

Equalizing Health Outcomes & Eliminating Health Disparities

Strategic Plan of the Nebraska Office of Minority Health

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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT

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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



Table of Contents

Executive Summary.....	1
History	2
The Office of Minority Health: A Description	4
Vision.....	4
Mission	4
Core Functions	4
The Plan.....	4
Goals and Objectives	4
Goal 1	4
Goal 2	5
Goal 3	6
Goal 4	7
Moving Forward -- Strategic Challenges.....	8
Demographic Change.....	8
Racial and Ethnic Minorities	8
Immigrants, Refugees, and Migrant Workers.....	8
Racial and Ethnic Minorities, Culture, and Health.....	9
Health Status of the Population.....	10
Mortality.....	10
Infant Mortality	10
Child Mortality	12
Adult Mortality	13
Physical Health.....	15
Infant Physical Health	15
Maternal Physical Health.....	16
Child Physical Health	17
Adult Physical Health	18
Behavioral Health and Substance Abuse	19
Infant Behavioral Health and Substance Abuse	20
Maternal Behavioral Health and Substance Abuse.....	20
Child Behavioral Health and Substance Abuse	20
Adult Behavioral Health and Substance Abuse	21
Social and Institutional Health	24
Refugees, Immigrants, and Migrant Workers.....	25
Access to Health Care.....	26
Health Insurance	26
Status of Health Care Providers.....	27
Provider Perceptions.....	27
Status of Minority Health Service Providers.....	28
Translation and Transportation.....	28
Quality.....	29
Culturally Competent and Linguistically Appropriate Health Care	29
References	32

Executive Summary

Health disparities are a prominent issue nationally as well as in Nebraska. *Healthy People 2010* defines two overarching goals: increasing the quality and years of healthy life and eliminating health disparities in the United States¹. The *Nebraska 2010 Health Goals and Objectives* outlines a set of health goals and objectives to be achieved by 2010. These goals are consistent with the national goals: eliminating health disparities and increasing the quality and years of healthy life for all people in Nebraska. The question is how to move this agenda forward in a way that optimizes resources and prioritizes needs.

As the Nebraska Health and Human Services System moves to make improvements to transform public health in our state², the Office of Minority Health serves as a catalyst for this transformation by identifying and advocating for populations that are disproportionately affected by illness. Given its finite resources, the Office of Minority Health allocates resources to those minority-serving public health institutions that meet the greatest needs while helping develop local synergies in existing structures. It must identify and address health concerns for segments of the Nebraskan population that are often overlooked. To optimize existing resources and focus acquisition of new resources, it proceeds strategically. This document represents an outline of the Office of Minority Health's current plan to achieve these ends while facilitating the achievement of the state's 2010 Health Goals and Objectives.

The goals of the Nebraska Office of Minority Health are:

Goal 1. Become the centralized source for information relevant to the health of minorities in Nebraska.

Goal 2. Provide strong and effective leadership in advocating for policies and programs to ensure access of racial/ethnic minorities to comprehensive health services in Nebraska.

Goal 3. Become the leading source of information, advocacy and training for cultural competency in the Nebraska health care system.

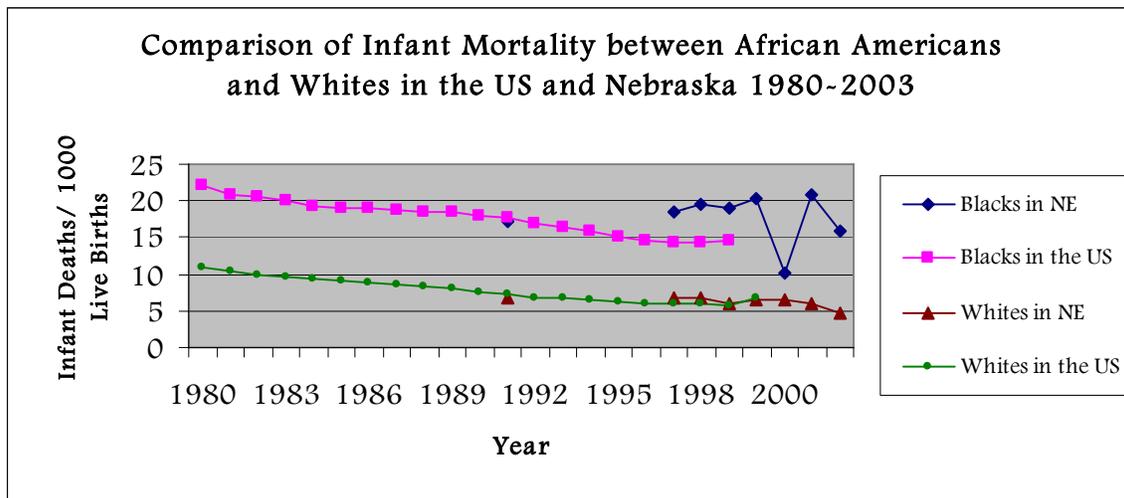
Goal 4. Enhance Nebraska's Public Health infrastructure to better meet the health needs of racial/ethnic minorities.

HISTORY

In public health, the infant mortality rate has traditionally been indicative of the existence of unmet health needs and unfavorable environmental factors such as economic conditions, nutrition, education, sanitation, and medical care³. In this way, infant mortality is a benchmark for the evolution of public health in Nebraska.

In 1991, the infant mortality rate in the state of Nebraska was 7.5/1000 live births⁴. The corresponding infant mortality rate for the U.S. was 8.9 infant deaths⁵. While on the surface it appeared as though Nebraska was ahead of the nation in meeting the health needs of its citizens, this was only partially true.

(Figure 1)



A closer analysis reveals an infant mortality rate of 17.2 for African American residents of the state. From 1993-1997 the infant mortality rate for African Americans in Nebraska was 17.1 infant deaths per 1,000 live births while the corresponding infant mortality rate for White infants was 7.6⁶. Furthermore, the infant mortality rate for African Americans continued to worsen, and during 1997 and 1998 Nebraska had the highest African American infant mortality rate in the nation (Figure 1)⁷. In fact, the relative risk of an African American child dying in Nebraska continued to be significantly higher in Nebraska than for African American infants in the U.S. as a whole (Figure 2)⁸.

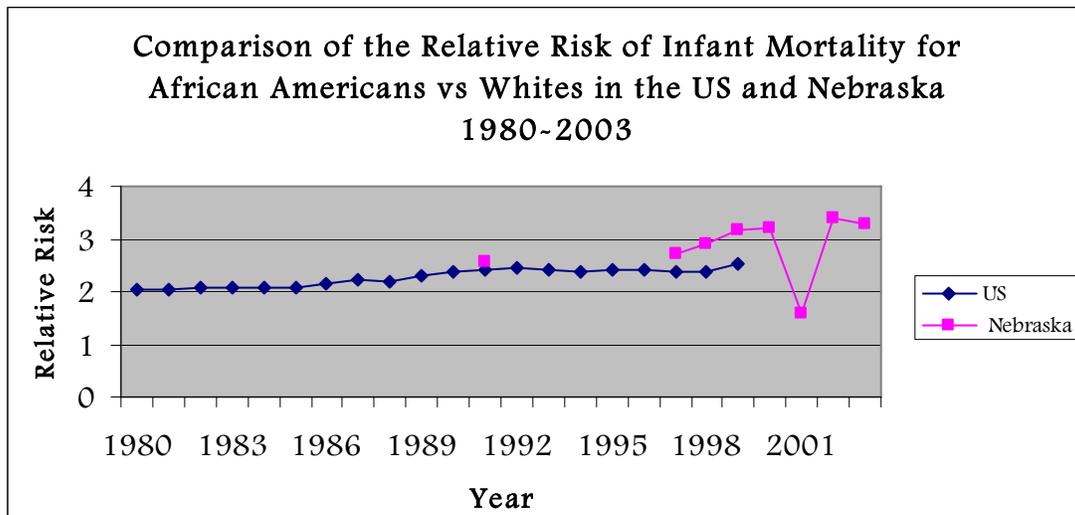
In response to this and the lack of substantial improvement in Nebraska’s overall infant mortality rate since 1992, former Governor Mike Johanns formed Nebraska’s Blue Ribbon Panel on Infant Mortality in 1999⁹. The panel acknowledged the widening disparity of infant mortality rates between African American and White infants and proposed recommendations to correct this problem¹⁰.

The Blue Ribbon Panel recommended the establishment of the Nebraska Minority Health Initiative, which is funded by the Health Care Cash Fund. These dollars were to fund interventions including case management, health behavior modification, social support and

Did You Know?
 In 1997-1998, Nebraska’s infant mortality rate for African Americans was the highest in the nation.

empowerment, prevention education, support of the role of fathers, and an integrated delivery system. The panel also recommended establishing a campaign that encouraged and supported efforts to increase the number of ethnic minority health care providers in the state¹¹.

(Figure 2)



During the late 1980s, a Minority AIDS Task Force was created in Lincoln. From this arose the Nebraska Minority Health Coalition, which approached the Director of Health in 1991 to advocate for the creation of a state agency-level Office of Minority Health. A 1992 report on the Health Status of Nebraska’s racial and ethnic minorities further reinforced this need. The Nebraska Office of Minority Health was created that same year.

Since its establishment, the Office of Minority Health has provided information and resources to address the disparity in the overall quality of health and quality of life for racial and ethnic minorities in Nebraska. Immediately upon its creation, the Office began to gather data¹² and work with the minority, professional, and public health communities to frame the issues that are associated with health and health care disparities in the state¹³. Although personnel have changed, the Office of Minority Health represents a solid component in Nebraska’s efforts to provide focus and support for health care professionals, community advocates, and consumers to develop effective ways of addressing the challenges faced by our rapidly changing and culturally diverse society¹⁴.

While the following pages examine the health status and disparities of the populations served by the Office of Minority Health; below are its Vision, Mission, Core Functions (based on the ten essential functions of public health), and Goals and Objectives of its strategic plan. Sources for input in formulating these strategies are as diverse as Nebraska, including stakeholders who are representatives of the entire state.

The Office of Minority Health: A Description

Vision

The Vision of the Office of Minority Health is to provide the infrastructure that allows all of its citizens to lead healthy and productive lives.

Mission

The Mission of the Office of Minority Health is to improve the health status of racial/ethnic minorities, Native Americans, refugees, and newly arrived immigrant groups in Nebraska.



Core Functions

1. Monitoring health problems and hazards and advocating for health equity.
2. Increasing public awareness about health disparities through information, education and empowerment.
3. Improving access to health services.
4. Promoting and advocating for cultural awareness and competency in the healthcare workforce.
5. Monitoring, collecting, developing, and providing relevant statistical data to identify health status.
6. Reviewing, evaluating, and recommending policies and programs to assure effective access and culturally competent health services.
7. Increasing representation in science and health professions of racial and ethnic minorities, Native Americans, and refugees and newly arrived immigrants.
8. Promoting and mobilizing collaboration and partnerships among federal, regional and state agencies, and community organizations.
9. Expanding community-based health promotion and disease prevention outreach efforts.
10. Developing grants and other resources.

The Plan

Goals and Objectives

Goal 1. Become the centralized source for information relevant to the health of minorities in Nebraska.

Objectives:

1. Establish and maintain the connections needed to gain access to all current information and analyses relevant to minorities in Nebraska.
 - a. Action: Organize a Nebraska Minority Health Information network (various NHHSS offices, UNMC, UNL, UNO, Creighton, UNK, Hastings College, tribal and urban Indian health organizations, local health departments, federally qualified health centers, etc)
 - b. Action: Coordinate with Epidemiologists internal and external to NHHSS.
2. Maintain on the OMH website current minority health data and analyses and direct links to relevant information on other websites.

3. Collaborate on publication of regular reports on minority health.
 - a. Action: Support efforts to conduct the Minority Behavioral Risk Factor Survey all counties in which racial/ethnic minorities comprise 5% or more of the population.
 - b. Action: Update quadrennially the *Health Status of Racial and Ethnic Minorities in Nebraska* report.
 - c. Action: Promote and support other studies as needed of health-related factors of minority populations in Nebraska.
4. Advocate for expanded and improved minority health data collection and coordination in Nebraska.
 - a. Action: Advocate for the inclusion of race/ethnicity identifiers in existing or new health data collection systems.
 - b. Action: Advocate for the inclusion of migrant and seasonal farm workers, refugees, and immigrants in minority health data collection and research projects.
 - c. Action: Advocate for the inclusion of socioeconomic variables in minority health data collection and analysis.
 - d. Action: Develop agreements and protocols for sharing de-identified data.
 - e. Action: Tie grant awards not only to the provision of service but also to accurate data collection, research, evaluation, and reporting in the area being studied.

Goal 2. Provide strong and effective leadership in advocating for policies and programs to ensure access of racial/ethnic minorities to comprehensive health services in Nebraska.

Objectives:

1. Educate the general public on health disparities.
 - a. Action: Minority Health Conference
 - b. Action: Billboards and other advertising media
2. Maintain on the OMH website current and comprehensive information on health equity issues for racial/ethnic minorities in Nebraska and strategies for addressing those issues.
 - a. Action: Publish comparative analysis of funds spent in Nebraska on minority public health – impact statements (lost wages, etc.)
3. Partner with the Minority Public Health Association, the Public Health Association, the Offices in Health Services, and other key public health leadership in developing and advocating for a priority public policy agenda for minority health equity, targeting policy makers and elected officials.
 - a. Action: Collaborate on the development of a two-year priority minority health public policy agenda.
 - b. Action: Co-sponsor annual Minority Health Lobby Day to advocate for the public policy agenda.
 - c. Action: Co-sponsor quadrennial Public Health Leadership Summits to identify long-range public policy and program goals.
4. Advocate for improved health coverage for racial/ethnic minorities.
 - a. Action: Develop more comprehensive information on public (Medicaid and Medicare) and private insurance coverage of minority population groups across the state. This may entail collaboration with state wide Managed Care Organizations (MCOs) and the state hospital association.
 - b. Action: Develop and implement a system to obtain feedback from health care providers who serve minority clients on the health coverage status of clients and how they address problems that occur due to lack of coverage.
 - c. Action: Develop a strategy with key stakeholders for providing improved health coverage.

5. Establish an ongoing program to educate key policymakers and legislators on issues impacting health disparities and our progress on meeting the goals established by the Minority Health Equity Work Plan.
 - a. Action: Collaborate on a semiannual “Lunch and Learn” program.
 - b. Action: Quarterly newsletter to policy makers and other stakeholders on health disparity issues.
6. Advocate for policies and projects to ensure that counties or local public health districts each have a plan for disaster/emergency planning with specific goals and objectives for racial/ethnic minorities.

Goal 3. Become the leading source of information, advocacy and training for cultural competency in the Nebraska health care system.

Objectives:

1. Educate public health providers about federal laws that require culturally competent, linguistically appropriate healthcare that protects minority health care consumers.
 - a. Action: Offer training to targeted public health providers on federal Culturally and Linguistically Appropriate Services (CLAS) standards, enforceable through the Civil Rights Act of 1964.
 - b. Action: Promote training within Nebraska Health and Human Services System in a language assistance module for Executive Order 13166, to reduce language barriers to health care services, and CLAS standards.
2. Promote cultural proficiency through curricula for organizations and providers of healthcare services to include:
 - a. Action: Develop and coordinate strategies to ensure health care providers serving minority populations in Nebraska have completed cultural competent training modules from the DHHS Office of Minority Health, www.thinkculturalhealth.org.
 - b. Action: Provide cultural diversity training to targeted health care providers.
3. Ensure the implementation of CLAS standards statewide.
 - a. Action: Collaborate with public health stakeholders on strategies to implement the CLAS standards statewide.
 - b. Action: Develop and implement procedures to evaluate and make recommendations on CLAS compliance of targeted public health providers in collaboration with other public health stakeholders.
4. Increase the number of racial and ethnic minority providers of health care in the state.
 - a. Action: Work with the Indian Health Service, U.S. Public Health Service, and University medical centers and their pipeline programs to develop and implement strategies to increase the number of racial and ethnic minority providers of health care in the state.
 - b. Action: Sponsor Career Fairs for health, allied health, behavioral health and public health professions in conjunction with ethnic community centers and institutions of higher learning statewide.
 - c. Action: Sponsor “shadow a health care professional” annually in April during Minority Health Month.
 - d. Action: Sponsor recruitment days at area middle/high schools with colleges/universities offering any health care certificate/degree.
 - e. Action: Promote minority health professional recruitment poster project.
 - f. Action: Solicit medical centers/colleges/centers offering a certificate as vendors for Minority Health Conference.
 - g. Action: Facilitating the re-licensing of immigrants and refugees who have been trained in other countries.

5. Follow up with the Office of Civil Rights on complaints about providers failing to supply an interpreter.
6. Training of public health and medical personnel across state on CLAS and cultural competency, to include current and upcoming students/residents

Goal 4. Enhance Nebraska's Public Health infrastructure to better meet the health needs of racial/ethnic minorities.

Objectives:

1. Increase the level of collaboration and cooperation among public health system partners.
 - a. Action: Identify and maintain a comprehensive database of public health partners, including both traditional and non-traditional, faith-based and community-based, within and external to state government.
 - b. Action: Bring public health partners together to identify and develop opportunities for collaborating on minority health programs.
2. Move public health partners forward to meet the Nebraska Healthy People 2010 goals and objectives, Turning Point, and Evaluation-based programming.
 - a. Action: Raise awareness among public health partners about health disparities and their negative impact on communities.
 - b. Action: Work with public health partners to develop of Nebraska Minority Health Equity Work Plan as a cohesive strategy for collaboration on community programs that help to meet the Nebraska Healthy People 2010 health goals and objectives.
3. Increase levels of funding for minority health programs.
 - a. Action: Dedicate an OMH staff member to grant procurement for program development.
 - b. Action: Work with public health partners to identify sources of funding and develop grant proposals.
 - c. Action: Focus grant procurement and allocation of resources on sustainable programs that are consistent with efforts to meet the 2010 health goals and objectives and utilize or create linkages to community public health partners.
 - d. Action: Tie funding to data collection and reporting.
 - e. Action: Encourage and assist local and regional public health stakeholders to leverage existing state and federal funds to enable development of sustainability plans to respond to present and emerging health needs.

Moving Forward -- Strategic Challenges

Demographic Change

Racial & Ethnic Minorities

Nebraska continues to become more diverse. According to the 2000 Census, the population of Nebraska was 1,711,263. Of that number, the largest minority population in Nebraska was Hispanic (5.5%) followed by Black or African American (4.0%), persons of mixed race (1.4%), Asians (1.3%), and Native Americans (0.9%)¹⁵. The Hispanic/Latino population increased from 36,969 in 1990 to 94,425 in the year 2000. This represents a 155% increase of the Hispanic population in the state over a ten-year period¹⁶.



While the total population of Nebraska increased 2.1% from 2000-2005, the minority population, including persons of mixed race, increased by 14.6%.

Table 1. Growth of Nebraska's Minority Population 2000-2005¹⁷

Racial/Ethnic Group	2000	Percentage of Total	2005	Percentage of Total
Total for NE	1,711,263	100%	1,747,214	100%
African American	68,450.52	4%	74,815	4.3%
Hispanic/Latino	94,119.47	5.5%	11,9975	6.9%
Native American	15,401.37	0.9%	16,562	0.95%
Asian	22,246.42	1.3%	26,746	1.5%
Mixed Race	23,957.68	1.4%	18,859	1.1%
Total Minority	224,175.5	13.1%	256,957	14.7%

The U.S. Census Bureau projects that racial and ethnic minorities will make up 15% of Nebraska's population by 2025. The White population is expected to increase less than ten percent over the next 20-25 years, while the Asian and Hispanic/Latino populations are each expected to increase 82%, the Black/African American population is expected to increase 51%, and the Native American population is expected to increase 56%. With this expected growth in minority populations in Nebraska, it is imperative that efforts be made now to eliminate the disparities in health.

Did You Know?

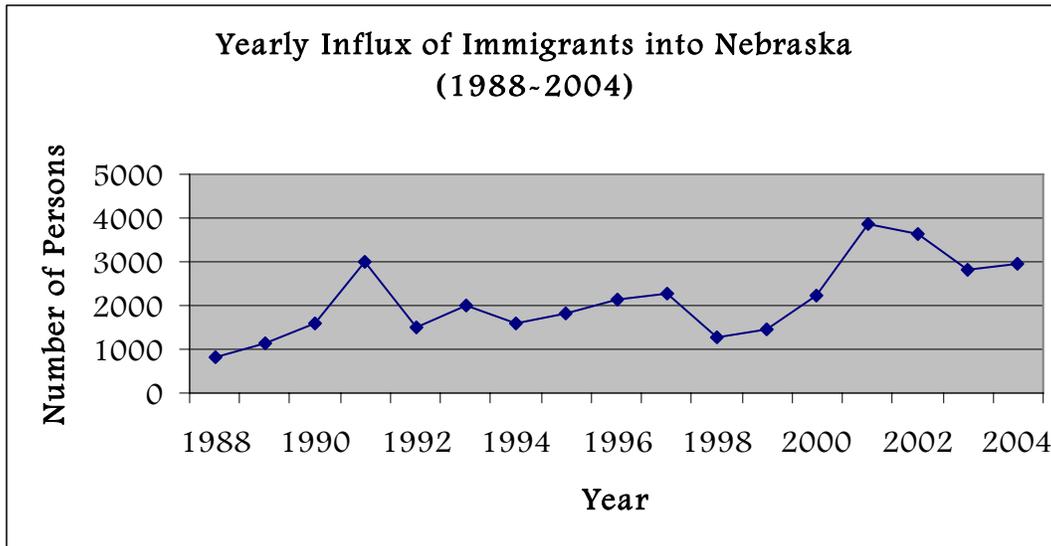
Only recently have people been codified in the U.S. Census as "mixed" or "other" race. One drop of "Black" blood made one Black at various times in American history. During the early settlement of America by Europeans one's race was determined by the race of the mother, since many White males impregnated African women.

Additionally, in 2000, the number of counties in Nebraska with minority populations of 5% or greater was 29. By 2005, that number increased to 33. As of October 2006, six additional counties have between 4% and 5% minority populations.

Immigrants, Refugees, and Migrant Workers

The 2000 Census recorded 74,638 foreign-born residents in Nebraska. This represented 4.4% of Nebraska's overall population and an increase of 164.7% above the 1990 population of foreign-born residents in the state (28,198 residents). Roughly 57.8% of Nebraska's immigrant population arrived in the state since 1990¹⁹. The number of Latinos in Nebraska has increased by 27% since 2000, representing 70% of the state's population growth for that time period²⁰. The overall trend of immigration into Nebraska has been increasing (Figure 3). In fact, in October 2006, the U.S. agreed to receive over 10,000 Burundians from Tanzania.

(Figure 3)¹⁸



The effect of these large increases in immigration on local economies is far different than what might have been expected using traditional models of immigration that focus almost exclusively on labor supply. The impact of a tenfold increase in the Hispanic population in Dawson County, Nebraska increased average wages and boosted the local economy²¹. University of Nebraska professor Henrik Van den Berg explains this impact by saying, “immigrants eat, buy housing, spend on entertainment, and shop locally, they also add to the demand for labor in the local economy”²².

Racial and Ethnic Minorities, Culture, and Health

When examining health issues among racial and ethnic minority populations, it is important to keep in mind the heterogeneity of the racial and ethnic minority groups in Nebraska. Each group has vastly different histories, languages, spiritual practices, demographic patterns, and cultures. It is also important to note that there are significant differences *within* any one racial or ethnic minority group. For example, the needs of Mexican Americans are different from the needs of Puerto Rican Americans or Cuban Americans, yet all are categorized as “Hispanic/Latino.” Likewise, there are differences among the Asian populations in Nebraska (Asian Indians, Iraqi, Afghani, Chinese, Filipino, Japanese, Korean, and Vietnamese), and among the major Native American tribes of Nebraska (Winnebago, Omaha, Santee, Lakota Sioux, and Ponca).

In the case of the Native American nations, there is the added cultural complexity of states interfacing with sovereign nations to develop ongoing services and sharing of resources. State agencies need to receive formal sanction through these tribal hierarchies and need to operate with the formal approval of tribal councils before any transactions can proceed. There are four federally-recognized Native American tribes in Nebraska: the Winnebago, Omaha, Santee, and Ponca.

Health Status of the Population

A more detailed analysis of the health status of Nebraska's population in general and Nebraska's racial and ethnic minorities, refugees, and migrant workers in particular, is provided elsewhere²³. The purpose of this discussion is to provide a framework for understanding health disparities and their implications; as well as identifying a platform for corrective action.

First, this report examines the data on infants, children, and adults in general separately. Data on pregnant and postpartum women will be clustered with the information on infants.

Second, mortality will be considered as the global indicator of population health. To be concerned with the health of a population is to be concerned with its mortality. Why are a group of people dying? How soon are they dying relative to other groups? Are there individual disparities between subpopulations in the relative frequency, occurrence, and causes of death? If so, what are the causes of these disparities and how can we "raise the bar" and improve the health of everyone?

Third, the report examines the health of the population in terms of three domains: physical, mental, and social health.

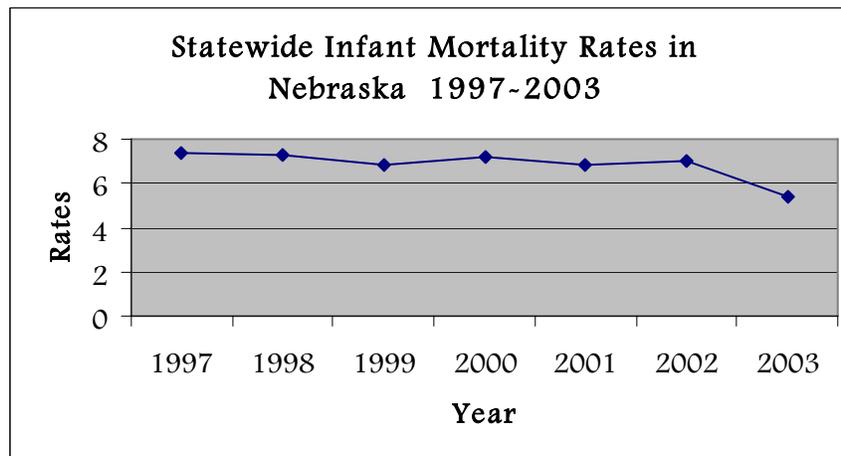
Mortality

Infant Mortality

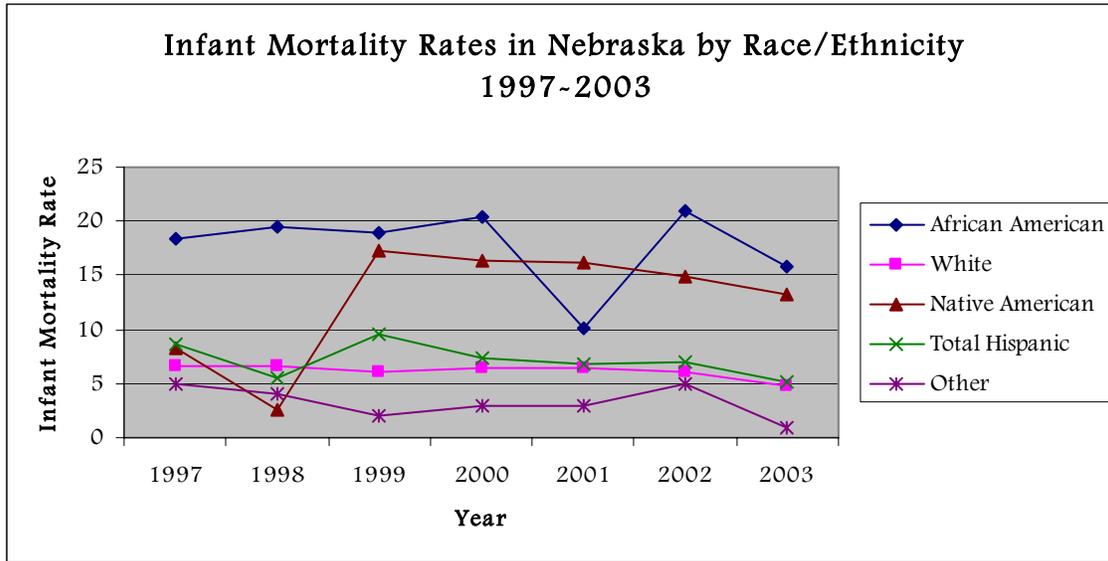
Infant mortality in Nebraska is examined in more detail in the figures below (Figures 4, 5, and 6). From 1997 to 2003 the overall death rates of infants in Nebraska was on a downward trend, from 7.4 deaths per 1,000 live births to 5.4 deaths per 1,000 live births²⁴. Again, these numbers mask significant problems occurring in specific subpopulations (Figure 4)²⁵.



(Figure 4)

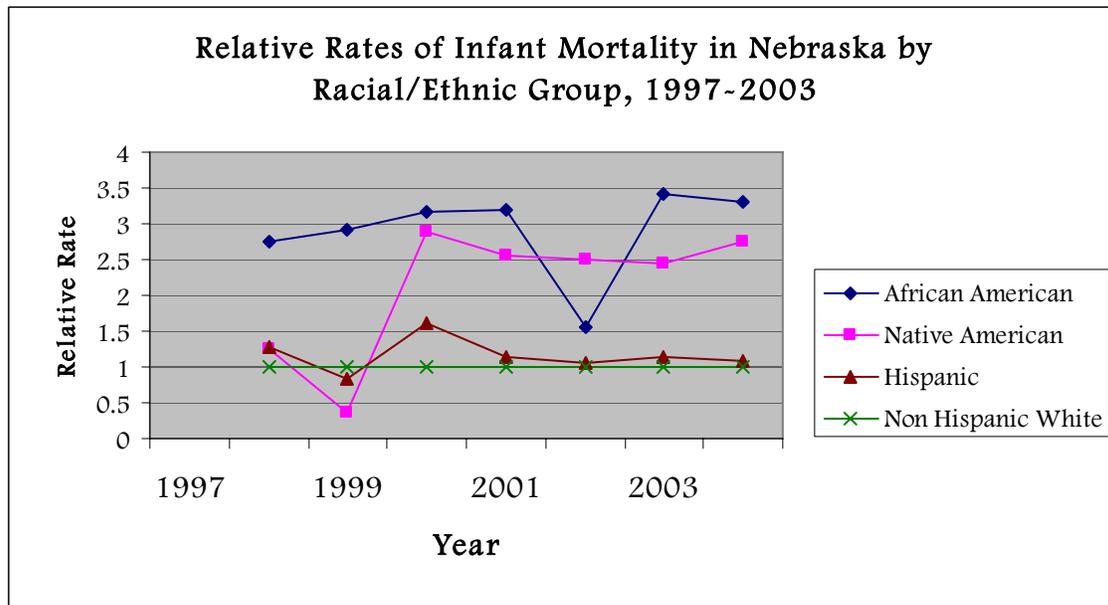


(Figure 5)



In Nebraska, the infant mortality rate for African Americans has been as high as 3.4 times the infant mortality rate of White, non-Hispanic infants. Native American infants have been dying at a rate as high as 2.9 times that of White infants (Figure 5)²⁶.

(Figure 6)

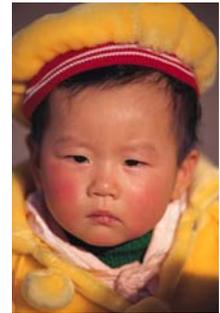


Clearly, disparities in infant mortality are present among different racial/ethnic groups in Nebraska; however infant mortality cannot be viewed in isolation. It should be examined both in comparison with the trends occurring throughout the country as a whole and among the subgroups that compose the aggregate infant mortality figure.

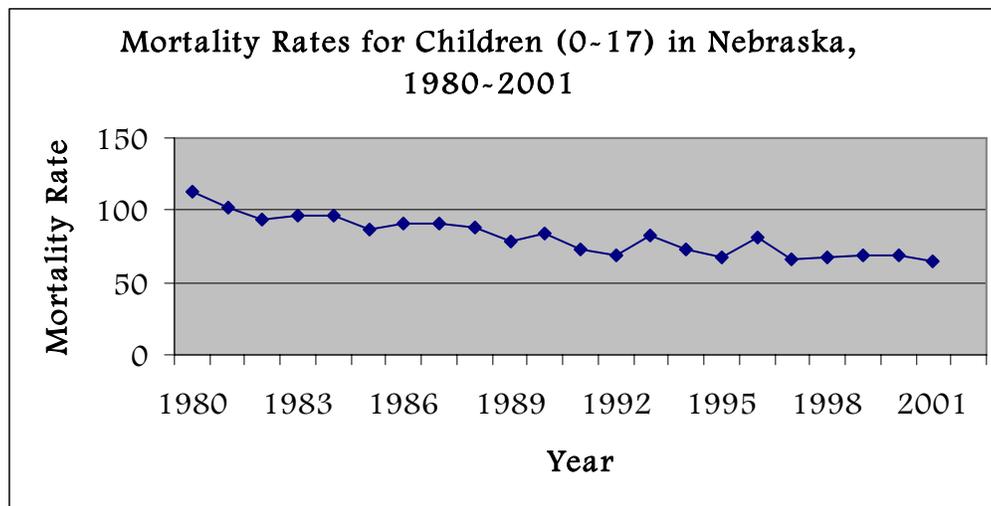
For example, infant mortality steadily declined in Nebraska from 1925 to 1991²⁷ from roughly 58 to 7.5 infant deaths per 1,000 live births. From 1990-1997 the infant mortality for Whites decreased by an additional 5.6%. However, when compared with the national decline of infant mortality among Whites over the same period (22.1%), Nebraska ranked *third lowest* in improvement of White infant mortality rates²⁸.

Child Mortality

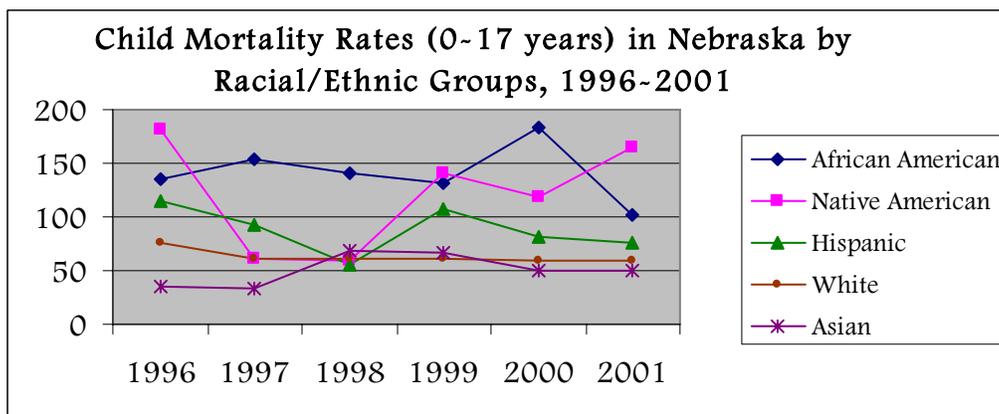
The child death rates for Nebraska are provided below (Figures 6 and 7)²⁹. Overall, these rates in Nebraska have been consistently on the decline from 1980-2001. However, when examined by racial/ethnic group the trend from 1996-2001 is that these rates have increased somewhat for Asians, increased significantly for Native Americans, and have essentially remained elevated for African Americans. Recently, the rate for Hispanics has essentially been the same as that for non-Hispanic whites. A profile of child deaths in Nebraska indicates that the majority of child deaths result from infant deaths (39% 0-1 month, 18% 1-12 months)³⁰. A complete profile of child deaths in Nebraska by age is provided below (Figure 8)³¹, indicating that 57% of the overall child death rate is represented by infant mortality.



(Figure 7)



(Figure 8)

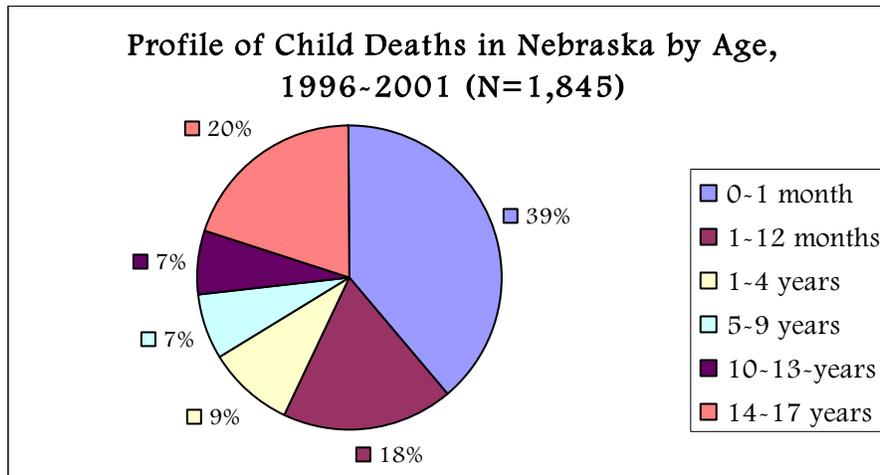


Adult Mortality

That there are differences in the health and well-being of the various racial and ethnic groups in Nebraska is suggested by the disparities in life expectancy at time of birth among these groups³² as well as disparities in the years of productive life lost³³.

Life expectancy at birth is the average number of years that a group of people (a “cohort”) would live if the group were to experience current age-specific death rates. Life expectancies at birth in the United States and in Nebraska have been continuously increasing over the last 30 years. In Nebraska, the average life expectancy in 2000-2002 was 78.3 years, compared to 72.7 years in 1969-1971.

(Figure 9)



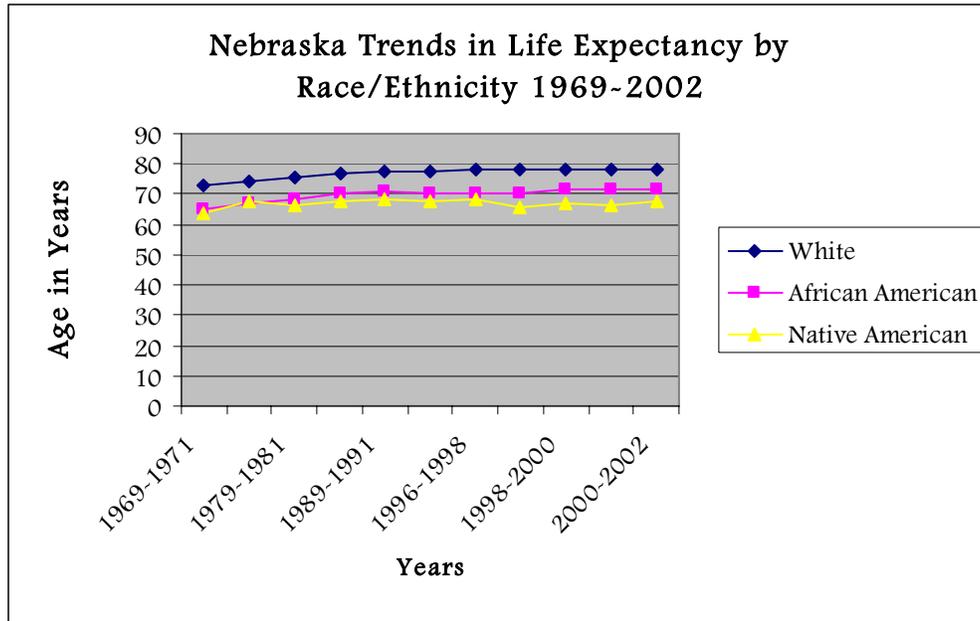
Although average life expectancies have increased in recent years for all major racial and ethnic groups in Nebraska, there are still substantial disparities for some groups. Native Americans have experienced some improvement since 1979-1981, when the average life expectancy at birth for this group was 63.7 years. In 2000-2002 data, life expectancy had risen to 67.9 years. However, this figure is more than 10 years below the rate for Whites and 3.7 years below the rate for African Americans. Data on the Asian population was unavailable.

While life expectancy has been on the rise overall, the comparative trends have demonstrated that the disparities between racial/ethnic groups are consistent (Figure 3).

Did You Know?

In Nebraska, the average life expectancy of a Native American person is more than 10 years less than that of a White person.

(Figure 10) ^{34,35}



Years of potential life lost (YPLL) are a measure of premature death. YPLL indicates that the younger the age of the person at death, the more years of potential life that is lost. Thus, this measure is useful in gauging the loss of contributions to human society due to disease or injury. Nebraska data show substantially higher rates of YPLL for some racial and ethnic minority groups compared to White residents.

Table 2. Years of Potential Life Lost – All Causes Based on 75 Productive Years of Life for Nebraska by Race/Ethnicity ³⁶

	1993-1997			1998-2002		
	YPLL	Age-Adjusted Rate/100,000	Minority/White Ratio*	YPLL	Age-Adjusted Rate/100,000	Minority/White Ratio
NE Total All Causes	537,598	6,823.4		529,007	6,279.2	
White	485,288	6,519.2	1.0	472,424	6,208.7	1.0
African American	39,708	13,669.2	2.1	40,430	12,587.1	2.0
Native American	9,432	16,358.8	2.5	10,712	16,909.6	2.7
Asian American	2,632	3,206.9	0.5	3,965	3,729.4	0.6
Hispanic American	19,120	6,215.4	0.9	24,853	5,458.2	0.9

The YPLL decreased for African Americans in Nebraska between the periods 1993-1997 and 1998-2002. However it remained twice that of Whites. The YPLL increased for Native Americans and Asian Americans during this period, and for Hispanic Americans it remained the same. Only for Native Americans and African Americans were the YPLL lost greater than Whites by whole number multiples. The YPLL for Native Americans was nearly 3 times that of Whites. For African Americans, YPLL is twice as great as that for Whites. Once again, this disparity is a significant indicator of people who are dying prematurely. The question is why are they dying prematurely? The next step in answering this question is to identify causes of death among Nebraskans by race and ethnicity.

Physical Health

Infant Physical Health

That a child will live to see its first birthday is based on multiple factors. Pregnancy, the period immediately after birth, and the long period during which a child completes its infancy are fraught with different types of dangers. These dangers usually correspond with the child's level of development and the environmental challenges it faces. To better clarify the composite nature of these risks, we reexamine mortality for infants and look at the factors that determine that mortality. It is clear (Table 2) that disparities among racial and ethnic groups exist in Nebraska for both categories.



The average infant mortality rate and relative risk of infant mortality from 1998-2002 has risen for African Americans and Native Americans and the relative risk of infant mortality has risen for Asian Americans.

Infant mortality (the death of children less than 1 year of age) reflects the results of neonatal mortality (first 30 days after birth) and post neonatal mortality (from 30 days to 1 year). Neonatal mortality is most clearly associated with prematurity, congenital anomalies, birth defects, and maternal and perinatal complications of pregnancy. The rates and relative risks in the neonatal category were elevated among African Americans, Asian Americans, and Native Americans. Post neonatal mortality is more associated with causes such as Sudden Infant Death Syndrome (SIDS) and accidents. The rates and relative risks in this category were elevated among African Americans and Native Americans.

Table 3. Infant Mortality Rates and Relative Risk of Mortality and Inadequate Prenatal Care for Nebraska Racial and Ethnic Minorities³⁷

Category	1993-1997 Rate per 1000 live births	1993-1997 Relative Risk	1998-2002 Rate per 1000 live births	1998-2002 Relative Risk
Infant Mortality				
NE Total	8.1		7.0	
African American	17.1	2.3	17.9	2.8
Asian American	5.2	0.7	5.0	0.8
Hispanic American	9.2	1.2	7.2	1.1
Native American	8.9	1.2	13.6	2.2
White	7.5	1.0	6.3	1.0
Neonatal Mortality				
NE Total	5.2		4.7	
African American	10.9	2.2	11.9	2.8
Asian American	3.6	0.7	3.8	0.9
Hispanic American	6.4	1.3	5.1	1.2
Native American	2.8	0.6	7.0	1.6
White	4.9	1.0	4.3	1.0
Post Neonatal Mortality				
NE Total	2.8		2.2	
African American	6.1	2.3	6.0	3.0
Asian American	1.5	0.6	1.1	0.6
Hispanic American	2.8	1.1	2.1	1.1
Native American	6.2	2.4	6.5	3.3
White	2.6	1.0	2.0	1.0

Disparities in infant mortality are clearly illustrated by Table 3. The question is what are the causes and how are they distributed across the different populations of Nebraska?

Table 4. Leading Causes of Infant Deaths by Race/Ethnic Origin in Nebraska 1998-2002³⁸

Cause of Death	NE Total (N=858)	White (N=692)	African American (N=120)	Native American (N=29)	Asian American (N=13)	Hispanic American (N=96)
Birth Defects	24.8%	27.9%	8.3%	13.8%	30.7%	25%
SIDS	13.3%	12.7%	16.6%	13.8%	---	10.4%
Prematurity	8.9%	7.9%	15.0%	---	---	11.5%
Maternal Complications	8.3%	7.5%	13.3%	---	---	11.5%
Other Respiratory Conditions	7.3%	7.4%	7.5%	---	---	6.3%
Other Perinatal Conditions	6.9%	7.1%	7.5%	---	---	6.3%

The distribution of these leading causes of infant death is somewhat different for Nebraska’s racial and ethnic groups. African American infants are the most likely to die of SIDS, prematurity, maternal complications of pregnancy, respiratory conditions, and other perinatal conditions. However, they are the least likely to die of birth defects. Native American infants are equally likely to die of SIDS as of birth defects. Asian American infants are the most likely to die of birth defects, followed by White and Hispanic infants.

Perinatal Health and Factors Impacting Pregnancy Outcomes and Infant Health



For purposes of this report, the term perinatal health is being used broadly to include preconception and prenatal care, labor and delivery, postpartum care, and interconceptional health. A woman’s health status is the result of cumulative impacts over her lifetime and her health status and health behaviors are closely linked to the health of her infant. Consequently, infant health is also a function of maternal health.

This report also approaches perinatal health from a holistic perspective, which recognizes the multiple influences of biological, psychological, and social factors on women’s health. In recent years, clinical aspects of prenatal care have been recognized as only part of the solution for poor pregnancy outcomes rather than the sole explanation. It is now generally accepted that a woman’s broad experiences influence her health and well-being and subsequently that of her infant. Using a holistic approach, factors such as behavioral health status, religious and cultural beliefs, social supports, nutritional status, safety, substance use, and physical activity must all be considered in assessing gaps and barriers and making recommendations for improvement³⁹.

Maternal Physical Health

Understanding why racial and ethnic minority women continue to experience significant disparities in pregnancy outcomes is a complex process because the usual measures, such as entry into prenatal care, are insufficient in determining the full range of issues and solutions.

The *Nebraska Pregnancy Risk Assessment Monitoring System 1999 Databook*, while not a formal study of maternal health during pregnancy, provides useful information on the health

of pregnant mothers in the state⁴⁰. The 1999 data are for Nebraska residents who delivered a live infant during the 6-month period of July through December 1999 and cannot be generalized for the full year. Some data regarding the health of the 826 respondents are provided below.

Table 5. Nebraska PRAMS Indicators Reflecting Maternal Health during Pregnancy, by Race/Ethnicity (1999)⁴¹

Racial and Ethnic Group	Medical Treatment during Pregnancy	Hospitalized during Pregnancy
African American	56.6%	27.3%
Asian	42.0%	15.4%
Native American	54.0%	15.7%
Hispanic American	37.7%	17.0%
White	45.1%	17.0%

Of the PRAMS respondents, more than 50% of African American and Native American women required medical treatment during pregnancy and almost 30% of African American respondents needed to be hospitalized during their pregnancies.

In the following year, PRAMS examined hospitalization among those women reporting medical problems during pregnancy. 52.4% of African American women also required hospitalization for medical treatment. A breakdown by ethnicity is provided below.

Table 6. Hospitalization among Women Reporting Medical Problems during Pregnancy by Race/Ethnicity (2000)⁴²

Racial and Ethnic group	Percentage Hospitalized During Pregnancy
African American	52.4%
Asian American	44.1%
Caucasian	47.1%
Hispanic	43.3%
Overall	47.0%

In 2000, more than half of the African American women requiring medical treatment during pregnancy needed to be hospitalized. This represented the largest group of women who needed to be hospitalized. It was followed by White women (47.1%), Asian American women (44.1%), and Hispanic women (43.3%). Data on Native American women was not available.

Child Physical Health

The Nebraska Child Death Review Team (CDRT) has made great strides in identifying causes of death in Nebraska’s children^{43, 44, 45, 46}. The CDRT identified the top 10 causes of death among Nebraska children between 1996 and 2001 (Table 5).

Did You Know?

In 2000, over half of the African American women requiring medical treatment during pregnancy needed to be hospitalized.

Table 7. Top 10 Causes of Death for Children in Nebraska 1996-2001⁴⁷

Cause of Death	Number of Deaths	Percentage
Pregnancy-Related	541	30
Birth Defects, Inherited and Chromosomal Disorders	380	21.1
Motor Vehicle Related Incidents	259	14.4
Sudden Infant Death Syndrome	160	8.8
Infections, Chronic and Other Medical Conditions	138	7.6
Unintentional Injuries	98	5.4
Suicide	70	3.9
Cancer	64	3.6
Homicide/Criminal Child Abuse & Neglect	63	3.5
Caretaker Neglect	29	1.6

Pregnancy-related factors include prematurity, maternal complications, and events of labor and delivery. Among the infant deaths associated with prematurity, over half were infants of multiple gestation (twins, triplets, or quadruplets). These infants are known to have higher prematurity and mortality rates. Drowning was the leading cause of death for children ages 1-4 years. The most frequent location of drowning was a swimming pool. Teens and young adults (ages 15-24) had the highest motor vehicle crash death and hospital discharge rates⁴⁸.

Adult Physical Health

The two leading causes of death for Nebraska adults are heart disease and cancer. Heart disease is first among Whites, African Americans, and Native Americans; and cancer is first among Asian Americans and Hispanic Americans. Heart disease and cancer are followed by diabetes, stroke, motor vehicle accidents (MVA), and non-MVAs.



Table 8. Leading Causes of Death among Nebraskans by Racial/Ethnic Origin & Percent (Based on Number of Deaths, 1998-2002)⁴⁹

White (72,935 Deaths)	%	African American (2,362 Deaths)	%	Native American (554 Deaths)	%	Asian American (222 Deaths)	%	Hispanic American (948 Deaths)	%
Heart Disease	28.7	Heart Disease	22.5	Heart Disease	23.5	Cancer	30.6	Cancer	17.4
Cancer	22.1	Cancer	21.2	Cancer	13.0	Heart Disease	18.0	Heart Disease	15.3
Stroke	7.4	Stroke	7.1	Diabetes	6.3	Stroke	8.1	MVA	9.2
Chronic Lung Pneumonia	4.9	Diabetes	4.8	Cirrhosis	6.3	MVA	6.3	Non MVA	5.4
Diabetes	2.4	Homicide	3.6	Non MVA	5.8	Diabetes	3.2	Diabetes	5.1
Non MVA	2.4	Infectious/Para	3.0	MVA	5.2	Non MVA	3.2	Stroke	4.2
Alzheimer's	2.4	Nephritis/Nephrosis	3.0	Stroke	3.8	Suicide	2.7	Homicide	4.1
MVA	1.9	Chronic Lung	2.4	Chronic Lung	2.9	Birth Defects	2.3	Suicide	2.7
Mental Psychosis	1.8	Pneumonia	1.9	Infectious/Para	2.7	Homicide	2.3	Birth Defects	2.6
		Non MVA MVA	1.5 1.5	Homicide	2.5	All other Causes	5.4	Cirrhosis	2.3

Homicide, the 5th leading cause of death among African Americans, 7th leading cause of death among Hispanic Americans, and 9th leading cause of death among Asian Americans, may require a more focused approach which may involve holistic interventions including assessments of poverty (class) and ethnicity (race) on social development, conflict resolution, and anger management training in high risk groups. The generational impact of centuries of oppression, genocide, colonization, slavery, etc, continue to impact racial/ethnic minorities, Native Americans, refugees, and immigrants. These are but some of the approaches being explored in the evolving discipline of violence prevention. Public health and medical practitioners are frequently confronted with violence-related injury but are provided little formal training on youth violence or suicide⁵⁰. The World Health Organization (WHO) has developed TEACH-VIP, an acronym for Training, Education, and Advancing Collaboration in Health on Violence and Injury Prevention to address the significant youth homicide rates existing in the world, rates that can exceed 10 per 100,000. TEACH-VIP is one of the emerging multidisciplinary approaches to violence prevention being developed to address the absence of training in this area for medical and public health professionals⁵¹. The Centers for Disease Control (CDC) has developed a Public Health approach to violence prevention which is a four-step process consisting of:

1. Defining the problem
2. Identifying the risk and protective factors
3. Developing and testing prevention strategies and;
4. Assure widespread adoption of successful strategies^{52,53}.

The CDC is not only addressing youth violence; its purview includes child maltreatment, intimate partner violence, sexual violence, suicide, and international violence prevention efforts. The CDC strategy is predicated on a Social-Ecological Model, which takes into consideration the complex interactions between an individual, the people in their life, and their community and society in general⁵⁴. The development of solutions is by no means a closed loop; around the country entities such as school districts are being awarded funding to develop violence prevention programs^{55, 56}.

Behavioral Health and Substance Abuse

Identifying the behavioral health of the population is more elusive. In 2003, the President's New Freedom Commission on Mental Health issued its report, *Achieving the Promise: Transforming Mental Health Care in America*, which concluded that significant barriers still remain in access, quality, and outcomes of care for minorities. As a result of these barriers, minority populations bear a disproportionately high burden of disability from mental disorders. The report concurred with the Surgeon General's conclusion that this higher burden does not arise from a greater prevalence or severity of illnesses in minority populations; it stems from receiving less care and poorer quality of care. The Commission concluded that the mental health system has not kept pace with the diverse needs of racial and ethnic minorities⁵⁷. To the extent that certain health risk behaviors are reflective of a community's mental health, the Office of Minority Health has sponsored a number of *Minority Behavior Risk Factor Surveillance Surveys* that examine health risk behavior by specific county. While these studies have predominantly examined parameters such as exercise, demographics, health insurance, HIV/AIDS, and health care barriers; they have also consistently examined alcohol and tobacco



use in specific Nebraska communities. They have not been targeted specifically at mental health issues^{58, 59, 60}.

Also in 2003, the National Institute on Drug Abuse released an updated version of its 1995 report *Drug Use among Racial and Ethnic Minorities - Revised*. By focusing attention on the needs of, and barriers to, quality care faced by racial and ethnic minorities, these reports

Did You Know?

President Bush's New Freedom Commission on Mental Health concluded that significant barriers still remain in access, quality, and outcomes of care for minorities.

provide a road map for federal, state, and local leaders to follow in eliminating disparities in the availability, accessibility, and utilization of behavioral health services.

Consideration must also be given to the fact that behavioral health issues differ for infants, mothers, children, and adults; and, of course, among racial/ethnic groups as well. These distinctions are more than artificial and require specific kinds of intervention for their correction.

Infant Behavioral Health and Substance Abuse

Nationally, it is suspected that between 5.5% and 18% percent of all births are affected by illegal substance use during pregnancy⁶¹. Some of the complications associated with the use of drugs such as cocaine and methamphetamine include premature rupture of membranes (PROM), preterm delivery, and pre-eclamptic symptoms. However, these symptoms also occur in mothers who do not use illegal drugs, and in their absence it is difficult to attribute to a mother's drug use. Exposure to cocaine, methamphetamine, and alcohol in-utero can have harmful and lasting effects on an infant, some of which may affect subsequent infant learning and behavior^{62, 63, 64}.

Maternal Behavioral Health and Substance Abuse

Perinatal depression has been studied with increasing frequency. The prevalence of perinatal depression among women is greater than often suspected⁶⁵. The risks to women and infants of untreated depression during pregnancy and postpartum are extensive⁶⁶; with links to spontaneous abortion, increased uterine artery resistance, small head circumference, neonatal growth retardation, preterm delivery, low birth weight babies, and lower APGAR scores⁶⁷. Depression, depending on its severity, can compromise a mother's ability to operate in the world. She may be less likely to seek prenatal care, she is more likely to smoke and use alcohol⁶⁸, and her ability to seek help is impaired. Additionally, severe depression can lead to psychosis and self destructive behaviors.



Child Behavioral Health and Substance Abuse

Suicide is one of the top ten causes of child death in Nebraska. Improved access to confidential mental health services might have been able to reduce this number. Approaches such as the Nebraska Professional Partner Program represent viable solutions to improve access to services⁶⁹. Efforts such as the work of the Nebraska Early Childhood Mental Health Work Group have helped to develop a policy framework to address the social, emotional, and behavioral health issues troubling younger children⁷⁰.

Adult Behavioral Health and Substance Abuse

Racial and Ethnic Minority Populations in Nebraska

The four largest racial and ethnic minority categories represent literally hundreds of different cultures. Culture, which is broadly defined as a common heritage or set of beliefs, norms, and values; plays a key role in the way people communicate their symptoms and which ones they report. Culture can also affect whether people seek help for their problems, what types of help they seek, what types of coping skills and social supports they have, and even how much stigma they and their families attach to mental and/or substance abuse disorders.

Understanding what communities do to cope with behavioral anomalies gives us a clearer picture of what resources are available to promote and achieve physical and behavioral health. “Culture influences the experience of symptoms, the idioms used to report them, decisions about treatment, doctor-patient interactions, the likelihood of outcomes such as suicide, and the practices of professionals. As a result, some conditions are universal and some culturally distinct, but all are meaningful within particular contexts”⁷¹.

When a community’s intact culture must adapt to drastic changes in its environment this can produce results that obliterate families, communities, tribes, and nations for centuries. One example of this would be the forced removal of the Cherokee nation from northern Georgia to Oklahoma, the “Trail of Tears”^{72, 73, 74}. This act cost many lives and disoriented a nation that was culturally tied to the land that they had lived upon for generations.

Did You Know?

The Boarding School system for Native Americans, which began with President Grant’s 1869 “Peace Policy,” continued well into the 20th century. Native Americans were forced to attend either church or BIA-run schools. Church officials, missionaries, and local authorities took children as young as five from their parents and shipped them off to boarding schools or day schools on reservations. Parents caught trying to hide their children lost food rations⁷⁵. Children were systematically removed from their parents, friends, and culture (viz. they were estranged from their advocates and protectors against the onslaughts of the outside world and their traditional way of understanding what was happening to them).

When that culture is systematically stripped from the people as in the case of Native American boarding schools^{76, 77}; the ability of the community to cope is considerably reduced. Children in many of the American Indian Boarding schools experienced widespread abuses including forced assimilation, grueling labor, and sexual and physical abuse⁷⁸. In *Lakota Woman*, Mary Crow Dog speaks of Bureau of Indian Affairs (BIA) agents barging into the homes of Sioux Indians and dragging children away from their families in order to assimilate them. At the boarding schools, the children were forced to cut their hair, kept away from their families, and sometimes were told that their families were dead or did not want them anymore⁷⁹.

During a ceremony for the 175th anniversary of the establishment of the Bureau of Indian Affairs on September 8, 2000, Kevin Grovner, Assistant Secretary- Indian Affairs Department of the Interior noted that historically, the Bureau of Indian Affairs committed acts against the children entrusted to its boarding schools that brutalized them emotionally, psychologically, physically, and spiritually⁸⁰.

Embedded in this destruction of culture was a pattern of unmonitored, unchecked physical and sexual aggression perpetrated by boarding school officials against a vulnerable and institutionalized population. Sexual abuse was rampant at reservation schools until the end of the 1980s, in part because pre-1990 loopholes in state and federal law, mandating the reporting of child sexual abuse. “In 1987 the FBI discovered evidence that John Boone, a teacher at the BIA- run Hopi day school in Arizona had sexually abused as many as 142 boys from 1979 until his arrest in 1987”⁸¹. The principal failed to investigate any allegation of abuse. Mr. Boone was but one of several BIA schoolteachers caught molesting children on reservations in the late 1980s⁸².

The “Did You Know?” box above examines only a small page of the histories of Native American people, illustrate how the history and culture of a racial/ethnic group or Nation inform their current health status – physical and behavioral. Limits of time do not permit the illustrations from histories of today’s African American, Hispanic, and Asian American populations have also suffered. The point is that communities do not suffer such extensive assaults and remain unscathed. Any strategy to address a community’s illness must consider its cultural context.

Hispanics or Latinos

In 2000, three-fourths (75.2%) of the Hispanics or Latinos in Nebraska were of Mexican origin. The next highest concentration was persons from Central America (5.6%), including the countries of Guatemala and El Salvador. Many persons from Central America came to the United States as refugees in the 1980s and 1990s after experiencing systematic violation of human rights in their own countries.



These experiences have placed them at high risk for mental disorders such as Post Traumatic Stress Disorder (PTSD), anxiety, and depression. Studies of this population suggest that as many as 68% of refugees from Latin America meet the diagnostic criteria for PTSD^{83, 84, 85}.

Yet residency in the U.S. apparently has its own risks. The Centers for Disease Control and Prevention Youth Risk Survey found a 10.7% attempted suicide rate among Latino youth, compared with a 6.3% attempted suicide rate for White, non-Latino youth.

African Americans

Several studies suggest that African Americans are more likely than Whites to be diagnosed with schizophrenia, and less likely to be diagnosed with bipolar disorder⁸⁶. There is considerable debate, however, over whether these differences are real or result from misdiagnosis by clinicians. Many researchers argue that African Americans are more likely than Whites to have their mental health conditions misdiagnosed as severe mental illness⁸⁷. This can occur from the use of instruments not designed to assess mental disorder in African Americans, or from the misinterpretation of signs and symptoms. Strakowski, et al. (1993) found that African American patients were five times more likely to be diagnosed with schizophrenia than White patients. Neighbors (1997) agreed that the data suggest that schizophrenia may be over-diagnosed in African Americans. The National Co-morbidity Study⁸⁸ found, however, that African Americans were less likely than Whites to suffer from major depression. Strakowski (2003) hypothesized that one possible explanation for the higher prevalence of schizophrenia among African Americans was that mood disorders in African Americans were being misdiagnosed as schizophrenia. He suggested that possible reasons for misdiagnosis include: differences in symptom presentation compared to Whites, failure by clinicians to identify affective symptoms within African Americans, and racial stereotyping. The implication of this is that improper diagnosis can lead to inappropriate treatment, which is not without its side effects.

A study comparing African American and White patients who were similar demographically, after controlling for differences in clinical course, found that African Americans: 1) received antipsychotics for a significantly greater percentage of follow-up time; 2) were more likely to receive antipsychotics during periods without psychotic symptoms and; 3) were significantly more likely to receive conventional antipsychotics⁸⁹. Furthermore, the literature suggests that

African American patients with psychotic disorders receive higher doses of antipsychotic medication than White patients, are more likely to receive injections of antipsychotics and are less likely to receive second-generation antipsychotics⁹⁰.

It is important to note that suicide rates have been found to be lower among African American women than any other population⁹¹. Some researchers suggest that this is because African American women have stronger coping mechanisms than other populations⁹².

Native Americans



Until recently, there had been no large-scale studies of the prevalence of mental disorders among Native Americans. One recent nationally-representative study looked at mental distress among a large sample of adults⁹³. Overall, Native Americans and Alaska Natives reported higher rates of frequent distress – nearly 13 percent compared to nearly 9 percent of the general population. The findings of this study suggest that American Indians and Alaska Natives experience greater psychological distress than the overall population.

Native American adolescents are much more likely to be diagnosed with Attention Deficit Hyperactivity Disorder than are other adolescents. Depression and adjustment reactions are the most prevalent mental health problems among Native Americans⁹⁴.

U.S. Surgeon General Dr. Richard H. Carmona noted that “the rate of suicides among American Indian and Alaska Native (AI/AN) youth ages 5 to 14 was 2.6 times higher than the national average. For AI/AN youth ages 15 to 24, the rate is 3.3 times higher than the national average.” Young people ages 15 to 24 constitute 40% of all suicides among AI/AN populations⁹⁵.

Suicide rates among Native Americans vary greatly among tribes and over time. AI/AN suicide rates were highest in the Tucson, Aberdeen, and Alaska areas. These areas had rates that were five to seven times higher than the overall U.S. rates⁹⁶.

Asian Americans or Pacific Islanders

Asian American/Pacific Islanders is probably the most diverse racial and ethnic group in terms of country of origin, religious/spiritual affiliation, cultural background and traditions, and generational and immigration experiences. Little research exists on the mental health status of many Asian American/Pacific Islander groups. Prevalence rates of mental illness among Asian Americans/Pacific Islanders are believed by some researchers to be no different from those of other Americans. Post-traumatic stress disorder (PTSD), however, is believed to be much more prevalent in the Asian community than in the population as a whole. Preliminary results from the National Latino and Asian American Study^{97,98} indicate that Vietnamese show a higher incidence of mental disorders than other Asian American groups.



Prevalence of Alcohol Abuse and Dependence

The percent of adults in the United States who abuse alcohol or who are alcohol dependent rose from 7.4% in 1991-1992 to 8.5% in 2001-2002 according to results from the *2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions*⁹⁹. This recently released study of 43,000 non-institutionalized adults in the United States was directed by the

National Institute on Alcohol Abuse and Alcoholism. Results showed that the rate of alcohol abuse¹⁰⁰ among adults increased over the past decade from 3.03% to 4.65% of the adult population, while the rate of alcohol dependence (commonly known as alcoholism) declined from 4.38% to 3.81%¹⁰¹. The study found that alcohol abuse is more prevalent among Whites than among Hispanics/Latinos, African Americans, and Asians; and that alcohol dependence is more prevalent among Native Americans, Hispanics/Latinos, and Whites than among Asians. From 1991-1992 to 2001-2002, the prevalence of alcohol abuse increased among all racial and ethnic subgroups except American Indians and Asians. The increases were significant for Whites, African Americans, and Hispanics/Latinos. Among the young adult age group (18-29 years), African American and Hispanic/Latino men and Asian women showed significant increases in alcohol dependence.

Overall, alcohol dependence rates decreased significantly among Whites and Hispanics/ Latinos; however, the changes were significant only for White men and for Hispanic/Latino men in the 18-29 and 45-64 age groups. Alcohol dependence prevalence remained relatively stable among African Americans, Native Americans, and Asians. However, African American women and Asian men age 18-29 showed significant increases in alcohol dependence.

Did You Know?

Alcohol **abuse** is more prevalent among Whites than among Hispanics, African Americans, and Asian Americans; but alcohol **dependence** is more prevalent among Native Americans, Hispanics, and Whites than among Asian Americans

While these national statistics are helpful in contextualizing mental illness in minorities in general, mental health occurs in a personal social and cultural context. More work is required locally to assess the mental health status of Nebraska's racial and ethnic minorities to target the efficient use of resources.

Social and Institutional Health

Several methods may be used to assess the social health of a given group within society. First, there are social parameters that serve as markers of how a group operates in the world (i.e. economic indicators such as income, level of education, marital status). An example of this is discussed elsewhere regarding maternal and child health. Second, there are societal and behavioral indications that certain groups may be systematically treated differently by the institutions of a community or society, reflecting patterned differences in the responses of these institutions to those groups and characteristic outcomes of those groups that can be identified (e.g. the National Institute of Medicine Study displaying disparities in health care delivery, or the practice of redlining with its economic consequences). These institutional practices can place groups at risk and can clearly create disparities in their health. Third, assessing the representation and participation of specific social groups in the decision making processes that affect them and their communities relates to the perceived power to shape one's destiny and social context. Knowing how society works and how to effectively participate in it would be considered healthy. The discussion on this aspect of a community's health will not be exhaustive in this document but it is presented as an arena to be explored in consideration of the health status of racial and ethnic minorities, Native Americans, immigrants, refugees, and migrant workers.



Maternal and child health, as stated earlier, is an important predictor of the health of the next generation of Americans. The infant mortality rate is sensitive to a wide range of factors, such as access to quality health care, personal health behaviors, and the existence of safe, supportive

environments; and provides data and insight into issues. For purposes of this report, the maternal and child (MCH) population includes women of reproductive age, their infants, and children through 19 years of age.

Table 8. Demographics of PRAMS Databook Sample, by Race/Ethnicity¹⁰²

Race/ Ethnicity	Teen Birth (12-19 years)	Education <12 th Grade	City Residence	Married	Birth < 2500 grams	Two or more income sources	Residential Crowding (2 + persons per room)
African American	26.5%	27.5%	99.2%	32.7%	13.3%	41.0%	10.7%
Asian	4.4%	13.2%	86.7%	82.0%	11.6%	15.3%	19.7%
Native American	16.9%	38.1%	52.6%	37.6%	8.5%	37.5%	14.1%
Hispanic	19.7%	59.3%	46.1%	60.9%	5.0%	22.6%	27.6%
White	11.4%	7.4%	54.2%	78.7%	4.6%	32.1%	5.9%

A little more than a quarter of the African American mothers in the sample were teenagers. Almost two-thirds of the Hispanic mothers had not completed high school. The African American women in the sample were almost exclusively from an urban setting. Roughly four-fifths of the Asian and White women in the sample were married. African American women in the sample had the greatest percentage of low birthweight infants and the greatest number of families with multiple sources of income. Finally, more than a quarter of the Hispanic mothers lived in a situation where they experienced overcrowding in the home (defined as 2 or more people per room).

Refugees, Immigrants, and Migrant Workers

Immigrants (who come to America with no duress) are an integral component of American society, contributing both to the diversity and the economy of the nation. The health of refugees, immigrants, and migrant workers has an impact on the state health system and its resources. Over the past 20 years, the U.S. has experienced one of the largest waves of immigration in its history¹⁰³. However, there remain considerable gaps in the information from national databases able to assess the considerable heterogeneity in the incoming immigrant populations¹⁰⁴. More than 30 million immigrants have found new homes in the U.S., not just on the East and West Coasts, but also in the heartland¹⁰⁵. Immigrants are disproportionately found among the low-income and uninsured. One in four low-income children lives in an immigrant family¹⁰⁶, three in five low-income non-citizens are uninsured¹⁰⁷, and one in five school children is an immigrant or has an immigrant parent¹⁰⁸. In addition, immigrant parents are at particularly high risk of alienation or even exclusion from health care systems and support services available to low-income and vulnerable populations¹⁰⁹. This underscores the importance of reaching immigrant communities with culturally sensitive, linguistically appropriate messages to optimize available resources.



As with the immigrant population, the lack of information on the health needs of refugee communities is considerable. In opposition to popular notions, one cannot assume that refugees have had health screenings upon arrival in the U.S. or that they are healthy¹¹⁰. Consequently, preventive efforts need to be designed to address health needs that are prevalent in the target refugee populations (e.g.

infectious diseases, nutrient deficiencies). To do this efficiently, one needs to work with refugee communities so that they have input in actively defining these needs¹¹¹. Secondary or migrant refugees, who may have settled in Iowa but later leave to join families in Nebraska, often are without health care benefits made available to them during their first eight months in the U.S.

Even less information is known about migrant worker communities. We do know that the life expectancy of a migrant farm worker is 49 years, and that about 25% of farm labor in the U.S. is performed by children¹¹². The health of the children is at risk largely from farm injuries and pesticide poisoning¹¹³. Further, children are more at risk for pesticide poisoning because they absorb more pesticides per pound, and their nervous systems and developing organs are more vulnerable. A study in New York State indicated that over 40% of children interviewed had worked in fields that were wet with pesticides and 40% had been sprayed while in the fields^{114,115}. Malnutrition and parasitic infections are also frequent among this population. A 1983 regional survey of migrant women and children discovered that 34.2% of the sample was infected with 12 different types of intestinal parasites¹¹⁶. Respiratory diseases related to poverty and poor sanitation can foment problems such as tuberculosis, pneumonia, asthma, and bronchitis¹¹⁷. An assessment of migrant workers and how they impact on the current health care system in Nebraska is in order.



Access to Health Care

Health Insurance

Lack of health insurance is a significant barrier to health care access. The inability to pay for health services is closely linked to socioeconomic status. For someone with limited financial resources; food, clothing, and shelter become immediate priorities and long-term health care becomes secondary. The Nebraska Behavioral Risk Factor Surveillance System (BRFSS) revealed that from 1998-2002, roughly 10.6% of all Nebraska adults 18 years and older had no health care plan or insurance¹¹⁸. The racial/ethnic breakdown of this number is provided in Table 9.

Table 9. Percentage of Racial/Ethnic Groups without Health Insurance from 1998-2002¹¹⁹

Racial/Ethnic Group	Percentage without Health Insurance
White	9.1
African American	16.3
Asian American	16.9
Native American	20.9
Hispanic American	32.1
All Groups as a % of the population	10.6

Examined from a different perspective, one might consider that African Americans are about 1.8 times as likely as Whites not to have health insurance and Hispanic Americans are roughly 3.5 times as likely as Whites not to have insurance in Nebraska (Table 10).

Table 10. Relative Risk of Racial Ethnic Minorities not having Health Insurance Compared with Whites in Nebraska 1998-2002¹²⁰

Racial/Ethnic Group	Relative Risk of Not Having Health Insurance
White	1
African American	1.79
Asian American	1.89
Native Americans	2.30
Hispanic Americans	3.53

It has been suggested that some of these numbers might be elevated due to the limited sample size of the BRFSS¹²¹. However, the Center for Studying Health System Change states that uninsured Whites have greater financial resources¹²², one of the reasons they tend to have relatively fewer problems accessing care. One of the Nebraska 2010 Health Goals and Objectives is to increase the proportion of persons with health insurance to 100%¹²³. Because the cost of health care to small to midsize employers may be prohibitive, this may suggest that it is time to advocate for health insurance purchasing consortiums among small to midsize employers that can distribute some of the risk involved.

Status of Health Care Providers

Preventing disease is the most strategic approach to providing health care. When a person has a medical home with a familiar health care provider, many regular and fundamental health screenings focused on risk areas can occur. Furthermore, good relationships between patients and health care providers contribute to the addressing of unexpected changes that occur before they become catastrophic events. The number of primary care physicians practicing in Nebraska from 1990 to 2005 increased by 0.4%. This includes a 1.7% decrease in primary care physicians in metropolitan areas¹²⁴. In 2005, 49 of Nebraska’s 93 counties were designated as health professional shortage areas (HPSAs). Medically Underserved Areas (MUAs) and Populations (MUPs) are also federal designations of health care shortage. MUAs represent geographical areas and MUPs define specific populations with a shortage of primary health care services. Of Nebraska’s 93 counties, 71 contained, in full or in part, a designated MUA or MUP. This information is periodically updated on the HRSA (U.S. Department of Health and Human Services, Bureau of Health Professions) website¹²⁵. Over 19.5% (N=336,045) of the state’s population live within one of these areas and is potentially affected by a shortage of health care services¹²⁶.



Provider Perceptions

How can two people separated only by culture and skin color receive different treatments for the same medical condition? Should not one person with the symptoms of a heart attack be given the same consideration of another person with the same symptoms? Often, individuals with the same symptoms are treated differently. The ground breaking study of the Institute of Medicine verified that such practices occur repeatedly¹²⁷. “Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients’ insurance status and income are controlled¹²⁸. The perception and behavior of health care professionals is an important component in the perpetuation of health care disparities. As recently as February of 2006, a study by Dr. Michele van Ryn at the University of Minnesota illustrates this point. Van Ryn and colleagues evaluated the parameters associated with whether or not doctors recommended coronary artery bypass surgery (CABG) for heart patients. The study consisted of 532 patients who were all appropriate candidates for

CABG. The sample was composed of 34% White patients, 30% African American patients, and 36% Hispanic patients. Only 21% of the African American men were recommended for CABG compared to 40% of the White and Hispanic¹²⁹. The training of health care providers in cultural competency must lend itself to recognizing some of these biases and strive for equity in medical practice.

Status of Minority Healthcare Providers

The health care system is more responsive to people when people can see themselves as part of the health care system. There are a shortage of health care providers from racial and ethnic minority groups in the U.S. and Nebraska. For example, less than four percent of all U.S. physicians are African American despite the fact that African Americans comprise roughly 12% of the U.S. population¹³⁰. In Nebraska, African Americans make up 4% of the population yet only 0.9% of the physicians in the state are African American. Hispanics compose 5.5% of the population, yet only 1.2% of the physicians in the state are Hispanic. Native Americans comprise 0.9% of the population yet only 0.3% of the physicians in the state are Native American. Asians, on the other hand, make up 1.3% of the population and represent 4.8% of Nebraska’s physicians. This requires working with the educational system and the health professional training organizations to improve the number of racial and ethnic minorities in health care in Nebraska. The numbers are similar for nurses and dentists¹³¹. A number of immigrants (racial/ethnic) are physicians in their countries, but not allowed to practice in the U.S.

Translation and Transportation

If a health care facility or health plan is to serve a community with specific language or transportation needs they must do an appropriate needs assessment for their client/patient population in order to meet these needs. Tying the appropriate needs assessment to grant and funding opportunities is one way to ascertain whether programs are addressing the needs of their communities by providing equal access to health care. Tracking the number of non-English speaking clients who have utilized services is another way to ascertain the needs of clients. Transportation services are clearly significant when one considers the distance between health care providers in what is largely a rural state. The Office of Rural Health has done an outstanding job in providing the distribution of: 1) Nebraska Community Health Centers and Indian Health Services Facilities (11 as of 8-2005); 2) Nebraska Medicare Certified Rural Health Clinics (111 as of 8-2005) and; 3) Nebraska Critical Access Hospitals (61 as of 8-2005)¹³².

Did You Know?	
Languages Spoken in Nebraska	
Afrikaans	Mandarin/Chinese
Albanian/Shiquip	Marathi
Amharic/Ethiopian	Mongolian
Arabic/Egyptian/Lebanese/Syrian	Native American
Armenian/Haieren	Nepalese/Nepali
Bengali/Bangla	Nuer
Cambodian/Khmer	Other
Chinese/Cantonese	Pashto/Pashtu
Dutch	Polish
English	Portugese
Farsi/Persian/Dari	Romanian/Moldavian
Filipino/Tagalog	Russian
French	Samoan
German	Serbo-Croatian/Bosnian
Hindi/Indian/Urdu	Slovak
Hmong	Spanish
Indonesian	Tajik
Japanese	Thai/Tai/Thaiklang
Kanjobal	Tonga/Tongan
Korean	Turkish
Kurdish/Zimany/Kurdy	Ukrainian
Lao/Laotian	Vietnamese
Malay/Bahasa/Malaysia	

Source: Nebraska Department of Education

Quality

Limitations of quality of care measurements have been described elsewhere^{133, 134}. Yet, there has been a scarcity of discussion on the failure of existing measures to identify socioeconomic and racial/ethnic disparities in quality. These disparities in health care delivery and process are a threat to quality. If the idea is that health care quality ensures that resources are allocated according to medical need, risk and benefit, then alternate standards are not consistent with quality. Yet, a health plan can receive an excellent Health Plan Employer Data and Information Set (HEDIS) rating by immunizing large numbers of children for hepatitis who are at the lowest risk. However, children at the highest risk in that community would remain un-immunized and the issue would go unrecognized until children begin to suffer the secondary effects of hepatitis B. Clearly, current quality measures are too crude to capture critical disparities¹³⁵. Racial/ethnic and socioeconomic disparities must be recognized as reflecting significant quality problems. The collection of relevant and reliable data is needed to provide a more comprehensive view of quality.



A National Committee for Quality Assurance (NCQA)-commissioned report recommended that managed care organizations (MCOs) include non-clinical determinants of outcomes, including socioeconomic and racial/ethnic data as part of the core information on patients¹³⁶. For example, instead of simply indicating the gross rates of Pap screening performed among eligible women from the number of screens performed, MCOs might also be required to report separate rates by socioeconomic position and race/ethnicity. This would promote greater accountability for care provided to women at highest risk for cervical dysplasia¹³⁷. An approach to disparities should account for the relationships between socioeconomic position, race, ethnicity, and morbidity. Consideration should be given to linking reimbursement rates to the socioeconomic position and racial/ethnicity composition of the enrolled population. The Centers for Medicaid and Medicare Services has explored plans to base Medicare rates on case-mix adjustment¹³⁸. Case-mix adjustment is a tool that adjusts for sociodemographic differences in the population, or in this case, the health plan. For example, a third party payor may reimburse a given fee for the management of a case of diabetes. However, if the diabetes is complicated by cataracts and or kidney disease, the amount of resources that need to be devoted to that patient may increase significantly. If a health plan provides service to a population with an inordinate amount of patients with secondary illnesses, their reimbursement may have to be readjusted based on their mix of cases.

Culturally Competent and Linguistically Appropriate Health Care

To provide appropriate service to a patient or community, the health care provider must be able to communicate with that patient or community. This not only requires an understanding of the language used by that patient or community, both verbal and nonverbal, but also requires some understanding of how that patient or community assigns meaning to the information that language conveys. In short, it requires cultural as well as linguistic competence.

According to Goode and Jones, linguistic competence is “the capacity of an individual or organization and its personnel to effectively communicate with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals with disabilities”¹³⁹. This may include but is not limited to the following: the use of bilingual/bicultural staff; cultural brokers, multilingual telecommunications systems; ethnic media in languages other than English (e.g. television, radio, newspapers, periodicals); print materials in

easy-to-read, low literacy, picture and symbol formats; and materials in alternative formats (e.g. Braille, audiotape, enlarged print)¹⁴⁰.

Cultural competence has been described in many ways. The Department of Health and Human Services (DHHS) has described it as “the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group”¹⁴¹. Betancourt and his colleagues have described cultural competence in health care as “the ability of systems to provide care to patients with diverse values, beliefs, and behaviors; including tailoring delivery to meet patients’ social, cultural, and linguistic needs”¹⁴². Lavizzo-Mourey and Mackenzie have taken a more epidemiological and policy approach. They describe cultural competency as “a demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy.”

Did You Know?

It’s the law... all patients are entitled to health care that is culturally competent and linguistically appropriate.

They go on to state that “the most significant aspect of this concept is the inclusion and integration of these three areas that are usually considered separately when they are considered at all”¹⁴³. What all these definitions imply is that to provide effective health care in the long-term, one must not only be able to communicate with patients/clients linguistically, but also be able to understand the implications of that care from the patient’s/client’s perspective. This may determine something as simple as whether the patient/client returns for follow-up.

One approach to the development of culturally competent health system has been the use of health care promoters or *Promotoras*. *Promotoras* are community members who become liaisons between their community and health, human service, and social service organizations. They work with organizations and institutions both formally and informally, either as employees or volunteers. They bring information to their communities and often play the roles of advocate, educator, mentor, outreach worker, role model, and translator¹⁴⁴. *Promotoras* have been effectively employed to increase adherence to chronic disease screening among women along the U.S.-Mexico border¹⁴⁵, they have been employed to effectively promote cardiovascular health¹⁴⁶, and have effectively been employed by Planned Parenthood to fulfill its mission to allow women to manage their fertility and to ensure they are provided culturally appropriate healthcare¹⁴⁷. The concept of the *Promotora* is not new. The Chinese used community health workers, the “Barefoot Doctor,” to augment their health care system in rural areas. Also, community outreach workers were trained and operated on a volunteer basis in the Bronx to serve as health advocates, educators, and mentors in African American and Hispanic communities, specifically tenement houses¹⁴⁸. Cultural and linguistic competency training for health systems and health providers is critical as our society becomes more diverse.

To that end, the U.S. Government has developed national standards for culturally and linguistically appropriate services (CLAS) in healthcare^{149, 150}. In 1997, the DHHS Office of Minority Health undertook the development of national standards to provide an alternative to the patchwork of independently developed definitions, practices, and requirements concerning CLAS. The project was initiated to develop recommended National CLAS standards to support a more consistent and comprehensive approach to cultural and linguistic competence in health care. More information on CLAS Standards is available at www.hhss.ne.gov/minorityhealth/CLAS_Standards.htm.



One might consider there to be a spectrum of cultural competency in which one begins by being culturally illiterate. With study and training one moves along the spectrum and becomes culturally sensitive and finally with practice and interaction, one becomes culturally proficient. The concept of a spectrum of cultural competence has been developed further elsewhere¹⁵¹. Another useful analogy would be journeying to a foreign country. There are different customs and beliefs in a given society as well as a different language. The more you recognize and honor those beliefs and the more proficient you become at speaking the language, the easier it is to navigate in that country. The first thing required is being consciously aware of one's incompetence with regards to cultures different from one's own. Few of us will become proficient in another culture, but each of us can adopt an attitude of cultural humility in recognizing the depths of growing numbers of diverse communities across Nebraska.

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