

## **Executive Report**

# **2015 PRC Child & Adolescent Community Health Needs Assessment**

**Douglas & Sarpy Counties, Nebraska  
Pottawattamie County, Iowa**

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*Prepared for:*

Children's Hospital & Medical Center  
Boys Town National Research Hospital  
Building Healthy Futures

*By:*

**Professional Research Consultants, Inc.**  
11326 P Street Omaha, NE 68136-2316  
[www.PRCCustomResearch.com](http://www.PRCCustomResearch.com)

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# Introduction



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## Project Overview

### Project Goals

The goal of this 2015 PRC Child & Adolescent Health Needs Assessment, a follow-up to similar researchss conducted in 2012, is to gather data to assist in determining the health status, behaviors and needs of children and adolescents in the Omaha Metropolitan Area. This assessment was conducted on behalf of Children's Hospital & Medical Center, Boys Town National Research Hospital, and Building Healthy Futures by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

### Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the 2015 PRC Child & Adolescent Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

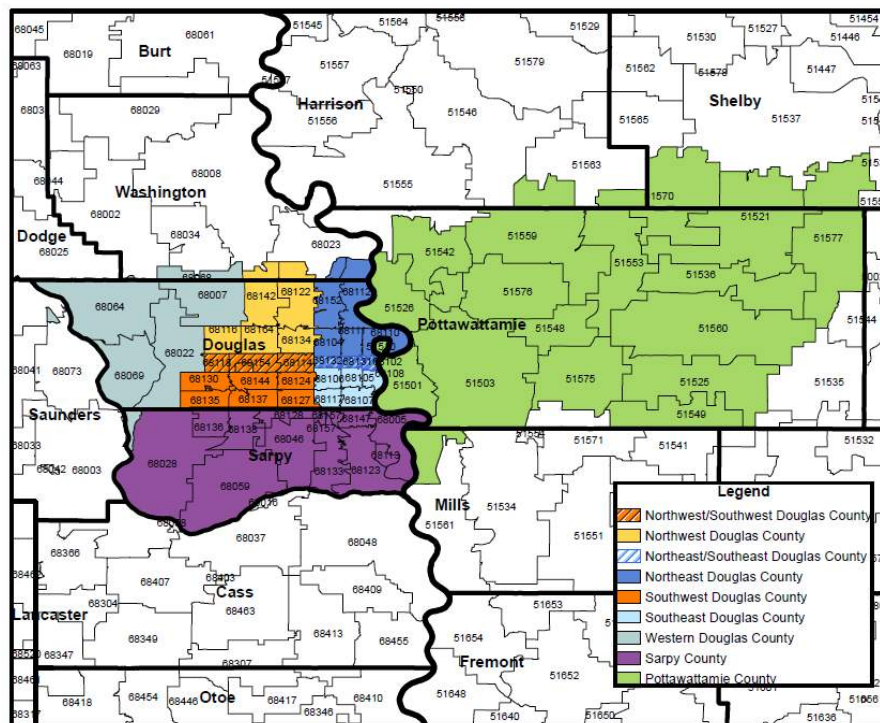
### PRC Community Health Survey

#### *Survey Instrument*

The final survey instrument used for this study was developed by Children's Hospital & Medical Center, Boys Town National Research Hospital, Building Healthy Futures, and PRC, and is similar to the previous survey used in the region, allowing for data trending.

#### *Community Defined for This Assessment*

The study area for the survey effort (referred to as the "Metro Area" in this report) includes each of the residential ZIP Codes comprising Douglas and Sarpy counties in Nebraska as well as Pottawattamie County in Iowa; this community definition was determined by the sponsors of this study. For more specific assessment, Douglas County is divided into 5 geographical areas (Northeast Omaha, Southeast Omaha, Northwest Omaha, Southwest Omaha, and Western Douglas County). A geographic description is illustrated in the following map.



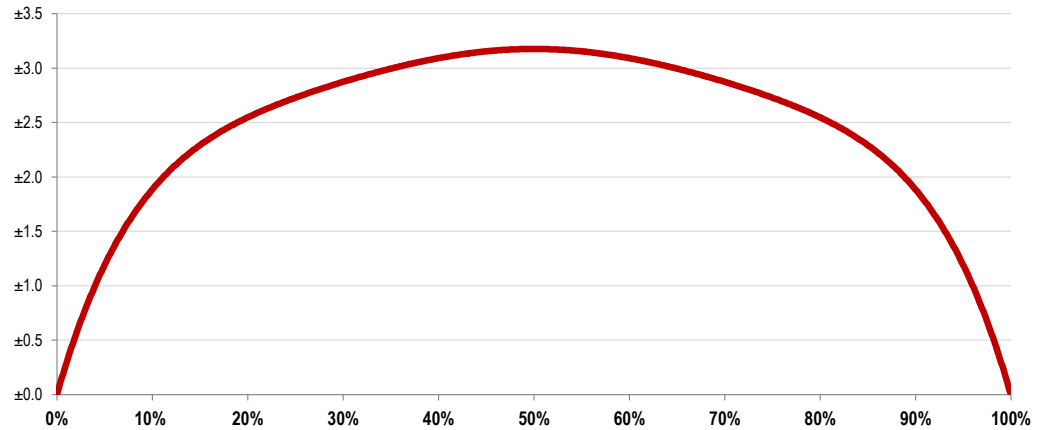
### Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Child & Adolescent Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities. In addition, these telephone interviews were supplemented with surveys among families in the metropolitan area requested to participate in the study via a questionnaire completed online.

The sample design used for this effort consisted of a stratified random sample of 966 parents of children under 18 in the Metro Area (795 conducted via landline telephone or cell phone, and 163 collected through online surveys). By geography, a total of 691 surveys were conducted in Douglas County (including oversampling in Northeast and Southeast Omaha), 150 in Sarpy County and 125 in Pottawattamie County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Metro Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 964 respondents is  $\pm 3.2\%$  at the 95 percent level of confidence. By county: the maximum error rate is  $\pm 3.7\%$  for Douglas County results,  $\pm 8.0\%$  for Sarpy County, and  $\pm 8.8\%$  for Pottawattamie County.

### Expected Error Ranges for a Sample of 964 Respondents at the 95 Percent Level of Confidence



- Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.
- Examples:
- If 10% of the sample of 964 respondents answered a certain question with a "yes," it can be asserted that between 8.1% and 11.9% (10%  $\pm$  1.9%) of the total population would offer this response.
  - If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.8% and 53.2% (50%  $\pm$  3.2%) of the total population would respond "yes" if asked this question.

#### Respondent Selection

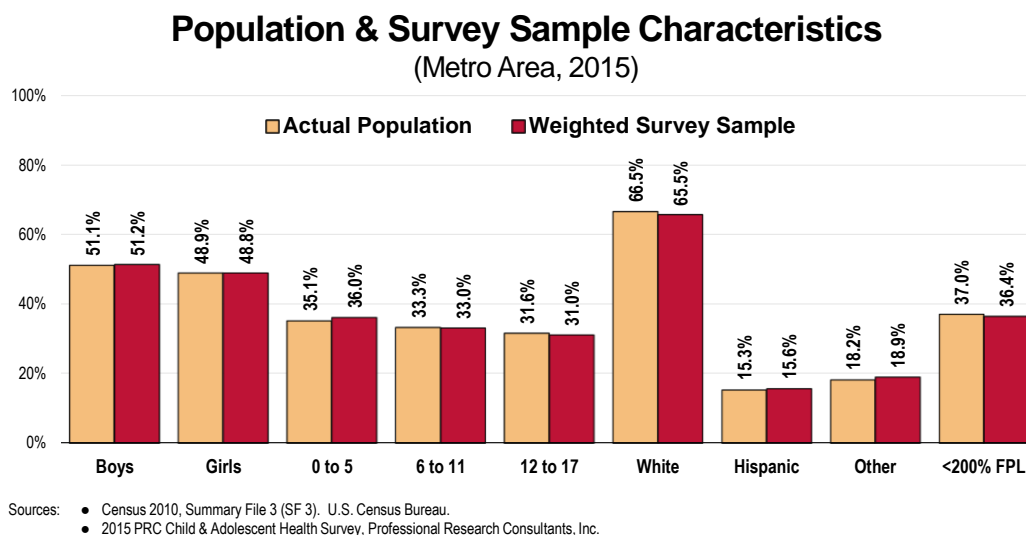
Survey respondents were adults age 18 and older who have children residing in the household for whom they are a healthcare decision-maker. For households with more than one child under the age of 18, most questions were asked about a randomly selected child in the household, determined by which child has had the most recent birthday. This random selection process allows for the best representation of children by age and gender.

#### Sample Characteristics

To accurately represent the population studied (Metro Area children and adolescents), PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample of Metro Area children and adolescents, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely the child's gender, age, race/ethnicity, and household poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.



The following chart outlines the characteristics of the Metro Area sample for key child/adolescent demographics, compared to actual population characteristics revealed in census data.



Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the United States Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g., the 2014 guidelines place the poverty threshold for a family of four at \$23,850 annual household income or lower*). In sample segmentation: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level, earning up to twice the poverty threshold; and “mid/high income” refers to those households living on incomes which are twice or more the federal poverty level. The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of Metro Area children and adolescents with a high degree of confidence.

### Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by the sponsors of this study; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns among the families and children/adolescents with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 149 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Key Informant Type	Number Invited	Number Participating
Community/Business Leader	55	30
Other Healthcare Provider	41	20
Physician	172	80
Public Health Representative	11	10
Social Services Provider	16	9

Final participation included representatives of the organizations outlined below.

- Aetna Better Health of Nebraska
- Arbor Family Counseling
- Boys Town
- Boys Town National Research Hospital
- Boys Town Pediatrics
- Building Healthy Futures
- Charles Drew Health Center
- CHI Health
- Child Saving Institute
- Children's Hospital & Medical Center
- Children's Physicians
- Children's Physicians - Dundee
- Children's Physicians - Plattsmouth
- Children's Physicians - Spring Valley
- Children's Physicians - UNMC
- Choices Counseling and Consulting, Inc.
- Completely KIDS
- Council Bluffs Community Schools
- Creighton University
- Creighton University College of Nursing
- Creighton University School of Dentistry
- Daniel J. Bruckner, LIMHP, Momentum Therapy Group
- Douglas County

- Douglas County Health Department
- Douglas/Sarpy County WIC
- Eye Consultants
- Families in Action
- Gretchen Swanson Center for Nutrition
- Holland Children's Movement
- Hy-Vee
- Kugler Vision, PC
- Learning Community of Douglas and Sarpy Counties
- Live Well Omaha
- MMI
- Munroe-Meyer Institute Psychology Department
- Nebraska Foundation for Children's Vision
- Nebraska Medicine Department of Pediatrics
- Nebraska Optometric Association
- NMC
- Omaha Healthy Kids Alliance
- OneWorld Community Health Center
- Region 6 Behavioral Healthcare
- The Kim Foundation
- University of Nebraska Medical Center
- UNO Health Services
- Visiting Nurse Association's Cooking Matters
- Women's Fund of Omaha
- Wood haven Counseling Associates
- Youth Emergency Services

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations (including African Americans, AIDS/HIV infected persons, Asians, autistic individuals, bi-racial residents, Burmese population , persons of Caribbean descent, Caucasians, Chinese residents, the disabled, families in the court system, foster children/state wards, Guatemalans, Hispanics, the homeless, immigrants, Karen people, Kenyans, Koreans, LGBT community, low income residents, Medicaid/Medicare beneficiaries, the mentally ill, those of Middle Eastern descent, minorities in Omaha Public Schools, Muslims, Native Indians, Nepalese individuals, non-English speaking residents, refugees, rural children, Somalis, substance abusers, Sudanese people, people of Thai ethnicity, the uninsured/underinsured, Vietnamese individuals, and young children), or other medically underserved populations (including autistic individuals, children living with extended family members, children with complex medical conditions, the disabled, foster children/state wards, Hispanics, the homeless, immigrants, incarcerated population, children with lack of

parental supervision, LGBT community, those with a low education level, low income residents, Medicaid/Medicare beneficiaries, the mentally ill, refugees, rural children, children with special care needs, teens and young adults, undocumented individuals, the uninsured/underinsured, and young children).

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

*NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.*

### **Public Health, Vital Statistics & Other Data**

A variety of existing (secondary) data sources was consulted to complement the research quality of this Child & Adolescent Health Needs Assessment. Data for the Metro Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- [Centers for Disease Control & Prevention](#)
- [Douglas County Health Department](#)
- [GeoLytics Demographic Estimates & Projections](#)
- [National Center for Health Statistics](#)
- [Iowa Department of Public Health](#)
- [Nebraska Department of Health Services](#)
- [statehealthfacts.org](#)
- [countyhealthrankings.org](#)
- [Metro Area Census Bureau](#)
- [Metro Area Department of Health and Human Services](#)

Note that secondary data are compared to state and national data where available.

### **Benchmark Data**

#### ***Trending***

A similar survey was administered in the Metro Area in 2012 by PRC on behalf of Boys Town National Research Hospital and Children's Hospital & Medical Center. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

### National Data

National survey data, which are also provided in comparison charts, are taken from the 2014 *PRC National Child & Adolescent Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the population of American children and youth with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

### Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.



Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

### Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% variation from the comparative measure.

### Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of child/adolescent health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the children and adolescent health needs.

For example, certain population groups — such as the homeless, institutionalized children, or children of parents who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, undocumented residents, and children of certain racial/ethnic or immigrant groups — might not be identifiable

or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of children and adolescents in the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

## Summary of Findings

### Significant Health Needs of the Community

The following “areas of opportunity” represent the significant health needs of children and adolescents in the community, based on the information gathered through this Child & Adolescent Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for children’s health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	<ul style="list-style-type: none"> <li>• Difficulty Accessing Children’s Healthcare <ul style="list-style-type: none"> <li>◦ Appointment Availability</li> <li>◦ Lack of Transportation</li> </ul> </li> <li>• Child Has a Specific Source of Ongoing Medical Care</li> <li>• Child Needed to See a Specialist</li> <li>• Emergency Room Utilization</li> <li>• Relying on the Internet for Healthcare Info</li> </ul>
Injury & Violence	<ul style="list-style-type: none"> <li>• Adolescent Deaths</li> <li>• Bicycle Safety</li> <li>• Helmet Usage While Skating</li> <li>• Neighborhood Safety</li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>• Diagnosed Depression</li> <li>• Symptoms of Chronic Depression</li> <li>• Child Worries A Lot</li> <li>• Child Has Difficulty Sleeping</li> <li>• Suicide Attempts [High Schoolers]</li> <li>• <i>Mental and Emotional Health ranked as a top concern in the Online Key Informant Survey.</i></li> <li>• <i>Cognitive and Behavioral Conditions ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
Nutrition, Physical Activity & Weight	<ul style="list-style-type: none"> <li>• <i>Nutrition, Physical Activity, and Weight ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
Oral Health	<ul style="list-style-type: none"> <li>• Regular Dental Care</li> <li>• Dental Insurance Coverage</li> </ul>
Vision, Hearing & Speech Conditions	<ul style="list-style-type: none"> <li>• Hearing Problems</li> <li>• Speech/Language Problems</li> <li>• Chronic Ear Infections</li> </ul>
Asthma & Other Respiratory Conditions	<ul style="list-style-type: none"> <li>• Hospitalizations Due to Asthma</li> </ul>

— continued on next page —

**Areas of Opportunity (continued)**

Sexual Health	<ul style="list-style-type: none"><li>• Gonorrhea Incidence [All Ages]</li><li>• Chlamydia Incidence [All Ages]</li><li>• Birth Control Use [High Schoolers]</li><li>• <i>Sexual Health ranked as a top concern in the Online Key Informant Survey.</i></li></ul>
Substance Abuse	<ul style="list-style-type: none"><li>• Drinking &amp; Driving [High Schoolers]</li><li>• Lifetime Illicit Drug Use [High Schoolers]</li></ul>



## Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of child and adolescent health indicators in the Metro Area, including comparisons among the individual counties and sub-areas of Douglas County, as well as trend data.

### Reading the Summary Tables


















































- In the following charts, Metro Area results are shown in the larger, blue column.
- The green columns [to the left of the Metro Area column] provide comparisons among the three counties and among the five sub-areas of Douglas County, identifying differences for each as “better than” (☀), “worse than” (☹), or “similar to” (☺) the combined opposing areas.
- The columns to the right of the Metro Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the Metro Area compares favorably (☀), unfavorably (☹), or comparably (☺) to these external data.




































































































Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.



















































































#### TREND SUMMARY (Current vs. Baseline Data)































**Survey Data Indicators:** Trends for survey-derived indicators represent significant changes since 2012. Note that survey data reflect the ZIP Code-defined Metro Area.



















**Other (Secondary) Data Indicators:** Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Note that secondary data reflect county-level data for the Metro Area.







Overall Health	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child's Overall Health Is "Fair/Poor"	<div> 5.8</div>	<div> 7.7</div>	<div> 2.2</div>	<div> 3.0</div>	<div> 1.7</div>	<div> 4.4</div>	<div> 4.1</div>	<div> 4.8</div>	4.3		<div> 2.3</div>		<div> 3.2</div>	
% [Age 0-17] Child's Activities/Abilities Limited Due to Health Condition	<div> 11.2</div>	<div> 8.9</div>	<div> 5.8</div>	<div> 3.2</div>	<div> 5.2</div>	<div> 6.9</div>	<div> 9.5</div>	<div> 13.2</div>	8.2		<div> 6.9</div>			
% [Age 5-17] Child Has Special Health Needs	<div> 73.5</div>	<div> 55.2</div>	<div> 58.2</div>	<div> 62.8</div>	<div> 65.3</div>	<div> 62.8</div>	<div> 62.0</div>	<div> 59.7</div>	62.3		<div> 68.3</div>			
% [Age 0-17] Child is Prescribed Medication	<div> 37.4</div>	<div> 25.1</div>	<div> 28.7</div>	<div> 24.4</div>	<div> 38.7</div>	<div> 29.4</div>	<div> 30.9</div>	<div> 28.1</div>	29.6		<div> 27.3</div>			
% [Age 0-17] Child Participates in Special Therapy	<div> 15.0</div>	<div> 6.9</div>	<div> 5.4</div>	<div> 7.7</div>	<div> 2.5</div>	<div> 8.4</div>	<div> 10.0</div>	<div> 14.3</div>	9.4		<div> 8.3</div>			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better  similar  worse</div>					














Access to Health Services	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	
% [Age 0-17] Child Is Uninsured	 7.0	 6.5	 2.8	 2.4	 1.2	 4.3	 4.5	 8.7	4.8		 6.5	 0.0	 4.4	
% [Insured Child] Child Went Without Insurance in Past Year	 14.2	 12.9	 3.4	 1.5	 5.1	 7.4	 7.6	 7.6	7.4		 13.3			
% Pays a Deductible on Child's Private Insurance	 80.3	 82.4	 87.8	 88.3	 98.6	 87.0	 85.9	 84.5	86.5					
% Size of Deductible Prevented Child's Needed Healthcare in Past Year	 1.9	 5.7	 0.7	 5.5	 5.7	 3.7	 2.8	 4.3	3.5					
% [Age 0-17] Difficulties Accessing Child's Healthcare (Composite)	 39.7	 26.7	 20.4	 25.3	 12.5	 27.1	 18.6	 36.3	26.2		 29.4		 20.9	
% [Age 0-17] Difficulty Finding Physician for Child in Past Year	 5.6	 4.1	 4.5	 2.5	 3.7	 4.0	 4.1	 5.4	4.2		 5.7		 3.5	
% [Age 0-17] Difficulty Getting Appointment for Child in Past Year	 13.2	 8.6	 8.2	 9.0	 7.0	 9.6	 4.4	 19.8	9.6		 11.5		 5.8	
% [Age 0-17] Cost Prevented Child's Dr Visit in Past Year	 7.6	 2.9	 4.8	 5.3	 3.7	 5.1	 7.3	 11.7	6.3		 6.3		 4.8	
% [Age 0-17] Transportation Hindered Child's Dr Visit in Past Year	 8.1	 7.4	 1.0	 2.2	 3.0	 4.5	 3.1	 8.3	4.6		 4.1		 2.6	
% [Age 0-17] Inconvenient Hrs Prevented Child's Dr Visit in Past Year	 20.2	 12.5	 9.2	 13.3	 3.6	 13.2	 4.8	 13.0	11.3		 14.2		 12.1	
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								 better  similar  worse					


















































Access to Health Services (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Cost Prevented Getting Child's Prescription in Past Year	 7.9	 8.6	 5.1	 3.1	 5.6	 6.0	 6.2	 6.7	6.1		 5.5		 3.6	
% [Age 0-17] Culture Difference Prevented Child's Dr Visit in Past Year	 2.5	 4.3	 0.0	 0.6	 0.0	 1.7	 0.7	 1.8	1.5		 0.8			
% [Child Needing Care] "Major/Moderate" Problem Getting Specialty Care						 18.2	 18.0		19.9		 32.3			
% [Age 0-17] Child Has a Specific Source of Care	 76.2	 85.5	 93.4	 95.3	 76.8	 87.2	 89.8	 83.0	87.3		 89.3	 100.0	 92.4	
% [Age 0-17] Child Has Had Routine Checkup in Past Year	 89.7	 80.3	 86.9	 84.2	 85.0	 85.3	 86.6	 81.4	85.2		 85.3		 84.2	
% Child Needed to See a Specialist in the Past Year	 26.7	 26.6	 26.7	 30.5	 35.4	 28.3	 30.0	 35.8	29.5		 24.2			
% [Parents] Feel Need to Leave the Area for Children's Health Svcs	 15.7	 9.3	 10.3	 8.0	 5.7	 10.4	 5.8	 30.8	11.7		 27.2			
% [Age 0-17] Child Used Some Type of UCC in the Past Year	 33.1	 30.3	 35.4	 29.6	 27.2	 31.7	 34.1	 34.1	32.4		 28.6			
% [Age 0-17] Child Has Had 2+ ER Visits in Past Year	 10.5	 13.7	 9.0	 4.7	 3.0	 8.7	 11.3	 14.6	10.0		 7.1			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better similar worse</div>					














Allergies	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Has Respiratory Allergies	 26.2	 13.9	 20.9	 13.2	 13.0	 18.0	 20.8	 14.7	18.3		 17.8			
% [Age 0-17] Child Has Food/Digestive Allergies	 4.4	 5.7	 7.1	 11.2	 17.2	 8.0	 3.8	 12.2	7.5		 8.8			
% [Age 0-17] Child Has Eczema/Skin Allergies	 21.6	 20.3	 19.0	 22.3	 14.0	 20.5	 22.2	 16.6	20.4		 22.5			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					
























Asthma	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Currently Has Asthma	 16.4	 4.5	 10.0	 2.4	 2.1	 7.7	 4.0	 2.1	6.2		 11.6	 8.7		
% [Age 0-17 With Asthma] ER/Urgent Care for Child's Asthma in Past Year									30.5		 46.8	 44.7		
% [Age 0-17 With Asthma] Child Hospitalized for Asthma in Past Year									8.4		 0.6	 16.3		
% [Age 5-17 With Asthma] Child Missed School Due to Asthma in Past Year									36.2		 39.2			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					






















































Asthma (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17 With Asthma] Parent Missed Work Due to Child's Asthma in Past Year									25.1			29.4	 34.6	
% [Age 0-17 With Asthma] Has an Asthma Action Plan									80.9				 83.3	
% [Age 5-17 With Asthma] School Has Copy of Asthma Action Plan									94.7					
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

Bone, Joint & Muscle Disorders	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Has Bone/Joint/Muscle Problems	<div></div> <div>5.5</div>	<div></div> <div>4.5</div>	<div></div> <div>2.7</div>	<div></div> <div>3.7</div>	<div></div> <div>3.9</div>	<div></div> <div>4.1</div>	<div></div> <div>6.5</div>	<div></div> <div>2.1</div>	4.4	<div></div> <div>6.0</div>			<div></div> <div>5.7</div>	
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div><div> similar</div><div> better</div><div> worse</div></div>					









































Cognitive & Behavioral Disorders	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	
% [Age 5-17] Child Has Autism	 4.4	 2.0	 0.6	 0.0	 1.8	 1.8	 2.0	 1.6	1.8		 1.4			
% [Age 0-17] Child Has Learning Disability	 13.6	 6.0	 6.2	 6.2	 10.9	 8.2	 8.9	 7.2	8.2		 8.0			
% [Age 0-17] Child Has Developmental Delays	 8.7	 5.4	 5.1	 5.3	 7.0	 6.1	 8.1	 5.3	6.5		 6.8			
% [Age 0-17] Child Has ADD/ADHD	 12.3	 5.1	 6.6	 8.1	 3.9	 7.9	 8.6	 10.5	8.3		 8.7	 9.4		
% [Age 5-17] Child Has Behavioral/Conduct Problems	 8.4	 4.9	 2.8	 5.1	 1.8	 5.2	 2.9	 8.6	5.1		 3.7			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								   better similar worse					
































Diabetes	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Has Diabetes/High Blood Sugar	 1.2	 0.8	 0.0	 0.0	 3.0	 0.6	 1.0	 0.0	0.6	 0.7			 0.4	
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

































































Health Education	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% Rely on the Internet for Healthcare Information	 4.4	 2.7	 2.9	 3.8	 2.0	 3.4	 10.3	 18.4	6.7			 9.6	 12.0	 7.5
% [Age 0-17] Parent Aware of Local Parenting Education Programs	 72.0	 56.0	 65.1	 63.3	 71.9	 64.6	 70.9	 62.2	65.8					 60.0
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					




















Injury & Safety	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Has Sustained Injury Requiring Treatment in Past Year	<div></div> <div>12.0</div>	<div></div> <div>10.0</div>	<div></div> <div>10.7</div>	<div></div> <div>16.6</div>	<div></div> <div>7.6</div>	<div></div> <div>12.3</div>	<div></div> <div>6.7</div>	<div></div> <div>13.9</div>	11.2		<div></div> <div>10.6</div>	<div></div> <div>15.1</div>		
% [Age 0-17] Child "Always" Uses Seat Belt/Car Seat	<div></div> <div>92.0</div>	<div></div> <div>89.4</div>	<div></div> <div>97.4</div>	<div></div> <div>91.9</div>	<div></div> <div>90.4</div>	<div></div> <div>92.5</div>	<div></div> <div>98.8</div>	<div></div> <div>96.3</div>	94.3		<div></div> <div>95.7</div>	<div></div> <div>95.1</div>		
% [Age 5-17] Child "Always" Wear a Bike Helmet	<div></div> <div>40.4</div>	<div></div> <div>29.5</div>	<div></div> <div>41.7</div>	<div></div> <div>41.9</div>	<div></div> <div>42.9</div>	<div></div> <div>39.1</div>	<div></div> <div>43.1</div>	<div></div> <div>29.7</div>	39.0		<div></div> <div>46.5</div>	<div></div> <div>40.3</div>		
% [Age 5-17] Child "Always" Wear a Skateboard/Scooter/Rollerblade Helmet	<div></div> <div>37.2</div>	<div></div> <div>23.7</div>	<div></div> <div>30.3</div>	<div></div> <div>29.3</div>	<div></div> <div>52.1</div>	<div></div> <div>31.9</div>	<div></div> <div>35.6</div>	<div></div> <div>21.4</div>	31.7		<div></div> <div>37.4</div>	<div></div> <div>27.1</div>		
% [Age 0-17] Neighborhood Is "Slightly" or "Not At All" Safe	<div></div> <div>39.0</div>	<div></div> <div>36.6</div>	<div></div> <div>4.0</div>	<div></div> <div>3.8</div>	<div></div> <div>3.7</div>	<div></div> <div>18.7</div>	<div></div> <div>3.7</div>	<div></div> <div>9.6</div>	14.3		<div></div> <div>14.2</div>	<div></div> <div>10.2</div>		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					





































































































Injury & Safety (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 5-17] Child Missed School in Past Year Because Felt Unsafe	 2.4	 6.9	 0.6	 3.6	 2.0	 3.3	 4.4	 3.0	3.4		 5.0		 1.8	
% [Age 5-17] Missed 10+ School Days Last Yr Due to Illness/Injury	 4.5	 4.8	 8.1	 6.6	 4.0	 5.9	 9.4	 11.3	7.3		 6.1			
% [Age 5-17] Bullied on School Property in the Past Year	 18.2	 24.5	 12.2	 14.2	 4.5	 16.1	 17.1	 25.3	17.4		 16.1			
% [Age 5-17] Child Electronically Bullied in Past Year	 6.8	 1.8	 6.1	 3.6	 3.7	 4.5	 4.6	 7.3	4.9		 7.5			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					












































































Mental & Emotional Health	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 5-17] Child's Mental Health Is "Fair/Poor"	<div> 9.8</div>	<div> 5.5</div>	<div> 6.5</div>	<div> 8.8</div>	<div> 2.3</div>	<div> 7.5</div>	<div> 7.7</div>	<div> 10.5</div>	7.9		<div> 5.5</div>			
% [Age 5-17] Parent Aware of Community Mental Health Resources	<div> 77.5</div>	<div> 59.9</div>	<div> 74.1</div>	<div> 75.3</div>	<div> 90.3</div>	<div> 73.6</div>	<div> 73.8</div>	<div> 78.5</div>	74.2		<div> 65.0</div>		<div> 67.2</div>	
% [Age 5-17] Needed Mental Health Svcs in the Past Yr	<div> 16.4</div>	<div> 8.3</div>	<div> 13.7</div>	<div> 12.1</div>	<div> 6.8</div>	<div> 12.4</div>	<div> 14.7</div>	<div> 18.4</div>	13.6		<div> 10.8</div>			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div><div> better</div><div> similar</div><div> worse</div></div>					










































Mental & Emotional Health (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	
% [Age 5-17] Child Unable to Get Needed Mental Health Svcs in Past Year									6.5			19.3		9.2
% [Age 5-17] Child Has Ever Taken Rx for Mental Health	 6.8	 7.1	 7.1	 5.1	 6.1	 6.4	 8.7	 13.3	7.7			6.9		13.7
% [Age 5-17] Child Worries A Lot	 23.0	 25.7	 26.2	 26.7	 15.8	 24.7	 29.8	 29.2	26.4			23.0		21.9
% [Age 5-17] Child Has Anxiety	 8.8	 8.3	 8.9	 6.5	 4.8	 7.8	 12.5	 18.3	10.1			7.9		
% [Age 5-17] Child Has Difficulty Sleeping	 25.4	 16.8	 11.0	 17.4	 8.2	 17.4	 22.1	 24.9	19.3			13.2		10.2
% [Age 5-17] Child Had Symptoms of Depression in Past Year	 3.6	 5.4	 6.0	 5.7	 1.2	 4.9	 3.0	 5.9	4.6			4.9		2.0
% [Age 5-17] Child Has Depression	 5.2	 6.1	 5.5	 5.9	 2.8	 5.4	 5.4	 11.2	6.1			2.6		
% [High Schoolers] Attempted Suicide in Past Year (Douglas County)									15.7			8.0		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

























Mortality	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
[Age 1-4] Mortality Rate per 100,000									23.4					
									25.2	23.7	26.0	25.7		
[Age 5-9] Mortality Rate per 100,000									10.6					
									12.1	10.9	11.7	12.3		
[Age 10-14] Mortality Rate per 100,000									13.8					
									15.7	17.8	14.1	15.2		
[Age 15-19] Mortality Rate per 100,000									51.9					
									44.7	50.3	47.0	55.7		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

































Neurological Disorders	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Has Migraines/Severe Headaches	<div> 6.6</div>	<div> 3.6</div>	<div> 8.8</div>	<div> 4.3</div>	<div> 8.1</div>	<div> 5.9</div>	<div> 3.8</div>	<div> 5.6</div>	5.4	<div> 6.7</div>				
% [Age 0-17] Child Has Brain Injury/Concussion	<div> 4.1</div>	<div> 1.2</div>	<div> 5.3</div>	<div> 4.0</div>	<div> 3.0</div>	<div> 3.7</div>	<div> 4.9</div>	<div> 4.9</div>	4.1	<div> 3.9</div>			<div> 2.5</div>	
% [Age 0-17] Child Has Epilepsy/Seizure Disorder	<div> 3.8</div>	<div> 0.3</div>	<div> 1.9</div>	<div> 0.8</div>	<div> 0.0</div>	<div> 1.5</div>	<div> 1.5</div>	<div> 0.7</div>	1.4	<div> 0.8</div>			<div> 1.5</div>	
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					























Nutrition & Weight	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	
% [Age 2-17] Child Has 5+ Servings of Fruits/Vegetables per Day	<div></div> <div>47.6</div>	<div></div> <div>48.4</div>	<div></div> <div>39.6</div>	<div></div> <div>45.3</div>	<div></div> <div>35.5</div>	<div></div> <div>44.6</div>	<div></div> <div>49.6</div>	<div></div> <div>50.7</div>	46.4		<div></div> <div>41.8</div>	<div></div> <div>46.4</div>		
% "Very/Somewhat" Difficult to Buy Fresh Produce	<div></div> <div>37.5</div>	<div></div> <div>42.2</div>	<div></div> <div>21.0</div>	<div></div> <div>16.9</div>	<div></div> <div>19.6</div>	<div></div> <div>28.0</div>	<div></div> <div>25.6</div>	<div></div> <div>34.9</div>	28.2		<div></div> <div>28.2</div>			
% [Age 2-17] Child Ate 3+ Fast Food Meals in Past Week	<div></div> <div>23.3</div>	<div></div> <div>13.9</div>	<div></div> <div>23.4</div>	<div></div> <div>18.2</div>	<div></div> <div>20.2</div>	<div></div> <div>19.9</div>	<div></div> <div>23.1</div>	<div></div> <div>22.1</div>	20.7		<div></div> <div>22.0</div>	<div></div> <div>19.9</div>		
% [Age 2-17] Ate 7+ Meals Together as a Family in Past Week	<div></div> <div>68.2</div>	<div></div> <div>75.6</div>	<div></div> <div>69.6</div>	<div></div> <div>77.5</div>	<div></div> <div>65.4</div>	<div></div> <div>72.3</div>	<div></div> <div>69.1</div>	<div></div> <div>78.2</div>	72.6		<div></div> <div>75.3</div>			
% [Age 5-17] Child Is Overweight or Obese	<div></div> <div>33.2</div>	<div></div> <div>32.6</div>	<div></div> <div>26.2</div>	<div></div> <div>25.0</div>	<div></div> <div>38.4</div>	<div></div> <div>29.3</div>	<div></div> <div>17.9</div>	<div></div> <div>31.9</div>	26.9		<div></div> <div>31.1</div>	<div></div> <div>30.2</div>		
% [Age 5-17] Child Is Obese	<div></div> <div>16.8</div>	<div></div> <div>23.4</div>	<div></div> <div>14.3</div>	<div></div> <div>11.6</div>	<div></div> <div>18.1</div>	<div></div> <div>15.7</div>	<div></div> <div>14.3</div>	<div></div> <div>19.5</div>	15.8		<div></div> <div>14.4</div>	<div></div> <div>14.6</div>	<div></div> <div>17.1</div>	
% [Parents] Have Been Told That Overwt Child [5-17] Is Overweight									14.2		<div></div> <div>16.3</div>	<div></div> <div>8.2</div>		
% [Overweight Kids 5-17] Perceive Child "About the Right Weight"									55.6		<div></div> <div>57.3</div>	<div></div> <div>54.3</div>		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					






Physical Activity	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	
% [Age 2-17] Child Was Physically Active One Hour/Day in Past Week	 60.2	 52.7	 45.8	 55.9	 60.6	 54.3	 48.1	 52.5	52.7		 43.2			
% [Age 2-17] Participates in Vigorous Physical Activity	 82.1	 60.9	 68.0	 73.1	 69.7	 71.4	 71.2	 67.5	70.9		 69.1		 71.3	
% [Age 2-17] Participates in Moderate Physical Activity	 60.3	 47.8	 54.4	 55.1	 63.7	 55.2	 51.8	 56.4	54.6		 49.3		 46.1	
% [Age 5-17] Child Watches 3+ Hours of TV per Day	 16.2	 27.4	 31.5	 23.1	 28.5	 24.3	 39.2	 41.1	29.6					
% [Age 5-17] Child Has a TV in Bedroom	 54.5	 40.6	 26.1	 26.6	 22.0	 36.0	 29.1	 50.2	36.0		 41.3			
% [Age 5-17] Child Has 3+ Hours of Electronic Use per Day	 28.8	 24.8	 30.5	 25.6	 14.1	 26.5	 24.0	 39.3	27.3					
% [Age 5-17] Has Computer/Device in the Bedroom	 43.2	 30.9	 42.7	 49.3	 42.1	 42.4	 45.6	 44.5	43.4		 39.4			
% [Age 5-17] Child Has 3+ Hours of Total Screen Time per Day	 59.7	 60.6	 58.6	 51.0	 54.7	 56.8	 68.8	 69.1	60.9		 63.8			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								 better  similar  worse					
























Oral Health	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 2-17] Child Has Had a Dental Visit in Past Year	<div> 83.6</div>	<div> 86.5</div>	<div> 88.8</div>	<div> 93.2</div>	<div> 84.5</div>	<div> 88.1</div>	<div> 89.1</div>	<div> 83.7</div>	87.8		<div> 84.9</div>	<div> 49.0</div>	<div> 96.0</div>	
% [Age 6-17] Child Has Had Dental Sealants	<div> 47.0</div>	<div> 44.4</div>	<div> 50.1</div>	<div> 60.4</div>	<div> 43.9</div>	<div> 50.9</div>	<div> 54.3</div>	<div> 56.0</div>	52.2		<div> 46.8</div>		<div> 53.3</div>	
% [Age 0-17] Child Has Had Fluoride Treatment	<div> 78.9</div>	<div> 66.9</div>	<div> 74.1</div>	<div> 87.1</div>	<div> 86.3</div>	<div> 78.3</div>	<div> 76.1</div>	<div> 82.6</div>	78.3					
% [Age 0-17] Has Private Dental Insurance	<div> 52.7</div>	<div> 46.0</div>	<div> 72.2</div>	<div> 72.5</div>	<div> 79.9</div>	<div> 62.7</div>	<div> 76.4</div>	<div> 57.2</div>	65.2				<div> 72.4</div>	
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

Prenatal & Infant Health	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% No Prenatal Care in First Trimester						 27.5	 21.8		26.2	 26.4	 23.5	 22.1	 29.6	
% of Low Birthweight Births						 7.5	 6.1		7.2	 6.6	 6.6	 8.0	 7.8	 7.6
Infant Death Rate						 5.5	 4.4	 5.4	5.3	 5.2	 4.8	 6.0	 6.0	 6.4
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					












Prenatal & Infant Health (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Was Ever Breastfed	 67.1	 79.0	 79.3	 77.6	 82.0	 76.3	 72.4	 71.1	74.8		 69.4	 81.9		
% Exclusively Breastfed Until 6 Months	 26.0	 31.4	 34.2	 34.4	 28.1	 31.5	 30.1	 25.9	30.6		 27.2	 25.5		
% Would Not Want New Baby to Have All Recommended Vaccines	 6.4	 3.8	 2.0	 7.7	 4.7	 5.2	 5.6	 5.4	5.3		 11.6			
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					








Sexual Activity	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
[All Ages] Gonorrhea Incidence per 100,000						 149.9	 43.1	 101.6	119.1	 77.0	 65.5	 107.5		
[All Ages] Chlamydia Incidence per 100,000						 588.3	 326.0	 425.6	505.0	 366.2	 371.5	 456.7		
% Births to Teenagers (Under Age 20)						 6.3	 4.0		5.6	 6.4	 6.5	 7.8	 8.2	
% [High Schoolers] Currently Sexually Active (Douglas County)									25.9			 34.0		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					


































Sexual Activity (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Sexually Active High Schoolers] Did Not Use Condom (Douglas County)									41.4			40.9		
% [Sexually Active High Schoolers] Did Not Use Any Birth Control (Douglas County)									19.1			13.7		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					
































Tobacco	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Household Member Smokes Inside the Home	<div> 6.0</div>	<div> 5.2</div>	<div> 3.2</div>	<div> 0.0</div>	<div> 3.7</div>	<div> 3.4</div>	<div> 1.9</div>	<div> 3.5</div>	3.1	<div> 3.7</div>			<div> 4.3</div>	
% [Age 0-17] Household Member Smokes Outside the Home	<div> 32.4</div>	<div> 27.5</div>	<div> 13.5</div>	<div> 11.6</div>	<div> 18.7</div>	<div> 20.6</div>	<div> 20.9</div>	<div> 23.7</div>	21.0				<div> 23.2</div>	
% [High Schoolers] Smoked Cigarettes in Past Month (Douglas County)									13.1	<div> 15.7</div>				
	Note: In the green section, each county is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div><div> better</div><div> similar</div><div> worse</div></div>					


































Substance Abuse	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	
% [High Schoolers] Drank Alcohol in Past Month (Douglas County)									27.4			34.9		
% [High Schoolers] Drove When Drinking in Past Month (Douglas County)									13.3			10.0		
% [High Schoolers] Used Marijuana in Past Month (Douglas County)									19.5			23.4		
% [High Schoolers] Ever Used Marijuana (Douglas County)									32.9			40.7		
% [High Schoolers] Ever Used Prescription Drugs (Not Rx) (Douglas County)									15.5			17.8		
% [High Schoolers] Ever Used Inhalants (Douglas County)									7.5			8.9		
% [High Schoolers] Ever Used Ecstasy (Douglas County)									6.1			6.6		
% [High Schoolers] Ever Used Cocaine (Any Form) (Douglas County)									6.2			5.5		
	Note: In the green section, each county is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

Substance Abuse (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	
% [High Schoolers] Ever Used Steroids (Not Rx) (Douglas County)									3.1			3.2		
% [High Schoolers] Ever Used Methamphetamines (Douglas County)									4.6			3.2		
% [High Schoolers] Ever Used Heroin (Douglas County)									2.4			2.2		
% [High Schoolers] Ever Used Injection Drugs (Douglas County)									3.9			1.7		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

Vision, Hearing & Speech	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Has Vision Problems	<div> 4.2</div>	<div> 3.0</div>	<div> 4.2</div>	<div> 2.0</div>	<div> 6.2</div>	<div> 3.5</div>	<div> 5.3</div>	<div> 2.8</div>	3.8		<div> 2.5</div>		<div> 3.1</div>	
% [Age 0-17] Child Has Hearing Problems	<div> 3.9</div>	<div> 9.3</div>	<div> 4.0</div>	<div> 7.7</div>	<div> 5.6</div>	<div> 6.2</div>	<div> 5.6</div>	<div> 2.5</div>	5.7		<div> 4.9</div>		<div> 3.5</div>	
% [Age 0-17] Child Has Speech/Language Problems	<div> 24.7</div>	<div> 6.7</div>	<div> 12.8</div>	<div> 12.3</div>	<div> 13.4</div>	<div> 14.1</div>	<div> 12.3</div>	<div> 17.4</div>	14.1		<div> 11.9</div>		<div> 10.8</div>	
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div><div> better</div><div> similar</div><div> worse</div></div>					

Vision, Hearing & Speech (continued)	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% [Age 0-17] Child Has Had 3+ Ear Infections (Ever)	<div> 29.0</div>	<div> 20.7</div>	<div> 33.4</div>	<div> 32.3</div>	<div> 28.1</div>	<div> 29.0</div>	<div> 30.4</div>	<div> 23.8</div>	28.7		<div> 23.5</div>			
% [Age 0-17] Child Has Had an Eye Exam in the Past 3 Years	<div> 82.6</div>	<div> 76.9</div>	<div> 89.5</div>	<div> 84.9</div>	<div> 84.2</div>	<div> 83.6</div>	<div> 85.6</div>	<div> 83.5</div>	84.0		<div> 78.8</div>			
% [Age 0-17] Child Has Had Hearing Tested in the Past 5 Years	<div> 78.8</div>	<div> 82.3</div>	<div> 91.3</div>	<div> 93.0</div>	<div> 79.5</div>	<div> 86.4</div>	<div> 92.3</div>	<div> 87.8</div>	87.8		<div> 84.9</div>	<div> 72.1</div>		
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div><div> better</div><div> similar</div><div> worse</div></div>					

Technology Access	Each Subarea vs. Other Subareas Combined								Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2020	TREND
% Have a Cell Phone for Personal Use	 88.9	 76.3	 93.3	 96.0	 93.7	 89.5	 97.0	 89.2	91.2	 91.5				
% [Age 5-17] Child Has Own Cell Phone	 31.6	 23.6	 40.9	 42.0	 32.2	 34.9	 43.5	 41.5	37.6	 43.0				
% Have Access to the Internet	 94.3	 88.4	 97.4	 98.2	 100.0	 94.9	 100.0	 98.4	96.3	 97.2			 93.7	
	Note: In the green section, each county is compared against all other counties combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.								<div> better</div> <div> similar</div> <div> worse</div>					

# Perceptions of Health Issues



**Professional Research Consultants, Inc.**

## Child Health

### Perceived Top Health Issues

The interrelated issues of **obesity, nutrition and exercise** received the largest share of responses (37.2%) as the perceived number-one health issue for children under the age of 12 among parents of children in that age group.

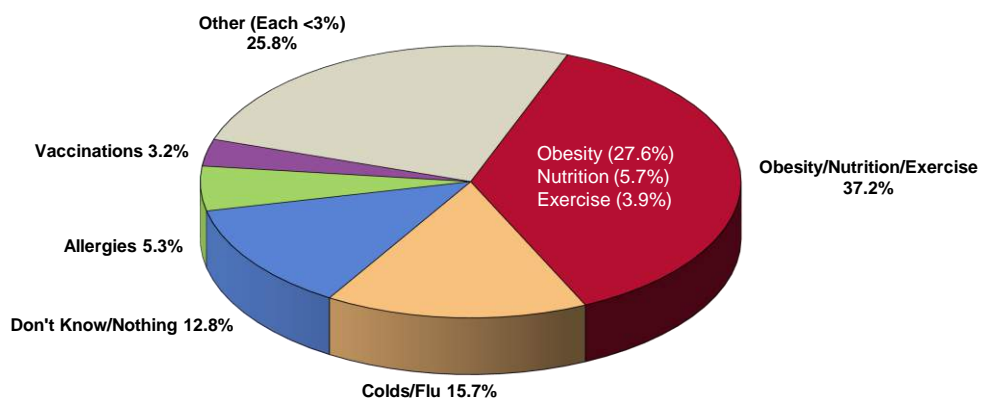
- Respondents also frequently identified colds/flu (15.7%), allergies (5.3%) and vaccinations (3.2%).

The initial inquiry of the PRC Child & Adolescent Health Survey asked respondents the following:

"In general, what do you feel is the number-one health issue affecting children under the age of 12 in your community today?"

This question was open-ended, meaning that respondents were free to mention whatever came to mind, and their verbatim responses were recorded. These responses were then grouped thematically for reporting here.

**Perceived Number-One Health Issue Affecting Children Under 12 in the Community**  
(Among Metro Area Parents With a Child Age 0-11, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 7]  
Notes: • Reflects respondents with a child under age 12 in the household.

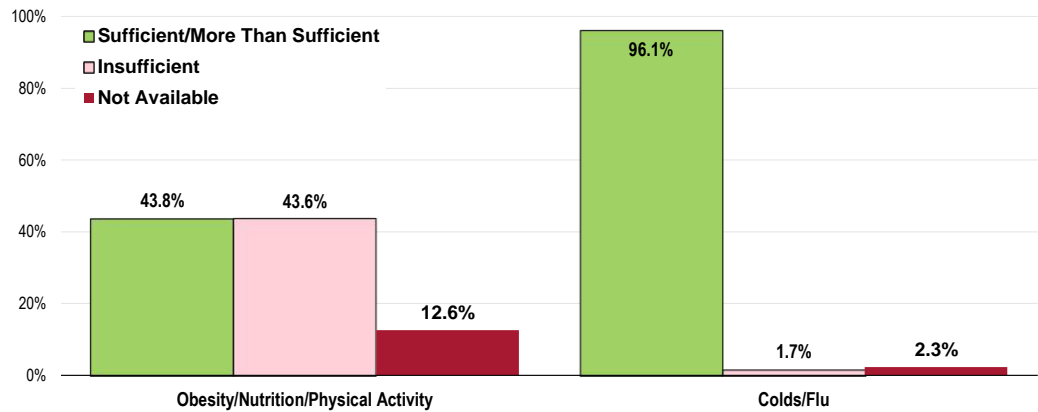
## Perceived Availability of Resources

Respondents were further asked to identify their perceptions of the availability of resources in the community to address that issue that they identified as the number-one concern.

**Those who mentioned obesity, nutrition or physical activity as the top children's health issue mostly see community resources as insufficient (or non-existent) to address these problems.**

**An overwhelming majority of those who mentioned cold/flu think the community resources directed at the issue are sufficient.**

**Perception of Existing Community Resources or Services for Number-One Health Issue Affecting Children Under 12**  
(By Perceived Primary Health Issue; Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 8]  
Notes: • Among respondents with children under age 12 who identified a top health concern.

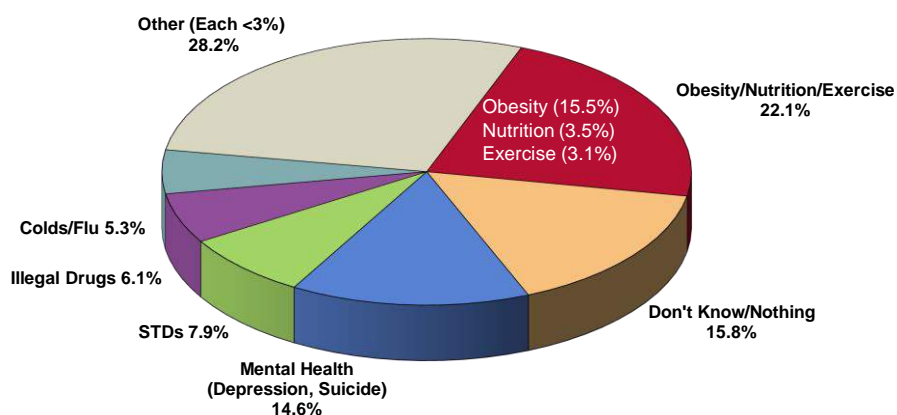
## Adolescent Health

### Perceived Top Health Issues

Combined, obesity, nutrition and physical activity received the largest share of responses (22.1%) when parents of children age 12-17 were asked to name the number-one health issue for adolescents.

- Other frequent responses included **mental health** (mentioned by 14.6%), **sexually transmitted diseases** (7.9%), **illegal drugs** (6.1%), and **colds/flu** (5.3%).

**Perceived Number-One Health Issue  
Affecting Adolescents (12-17) in the Community**  
(Among Metro Area Parents With an Adolescent Age 12-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 9]  
Notes: • Reflects respondents with an adolescent age 12-17 in the household.

## Perceived Availability of Resources

Respondents were further asked to identify their perceptions of the availability of resources in the community to address that issue that they identified as the number-one concern.

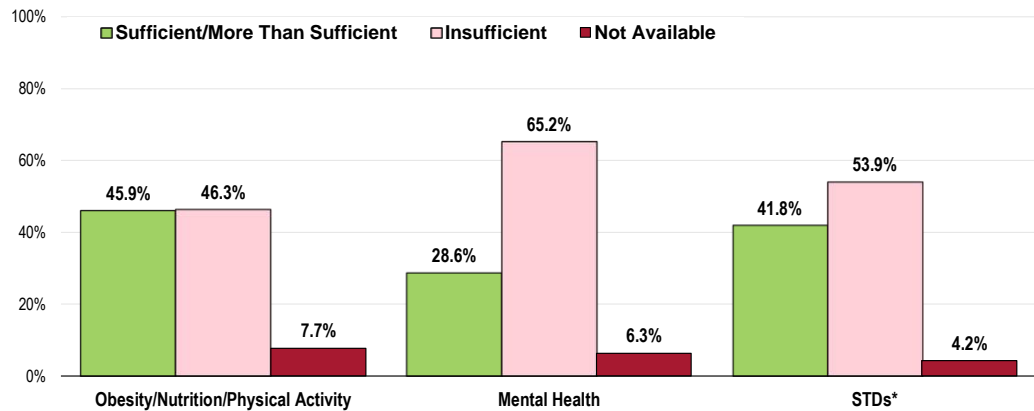
**A majority of those identifying obesity/nutrition/physical activity as their top concerns for adolescents view community resources as insufficient (or nonexistent) to address these needs.**

**Those seeing mental health as a top concern for adolescents, largely find community resources insufficient (or nonexistent) to undertake the issue.**

Although based on a relatively small sample, findings suggest the same for those identifying **STDs** as their top concerns.

### Perception of Existing Community Resources or Services for Number-One Health Issue Affecting Adolescents

(By Perceived Primary Health Issue; Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 10]  
Notes: • Among respondents with children age 12-17 who identified a top health concern.  
• \*Note that these responses are based on a relatively small sample size (n<50).



## Health Status



**Professional Research Consultants, Inc.**

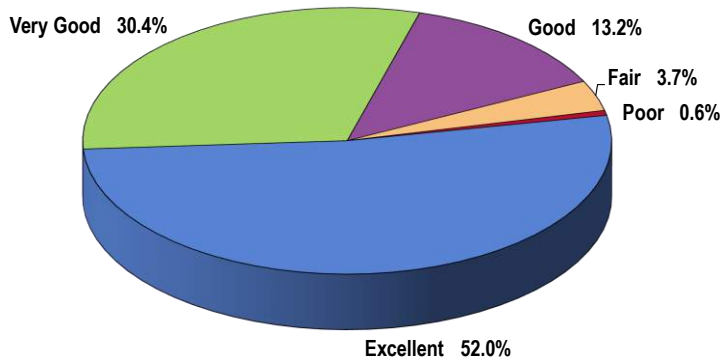
## Overall Health Status

### Evaluations of Child's Overall Health

A large percentage of Metro Area parents rate their child's overall health as "excellent" (52.0%) or "very good" (30.4%).

- Another 13.2% gave "good" ratings of their child's overall health.

**Child's Health Status**  
(Metro Area, 2015)

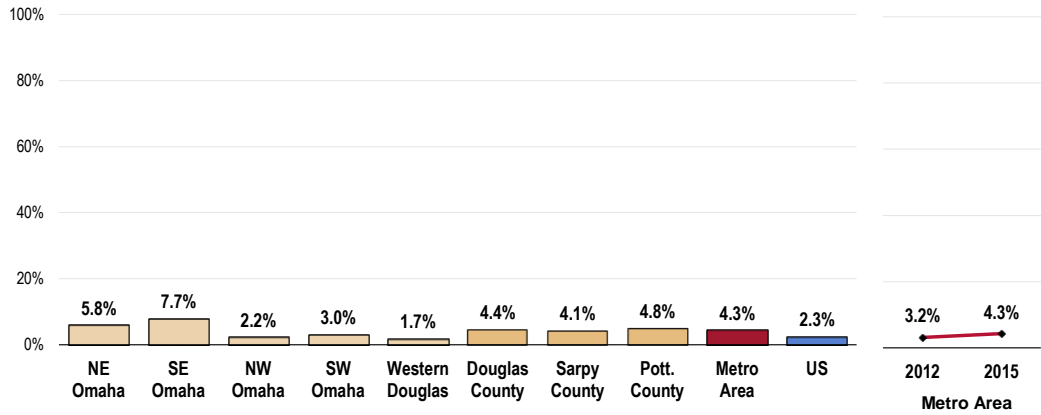


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 18]  
Notes: • Asked of all respondents about a randomly selected child in the household.

However, 4.3% of Metro Area adults believe that their child's overall health is "fair" or "poor."

- Higher than found nationwide.
- In Douglas County, highest (least favorable) in Southeast Omaha.
- No significant difference among Douglas, Sarpy, and Pottawattamie counties.
- TREND: Marks a statistically significant increase when comparing "fair/poor" overall health reports to previous survey results (health has worsened since 2012).

## Child Experiences “Fair” or “Poor” Overall Health

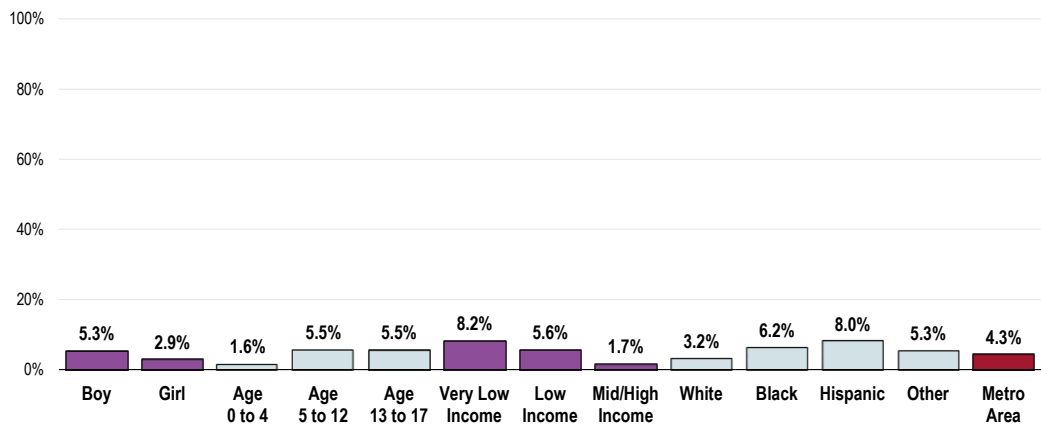


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 18]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

- When viewed by children’s basic demographic characteristics, children over age 4 are more likely to have fair/poor health as are those from very low income households when compared with children of mid/high income households (negative correlation with income).

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by gender, age groupings, household income (based on poverty status), and child’s race/ethnicity.

## Experience “Fair” or “Poor” Overall Health (Metro Area, 2015)



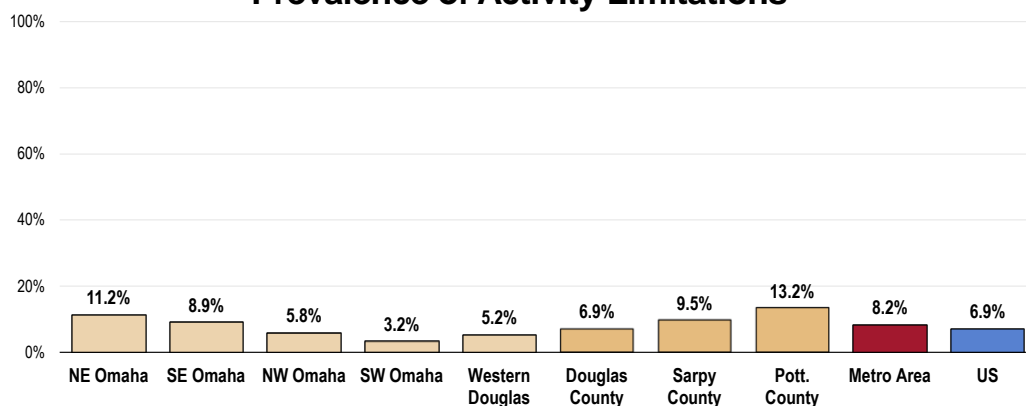
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 18]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

## Activity Limitations

A total of 8.2% of Metro Area children are limited or prevented in some way in their ability to do things most children of the same age can do because of a medical, behavioral, or other health condition.

- Similar to the US prevalence.
- In Douglas County, lowest in Southwest Omaha and highest in Northeast Omaha.
- No statistical difference by county.

### Prevalence of Activity Limitations

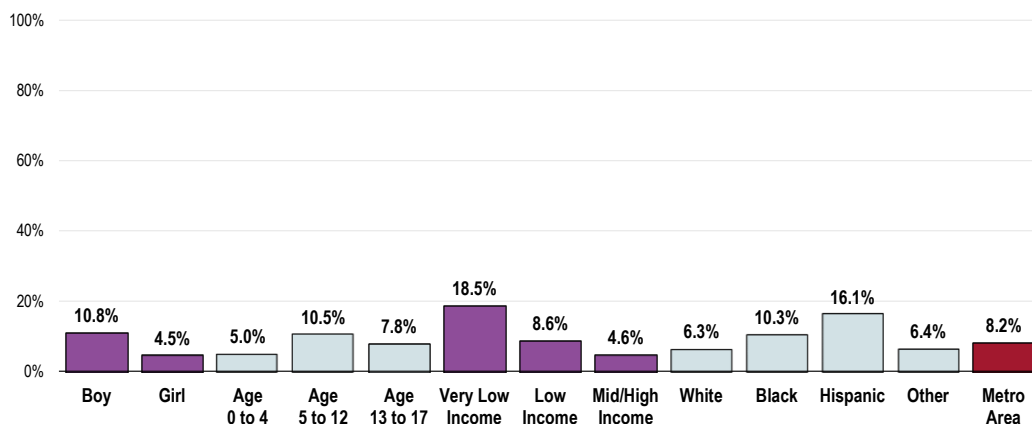


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 75]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Note that the following groups of children report a significantly higher prevalence of activity limitations:

- Boys.
- Those age 5 to 12 when compared to their younger counterparts.
- Children in very low income households (negative correlation with income).
- Hispanics when compared with Whites and "Other" races.

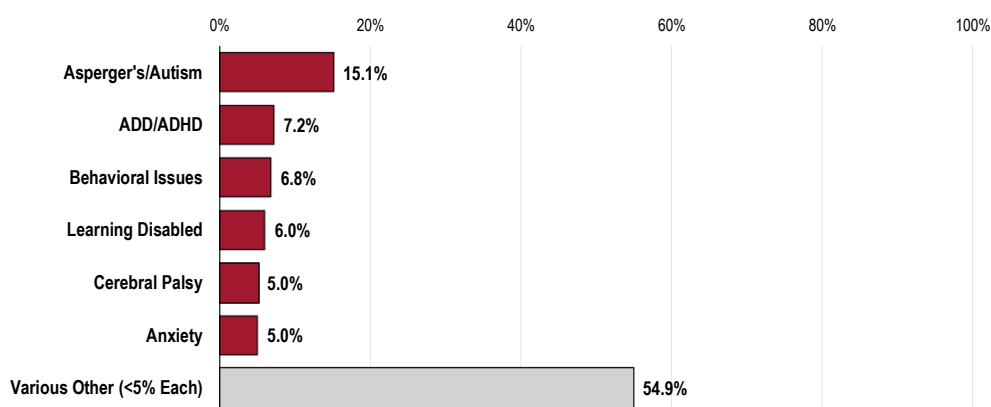
## Prevalence of Activity Limitations (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 75]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity limitations among Metro Area children are most often attributed to conditions such as **Asperger's syndrome/autism** (mentioned by 15.1% of parents of children with activity limitations), **ADD/ADHD** (7.2%), **behavioral issues** (6.8%), **learning disabilities** (6.0%), **cerebral palsy** (5.0%), and **anxiety** (5.0%).

## Type of Problem That Limits Activities (Among Those Reporting Activity Limitations; Metro Area Children, 2015)



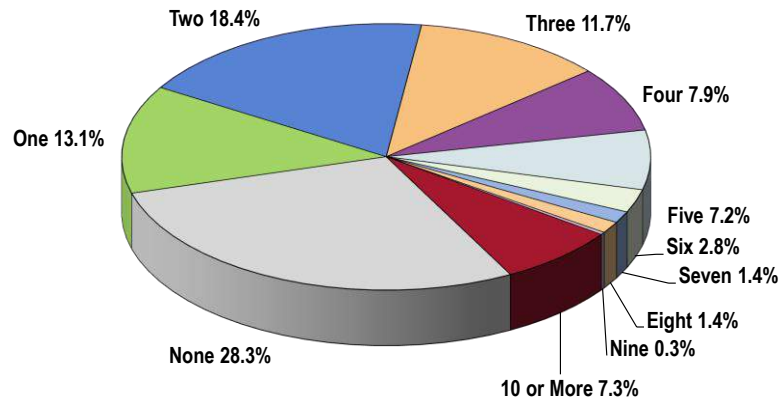
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 77]  
Notes: • Asked of respondents for whom the randomly selected child in the household has some type of activity limitation.

“During the past 12 months, about how many times did this child miss school because of illness or injury?”

## School Days Missed Due to Illness or Injury

While most Metro Area school-age children (age 5-17) missed fewer than three school days in the past year due to illness or injury, 7.3% are reported to have missed 10 or more.

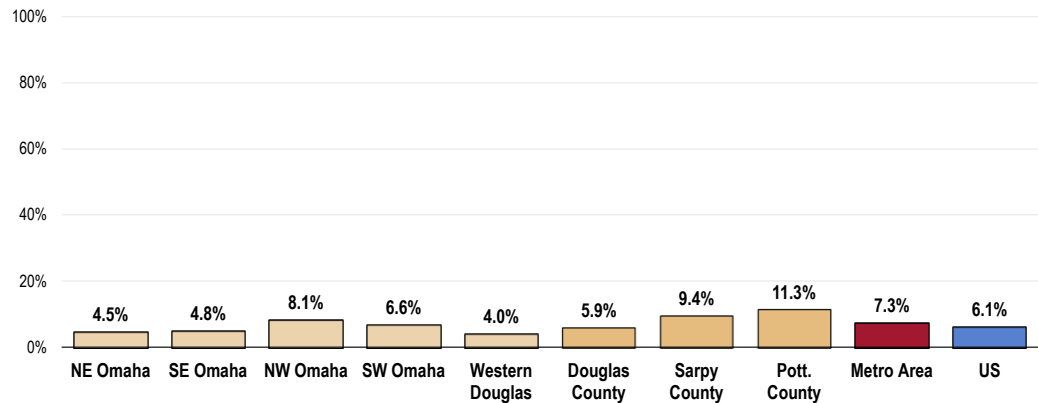
**Number of School Days Missed in the Past Year Due to Illness or Injury**  
(Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 111]  
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.

- Similar to national findings.
- The prevalence of school-age children who missed 10 or more days of school is not statistically different within Douglas County or among the three counties.
- TREND: Note that this inquiry was not addressed in the 2012 survey.

**Child Missed 10+ School Days in the Past Year Due to Illness or Injury**  
(Metro Area Children Age 5-17, 2015)

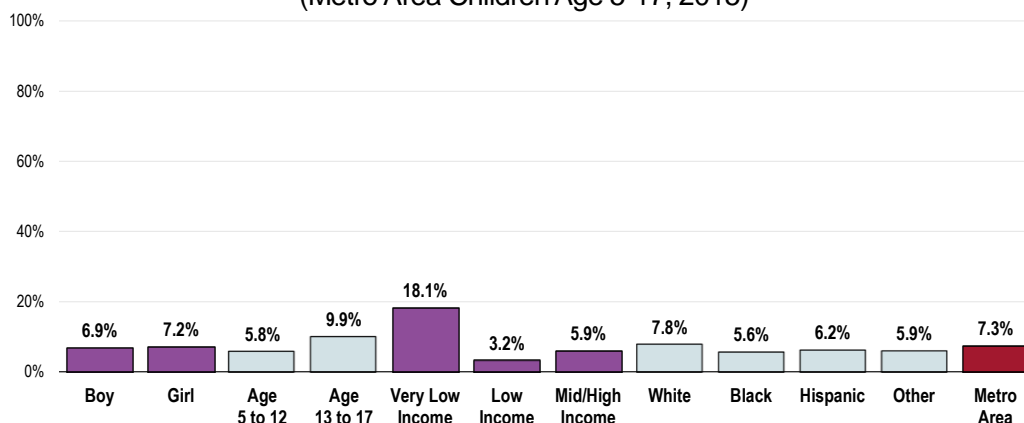


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 111]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.

When viewed by children's demographic characteristics:

- Teens miss more school days for illness/injury than younger children.
- Children in very low income households are more likely to have missed 10 or more school days than those in higher income families.

### Child Missed 10+ School Days in the Past Year Due to Illness or Injury (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 111]

Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Mental Health

### About Mental Health & Mental Disorders

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant girls and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Evaluation of Child's Mental Health

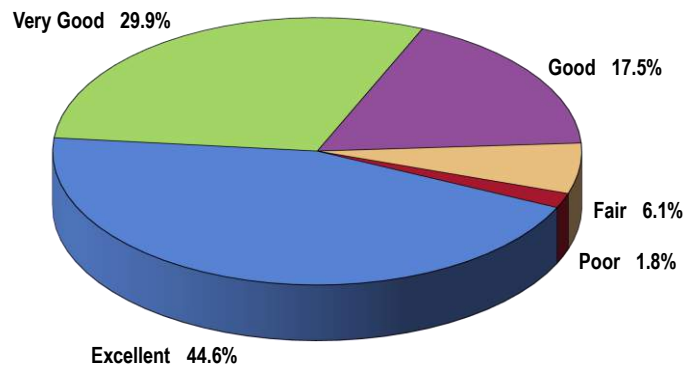
Nearly three-fourths of Metro Area parents with children age 5-17 rate their child's mental health — which includes stress, depression, and problems with emotions — as “excellent” (44.6%) or “very good” (29.9%).

- Another 17.5% gave “good” ratings of their child's mental health status.

“Now thinking about your child's mental health, which includes stress, depression and problems with emotions, would you say that, in general, your child's mental health is: excellent, very good, good, fair or poor?”



## Child's Mental Health Status (Metro Area Children Age 5-17, 2015)

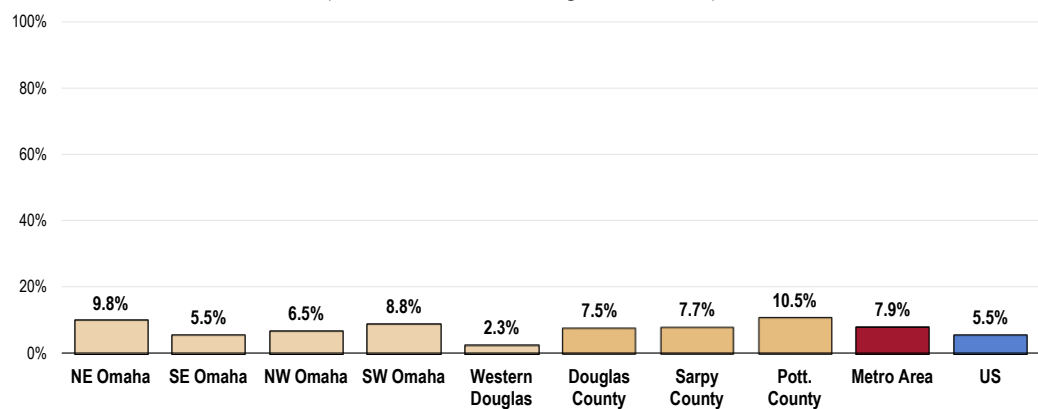


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 90]  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

**However, 7.9% of Metro Area parents believe that their school-age child's mental health is "fair" or "poor."**

- Statistically comparable to US mental health reports.
- In Douglas, most favorable in Western Douglas.
- Statistically comparable among the three Metro Area counties.

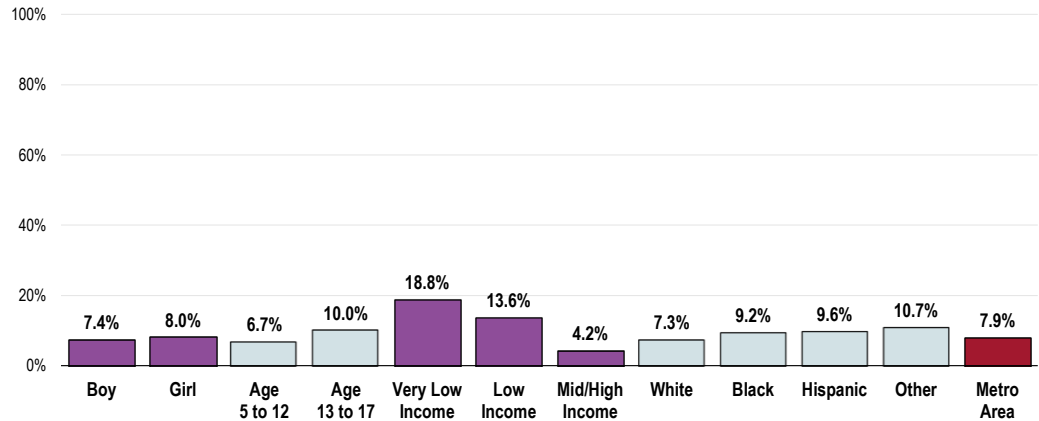
## Child Experiences "Fair" or "Poor" Mental Health (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 90]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- “Fair/poor” mental health status among children age 5-17 is more often noted for children in lower-income households (negative correlation with income).

### Child Experiences “Fair” or “Poor” Mental Health (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 90]  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

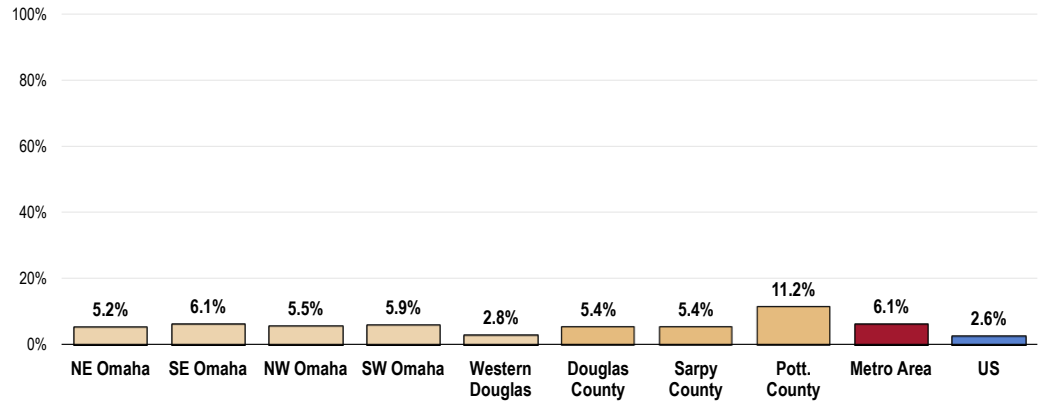
## Depression

### Prevalence of Diagnosed Depression

A total of 6.1% of Metro Area parents report that they have been told by a doctor or other healthcare provider that their school-age child had depression.

- Higher than seen nationwide.
- Statistically similar within Douglas County.
- Statistically similar by county.

## Child Has Been Diagnosed with Depression (Metro Area Children Age 5-17, 2015)

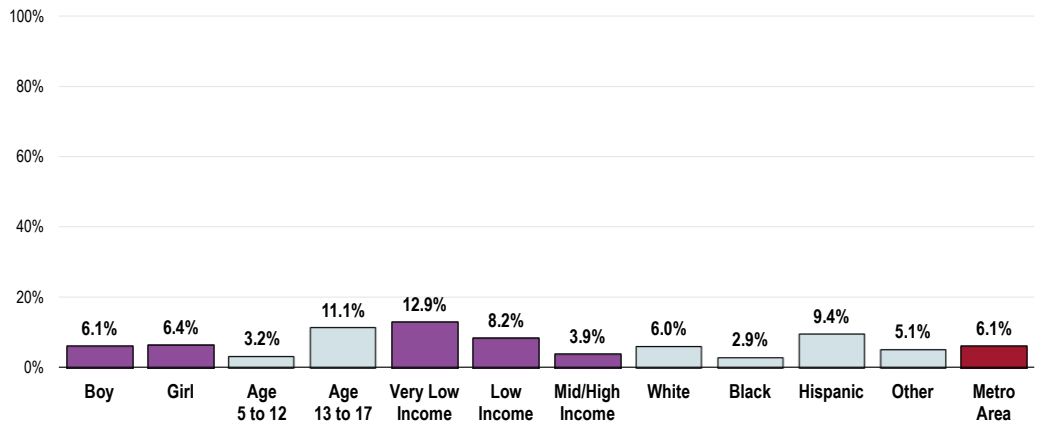


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 99]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- Teens are statistically more likely to have diagnosed depression, as are those in very low income households when compared with those from mid/high income families (negative correlation with income).

## Child Has Been Diagnosed with Depression (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 99]

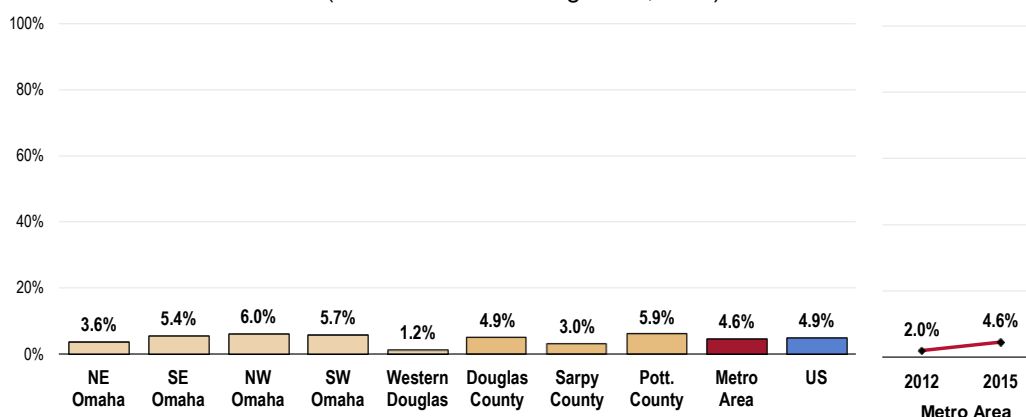
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Signs of Depression

A total of 4.6% of Metro Area parents indicate that their school-age child felt so sad or hopeless almost every day for two weeks or more in the past year that he/she stopped doing some usual activities.

- Close to the US proportion.
- In Douglas County, lowest in Western Douglas.
- No significant difference by county.
- TREND: Denotes a statistically significant increase in depression symptoms since 2012.

### Child Felt Sad or Hopeless for Two or More Weeks in the Past Year and Stopped Performing Usual Activities (Metro Area Children Age 5-17, 2015)

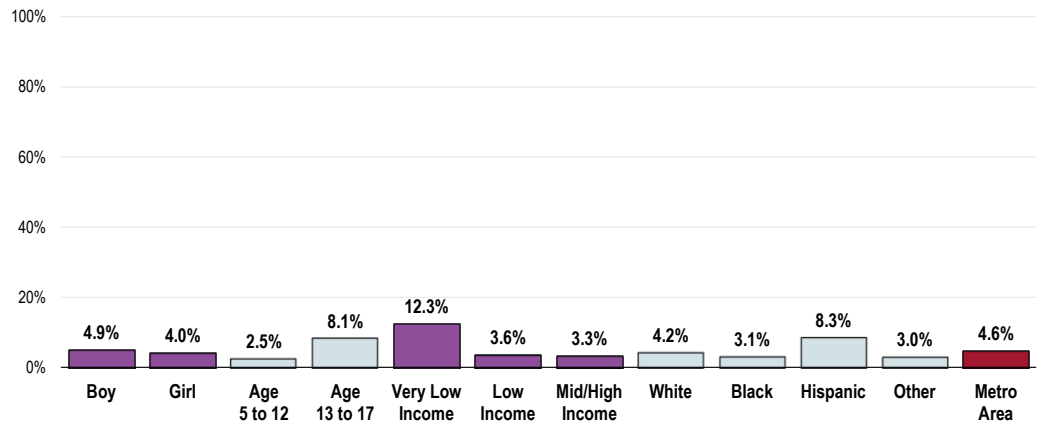


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 97]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Such signs of depression are notably higher among:

- Teens.
- Children living in very low income households.

### Child Felt Sad or Hopeless for Two or More Weeks in the Past Year and Stopped Performing Usual Activities (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 97]  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Further note that, of the 36 surveyed parents reporting signs of depression in their child, just 62.4% sought treatment for their child's feelings of sadness or hopelessness; nearly 40% did not.

## Suicide Attempts (Adolescents)

Among high school students (Douglas County only), 15.7% report attempting suicide in the past year (2014 Youth Risk Behavior Survey).

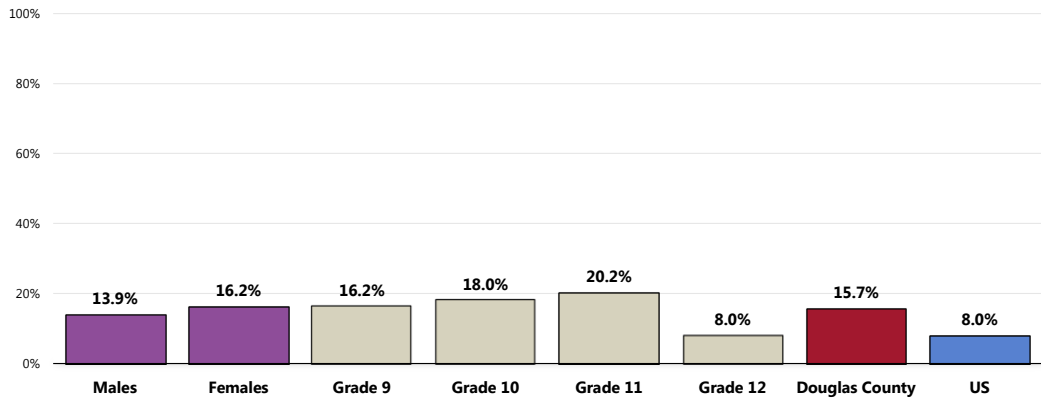
- Less favorable than national YRBS findings.
- No difference in suicide attempts by gender.
- 11th graders are more likely to have attempted suicide than 12th graders.

This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students.

For more information, visit:  
[www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs).

### Attempted Suicide in the Past Year

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2014)



Sources:

- Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.
- Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.

Notes:

- Attempted suicide one or more times during the 12 months before the survey.

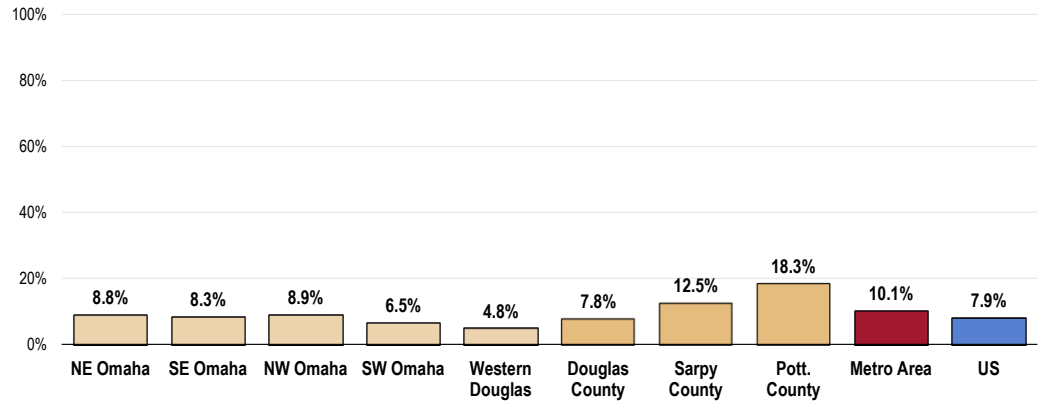
## Anxiety

### Prevalence of Anxiety Disorders

A total of 10.1% of Metro Area parents report that they have been told by a doctor or other healthcare provider that their school-age child had anxiety.

- Comparable to the US results.
- Statistically comparable among the sub-areas of Douglas County.
- By county, lowest in Douglas County; highest in Pottawattamie County.

## Child Has Been Diagnosed with Anxiety (Metro Area Children Age 5-17, 2015)



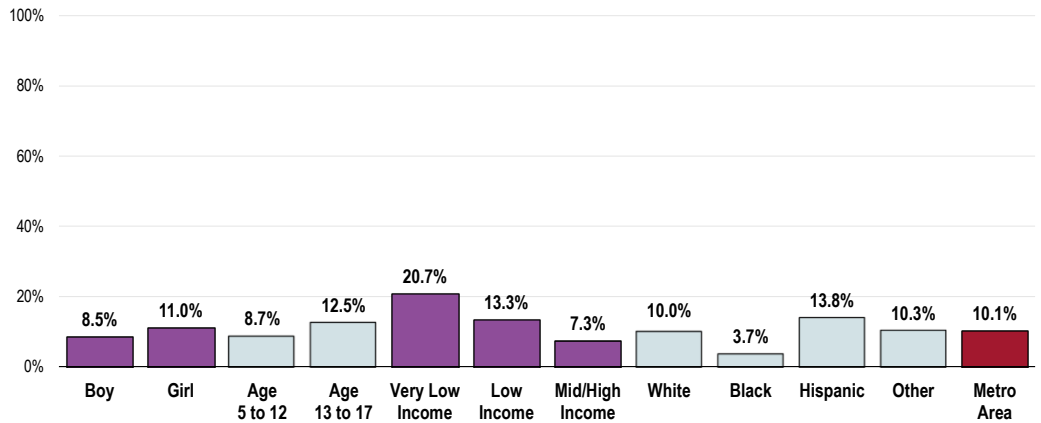
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 105]

• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- Note the negative correlation between income and anxiety.
- By race/ethnicity: Black children are much less likely to have been diagnosed with anxiety.

## Child Has Been Diagnosed with Anxiety (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 105]

Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

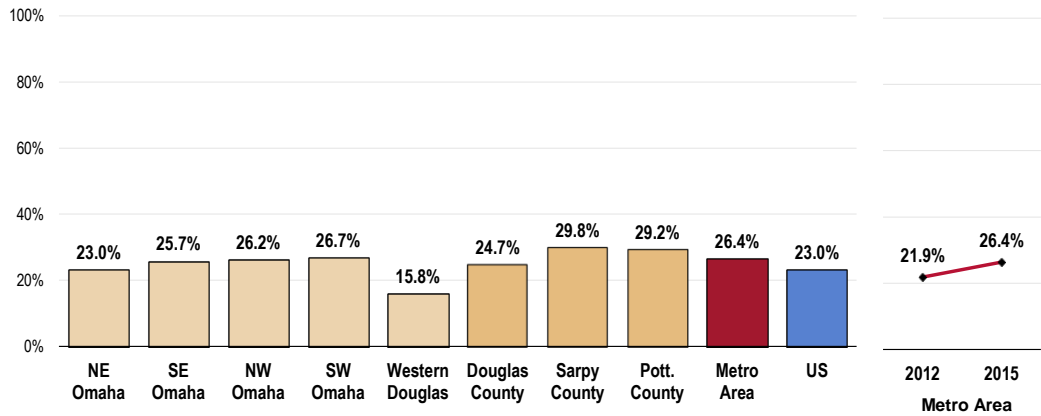
## Worry

"Would you say that this child worries a lot?"

**More than 1 in 4 Metro Area parents (26.4%) indicate that their school-age child worries a lot.**

- Statistically similar to US findings.
- Statistically similar within Douglas County.
- No significant difference by county.
- TREND: Worrying in children has become more common in the past three years.

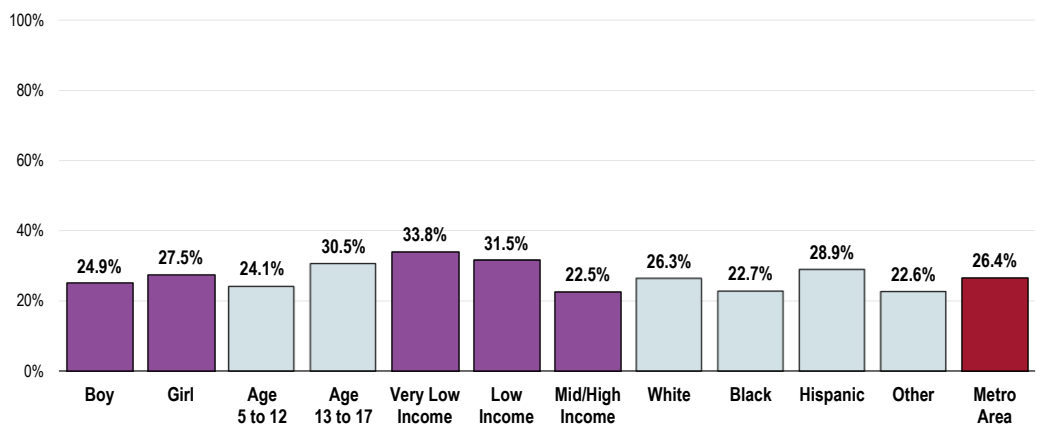
**Child Worries a Lot**  
(Metro Area Children Age 5-17, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 95]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- Frequent worry is more often noted among teenagers.

**Child Worries a Lot**  
(Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 95]  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

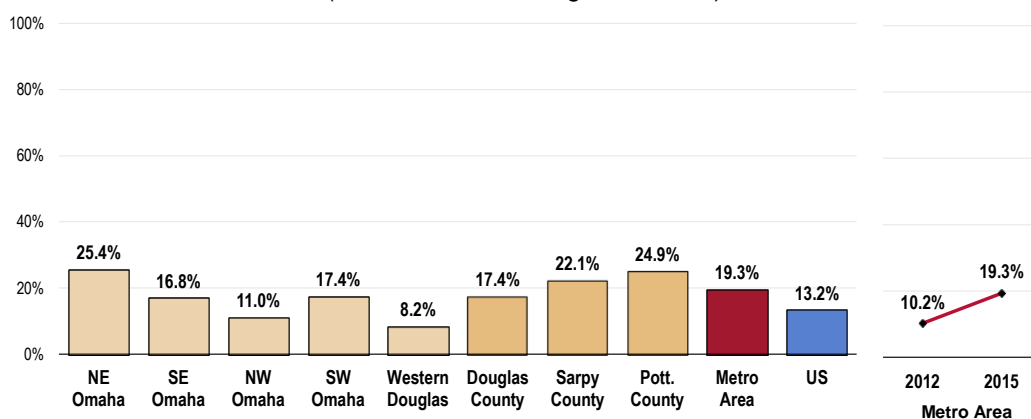


## Sleep Difficulties

A total of 19.3% of Metro Area parents indicate that their school-age child has difficulty falling asleep and/or sleeping through the night.

- Higher than national results.
- In Douglas County, highest in Northeast Omaha; lowest in Northwest Omaha and Western Douglas.
- No statistically significant difference when viewed by county.
- TREND: Since 2012, children experiencing sleep difficulties have significantly increased.

### Child Has Difficulties Falling Asleep and/or Sleeping Through the Night (Metro Area Children Age 5-17, 2015)



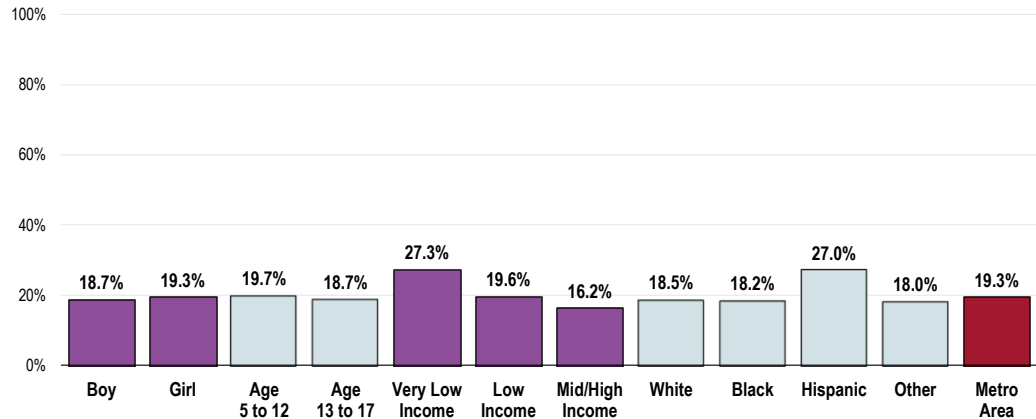
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 96]

• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- Although there appears to be a correlation with income, the differences below are not statistically significant.

### Child Has Difficulties Falling Asleep and/or Sleeping Through the Night (Metro Area Children Age 5-17, 2015)



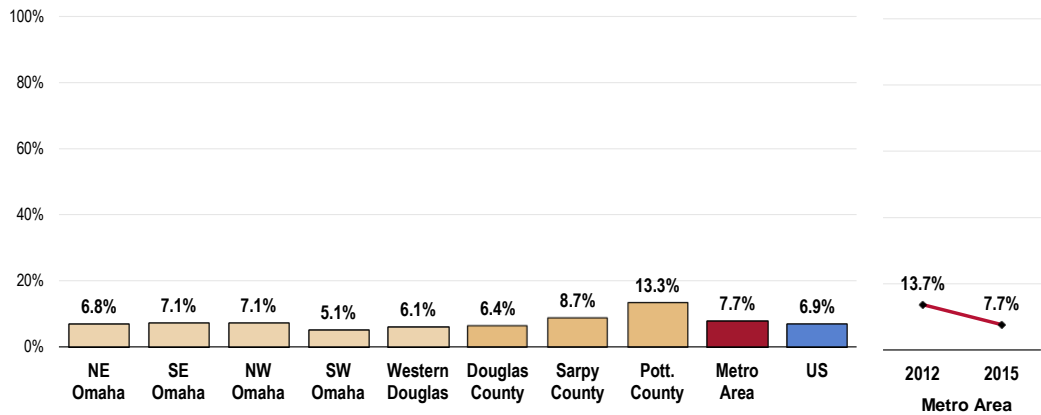
- Sources:
- 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 96]
- Notes:
- Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Prescriptions for Mental Health

A total of 7.7% of Metro Area parents report that their child (age 5-17) has ever taken prescribed medication for their mental health.

- Similar to the proportion of children across the nation.
- Similar among the areas of Douglas County.
- No statistical difference among Metro Area counties.
- TREND: A significant decrease in the prescribing of mental health drugs for children has occurred in the Metro Area in recent years.

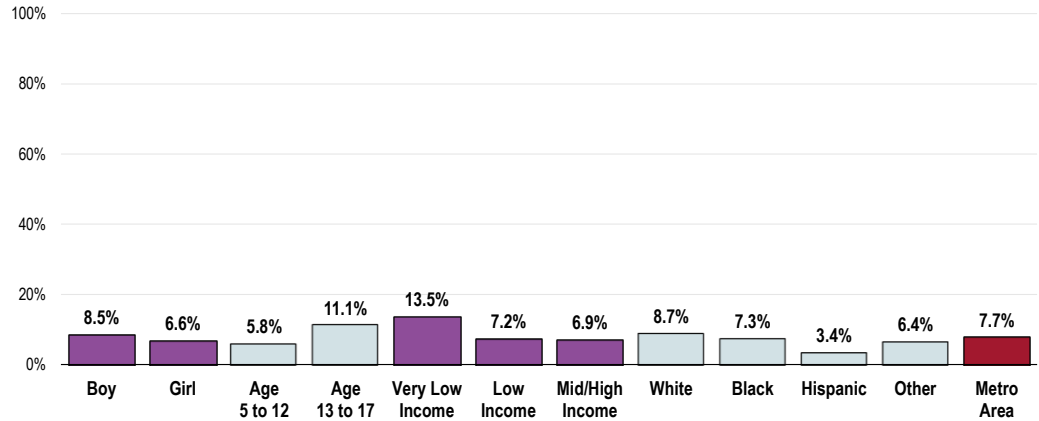
### Child Has Ever Taken Prescription Medication for Mental Health (Metro Area Children Age 5-17, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 94]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- Metro Area teenagers and White children are more likely to have taken prescription medication for their mental health than their demographic counterparts.

## Child Has Ever Taken Prescription Medication for Mental Health (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

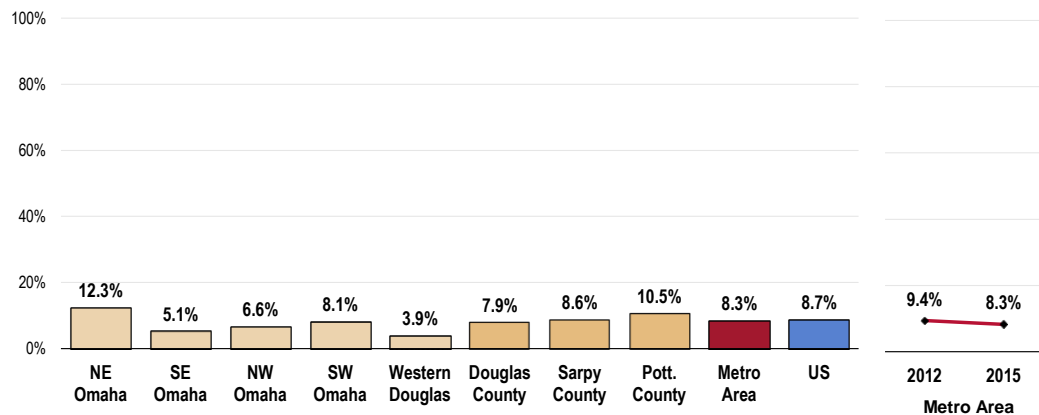
## Cognitive & Behavioral Disorders

### Prevalence of Attention Deficit Hyperactivity Disorder (ADHD)

A total of 8.3% of Metro Area children are reported to have ever suffered from or been diagnosed with ADHD (also sometimes referred to as attention deficit disorder, or ADD).

- Similar to the national prevalence.
- In Douglas County, unfavorably high in Northeast Omaha.
- Similar by county.
- TREND: No statistically significant change has occurred since 2012.

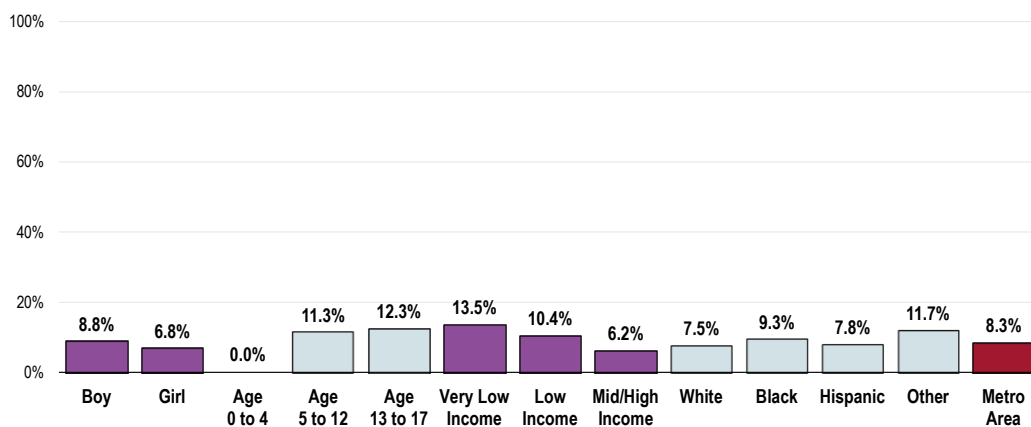
## Child Has ADD/ADHD (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 71]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- Metro Area children above age 4 are more likely to have suffered from/been diagnosed with ADD/ADHD.

### Child Has ADD/ADHD (Metro Area, 2015)



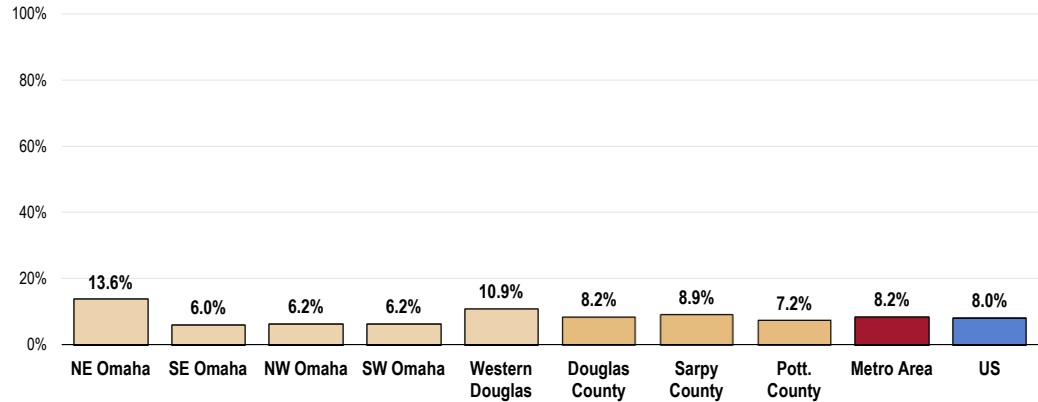
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 71]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Prevalence of Learning Disabilities

**A total of 8.2% of Metro Area children are reported to have some type of learning disability.**

- Nearly identical to the US prevalence.
- Highest in the Northeastern Omaha portion of Douglas County.
- The Metro Area counties show comparable findings.

## Child Has a Learning Disability (Metro Area, 2015)

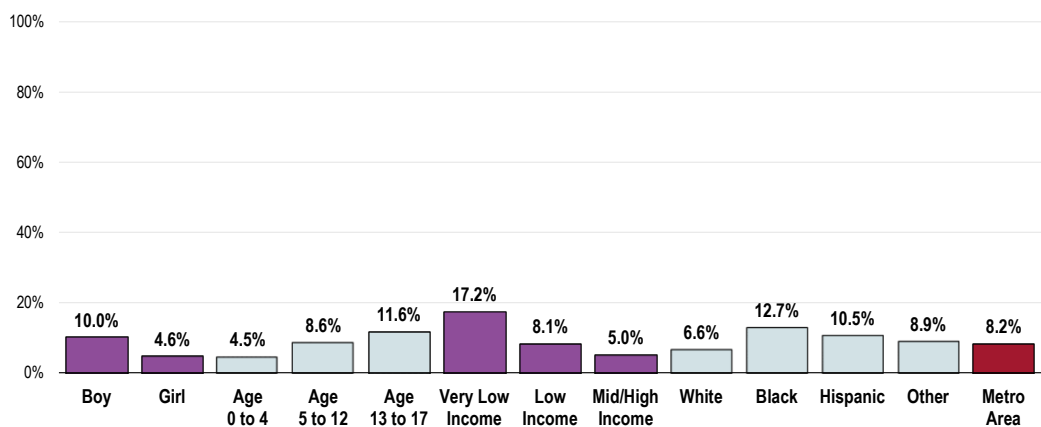


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 65]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Metro Area children more likely to have some type of learning disability include:

- Boys.
- Teenagers when compared with children under age 5 (note the positive correlation with age).
- Those in very low income households when compared with those in mid/high income households (note the negative correlation with income).

## Child Has a Learning Disability (Metro Area, 2015)



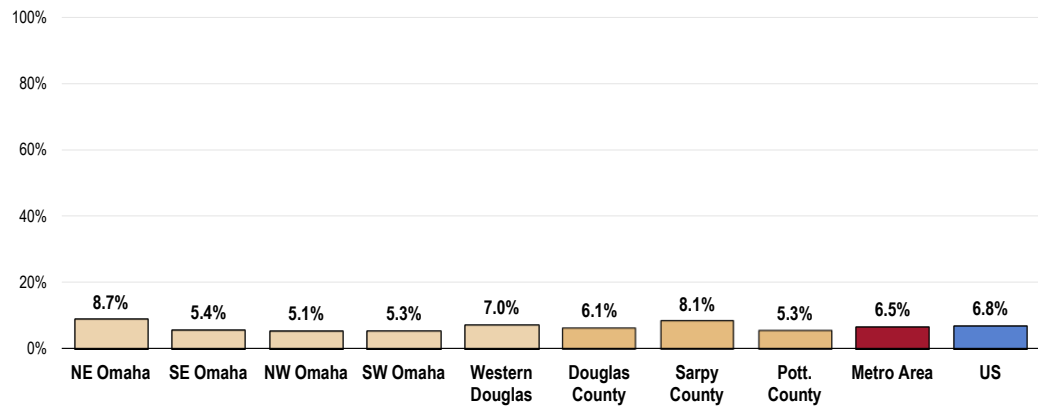
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 65]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Prevalence of Developmental Delays

A total of 6.5% of Metro Area children have been diagnosed with some type of developmental delay that affects his/her ability to learn.

- Similar to national findings.
- Statistically similar findings by area of Douglas County.
- Statistically similar by county.

### Child Has a Developmental Delay (Metro Area, 2015)

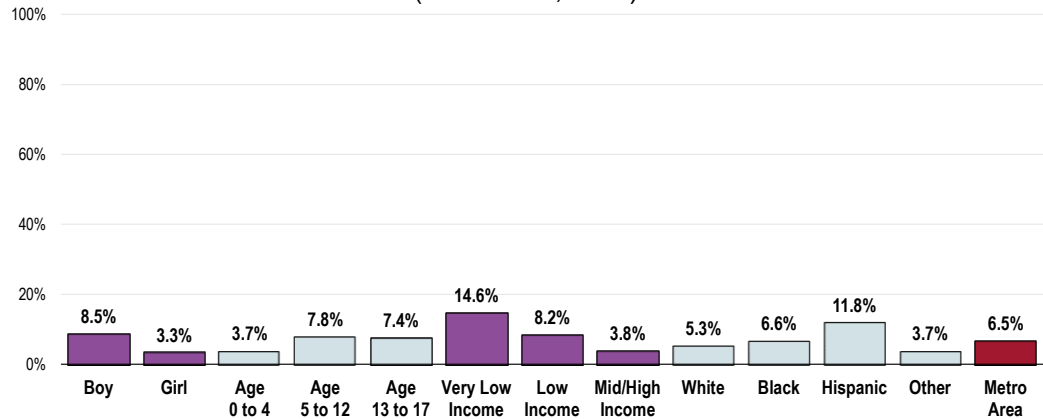


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 67]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

Children more likely to have developmental delays include:

- Boys.
- Children age 5 to 12 when compared to their younger counterparts.
- Those in very low income households when compared with those in mid/high income households (note the negative correlation with income).
- Hispanic children when compared with White children and "Other" race children.

## Child Has a Developmental Delay (Metro Area, 2015)



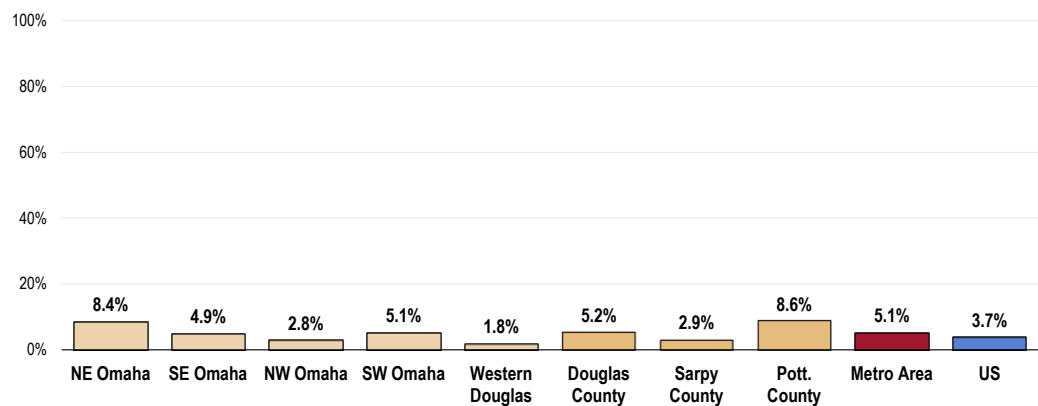
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 67]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Prevalence of Behavioral/Conduct Disorders

Among Metro Area parents of children age 5-17, 5.1% indicate that a doctor or other healthcare provider has ever told them that their child has some type of behavioral or conduct disorder, such as oppositional defiant disorder or conduct disorder.

- Statistically similar to the prevalence nationwide.
- Within Douglas County, no statistical difference.
- Statistically similar by county.

## Child Has a Behavioral/Conduct Disorder (Metro Area Children Age 5-17, 2015)



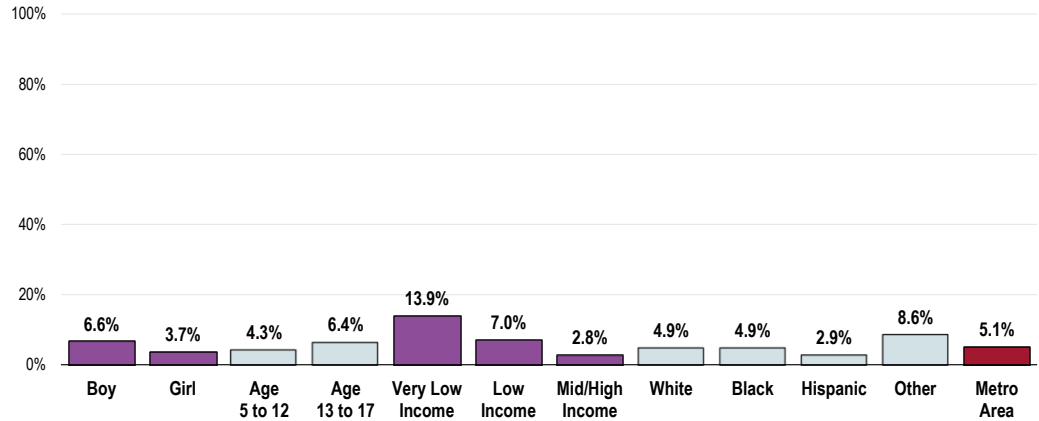
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 101]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- Note the negative correlation between income and behavioral/conduct disorders



among Metro Area school-aged children.

### Child Has a Behavioral/Conduct Disorder (Metro Area Children Age 5-17, 2015)



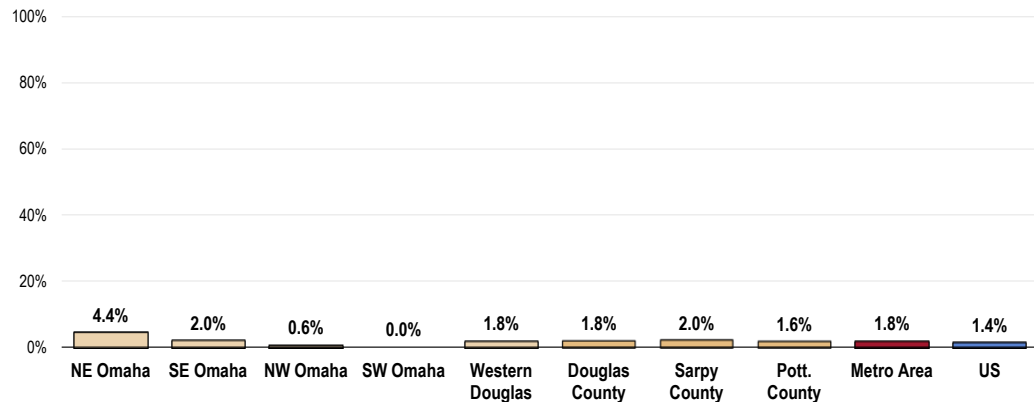
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 101]  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Prevalence of Autism

Among Metro Area parents of children age 5-17, 1.8% indicate that their child has been diagnosed with autism.

- Comparable to national results.
- In Douglas County, highest in Northeast Omaha; null response in Southwest Omaha.
- Comparable rates by county.

### Child Has Autism (Metro Area Children Age 5-17, 2015)

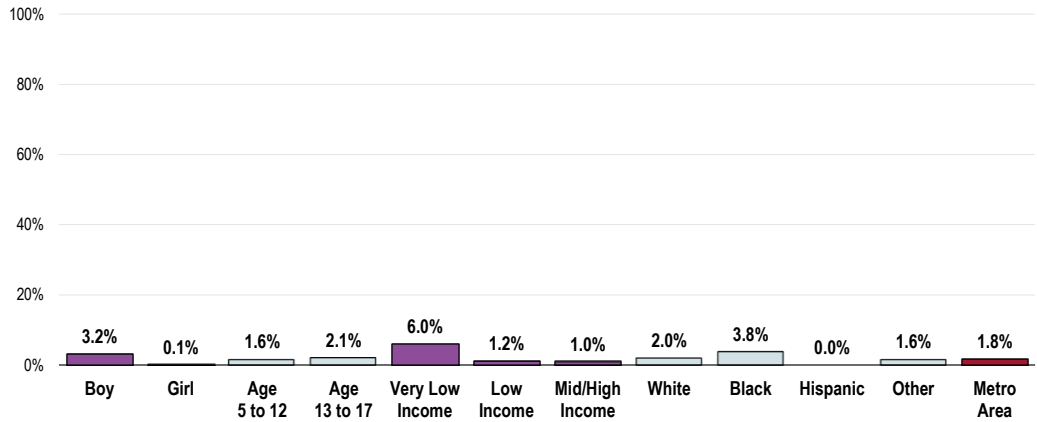


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 103]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Note the following:

- Boys are more likely to be autistic than are girls.
- There were no reports of Hispanic children having autism.

### Child Has Autism (Metro Area Children Age 5-17, 2015)



Sources: 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 103]  
Notes: Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Cognitive and Behavioral Conditions

Most key informants taking part in an online survey characterized Cognitive and Behavioral Conditions as a "major problem" in the community.

### Perceptions of Cognitive and Behavioral Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2015)

Major Problem Moderate Problem Minor Problem No Problem At All



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Lack of Providers

- Not enough mental health providers. – Physician*
- Insufficient supply of providers with expertise in this medical field for the Omaha metro. – Physician*
- Lack of providers, physicians, to see these patients in a timely fashion. – Physician*
- Many children do not have access to appropriately trained professionals. The populations most underserved are children who are low SES, in the juvenile justice system and in rural areas. – Physician*
- Many more children with the disorders and few specialty providers to help them. Condition disrupts all aspects of their lives. – Other Healthcare Provider*
- Lack of providers, and poor payment by third parties. – Physician*
- The lack of a full array of providers, the limited funding associated with many policies and the tremendous waiting lists for inpatient services. – Public Health Representative*
- Not enough mental health providers to address issues that are beyond the scope of primary care providers. – Other Healthcare Provider*
- There is limited access to board-certified medical specialists with expertise in cognitive and behavioral conditions. Child neurology, developmental-behavioral pediatrics and child psychiatry. A primary reason is the lack of subspecialists in these fields and long waiting lists. Because of the limited number of subspecialists and the long waiting lists, patients end up going to providers with less expertise. In Nebraska, there are also no Medicaid and limited insurance coverage for treatment of developmental disorders and autism. – Physician*
- We see a lot of these conditions, and there is little training in primary care. Few specialists to help with these conditions. – Physician*
- It is difficult to navigate the system. There is a shortage of Psychiatrists and Psychologists in our community and state. There is a stigma to accessing services which may delay treatment. – Social Services Provider*
- Not enough clinicians trained to meet the needs. Also, Monroe Meyer has a nightmare black boxish process for kids to get into it. – Physician*

### Lack of Resources

- Inadequate resources for mental health, psychologists and psychiatrists. Absence of a dedicated pediatric mental health facility or adequate beds. Every teacher or school nurse now diagnoses ADD/ADHD, basically over diagnosis and over medication of the population. MMI does a great job. – Physician*
- Lack of resources. – Physician*
- Limited mental health resources, especially for low income, underinsured families. Shortage of mental health providers for children and teens. Lack of substance abuse treatment options for teens. – Physician*
- Resources for treatment are limited. Diagnostic criteria appears to be inconsistent. Schools are overwhelmed and not able to handle the demand. – Physician*
- Lack of resources to manage these children over time. – Physician*
- Limited services available. Some of these services are very expensive and not covered by insurance, so families get stuck with extremely high bills to get their children the necessary care. We hear a lot about the lack of respite care for these families, and after school programs that will work with these families and allow the children to attend. – Community/Business Leader*
- Limited resources for handling the number of children with problems. – Physician*
- Little to no ability to admit patients to Inpatient Pediatric Psychiatric facilities. No Inpatient eating disorders treatment in the state. Difficult to get outpatient visits paid for, Psychiatry and Psychology, by insurance companies. – Physician*
- There are limited bed space for kids with significant behavioral impairments in Nebraska and the local community. – Other Healthcare Provider*

*Limited beds in Nebraska area to treat children and teens with mental and behavioral health needs. – Other Healthcare Provider*

*Insufficient resources available for education, treatment, and support for youth and their families. – Other Healthcare Provider*

*Minimal and overburden services for these problems. Very difficult to refer to specialty clinic. – Physician*

*Low socioeconomic area. Poor parental coping. Lack of mental health services. – Physician*

### Access to Care/Services

*Difficult in access to quality care providers, parental difficulty in caring for these children. Majority of these children in foster care, majority of these children in homes in poverty or living with parents unfit to care for them. – Physician*

*Not enough easy access for adolescents to receive care. – Other Healthcare Provider*

*Access to Behavioral Health services, particularly for kids, are limited. Barriers including access to services, transportation, and lack of insurance are key. Spanish speaking providers are also limited. – Community/Business Leader*

*Limited access to services. – Physician*

*Poor access to mental health services. – Community/Business Leader*

*Access to care, evaluation and the no pharmacological interventions are difficult to access, to implement at the school level. – Physician*

*Access to mental health providers evenings and weekends for low income families whose parents work at entry level jobs. Early childhood interventions largely center-based. Few resources for families to understand and obtain appropriate early developmental resources, toys, crayons, etc. See the home inventory questionnaires. – Physician*

*I think there are good resources available for autism and learning disabilities, although the physical location of some of those resources might be problematic. I think there are bigger problems in behavioral health, which I feel pediatric providers are slowly moving toward addressing. Some of this may fall under mental health. But I feel there are a lot of kids with behavioral and mental health issues that have limited access. Many of these families have limited resources, and the providers have limited availability, so if they are able to get in with a provider, it sometimes isn't followed through on because the families have limited resources and sometimes insight to keep these appointments. – Physician*

*I believe there to be an access to care issue associated with cognitive and behavioral health for the metropolitan area. Lack of adequate provider network that deals specifically with childhood and adolescent behavioral health issues, in particular. – Other Healthcare Provider*

### Conditions not Recognized/Addressed

*Far too many children are entering school with cognitive and behavioral conditions not being identified prior to starting school. Early identification is key to getting children support to be successful in school from the start, however children are not being identified or their physicians have a wait and see attitude. I also see many children being placed on ADD/ADHD meds at the request of the school when challenged by the child's behavior. Often the child meets the behavior requirements for needing these meds, but there is little other investigation about what is happening for the child, trauma, chaos, family violence, all of which affect the child's behavior. Additionally, I do not think we have the capacity to support all children in our community who may have Autism. There are many barriers for families to access services, especially minority children including long waits to see specialists. Few Spanish speaking specialists or even interpreters, confusing paperwork. – Social Services Provider*

*Cognitive and behavioral conditions are not recognized and addressed appropriately by adults. – Community/Business Leader*

*Not only in our community, but nationwide. Not as much emphasis is placed on mental health and assisting those with these issues with coping. Also, affordability of treatment, both prescription drugs and counseling. – Community/Business Leader*

*Not enough emphasis on mental health in schools and child care settings. – Community/Business Leader*

*This is a major issue because of the widespread exposure of children and adolescents to trauma and the lack of diagnosis and support of treatment. If treated early and consistently, many cognitive and behavioral issues can be managed to give the child the best chance at success. – Public Health Representative*

### Misdiagnosis

*These concerns are both misdiagnosed and under diagnosed. Many times the conditions are not identified until children have reached school age. Early diagnosis would benefit parents in awareness and knowledge of these concerns. – Social Services Provider*

*Parental concerns about behavioral problems are a large part of everyday practice in our healthcare site. Many patients are overmedicated for learned behavioral problems; others are under medicated for true psychiatric problems. – Physician*

*Ability to accurately diagnose is difficult, and silos exist between healthcare providers and educators for communication when delays may be identified. Currently the system is parent reliant. Parents must be the ones to initiate further evaluation from school districts. Ideally, better mechanisms would be in place to allow direct communication and referral from the provider community to the school district. Additionally, further education and comfort levels for health providers must be improved around screening for cognitive and behavioral conditions. – Community/Business Leader*

*I feel that these conditions are prevalent, but also over diagnosed and over treated with medication. Lack of resources to appropriately treat children, but also lack of parent understanding of diagnosis and appropriate treatment. – Physician*

### Lack of Funding for Services

*Lack of political will. The state does not want to invest its resources in humans with low return on their investment. They want community donors to pick up the slack. Most community donors did not personally experience their own children have difficulty accessing resources. So the acuity of health issues are difficult to articulate to stakeholders, except as an academic conversation. – Public Health Representative*

*There is a lack of funding for services, and in many cases a paucity of providers, especially with cultural and language competency for a multicultural population. In some cases, schools seem slow to move through the steps to identify problems and provide services, because of high needs, lack of funding, and limited personnel. Also, steps of moving through the process may be hindered at some schools by unequal distribution of behavioral health providers, and varied degrees of buy-in or tolerance of individuals in the various schools. – Physician*

### Influence on Learning and Quality of Life

*A major influence on a child's ability to learn and has long term impacts on their education, career success, health behaviors, etc. Overall. – Public Health Representative*

*Many students have mental health issues that impact their school behaviors, making it difficult for them to learn. – Social Services Provider*

*I work with many teens who struggle with depression and anxiety. These lead them to miss school and have trouble maintaining healthy relationships. – Community/Business Leader*

*If not treated results in poor quality of life, negative school behaviors, bad grades, violence and poverty. – Community/Business Leader*

*The number of children, particularly African American children, who are not experiencing academic success in the regular classroom setting and the increasing number of children being placed in special education classes. – Community/Business Leader*

*Autism and learning disabilities. – Physician*

*Depression, anxiety. – Physician*

### Rise in Incidence

*The prevalence has increased and the availability of specialists for diagnosis and management has not kept up with the needs. The waits are very long to get into Behavioral Pediatrics and Psychiatry. – Physician*

*Too many children with problems and feel related to dysfunctional lifestyles. – Physician*

*The number of children with these conditions is growing and resources are not accessible due to lack of supply of affordable services or inability to afford services. – Social Services Provider*

*They are on the rise and there are not enough services to assist the children, especially in the state of NE. – Social Services Provider*

*It is a major problem everywhere. – Physician*

*With an increasing frequency of autism, diagnosis of ADHD and developmental delays and behavioral issues, the need for resources to help children and parents is greater than ever. Access to resources will improve their long term outcomes. – Physician*

*More and more children are being diagnosed with ADHD and autism. There are a limited number of providers to address these issues. – Social Services Provider*

*We have seen a marked increase in ADHD and autism diagnoses in the last several years. There are school policies in place to help kids with ADHD, but they are not always enforced. We have basically no resources to help kids with autism unless they can afford to pay for specialty services like PT, OT, speech, behavioral health. – Physician*

*We hear this from many educators in our community. – Other Healthcare Provider*

### **Unstable Families**

*Because families are so overwhelmed with violence and other things in the community, I think they let these things slide. Getting tested for ADHD and other conditions often requires relatively sophisticated referrals from school counselor to primary care (which people don't always have) and then to a specialist. – Public Health Representative*

*Children in this community have to deal with a lot of change in households. Parents in and out of jail. Gun violence, physical and emotional trauma. – Physician*

*Parents are unsure how to manage children. Autism is being diagnosed at higher and higher rates. Teachers are not being educated and supported by administrative staff for all types of kids in classrooms. – Community/Business Leader*

*Primarily social problems with family and others. – Physician*

### **Coordination of Resources**

*Horrible coordination between physician's offices and OPS. When we sent children for EIP referral the schools never get back to us. Even if we have a signed release form. Evaluation and services for Spanish speaking clients is not good. Munroe Meyer is horrible to try to access, because no one answers the phone to schedule appointments. Our illiterate patients are sent English language packets to fill out before they can schedule appointments. All of this causes delay in evaluation and treatment for kids most at risk. – Physician*

*Challenges in coordination of resources for evaluation, diagnosis, care and services for these conditions. Particular challenges for children and youth with poor socioeconomic status or poor social support, (parents, etc.) – Physician*

### **Social Environment**

*Lack of the ability to achieve self-regulation, social media for approval for drama, trauma experience, increased caffeine, sugar, and white flour intake. – Community/Business Leader*

### **Not Focusing on Underlying Causes**

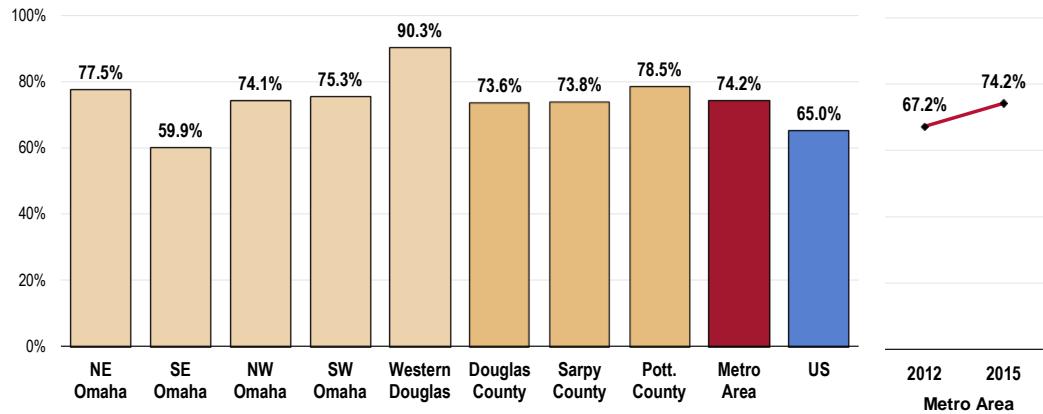
*These issues are pervasive but we are not focusing on underlying environmental causes but rather prescription medications to treat them. – Public Health Representative*

## Awareness of Mental Health Services

Nearly three-fourths of Metro Area parents (74.2%) say that they are aware of local community resources for mental health.

- Higher than found nationally.
- In Douglas County, awareness is lowest in the Southeast Omaha and highest in Western Douglas.
- Statistically similar by county.
- TREND: Over the past three years, Metro Area parents have become statistically more aware of the mental health resources available to them.

### Aware of Mental Health Resources in the Community (Among Parents of Metro Area Children Age 5-17, 2015)



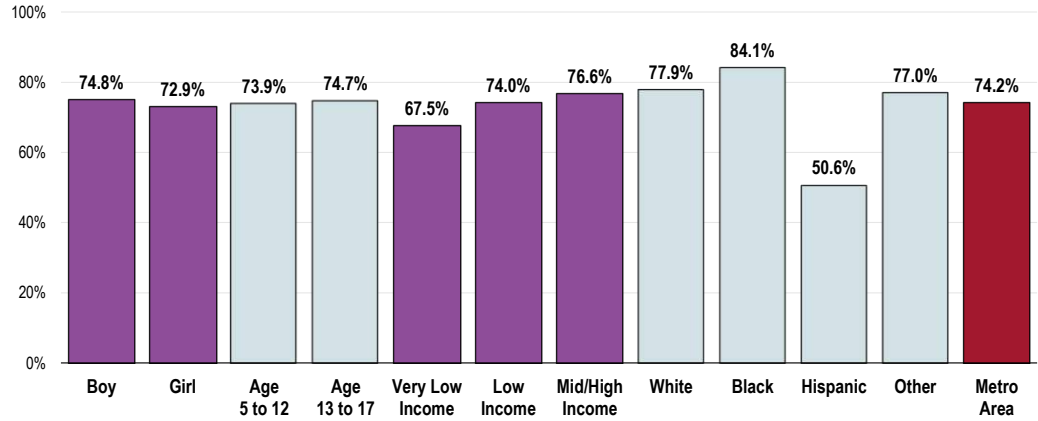
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 107]

• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

- Parents of Hispanic children are less likely to be aware of these services.

### Aware of Mental Health Resources in the Community (Among Parents of Metro Area Children Age 5-17, 2015)



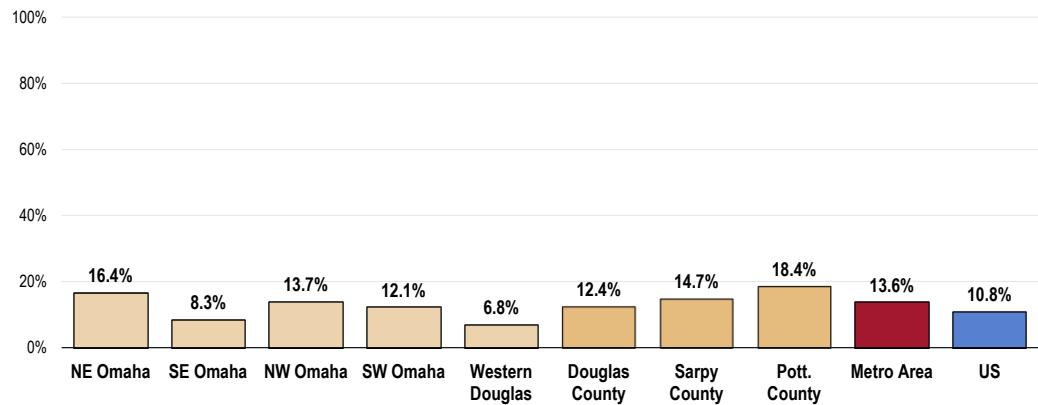
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 107]  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Need for Mental Health Services

A total of 13.6% of Metro Area parents report that their child (age 5-17) has needed mental health services in the past year.

- Statistically similar to the needs seen nationally.
- In Douglas County, demand for child mental health services is statistically lowest in Southeast Omaha.
- No statistical difference among Metro Area counties.

### Child Needed Mental Health Services in the Past Year (Metro Area Children Age 5-17, 2015)

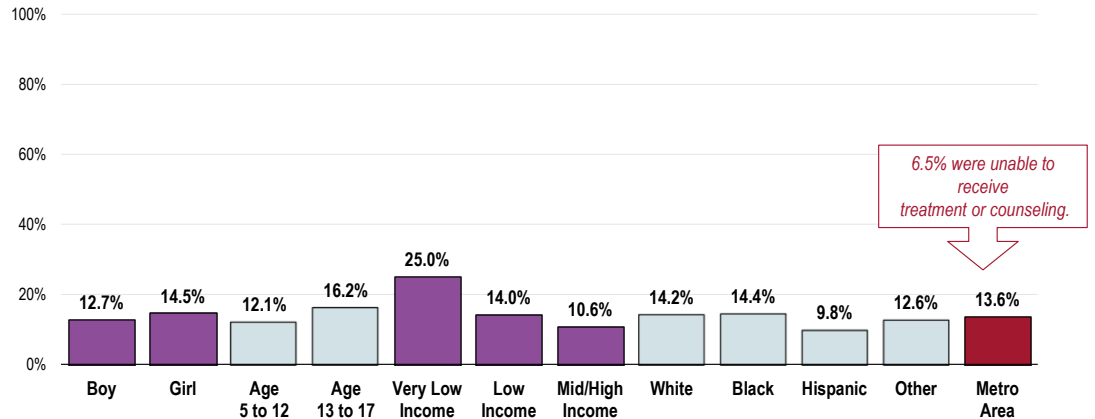


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 91-92]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



- Children in very low income households are more likely to have needed such services (negative correlation with income).

### Child Needed Mental Health Services in the Past Year (Metro Area Children Age 5-17, 2015)



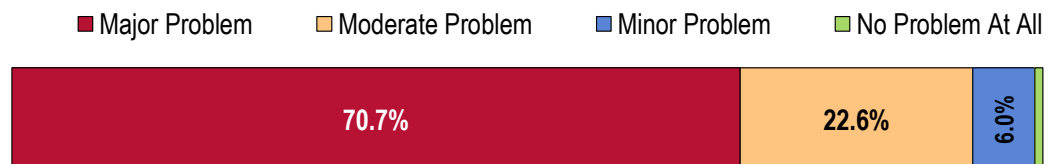
Sources: 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 91]  
 Notes: Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
 Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among these parents with children needing services, 6.5% report that their child did not receive any type of mental health treatment or counseling — reasons primarily related to **difficulty obtaining an appointment or cost**.

### Key Informant Input: Mental and Emotional Health

A high percentage of key informants taking part in an online survey characterized Mental and Emotional Health as a "major problem" in the community.

### Perceptions of Mental and Emotional Health as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Lack of Resources

*Difficult to find resources to help, violence in north Omaha. – Physician*

*Lack of resources. – Community/Business Leader*

*Depression and mental health problems are common and not enough resources to handle the problem in a timely fashion. Need for family support, as well as individual therapy, as environment is so much a part of the equation and parental/guardian mental health needs to be addressed in many cases. – Physician*

*There are a limited number of resources available for children and teens in our community, both inpatient and outpatient. – Social Services Provider*

*There is no system to access mental health services. It may take time for someone to get into services. There is a stigma about mental health services. Payment of services is an issue. Young people who are 19 to 21 aren't eligible for Medicaid, so they may not receive treatment for a major issue and it may cause them problems in functioning in daily life. – Social Services Provider*

*Inadequate resources for mental health Psychologists and Psychiatrists. Absence of a dedicated Pediatric mental health facility or adequate beds. Every teacher or school nurse now diagnosed ADD/ADHD, basically over diagnosis and over medication of the population. – Physician*

*Significant lack of services. – Physician*

*There is a severe lack of resources in this area. Children' are not receiving the psychological or psychiatric care that they need. Access to residential treatment is severely limited. There are not enough child psychiatrists, or trained psychologists for evaluations. – Community/Business Leader*

*Limited access to care and few residential options. Similar issue to Behavioral Health issues recorded earlier in this survey. – Other Healthcare Provider*

*Limited access to care and few residential treatment options. – Other Healthcare Provider*

*Inpatient treatment facilities are limited. Schools are overwhelmed and cannot handle. – Physician*

*No Pediatric long term mental health facilities. – Physician*

*I believe this ties to behavioral and cognitive health, the great unmet need for services in this area. – Other Healthcare Provider*

*Stigma holds parents back from connecting their youth with resources. Insufficient resources available in the community to meet the demand. Funding sources are not organized in a way to best meet the needs, i.e. system of care principles. School systems need assistance in what to do with youth they believe have these issues. – Other Healthcare Provider*

### Lack of Providers

*There are children who need access to Psychiatric care, but there are a shortage of Psychiatrists. – Community/Business Leader*

*Children with emotional and psychiatric disorders have limited access to care of medical subspecialists and often very limited insurance coverage for needed services and medication. – Physician*

*Not enough good providers and too many on medication. – Physician*

*Not enough providers. – Physician*

*Lack of providers, physicians, to see patients. – Physician*

*Too few providers of mental health services in the metro area. Very limited inpatient and crisis service available. – Physician*

*Service providers for children are limited, long term impacts on individual and community at large. – Public Health Representative*

*Lack of adequate mental healthcare professionals who care for kids and facilities to care particularly for adolescents. – Physician*

*Terrible availability of mental health professionals in all roles. Almost no psychiatrists. Almost no availability of inpatient treatment facilities. – Physician*

*The answer to this is much the same as behavior health, in that there are too few providers, limited insurance coverage and few in services. – Public Health Representative*

*Not enough providers for the care. Basic care can be started by a PCP but more evaluation is needed.*  
– Other Healthcare Provider

*Not enough providers or services in the community.* – Physician

*There is a shortage of child and adolescent Psychiatrists in the community.* – Physician

*No available providers. No access particularly for low income families.* – Physician

*Nearly impossible to find inpatient care when needed for adolescents, and very few Pediatric Psychiatrists.* – Physician

*No inpatient psychiatric.* – Physician

### Access to Care/Services

*Not enough easy access for adolescents to receive care.* – Other Healthcare Provider

*Limited access and insufficient services for diagnosis, treatment. Follow up for both acute and chronic issues with mental and emotional health.* – Physician

*Access to care is a critical issue.* – Physician

*Children cannot get access. If they can get access to care, it is usually a two to three month wait.* – Physician

*Very little access to treatment. Inpatient care, forget about it, does not exist. Outpatient care. Only after a long wait. Not enough therapists for uninsured children or Spanish speaking families.* – Physician

*There is very limited access to inpatient psychiatric care.* – Physician

*The issue of access to mental health services for young children from families of low income, in particular, has been a long standing issue. The Department of Health and Human Services has a history of denying such services for children aged five years old or younger because the type of treatment is deemed to be parent education or behavioral management. Under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Medicaid laws. States must provide medical assistance services necessary to correct or ameliorate a child's physical or mental condition, but this has not always been common practice. A past legislative attempt in 2012 through the introduction of LB 1063 attempted to prohibit broad exclusions based on diagnosis and age and apply a presumption in favor of the medical judgment of the treating provider. What resulted was a reporting requirement regarding Youth Medicaid Mental Health Services Authorization Requests.* – Community/Business Leader

*Similarly to Behavioral Health, I think there are many barriers, (particularly for children living in poverty) to accessing services. I also think there is still stigma in many cultures.* – Community/Business Leader

### Under Diagnosed

*I feel there are a lot of kids seen in pediatric offices with unidentified mental and emotional health issues. Lots of times the kid seems a little depressed but there is a lot more going on in the family than is being recognized. I think there's a significant amount of subclinical mental health problems that might actually be having a lasting and more significant impact.* – Physician

*Many youth are experiencing mental and emotional health issues, however are not identified or connected to services. Realistically, if all needs were identified, I do not believe the current MH system has the capacity to serve all children in need. Work force issues remain, along with training specific to trauma and children.* – Community/Business Leader

*Many children and teens have mental and emotional health issues that are unidentified and thus untreated.* – Physician

*It is often unrecognized and thus is left untreated.* – Physician

*I am most concerned about early intervention and prevention of development of psychopathology. My experience is that by the time a child is identified with issues in school or in a primary care physician's office, it has been going on for four to five years. Raising consciousness about early diagnosis and intervention is needed and matching appropriate resources with the needs of the family.* – Physician

*Afflicts a large number of children. Better treated early than allowed to linger for years into adulthood. Generates additional societal costs in caring for the outcomes that these children's actions often cause i.e. suicide attempts and risk behaviors.* – Physician

### Increase in Anxiety and Depression

*We've seen an increase in depression and anxiety in children and teens, and an increase in behavioral problems in the younger kids.* – Physician

*I am seeing a good number of depression and anxiety. As well as more kids with Asperger's Syndrome, who can have emotional problems as part of their illness. There are limited number of providers, either behavioral specialists or Pediatric Psychiatrists in the community, and wait times can be long for appointments. I don't feel we have enough Psychologists in the area who are familiar with autism, so my patients aren't getting the proper help that they need. – Physician*

*We have a very high rate of adolescent suicide attempts combined with limited inpatient and outpatient resources. In addition, there is not a community-wide effort to address adolescent mental health needs. The effort needs to involve parents, schools, social media, and the medical community. Since everyday interactions contribute to mental health, we need to have a community-wide effort. I think this will also help with sexual health, substance abuse, and violence among adolescents. A central clearing house for resources in this area would be helpful. Also, in that clearing house would be outcomes measured so that providers can see which organizations are doing well and which ones need to improve. – Physician*

*High adolescent depression and suicide rates. – Other Healthcare Provider*

### Trauma and Violence

*I think this is tied to the reasons for concern regarding behavioral health, violence, trauma and stress, including concerns for safety, food, shelter, and resources to provide stability in parenting. – Physician*

*Children and young adults are exposed to more and more violence annually than ever before. Support systems are waning and our community doesn't have enough resources to help kiddos to start learning coping skills early. – Physician*

*Children in our community are exposed to a variety of traumas in their lives. These traumas include, but certainly aren't limited to, divorce, abandonment, witnessing violence, experiencing violence, and sexual abuse. These children could certainly benefit from access to counseling to deal with these issues if it were readily available. Currently it's only available for a fraction of those who need it, so it is the absolute worst cases that get served. – Community/Business Leader*

*There are so many children who experience the mental and emotional effects of trauma. – Community/Business Leader*

*Gun violence, physical and emotional abuse, environmental changes. – Physician*

### Unstable Family Environment

*Many patients with unstable family environments, foster families, and single parent homes that have mental health and behavioral problems. ADHD, Oppositional Defiant, and Depression are all very common in my clinic. – Physician*

*Many children with very poor family support system. – Physician*

*Absent parents, parental mental health, latch-key kids, lack of services available. – Physician*

*When children are challenged with the ability to regulate their emotions and body, they are unable to learn. Many children in our community are coping with loss, violence, trauma, addiction, their own or a family member, abuse physical and emotional, neglect, bullying and poverty to name a few. If the child's family is also facing these similar challenges, the child has few resources to support their mental and emotional health. – Social Services Provider*

*The kids I deal with are in a constant survival mode. Lack of access to food, safety, consistent unpaid adult mentors, invested teachers. (OPS has the youngest and newest teachers in the worst situations, because teachers work their way to office jobs with years of persistence in the job.) (Not using excellence was intentional). Lack of facilities to stabilize families in high risk situations. Very generous donors will help students that pass high school go on to college, but they do not include health insurance in the package, so there is still no way to access specialized health and mental health needs that were dropped at graduation from high school. – Public Health Representative*

*Single teenage parenting, lead intoxication, and lack of rehabilitation resources. – Physician*

### Increasing Incidence

*Seeing increase in mental and behavioral health needs in children and adolescents. Not enough mental health resources in the community. – Social Services Provider*

*Adolescents identified this as a primary issue on a middle school survey, Youth Risk Behavior Survey. – Public Health Representative*

*It is everywhere. – Physician*

*Behavioral issues in schools are starting at younger ages and resources are inadequate to help families and schools understand and address them. – Social Services Provider*

*It is a major problem for children and adolescents in every community, ours being no different. We have families calling and emailing all the time, telling their stories and heartache that they've seen because of a variety of diagnoses, service issues and just the extreme difficulties these situations put on families. – Community/Business Leader*

*See it in schools, patients I treat and news. – Community/Business Leader*

*Discussions with practicing primary care doctors and patients. – Physician*

### Issue Not Recognized

*Not a lot of discussion of this in the community. Need to do some more ACE studies. – Public Health Representative*

*Mental health services are not emphasized in schools. – Community/Business Leader*

*Why would a Republican state like Nebraska even recognize this issue? We're more concerned about getting the governor a new airplane. – Physician*

*Again, I think this is an issue US wide. I'm a firm believer that more attention to mental and emotional health would prevent violence and improve educational outcomes. – Community/Business Leader*

### Latino Area Resources

*Families in Action has worked in the Latino community for over a decade, as such, we are a trust partner in working with our Latino families. Families who participate in Families in Action have sought out resources to address mental/emotional health concerns for their children. – Community/Business Leader*

*Many students have mental and emotional health issues. We do not have services for students who speak a language other than English. – Social Services Provider*

*Major lack of referral resources of LMHP, MSW in community. Minimal Spanish speaking providers, no other language providers for Nuer, Somali, Swahili, etc. – Physician*

### Loss of Social Skills

*Society does not support a wholesome environment. The need for drama to increase emotions due to match the stimulus of society's messages. Multiple traumas, poor nutrition. – Community/Business Leader*

*They have limited face to face interactions. Less time spent engaged in physical activity and less time interacting with parents. There is a push to limit the discomfort in their lives, which thus leads to an inability to handle stress when it does arise. – Community/Business Leader*

*Families are more stressed by the demands of everyday life. Children are spending more and more time with electronics as their babysitters, as opposed to interacting with parents and peers. This has led to a loss of social skills that are vital to healthy relationships. Also, the rise of social media has introduced a new form of bullying. Access to mental health services is limited. – Physician*

### Lack of Desire for Change

*Many adolescents suffer from it, and many refuse treatment. – Physician*

*Mental health has a stigma within some parts of the community. The negative association of having what some see as "mental issues" creates an unwanted desire to be seen for emotional health. – Social Services Provider*

### Self-Medicating

*Depression, substance use, and addiction are problems for many of our patients. Many of them are self-medicating for mental health disorders. Many of our hospital admission in teens/young adults are for attempted suicide. – Physician*

# **Chronic Disease & Special Health Needs**



**Professional Research Consultants, Inc.**

## Prevalence of Selected Medical Conditions

### Speech & Language Problems

#### Prevalence of Chronic Ear Infections

Among Metro Area parents of children under the age of 18, 28.7% indicate that their child has had three or more ear infections in his/her life.

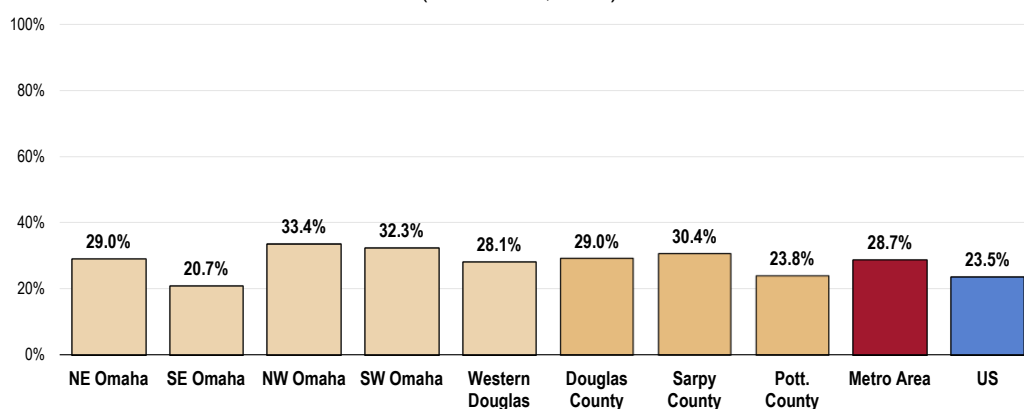
- Higher than the US prevalence.
- Among Douglas County areas, lowest in Southeast Omaha.
- No statistical difference by county.

Respondents were asked to report on the prevalence of a number of different chronic conditions and illnesses afflicting children.

*"Would you please tell me if this child has ever suffered from or been diagnosed with any of the following medical conditions ...."*

#### Child Has Had 3+ Ear Infections

(Metro Area, 2015)

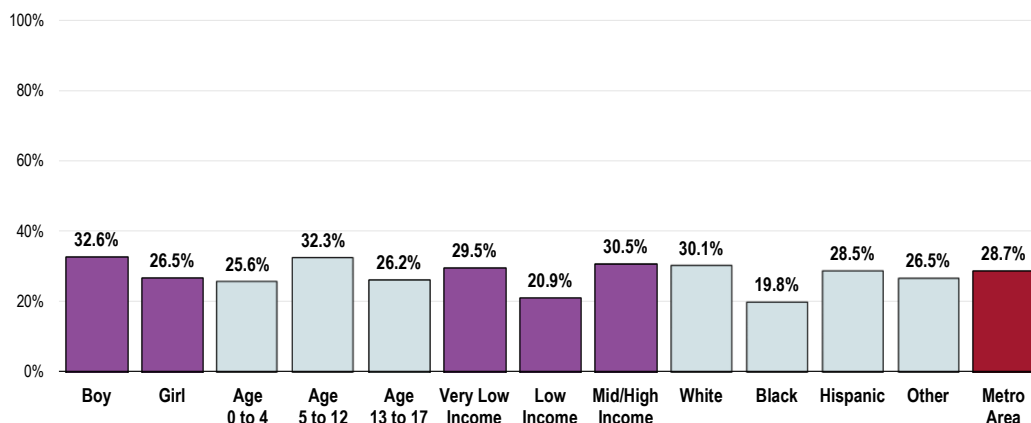


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 62]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Children more likely to have chronic ear infections include:

- Boys.
- Those in mid/high income households when compared with those in low income households.
- Whites when compared with Blacks.

## Child Has Had 3+ Ear Infections (Metro Area, 2015)



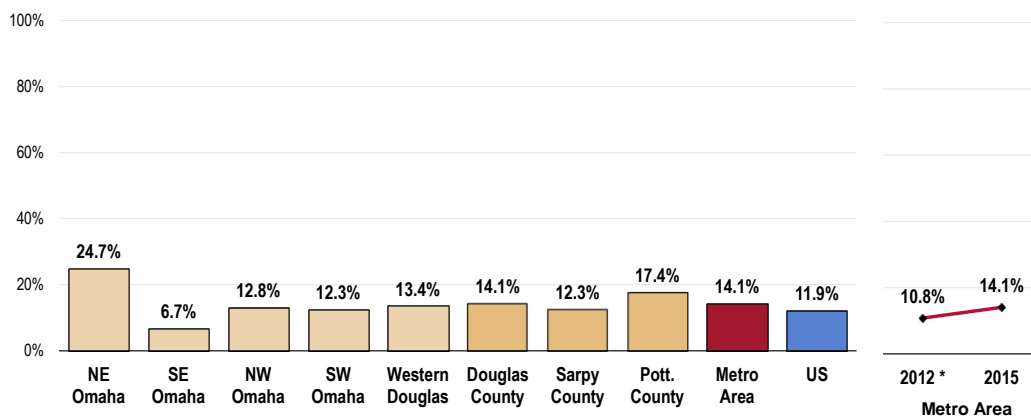
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 62]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Prevalence of Speech/Language Issues

A total of 14.1% of Metro Area children have some type of speech or language problem.

- Statistically comparable to US findings.
- In Douglas County, least favorable in Northeast Omaha; most favorable in Southeast Omaha.
- Statistically comparable findings by county.
- TREND: The Metro Area has seen an increase in speech or language issues since 2012.

## Child Has Speech/Language Problems (Metro Area, 2015)

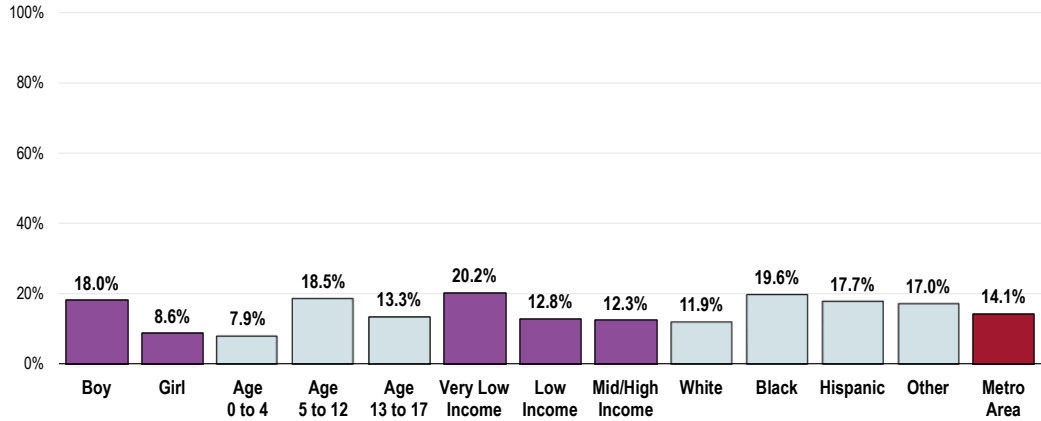


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 69]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• \*2012 data reflects children age 1-17.



- Boys and children age 5 to 12 are more likely to experience speech or language problems.

### Child Has Speech/Language Problems (Metro Area, 2015)



Sources: 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 69]

Notes: Asked of all respondents about a randomly selected child in the household.

Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

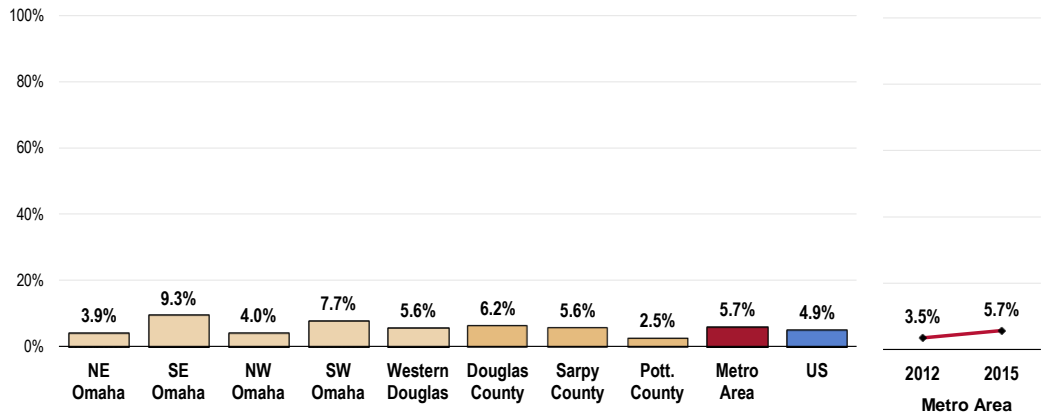
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Prevalence of Hearing Problems

A total of 5.7% of Metro Area children have been diagnosed with hearing problems.

- Similar to that found nationwide.
- No statistical difference within Douglas County.
- By county, lowest in Pottawattamie County.
- TREND: Marks a statistically significant increase in hearing problems in recent years.

### Child Has Hearing Problems (Metro Area, 2015)



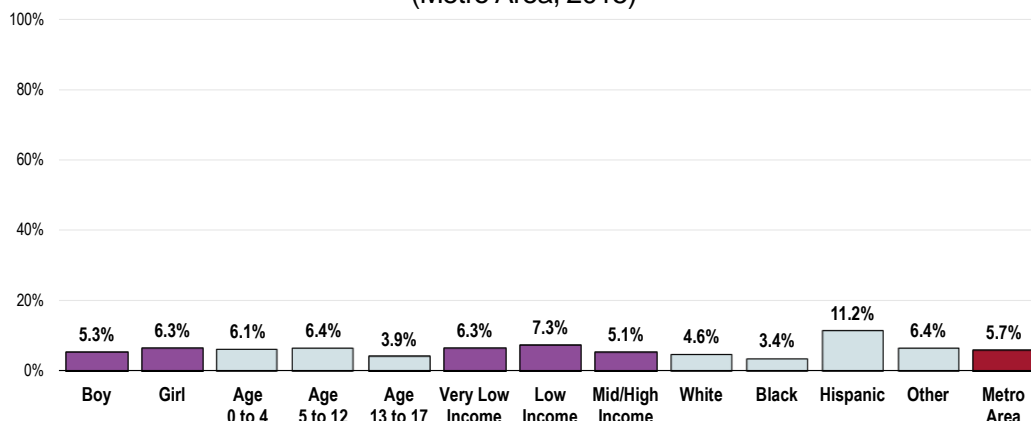
Sources: PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 39]

Notes: 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Asked of all respondents about a randomly selected child in the household.

- Hispanics are more likely than Whites and Blacks to have been diagnosed with hearing problems.

### Child Has Hearing Problems (Metro Area, 2015)



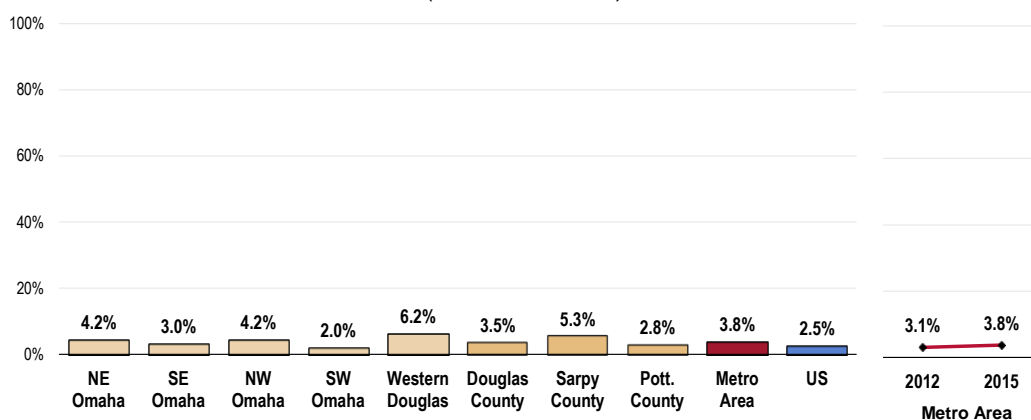
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 39]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Prevalence of Vision Problems

A total of 3.8% of Metro Area children have vision problems that cannot be corrected with glasses or contact lenses.

- Comparable to the national prevalence.
- Statistically comparable among areas within Douglas County.
- No statistical difference by county.
- TREND: Unchanged since 2012.

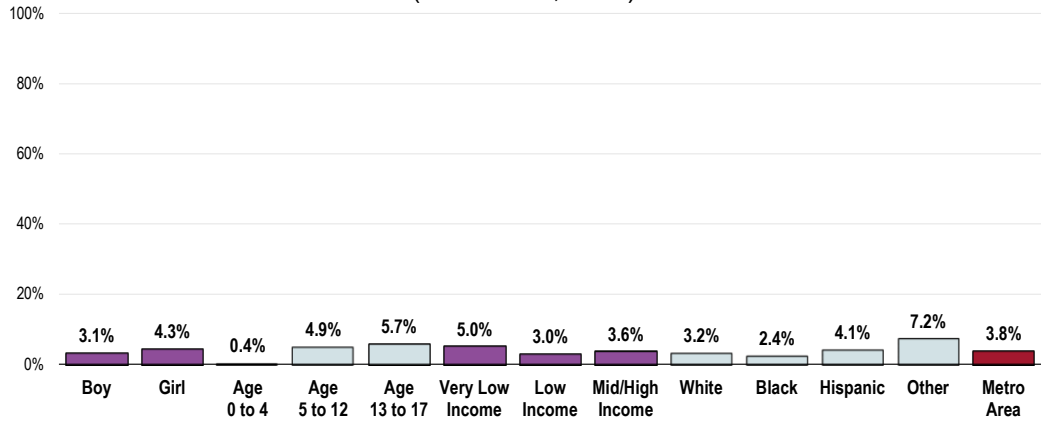
### Child Has Uncorrectable Vision Problems (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 37]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- Children over age 4 are more likely than younger children to have uncorrectable vision problems.

### Child Has Uncorrectable Vision Problems (Metro Area, 2015)

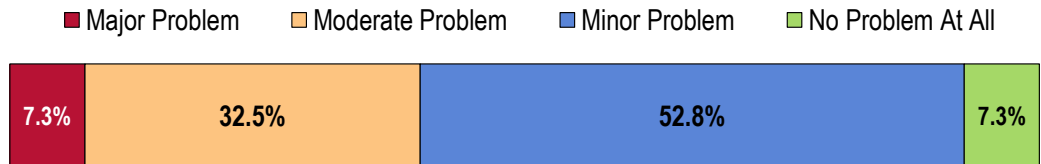


Sources: 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 37]  
Notes: Asked of all respondents about a randomly selected child in the household.  
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Vision, Hearing, and Speech Conditions

Key informants taking part in an online survey most often characterized Vision, Hearing, and Speech Conditions as a "minor problem" in the community.

### Perceptions of Vision, Hearing, & Speech Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Access for Underinsured/Uninsured

*A lot of children who don't qualify for Medicaid can't afford a vision exam. Again, even if they do have Medicaid, a lot of parents don't see this as a concern until they are told by the doctor to get this checked. – Physician*

*For vision needs, cost is a factor for the uninsured, and Medicaid will only cover one pair of glasses per year. The younger the child, the more likely the glasses will be broken or lost. Many times needs go unmet because the children don't complain of an actual vision problem. If children are not receiving routine preventative healthcare, vision, hearing and speech problems may not be recognized early in order to maximize treatment outcomes. – Physician*

*Few providers who accept Medicaid. – Physician*

### Lack of Resources for Early Intervention

*Despite the existence of a kindergarten vision exam mandate, most kids do not get properly examined. All too often, parents are encouraged to waive the exam because the Pediatrician did a screening. This is not enough. – Other Healthcare Provider*

*Early intervention needs more capacity and then when kids qualify, more preschool programming needs to be available. – Physician*

*Common problems that still slip through the cracks despite screening. Problem is that they are common and sometimes resources are overwhelmed. Another is that parents are sometimes reluctant to admit their children are “delayed.” – Physician*

### Lack of Follow Through

*Access is hard sometimes. Parents too busy to take patient to other appointments. Families have a hard time following through with recommendations. – Physician*

## Allergies

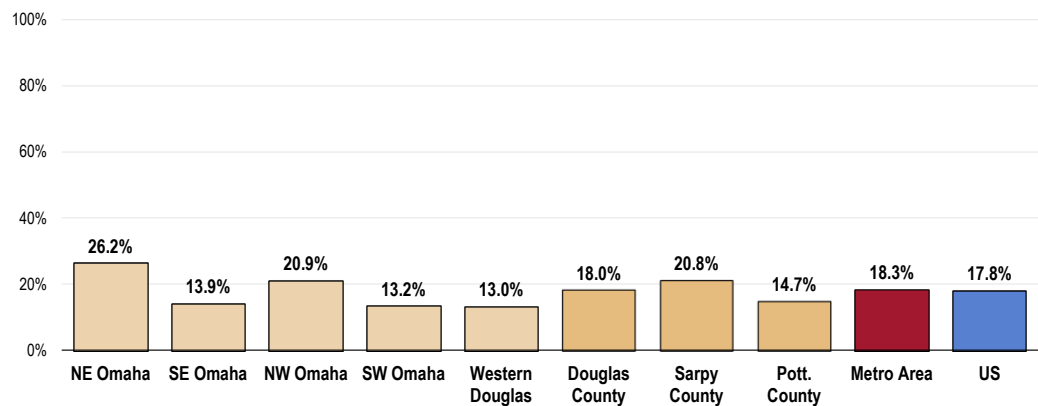
### Prevalence of Respiratory Allergies

A total of 18.3% of Metro Area children suffer from respiratory allergies.

- Similar to the US figure.
- In Douglas County, most prevalent in Northeast Omaha; statistically least prevalent in Southwest Omaha.
- Metro Area county findings are statistically similar.

### Child Has Respiratory Allergies

(Metro Area, 2015)

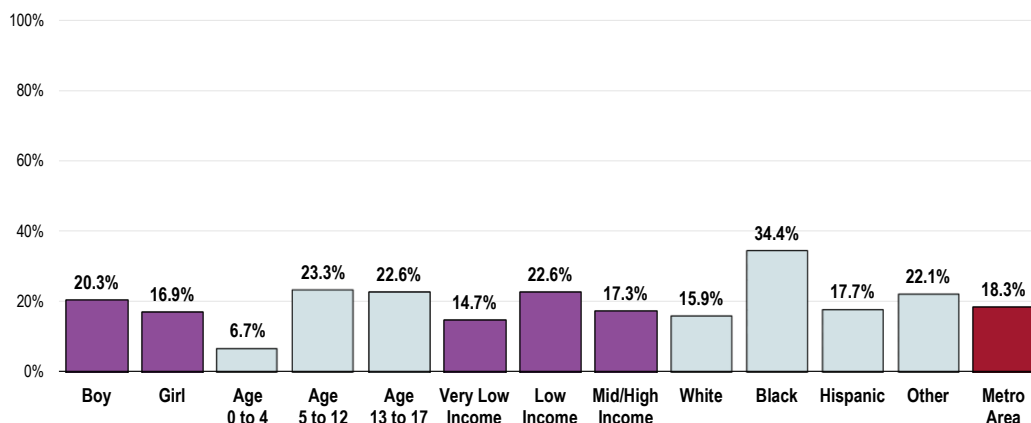


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 55]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Metro Area children more likely to have a respiratory allergy include:

- Those age 5 and older.
- Black children when compared with White children and Hispanic children.

## Child Has Respiratory Allergies (Metro Area, 2015)



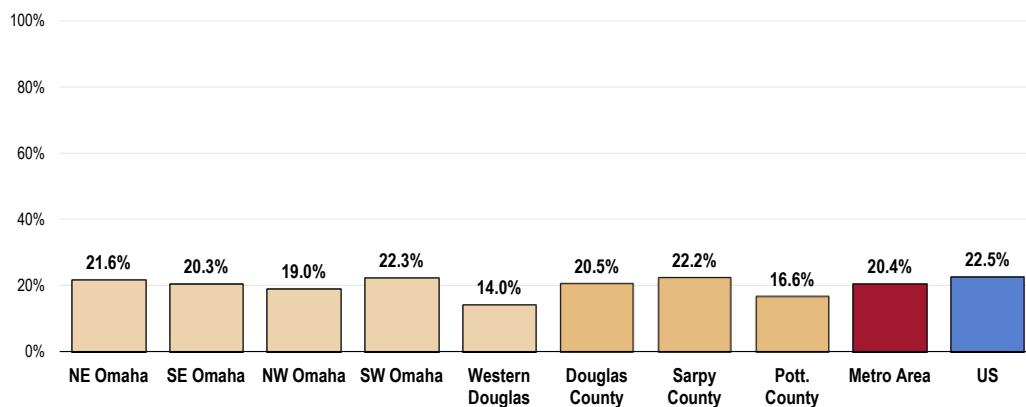
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 55]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Prevalence of Eczema/Skin Allergies

A total of 20.4% of Metro Area children have eczema or another skin allergy.

- Statistically similar to the prevalence nationwide.
- Statistically similar by area of Douglas County.
- No statistical difference among county findings.

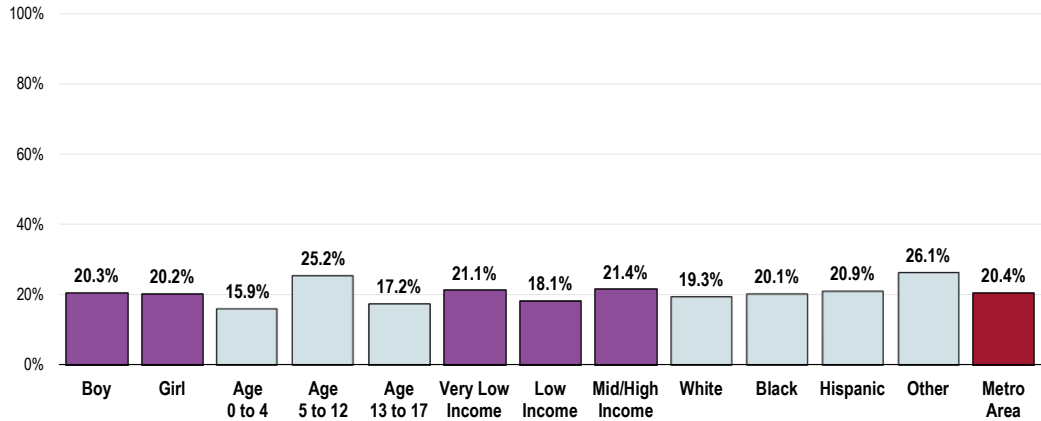
## Child Has Eczema/Skin Allergies (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 57]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- Children age 5 to 12 are more likely to experience eczema/skin allergies.

### Child Has Eczema/Skin Allergies (Metro Area, 2015)



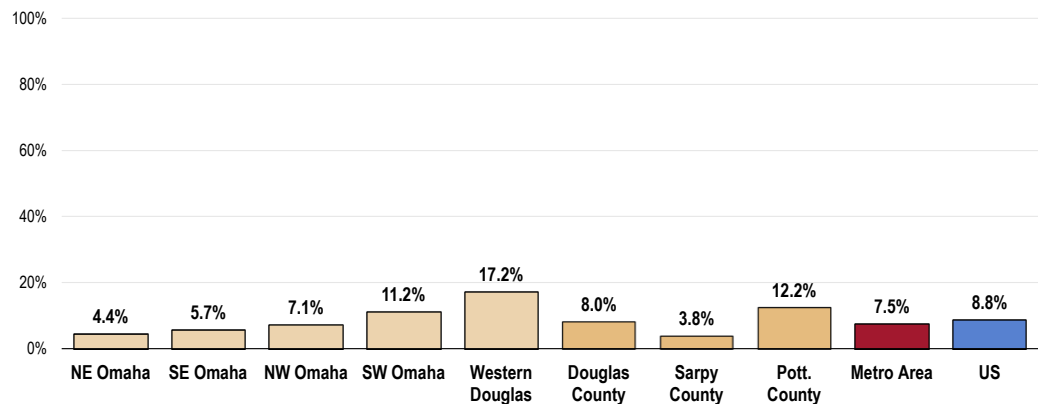
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 57]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Prevalence of Food/Digestive Allergies

A total of 7.5% of Metro Area children have some type of food or digestive allergy.

- Comparable to the national percentage.
- In Douglas County, highest in Western Douglas; lowest in Northeast Omaha.
- By county, highest in Pottawattamie County.

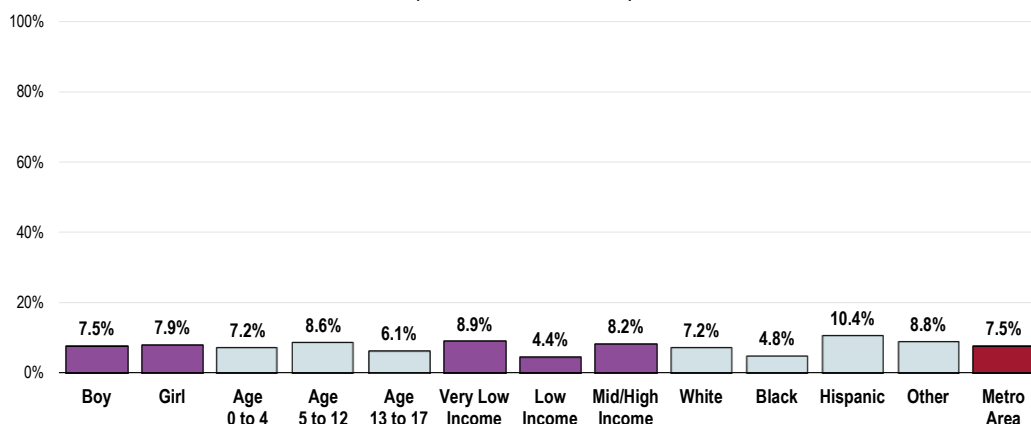
### Child Has Food/Digestive Allergies (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 56]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- No statistical difference when viewed by basic demographic characteristics.

### Child Has Food/Digestive Allergies (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 56]

Notes: • Asked of all respondents about a randomly selected child in the household.

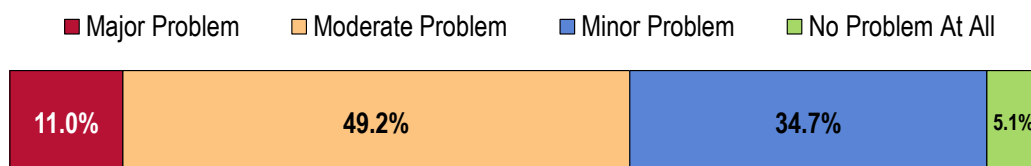
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Allergies

Nearly one-half of key informants taking part in an online survey characterized Allergies as a "moderate problem" in the community.

### Perceptions of Allergies as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

#### Rate of Occurrence

Allergies are on the rise in children and adolescents. – Social Services Provider

Higher incidence of allergies, and large proportion of untreated allergies. – Physician



*Large number of children with allergy symptoms such as atopic dermatitis and respiratory problems and food allergy. There are large amount of allergens in Omaha that contribute with these problems. – Physician*

*There are many children who have seasonal allergies and it will lead them to miss days of school because of congestion. – Community/Business Leader*

*I routinely see children who suffer from allergies, eczema and asthma. I feel seasonal allergies are prevalent in Midwest. – Other Healthcare Provider*

*Multiple patients with multiple food allergies or very severe uncontrolled eczema. – Physician*

### **Environmental Conditions**

*Midwest is high for allergies/pollen counts. – Other Healthcare Provider*

*High pollen counts every spring and fall in the Omaha metro with allergic rhinitis affecting asthma.*

*Food allergies continue to be on the rise. – Physician*

### **Poor Conditions in the Home**

*Poor conditions in the home and change in food preparation globally. – Physician*

*Many households in the north Omaha area have lead based paint as well as mold. These critical issues have impacted allergies and asthma in young children. – Social Services Provider*

### **Access to Affordable Healthy Food**

*Kids and families are not provided wholesome foods. Our society sends powerful messages to fill their little bodies with processed foods. Their bodies cannot assimilate, so their bodies break down. – Community/Business Leader*

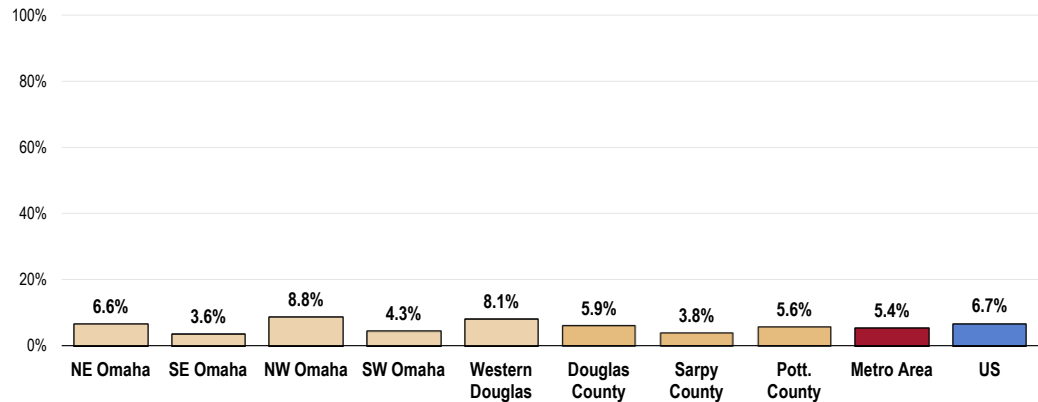
## Neurological Conditions

### Prevalence of Migraines/Severe Headaches

A total of 5.4% of Metro Area children suffer from migraines or severe headaches.

- Comparable to that experienced by children nationally.
- No statistical difference when viewed by sub-area of Douglas County.
- Statistically comparable findings by county.

#### Child Has Migraines/Severe Headaches (Metro Area, 2015)

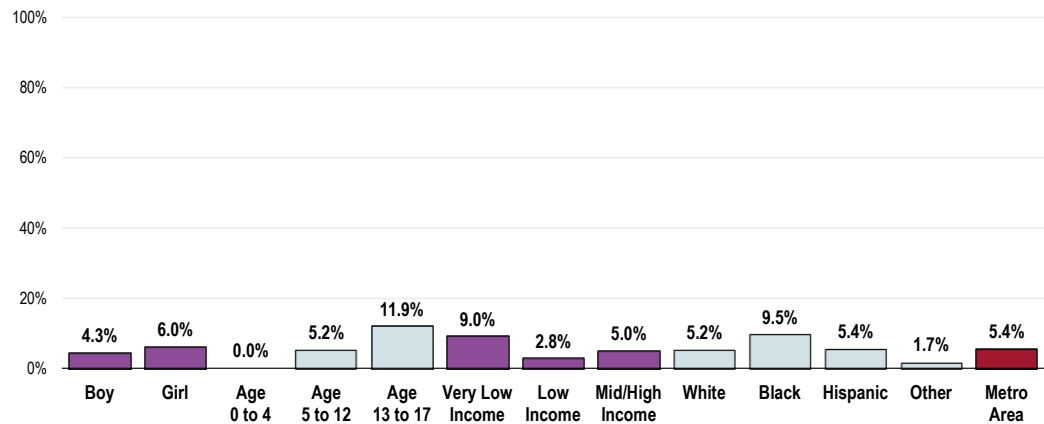


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 61]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Metro Area children more likely to suffer from migraines/severe headaches include:

- Teens (note the positive correlation with age).
- Blacks.

#### Child Has Migraines/Severe Headaches (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 61]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

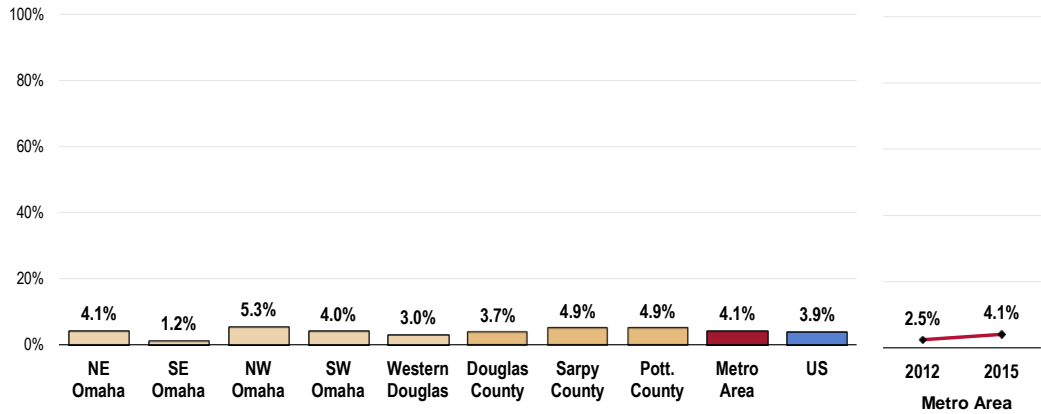
## Prevalence of Brain Injury/Concussion

A total of 4.1% of Metro Area children have suffered a brain injury or concussion.

- Similar to the US rate.
- In Douglas County, less of an issue in Southeast Omaha.
- No difference among County results.
- TREND: Statistically unchanged since 2012.

### Child Has Had a Brain Injury/Concussion

(Metro Area, 2015)



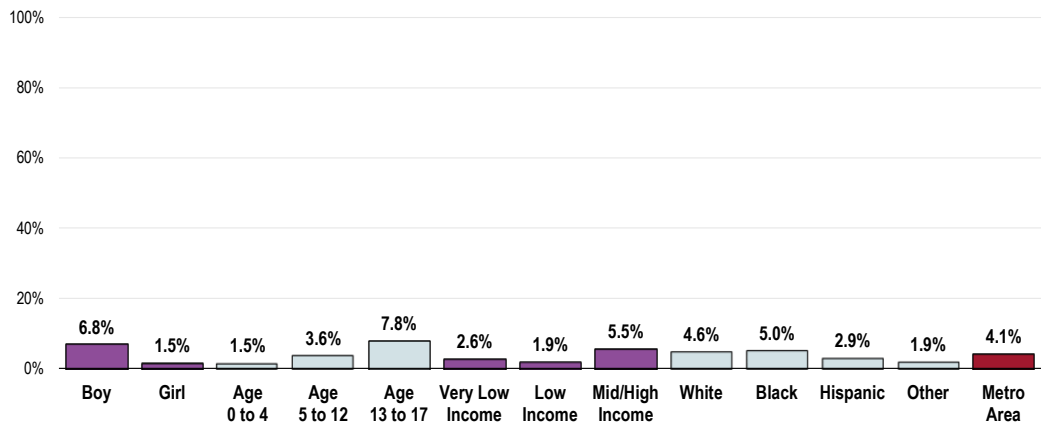
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 60]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents about a randomly selected child in the household.

- This is predominantly noted among boys and teens.
- Also higher among children in mid/high income households.

### Child Has Had a Brain Injury/Concussion

(Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 60]

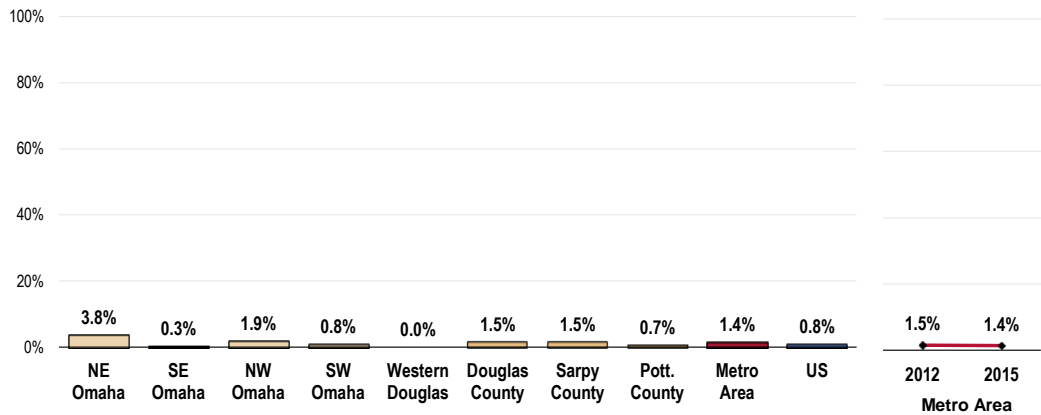
Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Prevalence of Seizure Disorder/Epilepsy

**Less than two percent (1.4%) of Metro Area children have epilepsy or a seizure disorder.**

- Statistically similar to the national findings.
- Within Douglas County, highest in Northeast Omaha, lower in Southeast Omaha, and absent in Western Douglas.
- Similar by county.
- TREND: Nearly identical to 2012 survey findings.

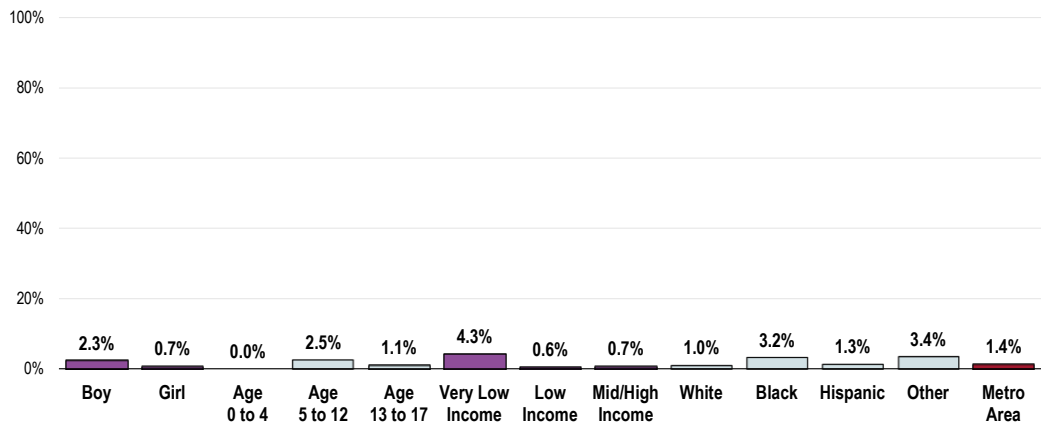
### Child Has Seizure Disorder/Epilepsy (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 58]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Boys are more likely than girls to suffer from seizures/epilepsy, as are children age 5 or older.

### Child Has Seizure Disorder/Epilepsy (Metro Area, 2015)

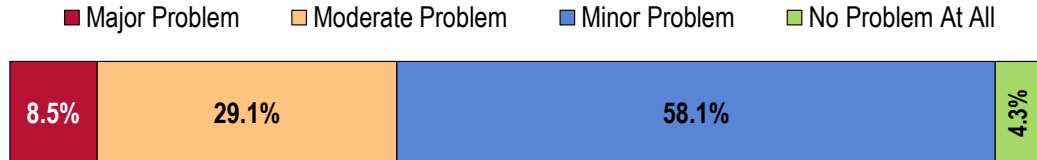


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 58]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Key Informant Input: Neurological Conditions

Most key informants taking part in an online survey characterized Neurological Conditions as a “minor problem” in the community.

### Perceptions of Neurological Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Lack of Providers

*There are only two Neurologists in the city and the wait is usually six months to get in to see them. – Physician*

*Many suffer from them, and there are not enough Pediatric Neurologists. The waiting list can be months long. – Physician*

*Lack of providers, physicians, to see patients. – Physician*

*There is often a long waiting list for a child neurology appointment. – Physician*

*Limited access to Pediatric Neurology specialists. – Physician*

### Lack of Resources

*Lack of services available in this community. – Social Services Provider*

*Many neurological conditions go untreated or are misdiagnosed as behavior concerns due to lack of preventive care for children and baby checkups. – Social Services Provider*

## Bone, Joint & Muscle Problems

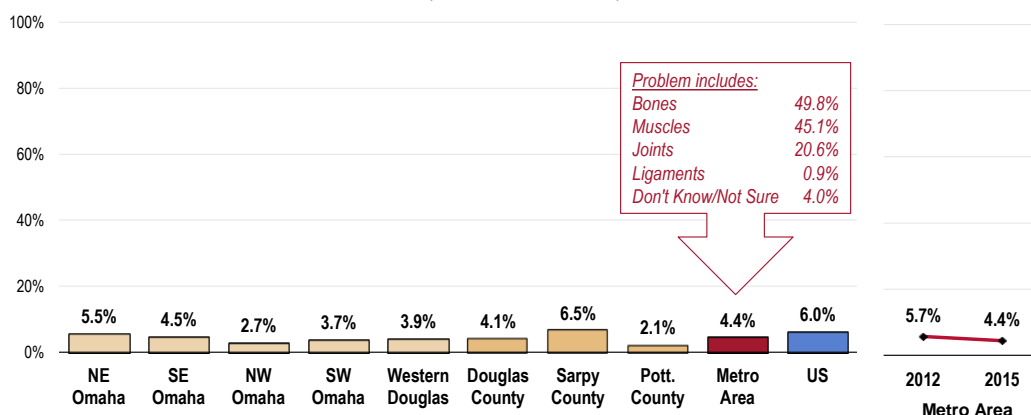
### Prevalence of Bone/Joint/Muscle Problems

A total of 4.4% of Metro Area children experience bone, joint or muscle problems.

- Comparable to the US proportion.
- No statistical difference within Douglas County.
- Statistically comparable by county.
- TREND: Statistically unchanged from 2012 findings.

Among these, the largest share (49.8%) identified that the problem included issues with their child's **bones**, followed by **muscles** (45.1%), **joints** (20.6%) and **ligaments** (0.9%).

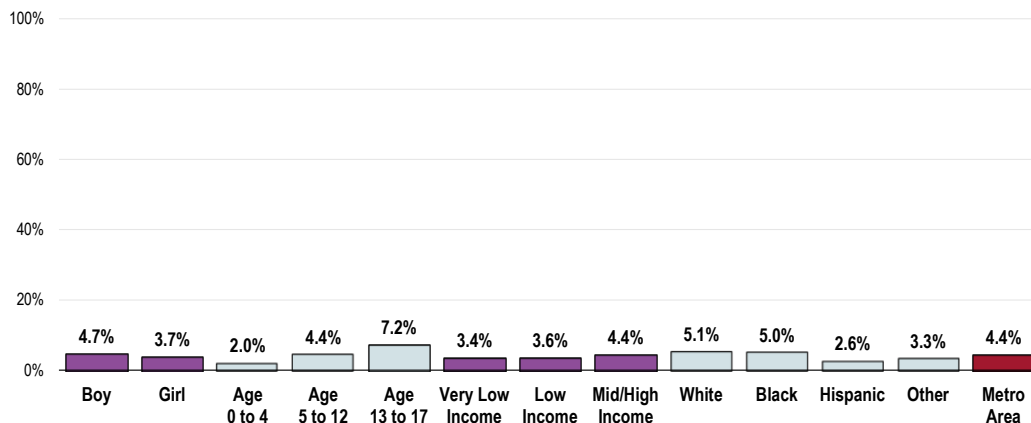
### Child Has Bone, Joint, or Muscle Problems (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 63-64]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Teens appear much more likely to suffer from bone, joint or muscle problems (note the positive correlation with age).

### Child Has Bone, Joint, or Muscle Problems (Metro Area, 2015)

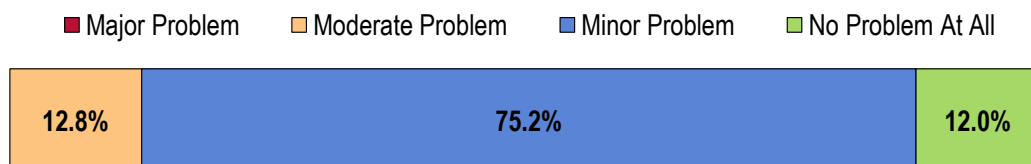


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 63]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Bone, Joint, and Muscle Conditions

Three-fourths of key informants taking part in an online survey characterized Bone, Joint and Muscle Conditions as a "moderate problem" in the community.

### Perceptions of Bone, Joint, and Muscle Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

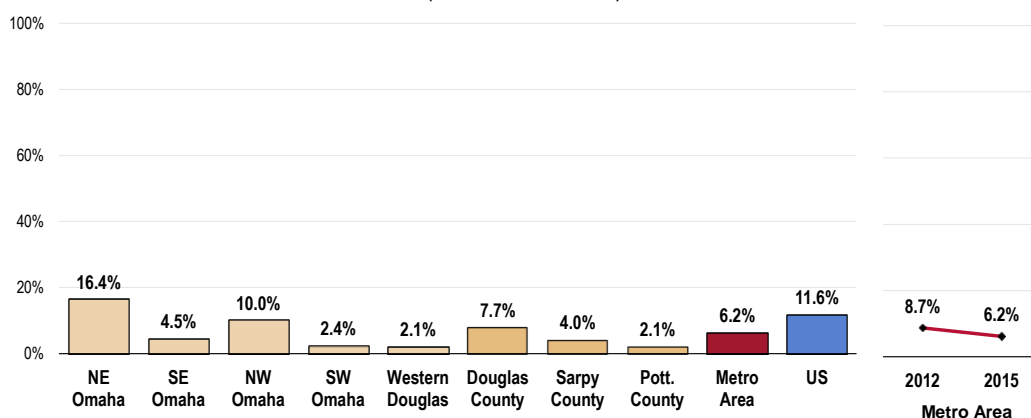
## Prevalence of Asthma

A total of 6.2% of Metro Area children age 0 to 17 currently have asthma.

- Notably lower than the national rate.
- In Douglas County, particularly high in Northeast Omaha; lowest in Western Douglas, Southeast and Southwest Omaha.
- By county, highest in Douglas County; lowest in Pottawattamie County.
- TREND: Denotes a statistically significant decrease (improvement) in asthma prevalence.

### Child Currently Has Asthma

(Metro Area, 2015)



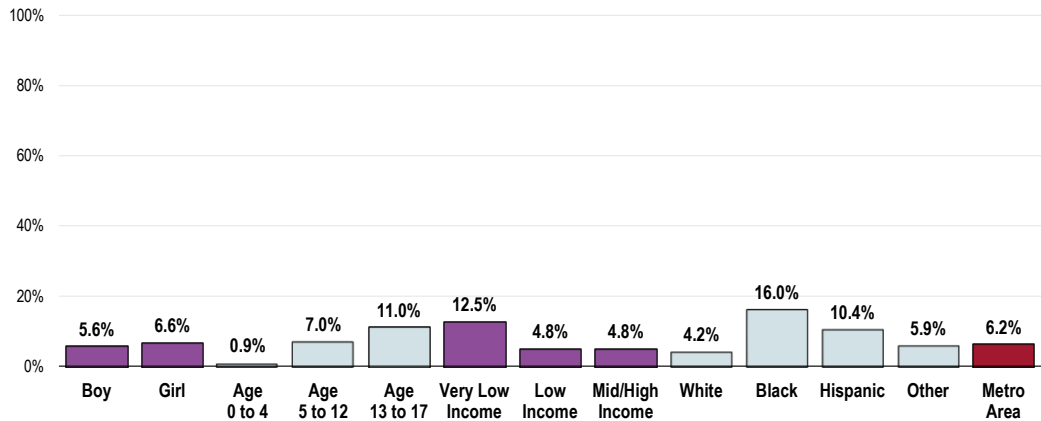
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 150]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Childhood asthma prevalence in the Metro Area is highest among:

- Older children (positive correlation with age).
- Those in very low income households.
- Black or Hispanic children.



## Child Currently Has Asthma (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 150]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

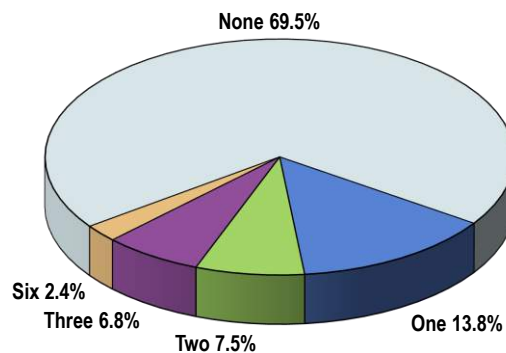
## Asthma-Related Care

### Emergent/Urgent Care

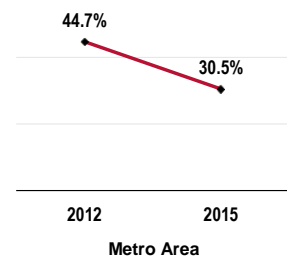
Among Metro Area children with asthma, 30.5% have had emergency room or urgent care visits due to their asthma at least once in the past year.

- Considerably more favorable than what occurs nationwide (not shown).
- TREND: Since 2012, the change in prevalence of children going to the ER or urgent care center for asthma related issues (although it appears sizeable) is not statistically significant.

## Number of Asthma-Related ER/Urgent Care Visits in the Past Year (Metro Area Children with Asthma, 2015)



Child Had At Least One  
Asthma-Related ER/Urgent  
Care Visit in the Past Year



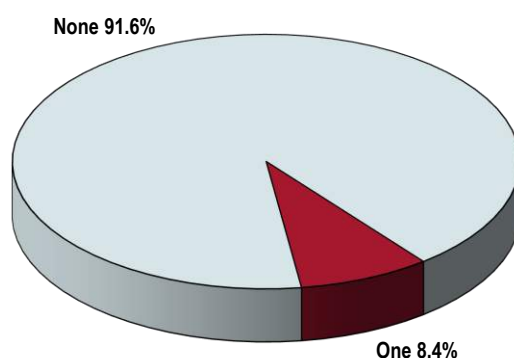
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 51]  
Notes: • Asked of respondents with a child who currently has asthma.

### Hospitalization

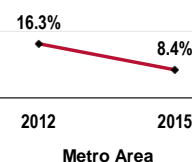
Among Metro Area children with asthma, 8.4% were hospitalized overnight in the past year because of asthma.

- Statistically less favorable than the national figure (not shown).
- TREND: Since 2012, this has remained statistically unchanged.

### Number of Asthma-Related Hospital Stays in the Past Year (Metro Area Children with Asthma, 2015)



Child Had At Least One  
Asthma-Related Hospital Stay  
in the Past Year



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 52]  
Notes: • Asked of respondents with a child who currently has asthma.

### Loss of Productivity

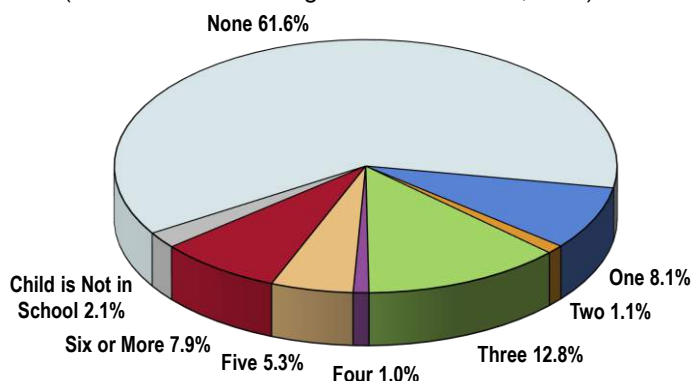
#### Missed School Days

Among Metro Area school-aged children with asthma, more than one-third (36.2%) missed school on one or more days in the past year because of asthma-related problems.

- In fact, over 10% missed **5+ school days** because of their asthma in the past year.
- Statistically comparable to national findings (not shown).

## Number of School Days Missed Due to Asthma in the Past Year

(Metro Area Children Age 5-17 with Asthma, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 53]  
Notes: • Asked of respondents with a child who currently has asthma.

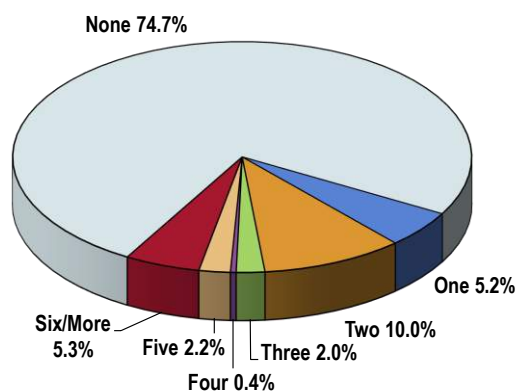
### Parents' Missed Workdays

Further, one-fourth (25.1%) of Metro Area parents with asthmatic children missed at least one day of work in the past year because of their child's asthma.

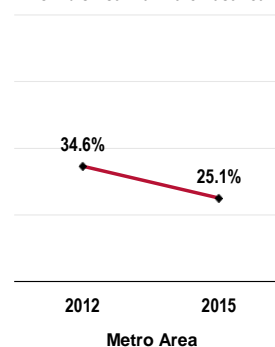
- The prevalence includes 7.5% of parents who missed **5+ workdays** in the past year due to their child's asthma.
- Statistically similar to national findings (not shown).
- TREND: Statistically, this has not changed significantly since 2012.

## Workdays Missed in the Past Year Due to Child's Asthma

(Metro Area Parents of Children with Asthma, 2015)



Parent Missed Work Due to Child's Asthma in the Past Year



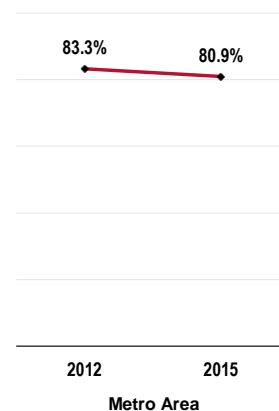
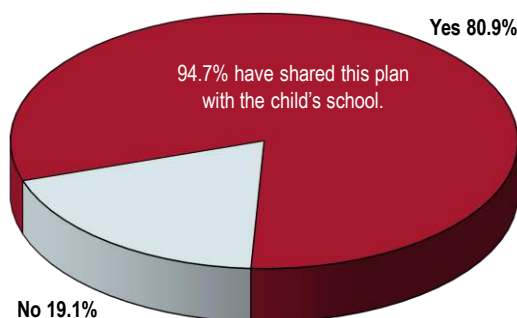
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 54]  
Notes: • Asked of respondents with a child who currently has asthma.

## Action Plan

**4 in 5 children with asthma (80.9%) have an asthma action plan.**

- Of the 50 school aged children with an asthma action plan, 94.7% of their parents have shared the plan with the child's school.
- TREND: The popularity of asthma action plans has stayed statistically the same over the past three years.

### Child Has an Asthma Action Plan (Among Parents of Children with Asthma, 2015)

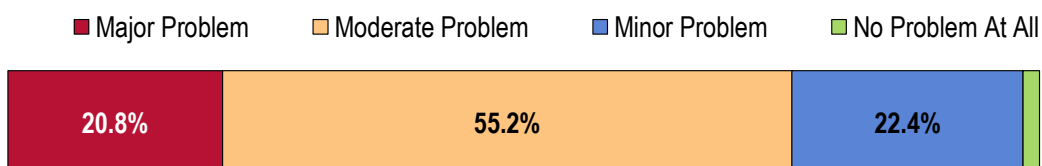


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 306-307]

## Key Informant Input: Asthma and Other Respiratory Conditions

A majority of key informants taking part in an online survey characterized Asthma and Other Respiratory Conditions as a “moderate problem” in the community.

### Perceptions of Asthma and Other Respiratory Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Living Conditions

*Due to the living conditions of children in poverty and the amount of pollutants in our environment, there is a prevalence of asthma conditions within certain populations. Parent education, in regard to the seriousness of asthma, is not always understood. – Social Services Provider*

*There is a high rate of asthma in the community related to living conditions, under recognition of symptoms, until they become severe, and lack of knowledge in the general public regarding chronicity and ongoing care. – Physician*

*Asthma was a health issue that came up in 2012's survey and is clearly prevalent in neighborhoods near factories, trucking or other in-home pollutants. – Public Health Representative*

*The increasing number of children diagnosed with and dying from asthma, which is related to the environmental health hazards that exist in the community. – Community/Business Leader*

*Environment. – Physician*

*Lead contamination in NE Omaha homes, Other environmental effects. – Social Services Provider*

*It requires regular monitoring and special care, which is hard to access in some parts of town. Also, in some parts of town the microenvironments within homes are likely causing/contributing to these issues. Until you address the substandard housing conditions people live in, the issues won't go away completely. – Public Health Representative*

*Parts of Omaha with low socioeconomic status, poor environment, second hand smoke exposure, delay in recognition of problems and seeking help. – Physician*

### Lack of Compliance with Treatment

*It is not taken seriously by patients and they are not prepared for emergencies. We (Nebraska) had the second highest death rate from asthma in the country a few years ago. – Physician*

*Not viewed as a problem individually among patients or families. Large difference is management among physicians. – Physician*

*Lack of compliance with medical treatment. – Physician*

*High prevalence, relatively poor compliance with recommended maintenance therapy. – Physician*

*10-20% of our patients have asthma. Many are poorly adherent to their treatments, for many reasons.*

*One of our patients died this year while on vacation from his asthma. – Physician*

### Leading Cause of School Absence

*This impacts children's attendance in school and ability to be active. Generally, it is preventable and treatable, so should be readily reduced. – Public Health Representative*

*Leading cause of school absence. Difficulty in getting adherence to meds by patients and families.*

*Lack of attention and resources for families to provide better environmental control. – Physician*

*Asthma is a common diagnosis and many environmental triggers. I feel there is a lot of missed days at school for asthma and better communication with schools about making sure kids are able to get appropriate treatments at school to return sooner. – Physician*

*Many children with asthma action plans for school. Many children with acute exacerbations leading to hospitalizations. – Physician*

### Access to Care

*Asthma is a growing concern in the Omaha community. Medication cost, availability, and training from prescribers lead to noncompliance and thus increased symptoms and hospitalizations. Given the local allergens, asthma sufferers can have difficulty during those periods as well, and if not previously controlled can be life threatening. Also, as growing numbers refuse influenza vaccination, the potential for serious outcomes is significant. – Physician*

*Based on ED utilization we know uncontrolled asthma is a problem in the minority populations, due to lack of education and money for medication. – Physician*

### ***Lack of Resources***

*Asthma is a huge problem in Omaha and there is no coordinated effort to address it. We need more resources to address indoor environmental triggers for asthma. – Public Health Representative*

### ***Influence of Allergies***

*Allergies and asthma go hand in hand. – Physician*

*Same response as the response to allergies. Many times these conditions go hand in hand. – Social Services Provider*

### ***Poor Nutrition***

*Our children's bodies are filled with processed food and chemicals. – Community/Business Leader*

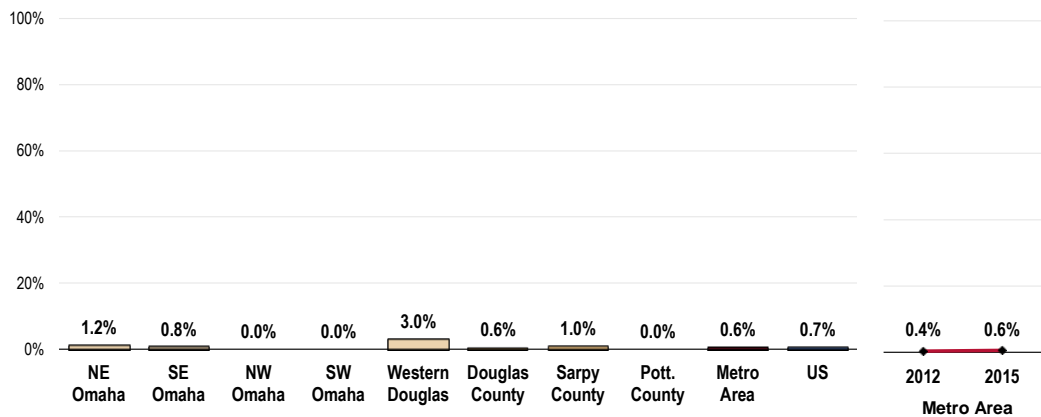
## Diabetes

**Less than one percent (0.6%) of Metro Area children age 0 to 17 has been diagnosed with diabetes by a doctor or other healthcare provider.**

- The Metro area rate is nearly identical to that of the US.
- In Douglas County, there were null responses in Northwest and Southwest Omaha.
- There were no reported childhood diabetes cases in Pottawattamie County.
- TREND: The prevalence of childhood diabetes in the Metro Area has barely changed since 2012.

### Child Has Diabetes

(Metro Area, 2015)

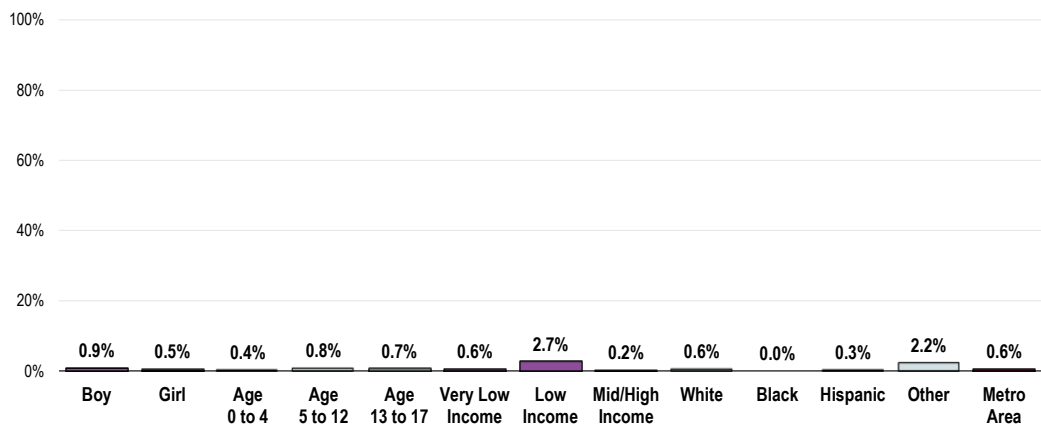


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 59]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Note the null response among parents of Black children.

### Child Has Diabetes

(Metro Area, 2015)

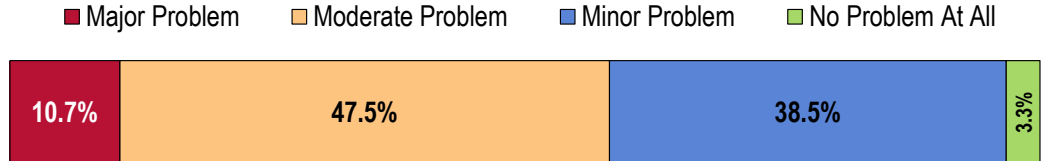


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 59]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Key Informant Input: Diabetes

The greatest share of key informants taking part in an online survey characterized Diabetes as a “moderate problem” in the community.

### Perceptions of Diabetes as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Obesity Epidemic

*Increase in obesity rates in children. Apparently not enough Endocrinologists. CH specialists not accepting any new patients, it seems. – Physician*

*The growing number of overweight and obese children are now experiencing diabetes at an early age and there are only a few programs that provide ongoing services, such as the Heroes program at Children's Hospital and CHI family program. There is concern about insurance payment for these services for many families and the Healthy Families program is evidence informed not evidence based. – Public Health Representative*

*With the obesity epidemic, more are at risk for diabetes. – Other Healthcare Provider*  
*Obese and inactive kids. – Physician*

### Poor Nutrition

*There are a number of food deserts in town. People don't always have access to healthy food. And, with the violence going on in certain parts of town, there are not always opportunities to play outside. And, the cost of the Kroc Center and other places may be too expensive, so the kids can't go there to be active. Add those together and there are kids who are at high risk for obesity and diabetes. – Public Health Representative*

*Lack of proper nutrition and inactivity. – Community/Business Leader*

*Processed food that contain a great deal of sugar and carbohydrates are cheaper and more accessible to children in the community. Options are not often given for healthy quality foods, other than at school. – Social Services Provider*

### Lack of Providers

*Lack of providers, physicians, to see these patients. – Physician*

*Minimal number of Pediatric Endocrinologists. – Physician*

*There are not enough pediatric endocrinologists in Nebraska. – Physician*

### Lack of Education

*Education and growing weight gain among youth. – Community/Business Leader*



***Rate of Occurrence***

*Mobile clinic screenings conducted by Families in Action reveal high instance of diabetic needs in Latino community for children and parents. – Community/Business Leader*

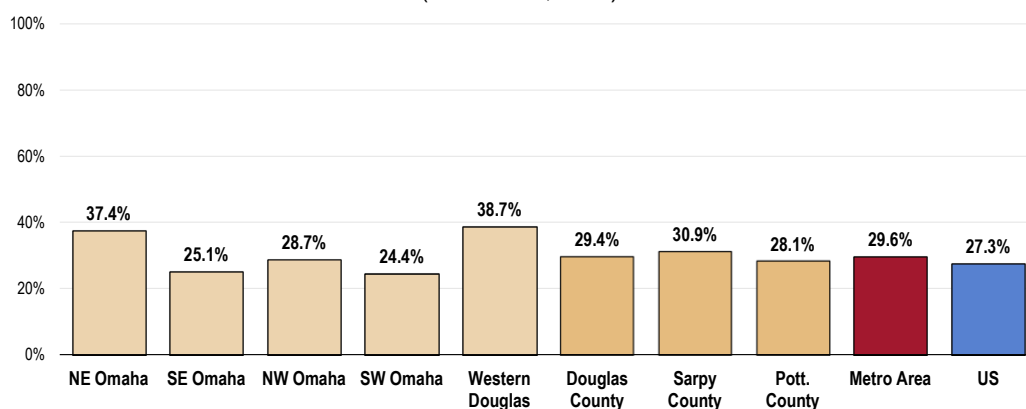
## Condition Requiring Prescriptions or Special Therapy

### Prescriptions

A total of 29.6% of Metro Area children has a condition that requires prescription medication(s), not counting vitamins.

- Similar to that found nationwide.
- In Douglas County, highest in Northeast Omaha and Western Douglas.
- Similar by county.

**Child Has a  
Condition That Requires Prescription(s)**  
(Metro Area, 2015)

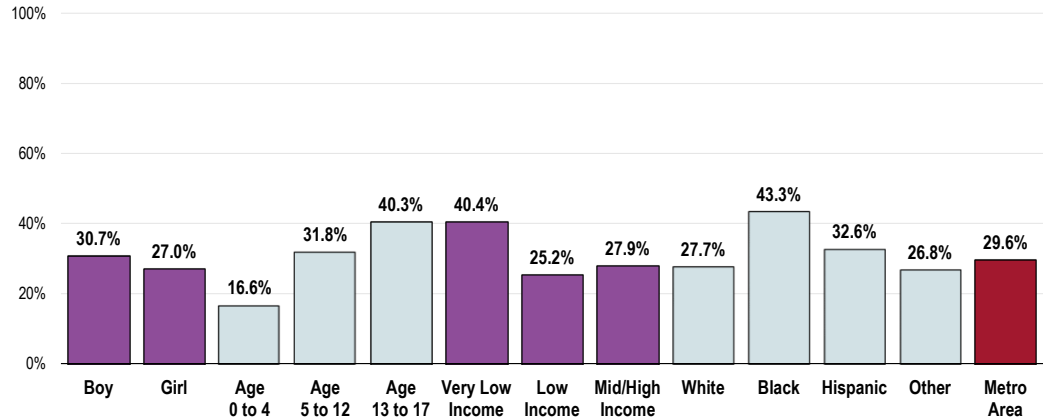


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 32]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

The following are more likely to have a condition that requires a prescription:

- Older children (note the positive correlation with age).
- Those in very low income households.
- Black children.

## Child Has a Condition That Requires Prescription(s) (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 32]

Notes: • Asked of all respondents about a randomly selected child in the household.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

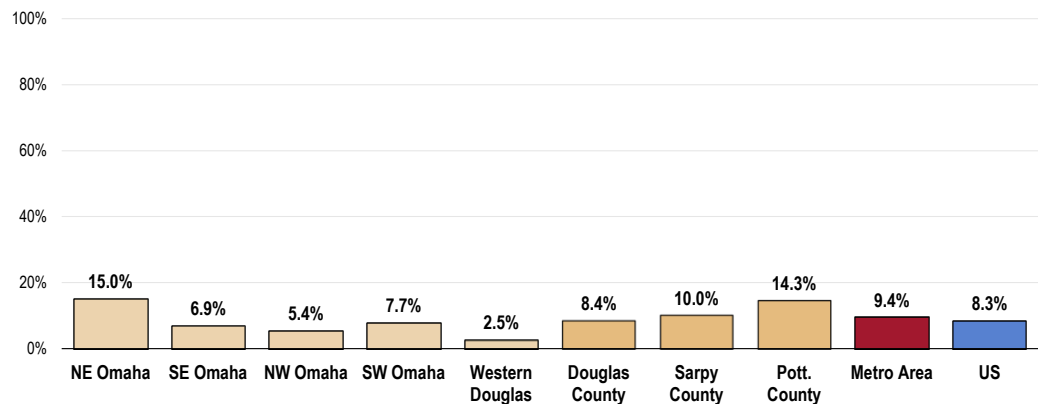
## Special Therapy

**A total of 9.4% of Metro Area children have a condition that requires special therapy.**

- Similar to the proportion of children receiving special therapy nationally.
- In Douglas County, highest in Northeast Omaha; lowest in Western Douglas.
- Statistically similar by county.

Special therapy might include physical, occupational or speech therapy.

## Child Has a Condition That Requires Special Therapy (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 34]

• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

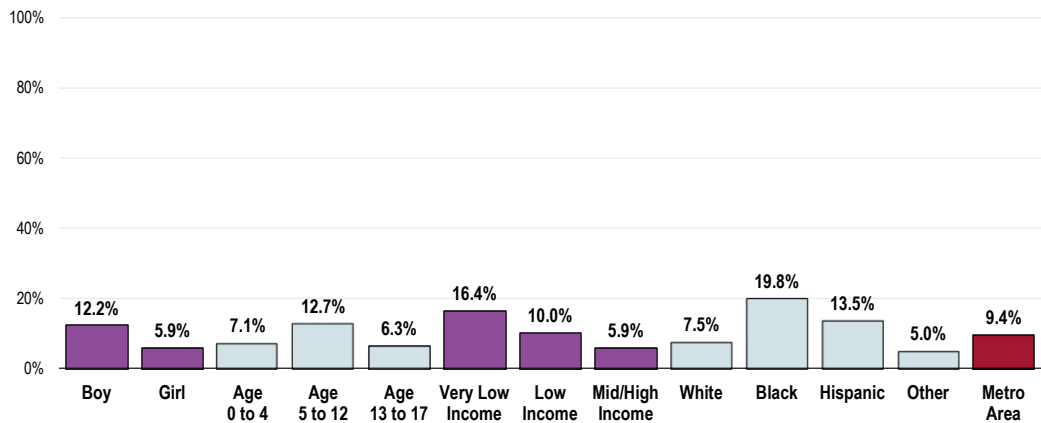
Notes: • Asked of all respondents about a randomly selected child in the household.

Children more likely to have a condition that requires special therapy includes:

- Boys.
- Children age 5 to 12.
- Those in very low income households (negative correlation with income).
- Black or Hispanic children.

### Child Has a Condition That Requires Special Therapy

(Metro Area, 2015)



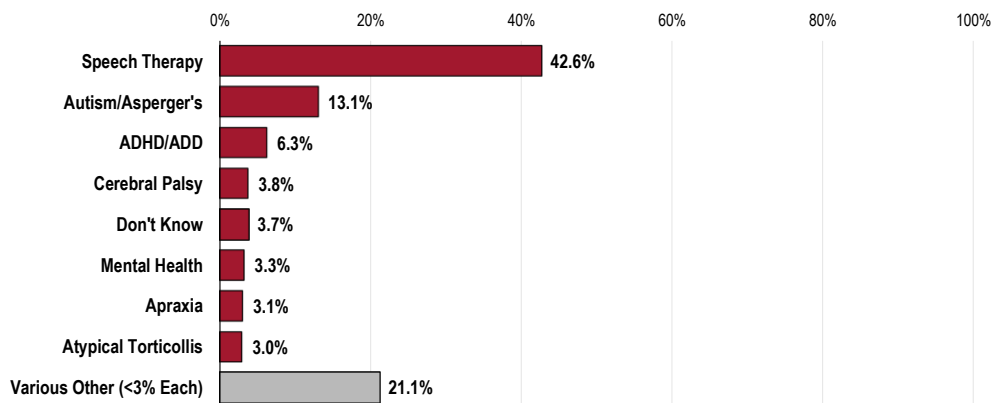
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 34]

Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

When these parents were asked to specify the condition requiring special therapy, **speech difficulties** was the most frequent response (42.6%), followed by **autism/Asperger's** (13.1%), **ADHD/ADD** (6.3%), and a variety of lesser-mentioned conditions.

### Type of Condition Requiring Therapy

(Among Parents of Children Who Need Therapy; Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 36]

Notes: • Asked of all respondents whose child has a condition which requires special therapy.

## Special Health Needs

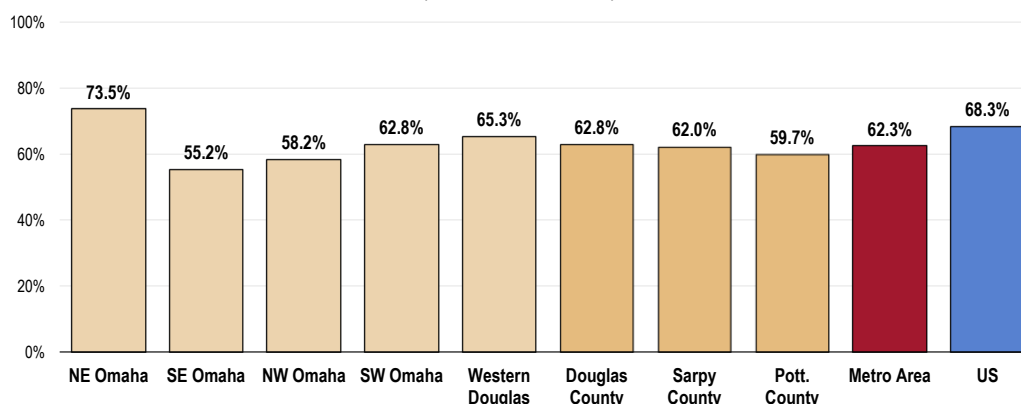
### Prevalence of Special Health Needs

In all, 62.3% of Metro Area children (age 0-17) are found to have special health needs.

- More favorable than US findings.
- In Douglas county, least favorable in Northeast Omaha; most favorable in Southeast Omaha.
- Statistically no difference among Metro Area counties.

### Child Has a Special Health Need

(Metro Area, 2015)



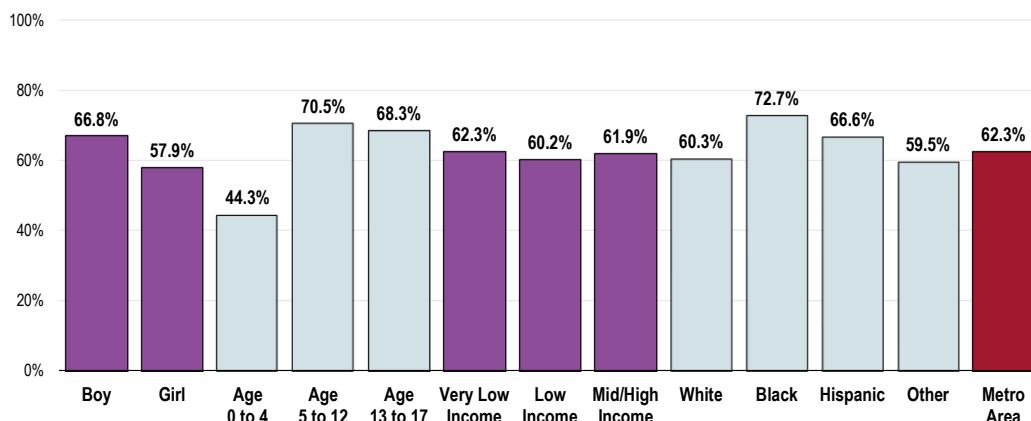
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 181]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents about a randomly selected child in the household.  
• Includes respondents reporting a child's diagnosis of any medical condition specifically measured in the survey, as well as any other not specifically addressed.

Special health needs are more prevalent among:

- Boys.
- Children age 5 and older.
- Black children.

## Child Has a Special Health Need (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 181]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
• Includes respondents reporting a child's diagnosis of any medical condition specifically measured in the survey, as well as any other not specifically addressed.

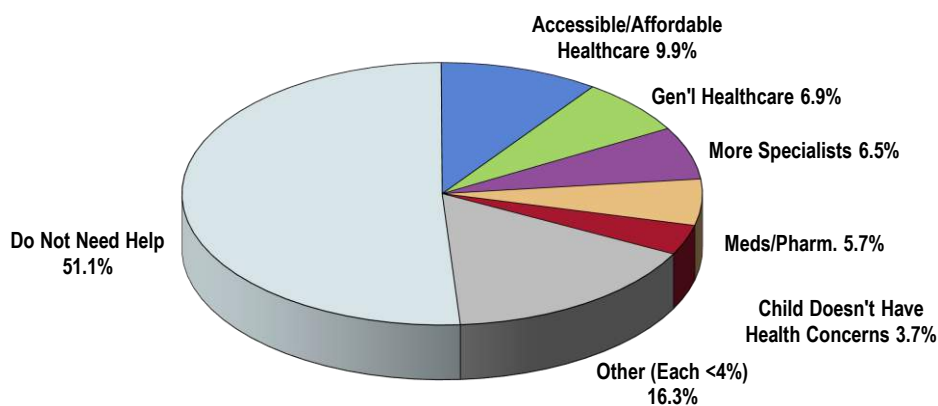
## Managing Children's Special Health Needs

### Parents' Greatest Needs for Child

Among parents of children with special health needs, just over half say that they "do not need any help."

- Other common needs mentioned by parents included: **accessible and affordable healthcare** (9.9%); **general healthcare** needs (6.9%); **more specialists** (6.5%); and **medication/pharmaceutical supplies** (5.7%).

### Respondents' Greatest Need for Child with Special Needs (Metro Area Parents of Children With Special Needs, 2015)



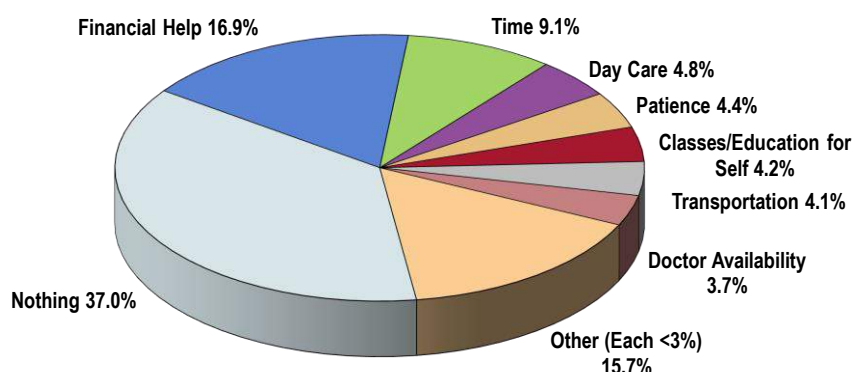
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 73]  
Notes: • Asked of all respondents whose child has a medical condition specifically measured in the survey, excludes those not respondent or unable to provide a response.

## Parents' Greatest Needs for Self

With regard to the needs of *parents themselves* in taking care of their child with special health needs, the largest share of respondents (37.0%) said “nothing;” however, 16.9% mentioned financial help (including references to “insurance” and “affordable care”).

- Other needs often mentioned included more time (9.1%), daycare (4.8%), patience (4.4%), and classes/education (4.2%).

### Respondents' Greatest Need for Self in Caring for Child with Special Needs (Metro Area Parents of Children w/Special Needs, 2015)



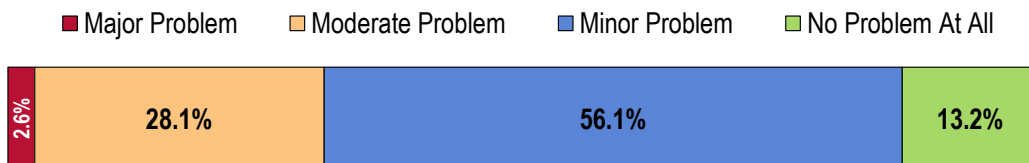
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 74]

Notes: • Asked of all respondents whose child has a medical condition specifically measured in the survey; does not include those who were uncertain or unable to provide a response.

## Key Informant Input: Cancer

A high percentage of key informants taking part in an online survey characterized Cancer as a “minor problem” for children/adolescents in the community.

### Perceptions of Cancer as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### *Access to Specialty Care*

*When the cancer treatment is not working and specialty care is needed, many parents are not educated in how to work the system to gain access to that level of care. – Community/Business Leader*

### *High Prevalence*

*We have a high rate of childhood cancer in our community. – Other Healthcare Provider*

### *Impacts Many*

*Such wide spread impact of each case. – Physician*



## **Prenatal & Infant Health**



**Professional Research Consultants, Inc.**

## Prenatal Care

### About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the Metro Area. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

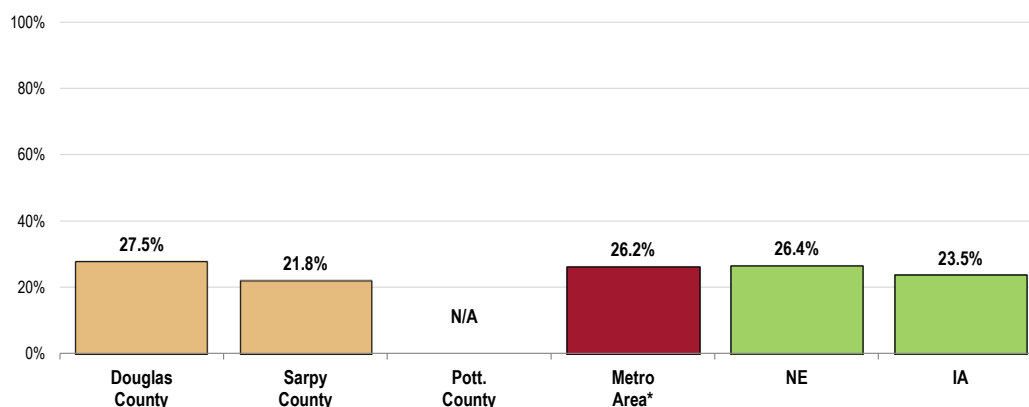
**Between 2011 and 2013, over one-fourth (26.2%) of all Metro Area births did not receive prenatal care in the first trimester of pregnancy.**

- The Metro Area lacks in prenatal care when compared to Iowa, but is nearly identical to what is found across Nebraska.
- Fails to satisfy the Healthy People 2020 target (22.1% or lower).
- Prenatal care in the first trimester is more prevalent in Sarpy County than in Douglas County.

### Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2011-2013)

**Healthy People 2020 Target = 22.1% or Lower**

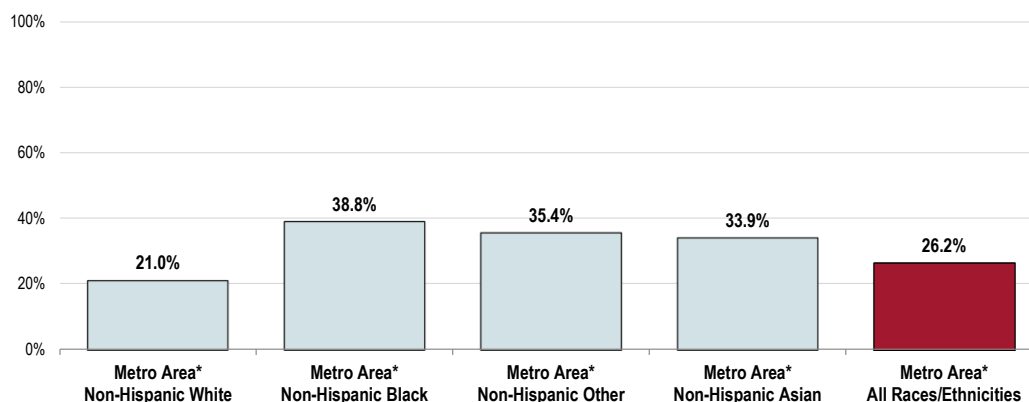


- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.
  - \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

- Lack of prenatal care is most prevalent among Black mothers and notably least prevalent among White mothers.

### Lack of Prenatal Care in the First Trimester (Percentage of Live Births, 2011-2013)

Healthy People 2020 Target = 22.1% or Lower

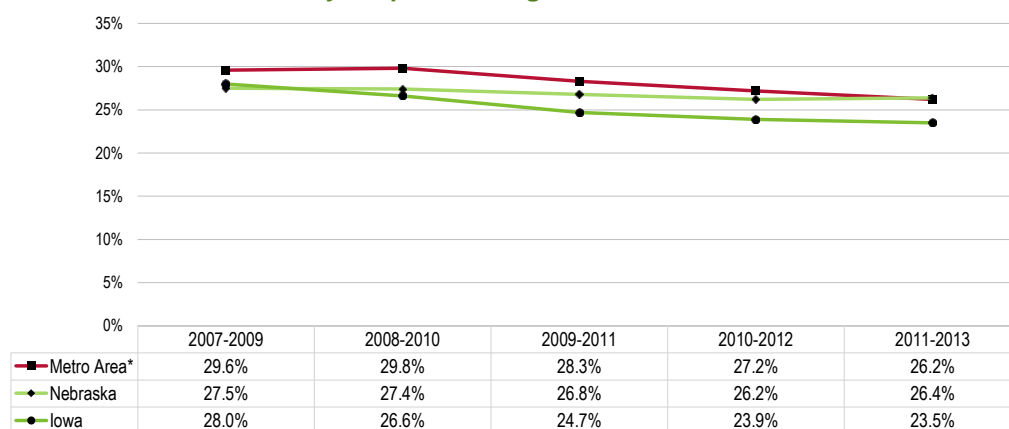


- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.
  - \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

- TREND: Receipt of prenatal care has improved in the Metro Area since 2007, following the Iowa trend; across Nebraska, the prevalence stayed constant.

### Lack of Prenatal Care in the First Trimester (Percentage of Live Births, 2011-2013)

Healthy People 2020 Target = 22.1% or Lower



- Sources:
- Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed using CDC Wonder.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.
  - \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

## Birth Outcomes & Risks

### Low-Weight Births

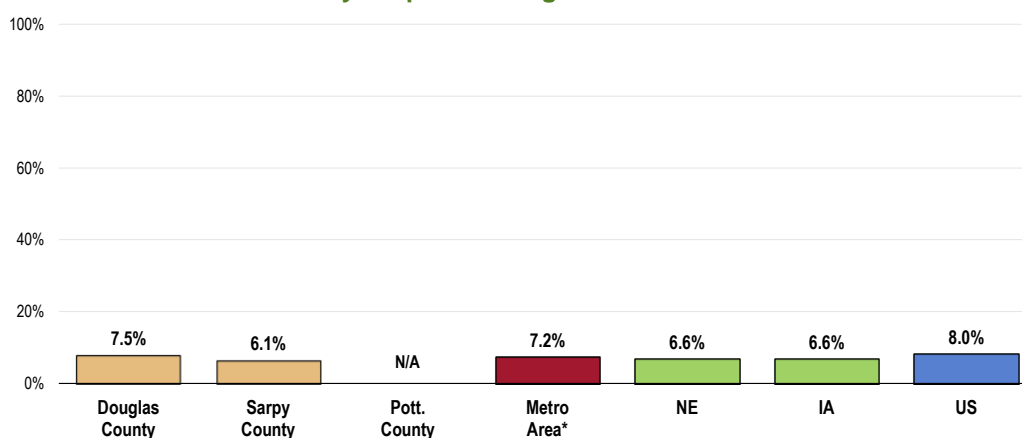
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

**A total of 7.2% of 2011-2013 Metro Area births were low-weight.**

- Worse than the Nebraska and Iowa proportions.
- Better than the national proportion.
- Satisfies the Healthy People 2020 target (7.8% or lower).
- Better weight outcomes in Sarpy County than in Douglas County.

### Low-Weight Births (Percent of Live Births, 2011-2013) Healthy People 2020 Target = 7.8% or Lower



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]

Note:

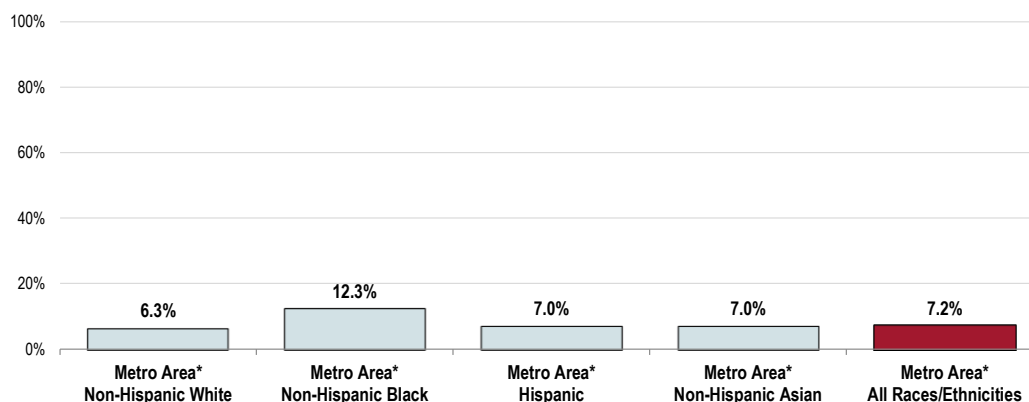
- This indicator reports the percentage of total births that are low birthweight (Under 2500g). This indicator is relevant because low -birthweight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.
- \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

- Low-weight births are notably more prevalent among Black mothers in the Metro Area.

## Low-Weight Births by Race/Ethnicity

(Percent of Live Births, 2011-2013)

Healthy People 2020 Target = 7.8% or Lower



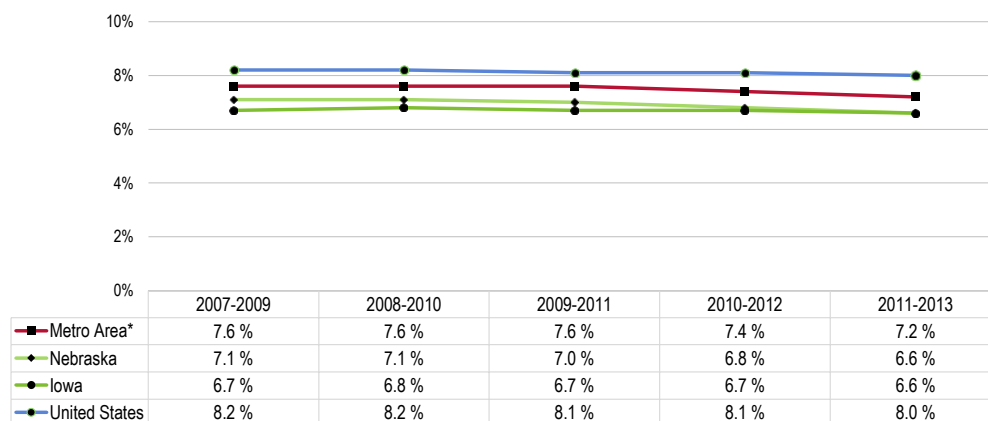
- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
- Note:
- This indicator reports the percentage of total births that are low birthweight (Under 2500g). This indicator is relevant because low-birthweight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.
  - \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

- TREND: The proportion of low-weight births has trended downward slightly in the Metro Area in recent years; the same can be said for Nebraska. Both Iowa and the US have remained stable.

## Low-Weight Births by Race/Ethnicity

(Percent of Live Births, 2011-2013)

Healthy People 2020 Target = 7.8% or Lower



- Sources:
- Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed using CDC Wonder.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
- Note:
- This indicator reports the percentage of total births that are low birthweight (Under 2500g). This indicator is relevant because low-birthweight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.
  - \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

## Child Deaths

### Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

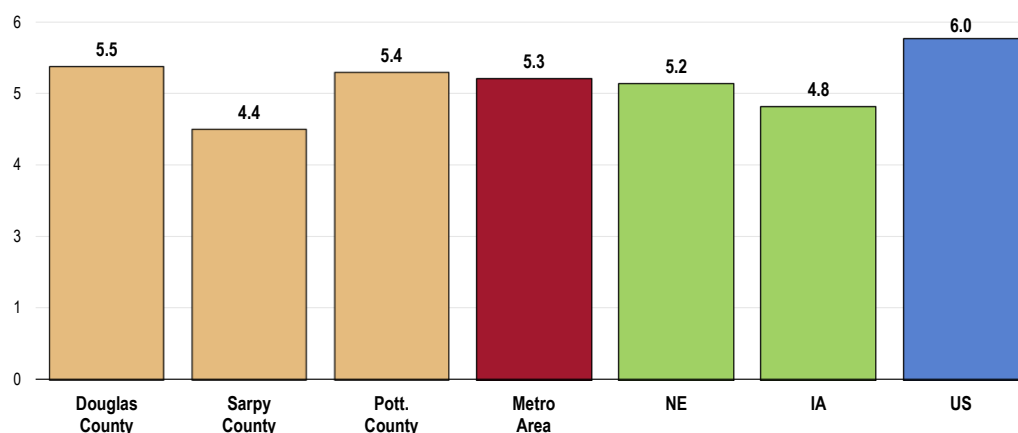
Between 2011 and 2013, there was an annual average of 5.3 infant deaths per 1,000 live births.

- Nearly identical to the Nebraska rate; less favorable than the Iowa rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.
- Favorably low in Sarpy County.

### Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2011-2013)

Healthy People 2020 Target = 6.0 or Lower



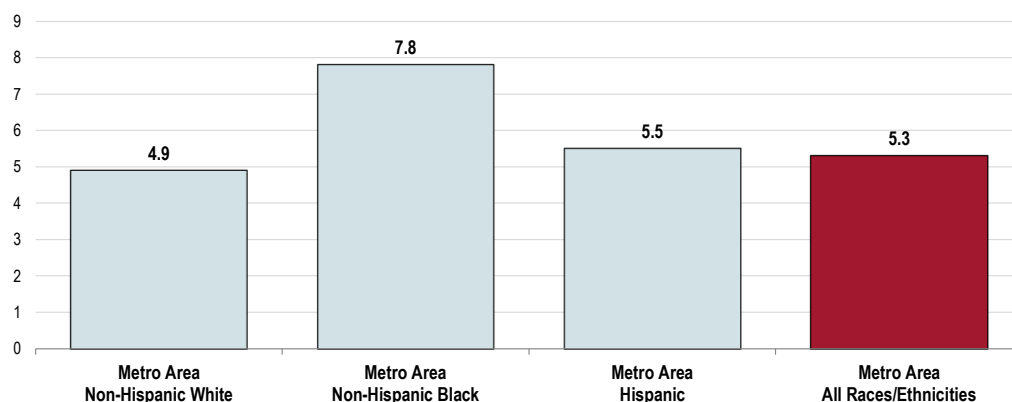
- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Infant deaths include deaths of children under 1 year old.
  - This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- The infant mortality rate is notably higher among births to Non-Hispanic Black mothers.

### Infant Mortality by Race/Ethnicity

(Annual Average Infant Deaths per 1,000 Live Births, 2011-2013)

Healthy People 2020 Target = 6.0 or Lower



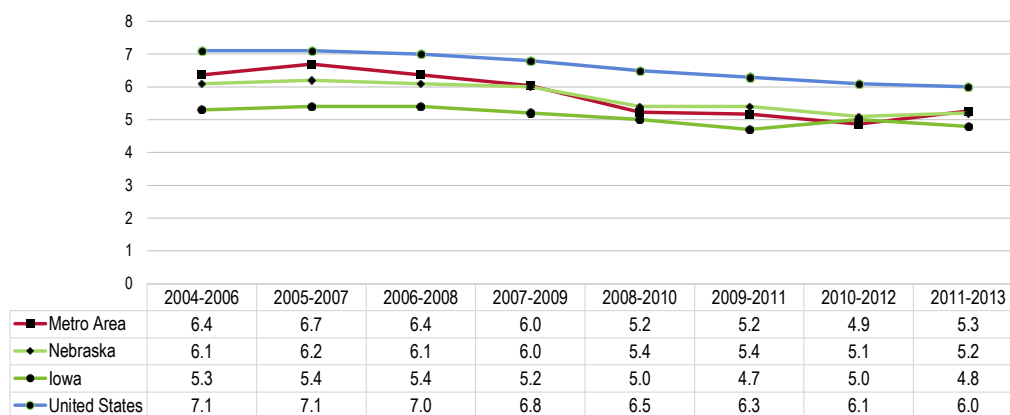
- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Infant deaths include deaths of children under 1 year old.
  - This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- TREND:** The infant mortality rate has trended downward slightly in recent years in the Metro Area, closely following the Nebraska trend.

### Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2020 Target = 6.0 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
  - Centers for Disease Control and Prevention, National Center for Health Statistics.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

## Child & Adolescent Deaths

Between 2011 and 2013, the Metro Area reported an annual average of 23.4 child deaths (age 1 to 4) per 100,000 population.

- Lower than the Nebraska rate but comparable to the Iowa rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target of 25.7 per 100,000 population.

With regard to children age 5 to 9, the Metro Area crude death rate was 10.6 per 100,000 population (2011-2013 data).

- Lower than the Nebraska rate but comparable to the Iowa rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 goal of 12.3 deaths per 100,000 population.

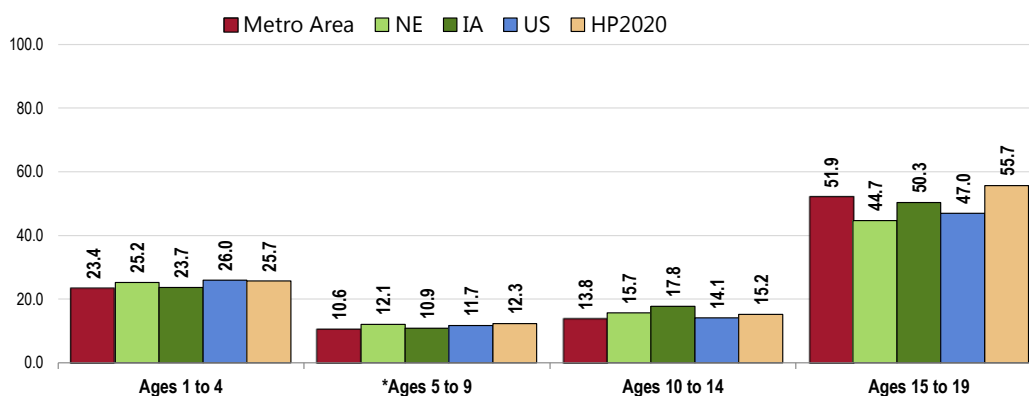
Among Metro Area youth age 10 to 14, the 2011-2013 crude death rate was 13.8 per 100,000 population.

- Lower than the Nebraska rate and the Iowa rate.
- Comparable to the national rate.
- Satisfies the related Healthy People 2020 goal of 15.2 deaths per 100,000 population.

Among Metro Area teens (age 15 to 19), the 2011-2013 crude death rate was 51.9 per 100,000 population.

- Higher than the Nebraska rate but comparable to the Iowa rate.
- Higher than the national rate.
- Satisfies the related Healthy People 2020 goal of 55.7 deaths per 100,000 population.

### Child & Adolescent Mortality Rates by Age Group (Annual Average Child Mortality per 100,000 Population; 2011-2013)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2015.

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-3.1]

Notes: • Rates are crude rates, representing the number of deaths of children in each age group per 100,000 population.

• \*The Metro Area age 5 to 9 rate reflects 2009-2013.



## Leading Causes of Child Deaths

The predominant cause of death between 2004-2013 for Metro Area children under one year of age was **perinatal conditions** (certain conditions occurring in the perinatal period, usually low birthweight, preterm birth, and complications of pregnancy, labor and delivery).

**Accidents** were the number-one leading cause of death for all other Metro Area children and adolescents (ages 1-19).

- Other leading causes of death for infants included congenital conditions and maternal factors or labor complications.
- Among children aged 1-4, cancer and homicide followed accidents as the leading causes of death.
- For children aged 5-9, cancer followed accidents as the leading cause of death.
- Cancer was the second-leading cause of death for Metro Area children 10-14, followed by suicide.
- Suicide and homicide followed accidents as the leading causes of death for Metro Area teens (15-19).

See also Injury & Safety in the Modifiable Health Risks section of this report.

## Leading Causes of Child Deaths by Age Group (Metro Area, 2004-2013)

Omaha Metro Area	Under 1 Year	Ages 1 to 4	Ages 5 to 9	Ages 10 to 14	Ages 15 to 19
Number-One Leading Cause	Perinatal Conditions*	Accidents	Accidents	Accidents	Accidents (especially Motor Vehicle Crashes)
Number-Two Leading Cause	Congenital Conditions**	Cancer	Cancer	Cancer	Suicide
Number-Three Leading Cause	Maternal factors or Labor/Delivery complications	Homicide	n/a	Suicide	Homicide

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2015.

- Notes: • \*Perinatal conditions include certain conditions occurring in the perinatal period, usually low birthweight, preterm birth, and complications of pregnancy, labor and delivery.
- \*\*Congenital conditions include congenital malformations, deformations and chromosomal abnormalities.

## Family Planning

### Births to Teen Mothers

#### About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

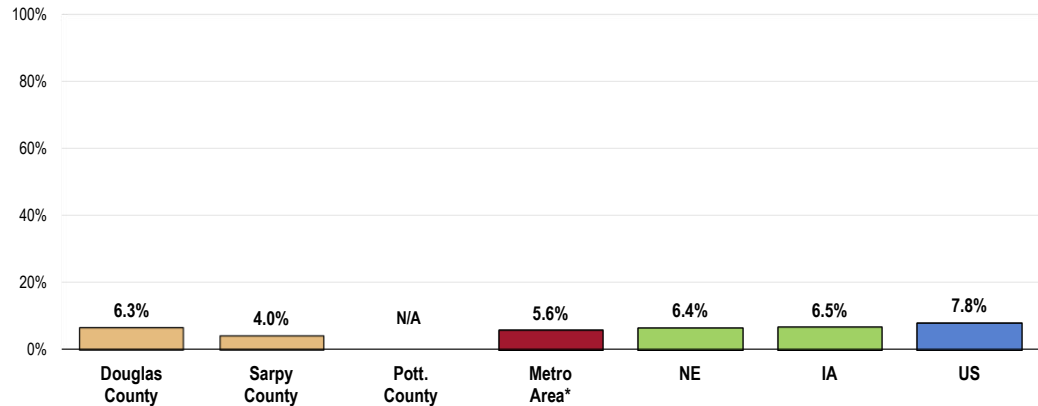
— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Between 2011 and 2013, 5.6% of all live births were to women under age 20.**

- Lower than the Nebraska and Iowa proportions.
- Lower than the national proportion.
- Higher in Douglas County than in Sarpy County.

#### Births to Teen Mothers (Under 20)

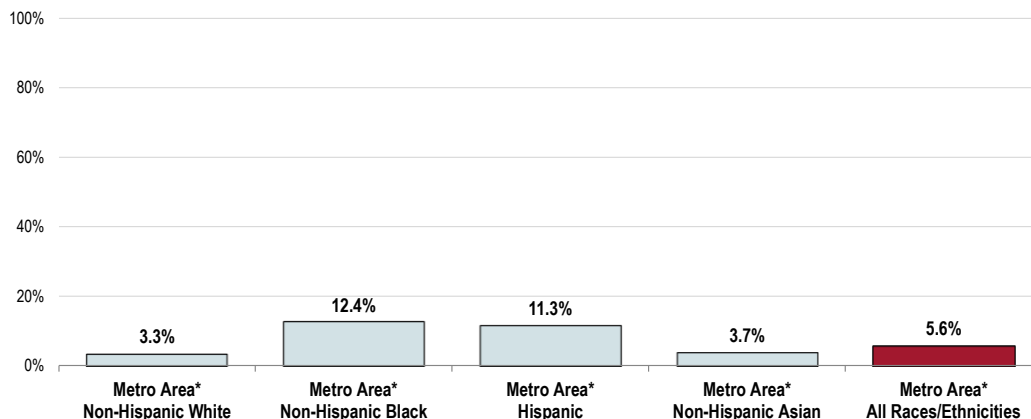
(Births to Women Under 20 as a Percentage of Live Births, 2011-2013)



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.  
 Note: • Numbers are a percentage of all live births within each population.  
 • \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

- By race and ethnicity, non-Hispanic Blacks exhibit the highest teen birth rate in the Metro Area, followed by Hispanics/Latinas.

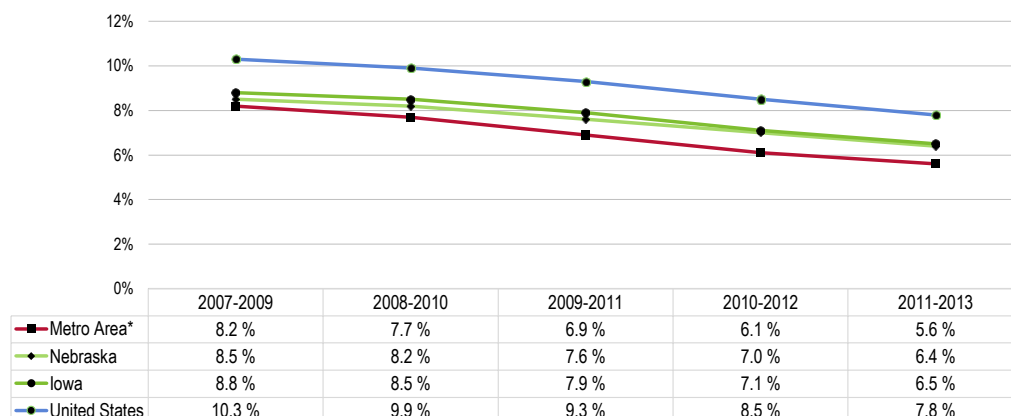
### Births to Teen Mothers (Under 20) (Births to Women Under 20 as a Percentage of Live Births, 2011-2013)



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System: 2011-2013 Accessed using CDC WONDER.  
Note: • Numbers are a percentage of all live births within each population.  
• \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

- TREND:** This percentage has decreased in the Metro Area since 2007 and has remained below the decreasing rates present in Nebraska, Iowa, and the US.

### Teen Birth Trends (Births to Women Under Age 20 as a Percentage of Life Births)



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.  
Notes: • This indicator reports the rate of total births to women under the age of 20 per 1,000 female population under 20. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.  
• \*Does not include Pottawattamie County, for which birth counts were too low for calculations.

## Postnatal Care



**Professional Research Consultants, Inc.**

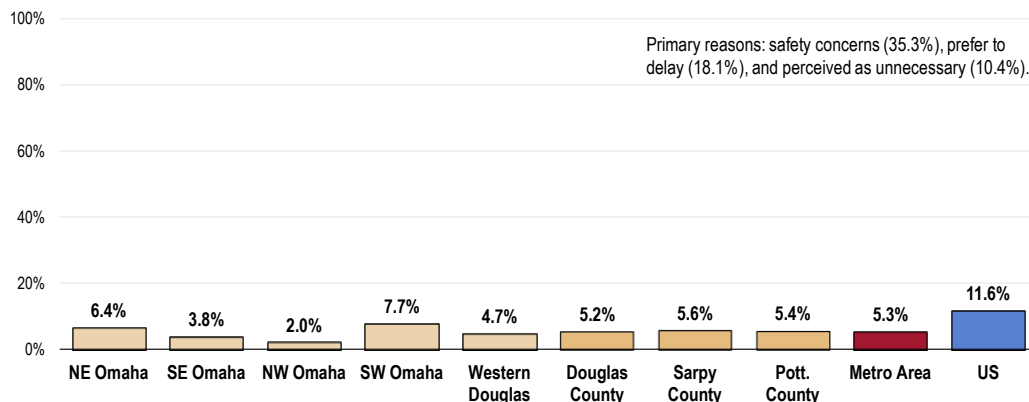
## Vaccinations

While 94.7% of parents say they would want their (hypothetical) newborn to receive all recommended vaccinations, a total of 5.3% would not.

- Less than half the percentage reported nationwide.
- In Douglas County, vaccinations are most accepted in Northwest Omaha.
- Similar by county.

Reasons given for this primarily included safety concerns (mentioned by 35.3%), a preference for delaying the process (18.1%), or perceiving that vaccines are unnecessary (10.4%).

### If Respondent Had a Newborn, Would Not Want Him/Her to Get All Recommended Vaccinations (Metro Area Parents, 2015)



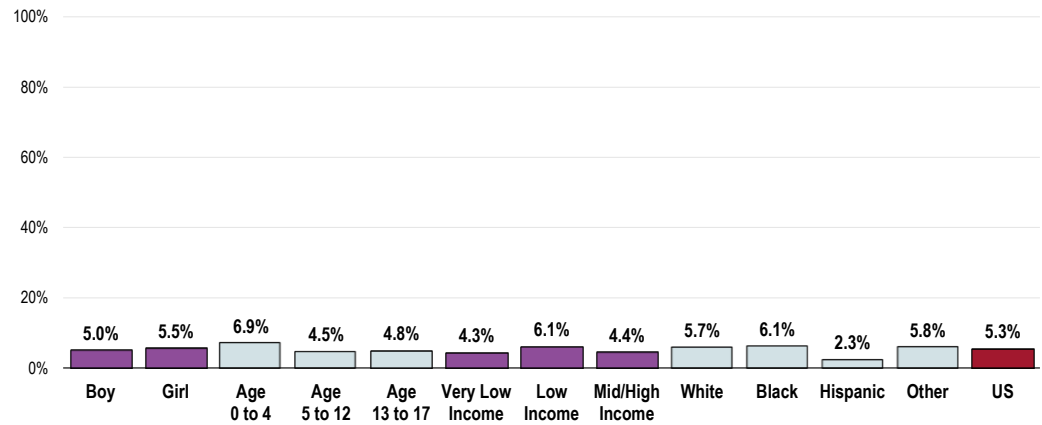
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 136]

• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

- Hispanic parents appear most likely to want their child to be vaccinated.

### If Respondent Had a Newborn, Would Not Want Him/Her to Get All Recommended Vaccinations (Metro Area Parents, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 136-137]  
Notes: • Asked of all respondents.

## Breastfeeding & Breast Milk

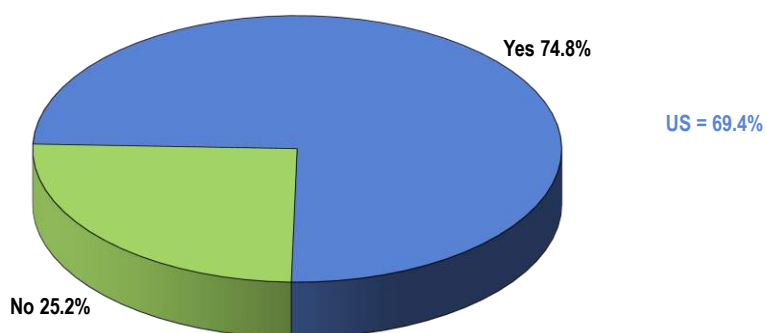
### Ever Breastfed

A total of 74.8% of Metro Area children age 0 to 17 were ever breastfed or fed using breast milk (regardless of duration).

- Greater than the US proportion.
- Fails to satisfy the Healthy People 2020 objective of 81.9% or higher.
- In Douglas County, breastfeeding is less prevalent in Northeast Omaha (not shown).
- No statistical difference by county (not shown).

“For the next question, I would like you to think back to when this child was an infant. As best you can recall, was this child ever breast-fed or fed using breast milk?”

**Child Was Ever Fed Breast Milk**  
(Metro Area, 2015)  
**Healthy People 2020 Target = 81.9% or Higher**



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 134]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-21.1]  
Notes: • Asked of those respondents with a randomly selected child who was fed breast milk as an infant.

### Exclusive Breastfeeding for Six Months

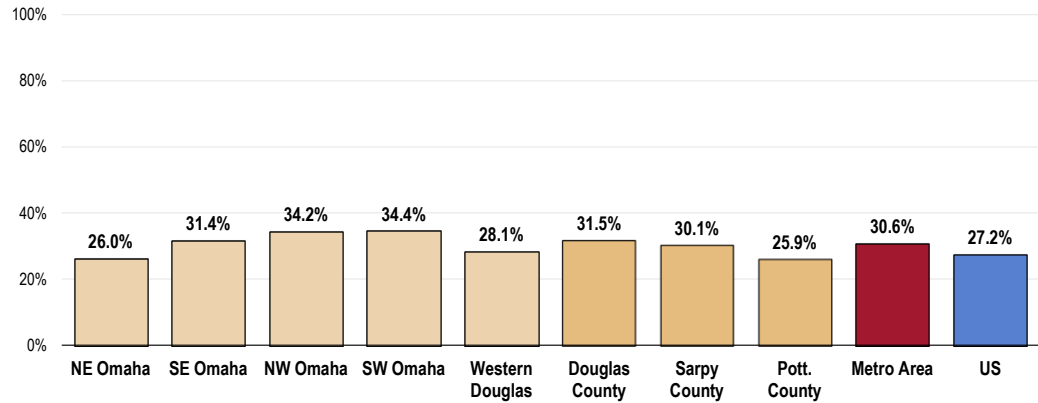
In total, 30.6% of all Metro Area children (as infants) were fed breast milk exclusively for the first 6 months of life.

- Statistically similar to US findings.
- Satisfies the Healthy People 2020 objective of 25.5% or higher.
- No statistical difference when viewed by sub-area of Douglas County.
- Statistically similar by county.

## Child Was Exclusively Breastfed for at Least 6 Months

(Metro Area, 2015)

Healthy People 2020 Target = 25.5% or Higher



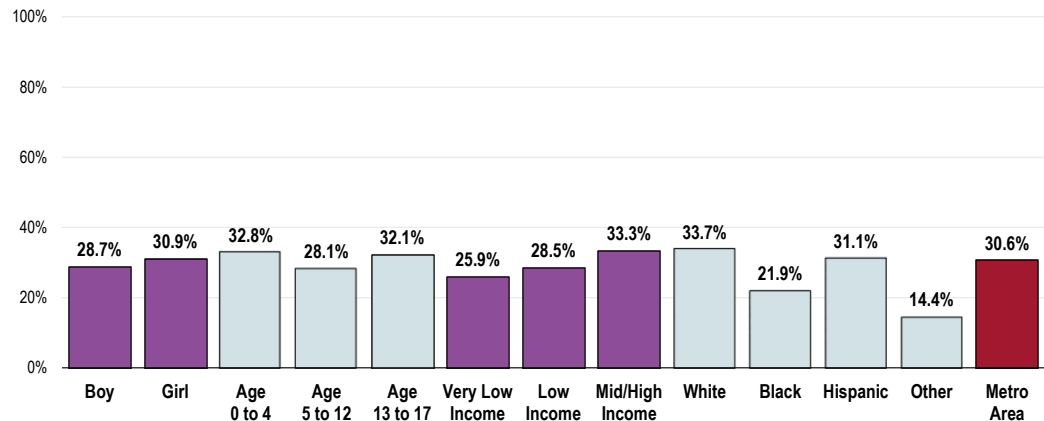
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 159]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-21.5]  
 Notes: • Asked of respondents all respondents about a randomly selected child in the household.

- Exclusive breastfeeding for the first 6 months is more common among White or Hispanic children.

## Child Was Exclusively Breastfed for at Least 6 Months

(Metro Area, 2015)

Healthy People 2020 Target = 25.5% or Higher

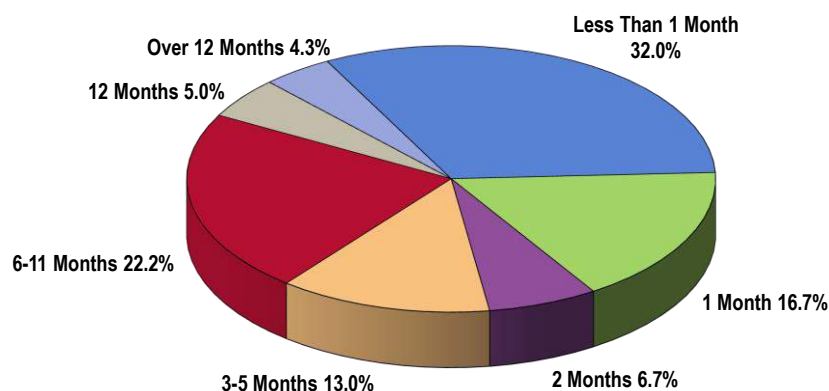


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 159]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-21.5]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



Nearly one-half of all breastfed children (48.7%) were **one month or less** when they were fed something other than breast milk or formula. 19.7% were exclusively breastfed until they were **between two and six months** old, whereas others (22.2%) were **between six and twelve months** old. Some children (9.3%) were not introduced to other foods until **age one or later**.

**Age of Child When Introduced to Foods Other Than Breast Milk**  
(Among Parents of Metro Area Children Who Were Ever Fed Breast Milk, 2015)



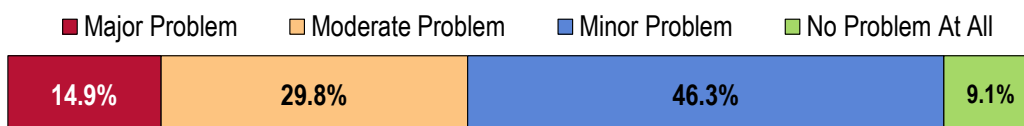
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 135]

Notes: • Asked of those respondents with a randomly selected child who was fed breast milk as an infant; excludes those whose children are currently being breastfed.

### **Key Informant Input: Infant and Child Health**

Key informants taking part in an online survey are most likely to consider Infant and Child Health as a “minor problem” for children/adolescents in the community.

**Perceptions of Infant and Child Health as a Problem for Children/Adolescents in the Community**  
(Key Informants, 2015)



Sources: • PRC Key Informant Focus Groups, March 2015.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Significant Disparities Throughout the Community

*Significant disparities continue to persist across ethnic and racial lines regarding infant mortality, prenatal health, and more. – Public Health Representative*

*Health disparities are still evident in our community when it comes to infant health. Until we can find the right mix of education and action to level the playing field, infant health will continue to be a major issue. – Public Health Representative*

*Parts of Omaha still have higher rates of infant mortality than other parts of town, so I assume that means there are gaps in education about prenatal care and infant health education. Also, the immigrant/refugee population is not always coming with accurate reporting of their immunization experiences, so they may be over and or under immunized. – Public Health Representative*

### Lack of Education

*There does not seem to be enough education about the importance of prenatal care. More home-based services for at-risk families are needed. Parents often struggle with knowing how to properly care for their infant and when to seek help. – Community/Business Leader*

*Not all parents have equal access to resources for education about prenatal care and infant health. If parents don't recognize a specific problem, they may not value preventative care. Family disruptions in safe and affordable housing, lack of transportation, questions of legal status, incarceration of parents/caregivers, and involvement in the foster care system may also be contributing factors. – Physician*

*Ignorance about development of infants, exposure to early trauma. Lack of education to parents to achieve self-regulation. – Community/Business Leader*

*Lack of education about key immunizations, particularly for caregivers. Access to prenatal care can be tricky because of physician locations. They keep moving west. – Community/Business Leader*

### Lack of Support for Mother and Family

*I believe infant health is a major problem not because of lack of access for prenatal care and immunizations, but because there are so few resources for mother's health post-natally, especially for low and no income mothers. Mother's physical and mental health is such a huge factor for the health and development of our communities low income infants and currently it is mostly ignored. – Social Services Provider*

*There is no emotional and mental health intervention for families with special need infants that I am aware of. Early intervention and support for the family and mother can promote better adjustment, and early detection of issues that can interfere in normal growth and development. – Physician*

### Access Difficulties

*Lack of resources for low income parents. Some have high deductibles or immunizations are not covered, others are motivated by the anti-immunization groups not to immunize their children. – Physician*

*Transportation to appointment is issue. Infant mortality is high. – Social Services Provider*

### High Infant Mortality Rate

*High infant mortality rate. – Other Healthcare Provider*

*The rates of infant mortality remain high among African Americans and the rates of SID and SUIDS remain higher than national rates. Messages about accidental suffocation due to overlays by parents and or other individuals are often related to an unsafe sleep environment. In addition, women of color are more likely to enter pregnancy overweight or with a chronic disease condition, which increases the likelihood of poor birth outcomes. – Public Health Representative*

### Prematurity Rates

*Prematurity. – Physician*

***Lack of Funding***

*Lack of funding for nurse visitation programs for young women at risk. Still have not great breastfeeding rates and I am not sure any hospital is rated as Baby Friendly. – Physician*

# Modifiable Health Risks



**Professional Research Consultants, Inc.**

## Nutrition

### About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed since 2012 and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

**Social Determinants of Diet.** Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

**Physical Determinants of Diet.** Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Fruits & Vegetables

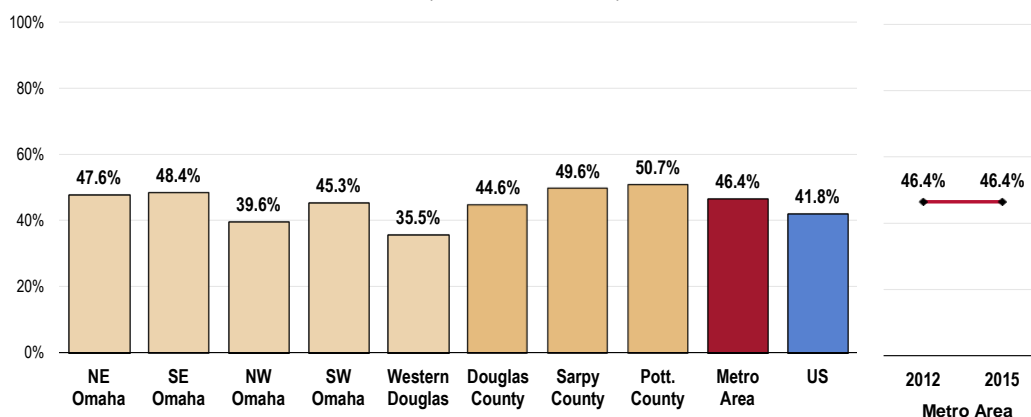
### Fruit & Vegetable Consumption

A total of 46.4% of Metro Area parents report that their child eats five or more servings of fruits and/or vegetables per day.

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods their child eats on a typical day.

- Statistically comparable to what is found nationally.
- Statistically comparable within Douglas County.
- No statistical difference among the Metro Area counties.
- TREND: Child fruit/vegetable consumption in the Metro Area has not changed since 2012.

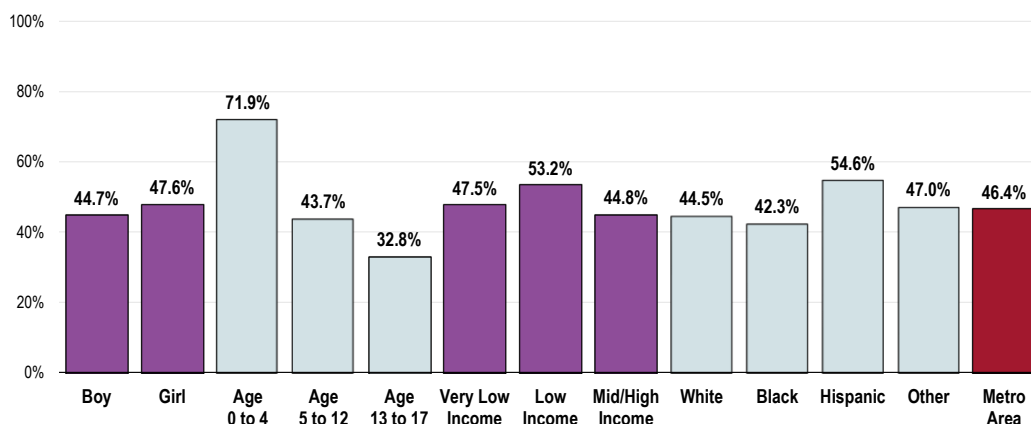
### Child Has Five or More Servings of Fruits/Vegetables per Day (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 173]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- Note the strong, negative correlation between age and fruit/vegetable consumption among Metro Area children (decreasing to 32.8% among teenagers).
- Hispanic children are more likely to get the recommended servings of fruit/vegetables each day.

### Child Has 5+ Fruits/Vegetables per Day (Metro Area, 2015)



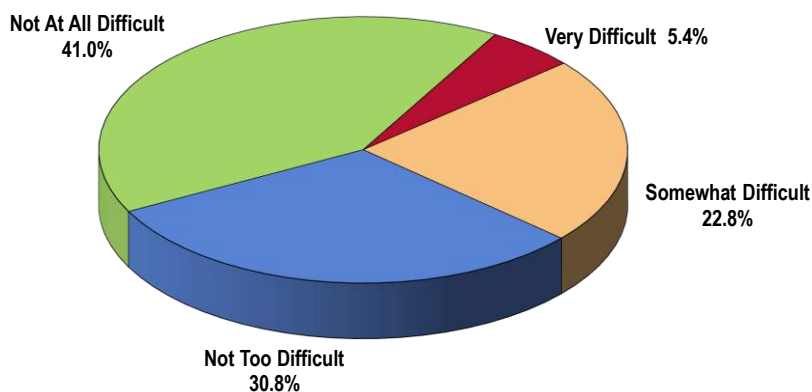
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 173]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Difficulty Accessing Fresh Produce

While most report little or no difficulty, 28.2% of Metro Area parents report that it is "very" or "somewhat" difficult for them to access affordable, fresh fruits and vegetables.

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford?"

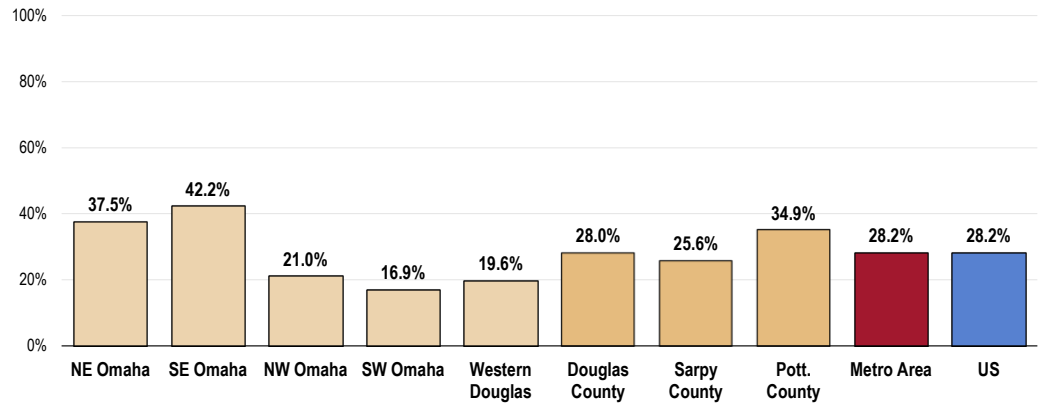
### Level of Difficulty Finding Fresh Produce at an Affordable Price (Metro Area Parents, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 131]  
Notes: • Asked of all respondents.

- Identical to that reported nationally.
- Within Douglas County, it is more difficult to access fresh produce in Northwest and Southwest Omaha.
- By county, there is no statistical difference present.

### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Metro Area Parents, 2015)



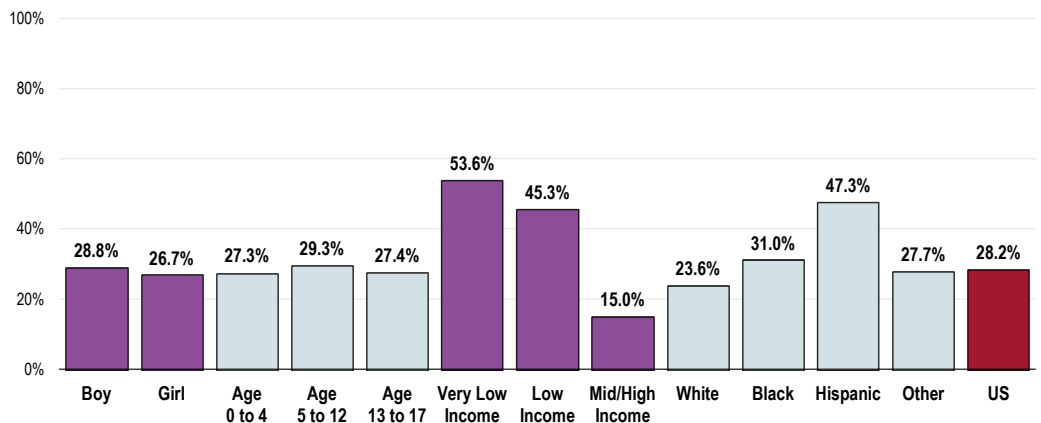
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 131]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Those more likely to report difficulty getting fresh fruits and vegetables include:

- Lower-income residents (up to 200% of the poverty threshold).
- Parents of Hispanic children.

### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Metro Area Parents, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 131]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).

• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

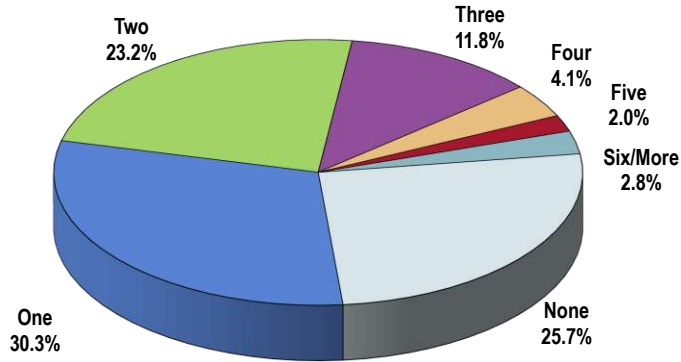


## Fast Food

"In the past 7 days, how many meals would you say this child has eaten from 'fast food' restaurants? Please include breakfasts, lunches, and dinners."

Nearly three-fourths of Metro Area children age 2-17 (74.2%) have had at least one "fast food" meal in the past week.

### Number of Fast Food Meals for Child in the Past Week (Metro Area Children Age 2-17, 2015)

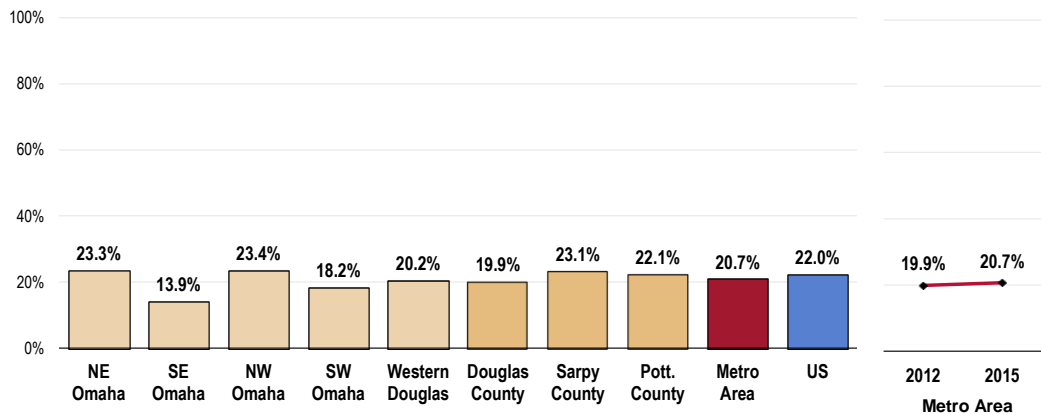


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 127]  
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

In fact, more than 1 in 5 parents (20.7%) report that their child has had three or more meals from "fast food" restaurants in the past week.

- Similar to the US figure.
- In Douglas County, most favorable in southeast Omaha.
- Similar by county.
- TREND: Fast food consumption is statistically similar to 2012 findings.

### Child Had Three or More Fast Food Meals in the Past Week (Metro Area Children Age 2-17, 2015)



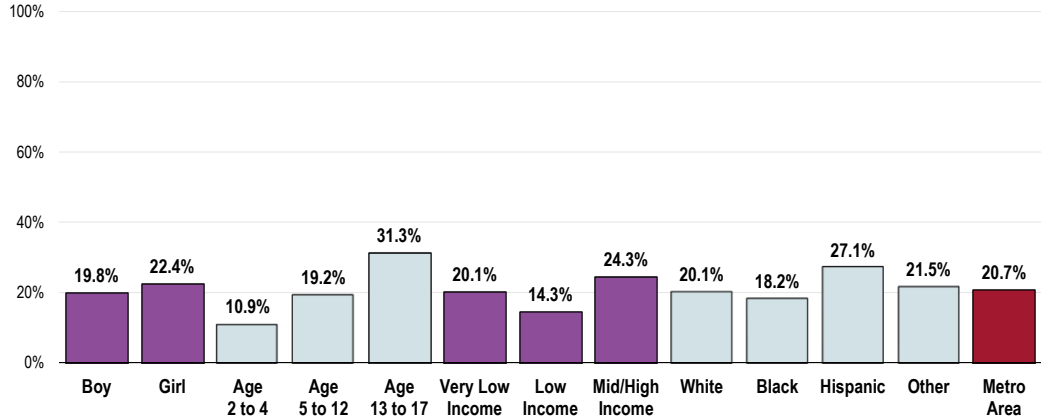
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 127]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

### Fast food consumption:

- Appears to increase with age.
- Is higher among mid/high income households.

### Child Has Three or More Fast Food Meals in the Past Week

(Metro Area Children 2-17, 2015)



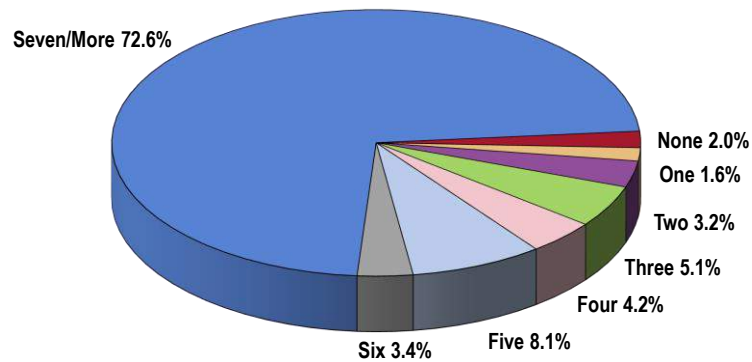
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 127]  
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Family Meals

More than 7 in 10 parents (72.6%) report sharing meals as a family an average of at least once a day (seven or more times in the past week).

### Number of Meals Eaten as a Family in the Past Week

(Metro Area, 2015)



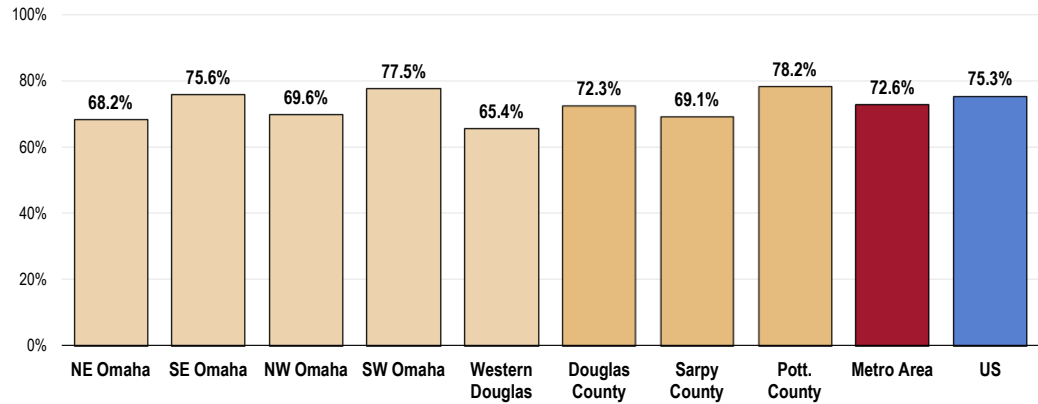
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 128]  
 Notes: • Asked of all respondents.

"In the past 7 days, how many meals did you eat together as a family? Please include breakfasts, lunches, and dinners."

- Similar to national reports.
- Statistically comparable results reported within Douglas County.
- Differences by county are not statistically significant.

### Shared 7+ Meals as a Family in the Past Week

(Metro Area, 2015)



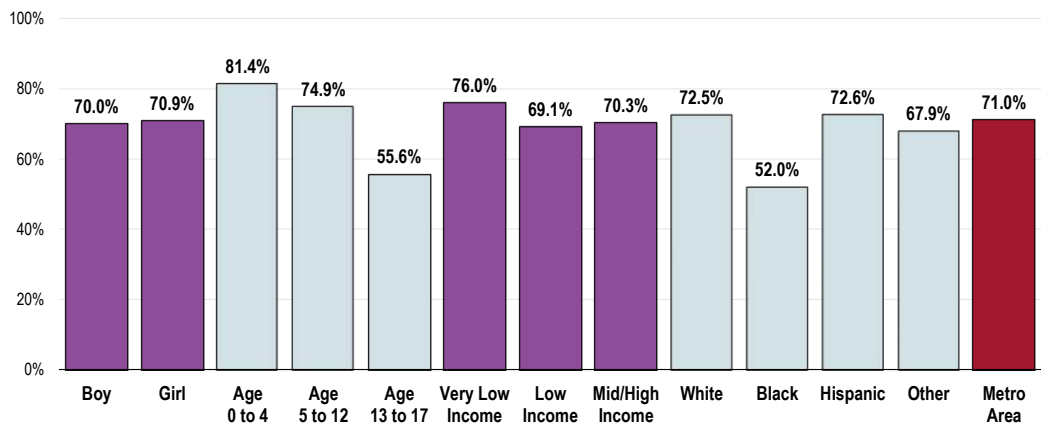
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 128]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

These children are less likely to have shared seven or more family meals in the past week:

- Teens (negative correlation with age).
- Black children.

### Shared 7+ Meals as a Family in the Past Week

(Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 128]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Physical Activity

### About Physical Activity

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

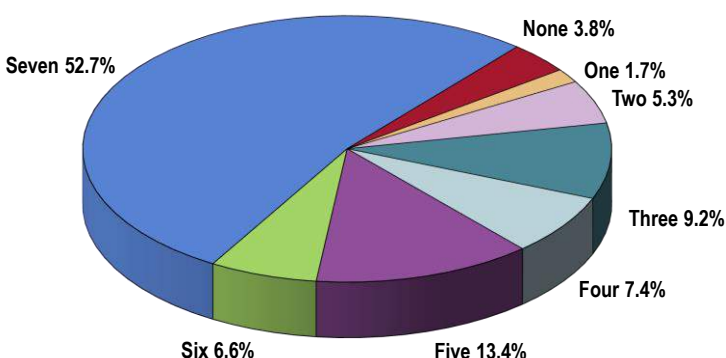
— Centers for Disease Control & Prevention (CDC)

### Recommended Physical Activity

Over one-half (52.7%) of Metro Area children age 2 to 17 had 60 or more minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- Note, however, that 10.8% had two or fewer days in the past week with adequate physical activity.

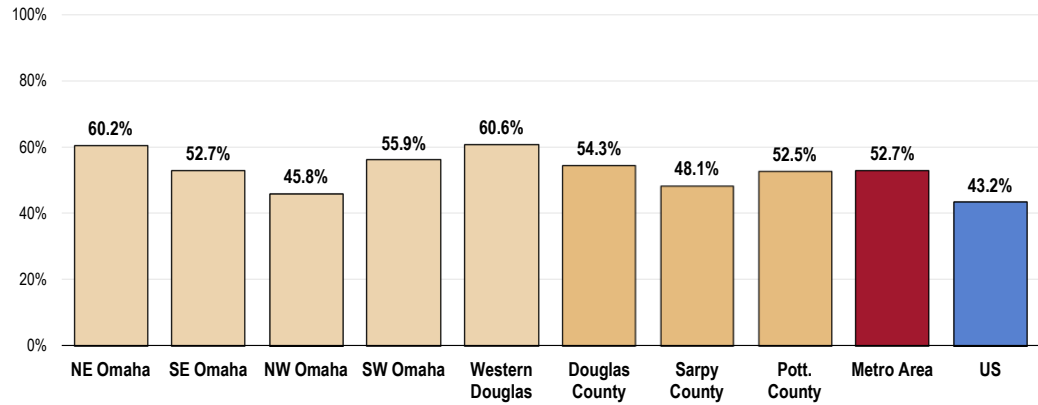
**Number of Days in the Past Week on Which  
Child Was Physically Active for One Hour or Longer**  
(Metro Area Children Age 2-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 124]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

- Notably more favorable than the national proportion.
- In Douglas County, less favorable in Northwest Omaha.
- The prevalence of children age 2-17 with recommended levels of physical activity does not vary significantly by county.

### Child Was Physically Active for One Hour or Longer on Every Day of the Past Week (Metro Area Children Age 2-17)

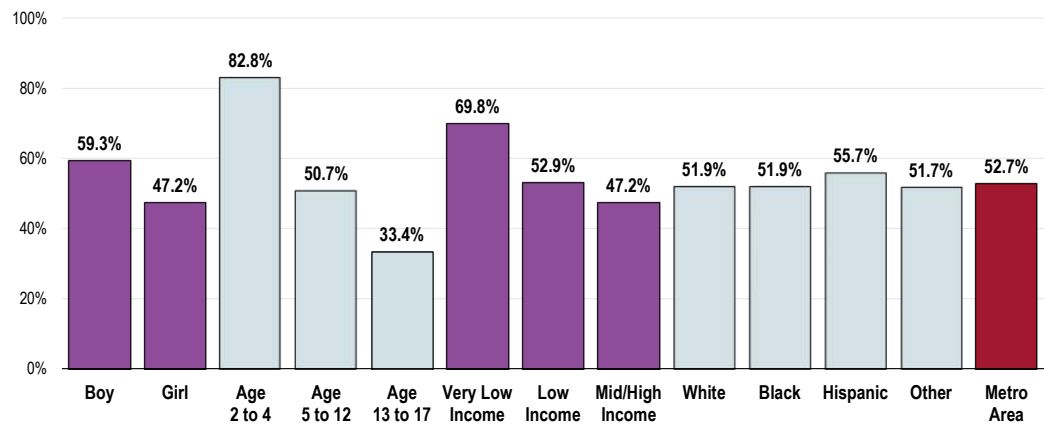


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 124]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Those less likely to meet recommended levels of physical activity include:

- Girls.
- Older children (strong negative correlation with age).
- Children in households with income above the federal poverty level.

### Child Was Physically Active for One Hour or Longer on Every Day of the Past Week (Metro Area Children Age 2-17)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 124]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Physical Activity Frequency & Duration

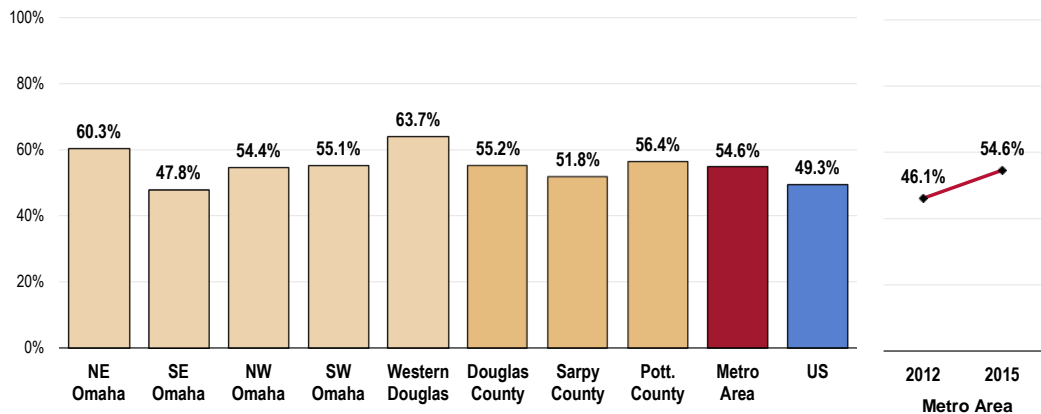
### Note:

- The term “moderate physical activity” includes 30 minutes of activity that does not make a child breathe hard, such as fast walking, slow bicycling, skating, or pushing a lawn mower.
- The term “vigorous physical activity,” includes exercise for 20 minutes that makes a child breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities).

In the past month, **54.6%** of Metro Area children age 2 to 17 participated in *moderate* physical activity five or more times per week, for at least 30 minutes at a time.

- More favorable than the US percentage.
- In Douglas County, least favorable in Southeast Omaha.
- Findings by county are statistically similar.
- TREND: Denotes a statistically significant increase since 2012.

### Child Participates in Moderate Physical Activity (Metro Area Children Age 2-17)

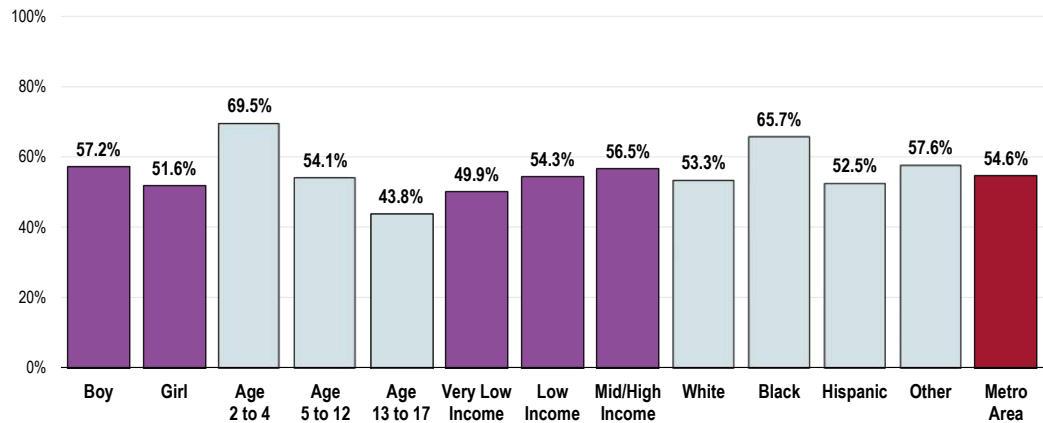


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 177]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.  
 • Includes exercising at least 5 times per week for 30+ minutes at a time, doing activities which do not make the child breathe hard, such as fast walking, slow bicycling, skating, or pushing a lawnmower.

- Older children are less likely to participate in moderate physical activity (note the negative correlation with age).

## Child Participates in Moderate Physical Activity (Metro Area Children Age 2-17)

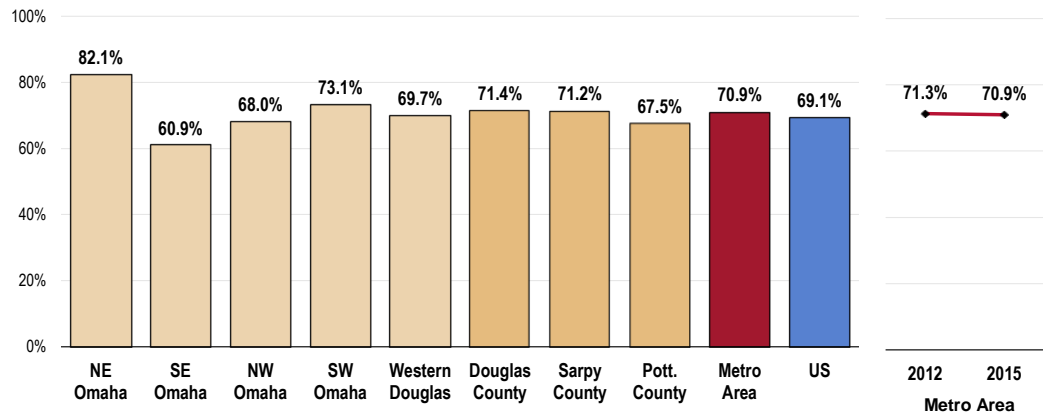


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 177]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.  
• Includes exercising at least 5 times per week for 30+ minutes at a time, doing activities which do not make the child breathe hard, such as fast walking, slow bicycling, skating, or pushing a lawnmower.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

**In the past month, over two-thirds (70.9%) of Metro Area children age 2 to 17 participated in *vigorous* physical activity three or more times a week, for at least 20 minutes at a time.**

- Similar to the US findings.
- In Douglas County, vigorous physical activity is quite low in Southeast Omaha and notably high in Northeast Omaha.
- No statistical difference among the Metro Area counties.
- TREND: Similar to 2012 findings.

## Child Participates in Vigorous Physical Activity (Metro Area Children Age 2-17)

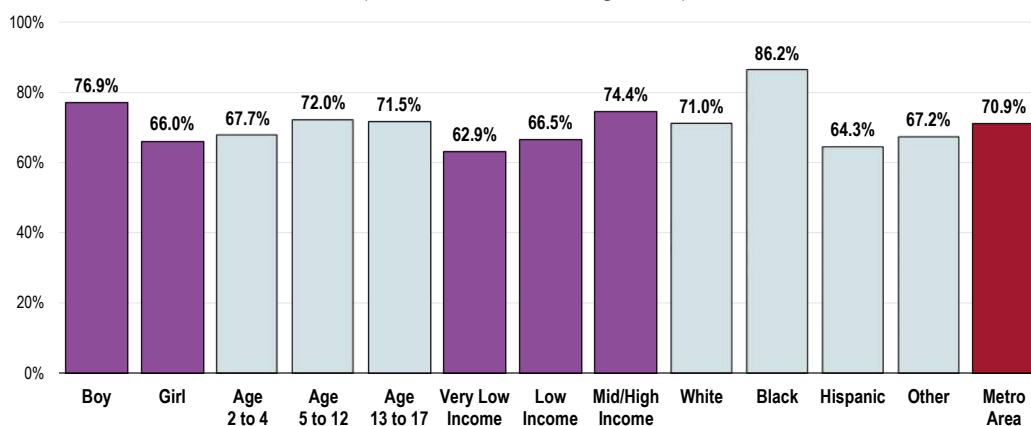


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 178]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.  
• Includes exercising at least 3 times per week for 20+ minutes each time, doing exercise which causes the child to breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities.

Those less likely to participate in vigorous physical activity include:

- Girls.
- Those in lower-income households (positive correlation with income).
- Children who are White, Hispanic, or “Other” races.

### Child Participates in Vigorous Physical Activity (Metro Area Children Age 2-17)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 178]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.  
• Includes exercising at least 3 times per week for 20+ minutes each time, doing exercise which causes the child to breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.



## Screen Time

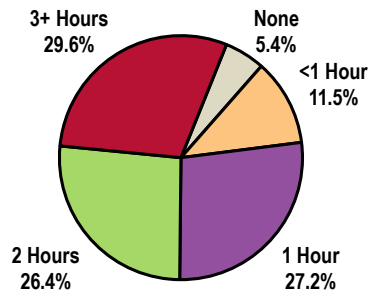
### Television Watching & Other Screen Time

Among children aged 5 through 17: 29.6% are reported to watch three or more hours of television on an average week day; 27.3% are reported to spend three or more hours on other types of screen time.

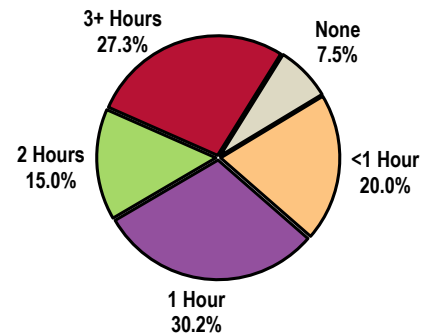
*"On an average week day, about how many hours or minutes does this child usually spend in front of a TV watching TV programs, videos, or playing video games?"*

*"On an average week day, how many hours or minutes does this child usually spend with computers, cell phones, handheld video games, and other electronic devices?"*

**Children's Screen Time**  
(Metro Area Children Age 5-17, 2015)



**Hours per Day of TV/Videos or Video Games**



**Hours per Day on a Computer, Cell Phone, Handheld Device, etc.**

Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 120, 122, 153-154]

Notes: • Asked of respondents for whom the randomly selected child in the household is age 5 to 17.

• For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."

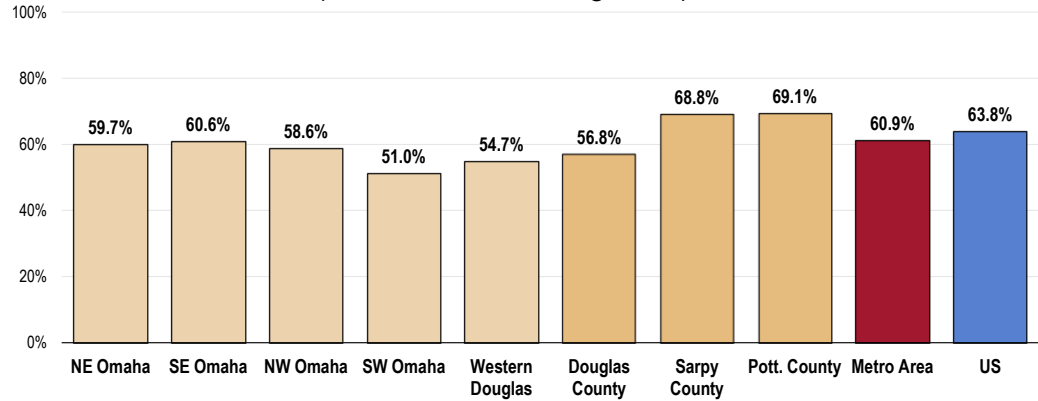
• "Three or more hours" includes reported screen time of 180 minutes or more per day.

### Total Screen Time

When combined, 60.9% of Metro Area school-age children (age 5-17) spend three or more hours per day on screen time (whether television, computer, video games, cell phone, handheld device, etc.).

- Similar to the national prevalence.
- Statistically similar among the areas comprising Douglas County.
- By county, more favorable in Douglas County.

### Children With 3+ Hours per School Day of Total Screen Time (TV, Computer, Video Games, Phone, Device, etc.) (Metro Area Children Age 5-17)

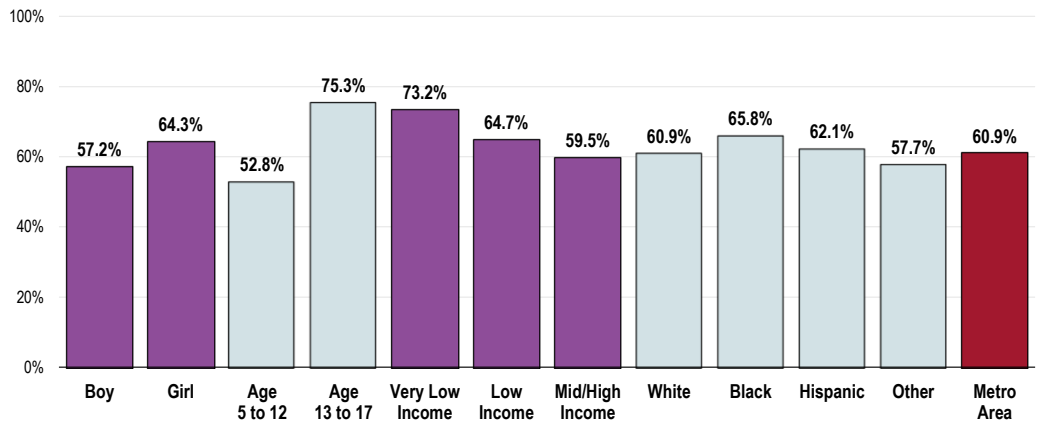


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 155]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of respondents for whom the randomly selected child in the household is age 5 to 17.  
• For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."  
• "Three or more hours" includes reported screen time of 180 minutes or more per day.

- Girls, teens (age 13 to 17), and children in lower-income households are more likely to spend 3+ hours per day on screen time.

### Children With 3+ Hours per School Day of Total Screen Time (TV, Computer, Video Games, Phone, Device, etc.) (Metro Area Children Age 5-17)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 155]

Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Electronic Media in Children's Bedrooms

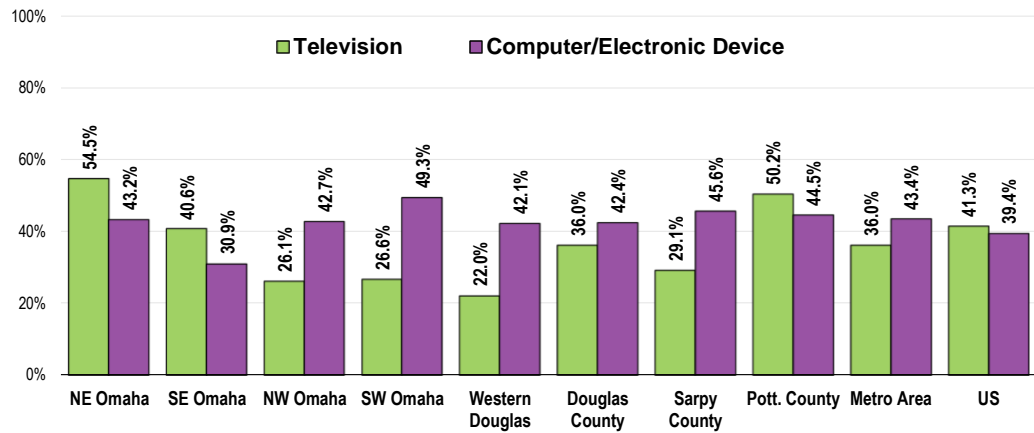
A total of 36.0% of Metro Area school-age children have televisions in their bedrooms.

- Lower than reported nationally.
- Within Douglas County, particularly high in Northeast Omaha; lower in Western Douglas, Northwest Omaha, and Southwest Omaha.

Even more Metro Area school-age children (43.4%) have access to computers or some type of electronic devices in their bedrooms.

- Statistically comparable to the US percentage.
- In Douglas County, Southeast Omaha has the lowest percentage.
- The three individual counties show comparable results.

### Access to Electronic Media in Children's Bedrooms (Metro Area Children Age 5-17, 2015)



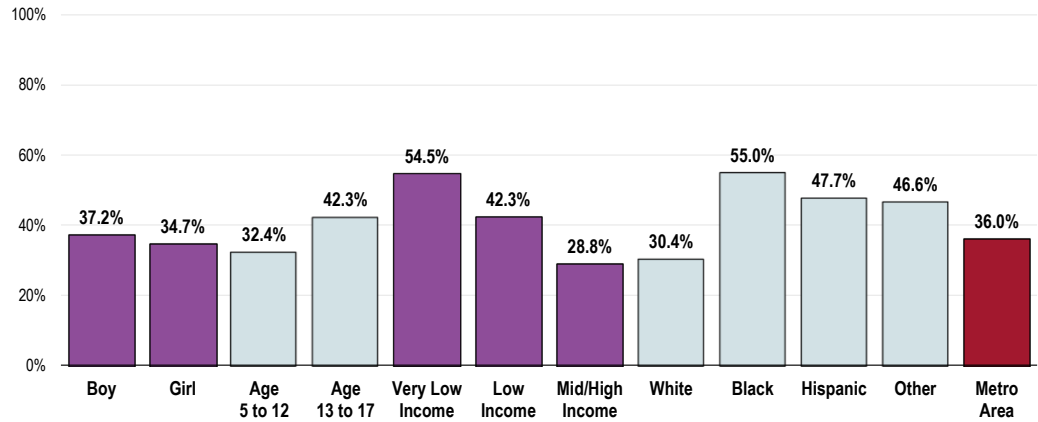
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 121, 123]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of those respondents for whom the randomly selected child in the household is age 5 to 17.

Those more likely to have a **television** in his/her bedroom include:

- Teenagers.
- Children in lower income households (negative correlation with income).
- Children who are Black, Hispanic, or "Other" races.

## Children Has a Television in His/Her Bedroom (Metro Area Children Age 5-17)

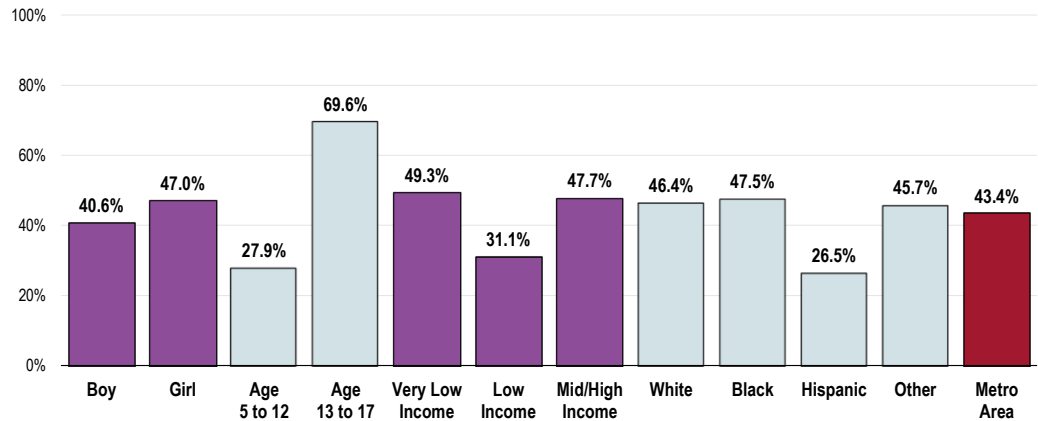


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 121]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Those more likely to have access to some type of **computer or other electronic device** in his/her bedroom include:

- Teenagers (69.6% prevalence).
- Children in households on either end of the income spectrum.
- Children who are Black, Hispanic, or "Other" races.

## Child Has a Computer or Device in His/Her Bedroom (Metro Area Children Age 5-17)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 123]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Weight Status

### Childhood Overweight & Obesity

#### About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5<sup>th</sup> percentile
- Healthy Weight ≥5<sup>th</sup> and <85<sup>th</sup> percentile
- Overweight ≥85<sup>th</sup> and <95<sup>th</sup> percentile
- Obese ≥95<sup>th</sup> percentile

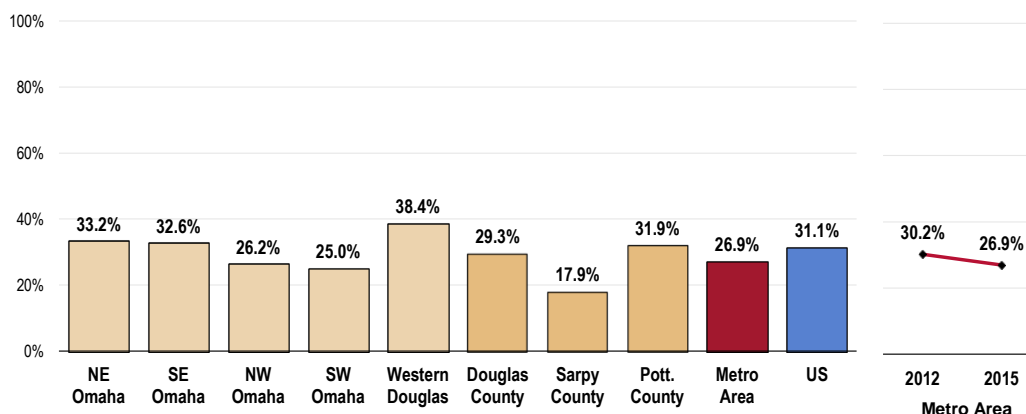
— Centers for Disease Control and Prevention

**Based on the heights/weights reported by surveyed parents, over one-fourth (26.9%) of Metro Area children age 5 to 17 are overweight or obese (≥85<sup>th</sup> percentile).**

- Statistically similar to the US proportion.
- No statistical difference within Douglas County.
- By county, most favorable in Sarpy County.
- TREND: Statistically similar to 2012 findings.

#### Child Is Overweight or Obese

(Metro Area Children Age 5-17 With a BMI in the 85<sup>th</sup> Percentile or Higher)

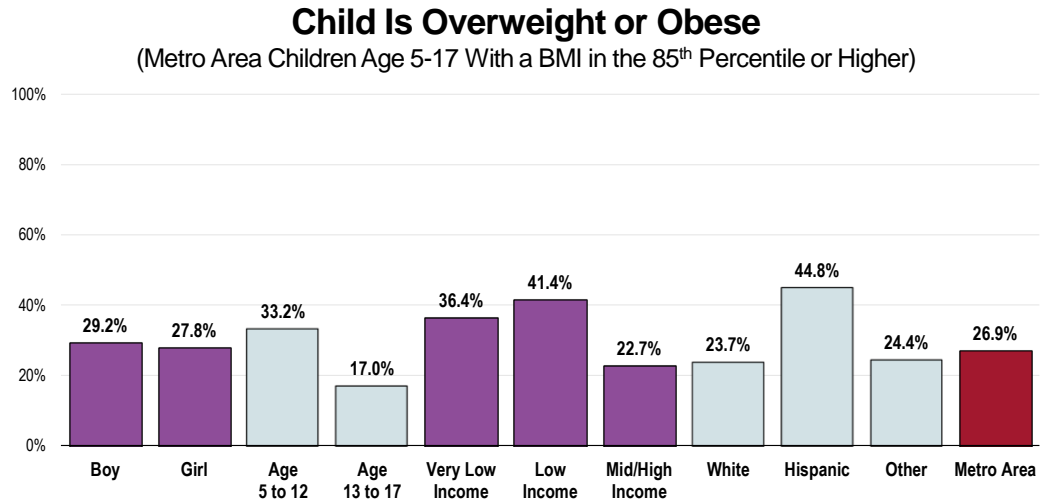


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 157]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
 • Overweight among children 5-17 is determined by child's Body Mass Index status at or above the 85<sup>th</sup> percentile of US growth charts by gender and age.

School-age children in the Metro Area who are more likely to be overweight or obese include:

- Those age 5 to 12.
- Those in households with incomes under 200% of the federal poverty level.
- Hispanic children.



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 157]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Overweight among children is determined by children's Body Mass Index status equal to or above the 85<sup>th</sup> percentile of US growth charts by gender and age.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
• Weight data for Non-Hispanic Black children is not available due to a small sample size.

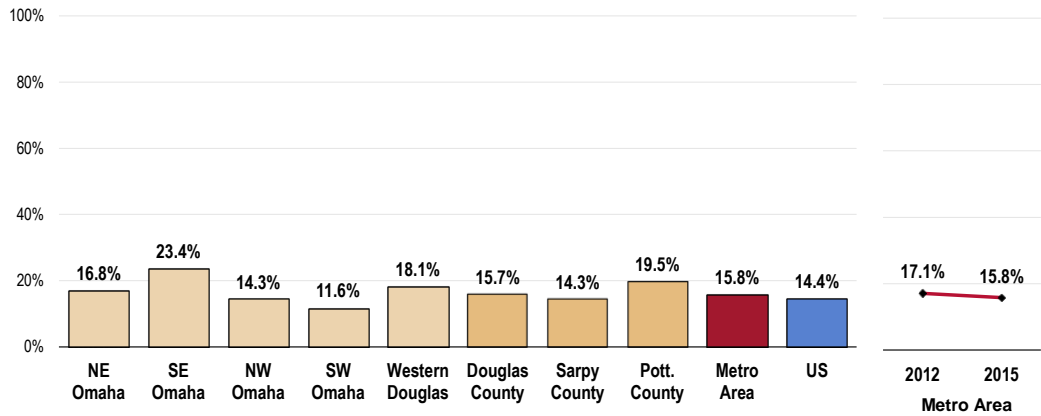
**Further, 15.8% of Metro Area children age 5 to 17 are obese (≥95<sup>th</sup> percentile).** *Note that this proportion is included in the "overweight or obese" percentage reported above.*

- Similar to the US rate.
- Close to the Healthy People 2020 target of 14.6% or lower.
- In Douglas County, least favorable in Southeast Omaha.
- Statistically similar proportions by county.
- TREND: Obesity is statistically unchanged from the 2012 findings.

## Child Obesity Prevalence

(Metro Area Children Age 5-17 with a BMI in the 95th Percentile or Higher)

**Healthy People 2020 Target = 14.5% or Lower**



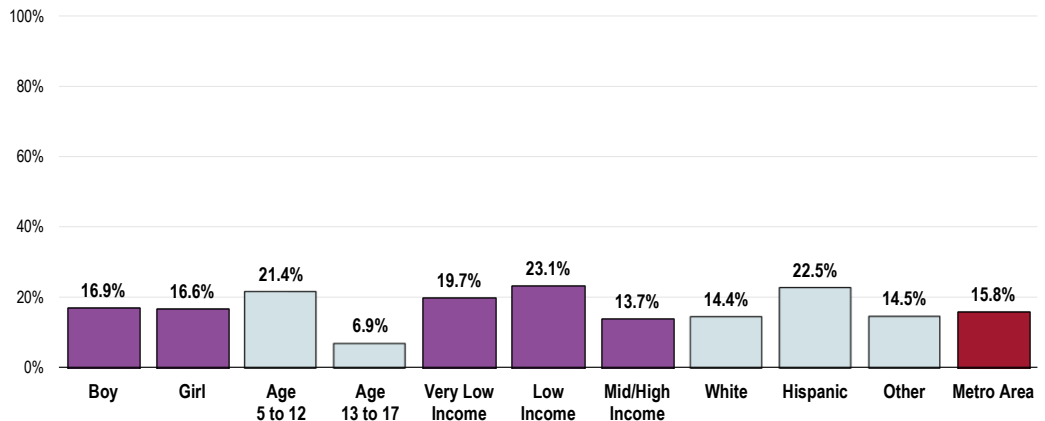
- Sources:
- PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 157]
  - 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]
- Notes:
- Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
  - Obesity among children is determined by children's Body Mass Index status equal to or above the 95<sup>th</sup> percentile of US growth charts by gender and age.

- Obesity is highest in Metro Area children in the 5-12 age group and those in low income households.

## Child Obesity Prevalence

(Metro Area Children Age 5-17 with a BMI in the 95<sup>th</sup> Percentile or Higher)

**Healthy People 2020 Target = 14.5% or Lower**



- Sources:
- 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 157]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]
- Notes:
- Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
  - Overweight among children is determined by children's Body Mass Index status equal to or above the 85<sup>th</sup> percentile of US growth charts by gender and age.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Weight data for Non-Hispanic Black children is not available due to a small sample size.

## Perceptions of Overweight

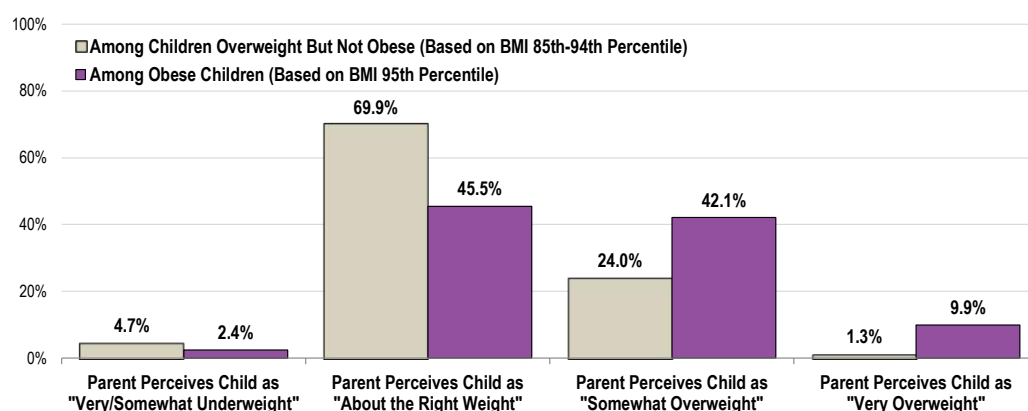
### Actual vs. Perceived Body Weight

Interestingly, among parents of children age 5-17 who are overweight or obese (based on BMI), the majority sees their child as being at “about the right weight.”

- Only 25.3% of parents with an overweight (not obese) child perceive their child as “somewhat overweight” or “very overweight.”
- Only 9.9% of parents with an obese child consider that child to be “very overweight.”

### Child’s Actual vs. Perceived Weight Status

(Metro Area Children Age 5-17 Who Are Overweight/Obese Based on BMI, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 132]

Notes: • Asked of those respondents for whom the randomly selected child at home is age 5 to 17.

• Overweight in children is defined as a Body Mass Index (BMI) value at or above the 85<sup>th</sup> percentile of US growth charts by gender and age; obesity in children is defined as a BMI value at or above the 95<sup>th</sup> percentile.

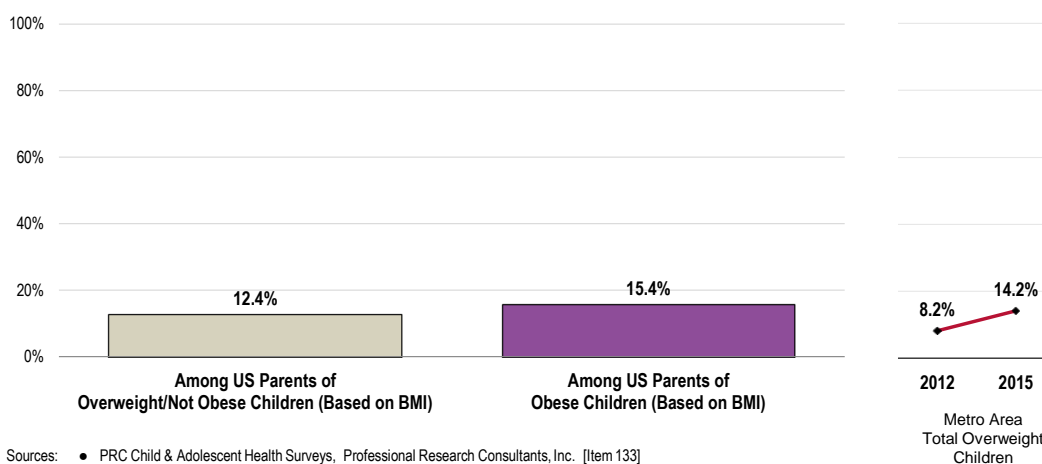


## Notification of Overweight Status

A clear majority of parents with overweight or obese children has not been told in the past year by a school or health professional that their child is overweight.

- Similar to the notification rate throughout the US (not shown).
- TREND: The change since 2012 is not statistically significant.

### Parent Has Been Told in the Past Year by a School or Health Professional That Their Child Is Overweight (Metro Area Children Age 5-17 Who Are Overweight/Obese Based on BMI, 2015)

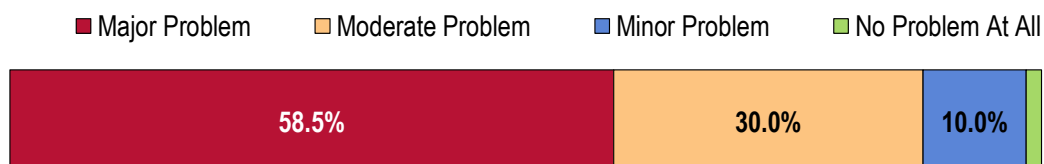


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 133]  
Notes: • Asked of those respondents for whom the randomly selected child at home is age 5 to 17.  
• Overweight in children is defined as a Body Mass Index (BMI) value at or above the 85<sup>th</sup> percentile of US growth charts by gender and age; obesity in children is defined as a BMI value at or above the 95<sup>th</sup> percentile.

## Key Informant Input: Nutrition, Physical Activity, and Weight

Most key informants taking part in an online survey characterized Nutrition, Physical Activity, and Weight as a “major problem” for children/adolescents in the community.

### Perceptions of Nutrition, Physical Activity, and Weight as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Obesity Epidemic

*Obesity rates are increasing, low-income families don't have the resources to purchase as healthy of foods and others. Unsafe neighborhoods and use of technology has limited physical activities.*

*Incomplete parks in East Omaha is a problem. – Community/Business Leader*

*The increased incidence of obesity and overweight among our youth. – Physician*

*Still have an epidemic of obese kids. Schools not really promoting health in an optimum way. Parents not walking kids to school and other patterns of inactivity that lead to sedentary life and obesity. – Physician*

*There is a high prevalence of obesity in younger children. – Community/Business Leader*

*High prevalence of obesity, high incidence of acute and chronic constipation with abdominal pain. – Physician*

*Obesity. – Physician*

*High proportion of children have elevated BMI for age. Limited availability of activities for children in the winter, especially those in lower socioeconomic status. – Physician*

*Obesity exists in greater than 50 percent of six year olds in OPS, leading cause of DM. – Physician*

*Obesity is a growing problem and too often sports and PE are the first programs cut by schools. Neighborhoods are not safe for children to play in. – Physician*

*Past surveys of parents indicate childhood obesity to be a widespread problem. – Social Services Provider*

*The high percentage of children in the community who meet the standards for obesity. – Community/Business Leader*

*Obesity epidemic. – Other Healthcare Provider*

*Up to 20% of children and adolescents are obese. We counsel parents and their children every day on obesity prevention and treatment, mostly unsuccessfully and without enough time or resources. – Physician*

*Providing height and weight identified obesity as one of the top priorities in youth. – Public Health Representative*

*Increasing rate of childhood obesity and related medical problems, leading to adult obesity and related medical problems. – Physician*

*Trend toward obesity is pervasive in current society and difficult to reverse without major changes including with adults. – Physician*

*There is clearly an epidemic of childhood obesity. However, in a majority of these cases, the problem is family obesity. It is nearly impossible to have a positive impact on the health of these children when the environment they are in is the single most important contributing factor to the problem at hand. – Physician*

*More and more children are coming into clinic obese. I feel that only a portion of pediatricians are counseling on this. It is becoming an issue. We need to educate our families what a healthy lifestyle is for children, and we need to treat the whole family, not just the child. Diet is one aspect of the obesity epidemic; we also need to address physical activity time versus screen time. – Physician*

*Obesity is becoming the number one health problem for all Americans. The lack of parental involvement in their children's lives and the shift to electronic recreation are two contributors. – Community/Business Leader*

*Many adults and children in the community have a BMI in the overweight or obese category. Many families do not have adequate knowledge of good nutrition, including healthy choices, portion control and healthy cooking methods. Many families live in neighborhoods that have poor access to nutritious foods, or feel that it is too expensive. Some families are solely dependent on the child receiving most meals at school. Many live in unsafe neighborhoods, or ones that are not conducive to having opportunities for exercise. Transportation and cost may be factors affecting ability to access exercise facilities. – Physician*

*Obesity is an increasing problem in the community, from Pediatric and adult perspectives. Less emphasis on physical activity at schools. – Other Healthcare Provider*

*Obesity is worsening. – Physician*

*Omaha is in the top ten for obesity in the United States. – Physician*

*Elevated BMIs, lack of knowledge for preparing healthy foods, unhealthy snacks. Heavier kids tend to grow into heavier adults with health problems. – Other Healthcare Provider*

*Lots of obesity and poor diet. – Physician*

*Too many overweight kids in our community, and school lunches in many schools are nutrient poor. – Physician*

*There are concerns with obesity and weight gain related to the lack of physical activity and nutritional foods. – Social Services Provider*

*More and more kids are becoming obese and doing so at a younger age. Parents seem to not care if their kids are obese; they think they will slim down at puberty. The ones who do worry about their kids' weight have limited resources to help them. I have yet to find a program that has been helpful in teaching families about good nutrition and exercise. What is available can be costly or not convenient for working families. – Physician*

*Overweight and obesity are common in Omaha, difficult to deal with as it needs to be a change for the whole family. I feel resources, especially for low income, are not readily available and accessible for longer term management. – Physician*

*The Obesity epidemic seems more prevalent in second generation immigrants, worsening with increase in technology. – Physician*

*Many are overweight and there is only one dedicated program to help, the HEROES program. My experience with the HEROES program is that its results are inconsistent. – Physician*

*We have many students that are overweight. – Social Services Provider*

*The obesity rate continues to rise. – Physician*

*Latino community, high instance of obesity in data recorded by Families in Action via mobile clinics. Also, participants report need for safe places to exercise. Focus groups and needs assessments conducted by Families in Action reveal a desire/need for programs incorporating nutritional education, physical activity and healthy eating. – Community/Business Leader*

### Access to Affordable Healthy Food

*Poor access to affordable, healthy food options. Those who are overweight tend to be in overweight families who have poor understanding of healthy foods, active lifestyles and health in general. Lack of understanding of why it is important to address weight concerns early and often. Resistance to help and often very defensive. – Physician*

*Access to healthy foods and places where kids can be active are limited to some residents, due to where they live. Decreased access to healthy food and play spaces effects weight status. – Public Health Representative*

*Poverty and inadequate access to healthier food choices. – Physician*

*I think there are cultural factors, as well as access to healthy food at reasonable costs that contribute to these issues. I also think that when neighborhoods are unsafe, children are less likely to be physically active. They also may not have access to organized activities that would provide more activity. – Community/Business Leader*

*Poor access to quality food, including in the school system. Obesity is a problem for the region and Nebraska ranks high for obesity in the US. Obesity must be addressed before the child is two years of age in order to have success with appropriate weight management in adulthood. – Physician*

*Families are busy. Fast food is readily available. Parents don't believe it is a concern, too expensive to eat healthy. – Physician*

*Cheap junk food is easier to access than healthy foods. Parents must have transportation to get to grocery stores with fresh foods. Fuel prices are sometimes higher in the poorer areas of the city. Children spend more and more time sitting playing with electronic devices, rather than running. It is also less safe for children to play outdoors. – Physician*

### Poor Lifestyles

*Lack of proper nutrition and inactivity. – Community/Business Leader*

*Kids have more obstacles for good nutrition and activity. Processed foods, fast foods and electronics make a healthy lifestyle challenging. – Physician*

*Kids who eat badly and not enough exercise. – Physician*

*Fat inactive kids. – Physician*

*Our eating habits are poor. – Physician*

### **Unsafe Environment Limits Access**

*Poverty and unsafe environments limit access to nutritious foods and opportunities for activity. There are few weight management programs for children and there is very limited insurance coverage for these. – Physician*

*As mentioned with diabetes, there are not a lot of places for safe play because the violence issues, or at least the perception of it, not a lot of places for healthy and affordable food. – Public Health Representative*

*Cheap foods are less nutritious. Many children do not have safe outdoor play areas. Single moms that work several jobs try to keep their children inside for safety. Schools have cut down on PE activities because they have more important things, like computers, to teach. – Public Health Representative*

*I think there are pockets in Omaha where nutrition and as physical activity are limited by the community the child lives in. Good grocery stores aren't as easily accessible in parts of north Omaha. The neighborhoods aren't safe in parts of north and sometimes south Omaha for kids to play outside for adequate physical activity. Many families could benefit from seeing a dietician, but this is not an easy resource to locate for a pediatric patient at least in an outpatient setting. – Physician*

### **Nationwide Problem**

*This is a problem everywhere, not just in Omaha. – Public Health Representative*

*Again, a major US problem. I've been involved in the community directly with nutrition programming and have witnessed a lack of knowledge on healthy foods, as well as a lack of desire to eat healthy among children and their families. – Community/Business Leader*

*Common social problem. – Physician*

*It is everywhere. – Physician*

### **Not Promoted in Schools**

*Schools cut physical activity time, less gym class and recess. Decreased time for lunch, not teaching nutrition and home economics in schools. – Community/Business Leader*

*Several issues are present; recess is continually cut from the school day. Older youth are subject to competitive sports teams or left with little to no options for recreation and physical activity. Non-athletes are scrutinized in many cafeterias on their food choices and more teens are reporting on the YRBS that they are using meal supplements and fad diets to control their weight. Finally, health curriculum has been reduced and is outdated, thus key age groups are not being taught healthy body image and healthy nutrition and physical activity habits. – Public Health Representative*

*Too little time devoted to this in the schools. – Physician*

*These complex issues were identified in a previous community health needs assessment, and although I have seen great efforts in the form of the Live Well Omaha Kids campaign, community gardens and local nonprofits hard at work to address the identified needs. I still see this work as ongoing and don't want to lose ground on the incredible momentum that has been built by so many. One policy effort that remains to be fully addressed is whether or not schools and or school districts will take advantage of the Community Eligibility Provision from the Healthy, Hunger-Free Kids Act of 2010 that allows schools and local educational agencies with high poverty rates to provide free breakfast and lunch to all students. – Community/Business Leader*

### **Important for Learning and Development**

*Health behaviors or lack thereof have huge impacts on a child's readiness and ability to learn and development. Disparities across racial and ethnic groups persist, much of which is related to access to healthy foods and safe places to be active among other social determinants of health. Positive improvements in these behaviors can have tremendous benefits for individuals. – Public Health Representative*

*When children are healthy and active, they are able to grow and learn to their fullest potential. – Social Services Provider*

***Lack of Nutrition Education***

*These services are related to the diabetes services where the first treatment and prevention services are to addressing nutrition and physical activity. – Public Health Representative*

*I work in a lower socio economic area. It is amazing to see the number of patients who believe sports drinks are healthy, or carbs like noodles and pasta and still considered "low fat" with no understanding of carbs. WIC dispenses juice like crazy so people assume it's healthy. There is such a poor understanding of nutrition and overall health status. It is so difficult to have a discussion with a 300# teen about their weight, fatigue, depression, acne, etc., when they can't begin to relate that the foods they eat contribute too all of their problems. – Other Healthcare Provider*

***Lack of Control***

*Not able to control the many environments of children to provide health eating and activity. Busy parents have to do the best that they can do. – Other Healthcare Provider*

# Tobacco

## Exposure to Environmental Tobacco Smoke

### About Tobacco Exposure

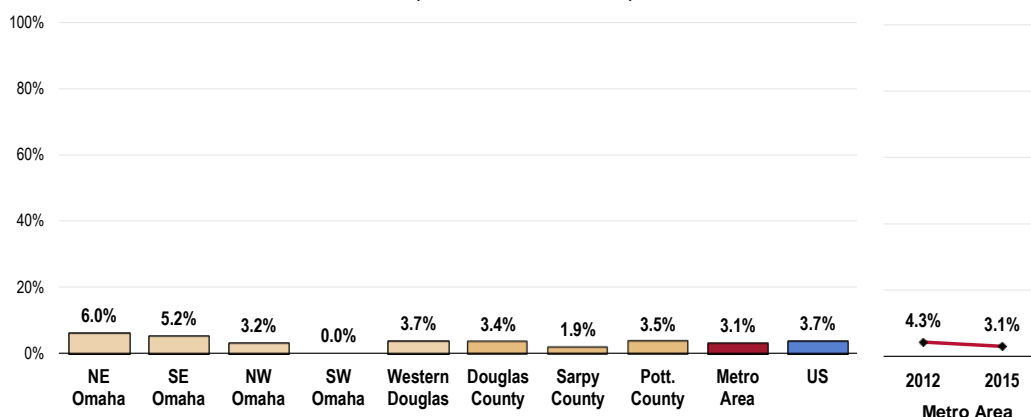
There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**A total of 3.1% of Metro Area parents report that someone in the household smokes inside the home.**

- Comparable to the US proportion.
- In Douglas County, Southwest Omaha did not report any regular smoking inside of homes with children.
- Similar among the individual counties.
- TREND: Shows no statistically significant change since 2012.

### Someone Smokes Tobacco Inside the House (Metro Area, 2015)

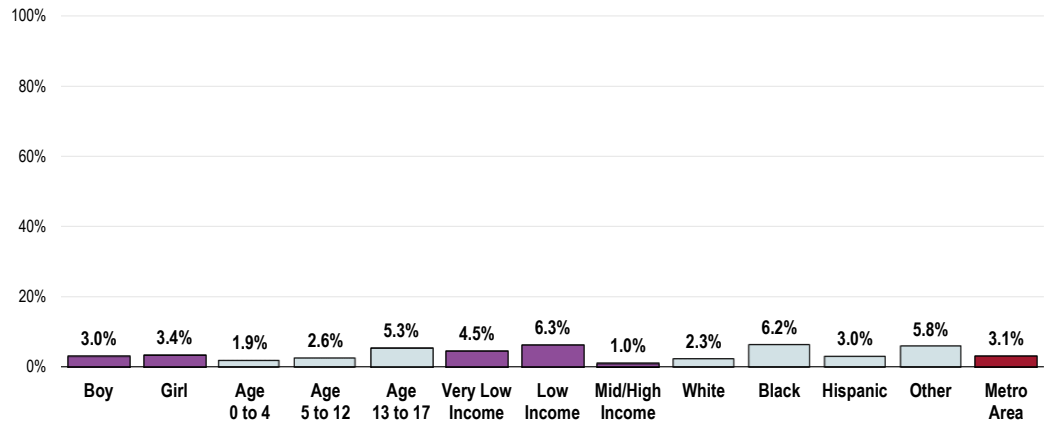


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 158]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

These Metro Area children are more likely to be exposed to tobacco smoke in the home:

- Older children (note the positive correlation with age).
- Those in low income households.

## Someone Smokes Tobacco Inside the House (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 158]

Notes: • Asked of all respondents.

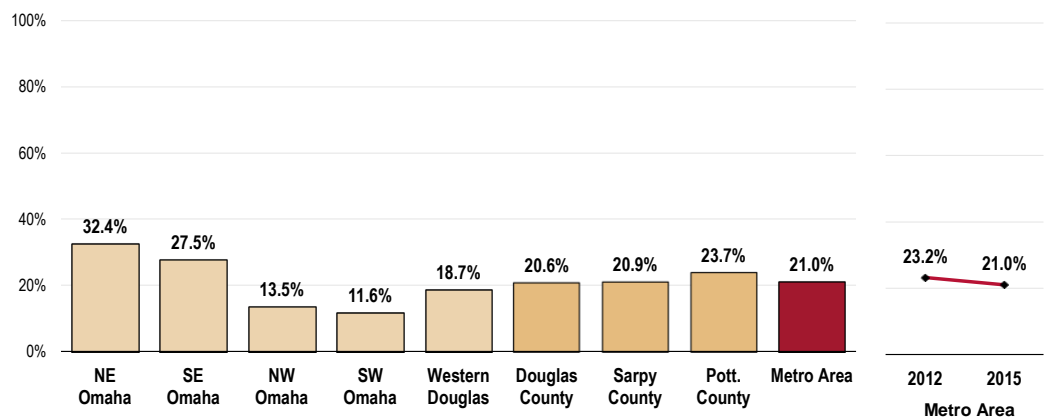
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

**Further, 21.0% of Total Service Area parents report that a member of their household smokes tobacco outside the home.**

- In Douglas County, Northeast and Southeast Omaha report a higher prevalence of outside smoking, while Northwest and Southwest Omaha have lower smoking levels.
- Comparable by county.
- TREND: No statistically significant changes in outdoor smoking have occurred within the past three years.

## Someone Smokes Tobacco Outside the House (Metro Area, 2015)

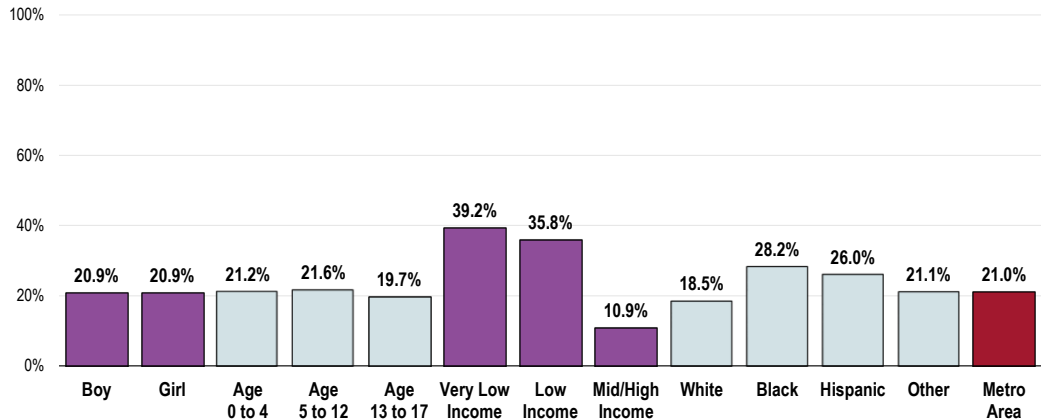


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 311]

Notes: • Asked of all respondents.

- Smoking outside the home is notably higher in lower-income households.

### Someone Smokes Tobacco Outside the House (Metro Area, 2015)



Sources: 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 311]

Notes: Asked of all respondents.

Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

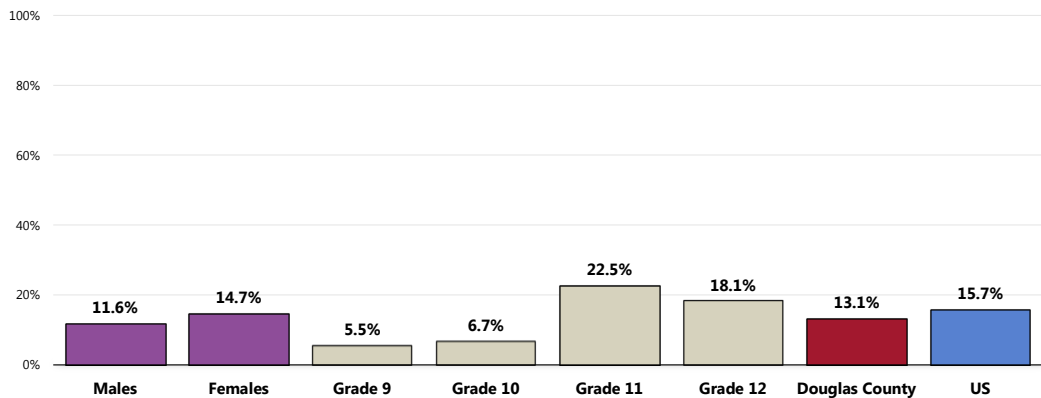
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Current Tobacco Use (Adolescents)

Among high school students (Douglas County only), 13.1% report smoking at least one cigarette on at least one day during the 30 days preceding the administration of the 2014 Youth Risk Behavior Survey.

- Similar to US findings.
- No difference by gender.
- Significantly higher in Douglas County 11<sup>th</sup> and 12<sup>th</sup> graders.

### Smoked Cigarettes in Past Month (Among High School Students; Douglas County Youth Risk Behavior Survey, 2014)



Sources: Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.

Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.

Notes: Smoked cigarettes on at least 1 day during the 30 days before the survey.

This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students.

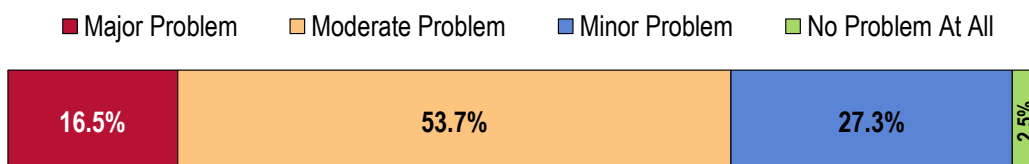
For more information, visit: [www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs).



## Key Informant Input: Tobacco Use

A majority of key informants taking part in an online survey characterized Tobacco Use as a “moderate problem” for children/adolescents in the community.

### Perceptions of Tobacco Use as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### High Prevalence in Young People

*It is harder to buy tobacco products now, but a lot of young people are still trying it. – Physician*  
*My observation that I have never been to an area where so many teens smoke. – Physician*  
*Kids still smoke. – Physician*  
*Kids are smoking. – Physician*  
*On the decline, though still high use among teens, especially those living in poverty. Though likely being replaced by marijuana quickly. – Physician*  
*Teenagers still believe that smoking is cool, and they also do it as a sign of rebellion. – Physician*

### Easy to Obtain Cigarettes

*Cigarettes are easy to obtain and incredibly addictive. – Physician*  
*Easy access from parents and older siblings. We have allowed cigar bars to surface because political will is so poor on banning the high risk behavior. – Public Health Representative*  
*Ease of access. – Physician*

### Long Term Health Issues

*Poor decisions as youth around tobacco use create long-term physical health issues as adults. – Other Healthcare Provider*  
*Kids shouldn't smoke at all. – Physician*

### E-Cigarette Popularity

*E-cigarettes are booming and are leading to increased tobacco use. – Social Services Provider*

### Second-Hand Smoke

*Tobacco smoke exposure more than use. – Physician*

### Lack of Education

*Lack of understanding of what tobacco does to the body and those around people who are using tobacco. – Community/Business Leader*

## Substance Abuse

### Alcohol (Adolescents)

#### Current Alcohol Use

Among high school students (Douglas County only), 27.4% report having at least one drink of alcohol on at least one day during the 30 days preceding the administration of the 2014 Youth Risk Behavior Survey.

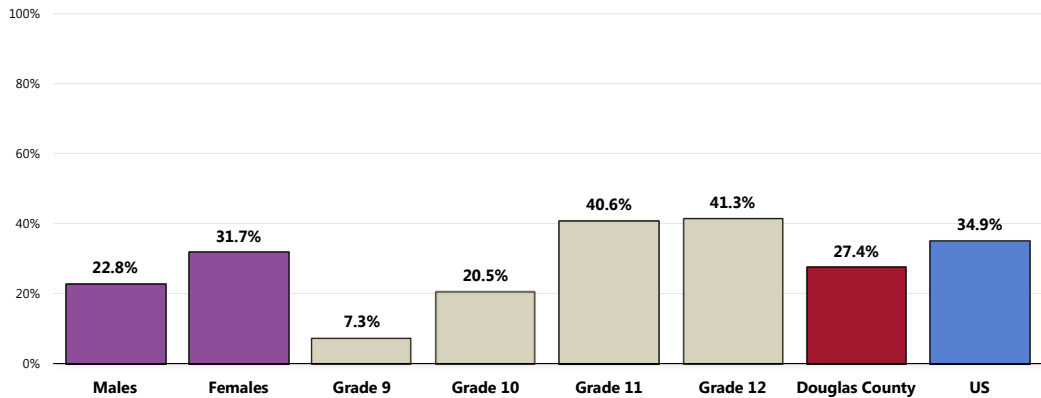
- More favorable than found nationally.
- More prevalent among girls than boys.
- Appears to increase with grade level in Douglas County.

This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students.

For more information, visit: [www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs).

#### Drank Alcohol in Past Month

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2014)



Sources: • Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.  
• Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.

Notes: • Had at least one drink of alcohol on at least one day during the 30 days before the survey.

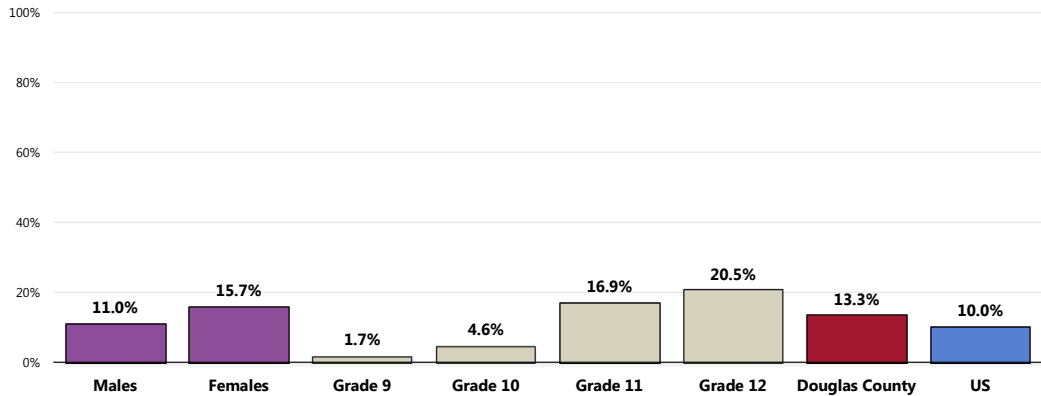
#### Current Drinking & Driving

A total of 13.3% of Douglas County high school students report having driven a car or other vehicle when drinking alcohol one or more times during the 30 days preceding the administration of the 2014 Youth Risk Behavior Survey.

- Similar to national findings.
- No statistical difference by gender.
- In Douglas County, this is highest among 11<sup>th</sup> and 12<sup>th</sup> graders.

## Drove When Drinking Alcohol in the Past Month

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2014)



Sources:

- Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.
- Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.

Notes:

- Drove a car or other vehicle when drinking alcohol one or more times during the 30 days before the survey.

## Drug Use (Adolescents)

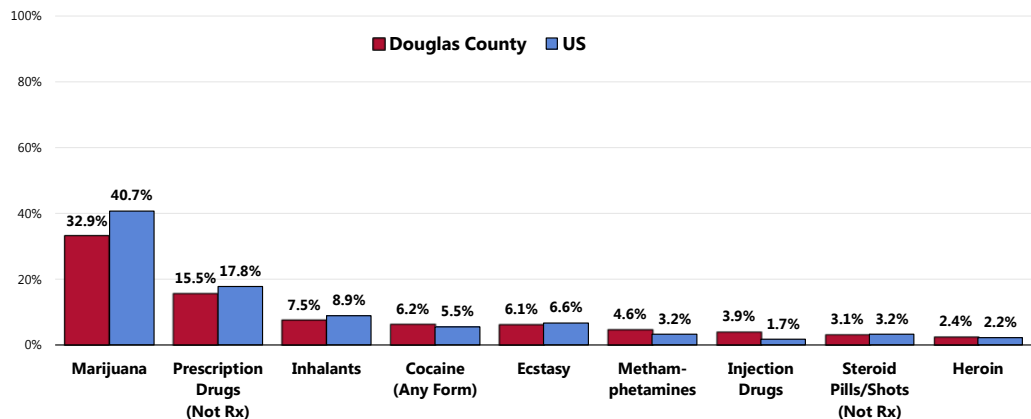
### Lifetime Use of Drugs

High school students (Douglas County only), report the highest lifetime usage of marijuana (32.9% have ever used), prescription drugs (15.5% have ever used drugs not prescribed to them), and inhalants (7.5% have ever used).

- Findings are significantly below national findings for lifetime usage of marijuana, but above the national findings for usage of injection drugs.

## Ever Used Specific Drugs

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2014)



Sources:

- Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.
- Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.

Notes:

- Prescription drugs include drugs such as Oxycontin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax.
- Inhalants include sniffing glue, breathing the contents of aerosol spray cans, or inhaling any paints or sprays to get high.
- Ecstasy also called "MDMA."
- Cocaine includes powder, crack or freebase forms of cocaine.
- Methamphetamine also called "speed," "crystal," "crank," or "ice."
- Heroin also called "smack," "junk," or "China white."

This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students.

For more information, visit: [www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs).

This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students.

For more information, visit: [www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs).

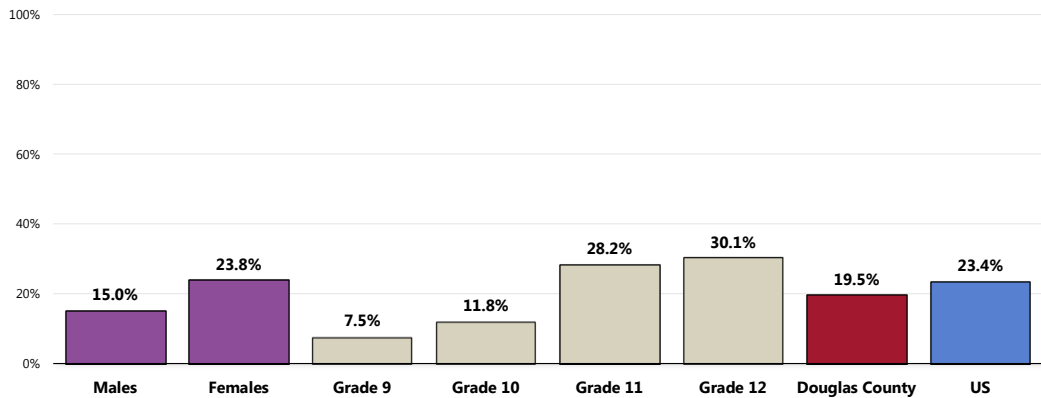
### Current Marijuana Use

A total of 19.5% of Douglas County high school students report having used marijuana one or more times during the 30 days preceding the administration of the 2014 Youth Risk Behavior Survey.

- Statistically similar to the national rate.
- Higher among girls than boys in Douglas County.
- Highest among 11th and 12th graders.

### Used Marijuana in Past Month

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2014)



Sources: • Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.  
• Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.

Notes: • Used marijuana one or more times during the 30 days before the survey.

This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students

For more information, visit [www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs)

### Key Informant Input: Substance Abuse

Key informants taking part in an online survey are most likely to consider Substance Abuse as a “moderate problem” for children/adolescents in the community.

### Perceptions of Substance Abuse as a Problem for Children/Adolescents in the Community

(Key Informants, 2015)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Access to Care/Services

- No access or providers. – Physician*
- Lack of access. – Physician*
- Not enough easy access for adolescents to receive care. – Other Healthcare Provider*
- Availability and affordability of services, Insurance Coverage or lack thereof, and stigma. – Community/Business Leader*
- The cost is the biggest barrier for most parents. – Community/Business Leader*
- Insurance coverage. – Physician*
- Money and education. – Community/Business Leader*
- Money, transportation, support from family and others, lack of quality programs. – Social Services Provider*

### Denial

- Failure to recognize the problem and seek intervention, treatment. – Physician*
- Denial of need, from both teens and parents, access to specialized services at times that work for families, concerns about legal issues, stigma associated with treatment. – Physician*
- Some don't see it as a problem. The youth have to be ready to change to seek treatment. Peer pressure may prevent a youth from getting treatment. – Social Services Provider*
- Denial of problem, access to care, social stigma. – Physician*
- Not agreeing that they have a problem. – Community/Business Leader*
- Desire for treatment or seeing that it is a problem, especially with marijuana, which most do not see as a problem. For other drugs, usually the barrier is lack of family support, poverty. – Physician*
- We only know if parents bring them in. – Physician*

### Lack of Programs

- Too few resources including providers of substance abuse treatment in adolescents and very limited inpatient capability. – Physician*
- Lack of resources. – Other Healthcare Provider*
- No appropriate outpatient treatments are available. There is lack of will to pay for these services as to be successful in treatment and relapse prevention. We need outpatient treatment resources available at the time when families can engage with child and adolescent in treatment without losing their job and without patient missing out on education. – Physician*
- Lack of facilities and trained professionals for kids. – Physician*
- Lack of high quality financially funded treatment centers, programs, etc. Being high often mirrors adult behavior and is viewed as socially acceptable. – Public Health Representative*
- Less than proactive solutions to engage students about the topic. – Community/Business Leader*

### Need Evidence Based Programs

- Like the behavioral issues, substance abuse is a symptom. Omaha Public Schools needs to invest in a different approach, rather than the current methods which are more formalities rather than solution focused where outcomes are measured. – Physician*
- Availability of evidence-based programs in our community. Insufficient payment sources for treatment. – Other Healthcare Provider*

### Drugs in Schools

- Drugs in high schools. – Physician*
- Lack of OPS having resources available in schools for students to access. – Physician*

### Education of Available Resources

- Lack of knowledge of resources and how to access them. Also underlying, untreated mental or*

*behavioral health problems that lead to self-medication, lack of insurance to cover treatment, parents not knowing how to give adequate support, or having substance abuse issues themselves. – Physician*  
*Knowing where to get information about it. – Physician*

### High Prevalence

*Ease of access, permissive behaviors beginning at home. – Physician*  
*Large number of methamphetamine and prescription narcotic abusers. – Physician*  
*The prevalence of drug use among our adolescents is very high across SES groups. This is especially true of synthetic marijuana. – Physician*

### Parents Problem Affecting Kids

*In my experience, there are a lot of parents and caregivers who are struggling with substance abuse that don't realize the effect it has on their children, and in turn are not seeking treatment to help the kids with the effects the substance abuse has had on them. – Community/Business Leader*

### Most Problematic Substances

**Key informants (who rated this as a “major problem”) most often identified marijuana, alcohol, and prescription medications as the most problematic substances abused by youth in the community.**

	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Marijuana	29.4%	45.7%	11.8%	30
Alcohol	52.9%	22.9%	8.8%	29
Prescription Medications	2.9%	20.0%	29.4%	18
Methamphetamines or Other Amphetamines	5.9%	5.7%	11.8%	8
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	5.9%	5.7%	11.8%	8
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	0.0%	17.6%	6
Cocaine or Crack	2.9%	0.0%	0.0%	1
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	0.0%	0.0%	2.9%	1
Heroin or Other Opioids	0.0%	0.0%	2.9%	1
Over-The-Counter Medications	0.0%	0.0%	2.9%	1

## Injury & Safety

### About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Prevalence of Injuries

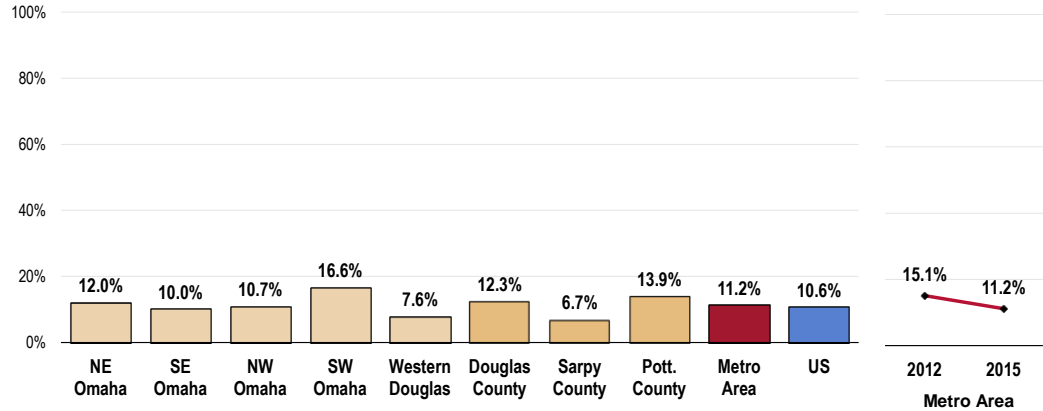
### Injuries Requiring Treatment

**While most Metro Area children were not injured seriously in the past year, 11.2% sustained injuries serious enough to require medical treatment.**

- Similar to US results.
- Statistically similar among Douglas County sub-areas.
- By county, most favorable in Sarpy County.
- TREND: Since 2012, the prevalence of serious injuries has significantly decreased.

“In the past two years, has this child been injured seriously enough to need treatment from a doctor or a nurse?”

### Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year (Metro Area, 2015)

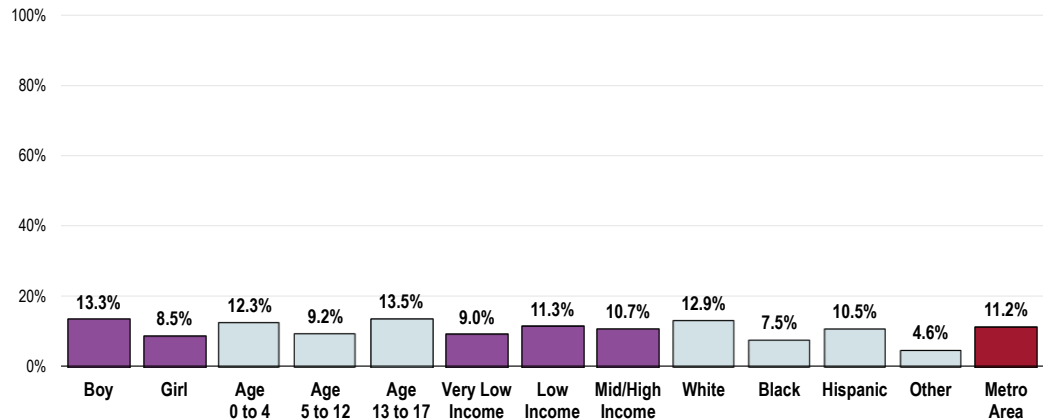


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 78-79]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents about a randomly selected child in the household.

- Boys are more likely to have sustained injuries requiring medical treatment, as are White children.

### Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year (Metro Area, 2015)



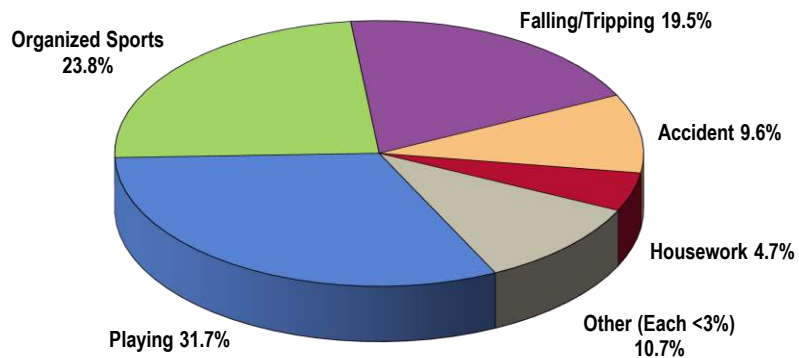
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 78]

Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



When asked what the child was doing when the injury occurred, parents of these children mentioned activities like **playing** (31.7%), **organized sports** (23.8%), **falling or tripping** (19.5%), **accidents** (9.6%), and **housework** (4.7%).

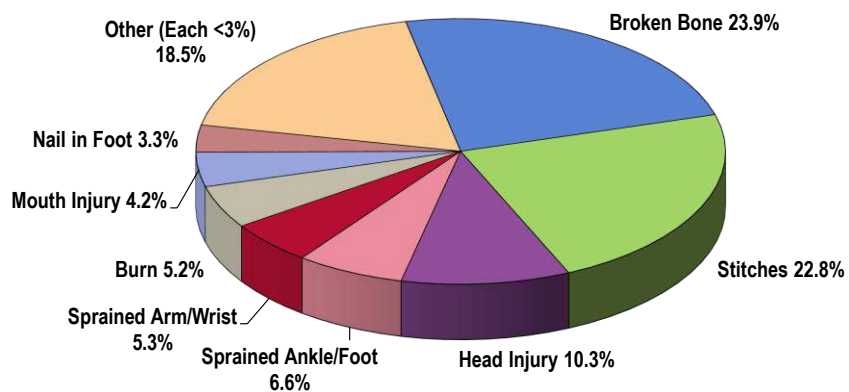
### Child's Activity When Most Seriously Injured in Past Two Years (Metro Area Children Seriously Injured in the Past Year, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 80]  
Notes: • Asked of all respondents for whom the randomly selected child in the household was seriously injured in the past two years.

When asked about the type of injury sustained, these parents frequently mentioned **broken bones** (23.9%), injuries requiring **stitches** (22.8%), **sprains** (11.9%), and **head injuries** (10.3%). Injuries mentioned with less frequency included **burns**, **mouth injuries**, and **a nail in the foot**.

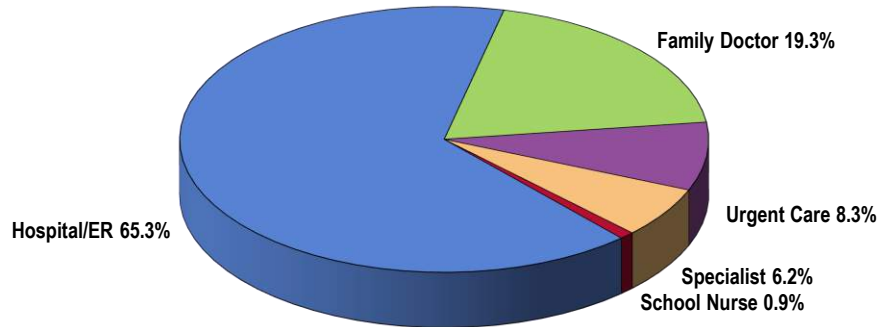
### Type of Injury Sustained (Metro Area Children Seriously Injured in the Past Year, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 81]  
Notes: • Asked of all respondents for whom the randomly selected child in the household was seriously injured in the past two years.

When asked where they sought help for the child's injury, just under two-thirds of parents mentioned a **hospital emergency room** (65.3%), followed by a **family physician** (19.3%), **clinic/urgent care center** (8.3%), a **specialist** (6.2%), and a **school nurse** (0.9%).

**Source for Help After the Injury**  
(Metro Area Children Seriously Injured in the Past Year, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 82]  
Notes: • Asked of all respondents for whom the randomly selected child in the household was seriously injured in the past two years.

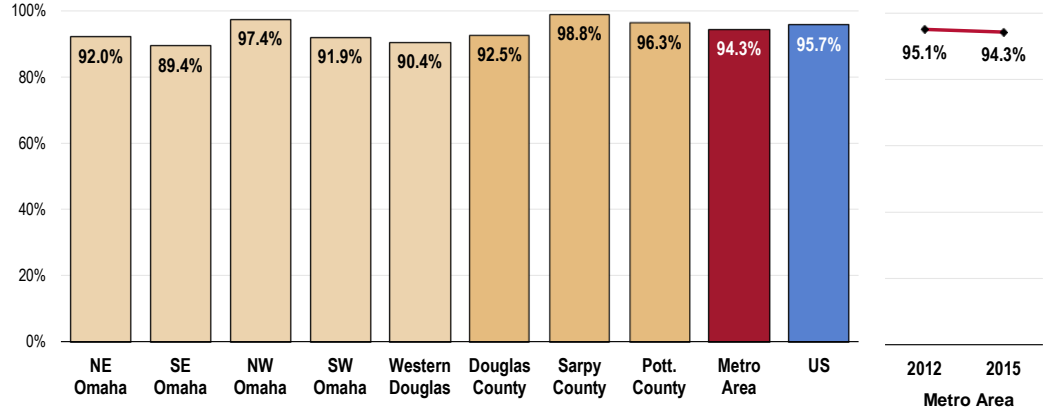
## Injury Control

### Car Seats & Seat Belts

A full 94.3% of Metro Area parents report that their child (age 0 to 17) “always” wears a seat belt (or appropriate car seat for younger children) when riding in a motor vehicle.

- Similar to what is reported nationally.
- Within Douglas County, seatbelt safety is highest in Northwest Omaha.
- By county, lowest in Douglas County; highest in Sarpy County.
- TREND: The proportion of children “always” wearing a seatbelt is statistically the same as it was three years ago.

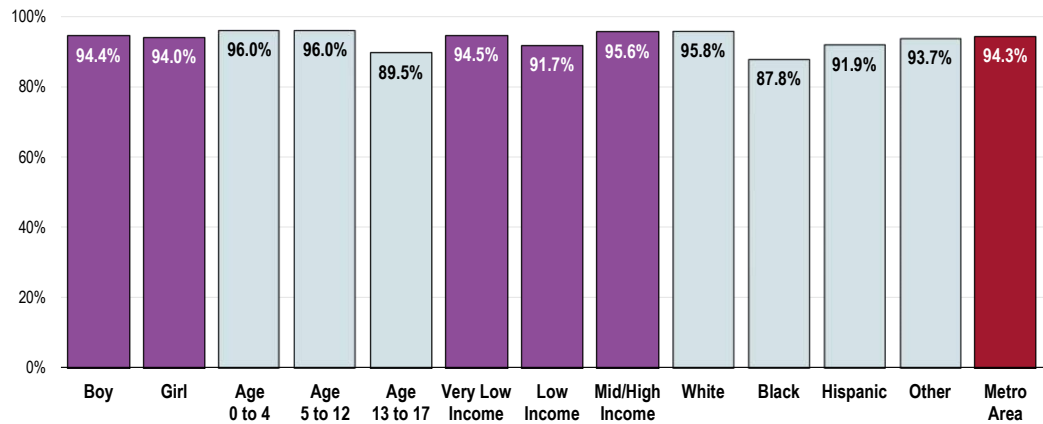
### Child “Always” Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 83]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Usage is significantly lower among teenagers and among Black children.

### Child “Always” Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle (Metro Area, 2015)



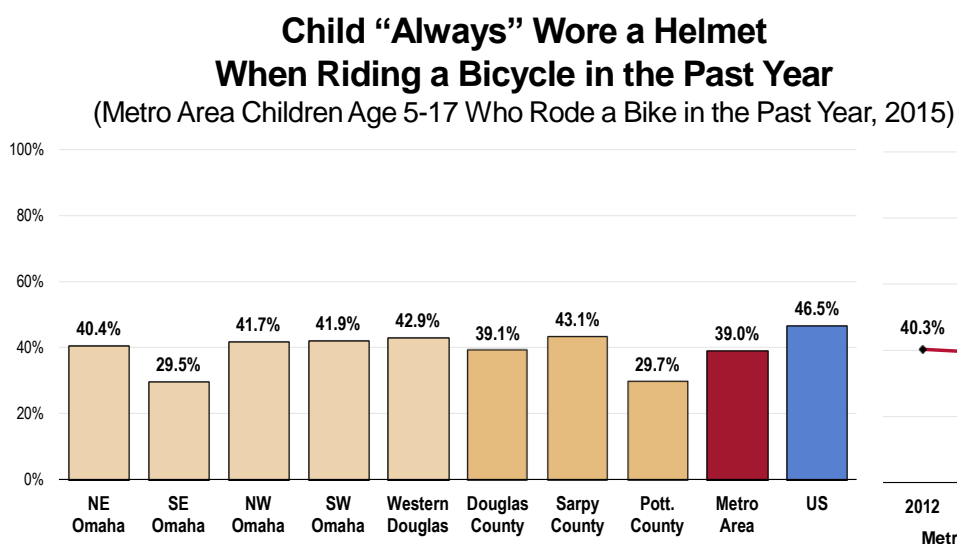
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 83]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

## Helmet Use

### Bicycles

A total of 39.0% of Metro Area children age 5 to 17 are reported to “always” wear a helmet when riding a bicycle.

- Less favorable than found across the US.
- Throughout Douglas County, bike safety is notably less favorable in Southeast Omaha.
- By county, least favorable in Pottawattamie County.
- TREND: Statistically unchanged in the past three years.



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 88]

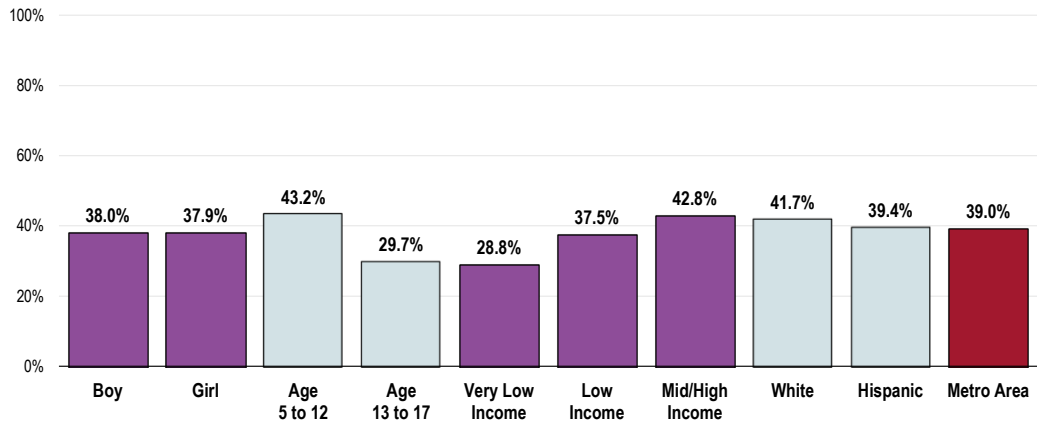
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a bike in the past year.

Children (age 5-17) less likely to “always” wear a bike helmet include:

- Teens.
- Those in lower-income households (positive correlation of bike safety with income).

### Child “Always” Wore a Helmet When Riding a Bicycle in the Past Year (Metro Area Children Age 5-17 Who Rode a Bike in the Past Year, 2015)



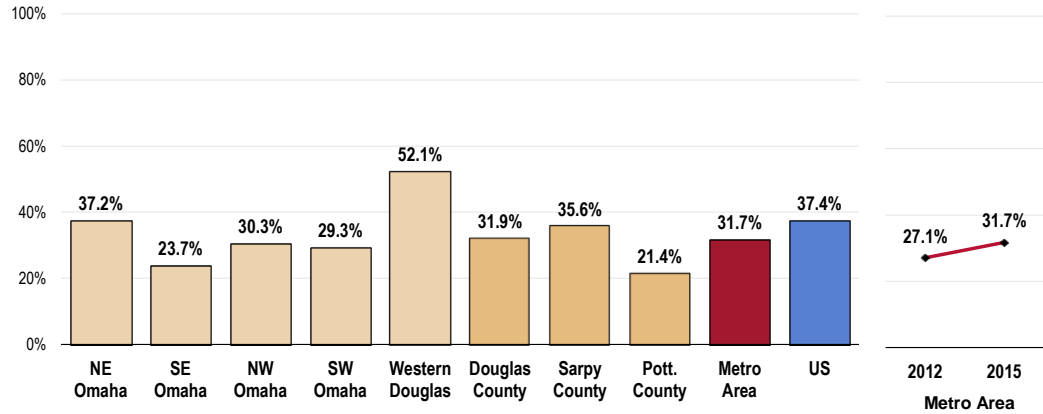
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 88]  
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a bike in the past year.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.  
• Bike safety data for Black and “Other” race children is not presented due to small sample sizes.

### Skateboards, Scooters, Skates & Rollerblades

A total of 31.7% of Metro Area children age 5 to 17 are reported to “always” wear a helmet when riding a skateboard, scooter, skates, or rollerblades (denominator reflects only those who engage in these activities).

- Below the national proportion.
- Of the Douglas County sub-areas, much higher in Western Douglas; lowest in Southeast Omaha.
- By county, lowest in Pottawattamie County.
- TREND: The use of helmets when engaging in these activities has remained statistically the same since 2012.

### Child “Always” Wore a Helmet on Skateboards, Scooters, Skates or Rollerblades in the Past Year (Metro Area Children Age 5-17 Who Engaged in These Activities in the Past Year, 2015)



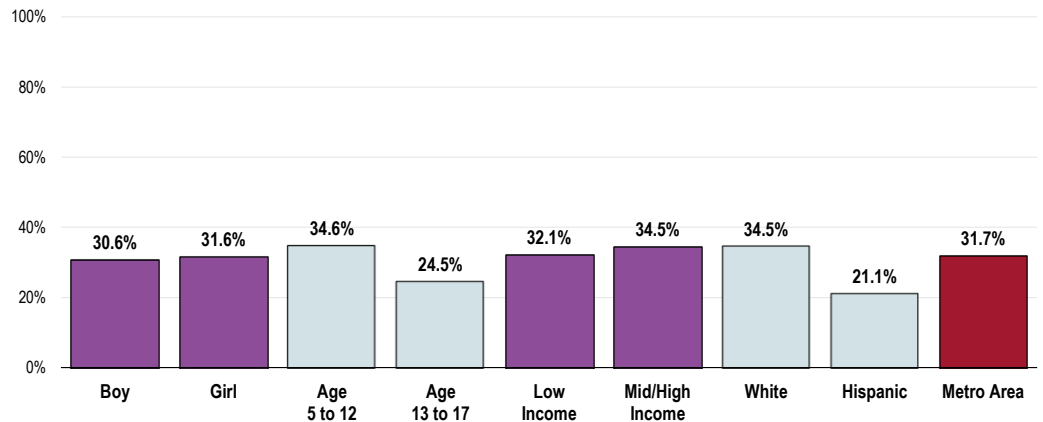
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 89]

• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a skateboard, scooter, skates or rollerblades in the past year; excludes the 50.5 of children who did not engage in these activities.

- Lowest among teens and among Hispanic children.

### Child “Always” Wore a Helmet on Skateboards, Scooters, Skates or Rollerblades in the Past Year (Metro Area Children Age 5-17 Who Engaged in These Activities in the Past Year, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 89]

Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a skateboard, scooter, skates or rollerblades in the past year; excludes the 50.5% of children who did not engage in these activities.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).

• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

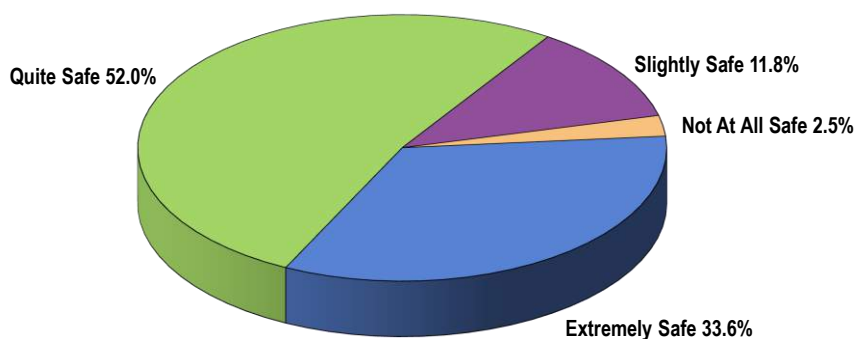
• Skating safety data for Black and “Other” race children as well as those living in very low income households is not presented due to small sample sizes.

## Violence & Safety

### Neighborhood Safety

While most Metro Area families live in “extremely safe” or “quite safe” neighborhoods, 14.3% of area parents live in neighborhoods they consider only “slightly safe” or “not at all safe.”

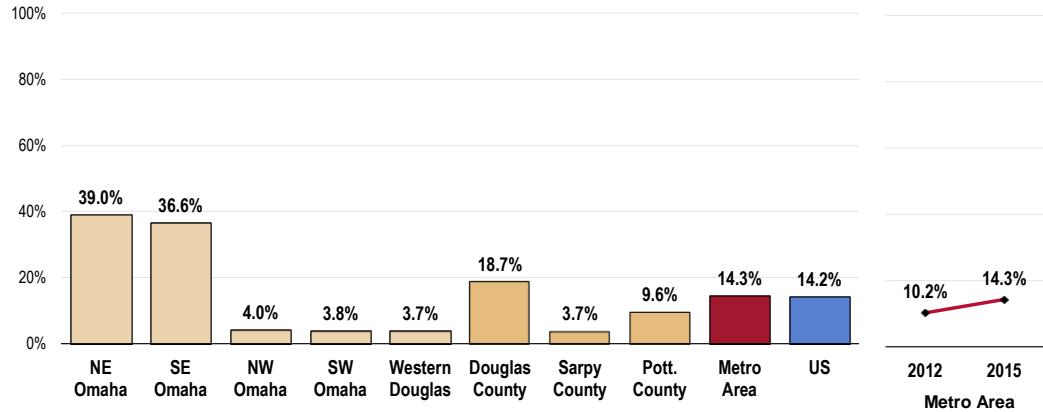
**Perceived Safety of Neighborhood**  
(Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 87]  
Notes: • Asked of all respondents.

- The prevalence of “slightly/not at all safe” responses is almost identical to national findings.
- Within Douglas County, Northeast Omaha and Southeast Omaha have a much greater proportion of children living in neighborhoods that are perceived as unsafe.
- By county, Douglas County neighborhoods are more often perceived as unsafe.
- TREND: These perceptions of a lack of neighborhood safety have increased significantly since 2012.

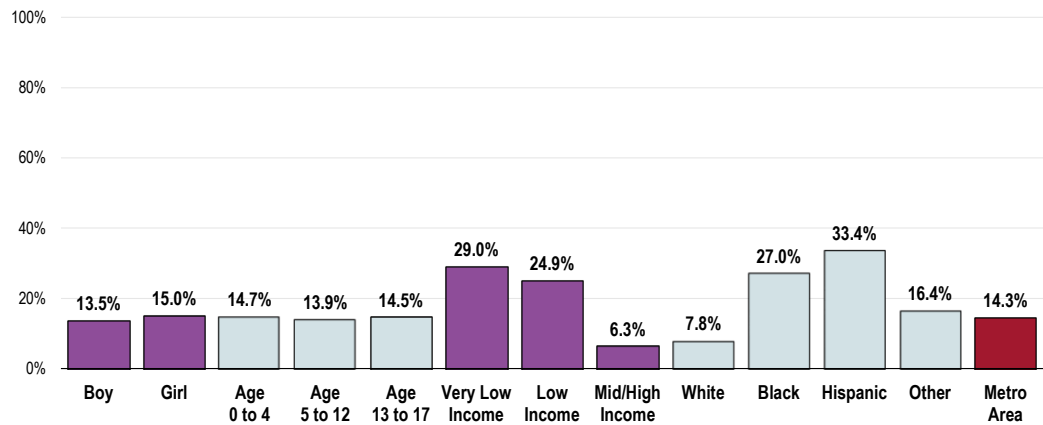
### Neighborhood Perceived to be “Slightly/Not At All” Safe (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 87]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

- Note the clear, negative correlation with household income levels.
- Also, parents of Hispanic or Black children are more likely to live in neighborhoods they consider “slightly/not at all” safe.

### Neighborhood Perceived to be “Slightly/Not At All” Safe (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 87]  
Notes: • Asked of all respondents.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes below 100% of the federal poverty level; “Low Income” includes households with incomes between 100% and 199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

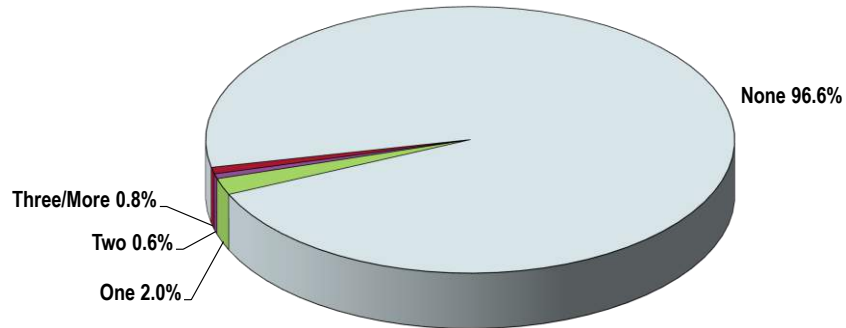


## Feeling Safe at School or Going to/From School

A total of 3.4% of Metro Area children age 5-17 missed school at least once in the past year because he/she felt unsafe either at school or on the way to/from school.

“During the past year, how many days did this child not go to school because he/she felt unsafe at school or on the way to or from school?”

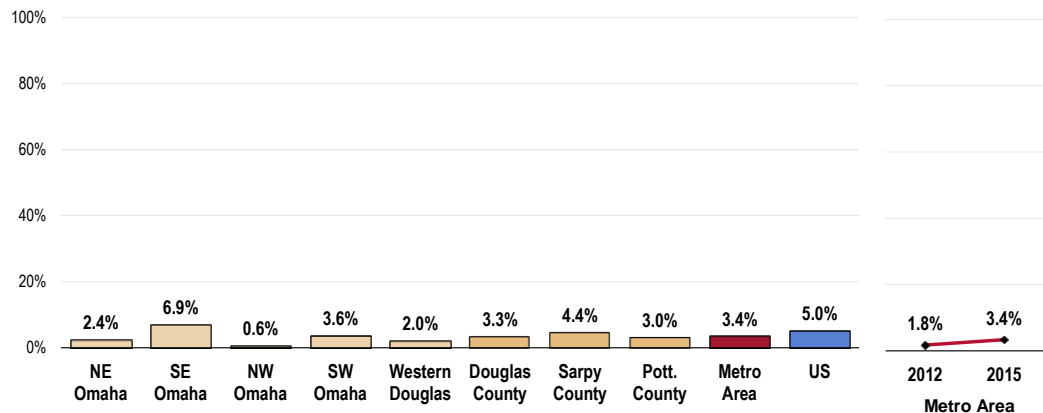
### School Days Missed in the Past Year Because Child Felt Unsafe at School or on the Way to/From School (Metro Area Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 84]  
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.

- Statistically similar to the US figure.
- In Douglas County, most prevalent in Southeast Omaha; least common in Northwest Omaha.
- Rates among the Metro Area counties are similar.
- TREND: The prevalence of children missing school due to feeling unsafe is statistically the same as it was in 2012.

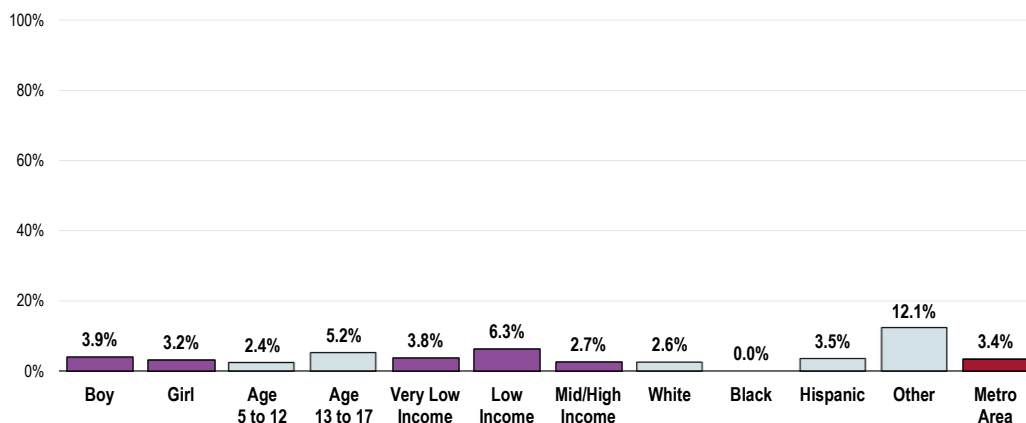
### Child Missed School in the Past Year Due to Feeling Unsafe (Metro Area Children Age 5-17, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 84]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.

- Higher among teens than younger children.
- “Other” race children are much more likely to miss school for safety reasons.

### Child Missed School in the Past Year Due to Feeling Unsafe (Metro Area Children Age 5-17, 2015)



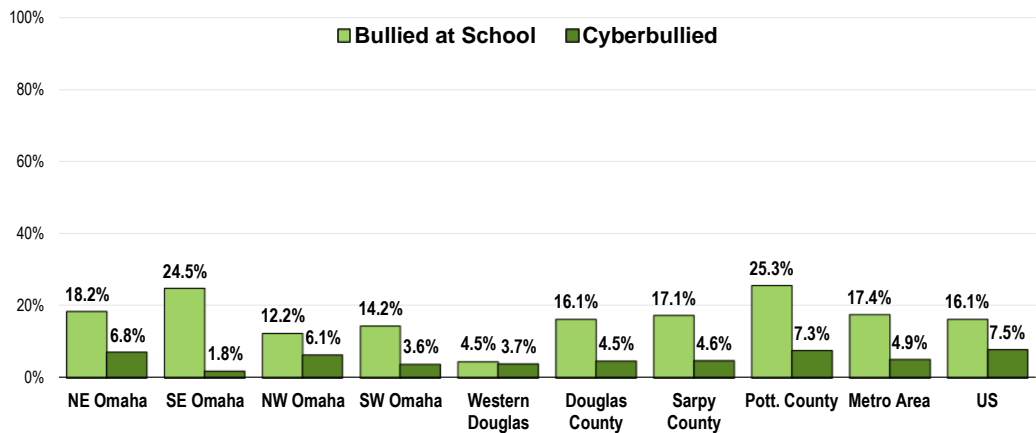
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 84]  
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Bullying

Among parents of school-age children, 17.4% report that their child has been bullied in the past year on school property; another 4.9% report that their child has been cyberbullied (these percentages are not mutually-exclusive).

- Both forms of bullying occur in the Metro Area at a statistically similar rate as seen nationwide.
- In Douglas County, the prevalence of bullying on school property is least favorable in Southeast Omaha and far more favorable in Western Douglas.
- By county, school bullying rates are least favorable in Pottawattamie County.
- In Douglas County, cyberbullying occurs at a more favorable rate in Southeast Omaha.
- Statistically, there is no difference in the proportion of children who are cyberbullied among the individual counties.

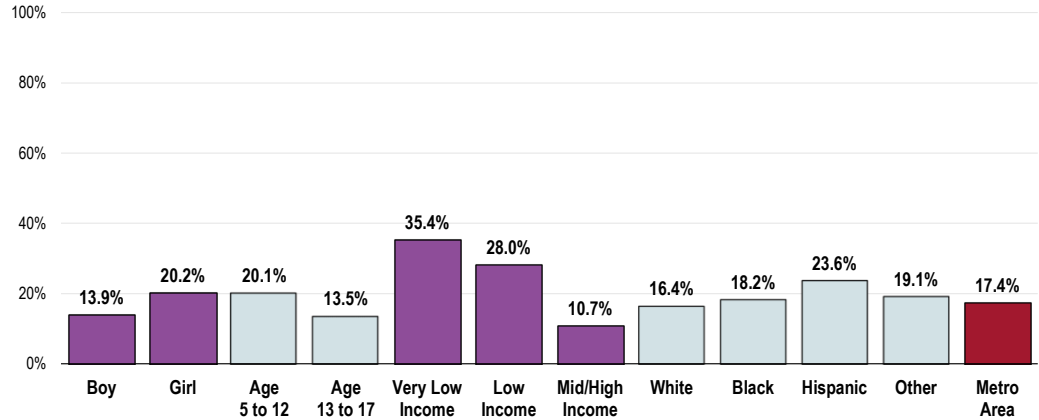
### Child Was Bullied in the Past Year (Metro Area Children 5-17, 2015)



- Sources:
- 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 85, 86]
  - 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of those respondents for whom the randomly selected child in the household is age 5 to 17.
  - Cyberbullying includes electronic bullying such as through email, chat rooms, instant messaging, websites, or texting.

- Girls and children age 5-12 are more likely to have experience bullying on school property in the past year.
- Note the strong negative correlation between bullying on school property and the child's household income status.

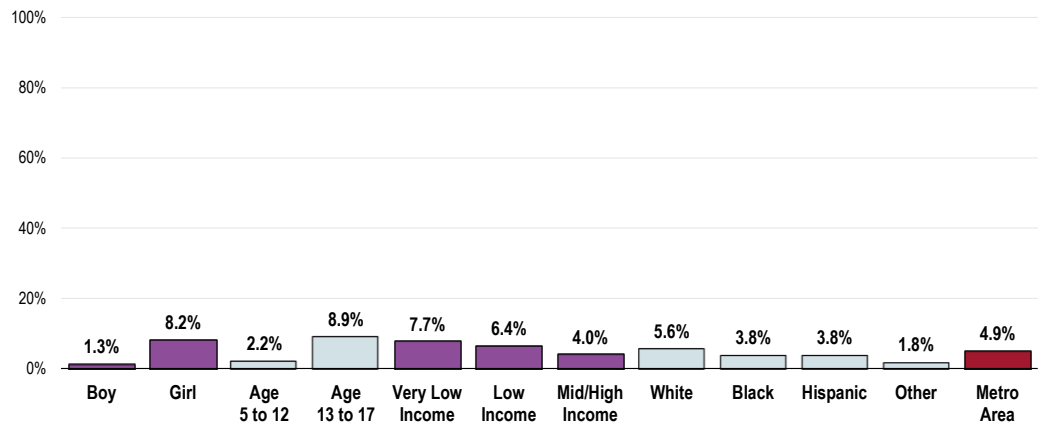
### Child Was Bullied on School Property in the Past Year (Metro Area Children Age 5-17)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 85]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

- Parents' reports of cyberbullying are highest among girls and teens.

### Child Was Cyberbullied in the Past Year (Metro Area Children Age 5-17)

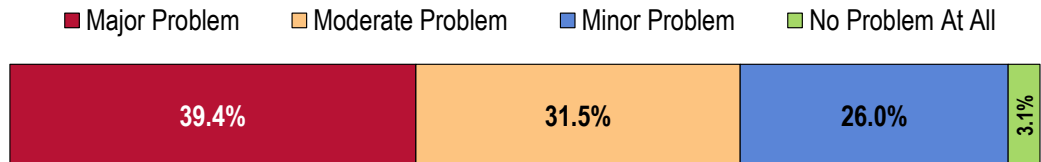


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 86]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.  
• Cyberbullying includes electronic bullying such as through email, chat rooms, instant messaging, websites, or texting.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Key Informant Input: Injury and Violence

Key informants taking part in an online survey generally characterized Injury and Violence as a “major problem” in the community.

### Perceptions of Injury and Violence as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Trauma Caused by Violence

*Anxiety and stress caused by repeated shootings and violence. Especially in the eastern portion of Omaha. – Other Healthcare Provider*

*I believe it is a major source of physical and mental trauma in children and adolescents. Unsafe neighborhoods, the number of children who know of a family member or friend who has been shot or died a violent death, and being taught at a young age what to do if you hear gunshots, leads to chronic stress for both children and parents. Chronic stress leads to both physical and mental health problems. – Physician*

*Research shows that domestic violence as an “adverse childhood experience” can have a significantly negative impact on adult health. I don’t feel we are doing enough in our community to recognize and address this. There are also parts of Omaha that have a significant amount of violence that seriously impacts child health and security. – Physician*

*Violence and the trauma it causes among children has large impacts on that child’s ability to thrive and learn. Many “at-risk” children have experience traumatic experiences and violence, yet do not have the skills or resources for getting supports. – Community/Business Leader*

*Violence perpetrated against children leaves long lasting physical and emotional scars. Sadly it is an ever present issue in Omaha and its surrounding areas. Violence either witnessed or perpetrated against our area’s children put them at risk of involvement with drugs and alcohol as well as damaging relationships with caregivers or future partners. The effects linger far beyond the violent act. – Physician*

*The effects of adverse psychological events in childhood has such a significant negative impact on future emotional, physical, academic, psychological success. – Physician*

*Children and adolescents witnessing violence and injury, which contributes to lifelong issues. – Social Services Provider*

*Prevalence of violence in our community is alarming. The trauma created by the violence is not being adequately identified and addressed. Long-term effects of this trauma will be seen in physical and mental health areas. – Other Healthcare Provider*

*They are witnessing real time at alarming rates. – Community/Business Leader*

*There is an epidemic in our community of children exposed to violence in their home and community. I believe this exposure is under reported to CPS. The ACE study also indicates exposure to violence is prevalent in the lives of children and adolescents. – Social Services Provider*

### Gun Violence

*Children have been in the direct line of gun violence in our community. The murder rate seems to be increasing. Armed robberies were in the news this week. Families in certain areas are impacted by gun violence on a regular basis. This affects their stability and safety. Child abuse and neglect are also issues in our community. – Social Services Provider*

*Gun violence and homicide. – Other Healthcare Provider*

*Still high rates of gun violence in town. – Public Health Representative*

*Shootings are common in Omaha. Students can't feel safe walking home from school. – Community/Business Leader*

*Shootings all the time. – Physician*

*Shootings. – Physician*

### Violence Killing Young People

*Too many young people are being killed from violence. When a five year old girl can't eat breakfast in her house without being killed by a stray bullet fired by some idiot out to prove his manhood, that's a problem. – Physician*

*More people are killed in Omaha than in Chicago, many of which are youth or young adults. – Physician*

*The increasing number of children who are victims of and/or witness to gun-related and other forms of violence. – Community/Business Leader*

*Still one of the major killers of our young people. Two very different problems. Too much violence toward young black men, in particular. – Physician*

### Gang Violence

*There is a prevalence of gang violence in Omaha. – Community/Business Leader*

*Gang activity. – Community/Business Leader*

*Our community has an extremely high problem with gang violence. It's a frustrating cycle to watch that doesn't seem to be improving at all. In fact, it seems to be worsening each day. – Community/Business Leader*

*Gang related violence, black and Hispanic related area violence, drug and sex trafficking. – Physician*

*Gun violence related to drugs, crime and gang activity. Injury due to failure to properly use bike helmets, seat belts, car seats. – Physician*

*High rates of drugs and gangs in our community lead to violence in North and South Omaha, but more and more we are seeing pockets of gang violence in areas outside of these areas. – Physician*

*Poverty and gangs. – Physician*

### Prevalent in Certain Neighborhoods

*In North and South Omaha children are exposed to very high levels of violence both on the street and in school. – Physician*

*Violence is prevalent in certain neighborhoods in Omaha and children are observers of the violence. – Public Health Representative*

*I think there are areas of the city where gang violence and the pressure to conform is growing. In many cases the violent behaviors could be linked to unaddressed or undiagnosed cognitive and behavioral health issues. – Other Healthcare Provider*

*The violence, particularly in north Omaha, is a major problem. – Physician*

### High Prevalence

*Significant prevalence. – Physician*

*Injury is continually a leading health issue for children and adolescents in Omaha. Violence, in particular, is a real threat to students in schools and in key neighborhoods that are seeing a spike in gang violence. In addition, we see that online bullying, texting while driving and other electronic related behaviors are increasing risk of injury and violence. – Public Health Representative*

*The violence is growing at a rapid rate in our community and it is starting at younger and younger ages. – Public Health Representative*

*It is everywhere. – Physician*

*So many poor and bad situations. – Physician*

### **Not Looking out for the Vulnerable**

*We have families have been forced to live in unsafe housing situations, with the alternatives being as bad as where they are. We blame the low income people for not having gotten education, not having a job etc. High quality child care across the city is expensive and if you are marginalized, you risk being judged on your parenting. We provide services to poor children up to age 19 and then drop them, making access to healthcare impossible even if they are in school. We put a lot of money into a school system (OPS) that is not equipped to deal with the level of need students actually have. We have no social way to deal with children living with gang members. We have created a real mess by not looking out for the community's most vulnerable people. Key themes are poor social health, poor financial health, and poor mental health. – Public Health Representative*

### **In the Media**

*Domestic violence and gang violence are all over the news. – Community/Business Leader*  
*See it every day on the news and with patients I treat. – Community/Business Leader*

### **Lack of Resources**

*Often, even if CPS is called, there are not enough resources in the community to help with the problem. Injury is the number one reason for mortality in infants and children, and little in the community has been done to address this. – Physician*  
*There is not enough resources to prevent violence of children. Furthermore, the Child Protective System often does not adequately address children's needs. – Community/Business Leader*

### **Vehicle Crashes**

*Injury, leading cause of death for many ages is motor vehicle crashes, which are often preventable. Seat belts, correct child seat use, graduated driver's license policy, etc. Violence. Disparities continue to exist in exposure to violence. These have long term impacts on individual's educational attainment, career success, mental health, overall health, etc. Early intervention and treatment is critical and resources are limited. – Public Health Representative*

### **Violence in Schools**

*We continue to have gun violence and bullying in schools, and in the community in Omaha. – Physician*

### **Violence Used to Address Issues**

*Less education, decreased tolerance, and increased use of violence to address issues. – Physician*

### **Lack of Regulation/Support**

*Lack of self-regulation for parents, lack of natural supports (tied into regulation), substance use, lack of a higher sense of self. – Community/Business Leader*

### **Not Recognized**

*Little attention is being given locally to this issue. – Physician*

## Sexual Activity

### Chlamydia & Gonorrhea

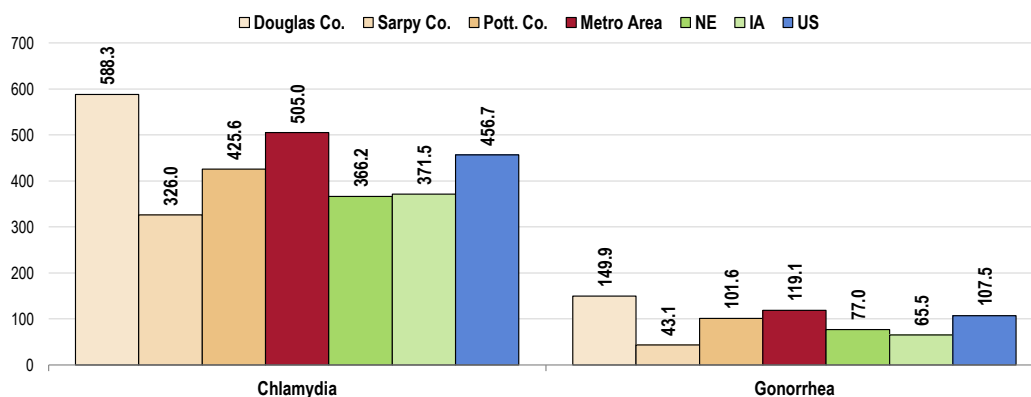
In 2012, there were 505.0 diagnosed chlamydia infections per 100,000 population in Douglas County.

- Notably higher than the Nebraska and Iowa rates.
- Higher than the national incidence rate.
- Unfavorably high in Douglas County and lowest in Sarpy County.

The gonorrhea incidence rate in the Metro Area was 119.1 cases per 100,000 population in 2012.

- Notably higher than the Nebraska and Iowa rates.
- Higher than the national incidence rate.
- Unfavorably high in Douglas County and lowest in Sarpy County.

### Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2012)

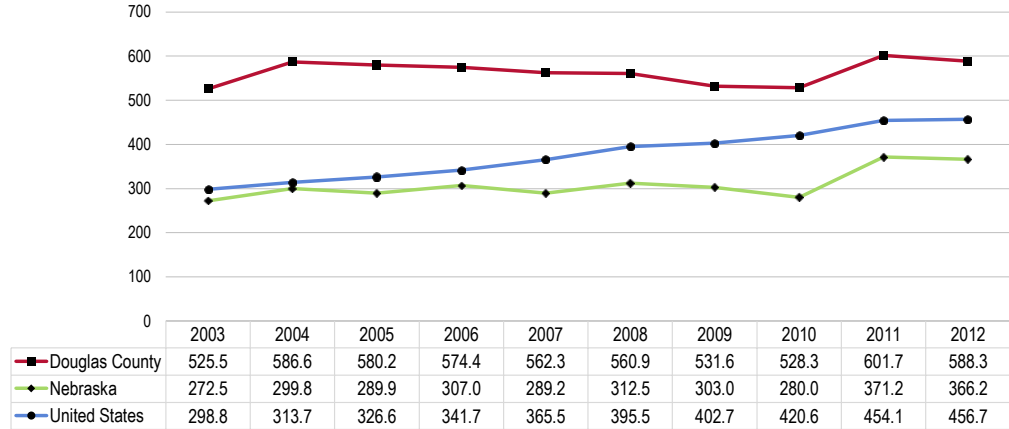


Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2012.  
 • Retrieved October 2015 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.



- **TREND:** Douglas County rates have been consistently above state and national rates over the past decade, as shown in the following two charts.

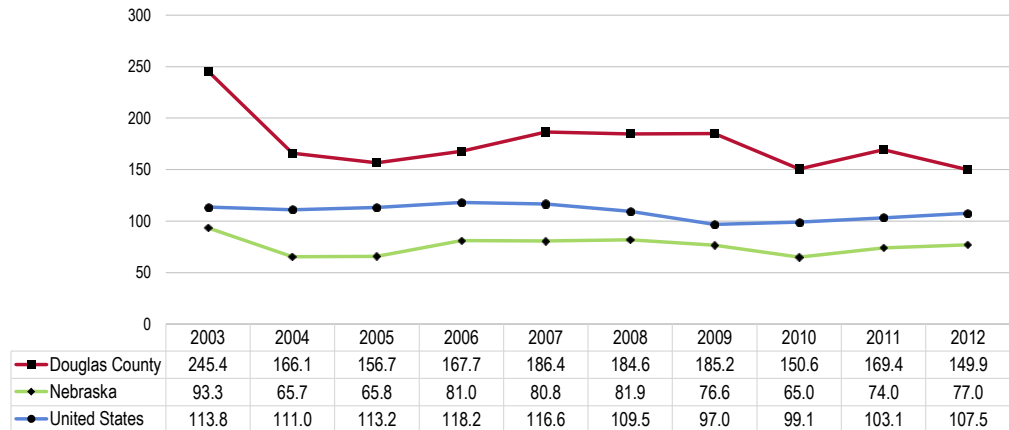
### Chlamydia Incidence (Annual Average Cases per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2015.

Notes: • Rates are annual average new cases per 100,000 population.

### Gonorrhea Incidence (Annual Average Cases per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2015.

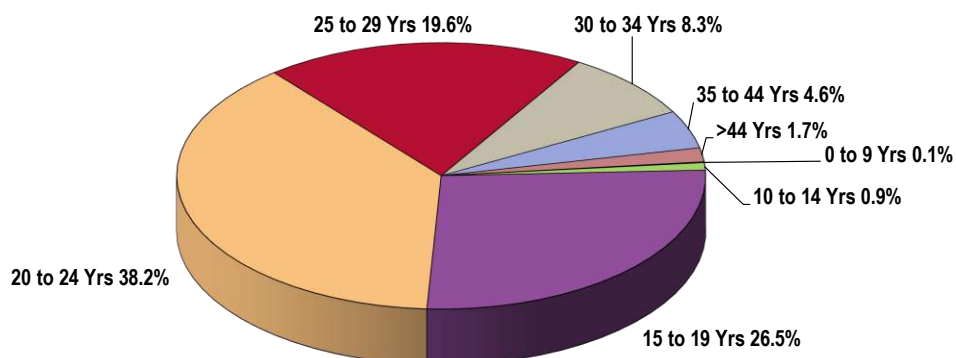
Notes: • Rates are annual average new cases per 100,000 population.

Of the 3,390 total chlamydia cases reported in Douglas County in 2014, over one-fourth (27.4%) were among adolescents and preteens age 10-19.

- Additionally, 57.8% of cases appear in young adults in their 20s.

### Chlamydia by Age Group

(Douglas County, 2014)



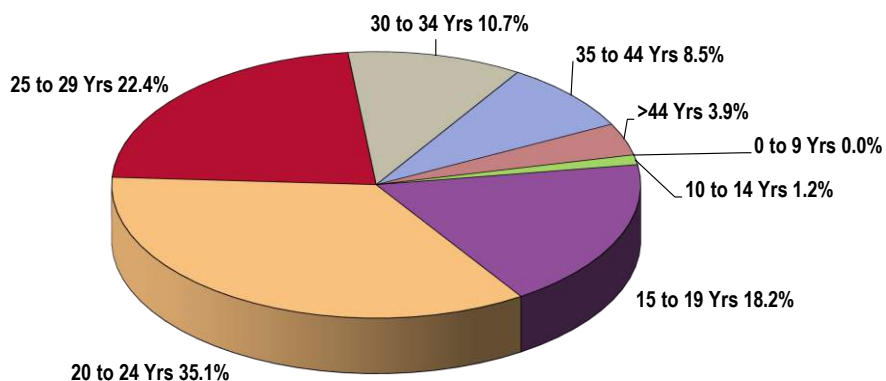
Sources: • Douglas County Health Department 2014 STD Report.  
Notes: • Percentages are based on 3,390 total cases.

Of the 961 total gonorrhea cases reported in Douglas County in 2014, 1 in 5 (19.4%) were among adolescents and preteens age 10-19.

- Additionally, 57.5% of cases appear in young adults in their 20s.

### Gonorrhea by Age Group

(Douglas County, 2014)



Sources: • Douglas County Health Department 2014 STD Report.  
Notes: • Percentages are based on 961 total cases.

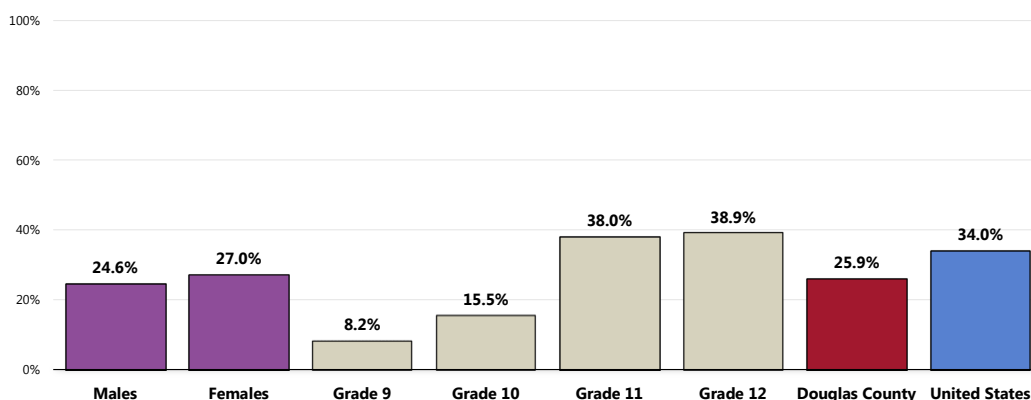
## Sexual Activity Among Adolescents

Among high school students (Douglas County only), 25.9% report having had sexual intercourse with at least one person during the three months preceding the administration of the 2014 Youth Risk Behavior Survey.

- Below national findings.
- No statistical difference by gender.
- Significantly higher in Douglas County 11th and 12th graders.

### Had Sexual Intercourse in Past Three Months

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2014)



This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students.

For more information, visit: [www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs).

- Sources:
- Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.
  - Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.
- Notes:
- Have had sexual intercourse with at least one person during the three months before the survey.

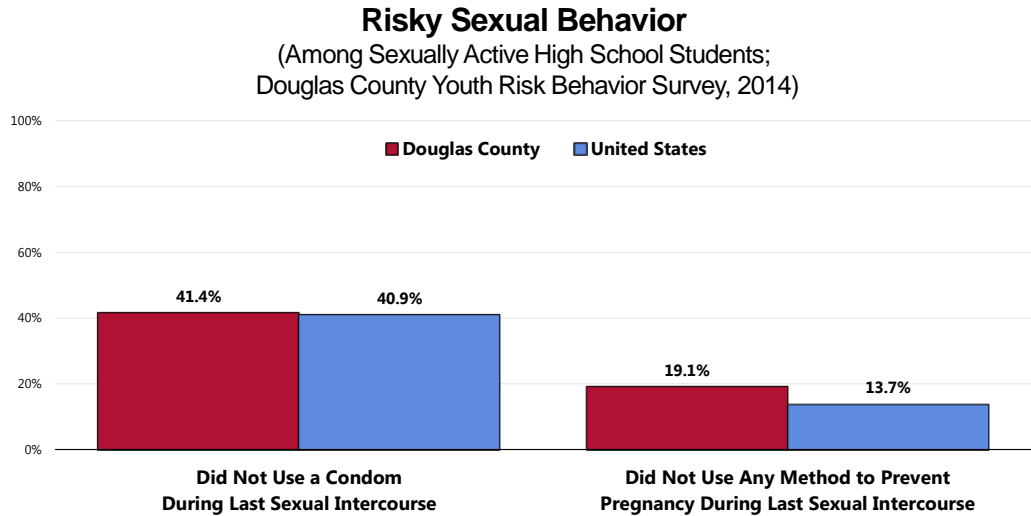
## Risky Sexual Behaviors

Among Douglas County high school students who are sexually active, 41.4% report not using a condom during their last sexual intercourse, and 19.1% report not using any method to prevent pregnancy.

- Note that the Douglas County prevalence of both risky behaviors is statistically similar to national findings.

This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students.

For more information, visit: [www.cdc.gov/healthyyouth/yrbs](http://www.cdc.gov/healthyyouth/yrbs).



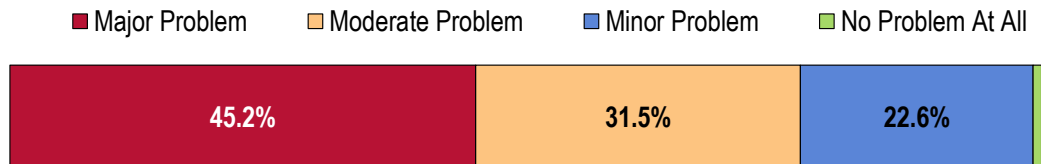
Sources: • Douglas County Health Department. 2014 Douglas County Youth Risk Behavior Survey Report.  
• Centers for Disease Control and Prevention (CDC). 2013 National High School Youth Risk Behavior Survey Data. Available at <http://apps.nccd.cdc.gov/youthonline>. Accessed October 2015.

Notes: • Among high school students who have had sexual intercourse with at least one person during the three months before the survey.  
• "Any method" includes condoms, birth control pills or Depo-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), implanon (or any implant), or any IUD before last sexual intercourse.

## Key Informant Input: Sexual Health

The largest share of key informants taking part in an online survey characterized Sexual Health as a "major problem" for youth in the community.

### Perceptions of Sexual Health as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### *Increasing Rate of STD's*

*STD campaigns and academic health center focus on STD research meetings that I have been involved in. – Other Healthcare Provider*

*High incidence of STD's, especially chlamydia. – Social Services Provider*

*High rate of STDs in NE. – Physician*

*High rates of STD's in Douglas county. – Public Health Representative*

*STD rates, therefore the prevalence of unprotected sex, continues to put Douglas County in the "epidemic" category. In 2014 STD rates went up again. – Community/Business Leader*

*Omaha continues to see high rates of STIs, including astonishing disparities. Teen pregnancy rates also show disparities. These issues impact a the life course trajectory of an individual, which is unacceptable given the ease of prevention. – Public Health Representative*

*The STI rates demonstrate the need. The lack of consistent sexual health education in Nebraska schools is huge. Kids that do go to school are poorly informed. Many Omaha, Nebraska parents and grandparents raising children are not accurately informed. Most of the learning has come from television. Nebraska should be ashamed at the poor job we have done. We have allowed misguided churches to take the lead on a very important health topic. We did not put the church in charge of heart surgeries because they are not qualified. Yet, many less people experience ailing hearts than have unfortunate sexual health experiences, such as unwanted pregnancy, STI's and even young people experiencing unwanted sex because they did not recognize it for what it was. These unwanted experiences can change a life forever. – Public Health Representative*

*We hold record numbers of kids with STD's. – Public Health Representative*

*High STD rate. – Other Healthcare Provider*

*High incidence of STD's in the metro. – Physician*

*Douglas County is STD Capitol. – Physician*

*Omaha is a conservative community and families/parents are not talking with their children and sex and STDs. Kids don't know where to go and are uncomfortable going. Condoms are sold in a way that kids are embarrassed to purchase. Teens don't have anyone to talk to. – Community/Business Leader*

*STD's, chlamydia and gonorrhea are above the national average. – Public Health Representative*

*Douglas County is one of the highest areas in the nation for sexually transmitted diseases. – Other Healthcare Provider*

*Highest rate of STDs in the country, in Omaha, NE. – Physician*

*The OPS district and many other Nebraska school districts still practice teaching abstinence as the best form of preventing pregnancies and STDs, rather than teaching teens about safe sex and pregnancy prevention via contraception. – Community/Business Leader*

*STD rates in this community are some of the highest in the nation. There is a need for more testing, treatment and messages about STD. – Public Health Representative*

*Douglas County is first or second in the country in the number of young people with STDs. Pregnant and parenting teens may be kicked out of their homes and forced to find safe housing. This affects their ability to raise their child, their safety and their future. – Social Services Provider*

*The STD rate and the results of the YRBS clearly indicates this is a top priority of the community that should be addressed and prevented at an early age. Education and testing have been very cost effective measures. However, the high rates are maintained. We simply must look at a way of preventing the spread through education and then monitoring and treating through increased availability and ease of testing. – Other Healthcare Provider*

*STD rates are high in this community. – Other Healthcare Provider*

*Douglas county has one of the highest teen STI rate in the country. There needs to be a central adolescent medicine clinic in Omaha that teens have easy access to. We also need more adolescent medicine specialist. – Physician*

*Douglas county reported to have high incidents of sexually transmitted disease amongst its adolescent population. – Other Healthcare Provider*

*Omaha continues to have the highest rates of certain STDs and high rates of teen pregnancy, which result in greater disparities in income, achievement, etc. – Public Health Representative*

*The rates of STDs and STIs in Omaha are very high for older teens. – Public Health Representative*

*Douglas County STD rates for gonorrhea and chlamydia have consistently been higher than state and national rates since 1998. The age group with the second highest rates for chlamydia are 15 to 19 year olds. This is a major problem in and of itself. Another major problem is the failure of Nebraska to institutionalize medically accurate, age-appropriate comprehensive sex education in our public schools. – Community/Business Leader*

*The increasing rate of STDs in our community is alarming. – Social Services Provider*

*Omaha has a high rate of STDs. – Social Services Provider*

*High rates of problems. – Physician*

*We are still trying to get a hold of the chlamydia problem in Omaha and last year's syphilis numbers in the community were the worst in decades, including a case of congenital syphilis in one of our patients. While teen pregnancy rates are improving, teens are not using condoms and contraception to their fullest capacity and have many misconceptions about them. – Physician*

*Chlamydia is at epidemic rates in Omaha and Douglas County but parents continue to say that it's not a problem. Someone is having sex and transmitting chlamydia. – Physician*

*Have not improved the rates of chlamydia much in the past few years. – Physician*

*Omaha has largest number of chlamydia cases in US in 12 to 24 year olds. OPS sex curriculum has not been updated for 27 years. UNO study of adult knowledge of sexual health found only 65 percent surveyed had correct knowledge. High school teens don't have money or assistance to access care. – Physician*

*The rate of chlamydia in Douglas county is one of the highest in the nation. – Physician*

*We hold the national title for the highest rates of chlamydia and gonorrhea in the country. Many teens are not comfortable talking to parents, and are not aware of confidential resources that are available. – Physician*

*The community has some of the highest chlamydia and gonorrhea rates in the nation. There is also a marked disparity in the birth rates between whites and racial/ethnic minorities, which is reflected in the poverty rates among racial/ethnic minorities and further contributes to broader health disparities. – Community/Business Leader*

### **Lack of Sex Education**

*Parents in Families in Action have expressed a desire for additional resources and education for their children/adolescents in this area. Public health data regarding Latino community. – Community/Business Leader*

*Not enough time or opportunity to educate about sexual behavior and the safety aspects. – Other Healthcare Provider*

*Education is lacking. – Physician*

*Limited opportunities for sexual health education in schools and school based health centers. – Physician*

*Sexual health education is lacking in our school systems. New initiatives and if or when OPS updates their curriculum will be very helpful in this. – Community/Business Leader*

### **Teen Pregnancy**

*Teen pregnancy is a problem that affects the teen, the baby, their families, and ends up costing society. – Community/Business Leader*

*Teen pregnancy, high rates of STI's, flippancy attitude about sex when discussing with teens I care for. – Physician*

***Access to Care/Services***

| *Not enough easy access for adolescents to receive care. – Other Healthcare Provider*

***Parental Fears and Overwhelming Personal Circumstances***

| *Parental fears, overwhelming personal circumstances. – Physician*

***Undeveloped Prefrontal Cortex's***

| *Undeveloped prefrontal cortexes. – Physician*

## **Access to Health Services**



**Professional Research Consultants, Inc.**



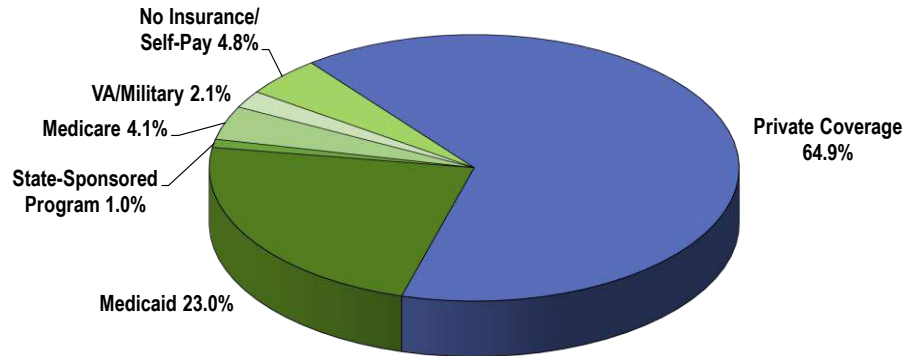
## Health Insurance Coverage

### Type of Health Insurance Coverage

A total of 64.9% of parents report having healthcare coverage for their child through private insurance. Another 30.2% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, state-sponsored CHIP, military benefits).

Survey respondents were asked a series of questions to determine their child's healthcare insurance coverage, if any, from either private or government-sponsored sources.

### Healthcare Insurance Coverage for Child (Metro Area, 2015)



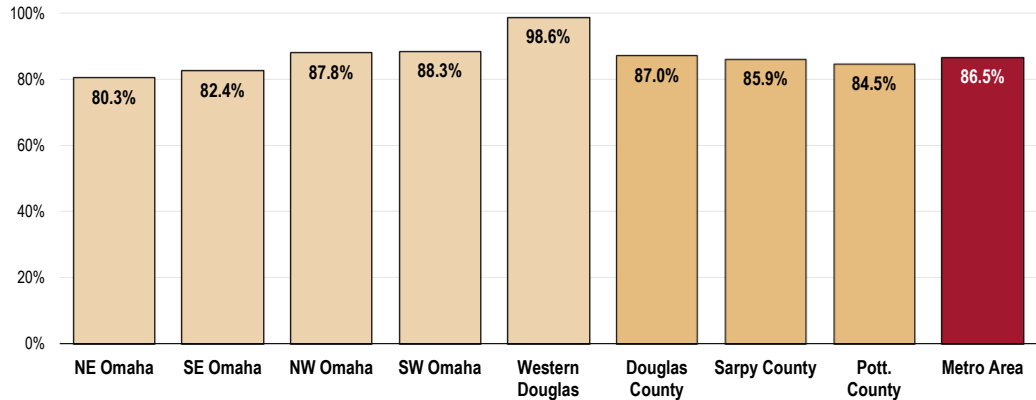
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 160]  
Notes: • Asked of all respondents.

### Insurance Deductible

A total of 86.5% of Metro Area adults with private insurance pay a deductible on their child's coverage.

- In Douglas County, deductibles are most prevalent in Western Douglas.
- The prevalence of deductibles is statistically similar by county.

### Pays a Deductible on Child's Insurance (Children with Private Insurance, 2015)

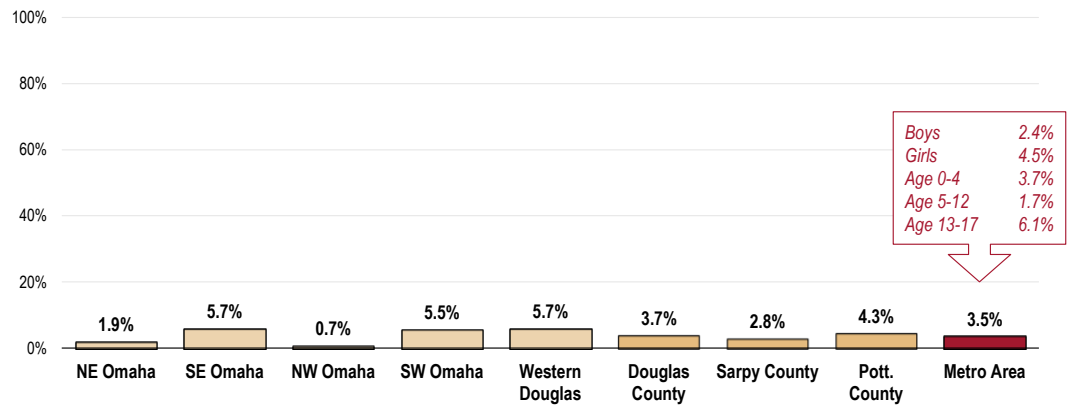


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 308]  
Notes: • Asked of all respondents for whom the randomly selected child in the household has private healthcare insurance coverage.

Among these children with deductibles on their insurance coverage, 3.5% have gone without healthcare at some point in the past year due to the size of the deductible.

- In Douglas County, this occurred relatively less often in Northwest Omaha.
- By county, deductibles prevented healthcare for children at similar rates.
- There is no difference in reception of healthcare based on deductible size between genders.
- Metro Area teenagers are more likely to go without medical care because of a large deductible than children age 5 to 12.

### Size of Deductible Prevented Child's Health Care in Past Year (Children with Deductible on Private Insurance, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 309]

Notes: • Asked of all respondents for whom the randomly selected child in the household has a deductible on their private insurance.

## Lack of Health Insurance Coverage

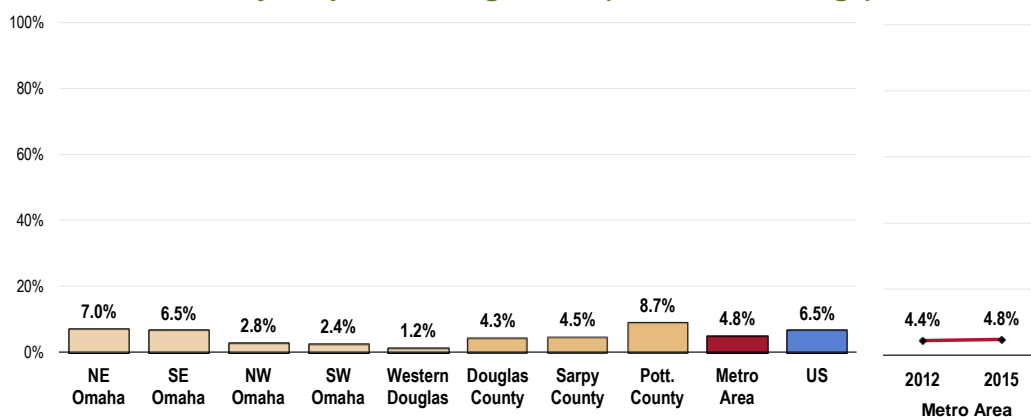
A total of 4.8% of Metro Area parents report having no insurance coverage for their child's healthcare expenses, through either private or public sources.

- Similar to national findings.
- The Healthy People 2020 target is universal coverage (100% insured).
- In Douglas County, the prevalence of uninsured children is lowest in Western Douglas.
- No statistical difference by county.
- TREND: Children's uninsured prevalence is statistically similar to 2012 findings.

### Lack Healthcare Insurance Coverage for Child

(Metro Area, 2015)

Healthy People 2020 Target = 0% (Universal Coverage)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 160]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]  
Notes: • Asked of all respondents.

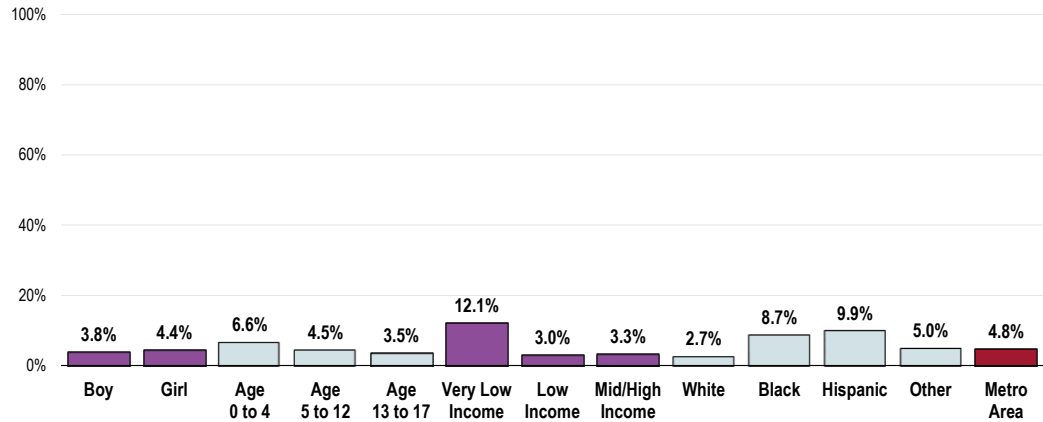
The following child segments are more likely to lack healthcare coverage:

- Children living at very low incomes.
- Hispanic children.

## Lack Healthcare Insurance Coverage for Child

(Metro Area, 2015)

Healthy People 2020 Target = 0% (Universal Coverage)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 160]

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

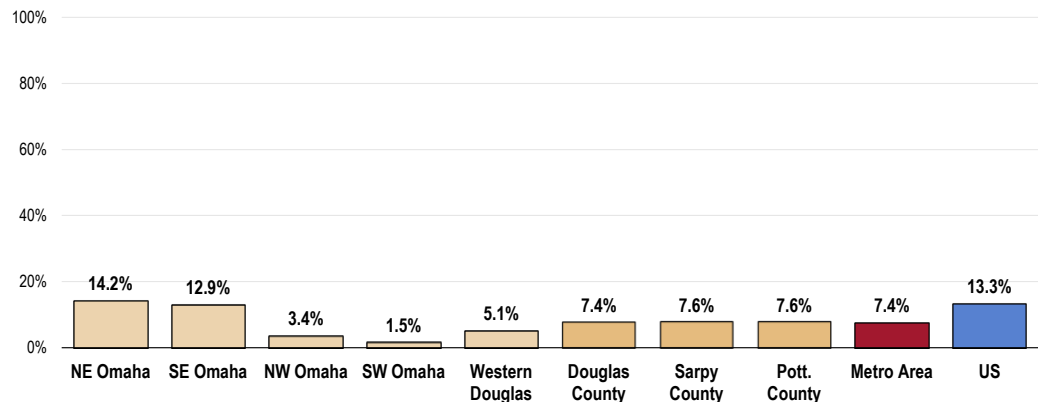
### Recent Lack of Coverage

Among parents with insurance for their child, 7.4% report that their child was without healthcare coverage at some point in the past year.

- More favorable than found in the US.
- In Douglas County, most favorable in Northwest and Southwest Omaha; least favorable in Northeast and Southeast Omaha.
- The individual counties have nearly identical findings.

## Insured Child Went Without Coverage at Some Point in the Past Year

(Metro Area Children with Insurance, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 118]

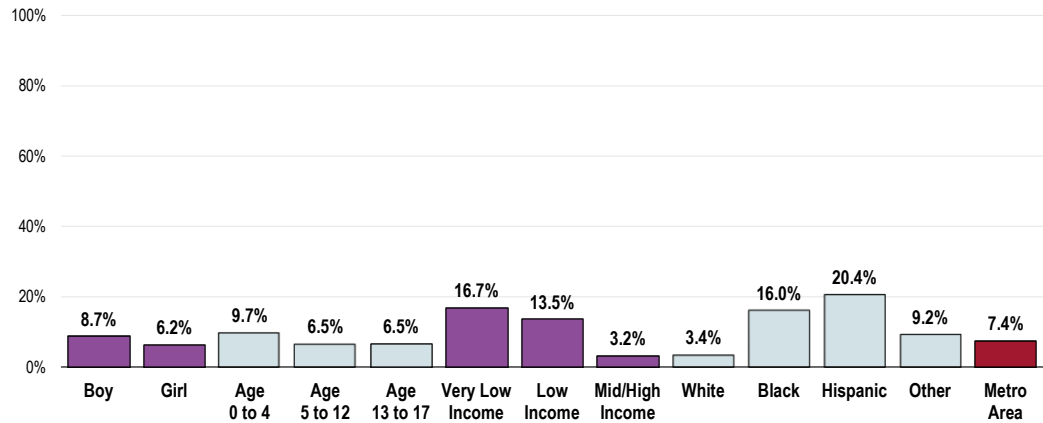
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents for whom the randomly selected child in the household has healthcare insurance coverage.

Among insured children, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Those in lower-income households (negative correlation with income).
- Hispanic.

### Insured Child Went Without Coverage at Some Point in the Past Year (Metro Area Children with Insurance, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 118]  
Notes: • Asked of all respondents for whom the randomly selected child in the household has healthcare insurance coverage.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Difficulties Accessing Healthcare

### About Access to Healthcare

Access to comprehensive, quality healthcare services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the healthcare system; 2) Accessing a healthcare location where needed services are provided; and 3) Finding a healthcare provider with whom the patient can communicate and trust.

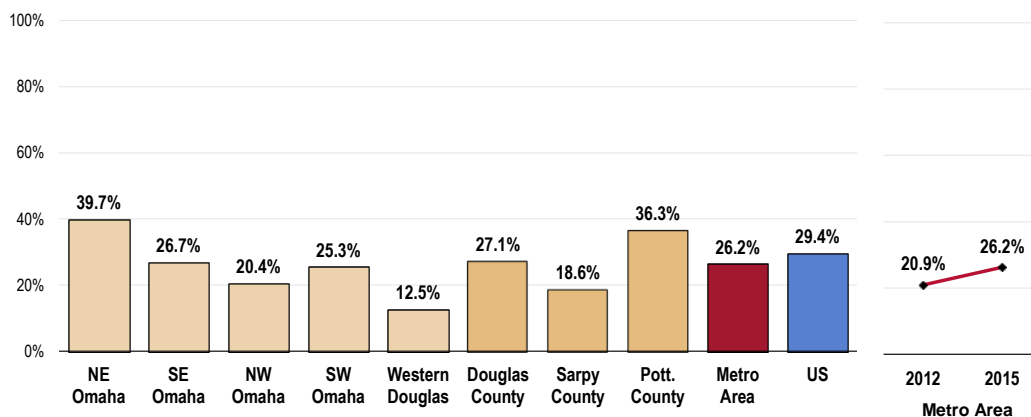
— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Over one-fourth (26.2%) of Metro Area parents report some type of difficulty or delay in obtaining healthcare services for their child in the past year.**

This indicator reflects the percentage of parents experiencing problems accessing healthcare for their child in the past year, regardless of whether they needed or sought care.

- Statistically similar to nationwide reports.
- In Douglas County, particularly least favorable in Northeast Omaha; most favorable in Northwest Omaha and especially Western Douglas.
- By county, notably least favorable in Pottawattamie County; most favorable in Sarpy County.
- TREND: The proportion of parents having trouble accessing healthcare for their child has increased significantly since 2012.

### Experienced Difficulties or Delays of Some Kind in Receiving Child's Needed Healthcare in the Past Year (Metro Area, 2015)

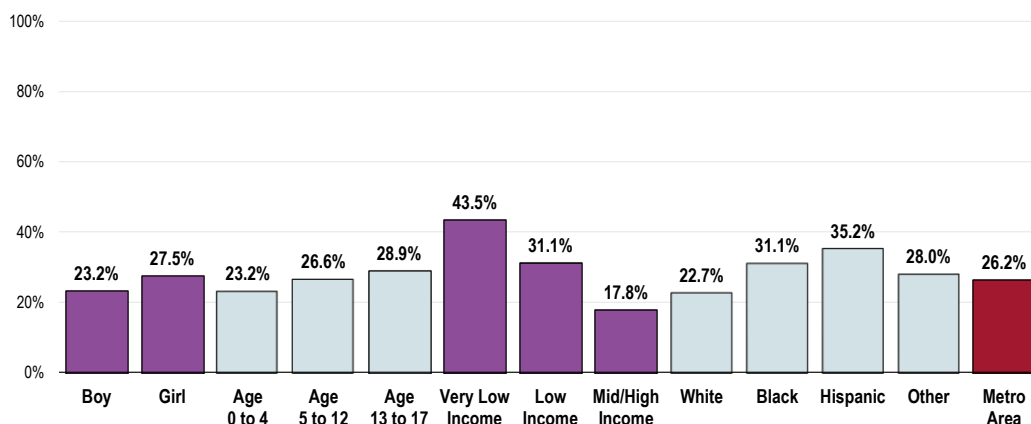


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 175]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Represents the percentage of respondents experiencing one or more barriers to accessing their child's healthcare in the past 12 months.

- Note also the strong, negative correlation of access difficulties with income.
- Hispanic children are most likely to be impacted by access barriers.

### Experienced Difficulties or Delays of Some Kind in Receiving Child's Needed Healthcare in the Past Year (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 175]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Represents the percentage of respondents experiencing one or more barriers to accessing their child's healthcare in the past 12 months.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Barriers to Healthcare Access

To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented their child from seeing a physician or obtaining a needed prescription in the past year.

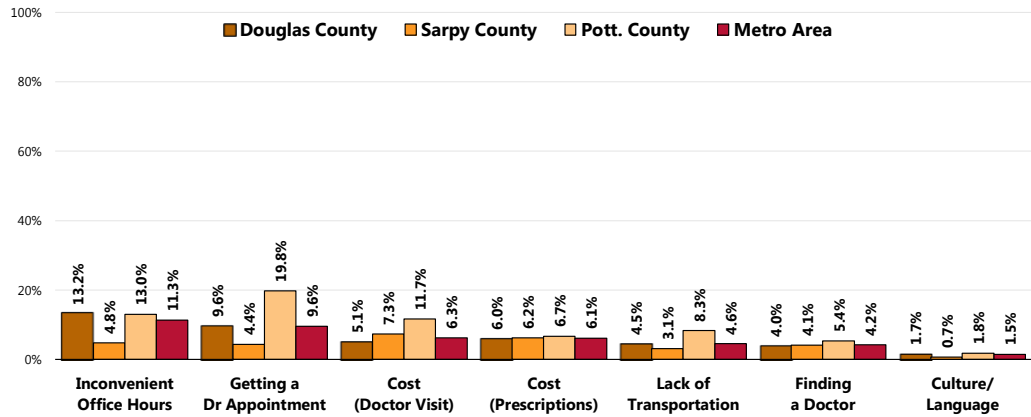
Again, these percentages reflect all children, regardless of whether medical care was needed or sought.

Of the tested access barriers, inconvenient office hours impacted the greatest share of Metro Area children (11.3% of parents say that inconvenient office hours prevented them from obtaining a visit to a physician for their child in the past year).

Lack of appointment availability impacted 9.6%.

- By county, note that parents living in Pottawattamie County reported significantly higher responses for the barriers of **difficulty getting an appointment** and **cost of doctor's visit** for their child, while Douglas County children were most often impacted by **inconvenient office hours** preventing access to care.

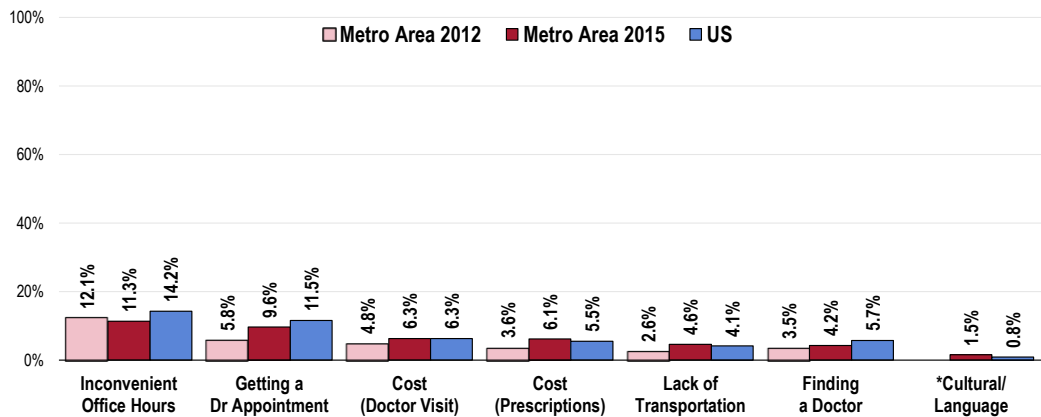
## Barriers to Access Have Prevented Child's Medical Care in the Past Year (By County, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 19-25]  
Notes: • Asked of all respondents about a randomly selected child in the household.

- The impact of these barriers in the Metro Area is statistically similar to what is seen across the nation.
- TREND: For many of the tested barriers, the proportions of Metro Area children impacted were statistically comparable to 2012 findings; however, statistically significant increases in untreated children were found for the barriers of **difficulty getting an appointment**, **lack of transportation** and **cost of prescriptions**.

## Barriers to Access Have Prevented Child's Medical Care in the Past Year (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 19-25]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• \*Culture/language difference was not included in the 2012 survey.



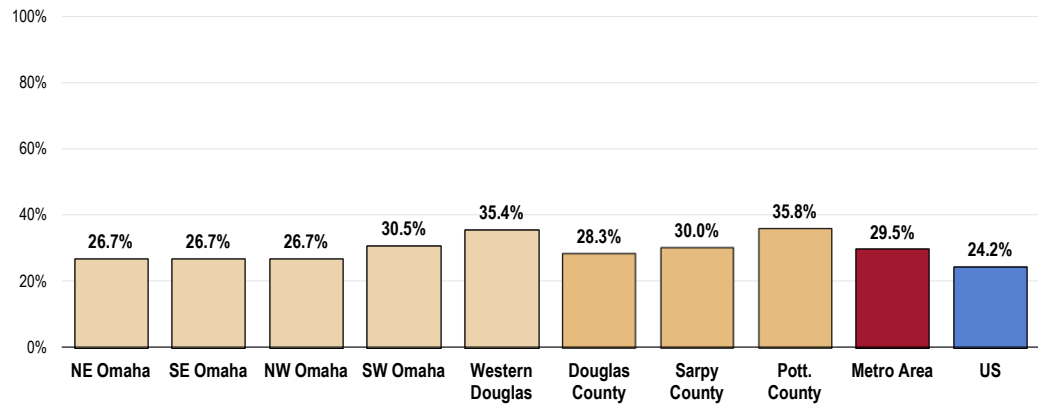
## Access to Specialty Care

A total of 29.5% of children are reported to have needed to see a specialist at some point in the past year.

- Higher than the US percentage.
- Statistically similar within Douglas County.
- No statistical difference by county.

### Child Needed a Specialist in the Past Year

(Metro Area, 2015)

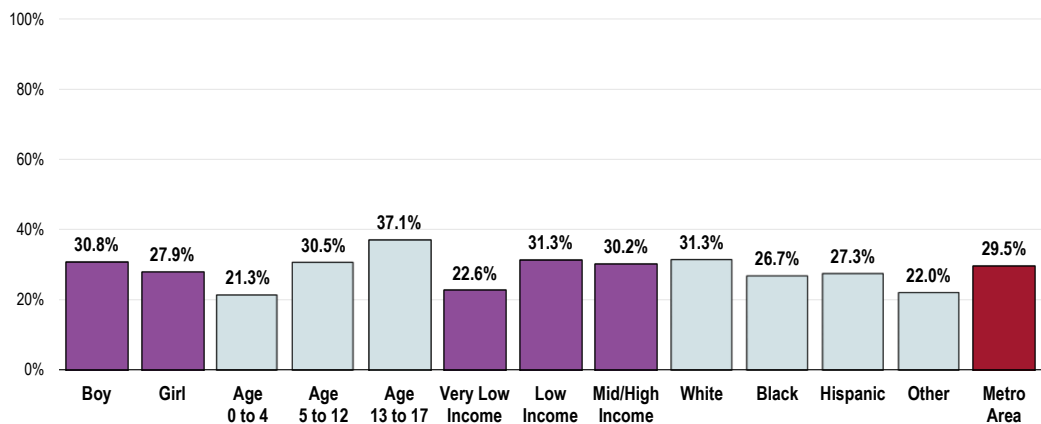


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 30]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Note the positive correlation between children's ages and the need for specialty care.

### Child Needed a Specialist in the Past Year

(Metro Area, 2015)

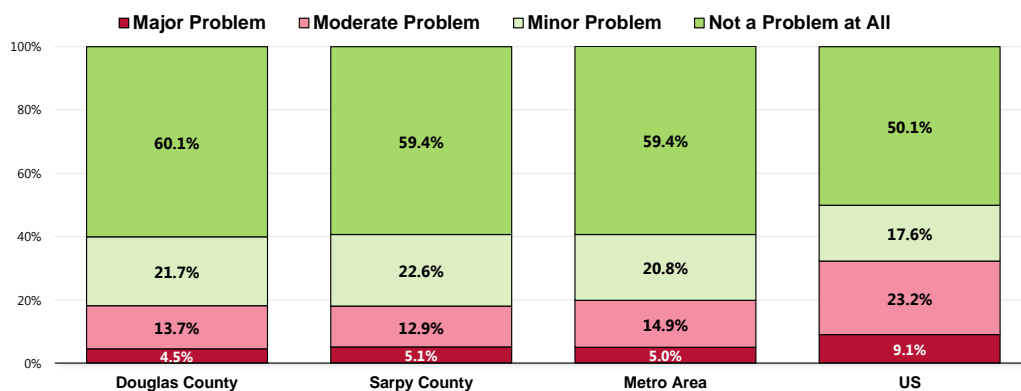


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 30]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Parents of children needing specialty medical care in the past year were further asked to evaluate the difficulty of getting the needed care; 40.6% expressed some level of difficulty, characterizing it as a “major,” “moderate,” or “minor problem.”

- In particular, 14.9% of these parents had “moderate problems” getting their child’s specialty care, and 5.0% had “major problems.”
- The prevalence of a “major” or “moderate” response is lower in the Metro Area than throughout the US.
- “Major/moderate problem” responses are similar between Douglas and Sarpy counties.

### Evaluation of Difficulty Getting Specialty Care for Child in the Past Year (Metro Area Parents of Children Needing to See a Specialist in the Past Year)



Source: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 31]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

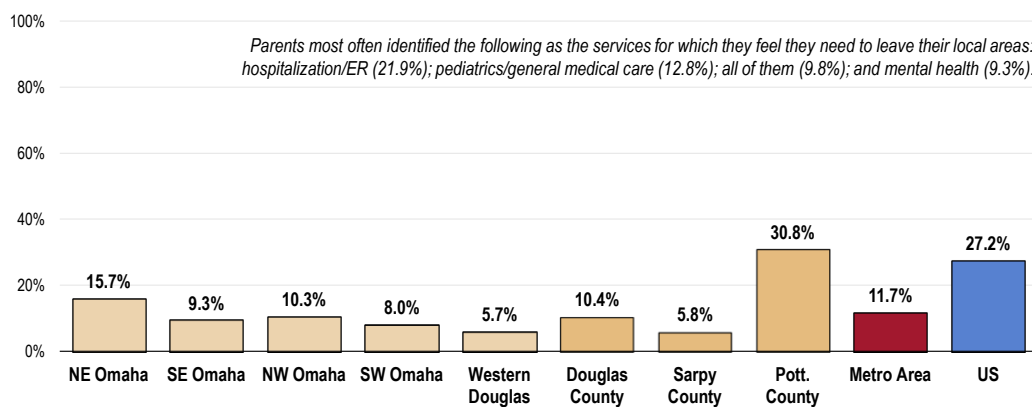
Notes: • Asked of respondents for whom the randomly selected child in the household has needed to see a specialist in the past year.  
• Pottawattamie County specialty care data is not available due to a small sample size.

## Outmigration for Children's Healthcare

A total of 11.7% of Metro Area parents report that they feel the need to leave their local areas in order to get certain children's healthcare services.

- Much more favorable than found nationwide.
- In Douglas County, outmigration rates are least favorable in Northeast Omaha.
- By county, far less favorable in Pottawattamie County; much more favorable in Sarpy County.

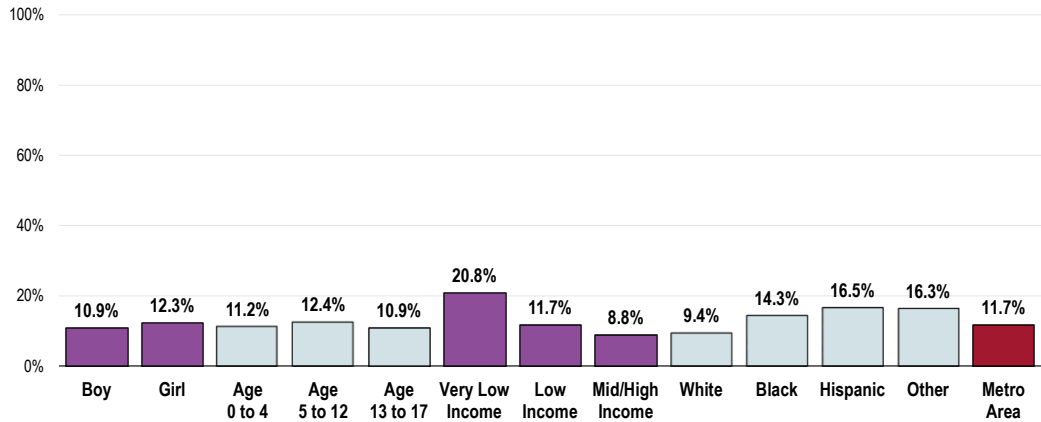
### Feel the Need to Leave the Area for Children's Healthcare Services (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 11-12]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.]  
 Notes: • Asked of all respondents.

- Parents with very low incomes are more likely to feel the need to leave their areas for children's health services.
- Outmigration is also more common among parents of Hispanic or non-White children.

### Feel the Need to Leave the Area for Children's Healthcare Services (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 11]

Notes: • Asked of all respondents about a randomly selected child in the household.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

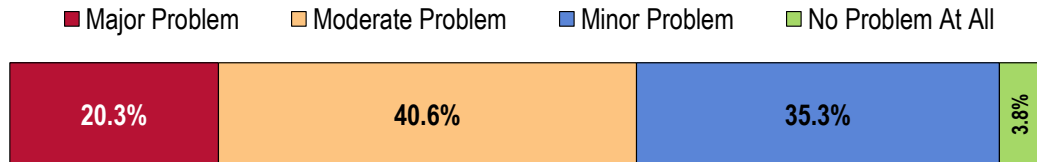
Asked to specify the services for which they feel they need to leave their areas to receive care, the greatest shares of responses were for **hospitalization/ER** (21.9%); **pediatrics/general medical care** (12.8%); **"all of them"** (9.8%); and **mental health** (9.3%).

Their reasons for feeling the need to leave their areas primarily related to belief that certain services or specialists are **not available locally** (37.1%), followed by **perceptions of quality** (35.1%), **access-related problems** (16.9%), and **past experience or preference** (4.3%).

## Key Informant Input: Access to Healthcare Services

The greatest share of key informants taking part in an online survey characterized Access to Healthcare Services as a “moderate problem” in the community.

### Perceptions of Access to Healthcare Services as a Problem for Children/Adolescents in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Location/Transportation

*Clinics on bus routes, clinics open evenings and weekends. – Community/Business Leader*

*Convenience and access to transportation are major problems. Even if a child has Medicaid, the transportation agreement only includes the parent and child with appointment, leaving the parent to find child care for other siblings. Families may miss appointments for lack of transportation, or difficulty navigating the bus system, especially with several children. Language may also be a barrier to access, with misunderstandings of care to be given, or inability to locate a provider with adequate language resources to communicate with the family. A child may not qualify for any insurance, or parental misunderstanding of the Medicaid process may cause intermittent losses of coverage. For economic reasons, families may move frequently, causing loss of previous records, and gaps in provision of care. – Physician*

*Language, transportation, health literacy ability to navigate the health system, cost, hours of operation. – Community/Business Leader*

*Transportation, language, accessibility, cultural competency. – Community/Business Leader*

*Affordability and proximity to physical healthcare locations. – Community/Business Leader*

*Availability within the community within walking distance. Availability of providers after school and on weekends. – Social Services Provider*

*Despite the efforts of OneWorld and the other health centers in Omaha, there are still too many children who are unable to access affordable high quality healthcare. Barriers still present include transportation and geography, capacity at the FQHC, and cost. – Community/Business Leader*

*There are a number of issues to access of healthcare for all children, including a number of barriers in transportation, funding or insurance, family acceptance or education, etc. Also, the location of specialists is not equal throughout the community, and some zip codes that are especially in need of services don't have those providers available at all. – Community/Business Leader*

*Limited access to urgent care services in the evenings and weekends in the eastern part of the city. Few Pediatricians in NE, Omaha. Limited insurance coverage for children who are undocumented, which can limit their ability to access medical specialists and care, such as radiology. Vision care is limited for many with self-pay or high deductible insurance and the school based health centers have a strategy to provide coverage. The lack of a complete public transportation system and the fact that provider offices are not located near bus lines makes it difficult for children, even with insurance. No vehicle to access care, especially in the east on third of the city, where car ownership is low. – Public Health Representative*

*Uninsured status. Difficulty with transportation. Transportation provided by Medicaid is horrible. Not enough Spanish language providers. – Physician*

### **Cost and Insurance**

*Cost and insurance. – Physician*

*Lack of health insurance or ability to pay for healthcare. – Social Services Provider*

*Access to care for low-income and moderate income children remains a problem in Omaha. Barriers such as transportation, ability to enroll in Medicaid, language, culture, lack of insurance makes access to care even more challenging. Additionally, one care families and taking time off of work for parents makes it very difficult. – Community/Business Leader*

*Poverty and access to care. Many qualify for Medicaid, but the process is long and not easy to navigate. – Physician*

*Lack of Medicaid accessible dental and mental health services for marginalized populations, including low wage white parents. – Public Health Representative*

*Although improvements in access to insurance have occurred, many families still struggle to have the time to access health services proactively or seek care before it becomes an emergency.*

*Furthermore, the base level coverage via the ACA often does not leave room for sick care visits without putting all the cost burden on families until their high deductible is reached. – Public Health Representative*

*Without the expansion of Medicaid, there are thousands of children without health insurance and, as a result, lack medical homes. – Community/Business Leader*

*Transportation, lack of trust in the healthcare community. Perception of becoming indebted because of a healthcare appointment. – Physician*

*Lack of resources in North Omaha. – Public Health Representative*

### **Education of Available Resources**

*Education on availability and insurance. – Community/Business Leader*

*Poverty, transportation, knowledge regarding available services. – Physician*

*In underserved parts of town and with immigrant/refugee populations, there is still a struggle to understand the healthcare system. Even with the school based health centers, I think families don't understand how to get into the system. – Public Health Representative*

*It is difficult for young adults who are parents to navigate the system. They are more likely to go to the Emergency Room than to establish a relationship with a medical doctor. They don't know the importance of a medical home. Family friendly hours will help families with working parents to access healthcare. Accessing dental care is challenging. Accessing mental health and substance abuse services is particularly difficult because we don't have a system and there is a stigma. – Social Services Provider*

### **Access to Specialists**

*Access to primary care is less of a problem, but access to specialists is a bigger problem, particularly in the areas of Psychiatry and Behavioral Health. – Physician*

*There are many kids with no insurance who cannot get into specialist. – Physician*

*Inpatient psychiatry. – Physician*

### **Undocumented Youth/Families**

*Undocumented youth and/or families. – Other Healthcare Provider*

### Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified mental health care, dental care, and specialty care as the most difficult to access in the community.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	87.5%	4.2%	0.0%	22
Dental Care	4.2%	33.3%	17.4%	13
Specialty Care	4.2%	8.3%	26.1%	9
Substance Abuse Treatment	0.0%	16.7%	17.4%	8
Primary Care	4.2%	16.7%	8.7%	7
Urgent Care	0.0%	4.2%	21.7%	6
Chronic Disease Care	0.0%	12.5%	0.0%	3
Prenatal Care	0.0%	4.2%	8.7%	3

## Primary Care Services

### About Primary Care

Improving healthcare services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving healthcare services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Specific Source of Ongoing Care

A total of 87.3% of Metro Area children were determined to have a specific source of ongoing medical care, such as a specific doctor's office or clinic they regularly use.

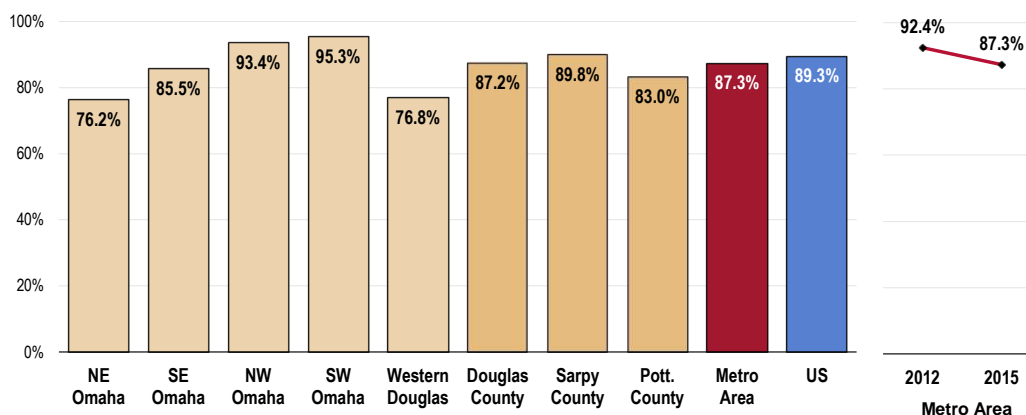
- Comparable to US findings.
- Fails to satisfy the Healthy People 2020 objective of 100.0%.
- In Douglas County, least favorable in Northeast Omaha and Western Douglas; most favorable in Northwest and Southwest Omaha.
- No significant difference among individual counties.
- TREND: Denotes a statistically significant decrease since 2012.

Having a specific source of ongoing care for a child includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, or some other kind of place to go if the child is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

### Have a Specific Source for Child's Ongoing Medical Care

Healthy People 2020 Target = 100%



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 172]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.2]

Notes: • Asked of all respondents about a randomly selected child in the household.

• Having a specific source of ongoing care for a child includes having a doctor's office, clinic, urgent care center, health department clinic, or some other kind of place to go if the child is sick or needs advice about his or her health. A hospital emergency room is not considered a source of ongoing care in this instance.

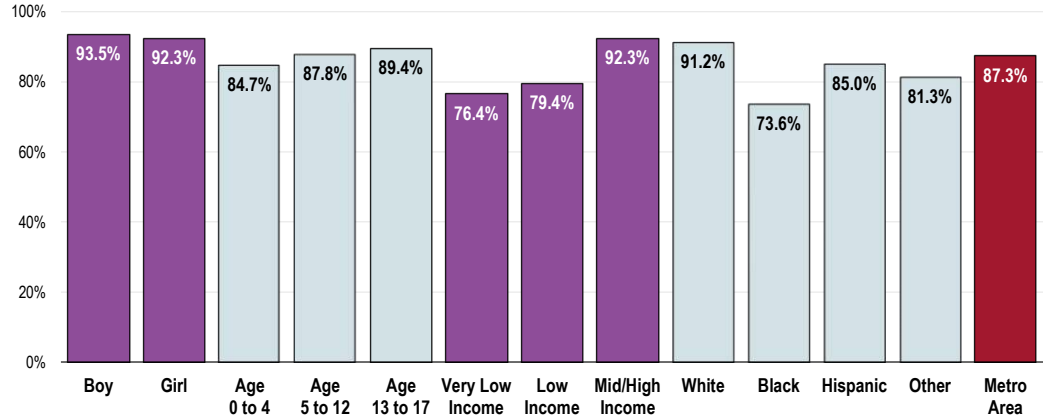


When viewed by demographic characteristics, the following children are less likely to have a specific source of care:

- Those in lower-income households.
- Black children.

### Have a Specific Source of Ongoing Medical Care (Metro Area, 2015)

Healthy People 2020 Target = 100%



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 172]

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives AHS-5.2]

Notes: • Asked of all respondents about a randomly selected child in the household.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

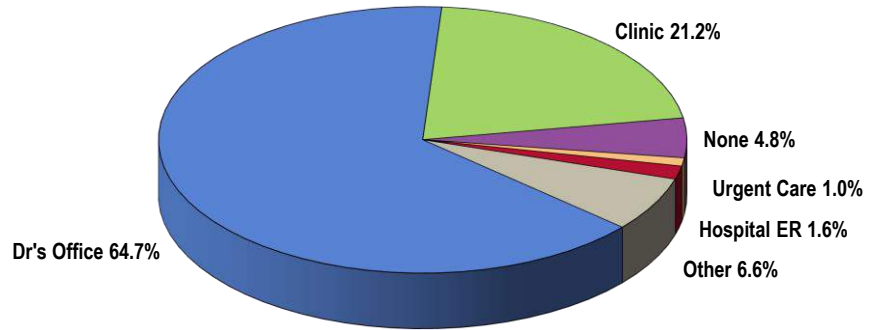
• Having a specific source of ongoing care for a child includes having a doctor's office, clinic, urgent care center, health department clinic, or some other kind of place to go if the child is sick or needs advice about his or her health. A hospital emergency room is not considered a source of ongoing care in this instance.

### Type of Place Used for Medical Care

When asked where they take their child if they are sick or need advice about their health, the greatest share of respondents (64.7%) identified a particular doctor's office.

A total of 21.2% say they usually go to some type of clinic, while 1.6% use a hospital emergency room for their child's medical care, and 1.0% relies on an urgent care clinic.

### Particular Place Utilized for Child's Medical Care (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 27-28]  
Notes: • Asked of all respondents about a randomly selected child in the household.

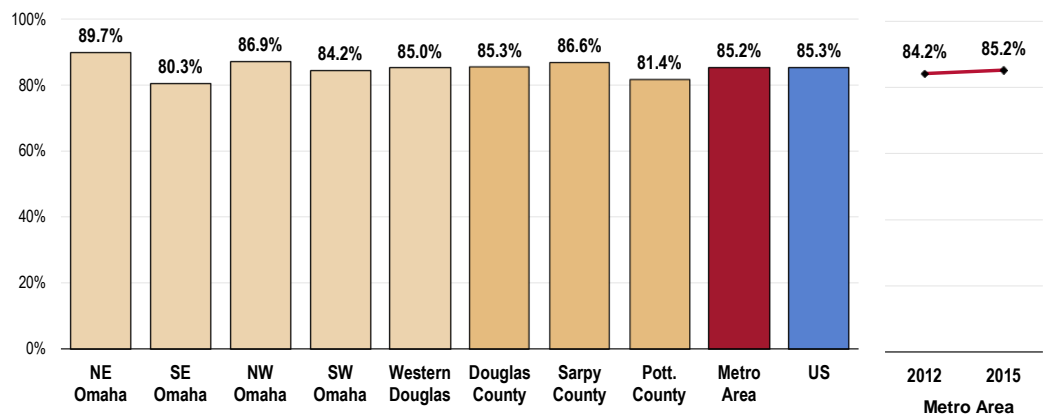
### Receipt of Routine Medical Care

A total of 85.2% of Metro Area children have had a routine checkup in the past year.

- Nearly identical to the US proportion.
- In Douglas County, lowest in Southeast Omaha; highest in Northeast Omaha.
- Statistically similar by county.
- TREND: Statistically similar to 2012 findings.

A routine checkup can include a well-child checkup or general physical exam, but does not include exams for a sports physical or visits for a specific injury, illness, or condition.

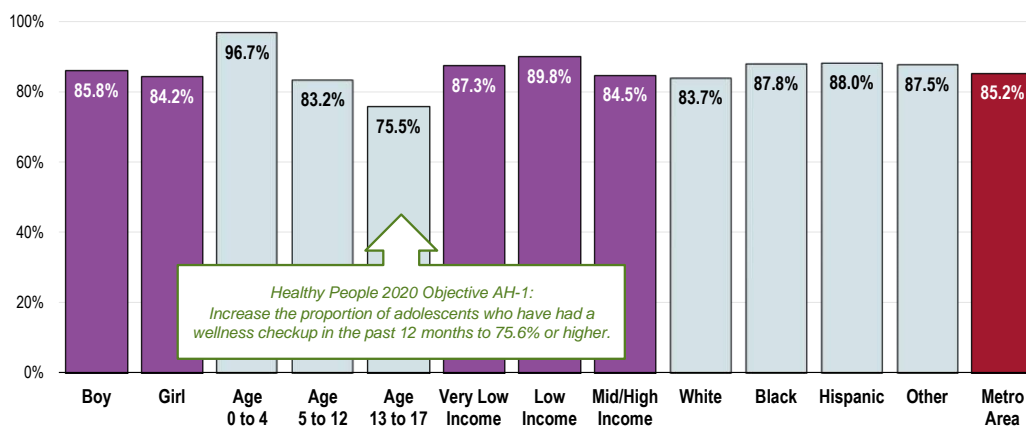
### Child Visited a Physician for a Routine Checkup in the Past Year (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 29]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- Note that routine checkups are highest among younger children; however, Metro Area teenagers are close to the Healthy People 2020 objective (75.6% or higher) for their age group.

### Child Visited a Physician for a Routine Checkup in the Past Year (Metro Area, 2015)



- Sources:
- 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 29]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AH-1]
- Notes:
- Asked of all respondents about a randomly selected child in the household.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Dental Care

### About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use**; **excessive alcohol use**; and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

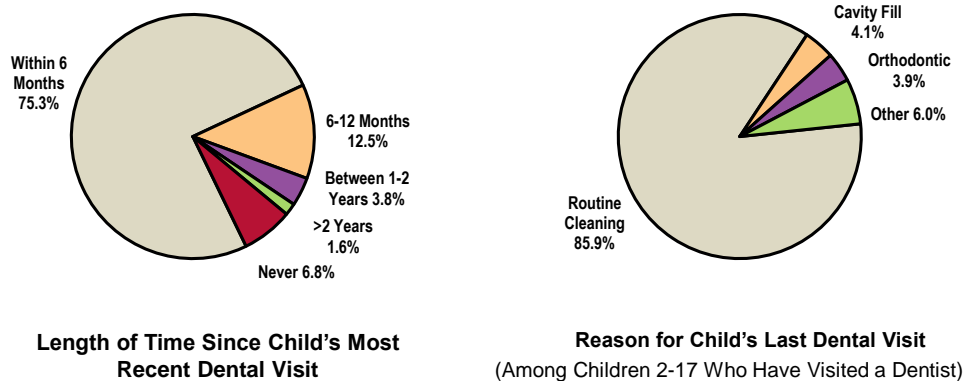
— Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Receipt of Dental Care

**Three-fourths of Metro Area children age 2-17 (75.3%) have received dental care (for any reason) in the past 6 months.**

- Asked to specify the reason for their child's most recent dental visit, 85.9% of parents mentioned a **routine cleaning** or checkup, while 4.1% had a **cavity filled**, and 3.9% specified an **orthodontic appointment**.

## Characteristics of Child's Most Recent Dental Visit (Metro Area Children Age 2-17, 2015)

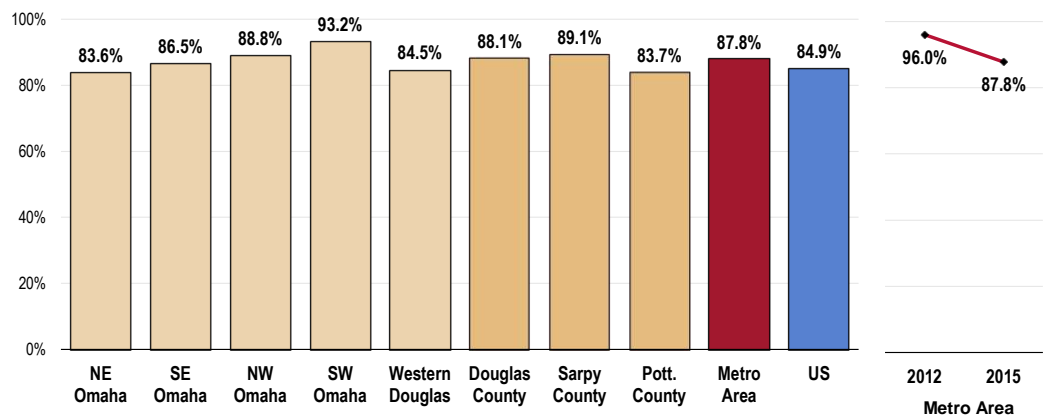


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 46-47]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 2 to 17.

In all, 87.8% of Metro Area children age 2-17 have visited a dentist or dental clinic (for any reason) in the past year.

- Statistically similar to national findings.
- Easily satisfies the Healthy People 2020 target.
- In Douglas County, recent dental care is highest in Southwest Omaha.
- Statistically similar by county.
- TREND: Marks a statistically significant decrease over time.

## Child Visited a Dentist or Dental Clinic Within the Past Year (Among Parents of Children Age 2-17) Healthy People 2020 Target = 49.0% or Higher



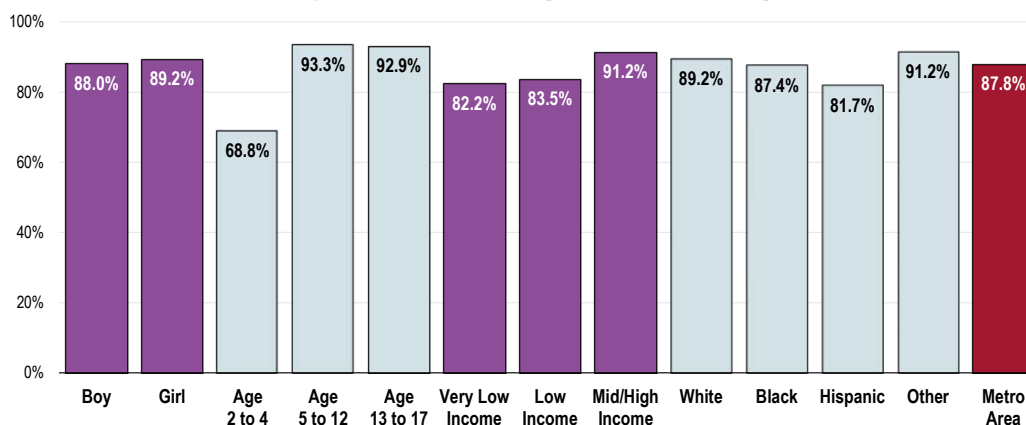
Sources: • PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 46]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]  
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 2 to 17.

These children are less likely to have visited a dentist or dental clinic in the past year:

- Children age 2 to 4.
- Children in lower-income households.
- Hispanic children.

### Child Visited a Dentist or Dental Clinic Within the Past Year (Metro Area Children Age 2-17, 2015)

**Healthy People 2020 Target = 49.0% or Higher**



Sources:

- 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 46]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-2.1]

Notes:

- Asked of those respondents for whom the randomly selected child in the household is age 2 to 17.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

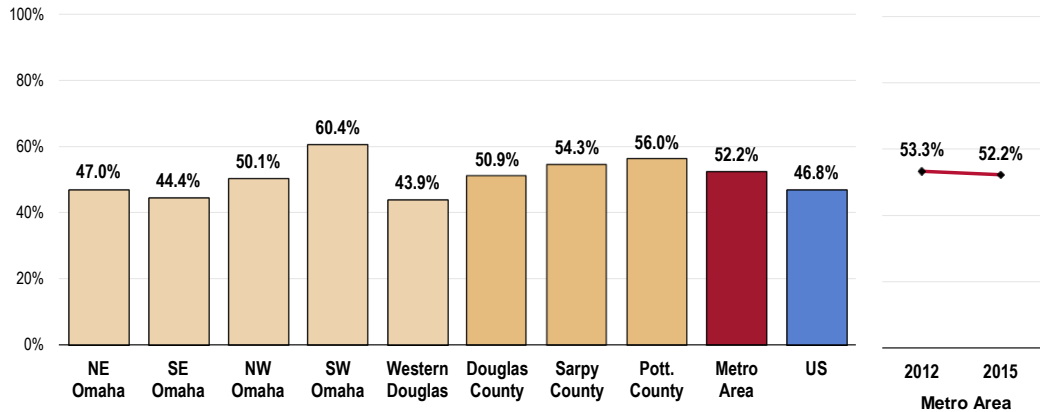
## Dental Sealants

The majority (52.2%) of parents report that their child (age 6 to 17) has had sealants put on their molars.

- More favorable than found nationwide.
- In Douglas County, most favorable in Southwest Omaha.
- The Metro Area counties show statistically similar results.
- TREND: Statistically unchanged since 2012.

### Child Has Received Dental Sealants on His or Her Molars

(Metro Area Children Age 6-17, 2015)



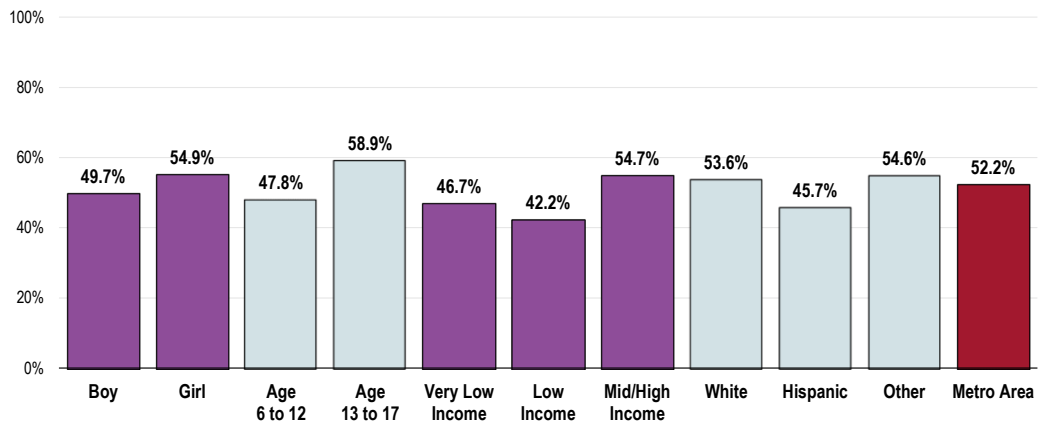
Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 48]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of those respondents for whom the randomly selected child in the household is age 6 to 17.

- The prevalence of dental sealants is lower among children age 6-12 and those living just above poverty.

### Child Has Received Dental Sealants on His or Her Molars

(Metro Area Children Age 6-17, 2015)



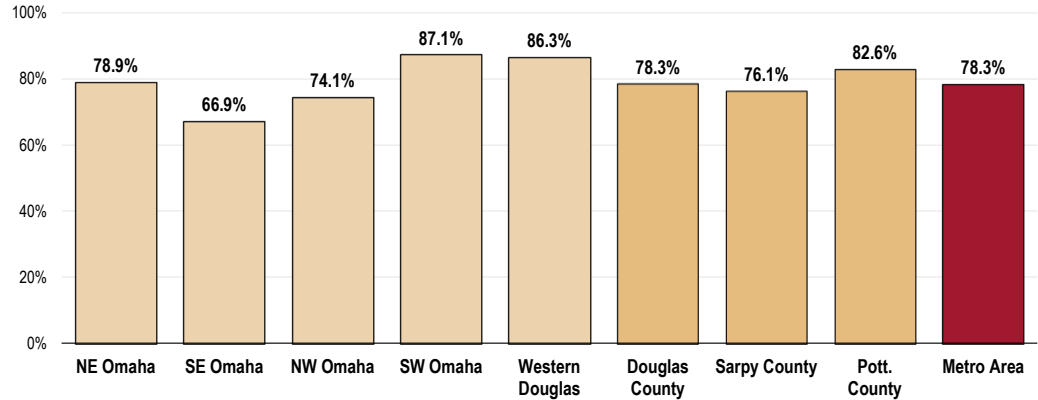
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 48]  
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 6 to 17.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • Dental sealant data for Black children is not presented due to a small sample size.

## Fluoride Treatment

More than three-fourths of Metro Area parents (78.3%) indicate that their child has received a fluoride treatment.

- In Douglas County, lowest in Southeast Omaha; highest in Southwest Omaha.
- No statistical difference by county.

**Child Has Received Fluoride Treatment**  
(Metro Area Children Age 0-17, 2015)

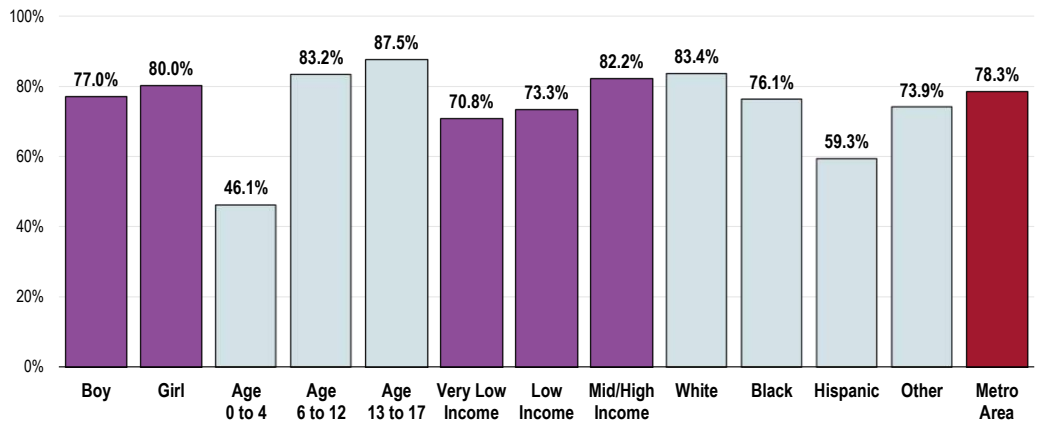


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 305]  
Notes: • Asked of all respondents.

Children less likely to have had a fluoride treatment include:

- Children under age 5.
- Those living in lower income households.
- Hispanic children.

**Child Has Received Fluoride Treatment**  
(Metro Area Children Age 0-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 305]  
Notes: • Asked of all respondents.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

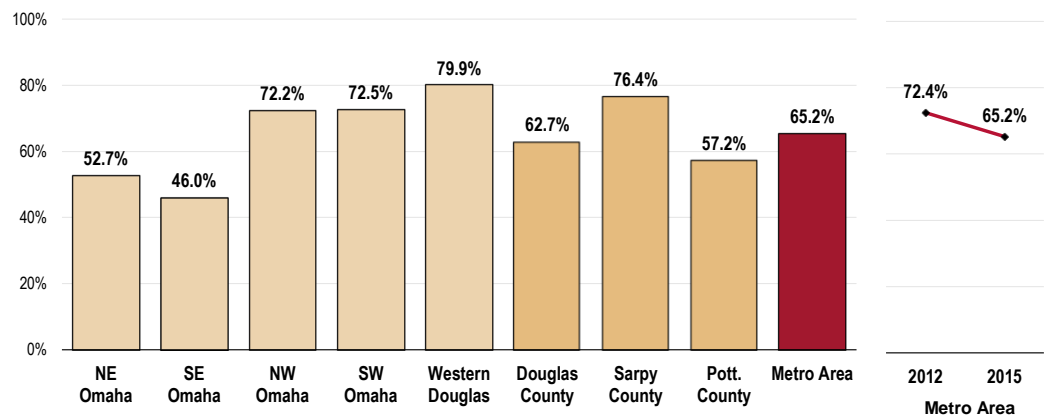


## Dental Insurance

Nearly two-thirds of Metro Area children (65.2%) have coverage through private dental insurance that covers all or part of their dental expenses.

- Within Douglas County, notably higher in areas west of 72<sup>nd</sup> street; lowest in Northeast Omaha and especially Southeast Omaha.
- Among the Metro area counties, Sarpy County has the highest proportion of children with dental insurance.
- TREND: Dental Insurance for children has dropped since 2012.

### Child Has Private Dental Insurance (Metro Area Children Age 0-17, 2015)

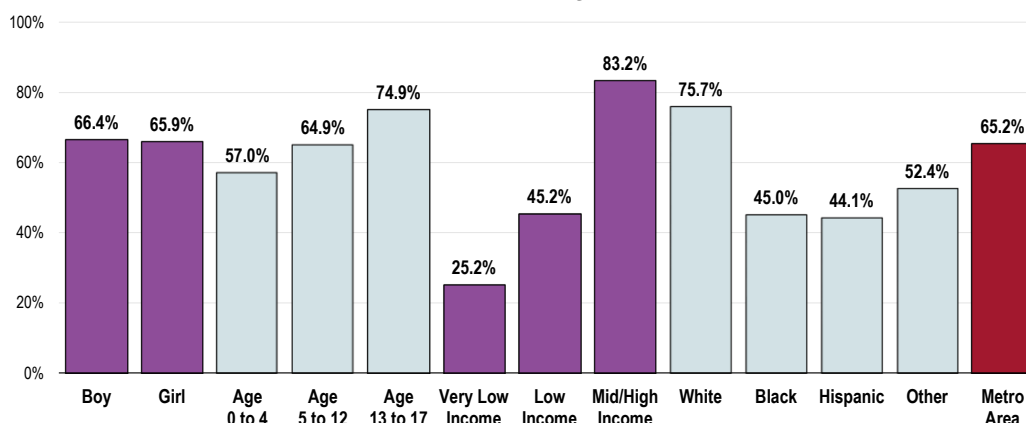


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 310]  
Notes: • Asked of all respondents.

Note the following:

- Younger children, non-white or Hispanic children are less likely to have some type of private dental insurance (positive correlation with age).
- There is a strong, positive correlation with income; merely one-fourth (25.2%) of children that live under the federal poverty level has insurance to help with dental care expenses.

### Child Has Private Dental Insurance (Metro Area Children Age 0-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 310]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

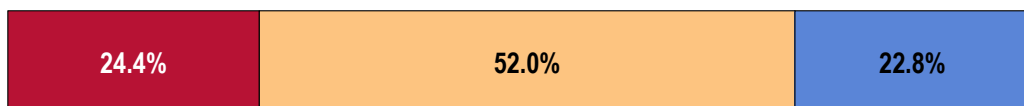
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Oral Health

Key informants taking part in an online survey largely characterized Oral Health/Dental Care as a "moderate problem" for children/adolescents in the community.

### Perceptions of Oral Health as a Problem for Children/Adolescents in the Community (Key Informants, 2015)

■ Major Problem    ■ Moderate Problem    ■ Minor Problem    ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Children with Unmet Dental Needs

*As an oral health care provider working in the community for five years with both academic health centers and the two FQHCs, I am uniquely aware of the unmet oral health needs of the children in our community. Significant needs still exist in north Omaha, and in our refugee communities. – Other Healthcare Provider*

*In Douglas County and the metropolitan area as a whole, there is an excess of dental providers. The fact that children often go without dental care (especially those with dental Medicaid benefits) needs to be addressed. Prevention through routine examinations could save the community time and treasure. Access to care is not a problem; we need to remove the barriers to care. – Other Healthcare Provider*

*A large number of young children and adolescent suffer from poor ongoing dental care. I see them every day in Pediatric Clinic and at DCYC. They have pain. – Physician*

*Many children do not receive dental care, which affects quality of life. – Physician*

*Most exams show multiple cavities in children's mouth, many children's parents answer 'no' to questions, has your child been seen by dentist in the past year. – Physician*

*Many children with untreated decay. – Other Healthcare Provider*

*Significant amount of dental caries in children. Decay becomes so bad and widespread that they then require repair under general anesthesia, which increases cost and risk to children. – Physician*

*Discussion with primary care practitioners and not for profit after school agencies in the community. – Physician*

### Limited Access for Underinsured/Uninsured

*Disproportionate impact of dental caries in underserved young children. Missed school days due to the dental issues. – Public Health Representative*

*Poor funding across the board for dental care. Dentists typically put limits on low income care to keep their practices financially healthy. They too do not want to invest in low return humans, poor patient and family compliance, etc. – Public Health Representative*

*Lack of dental insurance for kids and lack of providers willing to treat children without insurance. Also, a lot of families do not think oral health care is important. – Physician*

*Not often covered by health insurance. Parents are not aware of the needs of their child. – Other Healthcare Provider*

*No insurance and not enough dentists who take Medicaid. – Physician*

*Lack of providers who accept Medicaid. – Physician*

*Too few providers that accept Medicaid. – Physician*

### Affordable Care

*Oral health is expensive and under-utilized by some populations. – Community/Business Leader*

*The cost of dental care is prohibitive. – Community/Business Leader*

*Families in Action participants note that the high cost of dental care prohibits visits to dentist. Food insecurity, eating habits, high cost of nutritious foods all factor in to this. – Community/Business Leader*

*Lack of access to care or to resources to afford care. – Social Services Provider*

*Inadequate access and lack of trust. – Physician*

### Lack of Education

*Children are not taught at a young age the importance of dental care. Families too busy to take patient to dental appointments. – Physician*

*Research continues to support the influence of good oral and dental health in supporting healthy children who are ready to learn. Services seem to be rapidly increasing. – Public Health Representative*

*Due to lack of parent awareness of the importance of protecting teeth even before they come through the gums, damage is done long before the children come to school. Parents who have not had access to dental care are less likely to take their children for care. – Physician*

| *Lack of education and ability to afford care. – Community/Business Leader*

***Impacts all Other Areas of Health***

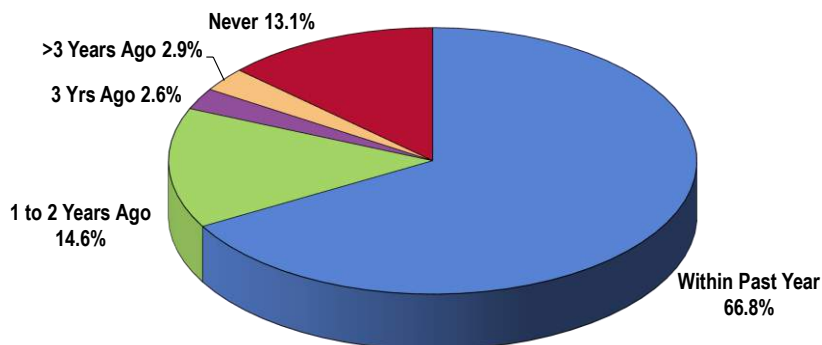
| *Oral health impacts all other areas of health. – Social Services Provider*

## Vision & Hearing

### Recent Eye Exams

Note the following frequency of eye exams among Metro Area children; as shown, 13.1% of Metro Area children have never had an eye exam.

**Child's Most Recent Eye Exam**  
(Metro Area, 2015)

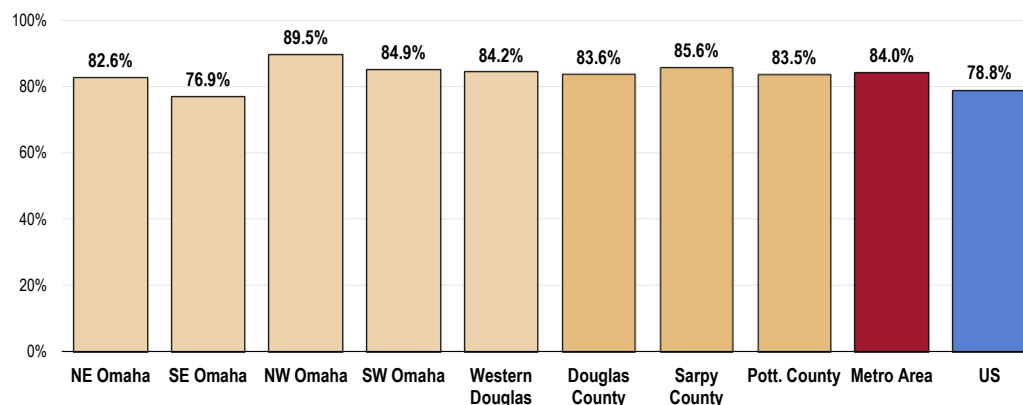


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]  
Notes: • Asked of all respondents about a randomly selected child in the household.

On the other hand, a total of 84.0% of Metro Area parents indicate that their child has had an eye exam within the past three years.

- More favorable than national results.
- In Douglas County, least favorable in Southeast Omaha; most favorable in Northwest Omaha.
- Similar among counties.

## Child Had an Eye Exam in the Past Three Years (Metro Area, 2015)

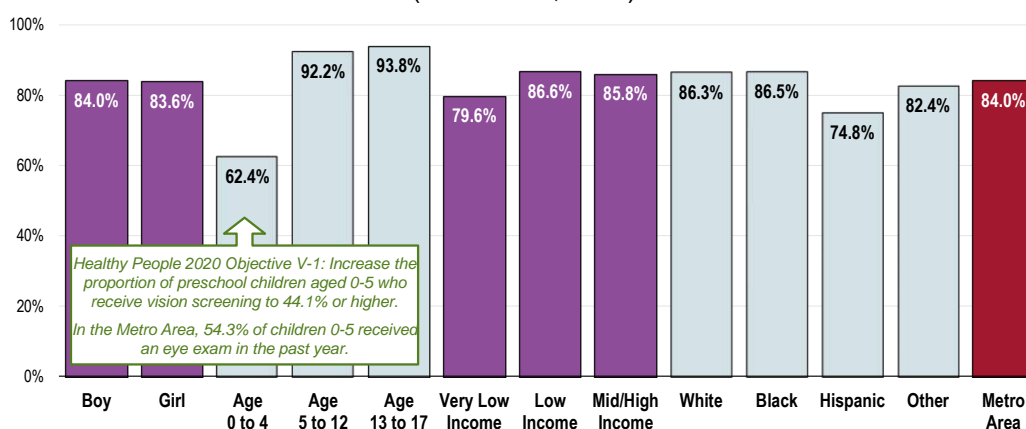


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Children less likely to have received an eye exam in the past 3 years include:

- Those under age 5. However, the prevalence of eye exams in the **past year**, among Metro Area children age 0 to 5, satisfies the Healthy People 2020 objective (44.1% or higher) for their age group.
- Hispanics when compared with Whites and Blacks.

## Child Had an Eye Exam in the Past Three Years (Metro Area, 2015)

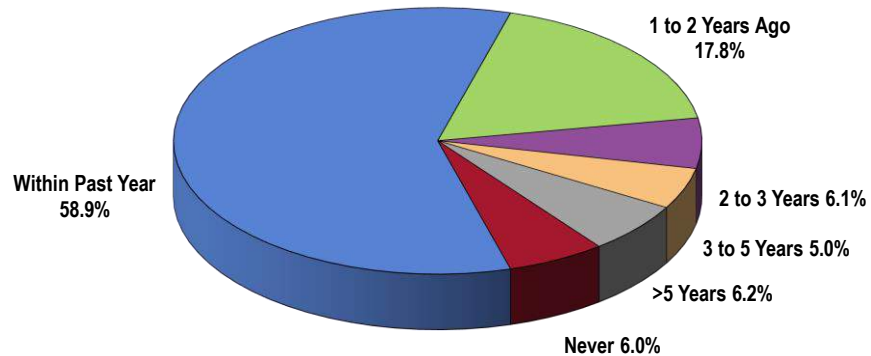


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective V-1]  
 Notes: • Asked of all respondents about a randomly selected child in the household.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Hearing Tests

Note that 6.0% of Metro Area parents indicate that their child has never had a hearing test.

### Child's Most Recent Hearing Test (Metro Area, 2015)

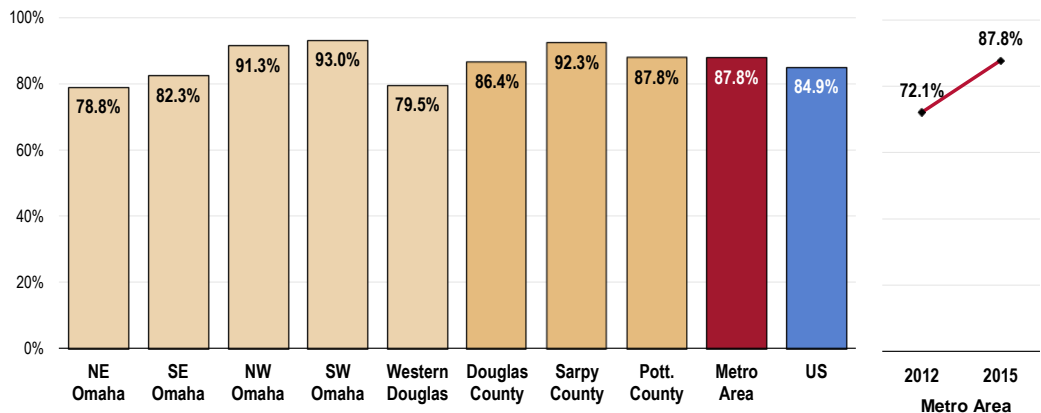


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 40]  
Notes: • Asked of all respondents about a randomly selected child in the household.

On the other hand, 87.8% of Metro Area children have had a hearing test within the past five years.

- Statistically similar to national reports.
- In Douglas County, lowest in Northeast Omaha; highest in Northwest and Southwest Omaha.
- By county, lowest in Douglas County; highest in Sarpy County.
- TREND: There has been a stark improvement in hearing testing since 2012.

### Child Had a Hearing Test in the Past Five Years (Metro Area, 2015)

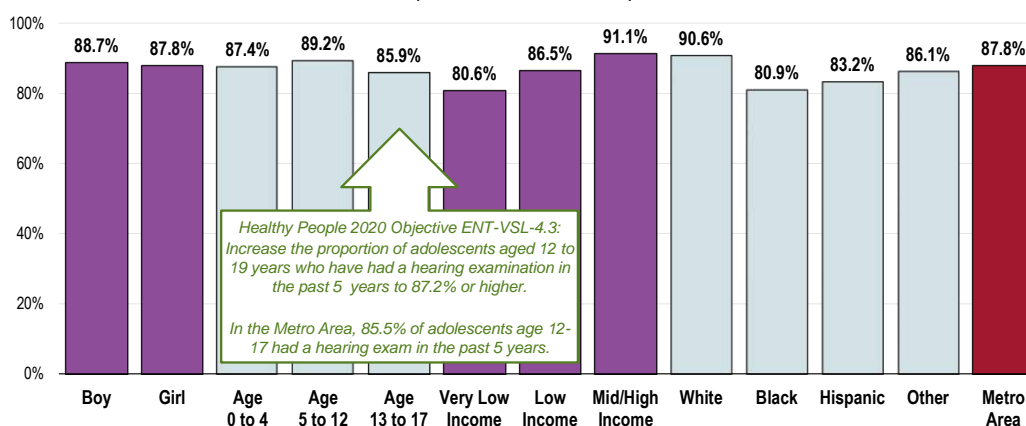


Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 40]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

Note the following:

- The prevalence of Metro Area children age 12 to 17 who have had a hearing test in the past five years is similar to the Healthy People 2020 objective (87.2% or higher) set for children age 12 to 19.
- Lower income children are less likely to have received a hearing test in the past 5 years.
- Hearing tests are less common among Black, Hispanic, or Other” race children.

### Child Had a Hearing Test in the Past Five Years (Metro Area, 2015)



Sources:

- 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 40]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective ENT-VSL-4.3]

Notes:

- Asked of all respondents about a randomly selected child in the household.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



## Emergent & Urgent Care

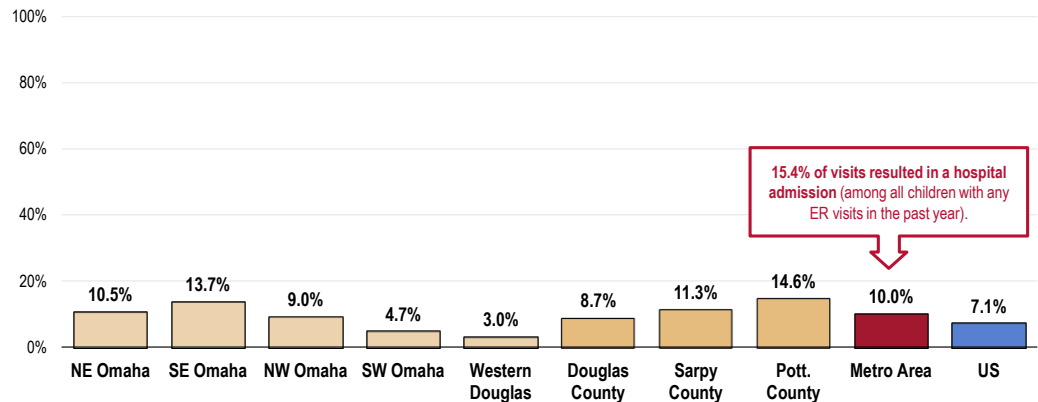
### Emergency Room Utilization

A total of 10.0% of Metro Area parents report taking their child to a hospital emergency room (ER) more than once in the past year.

- Higher than the US figure.
- Within Douglas County, multiple ER visits is most prevalent in Southeast Omaha, but least prevalent in Southwest Omaha and Western Douglas.
- No statistical difference in child ER visits among counties.

Of those whose child used a hospital ER, 15.4% say the visit resulted in a hospital admission.

### Child Used a Hospital Emergency Room More Than Once in the Past Year (Metro Area, 2015)

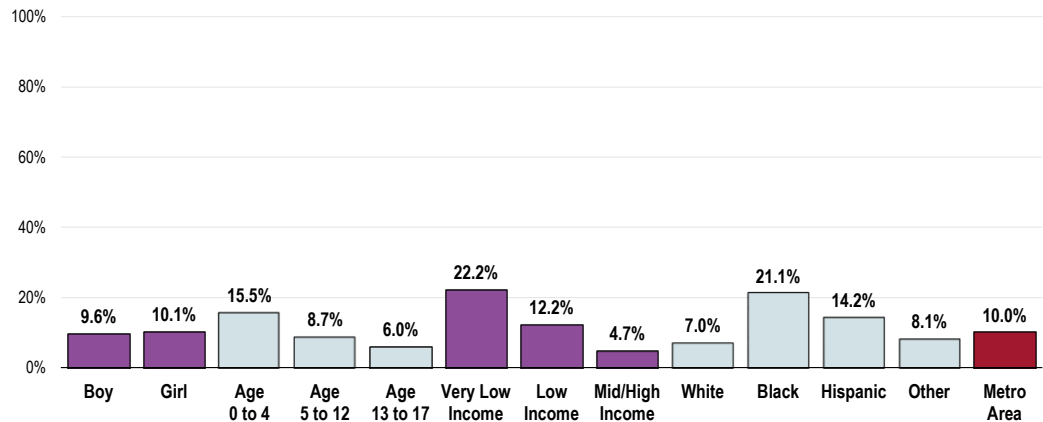


Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 41-42]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents about a randomly selected child in the household.

Children more likely to have used a hospital room for care more than once in the past year include:

- Younger children (negative correlation with age).
- Those in very lower income households (negative correlation with income).
- Black or Hispanic children.

## Child Used a Hospital Emergency Room More Than Once in the Past Year (Metro Area, 2015)



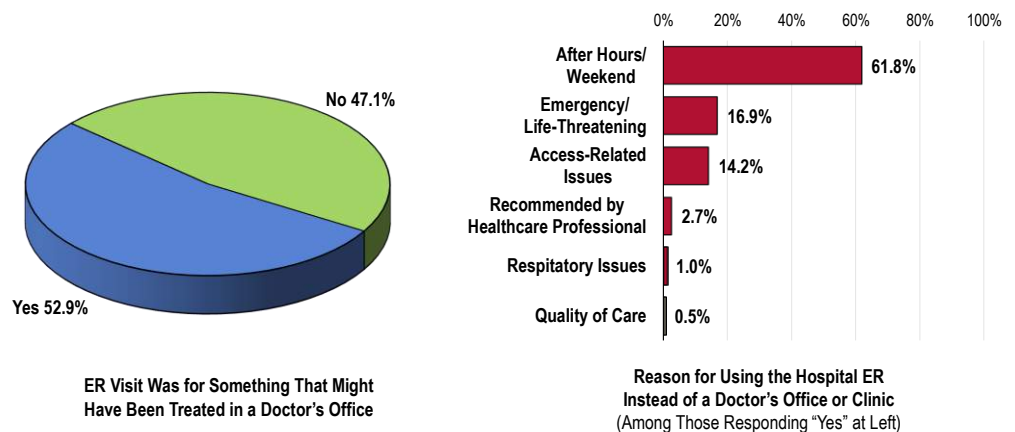
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 41]

Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among Metro Area parents of children with any ER visits in the past year, the majority (52.9%) says the visit was for something that might have been treated in a doctor's office.

- Asked why they used a hospital ER for their child's care, 61.8% indicated that they needed the care **after hours or on the weekend**, and 16.9% said the visit was to treat an actual **emergency or life-threatening situation**.
- Another 14.2% of Metro Area parents who took their child to a hospital ER in the past year did so because of **access-related issues** and 2.7% were **recommended there** by a healthcare professional.

## Emergency Room Visits (Among Metro Area Children With Any ER Visits in the Past Year, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 43-44]

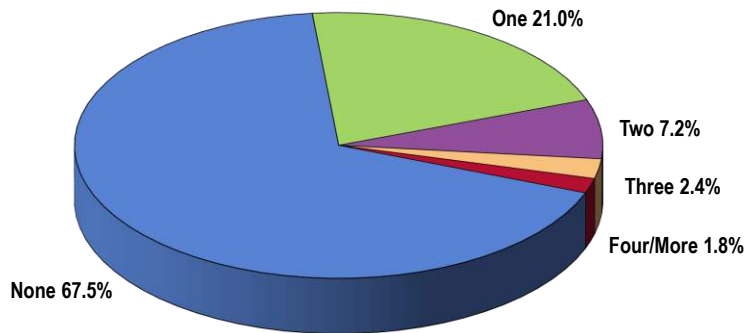
Notes: • Asked of respondents for whom the randomly selected child in the household used a hospital ER in the past year.

## Urgent Care Centers

A total of 32.4% of Metro Area children visited an urgent care center or other walk-in clinic at least once in the past year.

- The prevalence includes 4.2% of Metro Area children who visited an urgent care center **3+ times** in the past year.

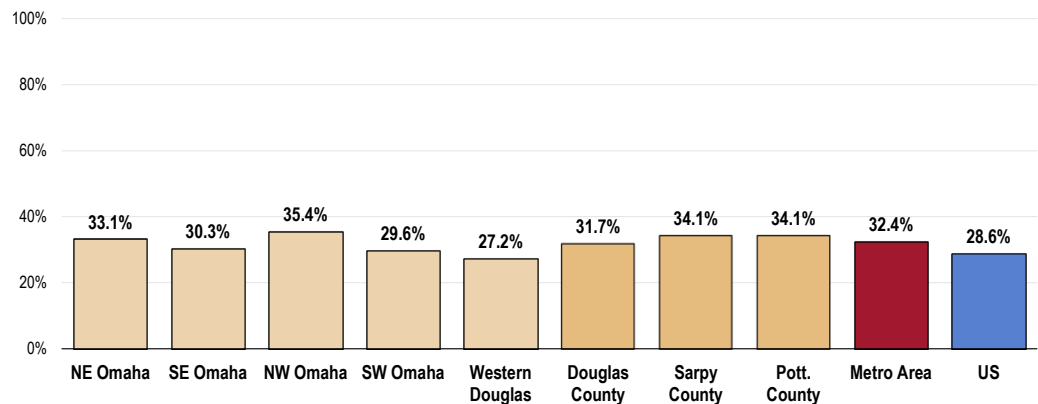
**Number of Visits to an Urgent Care Center or Other Walk-in Clinic in the Past Year**  
(Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 45]  
Notes: • Asked of all respondents about a randomly selected child in the household.

- The prevalence of Metro Area children using an urgent care clinic in the past year is statistically similar to the US figure.
- No statistical difference when viewed by sub-area of Douglas County.
- The counties comprising the Metro Area exhibit similar findings.

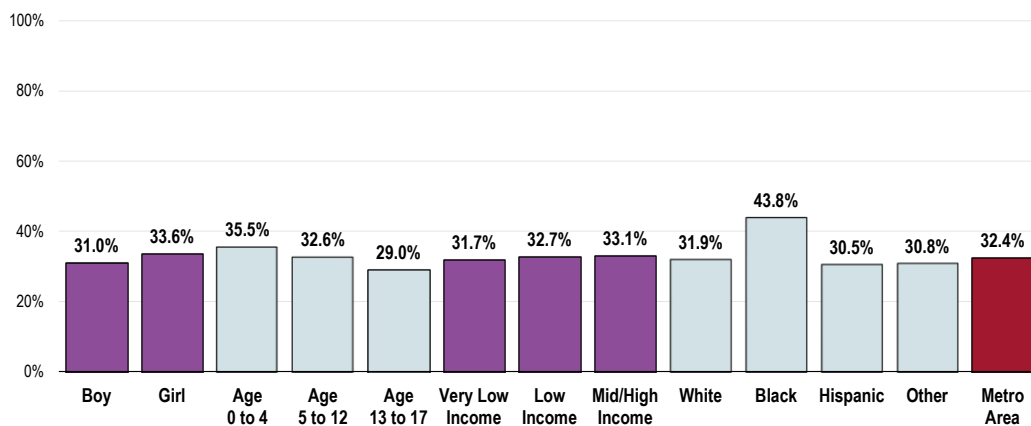
**Child Used an Urgent Care Center, QuickCare Clinic, or Other Walk-In Clinic in the Past Year**  
(Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 45]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- Despite a higher response among parents of Black children, this difference is not statistically significant.

### Child Used an Urgent Care Center, QuickCare Clinic, or Other Walk-In Clinic in the Past Year (Metro Area, 2015)



Sources: 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 45]

Notes: Asked of all respondents about a randomly selected child in the household.

Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

# Health Education & Outreach



**Professional Research Consultants, Inc.**

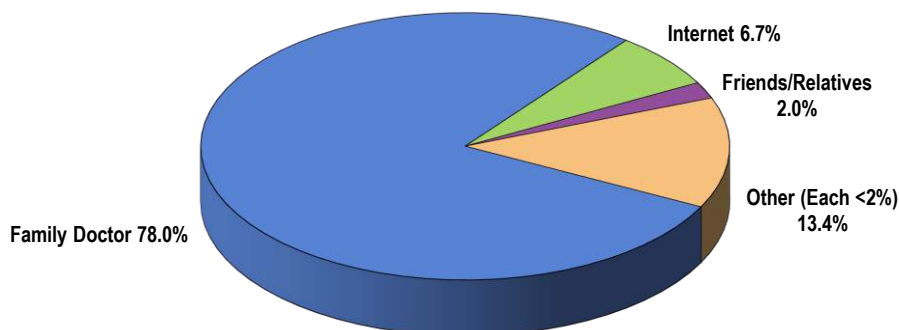
## Health Education

### Primary Source of Healthcare Information

Family physicians are the primary source of children's healthcare information for over three-fourths (78.0%) of Metro Area parents.

- The **Internet** received the second-highest response, with 6.7%.

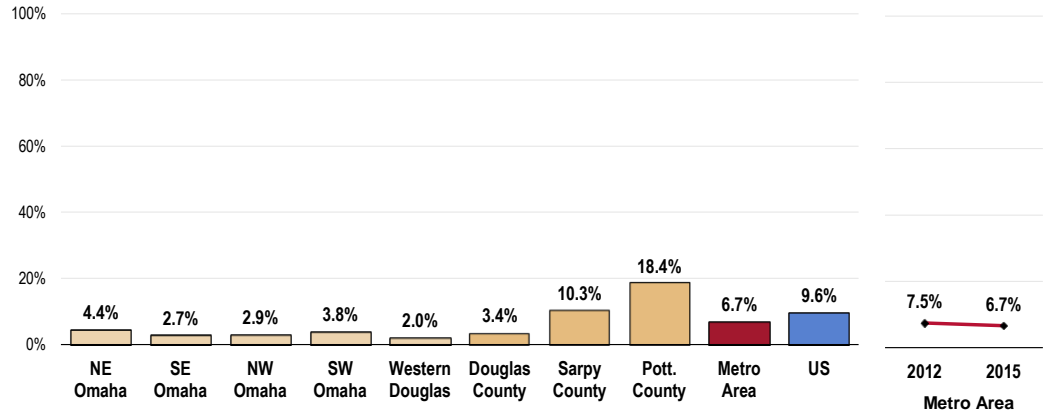
### Primary Source of Healthcare Information for Child (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 138]  
Notes: • Asked of all respondents about a randomly selected child in the household.

- The prevalence of Metro Area parents who rely on the **Internet** as their primary source of healthcare information for their child is lower than the national prevalence.
- Similar within Douglas County.
- Segmented by county, Pottawattamie County has a much higher reliance on the Internet for healthcare information, while Douglas County relies on the Internet the least.
- TREND: Internet usage for healthcare information has remained statistically the constant over time.

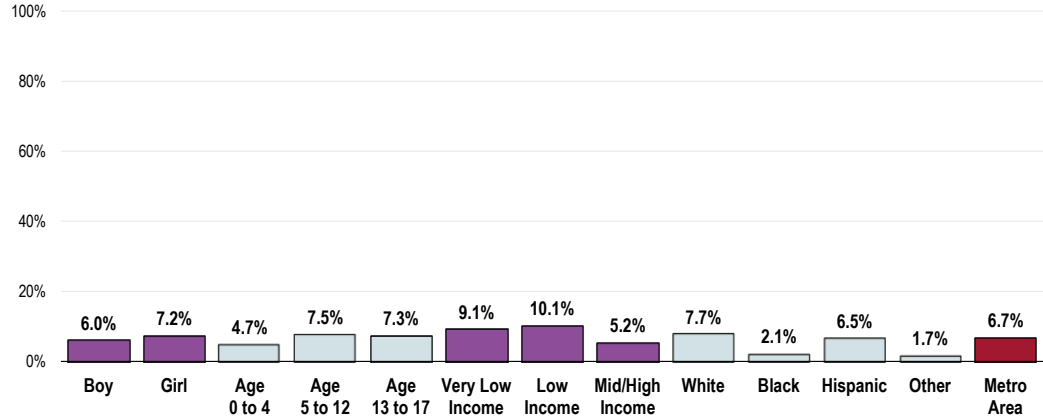
## Internet Is the Primary Source of Healthcare Information (Metro Area, 2015)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 138]  
• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents about a randomly selected child in the household.

- Reliance on the Internet for healthcare information is highest among Whites.

## Internet Is the Primary Source of Healthcare Information (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 138]  
Notes: • Asked of all respondents about a randomly selected child in the household.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

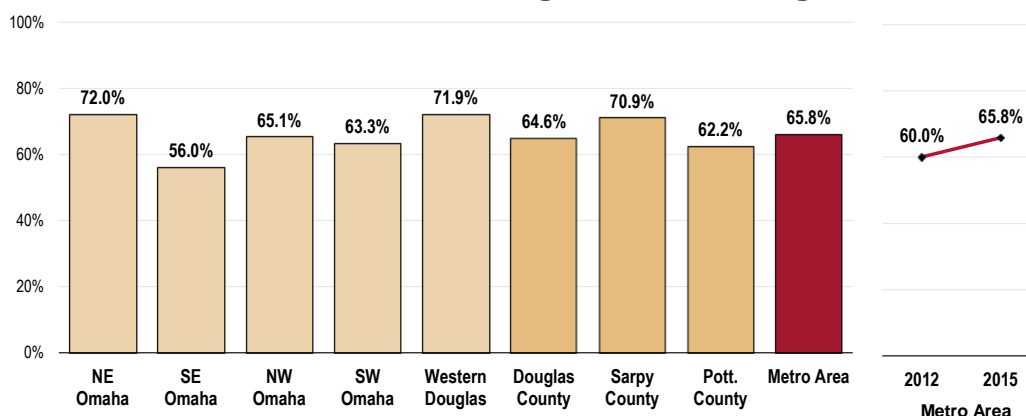
"Are you aware of any parenting education programs offered in your community?"

## Local Parenting Education

Among Metro Area survey respondents, 2 in 3 (65.8%) are aware of parenting education programs offered in the community.

- In Douglas County, a higher proportion of Northeast Omaha parents are aware of parenting education programs, whereas those in Southeast Omaha are least aware.
- No difference in awareness when viewed by county.
- TREND: Awareness of local parenting education programs has significantly increased since 2012.

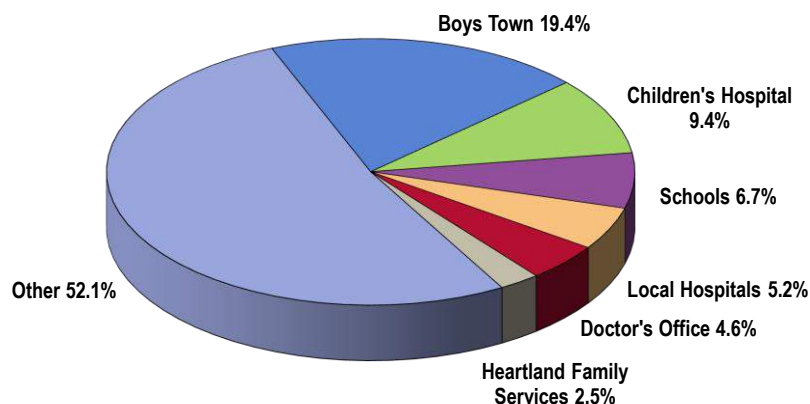
### Aware of Local Parenting Education Programs



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 312]  
Notes: • Asked of all respondents about a randomly selected child in the household.

When asked to specify which program they are aware of, the largest share of these respondents (19.4%) mentioned **Boys Town**, followed by **Children's Hospital** (9.4%) and **school programs** (6.7%).

### Local Parenting Education Programs Mentioned (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 313]  
Notes: • Asked of all respondents about a randomly selected child in the household.

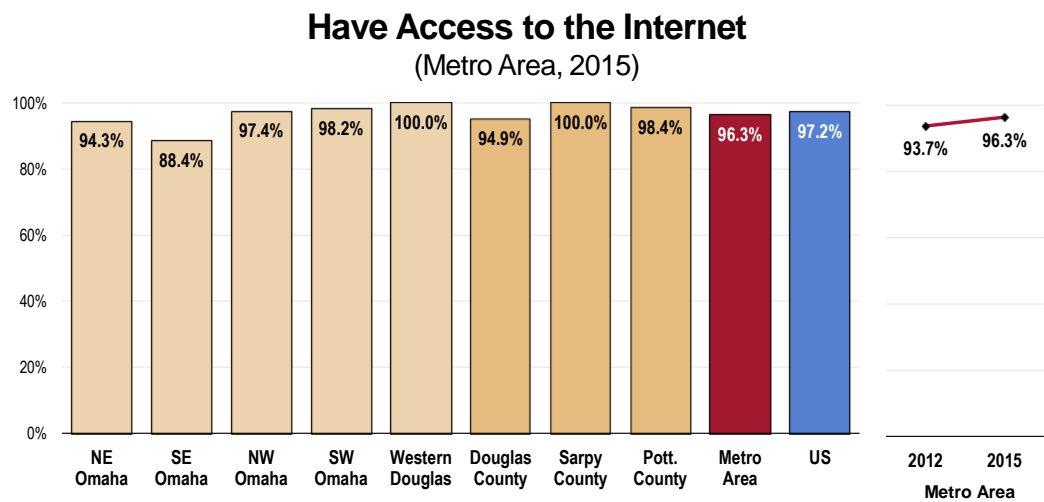


## Access to Technology

### Internet Access

The majority of respondents (96.3%) have access to the Internet.

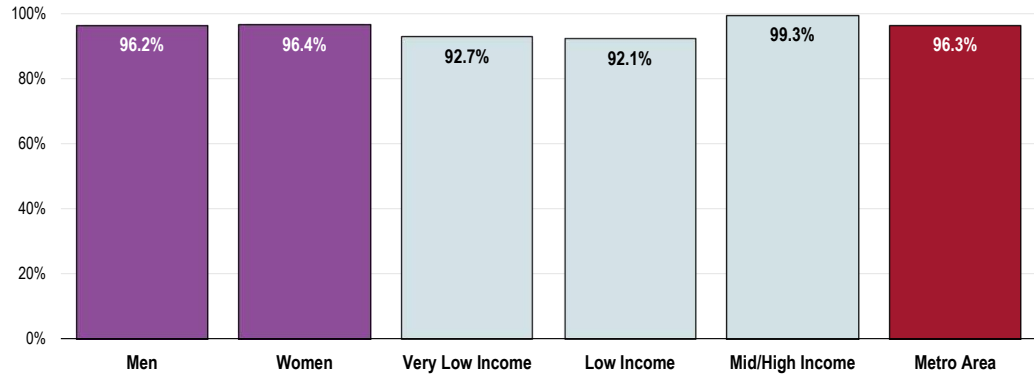
- Similar to Internet access across the US.
- In Douglas County, Internet access is lowest in Southeast Omaha, while higher in Southwest Omaha and Western Douglas.
- By county, Douglas County experiences the least access.
- TREND: Marks a statistically significant increase since 2012.



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 144]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- Those with incomes under 200% of the federal poverty level are less likely to have access to the Internet than those with higher incomes.

### Have Access to the Internet (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 144]

Notes: • Asked of all respondents.

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

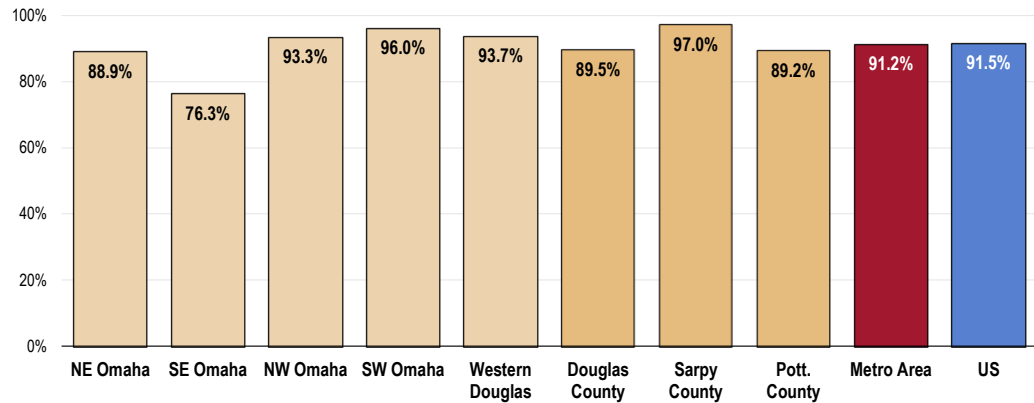
## Use of Cell Phones

### Parents

A total of 91.2% of Metro Area parents have a cell phone for their personal use.

- Close to the national percentage.
- In Douglas County, particularly low in Southeast Omaha; highest in Southwest Omaha.
- By county, highest in Sarpy County.

### Have a Cell Phone for Personal Use (Metro Area, 2015)



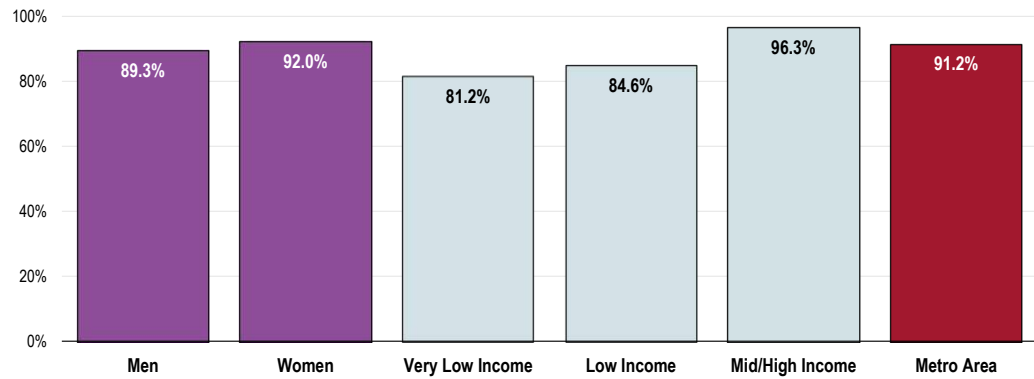
Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 145]

• 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

- Note the positive correlation between income level and cell phone ownership.

### Have a Cell Phone for Personal Use (Metro Area, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 145]

Notes: • Asked of all respondents.

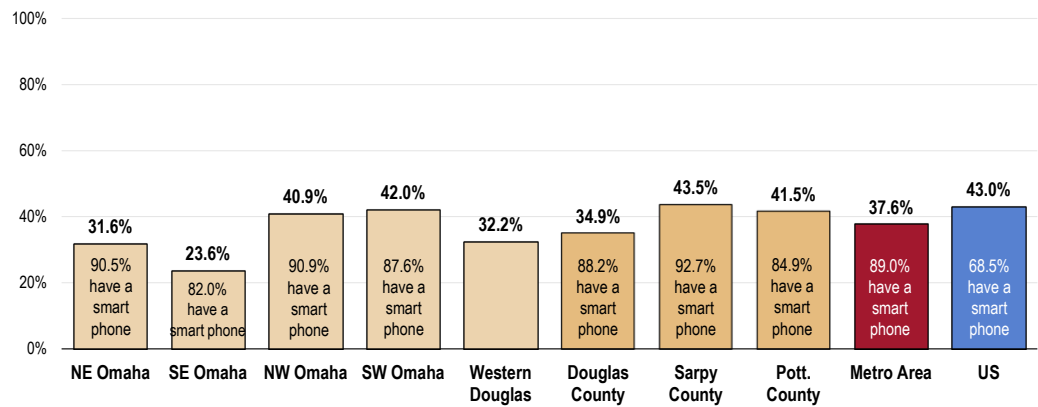
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Children

Among parents of school-age children, 37.6% indicate that their child has his/her own cell phone. Of these children, 89.0% have a smart phone on which he/she can download apps or games and visit social media sites.

- Lower than seen nationally.
- In Douglas County, notably low in Southeast Omaha; highest in Southwest Omaha.
- Of the Metro Area counties, Douglas County has the lowest percentage of children with their own phones.

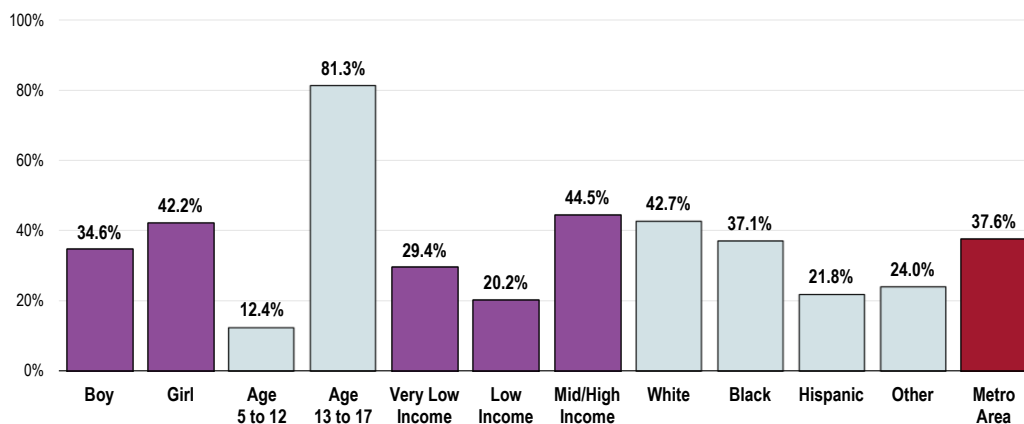
**Child Has Own Cell Phone**  
(Metro Area Parents of Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 147-148]  
 • 2014 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.  
 • Smart phone data for Western Douglas is not available due to a small sample size.

- Prevalence among Metro Area teens increases to 81.3%.
- Girls and those in households with higher incomes are also more likely to have cell phones.
- Hispanic children are least likely to have cell phones.

### Child Has Own Cell Phone (Metro Area Parents of Children Age 5-17, 2015)



Sources: • 2015 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 147]

Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes between 100% and 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Resources



**Professional Research Consultants, Inc.**

## Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Child & Adolescent Health Needs Assessment.

### Access to Healthcare Services

*Behaven Kids*  
*Boys and Girls Club*  
*Boys Town*  
*Boys Town Behavioral Health*  
*Building Healthy Futures*  
*Charles Drew Health Center*  
*CHI Health*  
*Children's Behavioral Health*  
*Children's Hospital & Medical Center*  
*Children's Physicians*  
*CHIP*  
*Community Centers*  
*Cooking Matters*  
*Eastern Nebraska Community Action Partnership*  
*Eastern Nebraska Office on Aging*  
*Families in Action*  
*Federally Qualified Health Centers*  
*Healthy Families*  
*Heartland Family Services*  
*HEROES Program*  
*Hope Medical Outreach*  
*Immanuel Medical Center*  
*Lutheran Family Services*  
*Meals on Wheels*  
*Medicaid*  
*Metro Transit*  
*Nebraska Medicine*  
*NOAH*  
*Omaha Public Library*  
*OneWorld Community Health Center*  
*Primary Care Physicians*  
*Private Physicians*  
*Project Harmony*  
*Region 6*  
*Retail Based Services*  
*School Based Health Centers*  
*Schools*  
*The Kim Foundation*  
*UNMC*  
*UNMC Community Programs*

UNMC Pediatrics  
Urgent Care  
Various Philanthropic Groups  
WIC

### Allergies

Allergy and Asthma Center  
Allergy Specialists  
Allergy, Asthma and Immunology  
Bambi's Health Food Market  
Charles Drew Health Center  
Children's Hospital & Medical Center  
Children's Physicians  
Children's Pulmonology  
Children's Specialty Services  
Day Break  
Dermatology Clinics  
Douglas County Health Department  
Federally Qualified Health Centers  
HealthQuest Chiropractic  
Midwest Allergy and Asthma Clinic  
Millard Wellness Center  
No Name Nutrition  
Omaha Healthy Families  
OneWorld Community Health Center  
Pediatric Physicians  
Primary Care Physicians  
Private Physicians  
School Based Health Centers  
Schools  
UNMC

### Asthma and Other Respiratory Conditions

Aetna Better Health of Nebraska  
American Lung Association  
Area FQHC's  
Asthma Specialists  
Attack on Asthma Nebraska  
Bambi's Health Food Market  
Camp Superkids  
Charles Drew Health Center  
Children's Hospital & Medical Center  
Children's Pulmonology  
Children's Respiratory Medicine Clinic  
County Health Department  
Creighton Asthma/Immunology  
Emergency Rooms  
Federally Qualified Health Centers  
Habitat for Humanity  
HealthQuest Chiropractic  
Home Visits With Home Health Nurses



*Midwest Allergy and Asthma Clinic*  
*Millard Wellness Center*  
*Nebraska Lung Association*  
*No Name Nutrition*  
*Omaha Asthma Alliance*  
*Omaha Healthy Families*  
*Omaha Healthy Kids Alliance*  
*OneWorld Community Health Center*  
*Primary Care Physicians*  
*Private Physicians*  
*Project AIR through Healthy Kids*  
*Pulmonary and Allergy Specialists*  
*School Based Health Centers*  
*Schools*  
*UNMC*  
*Urgent Care*  
*Visiting Nurse Association*

### Cancer

*Childhood Camps for Cancer*  
*Children's Hospital & Medical Center*  
*Hospitals*  
*Medicaid*  
*Ronald McDonald House*  
*Support Center*  
*Ted E. Bear Hollow*  
*UNMC*

### Cognitive and Behavioral Conditions

*A+ Wellness Center for Healing*  
*Autism Action Partnership*  
*Autism Society of Nebraska*  
*Beacon*  
*Behaven Kids*  
*Bergan Mercy*  
*Bilingual Counselors*  
*Boys and Girls Club*  
*Boys Town*  
*Boys Town Behavioral Health*  
*Boys Town Developmental Pediatrics*  
*Boys Town Family Home Program*  
*Boys Town Learning Academy*  
*Boys Town National Research Hospital*  
*Boys Town Psychiatric Services*  
*Boys Town Residential Treatment Center*  
*Bryan LGH Inpatient Psychiatric Facility*  
*Building Bright Futures*  
*Capstone Behavioral Health*  
*Catholic Charities*  
*Center for Holistic Development*

Charles Drew Health Center  
 CHI Creighton  
 CHI Health  
 CHI Psychiatric Associates  
 Children's Autism Diagnosis Clinic  
 Children's Behavioral Health  
 Children's Family Services  
 Children's Hospital & Medical Center  
 Children's Hospital Developmental Clinic  
 Children's Physicians  
 Children's Psychology  
 CMH Autism Clinic  
 Community Alliance  
 Community Therapist  
 Completely KIDS  
 Connections Program of Project Harmony  
 Cranial Sacral Therapy  
 Creighton Health Initiative  
 Creighton Psychiatry  
 Day Break  
 Douglas County  
 Early Childhood Network  
 Early Development Network  
 Eastern Nebraska Community Action Partnership  
 EIP  
 Emergency Rooms  
 Federally Qualified Health Centers  
 Four Winds Natural Healing Center  
 Great Oaks Counseling  
 Heartland Family Services  
 Holistic Center for Development  
 Hospitals  
 Immanuel Medical Center  
 Jail  
 Kid Squad  
 Lasting Hope Recovery Center  
 Lutheran Family Services  
 Madonna School  
 Medical Centers  
 Mental Health Providers  
 Mercy Hospital  
 Momentum Therapy Group  
 Munroe Meyer Institute  
 Nebraska Family Collaborative  
 NFC  
 Omaha Home for Boys  
 Omaha Public Schools  
 Omni Behavioral Health  
 OneWorld Community Health Center  
 Parents, Teachers and Information Nebraska

*Pediatric Therapy Center*  
*Philanthropic Organizations*  
*Primary Care Physicians*  
*Private Physicians*  
*ProCare*  
*Project Harmony*  
*PTI*  
*Region 6*  
*Reike*  
*School Based Health Centers*  
*Schools*  
*Sensory Integration*  
*The Kim Foundation*  
*UNMC*  
*UNMC Psychiatry*  
*Voc-Rehab*  
*Woodhaven*  
*Youth Center*

### Diabetes

*Bergan Mercy*  
*Boys and Girls Club*  
*CH/CSP*  
*CHI Diabetes Education Program*  
*CHI Health*  
*Children's Hospital & Medical Center*  
*Children's Specialty Services*  
*Diabetes Association*  
*Families in Action*  
*Farmer's Markets*  
*Girls, Inc.*  
*Gretchen Swanson*  
*Healthy Families*  
*HEROES Program*  
*Hospitals*  
*KROC Center*  
*Live Well Omaha*  
*Northstar*  
*OneWorld Community Health Center*  
*Planned Parenthood*  
*School Based Health Centers*  
*South Omaha Community Care Council*  
*UNMC*  
*WIC*  
*YMCA/YWCA*

### Hearing, Vision, and Speech Conditions

*Boys Town*  
*Boys Town National Research Hospital*  
*Building Healthy Futures*  
*Children's Ophthalmology*

*Children's Vision Coverage*  
*Early Intervention Network*  
*Low Cost Vision Clinic*  
*Munroe Meyer Institute*  
*Omaha Public Schools*  
*Private Physicians*  
*ProCare*  
*Schools*  
*UNO College of Education Speech Language Pathology*

### **Infant & Child Health**

*Attachment and Trauma Center*  
*Baby Blossoms*  
*BBC*  
*Breast is Best*  
*Child Saving Institute*  
*Children's Hospital Developmental Clinic*  
*Circle of Security Groups*  
*City Match*  
*County Health Department*  
*Douglas County*  
*Early Childhood Services*  
*Early Head Start*  
*Early Intervention Network*  
*Father CCP Classes*  
*Federally Qualified Health Centers*  
*Healthy Families*  
*Hospitals*  
*Immunization Group*  
*Lutheran Family Services*  
*Mental Health Adult Attachment Interviews*  
*MIECHV*  
*MMRI*  
*Munroe Meyer Institute*  
*Nebraska Children's Home Society*  
*OB/GYN Providers*  
*Omaha Healthy Start*  
*OneWorld Community Health Center*  
*Parent Child Interaction Therapy*  
*Private Physicians*  
*reallyreally.org*  
*Region 6*  
*Salvation Army*  
*School Based Health Centers*  
*Teacher Child Interaction Training*  
*Visiting Nurse Association*  
*WIC*

### **Injury & Violence**

*Attachment and Trauma Center*  
*Boys and Girls Club*

*Boys Town*  
*Boys Town Behavioral Health*  
*Boys Town Hotline*  
*Building Bright Futures*  
*Capstone Behavioral Health*  
*CASA*  
*Center for Hope*  
*Charles Drew Health Center*  
*CHI Health*  
*Child Saving Institute*  
*Children's Hospital & Medical Center*  
*Children's Hospital Safe Kids*  
*Children's Square*  
*Choices Counseling*  
*Churches*  
*City Council*  
*Community Coalitions*  
*Community Policing*  
*Compassion in Action*  
*Completely KIDS*  
*Connections Program of Project Harmony*  
*CPS*  
*Domestic Violence Shelters*  
*Don't Shake a Baby Messaging*  
*DREAM*  
*DV Classes*  
*eCPR*  
*Empowerment Network*  
*Father's Groups*  
*Girls, Inc.*  
*Heartland Family Services*  
*Hope Center*  
*Impact One*  
*Jail*  
*Lasting Hope Recovery Center*  
*Latino Center of the Midlands*  
*Law Enforcement*  
*Lutheran Family Services*  
*Munroe Meyer Institute*  
*Omaha Police Department*  
*Omaha Public Schools*  
*Omaha Safety Council*  
*Omni Behavioral Health*  
*Operation Youth Success*  
*Partnership for Kids*  
*Phoenix House*  
*Police*  
*Private Physicians*  
*Project Harmony*  
*Religious Organizations*

Schools  
 Social Worker  
 SOVIP  
 Step-Up  
 UNMC Psychiatry  
 Uta Halee  
 Voices Against Violence  
 Women's Center for Advancement  
 YMCA/YWCA  
 Youth Center  
 Youth Emergency Services

### **Mental and Emotional Health**

Alegent Health Medical Home  
 Alegent-Creighton  
 Beacon  
 Behaven Kids  
 BHECN  
 Boys and Girls Club  
 Boys Town  
 Boys Town Behavioral Health  
 Boys Town Family Home Program  
 Boys Town National Research Hospital  
 Boys Town Psychiatric Services  
 Boys Town Residential Treatment Center  
 Building Bright Futures  
 Building Healthy Futures  
 Capstone Behavioral Health  
 Catholic Charities  
 Center for Holistic Development  
 Charles Drew Health Center  
 CHI Alegent  
 CHI Creighton  
 CHI Health  
 Child Saving Institute  
 Children's Behavioral Health  
 Children's Eating Disorder Clinic  
 Children's Family Services  
 Children's Hospital & Medical Center  
 Children's Physicians  
 Children's Psychiatry  
 Children's Respite Care Center  
 Choices Counseling  
 Churches  
 Coalition for Children's Mental Health  
 Community Counselor  
 Community Therapist  
 Completely KIDS  
 Connections Program of Project Harmony  
 Creighton Health Initiative  
 Creighton Psychiatry

*Crisis Trained Officers*  
*Day Break*  
*ECNAP*  
*Energy Work, Reike*  
*Families*  
*Family Enrichment*  
*Federally Qualified Health Centers*  
*Full Circle Therapy*  
*Heartland Family Services*  
*Hospitals*  
*Immanuel Medical Center*  
*Individual and Family Counseling Services*  
*Jail*  
*Kid Squad*  
*Large Health Care Companies*  
*Lasting Hope Recovery Center*  
*LFS*  
*Lutheran Family Services*  
*Mental Health Hotline*  
*Mental Health Providers*  
*Mercy Hospital*  
*Methodist EAP*  
*Methodist Health System*  
*Momentum Therapy Group*  
*Munroe Meyer Institute*  
*NE Center for Healing and Hope*  
*Nebraska Children and Families Foundation*  
*Nebraska Family Collaborative*  
*Nebraska Family Help Line*  
*Nebraska Urban Indian Staff*  
*Omni Behavioral Health*  
*OneWorld Community Health Center*  
*Organizations*  
*Primary Care Physicians*  
*Private Physicians*  
*Project Harmony*  
*Region 6*  
*SAFE Program*  
*School Based Health Centers*  
*Schools*  
*State of Nebraska Social and Medical Services*  
*Ted E. Bear Hollow*  
*The Kim Foundation*  
*UNMC*  
*UNMC Psychiatry*  
*Woodhaven*  
*YMCA/YWCA*  
*Youth Center*  
*Youth Emergency Services*

### Neurological Conditions

Boys Town National Research Hospital  
Boys Town Neurology  
CHI Health  
Children's Hospital & Medical Center  
Children's Neurology  
Children's Specialty Services  
Munroe Meyer Institute  
UNMC Pediatrics

### Nutrition, Physical Activity & Weight

12 Month School Lunch Sites  
5-4-3-2-1 Go  
Action for Healthy Kids  
Area Parks  
Bergan Mercy  
Boys and Girls Club  
Boys Town GI Clinic  
Building Bright Futures  
Building Healthy Futures  
Businesses  
Charles Drew Health Center  
CHI Health  
Children's Better Bodies Program  
Children's Cooking Classes  
Children's Hospital & Medical Center  
Children's Obesity Clinic  
City Sprouts  
Community Centers  
Completely KIDS  
Cooking Matters  
Dietitians  
Dietitians at Children's  
Douglas County Health Department  
DREAM  
Educare, Early Childhood Programs  
Families in Action  
Farmer's Markets  
Federally Qualified Health Centers  
Food Banks  
Food Bank for the Heartland Backpack Program  
Girls, Inc.  
Gretchen Swanson  
Health Clubs  
Healthy Families  
Healthy Neighborhood Stores  
HEROES Program  
Hospitals  
Hummel Day Camp  
Hy-Vee



KROC Center  
 Lakeside Nutrition Program  
 Live Well Omaha  
 Live Well Omaha Kids  
 Metro Transit  
 NAP  
 NE Extension  
 No More Empty Pots  
 Non-Profit Organizations  
 Nutritionists  
 Omaha Together One Community  
 OneWorld Community Health Center  
 Partners for Healthy Schools  
 Partnership for Kids  
 Primary Care Physicians  
 Private Physicians  
 School Based Health Centers  
 Schools  
 SHAPE UP Nebraska  
 Social Worker  
 Trailblazers  
 UNL Extension  
 UNMC  
 Visiting Nurse Association  
 WIC  
 YMCA/YWCA

#### **Oral Health/Dental Care**

Building Healthy Futures  
 Charles Drew Health Center  
 Children's Hospital & Medical Center  
 CMH Dental Clinic  
 Community Health Fair  
 Creighton Clinic  
 Creighton Dental School  
 Creighton Free Clinic  
 Creighton Students  
 Dental Schools  
 Federally Qualified Health Centers  
 Medicaid  
 Mobile Dental Van  
 OneWorld Community Health Center  
 Ponca Health  
 Primary Care Physicians  
 Private Physicians  
 Project Smile  
 Ronald McDonald Dental Van  
 School Based Health Centers  
 Schools  
 Universities  
 UNMC Clinic

UNMC Dental

UNMC Pediatrics

### Sexual Health

1-844-690-CHKD

Adolescent Clinic at Methodist Women's

Adolescent Clinic at UNMC

Adolescent Health Project, Seven Partners

Boys Town Pediatrics

Charles Drew Health Center

CHI Health

Children's Hospital & Medical Center

County Health Department

Douglas County

Douglas County Health Department

Douglas County STD Clinic

Early Childhood Services

EPS

Faith Community Health Nurses

Federally Qualified Health Centers

Free Clinics

Girls, Inc.

Health Department

Library Testing

Methodist Women's Hospital Teen GYN Clinic

Nebraska AIDS Project

NOAH

Olson Center for Women's Health

Omaha Healthy Start

OneWorld Community Health Center

PFLAG

Pharmacists

Planned Parenthood

Primary Care Physicians

Private Physicians

Project Harmony

School Based Health Centers

Schools

Sherwood Foundation

Teen and Young Parent Program

Title X Funding

UNMC

UNMC Adolescent Clinic

Visiting Nurse Association

Women's Fund

Youth Emergency Services

### Substance Abuse

Addiction and Behavioral Health

Alcohol Anonymous

Arbor Family Counseling

*Boys Town*  
*Boys Town Behavioral Health*  
*Campus for Hope*  
*Catholic Charities*  
*Catholic Social Services*  
*Charles Drew Health Center*  
*Child Saving Institute*  
*Children's Hospital & Medical Center*  
*Criminal Justice System*  
*Heartland Family Services*  
*Hope Center*  
*Immanuel Medical Center*  
*Journeys*  
*Lasting Hope Recovery Center*  
*Lutheran Family Services*  
*Nebraska Children's Home Society*  
*NOVA*  
*Omaha Campus for Hope*  
*Omaha Police Department*  
*OneWorld Community Health Center*  
*Private Physicians*  
*Schools*  
*State Services*  
*The Independent Center*  
*UNO Recovery Community*  
*Valley Hope*  
*Woodhaven*

#### **Tobacco Use**

*1-800-Quit-Now*  
*Charles Drew Health Center*  
*Heartland Family Services*  
*OneWorld Community Health Center*  
*Primary Care Physicians*  
*Quit Lines*