the results of the Community Themes and Strengths surveys:
LLCHD Survey, June 2015
LLCHD Survey open February to June 2011
NDHHS Phone CT&S Survey, December 2011

Nebraska MAPP Assessment Initiative, June 1, 2015

Community Themes and Strengths

Lincoln

Documentation of Participant Responses

Carrousel Results:

#1 Our Health Care System – Hospitals, medical specialists, access, quality, costs, behavioral health, dental care

Strengths:

- Community health care support for healthcare agencies
- Excellent care in most areas of health - if insured
- Good clinicians - quality
- Lincoln, outstanding 1955-NOW - Big, big improvement
- Dental college
- Strong community clinics (PHC, LFS, LLCHD, Health 360)

Weaknesses:

- Money for services
- Lack of access to primary, dental, behavioral health - limited access to dental and behavioral health services
- High costs
- Access to specialist for children
- Outstanding medical bills
- Behavioral health care access for teens
- Political reluctance to accept federal funds to help cover health care for uninsured
- Frustration with HHS call centers
- BCBS - CHI insurance "battle"
- More support is needed for childhood health
- Limited choice in specialists
- Slow to innovate delivery service (telemedicine, phone, video, etc._
- Mental health services
- Need more focus on prevention
- Awareness of behavioral health

#2 Community Support for Raising Children – Safe, affordable childcare, school system, after school activities, recreational opportunities

Strengths:

- Good afterschool programs
- Community learning centers
- Strong education system
- Lighthouse
- Malone Center
- Parks and rec programs
- City parks
- Foster grandparents in schools
- LPS resources - WOW
- Bilingual liaisons (LPS)

Weaknesses:

- Access to $$ for childcare
- Affordable childcare for all families
- Health in childcare settings
- Knowledge of available programs
- Parenting education & nutrition for babies, especially children and access to good food
- Parenting education for new immigrants
- Access to after school programs - funding (personal issues
- Safe routes to schools
- Complex justice system
- Affordable child care options

#3 Community Supports for Older Adults – Recreation and exercise opportunities, housing option, transportation options, meals, long-term care services)

Strengths:

- Senior exercise programs at fitness center
- Meals on Wheels
- Many long term care facilities
- Senior Center
- Senior Handymen program
- Ditto - Aging Partners!!
- SHIIP staff & services
- OLLI
- Aging Partners - WOW

Weaknesses:

- Bus system (hard to get to places)
- Lack of $$ for seniors' one level housing
- Lack of affordable wheel chair transport
- Poverty problems
- Transportation options - need more affordable
- High cost of health services
- Family support
- Fall prevention

#4 Recreational and Leisure Options – Places to exercise and play (parks, trails, pools, fitness centers, etc.), fine arts events, organized leisure time activities (clubs, teams, social groups)

Strengths:

- Trail network
- Parks
- Friendly, walkable neighborhoods
- Organized bike rides
- Strong neighborhood organizations
- Awareness of health needs
- Many, many sports opportunities for kids
- Higher education sponsored cultural, recreation and sports events

Weaknesses:

- Need more designed for adults with limitations
- Sidewalk repair needed - City is slow to repair
- Car/bike/pedestrian/safety support beyond trails
- More central city green space is needed
- Tolerance between motorist & pedestrians
- Outdoor activity in winter - limited
- Children's sports are expensive
- Opportunities for those with disabilities

#5 Jobs and the Economy – Opportunities for employment and job advancement, "family-friendly" job culture, overall economic climate

Strengths:

- Seemingly lots of opportunity
- Unemployment rate
- Lincoln growing - building all over Lincoln
- National job draw
- Increase in minimum wage
- Low unemployment rate
- Lots of qualified applicants
- Strong local business network

Weaknesses:

- Low wages - in many cases, several incomes needed to support a family
- Bringing new people to Lincoln is difficult
- Underemployment
- Too many part time jobs - no benefits and lower pay
- Underemployment is increasing
- Unemployment for minorities
- Service jobs
- Jobs for veterans
- Part time jobs with no benefits
- Elderly population forced to work longer years
- Benefit costs/availability
- Need to attract new businesses

#6 Housing – Enough quality housing, affordability

Strengths:

- Home of some family
- Habitat for Humanity
- Neighbor Works
- Partnerships - LHA
- Voices of Hope
- Homeless Coalition
- Good job building
- Safety - LLCHD

Weaknesses:

- 450 total on market in May
- Waiting list - takes a year
- Subsidized housing older adults (and disabled) - need more
- High rent for less than desirable housing
- Slum lords
- Lack of affordable housing
- Limited housing for families of 5 +
- Mixed housing needed

#7 Safety and Social Supports to Fill Community Needs – Safe place to live, work and play, support networks for times of stress (neighbors, support groups, faith community, outreach, community organizations, etc.), adequate volunteers

Strengths:

- Some very strong neighborhoods
- Community groups/concerned citizens very active
- Strong leadership from faith organizations
- A+ parks and trails system
- Good police force, fire department, libraries
- Vet program for all
- Strong presence of faith-based organizations
- Overall a safe place to live

Weaknesses:

- Some neighborhoods more fractured - less feeling of "community"
- Not all areas feel safe for play
- Limited routes & hours of the bus services
- Be more neighborly to each other
- Keep our home areas - it's our JOB
- "Slumlord" rental properties
- Effect of poverty on health
- Pollution - air, water

#8 Health Issues – What are the most troubling health-related problems in our community?

- Mental health issues facing children
- Lack of physical activity among older adults (also all adults and kids)
- Stress, especially for minority populations
- Lack of money - choice of medicine needed or utility bill
- Lack of communication of different cultures!
- Identification of mental health concerns
- Health outcomes are neighborhood dependent (see: CHE mapping project)
- Mental health issues & the prison system
- Childhood obesity
- Lack of access to sports (minorities)
- Behavioral health challenges (refugees & immigrant communities)
- Unequal access to health foods and places for activity
- Awareness of nutrition and physical activity programs
- Older adult falls
- Obesity - All
- Substance "misuse"

#9 Risky Behaviors – What risky behaviors have the most impact on health and wellbeing in our community?

- Teen mental health untreated
- Teens being left to self after 19 years - out of foster care - no education, no job skills, no resources
- Driving issues such as distracted drivers & pedestrians
- Yellow lights not followed - no turn signals!
- Alcohol - overconsumption and the associated behaviors
- Drug of choice is alcohol too often
- Presence of carcinogens in food
- Nutrition & physical fitness - impact on health of young children (lack of P.E. in schools) - leading to childhood obesity
- Increase K2, etc.
- Children acting/living like adults on the streets

#10 What specific assets (resources) does our community have that can be used to improve community health?

- Existing collaborations & partnerships to try to get people into care
- Many specialists, locally, however many do not accept Medicaid
- Good representation from organizations that target specific health issues
- Good farmers markets, CSA's and health ag support for good food
- More coordination of health services & resources across time
- Reach out to the elder/disabled/vet
- Research for health food - UNL
- Strong school systems (public and private)
- Public access to physical exercise at little or no cost
- 10 health TV programming
- Collaborations & partnerships
- Community gardens
- A+ nonprofit organizations
- Excellent health leadership (LLCHD), hospitals and clinics
- New clinic linking physical and behavioral health under one roof
- UNL Extension
- LPS Wellness program
- Community Learning Centers
- Safe Kids

Consensus Workshop Results:

Where items are repeated within a list, more than one small group had mentioned the issue. Numbers in parentheses indicate number of priority dots awarded by participants.

Key Question – What are the most significant health issues and/or community conditions facing our area at this time?

Changing demographics	Lack of political will leading to ineffective policy (11)	Lack of funding for health related issues (6)	Poverty and the working poor (7)	(Need for) Integrated and collaborative approaches to wellness (12)	Lack of support for healthy lifestyles (15)	Mental health issues (11)	Lack of will to care for the environment (7)
• Growth - aging & new American populations	• Homeless youth, foster care - age out • Judicial system complex, hard to get out of • Lack of political will/ political inaction	• Behavioral health funding • Political reluctance to access federal insurance $$ • Appropriate funding for health initiatives • Dental health - cost prohibitive and lack of access	• Supports & resources for working poor • Income disparity (wealth vs. poverty) • Inconvenient bus system • Housing - affordable for large families • Poverty impacts health • $$ don't pay bills, resources don't cover expenses	• Collaborative and integrative approach to wellness • Community engagement - involvement, education, awareness, proactive instead of reactive • BCBS & CHI health insurance issues - costs • Effective "one-call" for resources (akin	• Obesity - universally (all ages) • Healthy, affordable convenient foods • More emphasis & funding for illness & injury prevention/ management • Equal access to physical activity & good nutrition -	• Mental/ behavior health - stigma and lack of access • Identifying youth mental health issues • Mental health issues	• Continued degradation of an unhealthy environment

- Homelessness
- Homeless youth

to the Digger's Hot Line)

- Tolerance between motorists and pedestrians
- Whole-person, whole-child approach to wellness

remove barriers

- Healthy eating - poor habits, access
- Increased emphasis on physical activity for all ages & abilities

Focus Group Lake Senior Center – September 1, 2015

(Facilitated by Steve Frederick with notes taken by Peggy Apthorpe)

Lincoln?

People who move here want to stay.
The quality of life is great.
Lincoln has a lot to offer but not NYC.
I enjoy life in Lincoln.
People care about people. Organizations help people. There are lots of opportunities and activities going on.
Community partnerships and collaborations are good.
Lincoln is a big city with a small town feel.

Strengths

Discounts
Lincoln is a superb place to be for health care. Omaha can do what Lincoln cannot. High quality professionals in many areas. Dr. Hutchins (oncologist) was mentioned specifically.
Madonna professionals make you feel you can do it (rehab).
Tabitha has a good hospice program.
No significant problems accessing health care when on Medicare were mentioned. One person said her doctor would only see her for one thing.
Food Net and Food Bank are good things.
Lincoln is a caring community that historically has kept up with resident's needs.

Weaknesses

Need more affordable and accessible public transportation especially for medical appointments.
In some cases the fragile family structure is an issue. Public assistance programs need change.
Too many opportunities for young people to use alcohol exist downtown.
Lack of parking and dangerous streets downtown are a problem.
Bad sidewalks are a fall hazard.
People expressed some uncertainty about the future housing needs of older adults.
Need for more affordable mental health services and for more mental health education and prevention programs.

Changes in recent years?

No state fair
Downtown has changed significantly in recent years.
Most in the group seemed comfortable with city growth and changes.
South 27th St. is a bottleneck.
City basically does a good job of street/traffic planning with the exception of South 27th St. area.

Health information

Few people in the group used the internet to access information.
Neighborhood meetings or groups might be a good place to convey important information about mental health issues, emergency preparedness and more.
The group agreed emergency preparedness is a good thing. Most in the group felt they had some plans.

Afternoon Focus Group Lake Senior Center – September 1, 2015

(Facilitated by Steve Frederick with notes taken by Peggy Apthorpe)

Lincoln?

Lincoln is a clean city.
Traffic is good during certain times of day – bad at other times.
Lincoln has one of the lowest unemployment rates, but there are low paying jobs so poverty rates are higher than they should be.
We need more well-paying jobs.
Public assistance programs need to be looked out.
43% of children below poverty even though parents sometimes work two jobs.

Strengths

Participants were generally very happy with the quality of health care and health care professionals in Lincoln. Some doctors are seen as angels.
There was concern about Medicare overcharging or fraud. One participant with extensive experience helping people with Medicare said it is not a big problem in Lincoln.
Facilities and professionals can bill Medicare whatever they want-- it does not mean Medicare will pay full price.
Overall health care including EMS are seen as excellent in Lincoln.
A couple participants mentioned the Aging Partners fitness center as being helpful to them.
People feel being the state capitol, home of state government and the fact we have three universities and SCC is a very good thing for Lincoln.
Activities offered are good. Sometime there are two or three things going on at once. The arena area is not necessarily a good venue for older adults.
Continuing education opportunities such as those offered through SCC a plus.
Law enforcement is way above average.
SCC/LPS Career Academy good and could lead to more well-paying job opportunities.
Innovation Campus may help provide more high paying jobs in the future.

Weaknesses

Parking and traffic in the downtown area are bad!
Transportation services shut down at night and on the weekends. Even when buses are running they are scarce in certain parts of the city.
Need more safe, affordable and accessible public transportation especially for medical appointments.
In some cases the fragile family structure is an issue. Public assistance programs need change.
Ageism is a weakness.
Fixed/Limited incomes are a problem for many people. This sometimes gets worse as they live longer than they planned outliving their money so to speak.
Some mentioned that their grandchildren do not expect to get social security.
Some older adults need help getting out of debt.
Lack of affordable housing and services in central Lincoln a weakness.

Changes in recent years?

Most in the group seemed comfortable with city growth and changes.
A lot of attention has been paid to Downtown Lincoln in recent years. Many services including grocery stores, doctor's offices etc. moved from central Lincoln to east or south Lincoln leaving people without accessible services in the central area. We need more subsidized housing options in central Lincoln.
Antelope Valley project has helped prevent flooding.

MAPP Focus Group Responses, March 2011

African American Focus Group Results
Conducted by Renee Massie, March

1. Describe your community if you were talking with a friend or family member who had never been here.

- Its updating – better place
- A lot of places within walking distance – ex: fast food places, drug store, grocery store.
- A few bike paths.
- Drugs in area.
- Every nationality – stores where you live, school and quick shop – things available right in the area, you don't go too far to get what you need.
- After school – F Street Recreation Center, Salvation Army (including Small Fry basketball) volleyball, all sorts of after school program.
- Safe environment to raise your kids.
- Very resourceful here if you know about them and how to use them.
- Good help to get you started.
- Quiet
- Available – several colleges (Southeast CC, barber college included), a lot of help to go to college
- Good schools, churches, program for adults and kids.
- Close knit
- Very friendly, very accepting
- Plenty of places to eat and shop.
- Plenty of sports activities

What activities do you do here?

- Walk
- Visit with neighbors
- Volunteer in my community
- Church
- Downtown – Pershing & Bob Devaney Sports Center

Compared to other cities?

- This population is still very safe and schools are safe.
- Jobs still available – might not be what you want.

2. What do you view as strengths of Lincoln as a community?

- Lots of activities for growth as well as senior citizens.

- A lot of positive things for kids to do after school to keep them [out of mischief].
- Safe environment for kids versus other states.
- Violence rate down.
- Crime rate low.
- Safety issues – real big.
- Lincoln helps one another.
- Sport driven for children
- Good schools.

3. What are their biggest concerns in your family, or among your friends' families?

- Ability to obtain loans for businesses (open up small businesses).
- Education
- Health – having [health] insurance.
- Stable employment.
- Employment – better [job options)], especially [for] those who have been incarcerated.
- Lack of ways to pay utilities.
- Getting deposits paid.
- Economic problems.
- Takes too long to get into housing
- Too long of a wait for an appointment at Peoples and the Mission when the person has an acute health condition.

4. How would you describe the interactions between Lincoln's community members from different backgrounds?

- Lincoln is an accepting community of different races.
- Longtime community members welcome new people of all backgrounds.
- Lincoln reaches out.
- Lincoln is a welcoming community.
- Lincoln lets people make communities within a community and tries to understand each other.
- For the most part time – others do have their own beliefs and they are not shunned and it's not a problem for others.
- Many different cultures have migrated here and some have become communities with the community which is not a problem.

How has Lincoln changed?

- People gravitate here because it is safe.

5. What are some of the things lacking in Lincoln?

- Lack of entertainment – pro sports, live entertainment, jazz, blues.
- Health needs are being met but it could be better.
- The length of time to see a doctor needs improvement (long discussion).
- Access to health care - afraid to get care because bills [stack] up, checks garnished – bills, dental

- Once upon a time you could go to the Health Department for $20.00 and now you cannot.
- Went to Peoples [Health Center--they said that people] pay what you can and then billed $5.00. Was told that the cost was $20.00, but later got a larger bill. [They are misleading people about health care costs.]
- Employment
- Health
- Hard to get doctor appointments – thank god for Mission.
- You have to wait for a long time.
- Long waiting lists.
- Lack of extended transportation – buses stop running at 6:30 or 7:00.
- If you don't have a car, you cannot get around.
- No evening medical appointments.

6. If a task force was being formed to improve things in your community, what topics do you think they would need to address and why?

- Meth problems
- [An easy way] to obtain housing for low income people.
- Not such a long waiting list for section 8 [subsidized housing where the waiting list is at least two years long].
- Address high drug use in schools and schools in drug-infested areas – has to do with health and wellness of children.
- Access healthcare issue – pay one price and billed another.
- Programs to improve the health of adults for a fee.
- Health issues -- people need to seek medical attention sooner.
- Employment – people need just to provide for their families.
- Healthcare – affordable.

NOTE: The word "task force" with all these people first made them think of the police until Renee explained that a task force can be for healthcare too. There was also discussion about police harassment and profiling.

MAPP Focus Group Questions, 1/20/2011

Spanish Parents Parenting Group – Everett School
20 persons attended + 5 non-Spanish parents

Describe Lincoln…"If you were talking with a friend or family member.

- Very pretty (Bonita)
- Tranquil
- Get a lot of help
- A lot of programs
- The help that is available to all
- A lot of opportunities

In family or friends, what are the biggest concerns?

- Difficulties with immigration laws.
- Prenatal care services.
- Pregnant women without SSN do not receive benefits.
- EWM benefits decreased or were canceled to people without SSN.
- Public transportation – should be available later in the day – many people have to walk.
- Immigration:
    - If the "new" immigration law is passed in Nebraska, people are going to be very fearful.
    - The city will become unsafe.
    - If a person gets sick, they will be unable to go to ER.
    - Unemployment.
- Not having transportation to get children to school.
- Not having a driver's license.
- Not having SSN.
- Not having relatives in town.
- Language barrier.
- More opportunities to learn English.
- If the immigration issue is not resolved – at least they ought to let people work; they are fearful of the police who know persons or find persons who are caught driving without a license.
- Sometimes they (police) have no reason to stop a person but look for a "pretext" to give tickets.
- Services at the Health Center are delayed; before, one "was attended" the same day; now it can be months to get a vaccination or to be seen by the dentist.

How would you describe the interactions between Lincoln's community members from different backgrounds?

- "A little good" – not real bad.
- In general it's bad, for example, if you don't speak English.
- Or people assume you speak English. The other person does not know I need an interpreter and does not request one.
- "Half & half" about right or wrong. Sometimes we tried to speak English and some people are mean and others polite.
- "African Americans" that live in same areas are very noisy, but if some Hispanics are, [these are apartment neighbors (JK)] African Americans will complain.
- There are some white people easy to talk to but African Americans are different.
- When there are festivals, different cultures get together; it is a great occasion for living together and to get to know other cultures
- We have to or must live together, know other people and other cultures.

Things lacking in Lincoln and topics to be addressed.

- Negative – Persons with dogs should "clean up" after them. Sometimes there is a lot of manure in the street and everywhere (yards, park, etc.)
- Most persons do not carry a bag to pick up after their dog, especially around Cooper Park (18 persons lived around this area and agreed about the above 2 statements.)
- The bathrooms are closed all the time. Only when there are games are they open and then afterwards they are closed. It is a problem. The water, at first, comes out dirty; like black. [This seems to be Cooper Park. (JK)]
- More health services needed – if a person is very sick, they cannot be attended immediately.
- The police ought to get an interpreter if the person does not speak English.
- Police should not be racists; they stop the persons they want. (e.g.) Some persons drive around with a dog on their lap and they don't stop them. It seems like legal residents have privileges that the undocumented do not.
- Educate persons who work in community and public services for example, police, teachers, nurses, doctors. It is important to educate public servants. [meaning cultural competence (JK)] – 18 agreed.
- Persons have dogs that bark all day.
- A child was bitten by a dog and the policeman (came) did not ticket the dog's owner; no one knew if the dog was vaccinated. The mother asked "who was more important the dog or the child"? The police and the animal control person said the dog was more important. [This could be a misunderstanding resulting from not knowing English or no interpreter (JK)]
- It seems the biggest problems are the dogs and the police.
- SNAP (Supplemental Nutrition Assistance Program) services have problems, for example, persons with disabilities need more things [than food (*JK*)] like detergent, toilet paper, bath soap, diapers, etc., and they can only buy food items, not items for personal hygiene.
- There are some places that offer these items but they run out rapidly.
- Everyone worries about racial profiling because even if one is a legal resident, police go on to detain a person if they look Latino.

- Help is needed for a family with a child who is smoking marijuana, but because they do not have documents, they have been rejected. Also, there are programs for boys but not the girls.
- (Help from) social workers and interpreters and other services from (HHS) the State department have been cut off.
- What was the point of the census of 2010 if many of the services do not exist anymore?
- Persons who rent are afraid to report the landlords because they know the tenants are undocumented.

* South at Cooper Park from 2nd to 11 – A-G Streets is where the issues with dog poop came up. There are no signs. If there were, people would take care of it.

Summary of the Community Themes and Strengths Assessment, February 2011 to June 2011

Assessment of the Community Themes and Strengths is one of four assessments as part of the Mobilizing for Action through Partnership and Planning (MAPP) process. The Community Themes and Strengths assessment is intended to answer the following questions:

- What is important in our community?
- How is the quality of life perceived in our community?
- What assets do we have that can be used to improve community health?

As the lead agency for MAPP, the Lincoln-Lancaster County Health Department (LLCHD) posted an online survey in both English and Spanish. The recommended survey from the Nebraska Department of Health and Human Services (NDHHS) was reviewed and the MAPP Steering Committee and staff edited and expanded the survey in several areas to solicit more information about local assets without affecting the core questions about health problems. As this was an online survey, there was the ability to allow for individuals to write in responses and a fairly significant number of persons did so.

The LLCHD survey was created using SurveyMonkey and was open for several months in early 2011, from late February to June. The survey was also available in hard copy form for those who did not have access to a computer. To increase participation, the Mayor's Office issued a press release, there was outreach to the community's cultural centers, the People's Health Center, Center for People in Need and to partner coalitions including WorkWell among others.

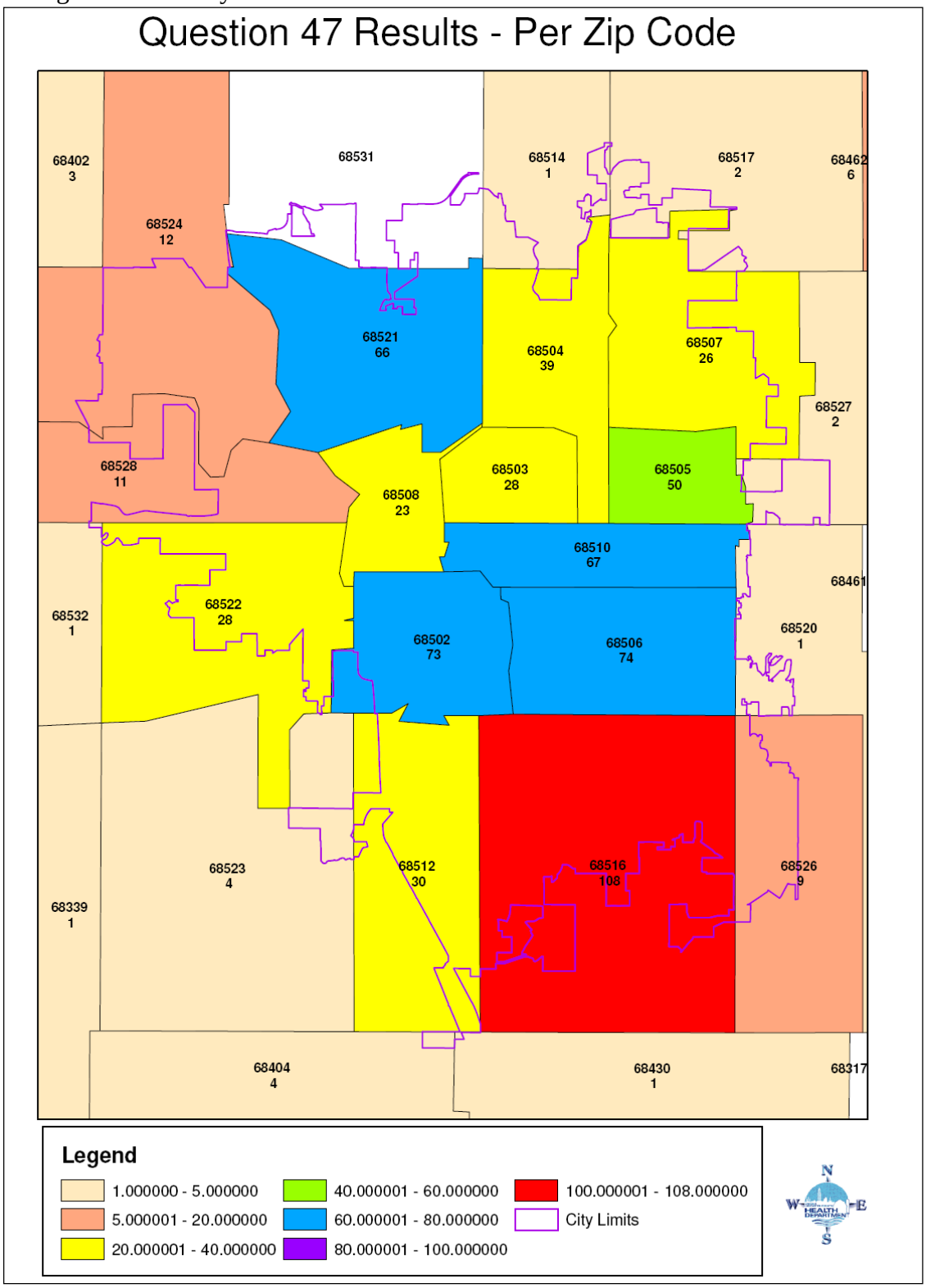
In addition, the LLCHD convened a couple of minority focus groups: one with members of the African American community and one with an audience of persons of Hispanic/Latino origin. The focus groups were facilitated by LLCHD staff members. This document provides the basic results without a great deal of analysis. In addition to this summary, a copy of the survey, and spreadsheets with the detailed answers, including comments are available.

Survey Results

A total of 837 people responded to the English version of the Community Themes and Strengths survey. There were only 9 people who responded to the Spanish version of the survey. The number of people who responded to either version of the survey was well below our expectations, especially given the outreach efforts of staff and the publicity about the survey. (In November, the NDHHS will share the Lancaster County results of their statewide stratified sample and we will analyze those results.) The LLCHD survey was a convenience survey, and so the results need to be viewed in that light. Given the small number of persons to the Spanish version, detailed results will not be included in the discussion that follows, but the results will be reviewed with the focus group information.

Who Responded to the Survey?

The following map shows the distribution of respondents from across Lancaster County. The majority of respondents were from Lincoln zip codes, but there were respondents from throughout the county.

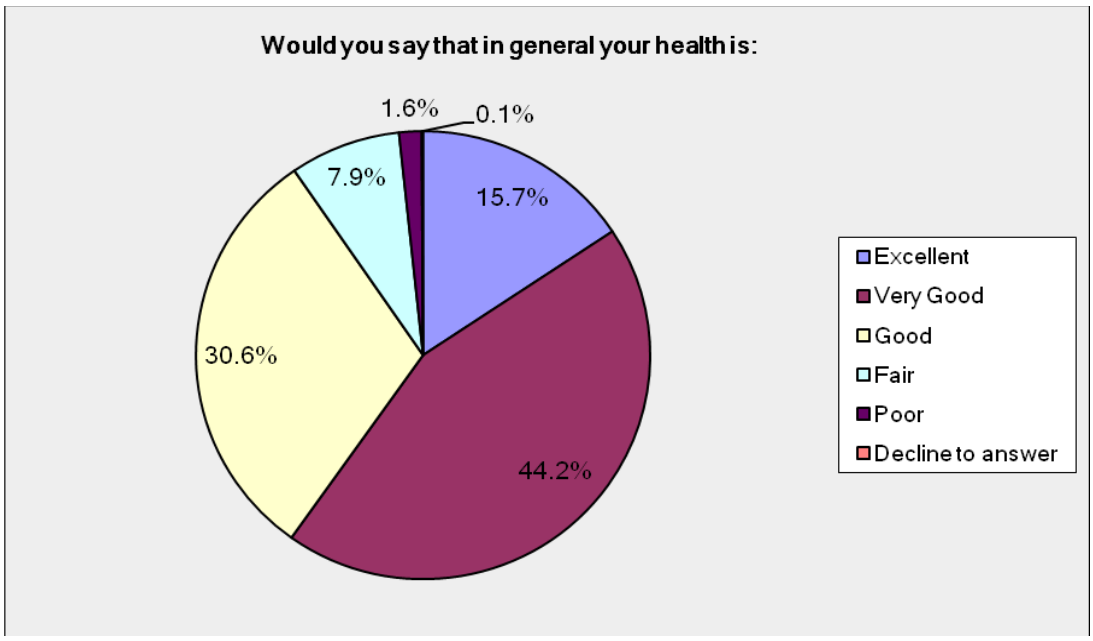


Since the survey was online and there was no logon for individuals, there was the possibility that individuals who live outside of Lancaster County could respond. It appears that some did, but the numbers were small (fewer than 20) and likely had no substantive effect on the results.

By gender, 71.7 percent of respondents of the survey were females; 28.3 percent were males. Almost sixty-eight percent of respondents (67.6%) were married; 11.5 percent indicated they were divorced and 15.9 had never married. The vast majority of respondents (94.3%) were in the working age population (aged 18 to 64) with the remainder (5.7%) were senior citizens (65 and older). Only two percent of the respondents indicated that they were persons of Hispanic origin. As for race, 94.4 percent of respondents indicated that they were white, 3 percent listed their race as multiracial or "other race", 1.1 percent indicated they were African Americans and one percent indicated they were Asians.

By education, fully 81.3 percent of respondents had attended some college classes with 74.3 percent having a college degree or higher; 18.1 percent had a high school diploma or GED, and only 0.7 percent had not graduated from high school. Given the high percentage of college graduates, the income distribution of respondents was also skewed to the high side: 7.8% had incomes below $20,000; 26.4 percent had incomes between $20,000 and $49,999; 21.6 percent had incomes between $50,000 and $74,999; 17.8 percent had incomes between $75,000 and $99,999 and 19 percent of respondents had incomes over $100,000. (7.8 percent declined to answer the question about income.)
Only 5.7 percent of respondents indicated that they had no health insurance while 90 percent indicated that they had private insurance. As for public health coverage: 5.5 percent of respondents had Medicare, 2.2 percent had Medicaid, 2 percent had TRICARE and 0.4 percent of respondents were covered by the Indian Health Service (IHS).

Personal Health Characteristics



As is shown in the chart above, 15.7% of respondents rated their health as Excellent, 44.2 percent said their health was Very Good and 30.6 % rated their health as Good. Of the 9.5 percent who rated their health as Fair or Poor, most (7.9 %) indicated they had Fair health. When asked about their health care providers, 86.6 percent of respondents indicated that they had a personal doctor and 88.6 percent said they had a personal dentist. A question was asked of those who do not have a personal doctor about where they go for medical care. The following table lists the responses (people could choose more than one answer).

Since you do not have a personal or family doctor, where do you usually go or where do you usually turn to when you need medical care? (Check all that apply)		
Answer Options	**Response Percent**	**Response Count**
Urgent Care Clinics (e.g., LincCare, Urgent Care Centers)	46.0%	46
Other (please specify)*	25.0%	25
Delay care as long as possible or forgo care entirely	21.0%	21
Emergency Room at one of the hospitals	17.0%	17
Visit a Chiropractor	15.0%	15
Free Clinics (e.g., Peoples City Mission, Clinic with a Heart)	12.0%	12
Health Department (Lincoln-Lancaster County Health Department)	5.0%	5
Peoples Health Center	5.0%	5
Planned Parenthood of Lincoln	4.0%	4
The Health Hub (Center for People in Need)	4.0%	4
Call 211 (Human Services Information Line)	3.0%	3
Faith Healer or provider of alternative medicine	3.0%	3
See a doctor in another community	3.0%	3
Urban Indian Health Center	3.0%	3
Lincoln Medical Education Partnership (LMEP)	2.0%	2
Veteran's Administration (VA) Medical Center	1.0%	1

*The other category listed a number of other providers such as UNL's Health Center, Women's Clinic, a specialist or doctors in another community. However, many of those listing "other" answered that they do not seek care because they have no insurance and no money.

Opinions about Medical Care

Survey respondents were next asked a series of questions about the health care system and asked to rate whether they strongly agree, agree, are neutral or have no opinion (don't know), disagree or strongly disagree. The following table reports the results. While the results show that most have positive responses to the question (Agree was the modal answer) there are a few issues (cost of care, office hours and waiting times) where the percent of persons disagreeing reaches up to 25 percent. Unfortunately, we did not ask follow-up questions in this section to capture positive and negative feedback.

					Strongly

General Question (restatement of Questions 5 through 14)	Strongly Agree (%)	Agree (%)	Neutral/No Opinion (%)	Disagree (%)	Disagree (%)
Generally satisfied with the health care system (public health, hospitals, doctors, mental health services, medical clinics)	19.4	**58.1**	12.3	8.3	1.9
Generally able to medical care when needed	35.6	**54.8**	4.1	4.0	1.5
Have easy access to medical specialists	25.4	**53.1**	13.3	5.7	2.4
Very satisfied with the medical care received	26.6	**55.0**	11.6	5.9	0.9
Individuals, personally, have no barriers in getting medical care when needed	28.8	**50.8**	7.3	9.6	3.5
Covering their share of the cost for a medical care visit is not a problem	16.8	**47.3**	10.6	18.0	7.3
Regular office hours of providers are not a problem	15.9	**52.8**	12.8	16.0	2.6
Wait times for appointments with a medical provider are reasonable	19.1	**63.7**	8.6	7.1	1.5
Waiting times in the office for scheduled appointments are short/no delays	11.7	**51.3**	13.8	19.7	3.5
Individual has experienced no language or cultural barriers when seeking care	38.8	**50.1**	7.9	2.4	0.8
Have no difficulties finding transportation to medical providers	43.0	**45.7**	7.6	2.4	1.3

Perceived Health Problems in the Community

Respondents to the survey were asked to rank the five most important "health problems" in Lancaster County. The health problems are shown in the following table, ranked by highest to lowest. While the list of problems was fairly comprehensive, people could specify "other." The most often identified "other" health problem was obesity. Seventy-seven of the other responses stated obesity and overweight as the problem and several people wanted to know why obesity was not listed among the choices.

Now, thinking about what you know from your personal experience and/or the experience of others you know, what do you think are the 5 most important "health problems" in our community (problems that have the greatest impact on overall community health)? Check up to 5:		
Answer Options	Response Percent	Response Count
Heart disease and stroke	56.6%	432
Cancers	55.6%	424
Mental health problems	51.0%	389
Diabetes	44.8%	342
Aging problems (e.g., arthritis/hearing/vision loss)	44.4%	339

Addiction	41.8%	319
High blood pressure	32.2%	246
Child abuse/neglect	25.3%	193
Domestic violence	19.5%	149
Teenage pregnancy	18.1%	138
Other (please specify)	15.9%	121
Health disparities	14.9%	114
Respiratory/lung disease	11.4%	87
Dental problems	10.9%	83
Motor vehicle crash injuries	10.1%	77
Sexually transmitted diseases (STDs)	9.0%	69
Rape/sexual assault	5.9%	45
Suicide	5.2%	40
Infectious diseases (e.g., hepatitis, TB)	5.1%	39
HIV/AIDS	1.8%	14
Firearm-related injuries	1.3%	10
Infant death	0.8%	6
Homicide	0.5%	4

A follow-up question asked respondents to prioritize the problems in terms of the first two needing to be addressed. The top three health problems (with 50 percent or more respondents listing heart disease and stroke, cancers and mental health problems) were also selected as the top three issues needing to be addressed, but 27 percent of respondents felt that mental health problems should be the first issue to address, with heart disease and stroke (18.9%) and cancers (18.5%) being close behind.

The results are shown in the following table:

Of the problems that you marked, which one or two would you say the community should address first? Check only 2:		
Answer Options	**Response Percent**	**Response Count**
Mental health problems	27.0%	203
Heart disease and stroke	18.9%	142
Cancers	18.5%	139
Child abuse/neglect	15.0%	113
Addiction	14.3%	108
Diabetes	14.2%	107
Other (please specify)*	12.7%	96
Aging problems (e.g., arthritis, hearing/vision loss)	11.7%	88
Teenage pregnancy	7.8%	59
Domestic violence	6.8%	51
Health Disparities	6.1%	46
High blood pressure	6.1%	46
Suicide	2.4%	18
Dental problems	2.1%	16
Motor vehicle crash injuries	2.1%	16
Rape/sexual assault	2.0%	15
Sexually transmitted diseases (STDs)	1.7%	13
Infectious diseases (e.g., hepatitis, TB)	1.5%	11
Respiratory/lung disease	1.5%	11

Firearm-related injuries	0.7%	5
Infant death	0.5%	4
HIV/AIDS	0.4%	3
Homicide	0.3%	2

* In the "Other" category, obesity or overweight was listed 45 times.

Risky Behaviors

Survey respondents next were asked to rank risky behaviors that have the most impact in the community. Not surprisingly, especially given the number of persons who took the time to right in "obesity" as a health problem, the highest ranked risky behavior was "being overweight or obese" at 64 percent. It may or may not surprise anyone that among the top risky behaviors, texting while driving (33.6%) was listed third, ahead of inactivity, drug abuse and smoking.

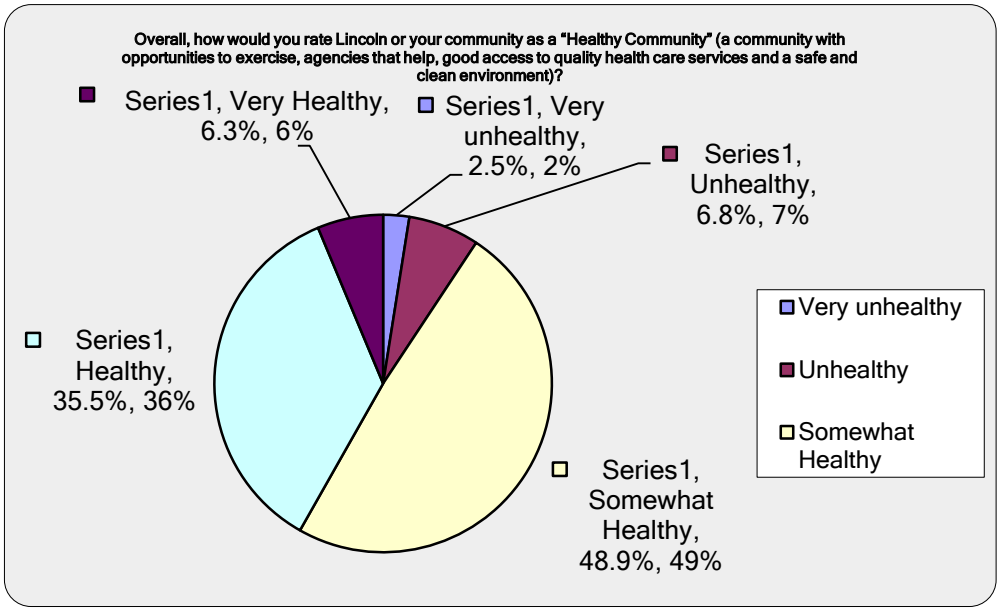
In the following list, what do you think are the 3 most important "risky behaviors" in our community? (those behaviors that have the greatest impact on overall community health) Check only 3:		
Answer Options	Response Percent	Response Count
Being overweight or obese	64.0%	486
Alcohol abuse	48.4%	367
Drivers who text or use a cell phone	33.6%	255
Lack of exercise	31.8%	241
Drug abuse	24.8%	188
Poor eating habits	24.5%	186
Tobacco use	19.8%	150
Not using birth control	11.2%	85
Unsafe sex	9.5%	72
Dropping out of school	9.4%	71
Not getting "shots" to prevent disease	6.6%	50
Not using seat belts	5.7%	43
Racism	4.5%	34
No or improper use of child safety seats	2.9%	22
Other (please specify)	2.9%	22

Overall Opinion of Whether Lincoln is a Healthy Community

After asking about personal health and community health issues, respondents were asked to appraise the community's overall health. The responses below are also graphed. The graph shows that those people who rate the community as Unhealthy (6.8%) or Very Unhealthy (2.5%) are a clear minority although almost half (48.9%) of the respondents only rated the community as "somewhat healthy."

Overall, how would you rate Lincoln or your community as a "Healthy Community" (a community with opportunities to exercise, agencies that help, good access to quality health care services and a safe and clean environment)?		
Answer Options	Response Percent	Response Count
Very unhealthy	2.5%	19

Unhealthy	6.8%	52
Somewhat Healthy	48.9%	373
Healthy	35.5%	271
Very Healthy	6.3%	48

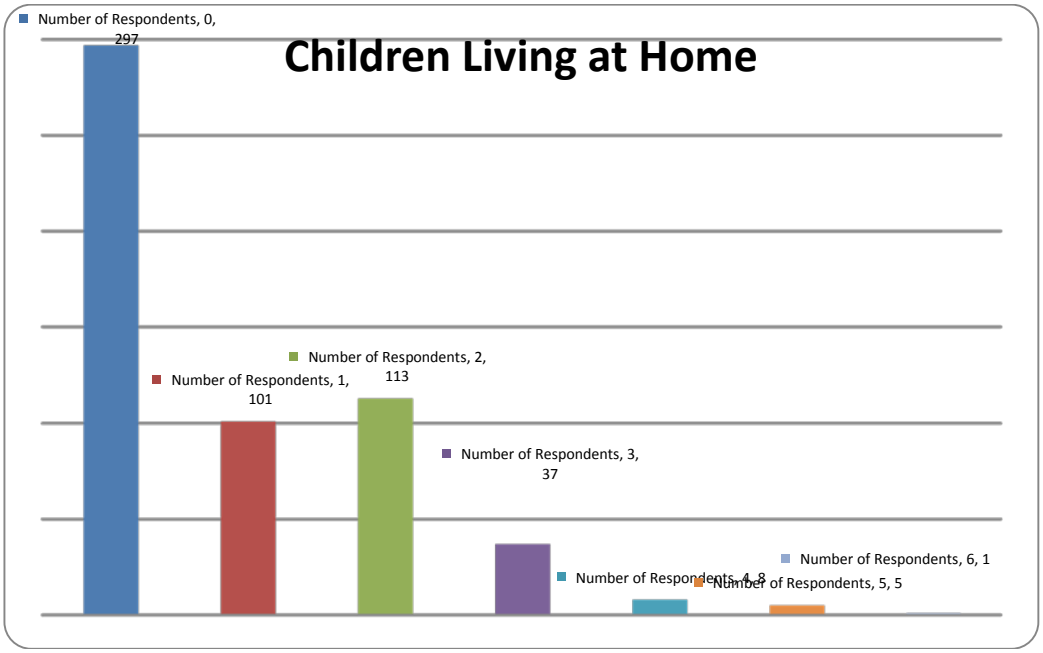


Responses to Questions about Children and Teens and Community Assets

Questions related to raising children and the quality of community attributes for children and teens (questions verbatim)	**Strongly Agree (%)**	**Agree (%)**	**Neutral/No Opinion (%)**	**Disagree (%)**	**Strongly Disagree (%)**
Lincoln and communities in Lancaster County are good places to raise children	29.1	**58.0**	10.8	1.6	0.5
I have access to safe child care services	15.4	30.1	**52.3**	1.9	0.4
Child care services are affordable	3.6	17.2	**51.9**	21.0	6.3
I am very satisfied with the school system in my community	15.5	**36.8**	32.7	11.5	3.6
There are adequate after school programs for elementary age children to attend	5.2	26.1	**56.0**	10.4	2.3
There are adequate after school opportunities for	4.0	20.2	**54.4**	16.9	4.6

middle and high school age students					
There are plenty of recreation opportunities for children in my community	9.0	**37.7**	34.2	15.5	3.6

Neutral was a modal response for many of the questions, but it should be noted that the Neutral/ No Opinion also included people who have no knowledge of services for children as they have no children. From the demographics we know that the majority of respondents have no children or did not answer.



There were 101 people who responded about positives (question 27) about child care and schools and 113 who responded about negatives (question 28). ***(NOTE: The positive and negative responses asked at the end of each topic area are available in the spreadsheets.)***

<u>Responses to Questions about Adults (especially Older Adults) and Related Community Assets</u>

Questions related to the quality of community attributes for adults and the elderly (questions verbatim)	**Strongly Agree (%)**	**Agree (%)**	**Neutral/No Opinion (%)**	**Disagree (%)**	**Strongly Disagree (%)**

There are plenty of recreation and exercise opportunities (parks, trails, fitness centers) for adults in my community	18.3	**64.7**	7.2	9.3	0.5
This community is a good place to grow old	14.9	**55.2**	18.0	10.2	1.7
There are locally available housing options (retirement housing, apartments, assisted living) that are elder-friendly	9.0	**50.1**	31.9	7.2	1.7
There are good and affordable transportation options (public buses, shuttles, Handi-vans and taxis) available for older adults to get to medical facilities or to shopping centers	4.4	28.0	**36.5**	22.4	8.7
There are enough programs that provide meals for older adults in my community	3.4	22.8	**58.0**	14.3	1.6
There are a range of available services that support older adults who live alone	3.4	22.6	**56.9**	15.4	1.8
There are adequate local options (residential care, intermediate and skilled nursing homes) for those persons who need long-term care services	5.1	34.1	**45.5**	13.5	1.8

The distribution of answers for several of these questions showed a variance in opinions about the statement in the question. For the last four questions, respondents who disagreed were almost as prevalent as those who agreed with the question. When asked about positives (question 36) and negatives (question 37), 54 people took the time to record a positive comment and 95 persons recorded a negative comment.

Responses to Questions about Jobs, Safety and the Quality of Life

The following table displays the results of the questions related to jobs, public safety and the quality of life in Lincoln and Lancaster County. While the majority of respondents agreed with the questions, there were a number of questions where people disagreed.

Questions related to the quality of community		**Agree (%)**		**Disagree (%)**	

attributes related to jobs and the work environment (questions verbatim)	Strongly Agree (%)		Neutral/No Opinion (%)		Strongly Disagree (%)
There are good jobs available in the community although the recent recession has made it more difficult to find jobs	6.0	**52.9**	15.9	19.0	6.2
There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities)	4.6	**40.2**	25.7	25.0	4.5
Local employers care about the health of employees and promote healthy behaviors	5.7	**44.9**	25.2	19.5	4.7
The community is a safe place to live (safety in the home, the workplace, schools, playgrounds, parks, shopping areas)	13.9	**70.2**	9.9	5.3	0.7
In this community neighbors know and trust one another and look out for one another	6.9	**54.0**	21.6	14.9	2.6
There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need	7.2	**55.9**	25.6	9.0	2.3
I am generally satisfied with the quality of life in Lincoln and Lancaster County (considering my sense of safety and well-being).	19.6	**65.6**	9.5	4.7	0.7

Also, 60 people took the time to include positive comments (question 45) and 84 people commented negatively (question 46).

Additional Information

MAPP Steering Committee members and interested persons will be provided the following:

1) A .pdf copy of the survey,

2) Excel spreadsheets with survey responses in detail,

3) Focus group results for the African American and Hispanic focus groups.

4) When the Nebraska Department of Health and Human Services releases the results from their random sample survey of county residents those results will also be shared with the committees.

If you have any questions please feel free to contact Charlotte Burke at 402-441-8094 or cburke@lincoln.ne.gov.

Gallop Ranks Lincoln No. 1: http://www.gallup.com/poll/146789/Jobs-Key-Residents-Satisfaction-Communities.aspx

Community Themes and Strengths Survey Results 2015

News Release

LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT
3131 "O" Street, Lincoln, NE 68510, 402-441-8000

FOR IMMEDIATE RELEASE: June 9, 2015
FOR MORE INFORMATION: Judith Halstead, MS, Health Director, 402-441-8001
Steve Frederick, Health Data and Evaluation Division Manager, 402-441-6271

Community Health and Assets Survey

The Lincoln-Lancaster County Health Department (LLCHD) is leading a community effort to assess the health in Lincoln and Lancaster County. A local community health assessment is a requirement for local health departments seeking accreditation. As one aspect of our assessment, we would like to know how people perceive the quality of life in Lincoln and Lancaster County's communities. In an effort to obtain the perceptions, we are launching a brief online survey that will be open from now until l the week of July 6th. The survey will take about 10 minutes and we would like to have input from community residents, both new and long-term residents.

The survey is called the Community Themes and Strengths survey and it asks how people rate local medical and public health services; access to recreational opportunities; how safe they feel; whether child care services are available and affordable; the availability of services for older residents; and other aspects of life in the community. In addition, the survey also asks people to give their input about health risks and rank the health issues they believe are most important. It is essential that we hear from the public about these issues as we assess the health of the community.

The survey is open until the week of July 6th and available in both English and Spanish versions. The link to the English version is https://www.surveymonkey.com/s/PBVZR76 and the link to the Spanish version is https://es.surveymonkey.com/s/PGQB5QQ. The survey is available on the City's website, Interlinc, in the Featured Sites or by typing "community" into the Search box. A link to the survey is also on the Health Department's home page. If you have any questions please contact Steve Frederick at 402-441-6271.

Results

This summer, after reviewing the survey with the MAPP committee LLCHD posted the Community Themes and Strengths survey online. After a strong start with the survey being posted on the City's website and by sending the link via e-mail to our community partners, a number of other community efforts/surveys that solicited public input were initiated (i.e., Taking Charge survey and Prosper Lincoln). Due to the competition with those efforts the number of survey responses was disappointing after the first couple of weeks was disappointing. A total of 279 people responded to the English version of the Community Themes and Strengths survey. There were only 7 people who responded to the Spanish version of the survey. The number of people who responded to either version of the survey was well below our expectations, especially given the outreach efforts of staff and the publicity about the survey. The LLCHD survey was a convenience survey, and so the results need to be viewed in that light and more weight is given to the surveys in 2011, both the convenience and state-sponsored random surveys. Given the small number of persons to the Spanish version, detailed results will not be included in the discussion that follows, but the results will be reviewed with the focus group information.

Who Responded to the 2015 CT&S Survey?

By gender, 74.8 percent of respondents of the survey were females; 25.2 percent were males. Seventy-six percent of respondents were married; 10.4 percent indicated they were divorced and 10.4 had never married. The vast majority of respondents (94%) were in the working age population (aged 18 to 64) with the remainder (6%) senior citizens (65 and older). Only 2.8 percent (7) of the respondents indicated that they were persons of Hispanic origin. As for race, 89 percent of respondents indicated that they were white, 4.1 percent listed their race as multiracial or "other race", 3.6 percent indicated they were African Americans and only two (0.8 percent) indicated they were Asians.

By education, fully 82 percent of respondents had a college degree or higher; 12.2 percent had a high school diploma or GED, and only one person had not graduated from high school. Given the high percentage of college graduates, the income distribution of respondents was also skewed to the high side. Of those who responded: 5.3% had incomes below $20,000; 19.75 percent had incomes between $20,000 and $49,999; 18.5 percent had incomes between $50,000 and $74,999; 21.4 percent had incomes between $75,000 and $99,999 and 35 percent of respondents had incomes over $100,000. (13 percent declined to answer the question about income.)

Only 2.4 percent of respondents indicated that they had no health insurance while 83 percent indicated that they had private insurance. As for public health coverage: 4.5 percent of respondents had Medicare, 2.0 percent had Medicaid, 1.2 percent had TRICARE and 1.2 percent of respondents were covered by the Indian Health Service (IHS).

The average length of time that respondents have lived in the community was 24 years, 5 months.

Personal Health Characteristics

When asked about their personal health status 17.9% of respondents rated their health as Excellent, 39.1 percent said their health was Very Good and 35.8 % rated their health as Good. Of the 7.2 percent who rated their health as Fair or Poor, most (5.7%) indicated they had Fair health.

When asked about their health care providers, 88.5 percent of respondents indicated that they had a personal doctor and 90.7 percent said they had a personal dentist. A question was asked of those who do not have a personal doctor about where they go for medical care. The top five answers were: Urgent Care Clinics (37.1%), Other* (28.6%),Delay care as long as possible or forego care entirely (22.9%), Free Clinics (17.1%), Peoples Health Cener (17.1%).

*The other category listed a number of other providers such as a specialist or doctors in another community. However, many of those listing "other" answered that they do not seek care because they have no insurance and no money.

Opinions about Medical Care

Survey respondents were next asked a series of questions about the health care system and asked to rate whether they strongly agree, agree, are neutral or have no opinion (don't know), disagree or strongly disagree. The following table reports the results. While the results show that most have positive responses to the question (Agree was the modal answer) there are a few issues (office hours and waiting times) where the percent of persons disagreeing/strongly disagreeing reaches up to 25 percent. Unfortunately, we did not ask follow-up questions in this section to capture positive and negative feedback.

General Question (restatement of Questions 5 through 14)	**Strongly Agree (%)**	**Agree (%)**	**Neutral/No Opinion (%)**	**Disagree (%)**	**Strongly Disagree (%)**
Generally satisfied with the health care system (public health, hospitals, doctors, mental health services, medical clinics)	19.0	**51.6**	15.89	10.5	3.1
Generally able to medical care when needed	43.8	**48.5**	1.9	3.1	2.7
Have easy access to medical specialists	37.1	**46.1**	9.4	3.9	3.5
Very satisfied with the medical care received	36.1	**47.8**	9.8	3.9	2.4
Barriers to health Care?					
Individuals, personally, have no barriers in getting medical care when needed	24.2	**36.7**	15.2	17.2	6.6
Covering their share of the cost for a medical care visit is not a problem	12.9	**42.0**	18.0	22.8	4.3
Regular office hours of providers are not a problem	18.8	**43.5**	11.0	22.4	4.3

Individual has experienced no language or cultural barriers when seeking care	49.2	**36.1**	9.1	5.2	0.4
Have no difficulties finding transportation to medical providers	57.1	**35.4**	3.2	2.0	2.4

Perceived Health Problems in the Community

Respondents to the survey were asked to rank the three most important "health problems" in Lancaster County. The 10 most mentioned health problems are shown in the following table, ranked by highest to lowest.

Choices	Percent (%)
1. Mental/behavioral health	59.7
2. Obesity	53.5
3. Substance or Drug Abuse/Overdose	27.1
4. Health disparities/inequities	24.4
5. Diabetes	22.1
6. Aging problems (e.g., arthritis, hearing/vision loss)	19.4
7. Heart Disease and Stroke	14.7
8. Child abuse/neglect	11.2
9. Domestic Violence	10.5
10. Suicide	9.7

A follow-up question asked respondents to prioritize the problems in terms of the first one needing to be addressed. The top two health problems (mental health problems, obesity) were also selected as the top two issues needing to be addressed. The top five (with three ties are shown below.

The results are shown in the following table:

Choices	Percent (%)
1. Mental/behavioral health	31.5
2. Obesity	21.8
3. Health disparities/inequities	12.5
4. Diabetes	5.4
5. Aging problems (e.g., arthritis, hearing/vision loss)	4.7
Tie Substance or Drug Abuse/Overdose	4.7
Tie Child abuse/neglect	4.7

Risky Behaviors

Survey respondents next were asked to rank risky behaviors that have the most impact in the community. Not surprisingly, the highest ranked risky behavior was "being overweight or obese" at 45.9 percent. Eleven issues received more than 10 percent response:

Most Important Issue or Behavior	Percent (%)
1. Being overweight or obese	45.9
2. Poverty	42.8
3. Alcohol and Substance Abuse	41.6
4. Behavioral Health Issues	36.2
5. Physical inactivity	28.0
6. Distracted drivers (texting/using cell phone)	25.3
7. Access to care	14.7
8. Child abuse/neglect	22.8
9. Tobacco use/smoking	17.9
10. Not getting vaccinations to prevent disease	13.2
11. Language/cultural barriers	11.3

Overall Opinion of Whether Lincoln is a Healthy Community

After asking about personal health and community health issues, respondents were asked to appraise the community's overall health. Those people who rate the community as Unhealthy (2.8%) or Very Unhealthy (0.8%) are a clear minority and 11.0 percent rated the overall health as "Somewhat unhealthy." On the positive side, "Healthy" was the highest rating (42.4%) followed by "Somewhat Healthy" and "Very Healthy" (5.5%). Highlighted cells reflect a different outcome from the survey in 2011—orange is now the modal group and the yellow was the modal group in 2011.

Responses to Questions about Children and Teens and Community Assets

Questions related to raising children and the quality of community attributes for children and teens (questions verbatim)	**Strongly Agree (%)**	**Agree (%)**	**Neutral/No Opinion (%)**	**Disagree (%)**	**Strongly Disagree (%)**
My community is a good place to raise children	34.9	**54.7**	8.1	1.9	0.4
I have access to safe child care services	18.3	**51.4**	25.3	4.3	0.8
Child care services are affordable	5.1	14.4	**39.7**	30.4	10.5
I am very satisfied with the school system in my community	23.3	**43.0**	22.0	9.7	1.9
There are adequate after school programs for	10.2	**36.3**	34.8	17.2	1.6

elementary age children to attend					
There are adequate after school opportunities for middle and high school age students	7.8	23.0	**40.5**	23.4	5.5
There are plenty of recreation opportunities for children in my community	14.8	**43.6**	25.7	13.6	2.3

Neutral was a modal response for a couple of the questions, but it should be noted that the Neutral/ No Opinion also included people who have no knowledge of services for children as they have no children. From the demographics we know that the majority of respondents have no children or did not answer.

Responses to Questions about Adults (especially Older Adults) and Related Community Assets

Questions related to the quality of community attributes for adults and the elderly (questions verbatim)	**Strongly Agree (%)**	**Agree (%)**	**Neutral/No Opinion (%)**	**Disagree (%)**	**Strongly Disagree (%)**
There are plenty of recreation and exercise opportunities (parks, trails, fitness centers) for adults in my community	22.7	**60.1**	8.2	6.6	1.5
This community is a good place to grow old	21.4	**56.8**	14.0	7.0	0.8
There are locally available housing options (retirement housing, apartments, assisted living) that are elder-friendly	12.2	32.3	**37.4**	14.6	3.5
There are good and affordable transportation options (public buses, shuttles, Handi-vans and taxis) available for older adults to get to medical facilities or to shopping centers	7.1	16.9	**33.5**	30.7	11.8
There are enough programs that provide meals for older adults in my community	4.0	21.6	**52.4**	19.2	2.8
There are a range of available services that	4.0	23.7	**48.2**	20.2	4.0

support older adults who live alone					
There are adequate local options (residential care, intermediate and skilled nursing homes) for those persons who need long-term care services	6.4	29.0	**40.5**	19.4	4.8

The distribution of answers for several of these questions showed a variance in opinions about the statement in the question. For the last three questions, respondents who disagreed were almost as prevalent as those who agreed with the question.

Responses to Questions about Jobs, Safety and the Quality of Life

The following table displays the results of the questions related to jobs, public safety and the quality of life in Lincoln and Lancaster County. While the majority of respondents agreed with the questions, there were a number of questions where people disagreed.

Questions related to the quality of community attributes related to jobs and the work environment (questions verbatim)	**Strongly Agree (%)**	**Agree (%)**	**Neutral/No Opinion (%)**	**Disagree (%)**	**Strongly Disagree (%)**
There are good jobs available in the community although the recent recession has made it more difficult to find jobs	12.2	**62.4**	12.0	11.2	2.3
There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities)	10.0	**45.4**	26.0	15.9	2.7
Local employers care about the health of employees and promote healthy behaviors	5.8	**42.0**	30.7	19.0	2.3
The community is a safe place to live (safety in the home, the workplace, schools, playgrounds, parks, shopping areas). Neighbors know and trust one another and look out for one another.	11.7	**59.9**	18.3	9.3	0.8

There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need	9.3	**56.6**	18.6	14.3	1.2
I am generally satisfied with the quality of life in Lincoln and Lancaster County (considering my sense of safety and well-being).	23.3	**63.8**	10.1	3.5	0.0

2011 Nebraska Community Themes and Strengths Assessment Survey Results

Lincoln-Lancaster County Health Department

Covering: Lancaster County

Prepared by the Nebraska Department of Health and Human Services

December 5, 2011

Introduction and Methodology

The following is a brief overview of the methods used to collect and report data from the 2011 Nebraska Community Themes and Strengths Assessment Survey. Survey administration was conducted by the University of Nebraska Medical Center while the analysis and reporting of information presented within this document was conducted by the Nebraska Department of Health and Human Services (NDHHS).

The purpose of the survey is to better inform state and local health planning efforts. The NDHHS and many local health departments (LHDs) are in the process of implementing the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning process. One of the four MAPP assessments is to conduct a community themes and strengths assessment. This survey is being used to meeting this assessment component of the State of Nebraska MAPP process.

Questionnaire Design

The questionnaire used in this study was based largely on a 2008 Community Health Survey developed jointly by representatives from LHDs in Nebraska as well as the NDHHS. The 2008 survey was designed as a paper and pencil survey and has been used by many LHDs when conducting their MAPP assessments. This survey was modified from the original version to expand the scope and breadth of the topics covered on the questionnaire and to convert the questionnaire from a paper and pencil format to a telephone format. The survey was modified following a review of surveys from other states and communities and by utilizing guidance and feedback from LHDs, the Public Health Association of Nebraska (PHAN), NDHHS, and a questionnaire design expert.

Survey Administration

The survey was administered via telephone between July and October 2011 using random digit dial methods. The sample was stratified by 18 regions in Nebraska, which consisted of 17 LHDs who chose to be part of the stratified design and the remaining four non-participating LHDs lumped together in the remaining stratum. To ensure that each participating LHD had sufficient numbers for local analysis and reporting the sample was divided equally across the 18 regions with a total of 500 completed surveys being targeted in each region. A total of 9,077 surveys were collected and a raw database was delivered by UNMC to the NDHHS in late October 2011.

Data Analysis

The sample was compiled by telephone area code and prefix. While this is a common and largely accurate sampling selection process telephone numbers can sometimes fall outside of the county or region for which they are targeted. Individuals who complete the survey are asked to report which county and zip code they live in, and in some instances their self-reported county of residence was different than the survey stratum they were grouped in during the data collection process. As a result, the self-reported county of residence variable was used to group respondents into the 18 regions, which did result in some regions having slightly less than 500 completed surveys and some having slightly more (the range was from 466 in one LHD to 592 in the non-participating LHD region).

Data were weighed by LHD region, gender, and age to be reflective of the LHD and State of Nebraska population. All analyses presented in this report were conducted using SAS, Version 9.2, and to obtain correct standard errors for weighted percentages, SAS-callable SUDAAN, Version 10.0.1, was used.

On some of the survey questions a fairly large percentage of respondents answered ‘don’t know.’ To allow for the calculation of survey means these responses were coded as missing, along with a very small number who refused to answer some of the questions. The number and percentage of missing data is presented within each table in this document.

See footnotes under each data table for further description of the survey methods and to inquire further about the survey methods or data results you can contact the NDHSS at 402-471-2353.

Table 1a: Mean Values for Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Diff from State[f]
1a1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	517	1.42	(1.30 - 1.54)	7	1.3%	8,998	1.59	(1.53 - 1.64)	79	0.9%	NS
Region^^	511	1.33	(1.23 - 1.42)	13	2.5%	8,994	1.36	(1.32 - 1.41)	83	0.9%	NS
1a2. The healthcare services that are available in your community/region are excellent:											
Community^	520	1.59	(1.47 - 1.71)	4	0.8%	8,969	1.82	(1.76 - 1.89)	108	1.2%	-
Region^^	505	1.48	(1.38 - 1.58)	19	3.6%	8,895	1.58	(1.53 - 1.64)	182	2.0%	NS
1a3. There are enough medical specialists available in your:											
Community^	511	1.74	(1.56 - 1.92)	13	2.5%	8,890	2.07	(2.00 - 2.15)	187	2.1%	-
Region^^	502	1.60	(1.45 - 1.74)	22	4.2%	8,851	1.69	(1.63 - 1.75)	226	2.5%	NS
1a4. The hospital care being provided in your *community/region* is excellent:											
Community^	516	1.56	(1.41 - 1.71)	8	1.5%	8,859	1.92	(1.86 - 1.99)	218	2.4%	-
Region^^	503	1.46	(1.34 - 1.59)	21	4.0%	8,790	1.63	(1.57 - 1.69)	287	3.2%	NS
1a5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (Scale Flipped)*	517	3.26	(3.04 - 3.49)	7	1.3%	8,907	3.24	(1.00 - 3.34)	170	1.9%	NS
1a6. Percentage who personally received healthcare services in their region during the past 12 months**	523	72.8%	(64.1 - 80.0)	1	0.2%	9,059	72.0%	(68.9 - 74.9)	18	0.2%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value (or percentage where noted) weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean or percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean/percentage significantly higher than the state ($p < 0.05$); "-" = LHD mean/percentage significantly lower than the state ($p < .05$); "NS" = LHD mean/ percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

* This survey question (i.e., data measure) was asked in the opposite direction compared almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, the scale for this question was recoded to make results comparable to the mean value for the other questions, where a value of 1 was recoded to a value of 5, 2 to 4, and 3 remained the same, 4 to 2, and 5 to 1. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

** Received health care services at a hospital, emergency room, doctors' office, or health clinic in their region (including their community and/or broader region) during the past 12 months

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 1b: The Percentage who Somewhat or Strongly Disagree with Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
1b1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	517	5.6%	(3.1 - 9.8)	7	1.3%	8,998	9.1%	(7.8 - 10.8)	79	0.9%	NS
Region^^	511	1.9%	(0.9 - 3.9)	13	2.5%	8,994	4.2%	(3.2 - 5.5)	83	0.9%	NS
1b2. The healthcare services that are available in your community/region are excellent:											
Community^	520	4.8%	(2.9 - 8.0)	4	0.8%	8,969	12.2%	(10.6 - 14.0)	108	1.2%	-
Region^^	505	2.5%	(1.3 - 4.8)	19	3.6%	8,895	6.3%	(5.0 - 7.9)	182	2.0%	-
1b3. There are enough medical specialists available in your:											
Community^	511	11.0%	(7.3 - 16.0)	13	2.5%	8,890	20.8%	(18.8 - 22.9)	187	2.1%	-
Region^^	502	6.7%	(3.9 - 11.4)	22	4.2%	8,851	10.6%	(9.0 - 12.5)	226	2.5%	NS
1b4. The hospital care being provided in your community/region is excellent:											
Community^	516	6.2%	(3.5 - 10.7)	8	1.5%	8,859	15.0%	(13.3 - 16.8)	218	2.4%	-
Region^^	503	2.9%	(1.1 - 7.7)	21	4.0%	8,790	7.0%	(5.6 - 8.8)	287	3.2%	NS
1b5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (% who somewhat/strongly agree)*	517	56.3%	(48.2 - 64.0)	7	1.3%	8,907	56.2%	(1.0 - 59.1)	170	1.9%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

* This survey question (i.e., data measure) was asked in the opposite direction compared to almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, to be consistent with the other measures in this table, the percentage for this measure reflects the undesirable response, which in this case is the percentage who answered somewhat or strongly agree. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 2a: Mean Values for Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older who have personally received healthcare services within their region during the past 12 months*, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	%Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	From State[f]
2a1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	410	1.39	(1.26 - 1.52)	5	1.2%	6,707	1.57	(1.51 - 1.64)	43	0.6%	NS
Region^^	407	1.29	(1.19 - 1.40)	8	1.9%	6,684	1.35	(1.29 - 1.40)	66	1.0%	NS
2a2. The healthcare services that are available in your community/region are excellent:											
Community^	411	1.57	(1.43 - 1.71)	4	1.0%	6,685	1.80	(1.73 - 1.87)	65	1.0%	-
Region^^	400	1.50	(1.38 - 1.62)	15	3.6%	6,637	1.55	(1.49 - 1.61)	113	1.7%	NS
2a3. There are enough medical specialists available in your:											
Community^	404	1.83	(1.62 - 2.05)	11	2.7%	6,627	2.08	(2.00 - 2.16)	123	1.8%	NS
Region^^	398	1.68	(1.51 - 1.85)	17	4.1%	6,602	1.66	(1.60 - 1.72)	148	2.2%	NS
2a4. The hospital care being provided in your *community/region* is excellent:											
Community^	409	1.55	(1.37 - 1.73)	6	1.4%	6,610	1.89	(1.82 - 1.96)	140	2.1%	-
Region^^	398	1.50	(1.34 - 1.65)	17	4.1%	6,571	1.60	(1.53 - 1.66)	179	2.7%	NS
2a5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (Scale Flipped)**	411	3.21	(2.94 - 3.49)	4	1.0%	6,636	3.19	(3.08 - 3.31)	114	1.7%	NS

* Received health care services at a hospital, emergency room, doctors' office, or health clinic in their region (including their community and/or broader region) during the past 12 months

[a] Non-weighted number of survey respondents, among those reported having personally received healthcare services within their region during the past 12 months (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

** This survey question (i.e., data measure) was asked in the opposite direction compared almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, the scale for this question was recoded to make results comparable to the mean value for the other questions, where a value of 1 was recoded to a value of 5, 2 to 4, and 3 remained the same, 4 to 2, and 5 to 1. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 2b: The Percentage who Somewhat or Strongly Disagree with Measures related to the Healthcare System, among Nebraska Adults aged 18 and Older who have personally received healthcare services within their region during the past 12 months*, 2011

	Lincoln-Lancaster County Health Department					State of Nebraska					
Data Measure	**Sample Size (n)[a]**	**% Who Disagree[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**% Who Disagree[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	LHD Diff **From** From **State**
2b1. There are enough healthcare services, such as hospitals, emergency rooms, doctors' offices, health clinics, and so forth, available in your:											
Community^	410	6.0%	(3.1 - 11.4)	5	1.2%	6,707	9.4%	(7.8 - 11.3)	43	0.6%	NS
Region^^	407	2.3%	(1.1 - 5.1)	8	1.9%	6,684	3.9%	(2.8 - 5.4)	66	1.0%	NS
2b2. The healthcare services that are available in your community/region are excellent:											
Community^	411	5.2%	(3.0 - 8.9)	4	1.0%	6,685	11.7%	(9.9 - 13.7)	65	1.0%	-
Region^^	400	3.3%	(1.6 - 6.4)	15	3.6%	6,637	5.5%	(4.2 - 7.3)	113	1.7%	NS
2b3. There are enough medical specialists available in your:											
Community^	404	12.7%	(8.3 - 19.1)	11	2.7%	6,627	20.8%	(18.6 - 23.2)	123	1.8%	NS
Region^^	398	8.2%	(4.5 - 14.5)	17	4.1%	6,602	9.6%	(8.0 - 11.5)	148	2.2%	NS
2b4. The hospital care being provided in your *community/region* is excellent:											
Community^	409	7.0%	(3.7 - 12.7)	6	1.4%	6,610	13.9%	(12.2 - 15.8)	140	2.1%	NS
Region^^	398	3.7%	(1.3 - 10.3)	17	4.1%	6,571	6.2%	(4.8 - 8.0)	179	2.7%	NS
2b5. Sometimes the cost of medical care prevents you from getting the care you need for yourself or your family (% who somewhat/strongly agree)**	411	56.7%	(48.4 - 64.7)	4	1.0%	6,636	54.9%	(51.5 - 58.2)	114	1.7%	NS

* Received health care services at a hospital, emergency room, doctors' office, or health clinic in their region (including their community and/or broader region) during the past 12 months

[a] Non-weighted number of survey respondents, among those reported having personally received healthcare services within their region during the past 12 months (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

^ Community was defined as the town, city, or metropolitan area that you live in, or that is closest to your home if you do not live in town

^^ Region was defined as the area within a one hour drive from your home, which includes your community

** This survey question (i.e., data measure) was asked in the opposite direction compared to almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, to be consistent with the other measures in this table, the percentage for this measure also reflects the undesirable response, which in this case is the percentage who responded with an answer of somewhat or strongly agree. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 3a: Mean Values for Measures related to Supports for Raising Children, among Nebraska Adults aged 18 and Older, 2011

	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff
Data Measure	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**From State[f]**
Among All Survey Respondents											
3a1. Safe and affordable childcare is available within your community	394	2.16	(1.97 - 2.35)	130	24.8%	7,329	2.11	(2.02 - 2.20)	1,748	19.3%	NS
3a2. Your community has excellent schools	505	1.63	(1.47 - 1.79)	19	3.6%	8,745	1.66	(1.58 - 1.74)	332	3.7%	NS
3a3. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	398	2.26	(2.03 - 2.50)	126	24.0%	7,346	2.43	(2.33 - 2.53)	1,731	19.1%	NS
3a4. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	437	2.04	(1.83 - 2.24)	87	16.6%	8,023	2.02	(1.94 - 2.11)	1,054	11.6%	NS
Among Those with Kids <18 Living at Home											
3a5. Safe and affordable childcare is available within your community	124	2.17	(1.84 - 2.49)	14	10.1%	1,972	2.11	(1.96 - 2.26)	155	7.3%	NS
3a6. Your community has excellent schools	136	1.72	(1.44 - 2.00)	2	1.4%	2,104	1.67	(1.51 - 1.83)	23	1.1%	NS
3a7. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	126	2.43	(2.10 - 2.76)	12	8.7%	1,980	2.45	(2.28 - 2.63)	147	6.9%	NS
3a8. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	127	2.16	(1.84 - 2.47)	11	8.0%	2,034	2.00	(1.87 - 2.14)	93	4.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 3b: Percentage who Somewhat or Strongly Disagree with Measures related to Supports for Raising Children, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
3b1. Safe and affordable childcare is available within your community	394	12.6%	(8.1 - 19.1)	130	24.8%	7,329	14.9%	(12.5 - 17.7)	1,748	19.3%	NS
3b2. Your community has excellent schools	505	5.6%	(2.9 - 10.6)	19	3.6%	8,745	8.6%	(6.5 - 11.3)	332	3.7%	NS
3b3. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	398	19.5%	(13.5 - 27.4)	126	24.0%	7,346	27.0%	(24.0 - 30.2)	1,731	19.1%	NS
3b4. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	437	15.2%	(10.2 - 22.1)	87	16.6%	8,023	16.0%	(13.8 - 18.6)	1,054	11.6%	NS
Among Those with Kids <18 Living at Home											
3b5. Safe and affordable childcare is available within your community	124	14.4%	(7.4 - 26.0)	14	10.1%	1,972	15.8%	(11.9 - 20.8)	155	7.3%	NS
3b6. Your community has excellent schools	136	6.1%	(2.0 - 16.8)	2	1.4%	2,104	10.2%	(6.4 - 16.0)	23	1.1%	NS
3b7. There are enough after school programs for elementary school children in your community, including after school programs run by school and community groups	126	22.8%	(13.9 - 35.2)	12	8.7%	1,980	28.3%	(23.5 - 33.6)	147	6.9%	NS
3b8. There are enough after school opportunities for middle and high school students in your community, such as sports teams, clubs, and groups	127	16.6%	(9.2 - 28.1)	11	8.0%	2,034	15.5%	(12.3 - 19.4)	93	4.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 4a: Mean Values for Measures related to Supports for Older Adults, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Diff From State[f]
Among All Survey Respondents											
4a1. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	467	2.17	(1.98 - 2.37)	57	10.9%	8,615	2.29	(2.20 - 2.39)	462	5.1%	NS
4a2. There is enough transportation available in your community to take older adults to medical facilities and shopping	453	2.81	(2.59 - 3.02)	71	13.5%	8,419	2.77	(2.67 - 2.86)	658	7.2%	NS
4a3. There are enough programs that provide meals for older adults in your community	437	2.62	(2.37 - 2.88)	87	16.6%	8,241	2.48	(2.38 - 2.58)	836	9.2%	NS
4a4. There are a lot of social networks and groups in your community available for older adults that are living alone	416	2.60	(2.43 - 2.78)	108	20.6%	7,646	2.82	(2.72 - 2.91)	1,431	15.8%	NS
Among Survey Respondents Aged 65+											
4a5. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	162	1.96	(1.69 - 2.23)	12	6.9%	3,495	2.13	(2.01 - 2.25)	153	4.2%	NS
4a6. There is enough transportation available in your community to take older adults to medical facilities and shopping	149	2.66	(2.35 - 2.96)	25	14.4%	3,386	2.50	(2.36 - 2.63)	262	7.2%	NS
4a7. There are enough programs that provide meals for older adults in your community	145	2.17	(1.89 - 2.45)	29	16.7%	3,371	2.12	(1.99 - 2.24)	277	7.6%	NS
4a8. There are a lot of social networks and groups in your community available for older adults that are living alone	137	2.26	(1.99 - 2.54)	37	21.3%	3,041	2.70	(2.56 - 2.84)	607	16.6%	-

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 4b: Percentage who Somewhat or Strongly Disagree with Measures related to Supports for Older Adults, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
4b1. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	467	19.5%	(13.7 - 27.1)	57	10.9%	8,615	23.5%	(20.5 - 26.7)	462	5.1%	NS
4b2. There is enough transportation available in your community to take older adults to medical facilities and shopping	453	37.6%	(29.9 - 46.0)	71	13.5%	8,419	36.0%	(32.8 - 39.4)	658	7.2%	NS
4b3. There are enough programs that provide meals for older adults in your community	437	30.6%	(22.8 - 39.8)	87	16.6%	8,241	26.4%	(23.2 - 29.8)	836	9.2%	NS
4b4. There are a lot of social networks and groups in your community available for older adults that are living alone	416	25.8%	(19.4 - 33.5)	108	20.6%	7,646	34.2%	(30.9 - 37.6)	1,431	15.8%	NS
Among Survey Respondents Aged 65+											
4b5. There is enough housing to meet the needs of older adults in your community, including assisted living, retirement centers, and maintenance free homes and apartments	162	15.4%	(9.2 - 24.6)	12	6.9%	3,495	20.5%	(16.8 - 24.7)	153	4.2%	NS
4b6. There is enough transportation available in your community to take older adults to medical facilities and shopping	149	33.4%	(24.2 - 44.2)	25	14.4%	3,386	29.6%	(25.7 - 33.8)	262	7.2%	NS
4b7. There are enough programs that provide meals for older adults in your community	145	20.0%	(12.8 - 29.9)	29	16.7%	3,371	19.4%	(15.9 - 23.3)	277	7.6%	NS
4b8. There are a lot of social networks and groups in your community available for older adults that are living alone	137	19.8%	(12.5 - 30.1)	37	21.3%	3,041	33.6%	(29.1 - 38.5)	607	16.6%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 5a: Mean Values for Measures related to Recreational and Leisure Options, among Nebraska Adults aged 18 and Older, 2011

	Lincoln-Lancaster County Health Department						State of Nebraska						LHD Diff
Data Measure	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**		Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**		Missing Data[d]	% Missing[e]	**From State[f]**
5a1. There are a lot of places to exercise and play in your community, such as parks, walking/biking trails, swimming pools, gyms, fitness centers, and so forth	520	1.47	(1.36	1.58)	4	0.8%	8,978	1.81	(1.75	1.88)	99	1.1%	-
5a2. There are a lot of arts, music, and cultural events in your community	512	2.03	(1.88	2.18)	12	2.3%	8,734	2.63	(2.55	2.71)	343	3.8%	-
5a3. There are a lot of organized leisure time activities available for young adults in your community, such as groups, clubs, teams, and other social activities:													
Among all respondents	453	2.48	(2.28	2.67)	71	13.5%	8,030	2.83	(2.73	2.92)	1,047	11.5%	-
Among respondents 18-49 years old	137	2.52	(2.23	2.82)	12	8.1%	2,230	2.86	(2.72	3.01)	94	4.0%	NS
5a4. There are a lot of organized leisure time activities available for middle-age adults in your community, such as groups, clubs, teams, and other social activities:													
Among all respondents	469	2.48	(2.30	2.67)	55	10.5%	8,212	2.79	(2.70	2.88)	865	9.5%	-
Among respondents 50-64 years old	184	2.45	(2.22	2.68)	13	6.6%	2,847	2.80	(2.68	2.91)	202	6.6%	-

[a] Non-weighted number of survey respondents (excluding missing data)

[B] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[C] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[D] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[E] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[F] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 5b: Percentage who Somewhat or Strongly Disagree with Measures related to Recreational and Leisure Options, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Diff From State[f]
5b1. There are a lot of places to exercise and play in your community, such as parks, walking/biking trails, swimming pools, gyms, fitness centers, and so forth	520	6.2%	(4.1 9.4)	4	0.8%	8,978	12.8%	(10.9 15.0)	99	1.1%	-
5b2. There are a lot of arts, music, and cultural events in your community	512	14.1%	(10.0 19.5)	12	2.3%	8,734	34.1%	(31.4 36.8)	343	3.8%	-
5b3. There are a lot of organized leisure time activities available for young adults in your community, such as groups, clubs, teams, and other social activities:											
Among all respondents	453	26.7%	(20.0 34.7)	71	13.5%	8,030	38.9%	(35.7 42.2)	1,047	11.5%	-
Among respondents 18-49 years old	137	28.2%	(18.4 40.8)	12	8.1%	2,230	40.5%	(35.5 45.7)	94	4.0%	NS
5b4. There are a lot of organized leisure time activities available for middle-age adults in your community, such as groups, clubs, teams, and other social activities:											
Among all respondents	469	24.2%	(18.2 31.3)	55	10.5%	8,212	36.9%	(33.9 40.1)	865	9.5%	-
Among respondents 50-64 years old	184	25.6%	(18.9 33.8)	13	6.6%	2,847	37.5%	(33.3 41.8)	202	6.6%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 6a: Mean Values for Measures related to Jobs and the Economy, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
6a1. There are enough jobs, either in town or a short drive away, for people living in your community	485	2.73	(2.52 - 2.95)	39	7.4%	8,635	2.82	(2.72 - 2.91)	442	4.9%	NS
6a2. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	466	2.74	(2.57 - 2.92)	58	11.1%	8,226	2.99	(2.90 - 3.07)	851	9.4%	NS
6a3. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	467	2.75	(2.51 - 2.98)	57	10.9%	8,109	2.68	(2.59 - 2.77)	968	10.7%	NS
6a4. The economy in your community is strong	508	2.44	(2.26 - 2.63)	16	3.1%	8,821	2.57	(2.49 - 2.66)	256	2.8%	NS
Among the Working Age (18-64 year olds)											
6a5. There are enough jobs, either in town or a short drive away, for people living in your community	335	2.72	(2.47 - 2.96)	11	3.2%	5,274	2.80	(2.69 - 2.92)	99	1.8%	NS
6a6. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	327	2.73	(2.53 - 2.92)	19	5.5%	5,145	2.96	(2.86 - 3.05)	228	4.2%	NS
6a7. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	329	2.78	(2.51 - 3.05)	17	4.9%	5,127	2.67	(2.57 - 2.78)	246	4.6%	NS
6a8. The economy in your community is strong	338	2.48	(2.27 - 2.69)	8	2.3%	5,290	2.57	(2.47 - 2.67)	83	1.5%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 6b: Percentage who Somewhat or Strongly Disagree with Measures related to Jobs and the Economy, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Diff From State[f]
Among All Survey Respondents											
6b1. There are enough jobs, either in town or a short drive away, for people living in your community	485	34.1%	(27.1 - 41.9)	39	7.4%	8,635	38.5%	(35.4 - 41.7)	442	4.9%	NS
6b2. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	466	31.7%	(25.0 - 39.3)	58	11.1%	8,226	41.3%	(38.2 - 44.5)	851	9.4%	NS
6b3. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	467	35.8%	(28.4 - 43.9)	57	10.9%	8,109	32.0%	(29.0 - 35.2)	968	10.7%	NS
6b4. The economy in your community is strong	508	25.4%	(18.6 - 33.6)	16	3.1%	8,821	29.9%	(26.9 - 33.1)	256	2.8%	NS
Among the Working Age (18-64 year olds)											
6b5. There are enough jobs, either in town or a short drive away, for people living in your community	335	33.7%	(25.8 - 42.6)	11	3.2%	5,274	38.3%	(34.7 - 42.0)	99	1.8%	NS
6b6. The jobs in your community offer opportunities for advancement (such as promotions and on the job training)	327	31.2%	(23.8 - 39.7)	19	5.5%	5,145	40.3%	(36.7 - 44.1)	228	4.2%	NS
6b7. The jobs in your community are family friendly, allowing for things such as flexible scheduling, reasonable hours, health insurance, and so forth	329	37.2%	(28.9 - 46.4)	17	4.9%	5,127	31.6%	(28.2 - 35.3)	246	4.6%	NS
6b8. The economy in your community is strong	338	26.3%	(18.5 - 35.9)	8	2.3%	5,290	29.7%	(26.1 - 33.5)	83	1.5%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 7a: Mean Values for Measures related to Housing, Safety & Security, and Social Support & Civic Responsibility, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Housing											
7a1. There is enough quality housing available in your community, including homes and apartments	501	1.70	(1.57 - 1.82)	23	4.4%	8,717	2.07	(2.00 - 2.14)	360	4.0%	-
7a2. Quality housing in your community is affordable for the average person	492	2.41	(2.24 - 2.59)	32	6.1%	8,425	2.51	(2.42 - 2.61)	652	7.2%	NS
Safety and Security											
7a3. Your community is a safe place to live, work, and play	524	1.48	(1.37 - 1.59)	0	0.0%	9,038	1.60	(1.53 - 1.67)	39	0.4%	NS
7a4. There is a lot of crime in your community (Scale Flipped)*	515	1.94	(1.77 - 2.11)	9	1.7%	8,935	2.10	(2.03 - 2.18)	142	1.6%	NS
7a5. Neighbors know and trust one another and look out for each other in your community	517	1.80	(1.67 - 1.93)	7	1.3%	8,979	1.72	(1.64 - 1.80)	98	1.1%	NS
Social Support and Civic Responsibility											
7a6. There are enough support networks in your community for individuals and families during times of stress and need, such as support groups, faith community outreach, community agencies, and so forth	480	2.33	(2.12 - 2.53)	44	8.4%	8,394	2.43	(2.34 - 2.51)	683	7.5%	NS
7a7. People in your community pitch in and help out the community in times of need	502	1.80	(1.62 - 1.97)	22	4.2%	8,901	1.71	(1.63 - 1.79)	176	1.9%	NS
7a8. There are a lot of opportunities for individuals in your community to volunteer	507	1.56	(1.41 - 1.70)	17	3.2%	8,807	1.72	(1.65 - 1.80)	270	3.0%	NS
7a9. A lot of individuals in your community do volunteer work	466	2.23	(2.02 - 2.44)	58	11.1%	8,492	2.13	(2.05 - 2.21)	585	6.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* This survey question (i.e., data measure) was asked in the opposite direction compared almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, the scale for this question was recoded to make results comparable to the mean value for the other questions, where a value of 1 was recoded to a value of 5, 2 to 4, and 3 remained the same, 4 to 2, and 5 to 1. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 7b: Percentage who Somewhat or Strongly Disagree with Measures related to Housing, Safety & Security, and Social Support & Civic Responsibility, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Disagree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Housing											
7b1. There is enough quality housing available in your community, including homes and apartments	501	7.4%	(5.0 - 10.9)	23	4.4%	8,717	18.2%	(16.2 - 20.3)	360	4.0%	-
7b2. Quality housing in your community is affordable for the average person	492	23.6%	(17.9 - 30.4)	32	6.1%	8,425	28.1%	(25.0 - 31.4)	652	7.2%	NS
Safety and Security											
7b3. Your community is a safe place to live, work, and play	524	5.1%	(3.0 - 8.3)	0	0.0%	9,038	7.0%	(5.4 - 9.2)	39	0.4%	NS
7b4. There is a lot of crime in your community (% who somewhat/strongly agree)*	515	17.7%	(13.5 - 22.9)	9	1.7%	8,935	22.6%	(20.4 - 25.0)	142	1.6%	NS
7b5. Neighbors know and trust one another and look out for each other in your community	517	8.2%	(5.5 - 12.0)	7	1.3%	8,979	9.3%	(7.2 - 11.8)	98	1.1%	NS
Social Support and Civic Responsibility											
7b6. There are enough support networks in your community for individuals and families during times of stress and need, such as support groups, faith community outreach, community agencies, and so forth	480	21.3%	(15.2 - 28.9)	44	8.4%	8,394	24.7%	(21.9 - 27.7)	683	7.5%	NS
7b7. People in your community pitch in and help out the community in times of need	502	7.6%	(4.0 - 14.0)	22	4.2%	8,901	8.4%	(6.3 - 11.1)	176	1.9%	NS
7b8. There are a lot of opportunities for individuals in your community to volunteer	507	6.6%	(3.1 - 13.2)	17	3.2%	8,807	9.9%	(7.9 - 12.4)	270	3.0%	NS
7b9. A lot of individuals in your community do volunteer work	466	17.4%	(11.7 - 25.0)	58	11.1%	8,492	15.8%	(13.3 - 18.6)	585	6.4%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly disagree (unless noted) on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* This survey question (i.e., data measure) was asked in the opposite direction compared to almost all other survey questions that included the five-point agree/disagree response option scale (i.e., disagreement was the desirable response for this question where agree was desirable for most others). As a result, to be consistent with the other measures in this table, the percentage for this measure reflects the undesirable response, which in this case is the percentage who answered somewhat or strongly agree. However, this measure should be compared to the others with caution as a result of possible acquiescence bias (i.e., where respondents tend to agree more than disagree regardless of the assertion) or respondents getting into a response pattern.

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 8a: Mean Values for How Serious Various Health Issues are in the Community (on an 11-point scale ranging from 0=not serious at all to 10=extremely serious), among Nebraska Adults aged 18 and Older, 2011

Health Issue	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Aging problems (arthritis, hearing/vision loss)	495	5.99	(5.61 - 6.38)	29	5.5%	8,483	5.83	(5.66 - 6.01)	594	6.5%	NS
Cancer	494	6.95	(6.58 - 7.33)	30	5.7%	8,661	6.66	(6.46 - 6.85)	416	4.6%	NS
Child abuse and neglect	474	4.70	(4.21 - 5.20)	50	9.5%	8,243	4.07	(3.89 - 4.25)	834	9.2%	NS
Diabetes	482	6.76	(6.39 - 7.12)	42	8.0%	8,372	6.30	(6.11 - 6.50)	705	7.8%	NS
Heart disease	486	6.34	(5.92 - 6.76)	38	7.3%	8,315	6.02	(5.82 - 6.22)	762	8.4%	NS
High blood pressure	496	6.51	(6.15 - 6.88)	28	5.3%	8,395	6.46	(6.26 - 6.66)	682	7.5%	NS
Infectious diseases (flu, other viruses/infections)*	492	5.02	(4.71 - 5.33)	32	6.1%	8,522	4.88	(4.74 - 5.02)	555	6.1%	NS
Injuries (resulting from crashes, falls, violence, etc.)	494	4.91	(4.60 - 5.22)	30	5.7%	8,414	4.44	(4.26 - 4.63)	663	7.3%	NS
Mental health (including depression)	486	5.16	(4.73 - 5.60)	38	7.3%	8,119	4.65	(4.47 - 4.84)	958	10.6%	NS
Overweight and obesity	514	7.11	(6.76 - 7.46)	10	1.9%	8,886	6.83	(6.65 - 7.01)	191	2.1%	NS
Poor dental health	468	4.47	(4.09 - 4.84)	56	10.7%	8,056	4.51	(4.31 - 4.70)	1,021	11.2%	NS
Sexually transmitted diseases (STDs)	412	4.67	(4.23 - 5.12)	112	21.4%	6,582	4.34	(4.10 - 4.57)	2,495	27.5%	NS
Stroke	476	6.01	(5.62 - 6.40)	48	9.2%	8,225	5.57	(5.37 - 5.76)	852	9.4%	NS
Suicide	469	3.76	(3.33 - 4.19)	55	10.5%	8,392	3.23	(3.03 - 3.43)	685	7.5%	NS
Teenage pregnancy	469	5.38	(4.91 - 5.86)	55	10.5%	8,149	4.81	(4.59 - 5.02)	928	10.2%	NS
Unsafe environment (poor air/water, chemical expos.)	507	2.62	(2.22 - 3.03)	17	3.2%	8,817	3.02	(2.85 - 3.19)	260	2.9%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on an 11-point scale ranging from 0 to 10 where 0 = not serious at all in your community and 10 = extremely serious in your community

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* Includes infectious diseases, such as the flu, and other viruses and infections that are transmitted from person-to-person (excluding STDs)

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 8b: Percentage who Responded with a Value of 8, 9, or 10 for How Serious Various Health Issues are in the Community (based on an 11-point scale ranging from 0=not serious at all to 10=extremely serious), among Nebraska Adults aged 18 and Older, 2011

	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff
Health Issue	**Sample Size (n)[a]**	**%[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**%[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**From State[f]**
Aging problems (arthritis, hearing/vision loss)	495	24.4%	(18.9 - 30.9)	29	5.5%	8,483	23.9%	(21.6 - 26.3)	594	6.5%	NS
Cancer	494	46.7%	(38.6 - 55.0)	30	5.7%	8,661	41.6%	(38.6 - 44.8)	416	4.6%	NS
Child abuse and neglect	474	17.8%	(12.2 - 25.2)	50	9.5%	8,243	10.9%	(9.2 - 13.0)	834	9.2%	NS
Diabetes	482	42.6%	(34.6 - 50.9)	42	8.0%	8,372	35.0%	(32.1 - 38.1)	705	7.8%	NS
Heart disease	486	34.9%	(27.6 - 43.0)	38	7.3%	8,315	29.6%	(26.8 - 32.7)	762	8.4%	NS
High blood pressure	496	35.4%	(28.7 - 42.7)	28	5.3%	8,395	37.1%	(34.0 - 40.2)	682	7.5%	NS
Infectious diseases (flu, other viruses/infections)*	492	12.1%	(8.2 - 17.6)	32	6.1%	8,522	13.6%	(11.7 - 15.8)	555	6.1%	NS
Injuries (resulting from crashes, falls, violence, etc.)	494	10.4%	(6.0 - 17.5)	30	5.7%	8,414	10.5%	(8.3 - 13.1)	663	7.3%	NS
Mental health (including depression)	486	20.0%	(14.1 - 27.6)	38	7.3%	8,119	15.0%	(12.7 - 17.7)	958	10.6%	NS
Overweight and obesity	514	45.9%	(38.3 - 53.7)	10	1.9%	8,886	42.6%	(39.6 - 45.6)	191	2.1%	NS
Poor dental health	468	8.9%	(6.3 - 12.2)	56	10.7%	8,056	12.0%	(9.9 - 14.4)	1,021	11.2%	NS
Sexually transmitted diseases (STDs)	412	15.6%	(10.9 - 21.9)	112	21.4%	6,582	17.0%	(14.0 - 20.4)	2,495	27.5%	NS
Stroke	476	26.7%	(20.1 - 34.7)	48	9.2%	8,225	22.0%	(19.3 - 24.9)	852	9.4%	NS
Suicide	469	8.0%	(4.9 - 12.8)	55	10.5%	8,392	8.5%	(6.5 - 11.1)	685	7.5%	NS
Teenage pregnancy	469	22.7%	(16.4 - 30.6)	55	10.5%	8,149	18.1%	(15.7 - 20.9)	928	10.2%	NS
Unsafe environment (poor air/water, chemical expos.)	507	6.7%	(3.9 - 11.2)	17	3.2%	8,817	8.7%	(7.3 - 10.3)	260	2.9%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered with a value of 8, 9, or 10 on an 11-point scale ranging from 0 to 10 where 0 = not serious at all in your community and 10 = extremely serious in your community

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* Includes infectious diseases, such as the flu, and other viruses and infections that are transmitted from person-to-person (excluding STDs)

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 9a: Mean Values for How Much Different Behaviors Impact Overall Health in the Community (on an 11-point scale ranging from 0=no impact on overall health to 10=huge impact on overall health), among Nebraska Adults aged 18 and Older, 2011

	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff
Health Issue	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**Mean[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**From State[f]**
Alcohol abuse	509	5.84	(5.37 - 6.30)	15	2.9%	8,670	5.99	(5.80 - 6.18)	407	4.5%	NS
Drug abuse	498	6.15	(5.64 - 6.67)	26	5.0%	8,366	5.80	(5.60 - 6.00)	711	7.8%	NS
Drunk driving	512	6.33	(5.78 - 6.88)	12	2.3%	8,675	6.10	(5.90 - 6.29)	402	4.4%	NS
Not enough exercise	518	6.60	(6.07 - 7.13)	6	1.1%	8,807	6.61	(6.46 - 6.76)	270	3.0%	NS
Not getting vaccine 'shots' to prevent disease	478	5.07	(4.63 - 5.50)	46	8.8%	8,189	4.76	(4.55 - 4.96)	888	9.8%	NS
Not using child safety seats (or improper use)	484	4.50	(4.04 - 4.96)	40	7.6%	8,135	4.36	(4.16 - 4.57)	942	10.4%	NS
Not using seat belts while driving	504	5.01	(4.53 - 5.48)	20	3.8%	8,632	5.07	(4.87 - 5.26)	445	4.9%	NS
Poor eating habits	506	6.47	(6.00 - 6.93)	18	3.4%	8,637	6.50	(6.34 - 6.65)	440	4.8%	NS
Talking on a cell phone while driving	515	7.23	(6.90 - 7.55)	9	1.7%	8,762	6.85	(6.67 - 7.04)	315	3.5%	NS
Texting while driving	507	7.11	(6.62 - 7.61)	17	3.2%	8,327	6.77	(6.58 - 6.97)	750	8.3%	NS
Tobacco use (cigarettes and smokeless)	509	6.09	(5.67 - 6.52)	15	2.9%	8,697	6.35	(6.19 - 6.51)	380	4.2%	NS
Violence (domestic violence, fighting, etc.)	496	5.18	(4.70 - 5.67)	28	5.3%	8,471	4.86	(4.67 - 5.06)	606	6.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on an 11-point scale ranging from 0 to 10 where 0 = no impact on overall health in your community and 10 = huge impact on overall health in your community

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 9b: Percentage who Responded with a Value of 8, 9, or 10 for How Much Different Behaviors Impact Overall Health in the Community (based on an 11-point scale ranging from 0=no impact to 10=huge impact), among Nebraska Adults aged 18 and Older, 2011

	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff
Health Issue	**Sample Size (n)[a]**	**%[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**Sample Size (n)[a]**	**%[b]**	**95% CI (low --- high)[c]**	Missing Data[d]	% Missing[e]	**From State[f]**
Alcohol abuse	509	27.9%	(22.3 - 34.4)	15	2.9%	8,670	29.9%	(27.1 - 32.7)	407	4.5%	NS
Drug abuse	498	35.8%	(28.9 - 43.3)	26	5.0%	8,366	31.9%	(29.1 - 35.0)	711	7.8%	NS
Drunk driving	512	37.1%	(30.2 - 44.7)	12	2.3%	8,675	35.0%	(32.0 - 38.1)	402	4.4%	NS
Not enough exercise	518	40.1%	(33.0 - 47.7)	6	1.1%	8,807	38.5%	(35.5 - 41.6)	270	3.0%	NS
Not getting vaccine 'shots' to prevent disease	478	20.9%	(15.8 - 27.1)	46	8.8%	8,189	20.7%	(18.1 - 23.6)	888	9.8%	NS
Not using child safety seats (or improper use)	484	18.4%	(13.7 - 24.4)	40	7.6%	8,135	19.2%	(16.7 - 22.0)	942	10.4%	NS
Not using seat belts while driving	504	23.7%	(18.4 - 30.0)	20	3.8%	8,632	23.5%	(21.1 - 26.1)	445	4.9%	NS
Poor eating habits	506	37.0%	(30.1 - 44.6)	18	3.4%	8,637	36.8%	(33.8 - 39.9)	440	4.8%	NS
Talking on a cell phone while driving	515	51.9%	(44.0 - 59.8)	9	1.7%	8,762	48.2%	(45.1 - 51.3)	315	3.5%	NS
Texting while driving	507	51.0%	(43.0 - 58.9)	17	3.2%	8,327	46.1%	(42.9 - 49.3)	750	8.3%	NS
Tobacco use (cigarettes and smokeless)	509	32.4%	(25.6 - 40.1)	15	2.9%	8,697	34.9%	(31.9 - 37.9)	380	4.2%	NS
Violence (domestic violence, fighting, etc.)	496	21.3%	(15.6 - 28.4)	28	5.3%	8,471	20.6%	(18.0 - 23.5)	606	6.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered with a value of 8, 9, or 10 on an 11-point scale ranging from 0 to 10 where 0 = no impact on overall health in your community and 10 = huge impact on overall health in your community

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 10: Top 15 Responses to the Question "What do you think is the single most important health issues or health behavior that needs to be addressed in your community?*,"among Nebraska Adults aged 18 and Older, 2011

Lincoln-Lancaster County Health Department			State of Nebraska	
	Top 15 Health Issues/Behaviors (in rank order)	**%[a]**	**Top 15 Health Issues/Behaviors (in rank order)**	**%[a]**
1.	Overweight and Obesity	24.5%	Overweight and Obesity	24.3%
2.	Alcohol abuse	9.0%	Alcohol abuse	8.6%
3.	Cancer	7.5%	Cancer	7.0%
4.	Healthcare-related (quality, access, cost, coverage)[+]	6.1%	Drug abuse	6.7%
5.	Not enough exercise[#]	6.1%	Healthcare-related (quality, access, cost, coverage)[+]	5.9%
6.	Unhealthy eating and/or poor nutrition[!]	5.1%	Not enough exercise[#]	5.5%
7.	Diabetes	4.9%	Unhealthy eating and/or poor nutrition[!]	4.8%
8.	Mental health and/or suicide	4.9%	Distracted driving (texting, cell phone use)	4.5%
9.	Distracted driving (texting, cell phone use)	4.7%	Drunk driving	3.7%
10.	Drug abuse	3.4%	Tobacco use (cigarettes and/or smokeless)	2.9%
11.	Aging population and elderly conditions/needs^	2.9%	Violence/crime/safety[x]	2.7%
12.	Drunk driving	2.3%	Mental health and/or suicide	2.7%
13.	Heart disease	1.9%	Diabetes	2.5%
14.	Sexually Transmitted Diseases (STDs)	1.7%	Heart disease	2.4%
15.	Tobacco use (cigarettes and/or smokeless)	1.5%	Aging population and elderly conditions/needs^	2.4%
	Sample size (n)[b]	443	Sample size (n)[b]	7,377
	Missing data[c]	81	Missing data[c]	1,700
	Percentage Missing Data[d]	15.5%	Percentage Missing Data[d]	18.7%

* This survey question was open-ended, meaning that respondents could provide any response they wanted without prompt. However, 28 fields were pre-populated for interviewer coding, which reflected the health issues and behaviors asked about in survey questions 33-60. Responses outside of these pre-defined categories were typed in by the interviewer and analyzed for themes during the analysis process, in which case they were added to existing categories or new categories were created. Statewide, a total of 1,513 respondents, or 20.5% of all valid (non-missing) responses to this question did not fall into a pre-defined category and were typed in by the survey interviewer. Answers that covered multiple issues (e.g., diet and exercise) were kept as valid but not coded to a specific condition presented in this table, with the exception of 'aging population and elderly conditions/needs,' (see other footnote)

[a] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those gave an answer for each health issue out of the total number of valid respondents.

[b] Non-weighted number of survey respondents (excluding missing data)

[c] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer, or were otherwise missing

[d] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer, or were otherwise missing

[+] Consists of responses of healthcare-related quality, access, cost, insurance, nursing care, elder care, and utilization of healthcare services

[#] Consists of responses of not enough exercise and sedentary lifestyle as well as lack of exercise facilities and programs

[!] Consists of responses of unhealthy eating, overeating, poor nutrition, hunger, availability of healthy foods

[x] Consists of responses of violence (domestic violence, fighting, etc.), crime, and general safety

^ Consists of responses where aging problems (arthritis, Alzheimer's, dementia, etc.), older adults, and the elderly or elderly-related responses were mentioned. In some cases the response overlapped with another category (such as elderly medical care falling under 'healthcare related'). As a result, some respondents in this category are also included in another top 15 category (69 respondents statewide (<1% of valid respondents) fell into this category and another top 15 category).

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 11a: Mean Values for Measures related to Alcohol Use and Prevention, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	From State[f]
Among All Survey Respondents											
11a1. Alcohol use among individuals under 21 years old is a big problem in your community	500	2.35	(2.13 - 2.58)	24	4.6%	8,678	2.26	(2.16 - 2.35)	399	4.4%	NS
11a2. Your community should do more to prevent alcohol use among individuals under 21 years old	510	2.14	(1.90 - 2.38)	14	2.7%	8,757	2.02	(1.93 - 2.10)	320	3.5%	NS
11a3. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	519	4.05	(3.87 - 4.23)	5	1.0%	8,893	4.03	(3.96 - 4.11)	184	2.0%	NS
Among Female Respondents											
11a4. Alcohol use among individuals under 21 years old is a big problem in your community	298	2.27	(1.92 - 2.61)	17	5.4%	5,388	2.12	(2.02 - 2.22)	292	5.1%	NS
11a5. Your community should do more to prevent alcohol use among individuals under 21 years old	303	1.83	(1.60 - 2.06)	12	3.8%	5,455	1.90	(1.82 - 1.99)	225	4.0%	NS
11a6. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	311	4.25	(4.01 - 4.48)	4	1.3%	5,554	4.15	(4.06 - 4.23)	126	2.2%	NS
Among Male Respondents											
11a7. Alcohol use among individuals under 21 years old is a big problem in your community	202	2.44	(2.14 - 2.74)	7	3.3%	3,290	2.40	(2.24 - 2.56)	107	3.1%	NS
11a8. Your community should do more to prevent alcohol use among individuals under 21 years old	207	2.46	(2.07 - 2.84)	2	1.0%	3,302	2.14	(2.00 - 2.28)	95	2.8%	NS
11a9. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	208	3.86	(3.59 - 4.12)	1	0.5%	3,339	3.92	(3.79 - 4.04)	58	1.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. Mean values are based on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 11b: Percentage who Somewhat or Strongly Agree with Measures related to Alcohol Use and Prevention, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	% Who Agree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	% Who Agree[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
11b1. Alcohol use among individuals under 21 years old is a big problem in your community	500	67.9%	(58.9 - 75.7)	24	4.6%	8,678	72.0%	(68.7 - 75.1)	399	4.4%	NS
11b2. Your community should do more to prevent alcohol use among individuals under 21 years old	510	70.5%	(61.9 - 77.9)	14	2.7%	8,757	76.9%	(74.0 - 79.5)	320	3.5%	NS
11b3. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	519	17.9%	(13.1 - 24.0)	5	1.0%	8,893	18.9%	(16.9 - 21.1)	184	2.0%	NS
Among Female Respondents											
11b4. Alcohol use among individuals under 21 years old is a big problem in your community	298	68.4%	(56.3 - 78.5)	17	5.4%	5,388	75.2%	(71.6 - 78.5)	292	5.1%	NS
11b5. Your community should do more to prevent alcohol use among individuals under 21 years old	303	79.5%	(69.5 - 86.9)	12	3.8%	5,455	79.7%	(76.4 - 82.6)	225	4.0%	NS
11b6. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	311	15.2%	(9.2 - 24.1)	4	1.3%	5,554	17.8%	(15.3 - 20.6)	126	2.2%	NS
Among Male Respondents											
11b7. Alcohol use among individuals under 21 years old is a big problem in your community	202	67.3%	(53.7 - 78.5)	7	3.3%	3,290	68.8%	(63.2 - 73.9)	107	3.1%	NS
11b8. Your community should do more to prevent alcohol use among individuals under 21 years old	207	61.6%	(48.3 - 73.4)	2	1.0%	3,302	74.0%	(69.0 - 78.4)	95	2.8%	NS
11b9. Your level of agreement with the notion that "drinking is a rite of passage for youth," meaning it is an important milestone as they move into adulthood	208	20.6%	(13.6 - 29.9)	1	0.5%	3,339	20.1%	(16.9 - 23.7)	58	1.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older; consisting of those who answered somewhat or strongly agree on a five-point scale consisting of 1=strongly agree, 2=somewhat agree, 3=neither agree nor disagree, 4=somewhat disagree, and 5=strongly disagree

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 12a: Mean Values for Measures related to Overall Health and Quality of Life, Among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff
	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	Mean[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	From State[f]
Among All Survey Respondents											
12a1. How healthy is your community*	515	2.30	(2.17 - 2.42)	9	1.7%	8,933	2.37	(2.30 - 2.44)	144	1.6%	NS
12a2. How would you rate the overall quality of life in your community**	521	2.29	(2.15 - 2.43)	3	0.6%	9,035	2.41	(2.35 - 2.48)	42	0.5%	NS
Among Female Respondents											
12a3. How healthy is your community*	308	2.27	(2.11 - 2.44)	7	2.2%	5,573	2.39	(2.32 - 2.46)	107	1.9%	NS
12a4. How would you rate the overall quality of life in your community**	312	2.41	(2.26 - 2.56)	3	1.0%	5,647	2.42	(2.36 - 2.48)	33	0.6%	NS
Among Male Respondents											
12a5. How healthy is your community*	207	2.32	(2.14 - 2.51)	2	1.0%	3,360	2.35	(2.22 - 2.48)	37	1.1%	NS
12a6. How would you rate the overall quality of life in your community**	209	2.17	(1.94 - 2.39)	0	0.0%	3,388	2.40	(2.28 - 2.51)	9	0.3%	NS
Among Respondents 18-64 Years Old											
12a7. How healthy is your community*	339	2.36	(2.22 - 2.50)	7	2.0%	5,320	2.44	(2.35 - 2.52)	53	1.0%	NS
12a8. How would you rate the overall quality of life in your community**	345	2.36	(2.20 - 2.52)	1	0.3%	5,362	2.45	(2.38 - 2.53)	11	0.2%	NS
Among Respondents Aged 65 and Older											
12a9. How healthy is your community*	172	1.98	(1.81 - 2.15)	2	1.1%	3,563	2.06	(2.00 - 2.12)	85	2.3%	NS
12a10. How would you rate the overall quality of life in your community**	172	1.89	(1.73 - 2.05)	2	1.1%	3,622	2.22	(2.14 - 2.30)	26	0.7%	-

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Mean value weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older. See footnotes * and ** for further description of the response scales.

[c] 95% Confidence interval for the weighted mean (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD mean significantly higher than the state ($p < 0.05$); "-" = LHD mean significantly lower than the state ($p < .05$); "NS" = LHD mean not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* The response option scale for this question consisted of 1=very healthy, 2=somewhat healthy, 3=neither healthy nor unhealthy, 4=somewhat unhealthy, and 5=very unhealthy

** The response option scale for this question consisted of 1=excellent, 2=very good, 3=good, 4=fair, and 5=poor

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 12b: Indicators related to Overall Health and Quality of Life, among Nebraska Adults aged 18 and Older, 2011

Data Measure	Lincoln-Lancaster County Health Department					State of Nebraska					LHD Diff From State[f]
	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	Sample Size (n)[a]	%[b]	95% CI (low --- high)[c]	Missing Data[d]	% Missing[e]	
Among All Survey Respondents											
12b1. Feel that the overall health in their community is somewhat or very unhealthy*	515	13.9%	(9.5 - 20.0)	9	1.7%	8,933	17.3%	(14.6 - 20.2)	144	1.6%	NS
12b2. Feel that the overall quality of life in their community is fair or poor**	521	8.3%	(5.4 - 12.4)	3	0.6%	9,035	10.9%	(8.9 - 13.3)	42	0.5%	NS
Among Female Respondents											
12b3. Feel that the overall health in their community is somewhat or very unhealthy*	308	13.7%	(8.3 - 21.8)	7	2.2%	5,573	18.2%	(15.6 - 21.1)	107	1.9%	NS
12b4. Feel that the overall quality of life in their community is fair or poor**	312	7.3%	(4.4 - 12.1)	3	1.0%	5,647	10.6%	(8.7 - 12.8)	33	0.6%	NS
Among Male Respondents											
12b5. Feel that the overall health in their community is somewhat or very unhealthy*	207	14.2%	(7.9 - 24.1)	2	1.0%	3,360	16.3%	(12.0 - 21.9)	37	1.1%	NS
12b6. Feel that the overall quality of life in their community is fair or poor**	209	9.2%	(4.8 - 16.8)	0	0.0%	3,388	11.2%	(7.9 - 15.7)	9	0.3%	NS
Among Respondents 18-64 Years Old											
12b7. Feel that the overall health in their community is somewhat or very unhealthy*	339	14.6%	(9.5 - 21.7)	7	2.0%	5,320	19.0%	(15.9 - 22.6)	53	1.0%	NS
12b8. Feel that the overall quality of life in their community is fair or poor**	345	9.0%	(5.7 - 13.8)	1	0.3%	5,362	11.5%	(9.2 - 14.3)	11	0.2%	NS
Among Respondents Aged 65 and Older											
12b9. Feel that the overall health in their community is somewhat or very unhealthy*	172	10.4%	(5.8 - 18.0)	2	1.1%	3,563	9.6%	(7.6 - 12.0)	85	2.3%	NS
12b10. Feel that the overall quality of life in their community is fair or poor**	172	4.2%	(1.3 - 12.5)	2	1.1%	3,622	8.2%	(5.4 - 12.1)	26	0.7%	NS

[a] Non-weighted number of survey respondents (excluding missing data)

[b] Percentage weighted by local health department region, gender, and age to reflect Nebraska's population aged 18 and older

[c] 95% Confidence interval for the weighted percentage (lower and upper confidence limits)

[d] Non-weighted number of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[e] The percentage of eligible survey respondents who answered 'don't know/not sure,' refused to answer the question, or were otherwise missing

[f] Values represent: "+" = LHD percentage significantly higher than the state ($p < 0.05$); "-" = LHD percentage significantly lower than the state ($p < .05$); "NS" = LHD percentage not statistically different than the state ($p > 0.05$); significant differences are based on 95% confidence interval overlap

* The response option scale for this question consisted of 1=very healthy, 2=somewhat healthy, 3=neither healthy nor unhealthy, 4=somewhat unhealthy, and 5=very unhealthy

** The response option scale for this question consisted of 1=excellent, 2=very good, 3=good, 4=fair, and 5=poor

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 13: Demographics of Survey Respondents, among Nebraska Adults aged 18 and Older, 2011

NOTE: The demographic data presented below are simply to provide information about who completed the survey, and are not intended to be used to help explain differences between the LHD and State of Nebraska presented in Tables 1-12. The results presented in Tables 1-12 were weighed by participating local health department region, gender, and age to be reflective of the LHD and State of Nebraska population, where the resulted presented within this table are unweighted.

	LLCHD		State of NE	
Demographic	**n[a]**	**%[b]**	**n[a]**	**%[b]**
Total	524	100.0%	9,077	100.0%
Gender				
Female	315	60.1%	5,680	62.6%
Male	209	39.9%	3,397	37.4%
Missing Data	*0*	*0.0%*	*0*	*0.0%*
Age				
18-34	48	9.2%	662	7.3%
35-44	65	12.5%	959	10.6%
45-54	95	18.3%	1,617	17.9%
55-64	138	26.5%	2,135	23.7%
65-74	90	17.3%	1,734	19.2%
75+	84	16.2%	1,914	21.2%
Missing Data	*4*	*0.8%*	*56*	*0.6%*
Race/Ethnicity				
African American, NH	8	1.6%	51	0.6%
Asian/Pacific Islander, NH	9	1.7%	28	0.3%
Native American, NH	2	0.4%	65	0.7%
White, NH	484	94.0%	8,573	95.8%
Other, NH	0	0.0%	0	0.0%
Hispanic	12	2.3%	233	2.6%
Missing Data[c]	*9*	*1.7%*	*127*	*1.4%*

	LLCHD		State of NE	
Demographic	**n[a]**	**%[b]**	**n[a]**	**%[b]**
Education				
Less than High School	18	3.4%	490	5.4%
High School/GED	131	25.0%	3,159	34.9%
Some College	151	28.9%	2,786	30.8%
College Graduate	223	42.6%	2,616	28.9%
Missing Data	*1*	*0.2%*	*26*	*0.3%*
How long have you lived in your community?				
< 1 year	8	1.5%	130	1.4%
1-2 years	13	2.5%	254	2.8%
3-4 years	25	4.8%	349	3.8%
5-9 years	57	10.9%	802	8.8%
10+ years	420	80.3%	7,530	83.1%
Missing Data	*1*	*0.2%*	*12*	*0.1%*
How do you pay for most of your healthcare?				
Pay cash (no insurance)	39	7.5%	825	9.2%
Private health insurance	304	58.7%	4,623	51.7%
Medicaid	17	3.3%	256	2.9%
Medicare	130	25.1%	2,853	31.9%
Veteran's Administration	15	2.9%	212	2.4%
Indian Health Service	0	0.0%	18	0.2%
Other method	13	2.5%	147	1.6%
Missing Data	*6*	*1.1%*	*143*	*1.6%*

[b] Non-weighted number of survey respondents

[a] Non-weighted percentage of survey respondents by category

[c] Missing data reflect the number and percentage of survey respondents who answered 'don't know/not sure,' refused to answer, or were otherwise missing

Source: 2011 Nebraska Community Themes and Strengths Assessment Survey

Table 13 (expanded 12-14-11)*: Demographics of Survey Respondents, among Nebraska Adults aged 18 and Older, 2011

NOTE: The demographic data presented below are simply to provide information about who completed the survey, and are not intended to be used to help explain differences between the LHD and State of Nebraska presented in Tables 1-12. The results presented in Tables 1-12 were weighed by participating local health department region, gender, and age to be reflective of the LHD and State of Nebraska population, where the resulted presented within this table are unweighted.

	LLCHD of NE		State of NE	
Demographic	**n[a]**	**%[b]**	**n[a]**	**%[b]**
Total	524	100.0%	9,077	100.0%
Gender				
Female	315	60.1%	5,680	62.6%
Male	209	39.9%	3,397	37.4%
Missing Data[c]	*0*	*0.0%*	*0*	*0.0%*
Age				
18-34	48	9.2%	662	7.3%
35-44	65	12.5%	959	10.6%
45-54	95	18.3%	1,617	17.9%
55-64	138	26.5%	2,135	23.7%
65-74	90	17.3%	1,734	19.2%
75+	84	16.2%	1,914	21.2%
Missing Data[c]	*4*	*0.8%*	*56*	*0.6%*
Race/Ethnicity				
African American, NH	8	1.6%	51	0.6%
Asian/Pacific Islander, NH	9	1.7%	28	0.3%
Native American, NH	2	0.4%	65	0.7%
White, NH	484	94.0%	8,573	95.8%
Other, NH	0	0.0%	0	0.0%
Hispanic	12	2.3%	233	2.6%
Missing Data[c]	*9*	*1.7%*	*127*	*1.4%*
Income (annual household)				
< $25,000	98	20.8%	2,134	26.0%
$25,000 - $49,999	143	30.3%	2,579	31.4%
$50,000 - $74,999	90	19.1%	1,518	18.5%
$75,000+	141	29.9%	1,976	24.1%
Missing Data[c]	*52*	*9.9%*	*870*	*9.6%*

	LLCHD		State	
Demographic	**n[a]**	**%[b]**	**n[a]**	**%[b]**
Education				
Less than High School	18	3.4%	490	5.4%
High School/GED	131	25.0%	3,159	34.9%
Some College	151	28.9%	2,786	30.8%
College Graduate	223	42.6%	2,616	28.9%
Missing Data[c]	*1*	*0.2%*	*26*	*0.3%*
How long have you lived in your community?				
< 1 year	8	1.5%	130	1.4%
1-2 years	13	2.5%	254	2.8%
3-4 years	25	4.8%	349	3.8%
5-9 years	57	10.9%	802	8.8%
10+ years	420	80.3%	7,530	83.1%
Missing Data[c]	*1*	*0.2%*	*12*	*0.1%*
How do you pay for most of your healthcare?				
Pay cash (no insurance)	39	7.5%	825	9.2%
Private health insurance	304	58.7%	4,623	51.7%
Medicaid	17	3.3%	256	2.9%
Medicare	130	25.1%	2,853	31.9%
Veteran's Administration	15	2.9%	212	2.4%
Indian Health Service	0	0.0%	18	0.2%
Other method	13	2.5%	147	1.6%
Missing Data[c]	*6*	*1.1%*	*143*	*1.6%*
County of Residence within: LLCHD				
Lancaster	524	100.0%	-	-

[a] Non-weighted number of survey respondents

[b] Non-weighted percentage of survey respondents by category

[c] Missing data reflect the number and percentage of survey respondents who answered 'don't know/not sure,' refused to answer, or were otherwise missing

* The data presented in the original Table 13 were correct, the expansion added income and county of residence and corrected the labeling of footnotes Source: 2011 Nebraska Community Themes and Strengths Assessment Survey