Nebraska Minorities

Disparity Facts Chart Book

2021

Office of Health Disparities & Health Equity

Division of Public Health

Nebraska Department of Health & Human Services

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DEPT. OF HEALTH AND HUMAN SERVICES

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Introduction

The Office of Health Disparities and Health Equity (OHDHE) represents and advances the interests of the minority population of Nebraska for the purpose of reducing health disparities between racial and ethnic minorities and non-minorities.

If a health outcome varies greatly by a greater or lesser extent between populations, a disparity exists. Demographics, socioeconomic status, and geographical location all play a factor in one's ability to achieve good health.[1] In Nebraska, there continues to be significant gaps in health and wellness between non-minority and minority populations. Eliminating these disparities is essential to improving health outcomes for all Nebraskans, especially as our communities continue to become more diverse.

Health reports and data fact sheets are important tools which can measure the quality of health of all residents in Nebraska and aid in improving the health of all Nebraskans.

This report illustrates the socioeconomic and health care differences among Nebraska's racial and ethnic minority groups. It is formatted to provide a user-friendly summary of data findings, including highlights of selected minority health indicators and issues.

The topics covered in this report provide benchmarks upon which Nebraska's minority health status and disparities are consistently gauged.

All information and data are derived from the Nebraska Department of Health and Human Services Vital Statistics, Nebraska Behavioral Risk Factor Surveillance System (BRFSS), HIV Prevention Program, the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), and other programs, as well as national resource materials. All rates included are age-adjusted, unless noted otherwise, to the 2000 U.S. Population Standard. Population data is derived from Census and Vital Statistics data.

Some caution should be exercised while interpreting, analyzing, and/or using data herein, as some are based on small numbers.

Special thanks to the individuals who assisted in the retrieval of information and data from the various sources.

[1] Healthy People. (2020). Disparities. Retrieved from https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Demographics

The racial composition of the United States has changed dramatically throughout time, with minorities accounting for 38% of the total population in 2015.[2] The United States Census Bureau predicts that this percentage will rise to over 50% by 2044. This trend can also be seen in Nebraska.

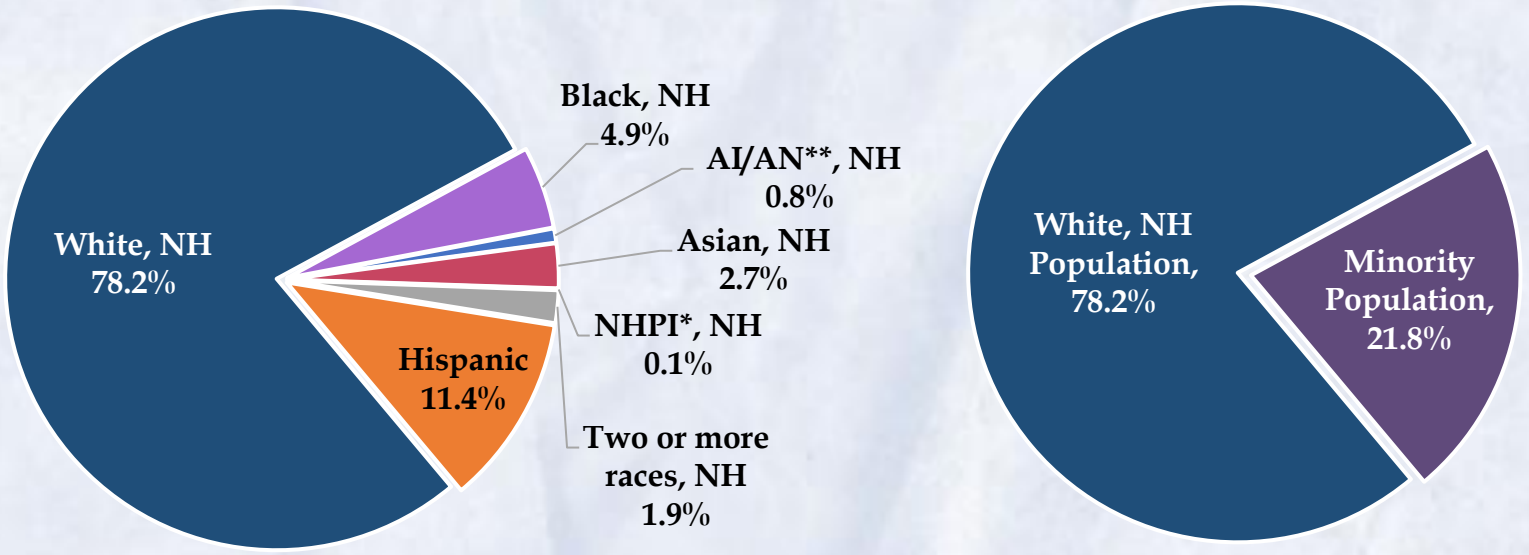
During the 20th century, Nebraska's population saw significant changes. From 1910-1920, Nebraska's African American population doubled to over 10,000.[3] In 1972, Nebraska was the first state to create an agency chiefly responsible for the advocacy of the Hispanic population. During that time, an estimated 30,000 Mexican Americans, the primary heritage of Hispanics in Nebraska, resided in the state.[4]

At the beginning of this century, minority populations accounted for approximately 12% of the U.S. population and 10% of the Nebraska population.[5] In total, Nebraska's minority population grew by almost 30% between 2000 and 2007. By 2050, minority groups are expected to make up approximately half of the total population in the United States, and those population projections are expected in Nebraska as well.

Currently in Nebraska, the minority population accounts for approximately 22% of the population, increasing by almost 30%. When compared to the White population increase (0.8%), tremendous increases were seen across all minority populations. The largest population increases were amongst the Asian (59.9%), Hispanic (31.2%), and Native Hawaiian and Other Pacific Islanders (23.8%) populations.

[2] U.S. Census Bureau. (2015). United States. Retrieved from www.census.gov/quickfacts/table/PST045216/00
[3] Danver, S. (2013) *Encyclopedia of politics of the American west*. Washington, DC: CQ Press
[4] Davis, R. (2008). Service not power: the early years of the Nebraska commission on Mexican-Americans, 1971-1975. *Nebraska History 89*: 67-83.
[5] Hobbs, F. and Stoops, N. (2002). Demographic trends in the 20th century: Census 2000 special report.

Nebraska Population by Race & Ethnicity 2019 Estimates



Nebraska Population by Race/Ethnicity	
White, Non-Hispanic	1,513,172
Black, Non-Hispanic	94,830
American Indian/Alaskan Native, Non-Hispanic	16,333
Asian, Non-Hispanic	51,496
Native Hawaiian and Other Pacific Islander, Non-Hispanic	1,229
Two or more races, Non-Hispanic	37,703
Hispanic	219,645
Minority Population Total	421,236
Total	1,934,408

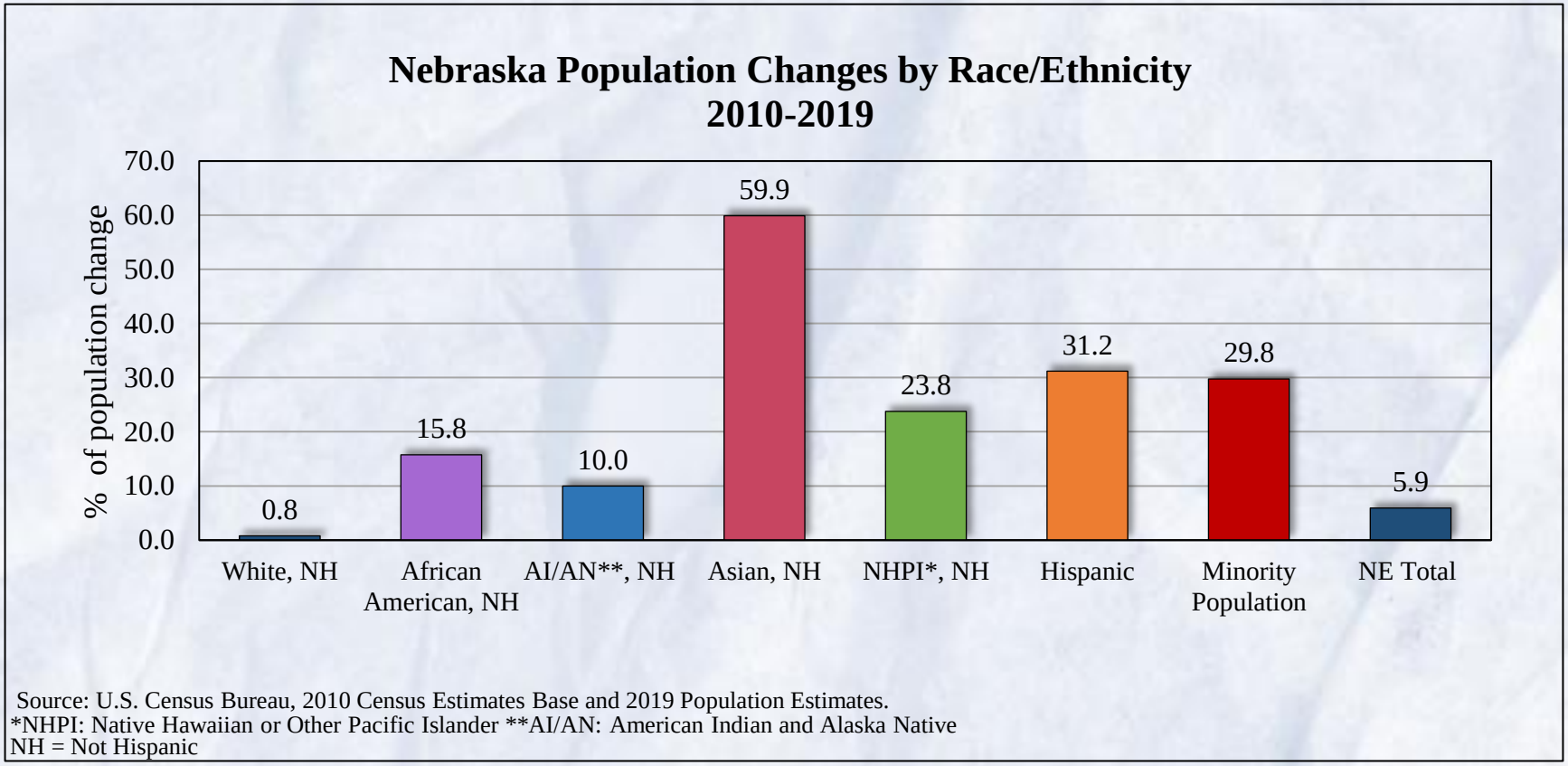
NH = Non-Hispanic
* Native Hawaiian and Other Pacific Islander . ** American Indian and Alaska Native
Source: US Census Bureau, 2019 Population Estimates

Change in Minority Populations

Between 2010 and 2019, Nebraska's total population increased by 5.9%, with a 29.8% growth in the minority population.

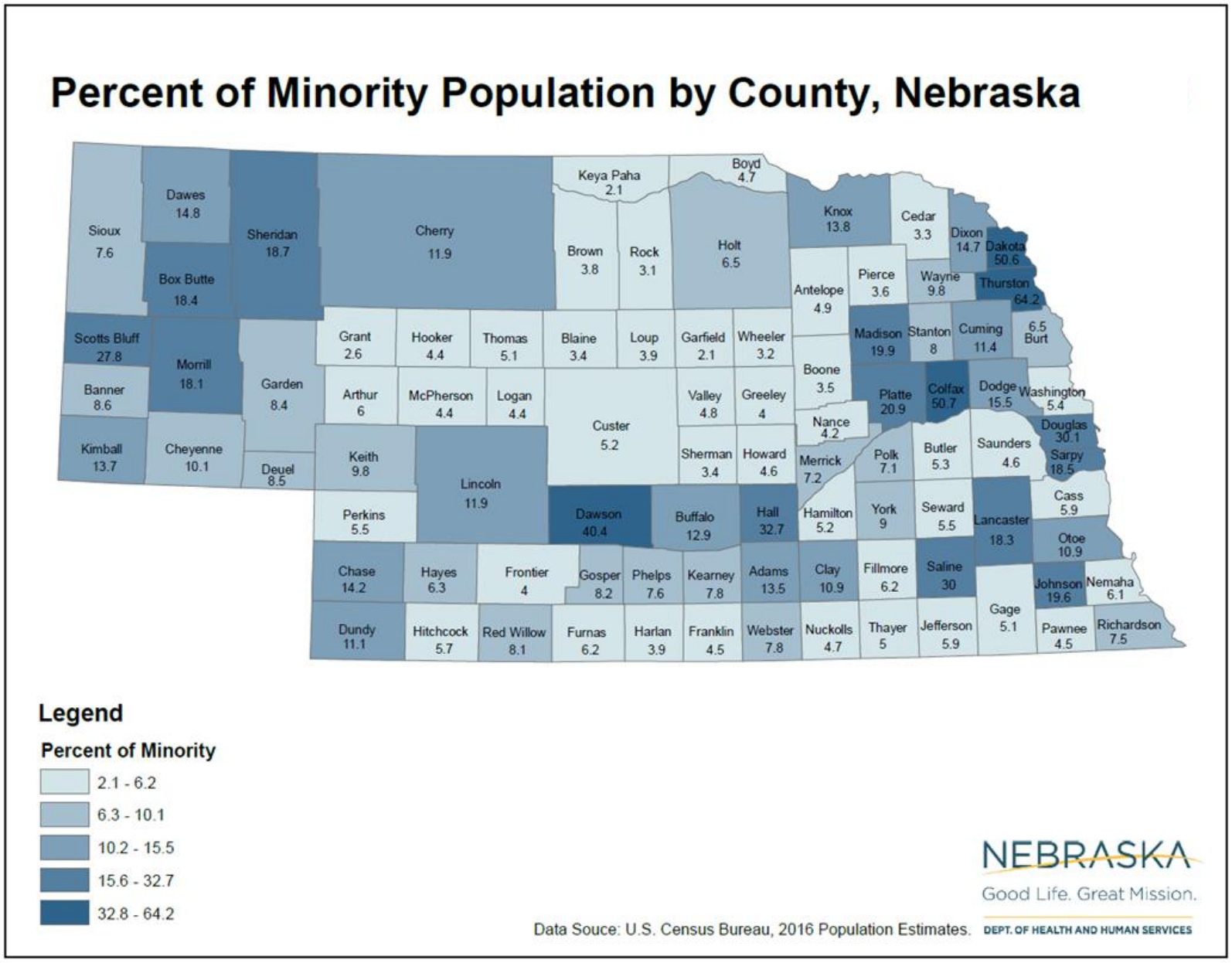
The largest minority population change was among Asians (59.9%), followed by the Hispanic population (31.2%) and the Native Hawaiian and Pacific Islanders (23.8%).

In 2019, minorities accounted for approximately 22% of the total Nebraska population.



Source: U.S. Census Bureau, 2010 Census Estimates Base and 2019 Population Estimates.
*NHPI: Native Hawaiian or Other Pacific Islander **AI/AN: American Indian and Alaska Native
NH = Not Hispanic

Minority Population by County Map



Social Determinants of Health

While a wide variety of factors can affect health, an increasing amount of research and importance has been growing around the social determinants of health (SDOH). These social determinants are often created by the conditions in which people live and work and can be divided into five broad groups: economic stability, education, social and community context, health and health care, and neighborhood and built environment. Each of these categories includes a number of SDOH indicators. For example, economic stability determinants can include such indicators as poverty and employment, while education can include graduation and enrollment in higher education.

Certain marginalized groups often have less access to the conditions that support good health. This interplay between race and the SDOH is important to consider. Racial and ethnic minority populations are far more likely to fall at the low end in each of these categories and disproportionately incur the negative consequences associated with those circumstances.

There are disparities solely between SDOH levels as well as disparities between race and ethnicity. These factors are intertwined, but also have distinct roles. The U.S. Census Bureau, non-profit foundations, and research institutions, along with numerous government bodies, have documented multiple complex linkages between factors unique to racial and ethnic minority populations and the social determinants of health.

[6]Healthy People (2010). Social Determinants of Health. Retrieved from www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

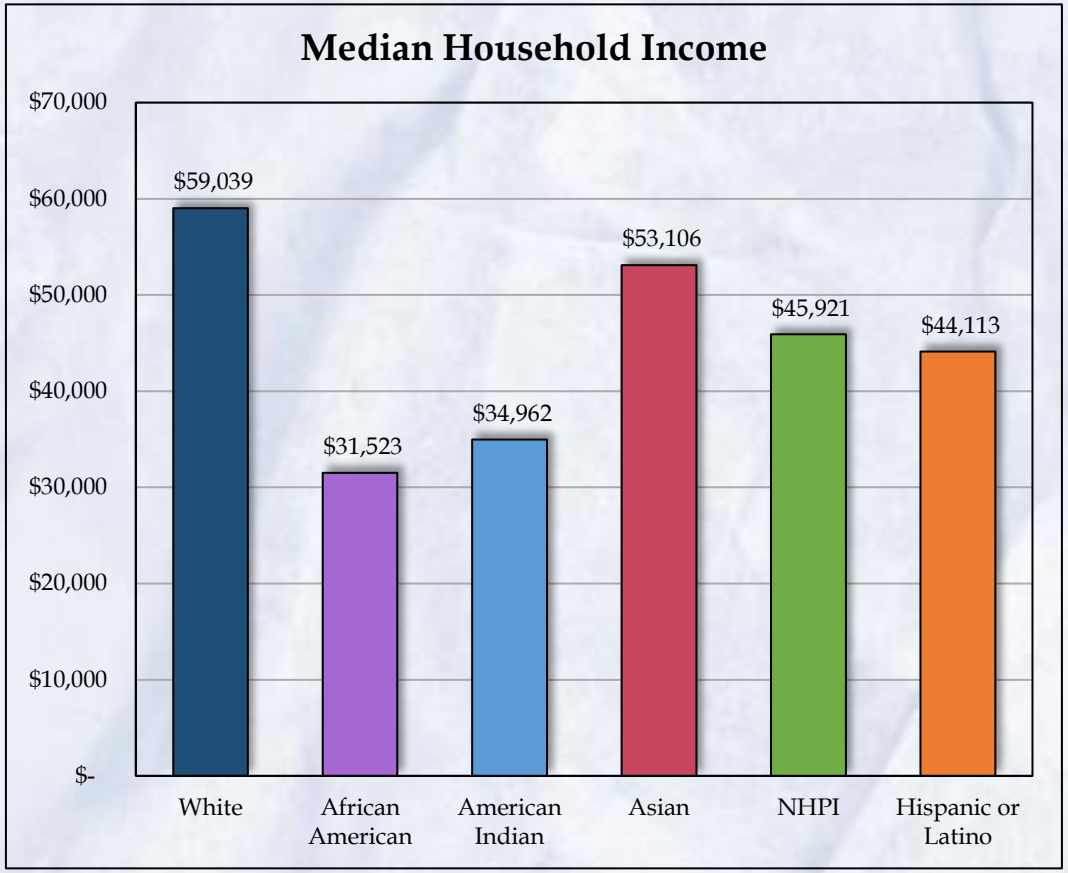
Household Income

Individuals with lower income levels are more likely to see higher mortality rates, the prevalence of acute or chronic diseases, and poorer mental health. The household income is calculated as the income of the householder and all other individuals 15 years old and over in the household in the past 12 months.

Key Disparities:

Among minority groups, African Americans had the lowest median income at $31,523 between 2013 and 2017.

Hispanics earned approximately $15,000 less than Whites, while American Indians earned approximately $24,007 less.



Source: U. S. Census Bureau American Community Survey 5-year Estimates, 2013-2017

Note: NHPI = Native Hawaiian and Other Pacific Islander

Poverty

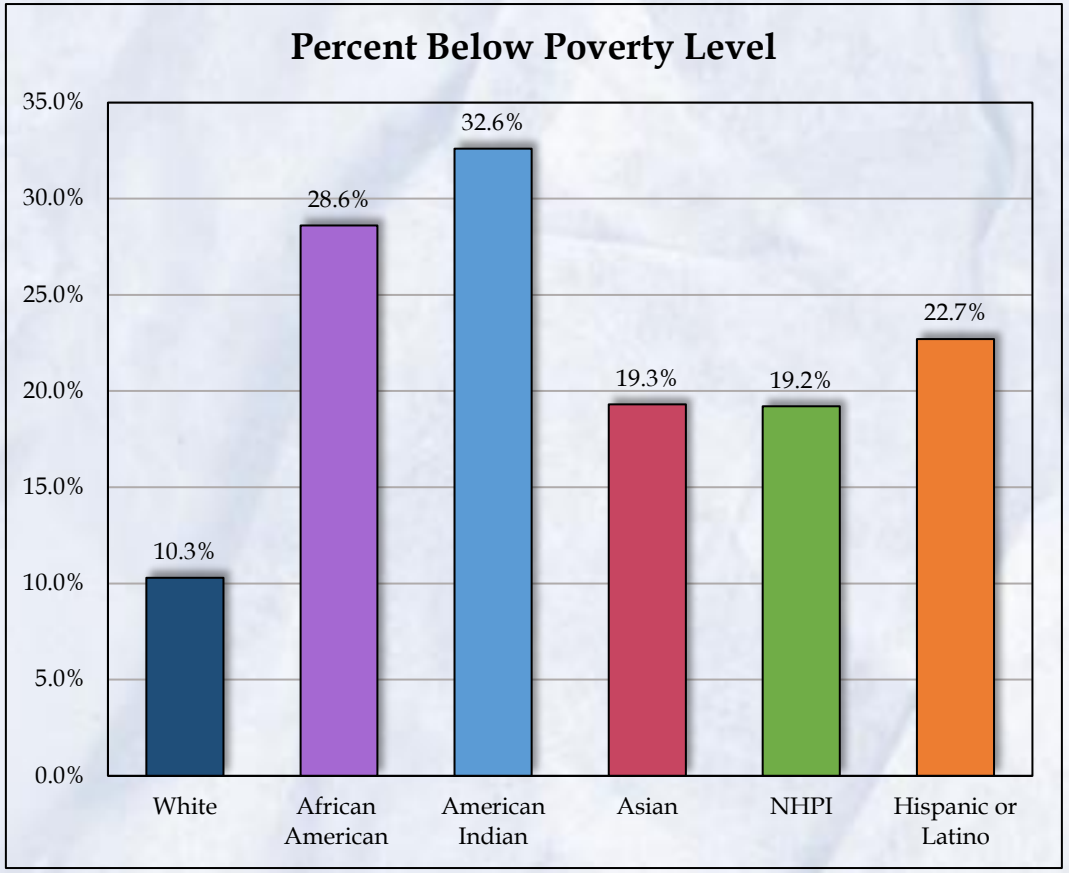
Poverty affects most aspects of life, from the affordability of health insurance to the quality of food selection. Poverty is much more prevalent among minority populations. The chart depicts those that were 100% below the federal poverty level.

Key Disparities:

Almost one-third of American Indians lived below the poverty level.

African Americans also saw higher percent of individuals living below the poverty level at 28.6%.

Asians (19.3%), Native Hawaiians and Other Pacific Islanders (19.2%), and Hispanics (22.7%) had twice the percent of individuals below the poverty line compared to Whites (10.3%).



Source: U. S. Census Bureau American Community Survey 5-year Estimates, 2013-2017

Note: NHPI = Native Hawaiian and Other Pacific Islander

Employment Status

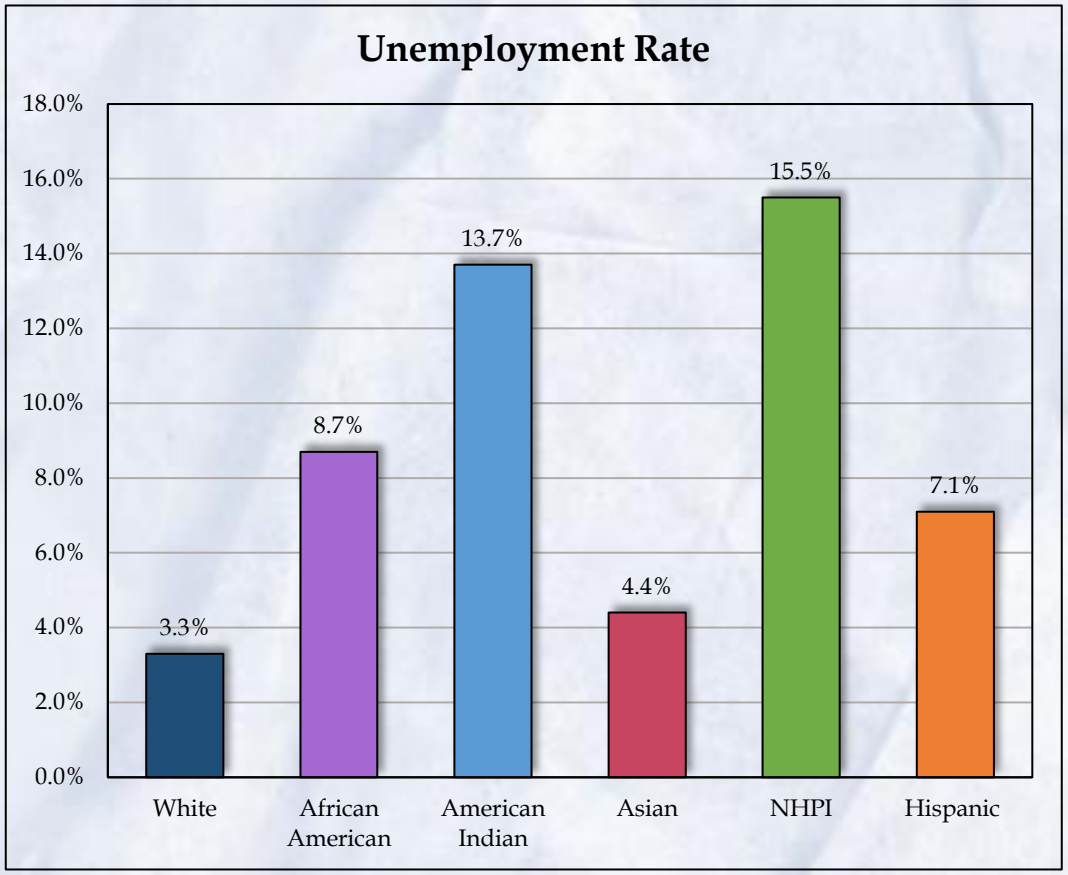
According to the Center for Global Policy Solutions, employment fragility is at the center of racial disparities in wealth in the United States.[7] Un-employment referred to individuals who were 16 and older, able to work and had actively searched for a job in the past four weeks, but did not have a job.

Key Disparities:

Native Hawaiians and Other Pacific Islanders had the highest unemployment rate at 15.5% which was 5 times greater than that of Whites.

American Indians had the second highest percentage of unemployed individuals at 13.7%.

The unemployment rate for African Americans (8.7%) was 3 times greater than that of Whites and the Hispanic (7.1%) unemployment rate was twice as high as that of Whites.



Source: U. S. Census Bureau American Community Survey 5-year Estimates, 2013-2017

Note: NHPI = Native Hawaiian and Other Pacific Islander

[7] Center for Global Policy Solutions. Retrieved from http://globalpolicysolutions.org/wp-content/uploads/2017/07/Unemployment-Data-by-Race.pdf

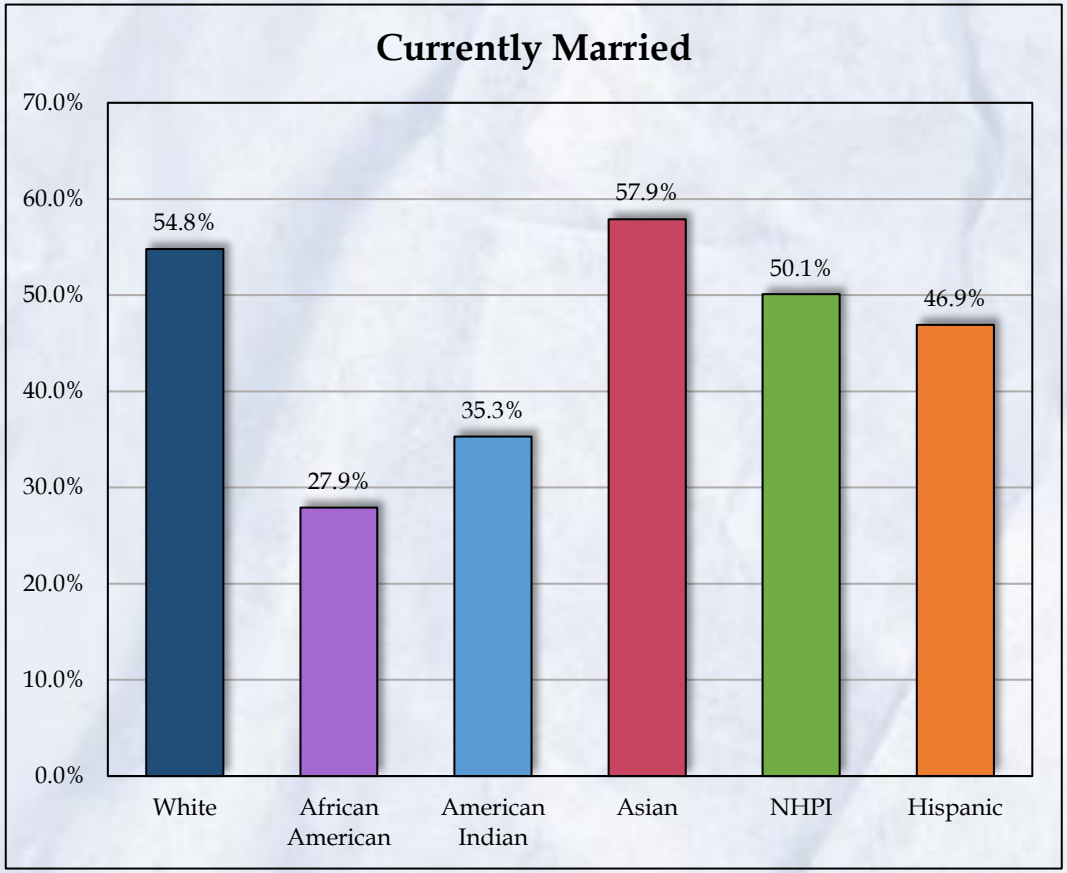
Marital Status

Married individuals are generally healthier than those that are unmarried and the children of married couples also tend to be healthier.[8] Studies have found that marriage improves certain mental health outcomes, shortens hospital stays, reduces number of doctor visits and nursing home admissions, lowers some health care costs, and increases the likelihood of having health insurance coverage.[9] The below chart represents the percentage of married individuals by race. Married, but separated individuals were not included in the calculations.

Key Disparities:

African Americans had the lowest proportion of married individuals at 27.9%, which was almost half that of the White population.

American Indians also had a lower proportion of married individuals at 35.3%.



Source: U. S. Census Bureau American Community Survey 5-year Estimates, 2013-2017

Note: NHPI = Native Hawaiian and Other Pacific Islander

[8] Gallagher, M. & Waite, L. (2000) *The case for marriage: why married people are happier, healthier, and better off financially.* New York, NY: Broadway Books.

[9] U.S Department of Health and Human Services. (2007). The effects of marriage on health: A synthesis of recent research evidence. Retrieved from https://aspe.hhs.gov/report/effects-marriage-health-synthesis-recent-research-evidence-research-brief

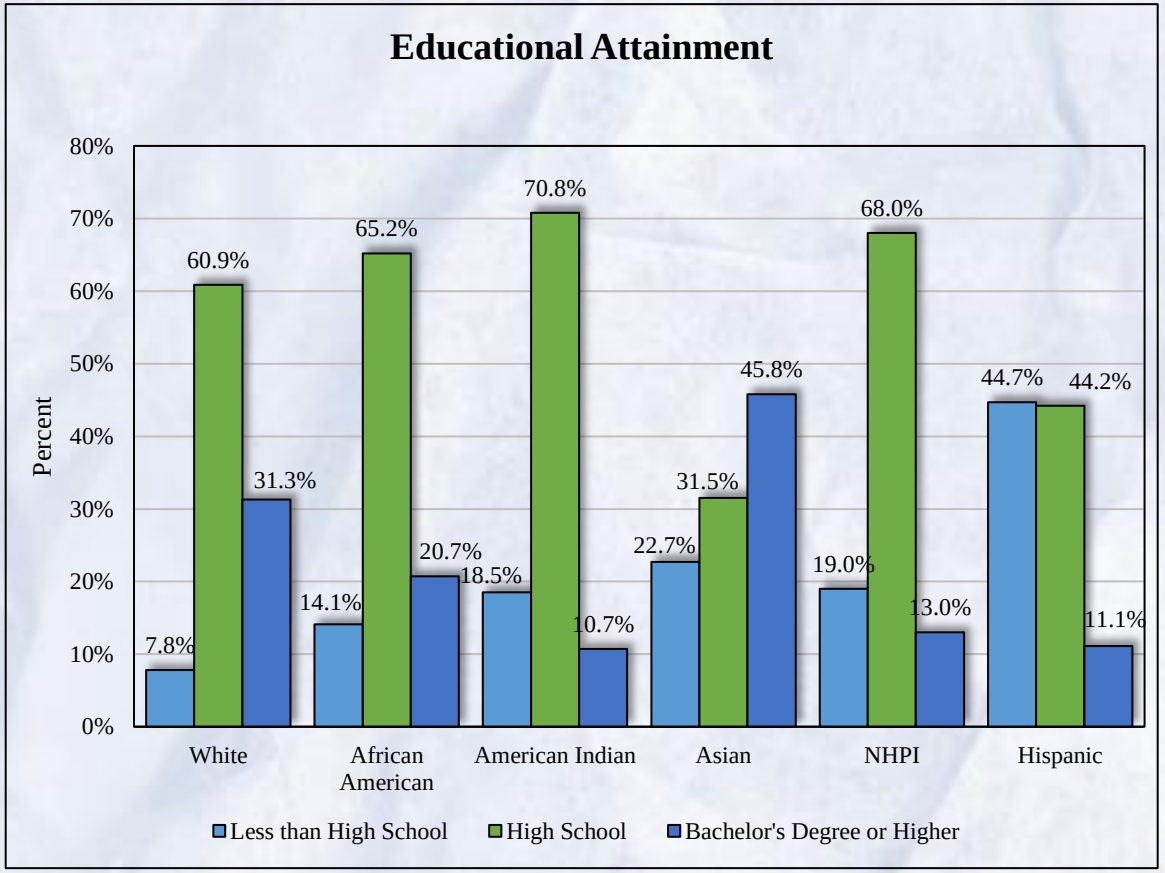
Educational Attainment

Education is positively associated with health. Individuals with higher educational attainment live longer and are generally healthier than those with fewer years of schooling.

Key Disparities:

Hispanics (44.7%) were most likely to have less than a high school education, which was 5.7 times greater than that of the White population (7.8%).

American Indians (10.7%) were least likely to have a bachelor's degree or higher, followed by Hispanics (11.1%).



Source: U. S. Census Bureau American Community Survey, 2013 – 2017

Notes: NHPI = Native Hawaiian and Other Pacific Islander

Less than high school are those that did not graduate high school

High school are those that graduate high school, those with some college, and associate's degrees

Bachelor's degree is those that graduated college and those with graduate degrees

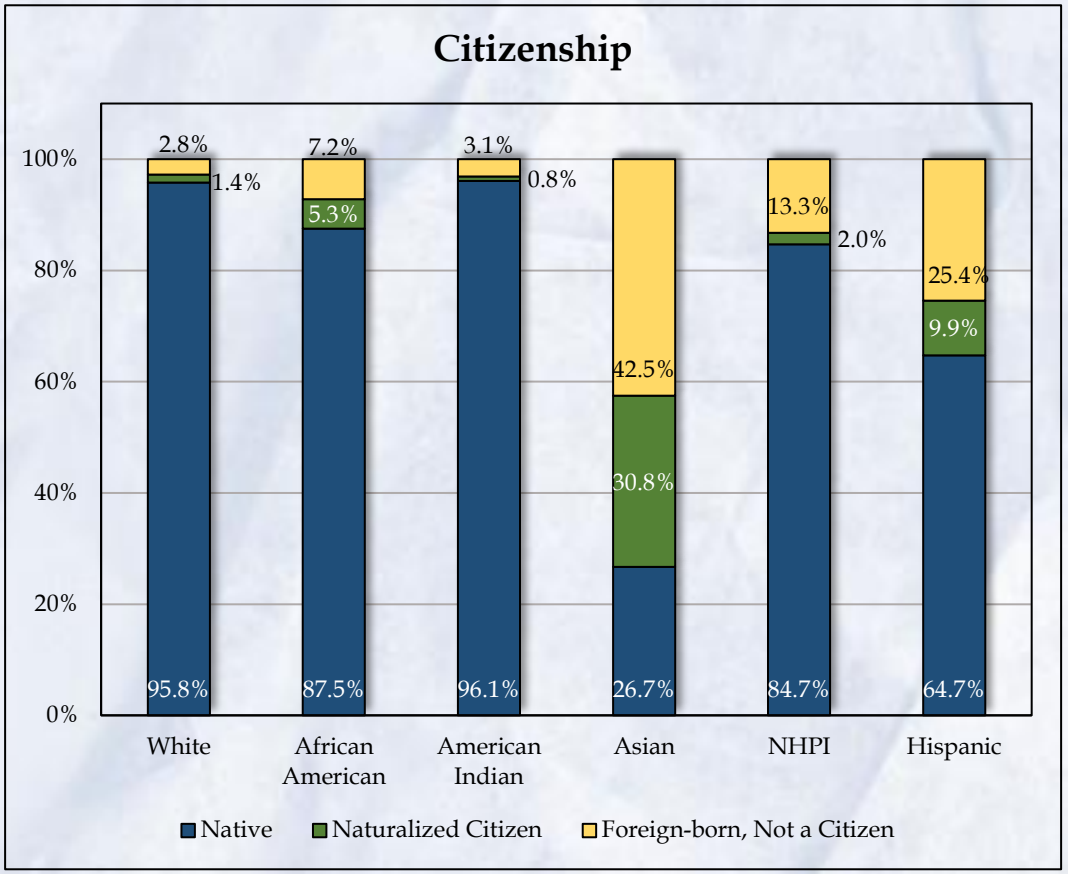
Citizenship

Immigrants often face barriers to receiving healthcare, such as language barriers and being unfamiliar with the complex healthcare system. The below chart shows the proportion of Nebraskans who are citizens by birth, foreign-born individuals who were naturalized, and foreign-born individuals who are currently not citizens.

Key Disparities:

The majority of the Asian population (42.5%) reported being foreign born and not holding citizenship.

Approximately one-fourth of the Hispanic population (25.4%) reported not holding citizenship, followed by the Native Hawaiian and Other Pacific Islanders population (13.3%).



Source: U. S. Census Bureau American Community Survey 5-year Estimates, 2013-2017

Note: NHPI = Native Hawaiian and Other Pacific Islander

Access to Care

Access to high-quality health care is the foundation for eliminating health disparities and increasing quality of life. Fortunately, many health problems that were once untreatable now have better outcomes or are even preventable due to advances in technology and treatment.[11]

To realize the benefits of these advances, patients must not only be able to gain entry to the health care system, but also have access to a location where such services are provided. Another obstacle for many includes finding culturally and linguistically appropriate services where patients feel secure and can develop relationships based on trust and communication.[12]

In recent years, major changes in the structure of the U.S. health care system, increasing costs, and government program reforms have adversely affected health care consumers, particularly vulnerable and at-risk populations.[13] Additional barriers to healthcare among minorities can include lack of transportation, lack of knowledge of where to obtain care or when to seek care, language, and cultural barriers, and discrimination. These barriers make it difficult to gain access to even the most basic health services, resulting in disproportionate increases in the incidence of disease, disability, and early death.

[11]Nebraska Department of Health and Human Services. (2007). Nebraska 2010 health goals and objectives: A midcourse review.
[12]Agency for Health Care Research and Quality. (2008). National health care disparities report 2007. Rockville, MD.
[13]Nebraska Department of Health and Human Services. (2007). Nebraska 2010 health goals and objectives: A midcourse review.

No Personal Physician

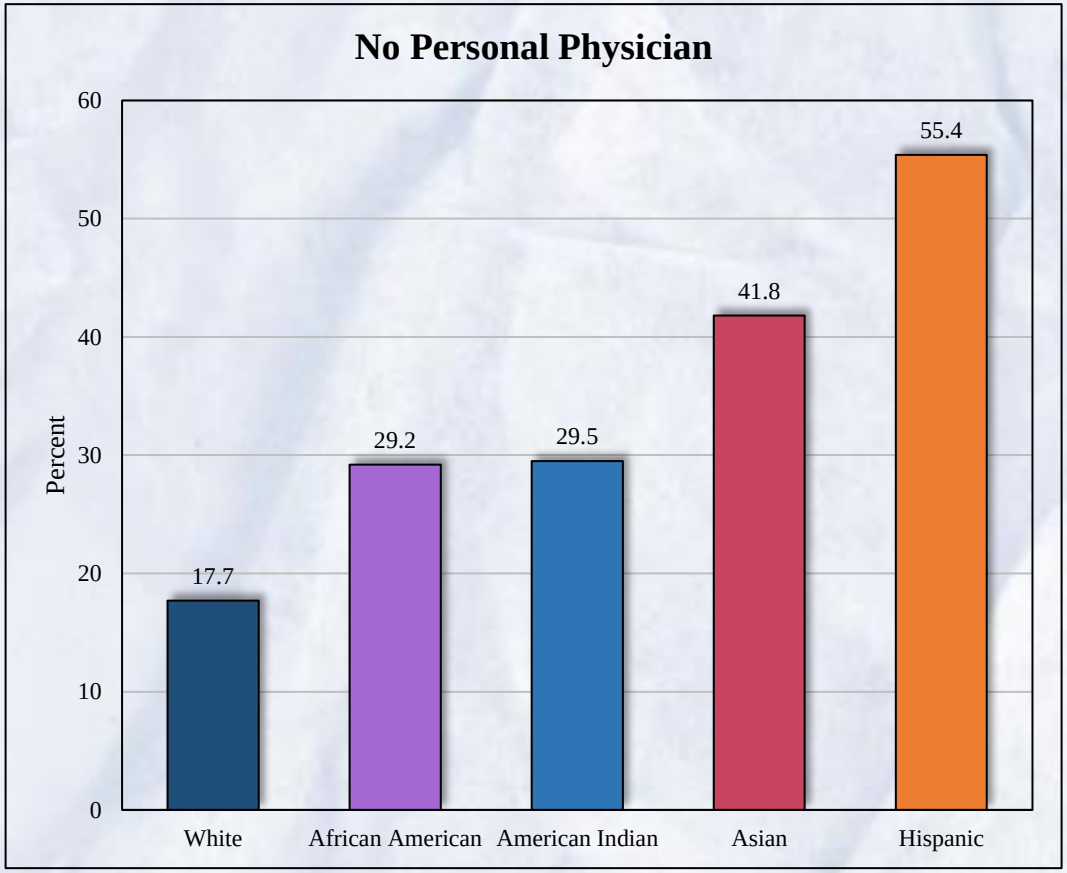
Primary care physicians provide a combination of direct care and, as necessary, counsel the patient in the appropriate use of specialists and advanced treatment locations. Individuals with a medical home are more likely to have routine medical visits and health screenings.[14]

Key Disparities:

More than half of Hispanics reported not having a personal physician, more than triple the percentage of Whites.

Forty-two percent of the Asian population reported not having a personal physician, which was 2.4 times higher than the White population.

Approximately 30% of American Indians and African Americans reported not having a personal physician, which was almost twice the rate of Whites.



Source: CDC BRFSS 2018

[14]National Institutes of Health. (2015). Choosing a primary care provider. Retrieved from https://medlineplus.gov/ency/article/001939.htm

No Health Care Coverage

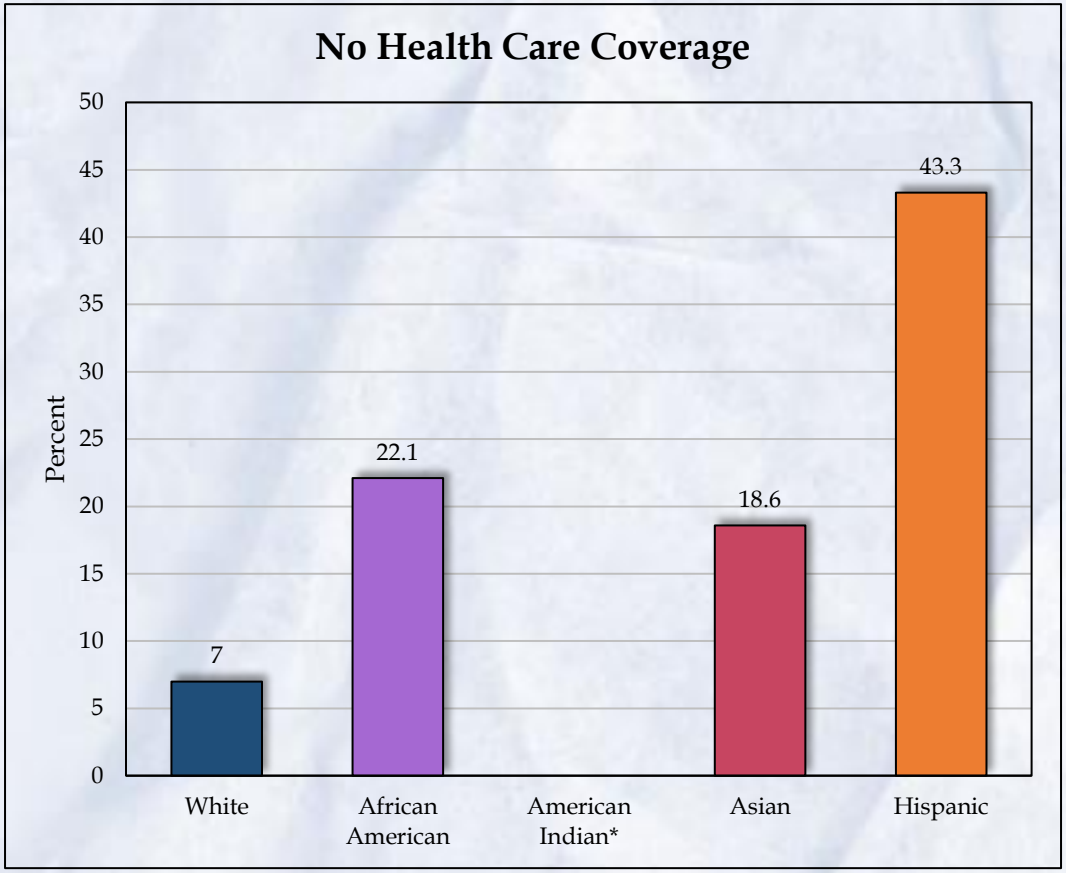
Lack of a health care plan or inadequate insurance coverage prevents many people from getting needed care because they are financially unable to pay for services without the help of insurance. Individuals with health insurance are generally more likely to have a primary care provider and to have received appropriate preventative care, such as early prenatal care, immunizations, or health screenings.

Key Disparities:

Hispanics (43.3%) were more than 6 times likely than Whites (7.0%) to report not having health care coverage.

African Americans (22.1%) and Asians (18.6%) also were more likely to report not having health care coverage.

*Due to small sample size, American Indian data was not included.



Source: CDC BRFSS 2018

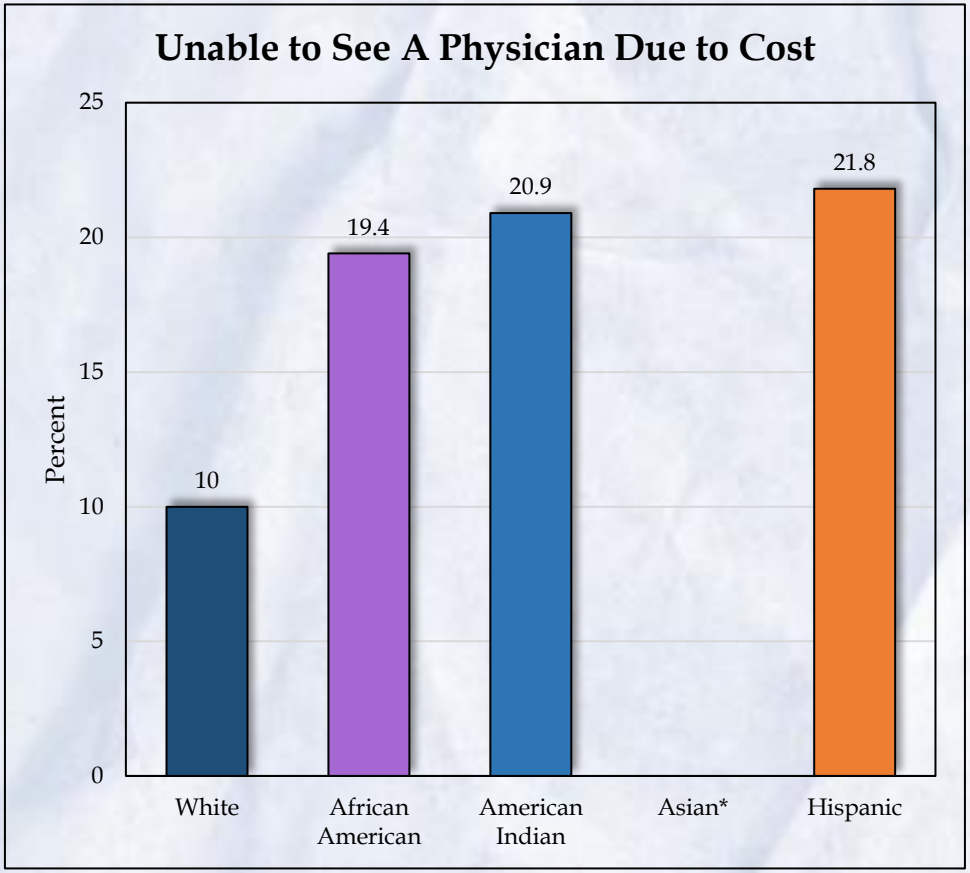
Unable to See A Physician Due To Cost

For people without insurance and limited financial resources, the decision of whether to see a doctor is often a financial choice rather than a medical one. Even when health benefits are available, they may not be sufficient to ensure access to needed health care services. Persons with health insurance may still be confronted with significant financial hardships in paying for or obtaining health services or products.

Key Disparities:

Around one in five American Indians (20.9%), Hispanics (21.8%), and African Americans (20.9%) were unable to see a physician due to cost. This was approximately double the percentage of Whites (10.9%).

*Due to small sample size, Asian data was not included.



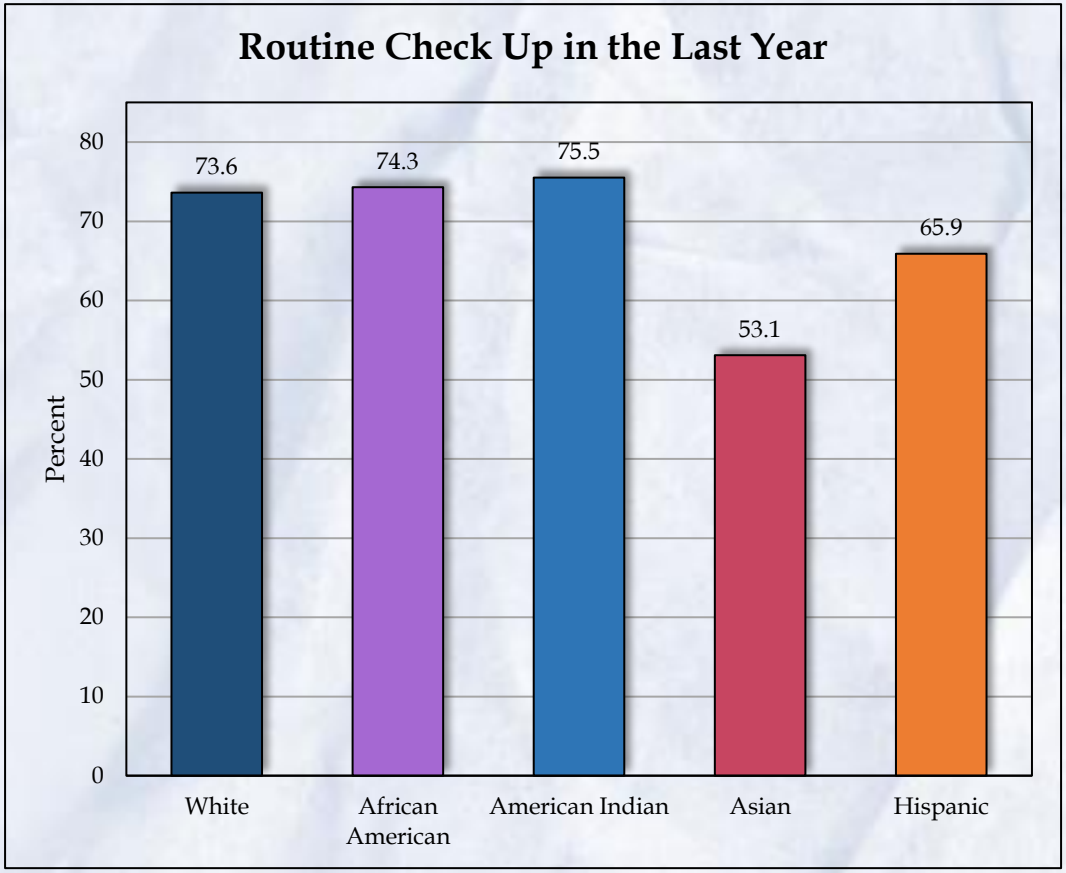
Source: CDC BRFSS 2018

Routine Check Up

Routine check-ups are helpful in finding problems before they become a cause for concern. Finding problems earlier makes chances for treatment better. Scheduling regular check-ups with a physician is an important step in maintaining a long, healthy life.

Key Disparities:

The Asian population (53.1%) was least likely to report having had a routine check up in the last year with just over half reporting such. This was followed by the Hispanic population with only 65.9% reporting having had a routine check up in the past year.



Source: CDC BRFSS 2018

Maternal, Infant, and Child Health

In any given year, six million women become pregnant. The health of mothers, infants, and children reflects the health status of a nation and forms the basis for the health of the next generation. In particular, the infant mortality rate is recognized worldwide as an indicator of health status and social well-being. Infant mortality is associated with socioeconomic status, access to health care, and the health status of women of childbearing age. Moreover, when women make positive health decisions while pregnant, it allows the next generation to start life as healthy as possible.[15]

In 2018, with an infant mortality rate of 5.7 per 1,000 live births, the U.S. was ranked 33rd out of 36 countries among developed nations. Within the United States, rates of infant mortality are higher in some areas. Nebraska was ranked 25th in 2018 with an infant mortality rate of 5.8 per 1,000 live births.

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

[15]Healthy People. (2012). Maternal, infant, and child health. Retrieved from www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26
[16]America's Health Rankings. (2018). *America's health rankings annual report*. Retrieved from https://www.americashealthrankings.org/learn/reports/2018-annual-report/findings-international-comparison

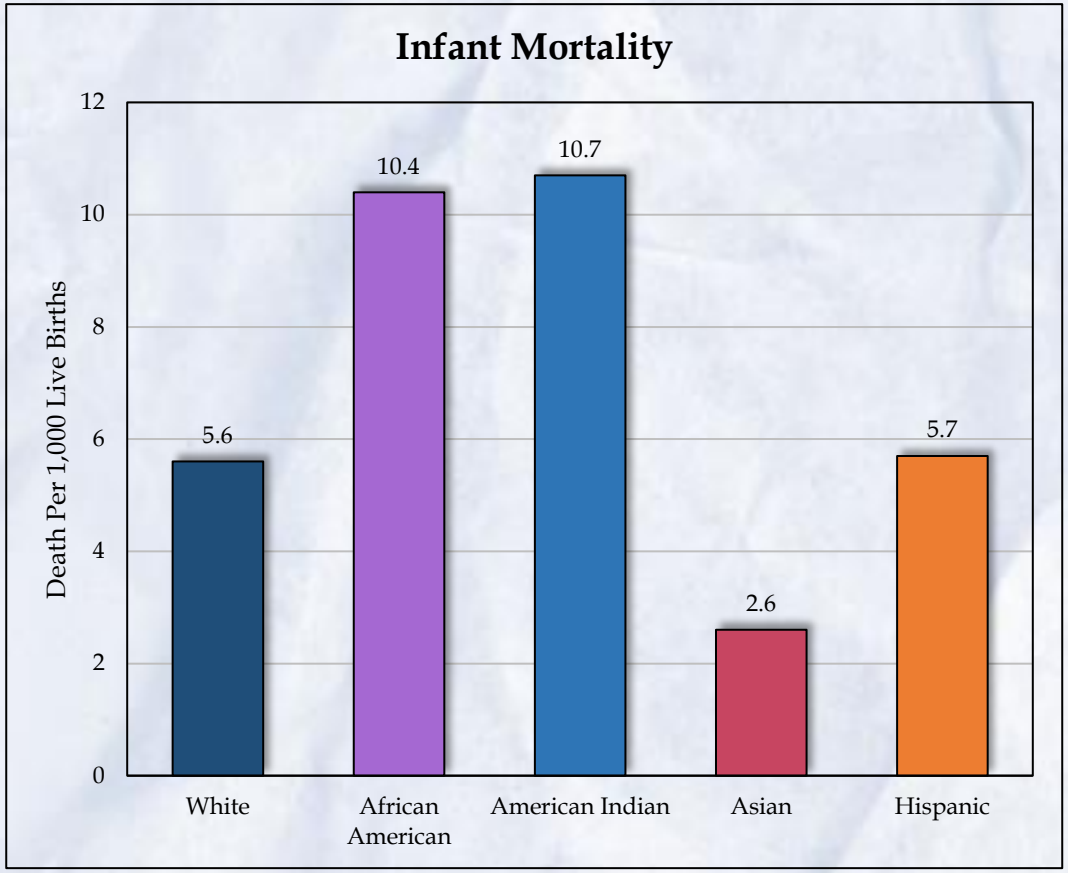
Infant Mortality

The infant mortality rate is defined as the number of infant deaths up to one year old per 1,000 live births in a given time period. The infant mortality rate only includes infant deaths that were initially classified as live births. Infant mortality is one of the most widely used indicators of the health and welfare of a population, as it reflects the general state of maternal health and the effectiveness of primary health care.[17]

Key Disparities:

American Indians (10.7 per 1,000 live births) and African Americans (10.4 per 1,000 live births) had the highest infant mortality rates, which were almost twice the infant mortality of Whites (5.6 per 1,000 live births).

The Asian population (2.6 per 1,000 live births) had the lowest infant mortality rate.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2013-2017

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

First Trimester Prenatal Care

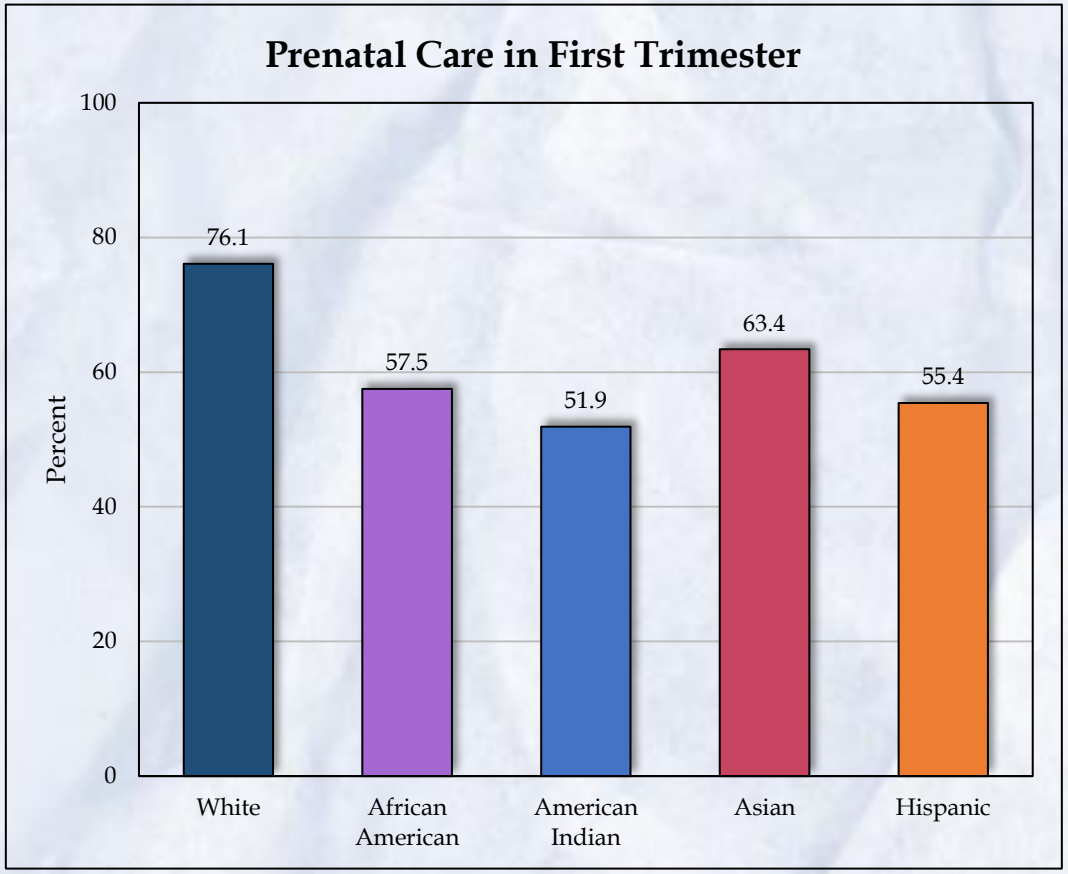
Early prenatal care is defined as care within the first trimester of pregnancy. Babies born to mothers who receive no prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those whose mothers receive prenatal care.[18] Prenatal care is more likely to be effective if women begin receiving care early during pregnancy.

Key Disparities:

American Indians were least likely to have had first trimester prenatal care at 51.9%.

African Americans (57.5%) and Hispanics (55.4%) were also less likely to have had first trimester prenatal care.

The Asian population (63.4%) to have had prenatal care in the first trimester was slightly lower than the White population (76.1%) as well.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2013-2017

[18]Office on Women's Health. U.S. Department of Health and Human Services. (2009). Prenatal care fact sheet. Retrieved from www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html

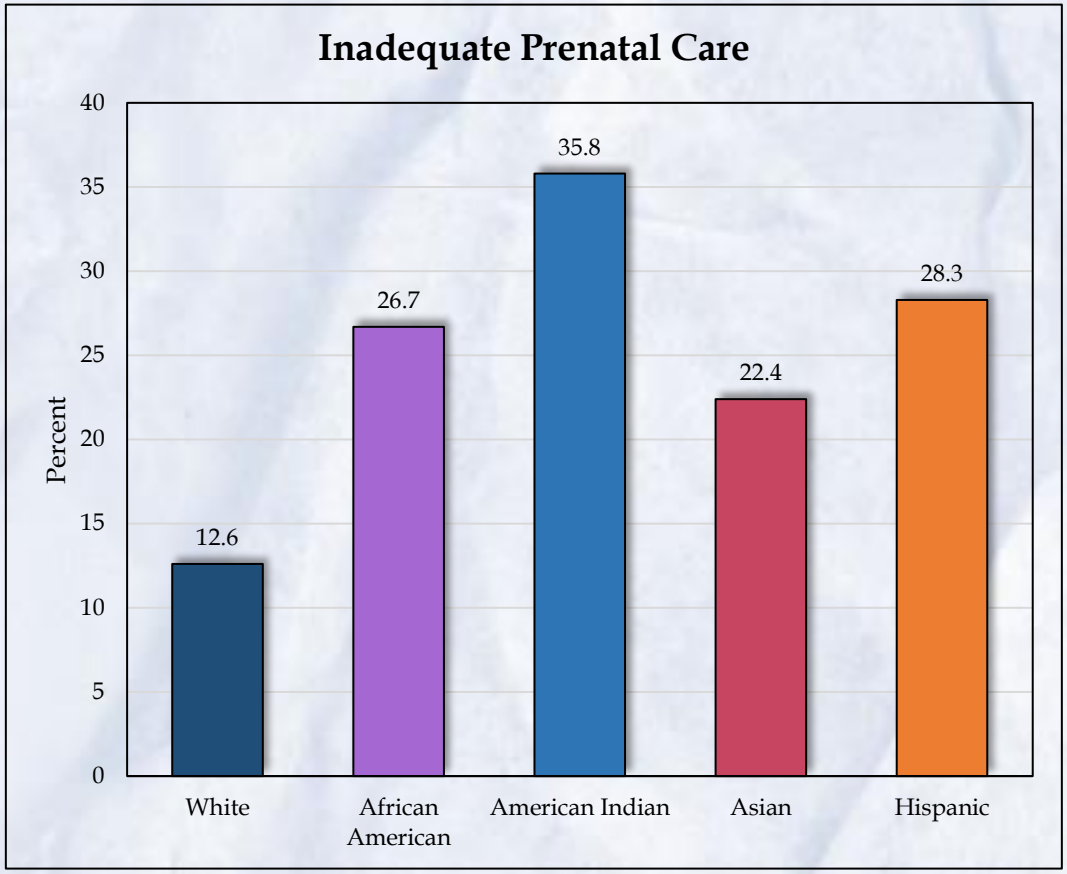
Inadequate Prenatal Care

Prenatal care is important, as healthcare providers can examine the health of mother and child and provide necessary information related to nutrition and behavioral risk factors that could affect both the mother and the baby.[19] Inadequacy of prenatal care was measured by the Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization Index.

Key Disparities:

All minority populations had higher percentages of inadequate prenatal care.

American Indians had the highest percentage of individuals with inadequate prenatal care at 35.8% which was almost three time higher than the White population (12.6%).



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2013-2017

[19]Centers for Disease Control and Prevention. (2017). Pregnancy and prenatal care. Retrieved from www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/PregnancyPrenatalCare.html

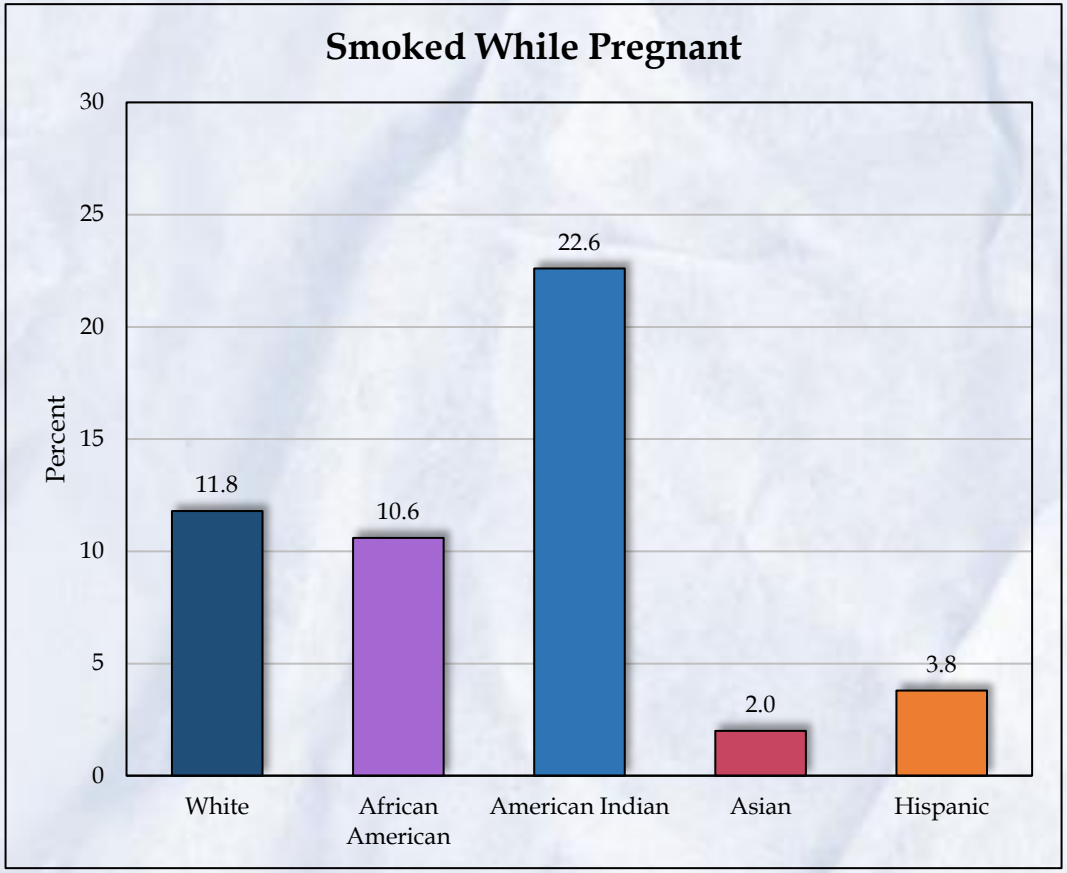
Tobacco Use During Pregnancy

Smoking while pregnant can cause health problems, including premature birth and infant death. Smoking during and after pregnancy is a risk factor of Sudden Infant Death Syndrome (SIDS). Babies born to mothers who smoke are also more likely to have birth defects, which include cleft lip or cleft palate.[20]

Key Disparities:

American Indians were most likely to report using tobacco during pregnancy at 22.6%, which was almost double the rate of Whites (11.8%).

The Asian (2.0%) and Hispanic (3.8%) populations were least likely to report having smoked while pregnant.



Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2013-2017

[20]Centers for Disease Control and Prevention. (2016). Tobacco use and pregnancy. Retrieved from www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy

PRAMS and Breastfeeding

The Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing population-based survey of new mothers. With the overarching goal of reducing infant illness and death, PRAMS collects state-specific data regarding attitudes and feelings about pregnancy, support systems, use of alcohol and tobacco during pregnancy, nutrition awareness, and the infant's early development. The data collected from PRAMS is used to understand the behaviors and experiences of new moms in relationship to unfavorable pregnancy outcomes. Maternal and child health indicators such as unintended pregnancies, prenatal care, and breastfeeding allow Nebraska to identify and monitor any changes in these areas.[21]

Breastfeeding is an especially important indicator and is associated with numerous health benefits for both infants and their mothers. The American Academy of Pediatrics (AAP) recommends that infants be exclusively breastfed for the first six months of life. For the next six months, the AAP recommends continuing breastfeeding, while introducing and gradually increasing solid food intake.[22] Breast milk helps to strengthen an infant's immune system, thus resulting in fewer cases of illness for newborns. Breastfeeding can also decrease the risk of breast and ovarian cancer in mothers and may decrease the risk of postpartum depression.[23]

Despite these benefits, breastfeeding rates remain low among certain groups, showing racial and economic disparities. These groups include women who are young, unmarried, African American, have less than a college degree, or are living below the federal poverty threshold. Furthermore, many women stop breastfeeding soon after they begin for various reasons, such as smoking, medication use, physical and mental health issues, or the need to return to work.[24]

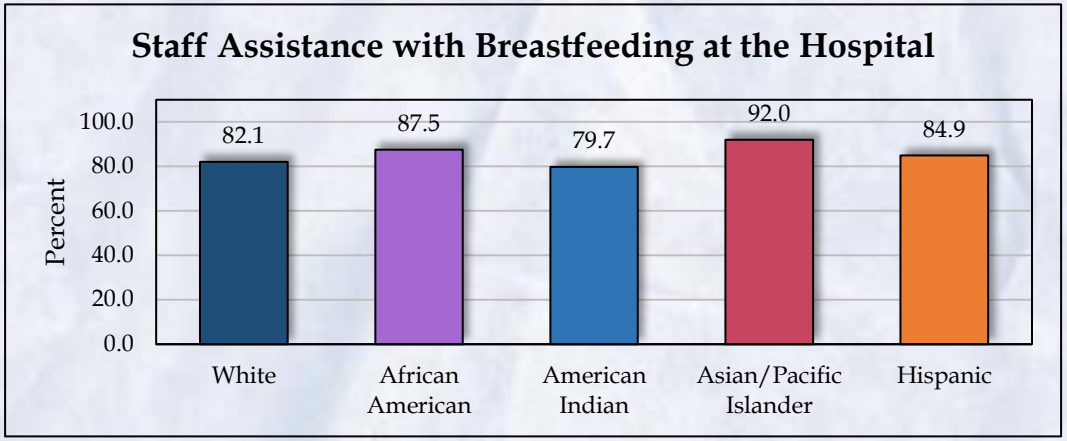
[21]Centers for Disease Control and Prevention. (2016). PRAMS. Retrieved from www.cdc.gov/prams
[22]American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. *Pediatrics*, *129*, e827-e841.
[23]Centers for Disease Control and Prevention. (2013). PRAMS and breastfeeding. Retrieved from www.cdc.gov/prams/breastfeeding.htm
[24]National Immunization Survey. (2010). Racial and ethnic differences in breastfeeding initiation and duration. *Morbidity and Mortality Weekly Report, 59(11)*, 327-334.

Assistance with Breastfeeding & Formula Gift

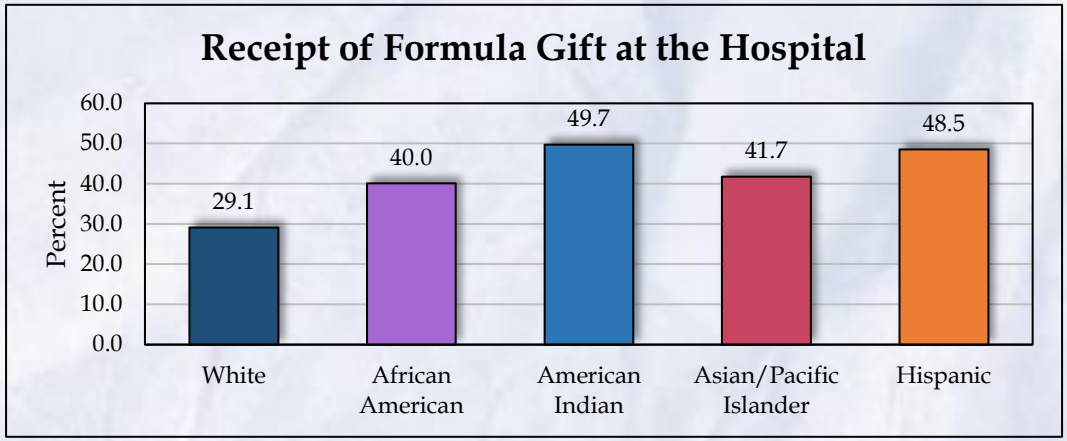
Key Disparities:

Asian women (92%) were most likely to have received assistance with breastfeeding from hospital staff, followed by African American women (87.5%).

American Indian women (79.7%) were the least likely to have received assistance with breastfeeding by hospital staff, which was slightly lower than the White population (82.1%).



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

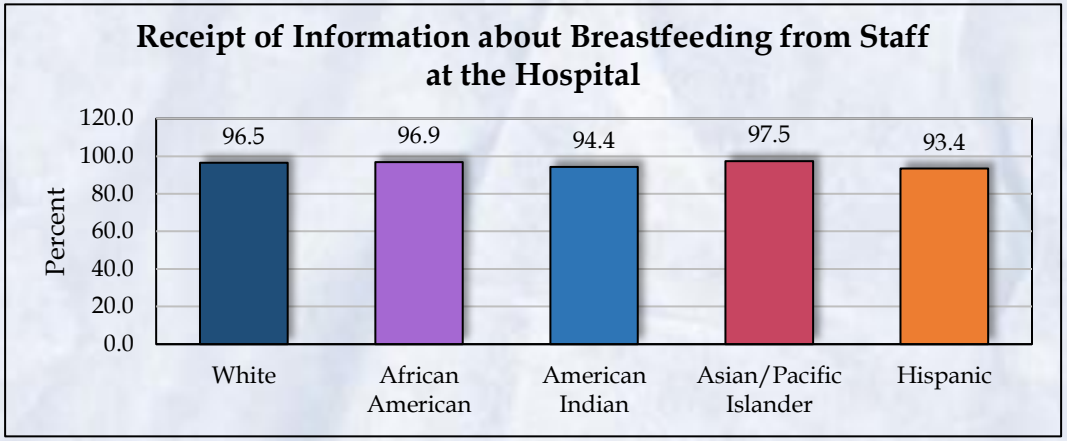
American Indian women (49.7%) were the most likely to receive a formula gift at the hospital, followed closely by Hispanic women (48.5%), which was 1.7 times higher than the White population (29.1%).

Approximately 2 out of 5 African American women (40%) and Asian/Pacific Islander women (41.7%) received a formula gift at the hospital.

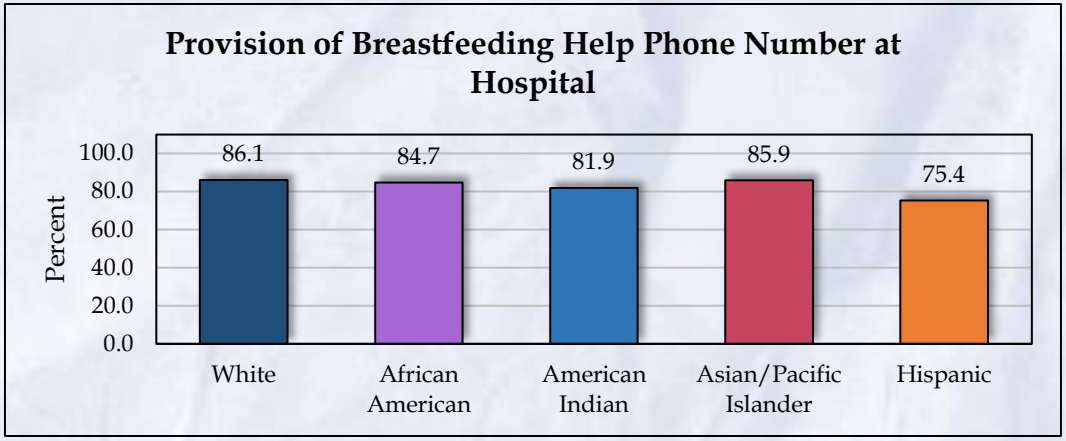
Provided Breastfeeding Information

Key Disparities:

Hispanic women (93.4%) and American Indian women (94.4%) were slightly less likely to have received breastfeeding information from hospital staff.



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

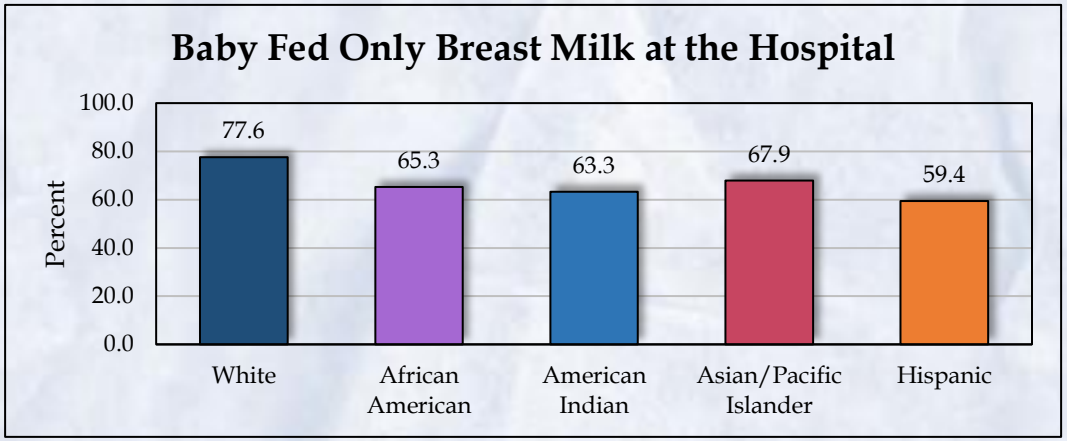
Hispanic women (75.4%) were least likely to report being provisioned breastfeeding help phone number. This was almost 11 percentage points lower than White women (86.1%).

Breastfeeding at the Hospital

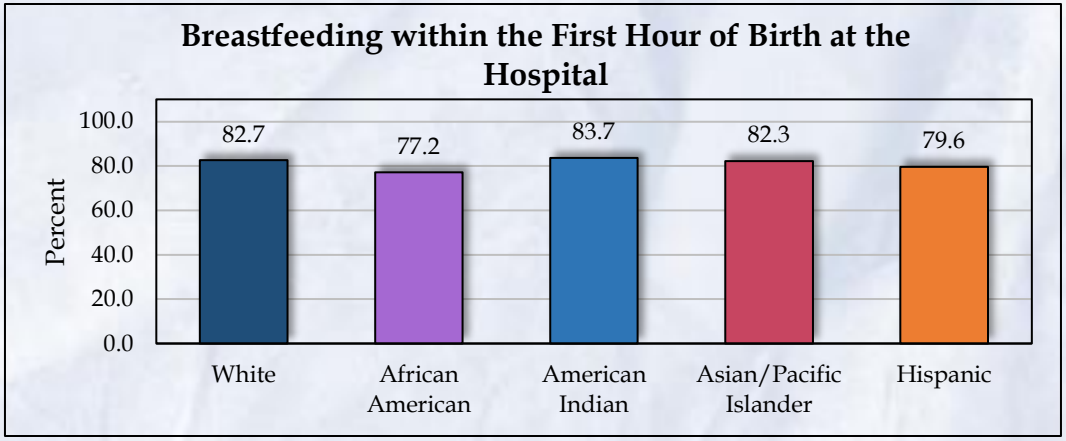
Key Disparities:

Hispanic women (59.4%) were least likely to have fed their baby only breast milk at the hospital. This was 18.2 percentage points lower than White women (77.6%).

Asian/Pacific Islander women (67.9%) had the highest percentage of babies fed only breast milk at the hospital, but this was still almost 10 percentage points lower than White women.



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

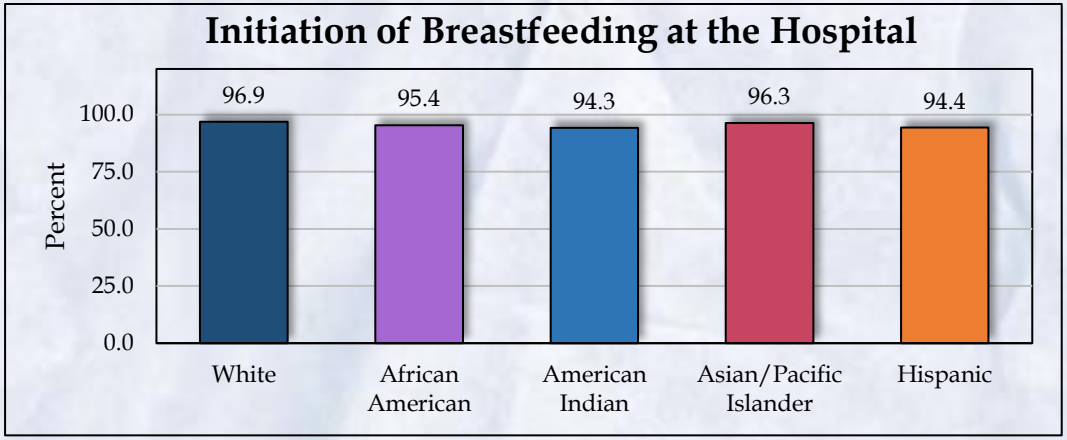
African American women (77.2%) were the least likely to report having breastfed within in the first hour of birth, followed by Hispanic women (79.6%).

American Indian (83.7%) and Asian/Pacific Islander (82.3%) women had similar rates of breastfeeding within the first hour of birth comparable to White women (82.7%).

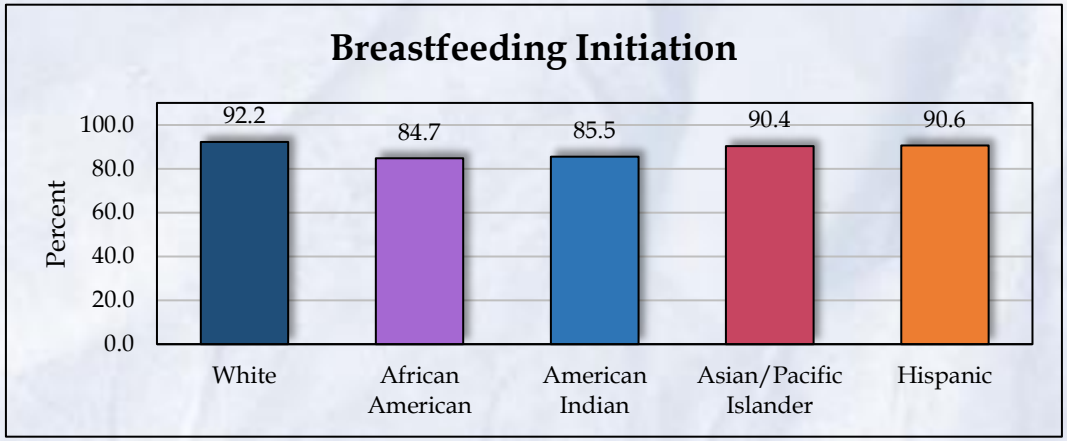
Initiation of Breastfeeding

Key Disparities:

American Indian (94.3%) and Hispanic (94.4%) women were the least likely to have breastfeeding initiated at the hospital, but this rate slightly less than other minority populations.



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

African American women (84.7%) had the lowest rate of breastfeeding initiation, followed closely by American Indian women (85.5%).

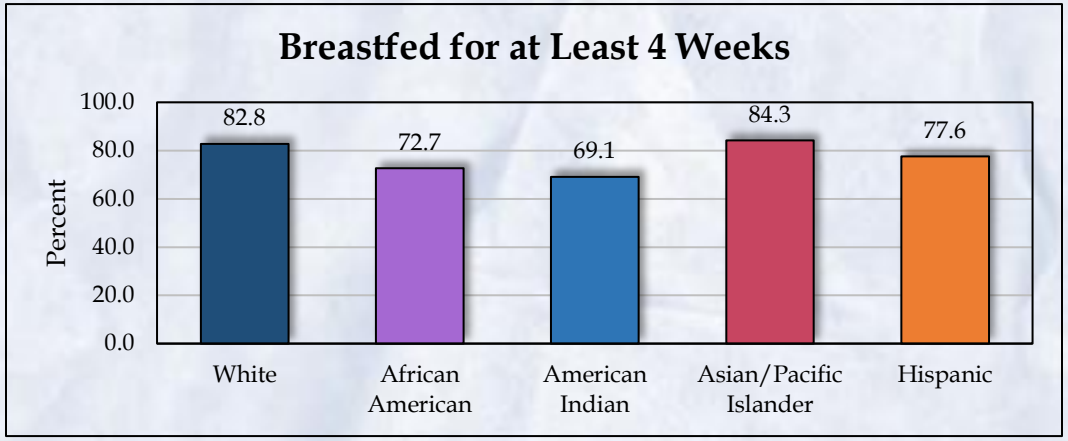
Asian/Pacific Islander (90.4%) and Hispanic (90.6%) had similar rates of breastfeeding initiation, which were slightly lower than the rate seen among White women (92.2%).

Length of Breastfeeding

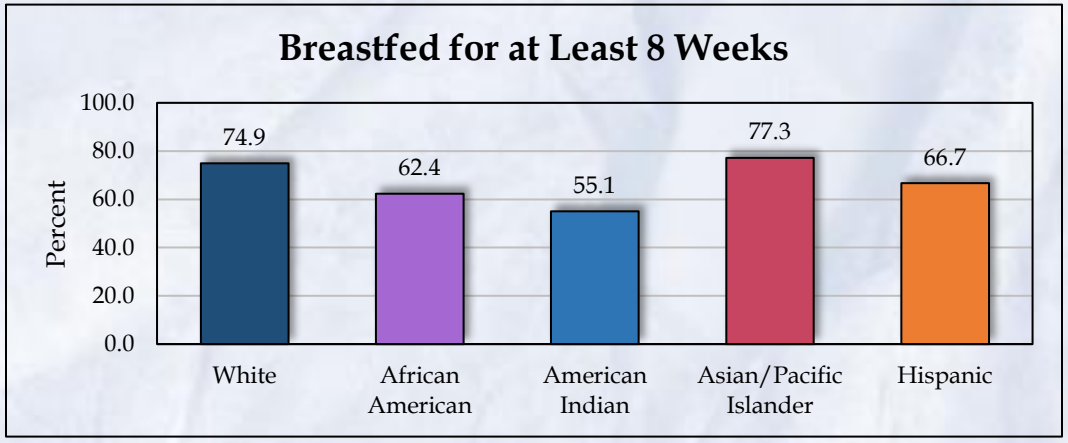
Key Disparities:

Asian/Pacific Islander women (84.3%) were most likely to report having breastfed for at least 4 weeks.

American Indian women (69.1%) were the least likely to report having breastfed for at least 4 weeks, followed by African American women (72.7%).



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

Asian women were most likely to have breastfed for at least eight weeks at 77.3%.

Two-thirds of Hispanic women breastfed for at least 8 weeks.

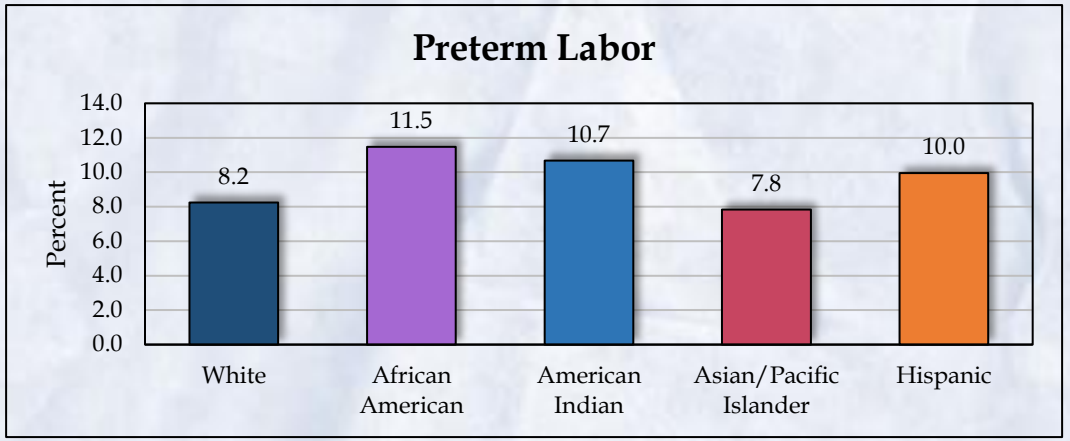
American Indian women (55.1%) and African American women (62.4%) were less likely to have breastfed for at least eight weeks, compared to 74.9% of White women.

Preterm Labor & HIV Testing

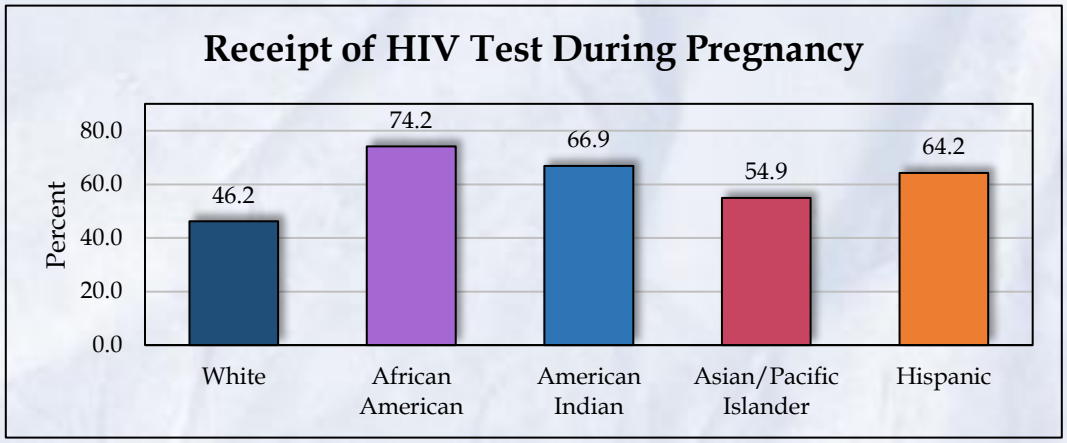
Key Disparities:

Among minority groups, African American women (11.5%) were most likely to go into preterm labor, followed by American Indian (10.7%) and Hispanic (10%) women.

Asian women (7.8%) were least likely to go into preterm labor, which was slightly lower than White women (8.2%).



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

Seventy-four percent of African American women were tested for HIV while pregnant compared to only 46.2% of White women.

Two-thirds of American Indian women (66.9%) were tested for HIV while pregnant followed by Hispanic women (64.2%).

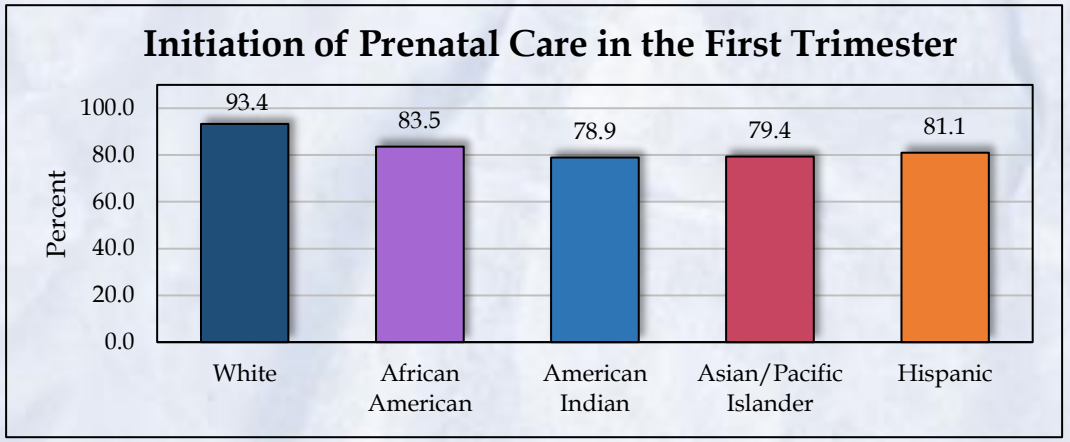
Just over half of Asian women (54.9%) were tested for HIV while pregnant.

Prenatal Care & Postpartum Depression Symptoms

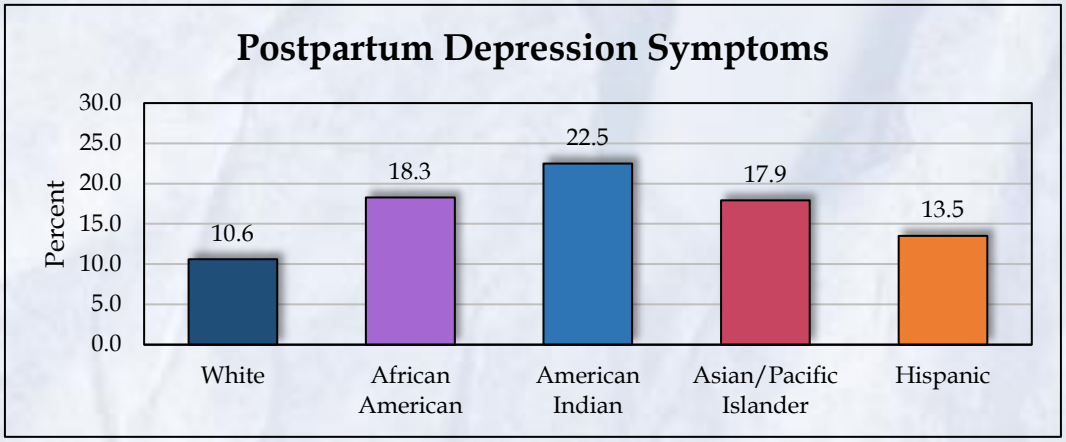
Key Disparities:

American Indian women (78.9%) were least likely to have prenatal care in the first trimester, followed by Asian/Pacific Islander (79.4%) and Hispanic (81.1%) women.

White women were most likely to have prenatal care in the first trimester at 93.4%, which was almost 10 percentage points higher than African American women (83.5%) who had the highest rate among minority groups.



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

American Indian women (22.5%) were most likely to experience postpartum depression symptoms. This was twice the rate of White women (10.6%).

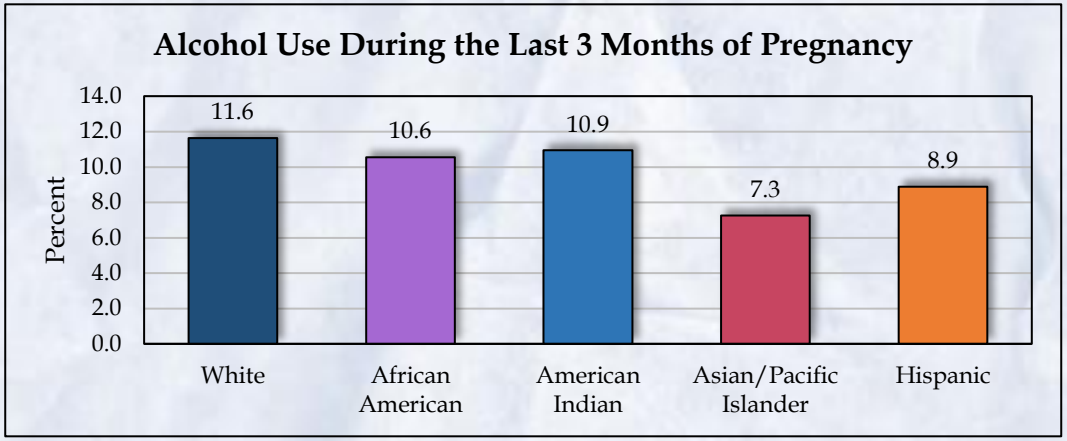
African American (18.3%) and Asian/Pacific Islander (17.9%) women were also more likely to experience postpartum depression symptoms, compared to White women.

Substance Use During Pregnancy

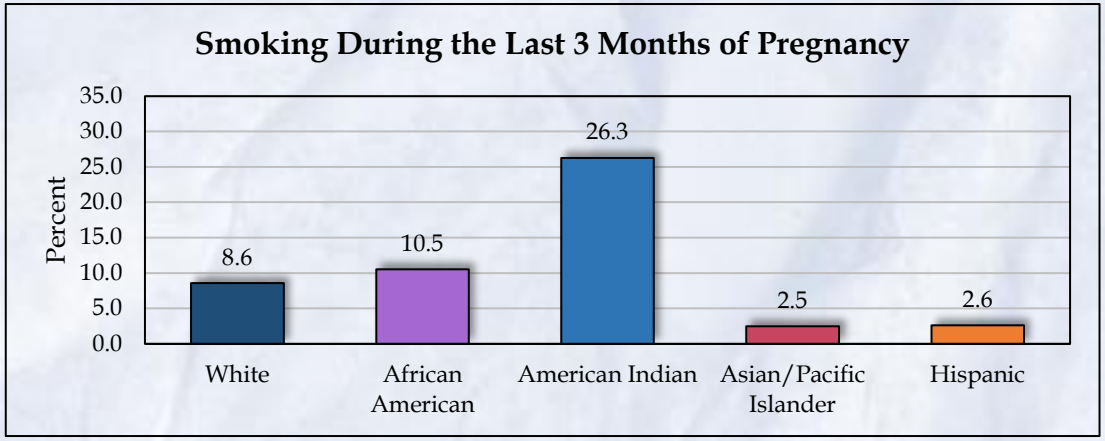
Key Disparities:

Approximately 1 in 10 African American (10.6%) and American Indian (10.9%) reported alcohol use during the last 3 months of pregnancy, which was slightly less than White women (11.6%).

Asian/Pacific Islander women were least likely to have used alcohol during the last three months of pregnancy at 7.3%.



Source: Nebraska PRAMS 2018-2019



Source: Nebraska PRAMS 2018-2019

Key Disparities:

American Indian women (26.3%) were most likely to have smoked during the last months of pregnancy. This was three times the rate of White women (8.6%) and 2.5 times the rate of African American women (10.5%), who had the second highest rate.

Health Status & Mortality

At the most basic level, the health status of any population can be expressed through two concepts – life and death. The challenge is in determining how to meaningfully measure and predict these concepts in order to track, compare, and explain changes in health status over time. Predicting mortality can be complex due to the variety of factors and determinants. However, researchers have found that perceived health status, a relatively simple measure, is the strongest predictor of mortality.[25]

New research suggests that several health measures can affect self-reported health status. Lack of social support or leisure-time, physical activity, smoking, and high body mass index often lead to respondents having low perceived health status.[26] However, if individuals intend to change those negative measures in the future, they rate their health better.

Life, on the other hand, is often expressed in terms of life expectancy at birth, which indicates the number of years a newborn infant would live if predominant patterns of mortality at the time of birth were to stay the same throughout their life. In 2018, Nebraska saw a 79.6 year life expectancy, compared to the United States at 78.7 years. [27] According to one source, life expectancy is a more accurate predictor of health care expenditures than age.[28]

[25]Goldstein, M., Siegel, J., and Boyer, R. (1984). Predicting changes in perceived health status. *American Journal of Public Health.*
[26]Bailis, D., Segall, A., and Chipperfield, J. (2003). Two views of self-rated general health status. Social Science Medicine, 56, 203-217.
[27]Centers for Disease Control and Prevention. (2018). Mortality in the United States, 2018. Retrieved from https://www.cdc.gov/nchs/fastats/life-expectancy.htm
[28]Shang, B., and Goldman, D. (2008). Does age or life expectancy better predict health care expenditures? *Health Economics*, Vol. 17, No. 4; 487–501.

Perceived Health Status

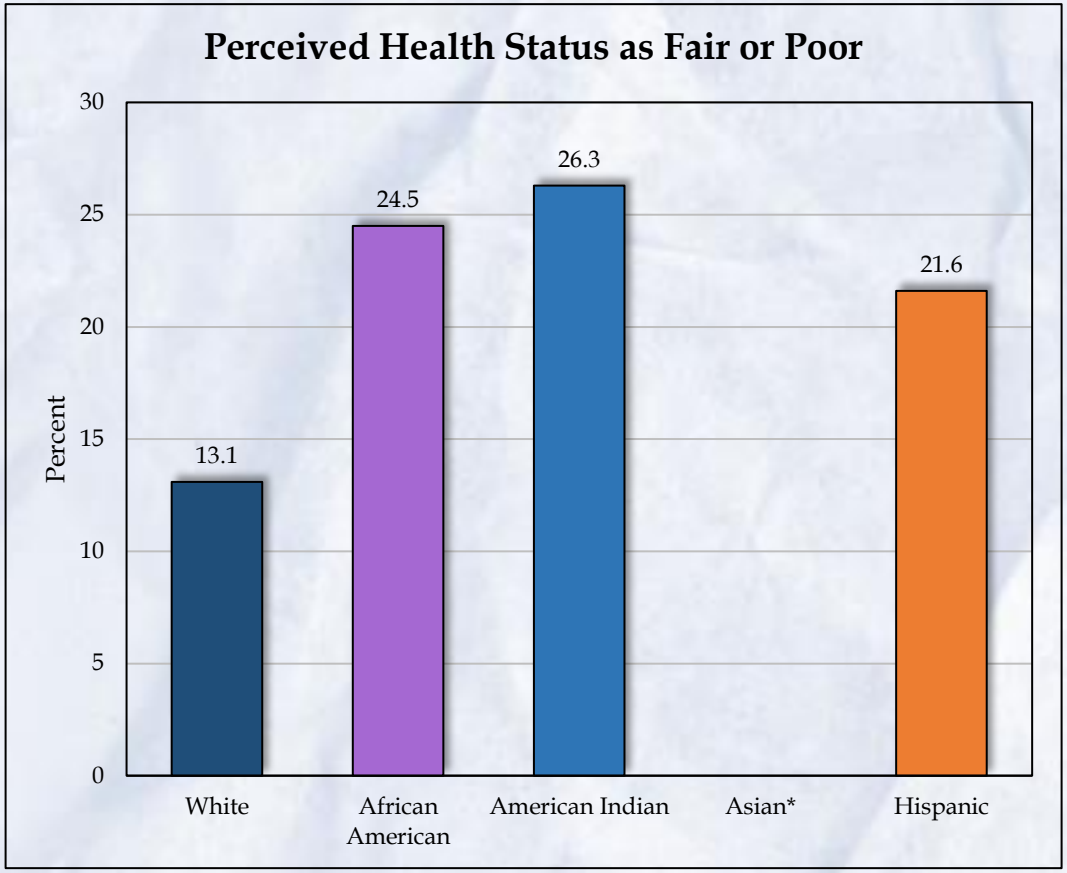
Perceived health status measures how an individual views his or her health – excellent, very good, good, fair, or poor. Individuals who are poor or uninsured are more likely to report being in fair or poor health and have higher rates of hospitalization and mortality compared to those who report excellent or good health. The perceived health status indicator is useful in making broad comparisons across populations that allow for diverse conditions.[29]

Key Disparities:

American Indians experienced the highest percentage (26.3%) of individuals who perceived their health status as fair or poor. This percentage was approximately double that of Whites (13.1%).

African Americans (24.5%) and Hispanics (21.6%) saw higher percentages of individuals who perceived their health status as fair or poor.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2018

[29]United States Office of Disease Prevention and Health Promotion. (2016). General health status. Retrieved from www.healthypeople.gov/2020/about/foundation-health-measures/General-Health-Status

Leading Causes of Death

For all racial and ethnic groups, cancer and heart disease were the most common causes of death.

Nebraska Total

Cancer was the leading cause of death for Nebraskans overall, accounting for 21.3% of all deaths from 2013-2017. Heart disease was the second leading cause of death for Nebraskans, accounting for 21.1% of all deaths.

Leading Causes of Death in Nebraska		
Cause of Death	Frequency	Percentage
Malignant Neoplasms	17,411	21.3%
Heart Disease	17,171	21.1%
Chronic Low Respiratory	5,670	7.0%
Cerebrovascular	3,941	4.8%
Unintentional Injury	3,866	4.7%
Alzheimer's Disease	3,002	3.7%
Diabetes Mellitus	2,573	3.2%
Influenza & Pneumonia	1,826	2.2%
Hypertension	1,265	1.6%
Suicide	1,215	1.5%
All Others	2,3267	29.0%

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017

Leading Causes of Death: Males

Between 2013 and 2017, the top 2 leading causes of death for males were cancer and heart disease with the exception of the Hispanic population, where unintentional injury was second.

Leading Causes of Death of Males by Race/Ethnicity									
White (38,392 deaths)	%	African American (1,609 deaths)	%	American Indian (300 deaths)	%	Asian/NHPI (269 deaths)	%	Hispanic (1,080 deaths)	%
Malignant Neoplasms	22.7%	Malignant Neoplasms	19.1%	Heart Disease	15.3%	Malignant Neoplasms	28.6%	Malignant Neoplasms	17.7%
Heart Disease	22.4%	Heart Disease	17.8%	Malignant Neoplasms	15.0%	Heart Disease	13.4%	Unintentional Injury	14.6%
Chronic Low. Respiratory Disease	7.1%	Homicide	6.6%	Unintentional Injury	11.3%	Cerebrovascular	6.7%	Heart Disease	13.4%
Unintentional Injury	5.8%	Unintentional Injury	5.9%	Liver Disease	7.7%	Unintentional Injury	6.3%	Cerebrovascular	4.6%
Cerebrovascular	4.2%	Chronic Low. Respiratory Disease	4.5%	Diabetes Mellitus	7.3%	Suicide	5.2%	Diabetes Mellitus	4.4%
Diabetes Mellitus	3.2%	Diabetes Mellitus	4.4%	Homicide	4.3%	Diabetes Mellitus	4.8%	Perinatal Period	3.7%
Suicide	2.4%	Cerebrovascular	4.0%	Suicide	4.3%	Chronic Low. Respiratory Disease	3.7%	Suicide	3.5%
Alzheimer's Disease	2.4%	Hypertension	2.4%	All Others	34.7%	All Others	31.2%	Liver Disease	3.3%
Influenza & Pneumonia	2.0%	Suicide	2.2%					Homicide	3.1%
Parkinson's Disease	1.6%	Nephritis	2.1%					Congenital Anomalies	2.4%
All Others	26.3%	All Others	30.9%					All Others	29.1%

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017
Note: (---) indicates less than 10 cases

Leading Causes of Death: Females

Between 2013 and 2017, for all populations the top two causes of death were cancer and heart disease. However, for White females, the leading cause of death was heart disease, followed by cancer. For minority populations, cancer was the leading cause of death, followed by heart disease.

Leading Causes of Death of Females by Race/Ethnicity									
White (39,123 deaths)	%	African American (1,367 deaths)	%	American Indian (288 deaths)	%	Asian (219 deaths)	%	Hispanic (708 deaths)	%
Heart Disease	20.3%	Malignant Neoplasms	20.9%	Malignant Neoplasms	15.6%	Malignant Neoplasms	26.5%	Malignant Neoplasms	21.6%
Malignant Neoplasms	20.1%	Heart Disease	16.8%	Heart Disease	13.2%	Heart Disease	12.3%	Heart Disease	12.7%
Chronic Low. Respiratory Disease	7.1%	Diabetes Mellitus	6.5%	Unintentional Injury	9.7%	Cerebrovascular	11.9%	Unintentional Injury	8.1%
Cerebrovascular	5.5%	Cerebrovascular	5.4%	Chronic Low. Respiratory Disease	5.6%	Diabetes Mellitus	5.0%	Cerebrovascular	6.4%
Alzheimer's Disease	5.1%	Chronic Low. Respiratory Disease	4.5%	Liver Disease	5.6%	Alzheimer's Disease	4.6%	Diabetes Mellitus	6.4%
Unintentional Injury	3.6%	Alzheimer's Disease	3.7%	Diabetes Mellitus	5.2%	Chronic Low. Respiratory Disease	4.6%	Perinatal Period	3.1%
Diabetes Mellitus	2.8%	Unintentional Injury	3.6%	Nephritis	4.5%	All Others	35.2%	Liver Disease	2.7%
Influenza & Pneumonia	2.5%	Nephritis	2.8%	All Others	40.6%			Nephritis	2.4%
Hypertension	1.9%	Hypertension	2.5%					Congenital Anomalies	2.3%
Nephritis	1.4%	Influenza & Pneumonia	2.2%					Hypertension	2.1%
All Others	29.7%	All Others	31.2%					All Others	32.3%

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017
Note: (---) indicates less than 10 cases

Leading Causes of Death: Whites

Between 2013 and 2017, unintentional injury was the leading cause of death among Whites ages 1-44 years, and cancer was the leading cause of death among Whites ages 45-64 years. Of those 65 years and older, heart disease was the leading cause of death, followed by cancer.

	Whites by Age Group										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 150	Unintentional Injury 23	Unintentional Injury 18	Unintentional Injury 22	Unintentional Injury 321	Unintentional Injury 362	Unintentional Injury 330	Malignant Neoplasms 1,031	Malignant Neoplasms 2,928	Heart Disease 14,104	Malignant Neoplasms 16,592
2	SIDS 71	Congenital Anomalies 17	Congenital Anomalies 12	Suicide 16	Suicide 177	Suicide 196	Malignant Neoplasms 282	Heart Disease 639	Heart Disease 1,499	Malignant Neoplasms 12,187	Heart Disease 16,509
3	Short Gestation 57	Malignant Neoplasms 12	Malignant Neoplasms 12	Malignant Neoplasms 12	Malignant Neoplasms 39	Malignant Neoplasms 87	Suicide 190	Unintentional Injury 398	Chronic Low. Respiratory Disease 482	Chronic Low. Respiratory Disease 4,851	Chronic Low. Respiratory Disease 5,490
4	Maternal Pregnancy Complication 52	Homicide ---	Benign Neoplasms ---	Chronic Low. Respiratory Disease ---	Homicide 30	Heart Disease 56	Heart Disease 175	Suicide 216	Unintentional Injury 448	Cerebro-vascular 3,341	Cerebro-vascular 3,748
5	Placenta Cord Membranes 45	Heart Disease ---	Influenza & Pneumonia ---	Congenital Anomalies ---	Heart Disease 19	Homicide 39	Diabetes Mellitus 52	Liver Disease 195	Diabetes Mellitus 329	Alzheimer's Disease 2,887	Unintentional Injury 3,636
6	Unintentional Injury 21	Influenza & Pneumonia ---	Diabetes Mellitus ---	Heart Disease ---	Congenital Anomalies 14	Liver Disease 24	Liver Disease 52	Chronic Low. Respiratory Disease 123	Cerebro-vascular 262	Diabetes Mellitus 1,828	Alzheimer's Disease 2,913
7	Respiratory Distress 18	Acute Bronchitis ---	Heart Disease ---	Benign Neoplasms ---	Diabetes Mellitus ---	Congenital Anomalies 13	Cerebro-vascular 31	Diabetes Mellitus 122	Liver Disease 244	Unintentional Injury 1,692	Diabetes Mellitus 2,352
8	Bacterial Sepsis 14	Benign Neoplasms ---	Meningitis ---	Cerebro-vascular ---	Influenza & Pneumonia ---	Diabetes Mellitus 12	Homicide 30	Cerebro-vascular 101	Suicide 193	Influenza & Pneumonia 1,548	Influenza & Pneumonia 1,752
9	Circulatory System Disease 11	Perinatal Period ---	Nephritis ---	Three Tied ---	Cerebro-vascular ---	Complicated Pregnancy 10	Influenza & Pneumonia 19	Influenza & Pneumonia 41	Influenza & Pneumonia 119	Hypertension 1,040	Hypertension 1,182
10	Atelectasis 10		Septicemia ---	Three Tied ---	Chronic Low. Respiratory Disease ---	Influenza & Pneumonia ---	Two Tied 16	Septicemia 40	Hypertension 104	Parkinson's Disease 1,009	Suicide 1,140

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017
Note: (---) indicates less than 10 cases

Leading Causes of Death: African Americans

Between 2013 and 2017, homicide was the leading cause of death among African Americans ages 15-34 years. For those between the ages 35 and 54, heart disease was the leading cause of death. Cancer was the leading cause of death among individuals ages 55 years and older and was the leading cause of death for all age groups combined.

	African Americans by Age Group										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	SIDS 20	Congenital Anomalies ---	Chronic Low. Respiratory Disease ---	Cerebro-vascular ---	Homicide 38	Homicide 44	Heart Disease 24	Heart Disease 63	Malignant Neoplasms 154	Malignant Neoplasms 357	Malignant Neoplasms 594
2	Congenital Anomalies 16	Heart Disease ---	Malignant Neoplasms ---	Influenza & Pneumonia ---	Unintentional Injury 19	Unintentional Injury 23	Unintentional Injury 20	Malignant Neoplasms 50	Heart Disease 123	Heart Disease 292	Heart Disease 515
3	Short Gestation 10	Homicide ---	Unintentional Injury ---	Malignant Neoplasms ---	Suicide 14	Suicide 18	Homicide 18	Unintentional Injury 26	Diabetes Mellitus 39	Diabetes Mellitus 100	Diabetes Mellitus 160
4	Maternal Pregnancy Complication ---	Unintentional Injury ---	Congenital Anomalies ---	Unintentional Injury ---	Malignant Neoplasms ---	Heart Disease ---	Malignant Neoplasms 16	Diabetes Mellitus 12	Cerebro-vascular 35	Cerebro-vascular 88	Unintentional Injury 144
5	Placenta Cord Membranes ---	Anemias ---	Homicide ---		Influenza & Pneumonia ---	Malignant Neoplasms ---	HIV ---	Nephritis 12	Chronic Low. Respiratory Disease 35	Chronic Low. Respiratory Disease 83	Cerebro-vascular 139
6	Atelectasis ---	Malignant Neoplasms ---	Influenza & Pneumonia ---		Chronic Low. Respiratory Disease ---	Influenza & Pneumonia ---	Diabetes Mellitus ---	Homicide 11	Unintentional Injury 28	Alzheimer's Disease 66	Chronic Low. Respiratory Disease 135
7	Bacterial Sepsis ---				Diabetes Mellitus ---	Chronic Low. Respiratory Disease ---	Cerebro-vascular ---	Cerebro-vascular 10	Influenza & Pneumonia 18	Hypertension 53	Homicide 128
8	Diarrhea ---				Heart Disease ---	Complicated Pregnancy ---	Liver Disease ---	Chronic Low. Respiratory Disease 10	Liver Disease 17	Nephritis 43	Hypertension 72
9	Neonatal Hemorrhage ---					Diabetes Mellitus ---	Suicide ---	Liver Disease ---	Septicemia 17	Influenza & Pneumonia 27	Nephritis 72
10	Unintentional Injury ---					Septicemia ---	Six Tied ---	HIV ---	Nephritis 15	Septicemia 25	Alzheimer's Disease 69

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017
Note: (---) indicates less than 10 cases

Leading Causes of Death: American Indian

Between 2013 and 2017, suicide was the leading cause of death among American Indians ages 10-14 years in Nebraska. Among American Indians ages 15-44 years, unintentional injury was the leading cause of death. Those ages 45-54, heart disease was the leading cause of death and those ages 55 years and older, cancer was the leading cause of death. Among all age groups combined, cancer was the leading cause of death, followed by heart disease.

	American Indians by Age Group										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies ---	Homicide ---	Homicide ---	Suicide ---	Unintentional Injury 16	Unintentional Injury 12	Unintentional Injury 13	Heart Disease 14	Malignant Neoplasms 25	Malignant Neoplasms 49	Malignant Neoplasms 90
2	SIDS ---	Malignant Neoplasms ---	Malignant Neoplasms ---	Unintentional Injury ---	Suicide ---	Homicide ---	Liver Disease ---	Liver Disease 14	Heart Disease 19	Heart Disease 44	Heart Disease 84
3	Nine Tied ---	Unintentional Injury ---			Malignant Neoplasms ---	Liver Disease ---	Suicide ---	Malignant Neoplasms ---	Diabetes Mellitus 44	Chronic Low. Respiratory Disease 19	Unintentional Injury 62
4	Nine Tied ---					Heart Disease ---	Diabetes Mellitus ---	Unintentional Injury ---	Liver Disease 10	Diabetes Mellitus 17	Liver Disease 39
5	Nine Tied ---					Suicide ---	Heart Disease ---	Diabetes Mellitus ---	Chronic Low. Respiratory Disease ---	Cerebro-vascular ---	Diabetes Mellitus 37
6	Nine Tied ---					Aortic Aneurysm ---	Homicide ---	Nephritis ---	Nephritis ---	Influenza & Pneumonia ---	Chronic Low. Respiratory Disease 25
7	Nine Tied ---					Malignant Neoplasm ---	Malignant Neoplasms ---	Viral Hepatitis ---	Unintentional Injury ---	Nephritis ---	Homicide 17
8	Nine Tied ---					Pneumonitis ---	HIV ---	Gallbladder Disorders ---	Viral Hepatitis ---	Septicemia ---	Nephritis 17
9	Nine Tied ---					Septicemia ---	Influenza & Pneumonia ---	Homicide ---	Eight Tied ---	Liver Disease ---	Suicide 16
10	Nine Tied ---						Three Tied ---	Six Tied ---	Eight Tied ---	Unintentional Injury ---	Influenza & Pneumonia 11

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017
Note: (---) indicates less than 10 cases

Leading Causes of Death: Asians

Between 2013 and 2017, unintentional injury was the leading cause of death for Asians ages 25-34 years. Cancer was the leading cause of death among Asians ages 35 years of age and older.

	Asians by Age Group										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies ---	Unintentional Injury ---			Suicide ---	Unintentional Injury ---	Malignant Neoplasms 13	Malignant Neoplasms 23	Malignant Neoplasms 32	Malignant Neoplasms 65	Malignant Neoplasms 135
2	Maternal Pregnancy Complication ---				Unintentional Injury ---	Homicide ---	Unintentional Injury ---	Heart Disease ---	Heart Disease 10	Heart Disease 47	Heart Disease 63
3	Necrotizing Enterocolitis ---					Malignant Neoplasms ---	Cerebro-vascular ---	Suicide ---	Cerebro-vascular ---	Cerebro-vascular 32	Cerebro-vascular 44
4	Short Gestation ---					Suicide ---	Complicated Pregnancy ---	Diabetes Mellitus ---	Unintentional Injury ---	Diabetes Mellitus 21	Diabetes Mellitus 24
5						Complicated Pregnancy ---	HIV ---	Unintentional Injury ---	Aortic Aneurysm ---	Chronic Low. Respiratory Disease 17	Unintentional Injury 24
6						Heart Disease ---	Heart Disease ---	Seven Tied ---	Chronic Low. Respiratory Disease ---	Alzheimer's Disease 16	Chronic Low. Respiratory Disease 20
7						Liver Disease ---	Suicide ---	Seven Tied ---	Septicemia ---	Unintentional Injury ---	Suicide 18
8						Tuberculosis ---		Seven Tied ---	Nine Tied ---	Septicemia ---	Alzheimer's Disease 16
9								Seven Tied ---	Nine Tied ---	Hypertension ---	Septicemia 10
10								Seven Tied ---	Nine Tied ---	Nephritis ---	Nephritis ---

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017
Note: (---) indicates less than 10 cases

Leading Causes of Death: Hispanics

Between 2013 and 2017, unintentional injury was the leading cause of death among Hispanics ages 5-44 years, and cancer was the leading cause of death for Hispanics ages 45 years and older.

	Hispanics by Age Group										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 32	Homicide ---	Unintentional Injury ---	Unintentional Injury ---	Unintentional Injury 56	Unintentional Injury 50	Unintentional Injury 36	Malignant Neoplasms 41	Malignant Neoplasms 75	Malignant Neoplasms 191	Malignant Neoplasms 344
2	Maternal Pregnancy Complication 13	Unintentional Injury ---	Congenital Anomalies ---	Malignant Neoplasms ---	Homicide 13	Suicide 15	Malignant Neoplasms 21	Unintentional Injury 24	Heart Disease 45	Heart Disease 154	Heart Disease 235
3	Placenta Cord Membranes 11	Malignant Injury ---	Influenza & Pneumonia ---	Suicide ---	Suicide 11	Homicide 12	Suicide 11	Heart Disease 22	Liver Disease 20	Cerebro-vascular 68	Unintentional Injury 215
4	Short Gestation 10	Acute Bronchitis ---	Meningitis ---	Anemias ---	Congenital Anomalies ---	Malignant Neoplasms ---	Heart Disease 10	Liver Disease 12	Cerebro-vascular 17	Diabetes Mellitus 64	Cerebro-vascular 95
5	SIDS ---	Benign Neoplasms ---		Benign Neoplasms ---	Malignant Neoplasms ---	Heart Disease ---	Homicide ---	Diabetes Mellitus ---	Diabetes Mellitus 17	Chronic Low. Respiratory Disease 26	Diabetes Mellitus 93
6	Unintentional Injury ---	Congenital Anomalies ---		Chronic Low. Respiratory Disease ---	Chronic Low. Respiratory Disease ---	Ten Tied ---	Liver Disease ---	Cerebro-vascular ---	Unintentional Injury 11	Influenza & Pneumonia 24	Perinatal Period 62
7	Bacterial Sepsis ---			Nephritis ---	Complicated Pregnancy ---	Ten Tied ---	Diabetes Mellitus ---	Hypertension ---	Chronic Low. Respiratory Disease ---	Nephritis 20	Liver Disease 55
8	Neonatal Hemorrhage ---				Heart Disease ---	Ten Tied ---	Cerebro-vascular ---	Influenza & Pneumonia ---	Septicemia ---	Alzheimer's Disease 19	Suicide 47
9	Respiratory Distress ---				Influenza & Pneumonia ---	Ten Tied ---	Three Tied ---	Nephritis ---	Suicide ---	Hypertension 18	Congenital Anomalies 42
10	Six Tied ---					Ten Tied ---	Three Tied ---	Four Tied ---	Two Tied ---	Unintentional Injury 17	Homicide 40

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017
Note: (---) indicates less than 10 cases

Chronic Disease & Related Mortality

Chronic diseases can be controlled but not cured; they are diseases of long duration and slow progression.[30] In most cases, chronic disease will require a lifetime of regular treatment. Chronic diseases are usually characterized by acute episodes of illness followed by periods of time where symptoms may be reduced or absent. Some chronic illnesses cause permanent disability.[31]

The onset of many chronic diseases results from accumulated exposure to multiple risk factors over an extended period. Therefore, it is often difficult to determine differences in exposure to risk. Some chronic diseases, such as heart disease and certain types of cancer, could be asymptomatic for many years. Additionally, racial and ethnic disparities in mortality rates due to heart disease or cancer, for example, may result from differences in the use of health services. Mortality data can provide valuable information on the health status and indicate the burden of disease of a population as well.

Chronic diseases are the leading cause of death and disability in the United States, accounting for 70% of all deaths or 1.7 million deaths every year.[32] In particular, cancer, heart disease, and stroke account for more than 50% of those deaths. Worldwide, 90% of chronic disease deaths occurred in low- and middle-income countries.

Damaging health behaviors, particularly tobacco use, lack of physical activity, and poor eating habits are major contributors to the leading chronic diseases. According to the CDC, more than a third of all adults do not get the recommended amount of aerobic physical activity, and 23% of individuals reported no physical activity at all.[33]

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

Hypertension Prevalence

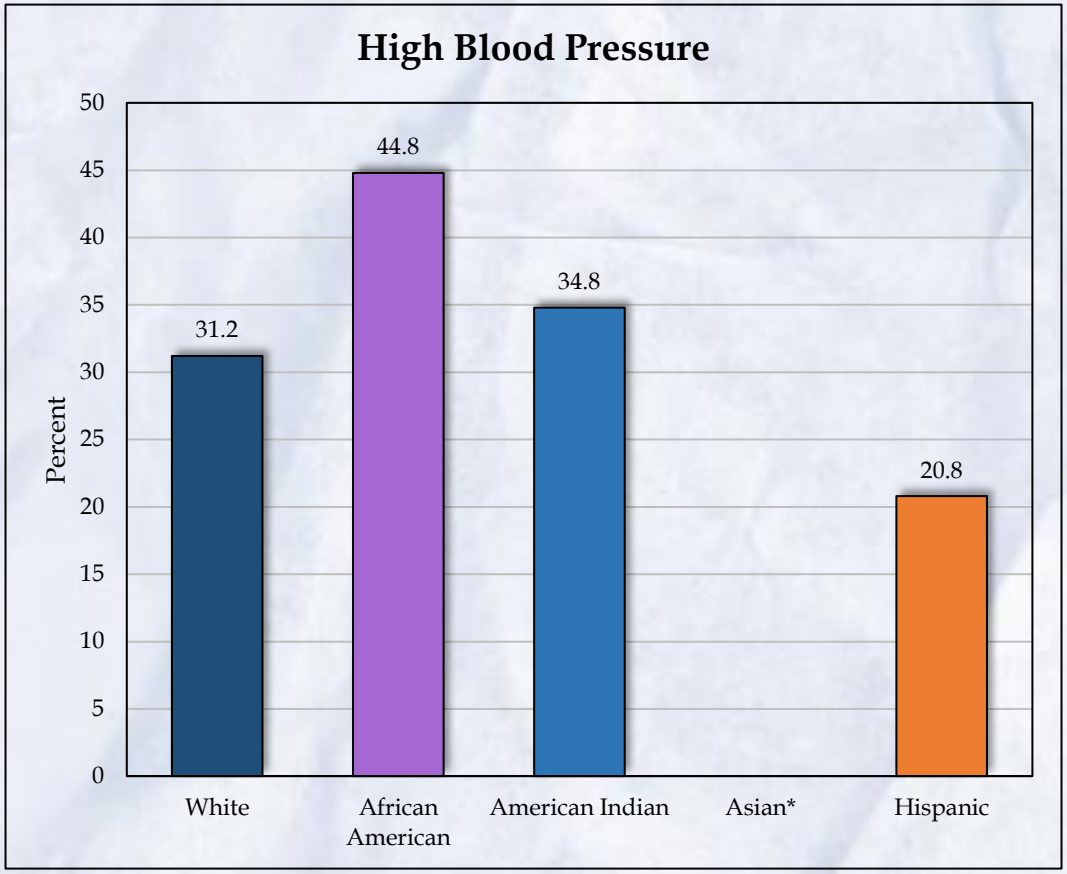
Blood pressure normally fluctuates throughout the day, but if it stays high for a long time, it can damage the heart. Hypertension, or high blood pressure, is blood pressure that is higher than normal. [34] Hypertension increases the risk for heart disease and stroke, which are leading causes of death in the United States. [35]

Key Disparities:

The African American population was the most likely to have high blood pressure with 44.8% reporting such.

American Indians (34.8%) were slightly more likely than the White population (31.2%) to have high blood pressure with around one-third reporting such.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2017

[34]Centers for Disease Control and Prevention, National Center for Health Statistics. (2020). High blood pressure. Retrieved from https://www.cdc.gov/bloodpressure/facts.htm

[35]Centers for Disease Control and Prevention, National Center for Health Statistics. (2018). Underlying cause of death, 1999-2017. CDC WONDER Online Database. Atlanta, GA: Centers for Disease Control and Prevention.

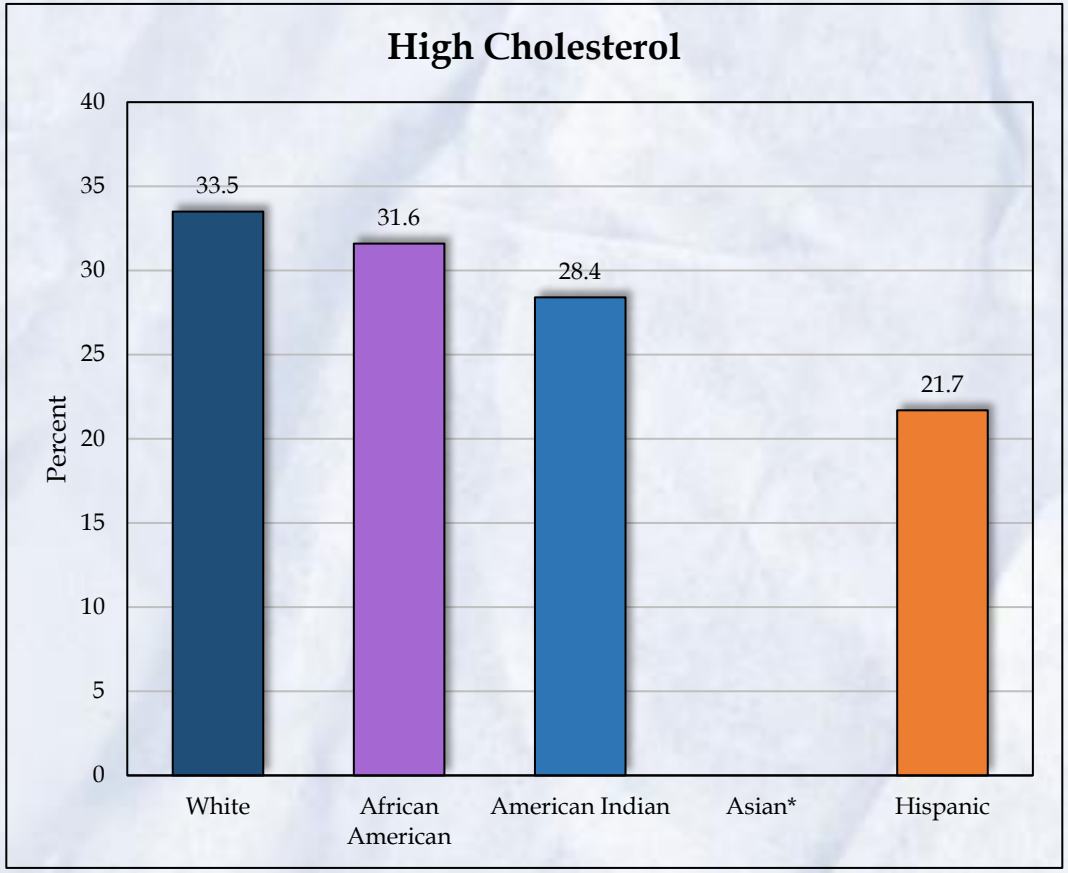
High Cholesterol Prevalence

Blood cholesterol is a waxy, fat-like substance made by the liver. The body makes all the cholesterol it needs to function properly, which is why experts recommend individuals eat as little dietary cholesterol as possible. Too much cholesterol puts individuals at greater risk for coronary heart disease, heart attack, and stroke.[36]

Key Disparities:

The White (33.5%) and African Americans (31.6%) were most likely to report having ever been diagnosed with high cholesterol, followed closely by American Indians (28.4%).

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2017

[36] The American Heart Association. (2020). Control your cholesterol. Retrieved from https://www.heart.org/en/health-topics/cholesterol/about-cholesterol

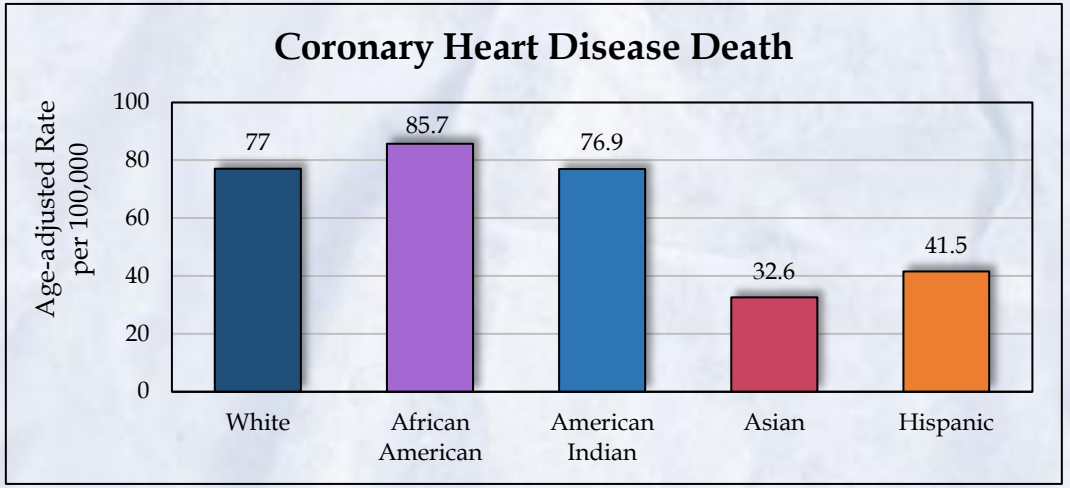
Heart & Cardiovascular Disease Death

Coronary heart disease is a type of heart disease that develops when the arteries of the heart cannot deliver enough oxygen-rich blood to the heart. It is the leading cause of death in the United States.[37] Cardiovascular disease can refer to a number of conditions to include coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, and congenital heart disease. [38]

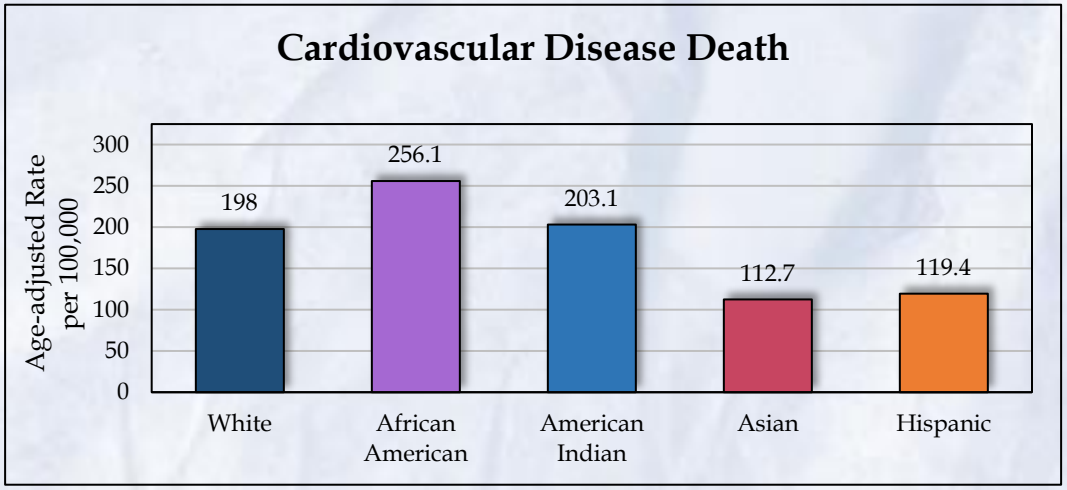
Key Disparities:

African Americans (85.7 per 100,000) had the highest death rate due to coronary heart disease, followed by the White (77 per 100,000) and American Indians (76.9 per 100,000).

Asian (32.6 per 100,000) and Hispanics (41.5 per 100,000) had the lowest death rate due to coronary heart disease.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

Key Disparities:

African Americans (256.1 per 100,000) had the highest death rate due to cardiovascular disease which was the highest of all minority populations.

American Indians (203.1 per 100,000) also had a higher death rate due to cardiovascular disease among the minority populations.

[37]National Heart, Lung, and Blood Institute. (n. d.). *Coronary Heart Disease.* Retrieved from https://www.nhlbi.nih.gov/health-topics/coronary-heart-disease
[38]World Health Organization. (2017). *Cardiovascular diseases (CVD).* Retrieved from https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)

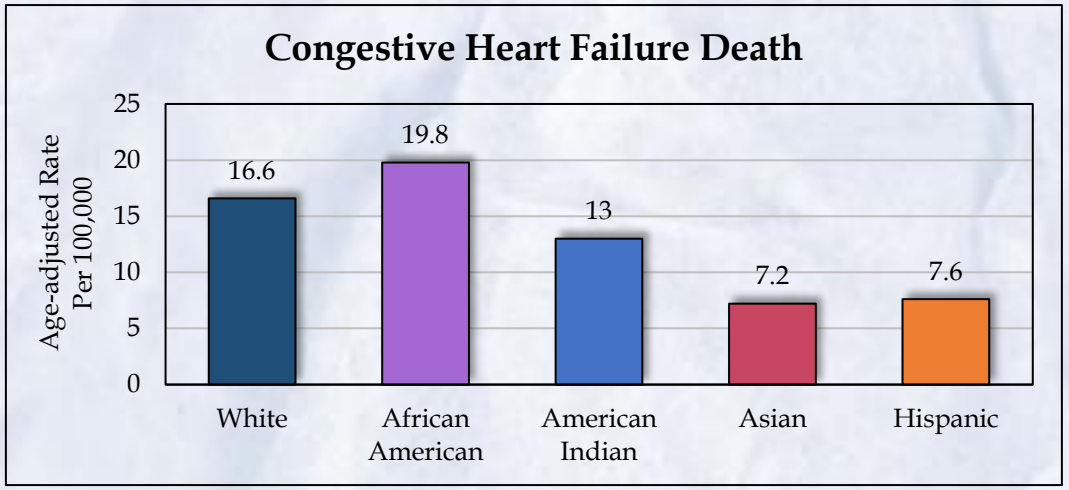
Congestive Heart Failure & Stroke Death

Heart failure, sometimes known as congestive heart failure, occurs when your heart muscle doesn't pump blood as well as it should.[39] A stroke occurs when blood flow to part of the brain stops. As the blood flow is interrupted, brain cells begin to die, as they cannot get the necessary oxygen. Strokes can cause brain damage, long-term disability, or death.[40] The risk of having a stroke may be reduced by refraining from smoking, maintaining a healthy weight, getting physical activity, and controlling high blood pressure and cholesterol.

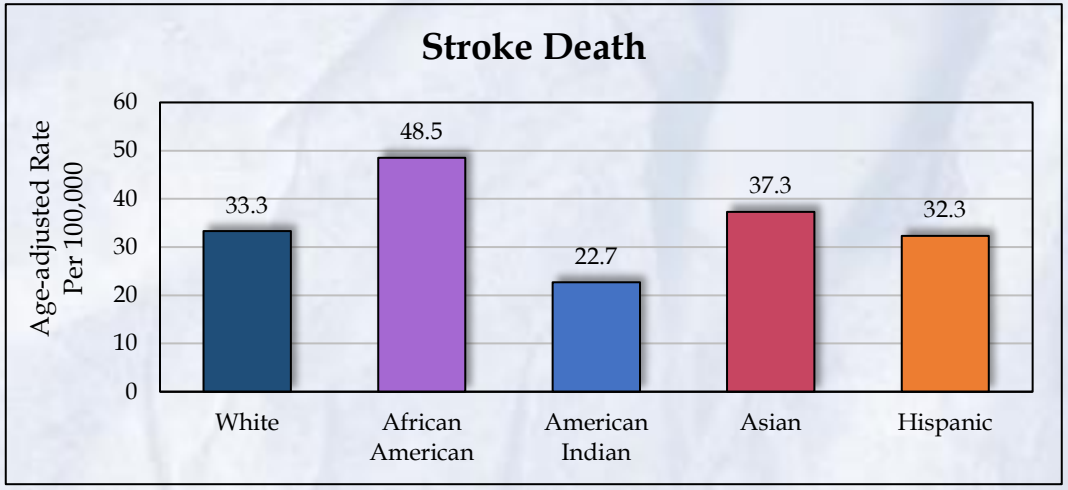
Key Disparities:

African Americans (19.8 per 100,000) had the highest death rate due to congestive heart failure which was the highest of all minority populations.

American Indians (13 per 100,000) also had a higher death rate due to congestive heart failure among the minority populations.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

Key Disparities:

African Americans had the highest rate of death due to stroke at 46.3%

American Indians (37.7%) reported somewhat higher stroke mortality rates than Whites (34.8%).

[39]Mayo Clinic. (2021). *Heart Failure.* Retrieved from https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142

[40]Centers for Disease Control and Prevention. (2016). About stroke. Retrieved from www.cdc.gov/stroke/about.htm

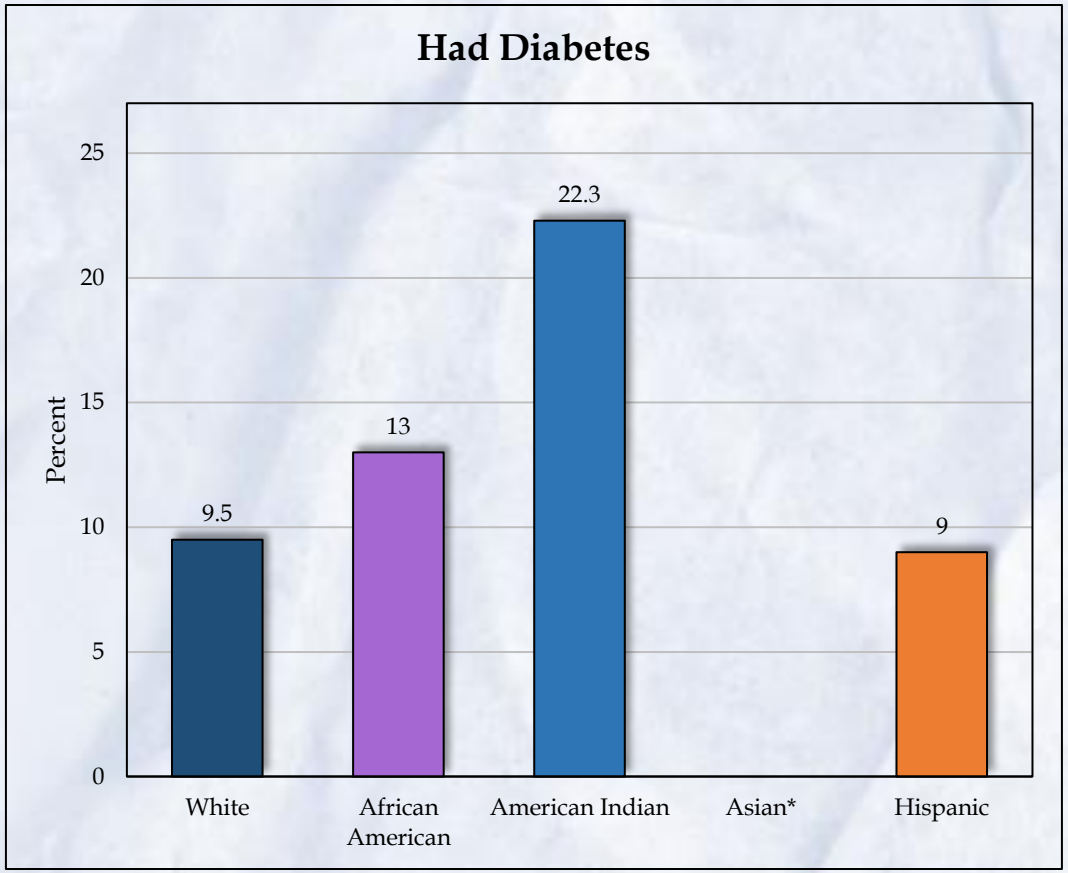
Diabetes Prevalence

Diabetes is a disease that occurs when one's blood sugar (glucose) is too high. Blood sugar is the body's main source of energy and when the body does not produce enough insulin to convert the sugar to energy, it stays in the blood and does not reach the cells. Over time high blood sugar can lead to several health problems.[41]

Key Disparities:
The American Indian population (22.3%) was most likely to report having diabetes, which was more than twice the rate of the White population (9.5%).

African Americans (13.0%) were also more likely to report having diabetes than the White population.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2018

[41] National Institute of Diabetes and Digestive and Kidney Disease. (2016). Diabetes overview. Retrieved from https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes

Diabetes Mortality

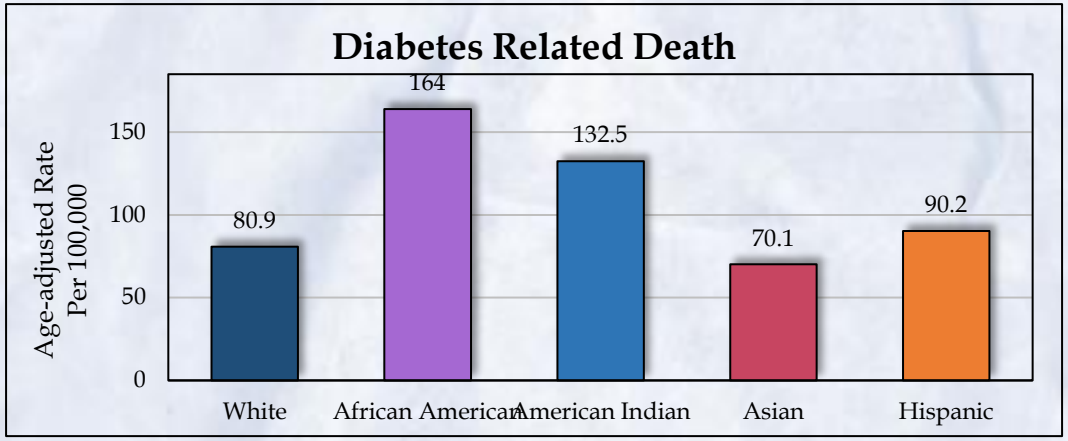
Diabetes-related deaths can be divided into two categories: deaths occurring early, which are associated with diabetic ketoacidosis (DKA) or hypoglycemia, and those resulting from long-term complications.[42] Complications from diabetes can include heart disease, blindness, and kidney failure.[43]

The chart represents includes all deaths related to diabetes.

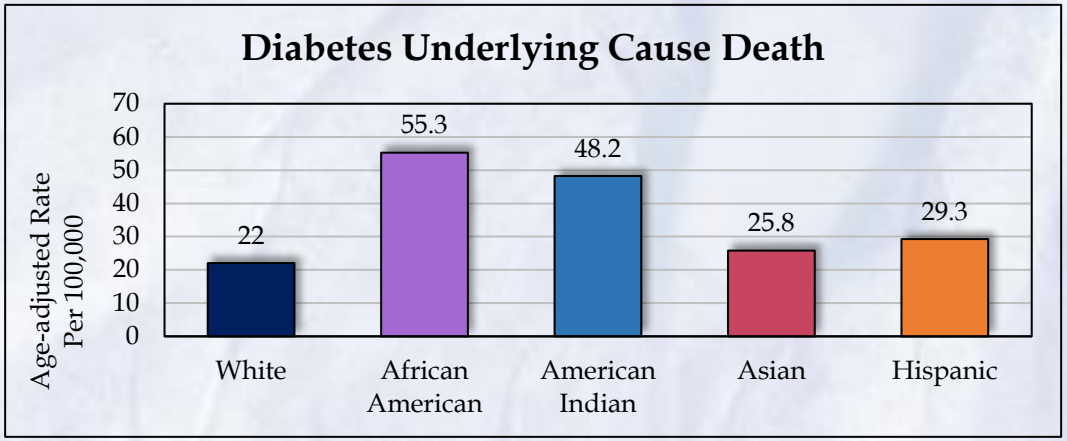
Key Disparities:

African Americans (164 per 100,000) had the highest diabetes related death rate, which was twice the rate of Whites (80.9 per 100,000).

American Indians (132.5 per 100,000) had the second highest diabetes related death rate. Hispanics (90.2 per 100,000) were also slightly higher than Whites.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

The chart represents the deaths which diabetes was the underlying cause, does not include all diabetes-related deaths.

Key Disparities:

African Americans (55.3 per 100,000) had the highest rate of diabetes as an underlying cause death, which was 2.5 times higher than the White population (22 per 100,000).

American Indians (48.2 per 100,000) had the second highest rate of diabetes as an underlying cause which was more than twice as high as Whites.

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

[43]Centers for Disease Control and Prevention. (2015). Basics about diabetes. Retrieved from www.cdc.gov/diabetes/basics/diabetes.html

Asthma Prevalence

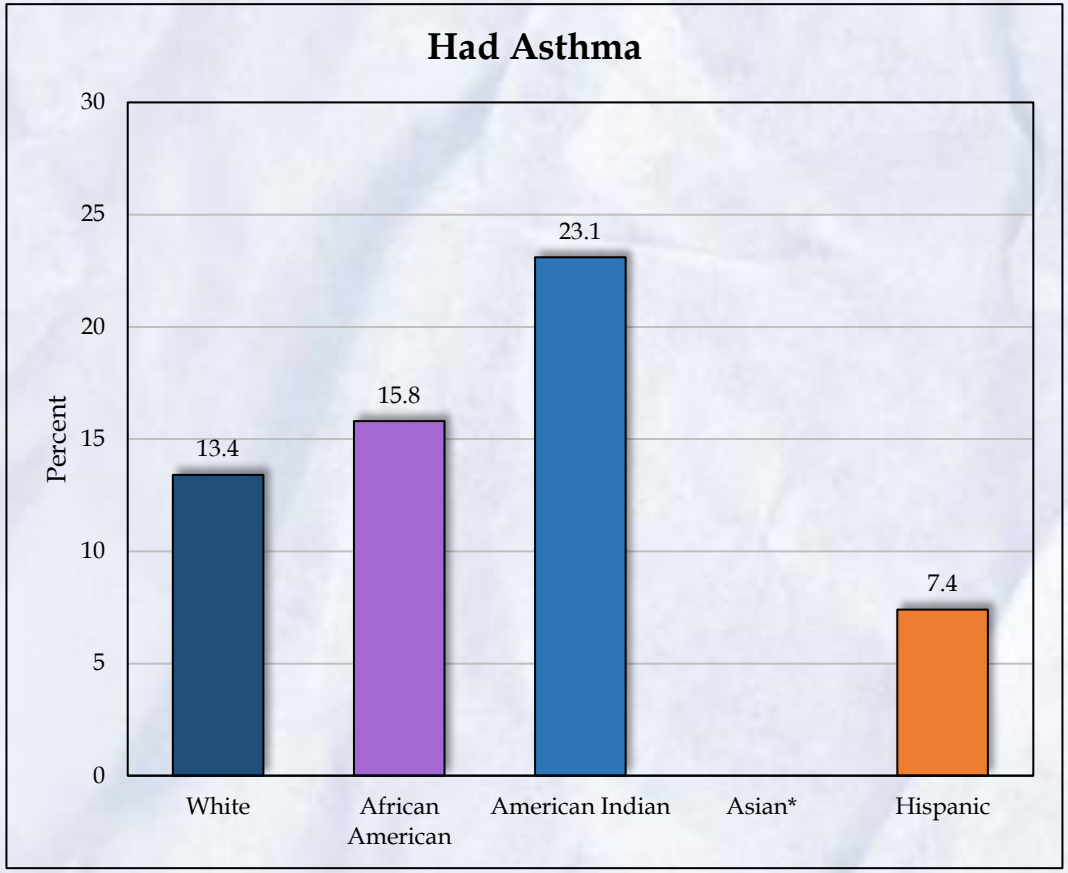
Asthma is a chronic condition that affects the airways of the lungs, in which the airways become narrowed and inflamed making it difficult to breathe.[44]

Key Disparities:

American Indians (23.1%) were most likely to report having had asthma, compared to 13.4% of Whites.

African American (15.8%) were slightly more likely to report having had asthma compared to the White population.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2018

[44]National Heart, Lung, and Blood Institute. (2020). Asthma. Retrieved from https://www.nhlbi.nih.gov/health-topics/asthma

Chronic Lung Disease

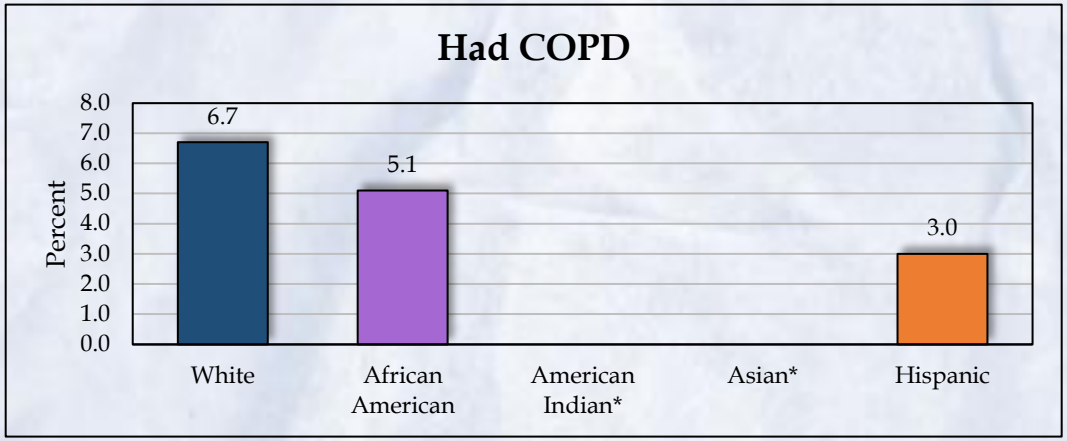
Chronic lung disease is a disorder that affects the lungs and other parts of the respiratory system. It typically develops slowly and may get worse over time. Types of chronic lung disease include asthma, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, asbestosis, pneumonitis, and other lung conditions.[45]

Key Disparities:

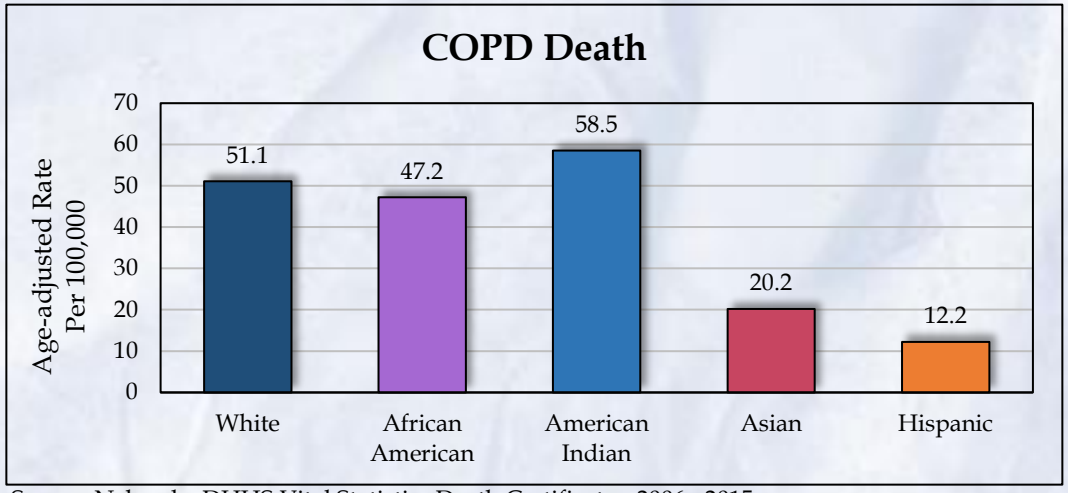
The African American population (5.1%) was slightly less likely than the White population (6.7%) to report having COPD.

Three percent of the Hispanic population reported they had COPD.

*Due to small sample size, American Indian and Asian data was not included.



Source: CDC BRFSS 2018



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006 - 2015

Key Disparities:

American Indians saw the highest death rate due to chronic lung disease at 61.7 per 100,000, approximately 15 points higher than that of Whites at 46.5 per 100,000.

African Americans reported a slightly higher death rate due to chronic lung disease than did Whites at 47.7 per 100,000.

[45]National Cancer Institute. (n.d.). Chronic lung disease. Retrieved from https://www.cancer.gov/publications/dictionaries/cancer-terms/def/chronic-lung-disease

Arthritis Prevalence

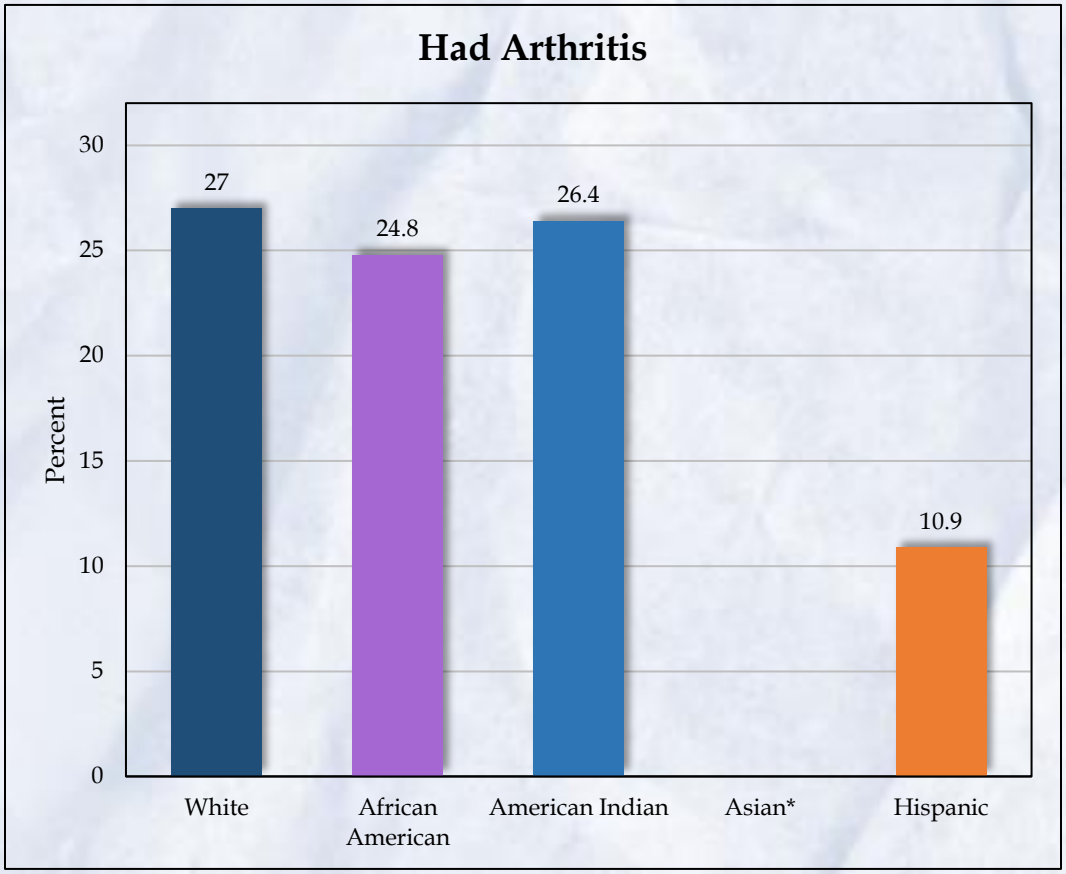
Arthritis includes more than 100 diseases that affect joints and the surrounding tissues and can cause pain and stiffness in the affected areas.[46] The most common type of arthritis in the United States is osteoarthritis, which wears down cartilage and makes it difficult for bones to glide over each other.[47]

Key Disparities:

The White (27%) and American Indians (26.4%) were most likely to report having ever been diagnosed with arthritis, followed closely by African Americans (24.8%).

The Hispanic (10.9%) population was the least likely to have ever been diagnosed with arthritis.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2018

[46]Centers for Disease Control and Prevention. (2016). Arthritis. Retrieved from www.cdc.gov/arthritis/basics/faqs.htm
[47]National Institutes of Health. (2016). What is osteoarthritis. Retrieved from www.niams.nih.gov/health_info/osteoarthritis/osteoarthritis_ff.asp

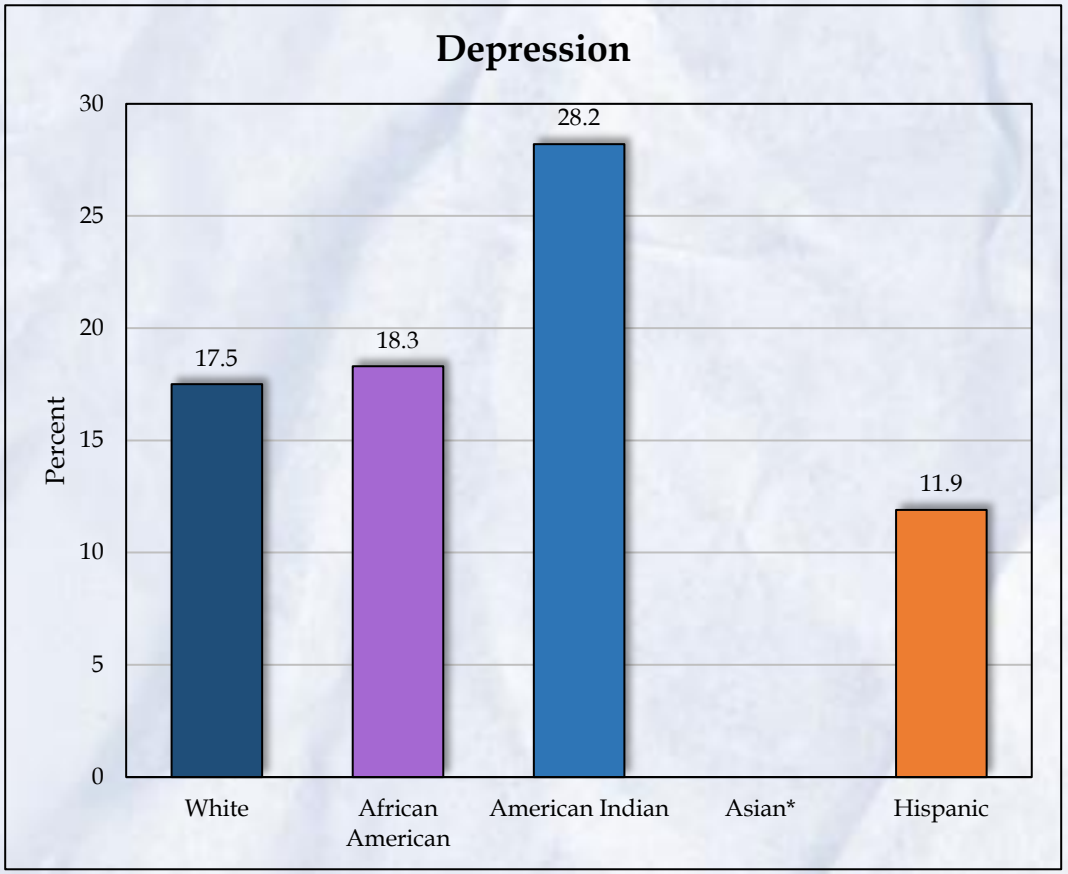
Depression Prevalence

Depressive disorders are often characterized by feelings of sadness and hopelessness, though individuals with a major depressive disorder may also experience loss of interest in activities, changes in weight or activity, insomnia, and difficulties concentrating. If not treated, individuals with depression face a higher risk of suicide, heart disease, and other mental disorders.[48]

Key Disparities:
The American Indian population (22.3%) was most likely to report having diabetes, which was more than twice the rate of the White population (9.5%).

African Americans (13.0%) were also more likely to report having diabetes than the White population.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2018

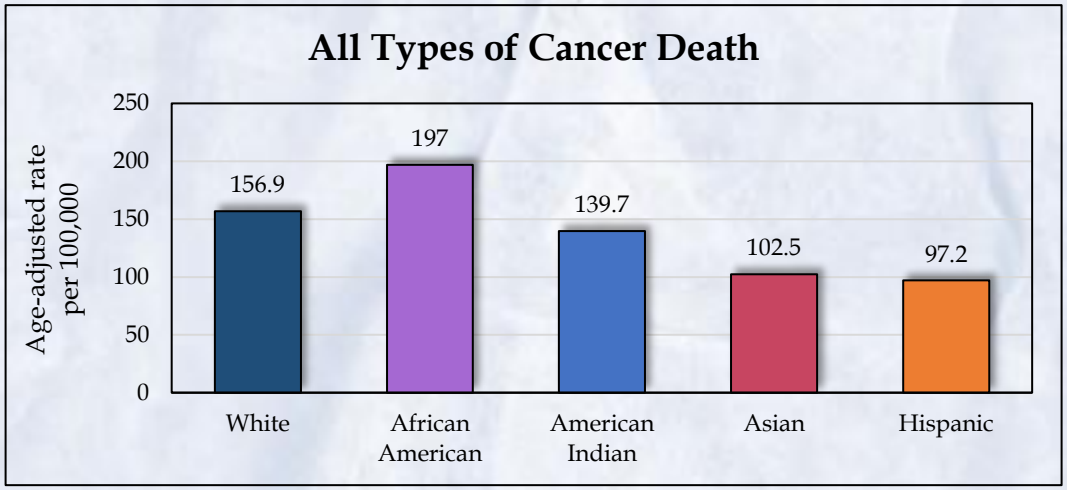
[48]Centers for Disease Control and Prevention. (2016). Depression. Retrieved from www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm

Cancer Mortality

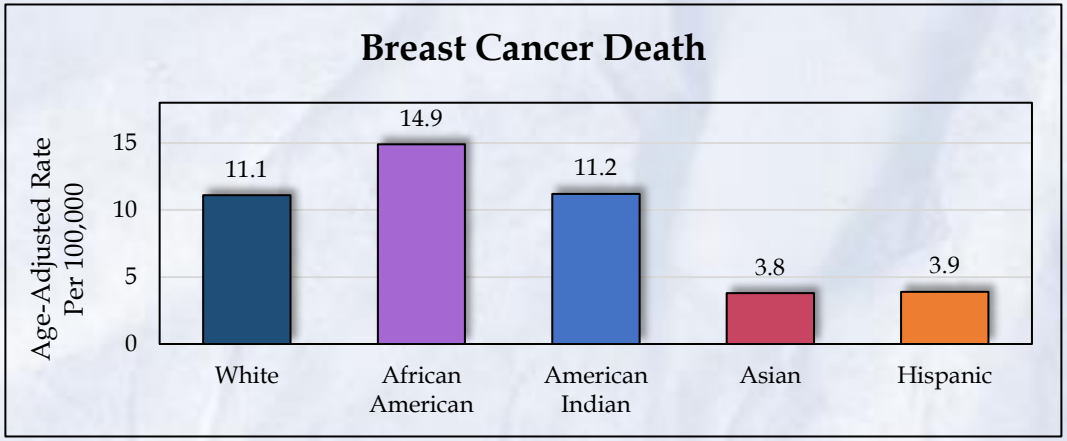
Key Disparities:

African Americans had the highest rate of death due to cancer from 2013-2017 at 197 per 100,000. Hispanics had a death rate due to cancer approximately half that of African Americans at 97.2 per 100,000.

Whites had the second-highest death rate due to cancer at 156.9 per 100,000 from 2013-2017, followed closely by American Indians at 139.7 per 100,000.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

After skin cancer, breast cancer is the most common cancer among women and the second leading cause of cancer death among women in the United States.[50]

Key Disparities:

American Indians had the highest breast cancer mortality rate at 14.9 per 100,000, followed by African Americans at 11.2 per 100,000 and Whites at 11.1 per 100,000.

[50]Centers for Disease Control and Prevention. (2017). Breast cancer. Retrieved from www.cdc.gov/cancer/breast/

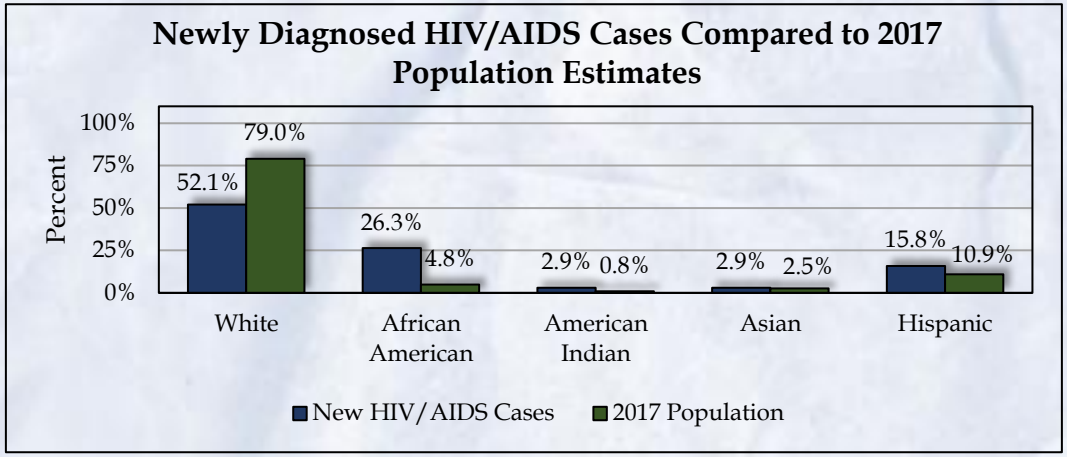
HIV/AIDS

While the Human Immunodeficiency Virus (HIV) is like other viruses such as the flu, the immune system cannot completely get rid of HIV. Over time, HIV can destroy cells that the body needs to fight off infections, and individuals are at a higher risk of disease due to a weakened immune system.[51] If untreated, HIV can lead to acquired immunodeficiency syndrome (AIDS), which leaves the body extremely vulnerable to certain diseases and cancers. In Nebraska, there was 411 newly diagnosed HIV/AIDS cases between 2013-2017.

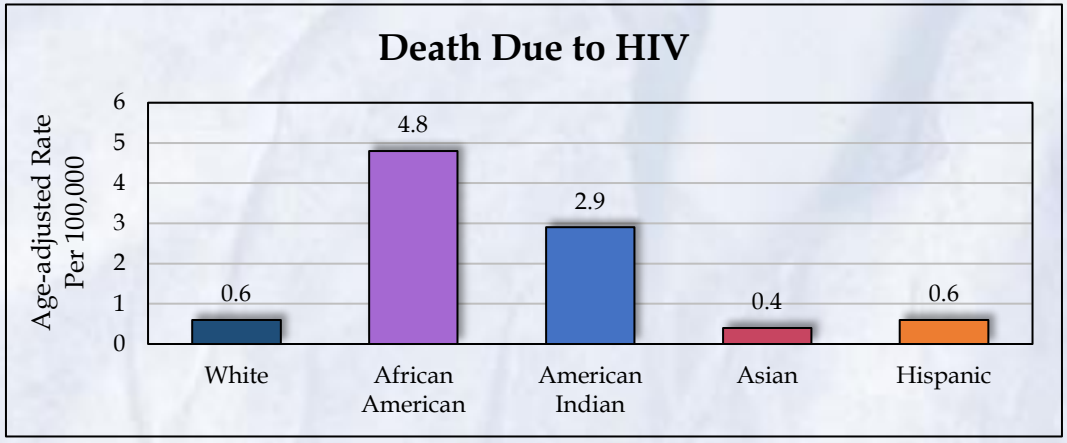
Key Disparities:

The White population saw the highest percentage of those newly diagnosed with HIV/AIDS at 52.1%. However, Whites make up a large percentage of the population.

African Americans had the highest percentage of those newly diagnosed with HIV/AIDS among minority populations at 26.3%, which was 1.7 times greater than the next highest minority population, Hispanics (15.8%).



Source: Nebraska DHHS, HIV Prevention Program 2013-2017; U.S. Census Bureau. (2019). Annual estimates of the resident population by sex, race, and Hispanic origin: April 1, 2010 to July 1, 2019.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

Key Disparities:

African Americans had the second-highest death rate due to HIV/AIDS at 4.8 per 100,000.

American Indians had an HIV-AIDS mortality rate of 2.9 per 100,000, compared to 0.6 per 100,000 for Whites.

[51] AIDS.gov. (2016). What is HIV/AIDS. Retrieved from www.aids.gov/hiv-aids-basics/hiv-aids-101/what-is-hiv-aids

Injury & Violence

According to the National Center for Health Statistics, there were 28.3 million injury episodes (intentional and unintentional) in the United States in 2018. This resulted in millions of physician office and emergency department visits and more than 240,000 deaths in 2018. [52] Additionally, the CDC estimates the lifetime medical and work loss costs associated with injuries was $671 billion annually (2013 rate).[53]

Nebraska recorded 16,904 deaths in 2018. Of these, almost 7% were from intentional and unintentional injuries, including 804 unintentional injury deaths, 271 suicides, and 35 homicides.[54] Both intentional and unintentional injuries are among the top 15 killers of Americans in all age groups, and the leading cause of death among those 1-44 years of age.[55] Approximately 91% of deaths among Nebraskans aged 10-24 in 2018 were due to injury and violence.[56]

Various factors can affect an individual's risk of injury or violence, including individual behaviors, physical environment, and access to services. Injury prevention generally falls into related categories, such as modifying the environment, as well as education and behavior change.[57]

[52]Centers for Disease Control and Prevention. (2021). *All injuries.* Retrieved from https://www.cdc.gov/nchs/fastats/injury.htm
[53]Centers for Disease Control and Prevention. (2021). *Cost of injury data.* Retrieved from https://www.cdc.gov/injury/wisqars/cost/
[54]Nebraska Department of Health and Human Services. (2007). Nebraska vital statistics report: death highlights. Retrieved from: http://dhhs.ne.gov/publichealth/Vital%20Statistics%20Reports/Death%20Summary%202007.pdf
[55]Healthy People 2010. (2012). Injury and Violence Prevention. Retrieved from http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=24
[56]Centers for Disease Control and Prevention. (2020). *Underlying cause of death 1999-2019.* CDC WONDER Online Database.
[57]Ibid.

Unintentional Injury Mortality

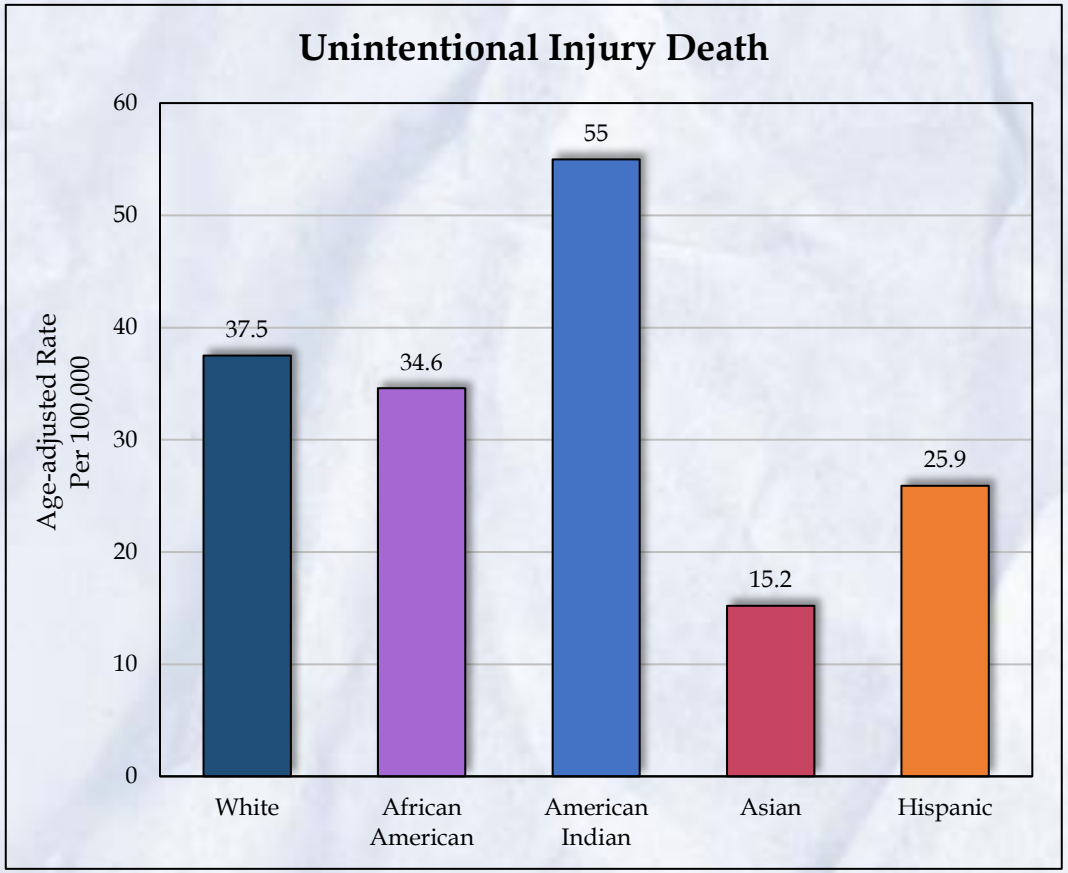
Unintentional injury deaths include those resulting from motor vehicle crashes, falls, residential fires, poisoning, and drowning, among others. In 2017, unintentional injury deaths were the fourth leading cause of death in the United States.[58] In Nebraska, it was the fifth leading cause of death.

Key Disparities:

The death rate due to unintentional injury was highest among American Indians at 55 per 100,000.

African Americans and Whites also saw higher rates of death due to unintentional injury at 34.6 and 37.5 per 100,000, respectively.

Over one-fourth of deaths for Hispanics (25.9 per 100,000) were due to unintentional injury.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

[58]Centers for Disease Control and Prevention. (2017). National Vital Statistics Systems – Mortality data. Retrieved from http://wonder.cdc.gov/ucd-icd10.html

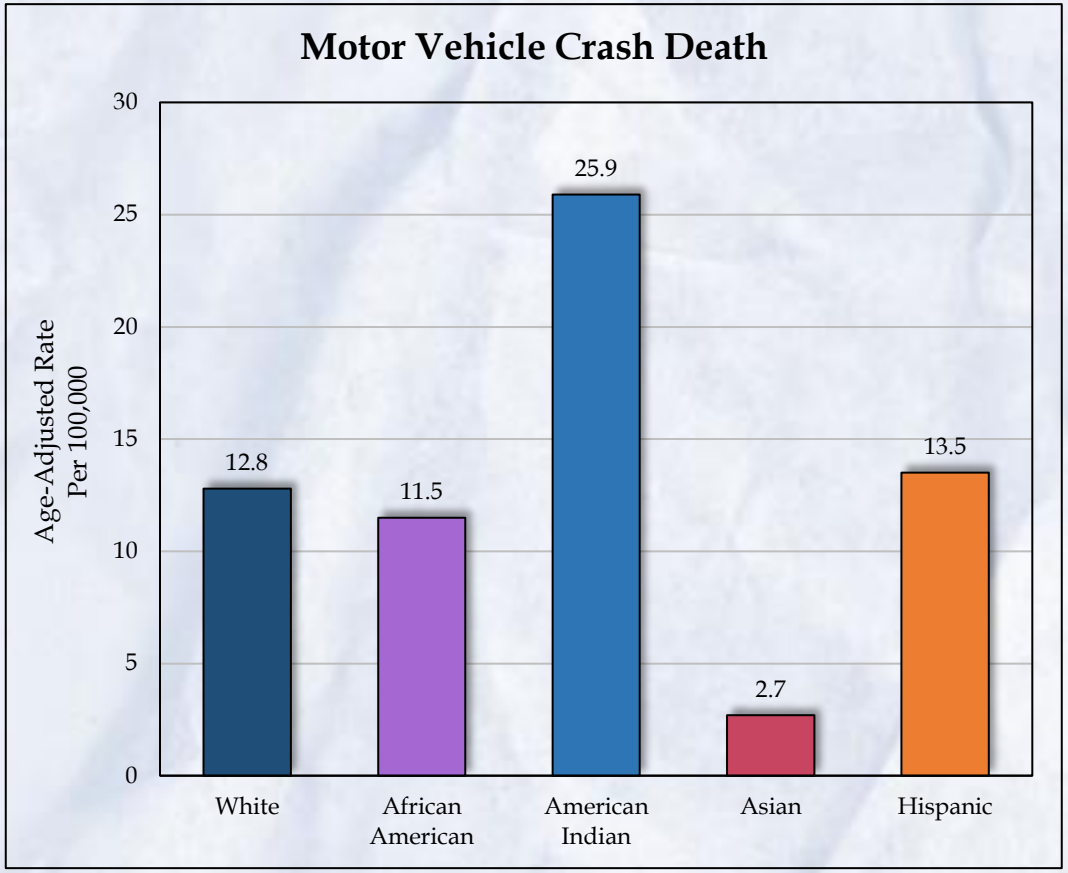
Motor Vehicle Fatalities

Motor vehicle crashes are one of the leading causes of death in the United States. In 2017 the cost of medical care and productivity loss associated with motor vehicle injuries and deaths in the U.S. was $75 billion.[59] In 2017 in Nebraska, approximately 99 individuals were involved in a motor vehicle crash, and 210 fatal crashes resulted in 228 deaths.[60]

Key Disparities:

The death rate due to motor vehicle accidents was highest among American Indians (25.9 per 100,000), compared to only 12.8 per 100,000 among Whites.

The Asian population saw the lowest death rate due to motor vehicle accidents at 2.7 per 100,000.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

[59]Centers for Disease Control and Prevention. (2018). WISQARS (Web-based Injury Statistics Query and Reporting System). Retrieved from https://www.cdc.gov/injury/wisqars/

[60]Nebraska Department of Transportation. (2017). Annual report: traffic crash facts. Lincoln, NE: State of Nebraska.

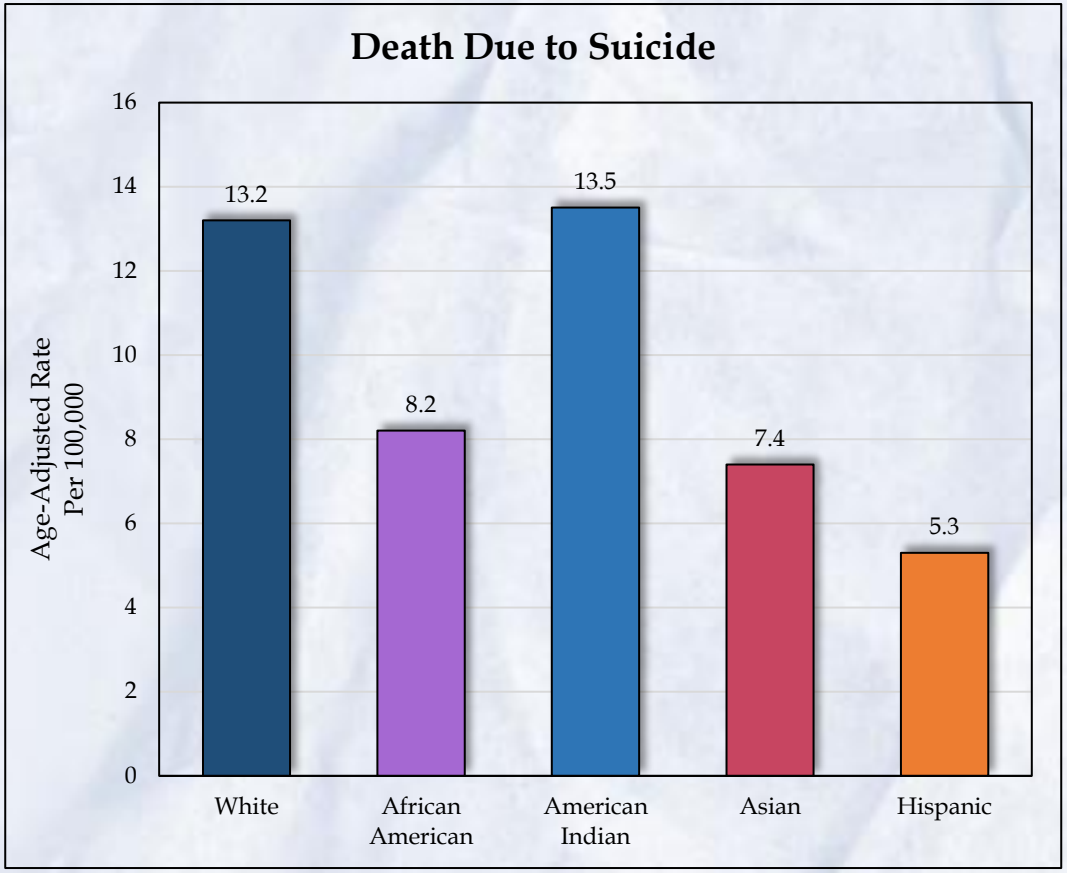
Suicide

In 2017, over 47,173 suicides were reported in the United States, and almost 479,000 individuals with self-inflicted injuries were treated in emergency departments. In 2017, suicide was the tenth leading cause of death in the United States.[61] In Nebraska, there were 1,215 suicides between 2013-2017 making it the tenth leading cause of death.[62]

Key Disparities:

The American Indian population had the highest death due to suicide at 13.5 per 100,000. This was slightly more than the White population at 13.2 per 100,000.

The Hispanic populations had the lowest death rates due to suicide 5.3 per 100,000.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

[61]Centers for Disease Control and Prevention. (2017). Suicide and self-harm injury. Retrieved from https://www.cdc.gov/nchs/fastats/suicide.htm
[62] National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017

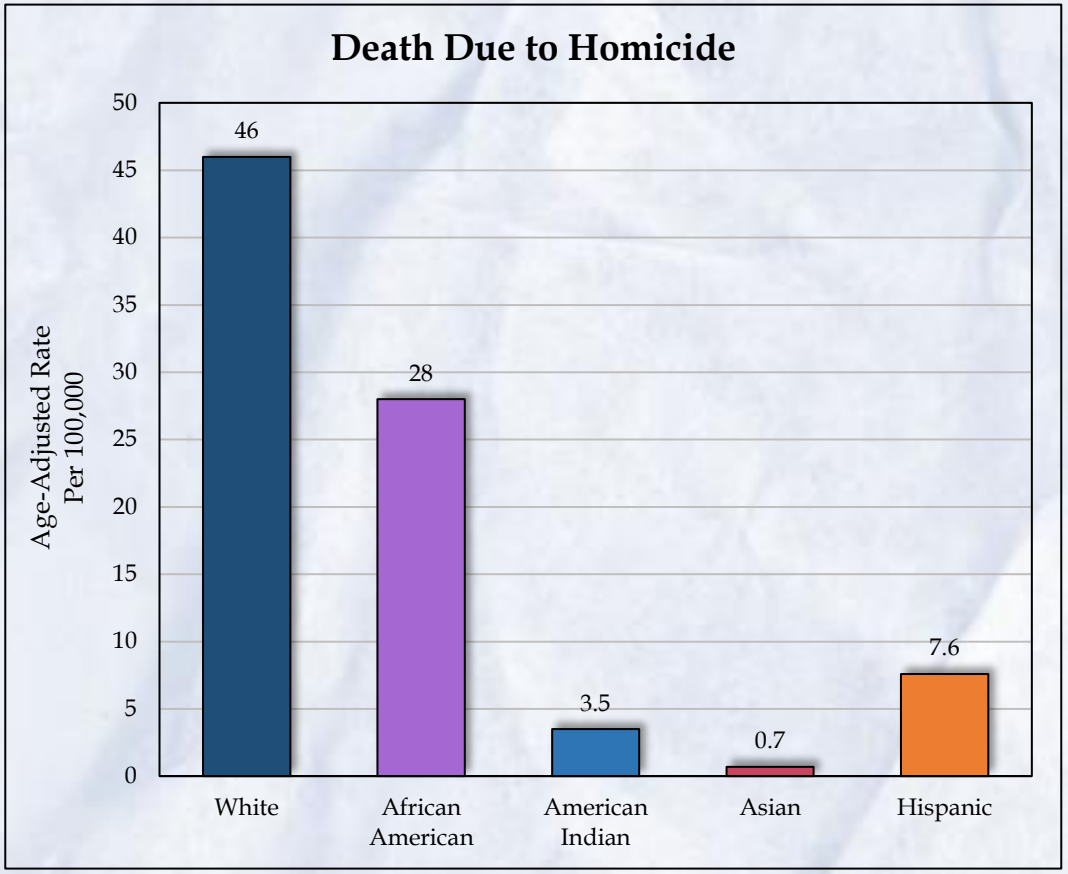
Homicide

In 2017, homicide accounted for 19,510 deaths in the United States. Approximately 72% of those deaths were the result of firearms.[63] In Nebraska, there were 323 homicides between 2013-2017.[64]

Key Disparities:

The death rate due to homicide was highest among Whites at 46 per 100,000.

African Americans also had high rates at 28 per 100,000. This was 3.7 times greater than the next highest rate, Hispanics at 7.6 per 100,000.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

[63]Centers for Disease Control and Prevention. (2017). National Vital Statistics System – Mortality Data. Retrieved from https://www.cdc.gov/nchs/fastats/homicide.htm

[64] National Center for Health Statistics (NCHS), National Vital Statistics System, 2013-2017

Substance Abuse

Substance abuse refers to the excessive use of potentially addictive substances, such as alcohol or drugs, which may modify bodily functions and negatively affect an individual's life. Social attitudes, in addition to political and legal responses to the consumption of alcohol and illicit drugs, make substance abuse one of the most complex public health issues. Along with the considerable health implications, substance abuse has been a crux in the criminal justice system and a major focal point in discussions regarding social values.

Substance abuse and its related effects are among society's top health and social concerns. From 2006-2010, excessive alcohol use accounted for more than 95,000 deaths per year in the United States due to various diseases, motor vehicle crashes, homicide, and suicide.[65] Excessive alcohol consumption can lead to cirrhosis of the liver and is associated with heart disease, cancer, and stroke. If abuse starts in youth, further damage occurs in the developing brain, resulting in lifelong impaired cognitive function and memory problems. Alcohol use by pregnant women is harmful to the fetus and can lead to miscarriage, stillbirth, and physical and mental birth defects.

Tobacco use also has a large impact on an individual's health status and is the leading cause of preventable death in the United States. Smoking can cause cancer, heart disease, stroke, lung diseases, diabetes, and other diseases. Cigarette smoking causes more than 480,000 deaths yearly in the United States.[66]

[65]Centers for Disease Control and Prevention. (2021). Deaths from excessive alcohol use in the U.S. Retrieved from https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html

[66]U.S. Department of Health and Human Services. (2014). *The health consequences of smoking – 50 years of progress: A report of the surgeon general*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

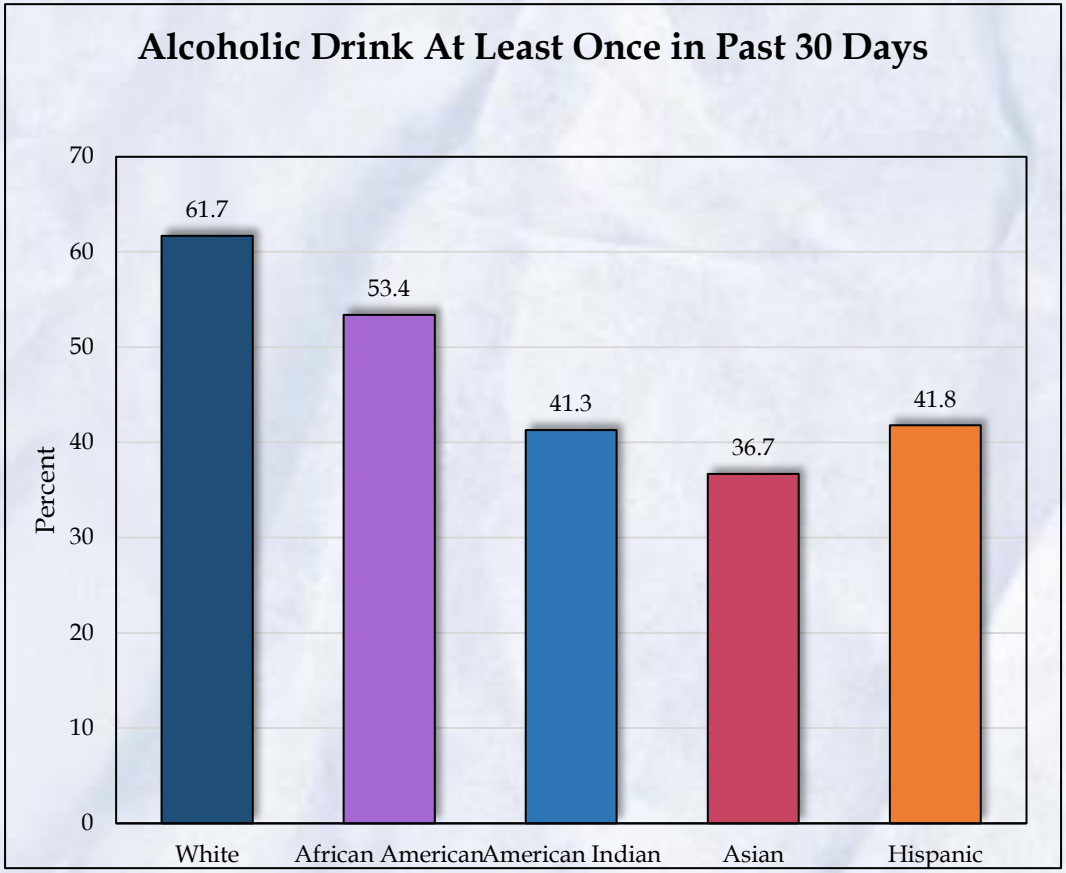
Alcohol Consumption

Excessive alcohol consumption has been associated with short-term and long-term health risks. The chart represents the percentage of individuals who responded to having drank at least one alcoholic drink in the past 30 days.

Key Disparities:

Whites (61.7%) were most likely to report having drank alcohol in the past 30 days, followed by African Americans (53.4%).

Hispanics (41.8%) and American Indians (41.3%) had similar percentages of individuals who reported alcohol consumption.



Source: CDC BRFSS 2018

Binge Drinking

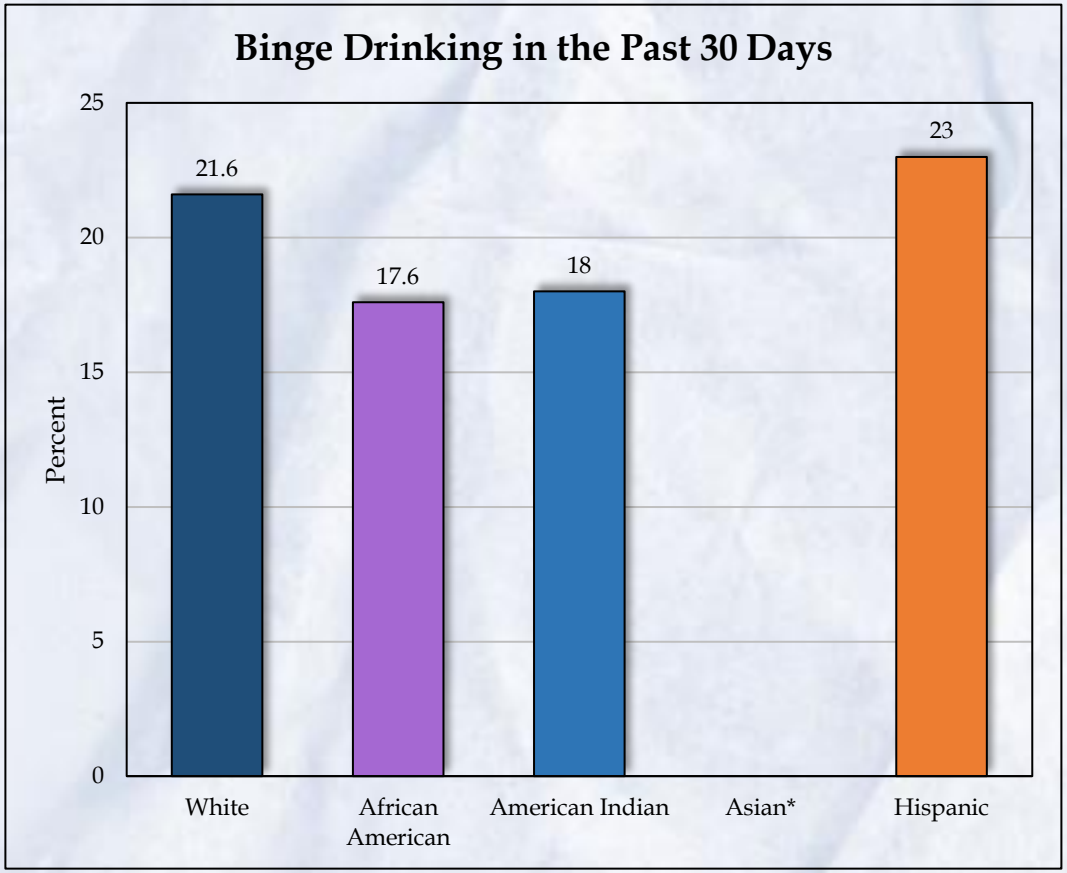
The Substance Abuse and Mental Health Services Administration (SAMHSA) defines binge drinking as drinking five or more alcoholic beverages on any one occasion.[67] The data comprised below includes males who had five or more drinks and females who had four or more drinks on any one day in the past month.

Key Disparities:

Hispanics reported the highest percentage of binge drinking in the past 30 days at 23%, followed closely by Whites (21.6%).

American Indians (18%) and African Americans had similar rates of binge drinking in the past 30 days.

*Due to small sample size, Asian population data was not included.



Source: CDC BRFSS 2018

[67]National Institutes of Health. (2016). Drinking levels defined. Retrieved from https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

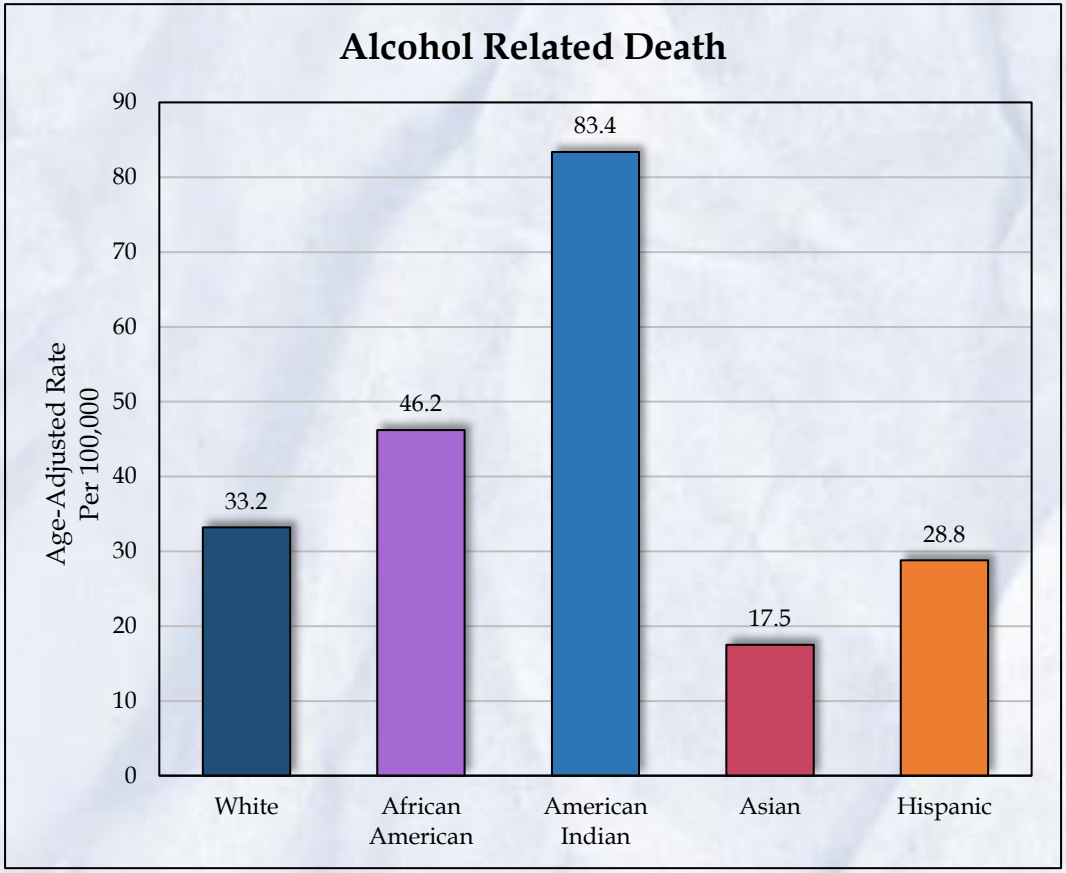
Alcohol-Related Deaths

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

Key Disparities:

The alcohol-related death rate for American Indians (83.4 per 100,000) was 2.5 times higher than that of Whites (33.2 per 100,000) from 2013-2017. African Americans also had a death rate somewhat higher than Whites at 46.2 per 100,000.

Hispanics (28.8 per 100,000) and Asians (17.5 per 100,000) had the lowest alcohol-related death rates.



Source: Nebraska DHHS Vital Statistics Death Certificates 2013-2017

Cigarette Smoking

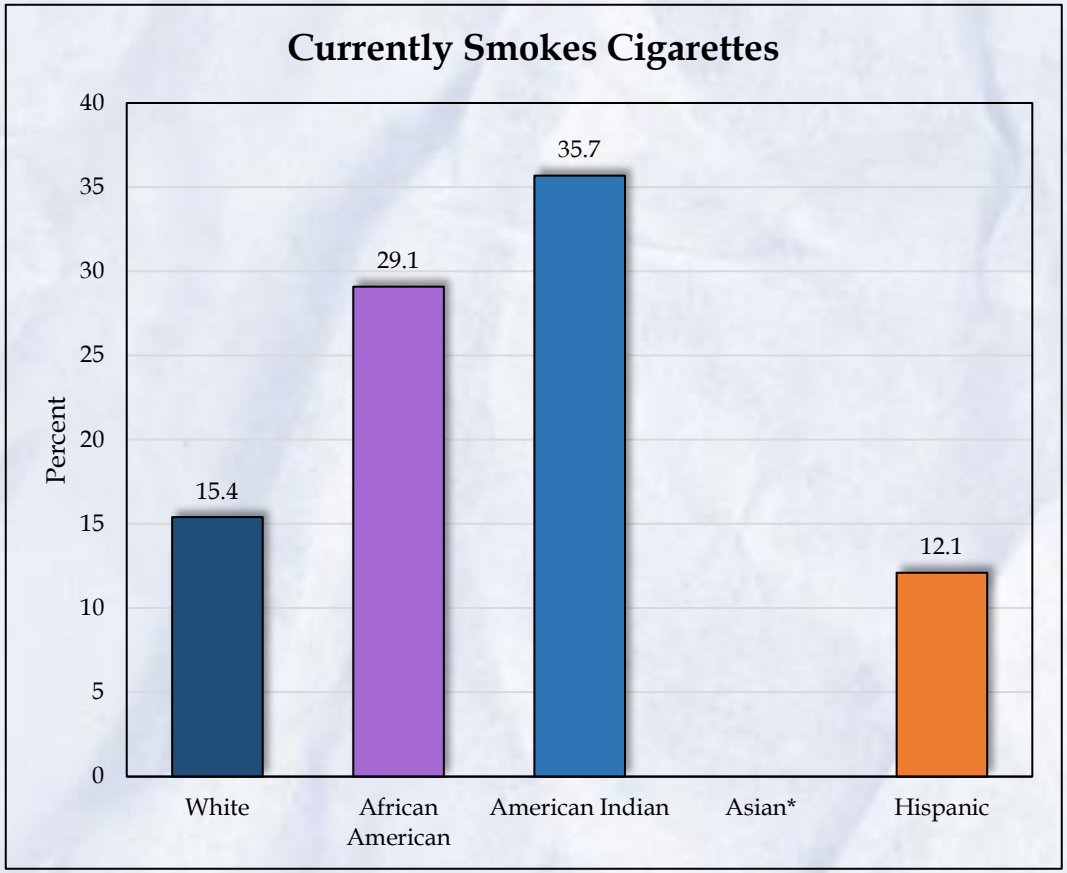
Smoking increases the risk of chronic diseases, such as lung disease, coronary heart disease, stroke, and various cancers.[68]

Key Disparities:

American Indians were most likely to report currently smoking cigarettes at 35.7% of the population, followed by African Americans at 29.1%.

The Hispanic population (12.1%) were less likely than Whites (15.4%) to report currently smoking cigarettes.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2018

[68]Centers for Disease Control and Prevention. (2016). Health effects of cigarette smoking. Retrieved from www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

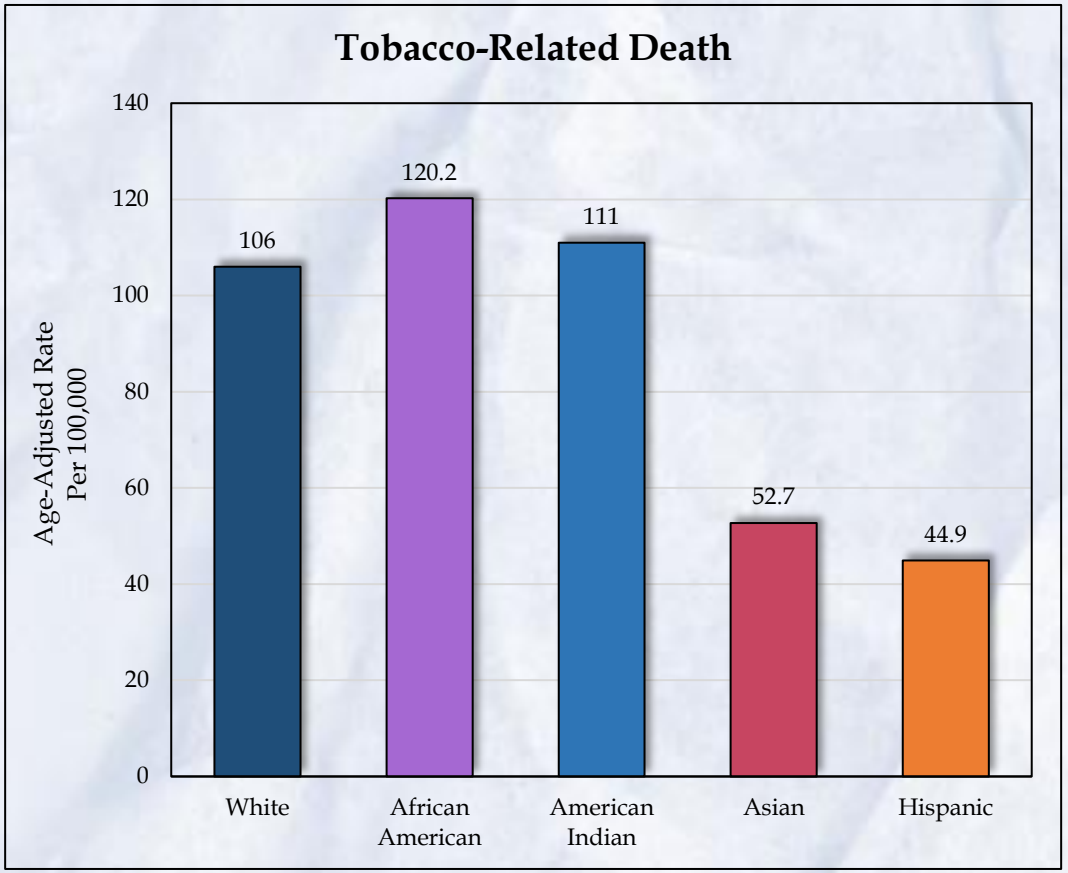
Tobacco-Related Death

Tobacco is the leading cause of preventable death and disease in the United States. Cigarette smoking causes nearly one in five deaths each year in the United States.[69]

Key Disparities:

African Americans had the highest tobacco related death rate at 120.2 per 100,000, followed by American Indians (111 per 100,000) and Whites (106 per 100,000).

The Hispanic population (44.9 per 100,000) and the Asian population (52.7 per 100,000) was lower than the death rates seen by Whites.



Source: CDC BRFSS 2018

[69]Centers for Disease Control and Prevention. (2013). QuickStats: number of deaths from 10 leading causes. Retrieved from www.cdc.gov/mmwr/preview/mmwrhtml/mm6208a8.htm?s_cid=mm6208a8_w

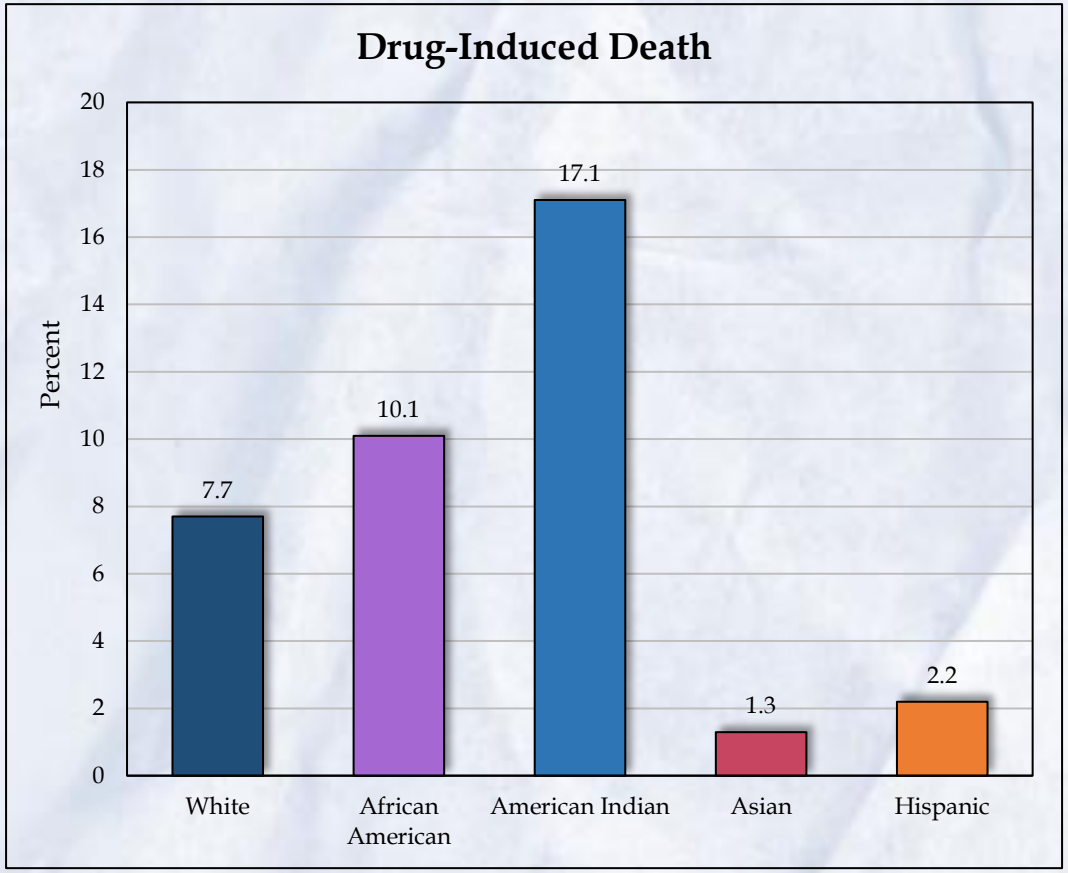
Drug-Induced Deaths

Drug-induced causes of death include not only deaths from dependent and nondependent use of drugs (legal and illegal use), but also poisoning from medically prescribed and other drugs. It excludes accidents, homicides, and other causes indirectly related to drug use.

Key Disparities:

American Indians saw the highest rate of drug-induced death at 17.1 per 100,000. During the same period, the drug-induced death rate for Whites was less than half that at 7.7 per 100,000.

African Americans also had a somewhat higher drug-induced death rate at 10.1 per 100,000.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2013-2017

Health Behaviors & Risk Factors for Illness

Health behaviors refer to an individual's actions regarding their health and well-being. Health behavior stresses individual responsibility in maintaining health and preventing illness through a variety of activities and prevention measures that result in a longer and health life.[70] The Centers for Disease Control and Prevention identified five health behaviors that are important in preventing chronic disease, which include getting adequate exercise, never smoking, consuming alcohol in moderation, maintaining healthy body weight, and obtaining enough sleep.[71]

Risk factors for illness include characteristics or habits of individuals that increase their likelihood of developing a disease. Around one-third of the deaths in the United States are a result of heart disease, stroke, and other cardiovascular diseases each year. Theses disease are the most widespread and costly health problems, accounting for $214 billion in health care expenditures annually in the United States.[72] These diseases are also the most preventable, as the risk factors can be somewhat easily controlled. These risk factors include high blood pressure, cholesterol, cigarette smoking, diabetes, obesity, and physical inactivity.

It is important to note that access to sufficiently nutritious foods, safe places to exercise, and other resources that result in improved health and well-being are often limited in low-income neighborhoods, and research shows that tobacco products and alcohol are marketed more aggressively to racial and ethnic minority groups.[73] These factors contribute to the disparities seen in positive health behaviors and to the prevalence of adverse health outcomes in racial and ethnic minority populations.

[70]Matarazzo, J.D. (1980). Behavioral health and behavioral medicine: frontiers for a new health psychology. American Psychologist, Vol. 35: 807-817.
[71]Liu Y., Croft J.B., Wheaton A.G., Kanny D., Cunningham T.J., Lu H., et al. (2013). Clustering of five health-related behaviors for chronic disease prevention among adults. Preventing Chronic Disease 2016;13:160054
[72]Centers for Disease Control and Prevention. (2020). Heart disease and stroke. Retrieved from https://www.cdc.gov/chronicdisease/resources/publications/factsheets/heart-disease-stroke.htm
[73]D. J. Moore, J. D. Williams, W. J. Qualls. (1996). Target marketing of tobacco and alcohol-related products to ethnic minority groups in the United States. Ethn Dis. 1996 Winter-Spring; 6(1-2): 8398.

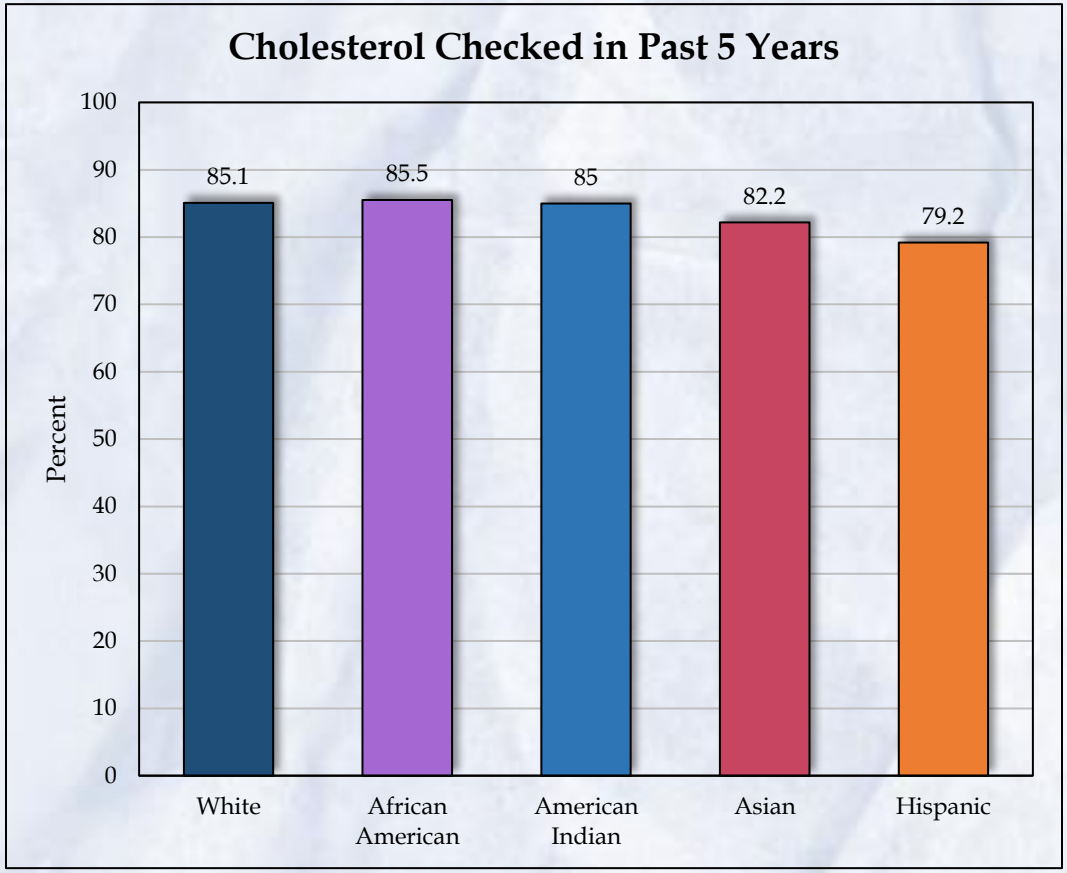
Cholesterol Awareness

It is important for individuals to get their cholesterol checked to stay healthy. High cholesterol increases individuals' risk for heart disease and stroke, which are two leading causes of death in the United States. Adults should have their cholesterol checked every 4-6 years or more frequently if there is a family history of early heart attacks or heart disease.[74]

Key Disparities:

The Hispanic population was the least likely to report having had their cholesterol checked in the past five years at 79.2%, followed by the Asian population (82.2%).

The American Indian, African American, and White populations had similar percentages of individuals who had their cholesterol checked in the past five years.



Source: CDC BRFSS 2017

[74]Centers for Disease Control and Prevention. (2018). How and when to have your cholesterol checked. Retrieved from https://www.cdc.gov/features/cholesterol-screenings/index.html

Colorectal Cancer Screening

Colorectal cancer is a type of cancer that starts in the colon or the rectum. Screening is key to preventing colorectal cancer. The American Cancer Society recommends regular screening begin at age 45 or older.[75]

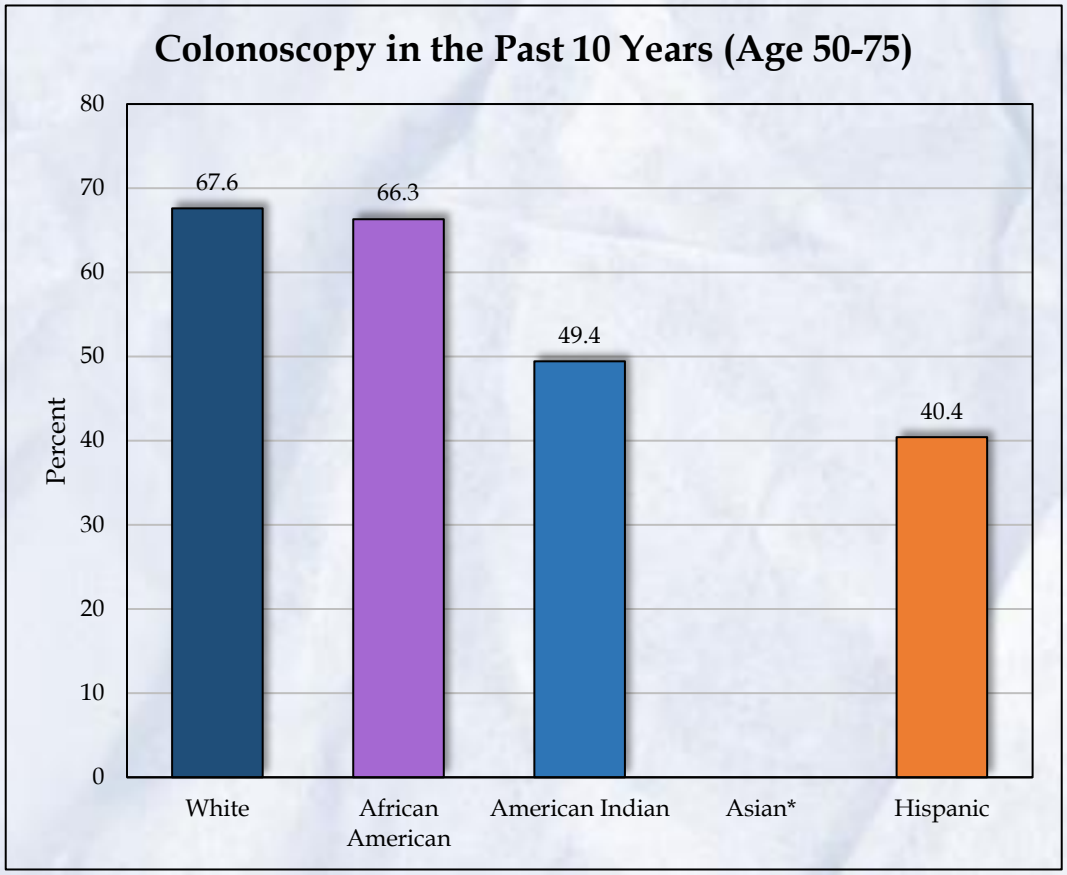
Key Disparities:

The Hispanic population was the least likely to report having a colonoscopy in the past ten years at 40.4%.

American Indians (49.4%) were the second least likely to report having a colonoscopy in the past ten years with only about half reporting such.

African Americans (66.3%) were slightly less likely than Whites (67.6%) to report having a colonoscopy in the past ten years.

*Due to small sample size, Asian data was not included.



Source: CDC BRFSS 2018

[75]The American Cancer Society. (2020). Can colorectal cancer be prevented? Retrieved from https://www.cancer.org/cancer/colon-rectal-cancer/causes-risks-prevention/prevention.html

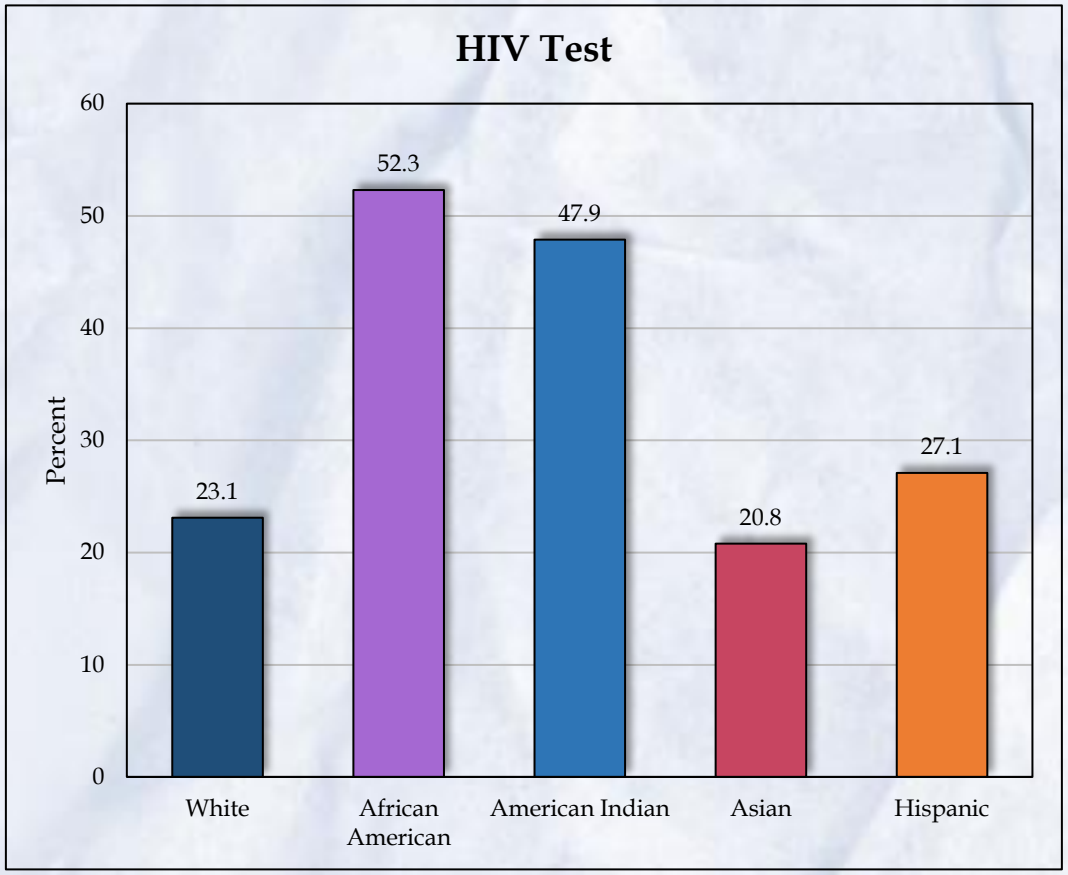
HIV Screening

It is estimated that 1.2 million people in the United States have HIV, including 161,800 people that are unaware they have it. Almost 40% of new HIV infections are transmitted by individuals who do not know they have it. Testing is the first step in sustaining a healthy life and preventing the transmission of HIV.[76]

Key Disparities:
The Asian population (20.8%) was the least likely to report having been tested for HIV, followed by the White population (23.1%) and Hispanic population (27.1%).

African Americans (52.3%) were most likely to report having been tested for HIV with more than half reporting such.

Almost half of the Hispanic population (47.9%) reported having been tested for HIV.



Source: CDC BRFSS 2018

[76]Centers for Disease Control and Prevention. (2020). HIV testing. Retrieved from https://www.cdc.gov/hiv/testing/index.html#:~:text=Antibody%20tests%20can%20take%2023,prick%20or%20with%20oral%20fluid.

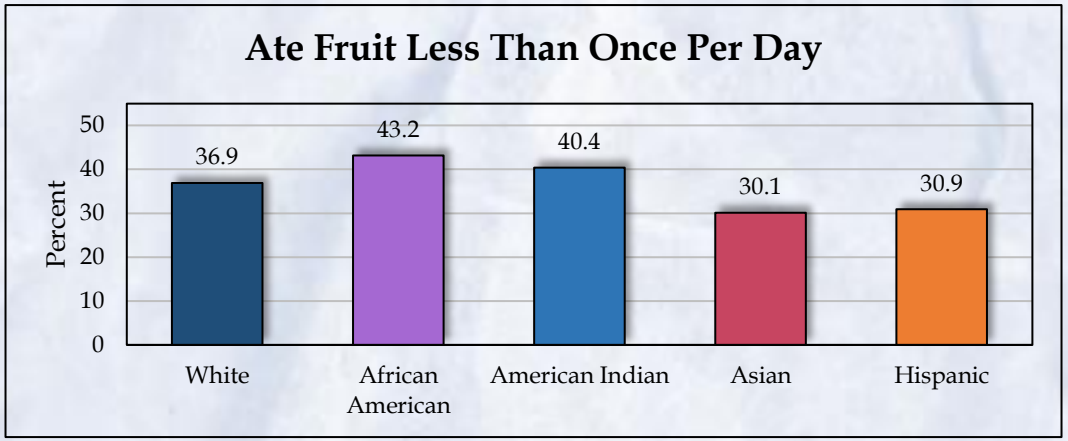
Fruit & Vegetable Consumption

Poor diet is a leading risk factor associated with death and disability in the United States. Having a diet rich in fruits and vegetables can help protect against several chronic diseases, including heart disease, diabetes, some cancers, and obesity. Dietary Guidelines for Americans recommends adults each 1.5-2 cups of fruits and 2 ½ cups of vegetable per day.[77]

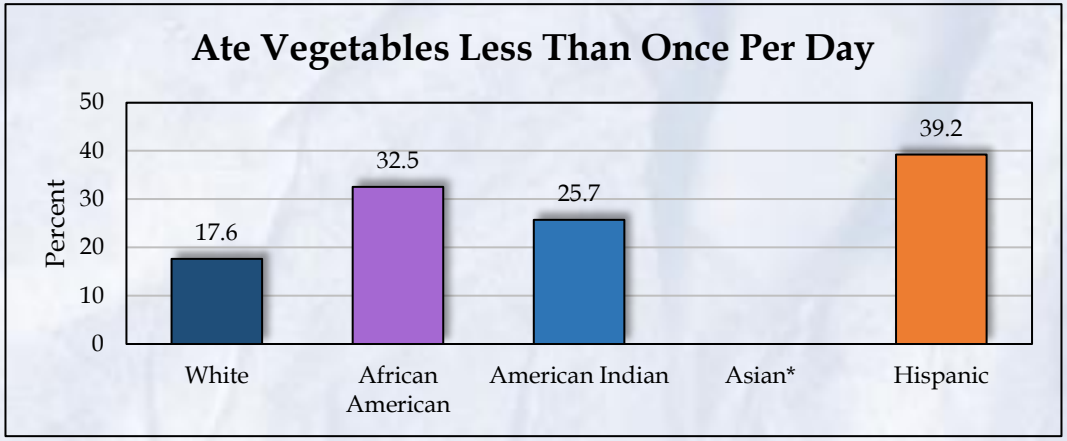
Key Disparities:

African Americans (43.2%) were most likely to report consuming fruit less than once per day, followed by American Indians (40.4%).

Slightly less than a third of Asians (30.1%) and Hispanics (30.9%) reported consuming fruit less than once per day, which was slightly lower than the White population (36.9%).



Source: CDC BRFSS 2017



Source: CDC BRFSS 2017

Key Disparities:

The Hispanic population was most likely to consume vegetables less than once per day at 39.2%, which was twice the rate of Whites.

African Americans (32.5%) had the second highest rate with almost one-third reporting consuming vegetables less than once per day. Over a quarter of American Indians reported consuming vegetables less than once per day.

*Due to small sample size, Asian data was not included.

[77]Centers for Disease Control and Prevention. (2018). State indicator report on fruits and vegetables. Retrieved from https://www.cdc.gov/nutrition/downloads/fruits-vegetables/2018/2018-fruit-vegetable-report-508.pdf

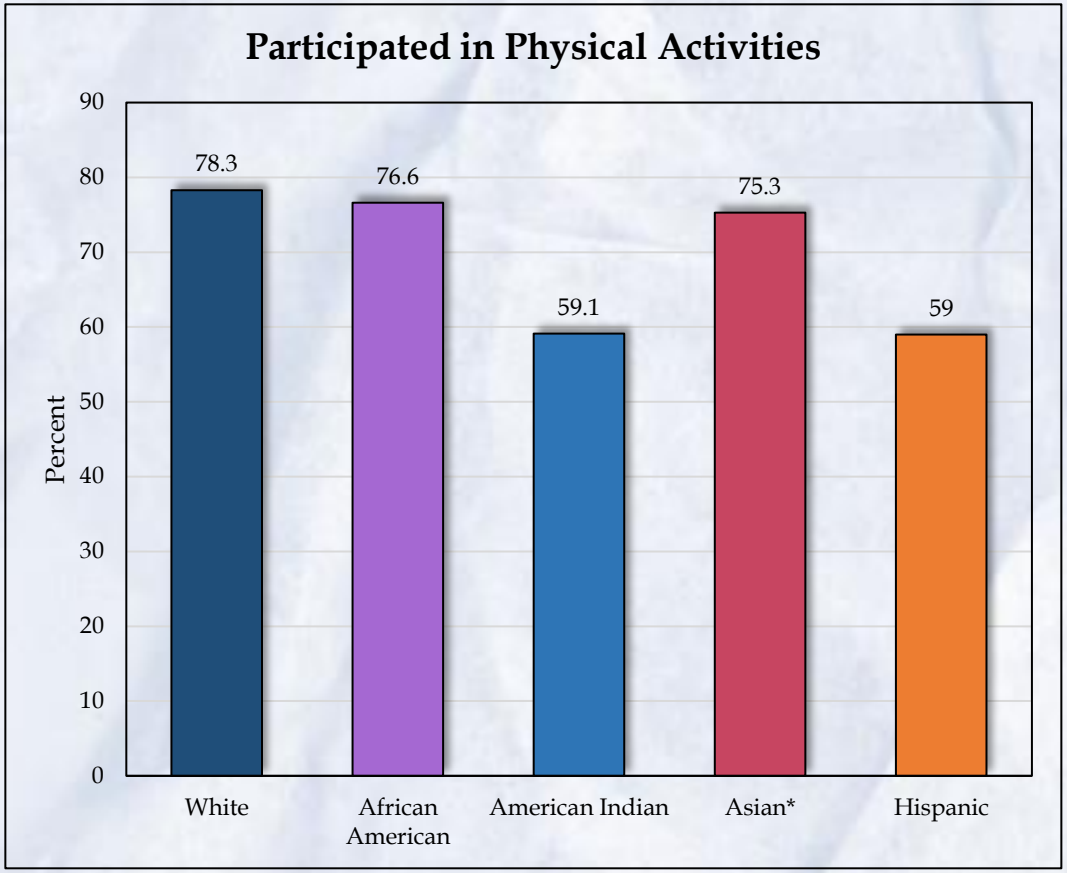
Physical Activity

Regular physical activity helps to improve health and can decrease the risk of numerous chronic diseases.[78]

Key Disparities:

American Indians (59.1%) and Hispanics (59%) were least likely to report having participated in physical activities.

The Asian (75.3%), African American (76.6%), and White (78.3%) populations had similar rates of individuals who reported having participated in physical activities with approximately three-quarter reporting such.



Source: CDC BRFSS 2018

[78]Centers for Disease Control and Prevention. (2016). Physical Activity. Retrieved from www.cdc.gov/physicalactivity/basics/index.htm

Overweight or Obese

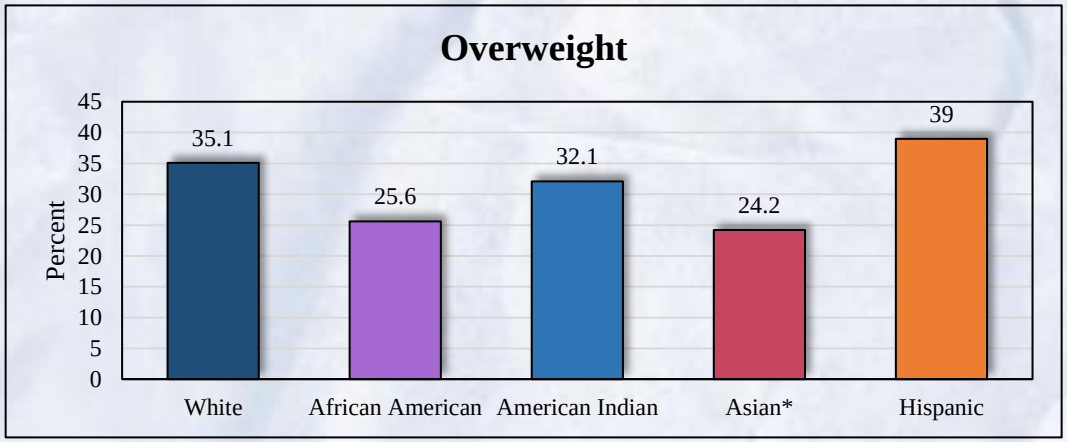
Body Mass Index (BMI) is an estimated measure of an adult's body fat, which is determined by the ratio of an individual's height and weight. Higher BMIs can indicate a higher risk of heart disease, high blood pressure, type 2 diabetes, and certain cancers.[79] Individuals with a BMI of 25-29.9 are considered overweight and individuals with a BMI of 30 or higher are considered obese.

Key Disparities:

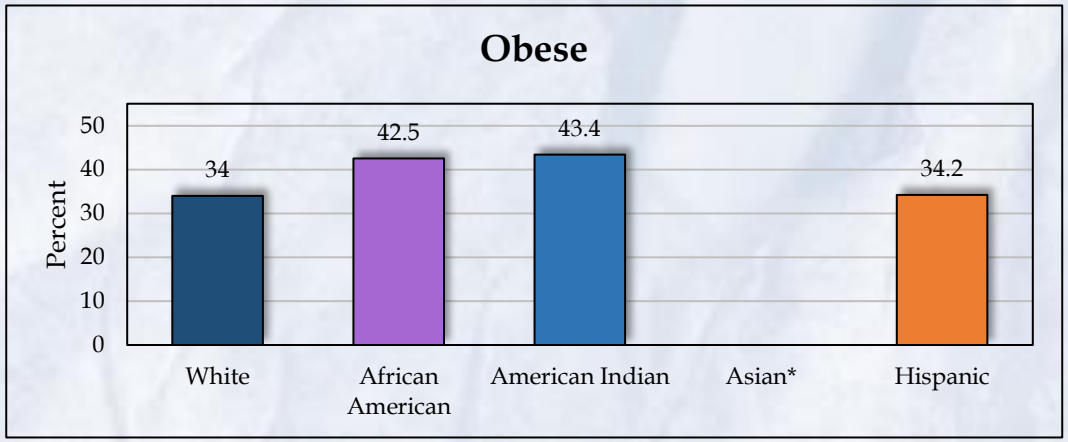
American Indians (43.4%) and African Americans (42.5%) had the highest number of individuals who were obese.

Hispanics (39%) were most likely to be overweight.

Approximately one-fourth of African Americans (25.6%) and Asians (24.2%) were overweight.



Source: CDC BRFSS 2018



Source: CDC BRFSS 2018

Key Disparities:

American Indians (43.4%) and African Americans (42.5%) had the highest number of individuals who were obese.

The Hispanic (34.2%) and White (34%) populations had almost the same percentage of obese individuals.

*Due to small sample size, Asian data was not included.

[79]Centers for Disease Control and Prevention. (2020). About adult BMI. Retrieved from https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Conclusion

Health disparities result from a complex interplay of genetics, individual behavior, socioeconomic status, environment, and access to health care.

It is essential to recognize the changing demographics in Nebraska and the effects they have across all dimensions of our society. Nebraska has seen shifting immigration patterns and continuous growth among minority populations in recent decades. Just in the last decade, minority populations in Nebraska have grown significantly. Yet, those within these groups face disparities across several social determinants of health and various health indicators. As Nebraska continues to become increasingly diverse, it is imperative to work toward eliminating health disparities among all populations.

While progress has been made in improving the health of all Nebraskans, disparities between racial and ethnic minorities and the White population persists. Disparities are particularly visible when examining access to health care. Minority populations were 2.7-6.2 times more likely to not have health care coverage compared to the White population. The lack of coverage potentially played a role in these individuals being 1.9-2.2 times more likely to be unable to see a doctor when needed due to cost. Additionally, minority populations were 1.6-3.1 times more likely than the White population to report not having a personal physician.

Accessing health care is essential in maintaining one's health status, lowering risks, and fostering good health behaviors. Minority populations were between 1.6-2 times more likely to report their health status as fair or poor compared to the White population. American Indians and African Americans seemed to be especially vulnerable to chronic disease and illnesses, some resulting in higher mortality rates.

Identifying and understanding where disparities exist is the first step towards achieving health equity. Addressing health disparities will require a multifaceted approach and the combined efforts of communities, health care providers, partner organizations, and government agencies across various sectors. Through the acknowledgment of the barriers faced by particular populations and the elimination of disparities, we can ensure that every individual has an equal and fair opportunity to be healthy.