Health Status of Hispanics in Nebraska

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Executive Summary

The Hispanic Health Status Report shows comprehensive Hispanic health disparity data. The data represents the ethnic minority health facts and socioeconomic status in Nebraska.

Highlights of the report include:

- Almost 26% of Hispanics are living in poverty, compared to 9.5% of non-Hispanic Whites. Forty-four percent of Hispanic female householders with no husband present are living in poverty, compared to 24% of non-Hispanic Whites.
- Approximately 50% of Hispanics ages 25 and older were less than high school graduates, and about 9% had a bachelor's degree or higher education.
- The median annual income of Hispanic households was about $37,952. This is over $14,000 less than the median income of Non-Hispanic White households, which was roughly $52,683.
- Almost 34% of Hispanics work in production, transportation, and material moving occupations; 21% work in service occupations.
- During 2006-2010, Hispanic men were 1.8 times less likely to die from all death causes as Non-Hispanic/Latino White men. Hispanic women were over 1.6 times less likely to die from all death causes as Non-Hispanic White women.
- In 2006-2010, Hispanic males were less likely to die from heart disease, as compared to White males. Hispanic females were also less likely as White females to die from heart disease.
- Hispanic males were less likely to die from all cancer cases (109.2 per 100,000) than Non-Hispanic/Latino White males (211.9 per 100,000). Hispanic females were less likely to die from cancer (91 per 100,000) in contrast to Non-Hispanic/Latino White females (144 per 100,000).
- The infant mortality rate was the same for Hispanics as Non-Hispanic Whites.
- The incidence rate of sexually transmitted diseases was more than double among Hispanics than Whites.
- In Nebraska, during 2006-2010, Hispanics had an incident rate for Chlamydia of 433.3 per 100,000 population, which was about 2.3 times higher than that for Non-Hispanic Whites.
- For 2006-2010, the Hispanic population had a total death rate of 8.7 per 100,000 population due to chronic lung disease.

It is our hope this report will serve as a data resource for the Hispanic communities in Nebraska and for those who work for and with Hispanics in Nebraska. The purpose of writing this report was to provide a resource to individuals interested in this type of Hispanic data. The data in this report represents health facts and socioeconomic status of Nebraska's Hispanic population.

Overall, the death data represents the major causes of death for

Hispanics in Nebraska. Maternal and child health data shows the Nebraska's Hispanic infant health status and the well-being of young Hispanic mothers. PRAMS data presents Hispanic mothers' breastfeeding situation and the support they are provided. BRFSS data comes from the database of the behavioral risk factor surveillance system which collects data by conducting surveys on the prevalence of major health risk factors among adults.

The data presented in this report can be used to target Hispanic health education and risk reduction activities throughout Nebraska to lower rates of premature death and disability. In this report, the Hispanic data is summarized and compared to total state of Nebraska data and Non-Hispanic White data to reveal the disparity status for various health issues.

Introduction

The Office of Health Disparities and Health Equity (OHDHE) strives to provide a more comprehensive look at health disparities among racial/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 Hispanic population in Nebraska, and will illustrate the contrast between this minority population and that of Non-Hispanic/Latino White (White) majority population. The statistical information contained here spans several different health issues including: mortality, chronic diseases, cancer, HIV and sexually transmitted diseases, heart disease, stroke, diabetes, and infectious diseases.

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 OMB.[1] The OMB defines a minimum of five race categories: White, African American, Hispanic, Asian, and Native Hawaiian or Other Pacific Islander. For the purpose of this report, an additional category, *some other race*, was added with OMB approval. In addition to the five race groups, the OMB also states that respondents should be offered the option of selecting one or more races.

The following definition is provided by OMB and the U.S. Census Bureau to identify ethnicity: [2]

Hispanic: A person having origins in any of the original peoples of Cuba, Mexico, Puerto Rico, South or Central American or other Spanish culture or origin regardless of race. People who identify their origin as "Spanish," "Hispanic" or "Latino" may be of any race

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.

Non-Hispanic White: A White person who does not consider themselves to be of Spanish, Hispanic, or Latino origin.

This report is one of a four-part series. The Nebraska minority health disparities facts reports focus on one racial/ethnic group per report. The information, and analysis methodology presented here are consistent in producing the report series which provides a multi-dimensional view and captures/tracks trends in disparities, while quantifying the potential for future progress in meeting quality goals.

[1] http://www.whitehouse.gov/omb/fedreg/ombdir15.html
[2] http://www.whitehouse.gov/omb/fedreg/ombdir15.html
2000 Census of Population, Public Law 94-171 Redistricting Data File: Race. *U.S. Census Bureau.*

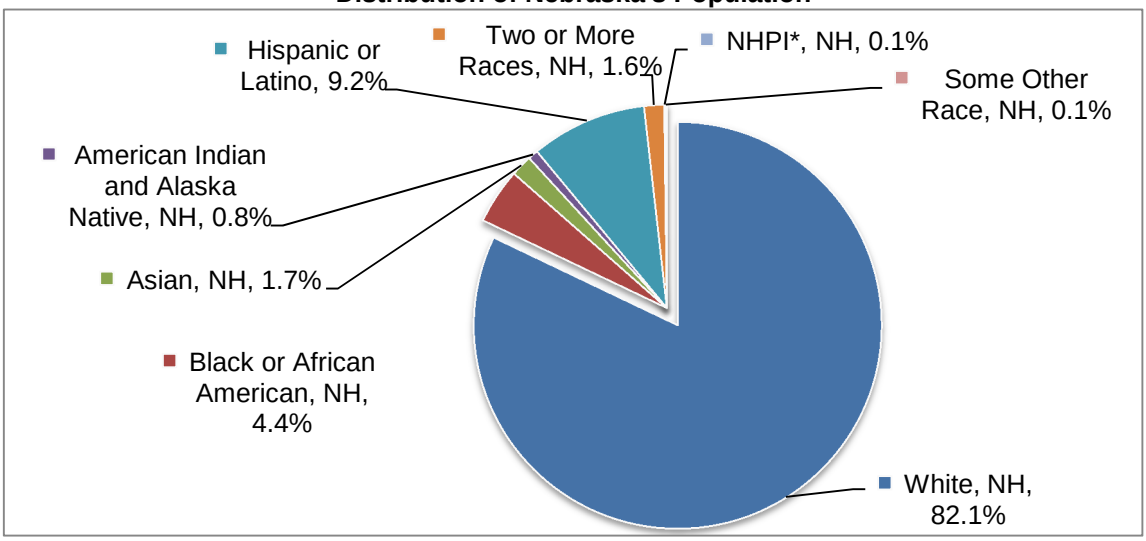
Data Sources

The data sources for this report come from the U.S. Census Bureau, the Nebraska Department of Health and Human Services Vital Statistics, Nebraska Behavioral Risk Factor Surveillance System (BRFSS), Cancer Registry, HIV Prevention Program, the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), and other programs. Population counts data come from the 2010 census. The socioeconomic data is from U.S. Census Bureau, 2009-2011 American Community Service three-year estimates. This report only presents part of the socioeconomic picture for Hispanics in Nebraska, for a more in depth look please look for the Nebraska Hispanic Socioeconomic Profile. 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 are more readily seen. The BRFSS rates presented in this fact sheet are age-adjusted as well, and surveys have been conducted annually since 1986 for the purpose of data collection on the prevalence of major health risk factors among adults residing in the state. Information gathered in these studies can be used to target health education and risk reduction activities throughout Nebraska in order to lower rates of premature death and disability. In this report, minority data will be summarized and compared to, when possible, total State of Nebraska data and Non-Hispanic/Latino White data, to reveal the disparity status for various health issues.

Demographics and Socioeconomics

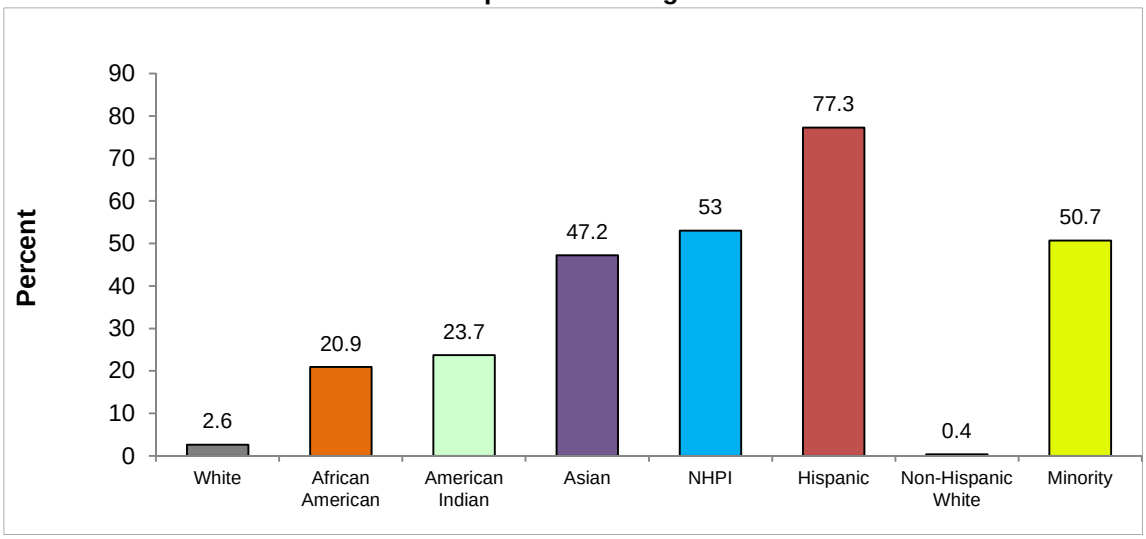
Nebraska has a rapidly growing minority population comprised increasingly by persons of Hispanic/Latino origin. Hispanics are the fastest-growing minority group in Nebraska. The Hispanic/Latino population increased from 36,969 in 1990 to 94,425 in 2000, to 167,405 in the year 2010. These numbers represent a 352.8% increase of the Hispanic population in the state between 1990 and 2010, a 155.4% increase between 1990 and 2000, and a 77.3% increase between 2000 and 2010. In 1990, the population of Nebraska was 1,578,385, of that number the Hispanic population accounted for 2.3%. In 2000, the population of Nebraska was 1,711,263 and the Hispanic population accounted for 5.5%. In 2010, the population of Nebraska had risen to 1,826,341 and the Hispanic population accounted for 9.2% of Nebraska's total population.

Distribution of Nebraska's Population



Total Population: 1,826,341
Note: *NHPI: Native Hawaiian or Other Pacific Islander; NH: non-Hispanic
U.S. Census Bureau, 2010 Census

Nebraska Population Change 2000-2010



Note: *Native Hawaiian or Other Pacific Islander; NH: non-Hispanic
U.S. Census Bureau, 2010 Census

Hispanic Population Distribution

According to the 2010 US Census[3], there were 167,405 Hispanics in Nebraska. This number represented approximately 9.2% of the total Nebraska population.

Table 1: Distribution of Hispanic Population 2010

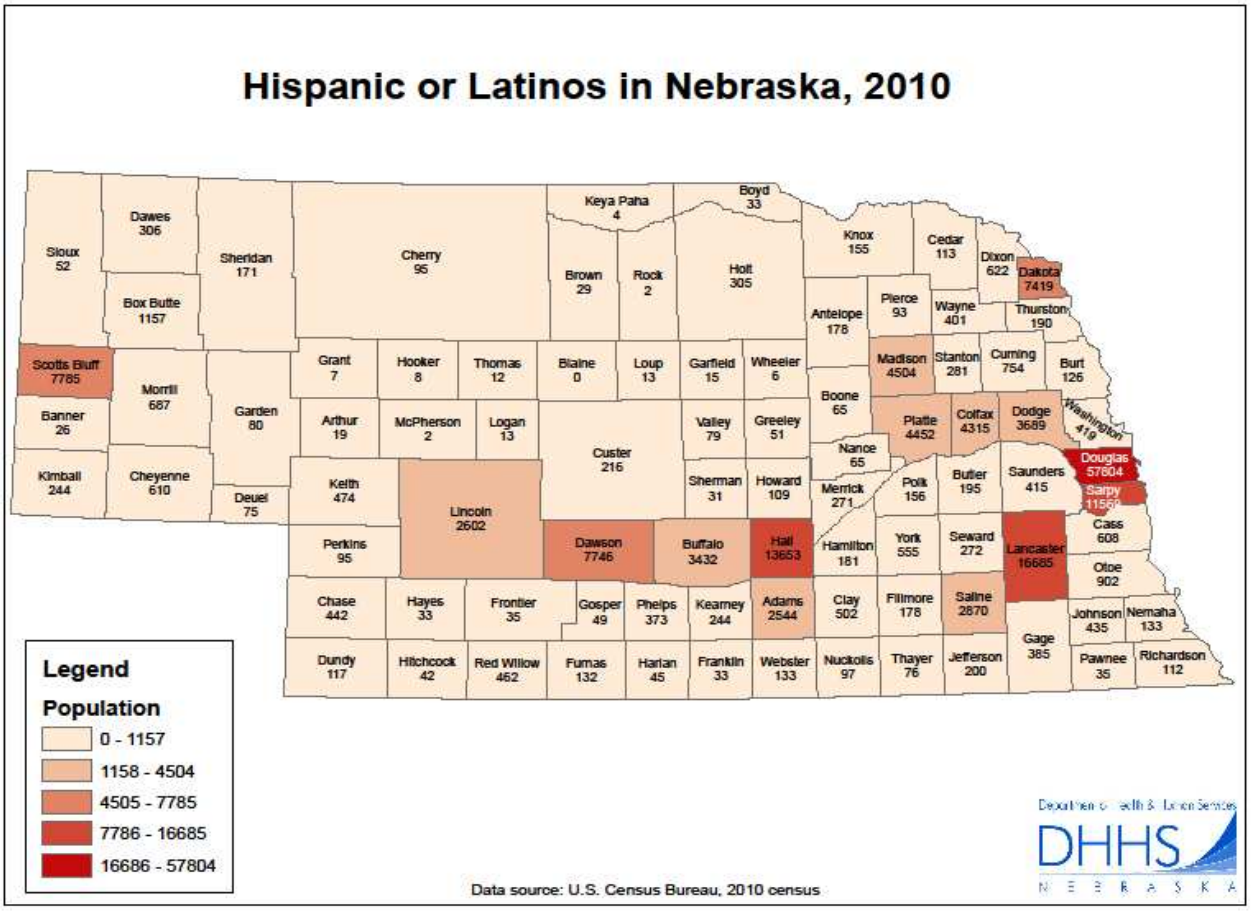
Subject	Number	Percent
RACE		
Total Nebraska population	1,826,341	
Hispanic or Latino (of any race)	167,405	9.2
Not Hispanic or Latino	1,658,936	90.8
Hispanic or Latino by Type		
Hispanic or Latino (of any race)	167,405	9.2
Mexican	128,060	7.0
Puerto Rican	3,242	0.2
Cuban	2,152	0.1
Dominican (Dominican 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

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] Population Division, U.S. Census Bureau, Estimates of the Population by Race and Hispanic Origin for the United States and States

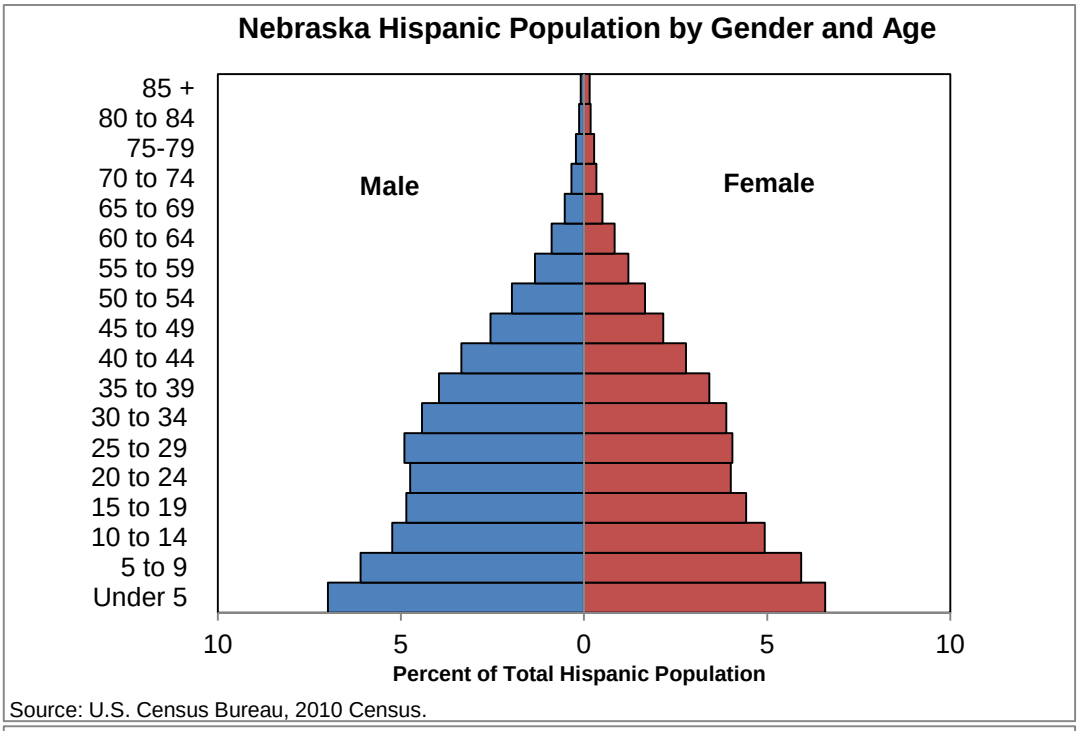
Hispanic Population by County

According to the U.S. Census Bureau, the total Hispanic population in the State of Nebraska was 167,405 in 2010. The map below illustrates the spread of this population over the different counties in Nebraska. The majority of the state's Hispanic population lived in the counties of: Douglas (57,804), Lancaster (16,685), Hall (13,653) and Sarpy (11,569). Other counties with a Hispanic population greater than 7,000 individuals are Scotts Bluff (7,785), Dawson (7,746), and Dakota (7,419).

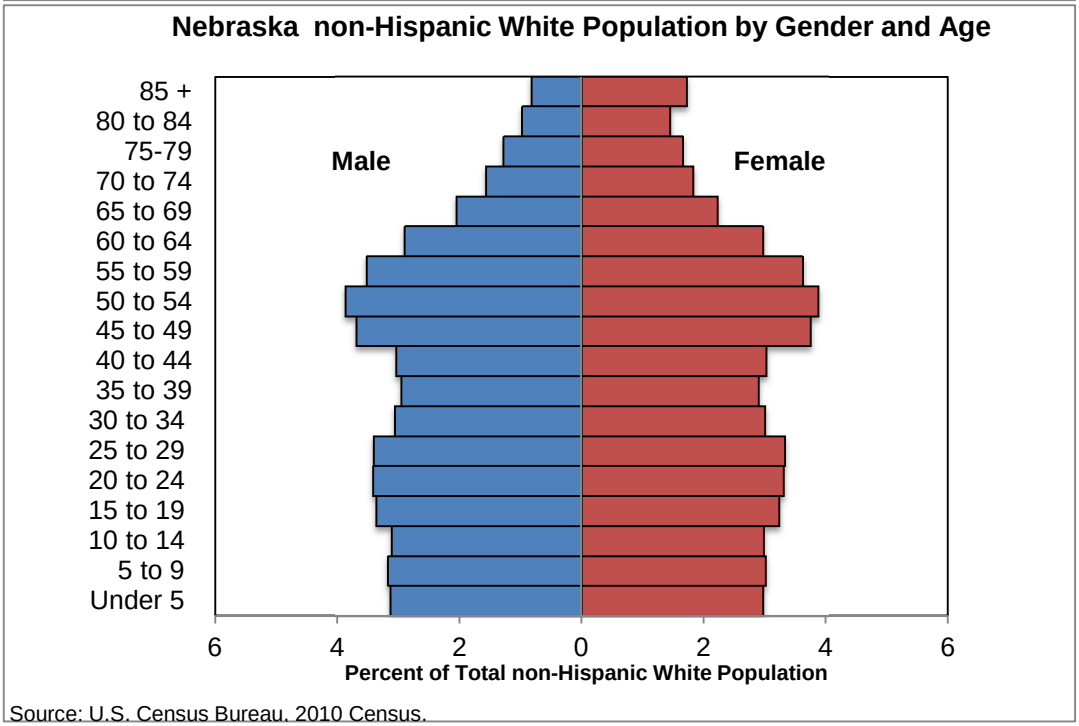


Hispanic Population by Age and Gender

Compared with the non-Hispanic White population, Hispanics had a larger proportion of young people and a smaller proportion of older people. In 2010, about one-third (36%) of Hispanics were under 15 years old, about 89% of Hispanics were younger than 45, while only 3% of Hispanics were 65 and older, compared to 18% of non-Hispanic Whites 15 and older, 56% younger than 45, and 16% 65 and older.



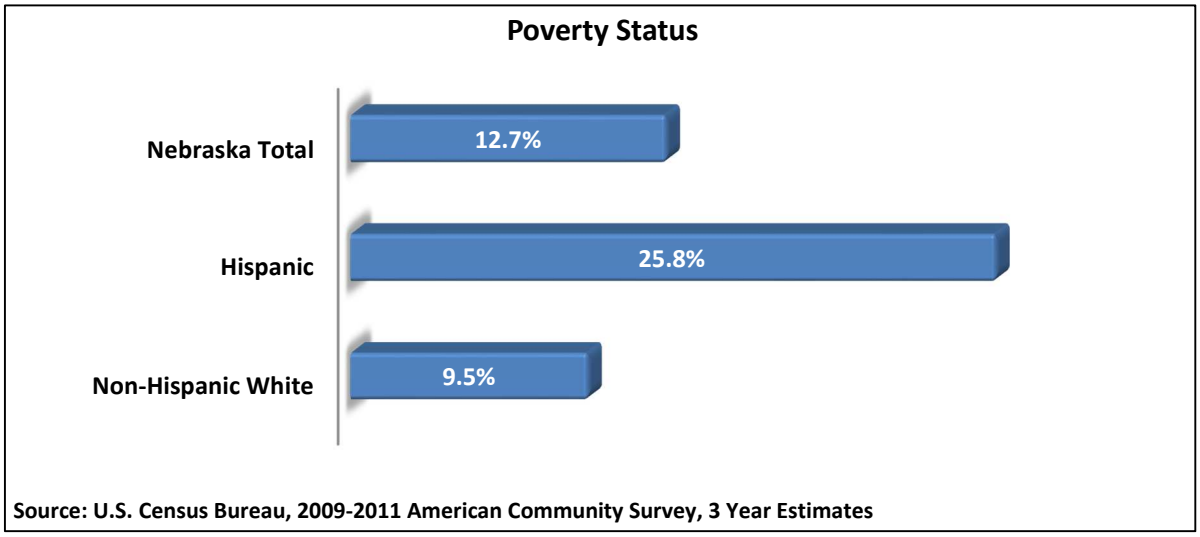
Source: U.S. Census Bureau, 2010 Census.



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

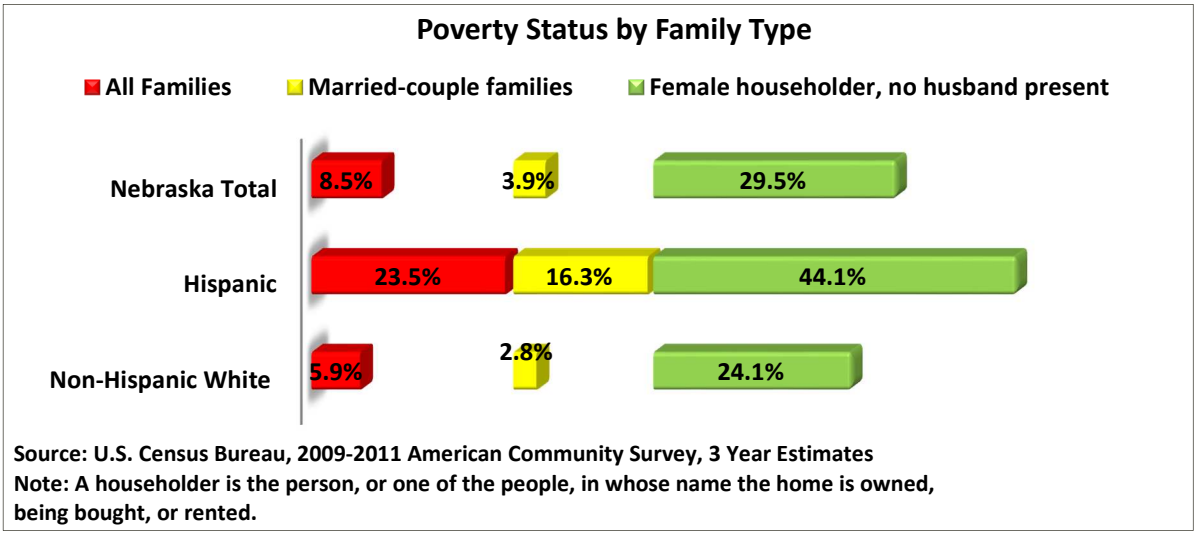
Poverty Status

Over 2.5 times as many Hispanics (of all ages) as non-Hispanic Whites reported living below the federal poverty level in the past 12 months (25.8% and 9.5%, respectively).



Poverty Status by Family Type

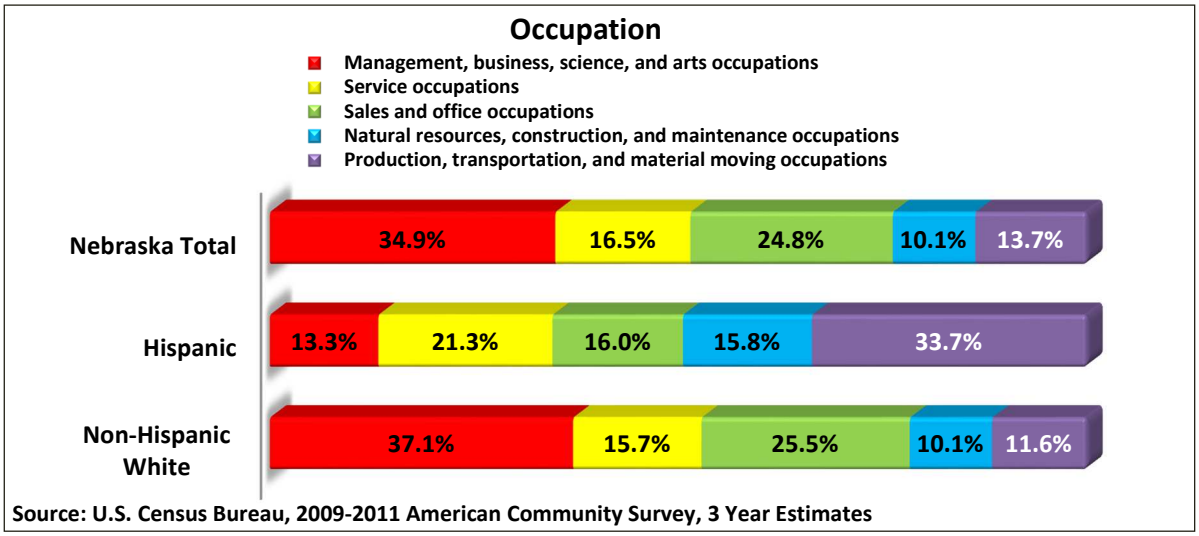
Hispanic families were almost 4 times as likely as non-Hispanic White families to be below the poverty level in the past 12 months. Twice as many Hispanic female householder, no husband present families (44.1%) as non-Hispanic White families of the same type (24.1%) were reported to be below the federal poverty level in the past 12 months. Hispanics (16.3%) were almost 6 times more likely than non-Hispanic Whites (2.8%) from married-couple families to be below the poverty level in the past 12 months.



Source: U.S. Census Bureau, 2009-2011 American Community Survey, 3 Year Estimates
Note: A householder is the person, or one of the people, in whose name the home is owned, being bought, or rented.

Occupation

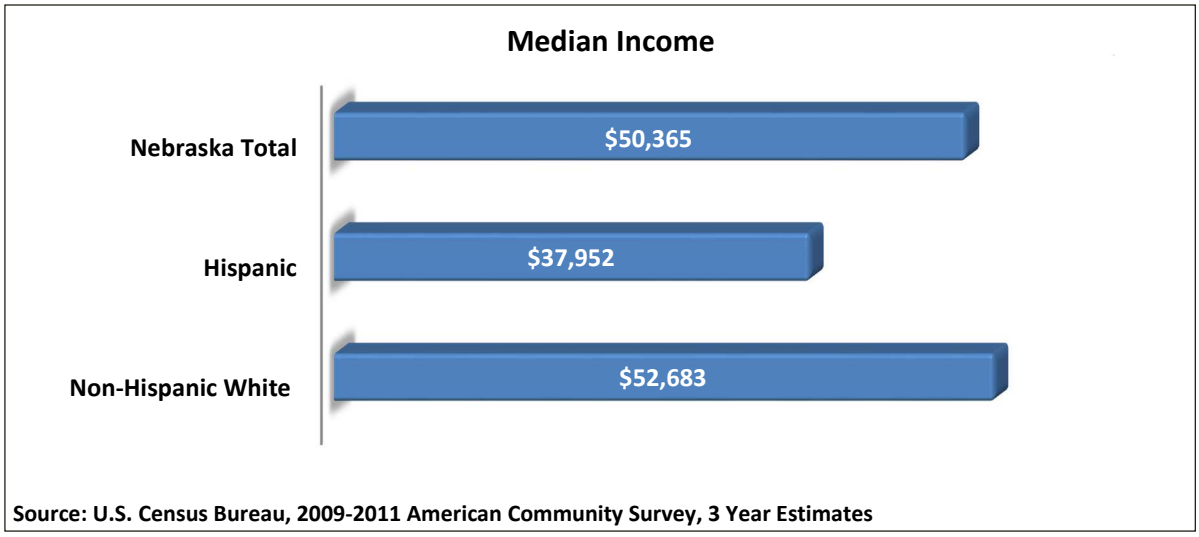
Hispanics (33.7%) were more likely than non-Hispanic Whites (11.6%) to work in a service, production, transportation, and material moving occupations. Non-Hispanic Whites (37.1%) were over 2.5 times more likely than Hispanics (13.3%) to work in management, business, science, and art occupations.



Source: U.S. Census Bureau, 2009-2011 American Community Survey, 3 Year Estimates

Median Income

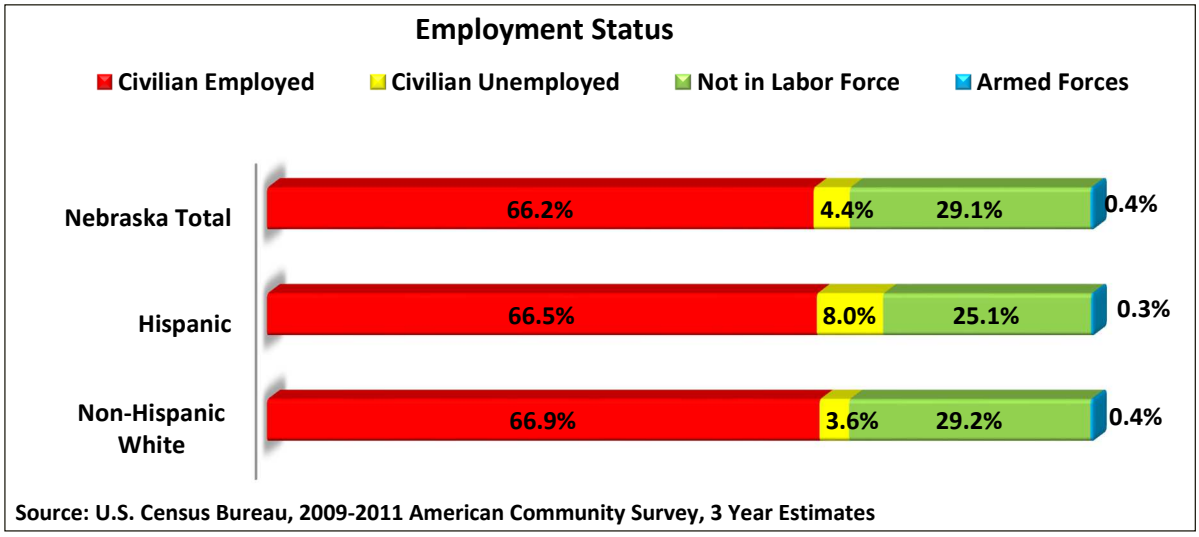
For non-Hispanic White households in Nebraska, the median income is almost 1.5 times that of Hispanics ($52,683 and $37,952, respectively).



Source: U.S. Census Bureau, 2009-2011 American Community Survey, 3 Year Estimates

Employment Status

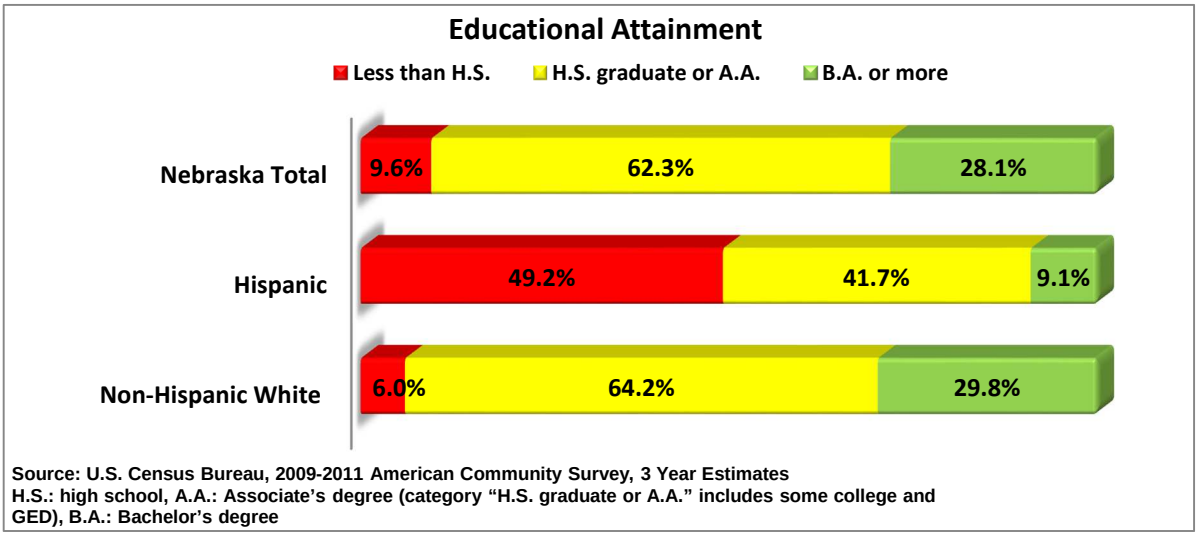
Hispanics (8%) were over two times more likely than non-Hispanic Whites (3.6%) to be civilian unemployed. While slightly less Hispanics (25.1%) 16 and over were not in the labor force at all, compared to non-Hispanic Whites (29.2%).



Source: U.S. Census Bureau, 2009-2011 American Community Survey, 3 Year Estimates

Educational Attainment

Hispanics were almost 8 times more likely (49.2%) than non-Hispanic Whites (6.0%) to achieve less than a high school education. Overall, almost three times as many non-Hispanic Whites completed a bachelor's degree or higher compared to Hispanics (9.1% and 29.8%, respectively.



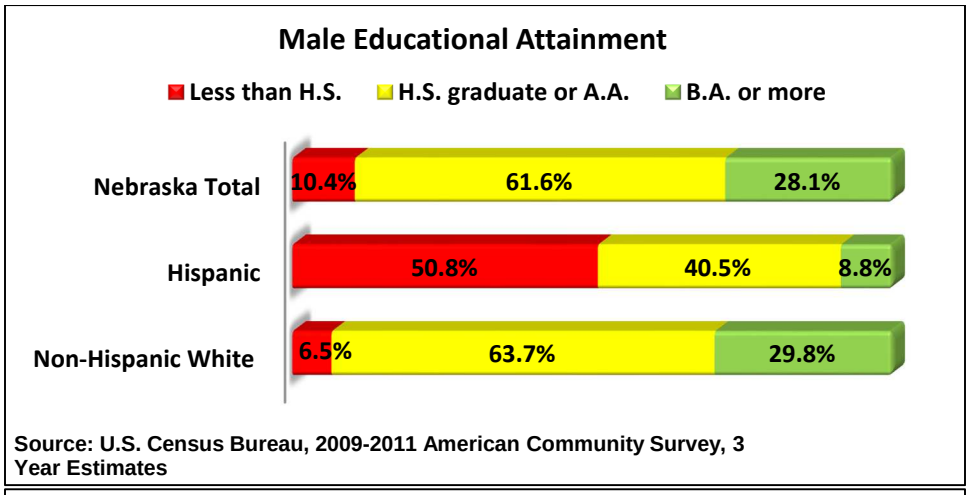
Source: U.S. Census Bureau, 2009-2011 American Community Survey, 3 Year Estimates
H.S.: high school, A.A.: Associate's degree (category "H.S. graduate or A.A." includes some college and GED), B.A.: Bachelor's degree

Educational Attainment by Gender

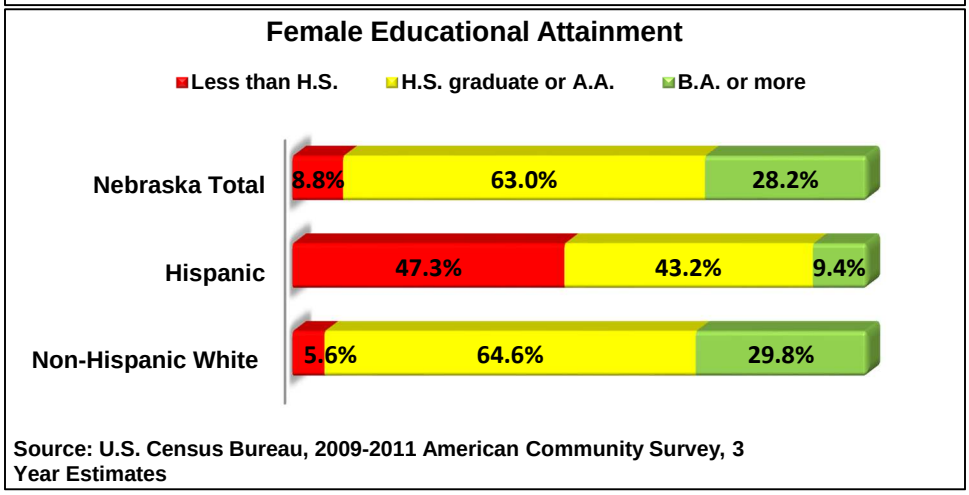
Fifty percent of Hispanic males and 47.3% of Hispanic females in Nebraska have less than a high school diploma, compared to approximately 6% (for either sex) of non-Hispanic Whites.

Approximately 40% of both Hispanic males and females have a high school diploma or associate's degree, compared to around 64% of non-Hispanic Whites.

The disparity grows again when looking at bachelor's degree attainment or higher; only 8.8% of Hispanic males and 9.4% of Hispanic females have a bachelor's degree or higher, compared to 29.8% of non-Hispanic Whites, both male and female.



Source: U.S. Census Bureau, 2009-2011 American Community Survey, 3 Year Estimates

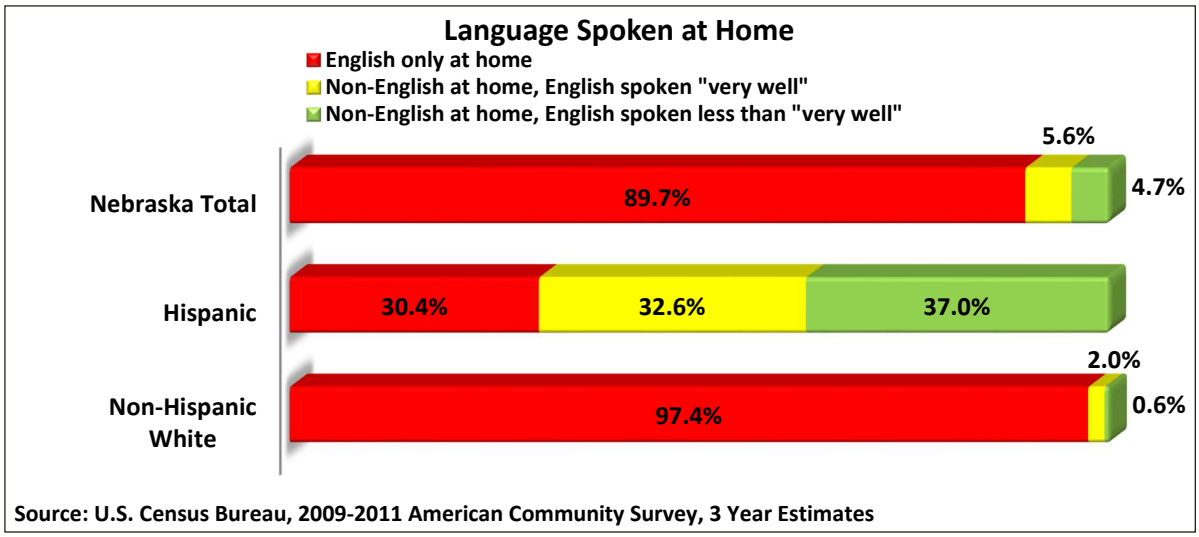


Source: U.S. Census Bureau, 2009-2011 American Community Survey, 3 Year Estimates

*H.S.: high school, A.A.: Associate's degree, B.A.: Bachelor's degree

Language Spoken at Home

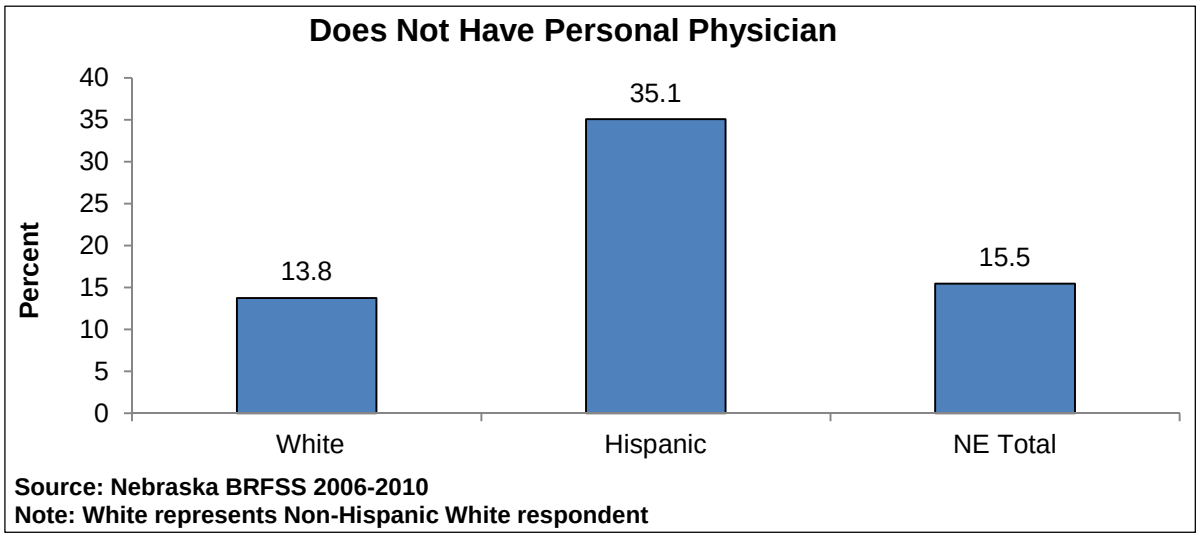
Throughout Nebraska, it is uncommon for non-Hispanic Whites to speak any other language besides English at home; this is not necessarily the case for minority groups in Nebraska. Only 30.4% of Hispanics speak English-only at home, compared to over 97% of non-Hispanic Whites. Almost 33% of Hispanics do not speak English at home, but otherwise speak English "very well". Thirty-seven percent of Hispanics do not speak English at home and English is *not* spoken "very well".



Access to Healthcare

Does Not Have a Personal Physician

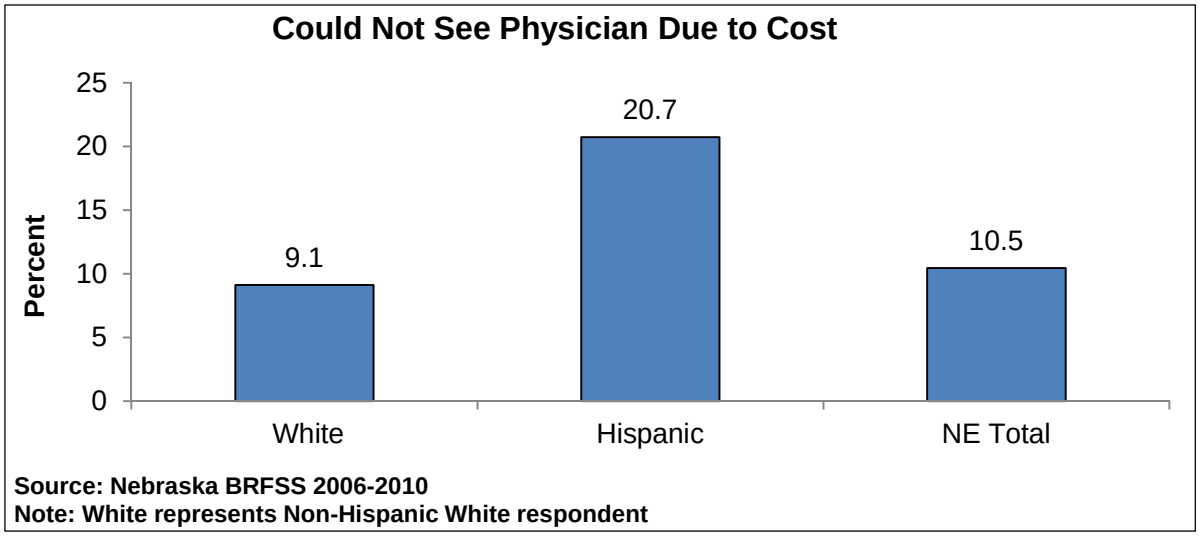
Altogether, 15.5% of adults in the 2006-2010 Nebraska BRFSS said they did not have a personal physician. Thirty-five percent of Hispanics experienced much higher rates of not having a personal physician than Whites at 13.8%.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

Could Not See Physician Due to Cost

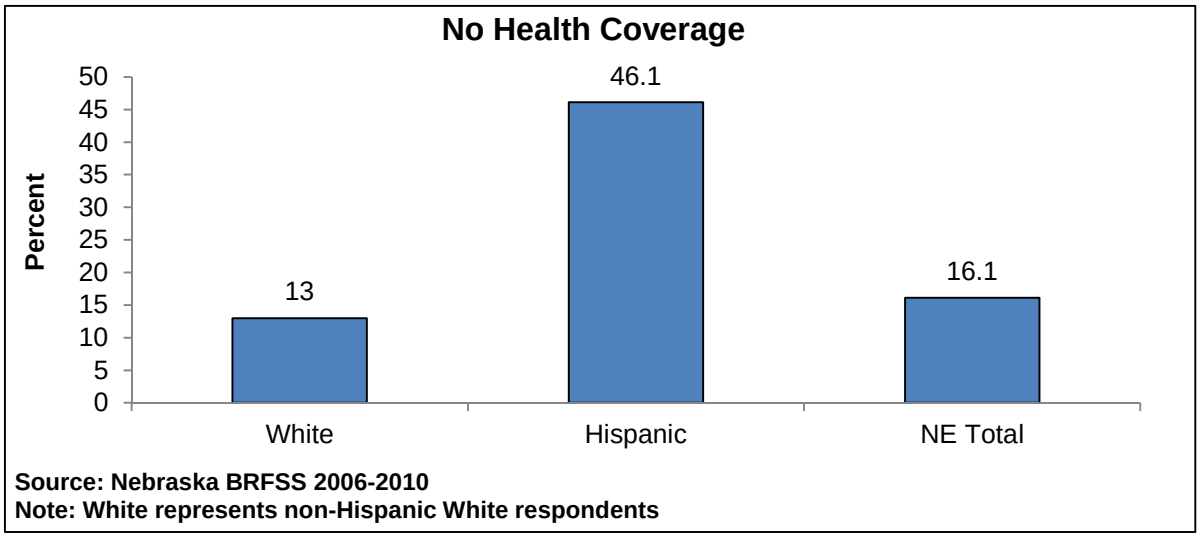
Altogether, 10.5% of adults in the 2006-2010 Nebraska BRFSS said they could not see a physician due to cost. Hispanics (20.7%) experienced significantly higher rates of inability to see a physician due to cost than Whites (9.1%).



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

No Health Coverage

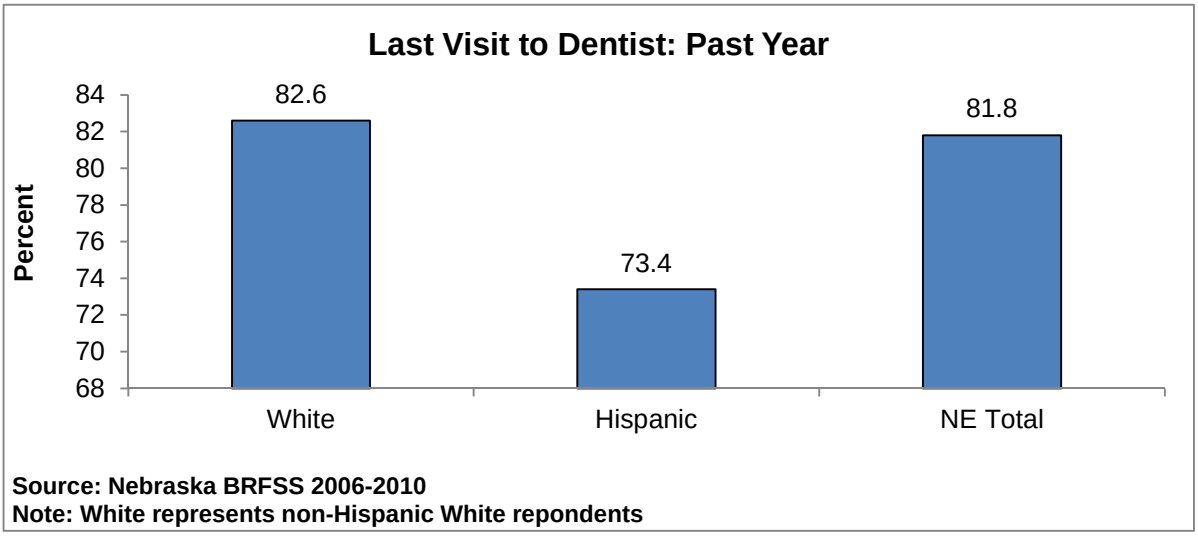
Overall 16% of adults in Nebraska in 2006-2010 reported they have no health insurance. Approximately 46% of Hispanics in Nebraska are not covered by health insurance, compared to only 13% of Whites.



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Dentist Visit

Approximately 82% of Nebraska adults reported visiting the dentist in the previous year. About 73% of Hispanics last visited the dentist within the previous year, compared to 82.6% of Whites.



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White repondents

Life Expectancy at Birth

The results show that the Hispanic population has higher life expectancy at birth than Whites. The life expectancy at birth in 2008-2010 for Hispanics was 87.3 years compared to 79.8 years for Whites. In 2008-2010, the life expectancy gap between Hispanics and Whites was 7.5 years. The life expectancy for non-Hispanic Whites has not changed much since 2002-2004, increasing from 78.9 to 79.8. Whereas, there has been a steady increase in life expectancy at birth for Hispanics during the same timeframe, increasing from 83.7 to 87.3.

Life Expectancy at Birth: Whites

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
Source: Nebraska DHHS Vital Statistics			

Life Expectancy at Birth: Hispanics

YEARS	*TOTAL/YRS*	*MALES/YRS*	*FEMALES/YRS*
2008-2010	87.3	84.3	90.4
2007-2009	86.0	84.9	87.7
2006-2008	85.2	83.8	87.2
2005-2007	85.1	84.3	86.6
2004-2006	75.9	73.7	78.4
2003-2005	71.3	69.3	73.9
2002-2004	83.7	81.1	86.7
Source: Nebraska DHHS Vital Statistics			

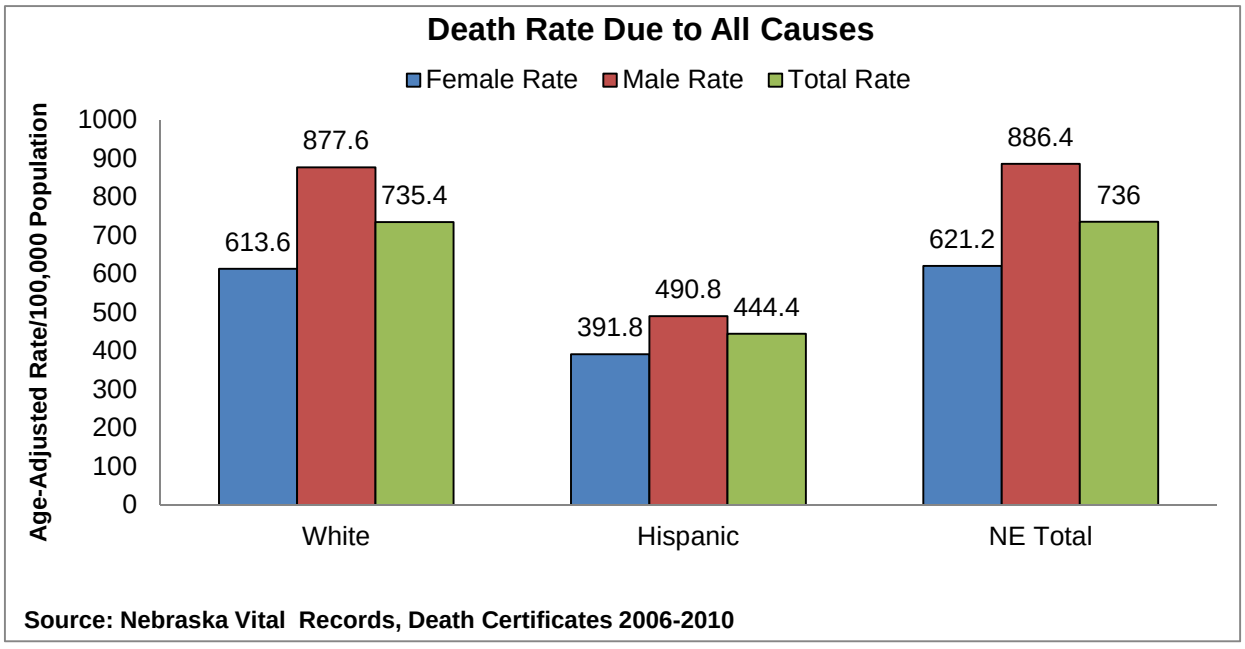
Life Expectancy at Birth: Nebraska Total

YEARS	*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
Source: Nebraska DHHS Vital Statistics			

Mortality

Mortality data acts as a mirror for current health problems and suggests patterns of risk across population subgroups. 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. Mortality data is one of the best sources of information in relation to the health of communities.

An overview chart of the death rates from all causes is shown below. During the years 2006-2010, Hispanic men and women were less likely to die of all diseases as compared to whites.



Source: Nebraska Vital Records, Death Certificates 2006-2010

Leading Causes of Death for Hispanics

Age distribution of a population influences the death rate, as such, these rates are usually age-adjusted to account for differences in racial and ethnic subgroups. The table below shows the 10 leading causes of death by race and gender for both Hispanic and Whites for the years 2006-2010. When looking at total death number, the Top 5 leading causes of death breakdown as follows:

Hispanics – cancer, heart disease, unintentional injury, diabetes related, and stroke are the top five.

Whites – heart disease, cancer, stroke, chronic lung disease, and unintentional injury account for the top five.

Leading Causes of Death Total – Both Genders (2006-2010)

Frequency	Number (Hispanics)	Percentage	Frequency	Number (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%
Cirrhosis	31	2.4%	Pneumonia	1,452	2.0%
Suicide	26	2.0%	Nephritis/Nephrosis	1,235	1.7%
Other	411	31.5%	Other	20,168	28%
Total	1291	100.0%	Total	71,940	100%

Source: National Center for Health Statistics, National Vital Statistics System, 2001-2010

Leading Causes of Death for Males

Hispanic males – The top five causes of death were cancer, unintentional injury, heart disease, stroke, and homicide.

White males – The top five causes of death were cancer, heart disease, chronic lung disease, stroke, and unintentional injury.

Leading Causes of Death: Males (2006-2010)					
Frequency	**Number (Hispanics)**	**Percentage**	**Frequency**	**Number (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: National Center for Health Statistics, National Vital Statistics System, 2001-2010					

Leading Causes of Death for Females

Hispanic females – The top five causes of death for Hispanic women were cancer, heart disease, unintentional injury, diabetes, and stroke.

White females – The top five causes of death for White women were heart disease, cancer, stroke, chronic lung disease, and Alzheimer's disease.

Leading Causes of Death: Females (2006-2010)

Frequency	Number (Hispanics)	Percentage	Frequency	Number (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%
Perinatal Condition	17	3.3%	Unintentional Injury	1,322	3.5%
Pneumonia	12	2.3%	Diabetes	1,065	2.9%
Homicide	12	2.3%	Pneumonia	819	2.2%
Nepthritis/Nephrosis	11	2.0%	Nephritis/Nephrosis	630	1.7%
Other	167	32%	Other	10,763	28.8%
Total	521	100%	Total	37,329	100.0%

Source: National Center for Health Statistics, National Vital Statistics System, 2001-2010

Mortality by Age

Unintentional injury is the leading cause of death between the ages of 1 and 44 years. However, cancer is the leading cause of death for all ages and accounts for 152 deaths between 45 and 64 years old. Heart disease accounts 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 & Pneumonia ---	Influenza & Pneumonia ---	Viral Hepatitis ---		Influenza & Pneumonia 20	Liver Disease 60
10	Influenza & 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

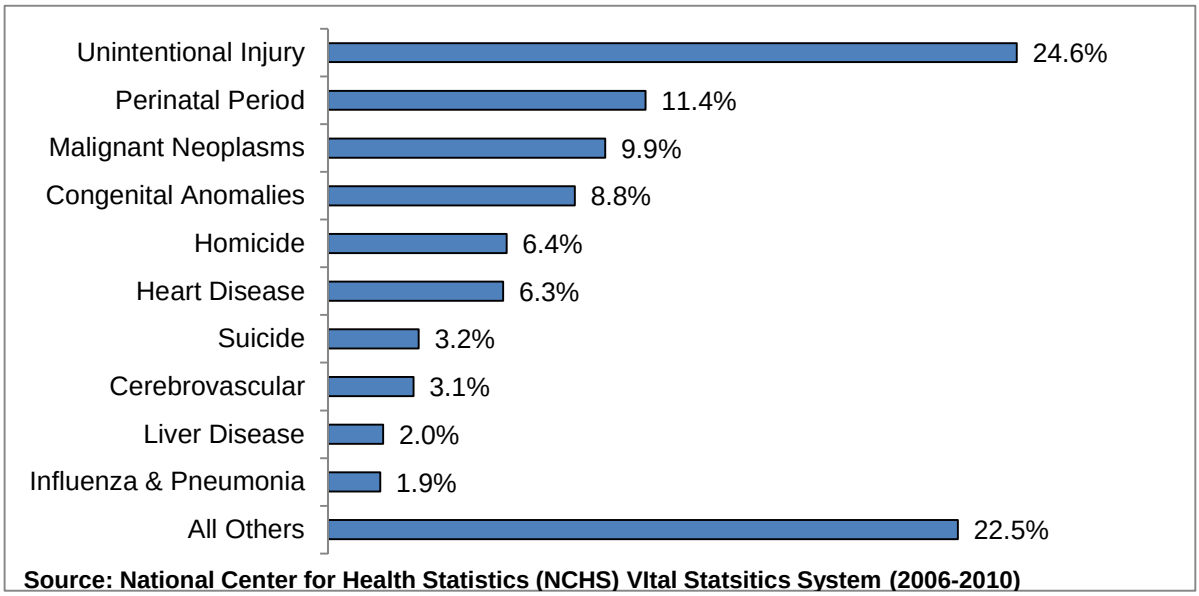
Years of Potential Life Lost

Years of potential life lost 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. Death before age 75 is considered premature mortality because the average life expectancy in the United States is now over 75 years. 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.

Years of Life Lost for Hispanics

Among the 33,029 total years, before age 75, of life lost among Hispanics between 2006 and 2010, 24.9% are attributed to unintentional injury. Approximately 11% of years of life lost are attributed to the perinatal period. Cancer is responsible for 10% of years of life lost.

Years of Potential Life Lost for Hispanics



Source: National Center for Health Statistics (NCHS) VItal Statsitics System (2006-2010)

Years of Potential Life Lost* by Cause of Death for Hispanics

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

*Years of Potential Life Lost between 2006-2010

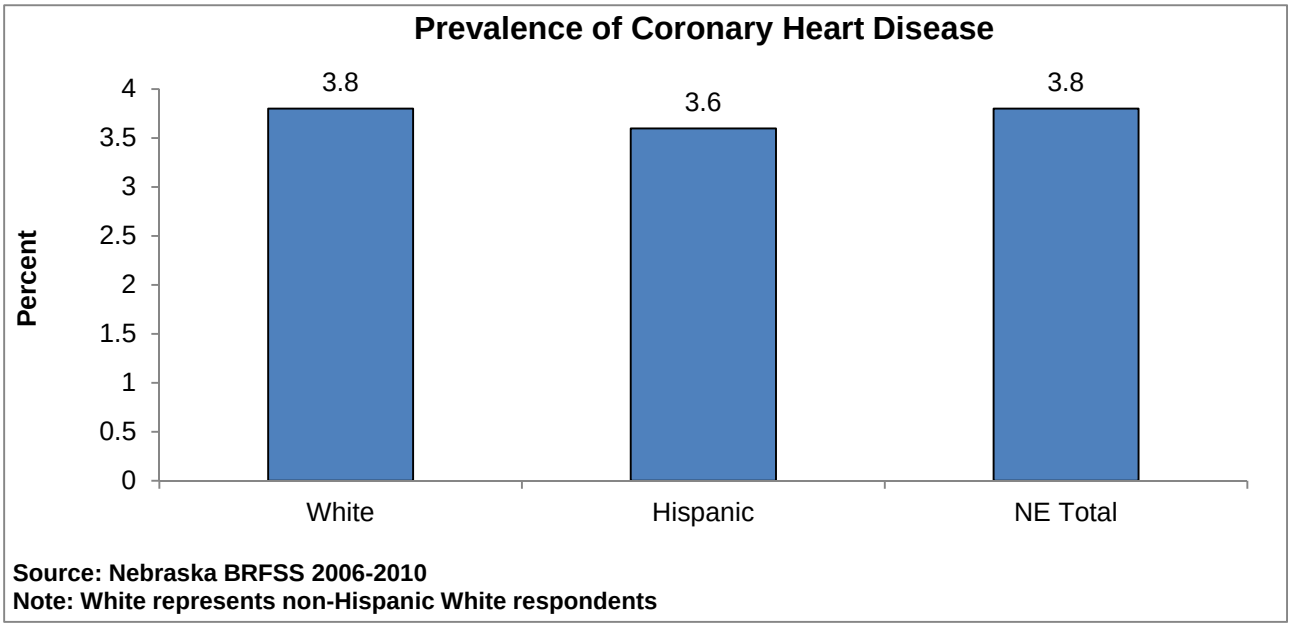
Chronic Diseases

During the 20th century, chronic diseases replaced infectious diseases (e.g., pneumonia, tuberculosis, and diarrhea) as leading causes of death in the United States. Chronic diseases – including all cardiovascular diseases, all cancers, diabetes mellitus, and chronic lower respiratory diseases – accounted for a large portion of all deaths among Nebraska residents during 2006-2010. Cancer, heart disease, diabetes, tobacco use, and motor vehicle accidents are discussed in the sections below.

Heart Disease

Prevalence of Coronary Heart Disease

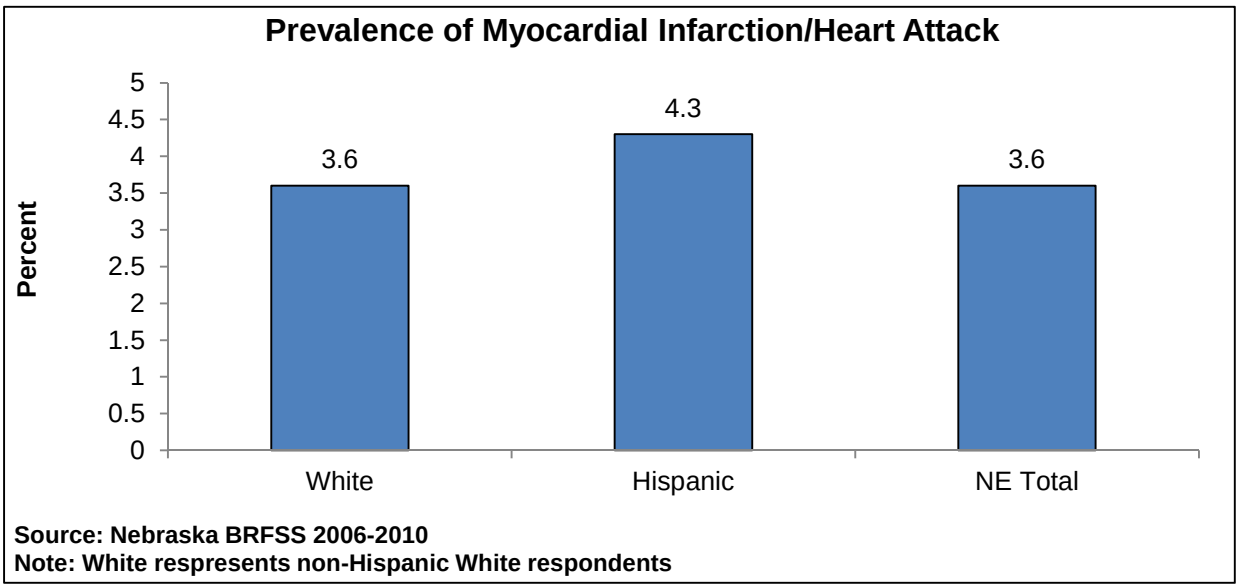
Cardiovascular disease involves the body's vascular or circulatory system, which is responsible for supplying oxygen and nutrients to the organs and cells. Heart disease and cerebrovascular disease (stroke) are major cardiovascular diseases and the leading causes of death in Nebraska. Hispanic Nebraskans (3.6%) and White Nebraskans (3.8%) see similar proportions of people with coronary heart disease.



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Prevalence of Heart Attack

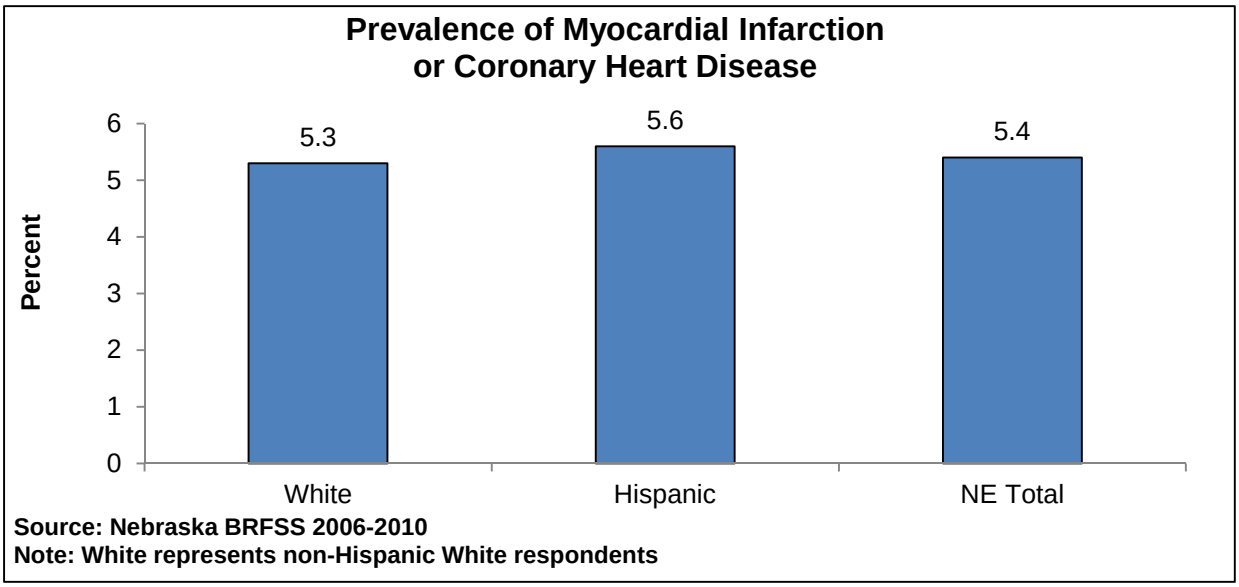
Approximately 4% of Hispanic Nebraskans have been told by a health professional that they have had a heart attack (myocardial infarction), compared to 3.6% of Whites.



Source: Nebraska BRFSS 2006-2010
Note: White respresents non-Hispanic White respondents

Prevalence of Heart Attack or Coronary Heart Disease

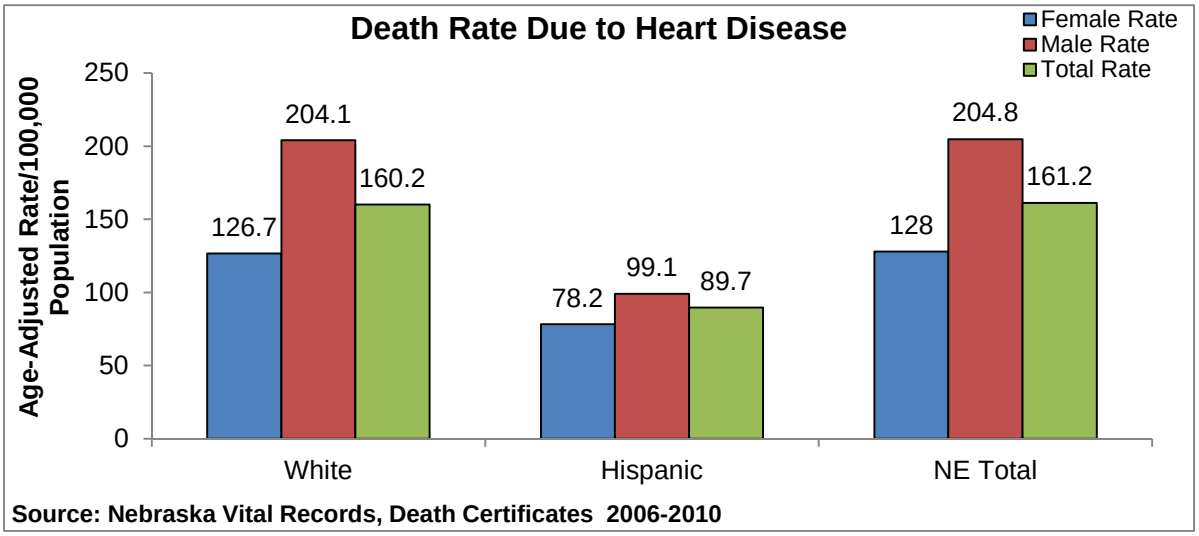
In 2006-2010, 5.6% of Hispanics had experienced a heart attack (myocardial infarction) or had coronary heart disease, compared to 5.3% of Whites.



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Heart Disease Mortality

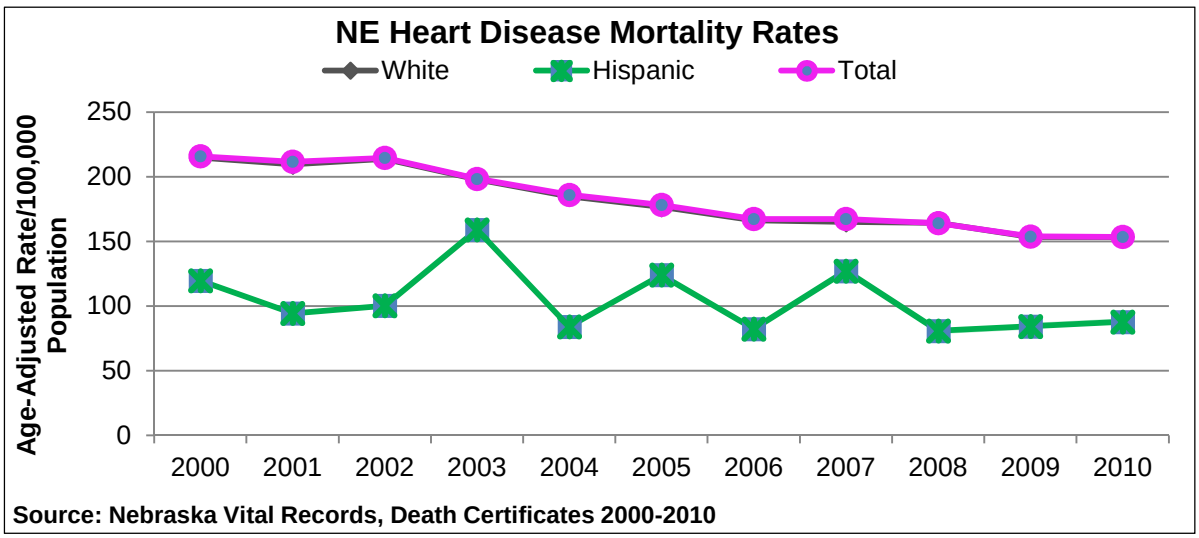
In 2006-2010, Hispanic males were less likely to die from heart disease, as compared to White males. Hispanic females were also less likely as White females to die from heart disease.



Source: Nebraska Vital Records, Death Certificates 2006-2010

Heart Disease Mortality: Trends

Looking at heart disease mortality data from the years 2000-2010, there was a downward trend in deaths for Hispanics. While both Hispanic and White trend lines show a downward trend, Hispanics experienced a lower death rate due to heart disease than Whites.

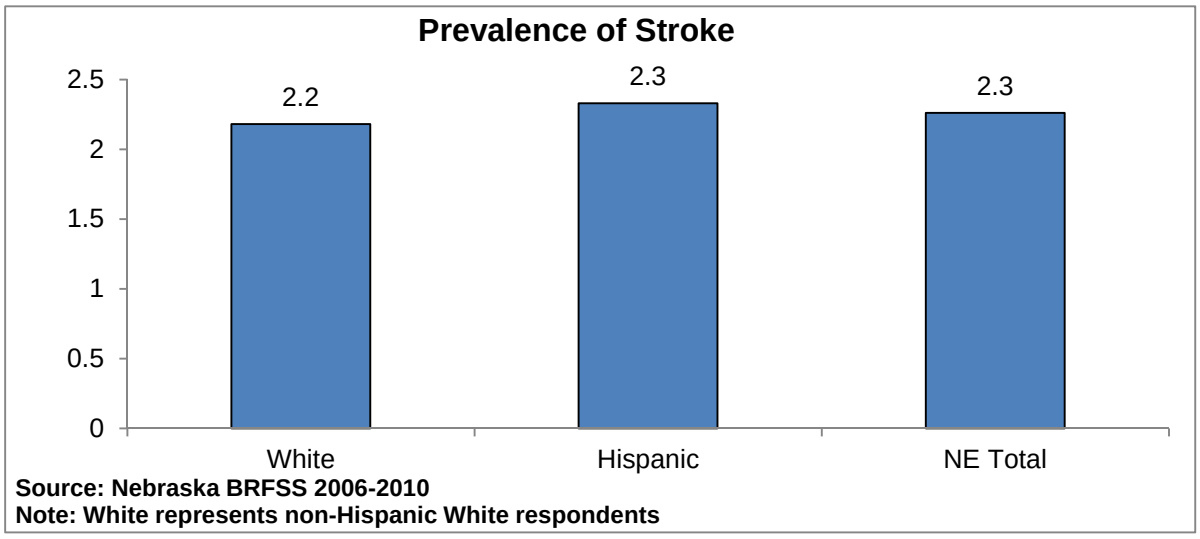


Source: Nebraska Vital Records, Death Certificates 2000-2010

Stroke

Prevalence of Stroke

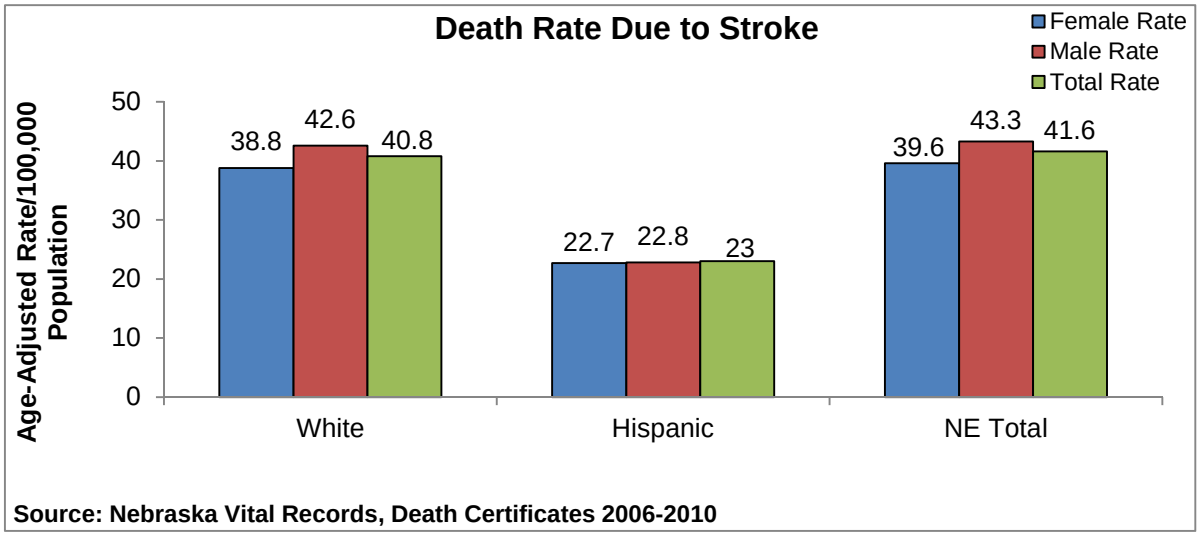
Approximately 2% of Hispanics in Nebraska experienced a stroke between 2006 and 2010.



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Stroke Mortality

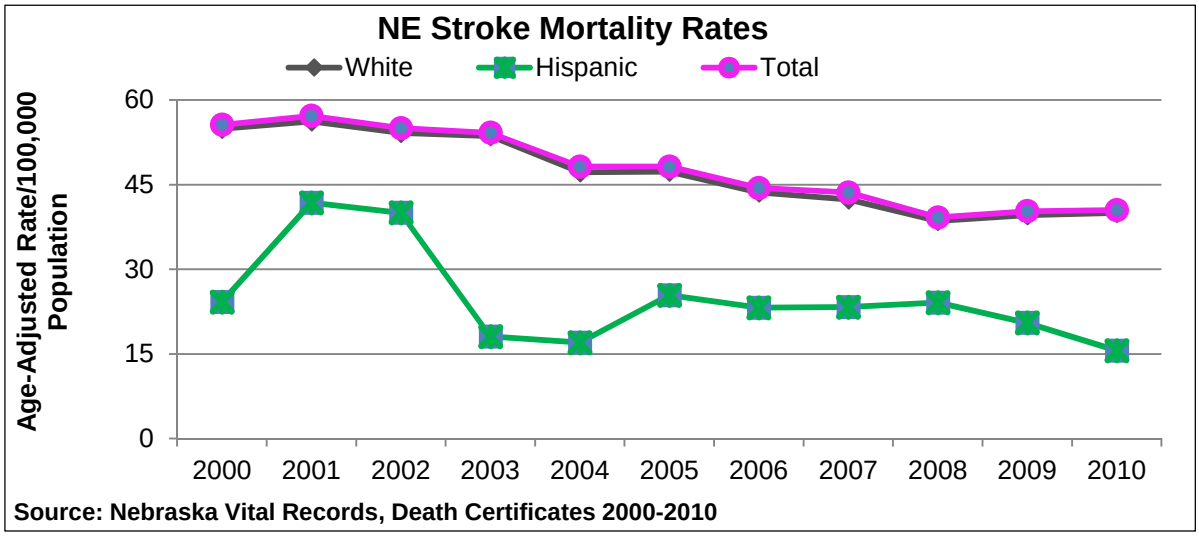
Stroke is the most severe clinical manifestation of cerebrovascular disease. From 2006-2010, Hispanic males were less likely than their Non-Hispanic/Latino White counterparts to have a stroke; the same is the case for females. As a group, Hispanics were less likely as Non-Hispanic/Latino Whites to die from stroke.



Source: Nebraska Vital Records, Death Certificates 2006-2010

Stroke Mortality: Trends

Stroke mortality data from year 2000-2010 shows that both Hispanics and Whites have a steady decline in death rates. However, stroke mortality rates remain lower among Hispanics as compared to Whites.

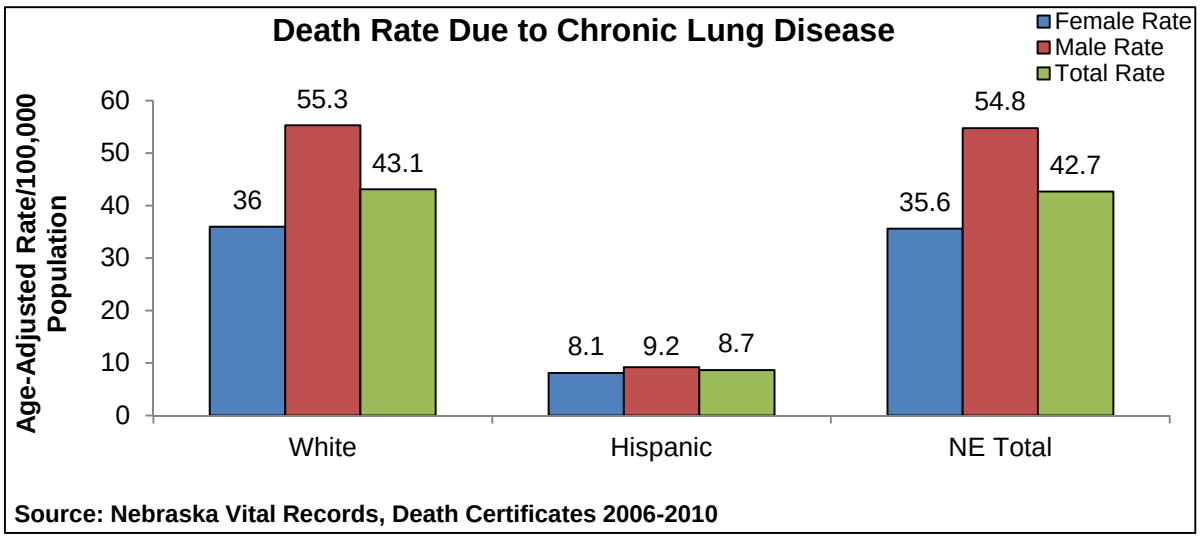


Source: Nebraska Vital Records, Death Certificates 2000-2010

Chronic Lung Disease

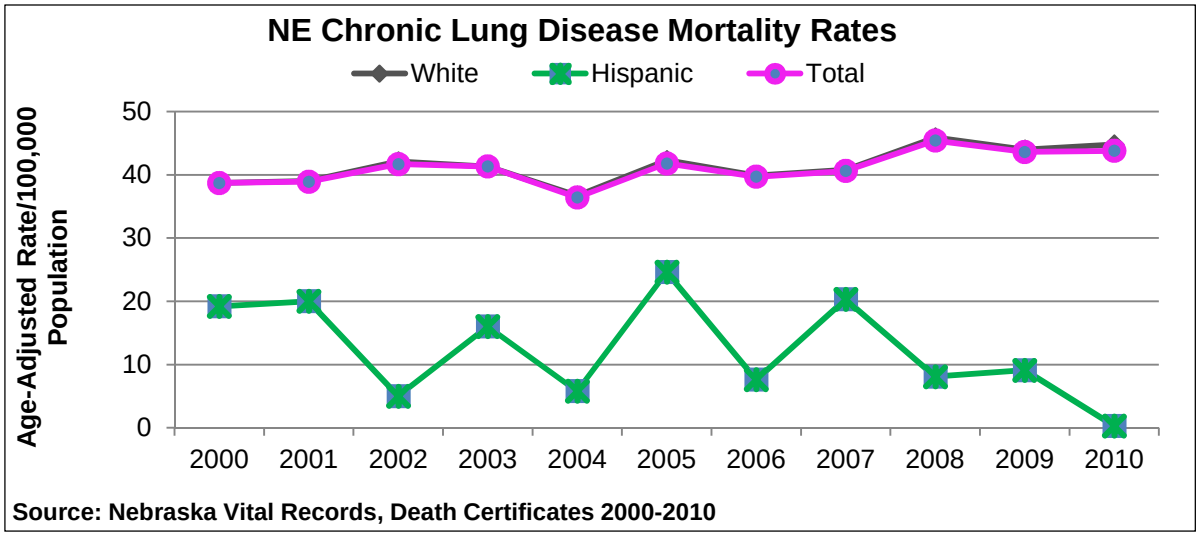
Chronic Lung Disease Mortality

For 2006-2010, the Hispanic population had a total death rate of 8.7 per 100,000 population due to chronic lung disease. With a death rate of 9.2, Hispanic males attributed to the disease less as compared to White males with 55.3. The death rate for Hispanic females was 8.1 deaths versus white female death rate of 36.



Chronic Lung Disease Mortality: Trends

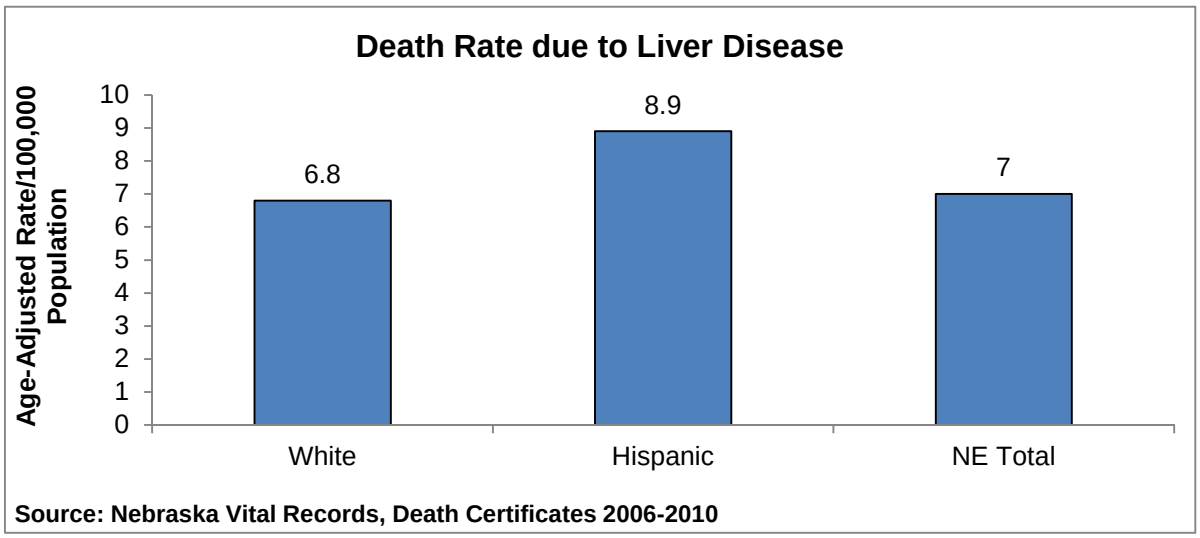
Chronic Lung Disease mortality data illustrates Hispanics' sporadic trend through the 2000-2010 decade. Since 2007, there has been a consistent decrease in chronic lung disease mortality in the Hispanic community.



Liver Disease

Liver Disease Mortality

The Hispanic liver disease death was 8.9 between 2006-2010, compared to 6.8 among Whites.

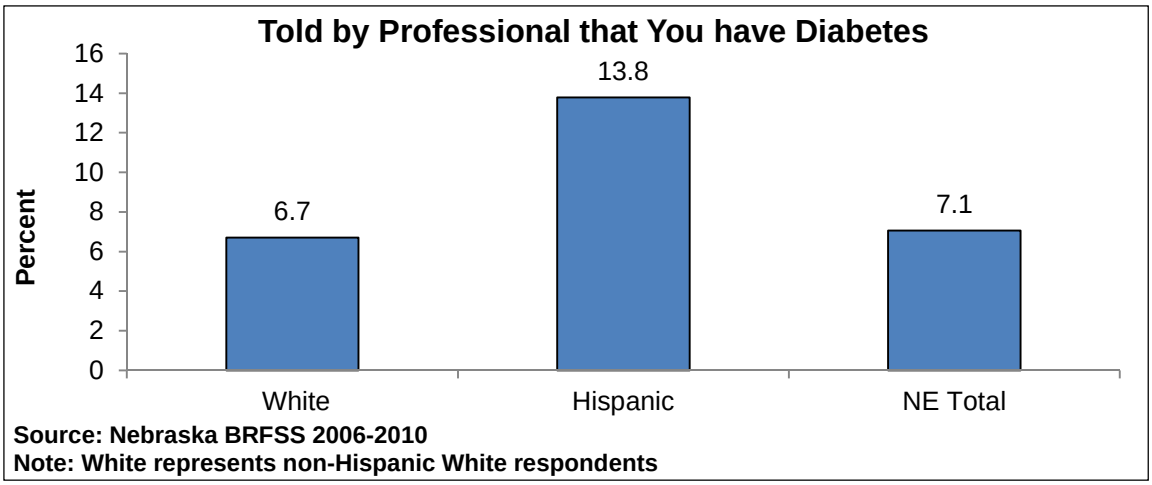


Source: Nebraska Vital Records, Death Certificates 2006-2010

Diabetes

Prevalence of Diabetes

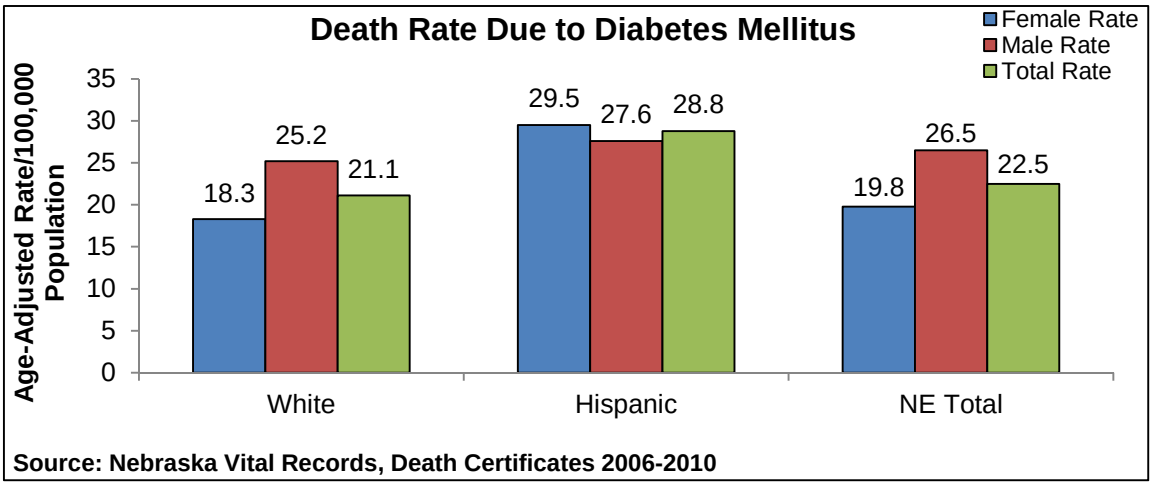
Diabetes mellitus is characterized by high levels of blood glucose, which result from deficient insulin production and/or insulin action. Respondents were asked whether they had ever been told by a doctor that they had diabetes. These numbers do not include women who were told by a doctor of the presence of gestational diabetes during their pregnancy. Altogether, 7.1% of Nebraskan adults reported a doctor had told them they have diabetes. Hispanics (13.8%) experienced significantly higher rates of diagnosed diabetes than Whites (6.7%).



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Diabetes Mortality

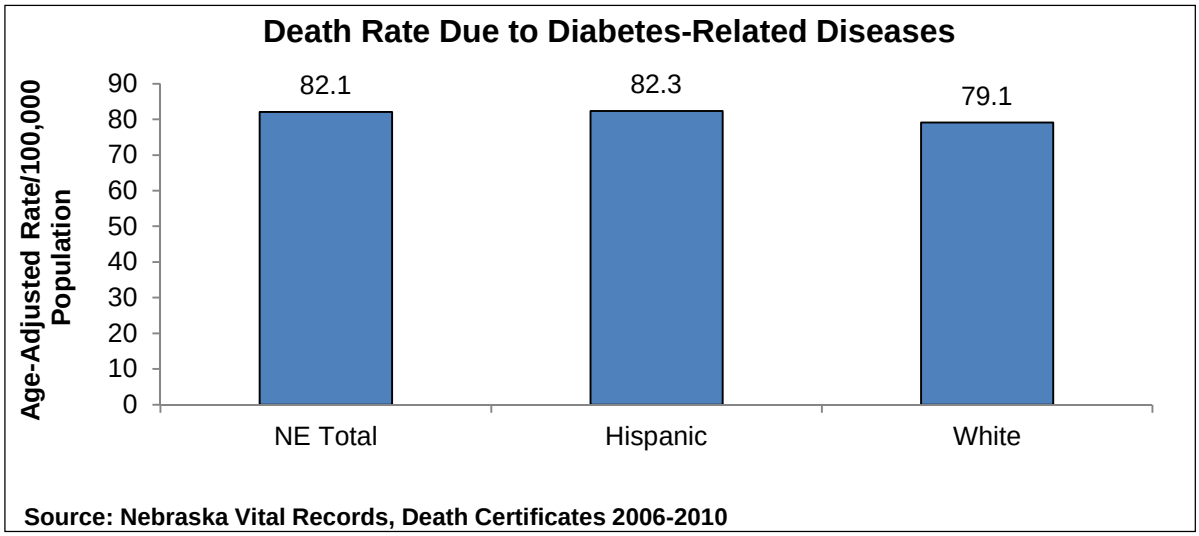
In 2006-2010, diabetes death rates were much higher for both Hispanic males and females as compared with those of Whites. Hispanic males were about 1.1 times more likely than White males to die from diabetes. Hispanic females had nearly 1.6 times the death rate in contrast to White females for diabetes. Hispanics were 36.5% more likely to die from diabetes compared to Whites.



Source: Nebraska Vital Records, Death Certificates 2006-2010

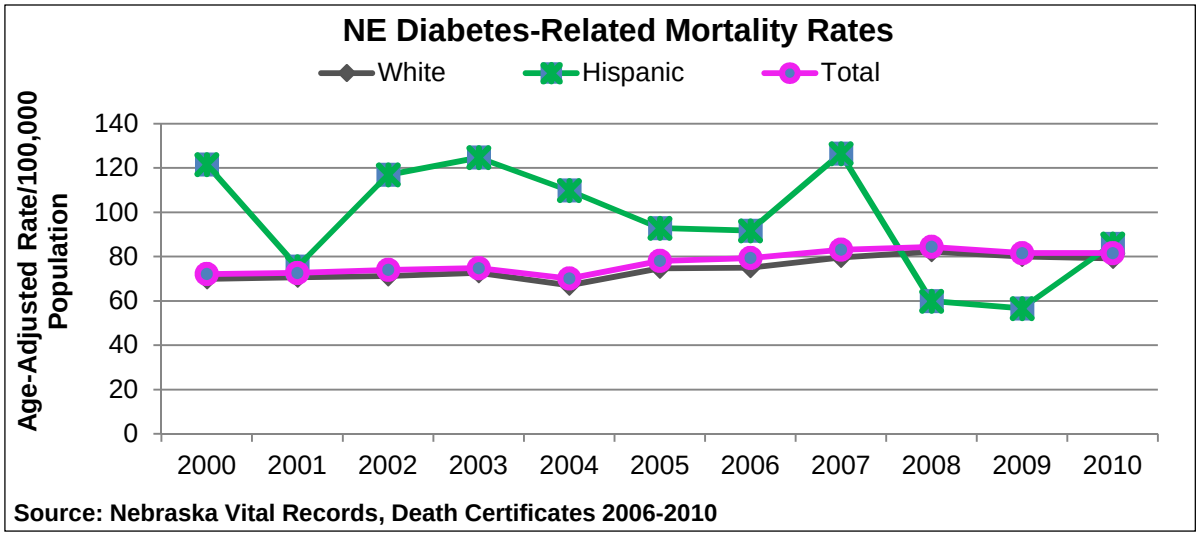
Diabetes-Related Mortality

Diabetes is associated with serious complications and premature death, and people with diabetes are at increased risk for many adverse health outcomes, including heart disease and stroke. Most people with diabetes die from related complications rather than directly from the disease itself; therefore, examination of diabetes as the underlying cause of death alone does not accurately represent its extensive contribution to overall mortality. During 2006-2010, diabetes-related death rates were higher for Hispanics as compared with those of Whites.



Diabetes-Related Mortality: Trends

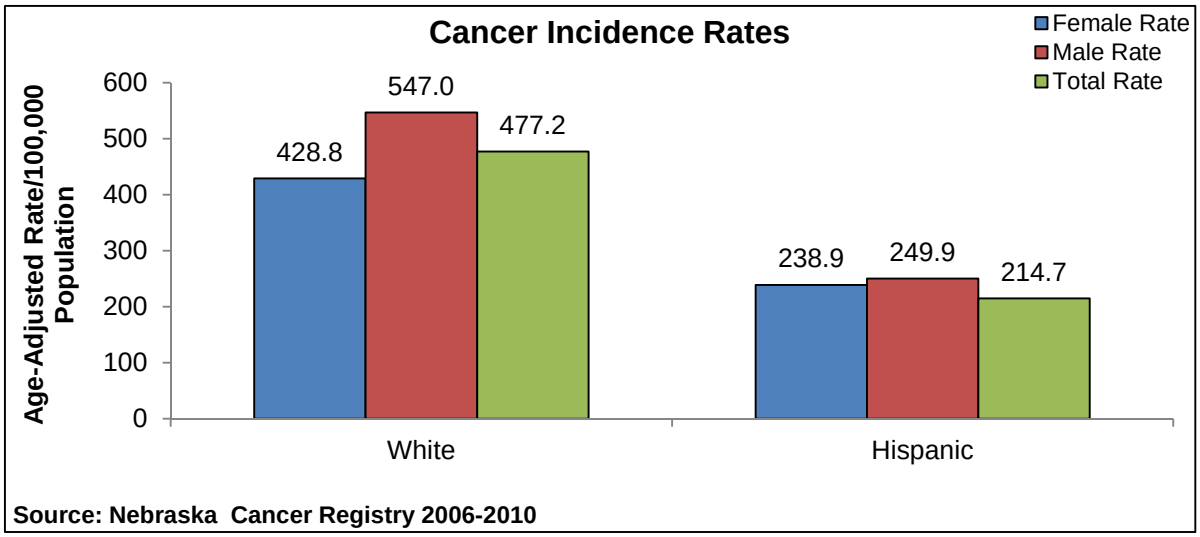
Diabetes mortality data shows that Hispanics have had a decrease in diabetes-related death rates between 2000 and 2010. However, until 2007 Hispanics have had a higher death rate per 100,000 population as compared to the White.



Cancer

Cancer Incidence

The figure below shows the cancer incidence rates for Hispanics and Whites during the period of 2006-2010. Overall, cancer incidence rates for males are higher than for females for both Hispanic and Whites. White incidence rates for cancer among both genders appear to be higher than for Hispanic population.

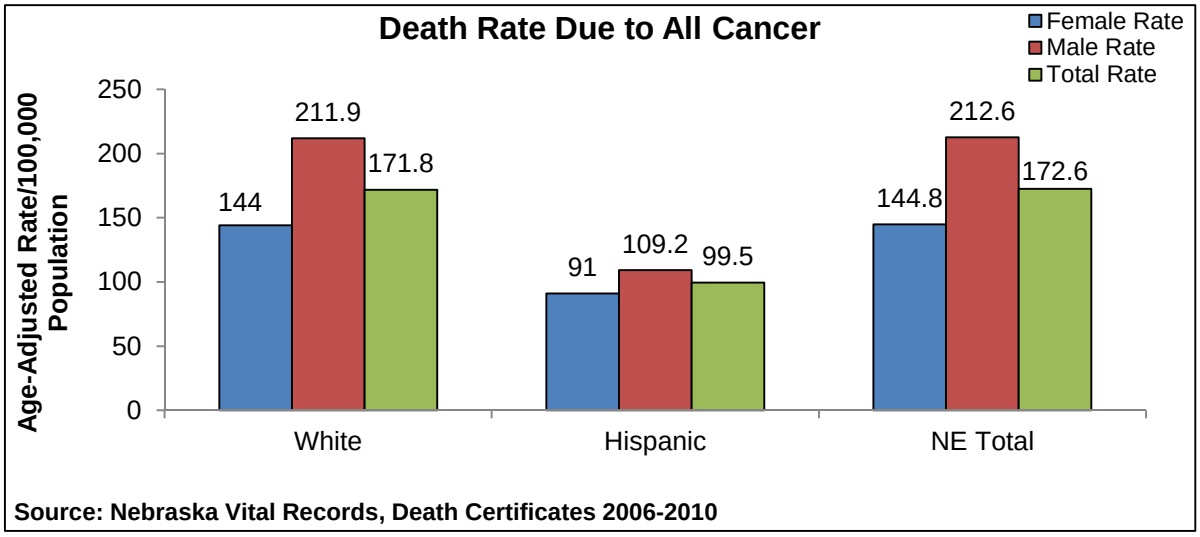


Source: Nebraska Cancer Registry 2006-2010

Cancer Mortality

Hispanic males were less likely to die from all cancer cases (109.2 per 100,000) than Non-Hispanic/Latino White males (211.9 per 100,000).

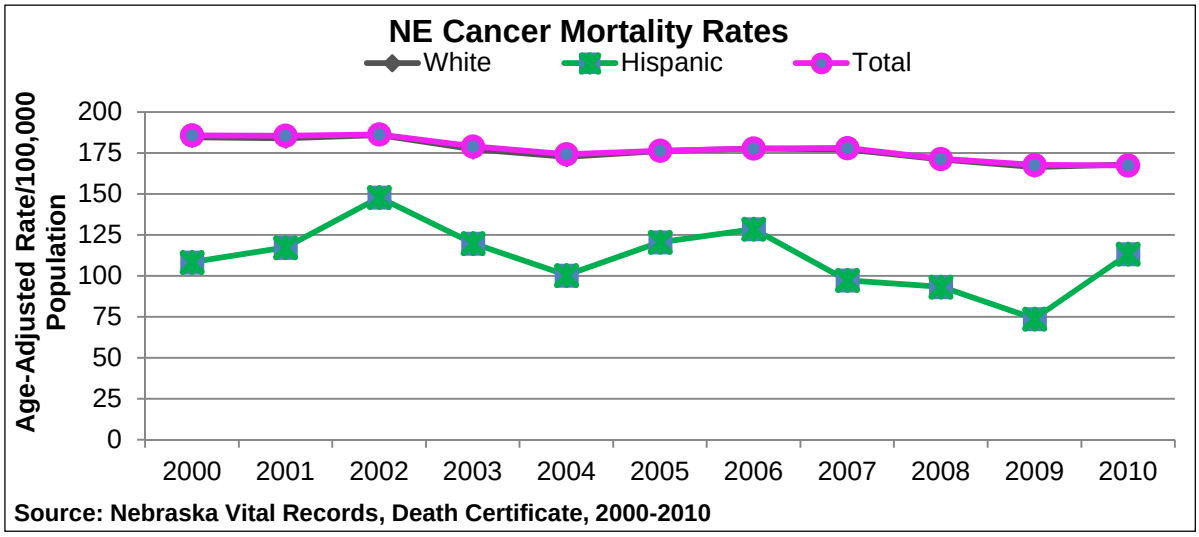
Hispanic females were less likely to die from cancer (91 per 100,000) in contrast to Non-Hispanic/Latino White females (144 per 100,000).



Source: Nebraska Vital Records, Death Certificates 2006-2010

Cancer Mortality: Trends

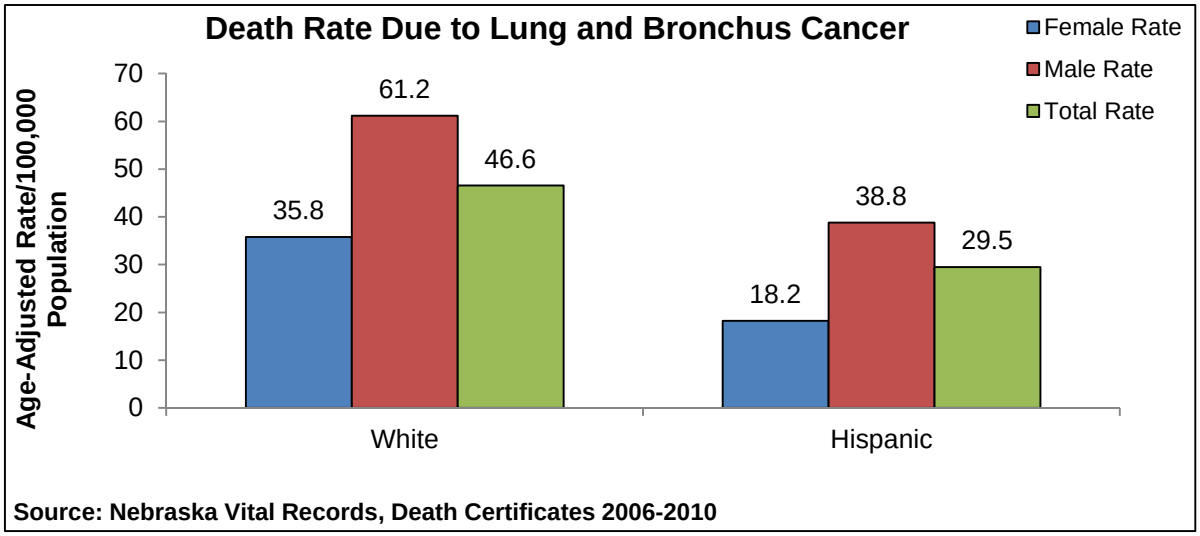
Cancer mortality data from year 2000-2010 shows that both Hispanics and Whites experienced a decline in cancer mortality. Cancer mortality rates remained lower among Hispanics as compared to Whites.



Source: Nebraska Vital Records, Death Certificate, 2000-2010

Lung and Bronchus Cancer Mortality

In 2006-2010, Hispanic females were about 50% less likely to die from lung and bronchus cancer, compared to White females. Hispanic males were 37% less likely to die from lung and bronchus cancer, compared to White males.



Source: Nebraska Vital Records, Death Certificates 2006-2010

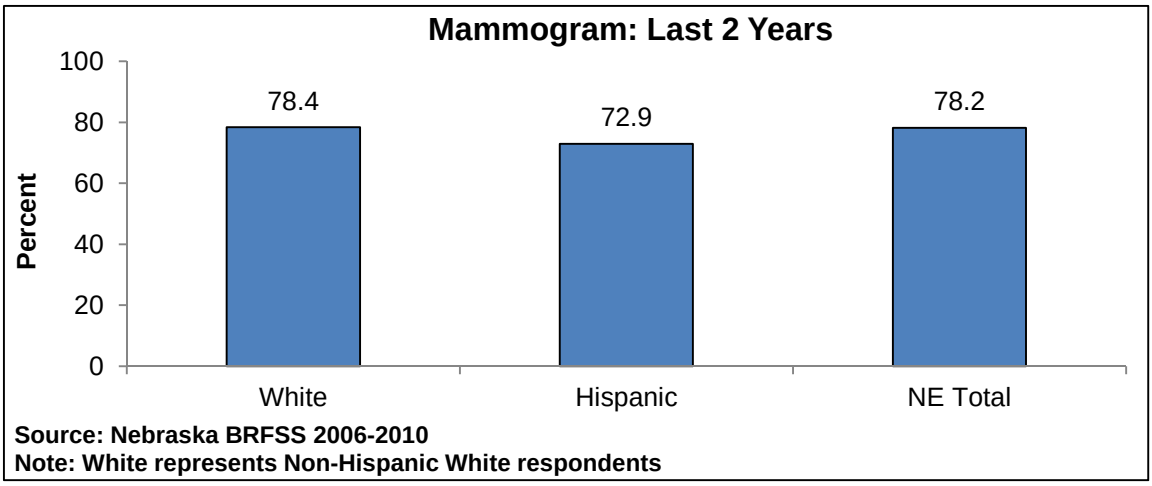
Cancer Screening

Mammogram

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.

Mammogram: Women 50-74

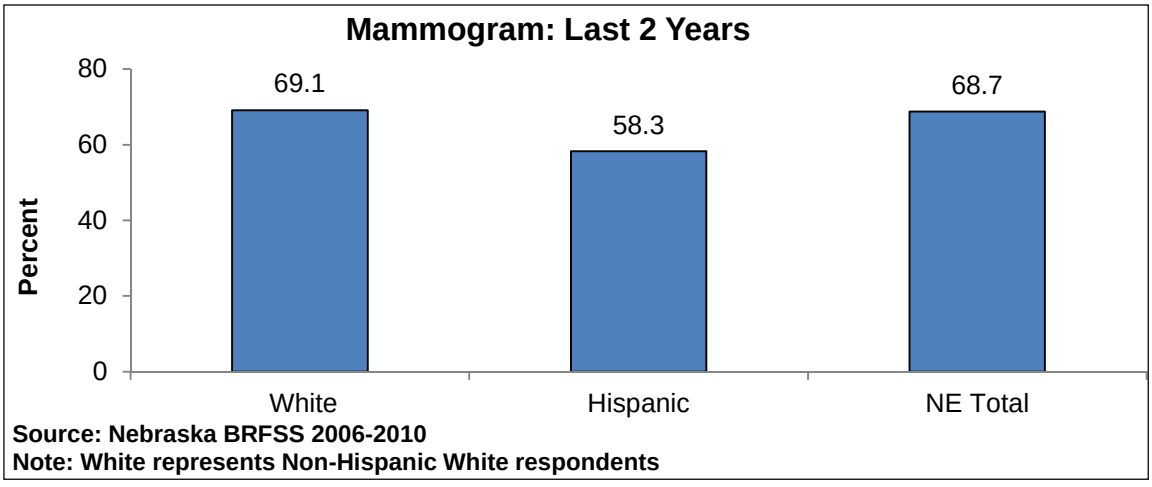
Recently it has been scientifically suggested that only women between the ages of 50 and 74 need to get mammograms, as opposed to 40+ years old (illustrated at the bottom of the page). Almost 73% of Hispanic women between 50 and 74 years old had received a mammogram within the previous 2 years, compared to 78.4% of Whites.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Mammogram: Women 40+

During the period of 2006-2010, 58.3% of Hispanic women ages 40 and older had a mammogram in the past two years, as compared to 69.1% of White women.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

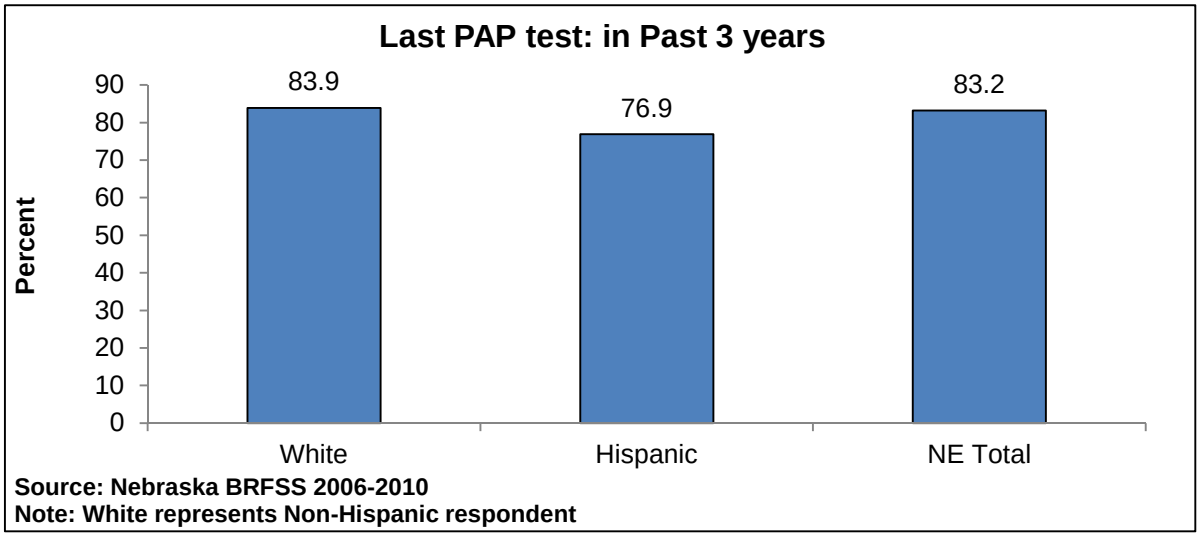
Pap Test

Women in the BRFSS survey were given the definition of a pap test as: “a test for cancer of the cervix.” They were then asked if they “ever had a Pap Test in past three years?”

Pap Test: Women 21-64

Recently it has been scientifically suggested that only women between the ages of 21 and 64 need to get a pap test, as opposed to 18+ years old (illustrated at the bottom of the page).

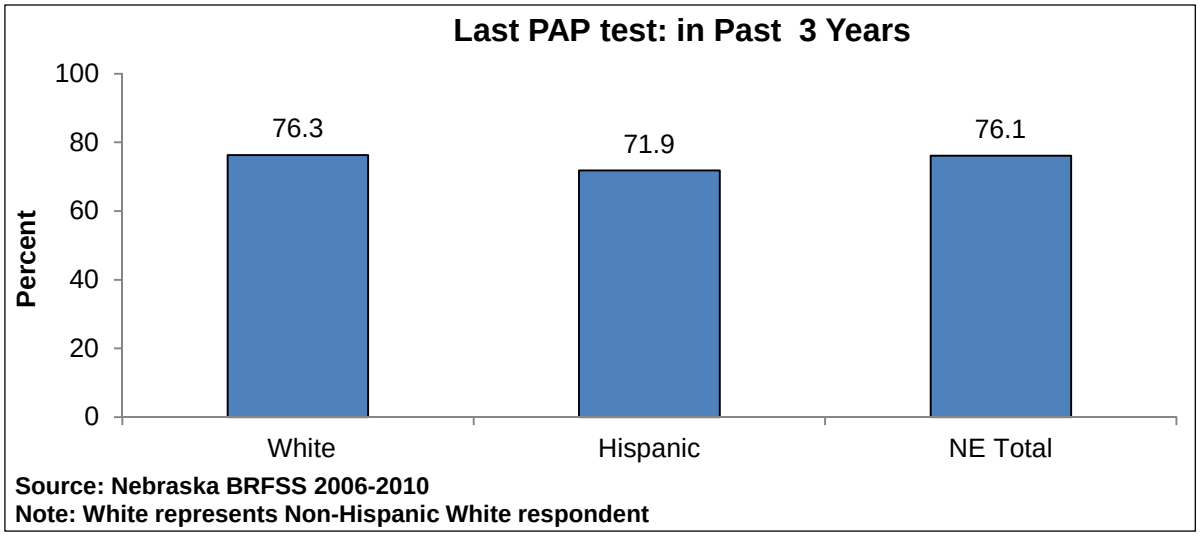
In 2006-2010, 76.9% of Hispanic women between 21-64 years old living in Nebraska had a pap test, compared to almost 84% of Whites.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic respondent

Pap Test: Women 18+

During the period of 2006-2010, Hispanic women 18+ were less likely to have had a pap test in the past three, compared to White women.



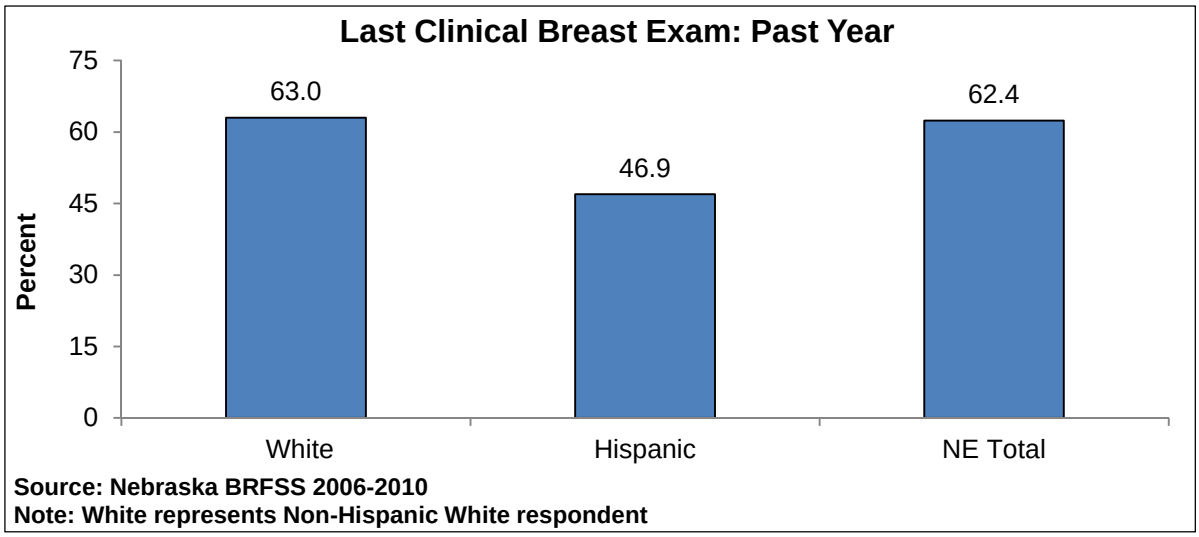
Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

Clinical Breast Exam

Women in the BRFSS survey were given the definition of clinical breast exam. They were read the following description: “a clinical breast exam is when a doctor, nurse, or other health professional feels the breast for lumps.”

Clinical Breast Exam: 40+

During the period of 2006-2010, Hispanic women ages 40 or older (46.9%) were less likely to have had a clinical breast exam compared to White women (63%), in the past one year.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

Infectious Disease

HIV/AIDS

HIV/AIDS Incidence

Newly Diagnosed HIV and Aids Cases by Race/Ethnicity								
	New HIV Only Diagnoses				1st AIDS Diagnoses			
	2010		2009		2010		2009	
Race and Ethnicity	#	%	#	%	#	%	#	%
Non-Hispanic White	42	62	34	49	14	45	14	42
Non-Hispanic Black	20	29	20	29	11	35	9	27
Hispanic	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

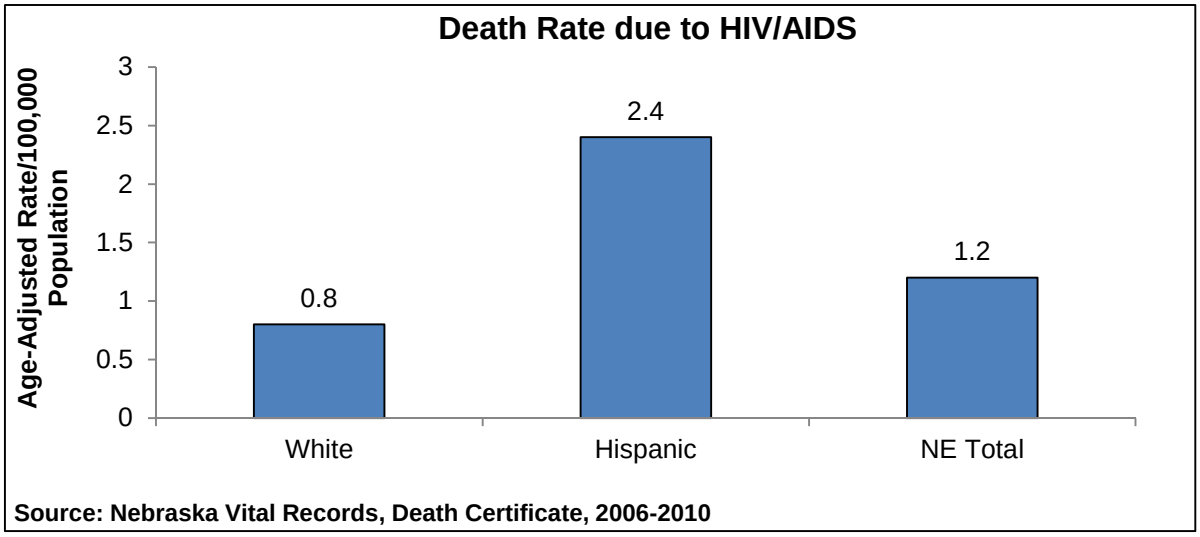
Source: Nebraska DHHS, HIV/AIDS Prevention and Care, 2010

Cumulative HIV and AIDS Cases by Race/Ethnicity				
	All HIV Diagnoses through 2010		Living HIV/AIDS Cases through 2010	
Race and Ethnicity	#	%	#	%
Non-Hispanic White	1,566	60.4	966	55.6
Non-Hispanic Black	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, HIV/AIDS Prevention and Care, 2010

HIV/AIDS Mortality

In 2006-2010, the death rate among Hispanics for HIV/AIDS was 2.4/100,000 population, compared to 0.8 among Whites

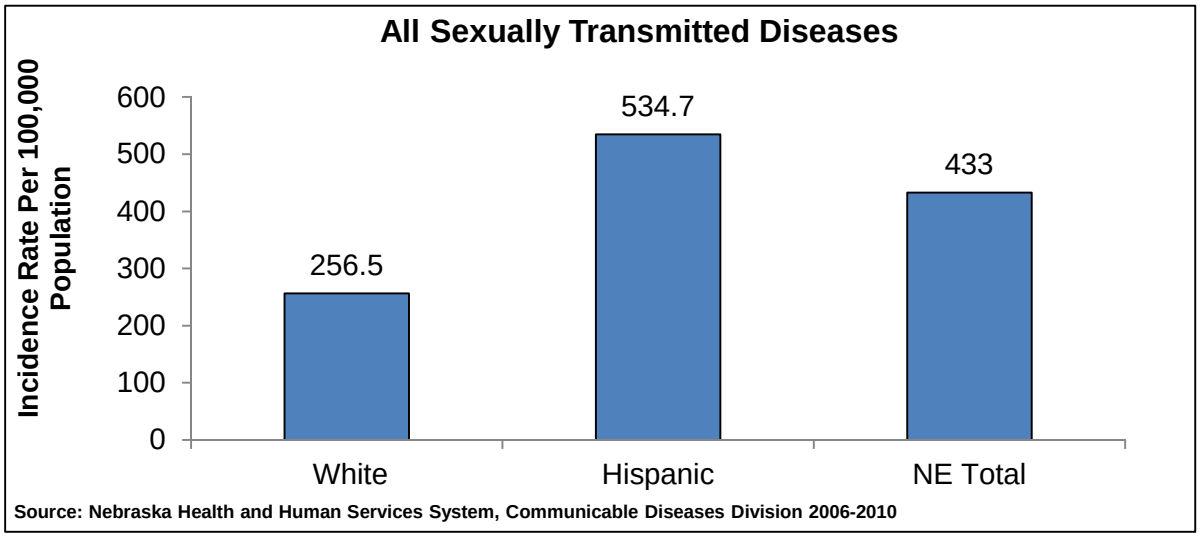


Source: Nebraska Vital Records, Death Certificate, 2006-2010

Sexually Transmitted Diseases

Incidence of Sexually Transmitted Disease

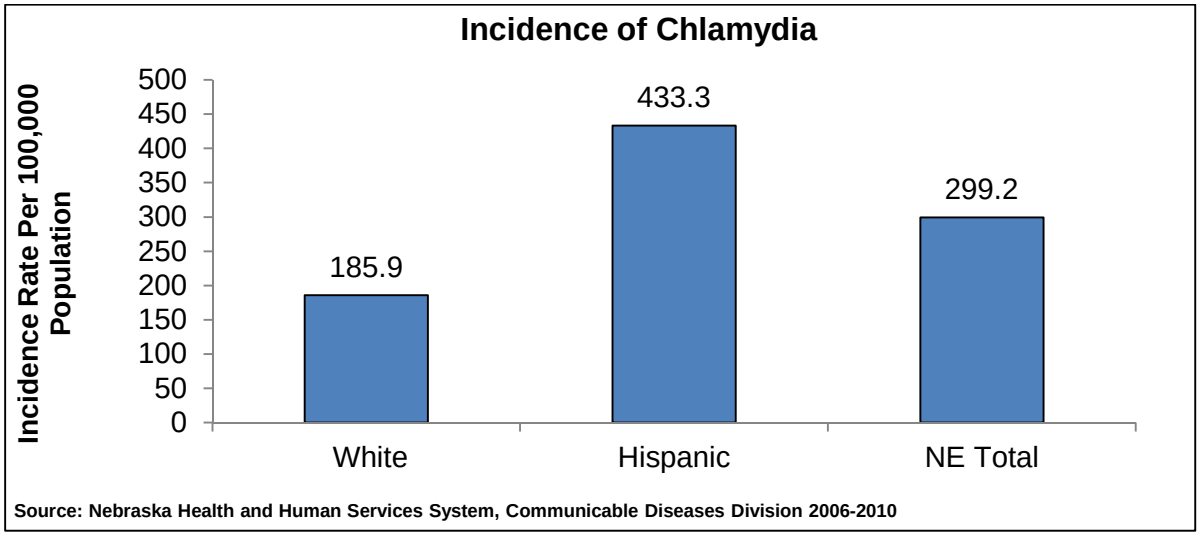
Sexually transmitted diseases (STDs) remain a major public health challenge in the United States. STDs can cause serious complications including infertility, blindness, fetal and infant deaths, and congenital defects. Racial and ethnic minorities are at a higher risk for sexually transmitted diseases, and experience higher rates of disease and disability than the overall population. In Nebraska, the incidence rates and relative risk of infection of all sexually transmitted diseases for Hispanics was 534.7 per 100,000 population, which was nearly two times greater than for the White population (256.5).



Source: Nebraska Health and Human Services System, Communicable Diseases Division 2006-2010

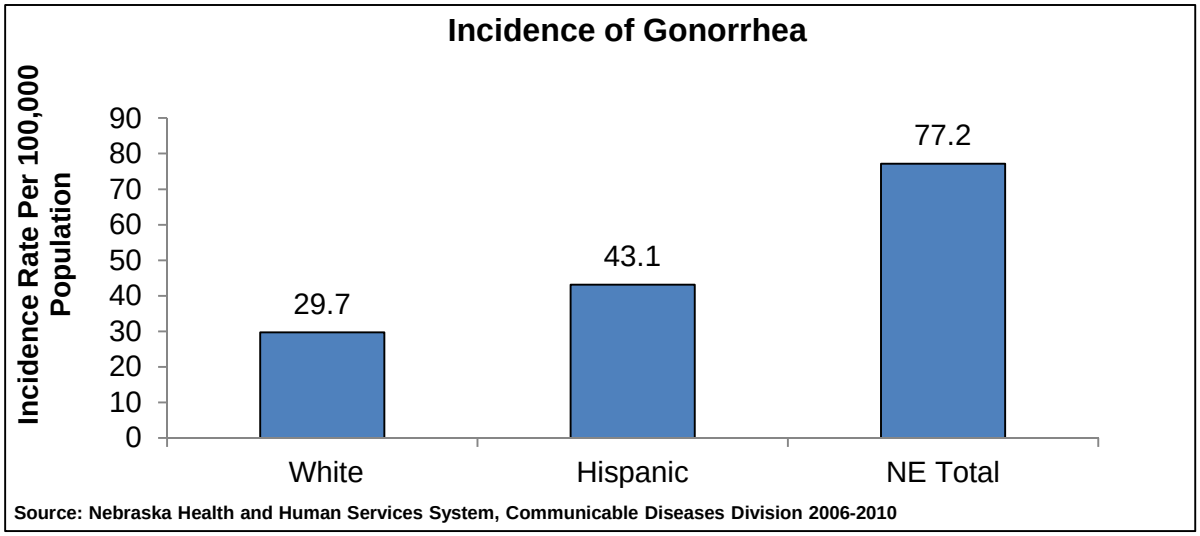
Incidence of Chlamydia

Incidences of chlamydia infections has increased in Nebraska, as it has nationwide. Though, expanded screening and improved testing methods may account for some of this increase. Chlamydia remains the most commonly reported infectious disease in the United States. In Nebraska, during 2006-2010, Hispanics had an incidence rate per 100,000 population for chlamydia of 433.3, which was about 2.3 times higher than that for Whites, and Nebraska Total incidence rate of 299.2.



Incidence of Gonorrhea

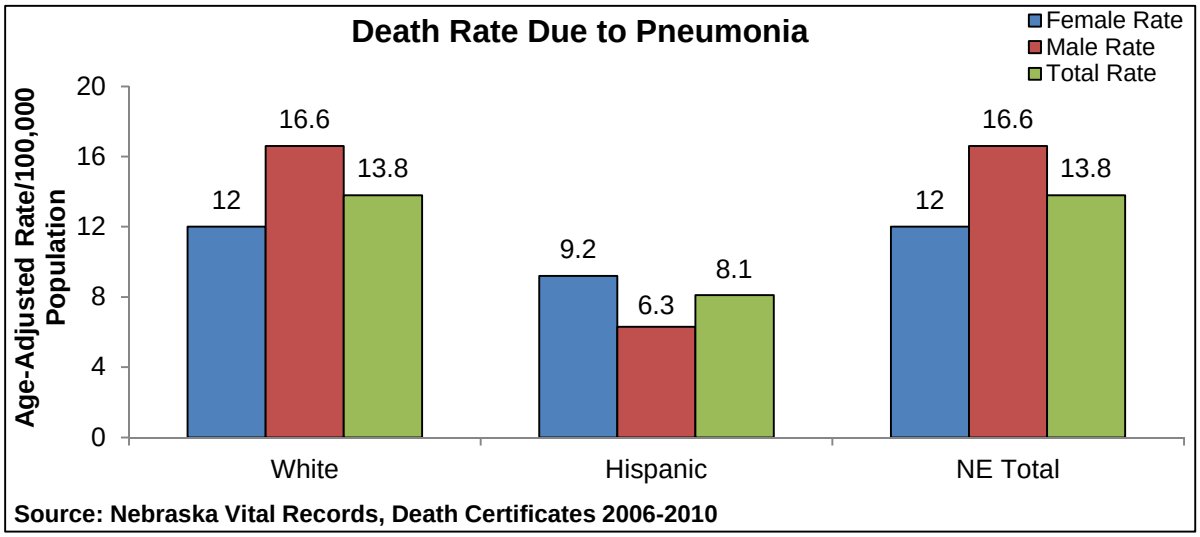
In Nebraska, during 2006-2010, Hispanics had an incidence rate for gonorrhea of 43.1 per 100,000 population, which is about 1.5 times higher than the incidence rate for Whites of 29.7 per 100,000 population.



Pneumonia

Pneumonia Mortality

The death rates due to pneumonia in the years of 2006-2010 for Hispanics and Whites were 8.1 and 13.8, respectively.



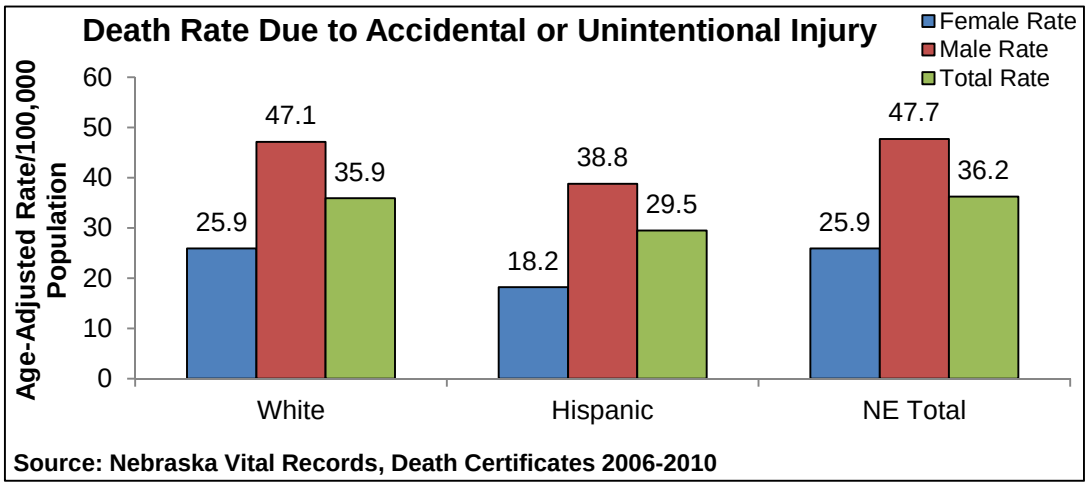
Intentional and Unintentional Injuries

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, for instance 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.

Accidental or Unintentional Injury

Accidental or Unintentional Injury Mortality

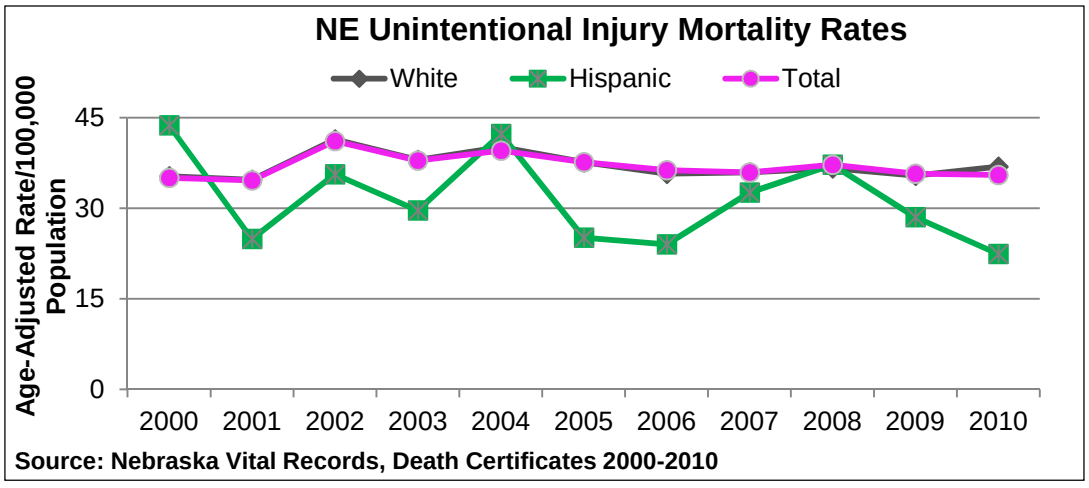
Hispanic males were less likely to die from accidental or unintentional injury than White males. Similarly, the Hispanic females were less likely to die due to an accident or unintentional injury than White females.



Source: Nebraska Vital Records, Death Certificates 2006-2010

Unintentional Injury Mortality: Trends

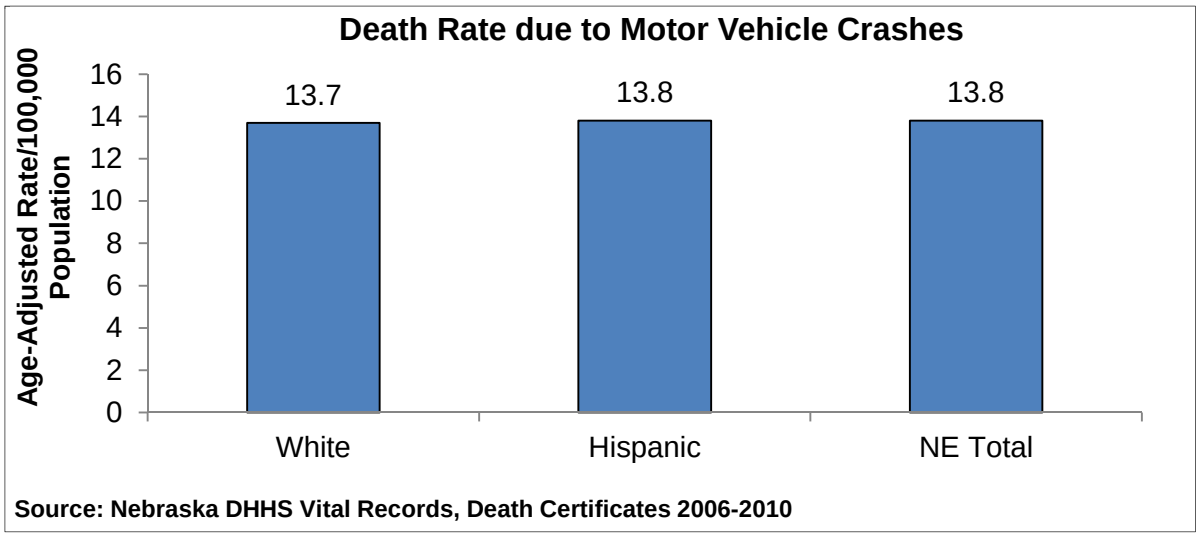
Unintentional injury mortality rate data from the years 2000-2010 reveals a downward trend in death rate for Hispanics. The rate of mortality remains lower than Whites.



Source: Nebraska Vital Records, Death Certificates 2000-2010

Motor Vehicle Crashes

In Nebraska during 2006-2010, Hispanics had a death rate of 13.1 per 100,000 population for motor vehicle crash death. The Hispanic death rate is not any different than that of Whites.

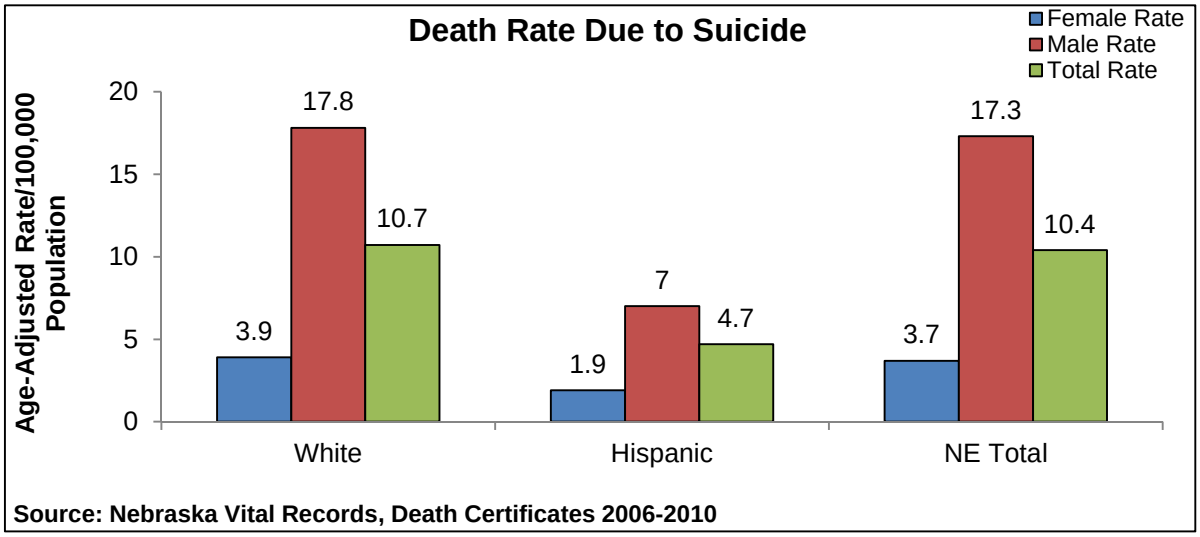


Source: Nebraska DHHS Vital Records, Death Certificates 2006-2010

Intentional Injury

Suicide

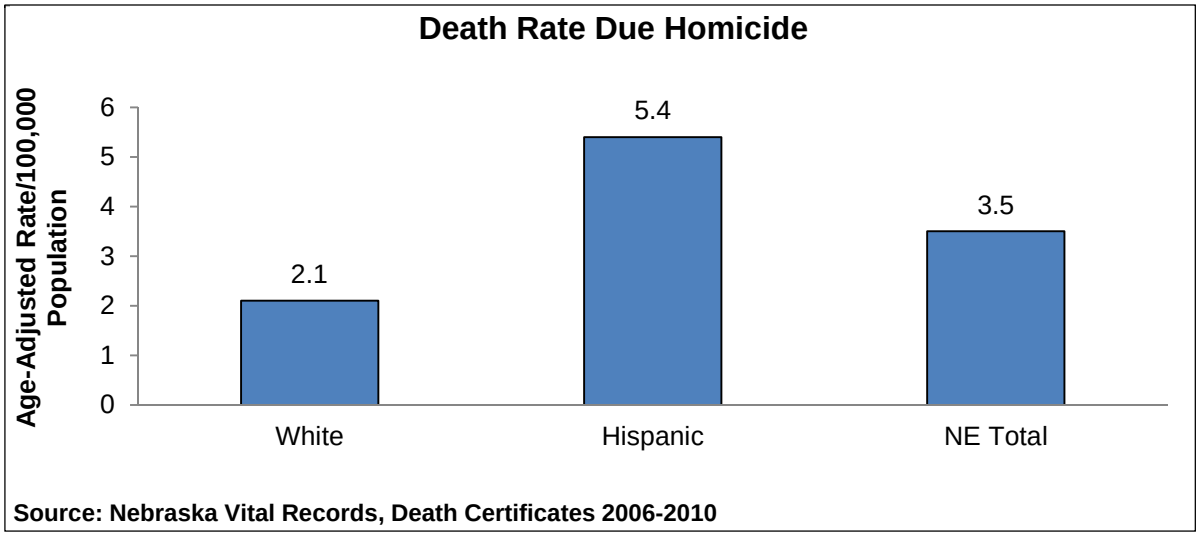
The death rate of 4.7 per 100,000 of suicide for Hispanics is approximately 2 times less than it is for Whites at 10.7 per 100,000. Hispanic males are less likely to die from suicide than White males. Hispanic females are 50% less likely than White females to die from suicide.



Source: Nebraska Vital Records, Death Certificates 2006-2010

Homicide

Homicide by definition includes deaths inflicted by another person with the intention to injure or kill. During 2006-2010, Hispanics' death rate due to homicide was 5.4 per 100,000 whereas Whites had a lower incidence of 2.1 per 100,000. Hispanics had a homicide rate 2.6 times higher than Whites.



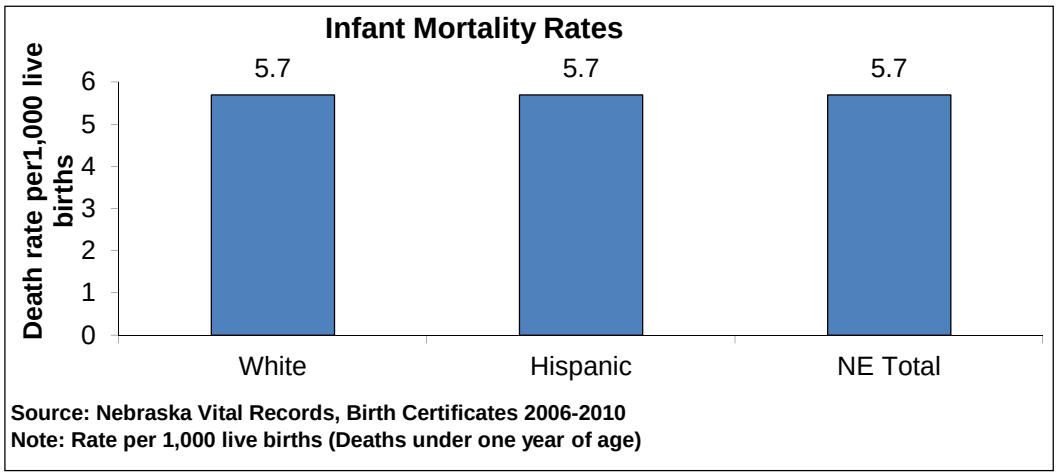
Source: Nebraska Vital Records, Death Certificates 2006-2010

Maternal and Child Health

Maternal and Child Health

Infant Mortality

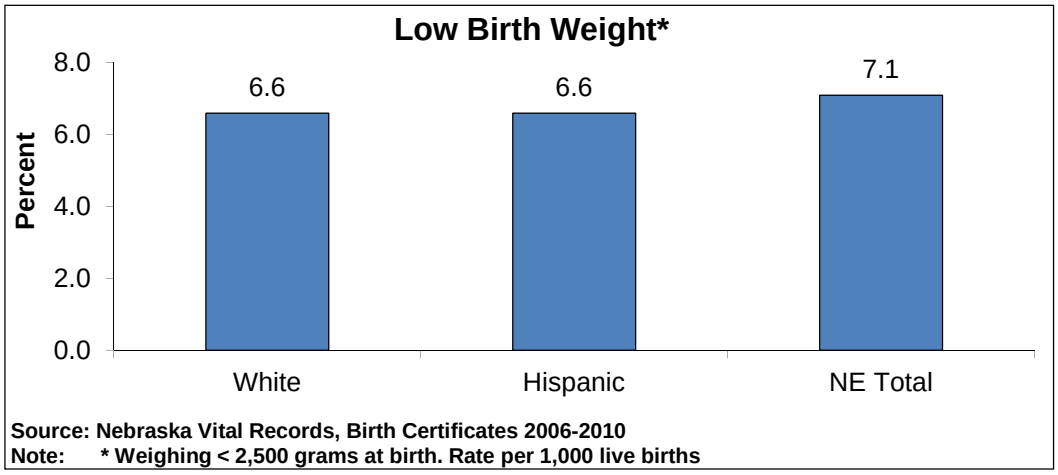
Infant mortality is a long-established measure not only of child health but also of the well-being of the society[4]. Infant mortality reflects the level of health status and health care of a population, and the effectiveness of preventive care and the attention paid to maternal and child health. Often considered the existence-benchmark of unmet health needs, maternal and child health in Nebraska is first assessed by infant mortality rates[5]. The figure below shows the infant death rate for Hispanic and Whites. In the five year period of 2006-2010, the infant mortality rate was same for Hispanic as for Whites.



Source: Nebraska Vital Records, Birth Certificates 2006-2010
Note: Rate per 1,000 live births (Deaths under one year of age)

Low Birth Weight

A newborn is considered to be of low weight if he/she weighs less than 2,500 grams at birth. These babies experience higher rates of illness and death than other infants. During 2006-2010, the infant mortality rate was the same for Hispanics as compared to Whites.



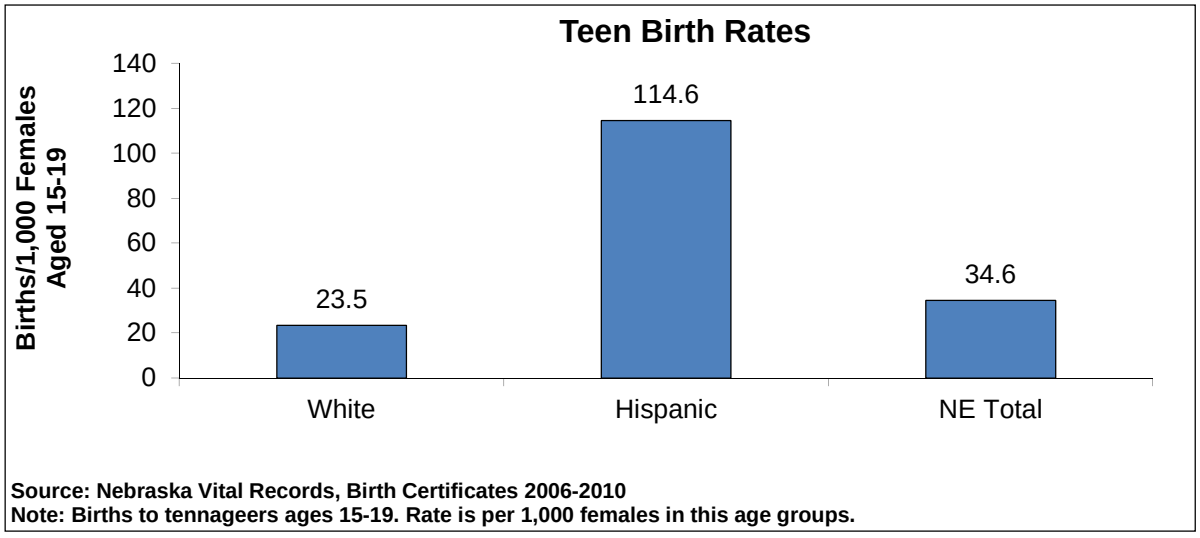
Source: Nebraska Vital Records, Birth Certificates 2006-2010
Note: * Weighing < 2,500 grams at birth. Rate per 1,000 live births

[4] http://www.statcan.gc.ca/pub/82-221-x/4060874-eng.htm

[5] http://www.hhs.state.ne.us/healthdisparities/Maternal&ChildHealthFactSheet.pdf

Teen Births

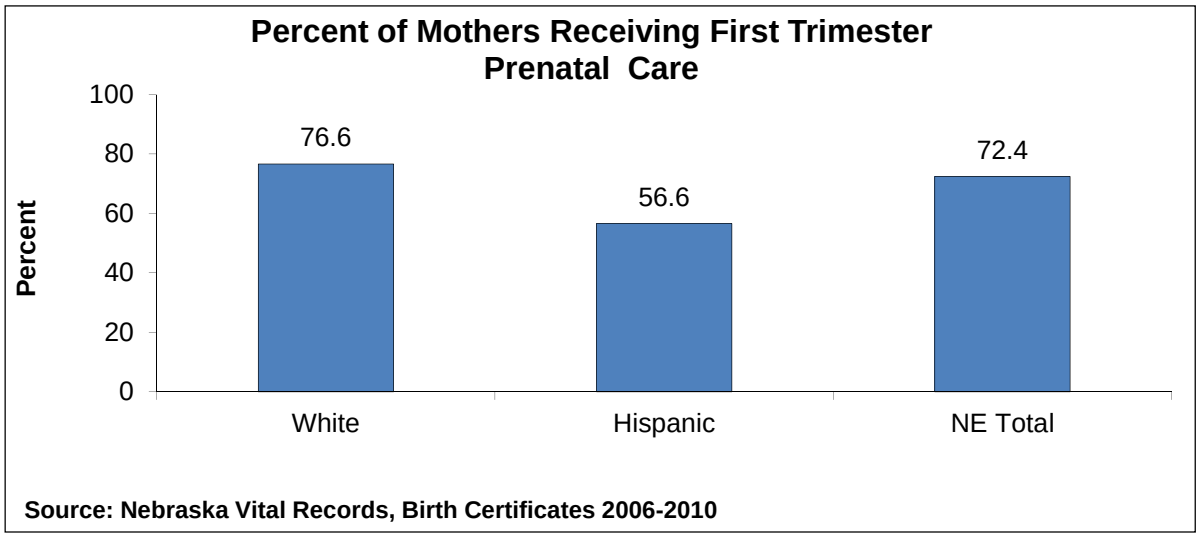
In Nebraska, the teen birth rate for Hispanics was higher than the rate for Whites. During 2006-2010, the teen birth rate for Hispanic female teens aged 15-19 (114.6) was nearly five times the rate for White female teens (23.5).



Source: Nebraska Vital Records, Birth Certificates 2006-2010
Note: Births to tennageers ages 15-19. Rate is per 1,000 females in this age groups.

Mothers Receiving First Trimester Prenatal Care

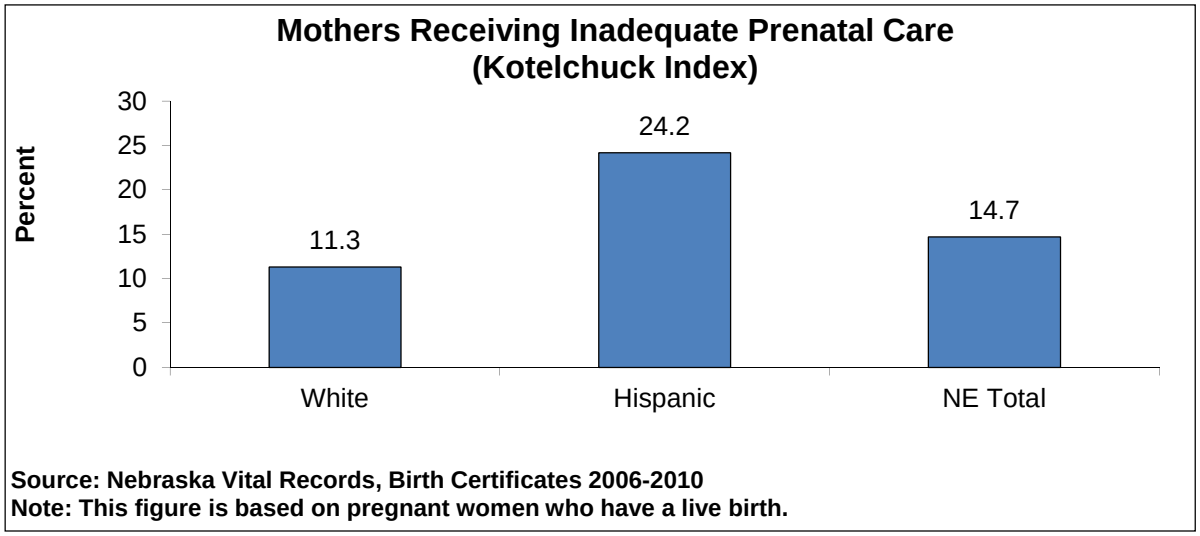
Mothers who initiated prenatal care after the first trimester of pregnancy and those who received no prenatal care at all are considered at-risk. In 2006-2010, the percentage beginning prenatal care in the first trimester for Hispanic mothers was 56.6 percent, compared to 76.6 percent for White mothers.



Source: Nebraska Vital Records, Birth Certificates 2006-2010

Kotelchuck Index

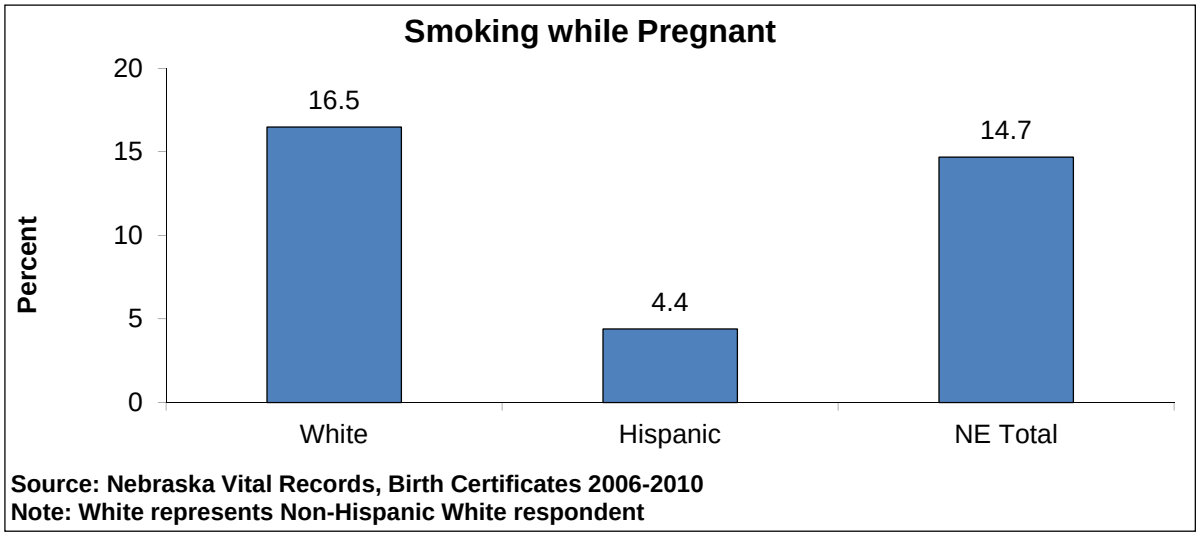
The Kotelchuck Index is a measure of adequacy or inadequacy of prenatal care by using a combination of the number of prenatal visits, gestation, and what trimester prenatal care was started. Based on the Kotelchuck Index, in 2006-2010, among Hispanic mothers, around one fourth (24.2%) received inadequate prenatal care, as did 11.3% of White mothers.



Source: Nebraska Vital Records, Birth Certificates 2006-2010
Note: This figure is based on pregnant women who have a live birth.

Smoking During Pregnancy

Nebraska adopted an objective to increase the proportion of women who abstain from cigarette smoking during pregnancy. Among Hispanic women in 2006-2010 only 4.4% reporting smoking while pregnant, compared to 16.5% of White women.



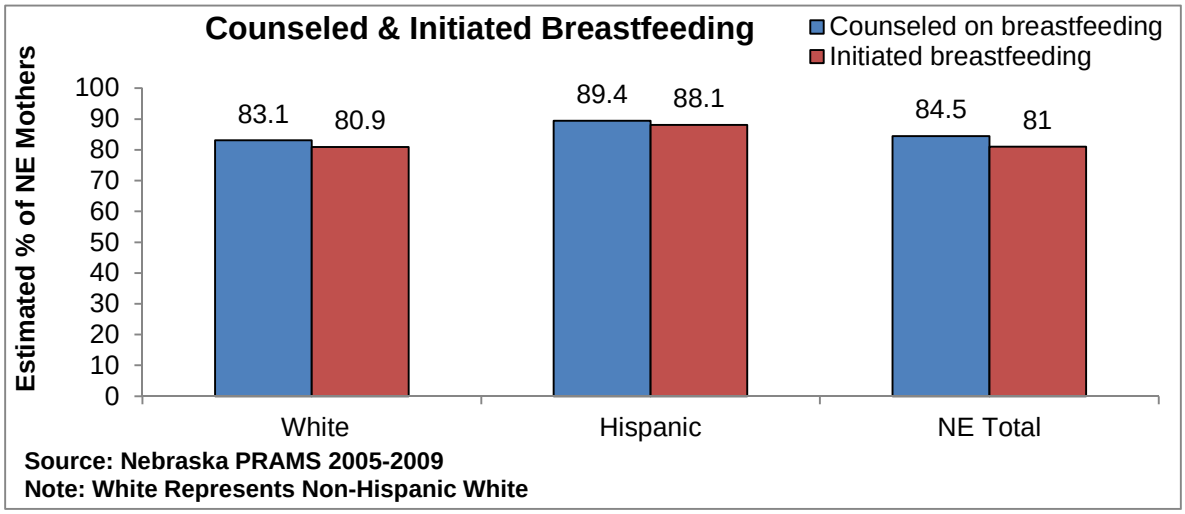
Source: Nebraska Vital Records, Birth Certificates 2006-2010
Note: White represents Non-Hispanic White respondent

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.[6] Breast milk strengthens infants' immune systems, thus resulting in fewer cases of illness for newborns.[7] Breastfeeding has also been associated with a decreased risk of pre-menopausal breast cancer in women.[8] 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.[9,10] 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.[11] The following PRAMS data come from different years. Data on counseling and initiation of breastfeeding and continued breastfeed are 2005-2009, and data on hospital support of breastfeeding and postpartum sadness are 2005-2008.

Receiving Counseling on Breastfeeding and Initiating Breastfeeding

The question asked on the PRAMS survey for 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 80.9%, while Hispanic mothers' breastfeeding initiation was 88.1%. When asked about receiving counseling on breastfeeding, 89.4% of Hispanic mothers received counseling while 83.1% of White mothers received counseling.

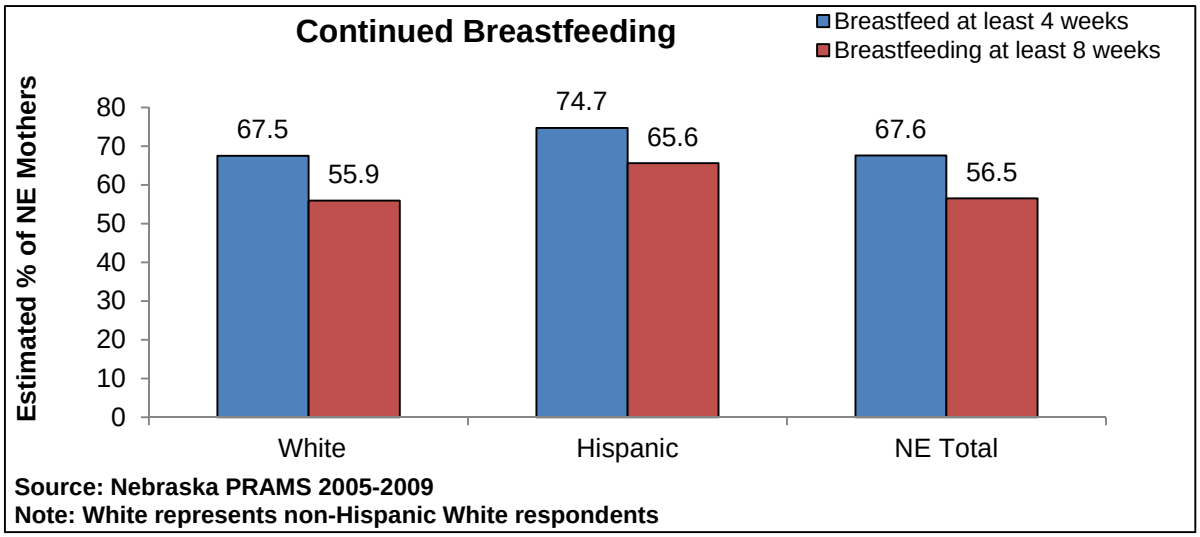


Source: Nebraska PRAMS 2005-2009
Note: White Represents Non-Hispanic White

[6] www.ahrq.gov/downloads/pub/evidence/pdf/bfout/brfout.pdf
[7] Howie PW, Forsyth JS, Ogston SA, Clark A, Florey CD. Protective effect of breastfeeding against infection. BMJ 1990; 300(6716):11-16
[8] www.ahrq.gov/downloads/pub/evidence/pdf/bfout/brfout.pdf
[9] 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
[10] Centers for Disease Control and Prevention(CDC). Breastfeeding trends and updated national health objectives for exclusive breasfeeding-United States, birth years 2000-2004. MMWRMorb Mortal Wkly Rep 2007; 56(30):760-763
[11] Ahluwalia IB, Morrow B, Hsia J, Why do women stop breastfeeding? Findings from the Pregnancy Risk Assessment and Moniotring System. Pediatrics 2005; 116(6):1408-1412

Continued Breastfeeding

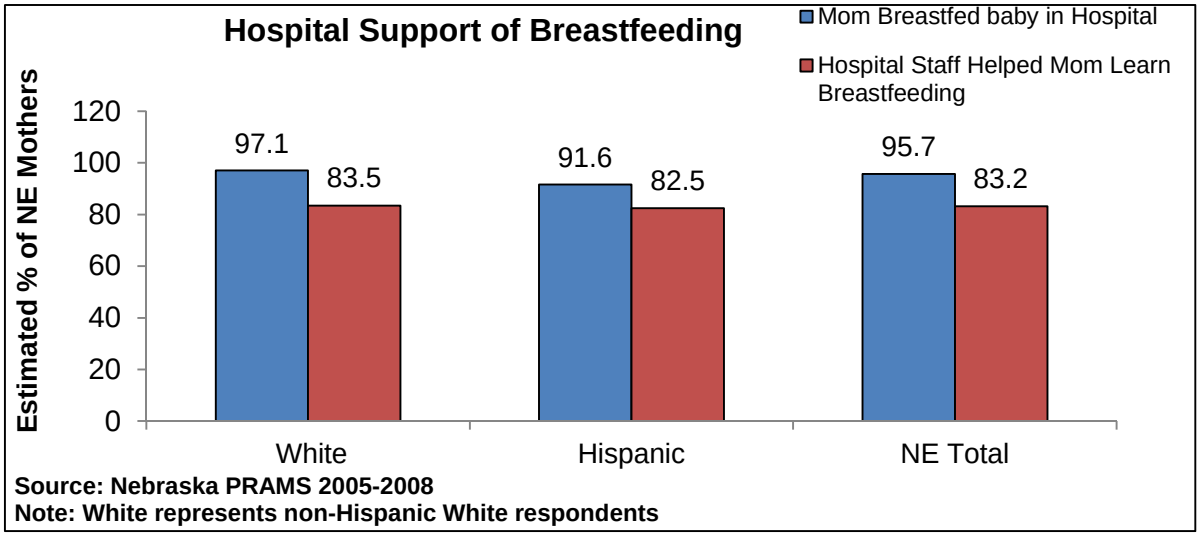
Continued breastfeeding is estimated among those who initiated it after giving birth. Exclusive breastfeeding at four weeks is based on the age when an infant received anything other than breast milk. Based on Nebraska PRAMS 2005-2009 data, a total of 74.7% of Hispanic mothers continued to breastfeed at four weeks, compared to 67.5% of White mothers. Almost 66% of Hispanic mothers continued to breast feed at least eight weeks, compared to 55.9% of White mothers.



Source: Nebraska PRAMS 2005-2009
Note: White represents non-Hispanic White respondents

Hospital Support of Breastfeeding

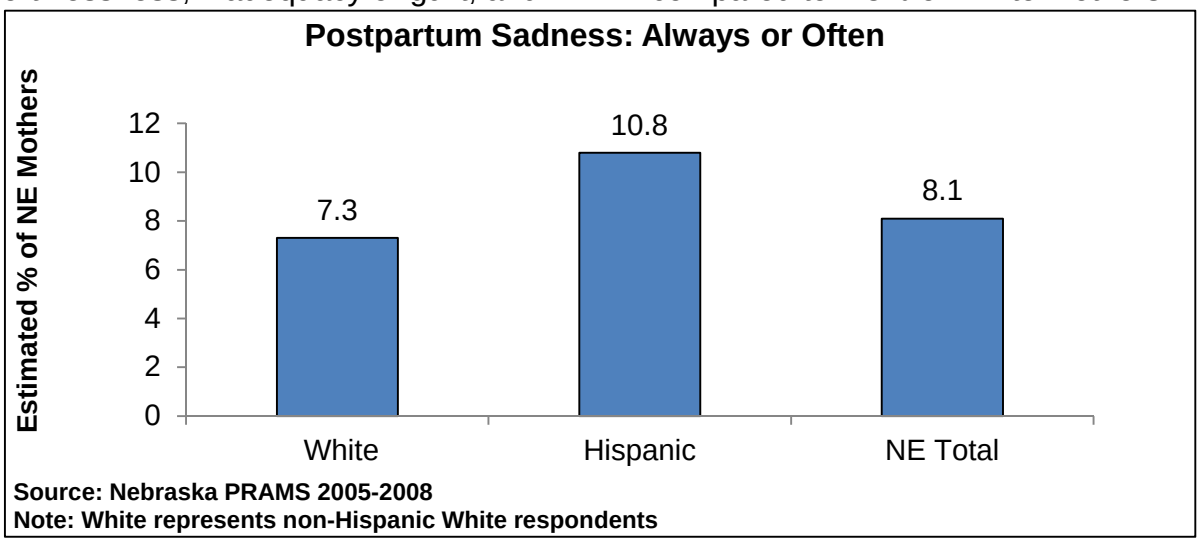
The chart below shows that there was a 5.5% difference in hospital staff support of breastfeeding in favor of White mothers as compared to Hispanic mothers. Almost 92% of Hispanic mothers breastfed their baby, compared to 97.1% of White mothers.



Source: Nebraska PRAMS 2005-2008
Note: White represents non-Hispanic White respondents

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. The chart below shows that 10.8% of Hispanic mothers always or often had post-partum sadness after the birth of their baby, compared to 7.3% of White mothers.



Source: Nebraska PRAMS 2005-2008
Note: White represents non-Hispanic White respondents

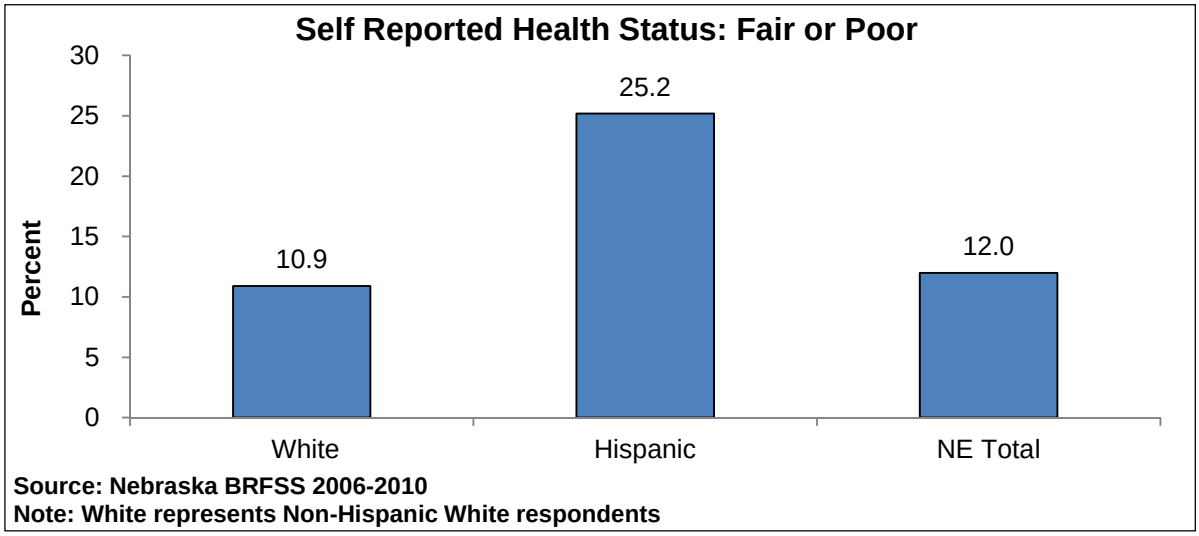
Behavioral Risk Factors

Health Status and Quality of Life

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

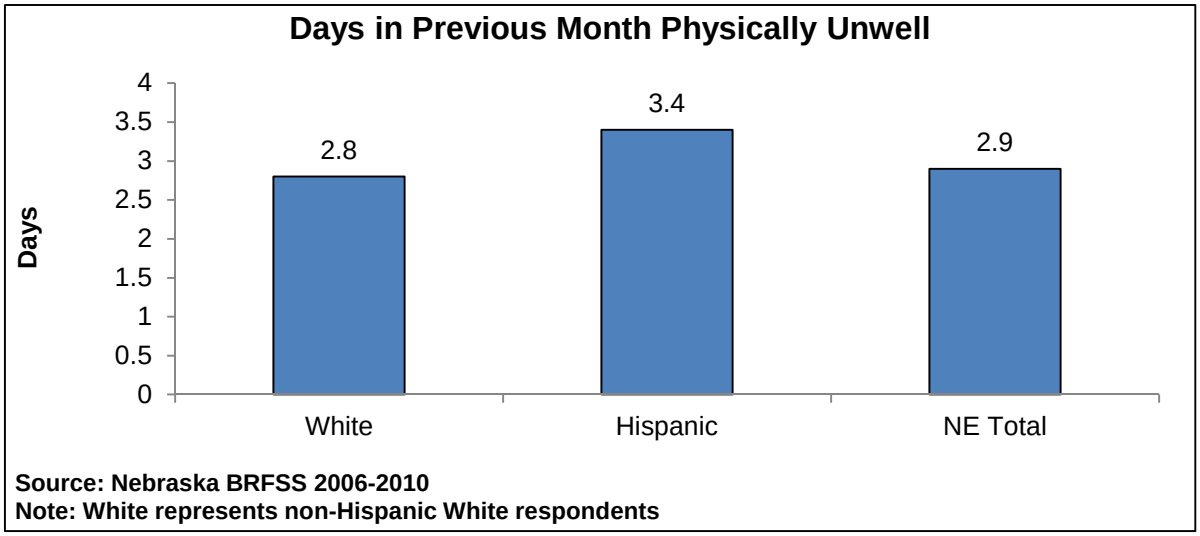
Respondents were asked "would you say that in general your health is: Excellent? Very Good? Good? Fair? Or Poor?" Hispanic adults in Nebraska were more likely (25%) than White adults (11%) to have fair or poor health. Twelve percent of all Nebraska adults have fair or poor health.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Physically Unwell

In 2006-2010, the BRFSS asked respondents to report how many days during the previous month did they feel physically unwell. Hispanics experienced an average of 3.4 days physically unwell in the previous month, compared to 2.8 days among Whites.

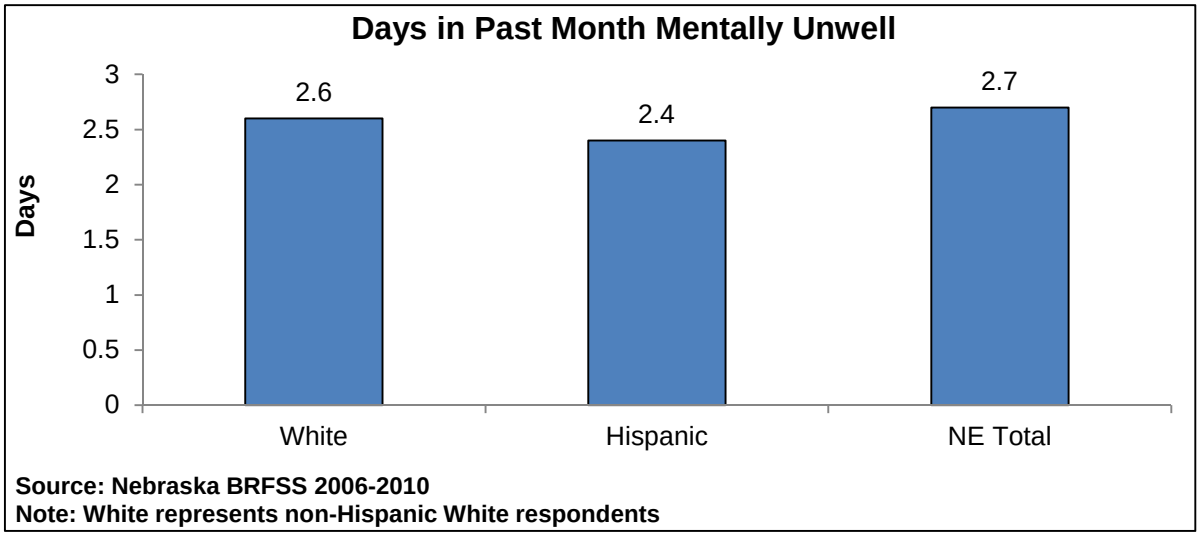


Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Mentally Unwell: Average Days

Respondents were asked about the average (mean) number of days that one's mental health was not good.

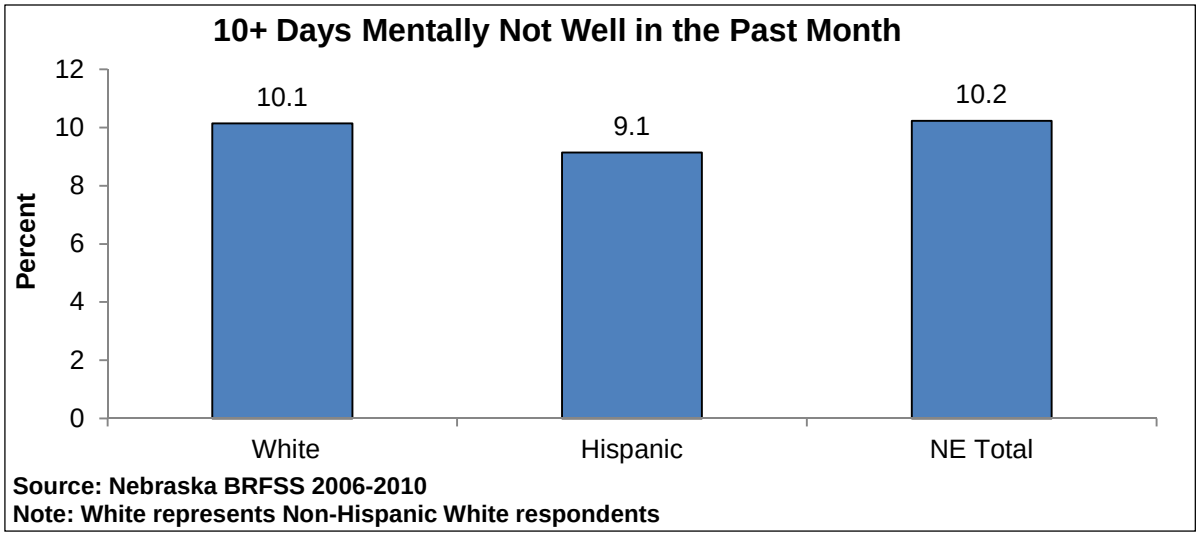
Hispanic Nebraskans experienced an average of 2.4 days mentally unwell in the previous month.



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Mentally Unwell: 10+ Days

Unlike the chart above, the chart below illustrates the percentage of people who reported being mentally unwell 10 or more days in the past month that the respondent was mentally unwell. In 2006-2010, 10.2% of Nebraska adults reported not being mentally well at least 10 days in the past month. The rate was lower for Hispanics (9.1%), than for Whites (10.1%).

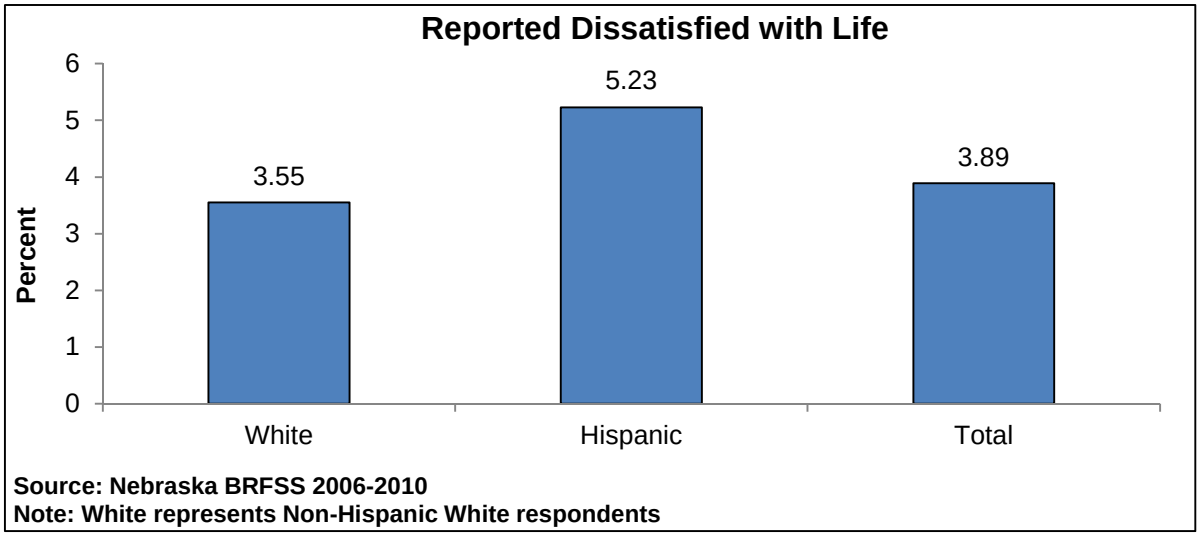


Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Life Satisfaction

Dissatisfied with Life

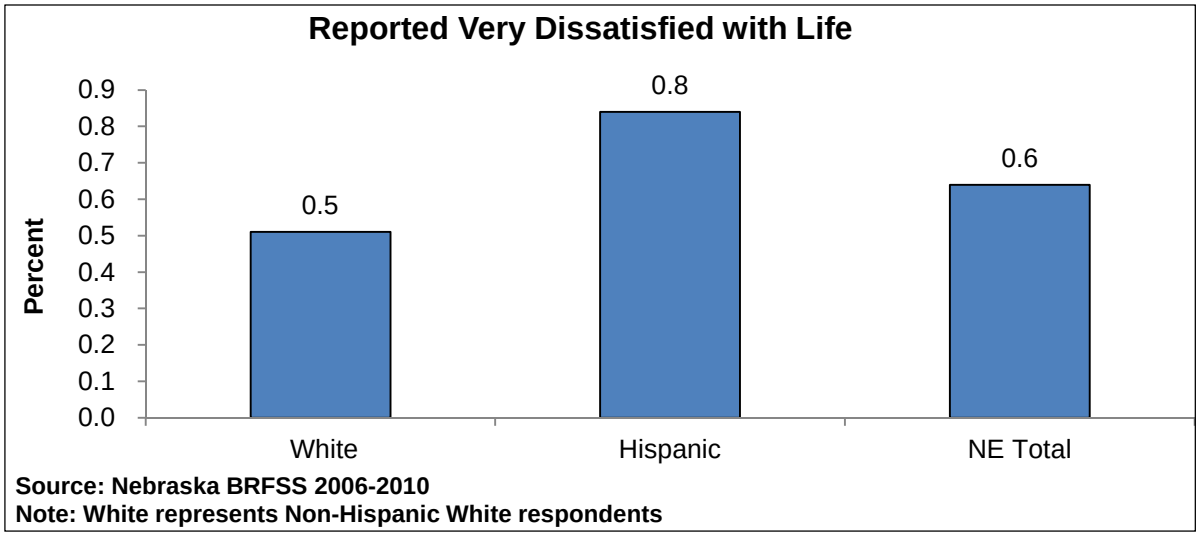
The question asked to gauge satisfaction with life was; “In general, how satisfied are you with your life: Very satisfied? Satisfied? Dissatisfied? Very Dissatisfied?” Hispanics were more likely to report being dissatisfied with life (5.23%), compared to Whites (3.55%).



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Very Dissatisfied with Life

Unlike the indicator above that illustrates those who are dissatisfied with life, this chart discusses those who are *very* dissatisfied with life. Hispanic adults (0.8%) in Nebraska were more likely than White adults (0.5%) to be very dissatisfied with their life.

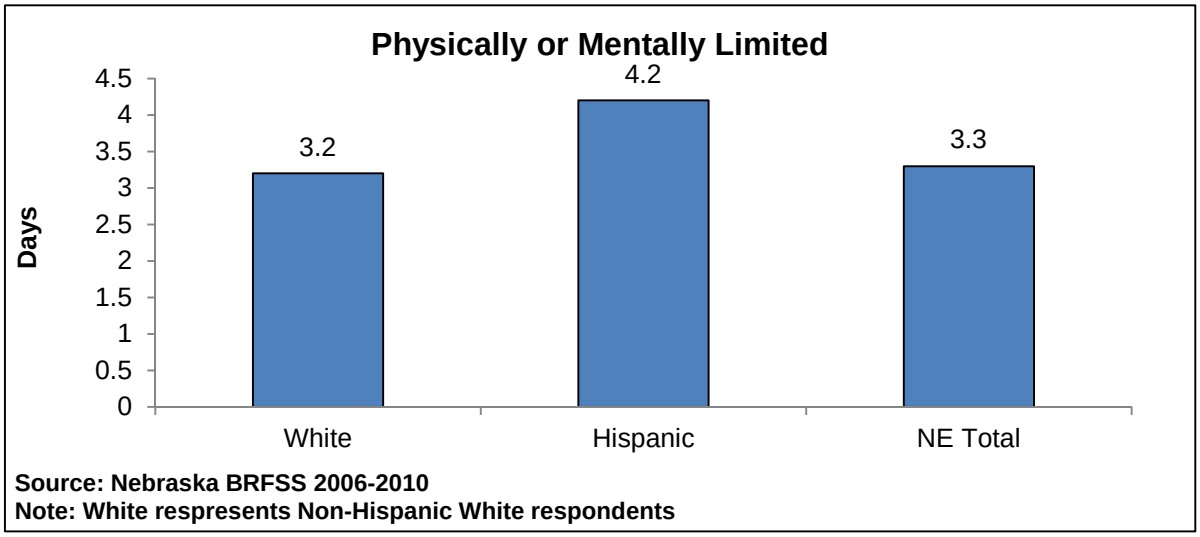


Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Activity Limitation

Activity Limitation: Average Days

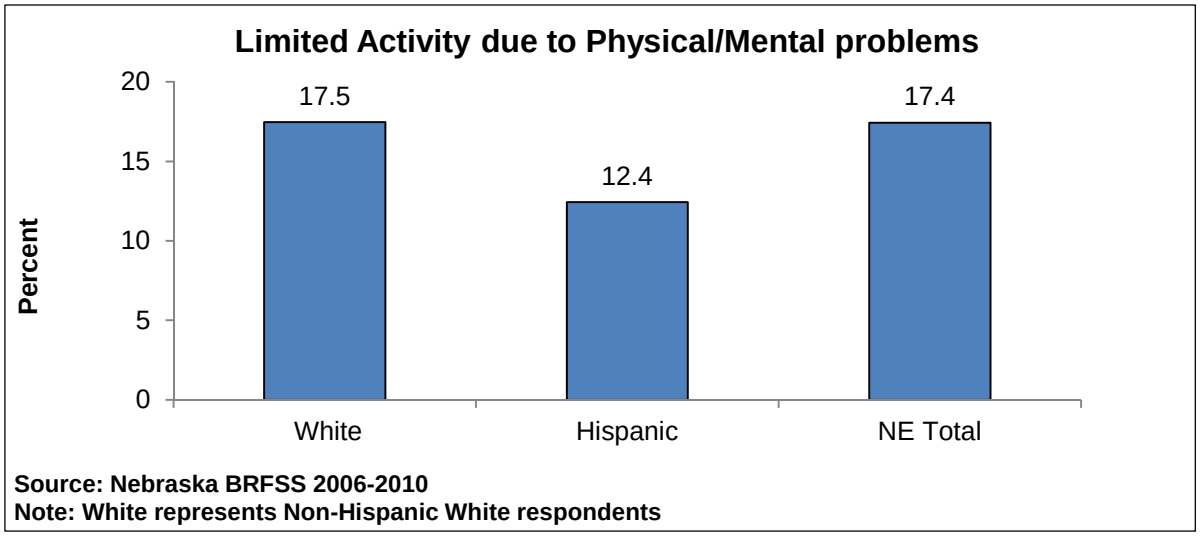
Adults in this survey were read the following description of activity limitation: “Are you limited in any way in any activities because of physical or emotional problems?” Hispanic Nebraskans averaged 4.2 days of activity limitation due to physical or mental problems in the previous month, compared to 3.2 days among Whites.



Source: Nebraska BRFSS 2006-2010
Note: White respresents Non-Hispanic White respondents

Activity Limitation

Unlike the chart above, this chart illustrates people who were physically or mentally limited in the past month. Hispanic adults (12.4%) experienced lower rates of activity limitation than Non-Hispanic/Latino White adults (17.5%).

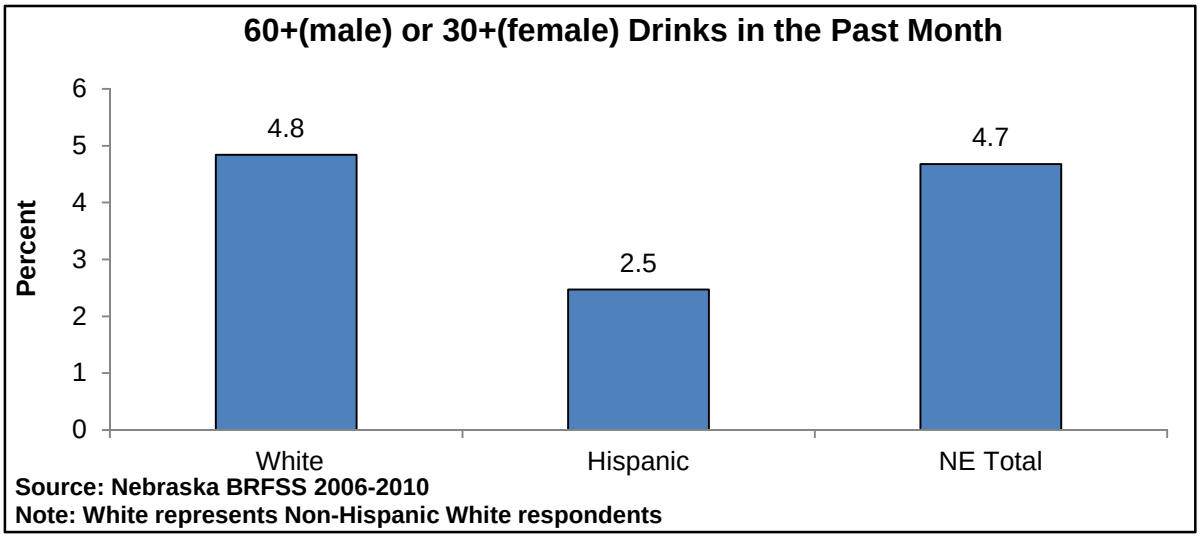


Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Alcohol Consumption

Heavy Drinking

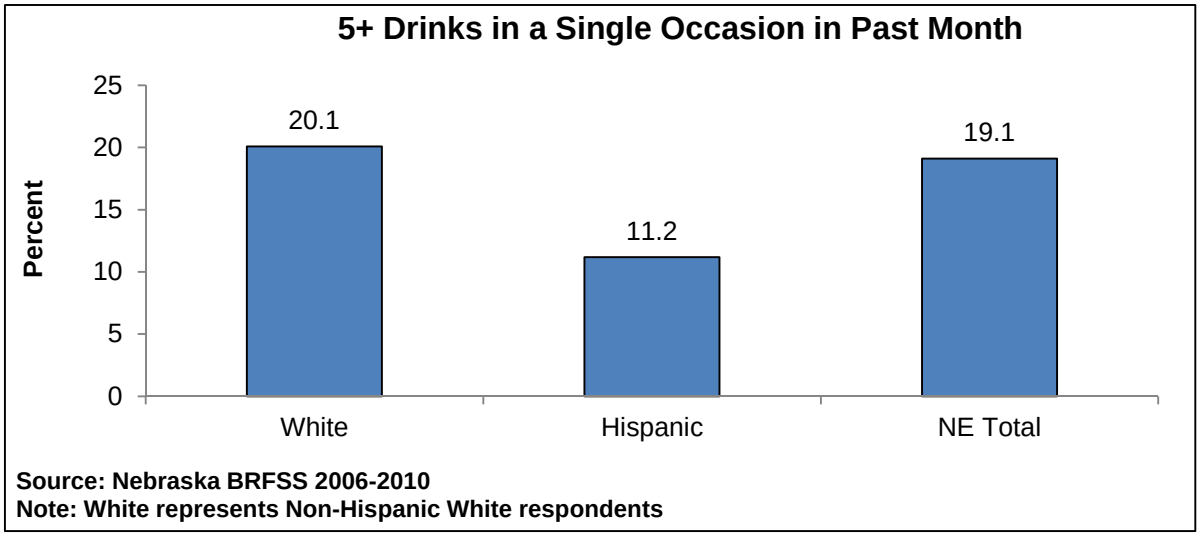
Heavy drinking refers to self-reported consumption of more than 60 drinks for men (an average of more than two drinks per day) and 30 drinks for women (an average of more than one drink per day) during the past month or 30 days preceding the survey. Hispanic adults (2.5%) in Nebraska were slightly less likely than White adults (4.8%) to have reported heavy drinking.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Binge Drinking

In this report, binge drinking refers to self-reported consumption of five or more drinks in one occasion during the previous month for both genders. The current definition of binge drinking (after 2006) is men drinking 5 or more drinks and women drinking 4 or more in one occasion over the past 30 days. In Nebraska in 2006-2010, 11% of Hispanics reported binge drinking, compared to 20.1% of Whites.

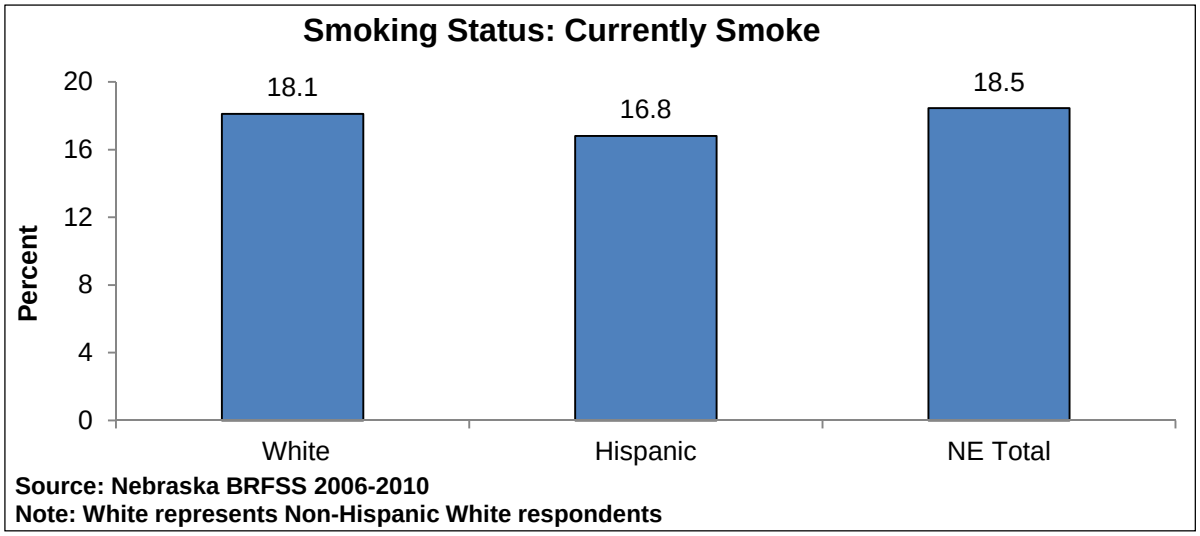


Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Tobacco Use

Cigarette Smoking

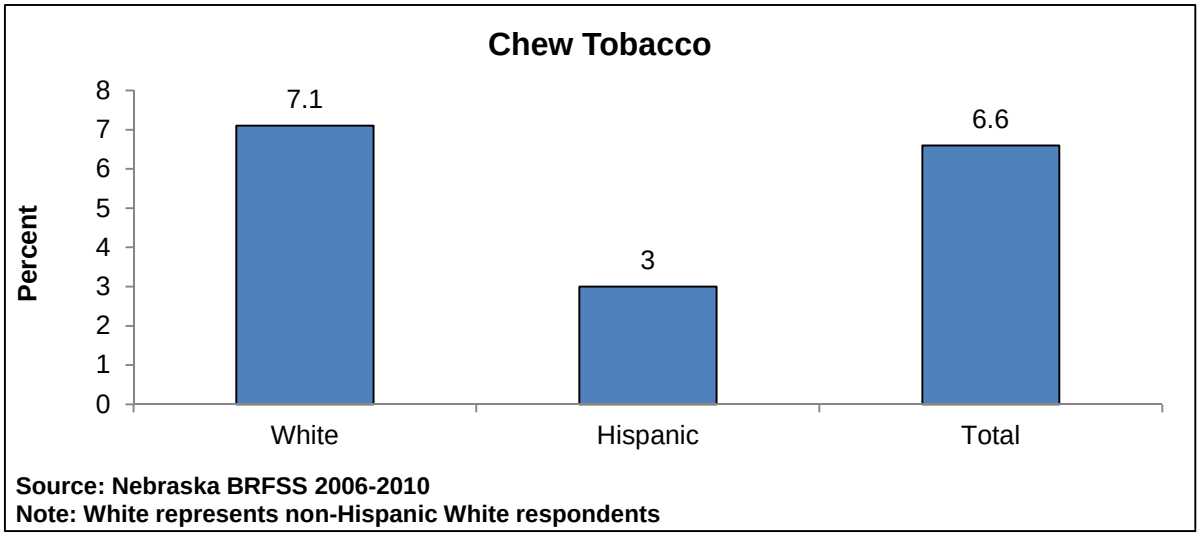
Cigarette smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung disease. Smoking may also result in injuries, death, and environmental damage due to fire. Respondents were classified as current smokers if they reported smoking at least 100 cigarettes in their lifetime, currently smoked, and smoked all of the past 30 days. Hispanic adults (16.8%) in Nebraska were less likely than White adults (18%) to be current smokers.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Chew Tobacco

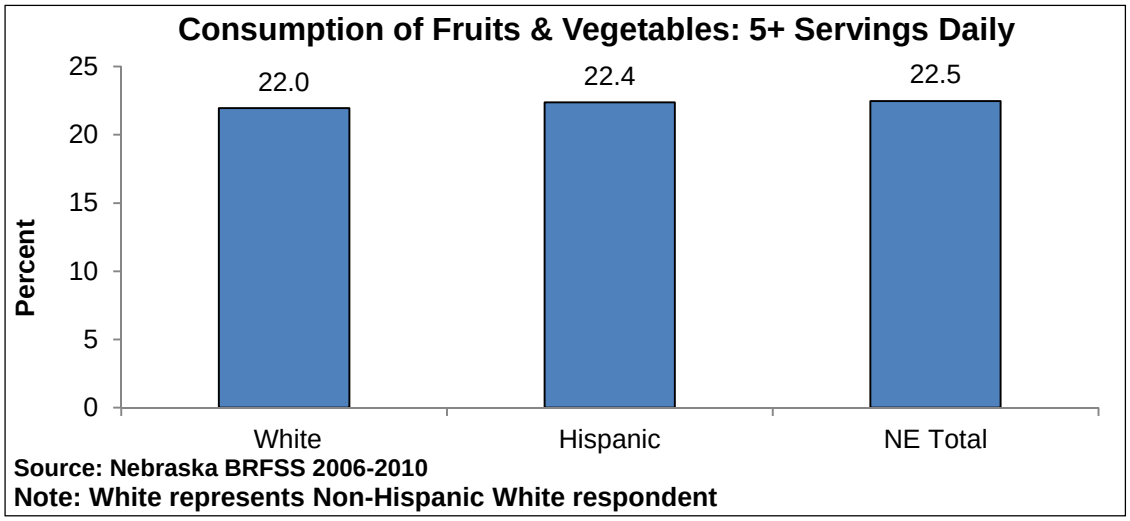
In the 2006-2010 BRFSS respondents were asked, 'Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?' Three percent of Hispanic Nebraskans chew tobacco, compared to 7.1% of Whites.



Source: Nebraska BRFSS 2006-2010
Note: White represents non-Hispanic White respondents

Consumption of Fruits and Vegetables

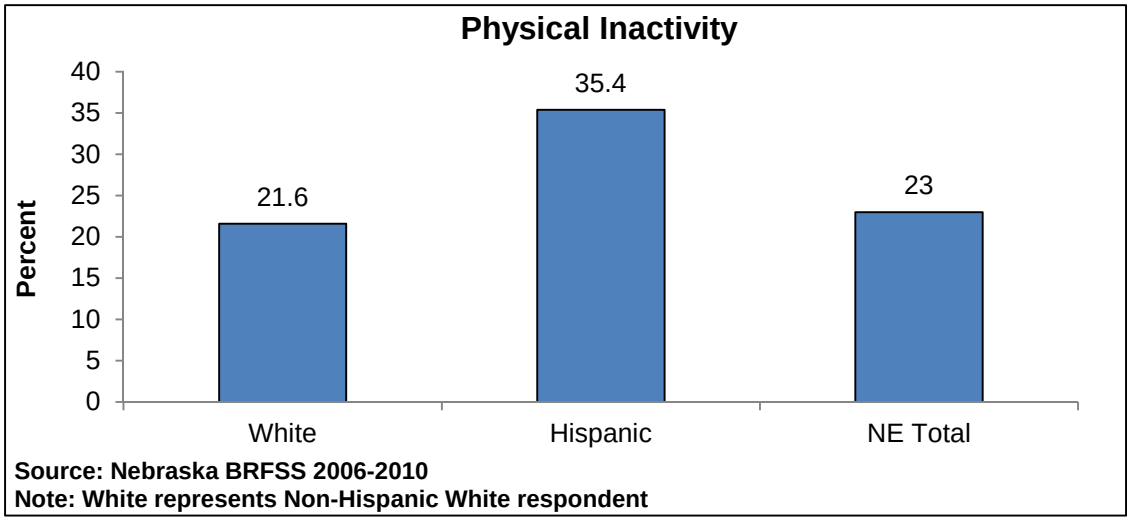
The 2000 Dietary Guidelines for Americans recommended five or more servings of fruits and vegetables per day for good nutrition. These guidelines serve as the basis for BRFSS questions on fruits and vegetables. BRFSS respondents were asked a series of questions about the foods and drinks they usually consumed. Hispanic adults (22.4%) in Nebraska were about as likely as White adults (22%) to have consumed five or more servings of fruits and vegetables per day.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

Physical Inactivity

A person is said to be physically inactive when they answer "no" to the 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?" or respondent reports performing an aerobic physical activity bout for less than 10 minutes in duration or respondent reports performing a nonaerobic activity. Approximately 35% of Hispanics are physically inactive, compared to 21.6% of Whites and 23% of Nebraska as a whole.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

Overweight and Obesity

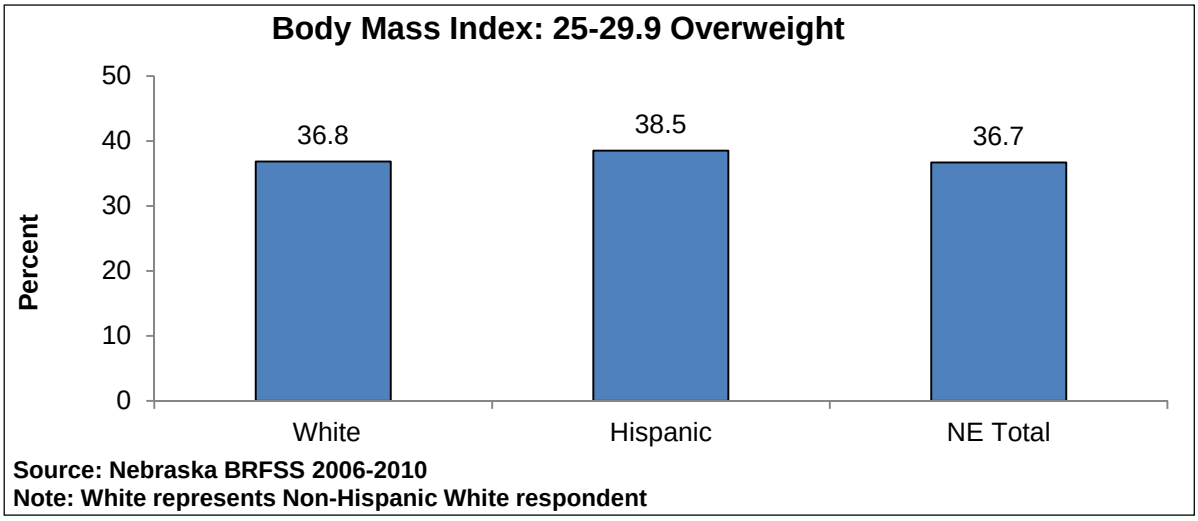
Being overweight or obese substantially raises the risk of illness from heart disease and stroke; high blood pressure; elevated blood cholesterol levels; type 2 diabetes; endometrial, breast, and colon cancers; liver and gallbladder disease; arthritis; sleep disturbances; and breathing problems. Obese persons (both children and adults) may also suffer from social stigmatization, discrimination, and low self-esteem.

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 but not obese: 25.0 to 29.9
- Overweight or Obese: 25.0 or greater
- Obese: 30.0 or greater

BMI 25-29.9: Overweight

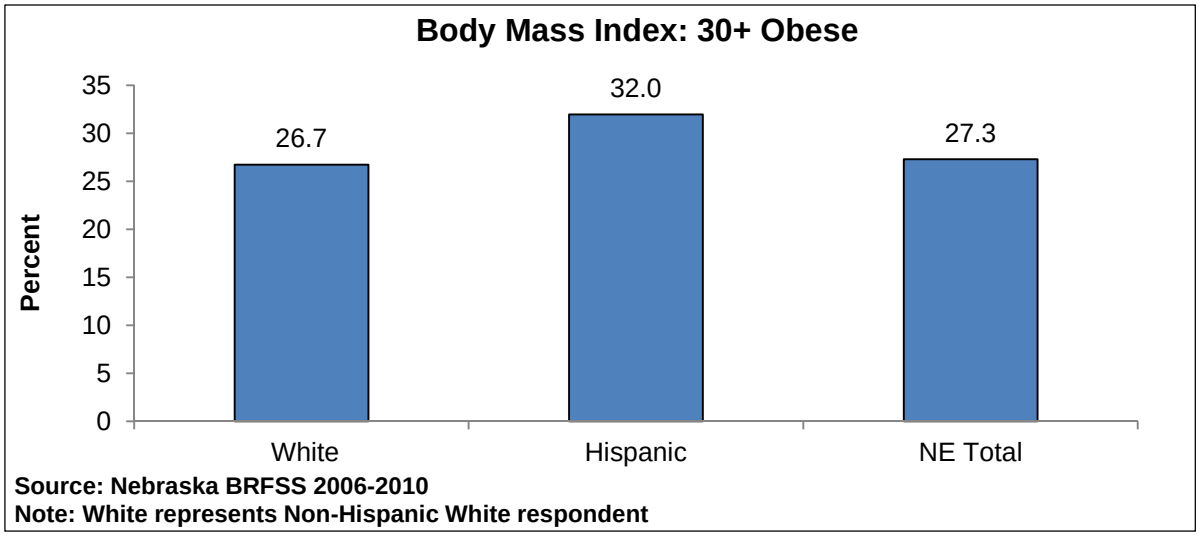
In 2006-2010, 36.7% of all Nebraska adults had a BMI between 25 and 29.9. The rate of reported BMI 25-29.9 was slightly higher for Hispanics (38.5%) than for Non-Hispanic/Latino Whites (36.8%).



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

BMI 30+: Obese

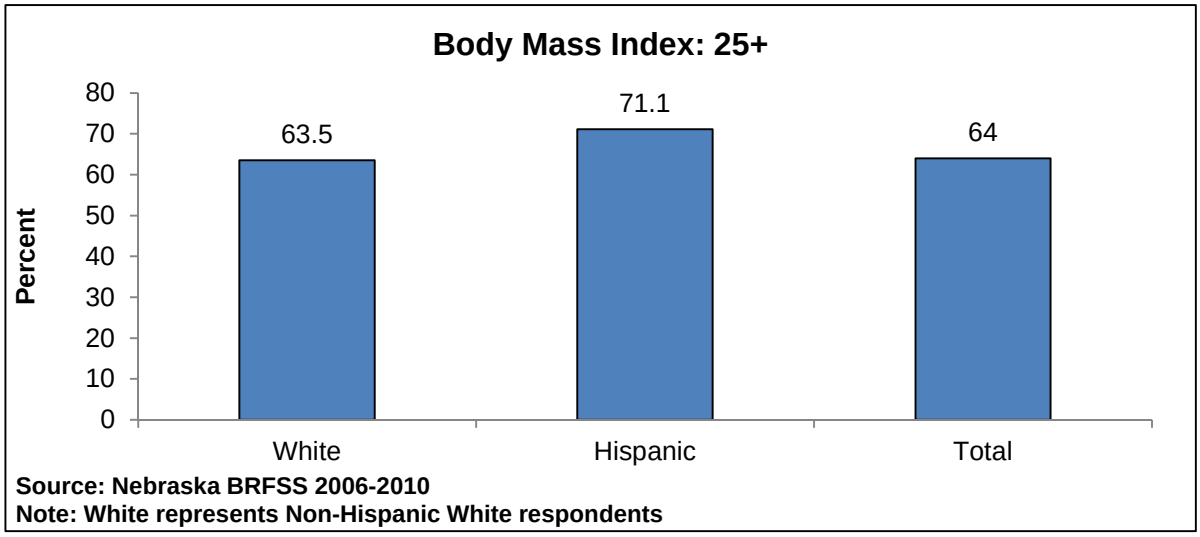
In the 2006-2010 BRFSS, 27.3% of Nebraska adults had a BMI of 30 or above. The rate of reported BMI 30 or above was higher for Hispanics (32.0%) than for Whites (26.7%).



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondent

BMI 25+: Overweight or Obese

In 2006-2010, 71% of Hispanics had a BMI of 25 or greater, compared to approximately 64% of Whites and of the Nebraska total.



Source: Nebraska BRFSS 2006-2010
Note: White represents Non-Hispanic White respondents

Appendix

Hispanic/Latino Profile of General Population and Housing Characteristics: 2010

Subject	Number	Percent
SEX AND AGE [1]		
Total population	167,405	100.0
Under 5 years	22,728	13.6
5 to 9 years	20,144	12.0
10 to 14 years	17,034	10.2
15 to 19 years	15,542	9.3
20 to 24 years	14,643	8.7
25 to 29 years	14,991	9.0
30 to 34 years	13,914	8.3
35 to 39 years	12,357	7.4
40 to 44 years	10,269	6.1
45 to 49 years	7,896	4.7
50 to 54 years	6,083	3.6
55 to 59 years	4,272	2.6
60 to 64 years	2,872	1.7
65 to 69 years	1,730	1.0
70 to 74 years	1,136	0.7
75 to 79 years	847	0.5
80 to 84 years	536	0.3
85 years and over	411	0.2
Median age (years)	22.8	(X)
16 years and over	104,366	62.3
18 years and over	98,221	58.7
21 years and over	88,916	53.1
62 years and over	6,254	3.7
65 years and over	4,660	2.8
Male population	88,149	52.7
Under 5 years	11,710	7.0
5 to 9 years	10,213	6.1
10 to 14 years	8,773	5.2
15 to 19 years	8,127	4.9
20 to 24 years	7,943	4.7
25 to 29 years	8,208	4.9
30 to 34 years	7,414	4.4
35 to 39 years	6,628	4.0
40 to 44 years	5,609	3.4
45 to 49 years	4,280	2.6
50 to 54 years	3,300	2.0
55 to 59 years	2,239	1.3
60 to 64 years	1,479	0.9
65 to 69 years	888	0.5
70 to 74 years	571	0.3
75 to 79 years	379	0.2
80 to 84 years	230	0.1

Subject	Number	Percent
85 years and over	158	0.1
Median age (years)	23.3	(X)
16 years and over	55,794	33.3
18 years and over	52,617	31.4
21 years and over	47,731	28.5
62 years and over	3,048	1.8
65 years and over	2,226	1.3
Female population	79,256	47.3
Under 5 years	11,018	6.6
5 to 9 years	9,931	5.9
10 to 14 years	8,261	4.9
15 to 19 years	7,415	4.4
20 to 24 years	6,700	4.0
25 to 29 years	6,783	4.1
30 to 34 years	6,500	3.9
35 to 39 years	5,729	3.4
40 to 44 years	4,660	2.8
45 to 49 years	3,616	2.2
50 to 54 years	2,783	1.7
55 to 59 years	2,033	1.2
60 to 64 years	1,393	0.8
65 to 69 years	842	0.5
70 to 74 years	565	0.3
75 to 79 years	468	0.3
80 to 84 years	306	0.2
85 years and over	253	0.2
Median age (years)	22.2	(X)
16 years and over	48,572	29.0
18 years and over	45,604	27.2
21 years and over	41,185	24.6
62 years and over	3,206	1.9
65 years and over	2,434	1.5
RELATIONSHIP [1]		
Total population	167,405	100.0
In households	163,772	97.8
Householder	41,064	24.5
Spouse [2]	22,207	13.3
Child	69,720	41.6
Own child under 18 years	59,241	35.4
Other relatives	17,966	10.7
Under 18 years	7,821	4.7
65 years and over	987	0.6
Nonrelatives	12,815	7.7
Under 18 years	1,691	1.0
65 years and over	118	0.1
Unmarried partner	4,777	2.9
In group quarters	3,633	2.2
Institutionalized population	1,873	1.1

Subject	Number	Percent
Male	1,575	0.9
Female	298	0.2
Noninstitutionalized population	1,760	1.1
Male	971	0.6
Female	789	0.5
HOUSEHOLDS BY TYPE [3]		
Total households	41,064	100.0
Family households (families) [4]	32,349	78.8
With own children under 18 years	23,008	56.0
Husband-wife family	21,318	51.9
With own children under 18 years	15,224	37.1
Male householder, no wife present	4,219	10.3
With own children under 18 years	2,532	6.2
Female householder, no husband present	6,812	16.6
With own children under 18 years	5,252	12.8
Nonfamily households [4]	8,715	21.2
Householder living alone	5,814	14.2
Male	3,513	8.6
65 years and over	367	0.9
Female	2,301	5.6
65 years and over	621	1.5
Households with individuals under 18 years	25,291	61.6
Households with individuals 65 years and over	3,536	8.6
Average household size	3.65	(X)
Average family size	**4.01**	**(X)**
HOUSING TENURE [3]		
Occupied housing units	41,064	100.0
Owner-occupied housing units	20,229	49.3
Population in owner-occupied housing units	80,253	(X)
Average household size of owner-occupied units	3.97	(X)
Renter-occupied housing units	20,835	50.7
Population in renter-occupied housing units	69,765	(X)
Average household size of renter-occupied units	3.35	(X)

"X Not applicable. [1] When a category other than Total Population is selected, all persons in the household are 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] When a category other than Total Population is selected, all persons in the household are classified by the race, Hispanic or Latino origin, or tribe/tribal grouping of the householder.
[4] "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 are 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 are tabulated in nonfamily households. "Nonfamily households" consist of people living alone and households which do not have any members related to the householder.
[5] 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."
Source: U.S. Census Bureau, 2010 Census.

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.

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 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.

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.

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."

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 are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are 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 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.

Householder: The person, or one of the people, in whose name the home is owned, being bought, or rented.

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 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.
Infant Death: Death of a person under one year of age.

Injury deaths: Include deaths that are 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 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 Kotelchuk. 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.'

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).

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 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).

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 are 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 are 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%.