

Health Status of Asians in Nebraska

Office of Health Disparities and
Health Equity

Nebraska Department of Health
and Human Services

2016



Health Status of Asians in Nebraska

Courtney Phillips, MPA

Chief Executive Officer
Department of Health and Human Services

Judy Martin, MS

Deputy Director, Community and Environmental Health
Division of Public Health
Department of Health and Human Services

Susan A. Medinger, RD

Administrator, Community and Rural Health Planning Unit
Division of Public Health
Department of Health and Human Services

Josie Rodriguez, MS

Administrator, Office of Health Disparities and Health Equity
Division of Public Health
Department of Health and Human Services

Report Prepared by:

Anthony Zhang, MA, MPhil

Minority Health Epidemiologist

Lynne Le, MPH

Program Analyst

Department of Health & Human Services



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 Health Planning and Protection Unit; Josie Rodriguez, Administrator, Office of Health Disparities and Health Equity; Ming Qu, DHHS Health Section Administrator; Tom Safranek, State Epidemiologist.

A special thank-you to Norm Nelson, DHHS Statistical Analyst, who provided vital statistics data and BRFSS information for this report. We also wish to acknowledge several people for providing resources for this report: Jeff Armitage, Epidemiology Surveillance Coordinator, for providing some Nebraska health assessment data; and Brenda Coufal, DHHS Program Manager, Carol Gilbert and Allison Miles, Data Analysts, Pregnancy Risk Assessment Monitoring System (PRAMS). Thank you to Shandana Khattak, Statistical Analyst, for editing this report.

Table of Contents

Acknowledgements	3
Executive Summary.....	8
Introduction	10
Data Sources.....	11
Data Source Summary.....	12
Demographics	13
Distribution of Nebraska’s Population: 2014 Estimates	13
Nebraska Population Change: 2010-2014	14
Asians in Nebraska: Specific Groups	15
Nebraska Population: 2010	16
Asian Population Distribution	17
Distribution of Nebraska Asian Population	17
Asian Population by Counties	18
Socioeconomics	19
Poverty Status	19
Poverty Status by Family Type	19
Occupation	20
Income	20
Employment Status.....	21
Educational Attainment	22
Educational Attainment: Female	23
Educational Attainment: Male.....	23
Language Spoken at Home	24
Access to Healthcare	25
Does Not Have a Personal Physician	25
Could Not See Physician Due to Cost.....	25
No Health Coverage.....	26
Routine Check-Up in the Past Year	26
Life Expectancy at Birth.....	27
Life Expectancy at Birth: Nebraska Total.....	27
Life Expectancy at Birth: White.....	28

Life Expectancy at Birth: Asian	28
Mortality	29
Accidental (Unintentional) Deaths.....	30
Leading Causes of Death for Asian Americans	31
The Leading Causes of Death for Males	32
The Leading Causes of Death for Females	33
Years of Potential Life Lost.....	34
Chronic Disease.....	35
Heart Disease	35
Prevalence of Coronary Heart Disease.....	35
Prevalence of Heart Attack.....	36
Prevalence of Heart Attack or Coronary Heart Disease	36
Heart Disease Mortality.....	37
Stroke	38
Stroke Mortality	38
Chronic Obstructive Pulmonary Disease (COPD).....	39
COPD Mortality	39
Diabetes.....	40
Diabetes Mortality	40
Kidney Disease	41
Arthritis	41
Asthma	42
Ever Diagnosed with Asthma	42
Current Asthma.....	42
Cancer	43
Cancer Mortality.....	43
Infectious Disease.....	44
HIV/AIDS Incidence	44
Cumulative HIV and AIDS.....	44
Sexually Transmitted Diseases.....	45
Incidence of Gonorrhea	45

Incidence of Chlamydia	46
Maternal and Child Health	47
Infant Mortality	47
Low Birth Weight.....	48
Teen Births	48
Mothers Receiving First Trimester Prenatal Care	49
Kotelchuck Index	50
PRAMS and Breastfeeding	51
Receiving Counseling on Breastfeeding & Initiating Breastfeeding	52
Continued Breastfeeding	53
Baby Only Fed Breast Milk at the Hospital.....	53
Hospital Provision of Breastfeeding Information	54
Postpartum Depression Risk	55
Smoking During the Last Three Months of Pregnancy.....	55
Behavioral Risk Factors	56
Health Status.....	56
Fair or Poor Health	56
Physically Unwell: Average Number of Days.....	57
Physically Unwell: 14+ Days.....	57
Mental Health: Average Number of Days	58
Mentally Unwell: 14+ Days	58
Activity Limitation: Average Number of Days	59
Activity Limitation: 14+ Days.....	59
Cigarette Smoking.....	60
Any Alcohol Consumption in the Past 30 Days	60
Binge Drinking.....	61
Heavy Drinking	61
Physical Inactivity.....	62
Overweight and Obesity.....	63
Cancer Screening	64
Clinical Breast Exams (Ages 50-74)	64

Mammogram (Ages 50-74)	65
Pap Test (Ages 21-65)	66
Colorectal Cancer Screening (Ages 50-75)	67
Other Preventative Behavioral Factors.....	68
Use of Seatbelts	68
HIV Test (Ages 18-64).....	69
Flu Vaccination Past Year (Ages 18+).....	69
Flu Vaccination Past Year (Ages 65+).....	70
Ever Had Pneumonia Vaccination (Ages 65+)	70
Conclusion.....	71
Glossary of Terms	72

Executive Summary

The Asian Health Status Report shows comprehensive information regarding the health disparities faced by Asian Nebraskans including health behaviors, socioeconomic status, and a variety of other health indicators. It is our hope that this report will serve as a data resource for Asian communities in Nebraska, and for those who work for and with Asian people in Nebraska.

In Nebraska, 2014 estimates indicate that Asians accounted for 2.1% of the total population, or 39,854 people (non-Hispanic). This was a slight increase from 1.7% in 2010. Between 2010 and 2014, there was a 24% increase in the Asian population—the highest percent change among all racial and ethnic groups of Nebraska, despite being the fourth most numerous racial or ethnic group (behind non-Hispanic Whites, Hispanics, and African Americans).

As shown in this report, the health status of Asians is relatively good; sometimes, it is even better than that of non-Hispanic Whites. Despite this fact, it is still important to examine the health status of a population, especially one that is increasing as rapidly as the Asian population, in order to have a point of comparison in future reports. Finding areas of strength and weakness in the health of Asians is crucial to understanding where and why disparities exist, and serves as the first step to reducing or closing the health gap between two populations.

Highlights of the report include:

- A higher proportion of Asian families (37.9%) with a female householder and no husband present were in poverty than non-Hispanic White families of the same type (30.5%).
- Approximately one-third of Asian (33.3%) respondents were high school graduates or had some college education compared to 63.5% of non-Hispanic Whites. The largest proportion of Asian respondents (43.6%) had a bachelor's degree or higher.
- In total, 76.5% of Asians reported speaking another language at home; of those, 34.8% also speak English very well and 41.7% do not speak English very well.
- The proportion of Asians reporting no personal physician or provider was approximately 5% higher than the percent of Whites reporting the same.
- Similar proportions of Asians and Whites reported no healthcare coverage.

- For Asians, diabetes was in the top five causes of death. However, diabetes was absent from the list of top five for Whites. Among Asian females, hypertension was also a leading cause of death, which was absent for White females.
- About 0.5% of Asians reported ever being diagnosed with a stroke, which was lower than Whites (2.3%); However, the stroke mortality rate among Asian females was higher than the rate for Whites (37 per 100,000 compared to 34.2 per 100,000, respectively).
- Asians have far lower numbers of HIV and AIDS cases than non-Hispanic Whites.
- Higher proportions of Asian mothers continued breastfeeding at four and eight weeks post-pregnancy than White mothers.
- There were fewer Asian smokers and fewer Asians who had consumed any alcohol in the past 30 days.

There were many health indicators in which Asian Nebraskans ranked better than other racial and ethnic groups; however there were also a few areas where the health of Asians is not as favorable. For example, when it comes to chronic disease indicators such as strokes (mortality) and diabetes (leading cause of death), Asians experienced greater burdens than non-Hispanic Whites. Asians (and other racial or ethnic minorities) also suffer more than non-Hispanic Whites in terms of social determinants of health. They may not receive timely or adequate healthcare due to lack of access, language or cultural barriers, lack of insurance, among a number of other factors.

On a national level, many Asians suffer from hepatitis B, tuberculosis, chronic obstructive pulmonary disease, and a number of other ailments.¹ While it is possible that Asians in Nebraska experience the same illnesses, the Office of Health Disparities and Health Equity in the Nebraska Department of Health and Human Services lack sufficient data and cannot report on these indicators. The national statistics mentioned above support the notion that, despite their good current health status, disparities faced by Asians are not to be ignored.

The information presented in this report can be used to educate the public on disparities faced by Asian Nebraskans and can shed light on health indicators that require immediate attention. By addressing areas where the health of the Asian population is worse than the non-Hispanic White population, we, as a state, can work to decrease the health gap and to promote health equity in Nebraska.

¹ Office of Minority Health. Retrieved from <http://minorityhealth.hhs.gov/omh/browse.aspx?vl=3&vlid=63>

Introduction

The Office of Health Disparities and Health Equity (OHDHE) strives to provide a comprehensive look at health disparities among racial and ethnic minorities in Nebraska. As a building block toward that goal, the OHDHE has compiled this data report based on the most recent statistical information available. This report presents health status facts coupled with socioeconomic status information on the Asian population in Nebraska, and will show the contrast between Asians and the Non-Hispanic/Latino White (Whites) majority population. The statistical information contained here spans several different health issues including mortality, chronic diseases, cancers, HIV and sexually transmitted diseases, heart disease, stroke, cancer, diabetes, and infectious diseases.

This report is a part of a series of reports produced by OHDHE entitled the Nebraska Minority Health Disparities Facts Reports, each focusing on one specific racial or ethnic group. The organizations, information, and analysis methodology presented here are consistent in each report and provide a multi-dimensional view of health disparities experienced by minorities of Nebraska.

For the purpose of this report, 'race and ethnicity' as defined by the United States Census Bureau and the Federal Office of Management and Budget (OMB) are "self-identification data items in which residents choose the race or races with which they most closely identify, and indicate whether or not they are of Hispanic or Latino origin (ethnicity)." The racial classifications used by the Census Bureau adhere to the October 30, 1997 Federal Register Notice entitled Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity issued by the OMB². The OMB defines five minimum race categories: White, African American, American Indian/Alaska Native, Asian and Native Hawaiian/Other Pacific Islander.

As defined by the OMB and the U.S. Census Bureau:

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "White," or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian."

² <http://www.whitehouse.gov/omb/fedreg/ombdir15.html>

Data Sources

The data sources for this report come from the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS, 2010-2012), Nebraska Behavioral Risk Factor Surveillance System (BRFSS, 2011-2014), the Nebraska Department of Health and Human Services (DHHS) Vital Statistics, Nebraska DHHS HIV/AIDS Surveillance Program (2014), and other programs. The demographic and socioeconomic data in the report comes from U.S. Census Bureau and five-year data from the U.S. Census Bureau American Community Survey (2010-2014). The leading causes of death are compiled by the National Center for Injury Prevention and Control using data from the National Center for Health Statistics' Vital Statistics System. The CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP; <http://www.cdc.gov/nchhstp/atlas/>) is also used in this report.

From Nebraska Vital Statistics, different ethnic groups' data are presented in the format of age adjusted rate per 100,000 people. 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, so any differences between the populations are more readily seen. Please note that not all data are age-adjusted and are appropriately noted.

BRFSS surveys have been conducted annually since 1986 for the purpose of data collection on the prevalence of major health risk factors among adults. The data gathered in this survey can be used to target health education and risk reduction activities among Asians throughout Nebraska in order to lower rates of premature death and disability. In this report, the Asian American data is summarized and compared to Nebraska as a whole, where available, and to non-Hispanic White data to reveal the disparity status for various health issues. The BRFSS data presented are also age-adjusted and are paired with 95% confidence intervals.

Data Source Summary

As alluded to previously, our reports use a variety of data sources that may cover different time spans. We keep these reports as updated as possible, however due to data availability, the years covered by each data source may differ. The table below is a quick summary of the years covered by each data source in this report.

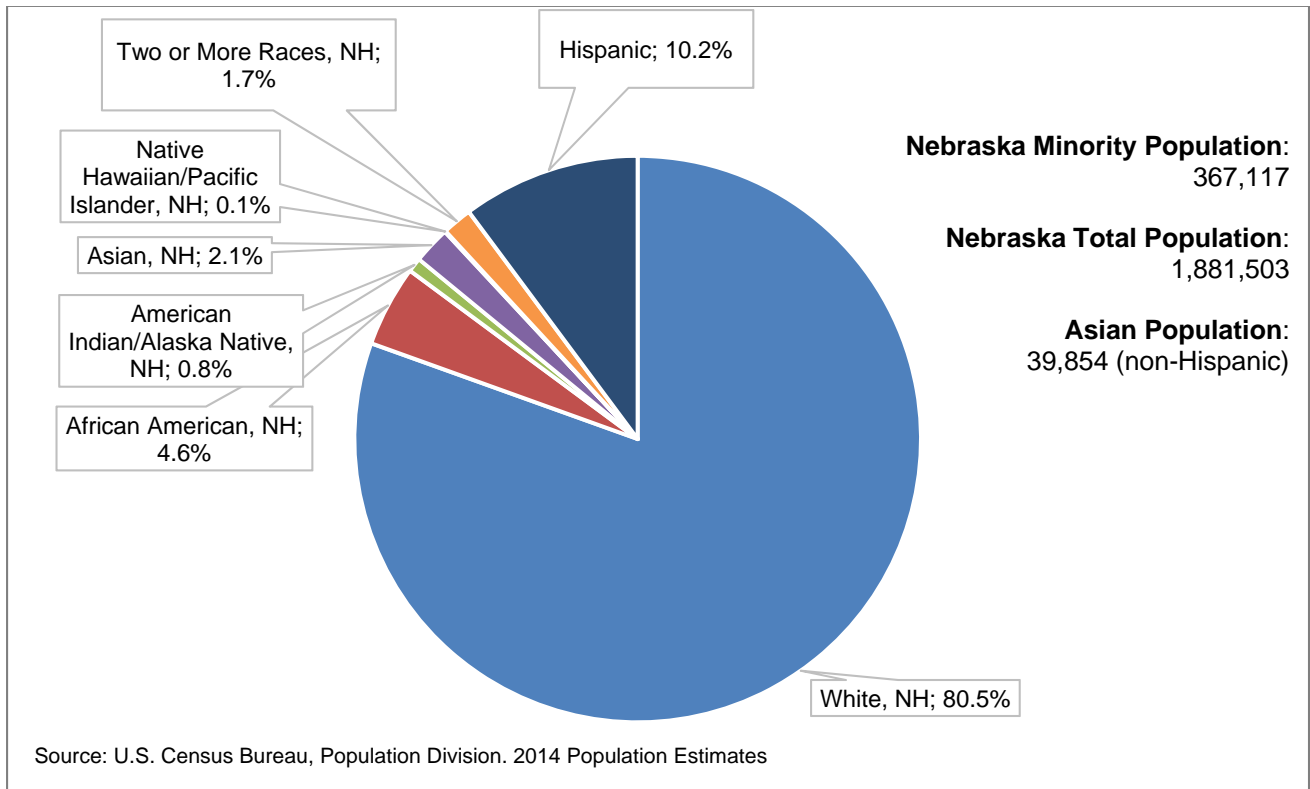
Data Source	Year
Pregnancy Risk Assessment Monitoring System (PRAMS)	2010-2012
Behavioral Risk Factor Surveillance System (BRFSS)	2011-2014
American Community Survey (ACS)	2010-2014
Nebraska DHHS Vital Statistics – Birth Certificates	2009-2013 & 2010-2014
Nebraska DHHS Vital Statistics – Death Certificates	2010-2014
National Center for Health Statistics Vital Statistics System	2010-2014
HIV and AIDS Surveillance Report	2014
CDC NCHHSTP Atlas (STD data)	2010-2014

Demographics

Distribution of Nebraska's Population: 2014 Estimates

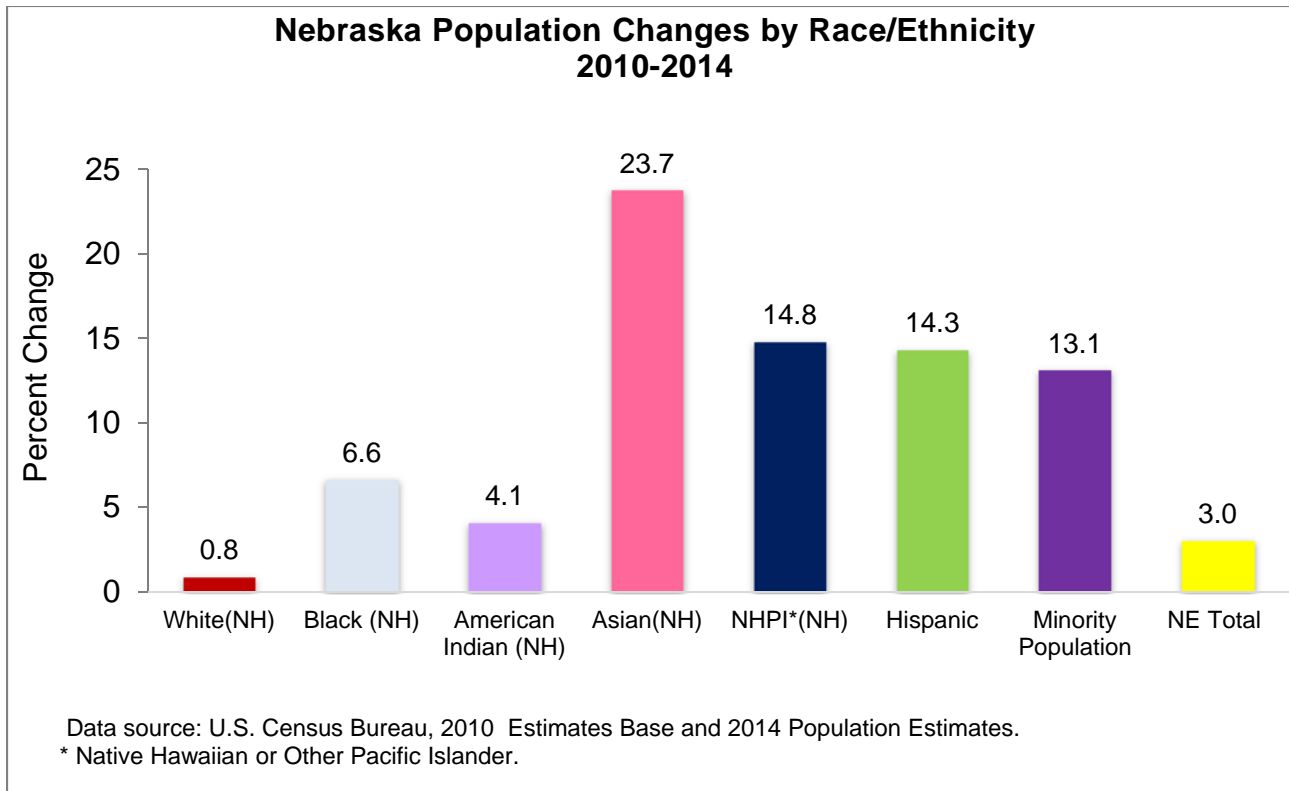
Using the 2010 U.S. Census as a base, it was estimated that the 2014 minority population of Nebraska was a slightly larger proportion of Nebraska's total population compared to 2010 (described on page 14). Hispanics remained the largest minority group and were followed by African Americans, then Asians. The proportion of Asians increased from 1.7% (in 2010) to 2.1% over four years; the 2% of Asians in the 2014 estimates is equivalent to 39,854 people (non-Hispanic).

Nebraska's Minority Population, 2014 Estimates



Nebraska Population Change: 2010-2014

For the five-year period of 2010-2014, the Asian population had the highest percent change. There was a difference of approximately 10% between Asians and Hispanics, the largest minority group in Nebraska, in terms of growth. Asians grew by nearly 24% whereas Hispanics grew by approximately 14%. Furthermore, the total minority population in Nebraska grew by 13% and Nebraska as a whole grew by 3%.



Asians in Nebraska: Specific Groups

Asians in Nebraska come from a wide variety of countries, as shown below. The most populous Asian groups were the Vietnamese (25.4%), the Asian Indian (16.4%), and the Chinese (15.4%). There were 14% of Asians who identified as "Other Asian," which includes groups not listed below and people who selected multiple Asian groups on the survey.

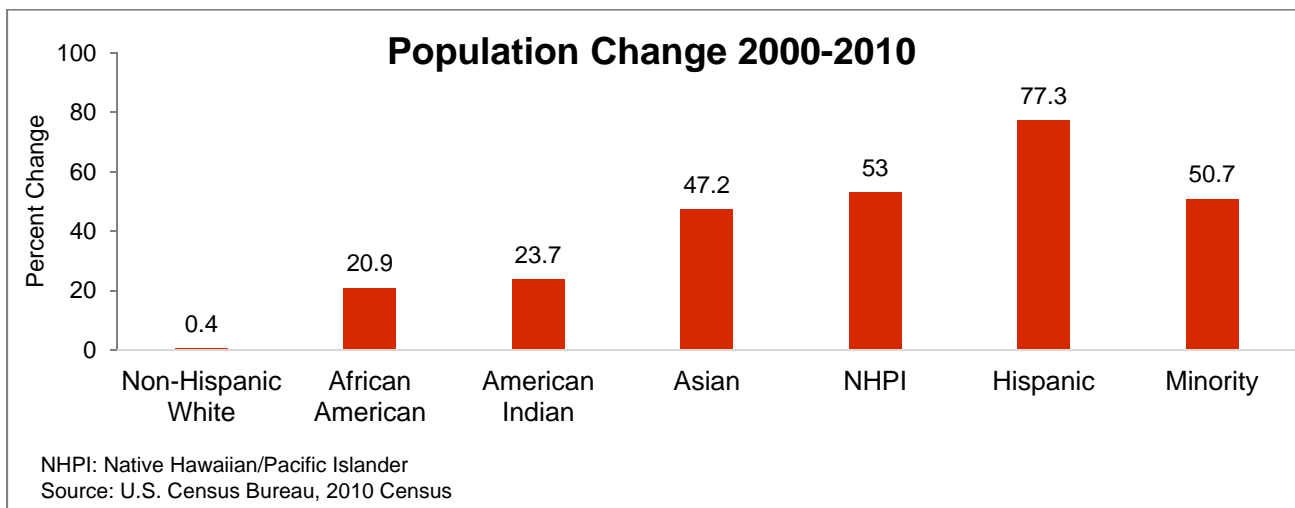
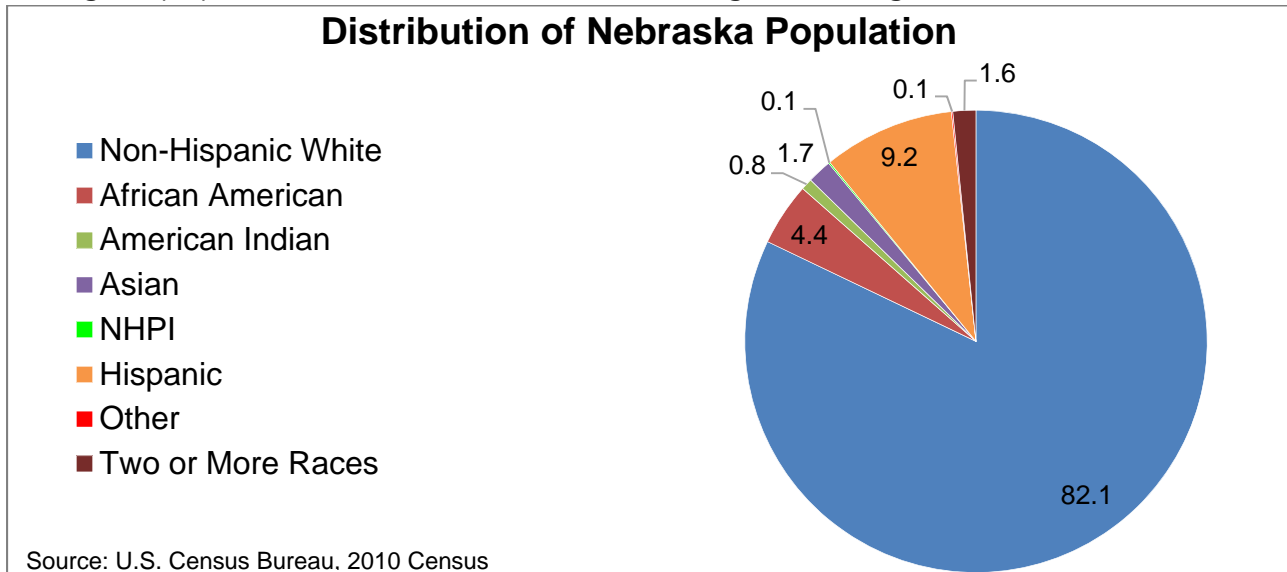
	2010-2014 ACS Estimates	
	Number	Percent
Asian Indian	5,865	16.4%
Bangladeshi	97	0.3%
Cambodian	279	0.8%
Chinese, except Taiwanese	5,502	15.4%
Filipino	2,134	6.0%
Hmong	195	0.5%
Indonesian	78	0.2%
Japanese	1,398	3.9%
Korean	2,959	8.3%
Laotian	782	2.2%
Malaysian	81	0.2%
Pakistani	240	0.7%
Sri Lankan	224	0.6%
Taiwanese	68	0.2%
Thai	1,065	3.0%
Vietnamese	9,081	25.4%
Other Asian	5,079	14.2%
Other Asian, not specified	569	1.6%

"Other Asian" Includes people who provided a response of another Asian group (such as Burmese); and includes people who provided multiple Asian responses.

"Other Asian, not specified" Includes people who answered the "Other Asian" response category and did not provide a specific group; and includes people who provided only a generic term such as "Asian."

Nebraska Population: 2010

Nebraska has a rapidly growing minority population comprised increasingly of Hispanic/Latino individuals. In 2010, the population of Nebraska had risen to 1,826,341; the Hispanic population accounted for 9.2% of Nebraska's total population and African Americans were second most numerous (4.4%). Although Asians account for a smaller proportion of Nebraska's minority population, they had the third highest percent change in population from 2000 to 2010 and the highest change in 2010-2014.



Asian Population Distribution

According to the U.S. Census³, there were 32,239 Asians in Nebraska in 2010. This number represented approximately 1.8% of the total Nebraska population.

Distribution of Nebraska Asian Population

Table 1: Distribution of Nebraska Asian Population, 2010

	Number	Percent
Total Nebraska population	1,826,341	
One Race		
Asian	32,239	1.8
Two or More Races		
Asians; White	6,108	0.3
Asians; Black or African American	442	0.0
Asians; American Indians and Alaska Native	157	0.0
Asians; Native Hawaiian and Other Pacific Islander	245	0.0
Asians; Some Other Race	413	0.0
Asians alone or in combination *	40,561	2.2
Asians alone	32,239	1.8
Asians in combination	8,322	0.5
Hispanic or Latino		
Asians alone, Hispanic or Latino	374	0.0
Asians alone, Not Hispanic or Latino	31,865	1.7

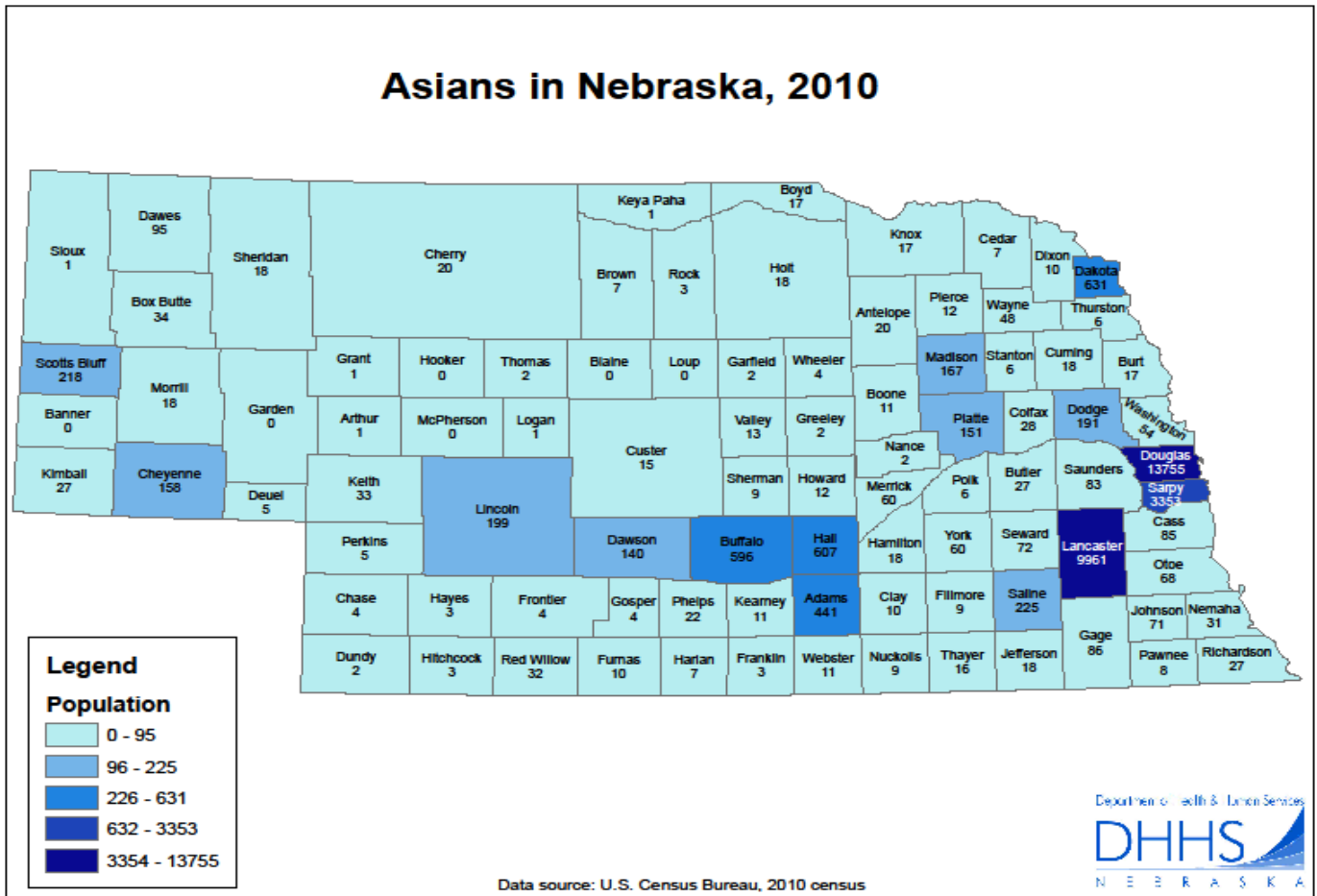
Source: U.S. Census Bureau, 2010 Census.

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 are tallied in each race category.

³ Source: Population Division, U.S. Census Bureau, 2010 Census

Asian Population by Counties

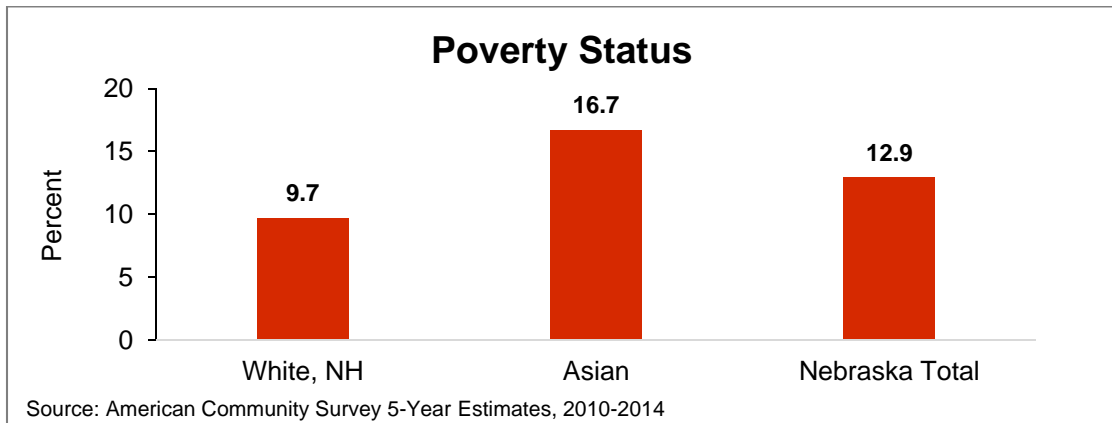
According to the U.S. Census Bureau, the total Asian population in Nebraska was 32,239 in 2010. The map below illustrates the spread of this population over the different counties in Nebraska. The majority of the state's Asian population lived in Douglas (13,755), Lancaster (9,961), and Sarpy (3,353) counties. Other areas with a population of at least 400 Asians were Dakota (631), Hall (607), Buffalo (596), and Adams (441) counties.



Socioeconomics

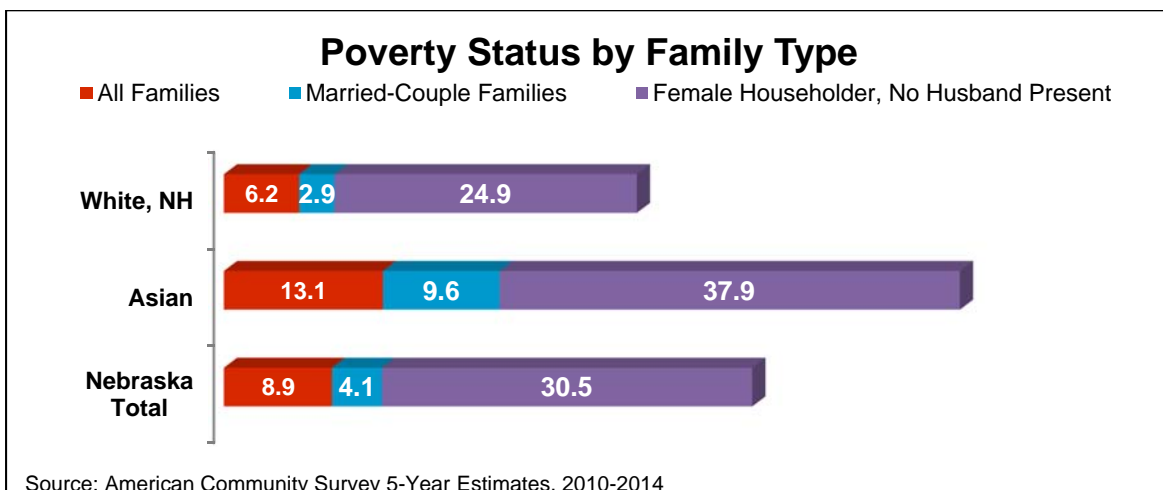
Poverty Status

The poverty rate was higher for Asian Americans than for Whites. Almost 17% of Asian Americans were living below the poverty level in the 12 months prior to being surveyed, compared to about 10% of Whites.



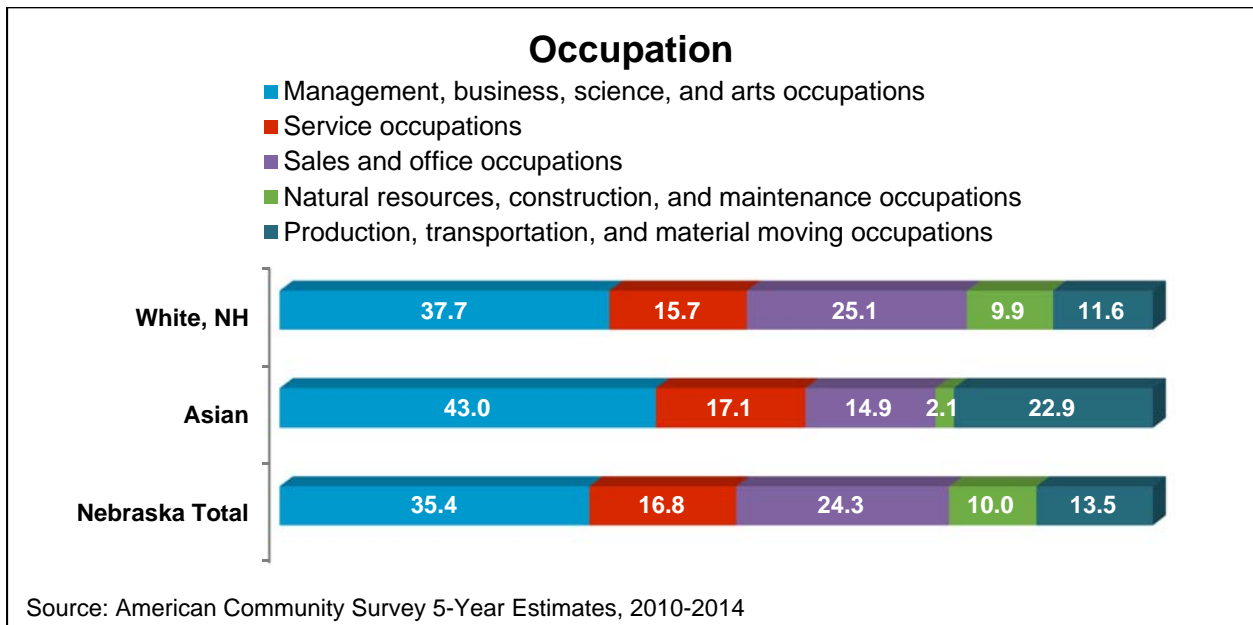
Poverty Status by Family Type

Asian families were two times as likely as non-Hispanic White families to be below the poverty level in the past 12 months. There were more Asian families with a female householder and no husband present below the poverty level (38%) than non-Hispanic White families of the same type (25%). Asian married-couple families (10%) were three times more likely than non-Hispanic Whites (3%) to be below the poverty level in the past 12 months.



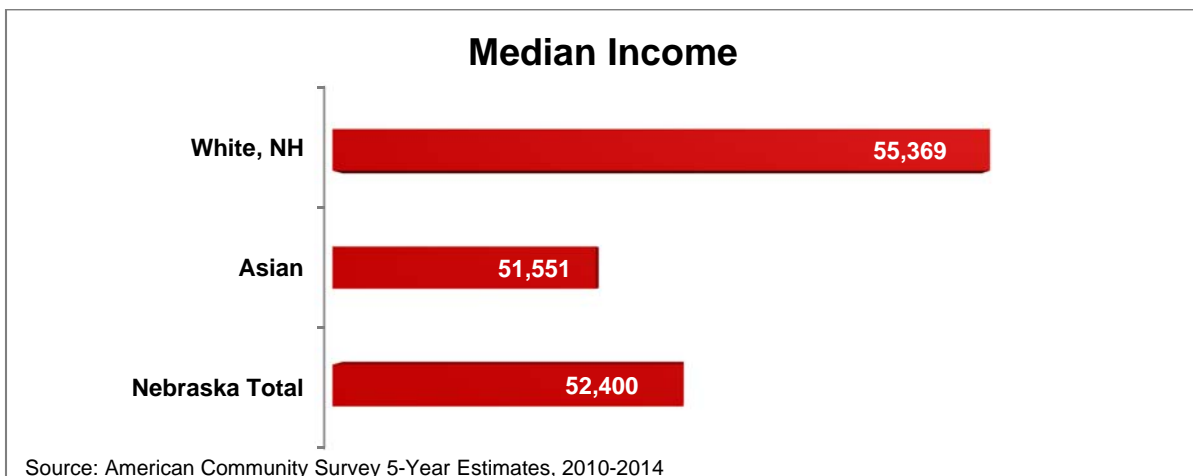
Occupation

Asians (17.1%) were more likely than non-Hispanic Whites (15.7%) to work in a “service” occupation and in “management, business, science, and art” occupations (43% for Asian, 37.7% for White). Asians were the least likely to work in the “natural resources, construction, and maintenance” sector.



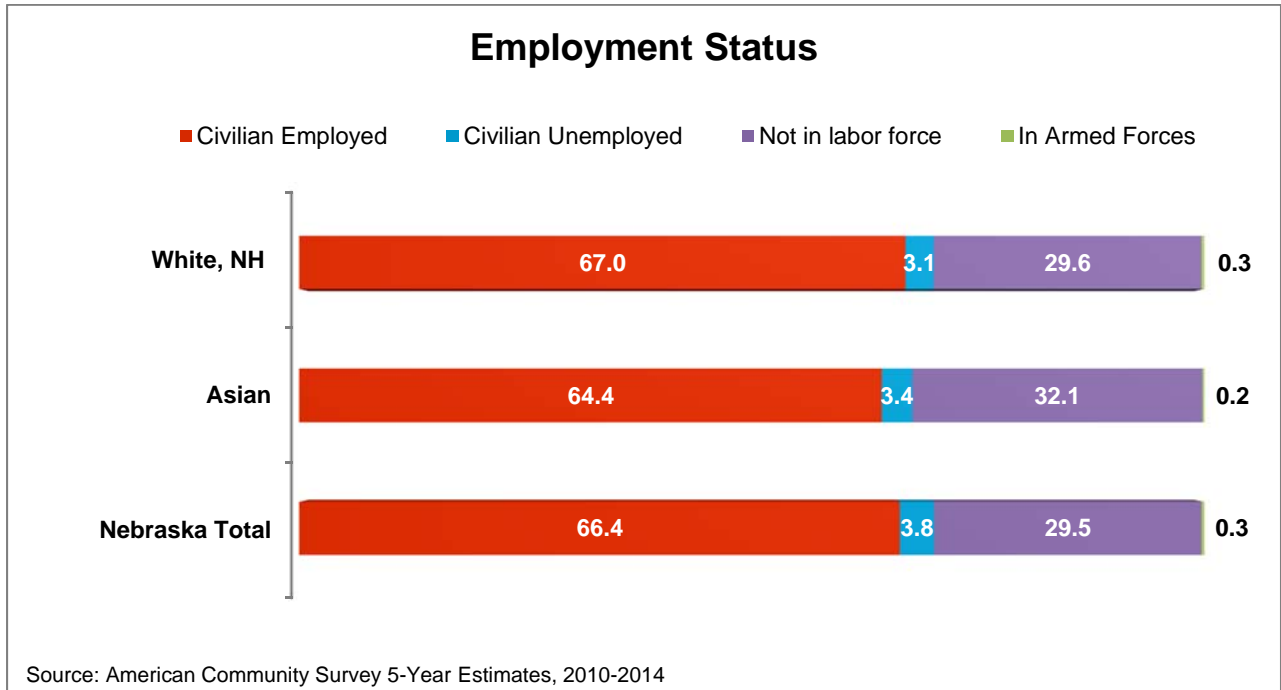
Income

The median annual income of Asian American households from the years 2010 to 2014 was \$51,551; this was \$3,818 less than the median income of White households (\$55,369). Please note that this information and chart uses 2014 inflation-adjusted dollars.



Employment Status

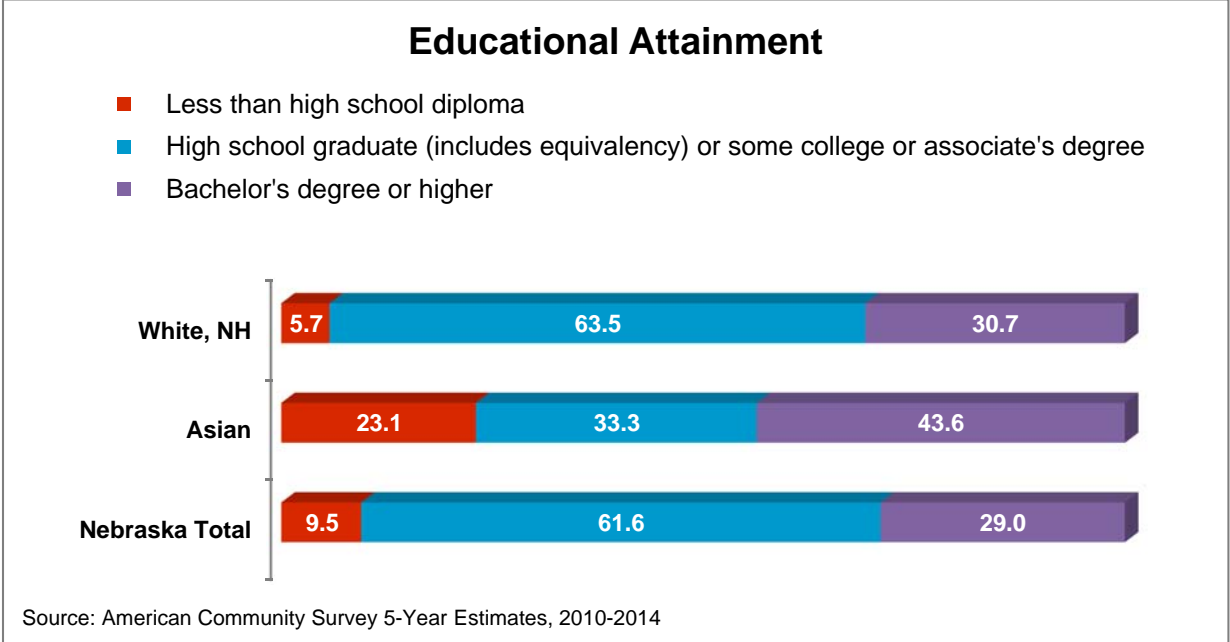
The Asian American population ages 16 years and older had an unemployment rate of 3.4%, whereas Non-Hispanic Whites of the same age group experienced 3.1% unemployment. From 2010-2014, 67.9% of Nebraska Asian Americans ages 16 years and older were in the labor force. In comparison, almost 70.4% of Whites 16 years and older were in the labor force.



Notes: The “Employed” category includes all civilians 16 years old and over who either (1) were “at work,” that is, 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,” that is, 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 are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are all institutionalized people and people on active duty in the United States Armed Forces.

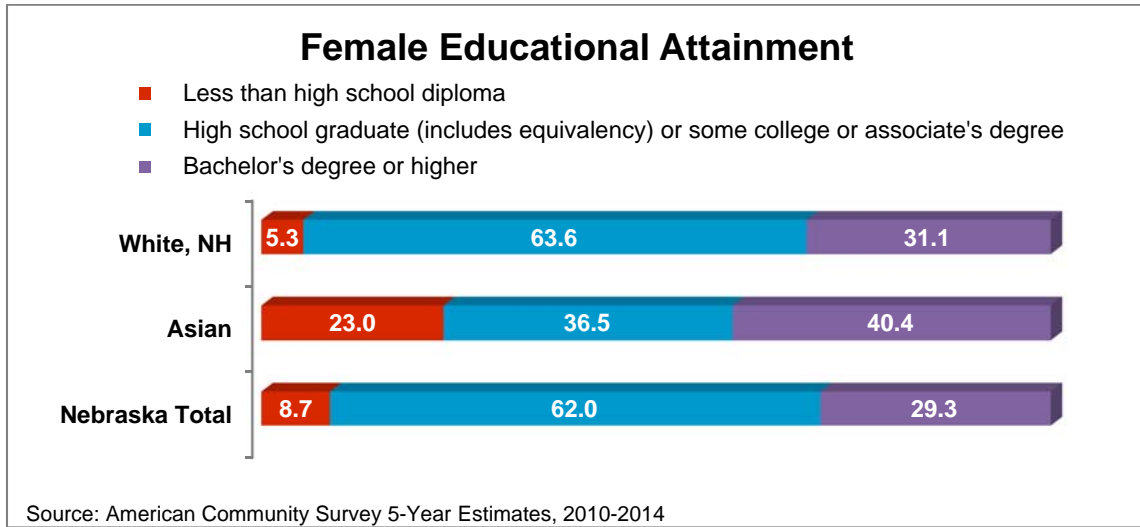
Educational Attainment

The proportion of Asians with less than a high school education was nearly five times the proportion of non-Hispanic Whites. However, a larger proportion of Asians reported obtaining a bachelor's degree or higher (43.6%) compared to the non-Hispanic White (30.7%) and the total Nebraska population (29%).



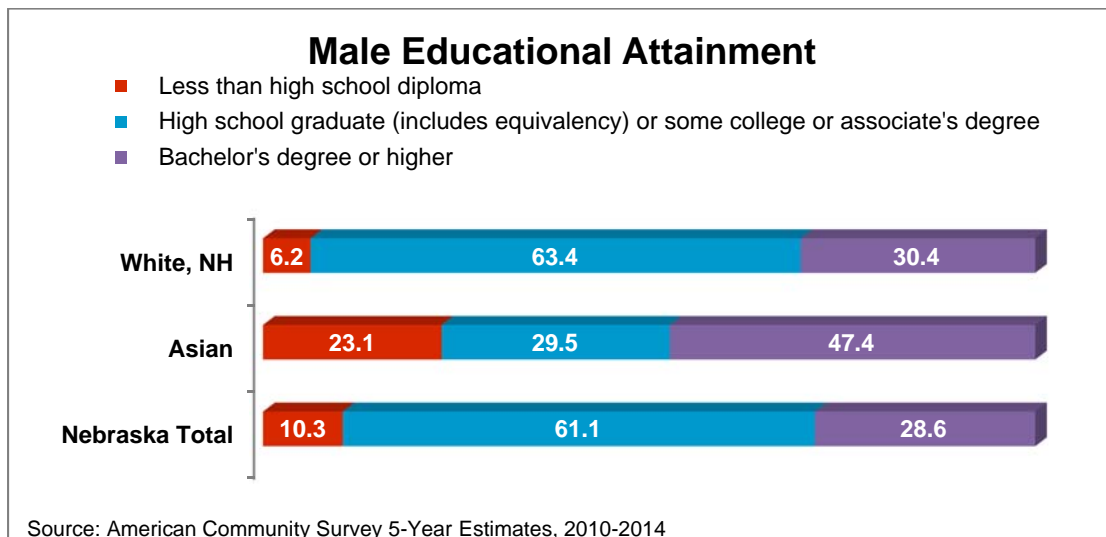
Educational Attainment: Female

About 23% of Asian American females ages 25 and older did not have a high school education—this was 4.3 times higher than the proportion of White females who reported the same. Additionally, 40.4% of Asian females had a Bachelor’s Degree or higher but only 31.1% of White females reported the same.



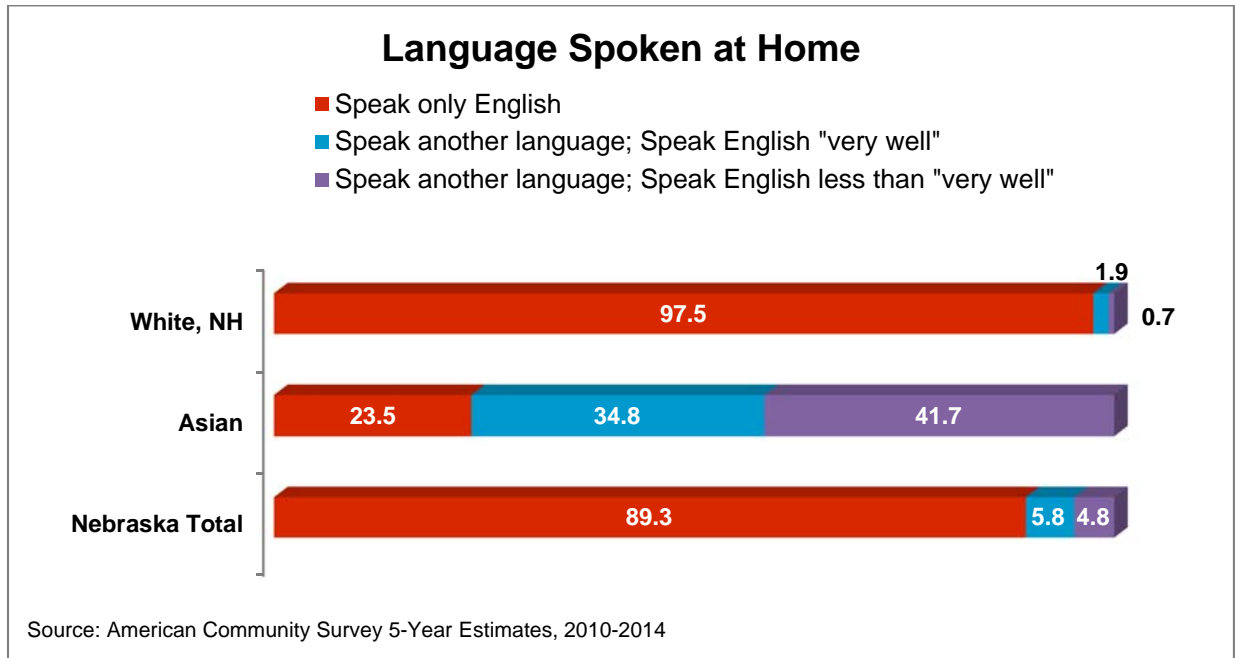
Educational Attainment: Male

Roughly 23% of Asian males ages 25 and older did not have a high school education—this was 2.2 times higher than the percent for White males. Among Asian males, 47.4% had a Bachelor’s Degree or higher, or 1.66 times higher than the percentage of White males.



Language Spoken at Home

Only 23.5% of Asians spoke English exclusively at home, compared to nearly 98% of non-Hispanic Whites. Approximately 35% Asians spoke another language at home and spoke English 'very well.' The proportion of Asians who spoke another language at home and spoke English less than 'very well' was nearly half of the surveyed Asian population (41.7%).

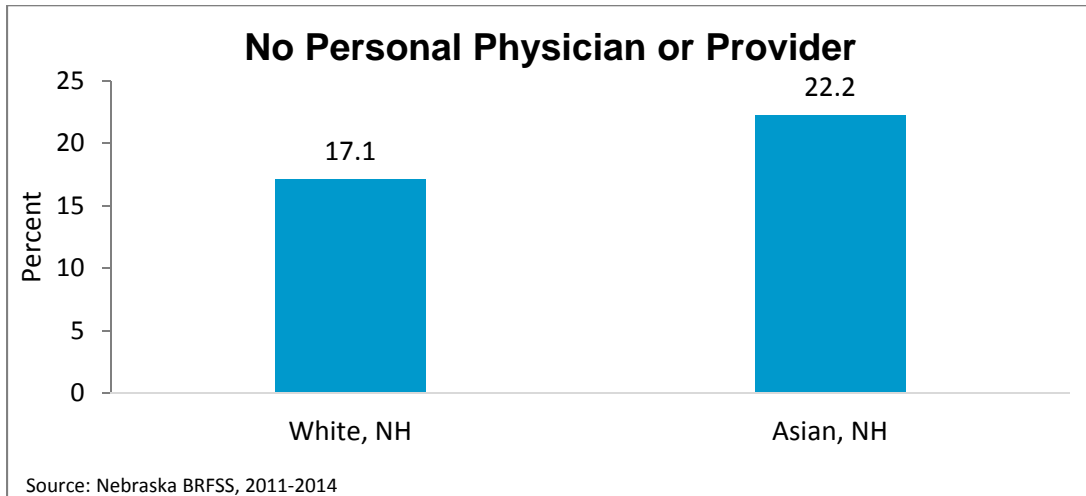


Note: Respondent's Ability to Speak English – Respondents who reported speaking a language other than English were asked to indicate their English-speaking ability based on one of the following categories: "Very well," "Well," "Not well," or "Not at all." Those who answered "Well," "Not well," or "Not at all" are sometimes referred as "Less than 'very well.'" Respondents were not instructed on how to interpret the response categories in this question.

Access to Healthcare

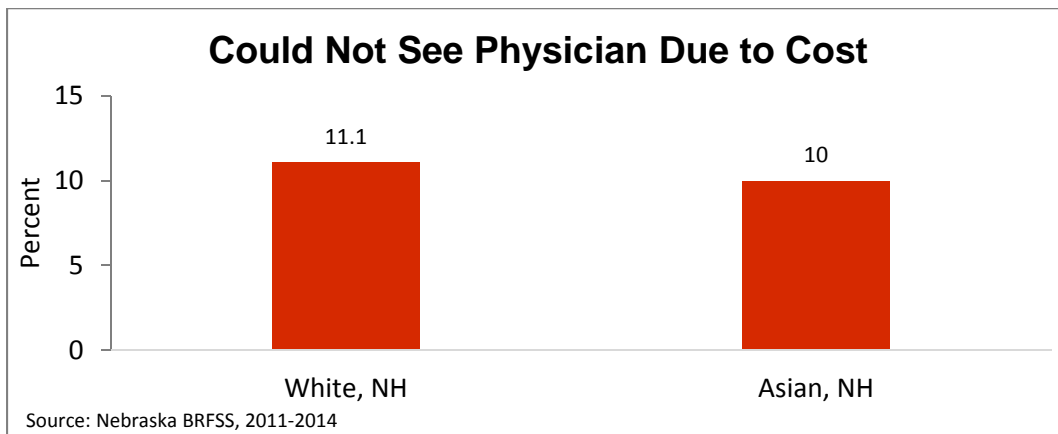
Does Not Have a Personal Physician

About 22% Asians reported not having a personal physician—about 5% higher than Whites (17%) according to BRFSS data from 2011-2014.



Could Not See Physician Due to Cost

Asian Americans and non-Hispanic Whites reported similar percentages of individuals who could not see a physician due to cost (10-11%).

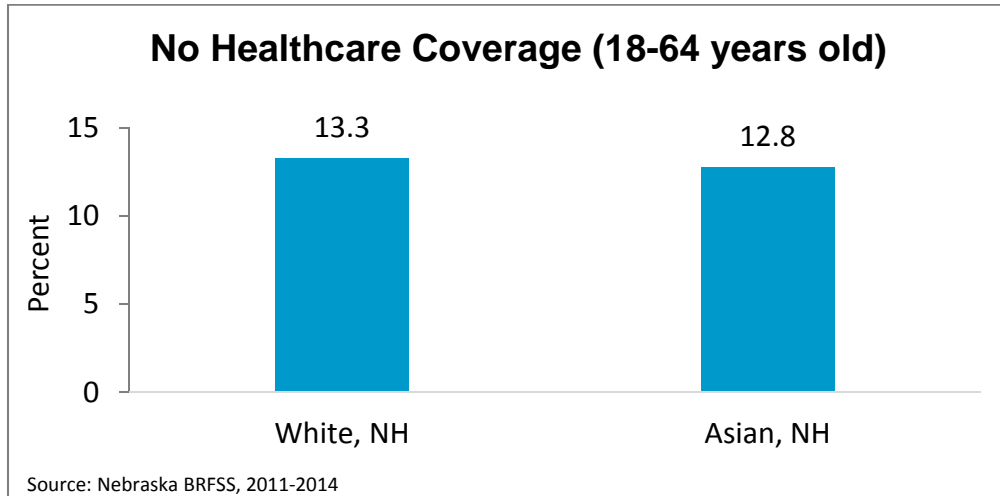


Confidence Intervals:

	No Personal Provider		Could Not Visit Due to Cost	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	16.6	17.6	10.7	11.5
Asian, NH	18.8	26	7.4	13.5

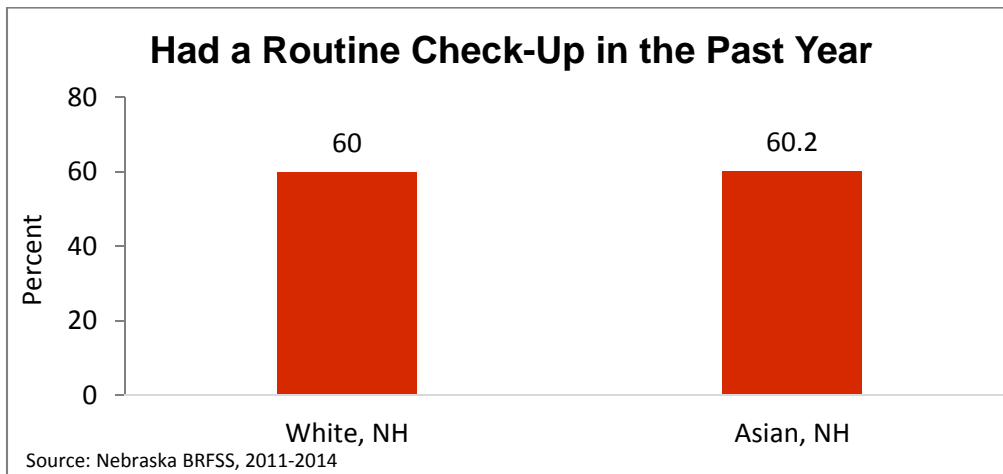
No Health Coverage

There were slightly more non-Hispanic Whites than Asians who did not have healthcare coverage according to the BRFSS survey. There was a difference of 0.5% between the two races.



Routine Check-Up in the Past Year

Overall, similar proportions of non-Hispanic Whites and Asians had routine check-ups in the year preceding the BRFSS survey (approximately 60%).



Confidence Intervals:

	No Coverage		Routine Checkup	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	12.9	13.8	59.4	60.6
Asian, NH	9.8	16.6	54.6	65.6

Life Expectancy at Birth

The results show that the Asian population has higher life expectancy at birth than Whites. The life expectancy at birth in 2012-2014 for Asians was 88.0 years compared to 80.0 years for non-Hispanic Whites. In 2008-2010, the life expectancy gap between Asians and Whites was 8.7 years. The life expectancy for Whites has not changed much since 2002-2004, increasing from 78.6 to 79.8. Whereas, there has been a steady increase in life expectancy at birth for Asian Americans during the same timeframe increasing from 85.5 to 88.5. Asian American women experience the greatest life expectancy.

Life Expectancy at Birth: Nebraska Total

YEARS	TOTAL (Years)	MALES (Years)	FEMALES (Years)
2012-2014	80.0	77.8	82.2
2011-2013	80.1	77.9	82.2
2010-2012	80.1	77.9	82.2
2009-2011	80.1	78.0	82.2
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

Life Expectancy at Birth: White

YEARS	TOTAL (Years)	MALES (Years)	FEMALES (Years)
2012-2014	80.0	77.8	82.2
2011-2013	80.1	77.9	82.2
2010-2012	80.1	77.9	82.2
2009-2011	80.1	78.0	82.2
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

Life Expectancy at Birth: Asian

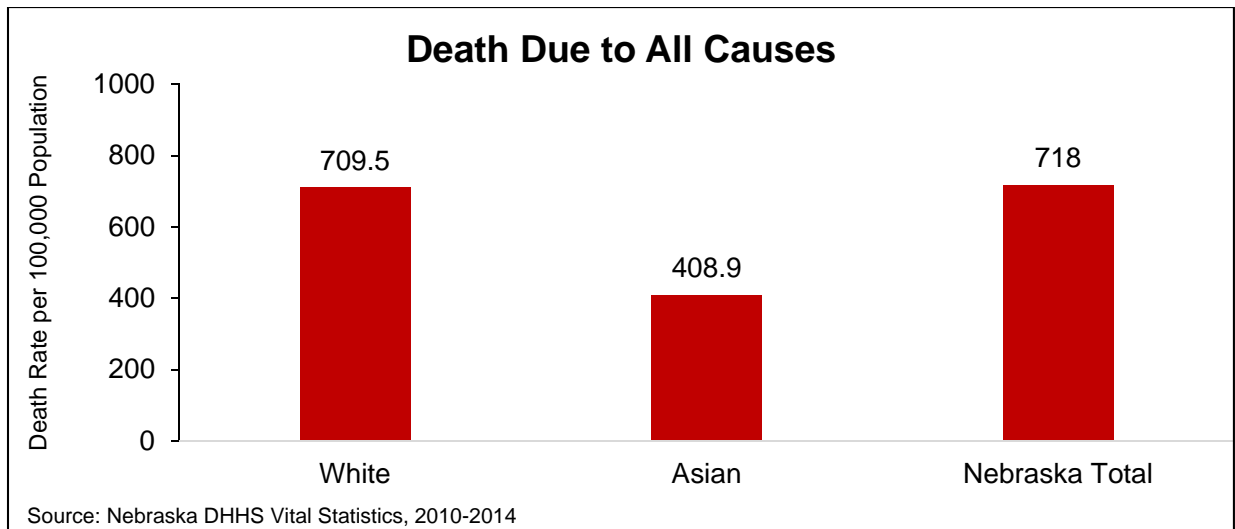
YEARS	TOTAL (Years)	MALES (Years)	FEMALES (Years)
2012-2014	88.0	86.9	88.8
2011-2013	87.5	86.4	86.1
2010-2012	86.0	86.4	86.1
2009-2011	86.8	86.4	87.4
2008-2010	88.5	92.0	88.1
2007-2009	91.1	88.0	93.6
2006-2008	91.5	87.3	97.8
2005-2007	87.2	84.0	92.9
2004-2006	86.5	85.2	88.5
2003-2005	86.2	88.1	84.9
2002-2004	85.5	84.4	87.5

Source: Nebraska DHHS Vital Statistics

Mortality

Mortality data acts as a mirror for current health problems, and suggests 'patterns of risk' across population sub-groups. Many causes of death are preventable or treatable, and therefore warrant the attention of public health prevention efforts. Mortality data is an important indicator of where federal, state, and local prevention efforts should be placed in building healthy communities. It is one of the best sources of information in relation to the health of communities. The death rate from all causes is a key measure of health status across populations.

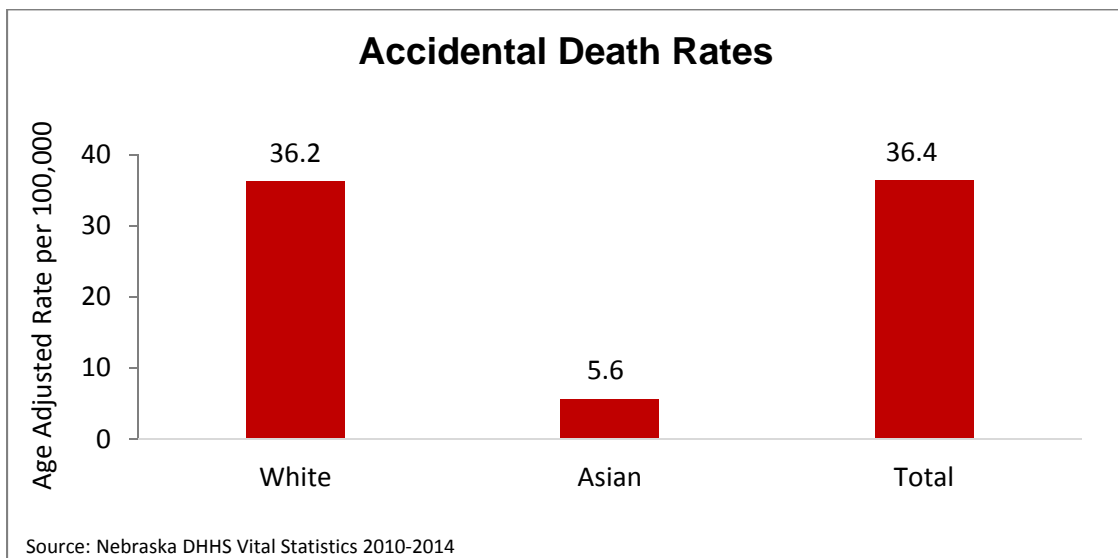
During the years 2010-2014, the death rate due to all causes was 1.74 times higher among White Nebraskans than Asians. The Nebraska death rate was higher than both the White and Asian categories; however, the rate for Whites was similar to the rate for the state.



Accidental (Unintentional) Deaths

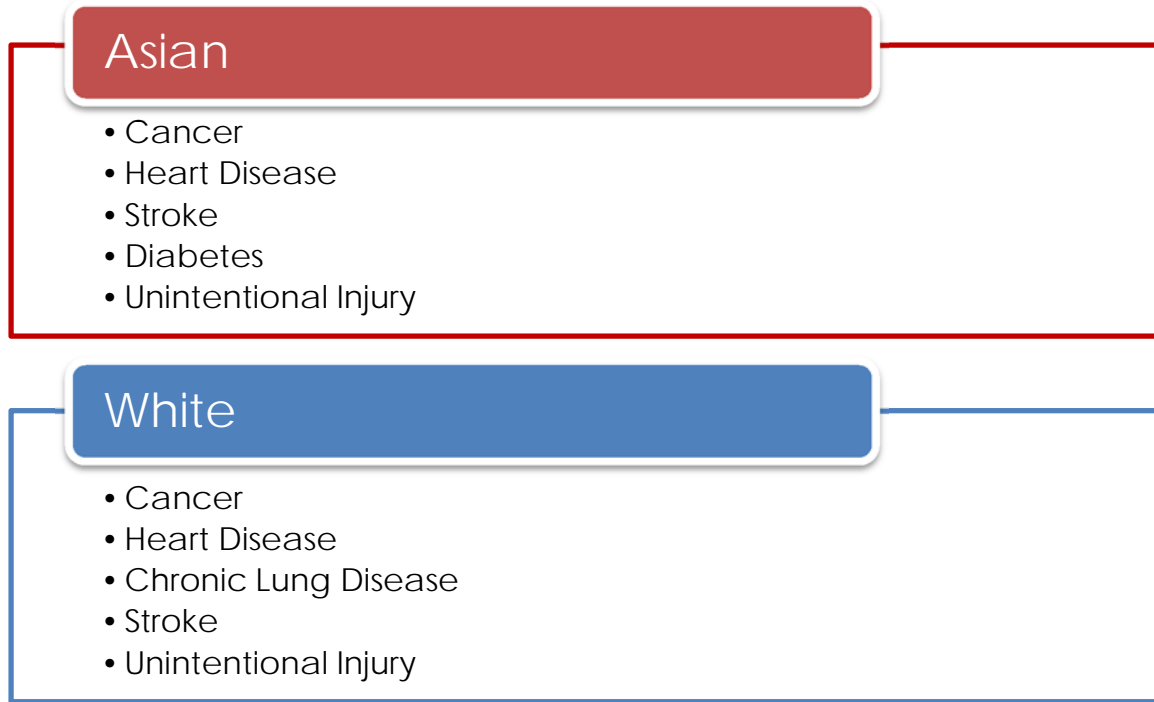
Injuries are a leading cause of premature death in the United States and Nebraska. They include unintentional types, such as motor vehicle crashes, falls, and suffocation, as well as intentional types including homicides and suicides. Injury deaths, by definition, are preventable, and reducing their risk requires an understanding of how injuries vary across physical and social environments.

The mortality rate of accidental deaths was 6.5 times higher for the White Nebraskan population and the total Nebraska population than for the Asian population.



Leading Causes of Death for Asian Americans

When looking at total death number, the top leading causes of death (for 2010-2014) break down as follows:



It is important to note that diabetes is present in the top five causes of death for Asians but is completely absent from the list of top five for Whites. This is true for Asians and Whites as whole populations and when separated by gender.

Leading Causes of Death: Total (2010-2014)

Frequency	Number (Asians)	Percentage	Frequency	Number (Whites)	Percentage
Cancer	124	52.1%	Cancer	16,456	22.1%
Heart	49	20.6%	Heart	15,957	21.5%
Stroke	26	10.9%	Chronic Lung	5,118	6.9%
Diabetes	14	5.9%	Stroke	3,900	5.2%
Unintentional Injury	13	5.5%	Unintentional Injury	3,464	4.7%
Total	238	100%	Total	74,363	100%

Source: National Center for Health Statistics Vital Statistics System 2010-2014

The Leading Causes of Death for Males

Asian Males

- Cancer
- Heart Disease
- Stroke
- Chronic Lung Disease/Unintentional Injury
- Diabetes/Suicide

White Males

- Cancer
- Heart Disease
- Chronic Lung Disease
- Unintentional Injury
- Stroke

Please note: there was a tie for chronic lung disease and unintentional injury for fourth leading cause of death, and between diabetes and suicide for the fifth leading cause of death for Asian males.

Leading Causes of Death: Males (2010-2014)

Frequency	Number (Asians)	Percentage	Frequency	Number (Whites)	Percentage
Cancer	59	31.4%	Cancer	8,708	23.9%
Heart	28	14.9%	Heart	8,083	22.2%
Stroke	x		Chronic Lung	2,624	7.2%
Chronic Lung/ Unintentional Injury	x		Unintentional Injury	2,079	5.7%
Diabetes/Suicide	x		Stroke	1,616	4.4%
Total	188	100.0%	Total	36,485	100.0%

Source: National Center for Health Statistics Vital Statistics System 2010-2014
 'x' denotes a number that was too small to report

The Leading Causes of Death for Females

Asian Females

- Cancer
- Heart Disease
- Stroke
- Diabetes
- Hypertension

White Females

- Heart Disease
- Cancer
- Chronic Lung Disease
- Stroke
- Alzheimer's Disease

The presence of diabetes and hypertension in the top five causes of death for Asian women is concerning for a number of reasons. These causes are absent among White females; furthermore, both diabetes and hypertension are largely preventable through lifestyle and diet changes and regular medical care by a physician. These two diseases are ideal targets for health education and prevention efforts.

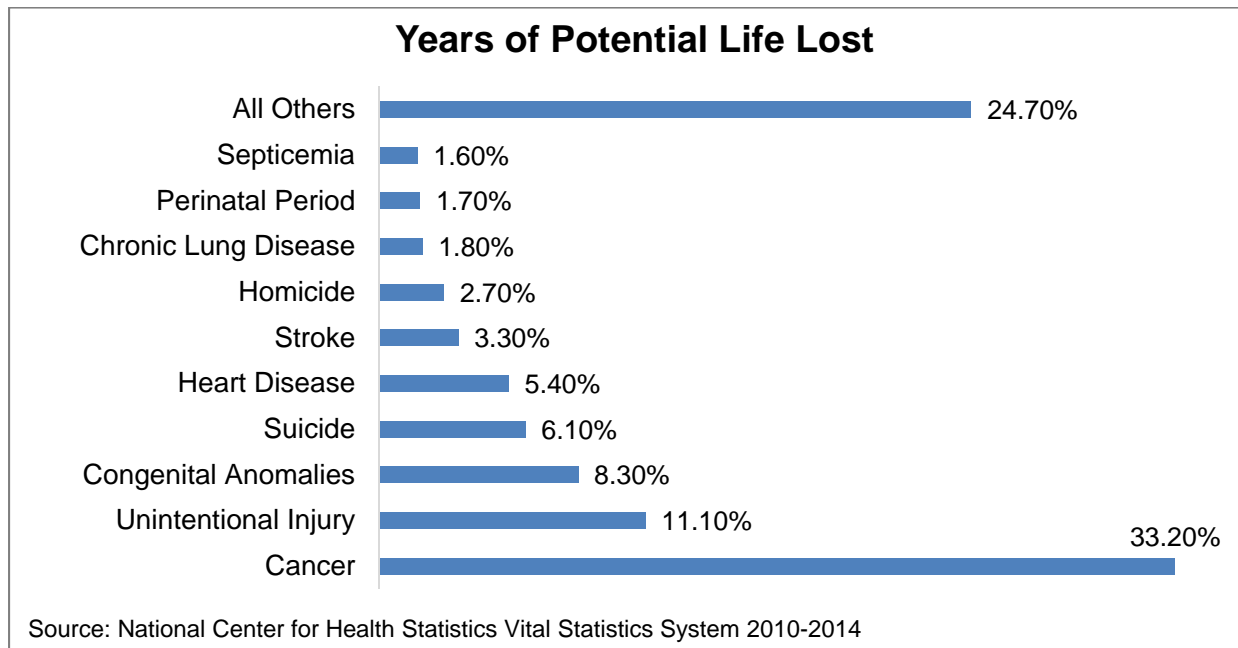
Leading Causes of Death: Females (2010-2014)

Frequency	Number (Asians)	Percentage	Frequency	Number (Whites)	Percentage
Cancer	65	34.8%	Heart	7,874	20.8%
Heart	21	11.2%	Cancer	7,748	20.5%
Stroke	17	9.1%	Chronic Lung	2,494	6.6%
Diabetes	x		Stroke	2,284	6.0%
Hypertension	x		Alzheimer's	1,881	5.0%
Total	187	100.0%	Total	37,878	100.0%

Source: National Center for Health Statistics Vital Statistics System 2010-2014
 'x' indicates values that were too small to report

Years of Potential Life Lost

Among the 4,504 total years of lost before the age 75, cancer was the top cause of death for Asians, accounting for 1,496 years of potential life lost (33.2%). This was followed by unintentional injury with 501 years lost (11.1%) and congenital anomalies (375 years, or 8.3%).



Years of Potential Life Lost for Asians (2010-2014)

	YPLL	Percent	Age-Adjusted Rate
All Causes	4504	100%	2468.8
Cancer	1496	33.2%	927.6
Unintentional Injury	501	11.1%	231.6
Congenital Anomalies	375	8.3%	157.7
Suicide	276	6.1%	108.8
Heart Disease	242	5.4%	154.3
Stroke	150	3.3%	101.7
Homicide	123	2.7%	51.2
Chronic Lung Disease	80	1.8%	56.1
Perinatal Period	75	1.7%	31.6
Septicemia	74	1.6%	31.9
All Others	1112	24.7%	31.9

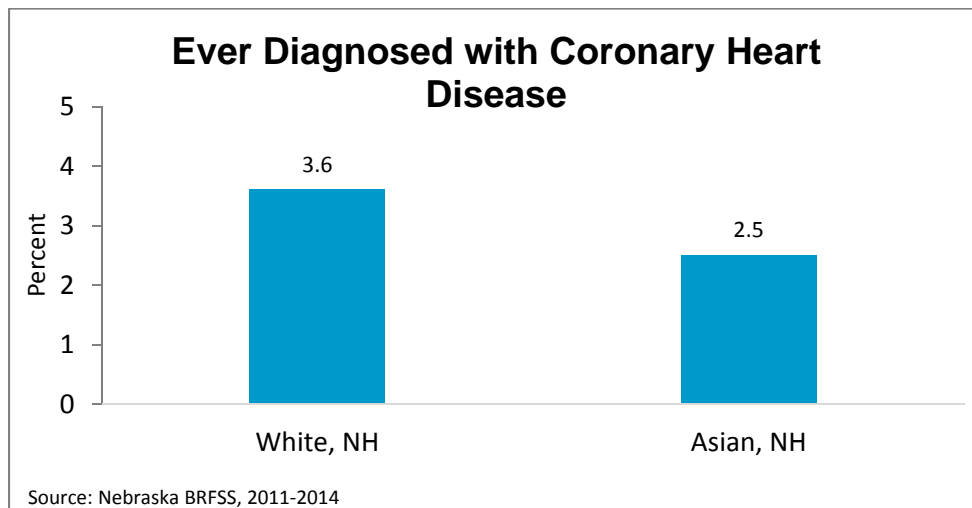
Chronic Disease

During the 20th century, chronic diseases replaced infectious diseases as leading causes of death in the United States. Chronic diseases – including all cardiovascular diseases, all cancers, diabetes mellitus, and chronic lower respiratory diseases – account for a large portion of all deaths among Nebraska residents. Heart disease, stroke, diabetes, and cancers are discussed in the sections below.

Heart Disease

Prevalence of Coronary Heart Disease

Cardiovascular disease involves the body's vascular or circulatory system, which is responsible for supplying oxygen and nutrients to the organs and cells. Heart disease and cerebrovascular disease or stroke are the major cardiovascular diseases and leading causes of death in Nebraska. Between the years 2011-2014, there were fewer Asian Americans than non-Hispanic Whites who reported ever being diagnosed with coronary heart disease.

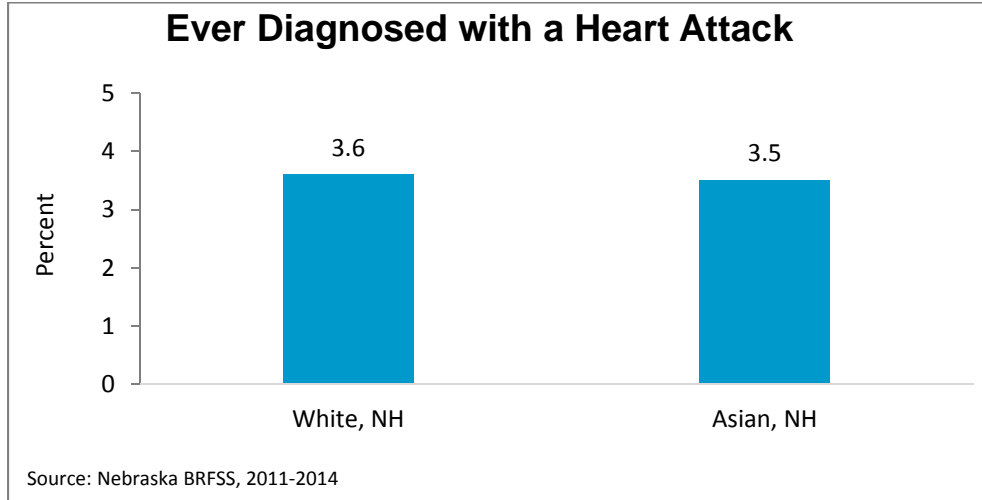


Confidence Intervals:

	CHD	
	Lower CI	Upper CI
White, NH	3.4	3.7
Asian, NH	1	5.9

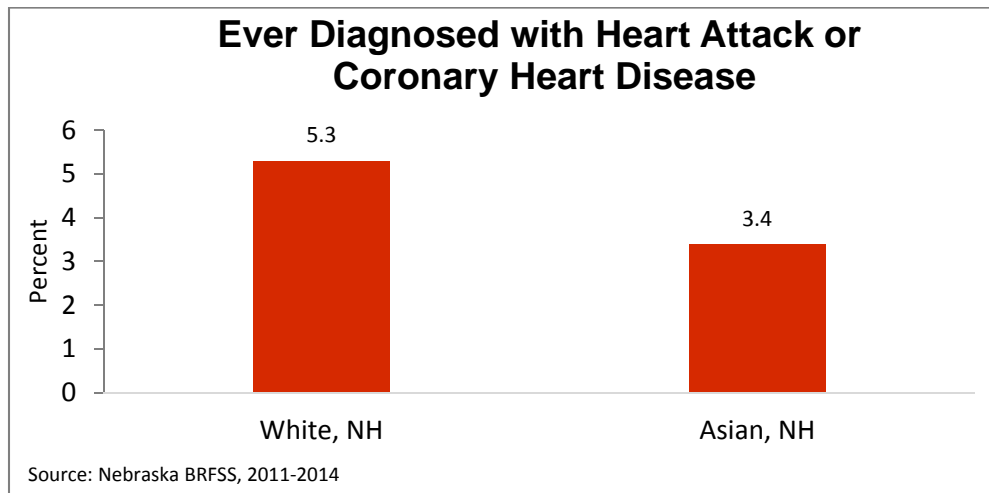
Prevalence of Heart Attack

Similar proportions of Asians and non-Hispanic Whites reported ever being diagnosed with a heart attack (~3.5%).



Prevalence of Heart Attack or Coronary Heart Disease

For the reporting period of 2011-2014, 3.4% of Asians had a heart attack (myocardial infarction) or had coronary heart disease compared to 5.3% of the White population.

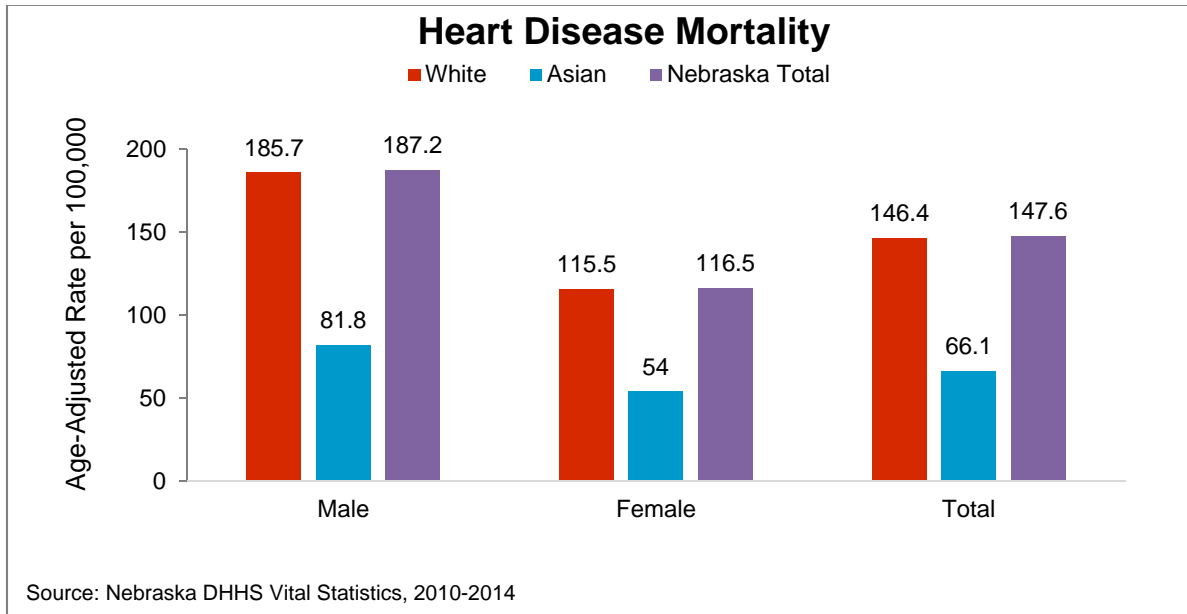


Confidence Intervals:

	Heart Attack		Heart Attack or CHD	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	3.4	3.7	5.1	5.5
Asian, NH	1.6	7.6	1.7	6.8

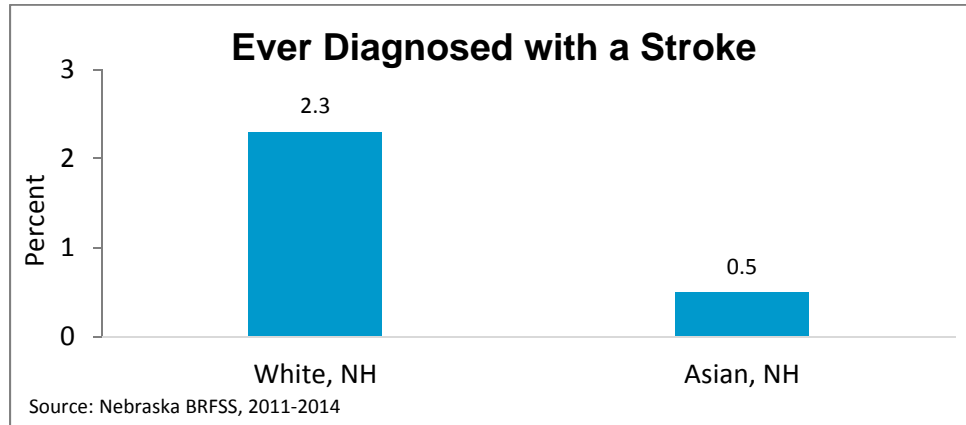
Heart Disease Mortality

Overall Asians (66.1 per 100,000) had a lower death rate due to heart disease compared to Whites (146.4 per 100,000). For both races and for the State of Nebraska as a whole, males had a higher heart disease mortality rate than females.



Stroke

The proportions of individuals reporting a stroke diagnosis were small, however the proportion for non-Hispanic Whites was much greater (2.3%) than that of Asians (0.5%).

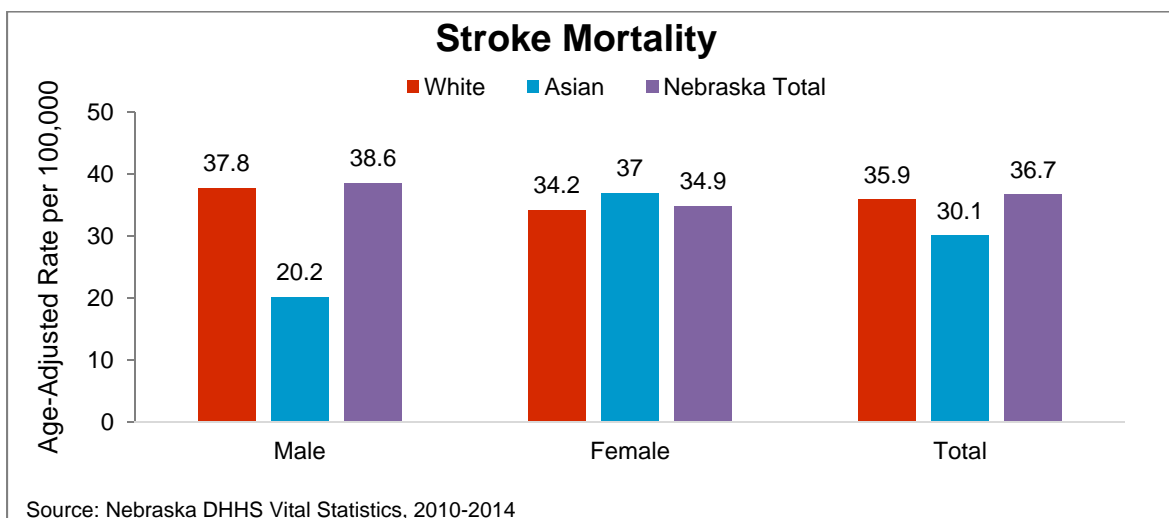


Confidence Intervals:

	Stroke	
	Lower CI	Upper CI
White, NH	2.1	2.4
Asian, NH	0.2	1.5

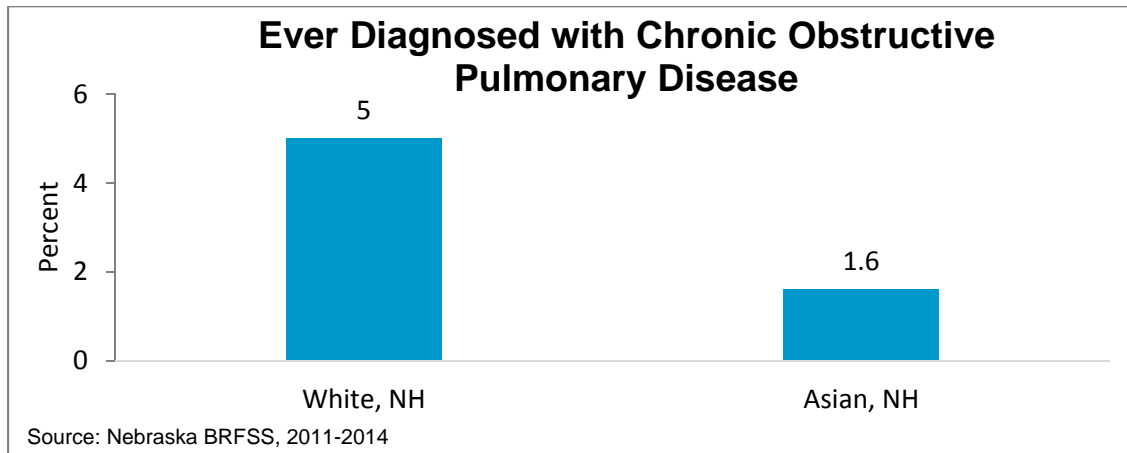
Stroke Mortality

Stroke is the most severe clinical manifestation of Cerebrovascular Disease. From 2010-2014, non-Hispanic Whites and Asians had similar death rates due to stroke (36 per 100,000 and 30 per 100,000, respectively), although the rate for non-Hispanic Whites was higher. The death rate of Asian females was nearly twice that of Asian males, while the rates between White males and females were relatively similar.



Chronic Obstructive Pulmonary Disease (COPD)

There was a larger proportion of White Nebraskans who had ever been diagnosed with COPD. Approximately 5% of Whites had been diagnosed with COPD compared to 1.6% of Asians.

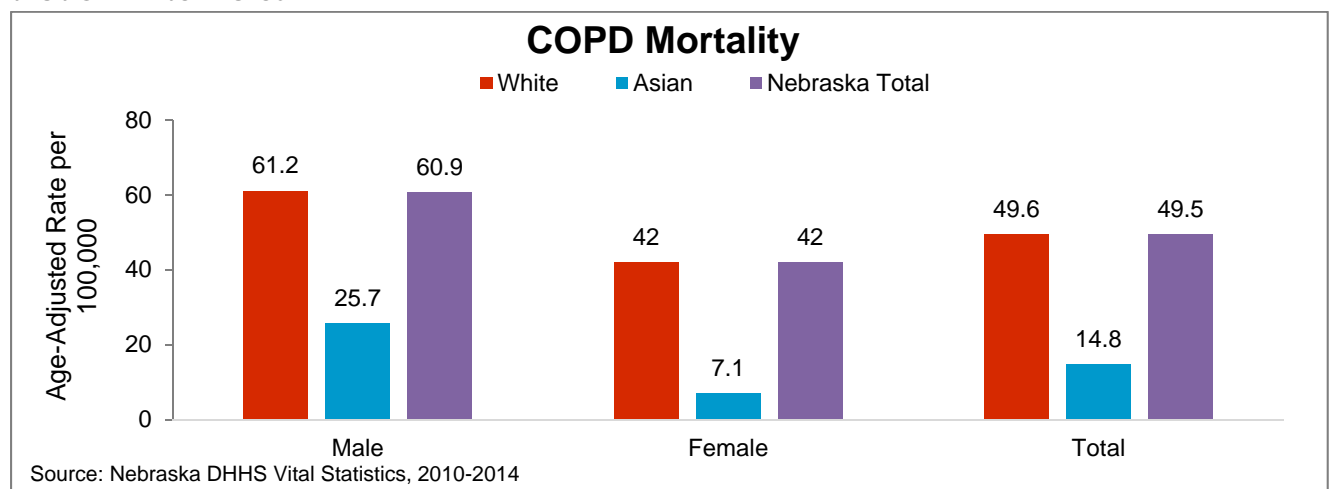


Confidence Intervals:

	COPD	
	Lower CI	Upper CI
White, NH	4.8	5.2
Asian, NH	0.6	4.4

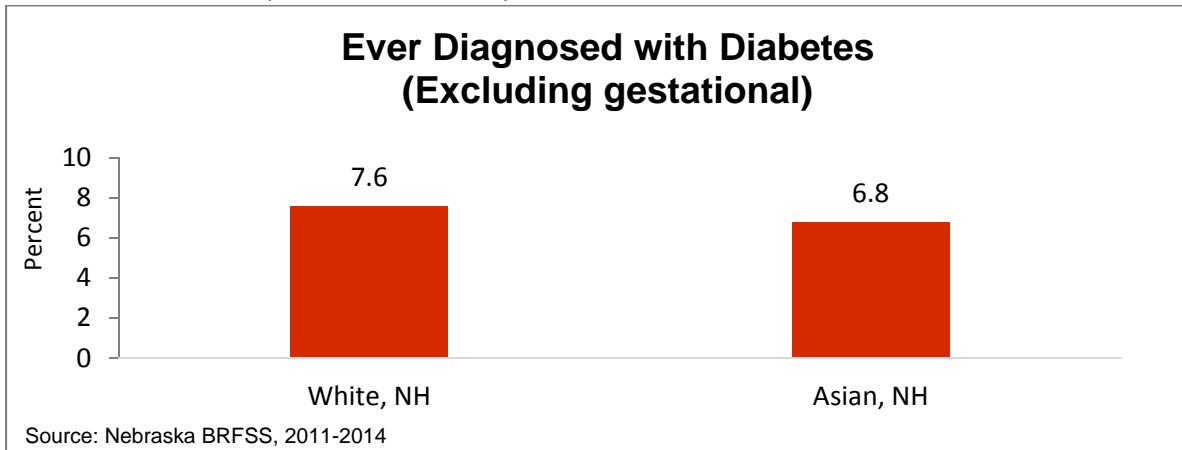
COPD Mortality

For 2010-2014, Asian Americans had lower COPD mortality rates than non-Hispanic Whites for either gender and overall. The mortality rate for Asian females was six times lower than that of White females, and the rate for Asian males was 2.3 times lower than that of White males.



Diabetes

Diabetes mellitus is characterized by high levels of blood glucose, which result from deficient insulin production and/or insulin action. Respondents were asked whether they had ever been told that they had diabetes. The data presented below does not include women who were told by a doctor of the presence of diabetes during their pregnancy. There was a smaller proportion of Asians who were ever diagnosed with diabetes (6.8%) compared to non-Hispanic Whites (7.6%).

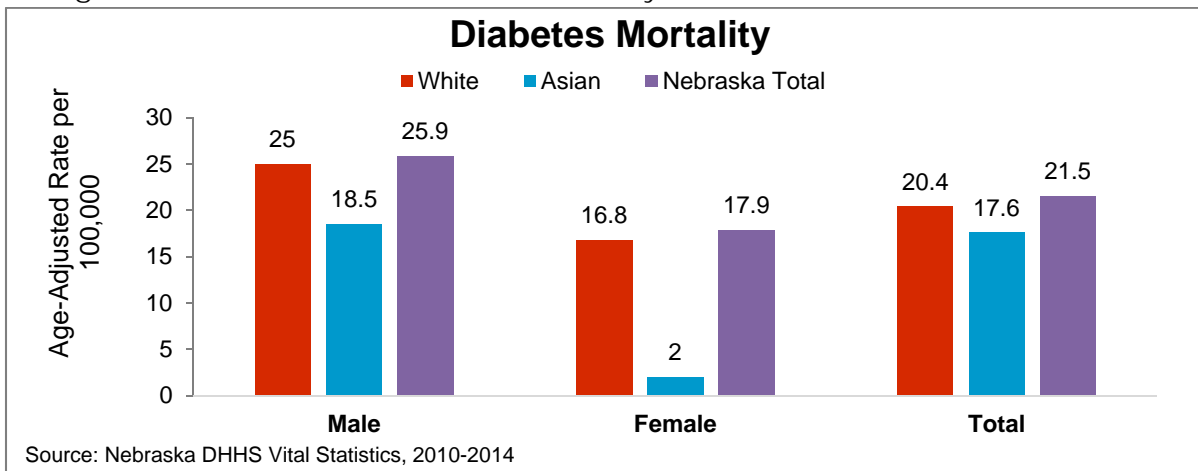


Confidence Intervals:

	Diabetes	
	Lower CI	Upper CI
White, NH	7.3	7.9
Asian, NH	4.4	10.2

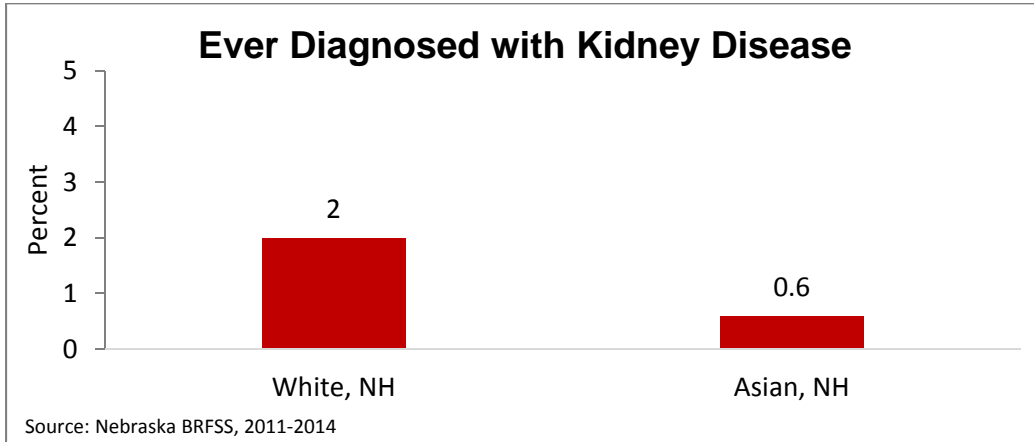
Diabetes Mortality

Although similar proportions of Asians and non-Hispanic Whites were ever diagnosed with diabetes, there were large differences between the mortality of Asian females and White females with diabetes, and Asian females and Asian males. Non-Hispanic Whites had higher male and female diabetes mortality rates.



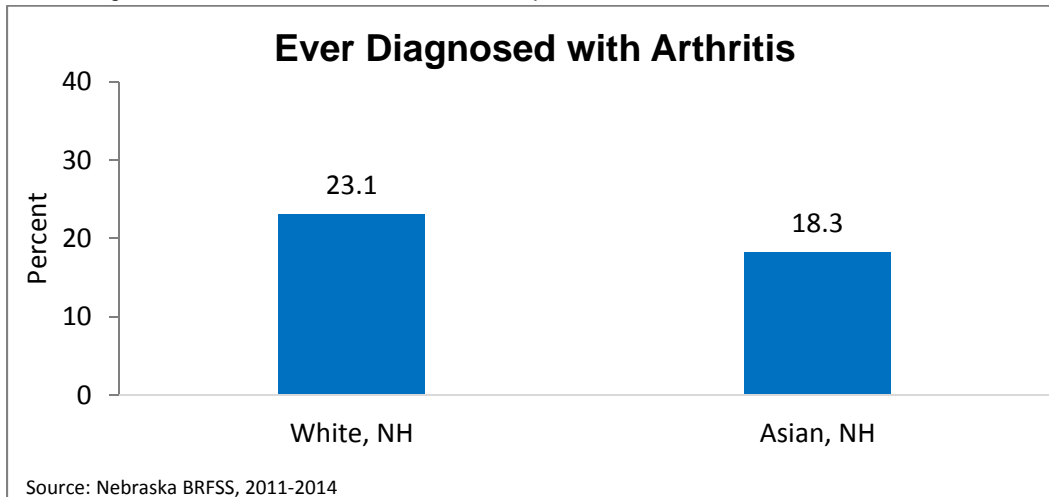
Kidney Disease

The proportion of White individuals who had ever been diagnosed with kidney disease was much greater than the proportion of Asians. Two percent of Whites had ever been diagnosed whereas only 0.6% of Asians had been diagnosed with kidney disease.



Arthritis

There was a 5% difference between the proportion of White Nebraskans and Asian Nebraskans who were ever diagnosed with arthritis. This inflammatory disease can reduce mobility and functionality of adults and inhibit their day-to-day activities. Nearly one-fourth of surveyed White Americans (23.1%) reported being diagnosed with arthritis, whereas nearly one-fifth (18.3%) of Asians reported the same.



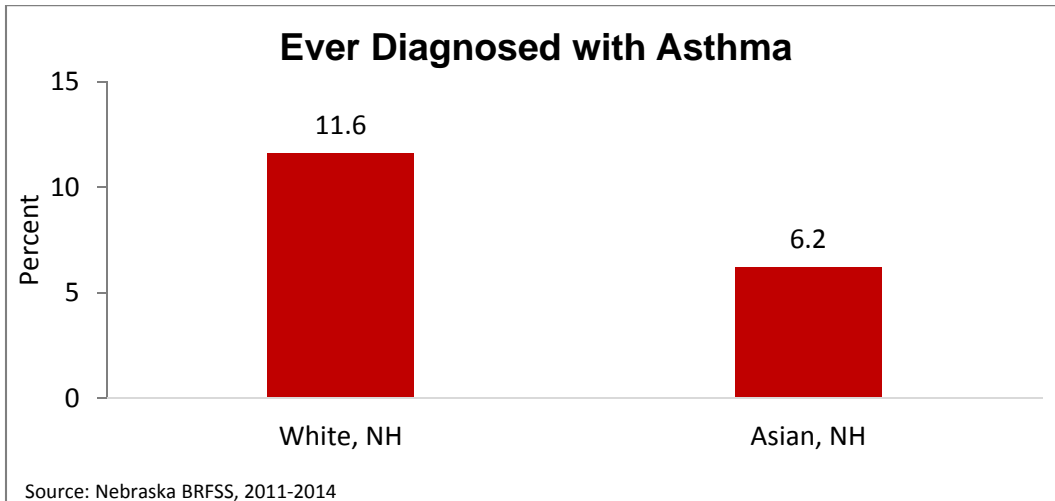
Confidence Intervals:

	Kidney Disease		Arthritis	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	4.8	5.2	22.7	23.5
Asian, NH	0.6	4.4	14.2	23.3

Asthma

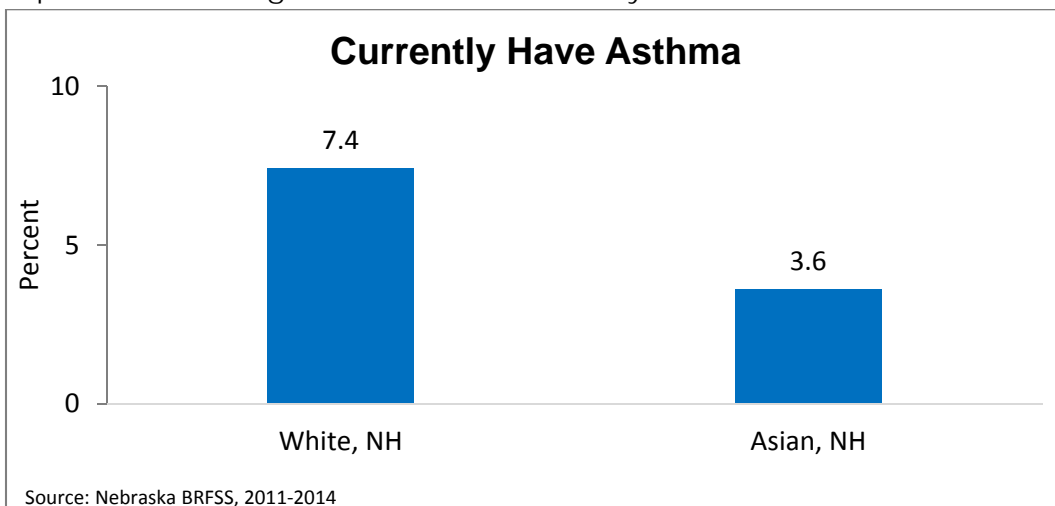
Ever Diagnosed with Asthma

Nearly twice the proportion of White respondents (11.6%) were ever diagnosed with asthma as Asian respondents (6.2%).



Current Asthma

Of those who were ever diagnosed with asthma, about 7.4% of Whites and 3.6% of Asians reported still having asthma at time of survey.

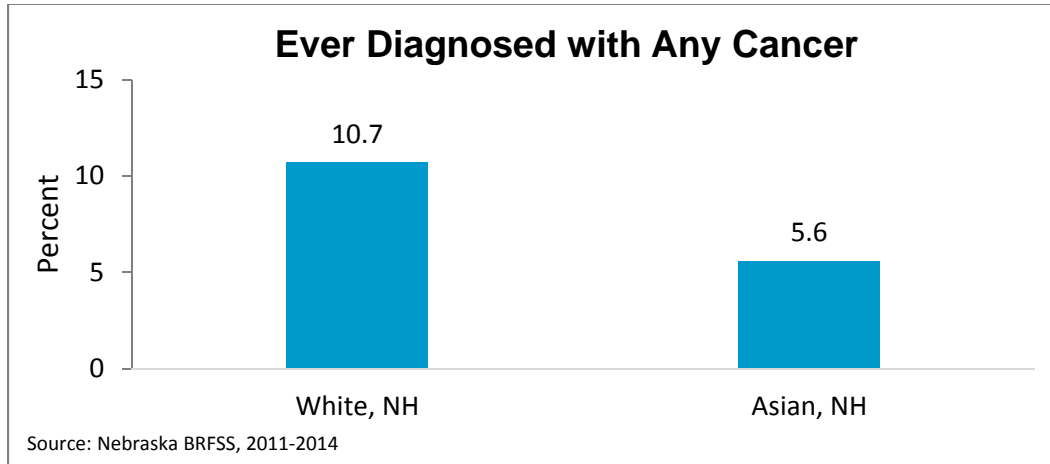


Confidence Intervals:

	Asthma (Ever)		Asthma (Current)	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	11.2	12	7.1	7.8
Asian, NH	4.3	8.8	2.2	5.9

Cancer

The figure below shows the proportion of individuals who were ever told they had cancer, according to 2011-2014 BRFSS surveys. The proportion of Asians who reported a cancer diagnosis was approximately half that of non-Hispanic Whites.

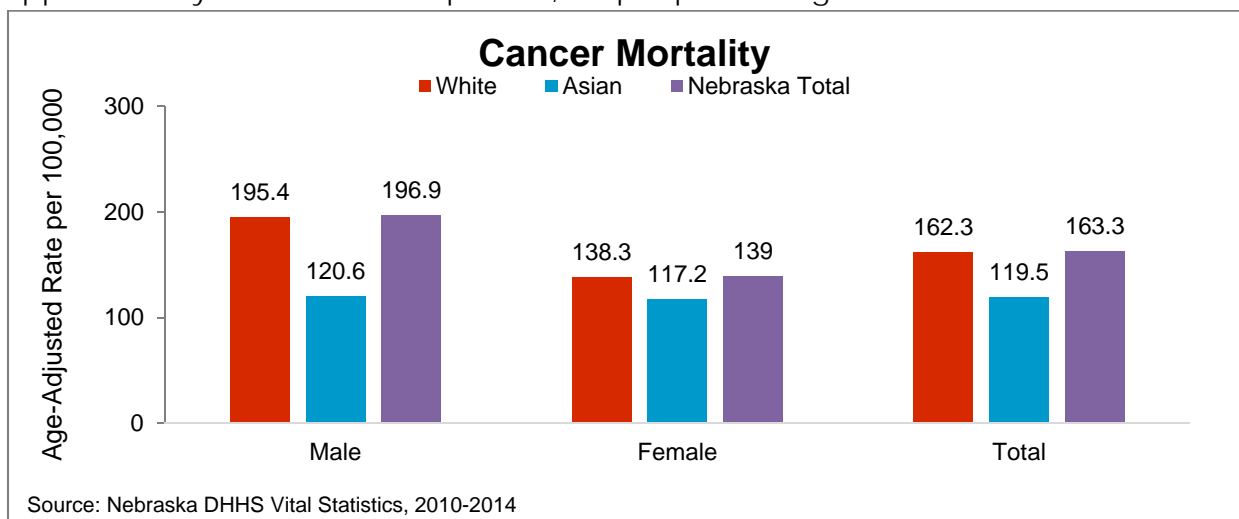


Confidence Intervals:

	Diagnosis of Any Cancer	
	Lower CI	Upper CI
White, NH	10.4	11
Asian, NH	3.1	9.9

Cancer Mortality

During the 2010-2014 time period, Whites had higher cancer mortality rates than Asians. There was a large difference in the rates for White and Asian males—there were approximately 75 more deaths per 100,000 people among White males.



Infectious Disease

HIV/AIDS Incidence

In 2014, there were 35 total new HIV diagnoses among non-Hispanic Whites in Nebraska, whereas there were too few diagnoses among Asians to report (represented by 'x'). There were also zero AIDS diagnoses and zero HIV-then-AIDS diagnoses to report for Asians, whereas non-Hispanic Whites had reportable numbers.

HIV/AIDS Incidence in 2014						
	<u>New HIV Only Diagnosis¹</u>		<u>New AIDS Diagnosis²</u>		<u>HIV then AIDS³</u>	
	Number	%	Number	%	Number	%
White, Non-Hispanic	35	57	9	39	3	60
Asian/Pacific Islander	x	x	0	0	0	0

Source: Nebraska DHHS. HIV and AIDS Surveillance Report. 2014.

Cumulative HIV and AIDS

The number of total HIV cases in 2014 among Asian Nebraskans was 47 times lower than the number for non-Hispanic Whites. Similarly, the proportion of Asian Nebraskans living with HIV or AIDS was 33 times smaller than the proportion for non-Hispanic Whites.

Cumulative HIV and AIDS Cases by Race/Ethnicity in 2014				
	<u>All HIV Diagnoses⁴</u>		<u>Living HIV/AIDS Cases⁵</u>	
	2014		2014	
	Number	%	Number	%
White, Non-Hispanic	1758	59.5	1300	53.5
Asian/Pacific Islander	37	1.3	39	1.6

Source: Nebraska DHHS, HIV and AIDS Surveillance Program Summary Report. 2014.

¹New HIV only diagnoses reflect newly diagnosed cases of HIV infection who were Nebraska residents at the time of HIV diagnosis, they do not include those cases that were subsequently diagnosed with AIDS

²First AIDS diagnosis reflect newly diagnosed cases of AIDS who were residents of Nebraska at the time of the AIDS diagnosis. They only include those AIDS cases who first learned of their HIV status when they were diagnosed with AIDS

³HIV then AIDS cases reflect cases that were first diagnosed with HIV and then subsequently diagnosed with AIDS in 2014

⁴All HIV diagnoses include newly diagnosed cases of HIV infection who were residents of Nebraska at the time of HIV diagnosis and AIDS cases that were diagnosed as AIDS while being Nebraska residents through 2014.

⁵Living HIV/AIDS cases reflects persons diagnosed with HIV or AIDS who were residents of Nebraska and who were living on December 31, 2014.

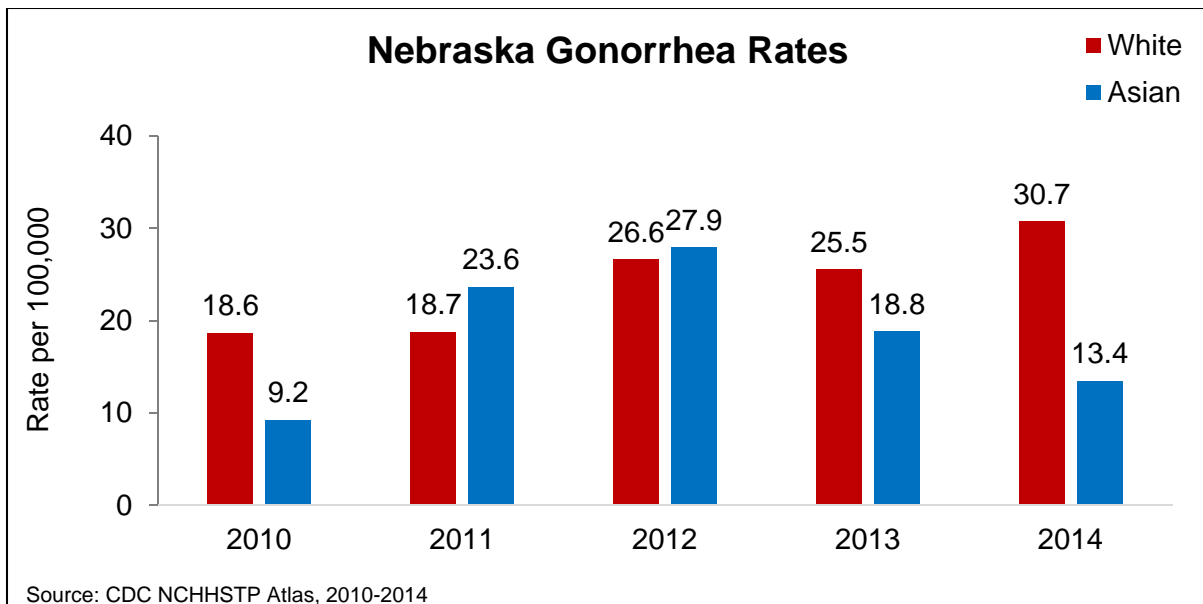
Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) remain a major public health challenge in the United States. STDs can cause serious complications including infertility, ectopic pregnancy, blindness, fetal and infant deaths, and congenital defects. Racial and ethnic minorities are at higher risk for sexually transmitted diseases, and experience higher rates of disease and disability than the overall population. STDs are also the cause of many harmful and often irreversible complications, such as reproductive health problems, fetal and prenatal health problems, and cancer.

Incidence of Gonorrhea

This information comes from the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). The rates below are calculated by the number of diagnosed cases for that year divided by the population of that race for the year.

In Nebraska, between 2010 and 2014, both the Asian and White populations experienced increases and decreases in gonorrhea incidence. In 2014, the rate of gonorrhea among Asians was approximately half the rate in 2012. For Whites, the 2014 rate was highest out of all five years and was 1.65 times higher than the rate in 2010.

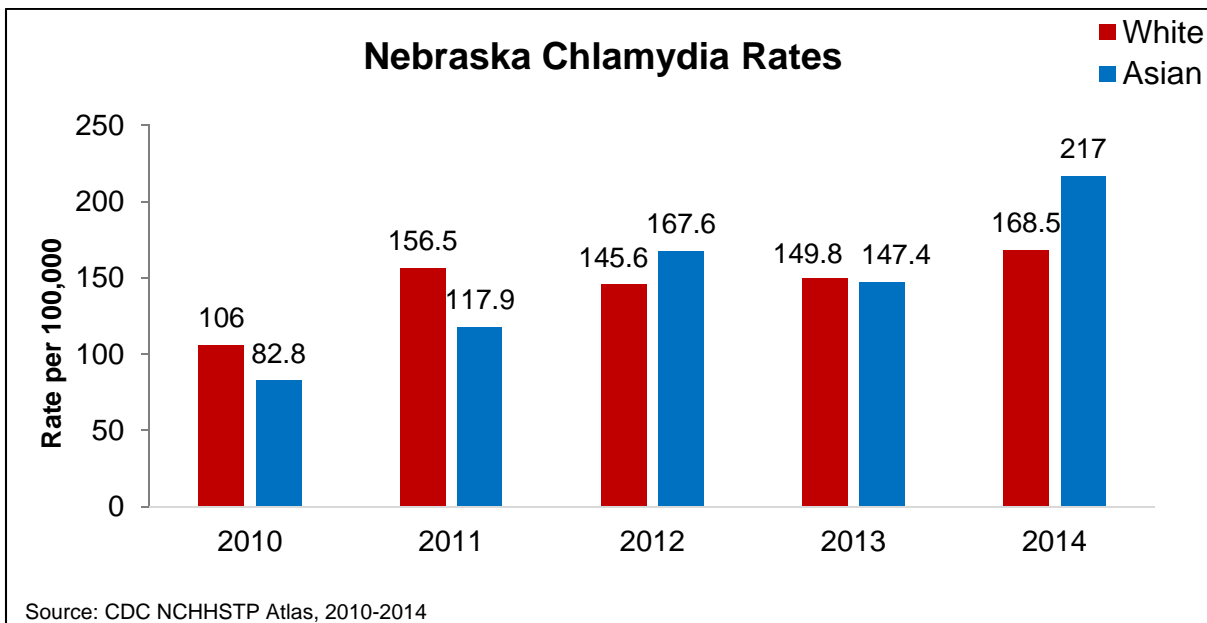


Please note: These rates are not age-adjusted. As stated above, these rates are calculated by the number of newly diagnosed cases *for that year* (e.g. between January 1, 2010 to December 31, 2010) divided by the population of that race *for the year* and are multiplied by 100,000.

Incidence of Chlamydia

This information comes from the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). The rates below are calculated by the number of diagnosed cases for that year divided by the population of that race for the year. As shown below, the incidence of chlamydia infections have increased among the White and Asian populations of Nebraska. Expanded screening and improved testing methods may account for some of these increases, in addition to increased infection. Chlamydia remains the most commonly reported infectious disease in the United States. It is estimated that there are approximately 2.8 million new cases in this country each year.

In Nebraska, between 2010 and 2014, the rate for Asian Americans increased by 2.62-fold. Among Whites, the rate increased by 1.59 times. The rate for Whites between 2011 and 2012 decreased, but was consequently met with increases in 2013 and 2014. Similarly, the rate of chlamydia decreased among Asians between 2012 and 2013, but increased again in 2014.



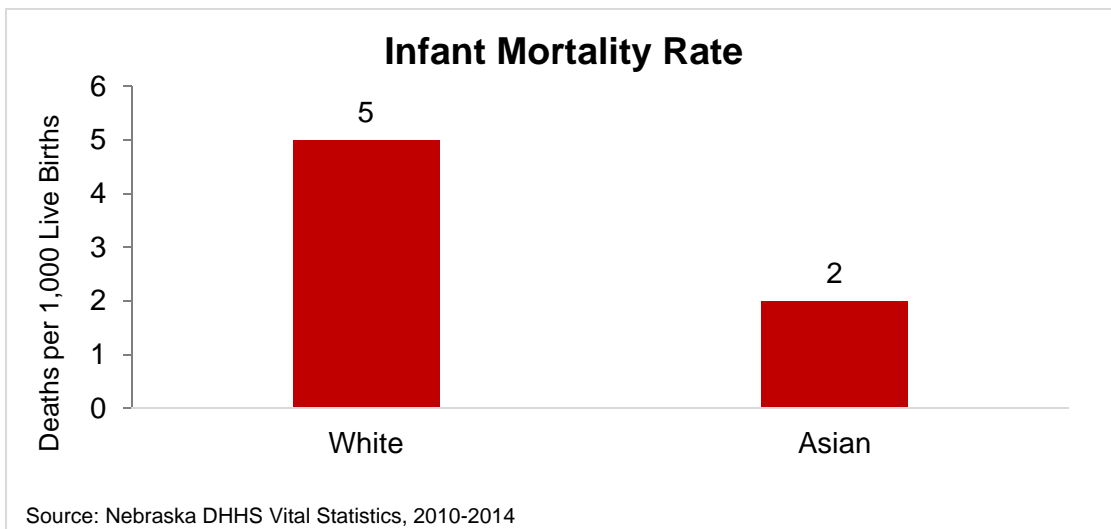
Please note: These rates are not age-adjusted. As stated above, these rates are calculated by the number of newly diagnosed cases *for that year* (e.g. between January 1, 2010 to December 31, 2010) divided by the population of that race *for the year* and are multiplied by 100,000.

Maternal and Child Health

Infant Mortality

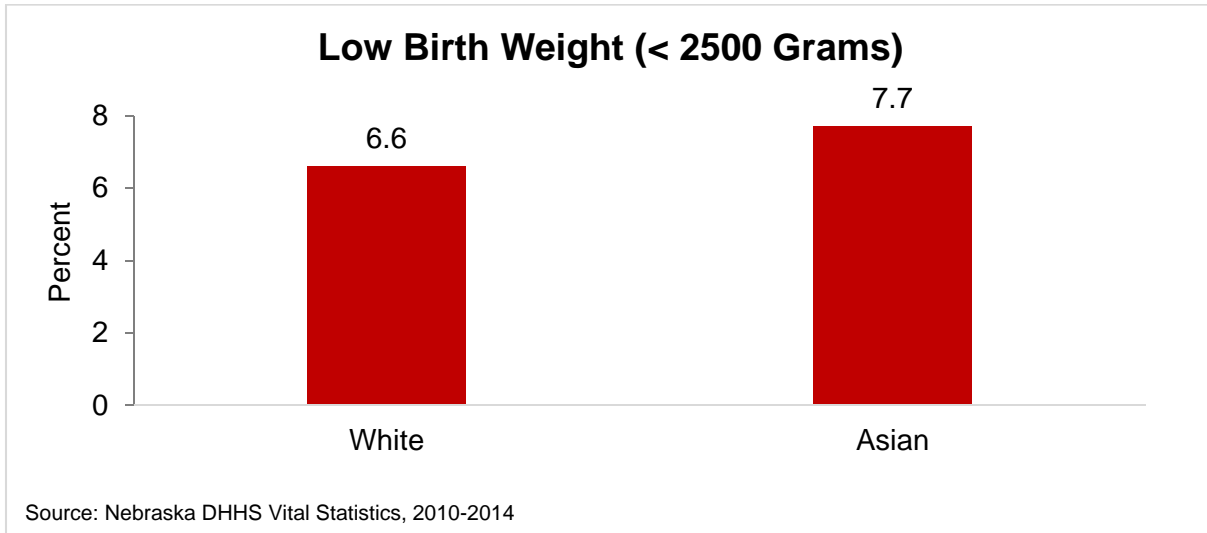
Infant mortality is a long-established measure, not only of child health, but also of the well-being of a society. It reflects the level of health status and health care of a population, and the effectiveness of preventive care and the attention paid to maternal and child health. Often considered the benchmark of the existence of unmet health needs, maternal and child health in Nebraska is first assessed by Infant Mortality rates.

The figure below shows the infant death rate for Asian Americans and Whites. In the five-year period of 2010-2014, the infant mortality rate was 2.5 times higher for Whites than for Asians.



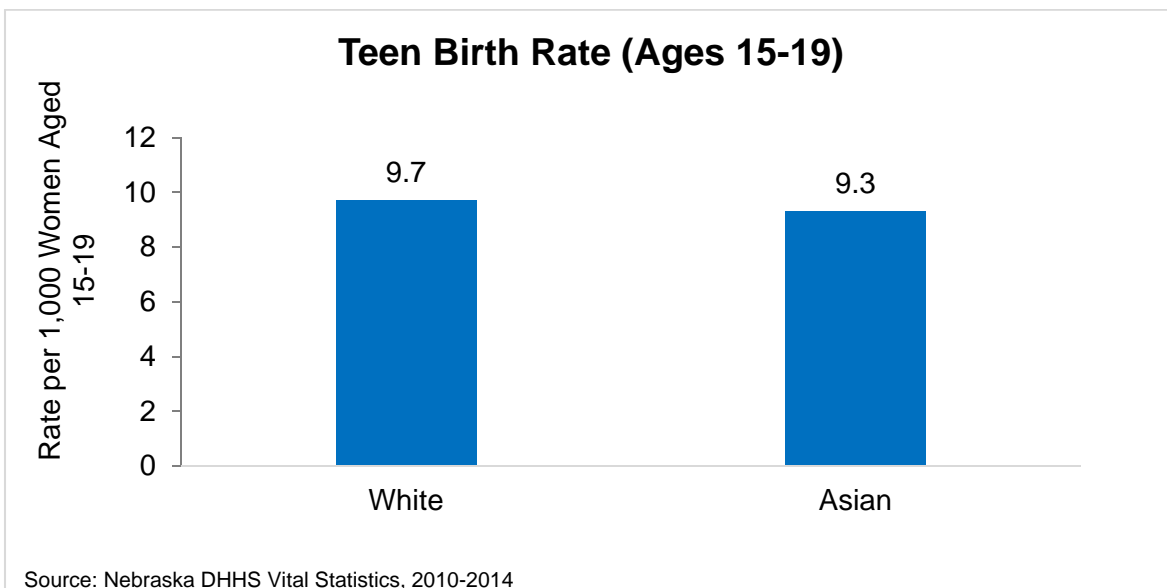
Low Birth Weight

A newborn is considered to be of low weight if he/she weighs less than 2,500 grams at birth (5 lbs, 8 oz.). These babies experience higher rates of illness and death than other infants. During 2010-2014, there were more low-birth weight Asian babies (7.7%) than White babies (6.6%).



Teen Births

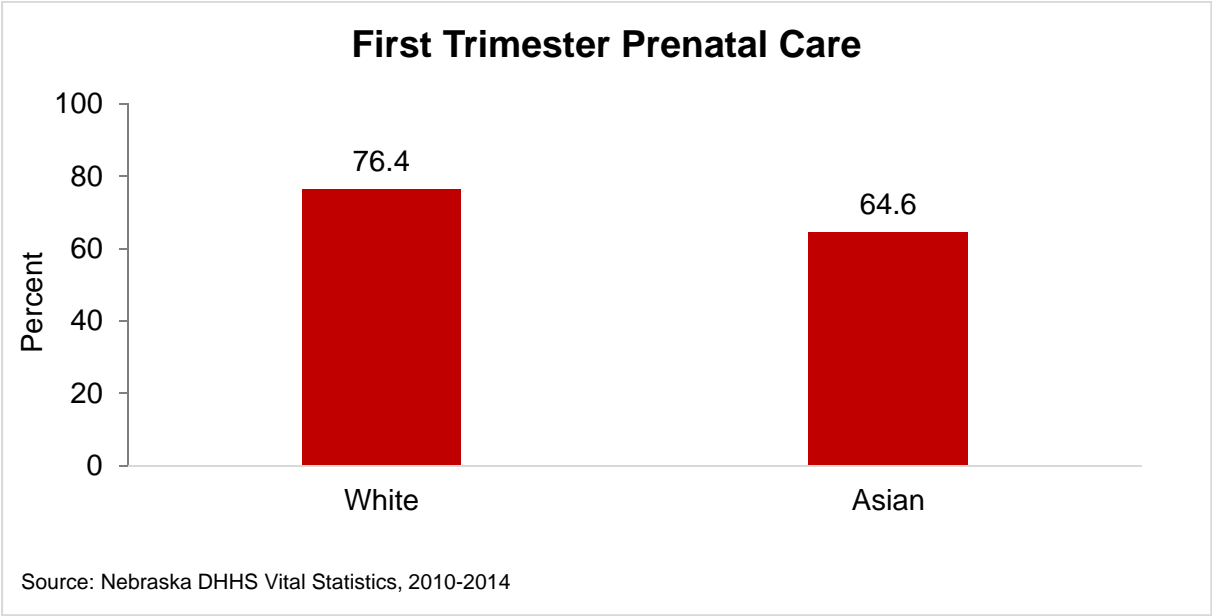
In Nebraska, the teen birth rate for Asian Americans was slightly lower than the rate for Whites. During 2010-2014, the teen birth rate for Asian American female teens was 9.3 per 1,000 women ages 15-19, compared to 9.7 for White female teens.



Mothers Receiving First Trimester Prenatal Care

Mothers who initiated prenatal care after the first trimester of pregnancy and those who received no prenatal care at all are considered at risk. In 2010-2014, the percentage of women beginning prenatal care in the first trimester for Asian American mothers was 64.6%, compared to 76.4% for White mothers.

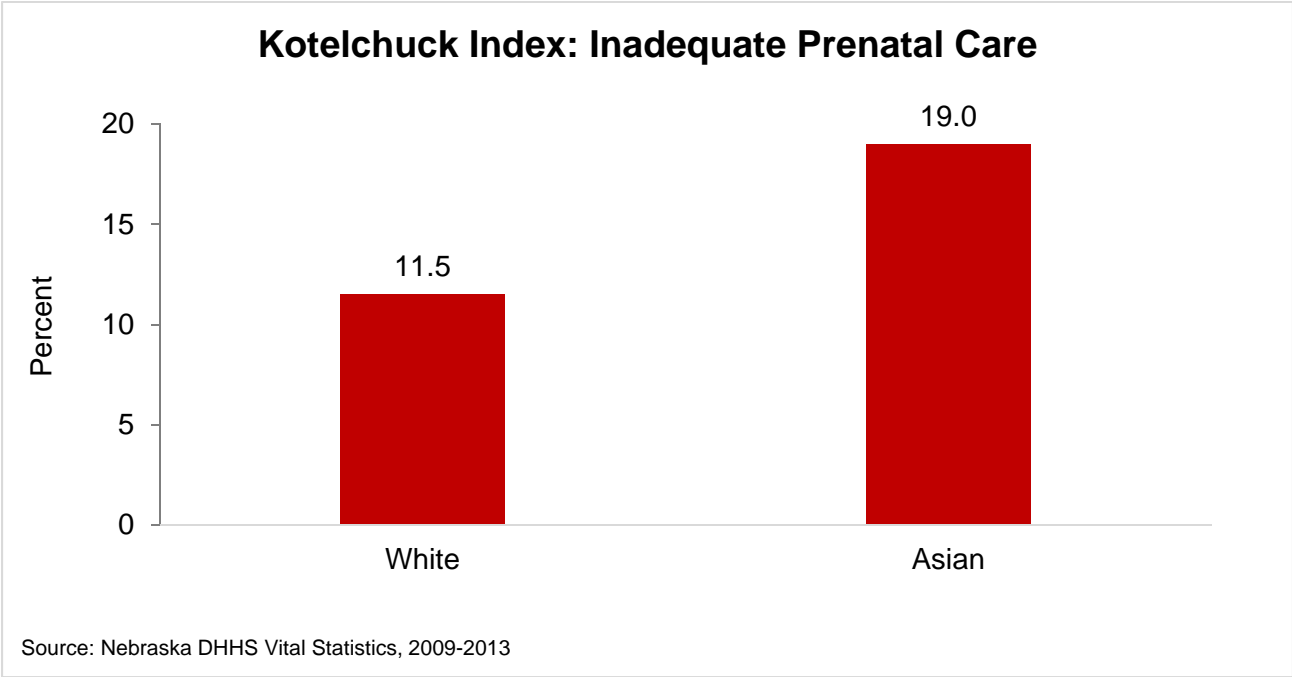
Pre-natal care is important for both mother and child. This ensures that the baby is growing and progressing normally and that the health of the mother is not at risk during pregnancy. The disparity between Asian and White mothers with regard to obtaining care during the first trimester of pregnancy represents a possible focus area for public health efforts. This would possibly improve the health of women and children and reduce the infant mortality rate.



Kotelchuck Index

The Kotelchuck Index is a measure of adequacy or inadequacy of prenatal care by using a combination of number of prenatal visits, gestation, and what trimester prenatal care was started.

Based on the Kotelchuck Index for the 2010-2014 timeframe, nearly one-fifth (19%) of Asian American mothers received **inadequate** prenatal care, whereas this was true for only one-tenth (11.5%) of White mothers.



PRAMS and Breastfeeding

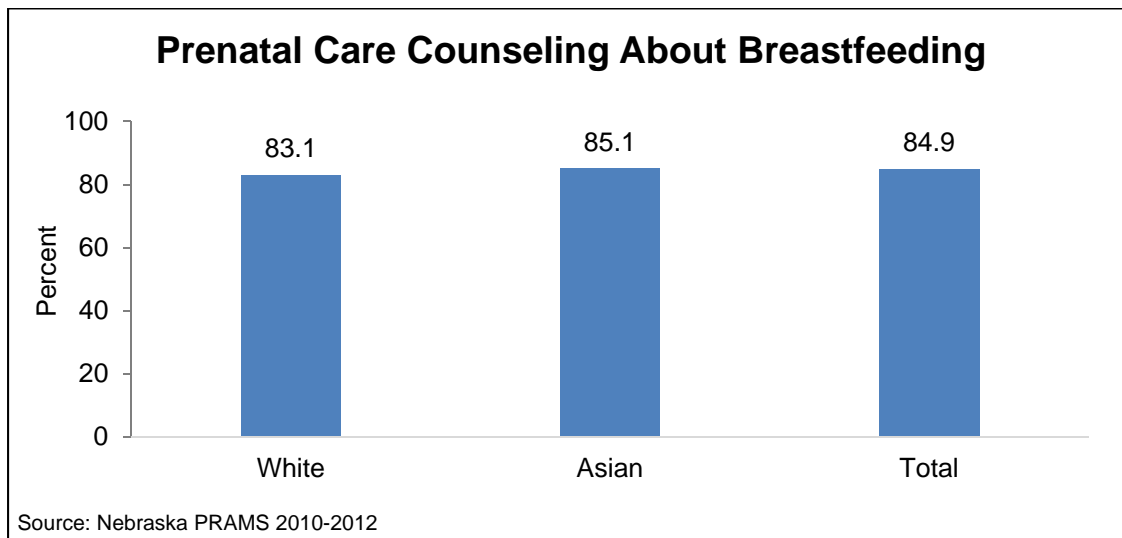
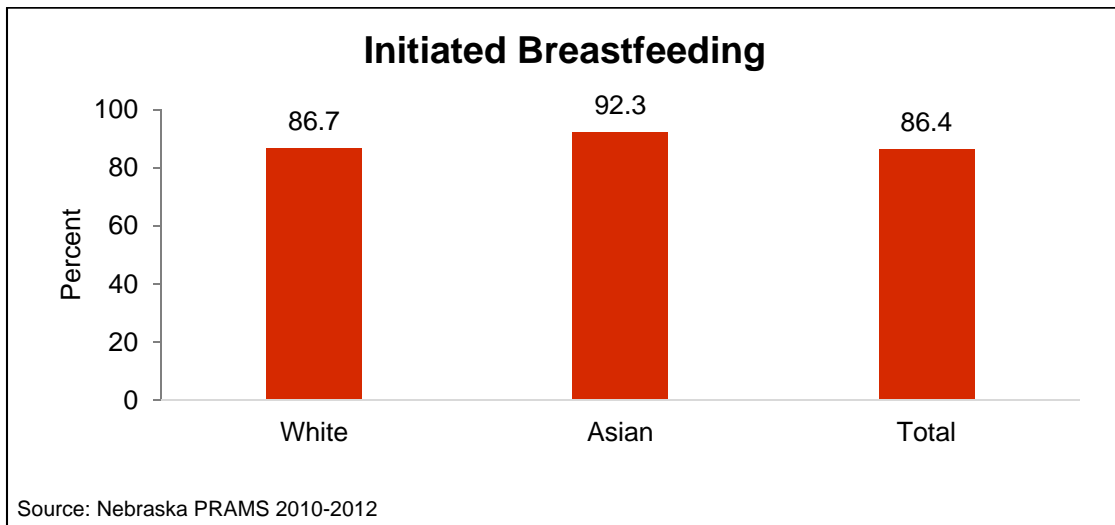
The Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing population-based surveillance system of maternal behaviors and experiences before, during, and after pregnancy. It is an initiative to reduce infant mortality and low birth weight infants, and was developed to supplement vital 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. Breast milk strengthens infants' immune systems, thus resulting in fewer cases of illness for newborns. Breastfeeding has also been associated with a decreased risk of pre-menopausal breast cancer in women. However, breastfeeding rates remain low among some groups of women, such as women who are young, Black, below the Federal Poverty Threshold, unmarried, or not college-educated. Many women also stop breastfeeding soon after initiation for various reasons, such as smoking, medication used, physical and mental health issues, or the need to return to work.

Receiving Counseling on Breastfeeding & Initiating Breastfeeding

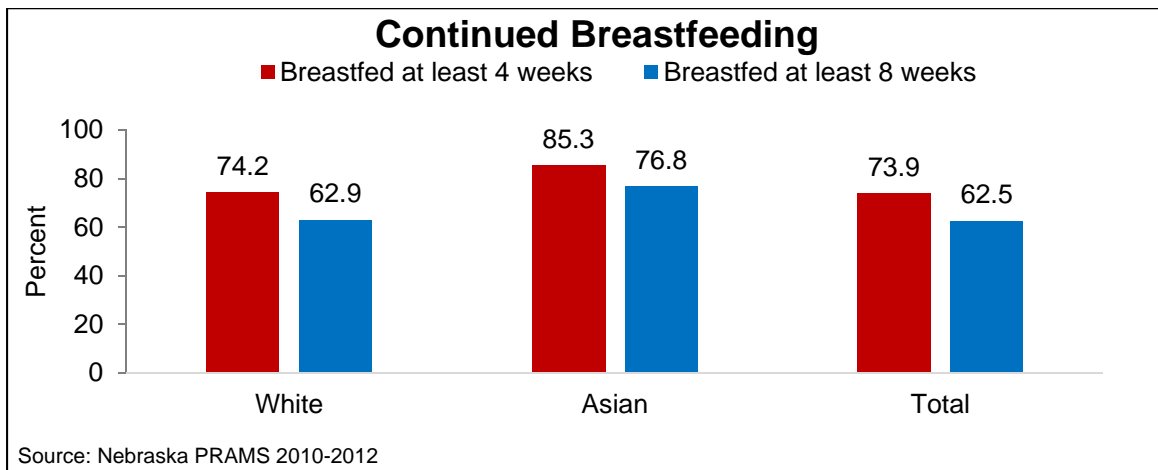
The question asked on the PRAMS survey about breastfeeding initiation was: "Did you ever breastfeed or pump breast milk to feed your newborn after delivery?"

The prevalence of breastfeeding initiation among White mothers during this period was 86.7%, while Asian American mothers' breastfeeding initiation was 92.3%. When asked about receiving counseling on breastfeeding, 85.1% of Asian American mothers received counseling while only 83.1% of White mothers received counseling.



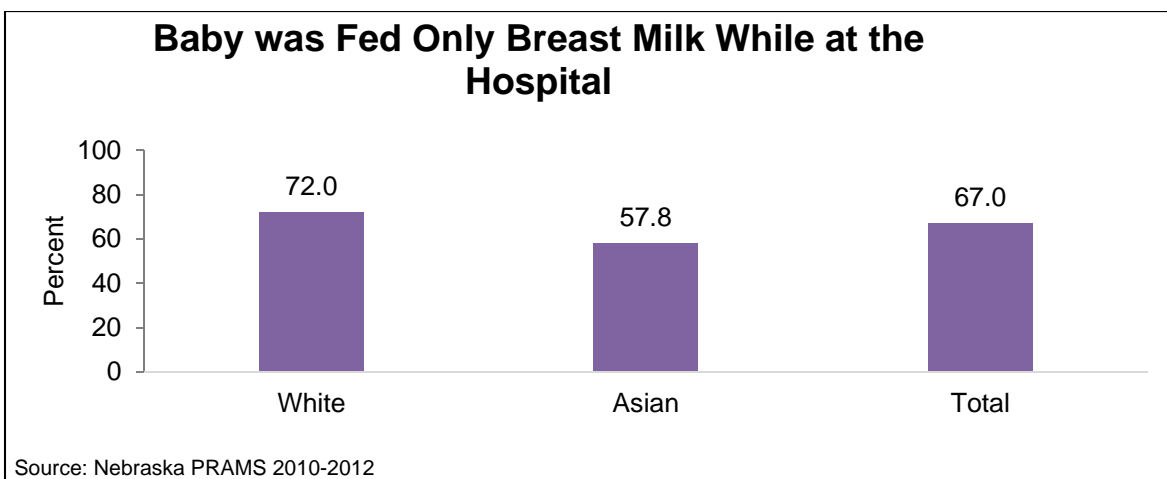
Continued Breastfeeding

Continuation of breastfeeding is estimated among those who initiated it after giving birth. Exclusive breastfeeding at four weeks is based on the age when an infant received anything other than breast milk. Based on Nebraska PRAMS 2010-2012 data, a total of 74.2% of White mothers continued to breastfeeding at four weeks, while 85.3% of Asian American mothers continued to breastfeed at four weeks. At eight weeks, 62.9% of White mothers continued breastfeeding, whereas 76.8% of Asian mothers did the same.



Baby Only Fed Breast Milk at the Hospital

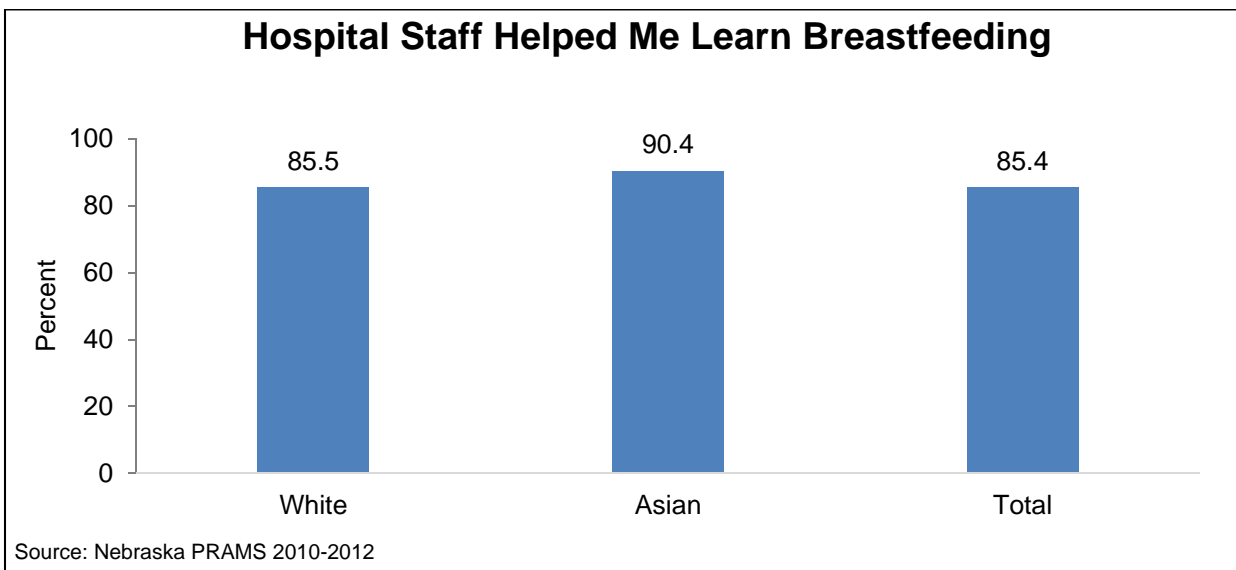
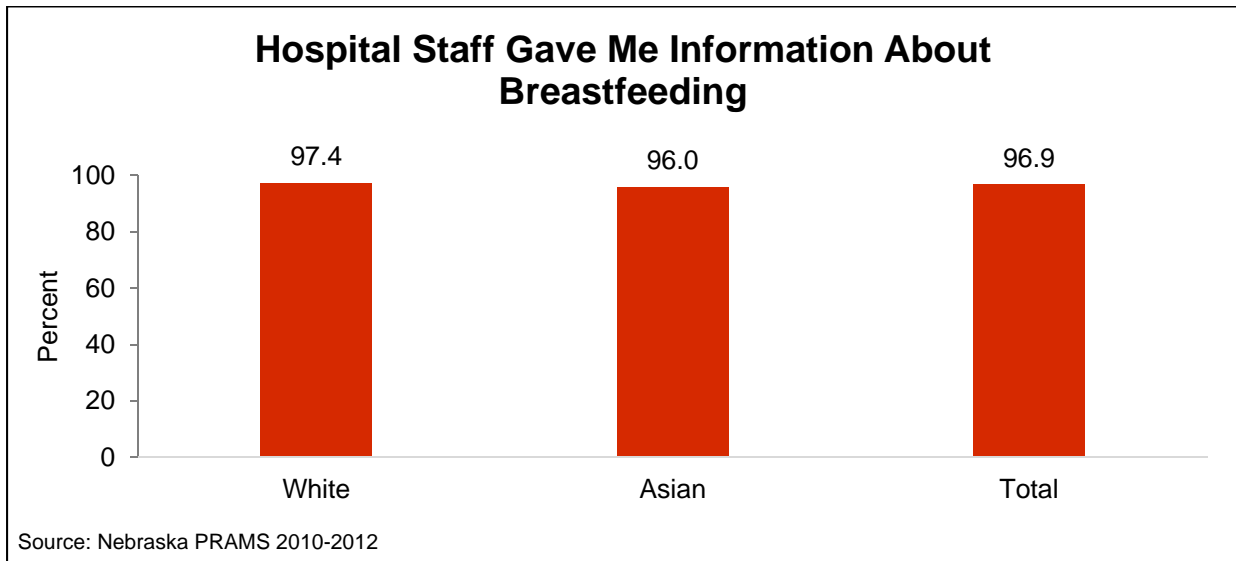
Fewer Asian mothers reported feeding their babies only breast milk while at the hospital (57.8%). This figure was lower than the percentage for White mothers and for Nebraska mothers as a whole.



Hospital Provision of Breastfeeding Information

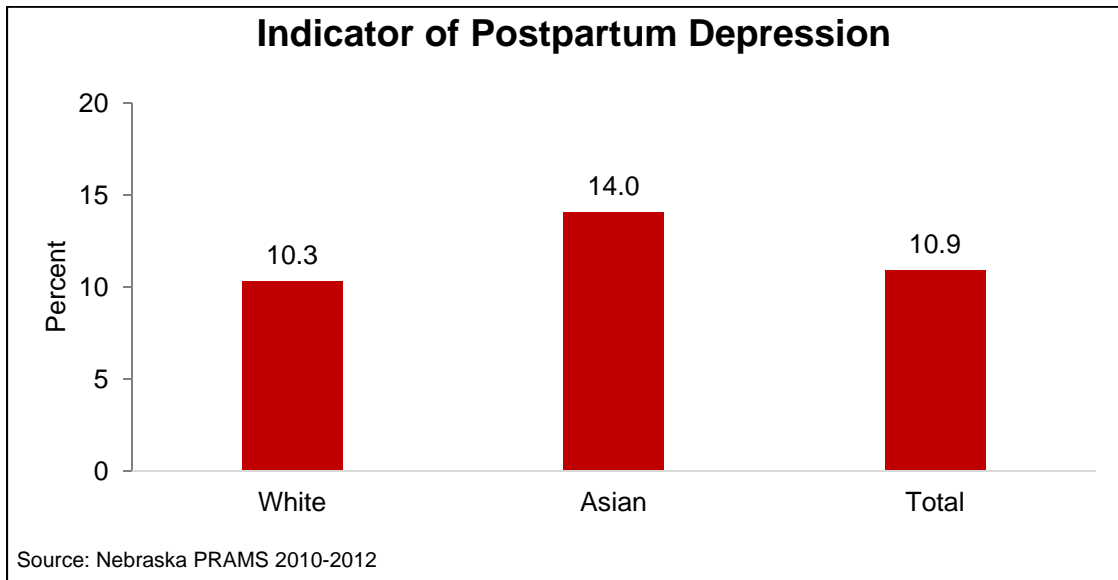
While mothers are still in the hospital, staff members may provide information about breastfeeding. Lactation specialists also help mothers learn the technique and offer coaching to help mothers learn how to breastfeed babies.

Similar percentages of White and Asian individuals reported obtaining information about breastfeeding while in the hospital (96-97%). However, a higher proportion of Asian mothers than White mothers reported learning how to breastfeed from hospital staff (90.4%).



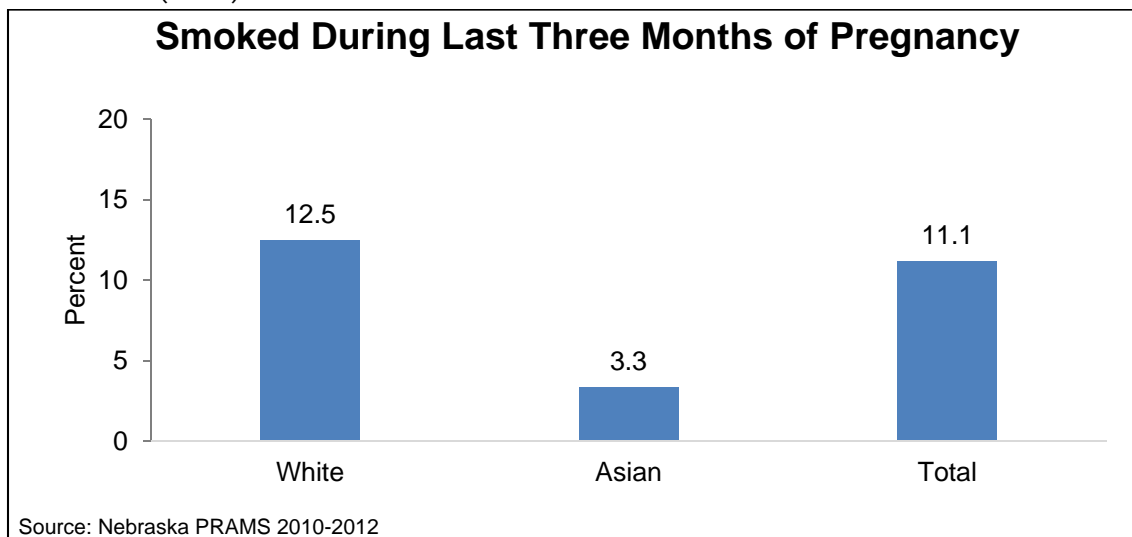
Postpartum Depression Risk

Postpartum depression is an affective mood disorder that usually starts within the first two to three months after a woman gives birth. Symptoms include persistent sadness, feelings of worthlessness, inadequacy or guilt, and somatic symptoms such as headaches and chest pains. A higher percentage of Asian mothers (14%) indicated postpartum depression than White mothers (10.3%) and Nebraska mothers (10.9%).



Smoking During the Last Three Months of Pregnancy

Smoking while pregnant has been shown to have negative health effects on developing babies. The percentage of White mothers (12.5%) who reported smoking during their last trimester was approximately four times greater than the proportion of Asian mothers (3.3%).



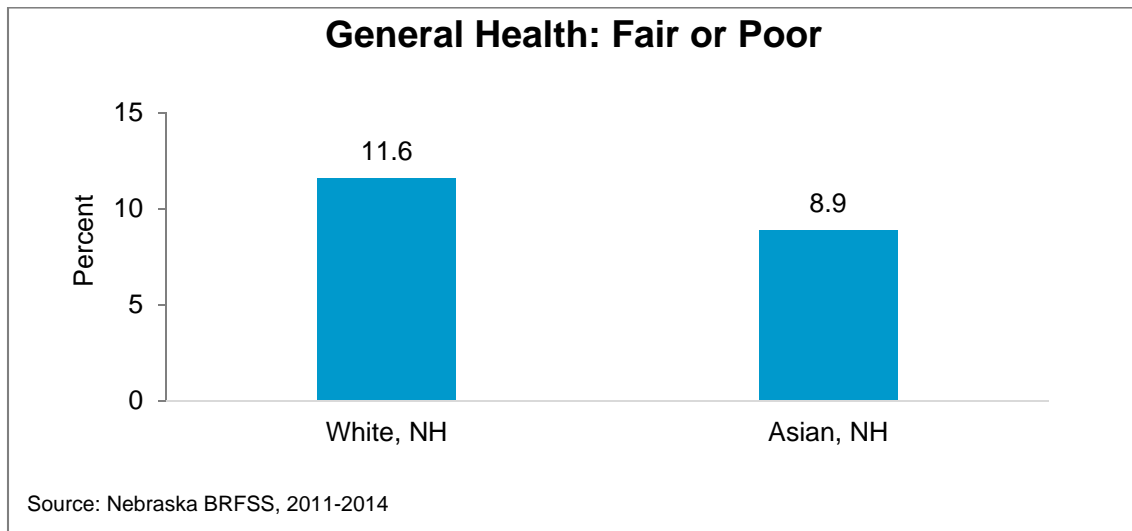
Behavioral Risk Factors

Health Status

Health-related quality of life measures seek to determine how adults perceive their own health, and how well they function physically, psychologically and socially during their usual daily activities.

Fair or Poor Health

Respondents were asked, "Would you say that in general your health is: Excellent? Very Good? Good? Fair? or Poor?" Nine percent of Asian American adults in Nebraska reported being in fair or poor health, compared to approximately 12% of Whites.

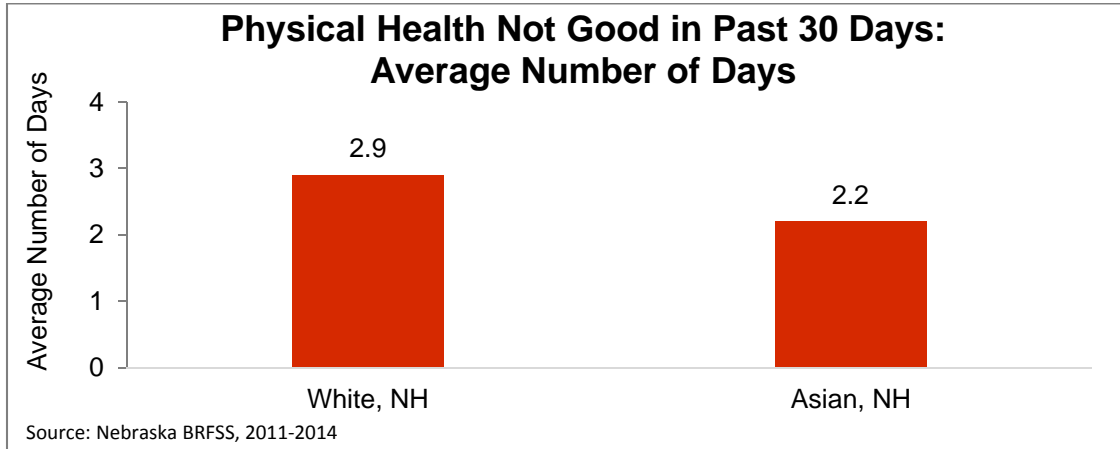


Confidence Intervals:

	Fair or Poor Health	
	Lower CI	Upper CI
White, NH	11.2	11.9
Asian, NH	6.3	12.6

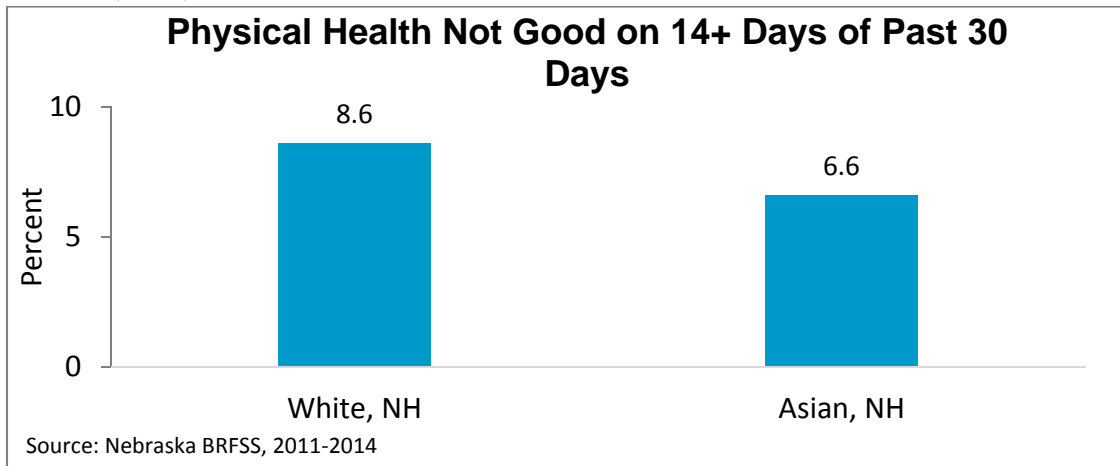
Physically Unwell: Average Number of Days

In the period of 2011-2014, the BRFSS asked respondents to report how many days during the previous month they felt physically unwell. Asians felt unwell an average of 2.2 days in the previous month as opposed to the White population that felt unwell for 2.9 days.



Physically Unwell: 14+ Days

Similar to the previous question, respondents gave information about the number of days in the past month that their physical health was "not good." The percent of Whites and Asians reporting at least 14 days of poor physical health were similar. However, the White population had a slightly higher percentage (8.6%) compared to the Asian population (6.6%).

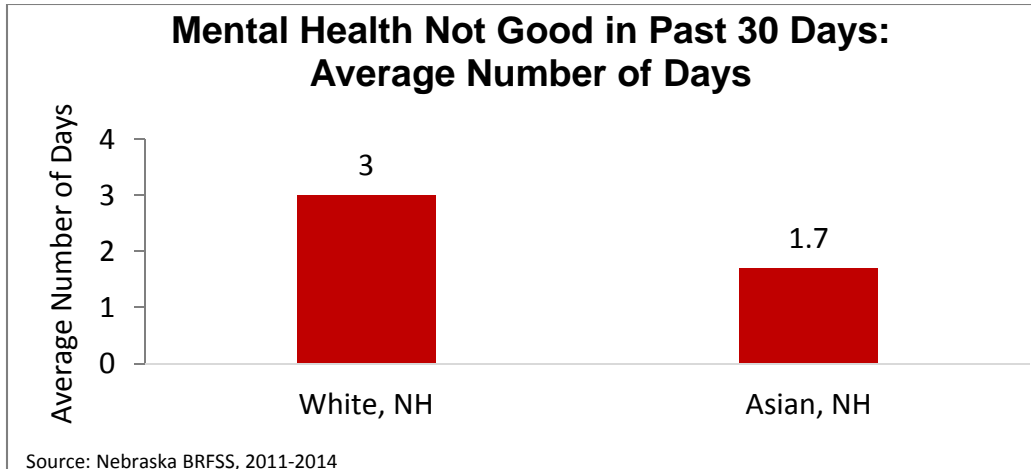


Confidence Intervals:

	Physical Health: Average Days		Physical Health: 14+ Days	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	2.8	3.0	8.2	8.9
Asian, NH	1.5	2.9	4.3	10.1

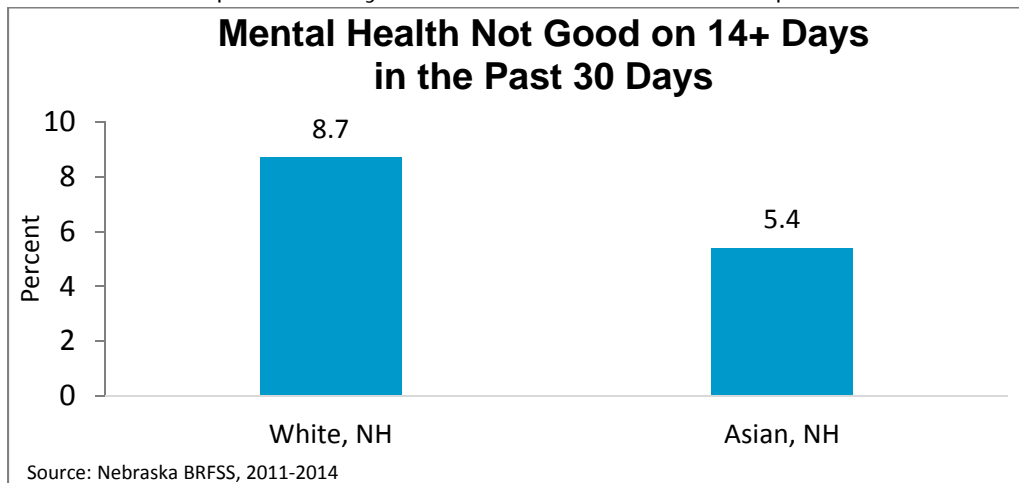
Mental Health: Average Number of Days

Respondents were asked about the average number of days that one's mental health was not good. Asians were mentally unwell for an average of 1.7 days in the past month, compared to three days for non-Hispanic Whites.



Mentally Unwell: 14+ Days

Respondents were asked about the average (mean) number of days that one's mental health was not good. In 2011-2014, 5.4% of Asians reported being mentally unwell for at least two weeks in the past 30 days, whereas 8.7% of Whites reported the same.

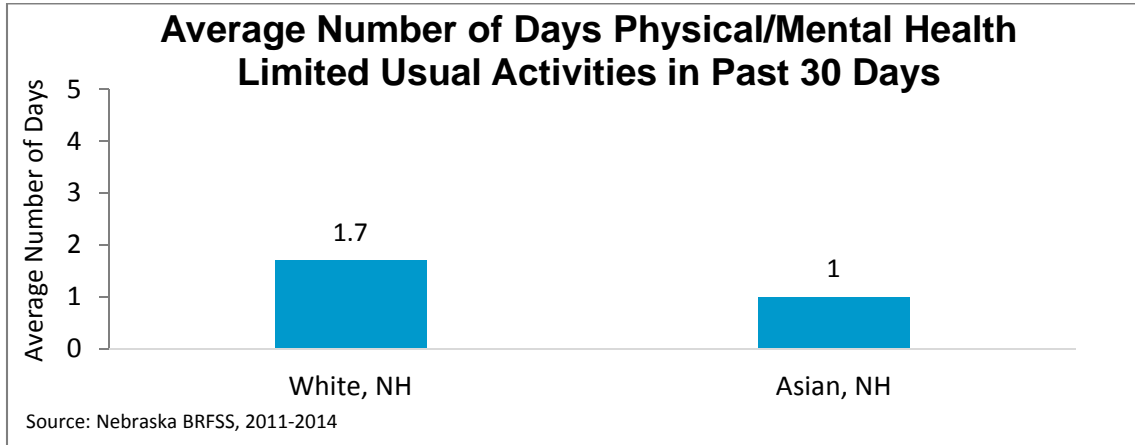


Confidence Intervals:

	Mental: Average # of Days		Mental: 14+ Days in Past 30 Days	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	2.9	3.1	8.4	9.1
Asian, NH	1.3	2.2	3.6	7.9

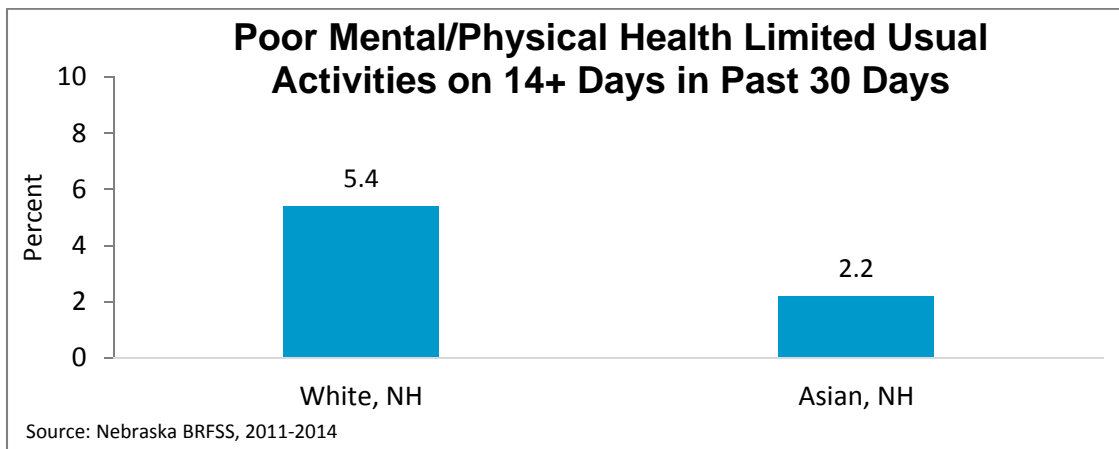
Activity Limitation: Average Number of Days

Adults in the survey were read the following description of activity limitation: “Are you limited in any way in any activities because of physical or emotional problems?” Asians averaged one day of activity limitation due to physical or mental problems in the previous month, compared to 1.7 days among Whites.



Activity Limitation: 14+ Days

Approximately 2% of Asian American adults reported that they have limited activity due to physical and/or mental problems, which was lower rate of limited activities than White adults at 5.4%.

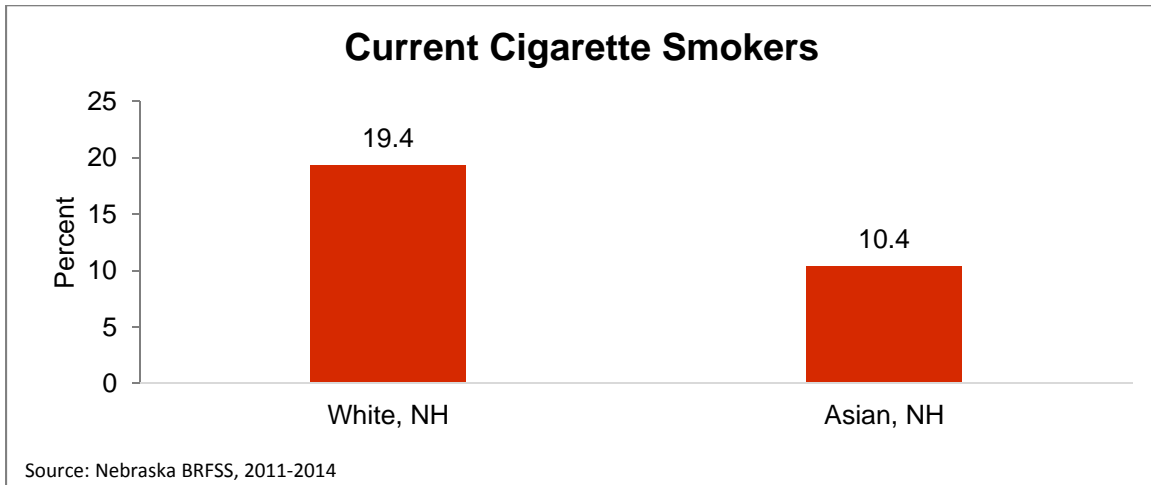


Confidence Intervals:

	Average # of Days		14+ Days in Past 30 Days	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	1.7	1.8	5.2	5.7
Asian, NH	0.7	1.4	1.2	4.0

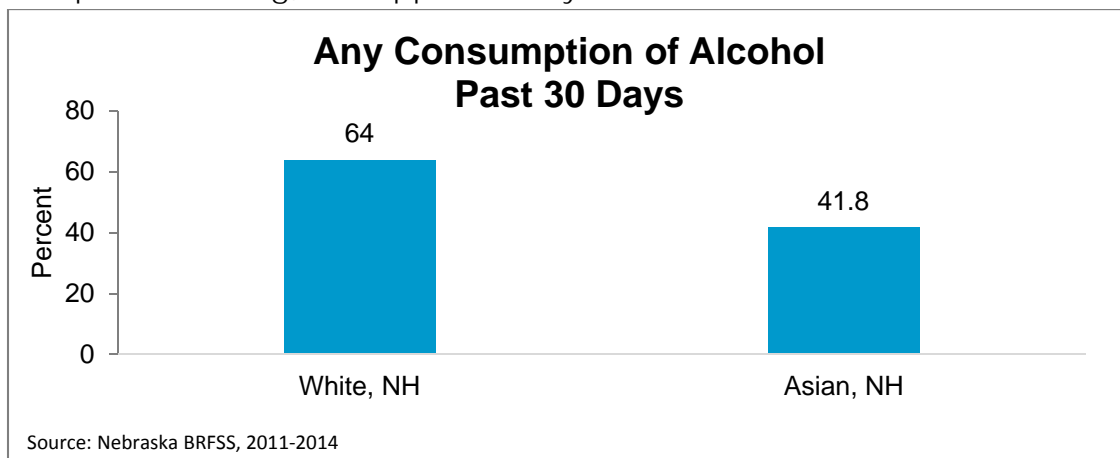
Cigarette Smoking

Cigarette smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung disease. Current smokers were defined as: “Persons who reported smoking at least 100 cigarettes in their lifetime, and who currently smoke some days or every day.” Asian American (nearly 10.4%) adults were less likely than White adults (19.4%) to be a current smoker.



Any Alcohol Consumption in the Past 30 Days

When asked about consumption of any alcohol in the past month, 64% of non-Hispanic Whites reported drinking, and approximately 42% of Asians did the same.

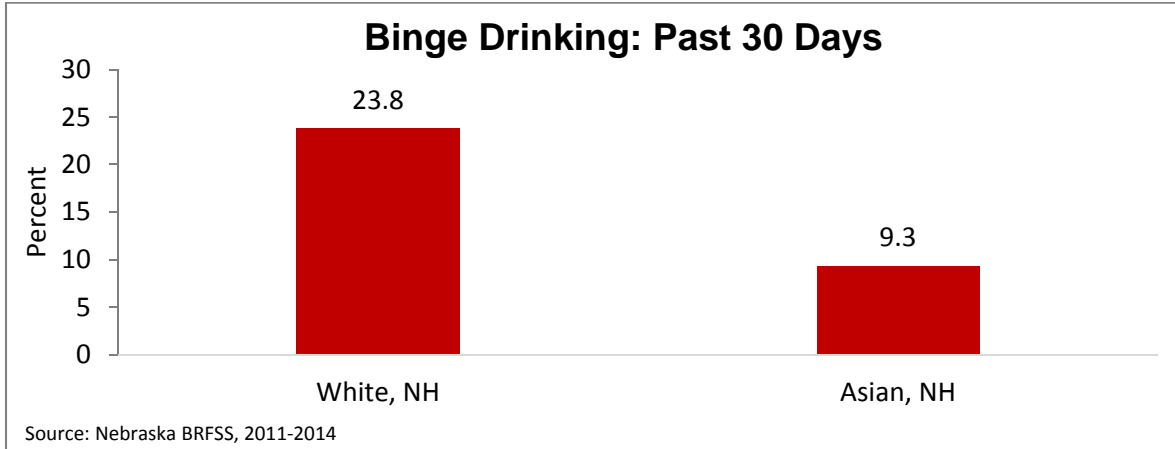


Confidence Intervals:

	Current Smoker		Alcohol Consumption	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	18.9	20	63.4	64.6
Asian, NH	7.2	14.6	36.2	47.6

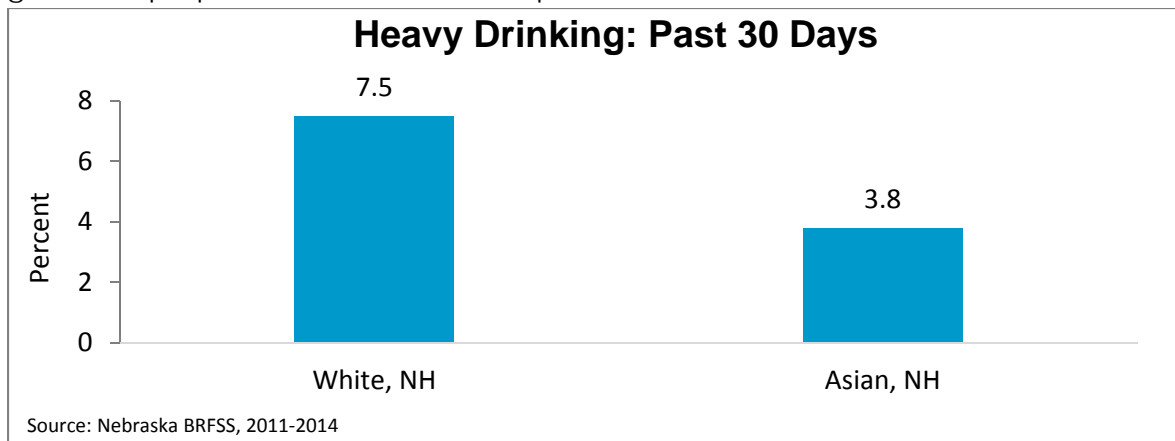
Binge Drinking

The definition of binge drinking, according to the CDC, is, “drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women.” The proportion of White Nebraskans who reported binge drinking within the past month was 2.5 times greater than the proportion of Asian Nebraskans (23.8% versus 9.3%, respectively).



Heavy Drinking

The CDC’s definition of heavy drinking states, “Drinking 15 or more drinks per week for men, or eight or more drinks per week for women.” According to 2011-2014 BRFSS survey results, the proportion of Whites who reported heavy drinking was nearly twice as large as the proportion of Asians who reported the same.

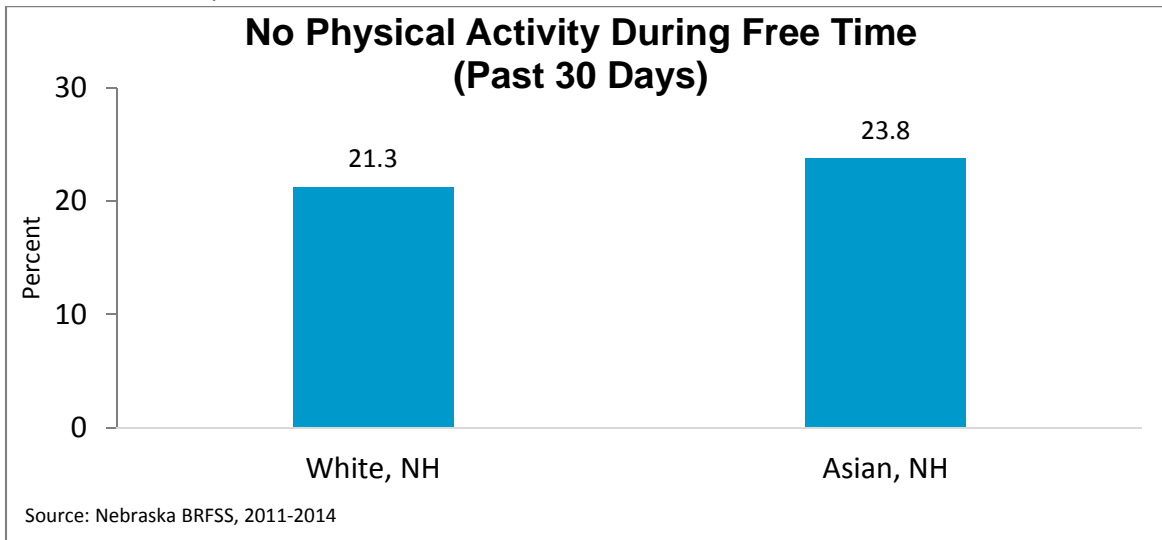


Confidence Intervals:

	Binge Drinking		Heavy Drinking	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	23.3	24.4	7.1	7.8
Asian, NH	6.8	12.5	2.1	7.0

Physical Inactivity

An individual is said to be inactive when they answer “no” to the following question: “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?” A slightly higher proportion of Asian Americans reported inactivity during free time than non-Hispanic Whites (a difference of 2.5%).



Confidence Intervals:

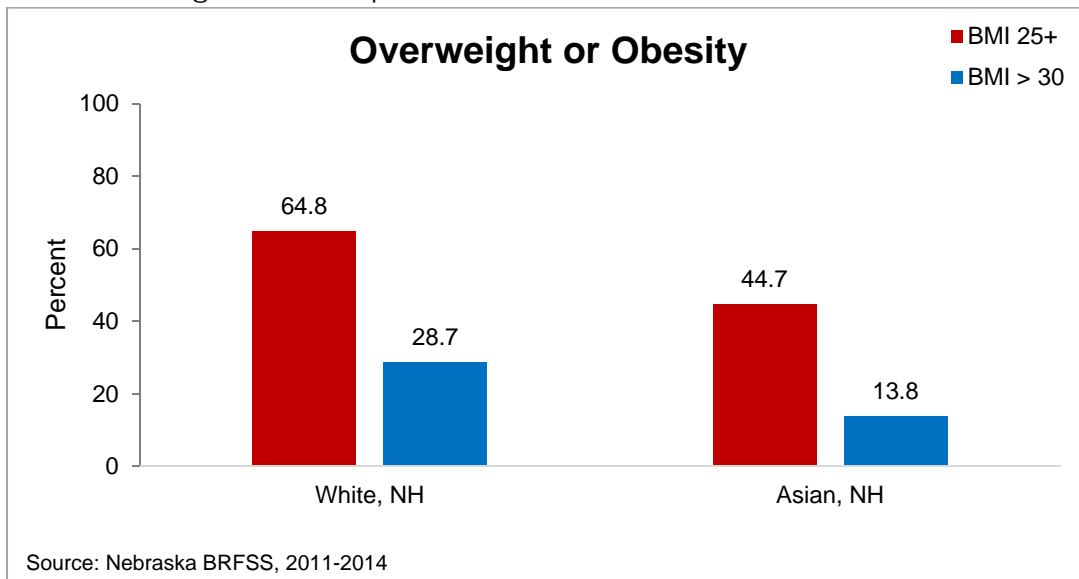
	Physical Inactivity	
	Lower CI	Upper CI
White, NH	20.9	21.8
Asian, NH	19.3	28.9

Overweight and Obesity

Being overweight or obese has been linked to increased risk of death. In addition, being overweight or obese substantially raises the risk of illness. The Body Mass Index (BMI) is used as a proxy measure for overweight and obesity in adults, until a better method of determining actual body fat is developed. BMI is calculated by dividing a person's weight in kilograms by the square of the person's height in meters.

- Overweight or obese: A BMI reading of 25.0 or greater
- Obese: A BMI reading of 30.0 or greater
- Overweight but not obese: A BMI reading of 25.0 to 29.9

According to 2011-2014 BRFSS data, over twice as many non-Hispanic Whites were obese (BMI > 30) as Asians (28.7% and 13.8%, respectively). Furthermore, 44.7% of Asians had a BMI of 25 or greater compared to 64.8% of Whites.



Confidence Intervals:

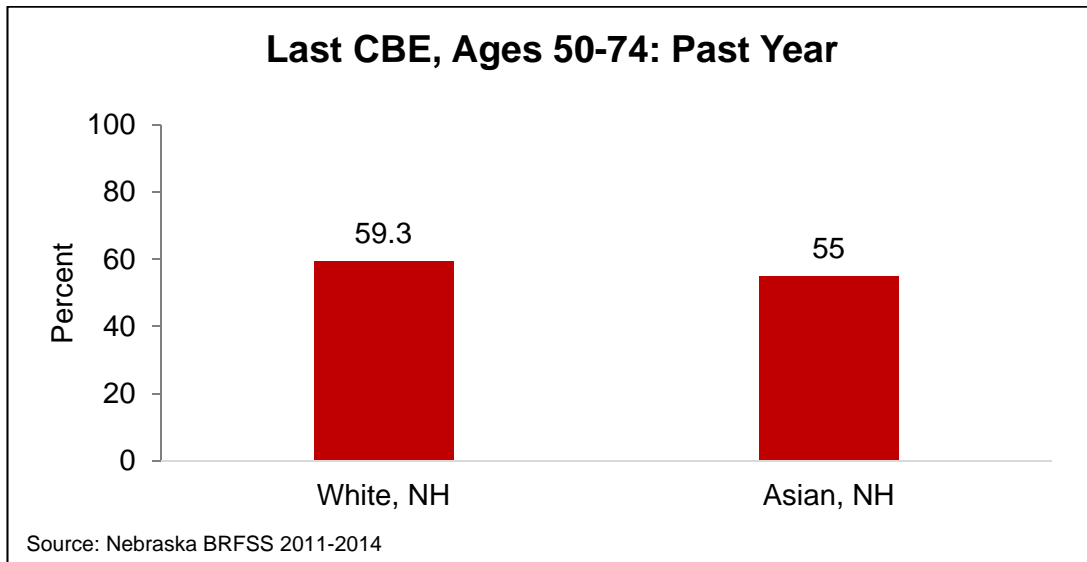
	BMI 25+		BMI > 30	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	64.2	65.4	28.1	29.2
Asian, NH	38.8	50.9	10.1	18.6

Cancer Screening

Cancer screening is important because the earlier cancer is detected, the better the outcomes may be. Localized cancers, or cancer that is only in one organ or area of the body, is easier to treat than cancer that has spread to multiple organs or areas within the body. With earlier detection, treatments may be less invasive and individuals will have less time away from their normal activities (e.g. work, exercise, raising children).

Clinical Breast Exams (Ages 50-74)

Women in the BRFSS survey were given the definition of clinical breast exam as: “when a doctor, nurse, or other health professional feels the breast for lumps.” They were then asked if they ever had a clinical breast exam. During the period of 2011-2014, Asian (55.0%) women were less likely than Whites (59.3%) to have a clinical breast exam in the past year among all women ages 50 to 74. Clinical breast exams are recommended every three years for women in their 20’s and 30’s, and annually for women ages 40 and older.



Please note: These numbers are not age-adjusted.

Confidence intervals:

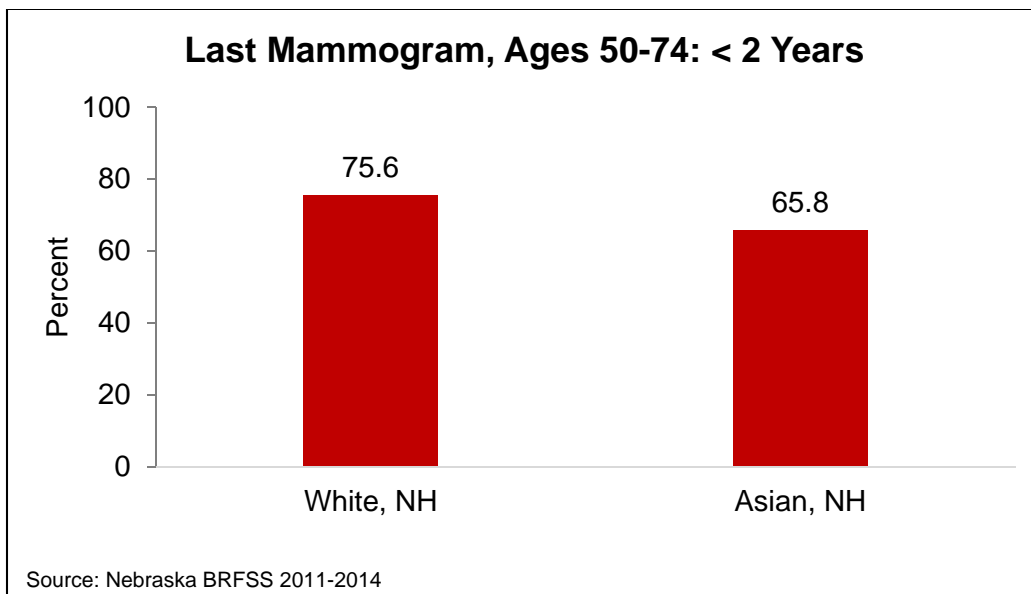
	Last CBE	
	Lower CI	Upper CI
White, NH	57.5	61.1
Asian, NH	30.8	77.1

Mammogram (Ages 50-74)

Mammograms are the best method to detect breast cancer early when it is easier to treat and before it is big enough to feel or cause symptoms.

Women in the BRFSS survey were read a statement describing a mammogram as an “x-ray of each breast to look for breast cancer”. They were then asked if they ever had a mammogram in the past two years.

The newest recommendation for mammogram is for women between the ages 50-74 to get checked every two years. Between 2011 and 2014, fewer Asian women (65.8%) had mammograms than White women (75.6%).



Please note: These numbers are not age-adjusted.

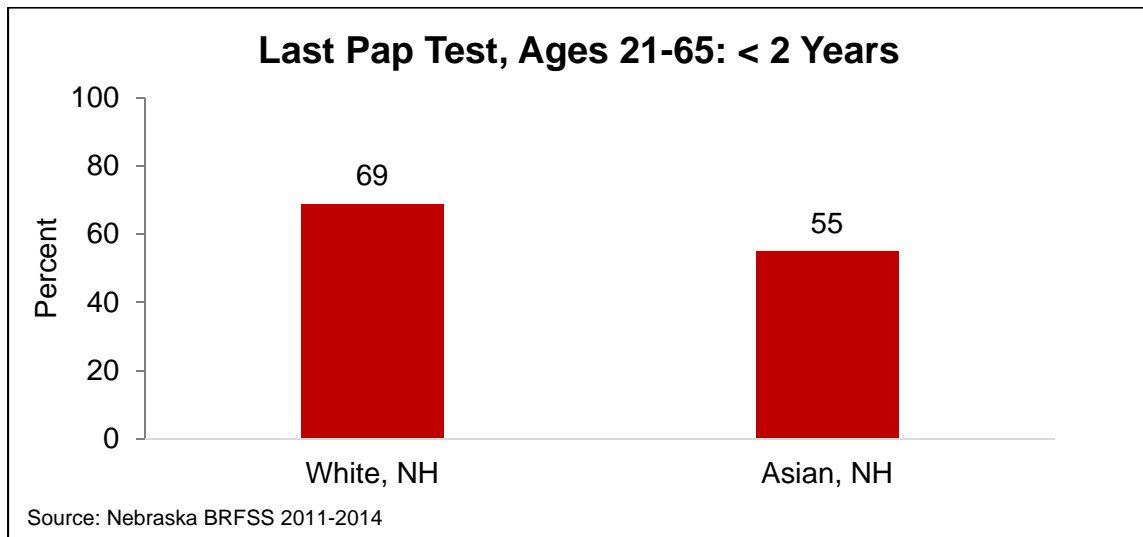
Confidence intervals:

	Last Mammogram	
	Lower CI	Upper CI
White, NH	74	77.1
Asian, NH	38.9	85.3

Pap Test (Ages 21-65)

The most recent recommendation from CDC and American Cancer Society is for women between the ages of 21 to 64 to get a Pap test every three years. Women in the BRFSS survey were given the definition of a Pap test as, "a test for cancer of the cervix," then asked if they "ever had a Pap Test in past three years."

The data below indicates that Asian women were less likely to get their Pap tests than White women (55% vs. 69% respectively) within the last two years.



Please note: These numbers are not age-adjusted.

Confidence intervals:

	Last Pap Test	
	Lower CI	Upper CI
White, NH	67.4	70.6
Asian, NH	40.5	68.7

Colorectal Cancer Screening (Ages 50-75)

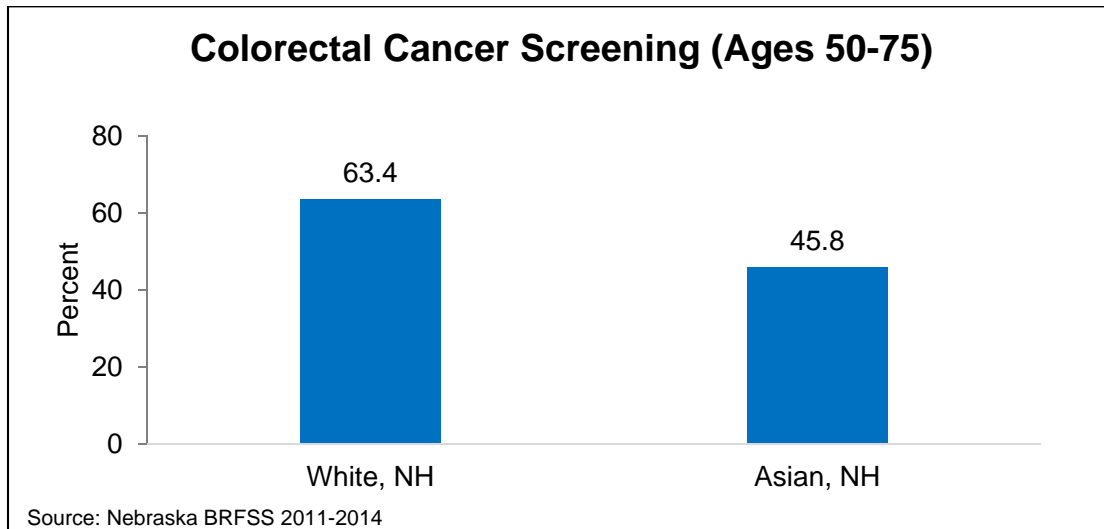
For people with average risk, the American Cancer Society suggests colorectal cancer screening beginning at age 50. Guidelines for people at above-average risk differ, and their risk status may be due to family history of colon cancer or other health issues. It is important to obtain screening because colorectal cancer can be prevented or treated when it is caught early.

For average risk individuals, it is recommended that people obtain⁴:

- Fecal occult blood tests (every year)
- Flexible sigmoidoscopies (every five years)
- Colonoscopies (every ten years)

The BRFSS results indicate the percentage of adults, aged 50-75, who had an FOBT within the last year or within the last three years, a sigmoidoscopy within the past five years, or a colonoscopy within the last ten years.

There was a 17.6% difference between the proportions of White Nebraskans and Asian Nebraskans obtaining colorectal cancer screening, with more Whites obtaining screening than Asians.



Confidence intervals:

	Colorectal Cancer Screening	
	Lower CI	Upper CI
White, NH	62.3	64.4
Asian, NH	30.3	62.2

⁴ American Cancer Society. American Cancer Society Recommendations for Colorectal Cancer Early Detection. <http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-ac-s-recommendations>

Other Preventative Behavioral Factors

In addition to the recommended cancer screenings, the BRFSS survey also includes questions about other important preventative measures such as seatbelt use, testing for disease, and vaccinations.

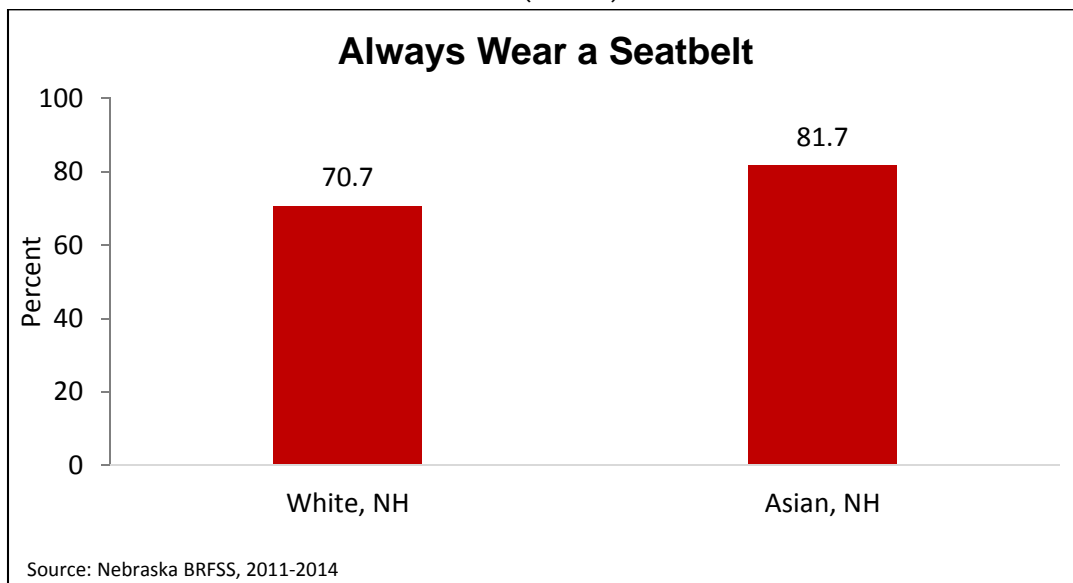
In recent years, there has been a larger public health push to increase the use of seatbelts by drivers and passengers; in fact, in many states it is now a punishable offense through tickets and fines.

Regular testing for diseases such as tuberculosis, HIV, and other STDs is important to having a full understanding of your own health. Testing is especially important among people who participate in activities that may leave them at higher risk for contracting a disease.

Additionally, vaccinations are also important to maintaining health. They reduce the severity or prevent the onset of diseases (e.g. the flu).

Use of Seatbelts

Slightly lower proportions of White Nebraskans (70.7%) reported that they always wear a seatbelt in the car than Asian Nebraskans (81.7%).

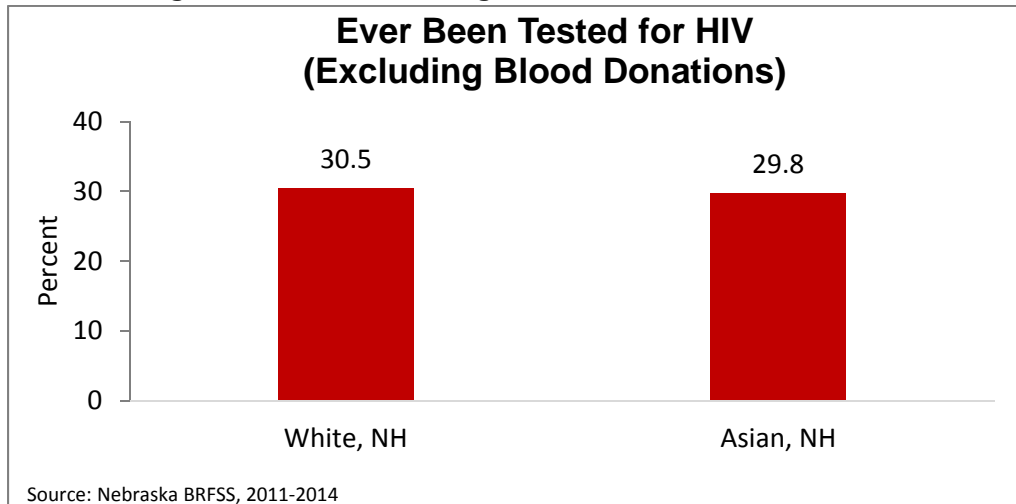


Confidence intervals:

	Seatbelt Use	
	Lower CI	Upper CI
White, NH	70.2	71.3
Asian, NH	77	85.6

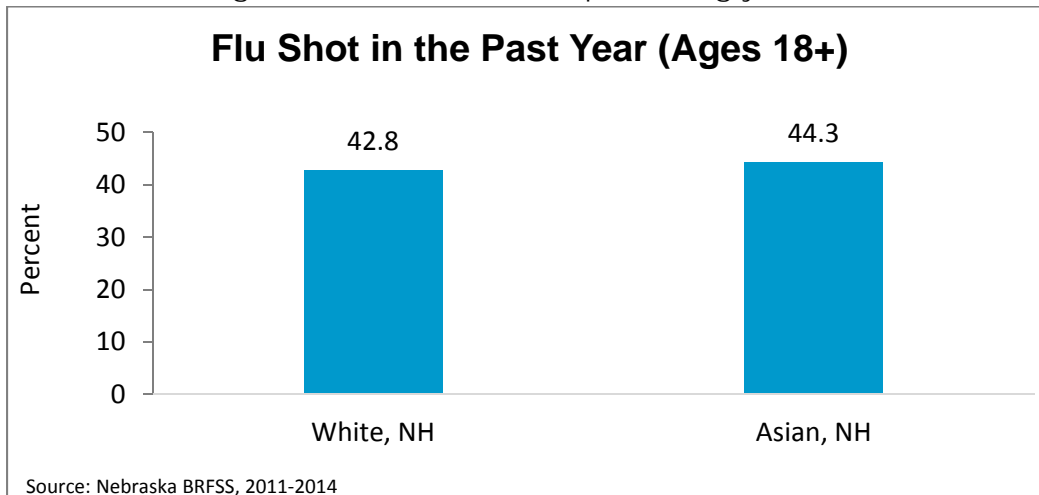
HIV Test (Ages 18-64)

When it comes to whether or not someone has been tested for HIV, similar proportions of White and Asian Nebraskans reported that they had ever been tested. Knowledge of HIV status is important to a person’s health, especially if they partake in behaviors that may put them at higher risk of contracting HIV.



Flu Vaccination Past Year (Ages 18+)

Among surveyed adults who were 18 years or older, about 43-44% of both White and Asian Nebraskans had gotten the flu shot in the preceding year.

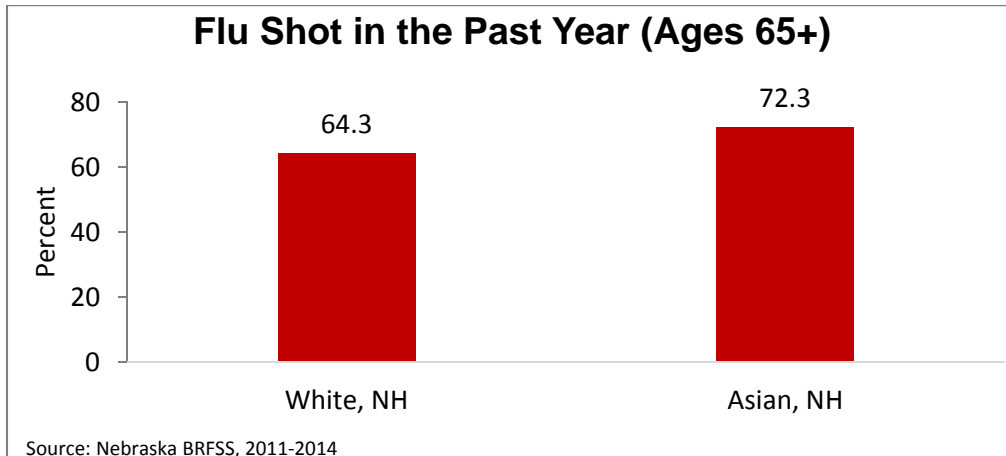


Confidence intervals:

	HIV Test		Flu Shot (18+)	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	29.9	31.2	42.3	43.4
Asian, NH	24	36.2	38.7	40.4

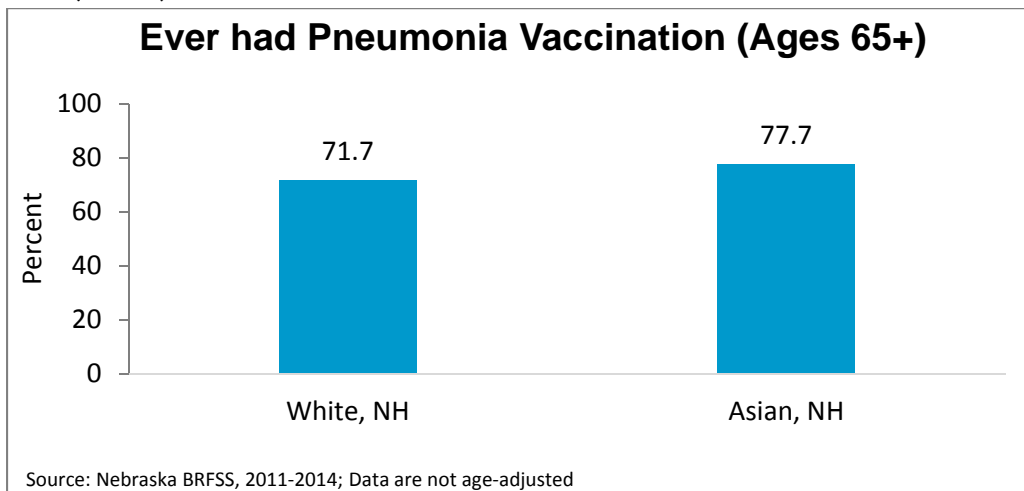
Flu Vaccination Past Year (Ages 65+)

Flu vaccines are especially important among the elderly because of their weakened ability to fight off disease. People who are 65 years old or older are also more likely to have weakened immune systems due to other diseases or conditions. Among Nebraskans, a higher percentage of Asians aged 65 and older (72.3%) had received a flu shot in the past year than Whites (64.3%).



Ever Had Pneumonia Vaccination (Ages 65+)

Pneumonia vaccinations are also important for those over the age of 65. Similar to flu vaccines, a higher proportion of Asian respondents reported getting vaccinated (77.7%) than whites (71.5%).



Confidence Intervals:

	Flu Shot (65+)		Pneumonia Shot (65+)	
	Lower CI	Upper CI	Lower CI	Upper CI
White, NH	63.4	65.1	70.9	72.4
Asian, NH	53.3	85.6	61.8	88.2

Conclusion

Although this report showed that the health status of Asian Americans in Nebraska is comparable or sometimes better than the health status of White Nebraskans, the Asian population should not be excluded from health prevention and education efforts. There are still disparities that exist between the White and Asian population, and these disparities may grow in coming years as the Asian population increases in size.

As current Asians in Nebraska become more westernized, it is possible that their health status may shift to be more in-line with the health status of Whites. This is due to something called the “healthy migrant effect.” As current and future Asians adopt unfavorable western lifestyles and eating habits, such as being sedentary or eating too much fast food, they may be faced with worse health outcomes.

Currently, data show that Asian and White Nebraskans have similar percentages of people reporting heart disease diagnoses. This is an example of where health efforts should be focused for both the Asian and White populations. Due to the existence of certain disparities, such as the absence of a personal provider for Asians, it is possible that the outcome of heart disease (for example, death due to heart disease) is worse for Asians than it is for Whites even though they have similar numbers of people with diagnoses. Our report showed that Asian females have a higher death rate due to stroke than White females, despite fewer Asians being diagnosed with strokes than Whites. Additionally, among Asians, some of the top causes of death include diabetes and hypertension—these diseases are absent among the leading causes for Whites. These examples represent areas of Asian health that need attention and intervention.

On a national level, many Asians suffer from hepatitis B, tuberculosis, chronic obstructive pulmonary disease, and a number of other ailments.⁵ While it is possible that Asians in Nebraska experience the same illnesses, the Office of Health Disparities and Health Equity in the Nebraska Department of Health and Human Services lack sufficient data and cannot report on these indicators. The national statistics mentioned above support the notion that, despite their good current health status, disparities faced by Asians are not to be ignored. It is important to include them in health programs focused on education and prevention, especially since they were the fastest growing minority group in Nebraska in recent years. Resources such as education or prevention programs should include Asian Nebraskans to help reduce disparities that exist and could increase the body of knowledge available about the health status of Asians as time progresses.

⁵ Office of Minority Health. Retrieved from <http://minorityhealth.hhs.gov/omh/browse.aspx?vl=3&vlid=63>

Glossary of Terms

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.

Death Rate: A death rate is a ratio between mortality and population; 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.

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 greater than 30 is considered to be indicative of obesity. BMI is calculated by dividing an individual's weight in kilograms by the individual's height in meters squared.

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 Control and Prevention (CDC), "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."

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.

Kotelchuck Index: It is a prenatal care index. "Special natality data summaries are 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. 'The Adequacy of Prenatal Care Utilization Index (APNCU), also known as the Kotelchuck Index, is one of the methods used to assess adequacy of prenatal care. Data for assessing prenatal care is taken from information collected on birth certificates. This index combines the month of pregnancy when prenatal care began with the number of prenatal visits to their health care provider during pregnancy. It also takes into account the length of gestation. Using these criteria, prenatal care is rated inadequate, intermediate, adequate, or intensive use.'

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."

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%.

Labor Force: All people classified in the civilian labor force plus members of the U.S. Armed Forces (people on active duty with the United States Army, Air Force, Navy, Marine Corps, or Coast Guard).

Not in Labor Force: All people 16 years old and older who are not classified as members of the labor force. This category consists mainly of students, housewives, 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).

Household: A household includes all the people who occupy a housing unit. (People not living in households are 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 are 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.

Poverty: Following the Office of Management and Budgets (OMBs) 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."

Department of Health & Human Services

DHHS



N E B R A S K A