

Nebraska Women's Health Needs Assessment

New Dimensions of Health for Nebraska Women Project



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Part of the
Nebraska Women's Health Strategic Plan

Nebraska Department of Health & Human Services
Office of Women's Health

&

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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



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

Introduction

The outcome goal for the New Dimensions of Health for Nebraska Women Project is healthier women in Nebraska, in all populations. This will be achieved through a statewide partnership of public and private organizations that will build a sustainable infrastructure for improved and expanded women's health services. The foundation for this infrastructure is the Nebraska Women's Health Plan. The following assessment of the current health status and health care needs of women across the state was a critical component in the development of the Plan.

The Nebraska Women's Health Needs Assessment draws on numerous published data sources, government-supported health program records, the results of new surveys, outcomes from focus group discussions, and information from interviews with professionals representing a number of health-related programs and agencies. The information is organized to highlight health-related needs of Nebraska women overall and, to the extent possible, the needs of those of different backgrounds and circumstances in terms of age, racial/ethnic group, language, culture, sexual orientation, economic status, and geographic location.

Since the intention of this report is to provide a broad, data-based overview of Nebraska women's health, it provides very little description or discussion of specific health conditions or risks. That information can be readily found in the various reports from which the following data have been derived, especially the *1999-2000 Nebraska Behavioral Risk Factor Surveillance System Report* (NHHSS, February 2003) and *Nebraska 2010 Health Goals & Objectives* (NHHSS, May 2002).

I. Health Status Indicators

A. Mortality

One perspective on the health status of a population can be found in statistics for rates of death from various causes (Centers for Disease Control and Prevention. National Center for Health Statistics. Healthy Women: State Trends in Health and Mortality). Heart disease is the leading cause of death for women in Nebraska as well as in the U.S. overall, claiming the lives of nearly 2,500 women in the state annually (see Table 1). There are more than three times as many deaths from heart disease as from stroke, the second-ranked underlying cause of death. Diabetes is a major contributing cause of death among Nebraska women, especially in conjunction with heart disease.

Chronic lower respiratory diseases (including bronchitis, emphysema, asthma, and others) slightly outrank lung cancer as the third leading cause of death. Nebraska women are less likely to die from breast cancer than from lung cancer, and they are just as likely to die from unintentional injuries. Alzheimer's disease, influenza and pneumonia, colorectal cancer, and

diabetes as the underlying cause fill out the remaining ranks of the ten leading causes of death for Nebraska women.

Nebraska women have slightly lower age-specific mortality rates overall than women nationally. This advantage applies to each of the leading causes of death, except for unintentional injuries and Alzheimer’s disease. Nebraska women have substantially lower mortality rates than Nebraska men, in keeping with national trends.

Table 1. Leading Causes of Death for Nebraska Women, 1997-1999

Cause of death	Nebraska women’s mortality rate*	National women’s mortality rate*	Annual average deaths of Nebraska women
All causes	689	736	7,949
Heart disease	199	221	2,464
Diabetes (related cause)	62	68	691
Stroke	58	62	728
Chronic lower respiratory diseases	35	37	384
Lung cancer	34	41	329
Breast cancer	25	28	252
Unintentional injuries	25	23	259
Alzheimer’s disease	20	17	271
Influenza and pneumonia	20	21	253
Colorectal cancer	18	18	198
Diabetes (underlying cause)	17	23	182

* Mortality rates are per 100,000 women, 1997-99 annual average, all ages, age-adjusted to the 2000 U.S. standard population.

The leading causes of death shown in Table 1 apply across all adult age groups, although their relative ranks change somewhat as women age (see Table 2). Nebraska women in the youngest age group, 25 to 44, are most likely to die from unintentional injuries. Heart disease is the leading cause of death from age 45 onward. Lung cancer and breast cancer outrank stroke and chronic respiratory diseases for those ages 45 to 64. Mortality rates for nearly all causes of death increase substantially with age, resulting in a total increase in mortality by about 260 percent with each ten-year age span.

Racial/ethnic background is a major factor in health status and leading causes of death (see Table 3). The relatively small number of Nebraska women who belong to minority groups makes it difficult to obtain published mortality data broken down by both gender and racial/ethnic group. The best available statistics show the relative risk of mortality from different causes for women in different minority groups as compared to White women, averaged over the years 1994 to 1998 (*Health Status of Racial and Ethnic Minorities in Nebraska*, NHHSS, 2001; Minority Health

Information, NHHSS, 2002). However, some of the needed statistics were available only for the years 1997 to 1999, and some were only available at the national level.

Table 2. Mortality Rates per 100,000 Nebraska Women by Cause and Age: Leading Causes 1997-1999

Cause	Age	25-44	45-54	55-64	65-74	75-84	85+
All causes		97	266	689	1,771	4,577	14,471
Heart disease		11	44	138	430	1,399	5,583
Diabetes-related (multiple cause)		4	21	75	210	490	989
Stroke		3	7	34	111	450	1,667
Chronic lower respiratory diseases		-	-	45	154	298	421
Lung cancer		3	24	81	171	190	167
Breast cancer		7	29	54	85	136	204
Unintentional injuries		17	19	19	38	89	331
Alzheimer's disease		-	-	-	20	149	763
Influenza and Pneumonia		-	-	11	26	127	668
Colorectal cancer		-	13	30	60	127	249
Diabetes (underlying cause)		-	7	24	52	132	236

Table 3. Nebraska Women's Relative Mortality Risk for Selected Causes by Racial/Ethnic Group, 1994-1998

Cause	Mortality Risk Relative to White Women			
	Black	Native American	Asian/Pacific Islander	Hispanic ^a
All causes ^b	1.6	2.1	0.5	0.6
Heart disease	1.5	1.7	0.3	0.5
Diabetes-related	2.8	4.1	-	1.6
Stroke	1.6	0.9	0.8	0.3
Chronic lower respiratory diseases ^c	0.6	0.6	0.3	0.4
Lung cancer	1.3	0.9	-	0.4
Breast Cancer	1.3	-	-	-
Unintentional injuries	0.8	2.0	0.8	0.7
Cirrhosis	2.5	13.9	-	2.9

^amay be of any race

^bbased on 1997-1999 data

^cbased on 1997-1999 national data

Heart disease is the leading cause of death for Nebraska women across all racial/ethnic groups, although the relative risk varies. Differences in health disease mortality rates are the primary reason for differences in overall mortality rates among the groups. In Nebraska, Native American and Black women have substantially higher mortality rates overall than White women. Asian and Hispanic women have much lower mortality rates. This pattern is true at the national level as well.

Native American women clearly have the poorest health status among the major racial/ethnic groups in Nebraska and are twice as likely to die each year than White women. Cirrhosis is included in Table 3 because it is the third leading cause of death for Native American women causing deaths at a rate nearly 14 times as high as for White women in Nebraska. Native American women are four times more likely to die from diabetes-related causes than their White counterparts and are also much more likely to die from unintentional injuries and heart disease.

Black women also have substantially higher mortality rates in Nebraska than White women. Their greatest increased risks are for diabetes-related causes, cirrhosis, stroke and heart disease. They have a moderately elevated risk of death from lung cancer and breast cancer.

Hispanic women have lower risks of mortality than White women in Nebraska from all major causes except cirrhosis and diabetes-related causes. Asian women in Nebraska have lower risks for all causes of death for which reliable data could be obtained.

Disparities in mortality rates are reflected in estimated life expectancies. A White female born in Nebraska during the years 1996 to 1998 can expect to live 80.7 years on average, compared to 72.8 years for a Black female and 72.3 years for a Native American female. These statistics are not available for other racial/ethnic groups.

B. Chronic Health Conditions

Some chronic health conditions are not directly reflected in mortality statistics, but they can have a negative impact on functionality and quality of life. Two of these, arthritis and osteoporosis, are most likely to affect older women, although arthritis can occur at any age.

Arthritis

“Arthritis is the leading chronic condition and cause of activity limitation among women in the U.S.” (Nebraska 2010 Health Goals and Objectives). Chronic pain associated with the disease can cause mental health problems as well.

According to the 1999-2000 Behavioral Risk Surveillance System Report (BRFSS), one-third (33%) of Nebraska women reported they had been diagnosed with arthritis or had joint symptoms consistent with that disease. This is a somewhat higher rate than that of their male counterparts (28%). More than half of all BRFSS respondents (both sexes) age 65 and older had arthritis.

One third of those diagnosed with arthritis were currently being treated for the disease. Half of the respondents with joint symptoms reported that their physical activities had been limited for at least one month during the past year.

The risk factors for osteoarthritis, the most common form, include an inherited predisposition, joint injury, increasing age, female, African American (for activity limitation), rural residence, low household income, low level of education, participation in different types of sports, certain occupations requiring kneeling or squatting and heavy lifting, and being overweight (Nebraska 2010 Health Goals and Objectives).

Osteoporosis

“Osteoporosis is not part of normal aging although many people continue to believe this is true” (*America’s Bone Health*, National Osteoporosis Foundation report 2002). Osteoporosis and low bone mass are a health threat for nearly 200,000 Nebraska women in 2002 based on estimates by the Foundation. The Nebraska estimates were calculated by applying national prevalence rates for women age 50 and older in different racial/ethnic groups to the Nebraska population profile from the 2000 Census (see Table 4).

Non-Hispanic White and Asian women have much higher rates of osteoporosis and low bone mass than Black or Hispanic women, with nearly three-fourths (72%) at risk. This is also true for low bone mass, but the differences are not as great. Black women have the lowest prevalence rates, although 40 percent are still at risk.

Table 4. Osteoporosis and Low Bone Mass Prevalence Rates for U.S. Women Age 50 and Older by Race/Ethnicity

Race/ethnicity	Osteoporosis	Low Bone Mass	Total Risk
Non Hispanic, White or Asian	20%	52%	72%
Black	5%	35%	40%
Hispanic	10%	49%	59%

This “silent” disease usually progresses without symptoms until a bone fracture occurs. The spine, hip and wrist are the most common fracture sites. Hip fractures are the most debilitating with a 10 to 20 percent mortality rate during the six months following the fracture and 25 percent requiring long term care. Multiple vertebral fractures may result in kyphosis or stooped posture, which can cause severe, chronic pain.

The national prevalence rates for bone fractures indicate that 1 in 2 White women age 50 and older can be expected to have a bone fracture in their remaining lifetime, compared to 1 in 8 men of that age.

Diabetes

Diabetes is a serious chronic disease that is an underlying or related cause of more than 10 percent of Nebraska women's deaths annually, primarily in conjunction with cardiovascular disease. It also presents the risk of serious, debilitating conditions, including amputations and blindness.

The diagnosed diabetes prevalence rate among Nebraska women is estimated to be 5 percent based on the 1999-2000 BRFSS. However, experts believe that only half of diabetes cases are diagnosed. Nebraska women of color, except for Asian women, are more likely to have diabetes than their White counterparts, especially Native American women with rates more than three times as high and Black women with rates nearly double that of White women (see Table 5).

Table 5. Age-Specific Prevalence of Diagnosed Diabetes by Race/Ethnicity for Nebraska Women, Ages 45-64, 1997-2001

White	Black	Native American*	Asian*	Hispanic
6.8	12.9	23.6	6.0	7.7

**Note: The statistics for these population groups are based on very small numbers.*

Asthma

Asthma is a serious, chronic disease that causes inflammation of the airways and restricts breathing. An estimated 11 percent of Nebraska women have asthma, similar to national rates for women. Although the asthma mortality rate is relatively low for Nebraska women (2.7 per 100,000), compared to the leading causes of death, it is substantially higher than the national rate (2.0).

HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a life-threatening condition caused by the HIV virus. In Nebraska, women account for 13 percent of the 1,092 cumulative AIDS cases since the beginning of the epidemic, compared to 17 percent nationally. However, females accounted for 27 percent of the 79 new AIDS cases in 2000, up from just 10 percent in 1995.

Black women were much more likely than White women to die from AIDS in the years 1994 to 1998. No Hispanic women died of AIDS during that period. These statistics are not available for other racial/ethnic groups.

C. Health Risk Factors

Most of the leading causes of mortality and chronic conditions for Nebraska women identified in the preceding sections of this report are diseases for which the risks can be reduced through behavioral measures: healthy diet, appropriate exercise, not smoking, and not abusing alcohol or other substances. The probability of effective treatment or cures for many diseases is increased when there is early diagnosis as a result of screening procedures and other routine health examination services. The Behavioral Risk Factor Surveillance System provides an overview of the health risk behaviors of Nebraska adults overall and for selected demographic groups.

Table 6 summarizes the available published findings for Nebraska women from the BRFSS 1999-2000 survey.

Table 6. Summary of Selected Responses to Behavioral Risk Factor Survey for Nebraska Women: 1999-2000

A. Overall health, weight, diet and exercise	Nebraska Women %
Self-reported “fair” or “poor” general health	12
Average number of days in past month health not good:	
Physical health	3.1 days
Mental health	3.0 days
Overweight, not obese	30
Obese	18
Attempting to lose weight among those:	
Obese	66
Overweight, not obese	56
Not overweight	26
Advised by health professional to lose weight	11
Daily servings of fruit and vegetables:	
5 or more	25
3 to 4	41
<3 times a day	34
Physically inactive	30
No regular and sustainable exercise	80
No regular and vigorous exercise	87
B. Risk Behaviors	
Had 1 or 2 sunburns in past year	23
Had 3 or more sunburns in past year	11
Engaged in binge drinking in past month	8
Engaged in heavy drinking in past month	<1
Drove after drinking too much in past month	1
Currently smokes	20

Table 6, continued

Smokes more than 1 pack a day	2
Anyone smoked in home in past month	24
Smoking not allowed in employment work areas	88
Ever had blood tested for HIV/AIDS	33
Self-reported at high/medium risk of HIV infection	5
C. Health Coverage, Screening and Routine Care	
No health care coverage	8
Among uninsured, length of time since coverage:	
Less than a year	36
1 to 4 years	24
5 years or more	34
Avoided needed doctor visit in past year due to cost	8
Time since last routine doctor checkup:	
Within past year	77
5 years or more	6
Ever told blood pressure high	23
Blood pressure checked in past 2 years	97
Ever told cholesterol high	28
Cholesterol checked in past 5 years	65
Dental visit in past year	75
Teeth cleaned by dental professional in past year	78
Had 6 or more teeth extracted due to disease or decay	19
50 years and older:	
Ever had blood stool test	29
Ever had sigmoidoscopy or proctoscopic exam	33
65 years and older:	
Had a flu shot in past 12 months	67
Ever had a pneumonia shot	58
Had Pap test in past 3 years	78
Had Pap test in past 3 years (those with no hysterectomy)	84
Had a clinical breast exam in past year	78
40 years and older:	
Had mammogram in past 2 years	71
Had mammogram in past year	59
D. Family Planning: Age 18 to 44	
Knows folic acid helps prevent birth defects	36
Takes optimal level of folic acid through dietary supplements	46
If pregnant now or in past 5 years:	
Pregnancy unintended	34

Table 6, continued

Birth control	
Using birth control	58
Not sexually active	17
Not using because wish to become pregnant	5
Not using and at risk for unintended pregnancy	11
Don't know or did not answer	9
Among birth control users, method used:	
Tubes tied	21
Partner had vasectomy	16
Pill	34
Condoms	14
Other methods, don't know	15
Usual source of women's health services:	
Family physician	42
Private gynecologist	31
Family planning clinic	9
Ever used family planning clinic	27

The health-related statistics presented in Table 6 raise a number of red flags in terms of Nebraska women's health. Of particular concern is the finding that 48 percent of Nebraska women are overweight or obese, increasing their risk of diabetes, heart disease, arthritis, and other serious or chronic diseases. Contributing to and compounding the problem is the lack of regular and sustained exercise by 80 percent of women in the state.

Many women are not getting the types of health screenings that could detect serious diseases at an early stage. Nearly three-fourths of women age 50 and older (71%) had never had a blood stool test. More than a third of women (35%) had not had their cholesterol checked in the past 5 years. One-fifth (22%) of all women had not had a Pap smear in the past 3 years, including one-sixth (16%) of those who had not undergone a hysterectomy. More than one-fourth of women (29%) age 40 and older had not had a mammogram in the past 2 years. In the past year, nearly one-fourth of Nebraska women had not had a routine doctor's exam (23%) or had not seen a dentist (25%).

In most of these areas, considerable progress will have to be made in order for Nebraska women to reach the state health goals for 2010.

II. Behavioral Health & Violence against Women

Mental Health

Mental illness is a serious problem for tens of thousands of women in Nebraska. It ranks second only to cardiovascular conditions in the level of disease burden in the United States and other countries with similar economies according to international studies.

A 2001 report by the Division of Mental Health, Substance Abuse and Addiction Services of the Nebraska Department of Health and Human Services (the Division) provides estimates of the prevalence of serious mental illness (SMI) among adults and serious emotional disturbance (SED) among children for the lower income Nebraska population (< 300% poverty level). The report also provides the rates of access to public sector mental health services for those estimated to have serious mental disorders. The public sector was defined to include the Division (contracted providers and Regional Centers) and Medicaid.

An estimated 8 percent of all lower-income females in Nebraska have serious mental health problems, compared to 6 percent of lower-income males. That translates to 38,821 females in the year 2000 in need of public sector mental health services. The number of women served by the public sector mental health system that year was 22,602, or 58 percent of those with SED or SMI (excluding substance abuse treatment). By contrast, the comparable access to care rate for males was 74 percent.

The report provides access to care rates for each of the six health regions by sex. Access to care rates were highest for females in the central (72%) and southeast (70%) and lowest in the north (41%) and east (49%) regions. In the middle, were the west (56%) and southwest (66%). Males showed a similar regional pattern, but with higher rates than females in each region.

The access rate for all lower-income persons with SMI or SED was 65 percent. Those over age 65 had much lower rates than others: only 18 percent of the elderly with serious mental disorders received public mental health services.

Overall, racial/ethnic minority group members had lower access rates (55%) than those who were White, non-Hispanic (63%). However, the disparity had a strong regional pattern: minority group members had much lower access rates than others in every region except the southeast, where there was no difference and in the east, where minority group members had somewhat better access rates than others.

The results indicate a sizeable unmet need for public mental health services. Division officials report that the current capacity for public mental health services is inadequate to meet consumer demand and, consequently, there are extensive waiting lists for services. The greatest area of unmet need is for non-residential services. One problem is the increasing number of individuals in need who lack adequate insurance coverage.

There are no clear explanations for why lower-income women are less likely to access services than their male counterparts. Many respondents to the Nebraska Women's Health Survey (NHHSS, 2003) noted that time is a major obstacle in accessing health services. Compounding the time constraints is the general lack of child care facilities at treatment centers. Women who are family caregivers face serious obstacles to entering residential treatment, including the possible loss of custody of their children. The stigma of mental illness prevents many from seeking treatment. The question as to whether this is a greater obstacle for women than for men still remains.

The very low access rates for those over age 65 are consistent with national studies showing that the elderly who have mental health are less likely than others to seek professional help. One likely reason is cost. Although many have Medicare, it covers only half of mental health services and does not cover prescription drugs. Other reasons that have been cited include: stigma, denial of problems, access barriers, funding issues, lack of collaboration and coordination between mental health and aging networks, and shortages of appropriate health professionals (American Association of Geriatric Psychiatry, 2002).

Substance Abuse

Substance abuse is a serious problem among Nebraska girls and women, with an estimated 20,000 females age 12 and older dependent on alcohol or other drugs. (*Nebraska State Demand Needs Assessment Studies: Alcohol and Other Drugs*, NHHSS, 2001). The 3 percent dependency rates for adolescent and adult females are lower than for males (4% age 12 to 18, 5% age 19 and older).

Alcohol accounts for most of the dependency. Among substance dependent females, 87 percent of adolescents and 70 percent adults are alcohol dependent. Among substance dependent males, alcohol accounts for even more of the dependency (adolescents 91%, adults 78%). The consumption of alcohol is common across the state. Among adult women, 75 percent had consumed alcohol in the past year. One-fourth (25%) of girls age 12 to 18 drank alcohol in the past year. Regional differences in alcohol consumption and dependency are small.

Marijuana is the next most common dependency, but less than one percent of females are dependent on it. Statewide, 19 percent of women have ever used marijuana compared to 13 percent for girls. However, girls are more likely to have used marijuana in the past year (7% vs. 3%). Dependency rates are similar for the two age groups: 0.9% for girls and 0.8% for women.

Of the estimated 20,000 Nebraska women and girls in need of substance abuse treatment, only 5,363 were served in 2000 by public sector programs (Nebraska Division of Mental Health, Substance Abuse and Addiction Services contracted programs and Regional Centers, plus Medicaid). The 27 percent public program treatment rate for females is only slightly lower than for males (30%). Undoubtedly, many receive treatment outside the public sector programs. However, there is clearly a large unmet need for services.

Women face similar obstacles to obtaining substance abuse treatment as they do for mental health services described earlier (e.g., cost, availability, child care and custody issues, and time constraints). A particular problem is the fact that there is only one residential treatment program in the state for pregnant women and women with young children where mother and child can live together (at St. Monica's Behavioral Health Services for Women, Lincoln, Nebraska).

The Nebraska Coalition for Women's Treatment is working to address a number of substance abuse treatment issues for women. One of their roles is educating the public and professionals on women's treatment issues and advocating for gender competent treatment. They not only provide opportunities for collaboration among women's treatment programs, but also work with other agencies to address the co-occurrence of substance abuse, mental illness, and violence. They provide a trauma-screening tool and training for mental health, substance abuse, and domestic violence/sexual assault programs.

Domestic Violence & Sexual Assault

Domestic violence and sexual assault have a serious impact on many thousands of Nebraska women and children each year. In 2000, the Nebraska Commission on Law Enforcement and Criminal Justice received 3,933 reports of domestic assaults outside the city of Omaha (a 3 percent increase over 1999) and 433 cases of forcible rape (a 5 percent increase over 1999). Of the 2,918 individuals arrested for domestic assault, 76 percent were male. Since the Omaha Police Department did not report domestic assault statistics for 2000, the number of domestic assaults in the state as reported above is seriously deflated.

The Nebraska Domestic Violence Sexual Assault Coalition reports serving 6,138 adult victims (primarily women) and 3,564 children and adolescents in FY 2000. That year, the crisis line fielded 73,055 crisis calls. The Coalition, a statewide advocacy organization with a network of 22 programs, provides a variety of services including shelter, counseling, advocacy, transportation, financial assistance, telephone crisis line support, and prevention programs. It is important to note that domestic violence and sexual assault are distinct forms of violence and different types of responses and programs are needed to address the problems.

The actual incidence of violence against women is much greater because many women do not report the crimes. National studies estimate that 20 to 33 percent of all women will be physically assaulted by a partner or ex-partner during their lifetime. Domestic violence accounts for the symptoms of 22 to 35 percent of women who visit emergency rooms in the U.S.

Co-occurrence of Behavioral Health Problems with Domestic Violence & Sexual Assault

Women who are victims of domestic violence or sexual assault are more likely to have behavioral health problems (e.g., substance abuse, mental health disorders) than other women. A recent needs assessment study by the University of Nebraska at Omaha Department of Criminal Justice examined the relationship among treatment programs for domestic violence, sexual assault, and behavioral health in Nebraska. In spite of the impact that domestic violence and sexual assault have on behavioral health of the victims, treatment programs are generally not designed to deal with these co-occurring problems. The report makes recommendations for coordinated efforts to improve the quality of these services.

III. Health Care Needs & Barriers for Women with Disabilities

Women with disabilities experience many barriers that reduce the quality and accessibility of their health care. Although their numbers are small compared to the total population, they consume a significant share of the nation's health care services. Despite this, they are often underrepresented in health surveys and so data on their needs and significant health disparities are not available. A recent study reported that 31 percent of the participating women with physical disabilities were refused care by a physician because of their disability (*National Study of Women with Physical Disabilities*, Center for Research on Women with Disabilities, Baylor College of Medicine, 1997). More women with physical disabilities reported chronic urinary tract infections, heart disease, depression, and osteoporosis at younger ages than the comparison group of women without disabilities.

The national study also found disparities for women with disabilities in several areas of gynecologic health care. Overall, women without disabilities receive mammograms 11 percent more often than women with disabilities. Younger women with disabilities have a significantly higher rate of hysterectomy than able-bodied women. The reasons are primarily non-medical: for purposes of birth control or ease of managing menstruation. The causes of these disparities are often invisible barriers unique to this population – physicians denying services to women who cannot mount examination tables on their own or the lack of mammogram equipment capable of accommodating a woman in a wheelchair with limited muscle control. In addition, there is an attitudinal barrier, as some members of society, including some health care providers, perceive women with disabilities as asexual. Contributing to this problem is the fact that many women with disabilities are still receiving services from their original pediatricians.

Women with cognitive impairments including mental retardation in our state report that some health care providers are reluctant to treat health problems including cancer aggressively. It is their perception that these physicians believe that the women are expendable members of our

society and health care resources can be used better elsewhere. If the woman is non-verbal or has behavioral problems, the care issue is exacerbated.

Although there is little data on Nebraska women with disabilities, their health care needs must be addressed in any system to improve health care for all women in our state. Not only do these women experience health care barriers related to their disability, many of them also often face additional health care barriers related to being low-income.

IV. Health Service Gaps for Low-Income Women

Nebraska women face a number of barriers to obtaining health care services, including affordability, long distance, lack of transportation, denial of services, lack of handicap access, limited English language skills, inconvenient hours of service, and lack of time. It is difficult to quantify these barriers in terms of the numbers of Nebraska women impacted by them. However, rough estimates can be made for some of these problems.

Low-income women face the double jeopardy of increased risk for health problems and fewer financial resources to access needed health services compared to those with higher incomes. This section of the report looks at the extent to which low-income women in Nebraska utilize certain public health service programs, and identifies health coverage and service gaps by age and racial/ethnic group.

In Nebraska, the principal programs that provide free or reduced-rate health care services to low-income women are Medicaid, the Title X family planning program, and the Every Woman Matters (EWM) health-screening program. The Title V/MCH Block Grant supports direct health care services on a limited basis (approximately 1,000 women per year), with a greater emphasis placed on enabling and population-based services. In addition, the Women, Infants, and Children Program (WIC) provides nutrition services to pregnant and breast feeding women, and numerous programs provide health education services. This analysis is limited to the first three programs above providing direct health care services statewide.

Data Sources & Estimation Procedures

Population of Low-Income Women

Low-income women were defined for this report as those who are age 12 and older with household incomes below 200 percent of the federal poverty level. This criterion was used because Title X and EWM programmatic data are available for that category. Also, it is widely accepted as an income level below which families have difficulty meeting basic needs. Estimating the number of low-income women in various age and racial-ethnic groups required a considerable amount of estimation based on population numbers and poverty rates from the 2000

Census data for Nebraska by age, sex, and racial/ethnic group; regional and national Census Bureau estimates of income as a percent of poverty by age, sex, and racial/ethnic groups; and Nebraska Medicaid monthly eligibility data from 1999 through May 2003. Essentially, regional and national data were used to extrapolate from Nebraska poverty rates for the various groups to the 200 percent of poverty rates. Increases in total Medicaid eligibility numbers between 1999 and May 2003, after adjusting for population increases and changes in eligibility criteria, were used to adjust the estimated 200 percent of poverty rates. In most cases the increase was 25 percent. The adjusted rates were applied to the Nebraska population data for 2000 and then were adjusted to 2003 based on the overall state population increase.

Program Participation

Title X is a federally funded Family Planning Program that provides reproductive health care and contraceptive services. Title X funds are used to enable clinics to provide an assortment of preventive health services; including contraceptive services; gynecological exams; pregnancy testing; Sexually Transmitted Diseases (STD) risk prevention counseling; screening for cervical and breast cancer; screening for high blood pressure, anemia, and diabetes; screening for STDs including HIV; basic infertility services; health education; and referrals for other health social services.

In Nebraska, 23 clinics across the state provide Title X services. The Title X program is open to any one, with a sliding fee scale for those with incomes under 200% of the federal poverty level. In 2002, over 90% of Title X clients had incomes below that level.

The Every Woman Matters (EWM) program is open to women age 40 to 64 (although initially younger women were allowed and are still being served, as are a few older women) with incomes below 225 percent of the federal poverty level who are uninsured or underinsured. In general, women on Medicaid are not eligible, although a few are served. EWM provides free or low-cost screening services, including pelvic exams, Pap tests, clinical breast exams, teaching of breast self exam, blood pressure checks, cholesterol checks, blood glucose checks, and mammograms. EWM also pays for needed follow up tests to diagnose breast and cervical cancer.

Medicaid eligibility is much more complicated, requiring both categorical eligibility as well as income eligibility. The eligibility categories include: under age 21, caretaker of a dependent child, caretaker for a relative, blind or disabled, age 65 or older, and participants in the Every Woman Matters program who are being treated for breast or cervical cancer. The income criteria vary across and with the categories. For those under 17 and uninsured, the criterion is 185 percent of the federal poverty level (FPL). For blind, disabled or aged, the income criterion is 100 percent of FPL. For those with dependent children the criterion is based on eligibility for ADC cash assistance, which, depending on the number of children, might be less than 50 percent of FPL. Others may qualify under the medically needy criteria of \$392 income a month. Those who exceed the medically needy income level may get partial assistance with medical bills, but have to spend their income down to the medically needy level. With the exception of uninsured children, Medicaid program participants are extremely low income, and represent only a small portion of the low income population under 200 percent FPL.

The analysis relied on fairly good 2002 program participation data from the Title X and EWM programs by sex, age, and racial/ethnic group; although some extrapolation was required to cross-classify participants by age, sex, racial-ethnic group and income level. Medicaid enrollment data for May 2003 were available for females by age and racial/ethnic group. Clients who categorized as non-Hispanic and belonging to more than one racial group were distributed proportionately among non-White clients.

Health Coverage

Estimates of the percent of women without adequate health coverage (either uninsured or underinsured) were based on the 1999 Behavioral Risk Factor Survey (BRFS) for Nebraska and a health coverage analysis of the 1995 BRFS for Nebraska. Uninsured is defined as having no source of health coverage, including Medicaid and Medicare as well as private insurance. Underinsured is defined as a “yes” response to the question, “Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?” This is a very conservative definition of underinsured, especially since respondents might not consider an annual exam to constitute a “need” to see a doctor.

The 1995 BRFS analysis produced an estimate that 15 percent of all Nebraska adults were uninsured or underinsured. The 1999 BRFS showed that low income Nebraskans (household incomes less than \$20,000) were more than twice as likely as the general population to be uninsured or underinsured, and that women were more likely than men to be underinsured. The estimated 25 percent increase in poverty rates since 1999 undoubtedly indicates a similar increase in the percent of low-income Nebraskans who are inadequately insured. The application of these adjustment factors resulted in an estimate that 45 percent of low-income Nebraska women, age 18 to 64, are inadequately insured. Because it is easier for low-income children to obtain Medicaid coverage, only 22 percent were estimated to be inadequately insured. The BRFS results from 1999 indicate that Nebraskans age 65 and older are about one-third as likely as the general population to be uninsured or underinsured due to the availability of Medicare and a relatively high rate of Medicaid eligibility. Consequently, the estimate of inadequate coverage was set to 15 percent for that group.

In order to estimate health coverage for women of color, inadequate coverage rates were calculated as a percent of the non-Medicaid population for low-income women overall, and then applied to the percent of non-Medicaid population for Black women and Hispanic women. Health coverage estimates were not made for Native American women because many of them have access to health care through the Indian Health Service.

Results

The following statistics should be considered as rough estimates given the considerable degree to which they had to be extrapolated from various data sources. This is particularly true of estimates of the size of the low-income population of women in Nebraska and the extent of adequate health care coverage. Program participation data are much more reliable because they required only a minor amount of estimation.

Nebraska Low Income Women Population Statistics

Estimates of the low-income population of Nebraska women ages 12 and older are presented in Table 7 below. The statistics are presented for all women, and then for the three largest minority groups. Statistics are not presented separately for White, non-Hispanic women because of difficulties in estimating the program statistics. However, because they are a large majority of women in the state, the overall statistics are a reasonable proxy for them.

Table 7. Nebraska Women with Incomes Below 200 Percent of Federal Poverty Level by Age and Racial/Ethnic Group, 2003

	Age Group	12 to 17	18 to 44	45 to 64	65 +
Total Nebraska Women 2003		87,507	324,559	205,085	141,898
Estimated # below 200% Federal Poverty Level		27,314	123,766	43,559	73,964
Estimated % below 200% Federal Poverty Level		31%	38%	21%	42%
<hr/>					
Total Nebraska Hispanic Women 2003		4,628	19,879	4,408	1,460
Estimated # below 200% Federal Poverty Level		2,567	13,127	1,987	872
Estimated % below 200% Federal Poverty Level		55%	66%	45%	60%
<hr/>					
Total Nebraska Black Women 2003		4,389	17,165	6,823	3,050
Estimated # below 200% Federal Poverty Level		3,197	11,951	3,505	1,883
Estimated % below 200% Federal Poverty Level		73%	70%	51%	62%
<hr/>					
Total Nebraska Native American Women 2003		1,290	5,015	1,844	624
Estimated # below 200% Federal Poverty Level		972	4,564	1,246	330
Estimated % below 200% Federal Poverty Level		75%	91%	68%	53%

Nebraska women who are Hispanic, Black, or Native American are much likely to be low income than other women, although a large majority of women with incomes below 200 percent of the federal poverty level are White, non-Hispanic. Among the women of color, Native American women are most likely to be low income, followed by Black women, and then Hispanic women.

Health Coverage & Utilization Rates

Table 8 presents the utilization rates for Medicaid, Title X, and EWM for low-income Nebraska women by age and estimates the numbers who are inadequately insured and not receiving program services. Overall the results show that one-quarter to one-third of low-income women age 18 to 64 are inadequately insured but are not receiving important public health services on an annual basis.

Table 8. Health Coverage and Public Health Program Utilization Rates for Low-Income Nebraska Women by Age, 2002-2003

	Age Group	12 to 17	18 to 44	45 to 64	65 +
Nebraska Women 2003					
Estimated # below 200% Federal Poverty Level		27,314	123,766	43,559	73,964
Medicaid eligible		14,287	26,045	8,035	13,694
Estimated # un-/under insured		6,052	55,695	19,602	11,095
Title X Family Planning Program Clients (<200%FPL)					
Medicaid covered		529	2,917	118	0
not Medicaid covered		2,150	21,465	872	0
Title X utilization rate		10%	20%	2%	0%
Every Woman Matters Program Client (<200% FPL)					
EWM utilization rate		0%	2%	11%	1%
Health Coverage and Services for Women < 200% FPL:					
Medicaid Eligible		52%	21%	18%	23%
Adequately covered by private insurance/Medicare		26%	34%	37%	62%
Uninsured or Underinsured (non Medicaid):					
Title X client		8%	17%	2%	0%
EWM client		0%	2%	11%	1%
Not served by Title X or EWM		14%	26%	32%	14%
Total		100%	100%	100%	100%
Number low-income, inadequately insured women not receiving Title X or EWM services in 2002		1,045	31,814	14,124	8,187

Although Medicaid is the public health program most utilized by low-income women in every adult age group, it only reaches a small portion of them. Whereas half of low-income girls age 12 to 17 are Medicaid eligible, the program reaches only one-fifth of adult women. This reflects the very restrictive adult eligibility criteria for the program.

One-fifth of all low-income women age 18 to 44 participate in the Title X program, as do 10 percent of girls age 12 to 17. Among women age 18 to 44 who are inadequately insured, the Title X utilization rate is 39 percent, assuming that all non-Medicaid clients are uninsured or

underinsured. Since Title X would provide subsidized services to any woman with an income less than 200 percent of poverty, the utilization rate is fairly low.

The Every Woman Matters program serves 11 percent of low-income women age 45 to 64, including 23 percent of those who have no insurance or are underinsured. One reason for the low utilization rate is that some of the women who use the program only go in for screening every two or three years, thereby deflating the annual utilization rate. It should be noted that some women may be getting both Title X and EWM services – it was not possible to get an unduplicated count. Consequently, the estimate of those getting at least one service may be slightly inflated.

Only 14 percent of young women age 12 to 17 are inadequately insured and not receiving Title X services. However, since those services are primarily for sexually active individuals, many of those without services might not need them. Neither Title X nor EWM are targeted to women age 65 and older, so it is to be expected that few older women are receiving these services. However, there is reason to be concerned about access to health services for seniors who do not have Medicare B or any “Medigap” insurance, including prescription drug coverage.

Health Coverage & Utilization Rates for Low-Income Minority Women

Tables 9 to 11 present health coverage and public program utilization rates for low-income women in racial/ethnic minority groups: Hispanic, Black, and Native American. The results in Table 3 show that Hispanic women have relatively high rates of utilization for both the Title X and EWM programs compared to other groups of low-income women. Less than one-sixth of those aged 18 to 64 are estimated to be inadequately insured and not receiving services. However, an unknown percent of them receive both Title X and EWM services, inflating the unduplicated estimate of those receiving any service. Unlike other groups, Hispanic women who are Medicaid eligible have a very high utilization rate for Title X (88% compared to 11% for all low-income women). Hispanic women age 65 and over are much more likely than low-income women overall to be Medicaid eligible, but have comparable rates for younger ages.

As a consequence of their relatively high utilization rates for Title X and EWM, Hispanic women age 18 and older are less likely to have health service gaps than other groups of women. It's possible that they utilize these programs because they are offered in settings that are more culturally and linguistically appropriate than are most private sector services.

Table 9. Health Coverage and Public Health Program Utilization Rates for Low-Income, Nebraska Hispanic Women by Age, 2002-2003

	Age Group	12 to 17	18 to 44	45 to 64	65 +
Nebraska Hispanic Women 2003					
Estimated # below 200% Federal Poverty Level		2,567	13,127	1,987	872
Medicaid eligible		1,504	1,865	342	424
Estimated # un-/underinsured		494	6,418	908	87
Title X Family Planning Program Clients (<200%FPL)		398	5,656	457	0
Medicaid covered		190	1,635	132	0
Not Medicaid covered		208	4,021	325	0
Title X utilization rate		16%	43%	23%	0%
Every Woman Matters Program Client (<200% FPL)		0	140	267	40
EWM utilization rate		0%	1%	13%	5%
Health Coverage and Services for Women < 200% FPL:					
Medicaid Eligible		59%	14%	17%	49%
Adequately covered by private insurance/Medicare		22%	37%	37%	30%
Uninsured or Underinsured (non Medicaid):					
Title X client		8%	31%	16%	0%
EWM client		0%	1%	13%	5%
Not served by Title X or EWM		11%	17%	16%	5%
Total		100%	100%	100%	100%
Number low-income, inadequately insured women not receiving Title X or EWM services in 2002		286	2,257	316	36

Table 4 shows that Black women are half as likely to use Title X and EWM services as are low-income women overall. This might be due partly to relatively high Medicaid eligibility rates. Unlike Hispanic women, Black women with Medicaid coverage do not use the Title X program. Because of their high Medicaid eligibility, the health service gap for low-income Black women in Nebraska is similar to the general population of low-income women.

Table 10. Health Coverage and Public Health Program Utilization Rates for Low-Income, Nebraska Black Women by Age, 2002-2003

	Age Group	12 to 17	18 to 44	45 to 64	65 +
Nebraska Black Women 2003					
Estimated # below 200% Federal Poverty Level		3,197	11,951	3,505	1,883
Medicaid eligible		2,478	5,139	1,046	802
Estimated # un-/underinsured		719	6,812	2,459	186
Title X Family Planning Program Clients (<200%FPL)		200	1,220	23	0
Medicaid covered		80	294	5	0
Not Medicaid covered		120	926	17	0
Title X utilization rate		6%	10%	1%	0%
Every Woman Matters Program Client (<200% FPL)		0	99	189	28
EWM utilization rate		0%	1%	5%	1%
Health Coverage and Services for Women < 200% FPL:					
Medicaid Eligible		78%	43%	30%	43%
Adequately covered by private insurance/Medicare		12%	25%	31%	46%
Uninsured or Underinsured (non Medicaid):					
Title X client		4%	8%	0%	0%
EWM client		0%	1%	5%	1%
Not served by Title X or EWM		7%	24%	33%	10%
Total		100%	100%	100%	100%
Number low-income, inadequately insured women not receiving Title X or EWM services in 2002		214	2,857	1,151	157

Low-income Native American women in Nebraska are only one-third as likely to use Title X services, but just as likely to use EWM services as compared to the general population of low-income women (see Table 5). Since their Medicaid eligibility rates are similar to the general population for in both the 18 to 44 and the 45 to 64 age groups, there is no obvious reason for the disparity.

The availability of Indian Health Service programs to Native American women in Nebraska makes it difficult to calculate a health service gap for them. Most would be technically eligible for services, but information was not available on the extent to which they had adequate access to needed services.

Table 11. Health Coverage and Public Health Program Utilization Rates for Low-Income, Nebraska Native American Women, by Age 2002-2003

	Age Group	12 to 17	18 to 44	45 to 64	65 +
Nebraska Native American Women 2003					
Estimated # below 200% Federal Poverty Level		972	4,564	1,246	330
Medicaid eligible		654	990	262	145
Estimated # un-/underinsured		**	**	**	**
Title X Family Planning Program Clients (<200%FPL)		41	309	23	0
Medicaid covered		8	37	3	
Not Medicaid covered		33	272	20	0
Title X utilization rate		4%	7%	2%	0%
Every Woman Matters Program Client (<200% FPL)		0	79	150	22
EWM utilization rate		0%	2%	12%	7%
Health Coverage and Services for Women < 200% FPL:					
Medicaid Eligible		67%	22%	21%	44%
Adequately covered by private insurance/ Medicare		**	**	**	**
Uninsured or Underinsured (non Medicaid):					
Title X client		3%	6%	2%	0%
EWM client			2%	12%	7%
Not served by Title X or EWM		**	**	**	**
Total		**	**	**	**
Number low-income, inadequately insured women not receiving Title X or EWM services in 2002		**	**	**	**

** The availability of health care through the Indian Health Service makes this statistic difficult to estimate

Health Service Gaps Discussion

The above analysis indicates that the Title X and Every Woman Matters programs are important sources of health care for many low-income Nebraska women. However, a substantial percentage of these women have a health service gap because they are inadequately insured and are not participating in either of these programs on an annual basis.

Overall, the results do not indicate a disproportionate health service gap for low-income minority women compared to low-income women overall. However, because women from racial/ethnic minority groups tend to have lower incomes than White, non-Hispanic women, they are more likely to be at risk of inadequate health care coverage.

Low-income women in Nebraska are more likely to receive health services through Medicaid than through Title X or Every Woman Matters. Although technically that qualifies them as adequately insured, women in the Medicaid program have some service exclusions and may find it difficult to access a provider who will accept Medicaid patients. Furthermore, we cannot assume that all Medicaid clients are adequately using the services that are available. Similarly, we cannot assume that all low-income women with “adequate” insurance coverage are seeking out and receiving adequate health care.

Hopefully, the analysis presented here can provide some guidance for efforts to identify the health service gaps for low-income Nebraska women and opportunities for expanding and improving their health care services.

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