



Partnership for a Healthy Nebraska



# ALIGN Nebraska Prenatal Care and Infant Mortality Policy Brief

Average Isn't Good Enough for Nebraska's Kids

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**[www.HealthyNebraska.org](http://www.HealthyNebraska.org)**

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# EXECUTIVE SUMMARY

Nebraska's infant mortality rate of 5.5/1,000 births in 2020 is higher than most of the developed world as well as many other states. In addition, Nebraska's racial and ethnic disparities in infant deaths are much worse than the United States average. We think that is unacceptable and needs to change.

Starting with historical data and a detailed analysis of 2020 Nebraska births, this policy brief provides an overview of the problem and a study of multiple key risk factors. To gather more information, we met with multiple stakeholders in healthcare, public health, and community organizations, as well as conducting focus group interviews with women of childbearing age in Lincoln and Grand Island.

Based on an analysis of Nebraska birth data and input from multiple organizations, we propose a statewide effort to increase the percentage of pregnant women receiving early and adequate prenatal care as a core step to reducing Nebraska's infant mortality to <4/1,000 by 2030, which has been achieved by several other states and most other developed countries. Improving access to prenatal care could also help decrease Nebraska's excessive disparities in Black and Hispanic infant mortality and potentially decrease maternal morbidity and mortality as well.

We propose a state goal of increasing the receipt of early and adequate prenatal care for Medicaid covered births in all Nebraska public health districts to >80% by 2025. Through stakeholder input and focus group interviews, many barriers were elicited, all of which create opportunities to improve access to high quality prenatal care for Nebraska's pregnant women. To achieve this goal, we propose 8 policy recommendations:

1. All Nebraska communities and public health districts should set a goal of >80% of Medicaid eligible pregnancies receiving early and adequate prenatal care by 2025.
2. A more timely hospital-based method of tracking progress should be established so progress toward this goal can be assessed on a quarterly basis.
3. A public education campaign should be launched to educate all Nebraskans on the importance of early and adequate prenatal care.
4. A list of community resources should be compiled for Nebraska communities to help pregnant women access prenatal care.
5. For uninsured women eligible for Medicaid, streamline the application process and set a goal of < 2 weeks from application start to preliminary Medicaid Managed Care Plan assignment while awaiting eligibility determination.
6. To better support women in minority and refugee populations, trusted peers should be recruited and trained to provide culturally appropriate assistance.
7. A universal, evidence-based health screening intake should be implemented for all pregnant Nebraska women to assist with timely referral for high risk conditions and communication to health plans to assist with social determinants of health.
8. To support and fund this effort, the potential return on investment from averted birth complications of a successful effort should be completed.

# STRATEGIC ROADMAP & LOGIC MODEL

## Key Targets

Decrease Nebraska **Infant Mortality** to <4 per 1,000 by 2030

Increase Rates of **Early & Adequate Prenatal Care** for Medicaid Recipients to >80% in All Nebraska Public Health Districts by 2025

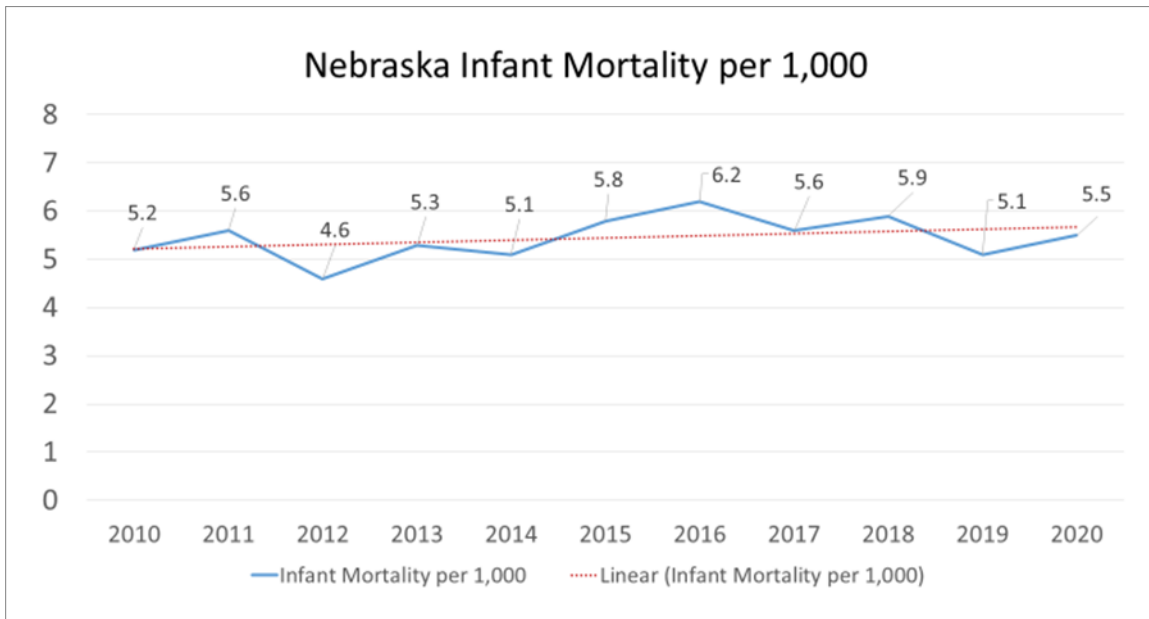
## 2023-2024 Intervention Strategies to Achieve 2025 Target

- 1.** Launch a Statewide Educational Campaign to Inform All Nebraska Women of the Importance of Early & Adequate Prenatal Care
- 2.** Ensure Availability of Local Assistance for Pregnant Women to Help Them Access Prenatal Care and Obtain Insurance Coverage if Needed
- 3.** Streamline the Application for Medicaid Eligibility and Set a Goal of < 2 weeks from Application Start to Preliminary Medicaid Managed Care Plan Assignment while Awaiting Eligibility Determination
- 4.** Pilot Community Support for Select High-Risk Demographic Groups (Community Health Worker/Community Breastfeeding Educator/Doula Model)
- 5.** Establish Universal Evidence-Based High-Risk Screening for Pregnant Women with Timely Referral and Communication of Risks to Medicaid Managed Care Plans
- 6.** Build a Hospital-Based Method of Tracking Birth Outcomes with Quarterly Data at the Community Level

# POLICY BRIEF

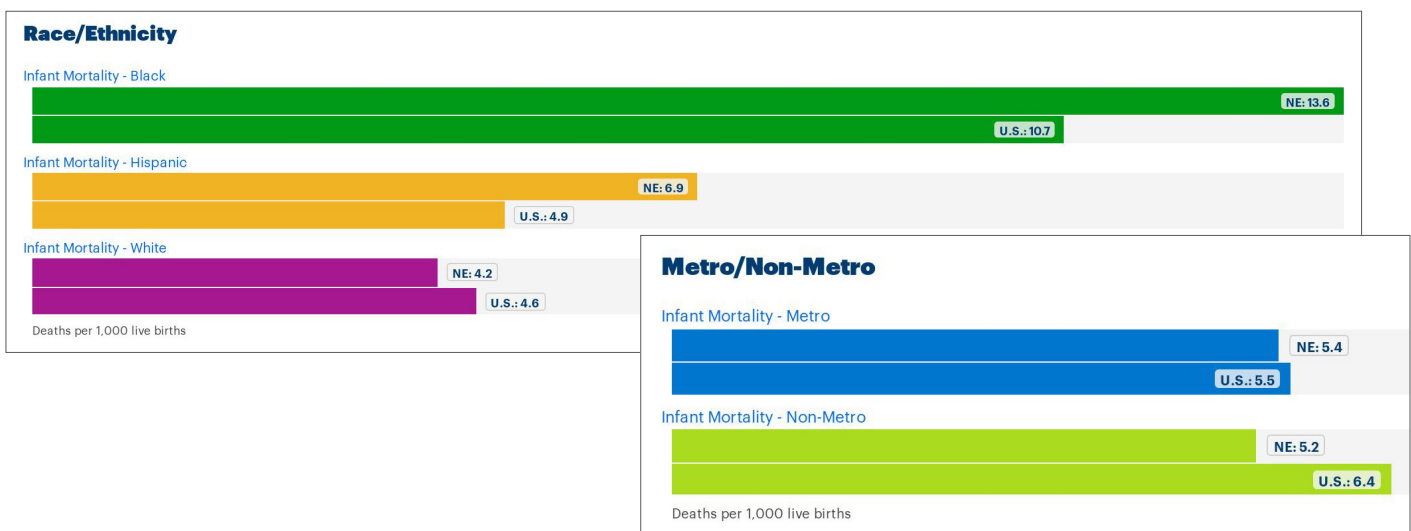
## Problem Definition & Baseline

- Infant Mortality in Nebraska was 5.5 per 1,000 live births in 2020, higher than most of the developed world and many other states.
- There has been little progress in reducing infant mortality in Nebraska since 2010, and unfortunately there is a slight upward trend over the last 10 years.

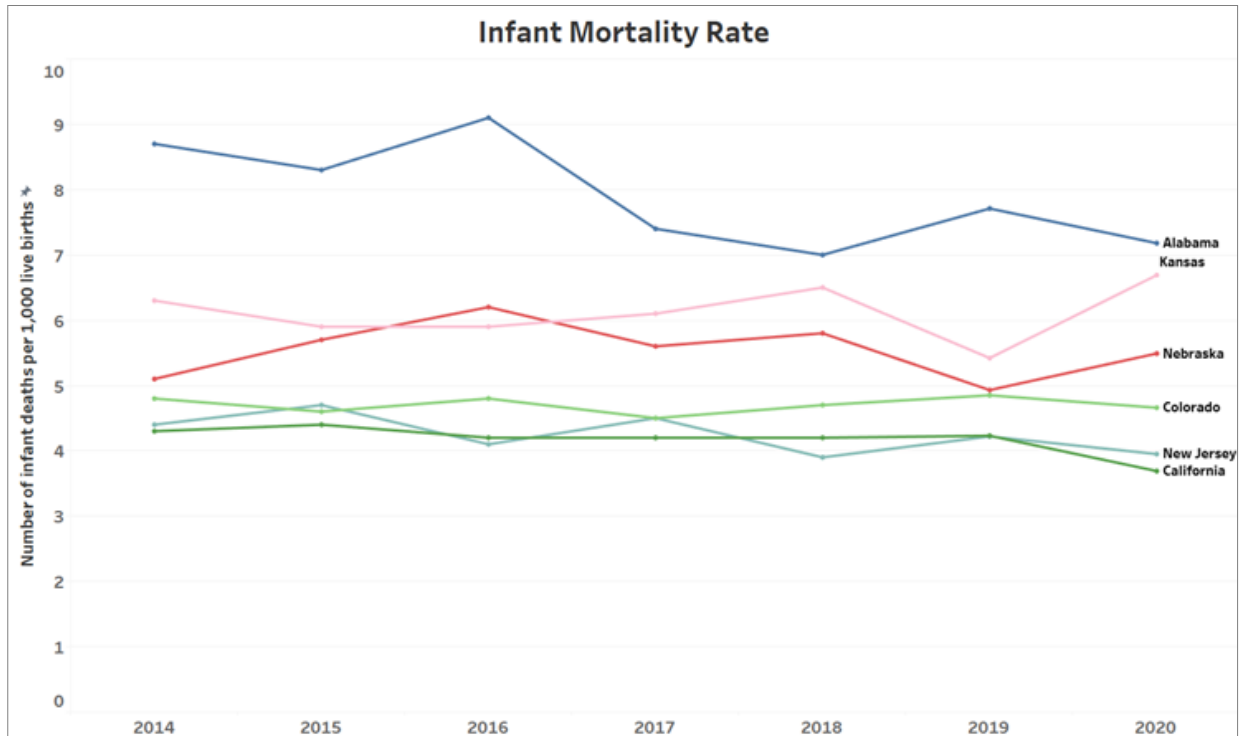


Data Source: CDC WONDER online database, <http://wonder.cdc.gov>

- In addition to having high infant mortality rates compared to most developed countries, Nebraska also has much worse racial disparities in infant mortality compared to US averages. One bright spot is better than US average infant mortality in rural areas. 2018-2019 Data ([https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR\\_MCH/state/NE](https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/NE)):



- Healthy People 2030 has set an infant mortality goal for the United States of reducing infant mortality to 5 per 1,000 live births by 2030, we advise setting a more ambitious goal for the state of Nebraska of <4 per 1,000 live births. Several states such as California and New Jersey are <4, so it should be feasible for Nebraska as well.



Data Source: CDC WONDER online database, <http://wonder.cdc.gov>

## Contributing Factors & Barriers in Nebraska

- Like many states, there are multiple demographic factors associated with preterm births and Neonatal Intensive Care Unit (NICU) admissions. A multivariate analysis of 2020 Nebraska Preterm Births as the dependent variable shows both high statistical significance and high odds ratios (>1.5) with maternal characteristics such as:
  - Both pre-pregnancy and gestational hypertension and diabetes,
  - Pregnancies with multiple births or congenital abnormalities, and
  - Receipt of late or inadequate prenatal care.

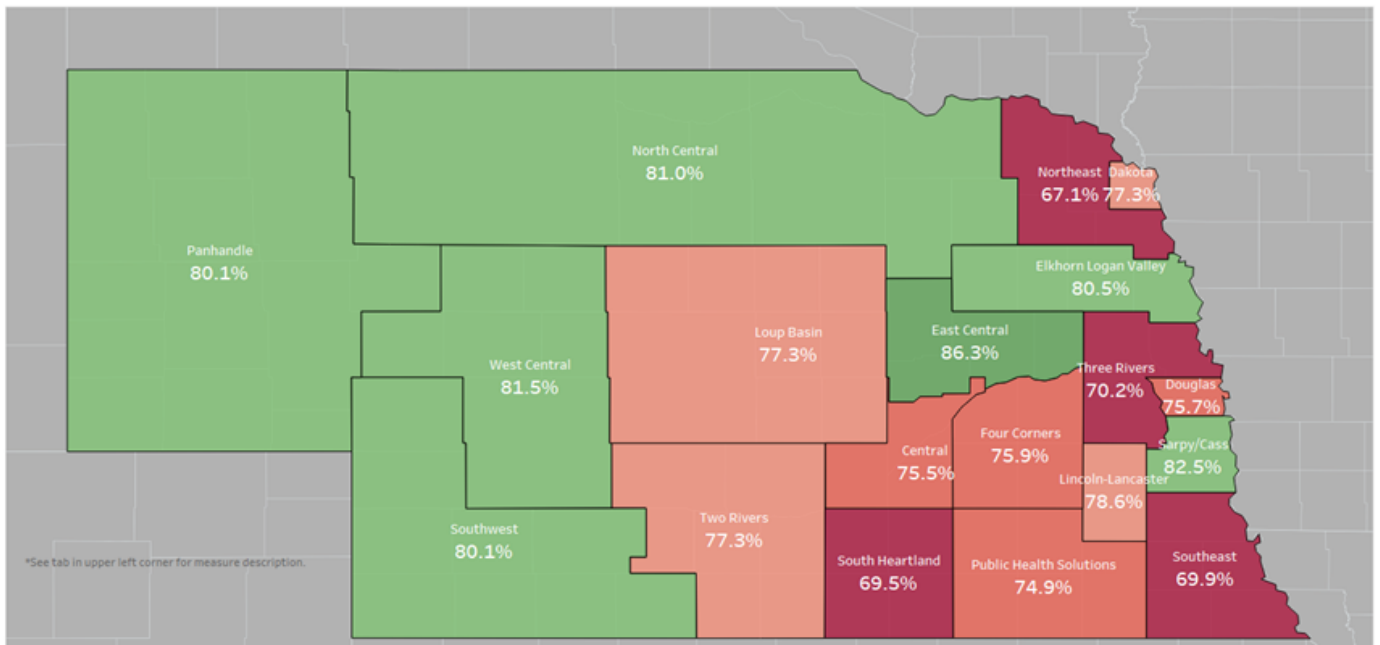
*(See Appendix A, Multivariate Analysis of Risk Factors for Preterm Births in Nebraska for 2020.)*
- Some contributing factors are difficult to change, but a significant mitigating factor that can be improved is early and adequate access to prenatal care, which is defined by a combination of timely initiation of prenatal care as well as the total number of prenatal visits received. In addition, the receipt of early and adequate prenatal care would likely improve the management of hypertension and diabetes, in turn potentially reducing the number of preterm births, NICU admissions, and infant mortality in Nebraska.

- Nebraska’s early and adequate access to prenatal care is below the Healthy People 2030 goal of 80% for the Medicaid covered population in the majority of public health districts. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08> However, several districts are higher than 80%, so reaching a target of >80% should be achievable. There may be aspects of care access in rural Nebraska that urban communities could learn from. *Note that the higher rates of early & adequate prenatal care in many rural public health districts may help to explain Nebraska’s lower than US average infant mortality in rural Nebraska.*

**Adequate Prenatal Care**

Percent of women who received care prior to the fifth month and more than 80% of the appropriate number of visits for the infant’s gestational age. Adequacy of Prenatal Care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into four categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant’s gestational age.

**Adequate Prenatal Care - Medicaid - Calendar Year 2020**



Data Source: United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, 2020 Natality Historic File. <https://public.tableau.com/app/profile/healthynebraska/viz/AdequatePrenatalCarebyPaymentSource/NatalityMap>

“I wish that I had known that babies could die...” Mother from Grand Island focus group.



- Racial and ethnic disparities in the receipt of early and adequate prenatal care may also help to explain Nebraska’s worse than US average disparities in infant mortality for Black and Hispanic populations. 2020 Nebraska Births show rates of early and adequate prenatal care for racial and ethnic minorities that are well below the Healthy People 2030 goal of 80%.

Data Source: United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, 2020 Natality Historic File.

Race	Births with Adequate Prenatal Care		Births with Inadequate Prenatal Care		Total # of Births
	#	%	#	%	
White	17,051	86.6%	2,631	13.4%	19,682
Black	1,289	74.0%	452	26.0%	1,741
AIAN	264	63.3%	153	36.7%	417
Asian	716	81.0%	168	19.0%	884
NHOPI	50	70.4%	21	29.6%	71
More than one race	570	83.2%	115	16.8%	685
<b>Total</b>	<b>19,940</b>	<b>84.9%</b>	<b>3,540</b>	<b>15.1%</b>	<b>23,480</b>

Ethnicity	Births with Adequate Prenatal Care		Births with Inadequate Prenatal Care		Total # of Births
	#	%	#	%	
Non-Hispanic	16,752	86.7%	2,579	13.3%	19,331
Hispanic	3,184	76.9%	959	23.1%	4,143
<b>Total</b>	<b>19,936</b>	<b>84.9%</b>	<b>3,538</b>	<b>15.1%</b>	<b>23,474</b>

## Focus Groups & Barriers to Care

We conducted focus groups and interviews in Lincoln and Grand Island with stakeholders from many sectors including community and cultural organizations, healthcare providers, and public health entities to understand and identify barriers to receiving prenatal care; identify attitudes, beliefs, feelings about healthcare and pregnancy; and determine knowledge of Presumptive Eligibility.

*"I had a perfect pregnancy, until I didn't."  
Mother from Grand Island focus group*

*(The Presumptive Eligibility Program offers low income women free health care coverage while women apply for Medicaid and await eligibility determination. The Nebraska Presumptive Eligibility Determination Form can be found here - <https://dhhs.ne.gov/Documents/MS-91.pdf>)*

*"I worked with a pregnant woman who missed her appointment on Oct 28 and did not go to deliver her baby on her due date Oct 29. Later she was admitted to the hospital at 4:00am. She was in delivery room for 10 hours. Something was wrong. The baby pulse was getting weaker. The doctor must do C-section. She refused for 2 hours. Her husband and mother-in-law tried to convince her to sign the release document for surgery, but she refused, until I walked into the room at 2:00pm. She was so scared and started crying when she saw me. I told her the surgery will save their lives. She gave me her parents phone numbers overseas to call them and asked them for forgiveness, and told them that she loves them, then she signed the document to do the surgery. I said to her, 'Nothing will happen to both of you, you are in good hands. I promise you I will be right here waiting to be the first person to hold your baby and to congratulate you' and I did." K.H., Sudanese Community Health Worker*

## Key focus group takeaways affecting early access:

- Lack of knowledge about importance of early prenatal care in some demographic groups
- Cultural norms of not seeking prenatal care in some demographic groups
- Lack of understanding of Presumptive Eligibility in Nebraska
- Medicaid enrollment challenges
  - Many women of child bearing age are not aware of Medicaid eligibility options and how to access them.
  - Difficulty with enrollment process for Medicaid, especially for those with lower health literacy, language barriers, and immigrant/refugees was a commonly mentioned factor
  - Personal enrollment logistics were also frequently cited, e.g., not enough minutes on cell phone plan to enroll over phone; lack of permanent address or telephone number for ongoing contact; access and cost of printing out required paystubs to verify income
- Lack of knowledge of culturally accessible community resources
- Desire to conceal pregnancy (from family or employer) resulting in delays in seeking care
- Employment barriers: Unsure of employee rights and insurance coverage, limited ability to take time off, penalized if taking time off for prenatal care appointments
- Anxiety/fear regarding care due to language barriers, lack of cultural supports, cost, transportation (e.g., no public transit in Grand Island), childcare while at appointments, limited evening /weekend appointment times
- Misconceptions --“If I apply for Medicaid it will affect my immigration status/VISA application.”
- COVID-related issues – cancelation of in-person services such as WIC, support groups, inter-agency relationships disrupted during the pandemic

*“My cell phone only has few minutes left in my plan so I have to hang up before we complete this application.”* Mother from Lincoln focus group

## Opportunities:

Focus groups reinforced that most Nebraska women are aware of the importance of prenatal care, however there are some refugee populations from areas of the world where early and adequate prenatal care was not widely available and they are not aware of the need for and importance of early and adequate prenatal care. This group does listen to “informal leaders” within their cultural community and looks to them for guidance and advice. Designing effective marketing and communication materials using “trusted voices” from within cultural communities could provide guidance and address barriers.

Although Medicaid managed care plans have programs to assist pregnant women with social barriers to access care and services, there are often significant delays between a woman receiving her first prenatal assessment of risk factors and communication of those risk factors to Medicaid managed care plans or referral. Shortening the time between these events could successfully address some of the identified barriers.

# POLICY RECOMMENDATIONS

Based on the prior review of 2020 Nebraska Vital Records data, focus group interviews, and stakeholder meetings, we propose the following policy recommendations to improve early and adequate access to prenatal care, reduce preterm births and NICU admissions, and ultimately reduce Nebraska's infant mortality rate to less than 4 per 1,000 by 2030:

1. Nebraska stakeholders should set SMART objectives for short and medium-term goals to lower infant mortality, starting with community and state targets for improvements in early and adequate access to prenatal care. We suggest that all Nebraska communities set a target of increasing early and adequate access to prenatal care for Medicaid eligible women to >80% by 2025.
2. Nebraska Vital Records are helpful in assessing progress, but take 1-2 years to compile. Implementing a strategy to improve prenatal care in Nebraska needs more frequent and timely data to assess progress. A system of monitoring progress on these goals using hospital birth data should be developed to assess progress on a quarterly basis.
3. A public education campaign should be implemented to make sure all demographic groups are aware of the importance of early and adequate prenatal care. Sites of delivery should include K-12 schools, ethnic community organizations, and entities that serve Nebraska refugee populations.
4. An up-to-date list of community resources should be compiled in each Nebraska community so women of child bearing age can more easily access assistance in applying for and receiving early and adequate prenatal care.
5. If possible, streamline the application for Medicaid Eligibility and set a goal of < 2 weeks from application start to preliminary Medicaid Managed Care Plan assignment while awaiting eligibility determination.
6. To better support women in minority and refugee populations, women from these populations should be recruited and trained with curriculums in community health work, community breastfeeding support, and doula support. A sustainable funding model for employing community health workers with these skills should be explored.
7. To help ensure that all pregnant Nebraska women receive recommended prenatal care interventions and support as efficiently as possible, an updated, evidence-based, and universal pregnancy risk assessment should be developed. The Nebraska Perinatal Quality Improvement Collaborative has already started this process. Once the revised assessment is completed, a system should be put in place to efficiently communicate the results of these assessments to Medicaid Managed Care plans and facilitate timely referral for high risk conditions. Options might be a state registry or universal electronic referral system.
8. To support and sustain this effort through 2030, the return on investment for reductions in preterm births or NICU admissions should be studied and calculated to justify long-term state and/or insurance plan funding to implement these recommendations.

# APPENDICES

## Appendix A

Data Source for Appendix A: United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, 2020 Natality Historic File.

### Multivariate Analysis of Risk Factors for Preterm Births in Nebraska in 2020

Independent Variables	Odds Ratio	Std. Error	z	P value	95% Confidence Interval	
<i>Payment Method</i>						
Private Insurance vs. Medicaid	0.940	0.060	-0.98	0.327	0.830	1.064
Self-Pay vs. Medicaid	0.680	0.075	-3.49	0.000	0.547	0.844
<i>Adequate Prenatal Care</i>						
Intermediate vs. Adequate	2.220	0.115	15.37	0.000	2.005	2.457
Inadequate Care vs. Adequate	2.677	0.167	15.78	0.000	2.369	3.026
<i>Mother's Characteristics</i>						
Increasing Age	1.023	0.005	4.96	0.000	1.014	1.032
Racial Minority	1.051	0.212	2.45	0.014	1.010	1.093
Hispanic Origin	0.915	0.021	-1.38	0.168	0.806	1.038
WIC Status	0.923	0.059	-1.31	0.190	0.820	1.040
Increasing Education Status	0.902	0.016	-5.91	0.000	0.872	0.934
Marital Status vs. Single	1.292	0.076	4.35	0.000	1.150	1.450
<i>PrePregnancy and Pregnancy Characteristics</i>						
Cigarette Use	1.135	0.091	1.58	0.115	0.970	1.330
Prepregnancy Diabetes	3.562	0.519	8.71	0.000	2.676	4.740
Prepregnancy Hypertension	2.660	0.315	8.25	0.000	2.108	3.356
Body Mass Index (BMI)	0.999	0.003	-0.42	0.673	0.992	1.005
Gestational Diabetes	1.596	0.121	6.18	0.000	1.376	1.851
Gestational Hypertension	3.153	0.194	18.68	0.000	2.795	3.556
Male Sex vs. Female Sex	1.158	0.052	3.24	0.001	1.060	1.265
Multiple vs. Singleton	14.997	1.247	32.54	0.000	12.741	17.650
Congenital Abnormality	2.710	0.687	3.93	0.000	1.649	4.455
<i>Urban/Rural</i>						
Micropolitan vs. Rural	1.055	0.085	0.67	0.505	0.902	1.234
Small-Metro vs. Rural	0.888	0.095	-1.10	0.270	0.720	1.096
Medium-Metro vs. Rural	1.108	0.072	1.58	0.115	0.975	1.259
Constant	0.271	0.006	-16.20	0.000	0.018	0.420

### Multivariate Analysis Summary

- **Payment Method:** After adjustment for risk factors, Medicaid compared to Private Insurance did not show an increased risk. Self-pay was associated with a significantly lower risk, likely explained by demographic factors (e.g., higher income) for this small subset of women.
- **Early & Adequate Prenatal Care:** Intermediate or inadequate care (defined by timely initiation & number of prenatal visits) as compared to adequate visits show higher likelihood of preterm births, with inadequate showing an increasingly detrimental effect as compared to intermediate.

- **Mother's Characteristics:** Several demographic factors including increasing age, Caucasian vs. Racial Minority, education, and marital status were statistically significant, but effect sizes are comparatively small when compared to effect of prenatal care and medical risks. Note that when comparing individual races, effects were not statistically significant.
- **Pregnancy Characteristics, Medical Risks, & Smoking:** Manageable pregnancy risks such as diabetes and hypertension were both statistically significant with comparatively higher odds ratios, similar to the effects of the adequacy of prenatal care.
- **Urban/Rural:** After controlling for other factors, there were not significant differences based on degrees of urban vs. rural.

The multivariate analyses and summary statistics are compiled from 2020 Nebraska births. If your community would like more detailed information at the community, county, or public health district level, please contact Ted Fraser at [tfraser@healthynebraska.org](mailto:tfraser@healthynebraska.org). A dictionary of available variables is here: [Nativity Data Fields - 2020 | Tableau Public](#)

We anticipate having 2021 Nebraska Birth data by early 2023.

## Appendix B - Summary Statistics

*Data Source for Appendix B: United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, 2020 Natality Historic File.*

### Summary Statistics for Births by Payer Source and Public Health District

Health Department	Payment Source						Total # of Births
	Medicaid		Private Insurance		Other		
	#	%	#	%	#	%	
Central District Health Department	482	48.2%	482	48.2%	36	3.6%	1,000
Dakota County Health Department	225	69.0%	99	30.4%	<10	na	326
Douglas County Health Department	2,831	37.8%	4,205	56.2%	445	5.9%	7,481
East Central District Health Department	256	33.6%	474	62.2%	32	4.2%	762
Elkhorn Logan Valley Public Health Department	241	34.9%	427	61.9%	22	3.2%	690
Four Corners Health Department	112	23.4%	331	69.2%	35	7.3%	478
Lincoln-Lancaster County Health Department	1,237	34.4%	2,194	61.0%	165	4.6%	3,596
Loup Basin Public Health Department	88	26.9%	220	67.3%	19	5.8%	327
North Central District Health Department	147	25.0%	410	69.7%	31	5.3%	588
Northeast Nebraska Public Health Department	161	42.1%	207	54.2%	14	3.7%	382
Panhandle Public Health District	302	34.2%	529	59.9%	52	5.9%	883
Public Health Solutions District Health Department	239	40.4%	333	56.3%	20	3.4%	592
Sarpy/Cass Department of Health and Wellness	555	21.4%	1,601	61.8%	436	16.8%	2,592
South Heartland District Health Department	154	31.8%	319	65.9%	11	2.3%	484
Southeast District Health Department	113	29.0%	257	65.9%	20	5.1%	390
Southwest Nebraska Public Health Department	136	33.0%	260	63.1%	16	3.9%	412
Three Rivers Public Health Department	305	34.1%	538	60.1%	52	5.8%	895
Two Rivers Public Health Department	400	32.2%	764	61.5%	78	6.3%	1,242
West Central District Health Department	135	37.5%	204	56.7%	21	5.8%	360
<b>Total</b>	<b>8,119</b>	<b>34.6%</b>	<b>13,854</b>	<b>59.0%</b>	<b>1,505</b>	<b>6.4%</b>	<b>23,480</b>

## Summary Statistics on Receipt of Early & Adequate Prenatal Care by Public Health District

Health Department	Births with Adequate Prenatal Care by Payment Source								Total # of Births
	Births with Adequate Prenatal Care		Medicaid		Private Insurance		Other		
	#	%	#	%	#	%	#	%	
Central District Health Department	807	80.7%	364	75.5%	419	86.9%	24	66.7%	1,000
Dakota County Health Department	263	80.7%	174	77.3%	87	87.9%	<10	na	326
Douglas County Health Department	6,380	85.3%	2,144	75.7%	3,904	92.8%	332	74.6%	7,481
East Central District Health Department	698	91.6%	221	86.3%	451	95.1%	26	81.3%	762
Elkhorn Logan Valley Public Health Department	595	86.2%	194	80.5%	385	90.2%	16	72.7%	690
Four Corners Health Department	418	87.4%	85	75.9%	303	91.5%	30	85.7%	478
Lincoln-Lancaster County Health Department	3,058	85.0%	972	78.6%	1,955	89.1%	131	79.4%	3,596
Loup Basin Public Health Department	275	84.1%	68	77.3%	189	85.9%	18	94.7%	327
North Central District Health Department	505	85.9%	119	81.0%	372	90.7%	14	45.2%	588
Northeast Nebraska Public Health Department	302	79.1%	108	67.1%	185	89.4%	<10	na	382
Panhandle Public Health District	759	86.0%	242	80.1%	480	90.7%	37	71.2%	883
Public Health Solutions District Health Department	490	82.8%	179	74.9%	296	88.9%	15	75.0%	592
Sarpy/Cass Department of Health and Wellness	2,247	86.7%	458	82.5%	1,471	91.9%	318	72.9%	2,592
South Heartland District Health Department	359	74.2%	107	69.5%	243	76.2%	<10	na	484
Southeast District Health Department	316	81.0%	79	69.9%	226	87.9%	11	55.0%	390
Southwest Nebraska Public Health Department	354	85.9%	109	80.1%	232	89.2%	13	81.3%	412
Three Rivers Public Health Department	764	85.4%	214	70.2%	505	93.9%	45	86.5%	895
Two Rivers Public Health Department	1,055	84.9%	309	77.3%	685	89.7%	61	78.2%	1,242
West Central District Health Department	295	81.9%	110	81.5%	172	84.3%	13	61.9%	360
<b>Total</b>	<b>19,940</b>	<b>84.9%</b>	<b>6,256</b>	<b>77.1%</b>	<b>12,560</b>	<b>90.7%</b>	<b>1,104</b>	<b>73.3%</b>	<b>23,480</b>

## Summary Statistics on Preterm Births by Nebraska Public Health District

Health Department	Births Under 37 Weeks Gestation		Births at 37 or More Weeks Gestation		Total # of Births
	#	%	#	%	
Central District Health Department	100	10.0%	900	90.0%	1,000
Dakota County Health Department	33	10.1%	293	89.9%	326
Douglas County Health Department	799	10.7%	6,682	89.3%	7,481
East Central District Health Department	58	7.6%	704	92.4%	762
Elkhorn Logan Valley Public Health Department	66	9.6%	624	90.4%	690
Four Corners Health Department	51	10.7%	427	89.3%	478
Lincoln-Lancaster County Health Department	359	10.0%	3,237	90.0%	3,596
Loup Basin Public Health Department	29	8.9%	298	91.1%	327
North Central District Health Department	35	6.0%	553	94.0%	588
Northeast Nebraska Public Health Department	43	11.3%	339	88.7%	382
Panhandle Public Health District	72	8.2%	811	91.8%	883
Public Health Solutions District Health Department	47	7.9%	545	92.1%	592
Sarpy/Cass Department of Health and Wellness	286	11.0%	2,306	89.0%	2,592
South Heartland District Health Department	45	9.3%	439	90.7%	484
Southeast District Health Department	37	9.5%	353	90.5%	390
Southwest Nebraska Public Health Department	36	8.7%	376	91.3%	412
Three Rivers Public Health Department	83	9.3%	812	90.7%	895
Two Rivers Public Health Department	142	11.4%	1,100	88.6%	1,242
West Central District Health Department	42	11.7%	318	88.3%	360
<b>Total</b>	<b>2,363</b>	<b>10.1%</b>	<b>21,117</b>	<b>89.9%</b>	<b>23,480</b>

## Summary Statistics on Preterm Births by Race & Ethnicity

Gestation by Race	37 Weeks & Over		Under 37 Weeks		Total # of Births
	#	%	#	%	
White	17,991	88.7%	2,295	11.3%	20,286
Black	1,506	82.6%	318	17.4%	1,824
AIAN	378	84.2%	71	15.8%	449
Asian	789	86.2%	126	13.8%	915
NHOPI	64	81.0%	15	19.0%	79
More than one race	604	85.2%	105	14.8%	709
<b>Total</b>	<b>21,332</b>	<b>87.9%</b>	<b>2,930</b>	<b>12.1%</b>	<b>24,262</b>

Gestation by Ethnicity	37 Weeks & Over		Under 37 Weeks		Total # of Births
	#	%	#	%	
Non-Hispanic	17,523	88.2%	2,346	11.8%	19,869
Hispanic	3,802	86.7%	584	13.3%	4,386
<b>Total</b>	<b>21,325</b>	<b>87.9%</b>	<b>2,930</b>	<b>12.1%</b>	<b>24,255</b>

## Summary Statistics on NICU Admissions by Race & Ethnicity

NICU Admissions by Race	No		Yes		Total # of Births
	#	%	#	%	
White	18,052	89.0%	2,240	11.0%	20,292
Black	1,565	85.8%	259	14.2%	1,824
AIAN	382	84.9%	68	15.1%	450
Asian	817	89.4%	97	10.6%	914
NHOPI	69	87.3%	10	12.7%	79
More than one race	615	86.7%	94	13.3%	709
<b>Total</b>	<b>21,500</b>	<b>88.6%</b>	<b>2,768</b>	<b>11.4%</b>	<b>24,268</b>

NICU Admissions by Ethnicity	No		Yes		Total # of Births
	#	%	#	%	
Non-Hispanic	17,545	88.3%	2,326	11.7%	19,871
Hispanic	3,948	89.9%	442	10.1%	4,390
<b>Total</b>	<b>21,493</b>	<b>88.6%</b>	<b>2,768</b>	<b>11.4%</b>	<b>24,261</b>

**For More Information:**

