Nebraska Health Disparities Report

Health Equity for all Nebraskans

Office of Health Disparities and Health Equity

Division of Public Health

Department of Health & Human Services

DHHS

NEBRASKA

September 2015

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State of Nebraska Health Disparities Report

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Table of Contents

ACKNOWLEDGEMENTS

The Office of Health Disparities and Health Equity wishes to express its gratitude to the following individuals for providing the guidelines for this report: Sue Medinger, Administrator, Community and Rural Health Planning Unit; Ming Qu, Administrator, Epidemiology and Informatics Unit; Dr. Tom Safranek, State Epidemiologist; and Josie Rodriguez, Administrator, Office of Health Disparities and Health Equity.

A special thank you to Norm Nelson, DHHS Statistical Analyst, who provided Vital Statistics data and Behavioral Risk Factor Surveillance information for this report. We also wish to acknowledge several people for providing resources for this report: Bryan Rettig, Program Analyst, Cancer Registry Data; Tina Brubaker, HIV Data Analyst, HIV Surveillance Program; Brenda Coufal, DHHS Program Manager; Carol Gildert, Data Analyst, Pregnancy Risk Assessment Monitoring System (PRAMS). Jeff Armitage, Epidemiologist, for reviewing select portions of this report and The Office of Health Disparities and Health Equity's Elice Hubbert, Savannah Mentzer, Dorice Palensky, Research Analysts for their preliminary work on this report. The office also thanks Shandana Khattak, Research Analyst, for formatting and editing, and Whitney Clausen and Lynne Le, Program Analysts, for final editing.

EXECUTIVE SUMMARY

Since its creation in 1992, the Office of Health Disparities and Health Equity (OHDHE, formerly the Office of Minority Health) in the Department of Health and Human Services has been a leader in Nebraska's efforts to improve the health and overall quality of life for the state's rapidly growing racial and ethnic minority populations. Central to this leadership role is a commitment to gathering information and providing timely and accurate documentation of changing demographic trends, key socioeconomic indicators, and the increasing disparities in health status and outcomes experienced by populations that are often overlooked.

One of OHDHE's priorities is to become a centralized source for information relevant to the health of minorities in Nebraska. The Nebraska Health Disparities Report is part of a series of reports that help support the office's overarching mission to improve the health status of Nebraska's racial and ethnic minorities, refugees and newly arrived immigrant groups. The series will continue to be a vital component in OHDHE's information dissemination efforts providing a comprehensive look at a myriad of health-related issues and concerns and the disparate outcomes experienced by some of the state's most vulnerable and historically medically underserved residents. Regular quadrennial updates will ensure it remains an up-to-date and useful resource for policymakers, service providers, and anyone interested in minority health issues.

Vision:

Health Equity for all Nebraskans

KEY FINDINGS

Socioeconomics

Income – Asians had the highest median income among all minority racial and ethnic groups ($53,135) and American Indians and African Americans had the lowest ($27,329 and $27,817, respectively).

Education – Of all minority groups, Asian Nebraskans had the highest proportion of people obtaining bachelor's degrees or higher. Hispanics had the highest proportion of individuals who had less than a high school education.

Employment – About 67% of White, Asian, and Hispanic Nebraskans were employed from 2008-2012. American Indians experienced the highest rate of unemployment at about 11%.

Occupation – Hispanics were the most likely to work in production, transportation, and material moving jobs, and African Americans were most likely to work in service and sales occupations.

Poverty – Approximately one-third of African Americans and American Indians were below 100% of the federal poverty level in 2008-2012.

Marital Status –Almost half of Hispanics and over half of Asians were married, while almost half of African Americans and American Indians were unmarried.

Housing Type – Approximately 30% of African American and American Indian households were ran by a woman with no husband present. Almost 40% of African American households were nonfamily households. Fifty to sixty percent of Asian and Hispanic households were married-couple households.

Housing Tenure – Over 60% of African American and American Indians lived in a rented residence. Approximately half of Asians and Hispanics lived in a rented residence.

Health Status

The following is a summary of the positive changes we have seen throughout Nebraska between 2001 and 2010. Although we still have progress to make, it is important to see how far we have come.

From 2001-2005 to 2006-2010: Positive Changes

Fair or Poor Health Reporting and No Personal Physician – The percentage of people reporting fair or poor health and no personal physician has declined among some racial and ethnic groups. Asians saw a large decrease in fair or poor health reporting, declining from 17% to 9%. Although we experienced a general decrease in people not having a personal physician, Hispanics (35.1%) still saw a high percentage without one.

Infant Mortality – The infant mortality rate has decreased across all racial and ethnic groups. American Indians almost reduced their infant mortality rate by half between 2001-2005 and 2006-2010. However, infant mortality remains a large problem in the African American community; Nebraska's African American community saw higher rates of infant mortality than the rest of the nation.

Heart Disease Mortality – Death from HD has decreased among all racial and ethnic groups. Roughly 241/100,000 African Americans Nebraskans died of HD in 2006-2010—the highest of all racial and ethnic groups. Although we saw decreases in heart disease death across groups, this disease is still a large problem in the African American and American Indian communities and no group reached their Healthy People 2010 objective.

Stroke Mortality – The number of people dying from stroke has decreased across all racial and ethnic groups. Twenty-three per 100,000 Hispanics died of stroke in 2006-2010. Although we saw decreases in stroke mortality across groups, this disease is still a large problem in the African American community. American Indians and Asians reached their Healthy People 2010 objective for stroke mortality.

Cancer Mortality – Death rate due to cancer has dropped among all racial and ethnic groups. Both Asians and Hispanics had a cancer death rate over 120/100,000 population in 2001-2005, which dropped to below 100/100,000 population in 2006-2010.

Current Smoking – The percentage of people who currently smoke has decreased among all racial and ethnic groups except American Indians who had an almost 2% increase from 2001-2005 to 2006-2010.

Physical Activity – The percentage of people getting moderate physical activity

has increased across all racial and ethnic groups. Sixty-five percent of American Indians get regular, moderate physical activity. Hispanics and American Indians saw a 10% increase in moderate and vigorous exercise. All groups reached their Healthy People 2010 objectives for moderate exercise.

Fruit and Vegetable Intake – The percentage of people getting five or more servings of fruits and vegetables a day has increased in all groups except American Indians (23.8% in 2001-2005 to 19.1% in 2006-2010). Half of Asian Nebraskans get five or more servings of fruits and vegetables daily.

Cancer: Years Lost – The amount of years lost due to cancer among those 75 and younger has decreased across all groups. American Indians saw a particularly large drop of almost 600 years, from 1759.4 years lost per 100,000 people in 2001-2005 to 1175.9 in 2006-2010.

Motor Vehicle Death: Years Lost – The amount of years lost among those who were 75 years old and younger due to motor vehicle fatalities has decreased across all groups. American Indians saw a particularly large drop of almost 1000 years, from 1415.4 years lost in 2001-2005 to 510.4 years lost in 2006-2010.

Even though we took great strides in some areas of health, in other areas we are still struggling. The continued issues Nebraska faces as we move toward our Healthy People 2020 objectives are listed below.

From 2001-2005 to 2006-2010: Continued Issues

Unable to See a Doctor Due to Cost – The percentage of people unable to see a doctor due to cost has increased among most groups, although American Indians saw an almost 10% decline. Twenty percent of both African Americans and Hispanics were unable to see a doctor because of cost. No group reached the Healthy People 2010 objective in this category.

Prenatal Care – The percentage of women receiving first trimester prenatal care has decreased across all racial and ethnic groups, which kept Nebraska from reaching its Healthy People 2010 prenatal care objective of 90% reception for all groups. Only about 50% of American Indian women received first trimester prenatal care in 2006-2010. Nebraska also sees a lower

percentage of women getting prenatal care compared to the United States.

Teen Birth – The percentage of girls aged 15-19 having babies has *declined* across all racial and ethnic groups. Most notably, 115/1,000 Hispanic teen girls and 100/1,000 American Indian girls had a baby in 2006-2010. Nebraska's teen birth rate is largely higher than the rest of the United States in all racial and ethnic groups; almost double the national rate.

Low Birth Weight – The number of babies born under 5 pounds 8 ounces has increased across most groups. No group reached their Healthy People 2010 low birth weight objectives. After an increase from 2001-2005 to 2006-2010, African Americans saw a low birth weight proportion of 13.3%. Nebraska's low birth weight rates were comparable to those of the United States.

Myocardial Infarction or Coronary Heart Disease – The proportion of people having a heart attack or coronary heart disease at least doubled across most racial and ethnic groups. African Americans and Asians both at approximately 2.5% in 2001-2005 jumped to 4.4% and 6.3% in 2006-2010, respectively.

Diabetes – The percentage of people with diabetes has increased across all racial and ethnic groups. Fourteen percent of Hispanics had been diagnosed with diabetes in 2006-2010; African Americans and American Indians saw approximately 13% of their populations with diabetes. Nebraska also had a higher percentage of people with diabetes when compared to the United States.

Years lost due to diabetes among those 75 and younger doubled in the American Indian population— increasing from 515.3 years lost to 1034.9 years lost between 2001-2005 and 2006-2010.

Drinking and Driving – The percentage of people driving after having too much to drink has increased across all racial and ethnic groups, except American Indians (who decreased).

Obesity – The percentage of people with obesity (a BMI of 30 or over) has increased across all racial and ethnic groups; all groups but Asians failed to reach their Healthy People 2010 obesity objectives. Almost 42% of American Indians were obese in 2006-2010. Where obesity affected American Indian and African American Nebraskans worse than the United States groups, Asians and Hispanics saw a smaller

proportion who were obese than their national populations.

Overweight – Nebraska experiences high levels of overweight people among all racial and ethnic groups. Around 38% of American Indians and Hispanics were overweight; almost 30% of African Americans were overweight.

Cholesterol – The percentage of people with high cholesterol has increased in all groups except African Americans (who declined 2%). All groups failed to reach their cholesterol objectives for Healthy People 2010. Fifty-six percent of Asians had been told they had high cholesterol in 2006-2010, a 20% increase from 2001-2005.

Mammograms – The percentage of women over the age of 40 who had received mammograms within the last two years declined across all racial and ethnic groups. All groups, while close to or achieving HP2010 objectives during the 2001-2005 period, dropped below the objective standards in 2006-2010.

Homicide – The death rate due to homicide was highest for African Americans (26/100,000 people), which was nearly 13 times the rate for non-Hispanic Whites. The amount of years lost due to homicide among those who were 75 and younger increased across all racial and ethnic groups. There were particularly large increases in the African American and American Indian populations.

For a more comprehensive look at how the health issues facing racial and ethnic minorities in Nebraska relate to Whites, please see the report cards on the following pages. These report cards offer visual and numeric representation of where racial and ethnic minorities stand in comparison to Whites in specific health indicators.

Disparities Visualizations

Socioeconomic and Health Disparities Report Card

Using Report Cards to measure racial and ethnic health disparities is a concise way to identify and document data related to racial and ethnic health used by a number of states. In this report, we adopted the format found in The New Mexico Disparity Report Card. Since 2006, New Mexico's Department of Health has produced an annual Racial and Ethnic Health Disparities Report Card; the most recent edition of New Mexico's report card was published in September 2012. A State Partnership Grant to improve minority health from the U.S. Department of Health and Human Services' Office of Minority Health funds the report card.

The Nebraska Disparity Report Card is not an epidemiological report; it is intended to be user-friendly and to succinctly convey key disparities findings for the general public. The report card not only drives the activities of the OHDHE and frames disparities reduction planning and related activities, but it also helps to increase awareness of health disparities.

In our report card, some data are omitted due to sample size issues. A confidence interval (CI) is a range that estimates the true population value for a statistic. In some cases, the Nebraska Behavioral Risk Fact Surveillance System (BRFSS) survey does not reach enough people in certain categories to produce statistically reliable estimates. Small sample sizes produce large variances (i.e. a deviation from the mean), resulting in a large CI. For this reason, we are unable to include data on some indicators with the exception of indicators specific to men and women (prostate cancer screening, mammograms, etc.). In this report, if the confidence interval for a subgroup is too large (i.e. CI half width > 10), the data are not reported. We use a 95% confidence interval. Data from BRFSS were also omitted if cell counts were less than 50, and mortality data were omitted if cell counts were less than 20. There were several exceptions to this, however; please refer to the Methodology and Data Sources section.

Grades for Health & Socioeconomic Indicators		
Grades	**Disparity Ratio**	**Meaning/Interpretation**
A	0.0 – 1	No disparity or minority group-favorable measure
B	1.1 – 1.4	Little disparity
C	1.5 – 1.9	A disparity exists, should be monitored, and may require intervention
D	2 – 2.4	Disparity requires intervention
F	≥ 2.5	Unacceptable disparity. Immediate intervention needed.
Grades: The grades in this report card indicate how well a population group is doing compared to Whites. Grades are representative only of the relationship between a certain group and Whites, not how favorably Nebraska is in relation to the indicator. **Disparity Ratio**: This ratio is calculated by dividing the rate or percentage for each population by the White population.		

Ratio Summaries for Health & Socioeconomic Indicators					
	B	C	D	F	**Number of 'B' Ratios or Larger**
African American	22	25	7	19	73
Asian	17	7	2	4	30
American Indian	23	19	16	29	87
Hispanic	17	7	12	12	48

The following report card adheres to the disparity ratio grading system listed on the previous page. American Indians had many 'F'-grades, meaning the disparity (compared to Whites) needs immediate attention; this included poverty, unemployment, lack of a high school education, and female householders with no husband present. African Americans also experienced large, 'F'-grade disparities in poverty, unemployment, and households ran by a female with no husband present. Hispanics had the largest 'F'-grade disparity in lack of high school education of all minority groups.

African Americans, American Indians, and Hispanics experienced very large ('F'-grade) disparities in teen birth in both 2001-2005 and 2006-2010; Hispanic teens reached a disparity ratio of almost five (4.9) in 2006-2010, an increase from 3.8 in 2001-2005. African Americans and American Indians, in 2001-2005, saw large disparities in infant mortality; however, in 2006-2010, African Americans improved to a 'D'-grade disparity and American Indians moved to a 'B'-grade. American Indians experienced 'F'-grade disparities throughout the decade in inadequate prenatal care while Hispanics and African Americans lived with 'D'-grade disparities for this indicator. African Americans and Asians experienced 'F'-grade disparity ratios in the prevalence of stroke in 2001-2005 but improved to 'C'-grade ratios in 2006-2010. American Indians and African Americans also had 'F'-grade disparities in diabetes mortality. Though decreasing between 2001-2005 and 2006-2010, American Indians still experienced large, 'F'-grade disparities in alcohol-related deaths (4.5 to 3.1, respectively).

African Americans (25) and American Indians (19) had the most 'C'-grade disparities while American Indians experienced the most 'D'-grade disparities (16). American Indians also had the most 'F'-grade disparities with 29 overall, followed by African Americans with 19.

Asians and Hispanics experienced 17 'B'-grade disparities, the fewest of the minority groups, while American Indians had the most B's (23). Generally, American Indians had the most 'B'-grade disparities or worse (87), followed by African Americans with 73.

Socioeconomic Indicators			
Socioeconomic Indicators	**2008-2012**	**Ratio to Whites**	**Grade**
Female Householder, No Husband Present (Percent)			
White, not Hispanic	8.0		
African American	27.6	3.5	F
Asian	5.9	0.7	A
American Indian	36.3	4.5	F
Hispanic	18.6	2.3	D
Living Below the Federal Poverty Level (Percent)			
White, not Hispanic	9.4		
African American	32.5	3.5	F
Asian	16.0	1.7	C
American Indian	38.2	4.1	F
Hispanic	25.4	2.7	F
Percent Unemployed (Percent)			
White, not Hispanic	3.2		
African American	10.5	3.3	F
Asian	3.6	1.1	B
American Indian	11.4	3.6	F
Hispanic	7.2	2.3	D
Percent Without High School Education (Percent)			
White, not Hispanic	6.1		
African American	16.5	2.7	F
Asian	19.9	3.3	F
American Indian	24.0	3.9	F
Hispanic	48.1	7.9	F
Percent Living in Renter-Occupied Housing (Percent)			
White, not Hispanic	28.8		
African American	65.4	2.3	D
Asian	52.1	1.8	C
American Indian	63.1	2.2	D
Hispanic	50.7	1.8	C

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Perceived Health Status: Fair or Poor (Percent)						
White	11.4			10.9		
African American	19.7	1.7	C	19.0	1.7	C
Asian	17.0	1.5	C	9.1	0.8	A
American Indian	24.7	2.2	D	22.9	2.1	D
Hispanic	25.2	2.2	D	25.2	2.3	D
Dissatisfied with Life (Percent)						
White	4.5			3.6		
African American	12.8	2.8	F	6.7	1.9	C
Asian	1.5	0.3	A	8.3	2.3	D
American Indian	3.9	0.9	A	9.5	2.6	F
Hispanic	4.5	1.0	A	5.2	1.4	B
Very Dissatisfied with Life (Percent)						
White	0.8			0.5		
African American	1.6	2.0	D	2.6	5.2	F
Asian				2.4	4.8	F
American Indian	2.6	3.3	F	2.1	4.2	F
Hispanic	0.5	0.6	A	0.8	1.6	C
No Personal Physician (Percent)						
White	14.0			13.8		
African American	17.5	1.3	B	16.8	1.2	B
Asian	17.9	1.3	B	15.9	1.2	B
American Indian	26.3	1.9	C	23.5	1.7	C
Hispanic	35.2	2.5	F	35.1	2.5	F
No Health Insurance (Percent)						
White	12.8			13.0		
African American	18.5	1.4	B	24.4	1.9	C
Asian	9.1	0.7	A	17.3	1.3	B
American Indian	32.0	2.5	F	34.5	2.7	F
Hispanic	39.0	3.0	F	46.1	3.5	F
Unable to See Physician Due to Cost (Percent)						
White	9.5			9.1		
African American	16.1	1.7	C	20.4	2.2	D
Asian	8.4	0.9	A	10.6	1.2	B
American Indian	23.6	2.5	F	16.1	1.8	C
Hispanic	17.3	1.8	C	20.7	2.3	D

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Infant Mortality/1,000 Births						
White	5.7			5.7		
African American	15.1	2.6	F	13.8	2.4	D
Asian	5.5	1.0	A	2.8	0.5	A
American Indian	15.2	2.7	F	7.7	1.4	B
Hispanic	6.8	1.2	B	5.7	1.0	A
Low Birth Weight (Percent)						
White	6.6			6.6		
African American	12.5	1.9	C	13.3	2.0	D
Asian	8.0	1.2	B	8.4	1.3	B
American Indian	6.8	1.0	A	7.3	1.1	B
Hispanic	6.3	1.0	A	6.6	1.0	A
Teen Births/1,000 Females ages 15-19						
White	30.4			23.5		
African American	90.4	3.0	F	84.7	3.6	F
Asian	23.9	0.8	A	21.1	0.9	A
American Indian	128.2	4.2	F	100.2	4.3	F
Hispanic	115.3	3.8	F	114.6	4.9	F
Inadequate Prenatal Care (Percent)						
White	9.4			11.3		
African American	20.6	2.2	D	24.6	2.2	D
Asian	11.5	1.2	B	17.1	1.5	C
American Indian	27.6	2.9	F	32.6	2.9	F
Hispanic	22.5	2.4	D	24.2	2.1	D

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Prevalence of Coronary Heart Disease (Percent)						
White	3.9			3.8		
African American	2.1	0.5	A	2.5	0.7	A
Asian	2.5	0.6	A	3.9	1.0	A
American Indian	9.3	2.4	D	5.9	1.6	C
Hispanic	1.3	0.3	A	3.6	0.9	A
Heart Disease Mortality/100,000 Population						
White	196.7			160.2		
African American	246.4	1.3	B	214.2	1.3	B
Asian	108.3	0.6	A	64.5	0.4	A
American Indian	280.1	1.4	B	131.7	0.8	A
Hispanic	114.6	0.6	A	89.7	0.6	A
Myocardial Infarction (Percent)						
White	3.7			3.6		
African American	1.2	0.3	A	3.0	0.8	A
Asian	0.5	0.1	A	3.5	1.0	A
American Indian	8.0	2.2	D	7.6	2.1	D
Hispanic	2.0	0.5	A	4.3	1.2	B
Myocardial Infarction or Coronary Heart Disease (Percent)						
White	5.6			5.3		
African American	2.8	0.5	A	4.4	0.8	A
Asian	2.5	0.4	A	6.3	1.2	B
American Indian	11.3	2.0	D	9.9	1.9	C
Hispanic	2.1	0.4	A	5.6	1.1	B
Prevalence of Stroke (Percent)						
White	2.0			2.2		
African American	6.2	3.1	F	3.8	1.7	C
Asian	6.0	3.0	F	3.7	1.7	C
American Indian	4.5	2.3	D	3.9	1.8	C
Hispanic	1.8	0.9	A	2.3	1.0	A
Stroke Mortality/100,000 Population						
White	51.7			40.8		
African American	84.2	1.6	C	66.6	1.6	C
Asian	65.7	1.3	B	28.4	0.7	A
American Indian	62.0	1.2	B	38.7	0.9	A
Hispanic	29.2	0.6	A	23.0	0.6	A

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Prevalence of Diabetes (Percent)						
White	5.7			6.7		
African American	10.5	1.8	C	12.7	1.9	C
Asian	6.8	1.2	B	8.6	1.3	B
American Indian	8.5	1.5	C	13.0	1.9	C
Hispanic	9.2	1.6	C	13.8	2.1	D
Diabetes Mortality/100,000 Population						
White	20.3			21.1		
African American	67.3	3.3	F	62.1	2.9	F
Asian	13.9	0.7	A	18.7	0.9	A
American Indian	91.0	4.5	F	93.2	4.4	F
Hispanic	45.6	2.2	D	28.8	1.4	B
Chronic Lung Disease Mortality/100,000 Population						
White	40.3			43.1		
African American	34.5	0.9	A	32.9	0.8	A
Asian	11.1	0.3	A	16.7	0.4	A
American Indian	58.4	1.4	B	58.2	1.4	B
Hispanic	14.7	0.4	A	8.7	0.2	A
Asthma (Percent)						
White	6.7			7.7		
African American	12.3	1.8	C	11.7	1.5	C
Asian	9.7	1.4	B	7.3	0.9	A
American Indian	15.5	2.3	D	9.7	1.3	B
Hispanic	3.8	0.6	A	4.5	0.6	A
Activity Limitations (Percent)						
White	15.3			17.5		
African American	17.9	1.2	B	16.5	0.9	A
Asian	12.7	0.8	A	11.6	0.7	A
American Indian	24.7	1.6	C	28.1	1.6	C
Hispanic	11.7	0.8	A	12.4	0.7	A
HIV/AIDS Mortality/100,000 Population						
White				0.8		
African American				7.3	9.1	F
American Indian				6.6	8.3	F
Hispanic				2.4	3.0	F

Area highlighted in gray depict no data available.

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Sexually Transmitted Diseases/100,00 Population						
White				256.5		
African American				3988.4	15.5	F
Asian				213.5	0.8	A
American Indian				1056.5	4.1	F
Hispanic				534.7	2.1	D
Chlamydia Incidence/100,000 Population						
White				185.9		
African American				2531.9	13.6	F
Asian				166.2	0.9	A
American Indian				821.8	4.4	F
Hispanic				433.3	2.3	D
Gonorrhea Incidence/100,000 Population						
White				29.7		
African American				1073.1	36.1	F
Asian				19.4	0.7	A
American Indian				140.1	4.7	F
Hispanic				43.1	1.5	C
Pneumonia Mortality/100,000 Population						
White				13.8		
African American				11.8	0.9	A
Asian				2.6	0.2	A
American Indian				27.6	2.0	D
Hispanic				8.1	0.6	A
Cancer Mortality/100,000 Population						
White	179.4			171.8		
African American	251.0	1.4	B	238.3	1.4	B
Asian	126.3	0.7	A	99.9	0.6	A
American Indian	215.4	1.2	B	153.2	0.9	A
Hispanic	121.3	0.7	A	99.5	0.6	A
Breast Cancer Mortality/100,000 Population						
White	23.9			20.2		
African American	38.8	1.6	C	28.3	1.4	B
Asian	5.2	0.2	A	12.4	0.6	A
American Indian	28.9	1.2	B	12.6	0.6	A
Hispanic	9.8	0.4	A	19.3	1.0	A

Area highlighted in gray depict no data available

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Prostate Cancer Mortality/100,000 Population						
White				23.3		
African American				39.8	1.7	C
Asian				5.6	0.2	A
American Indian				8.2	0.4	A
Hispanic				22.1	0.9	A
Unintentional Injury Mortality/100,000 Population						
White	38.4			35.9		
African American	27.2	0.7	A	32.6	0.9	A
Asian	35.6	0.9	A	21.6	0.6	A
American Indian	87.9	2.3	D	49.2	1.4	B
Hispanic	31.5	0.8	A	29.5	0.8	A
Motor Vehicle Accident Mortality/100,000 Population						
White	16.8			13.7		
African American	11.6	0.7	A	11.8	0.9	A
Asian	14.3	0.9	A	5.8	0.4	A
American Indian	39.9	2.4	D	16.1	1.2	B
Hispanic	15.5	0.9	A	13.8	1.0	A
Suicide/100,000 Population						
White	10.5			10.7		
African American	4.1	0.4	A	5.0	0.5	A
Asian	6.6	0.6	A	3.7	0.3	A
American Indian	16.9	1.6	C	12.7	1.2	B
Hispanic	4.9	0.5	A	4.7	0.4	A
Homicide/100,000 Population						
White				2.1		
African American				25.7	12.2	F
Asian				1.5	0.7	A
American Indian				13.6	6.5	F
Hispanic				5.4	2.6	F
Heavy Drinking (Percent)						
White	5.0			4.8		
African American	3.0	0.6	A	3.5	0.7	A
Asian	2.6	0.5	A	2.3	0.5	A
American Indian	5.3	1.1	B	9.5	2.0	D
Hispanic	3.8	0.8	A	2.5	0.5	A

Area highlighted in gray depict no data available

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Binge Drinking (Percent)						
White	18.1			20.1		
African American	12.4	0.7	A	14.3	0.7	A
Asian	10.5	0.6	A	7.9	0.4	A
American Indian	27.5	1.5	B	16.2	0.8	A
Hispanic	12.9	0.7	A	11.2	0.6	A
Drinking and Driving (Percent)						
White	4.6			6.3		
African American	3.3	0.7	A	5.6	0.9	A
American Indian	4.3	0.9	A	3.0	0.5	A
Hispanic	1.4	0.3	A	5.8	0.9	A
Alcohol-Related Mortality/100,000 Population						
White	27.5			28.2		
African American	37.7	1.4	B	42.2	1.5	C
Asian	23.7	0.9	A	15.4	0.5	A
American Indian	124.2	4.5	F	86.1	3.1	F
Hispanic	33.3	1.2	B	29.6	1.0	A
Current Cigarette Smoking (Percent)						
White	21.5			18.1		
African American	24.3	1.1	B	23.7	1.3	B
Asian	17.6	0.8	A	10.7	0.6	A
American Indian	41.8	1.9	C	43.7	2.4	D
Hispanic	19.8	0.9	A	16.8	0.9	A
Physical Inactivity (Percent)						
White	21.7			21.6		
African American	29.9	1.4	B	35.2	1.6	C
Asian	26.2	1.2	B	21.5	1.0	A
American Indian	27.7	1.3	B	28.3	1.3	B
Hispanic	43.0	2.0	D	35.4	1.6	C

Area highlighted in gray depict no data available.

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Body Mass Index: 25-29.9 (Percent)						
White	37.6			36.8		
African American	37.8	1.0	A	28.6	0.8	A
Asian	29.3	0.8	A	31.6	0.9	A
American Indian	36.1	1.0	A	35.0	1.0	A
Hispanic	42.1	1.1	B	38.5	1.0	A
Body Mass Index: 25+ (Percent)						
White	60.6			63.5		
African American	71.7	1.2	B	67.5	1.1	B
Asian	37.6	0.6	A	42.5	0.7	A
American Indian	65.4	1.1	B	77.6	1.2	B
Hispanic	67.3	1.1	B	71.1	1.1	B
Body Mass Index: 30+ (Percent)						
White	23.1			26.7		
African American	33.9	1.5	C	39.0	1.5	C
Asian	8.4	0.4	A	10.3	0.4	A
American Indian	29.6	1.3	B	41.7	1.6	C
Hispanic	25.5	1.1	B	32.0	1.2	B
High Blood Pressure (Percent)						
White	22.6			25.3		
African American	35.8	1.6	C	33.9	1.3	B
Asian	15.8	0.7	A	25.1	1.0	A
American Indian	36.2	1.6	C	28.2	1.1	B
Hispanic	17.1	0.8	A	21.8	0.9	A
High Cholesterol (Percent)						
White	27.8			32.0		
African American	29.9	1.1	B	27.6	0.9	A
Asian	36.1	1.3	B	56.0	1.8	C
American Indian	33.6	1.2	B	40.4	1.3	B
Hispanic	23.1	0.8	A	28.5	0.9	A
Mentally Unwell (Percent)						
White	9.7			10.1		
African American	12.9	1.3	B	13.1	1.3	B
Asian	2.6	0.3	A	8.5	0.8	A
American Indian	17.8	1.8	C	16.8	1.7	C
Hispanic	9.6	1.0	A	9.1	0.9	A

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Physically Unwell (Percent)						
White	9.8			9.7		
African American	12.1	1.2	B	15.2	1.6	C
Asian	4.9	0.5	A	11.6	1.2	B
American Indian	21.4	2.2	D	14.8	1.5	C
Hispanic	12.4	1.3	B	12.7	1.3	B
Physically Unwell (Days)						
White	2.9			2.8		
African American	3.7	1.3	B	4.1	1.5	C
Asian	1.6	0.6	A	3.5	1.3	B
American Indian	5.8	2.0	D	4.4	1.6	C
Hispanic	3.5	1.2	B	3.4	1.2	B
Never Receive Emotional Support (Percent)						
White	2.3			2.8		
African American	8.9	3.9	F	8.4	3.0	F
Asian	5.4	2.3	D	15.9	5.7	F
American Indian	3.0	1.3	B	7.5	2.7	F
Hispanic	13.1	5.7	F	14.0	5.0	F
Anxiety Disorder (Percent)						
White				9.8		
African American				14.8	1.5	C
Asian				0.0	0.0	A
American Indian				27.6	2.8	F
Hispanic				9.4	1.0	A
Depressive Disorder (Percent)						
White				15.8		
African American				13.0	0.8	A
Asian				1.2	0.1	A
American Indian				39.4	2.5	F
Hispanic				13.2	0.8	A
Severe Anxiety/Depression (Percent)						
White				6.5		
African American				8.6	1.3	B
American Indian				26.5	4.1	F
Hispanic				8.0	1.2	B

Area highlighted in gray depict no data available

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**	**Grade**	**2006 - 2010**	**Ratio to Whites**	**Grade**
Physically or Mentally Limited (Days)						
White	3.4			3.2		
African American	5.3	1.6	C	4.7	1.5	C
Asian	3.1	0.9	A	5.2	1.6	C
American Indian	8.6	2.5	F	5.7	1.8	C
Hispanic	3.6	1.1	B	4.2	1.3	C

The following health behavior section of these report cards illustrate positive health behaviors, like health screenings and physical activity. In instances where ratios were larger than one, the ratio favors the racial or ethnic group discussed. For instance, 79% of African Americans in 2006-2010 had their cholesterol checked in the last five years, compared to 72% of Whites; this creates a ratio of 1.1 in favor of African Americans. In these cases, grades of an 'A' (1.0-1.5) were given. When the ratio was 1.5 or greater, the grade of 'A+' was given. In instances where the ratio did not favor the minority group, grades of 'B' (0.5-0.9) and 'C' (0.1-0.4) were given.

The ranges used to assign grades to protective health behaviors are summarized below:

Grades for Protective Health Behaviors		
Grades	**Disparity Ratio**	**Meaning/Interpretation**
A+	$\geq$ 1.5	Disparity favors minority group
A	1.0 – 1.5	No disparity or minority group-favorable measure
B	0.5 – 0.9	Little disparity
C	0.1 – 0.4	A disparity exists, should be monitored, and may require intervention
Grades: The grades in this report card indicate how well a population group is doing compared to Whites. Grades are representative only of the relationship between a certain group and Whites, not how favorably Nebraska is in relation to the indicator. **Disparity Ratio**: This ratio is calculated by dividing the rate or percentage for each population by the White population.		

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**		**2006 - 2010**	**Ratio to Whites**	
Pap Test: Last 3 Years (Ages 18+) (Percent)						
White	84.4			76.3		
African American	89.2	1.1	A	84.2	1.1	A
Asian	93.5	1.1	A	70.6	0.9	B
American Indian	83.0	1.0	A	79.1	1.0	A
Hispanic	87.5	1.0	A	71.9	0.9	B
Pap Test: Last 3 Years (Ages 21-65) (Percent)						
White	87.1			83.9		
African American	94.1	1.1	A	89.6	1.1	A
Asian	85.1	1.0	A	73.8	0.9	B
American Indian	82.1	0.9	B	76.3	0.9	B
Hispanic	87.2	1.0	A	76.9	0.9	B
PSA Test: Last 2 Years (Percent)						
White	38.4			42.0		
African American	50.7	1.3	A	41.0	1.0	A
Asian	18.4	0.5	B	47.0	1.1	A
American Indian	21.7	0.6	B	55.7	1.3	A
Hispanic	27.6	0.7	B	26.6	0.6	B
DRE: Last 2 Years (Percent)						
White	59.7			55.6		
African American	63.6	1.1	A	70.0	1.3	A
Asian	35.8	0.6	B	56.5	1.0	A
American Indian	26.5	0.4	C	45.9	0.8	B
Hispanic	30.6	0.5	B	44.4	0.8	B

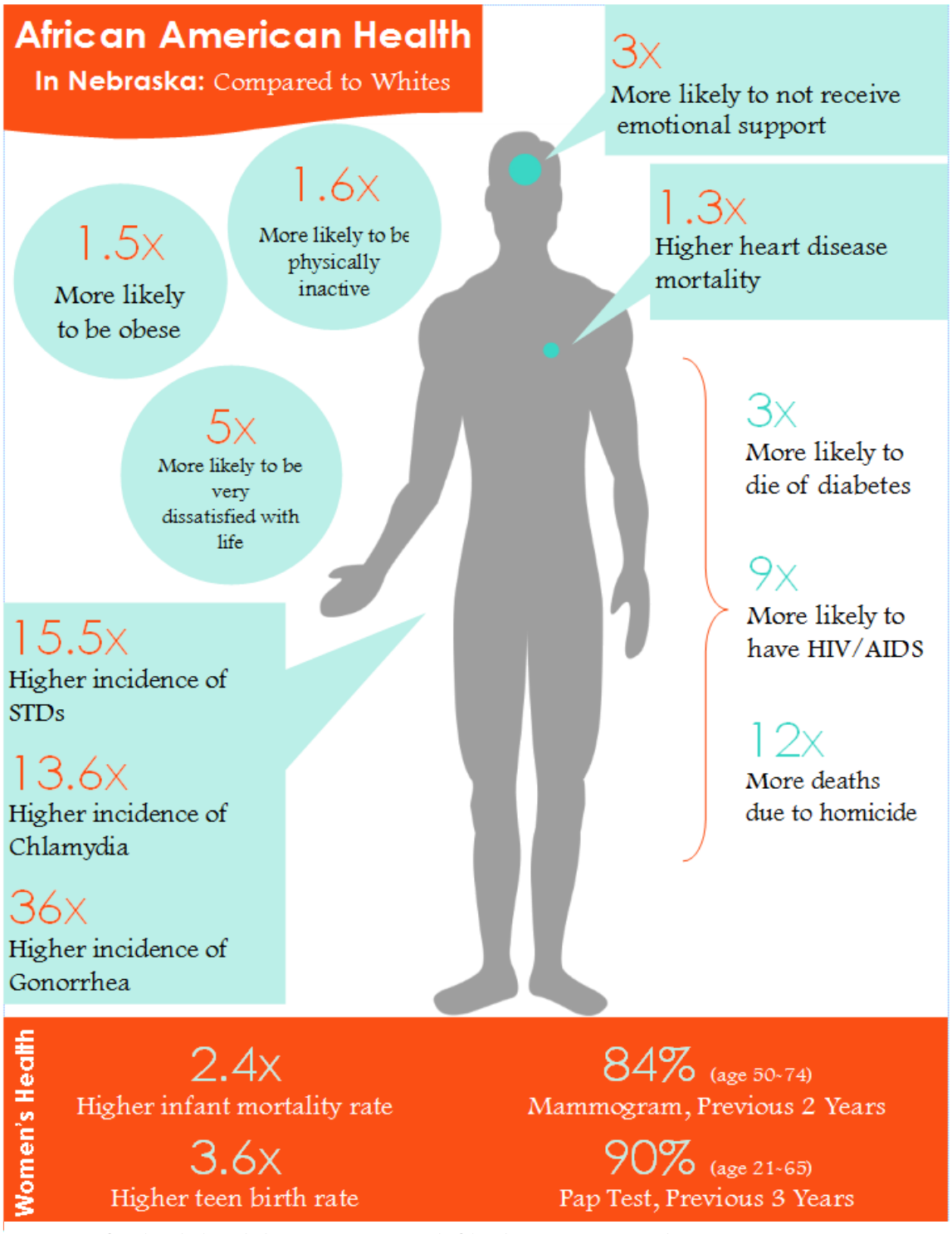
Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**		**2006 - 2010**	**Ratio to Whites**	
Blood Stool Test: Last 2 Years (Percent)						
White	30.6			21.7		
African American	32.1	1	A	27.1	1.2	A
Asian	17.6	0.6	B	26.7	1.2	A
American Indian	8.2	0.3	C	19.4	0.9	B
Hispanic	24.1	0.8	B	11.7	0.5	B
Moderate Exercise (Percent)						
White	43.0			52.9		
African American	38.8	0.9	B	44.5	0.8	B
Asian	31.7	0.7	B	34.8	0.7	B
American Indian	53.1	1.2	A	64.8	1.2	A
Hispanic	31.3	0.7	B	41.4	0.8	B
Vigorous Exercise (Percent)						
White	21.8			31.6		
African American	23.3	1.1	A	29.1	0.9	B
Asian	20.4	0.9	B	20.7	0.7	B
American Indian	25.5	1.2	A	33.7	1.1	A
Hispanic	13.3	0.6	B	24.7	0.8	B
5+ Fruits and Vegetables per Day (Percent)						
White	18.2			22.0		
African American	15.4	0.8	B	25.5	1.2	A
Asian	18.0	1.0	A	49.6	2.3	A+
American Indian	23.8	1.3	A	19.1	0.9	B
Hispanic	19.7	1.1	A	22.4	1.0	A

Protective Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**		**2006 - 2010**	**Ratio to Whites**	
Colonoscopy: Last 10 Years (Percent)						
White	37.4			50.6		
African American	17.0	0.5	B	54.3	1.1	A
Asian	8.6	0.2	C	45.4	0.9	B
American Indian	27.5	0.7	B	29.9	0.6	B
Hispanic	35.6	1.0	A	39	0.8	B
Mammogram: Last 2 Years (Ages 40+) (Percent)						
White	72.1			69.1		
African American	78.2	1.1	A	73	1.1	A
Asian	73.9	1.0	A	64	0.9	B
American Indian	68.5	1.0	A	61.5	0.9	B
Hispanic	73.4	1.0	A	58.3	0.8	B
Mammogram: Last 2 Years (Ages 50-74) (Percent)						
White	80.1			78.4		
African American	87.1	1.1	A	83.6	1.1	A
Asian	59.1	0.7	B	77.4	1.0	A
American Indian	96.8	1.2	A	66.5	0.8	B
Hispanic	80.2	1.0	B	72.9	0.9	B
Cholesterol Checked: Last 5 Years (Percent)						
White	68.6			72.7		
African American	71.7	1.0	A	79.4	1.1	A
Asian	63.6	0.9	B	75.4	1.0	A
American Indian	66.4	1.0	A	74.7	1.0	A
Hispanic	56.0	0.8	B	55.0	0.8	B

Health Indicators						
Health Indicators	**2001 - 2005**	**Ratio to Whites**		**2006 - 2010**	**Ratio to Whites**	
Flu Shot (Percent)						
White	35.6			43.7		
African American	33.3	0.9	B	38.2	0.9	B
Asian	27.7	0.8	B	44.6	1.0	A
American Indian	31.1	0.9	B	43.4	1.0	A
Hispanic	34.4	1.0	A	39.1	0.9	B
Pneumonia Shot (Percent)						
White	20.0			23.7		
African American	20.7	1.0	A	23.6	1.0	A
Asian	20.5	1.0	A	20.5	0.9	B
American Indian	28.1	1.4	A	27.6	1.2	A
Hispanic	18.2	0.9	B	25.4	1.1	A

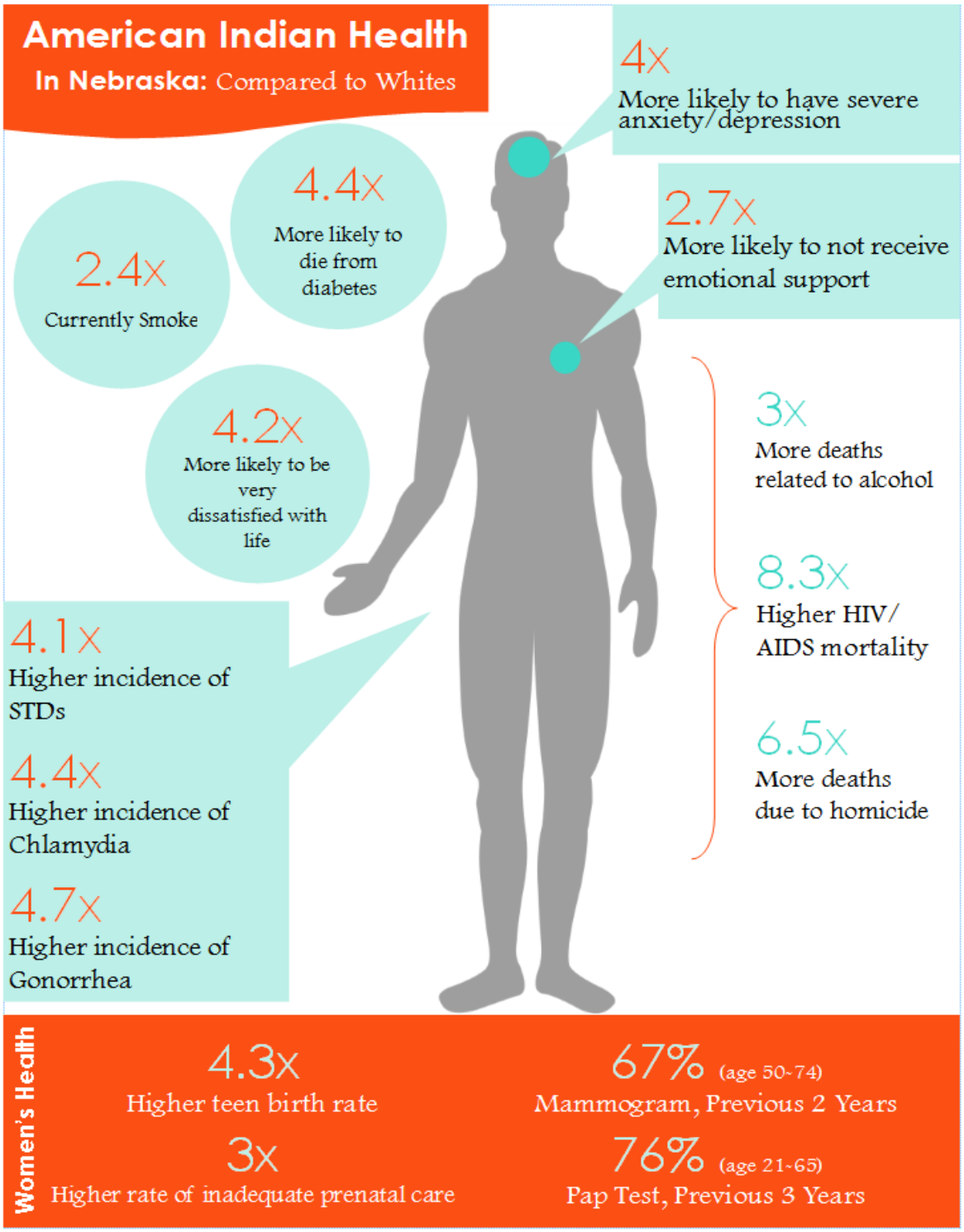
Infographics

African Americans



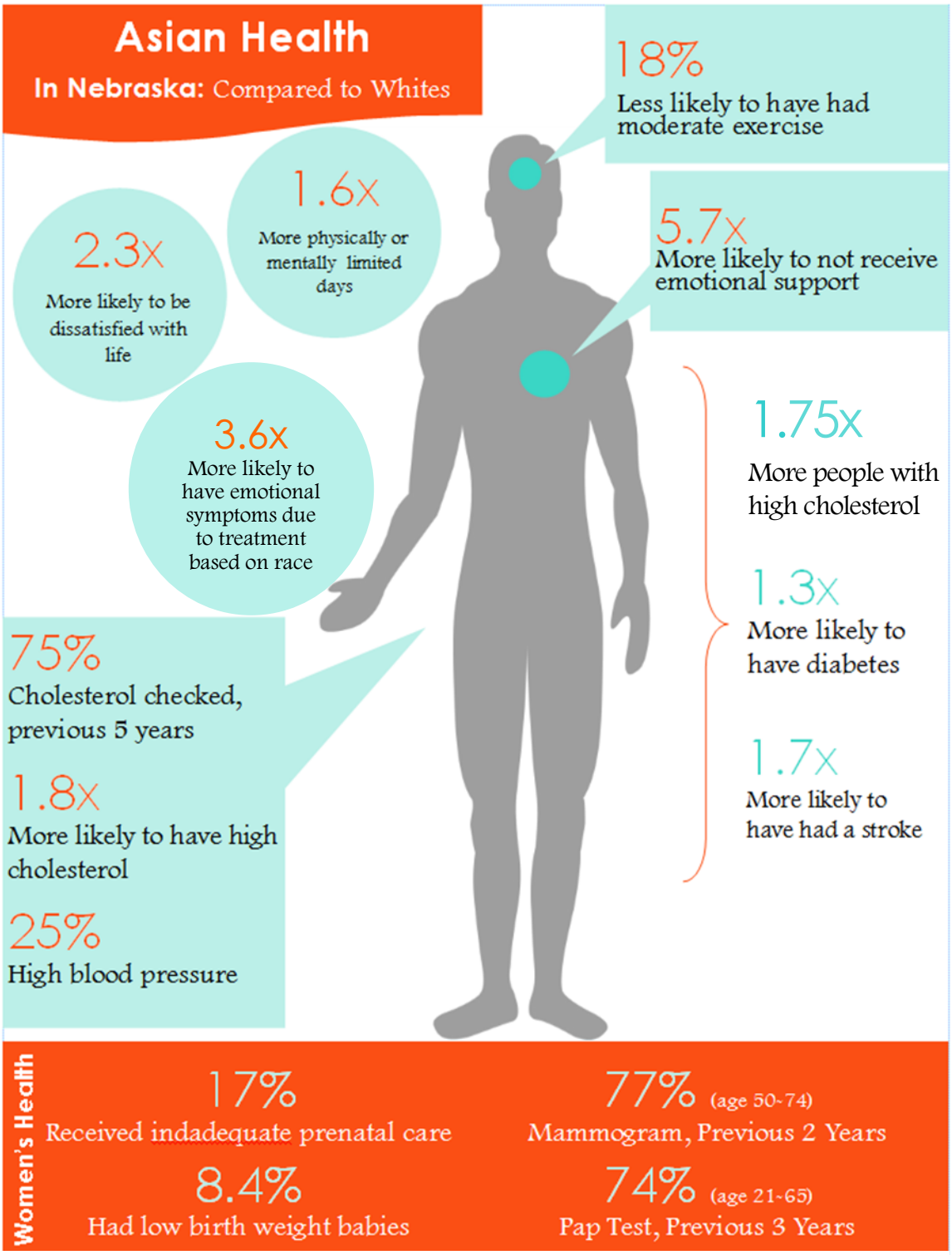
Source: Nebraska Vital Statistics; BRFSS; Communicable Disease; HIV Prevention Program; 2006-2010

American Indians



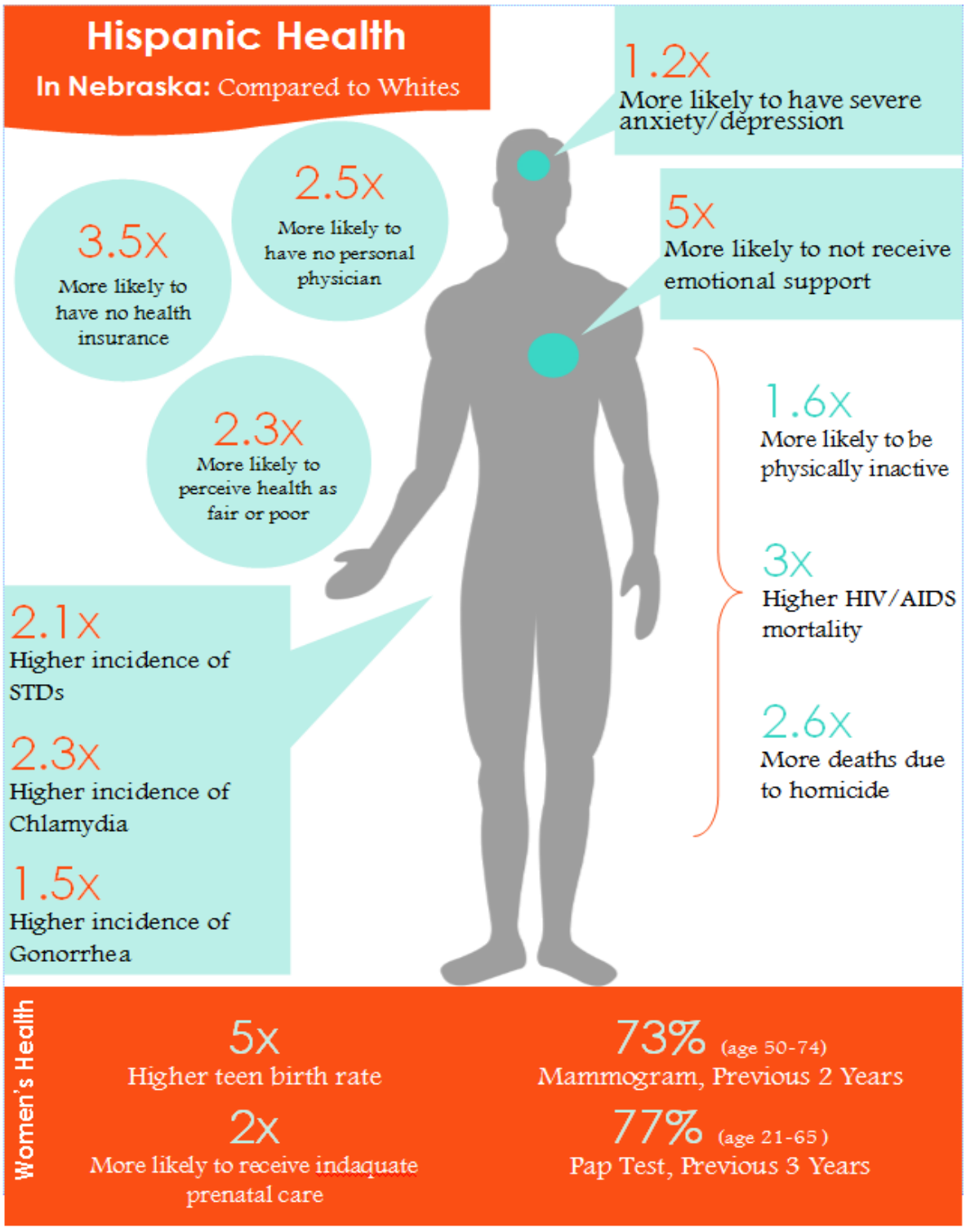
Source: Nebraska Vital Statistics; BRFSS; Communicable Disease; 2006-2010

Asians



Source: Nebraska Vital Statistics and BRFSS; 2006-2010

Hispanics



Source: Nebraska Vital Statistics; BRFSS; Communicable Disease; 2006-2010

Healthy People 2010 Progress

The following is a summary of the progress toward Healthy People 2010 objectives. All racial and ethnic groups moved closer to their Healthy People 2010 objective of having a personal physician, although all racial and ethnic minority groups fell short of the objective. All racial and ethnic groups saw a higher proportion of their population without health insurance in 2006-2010 than in 2001-2005, moving away from their HP2010 objective of 0.0%. Nebraska's teen birth rate decreased between 2001-2005 and 2006-2010. No group reached their objective for smoking while pregnant. No racial or ethnic group reached their HP2010 goal for cancer mortality. Even though all groups saw progress toward decreasing coronary heart disease mortality, they still did not reach their Healthy People 2010 goal. Diabetes-related death is still a major problem in Nebraska; African Americans, American Indians, and Hispanics have yet to reach their HP2010 objective. We have yet to reach objectives for drinking and driving, binge drinking, or cigarette smoking. All groups moved away from their obesity objectives and no groups, except Asians, reached their Healthy People objective for obesity. No groups in Nebraska reached their objectives for high cholesterol or high blood pressure. Although all groups met their objective for moderate physical activity, no group met their objective for preventive screenings.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Access to Healthcare					
Have a Personal Physician	%	%		%	
White	86	86.2	✓	85	✓
African American	82.5	83.2	✓	85	×
Asian	82.1	84.5	✓	85	×
American Indian	73.7	76.5	✓	85	×
Hispanic or Latino	64.8	64.9	✓	85	×
No Health Insurance	%	%		%	
White	12.8	13	×	0	×
African American	18.5	24.4	×	0	×
Asian	9.1	17.3	×	0	×
American Indian	32	34.5	×	0	×
Hispanic or Latino	39	46.1	×	0	×
Could Not See a Doctor Due to Costs	%	%		%	
White	9.5	9.1	✓	4	×
African American	16.1	20.4	×	4	×
Asian	8.4	10.6	×	4	×
American Indian	23.6	16.1	✓	4	×
Hispanic or Latino	17.3	20.7	×	4	×

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Maternal and Child Health					
Teen Birth per 1,000 Females Aged 15-19					
White	30.4	23.5	✓	Not Available	×
African American	90.4	84.7	✓		×
Asian	23.9	21.1	✓		×
American Indian	128.2	100.2	✓		×
Hispanic or Latino	115.3	114.6	✓		×
Adequate Prenatal Care	%	%		%	
White	90.6	88.7	×	90	×
African American	79.4	75.4	×	90	×
Asian	88.5	82.9	×	90	×
American Indian	72.4	67.4	×	90	×
Hispanic or Latino	77.5	75.8	×	90	×
Abstained from Smoking While Pregnant	%*	%		%	
White	85.8	83.5	×	98	×
African American	84.7	86.7	✓	98	×
American Indian	70.5	71.1	✓	98	×
Asian	96.1	96.3	✓	98	×
Hispanic or Latino	95.9	95.6	×	98	×

*Abstained from smoking data is for 2000-2004 timeframe, not 2001- 2005.

Maternal and Child Health					
Infant Mortality Rate per 1,000 Live Births					
White	5.7	5.7	×	4.5	×
African American	15.1	13.8	✓	4.5	×
Asian	5.5	2.8	✓	4.5	✓
American Indian	15.2	7.7	✓	4.5	×
Hispanic or Latino	6.8	5.7	✓	4.5	×
Prenatal Care in the First Trimester	%	%		%	
White	83.8	76.6	×	90	×
African American	69.9	56.6	×	90	×
Asian	81.3	67.3	×	90	×
American Indian	61.3	50.1	×	90	×
Hispanic or Latino	67.3	56.6	×	90	×
Low Birth Weight	%	%		%	
White	6.6	6.6	×	5	×
African American	12.5	13.3	×	5	×
Asian	8	8.4	×	5	×
American Indian	6.8	7.3	×	5	×
Hispanic or Latino	6.3	6.6	×	5	×

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Cancer					
Overall Cancer Death Rate/100,000 Population					
White	179.4	171.8	✓	147	×
African American	251	238.3	✓	147	×
Asian	126.3	99.9	✓	85.2	×
American Indian	215.4	153.2	✓	147	×
Hispanic or Latino	121.3	99.5	✓	72	×
Breast Cancer Death Rate/100,000 Population					
White	23.9	20.2	✓	20.7	✓
African American	38.8	28.3	✓	20.7	×
Asian	5.2	12.4	×	20.7	✓
American Indian	28.9	12.6	✓	20.7	✓
Hispanic or Latino	9.8	19.3	×	12	×
Prostate Cancer Death Rate/100,000 Population					
White	25.0	23.3	✓	25.9	✓
African American	48.1	39.8	✓	25.9	×
Asian	18.0	5.6	✓	0.0	×
American Indian	12.1	8.2	✓	25.9	✓
Hispanic or Latino	10.2	22.1	×	8	×

Chronic Disease					
Heart Disease Death Rate per 100,000 Population					
White	196.7	160.2	✓	Not	×
African American	246.4	214.2	✓	Available	×
Asian	108.3	64.5	✓		×
American Indian	280.1	131.7	✓		×
Hispanic or Latino	114.6	89.7	✓		×
Stroke Death Rate per 100,000 Population					
White	51.7	40.8	✓	47.4	✓
African American	84.2	66.6	✓	47.4	×
Asian	65.7	28.4	✓	32.7	✓
American Indian	62	38.7	✓	47.4	✓
Hispanic or Latino	29.2	23	✓	22.3	×
Diabetes Death Rate per 100,000 Population					
White	20.3	21.1	×	25.0	✓
African American	67.3	62.1	✓	25.0	×
Asian	13.9	18.7	×	25.0	✓
American Indian	91	93.2	×	25.0	×
Hispanic or Latino	45.6	28.8	✓	25.0	×

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001 - 2005	2006 - 2010			
Substance Abuse					
Drinking and Driving	%	%		%	
White	4.6	6.3	×	1	×
African American	3.3	5.6	×	1	×
American Indian	4.3	3.0	✓	1	×
Hispanic or Latino	1.4	5.8	×	1	×
Cigarette Smoking	%	%		%	
White	21.5	18.1	✓	12	×
African American	24.3	23.7	✓	12	×
Asian	17.6	10.7	✓	12	✓
American Indian	41.8	43.7	×	12	×
Hispanic or Latino	19.8	16.8	✓	12	×
Binge Drinking	%	%		%	
White	18.1	20.1	×	6	×
African American	12.4	14.3	×	6	×
Asian	10.5	7.9	✓	6	×
American Indian	27.5	16.2	✓	6	×
Hispanic or Latino	12.9	11.2	✓	6	×

Unintentional and Intentional Injury					
Unintentional Injury death rate/100,000 population					
White	38.4	35.9	✓	19.4	×
African American	27.2	32.6	×	19.4	×
Asian	34.6	21.6	✓	7.5	×
American Indian	87.9	49.2	✓	19.4	×
Hispanic or Latino	31.5	29.5	✓	19.4	×
Death Rate due to Motor Vehicle Accidents/100,000 Population					
White	16.8	13.7	✓	12	×
African American	11.6	11.8	×	12	✓
Asian	14.3	5.8	✓	12	✓
American Indian	39.9	16.1	✓	12	×
Hispanic or Latino	15.5	13.8	✓	12	×
Suicide/100,000 Population					
White	10.5	10.7	×	8.2	×
African American	4.1	5	×	8.2	✓
Asian	6.6	3.7	✓	2.1	×
American Indian	16.9	12.7	✓	8.2	×
Hispanic or Latino	4.9	4.7	✓	4.7	✓
Homicide/100,000 Population					
White	1.9	2.1	×	2	×
African American	20.4	25.7	×	2	×
Asian	0.9	1.5	×	2	✓
American Indian	8.0	13.6	×	2	×
Hispanic or Latino	5.9	5.4	✓	2	×

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Risk Factors for Illness					
BMI 30+	%	%		%	
White	23.1	26.7	×	15	×
African American	33.9	39	×	15	×
Asian	8.4	10.3	×	15	✓
American Indian	29.6	41.7	×	15	×
Hispanic or Latino	25.5	32	×	15	×
High Blood Pressure	%	%		%	
White	22.6	25.3	×	16	×
African American	35.8	33.9	✓	16	×
Asian	15.8	25.1	×	16	×
American Indian	36.2	28.2	✓	16	×
Hispanic or Latino	17.1	21.8	×	16	×
High Cholesterol	%	%		%	
White	27.8	32	×	17	×
African American	29.9	27.6	✓	17	×
Asian	36.1	56	×	17	×
American Indian	33.6	40.4	×	17	×
Hispanic or Latino	23.1	28.5	×	17	×
Physical Inactivity	%	%		%	
White	21.7	21.6	✓	32	×
African American	29.9	35.2	×	32	✓
Asian	26.2	21.5	✓	32	×
American Indian	27.7	28.3	×	32	×
Hispanic or Latino	43	35.4	✓	32	×

Protective Health Behaviors					
Mammogram in Last 2 years (Ages 40+)	%	%		%	
White	72.1	69.1	×	75	×
African American	78.2	73	×	75	×
Asian	73.9	64	×	75	×
American Indian	68.5	61.5	×	75	×
Hispanic or Latino	73.4	58.3	×	75	×
Cholesterol Checked Last 5 years	%	%		%	
White	68.6	72.7	✓	80	×
African Americans	71.7	79.4	✓	80	×
Asian	63.6	75.4	✓	80	×
American Indian	66.4	74.7	✓	80	×
Hispanic or Latino	56	55	×	80	×

Nebraska Objective	Nebraska		Progress	HP2010 Objective	Met
	2001-2005	2006-2010			
Health Behaviors					
Pap Test Last 3 years (Ages 18+)	%	%		%	
White	84.4	76.3	×	90	×
African American	89.2	84.2	×	90	×
Asian	93.5	70.6	×	90	×
American Indian	83.0	79.1	×	90	×
Hispanic or Latino	87.5	71.9	×	90	×
Moderate Physical Activity	%	%		%	
White	43	52.9	✓	30	✓
African American	38.8	44.5	✓	30	✓
Asian	31.7	34.8	✓	30	✓
American Indian	53.1	64.8	✓	30	✓
Hispanic or Latino	31.3	41.4	✓	30	✓
Vigorous Physical Activity	%	%		%	
White	21.8	31.6	✓	30	✓
African American	23.3	29.1	✓	30	×
Asian	20.4	20.7	✓	30	×
American Indian	25.5	33.7	✓	30	✓
Hispanic or Latino	13.3	24.7	✓	30	×
Blood Stool Test	%	%		%	
White	30.6	21.7	×	50	×
African American	32.1	27.1	×	50	×
Asian	17.6	26.7	✓	50	×
American Indian	8.2	19.4	✓	50	×
Hispanic or Latino	24.1	11.7	×	50	×

INTRODUCTION

The World Health Organization states that everyone has the right to enjoy the highest attainable standard of health in his or her society. Although, as history illustrates, having a right does not guarantee realization of the benefits accruing from it. Racial and ethnic minorities in the United States suffer from a greater burden of societal hardships and disease than Whites, with inequalities seen in chronic and communicable diseases, intentional and unintentional injury, and poorer health outcomes in maternal and child health.[1]

In 1998, Healthy People (HP) 2010 launched as a comprehensive set of disease prevention and health promotion objectives for the nation. The HP2010 initiative was designed to achieve two overarching goals: to increase quality and years of healthy life and eliminate health disparities. There are hundreds of population-based objectives and sub-objectives being monitored under this initiative by race and ethnicity, income or education, and, when applicable, by gender.

Healthy People 2010 challenged the nation to close the gap, eliminating widespread disparities in health and health care by the end of the decade.[2] Measuring the successes and failures of health against HP2010 objectives allows us to gain an appropriate picture of Nebraska's health and wellness, as HP2010 is the gauge that other states are also using to measure their health.

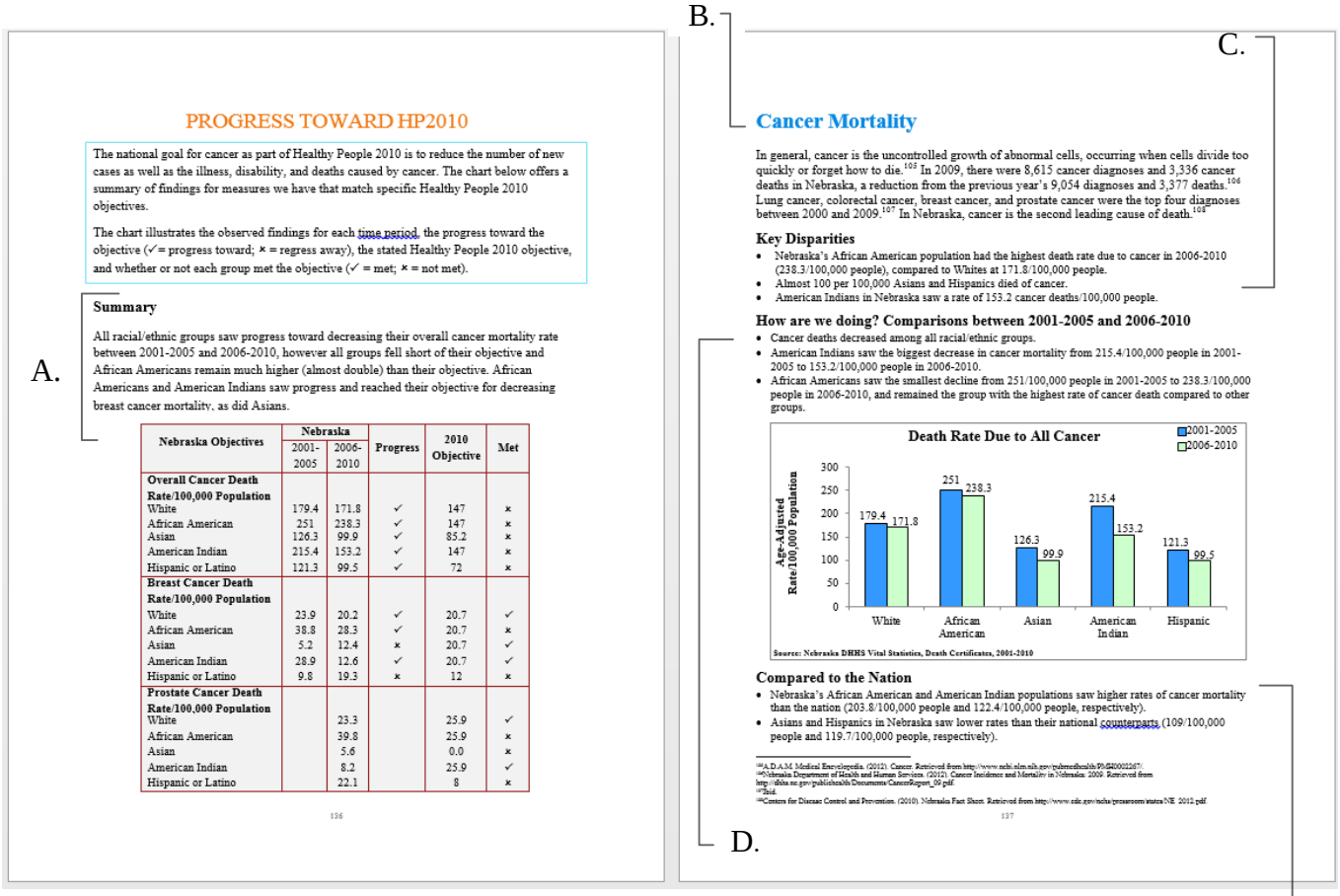
This report assesses the current state of Nebraska's racial and ethnic minority populations and in what way change, both positive and negative, occurred over the 10-year period from 2000-2010. This report was based on the 2003 *Health Status Report of Racial and Ethnic Minorities in Nebraska*, but has evolved into a document the Office of Health Disparities and Health Equity feels is a more comprehensive look at all racial and ethnic minorities who experience health disparities. It is important to remember that this is not the same report as the 2003 *Health Status Report*. Intended to provide an overarching picture of minority health in Nebraska, this report illustrates the existence and degree of health differences between Nebraska's racial and ethnic minority groups and majority Whites, foreign-born and native

[1]Heckler, Margaret M. (1985). "Report of the secretary's task force on black and minority health". U.S. Department of Health and Human Services.
[2]National Health care Current Disparities Report. (2006). Agency for Health care Research and Quality, Rockville, MD. Retrieved from http://www.ahrq.gov/qual/nhdr06/nhdr06.htm.

populations, disabled and non-disabled population, and so on. Whenever possible, it links Nebraska's experience to that of the nation as a whole.

Report Format

When health indicators match (in measure or description) Healthy People 2010 objectives, a summary will appear toward the beginning of the section (A). Beginning in the socioeconomic section, each page will start with a section describing the indicator discussed on that page (B). Next, there is a 'Key Disparities' section (C) which summarizes inequalities present between Nebraska's populations in discussion during the latest period. In most instances, where we have both 2001-2005 and 2006-2010 data available the 'Key Disparities' section will be followed by a 'How are we doing?' section (D), with a comparison between these two time periods. The graph follows these three sections and, when available, a comparison between Nebraska and the rest of the United States (E) will be at the bottom of each page.



Methodology and Data Sources

In accordance with the Centers for Disease Control and Prevention, this report recognizes that race and ethnicity are social constructs, representing distinct histories, languages, and cultures of groups within the United States. They are not valid biological or genetic categories and not scientifically based.[3] Indicators in the report were categorized by race and ethnicity using the standards defined by the Office of Management and Budget, the federal agency that defines guidelines for government publications. The descriptor 'Hispanic or Latino' is considered a designation of ethnicity, not race, and people of Hispanic or Latino origin may be of any race. There are a minimum of five federally recognized categories for classifying race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White.

Due to the varying methodology of the sources, some data is available for non-Hispanic Whites, in which case non-Hispanic White data is used instead of White alone data. Be advised, majority White data from Vital Statistics represents those who consider themselves White, Hispanic or not. Behavioral Risk Factor Surveillance System (BRFSS) data represents those, from all racial groups, who are not Hispanic. In this report Asians, Native Hawaiians, and other Pacific Islanders were grouped together because of the relatively small numbers of Hawaiians and Pacific Islanders. Grouping population groups together also helps combat uncertainty about the accuracy of the population counts needed to develop reliable statistics.

For several indicators, no data are available due to small population size. To help analyze small groups (i.e. race and ethnicity or less common diseases) multiple years of data were combined to produce a five-year annual average. With some exceptions, mortality data were not included if deaths were lower than 20. Exceptions include several indicators for certain racial and ethnic groups, and we advise that these data be interpreted with caution: stroke mortality (American Indian); Diabetes mortality (Asian); HIV/AIDS mortality (American Indian, Asian, Hispanic); Breast cancer mortality (American Indian, Asian); Prostate cancer mortality (American Indian, Asian); Infant mortality (American Indian, Asian); Years lost due to motor vehicle fatalities (American Indian, Asian); Years lost to suicide (American Indian, Asian); and chronic lung disease mortality (Asian, Hispanic).

[3]Casper, M., Barnett, E., Halverson, J., Elmes, G., Braham, V., Majeed, Z., Bloom, A., and Stanley, S. (2001). Women and heart disease: An atlas of racial and ethnic Current Disparities in mortality. 2nd ed. Retrieved from ftp://ftp.cdc.gov/pub/Publications/womens_atlas/00-atlas-all.pdf.

A confidence interval (CI) is a range that estimates the true population value for a statistic. In some cases, the Nebraska BRFSS does not reach enough people in certain categories to produce statistically reliable estimates. Small sample sizes produce large variances (i.e. a deviation from the mean), resulting in a large confidence interval. For this reason, we are unable to include data on some indicators, with the exception of indicators specific to men and women (prostate cancer screening, mammograms, etc.). In this report, if the confidence interval for a subgroup is too large (i.e. CI half width > 10), the data are not reported. We use a 95% confidence interval. For BRFSS, data were not reported if cell counts were less than 50 over a five-year period.

Most of the data in this report represent the 2006-2010 period, but were compared to 2001-2005 data whenever possible. When Nebraska indicators were compared to the United States, data was retrieved from the Healthy People 2020 site and 2010 data was used, unless otherwise specified. Sometimes old (2000 and 2010) indicators were used in this report since there was a definition change. In this report, red tables are used to summarize Nebraska's progress towards Healthy People 2010. The tables list the objectives for each indicator and whether or not the objectives were met; we would like to clarify that the objectives listed are specific to Nebraska but are very similar to national objectives. Years of potential life lost is a measure of premature death. It represents the number of years of life lost by deaths before the age of 75.

Population counts data are from the 2010 Census. The socioeconomic data is from U.S. Census Bureau, 2008-2012 American Community Survey. This report presents only part of the socioeconomic picture for minorities in Nebraska, for a more in depth view please look for the Nebraska Socioeconomic Profiles as published on the Office of Health Disparities and Health Equity website. From Vital Statistics, different ethnic groups' data are presented in the format of age adjusted rate per 100,000 for populations. Age adjustment is a statistical technique for calculating the rates or percentages for different populations as if they all had the age distribution of a standard population. Rates adjusted to the same standard population can be directly compared or contrasted to each other, that way any differences attributed to factors of the population is more readily seen. The BRFSS data presented in this fact sheet are age-adjusted as well. Data regarding maternal and child health are PRAMS data from 2009-2011. The data regarding mortality and leading causes of death were collected using the tenth revision of the International Classification of Diseases (ICD-10) codes.

Methodology Issues and Limitations

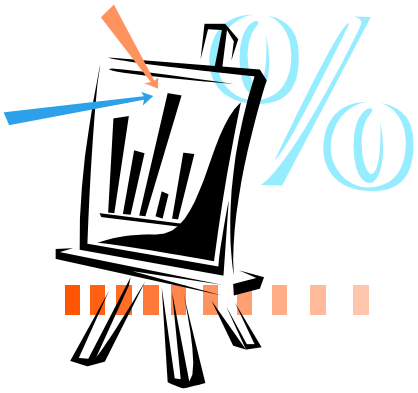
Data for race and ethnicity raise unique reliability problems. Those who collect the data often use different methods and standards. For some systems, the data reflect self-classification by the respondents according to the race with which they most closely identify. For other systems, someone else, who may or may not know the person well makes a judgment about the person's race, which may not represent that with which the person most closely identifies.

Even though small population groups and multiple years were combined to help analyze the data, the numbers of events or population sizes were still very small and one or two events can lead to large variations and misleading rates. This is an especially important caveat for American Indians, and Asian/Native Hawaiians and other American/Pacific Islanders.

To improve the health of all Nebraskans and to enable policymakers to identify future trends, target resources most effectively, and set program and policy priorities, it is critical that we keep collecting and disseminating reliable and accurate information about all components of health, including current health status, the determinants of health, as well as resources and outcomes. There were many areas, especially having to do with health issues affecting the state's American Indian and Asian populations, where we have no data whatsoever. Increased resources for data collection and analysis will be necessary if disparities are to be reduced.

When reading this report it is important to remember data related to racial and ethnic disparities are subject to various limitations. Typically data revolving around these groups were based on small populations, hence why sometimes groups were combined. Data from different years can also be combined to make two, three, or five year averages. Both of the aforementioned strategies were used to provide more reliable data for this report. Generally, self-reported data create problems with recall and social desirability bias. In addition, as with any cross-sectional report, the findings represent a snapshot in time and thus cannot be attributed to any causal inferences.

NEBRASKA DEMOGRAPHICS



The racial composition of the United States has changed dramatically with minorities accounting for 34% of the total population. In 2007, about 30% of adults and over 40% of children were members of racial or ethnic minority populations.[4] The sizes of the Hispanic and Asian populations have grown substantially, more than doubling since 1980.[5] According to projections from the U.S. Census Bureau, this pattern is part of a long-term trend and these trends can be seen in Nebraska as well.

During the 20th century, there was a change in the diversity of Nebraska. In 1910, there were approximately 4,500 African Americans in Omaha, a number that more than doubled by 1920.[6] In 1972, Nebraska was the first state to create an agency chiefly responsible for the advocacy of the Hispanic population.[7] During that time, an estimated 30,000 Mexican Americans, the primary heritage of Hispanics in Nebraska, resided in the state.[8] As of 2010, there are more than 133,000 Hispanics living in Nebraska.

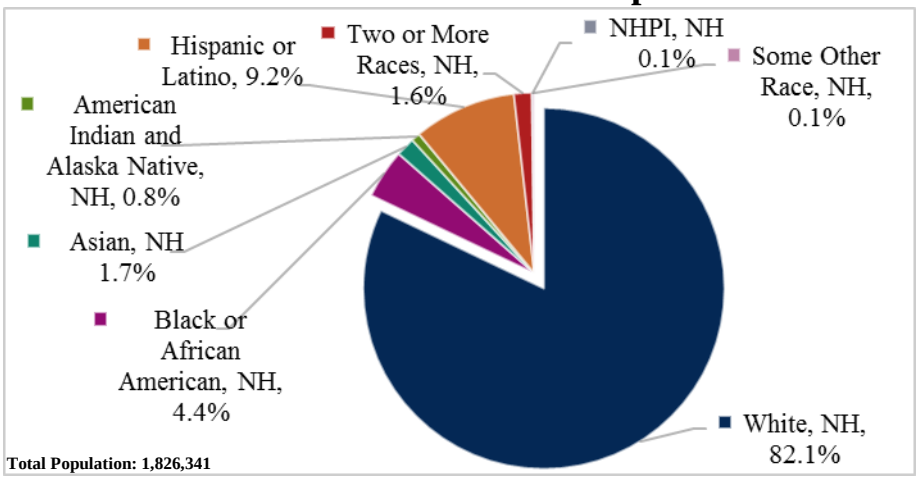
At the beginning of this century, minority populations accounted for approximately 12% of the U.S. population and 10% of the Nebraska population.[9] Nearly 20% of the total Nebraska population was a racial and ethnic minority, a proportion that is growing rapidly, according to 2014 estimates. In total, Nebraska's minority population grew 50.7% between 2000 and 2010. By 2050, minority groups are expected to make up nearly half of the total population in the United States and those population projections are expected to be mirrored in Nebraska.

[4]National Center for Health Statistics. (2009). Health, United States, 2008: With Chart book. Hyattsville, MD.
[5]Ibid.
[6]Nebraska Studies. African American Migration. Retrieved from http://www.nebraskastudies.org/0700/frameset_reset.html
[7]Davis, R. (2008). Service not power: The early years of the Nebraska commission on Mexican-Americans, 1971-1975. *Nebraska History 89*: 67-83.
[8]Ibid.
[9]Hobbs, F. and Stoops, N. (2002). Demographic trends in the 20th century: Census 2000 special report.

Nebraska's Population: Increasingly Diverse

Approximately 9% of Nebraska's 2010 population was Hispanic, 4.4% Black, 1.7% Asian, 0.8% American Indian, and 1.6% identified as two or more races.[10] Overall, Nebraska saw smaller proportions of all minority groups compared to the United States. Hispanics accounted for 16.3% of the United States' population; 6.2% of people indicated they were of some other race, while almost 13% were African American. Hispanics accounted for 51.4% of the Nebraska minority population (168,023). African Americans, Asians, and American Indian or Alaska Natives accounted for 24.6%, 9.5%, and 4.5% of the minority population, respectively.

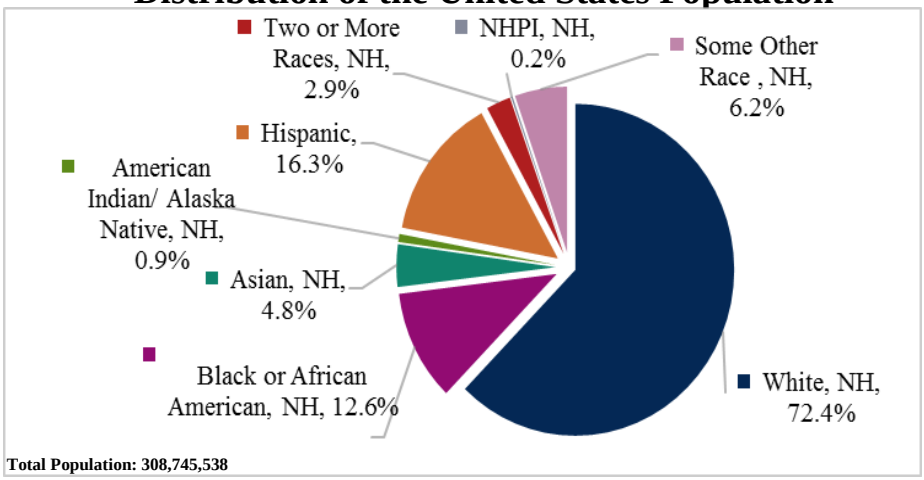
Distribution of Nebraska's Population



Note: *Native Hawaiian or Other Pacific Islander; NH: non-Hispanic

U.S. Census Bureau, 2010 Census

Distribution of the United States Population



Note: *Native Hawaiian or Other Pacific Islander; NH: non-Hispanic

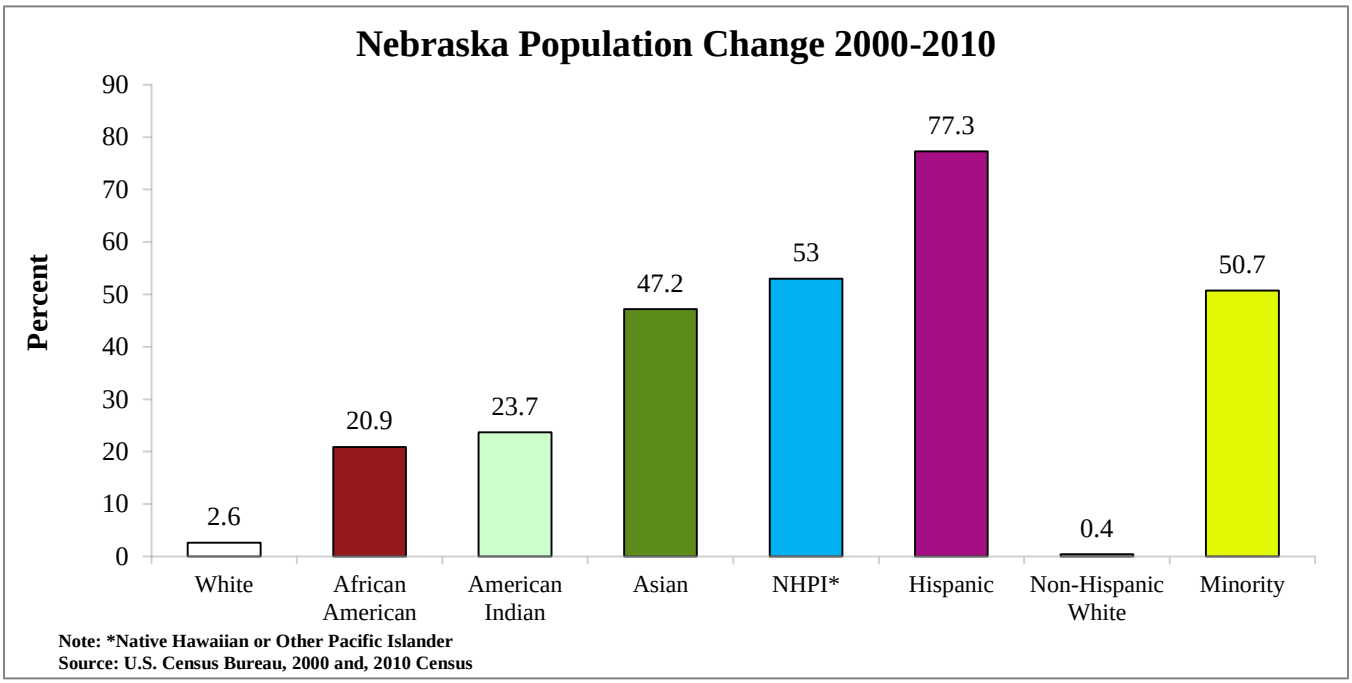
U.S. Census Bureau, 2010 Census

[10]U.S. Census Bureau, 2010 Census.

Nebraska's Minority Population: Growing Fast

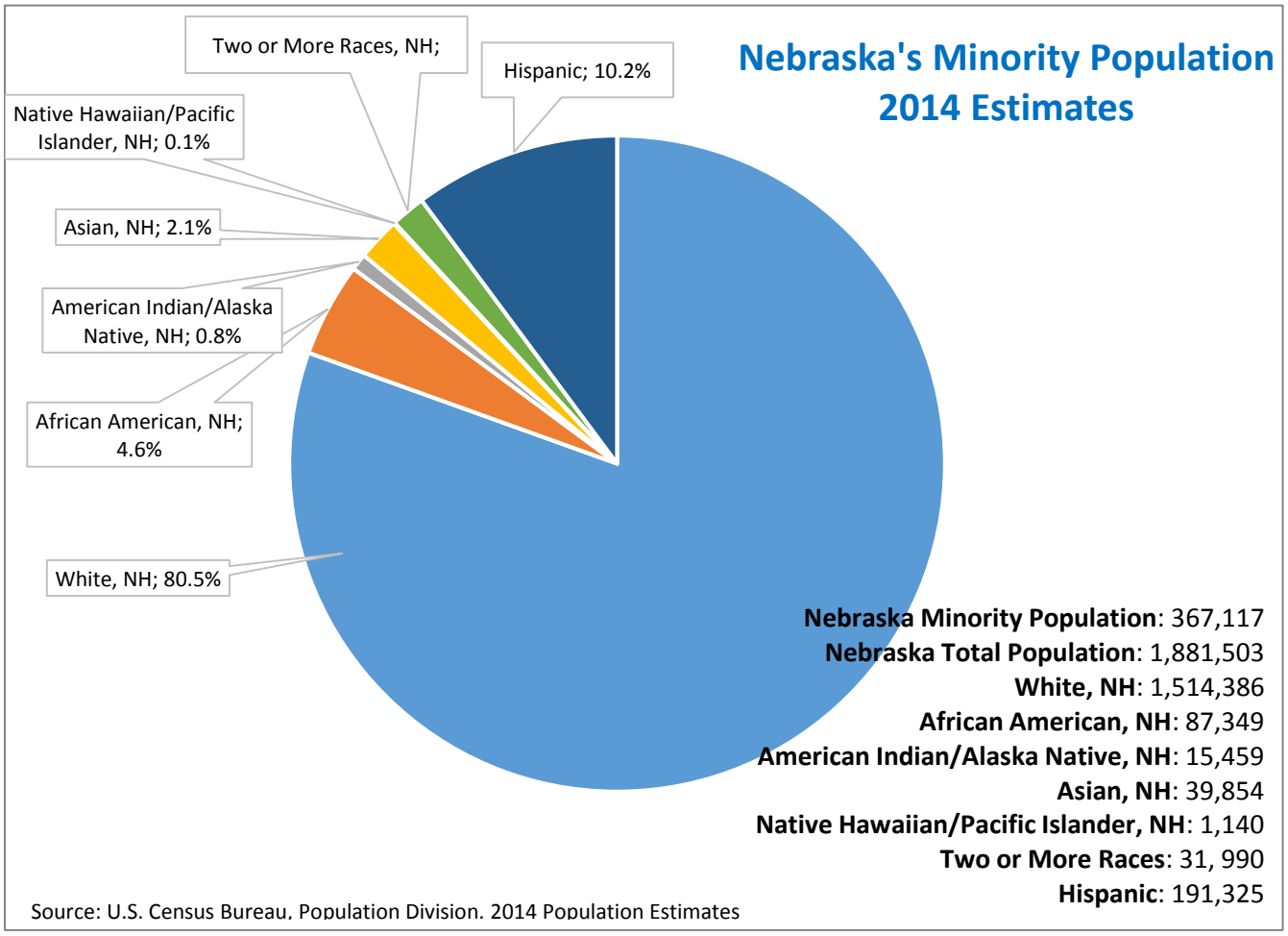
The minority population in Nebraska has been increasing much more rapidly than the White population. Between 2000 and 2010, the total population in Nebraska increased by about 6.7%. From 2000 to 2010, Nebraska's racial and ethnic minority population grew by 50.7% (from 163,457 to 326,915), compared to the White population that increased by less than 0.4%.

Specifically, the Hispanic population grew the most with a 77.3% increase, followed by the Native Hawaiian Pacific Islander population (53%). The Asian population increased by approximately 47%, followed by American Indian (23.7%) and African American (20.9%) populations.



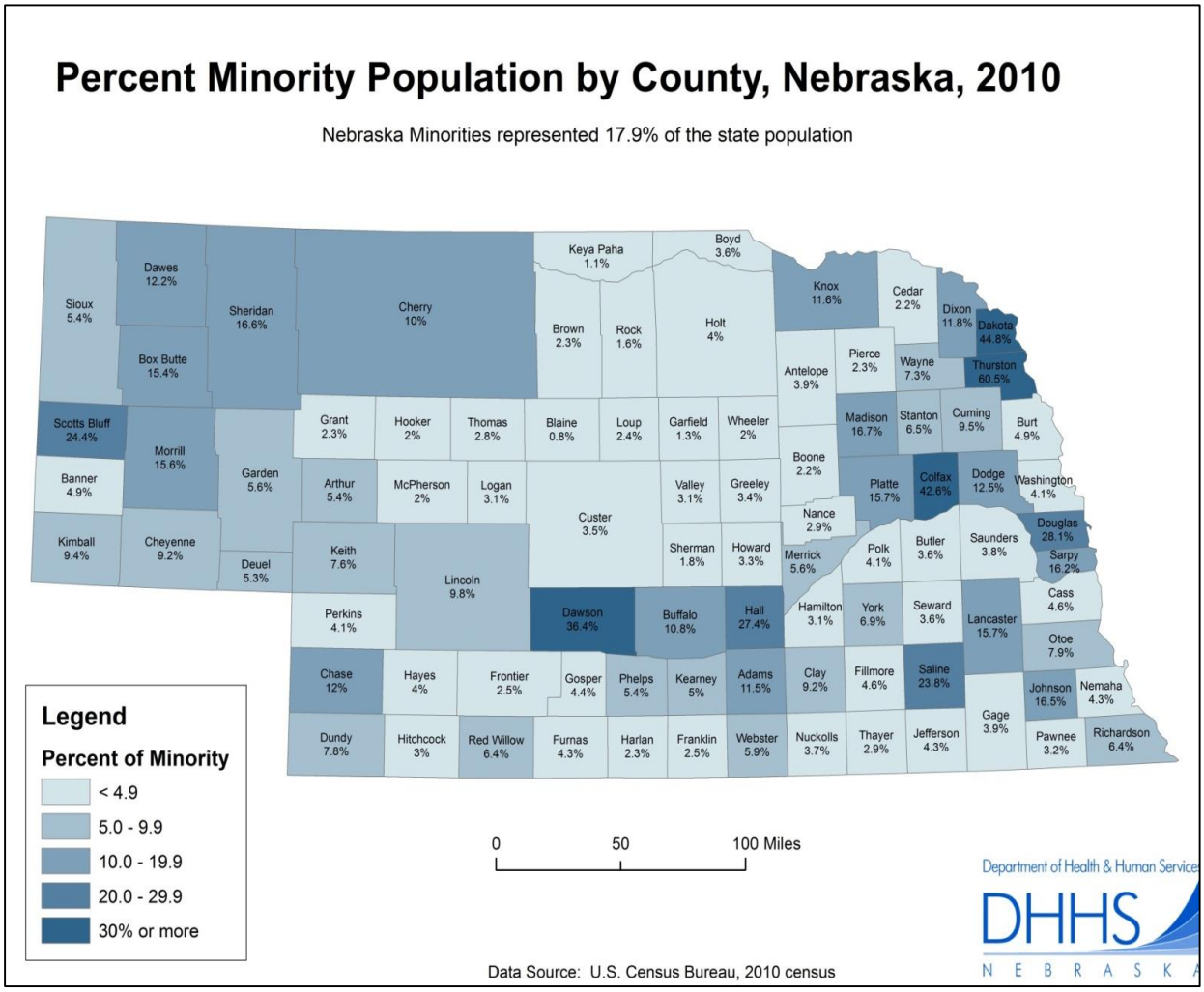
Nebraska's Population: 2014 Estimates

Using the U.S. Census Bureau Population Division's 2014 estimates (which are based on the U.S. 2010 Census), Nebraska's population consists of slightly more minorities than it did in 2010. As of 2014, it is estimated that Hispanics accounted for 10.2% of the minority population—the largest of the racial and ethnic minority groups. The second highest proportion belonged to African Americans (4.6%), followed by Asians (2.1%). Nebraska's estimated total minority population was 367,117 individuals, or 19.5% of the total Nebraska population (1,881,503).



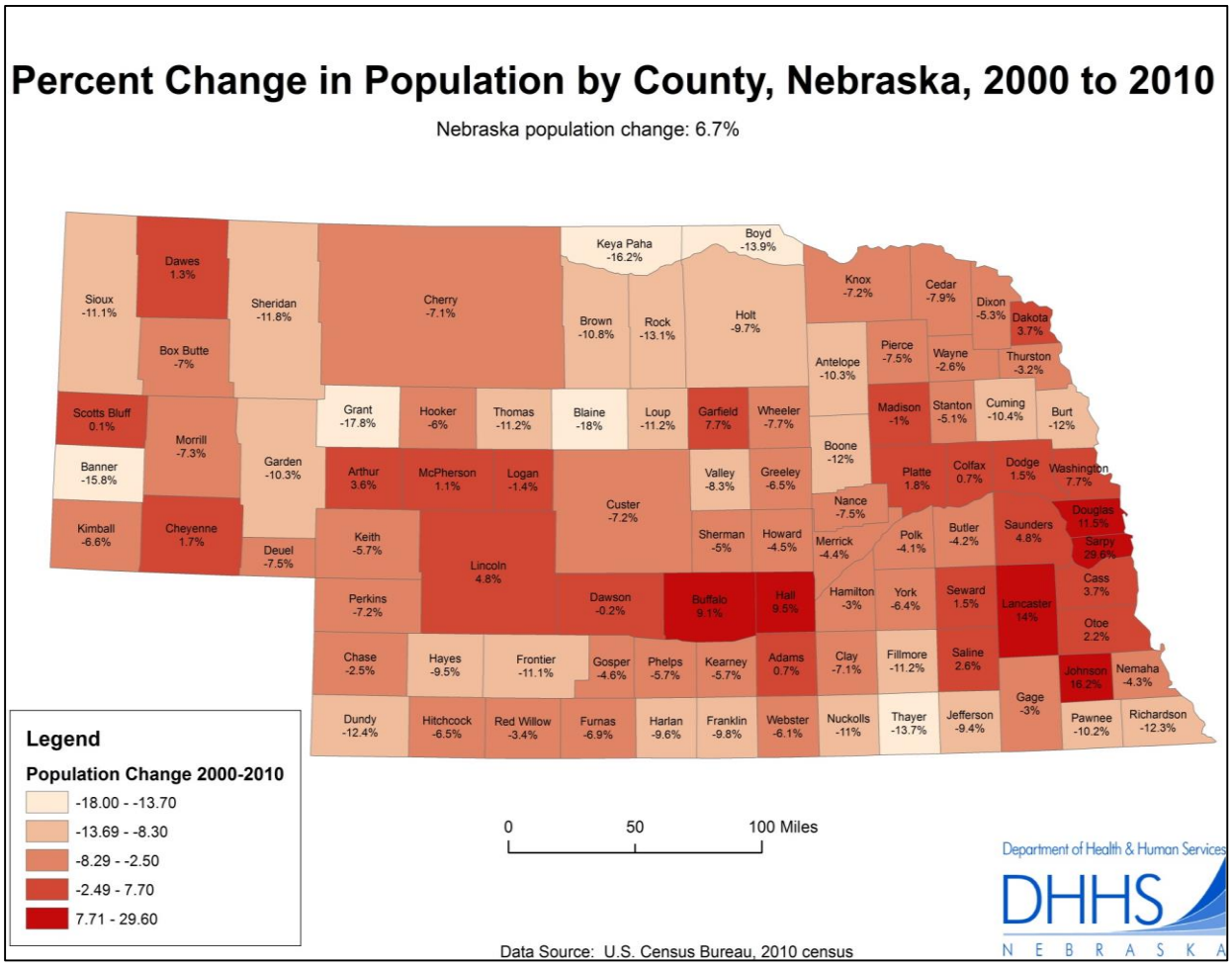
Minority Population Percentages by County of Residence

Racial and ethnic minority populations reside throughout the state. In 2010, of Nebraska's 93 counties, 4 (4.3%) had minority populations that constituted 30% or more of their total population. Forty-five counties had minority populations accounting for 5% or more of the total population, an increase from 38 counties in 2007. Thurston, Dakota, and Colfax counties had a minority population larger than 40% of the total population.



Population by County of Residence: Percent Change

Between 2000 and 2010, Sarpy County experienced the largest population change with a 29.6% increase. Johnson, Lancaster, and Douglas counties also saw double digit increases (16.2%, 14.0%, and 11.5%, respectively). Twenty-two other counties saw population growth, while the rest of the state's counties saw population reduction. Banner, Grant, Blaine, and Keya Paha counties all saw a 15.8% or greater reduction in their population size.



African American Population Distribution

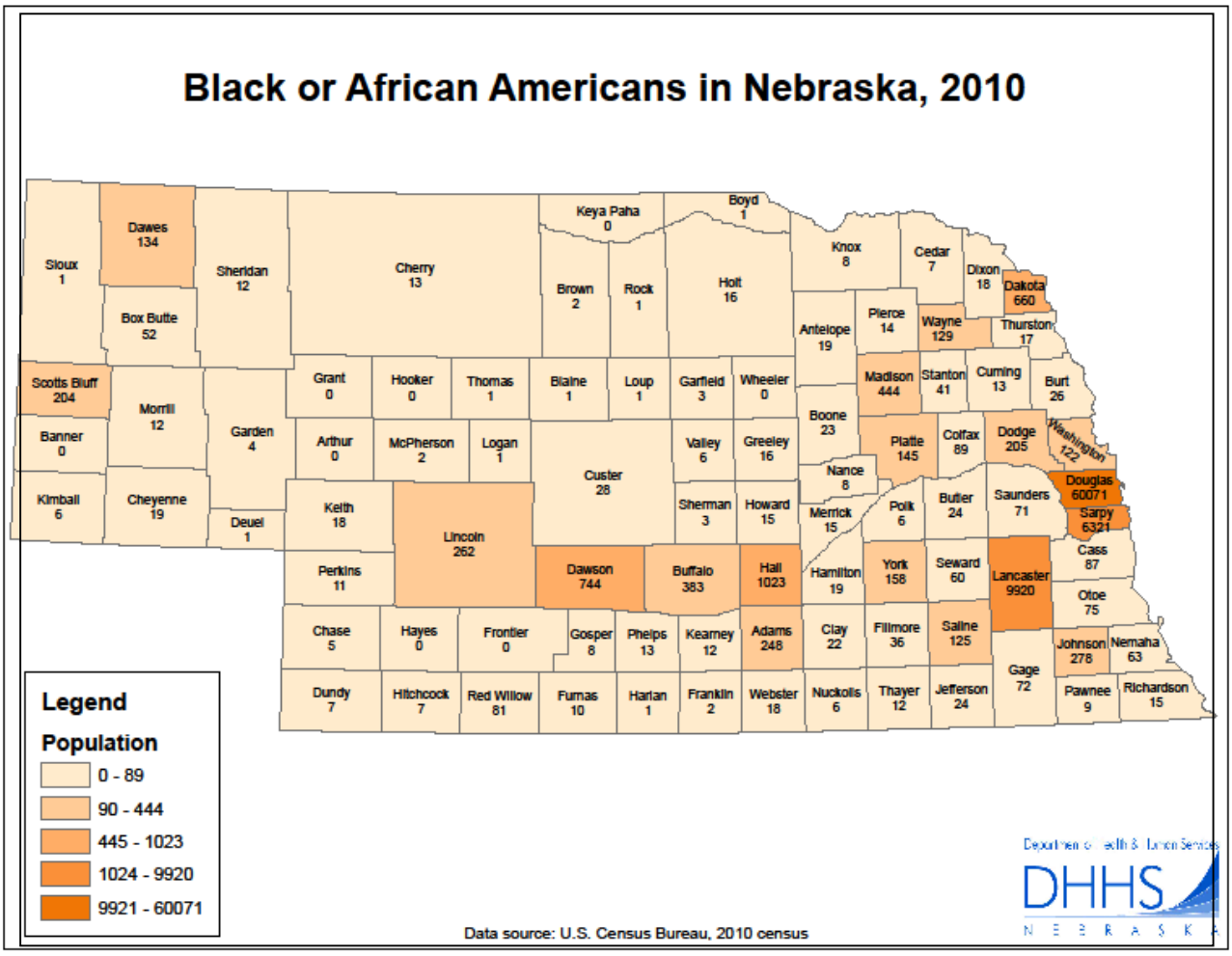
According to the U.S. Census, there were 82,885 African Americans in Nebraska in 2010. This number represented approximately 4.5% of the total Nebraska population. Nearly 5.4% of the total Nebraska population was African American alone or in combination.

Race & Ethnicity	Number	Percent
Total Nebraska population	1,826,341	
One Race		
Black or African American	82,885	4.5
Two or More Races		
Black or African American; White	11,225	0.6
Black or African American; American Indian and Alaska Native	1,317	0.1
Black or African American; Asian	442	0.0
Black or African American; Native Hawaiian and Other Pacific Islander	106	0.0
Black or African American; Some Other Race	1,033	0.1
Black or African American alone or in combination*	98,959	5.4
Black or African American alone	82,885	4.5
Black or African American in combination	16,074	0.9
HISPANIC OR LATINO		
African American, Hispanic or Latino	3770	0.2
African American, Not Hispanic or Latino	80,959	4.4

Source: U.S. Census Bureau, 2010 Census
Notes: *The race concept alone or in combination includes people who reported a single race alone and people who reported that race in combination with one or more of the other race groups. The "alone or in combination" concept, therefore, represents the maximum number of people who reported as that race group, either alone or in combination with another race(s). The sum of the six individual race "alone or in combination" categories may add to more than the total population because people who reported more than one race were tallied in each race category.

African American Populations by County of Residence

In 2010, Douglas County recorded 60,071 African Americans in their population; Lancaster County counted 9,920 African Americans. This was followed by Sarpy County, where 6,321 African Americans live. Approximately 41% of Douglas County's minority population was African American. Hall County recorded 1,023 African Americans in their population; other counties like Dawson (744) and Dakota (660) saw African American populations larger than 600.



Asian Population Distribution

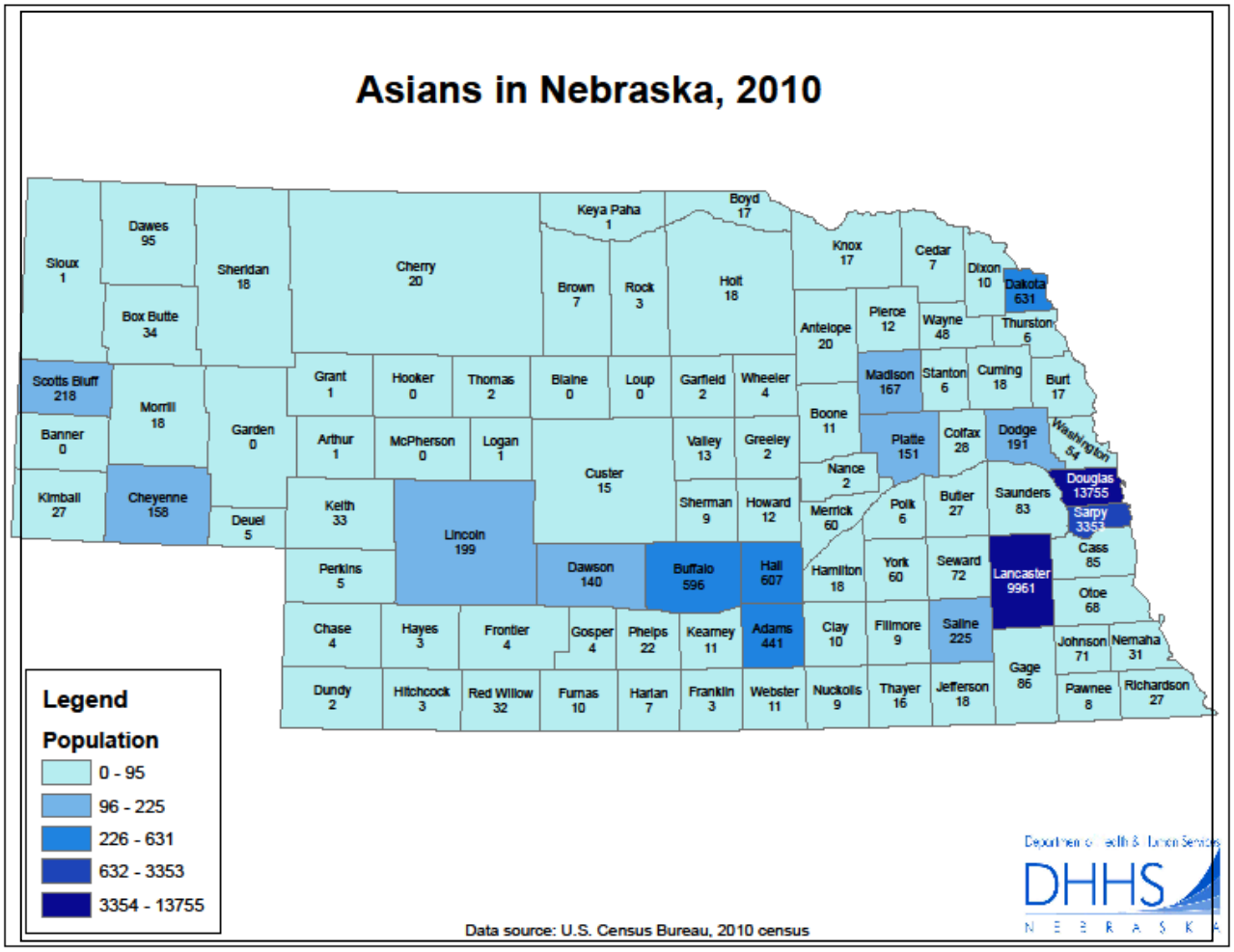
According to the U.S. Census Bureau, there were 32,293 Asians in Nebraska in 2010. This number represented approximately 1.8% of the total Nebraska population.

Race & Ethnicity	Number	Percent
Total Nebraska population	1,826,341	
One Race		
Asian	32,293	1.8
Two or More Races		
Asian; White	6,108	0.3
Asian; Black or African American	442	0.0
Asian; American Indians and Alaska Native	157	0.0
Asian; Native Hawaiian and Other Pacific Islander	245	0.0
Asian; Some Other Race	413	0.0
Asian alone or in combination*	40,615	2.2
Asian alone	32,293	1.8
Asian in combination	8,322	0.5
HISPANIC OR LATINO		
Asian alone, Hispanic or Latino	374	0.0
Asian alone, Not Hispanic or Latino	31,919	1.7

Source: U.S. Census Bureau, 2010 Census
Notes: *The race concept alone or in combination includes people who reported a single race alone and people who reported that race in combination with one or more of the other race groups. The "alone or in combination" concept, therefore, represents the maximum number of people who reported as that race group, either alone or in combination with another race(s). The sum of the six individual race "alone or in combination" categories may add to more than the total population because people who reported more than one race were tallied in each race category.

Asian Populations by County of Residence

In 2010, Lancaster County saw a very comparable population count for Asians (9,961) and African Americans (9,920). Douglas County still had the largest Asian population at 13,755. Ranking third, Sarpy County recorded their Asian population at 3,353. Buffalo (596), Hall (607), and Dakota (631) had Asian populations over 500.



American Indian Population Distribution

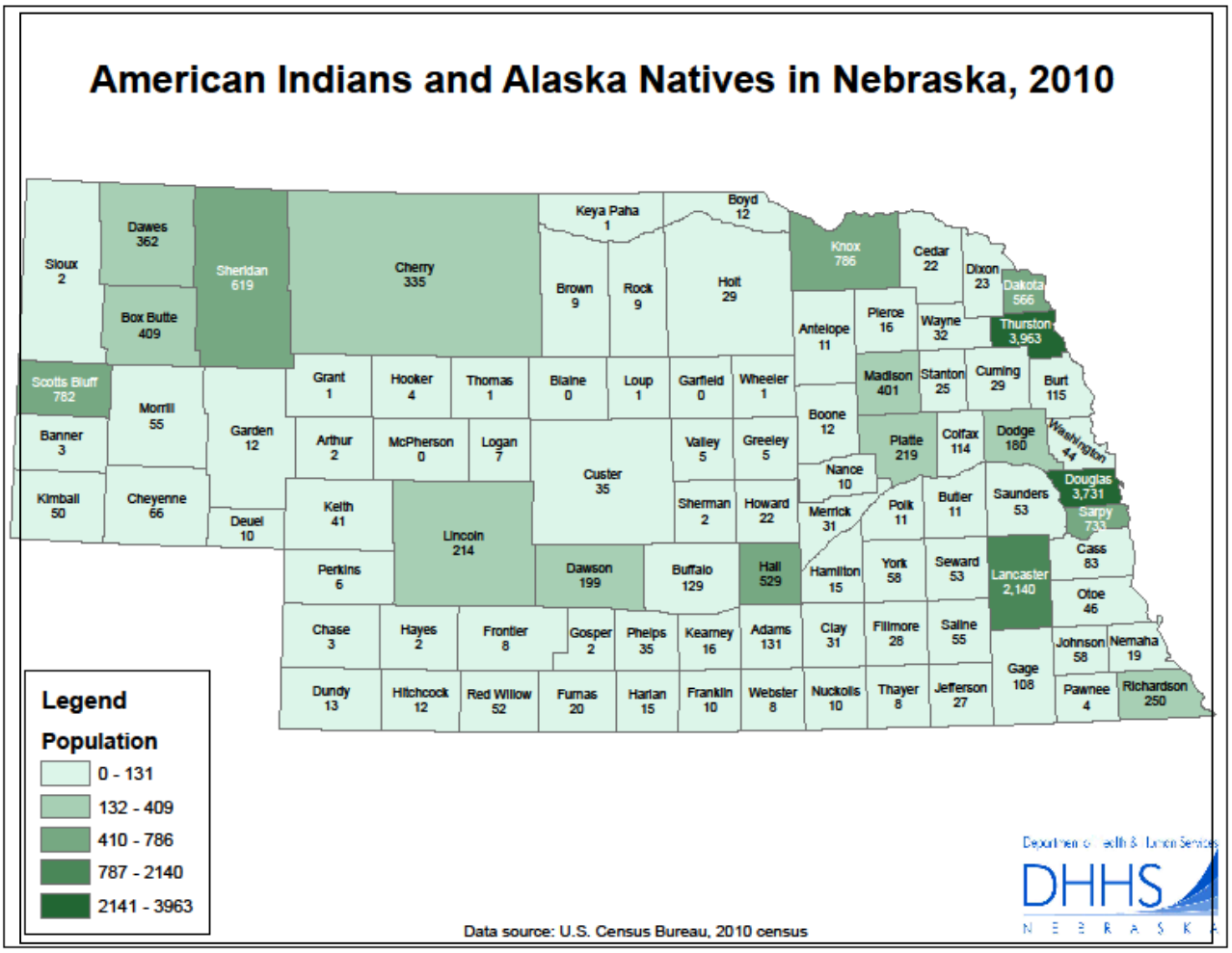
According to the U.S. Census, there were 18,427 American Indians in Nebraska in 2010. This number represented approximately 1.0% of the total Nebraska population. Nearly 1.6% of the total Nebraska population was American Indian alone or in combination.

Race & Ethnicity	Number	Percent
Total Nebraska population	1,826,341	
One Race		
American Indian and Alaska Native	18,427	1.0
Two or More Races		
American Indian and Alaska Native ;White	7,587	0.4
American Indian and Alaska Native; Black or African American	1,317	0.1
American Indian and Alaska Native; Asian	157	0.0
American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander	37	0.0
American Indian and Alaska Native; Some Other Race	536	0.0
American Indian and Alaska Native alone or in combination*	29,816	1.6
American Indian and Alaska Native alone	18,427	1.0
American Indian and Alaska Native in combination	11,389	0.6
HISPANIC OR LATINO		
American Indian and Alaska Native alone, Hispanic or Latino	3,630	0.2
American Indian and Alaska Native alone, Not Hispanic or Latino	14,797	0.8

Source: U.S. Census Bureau, 2010 Census
Notes: *The race concept alone or in combination includes people who reported a single race alone and people who reported that race in combination with one or more of the other race groups. The “alone or in combination” concept, therefore, represents the maximum number of people who reported as that race group, either alone or in combination with another race(s). The sum of the six individual race “alone or in combination” categories may add to more than the total population because people who reported more than one race were tallied in each race category.

American Indian and Alaska Native Populations by County of Residence

In 2010, Thurston County recorded the largest number of American Indian and Alaska Native (AI/AN) residents at 3,963 people, or 94% of their entire minority population. Knox County also recorded almost 78% of their minority population as American Indian and Alaska Native. American Indian/Alaska Native accounted for almost half of the minority population in Richardson County. Other counties like Cherry (58%) and Sheridan (68%) saw AI/ANs accounting for more than half of their minority populations.



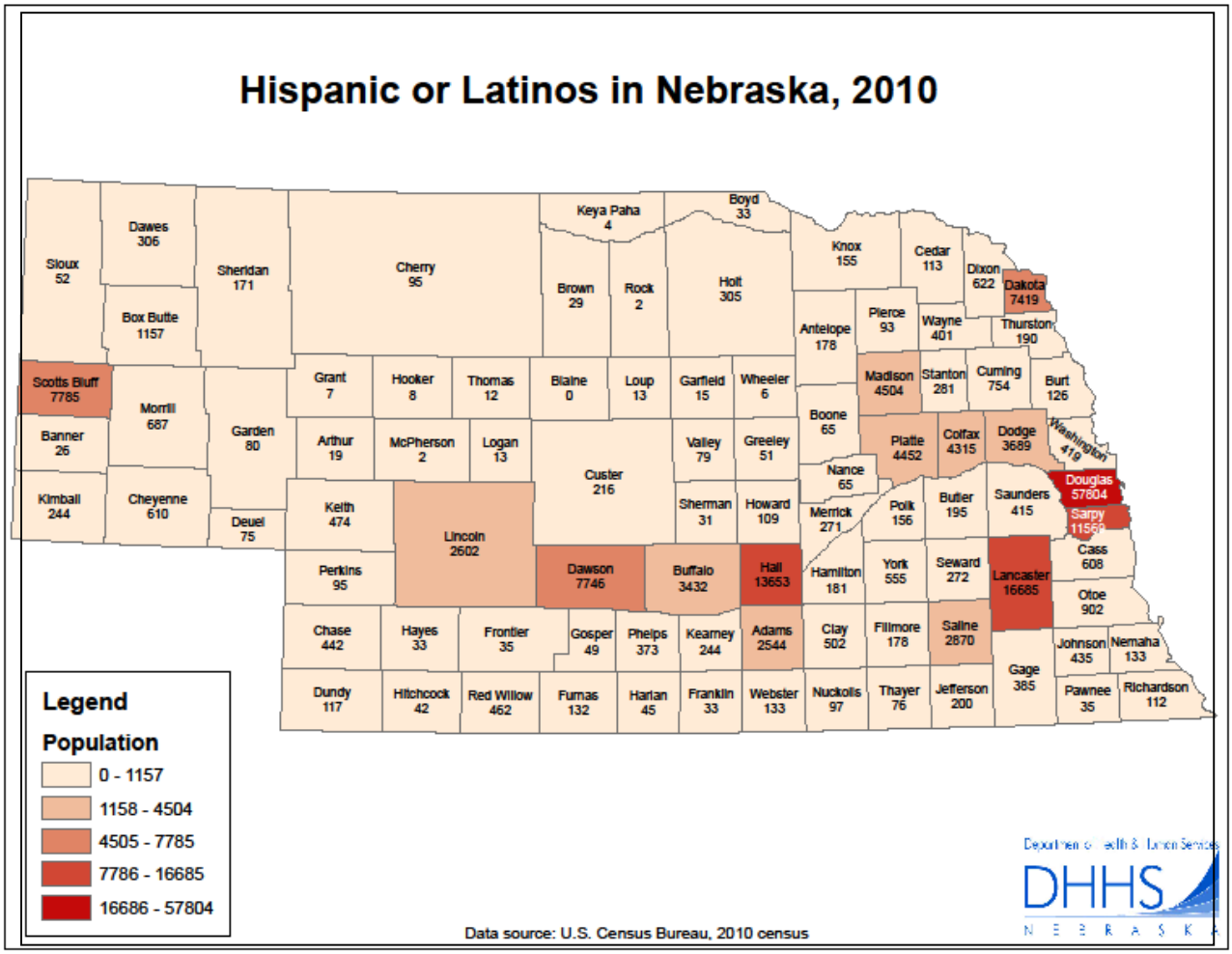
Hispanic Population Distribution

According to the 2010 U.S. Census, there were 167,405 Hispanics in Nebraska. This number represented approximately 9.2% of the total Nebraska population.

Race & Ethnicity	Number	Percent
Total Nebraska population	1,826,341	
Hispanic or Latino (of any race)	167,405	9.2
Not Hispanic or Latino	1,658,936	90.8
Hispanic or Latino By Type		
Hispanic or Latino (of any race)	167,405	9.2
Mexican	128,060	7.0
Puerto Rican	3,242	0.2
Cuban	2,152	0.1
Dominican (Dominican Republic)	358	0.0
Central American (excludes Mexican)	17,242	0.9
Costa Rican	166	0.0
Guatemalan	8,616	0.5
Honduran	1,547	0.1
Nicaraguan	347	0.0
Panamanian	398	0.0
Salvadoran	6,016	0.3
Other Central American	152	0.0
South American	2,824	0.2
Argentinean	243	0.0
Bolivian	86	0.0
Chilean	228	0.0
Colombian	974	0.1
Ecuadorian	233	0.0
Paraguayan	38	0.0
Peruvian	628	0.0
Uruguayan	24	0.0
Venezuelan	319	0.0
Other South American	51	0.0
Other Hispanic or Latino	13,527	0.7
Spaniard	1,644	0.1
Spanish	1,373	0.1
Spanish American	63	0.0
All other Hispanic or Latino	10,447	0.6

Hispanic Populations by County of Residence

In 2010, 57,804 of Douglas County's 145,081 racial and ethnic minority population were Hispanic. Lancaster County saw the next largest Hispanic population at 16,685. Other counties had smaller Hispanic populations overall, but compared to their total minority population the Hispanic population was large. Saline County, with a minority population of 3,383 had 2,870 or 85% Hispanic individuals. Eighty-five percent of Scotts Bluff County's minority population was Hispanic; large Hispanic-proportions could also be seen in Dawson (87%), Platte, (88%), and Colfax (96%) Counties.



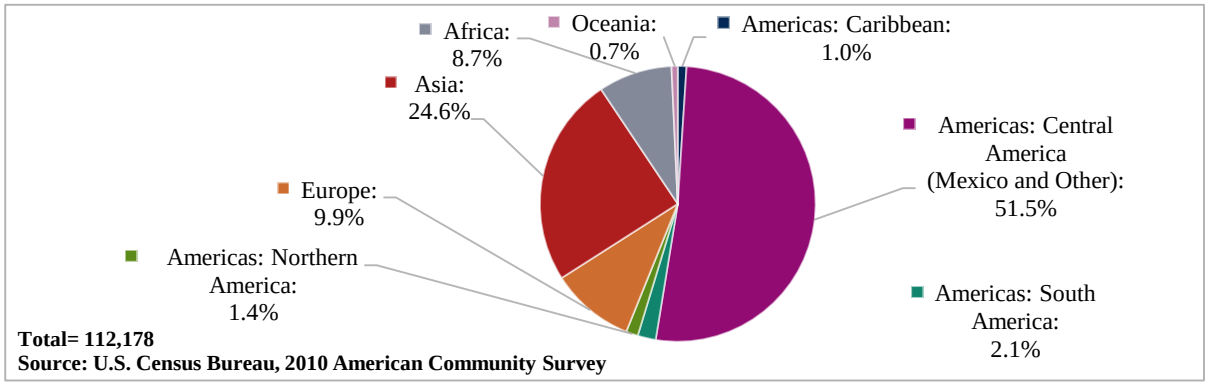
Foreign-Born Population

The foreign-born population, individuals not U.S. citizens at birth, is classified by citizenship status: those who have become U.S. citizens through naturalization and those who are not U.S. citizens. Natives, as defined by the Census Bureau, were born in the United States, in the U.S. Island areas such as Puerto Rico, or were born in a foreign country to at least one parent who was a United States citizen. The foreign-born population includes immigrants, legal nonimmigrants (e.g., refugees and persons on student or work visas), and persons illegally residing in the United States.[11]

In recent years, immigrants from Latin America and Asia have significantly outnumbered immigrants from Europe, a predominant immigrant population in the past. In 1980, Mexico became the leading country of birth of the foreign-born population. Along with changing patterns in country of origin, settlement patterns are also changing. Prior to 1980 the United States primarily saw immigration from Ireland (1850-1970), Germany (1880-1920), and Italy (1930-1970), settling in major urban areas in California, New York, Florida, and Texas.[12] In addition to these areas, new immigrants are now relocating in record numbers to non-traditional immigrant-receiving communities in Nebraska, Arizona, and Arkansas.[13]

In 2010, 6.1% (112,178) of Nebraska's total population was foreign-born; and of those, over half of the population was indigenous to Latin America (the Caribbean, Central America, and South America) and about one-fourth were born in Asia. Most of Nebraska's foreign-born populations are very recent entrants to the United States. Two-thirds of the foreign-born in Nebraska arrived in the United States after 1990, with almost one-third coming in only six years (2000-2006).

Place of Birth for Nebraska's Foreign-Born Population, 2010



[11]Schmidley, A. D. (2001). U.S. Census Bureau. *Profile of the Foreign-Born Population in the United States: 2000*. U.S. Government Printing Office, Washington, DC.
[12]Ibid.
[13]Singer, A. (2004). Center on Urban and Metropolitan Policy. *The rise of new immigrant gateways*. The Brookings Institution. p. 5.

Foreign-Born Population Change

Compared to the rest of the United States, Nebraska ranked eighth in the nation for percent-change in the foreign-born population between 1990 and 2010. Specifically, the number of foreign-born persons living in Nebraska rose by 297.8% (three times the national rate of 102%) between 1990 and 2010, an increase from 28,198 to 112,178 residents. North Carolina ranked number 1 with a 524.9% increase and 719,137 foreign-born residents in 2010 while Indiana came in 15th with a 219.1% increase and 300,789 residents.

State Rank by Change in Foreign Born Population 1990 2010					
STATE	**1990**	**2000**	**2010**	**PERCENT CHANGE 1990-2010**	**RANK 1990-2010**
North Carolina	115,077	430,000	719,137	524.9	1
Georgia	173,126	577,273	942,959	444.7	2
Arkansas	24,867	73,690	131,667	429.5	3
Tennessee	59,114	159,004	288,993	388.9	4
Nevada	104,828	316,593	508,458	385.0	5
South Carolina	49,964	115,978	218,494	337.3	6
Kentucky	34,119	80,271	140,583	312.0	7
Nebraska	**28,198**	**74,638**	**112,178**	**297.8**	**8**
Alabama	43,533	87,772	168,596	287.3	9
Utah	58,600	158,664	222,638	279.9	10
Colorado	142,434	369,903	497,105	249.0	11
Minnesota	113,039	260,463	378,483	234.8	12
Delaware	22,275	44,898	71,868	222.6	13
Iowa	43,316	91,085	139,477	222.0	14
Indiana	94,263	186,534	300,789	219.1	15
United States	19,767,316	31,107,889	39,955,854	102.1	

Source: U.S. Census Bureau, 1990 and 2000 Census; 2010 American Community Survey

Languages Spoken in Nebraska

Language(s)	Country of Origin	Language(s)	Country of Origin
Afrikaans/IsiZulu/IsiXhosa	South African	Nepalese/Nepali/Maithali	Nepal
Albanian/Shiquip	Albania	Pashto/Pashtu	Pakistan and Afghanistan
Amharic/Ethiopian	Ethiopia	Polish	Poland
Arabic/Egyptian/Lebanese/Syrian	African and Middle East	Portuguese	Portugal, Brazil, and Mozambique
Armenian/Haieren	Armenia	Quechua/Aymara	Peru
Bengali/Bangla	Bangladesh	Romanian/Moldavian	Romania and Moldavia
Bosnian/Croatian/Serbian	Bosnia, Croatia, and Serbia	Russian	Russia and the former Soviet Union
Burmese/Karen/Shan	Myanmar (Burma)	Samoan	Samoa
Cambodian/Khmer	Cambodia	Setowana	Botswana
Creole	Haiti	Sinhala	Sri Lanka
Czech	Czechoslovakia (the Czech Republic)	Slovak	Slovakia
Dinka/Fur/Nuba/Nuer	Sudan	Somali	Somalia
Dutch	Netherlands and Belgium	Spanish	Spain, North-Central-South Americas, Islands of the Caribbean
English	*Most Countries*	Sqahili	Uganda
Farsi/Persian/Dari	Iran and Afghanistan	Swedish	Sweden
Filipino/Tagalog	Philippines	Tajik	Tajikistan
French	France and African	Thai/Tai/Thaiklang	Thailand
German	Germany	Tongan	Tonga
Greek	Greece	Turkish	Turkey
Hindi/Gujarati/Telugu/Hakha-Chin/Marathi	India	Ukrainian	Ukraine
Hmong	Laos and Thailand	Urdu	Pakistan
Indonesian	Indonesia	Vietnamese/BaRia	Viet Nam
Italian	Italy	Zagawa	Chad
Japanese	Japan		
Kanjobal	Guatemala		
Kirundi	Burundi, Rwanda, and Tanzania		
Korean	Korea		
Kurdish/Zimany/Kurdy	Iraq and Kurdistan		
Lao/Laotian	Laos		
Latvian	Latvia		
Lingala	Democratic Republic of Congo		
Lorma	Liberia		
Malay/Bahasa/Malaysian	Malaysia		
Mandarin/Cantonese/Taiwanese	China, Hong Kong, and Taiwan		
Mongolian	Mongolia		
Native American			
Omaha-Ponca	Omaha and Ponca		
Dakota/Lakota	Santee Sioux		
Ho-chunk	Winnebago		
Algonquin	Sac and Fox		
Chiwere	Iowa		
Others	…Tribes of Nebraska		

Resources: Nebraska Department of Education, Languages 2005 / Sarpy County, NE – Languages for CDC 2007 / Native Languages of the Americas website 1998-2009 – Retrieved 09.21.10 / Lincoln Public Schools – ELL Program Count for 2010-2011 / Asian Community and Cultural Center-Fusion Project, Lincoln, NE – Contacted 06.04.10 / UNL International Student and Scholar Statistical Data Spring 2011 / Nebraska is Home website 2008 – Retrieved 02.28.11/ Compiled by DHHS Office of Health Disparities and Health Equity

Languages Spoken in Nebraska: Population Proportions

Ninety percent of the Nebraska population speaks only English. Spanish was the most common language outside of English spoken in the homes of Nebraskans. There were 115,547 (6.8%) Nebraskans who speak Spanish at home; compared to 37.6% of the United States population.

LANGUAGE SPOKEN AT HOME	Nebraska (residents 5 years and older)	
	Estimate	Percent
Nebraska Total:	1,697,746	
Speak only English	1,523,316	89.73
Spanish or Spanish Creole:	115,547	6.81
French (incl. Patois, Cajun):	4,758	0.28
French Creole:	184	0.01
Italian:	1,480	0.09
Portuguese or Portuguese Creole:	652	0.04
German:	6,066	0.36
Yiddish:	136	0.01
Other West Germanic languages:	586	0.03
Scandinavian languages:	448	0.03
Greek:	321	0.02
Russian:	1,319	0.08
Polish:	1,006	0.06
Serbo-Croatian:	500	0.03
Other Slavic languages:	2,781	0.16
Armenian:	10	0.00
Persian:	848	0.05
Gujarati:	180	0.01
Hindi:	1,523	0.09
Urdu:	538	0.03
Other Indic languages:	1,268	0.07
Other Indo-European languages:	1,629	0.10
Chinese:	3,640	0.21
Japanese:	938	0.06
Korean:	1,046	0.06
Mon-Khmer, Cambodian:	132	0.01
Hmong:	60	0.00
Thai:	715	0.04
Laotian:	515	0.03
Vietnamese:	7,007	0.41
Other Asian languages:	4,785	0.28
Tagalog:	1,874	0.11
Other Pacific Island languages:	715	0.04
Navajo:	4	0.00
Other Native North American languages:	1,518	0.09
Hungarian:	39	0.00
Arabic:	3,616	0.21
Hebrew:	108	0.01
African languages:	5,691	0.34
Other and unspecified languages:	247	0.01
Source: U.S. Census Bureau, 2009-2011 American Community Survey		

Languages Spoken in Nebraska by Ability to Speak English

LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH	Nebraska (residents 5 years and older)	
	Estimate	Percent
Nebraska Total:	1,697,746	
Speak only English	1,523,316	89.73
Spanish or Spanish Creole:	115,547	6.81
Speak English "very well"	58,762	3.46
Speak English less than "very well"	56,785	3.34
French (incl. Patois, Cajun):	4,758	0.28
Speak English "very well"	3,396	0.20
Speak English less than "very well"	1,362	0.08
French Creole:	184	0.01
Speak English "very well"	163	0.01
Speak English less than "very well"	21	0.00
Italian:	1,480	0.09
Speak English "very well"	1,185	0.07
Speak English less than "very well"	295	0.02
Portuguese or Portuguese Creole:	652	0.04
Speak English "very well"	525	0.03
Speak English less than "very well"	127	0.01
German:	6,066	0.36
Speak English "very well"	5,416	0.32
Speak English less than "very well"	650	0.04
Yiddish:	136	0.01
Speak English "very well"	94	0.01
Speak English less than "very well"	42	0.00
Other West Germanic languages:	586	0.03
Speak English "very well"	517	0.03
Speak English less than "very well"	69	0.00
Scandinavian languages:	448	0.03
Speak English "very well"	374	0.02
Speak English less than "very well"	74	0.00
Greek:	321	0.02
Speak English "very well"	256	0.02
Speak English less than "very well"	65	0.00
Russian:	1,319	0.08
Speak English "very well"	788	0.05
Speak English less than "very well"	531	0.03
Polish:	1,006	0.06
Speak English "very well"	765	0.05
Speak English less than "very well"	241	0.01
Serbo-Croatian:	500	0.03
Speak English "very well"	298	0.02
Speak English less than "very well"	202	0.01
Other Slavic languages:	2,781	0.16
Speak English "very well"	2,259	0.13
Speak English less than "very well"	522	0.03

Source: U.S. Census Bureau, 2009-2011 American Community Survey

Languages Spoken in Nebraska by Ability to Speak English (Cont.)

LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH	Nebraska (residents 5 years and older)	
	Estimate	Percent
Armenian:	10	0.00
Speak English "very well"	10	0.00
Speak English less than "very well"	0	0.00
Persian:	848	0.05
Speak English "very well"	287	0.02
Speak English less than "very well"	561	0.03
Gujarati:	180	0.01
Speak English "very well"	77	0.00
Speak English less than "very well"	103	0.01
Hindi:	1,523	0.09
Speak English "very well"	1,391	0.08
Speak English less than "very well"	132	0.01
Urdu:	538	0.03
Speak English "very well"	301	0.02
Speak English less than "very well"	237	0.01
Other Indic languages:	1,268	0.07
Speak English "very well"	808	0.05
Speak English less than "very well"	460	0.03
Other Indo-European languages:	1,629	0.10
Speak English "very well"	1,189	0.07
Speak English less than "very well"	440	0.03
Chinese:	3,640	0.21
Speak English "very well"	1,481	0.09
Speak English less than "very well"	2,159	0.13
Japanese:	938	0.06
Speak English "very well"	567	0.03
Speak English less than "very well"	371	0.02
Korean:	1,046	0.06
Speak English "very well"	596	0.04
Speak English less than "very well"	450	0.03
Mon-Khmer, Cambodian:	132	0.01
Speak English "very well"	58	0.00
Speak English less than "very well"	74	0.00
Hmong:	60	0.00
Speak English "very well"	44	0.00
Speak English less than "very well"	16	0.00
Thai:	715	0.04
Speak English "very well"	334	0.02
Speak English less than "very well"	381	0.02
Laotian:	515	0.03
Speak English "very well"	164	0.01
Speak English less than "very well"	351	0.02

Source: U.S. Census Bureau, 2009-2011 American Community Survey

Languages Spoken in Nebraska by Ability to Speak English (Cont.)

LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH	Nebraska (residents 5 years and older)	
	Estimate	Percent
Vietnamese:	7,007	0.41
Speak English "very well"	2,552	0.15
Speak English less than "very well"	4,455	0.26
Other Asian languages:	4,785	0.28
Speak English "very well"	2,441	0.14
Speak English less than "very well"	2,344	0.14
Tagalog:	1,874	0.11
Speak English "very well"	1,584	0.09
Speak English less than "very well"	290	0.02
Other Pacific Island languages:	715	0.04
Speak English "very well"	566	0.03
Speak English less than "very well"	149	0.01
Navajo:	4	0.00
Speak English "very well"	4	0.00
Speak English less than "very well"	0	0.00
Other Native North American languages:	1,518	0.09
Speak English "very well"	1,286	0.08
Speak English less than "very well"	232	0.01
Hungarian:	39	0.00
Speak English "very well"	15	0.00
Speak English less than "very well"	24	0.00
Arabic:	3,616	0.21
Speak English "very well"	1,674	0.10
Speak English less than "very well"	1,942	0.11
Hebrew:	108	0.01
Speak English "very well"	104	0.01
Speak English less than "very well"	4	0.00
African languages:	5,691	0.34
Speak English "very well"	2,917	0.17
Speak English less than "very well"	2,774	0.16
Other and unspecified languages:	247	0.01
Speak English "very well"	132	0.01
Speak English less than "very well"	115	0.01

Source: U.S0 Census Bureau, 2009-2011 American Community Survey

Language Spoken at Home by Ability to Speak English and by Age Group

Almost 55% of the population 5 years and older and 69% of those 18 years and older who speak a language other than English speak English 'very well.' Approximately 50% of those who speak Spanish, any Asian or Pacific Island language, or other languages can also speak English 'very well.' Almost 77% of those who speak other Indo-European languages can speak English 'very well.' Approximately 75% of those who were 5-17 years old who speak Spanish can speak English 'very well.' Only 58% of those 5-17 year olds who speak an Asian or Pacific Island language can speak English 'very well.'

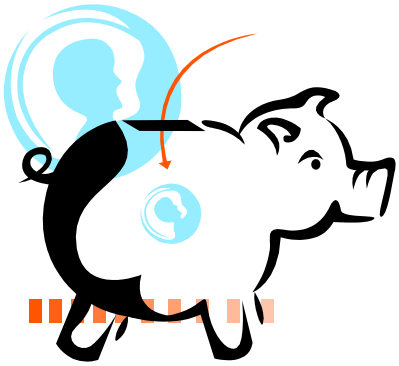
LANGUAGE SPOKEN AT HOME			
	Nebraska total	Percent of specified language speakers	
		Speak English very well	Speak English less than very well
	Estimate	Estimate	Estimate
Population 5 years and over	1,697,746	95.3	4.7
Speak only English	89.7%	(X)	(X)
Speak a language other than English	10.3%	54.7	45.3
Spanish or Spanish Creole	6.8%	50.9	49.1
Other Indo-European languages	1.5%	76.6	23.4
Asian and Pacific Island languages	1.3%	48.5	51.5
Other languages	0.7%	54.6	45.4
SPEAK A LANGUAGE OTHER THAN ENGLISH			
Spanish or Spanish Creole	115,547	50.9	49.1
5-17 years	32,331	74.7	25.3
18-64 years	79,164	41.4	58.6
65 years and over	4,052	45.0	55.0
Other Indo-European languages	26,233	76.6	23.4
5-17 years	3,939	79.1	20.9
18-64 years	16,769	75.9	24.1
65 years and over	5,525	77.1	22.9
Asian and Pacific Island languages	21,427	48.5	51.5
5-17 years	4,035	58.4	41.6
18-64 years	16,152	47.4	52.6
65 years and over	1,240	30.5	69.5
Other languages	11,223	54.6	45.4
5-17 years	2,968	69.6	30.4
18-64 years	7,743	48.6	51.4
65 years and over	512	59.4	40.6
CITIZENS 18 YEARS AND OVER			
All citizens 18 years and over	1,306,419	98.3	1.7
Speak only English	94.5%	(X)	(X)
Speak a language other than English	5.5%	69.3	30.7
Spanish or Spanish Creole	3.3%	67.1	32.9
Other languages	2.2%	72.5	27.5

Sources: U.S. Census Bureau, 2009-2011 American Community Survey

Counties With Largest Limited English Proficiency (LEP) Population

Nebraska Counties	Total Population (5 years and older)	Total number that speak English less than very well	% that speak English less than very well
Douglas County	466,259	27,598	6%
Lancaster County	259,508	11,574	4.5%
Hall County	52,127	5,689	10.9%
Sarpy County	139,271	4,452	3.2%
Dakota County	18,949	4,222	22.3%
Dawson County	22,268	4,178	18.8%
Madison County	32,114	2,236	7.0%
Colfax County	9,298	2,224	23.9%
Dodge County	34,199	1,783	5.2%
Platte County	29,376	1,653	5.6%
Saline County	13,148	1,305	9.9%
Adams County	28,981	1,177	4.0%
Scotts Bluff County	33,957	1,127	3.3%
Buffalo County	42,190	1,098	2.6%
Lincoln County	33,719	557	1.7%
Cuming County	8,719	479	5.5%
Phelps County	8,717	363	4.2%
York County	13,052	312	2.4%
Dixon County	5,601	301	5.4%
Otoe County	14,644	290	2.0%
Source: U.S. Census Bureau, 2006-2010 American Community Survey			

SOCIOECONOMICS



Socioeconomic status (SES) is a general measure of some combination of education, income, and occupation. Even though the exact relationship between socioeconomic factors and health is not completely understood, there is extensive evidence that one does exist; in fact, lower SES is associated with increased morbidity and mortality.[14] A "wealth-health" connection holds across the entire SES gradient, with the middle class having better health status than the lower class and the upper class having better health status than the middle class.[15] Some researchers even consider SES to be the most important determinant of racial and ethnic health disparities.[16]

The interplay between race and SES is important as well. Racial and ethnic minority populations are far more likely to fall at the low end of the socioeconomic gradient and disproportionately incur the negative consequences associated with those circumstances. When looking at health disparities, it is important to resist the urge to reduce the debate to an either/or choice with race and ethnicity on one hand and SES on the other. There are disparities solely between SES levels as well as disparities created between race and ethnicity. The factors are intertwined but also play distinct, independent roles; sometimes relationships can be seen between level of education and income and other times the less educated populations make more money than the populations with more people graduating.

The U.S. Census Bureau, non-profit foundations, and research institutions, along with numerous government bodies have documented multiple complex linkages between factors unique to racial and ethnic minority populations and the more general measures of SES.

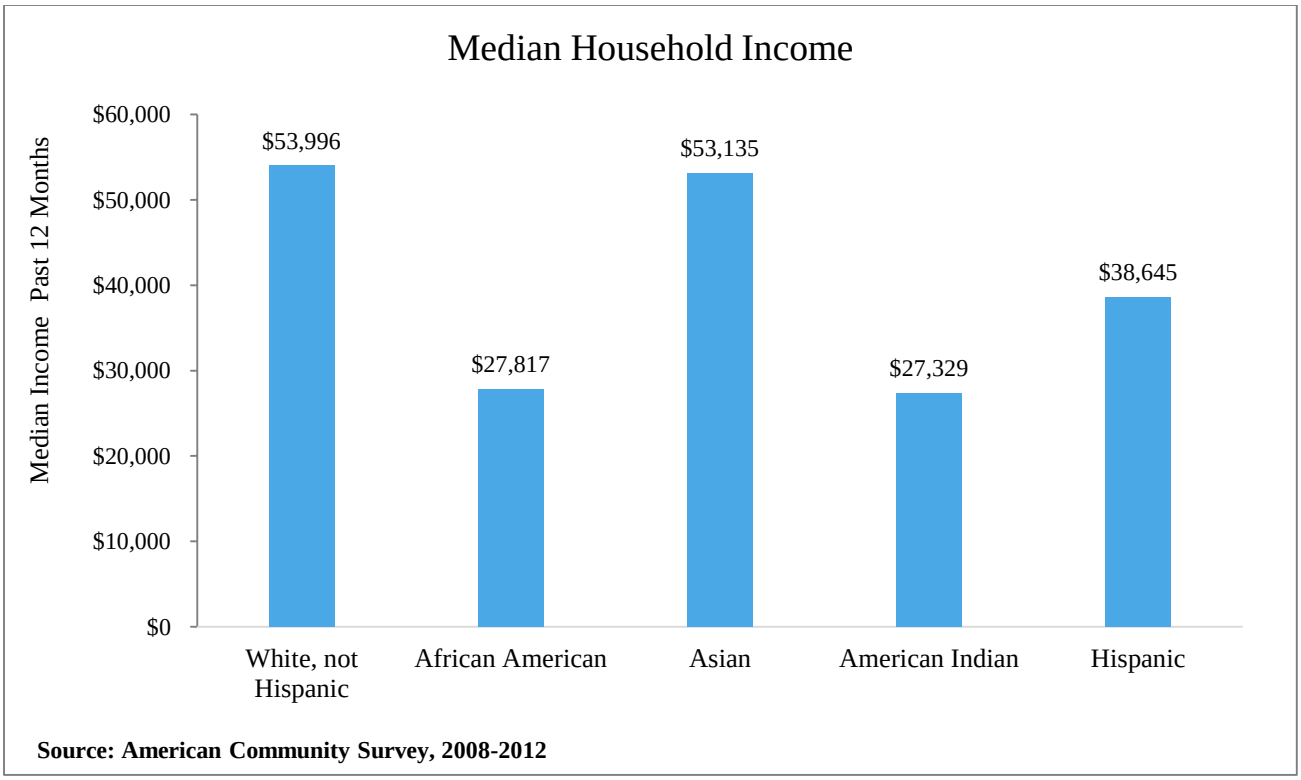
[14]American Psychological Association. (2013). Work, stress, and health and socioeconomic status.
[15]Meyers, K., Kaiser Permanente Institute for Health Policy. "Racial and ethnic health Current Disparities: influences actors and policy opportunities. http://www.kpihp.org/publications/docs/Current Disparities.pdf.
[16]Isaacs, S. and Schroeder, S. (2004). Class: The ignored determinant of the nation's health. *The New England Journal of Medicine*, *35*, 11.

Household Income

In the United States, health is strongly correlated with income regardless of indicator. Whether it be mortality, prevalence of acute or chronic illness, or mental health, poor people are more affected by these problems than their wealthier counterparts.[17] For the purposes of this chart, the median household income in the past 12 months was calculated using 2012 inflation-adjusted dollars. The householder race determined the race as reported below.

Key Disparities

- In Nebraska, the median income of non-Hispanic White households was $53,996, which was higher than any racial or ethnic group, though Asians had a median income that was slightly less ($53,135).
- Hispanics earned more ($38,645) than African Americans ($27,817) and American Indians ($27,329).



Source: American Community Survey, 2008-2012

[17]Institute for Research on Poverty. Health and Poverty. Retrieved from http://www.irp.wisc.edu/research/health.htm

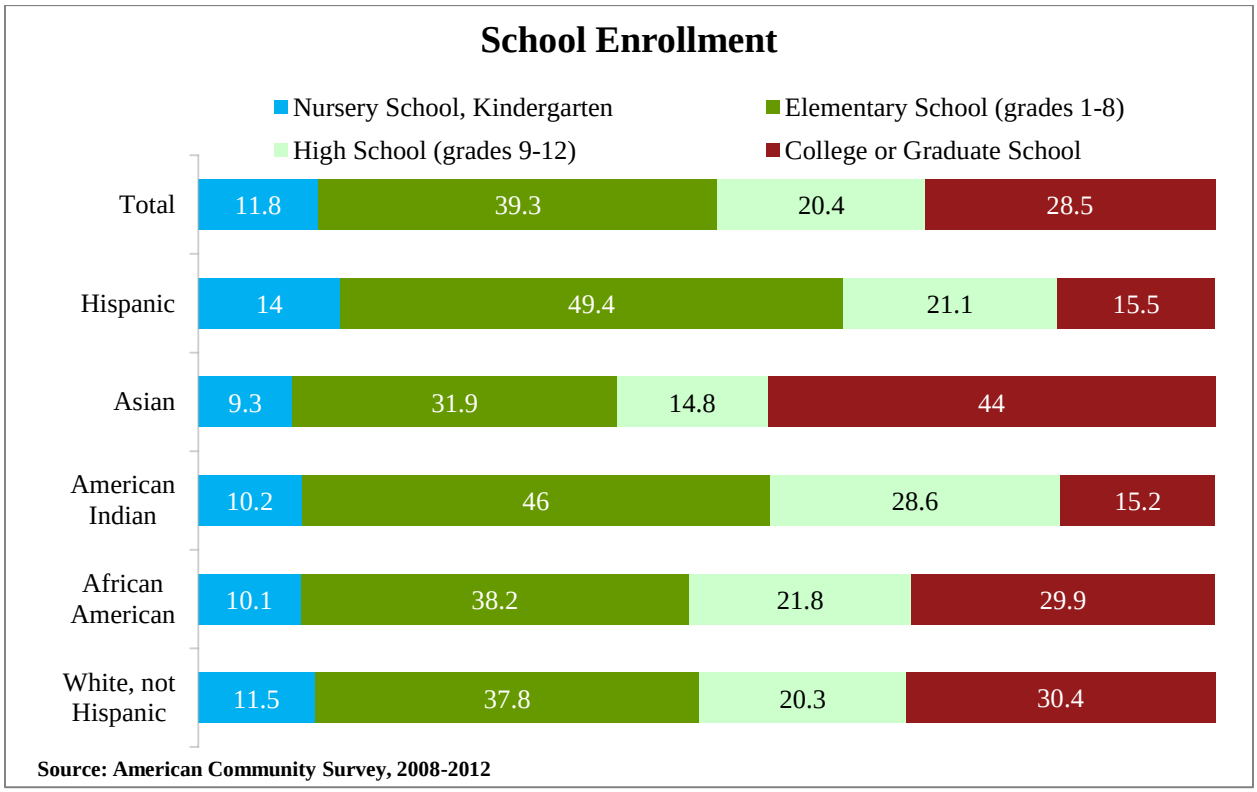
School Enrollment

Due to the younger median age of most minority groups when compared to non-Hispanic Whites in Nebraska, it is important to understand the school enrollment for each racial minority population.

The data below represent the racial and ethnic distributions among those who were enrolled in school, ages 3 and up. For example, of the Hispanic individuals who were enrolled in school, 14% of them were in nursery school or kindergarten.

Key Disparities

- Similar proportions of each minority group were enrolled in nursery school and kindergarten, though Hispanics had a slightly higher percentage (14%).
- Among minority groups, Asian Americans had the largest proportion of population enrolled in college or graduate school (44%), while American Indians (15.2%) and Hispanics (15.5%) had the lowest, compared to non-Hispanics Whites (30.4%).
- All other minority populations had higher population percentages enrolled in elementary school and high school (except Asians), compared to non-Hispanic Whites (37.8% and 20.3%, respectively).



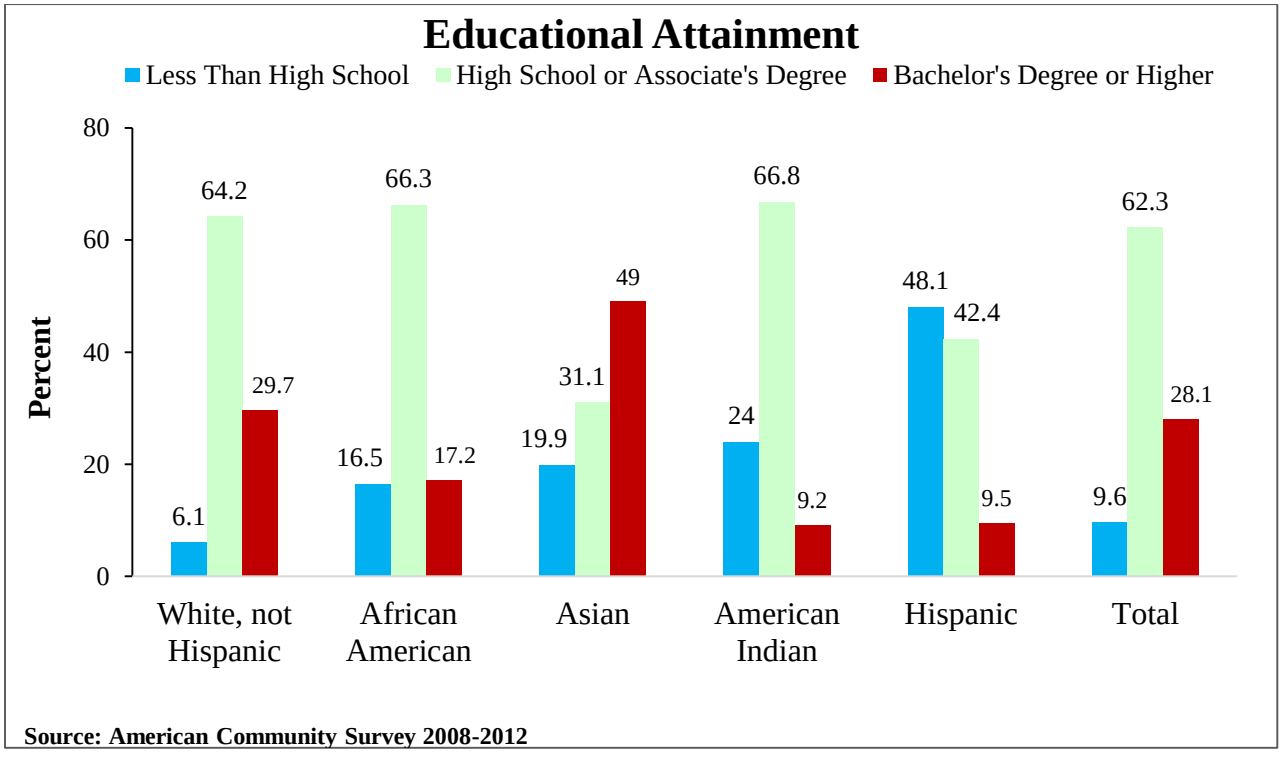
Source: American Community Survey, 2008-2012

Educational Attainment

Education is strongly associated with health. Those with less education are often less healthy than those with a higher education. Individuals who are more highly educated have lower morbidity rates from common diseases and life expectancy is higher for those people with a higher education.[18] The chart and numbers below depict the education attainment for Nebraskans aged 25 and older.

Key Disparities

- In Nebraska, Asians (49%) saw the highest proportion of bachelor's degree attainment.
- Between 2008 and 2012, almost one-half of Nebraska's Hispanic population, aged 25 years and older, had less than a high school diploma or equivalency, compared to 6.1% of Whites.
- While about 67% earned a high school diploma, only about 10% of American Indians furthered their education.



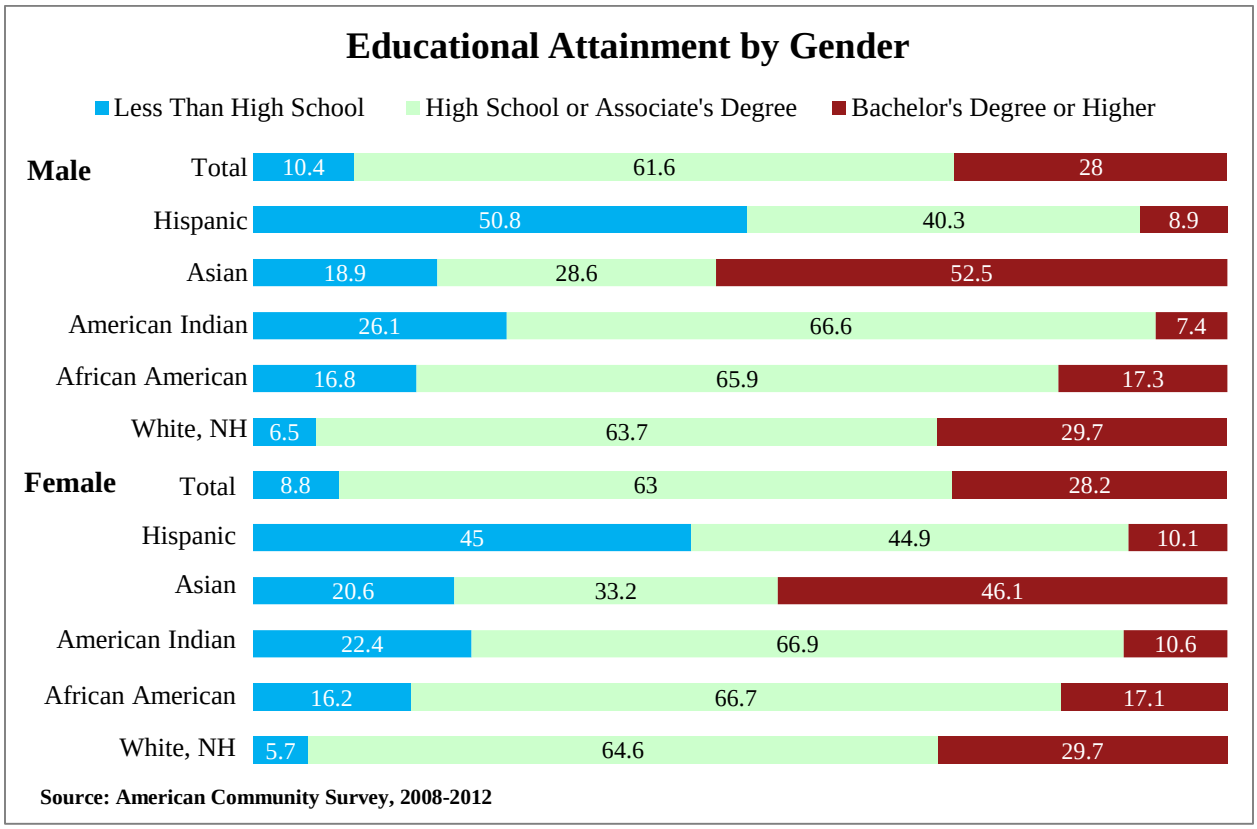
Source: American Community Survey 2008-2012

[18]Cutler, D. and Lleras-Muney, A. (2007). Education and health. Retrieved from http://www.npc.umich.edu/publications/policy_briefs/brief9/policy_brief9.pdf.

Educational Attainment by Gender

Key Disparities

- Overall, a higher proportion of males aged 25 and older did not graduate high school (10.4%) than females (8.8%).
- Both male (50.8%) and female (45%) Hispanics had the highest percentage that did not graduate high school when compared to all other minority groups.
- The American Indian populations had a lower proportion of females (22.4%) than males (26.1%) who did not graduate high school.
- Hispanic females (10.1%) had a higher proportion of those with a bachelor's degree or higher compared to males (8.9%)



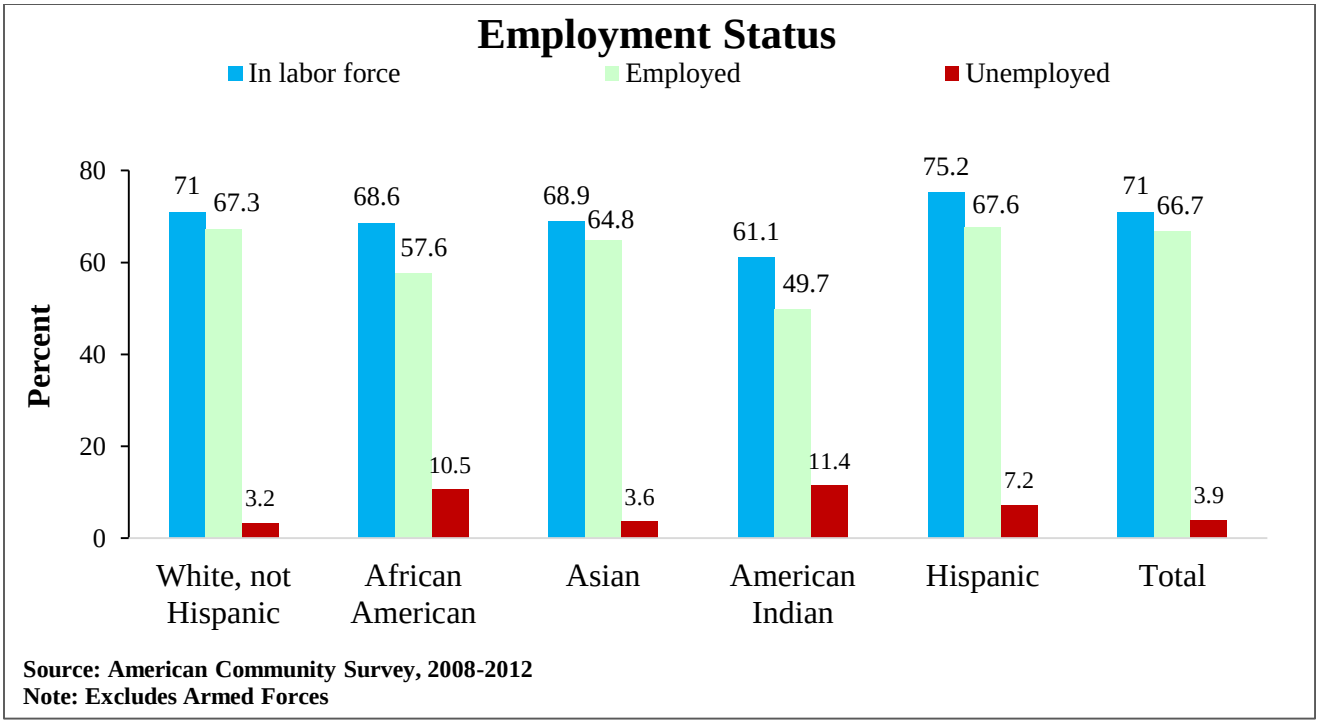
Source: American Community Survey, 2008-2012

Employment

The employed were people who had worked for pay or profit, did at least 15 hours of unpaid work in a family-run business, or are temporarily absent from their regular jobs. The unemployed were those who did not have a job, had actively looked for a job in the last 4 weeks, and were currently available to work. Please note that the information presented below is for those who were 16 and older, and does not include the Armed Forces.

Key Disparities

- Nebraska's American Indian population saw the highest percentage of unemployment (11.4%), compared to Whites (3.2%).
- Almost 11% of African Americans were unemployed; a number about three times that of non-Hispanic Whites (3.2%).
- The unemployment rate for Hispanics (7.2%) was more than double that of non-Hispanic Whites (3.2%).



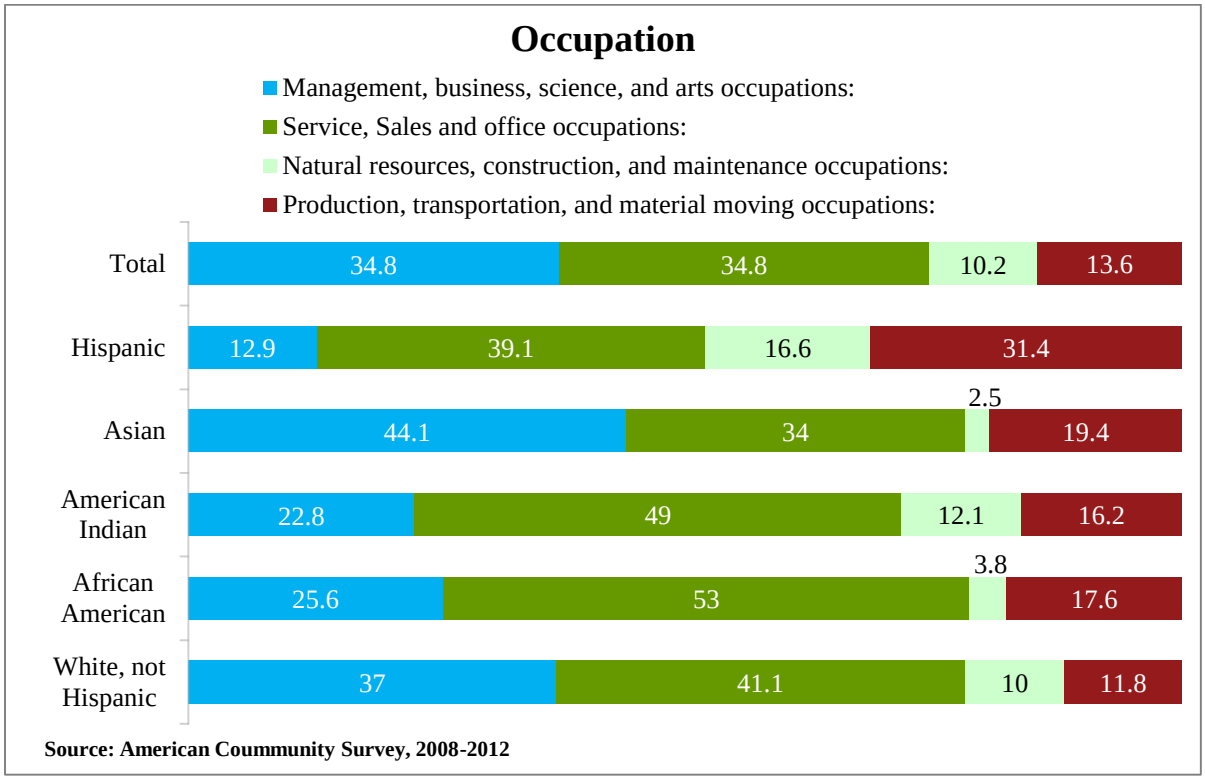
Source: American Community Survey, 2008-2012
Note: Excludes Armed Forces

Occupation

Occupations vary among racial and ethnic groups in Nebraska. Possible occupations include those from the business, service, maintenance, and production sectors. Shown below are the disparities that were seen in the Nebraska minority populations in terms of occupation.

Key Disparities

- Hispanics (31.4%) were more likely to work in production, transportation, and material moving jobs than other minorities and non-Hispanic Whites (11.8%).
- African Americans (53%) and American Indians (49%) were more likely to work in service and sales occupations, whereas this was only true for about 41% of non-Hispanic Whites.
- Hispanics (12.9%), American Indians (22.8%), and African Americans (25.6%) were far less likely to work in management, professional, and related occupations compared with 37% of non-Hispanic Whites.

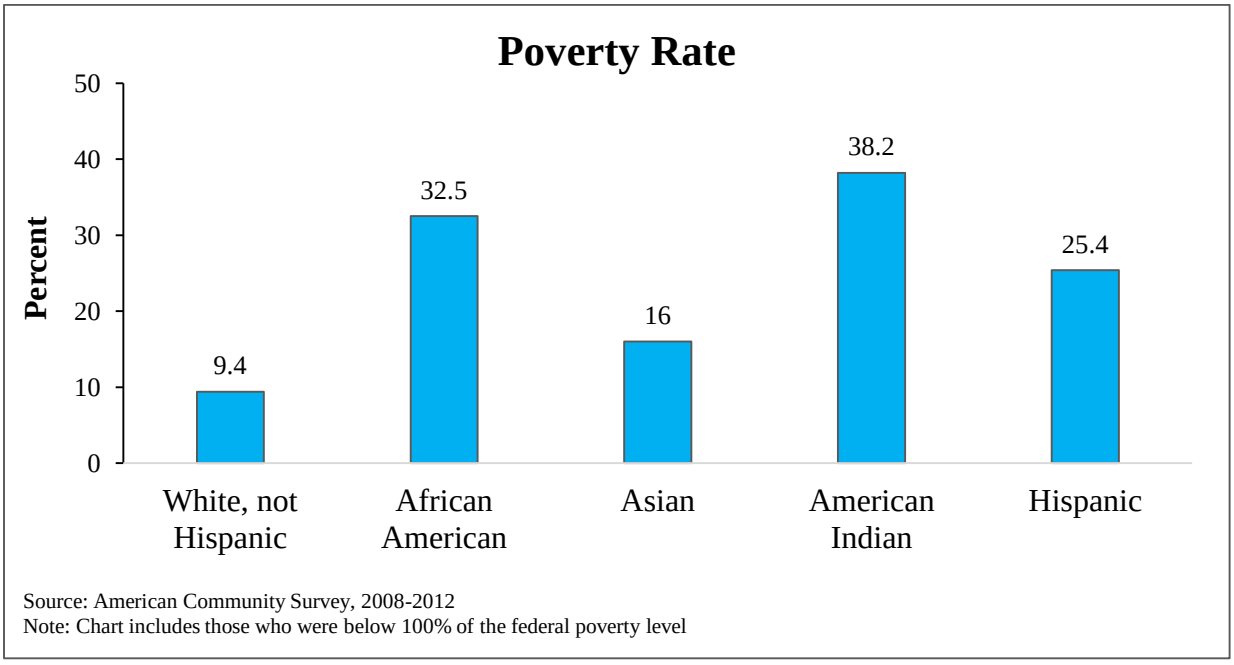


Poverty

Poverty affects most aspects of life, from the affordability of health insurance to the quality of food selection. Poverty is much more prevalent in minority populations than the White population. In 2010, the United States hit a 15% poverty rate; in Nebraska, that rate was approximately 10%.

Key Disparities

- Nebraska's American Indian (38.2%) and African American (32.5%) populations saw the highest percentage of poverty, compared to 9.4% of Whites.
- The proportion of Hispanic (25.4%) individuals below the federal poverty level was more than double the proportion for non-Hispanic Whites.
- Asians (16%) had a proportion living in poverty that was most similar to non-Hispanic Whites, though the proportion for Asians was still greater.

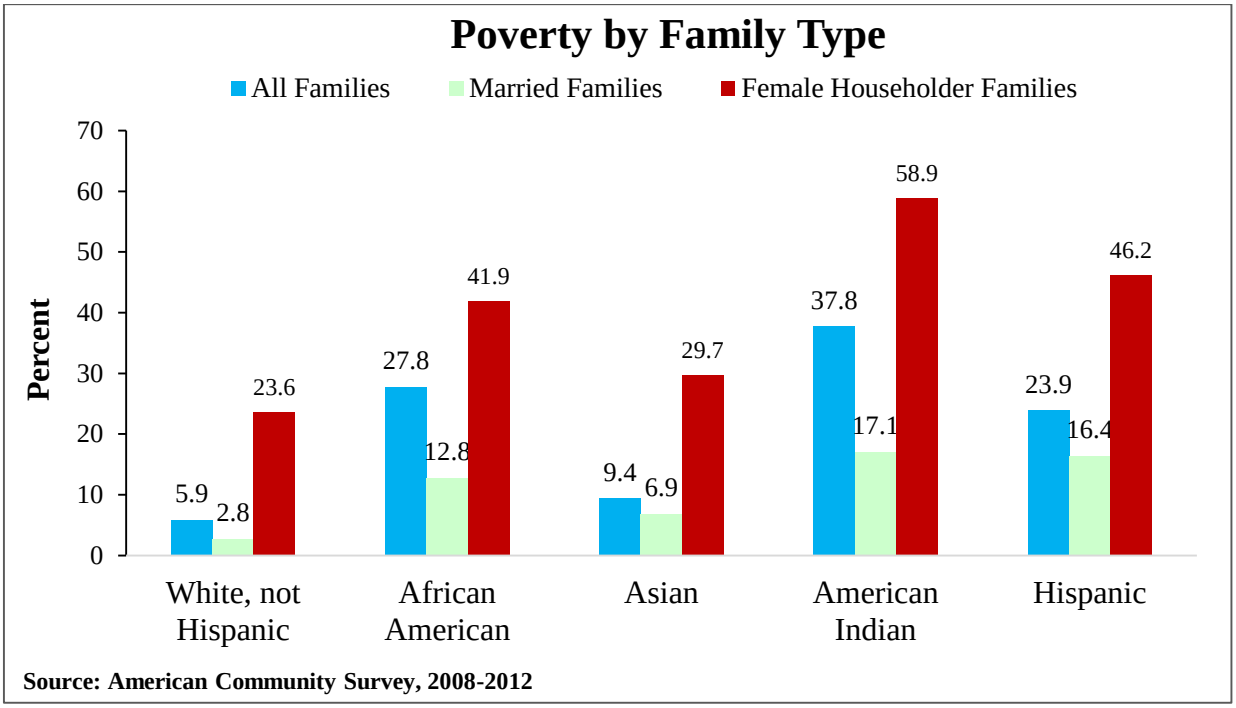


Source: American Community Survey, 2008-2012
Note: Chart includes those who were below 100% of the federal poverty level

Poverty Rate by Family Type

Key Disparities

- For each family type, minority populations had higher proportions of poverty than non-Hispanic Whites.
- American Indians experienced the highest proportion of poverty for each family type compared to other minority groups and non-Hispanic Whites. Of female householder families, American Indians also experienced the most poverty at almost 59%.
- Asian Americans had proportions of poverty that were most similar to non-Hispanic Whites, though still experienced more poverty in each group.
- When comparing poverty in married families, American Indian (17.1%) and Hispanic (16.4%) families experienced similar proportions, each at about six times higher than non-Hispanic Whites (2.8%).



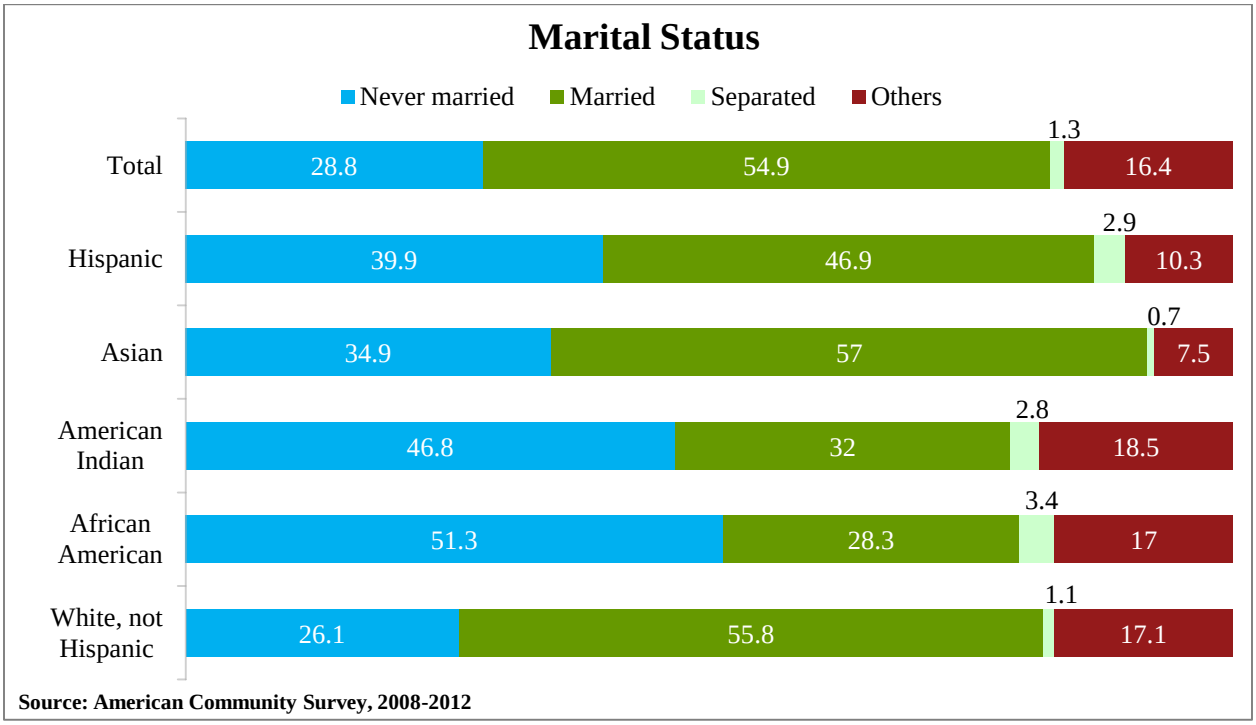
Source: American Community Survey, 2008-2012

Marital Status

Evidence has shown that, in general, married people are healthier than the unmarried, and the excess mortality of those that have not been married is growing over time in relation to those that are married.[19] Where the gap between African Americans and Whites reporting good health is narrowing among never-married people, the gap between previously married African Americans and Whites is widening.[20]

Key Disparities

- Nebraska's African American population saw the highest percentage of people never married, compared to approximately 26% of Whites.
- Almost 60% of Asians were married in Nebraska, while the next largest proportion of Asians (34.9%) included those that had never been married.
- Only 28.5% of African Americans were married.
- A larger proportion of American Indians had never been married (46.8%) compared to those who were (32%).
- Hispanic Nebraskans saw a higher proportion of married people (46.9%), compared to other marital statuses.
- African Americans had the highest proportion of those separated (3.4%) compared to other racial and ethnic groups.



Source: American Community Survey, 2008-2012

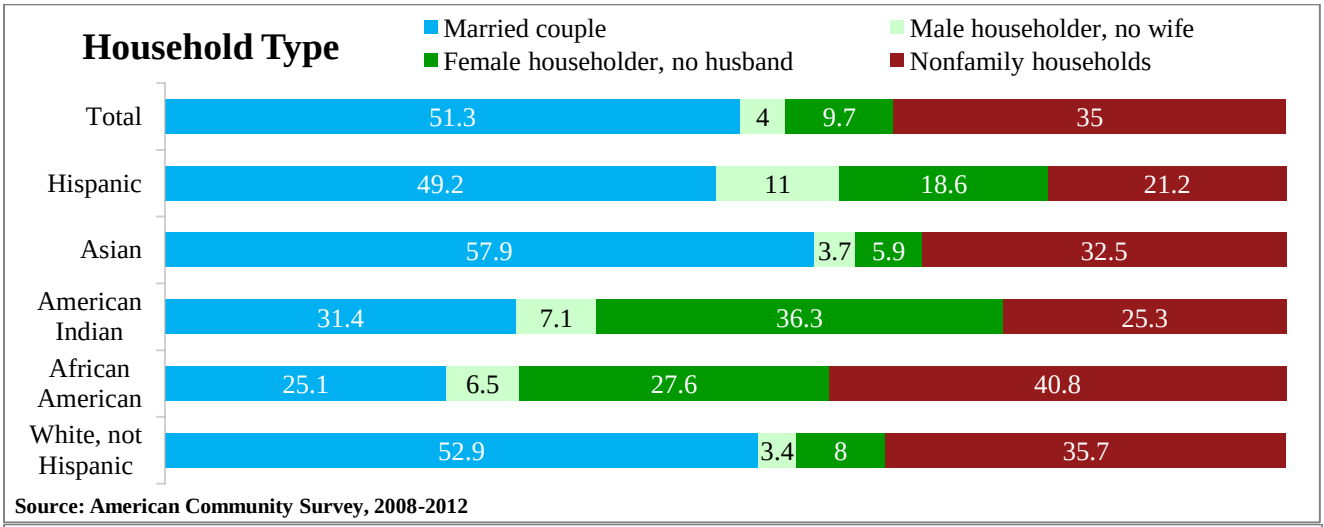
[19]Liu, H and Umberson, D. (2008). The times they are a changin': Marital status and health differentials from 1976 to 2003. *Journal of Health, Society, and Behavior, 49*: 239-253.
[20]Ibid.

Household Type and Tenure

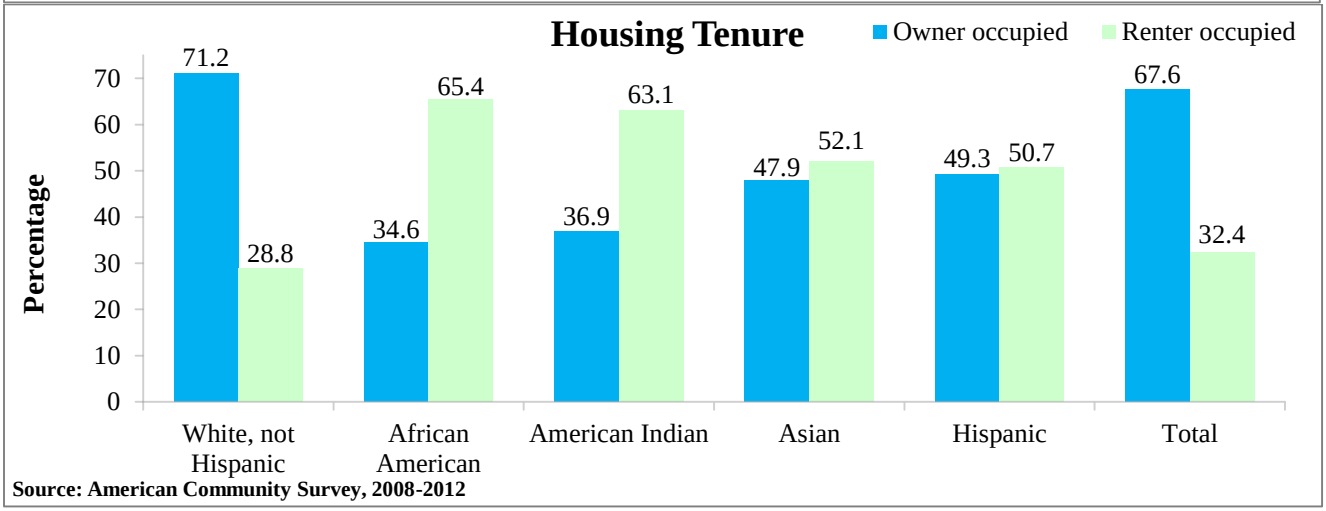
There were many observable disparities and correlations between household type and tenure (whether a home is owned or rented). For instance, those populations with higher rates of households ran by females with no husband present also had higher rates of renters.

Key Disparities

- Nebraska's African American population saw the lowest percentage of married-couple households (25.1%), compared to almost 53% of Whites.
- Almost 31% of American Indians lived in married-couple households.
- Nebraska's American Indian population saw the highest percentage of households headed by women with no husband present (36.3%), over 4.5 times the rate for White households (8%).
- A quarter of African American households (27.6%) were female households with no husband present.
- Nebraska's African American population saw the lowest percentage of homeowners (34.6%), compared to almost 71% of Whites.
- Approximately 37% of American Indians were homeowners.



Source: American Community Survey, 2008-2012



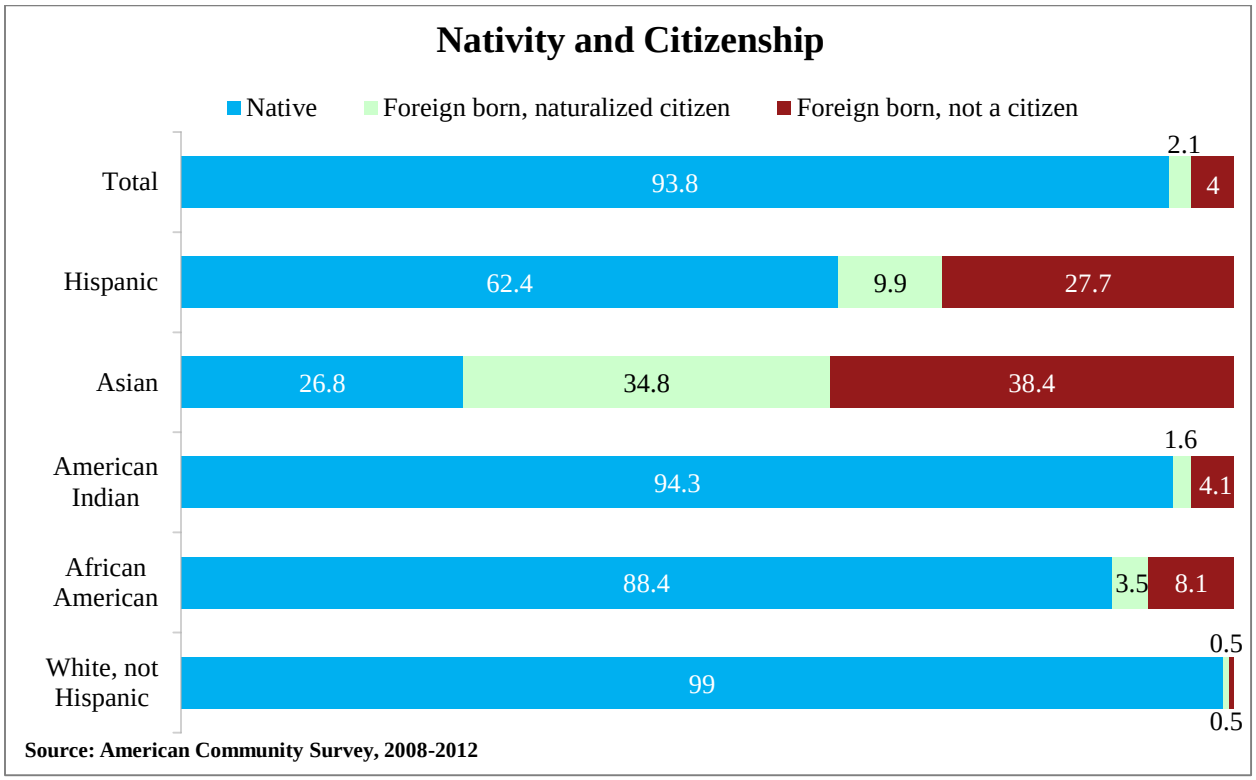
Source: American Community Survey, 2008-2012

Nativity and Citizenship

From 2000 to 2012, Nebraska experienced a 59% increase in foreign-born residents, increasing from 74,638 in 2000 to 118,522 in 2012.[21] Between October 1997 and September 2006, 27,290 persons were granted legal, permanent residence in Nebraska (including new arrivals and persons who adjusted their status).

Key Disparities

- Approximately 73.2% of the Asian population and 37.6% of the Hispanic population in Nebraska were foreign born, while only 1% of non-Hispanic Whites were foreign born.
- A higher proportion of Hispanics (27.7%) and Asians (38.4%) than non-Hispanic Whites (0.5%) were born abroad and were not U.S. citizens.
- Similar proportions of the American Indian (95.9%) and African American (91.9%) populations were U.S. citizens, either through birth or naturalization as non-Hispanic Whites (99%).



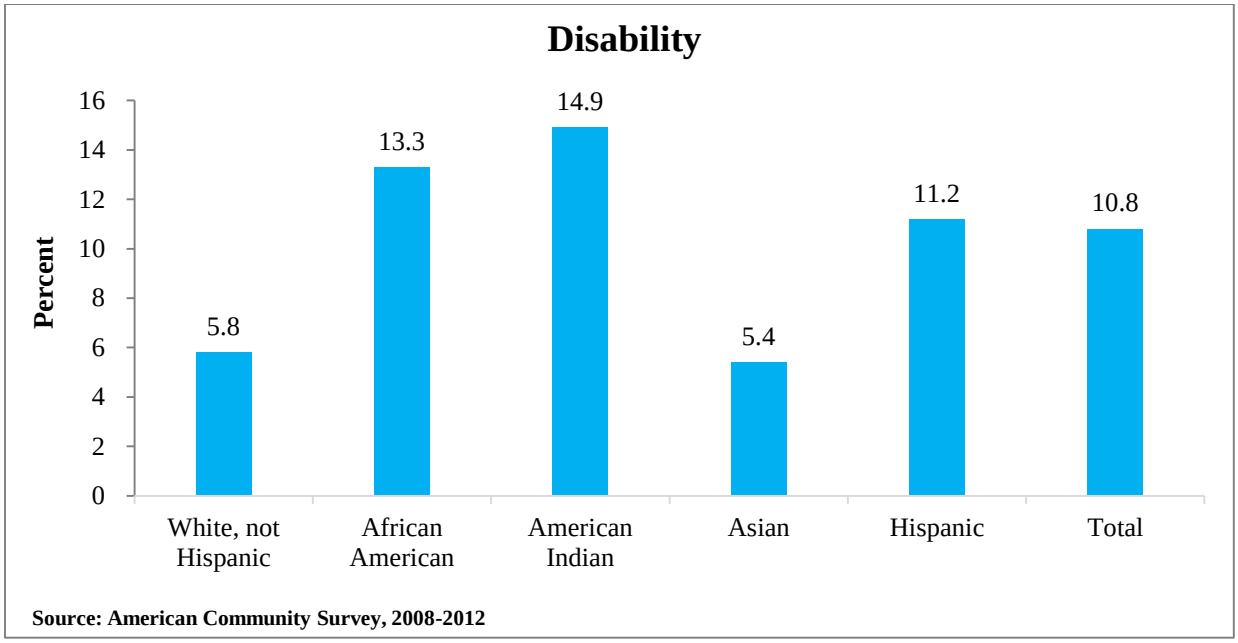
[21]Federation for American Immigration Reform. Nebraska. Retrieved from http://www.fairus.org/states/nebraska

Disabililty

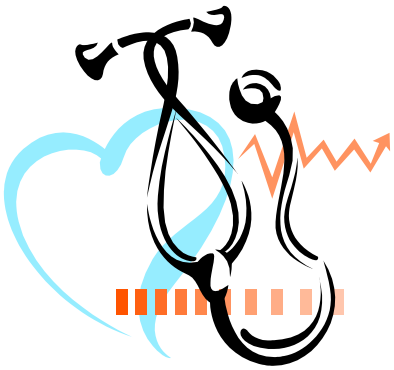
The Census Bureau defines disability as a long-lasting sensory, physical, mental, or emotional condition or conditions that make it difficult for a person to do functional or participatory activities. Those who were living with a disability require the same health screenings and have the same needs as those who are not disabled, though disparities can be seen between those who were disabled and not disabled.

Key Disparities

- Nebraska American Indians (14.9%) and African Americans (13.3%) were more than 2.3 times more likely to be disabled than non-Hispanic Whites (5.8%).
- Hispanics (11.2%) also had a higher proportion of disability compared to non-Hispanic Whites.
- Asians (5.4%) had a proportion of disability that was most similar to, and less than, non-Hispanic Whites.



ACCESS TO HEALTH CARE



Access to high-quality health care is the foundation to eliminating health disparities and increasing both quality of life and years of healthy life. The onset of many health problems that were once untreatable can be prevented altogether, or their debilitating impacts lessened thanks to advances in technology and treatment methods.[22]

Rising health care costs, changes in payment and health care delivery, and Medicaid reform all affect health care consumers, especially vulnerable and at-risk populations. Access to health care requires not only entry into either the health care system or the sites where necessary services are provided, but also finding culturally and linguistically appropriate services with providers that patients can develop relationships "based on mutual communication and trust."[23]

The Nebraska Department of Health and Human Services, Division of Public Health set a goal to see 100% of people under 65 years of age insured (based on Healthy People 2010), yet 50 million adults remain uninsured. This is an increase of over 1 million people from the previous year, with over half of those additional people being middle-income.[24] Nebraska sees a larger proportion of people insured than the nation. For minorities, lack of transportation, lack of knowledge of where to obtain care or when to seek care, language and other cultural barriers, and covert or overt discrimination reduce their ability to get necessary health care.[25]

In recent years, major changes in the structure of the U.S. health care delivery system, increasing health care costs, and government program reforms have adversely affected health care consumers, particularly vulnerable and at-risk populations.[26] Many people, especially members of racial and ethnic minority groups, face barriers that make it difficult to gain access to even the most basic of health services resulting in disproportionate increases in incidence of disease, disability, and early death.[27]

[22]Nebraska Department of Health and Human Services. (2007). Nebraska 2010 health goals and objectives: A midcourse review.
[23]Agency for Health care Research and Quality. (2008). National Health care Disparities Report 2007. Rockville, MD.
[24]Ibid.
[25]National Center for Health Statistics. (2007). Health, United States, 2007. Hyattsville, MD.
[26]Nebraska Department of Health and Human Services. (2007). Nebraska 2010 health goals and objectives: A midcourse review.
[27]Smedley, B. D., Stith, A. Y., Nelson, A.R. (Eds.). (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Institute of Medicine. Washington, D.C: National Academy Press.

PROGRESS TOWARD HP2010

The national goal for access to care as part of Healthy People 2010 is to improve access to comprehensive, high-quality health care services for all people throughout the nation. The chart below offers a summary of findings for measures we have that match specific Healthy People 2010 objectives. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✖ = regress away or remain same), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✖ = not met).

Summary

All racial and ethnic groups saw progress toward their Healthy People 2010 objective for having a personal physician and although some groups were within 2% of reaching their goal, no group met the objective of 85% having a personal physician. Few groups saw progress in the ability to see a doctor and no groups met the objective.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Have a Personal Physician	%	%			
White	86	86.2	✓	85%	✓
African American	82.5	83.2	✓	85%	✖
Asian	82.1	84.5	✓	85%	✖
American Indian	73.7	76.5	✓	85%	✖
Hispanic or Latino	64.8	64.9	✓	85%	✖
No Health Insurance	%	%			
White	12.8	13	✖	0%	✖
African American	18.5	24.4	✖	0%	✖
Asian	9.1	17.3	✖	0%	✖
American Indian	32	34.5	✖	0%	✖
Hispanic or Latino	39	46.1	✖	0%	✖
Could Not See a Doctor Due to Costs	%	%			
White	9.5	9.1	✓	4%	✖
African American	16.1	20.4	✖	4%	✖
Asian	8.4	10.6	✖	4%	✖
American Indian	23.6	16.1	✓	4%	✖
Hispanic or Latino	17.3	20.7	✖	4%	✖

No Personal Physician

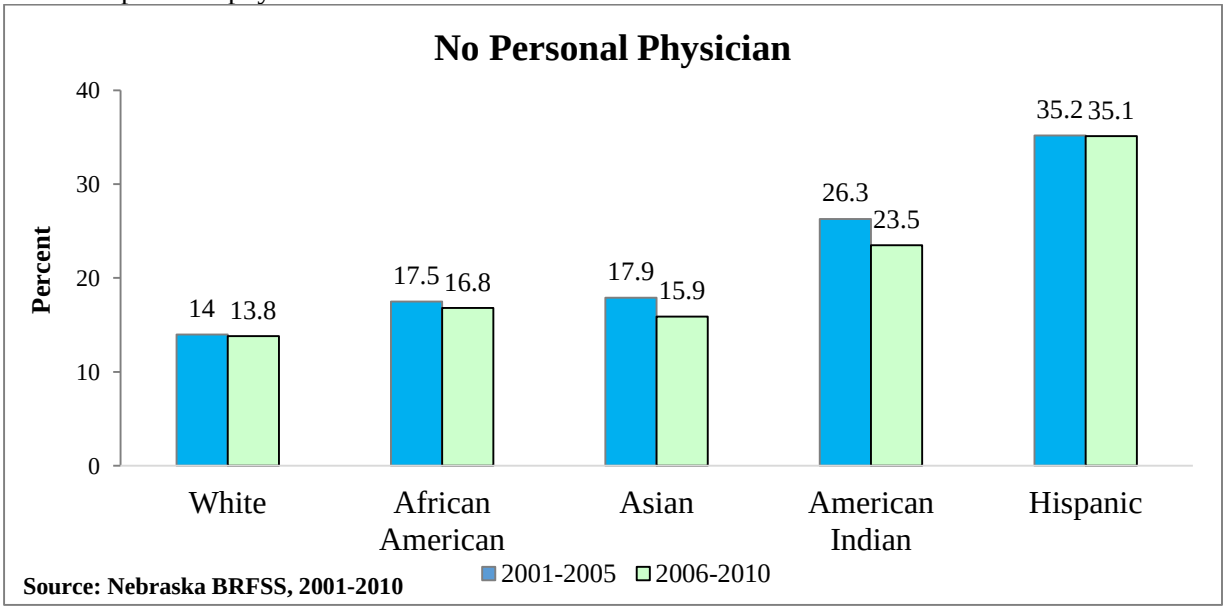
Including various specialties in the medical profession, primary care physicians provide a combination of direct care and, as necessary, counsel the patient in the appropriate use of specialists and advanced treatment locations.[28] Persons with a usual place of care are more likely to have routine medical visits and health screenings.[29]

Key Disparities

- Nebraska's Hispanic population saw the highest percentage of people not having a personal physician (35%), compared to 13.8% of Whites.
- Almost 24% of American Indians had no personal physician during 2006-2010.
- Nebraska's African American (16.8%) and Asian (15.9%) populations experienced a similar proportion with no personal physician.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Asians and American Indians saw the biggest drop in not having a personal physician, with a 2% and 3% change, respectively.
- Hispanics saw the smallest decline (35.2% to 35.1%) and remain the least likely (by almost 12%) to have a personal physician.



Compared to the Nation

- African Americans (83.2%), Asians (84.1%), and Whites (86.2%) in Nebraska saw higher proportions of people with a personal physician, compared to the nation (72.8%, 72.2%, and 77.6%, respectively).
- American Indians (76.5%) and Hispanics (64.9%) were doing worse when compared to the nation (80.7% and 67.3%, respectively).

Note: The data available from Healthy People 2020 reported this measure only as those who have a personal physician.

[28]MedlinePlus. (2011). Choosing a primary care provider. Retrieved from http://www.nlm.nih.gov/medlineplus/ency/article/001939.htm.
[29]Blewett, L., Johnson, P., Lee, B., and Scal, P. (2008). When a usual source of care and usual provider matter: Adult prevention and screening services. J Gen Intern Med; 23 (9): 1354-1360.

No Health Insurance (Ages 18-64)

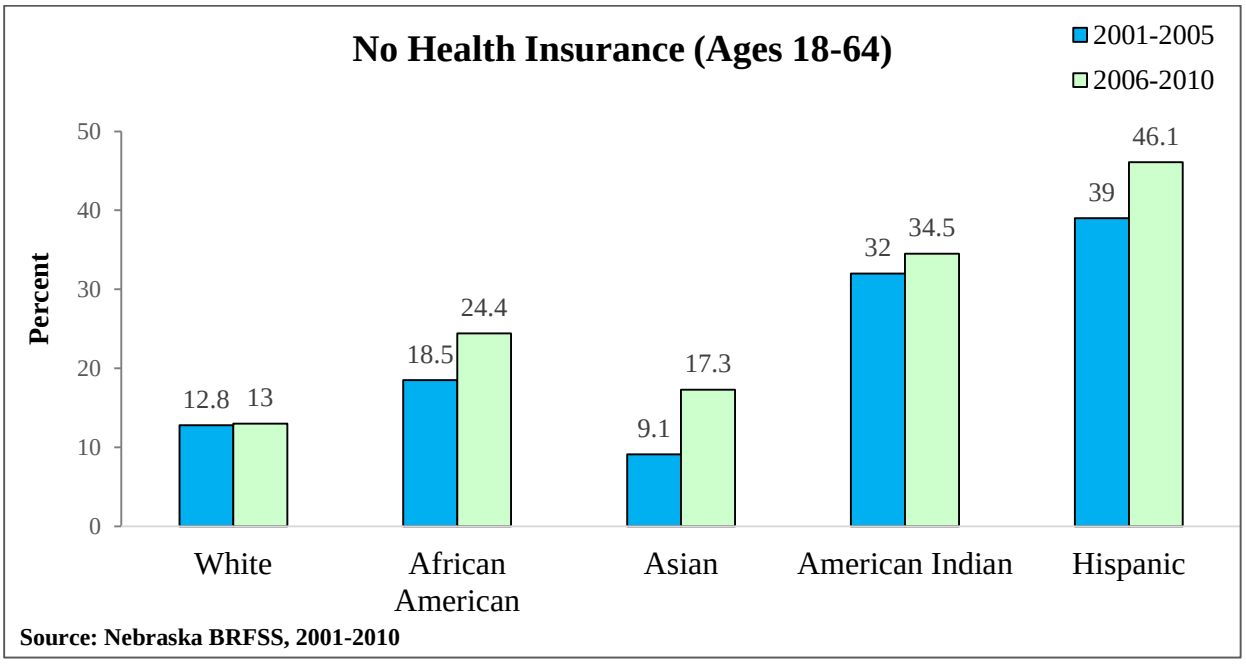
According to the BRFSS, having no health care coverage resulted from an answer of 'no' to the question, "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?"

Key Disparities

- Approximately 46% of Nebraska's Hispanic population had no health coverage in 2006-2010, compared to 13% of Whites.
- Almost 35% of American Indians were without health coverage in 2006-2010.
- Asian (17.3%) and African American (24.4%) Nebraskans saw the smallest proportion of people without health coverage.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All racial and ethnic minority groups saw an increase in the number of people not covered by health insurance.
- Asian Nebraskans saw the largest increase, jumping from 9.1% in 2001-2005 to 17.3% in 2006-2010.
- Hispanics had the largest proportion of uninsured throughout the decade and increased from 2001-2005 (39%) to 2006-2010 (46.1%).



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- Hispanics in Nebraska (46.1%) witnessed a larger proportion of people not covered by health insurance, compared to their national counterparts (30%).
- African Americans (24.4%) see similar proportions not covered by health insurance when compared to their national populations (20.4%).

Could Not See a Physician Due to Cost

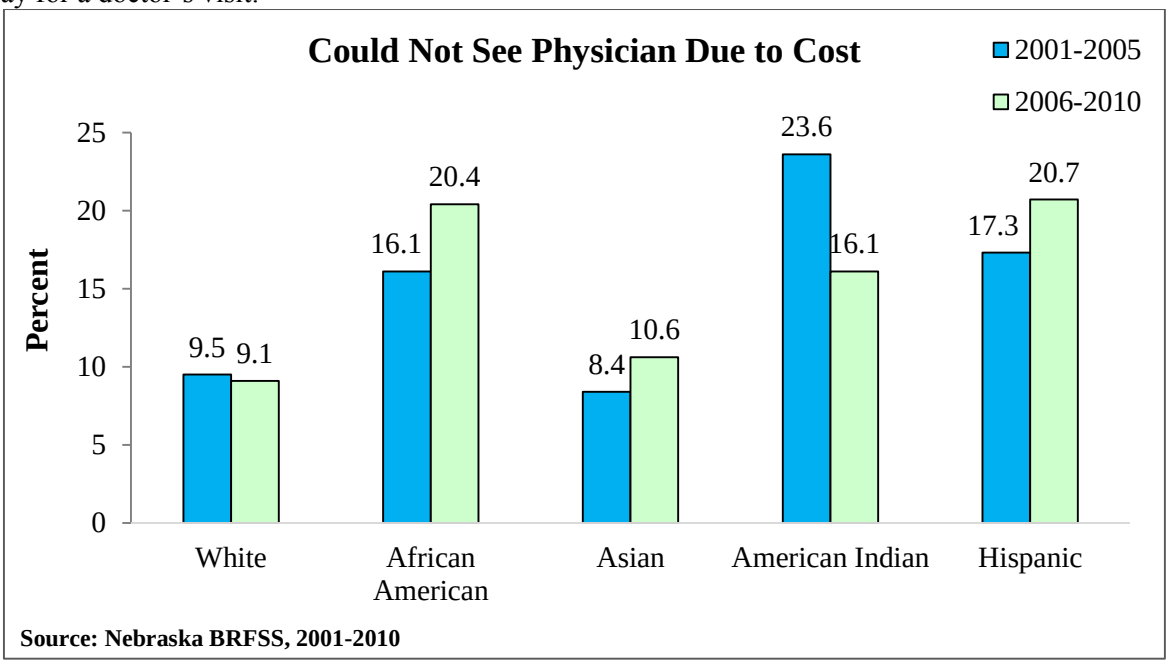
For people with no insurance and limited financial resources, the decision of whether or not to see a doctor is often a financial choice rather than a medical one. Even when health benefits are available, they may not be sufficient to ensure access to needed health care services. Persons with health insurance may still be confronted with significant financial hardships in paying for or obtaining health services or products. Families may have to choose to insure only some members, often children, while leaving other family members at risk for catastrophic illness, disability, and early death.

Key Disparities

- Nebraska's Hispanic population experienced the highest percentage of people unable to see a doctor due to cost (20.7%), compared to 9.1% of Whites.
- Twenty percent of African Americans were also unable to see a doctor due to cost.
- Sixteen percent of American Indians in Nebraska were unable to see a doctor due to cost.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- American Indians had the largest improvement between the 5-year periods. In 2001-2005, almost 24% of the American Indian population reported not being able to see a physician for financial reasons; however, in 2006-2010 this number decreased to approximately 16%.
- All other minority groups saw an increase in *inability* to see a physician due to cost. African Americans saw almost a 4.5% increase, while Hispanics saw more than a 3% increase in inability to pay for a doctor's visit.



HEALTH STATUS AND MORTALITY

At the most basic level, the health status of any population can be expressed through two concepts – life and death. The challenge is to find meaningful ways to measure them so they can be used to describe, compare, and track health change over time. In a longitudinal, Midtown Manhattan study, researchers found that perceived health status was the strongest predictor of mortality.[30]

New research suggests that there are several key health measures that effect self-reported health status; lack of social support or leisure-time physical activity, smoking, and high body mass index lead to respondents having low perceived health status.[31] However, if people intend on changing those negative measures in the future, they rate their health better.

Life expectancy at birth indicates the number of years a newborn infant would live if predominant patterns of mortality at the time of their birth were to stay the same throughout its life.[32] Life expectancy at birth describes the overall mortality level of a population, summarizing the mortality pattern across age groups. Nebraska experiences a 79.2-year life expectancy, compared to the United States at 78.6. Low-income countries experience only a 57-year life expectancy. According to Shang and Goldman, life expectancy is actually more of a predictor of health care expenditures than age.[33]

Mortality is a powerful indicator of population health. The racial disparities in mortality rates in Nebraska only highlight how apparent health disparities are in our communities.

[30]Goldstien, M., Siegel, J., and Boyer, R. (1984). Predicting changes in perceived health status. *American Journal of Public Health.*
[31]Bailis, D., Segall, A., and Chipperfield, J. (2003). Two views of self-rated general health status. *Social Science Medicine*, 56, 203-217.
[32]The World Bank. (2012). Life expectancy at birth, total (years). Retrieved from http://data.worldbank.org/indicator/SP.DYN.LE00.IN.
[33]Shang, B. and Goldman, D. (2008). Does age or life expectancy better predict health care expenditures?
Health Economics, Vol. 17, No. 4; 487–501.

Perceived Health Status

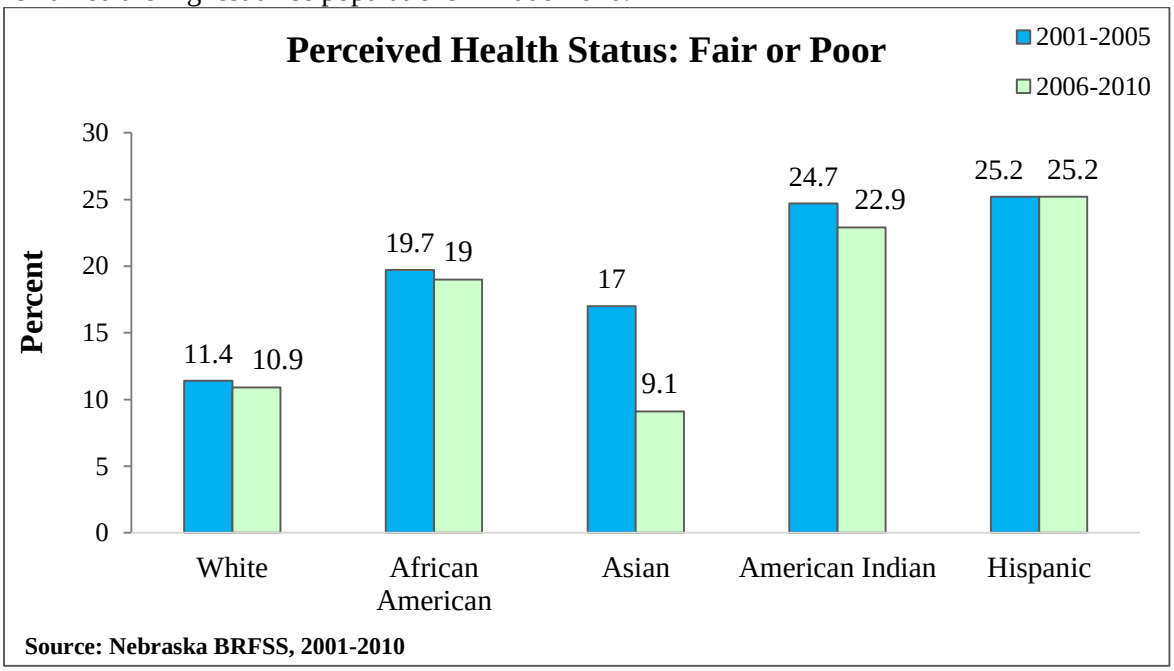
Perceived health status is strongly related to individual health outcomes. Persons who are poor and those who are uninsured are more likely to report being in fair or poor health.[34] People who reported fair or poor health, the lowest two options among answers to the BRFSS survey question, had higher rates of hospitalization and mortality compared to persons who report excellent to good health.[35]

Key Disparities

- Nebraska's Hispanic population experienced the highest proportion of fair or poor perceived health at 25.2%, compared to 10.9% of Whites.
- Almost 23% of American Indians and 20% of African Americans perceived their health as fair or poor.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Between 2001 and 2010, all groups saw a decline in fair or poor health reporting; Asians saw the largest drop from 17% to 9.1%.
- Hispanics only saw a .01% decrease in fair or poor health reporting from 2001-2005 to 2006-2010.
- The highest three populations (Hispanics, American Indians, and African Americans) in 2001-2005 remained the highest three populations in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- African Americans in Nebraska (19%) and African Americans in the rest of the United States (20.7%) saw similar proportions in reporting fair or poor health.
- Slightly more Hispanics in Nebraska (25.2%) reported fair or poor health than Hispanics in the United States (19.9%).

[34]Bhandari, S. (2006). Health status, health insurance, and health services utilization: 2001. U.S. Department of Commerce, U.S. Census Bureau.
[35]Ibid.

Life Satisfaction: Dissatisfied

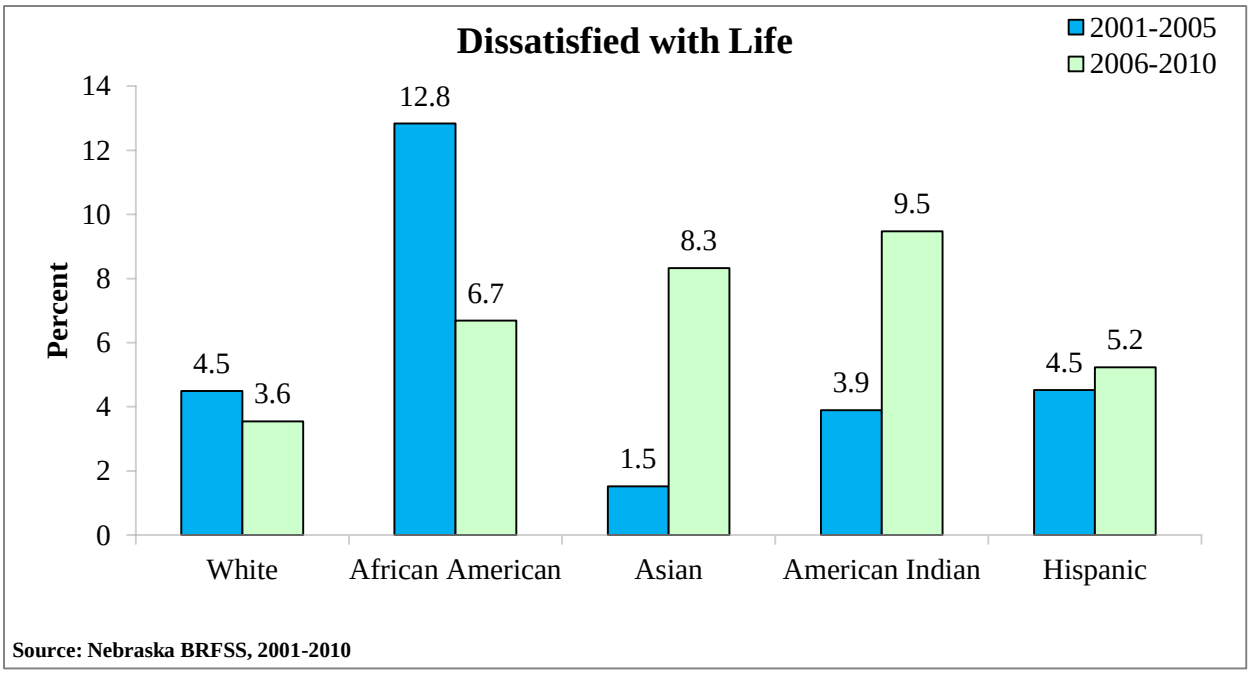
Respondents of the BRFSS survey could answer either very satisfied, satisfied, dissatisfied, or very dissatisfied when asked, "In general, how satisfied are you with your life?"

Key Disparities

- Almost 9.5% of Nebraska American Indians reported being dissatisfied with life, compared to 3.6% of White Nebraskans.
- Approximately 8% of Asians and 7% of African Americans were dissatisfied with life.
- Only 5.2% of Hispanics were dissatisfied with life.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Both Asians and American Indians saw a large increase in dissatisfaction with life between 2001-2005 (1.5% and 3.9%, respectively) and 2006-2010 (8.3% and 9.5%, respectively); American Indians became the highest group in 2006-2010.
- African American Nebraskans saw a large reduction in life dissatisfaction between 2001-2005 (12.8%) and 2006-2010 (6.7%).



Source: Nebraska BRFSS, 2001-2010

Life Satisfaction: Very Dissatisfied

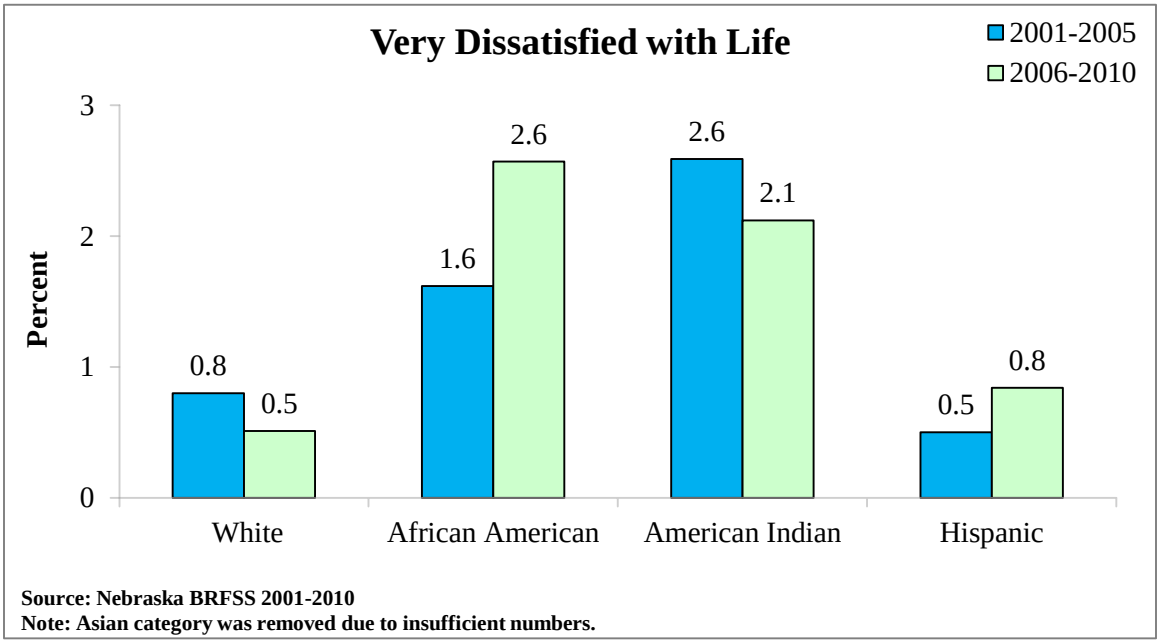
Life dissatisfaction, both long term and coexisting, has been found to have strong adverse effects on health-related quality of life, which is a persons perceived well-being and functioning in physical, mental, and social domains of life.[36] Please note that Asian numbers were not included as they were insufficient to produce data.

Key Disparities

- Nebraska's African American population saw the highest percentage of people very dissatisfied with their lives (2.6%), compared to 0.5% of Whites.
- African Americans (2.6%) and American Indians (2.1%) had comparable percentages of those who were dissatisfied with their lives.
- Hispanics had low rates of life (high) dissatisfaction (0.8%).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Life dissatisfaction increased in the Hispanic and African American populations between 2001-2005 and 2006-2010. African Americans saw the largest increase from 1.6% to 2.6%.
- American Indians saw a half-percent decrease in life dissatisfaction between 2001-2005 and 2006-2010.



Source: Nebraska BRFSS 2001-2010
Note: Asian category was removed due to insufficient numbers.

[36]Saharinen, T., Koivumaa-Honkanen, H., Hintikka, J., Kylma, J., Lehto, SM., Honkalampi, K., Haatainen, K., and Wiinamaki, H. (2013). The effect of long-term life dissatisfaction on health-related quality of life among general population subjects. *Journal of Psychiatry Mental Health Nurses.*

Life Expectancy at Birth in the State of Nebraska

Life expectancy is a measure often used to gauge the overall health of a population and a measure of overall quality of life in a country.[37] As a summary measure of mortality, life expectancy at birth represents the average number of years of life a group of people born in the same year will live if mortality at each age remains constant in the future.[38] Shifts in life expectancy are often used to describe trends in mortality. Life expectancy at birth is strongly influenced by infant and child mortality.[39]

Key Disparities

- The average life expectancy of an American Indian was 75.5 years, compared to 79.8 years for Whites.
- The life expectancy at birth for an African American was 73.7 years.

How are we doing? Comparisons over the years

- In 2007-2009, the life expectancy gap grew between African Americans and American Indians to a difference of 4 years; in 2008-2010 the gap closed to less than 2 years.
- The life expectancy for Whites did not change much since 2004-2006 (increasing from 79.4 to 79.8).

State of Nebraska

	TOTAL/YRS	*MALES/YRS*	*FEMALES/YRS*
2008-2010	79.8	77.6	82.0
2007-2009	79.4	77.0	81.6
2006-2008	79.2	76.7	81.6
2005-2007	79.2	76.7	81.6
2004-2006	79.3	76.7	81.8
2003-2005	79.0	76.5	81.3
2002-2004	78.6	76.2	81.0
2001-2003	78.4	75.9	80.7
2000-2002	78.3	75.7	80.8
1999-2001	78.2	75.6	80.7
1998-2000	78.2	75.5	80.8
1997-1999	77.7	74.8	80.5
1996-1998	77.6	74.7	80.4
1994-1996	77.4	74.3	80.3
1989-1991	77	73.7	80.3
1984-1986	76.4	72.8	80
1979-1981	75.7	71.8	79.6
1974-1976	74.3	70.6	78.1
1969-1971	72.7	68.9	76.8

Source: Nebraska DHHS Vital Statistics

[37]Sandana, R., Mathers, C., Murray, C., and Iburg, K. (2003). Comparative analyses of more than 50 household surveys on health status. Retrieved from http://www.who.int/healthinfo/paper15.pdf.
[38]Central Intelligence Agency. (2013). The world factbook. Life expectancy at birth.
[39]National Center for Health Statistics. (2008). Health, United States, 2008. Hyattsville, Maryland.

White

YEARS	TOTAL/YRS	MALES/YRS	FEMALES/YRS
2008-2010	79.8	77.5	82.0
2007-2009	79.7	77.3	81.9
2006-2008	79.5	77.0	81.9
2005-2007	79.5	77.0	81.9
2004-2006	79.5	76.9	82.0
2003-2005	79.2	76.8	81.6
2002-2004	78.9	76.4	81.2
2001-2003	78.6	76.2	80.9
2000-2002	78.3	75.7	80.8
1999-2001	78.3	75.6	80.9
1998-2000	78.3	75.5	80.9
1997-1999	78.1	75.2	80.9
1996-1998	77.9	75.1	80.7
1994-1996	77.7	74.6	80.6
1989-1991	77.5	73.9	80.6
1984-1986	76.6	72.9	80.3
1979-1981	75.7	72	79.8
1974-1976	74.5	70.8	78.4
1969-1971	73	69.2	77.2

Source: Nebraska DHHS Vital Statistics

African American

YEARS	TOTAL/YRS	MALES/YRS	FEMALES/YRS
2008-2010	73.7	71.2	76.1
2007-2009	73.0	70.6	75.2
2006-2008	73.0	70.6	75.4
2005-2007	72.8	70.3	75.3
2004-2006	72.7	69.8	75.4
2003-2005	72.3	69.2	75.3
2002-2004	72.2	69.1	75.3
2001-2003	71.7	68.1	75.3
2000-2002	71.6	68.1	75.1
1999-2001	71.4	68.4	74.4
1998-2000	71.4	68.8	73.9
1997-1999	70.4	67.9	72.8
1996-1998	70.1	67.3	72.7
1994-1996	70.0	66.4	73.5
1989-1991	70.7	67.1	74.2
1984-1986	70.1	66.6	73.6
1979-1981	68.5	64.9	72.1
1974-1976	67.1	62.8	71.8
1969-1971	64.8	61.1	68.6

Source: Nebraska DHHS Vital Statistics

American Indian

YEARS	*TOTAL/YRS*	*MALES/YRS*	*FEMALES/YRS*
2008-2010	75.5	71.7	78.4
2007-2009	77.0	74.8	78.9
2006-2008	74.0	71.6	76.1
2005-2007	70.2	67.9	72.5
2004-2006	70.1	66.7	75.2
2003-2005	70.4	66.9	74.0
2002-2004	70.7	66.7	75.2
2001-2003	69.0	66.5	71.3
2000-2002	67.9	65.6	70.1
1999-2001	66.5	65.8	67.4
1998-2000	66.7	65	68.3
1997-1999	65.9	63.5	67.9
1996-1998	68.1	64.2	72.3
1994-1996	67.6	62.6	73.2
1989-1991	66.6	62.9	70.4
1984-1986	67.4	63.5	72.0
1979-1981	63.7	59.7	67.8

Source: Nebraska DHHS Vital Statistics

Leading Causes of Death in the State of Nebraska

For all racial and ethnic groups, heart disease and lung cancer were the most common causes of deaths. In some cases, cancer was followed by heart disease, and in other cases, the opposite was true. When comparing racial and ethnic groups to non-Hispanic Whites without considering gender, cancer was the most common killer for minority groups whereas heart disease was the number one killer among White individuals.

African Americans compared to Whites

Leading Causes of Death Total					
Cause of Death	**Frequency (African Americans)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	569	22.0%	Heart	16,439	22.9%
Heart	492	19.0%	Cancer	16,293	22.6%
Stroke	156	6.0%	Stroke	4,192	5.8%
Diabetes	143	5.5%	Chronic Lung	4,187	5.8%
Homicide	119	4.6%	Unintentional Injury	3,213	4.5%
Unintentional Injury	111	4.3%	Alzheimer's	2,700	3.8%
Chronic Lung	73	2.8%	Diabetes	2,061	2.9%
Nephritis/Nephrosis	73	2.8%	Pneumonia	1,452	2.0%
Perinatal Conditions	67	2.6%	Nephritis/Nephrosis	1,235	1.7%
Other	788	30.4%	Other	20,168	28%
Total	2,591	100.0%	Total	71,940	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

African American males compared to White males

Leading Causes of Death: Males					
Cause of Death	**Frequency (African Americans)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	286	21.3%	Cancer	8,539	24.7%
Heart	253	18.9%	Heart	7,978	23.1%
Homicide	102	7.6%	Chronic Lung	2,136	6.2%
Stroke	67	5.0%	Unintentional Injury	1,891	5.5%
Unintentional Injury	67	5.0%	Stroke	1,645	4.8%
Diabetes	57	4.3%	Diabetes	996	2.9%
Chronic Lung	40	3.0%	Alzheimer's	783	2.3%
Perinatal Condition	39	2.9%	Suicide	725	2.1%
Nephritis/Nephrosis	30	2.2%	Pneumonia	633	1.8%
Other	399	29.8%	Other	9,284	26.8%
Total	1340	100.0%	Total	34,610	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

African American females compared to White Females

Leading Causes of Death: Females					
Cause of Death	**Frequency (African Americans)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	283	22.6%	Heart	8,461	22.7%
Heart	239	19.1%	Cancer	7,754	20.8%
Stroke	89	7.1%	Stroke	2,547	6.8%
Diabetes	86	6.9%	Chronic Lung	2,051	5.5%
Unintentional Injury	44	3.5%	Alzheimer's	1,917	5.1%
Nephritis/Nephrosis	43	3.4%	Unintentional Injury	1,322	3.5%
Chronic Lung	33	2.6%	Diabetes	1,065	2.9%
Alzheimer's	28	2.2%	Pneumonia	819	2.2%
Perinatal Conditions	28	2.2%	Nephritis/Nephrosis	630	1.7%
Other	378	30.2%	Other	10,763	28.8%
Total	1,251	100.0%	Total	37,329	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

Asians compared to Whites

Leading Causes of Death Total					
Cause of Death	**Frequency (Asians)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	83	30.4%	Heart	16,439	22.9%
Heart	36	13.2%	Cancer	16,293	22.6%
Unintentional Injury	21	7.7%	Stroke	4,192	5.8%
Stroke	20	7.3%	Chronic Lung	4,187	5.8%
Chronic Lung	9	3.3%	Unintentional Injury	3,213	4.5%
Diabetes	9	3.3%	Alzheimer's	2,700	3.8%
Suicide	6	2.2%	Diabetes	2,061	2.9%
Perinatal Conditions	6	2.2%	Pneumonia	1,452	2.0%
Alzheimer's	5	1.8%	Nephritis/Nephrosis	1,235	1.7%
Other	78	28.6%	Other	20,168	28%
Total	273	100%	Total	71,940	100%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

Asian males compared to White males

Leading Causes of Death: Males					
Cause of Death	**Frequency (Asians)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	41	30.4%	Cancer	8,539	24.7%
Heart	17	12.6%	Heart	7,978	23.1%
Unintentional Injury	15	11.1%	Chronic Lung	2,136	6.2%
Stroke	7	5.2%	Unintentional Injury	1,891	5.5%
Diabetes	5	3.7%	Stroke	1,645	4.8%
Chronic Lung	4	3.0%	Diabetes	996	2.9%
Suicide	4	3.0%	Alzheimer's	783	2.3%
Perinatal Condition	4	3.0%	Suicide	725	2.1%
Hereditary CNS Disease	3	2.2%	Pneumonia	633	1.8%
Other	35	25.9%	Other	9,284	26.8%
Total	135	100.0%	Total	34,610	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

Asian females compared to White females

Leading Causes of Death: Females					
Cause of Death	**Frequency (Asians)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	42	30.4%	Heart	8,461	22.7%
Heart	19	13.8%	Cancer	7,754	20.8%
Stroke	13	9.4%	Stroke	2,547	6.8%
Unintentional Injury	6	4.3%	Chronic Lung	2,051	5.5%
Chronic Lung	5	3.6%	Alzheimer's	1,917	5.1%
Alzheimer's	4	2.9%	Unintentional Injury	1,322	3.5%
Diabetes	4	2.9%	Diabetes	1,065	2.9%
Nephritis/Nephrosis	4	2.9%	Pneumonia	819	2.2%
Other Infectious Disease	4	2.9%	Nephritis/Nephrosis	630	1.7%
Other	37	26.8%	Other	10,763	28.8%
Total	138	100.0%	Total	37,329	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

American Indian/Alaska Natives compared to Whites

Leading Causes of Death Total					
Cause of Death	**Frequency (American Indians)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	71	14.3%	Heart	16,439	22.9%
Heart	66	13.3%	Cancer	16,293	22.6%
Diabetes	48	9.7%	Stroke	4,192	5.8%
Unintentional Injury	39	7.8%	Chronic Lung	4,187	5.8%
Cirrhosis	34	6.9%	Unintentional Injury	3,213	1.6%
Chronic Lung	22	4.4%	Alzheimer's	2,700	3.8%
Stroke	18	3.6%	Diabetes	2,061	2.9%
Homicide	16	3.2%	Pneumonia	1,452	2.0%
Nephritis/Nephrosis	14	2.8%	Nephritis/Nephrosis	1,235	1.7%
Other	167	33.7%	Other	20,168	28%
Total	495	100.0%	Total	71,940	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

American Indian/Alaska Native males compared to White males

Leading Causes of Death: Males					
Cause of Death	**Frequency (American Indians)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	37	14.5%	Cancer	8,539	24.7%
Heart	37	14.5%	Heart	7,978	23.1%
Diabetes	27	10.5%	Chronic Lung	2,136	6.2%
Unintentional Injury	26	10.2%	Unintentional Injury	1,891	5.5%
Cirrhosis	19	7.4%	Stroke	1,645	4.8%
Suicide	12	4.7%	Diabetes	996	2.9%
Stroke	11	4.3%	Alzheimer's	783	2.3%
Chronic Lung	9	3.5%	Suicide	725	2.1%
Homicide	8	3.1%	Pneumonia	633	1.8%
Other	70	27.3%	Other	9,284	26.8%
Total	256	100.0%	Total	34,610	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

American Indian/Alaska Native females compared to White females

Leading Causes of Death: Females					
Cause of Death	**Frequency (American Indians)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	34	14.2%	Heart	8,461	22.7%
Heart	29	12.1%	Cancer	7,754	20.8%
Diabetes	21	8.8%	Stroke	2,547	6.8%
Cirrhosis	15	6.3%	Chronic Lung	2,051	5.5%
Chronic Lung	13	5.4%	Alzheimer's	1,917	5.1%
Unintentional Injury	10	4.2%	Unintentional Injury	1,322	3.5%
Nephritis/Nephrosis	10	4.2%	Diabetes	1,065	2.9%
Septicemia	8	3.3%	Pneumonia	819	2.2%
Homicide	8	3.3%	Nephritis/Nephrosis	630	1.7%
Other	91	38.1%	Other	10,763	28.8%
Total	239	100.0%	Total	37,329	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

Hispanics compared to Whites

Leading Causes of Death Total					
Cause of Death	**Frequency (Hispanics)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	240	18.6%	Heart	16,439	22.9%
Heart	193	14.9%	Cancer	16,293	22.6%
Unintentional Injury	180	13.9%	Stroke	4,192	5.8%
Diabetes	60	4.6%	Chronic Lung	4,187	5.8%
Stroke	59	4.6%	Unintentional Injury	3,213	4.5%
Prenatal Conditions	48	3.7%	Alzheimer's	2,700	3.8%
Homicide	43	3.3%	Diabetes	2,061	2.9%
Birth Defects	39	3.0%	Pneumonia	1,452	2.0%
Cirrhosis	31	2.4%	Nephritis/Nephrosis	1,235	1.7%
Other	398	30.8%	Other	20,168	28%
Total	1291	100.0%	Total	71,940	100%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

Hispanic males compared to White males

Leading Causes of Death: Males					
Cause of Death	**Frequency (Hispanics)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	128	16.6%	Cancer	8,539	24.7%
Unintentional Injury	127	16.5%	Heart	7,978	23.1%
Heart	114	14.8%	Chronic Lung	2,136	6.2%
Stroke	31	4.0%	Unintentional Injury	1,891	5.5%
Homicide	31	4.0%	Stroke	1,645	4.8%
Diabetes	30	3.9%	Diabetes	996	2.9%
Perinatal Condition	30	3.9%	Alzheimer's	783	2.3%
Cirrhosis	27	3.5%	Suicide	725	2.1%
Suicide	21	2.7%	Pneumonia	633	1.8%
Other	230	29.9%	Other	9,284	26.8%
Total	769	100%	Total	3,4610	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

Hispanic females compared to White females

Leading Causes of Death: Females					
Cause of Death	**Frequency (Hispanics)**	**Percentage**	**Cause of Death**	**Frequency (Whites)**	**Percentage**
Cancer	112	21.5%	Heart	8,461	22.7%
Heart	79	15.2%	Cancer	7,754	20.8%
Unintentional Injury	53	10.2%	Stroke	2,547	6.8%
Diabetes	30	5.8%	Chronic Lung	2,051	5.5%
Stroke	28	5.4%	Alzheimer's	1,917	5.1%
Birth Defects	20	3.8%	Unintentional Injury	1,322	3.5%
Perinatal Condition	17	3.3%	Diabetes	1,065	2.9%
Pneumonia	12	2.3%	Pneumonia	819	2.2%
Homicide	12	2.3%	Nephritis/Nephrosis	630	1.7%
Other	158	30.3%	Other	10,763	28.8%
Total	521	100%	Total	37,329	100.0%

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010

Nebraska Leading Causes of Death by Age Group

Whites

Unintentional injury was the leading cause of death from age 1-44 years old. Cancer was the leading cause of death among 45-54 and 55-64 year olds. Of those 65 years and older, a majority, 30,771, died of heart disease; heart disease was the leading cause of death among White Nebraskans.

Rank	White Age Groups										All Ages
	<1	1 4	5 9	10 14	15 24	25 34	35 44	45 54	55 64	65+	
1	Congenital Anomalies 336	Unintentional Injury 95	Unintentional Injury 70	Unintentional Injury 99	Unintentional Injury 893	Unintentional Injury 532	Unintentional Injury 643	Malignant Neoplasms 2,307	Malignant Neoplasms 5,052	Heart Disease 30,771	Heart Disease 35,541
2	SIDS 150	Congenital Anomalies 29	Malignant Neoplasms 33	Malignant Neoplasms 24	Suicide 275	Suicide 257	Malignant Neoplasms 632	Heart Disease 1,493	Heart Disease 2,539	Malignant Neoplasms 24,121	Malignant Neoplasms 32,438
3	Short Gestation 111	Malignant Neoplasms 20	Congenital Anomalies 15	Suicide 24	Malignant Neoplasms 87	Malignant Neoplasms 158	Heart Disease 537	Unintentional Injury 792	Chronic Low. Respiratory Disease 666	Cerebrovascular 8,544	Cerebrovascular 9,326
4	Placenta Cord Membranes 90	Homicide 19	Homicide ---	Congenital Anomalies ---	Homicide 49	Heart Disease 127	Suicide 342	Suicide 378	Unintentional Injury 496	Chronic Low. Respiratory Disease 8,158	Chronic Low. Respiratory Disease 9,057
5	Maternal Pregnancy Comp. 85	Heart Disease ---		Heart Disease ---	Heart Disease 44	Homicide 70	Liver Disease 110	Liver Disease 298	Diabetes Mellitus 435	Alzheimer's Disease 4,898	Unintentional Injury 6,649
6	Respiratory Distress 37			Homicide ---	Congenital Anomalies 19	Diabetes Mellitus 26	Cerebrovascular 88	Cerebrovascular 252	Cerebrovascular 405	Diabetes Mellitus 3,196	Alzheimer's Disease 4,953
7	Unintentional Injury 34			Nephritis ---	Influenza and Pneumonia 10	Cerebrovascular 22	Diabetes Mellitus 72	Diabetes Mellitus 214	Liver Disease 269	Influenza and Pneumonia 3,058	Diabetes Mellitus 3,949
8	Atelectasis 28				Chronic Low. Respiratory Disease ---	Congenital Anomalies 22	HIV 71	Chronic Low. Respiratory Disease 177	Suicide 221	Unintentional Injury 2,995	Influenza and Pneumonia 3,351
9	Bacterial Sepsis 25				Cerebrovascular ---	Influenza and Pneumonia 21	Homicide 70	Influenza and Pneumonia 92	Nephritis 164	Nephritis 2,287	Nephritis 2,537
10	Neonatal Hemorrhage 22				Complicated Pregnancy ---	HIV 17	Influenza and Pneumonia 37	Viral Hepatitis 79	Septicemia 120	Hypertension 1,525	Suicide 1,777

Source: National Center for Health Statistics, National Vital Statistics System, 2001-2010
Note: '---' indicates less than 10 cases

African Americans

Homicide, responsible for 146 deaths among African Americans, was the leading cause of death among 15-34 year olds. Cancer was the leading cause of death among 45-64 year olds, and those 65 and older; cancer was the leading cause of death for all age groups combined.

Rank	African American Age Groups										All Ages
	<1	1 4	5 9	10 14	15 24	25 34	35 44	45 54	55 64	65+	
1	SIDS 43	Unintentional Injury ---	Unintentional Injury ---	Chronic Low. Respiratory Disease ---	Homicide 90	Homicide 56	Heart Disease 68	Malignant Neoplasms 171	Malignant Neoplasms 234	Malignant Neoplasms 634	Malignant Neoplasms 1,101
2	Short Gestation 37	Homicide ---	Malignant Neoplasms ---	Heart Disease ---	Unintentional Injury 35	Unintentional Injury 32	Malignant Neoplasms 35	Heart Disease 141	Heart Disease 155	Heart Disease 603	Heart Disease 1,003
3	Congenital Anomalies 29	Malignant Neoplasms ---	Chronic Low. Respiratory Disease ---	Homicide ---	Suicide 12	Heart Disease 20	Unintentional Injury 34	Cerebrovascular 51	Cerebrovascular 56	Cerebrovascular 193	Cerebrovascular 324
4	Maternal Pregnancy Comp. 26	Congenital Anomalies ---	Homicide ---	Congenital Anomalies ---	Heart Disease ---	Suicide 12	Homicide 24	Unintentional Injury 33	Diabetes Mellitus 51	Diabetes Mellitus 182	Diabetes Mellitus 277
5	Placenta Cord Membranes ---	Perinatal Period ---	Influenza and Pneumonia ---	Unintentional Injury ---	Malignant Neoplasms ---	HIV 10	HIV 17	Diabetes Mellitus 26	Chronic Low. Respiratory Disease 36	Chronic Low. Respiratory Disease 114	Homicide 203
6	Respiratory Distress ---	Anemias ---	---	Malignant Neoplasms ---	Chronic Low. Respiratory Disease ---	Malignant Neoplasms 10	Cerebrovascular 13	Chronic Low. Respiratory Disease 22	Nephritis 28	Nephritis 99	Unintentional Injury 203
7	Influenza and Pneumonia ---	Cerebrovascular ---	---	---	Cerebrovascular ---	Diabetes Mellitus ---	Diabetes Mellitus 11	HIV 17	Hypertension 17	Alzheimer's Disease 76	Chronic Low. Respiratory Disease 196
8	Homicide ---	Heart Disease ---	---	---	Complicated Pregnancy ---	Anemias ---	Nephritis ---	Liver Disease 16	Septicemia 16	Hypertension 57	Nephritis 154
9	Necrotizing Enterocolitis ---	Meningitis ---	---	---		Cerebrovascular ---	Chronic Low. Respiratory Disease ---	Nephritis 15	Unintentional Injury 15	Septicemia 41	Perinatal Period 129
10	Unintentional Injury ---	---	---	---		Chronic Low. Respiratory Disease ---	Suicide ---	Septicemia 14	Viral Hepatitis 11	Influenza and Pneumonia 40	Hypertension 85

Source: National Center for Health Statistics, National Vital Statistics System, 2001-2010
Note: '---' indicates less than 10 cases

American Indians

Unintentional injury was the leading cause of death among 10-34 year old American Indians in Nebraska. Heart disease was the leading cause of death among 45-54 year olds and those 65 and older. Liver disease and unintentional injury were both responsible for 15 deaths among 35-44 year old American Indians. Heart disease was the leading cause of death among all age groups combined.

Rank	American Indian Age Groups										All Ages
	<1	1 4	5 9	10 14	15 24	25 34	35 44	45 54	55 64	65+	
1	SIDS 10	Homicide ---	Congenital Anomalies ---	Unintentional Injury ---	Unintentional Injury 24	Unintentional Injury 14	Liver Disease 15	Heart Disease 26	Malignant Neoplasms 43	Heart Disease 82	Heart Disease 164
2	Congenital Anomalies ---	Cerebrovascular ---	Unintentional Injury ---	Suicide ---	Homicide 11	Suicide ---	Unintentional Injury 15	Liver Disease 24	Heart Disease 36	Malignant Neoplasms 78	Malignant Neoplasms 151
3	Short Gestation ---	Heart Disease ---	---	---	Suicide 11	Diabetes Mellitus ---	Heart Disease 12	Malignant Neoplasms 22	Liver Disease 24	Diabetes Mellitus 40	Unintentional Injury 93
4	Homicide ---	Influenza and Pneumonia ---	---	---	Heart Disease ---	Liver Disease ---	Malignant Neoplasms ---	Unintentional Injury 17	Diabetes Mellitus 22	Chronic Low. Respiratory Disease	Diabetes Mellitus 80
5	Maternal Pregnancy Comp. ---	Perinatal Period ---	---	---	Liver Disease ---	Heart Disease ---	Suicide ---	Diabetes Mellitus 10	Chronic Low. Respiratory Disease ---	Cerebrovascular 23	Liver Disease 76
6	Circulatory System Disease ---	Unintentional Injury ---	---	---	Malignant Neoplasms ---	Homicide ---	Diabetes Mellitus ---	Cerebrovascular ---	Nephritis ---	Nephritis 18	Chronic Low. Respiratory Disease
7	Placenta Cord Membranes ---	---	---	---	---	Gallbladder Disorders ---	Cerebrovascular ---	Chronic Low. Respiratory Disease ---	Unintentional Injury ---	Influenza and Pneumonia 10	Cerebrovascular 37
8	Bacterial Sepsis ---	---	---	---	---	HIV ---	Nephritis ---	Nephritis ---	Septicemia ---	Unintentional Injury 10	Nephritis 33
9	Influenza and Pneumonia ---	---	---	---	---	Malignant Neoplasms ---	Septicemia ---	Septicemia ---		Septicemia ---	Suicide 27
10		---	---	---	---	Pneumonitis ---	HIV ---	Viral Hepatitis ---		Liver Disease ---	Homicide 25

Source: National Center for Health Statistics, National Vital Statistics System, 2001-2010
Note: '---' indicates less than 10 cases

Asians

Cancer was the leading cause of death among 35-64, and 65+ year old Asians. Cancer was also the leading cause of death among all age groups combined.

Rank	Asian Age Groups										All Ages
	<1	1 4	5 9	10 14	15 24	25 34	35 44	45 54	55 64	65+	
1	Congenital Anomalies ---	Congenital Anomalies ---	Unintentional Injury ---	---	Unintentional Injury ---	Unintentional Injury ---	Malignant Neoplasms ---	Malignant Neoplasms 25	Malignant Neoplasms 40	Malignant Neoplasms 77	Malignant Neoplasms 155
2	Maternal Pregnancy Comp. ---	Heart Disease ---	---	---	Suicide ---	Malignant Neoplasms ---	Unintentional Injury ---	Unintentional Injury 10	Heart Disease ---	Heart Disease 53	Heart Disease 72
3	Intrauterine Hypoxia ---	---	---	---	Homicide ---	Suicide ---	Suicide ---	Heart Disease ---	Cerebrovascular ---	Cerebrovascular 33	Unintentional Injury 47
4	Congenital Pneumonia ---	---	---	---	Influenza and Pneumonia ---	Heart Disease ---	Nephritis ---	Cerebrovascular ---	Unintentional Injury ---	Chronic Low. Respiratory Disease 16	Cerebrovascular 43
5	Malignant Neoplasms ---	---	---	---	---	Homicide ---	---		Viral Hepatitis ---	Diabetes Mellitus 12	Chronic Low. Respiratory Disease 17
6	Placenta Cord Membranes ---	---	---	---	---	Influenza and Pneumonia ---	---		Diabetes Mellitus ---	Unintentional Injury 11	Diabetes Mellitus 14
7	SIDS ---	---	---	---	---	---	---		Parkinson's Disease ---	Alzheimer's Disease ---	Suicide 13
8	Short Gestation ---	---	---	---	---	---	---		Nephritis ---	Hypertension ---	Perinatal Period 10
9	---	---	---	---	---	---	---		Suicide ---	Nephritis ---	
10	---	---	---	---	---	---	---		---	Parkinson's Disease ---	

Source: National Center for Health Statistics, National Vital Statistics System, 2001-2010
Note: '---' indicates less than 10 cases

Hispanics

Unintentional injury was the leading cause of death between the ages of 1 and 44 years. However, cancer was the leading cause of death for all ages combined and accounted for 152 deaths between 45 and 64 year olds. Heart disease accounted for 233 deaths among those 65 and older.

Rank	Hispanic Age Groups										All Ages
	<1	1 4	5 9	10 14	15 24	25 34	35 44	45 54	55 64	65+	
1	Congenital Anomalies 55	Unintentional Injury 20	Unintentional Injury ---	Unintentional Injury 12	Unintentional Injury 101	Unintentional Injury 64	Unintentional Injury 46	Malignant Neoplasms 73	Malignant Neoplasms 78	Heart Disease 233	Malignant Neoplasms 444
2	Short Gestation 24	Homicide ---	Congenital Anomalies ---	Malignant Neoplasms ---	Homicide 23	Homicide 26	Malignant Neoplasms 36	Heart Disease 44	Heart Disease 43	Malignant Neoplasms 233	Heart Disease 360
3	SIDS 22	Congenital Anomalies ---	Malignant Neoplasms ---	Congenital Anomalies ---	Suicide 12	Suicide 13	Heart Disease 25	Unintentional Injury 37	Diabetes Mellitus 17	Diabetes Mellitus 85	Unintentional Injury 327
4	Maternal Pregnancy Comp. 21	Heart Disease ---	Cerebrovascular ---	Nephritis ---	Malignant Neoplasms ---	Malignant Neoplasms 11	Suicide 12	Cerebrovascular 20	Liver Disease 14	Cerebrovascular 53	Diabetes Mellitus 120
5	Placenta Cord Membranes 12	Malignant Neoplasms ---	---	Suicide ---	Cerebrovascular ---	Heart Disease ---	HIV 11	Liver Disease 19	Cerebrovascular 13	Nephritis 46	Perinatal Period 110
6	Homicide ---	Anemias ---	---	---	Complicated Pregnancy ---	HIV ---	Homicide 10	Diabetes Mellitus 12	Unintentional Injury 10	Chronic Low. Respiratory Disease 35	Cerebrovascular 100
7	Unintentional Injury ---	Cerebrovascular ---	---	---	Heart Disease ---	Diabetes Mellitus ---	Liver Disease 10	Suicide ---	Nephritis ---	Alzheimer's Disease 24	Homicide 78
8	Atelectasis ---	Chronic Low. Respiratory Disease ---	---	---		Cerebrovascular ---	Cerebrovascular ---	HIV ---	Suicide ---	Unintentional Injury 21	Congenital Anomalies 70
9	Gastritis ---	Meningitis ---	---	---		Influenza and Pneumonia ---	Influenza and Pneumonia ---	Viral Hepatitis ---		Influenza and Pneumonia 20	Liver Disease 60
10	Influenza and Pneumonia ---	Perinatal Period ---	---	---				Homicide ---		Liver Disease 15	Nephritis 56

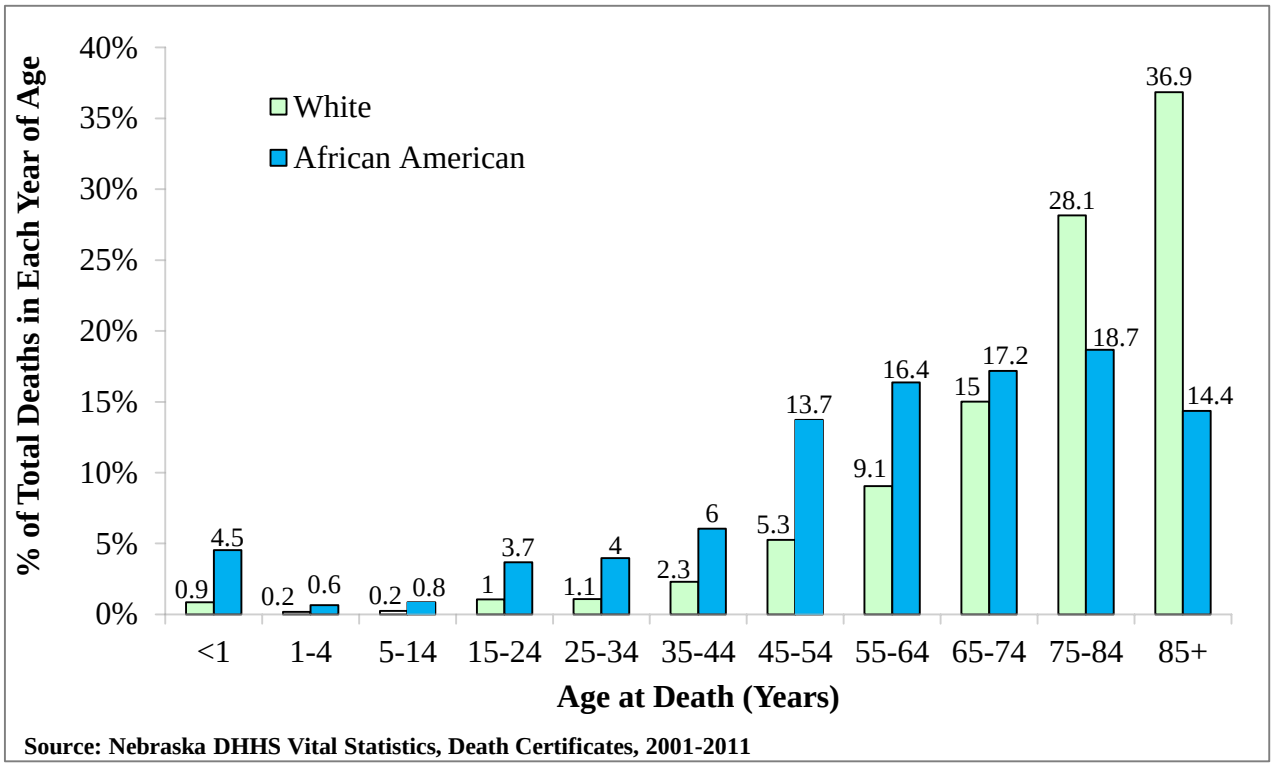
Source: National Center for Health Statistics, National Vital Statistics System, 2001-2010
Note: '---' indicates less than 10 cases

Mortality Distribution by Age in the State of Nebraska

African American

Almost 67% of all African American deaths occurred before age 75, compared to 35% of White deaths. Four and a half percent of all African American deaths occurred at 1 year or younger, which was the highest percentage until 35-44 years old. The largest proportion of African Americans died between 75 and 84 years of age (18.7%). Among all deaths, 14.4% of African Americans died at ages 85 and older, compared to almost 37% of Whites.

African American and White Mortality Distributions by Age at Death

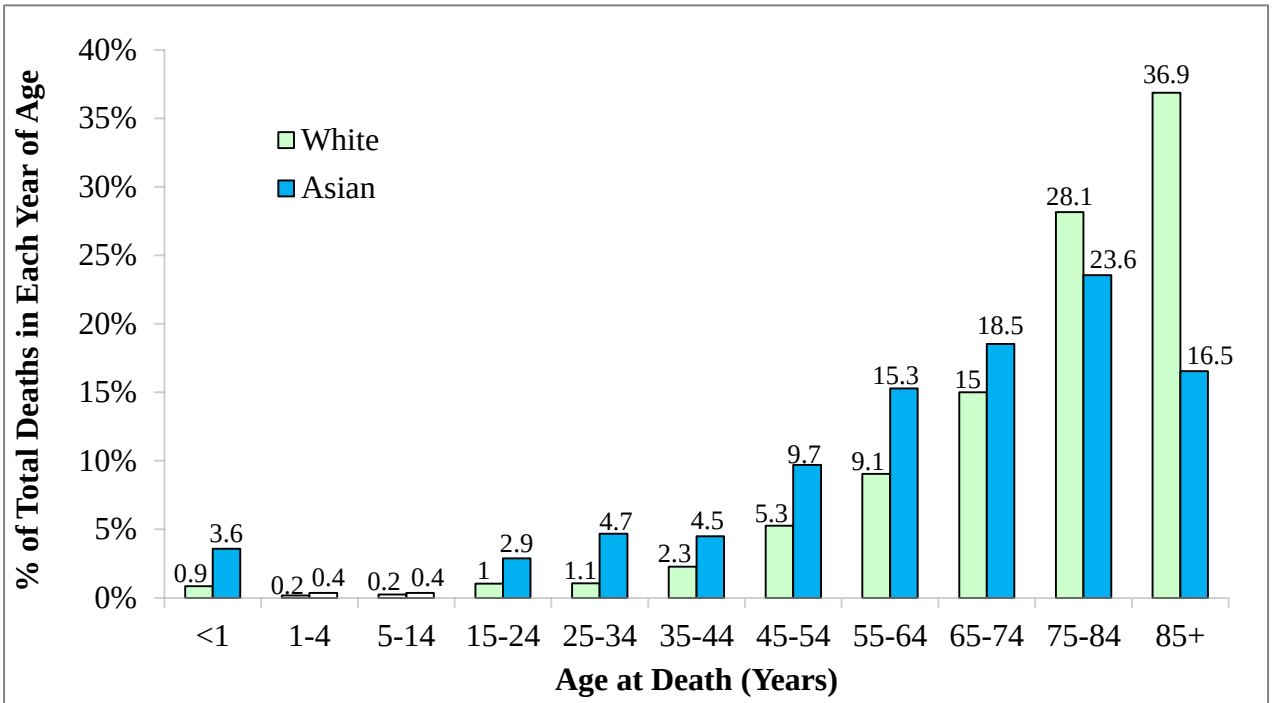


Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2011

Asian

Sixty percent of all Asian deaths occurred before the age of 75, compared to 35% of Whites. Approximately 3.5% of Asian deaths occurred at one year old or younger, which was the highest proportion until 25-34 years old. The largest proportion of deaths occurred between 75 and 84 years old among the Asian population (23.6%). Only 16.5% of deaths among Asians occurred at 85 years old or older, compared to almost 37% of Whites.

Asian and White Mortality Distributions by Age at Death

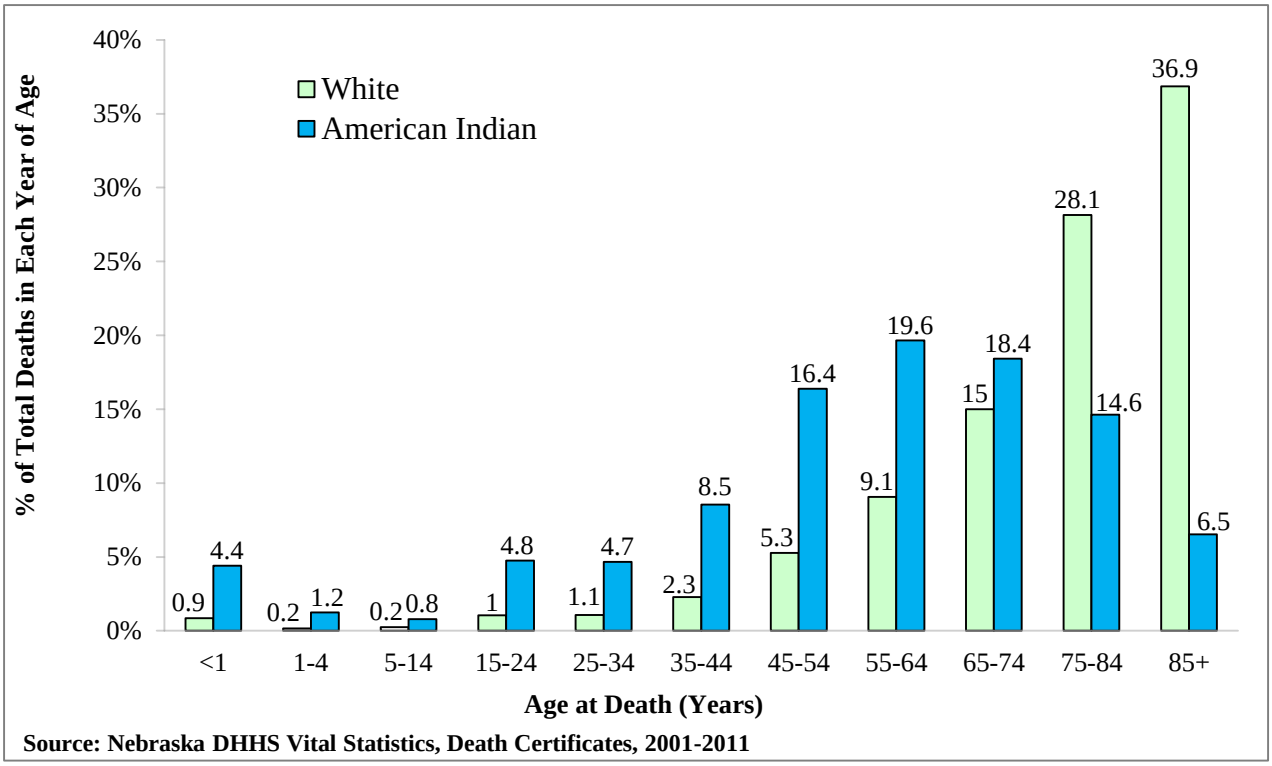


Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2011

American Indian

Almost 80% of all American Indian deaths occurred before the age of 75, compared to 35% of deaths among Whites. Approximately 4.5% of deaths among American Indians occurred at 1 year of age or younger, which was a similar proportion to deaths that occurred at ages 15-24 and 25-34 and was only largely exceeded beginning between the ages of 35 and 44. The largest proportion of deaths among American Indians occurred between the ages of 55 and 64. Only 6.5% of deaths occurred at 85 years old or older, compared to almost 37% of deaths among Whites.

American Indian and White Mortality Distributions by Age at Death

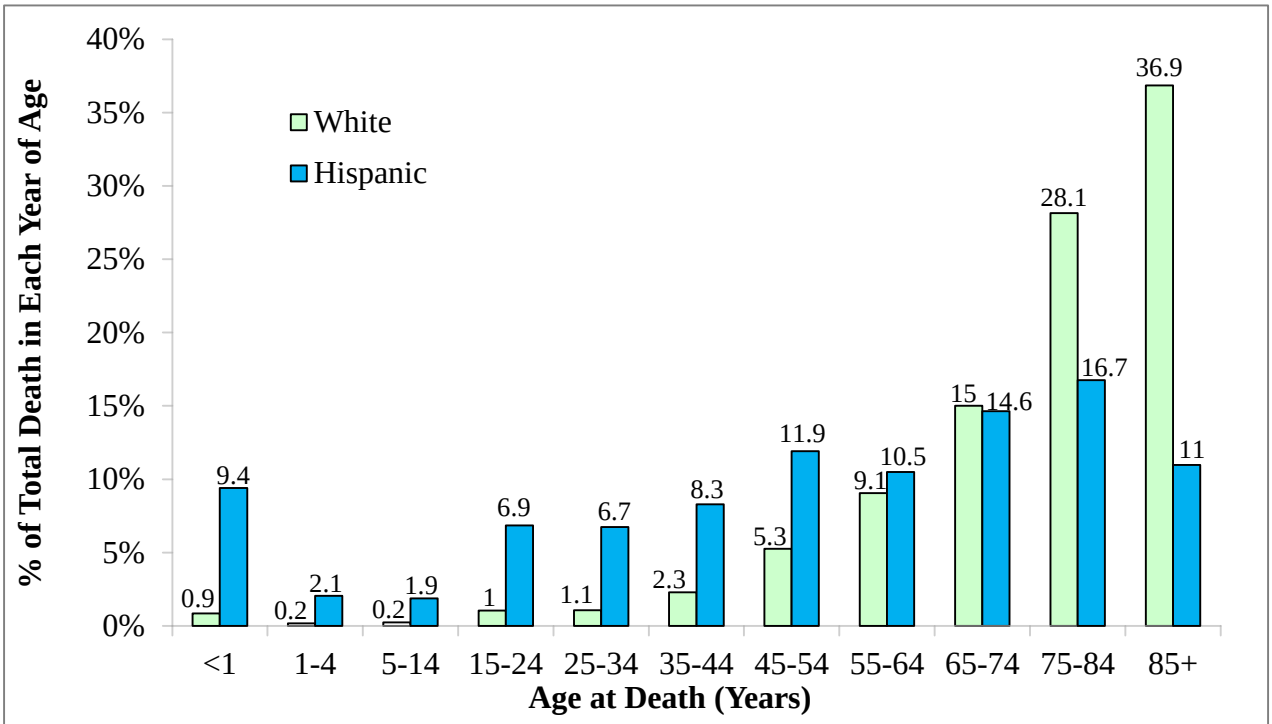


Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2011

Hispanic

Approximately 70% of deaths among Hispanics occurred before 75 years of age, compared to 35% of deaths among Whites. Almost 9.5% of Hispanic deaths occurred at 1 year of age or younger, the highest proportion of deaths until 45-54 years of age. The largest proportion of Hispanic deaths occurred between the ages of 75 and 84. Eleven percent of deaths among Hispanics occurred at 85 years old or older, compared to almost 37% of deaths among Whites.

Hispanic and White Mortality Distributions by Age at Death



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2011

Years of Potential Life Lost

In this report, on pages following mortality measures, there will be a discussion of certain health measures and the effects on potential life lost. Years of potential life lost (YPLL) is a measure of premature death as well as a measure of the relative impact of various diseases and other causes of mortality in a population.[40, 41] Death before age 75 is considered premature mortality because the average life expectancy in the United States is now over 75 years.[42] In 2007, the average age at death among Nebraska residents was 75.2 years.[43]

For each person who died prematurely, the age at death is subtracted from 75; for example, a person dying at age 50 would contribute 25 years of potential life lost. The total years of potential life lost in the population is then divided by the size of the population under age 75. The leading cause of potential life lost is cancer, with approximately 15 years of potential life lost per 1,000 residents. Cancer is followed by accidents (9 YPLL per 1,000) and heart disease (8 YPLL per 1,000).

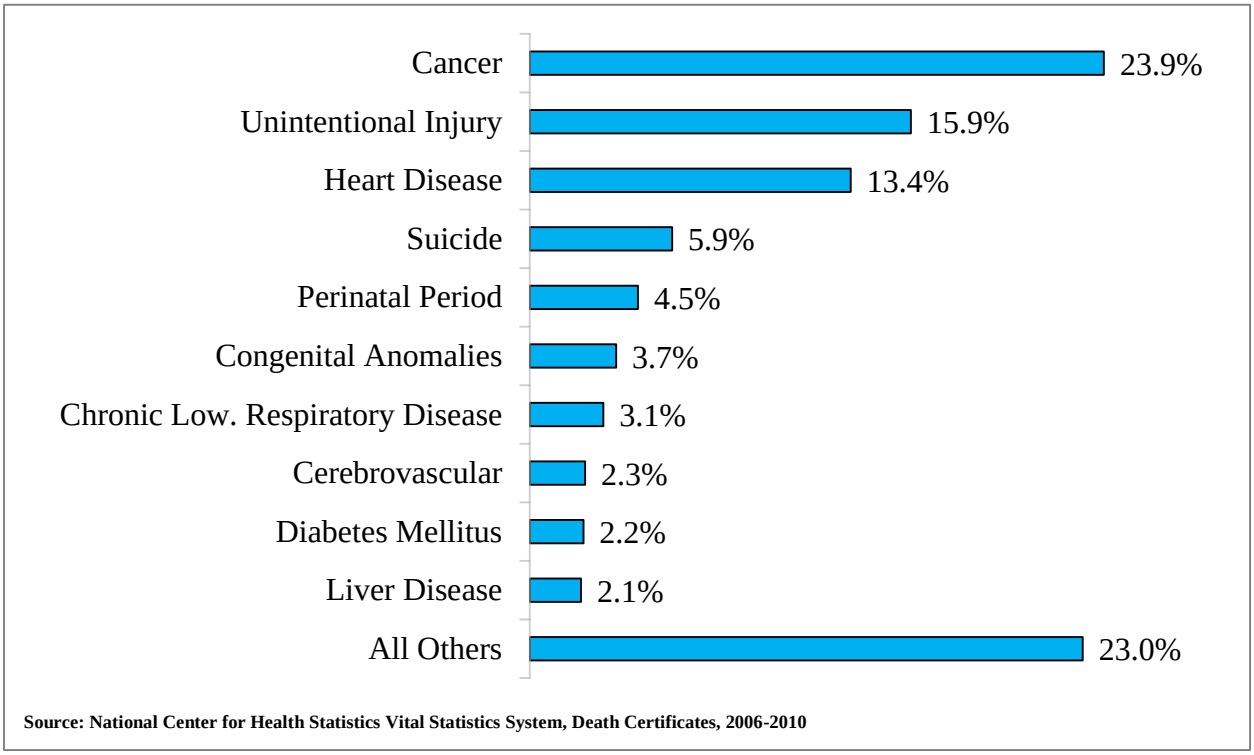
Leading causes of years of life lost by racial and ethnic groups for Nebraska are listed on the following pages. These graphs help emphasize what some populations are struggling with in terms of mortality.

[40]National Center for Health Statistics. (2008). Health, United States, 2008. Hyattsville, Maryland.
[41]Last, M. (2002). Years of potential life lost. Encyclopedia of Public Health.
[42]National Center for Health Statistics. (2008). Health, United States, 2008. Hyattsville, Maryland.
[43]Nebraska Department of Health and Human Services. (2009). Nebraska 2007 vital statistics report.

Leading Causes of Years of Potential Life Lost

White

Among the 454,116 total years of life lost among Whites in Nebraska between 2006 and 2010, almost 24% of them were attributed to cancer. Unintentional injury was responsible for the next largest proportion of years of life lost (15.9%), followed by heart disease (13.4%).



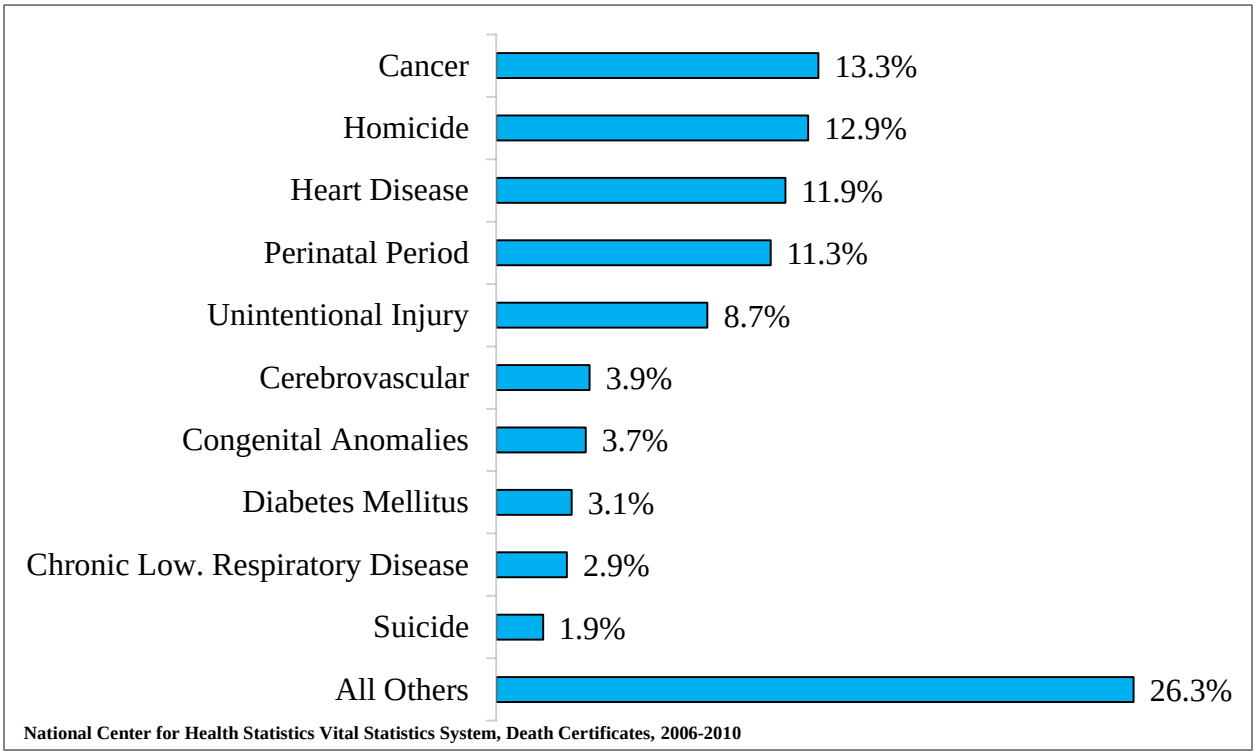
Source: National Center for Health Statistics Vital Statistics System, Death Certificates, 2006-2010

Cause of Death	YPLL	Percent
All Causes	454,116	100%
Cancer	108,400	23.9%
Unintentional Injury	72,020	15.9%
Heart Disease	60,985	13.4%
Suicide	26,678	5.9%
Perinatal Period	20,403	4.5%
Congenital Anomalies	16,930	3.7%
Chronic Lower Respiratory Disease	14,116	3.1%
Cerebrovascular	10,627	2.3%
Diabetes Mellitus	9,955	2.2%
Liver Disease	9,682	2.1%
All Others	104,320	23%

Source: National Center for Health Statistics Vital Statistics System, Death Certificates, 2006-2010

African American

Among the 45,664 years of total life lost among African Americans between 2006 and 2010 in Nebraska, approximately 13.3% of those years lost were attributed to cancer. Almost 13% of the years of life lost were due to homicide, while almost 12% were due to heart disease. Approximately 11% of years lost were attributed to the perinatal period.

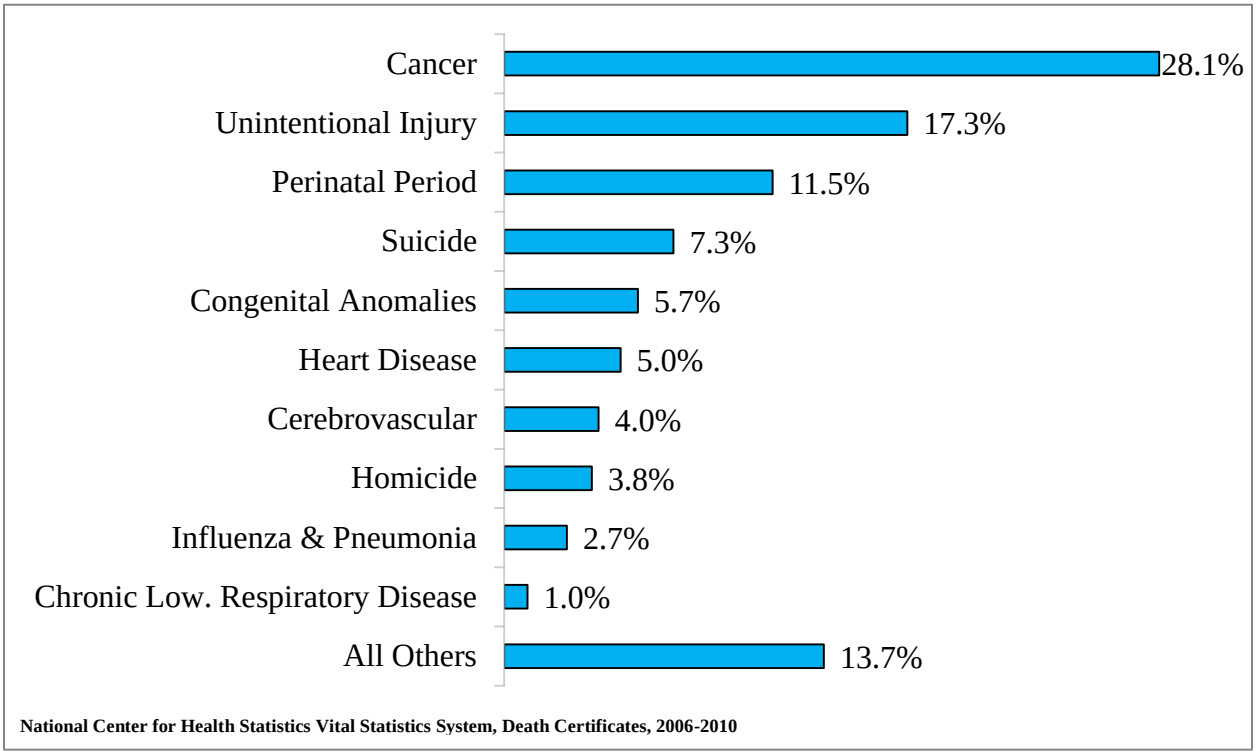


Causes of Death	YPLL	Percent
All Causes	45,664	100%
Cancer	6,076	13.3%
Homicide	5,883	12.9%
Heart Disease	5,451	11.9%
Perinatal Period	5,173	11.3%
Unintentional Injury	3,982	8.7%
Cerebrovascular	1,759	3.9%
Congenital Anomalies	1,686	3.7%
Diabetes Mellitus	1,421	3.1%
Chronic Low. Respiratory Disease	1,333	2.9%
Suicide	882	1.9%
All Others	12,018	26.3%

Source: National Center for Health Statistics Vital Statistics System, Death Certificates, 2006-2010

Asian

Among the 3,913 total years of life lost among Asians between 2006 and 2010, 28.1% of those were attributed to cancer. Unintentional injury accounts for 17.3% of years lost, or 676 years of life lost. Eleven and a half percent of years lost were attributed to the perinatal period.

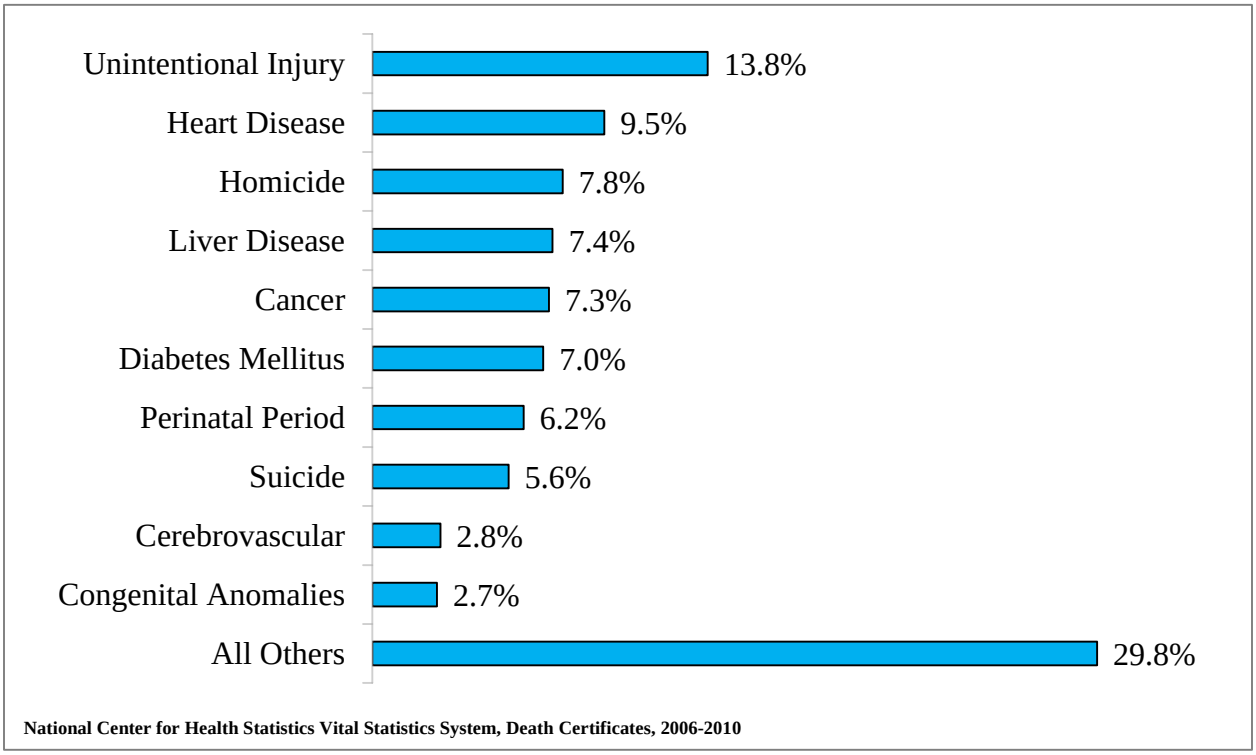


Causes of Death	YPLL	Percent
All Causes	3,913	100%
Cancer	1,099	28.1%
Unintentional Injury	676	17.3%
Perinatal Period	450	11.5%
Suicide	284	7.3%
Congenital Anomalies	224	5.7%
Heart Disease	195	5.0%
Cerebrovascular	158	4.0%
Homicide	147	3.8%
Influenza and Pneumonia	105	2.7%
Chronic Low. Respiratory Disease	39	1.0%
All Others	536	13.7%

Source: National Center for Health Statistics Vital Statistics System, Death Certificates, 2006-2010

American Indian

Among the 10,829 total years of life lost among American Indians between 2006 and 2010 in Nebraska, 13.8% of those years lost were attributed to unintentional injury. Heart disease accounted for 9.5% of total years lost. Liver disease, homicide, diabetes, and cancer accounted for 7-7.8% each of years lost among American Indians.



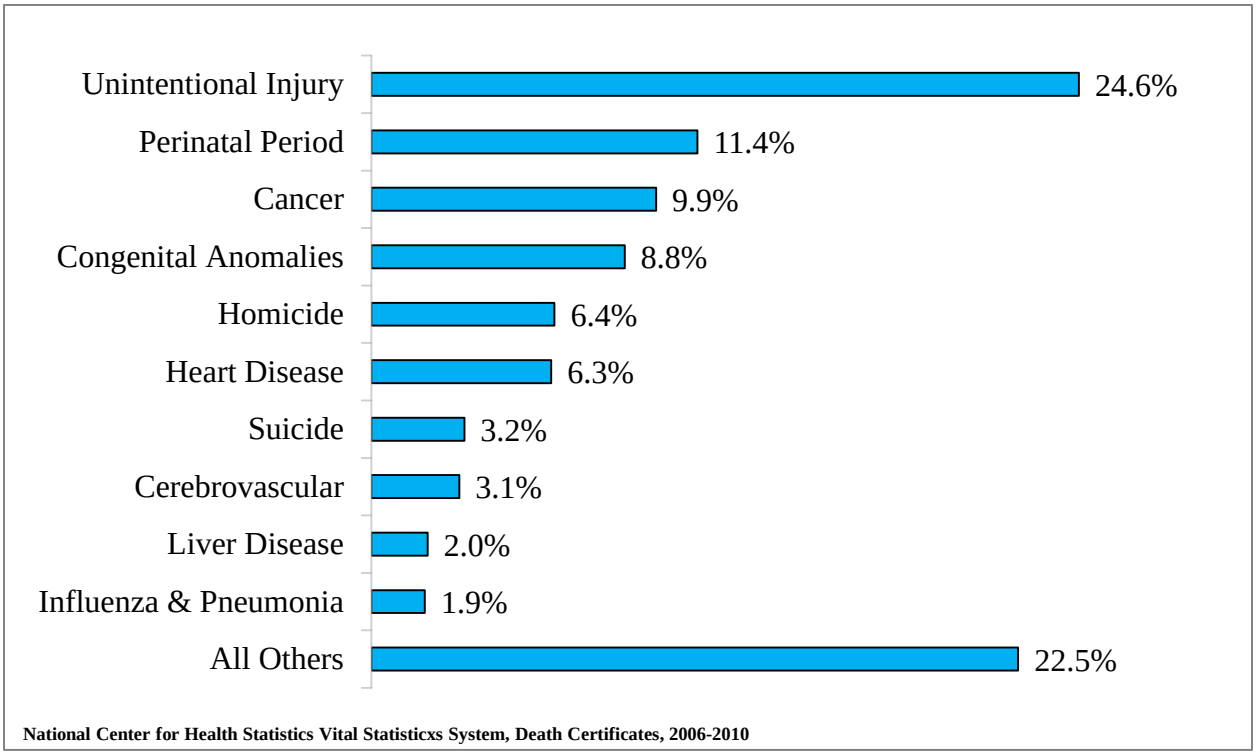
National Center for Health Statistics Vital Statistics System, Death Certificates, 2006-2010

Causes of Death	YPLL	Percent
All Causes	10,829	100%
Unintentional Injury	1,495	13.8%
Heart Disease	1,033	9.5%
Homicide	848	7.8%
Liver Disease	803	7.4%
Cancer	787	7.3%
Diabetes Mellitus	761	7.0%
Perinatal Period	674	6.2%
Suicide	607	5.6%
Cerebrovascular	303	2.8%
Congenital Anomalies	288	2.7%
All Others	3,230	29.8%

Source: National Center for Health Statistics Vital Statistics System Death Certificates, 2006-2010

Hispanic

Among the 33,029 total years of life lost among Hispanics between 2006 and 2010, 24.6% were attributed to unintentional injury. Approximately 11% of years of life lost were attributed to the perinatal period. Cancer was responsible for almost 10% of years of life lost.



Causes of Death	YPLL	Percent
All Causes	33,029	100%
Unintentional Injury	8,132	24.6%
Perinatal Period	3,749	11.4%
Cancer	3,273	9.9%
Congenital Anomalies	2,914	8.8%
Homicide	2,107	6.4%
Heart Disease	2,069	6.3%
Suicide	1,071	3.2%
Cerebrovascular	1,011	3.1%
Liver Disease	650	2.0%
Influenza and Pneumonia	617	1.9%
All Others	7,436	22.5%

Source: National Center for Health Statistics Vital Statistics System, Death Certificates, 2006-2010

CHRONIC DISEASE

Chronic diseases can be controlled but not cured; they are diseases of long duration and slow progression.[44] In most cases, a chronic disease will require a lifetime of regular treatment. Chronic diseases are usually characterized by acute episodes of illness followed by periods of time where symptoms may be reduced or absent. Some chronic illnesses cause permanent disability.[45]

The onset of many chronic diseases results from accumulated exposure to multiple risk factors over an extended period, so it is often difficult to determine group differences in exposure to risk. Some chronic diseases, such as heart disease and certain types of cancer, may be asymptomatic for many years. Consequently, racial and ethnic differences in mortality due to heart disease or cancer, for example, may result from group differences in the use of health services that might have resulted in early detection and treatment lessening the adverse consequences of a chronic condition, including disability and early death.

Chronic diseases as a group are the leading cause of death and disability in the United States, accounting for 70% of all deaths or 1.7 million deaths every year.[46] In particular, cancer, heart disease, and stroke account for more than 50% of those deaths. Worldwide, 90% of chronic disease death occurred in low- and middle-income countries. Arthritis is the most common cause of disability; one fourth of all people with a chronic condition experience a disability.[47]

Diabetes is the most common cause of kidney failure, non-traumatic lower-extremity amputations, and blindness among adults.[48] Damaging health behaviors, particularly tobacco use, lack of physical activity, and poor eating habits are major contributors to the leading chronic diseases. According to the CDC, more than a third of all adults do *not* get the recommended amount of aerobic physical activity and 23% report no physical activity at all.[49] To that end, more than 43 million Americans smoke and 17% of adults binge drink. It is clear that a lot America's poor health behaviors are related to chronic diseases.

[44]World Health Organization. (2013). Chronic disease. Retrieved from http://www.who.int/topics/chronic_diseases/en/.
[45]Schueler, S., Beckett, J., and Gettings, S. (2010). Chronic disease. Retrieved from http://www.freemd.com/chronic-disease/.
[46]Centers for Disease Control and Prevention. (2012). Chronic disease and health promotion.
[47]Ibid.
[48]Ibid.
[49]Ibid.

PROGRESS TOWARD HP2010

The national goal for heart disease, stroke, and diabetes as part of Healthy People 2010 is to improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors, as well as reduce economic costs that result from of diabetes. The chart below offers a summary of findings for measures we have that match specific Healthy People 2010 objectives. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✖ = regress away or remained the same), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✖ = not met).

Summary

The data for heart disease are listed below, however there were no HP2010 objectives for heart disease. All racial and ethnic groups saw progress toward their stroke objectives. Both Asian and American Indian Nebraskans reached their Healthy People 2010 objectives; Hispanics were within 1/100,000 in reaching their goal regarding stroke death.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Heart Disease Death Rate per 100,000 Population					
White	196.7	160.2	✓	Not Available	✖
African American	246.4	214.2	✓		✖
Asian	108.3	64.5	✓		✖
American Indian	280.1	131.7	✓		✖
Hispanic or Latino	114.6	89.7	✓		✖
Stroke Death Rate per 100,000 Population					
White	51.7	40.8	✓	47.4	✓
African American	84.2	66.6	✓	47.4	✖
Asian	65.7	28.4	✓	32.7	✓
American Indian	62	38.7	✓	47.4	✓
Hispanic or Latino	29.2	23	✓	22.3	✖
Diabetes Death Rate per 100,000 Population					
White	20.3	21.1	✖	25.0	✓
African American	67.3	62.1	✓	25.0	✖
Asian	13.9	18.7	✖	25.0	✓
American Indian	91	93.2	✖	25.0	✖
Hispanic or Latino	45.6	28.8	✓	25.0	✖

Coronary Heart Disease

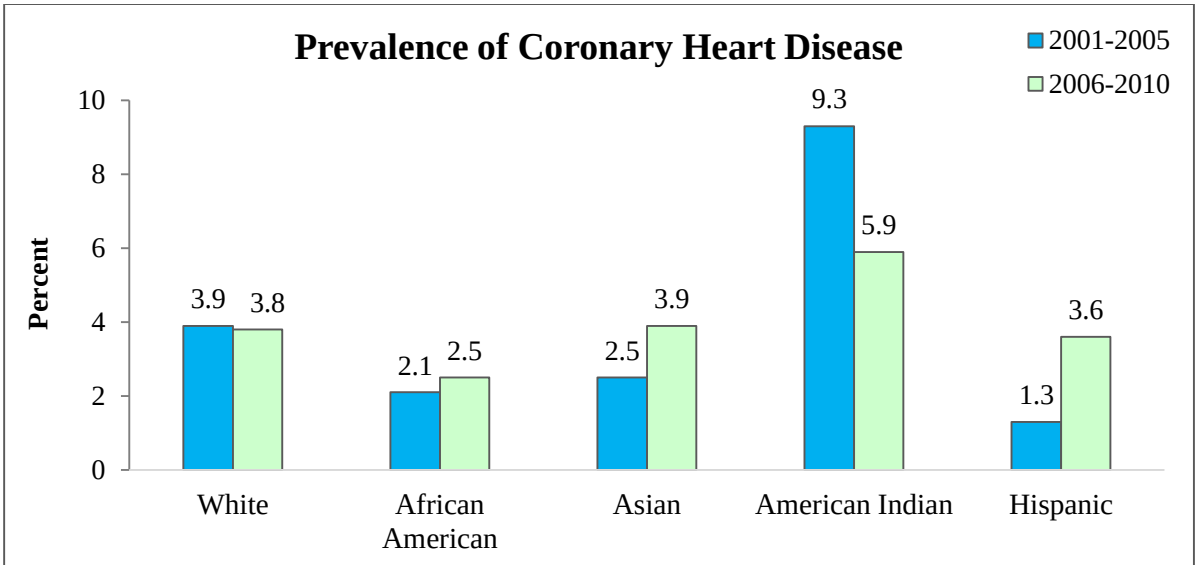
Coronary heart disease is the narrowing of coronary arteries from the buildup of plaque. With narrowed passageways, the amount of blood delivered to the heart is lessened and puts one at risk for heart attack.[50] Numerous tests can diagnose coronary heart disease, like electrocardiograms, stress testing, or an echocardiograph.[51]

Key Disparities

- Nebraska's American Indian population had the highest percentage of people who had been told they have coronary heart disease (5.9%), compared to 3.8% of Whites.
- Almost 4% of Asian Nebraskans had been told that they have coronary heart disease.
- Nearly 4% of Hispanic Nebraskans had been told by a professional that they have coronary heart disease.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentage of people told they have coronary heart disease increased in the African American, Asian, and Hispanic populations, and Hispanics experienced the largest increase from 1.3% to 3.6%.
- Nebraska's American Indian population saw a dramatic reduction in people who had been told they have coronary heart disease, dropping from 9.3% in 2001-2005 to 5.9% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010
Note: Questions regarding CHD were not included in BRFSS in 2001, 2002, 2004

Compared to the Nation

- African Americans in Nebraska saw a lower prevalence of coronary heart disease compared to the national African American population (6.5%).
- Hispanics saw a lower proportion with heart disease compared to the nation (6.1%)
- Approximately 6% of Nebraska American Indians had coronary heart disease, compared to 11.6% of American Indians in the rest of the United States.

[50]National Heart, Lung, and Blood Institute. What is coronary heart disease? Retrieved from http://www.nhlbi.nih.gov/health/health-topics/topics/cad/.
[51]Ibid.

Myocardial Infarction

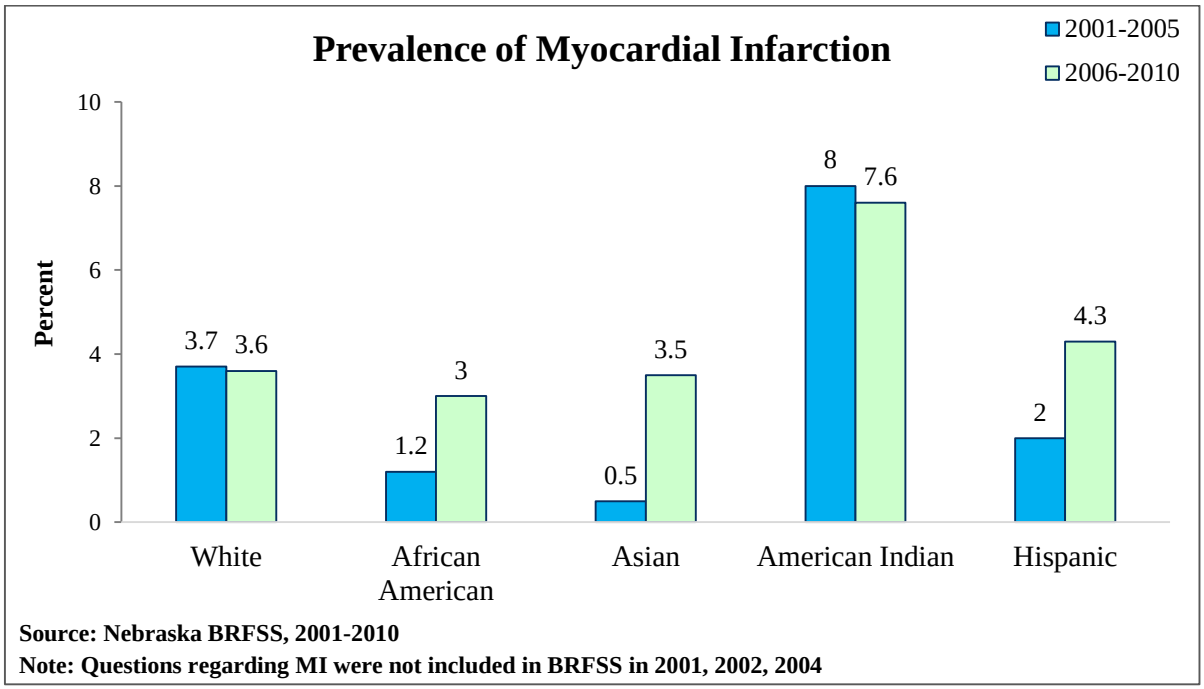
A heart attack or myocardial infarction is permanent damage to the heart muscle. Those people with coronary heart disease experience narrowing of arteries, which eventually starves heart cells of oxygen-dense blood.[52] Heart muscle cells that are not exposed to blood will die off, leading to a heart attack.

Key Disparities

- Nebraska's American Indian population had the highest percentage of people who had been told they had an MI (7.6%), compared to 3.6% of Whites.
- Four point three percent of Hispanics were told they had an MI.
- Both African Americans and Asians saw comparable percentages, at 3% and 3.5%, respectively.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Asian Nebraskans saw the largest increase from 0.5% in 2001-2005 to 3.5% in 2006-2010.
- Hispanic Nebraskans saw a 2% increase, from 2% to 4.3%.
- American Indians, experiencing the highest rate throughout the decade, saw a slight decline from 8% in 2001-2005 to 7.6% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010
Note: Questions regarding MI were not included in BRFSS in 2001, 2002, 2004

Compared to the Nation

- The prevalence of heart attack among Hispanics in Nebraska was almost 1.5 times the prevalence of heart attack among Hispanics in the United States (2.8%).
- Three percent of African Americans in Nebraska had a heart attack, compared to 3.8% of African Americans in the United States.

[52]WebMD. (2013). Heart attacks and heart disease. Retrieved from http://www.webmd.com/heart-disease/guide/heart_disease_heart_attacks.

Coronary Heart Disease *or* Myocardial Infarction

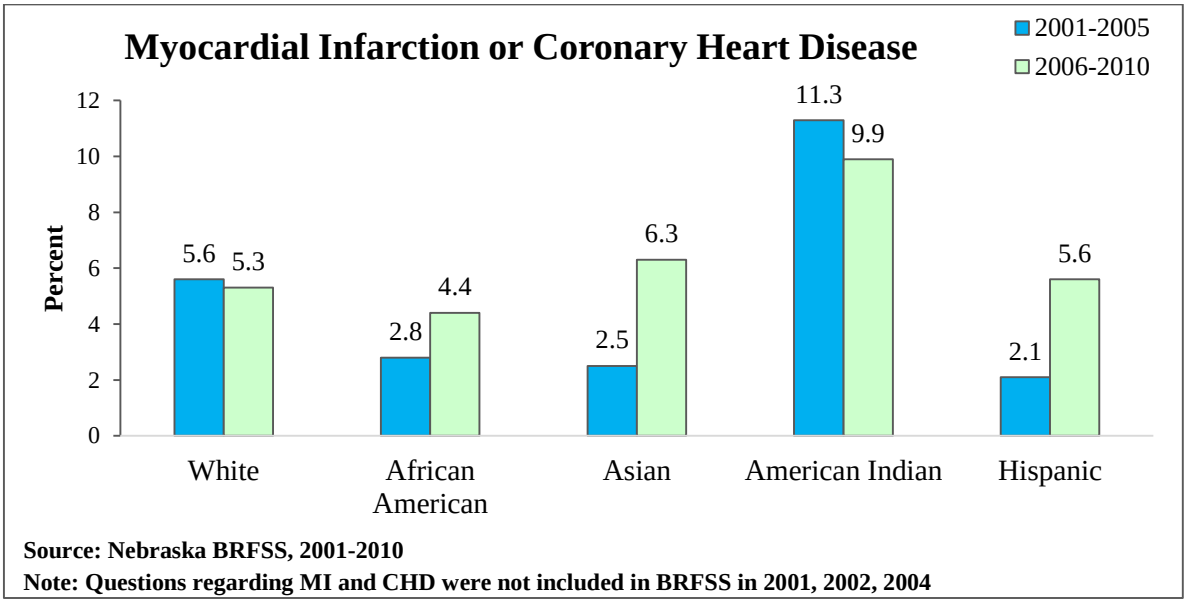
The indicator 'myocardial infarction (MI) or coronary heart disease (CHD)' illustrates the percentage of people who have suffered from either of these conditions.

Key Disparities

- Almost 10% of American Indians had an MI or had CHD in 2006-2010, compared to 5.3% of Whites.
- Approximately 6% of Asians (6.3%) and Hispanics (5.6%) had suffered an MI or CHD.
- Only 4.4% of African Americans had a heart attack or reported having coronary heart disease in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Most minority groups in Nebraska saw an increase in the number of individuals with CHD or an MI between 2001-2005 and 2006-2010.
- Almost 6% of Hispanics had an MI or CHD in 2006-2010, almost 3 times the percentage from 2001-2005 (2%).
- Over twice as many Asians had an MI or CHD in 2006-2010 (6.3%) than 2001-2005 (2.5%).
- American Indians saw a reduced proportion of people with MI or CHD from 2001-2005 (11.3%) to 2006-2010 (9.9%).



Source: Nebraska BRFSS, 2001-2010
Note: Questions regarding MI and CHD were not included in BRFSS in 2001, 2002, 2004

Compared to the Nation

- African Americans, Hispanics, and American Indians in Nebraska reported a smaller proportion of the population with CHD or MI, compared to their national counterparts (6.5%, 6.1%, and 11.6%, respectively).
- Approximately 4% of Asians in the United States had been told they had CHD or a MI, compared to 6.3% of Asians in Nebraska.

Heart Disease Mortality

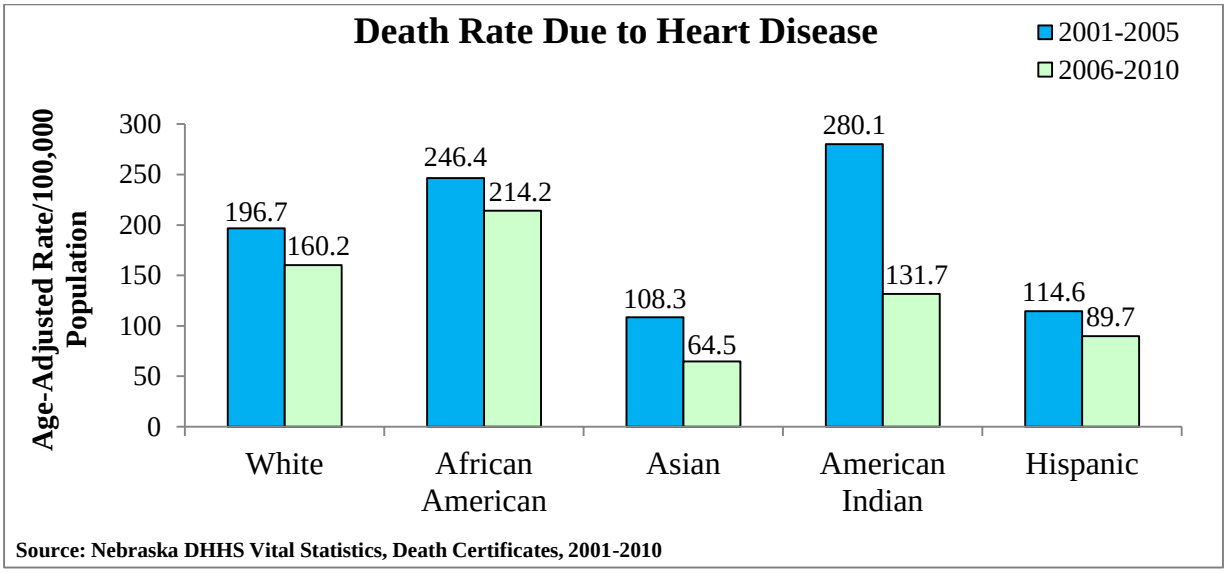
Heart disease (HD) is a general term that includes coronary heart disease, rheumatic heart disease, hypertension, and heart failure, among others. HD is caused by the buildup of plaque in the heart's arteries.[53] A poor diet, tobacco use, obesity, and physical inactivity are linked to HD.[54]

Key Disparities

- Nebraska's African American population (214.2/100,000 people) had the highest heart disease death rate in 2006-2010, compared to Whites at 160.2/100,000 people.
- Asian Americans saw the lowest death rate at 64.5/100,000 people, followed by Hispanics at 89.7/100,000 people.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Heart disease mortality decreased across all racial and ethnic groups, with American Indians seeing the largest reduction from 280.1/100,000 people in 2001-2005 to 131.7/100,000 people in 2006-2010; dropping below Whites.
- African Americans saw the highest heart disease death rate in 2006-2010, over American Indians who ranked highest in 2001-2005.
- Asian and Hispanic Americans dropped below 100 in 2006-2010, at 64.5/100,000 people and 89.7/100,000 people, respectively.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Compared to the Nation

- Nebraska's African American and American Indian populations saw higher HD mortality rates than the U.S. (133.4/100,000 people and 84.9/100,000 people, respectively).
- Nebraska's Hispanic and Asian communities saw comparable rates to the nation (92.3/100,000 people and 68.7/100,000 people, respectively).

[53] A.D.A.M. Medical Encyclopedia. (2012). Coronary Heart Disease. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004449/.
[54] Centers for Disease Control and Prevention. (2009). Heart Disease Behavior. Retrieved from http://www.cdc.gov/heartdisease/behavior.htm.

Trends: Heart Disease Mortality

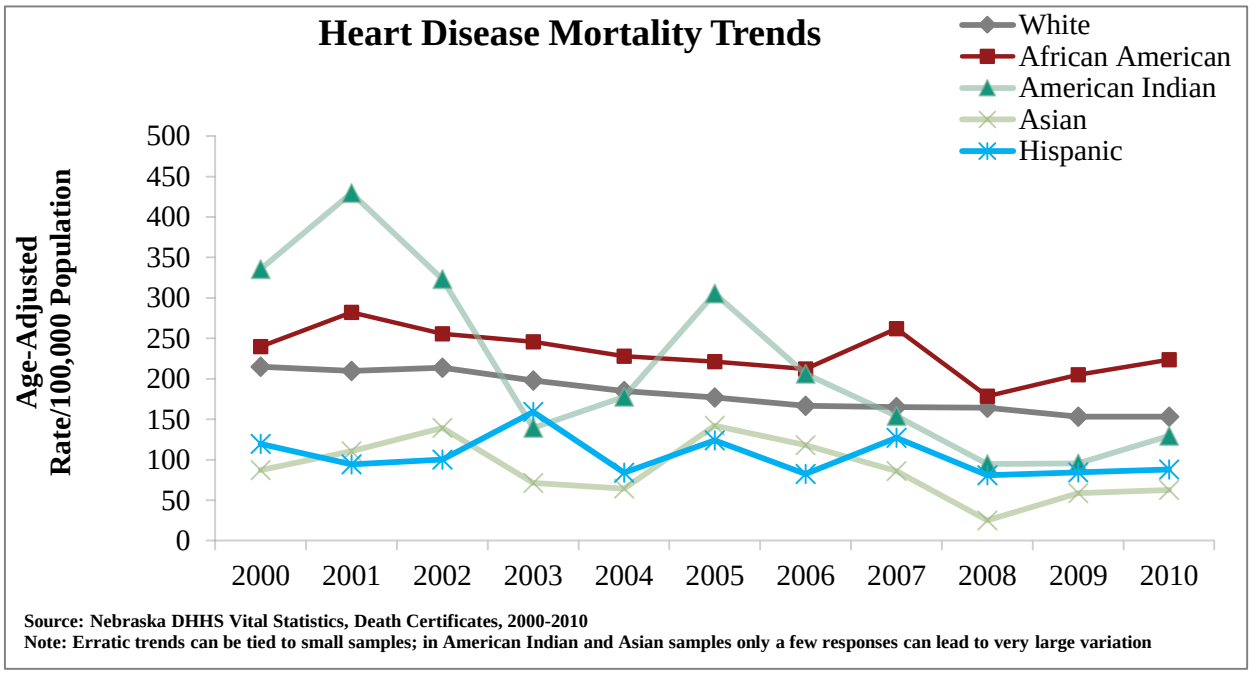
Heart disease is responsible for more than 597,600 deaths every year, at a rate of 193.6 per 100,000 population in the United States.[55] In Nebraska, 2007 marked the fifth consecutive year in which fewer than 4,000 heart disease deaths were recorded.

Key Disparities

- Between 2000 (335.5/100,000 people) and 2002 (323.4/100,000 people), American Indians saw the highest rate of heart disease mortality; they saw the highest rate again in 2005 (305.5/100,000 people) compared to Whites who saw gradual decline in mortality throughout the decade.
- Most consistently, African Americans saw the highest rate of heart disease mortality throughout the decade.
- Asians saw the lowest rates of heart disease mortality seven out of ten years.

Trends between 2000 and 2010

- American Indians saw a large decrease in heart disease mortality between 2001 (429.6/100,000 people) and 2003 (139.5/100,000 people), only to rank the highest among all groups again in 2005.
- Asians saw a very low rate of heart disease mortality in 2008 (25.2/100,000 people), in fact most groups saw their lowest rate in 2008.
- Where Hispanics and Asians may have experienced a leveling off at the end of the decade (2009-2010), African Americans and American Indians experienced another increase in heart disease mortality.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2000-2010
Note: Erratic trends can be tied to small samples; in American Indian and Asian samples only a few responses can lead to very large variation

[55]Centers for Disease Control and Prevention (2013). Heart disease. Retrieved from http://www.cdc.gov/nchs/fastats/heart.htm.

Years Lost Due to Heart Disease

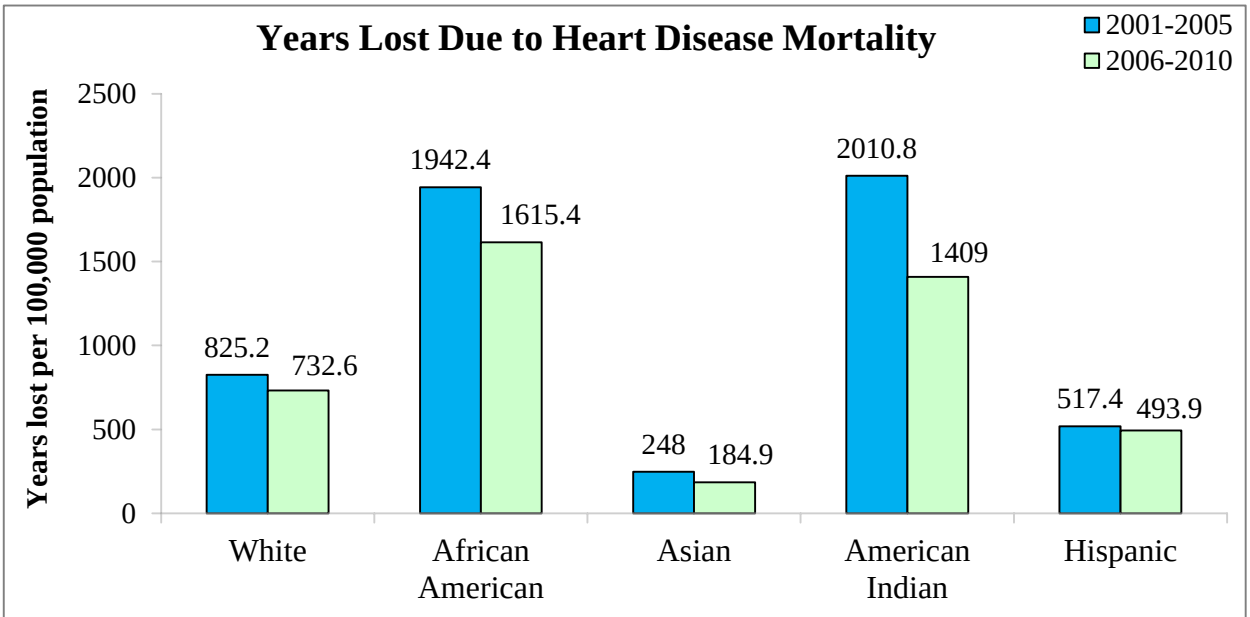
Twenty-six and a half million people, or 11.5% of the population, in the United States have been diagnosed with heart disease.[56] In 2009, almost 15 million physicians' visits resulted in a heart disease diagnosis and four million hospital discharges first-listed heart disease, with an average four-day stay.[57] Approximately 43% of all nursing home residents have heart disease.[58] Heart disease remains the third leading cause of years of potential life lost.[59] The data below reflects deaths that occurred before age 75.

Key Disparities

- Nebraska's African American population had the highest amount of years lost due to heart disease (1,615.4) in 2006-2010, compared to Whites at 732.6.
- A combined 2,010.8 years were lost due to heart disease in the American Indian population in 2001-2005, compared to 825.2 in the White population.
- African Americans and American Indians saw more years lost due to heart disease than any other group.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The number of years lost due to heart disease has decreased across all groups between 2001-2005 and 2006-2010.
- American Indians saw the largest decrease in number of years lost per 100,000 people, dropping from the highest number (2,010.8) in 2001-2005 to 1,409 in 2006-2010.
- African Americans saw a smaller drop than American Indians resulting in the highest amount of years lost to heart disease in the 2006-2010 time period among all groups.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[56]Centers for Disease Control and Prevention (2013). Heart disease. Retrieved from http://www.cdc.gov/nchs/fastats/heart.htm.
[57]Ibid.
[58]Ibid.
[59]Centers for Disease Control and Prevention. (2010). Years of potential life lost (YPLL) before age 65. Retrieved from http://webappa.cdc.gov/cgi-bin/broker.exe.

Stroke Prevalence

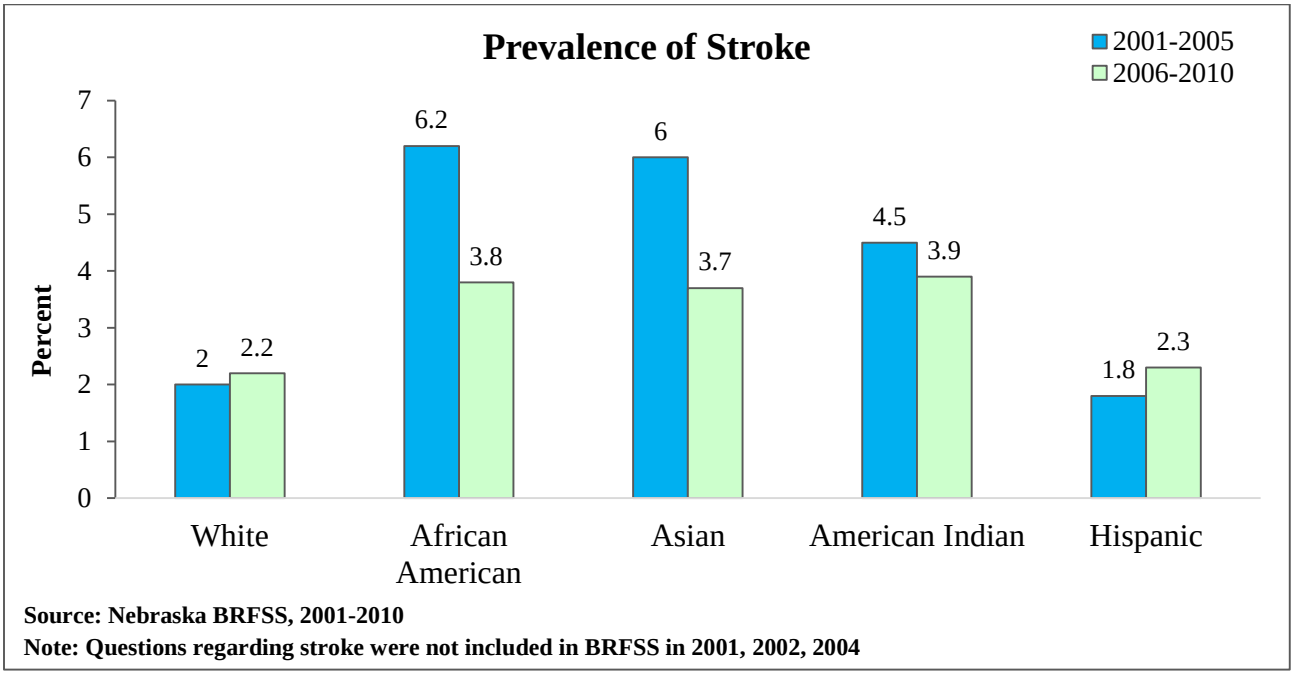
Stroke occurs when blood flow to part of the brain stops. Risk of stroke may be reduced by not smoking, maintaining a healthy weight, getting physical activity, and controlling high blood pressure and cholesterol.

Key Disparities

- Nebraska's African American, American Indian, and Asian populations (approximately 3.8%) saw higher percentages of people that were told they had a stroke compared to Whites (2.2%).
- The prevalence of stroke in the Hispanic population (2.3%) was similar to that in the White population (2.2%).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentage of people who had been told they had a stroke decreased in the African American, Asian, and American Indian populations.
- African Americans saw the largest decline from 6.2% to 3.8%.
- Hispanics saw an increase from 1.8% in 2001-2005 to 2.3% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010
Note: Questions regarding stroke were not included in BRFSS in 2001, 2002, 2004

Compared to the Nation

- Hispanics and African Americans in Nebraska experienced similar morbidity as their national counterparts (2.5% and 3.9%, respectively).
- More than twice the percentage of Asians in Nebraska experienced a stroke compared to Asians in the United States (1.5%).
- More American Indians in the United States (5.9%) experienced a stroke than American Indians in Nebraska.

Stroke Mortality

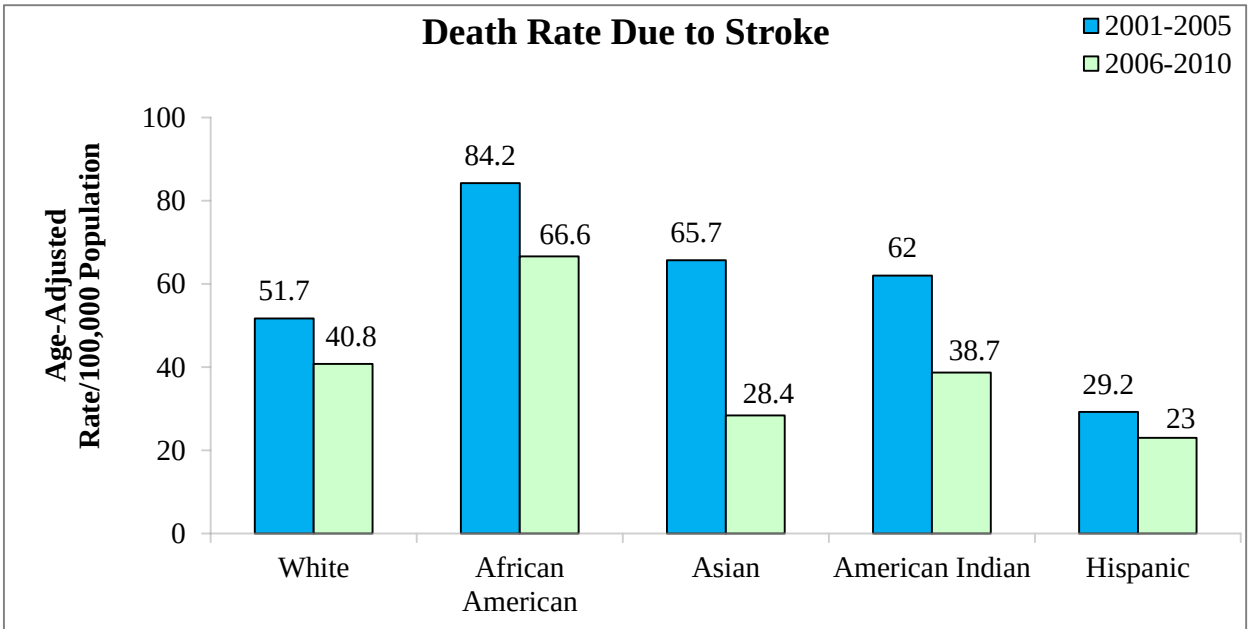
Among survivors, stroke can cause significant disability, including paralysis, as well as speech and emotional problems. However, stroke is a leading cause of death in both the United States (3rd) and Nebraska (4th).[60,61]

Key Disparities

- Nebraska's African American population saw the highest death rate due to stroke (66.6/100,000 people), compared to Whites (40.8/100,000 people).
- Almost 39 per 100,000 American Indians died due to stroke.
- Hispanics saw the lowest death rate due to stroke at 23/100,000 people.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Death due to stroke has declined among all racial and ethnic groups.
- Asians saw the greatest decline from 65.7/100,000 people in 2001-2005, when they ranked second highest, to 28.4/100,000 people in 2006-2010, ranked second best.
- American Indians dropped from 62/100,000 people to below the proportion for Whites in 2006-2010.
- African Americans experienced the highest stroke mortality throughout the decade.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Compared to the Nation

- Nebraska's African American, White, and American Indian populations saw higher rates of stroke death than their national groups (53/100,000 people, 37.7/100,000 people, and 28.1/100,000 people, respectively).
- The Asian and Hispanic populations in Nebraska saw lower rates than their national counterparts (33.2/100,000 people and 32.1/100,000 people, respectively).

[60]Centers for Disease Control and Prevention. (2008). Nebraska: Burden of chronic disease. Retrieved from http://www.cdc.gov/chronicdisease/states/pdf/nebraska.pdf.
[61]A.D.A.M. Medical Encyclopedia. (2011). Stroke. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001740/

Trends: Stroke Mortality

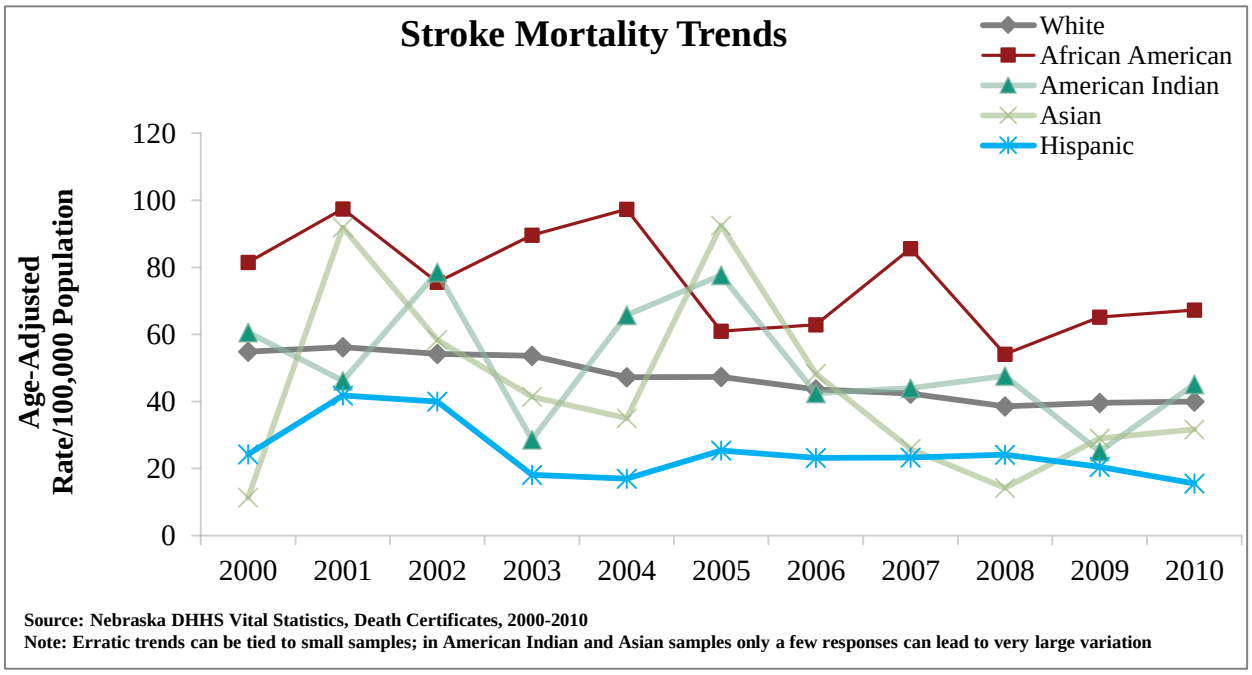
Stroke is the leading cause of serious, long-term disability in the United States.[62] Three quarters of all strokes happen to people over the age of 65, although stroke can and does happen at any age.[63] With high blood pressure as the most important risk factor, a stroke occurs every 40 seconds in the United States.[64]

Key Disparities

- In 2000, Nebraska's Asian population (11.4/100,000 people) experienced the lowest rate of stroke mortality; however, in 2001 (91.9/100,000 people) they almost reached African Americans, who generally saw the highest rate. Asians exceed African Americans in 2005 (92.5/100,000 people).
- Hispanics experienced the lowest rate of stroke mortality throughout the decade, with Asians having lower rates only a few times.
- Eight of the 10 years, American Indians had a higher or similar rate as Whites.

Trends between 2000 and 2010

- At the end of the decade, most groups seem to have found a constant, and Hispanics continued to decline while American Indians saw the sharpest increase.
- Asians saw a slight increase between 2009 and 2010, after three years of steady decline.
- African Americans saw their lowest rate in the 2000s in 2008, though still higher than all groups.
- In the first part of the decade, American Indians saw sharp increases and declines in stroke mortality, however, from 2006 forward there was much less variation.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2000-2010
Note: Erratic trends can be tied to small samples; in American Indian and Asian samples only a few responses can lead to very large variation

[62]The Internet Stroke Center. Retrieved from http://www.strokecenter.org/patients/about-stroke/stroke-statistics/.
[63]Ibid.
[64]Ibid.

Years Lost due to Stroke

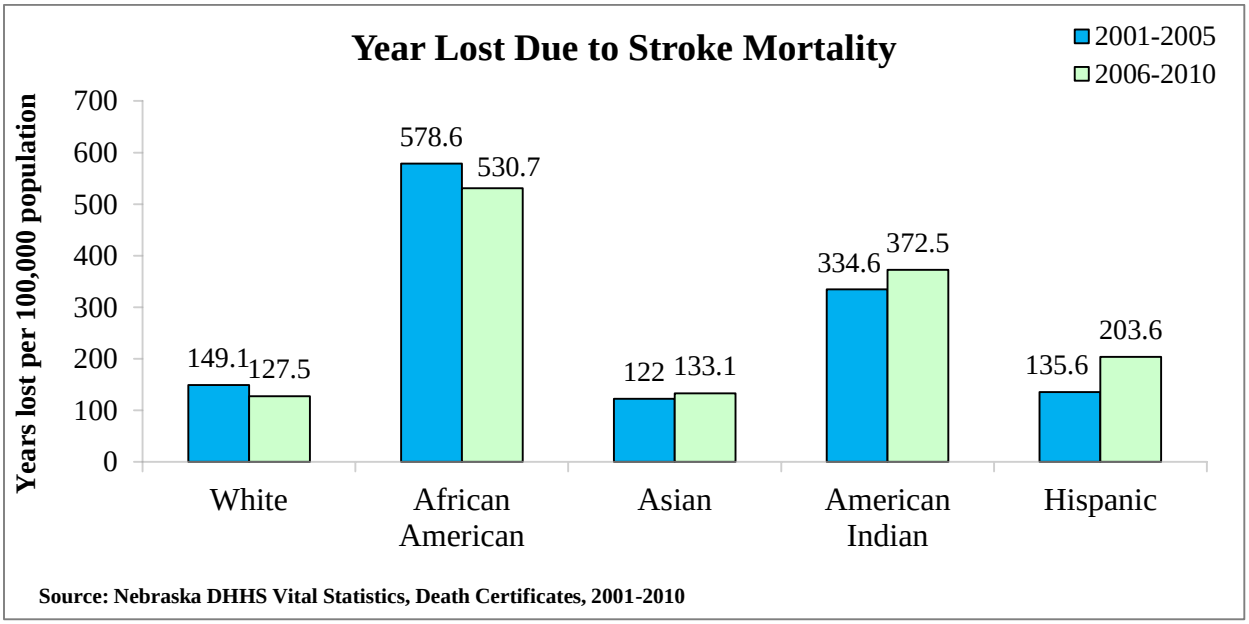
Stroke kills 130,000 Americans every year and someone has a stroke every 40 seconds.[65] Stroke reduces mobility in more than half of stroke survivors age 65 and over.[66] Moreover, stroke costs the United States $54 billion annually.[67]

Key Disparities

- Nebraska's African American population saw the largest amount of years lost due to stroke (530.7) in 2006-2010, compared to Whites (127.5).
- American Indians saw 372.5 years of life lost per 100,000 people in 2006-2010, while Hispanics saw 203.6 years lost.
- All groups saw more years of life lost due to stroke compared to Whites.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Years lost due to stroke decreased in the African American and White populations; it increased in the Asian, American Indian, and Hispanic populations.
- African Americans saw a decrease, decreasing from 578.6 years lost in 2001-2005 to 530.7 in 2006-2010.
- Asians saw an increase of 122 in 2001-2005 to 133.1 in 2006-2010.
- Hispanics increased from of 135.6 years lost to 203.6 in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[65]Centers for Disease Control and Prevention. (2012). Stroke Fact Sheet. Retrieved from http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_stroke.htm.
[66]Ibid.
[67]Ibid.

Chronic Lung Disease Mortality

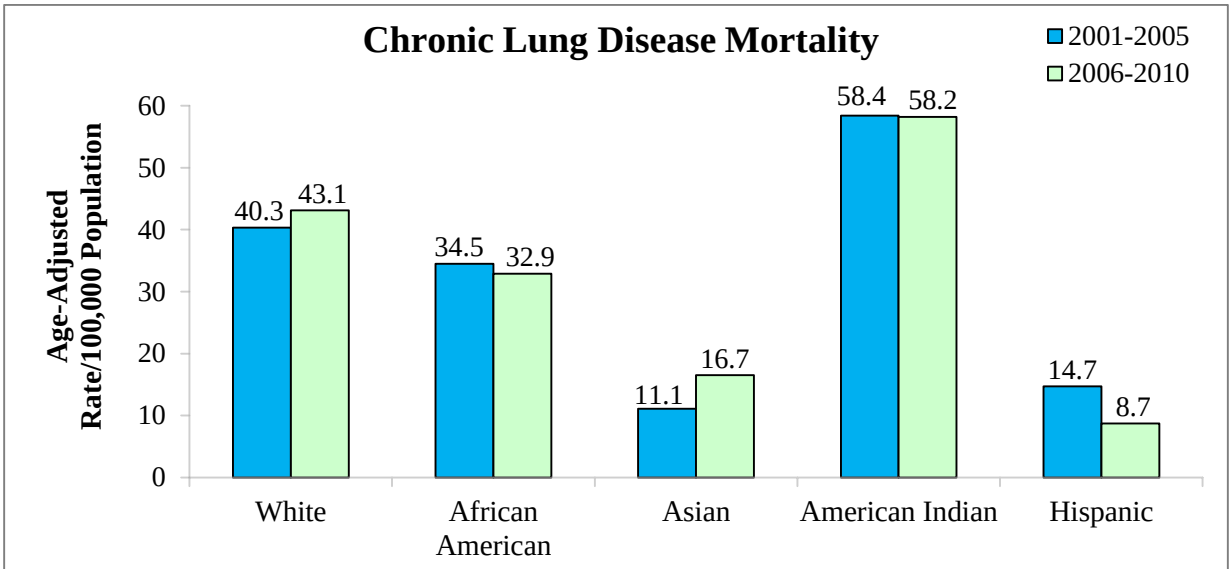
Chronic lung disease (CLD) is a general term for a group of conditions that affect the respiratory system.[68] Nebraska saw an approximate rate of 45/100,000 population for CLD in 2010. Commonly presenting as asthma, chronic obstructive pulmonary disease, occupational lung diseases or pulmonary hypertension, CLD is largely preventable.[69] Chronic lung disease also affects premature babies who have undeveloped lungs, low amounts of surfactant, high oxygen concentration, or who have been exposed to mechanical ventilation.

Key Disparities

- Nebraska's American Indian population saw the highest rate of lung disease mortality (58.2/100,000 people), compared to 43.1/100,000 Whites in 2006-2010.
- Almost 33/100,000 Nebraska African Americans died of lung disease in 2006-2010.
- Asian and Hispanics consistently saw a lower rate than other groups.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Chronic lung disease mortality increased among Whites, and Asians, decreasing in African Americans, American Indians, and Hispanics.
- Hispanics saw the largest drop from 14.7/100,000 people in 2001-2005 to 8.7/100,000 people in 2006-2010.
- Asians saw the largest increase from 11.1/100,000 people in 2001-2005 and 16.7/100,000 people in 2006-2010.
- American Indians saw the largest proportion affected by chronic lung disease in both 2001-2005 and 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[68]U.S. Department of State. Addressing the challenges of non-communicable disease: Chronic lung disease. Retrieved from http://www.state.gov/documents/organization/172809.pdf.
[69]Ibid.

Trends: Chronic Lung Disease Mortality

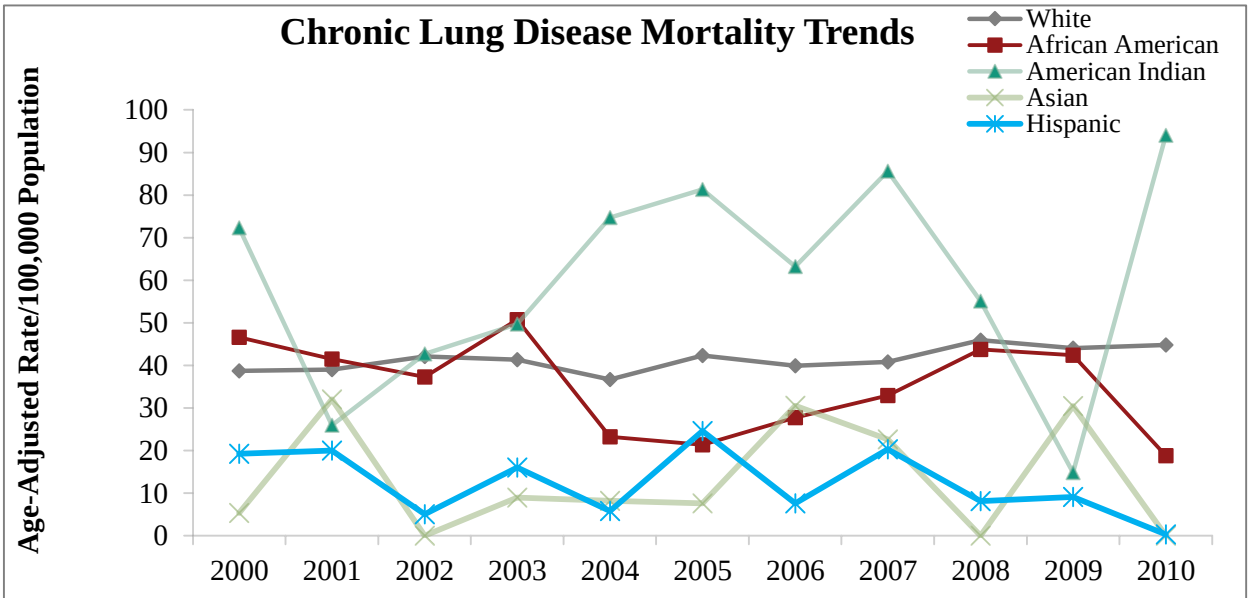
Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term for diseases that impair lung function and create breathlessness.[70] Chronic bronchitis and emphysema are common types of COPD; it is a life-threatening disease.[71]

Key Disparities

- Eight years out of 10, American Indians had the highest rates of chronic lung disease mortality, with a spike between 2009 and 2010.
- After an increase between 2000 (5.3/100,000 people) and 2001 (32/100,000 people), Asians saw zero deaths due to chronic lung disease per 100,000 people in 2002. This happened again in 2008 and 2010 (following a steep increase).
- Hispanics also had a relatively low rate, increasing above African Americans only once in the decade.

Trends between 2000 and 2010

- After a dramatic decline between 2000 (72.3/100,000 people) and 2001 (25.9/100,000 people), American Indians witnessed a steady increase for the next four years followed by a two year decline (from 85.6/100,000 people to 14.8/100,000 people) and finally saw a large increase from 14.8/100,000 people in 2009 to 94/100,000 people in 2010.
- Hispanics, African Americans, and Asians saw decreases in their chronic lung disease mortality rate between 2009 and 2010.
- Hispanics saw a steady decline since 2007 and both African Americans (from 42.4/100,000 people to 18.8/100,000 people) and Asians (from 30.4/100,000 people to 0/100,000 people) experienced dramatic decreases in their rates.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2000-2010
Note: Erratic trends can be tied to small samples; in American Indian and Asian samples only a few responses can lead to very large variation

[70]World Health Organization. (2013). Living with chronic lung disease. Retrieved from http://www.who.int/features/2007/copd/en/index.html.
[71]Ibid.

Years Lost due to Chronic Lung Disease

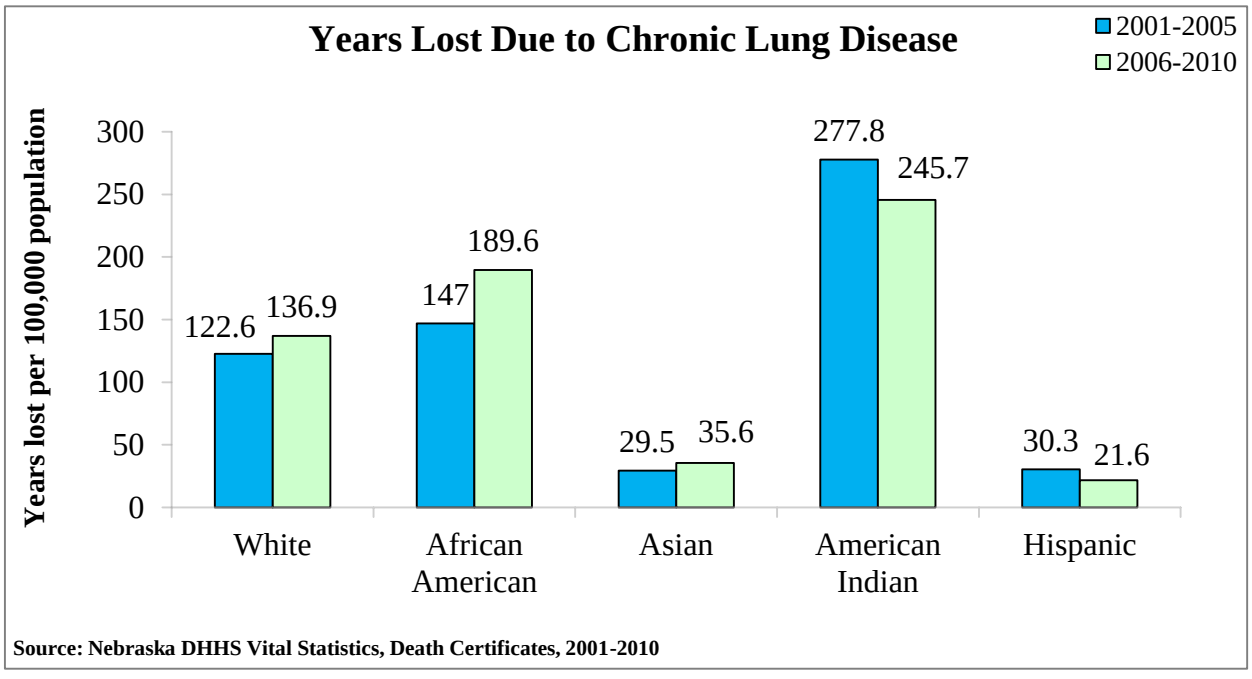
People with chronic lung disease fight for the appropriate amount of air even while doing everyday tasks.[72] Struggling to stay physically active, they risk early death. Affecting 64 million people across the world, chronic lung disease is predicted to become the third leading cause of death by 2030.[73] The chart below represents data for those who died before the age of 75.

Key Disparities

- Nebraska's American Indian population saw the largest amount of years lost due to chronic lung disease in both 2001-2005 (277.8) and 2006-2010 (245.7), compared to Whites (136.9).
- African Americans saw 189.6 years lost due to chronic lung disease per 100,000 people in 2006-2010.
- Nebraska Asians saw more years lost than Hispanics in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The amount of years lost due to chronic lung disease rose in the White, African American, and Asian populations and decreased in the American Indian and Hispanic populations.
- American Indians saw the largest decrease, dropping from 277.8 in 2001-2005 to 245.7 in 2006-2010.
- African Americans saw an over 40-year increase from 147 in 2001-2005 to 189.6 in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[72]World Health Organization. (2013). Living with chronic lung disease. Retrieved from http://www.who.int/features/2007/copd/en/index.html.
[73]Ibid.

Asthma

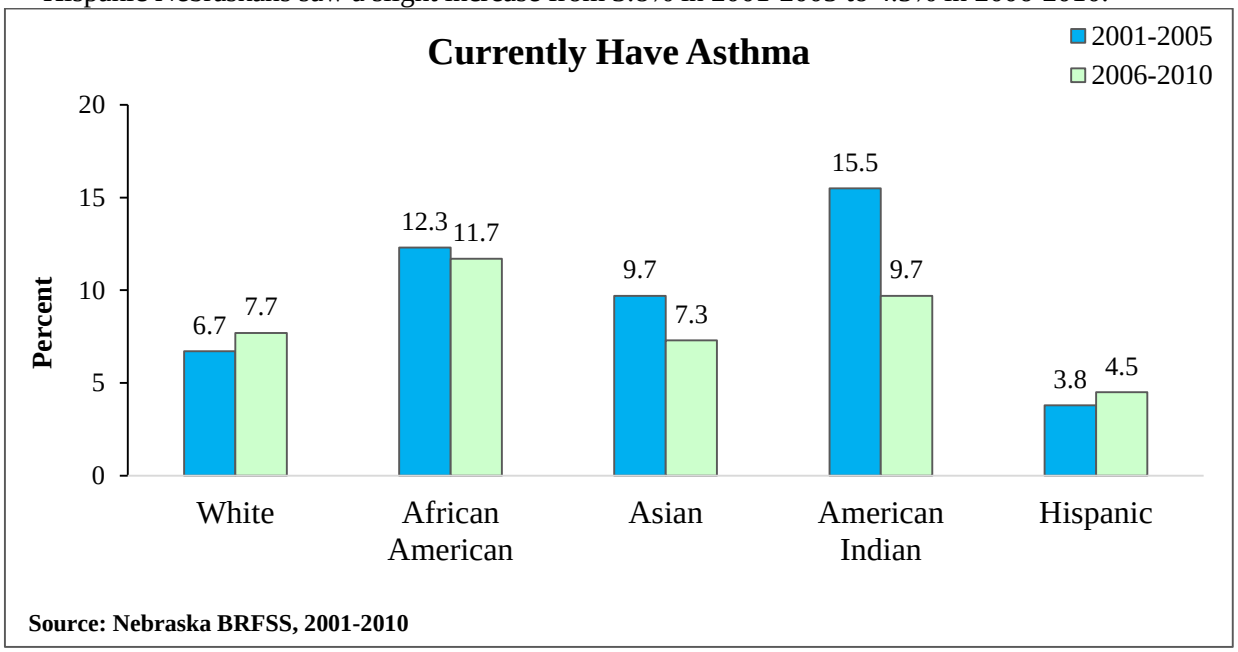
Asthma affects more than 34 million people. Asthma symptoms include coughing, wheezing, and chest tightness.[74] This measure was evaluated by asking, 'Have you ever been told by a doctor (nurse or other health professional) that you have asthma?' Current asthma was defined as an affirmative response to that question followed by an affirmative response to the subsequent question 'Do you still have asthma?'

Key Disparities

- Nebraska's African American population experienced the highest proportion of people with asthma (11.7%), compared to Whites (7.7%).
- Almost 10% of American Indians had asthma.
- Hispanic Nebraskans saw the lowest percentage of people with asthma at 4.5%.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentages of people who currently have asthma have decreased in the African American, Asian, and American Indian populations.
- The largest decline was from 15.5% in 2001-2005 to 9.7% in 2006-2010 in the American Indian population; Asians experienced the next largest decrease in asthma, dropping from 9.7% in 2001-2005 to 7.3% in 2006-2010.
- Hispanic Nebraskans saw a slight increase from 3.8% in 2001-2005 to 4.5% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- African Americans in Nebraska (11.7%) reported a larger percentage of those with asthma than the national population (10.5%).
- Approximately 7% of Hispanics in the United States reported currently having asthma, compared to 4.5% of Hispanics in Nebraska.

[74]WebMD. (2013). Asthma overview. Retrieved from http://www.webmd.com/asthma/default.htm.

Diabetes

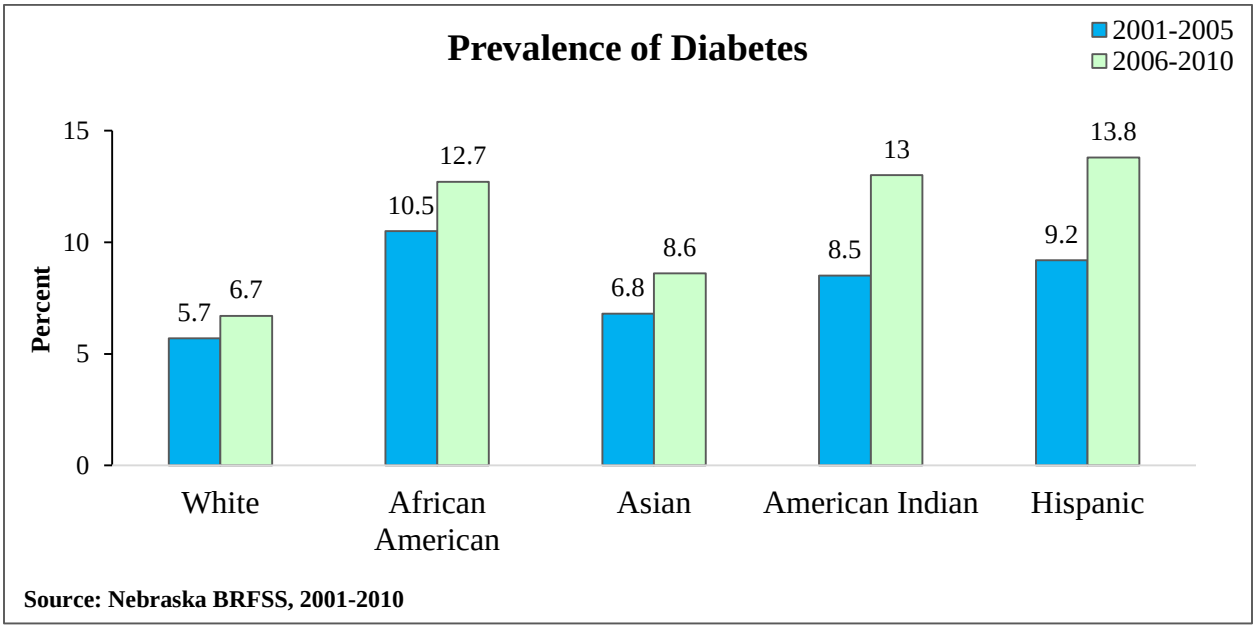
Diabetes is typically a chronic disease, characterized by high levels of sugar in the blood.[75] Diabetes can be caused by resistance to or creation of too little insulin, a hormone produced to control blood sugar.[76] Where the cause of type 1 diabetes is unknown, some cases of type 2 diabetes can be prevented. Type 2 diabetes may be caused by physical inactivity, poor diet, and excess body weight.[77]

Key Disparities

- Nebraska's Hispanic population saw the highest percentage of diabetes (13.8%) in 2006-2010, compared to 6.7% of Whites, closely followed by American Indians (13%) and African Americans (12.7%).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All groups saw an increase in professionally diagnosed diabetes between 2001-2005 and 2006-2010.
- Hispanics saw the largest increase jumping from 9.2% in 2001-2005 to 13.8% in 2006-2010; American Indians saw a similar increase from 8.5% in 2001-2005 to 13% in 2006-2010.
- Asian Nebraskans, though seeing better percentages than American Indians, Hispanics, or African Americans were still almost 2% higher than Whites; jumping almost 2% from 2001-2005 to 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- Almost 14% of Hispanics in Nebraska reported having diabetes, compared to approximately 8% of Hispanics in the United States.
- African Americans in Nebraska (12.7%) and the United States (13.5%) saw similar percentages of those with diabetes.

[75]A.D.A.M Medical Encyclopedia. (2012). Diabetes. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002194/.
[76]Ibid.
[77]Ibid.

Diabetes Mortality

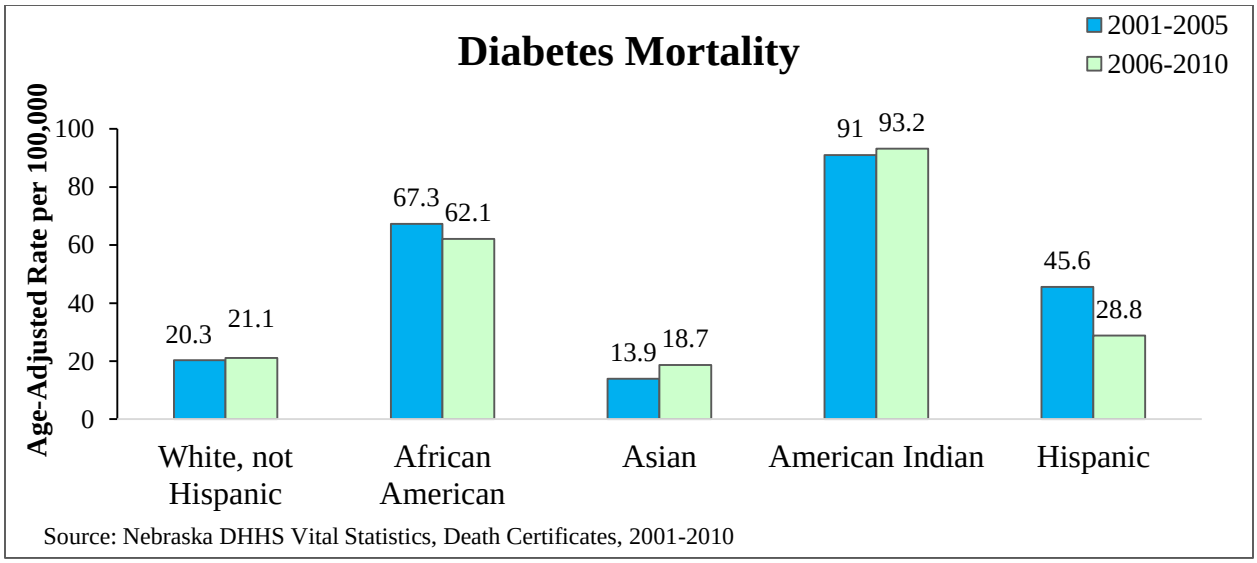
Almost 26 million children and adults in the United States have diabetes; that is 8.3% of the population.[78] Seventy-nine million people have pre-diabetes and seven million people are undiagnosed, which is determined by measuring fasting glucose and A1C levels.[79]

Key Disparities

- Nebraska's American Indian population saw the highest rate of diabetes mortality (93.2/100,000 people), compared to 21.1/100,000 people Whites, in 2006-2010.
- Sixty-two per 100,000 African Americans died due to diabetes, a decrease from 2001-2005.
- Almost 30/100,000 Hispanics died due to diabetes.
- Nebraska's Asian population saw the lowest rate of diabetes mortality (18.7/100,000).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- American Indians and Asians saw an increase in diabetes mortality from 2001-2005 to 2006-2010.
- African Americans and Hispanics saw a decrease, dropping from 67.3 to 62.1/100,000 population and 45.6 to 28.8/100,000 population, respectively



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Compared to the Nation

- The national African American population saw a significantly higher rate (114/100,000 people) than Nebraskan African Americans (62.1/100,000 people).
- Nebraska Asians saw almost a third as many people die from diabetes than the national rate (54.1/100,000 people).
- Hispanics in Nebraska saw a much lower rate of diabetes mortality (28.8/100,000 people) than Hispanics in the United States (84.3/100,000 people), while Nebraska's American Indian population saw a rate that was comparable to the national population (95/100,000 people).

[78]American Diabetes Association (2011). Statistics About Diabetes. Retrieved from http://www.diabetes.org/diabetes-basics/diabetes-statistics/
[79]Ibid.

Diabetes-related Mortality

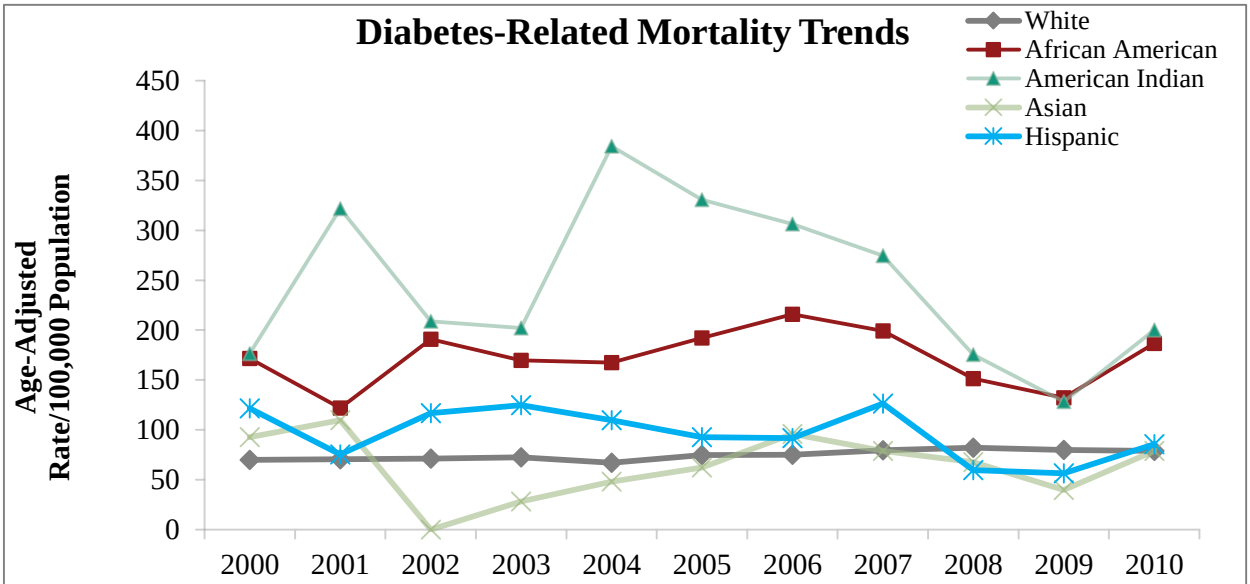
Diabetes-related mortality can be divided into two parts: deaths occurring early, which are associated with diabetic ketoacidosis (DKA) or hypoglycemia and those resulting from long-term micro- and macrovascular complications.[80] There are three causes of DKA: disease onset, result of simultaneous illness, and following insulin omission.[81] The data includes all mentions of diabetes on the death certificate, whether as an underlying or a multiple cause of death.

Key Disparities

- American Indians consistently saw the highest rates of diabetes mortality; between 2006-2010, the age-adjusted rate was approximately 207 cases per 100,000 people.
- African Americans were the group with the second highest diabetes-related deaths, with 176 per 100,000 people in 2006-2010.
- Asians more often than not saw the lowest rates of diabetes mortality than any other group.

Trends between 2000 and 2010

- Experiencing two spikes in mortality in 2001 and 2004, American Indians saw a decrease in diabetes mortality; however, in 2010 there was another increase.
- Asians saw a steady increase in mortality after a dramatic decrease between 2001 and 2002 and after 2006 there were several years of decreasing mortality from 2006 to 2009.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2000-2010
Note: Erratic trends can be tied to small samples; in American Indian and Asian samples only a few responses can lead to very large variation

[80]Daneman, D. (2001). Diabetes-related mortality: A pediatrician's view. Retrieved from http://care.diabetesjournals.org/content/24/5/801.full.
[81]Ibid.

Years Lost Due to Diabetes Mortality

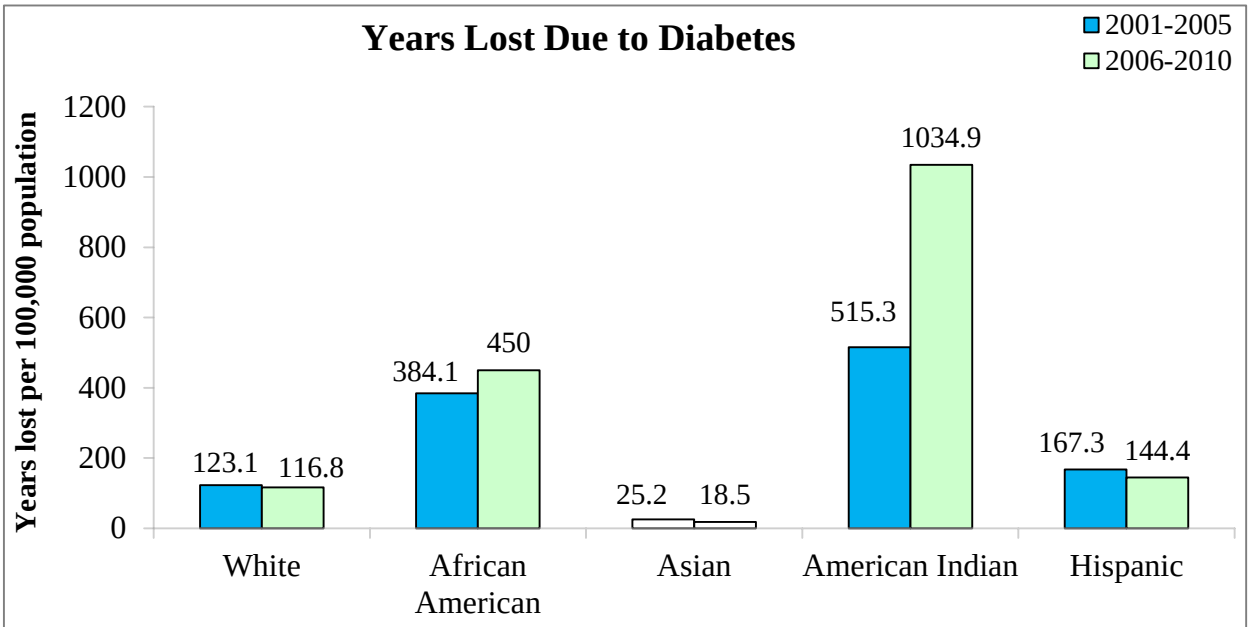
Things like heart disease and stroke are two to four times more likely to occur in people with diabetes.[82] Almost 70% of those with diabetes also reported having hypertension.[83] Diabetes is the leading cause of kidney failure, non-traumatic lower-limb amputation, and new cases of blindness in adults.[84] Of people of similar age, those with diabetes are twice as likely as those without diabetes to die.[85] This information is for those who died before the age of 75.

Key Disparities

- Nebraska's American Indian population saw the highest number of years lost due to diabetes (1034.9), compared to Whites (116.8) per 100,000 people.
- African Americans saw the second largest amount of years lost (450) due to diabetes in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The amount of years lost due to diabetes increased in African Americans and American Indians from 2001-2005 to 2006-2010 and decreased in Whites, Asians, and Hispanics.
- American Indians saw double the years lost in 2006-2010 (1034.9) than in 2001-2005 (515.3).
- African Americans experienced over a 65-year increase.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[82]Centers for Disease Control and Prevention. (2011). 2011 national diabetes fact sheet. Retrieved from http://www.cdc.gov/diabetes/pubs/estimates11.htm.
[83]Ibid.
[84]Centers for Disease Control and Prevention. (2011). National diabetes fact sheet: National estimates and general information on diabetes and prediabetes in the United States.
[85]Ibid.

Arthritis

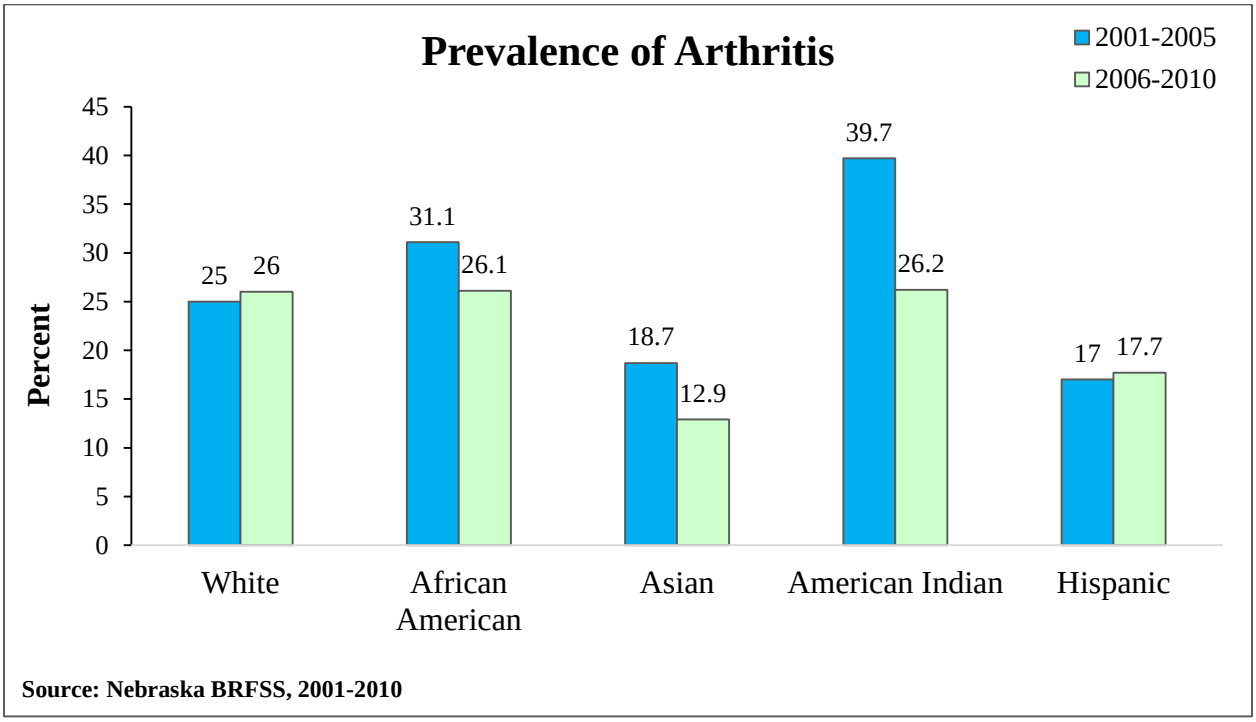
Arthritis is a complex union of musculoskeletal disorders, which consists of over 100 different diseases or conditions affecting people of all ages, races, and genders. Those who answered 'yes' to the question, "Have you ever been told by a health professional that you have arthritis?" were included in the chart below.

Key Disparities

- Nebraska American Indians (26.2%) and African Americans (26.1%) experienced the largest amount of those affected by arthritis, similar to the number experienced by Whites (26%).
- Almost 13% of Asians had been told they had arthritis, as well as 17.7% of Hispanics.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The prevalence of arthritis decreased among African Americans, Asians, and American Indians from 2001-2005 to 2006-2010.
- American Indians experienced more than 10% decrease in arthritis.



Source: Nebraska BRFSS, 2001-2010

Activity Limitations

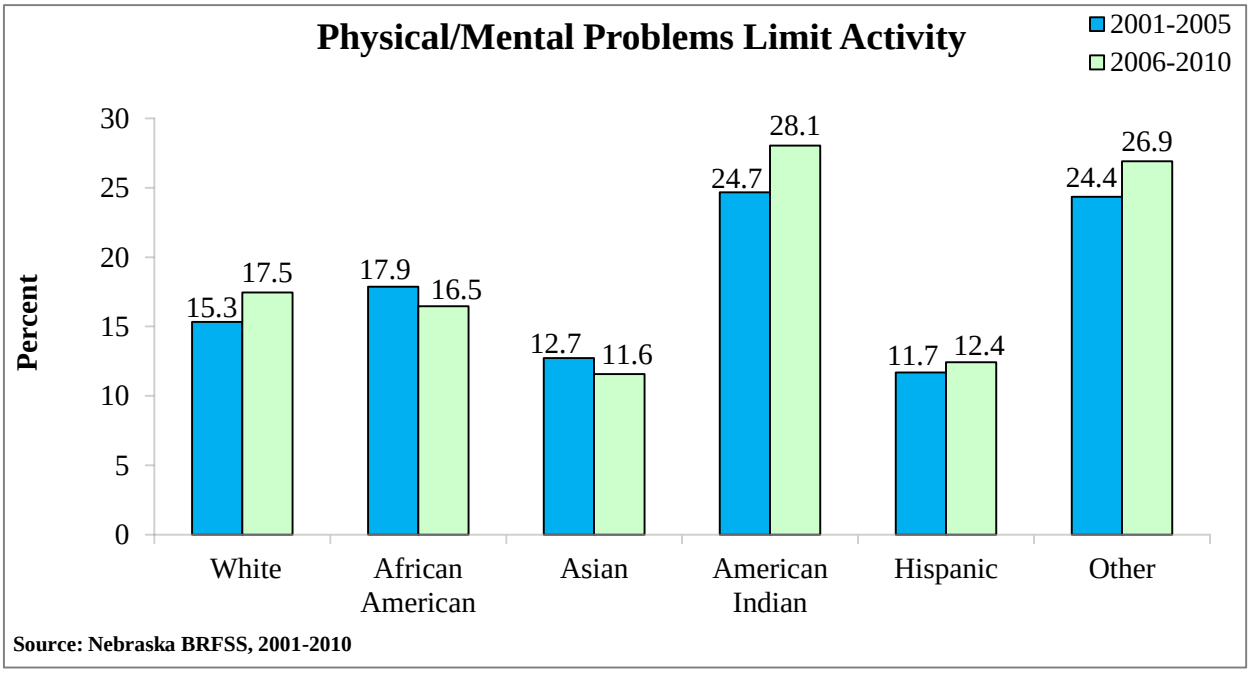
Limitation in activity refers to a long-term reduction in a person's ability to carry out activities. Activity limitations were assessed by asking people if they are limited in activities of daily living, instrumental activities of daily living (using the phone, doing light housework, preparing meals), play, school, or work, or remembering.[86]

Key Disparities

- Nebraska's American Indian population saw the largest percentage of people experiencing activity limitations due to physical or mental problems (28.1%), compared to 17.5% of Whites.
- Sixteen and one half percent of African Americans experience activity limitation due to physical or mental problems.

How are we doing? Comparisons between 2001-2005 and 2006-2010

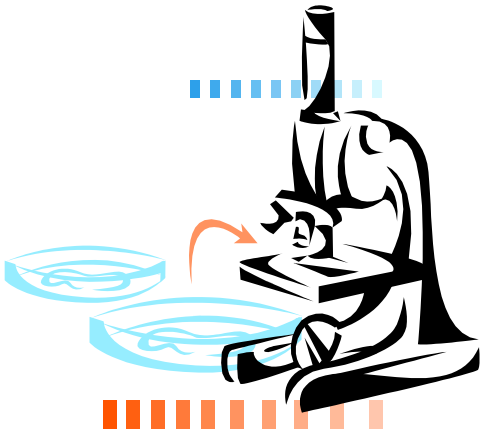
- Activity limitation increased in the White and American Indian populations; American Indians increased from 24.7% in 2001-2005 to 28.1% in 2006-2010.
- African Americans and Asians saw a decline in activity limitations between 2001-2005 and 2006-2010.
- Hispanics saw less than a 1% increase in activity limitation.



Source: Nebraska BRFSS, 2001-2010

[86]Healthypeople.gov. (2011). General health status. Retrieved from http://www.healthypeople.gov/2020/about/genhealthabout.aspx#limitation.

INFECTIOUS DISEASE



Infectious diseases kill more people worldwide than any other one cause.[87] Infectious diseases are illnesses caused by organisms like bacteria or viruses.[88] Normally harmless, some bacteria (under certain conditions) can cause disease.[89] While some infectious diseases can be passed from person to person, others are passed between species, from animal or insect to humans, while others are passed by eating contaminated food or water.[90] Many infectious diseases, like measles or chickenpox can be prevented with vaccinations.

There are four primary types of germs. Bacteria are one-celled germs that multiply rapidly and could release chemicals that make you sick. Viruses are capsules holding genetic material that use your own cells to multiply. Fungi are primitive plants, like mildew. In addition, protozoa are one-celled animals that use other living things as food and a host.

Anyone can contract an infectious disease, but those with improperly functioning immune systems are at an increased risk; for instance, those taking steroids that suppress the immune system, those with HIV/AIDS, or people with certain types of cancer.[91] Washing your hands, obtaining vaccinations, safe food handling, staying home if you are sick, as well as not sharing personal items will decrease the risk of contracting an infectious disease.[92]

Disparities exist among racial and ethnic groups concerning infectious disease. For instance, African American males saw a HIV/AIDS death rate almost eight times that of White males in 2008; Hispanics' rate was almost double that of Whites. African Americans also saw the highest rate of deaths due to influenza and pneumonia.

For the purposes of this report, only sexually transmitted diseases were chosen for this section, as Nebraska experiences large disparities in HIV/AIDS and other STDs.

[87]MedlinePlus. (2012). Infectious disease. Retrieved from http://www.nlm.nih.gov/medlineplus/infectiousdiseases.html.
[88]Mayo Clinic. (2012). Infectious disease. Retrieved from http://www.mayoclinic.com/health/infectious-diseases/DS01145.
[89]Ibid.
[90]Ibid.
[91]Ibid.
[92]Ibid.

HIV/AIDS Diagnoses

In 2010, 29% of newly diagnosed HIV cases were found among African Americans, as well as 35% of new AIDS cases. During 2010, in the United States, African Americans accounted for 44% of new HIV infections. African Americans saw HIV as the fifth leading cause of death among 25-44 year olds. In Nebraska during 2010, Hispanics accounted for 4% of all new HIV cases and 16% of new AIDS cases. In 2009 in the United States, Hispanics accounted for 13% of new HIV infections, compared 21% of new AIDS diagnoses in Nebraska.[93]

Newly Diagnosed HIV and AIDS Cases by Race/Ethnicity

	New HIV Only Diagnoses				1st AIDS Diagnoses			
	2010		2009		2010		2009	
	#	%	#	%	#	%	#	%
Race and Ethnicity								
White	42	62	34	49	14	45	14	42
African American	20	29	20	29	11	35	9	27
Hispanic, All Races	3	4	9	13	5	16	7	21
Asian/Pacific Islander	1	1	3	4	1	3	2	6
American Indian/Alaska Native	1	1	0	--	0	--	0	--
Multiple Races	1	1	3	4	0	--	1	3

Source: Nebraska DHHS, Nebraska HIV Prevention Program

Cumulative HIV and AIDS Cases by Race/Ethnicity

	All HIV Diagnoses 1983 through 2010		Living HIV/AIDS Cases 1983 through 2010	
	#	%	#	%
Race and Ethnicity				
White	1,566	60.4	966	55.6
African American	637	24.6	478	27.5
Hispanic	288	11.1	217	12.5
Asian/Pacific Islander	33	1.3	31	1.8
American Indian/Alaska Native	41	1.6	26	1.5
Multiple Races	24	.9	17	1

Source: Nebraska DHHS, Nebraska HIV Prevention Program

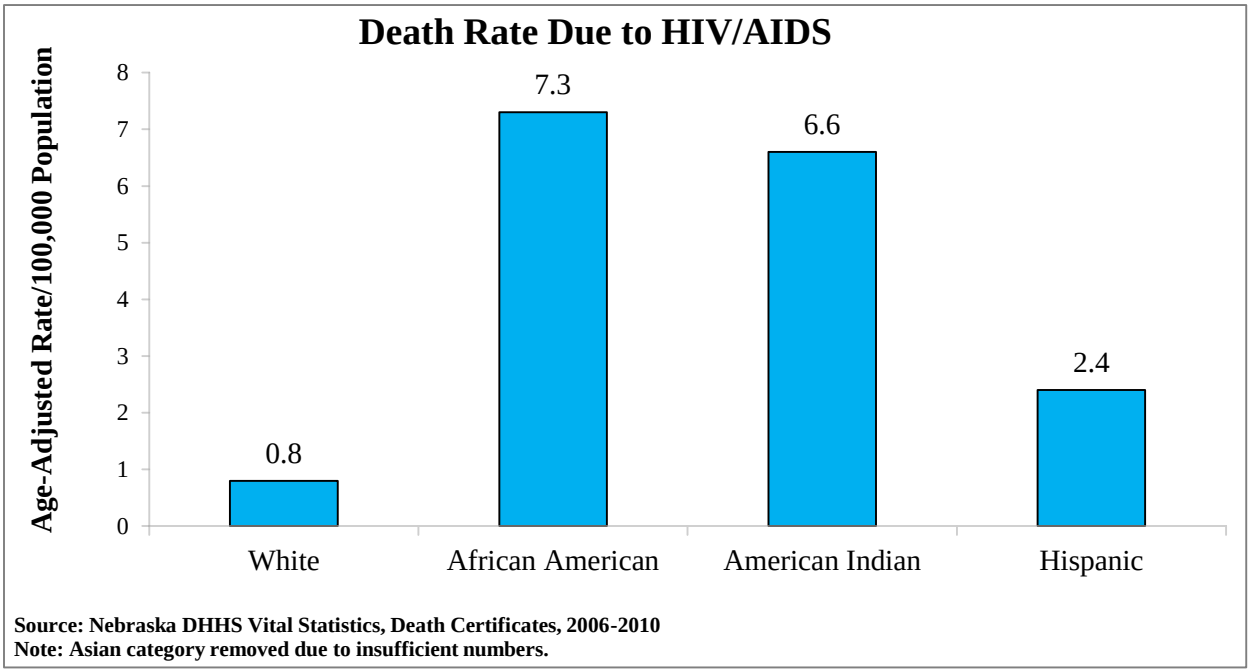
[93]Centers for Disease Control and Prevention. (2014). HIV among Latinos. Retrieved from http://www.cdc.gov/hiv/risk/racialEthnic/hispanicLatinos/facts/index.html.

HIV/AIDS Mortality

HIV stands for Human Immunodeficiency Virus and while it is quite similar to other viruses like the flu, the human immune system cannot fight off HIV. Eventually, HIV destroys enough cells that the body cannot fight infection, at this point HIV can lead to AIDS, also known as Acquired Immunodeficiency Syndrome.[94]

Key Disparities

- In 2006-2010, African Americans experienced a 7.3/100,000 population death rate due to HIV/AIDS, compared to 0.8/100,000 for Whites.
- American Indians (6.6/100,000 population) also experienced a higher death rate due to HIV/AIDS.
- Almost 2.5/100,000 Hispanics died of HIV/AIDS in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2006-2010
Note: Asian category removed due to insufficient numbers.

Compared to the Nation

- Almost 12/100,000 African Americans in the United States died due to HIV infections in 2010, compared to 7.3/100,000 African American Nebraskans.
- Six times the number of American Indians in Nebraska died of HIV infections in 2010 than American Indians in the United States (1.6/100,000 population).
- Hispanics in Nebraska and the United States experienced similar HIV mortality (2.4 and 2.8/100,000 population, respectively).

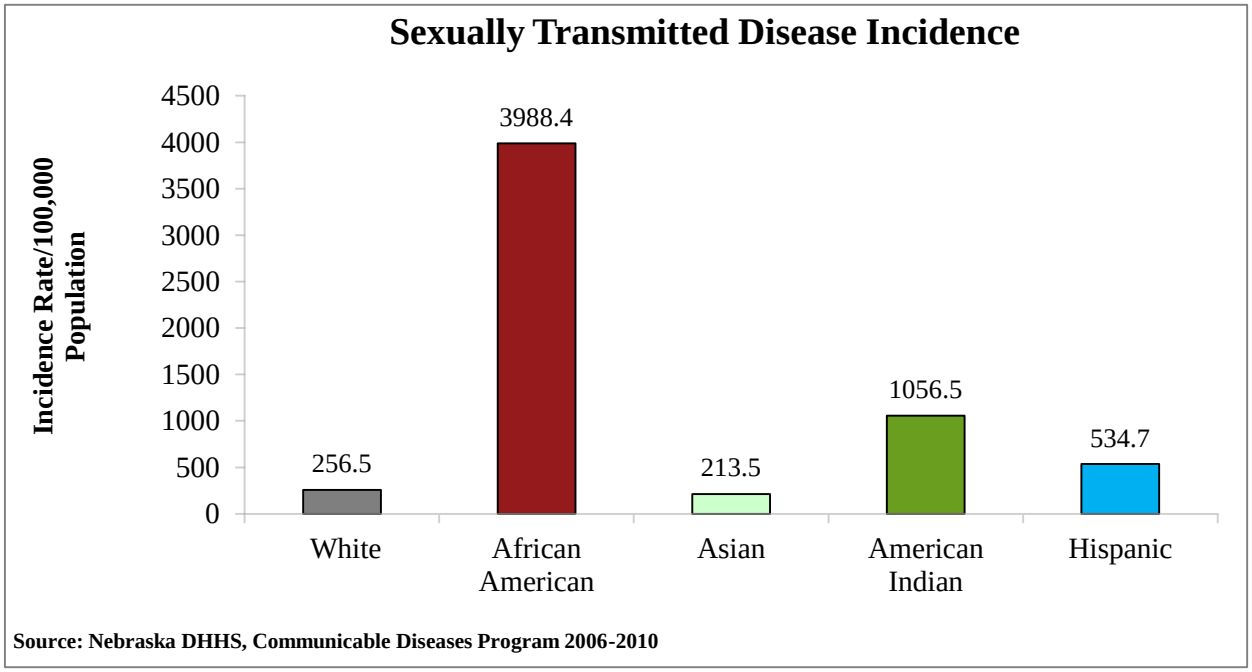
[94]AIDS.gov. (2012). What is HIV/AIDS? Retrieved from https://www.aids.gov/hiv-aids-basics/hiv-aids-101/what-is-hiv-aids/

Sexually Transmitted Disease Incidence

Sexually transmitted diseases (STD) are typically transmitted through sexual contact. The organisms that cause these diseases or infections are usually passed through blood or other bodily fluids.[95] Some infections can be passed in other ways like from mother to infant during pregnancy or childbirth; people can also get an infection from sharing a needle.[96] Some people who have sexually transmitted diseases or infections show no signs or symptoms; they otherwise appear healthy.

Key Disparities

- Nebraska's African American population experienced the highest rate of sexually transmitted diseases 3988.4 per 100,000 people compared to Whites (256.5/100,000 people).
- American Indians saw a STD rate of 1056.5/100,000 people per 100,000 people.
- Hispanic Nebraskans had a STD rate approximately half that of American Indians.



Source: Nebraska DHHS, Communicable Diseases Program 2006-2010

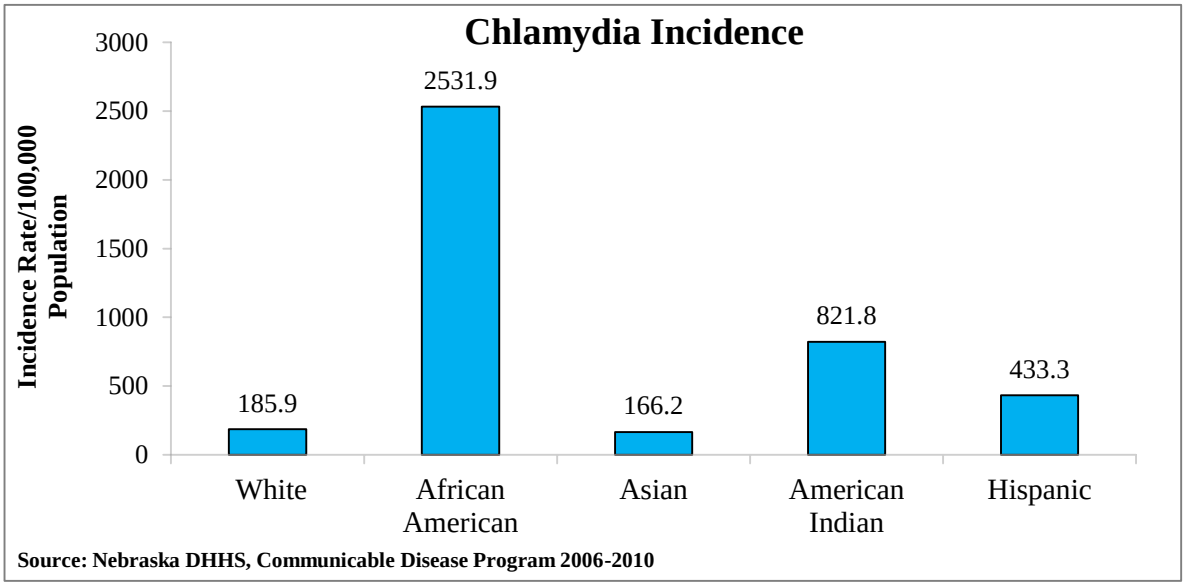
[95]Mayo Clinic. (2013). Sexually Transmitted Diseases. Retrieved from http://www.mayoclinic.com/health/sexually-transmitted-diseases-stds/DS01123.
[96]Ibid.

Chlamydia Incidence

Chlamydia, a bacterial infection caused by *Chlamydia trachomatis*, is a common STD, affecting both men and women. Although it is easily cured, if left untreated chlamydia can lead to infertility in women.[97]

Key Disparities

- African Americans saw the highest rate of chlamydia incidence among all groups at 2,531.9/100,000 population followed by American Indians at 822/100,000 compared to approximately 186/100,000 Whites.
- Hispanics saw a chlamydia incidence rate of 433.3/100,000 people.



Source: Nebraska DHHS, Communicable Disease Program 2006-2010

Compared to the Nation

- Almost 1,000 more African Americans per 100,000 people in Nebraska (2,531.9) were diagnosed with chlamydia than African Americans in the United States (1,383/100,000 population).
- A similar number of Hispanic Nebraskans (433.3/100,000 population) and Hispanics in the rest of the United States (467.9/100,000 population) were diagnosed with chlamydia; the same is true for Asian Nebraskans (166.2) and Asians in the rest of the United States (134.1).
- More American Indians in Nebraska were diagnosed with chlamydia than American Indians in the United States (705.2/100,000 population).

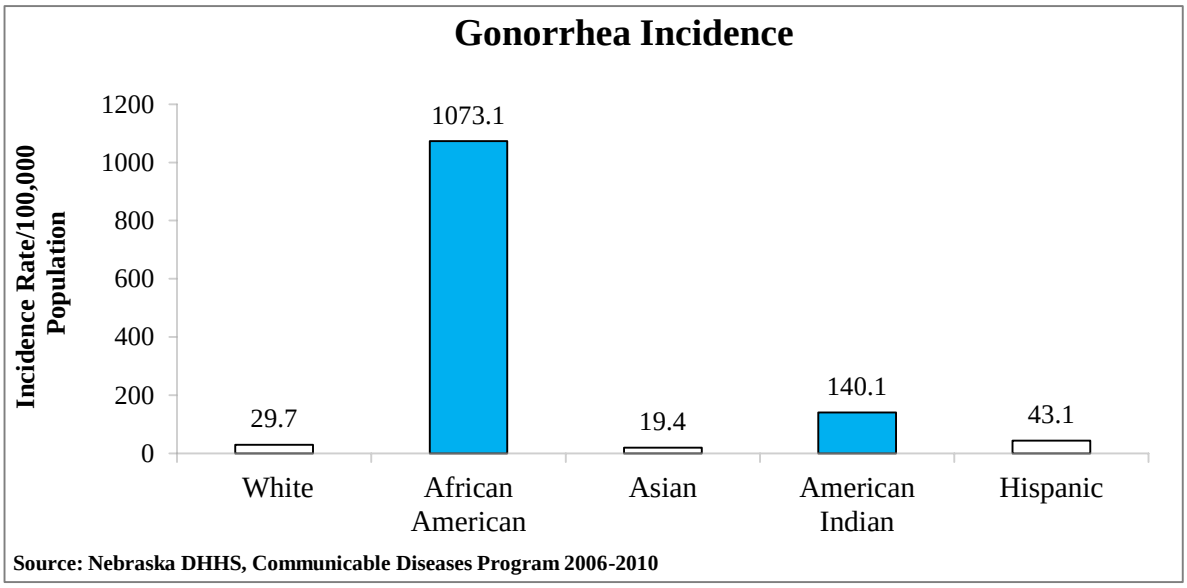
[97]Centers for Disease Control and Prevention. Chlamydia – CDC fact sheet. Retrieved from http://www.cdc.gov/Std/chlamydia/STDFact-Chlamydia.htm.

Gonorrhea Incidence

Caused by infection with the *Neisseria gonorrhoeae* bacterium, gonorrhea infects the mucous membranes of the reproductive tract.[98]

Key Disparities

- African Americans (1,073.1/100,000 population) experienced a much higher gonorrhea incidence rate compared to other racial and ethnic groups at 7.7 times higher than the rate for American Indians.
- Approximately 140/100,000 American Indians were diagnosed with gonorrhea between 2006 and 2010, compared to 29.7/100,000 Whites.



Source: Nebraska DHHS, Communicable Diseases Program 2006-2010

Compared to the Nation

- Twice as many African American Nebraskans were diagnosed with gonorrhea than African Americans in the rest of the United States (512.2/100,000 population).
- More Hispanics in the United States (63.2/100,000 population) were diagnosed with gonorrhea than Hispanics in Nebraska.
- A similar amount of Asians in Nebraska and the United States (18.1) were diagnosed with gonorrhea.
- More American Indian Nebraskans than American Indians in the United States (125.7/100,000 population) were diagnosed with gonorrhea.

[98]Centers for Disease Control and Prevention. Gonorrhea – CDC fact sheet. Retrieved from http://www.cdc.gov/std/gonorrhea/STDFact-gonorrhea.htm.

CANCER

Cancer was the leading cause of death in Nebraska in 2010, which accounted for 3,437 resident deaths. This figure represents just under one-fourth of all deaths that occurred among Nebraska residents in 2010. In 2007, 3,477 persons in the state died from cancer, about 1% less than the leading cause of death, heart disease.[99] Cancer was the leading cause of death among people between the ages of 45 and 74; people in this age group were almost twice as likely to die from cancer.

Cancer can develop in almost any tissue; evidence suggests that several types of cancer can be prevented and that the prospects for surviving cancer continue to improve with early detection and treatment; advances in research, detection, and treatment are responsible for both the decline in incidence and death rates for all types of cancer.[100]

Adherence to screening recommendations for cancers of the breast, cervix, and colon/rectum is effective in reducing cancer deaths.[101] For minority populations, access to culturally and linguistically appropriate information on prevention, early detection, and treatment are essential. Complex and interrelated factors affect the risk of developing cancer; these factors also contribute to the cancer incidence and death rate among racial, ethnic, and underserved groups.[102]

National data indicate that African Americans are about 34% more likely to die of cancer than non-Hispanic Whites and more than twice as likely to die of cancer as Asians, American Indians, and Latinos or Hispanics.[103] African American women are more likely to die of breast and colon cancers than are women of any other racial or ethnic group. African American men have the highest death rates of colon and rectum, lung, and prostate cancers. Age-adjusted lung cancer death rates are approximately 40% higher among African American males than White males. Hispanics have higher rates of cervical, esophageal, gallbladder, and stomach cancers. Asians experience higher rates of stomach and liver cancer than other racial and ethnic groups. Certain racial and ethnic groups have lower survival rates than Whites for most cancers.

[99]Nebraska Cancer Registry 2007 Annual Report. (2010). Cancer incidence and mortality in Nebraska: 2007. Retrieved from http://nlc1.nlc.state.ne.us/epubs/H8320/A001-2007.pdf.
[100]Healthy People. (2012). Cancer. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=5.
[101]Healthy People 2010 U.S. Department of Health and Human Services. (2000). *Healthy People 2010*. 2nd Ed. With Understanding and Improving Health and Objectives for Improving Health. 2 Vol. Washington, DC: U.S. Government Printing Office.
[102]Healthypeople.gov. (2012). Cancer. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=5.
[103]Landis, S.H., Murray, T., Bolden, S., et al. (2000). Cancer statistics, 2000. *CA: A Cancer Journal for Clinicians* 50(1):2398-2424.

PROGRESS TOWARD HP2010

The national goal for cancer as part of Healthy People 2010 is to reduce the number of new cases as well as the illness, disability, and deaths caused by cancer. The chart below offers a summary of findings for measures we have that match specific Healthy People 2010 objectives. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✖ = regress away), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✖ = not met).

Summary

All racial and ethnic groups saw progress toward decreasing their overall cancer mortality rate between 2001-2005 and 2006-2010, however all groups fell short of their objective and African Americans remain much higher (almost double) than their objective. African Americans and American Indians saw progress and reached their objective for decreasing breast cancer mortality, as did Asians.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Overall Cancer Death Rate/100,000 Population					
White	179.4	171.8	✓	147	✖
African American	251	238.3	✓	147	✖
Asian	126.3	99.9	✓	85.2	✖
American Indian	215.4	153.2	✓	147	✖
Hispanic or Latino	121.3	99.5	✓	72	✖
Breast Cancer Death Rate/100,000 Population					
White	23.9	20.2	✓	20.7	✓
African American	38.8	28.3	✓	20.7	✖
Asian	5.2	12.4	✖	20.7	✓
American Indian	28.9	12.6	✓	20.7	✓
Hispanic or Latino	9.8	19.3	✖	12	✖
Prostate Cancer Death Rate/100,000 Population					
White	25.0	23.3	✓	25.9	✓
African American	48.1	39.8	✓	25.9	✖
Asian	18.0	5.6	✓	0.0	✖
American Indian	12.1	8.2	✓	25.9	✓
Hispanic or Latino	10.2	22.1	✖	8	✖

Cancer Mortality

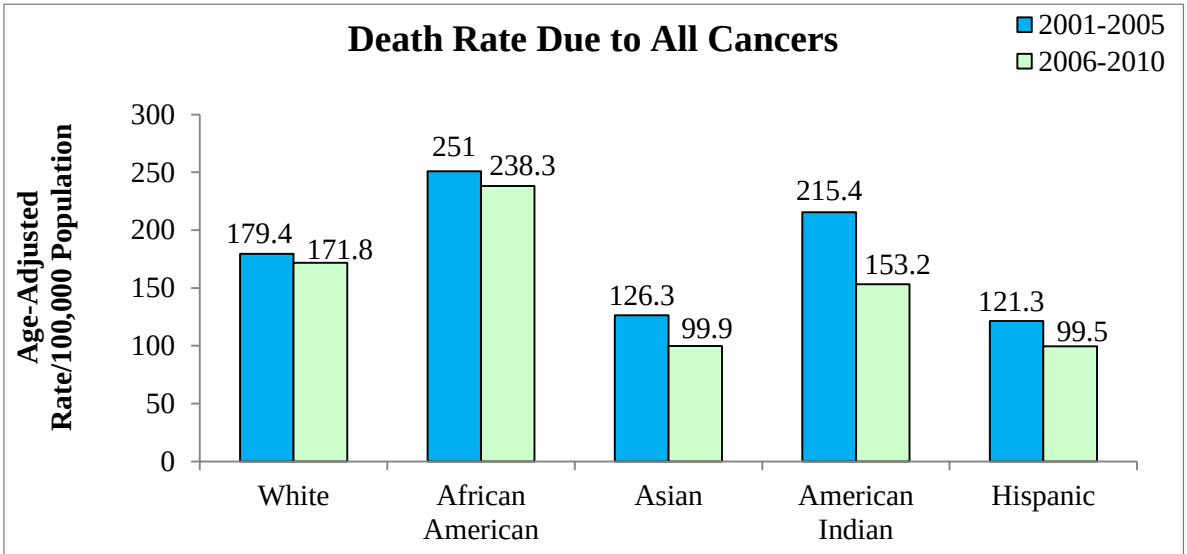
In general, cancer is the uncontrolled growth of abnormal cells, occurring when cells divide too quickly or forget how to die.[104] In 2009, there were 8,615 cancer diagnoses and 3,336 cancer deaths in Nebraska, a reduction from the previous year's 9,054 diagnoses and 3,377 deaths.[105] Lung cancer, colorectal cancer, breast cancer, and prostate cancer were the top four diagnoses between 2000 and 2009.[106] In Nebraska, cancer is the second leading cause of death.[107]

Key Disparities

- Nebraska's African American population had the highest death rate due to cancer in 2006-2010 (238.3/100,000 people), compared to Whites at 171.8/100,000 people.
- Almost 100 per 100,000 Asians and Hispanics died of cancer.
- American Indians in Nebraska saw a rate of 153.2 cancer deaths/100,000 people.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Cancer deaths decreased among all racial and ethnic groups.
- American Indians saw the biggest decrease in cancer mortality from 215.4/100,000 people in 2001-2005 to 153.2/100,000 people in 2006-2010.
- African Americans saw the smallest decline from 251/100,000 people in 2001-2005 to 238.3/100,000 people in 2006-2010, and remained the group with the highest rate of cancer death compared to other groups.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Compared to the Nation

- Nebraska's African American and American Indian populations saw higher rates of cancer mortality than the nation (203.8/100,000 people and 122.4/100,000 people, respectively).
- Asians and Hispanics in Nebraska saw lower rates than their national counterparts (109/100,000 people and 119.7/100,000 people, respectively).

[104] A.D.A.M. Medical Encyclopedia. (2012). Cancer. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002267/.
[105] Nebraska Department of Health and Human Services. (2012). Cancer Incidence and Mortality in Nebraska: 2009. Retrieved from http://dhhs.ne.gov/publichealth/Documents/CancerReport_09.pdf.
[106] Ibid.
[107] Centers for Disease Control and Prevention. (2010). Nebraska Fact Sheet. Retrieved from http://www.cdc.gov/nchs/pressroom/states/NE_2012.pdf.

Trends: Cancer Mortality

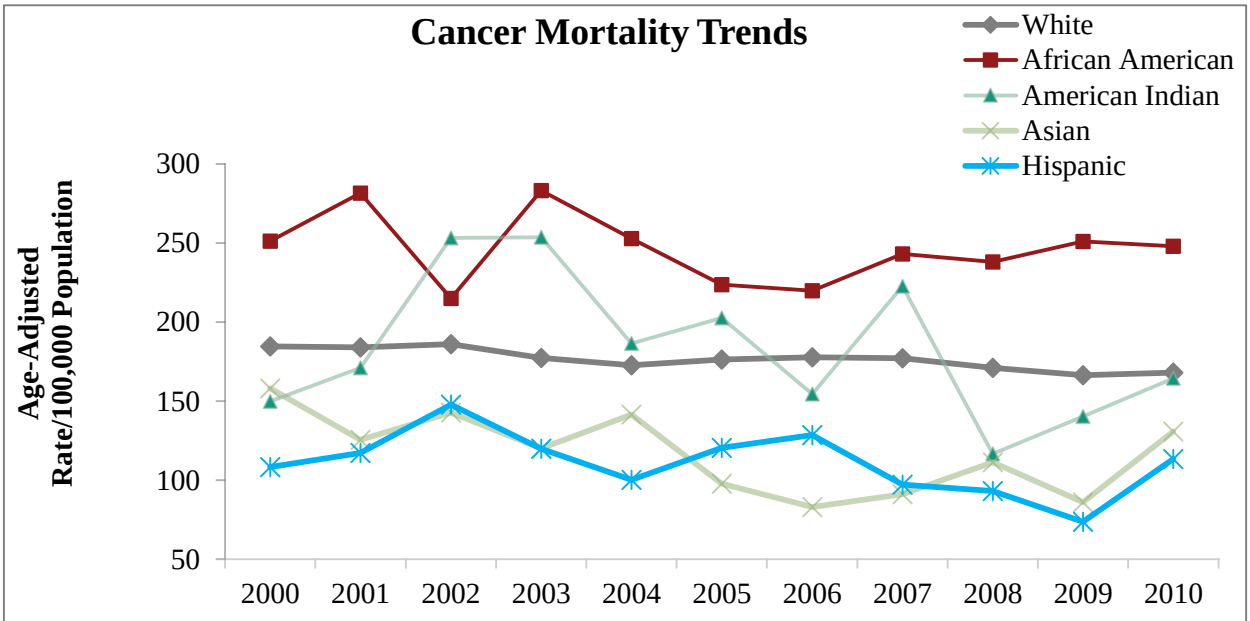
More than one million people are diagnosed with cancer each year in the United States.[108] Cancer cost $201.5 billion in 2008; $77.4 billion in direct medical costs and $124 billion in indirect mortality costs.[109] Fortunately, cancer research has come a long way; scientists have learned more about cancer in the previous two decades than had been learned in all centuries before.[110]

Key Disparities

- African Americans experienced the highest rates of cancer mortality in all but one year in the 2000s.
- American Indians also saw higher rates of cancer mortality, seeing higher rates than Whites for half of the decade and higher than Asians and Hispanics across the decade.
- Asians and Hispanics had the lowest cancer mortality rate.

Trends between 2000 and 2010

- African American mortality rates seem to have leveled out toward the end of the decade; however, they were by far the highest during this time.
- Hispanics consistently saw a two-year increase followed by a two-year decrease throughout the decade.
- American Indians, Asians, and Hispanics experienced an increase in cancer mortality between 2009 and 2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2000-2010

[108]American Cancer Society. Retrieved from http://www.cancer.org/cancer/index.
[109]American Cancer Society. (2013). Economic impact of cancer. Retrieved from http://www.cancer.org/cancer/cancerbasics/economic-impact-of-cancer.
[110]American Cancer Society. (2012). The twenty-first century. Retrieved from http://www.cancer.org/cancer/cancerbasics/thehistoryofcancer/the-history-of-cancer-twenty-first-century-and-beyond.

Years Lost Due to Cancer

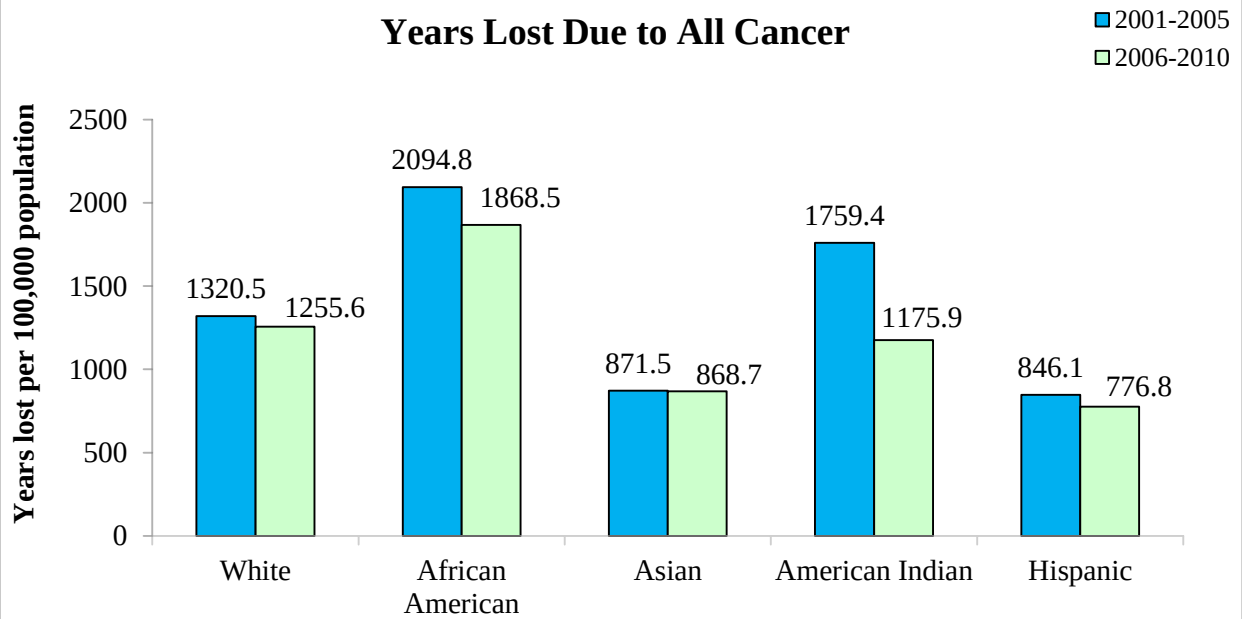
Each person who died of cancer in 2008 lost an average of 15.5 years of life.[111] In 2010, in the United States, malignant neoplasms accounted from 1,843,612 years of life lost, or almost 17% of the total years lost over all.[112]

Key Disparities

- Nebraska's African American population saw the highest amount of years lost due to cancer per 100,000 people (1,868.5) in 2006-2010, compared to Whites (1,255.6).
- American Indians saw almost 1,175.9 years lost to cancer in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Years lost due to cancer decreased among all groups from 2001-2005 to 2006-2010.
- American Indians saw the largest decrease 583.5 years dropping from 1,759.4 in 2001-2005 to 1,175.9 in 2006-2010.
- African Americans remained highest from 2001-2005 to 2006-2010, but still dropped from 2,094.8 years lost to 1,868.5 years lost.
- American Indians went from seeing the second largest amount of years lost in 2001-2005, to an amount lower than Whites in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[111]National Cancer Institute. (2008). Cancer trends progress report. Retrieved from http://progressreport.cancer.gov/doc_detail.asp?pid=1anddid=2009andchid=96andcoid=930.
[112]Centers for Disease Control and Prevention. (2010). Years of potential life lost before age 65. Retrieved from http://webappa.cdc.gov/cgi-bin/broker.exe.

Breast Cancer Mortality

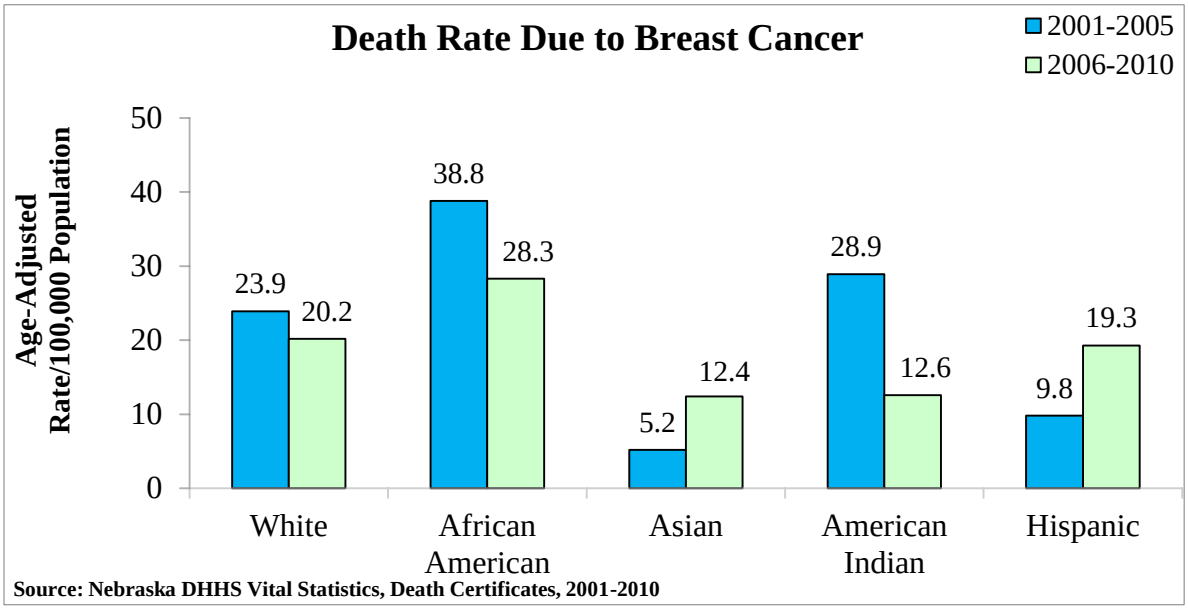
Among women, breast cancer is the most frequently diagnosed cancer and second most common cause of a cancer-related death, after lung cancer.[113] Approximately 7% of Nebraska cancer deaths in 2007 were due to breast cancer.[114]

Key Disparities

- African American women in Nebraska experienced the highest breast cancer death rate (28.3/100,000), compared to Whites at 20.2/100,000 people.
- Approximately 13 per 100,000 Asian and American Indian women died from breast cancer.
- Hispanic women saw a breast cancer mortality rate of 19.3 per 100,000 people.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Both Asian and Hispanic women saw an increase in breast cancer death from 2001-2005 to 2006-2010, while White, African American, and American Indian women saw a decline.
- American Indian women saw the greatest decline from 28.9/100,000 people in 2001-2005 to 12.6/100,000 people in 2006-2010, taking them from the second to third highest rate of breast cancer death.
- African American women saw a small decline from 38.8/100,000 people to 28.3/100,000 people and remained the group with highest rate of breast cancer death.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Note: Please interpret these numbers with caution, as there were fewer than 10 cases for Asians and American Indians

Compared to the Nation

- Nebraska's Asian, American Indian, and Hispanic women saw higher breast cancer mortality rates than their national populations (11.9, 11.5, and 14.4, respectively).
- African American women in Nebraska saw lower rates of breast cancer mortality than their U.S. population (30.3).

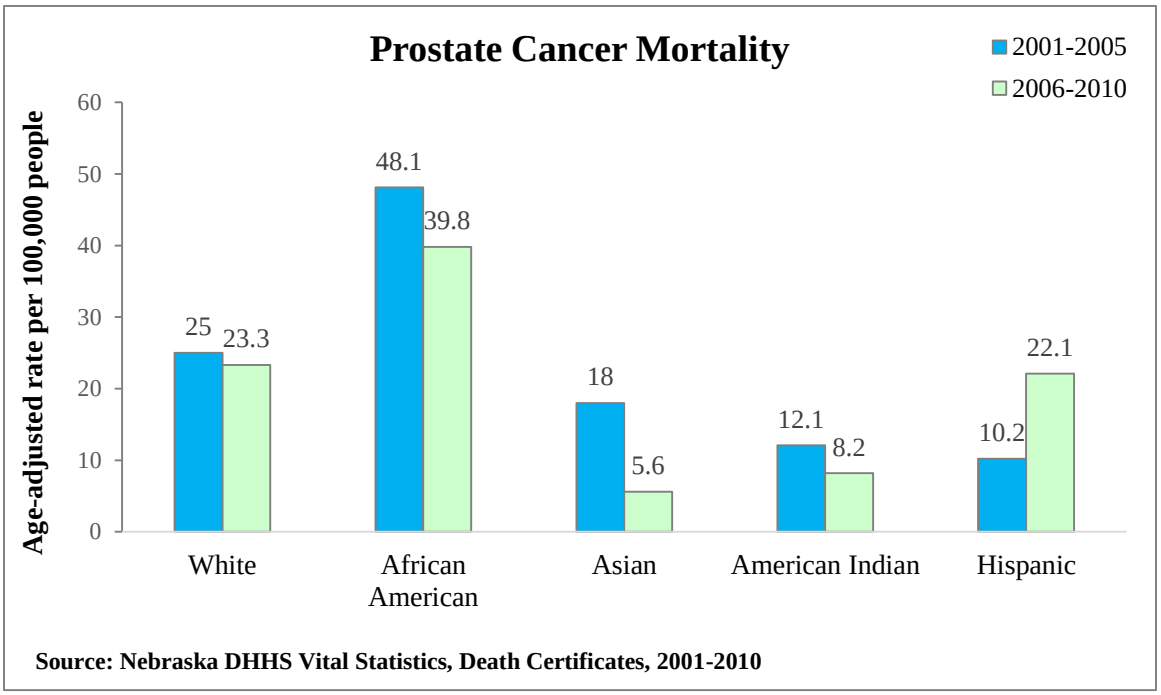
[113]Nebraska Department of Health and Human Services. (2010). Nebraska 2010 vital statistics report: Death highlights. Retrieved from http://dhhs.ne.gov/publichealth/Vital%20Statistics%20Reports/Death%20Summary%202010.pdf.
[114]Ibid.

Prostate Cancer Mortality

Prostate cancer is the leading cause of death for men over 75, though rarely found in men younger than 40. Men with familial history of prostate cancer, who are older than 60, or who are African American are at an increased risk of getting prostate cancer.[115] African American men are most likely to develop cancer at every age.

Key Disparities

- Nebraska's African American population experienced a much higher prostate cancer death rate (39.8/100,000 population) than any other group.
- Hispanics (22.1) had comparable rates to Whites (23.3), but Hispanics experienced higher mortality rates than Asians (5.6) or American Indians (8.2).



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Note: Please interpret these numbers with caution, as there were fewer than 10 cases for Asians, American Indians, and Hispanics

Compared to the Nation

- African Americans in the United States (48/100,000 population) saw a higher rate of prostate cancer death than African American Nebraskans.
- More American Indians (15.3/100,000 population) and Asians (9.6/100,000 population) in the United States died of prostate cancer than Nebraskan counterparts.
- Hispanics in Nebraska (22.1) and Hispanics in the United States (18.4) saw similar rates of prostate cancer death.

[115] A.D.A.M. Medical Encyclopedia. (2011). Prostate cancer. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001418/.

MATERNAL, INFANT, AND CHILD HEALTH

In any given year, six million women become pregnant. The health of mothers, infants, and children reflects the health status of a nation and forms the basis for the health of the next generation. In particular, the infant mortality rate is recognized worldwide as an indicator of health status and social well-being. Infant mortality is associated with socioeconomic status, access to health care, and the health status of women of childbearing age. Moreover, when women make positive health decisions while pregnant it allows the next generation to start life as healthy as possible. Things like access to health care and chronic stress are associated, both positively and negatively, with maternal health outcomes.[116]

Within the United States, rates of infant mortality are higher in some areas than others. Nebraska was ranked 16th in 2010 with an infant mortality rate of 6.2/per 1,000 live births, this was a positive move from 25th in 2007 when the infant mortality rate was 6.5/per 1,000 live births.

Racial and ethnic minority populations are disproportionately at risk for infant death, maternal death, and babies being born at low birth weights. Inadequate prenatal care, poor environmental and economic conditions, and lifestyle choices such as alcohol and tobacco use during pregnancy lead to higher incidence of adverse birth outcomes.

[116]Healthypeople.gov (2012). Maternal, infant, and child health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26.

PROGRESS TOWARD HP2010

The national goal for maternal, infant, and child health as part of Healthy People 2010 is to improve the health and well-being of women, infants, children, and families throughout the nation. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✖ = regress away or remain the same), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✖ = not met).

Summary

Nebraska racial and ethnic groups saw progress toward their infant mortality objectives; Asians met the objective with an infant mortality rate of 2.8 per 1,000 live births. American Indians saw progress toward their low weight birth objectives, but fell short of reaching 5% in 2006-2010. All racial and ethnic groups experienced a decrease in mothers receiving first trimester prenatal care.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Infant Mortality Rate per 1,000 Live Births					
White	5.7	5.7	✖	4.5	✖
African American	15.1	13.8	✓	4.5	✖
Asian	5.5	2.8	✓	4.5	✓
American Indian	15.2	7.7	✓	4.5	✖
Hispanic or Latino	6.8	5.7	✓	4.5	✖
Prenatal Care in the First Trimester	%	%			
White	83.8	76.6	✖	90%	✖
African American	69.9	56.6	✖	90%	✖
Asian	81.3	67.3	✖	90%	✖
American Indian	61.3	50.1	✖	90%	✖
Hispanic or Latino	67.3	56.6	✖	90%	✖
Low Birth Weight	%	%			
White	6.6	6.6	✖	5%	✖
African American	12.5	13.3	✖	5%	✖
Asian	8	8.4	✖	5%	✖
American Indian	6.8	7.3	✖	5%	✖
Hispanic or Latino	6.3	6.6	✖	5%	✖

Summary

Fortunately, all racial and ethnic groups saw progress in reducing their teen birth rates from 2001-2005 to 2006-2010; however there were no HP2010 objectives for teen birth. American Indians were very close to reaching their HP2010 goal for adequate prenatal care in 2001-2005, but regressed in 2006-2010 by 6%.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Teen Birth per 1,000 Females Aged 15-19					
White	30.4	23.5	✓	Not	×
African American	90.4	84.7	✓	Available	×
Asian	23.9	21.1	✓		×
American Indian	128.2	100.2	✓		×
Hispanic or Latino	115.3	114.6	✓		×
Adequate Prenatal Care	%	%			
White	90.6	88.7	×	90%	×
African American	79.4	75.4	×	90%	×
Asian	88.5	82.9	×	90%	×
American Indian	72.4	67.4	×	90%	×
Hispanic or Latino	77.5	75.8	×	90%	×
Abstained from Smoking While Pregnant	%*	%			
White	85.8	83.5	×	98%	×
African American	84.7	86.7	✓	98%	×
American Indian	70.5	71.1	✓	98%	×
Asian	96.1	96.3	✓	98%	×
Hispanic or Latino	95.9	95.6	×	98%	×

*Abstained from smoking data is for 2000-2004 timeframe, not 2001- 2005.

Infant Mortality

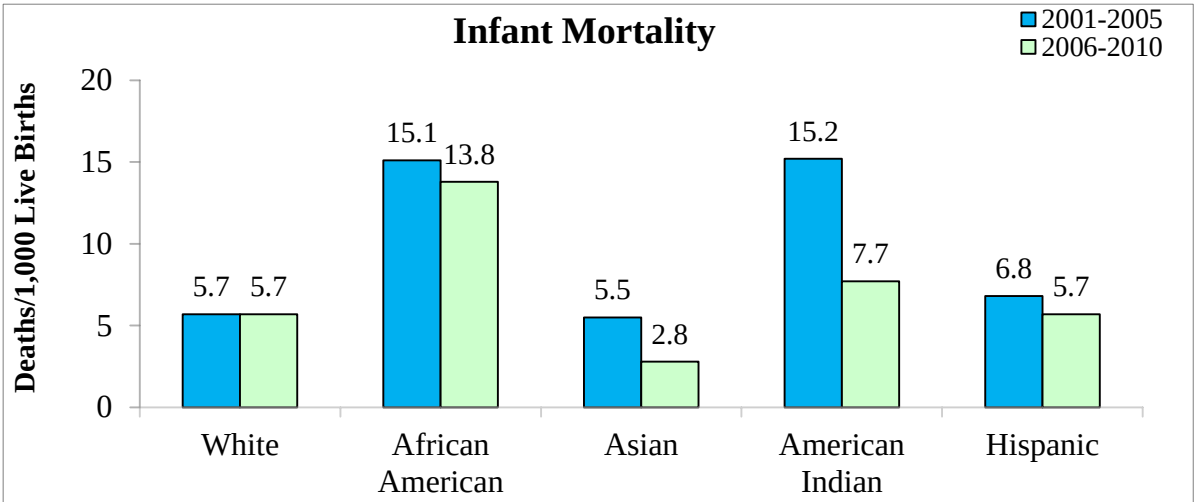
The infant mortality rate was defined as the number of deaths by infants up to 1 year old per 1,000 live births in a given time period. The infant mortality rate only includes infant deaths that were initially classified as live births. Infant mortality is one of the most widely used indicators of the health and welfare of a population because it reflects the general state of maternal health and effectiveness of primary health care.[117]

Key Disparities

- Nebraska's African American population experienced the highest rate of infant mortality (13.8/1,000 population), compared to Whites and Hispanics at 5.7/ 1,000 population.
- American Indians saw a 7.7/1,000 infant mortality rate.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All groups saw a reduction in their infant mortality rates between time periods, except for Whites who remained the same.
- American Indians saw the largest decrease in infant mortality dropping from 15.2/1,000 people in 2001-2005 to 7.7/1,000 in 2006-2010; though they still saw the second highest infant mortality rate.
- African Americans continued to have the worst infant mortality rate, but dropped to 13.8/1,000 people in 2006-2010 from 15.1/1,000 in 2001-2005.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2001-2010
Note: This figure is based on pregnant women who have a live birth

Compared to the Nation

- African Americans in Nebraska saw a higher infant mortality rate than African Americans in the U.S. (12.4/1,000 people).
- Both Asian and American Indian Nebraskans saw lower infant mortality rates than their national counterpart, with Nebraska Asians seeing almost half that of the national population (4.5/1,000 people and 8.4/1,000 people, respecitvely).
- Nebraska's White and Hispanic populations saw comparable infant moratlity rates as the nation (5.6/1,000 live births).

[117]Centers for Disease Control and Prevention. (2012). Infant mortality. Retrieved from http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm.

First Trimester Prenatal Care

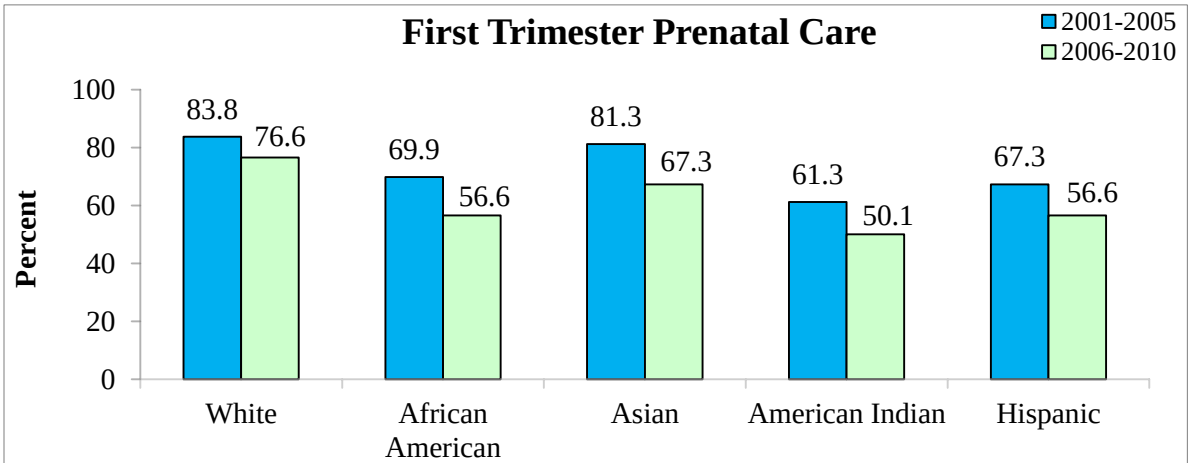
'Early prenatal care' was defined as care within the first trimester of her pregnancy. Babies born to mothers who receive no prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those whose mothers received prenatal care.[118] Prenatal care is more likely to be effective if women begin receiving care early in pregnancy.

Key Disparities

- Half of Nebraskan American Indian women received prenatal care, the lowest among all groups and compared to 76.6% of White mothers.
- Almost 57% of African Americans and Hispanics received first trimester prenatal care.
- Nebraska Asians had the second best proportion of mothers who received prenatal care, at 67.3%.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentage of mothers receiving prenatal care dropped among all racial and ethnic groups between 2001-2005 and 2006-2010, and African Americans saw an almost 15% decline from 2001-2005.
- In 2001-2005, Asian mothers saw a 2.5% difference in reception of prenatal care compared to Whites, but that disparity grew to almost 10% in the 2006-2010 when the percentage of Asian mothers who received care dropped by 14%.
- Dropping from over 60% in 2001-2005, 50% of American Indian mothers received care in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2001-2010
Note: This figure is based on pregnant women who had a live birth

Compared to the Nation

- Overall, Nebraska saw less women who received first trimester prenatal care compared to the United States.
- Fewer Asian and Hispanic women in Nebraska obtained first trimester prenatal care, compared to 77.7% of Asians and 64.7% of Hispanics in the nation.
- African Americans and American Indians saw similar proportions of women getting early prenatal care compared to their national counterparts.

[118]Womenshealth.gov. (2009). Prenatal care fact sheet. Retrieved from http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.cfm.

Low Birth Weight

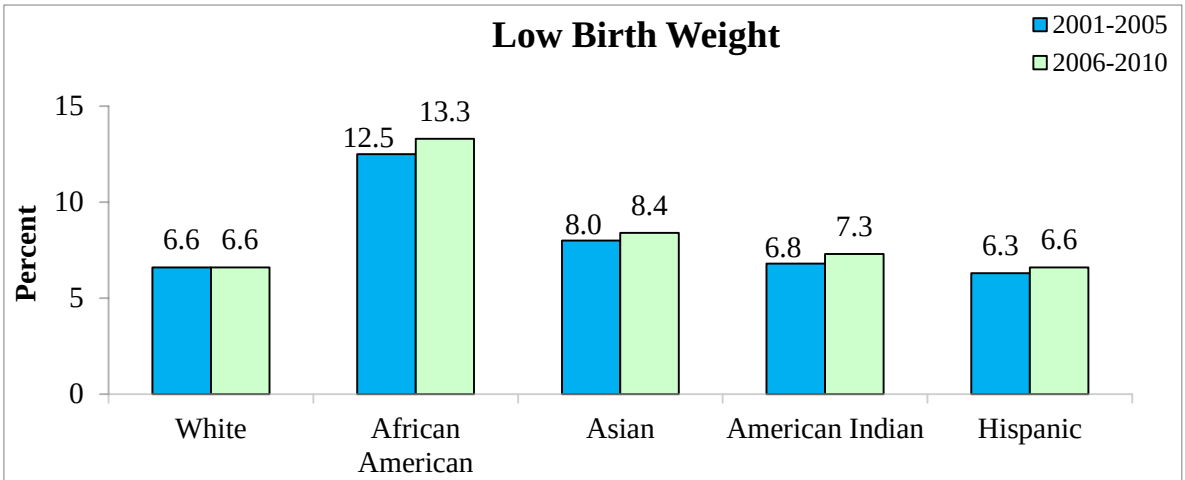
Infants weighing less than 2,500 grams (5 lbs., 8 oz.) at birth were considered low birth weight (LBW).[119] Approximately two-thirds of LBW infants and 98% of very LBW infants are born preterm. LBW infants who survive their first year are at increased risk of physical, neurological, and developmental complications compared to normal birth-weight infants.[120] Low birth weight (LBW) rates have been increasing nationwide as well as in Nebraska.[121]

Key Disparities

- Nebraska's African American population had the highest prevalence of low birth weight births (13.3%), compared to Hispanics (6.6%) and Whites (6.6%).
- Nebraska Asians (8.4%) saw the second highest rate of low birth weight babies.
- Although the proportion of LBW babies was the same for Whites and Hispanics during 2006-2010, the percentage for Hispanics was actually an increase over 2001-2005.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Low birth weight rates increased for all minority groups from 2001-2005 to 2006-2010.
- African Americans saw the biggest jump from 12.5% to 13.3%, which was two times the rate of Whites (6.6%).
- Hispanics' low birth weight percentage rose .3% and was then identical to Whites.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2001-2010
Note:This figure is based on pregnant women who had a live birth

Compared to the Nation

- The proportion of low birth weights among racial and ethnic groups in Nebraska were very similar to those groups in the United States.
- African Americans in the United States (13.2%) and Nebraska (13.3%) saw the same percentage of LBW babies being born.
- The largest difference between Nebraska (6.6%) and the United States (7%) was among Hispanics.

[119]Lucile Packard Children's Hospital at Stanford. (2013). Low birth weight. Retrieved from http://www.lpch.org/DiseaseHealthInfo/HealthLibrary/hrnewborn/lbw.html.
[120]Ibid.
[121]Ibid.

Abstained from Smoking During Pregnancy

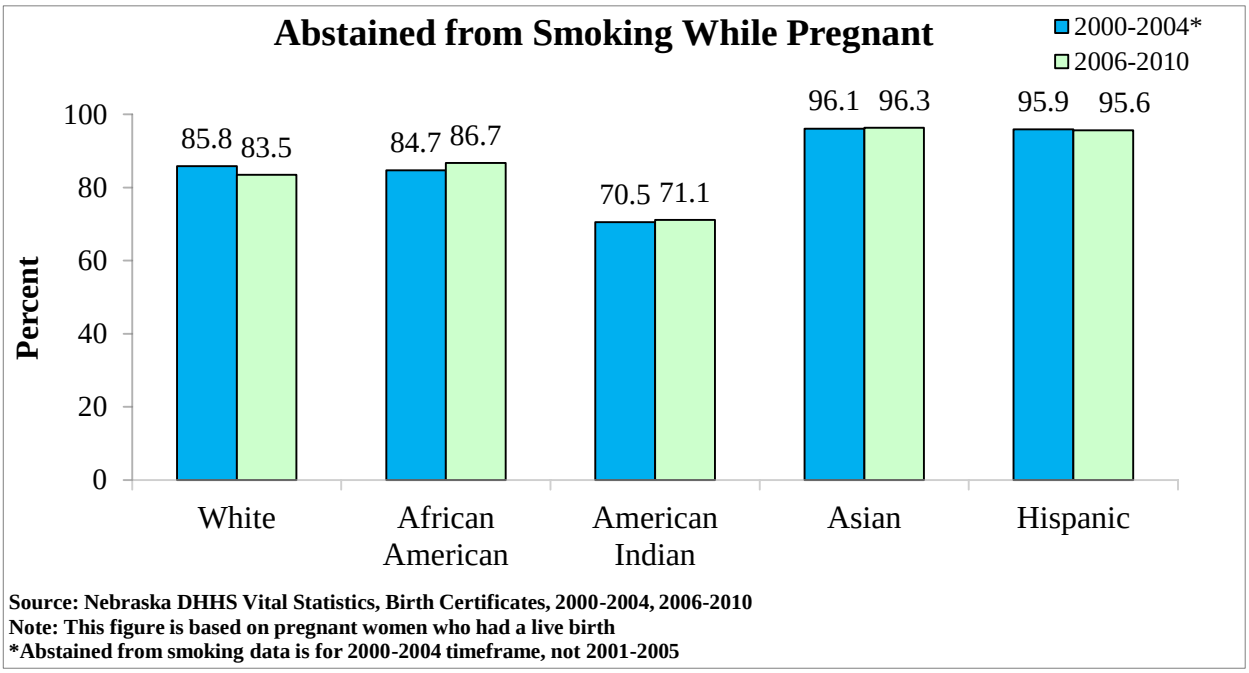
Smoking while pregnant causes a myriad of health problems, starting with lower oxygen levels during pregnancy.[122] Maternal smoking is responsible for 20–30% of low birth weight babies, up to 14% of preterm deliveries, and roughly 10% of all infant deaths. Continuing to smoke around children after they are born also causes problems; lung disease, asthma, and inner ear infections are all common problems in children exposed to secondhand smoke.[123]

Key Disparities

- Approximately 70% of American Indian women in Nebraska reported abstaining from smoking while pregnant, the lowest among all groups, and compared to 83.5% of Whites.
- Approximately 96% of Asian and Hispanic women reported not smoking while pregnant.

How are we doing? Comparisons between 2000-2004* and 2006-2010

- Smoking abstinence while pregnant remained relatively constant among all groups between 2000-2004 and 2006-2010.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2000-2004, 2006-2010
Note: This figure is based on pregnant women who had a live birth
***Abstained from smoking data is for 2000-2004 timeframe, not 2001-2005**

Compared to the Nation

- Nebraska Hispanics and Asians saw a similar percentage of women abstaining from smoking while pregnant to those in the United States (97.9% and 98.4% abstaining, respectively).
- More American Indians in the U.S. abstained (79.4%) than American Indians in Nebraska (71.1%).
- Slightly more African Americans in the U.S. abstained from smoking (90.1%) than African Americans in Nebraska (86.7%).

[122]WebMD. (2012). Smoking during pregnancy. Retrieved from http://www.webmd.com/baby/smoking-during-pregnancy.
[123]Ibid.

Teen Births

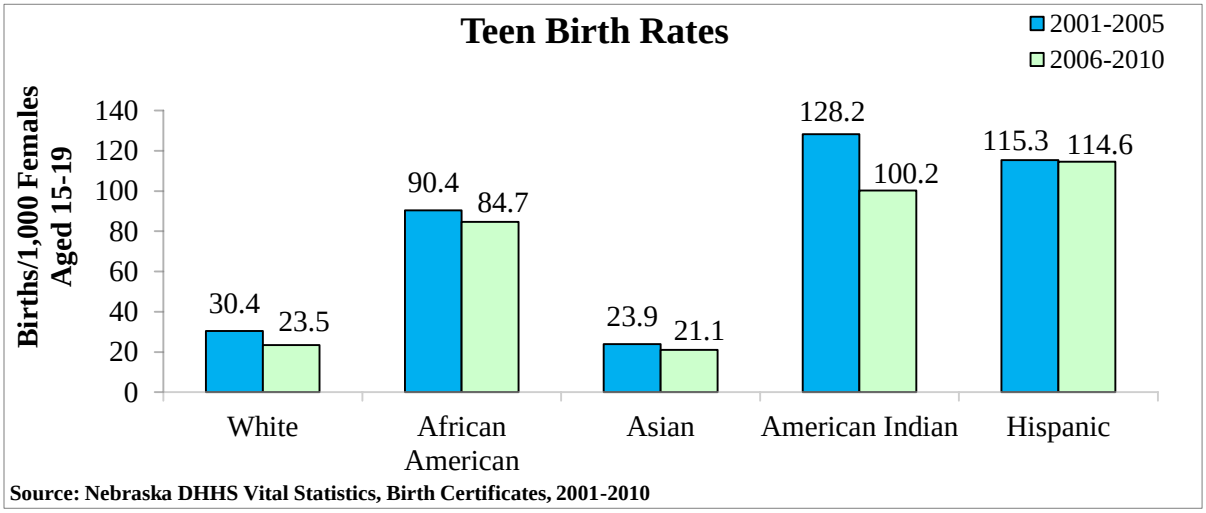
Teen birth was defined as any live birth among females age 15-19 years old. As a group, adolescent mothers and their children are at risk for a host of adverse outcomes. Adolescent mothers as well as their children are more likely to drop out of school. Teen mothers are more likely to remain single parents. Children of teen mothers tend to have behavioral, economic, and medical problems; they also are more likely to become teen parents themselves.[124]

Key Disparities

- Nebraska's Hispanic population saw the highest rate of teen births (114.6/1,000 females), compared to Whites at 23.5/1,000 females and Asians at 21.1/1,000 females.
- 100/1,000 American Indian teen girls reported giving birth.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Where the teen birth rate in Nebraska decreased among all races, American Indian's saw the greatest decrease in teen birth dropping from 128.2/1,000 females to 100.2/1,000 females.
- The Hispanic teen birth rate only decreased by 0.8 between 2001-2005 and 2006-2010 making teen birth most prevalent among Hispanic girls after American Indians' rate dropped by 28.
- African American teen birth rates dropped (to 84.7/1,000 females), but were still over three times the rate of Whites.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2001-2010

Compared to the Nation

- All racial and ethnic minority groups saw teen birth rates twice as high or higher than their U.S. populations.
- Nebraska Hispanics saw the largest difference between Nebraska (114.6/1,000 females) and the United States (56/1,000 females).
- Nebraska American Indians (100.2/1,000 females) also saw a large difference (39/1,000 females).
- Asians (21.1/1,000 females) and African Americans (84.7/1,000 females) in Nebraska saw a teen birth rate twice as high as Asians (11/1,000 females) and African Americans (51/1,000 females) in the United States.

[124]Centers for Disease Control and Prevention. (2012). About teen pregnancy. Retrieved from http://www.cdc.gov/teenpregnancy/aboutteenpreg.htm.

Inadequate Prenatal Care

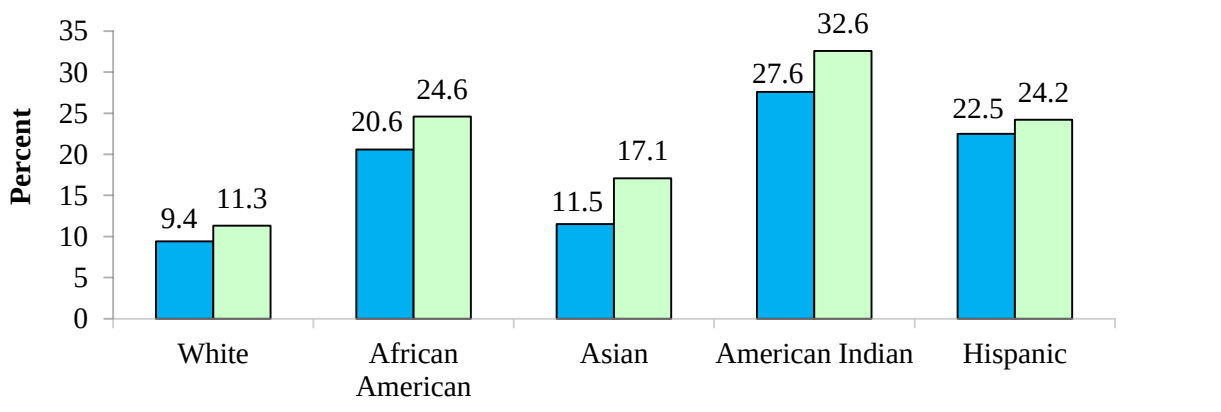
The Kotelchuck Index measures adequacy of prenatal care by using a formula calculated with the number of prenatal visits, gestation, and which trimester prenatal care began.

Key Disparities

- Nebraska's American Indian population saw the highest percentage of women not receiving adequate prenatal care (32.6%) according to the Kotelchuck Index, compared to Whites (11.3%).
- The African American (24.6%) and Hispanic (24.2%) populations had comparable percentages of women who had not received adequate prenatal care.
- Seventeen percent of Asian women did not receive adequate prenatal care.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentage of mothers who received inadequate prenatal care increased among all populations.
- Nebraska Asians saw the largest increase from 11.5% in 2001-2005 to 17.1% in 2006-2010.
- African Americans increased 4%, from 20.6% in 2001-2005 to 24.6% in 2006-2010.
- American Indians increased from 27.6% in 2001-2005 to 32.6% in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2001-2010
Note: This figure is based on pregnant women who had a live birth

Compared to the Nation

- Overall, Nebraska saw better rates of early and adequate prenatal care compared to the United States.
- Hispanics in Nebraska saw about 10% less of the population not receiving adequate prenatal care compared to the United States (34.5%).
- African Americans and American Indians saw more than 10% less of the population not receiving prenatal care compared to the nation (39% and 44.5%, respectively).

PRAMS & BREASTFEEDING

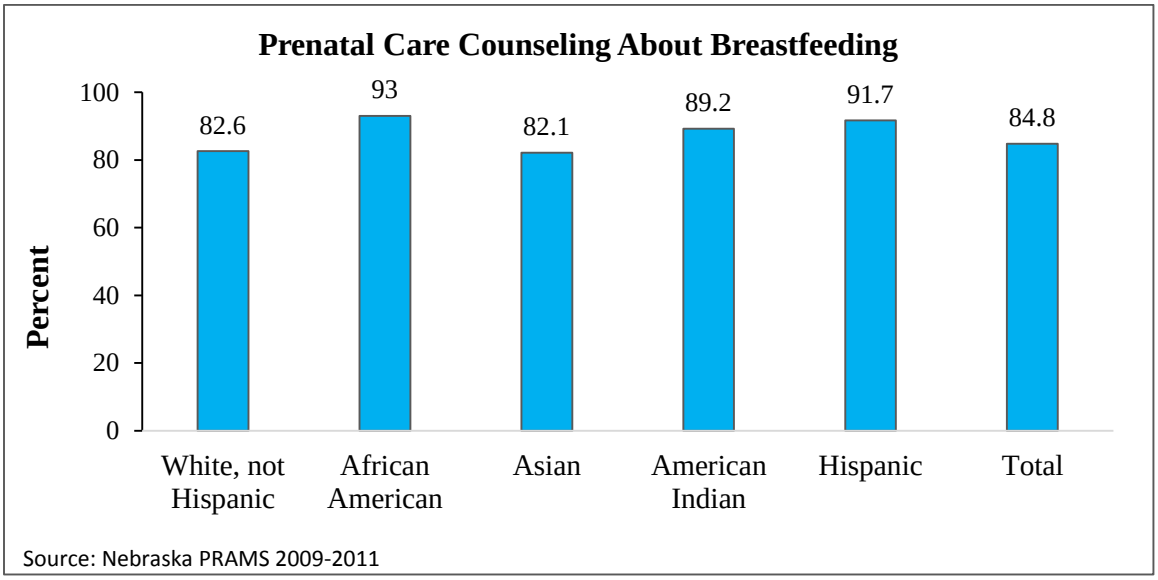
The Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing population-based surveillance system of maternal behaviors and experiences before, during, and after pregnancy. It is an initiative to reduce infant mortality and low birth weight infants, and was developed to supplement vital records data by providing state-specific data to be used for planning and evaluating prenatal health programs.

Breastfeeding is associated with numerous health benefits for both infants and mothers.[125] Breast milk strengthens infants' immune systems, thus resulting in fewer cases of illness for newborns.[126] Breastfeeding has also been associated with a decreased risk of pre-menopausal breast cancer in women.[127] However, breastfeeding rates remain low among some groups of women, such as women who are young, African American, below the Federal Poverty Threshold, unmarried, or less than college-educated.[128,129] Many women also stop breastfeeding soon after initiation for various reasons, such as smoking, medication use, physical and mental health issues, or the need to return to work.[130]

[125]www.ahrq.gov/downloads/pub/evidence/pdf/bfout/brfout.pdf
[126] Howie PW, Forsyth JS, Ogston SA, Clark A, Florey CD. Protective effect of breastfeeding against infection. BMJ 1990; 300(6716):11-16
[127]www.ahrq.gov/downloads/pub/evidence/pdf/bfout/brfout.pdf
[128]Centers for Disease Control and Prevention (CDC). Racial and socioeconomic disparities in breastfeeding-United States, 2004. MMWR Morb Mortal Wkly Rep 2006; 55(12): 335-339
[129]Centers for Disease Control and Prevention (CDC). Breastfeeding trends and updated national health objectives for exclusive breastfeeding-United States, birth years 2000-2004. MMWRMorb Mortal Wkly Rep 2007; 56(30):760-763
[130]Ahluwalia IB, Morrow B, Hsia J, Why do women stop breastfeeding? Findings from the Pregnancy Risk Assessment and Monitoring System. Pediatrics 2005; 116(6):1408-1412

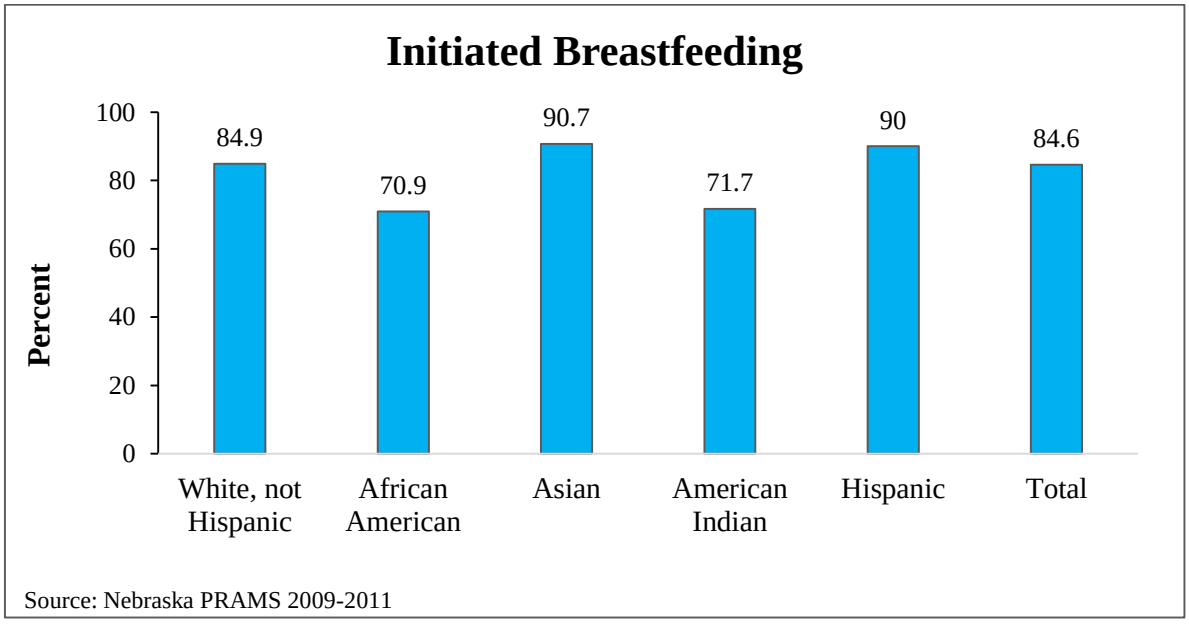
Prenatal Care Counseling

African American mothers reported the highest percentage (93%) of women obtaining prenatal care counseling about breastfeeding. A similar proportion of American Indian (89.2%) and Hispanic (91.7%) women reported receiving prenatal care counseling on breastfeeding.



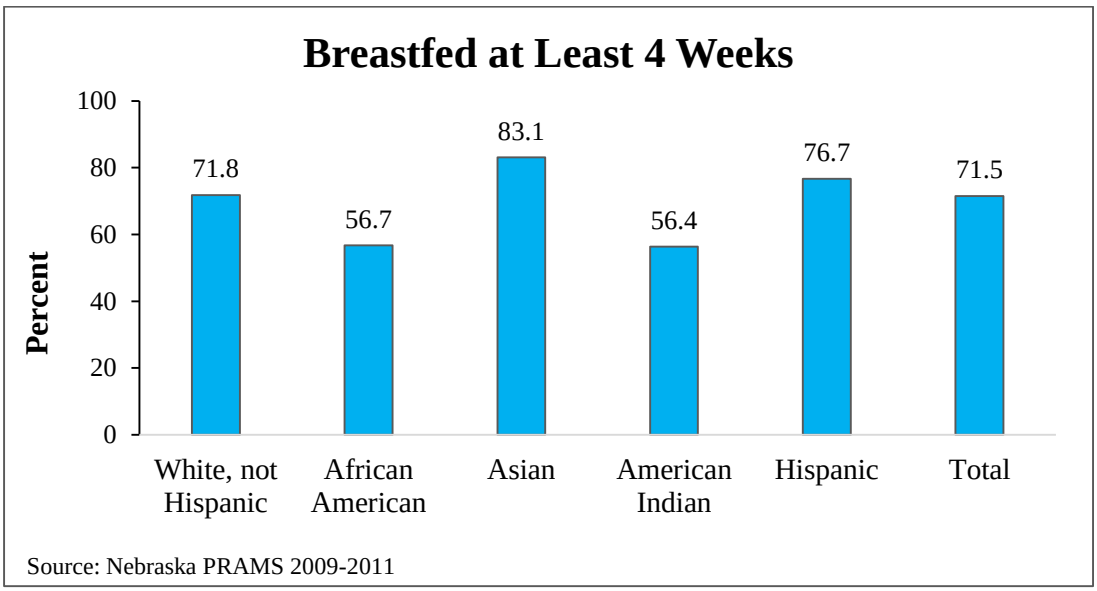
Initiated Breastfeeding

Asian and Hispanic women reported the highest proportion of those who initiated breastfeeding. African American and American Indian women initiated breastfeeding the least.



Breastfed at Least 4 Weeks

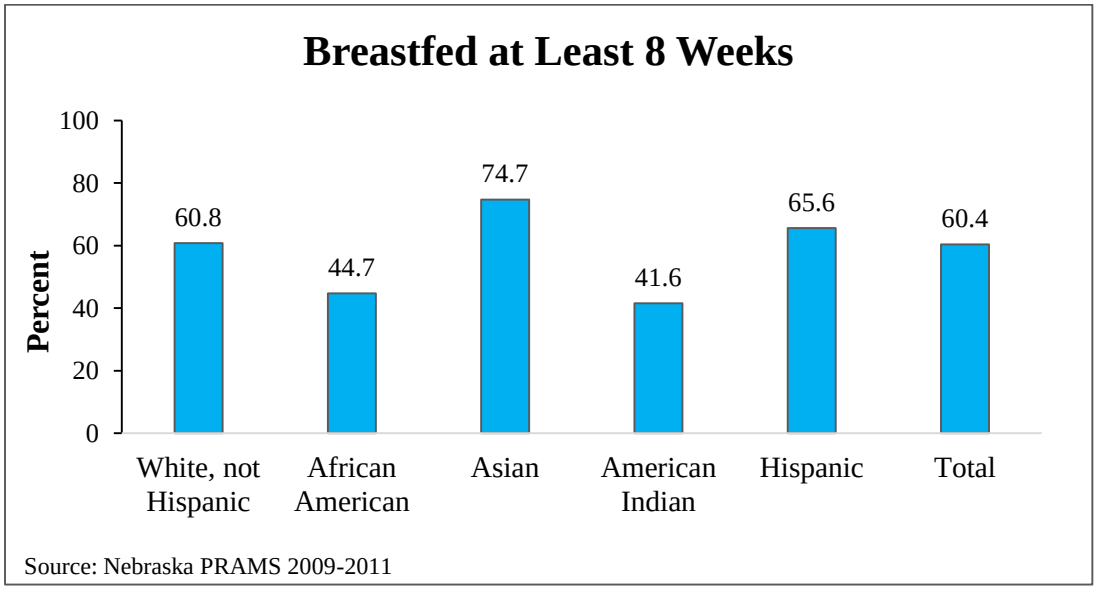
Approximately 83% of Asian and Pacific Islanders breastfed at least 4 weeks. Only 56% of African Americans and American Indians breastfed for at least 4 weeks.



Source: Nebraska PRAMS 2009-2011

Breastfed at Least 8 Weeks

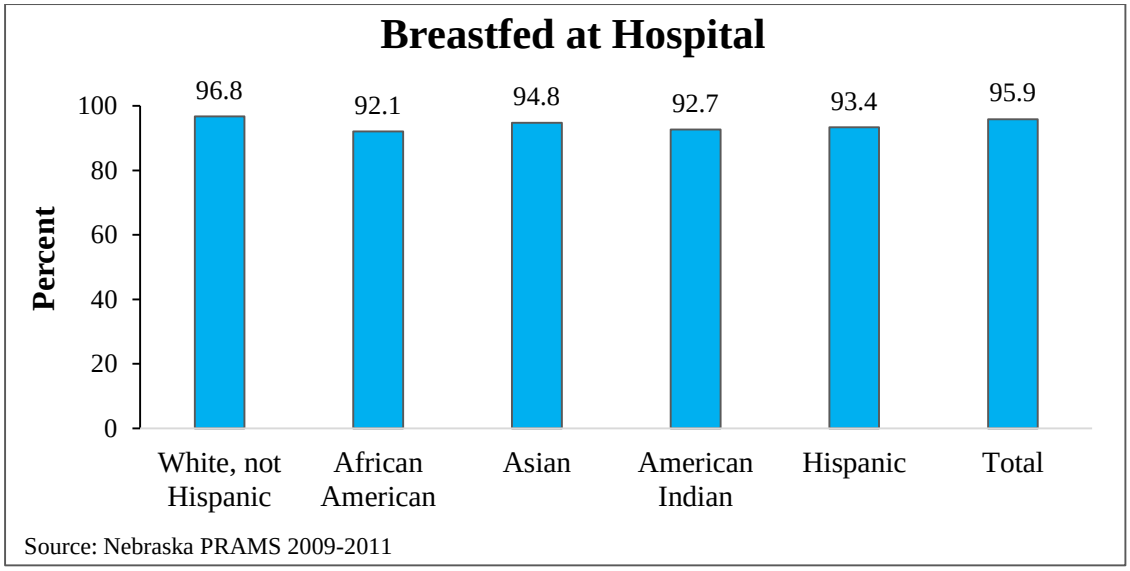
Asian Pacific Islanders had the largest proportion of women who breastfed for at least 8 weeks. A similar proportion of African American (44.7%) and American Indian (41.6%) mothers breastfed for at least 8 weeks.



Source: Nebraska PRAMS 2009-2011

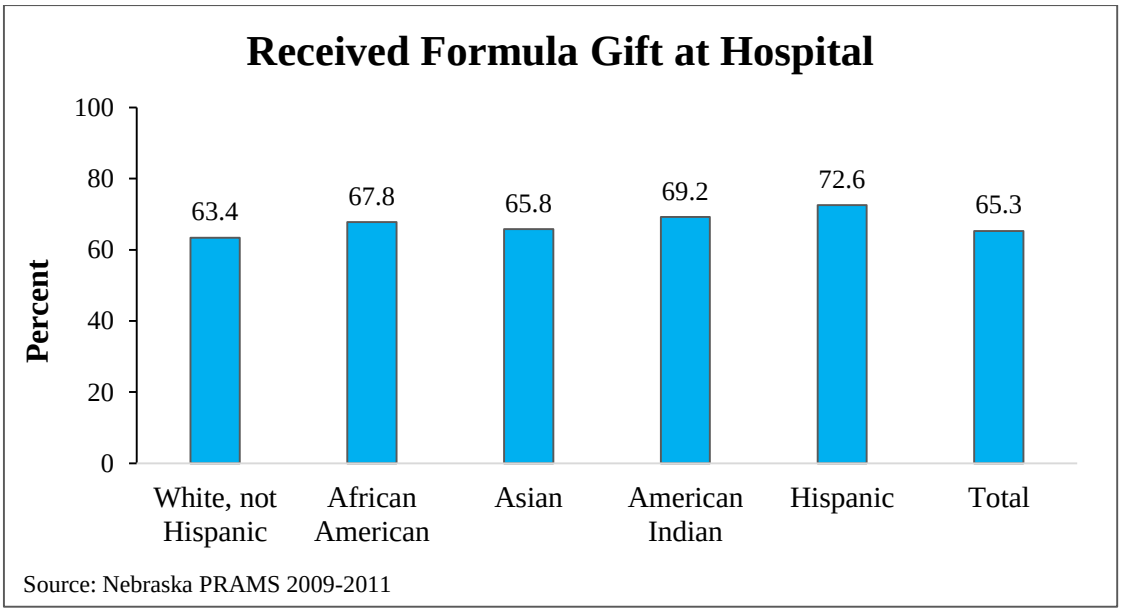
Breastfed at Hospital

A similar proportion of all women (about 93%) regardless of race or ethnicity breastfed at the hospital.



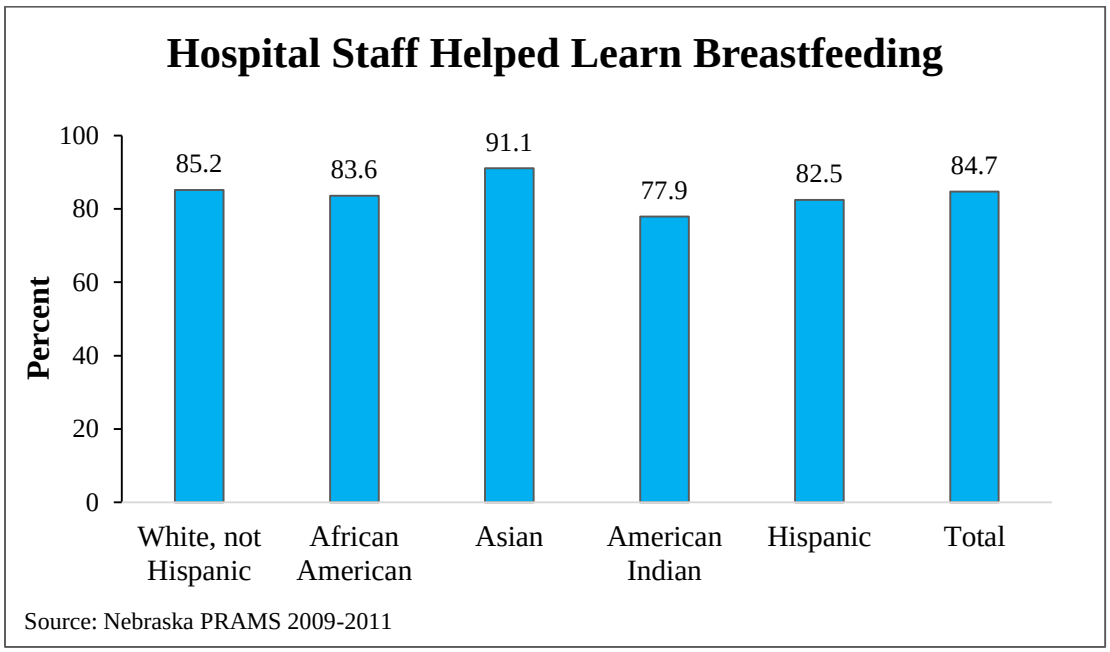
Received Formula Gift at Hospital

Almost 73% of Hispanic women received a formula gift at the hospital. Approximately 66% of both African American and Asian women received a formula gift at the hospital.



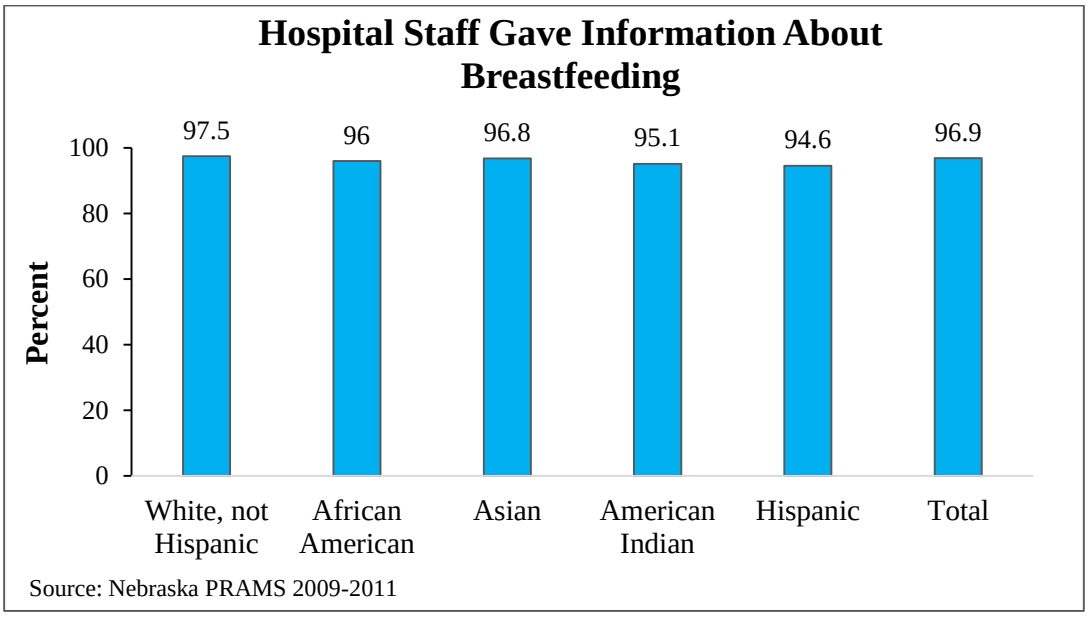
Hospital Staff Helped Learn Breastfeeding

Approximately 90% of Asian women reported getting help from hospital staff on breastfeeding. About 83% of African American and Hispanic women received help from hospital staff about breastfeeding.



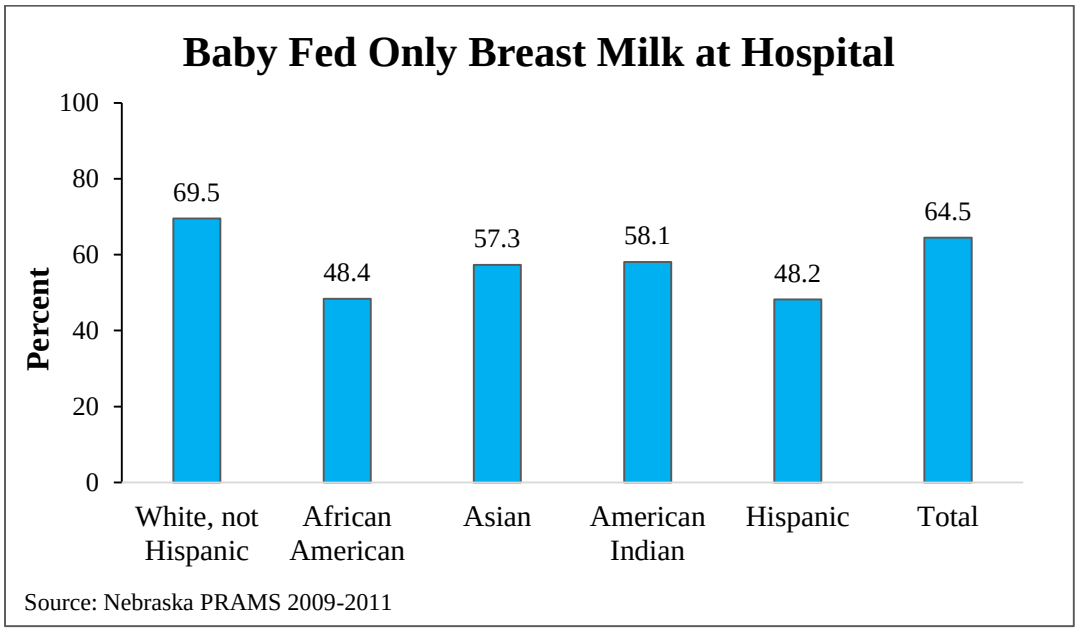
Hospital Staff Gave Information about Breastfeeding

Similar proportions of women from all race and ethnicities were given information about breastfeeding at the hospital.



Baby Fed Only Breast Milk at Hospital

Approximately 57% of both American Indian and Asian women report that their baby was fed breast milk exclusively during their time at the hospital. Less than half of African American and Hispanic women said their child was only breastfed at the hospital.



INJURY AND VIOLENCE

According to the National Center for Health Statistics, injuries (intentional and unintentional) resulted in 2.8 million (inpatient) hospitalizations, 41.3 million visits to hospital emergency departments, and 105.3 million physician's office visits in 2004. According to 2006 CDC estimates, the lifetime cost of injuries occurring in a single year in the United States is $406 billion, including medical expenses and productivity losses.[131]

Nebraska recorded 15,256 deaths in 2007; over 16% were from intentional and unintentional injuries: 674 unintentional injury deaths, 181 suicides, and 71 homicides.[132] Both intentional and unintentional injuries are among the top 15 killers of Americans in *all* age groups. The CDC claims, in the United States, injuries and violence (including suicide) are the leading cause of death among those 1-44 years old.[133,134] Approximately 72% of deaths among adolescents aged 10-24 are due to injuries from motor vehicle crashes, homicide, suicide, and all other unintentional injuries.[135] Even though many people consider accidents and injuries as part of life, most are 'predictable and preventable.'[136]

The choices people make, like alcohol use or risk-taking can increase injury. The physical environment can increase injury related to things like falls, fires, drowning, or violence; and other things like the social environment including education, relationships, or culture affect risk of injury as well. Finally, the accessibility of health care services can all contribute to one's risk of unintentional injury or violence.[137] In an ever-changing culture, the area of injury and violence is also changing. Research is needed in the areas of motor vehicle accidents because of distracted driving, injuries related to recreational activities, and violence related to bullying and dating in order for us to understand the depth of injury and violence.

[131]Nebraska Health and Human Services, Division of Public Health. (2007). Nebraska 2010 Health Goals and Objectives: A Midcourse Review.
[132]Nebraska Vital Statistics. Nebraska Vital Statistics Report 2007: Death Highlights. Retrieved from http://dhhs.ne.gov/publichealth/Vital%20Statistics%20Reports/Death%20Summary%202007.pdf. Accessed June 18, 2009.
[133]Healthy People 2010. (2012). Injury and Violence Prevention. Retrieved from http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=24.
[134]Centers for Disease Control and Prevention. (2012). Injury and violence. Retrieved from http://www.cdc.gov/healthyyouth/injury/index.htm.
[135]Ibid.
[136]Ibid.
[137]Ibid.

PROGRESS TOWARD HP2010

The national goal for injury and violence prevention as part of Healthy People 2010 is to reduce injuries, disabilities, and deaths due to unintentional injury and violence. The chart below offers a summary of findings for measures we have that match specific Healthy People 2010 objectives. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✗ = regress away), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✗ = not met).

Summary

All groups, except African Americans saw progress toward their Healthy People objective for unintentional injury mortality, though no groups met their objectives. African Americans did meet their goal for decreasing deaths due to both motor vehicle accidents and suicide.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Unintentional Injury death rate/100,000 Population					
White	38.4	35.9	✓	19.4	✗
African American	27.2	32.6	✗	19.4	✗
Asian	35.6	21.6	✓	7.5	✗
American Indian	87.9	49.2	✓	19.4	✗
Hispanic or Latino	31.5	29.5	✓	19.4	✗
Death Rate due to Motor Vehicle Accidents/100,000 Population					
White	16.8	13.7	✓	12	✗
African American	11.6	11.8	✗	12	✓
Asian	14.3	5.8	✓	12	✓
American Indian	39.9	16.1	✓	12	✗
Hispanic or Latino	15.5	13.8	✓	12	✗
Suicide/100,000 Population					
White	10.5	10.7	✗	8.2	✗
African American	4.1	5	✗	8.2	✓
Asian	6.6	3.7	✓	2.1	✗
American Indian	16.9	12.7	✓	8.2	✗
Hispanic or Latino	4.9	4.7	✓	4.7	✓
Homicide/100,000 Population					
White	1.9	2.1	✗	2	✗
African American	20.4	25.7	✗	2	✗
Asian	0.9	1.5	✗	2	✓
American Indian	8.0	13.6	✗	2	✗
Hispanic or Latino	5.9	5.4	✓	2	✗

Unintentional Injury Mortality

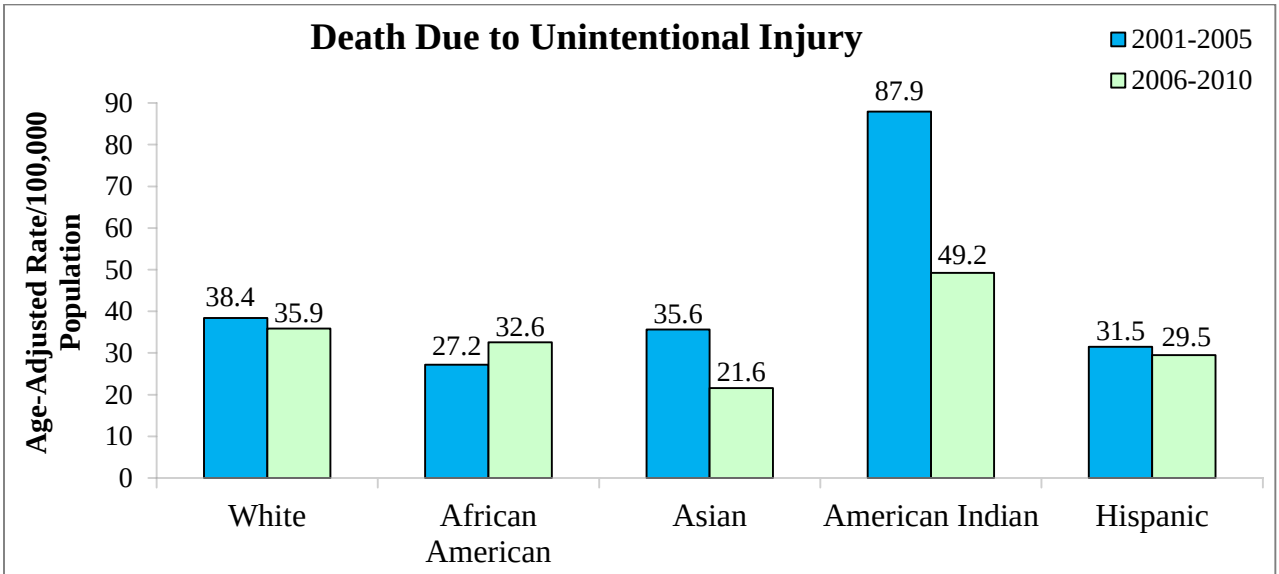
Two-thirds of all injury deaths in the United States are due to unintentional injuries (i.e., those resulting from motor vehicle crashes, falls, residential fires, poisoning, drowning, etc.). In 2005, deaths from unintentional injuries totaled 117,809 making it the fifth leading cause of death in the U.S.[138]

Key Disparities

- Nebraska's American Indian population had the highest death rates from unintentional injuries (49.2/100,000 people), compared to Whites (35.9/100,000 people).
- Almost 33/100,000 African Americans died of unintentional injury.
- Hispanics saw 29.5/100,000 people die due to unintentional injury, followed by Asians (21.6/100,000)—these ethnic groups had the lowest rates of all groups during 2006-2010.

How are We Doing? Comparisons between 2001-2005 and 2006-2010

- The rate of unintentional injury in the American Indian population dropped between 2001-2005 (87.9/100,000 people) and 2006-2010 (49.2/100,000 people), but was still the highest rate of all racial and ethnic groups.
- Asian and Hispanic Nebraskans saw a decline in their unintentional injury rate between 2001-2005 (35.6/100,000 people and 31.5/100,000 people, respectively) and 2006-2010 (21.6/100,000 people and 29.5/100,000 people, respectively).
- The African American population saw an increase in their unintentional injury rate increasing from 27.2/100,000 people in 2001-2005 to 32.6/100,000 people in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Compared to the Nation

- Aside from Whites, all racial and ethnic groups saw higher rates of unintentional injury mortality compared to their national groups.
- American Indians in Nebraska (49.2) saw the largest difference from their national population (46.9).
- As a state (36.1), we saw lower rates of unintentional injury mortality than the United States (38).

[138]National Center for Health Statistics. (2008). Health, United States, 2008 With Chart book on Trends in the Health of Americans.

Trends: Unintentional Injury Mortality

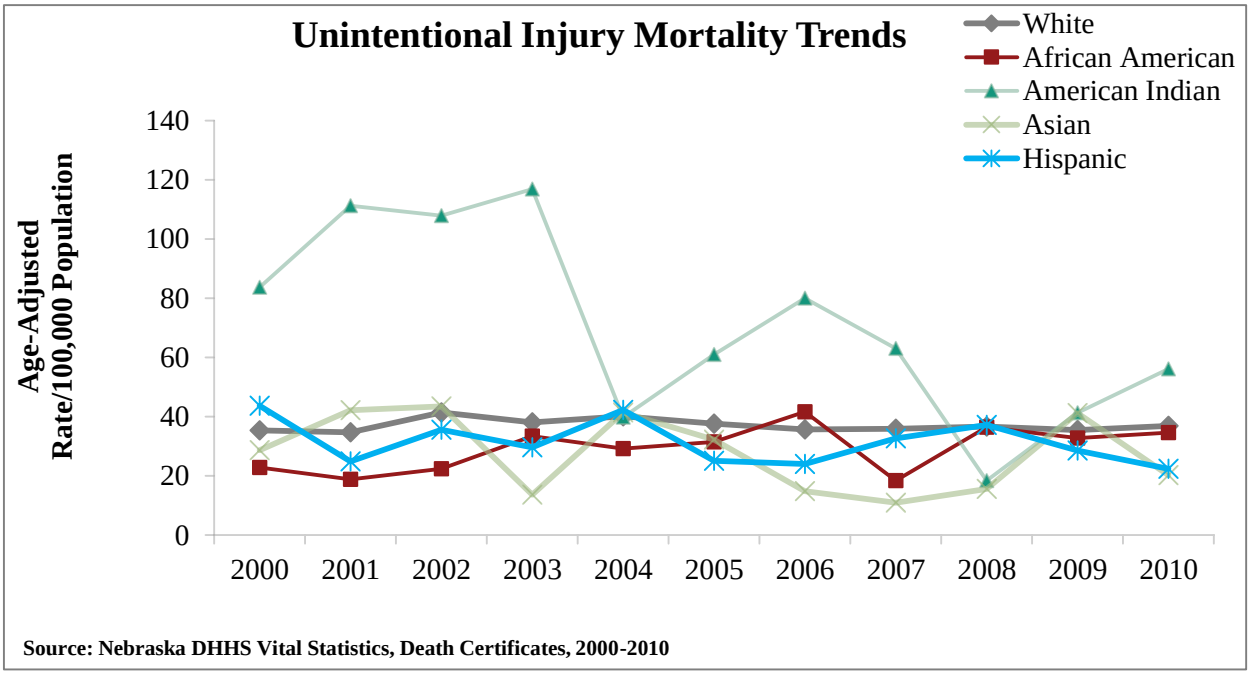
In many cases, unintentional injury is predictable and preventable. While reporting on accidents (for both men and women), the Office on Women's Health suggests not driving while sleepy or riding with a drunk driver, wearing a seat belt, using handrails, wearing safety protection, learning to swim, and using equipment and tools properly to avoid accidents.[139]

Key Disparities

- Nebraska's American Indian population experienced the highest level of unintentional injury mortality eight out of 10 years. American Indian rates, when higher, were generally higher (116.8/100,000 people) than the rest of the population (approximately 30/100,000 people).
- Other populations experienced relatively similar rates of unintentional injury mortality.
- Asians and African Americans saw the lowest levels of mortality four years in the decade.

Trends between 2000 and 2010

- American Indians, after a three year increase, dropped significantly from 2003 (116.8/100,000 people) to 2004 (39.8/100,000 people), but did not reach their lowest rate (18.4/100,000 people) until 2008. They started increasing again after 2008.
- Asians dropped below 20/100,000 population four times during the decade and did not rise above 44.
- African Americans also remained mostly between 20/100,000 people and 40/100,000 people deaths per 100,000 population throughout the decade.
- Only rising above 40/100,000 population twice, Hispanics also saw steady rates in the 20s and 30s per 100,000 people.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2000-2010

[139]Women's Health. (2011). Accidents (unintentional injuries). Retrieved from http://womenshealth.gov/mens-health/top-health-concerns-for-men/accidents-unintentional-injuries.cfm.

Years Lost Due to Unintentional Injury

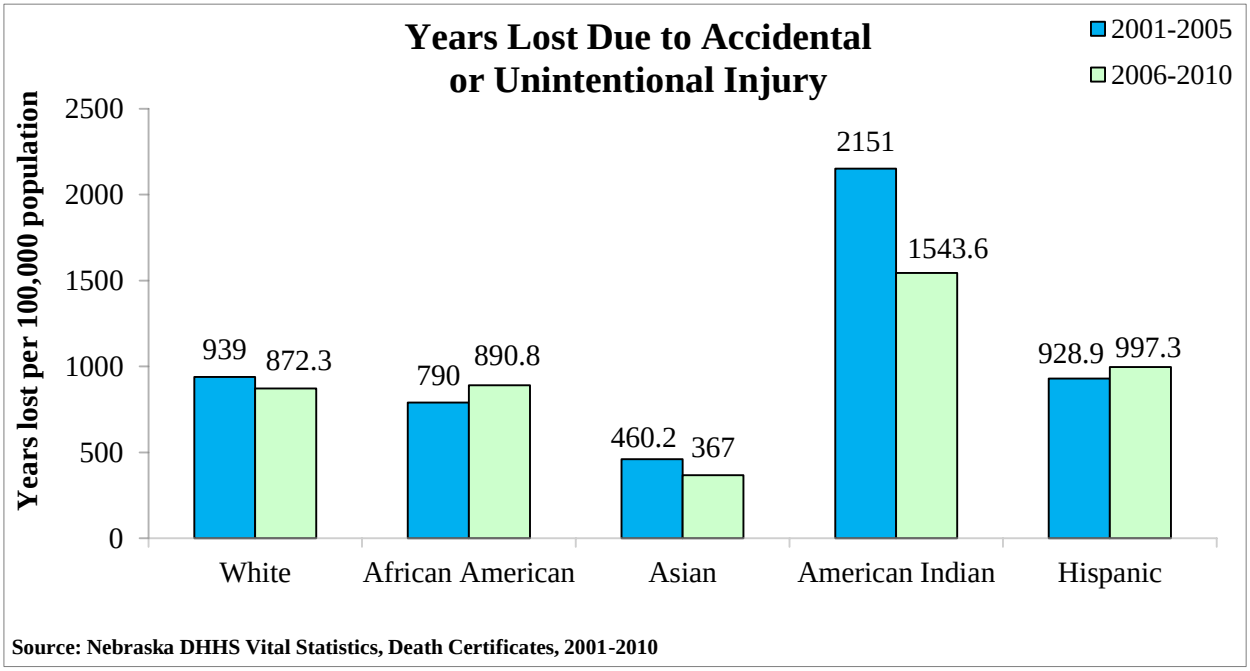
Unintentional injury is the leading cause of death among 0-19 year olds.[140] The burden of premature death from unintentional injury, calculated from the CDC, is heavier for males than for females.[141] Unintentional injury is the leading cause of years of life lost in the United States.[142] In Nebraska, unintentional injury was the second leading cause of years of potential life lost after cancer.[143] Nebraska sees more life lost due to unintentional injury (1,011/100,000 people) than the United States (890/100,000 people). Years lost per 100,000 people were calculated based on those who died before the age of 75.

Key Disparities

- Nebraska's American Indian population witnessed the largest amount of life lost due to unintentional injury (1,543.6 per 100,000 people) in 2006-2010, compared to Whites (872.3 per 100,000 people).
- Hispanics experienced 997.3 years of life lost in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The amount of life lost decreased in the White, American Indian, and Asian population between 2001-2005 and 2006-2010, and increased in the African American and Hispanic populations.
- American Indians saw the largest decline in YPLL due to unintentional injury dropping from 2,151 in 2001-2005 to 1,543.6 in 2006-2010.
- African Americans saw rates higher than only Asians in 2001-2005, but due to an increase, jumped higher than Whites in 2006-2010 after Whites saw a decline in years lost.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[140]Centers for Disease Control and Prevention. (2012). Years of potential life lost from unintentional injuries among persons aged 0-19 years. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6141a2.htm.
[141]Ibid.
[142]Ibid.
[143]Nebraska Department of Health and Human Services. (2011). Report identifies injuries as major problem in Nebraska. Retrieved from http://dhhs.ne.gov/Pages/newsroom_newsreleases_2011_apr_injuries.aspx.

Motor Vehicle Fatalities

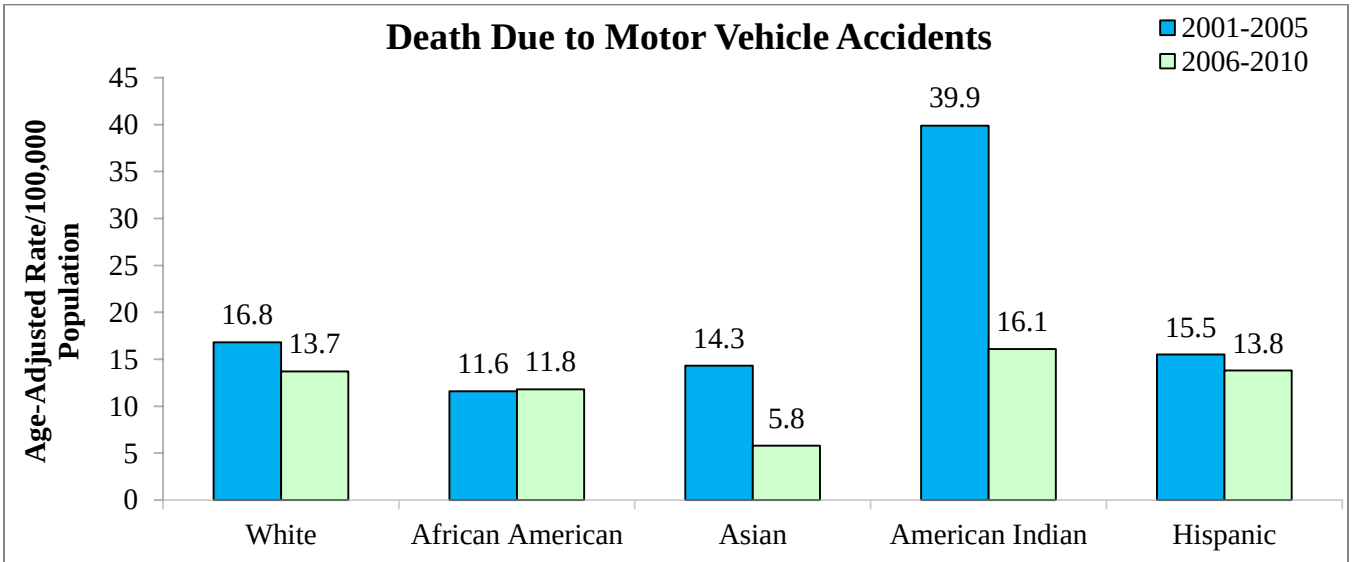
More than 30,000 people are killed in motor vehicle accidents every year in the United States.[144] These crashes and deaths resulted in $41 billion in medical costs and losses in productivity. In Nebraska, we saw a $245 million bill; that is $3 million in medical bills and $242 million in work-loss costs.[145] Young adults, 20-34 and motor vehicle occupants are responsible for the majority of costs ($99 million and $197 million, respectively).[146]

Key Disparities

- Nebraska's American Indian population had the highest motor vehicle death rate (16.1/100,000 population), compared to 13.7/100,000 population for Whites.
- Hispanics (13.8/100,000 population) saw a similar death rate to Whites.
- Asians had the lowest rate with 5.8/100,000 population, followed by African Americans at 11.8/100,000 population.

How are We Doing? Comparisons between 2001-2005 and 2006-2010

- The overall rate of motor vehicle fatalities decreased among all racial and ethnic groups, except African Americans.
- American Indians saw the largest drop from 39.9/100,000 people in 2001-2005 to 16.1/100,000 people in 2006-2010; however, they were still the group most affected by motor vehicle fatalities.
- Hispanics dropped from 15.5/100,000 people in 2001-2005 to 13.8/100,000 people in 2006-2010, while Asians dropped from 14.3/100,000 people in 2001-2005 to 5.8/100,000 people.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2001-2010

Compared to the Nation

- Nebraska Hispanics (13.8/100,000 people) saw a higher rate of motor vehicle fatalities compared to the Hispanics in the nation (9.3/100,000 people).
- African Americans and American Indians saw similar rates of motor vehicle fatalities as the nation (10.6/100,000 people, 15.1/100,000 people, and 4.9/100,000 people, respectively).

[144]Centers for Disease Control and Prevention. (2011). State-based costs of deaths from crashes. Retrieved from http://www.cdc.gov/Motorvehiclesafety/statecosts/index.html.
[145]Ibid.
[146]Ibid.

Years Lost Due to Motor Vehicle Fatalities

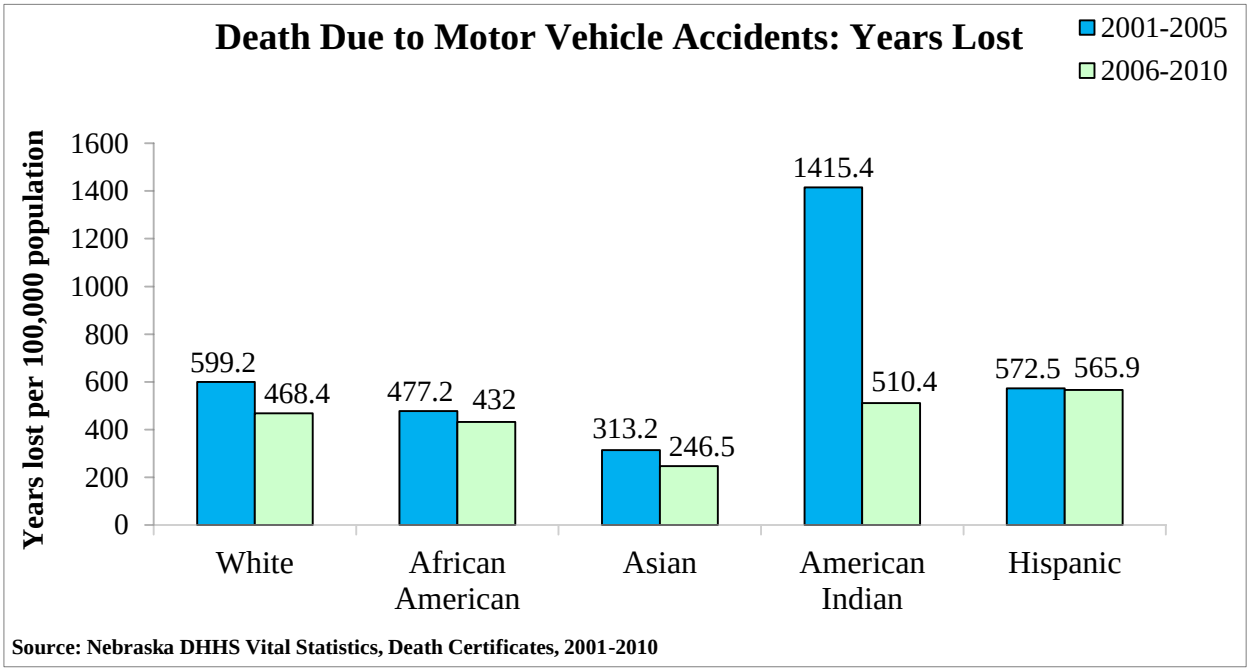
When the various parts of unintentional injury death were separated out, motor vehicle accidents ranked fourth among leading causes of life lost.[147] In 2012, motor vehicle fatalities remained the leading cause of unintentional injury death among people 0-19 years old.[148] Years lost per 100,000 people were calculated based on those who died before the age of 75.

Key Disparities

- In 2006-2010, Hispanics experienced 565.9 years of life lost per 100,000 people due to motor vehicle fatalities, compared to 468.4 per 100,000 in Whites.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The amount of life lost due to motor vehicle fatalities decreased among all groups between 2001-2005 and 2006-2010.
- American Indians saw the largest drop in YPLL from 1,415.4 in 2001-2005 to a comparable rate to the rest of the groups at 510.4 in 2006-2010.
- Hispanics saw relatively constant levels of life lost throughout the decade.
- Both Asian and African American numbers remained below that of Whites from 2001 to 2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[147]Subramanian, R. (2012). Motor vehicle traffic crashes as a leading cause of death in the United States, 2008 and 2009. Retrieved from http://www-nrd.nhtsa.dot.gov/Pubs/811620.pdf.
[148]Centers for Disease Control and Prevention. (2012). Vital signs: Unintentional injury deaths among persons aged 0-19 years – United States, 2000-2009. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm61e0416a1.htm.

Suicide

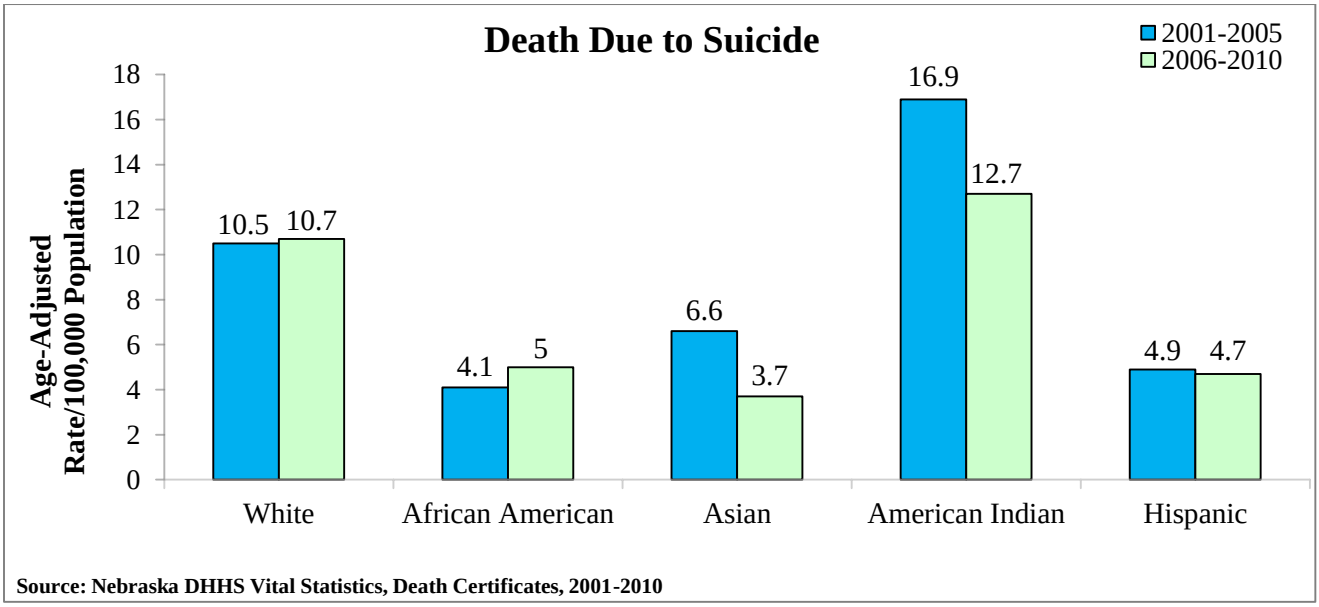
On average about one-third of injury-related deaths in the U.S. are the result of suicide or homicide.[149] Of Nebraska's 926 injury-related deaths in 2007, 37% were the result of suicide or homicide. An American dies of suicide every 16 minutes and 90% of those who die by suicide have a treatable mental illness or substance abuse disorder.

Key Disparities

- American Indians experience higher rates of suicide (12.7/100,000 population) than any other racial and ethnic group.
- Asian Americans experience the lowest rate (3.7/100,000 people), followed by Hispanics and African Americans (4.7/100,000 people and 5/100,000 people, respectively).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Although rates for American Indians have decreased (16.9/100,000 population from 2001-2005 to 12.7/100,000 population from 2006-2010), rates remain the highest of all racial groups.
- African Americans (4.1/100,000 population and 5/100,000 population, respectively) and Hispanics (4.9/100,000 population and 4.7/100,000 population, respectively) had similar rates between 2001-2005 and 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Compared to the Nation

- Almost twice as many Asians in the United States died due to suicide (6.2/100,000 population) as Asian Nebraskans.
- Almost 6/100,000 Hispanics in the United States committed suicide, compared to 4.7/100,000 Hispanic Nebraskans.
- Both American Indians and African Americans saw similar rates to their national counterparts (10.8 and 5.2, respectively).

[149]Nebraska Health and Human Services, Division of Public Health. (2007). Nebraska 2010 Health Goals and Objectives: A Midcourse Review.

Years Lost Due to Suicide

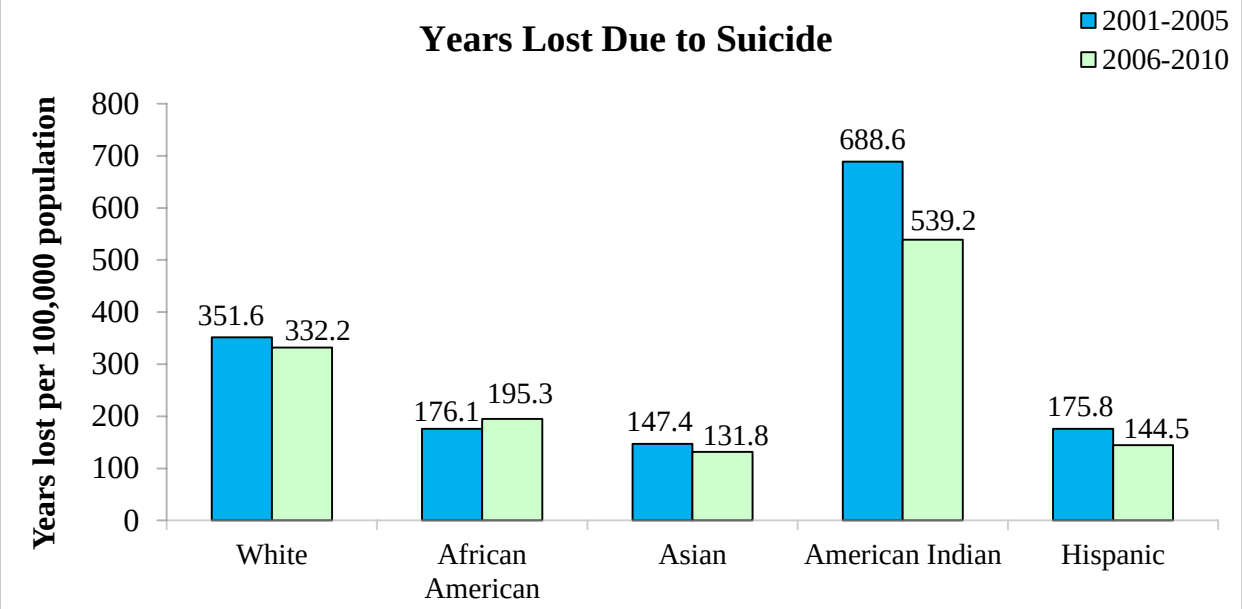
More than one million years of life are lost due to suicide every year.[150] Nebraska sees low rates of suicide compared to the rest of the United States.[151] The numbers and figure below represent those who died before the age of 75.

Key Disparities

- In 2006-2010, American Indians remained most affected by suicide, experiencing 539.2 years lost.
- All other groups experienced fewer years of life lost than that of Whites.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The amount of years of lost life due to suicide decreased among all groups, except African Americans, who increased from 176.1 in 2001-2005 to 195.3 in 2006-2010.
- American Indians had the largest decrease among all groups from 688.6 years of life lost due to suicide in 2001-2005 to 539.2 years of life lost in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

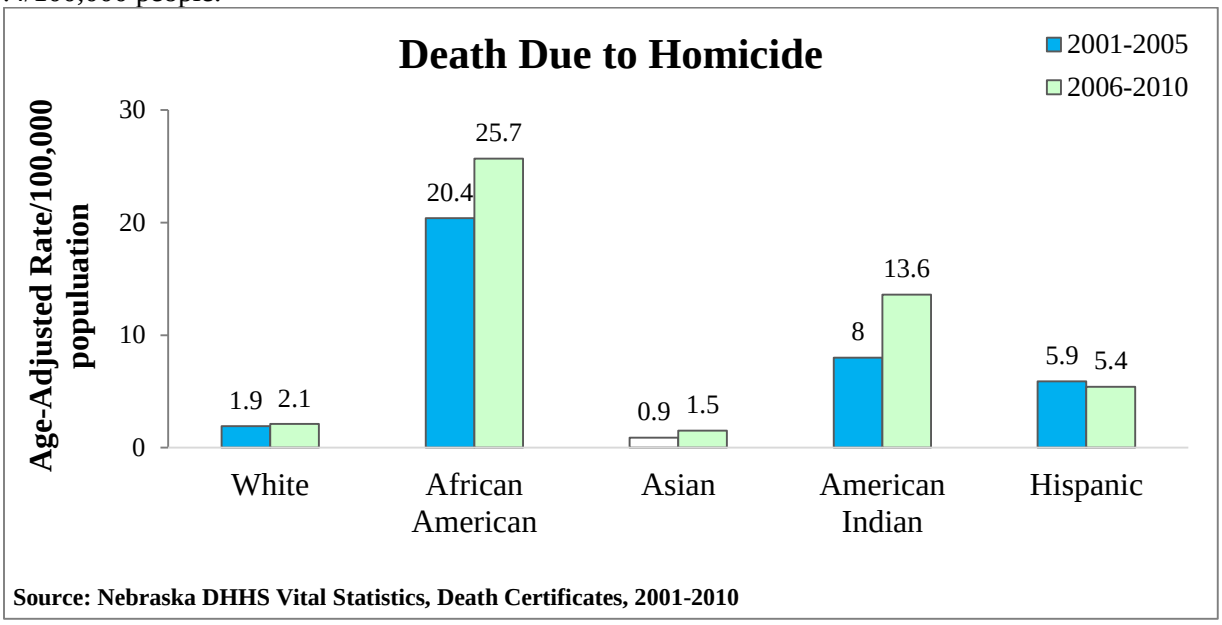
[150]Research America. Facts about: Suicide. Retrieved from http://www.researchamerica.org/uploads/factsheet21suicide.pdf.
[151]Ibid.

Homicide

Homicide accounted for 16,259 deaths in 2010. Specifically, 11,078 of those deaths were firearm homicides.[152] Homicide victimization was disproportionately high among African Americans and Hispanics or Latinos in the United States, especially young men aged 15 to 24.[153]

Key Disparities

- African Americans were disproportionally affected by homicide (25.7/100,000 people) compared to all other racial and ethnic groups, but especially compared to Asians (1.5/100,000 people) and Whites (2.1/100,000 people).
- American Indians experienced the second highest rate of homicide at 13.6/100,000 population.
- A large difference was seen between African Americans and Hispanics, who have the third highest rate at 5.4/100,000 people.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Compared to the Nation

- Both African Americans and American Indians in Nebraska experienced much higher rates of homicide than the nation (17.7/100,000 people and 5.7/100,000 people, respectively).
- Nebraska Hispanics saw the same rate of homicide as the nation (5.3/100,000 people).

[152]Centers for Disease Control and Prevention. (2013). Assault or homicide. Retrieved from http://www.cdc.gov/nchs/fastats/homicide.htm.
[153]U.S. Department of Health and Human Services. (2000). Healthy People 2010. 2nd Ed. With Understanding and Improving Health and Objectives for Improving Health. Washington, DC: U.S. Government Printing Office.

Years Lost Due to Homicide

In 2010, homicide was the sixth leading cause of life lost in the United States.[154] The numbers and figure below represent those who died before the age of 75.

Key Disparities

- Nebraska's African American population experienced the largest amount of life lost due to homicide (1,217.1 years per 100,000 people), compared to Whites (85.7 per 100,000) in 2006-2010.
- American Indians saw 650.7 years per 100,000 people lost due to homicide in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The amount of years lost due to homicide increased among all racial and ethnic groups between 2001-2005 and 2006-2010.
- Both American Indians and African Americans saw large increases in years lost, approximately 300 years lost, due to homicide between 2001-2005 and 2006-2010.
- Asians saw more than a 50-year increase in the number of years lost due to homicide from 2001-2005 and 2006-2010.

Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

[154]Centers for Disease Control and Prevention. (2010). Years of potential life lost before age 65. Retrieved from http://webappa.cdc.gov/cgi-bin/broker.exe.

SUBSTANCE ABUSE

Substance abuse refers to excessive use of a potentially addictive substance, like alcohol or drugs, that may modify bodily functions and negatively affect a person's life. Social attitudes as well as political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a crux in the criminal justice system and a major focal point in discussions about social values; arguments occur over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Substance abuse and its related effects are among society's top health and social concerns. Each year about 100,000 deaths in the United States are related to alcohol consumption including motor vehicle crashes, drowning, homicide, and suicide. Excessive alcohol consumption can lead to cirrhosis of the liver and is also associated with heart disease, cancer, and stroke. It is the third leading cause of preventable death, behind other modifiable health behaviors (diet, physical activity, and tobacco use). If abuse starts in youth, further damage occurs in the developing brain, resulting in lifelong impaired cognitive function and memory problems. Alcohol use by pregnant women is harmful to the fetus and can lead to miscarriage, stillbirth, and physical and mental birth defects. In the United States in 2009, 42% of adolescents who had ever tried alcohol were current drinkers and 54% of adults who had ever tried alcohol were current drinkers. In addition, 16% of adults and 24% of adolescents reported consuming five or more drinks (binge drinking) on a single occasion at least once in the previous year.

Forty-five million people in the United States smoke cigarettes.[155] Almost 20% of all adults and 20% of high school students are at increased risk for many preventable health issues, like lung cancer, heart disease, stroke, or heart attack because of smoking. To that end, more than 80% of adult smokers smoked their first cigarette before the age of 18.[156] Cigarette smoking is responsible for one out of every five deaths in the United States.

[155]Centers for Disease Control and Prevention. (2012). Adult cigarette smoking in the United States: Current Estimates. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm.
[156]Centers for Disease Control and Prevention. (2012). Youth and tobacco use. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm.

PROGRESS TOWARD HP2010

The national goal for substance abuse as part of Healthy People 2010 is to reduce substance abuse in order to protect the health, safety, and quality of life for all, especially children. The chart below offers a summary of findings for measures we have that match specific Healthy People 2010 objectives. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✗ = regress away or stayed the same), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✗ = not met).

Summary

Asian Nebraskans were the only group to meet their Healthy People 2010 objective for decreasing current smoking, but African Americans and Hispanics made progress toward their goal. Moreover, Asians, American Indians, and Hispanics made progress toward decreasing binge drinking, but all groups fell short of meeting the objective.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001 - 2005	2006 - 2010			
Drinking and Driving	%	%			
White	4.6	6.3	✗	1	✗
African American	3.3	5.6	✗	1	✗
American Indian	4.3	3.0	✓	1	✗
Hispanic or Latino	1.4	5.8	✗	1	✗
Cigarette Smoking	%	%			
White	21.5	18.1	✓	12	✗
African American	24.3	23.7	✓	12	✗
Asian	17.6	10.7	✓	12	✓
American Indian	41.8	43.7	✗	12	✗
Hispanic or Latino	19.8	16.8	✓	12	✗
Binge Drinking	%	%			
White	18.1	20.1	✗	6	✗
African American	12.4	14.3	✗	6	✗
Asian	10.5	7.9	✓	6	✗
American Indian	27.5	16.2	✓	6	✗
Hispanic or Latino	12.9	11.2	✓	6	✗

Heavy Drinking

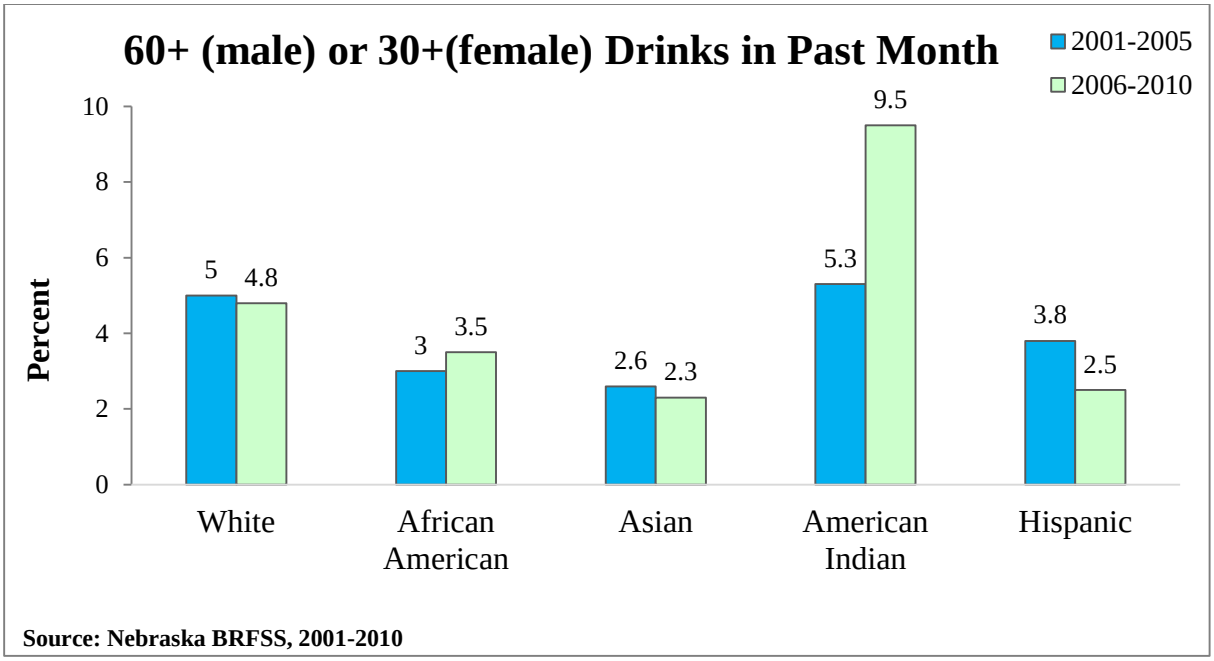
Heavy drinking was defined as males consuming more than 60 alcoholic beverages in one month and women consuming more than 30 alcoholic beverages in one month. Things like cancer, cardiovascular disease, cirrhosis, and depression are all linked to chronic heavy drinking.[157]

Key Disparities

- American Indians saw the highest percentage of people who engaged in heavy drinking (9.5%), compared to 4.8% of Whites.
- Three and one half percent of African Americans engaged in heavy drinking.
- A comparable percentage of Asians (2.3%) and Hispanics (2.5%) drank heavily.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Heavy drinking almost doubled in the American Indian community, jumping from 5.3% in 2001-2005 to 9.5% in 2006-2010.
- Heavy drinking declined in the Asian and Hispanic communities; the largest drop, from 3.8% to 2.5%, was in the Hispanic population.
- African Americans saw a slight (.5%) increase from 2001-2005 (3%) to 2006-2010 (3.5%).



Compared to the Nation

- Overall, Nebraska saw similar rates of heavy drinking as the nation.
- Almost 3% of Hispanics and African Americans in the United States drank heavily.

[157]WebMD. (2011). 12 health risks of chronic heavy drinking. Retrieved from http://www.webmd.com/mental-health/alcohol-abuse/features/12-health-risks-of-chronic-heavy-drinking.

Binge Drinking

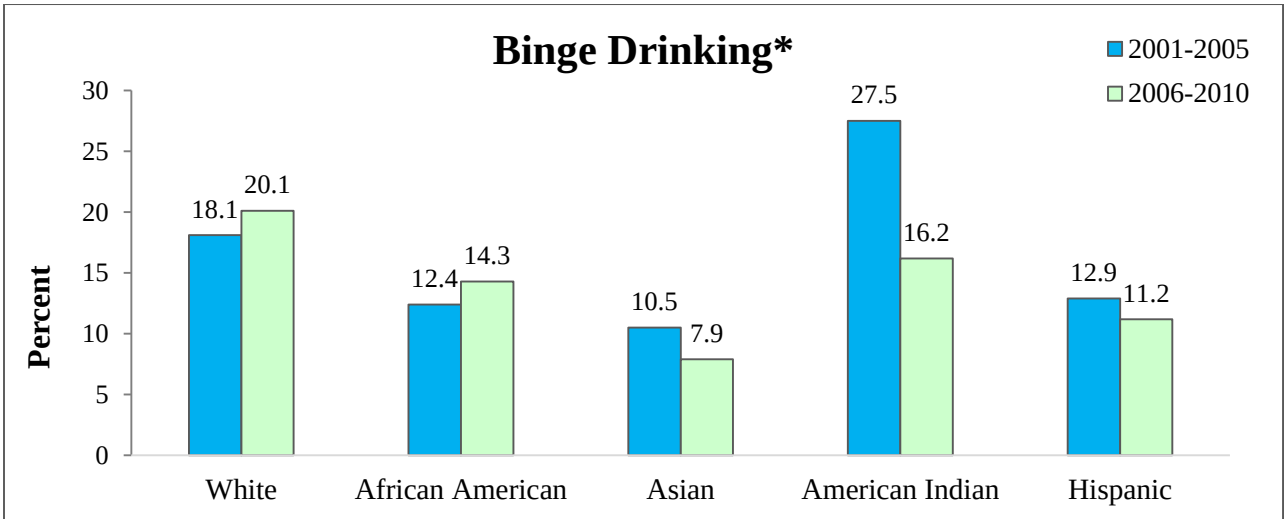
Before 2005, binge drinking was defined as consuming five or more alcoholic drinks for men and for women on any one occasion. Beginning in 2006, it was defined as consuming five or more drinks for men *or* four or more drinks for women on any occasion.[158] Therefore, data presented below for the years 2001-2005 were compiled based on the former definition, and the numbers for 2006-2010 were compiled using the new definition.

Key Disparities

- Nebraska's American Indian population (16.2%) saw the highest level of binge drinking among all racial and ethnic minorities.
- Approximately 14% of African Americans in Nebraska reported binge drinking.
- Both Asians and Hispanics experienced a lower prevalence of binge drinking than African Americans and American Indians.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Binge drinking decreased drastically among the American Indian population, from 27.5% in 2001-2005 to 16.2% in 2006-2010.
- Asian Nebraskans saw an almost 3% decrease in binge drinking from 2001-2005 (10.5%) to 2006-2010 (7.9%).
- African Americans saw a 2% increase in binge drinking, jumping from 12.4% in 2001-2005 to 14.3% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010
***Numbers for 2001-2005 were compiled using the definition of binge drinking predating 2005; 2006-2010 data were compiled using the new binge drinking definition.**

Compared to the Nation

- Almost 10% of African Americans in the United States reported binge drinking in 2010, compared to 14.3% of African American Nebraskans.
- Approximately 15% of Hispanics in the United States reported binge drinking, compared to 11.2% of Hispanic Nebraskans.

[158]New Jersey State Health Assessment Data. 2014. Retrieved from https://www26.state.nj.us/doh-shad/indicator/view/AlcConBinDri.UT_US.html.

Drinking and Driving

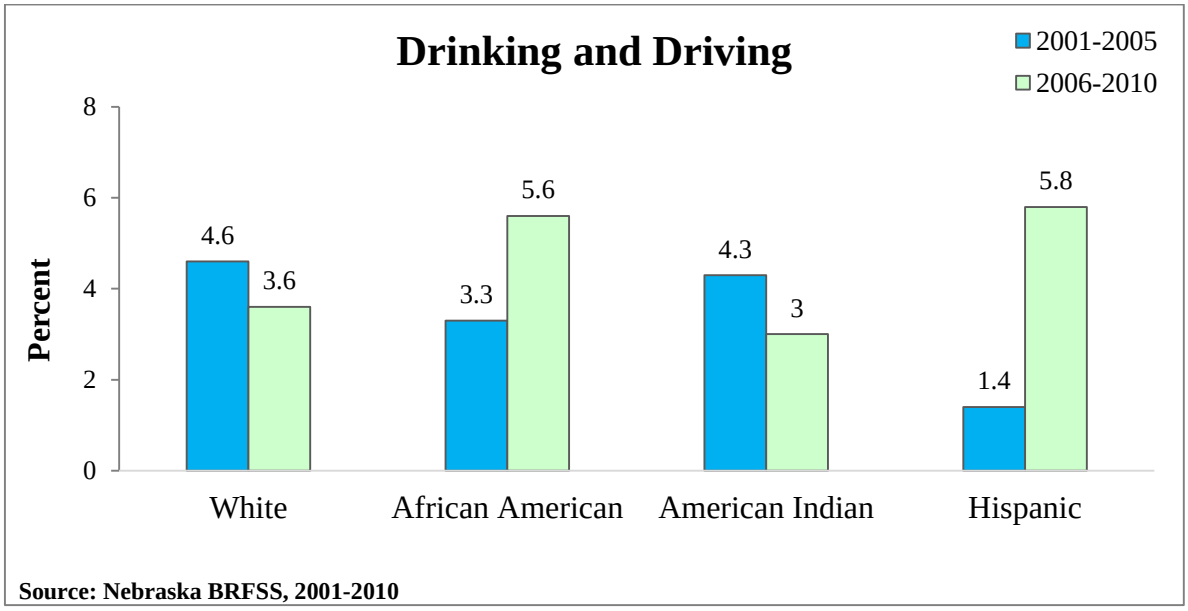
In 2010, there were 1,687 motor vehicle crashes related to alcohol in Nebraska.[159] In the U.S., it was determined that people participated in drinking and driving 112 million times in 2010.[160] Alcohol-related motor vehicle crashes cost an estimated $130.6 million in lost productivity, medical and administrative expenses, motor vehicle damage, and employer costs. Please note that Asian numbers were not included as they were insufficient to produce data.

Key Disparities

- Three percent of American Indians reported driving under the influence, in 2006-2010.
- In 2006-2010, African Americans (5.6%) and Hispanics (5.8%) fall just below Whites at 6.3%.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Hispanics increased from 1.4% in 2001-2005 to 5.8% in 2006-2010.
- American Indians, the only group to see a decrease, declined from 4.3% in 2001-2005 to 3% in 2006-2010.
- The percentage of African Americans who drank and drove jumped over 1.5 times their 2001-2005 percentage, from 3.3% to 5.6%.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- Almost 5 times as many African American and Hispanic Nebraskans reported drinking and driving compared to their national counterparts (1.2% and 1.7%, respectively).

[159]Douglas County Sheriff. (2011). You drink you drive you lose! Retrieved from http://www.omahasheriff.org/news-and-press-releases/53-news-and-press-releases/288-you-drink-you-drive-you-lose.
[160]Center for Disease Control and Prevention. (2011). Drinking and driving: A threat to everyone. Retrieved from http://www.cdc.gov/vitalsigns/drinkinganddriving/.

Alcohol-Related Deaths

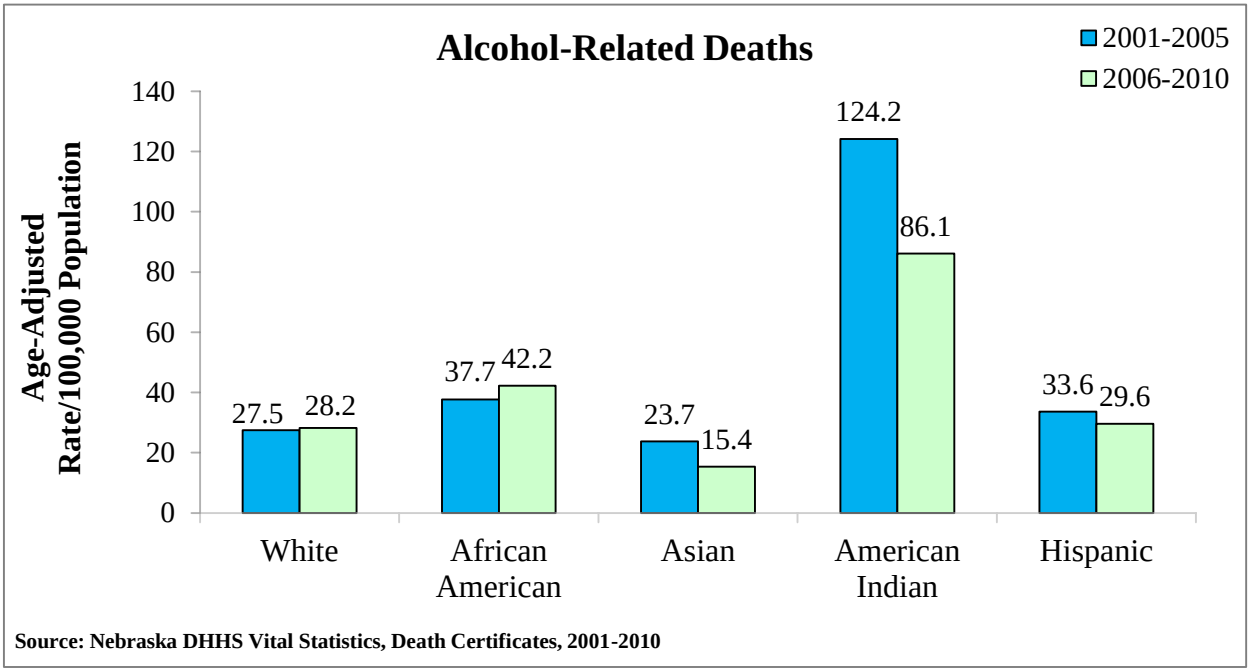
Alcohol can be a direct cause of death as in the case of alcohol poisoning, or a contributing factor in death, as with chronic liver disease, motor vehicle crashes, and homicide.

Key Disparities

- Nebraska's American Indian population, in both 2001-2005 (124.2/100,000 population) and 2006-2010 (86.1), saw the highest rate of alcohol-related deaths, compared to approximately 28/100,000 population of Whites.
- About 42 in 100,000 African Americans died from an alcohol-related incident.
- Almost 30 in 100,000 Hispanics died due to alcohol from 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Between 2001-2005 and 2006-2010, the American Indian alcohol-related death rate dropped from 124.2 to 86.1/100,000 population.
- Both Asian and Hispanic Americans' alcohol-related death rates dropped between 2001-2005 and 2006-2010.
- African Americans saw an increased rate, jumping from 37.7 in 2001-2005 to 42.2 in 2006-2010.



Source: Nebraska DHHS Vital Statistics, Death Certificates, 2001-2010

Current Cigarette Smoking

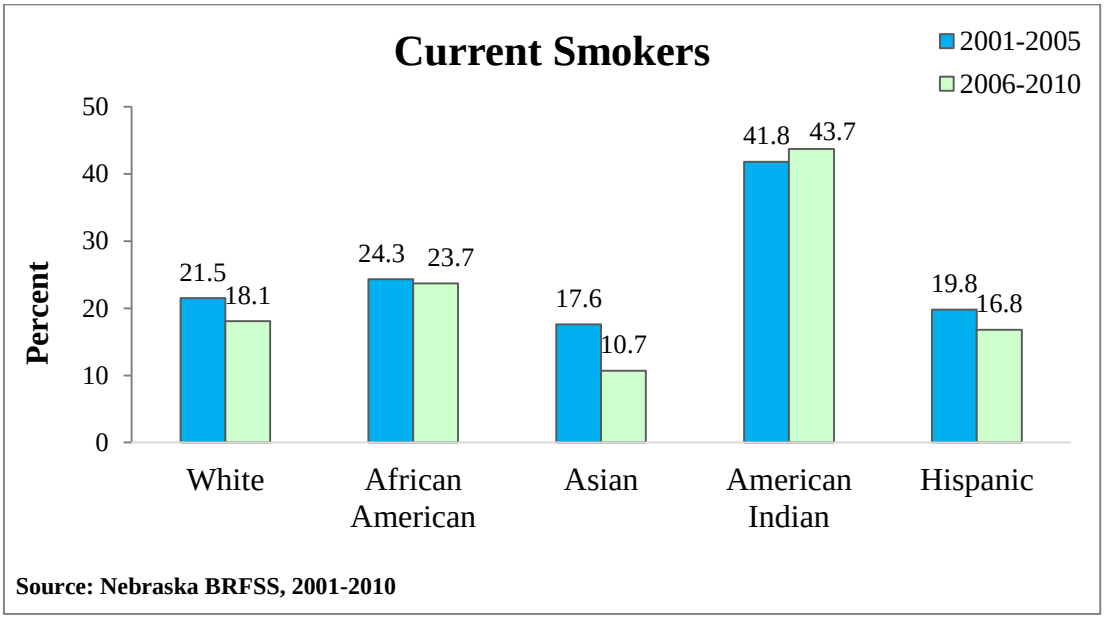
Tobacco is the leading cause of preventable death and disease in the United States. It increases the risk of chronic diseases like lung disease, coronary heart disease, stroke, and various cancers.[161] Persons were considered to be using cigarettes if they reported that they smoked at least 100 cigarettes in their lifetime and now report smoking cigarettes every day or some days.

Key Disparities

- Nebraska's American Indian population reported 43.7% tobacco usage, compared to 18.1% of Whites.
- Ten percent of Asians reported using tobacco, the lowest reported use of all groups.
- Nebraska African Americans reported the second highest percentage, not including the 'other' category, at 23.7%.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Tobacco use declined among all racial and ethnic groups, except for American Indians who saw a 2% increase from 2001-2005 (41.8%) to 2006-2010 (43.7%).
- Asians saw the largest drop from 17.6% in 2001-2005 to 10.7% in 2006-2010.



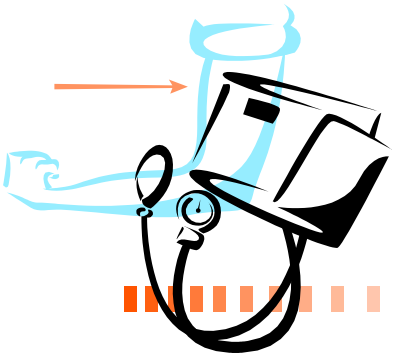
Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- Aside from Whites and Asians, all racial and ethnic groups in Nebraska reported higher rates of smoking compared to their national populations.
- Nebraska's American Indian population saw more than 1.5 times the proportion of people smoking than the national population (31.4%).
- More African Americans and Hispanics in Nebraska reported smoking than their national groups (20.6% and 12.5%, respectively).
- Nebraska Asians reported smoking similarly with the national population (9.2%).

[161]Center for Multicultural Health. (2010). Health status by race and ethnicity: 2010. Salt Lake City, UT: Utah Department of Health.

RISK FACTORS FOR ILLNESS



Heart disease and stroke are the first and third leading causes of death in the United States and combined are the most widespread and costly health problems, accounting for $500 billion in health care expenditures we see as a nation.[162] And even though they are among the most devestating of diseases, they are also the most preventable since health behaviors are their chief risk factors.[163]

Obesity, high blood pressure, and high cholesterol are all risk factors for heart disease and stroke. Fortunately, these risk factors are preventable, and fixable. One way to measure obesity is by body mass index. Body mass index (BMI) is a score of the relationship between body weight and height; those with a high BMI could be at risk for obesity-related health problems. Blood pressure and cholesterol can be measured by a health care professional. High blood pressure, otherwise known as hypertension, can effect everyone - even children and young people. Fortunately, with proper screening health professionals can identify prehypertension, ranging from 102-139 over 80-89. If either of the number ranges (systolic or diastolic) are high, a person is prehypertensive or hypertensive.[164] Stage one hypertension is 140-159 over 90-99 and stage two is 160 or higher over 100 or higher. Cholesterol is measured in milligrams per deciliter of blood. The ideal cholesterol level is below 200 mg/dL, borderline high cholesterol is between 200 and 239 mg/dL, and high cholesterol is 240 mg/dL or above.[165]

Risk factors for adverse health outcomes are more prevalent among racial and ethnic minority populations and persons in lower socioeconomic circumstances, including higher reported rates of smoking, heavy drinking, obesity, lower consumption of fruits and vegetables, and limited participation in leisure-time physical activity. Health disparities exist in not only obesity, but also in having high blood pressure and high cholesterol; and most often these health problems coexist in individuals.

[162]Healthy People. (2012). Heart disease and stroke. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21.
[163]Ibid.
[164]National Heart, Lung, and Blood Institute. (2012). What is high blood pressure? Retrieved from http://www.nhlbi.nih.gov/health/health-topics/topics/hbp/.
[165]Mayo Clinic. (2013). High cholesterol: Tests and diagnosis. Retrieved from http://www.mayoclinic.com/health/high-blood-cholesterol/DS00178/DSECTION=tests-and-diagnosis.

PROGRESS TOWARD HP2010

The national goal for overweight and other risk factors for illness as part of Healthy People 2010 is to promote health and reduce chronic disease associated with diet and weight. The chart below offers a summary of findings for measures we have that match specific Healthy People 2010 objectives. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✖ = regress away or remain the same), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✖ = not met).

Summary

African Americans made progress in the categories of high blood pressure and high cholesterol. Asians were the only group to reach their obesity objective. Throughout the decade, both Asian Nebraskans and American Indian Nebraskans saw physical inactivity proportions under the HP2010 objective. Though the percentage of American Indians being physical inactive increased in 2006-2010, they still reached their objective. Hispanic Nebraskans, though not reaching their objective, decreased their physical inactivity by almost 10%.

Nebraska Objective	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
BMI 30+	%	%			
White	23.1	26.7	✖	15	✖
African American	33.9	39	✖	15	✖
Asian	8.4	10.3	✖	15	✓
American Indian	29.6	41.7	✖	15	✖
Hispanic or Latino	25.5	32	✖	15	✖
High Blood Pressure	%	%			
White	22.6	25.3	✖	16	✖
African American	35.8	33.9	✓	16	✖
Asian	15.8	25.1	✖	16	✖
American Indian	36.2	28.2	✓	16	✖
Hispanic or Latino	17.1	21.8	✖	16	✖
High Cholesterol	%	%			
White	27.8	32	✖	17	✖
African Americans	29.9	27.6	✓	17	✖
Asian	36.1	56	✖	17	✖
American Indian	33.6	40.4	✖	17	✖
Hispanic or Latino	23.1	28.5	✖	17	✖
Physical Inactivity	%	%			
White	21.7	21.6	✓	32	✓
African Americans	29.9	35.2	✖	32	✖
Asian	26.2	21.5	✓	32	✓
American Indian	27.7	28.3	✖	32	✓
Hispanic or Latino	43	35.4	✓	32	✖

Physical Inactivity

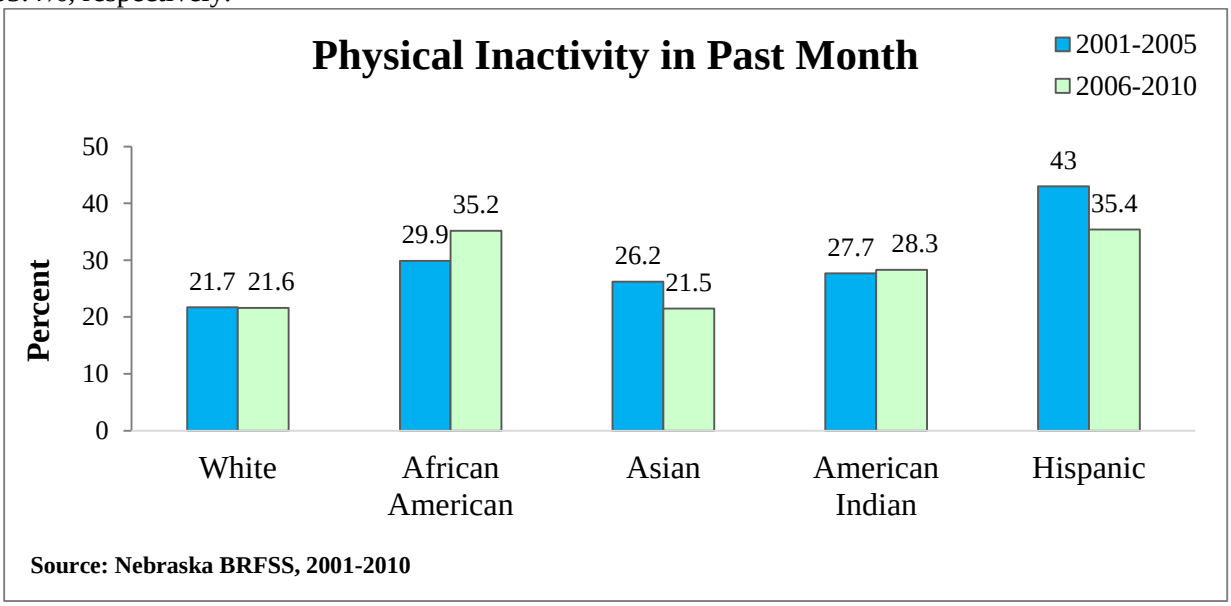
Physical inactivity refers to those people who got no leisure-time physical activity in the past month. Globally, 31% of people (15 and over) were 'insufficiently active' in 2008. Moreover, 3.2 million deaths every year can be attributed to physical inactivity.[166]

Key Disparities

- Nebraska Hispanics (35.4%) and African Americans (35.2%) saw the highest percentage of people who were physically inactive, compared to 21.6% of Whites.
- Twenty-eight (28.3%) of American Indians reported physical inactivity.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- African Americans saw an increase in physical inactivity from 2001-2005 (29.9%) to 2006-2010 (35.2%).
- Asians and Hispanics saw a decrease in physical inactivity, decreasing from 26.2% and 43% to 21.5% and 35.4%, respectively.



Compared to the Nation

- Asians and American Indians in the United States (20% and 28.9%, respectively) reported similar levels of physical inactivity as their Nebraskan groups (21.5% and 28.3%, respectively).
- African Americans were the most physically inactive in Nebraska (35.2%) and were more physically inactive than their national counterpart (27.6%).
- More Hispanics in Nebraska reported physical inactivity compared to the national population (28.5%).

[166]World Health Organization. (2013). Physical inactivity: A global public health problem. Retrieved from http://www.who.int/dietphysicalactivity/factsheet_inactivity/en/.

Overweight: BMI 25-29.9

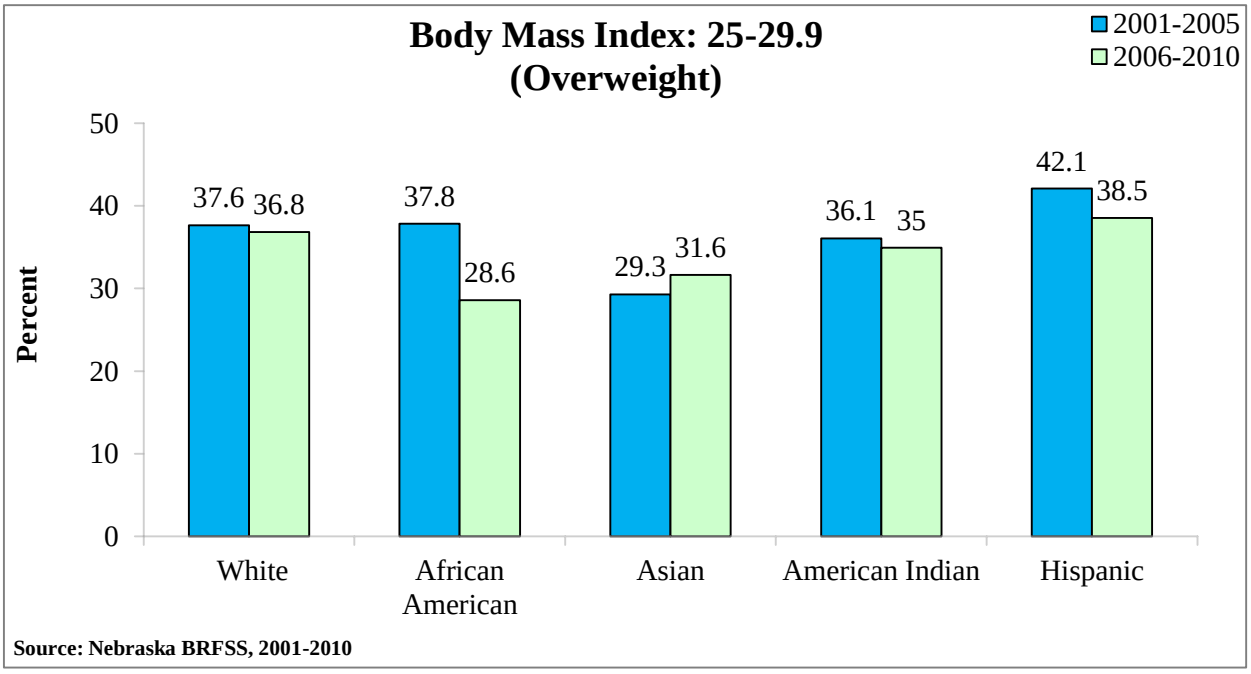
Body Mass Index, or BMI, is a wellness score based on an individual's height and weight. BMI is a body fat measure that applies to adult men and women. BMI is used as a screening tool to initiate the identification of possible weight problems; BMI is not a diagnostic tool. A BMI in the range of 25-29.9 is considered overweight.

Key Disparities

- Almost 39% of Hispanics were overweight (BMI of 25-29.9) in 2006-2010, compared to 36.8% of Whites.
- Thirty-five percent of American Indians and approximately 32% of Asians were overweight.
- African Americans saw the lowest percentage of people with a BMI between 25 and 29.9 in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Most groups saw a reduction in those with a BMI between 25 and 29.9 between 2001-2005 and 2006-2010, except for Asians.
- African Americans decreased the most from 2001-2005 (37.8%) to 2006-2010 (28.6%).
- Hispanics decreased almost 4% between 2001-2005 and 2006-2010.
- Asians increased from 29.3% to 31.6% with a BMI of 25-29.9.



Compared to the Nation

- Almost 34% of African Americans in the United States were overweight, compared to 28.6% of African Americans in Nebraska.
- Hispanics in Nebraska (38.5%) saw a similar percentage overweight as the nation (38%).
- In general, Nebraska (36.7%) had a very similar proportion of people overweight when compared to the nation (36.2%).

Obese: BMI 30+

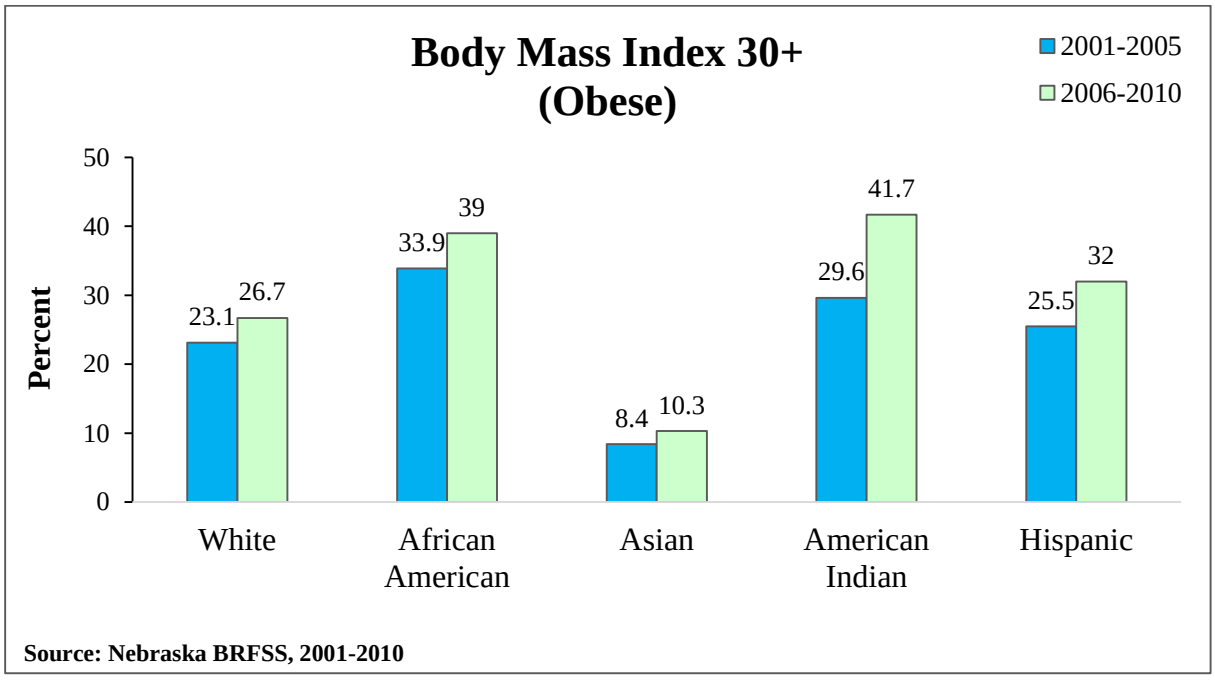
A BMI of 30 or higher is considered obese.

Key Disparities

- Nebraska's American Indian population saw the highest percentage (41.7%) of those with a BMI 30 or higher, compared to 26.7% of Whites.
- Thirty-two percent of Hispanics and 39% of African Americans had a BMI 30 or higher.
- Asians saw relatively low numbers of obesity according to BMI, with only 10.3% of the population seeing a 30+ BMI.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All racial and ethnic groups saw an increase in BMI 30 or higher.
- American Indians jumped more than 10% from 29.6% in 2001-2005 to 41.7% in 2006-2010, and Hispanics increased 6%, to 32% in 2006-2010 compared to only a 3% increase in Whites.
- Those groups that saw the highest percentages in 2001-2005 (African Americans, American Indians, and Hispanics) remain the highest groups in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- There was a slightly smaller percentage of African Americans in Nebraska who were obese (39%) compared to the nation (41.1%).
- Contrarily, Hispanics in Nebraska experienced more obesity (32%) than those in the United States (30.6%).

Overweight or Obese: BMI 25+

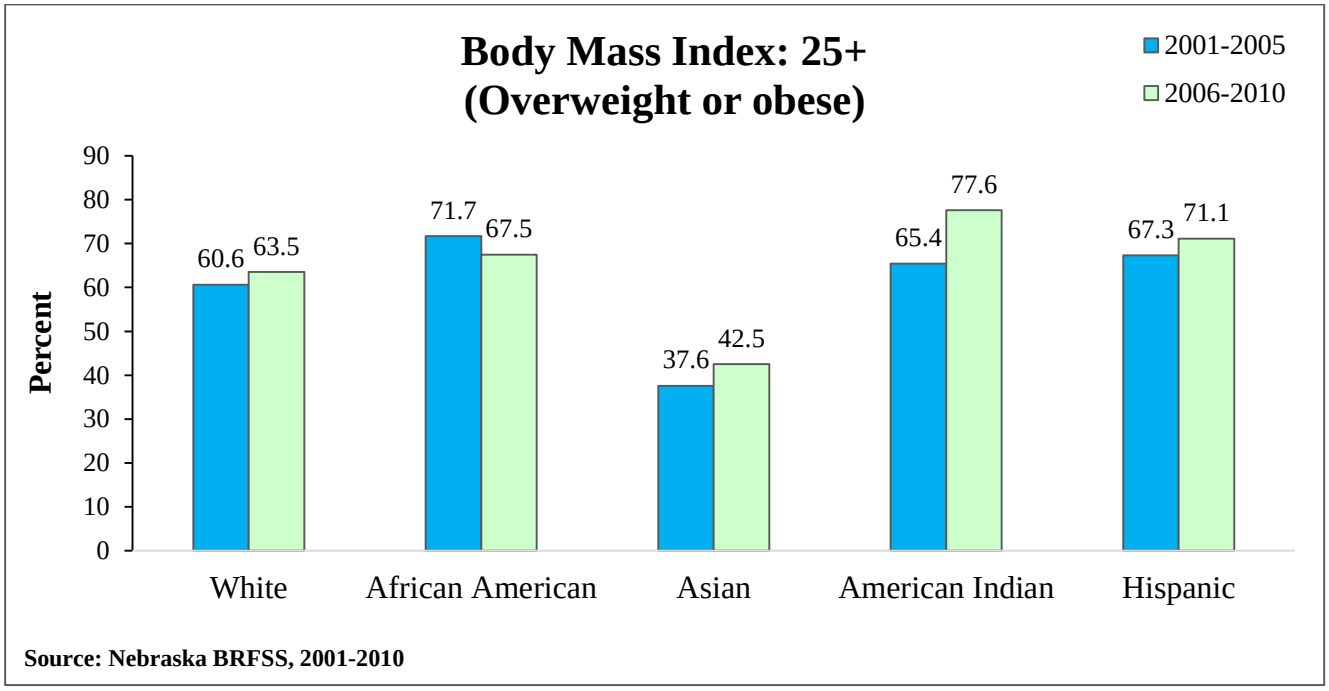
The information presented below is for those who had a BMI of at least 25—this includes both overweight and obese individuals.

Key Disparities

- Almost 78% of American Indians in Nebraska in 2006-2010 were overweight or obese, compared to 63% of Whites.
- Approximately 71% of Hispanics had a BMI of 25 or more, a similar 68% of African Americans were measured the same.
- Asians saw the lowest proportion of people overweight or obese (42.5%).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentage of Asian, American Indian, and Hispanic who were overweight or obese increased from 2001-2005 (37.6%, 65.4%, and 67.3%, respectively) to 2006-2010 (42.5%, 77.6%, and 71.1%, respectively).
- African Americans saw a slight decline from 2001-2005 (71.7%) to 2006-2010 (67.5%).



Source: Nebraska BRFSS, 2001-2010

High Blood Pressure

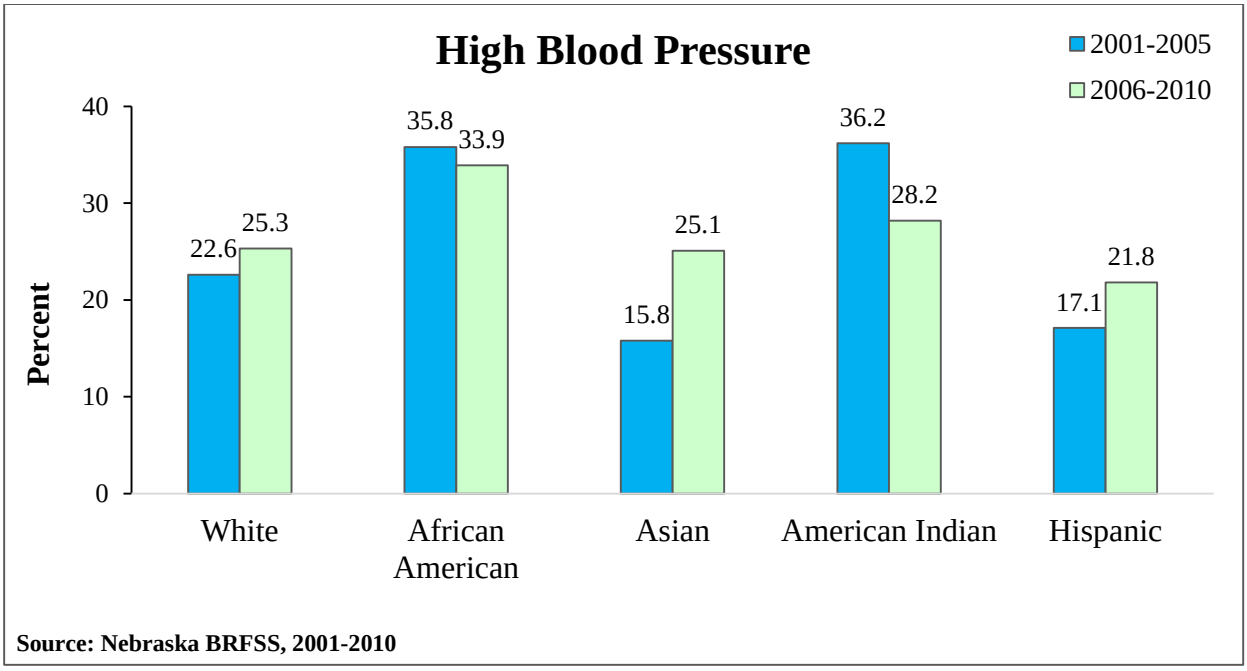
High blood pressure is clinically known as hypertension. Blood pressure is a measure of blood force against the walls of the arteries while your heart pumps blood.[167] Things like the conditions of the kidneys or nervous system, body hormone levels, and how much water or salt is in the body affects blood pressure.[168] People who are obese, African American, frequently stressed, or drink too much are more susceptible to hypertension. This measure was evaluated by asking, 'Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?'

Key Disparities

- Nebraska's African American population saw the highest percentage of high blood pressure (33.9%), compared to 25.3% of Whites.
- Approximately 28% of American Indians were told they had high blood pressure.
- Asians (25.1%) recorded more people with hypertension than Hispanics (21.8%).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Hypertension increased in the White, Asian, and Hispanic communities between 2001-2005 and 2006-2010.
- Asians saw the largest change jumping from 15.8% in 2001-2005 to 25.1% in 2006-2010.
- African Americans decreased only 2% between the two time periods, remaining highly affected throughout the decade.
- American Indians saw a large decline in hypertension dropping almost 10%, from 36.2% in 2001-2005 to 28.2% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

[167] A.D.A.M. Medical Encyclopedia. (2011). Hypertension. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001502/.
[168] Ibid.

High Cholesterol

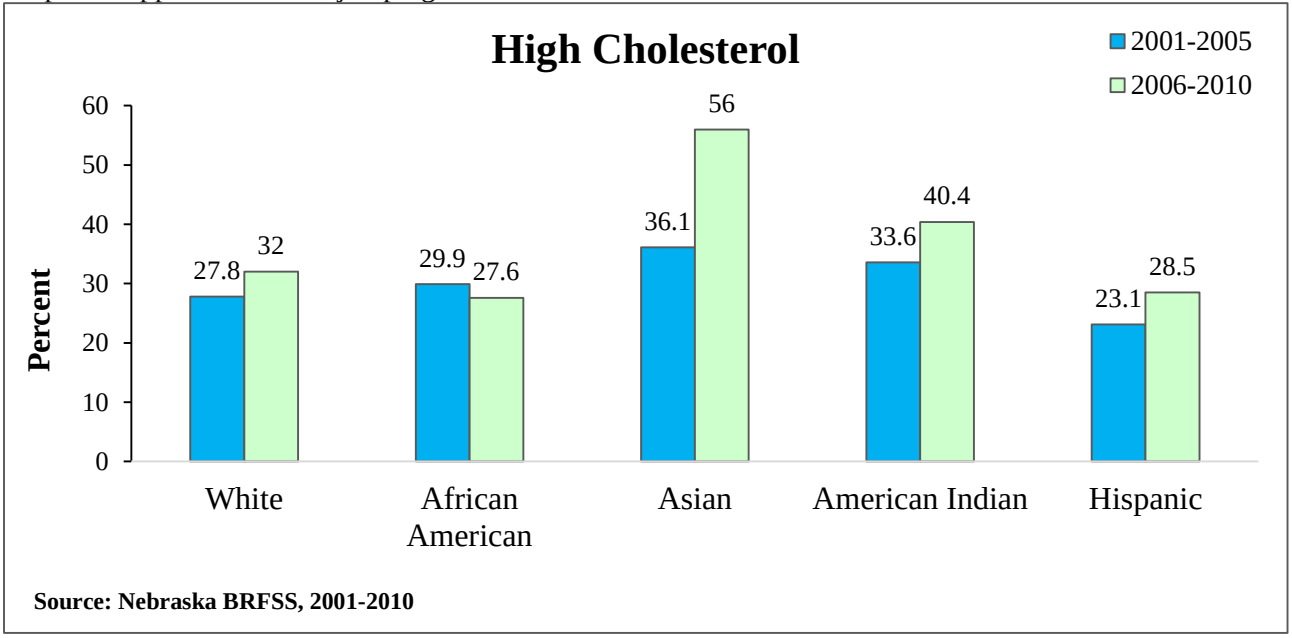
Experts recommend that all adults aged 20 years and older have their cholesterol checked at least once every five years to help them take action to prevent or lower the risk of coronary heart disease.[169] Blood cholesterol increases with age; those who have a familial history of high cholesterol, are overweight, or eat many fatty foods should get their cholesterol tested. This measure was evaluated by asking, 'Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?'

Key Disparities

- Nebraska's Asian population saw the highest percentage of people with high cholesterol (56%), compared to 32% of Whites.
- Forty percent of American Indians and almost 29% of Hispanics were told they had high cholesterol.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Asians, American Indians, and Hispanics saw an increase in high cholesterol between 2001-2005 and 2006-2010.
- Asians saw the largest increase of 20%, moving from 36% in 2001-2005 to 56% in 2006-2010.
- American Indians saw 40% of their population with high cholesterol in 2006-2010, after an increase from 2001-2005 (33.6%).
- Hispanics approached 30%, jumping from 23% in 2001-2005 to 28.5% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- Approximately 28% of African Americans in Nebraska were told they had high cholesterol, compared to 34.5% of African Americans in the United States.
- A smaller percentage of Hispanics in Nebraska (28.5%) as Hispanics in the United States (34.1%) were told they had high cholesterol.

[169]Medline Plus. (2013). Cholesterol. Retrieved from http://www.nlm.nih.gov/medlineplus/cholesterol.html#skip.

Never Receive Emotional Support

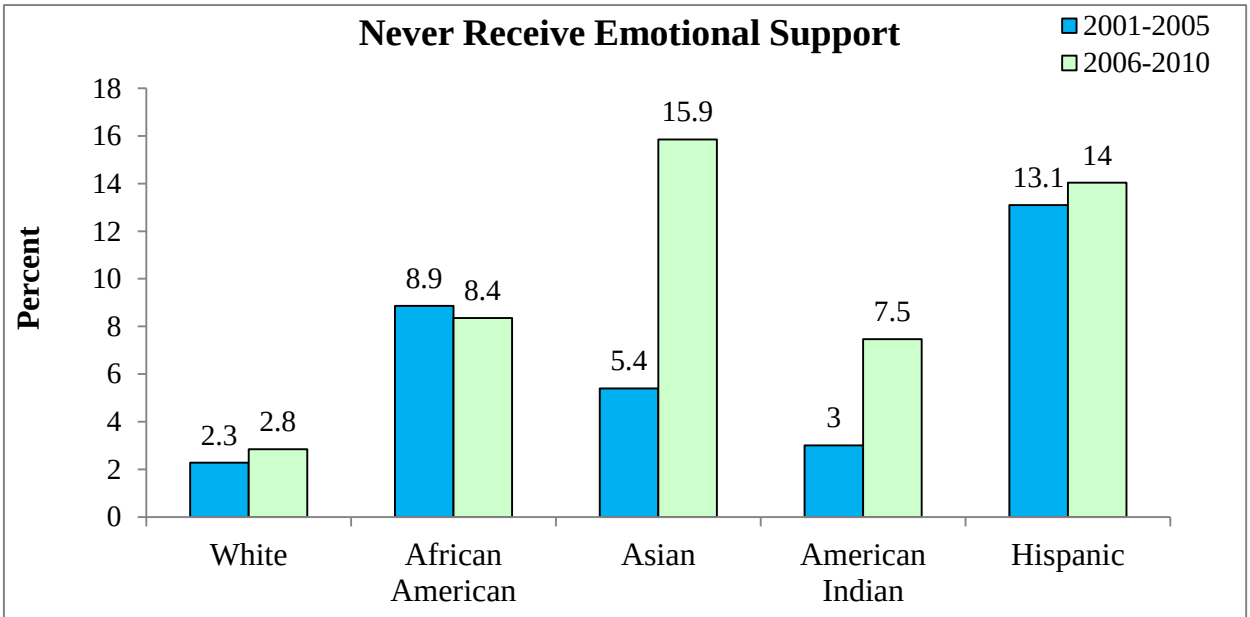
Respondents of the Nebraska BRFSS were asked, 'how often do you get the social and emotional support you need: Always? Usually? Sometimes? Rarely? Never?' Respondents who answered 'never' to that question were accounted for in the chart below.

Key Disparities

- Almost 16% of Asian Nebraskans reported never getting the emotional support they need, compared to 2.8% of Whites.
- Fourteen percent of Hispanics never received emotional support.
- Around 8% of African Americans (8.4%) and American Indians (7.5%) did not get the emotional support they need.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All groups, excepting African Americans, reported an increase of never receiving emotional support from 2001-2005 to 2006-2010.
- Asians experienced a 10% increase from 2001-2005 (5.4%) to 2006-2010 (15.6%).
- American Indians saw an increase in never receiving emotional support from 3% in 2001-2005 to 7.5% in 2006-2010.



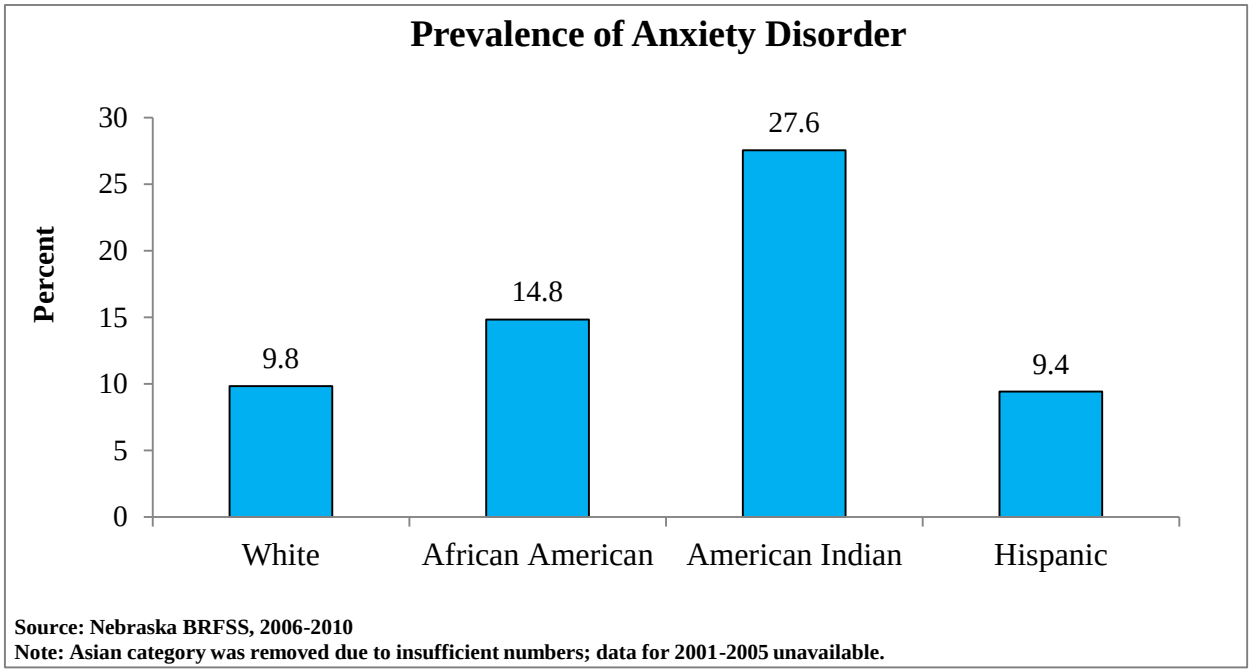
Source: Nebraska BRFSS, 2001-2010

Anxiety Disorder

Respondents of the Nebraska BRFSS were asked, 'Has a doctor or other health care provider EVER told you that you had an anxiety disorder (including acute stress disorder, panic disorder, phobia, post-traumatic stress disorder, or social anxiety disorder)? Respondents who answered 'yes' to that question were accounted for in the chart below. Please note that the Asian category was removed due to insufficient numbers and that data for 2001-2005 were not available.

Key Disparities

- Twenty-seven and a half percent of American Indians in Nebraska reported having an anxiety disorder, compared to 9.8% of Whites.
- Almost 15% of African Americans in Nebraska had an anxiety disorder.



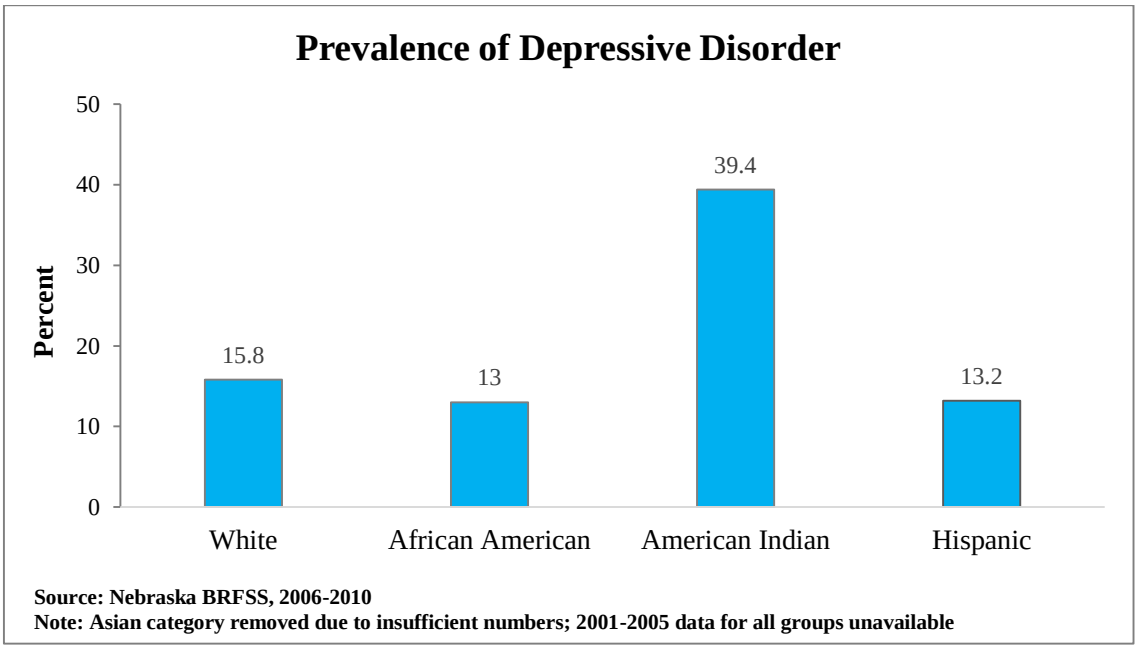
Source: Nebraska BRFSS, 2006-2010
Note: Asian category was removed due to insufficient numbers; data for 2001-2005 unavailable.

Depressive Disorder

The chart below represents respondents from the Nebraska BRFSS who answered 'yes' to the question, 'Has a doctor or other health care provider ever told you have a depressive disorder?'

Key Disparities

- Almost 40% of American Indians in Nebraska had been diagnosed with a depressive disorder, compared to 15.8% of Whites.
- Approximately 13% of both African Americans and Hispanics had been diagnosed with a depressive disorder, slightly less than that of whites.



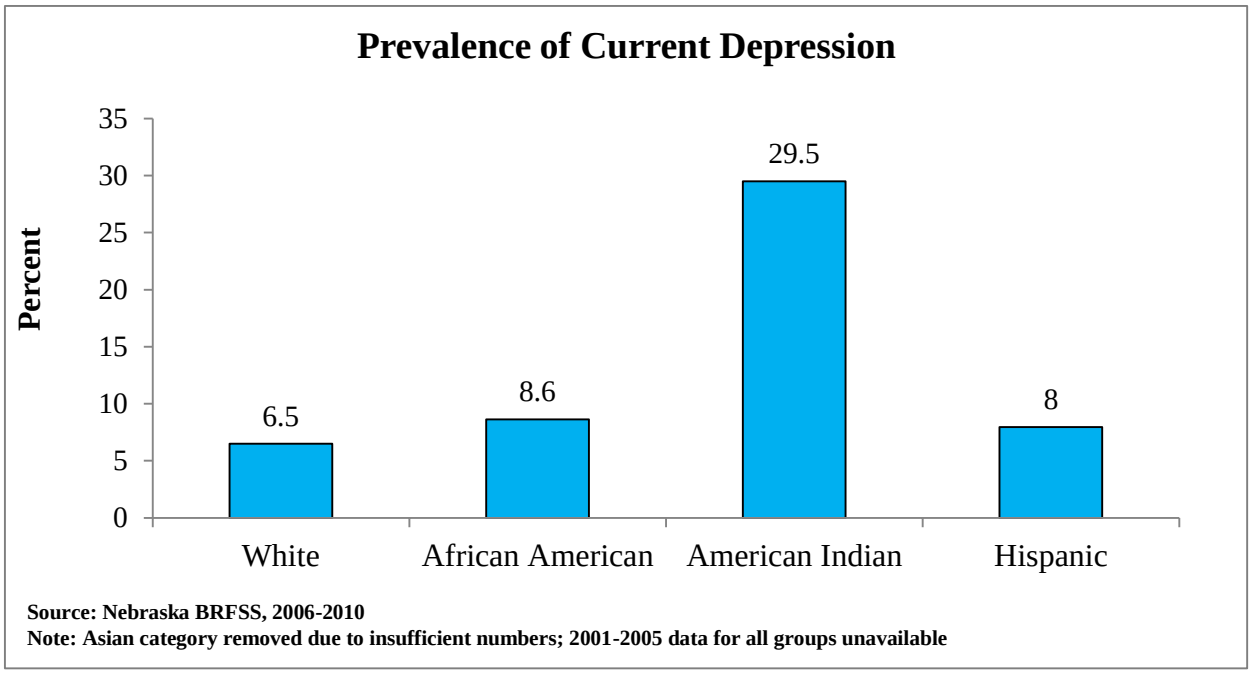
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers; 2001-2005 data for all groups unavailable

Current Depression

The severity of depression index was calculated from eight questions. Respondents answered, "Over the last two weeks, how many days have you: had little interest or pleasure in doing things? Felt down, depressed, or hopeless? Had trouble in falling asleep or staying asleep or sleeping too much? Felt tired or had little energy? Had a poor appetite or eaten too much? Felt bad about yourself or that you were a failure or had let yourself or your family down? Had trouble concentrating on things, such as reading the newspaper or watching the TV? Moved or spoken so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual? Scores of 10 or greater indicate depression. Please note that Asian numbers were not included as they were insufficient to produce data.

Key Disparities

- Nebraska American Indians saw 29.5% of the population were currently depressed, compared to 6.5% of Whites.
- Approximately 8% of both African Americans and Hispanics were currently depressed.



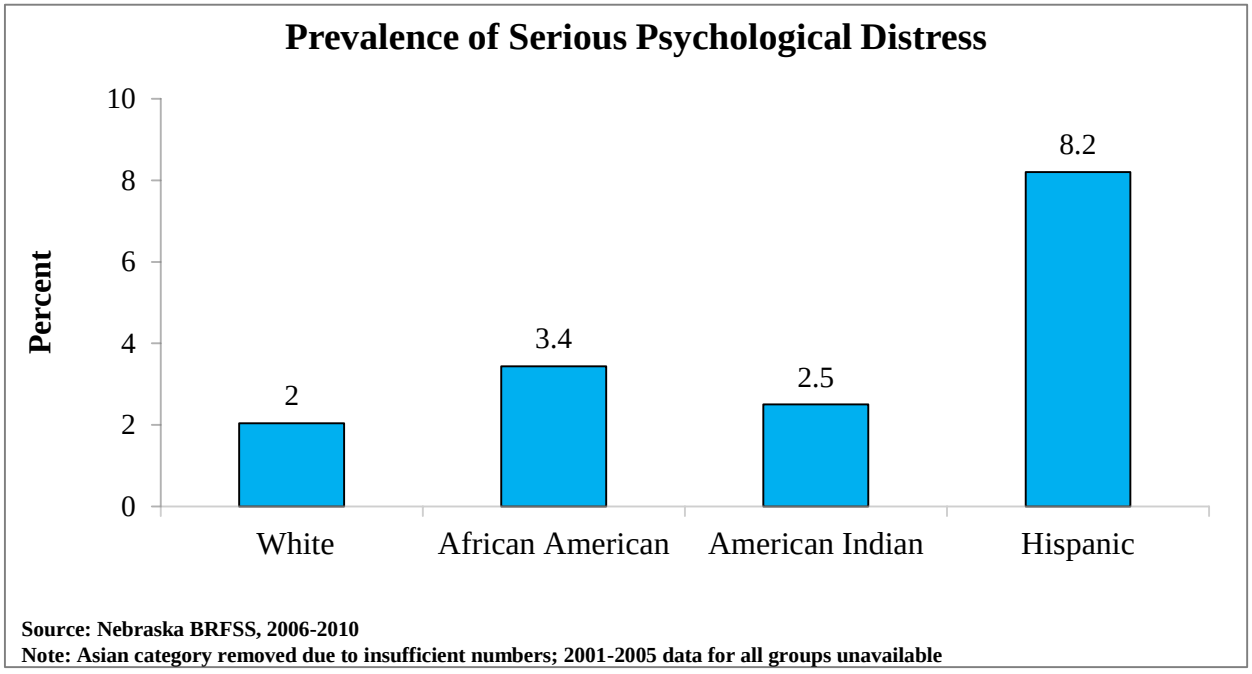
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers; 2001-2005 data for all groups unavailable

Serious Psychological Distress (SPD)

This measure was evaluated by asking six questions about how often a respondent, in the past 30 days, was feeling nervous, hopeless, restless, depressed, and worthless. Another question asked how often in the past 30 days did the respondent feel that everything was an effort. Questions were scored between zero ('none of the time') and four ('all of the time'). Those totaled scores of 13 or more represented serious psychological distress. Please note that Asian numbers were not included as they were insufficient to produce data.

Key Disparities

- Nebraska's Hispanic population (8.2%) experienced the highest percentage of people who had serious psychological distress, compared to 2% of Whites.
- Almost 3.5% of African Americans experienced serious psychological distress.



Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers; 2001-2005 data for all groups unavailable

Mentally Unwell: 10+ days

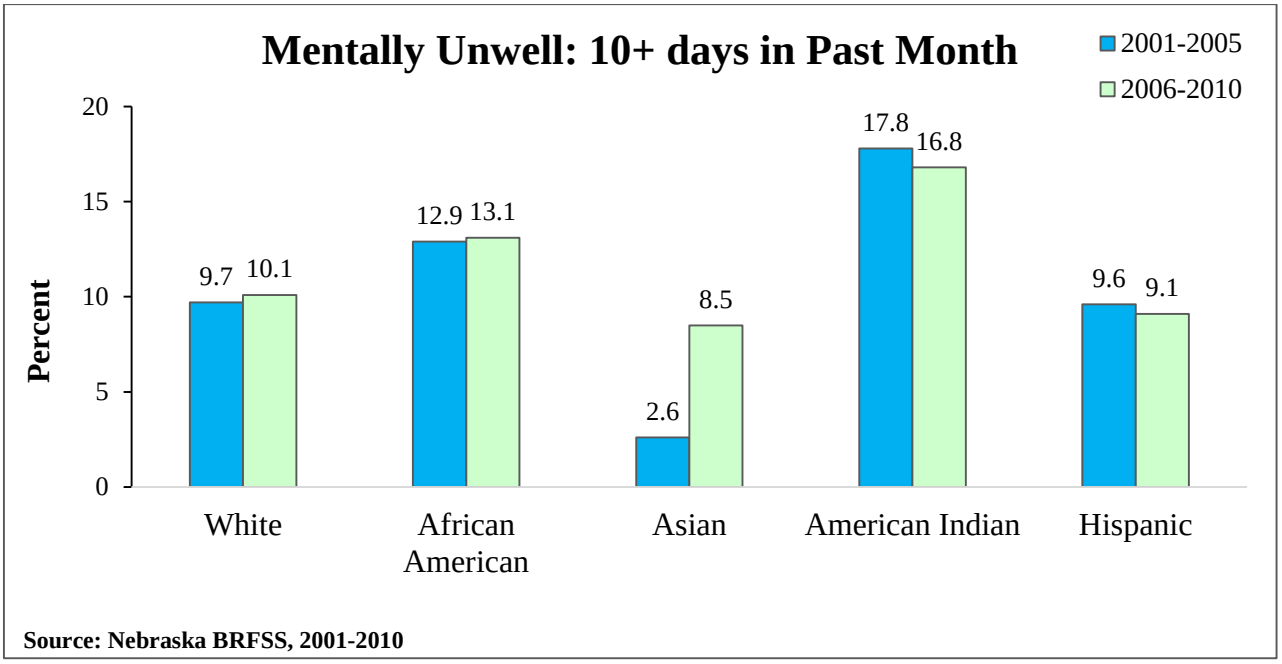
This measure was evaluated by asking, 'Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?' Those represented in the chart below responded with 10 or more days.

Key Disparities

- Nebraska's American Indian population (16.8%) saw the highest percentage of people who experienced 10 or more days of being mentally unwell, compared to 10.1% of Whites.
- Approximately 13% of African Americans reported 10 or more days of being mentally unwell.
- Asian Nebraskans (8.5%) and Hispanic Nebraskans (9.1%) saw similar proportions feeling mentally unwell.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- American Indians saw a decline in those responding that they have experienced 10 or more days of mental unrest.
- Both African Americans and Hispanics saw a slight change, a 0.2% increase and a 0.5% decrease, respectively.
- Asian Nebraskans saw a larger increase, jumping from 2.6% to 8.5% between 2001-2005 and 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Mentally Unwell: Average Number of Days

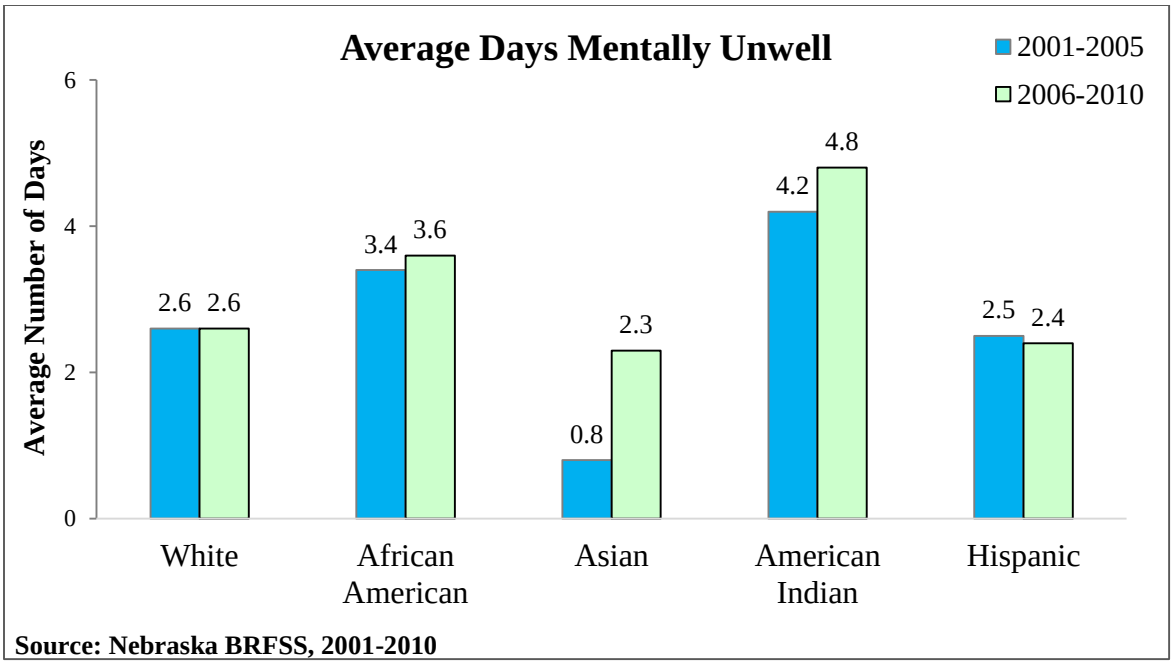
The chart below shows the average number of days respondents stated that they did not feel mentally well.

Key Disparities

- American Indians reported the highest average number of mentally unwell days for both 2001-2005 and 2006-2010.
- African Americans had the second highest average number of days spent mentally unwell for the decade.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Although they had the lowest numbers of mentally unwell days, Asians experienced a large increase in the average number of unwell days between 2001-2005 and 2006-2010.
- African Americans and American Indians also had increases in average number of days, although slight.



Source: Nebraska BRFSS, 2001-2010

Physically Unwell: 10+ days

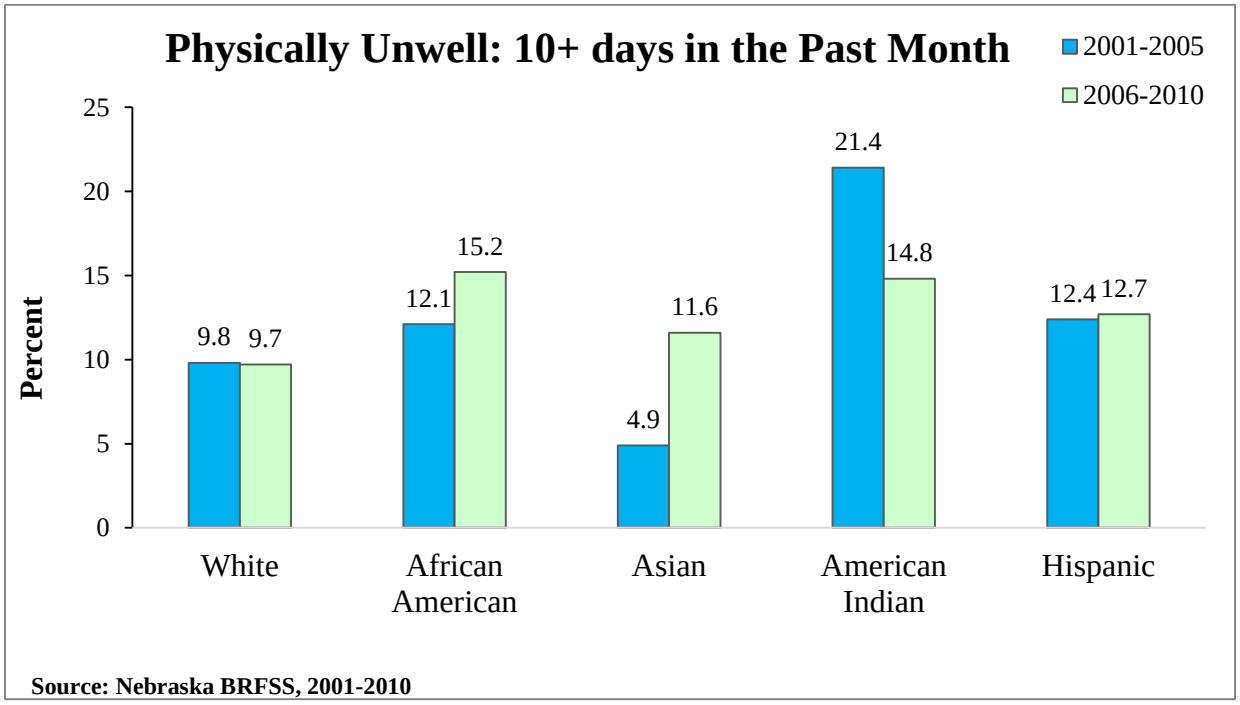
Respondents were asked, 'Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?' Those represented in the chart below responded with 10 or more days.

Key Disparities

- Nebraska's African American population (15.2%) saw the highest percentage of people who experienced ten or more days of being physically unwell, compared to 9.7% of Whites.
- Almost 15% of American Indians in Nebraska reported 10 or more days of being physically unwell.
- Asian Nebraskans (11.6%) and Hispanic Nebraskans (12.7%) saw similar proportions of people feeling physically unwell.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- American Indians saw a large decline in those reporting feeling physically unwell 10 or more days, dropping from 21.4% to 14.8%, moving from first in 2001-2005, to second in 2006-2010.
- Asians saw a large increase, jumping from 4.9% in 2001-2005 to 11.6% in 2006-2010.
- Nebraska African Americans increased from 12.1% to 15.2% between 2001-2005 and 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Physically Unwell: Average Number of Days

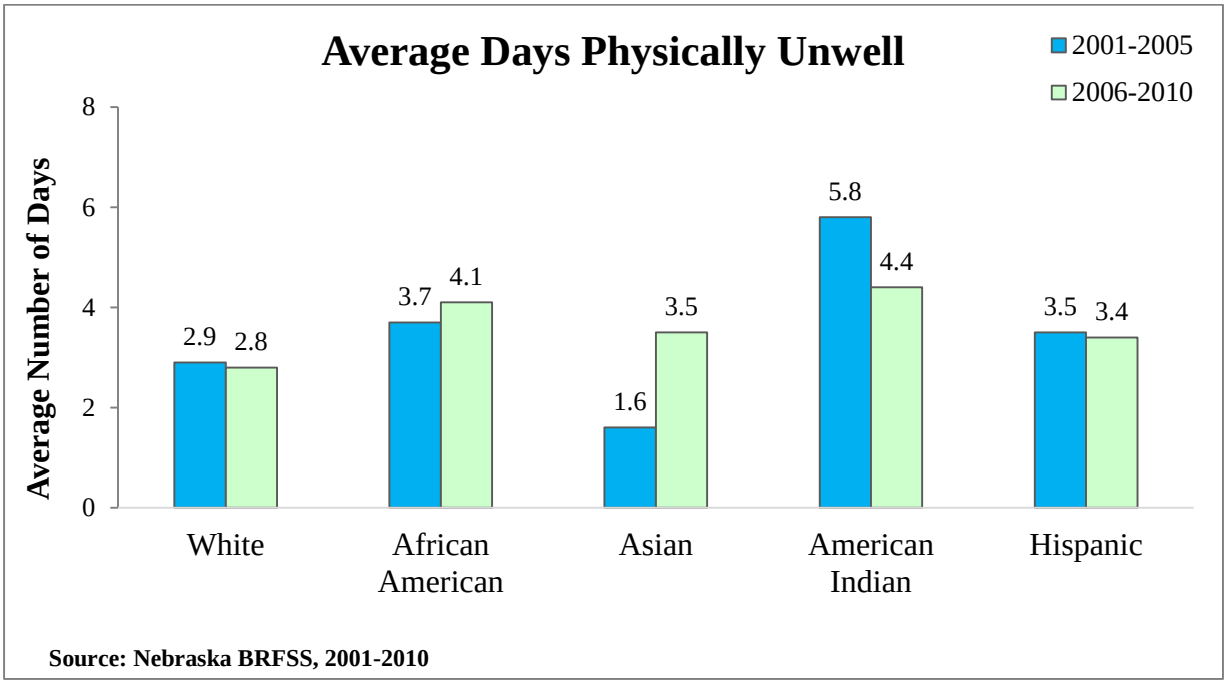
Similar to the previous page, respondents were asked about their physical health and how many days it was not good. The chart below represents the average number of days per month each group indicated they were physically unwell.

Key Disparities

- Nebraska American Indians and African Americans spent approximately 4 days of the previous month physically unwell, compared to Whites (2.8 days).
- Asians in Nebraska spent 3.5 days physically unwell in a month in 2006-2010; Hispanics reported a similar amount of days (3.4).

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Asian Nebraskans experienced a large increase in days spent physically unwell jumping from 1.6 days in 2001-2005 to 3.5 days in 2006-2010; African Americans also saw a slight increase.
- American Indians dropped from 5.8 days in 2001-2005 to 4.4 days in 2006-2010.



Physically or Mentally Limited: Average Number of Days

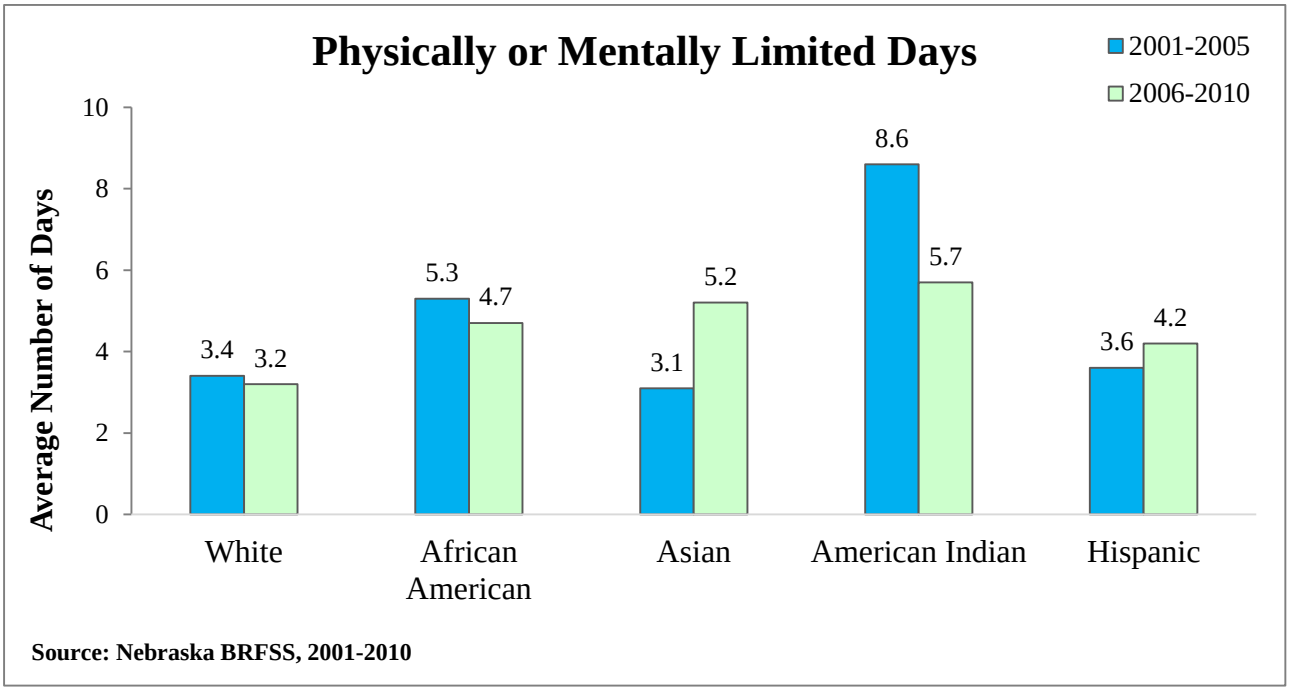
Respondents were asked, 'During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?' Those days were averaged and are represented in the table below.

Key Disparities

- American Indians spent almost six days on average physically or mentally limited in the previous month, compared to three days for Whites.
- African Americans and Asians spent approximately five days physically or mentally limited in the previous month.
- Hispanics experienced only an average of four days where they were physically or mentally limited.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- American Indians saw a large reduction in days spent physically or mentally limited, dropping from 8.6 days to 5.7 days in 2006-2010.
- Asians increased from 3.1 days physically or mentally limited to 5.2 days.



Source: Nebraska BRFSS, 2001-2010

HEALTH BEHAVIORS:
Protective Factors for Illness

Behavioral health refers to the reciprocal relationship between human behavior and the well-being of the body, mind, and spirit. Health behavior stresses individual responsibility in maintaining health and preventing illness through a variety of self-initiated individual or shared activities.[170] Things like cancer screenings and individual behaviors and lifestyle choices such as abstaining from alcohol and tobacco, being physically active, and being a healthy weight are all protective factors and positive health behaviors.

Research suggests that four specific health behaviors yield a longer and healthier life. Avoiding *excessive* alcohol use is one of the best health behaviors.[171] Abstaining from tobacco is another strong predictor of health status since tobacco use is related to a myriad of health problems. Smoking is one of the chief modifiable risk behaviors that, upon quitting, leads to a healthier life. Eating more fruits and vegetables or having a generally more balanced diet and engaging in physical activity helps stave off significant health problems like chronic disease.[172] Engaging in physical activity and other positive health behaviors helps increase quality of life and life expectancy. Unfortunately, sedentary jobs have increased 83% since 1950.[173]

Screening is also a very important part of health behavior. Screenings are tests done to find a condition before symptoms begin. Screenings can include physical exams, laboratory tests, imaging procedures, and genetic tests.[174] Understanding there is a problem is the first step to appropriate action against disease. It is important to remember, however, that access to sufficiently nutritious foods, safe places to exercise, and other resources that result in improved health and well-being are often limited in low-income neighborhoods and research shows that tobacco products and alcohol are marketed more aggressively to racial and ethnic minority groups.[175]

[170]Matarazzo, J.D. (1980). Behavioral health and behavioral medicine: Frontiers for a new health psychology. *American Psychologist*, Vol. 35: 807-817.
[171]Centers for Disease Control and Prevention. (2012). Four specific health behaviors contribute to a longer life. Retrieved from http://www.cdc.gov/features/livelonger/.
[172]Ibid.
[173]American Heart Association. (2012). The price of inactivity. Retrieved from http://www.heart.org/HEARTORG/GettingHealthy/PhysicalActivity/StartWalking/The-Price-of-Inactivity_UCM_307974_Article.jsp.
[174]National Cancer Institute. (2012). What is cancer screening. Retrieved from http://www.cancer.gov/cancertopics/pdq/screening/overview/patient.
[175]Moore, DJ, Williams, JD, Qualls, WJ. (1996) "Target marketing of tobacco and alcohol-related products to ethnic minority groups in the United States". Ethn Dis Winter-Spring; 6(1-2):83-98.

PROGRESS TOWARD HP2010

The national goal for these combined health measures, collectively called health behaviors as part of Healthy People 2010 is to increase the number of people obtaining health screenings and improve health, fitness, and quality of life through health screening and physical activity. The chart below offers a summary of findings for measures we have that match specific Healthy People 2010 objectives. The objectives are specific to Nebraska but are very similar to, if not the same as, national objectives.

The chart illustrates the observed findings for each time period, the progress toward the objective (✓= progress toward; ✗ = regress away or remained the same), the stated Healthy People 2010 objective, and whether or not each group met the objective (✓ = met; ✗ = not met).

Summary

All groups made progress toward colonoscopy screening, moderate physical activity, and vigorous physical activity objectives for HP 2010. All groups met their objective for moderate physical activity.

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Mammogram in Last 2 years (ages 40+)	%	%			
White	72.1	69.1	✗	75	✗
African American	78.2	73	✗	75	✗
Asian	73.9	64	✗	75	✗
American Indian	68.5	61.5	✗	75	✗
Hispanic or Latino	73.4	58.3	✗	75	✗
Pap Test Last 3 years (Ages 18+)	%	%			
White	84.4	76.3	✗	90	✗
African American	89.2	84.2	✗	90	✗
Asian	93.5	70.6	✗	90	✗
American Indian	83.0	79.1	✗	90	✗
Hispanic or Latino	87.5	71.9	✗	90	✗

PROGRESS TOWARD HP2010

Nebraska Objectives	Nebraska		Progress	2010 Objective	Met
	2001-2005	2006-2010			
Cholesterol Checked Last 5 years	%	%			
White	68.6	72.7	✓	80	×
African Americans	71.7	79.4	✓	80	×
Asian	63.6	75.4	✓	80	×
American Indian	66.4	74.7	✓	80	×
Hispanic or Latino	56	55	×	80	×
Moderate Physical Activity	%	%			
White	43	52.9	✓	30	✓
African American	38.8	44.5	✓	30	✓
Asian	31.7	34.8	✓	30	✓
American Indian	53.1	64.8	✓	30	✓
Hispanic or Latino	31.3	41.4	✓	30	✓
Vigorous Physical Activity	%	%			
White	21.8	31.6	✓	30	✓
African American	23.3	29.1	✓	30	×
Asian	20.4	20.7	✓	30	×
American Indian	25.5	33.7	✓	30	✓
Hispanic or Latino	13.3	24.7	✓	30	×
Blood Stool Test	%	%			
White	30.6	21.7	×	50	×
African American	32.1	27.1	×	50	×
Asian	17.6	26.7	✓	50	×
American Indian	8.2	19.4	✓	50	×
Hispanic or Latino	24.1	11.7	×	50	×

Cholesterol Checked: Last Five Years

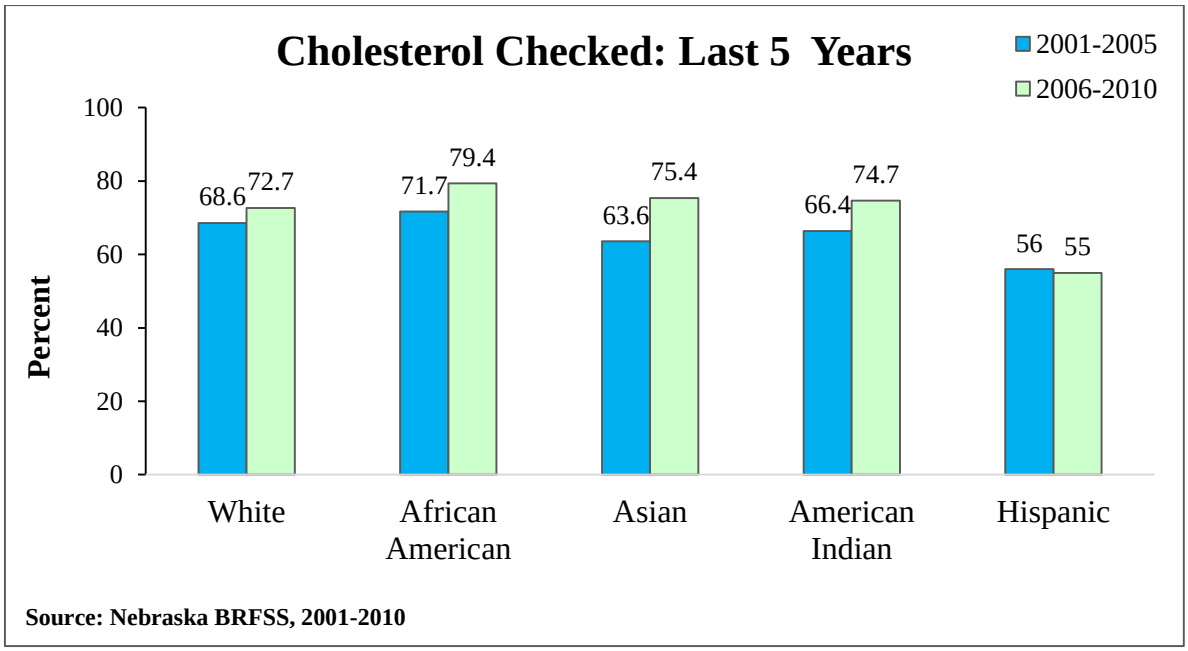
Measured through a blood draw, a cholesterol check is imperative in order to understand a person's heart health. High blood cholesterol is related to coronary heart disease and stroke.[176] This measure was evaluated by asking, 'About how long has it been since you had your cholesterol checked?'

Key Disparities

- Nebraska Hispanics reported the lowest percentage of people getting their cholesterol checked within the last 5 years (55%), compared to 72.7% of Whites and almost 80% of African Americans.
- Approximately 75% of Asians and American Indians last had their cholesterol checked within five years.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- There was an increase in the percentage of people who had their cholesterol checked within five years from 2001-2005 to 2006-2010 among all groups, except Hispanics who *decreased* 1%.
- Asians experienced the largest increase jumping from 63.6% to 75.4%; American Indians also increased from a percentage in the 60s (66.4%) to one in the 70s (74.7%).
- African Americans experienced a large increase from 71.7% in 2001-2005 to 79.4% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the United States

- Nebraska Hispanics saw a lower percentage of people who got their cholesterol checked within the last five years, compared to the United States (64.2%).
- Nebraska African Americans saw higher percentage get their cholesterol checked than their U.S. counterparts (77%, respectively).

[176]American Heart Association. (2012). How to get your cholesterol checked. Retrieved from http://www.heart.org/HEARTORG/Conditions/Cholesterol/SymptomsDiagnosisMonitoringofHighCholesterol/How-To-Get-Your-Cholesterol-Tested_UCM_305595_Article.jsp.

Mammogram: Last Two Years (ages 40+)

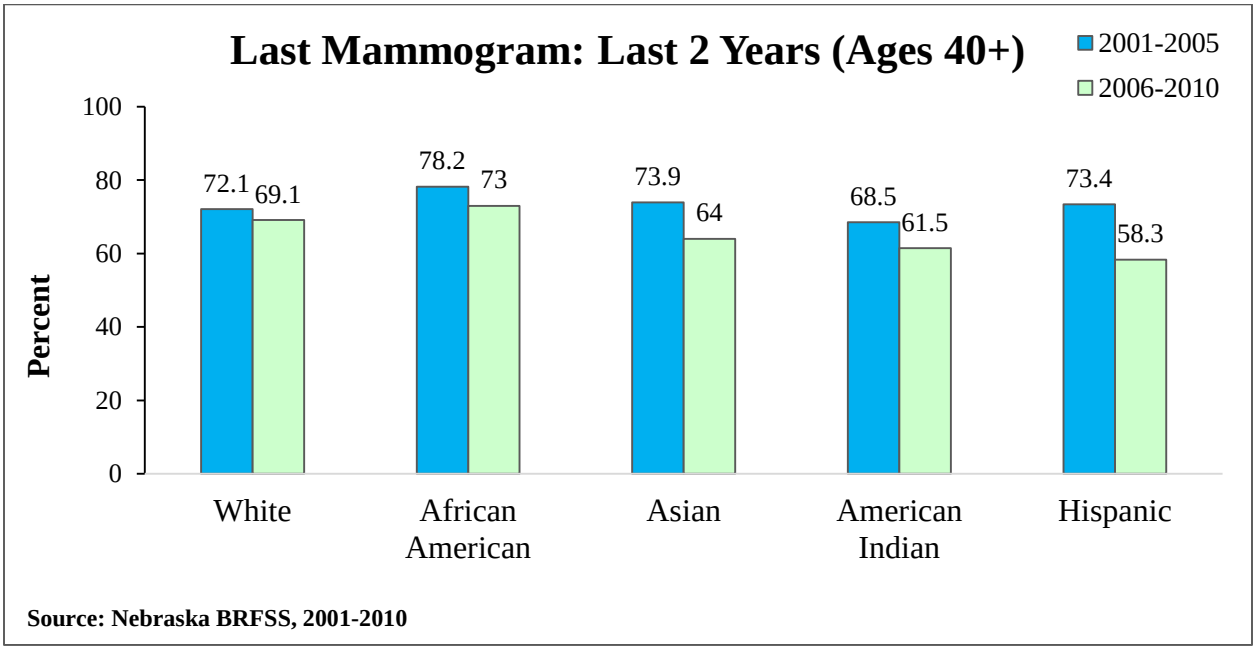
Mammograms are x-ray pictures of the breast that can detect breast cancer in women who otherwise have no signs or symptoms.[177] Aside from skin cancer, breast cancer is the most common type of cancer and the leading cause of cancer death in women.[178] This measure was evaluated by asking, '1. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram? 2. How long has it been since you had your last mammogram?'

Key Disparities

- Nebraska's Hispanic population saw the least amount of women who obtained mammograms in the previous 2 years in 2006-2010 (58.3%), compared to 69.1% of Whites and 73% of African Americans.
- Sixty-four percent of Asians reported screening for breast cancer.
- With a similar proportion to Hispanics, only 61.5% of American Indian women received a mammogram.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All groups saw a decline in obtaining mammograms; Hispanics saw the largest decline dropping from 73.4% in 2001-2005 to 58.3% in 2006-2010.
- African Americans dropped from above the HP2010 objective (78.2%) in 2001-2005, to below it (73%) in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- Nebraska Hispanic women (58.3%) saw the largest difference from their national population with almost 77% obtaining mammograms.
- Almost 79% of African American women in the United States 40+ had a mammogram within the past 2 years, compared to 73% of Nebraska African American women.

[177]National Cancer Institute. (2012). Mammograms. Retrieved from http://www.cancer.gov/cancertopics/factsheet/detection/mammograms.
[178]Centers for Disease Control and Prevention. (2012). Breast cancer statistics. Retrieved from http://www.cdc.gov/cancer/breast/statistics/.

Mammogram: Last Two Years (ages 50-74)

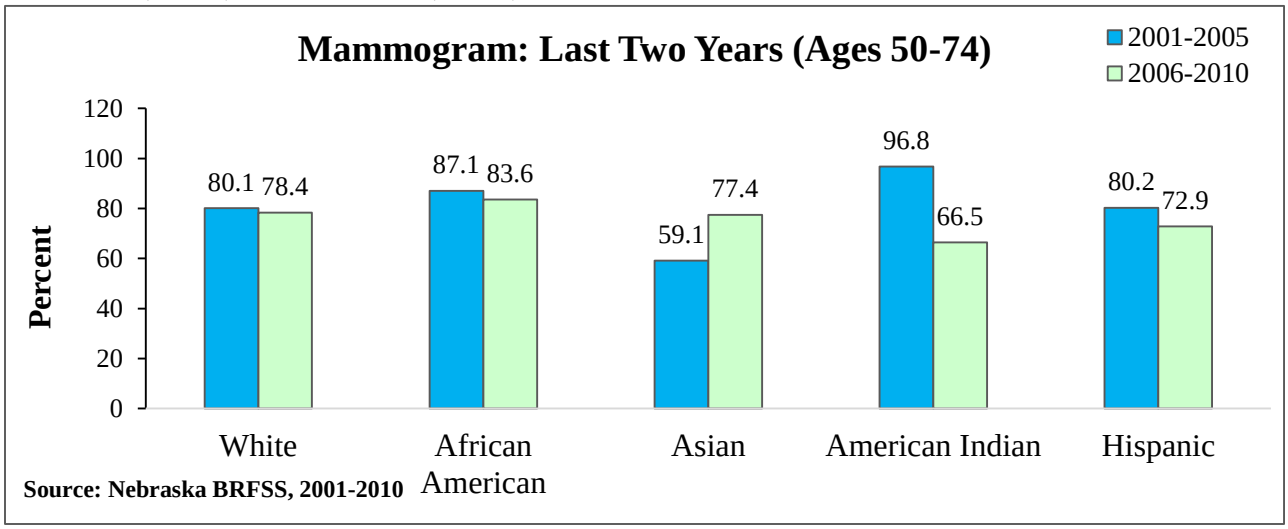
In 2009, the U.S. Preventive Services Task Force began recommending women 50 to 74 years old continue to get routine mammograms (every two years), but women 40-49 years old with no family history of cancer should discuss individualized screening plans with their doctor.[179] Finding cancer in younger women only reduces mortality by a very small percentage; more likely there will be over-diagnoses and unnecessary treatment.

Key Disparities

- Nebraska's American Indian population (66.5%) experienced the lowest percentage of women, between ages 50 and 74, who have had a mammogram in the last two years, compared to Whites (78.4%).
- Almost 84% of African American women aged 50 to 74 received a mammogram in the last two years.
- Almost 73% of Hispanic women in Nebraska aged 50 to 74 had received a mammogram; approximately 77% of Asian women had a mammogram in the previous two years.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Most groups, if even slightly, saw a reduction in mammograms between 2001-2005 and 2006-2010.
- American Indians saw the largest reduction in mammograms among women aged 50-74 between 2001-2005 (96.8%) and 2006-2010 (66.5%).
- Nebraskan Asian women saw an increase in the percentage obtaining mammograms in the last two years from 2001-2005 (59.1%) and 2006-2010 (77.4%).



Compared to the Nation

- Approximately 82% of African American women (between 50 and 74) in the United States had a mammogram in 2010, compared to 83.6% of Nebraska women of the same age.
- Approximately 80% of Nebraska Asian women had a mammogram, compared to 64.2% of Asian women in the United States.
- Almost 80% of Hispanic women in the United States reported getting a mammogram, compared to 72.9% of Hispanic women in Nebraska.
- A similar proportion of American Indian Nebraskans reported receiving a mammogram as American Indian women in the United States.

[179]Block, L., Jarlenski, M., Wu, A., Bennett, W. (2013). Mammography use among women ages 40-49 after the 2009 U.S. preventive services task force recommendation. *Journal of General Internal Medicine.*

Pap test: Last Three Years (Ages 18+)

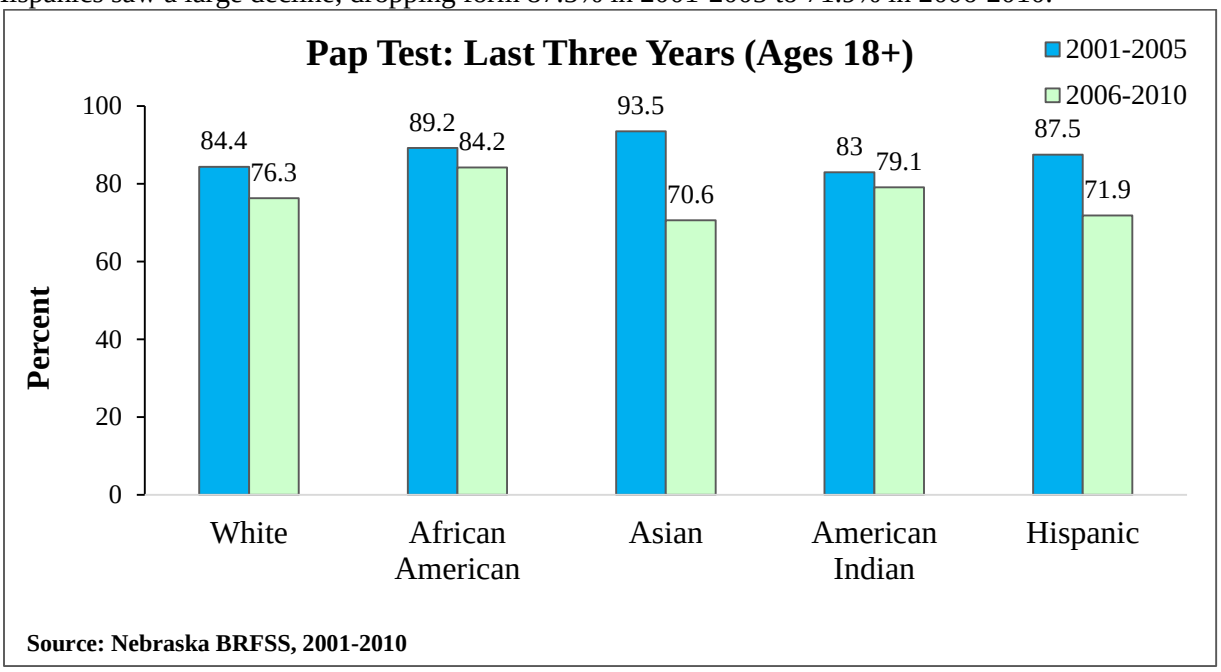
A Pap test checks for changes in the cells of a woman's cervix; this can test for infection, abnormal cervical cells, or cervical cancer.[180] This measure was evaluated by asking, 'A Pap test is a test for cancer of the cervix. Have you ever had a Pap test? How long has it been since you had your last Pap test?'

Key Disparities

- Nebraska's Asian population (70%) saw the lowest proportion of women getting a Pap test in the last three years, compared to 76.3% of Whites.
- Nearly 72% of Hispanics received a Pap test in the last three years.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All groups saw a decrease in the proportion of women getting Pap tests between 2001-2005 and 2006-2010.
- Asians saw the largest decrease from 93.5% to 70.6%; they dropped from the highest proportion in 2001-2005 to the lowest proportion in 2006-2010.
- The highest proportion of women getting Pap tests within the last five years were African American, though they dropped 5% between the first and second half of the decade.
- Hispanics saw a large decline, dropping form 87.5% in 2001-2005 to 71.9% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- African Americans in the United States (86.2%) and Nebraska (84.2%) saw similar proportions of women 18 and older had gotten a pap test in the last three years in 2006-2010.
- More Hispanic women in the United States (84.3%) got a pap test in the previous three years than Hispanic women in Nebraska (71.9%).

[180]Women's Health. (2009). Pap test face sheet. Retrieved from http://womenshealth.gov/publications/our-publications/fact-sheet/pap-test.html#

Pap Test: Last Three Years (ages 21-65)

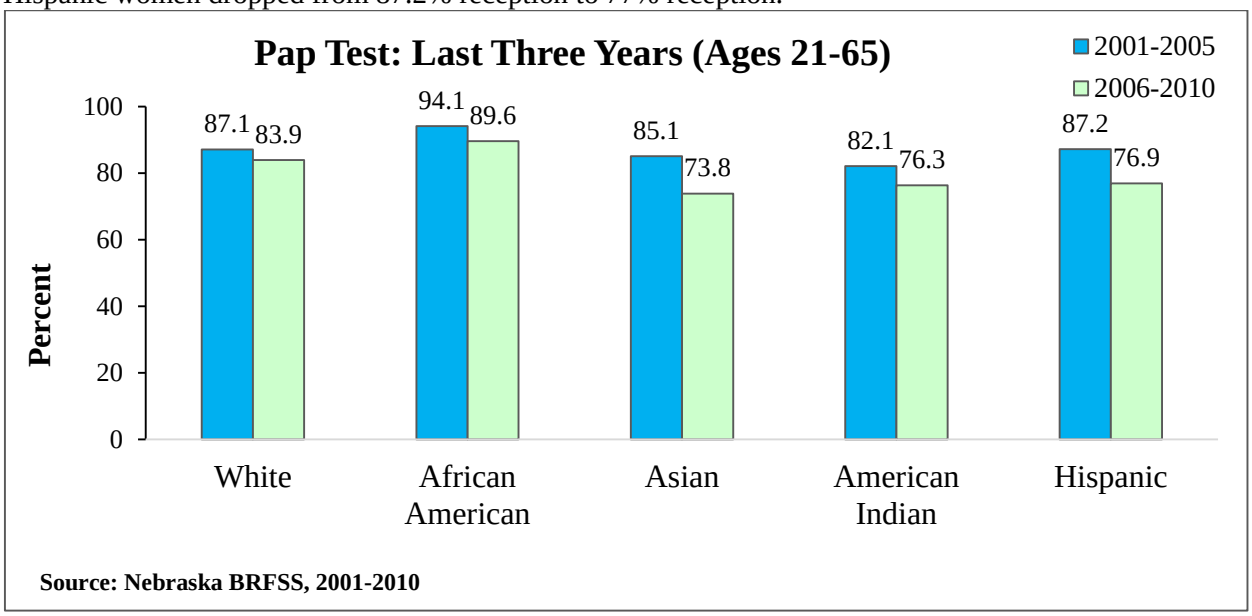
A Pap test checks for changes in the cells of a woman's cervix; this can test for infection, abnormal cervical cells, or cervical cancer.[181] This measure was evaluated by asking, 'A Pap test is a test for cancer of the cervix. Have you ever had a Pap test? How long has it been since you had your last Pap test?'

Key Disparities

- Aside from those women in the 'other' category, Asian women (73.8%), between 21 and 65 years of age, were the least likely to have had a Pap test in the last three years, compared to almost 84% of Whites.
- Approximately 76% of both American Indian- and Hispanic women received a Pap test in 2006-2010.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Across all groups, there was a reduction in reception of Pap tests among 21-65 year old women.
- Asian women saw a reduction from 85.1% in 2001-2005 to 73.8% in 2006-2010.
- Hispanic women dropped from 87.2% reception to 77% reception.



Compared to the Nation

- Approximately 88% of African American women (between 21 and 65) in the United States had a Pap test in 2010, compared to 90% of Nebraska women of the same age.
- Approximately 74% of Nebraska Asian women had a Pap test, compared to 76% of Asian women in the United States.
- Eighty-six percent of Hispanic women in the United States reported getting a Pap test, compared to approximately 77% of Hispanic women in Nebraska.
- Eighty-one percent of American Indian women in the United States reported getting a Pap test, compared to 76.3% of American Indian women in Nebraska.

[181] Womenshealth.gov (2009). Pap test face sheet. Retrieved from http://womenshealth.gov/publications/our-publications/fact-sheet/pap-test.cfm#a.

PSA: Last Two Years (Ages 18+)

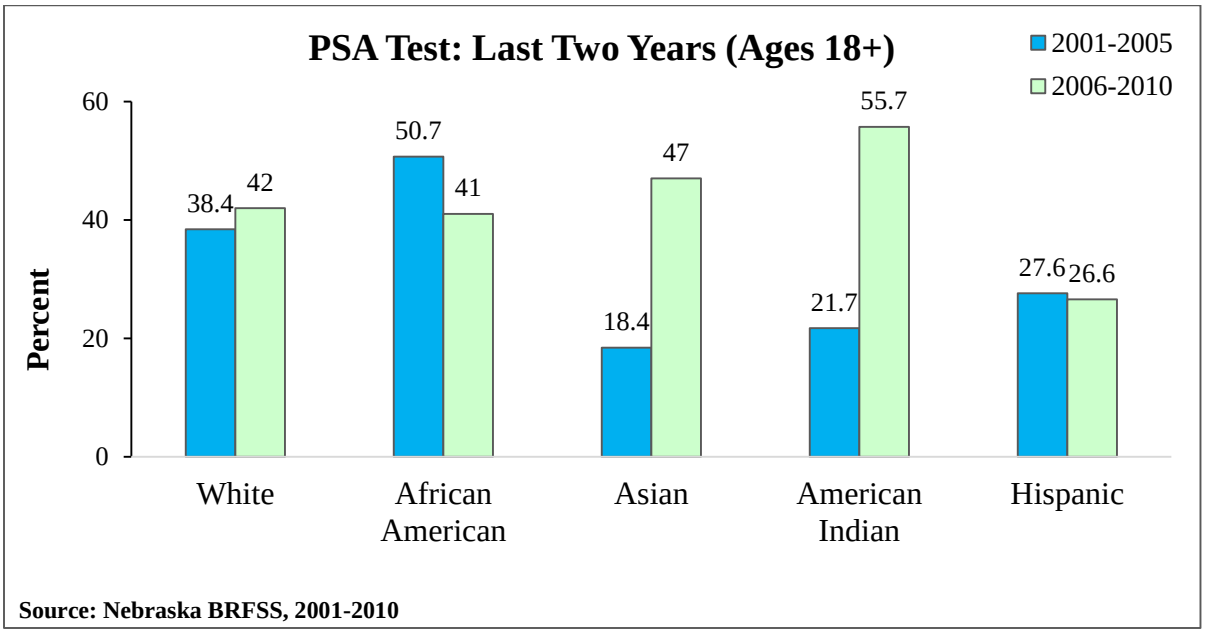
PSA, or prostate-specific antigen, is a protein produced by the prostate. Cancer can be detected when PSA reaches certain detectable-levels in the bloodstream.[182] PSA is measured by taking a blood sample from the patients arm.[183] This measure was evaluated by asking, 'A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?'

Key Disparities

- Nebraska's Hispanic population saw the smallest proportion of men getting PSA tests (26.6%), compared to 42% of Whites.
- Fifty-five percent (55.7%) of American Indian men received a PSA test in the last two years.
- Forty-one percent of African American men and 47% of Asian men received a PSA test in the last two years.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Asians and American Indians saw a large increase in the percentage of men who obtained a PSA test in the last two years; American Indians increased from 21.7% in 2001-2005 to 55.7% in 2006-2010.
- Asians increased from 18.4% in 2001-2005 to 47% in 2006-2010.
- African Americans saw a decline in percentage of men getting a PSA, dropping from 50.7% in 2001-2005 to 41% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- More African American men in the United States (58.7%) than African American men in Nebraska (41%) had gotten a PSA test in the previous two years.
- More Hispanic men in the United States (39.5%) than Hispanic men in Nebraska (26.6%) had gotten a PSA test in the previous two years.

[182]Prostate Cancer Foundation. (2013). PSA and DRE screening. Retrieved from http://www.pcf.org/site/c.leJRIROrEpH/b.5802071/k.C620/PSA__DRE_Screening.htm.
[183]Ibid.

DRE: Last Two Years (Ages 50+)

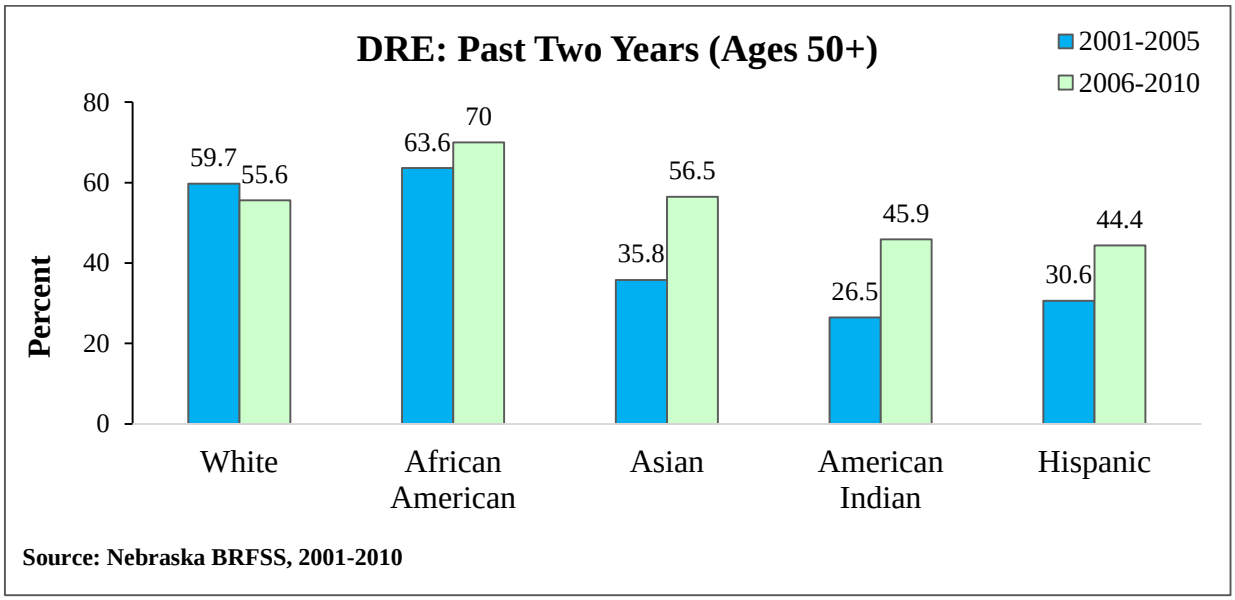
A DRE or digital rectal exam examines the prostate for any irregularities in size, shape, and texture.[184] This measure was evaluated by asking, ' A digital rectal exam is an exam in which a doctor, nurse, or other health professional places a gloved finger into the rectum to feel the size, shape, and hardness of the prostate gland. Have you ever had a digital rectal exam?'

Key Disparities

- Nebraska's Hispanic population saw the lowest proportion of men who have had a DRE in the last two years (44.4%), compared to 55.6% of Whites.
- Almost 46% of American Indian men have had a DRE in the past two years.
- Seventy percent of African American men have had a DRE in the past two years, the highest proportion for any group.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- There was a general increase in men having a DRE in the last two years; Asians saw the largest increase of 20.7% from 35.8% in 2001-2005 to 56.5% in 2006-2010.
- American Indians increased from 26.5% to 45.9%, while Hispanics increased from 30.6% to 44.4%.
- African Americans, though seeing the best numbers, saw the smallest increase, from 63.6% to 70%.



Source: Nebraska BRFSS, 2001-2010

[184]Prostate Cancer Foundation. (2013). PSA and DRE screening. Retrieved from http://www.pcf.org/site/c.leJRIROrEpH/b.5802071/k.C620/PSA__DRE_Screening.htm.

Blood Stool Test: Last Two Years (Ages 18+)

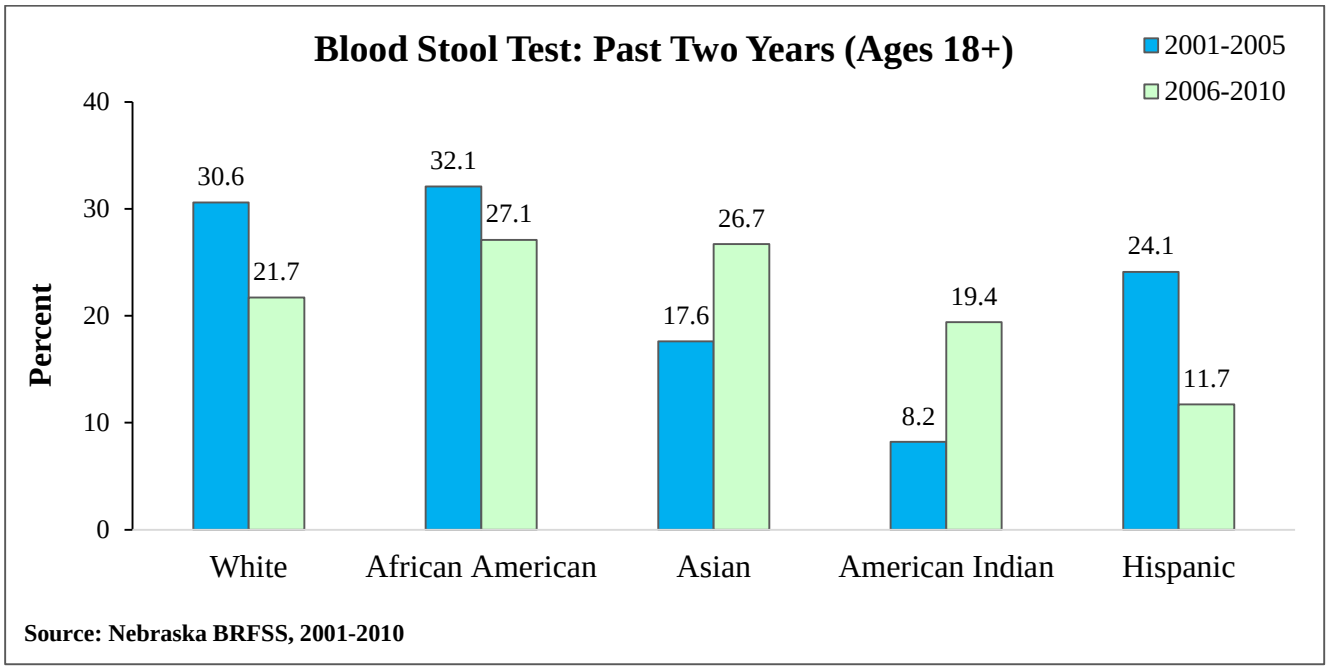
A blood stool test can detect various conditions like benign or malignant growths of the colon, hemorrhoids, intestinal infections, ulcers, Crohn's disease, or diverticular disease. This measure was evaluated by asking participants, 'A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?'

Key Disparities

- Nebraska Hispanics saw the lowest percentage of people having had a blood stool test in the last two years (11.7%), compared to 21.7% of Whites.
- Approximately 27% of both African Americans and Asians had a blood stool test within the last two years.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Both Asians and American Indians saw an increase in the number of individuals that have had a blood stool test within the last two years.
- American Indians increased the most from 8.2% in 2001-2005 to 19.4% in 2006-2010.
- African Americans saw the highest percentage among all groups across both time periods, despite a decrease from 32.1% in 2001-2005 to 27.1% in 2006-2010.
- Hispanics experienced a large decline in receiving a blood stool test in the past two years, from 24.1% in 2001-2005 to 11.7% from 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- More African Americans in Nebraska reported their last blood stool test within two years than African Americans in the United States (19.9%).
- Hispanics in Nebraska (11.7%) and Hispanics in the United States (11.6%) reported the same percentage of the population 50 and older getting a blood stool test.

Colonoscopy: Last 10 Years

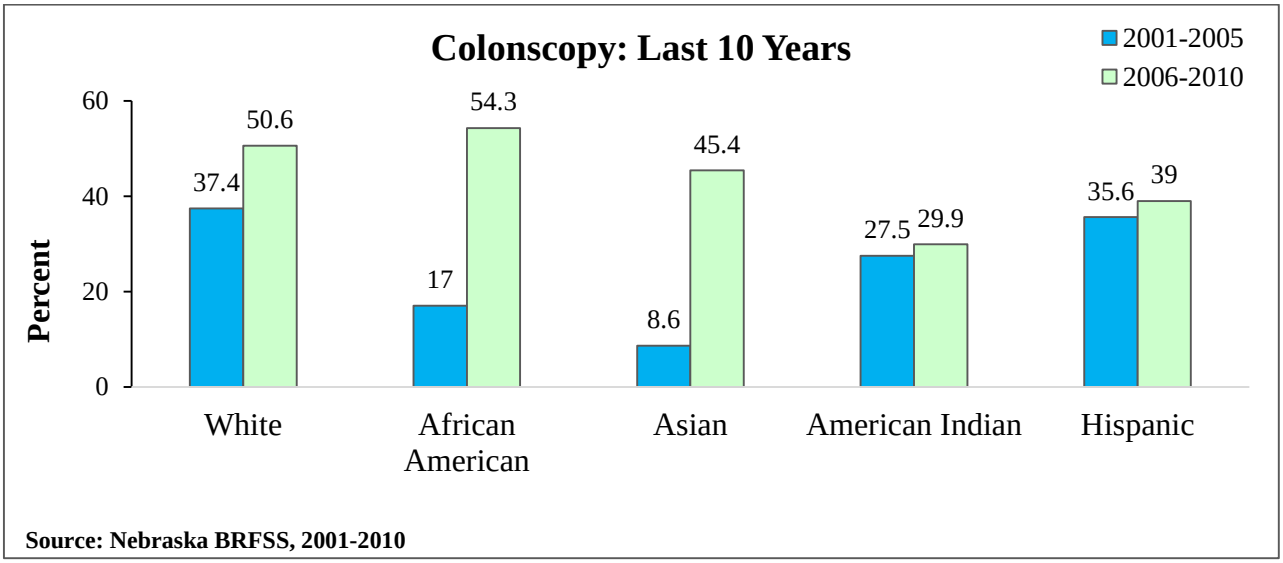
A colonoscopy screens for any changes or abnormalities in the large intestine and rectum and is recommended every 10 years. Colonoscopies explore possible causes of abdominal pain, chronic pain, or intestinal problems. Colonoscopies also screen for colon cancer, the second leading cause of cancer death in the United States.[185] Early detection of colon cancer can often lead to full recovery.[186] Colonoscopies are usually recommended for people who are 50 or older, however the data below includes everyone who was 18 or older.

Key Disparities

- Nebraska's American Indian population saw the smallest proportion of the population who had a colonoscopy from 2006-2010 (29.9%), compared to 50.6% of Whites.
- Almost 54.3% of African Americans reported having a colonoscopy within the last 10 years, the highest percentage for all groups.
- Hispanics in Nebraska (39%) also saw a smaller amount of people reporting colonoscopy screenings.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentage of people getting colonoscopies in each racial or ethnic group increased between 2001-2005 and 2006-2010.
- Asians saw the largest increase, 8.6% in 2001-2005 and jumping to 45.4% in 2006-2010.
- African Americans also saw a large increase from 17% in 2001-2005 to 54.3% in 2006-2010.
- Seeing only a small increase to 27.5% from 29.9%, American Indians went from seeing the third best percentage (28.3%) in 2001-2005 to seeing the worst in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- African American and Asian Nebraskans reported a similar number of people who had had a colonoscopy in the last 10 years as the Nation (60% and 49.9%, respectively).
- Forty-six percent of Hispanics in the United States had a colonoscopy in the last 10 years, compared to 39% of Hispanics in Nebraska.
- Twice as many American Indians in the United States had a colonoscopy in the previous 10 years than American Indian Nebraskans.

[185]National Cancer Institute. (2012). General information about colorectal cancer. Retrieved from http://www.cancer.gov/cancertopics/pdq/prevention/colorectal/Patient/page2.
[186]Mayo Clinic. (2011). Colonoscopy. Retrieved from http://www.mayoclinic.com/health/colonoscopy/my00621.

Flu Shot

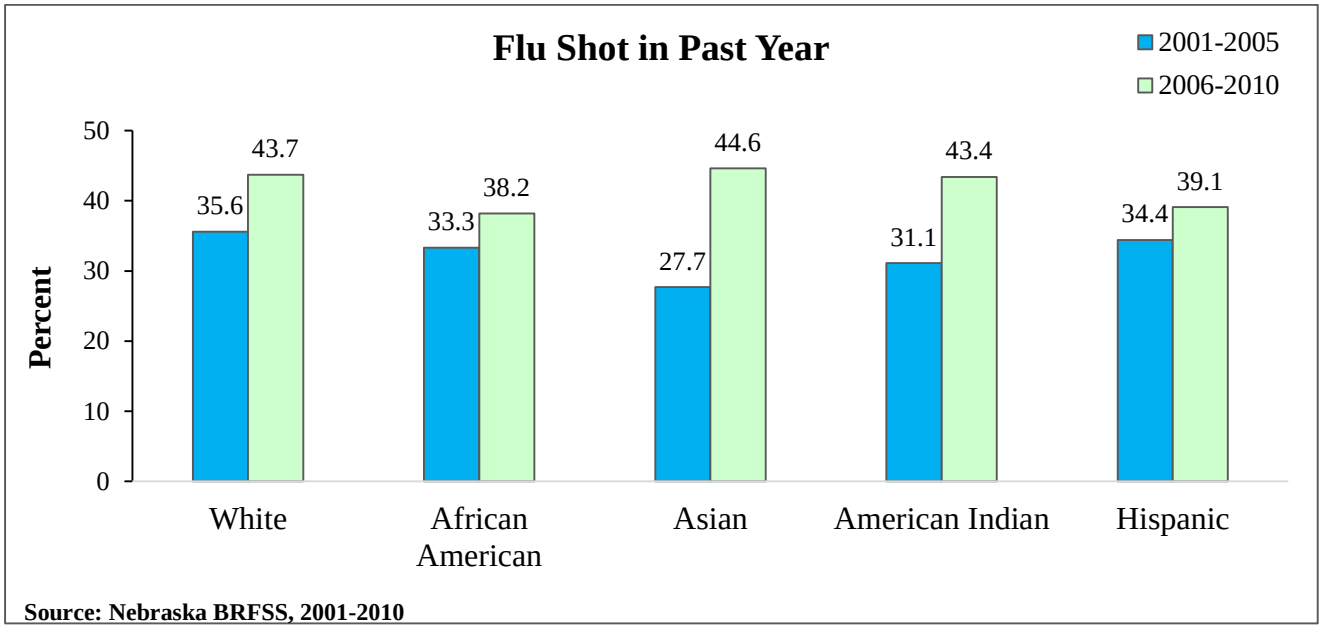
Respondents were asked, 'A flu shot is an influenza vaccine injected into your arm. During the past 12 months, have you had a flu shot?' Represented in the chart below were those who had a flu shot.

Key Disparities

- Approximately 39% of both Hispanics and African Americans received a flu shot in the year prior to the survey.
- Almost 45% of Asian Nebraskans got a flu shot in the previous year.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- The percentage of people who got a flu shot increased among all racial and ethnic groups between 2001-2005 and 2006-2010.
- Asians saw the largest increase from 27.7% in 2001-2005 to 44.6% in 2006-2010, an increase that put them at the group with the highest vaccination proportion.
- American Indians also saw a large increase from 31.1% in 2001-2005 to 43.4% in 2006-2010 receiving flu shots in the last year.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- More African Americans in Nebraska (38.2%) reported having a flu shot in the previous year than African Americans in the United States (32.7%).
- More Hispanics in Nebraska (39.1%) reported having a flu shot in the previous year than their national counterparts (29.4%).

Pneumonia Shot

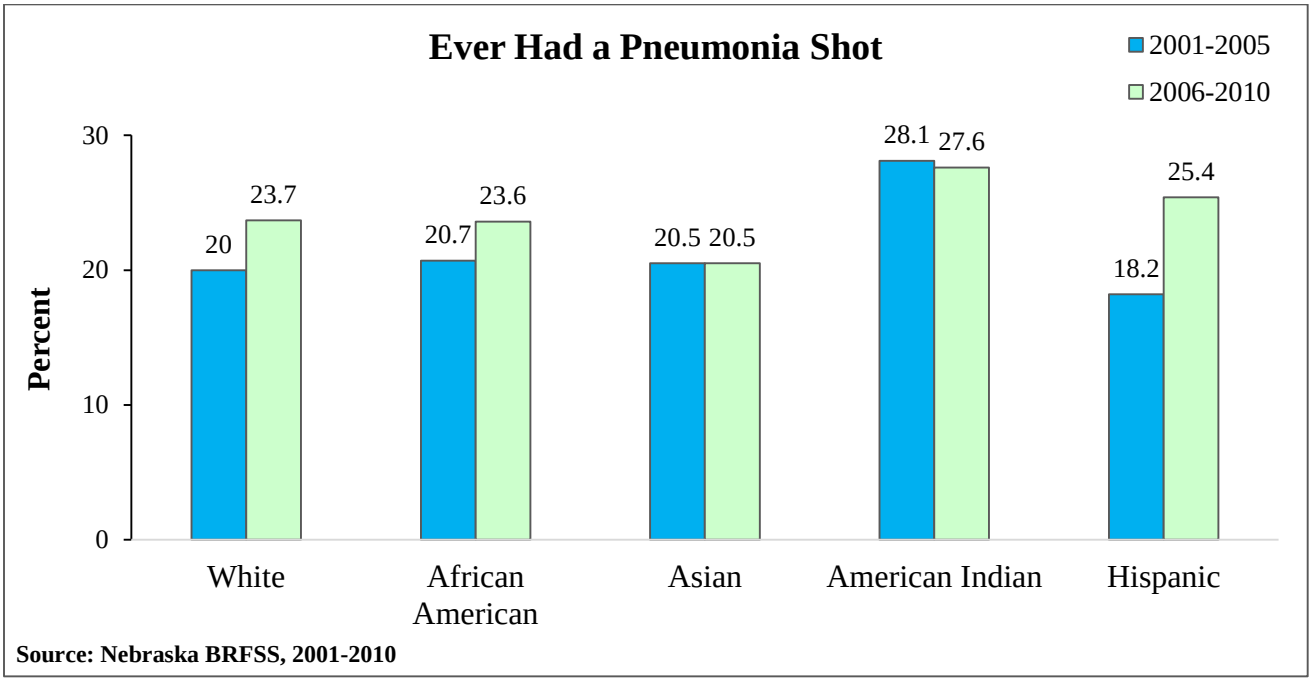
Respondents were asked, ‘a pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person’s lifetime and is different from the flu shot. Have you ever had a pneumonia shot?’ Those respondents who had had a pneumonia shot were included in the chart below.

Key Disparities

- Approximately 21% of Asians had ever received a pneumonia shot.
- American Indians saw the largest proportion of people who got a pneumonia shot at 27.6%.
- Approximately 25% of Hispanics got a pneumonia shot in the last year.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- Most groups saw an increase in pneumonia shot reception, with Hispanics increasing from 18.2% to 25.4%.
- Asians and American Indians saw equal or very similar rates between 2001-2005 and 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation

- More African Americans in Nebraska than African Americans in the United States (18.6%) reported receiving a pneumonia shot.
- Almost 10% more Hispanics in Nebraska reported getting a pneumonia shot than Hispanics in the rest of the United States (14.8%).
- Almost twice as many Asian Nebraskans got a pneumonia shot compared to Asians in the United States (11.5%).

Physical Activity: Moderate Exercise

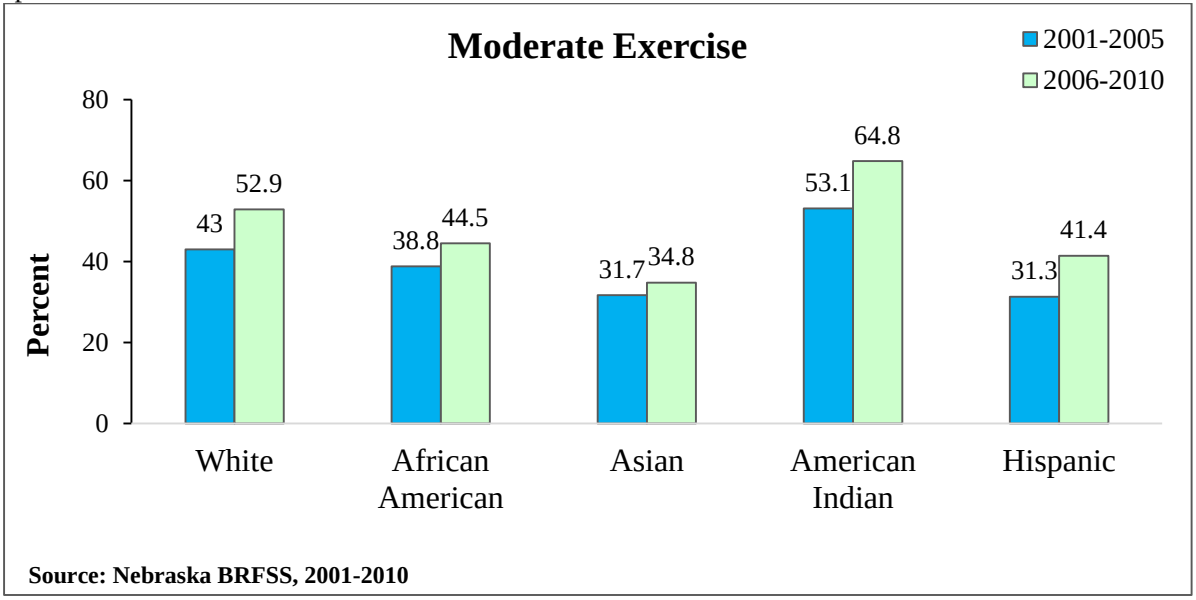
Regular physical activity is important at all stages of life for maintaining health, enhancing quality of life, and preventing premature death. Moderate exercise should feel somewhat difficult; breathing quickens, but you are not out of breath, light sweat develops, but you can still carry on a conversation.[187] This measure was evaluated by asking, 'Thinking about the moderate activities you do (when you are not working if "employed" or "self-employed") in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate?'

Key Disparities

- Nebraska's Asian population saw the lowest proportion of people getting moderate physical activity (34.8%), compared to Whites (52.9%) in 2006-2010.
- American Indians reported the highest percentage of people getting moderate physical activity at 64.8%.
- Forty-one percent of Hispanics and a similar 44.5% of African Americans reported getting moderate physical activity.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- All population groups saw an increase in moderate physical activity from 2001-2005 to 2006-2010.
- American Indians, with 53.1% of their population exercising in 2001-2005, saw an 11% increase in 2006-2010 (64.8%).
- Hispanic Americans increased 10% from 2001-2005 to 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation (in 2009)

- African Americans in Nebraska (44.5%) saw a similar proportion of people getting moderate physical activity compared to the nation (43%).
- A slightly larger proportion of Hispanics in the United States (46.5%) get moderate physical activity compared to Hispanics in Nebraska (41.4%).

[187]Mayo Clinic. (2011). Exercise intensity: Why it matters, how it's measured. Retrieved from http://www.mayoclinic.com/health/exercise-intensity/SM00113.

Physical Activity: Vigorous Exercise

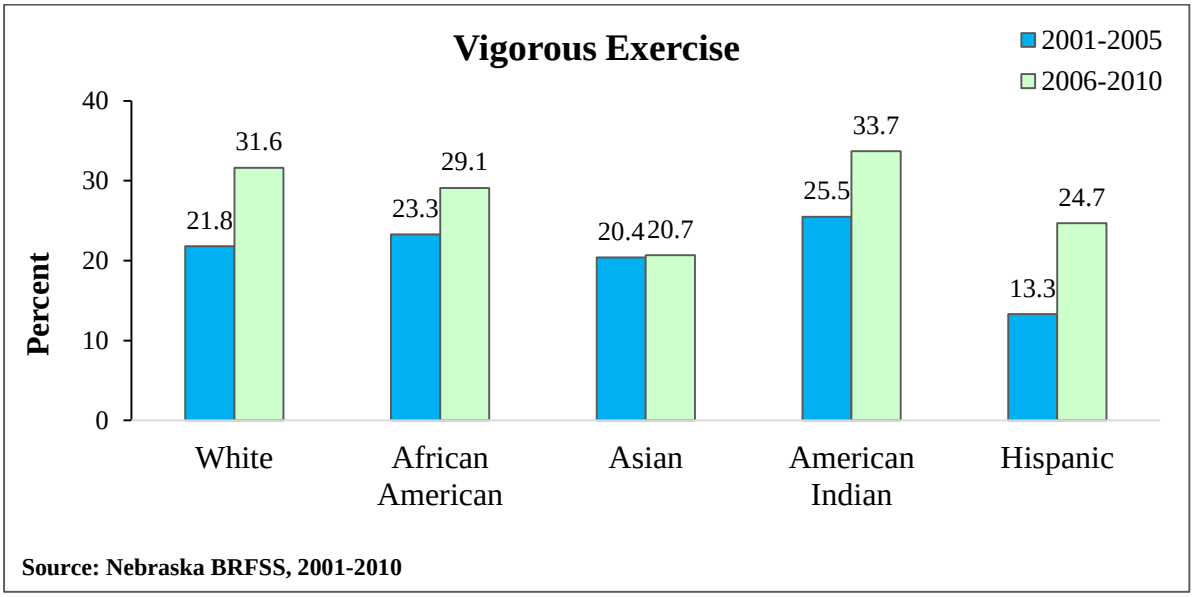
Vigorous exercise is characterized by deep and rapid breathing, sweat development after a few minutes, and inability to speak more than a few words.[188] Regular physical activity decreases the risk of death from heart disease, lowers the risk of developing diabetes, and is associated with a decreased risk of colon cancer.[189] Physical activity also helps prevent and reduce high blood pressure.[190] This measure was evaluated by asking, 'Thinking about the vigorous activities you do (when you are not working if "employed" or "self-employed") in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate?'

Key Disparities

- Nebraska's Asian population saw the smallest proportion of people exercising vigorously (20.7%), compared to 31.6% of Whites.
- Nearly 34% of American Indians reported getting vigorous exercise, the highest amount for any group.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- There was a general increase in all populations getting vigorous exercise; Hispanics saw the largest increase from 13.3% in 2001-2005 to 24.7% in 2006-2010.
- American Indians increased from 25.5% to 33.7% in 2006-2010.



Source: Nebraska BRFSS, 2001-2010

Compared to the Nation (in 2009)

- Slightly more African Americans in Nebraska got vigorous physical activity (29.1%) compared to the national population (25.6%).
- Slightly less Hispanics in Nebraska (24.7%) got vigorous physical activity compared to the national population (29.1%).

[188]Mayo Clinic. (2011). Exercise intensity: Why it matters, how it's measured. Retrieved from http://www.mayoclinic.com/health/exercise-intensity/SM00113.
[189]Centers for Disease Control and Prevention. (2011). Physical activity and health. Retrieved from http://www.cdc.gov/physicalactivity/everyone/health/index.html.
[190]Ibid.

Fruits and Vegetables: 5+ Servings

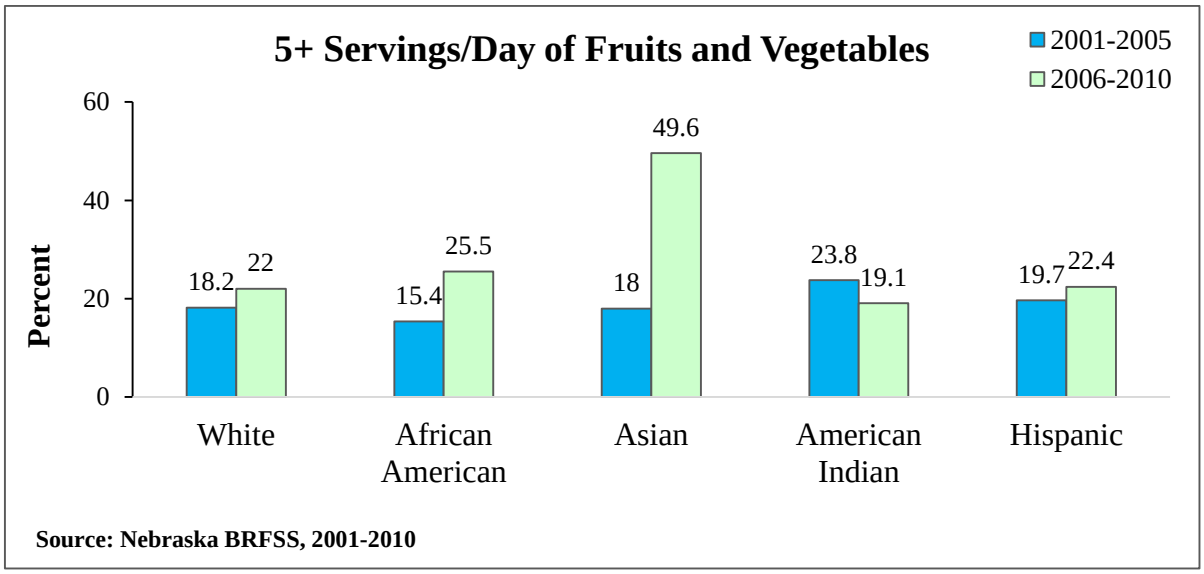
Diets high in fruits and vegetables can reduce the risk for cancer and chronic disease. Providing essential vitamins and minerals, fruits and vegetables also have fiber and are low in fat and calories.[191] Half of your dinner plate should consist of fruits and vegetables.[192] This measure was evaluated by asking, '1) How often do you drink fruit juices such as orange, grapefruit, or tomato? 2) Not counting juice, how often do you eat fruit? 3) How often do you eat green salad? 4) How often do you eat potatoes, not including French fries, fried potatoes, or potato chips? 5) How often do you eat carrots? and 6) Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat?' Participants were not given a definition of serving size.

Key Disparities

- Nebraska's American Indian population saw the least amount of people getting five or more servings of fruits and vegetables (19%), compared to 22% of Whites.
- Twenty-two percent of Hispanic Nebraskans got five or more servings of fruits and vegetables, a comparable proportion to Whites.

How are we doing? Comparisons between 2001-2005 and 2006-2010

- American Indians were the only group that saw a decline in their fruit and vegetable consumption, dropping from 23.8% to 19% in 2006-2010.
- Asians saw the largest increase jumping dramatically from 18% to nearly 50%.
- African Americans increased their fruit and vegetable consumption, from 15.4% in 2001-2005 to 25.5% in 2006-2010.

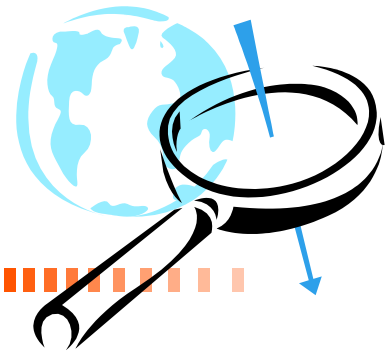


Compared to the Nation (in 2009)

- Approximately 21% of African Americans in the United States got five or more servings of fruits and vegetables per day, compared to 25.5% of African Americans in Nebraska.
- Slightly less Hispanics in the United States (21.5%) compared to 22.4% of Hispanics in Nebraska got five or more servings of fruits and vegetables per day.

[191]Centers for Disease Control and Prevention. (2012). Fruits and vegetables. Retrieved from http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html.
[192]Ibid.

REACTIONS TO RACE:
Perceived Treatment and Health



As we have illustrated throughout this report, Nebraska sees a disproportionate amount of health problems affecting minority populations. And, although some people may attribute these inequalities to socioeconomic differences, research sees them persist among people with similar insurance coverage and socioeconomic status. These biological health issues are disconcerting as we ask not only why they are happening but also why some people are affected while others are not. Some health effects can be drawn to cultural differences, but as we see discrepancies between the newly immigrated and assimilated immigrants, it is important to dig deeper. Maybe these health effects are more than just biological.

Racial and ethnic health disparities have been widely researched and documented across the United States, and in the Midwest. Morbidity and mortality are markedly higher for minority racial and ethnic groups; and this is happening when race is seen as merely a social construct, outside of biological health. Some racial and ethnic minorities also see lower income levels, less home-ownership, and more unemployment. The idea of 'white privilege' or the unearned higher status in society based on perceived skin color, alone is seen as one reason for unequal health outcomes, as it subsequently disadvantages minorities leaving them without or struggling to receive resources that are necessary for good health.

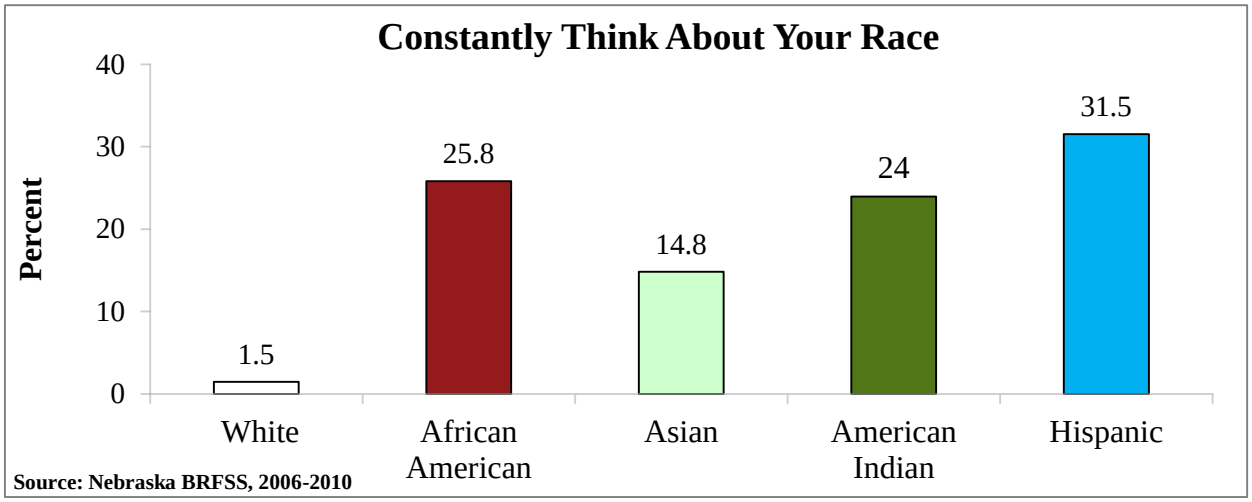
The BRFSS has a particular module called, Reactions to Race, which explores and discusses previously uncharted social and emotional factors related to race. Created by Dr. Camara Jones, Reactions to Race looks at the effects of self- vs. socially-assigned race on biological and mental health, illustrating work-related treatment based on race, as well as treatment in hospitals and other social settings.

Thought About Race

Participants in the BRFSS were asked how often they think about their race. Survey results showed that many minorities think about race constantly.

Key Disparities

- Whites (1.5%) reported the lowest rates of thinking about their race constantly, compared to Hispanics (31.5%), which is 21 times the rate of Whites and the highest among all racial and ethnic groups.
- African Americans (25.8%) reported the second highest rate, followed closely by American Indians (24%).
- Asians reported the lowest percentage among racial and ethnic minority groups at 14.8%.

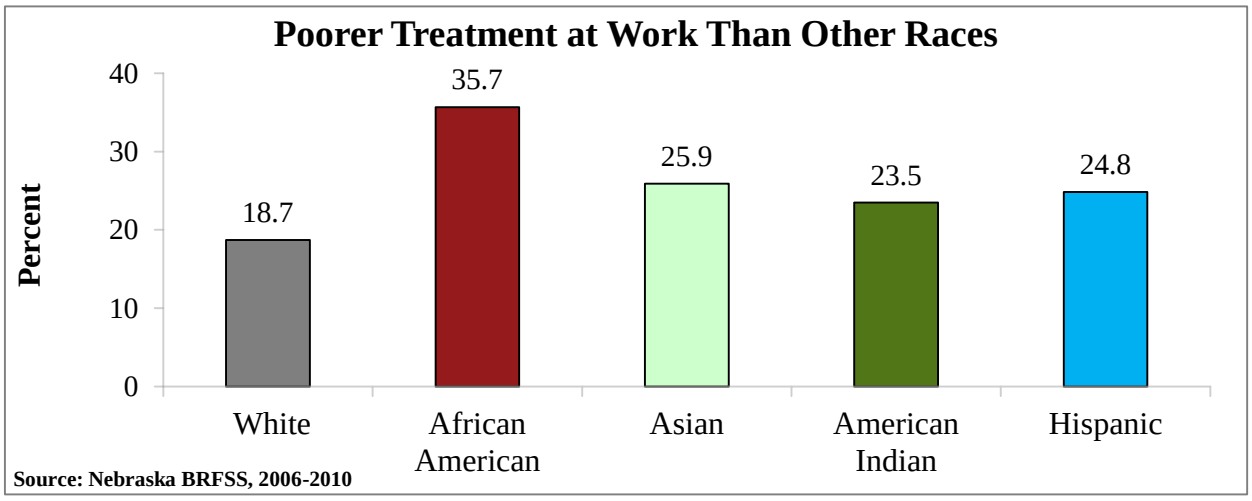


Work Treatment

Participants were asked how they thought they were treated at work compared to other races; many people reported they were treated worse.

Key Disparities

- Almost 36% of the African American respondents felt they were treated worse than other races in the work place.
- Asians (25.9%), Hispanics (24.8%), and American Indians (23.5%) reported comparable proportions.

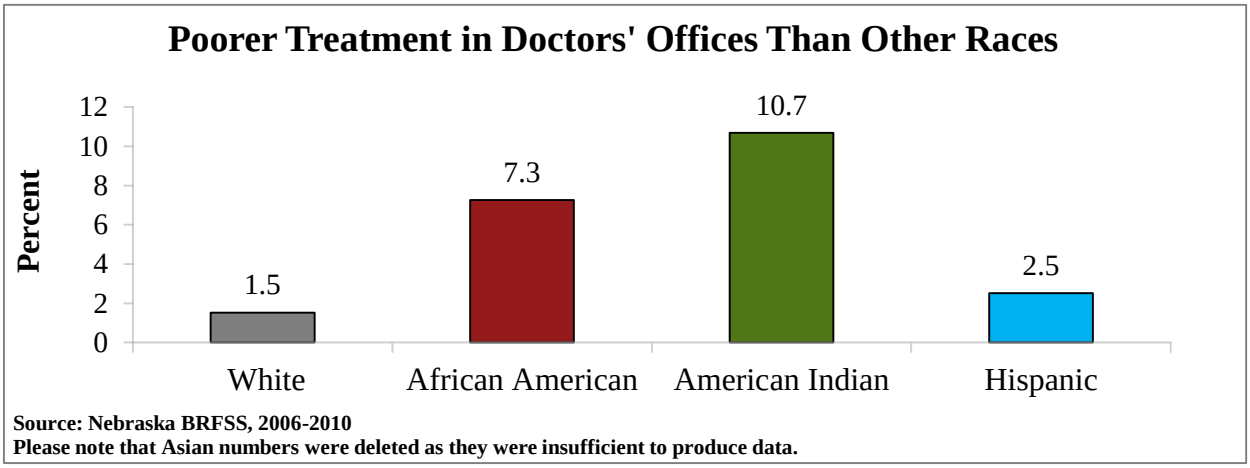


Experiences with Doctors' Offices

Participants were asked if they felt their experiences seeking health care in the past 12 months were worse than, the same as, or better than people of other races. Some reported they were treated worse. Please note that Asian numbers were not included as they were insufficient to produce data.

Key Disparities

- American Indians (10.7%) saw the highest percentage of people feeling like they were treated worse and African Americans (7.3%) reported the second highest percentage.
- Hispanics (2.5%) reported a similar proportion that perceived worse treatment as Whites (1.5%).



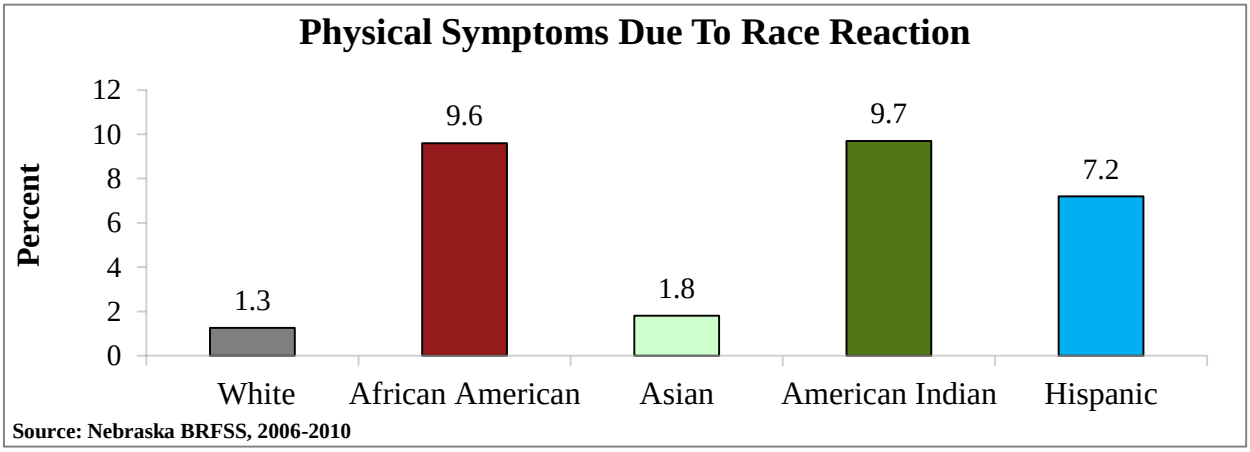
Source: Nebraska BRFSS, 2006-2010
Please note that Asian numbers were deleted as they were insufficient to produce data.

Physical Symptoms Due To Race

Participants were asked whether they experienced physical symptoms, like headache, upset stomach, racing heart, or tense muscles, because of how they were treated based on their race.

Key Disparities

- African Americans (9.6%) and American Indians (9.7%) had the highest percentages of physical symptoms due to race compared to Whites (1.3%).
- Hispanics (7.2%) also saw a relatively high percentage, compared to Whites and Asians (1.8%), that experienced physical symptoms as a reaction to treatment.



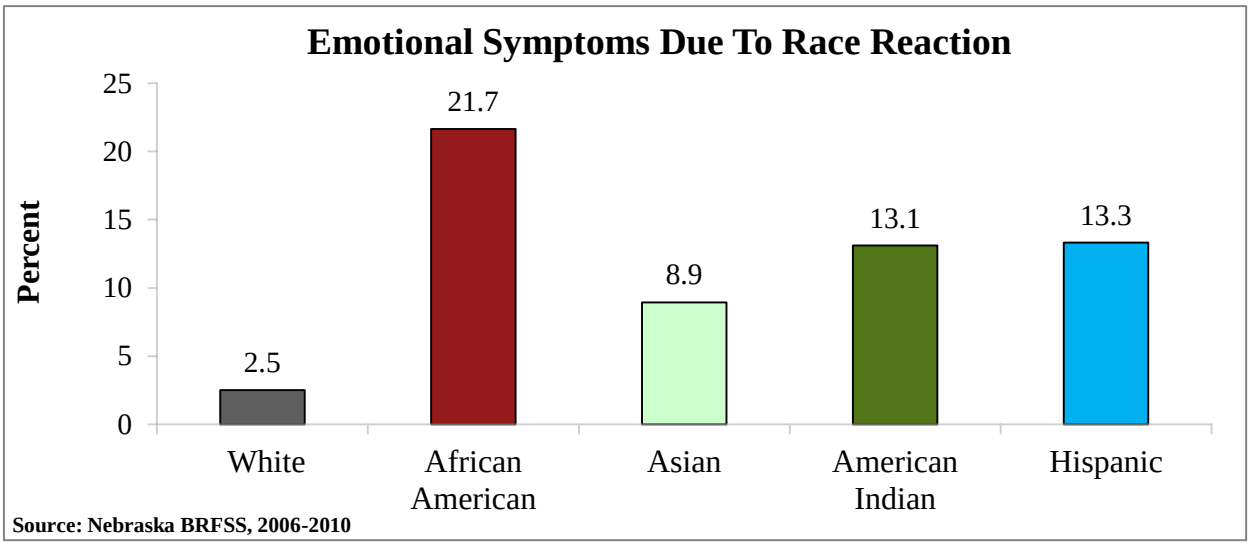
Source: Nebraska BRFSS, 2006-2010

Emotional Symptoms Due To Race

Participants were asked if they ever experienced emotional symptoms based on how they were treated based on their race. Some individuals reported they had experienced emotional symptoms due to race.

Key Disparities

- The African American (21.7%) population had the largest proportion expressing that they had experienced emotional symptoms due to their race, almost 9 times the rate of Whites (2.5%) experiencing the same symptoms.
- American Indian and Hispanic populations were comparable at 13% and 13.3%, respectively
- Asians reported the lowest percentage of emotional symptoms due to race among racial and ethnic minorities at 8.9%.



RISK FACTORS FOR NEBRASKA IMMIGRANTS

The United States has a long history of welcoming immigrants from around the world. Through the years, there have been ebbs and flows in immigration levels, with some eras described as "great waves" of immigration. Currently the United States is again experiencing high levels of immigration.[193] The Census Bureau does not ask questions about immigration status of respondents, except a question about citizenship status. After migration the United States, some foreign-born residents become naturalized citizen, which requires at least five years of residence.[194]

Immigration is a major contributor to population growth in the United States. According to the U.S. Census Bureau, it took only 39 years – from 1967 to 2006 – for the United States population to increase by an estimated 100 million people with legal immigrants and their offspring constituting a major portion of this increase. Over the last 10 years, the United States has welcomed an average of 900,000 new, legal immigrants every year.[195] Nebraska, in particular, ranked 18th out of 51 states (including District of Columbia) for percent change between 2000 and 2011, seeing a 55.6% increase in that time period.[196] Between October 1, 1997 and September 30, 2006, 27,290 persons were granted legal, permanent residence in Nebraska (this includes both new arrivals and persons who adjusted their status).[197] Nebraska immigrant admissions for the most recent 10 year period for which data were available averaged 2,808 people per year; 2001 had the highest number of immigrant admissions, 3,839. Additionally, 6.3% of Nebraska's population is foreign born and almost half of those entered Nebraska in the year 2000 or later.[198]

For the purposes of this report, survey participants listed as born outside of the United States/foreign-born were considered to be immigrants. Only those indicators that demonstrated the disparities faced by immigrant individuals are presented.

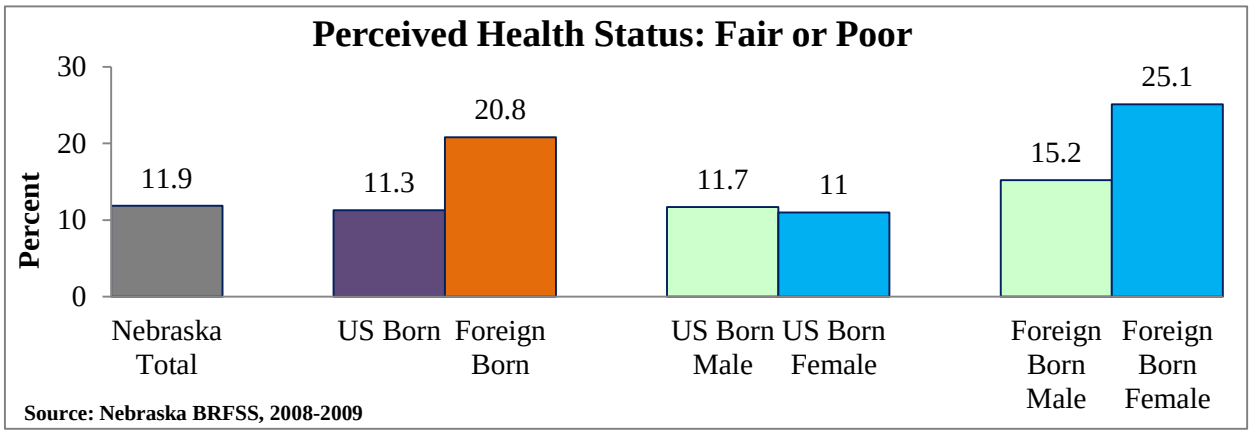
[193]U.S. Citizenship and Immigration Services. (2012). USCIS strategic plan. Retrieved from http://www.uscis.gov/files/nativedocuments/USCIS_Strategic_Plan_2008-2012.pdf.
[194]Schmidley, A. D. (2001). U.S. Census Bureau. *Profile of the Foreign-Born Population in the United States: 2000*. U.S. Government Printing Office, Washington, DC.
[195]U.S. Citizenship and Immigration Services. (2012). USCIS strategic plan. Retrieved from http://www.uscis.gov/files/nativedocuments/USCIS_Strategic_Plan_2008-2012.pdf.
[196]Migration Policy Institute. (2012). Nebraska: Social and demographic characteristics. Retrieved from http://www.migrationinformation.org/datahub/state.cfm?ID=NE.
[197]Zhang, A. (2009). Racial/ethnic minority population growth state of Nebraska.
[198]Ibid.

Perceived Health Status

A person's perceived health status has been reported to be the most important indicator of morbidity and mortality. When asked, 'Would you say that in general your health is excellent? Very good? Good? Fair? Or, Poor?' some respondents reported they were in fair or poor health.

Key Disparity

- A greater disparity among females existed, as 25% of foreign-born females experienced fair or poor health, while only 11% of U.S.-born females reported the same.

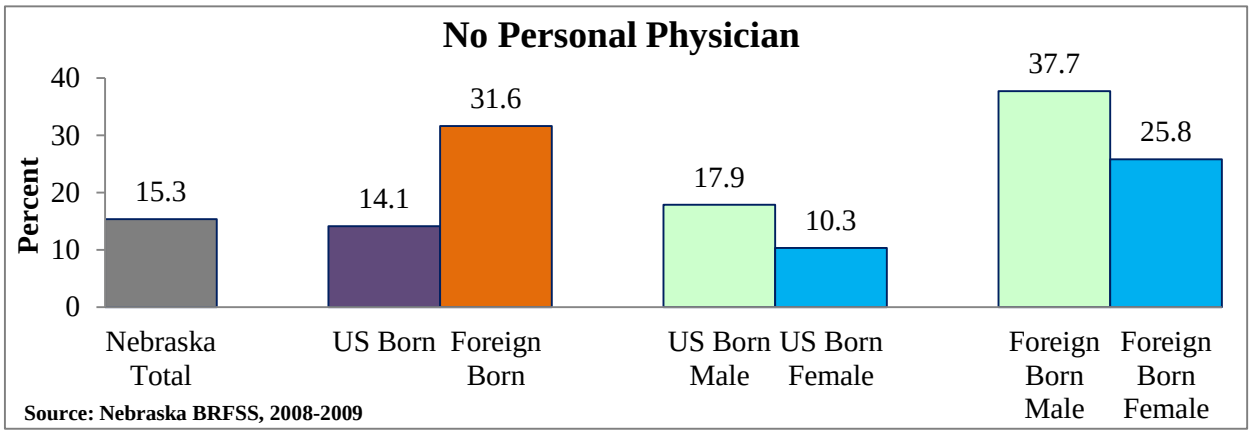


No Personal Physician

People without a personal physician are less likely to have routine checkups and more likely to have fractured, inadequate care. Correlations have been seen among those with no health insurance and those that report having no primary care provider.

Key Disparities

- The proportion of foreign-born without a personal physician (32%) was more than double that of U.S.-born (14%).
- Both foreign-born men (37.7%) and women (25.8%) were without a personal physician compared to U.S.-born men (17.9%) and women (10.3%).

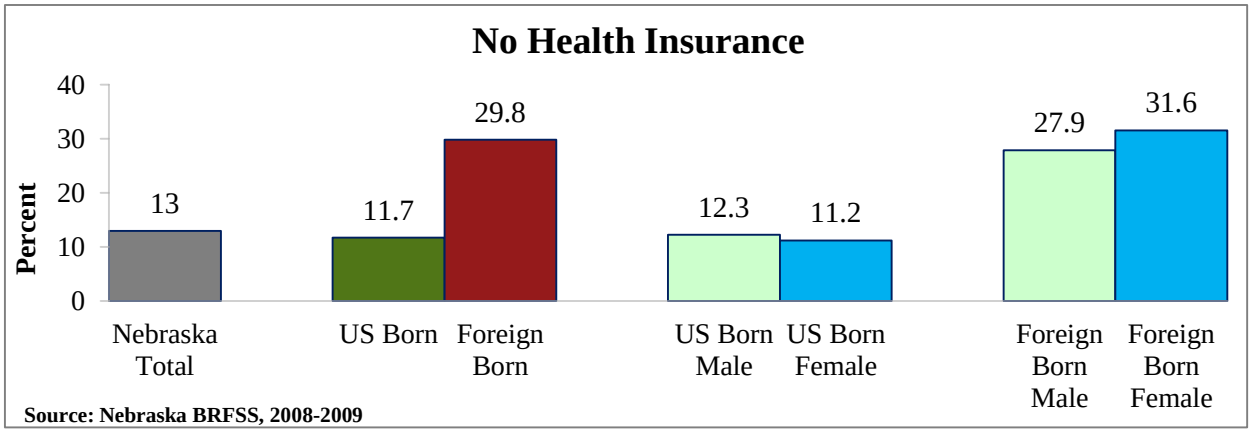


No Health Insurance

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

Key Disparities

- Overwhelmingly, a larger proportion of foreign-born residents (29.8%) did not have health insurance compared to U.S.-born residents (11.7%).
- Trends among males and females remained consistent with the overall trend of higher health insurance coverage among U.S.-born residents.

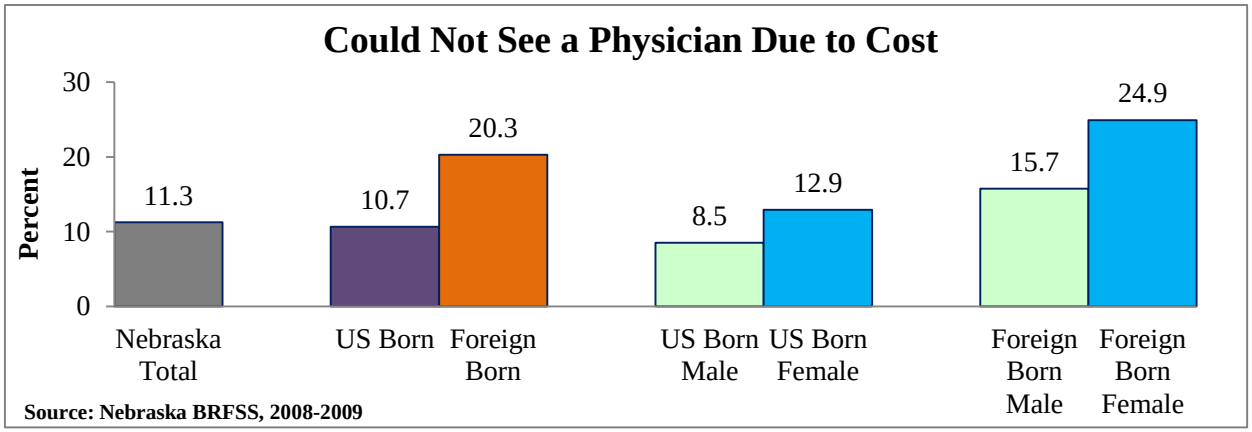


Unable to See a Physician Due to Cost

When asked, 'Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?' more of the foreign-born population answered, 'yes.'

Key Disparity

- The proportion of foreign-born that could not see a physician (20%) was almost twice as much as United States-born (11%) respondents.

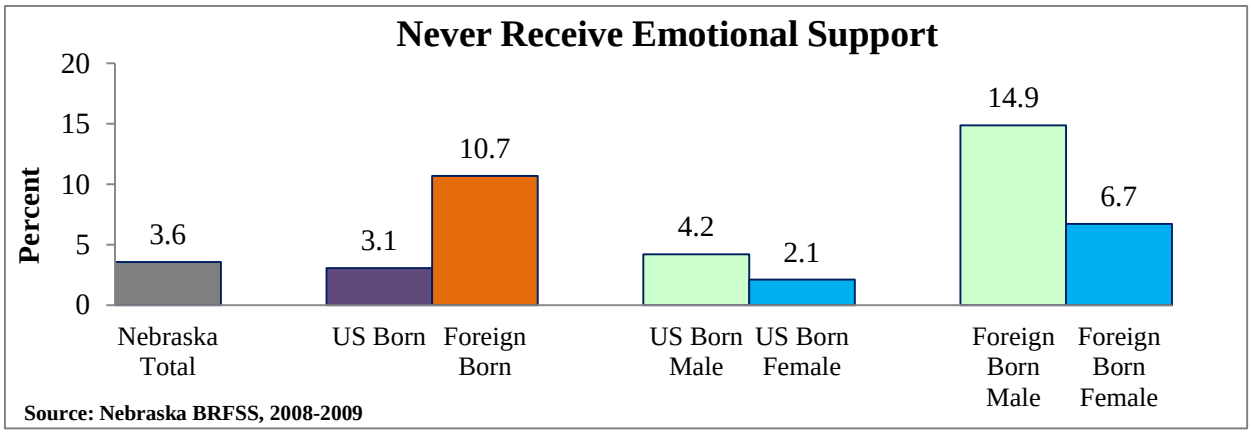


Receive Emotional Support: Never

Participants were asked to respond to the question, 'How often do you get the social and emotional support you need?' with either the response 'always' or the response 'never.' A larger proportion of the foreign-born population felt they did not receive the emotional support they needed.

Key Disparities

- The proportion of foreign-born who said they never received emotional support (11%) was greater than the United States-born (3%).
- A disparity also existed between foreign-born males (14.9%) and females (6.7%).
- Foreign-born males (14.9%) were 3.5 times as likely to never receive emotional support as U.S-born males (4.2%).

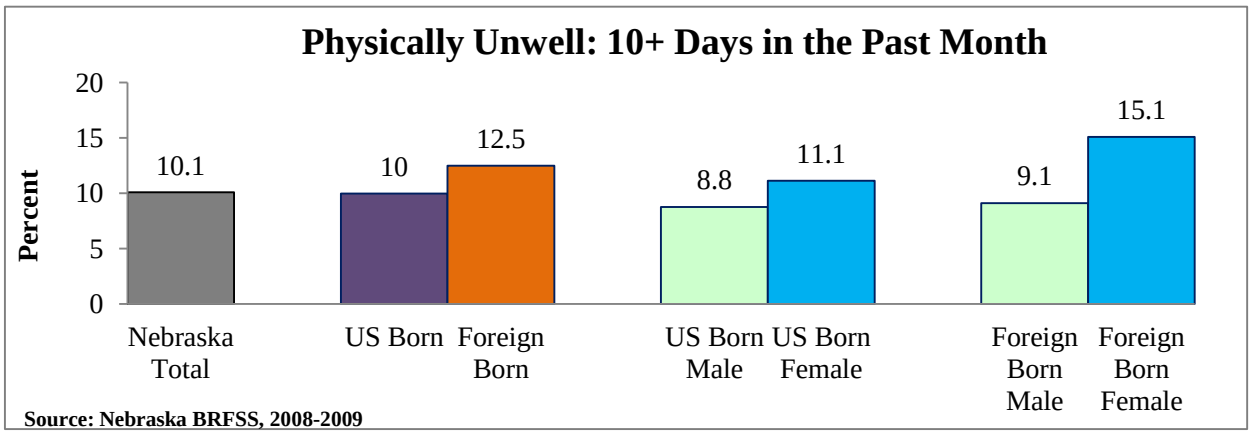


Physically Unwell

Respondents were asked, 'Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?'

Key Disparity

- The gender disparity was greater in the foreign-born population than in the U.S.-born population. In the foreign-born population, 15% of females reported not being physically well for 10 or more days in the past month compared to 9% of males, while in the U.S.-born population, 11% of females and 9% of males reported the same.

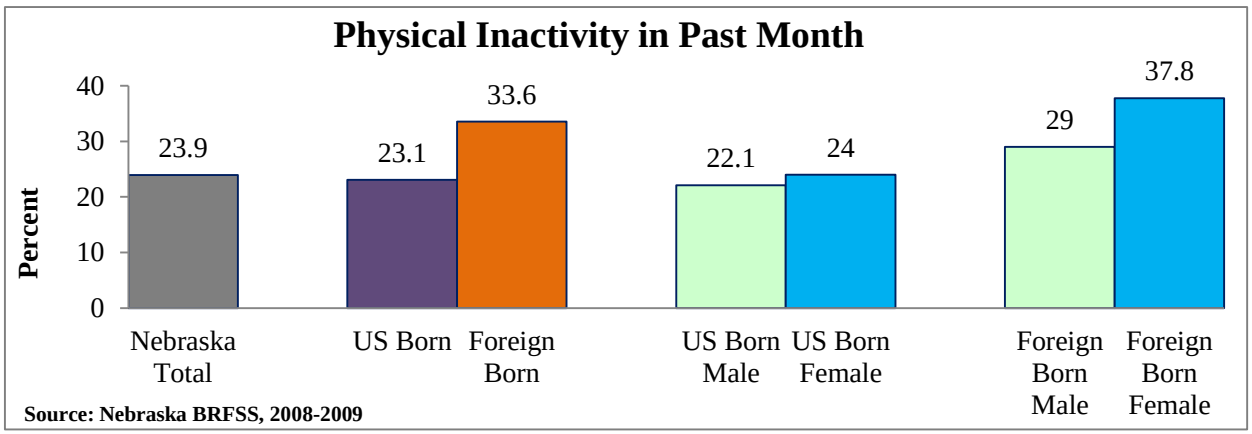


Physical Inactivity

Regular physical activity is important at all stages of life for maintaining health, enhancing quality of life, and preventing premature death. On average, physically active people outlive those who are inactive.

Key Disparities

- It was more likely for a foreign-born (34%) than a United States-born (23%) person to report physical inactivity outside of work.
- The gender disparity was smaller in the U.S.-born population than in the foreign-born population. In the U.S.-born population, 22% of males were physically inactive outside of work compared to 24% of females, while 29% of males and 38% of females in the foreign-born population reported the same.



RISK FACTORS FOR LIMITED ENGLISH SPEAKING NEBRASKANS

Individuals whose primary language is not English and who have a limited ability to read, speak, write, or understand English are considered limited English proficient, or "LEP." The Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," requires Federal agencies to examine the services they provide, identify any need for services to LEP persons, and develop and implement a system to provide those services so persons with limited English proficiency can have meaningful access to them (EOLEP, 2000).

Before Executive Order 13166 in 2000, few studies explicitly documented and assessed access to care and health status among LEP individuals. One study conducted by Kandula et al. (2004) reviewed 10 leading health indicators among immigrants in the U.S. The 10 indicators were physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunizations, and access to health care. The study found that 1) data about the health of immigrants were limited and often did not distinguish between U.S. and foreign-born, 2) differences in culture and language both inhibit providers' understanding of issues and limit immigrants' ability to take full advantage of disease prevention and health intervention services, and 3) immigrants were substantially disadvantaged for access to care.

Between 1990 and 2010, the LEP population grew by 80%.[199] Spanish remains the most prevalent language spoken by the LEP population followed by Chinese, French, Italian, and German; languages that were in the top five languages spoken in 1990 are now not even in the top 10.[200] LEP individuals self-assess their own level of English proficiency, and, there are no set definitions for the measurement of speaking English 'not very well.' In this report, LEP was defined as those who speak English "not well/not at all." Only those indicators that demonstrated the disparities faced by LEP individuals are presented.

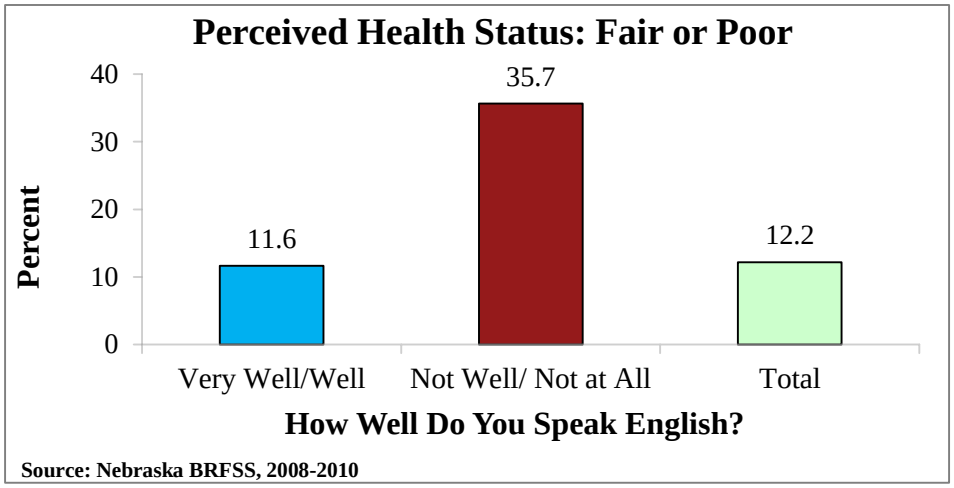
[199]Maxwell, L. (2011). Limited-English-proficient population rises 80 percent since 1990. Retrieved from http://blogs.edweek.org/edweek/learning-the-language/2011/12/limited_english_proficient_pop.html.
[200]Ibid.

Perceived Health Status

General health, as defined by the BRFSS, included respondents who indicated that their general health was fair or poor when given the following choices: excellent, very good, good, fair, or poor.

Key Disparities

- Nebraskan adults who denoted that they could speak English very well or well were generally less likely (11.6%) to report a health status as fair or poor when given the choices excellent, very good, good, fair, and poor, when compared to adults with limited English proficiency.
- For the state as a whole, 12.2% of Nebraskan adults reported a fair or poor health status.

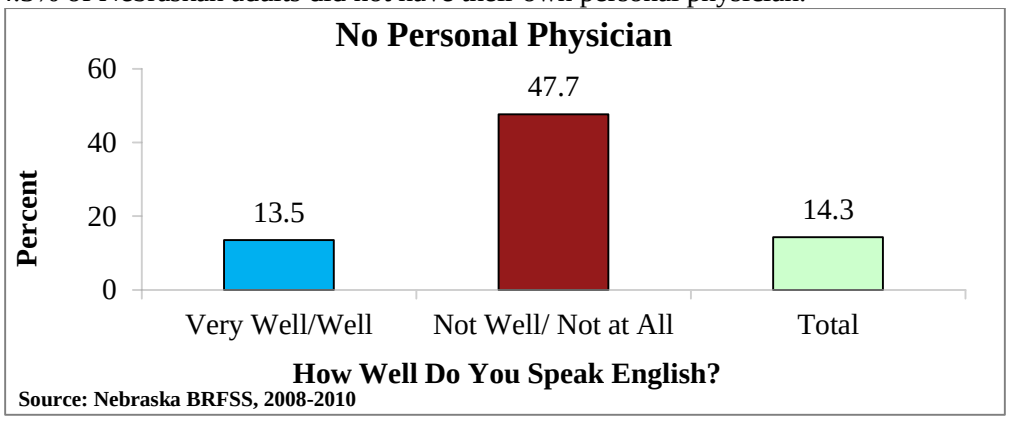


No Personal Physician

Having no personal doctor or health care provider was defined by the BRFSS as an indication by the respondent that they do not believe that they have one person they think of as their personal doctor or health care provider.

Key Disparities

- In Nebraska, adults who were English proficient were significantly more likely to have their own personal physician (13.5%), compared to those who were not English proficient (47.7%).
- Overall, 14.3% of Nebraskan adults did not have their own personal physician.

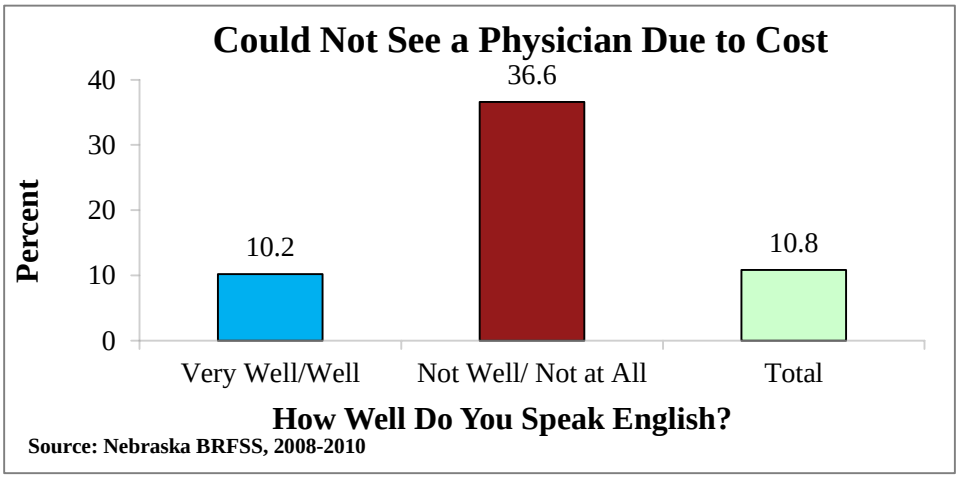


Unable to See a Physician Due to Cost

According to the BRFSS, this measure included those respondents who indicated that they could not see a physician within the past twelve months due to the cost.

Key Disparities

- Among the Nebraskan adults who indicated that they could speak English very well or well, 10.2% could not see a physician due to the cost. On the other hand, 36.6% of adults who cannot speak English well or at all could not see a physician due to the cost.

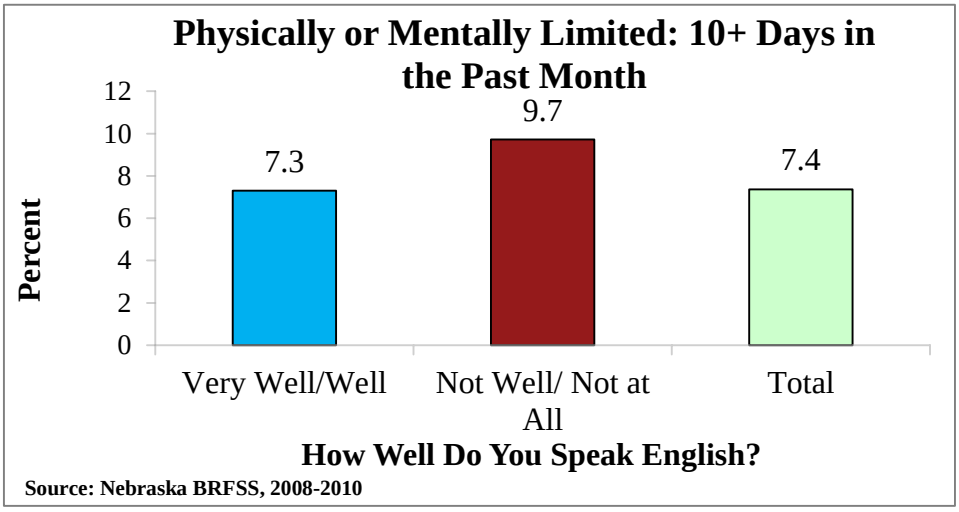


Physically or Mentally Limited

Respondents who indicated that they were not mentally well for ten or more days in the past month are represented in the chart below.

Key Disparities

- There was not a large difference in mental health, as measured by having more than ten days not mentally well in the past month, between English proficient (7.3%) and non-proficient (9.7%) Nebraskans.
- For Nebraska as a whole, 7.4% reported having more than ten days of not being mentally well in the past month.

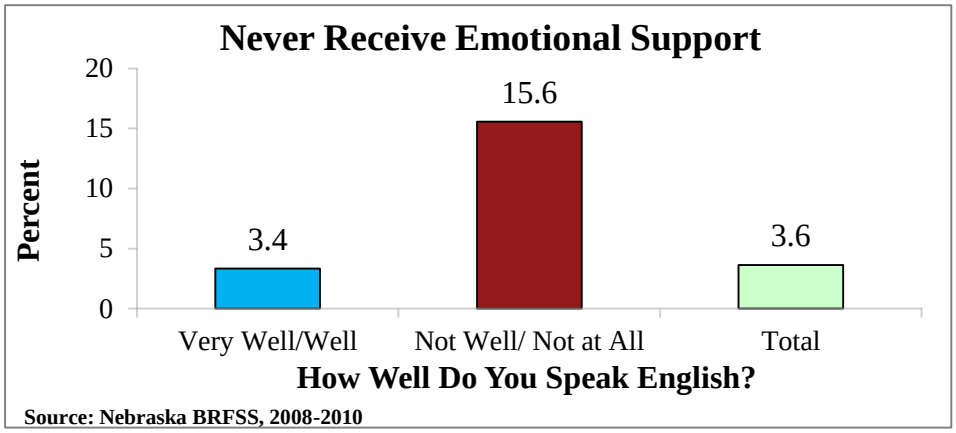


Receive Emotional Support: Never

Never receiving emotional support, as defined by the BRFSS, was a response that they never received the social and emotional support they needed when given the choices: always, usually, sometimes, rarely, or never.

Key Disparities

- For adults with limited English proficiency, 15.6% reported that they never received emotional support. This proportion was almost five times higher than that of English-proficient adults (3.4%).

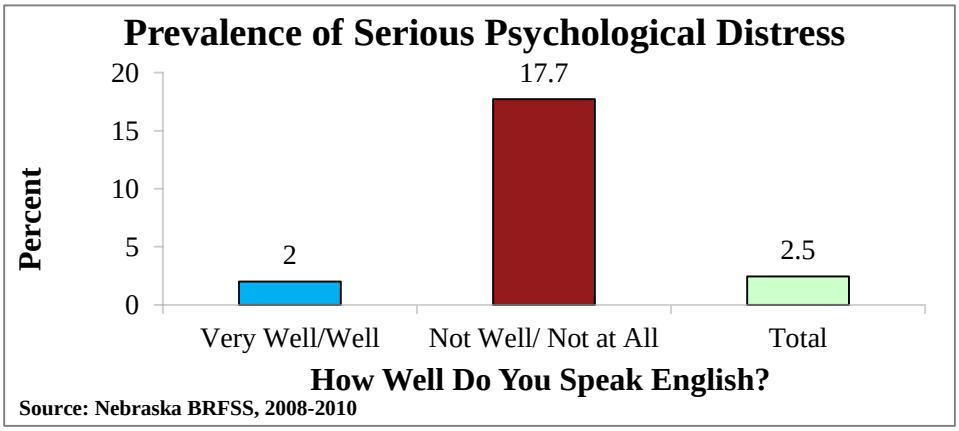


Serious Psychological Distress (SPD)

Respondents were asked a series of six questions that assessed how they had been feeling for the past thirty days. Responses were each allocated a score of 0-4 depending on severity. Scores were tallied, and respondents with a score of 13 or higher were classified as having SPD.

Key Disparities

- Almost 18% of adults in Nebraska who did not speak English well or at all were found to suffer from SPD, a higher number than adults who can speak English well or very well (2%).
- Overall, in the state of Nebraska, 2.5% of the adults were diagnosed with SPD.

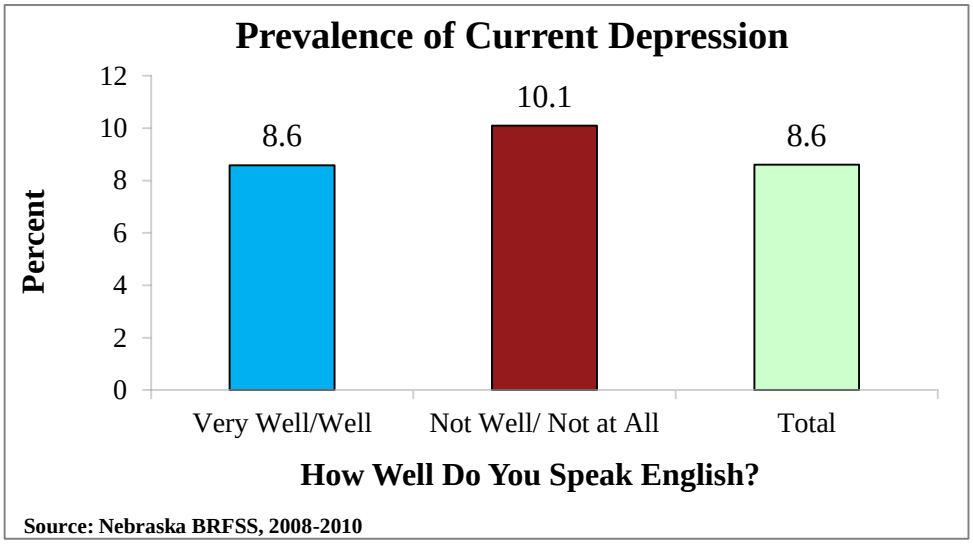


Current Depression

Respondents were asked a series of questions about their mood and asked to think about how many days they had felt that way in the past two weeks. To construct the Severity of Depression Index, the number of days that respondents reported suffering from symptoms was summed over all eight questions. An algorithm developed by the CDC was then used to reconfigure these scores to fit into the four-category scheme developed as part of the original 8-question Patient Health Questionnaire depression scale. Using this index, reconfigured scores of 10 or greater indicate depression.

Key Disparities

- Approximately 10% of non-English-proficient adults had depression.
- As a whole, 8.6% of Nebraskan adults were diagnosed with depression.

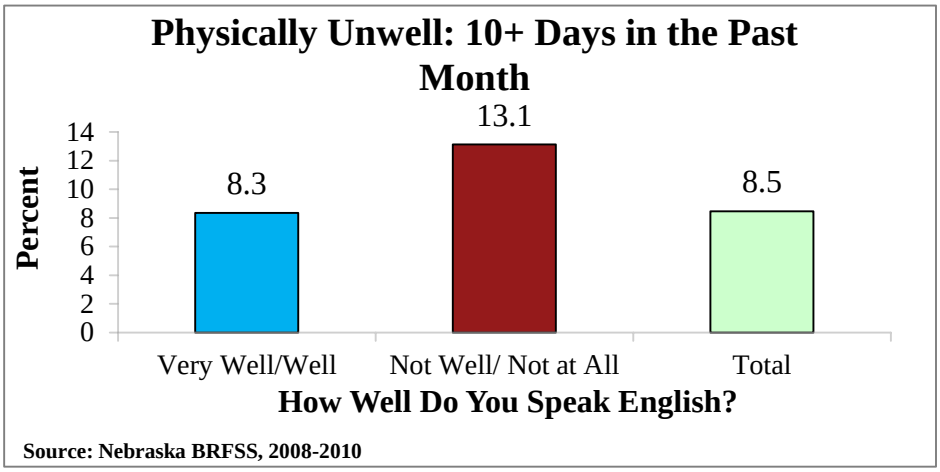


Physically Unwell

Represented in the chart below are the respondents that indicated that they were not physically well for 10 or more days in the past month.

Key Disparities

- It appears that adults in Nebraska with limited English proficiency were more likely (13.1%) to have more than 10 days physically not well in the past month, as compared to those that were English proficient (8.3%).
- Overall, 8.5% of adults in Nebraska reported having more than 10 days in which they were not physically well in a month.

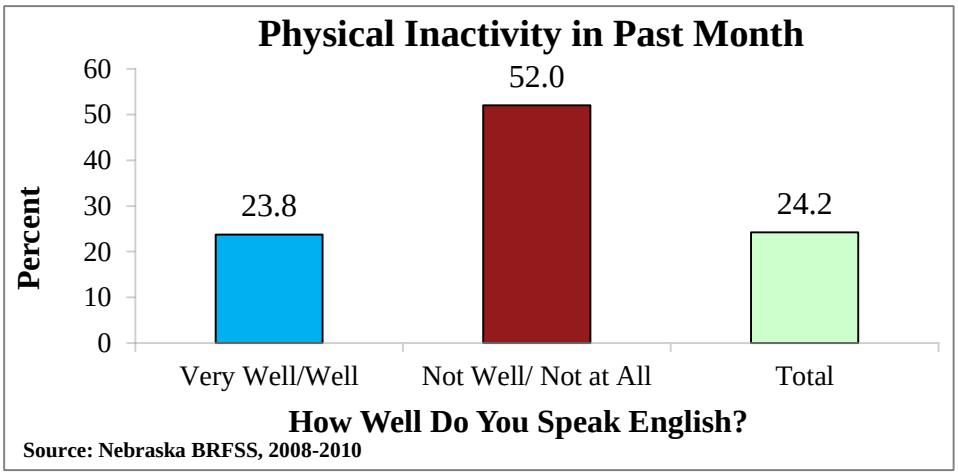


Physical Inactivity

Physical inactivity was defined by the BRFSS as no participation in any physical activities outside of a regular job. These physical activities include, but are not limited to running, golfing, gardening, or walking.

Key Disparities

- Adults in Nebraska who indicated they did not speak English well or at all were much more likely (52%) to be physically inactive, than those adults who can speak English very well or well (23.8%).
- The total prevalence of physical inactivity was found to be 24.2% of Nebraska adults.

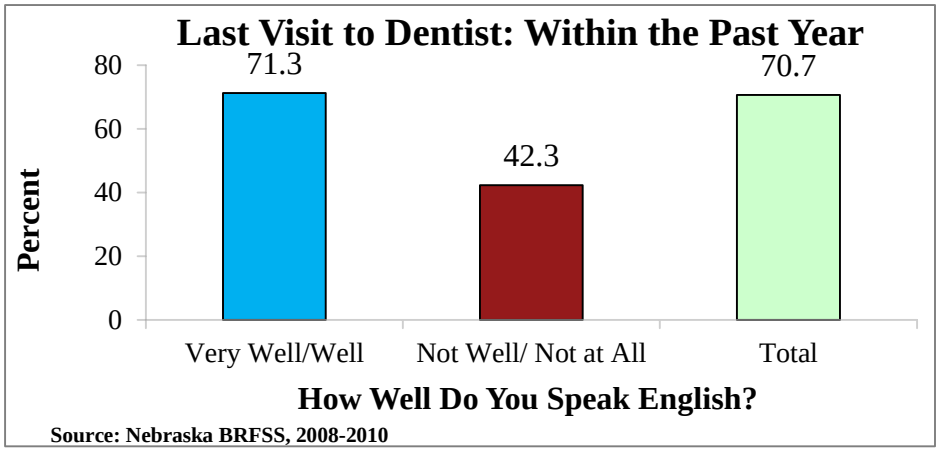


Visits to the Dentist

Having visited the dentist in the past 12 months was defined by the BRFSS by the indication of having visited a dentist any time within the past 12 months for any reason, including visits to dental specialists, such as orthodontists.

Key Disparities

- Surveyed Nebraska adults who identified as proficient English speakers were more likely (71.3%) to have visited the dentist in the past year, compared to adults identifying as non-proficient English speakers (42.3%).
- Of all Nebraska adults surveyed, 70.7% had visited the dentist in the past year.

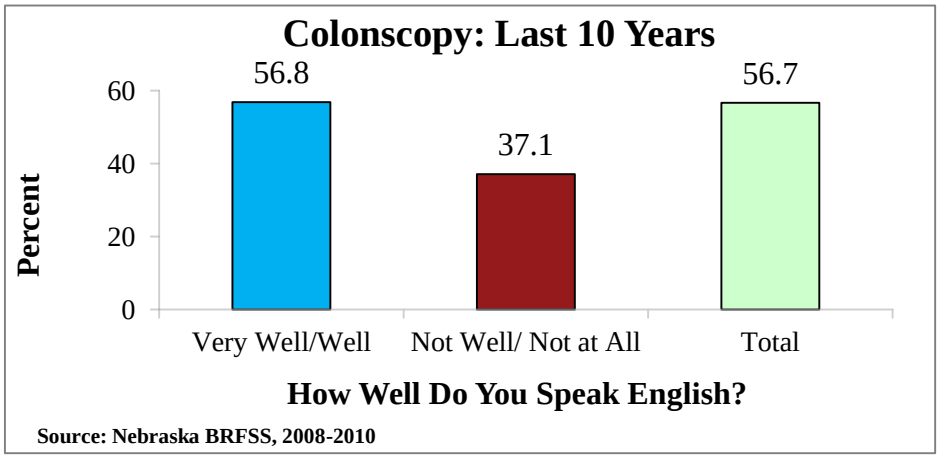


Colonoscopy: Last 10 Years

Having a colonoscopy in past ten years was defined by BRFSS as having had a colonoscopy at least once within the past 10 years, which is one of the recommended screening methods for colorectal cancer.

Key Disparities

- As compared to Nebraska adults who could speak English very well or well (56.8%), adults who could not speak English well or at all were significantly less likely (37.1%) to have had their last sigmoidoscopy/colonoscopy in the past 10 years.
- In Nebraska, 56.7% of all adults had their last sigmoidoscopy/colonoscopy within the past 10 years.

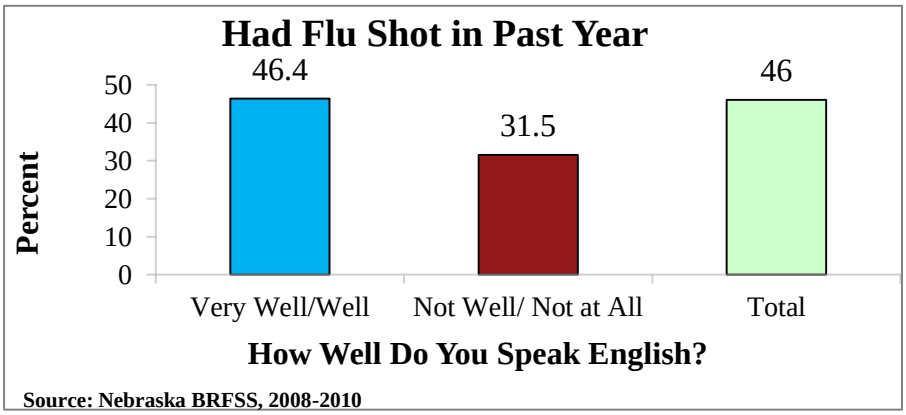


Flu Shot

Respondents who indicated they had received a flu shot in the past year when given the description, "A flu shot is an influenza vaccine injected into your arm" were included in the chart below.

Key Disparities

- In Nebraska, adults who identified with being non-proficient English speakers were significantly less likely (31.5%) to have had a flu shot in the past year, when compared to proficient English speaking adults (46.4%).
- For the state of Nebraska, 46% of adults reported that they had received a flu shot in the past year.



RISK FACTORS FOR DISABLED NEBRASKANS

A disability is any impairment, activity limitation, or participation restriction. An impairment can include an issue in bodily function or structure, while an activity limitation could be a difficulty encountered during task-execution or action. An individual could struggle with participation restriction if they struggle with involvement in typical life situations. Those with disabilities require interventions to remove environmental and social barriers.[201]

Approximately 15% of the world's population is living with a disability and 2-4% experience significant difficulties.[202] A disability is not just a health problem, but also a complex phenomenon that illustrates an interaction between someone's body and features of society.[203]

Those who are disabled require the same health screenings and have the same needs as those who are not disabled. People who are living with disabilities face other external struggles like poverty and social exclusion; they are also susceptible to secondary conditions.[204] In the United States, health disparities can be seen between those who are disabled and not disabled. Moreover, 27% of those who are disabled see cost as a barrier to obtaining care, compared to 12.5% of people who are not disabled.[205] In Nebraska, we continually see those who are living with a disability struggling with obesity and high blood pressure more than those who are not disabled. Individuals with disabilities may not reach physical activity recommendations, and are more often diagnosed with chronic diseases.

For the purposes of this report, only those indicators that demonstrated the disparities faced by individuals with a disability are presented. "Disability" is defined as either limited activity due to physical, mental, or emotional problems, *or* the requirement of special equipment such as canes, wheelchairs, or special beds or telephones.

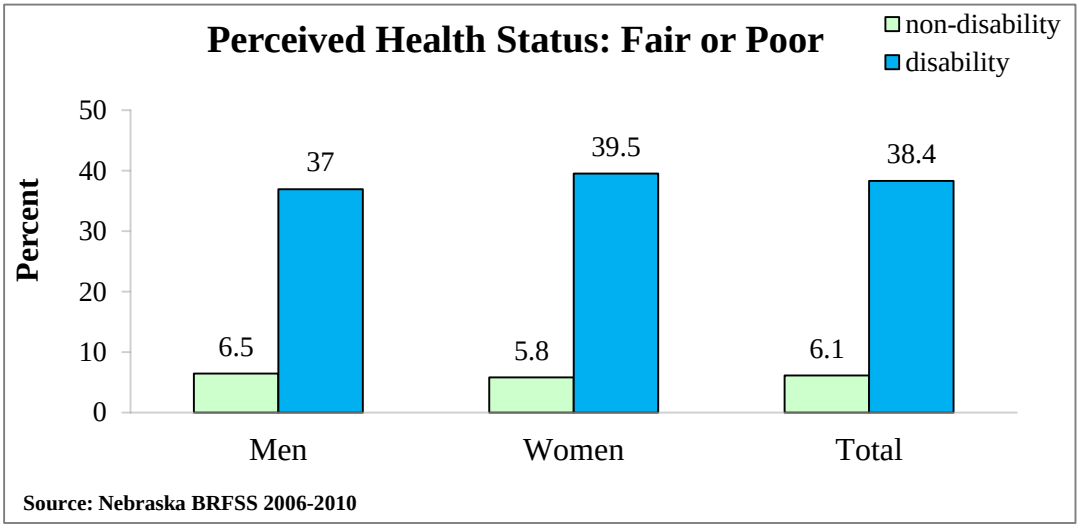
[201]World Health Organization. (2013). Disabilities. Retrieved from http://www.who.int/topics/disabilities/en/
[202]World Health Organization. (2013). World report on disabilities. Retrieved from http://www.who.int/disabilities/world_report/2011/report/en/index.html.
[203]Ibid.
[204]Ibid.
[205]Centers for Disease Control and Prevention. (2012). Differences in health status among people with disabilities compared to people without disabilities. Retrieved from http://www.cdc.gov/ncbddd/disabilityandhealth/healthstatus.html.

Perceived Health Status

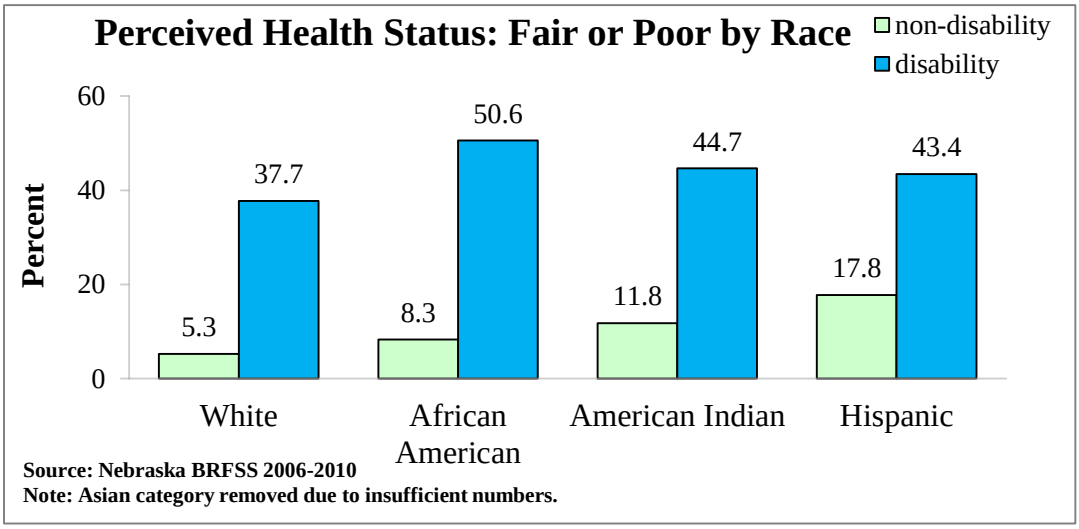
A person's perceived health status has been reported to be the most important indicator of morbidity and mortality. When asked 'Would you say that in general your health is excellent? Very good? Good? Fair? Or Poor?' some respondents reported they were in fair or poor health. Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Approximately 38% of the disabled population rated their general health as fair or poor, compared to 6.1% of the non-disabled population.
- Almost seven times the amount of disabled women (39.5%) rated their health status as fair or poor compared to non-disabled women (5.8%). Similar patterns exist for men.
- Between 40 and 50% of African American, American Indian, and Hispanic disabled Nebraskans reported fair or poor health.



Source: Nebraska BRFSS 2006-2010



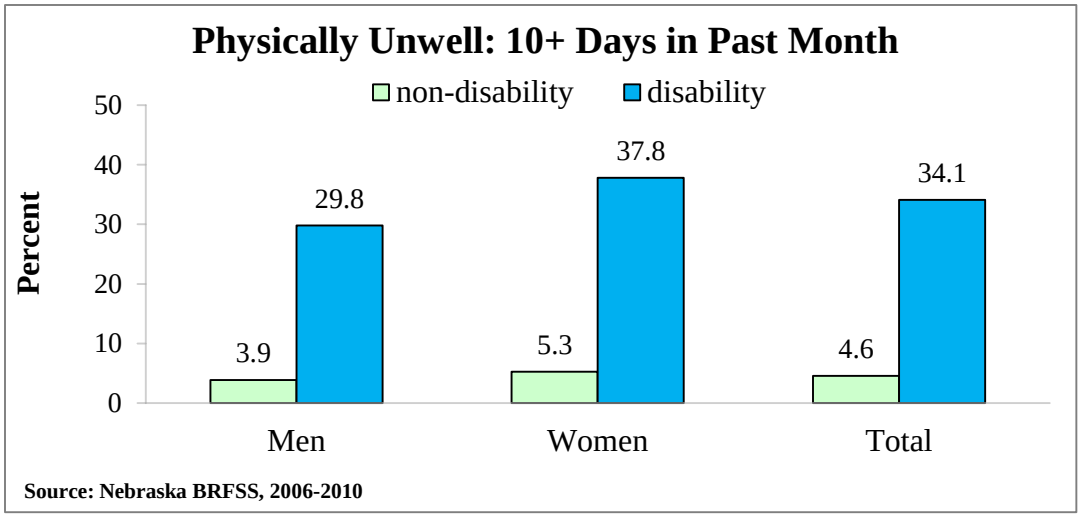
Source: Nebraska BRFSS 2006-2010
Note: Asian category removed due to insufficient numbers.

Physically Unwell

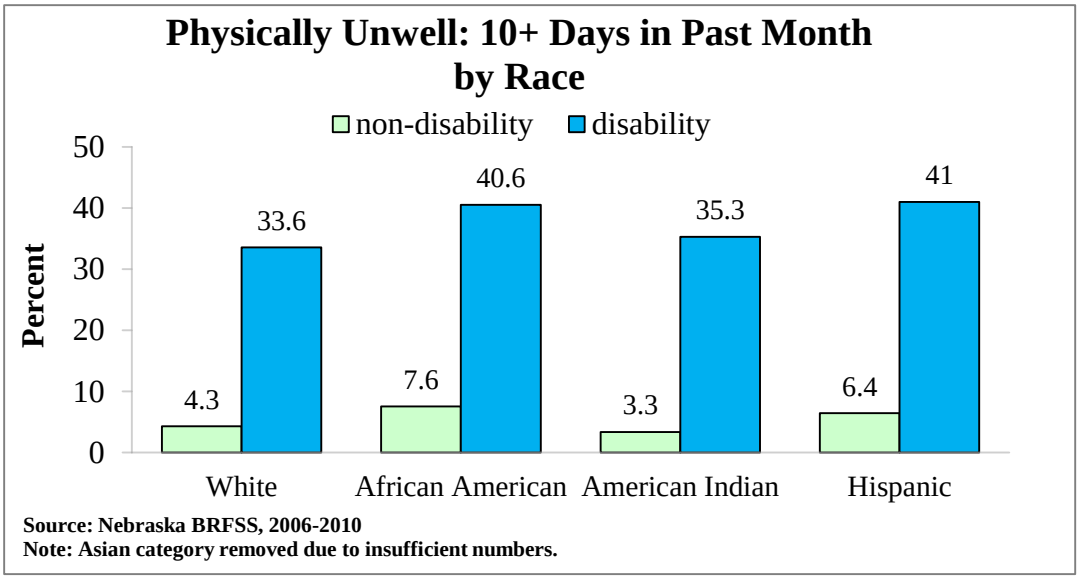
Respondents were asked, 'Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?' Those represented in the charts below answered 10 or more days. Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Thirty-four percent of the disabled population reported being physically unwell 10 or more days in the last month, compared to 4.6% of the non-disabled population.
- Seven times the number of disabled women reported 10 or more days of being physically unwell than non-disabled women (5.3%).
- Almost 30% of disabled men reported 10 or more days of being physically unwell in the last month, 7.6 times the amount of non-disabled men (3.9%).
- Between a 29% and 35% difference existed among racial groups according to ability status, with the greatest difference among Hispanics.



Source: Nebraska BRFSS, 2006-2010



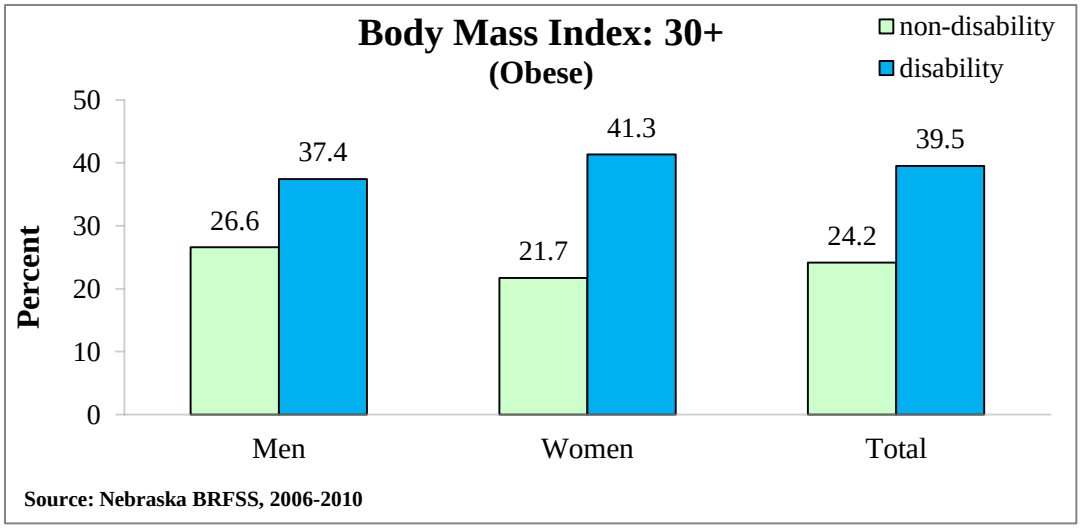
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Obese: BMI 30+

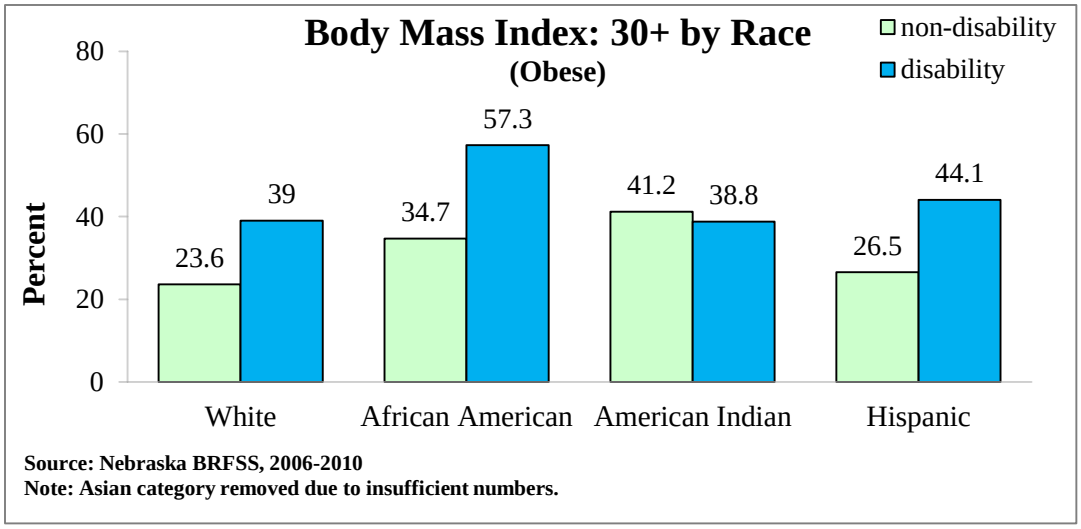
Body Mass Index, or BMI, is a wellness score based on an individual's height and weight. BMI is a body fat measure that applies to adult men and women. BMI is used as a screening tool to initiate the identification of possible weight problems; BMI is not a diagnostic tool. Those with a BMI of 30 and over were considered obese. Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Almost 40% of the disabled population was obese, compared to 24% of the non-disabled population.
- Twice the number of disabled women (41.3%) were obese than non-disabled women (21.7%).
- Approximately 37% of disabled men were obese, almost 1.5 times the number of non-disabled men that were obese (26.6%).
- Among all races, the proportions of obesity were higher in the disabled populations, except among American Indians.
- Almost 60% of disabled African Americans were obese, compared to 39% of disabled Whites.



Source: Nebraska BRFSS, 2006-2010



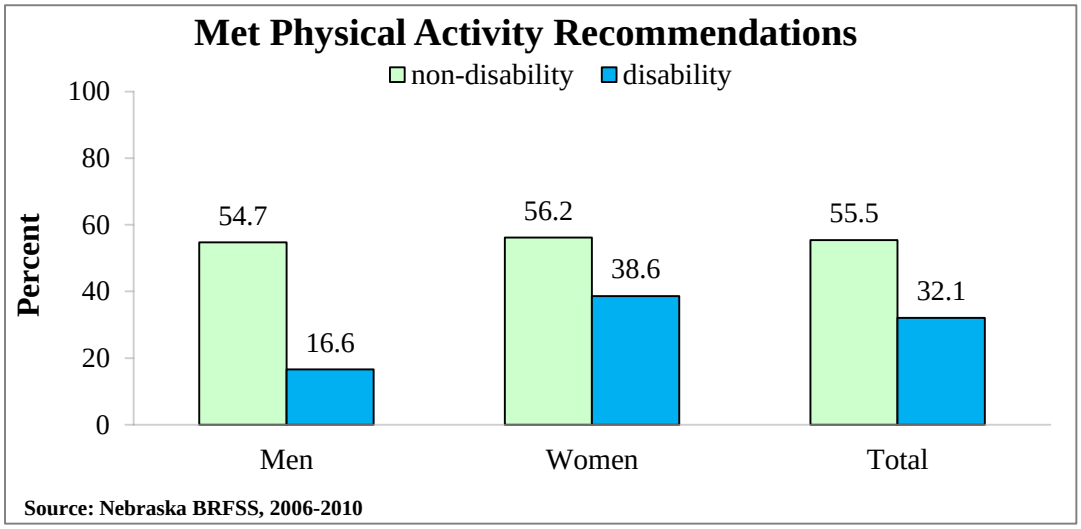
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Physical Activity

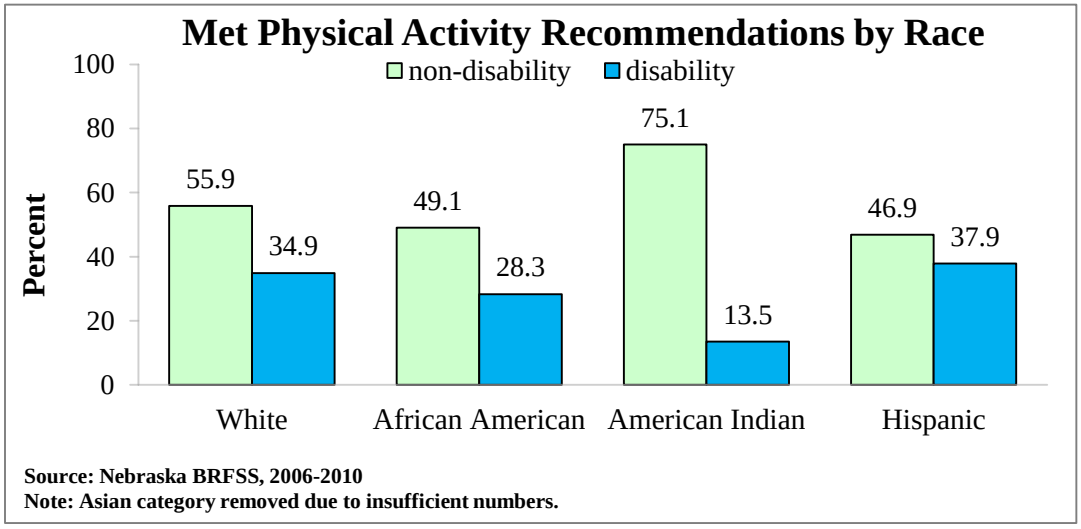
Respondents were asked, 'How many minutes each working day do you spend doing the types of activities described as light, moderate, or vigorous?' Respondents were then read what "vigorous" and "moderate" activities were like. Respondents who met recommended (moderate and/or vigorous) physical activity got 30 or more minutes per day of moderate physical activity for five or more days per week and/or 20 or more minutes per day of vigorous physical activity on three or more days per week. Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Thirty-two percent of the disabled population met daily physical activity requirements, compared to 55.5% of the non-disabled population.
- Nearly 17% of disabled men met physical activity recommendations, 3.3 times less than non-disabled men (54.7%).
- Seventy-five percent of non-disabled American Indians met physical activity recommendations, compared to 13.5% of disabled American Indians – the largest difference among all racial and ethnic groups.



Source: Nebraska BRFSS, 2006-2010



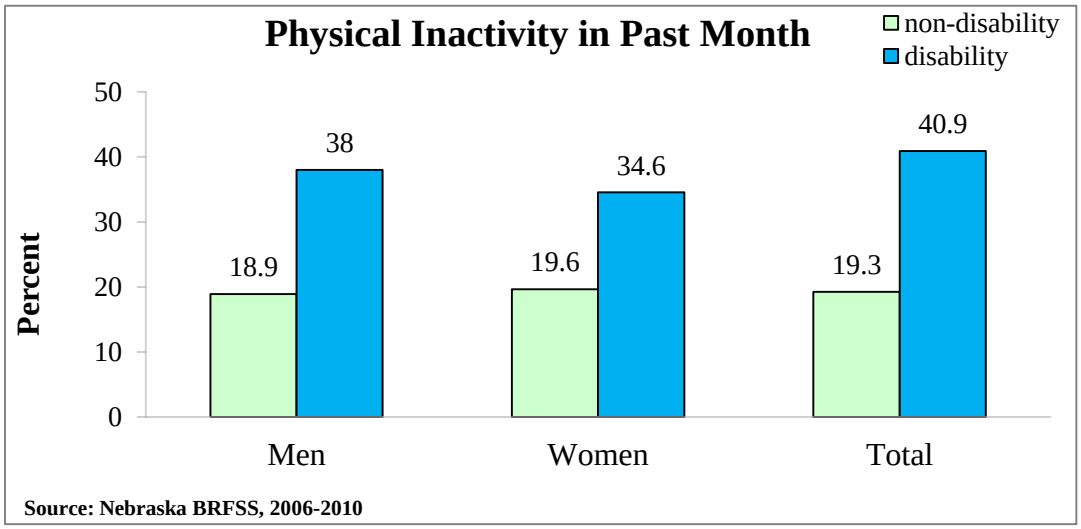
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Physical Inactivity

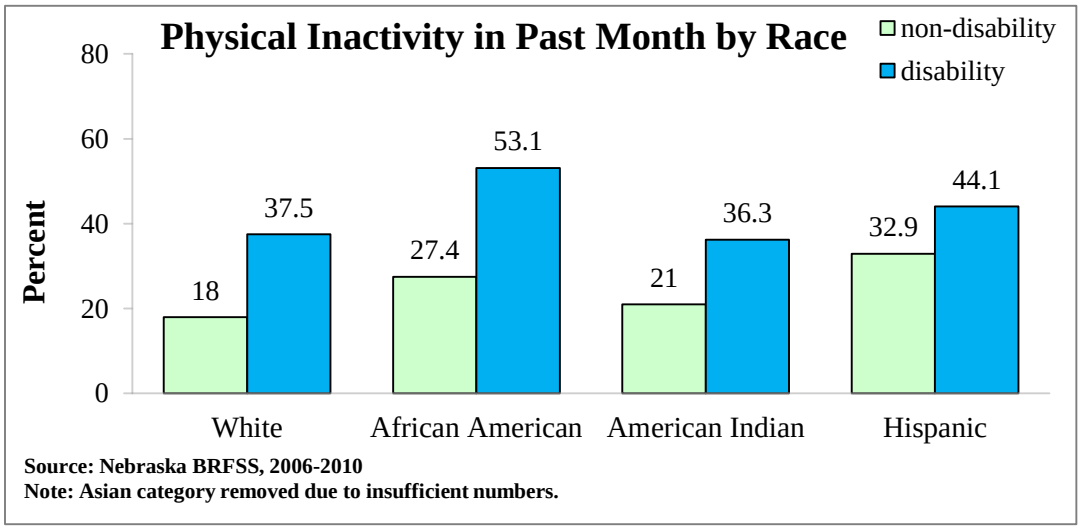
For this indicator respondents were asked, 'During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Nearly 41% of the disabled population did not exercise outside of work, compared to 19% of the non-disabled population.
- Approximately 1.8 times the number of disabled women (34.6%) did not exercise outside of work than non-disabled women (19.6%).
- Thirty-eight percent of disabled men did not exercise outside of work, twice the number of non-disabled men (18.9%).
- Approximately 53% of disabled African Americans do not exercise outside of work compared to 37.5% of Whites.



Source: Nebraska BRFSS, 2006-2010



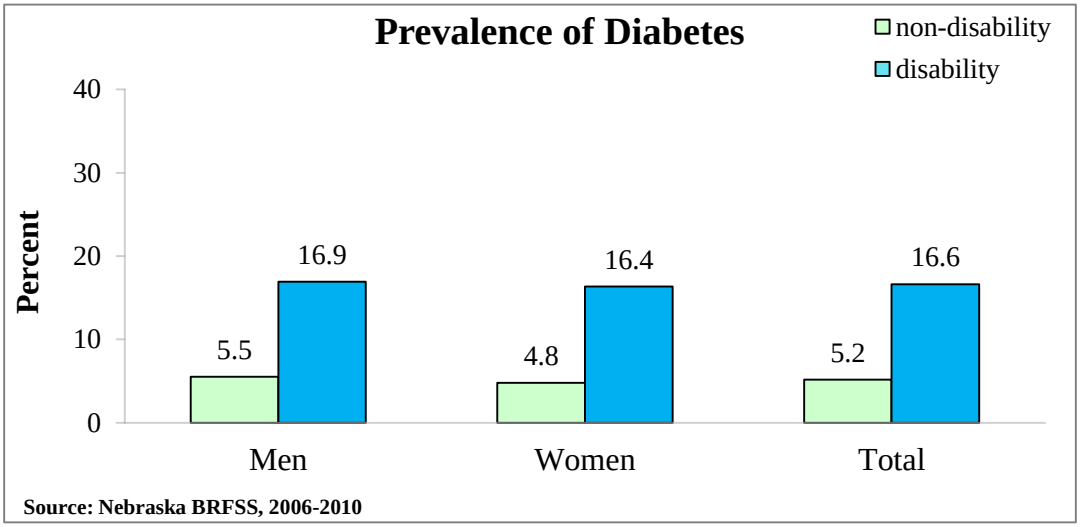
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Diabetes

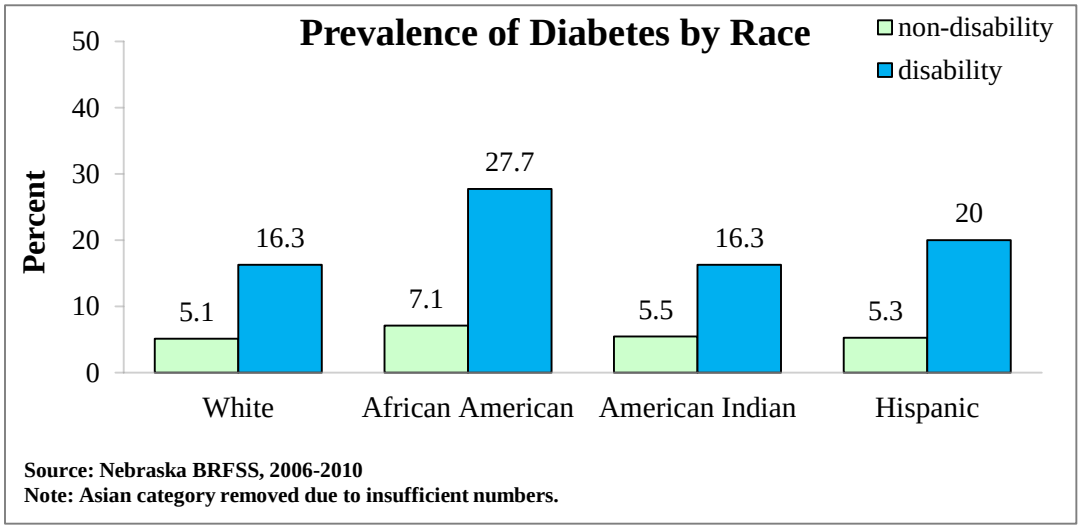
Respondents were asked, 'Have you ever been told by a doctor that you have diabetes? (Females diagnosed only while pregnant were excluded.)'

Key Disparities

- Doctors have told 17% of the disabled population that they had diabetes, compared to only 5.2% of those who were not disabled.
- Disabled women (16.4%) saw almost 3.5 times the percentage of people told they had diabetes by a doctor than non-disabled women (4.8%).
- Almost 17% of disabled men were diagnosed with diabetes, approximately three times more than non-disabled men (5.5%).
- Among those that were disabled, African Americans reported the highest prevalence of diabetes when compared to all other groups.



Source: Nebraska BRFSS, 2006-2010



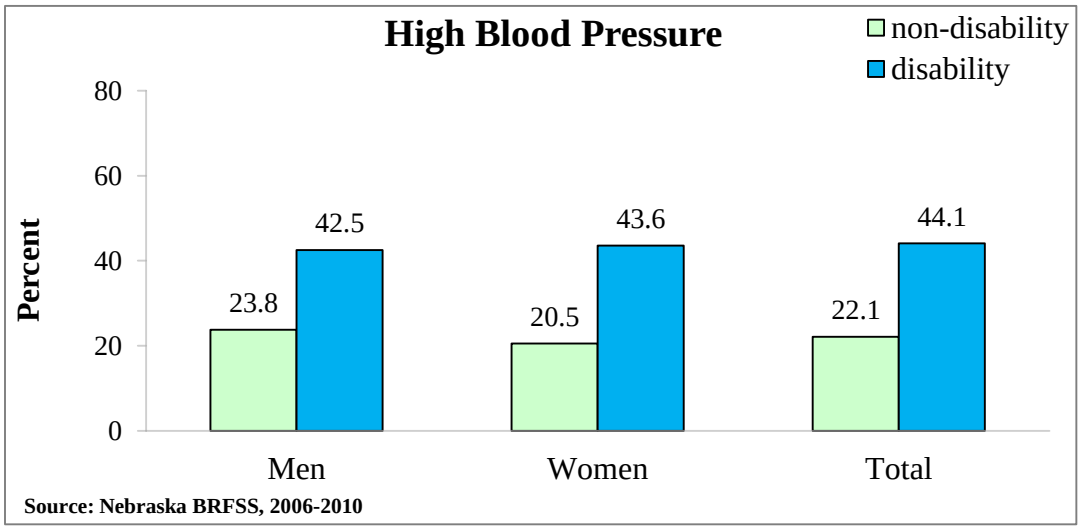
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Blood Pressure: High

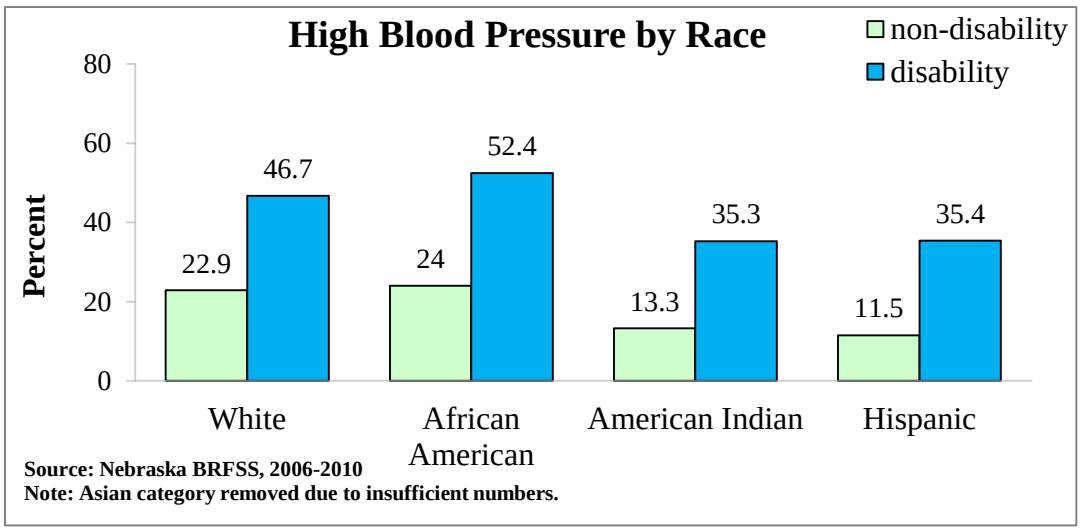
This measure was evaluated by asking, 'Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Approximately 44% of the disabled population had high blood pressure, compared to 22% of those who were not disabled.
- Disabled women (43.6%) saw more than twice the number of people ever being told they had high blood pressure than non-disabled women (20.5%).
- Approximately 42% of disabled men had been told they had high blood pressure, almost twice as many as non-disabled men (23.8%).
- Disabled American Indian and Hispanic respondents reported similar proportions of high blood pressure (around 35%), while African Americans experienced a higher prevalence of high blood pressure (52%).



Source: Nebraska BRFSS, 2006-2010



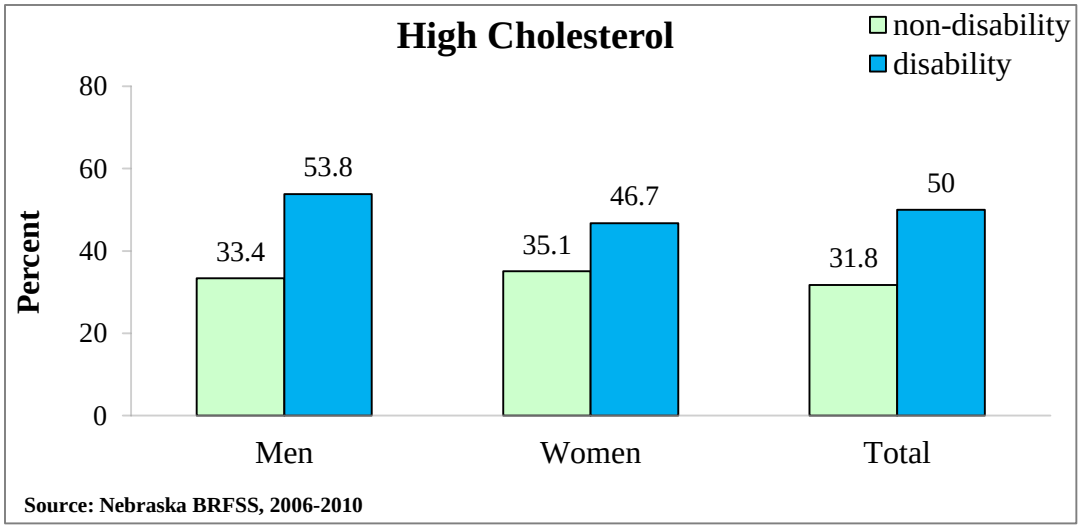
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Cholesterol: High

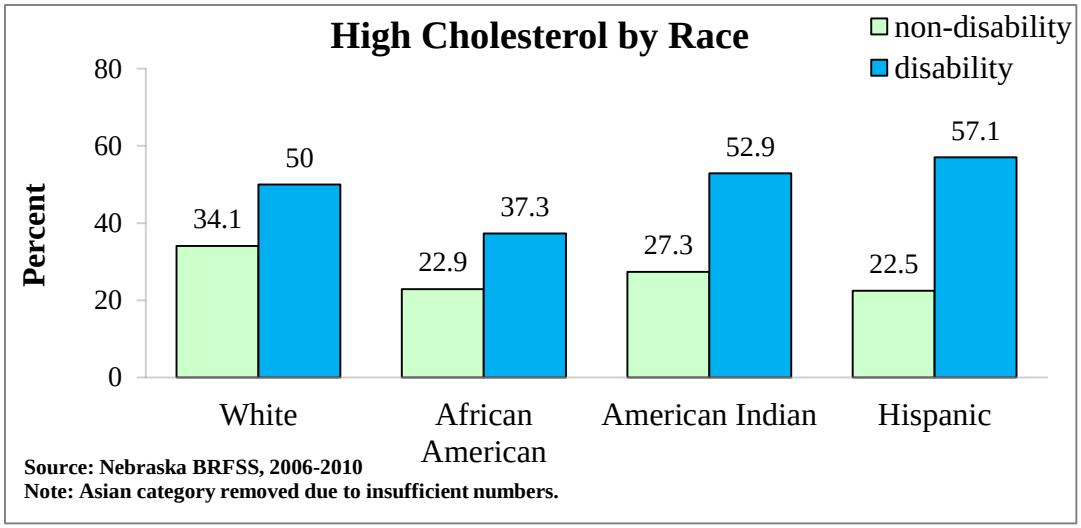
This measure was evaluated by asking, 'Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Half the disabled population were told they had high cholesterol, compared to approximately 32% of the non-disabled population.
- Nearly 1.4 times the amount of disabled women reported being told they had high cholesterol than non-disabled women (46.7%).
- Almost 54% of disabled men had been told they had high cholesterol, 1.6 times the number of non-disabled men (33.4%).
- Almost 60% of disabled Hispanic Nebraskans had been told they had high cholesterol, compared to 23% of non-disabled Hispanic Nebraskans.
- Hispanics (57.1%) and American Indians (52.9%) had the highest proportions of individuals who had been told they had high cholesterol, compared to other groups.



Source: Nebraska BRFSS, 2006-2010



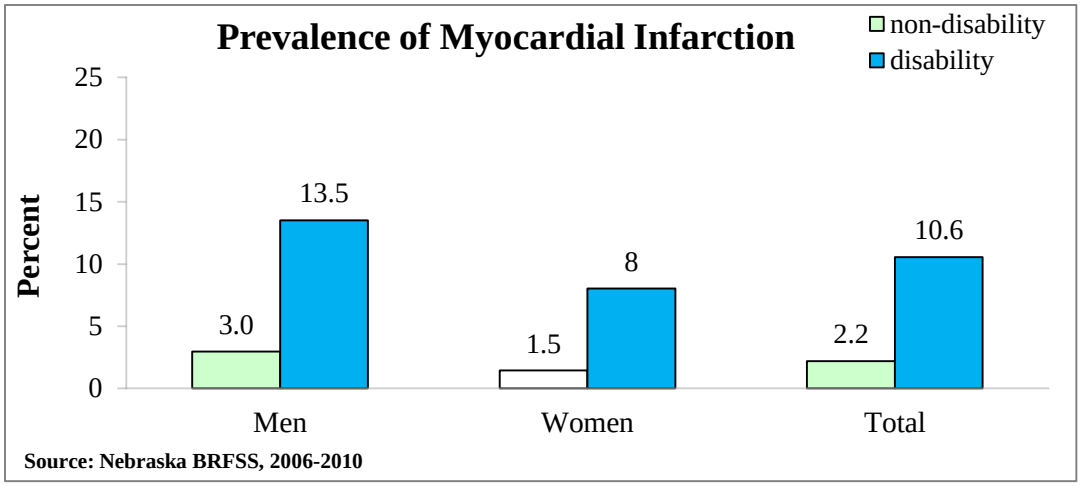
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Myocardial Infarction

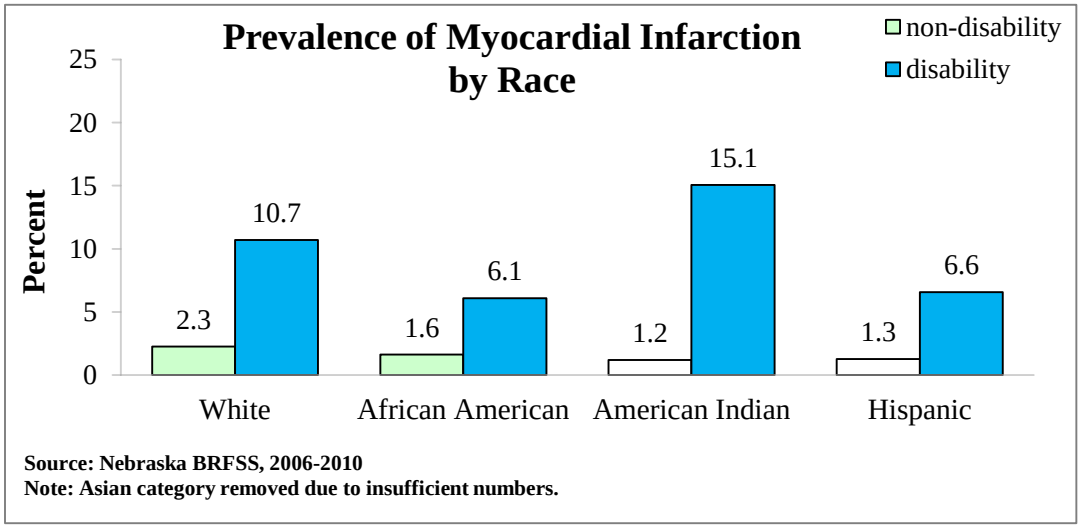
Respondents were asked, 'Has a doctor, nurse, or other health professional ever told you that you had any of the following: A heart attack, also called a myocardial infarction? Angina or coronary heart disease? A stroke?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Almost 11% of the disabled population had an MI, compared to 2% of the non-disabled population.
- More than five times the proportion of disabled women (8%) had an MI than non-disabled women (1.5%).
- Approximately 13% of disabled men reported having a heart attack, 4.5 times the number of non-disabled men (3%).
- Fifteen percent of disabled American Indians had a heart attack, compared to 1.2% of non-disabled American Indians.



Source: Nebraska BRFSS, 2006-2010



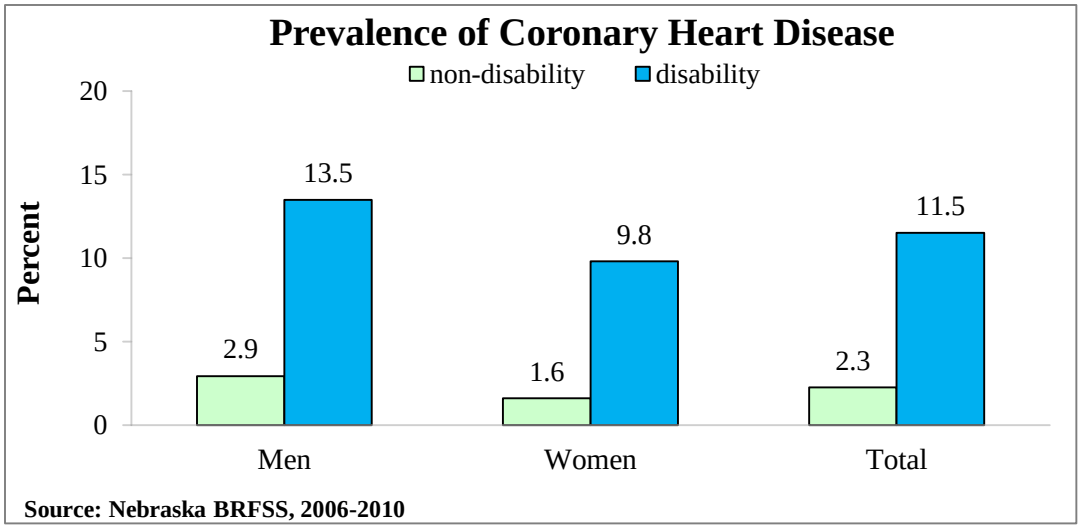
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Coronary Heart Disease

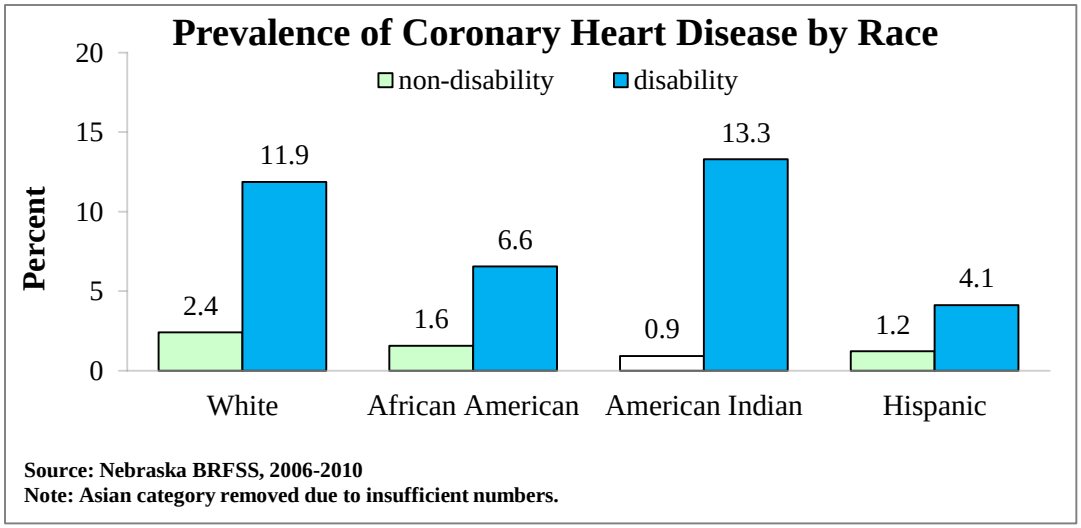
Respondents were asked, 'Has a doctor, nurse, or other health professional ever told you that you had any of the following: A heart attack, also called a myocardial infarction? Angina or coronary heart disease? A stroke?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Eleven and one half percent of the disabled population had been diagnosed with heart disease, compared to only 2.3% of the non-disabled population.
- Six times the percentage of disabled women (9.8%) were diagnosed with heart disease as non-disabled women (1.6%).
- Almost 14% of disabled men had been diagnosed with heart disease, more than 4.5 times the percentage of non-disabled men (2.9%).
- Approximately 13% of disabled American Indians had been diagnosed with CHD, compared to less than 1.0% of non-disabled American Indians.



Source: Nebraska BRFSS, 2006-2010



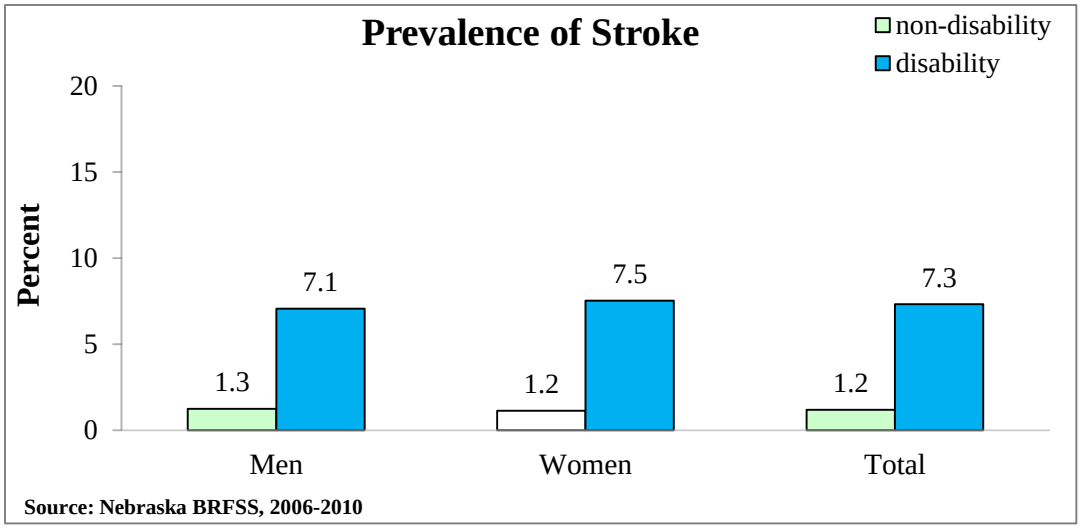
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Stroke

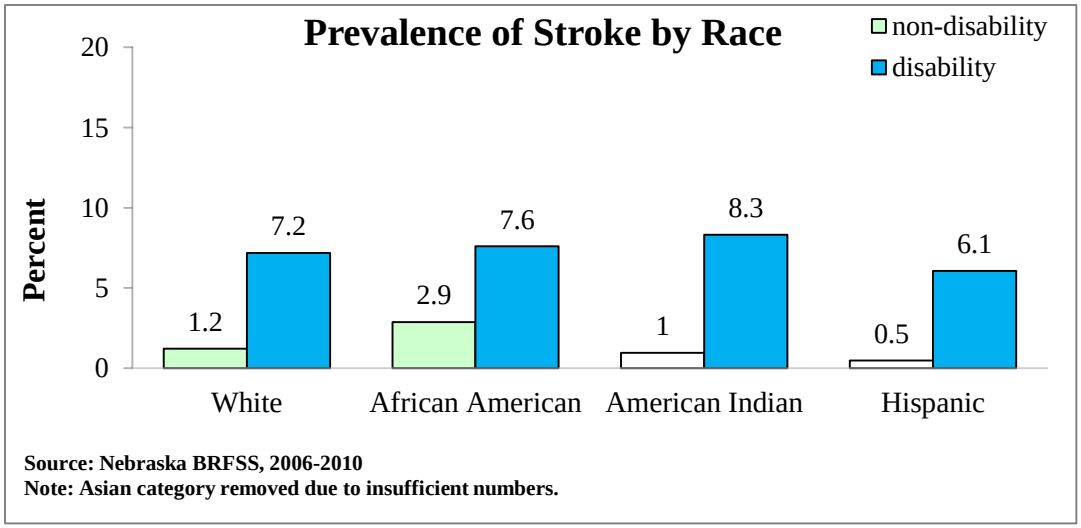
Respondents were asked, 'Has a doctor, nurse, or other health professional ever told you that you had any of the following: A heart attack, also called a myocardial infarction? Angina or coronary heart disease? A stroke?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Approximately 7% of the disabled population had a stroke, compared to 1.2% of those who were not disabled.
- More than six times as many disabled women (7.5%) had a stroke than non-disabled women (1.2%).
- Seven percent of disabled men had a stroke, more than five times the amount of non-disabled men (1.3%).
- Approximately 8% of disabled American Indians had a stroke, compared to 1.0% of non-disabled American Indians.



Source: Nebraska BRFSS, 2006-2010



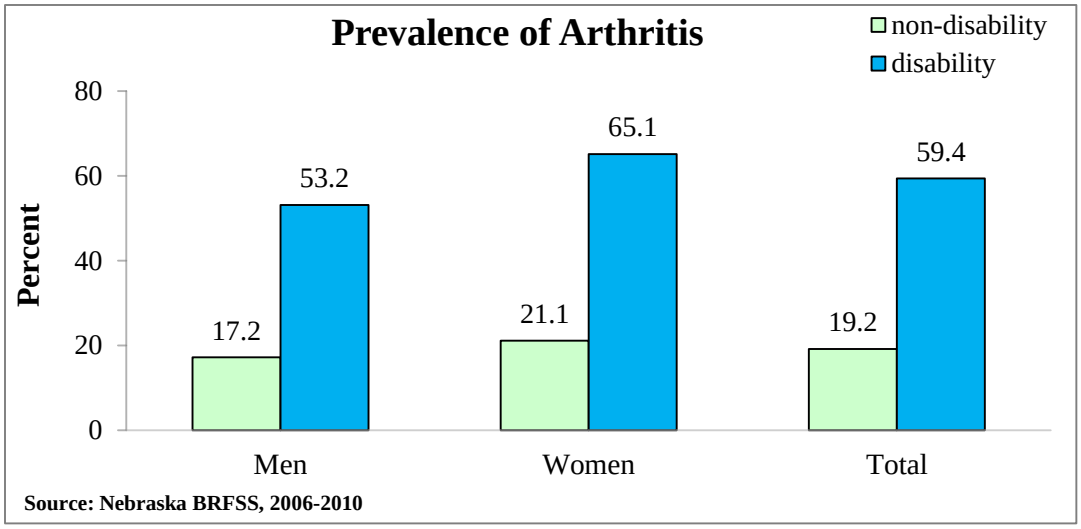
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Arthritis

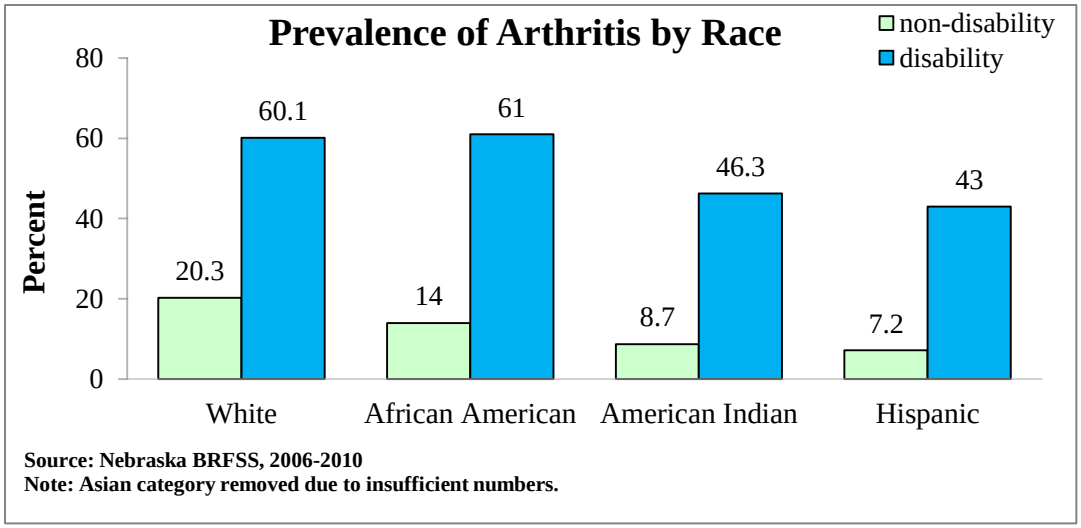
Those illustrated in the chart below answered, "yes" to, 'Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Approximately 59% of the disabled population had been diagnosed with arthritis, compared to 19.2% of the non-disabled population.
- Three times the percentage of disabled women reported being diagnosed with arthritis than non-disabled women (21.1%).
- Fifty-three percent of disabled men had been told that they have arthritis, three times the percentage of non-disabled men (17.2%).
- Sixty-one percent of disabled African Americans reported being diagnosed with arthritis, compared to 14% of non-disabled African Americans.



Source: Nebraska BRFSS, 2006-2010



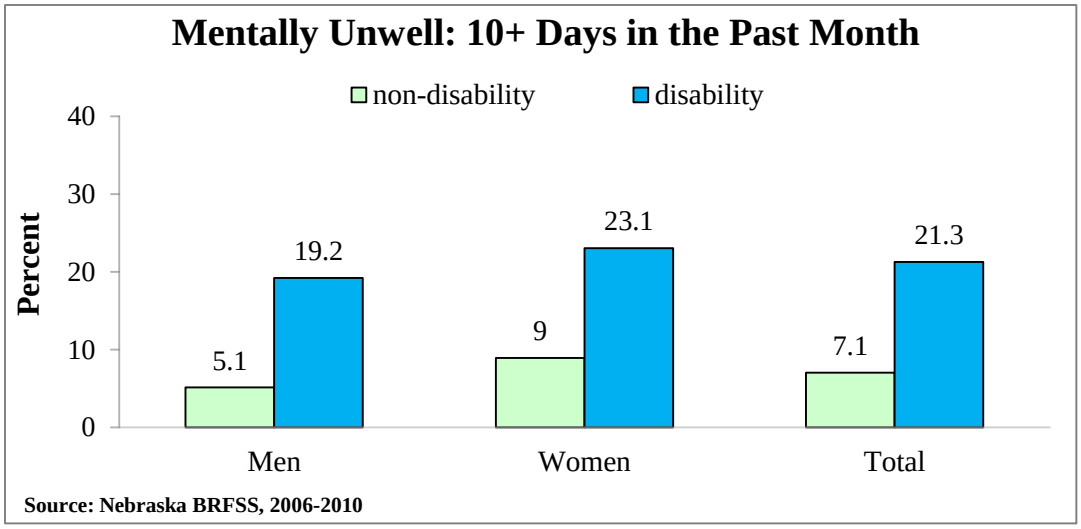
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Mentally Unwell

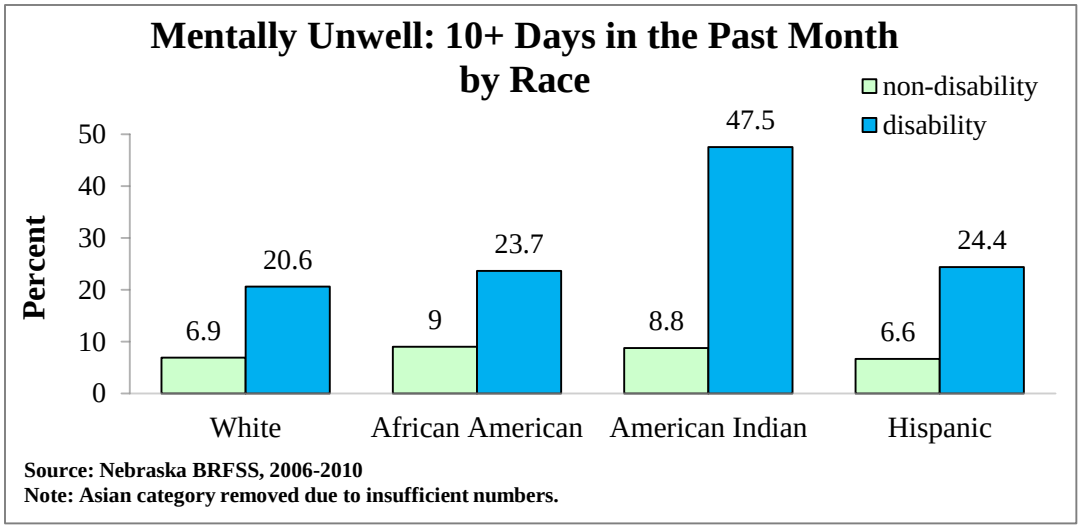
Respondents were asked, 'Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Approximately 21% of the disabled population reported being mentally unwell 10 or more days in the past month, compared to 7.1% of the non-disabled population.
- Two and a half times the number of disabled women (23.1%) reported being mentally unwell than non-disabled women (9%).
- Slightly more than 19% of disabled men reported 10 or more days of being mentally unwell in the past month, 3.7 times the percentage of non-disabled men (5.1%).
- Almost half of the disabled American Indian population reported 10 or more days being mentally unwell, compared to less than 9% of non-disabled American Indians.



Source: Nebraska BRFSS, 2006-2010



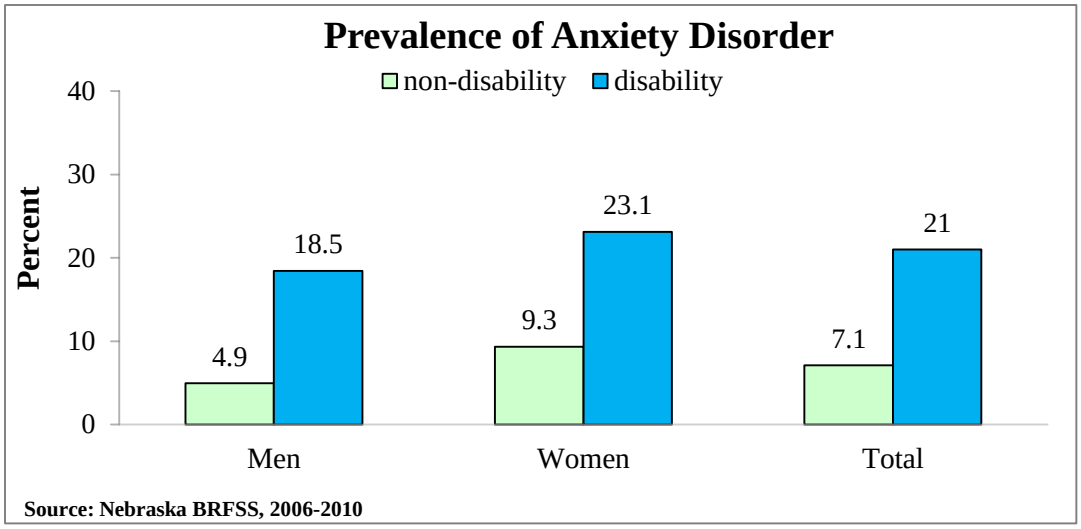
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Anxiety Disorder

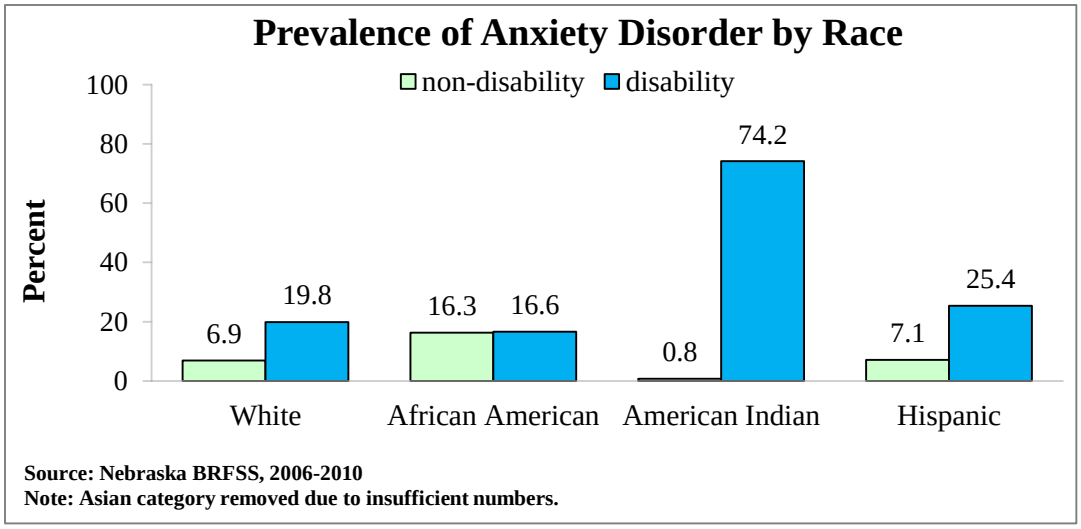
Respondents were asked, 'Has a doctor or other health care provider ever told you that you had an anxiety disorder (including acute stress disorder, panic disorder, phobia, post-traumatic stress disorder, or social anxiety disorder)?' Whomever answered "yes" was included in the chart below. Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Twenty-one percent of the disabled population had been diagnosed with an anxiety disorder, compared to 7.1% of the non-disabled population.
- Over twice as many disabled women (23.1%) as non-disabled women (9.3%) had been diagnosed with an anxiety disorder.
- Approximately 19% of disabled men had been diagnosed with an anxiety disorder, 3.8 times the number of non-disabled men (4.9%).
- Almost 75% of the disabled American Indian population reported having anxiety, compared to less than 1.0% of the non-disabled American Indian population.



Source: Nebraska BRFSS, 2006-2010



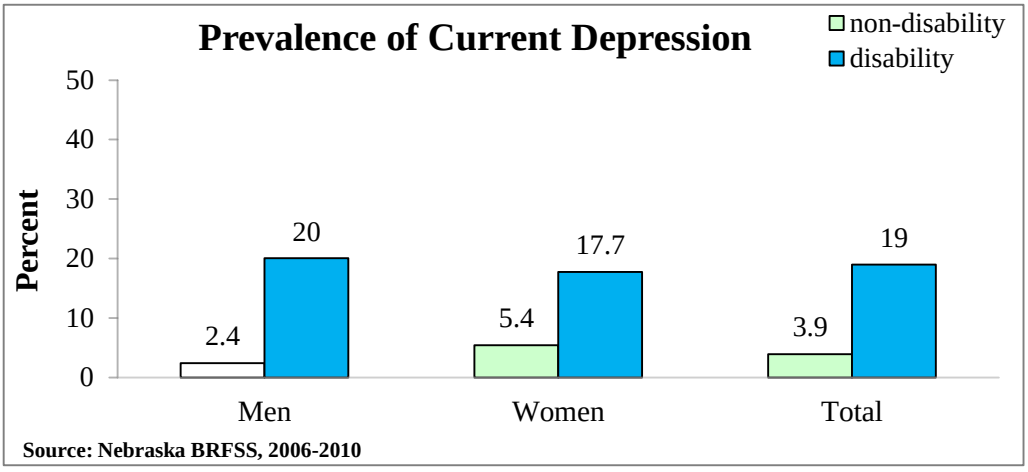
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

Current Depression

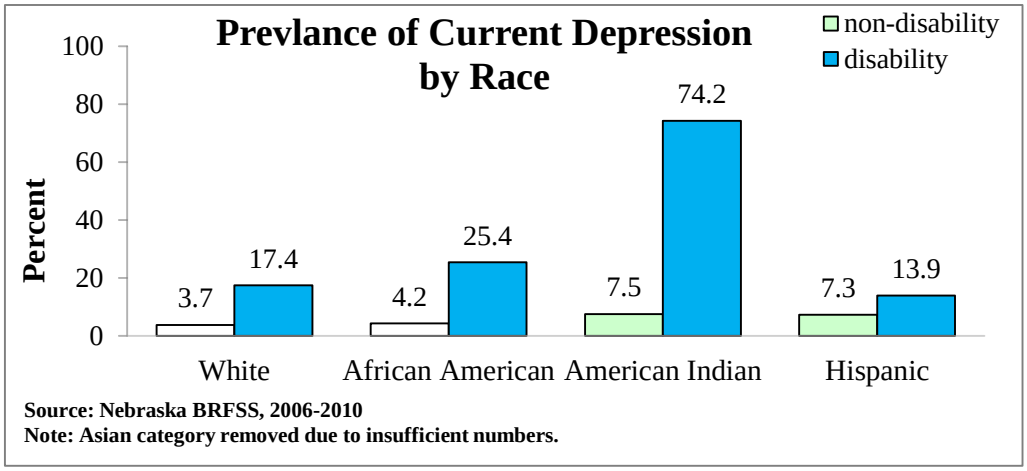
The severity of depression index was calculated from eight questions. Respondents answered, "Over the last two weeks, how many days have you: Had little interest or pleasure in doing things? Felt down, depressed, or hopeless? Had trouble in falling asleep or staying asleep or sleeping too much? Felt tired or had little energy? Had a poor appetite or eaten too much? Felt bad about yourself or that you were a failure or had let yourself or your family down? Had trouble concentrating on things, such as reading the newspaper or watching the TV? Moved or spoken so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual? Scores of 10 or greater indicated depression. Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Nineteen percent of the disabled population was currently depressed, compared to 3.9% of the non-disabled population.
- Twenty percent of disabled men were currently depressed, over eight times the number of non-disabled men who were depressed (2.4%).
- Almost 75% of disabled American Indians reported current depression, compared to 7.5% of non-disabled American Indians and 17.4% of disabled Whites.



Source: Nebraska BRFSS, 2006-2010



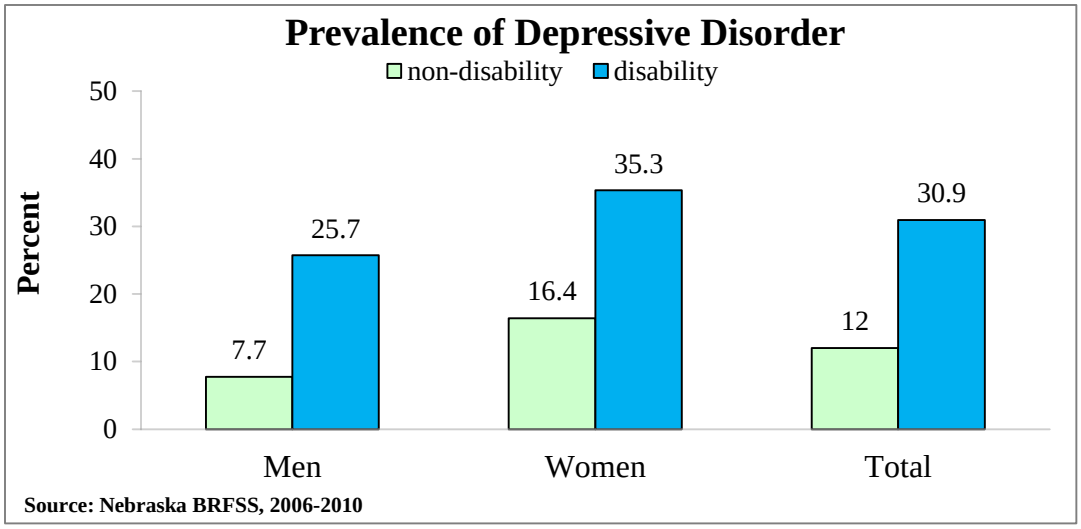
Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

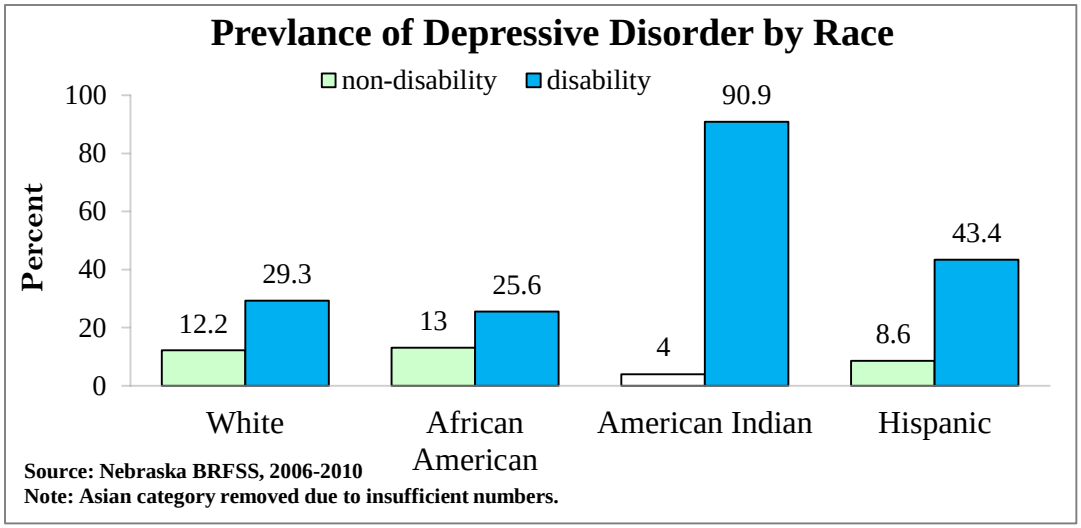
Depressive Disorder

Respondents were asked, 'Has a doctor or other health care provider ever told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?' Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Almost 31% of the disabled population had been diagnosed with a depressive disorder, compared to 12% of the non-disabled population.
- Twice as many disabled women (35.3%) were diagnosed with a depressive disorder than non-disabled women (16.4%).
- Nearly 26% of disabled men had been diagnosed with a depressive disorder, more than three times as many as non-disabled men (7.7%).
- Almost 91% of disabled American Indians reported ever being diagnosed with a depressive disorder, compared to 4% of non-disabled American Indians and 30% of *disabled* Whites.



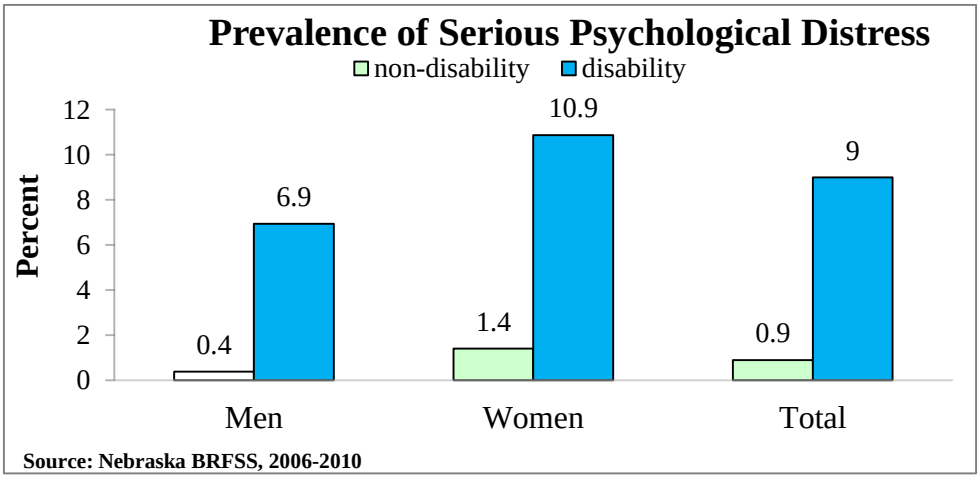


Serious Psychological Distress (SPD)

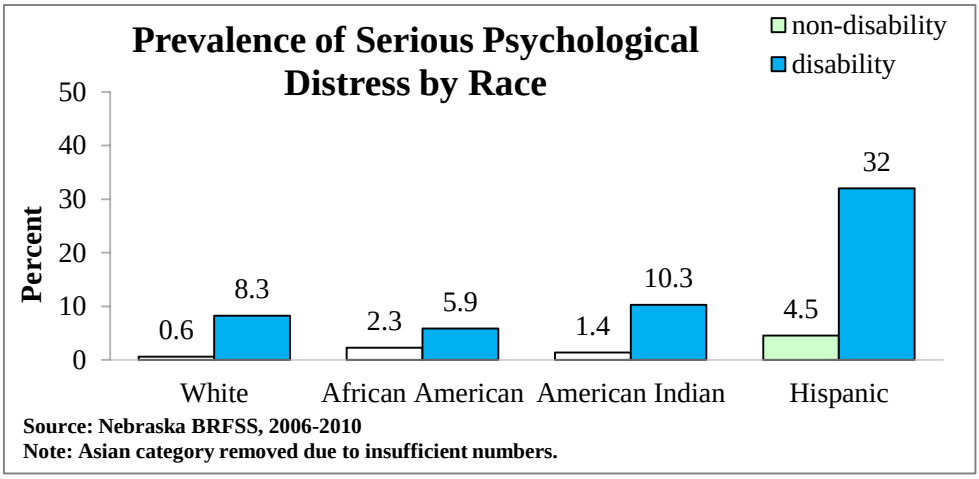
To determine whether a respondent was experiencing 'serious psychological distress', they were asked six questions 'about how you have been feeling during the past 30 days' (the K-6 scale). These questions are: "During the past 30 days about how often did you feel: Hopeless—all of the time, most of the time, some of the time, a little of the time, or none of the time? Nervous? Restless or fidgety? So depressed that nothing could cheer you up? That everything was an effort? Worthless?" Responses to the six questions above were each allocated a score of 0 to 4 (where 0=none of the time, 1=a little of the time, 2=some of the time, 3=most of the time and 4=all of the time). These scores were then summed, resulting in an overall score of 0 to 24 for each respondent. Survey participants with scores of 13 or higher were classified as having SPD. Data for Asians were excluded due to insufficient numbers.

Key Disparities

- Nine percent of the disabled population experienced serious psychological distress, compared to about 1% of the non-disabled population.
- Almost eight times the number of disabled women (10.9%) than non-disabled women (1.4%) experienced serious psychological distress.
- Both disabled (32%0 and non-disabled (4.5%) Hispanic Nebraskans reported high proportions of serious psychological distress compared to disabled (8.3%) and non-disabled (0.6%) White Nebraskans.



Source: Nebraska BRFSS, 2006-2010



Source: Nebraska BRFSS, 2006-2010
Note: Asian category removed due to insufficient numbers.

RISK FACTORS FOR LOW-INCOME NEBRASKANS

Socioeconomic status (SES) is said to be the single largest predictor of health. Specifically, SES underlies health care, environmental exposure, and health behavior; not to mention, chronic stress associated with poverty is associated with increased morbidity and mortality.[206] Socioeconomic status is a combination of income, education, and occupation, all of which contribute in their own ways to health disparities. However, according to Dr. David Williams, PhD, MPH low income is the greatest threat to good health.[207] Low-income people, for the sake of this report, were those people making less than $25,000 per year.

In examining health disparities that exist within a population, the John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health used the metaphor of a ladder to describe not only access to health care, but also whether or not "good health" was within reach for a population. Rungs on the ladder depict the resources needed to live life healthy, well, and secure. Education, comfortable housing, social and familial networks, income, and employment place many people in higher positions. Conversely, others experience generational poverty, extended periods of unemployment, poor education, low wages, and substandard housing.

For the purposes of this report, only those indicators that demonstrate the disparities faced by individuals with low-income are presented.

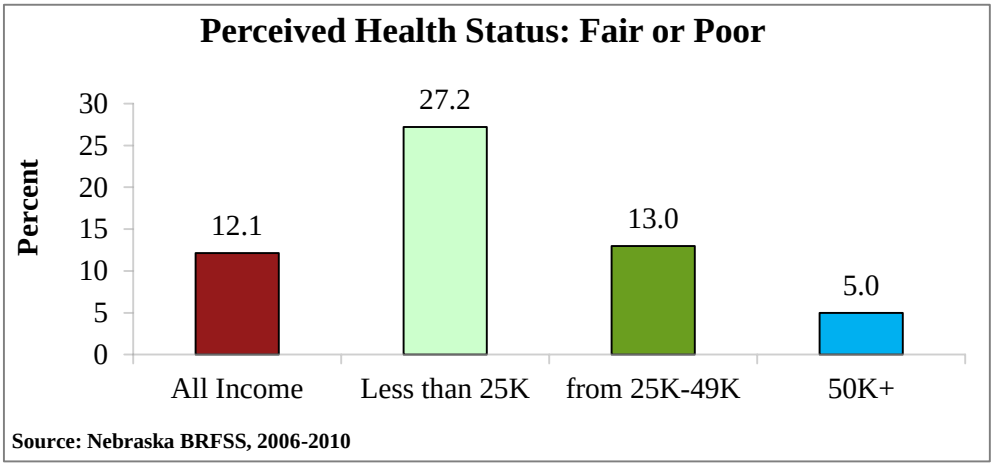
[206] Adler, N. and Newman, K. (2002). Socioeconomic disparities in health: Pathways and policies. *Health Affairs, 21,* 60-76.
[207] Williams, D. (2001). Low income, not race or lifestyle, is the greatest threat to health. Retrieved from http://pweb1.rwjf.org/reports/grr/026422.htm.

Perceived Health Status

When asked 'Would you say that in general your health is Excellent? Very good? Good? Fair? Or Poor?' Some respondents reported they were in fair or poor health.

Key Disparity

- Over five times the proportion of people who made less than $25,000 reported fair or poor health compared to those who made $50,000 or more.

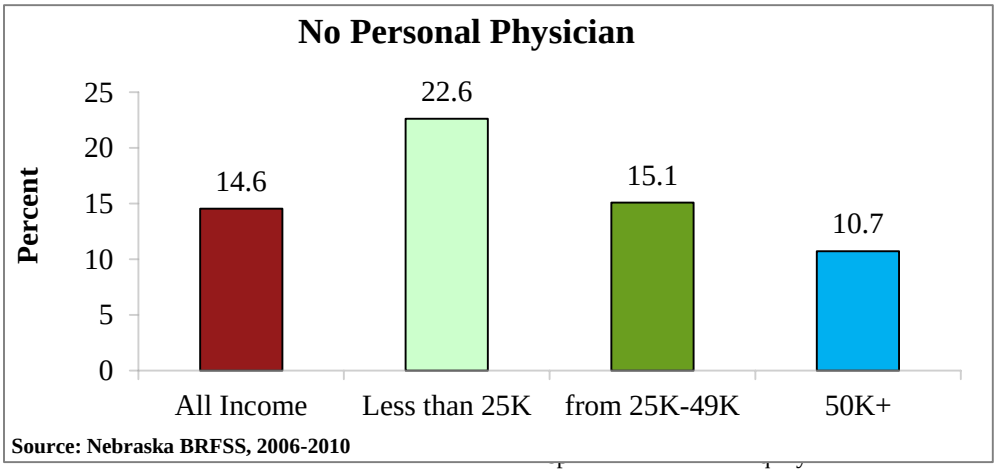


No Personal Physician

Respondents were asked, 'Do you have one person you think of as your personal doctor or health care providers?'

Key Disparity

- Almost 23% of those making less than $25,000 had no personal physician, compared to 10.7% of those making $50,000 or more.

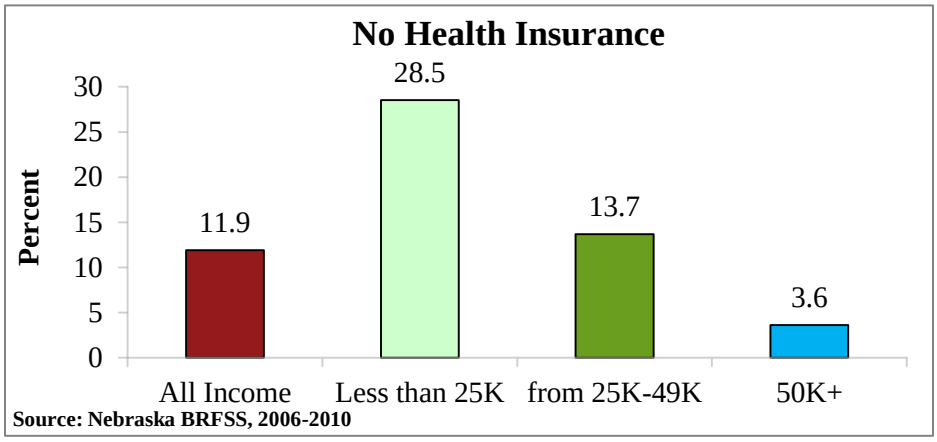


No Health Insurance

Having no health care coverage results from an answer of 'no' to the question, 'Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?'

Key Disparities

- Approximately 29% of those making less than $25,000 per year did not have health care coverage, almost eight times the percentage of those making $50,000 or more (3.6%).
- Almost 12% of those in all income levels had no insurance coverage, still less than half as many as those who made less than $25,000.

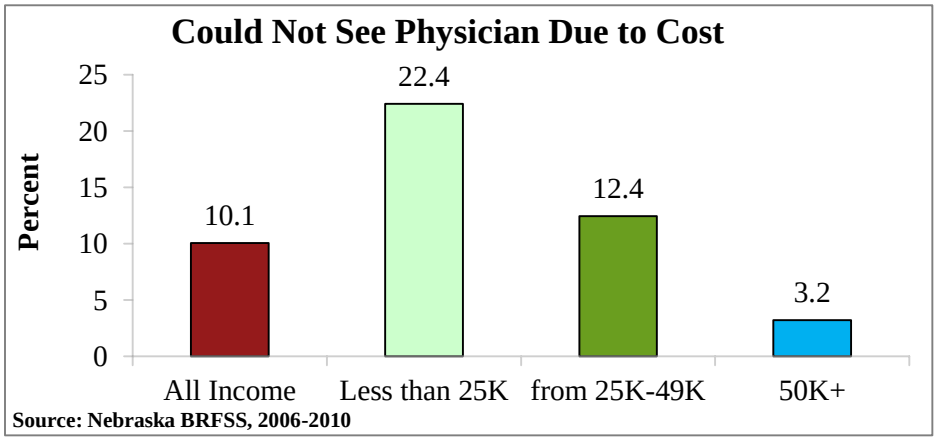


Unable to See a Physician Due to Cost

Respondents were asked, 'Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?'

Key Disparity

- Approximately 22%, or seven times the proportion, of people making less than $25,000 per year compared to those making $50,000 or more (3.2%) could not see a physician due to cost.



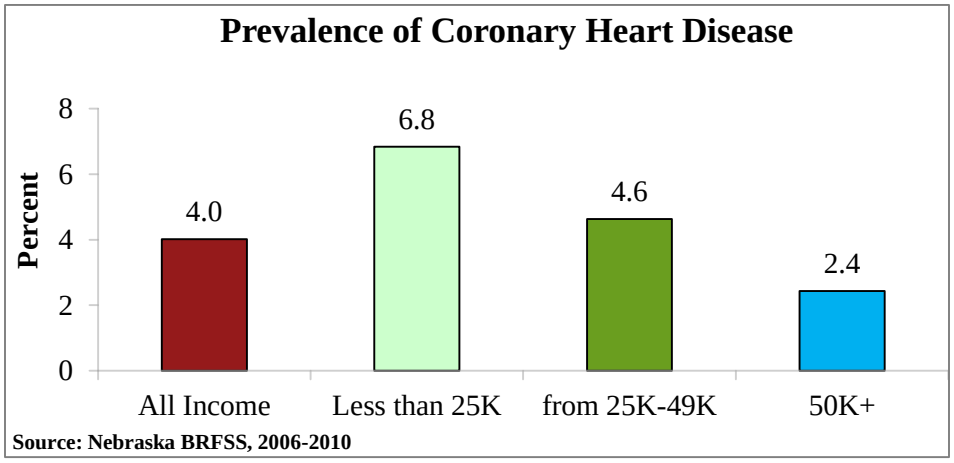
Coronary Heart Disease and Stroke

Respondents were asked, 'Has a doctor, nurse, or other health professional ever told you that you had any of the following: A heart attack, also called a myocardial infarction? Angina or coronary heart disease? A stroke?'

Coronary Heart Disease

Key Disparity

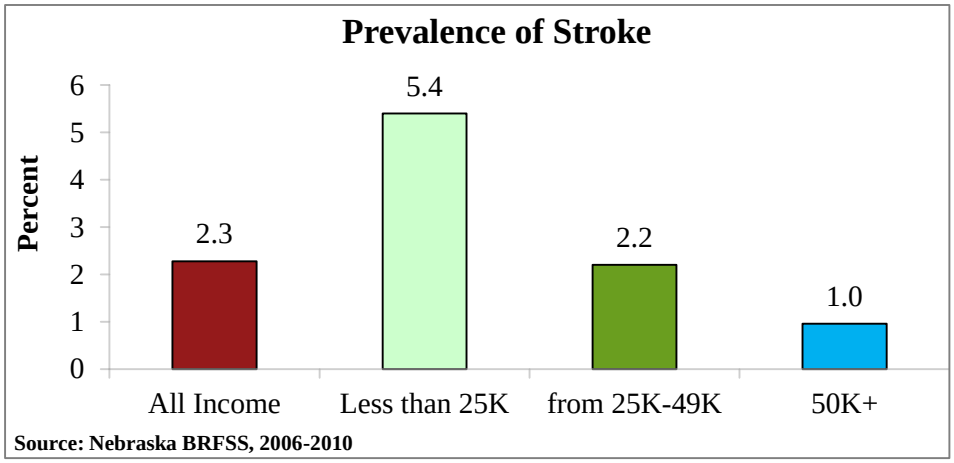
- Almost 7% of those making less than $25,000 a year had been told that they had coronary heart disease, compared to 2.4% of those making $50,000 or more.



Stroke

Key Disparity

- Almost 5% of those making less than $25,000 per year had been told they had a stroke, compared to 1% of those making more than $50,000.

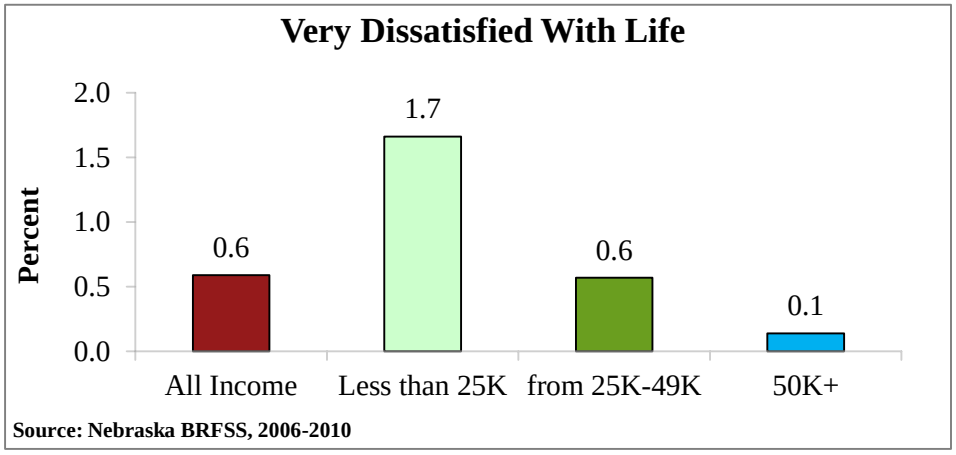


Life Satisfaction: Very Dissatisfied

Respondents could answer very satisfied, satisfied, dissatisfied, or very dissatisfied when asked, "In general, how satisfied are you with your life?" Reported here are those who responded "very dissatisfied."

Key Disparity

- Compared to 0.1% of those making $50,000 or more, 1.7% of those making less than $25,000 were very dissatisfied with life.

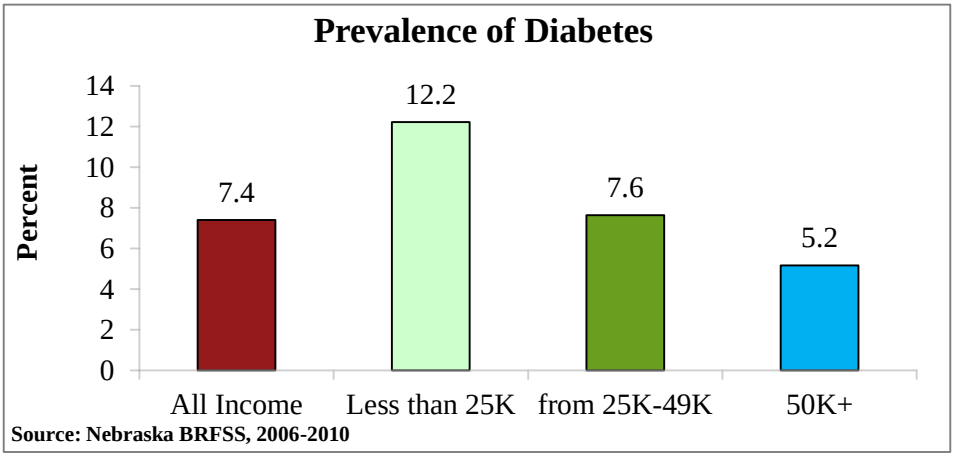


Diabetes

Respondents were asked, 'Have you ever been told by a doctor that you have diabetes? (Females diagnosed only while pregnant were excluded.)'

Key Disparity

- Approximately 12% of those making less than $25,000 had been told that they have diabetes, compared to 5% of those making $50,000 or more.

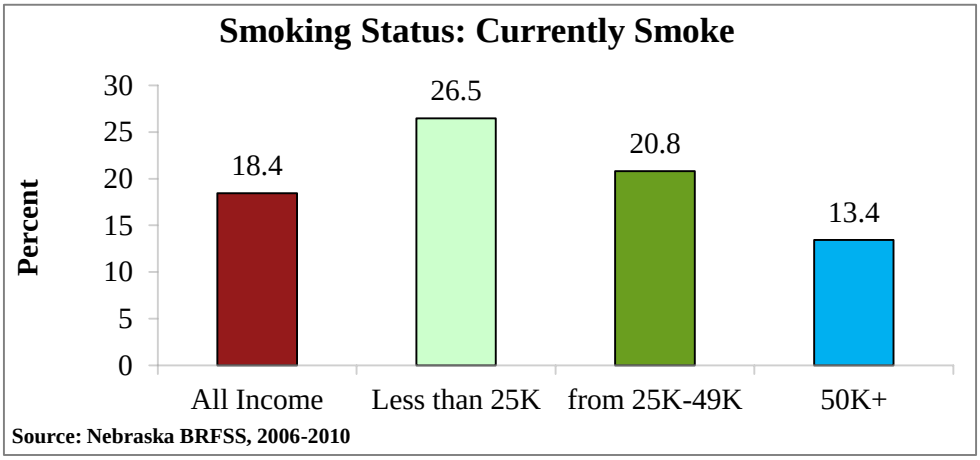


Current Cigarette Smoking

Persons were considered to be a current smoker if they report that they smoked at least 100 cigarettes in their lifetime and now report smoking cigarettes every day or some days.

Key Disparity

- Almost 27% of those making $25,000 or less per year reported currently smoking cigarettes, compared to 13.4% of those people making $50,000 or more.

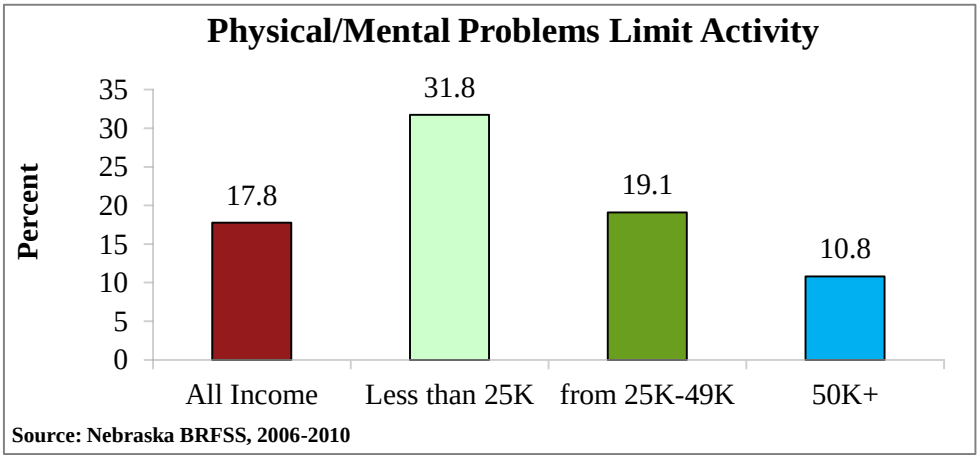


Activity Limitations

Activity limitations were assessed by asking people if they are limited in activities of daily living, instrumental activities of daily living (using the phone, doing light housework, preparing meals), play, school, or work, or remembering.

Key Disparity

- Three times as many people who made less than $25,000 per year (31.8%) compared to those making $50,000 or more (10.8%) reported physical or mental problems that limit their activity.

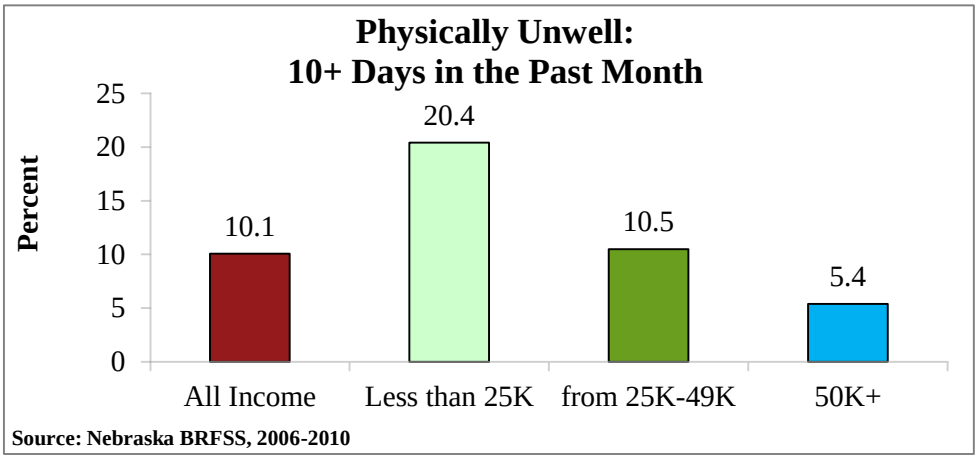


Physically Unwell

Respondents were asked, 'Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?' Those represented in the chart below answered 10 or more days.

Key Disparity

- Approximately 20% of those making less than $25,000 reported being physically unwell 10 or more days in the previous month, compared to 5.4% of those making $50,000 or more.

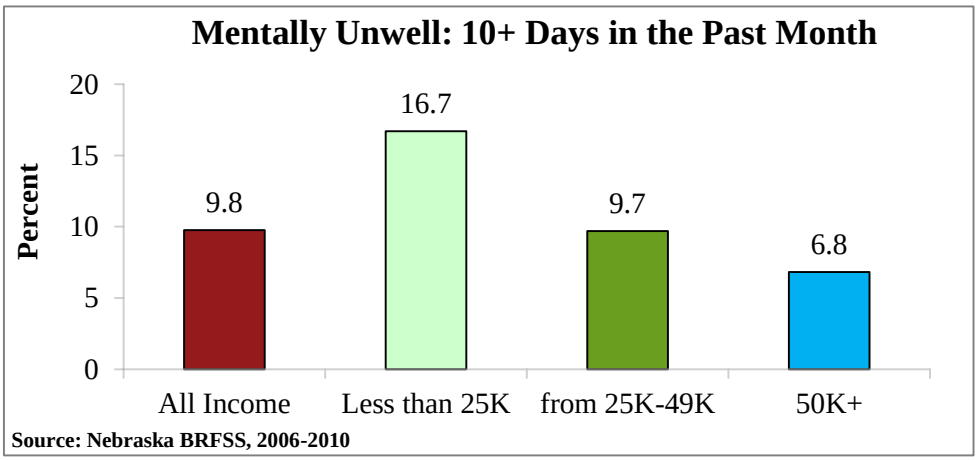


Mentally Unwell

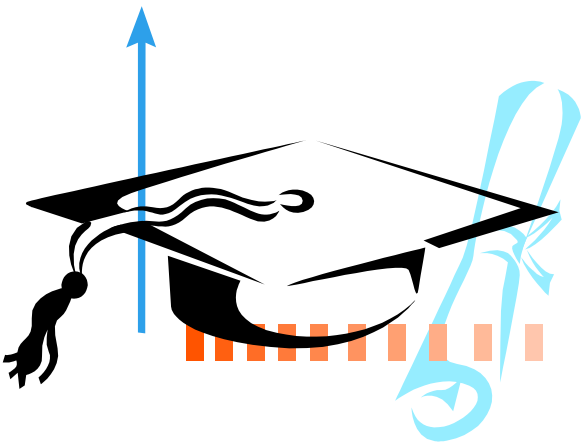
This measure was evaluated by asking, 'Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?'

Key Disparity

- Almost 2.5 times more people making less than $25,000 per year (16.7%) reported 10 or more days of being mentally unwell in the previous month than those making $50,000 or more (6.8%).



RISK FACTORS FOR LESS EDUCATED NEBRASKANS



Education and health are arguably some of the most important characteristics of human capital; both education and health make people more productive.[208] Additionally, health and prosperity are positively associated. This relationship can be explained in possibly three different ways: better health may allow one to invest more in education, certain factors impact health and education in similar ways, or education leads to better health.[209]

Lower education levels are linked to poor health, more stress, and lower self-confidence.[210] According to the National Poverty Center, those people who are more highly educated have lower morbidity rates from common diseases.[211] Moreover, although life expectancy is increasing overall, the gap in life expectancy between those with and without a bachelor's degree continues to grow.[212]

Better educated people have lower morbidity rates from the most common acute and chronic diseases, independent of basic demographic and labor market factors. Life expectancy is increasing for everyone in the United States, yet differences in life expectancy have grown over time between those with and without a college education.[213] It is clear, given the vast research correlating the two, that education and health are more related than some people might think. In the following section, we will see that reflected in Nebraska as well.

For the purposes of this report, only those indicators that demonstrated the disparities faced by individuals with less education are presented.

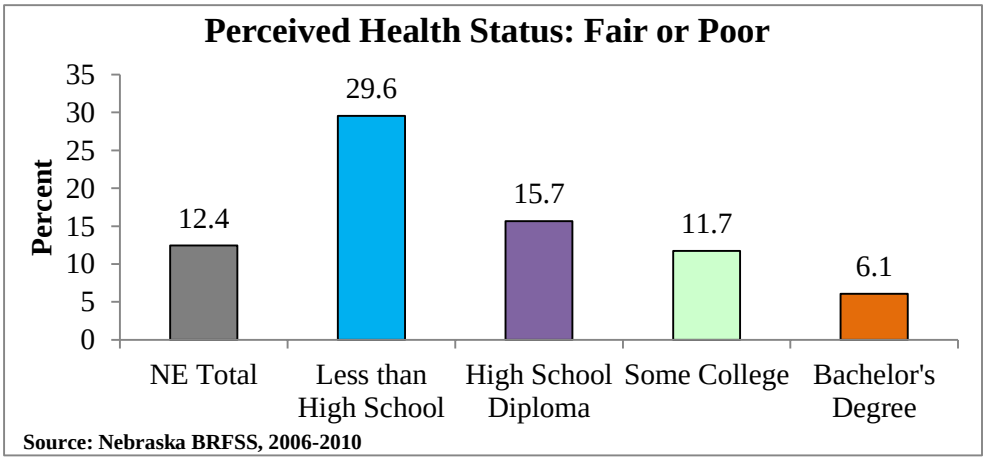
[208]Groot, W. and Maassen van den Brink, H. (2006). What does education do to our health. Retrieved from http://www.oecd.org/education/country-studies/37425763.pdf.
[209]Ibid.
[210]World Health Organization. (2013). The determinants of health. Retrieved from http://www.who.int/hia/evidence/doh/en/.
[211]Cutler, D. and Lleras-Muney, A. (2007). Education and health. Retrieved from http://www.npc.umich.edu/publications/policy_briefs/brief9/
[212]Ibid.
[213]Cutler, D. and Lleras-Muney, A. (2007). Education and health. Retrieved from http://www.npc.umich.edu/publications/policy_briefs/brief9/policy_brief9.pdf

Perceived Health Status

When asked 'Would you say that in general your health is excellent? Very good? Good? Fair? Or Poor?' some respondents reported they were in fair or poor health.

Key Disparity

- Almost 30% of the population with less than a high school education reported fair or poor health status, compared to only 6% of those with a bachelor's degree or higher.

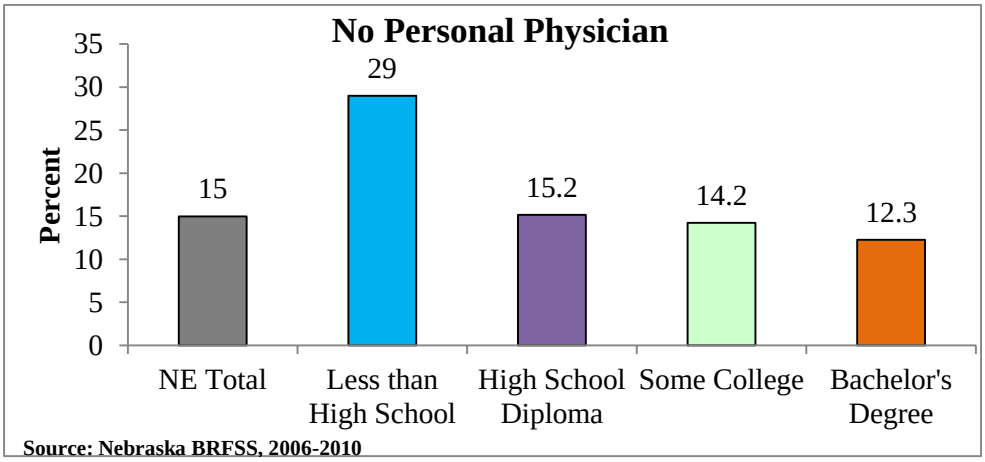


No Personal Physician

Respondents were asked, 'Do you have one person you think of as your personal doctor or health care providers?'

Key Disparity

- Almost 30% of those with less than a high school degree did not have a personal physician, compared to 12.3% of those with a bachelor's degree.

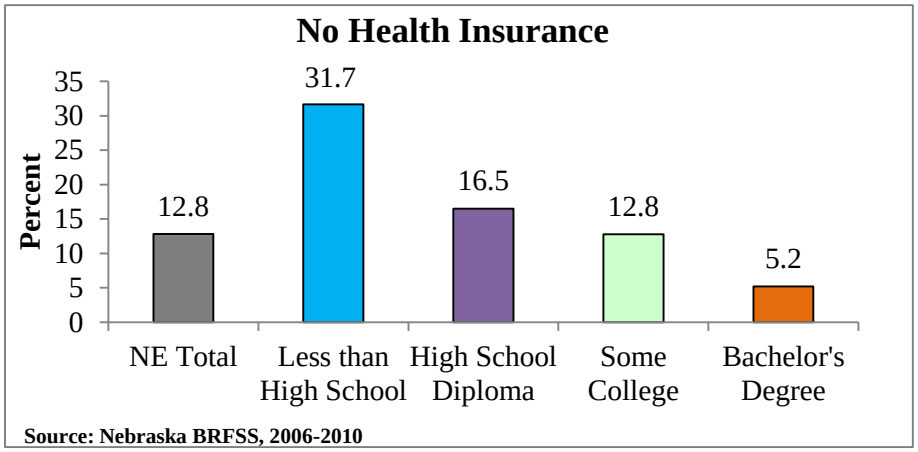


No Health Insurance

Having no health care coverage results from an answer of 'no' to the question, 'Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?'

Key Disparity

- Those with less than a high school education (31.7%) were 6 times as likely as those with a bachelor's degree (5.2%) to have no health coverage.

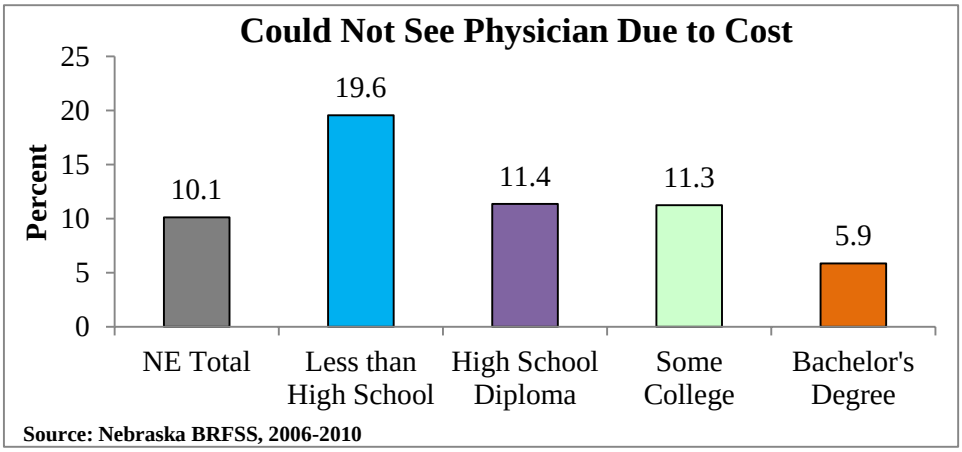


Unable to See a Physician Due to Cost

Respondents were asked, 'Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?'

Key Disparity

- More than three times the proportion of people without a high school education (19.6%) could not see a doctor due to cost compared to those with a bachelor's degree (5.9%).

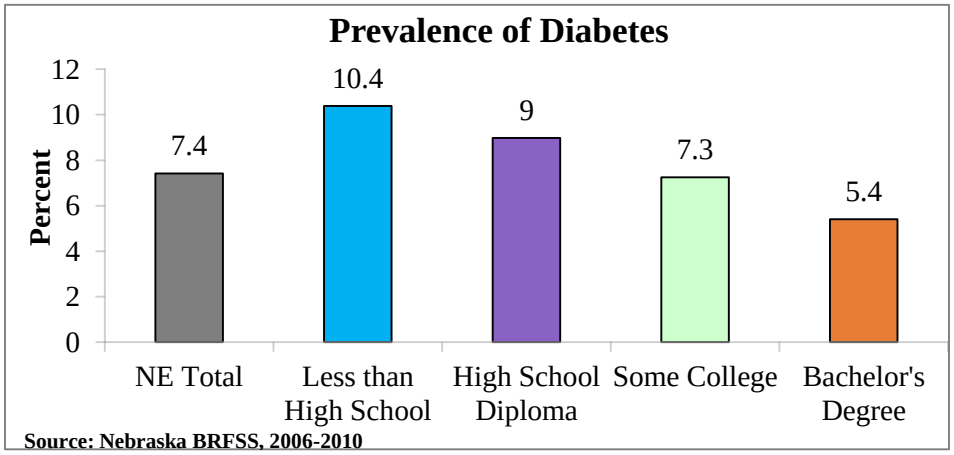


Diabetes

Respondents were asked, 'Have you ever been told by a doctor that you have diabetes? (Females diagnosed only while pregnant were excluded.)'

Key Disparity

- Almost twice as many people with less than a high school degree (10.4%) had diabetes compared to those with a bachelor's degree (5.4%).

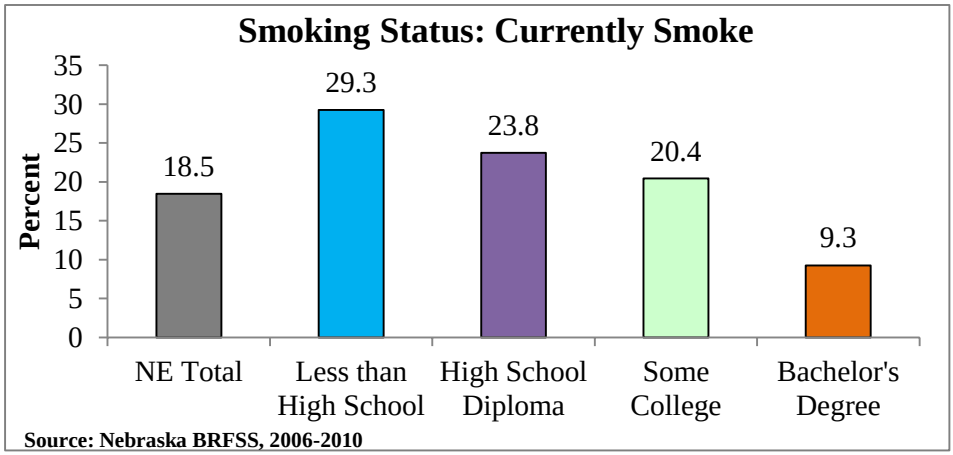


Current Cigarette Smoking

Persons were considered to be using cigarettes if they reported that they smoked at least 100 cigarettes in their lifetime and now report smoking cigarettes every day or some days.

Key Disparity

- More than three times the proportion of people with less than a high school degree (29.3%) currently smoked cigarettes, compared to 9.3% of those with a bachelor's degree.



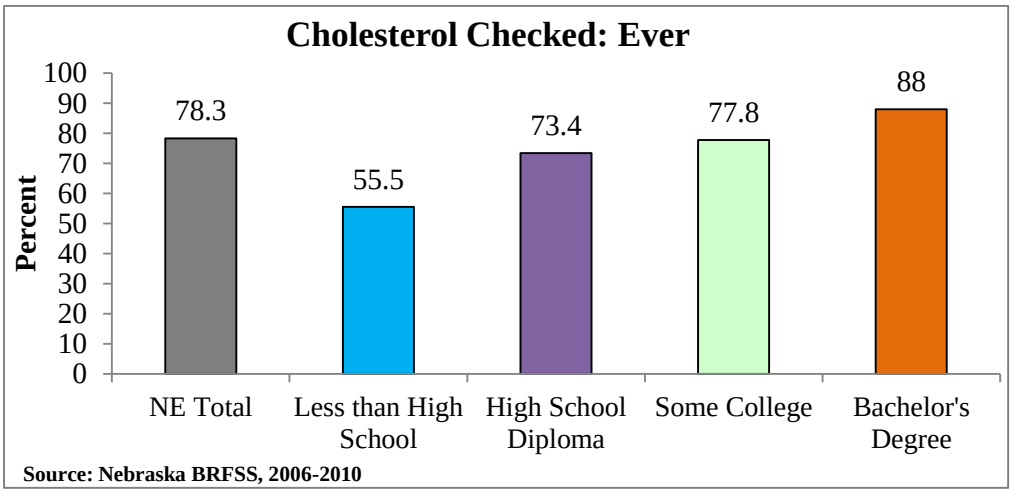
Cholesterol Check

This measure was evaluated by asking, 'About how long has it been since you had your cholesterol checked?'

Cholesterol Checked: Ever

Key Disparity

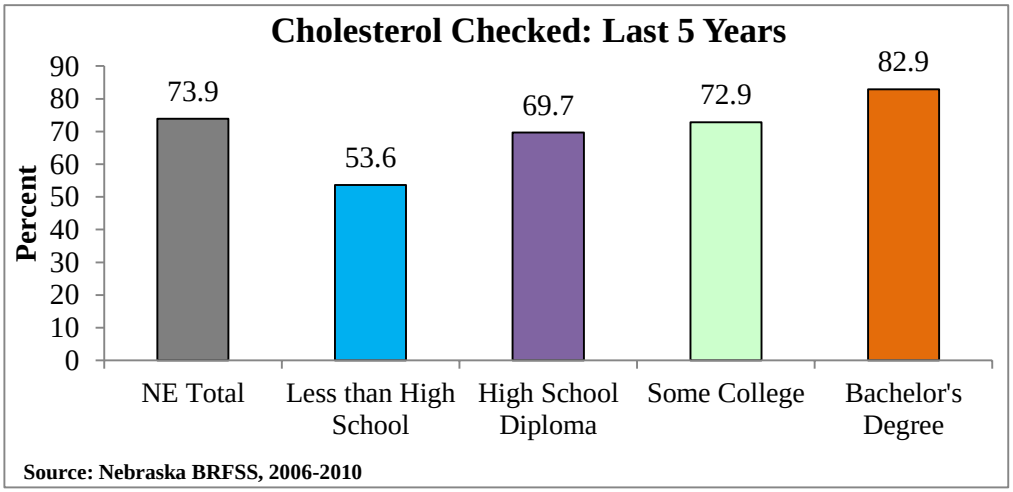
- Slightly over half of the people with less than a high school education had ever gotten their cholesterol checked, compared to almost 90% of those with a bachelor's degree.



Cholesterol Checked: Last 5 Years

Key Disparity

- Approximately 54% of people with less than a high school education had their cholesterol checked within the last 5 years, compared to almost 83% of those with a bachelor's degree.

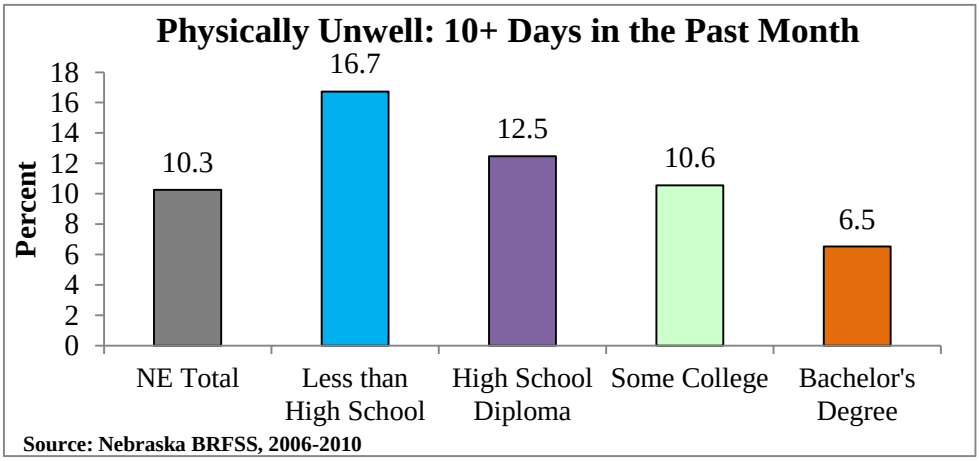


Physically Unwell

Respondents were asked, 'Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?' Those represented in the chart below answered 10 or more days.

Key Disparity

- Almost 17% of those people with less than a high school experienced 10 or more days being physically unwell in the previous month, compared to 6.5% of those with a bachelor's degree.

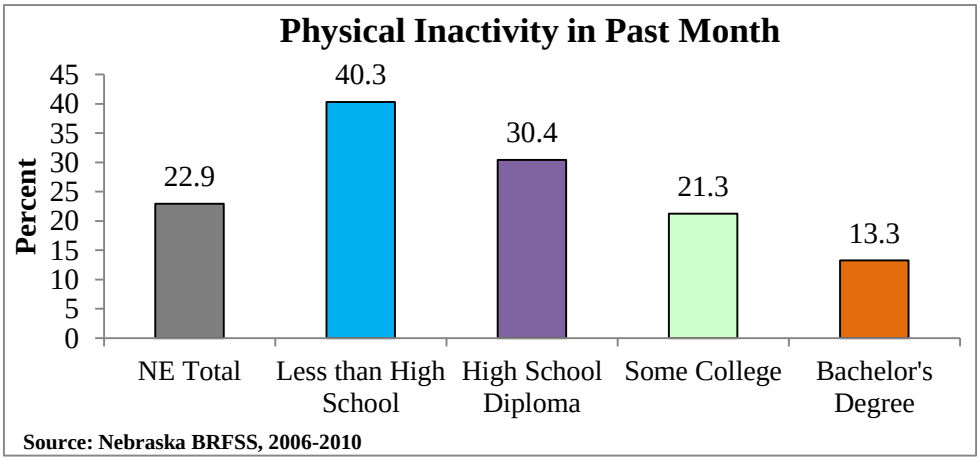


Physical Inactivity

For this indicator respondents were asked, 'During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?'

Key Disparity

- Those with less than a high school education (40.3%) were 3 times as likely as those with a bachelor's degree (13.3%) to get no exercise outside of work.

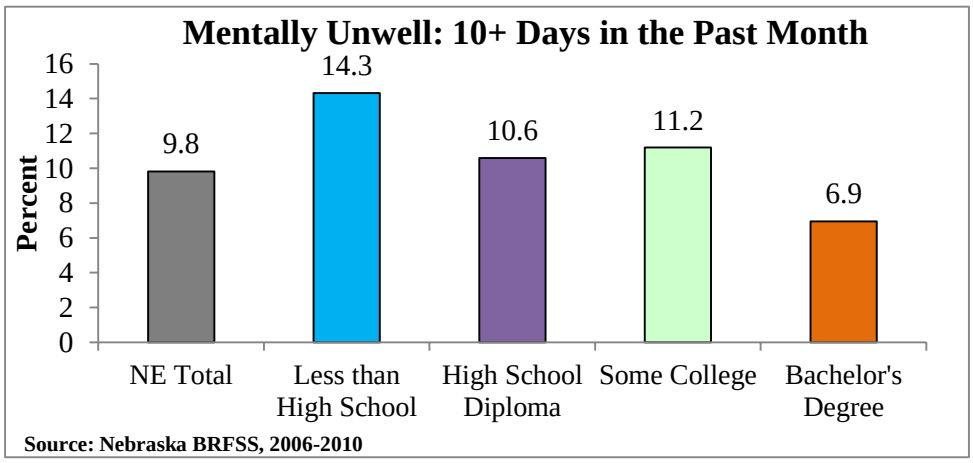


Mentally Unwell

This measure was evaluated by asking, 'Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?'

Key Disparity

- While approximately 7% of those with a bachelor's degree experienced 10 or more days being mentally unwell in the previous month, around 14% of those with less than a high school education reported the same.

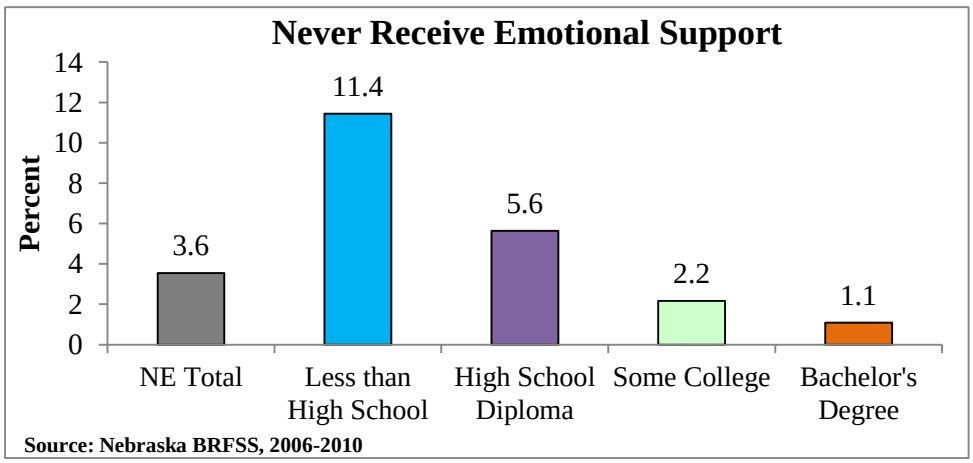


Receive Emotional Support: Never

Never receiving emotional support was defined by the BRFSS as an affirmative answer of never receiving the social and emotional support needed.

Key Disparity

- Those with less than a high school education (11.4%) were ten times more likely than those people with a bachelor's degree (1.1%) to say they never get the emotional support they need.

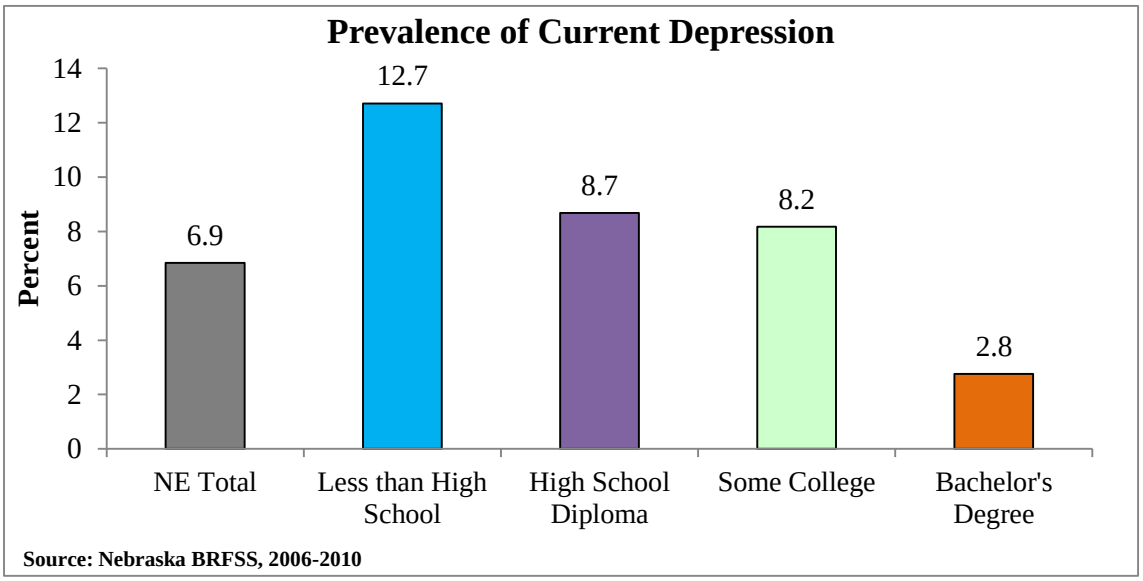


Current Depression

Respondents were asked a series of questions about their mood and asked to think about how many days they had felt that way in the past two weeks. To construct the Severity of Depression Index, the number of days that respondents reported suffering from symptoms was summed over all eight questions. An algorithm developed by the CDC was then used to reconfigure these scores to fit into the four-category scheme developed as part of the original 8-question Patient Health Questionnaire depression scale. Using this index, reconfigured scores of 10 or greater indicated depression.

Key Disparity

- Almost five times as many people with less than a high school education (12.7%) had an anxiety/depression severity score of 10 or greater, compared to only 2.8% of those with a bachelor's degree.

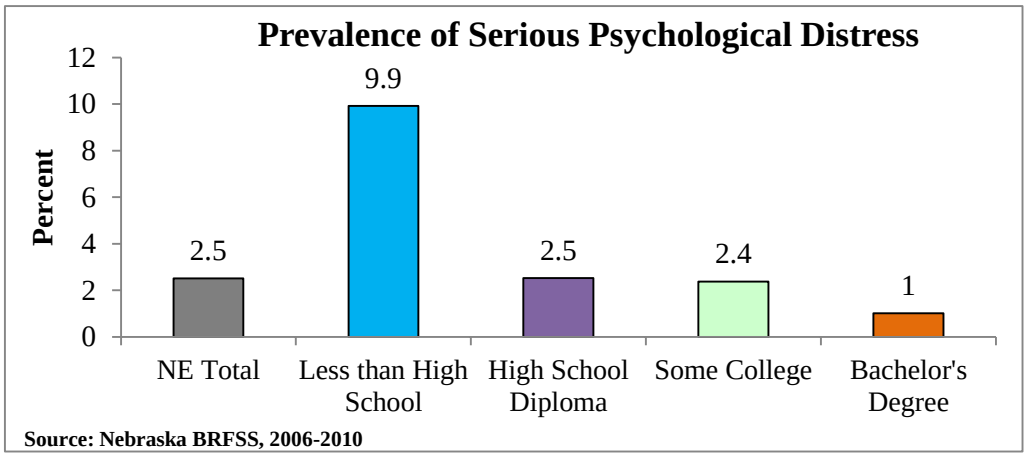


Serious Psychological Distress (SPD)

Respondents were asked a series of six questions that assessed how they had been feeling for the past 30 days. Responses were each allocated a score of 0-4 depending on severity. Respondents with a score of 13 or higher were classified as having SPD.

Key Disparity

- Nine times as many people with less than a high school education (9.9%) experienced serious psychological distress, compared to those with a bachelor's degree (1%).

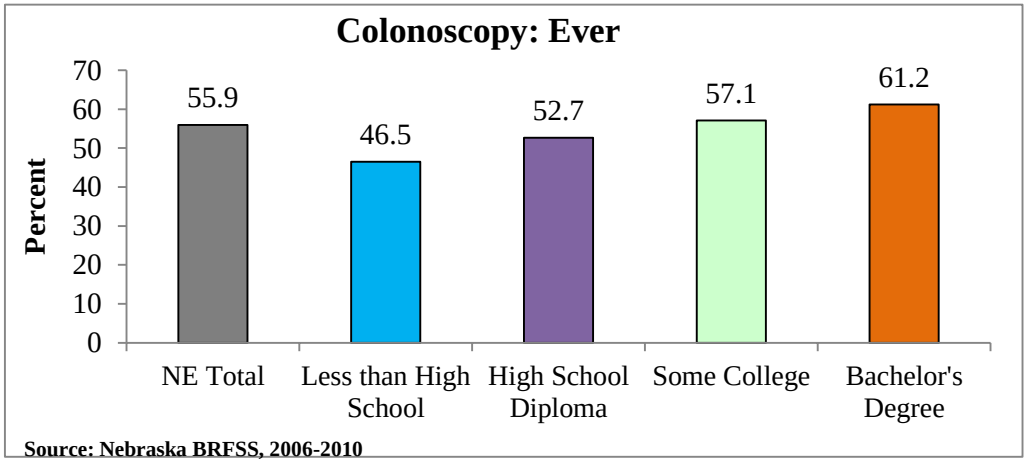


Colonoscopy: Ever

A colonoscopy is an exam in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Respondents were asked, 'Have you ever had either of these exams? For a sigmoidoscopy, a flexible tube is inserted into the rectum to look for problems. A colonoscopy is similar, but uses a longer tube, and you are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test.'

Key Disparity

- Approximately 61% of those with a bachelor's degree had a sigmoidoscopy or colonoscopy, compared to 46.5% of those with less than a high school education.



RISK FACTORS FOR RURAL NEBRASKANS

There are many ways the United States categorizes place, and there are discrepancies on what is urban and what is rural. For example, the Census Bureau uses the term 'urban' and the Office of Management and Budget uses the term 'metropolitan'. While the Census' 'urbanized area' and the OMB's 'metropolitan area' are both defined as having 50,000 people or more, not all census-defined urban clusters (between 2,500 and 50,000 people) are OMB-defined micropolitan areas (between 10,000 and 50,000 people). For the purposes of this report the following definitions were used as defined by Nebraska Vital Records: 'metropolitan' included nine counties, two of which have a city of 50,000 or more residents and seven that are metropolitan outlying counties, 'micropolitan' areas consisted of the 10 counties that are not metropolitan and have at least once city of 10,000 or more residents, and 'rural' included all of the remaining 74 counties.

Certain aspects of rural life, compared to urban life, create obstacles to obtaining health care. The obstacles that make obtaining health care challenging, like economic factors, cultural and social differences, educational shortcomings, lack of legislator-recognition, and isolation, also contribute to negative health behaviors and unhealthy lifestyles.[214]

There are various imbalances when it comes to health in rural areas. Only about 10% of physicians work in rural areas, while almost a quarter of the population lives there. Rural residents are less likely to have employer-provided health coverage and are less likely to be covered by Medicaid. Where only one-third of motor vehicle accidents happen in rural areas, two-thirds of all motor vehicle accident deaths occur in rural areas. Rural residents are more likely to be poor, twice as likely to die from unintentional injury, and rely more heavily on the federal Supplemental Nutrition Assistance Program (formerly food stamps).[215]

For the purposes of this report, only those indicators that demonstrated the disparities faced by individuals living in rural areas are presented.

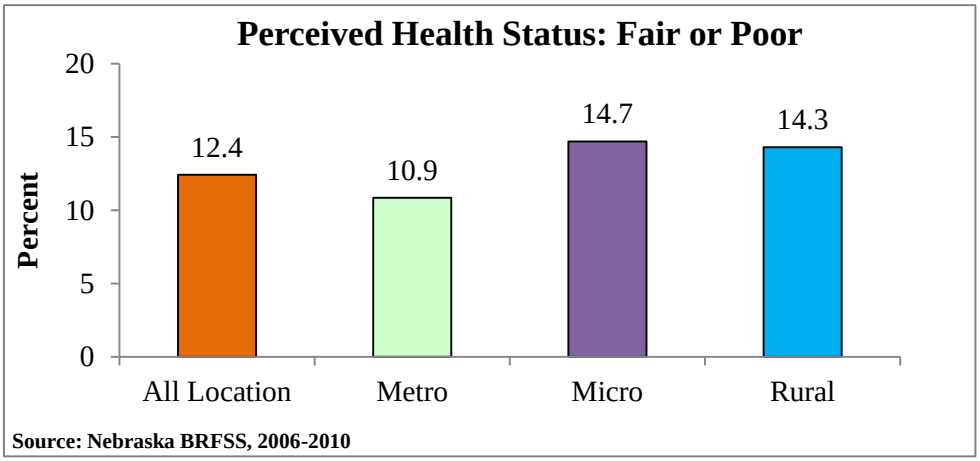
[214]National Rural Health Association. (2013). What's different about rural health care? Retrieved from http://www.ruralhealthweb.org/go/left/about-rural-health.
[215]Ibid.

Perceived Health Status

When asked 'Would you say that in general your health is Excellent? Very good? Good? Fair? Or Poor?' some respondents reported they were in fair or poor health.

Disparities

- Fourteen percent of rural Nebraskans self-reported fair or poor health status, compared to almost 11% of those living in a metropolitan area.

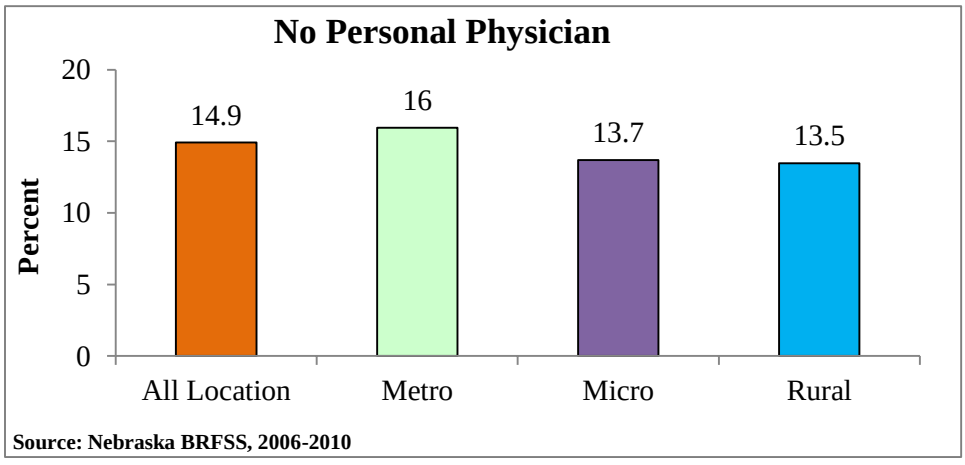


No Personal Physician

Respondents were asked, 'Do you have one person you think of as your personal doctor or health care providers?'

Disparities

- Thirteen and a half percent of rural Nebraskans did not have a personal physician, compared to 16% of those who lived in metropolitan areas.

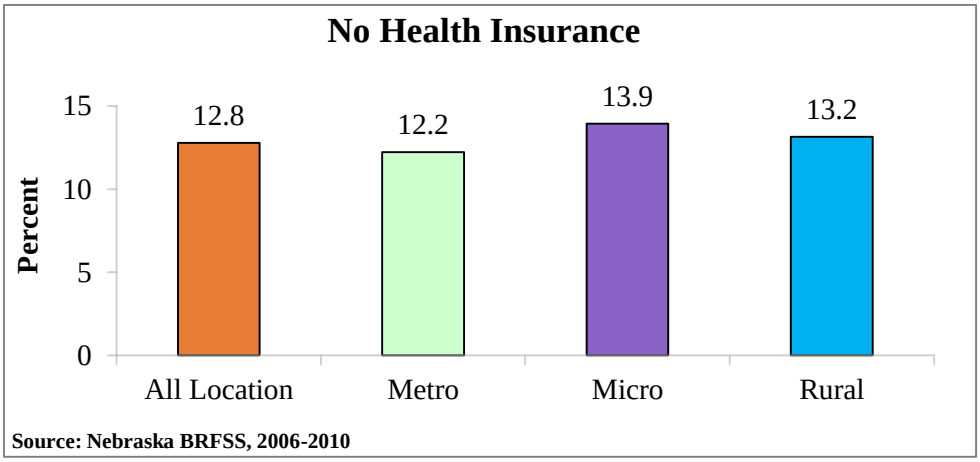


No Health Insurance

Having no health care coverage resulted from an answer of 'no' to the question, 'Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?'

Disparities

- Approximately 13% of those who lived in rural Nebraska had no health insurance, compared to 12% of those who lived in a metropolitan area. Overall, the proportions for each group were very similar.

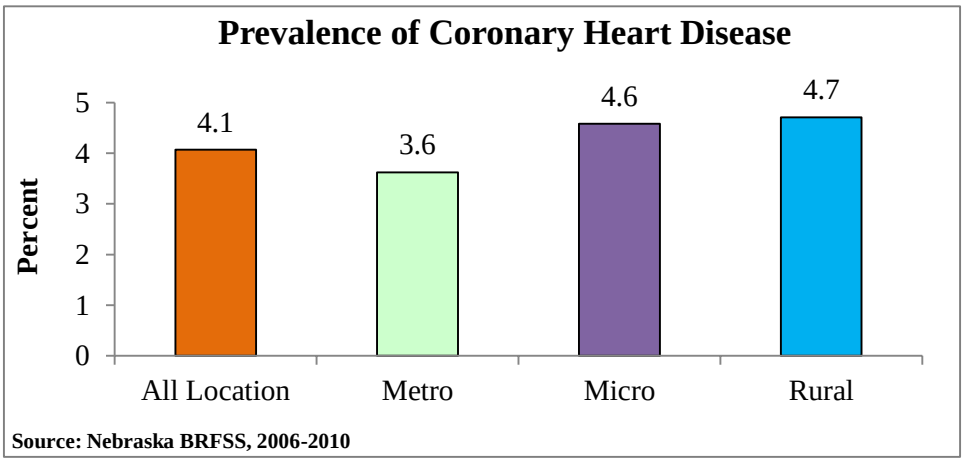


Coronary Heart Disease

Respondents were asked, 'Has a doctor, nurse, or other health professional ever told you that you had any of the following: A heart attack, also called a myocardial infarction? Angina or coronary heart disease? A stroke?'

Disparities

- Almost 5% of rural Nebraskans had been told by their health care professional that they have coronary heart disease, compared to 3.6% of those who live in a metropolitan area.

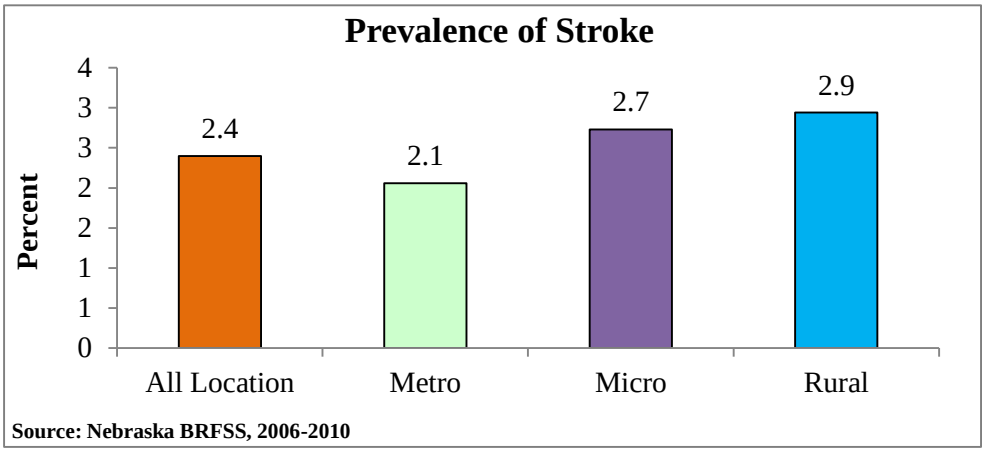


Stroke

Respondents were asked, ‘Has a doctor, nurse, or other health professional ever told you that you had any of the following: A heart attack, also called a myocardial infarction? Angina or coronary heart disease? A stroke?’

Disparities

- Almost 3% of rural Nebraskans had been told they had a stroke, compared to about 2% of metropolitan Nebraskans.

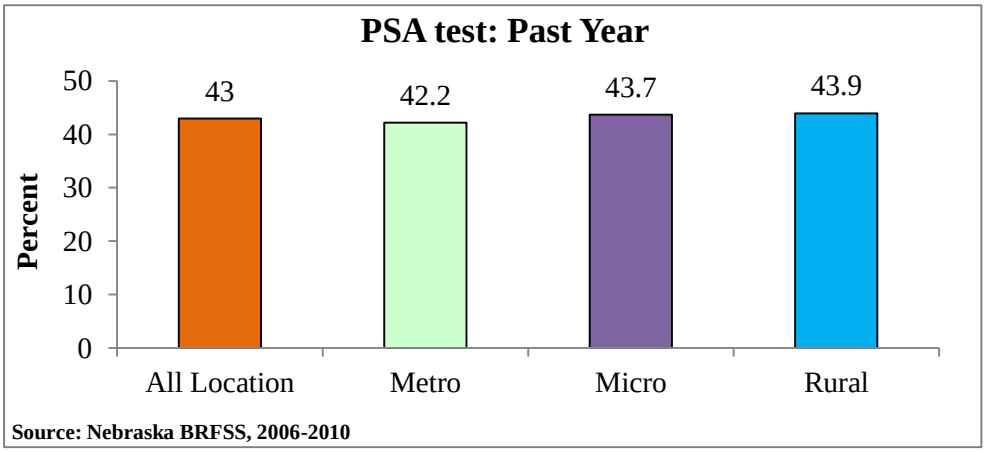


PSA: Past Year

This measure was evaluated by asking, 'A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?’

Disparities

- Almost 44% of rural Nebraskans had a PSA test in the previous one year, compared to 42.2% of those who lived in a metropolitan area.

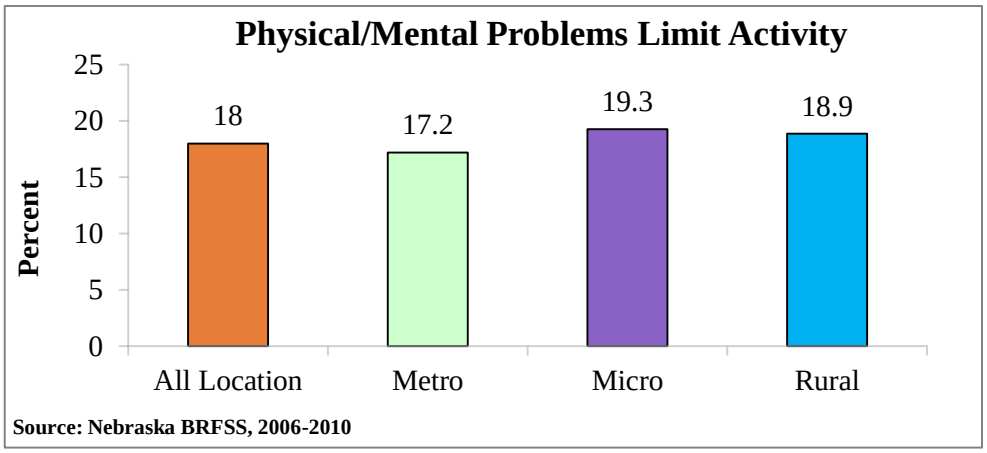


Activity Limitations

Activity limitations were assessed by asking people if they are limited in activities of daily living, instrumental activities of daily living (using the phone, doing light housework, preparing meals), play, school, or work, or remembering.

Disparities

- Almost 19% of rural Nebraskans reported physical or mental problems limiting their activity, compared to 17% of those living in a metropolitan area.

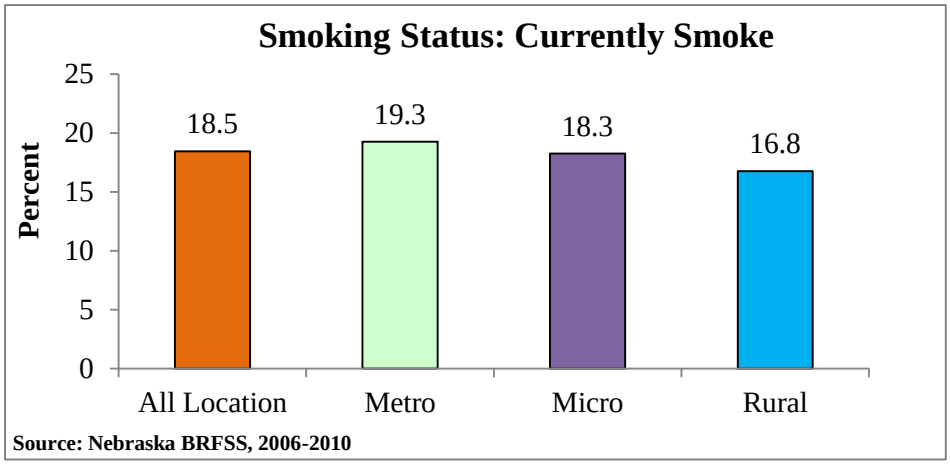


Current Cigarette Smoking

Persons were considered to be using cigarettes if they reported that they smoked at least 100 cigarettes in their lifetime and now report smoking cigarettes every day or some days.

Disparities

- Almost 17% of rural Nebraskans currently smoked, compared to 19.3% of metropolitan Nebraskans.

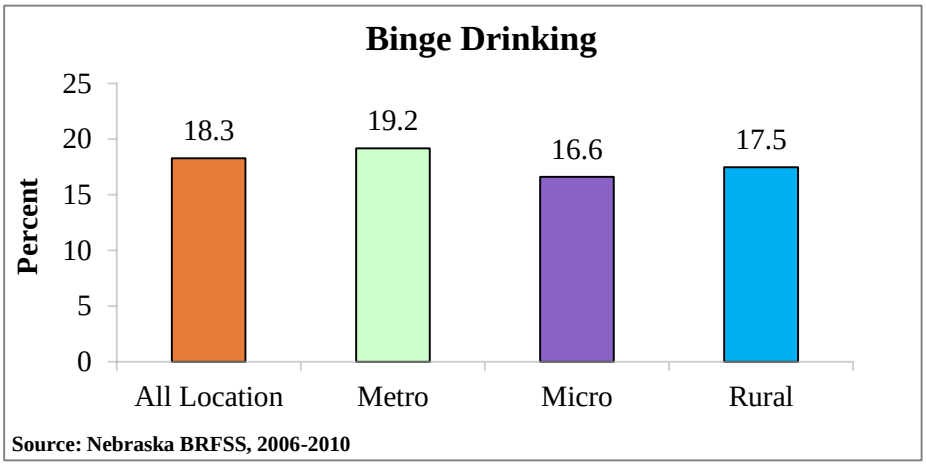


Binge Drinking

Typically, binge drinking is defined by levels of alcohol consumption that result in impairment, traditionally measured by men having five or more alcoholic beverages in one occasion and women having four or more.

Disparities

- Seventeen and a half percent of rural residents had five or more drinks in one occasion in the past month prior to the survey, compared to 19.2% of those who lived in a metropolitan area.

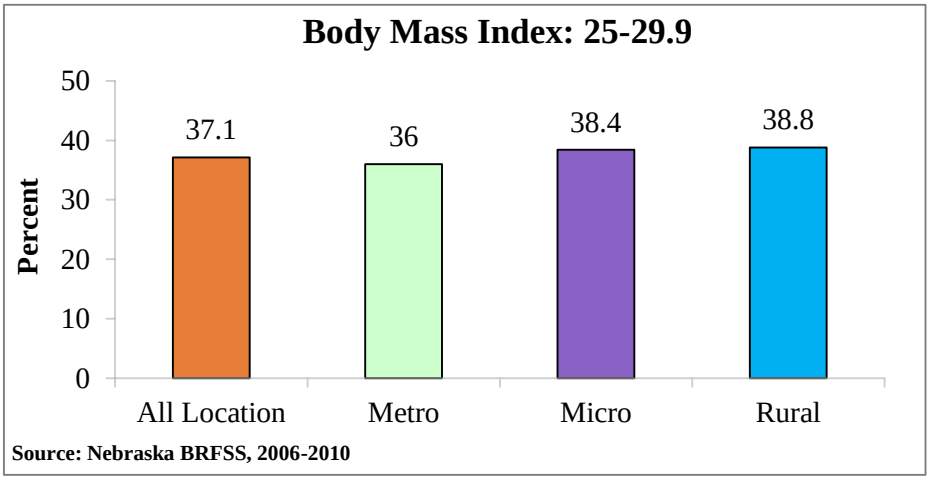


Overweight: BMI 25-29.9

Although it is not a diagnostic tool, body mass index (BMI) can be a good indicator of a person's health status. A BMI of 25-29.9 is considered overweight.

Disparities

- Almost 39% of those people living in rural Nebraska were overweight (having a BMI of 25-29.9), compared to 36% of those living in metropolitan Nebraska.

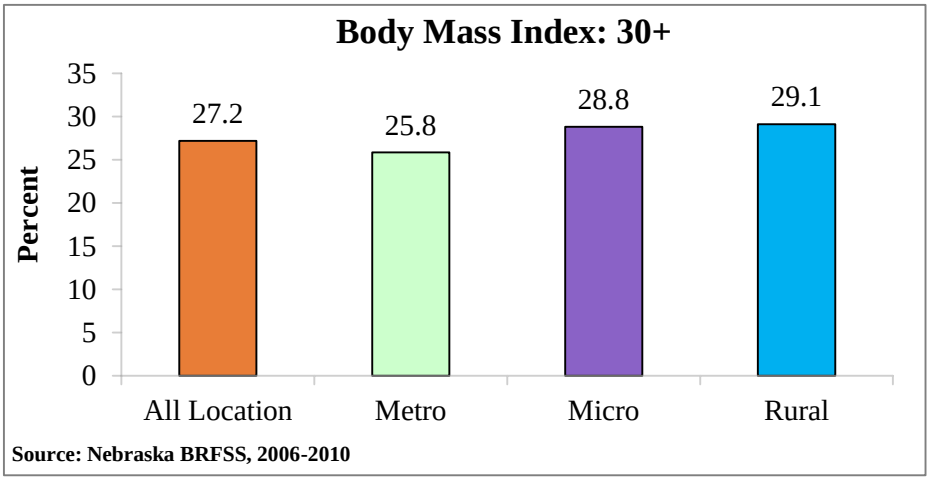


Obese: BMI 30+

A BMI of 30 or higher is considered obese.

Disparities

- Approximately 29% of rural Nebraskans were obese according to BMI, compared to almost 26% of metropolitan Nebraskans.



CONCLUSION

Health disparities result from a complex interplay of genetics, behavior, and access to health care; focusing public health efforts on prevention, early detection, and health indicators has been seen to, in the United States and Nebraska, drastically improve quality of health among all populations.

As a result of preventative and educational efforts, Nebraska has seen progress toward reaching Healthy People 2010 objectives in areas of maternal and child health, chronic disease, cancer, and protective factors for health.

As we see our immigration patterns shift and population growth speeding up, now is the time to increase our efforts to reduce health disparities. Our Hispanic population increased 77.3% between 2000 and 2010. Seeing the lowest level of education, Hispanics still report moderate income, compared to other groups; yet, they report fair or poor health and were unable to see a physician due to cost. African Americans, who report the lowest income and a high poverty rate, also see the population unable to see a physician due to cost. American Indians, with the highest unemployment rate and highest poverty rate experience the lowest life expectancy.

Nebraska saw a reduction in our infant mortality and teen birth rates; however, Nebraska's racial and ethnic minority teen birth rate is still more than double the numbers seen in the United States. There continues to be a large disparity between African Americans, Hispanics and American Indians when compared to Whites in terms of teen birth. Heart disease and stroke mortality is decreasing, while prevalence of diabetes is increasing. However, less years of life had been lost due to cancer when compared to previous years.

Behavior is a very difficult thing to change, and health behavior is arguably even harder to change. Usually affected by an elaborate interaction between policy, individual choice, motivation, and the environment, health behavior is not simple. Nebraska has seen progress in areas like levels of physical activity and consumption of fruits and vegetables as well as lower levels of binge drinking than the nation.

Immigrating and having limited-English proficiency increases the likelihood that an individual will experience health disparities. A larger proportion of foreign-born residents did not have health insurance or a personal physician, compared to those who were born in the United States. Immigrants were also twice as likely to report fair or poor health and were more than three times as likely to report never receiving emotional support compared to U.S.-born citizens. Almost 18% of LEP individuals experienced serious psychological distress, compared to 2% of those who speak English well or very well. The LEP population was also two times less likely to get exercise outside of work and almost four times less likely to have a personal physician. The LEP population was three times as likely as those who spoke English well to report fair or poor health and an inability to see a physician due to cost. Finally, those who did not speak English well or at all were five times as likely to have reported never receiving emotional support compared to those who spoke English well or very well.

Education and income are strong predictors of health. Those with less education and lower income were much more effected by negative health outcomes than their more educated and wealthier counterparts. For example, almost 5.5 times more people who made less than $25,000 per year than those who made $50,000 or more reported fair or poor health status. Moreover, those with less than a high school education were three times less likely than those with a bachelor's degree to get exercise outside of work. Almost nine times as many people with less than a high school education experienced serious psychological distress, compared to those with a bachelor's degree. Every indicator reinforced the relationship that the more money you make and the more education you achieve, the more likely you are to be healthy.

To see further progress as we move toward 2020, it is imperative that public health, health care, government, and communities work together to combat the issues and create a welcoming environment for change. Addressing health disparities requires participation from the population, communities, multi-sector stakeholders, and all levels of government to understand what is needed and to collaborate to realize genuine change.

APPENDIX

General Population and Housing Characteristics

Total Population

Subject	Total Population		Males		Females	
AGE	Number	Percent	Number	Percent	Number	Percent
Total population	1,826,341	100.0	906,296	49.6	920,045	50.4
Under 5 years	131,908	7.2	67,630	3.7	64,278	3.5
5 to 9 years	128,928	7.1	65,888	3.6	63,040	3.5
10 to 14 years	122,706	6.7	62,686	3.4	60,020	3.3
15 to 19 years	128,930	7.1	66,033	3.6	62,897	3.4
20 to 24 years	129,276	7.1	66,232	3.6	63,044	3.5
25 to 29 years	129,076	7.1	65,891	3.6	63,185	3.5
30 to 34 years	116,100	6.4	59,085	3.2	57,015	3.1
35 to 39 years	110,361	6.0	56,043	3.1	54,318	3.0
40 to 44 years	110,477	6.0	55,905	3.1	54,572	3.0
45 to 49 years	128,491	7.0	64,171	3.5	64,320	3.5
50 to 54 years	130,235	7.1	65,210	3.6	65,025	3.6
55 to 59 years	117,686	6.4	58,068	3.2	59,618	3.3
60 to 64 years	95,490	5.2	47,051	2.6	48,439	2.7
65 to 69 years	68,834	3.8	33,056	1.8	35,778	2.0
70 to 74 years	54,292	3.0	25,108	1.4	29,184	1.6
75 to 79 years	46,435	2.5	20,206	1.1	26,229	1.4
80 to 84 years	37,808	2.1	15,243	0.8	22,565	1.2
85 years and over	39,308	2.2	12,790	0.7	26,518	1.5
Median age (years)	36.2	(X)	35.0	(X)	37.5	(X)
16 years and over	1,417,810	77.6	697,101	38.2	720,709	39.5
18 years and over	1,367,120	74.9	671,147	36.7	695,973	38.1
21 years and over	1,286,989	70.5	630,293	34.5	656,696	36.0
62 years and over	300,516	16.5	132,854	7.3	167,662	9.2
65 years and over	246,677	13.5	106,403	5.8	140,274	7.7

Source: U.S. Census Bureau, 2010 Census

Subject			Subject		
RELATIONSHIP [1]	Number	Percent	**HOUSEHOLD BY TYPE [1]**	Number	Percent
In households	1,775,176	7.2	**Total households**	721,130	100.0
Householder	721,130	7.1	**Family households [3]**	467,206	64.8
Spouse [2]	366,258	6.7	**Own children under 18**	214,532	29.7
Child	519,519	7.1	**Husband-wife family**	366,258	50.8
Own child under 18	420,081	7.1	Own child under 18	152,991	21.2
Other relatives	68,976	7.1	**Male householder**	30,223	4.2
Under 18 years	28,316	6.4	Own child under 18	16,815	2.3
65 years and over	7,304	0.4	**Female householder**	70,725	9.8
Nonrelatives	99,293	5.4	Own child under 18	44,726	6.2
Under 18 years	8,511	0.5	**Nonfamily households [4]**	253,924	35.2
65 years and over	3,122	0.2	**Householder living alone**	206,807	28.7
Unmarried partner	43,569	2.4	Male	94,836	13.2
In group quarters	51,165	2.8	65 years and over	20,691	2.9
Institutionalized	23,633	1.3	Female	111,971	15.5
Male	12,993	0.7	65 years and over	54,639	7.6
Female	10,640	0.6	**With individuals under 18**	231,041	32.0
Noninstitutionalized	27,532	1.5	**With individuals 65 years and over**	172,198	23.9
Male	14,110	0.8	**Average household size**	2.46	(X)
Female	13,422	0.7	**Average family size**	3.04	(X)
HOUSING TENURE [1]					
Occupied housing units	721,130	100.0	**Renter-occupied housing units**	236,400	32.8
Owner-occupied housing units	484,730	67.2	**Population in renter-occupied housing units**	522,258	(X)
Population in owner-occupied housing units	1,252,918	(X)	**Average household size of renter-occupied units**	2.21	(X)
Average household size of owner-occupied units	2.58	(X)			

"X" Not applicable.

[1] When a category other than Total Population is selected, all persons in the household were classified by the race, Hispanic or Latino origin, or tribe/tribal grouping of the person.

[2] "Spouse" represents spouse of the householder. It does not reflect all spouses in a household. Responses of "same-sex spouse" were edited during processing to "unmarried partner."

[3] "Family households" consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couple households were included in the family households category if there is at least one additional person related to the householder by birth or adoption. Same-sex couple households with no relatives of the householder present were tabulated in nonfamily households. "Nonfamily households" consist of people living alone and households which do not have any members related to the householder.

Source: U.S. Census Bureau, 2010 Census.

Note: As part of the release of Summary File 2 (SF2) data, the Census Bureau released quick-table DP-1 for 38 states between December 15, 2011 and April 5, 2012. Some of the data cells in these tables were found to be erroneous (the male institutionalized population count and percentage). The tables were removed on April 9, 2012, and the data cells were corrected and re-released on April 26, 2012.

African American Population

Subject	Total Population		Males		Females	
AGE	Number	Percent	Number	Percent	Number	Percent
Total population	82,885	100.0	42,138	50.8	40,747	49.2
Under 5 years	7,953	9.6	4,051	4.9	3,902	4.7
5 to 9 years	7,324	8.8	3,749	4.5	3,575	4.3
10 to 14 years	6,986	8.4	3,595	4.3	3,391	4.1
15 to 19 years	7,631	9.2	3,998	4.8	3,633	4.4
20 to 24 years	7,098	8.6	3,666	4.4	3,432	4.1
25 to 29 years	6,819	8.2	3,525	4.3	3,294	4.0
30 to 34 years	5,913	7.1	3,116	3.8	2,797	3.4
35 to 39 years	5,456	6.6	2,792	3.4	2,664	3.2
40 to 44 years	5,102	6.2	2,665	3.2	2,437	2.9
45 to 49 years	5,513	6.7	2,881	3.5	2,632	3.2
50 to 54 years	5,050	6.1	2,543	3.1	2,507	3.0
55 to 59 years	3,875	4.7	1,963	2.4	1,912	2.3
60 to 64 years	2,751	3.3	1,290	1.6	1,461	1.8
65 to 69 years	1,837	2.2	842	1.0	995	1.2
70 to 74 years	1,389	1.7	628	0.8	761	0.9
75 to 79 years	1,030	1.2	437	0.5	593	0.7
80 to 84 years	666	0.8	258	0.3	408	0.5
85 years and over	492	0.6	139	0.2	353	0.4
Median age (years)	28.3	(X)	27.9	(X)	28.7	(X)
16 years and over	59,105	71.3	29,957	36.1	29,148	35.2
18 years and over	56,024	67.6	28,321	34.2	27,703	33.4
21 years and over	51,445	62.1	25,944	31.3	25,501	30.8
62 years and over	6,879	8.3	2,979	3.6	3,900	4.7
65 years and over	5,414	6.5	2,304	2.8	3,110	3.8

Source: U.S. Census Bureau, 2010 Census

Subject			Subject		
RELATIONSHIP [1]	Number	Percent	**HOUSEHOLD BY TYPE [1]**	Number	Percent
In households	82,885	100.0	**Total households**	30,185	100.0
Householder	78,570	94.8	**Family households [3]**	18,508	61.3
Spouse [2]	30,185	36.4	**Own children under 18**	10,911	36.1
Child	7,251	8.7	**Husband-wife family**	7,826	25.9
Own child under 18	28,583	34.5	Own child under 18	3,929	13.0
Other relatives	22,448	27.1	**Male householder**	2,079	6.9
Under 18 years	6,521	7.9	Own child under 18	1,132	3.8
65 years and over	3,169	3.8	**Female householder**	8,603	28.5
Nonrelatives	389	0.5	Own child under 18	5,850	19.4
Under 18 years	6,030	7.3	**Nonfamily households [3]**	11,677	38.7
65 years and over	711	0.9	**Householder living alone**	9,820	32.5
Unmarried partner	132	0.2	Male	4,938	16.4
In group quarters	2,592	3.1	65 years and over	633	2.1
Institutionalized	4,315	5.2	Female	4,882	16.2
Male	2,838	3.4	65 years and over	1,155	3.8
Female	2,362	2.8	**With individuals under 18**	12,466	41.3
Noninstitutionalized	476	0.6	**With individuals 65 years and over**	4,337	14.4
Male	1,477	1.8	**Average household size**	2.58	(X)
Female	975	1.2	**Average family size**	3.30	(X)
HOUSING TENURE [1]					
Occupied housing units	30,185	100.0	**Renter-occupied housing units**	19,609	65.0
Owner-occupied housing units	10,576	35.0	**Population in renter-occupied housing units**	48,648	(X)
Population in owner-occupied housing units	29,188	(X)	**Average household size of renter-occupied units**	2.48	(X)
Average household size of owner-occupied units	2.76	(X)			

"X" Not applicable.

[1] When a category other than Total Population is selected, all persons in the household were classified by the race, Hispanic or Latino origin, or tribe/tribal grouping of the person.

[2] "Spouse" represents spouse of the householder. It does not reflect all spouses in a household. Responses of "same-sex spouse" were edited during processing to "unmarried partner."

[3] "Family households" consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couple households were included in the family households category if there is at least one additional person related to the householder by birth or adoption. Same-sex couple households with no relatives of the householder present were tabulated in nonfamily households. "Nonfamily households" consist of people living alone and households which do not have any members related to the householder.

Source: U.S. Census Bureau, 2010 Census.

Note: As part of the release of Summary File 2 (SF2) data, the Census Bureau released quick-table DP-1 for 38 states between December 15, 2011 and April 5, 2012. Some of the data cells in these tables were found to be erroneous (the male institutionalized population count and percentage). The tables were removed on April 9, 2012, and the data cells were corrected and re-released on April 26, 2012.

Asian Population

Subject	Total Population		Males		Females	
AGE	Number	Percent	Number	Percent	Number	Percent
Total population	32,293	100.0	15,456	47.9	16,837	52.1
Under 5 years	2,546	7.9	1,287	4.0	1,259	3.9
5 to 9 years	2,607	8.1	1,278	4.0	1,329	4.1
10 to 14 years	2,177	6.7	1,088	3.4	1,089	3.4
15 to 19 years	2,362	7.3	1,206	3.7	1,156	3.6
20 to 24 years	3,316	10.3	1,656	5.1	1,660	5.1
25 to 29 years	3,485	10.8	1,685	5.2	1,800	5.6
30 to 34 years	2,975	9.2	1,473	4.6	1,502	4.7
35 to 39 years	2,938	9.1	1,434	4.4	1,504	4.7
40 to 44 years	2,419	7.5	1,151	3.6	1,268	3.9
45 to 49 years	1,818	5.6	847	2.6	971	3.0
50 to 54 years	1,494	4.6	629	1.9	865	2.7
55 to 59 years	1,297	4.0	520	1.6	777	2.4
60 to 64 years	1,103	3.4	459	1.4	644	2.0
65 to 69 years	707	2.2	317	1.0	390	1.2
70 to 74 years	477	1.5	211	0.7	266	0.8
75 to 79 years	274	0.8	102	0.3	172	0.5
80 to 84 years	174	0.5	69	0.2	105	0.3
85 years and over	124	0.4	44	0.1	80	0.2
Median age (years)	29.5	(X)	28.5	(X)	30.4	(X)
16 years and over	24,534	76.0	11,594	35.9	12,940	40.1
18 years and over	23,654	73.2	11,137	34.5	12,517	38.8
21 years and over	21,984	68.1	10,292	31.9	11,692	36.2
62 years and over	2,311	7.2	976	3.0	1,335	4.1
65 years and over	1,756	5.4	743	2.3	1,013	3.1

Source: U.S. Census Bureau, 2010 Census

Subject			Subject		
RELATIONSHIP [1]	Number	Percent	**HOUSEHOLD BY TYPE [1]**	Number	Percent
In households	Number	Percent	**Total households**	9,801	100.0
Householder	32,293	100.0	**Family households [3]**	6,798	69.4
Spouse [2]	31,304	96.9	**Own children under 18**	4,080	41.6
Child	9,801	30.4	**Husband-wife family**	5,525	56.4
Own child under 18	6,931	21.5	Own child under 18	3,413	34.8
Other relatives	9,887	30.6	**Male householder**	463	4.7
Under 18 years	7,858	24.3	Own child under 18	197	2.0
65 years and over	2,582	8.0	**Female householder**	810	8.3
Nonrelatives	592	1.8	Own child under 18	470	4.8
Under 18 years	497	1.5	**Nonfamily households [3]**	3,003	30.6
65 years and over	2,103	6.5	**Householder living alone**	2,095	21.4
Unmarried partner	141	0.4	Male	1,130	11.5
In group quarters	44	0.1	65 years and over	61	0.6
Institutionalized	471	1.5	Female	965	9.8
Male	989	3.1	65 years and over	176	1.8
Female	97	0.3	**With individuals under 18**	4,344	44.3
Noninstitutionalized	70	0.2	**With individuals 65 years and over**	1,175	12.0
Male	892	2.8	**Average household size**	2.93	(X)
Female	403	1.2	**Average family size**	3.54	(X)
HOUSING TENURE [1]					
Occupied housing units	9,801	100.0	**Renter-occupied housing units**	5,028	51.3
Owner-occupied housing units	4,773	48.7	**Population in renter-occupied housing units**	12,325	(X)
Population in owner-occupied housing units	16,419	(X)	**Average household size of renter-occupied units**	2.45	(X)
Average household size of owner-occupied units	3.44	(X)			

"X" Not applicable.

[1] When a category other than Total Population is selected, all persons in the household were classified by the race, Hispanic or Latino origin, or tribe/tribal grouping of the person.

[2] "Spouse" represents spouse of the householder. It does not reflect all spouses in a household. Responses of "same-sex spouse" were edited during processing to "unmarried partner."

[3] "Family households" consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couple households were included in the family households category if there is at least one additional person related to the householder by birth or adoption. Same-sex couple households with no relatives of the householder present were tabulated in nonfamily households. "Nonfamily households" consist of people living alone and households which do not have any members related to the householder.

Source: U.S. Census Bureau, 2010 Census.

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American Indian/Alaska Native Population

Subject	Total Population		Males		Females	
AGE	Number	Percent	Number	Percent	Number	Percent
Total population	18,427	100.0	9,044	49.1	9,383	50.9
Under 5 years	1,975	10.7	1,008	5.5	967	5.2
5 to 9 years	2,021	11.0	1,052	5.7	969	5.3
10 to 14 years	1,804	9.8	887	4.8	917	5.0
15 to 19 years	1,821	9.9	927	5.0	894	4.9
20 to 24 years	1,517	8.2	784	4.3	733	4.0
25 to 29 years	1,345	7.3	687	3.7	658	3.6
30 to 34 years	1,295	7.0	636	3.5	659	3.6
35 to 39 years	1,189	6.5	571	3.1	618	3.4
40 to 44 years	1,175	6.4	559	3.0	616	3.3
45 to 49 years	1,108	6.0	514	2.8	594	3.2
50 to 54 years	980	5.3	441	2.4	539	2.9
55 to 59 years	821	4.5	376	2.0	445	2.4
60 to 64 years	567	3.1	269	1.5	298	1.6
65 to 69 years	313	1.7	119	0.6	194	1.1
70 to 74 years	237	1.3	126	0.7	111	0.6
75 to 79 years	139	0.8	58	0.3	81	0.4
80 to 84 years	60	0.3	14	0.1	46	0.2
85 years and over	60	0.3	16	0.1	44	0.2
Median age (years)	25.2	(X)	24.1	(X)	26.4	(X)
16 years and over	12,282	66.7	5,916	32.1	6,366	34.5
18 years and over	11,531	62.6	5,525	30.0	6,006	32.6
21 years and over	10,492	56.9	5,008	27.2	5,484	29.8
62 years and over	1,133	6.1	478	2.6	655	3.6
65 years and over	809	4.4	333	1.8	476	2.6

Source: U.S. Census Bureau, 2010 Census

Subject			Subject		
RELATIONSHIP [1]	Number	Percent	**HOUSEHOLD BY TYPE [1]**	Number	Percent
In households	18,427	100.0	**Total households**	5,162	100.0
Householder	17,650	95.8	**Family households [3]**	3,651	70.7
Spouse [2]	5,162	28.0	**Own children under 18**	2,208	42.8
Child	1,850	10.0	**Husband-wife family**	1,688	32.7
Own child under 18	6,601	35.8	Own child under 18	982	19.0
Other relatives	5,068	27.5	**Male householder**	508	9.8
Under 18 years	2,427	13.2	Own child under 18	279	5.4
65 years and over	1,439	7.8	**Female householder**	1,455	28.2
Nonrelatives	90	0.5	Own child under 18	947	18.3
Under 18 years	1,610	8.7	**Nonfamily households [3]**	1,511	29.3
65 years and over	282	1.5	**Householder living alone**	1,137	22.0
Unmarried partner	37	0.2	Male	585	11.3
In group quarters	741	4.0	65 years and over	85	1.6
Institutionalized	777	4.2	Female	552	10.7
Male	461	2.5	65 years and over	110	2.1
Female	347	1.9	**With individuals under 18**	2,694	52.2
Noninstitutionalized	114	0.6	**With individuals 65 years and over**	626	12.1
Male	316	1.7	**Average household size**	3.28	(X)
Female	134	0.7	**Average family size**	3.86	(X)
HOUSING TENURE [1]					
Occupied housing units	5,162	100.0	**Renter-occupied housing units**	3,217	62.3
Owner-occupied housing units	1,945	37.7	**Population in renter-occupied housing units**	10,260	(X)
Population in owner-occupied housing units	6,681	(X)	**Average household size of renter-occupied units**	3.19	(X)
Average household size of owner-occupied units	3.43	(X)			

"X" Not applicable.

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[2] "Spouse" represents spouse of the householder. It does not reflect all spouses in a household. Responses of "same-sex spouse" were edited during processing to "unmarried partner."

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Source: U.S. Census Bureau, 2010 Census.

Note: As part of the release of Summary File 2 (SF2) data, the Census Bureau released quick-table DP-1 for 38 states between December 15, 2011 and April 5, 2012. Some of the data cells in these tables were found to be erroneous (the male institutionalized population count and percentage). The tables were removed on April 9, 2012, and the data cells were corrected and re-released on April 26, 2012.

Hispanic Population

Subject	Total Population		Males		Females	
AGE	Number	Percent	Number	Percent	Number	Percent
Total population	167,405	100.0	88,149	52.7	79,256	47.3
Under 5 years	22,728	13.6	11,710	7.0	11,018	6.6
5 to 9 years	20,144	12.0	10,213	6.1	9,931	5.9
10 to 14 years	17,034	10.2	8,773	5.2	8,261	4.9
15 to 19 years	15,542	9.3	8,127	4.9	7,415	4.4
20 to 24 years	14,643	8.7	7,943	4.7	6,700	4.0
25 to 29 years	14,991	9.0	8,208	4.9	6,783	4.1
30 to 34 years	13,914	8.3	7,414	4.4	6,500	3.9
35 to 39 years	12,357	7.4	6,628	4.0	5,729	3.4
40 to 44 years	10,269	6.1	5,609	3.4	4,660	2.8
45 to 49 years	7,896	4.7	4,280	2.6	3,616	2.2
50 to 54 years	6,083	3.6	3,300	2.0	2,783	1.7
55 to 59 years	4,272	2.6	2,239	1.3	2,033	1.2
60 to 64 years	2,872	1.7	1,479	0.9	1,393	0.8
65 to 69 years	1,730	1.0	888	0.5	842	0.5
70 to 74 years	1,136	0.7	571	0.3	565	0.3
75 to 79 years	847	0.5	379	0.2	468	0.3
80 to 84 years	536	0.3	230	0.1	306	0.2
85 years and over	411	0.2	158	0.1	253	0.2
Median age (years)	22.8	(X)	23.3	(X)	22.2	(X)
16 years and over	104,366	62.3	55,794	33.3	48,572	29.0
18 years and over	98,221	58.7	52,617	31.4	45,604	27.2
21 years and over	88,916	53.1	47,731	28.5	41,185	24.6
62 years and over	6,254	3.7	3,048	1.8	3,206	1.9
65 years and over	4,660	2.8	2,226	1.3	2,434	1.5

Source: U.S. Census Bureau, 2010 Census

Subject			Subject		
RELATIONSHIP [1]	Number	Percent	**HOUSEHOLD BY TYPE [1]**	Number	Percent
In households	167,405	100.0	**Total households**	41,064	100.0
Householder	163,772	97.8	**Family households [3]**	32,349	78.8
Spouse [2]	41,064	24.5	**Own children under 18**	23,008	56.0
Child	22,207	13.3	**Husband-wife family**	21,318	51.9
Own child under 18	69,720	41.6	Own child under 18	15,224	37.1
Other relatives	59,241	35.4	**Male householder**	4,219	10.3
Under 18 years	17,966	10.7	Own child under 18	2,532	6.2
65 years and over	7,821	4.7	**Female householder**	6,812	16.6
Nonrelatives	987	0.6	Own child under 18	5,252	12.8
Under 18 years	12,815	7.7	**Nonfamily households [3]**	8,715	21.2
65 years and over	1,691	1.0	**Householder living alone**	5,814	14.2
Unmarried partner	118	0.1	Male	3,513	8.6
In group quarters	4,777	2.9	65 years and over	367	0.9
Institutionalized	3,633	2.2	Female	2,301	5.6
Male	1,873	1.1	65 years and over	621	1.5
Female	1,575	0.9	**With individuals under 18**	25,291	61.6
Noninstitutionalized	298	0.2	**With individuals 65 years and over**	3,536	8.6
Male	1,760	1.1	**Average household size**	3.65	(X)
Female	789	0.5	**Average family size**	4.01	(X)
HOUSING TENURE [1]					
Occupied housing units	41,064	100.0	**Renter-occupied housing units**	20,835	50.7
Owner-occupied housing units	20,229	49.3	**Population in renter-occupied housing units**	69,765	(X)
Population in owner-occupied housing units	80,253	(X)	**Average household size of renter-occupied units**	3.35	(X)
Average household size of owner-occupied units	3.97	(X)			

"X" Not applicable.

[1] When a category other than Total Population is selected, all persons in the household were classified by the race, Hispanic or Latino origin, or tribe/tribal grouping of the person.

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Source: U.S. Census Bureau, 2010 Census.

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White Population

Subject	Total Population		Males		Females	
AGE	Number	Percent	Number	Percent	Number	Percent
Total population	1,658,936	100.0	818,147	49.3	840,789	50.7
Under 5 years	109,180	6.6	55,920	3.4	53,260	3.2
5 to 9 years	108,784	6.6	55,675	3.4	53,109	3.2
10 to 14 years	105,672	6.4	53,913	3.2	51,759	3.1
15 to 19 years	113,388	6.8	57,906	3.5	55,482	3.3
20 to 24 years	114,633	6.9	58,289	3.5	56,344	3.4
25 to 29 years	114,085	6.9	57,683	3.5	56,402	3.4
30 to 34 years	102,186	6.2	51,671	3.1	50,515	3.0
35 to 39 years	98,004	5.9	49,415	3.0	48,589	2.9
40 to 44 years	100,208	6.0	50,296	3.0	49,912	3.0
45 to 49 years	120,595	7.3	59,891	3.6	60,704	3.7
50 to 54 years	124,152	7.5	61,910	3.7	62,242	3.8
55 to 59 years	113,414	6.8	55,829	3.4	57,585	3.5
60 to 64 years	92,618	5.6	45,572	2.7	47,046	2.8
65 to 69 years	67,104	4.0	32,168	1.9	34,936	2.1
70 to 74 years	53,156	3.2	24,537	1.5	28,619	1.7
75 to 79 years	45,588	2.7	19,827	1.2	25,761	1.6
80 to 84 years	37,272	2.2	15,013	0.9	22,259	1.3
85 years and over	38,897	2.3	12,632	0.8	26,265	1.6
Median age (years)	38.2	(X)	36.9	(X)	39.5	(X)
16 years and over	1,313,444	79.2	641,307	38.7	672,137	40.5
18 years and over	1,268,899	76.5	618,530	37.3	650,369	39.2
21 years and over	1,198,073	72.2	582,562	35.1	615,511	37.1
62 years and over	294,262	17.7	129,806	7.8	164,456	9.9
65 years and over	242,017	14.6	104,177	6.3	137,840	8.3

Source: U.S. Census Bureau, 2010 Census

Subject			Subject		
RELATIONSHIP [1]	Number	Percent	**HOUSEHOLD BY TYPE [1]**	Number	Percent
In households	1,658,936	100.0	**Total households**	680,066	100.0
Householder	1,611,404	97.1	**Family households [3]**	434,857	63.9
Spouse [2]	680,066	41.0	**Own children under 18**	191,524	28.2
Child	344,051	20.7	**Husband-wife family**	344,940	50.7
Own child under 18	449,799	27.1	Own child under 18	137,767	20.3
Other relatives	360,840	21.8	**Male householder**	26,004	3.8
Under 18 years	51,010	3.1	Own child under 18	14,283	2.1
65 years and over	20,495	1.2	**Female householder**	63,913	9.4
Nonrelatives	6,317	0.4	Own child under 18	39,474	5.8
Under 18 years	86,478	5.2	**Nonfamily households [3]**	245,209	36.1
65 years and over	6,820	0.4	**Householder living alone**	200,993	29.6
Unmarried partner	3,004	0.2	Male	91,323	13.4
In group quarters	38,792	2.3	65 years and over	20,324	3.0
Institutionalized	47,532	2.9	Female	109,670	16.1
Male	21,760	1.3	65 years and over	54,018	7.9
Female	11,418	0.7	**With individuals under 18**	205,750	30.3
Noninstitutionalized	10,342	0.6	**With individuals 65 years and over**	168,662	24.8
Male	25,772	1.6	**Average household size**	2.39	(X)
Female	13,139	0.8	**Average family size**	2.97	(X)
HOUSING TENURE [1]					
Occupied housing units	680,066	100.0	**Renter-occupied housing units**	215,565	31.7
Owner-occupied housing units	464,501	68.3	**Population in renter-occupied housing units**	452,493	(X)
Population in owner-occupied housing units	1,172,665	(X)	**Average household size of renter-occupied units**	2.10	(X)
Average household size of owner-occupied units	2.52	(X)			

"X" Not applicable.
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Source: U.S. Census Bureau, 2010 Census.
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Glossary

Age-Adjusted Death Rate: A weighted average of a crude death rate according to a standard distribution. Age adjusting is a process by which the age composition of a population is held constant so that changes or differences in age composition can be eliminated from the analysis. This is necessary because older populations have higher death rates merely because death rates increase with age. Age adjusting allows the researcher to make meaningful comparisons over time and among groups in the risk of mortality. The death rates in this report have been adjusted according to the age distribution of the United States population in 2000 so that these rates are stabilized from fluctuation due to changes and difference in age composition of the population under study. This is calculated by the sum of age-specific death rates for each age group, multiplied by standard population in each age group, and divided by the total standard population.

Body Mass Index (BMI): A measure of weight relative to height. A BMI of less than 25 is considered ideal or healthy; a BMI of 25-29 is considered overweight; and a BMI of 30 or higher is indicative of obesity. BMI is calculated by dividing an individual's weight in kilograms by the individual's height in meters squared.

Birth Weight: The first weight of the fetus or newborn obtained after birth. This weight should be measured preferably within the first hour of life before significant postnatal weight loss has occurred.

Cause of Death: Deaths, by cause, are classified according to the International Classification of Diseases, Tenth Revision, of the World Health Organization.

Death Rate: A death rate is a ratio between mortality and population, or the number of deaths per specific number of people. This is the most widely used measure to determine the overall health of a community. Death rates are usually computed per 100,000 population. Rates allow meaningful comparisons between groups of unequal size.

Diabetes: Often times called diabetes mellitus, is a disease of the pancreas in which the body does not produce or properly use insulin, a hormone that is needed to convert glucose into energy. According to the Centers for Disease Prevention and Control and Prevention, "Diabetes mellitus is a group of diseases characterized by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. Diabetes can be associated with serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications."

Disability Status:

Limited Activity- Respondents who report that their activity is limited in any way because of physical, mental, or emotional problems.

Special Equipment Requirements- Respondents who report having health problems that require the use of special equipment such as a cane, wheelchair, special bed, or special telephone.

Employed: Employed includes all civilians 16 years old and over who were either (1) "at work" -- those who did any work at all during the reference week as paid employees, worked in their own business or profession, worked on their own farm, or worked 15 hours or more as unpaid workers on a family farm or in a family business; or (2) were "with a job but not at work" -- those who did not work during the reference week but had jobs or businesses from which they were temporarily absent due to illness, bad weather, industrial dispute, vacation, or other personal reasons. Excluded from the employed were people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded were people on active duty in the United States Armed Forces. The reference week is the calendar week preceding the date on which the respondents completed their questionnaires or were interviewed. This week may not be the same for all respondents.

Household: A household includes all the people who occupy a housing unit. (People not living in households were classified as living in group quarters.) A family household consists of a householder and one or more people living together in the same household who were related to the householder by birth, marriage, or adoption. It may also include people unrelated to the householder. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated people who share living arrangements.

Incidence: Incidence is an estimate of the number of new cases of disease that develop in a population in a specified time period, usually one year. Incidence is often used as an indicator of the need for preventive measures, or to evaluate the effectiveness of existing programs.

Infant Death: Death of a person under one year of age.

Infant Death Rate: The number of infant deaths per 1,000 live births, calculated as number of infant deaths divided by number of live births, multiplied by 1,000.

Injury deaths: Include deaths that were caused by forces external to the body. Examples of causes of injury death include drowning, fall, firearm, fire or burn, motor vehicle traffic, poisoning, and suffocation.

Kotelchuck Index: It is a prenatal care index. Special natality data summaries were prepared by the Office of Health Care Information. The office uses special programs to create an adequacy of prenatal care index, as formulated by Dr. Milton Kotelchuck. The index characterizes births as inadequate, intermediate, adequate and adequate plus as evaluated for when prenatal care began, weeks' gestation, and number of recommended physician's visits.

Labor Force: All people classified in the civilian labor force and members of the U.S. Armed Forces (people on active duty with the United States Army, Air Force, Navy, Marine Corps, or Coast Guard).

Low birth weight: A birth weight under 2500 grams, or 5 pounds, 8 ounces.

Live birth- The complete expulsion or extraction of a product of conception from its mother, irrespective of the period of gestation, which, after separation, breathes or shows any other evidence of life such as beating of a heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached, and is reportable.

Morbidity: A term used to describe disease, sickness or illness, as a departure from normal physiological and psychological conditions. It is normally expressed as a morbidity rate. Morbidity rates give the closest frame of the quality of life and health status in a given population.

Mortality: A term used to describe death. It is normally expressed as a rate, expressing the proportion of a particular population who die of one or more diseases or of all causes during a specified unit of time, usually a year. It is also the probability of dying within a specified time period. This rate is also called the "crude death rate."

Not in Labor Force: All people 16 years old and older who were not classified as members of the labor force. This category consists mainly of students, homemakers, retired workers, seasonal workers interviewed in an off-season who were not looking for work, institutionalized people, and people doing only incidental unpaid family work (less than 15 hours during the reference week).

Poverty: Following the Office of Management and Budget's Directive 14, the U.S. Census Bureau uses a set of money income thresholds that vary by family size and composition to detect who is poor. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family or unrelated individual is classified as being "below the poverty level."

Unemployed: All civilians 16 years old and over were classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job. Also included as unemployed were civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off, and were available for work except for temporary illness.

Unemployment Rate: The unemployment rate represents the number of unemployed people as a percentage of the civilian labor force. For example, if the civilian labor force equals 100 people and 7 people are unemployed, then the unemployment rate would be 7%.


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