

Executive Report

2018 PRC Child & Adolescent Health Needs Assessment

Douglas & Sarpy Counties, Nebraska Pottawattamie County, Iowa

Sponsored by:

Children's Hospital & Medical Center

In collaboration with:

Boys Town National Research Hospital
Building Healthy Futures

With support from:

Charles Drew Health Center, Inc.
Douglas County Health Department
Live Well Omaha
One World Community Health Centers, Inc.

Prepared by:

Professional Research Consultants, Inc.
11326 P Street Omaha, NE 68137-2316
www.PRCCustomResearch.com

2017-0735-02

© December 2018



Professional Research Consultants, Inc.

Table of Contents

Introduction	5
Project Overview	6
Project Goals	6
Methodology	6
Summary of Findings	15
Significant Health Needs of the Community	15
Mobilizing Action through Planning and Partnerships	18
Summary Tables: Comparisons With Benchmark Data	20
Summary of Key Informant Perceptions	38
Perceptions of Top Health Issues	39
Child Health	40
Adolescent Health	41
Current Health Status	42
Overall Health Status	43
Activity Limitations	43
School Days Missed Due to Illness or Injury	45
Special Health Needs	47
Mental Health	49
Evaluation of Child's Mental Health	49
Depression	51
Suicide Attempts (Adolescents)	54
Anxiety	55
Mental Health Services & Treatment	57
Awareness of Mental Health Services	60
Key Informant Input: Mental and Emotional Health	62
Chronic Disease	68
Allergies	68
Asthma	74
Bone, Joint, & Muscle Problems	77
Cognitive & Behavioral Disorders	78
Diabetes	92
Neurological Conditions	95
Condition Requiring Prescriptions or Special Therapy	100
Oral Health Problems	103
Vision, Hearing, & Speech Conditions	109
Weight Status	117
Serious Injuries	121

Fetal/Child Mortality	124
Infant Deaths	124
Child & Adolescent Deaths	126
Biological Influences	129
Birth Outcomes	130
Inadequate Prenatal Care	130
Births to Teen Mothers	131
Low-Weight Births	132
Key Informant Input: Infant Health	133
Breastfeeding & Breast Milk	135
Ever Breast-Fed	135
Exclusive Breastfeeding for Six Months	135
Social Environment Influences	137
Parenting	138
Household Adults Involved in Child's Care	138
Paid Parental Leave	140
Adverse Childhood Experiences	142
Exposed to Serious Mental Health Issues At Home	142
Exposure to Neighborhood Violence	143
Resilience Factors	145
Child Resilience	145
Family Resilience	148
Meeting Child's Needs	150
Demographics	152
Child Population	152
Linguistic Isolation	153
Children in Low-Income Households	154
Length of Time Living in Area	155
Housing Situation	156
Finances	157
Primary Source of Healthcare Information	161
Physical Environment Influences	163
Difficulty Accessing Fresh Produce	164
Safety	166
Bullying	166
Environmental Safety	167
Housing Conditions	171
Neighborhood Playgrounds & Parks	171
Unhealthy Housing Conditions	172

Detracting Elements of Neighborhood	173
Injury Control	175
Key Informant Input: Injury & Violence	179

Behavioral Influences **183**

Healthy Routines **184**

Nutrition	184
Physical Activity	192
Key Informant Input: Nutrition, Physical Activity, and Weight	196
Sleep Practices	200
Sleep Difficulties	201

Tobacco, Alcohol, & Other Drugs **203**

Exposure to Environmental Tobacco Smoke	203
Tobacco Use (Adolescents)	204
Alcohol Use (Adolescents)	205
Drug Use (Adolescents)	207
Key Informant Input: Tobacco, Alcohol, & Other Drugs	208

Sexual Behaviors **212**

Sexual Activity Among Adolescents	212
Chlamydia & Gonorrhea	213
Key Informant Input: Sexual Health	215

Use of Health Care & Preventive Services **219**

Primary Care Services	219
Dental Care	223
Vision & Hearing Care	227
Emergent & Urgent Care	231

Services **235**

Difficulties Accessing Healthcare **236**

Health Insurance Coverage	236
Barriers to Care	239

Care Coordination **242**

Access to Specialty Care **244**

Key Informant Input: Access to Health Services	246
--	-----

Resources **249**

Resources Available to Address the Significant Health Needs **250**

Appendix **257**

Evaluation of Implementation Plan **258**

Introduction



Professional Research Consultants, Inc.

Project Overview

Project Goals

This 2018 PRC Child & Adolescent Health Needs Assessment, a follow-up to similar studies conducted in 2012 and 2015, is a systematic, data-driven approach to determining the health status, behaviors, and needs of children and adolescents in the Omaha Metropolitan Area. This assessment was conducted by Professional Research Consultants, Inc. (PRC) on behalf of **Boys Town National Research Hospital, Children's Hospital & Medical Center, and Building Healthy Futures**. Supporting organizations include: Charles Drew Health Center, Inc.; Douglas County Health Department; Live Well Omaha; and One World Community Health Centers, Inc.

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

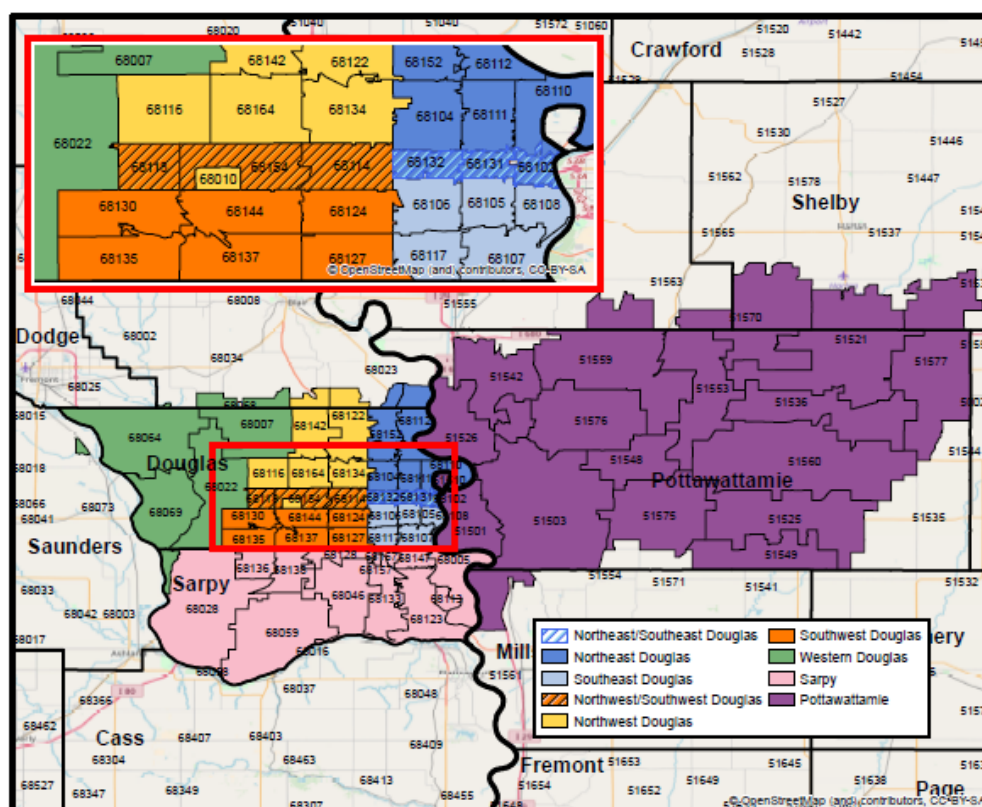
PRC Child & Adolescent Health Survey

Survey Instrument

The final survey instrument used for this study was developed by Children's Hospital & Medical Center, Boys Town, Building Healthy Futures, and PRC and aligns to the Institute of Medicine's Conceptual Framework for Child Health. The survey instrument is also similar to the previous surveys 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) is defined as 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.



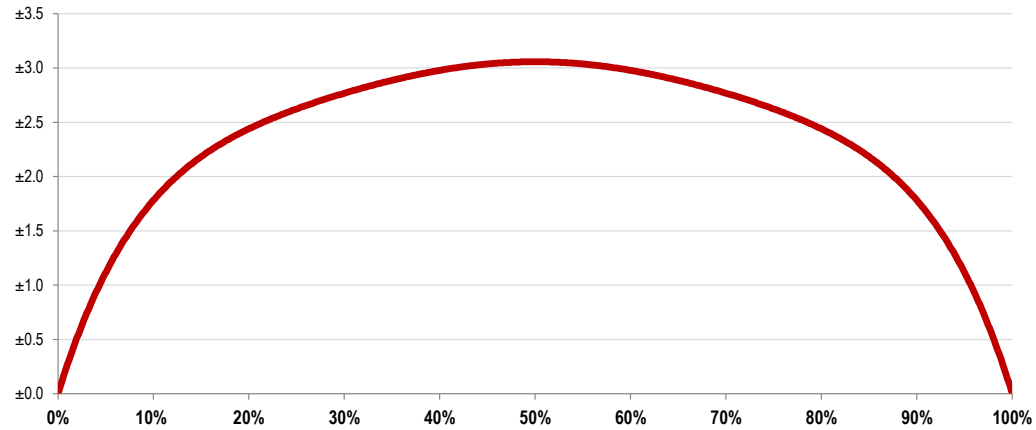
Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Child & Adolescent Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a stratified random sample of 995 parents of children under 18 in the Metro Area. By geography, a total of 680 surveys were conducted in Douglas County, 213 in Sarpy County, and 102 in Pottawattamie County. Once the interviews were completed, these were weighted in proportion to the actual child 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 PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 995 respondents is $\pm 3.0\%$ at the 95 percent confidence level. By county: the maximum error rate is $\pm 3.8\%$ for Douglas County, $\pm 6.7\%$ for Sarpy County, and $\pm 9.7\%$ for Pottawattamie County.

Expected Error Ranges for a Sample of 995 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 995 respondents answered a certain question with a "yes," it can be asserted that between 8.2% and 11.8% ($10\% \pm 1.8\%$) 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 47.0% and 53.0% ($50\% \pm 3.0\%$) of the total population would respond "yes" if asked this question.

Respondent Selection

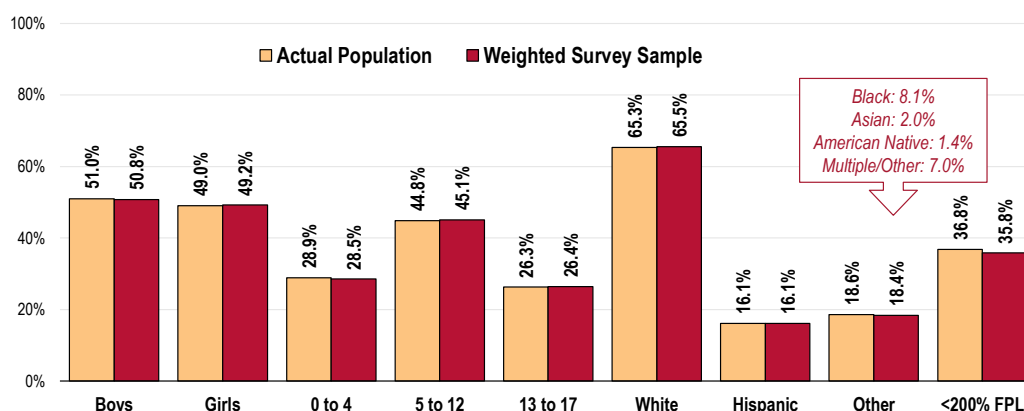
Survey respondents were adults age 18 and older who are a healthcare decision maker for children residing in the household. For households with more than one child under the age of 18, questions were asked about the child with the most recent birthday. This random selection process allows for the best 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 methodology. While this produces a highly representative sample of children and adolescents in the total service area, 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, the sample is 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 child's 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.

Population & Survey Sample Characteristics (Metro Area, 2018)



Sources:

- Census 2010, Summary File 3 (SF 3). U.S. Census Bureau.
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g.*, the 2018 guidelines place the poverty threshold for a family of four at \$25,100 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 (100%-199% of) the poverty threshold; and “**mid/high income**” refers to those households living on incomes which are twice or more ($\geq 200\%$ of) 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 child and adolescent population in the defined area 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 children and adolescents in the community, an Online Key Informant Survey also was 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 and business 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, 166 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physicians	72	33
Public Health Representatives	36	19
Other Health Providers	56	33
Social Services Providers	28	14
Community Leaders	110	67

Final participation included representatives of the organizations outlined below.

- Abide
- Big Brothers Big Sisters of the Midlands
- Boys Town National Research Hospital and Clinics
- Boys Town Pediatrics
- Building Healthy Futures
- Center for Holistic Development, Inc.
- Charles Drew Health Center, Inc.
- CHI Health
- Child Saving Institute
- Children's Hospital and Medical Center
- Children's Physicians
- Children's Physicians-Plattsmouth
- Children's Physicians, UNMC
- City of Omaha
- Community Health Center
- Completely KIDS
- CRCC
- Creighton University
- Creighton University, College of Nursing
- D2 Center Directions Diploma
- Douglas County Health Department
- Families in Action
- FAMILY, Inc.
- Fontenelle Elementary School
- Food Bank for the Heartland
- Girls Inc. of Omaha
- Gretchen Swanson Center for Nutrition
- Gretna Public Schools
- Heart Ministry Center
- Heartland Hope Mission
- Learning Community Center of North Omaha
- Live Well Omaha Kids
- Lutheran Family Services of Nebraska
- Methodist Hospital Community Counseling Program
- Mid-America Council, Boy Scouts

- of America
- Millard Public Schools
- Nebraska Alliance of Child Advocacy Centers
- Nebraska Children's Home Society
- Nebraska Department of Health and Human Services, Division of Public Health, Maternal Child Adolescent Health Program
- Nebraska Early Childhood Collaborative, Early Childhood Services
- Nebraska Extension UNL
- Nebraska Foundation for Children's Vision (NFCV)
- Nebraska Legislature
- Nebraska Perinatal Quality Improvement Collaborative (NPQIC)
- Nebraska Total Care
- NorthStar Foundation
- Omaha Healthy Start
- Omaha Home for Boys
- Omaha Public Schools District
- Omaha Public Schools ESL, Refugee, and Migrant Education
- OneWorld Community Health Centers
- Papillion LaVista Community Schools
- Peter Kiewit Foundation
- Pottawattamie County WIC Program
- Project Everlast Omaha
- Project Harmony
- Ralston Public Schools
- Sarpy County Cooperative Head Start
- Saving Grace Perishable Food Rescue
- School-Based Health Centers
- Springfield Platteview Community Schools
- State Senate
- The Adolescent Health Project
- The Omaha Community Foundation
- United Way of the Midlands
- UNMC Department of Pediatrics
- Visiting Nurses Association
- Westside Community Schools
- YMCA of Greater Omaha
- Youth Emergency Services

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

Minority and other medically underserved populations represented:

abused/neglected children, African-Americans, Asians, autistic children, those with behavioral issues, Burmese population, Caucasians, children living in poverty, children with disabilities, those with medical conditions, children with congenital anomalies, families in the court system, the disabled, foster children/state wards, Hispanics, homeless children, immigrant/refugee children, Koreans, LGBTQ community, children living in low-income homes, those with medical comorbidities/medically complex conditions, Medicare/Medicaid recipients, the mentally ill, Native Americans, Nepalese individuals, non-English speaking children, pediatric transplant patients, single parents, Somalis, Sudanese people, teen parents, children of Thai ethnicity, undocumented children, the uninsured/underinsured

In the online survey, key informants were asked to rate the degree to which various children's 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 be 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 regarding participants' opinions and perceptions of the health needs of the children 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, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division for Adolescent and School Health
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Centers for Disease Control and Prevention, National High School Youth Risk Behavior Survey
- Community Commons
- Data Resource Center for Child & Adolescent Health, Child and Adolescent Health Measurement Initiative, National Survey of Children's Health
- Douglas County Health Department
- ESRI ArcGIS Map Gallery
- Geolytics Demographic Estimates & Projections
- Iowa Department of Public Health, Bureau of Health Statistics
- Nebraska Department of Health and Human Services
- OpenStreetMap (OSM)
- US Census Bureau, Decennial Census
- US Department of Health & Human Services

Note that secondary data reflect county-level data.

Benchmark Data

Trending

Similar surveys were administered in the Metro Area in 2012 and 2015 by PRC on behalf of Boys Town National Research Hospital, Children's Hospital & Medical Center, and Building Healthy Futures. 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 provided in comparison charts, are taken from the 2017 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. Vital statistics and other national data also are 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 the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error, but might be subject to reporting error) 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 community's 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 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 Health Services	<ul style="list-style-type: none"> • Difficulty Accessing Children’s Healthcare <ul style="list-style-type: none"> ◦ Finding a Physician ◦ Appointment Availability ◦ Lack of Transportation ◦ Cost of Prescriptions
Cognitive & Behavioral Conditions	<ul style="list-style-type: none"> • Autism Prevalence • Cognitive & Behavioral Conditions ranked as a top concern in the Online Key Informant Survey.
Diabetes	<ul style="list-style-type: none"> • Childhood Diabetes Prevalence
Injury & Violence	<ul style="list-style-type: none"> • Age 1-4 Mortality • Children Exposed to Neighborhood Violence • Children Feeling Unsafe at School or Going To/From School
Mental Health	<ul style="list-style-type: none"> • Symptoms of Depression [5-17] • Suicide Attempts [High Schoolers] • Diagnosed Anxiety [5-17] • Chronic Worrying [5-17] • Child Has Difficulty Sleeping [5-17] • Lived with Someone with Serious Mental Health Issues • Family Stays Hopeful in Difficult Times • Mental & Emotional Health ranked as a top concern in the Online Key Informant Survey.
Neurological Conditions	<ul style="list-style-type: none"> • Brain Injuries/Concussions
Oral Health	<ul style="list-style-type: none"> • Condition of Teeth
Nutrition, Physical Activity, & Weight	<ul style="list-style-type: none"> • Overweight & Obesity • Fast Food Consumption • Nutrition, Physical Activity, and Weight ranked as a top concern in the Online Key Informant Survey.
Sexual Health	<ul style="list-style-type: none"> • Gonorrhea Incidence [Children/Adults] • Chlamydia Incidence [Children/Adults] • Condom Use [High Schoolers] • Use of Birth Control [High Schoolers] • Sexual Health ranked as a top concern in the Online Key Informant Survey.

— continued on next page —

Tobacco, Alcohol & Other Drugs

- Member of Household Smokes
- Drinking & Driving [High Schoolers]
- Lifetime Illicit Drug Use [High Schoolers]
 - Steroids (not Rx)
 - Heroin

Vison, Hearing, & Speech Conditions

- Chronic Ear Infections
- Prevalence of Speech/Language Problems
- Hearing Problems

Community Feedback on Prioritization of Health Needs

On November 5, 2018, findings from this Community Health Needs Assessment (CHNA) were presented at Live Well Omaha's 2018 Changemaker Summit. The Changemaker Summit is the region's largest multi-sector health conference, which gathers more than 170 leaders from across Douglas, Sarpy, Cass and Pottawattamie Counties to celebrate the milestones of our collective work and advance future work while learning from local, regional and national experts. At this event, Professional Research Consultants, Inc. (PRC) highlighted data reflecting the significant health issues identified from the research (see Areas of Opportunity above). In addition, data was also shared specific to a Forces of Change Assessment, a Local Public Health Systems Assessment, and a Community Strengths and Themes Assessment (see *Mobilizing Action through Planning and Partnerships* in the section that follows).

Following the presentation, attendees broke into small groups for reflection and sharing, structured around the following questions:

- What stood out to you in the data, and why?
- Why is this important to the health of those facing the greatest inequities?
- Where are themes beginning to align for action?
- How do the facts align between the numbers and the story told by the additional assessments completed by the health department?

Once reconvened, the small groups shared an overview of their discussions with the larger group. Then, attendees were provided an explanation of the prioritization exercise that followed. In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings of health issues using a small remote keypad.

Individuals' ratings yielded the following prioritized list of community health needs for children and adolescents in the Metro Area:

1. **Mental Health**
2. **Nutrition, Obesity & Physical Activity**
3. **Access to Health Services**
4. **Sexual Health**
5. **Tobacco, Alcohol & Other Drugs**

Organizations sponsoring or supporting this CHNA will use the information from this Community Health Needs Assessment to develop implementation strategies to address the significant health needs in the community. The results of this prioritization exercise will be used to inform the development of action plans to guide community health improvement efforts in the coming years.

Mobilizing Action through Planning and Partnerships

Douglas County Health Department and Children's Hospital & Medical Center partnered to facilitate a series of strategic assessments by using the Mobilizing for Action through Planning and Partnerships (MAPP) process. This framework applies strategic thinking to the priority health issues to identify resources to meet the challenges and opportunities. By using this process in concert with the CHNA data, our community is positioned to improve the efficiency and effectiveness of local public health systems across the region.

Insufficient Infrastructure leads to Disconnected and Siloed Health and Public Health System	Inequity and Disparities in Delivery of Healthcare and Prevention Programs	Inconsistent Infrastructure, Dissemination, and Use of Health Data	Our Collective Limiting Beliefs Prevent us from Being Innovative	Barriers in Access to Healthcare Services	Gaps in Services and Infrastructure to Support Behavioral Health Needs in our Community
As a community, we need to identify and address the root cause contributors to health (e.g., poverty, social determinants of health).	Inequity exists in the way that we deliver health care and prevention programs to diverse populations.	Data are not disseminated or translated to the community level, limiting access for decision-making.	Fear (of culture change, of disrupting status quo, of not having a unified plan, of failure, etc.) prevents us from being innovative in our work.	Barriers in access to our health system exist including difficulties related to navigation, coordination, and referrals.	Need to increase our behavioral health workforce.
There is an opportunity for increased collaboration for health and public health research.	Our diverse community population is not served at the same standard.	Improve the use of technology related to the utilization and sharing of data (e.g., integrated registries, real time data, and GIS mapping).	Barriers exist related to implementation of and response to technology (e.g., EHR) and innovation (e.g., telehealth) in healthcare that impact access, cost, and efficiency.	Access to care – insufficient socioeconomic supports, cost awareness, and workforce support lead to ongoing problems with access to care in our community.	Pervasive experience of trauma by community members impacts all sectors.
Insufficient system infrastructure (aligned vision, engagement, sustainability, broad partnerships, coordination) to create meaningful and measurable change around a specific topic.	Our community is not addressing greater social needs through policies and built environment improvement opportunities.	We have an opportunity to improve evaluation of our community-based work.	Recognition of a need to prepare our community for the impact of climate change.	Access to health services • Difficulty accessing healthcare for children	Recognition of behavioral health as a community health issue and the need for increased funding to address the problems.
Disconnected and Siloed Health, Public Health, and Community Efforts (no clear unified vision across the community)	Continue to address and create change around the "isms" (e.g., racism, sexism, classism) in our community and how they impact health.	Difficulty Demonstrating Community Health Outcomes (barriers to accessing data)	Environmental support (green space, climate change, recreation)	Access to healthcare services • Specific source of ongoing medical care • Emergency room utilization	Mental Health (depression, suicide attempts, anxiety, chronic worrying)
Funding Models that are not Responsive to Community Need and Capacity	A need to continue to recognize and respond to our community's diversity (aging, refugees, immigrants, LGBTQ, etc.) through appropriate cultural and linguistic competence.		Hope for the future / commitment to sustain and hold responsibility for the future		Tobacco, Alcohol & other drugs
Our local public health ecosystem is underfunded and under-supported (e.g., finances, policy, and influence).	Equity within & across all spectra: housing, education, healthcare, food access, neighborhood resources, green space.				Cognitive & Behavioral Conditions
Need to improve the diversity of and cultural competence of our health and public health workforce.	Stability & prosperity (financial / economic to ensure equitable access to all things)				Mental Health (suicide deaths)
There are opportunities to improve cross sector sharing of information and communication to our community.					Substance Abuse
Our communication focuses on health and public health threats / hazards rather than positive outcomes or health improvements (e.g., community health improvement plan not communicated).					

Inadequate Engagement of Community Members	No Collective Strategic Policy Agenda for Health and Public Health	Chronic Disease & Risk Factors	Injury & Violence	Sexual Health	Screening & Early Childhood
We need to work together to engage the true community in the development, implementation, and evaluation of our work.	Need for a common policy agenda and improved advocacy for health and public health.	Childhood diabetes prevalence	Injury & violence	Sexual Health	Oral Health – condition of teeth
We are not fully engaging our community leaders around health.	We are not fully engaging our community leaders around health.	Nutrition, Physical Activity, and Weight	Brain Injuries / Concussions	Sexually Transmitted Diseases	Vision, Hearing & Speech Conditions
Focus on inclusion that builds trust in our neighborhoods to help build social connections and buy in.	The current policy climate and political uncertainty impact how we do or don't do business.	Cancer • Leading cause of death	Injury & Violence		
Social connectedness: diversity / inclusion / neighborhoods		Diabetes	Safety (housing, neighborhoods, crime)		
		Nutrition, Physical Activity, & Weight			
		Dementia, including Alzheimer's Disease			
		Heart Disease & Stroke			
		Respiratory Diseases			

Forces of Change Assessment	Local Health & Public Health Systems Assessment	Community Themes and Strengths Assessment / Community Voice	Adult Community Survey	Child & Adolescent (Parent) Community Survey
-----------------------------	---	---	------------------------	--

TREND SUMMARY

(Current vs. Baseline Data)

Survey Data Indicators:

Trends for survey-derived indicators represent significant changes since 2012 (or 2015, for questions not asked in 2012).

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).

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. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables





























































































- In the following tables, 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.








Social Determinants	Disparity Within Douglas County					Disparity Among Counties			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	
Linguistically Isolated Population (Percent)						4.6	1.1	1.7	3.5	3.1	1.8	4.5		
Children Below 200% FPL (Percent)						39.9	23.8	36.8	35.9	38.5	36.4	43.3		
% Worry/Stress Over Rent/Mortgage in Past Year	44.1	48.5	28.1	23.0	24.4	34.0	26.2	34.3	32.4			39.2		
% Rundown Housing in Neighborhood	46.3	28.8	12.9	9.7	3.4	21.2	11.3	25.0	19.4	13.4	11.6	13.3		
% Vandalism in Neighborhood	27.9	18.9	7.7	6.9	0.0	13.3	3.8	8.6	10.8	4.9	4.8	7.7		
% Experienced Unhealthy Housing Conditions in Past Year	19.7	14.4	8.3	3.4	3.9	10.1	8.3	10.0	9.7					
% Have Enough Savings to Fully Cover Emergency Expense	66.4	75.5	79.4	91.2	91.8	80.2	80.5	71.8	79.4					
% Child Ever Lived w/ Someone w/ Serious Mental Hlth Issues	19.9	13.0	9.5	9.5	5.0	12.0	12.6	24.5	13.4	10.1	9.6	7.8		
% 2+ Household Adults Involved in Care of Child	76.5	85.6	86.4	90.8	95.7	86.2	87.0	83.0	86.0					
	Note: In the green section, each subarea 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.													
											better similar worse			

























Overall Health	Disparity Within Douglas County					Disparity Among Counties			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 Activities/Abilities Limited Due to Health Condition	13.7	7.0	8.3	7.6	9.9	9.0	6.5	15.8	9.1	11.5			8.2	
% [Age 5-17] Missed 10+ School Days Last Yr Due to Illness/Injury	12.6	3.0	4.6	7.5		6.9	7.8	14.5		7.9	5.3			7.3
% [Age 0-17] Child Has Special Health Needs	61.8	58.4	66.5	53.7	68.5	60.4	67.8	67.6	62.7		62.8			62.3
% [Age 0-17] Condition Requiring Meds	40.5	28.3	32.8	24.0	33.2	30.8	32.2	37.7		31.8	28.9			29.6
% [Age 0-17] Condition Requiring Special Therapy	10.8	11.7	8.9	11.3	23.3	11.5	9.2	12.3	11.1		12.7			9.4
	Note: In the green section, each subarea 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 similar worse</div>				










Access to Health Services	Disparity Within Douglas County					Disparity Among Counties			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 Is Uninsured	4.0	4.9	0.8	5.3	1.7	3.6	5.5	0.0	3.7	5.9			0.0	4.4
% [Age 0-17] Child Has Been Without Insurance At Some Point	18.3	12.6	7.2	6.3	5.3	10.1	10.4	7.0		9.8	13.0			
% [Insured] Deductible Prevented Needed Health Care/Past Yr	7.5	12.7	7.1	10.4	1.8	9.0	10.1	2.9	8.6					









Access to Health Services (continued)	Disparity Within Douglas County					Disparity Among Counties			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] Difficulty Finding Physician for Child in Past Year	 6.0	 4.7	 3.9	 6.9	 1.7	 5.2	 4.6	 9.7	5.5			 9.8		 3.5
% [Age 0-17] Difficulty Getting Appointment for Child in Past Year	 12.0	 6.6	 8.8	 10.4	 8.7	 9.4	 5.1	 17.5	9.3			 16.4		 5.8
% [Age 0-17] Cost Prevented Child's Dr Visit in Past Year	 5.3	 5.8	 4.6	 6.0	 5.4	 5.4	 5.3	 3.8	5.2			 8.6		 4.8
% [Age 0-17] Transportation Hindered Child's Dr Visit in Past Year	 9.6	 12.0	 2.0	 5.7	 4.1	 6.8	 2.9	 14.1	6.7			 5.6		 2.6
% [Age 0-17] Cost Prevented Getting Child's Prescription in Past Year	 4.7	 8.8	 4.3	 5.5	 8.9	 6.0	 5.2	 9.5	6.2			 7.2		 3.6
% [Age 0-17] Culture Difference Prevented Child's Dr Visit in Past Year	 3.5	 3.5	 0.0	 2.4	 0.0	 2.1	 1.3	 3.5	2.1			 3.9		 1.5
% Parent Could Have Used Help Coordinating Child's Care/Past Yr	 23.8	 13.9	 11.7	 11.8	 6.2	 14.2	 14.7	 16.7	14.5					
% Child Needed to See a Specialist in the Past Year	 33.5	 32.8	 40.1	 30.4	 35.3	 34.2	 29.8	 35.1	33.4			 34.4		 29.5
% [Child Needing Care] "Major/Moderate" Problem Getting Specialty Care						 22.4	 14.5		21.4			 43.0		 19.9
% [Age 0-17] Child Has Had Routine Checkup in Past Year	 94.9	 85.6	 89.1	 80.8	 87.6	 85.2	 82.0	 84.2	84.4			 85.7		 84.2



Access to Health Services (continued)	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
% [Age 0-17] Child Has Had 2+ ER Visits in Past Year	 12.5	 11.6	 5.7	 14.0	 5.6	 10.5	 3.9	 8.4
% [Age 0-17] Child Used Some Type of UCC in the Past Year	 27.2	 36.7	 30.7	 36.7	 36.8	 33.4	 39.7	 47.2
Note: In the green section, each subarea 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.								
























































Metro Area	Metro Area vs. Benchmarks				TREND
	vs. NE	vs. IA	vs. US	vs. HP2020	
8.9			 9.8		 10.0
36.2			 37.6		 32.4
 better  similar  worse					
















Allergies	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
% [Age 0-17] Child Has Respiratory Allergies	 19.4	 20.0	 18.1	 9.5	 17.2	 16.3	 19.5	 19.3
% [Age 0-17] Child Has Eczema/Skin Allergies	 33.4	 14.1	 25.4	 19.0	 12.3	 21.8	 18.9	 18.1
% [Age 0-17] Child Has Food/Digestive Allergies	 11.9	 5.8	 6.0	 4.2	 0.0	 6.2	 9.8	 8.7
Note: In the green section, each subarea 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.								




















































Metro Area	Metro Area vs. Benchmarks				TREND
	vs. NE	vs. IA	vs. US	vs. HP2020	
17.3			 21.7		 18.3
20.8			 22.5		 20.4
7.2			 11.8		 7.5
 better  similar  worse					














Asthma	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
% [Age 0-17] Child Currently Has Asthma	 14.8	 11.4	 7.9	 2.7	 6.5	 8.4	 10.3	 10.3





















































Metro Area	Metro Area vs. Benchmarks				TREND
	vs. NE	vs. IA	vs. US	vs. HP2020	
9.0			 12.8		 8.7




















Child Development	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
% Child Developmentally On Track	 90.1	 93.7	 97.3	 90.1	 89.3	 92.6	 90.8	 89.0
% Parent Has Enough Information to Know if Child is on Track	 95.3	 95.5	 98.9	 95.1	 98.3	 96.4	 97.6	 95.9
% Family Talks Together "All of the Time" Through Problems	 54.8	 48.5	 61.0	 54.4	 49.0	 54.5	 54.8	 51.5
% Family Works Together "All of the Time" Through Problems	 49.6	 46.1	 56.6	 51.1	 51.7	 51.1	 50.4	 46.1
% Family Knows It Can Use Strengths "All of the Time" w/ Problems	 62.2	 47.9	 64.5	 59.9	 62.5	 59.1	 60.7	 48.4
% Family Stays Hopeful "All of the Time" in Difficult Times	 51.1	 45.6	 54.0	 48.4	 53.0	 49.9	 52.5	 44.8
% [Age 6Mos-5Yrs] "Always/Usually" Bounce Back with Challenge								
% [Age 6-17] "Always/Usually" Stay Calm with Challenge	 69.8	 74.4	 77.5	 85.2		 78.2	 77.8	 69.5
Note: In the green section, each subarea 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.								


























































Metro Area	Metro Area vs. Benchmarks				TREND
	vs. NE	vs. IA	vs. US	vs. HP2020	
91.9					
96.6					
54.2	 40.6	 43.6	 46.6		
50.5	 41.3	 43.6	 47.2		
58.4	 44.4	 49.8	 52.3		
50.0	 50.1	 49.1	 55.8		
85.1					
77.3					
 better  similar  worse					



















Cognitive & Behavioral Disorders	Disparity Within Douglas County					Disparity Among Counties			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 ADD/ADHD	 19.3	 8.7	 10.9	 6.8	 10.9	 10.8	 9.4	 15.9	11.1		 12.7		 9.4	
% [Age 0-17] Child Has Learning Disability	 11.2	 6.0	 5.8	 4.8	 7.7	 6.7	 7.2	 14.4		7.6		 12.1		 8.2
% [Age 0-17] Child Has Developmental Delays	 6.2	 6.8	 3.9	 5.9	 3.5	 5.5	 6.8	 11.4	6.4			 9.3		 6.5
% [Age 5-17] Child Has Behavioral/Conduct Problems	 7.3	 2.0	 4.8	 3.5		 4.0	 3.2	 9.6		4.4		 5.3		 5.1
% [Age 5-17] Child Has Autism/Spectrum Disorder	 2.9	 6.0	 3.0	 2.8		 3.7	 5.5	 3.8	4.1			 5.2		 1.8
	Note: In the green section, each subarea 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.										 better	 similar	 worse	
































































Diabetes	Disparity Within Douglas County					Disparity Among Counties			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	 4.2	 0.3	 1.7	 1.4	 0.0	 1.7	 1.1	 1.3	1.5	 3.6			 0.4	
Note: In the green section, each subarea 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>					






















Health Education	Disparity Within Douglas County					Disparity Among Counties			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	 11.6	 6.3	 11.8	 9.7	 9.0	 9.8	 9.7	 7.8	9.6					 7.5
% [Parents] "Extremely" Confident Accessing Health Info for Child	 81.7	 71.6	 74.7	 82.8	 90.4	 78.6	 87.4	 84.9						81.2
% [Parents] "Extremely" Confident Accessing Activity Info for Child	 65.3	 53.1	 68.1	 77.0	 88.5	 68.3	 74.1	 68.1	69.5					
% [Parents] "Extremely" Confident Meeting Child's Emotional Needs	 73.6	 67.5	 72.4	 76.8	 85.4	 73.6	 78.6	 73.2	74.6					
% [Parents] "Extremely" Confident in Meeting Child's Physical Needs	 79.2	 74.9	 84.3	 86.6	 96.6	 82.7	 90.6	 82.6	84.4					
% [Parents] "Extremely" Confident in Meeting Child's Social Needs	 65.4	 66.7	 73.2	 74.5	 88.6	 71.7	 72.8	 73.8	72.1					
	Note: In the green section, each subarea 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.								 better  similar  worse					

Injury & Safety	Disparity Within Douglas County					Disparity Among Counties			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	 13.6	 9.8	 11.7	 9.1	 15.3	 11.1	 13.8	 12.8	11.9	 12.7			 15.1	
% [Age 5-17] Child "Always" Wear a Bike Helmet	 33.7	 37.5	 46.1	 52.7		 44.4	 47.3	 27.7		43.3	 45.9			 40.3

Injury & Safety (continued)	Disparity Within Douglas County					Disparity Among Counties			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] Neighborhood Is "Slightly" or "Not At All" Safe	 41.3	 24.1	 6.3	 4.1	 2.3	 15.9	 3.6	 11.4	12.8	 15.3			 10.2	
% Child Exposed to Neighborhood Violence (Ever)	 16.5	 10.4	 6.6	 5.4	 0.0	 8.5	 6.3	 12.6	8.5	 3.7	 5.3	 3.9		
% Children "Never" Play in Playgrounds/Parks in Neighborhood	 12.9	 3.5	 3.1	 2.5	 5.9	 5.0	 4.8	 10.9	5.5					
% [Age 5-17] Child Missed School in Past Year Because Felt Unsafe	 12.6	 15.4	 7.4	 4.1		 8.6	 8.0	 3.8	7.9	 7.8			 1.8	
% [Age 5-17] Bullied in the Past Year	 24.1	 14.3	 27.7	 12.7		 18.7	 19.1	 24.5	19.4				 21.2	
% Discussed Water Safety w/ Hlth Professional	 41.8	 41.3	 58.1	 37.8	 50.2	 45.2	 49.3	 37.6	45.3					
	Note: In the green section, each subarea 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>				

Mental & Emotional Health	Disparity Within Douglas County					Disparity Among Counties			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"	 8.4	 8.7	 5.7	 3.1		 5.7	 3.4	 11.2	5.8		 10.3		 7.9	
% [Age 5-17] Child Has Depression	 10.0	 7.1	 6.7	 6.0		 7.3	 6.7	 10.6	7.5		 7.2		 6.1	

Mental & Emotional Health (continued)	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
% [Age 5-17] Child Had Symptoms of Depression in Past Year	 8.1	 2.4	 2.9	 4.6		 4.6	 2.5	 9.9
% [Douglas County High Schoolers] Attempted Suicide in Past Year								
% [Age 5-17] Child Has Anxiety	 13.7	 12.5	 18.0	 12.2		 13.8	 10.6	 19.4
% [Age 5-17] Child Worries A Lot	 32.0	 32.0	 32.9	 29.5		 30.6	 25.3	 28.0
% [Age 5-17] Child Has Difficulty Sleeping	 22.1	 16.5	 23.6	 19.2		 19.9	 14.6	 23.4
% [Age 5-17] Parent Aware of Community Mental Health Resources	 79.8	 60.1	 83.1	 77.9		 76.3	 85.1	 75.1
% [Age 5-17] Needed Mental Health Svcs in the Past Yr	 18.2	 11.8	 14.3	 12.9		 14.1	 13.8	 21.2
% [Age 5-17] Child Has Ever Taken Rx for Mental Health	 10.0	 11.5	 10.9	 9.0		 10.5	 9.4	 19.1
% [Age 5-17] Child Rec'd Professional Treatment/Counseling in Past Yr	 16.5	 10.2	 14.3	 12.4		 13.1	 12.2	 21.2
% [Age 5-17] Has Adult Outside Household for Advice/Guidance	 94.5	 95.3	 99.6	 94.1		 96.1	 97.1	 95.3
Note: In the green section, each subarea 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.								

























































































Metro Area	Metro Area vs. Benchmarks				
	vs. NE	vs. IA	vs. US	vs. HP2020	TREND
4.7			 5.7		 2.0
13.0			 7.4		 12.4
13.7			 13.4		 10.1
29.2			 27.1		 21.9
19.1			 18.7		 10.2
78.1			 60.5		 67.2
14.8			 13.6		 13.6
11.1			 10.0		 13.7
13.8			 10.8		 12.7
96.2					
 better  similar  worse					




































































Mortality	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
[Age 1-4] Mortality Rate per 100,000								
[Age 5-9] Mortality Rate per 100,000								
[Age 10-14] Mortality Rate per 100,000								
[Age 15-19] Mortality Rate per 100,000								
Note: In the green section, each subarea 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.								















































Metro Area	Metro Area vs. Benchmarks				TREND
	vs. NE	vs. IA	vs. US	vs. HP2020	
27.3	28.6	28.5	24.8	25.7	
10.5	12.5	10.1	11.8	12.3	
12.6	11.8	17.4	14.4	15.2	
46.1	47.4	41.1	48.3	55.7	
better similar worse					
























Neurological Disorders	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
% [Age 0-17] Child Has Migraines/Severe Headaches	12.8	4.9	6.8	3.9	12.6	7.1	7.0	4.0
% [Age 0-17] Child Has Brain Injury/Concussion	6.1	3.6	4.8	2.8	10.2	4.6	4.7	4.9
% [Age 0-17] Child Has Epilepsy/Seizure Disorder	3.8	2.1	2.7	1.8	1.7	2.5	0.0	3.0
Note: In the green section, each subarea 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.								





Metro Area	Metro Area vs. Benchmarks				TREND
	vs. NE	vs. IA	vs. US	vs. HP2020	
6.7			8.6		5.4
4.6			3.6		2.5
2.0			3.1		1.5
better similar worse					
























Nutrition, Physical Activity & Weight	Disparity Within Douglas County					Disparity Among Counties			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] Daily 5+ Servings of Fruits/Vegetables in Past Week	 46.8	 46.1	 32.6	 29.9	 34.7	 37.6	 29.2	 29.2	34.9					
% "Very/Somewhat" Difficult to Buy Fresh Produce	 30.8	 25.8	 21.2	 12.9	 17.0	 21.4	 17.6	 30.9	21.5			 32.6		 28.2
% [Age 2-17] Child Ate 3+ Fast Food Meals in Past Week	 26.5	 23.4	 28.3	 29.7	 14.6	 26.2	 26.2	 30.8	26.5			 27.6		 19.9
% [Age 2-17] Ate 7+ Meals Together as a Family in Past Week	 51.1	 68.0	 43.5	 40.8	 44.7	 49.5	 48.2	 55.3	49.8			 46.2		
% [Age 2-17] Daily 1+ Serving of Sugar-Sweetened Beverages	 26.1	 29.5	 13.0	 18.4	 10.1	 20.4	 20.5	 28.8	21.2					
% [Age 2-17] Child Was Physically Active One Hour/Day in Past Week	 57.8	 62.8	 52.0	 51.0	 65.0	 56.0	 53.2	 46.8	54.5			 45.3		 52.7
% [Age 5-17] Daily 2+ Hours Screen Time	 46.5	 36.8	 42.6	 44.1		 42.6	 47.1	 51.6	44.5					
% [Age 5-17] Child Is Overweight or Obese	 40.8	 43.4	 34.9	 29.0		 35.1	 34.4	 43.1	35.9			 32.6		 30.2
% [Age 5-17] Child Is Obese	 22.9	 34.9	 25.2	 18.7		 24.1	 19.0	 22.9	22.8			 18.2	 14.5	 17.1
% [Parents] Have Been Told That Overwt Child [5-17] Is Overweight						 35.1	 14.4		28.0			 22.4		 8.2
Note: In the green section, each subarea 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  similar  worse </div>														

















Oral Health	Disparity Within Douglas County					Disparity Among Counties			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 1-17] "Fair/Poor" Rating of Teeth	 14.7	 14.7	 9.3	 5.8	 2.1	 10.1	 7.1	 11.2	9.5	 4.9	 3.6	 5.5		
% [Age 1-17] Chronic Toothaches in Past Year	 11.5	 6.6	 4.8	 2.6	 2.0	 5.7	 3.1	 5.7	5.1					
% [Age 1-17] Cavities/Decayed Teeth in Past Year	 14.3	 9.1	 9.7	 5.5	 9.7	 9.2	 7.5	 15.4	9.5	 9.6	 8.6	 11.7		
% [Age 1-17] Dental Visit in the Past Year	 84.7	 75.5	 82.8	 88.6	 86.6	 83.5	 79.7	 86.8	83.0	 83.2	 84.0	 81.2		
% [Dental Visit] Preventive Visit	 92.5	 97.5	 99.2	 98.4		 97.2	 97.6	 93.8	96.9					
% [Age 1-17] Difficulty Accessing Dental Care for Child in Past Yr	 6.9	 8.2	 2.8	 4.9	 4.7	 5.5	 5.2	 13.2	6.2					
% [Age 1-17] Dental Insurance	 87.4	 93.9	 92.4	 84.4	 89.8	 89.4	 89.1	 88.8	89.3					
	Note: In the green section, each subarea 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.													
											 better	 similar	 worse	















































Prenatal & Infant Health	Disparity Within Douglas County					Disparity Among Counties			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
% Inadequate Prenatal Care						 16.3	 12.0							
% of Low Birthweight Births						7.8								
% [Age 0-17] Child Was Ever Breastfed	 66.5	 76.9	 82.2	 77.5	 73.8	 76.2	 76.6	 68.9	75.5	 72.6		 81.9	 74.8	
% Exclusively Breastfed Until 6 Months	 30.7	 34.4	 35.2	 38.8	 35.3	 35.2	 33.3	 25.2	33.7	 29.1		 25.5	 30.6	
Infant Death Rate						 6.4	 5.1	 7.6	6.2	 5.8	 5.1	 5.9	 6.0	
[Douglas County] Neonatal Death Rate									4.5			 4.1		
[Douglas County] Postneonatal Mortality Rate									2.6			 2.0		
% Would Not Want New Baby to Have All Recommended Vaccines	 9.9	 5.2	 4.5	 9.2	 9.3	 7.3	 5.7	 8.6	7.1	 12.5			 5.3	
	Note: In the green section, each subarea 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 similar worse</div>													

















Sexual Activity	Disparity Within Douglas County					Disparity Among Counties			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	
% Births to Teenagers (Under Age 20)						 4.7	 2.6			4.6	4.6			
[All Ages] Gonorrhea Incidence per 100,000						 195.8		 96.0	142.8	 78.1	 53.1	 110.7	 115.4	
[All Ages] Chlamydia Incidence per 100,000						 734.1		 460.5	546.8	 399.6	 382.0	 456.1	 468.6	
% [Douglas County High Schoolers] Currently Sexually Active									18.3			 28.7	 20.8	
% [Sexually Active Douglas County High Schoolers] Did Not Use Condom									41.4			 46.2	 38.8	
% [Sexually Active Douglas County High Schoolers] Did Not Use Any Birth Control									15.8			 13.8	 19.1	
	Note: In the green section, each subarea 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	Disparity Within Douglas County					Disparity Among Counties			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
% [Douglas County High Schoolers] Drank Alcohol in Past Month									23.2		 29.8		 24.0	
% [Douglas County High Schoolers] Drove When Drinking in Past Month									10.5		 5.5		 9.1	

Substance Abuse (continued)	Disparity Within Douglas County					Disparity Among Counties			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
% [Douglas County High Schoolers] Ever Used Marijuana									25.5		 35.6		 30.4	
% [Douglas County High Schoolers] Ever Used Prescription Drugs (Not Rx)									11.3		 14.0		 15.5	
% [Douglas County High Schoolers] Ever Used Inhalants									4.0		 6.2		 8.1	
% [Douglas County High Schoolers] Ever Used Ecstasy									3.4		 4.0		 4.5	
% [Douglas County High Schoolers] Ever Used Cocaine (Any Form)									4.2		 4.8		 4.2	
% [Douglas County High Schoolers] Ever Used Steroids (Not Rx)									2.6		 2.9		 2.2	
% [Douglas County High Schoolers] Ever Used Methamphetamines									2.3		 2.5		 4.3	
% [Douglas County High Schoolers] Ever Used Heroin									2.1		 1.7		 1.7	
% [Douglas County High Schoolers] Ever Used Injection Drugs									1.3		 1.5		 3.3	
% [Douglas County High Schoolers] Used Marijuana in Past Month									14.7		 19.8		 16.2	
	Note: In the green section, each subarea 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>					

Tobacco	Disparity Within Douglas County					Disparity Among Counties			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
% Member of Household Smokes	 30.9	 15.6	 17.2	 18.8	 10.6	 19.5	 17.5	 23.1	19.4	 18.0	 17.4	 15.5		
% [Douglas County] Tobacco Use During Pregnancy									7.4					
% [Douglas County High Schoolers] Smoked Cigarettes in Past Month									7.5	 8.8			 11.0	
	Note: In the green section, each subarea 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>					

Vision, Hearing & Speech	Disparity Within Douglas County					Disparity Among Counties			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)	 20.0	 23.1	 21.8	 21.5	 43.6	 23.1	 28.6	 21.3	24.1		 17.9		 28.7	
% [Age 0-17] Child Has Speech/Language Problems	 13.8	 13.7	 10.6	 16.6	 14.7	 13.8	 17.2	 16.9	14.9		 14.7		 10.8	
% [Age 0-17] Child Has Hearing Problems	 12.0	 4.3	 7.5	 5.4	 2.1	 6.7	 3.2	 13.0	6.6		 6.8		 3.5	
% [Age 0-17] Child Has Vision Problems	 25.3	 29.0	 24.8	 28.6	 20.1	 26.6	 22.8	 31.3	26.2					
% Difficulty Accessing Vision Care for Child in Past Year	 6.5	 4.5	 3.9	 5.1	 0.0	 4.6	 2.5	 3.2	4.0					

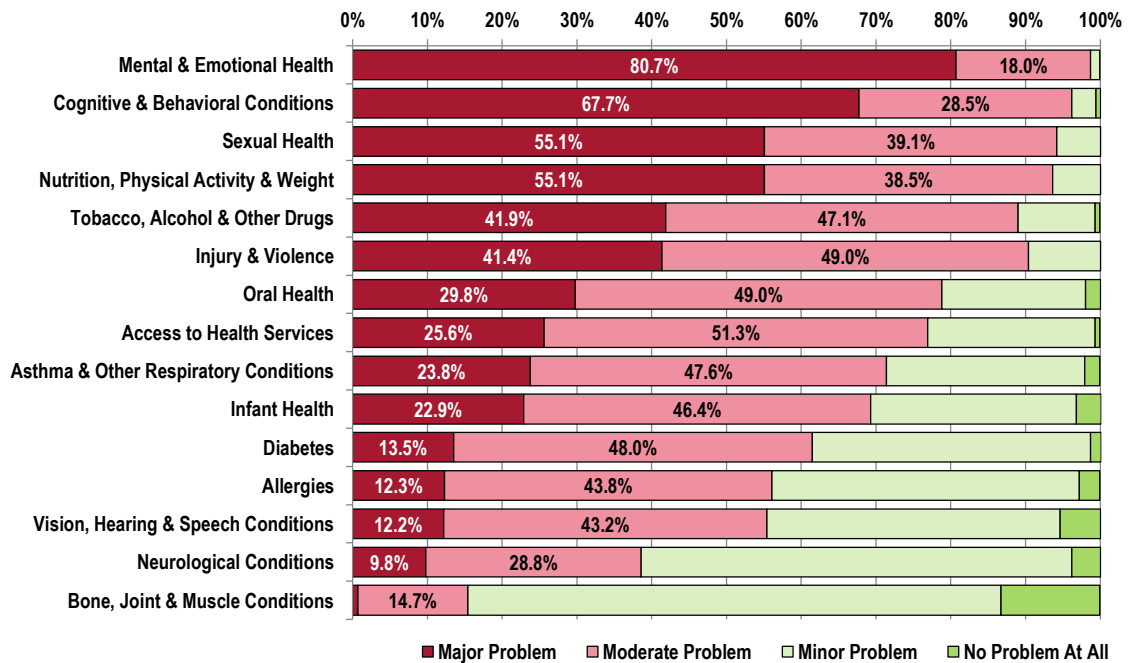
Vision, Hearing & Speech (continued)	Disparity Within Douglas County					Disparity Among Counties		
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County
% [Age 0-17] Child Has Had an Eye Exam in the Past 3 Years	 73.5	 73.4	 66.0	 74.3	 77.4	 72.1	 67.9	 74.2
% [Age 0-17] Child Has Had Hearing Tested in the Past 5 Years	 85.7	 90.4	 82.9	 85.2	 90.3	 86.1	 83.3	 87.6
Note: In the green section, each subarea 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.								

Metro Area	Metro Area vs. Benchmarks				TREND
	vs. NE	vs. IA	vs. US	vs. HP2020	
71.4			 82.3		 84.0
85.7			 85.2		 72.1
 better  similar  worse					

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 15 health issues is a problem for children and/or adolescents in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)

Key Informants: Relative Position of Health Topics as Problems in the Community



Perceptions of Top Health Issues



Professional Research Consultants, Inc.

Child Health

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?”

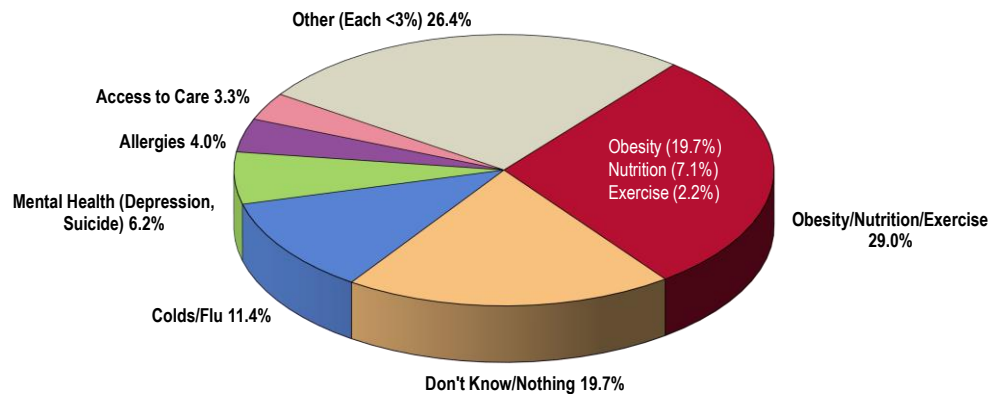
This question was open-ended, meaning that respondents were free to mention whatever came to mind, and their verbatim responses were recorded. These responses were then grouped thematically for reporting here.

The interrelated issues of **obesity, nutrition, and exercise** received the largest share of responses (29.0%) from parents as the perceived number-one health issue for children under the age of 12.

Responses of “don’t know” or “nothing” came second with 19.7% of responses.

- Respondents also frequently identified **colds/flu** (mentioned by 11.4%), **mental health issues** (6.2%), **allergies** (4.0%), and **access to care** (3.3%)

Perceived Number-One Health Issue Affecting Children Under 12 in the Community
(Among Metro Area Parents With a Child Age 0-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Reflects total sample of respondents.

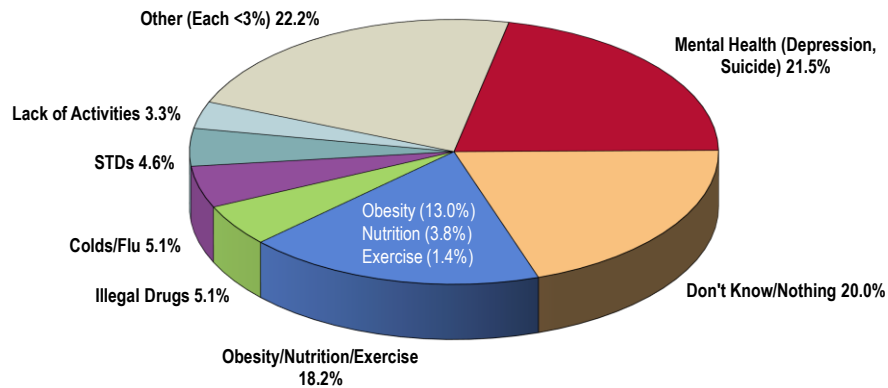
Adolescent Health

"In general, what do you feel is the number-one health issue affecting adolescents age 12-17 in your community today?"

Mental health issues received the largest share of responses (21.5%) when parents were asked to name the number-one health issue for adolescents (age 12-17).

- Other frequent responses included **don't know/nothing** (mentioned by 20.0%), the combination of **obesity/nutrition/exercise** (18.2%), **illegal drugs** (5.1%), **cold/flu** (5.1%), **STDs** (4.6%), and **lack of activities** (3.3%).

Perceived Number-One Health Issue Affecting Adolescents (12-17) in the Community
(Among Metro Area Parents With a Child Age 0-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 7]
Notes: • Reflects the total sample of respondents.

Current Health Status



Professional Research Consultants, Inc.

Overall Health Status

Activity Limitations

NOTE:

Differences noted in the text represent significant differences determined through statistical testing.

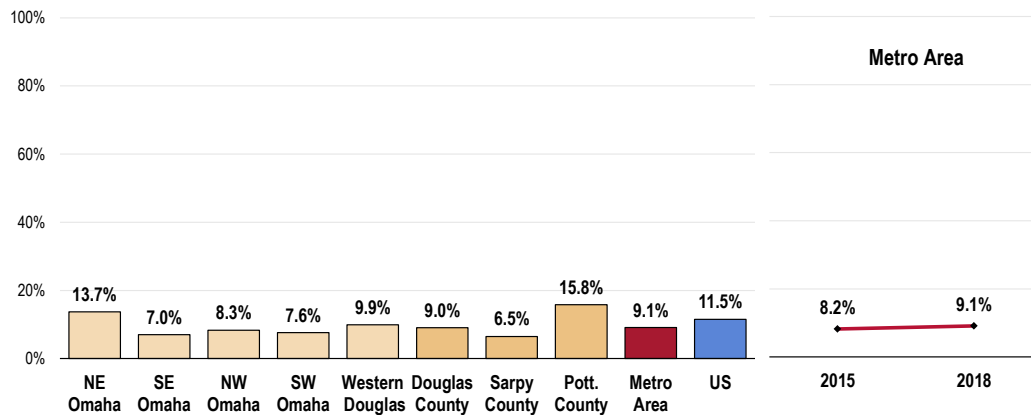
The terms "child" and "children" are used throughout this report to refer to children and adolescents of all ages (0-17), unless otherwise specified.

Although survey respondents are often referred to as "parents" throughout this report, they may in fact be a grandparent or other guardian for a child in the household.

A total of 9.1% of Metro Area children are limited or prevented in some way in his/her 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 figure.
- Statistically similar by area within Douglas County.
- By Metro Area county, activity limitations are highest in Pottawattamie County.
- TREND: No significant change since first measured in 2015.

Prevalence of Activity Limitations



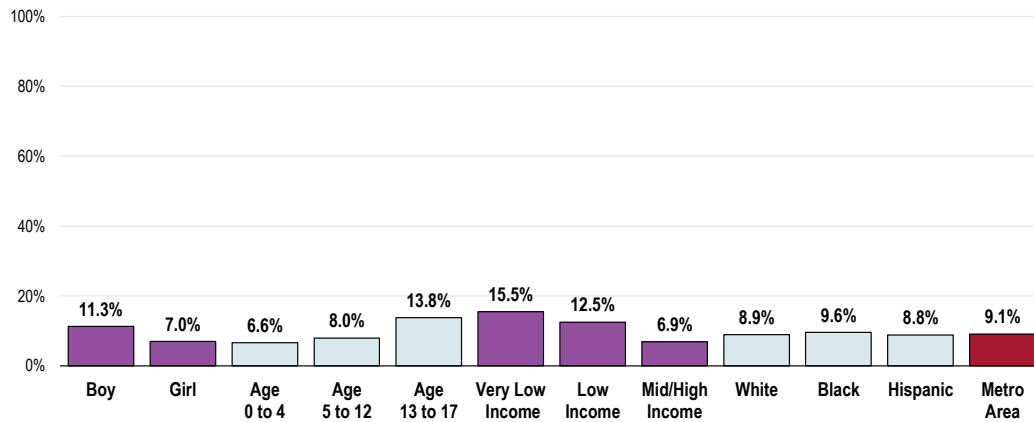
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 66]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

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

- Boys.
- Teenagers (age 13-17; note the correlation with age).
- Children in very low-income households.

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.

Prevalence of Activity Limitations (Metro Area, 2018)

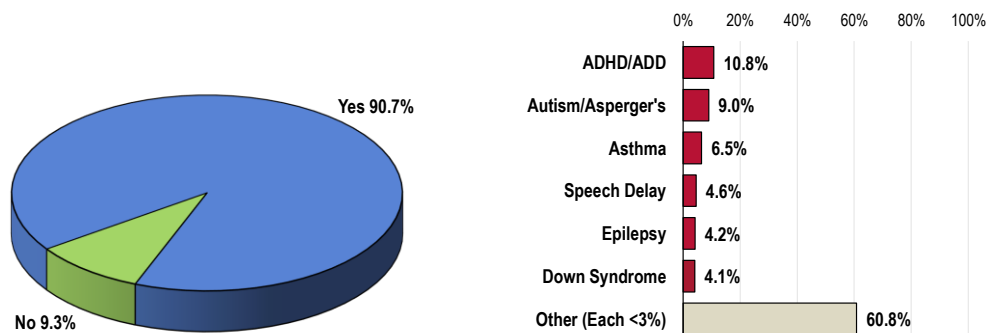


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 66]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

For children with activity limitations, the vast majority (90.7%) is living with a condition that is expected to last 12 months or more.

Activity limitations among Metro Area children are most often attributed to conditions such as **ADHD/ADD** (mentioned by 10.8% of parents of children with activity limitations), **autism/Asperger syndrome** (9.0%), **asthma** (6.5%), **speech delay** (4.6%), **epilepsy** (4.2%), and **Down syndrome** (4.1%).

Description of Activity Limitations (Among Children With Activity Limitations; Metro Area, 2018)



Activity Limitation Is the Result of a Long-Term Condition

Type of Problem that Most Limits Activities
 (Includes only those respondents who could name the problem)

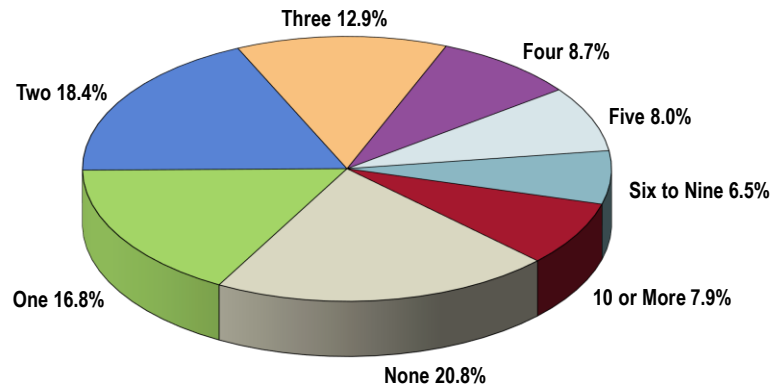
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 67-68]
 Notes: • Asked of respondents for whom the randomly selected child in the household has some type of activity limitation.

“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 the majority of Metro Area school-age children (age 5-17) missed four or fewer school days in the past year due to illness or injury, 7.9% are reported by parents to have missed 10 or more.

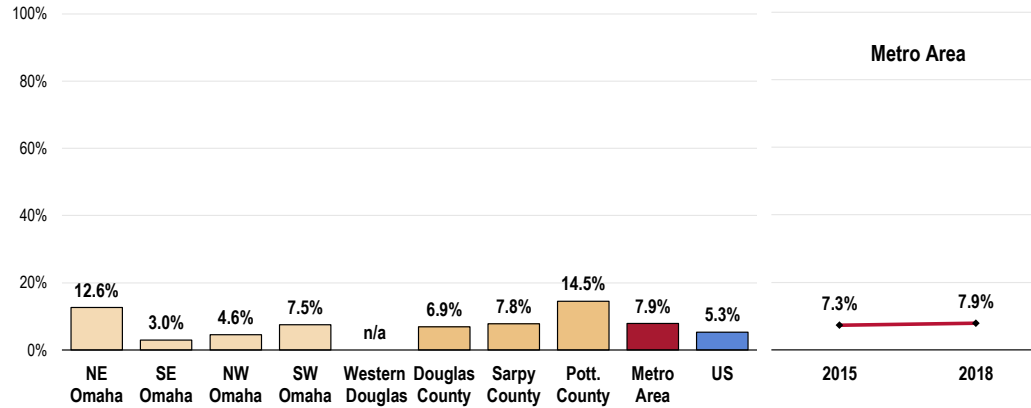
**Number of School Days Missed
in the Past Year Due to Illness or Injury**
(Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.

- The prevalence of school-age children who missed 10 or more days of school in the past year due to illness or injury is similar to US reports.
- Within Douglas County, this prevalence is highest in Northeast Omaha.
- Similar by county.
- TREND: Statistically unchanged over time.

Child Missed 10+ School Days in the Past Year Due to Illness or Injury (Metro Area Children Age 5-17, 2018)

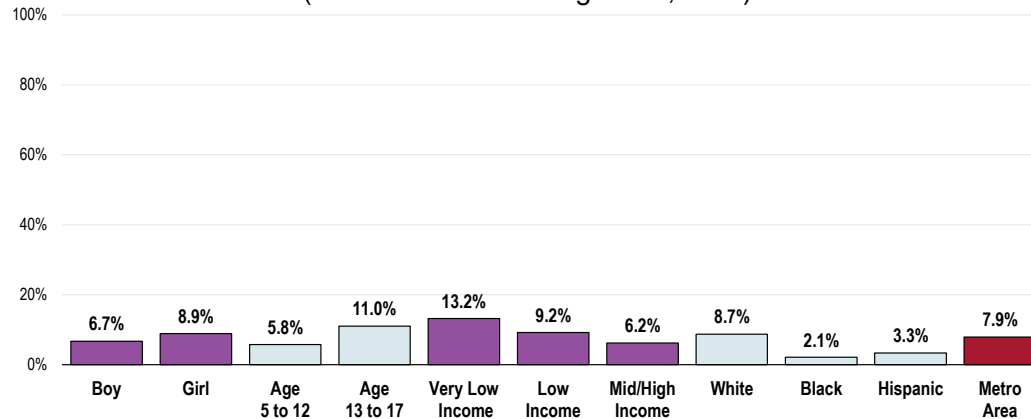


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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, missed school days due to illness or injury is highest among teenagers and White children. Other differences in demographics shown in the following chart are not statistically significant.

Child Missed 10+ School Days in the Past Year Due to Illness or Injury (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Special Health Needs

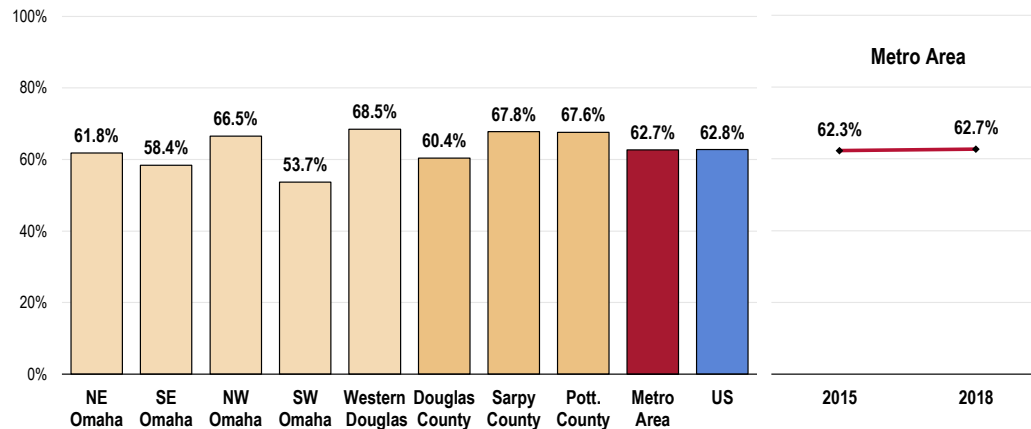
Prevalence of Special Health Needs

In all, over six in 10 Metro Area children (62.7%) are found to have special health needs.

- Almost identical to the US figure.
- Highest in Northwest Omaha when looking within Douglas County.
- By county, this prevalence is lowest in Douglas County.
- TREND: This prevalence has remained relatively unchanged since first measured in 2015.

Here, children with special health needs include those reported to have one or more of the chronic disease conditions tested in the survey or another chronic condition not specifically tested.

Child Has a Special Health Need (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 127]

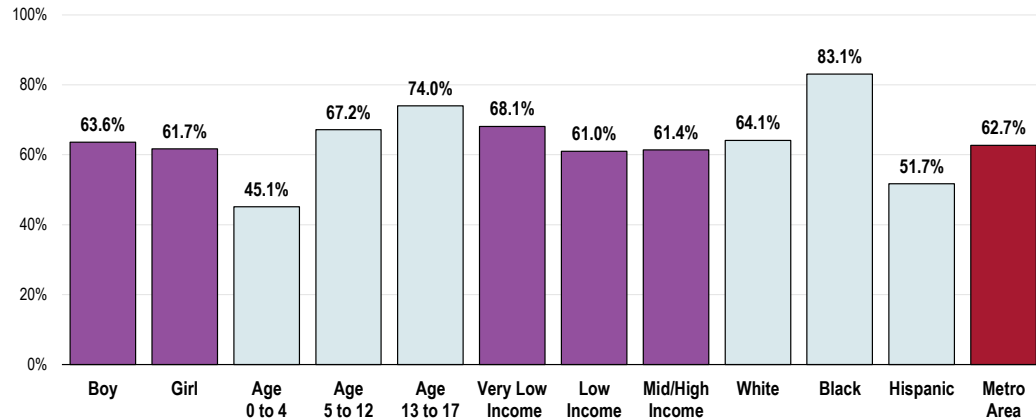
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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.

- More than eight in 10 Black children are reported to have a special health need.
- Also note the strong correlation with age.

Child Has a Special Health Need (Metro Area, 2018)



- Sources:
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 127]
- 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.
 - Includes respondents reporting a child's diagnosis of any medical condition specifically measured in the survey, as well as any other not specifically addressed.

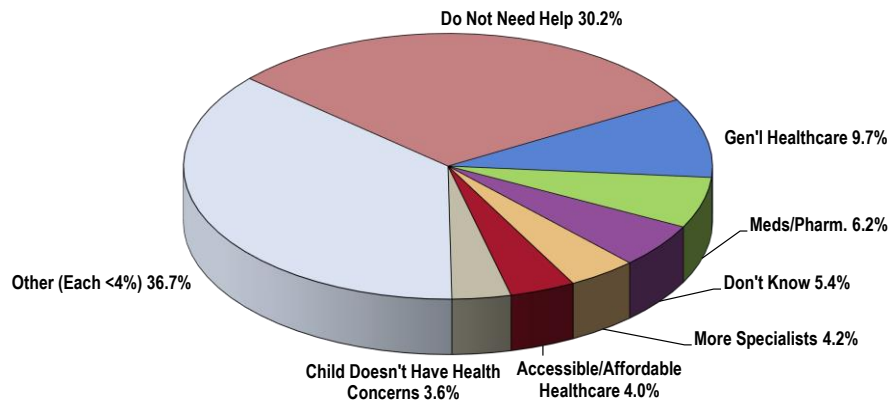
Parents' Greatest Needs for Child

A total of 9.7% of Metro Area parents of children with special health needs identified general healthcare as their greatest need for this child.

- Other common needs mentioned by parents included: **medication/pharmaceutical supplies** (6.2%), **more specialists** (4.2%), and **accessible and affordable healthcare** (4.0%).

"What is your greatest need for your child with special needs?"

Respondents' Greatest Need for Child with Special Needs (Metro Area Parents of Children With Special Needs, 2018)



- Sources:
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 314]
- Notes:
- Asked of all respondents whose child has a medical condition specifically measured in the survey.

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, and 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)

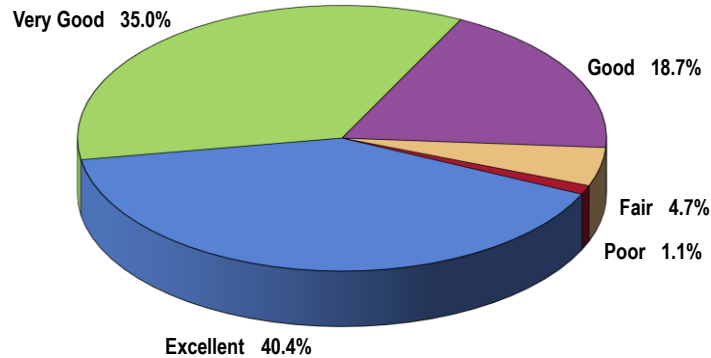
Evaluation of Child's Mental Health

Most Metro Area parents of children age 5-17 rate their child's mental health — which includes stress, depression, and problems with emotions — as “excellent” (40.4%) or “very good” (35.0%).

- Another 18.7% 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, 2018)

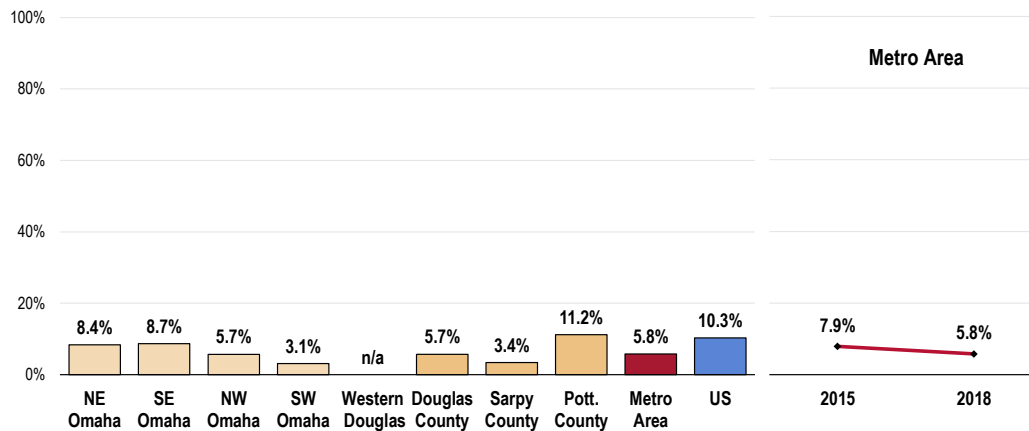


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 77]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

However, 5.8% of Metro Area parents believe that their school-age child's mental health is "fair" or "poor."

- More favorable than national findings.
- In Douglas County, "fair/poor" mental health ratings are lowest in Southwest Omaha.
- No statistically significant difference when viewed by county.
- TREND: Statistically similar to 2015 survey findings.

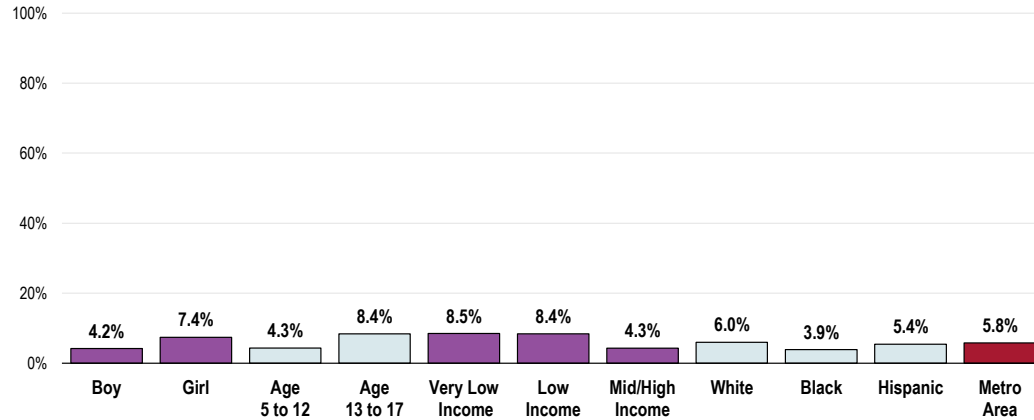
Child Experiences "Fair" or "Poor" Mental Health (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 77]
 • 2018 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 girls and teenagers.

Child Experiences “Fair” or “Poor” Mental Health (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 77]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Depression

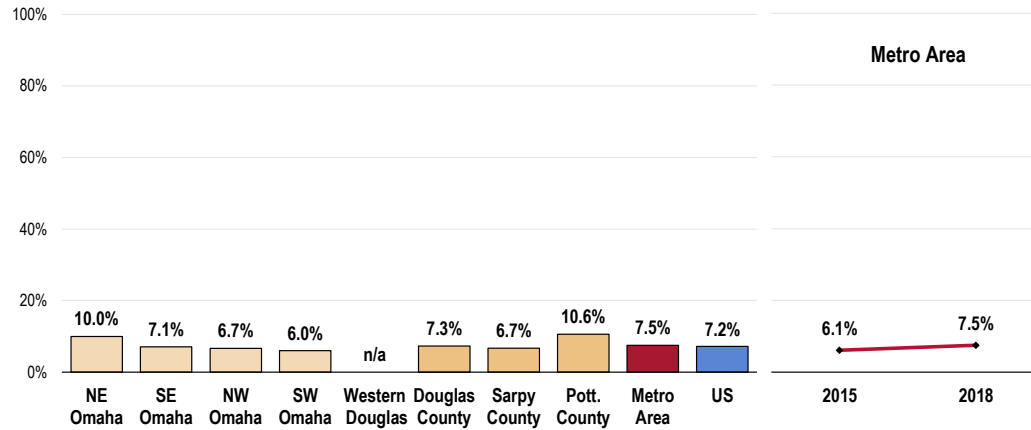
Diagnosed Depression

A total of 7.5% of Metro Area parents report that they have been told by a doctor or other healthcare provider that their school-age child had depression.

- Almost identical to that found across the US.
- No significant differences by area within Douglas County or among the three Metro Area counties.
- TREND: Statistically unchanged since first measured in 2015.

Child Has Been Diagnosed with Depression

(Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 86]

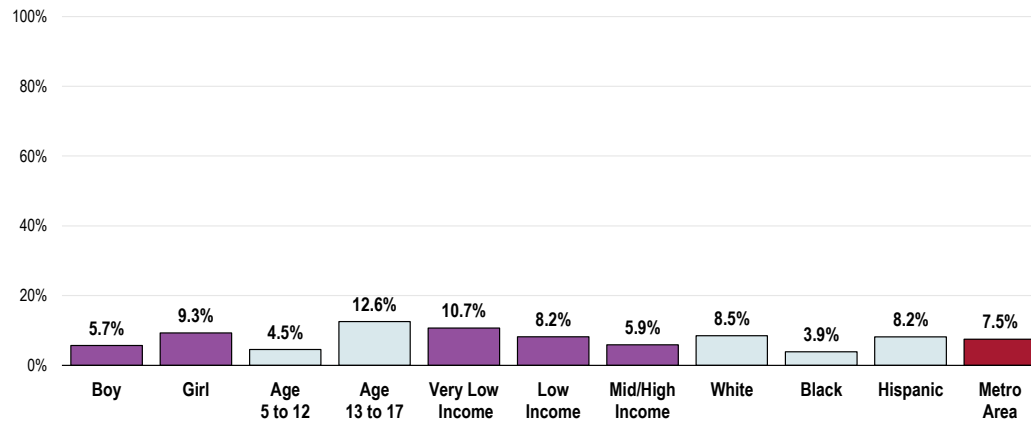
Notes: • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

- Teens and girls are statistically more likely to have diagnosed depression than their demographic counterparts.

Child Has Been Diagnosed with Depression

(Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 86]

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

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

Notes: • 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

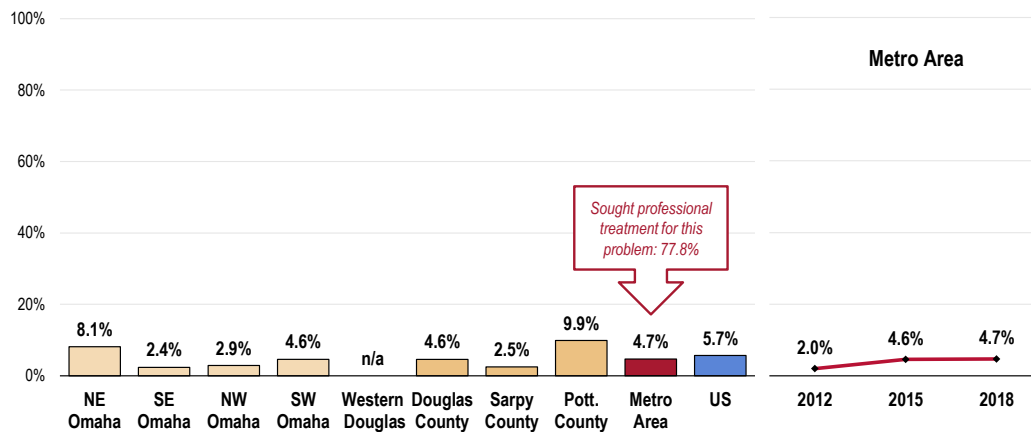
Signs of Depression

A total of 4.7% 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 the child stopped doing some usual activities.

- Comparable to the US percentage.
- Comparable by Douglas County community and among the Metro Area counties.
- TREND: Represents an increase over 2012 findings (though almost identical to 2015).

Of the 44 surveyed parents reporting signs of depression in their child, just over three-quarters (77.8%) sought treatment for their child's feelings of sadness or hopelessness; more than one in five (22.2%) did not.

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, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 84-85]

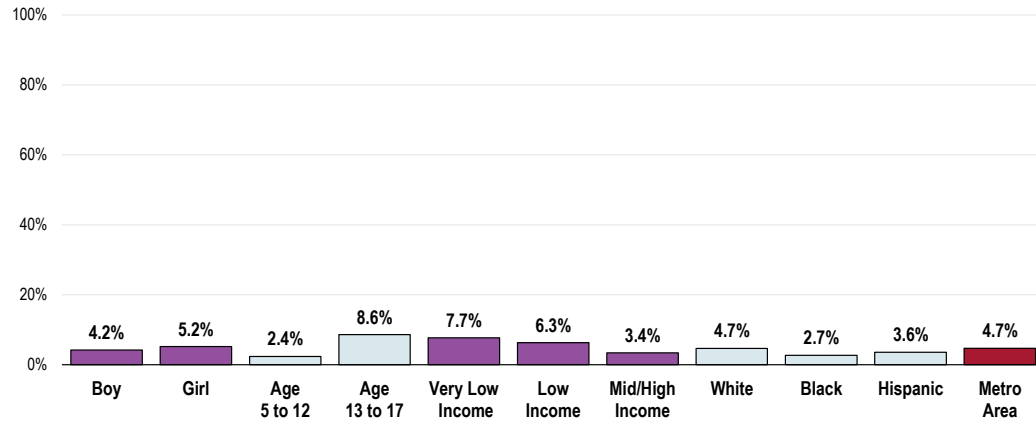
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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 highest among teenagers when compared against children age 5-12.

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, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 84]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

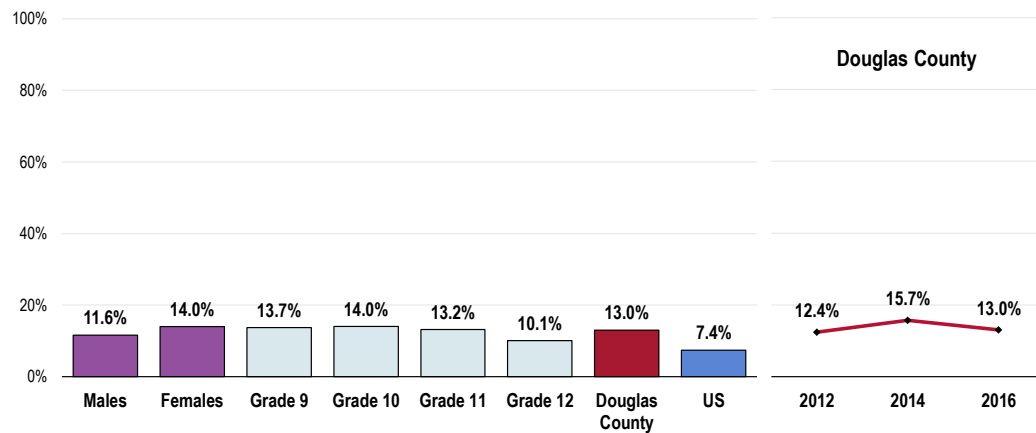
Suicide Attempts (Adolescents)

Among high school students in Douglas County, 13.0% report attempting suicide in the past year (2016 Youth Risk Behavior Survey).

- Higher than national findings.
- Higher in high school girls than boys.
- Lowest among Douglas County 12th Graders.
- TREND: Represents a significant decrease since 2014, though similar to 2012.

Attempted Suicide in the Past Year

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2016)



Sources: • Douglas County Health Department. 2016/17 Douglas County Youth Risk Behavior Survey Report.

• Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed September 2018.

Notes: • Attempted suicide one or more times during the 12 months before the survey.

Anxiety

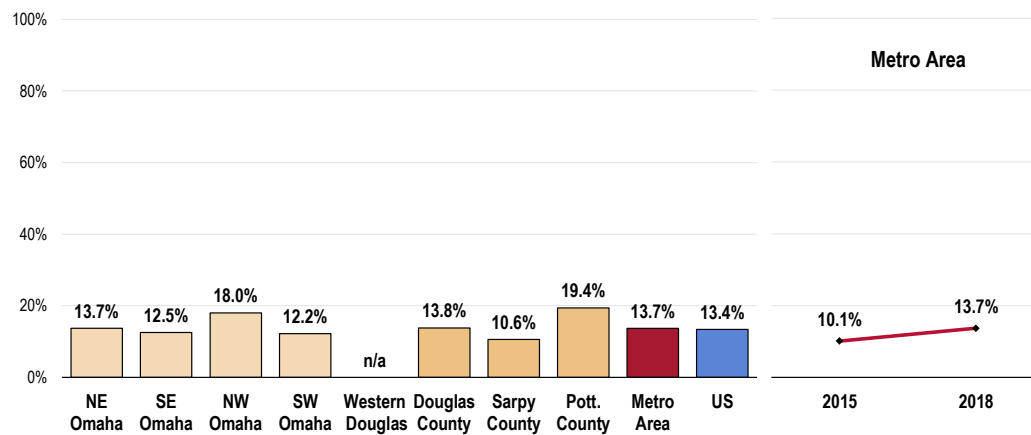
Anxiety Disorders

A total of 13.7% of Metro Area parents report that they have been told by a doctor or other health care provider that their school-age child had anxiety.

- Almost identical to US findings.
- No significant differences by area.
- TREND: Statistically higher than that reported in 2015.

Child Has Been Diagnosed with Anxiety

(Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 89]

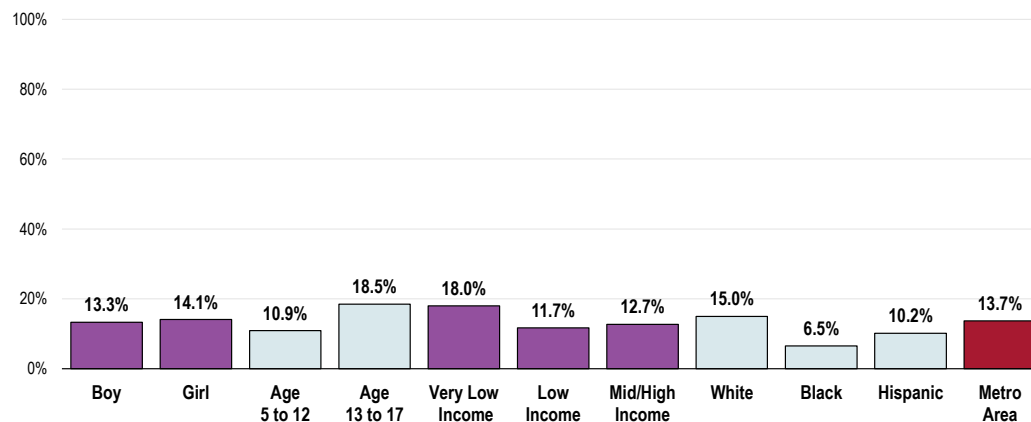
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

- Teens and White children are statistically more likely to have an anxiety diagnosis.

Child Has Been Diagnosed with Anxiety

(Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 89]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

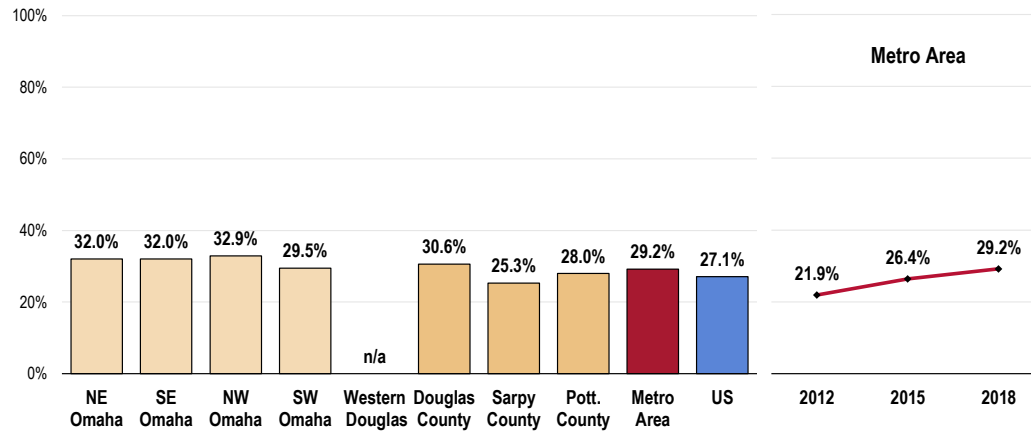
Worry

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

A total of 29.2% of Metro Area parents indicate that their school-age child worries a lot.

- Statistically similar to the national proportion for school-age children.
- No statistically significant difference by area.
- TREND: Worry has steadily increased since 2012 findings.

Child Worries a Lot (Metro Area Children Age 5-17, 2018)

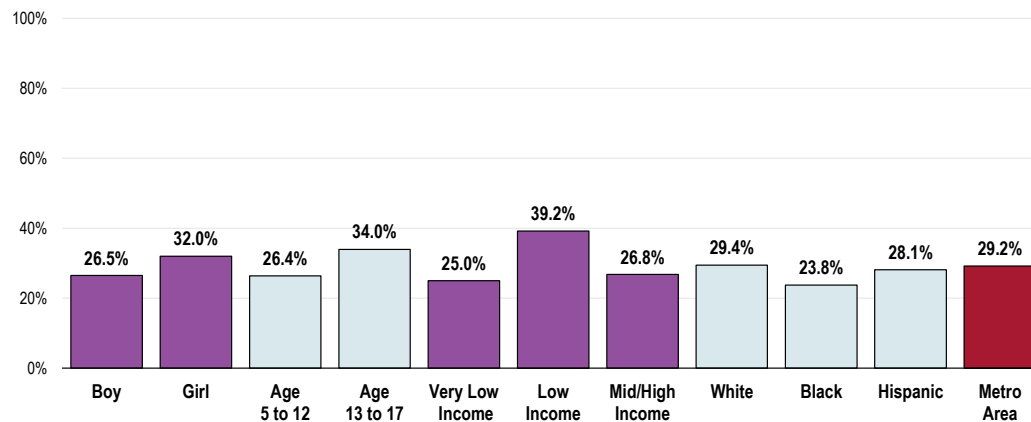


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 82]
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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 prevalent among teens and children living in low-income households (between 100% and 199% of the federal poverty level).

Child Worries a Lot (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 82]
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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Mental Health Services & Treatment

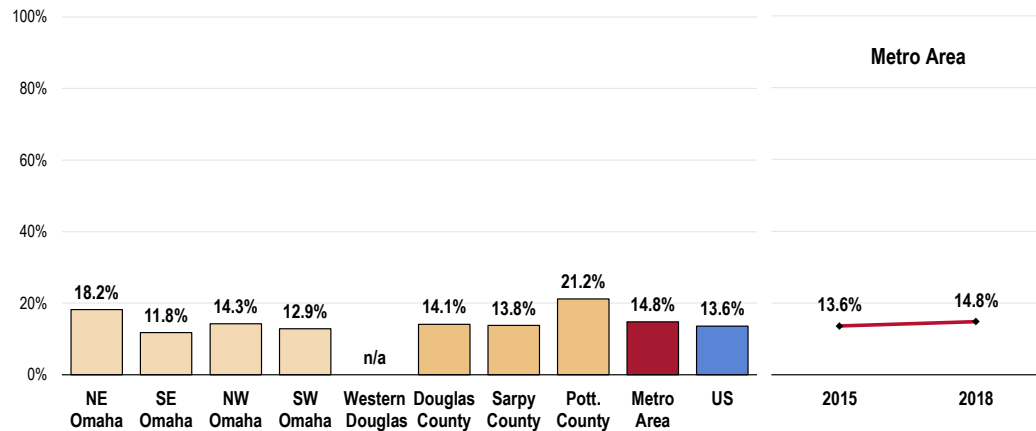
Need for Mental Health Services

A total of 14.8% of Metro Area parents report that their child (age 5-17) has needed mental health services in the past year.

- Similar to the US proportion.
- Differences within Douglas County and among the three Metro Area counties are not statistically significant.
- TREND: Statistically unchanged since 2015.

Child Needed Mental Health Services in the Past Year

(Metro Area Children Age 5-17, 2018)



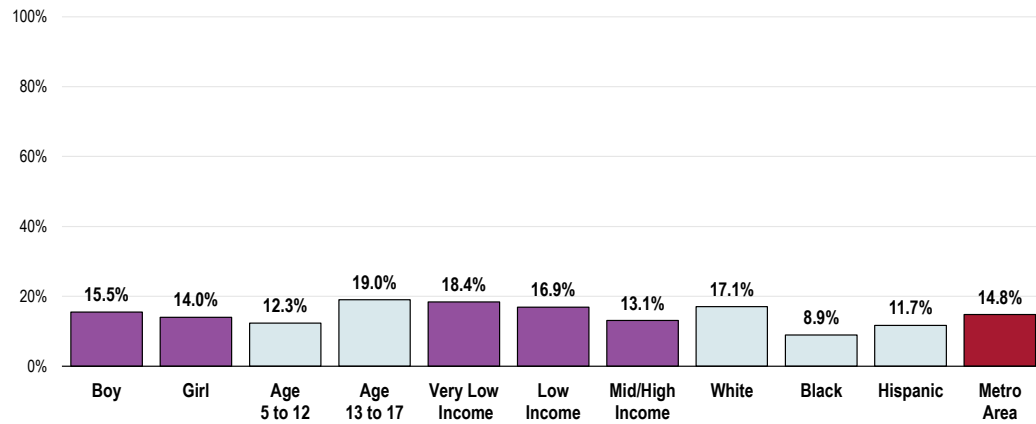
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 78]

• 2018 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.

- Those more likely to have needed such services include teens and White children.

Child Needed Mental Health Services in the Past Year (Metro Area Children Age 5-17, 2018)



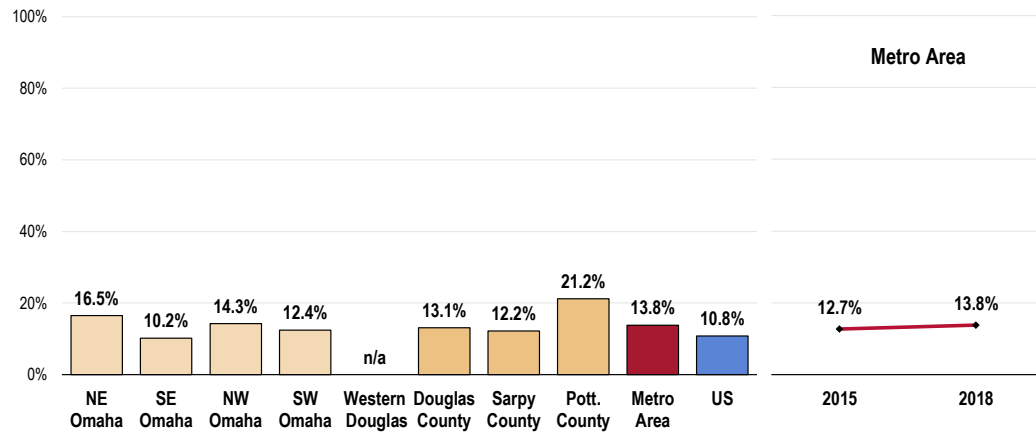
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 78]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Received Treatment/Counseling for Mental Health

A total of 13.8% of Metro Area parents with children age 5-17 report that their child received mental health treatment or counseling in the past year.

- Statistically similar to the US.
- No significant differences when viewed by area.
- TREND: Statistically comparable to 2015 findings.

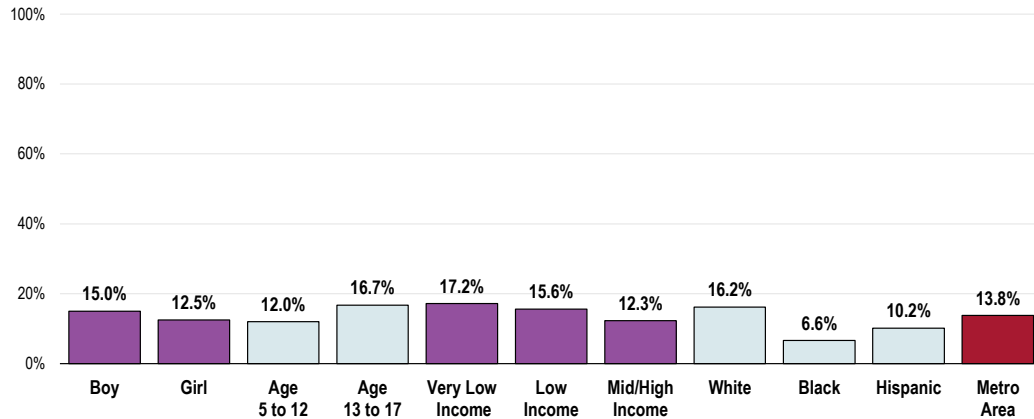
Child Received Treatment or Counseling in the Past Year (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 79]
 • 2018 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.

- When viewed by demographic characteristics, Black and Hispanic children are less likely to have received mental health treatment or counseling than White children.

Child Received Treatment or Counseling in the Past Year (Metro Area Children Age 5-17, 2018)



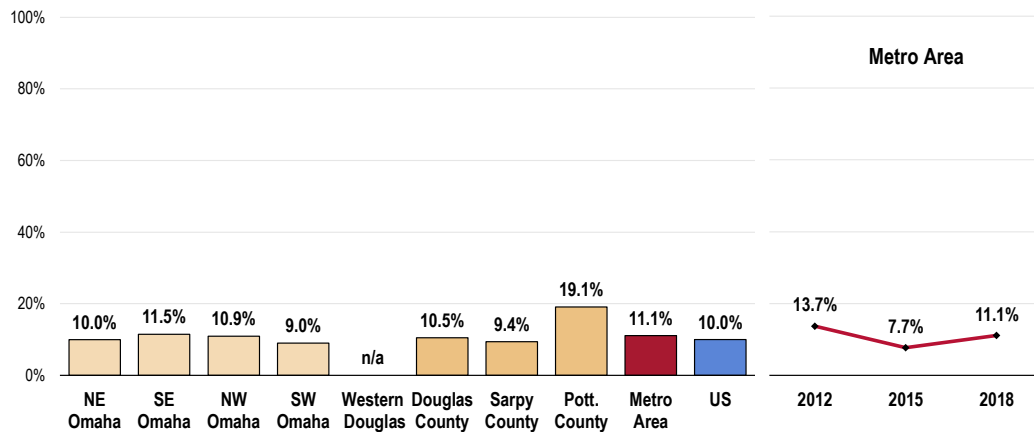
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 79]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Prescriptions for Mental Health

A total of 11.1% of Metro Area parents report that their child (age 5-17) has ever taken prescribed medication for his/her mental health.

- Comparable to US reports.
- Differences among communities are not statistically significant.
- TREND: Statistically similar to 2012 findings, though higher than 2015.

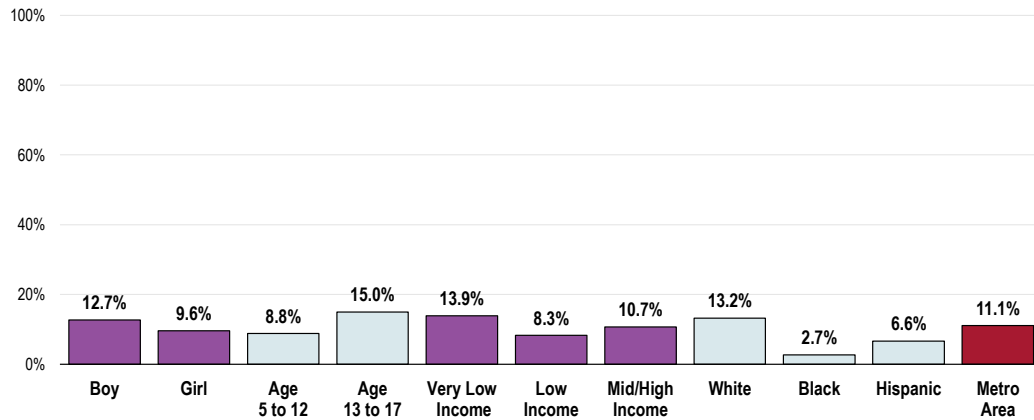
Child Has Ever Taken Prescription Medication for Mental Health (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 81]
 • 2018 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 and White children are more likely to have taken prescription medication for their mental health when compared against their demographic counterparts.

Child Has Ever Taken Prescription Medication for Mental Health (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 81]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

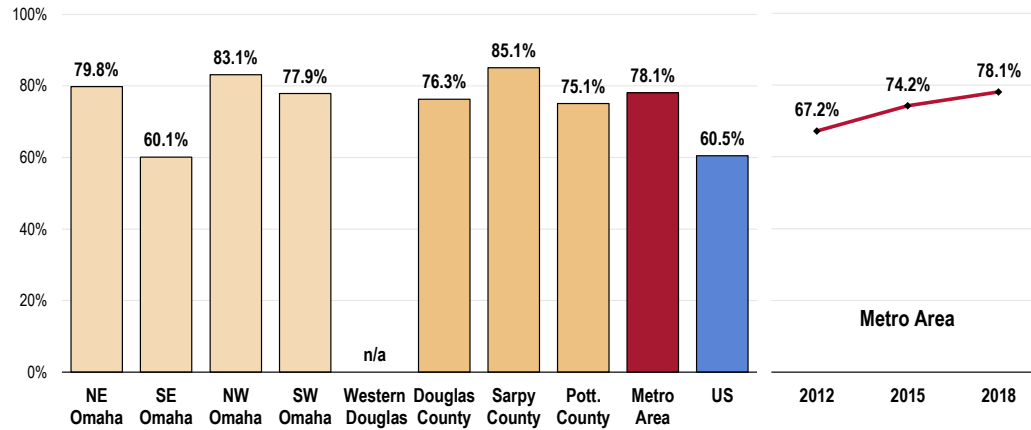
Awareness of Mental Health Services

More than three-quarters (78.1%) of Metro Area parents say that they are aware of local community resources for mental health.

- Awareness is much higher than found nationally.
- Within Douglas County, this awareness is highest in Northwest Omaha and lowest in Southeast Omaha.
- Highest in Sarpy County when comparing the three Metro Area counties.
- TREND: Notably higher than 2012 findings.

Aware of Mental Health Resources in the Community

(Among Parents of Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 90]

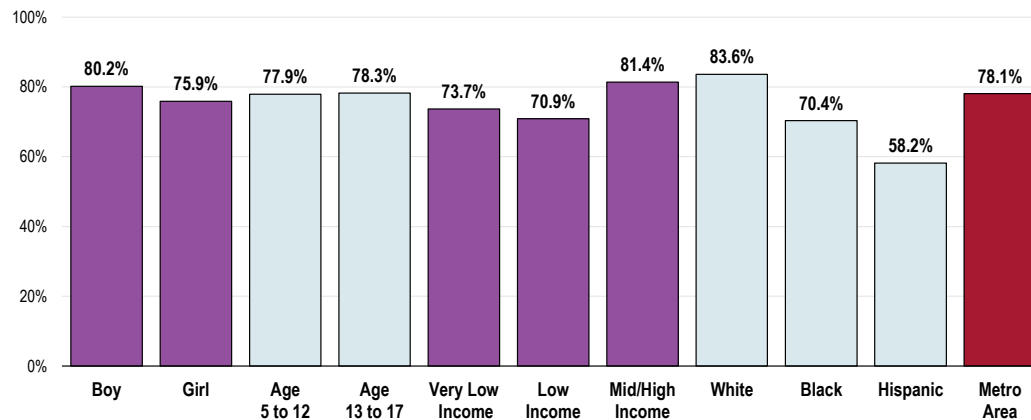
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

- Parents of White children are more likely to be aware of these services, as are those at higher incomes. Note the 25.4% difference in awareness between parents of White children and parents of Hispanic children.

Aware of Mental Health Resources in the Community

(Among Parents of Metro Area Children Age 5-17, 2018)



Sources: • 2018 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Mental and Emotional Health

Eight in 10 key informants taking part in an online survey characterized *Mental and Emotional Health* as a “major problem” for children/adolescents in the community.

Perceptions of Mental & Emotional Health as a Problem for Children/Adolescents in the Community

(Key Informants, 2018)

■ 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 about a randomly selected child in the household.

Top Concerns

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

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences are connected to mental health issues in youth. Untreated anxiety and depression make it difficult for youth to do well in school, home, and other places. We are seeing family members in the household also deal with these issues and are often untreated. A mix of medication and therapy is key. - Community/Business Leader

Omaha is not immune to terroristic events like the Von Maur massacre and the shooting at Millard South High School. We have troubled youth being bullied that live in unsupportive, non-nurturing home environments; their mental health needs are being ignored or in a situation where parents want to get help for their child, but the appropriate programs and resources are difficult to obtain or are non-existent. We don't do enough in our community or the country regarding prevention programs. - Public Health Representative

Many youths have experienced trauma. There is a stigma about treatment for mental health issues. Youth who have been in foster care were required to attend therapy, so they aren't as willing to attend it when not in foster care. - Social Services Provider

Parents and families are faced with multiple challenges as it relates to social determinants of health. This includes employment conditions, increased levels of social exclusion, less access to preventative programs and services, and disparities in their ability to control their lives. The stressors that result put individuals and families under low to high levels of stress that occur over long periods of time. Often there are few “breaks” in the level of stress experienced by parents and families which can lead to maladjustment. This consistent stress and the negative experiences that frequently result for our underserved and diverse population of children, adolescents, and their families can have a negative impact on their social, emotional, cognitive, mental, relational, and physical development and status. Depression, anxiety, anger, relational conflict can develop and lead to negative environments or violence. Lack of knowledge and skills in coping by youth and parents. - Other Health Provider

Children coming out of crisis oriented and dysfunctional households often need more emotional support when compared with students in what seems to be a functional family system. Often there is hesitation for parents to seek this important care for their child. - Other Health Provider

All of a child's life experiences are combined to come up with their level of ‘trauma’. For some of our youth, these experiences are far bigger than what they can handle on their own. - Community/Business Leader

A lot of chemical imbalance and generational challenges passed down. I believe there are a lot of untreated symptoms. Drugs and alcohol also play a big role when having kids. It seems to be so common that we can't tell who has it, versus who does not. I also think there are various levels but that can be hard to diagnose. - Social Services Provider

Many have family history of mental illnesses, drug exposure, poor social circumstances during limited access to mental health services. - Physician

Poverty, lack of education, inability to utilize the education provided to a person. Lack of compassionate family planning counseling for individuals with special needs. Drugs and alcohol abuse. Inability to face reality that a family member needs help with mental health issues. The stigma is there. - Community/Business Leader

We have children and teens who continue to react to trauma around them. Parents and caregivers need additional support and guidance to be present with their children during each interaction. Help children develop skills for self-discipline. - Community/Business Leader

The widespread nature of adverse childhood experiences which frequently contributes to mental health issues is key to address for ensuring that people have a healthy childhood and a resilient life. - Public Health Representative

Many children have experienced trauma and do not have a place to talk about this and deal with it. We need more mental health providers and low-cost treatment. Many refugee children are at risk for mental health problems. - Other Health Provider

Because the lives of children are so complex, the adults in their lives are so ill-equipped to parent and protect children, and we know that social-emotional development is influenced by traumatic experiences and difficulties accumulate over the life course. Sometimes mental health is maladaptive coping. - Public Health Representative

Many young people are impacted by trauma associated with poverty. Resources and better aligned partnerships should focus on the root causes. An intense focus is needed to normalize mental illness, especially within underrepresented communities. - Community/Business Leader

Connected to injury and violence and ACE's our children are being exposed to more and more situations to impact them on a mental health level. - Public Health Representative

Children in this community have to deal with a lot of trauma and consistent change. They don't find it necessary to have a child seek help. Families also lack the education around mental health issues and still some believe it is a stigma. - Physician

Much is related to previous item on violence. Children's mental health problems are exacerbated by violence. Access to high quality and timely mental health services is limited. Most children who have a MH condition do not ever get help for it. - Other Health Provider

Many of our kids are exposed to trauma, particularly from immigration related issues and poverty. - Community/Business Leader

Same as injury and violence. They really go hand-in-hand with trauma. - Community/Business Leader

Is closely related to ACEs. - Social Services Provider

High ACE's score, high rate of attempting suicide in youth. - Public Health Representative

Prevalence/Incidence

Mental health challenges affect one in five families. Providers are becoming fewer because services lose money or are unreimbursed. Families have no central point of access to services, oftentimes presenting kids and adolescents in crises in emergency rooms for lack of viable alternatives. - Community/Business Leader

Mental health is a major issue with all segments of society. It is particularly concerning with young people. Teen suicide is present and tragic. We need to help young people by identifying those most in need and who are possibly suicidal. - Community/Business Leader

Mental health appointments are in the top 4 reasons for appointments for children. It is unknown why we have the behavior disorder increase, but the appearance of depression has increased each year. The influence of stresses and environmental exposures are part of the reason for the increases. - Other Health Provider

We know there are high rates of children experiencing mental health challenges and that there is a significant lack of access to resources to address those needs. Mental health impact all of components of health and quality of life. - Public Health Representative

At annual well checks, we are screening all children 12 years and above for depression, and it is surprising to see how many children are symptomatic. There is a lot of family dysfunction that I see in homes and many split homes nowadays. - Physician

Major issue with anxiety and depression in the community as well as diagnoses of bipolar, ODD, ADD, ADHS, conduct disorders, cost of medications, availability of medications and services. - Other Health Provider

In my role, I look at suicidal tendencies, self-harm, which seems to be on the increase. We also see more and more kids that do not report. - Community/Business Leader

Anxiety rising among young people. Suicide rising. Cyberbullying. - Community/Business Leader

Increase in teen suicide, youths and teen depression and, or anxiety, class disruption. - Other Health Provider

It's a concern for everyone, no matter the age or background. We need to shift the mindset of society to approach mental health, just as we do physical health. - Community/Business Leader

I see a lot of past treated, untreated mental health problems in our population as well as present problems. Lack of low cost, no cost options. - Community/Business Leader

Seeing more children with signs and symptoms of mental health conditions. However, waits for mental health services exist. Sometimes hard to get parents of children to keep a mental health appointment if it is one to two months after the crisis occurred. - Community/Business Leader

We are seeing younger and younger students with emotional issues. We also see an increase in depression and anxiety along with suicide ideation. - Community/Business Leader

I see a lot of patients with anxiety, depression. It seems like every year there are more children complaining of this. - Physician

Increased emergency room visits are presently approximately 50% mental health concerns. ESU data reflect increased need of mental health support in schools. Lack of access to mental health providers especially in rural areas. - Other Health Provider

Mental health in general is a widespread concern in the community. There is little funding in Nebraska around this issue and needs to be addressed, especially in the adolescent population before things get any more out of hand. - Public Health Representative

Statistics show that it is a major issue. Suicide is one of the leading causes of death for adolescents in Nebraska. Access to services and availability of services is lacking too. - Social Services Provider

Statistics and anecdotal evidence point to sharp increases in reported need for mental health services for youth; causes are across the board. - Community/Business Leader

Due to the number and types mental health issues we see in children and adolescents that apply for our program. - Community/Business Leader

Personal experience with the system. Experience with families we work with. Experience of employees with the system. - Community/Business Leader

Surveys, assessments, statistics indicate it is a problem. - Public Health Representative

More kids with anxiety and depression. - Physician

Based upon community metrics. - Community/Business Leader

I see it every day. Immanuel is it. - Community/Business Leader

Access to Care/Services

There aren't enough inpatient psych beds in the community to address the need. Discharges from hospitals after suicide attempts are delayed waiting for a bed. Children with medical and mental health issues don't have any place to go. More preventive services and qualified/affordable options are needed for families. - Other Health Provider

I just think in general, all communities throughout Omaha are in need of more services for those suffering from various mental health issues. If you spend any time at all in our area schools or look at the number of cases within our schools relating to behavioral issues, the root of many of these incidents often stems back to mental health issues that may be undiagnosed or treated in our youth. The bigger issue is a severe lack of funding and attention from both the state and federal level to even begin to address that there are problems. - Community/Business Leader

There are not enough services for children who are identified. Even with the services that are available, they are often not convenient for families in terms of the hours that they are willing to see patients. I believe that the stigma of mental health still affects parent's willingness to follow-through with obtaining help for their children even when their PCP is recommending it. The parents own history of mental health diagnoses also contributes to poor follow-through. - Other Health Provider

Lack of mental health services. There are few inpatient areas, a long waiting list for inpatient services. Lack of coordination with our outpatients' services. Many people are able to fall through the cracks. - Community/Business Leader

There are not enough resources in the community to provide mental health support for children and families. This is especially true in Eastern Pottawattamie County, which is predominantly rural. The 1st Five Health Mental Development Program at FAMILY, Inc. aims to improve this. - Other Health Provider

When people exhaust the limited resources and or are unable to cope with their life or world view, they begin to cognitively live and make choices that may not be in their best interest or the best interest of those around them. In the absence of healthy choices, the option of unhealthy choices may look acceptable. - Community/Business Leader

Mental health resources are so limited that children with minor mental health needs cannot be serviced so as to prevent larger mental health issues down the road. - Physician

I believe it is a concern because there a few treatment options and lack of resources in the community. Mental health issues keep trending up, but we are not able to keep up with the demand on professionals trained in this area. – Physician

The amount of medications given and the issues that plague our schools is evidence of serious lack of resources for mental health in Nebraska. - Other Health Provider

Access to this type of service is sorely lacking in the community. Wait lists are long and services are limited. - Other Health Provider

There are not enough resources. Mental health concerns come up frequently, both with schools and with clients. - Community/Business Leader

Access to services and providers, parental support to keep and or make appointments. - Other Health Provider

Treatment options are very limited as well as payment sources for mental health. - Public Health Representative

Limited access to child, adolescent psychiatrists and psychologists make mental health a major problem in my community. - Physician

Limited inpatient beds. - Other Health Provider

Available services. - Community/Business Leader

Lack of Providers

Lack of access to psychologists/therapists and child & adolescent psychiatrists is a huge issue. There aren't enough providers; availability for new patients is very low, & timeliness for such services is unrealistic (as patients/families are often already "in crisis" by the time they reach out for help). Lack of health insurance coverage &/or funds to self-pay can make services difficult/impossible, as well. There can also be a stigma related to mental health issues which decreases patients/families wanting to see appropriate specialists. All of these things result in increased burden on primary care providers, who often don't have the time &/or expertise to provide necessary therapy &/or prescribe medications when needed. – Physician

There is a significant shortage of providers who specialize in mental health issues, particularly for children under the age of 5. Many children in our metro area demonstrate multiple indicators of adverse childhood experiences (ACES). Lack of preventive care for children who have Medicaid or other public health insurance. - Community/Business Leader

We are so limited on quality therapists who have room for new patients. For children and adolescents who don't have insurance it's even harder to find services. I also believe that mental health is often ignored or not recognized as an issue for a child. Their parent has to be willing to get them services. - Public Health Representative

Shortage of psychiatrists, psychologist and increase in anxiety and depression due to social media. Lack of social connectedness and increase expectations at a younger age. - Physician

Limited access to providers, limited insurance coverage for costs of care. - Physician

Poor access to providers to help those in need. Media and access to it are not helpful with anxiety and depression on the rise. - Physician

Limited access to behavioral health services, particularly counseling. - Physician

There is limited availability for psychiatry and ongoing behavioral, mental health treatment for youth in the area. - Social Services Provider

Not nearly enough providers, especially psychiatrists for medical management, limited in-patient treatment. - Physician

There are a limited number of mental health providers within our community, particularly those that support children and adolescents. - Public Health Representative

There is a lack of behavioral health providers throughout the state. - Community/Business Leader

Lack of community providers who go into the home, lack of insurance and unable to pay the cost. - Community/Business Leader

Growing need, lack of providers, lack of funding from state and federal sources. - Community/Business Leader

Limited providers and increasingly known population of undocumented children. - Other Health Provider

Lack of providers to cover current population needs. - Physician

Access to mental health providers is difficult. - Other Health Provider

Takes too long to see a psychiatrist. - Physician

Lack of providers and lack of resources. - Physician

Limited providers. - Physician

Denial/Stigma

Mental health is very stigmatized in many cultures; however, in the African-American culture, the words bring such shame that the mental health issue is not addressed for fear of discrimination. And once diagnosed, no services. - Community/Business Leader

Stigma associated with mental health remains to be a barrier to children and families accessing care. Additionally, workforce issues impact availability of qualified providers able to meet the many needs of children in our community. - Community/Business Leader

I don't think that many people are comfortable in seeking mental health assistance in my community. - Social Services Provider

Again, troubles displaying themselves as misbehavior and failure in educational settings. - Community/Business Leader

Stigma in using services, definite need in this area, reportedly that Sarpy County is the highest per capita rate of suicide. - Community/Business Leader

Stigma and lack of education about mental health, mental illness. - Other Health Provider

Diagnosis/Treatment

More and more people are recognizing the impact of mental health on kids but are either unaware of treatment options or unable to access them. - Physician

So many of our youth experience trauma that affects their mental health. Untreated mental health problems are manifesting themselves in classroom behavior and gang involvement. - Community/Business Leader

I don't believe mental health is explored or identified early enough in children and adolescents. - Community/Business Leader

Lack of diagnosis, lack of mental health providers. - Community/Business Leader

I believe the mental health conditions may be very complicated to identify and treat. - Community/Business Leader

Early detection is critical. - Community/Business Leader

Culture/Social Norms

Much STRESS in our children and youth. Overwhelmed resources- trained personnel to meet the need for all affected. Uniform screening for those at risk not implemented in all health sectors or schools. Not all those screened positive are following through to get help - Physician

Children are entering into a new era, which promotes low self-esteem or too high of expectations for kids. Many times, children and young adults feel like they have nowhere to turn when having certain thoughts. Gender identity is a 'new realm' for the older population and youth need somewhere to turn to. - Public Health Representative

Mental and behavioral health referenced as primary concern of schools, rise of social isolation, increase in adolescent stress levels, suicide, demand for expansion of services in schools. - Community/Business Leader

Social media. - Other Health Provider

Funding

There simply isn't enough public funding for mental health across all age groups, but for children and adolescents, the need is even more critical. Young people often lack the terminology and resources to address their mental health needs, and adults in their lives often are unable to help, or unaware of how to help. Cultural differences and shaming of those with mental health concerns often lead to these conditions being underdiagnosed, to misdiagnoses, or to lack of follow-up care. Financial concerns/lack of insurance is always an issue as well. - Community/Business Leader

Lack of funding from state, national and local government. - Community/Business Leader

Affordable Care/Services

Mental health services are expensive, even if a person is fully insured. Co-pays for mental health services through insurance plans are exorbitant. If children do not qualify for Medicaid, mental health services are financially out of reach especially if the family walks that line of being just above the poverty line. In our community there is a lack of mental health providers that are bilingual, and trauma informed. Sliding fee scales are often too expensive for struggling families. Additionally, our community lacks mental health providers trained in modalities for young children. - Social Services Provider

School Violence

Drawing from the national scene, with school children committing acts of extreme violence in schools around the country, Omaha is simply one event removed from becoming a national flash point. Children seem to exhibit increasing anger, rooted in fractured relationships with parents. While not abusive, fractured relationships can be defined as "passive neglect" in what otherwise outwardly appears a healthy family unit. This is not to mention myriad unhealthy family units affected by parental use of drugs and alcohol. The most helpful definition of depression that I have known is this: depression is anger turned inward. It wreaks havoc in the minds of children and adolescents, and it will not respond to pharmacologic intervention. Angry children bring guns and knives to school - weapons to which they have gained access largely because of parental un-involvement in their lives and consequential unawareness of the child's activities. Destruction of lives and property follows. - Community/Business Leader

Vulnerable Populations

Refugees are fleeing violence, persecution, and trauma. They also are dealing with the difficulties of adjusting to a new culture, climate, and language. Culturally effective mental health services are a HUGE need. One-on-one talk therapy is not necessarily the best solution for someone suffering long term trauma and coming from a communal culture. - Social Services Provider

Chronic Disease

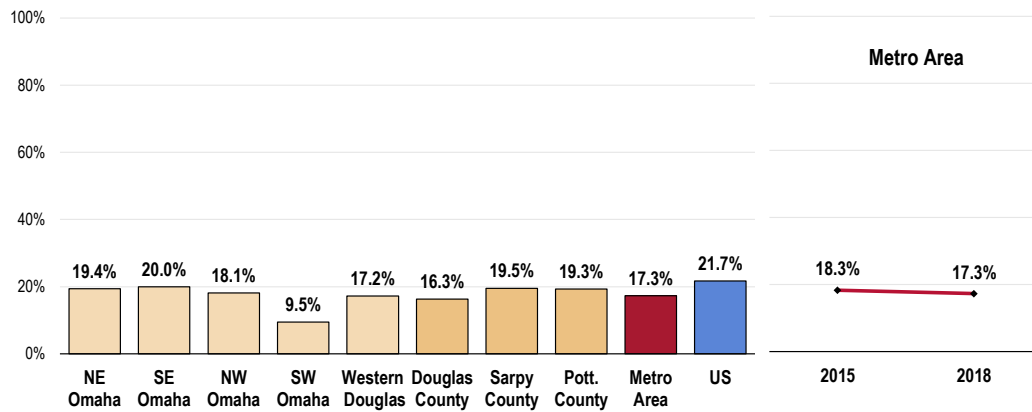
Allergies

Respiratory Allergies

A total of 17.3% of Metro Area children suffer from respiratory allergies.

- Lower than the US percentage.
- In Douglas County, notably low in Southwest Omaha.
- Differences by county are not statistically significant.
- TREND: Statistically similar over time.

Child Has Respiratory Allergies (Metro Area, 2018)

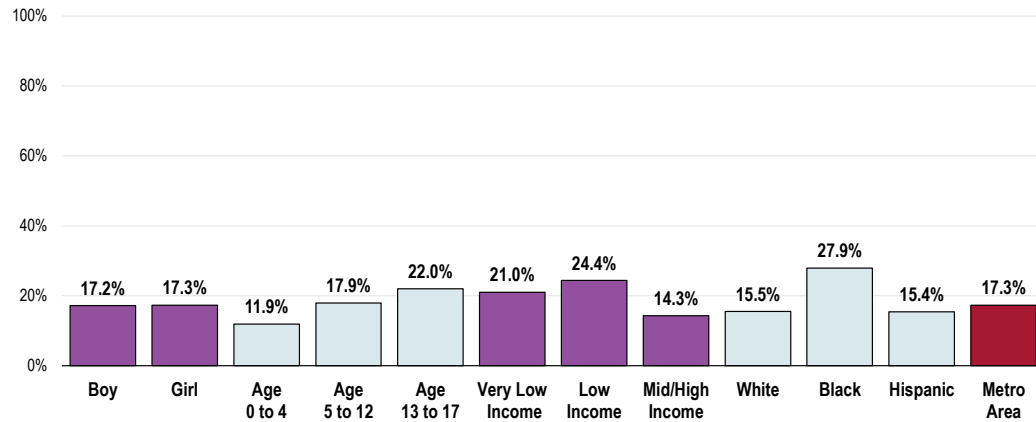


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 54]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

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

- Those in lower-income households.
- Black children.

Child Has Respiratory Allergies (Metro Area, 2018)



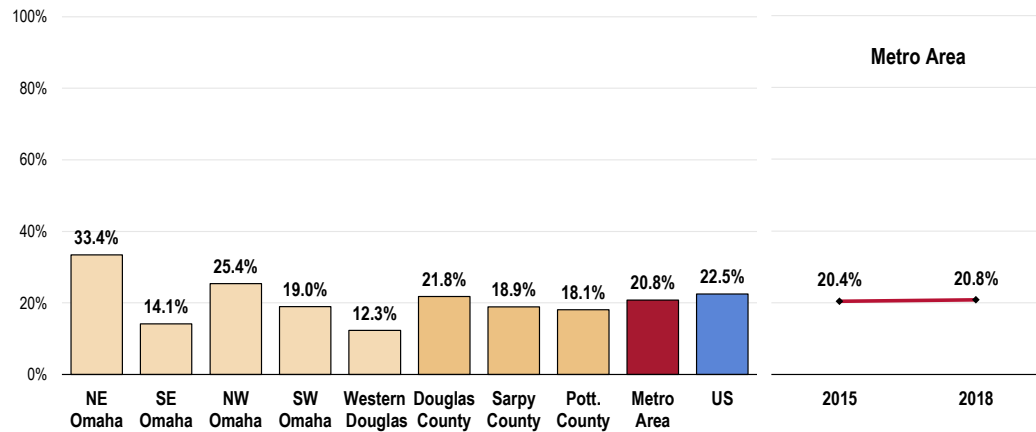
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 54]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Eczema/Skin Allergies

One in five Metro Area children (20.8%) have eczema or another skin allergy.

- Statistically similar to national findings.
- Within Douglas County, notably high in Northeast Omaha.
- Statistically similar among the three Metro Area counties.
- TREND: Almost identical to prior survey findings.

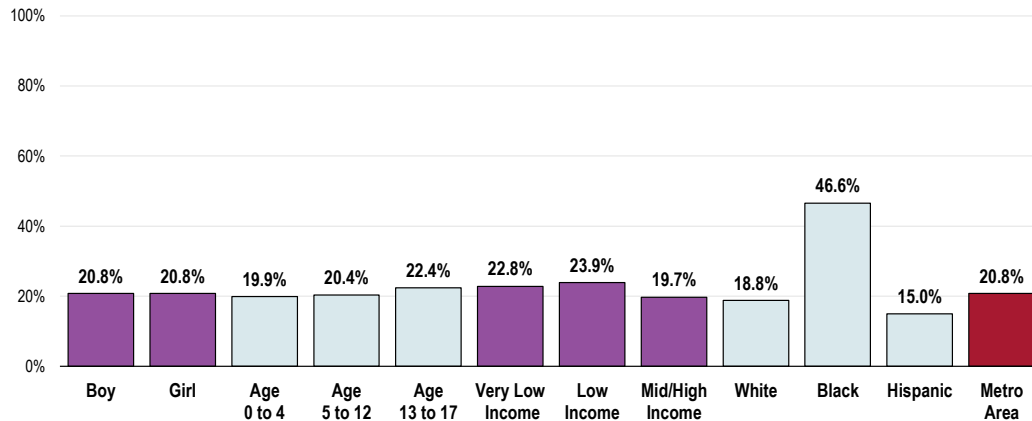
Child Has Eczema/Skin Allergies (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 57]
 • 2018 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 exceptionally high proportion of Black children with eczema/skin allergies.

Child Has Eczema/Skin Allergies (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 57]

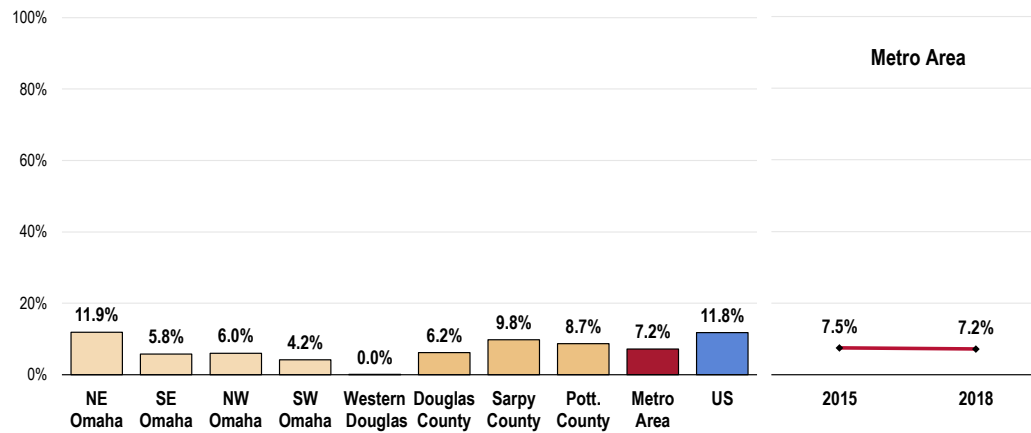
Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to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

Food/Digestive Allergies

A total of 7.2% of Metro Area children have some type of food or digestive allergy.

- Lower than the national prevalence.
- In Douglas County, this prevalence is highest in Northeast Omaha. Note that no parent in Western Douglas reported child food or digestive allergies.
- Similar by county.
- TREND: No statistically significant change in food/digestive allergies has occurred in the past three years.

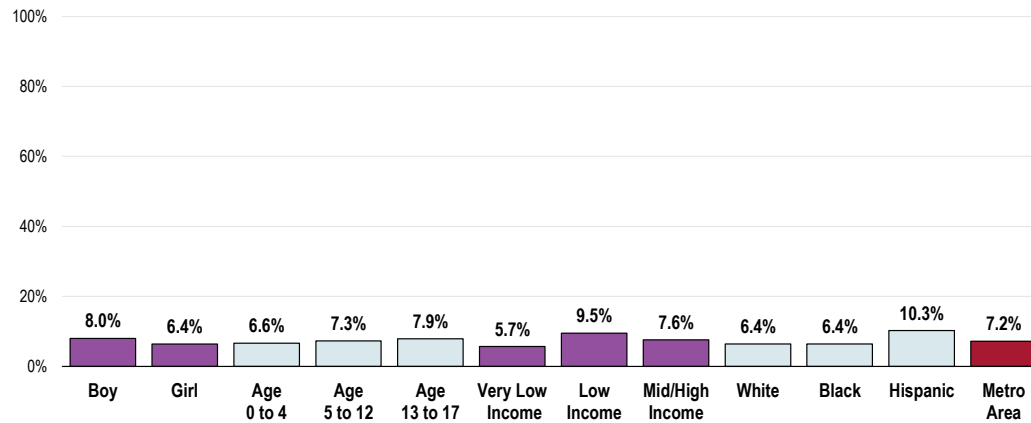
Child Has Food/Digestive Allergies (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 55]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

- No significant differences by child demographics.

Child Has Food/Digestive Allergies (Metro Area, 2018)

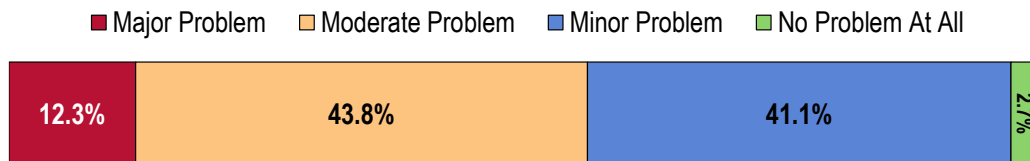


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 55]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Allergies

Key informants taking part in an online survey characterized **Allergies** as a “moderate problem” slightly more often than a “minor problem” for children/adolescents in the community.

Perceptions of Allergies as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Prevalence/Incidence

Asthma is a major health issue. More and more school-age children have inhalers for asthma. Food allergies are more common than ever before: strawberries, fish, nuts, tree nuts, peanuts, bee stings, latex, unknown allergens in the environment. More and more students have Epipens prescribed for their particular allergic reaction if Benadryl does not work. - Community/Business Leader

Lots of seasonal allergies spring, summer, and fall. Increasing rates of food allergies in children, and cost of epinephrine are major issues. - Physician

I am aware that prevalence is increasing overall in the population. Families with limited resources and limited health knowledge face challenges in managing allergies. - Public Health Representative

It seems like there are many kids with allergies today, and the incidence seems more prevalent. - Other Health Provider

Increase in the number of students in an academic setting with potentially life-threatening allergies to substances such as peanuts, tree nuts, and so on. - Other Health Provider

Mainly because there is an increase and from what I see, some parents do not consider this a problem and do not take the steps to prevent further harm to their children. - Community/Business Leader

The number of children, adolescents with allergies, especially environmental and food allergies is increasing. - Public Health Representative

High incidence of allergies in the Midwest, leads to asthma exacerbations, missed school, decreased ability to be active. - Physician

High prevalence of allergies to grasses, molds, trees. - Other Health Provider

I see it on a regular basis. Improper diets. - Community/Business Leader

Environmental Contributors

Many of the children are experiencing asthma attacks related to allergies. They may be exposed to living conditions without air conditioning or proper ventilation. - Social Services Provider

Respiratory allergies are a big concern due to air quality in the homes, living conditions. - Physician

Families live in older homes, exposure to mold, smoking in the household. Unsanitary conditions.

Family and child compliance with medical treatment. - Physician

Living in the Midwest. - Community/Business Leader

Health Awareness/Education

Many of the children that I serve do not have access to good allergy understanding. Therefore, the children come to school with physical symptoms impacted by their allergies, that cause them to be unable to learn. Consistent education that allows parents to understand even over the counter medications to assist their child would be very helpful. - Community/Business Leader

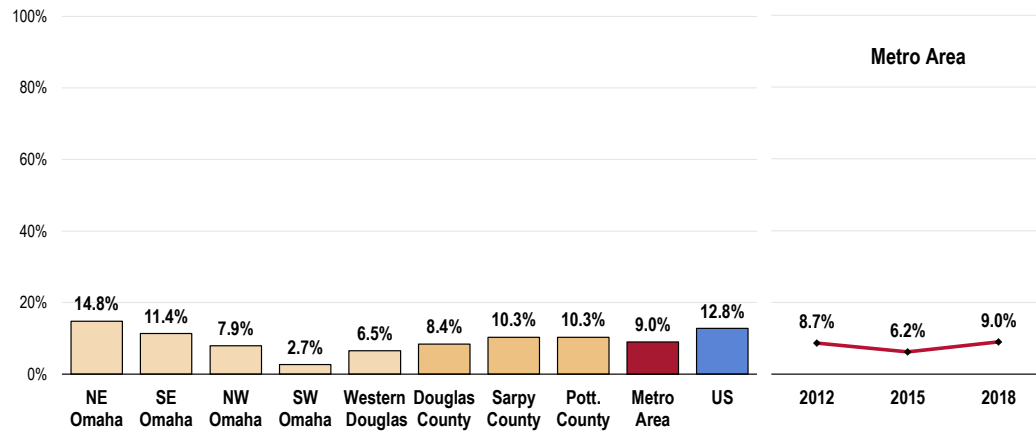
Asthma

Prevalence of Asthma

A total of 9.0% of Metro Area children age 0 to 17 currently have asthma.

- Lower than the US rate.
- Within Douglas County, Northeast Omaha reports the highest prevalence of asthma, while Southwest Omaha reports the lowest.
- Statistically similar among the Metro Area counties.
- TREND: Remains statistically unchanged over time.

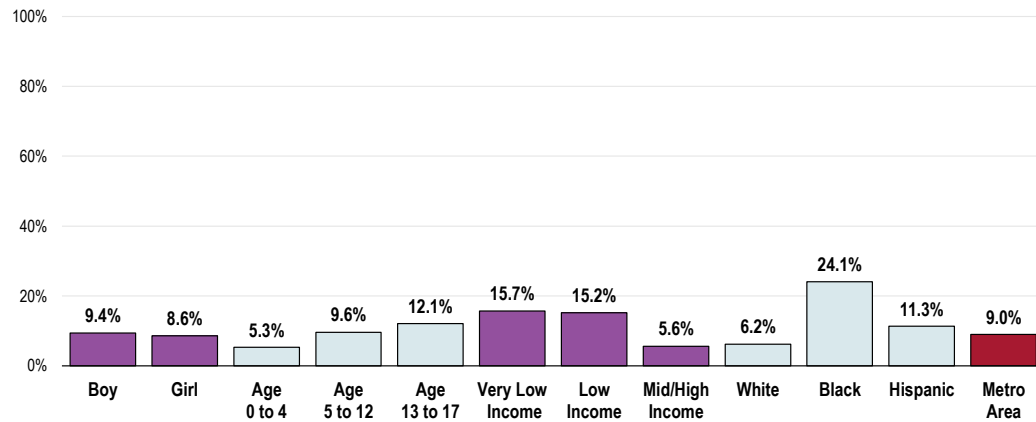
Child Currently Has Asthma (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 125]
 • 2018 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 Black children.
- Asthma diagnoses also increase with age and decreases with income.

Child Currently Has Asthma (Metro Area, 2018)

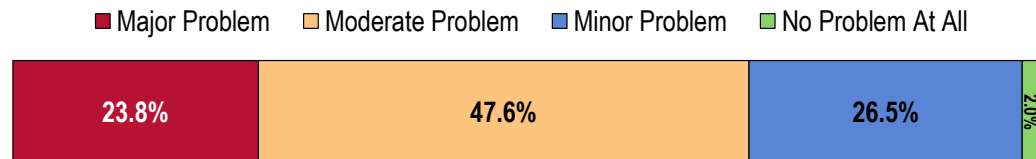


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 125]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Asthma & Other Respiratory Conditions

Key informants taking part in an online survey most often characterized *Asthma and Other Respiratory Conditions* as a "moderate problem" for children/adolescents in the community.

Perceptions of Asthma & Other Respiratory Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Prevalence/Incidence

We are experiencing an increase in the number of children we serve who have specific action plans for asthma. We also struggle with some families in regard to providing a specific plan, as well as providing the specified medication in our early childhood setting. Physicians may not be aware of the need for children in a childcare/preschool setting to have a specific action plan such as they do in a public/private school setting. - Community/Business Leader

There seem to be a lot of children and adolescents using inhalers for asthma. - Other Health Provider
Too many kids with asthma that causes them to miss school and use the Emergency Room. - Community/Business Leader

We have seen a great increase in the amount of asthma-related events that are occurring within the school day. Asthma action plans are growing yearly. - Community/Business Leader

Combined with the lack of exercise we are seeing an increase in asthma cases and use of medications. - Community/Business Leader

The increasing number of ER visits associated with asthma, resulting from the environmental hazards found in a significant number of homes, such as lead, dust, mold, insects, rodents, etc. - Community/Business Leader

In OPS, 30% of the student population has a known diagnosis of asthma. - Other Health Provider

High prevalence of allergies will flare asthmatics. Lack of understanding for those with mild asthma who do not carry albuterol. - Other Health Provider

Approximately 30% of the students in Omaha Public Schools have Asthma listed as provider-diagnosed condition. - Other Health Provider

There are still many children who use emergency or urgent care services to manage their asthma. School absence is also a problem that is compounded by suboptimal management of asthma. - Physician

Reports from schools that 25% of their enrolled children have asthma. - Community/Business Leader

Population, particularly in North Omaha, has a high incidence. Major cause of missed school, ED visits. Undertreated, as a whole. – Physician

A large number are impacted, and many are not well managed. - Social Services Provider

I see a lot of kids requiring the use of an inhaler. - Physician

Based upon the number of respiratory issues we see. - Other Health Provider

Environmental Contributors

I believe that our environment has been changed over the years, due to heavy pesticides, herbicides, and the overuse of household chemicals in general. Children no longer go outside and play in the dirt and get accustomed to allergens. Fewer pets in some areas. There is an increase in pollution. We still burn fields for farm work, no one can breathe easy with smoke in the air. Some students do not take their medication correctly and do not want to take it simply due because they are adolescents and want to make their own decisions. - Community/Business Leader

They have difficulty accessing medications, and parents missing work adds to the stress. There are housing issues. The presence of mold and drafts can cause issues for children with asthma and allergies. High-density housing exposes children with asthma to cigarette or other smoke from neighboring families—even if smoking is not allowed inside, smoke exposure through vents, in vehicles and doorways is nearly unavoidable. Children with sensitive airways and especially those with uncontrolled asthma, may have increased issues in this type of environment. - Social Services Provider

Lead issues have not been completely, fully addressed. House stock and living conditions of families need to be improved, as they trigger many of the asthma related issues. - Community/Business Leader

Chronic disease could be aided by policy changes for healthier homes and air. Access to best care-medications and support difficult. - Physician

Living in households where smoking takes place and lack of knowledge. - Community/Business Leader

Quality housing, rental housing inspection with health issues in mind are needed. - Community/Business Leader

Disparities related to asthma. Poor housing stock. - Community/Business Leader

Health Awareness/Education

Health literacy when it comes to understanding and then applying the information to everyday life. We need more certified asthma educators for families to access for questions and support. - Other Health Provider

Lack of patient, family education regarding signs and symptoms of acute attack and the long-term concerns for poorly controlled asthma. - Other Health Provider

Families lack the education on how severe asthma can be. Environment, compliance by parents and child. No insurance. - Physician

Children in the minority communities know very little about the signs and how to follow-up. Education and health care for asthma is lacking. - Community/Business Leader

Disease Management

Follow-up with preventative healthcare so that children with moderate asthma end up using the emergency department instead of going to their primary care provider or their specialty provider. Agencies like Omaha Healthy Kids Alliance could be utilized more to address asthma triggers in the home. - Other Health Provider

It is a common condition of children, and compliance to treatment plan is not consistently followed by many. - Other Health Provider

Diagnosis/Treatment

Kids visit the ED with problems that arise from this condition being untreated or because of parental low health literacy about the seriousness of this condition. - Other Health Provider

Pregnancy

Improper diets during pregnancy. - Community/Business Leader

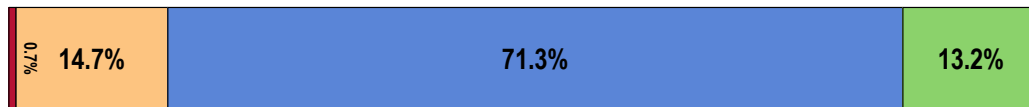
Bone, Joint, & Muscle Problems

Key Informant Input: Bone, Joint, & Muscle Conditions

More than seven in 10 key informants taking part in an online survey characterized **Bone, Joint, and Muscle Conditions** as a “minor problem” for children/adolescents in the community.

Perceptions of Bone, Joint & Muscle Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2018)

■ 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 about a randomly selected child in the household.

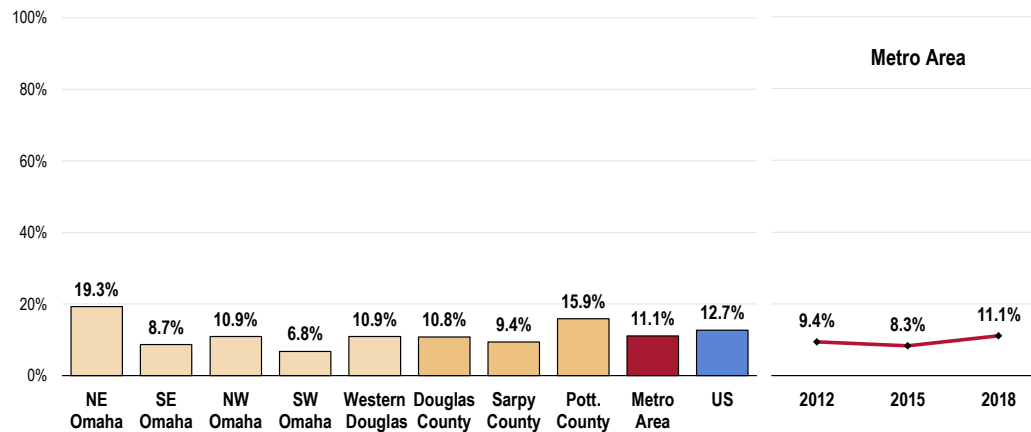
Cognitive & Behavioral Disorders

Attention Deficit Hyperactivity Disorder (ADHD)

A total of 11.1% 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 US figure.
- In Douglas County, highest in Northeast Omaha and lowest in Southwest Omaha.
- Differences by county are not statistically significant.
- TREND: The slight increase in ADHD diagnoses since 2012 is not statistically significant.

Child Has ADD/ADHD (Metro Area, 2018)



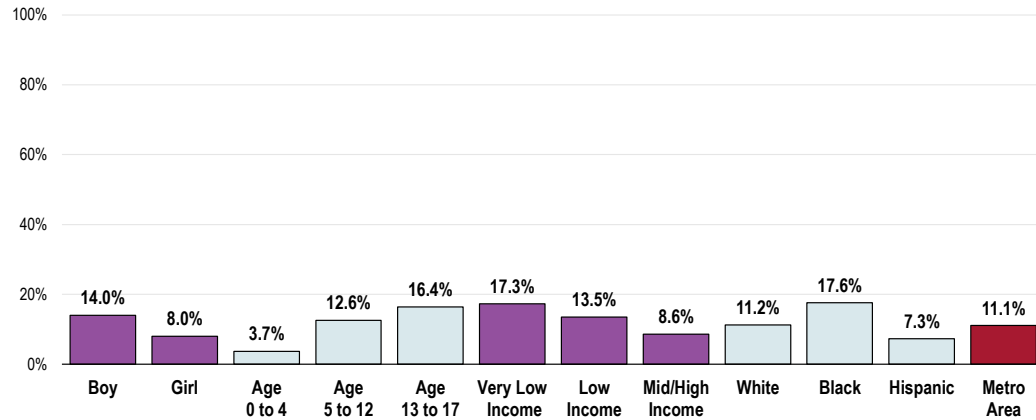
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 65]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

Metro Area children more likely to have suffered from/been diagnosed with ADD/ADHD include the following:

- Boys.
- Those age 5 and older.
- Children in very low-income households.

Child Has ADD/ADHD (Metro Area, 2018)



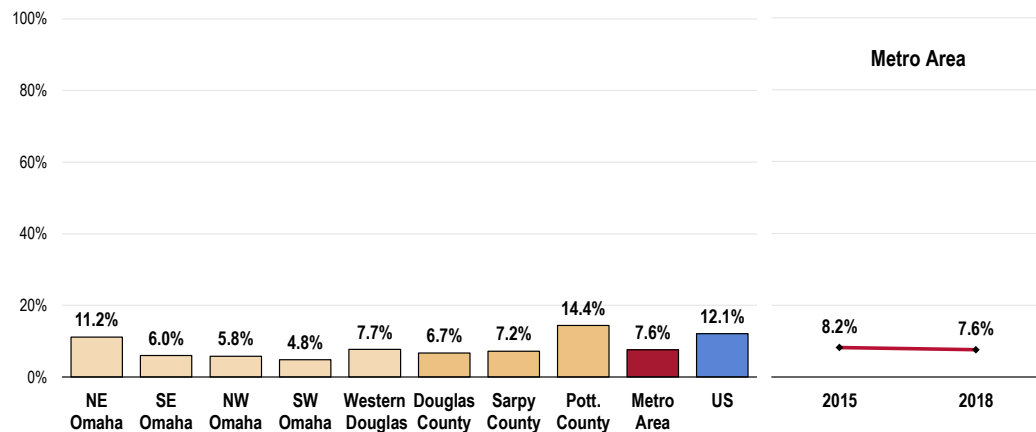
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 65]
Notes: • Asked of all respondents about a randomly selected child in the household.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Learning Disabilities

A total of 7.6% of Metro Area children are reported to have some type of learning disability.

- Lower than the US percentage.
- In Douglas County, highest in Northeast Omaha.
- By county, significantly higher in Pottawattamie County.
- TREND: The proportion of Metro Area children with learning disabilities has not significantly changed in the past three years.

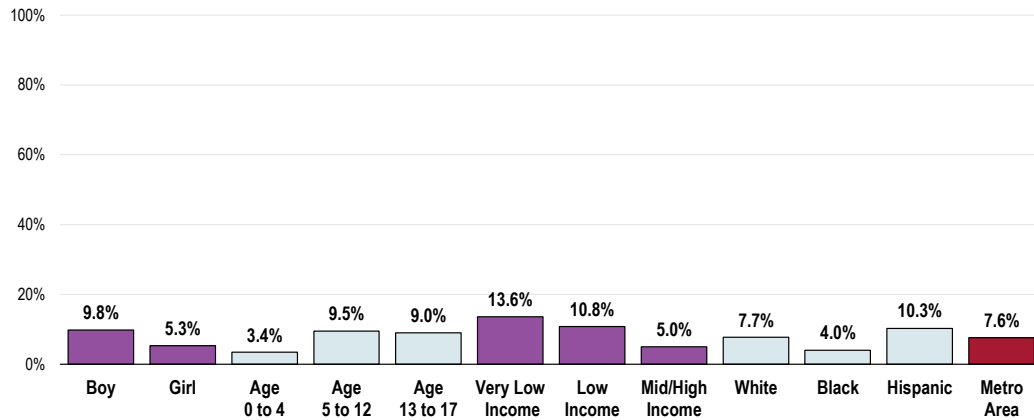
Child Has a Learning Disability (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 62]
Notes: • Asked of all respondents about a randomly selected child in the household.

- Boys, children older than age 4, and Metro Area children living in lower income households are more likely to have some type of learning disability.

Child Has a Learning Disability (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 62]

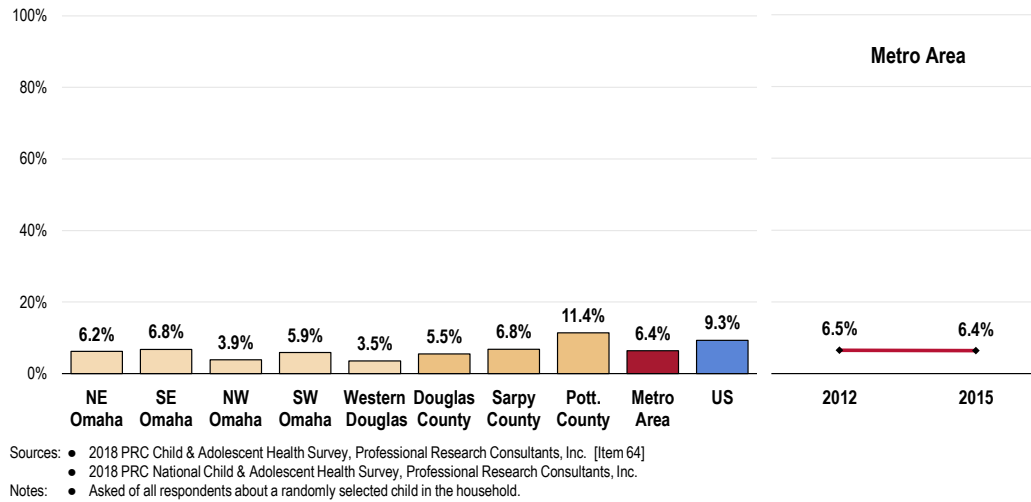
Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to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

Developmental Delays

A total of 6.4% of Metro Area children have been diagnosed with some type of developmental delay that affects his/her ability to learn.

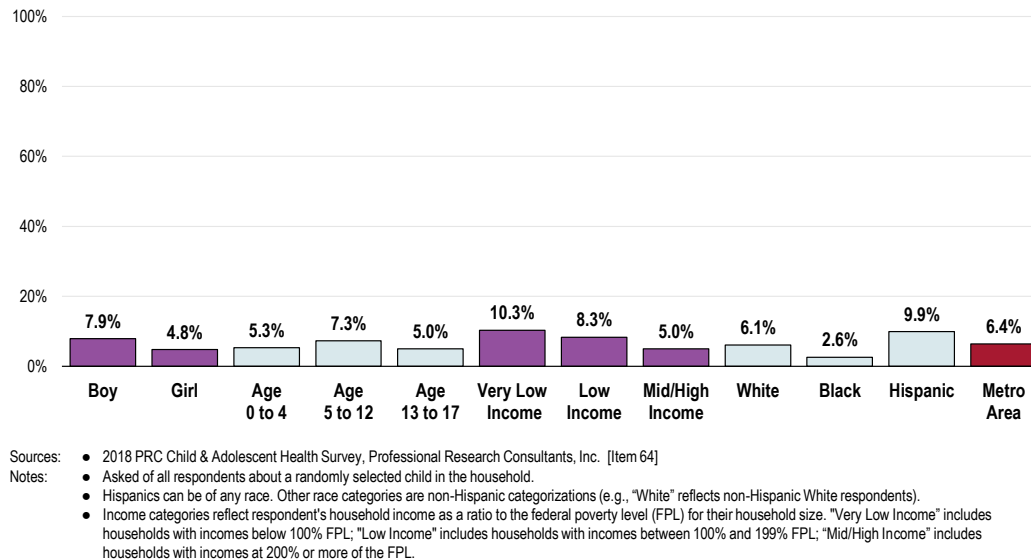
- Statistically lower than the US prevalence.
- Statistically similar among Douglas County communities, as well as by county.
- TREND: The prevalence of children diagnosed with some type of developmental delay has remained constant over time.

Child Has a Developmental Delay (Metro Area, 2018)



- Boys and Hispanic children show a higher reported prevalence of developmental delays.

Child Has a Developmental Delay (Metro Area, 2018)



Child Developmentally On Track

The vast majority of parents (91.9%) report that their child is developmentally on track compared to others their age.

- Within Douglas County, children in Northwest Omaha are reported to be the most on-track developmentally.
- No significant differences by county.

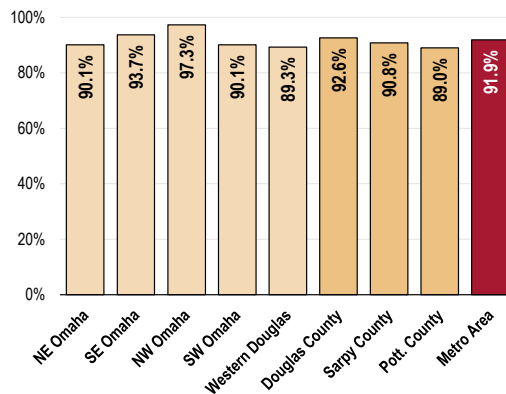
Of all parents surveyed, 96.6% report that they have enough information to know if their child is on track. Top sources for this information include a **physician** and **school**.

"Is this child developmentally on track compared to other children?"

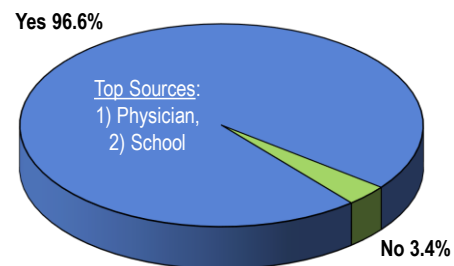
"Do you feel that you have enough information to know whether this child is on track?"

"Where do you get that information from?"

Child Is Developmentally On Track (Metro Area Children, 2018)



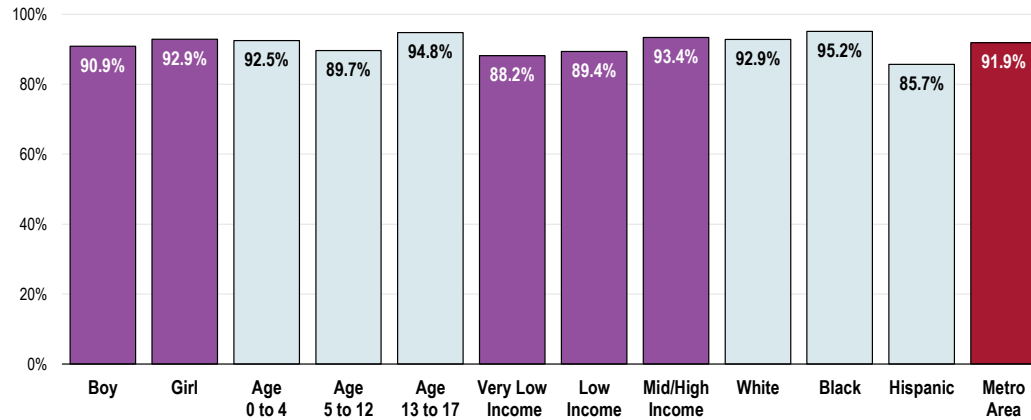
Has Enough Information To Know If Child Is On Track (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 327-329]
Notes: • Asked of all respondents about a randomly selected child in the household.

- Children more likely to be reported as developmentally on-track include teens, as well as Non-Hispanic children.

Child Is Developmentally On Track (Metro Area Children, 2018)



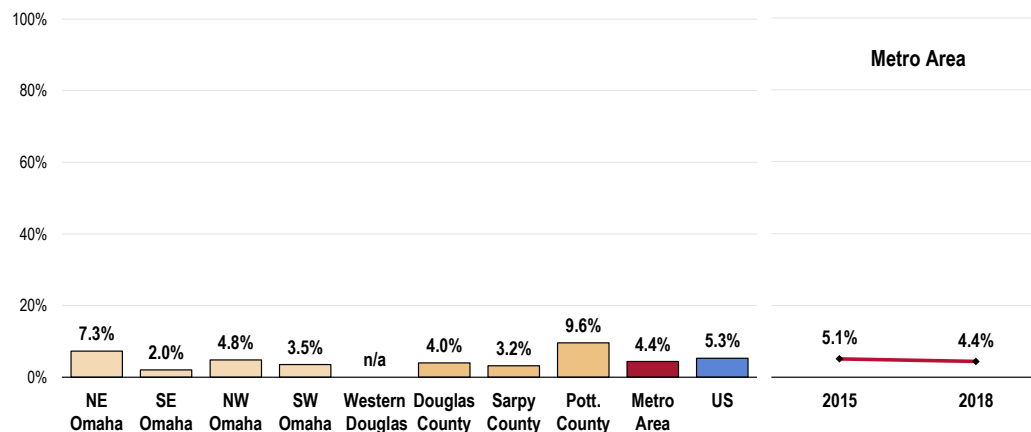
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 325]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Behavioral/Conduct Disorders

Among Metro Area parents of children age 5-17, 4.4% indicate that a doctor or other health care provider has ever told them that their child has some type of behavioral or conduct disorder, such as oppositional defiant disorder or conduct disorder.

- Similar to US findings.
- No statistically significant differences by area or county.
- TREND: Similar to that first measured in 2015.

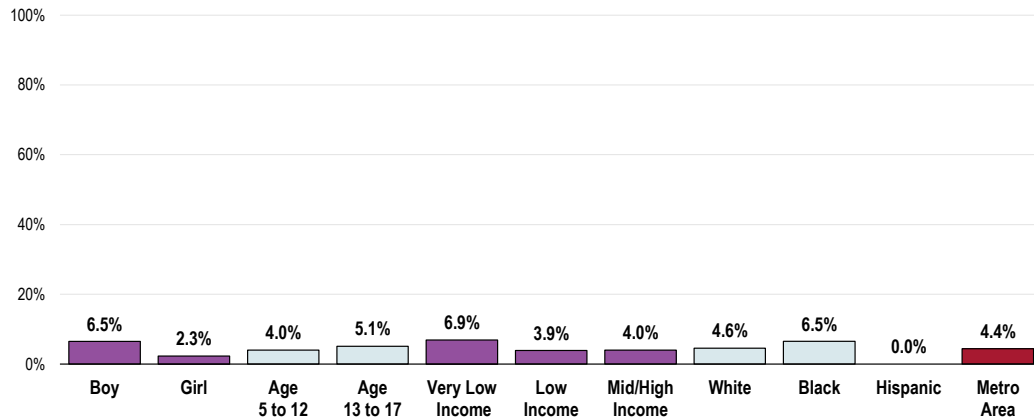
Child Has a Behavioral/Conduct Disorder (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 87]
 • 2018 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.

- Behavioral/conduct disorders among children in the Metro Area are more prevalent among boys.
- Also note that no parents of Hispanic children noted a behavioral or conduct disorder.

Child Has a Behavioral/Conduct Disorder (Metro Area Children Age 5-17, 2018)



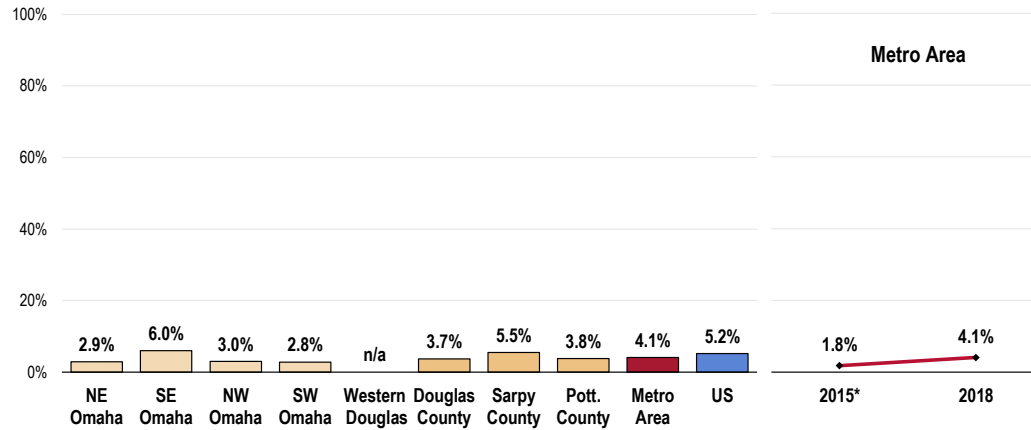
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 87]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Autism/Spectrum Disorders

Among Metro Area parents of children age 5-17, 4.1% indicate that their child has been diagnosed with autism, Asperger syndrome, pervasive developmental disorder, or autism spectrum disorder.

- Similar to US findings.
- Statistically similar by Douglas County areas, as well as among the three Metro Area counties.
- TREND: Represents a statistically significant increase since first measured in 2015.
Note that prior data did not specifically include other diagnoses other than autism.

Child Has Autism/Spectrum Disorder (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 88]

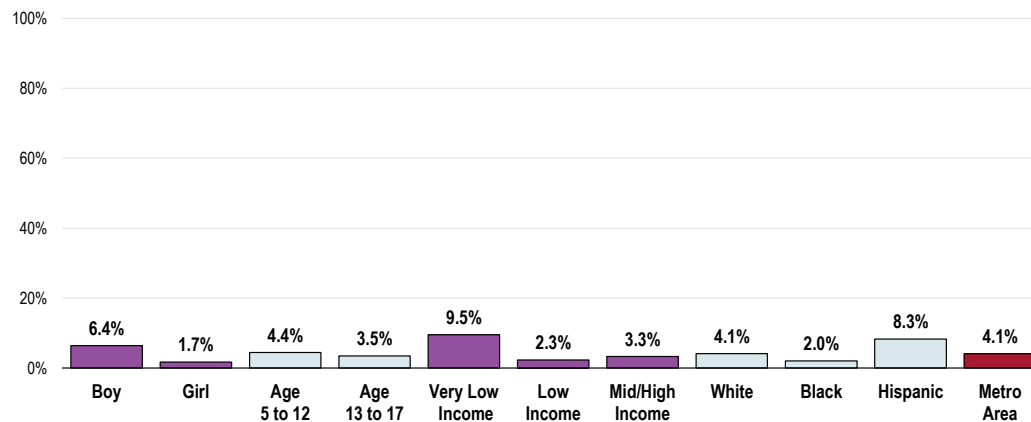
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

• *2015 data did not specifically include additional diagnoses on the autism spectrum, such as Asperger's disorder, pervasive developmental disorder, or autism spectrum disorder.

- School-age children more likely to be on the autistic spectrum include boys and children living in very low-income households (under 100% FPL).

Child Has Autism /Spectrum Disorder (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 88]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Cognitive & Behavioral Conditions

Over two-thirds of key informants taking part in an online survey characterized *Cognitive and Behavioral Conditions* as a “major problem” for children/adolescents in the community.

Perceptions of Cognitive & Behavioral Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2018)

■ 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 about a randomly selected child in the household.

Top Concerns

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

Prevalence/Incidence

Cognitive and behavioral conditions seem to be increasingly common in our community. Streamlining resources and clearly identifying access to assistance would be beneficial, while also looking at some possible adjustments within our school systems that could benefit ALL children - with or without any adverse cognitive & behavioral condition (such as additional/extended recess, nutrition, etc.). I would like to see less reliance on long term medications for children and more resources/information/research on alternative approaches to these conditions. - Public Health Representative

We provide developmental screening at our agency, and nearly every child we screen has a parent whom has concerns about ADD/ADHD, autism, and others. Additionally, we are often contacted by medical providers (family practice, pediatrics) to provide short-term, enhanced care coordination services to children who are not developing appropriately. Almost half of our referrals are for children with behavioral concerns. There seems to be a disconnect with providing services to these children and families. Behavioral health providers are stretched too thin and do not have enough availability to provide services to all children and families who need it. Additionally, non-traditional community services for behavioral health are not advertised well to families so that they can be utilized. Particularly in the Pottawattamie County area, it is important to have the 1st Five Program to provide gap connection services to help those families get connected with traditional and non-traditional resources - Other Health Provider

A number of surveys indicate that cognitive/behavioral conditions are significant in our community. Foster/adopted children are more likely to have ADD/ADHD, which adds to the challenges that this group faces. When bullying is discussed in our community, children with cognitive/behavioral conditions see to be more at risk. Next to Sarpy County, we have the highest prematurity rate in the state, with these infants more at risk for learning disabilities. - Public Health Representative

It's my opinion that we are seeing an increased number of children with cognitive/behavioral conditions but are not able to meet the need. Often, we are unable to meet the child's need due to the parent being unwilling or unable (transportation barrier, other children, work hours, inability to afford treatment) to take their children to the recommended therapy. Children diagnosed with autism in need of services are placed on wait-list after wait-list. Our community is not able to meet the demand for these children and their families. - Other Health Provider

I am seeing a lot of patients with ADHD and oppositional behaviors. Many the result of parents who are separated or the children are part of the foster system. - Physician

ADHD, ODD, substance abuse. Trauma and neglect. - Physician

ADD, ADHD continues to be a big concern in school classrooms and not only affects the child in need but also the other students who are trying to learn in the classroom. - Physician

Learning problems, ADHD, aggressive behavior, school failure. - Physician

We are seeing more cases of ADD/ADHD. In the school settings, it is becoming more prevalent that they will be treated with other ways not including medications, which can sometimes be good or bad. Unfortunately, staff has not been properly trained to deal with the students who are treated in other ways. - Community/Business Leader

Increase in ADD, ADHD. - Other Health Provider

There seems to be a high percentage of children and adolescents with ADD/ADHD, ODD, and IEPs in our after-school programs. - Community/Business Leader

Cognitive and behavioral conditions are widespread, and there are supports/services to address. However, the flexibility of accessing these services does not allow for many families to access them. Hours of operation, days of operation, location in the community prevents access for all. - Community/Business Leader

There are limited resources for the identification of the problems and then the support for the therapies needed. The time that it takes for behavioral appointments is a strain on the families who have both parents who are working. - Other Health Provider

I feel there is a rise in the number of patients being seen for these issues. I think a major reason for this is there needs to be better parenting classes for parents. I also think too many kids spend hours on technology and fewer kids are doing actually hands on learning activities - Other Health Provider

Increasing rates of ADHD and autism, and limited resources for treatment, especially intensive therapy for autism. - Physician

More children are being screened for these conditions by their primary care provider, and we are identifying more kids. - Other Health Provider

Nebraska is one of the highest utilizing states for psychotropic drugs. - Community/Business Leader

They are increasing steadily in severity and prevalence in the community. - Public Health Representative

We see an increase in autism in our area and continue to add staff to work with these students. - Community/Business Leader

The number of children needing behavioral health appointments. They are unable to see a provider until 2-3 months out. If there is a crisis situation, they are sent to the Emergency Department, Immanuel or Mercy. - Other Health Provider

Rising rates of diagnosis, ability to identify autism earlier, disparities and ensuring the diagnosis is appropriate. - Community/Business Leader

Cognitive and behavioral conditions are major problems for children and adolescents because they are often over-diagnosed and/or undertreated. - Community/Business Leader

We work in the behavioral health field, so see this quite often. I think our communities, schools and providers are doing a good job of addressing these concerns, but there is still a lot of work to be done. - Community/Business Leader

More children with this diagnosis. - Physician

Access to Care/Services

There is a lack of resources and services. Many of the programs do not understand how to work with minority children, youth, and families. - Community/Business Leader

We are seeing a rise in behavioral health problems and it is very difficult to get patients into psychology and psychiatric services in a timely manner. Typically, parents don't bring the child to PCP until it is a crisis situation and then the waits are very long. The other issue is patients who are severe enough to be admitted to acute inpatient psychiatry units are discharged with instructions to follow up with psychiatry for medication checks and refills but can't get in to see a psychiatrist for months. The PCP's are forced to manage the meds for several months. There is also a great shortage of developmental and behavioral pediatricians and the wait for evaluations for autism and difficult to manage ADHD is anywhere from 2-6 months. Once seen and diagnosed with autism the wait for ABA therapy can be over a year. At a time when the developmental clock is ticking we are losing the chance of helping these kids. - Physician

Lack of seamless access to care. A family is in crisis if their child is expelled from kindergarten or day care, and there is no instant fix. Better access to parenting classes would be helpful. Mental health disorders and autism are very difficult to handle for primary care providers, especially in population that are immigrant and non-English speaking. Lots of walls to care. MONTHS and waiting lists for Monroe-Meyer, few developmental pediatricians. Could we have a directory of resources for this? - Physician

State does not adequately provide the resources for the provision of behavioral health services for children. Uses Medicaid and NE was a state that chose not to participate in ACA. High rate of out-of-state placements due to behavioral health care. State rated very low in provision of services. - Community/Business Leader

Behavioral Conditions often require ongoing treatment which usually includes medication and counseling. It is often difficult for families to access the counseling and education of their child along with their own medication. Education of the parent is essential in understanding how to manage and support the student with these conditions. ADHD is also a condition that often requires medication and behavior management with education of the parents in improved organization, and routine in the household assists in better ADHD management for the child. Parents need to know community resources (e.g. Autism Center of Nebraska). - Other Health Provider

Access to resources for cognitive and behavioral conditions in Omaha are limited and therefore, these illnesses are major problems in our community. Primary caregivers (pediatricians and family practice physicians) are not necessarily adequately trained to treat these conditions, so they are sent to behavioral pediatricians/behavioral therapists, and I do not believe there are enough to treat all patients. - Physician

Additional resources are needed to address early accurate detection of cognitive and behavioral conditions. DE stigmatization and understanding of cultural norms should be given more consideration when strategies are being developed. - Community/Business Leader

Personal experience with understanding the lack of resources when people have looked for them and waiting lists for help. - Other Health Provider

There is more demand for services than can be provided in a timely manner. - Social Services Provider

There are wait lists. There are no services available for young adults who have high functioning autism. - Community/Business Leader

More affected children than available services. Service providers in silos without much coordination for access, services and follow up. Limited money to pay for services. Some parents unable to effectively help their children obtain help. - Physician

Lack of services and financial means of the public. - Community/Business Leader

Wait lists, travel distance to providers, cost and no insurance. - Community/Business Leader

Lack of mental health services available. - Social Services Provider

Limited access to care, poor parent compliance. - Physician

Lack of resources and lack of providers. - Physician

School

Services in schools are lacking. Some school districts are better than others. - Community/Business Leader

Children in the area I serve often fall through the cracks in the public schools. Learning disabilities and cognitive/behavioral conditions are often underdiagnosed or responded to punitively rather than with empathy. Many of these same children come from homes that lack a solid foundation of support as well. - Community/Business Leader

Seeing the impact that behavioral conditions have a child's access to be successful in school. - Community/Business Leader

The high levels of signs and symptoms of issues within the local school systems related to violence, missing, skipping school, disciplinary actions, and dropout rates particularly for the ethnic, racial minority populations. - Public Health Representative

The increasing number of young people enrolled in special education classes. The amount of trauma experienced by young people in the community and the unavailability of diagnostic and treatment facilities. - Community/Business Leader

The first years in a child's life are extremely important for helping them reach cognitive milestones. When children aren't taken care of well, nurtured and enriched, you see these behavioral and cognitive delays once they begin school. - Community/Business Leader

Affects daily life, can lead to problems in school and problems at home. Can cause difficulty building relationships with other children at school leading to isolation. - Other Health Provider

While Early Development Network services are very helpful for issues like developmental delay in 0-3-year-olds, the criteria to qualify for services are set high to limit burden on the system. School-based evaluation for potential learning disorders in older children can be difficult to initiate & takes a long time to complete. And schools are unable to diagnose specific issues like dyslexia. Private resources for learning disability (LD) evaluation & treatment are not covered by health insurance & can be expensive. The area's best place to refer for autism evaluation & treatment/resources is UNMC's Munroe Meyer Institute. - Physician

ADD/ADHD, Autism, and learning disabilities are not properly looked at with regard to kids in school. The autism spectrum is so large that when we have a child with autism we are at the mercy of the diagnosing physician, which is sometimes difficult to connect. - Community/Business Leader

The number one issue teachers describe seeing in their settings are emotional and behavioral health issues. Our state and our city have not made emotional and behavioral health needs a priority. Our current system does not serve families and children well. - Physician

Early childhood providers (EDN, Schools, Head Start) are dealing with children who demonstrate significant behavior concerns. Many children are getting "kicked out" of community childcare centers and parents are left struggling with managing behavior. Autism verifications are also increasing, especially for children under the age of 3 (educational verification). Mental health issues both within the child and within the child's family are contributing to an increase in challenging behaviors that interfere with the child's ability to remain on a typical developmental trajectory. - Community/Business Leader

Increasing number of children having serious trouble in school. - Community/Business Leader

Major issue that prevents success in school. - Community/Business Leader

Lack of Providers

There are very few mental health providers available and wait times are extremely long for many patients to access service. The providers in the area are stretched thin and while we often want to coordinate care with one and other, don't have the time or resources to do so. - Physician

This is a problem for having enough skilled practitioners able to address the issues. Early autism treatment is vital but very expensive with the high number of therapy hours required per week for each child. Early Development Network programs are "advising" programs for parents and not the intensive therapies required. The Omaha Metro area has limited opportunities for children aging out of school programs and into supported work and living arrangements that are sustainable for a young person's lifetime. The Minneapolis area is a great example of community planning/development for access and services that are adaptable for people not able to drive. - Other Health Provider

Cognitive and behavioral conditions are major problems for child/adolescent due to lack of providers with expertise in treating related health concerns such as ADD/ADHD, autism, and learning disabilities. - Other Health Provider

Not enough providers, difficult to get appointments and then families do not keep appointments due to parental issues. - Other Health Provider

Limited behavioral health access continues to be a problem across the US and remains one of the main contributing factors in disability and lost productivity. A large number of our mentally ill community end in prisons, as well. - Physician

These are problems in our community because there aren't enough practitioners in our community to meet the needs of all of our children. - Community/Business Leader

There are too few providers of these services in the area. Some PCP's may treat these without full knowledge of current evidence-based practice. - Physician

Limited availability of providers, limited insurance coverage for costs of care. - Physician

Not enough mental health providers limited resources, access to autism specialists. - Physician

Limited practitioners. - Other Health Provider

Health Awareness/Education

I think that children have a lot of behavioral and mental health issues and parents are not sure or don't have the skills to cope with them. There are not enough Medicaid-approved mental health providers and there are frequent waits for children needing to see a psychiatrist. There is a lack of mental health supports if a child needs more support than outpatient therapy can provide but isn't yet in need of a PRTE placement. There is a shortage of providers that are able to assess and work with children on the autism spectrum and many times, public schools are unwilling or unable to provide the supports needed for these children via a 504 plan or IEP plan. - Other Health Provider

Many times, parents and care givers don't recognize behavioral health concerns as needing to be addressed from a healthcare standpoint. - Public Health Representative

There is a lack of understanding about these diseases, lack of medical assistance, lack of medical services for these diseases and a lack of education on how to interact with individuals who have these conditions. - Community/Business Leader

Lack of information and education within Latino community, cognitive and behavioral health concerns. Parent and child/adolescent education needs to be improved. - Community/Business Leader

Poor education or lack of education. People that have mental health issues themselves are parents now. They had trouble navigating the world, and now they have children with even deeper problems. Multiple and complex mixtures of prescribed medications to try and help with mental health issues and a lack of behavioral mental health treatment with counselors, therapists, and doctors. Single parents with limited mental capacity, mental illness as a diagnosis and these individuals are attempting to parent children on their own or with family support that also has serious mental health issues. Individuals struggle to stay on medication as well as get proper mental health therapy with human contact not just pharmaceutical treatment. - Community/Business Leader

Children in this community have to deal with a lot of trauma and consistent change. Families also lack the education around mental health issues and still some believe it is a stigma. - Physician

Low education in parents and also diets. - Community/Business Leader

Denial/Stigma

Many do not recognize the signs or are in denial. They lack trust of the system because they do not want their children to be labeled. - Social Services Provider

Many children and adolescents don't receive treatment because of the stigma of mental health and substance abuse. Therapy isn't seen as a benefit by many people when, if they used therapy, conditions could be managed early on. The suicide rate in Omaha is too high. - Social Services Provider

Many parents don't believe in seeking services for mental health issues. There still remains a stigma in certain cultures and communities. There is not enough access to trainings to inform families and communities regarding these conditions. - Social Services Provider

Due to stigma, misinformation, no information and access may deter a child early on from receiving services. - Community/Business Leader

Stigma and access are major reasons why behavioral health resources are not utilized for early diagnosis. Lack of racial and cultural equity exist and hinder usage of services. - Other Health Provider

Diagnosis/Treatment

I believe there are a lot of chemical and other neurological conditions untreated or misdiagnosed in the community at large. I think we have created a system that focuses on intervention rather prevention. Many of these challenges are also generational. They are behaviors that are caught from the family leaders and community. - Social Services Provider

Children with these conditions often do not receive consistent care leading to improved outcomes. Parents would benefit from additional education and support, so they feel that the child and family receive support, not judgement. - Community/Business Leader

These challenges impact an individual's ability to maximize their full potential if not identified and addressed early. - Social Services Provider

[In the WIC Program,] during health screenings parents often self-report cognitive and behavioral concerns their children are being treated for. - Public Health Representative

Vulnerable Populations

This is a major consideration in North Omaha. Many of our families have children who show the signs of ADD or ADHD, but in reality, their behaviors are more likely based on home trauma that results in behaviors mimicking that of ADHD and ADD. We also see a strong family correlation between current needs of children and the needs their parents had. Many of these needs never were treated or diagnosed in the parents and therefore parents see no need to treat their children. There is also a general sense that using medication for ADD or ADHD is a negative. There is a fear that these medications will create a zombie child. Learning disabilities are also difficult to diagnose in a school where children come to the learning environment not being ready to learn. It is difficult to understand if it's just lack of access or if it truly is a learning disability. - Community/Business Leader

I work with refugee families. It can be difficult to get providers to understand that children can need BOTH special education and ESL support - and that one thing isn't causing the other. Many providers are hesitant to work cross culturally or with interpreters because they lack cultural proficiency. - Social Services Provider

As a group, individuals with disabilities have among the highest poverty rates, lowest educational levels, lowest average incomes, and highest out-of-pocket expenses of all population groups. Any substantial shock to the financial stability of people with disabilities can threaten their access to necessary housing, nutrition, medical care, and other resources, the absence of which may result in further vulnerability and possible poverty. (Journal of Sociology and Social Welfare, March, 2001, Volume XXVIII). - Community/Business Leader

Systems are difficult to navigate, especially for families who speak languages other than English (or do not speak English well); waits for appointments with specialists are quite long; stigma related to diagnosis; out of pocket costs for services for children who do not qualify for Medicaid - Social Services Provider

Again, LEP families- particularly non-Spanish speakers- have very limited mental health care options that are available to them. - Social Services Provider

Parenting

The issue here, I believe, lies in parenting problems. Children are being left to electronic devices, disregarded when considered by parents as inconvenient, untended and unstimulated by healthy interaction with loving parents. As a result, children struggle with unacceptable behavior in their desperate search for healthy adult attention. Likewise, the combination of a lack of healthy parental interaction and the overload of garbage stimulation obtained through unsupervised video games and cell phones results in impaired reasoning skills and "common sense" in the developing child. Add to this the emotional damage wrought by inability to bond with disaffected parents and you get an insecure, anxious, impulsive child who knows no boundaries, and struggles both in the social environment and in the classroom. Autism falls in a different category, though autistic children may be at increased risk of experiencing the foregoing scenario due to their underlying disease spectrum. - Community/Business Leader

I believe that many children are being raised without the advantages of a two-parent family. Therefore, children are more likely to develop behavioral problems that manifest in poor attendance at our schools, joining of gangs, and social misfit. - Community/Business Leader

Affordable Care

Many parents are struggling to afford the medications that are prescribed for their children. They may have health insurance, but the co-pays and deductibles are so high that they cannot use it. And medication costs are very high. Children who take medications inconsistently do not do well. - Community/Business Leader

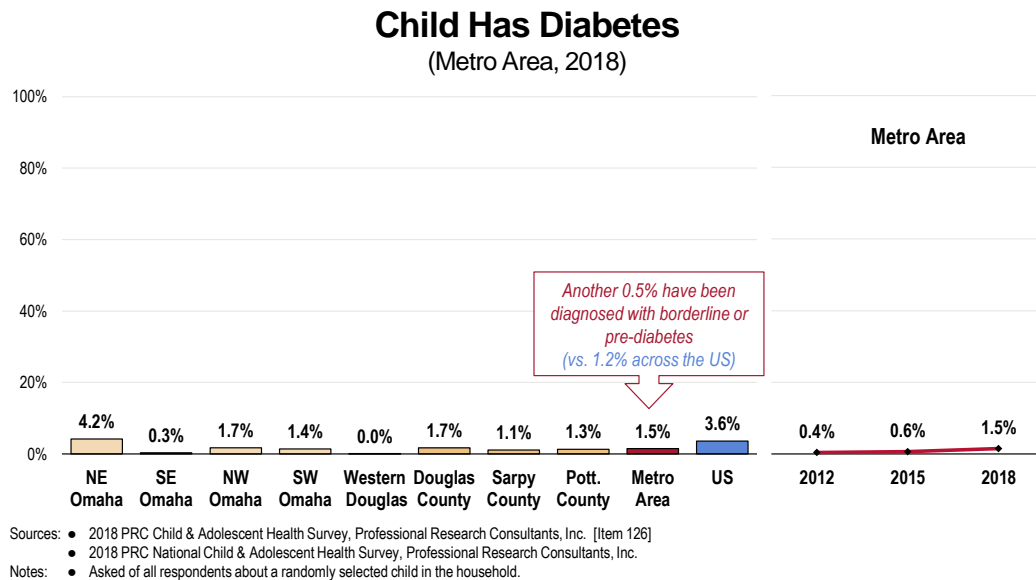
Diabetes

Prevalence of Diabetes

A total of 1.5% of Metro Area children age 0 to 17 have been diagnosed with diabetes.

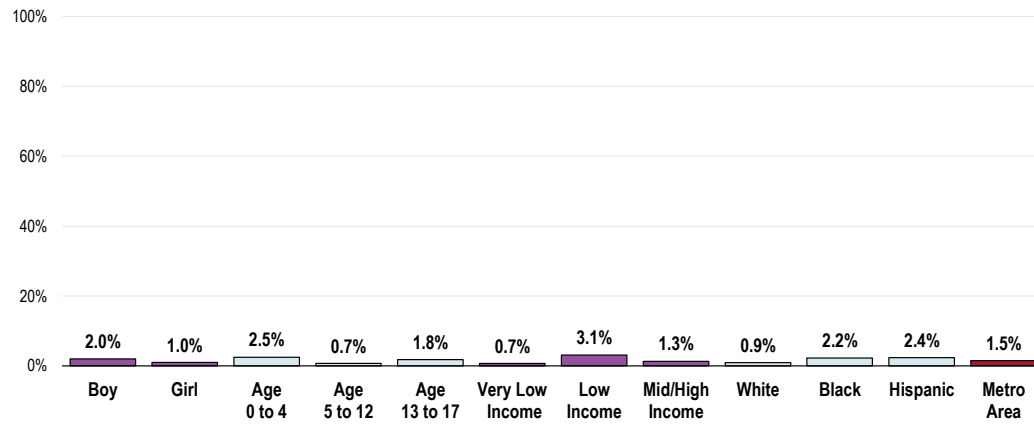
- Lower than the US prevalence.
- In Douglas County, significantly lower in Southeast Omaha and Western Douglas (where none reported).
- No statistical difference among individual counties.
- TREND: Above findings from prior years.

In addition to the prevalence of diabetes noted above, another 0.5% of children have been diagnosed with borderline or pre-diabetes (significantly below US findings).



- No significant differences by demographic characteristics.

Child Has Diabetes (Metro Area, 2018)

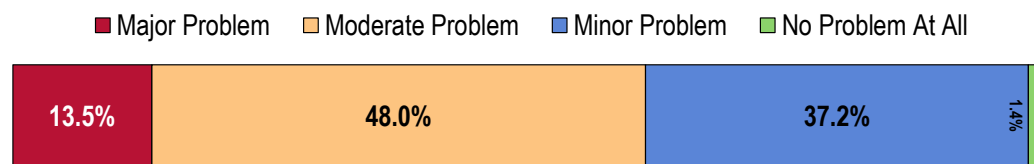


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 126]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Diabetes

The greatest share of key informants taking part in an online survey characterized *Diabetes* as a "moderate problem" for children/adolescents in the community.

Perceptions of Diabetes as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Obesity/Overweight

We witness as a community a steady increase in childhood obesity and along with obesity is the increased risk of acquiring Type 2 diabetes. There is still a long road ahead of providing easier access to healthier food choices for all families; junk food and non-nutritional food becomes the primary food source for many socioeconomically challenged families and unfortunately, the only opportunity for a well-balanced nutritional meal is offered at the child's school. - Public Health Representative

Obesity rates are soaring among young people. Research shows this leads to a myriad of issues in adult life. If young people created better habits early on, it would help ensure that they stay free of diabetes and other obesity-related health issues. - Community/Business Leader

We are seeing an increase in obesity, pre-diabetes and type II DM. The wait to get into endocrine for type I or type II or other endocrinology problems is several months. - Physician

With growing obesity among children, DM will grow. - Community/Business Leader

Overweight and at risk from genetics of parents. - Community/Business Leader

Access to Healthy Food

Poor food choices and options. No understanding to choose other options. Lack of physical health and wellness. Every child will choose sugar over greens when they make the decision on their own. Every parent will give kids sugar over greens when the goal is to quiet the kids versus develop them. Cost of healthy options versus convenience and low prices of unhealthy foods. - Social Services Provider

Lack of whole foods to purchase, lack of money to purchase whole foods, lack of knowledge related to good nutrition. - Community/Business Leader

The lack of access to healthy foods results in a dependence on foods full of sugar and other preservatives that lead to diabetes. - Community/Business Leader

Health Awareness/Education

It's a tough issue no one wants to openly discuss. Nutrition in schools and at home is affecting millions of kids, but there is very little work that is being done to solve the problem. Lack of education and information on nutritional value of food. - Community/Business Leader

Education for parents on dangers of high carb sugar meals and lack of parental support when physicians try to help. - Other Health Provider

Lifestyle

Parents work most of the time and don't make a priority to feed healthy food to their children, and the adolescents prefer to have fast food than to eat the food from home or school many times. - Community/Business Leader

Unhealthy eating and lack of physical activity put them at risk for pre-diabetes, and then developing diabetes earlier in life. - Community/Business Leader

Prevalence/Incidence

We are seeing more and more diabetics every year, and they seem to be getting younger. They are also using more new devices, such as pumps, and continuous monitoring systems. - Community/Business Leader

Higher rate of diabetes for Latinos. - Community/Business Leader

Disease Management

As children get older and have this condition, they sometimes resist compliance. We see some children through CPS referral with medical neglect or non-compliance. - Other Health Provider

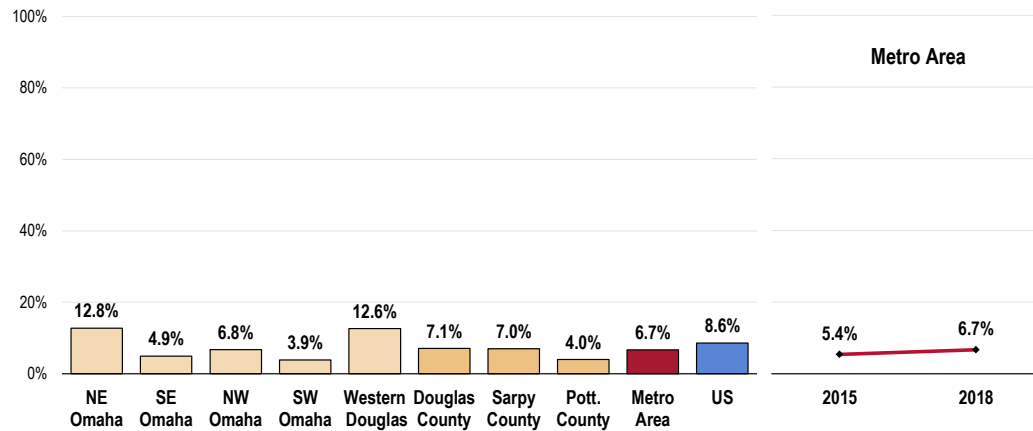
Neurological Conditions

Migraines/Severe Headaches

A total of 6.7% of Metro Area children suffer from migraines or severe headaches.

- Comparable to the US percentage.
- Within Douglas County, Northeast Omaha has the highest reported prevalence of migraines or severe headaches.
- Comparable by county.
- TREND: Statistically unchanged since first measured in 2015.

Child Has Migraines/Severe Headaches (Metro Area, 2018)



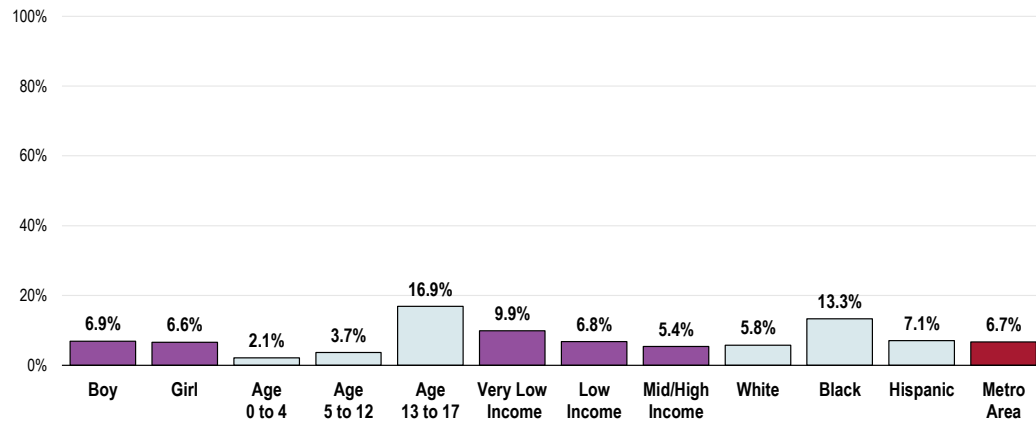
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 60]

• 2018 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 teens are much more likely to suffer from migraines/severe headaches than younger children.
- Other differences by demographics are not statistically significant.

Child Has Migraines/Severe Headaches (Metro Area, 2018)



Sources: • 2018 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).

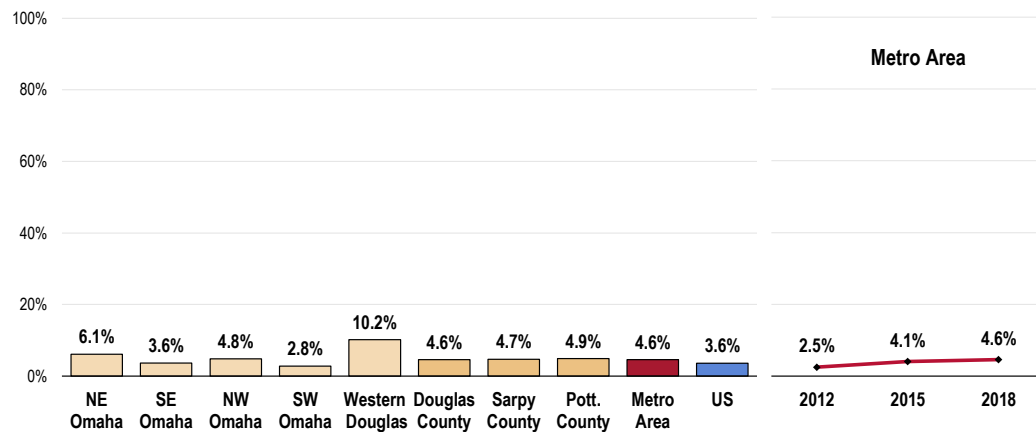
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households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

Brain Injury/Concussion

A total of 4.6% of Metro Area children have suffered a brain injury or concussion.

- Similar to the US figure.
- No significant differences by area.
- TREND: Marks a statistically significant increase in brain injuries since 2012.

Child Has Had a Brain Injury/Concussion (Metro Area, 2018)



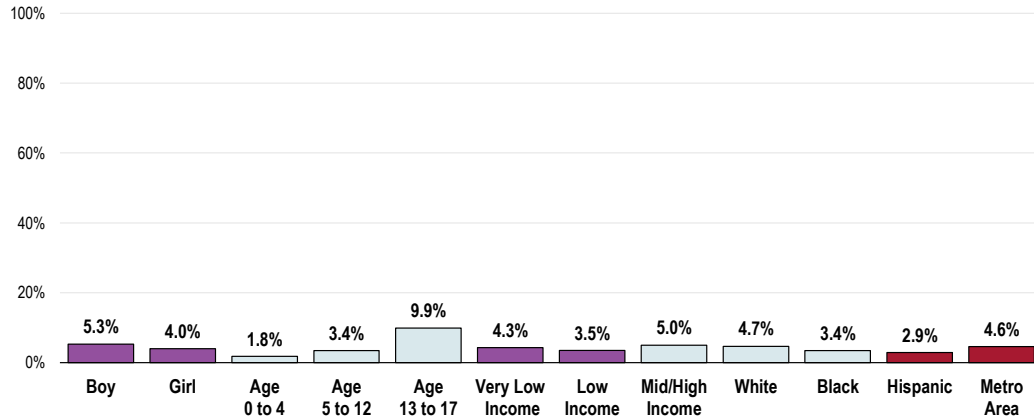
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 59]

Notes: • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

- Brain injury/concussion is predominantly noted among teens.

Child Has Had a Brain Injury/Concussion (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 59]

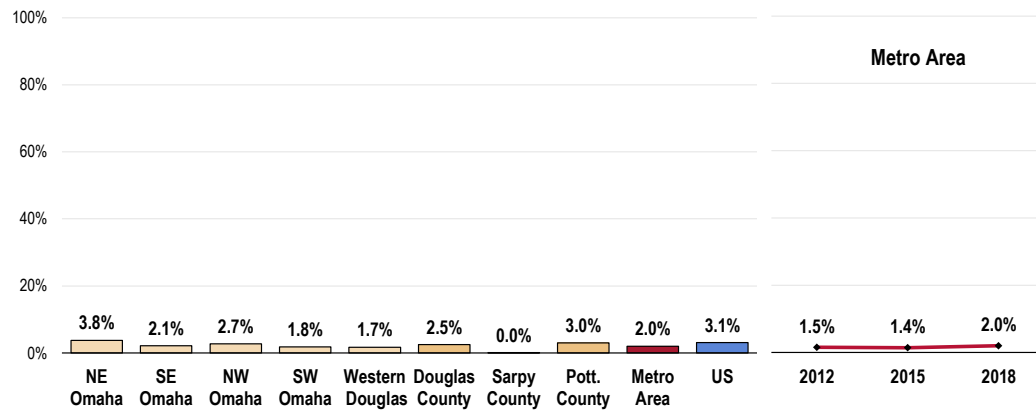
Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to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

Seizure Disorder/Epilepsy

A total of 2.0% of Metro Area children have epilepsy or a seizure disorder.

- Similar to the US rate.
- The areas within Douglas County show similar findings.
- By county, much lower in Sarpy County, where no parents reported a seizure disorder or epilepsy for their child.
- TREND: Statistically, there has been no change in the prevalence of seizure disorders since 2012.

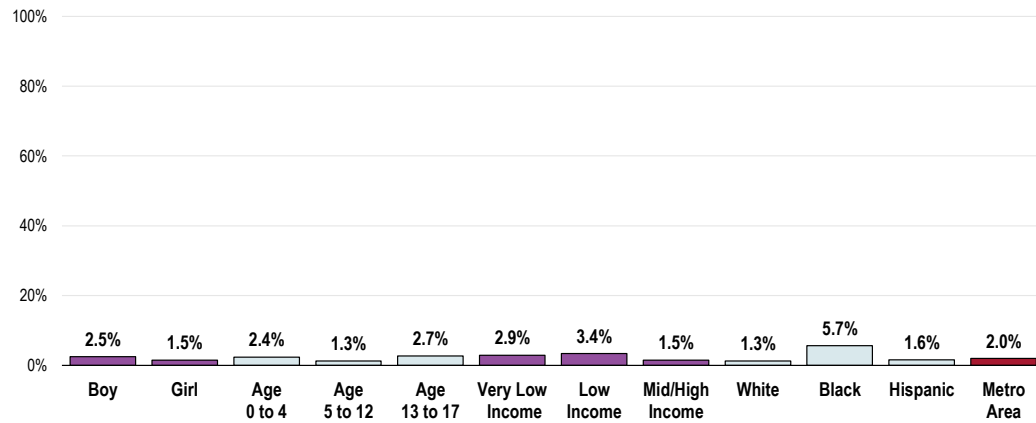
Child Has Seizure Disorder/Epilepsy (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 58]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

- There are no significant differences when viewed by demographics.

Child Has Seizure Disorder/Epilepsy (Metro Area, 2018)

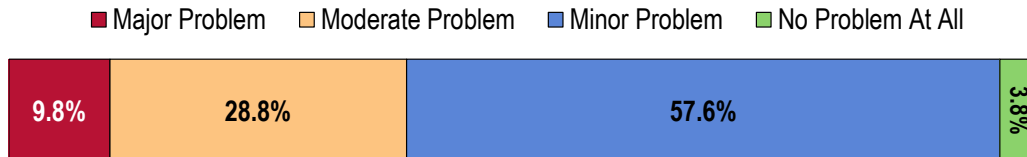


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 58]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Neurological Conditions

Over half of key informants taking part in an online survey characterized *Neurological Conditions* as a “minor problem” for children/adolescents in the community.

Perceptions of Neurological Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Access to Care/Services

Long waits for seeing a neurologist, inconsistent quality of neuroradiology, poor interaction between neurosurgery and neurology. - Physician
Patients tend to spend months waiting for appointments to see a neurologist. - Physician
Long waiting lists to access qualified neurologists in the community. – Physician
Access to appointments. - Other Health Provider

Lack of Providers

There are few well-trained children’s neurologists in the Omaha area. Treatment is not state-of-the-art. - Physician
Limited neuropsychiatric. - Other Health Provider
Limited numbers of providers. - Physician

Culture/Social Norms

They worry at very young ages about adult problems. - Community/Business Leader

Health Awareness/Education

Lack of education on what these conditions entail and how to spot the symptoms. I had a 5th grade student’s mom pass away in our parking lot because she was having a seizure. The student pounded on her chest to keep her awake, which helped her survive for a few days. Another student was in the car and had no idea what was happening or what he could have done - Need more training for our families on how to treat and notice symptoms. - Community/Business Leader

Prevalence/Incidence

We are dealing with more concussions. - Community/Business Leader

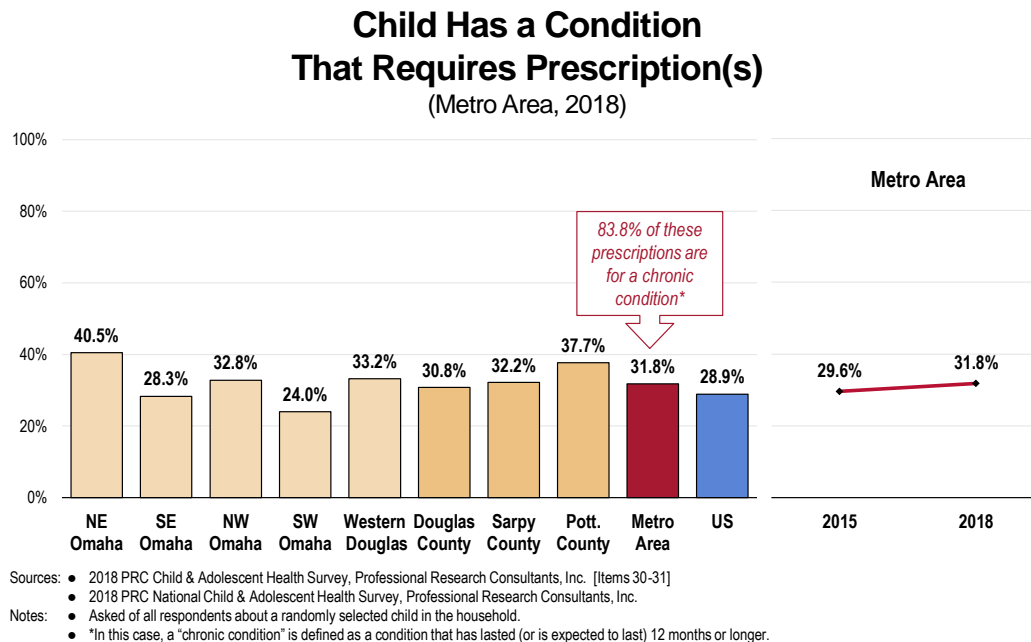
Condition Requiring Prescriptions or Special Therapy

Prescriptions

More than three out of 10 Metro Area children (31.8%) have a condition that requires prescription medication(s) (not counting vitamins).

- Statistically similar to the prevalence nationwide.
- Highest in Northeast Omaha when looking at areas within Douglas County.
- No statistically significant difference by county.
- TREND: The increase over time is not statistically significant.

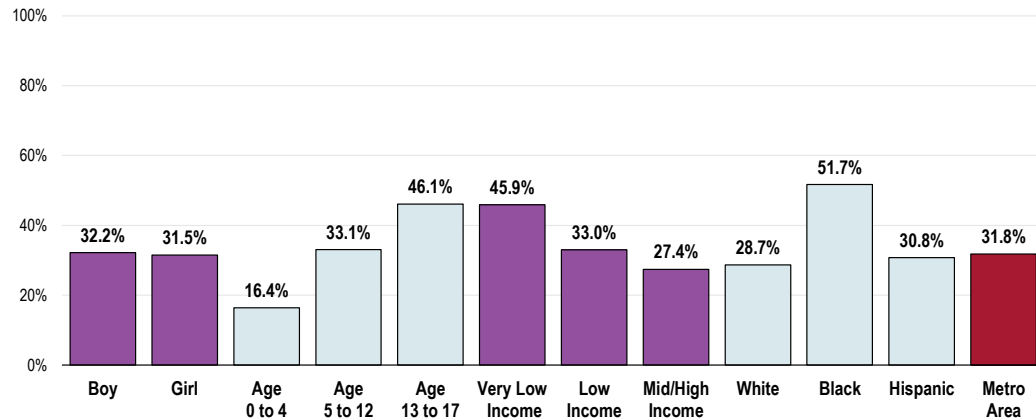
More than four-fifths (83.8%) of these prescriptions are for a chronic condition.



Note that over half of **Black** children are reported to have a condition that requires a prescription. The following demographic groups also are more likely to use prescriptions for a condition:

- Older children (strong correlation with age).
- Very low-income children.

Child Has a Condition That Requires Prescription(s) (Metro Area, 2018)



Sources: • 2018 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

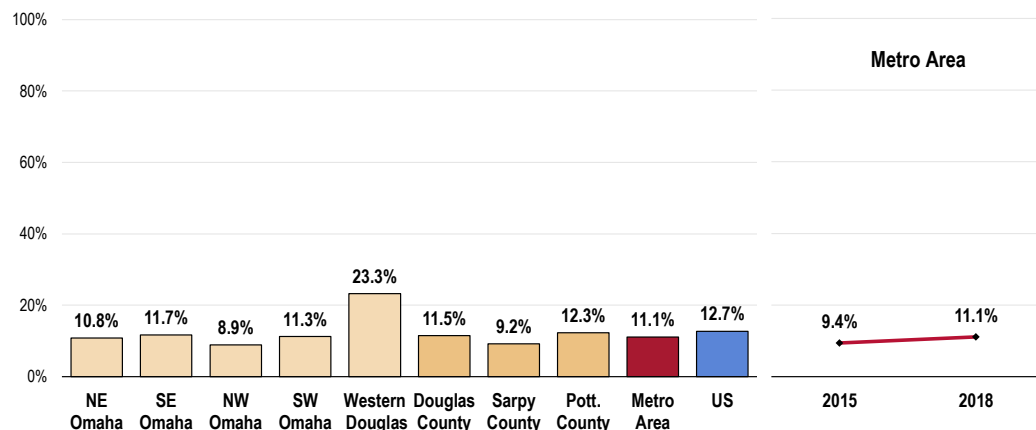
Special Therapy

A total of 11.1% of Metro Area children has a condition that requires special therapy.

- Statistically similar to the national proportion of children receiving special therapy.
- Within Douglas County, special therapy is notably highest in Western Douglas.
- No statistically significant difference among the three Metro Area counties.
- TREND: Statistically similar in the Metro Area over time.

Special therapy might include physical, occupational, or speech therapy.

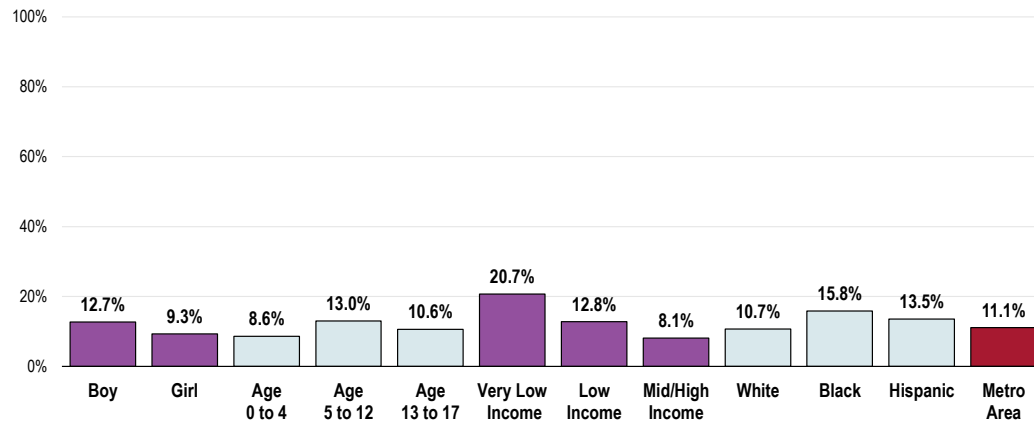
Child Has a Condition That Requires Special Therapy (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 32]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Children in very low-income households are more often reported to utilize special therapy than those in higher-income households.

Child Has a Condition That Requires Special Therapy (Metro Area, 2018)



Sources: • 2018 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Oral Health Problems

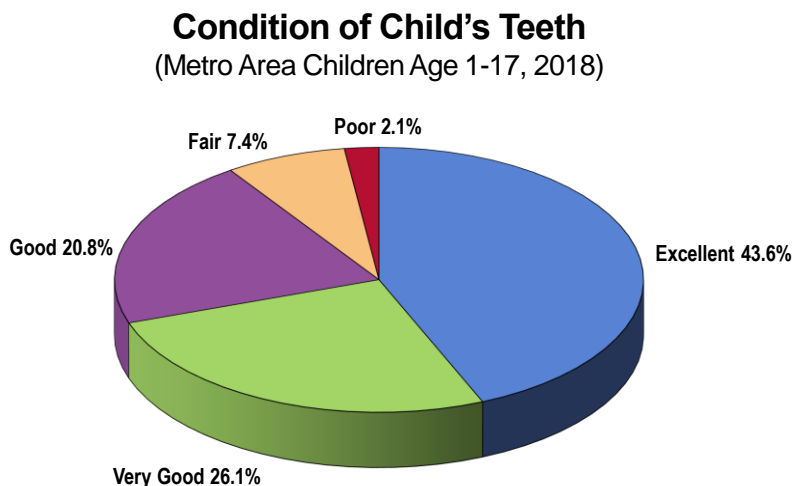
Condition of Teeth

"How would you describe the condition of this child's teeth?"

Would you say:
excellent, very good,
good, fair, or poor"

Most parents of children age 1 to 17 would rate the condition of their child's teeth as "excellent" (43.6%) or "very good" (26.1%).

Another 20.8% gave "good" ratings.

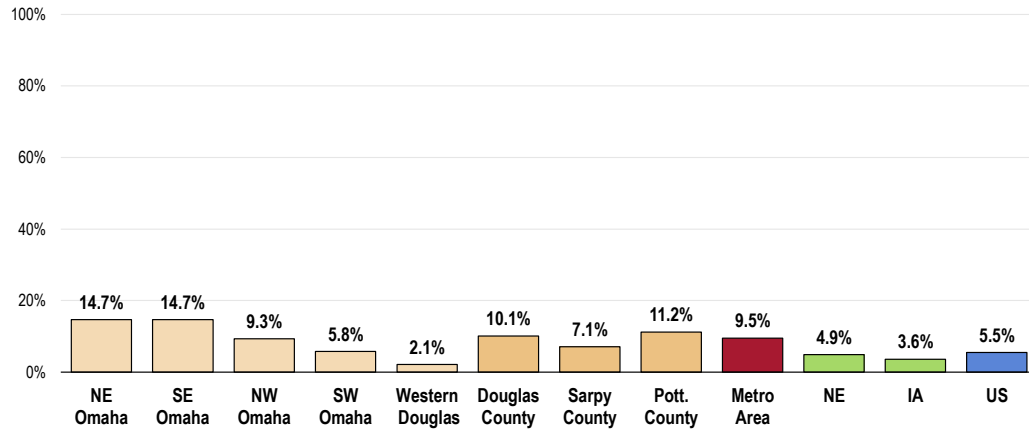


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 307]
Notes: • Asked of all respondents about a randomly selected child in the household age 1 to 17.

Conversely, 9.5% of parents believe their condition of their child's teeth are "fair/poor".

- Metro Area "fair/poor" ratings are higher than state and national findings.
- Within Douglas County, "fair/poor" ratings are higher in the eastern parts of Omaha.
- No significant difference by county.

“Fair/Poor” Condition of Child’s Teeth (Metro Area Children Age 1-17, 2018)



Sources:

- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 307]
- Child and Adolescent Health Measurement Initiative. 2016 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.

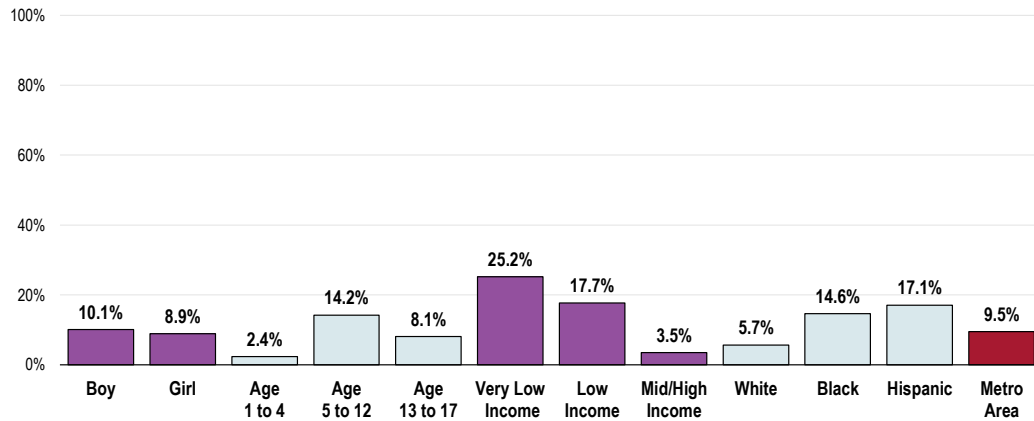
Notes:

- Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.

The following demographic groups have a higher reported prevalence of “fair/poor” teeth:

- Children older than age 4, particularly those age 5-12.
- Those in lower-income households (negative correlation with income).
- Hispanic children.

“Fair/Poor” Condition of Child’s Teeth (Metro Area Children Age 1-17, 2018)



Sources:

- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 307]
- Asked of those respondents for whom the randomly selected child in the household is age 1 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% FPL; “Low Income” includes households with incomes between 100% and 199% FPL; “Mid/High Income” includes households with incomes at 200% or more of the FPL.

“During the past 12 months, has this child had frequent or chronic difficulty with”

Chronic Dental Issues

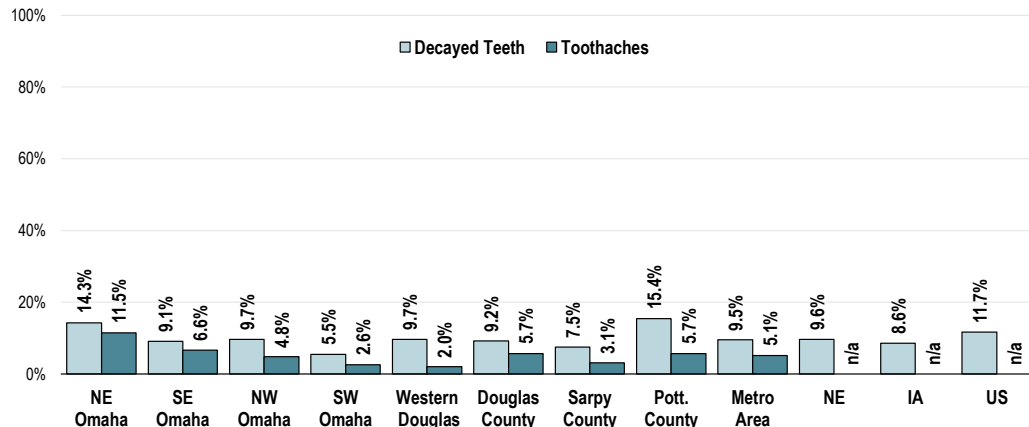
A total of 9.5% of parents with children age 1-17 report frequent or chronic difficulty with decayed teeth or cavities in the past year.

- Significantly below national findings.
- Similar to that seen in both Nebraska and Iowa.
- Within Douglas County, this prevalence is lowest in Southwest Omaha.
- No significant differences by county.

A total of 5.1% of children age 1-17 are reported to have frequent or chronic difficulty with toothaches in the past year.

- Within Douglas County, the prevalence of chronic toothaches is highest in Northeast Omaha and lowest in Southwest Omaha.
- No significant differences by county.

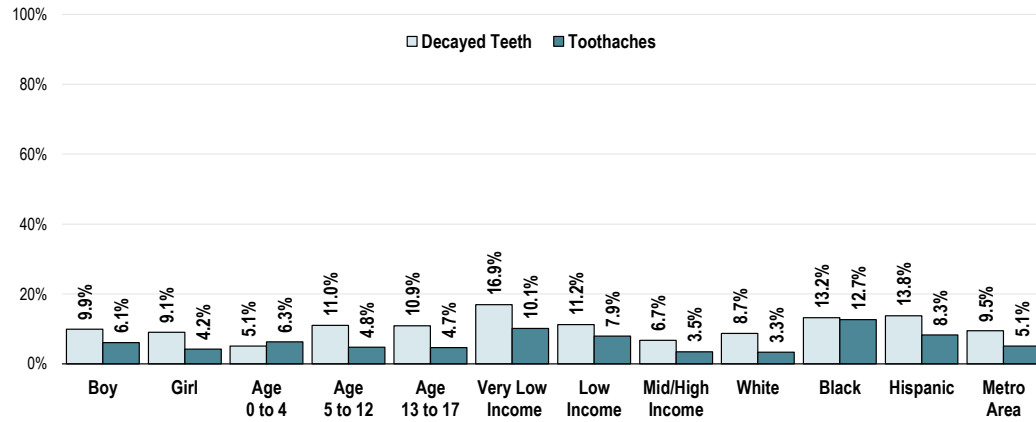
Chronic Dental Issues (Metro Area Children Age 1-17, 2018)



- Sources:
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 308-309]
 - Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.
- Notes:
- Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
 - Current state and national data specific to toothaches is unavailable.

- No significant differences in the prevalence of decayed teeth by demographics.
- Toothaches are more prevalent among children living in very low-income households and among Black children.

Chronic Dental Issues (Metro Area Children Age 1-17, 2018)

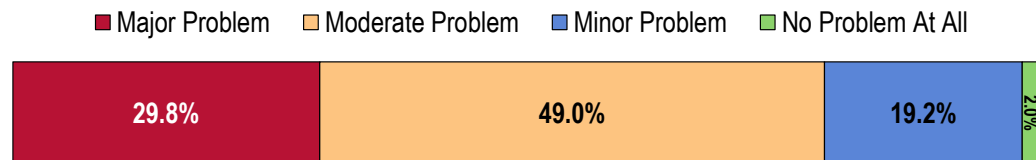


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 308-309]
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Oral Health

Almost half of key informants taking part in an online survey characterized *Oral Health* 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, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Access to Care/Services

Lack of access, transportation concerns, cultural/language barriers, lack of adequate nutrition, financial concerns, lack of insurance, lack of education. - Community/Business Leader

Lack of resources to obtain oral health care. - Community/Business Leader

Extraordinary dental decay in children who have limited access to care. Coordination and collaboration to improve access is limited. Payment for care is limited to those with insurance. Limited number of providers will care for those without insurance and in neighborhoods in east Omaha. Need to have more preventive care so that cavities can be prevented. - Physician

Revised American Academy of Pediatric Dentist guidelines indicate children should receive their first dental screening no later than the child's first birthday, yet we still have dentists in the area who tell parents their child is “too young” and should wait until they are preschool age. - Community/Business Leader

Lack of providers accepting Medicaid is a significant barrier for access to oral health care in our community. The relatively low number of providers is driven by the low reimbursements experienced for oral health care. - Community/Business Leader

There are many underserved, underinsured children who need extractions or caps for decay of teeth from lack of regular brushing and sealants. - Physician

The number one referral for school age children in OPS. Undocumented status and working poor contribute to this. - Other Health Provider

Many providers aren't accepting new Medicaid clients which leads to a wait list for services for this group of children. - Community/Business Leader

Access and affordability for low-income populations. - Community/Business Leader

Lack of access to dental care and the need for anesthesia for young children with poor oral hygiene creates barriers. – Physician

Lack of adequate insurance for dental concerns. Little focus on prevention. - Other Health Provider

Lack of dentist to see low-income patients, bad diets. - Physician

Lack of Medicaid dental providers. - Public Health Representative

Access to appointments and providers for the Medicaid population. Knowledge, health literacy issue. - Other Health Provider

Children in our community have limited access to oral health care. - Physician

The consistent need for the dental mobile. - Community/Business Leader

Not enough access to dental care. – Physician

Affordable Care/Services

When parents only have so much money, sacrifices have to be made. Oral health in our community is a critical need as the number of children under 12 that have never had an oral exam is astonishing. - Community/Business Leader

This relates to unaffordability. Dental insurance does not seem as readily available, especially to families in income brackets at 100% of poverty or less. When covered, out-of-pocket expenses still can be significant. Drug use among teens and young adults also contributes to early decay. I think it also relates to a basic lack of understanding of the need for dental health and the risks that are associated with dental decay. - Community/Business Leader

While resources through FQHCs are available, they are limited and typically focused on certain neighborhoods or demographics. Also, while many children have health insurance, their parents may forego dental coverage because of its cost. Availability of ongoing oral care at affordable prices is limited, often leaving individuals on waiting lists for weeks to months. - Social Services Provider

Many families don't know where to access low-cost, convenient dental care. Some parents don't know the importance of preventive dental care. Dental care is unaffordable for many families, so children go without getting cavities treated. - Other Health Provider

Oral health is an expense that isn't addressed until major pain occurs. Education and access need to be increased. - Community/Business Leader

Cost versus services for those who do not have insurance or a way to get dental care. - Other Health Provider

Dental services are very expensive and without insurance, it is hard to afford. - Community/Business Leader

Cost, lack of education, poverty. - Community/Business Leader

Prevalence/Incidence

Many young children under the age of six are already experiencing cavities and are receiving fillings in their teeth. Many older children have never even visited a dentist. - Social Services Provider

Creighton dental students come to the school two times a year, and we usually have over 100 referrals to dental offices for severe and chronic dental needs. The kids do not see a dentist regularly. Lack of transportation and interpreters are factors. - Community/Business Leader

I have seen firsthand the number of children who have been in surgery for teeth extractions due to poor dental health. - Community/Business Leader

It is the number one chronic health condition of children. - Public Health Representative

Dental issues are at the highest rate now for children. - Other Health Provider

Long-term bottle use causing poor dental health. – Physician

Too many cavities. - Physician

Health Awareness/Education

In my opinion families lack the education about how important oral health is. Families unable to take time in busy schedule to take child in to the dentist. - Physician

No real need or understanding for it. - Social Services Provider

More awareness is needed about the impact oral health has on physical health. Access to culturally competent oral health providers is limited and many of the oral health providers that provide care to Medicaid or uninsured families are limited. - Community/Business Leader

Nutrition

American food is jam packed with sugar. Kids are drinking soda and energy drinks all day. Dental care is expensive and uncomfortable, so some people don't go. It's also becoming trendy to embed jewelry in your teeth. Many refugee and immigrant families did not have dental care available in their home countries other than having infected teeth pulled out, so they are unaware that dentists will do other things here to prevent having to pull a tooth. - Social Services Provider

Improper foods. - Community/Business Leader

School

FAMILY, Inc. provides oral health screening services within the schools in order to prevent barriers with accessing preventative dental care for students. 10 years into this program, there are still few dental providers who will provide services to Medicaid patients and a high rate of caries in the populations served. Recent CMS 410 data suggested that only 59.5% of Medicaid eligible children received any oral health or dental service during 2016 (most recent data). This includes the screening services provided at FAMILY, Inc. as well as services provided by a dental provider. While this isn't a holistic picture of all persons visiting dental offices, there is certainly room to improve on oral health in Pottawattamie County. Further, an oral health coalition surrounding dental visits by age 1 recently recruited dental providers to provide this age 1 visit to children. There was also a media campaign regarding the importance of this visit which was a surprise to many. - Other Health Provider

Reports from school nurses and dental professionals. - Community/Business Leader

Vision, Hearing, & Speech Conditions

Chronic Ear Infections

Among Metro Area parents of children under the age of 18, almost one-quarter (24.1%) indicate that their child has had three or more ear infections in his/her life.

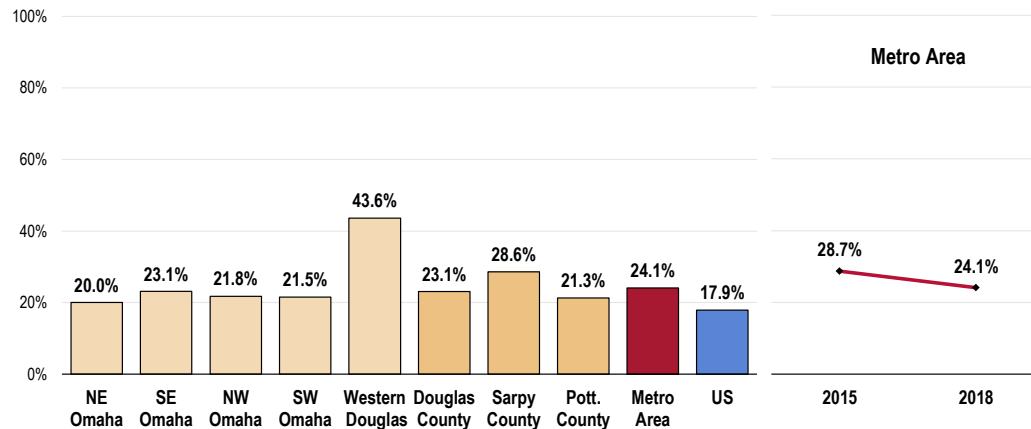
- Higher than US findings.
- In Douglas County, the prevalence is notably higher in Western Douglas.
- No significant differences by county.
- TREND: Represents a statistically significant decrease since first measured in 2015.

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 Three or More Ear Infections

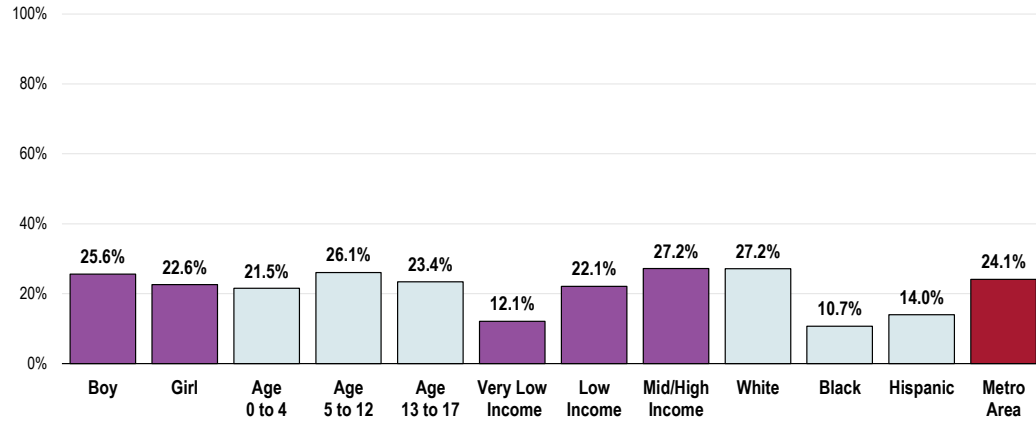
(Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 61]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

- The prevalence of 3+ ear infections appears correlated to income and is highest among children living in higher-income households.
- Parents of White children also report a higher prevalence.

Child Has Had 3+ Ear Infections (Metro Area, 2018)



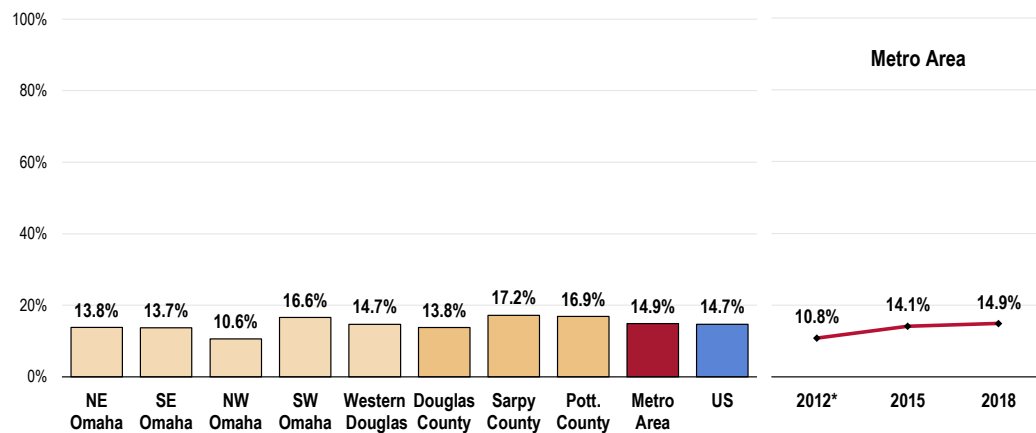
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 61]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Speech/Language Issues

A total of 14.9% of Metro Area children have some type of speech or language problem.

- Almost identical to the national proportion.
- Statistically comparable by area.
- TREND: The prevalence of children with speech or language problems has statistically increased since first measured in 2012. *Note that 2012 data excluded children under the age of one.*

Child Has Speech/Language Problems (Metro Area, 2018)

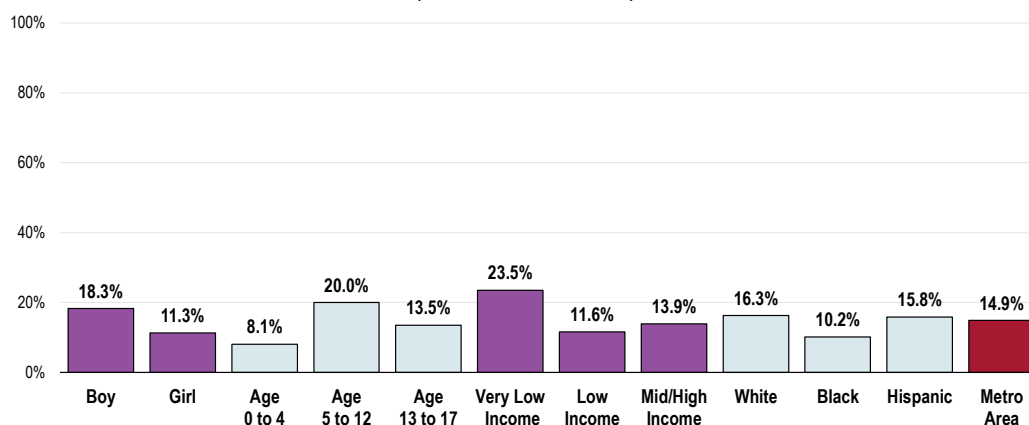


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 63]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • *2012 data reflects children age 1-17.

The following demographic groups are more likely to experience speech or language problems than their demographic counterparts:

- Boys.
- Older children (particularly those age 5-12).
- Those in very low-income households.

Child Has Speech/Language Problems (Metro Area, 2018)



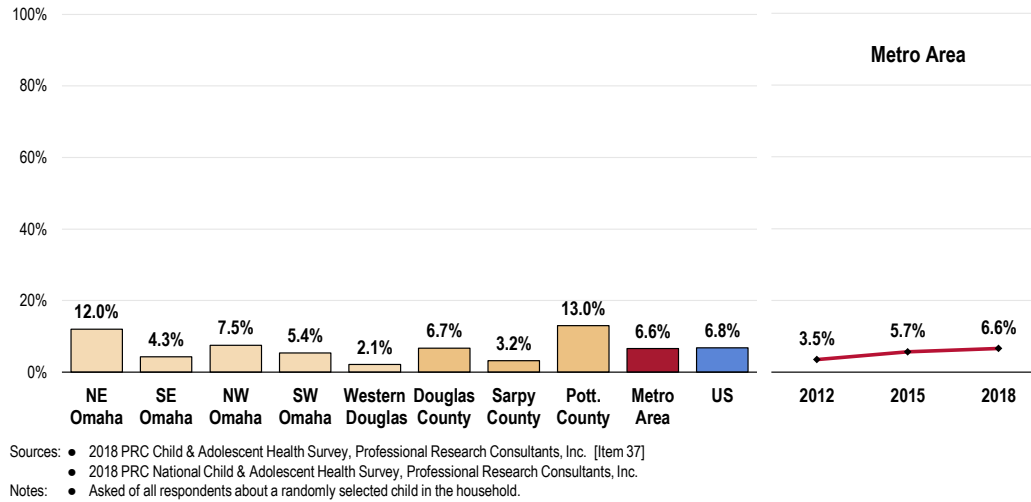
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 63]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Hearing Problems

A total of 6.6% of Metro Area children have been diagnosed with hearing problems.

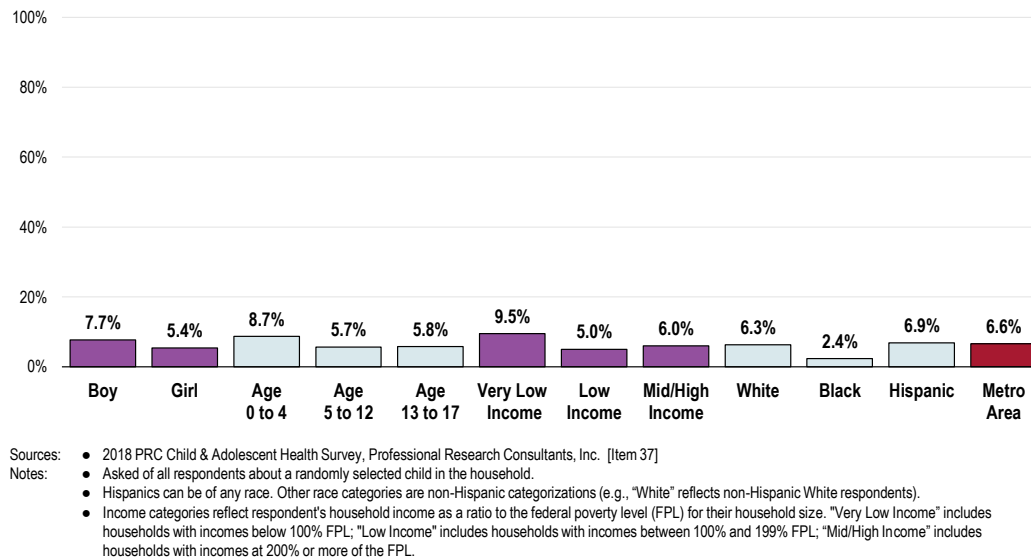
- Almost identical to national findings.
- In Douglas County, this prevalence is highest in Northeast Omaha.
- By county, notably higher in Pottawattamie County.
- TREND: The prevalence of children with hearing problems has statistically increased since 2012.

Child Has Hearing Problems (Metro Area, 2018)



- Based on demographics in the Metro Area, there are no significant differences in the prevalence of child hearing problems

Child Has Hearing Problems (Metro Area, 2018)

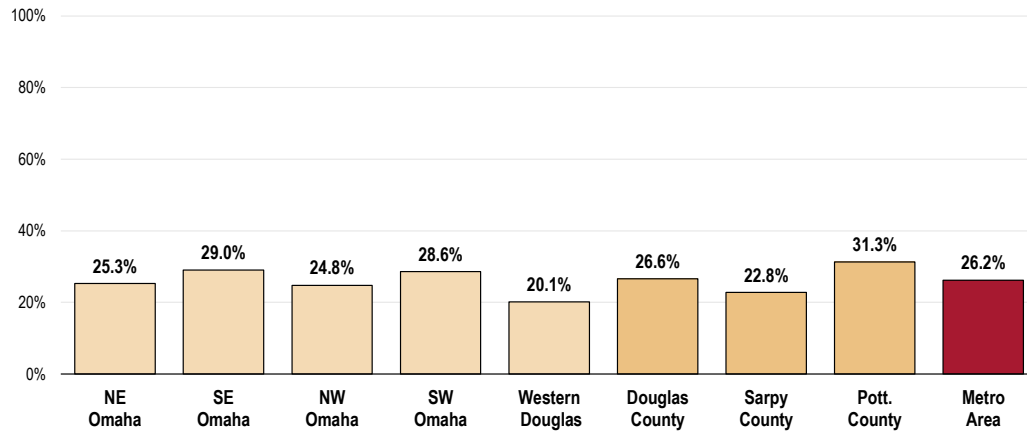


Vision Problems

Over one-quarter (26.2%) of Metro Area children have vision problems.

- No significant differences by area.

Child Has Vision Problems (Metro Area, 2018)

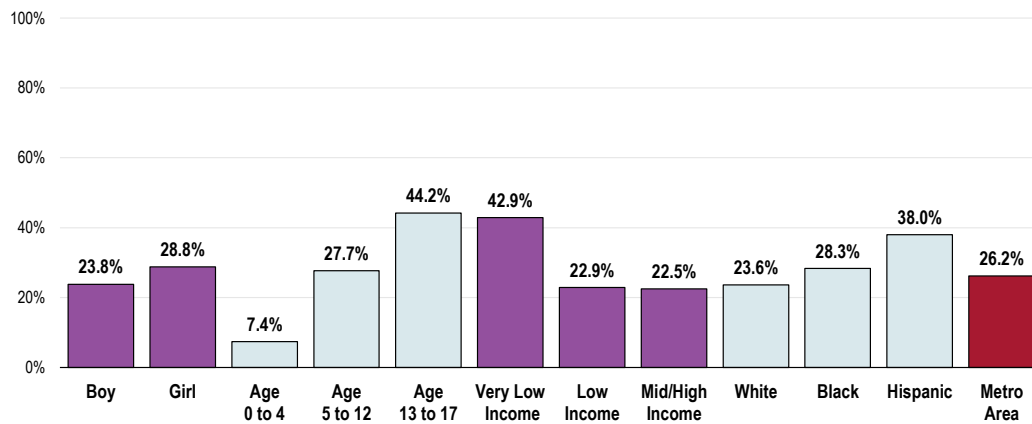


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 305]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 : • This indicator does not exclude vision problems able to be corrected by glasses or contacts.

Children more likely to have vision problems include:

- Older children (strong correlation with age).
- Those living in very low-income households.
- Hispanic children.

Child Has Vision Problems (Metro Area, 2018)



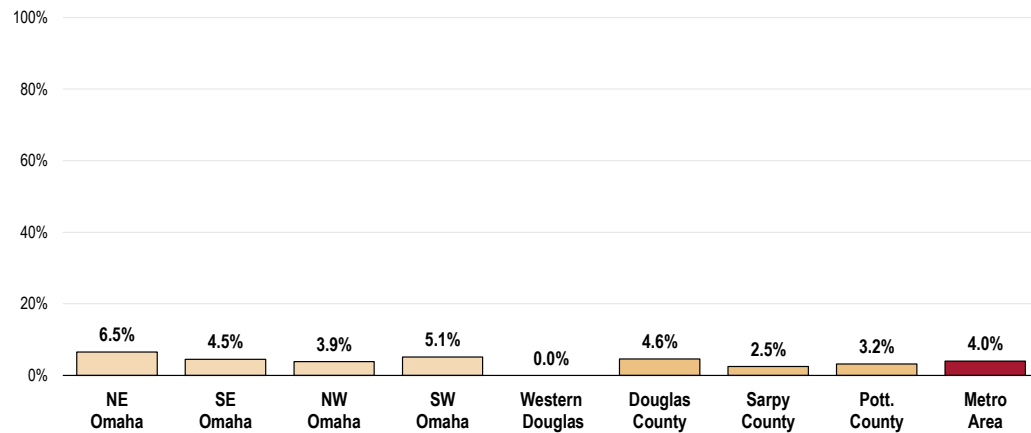
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 305]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Difficulties Accessing Vision Care

A total of 4.0% of Metro Area adults report difficulties accessing vision care for their child in the past year.

- Within Douglas County, these reported difficulties are lowest in Western Douglas (where no parents reported any difficulties).
- No significant difference when viewed by county.

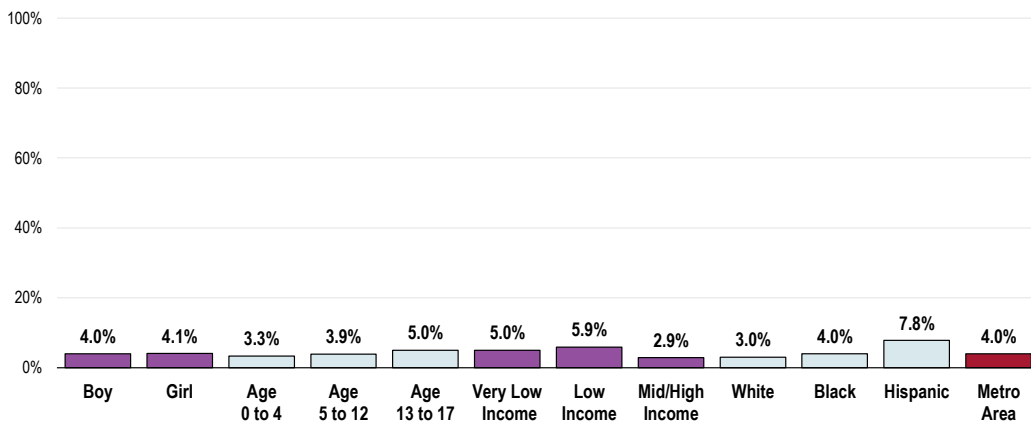
Difficulties Accessing Child's Vision Care in Past Year (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 306]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 : • This question was asked about all children, regardless if they needed or sought care.

- No significant differences in access difficulties by demographics.

Difficulties Accessing Child's Vision Care in Past Year (Metro Area, 2018)

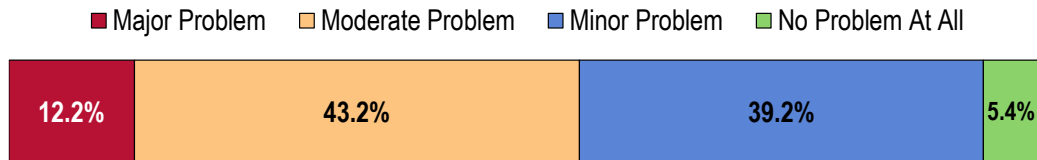


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 306]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Vision, Hearing, & Speech Problems

A majority of key informants taking part in an online survey characterized *Vision, Hearing, & Speech Problems* as a “moderate problem” for children/adolescents in the community.

Perceptions of Vision, Hearing & Speech Conditions as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Health Awareness/Education

Children are often diagnosed much later in life after entering school because parents were unaware of resources or unaware of appropriate developmental expectations. - Physician

Parents can't see the physical problem with vision and hearing, so they don't think it is a big deal. In regard to speech, families don't want to or don't have time to put in the extra time to get the kid help. - Physician

Parents generally lack awareness about the importance of annual vision exams, especially for early childhood populations. - Community/Business Leader

Diagnosis/Treatment

Area Lions Clubs have conducted thousands of vision screenings over the past couple years and identified hundreds of children (particularly children under age 5) that require vision correction. In regard to speech/language conditions, the number of children under the age of 5 with a diagnosed speech or language delay continues to be one of the primary means of qualifying for special education or early intervention in the metro area. - Community/Business Leader

Kids are diagnosed with these conditions and then the follow through from parents is minimal. Lack of transportation and interpreters are large factors. - Community/Business Leader

Access to Care

Vision care resources are very limited to those with insurance. Rare vision care providers in east Omaha. Coordinating care for those who have screened positive for vision referral is challenging and not reimbursable. - Physician

Lack of access to affordable health care leads to more vision, hearing and speech conditions. - Community/Business Leader

Impacts on Education

All these components have huge impact on a student's ability to learn and succeed in life and school. - Community/Business Leader

Vision is an issue that affects learning. – Physician

Preventive Health Care

Children are not always able to get corrective lenses, or sensitive hearing screening with appropriate interventions. Providers are scarce, and payers are not available for all. - Physician

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 <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

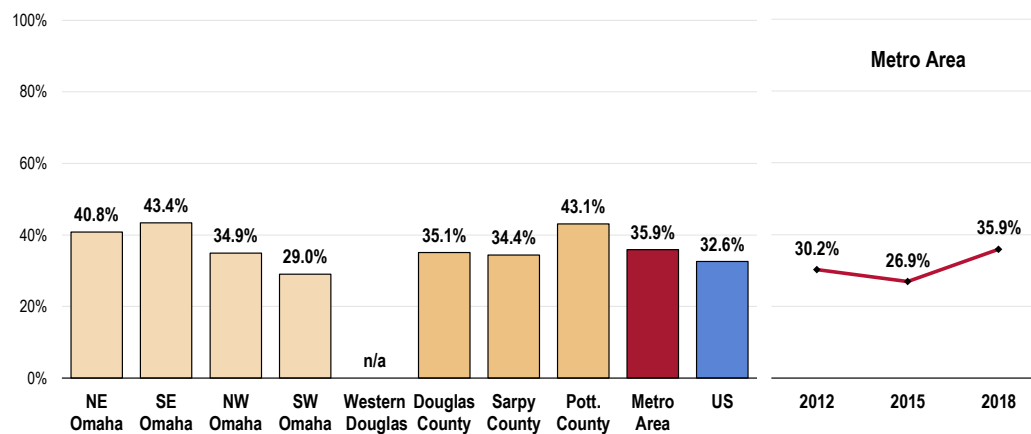
— Centers for Disease Control and Prevention

Based on the heights and weights reported by surveyed parents, 35.9% of Metro Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Statistically similar to the overweight prevalence reported nationwide.
- Within Douglas County, lowest in Southwest Omaha.
- No significant difference among the three Metro Area counties.
- TREND: Statistically higher than prior survey findings.

Child Is Overweight or Obese

(Metro Area Children Age 5-17 With a BMI in the 85th Percentile or Higher)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 135]

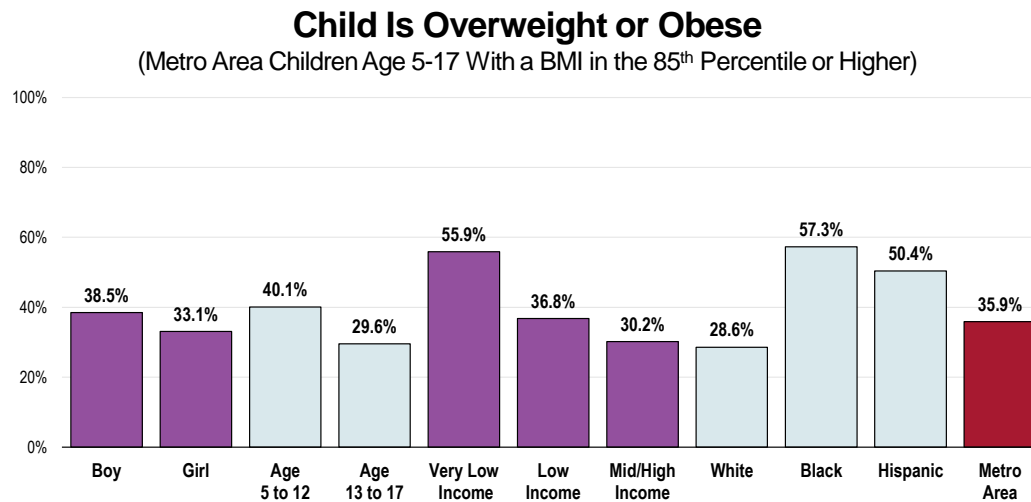
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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 85th percentile of US growth charts by gender and age.

School-age children in Metro Area who are more likely to be overweight or obese include:

- Those age 5-12.
- Those in households with very low incomes (negative correlation with income).
- Black children.
- Hispanic children.



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 135]
 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 85th 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

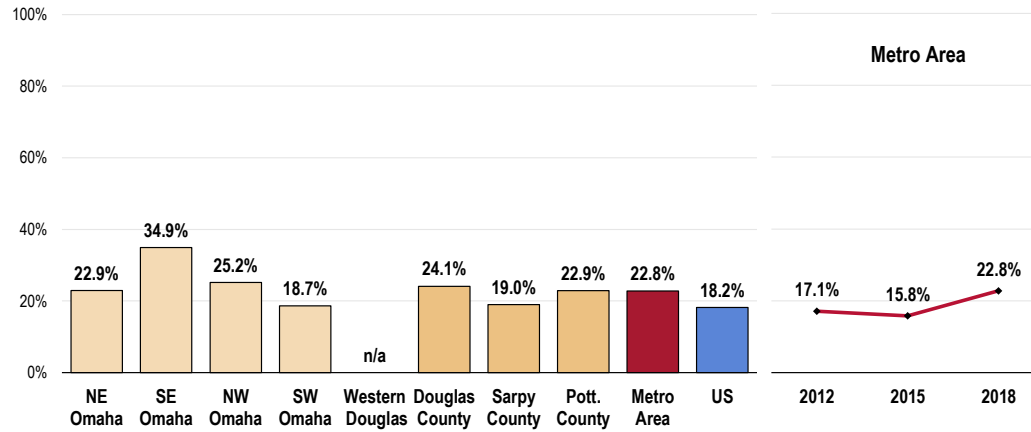
In addition, 22.8% of Metro Area children age 5 to 17 are obese (≥95th percentile). *Note that this proportion is included in the "overweight or obese" percentage reported above.*

- Significantly higher than the US findings.
- Fails to satisfy the Healthy People 2020 target (14.5% or lower).
- In Douglas County, obesity is most prevalent among children in Southeast Omaha.
- Statistically similar findings by county.
- TREND: Represents a statistically significant increase over time.

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: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 130]
 • 2018 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 95th percentile of US growth charts by gender and age.

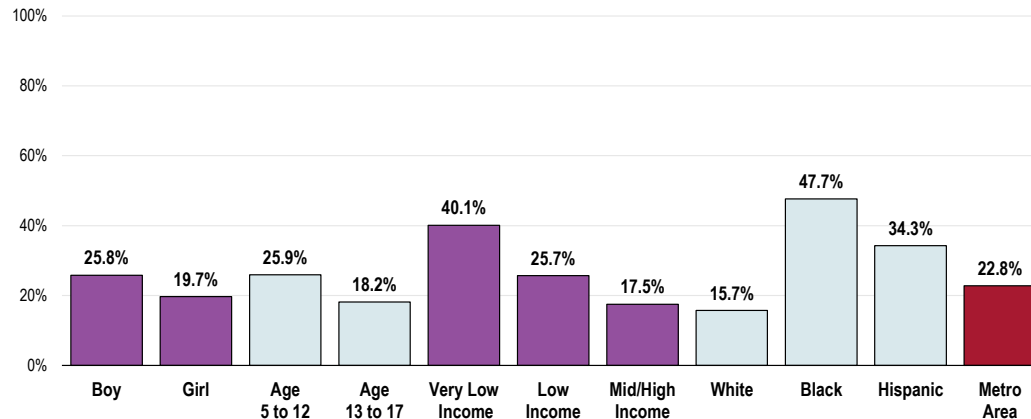
Note the following demographics groups with higher reported prevalences of obesity:

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

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



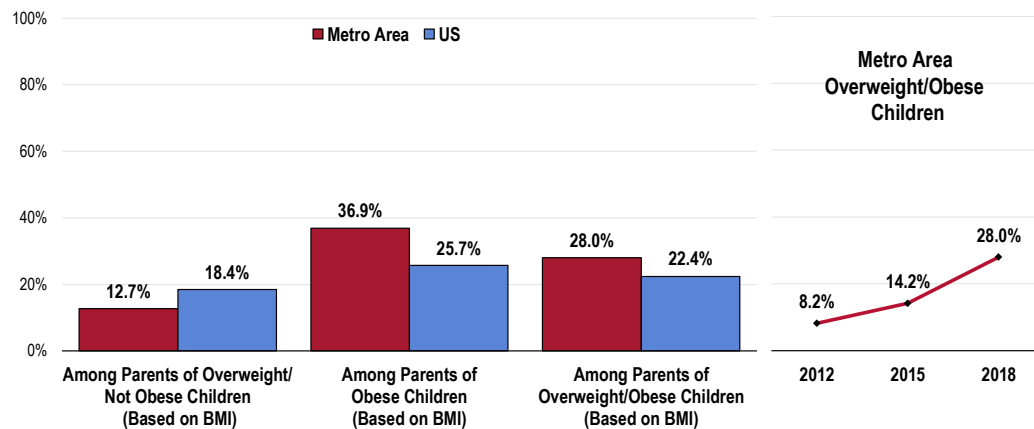
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 130]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]
 Notes: • Asked of those respondents for whom the randomly selected 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 85th 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

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, while just 28.0% have.

- Statistically similar to US findings.
- Higher in Douglas County (not shown).
- TREND: The prevalence of these notifications has more than tripled since 2012.

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, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 337]

Notes: • Reflects all respondents for whom the randomly selected child at home is age 5-17 and overweight/obese.

• Overweight in children is defined as a Body Mass Index (BMI) value at or above the 85th percentile of US growth charts by gender and age; obesity in children is defined as a BMI value at or above the 95th percentile.

Serious Injuries

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)

Prevalence of Injuries

Injuries Requiring Treatment

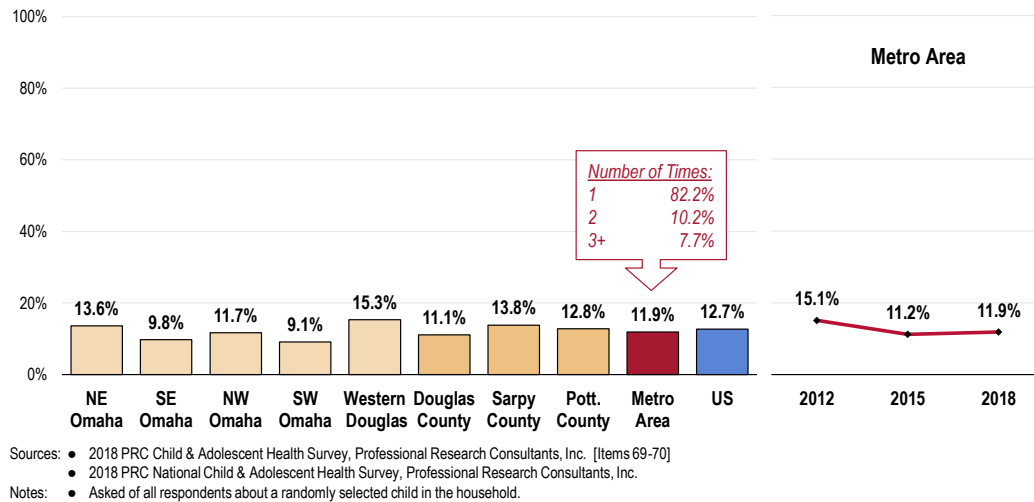
While most Metro Area children were not injured seriously in the past year, 11.9% sustained injuries serious enough to require medical treatment.

- Statistically comparable to US findings.
- Statistically comparable by area.
- TREND: Statistically lower than 2012 findings (but similar to 2015).

“In the past two years, has this child been injured seriously enough to need treatment from a doctor or a nurse?”

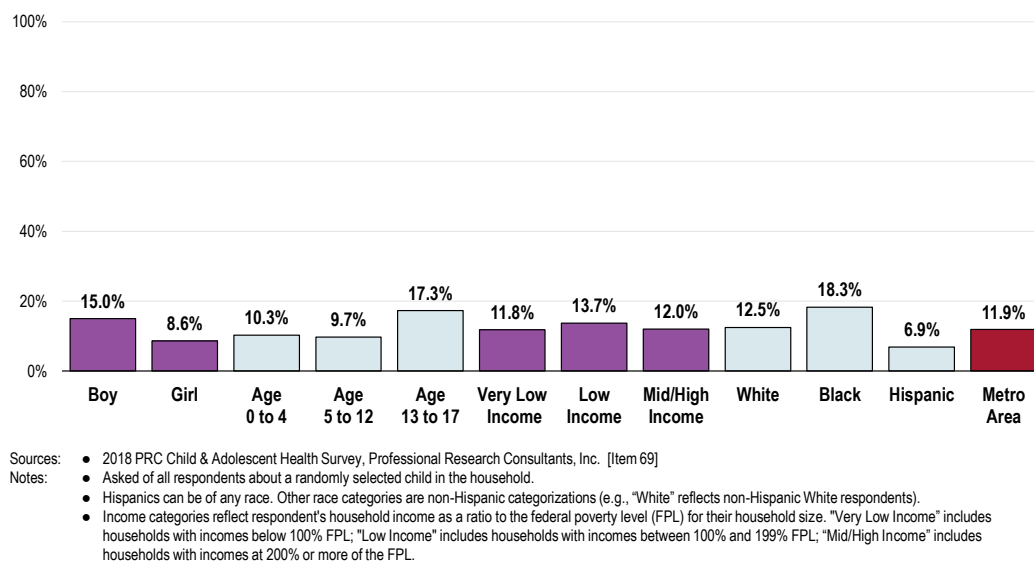
Most (82.2%) of these children were seriously injured just once in the past year, while 7.7% were seriously injured 3+ times.

Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year (Metro Area, 2018)



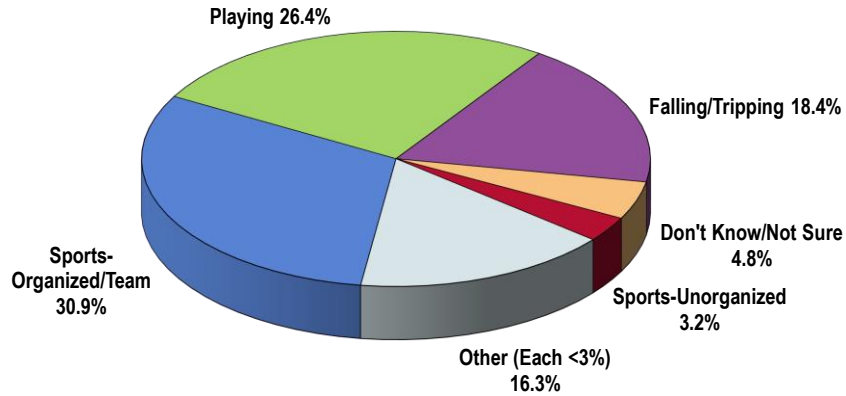
- The prevalence of serious injuries requiring medical treatment is higher among boys, teens, and non-Hispanic children.

Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year (Metro Area, 2018)



When asked what the child was doing when the injury occurred, parents of these children mentioned activities like **organized sports** (30.9%), **playing** (26.4%), **falling or tripping** (18.4%), and **unorganized sports** (3.2%).

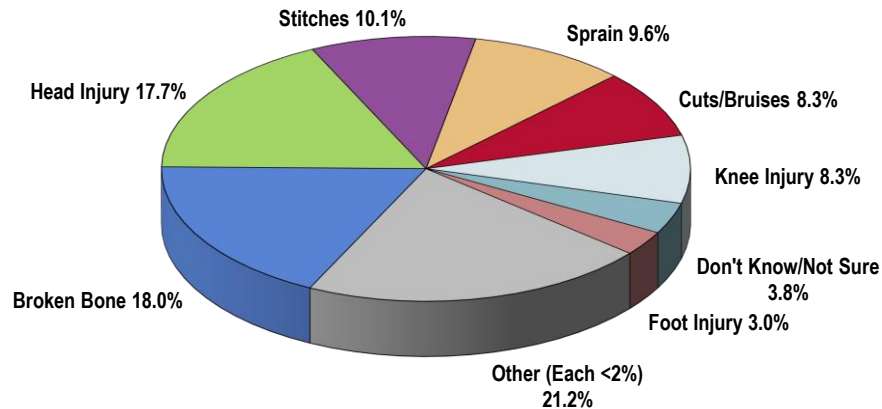
Child's Activity When Most Seriously Injured in Past Year (Metro Area Children Seriously Injured in the Past Year, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 71]
Notes: • Asked of all respondents for whom the randomly selected child in the household was seriously injured in the past year.

When asked about the type of injury sustained, these parents frequently mentioned **broken bones** (18.0%) and **head injuries** (17.7%). Injuries mentioned with less frequency included injuries requiring **stitches**, **sprains**, **cuts/bruises**, **knee injuries**, and **foot injuries**.

Type of Injury Sustained (Metro Area Children Seriously Injured in the Past Year, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 72]
Notes: • Asked of all respondents for whom the randomly selected child in the household was seriously injured in the past year.

Fetal/Child Mortality

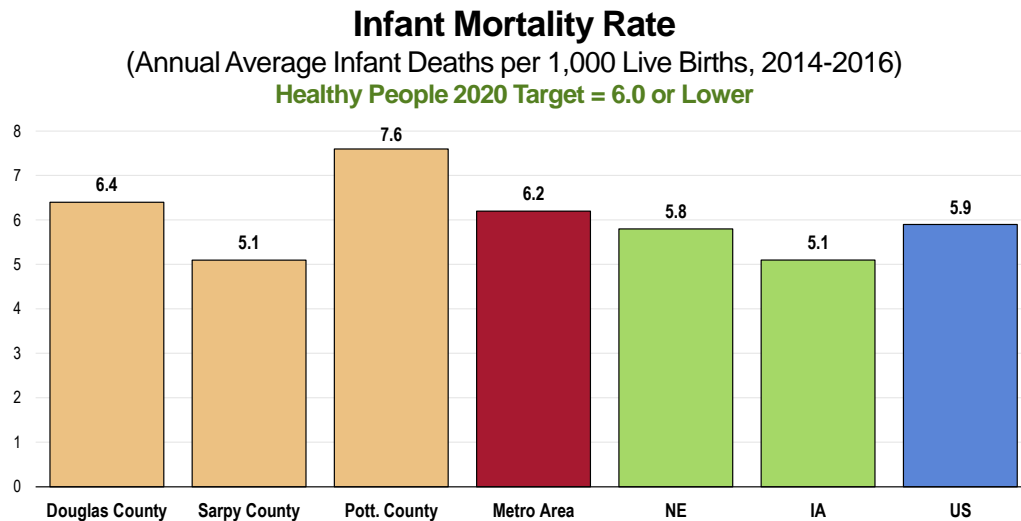
Infant Deaths

Infant Mortality

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

Between 2014 and 2016, there was an annual average of 6.2 infant deaths per 1,000 live births in Metro Area.

- Higher than both the Nebraska and Iowa state rates.
- Comparable to the national rate.
- Similar to the Healthy People 2020 target of 6.0 infant deaths per 1,000 live births or lower.
- By county, this rate is highest in Pottawattamie County.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2018. • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]

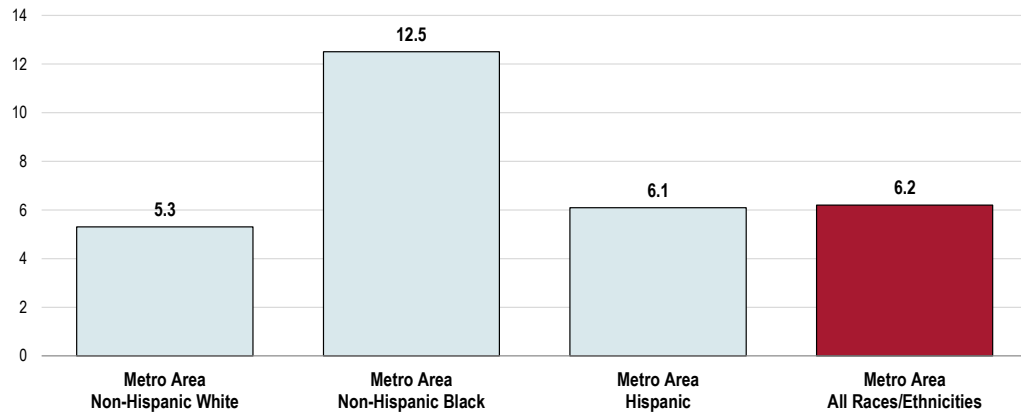
Notes: • Infant deaths include deaths of children under 1 year old.
• This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- The infant mortality rate is over two times higher among births to Non-Hispanic Black mothers than Non-Hispanic White mothers or Hispanic mothers.

Infant Mortality by Race/Ethnicity

(Annual Average Infant Deaths per 1,000 Live Births, 2014-2016)

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 September 2018.
 - 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.

Neonatal/Postnatal Mortality

Neonatal Deaths

According to 2016 data from Douglas County Vital Statistics, Maternal and Child Health Indicators, there were 4.5 deaths of children under 28 days of age per 1,000 live births in Douglas County (not shown).

- Fails to satisfy the Healthy People 2020 target of 4.1 neonatal deaths per 1,000 live births or lower (not shown).

Postneonatal Deaths

According to this same source, the year 2016 saw 2.6 deaths of children from 28 days of age to 1 year old per 1,000 live births in Douglas County (not shown).

- Fails to satisfy the Healthy People 2020 target of 2.0 postneonatal deaths per 1,000 live births or lower (not shown).

Child & Adolescent Deaths

Mortality Rates by Age Group

Between 2014-2016, Metro Area reported an annual average of 27.3 child deaths (age 1 to 4) per 100,000 population.

- Statistically similar to the Nebraska and Iowa rates.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 25.7 deaths or fewer per 100,000 population.

With regard to children age 5 to 9, the Metro Area crude death rate was 10.5 per 100,000 population (2014-2016 data).

- Lower than the Nebraska rate and similar to Iowa.
- Lower than the national rate.
- Satisfies the Healthy People 2020 goal of 12.3 deaths or fewer per 100,000 population.

Among Metro Area youth (age 10 to 14), the 2014-2016 crude death rate was 12.6 per 100,000 population.

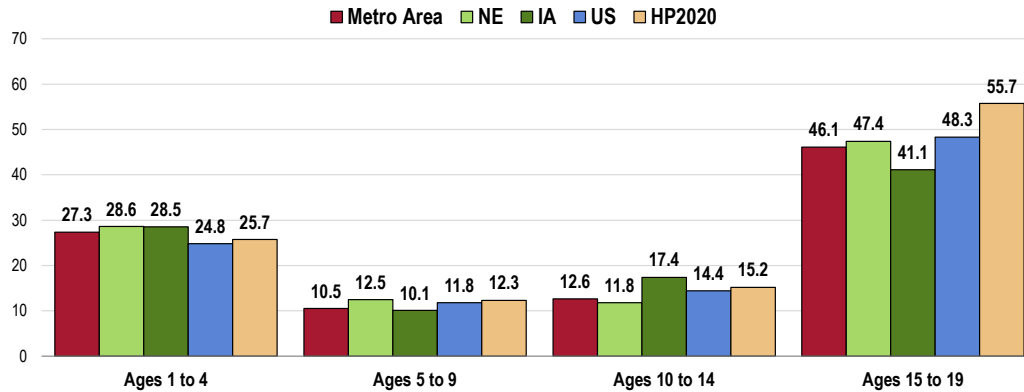
- Higher than the Nebraska rate but lower than the Iowa rate.
- Lower than the national rate.
- Satisfies the related Healthy People 2020 goal of 15.2 deaths or fewer per 100,000 population.

Among Metro Area teens (age 15 to 19), the 2014-2016 crude death rate was 46.1 per 100,000 population.

- Comparable to the Nebraska rate but higher than the Iowa rate.
- Similar to the national rate.
- Satisfies the related Healthy People 2020 goal of 55.7 deaths or fewer per 100,000 population.

Child & Adolescent Mortality Rates by Age Group

(Annual Average Child Mortality per 100,000 Population; 2014-2016)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2018.
 • 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.

Leading Causes of Child Deaths

For Metro Area infants (under one year of age) during the years of 2007-2016, the predominant cause of death was congenital conditions (certain conditions that include congenital malformations, deformations, and chromosomal abnormalities).

Cancer was the leading cause of death for children age 5-9 in the Metro Area.

For all other ages, accidents were the number-one leading cause of death.

- Among children under age 1, SIDS and pregnancy complications followed congenital conditions as the leading causes of death.
- Among children age 1-4, congenital conditions and cancer followed accidents (especially drowning and motor vehicle crashes) as the leading causes of death.
- For children age 5-9, congenital conditions and accidents followed cancer as the leading causes of death.
- Cancer was the second-leading cause of death for Metro Area children age 10-14.
- Homicide (especially firearms) and suicide (especially by firearms or suffocation) followed accidents as the leading causes of death for Metro Area teens (age 15-19).

See also *Serious Injuries in the Current Health Status: Chronic Disease* section of this report.

Leading Causes of Child Deaths by Age Group (Metro Area, 2007-2016)

	Under 1 Year	Ages 1 to 4	Ages 5 to 9	Ages 10 to 14	Ages 15 to 19
Number-One Leading Cause	Congenital Conditions*	Accidents (especially Drowning/ Motor Vehicle Crashes)	Cancer	Accidents	Accidents (especially Motor Vehicle Crashes/Poisoning)
Number-Two Leading Cause	SIDS	Congenital Conditions*	Congenital Conditions*	Cancer	Homicide (especially Firearms)
Number-Three Leading Cause	Pregnancy Complications	Cancer	Accidents	n/a	Suicide (especially by Firearms/Suffocation)

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2018.

Notes: • *Congenital conditions include congenital malformations, deformations, and chromosomal abnormalities.

Biological Influences



Professional Research Consultants, Inc.

Birth Outcomes

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. 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)

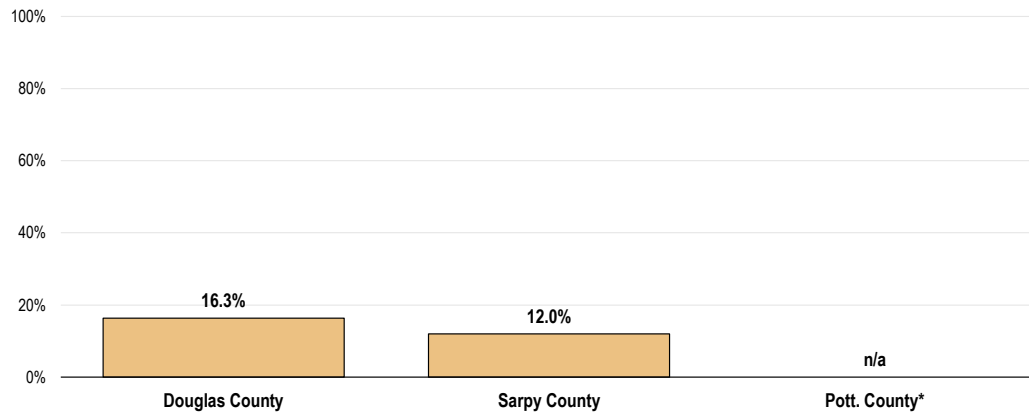
Inadequate Prenatal Care

In 2016, 16.3% of all Douglas County births and 12.0% of all Sarpy County births did not receive adequate prenatal care during the pregnancy.

- The proportion of mothers receiving inadequate prenatal care is significantly higher in Douglas County than in Sarpy County (current data for Pottawattamie County was not available).

This indicator was calculated using the Kotelchuk Index, which measures adequacy of prenatal care by using a combination of factors, such as number of prenatal visits, gestation, and when trimester prenatal care began.

Percentage of Births with Inadequate Prenatal Care (Metro Area, 2016)



Source: • Nebraska 2016 Vital Statistics Report. Nebraska Department of Health and Human Services.
 Note: • This indicator was calculated by using the Kotelchuk Index, which measures adequacy of prenatal care by using a combination of factors such as number of prenatal visits, gestation, and when trimester prenatal care began. 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.
 • *Current data for Pottawattamie County was not available.

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.

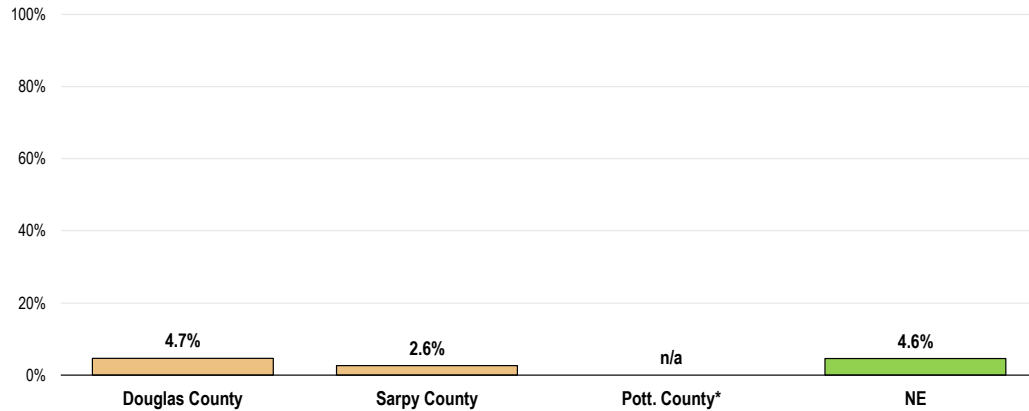
— Healthy People 2020 (www.healthypeople.gov)

In 2016, 4.7% of Douglas County births were to women under age 20, while this proportion was 2.6% for Sarpy County.

- The proportion of teen births in Douglas County is higher than that in Sarpy County (comparable data for Pottawattamie County was not available).

Births to Teen Mothers

(Percentage of Births to Women Under Age 20, 2016)



- Sources:
- Nebraska 2016 Vital Statistics Report. Nebraska Department of Health and Human Services.
- Notes:
- This indicator reports the percentage of live births to women under the age of 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.
 - *Comparable data for Pottawattamie County was not available.

Low-Weight Births

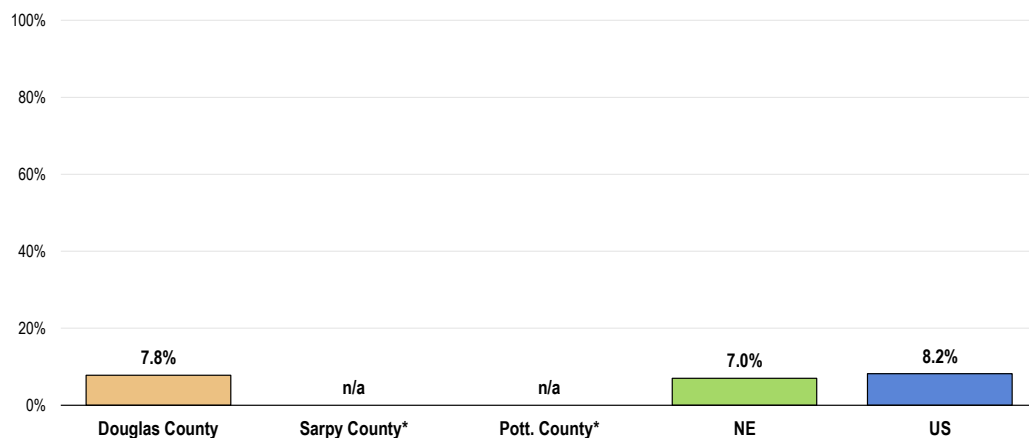
A total of 7.8% of 2016 Douglas County births were low-weight.

- Matches the Healthy People 2020 target of 7.8% or lower.
- Note that current data for Sarpy and Pottawattamie counties was not available.

Low-Weight Births

(Percent of Live Births, 2016)

Healthy People 2020 Target = 7.8% or Lower



- Sources:
- Nebraska 2016 Vital Statistics Report. Nebraska Department of Health and Human Services.
 - National Center for Health Statistics, Centers for Disease Control and Prevention. Percentage of Babies Born Low Birthweight By State, 2016. Accessed September 2018 from https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
- Note:
- This indicator reports total births that are low birth weight (Under 2500g), per 1,000 live births. This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.
 - *Comparable data for Sarpy and Pottawattamie counties was not available.

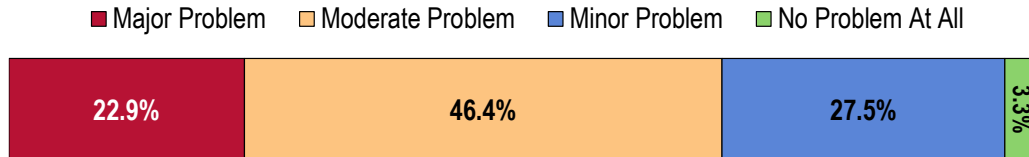
Low birthweight babies- those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth- are much more prone to illness and neonatal death than are babies of normal birthweight.

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

Key Informant Input: Infant Health

The greatest share of key informants taking part in an online survey characterized *Infant Health* as a “moderate problem” for children in the community.

Perceptions of Infant Health as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Vulnerable Populations

While our infant mortality rate is improved, the disparity between black and white babies who are dying continues to be high. Immunization rates continue to be lower than the Healthy People 2020 goals. Breastfeeding rates continue to be low to a concerning level. Unsafe sleep practices for infants cause 50% of infant deaths in Douglas County. - Public Health Representative

Mortality rate is substantially higher for African American mothers and babies, a disparity that represents our community. The availability of health education and risk prevention is around, but very limited and focused in few agencies. - Social Services Provider

I don't have the specific statistic, but after touring One World Community Health Centers, I can see the need is great for expectant mothers and infants in our community. Again, poverty and socio-economics play a large role in these issues. Whether it's a lack of understanding for the need or just not knowing where to go for help, it is critical to the health of expectant mothers, followed by the infants to have quality care immediately. - Community/Business Leader

Mostly a problem for low-income and immigrant population. Still many not seeking early and effective prenatal care. - Physician

We still continue to have a huge disparity between African Americans and whites when it comes to infant mortality that still needs to be prioritized. - Public Health Representative

The fertility and infant mortality rates among African-Americans in this community far exceed the national average. - Community/Business Leader

The gap in infant mortality related to race/ethnicity is too wide. - Public Health Representative

Health disparities exist in infant mortality. - Public Health Representative

Prenatal Care

Continued lack of prenatal care in first trimester. Disparities seen across ethnicities in regard to infant mortality and premature births, low breastfeeding rates. - Other Health Provider

FAMILY, Inc. provides prenatal and postpartum home visitation services to pregnant and newly parenting moms on Medicaid in Pottawattamie and Mills Counties. Communitywide concerns identified by our maternal health nurses include 1st trimester prenatal care access, breastfeeding intention and duration, oral health care, and many concerns regarding safety of mom and baby (DV, substance abuse, safe sleeping, etc.). Many clients are not accessing prenatal services during the 1st trimester. - Other Health Provider

Prenatal and infant health is a major problem, as many young parents do not seek prenatal care until it is almost time for them to deliver. - Social Services Provider

Still see too many with late prenatal care. Lack of immunizations, due to parent concerns on what is said on internet or they don't have insurance. - Physician

We see more and more kids who were traumatized in the womb and as infants than ever before. The kids are already behind their counterparts and are dealing with situations that are not being addressed by the parents and/or community. - Community/Business Leader

Adolescents trying to hide it from parents in the early stages. - Community/Business Leader

Late entry into care, low birth weight. - Physician

Health Awareness/Education

There is a lack of baseline knowledge or implementation of best practices surrounding perinatal health leading to a rising rate of prematurity in Nebraska. Infant death is also high, as is sleep-related death. There is a pervasive attitude in a growing population of parents to not immunize their children, and insurance status, drug use and other issues lead mothers to have inadequate prenatal care. - Physician

So many parents, young parents, don't understand the importance of prenatal health and once the baby is born, the parents are just in survival mode. This is a generational issue and will take education to address. - Community/Business Leader

Lack of education related to sexual health, birth control, and pre/postnatal care; cultural attitudes; cultural and language barriers; lack of access to proper resources, health care, and nutrition; financial concerns; lack of insurance. - Community/Business Leader

Access to Care/Services

Health care dollars spent on NICU care. The percent of the population not receiving adequate and early prenatal care. The significance of prenatal care to birth outcomes. The rising incidence of women experiencing traumatic childbirth. - Public Health Representative

Everything should start here. Our community does a very poor job of providing expecting families and/or families of individuals planning to have children with support, both emotional and physical. - Physician

Infant Mortality

Numbers for infant mortality are still high. Insurance concerns reduce early prenatal care, immunizations, and birth outcomes. - Other Health Provider

The infant mortality rate outside of Omaha Healthy Start participants. - Community/Business Leader

Teenage Pregnancy

With so many teen pregnancies, it's hard to believe many of those teens receive the prenatal care they need. - Community/Business Leader

Participated in a Head Start Health Services Advisory Committee, and this was a topic identified as a concern. Plus, teen pregnancy in the metropolitan area. - Other Health Provider

Affordable Care/Services

Cost, unable to travel to, lack of in-home providers, lack of education. - Community/Business Leader

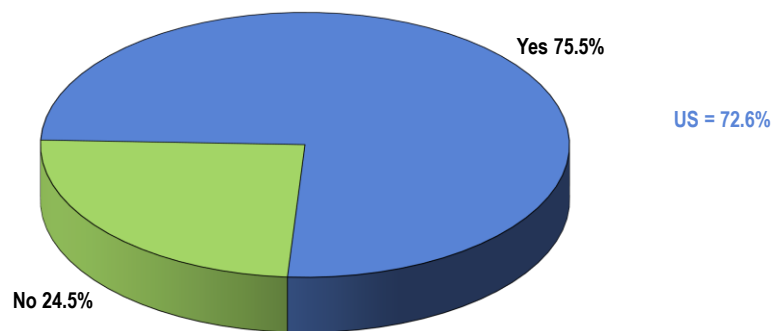
Breastfeeding & Breast Milk

Ever Breast-Fed

Three-fourths (75.5%) of Metro Area children age 0 to 17 were ever breast-fed or fed using breast milk (regardless of duration).

- Comparable to US findings.
- Fails to satisfy the Healthy People 2020 objective (81.9% or higher).
- Within Douglas County, breastfeeding rates are highest in Northwest Omaha and lowest in Northeast Omaha (not shown).
- Similar by county (not shown).

Child Was Ever Fed Breast Milk
(Metro Area, 2018)
Healthy People 2020 Target = 81.9% or Higher



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 113]
 • 2018 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 all respondents about a randomly selected child in the household.

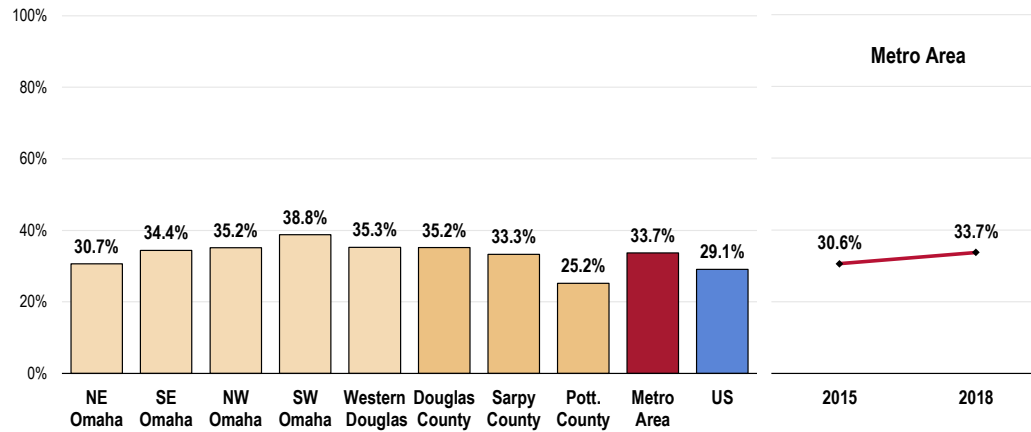
Exclusive Breastfeeding for Six Months

In total, one-third (33.7%) of all Metro Area children were fed breast milk exclusively for the first 6 months of life.

- Higher than the US proportion.
- Satisfies the Healthy People 2020 objective (25.5% or higher).
- No statistically significant difference by Douglas County area.
- By county, lowest in Pottawattamie County.
- TREND: Statistically unchanged over time.

Child Was Exclusively Breastfed for at Least 6 Months (Metro Area, 2018)

Healthy People 2020 Target = 25.5% or Higher



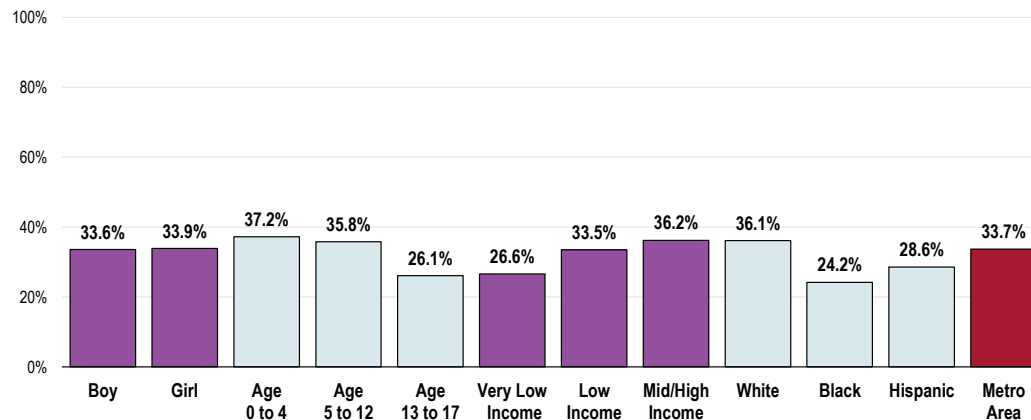
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 130]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-21.5]

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

- Exclusive breastfeeding for the first 6 months of life is more prevalent in children who are now 12 years or younger.
- Other differences by demographics are not statistically significant.

Child Was Exclusively Breastfed for at Least 6 Months (Metro Area, 2018)

Healthy People 2020 Target = 25.5% or Higher



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 130]
 • 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Social Environment Influences



Professional Research Consultants, Inc.

Parenting

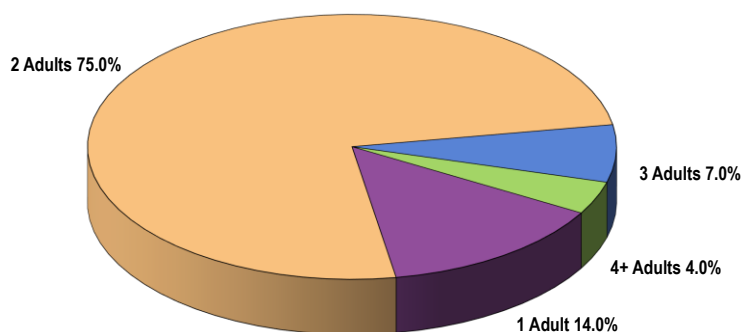
“How many adults living in this household are involved in the care of this child?”

Household Adults Involved in Child’s Care

A total of 14.0% of Metro Area children have just one adult in the household involved in their care.

Three-quarters (75.0%) of Metro Area children have two household adults, while 11.0% have three or more.

Number of Household Adults Involved in Care of Child (Metro Area Parents, 2018)

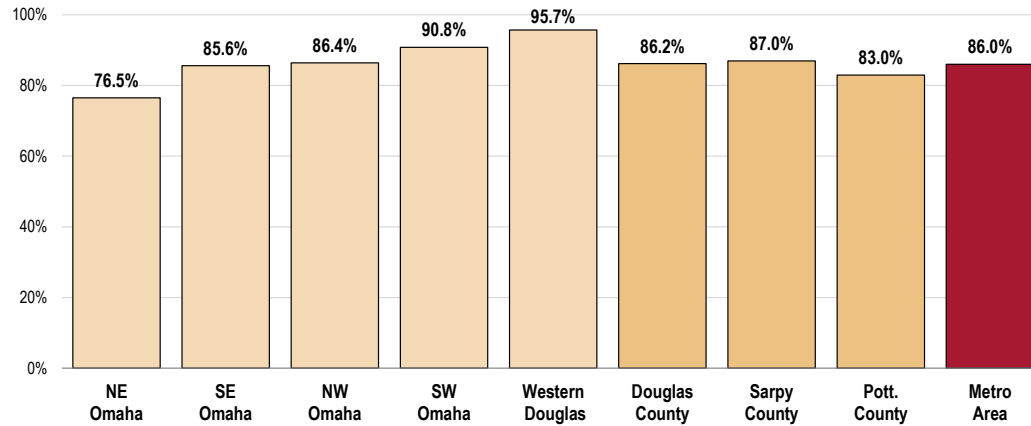


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 318]
Notes: • Asked of respondents with a child in the household.

In total, 86.0% of Metro Area children have two or more household adults involved in their care.

- Within Douglas County, this proportion is lowest in Northeast Omaha.
- Comparable among the three Metro Area counties.

Two or More Household Adults Involved in Care of Child (Metro Area Parents, 2018)

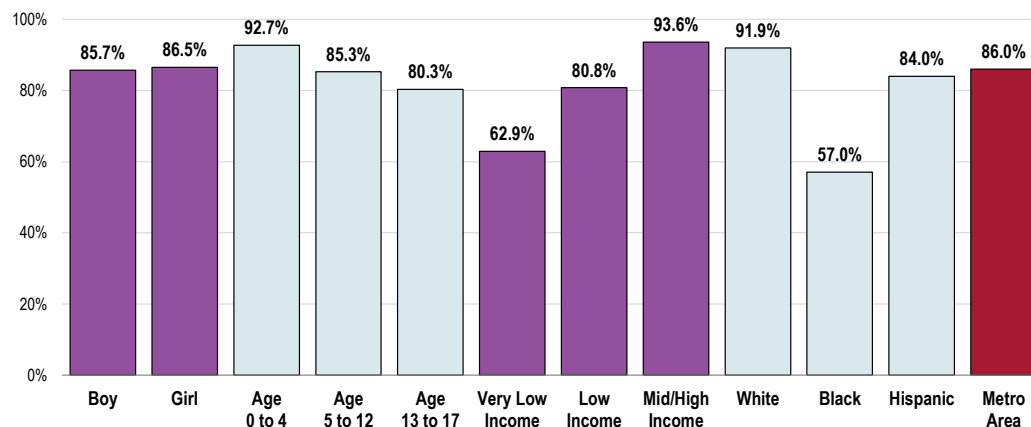


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 354]
 Notes: • Asked of all respondents about a randomly selected child in the household.

Note the following significant differences by key demographic characteristics:

- Children age 0-4 are much more likely to have 2+ household adults involved in their care than are older children.
- There is a strong correlation with income, with higher-income households being far more likely to have 2+ adults involved in the care of the child.
- Black children are notably less likely to have 2+ household adults involved in their care.

Two or More Household Adults Involved in Care of Child (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 354]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Paid Parental Leave

"Some companies offer paid parental leave as a benefit for parents after the birth or adoption of a child. This not vacation or sick time.

After the birth or adoption of this child, which of the following was true for the mother of this child? Would you say: the mother was not working, the mother's company offered paid parental leave, or the mother's company did not offer paid parental leave"

"After the birth or adoption of this child, which of the following was true for the father? Would you say: the father was not working, the father's company offered paid parental leave, or the father's company did not offer paid parental leave"

Among parents of children age 5 and younger, 34.1% report that paid parental leave was available for the mother following birth or adoption.

Another 36.4% were not offered paid leave, and a remaining 29.5% were not working at the time.

When asked the same question for fathers, 20.7% were offered paid leave, while a much larger 71.1% were not offered paid leave, and a remaining 8.1% were not working at the time.

Availability of Paid Parental Leave
(Metro Area Parents of Children Age 0-5, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 349, 351]
Notes: • Asked of all respondents with a child in the household under age 6 .

"After the birth or adoption of this child, about how many weeks, if any, did the mother take off that was considered paid parental leave? Please do not include vacation or sick time."

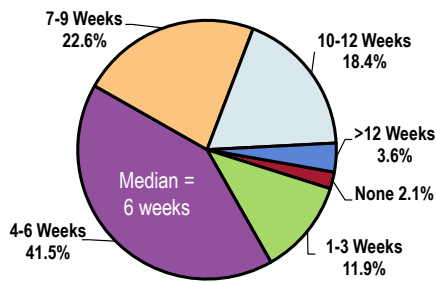
After the birth or adoption of this child, about how many weeks, if any, did the father take off that was considered paid parental leave? Again, do not include vacation or sick time."

For mothers whose company offered paid parental leave, the median amount of time taken is 6 weeks, with 41.5% of mothers having taken 4-6 weeks of paid leave and another 41.0% having taken 7-12 weeks.

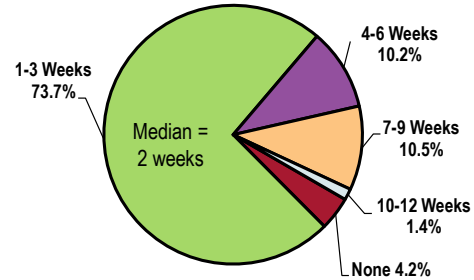
For fathers whose company offered paid parental leave, the median amount of paid leave taken was much lower (2 weeks).

73.7% of fathers took 1-3 weeks of paid leave off work.

Weeks of Paid Parental Leave Taken (Metro Area Parents of Children Under Age 6 Whose Company Offered Paid Leave, 2018)



Mother



Father

Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 350, 352]
Notes: • Asked of all respondents with a child in the household under age 6.

Adverse Childhood Experiences

Exposed to Serious Mental Health Issues At Home

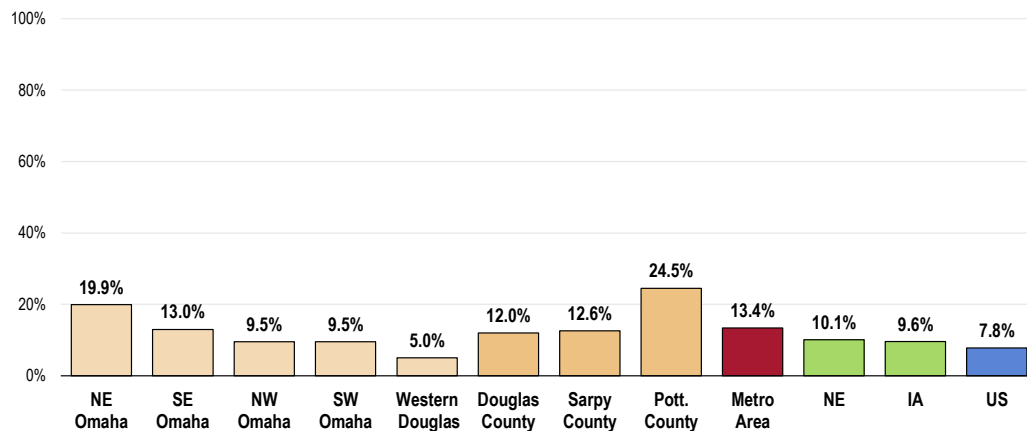
A total of 13.4% of Metro Area parents report that the randomly-selected child in the household has ever lived with someone with serious mental health issues.

“To the best of your knowledge, has this child ever lived with anyone who was mentally ill, suicidal, or severely depressed?”

- Significantly less favorable than state and national findings.
- Within Douglas County, this prevalence is least favorable in Northeast Omaha and most favorable in Western Douglas.
- By county, notable least favorable in Pottawattamie County.

Ever Lived With Someone With Serious Mental Health Issues

(Metro Area Children, 2018)



Sources:

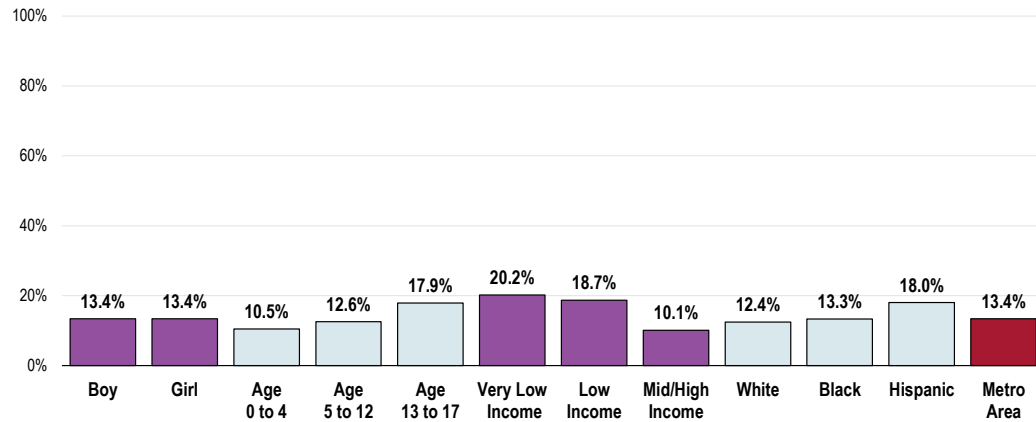
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 331]
- Child and Adolescent Health Measurement Initiative. 2016 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes:

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

- Teens and those living in lower-income households are more likely to have lived with someone with serious mental issues.
- Differences by gender and race/ethnicity are not statistically significant.

Ever Lived With Someone With Serious Mental Health Issues (Metro Area Children, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 331]

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).

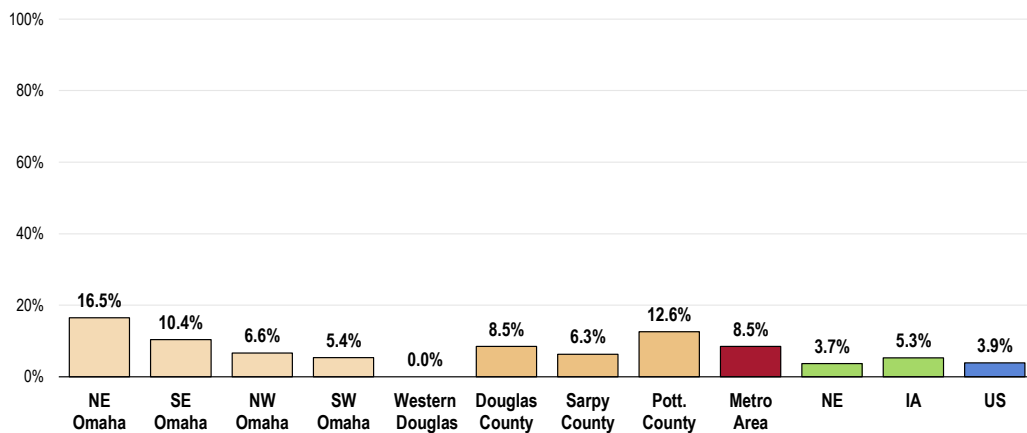
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households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

Exposure to Neighborhood Violence

A total of 8.5% of Metro Area parents report that their child has been exposed to neighborhood violence, either as a victim or as a witness.

- Notably higher than state or national findings.
- In Douglas County, these reports were highest in Northeast Omaha. Note that no parents in Western Douglas reported this type of exposure to violence.
- Statistically comparable by county.

Child Ever Exposed to Neighborhood Violence (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 319]

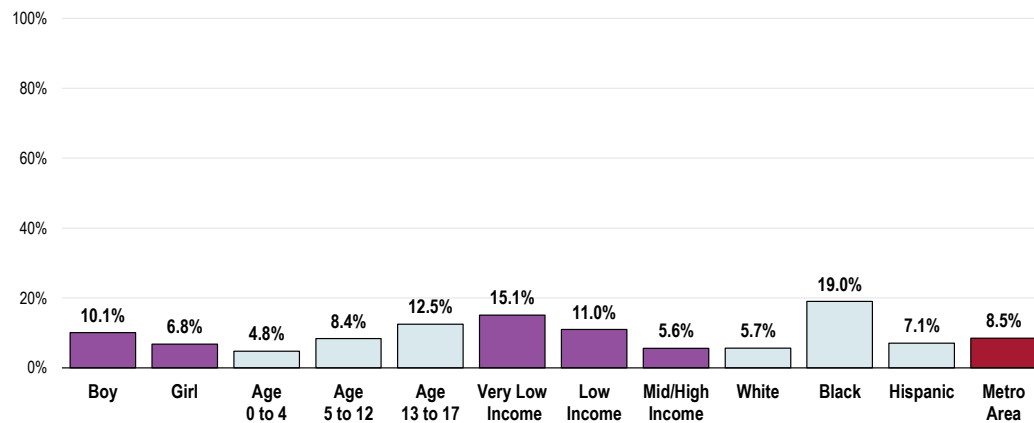
• Child and Adolescent Health Measurement Initiative. 2016 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.

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

Exposure to neighborhood violence is more common among:

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

Child Ever Exposed to Neighborhood Violence (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 319]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Resilience Factors

Child Resilience

Resilience Factors

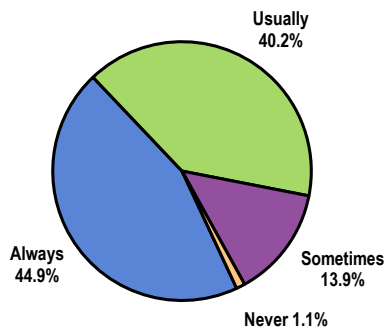
A total of 85.1% of parents with children age 6 months to 5 years report that their child “always” or “usually” bounces back when things do not go his/her way.

The remaining 15.0% of these children “sometimes” or “never” bounce back.

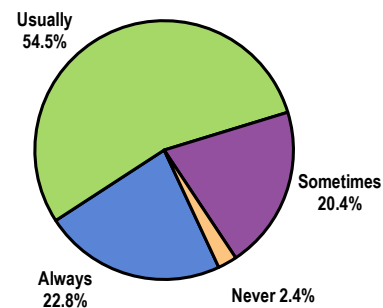
For children age 6-17, 77.3% of parents report that they “always” or “usually” stay calm and in control when faced with a challenge.

The remaining 22.8% of children in this age group “sometimes” or “never” stay calm in these situations.

How Often Does This Child... (Metro Area, 2018)



**Bounce Back When Things
Don't Go His/Her Way**
(Age 6 Mos-5 Yrs)

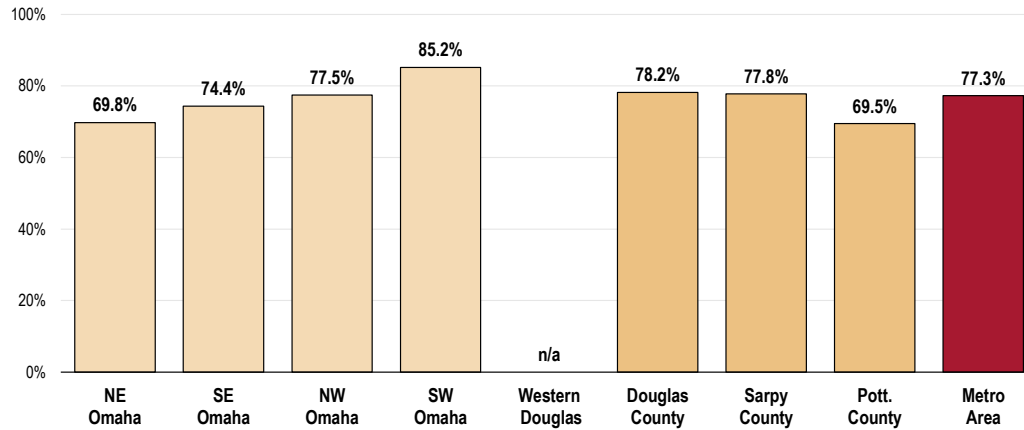


**Stay Calm and In Control When
Faced With a Challenge**
(Age 6-17)

Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 324-325]
Notes: • Asked of all respondents about a randomly selected child in the household.

- For Douglas County children age 6-17, the prevalence of those who “always/usually” stay calm when faced with a challenge is highest in southwest Omaha and lowest in Northeast Omaha.
- Comparable by county.

Child “Always/Usually” Stays Calm/In Control When Faced With a Challenge (Metro Area Children Age 6-17, 2018)

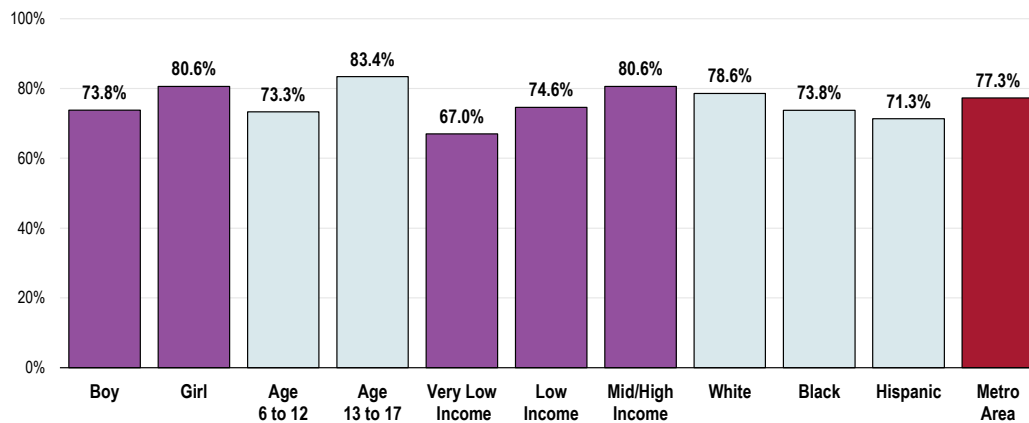


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 325]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 6 to 17.

The following demographic groups are reported to be less capable of handling challenges calmly:

- Boys.
- Younger children (age 6-12).
- Children in very low-income households.

Child “Always/Usually” Stays Calm/In Control When Faced With a Challenge (Metro Area Children Age 6-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 325]
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% FPL; “Low Income” includes households with incomes between 100% and 199% FPL; “Mid/High Income” includes households with incomes at 200% or more of the FPL.

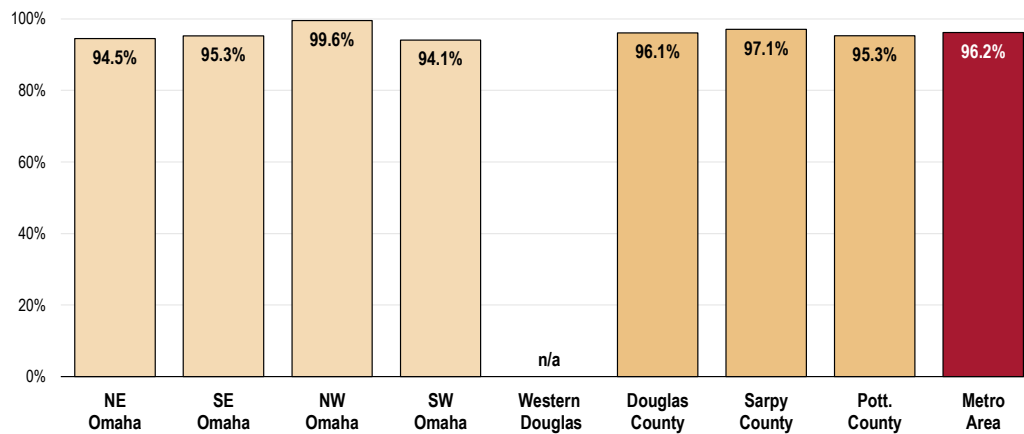
“Other than you or the other adults in your home, is there at least one other adult in this child’s school, neighborhood, or community who knows this child well and who he/she can rely on for advice or guidance?”

Adult for Advice/Guidance

The vast majority (96.2%) of parents of school-age children in the Metro Area report that their child can rely on at least one adult outside the household for advice or guidance.

- Within Douglas County, this prevalence is highest in Northwest Omaha.
- No significant differences among the three Metro Area counties.

Child Has An Adult for Advice/Guidance (Outside Household)
(Metro Area Children Age 5-17, 2018)

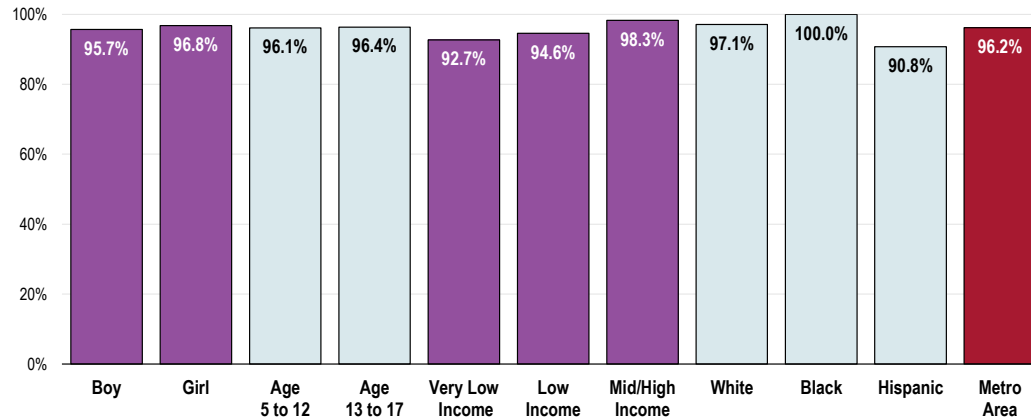


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 326]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 5 to 17.

The following are less likely to have this source of support:

- Children living in very low-income households.
- Hispanic children.

Child Has An Adult for Advice/Guidance (Outside Household) (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 325]
 Notes: • Asked of those 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Family Resilience

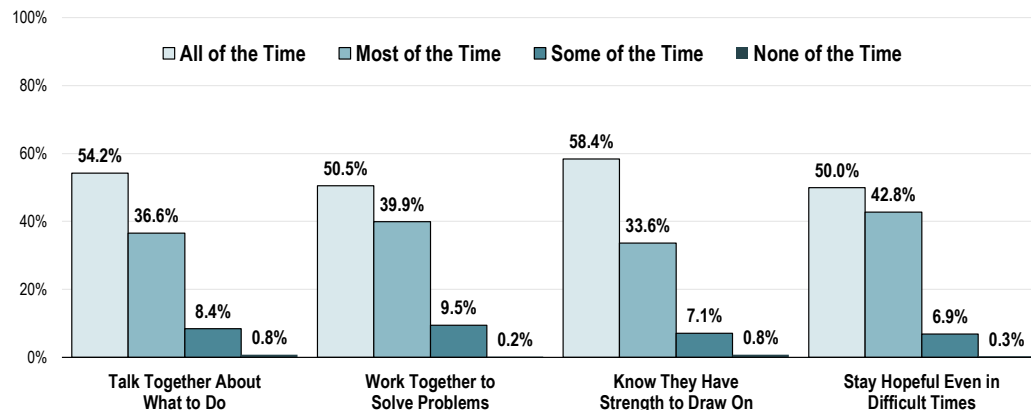
Parents were asked a series of questions related to family resilience, including how often the family:

"When your family faces problems, how often are you likely to do each of the following? Would you say: all of the time, most of the time, some of the time, or none of the time"

- Talks together about what to do;
- Works together to solve problems;
- Knows they have strength to draw on; and
- Stays hopeful even in difficult times.

For each question, at least half of parents responded that the family does these things "all of the time".

Family Resilience (Metro Area, 2018)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 344-347]
 Notes: • Asked of all respondents with a randomly selected child in the household.

Each of these indicators are significantly more favorable in the Metro Area versus the nation except for **staying hopeful in difficult times** (which is less favorable).

Again, except for **staying hopeful in difficult times** (which is similar), each of these indicators is significantly above state rates.

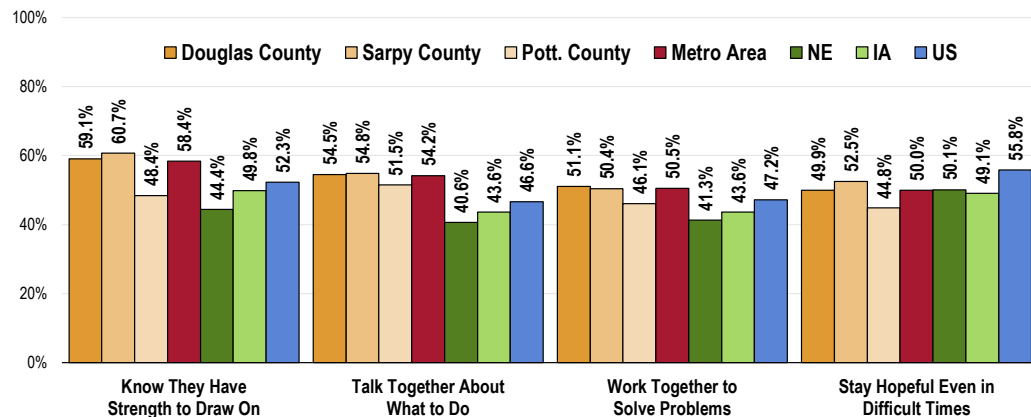
Within Douglas County (not shown):

- Families in Northwest Omaha are more likely to talk together through problems “all of the time”.
- Families in Southeast Omaha are less likely to know that they have strengths to draw on “all of the time”.
- No significant differences among the remaining questions.

Among the three Metro Area counties:

- Families in Pottawattamie County are less likely to know “all of the time” that they have strengths to draw on.
- No significant differences for the remaining questions.

Family Resilience: “All of the Time” Responses (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 344-347]
 • Child and Adolescent Health Measurement Initiative. 2016 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.

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

Meeting Child's Needs

Parents were asked a series of questions related to meeting their child's needs, including how confident the parent is:

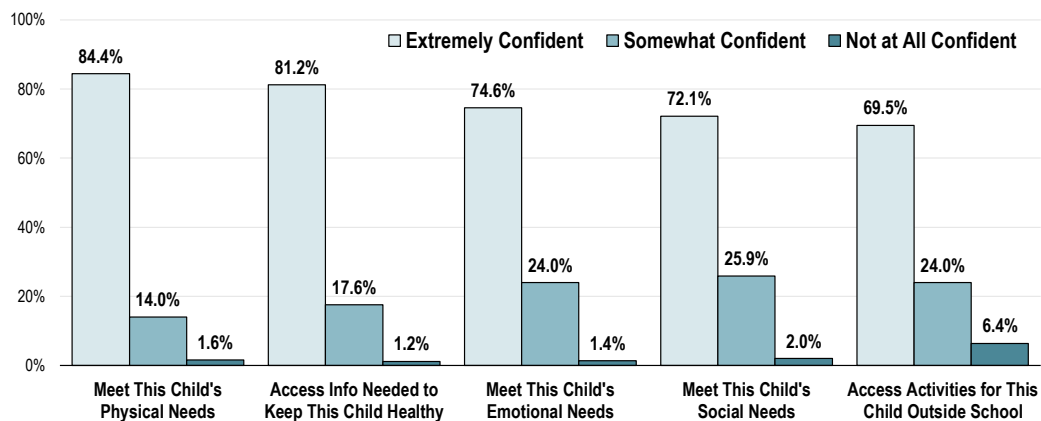
"How confident are you in your ability to access ... ?
Would you say:
extremely confident,
somewhat confident,
or not at all confident"

"How confident are you in your ability to meet this child's ... ?
Would you say:
extremely confident,
somewhat confident,
or not at all confident"

- Accessing the information they need to keep their child healthy;
- Accessing activities for their child outside of school (such as sports, dance classes, music lessons, or clubs);
- Meeting their child's emotional needs;
- Meeting their child's physical needs; and
- Meeting their child's social needs.

Responses ranged from 69.5% being "extremely confident" accessing activities for the child outside of school, to 84.4% being "extremely confident" in meeting the child's physical needs.

Parent's Confidence in Ability to... (Metro Area, 2018)



Sources: • PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 339-343]
Notes: • Asked of all respondents with a randomly selected child in the household.

Within Douglas County (not shown):

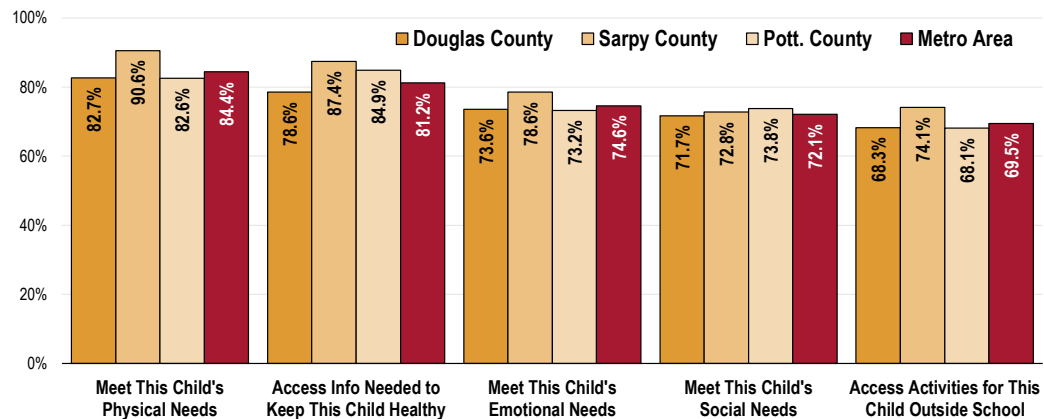
- Parents in Southeast Omaha are least confident accessing healthcare information, accessing activity information, and meeting their child's physical needs.
- Parents in Southwest Omaha are significantly more confident accessing activity information for their child.
- Parents in Western Douglas are most confident for each question.
- Other differences among areas are not statistically significant.

Among the three Metro Area counties:

- Parents in Douglas County report less confidence for accessing healthcare information and meeting the child's physical needs, while parents in Sarpy County report more confidence for these indicators.
- No significant differences for the remaining questions.

Parent “Extremely” Confident in Ability to...

(Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 339-343]
 Notes: • Asked of all respondents with a randomly selected child in the household.

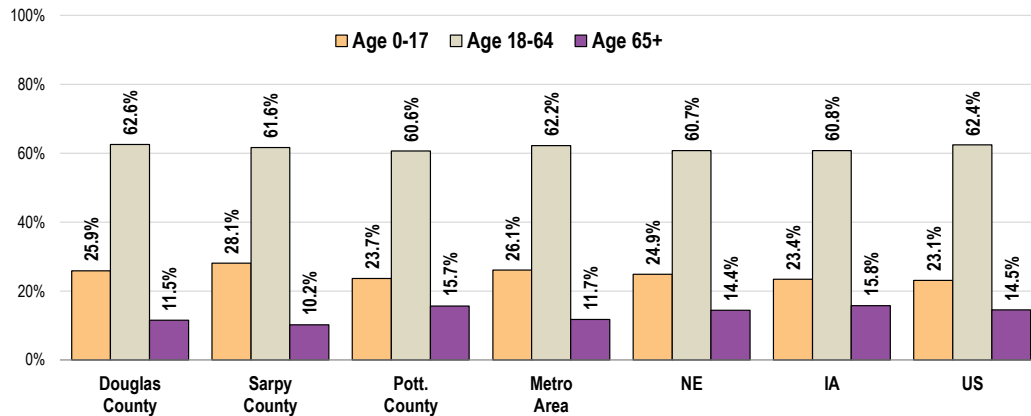
Demographics

Child Population

In the Metro Area, infants, children, and adolescents (age 0-17) 26.1% of the population.

- The percentage of youth (age 0-17) is similar to that found state- and nationwide.

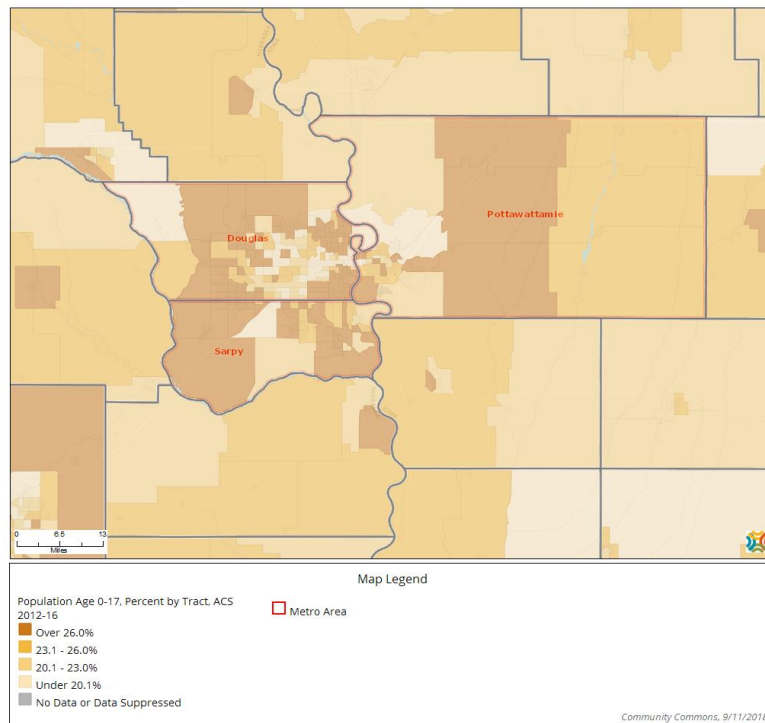
Total Population by Age Groups, Percent
(2012-2016)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved September 2018 from Community Commons at <http://www.chna.org>.

- The following map shows the percent of the Metro Area population under age 18 by census tract.

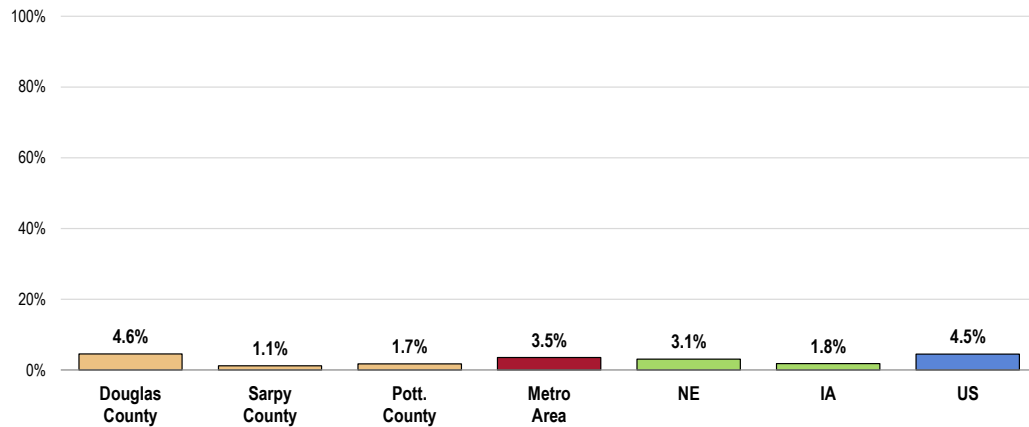


Linguistic Isolation

A total of 3.5% of the Metro Area population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English “very well”).

- Statistically higher than both state rates.
- Lower than the US rate.
- By Metro Area county, this proportion is highest in Douglas County.

Linguistically Isolated Population (2012-2016)

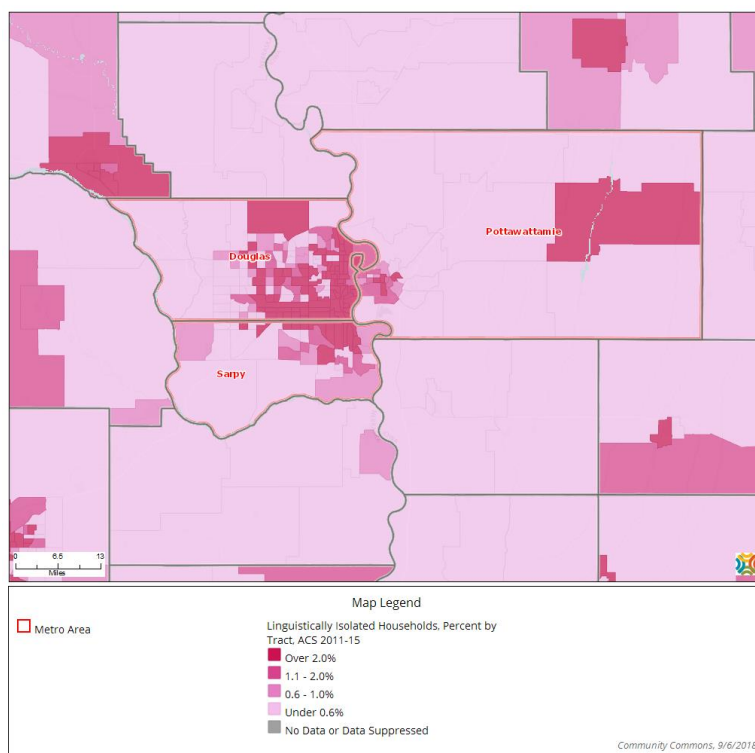


Sources: • US Census Bureau American Community Survey 5-year estimates.

• Retrieved September 2018 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of the population aged 5 and older who live in a home in which no person 14 years old and over speaks only English, or in which no person 14 years old and over speak a non-English language and speak English “very well.”

- Note linguistic isolation in the Metro Area census tracts.

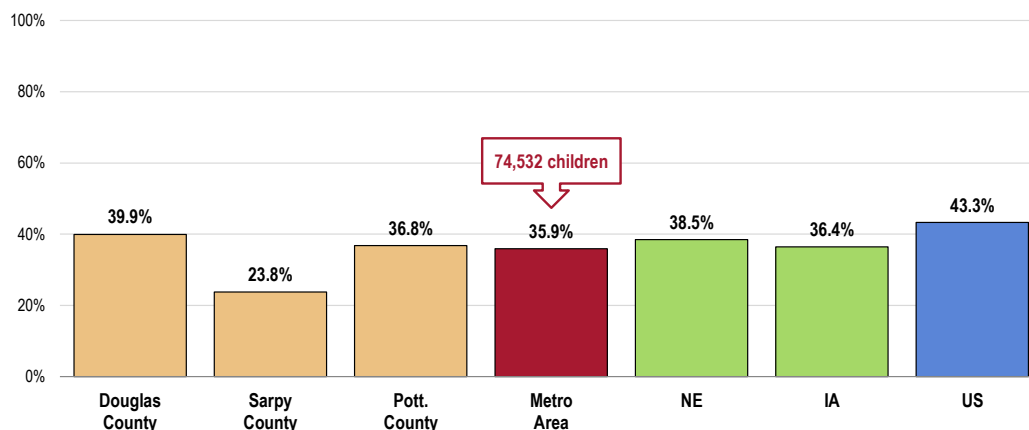


Children in Low-Income Households

A total of 35.9% of Metro Area children age 0-17 (representing an estimated 74,532 children) live below the 200% poverty threshold.

- Below the Nebraska proportion but comparable to Iowa.
- Well below the US proportion.
- By county, highest in Douglas County.

Percent of Children in Low-Income Households (Children 0-17 Living Below 200% of the Poverty Level, 2012-2016)

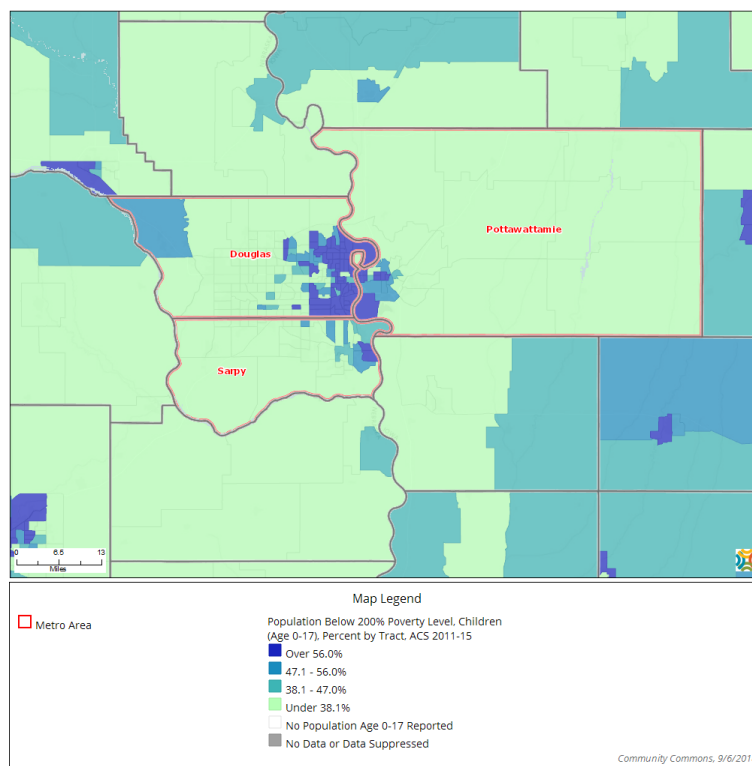


Sources: • US Census Bureau American Community Survey 5-year estimates.

• Retrieved September 2018 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

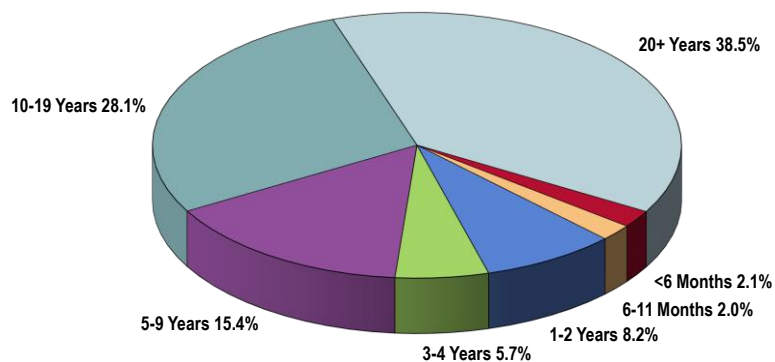
- Dark blue shading in the following map shows the areas within the Metro Area where over 50% of children are living in low-income households.



Length of Time Living in Area

Two-thirds (66.6%) of survey respondents have lived in the area for 10 years or more, while 4.1% have lived in the area under 1 year.

Length of Time Living in The Area (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 353]
Notes: • Asked of respondents with a child in the household.

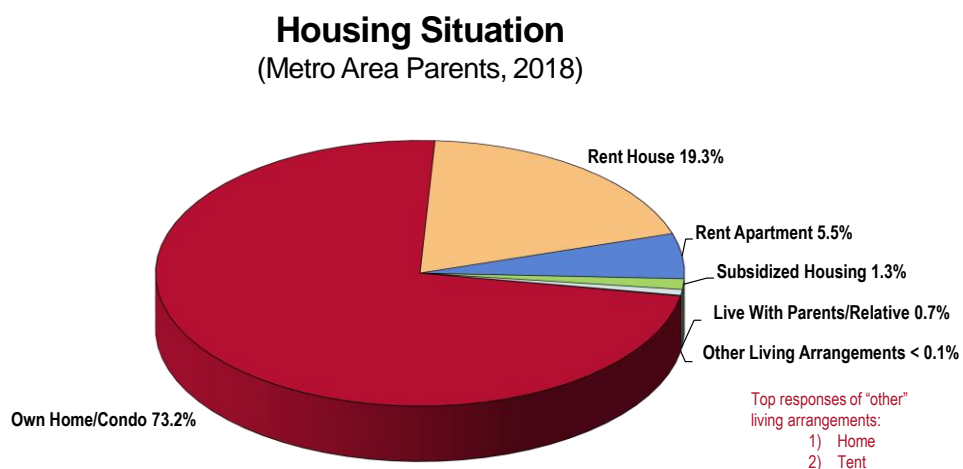
Housing Situation

When asked about their housing situation, 73.2% of survey respondents own their home or condo.

Another 19.3% rent their house and 5.5% rent an apartment.

- Less common responses include subsidized housing (1.3%) and living with parents or relatives (0.7%).

Of those few with an “other” living arrangement, the top explanations included “home” and “tent”.



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 121, 356]
Notes: • Asked of respondents with a child in the household.

Finances

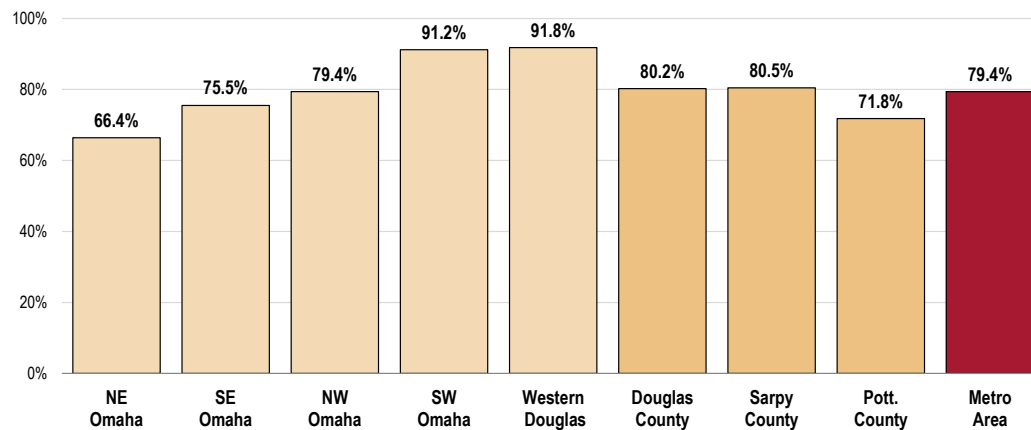
Financial Resilience

A total of 79.4% of Metro Area parents responded that they would have the finances to be able to afford a hypothetical \$400 emergency expense.

- Within Douglas County, this is least common in Northeast Omaha.
- Comparable by Metro Area county.

“Suppose that you have an emergency expense that costs \$400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?”

Have the Financial Resilience to Cover a \$400 Emergency Expense
(Metro Area Parents, 2018)

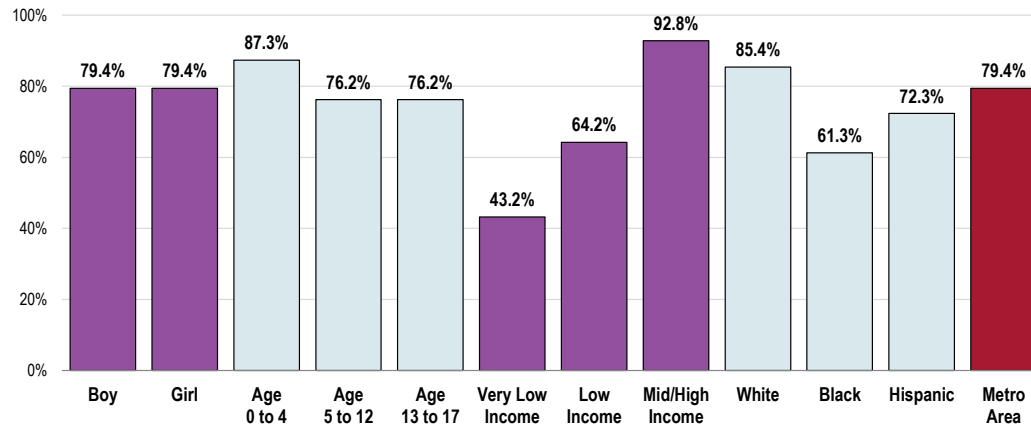


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 359]
Notes: • Asked of all respondents with a randomly selected child in the household.

Note the following demographic segments that are less likely to live in households with this level of financial resilience:

- Children age 5-17.
- Children in very low-income households (strong correlation with income, as might be expected).
- Black children.
- Hispanic children.

Have the Financial Resilience to Cover a \$400 Emergency Expense (Metro Area Parents, 2018)

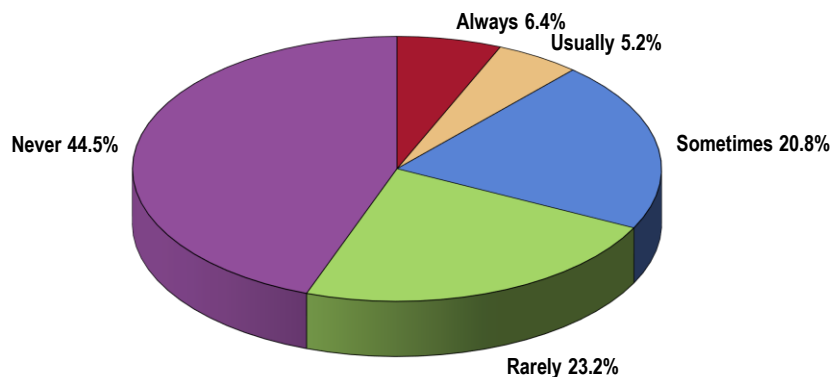


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 359]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Housing Insecurity

While most surveyed parents rarely, if ever, worry about the cost of housing, a considerable share (32.4%) reported that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

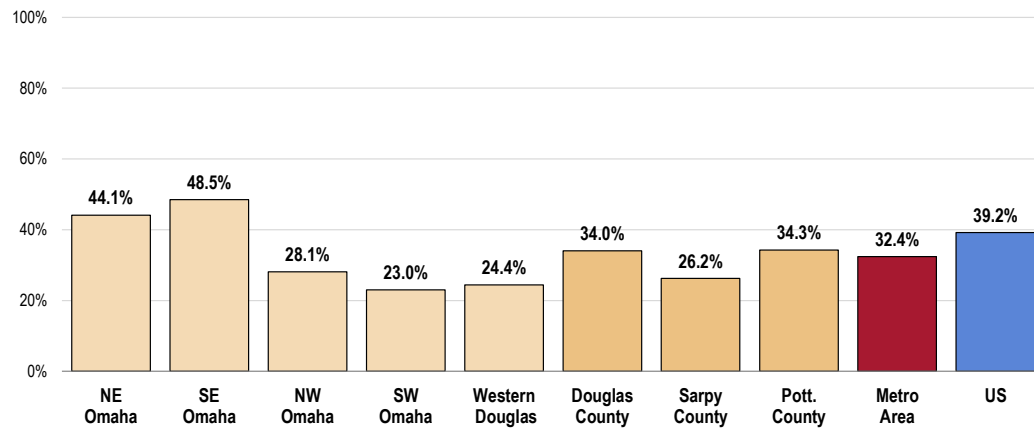
Frequency of Worry or Stress Over Paying Rent/Mortgage in the Past Year (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 357]
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Compared to the US prevalence, the Metro Area proportion of adults who worried about paying for rent or mortgage in the past year is more favorable.
- Within Douglas County, housing insecurity appears highest in Southeast and Northeast Omaha.
- Among the Metro Area counties, parents in Sarpy County report the lowest prevalence of housing insecurity.

“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year



Sources:

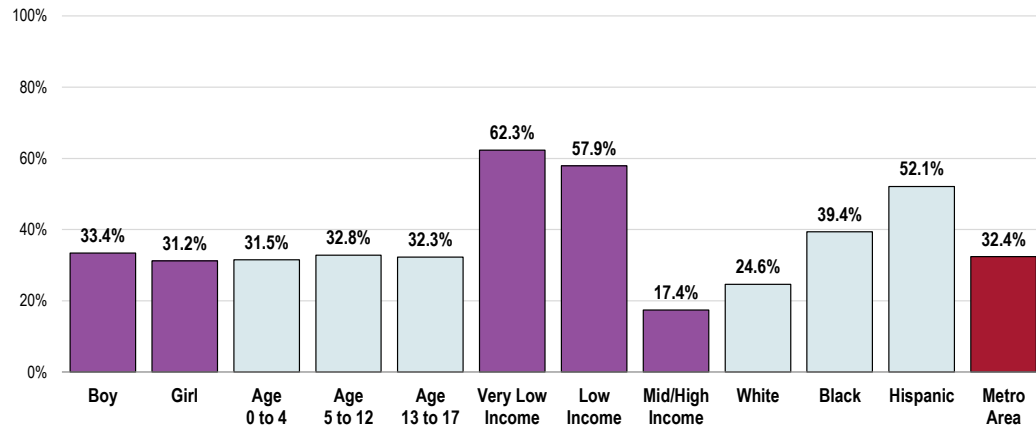
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 357]
- 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes:

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

- As might be expected, those living at lower incomes are much more likely to worry about housing security.
- Over half of respondents with a Hispanic child also report this insecurity, as do four in 10 respondents with a Black child.

“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 357]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

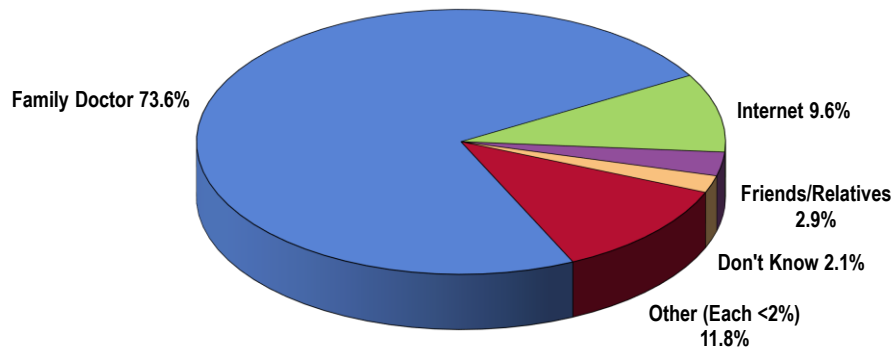
"Where do you get most of your healthcare information for this child?"

Primary Source of Healthcare Information

Family physicians are the primary source of children's healthcare information for 73.6% of Metro Area parents.

- The **Internet** received the second-highest response, with 9.6%.

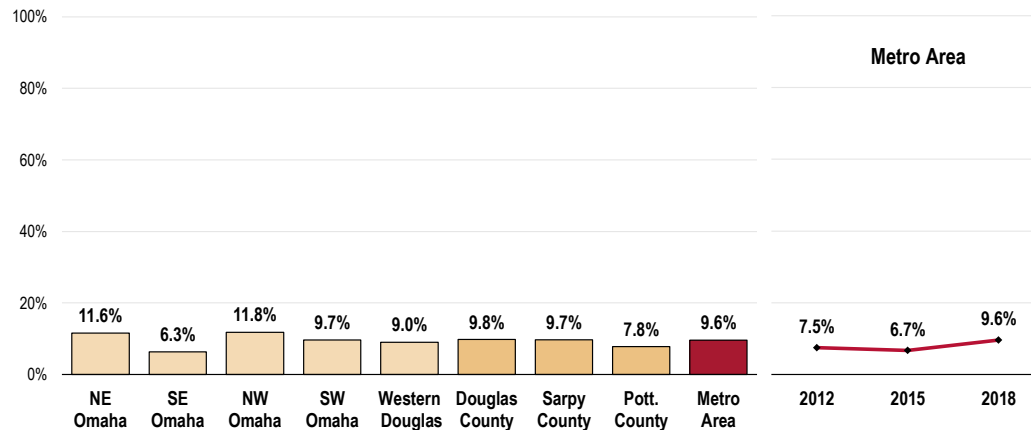
Primary Source of Healthcare Information for Child (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 338]
Notes: • Asked of all respondents about a randomly selected child in the household.

- The prevalence of Douglas County parents who rely on the **Internet** as their primary source of healthcare information for their child does not statistically vary by area.
- TREND:** Marks a statistically significant increase since 2015 (though similar to 2012).

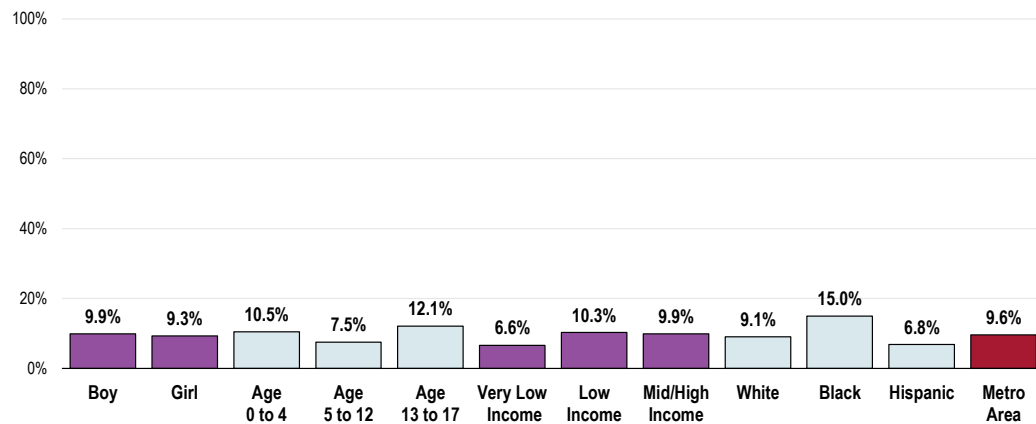
Internet is the Primary Source of Healthcare Information (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 338]
Notes: • Asked of all respondents about a randomly selected child in the household.

- Households with teens are more likely to rely on the Internet for healthcare information.
- Other differences by demographics are not statistically significant.

Internet is the Primary Source of Healthcare Information (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 338]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Physical Environment Influences



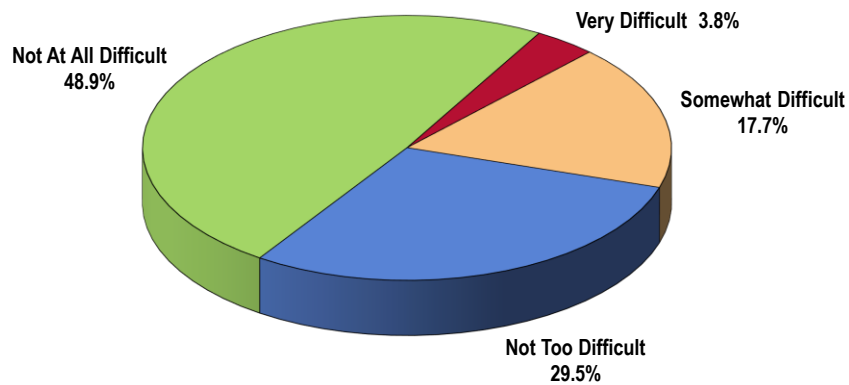
Professional Research Consultants, Inc.

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

Difficulty Accessing Fresh Produce

While most report little or no difficulty, 21.5% of Metro Area parents report that it is “very” or “somewhat” difficult for them to access affordable fresh fruits and vegetables.

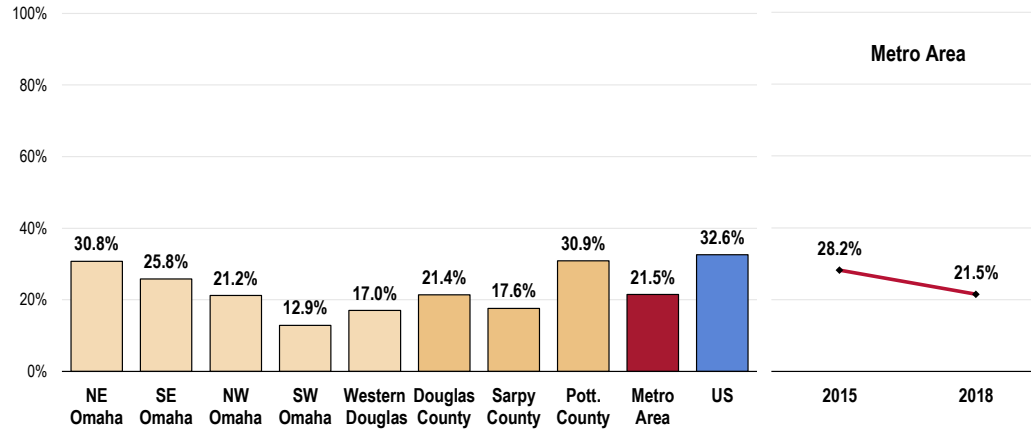
Level of Difficulty Finding Fresh Produce at an Affordable Price (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 112]
Notes: • Asked of all respondents about a randomly selected child in the household.

- Notably more favorable than the US proportion.
- Within Douglas County, access difficulties are highest in Northeast Omaha and lowest in Southwest Omaha.
- By county, this prevalence is highest in Pottawattamie County.
- TREND: Access to fresh produce has improved since first measured in 2015.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Metro Area Parents, 2018)



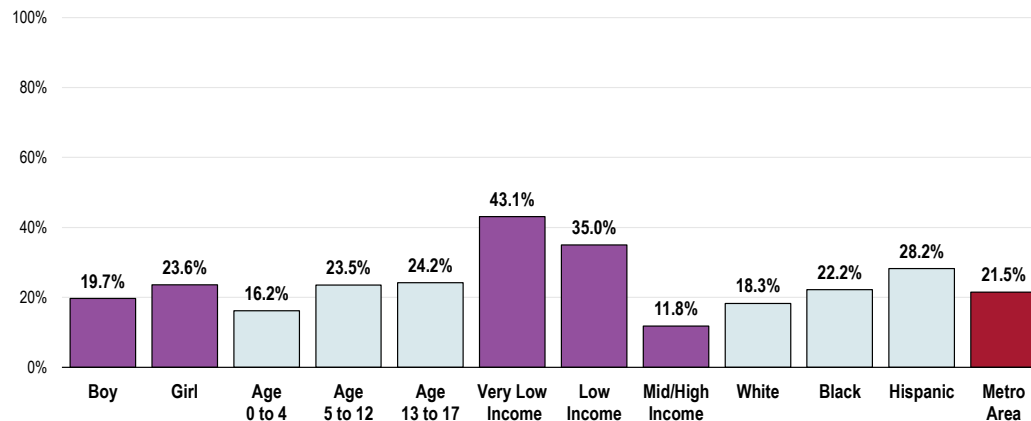
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 112]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

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

- Families with children age 5-17.
- Lower-income residents (note the negative correlation with income).
- Parents of Hispanic children.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 112]
 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% FPL; “Low Income” includes households with incomes between 100% and 199% FPL; “Mid/High Income” includes households with incomes at 200% or more of the FPL.

Safety

Bullying

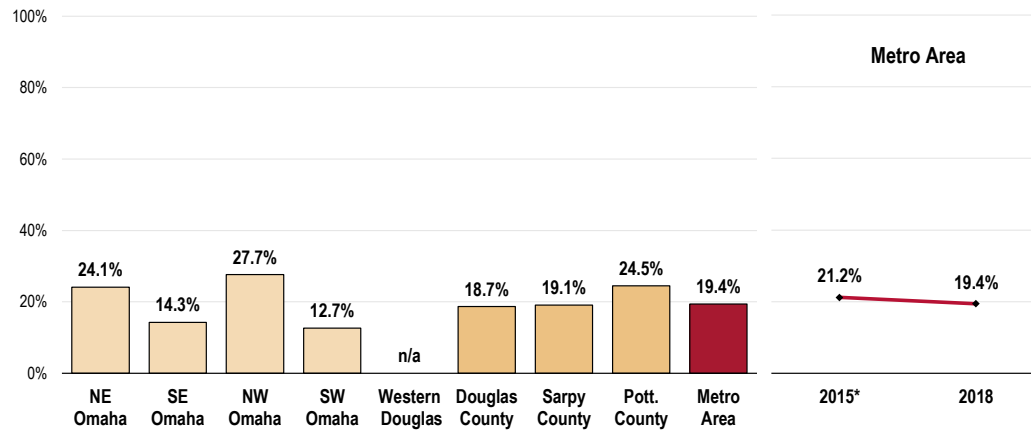
Among parents of school-age children (age 5-17), 19.4% report that their child has been bullied online, at school, or elsewhere in the past year.

- Within Douglas County, highest in Northwest Omaha.
- There are no statistically significant differences in reported prevalence of bullying among the three Metro Area counties.
- TREND: Statistically unchanged since first measured in 2015. *Note that prior data was asked as two questions.*

“During the past 12 months, has this child been bullied, whether online, at school, or some other place?”

NOTE: It is important to recognize that these measures are reported by parents and are limited to incidents of which parents are aware; it is reasonable to presume that the true incidence for these measures is potentially quite a bit higher.

Child Was Bullied in the Past Year (Metro Area Children Age 5-17, 2018)

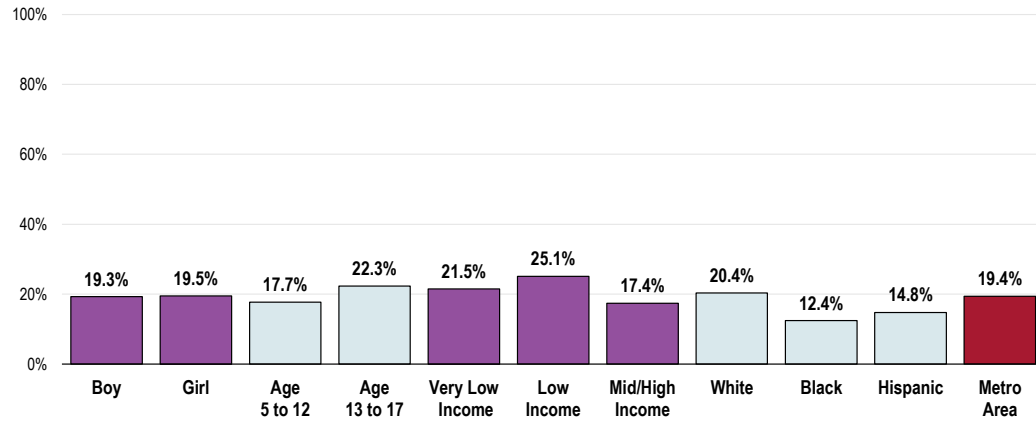


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 320]
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 5 to 17.
 • *2015 was asked as two questions (online and on school property).

- Parents' reports of bullying do not differ significantly by child demographics.

Child Was Bullied in the Past Year

(Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 320]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

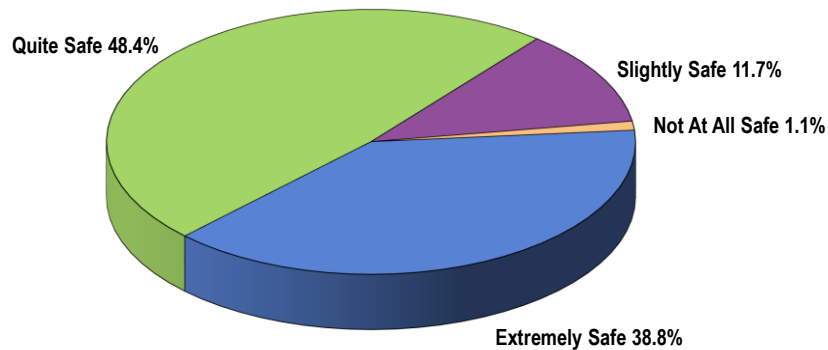
Environmental Safety

Perceived Safety of Neighborhood

While most Metro Area families live in "extremely safe" or "quite safe" neighborhoods, 12.8% of parents live in neighborhoods they consider only "slightly safe" or "not at all safe."

Perceived Safety of Neighborhood

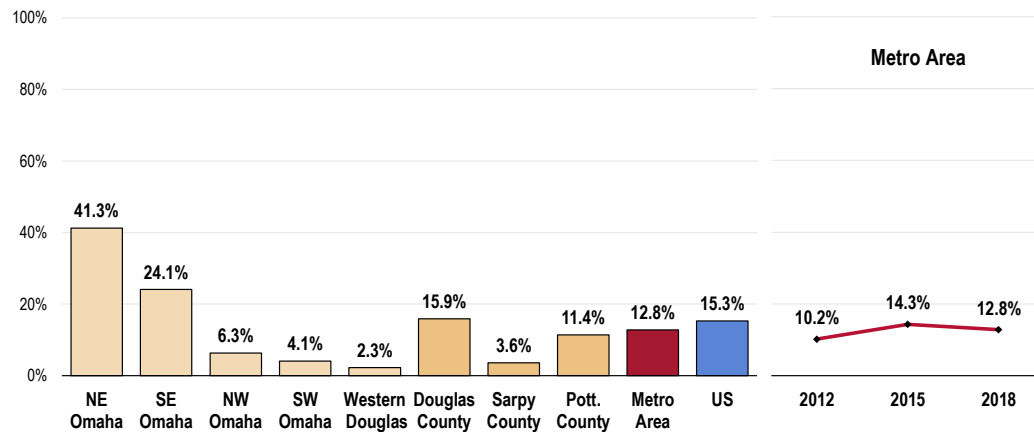
(Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 76]
 Notes: • Asked of all respondents about a randomly selected child in the household.

- The prevalence of “slightly/not at all safe” responses is comparable to national reports.
- Perceptions of poor neighborhood safety vary quite a bit within Douglas County, with Northeast and Southeast Omaha reporting the highest prevalences by far.
- Among the Metro Area counties, the Douglas County prevalence is also the highest.
- TREND: No clear trend in neighborhood safety over time.

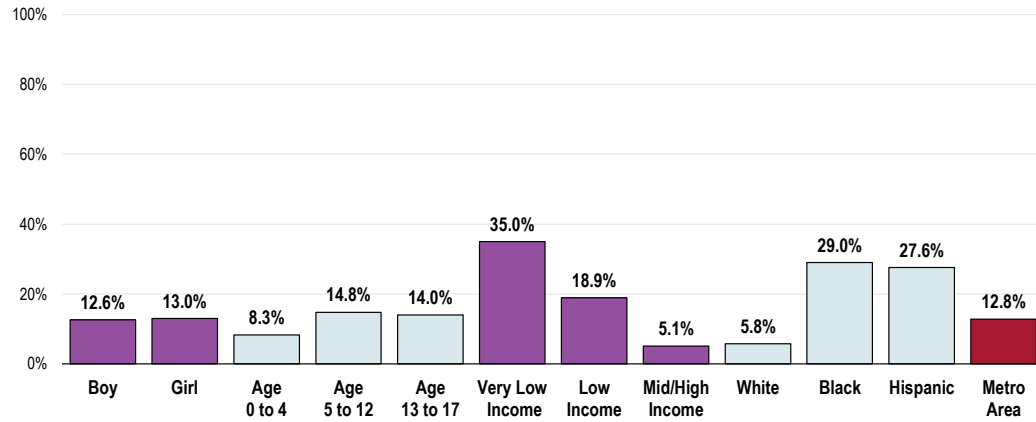
Neighborhood Perceived to be “Slightly/Not At All” Safe (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 76]
 • 2018 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 with household income levels.
- Also, parents of Black or Hispanic children are much more likely to live in neighborhoods they consider “slightly/not at all” safe.
- Parents of older children (age 5-17) also regard their neighborhoods as less safe.

Neighborhood Perceived to be “Slightly/Not At All” Safe (Metro Area, 2018)



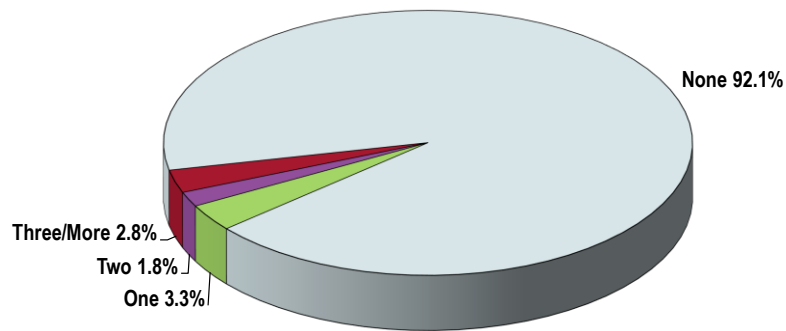
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 76]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Feeling Safe at School or Going to/From School

A total of 7.9% of Metro Area children age 5-17 missed school at least once in the past year because the child 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?"

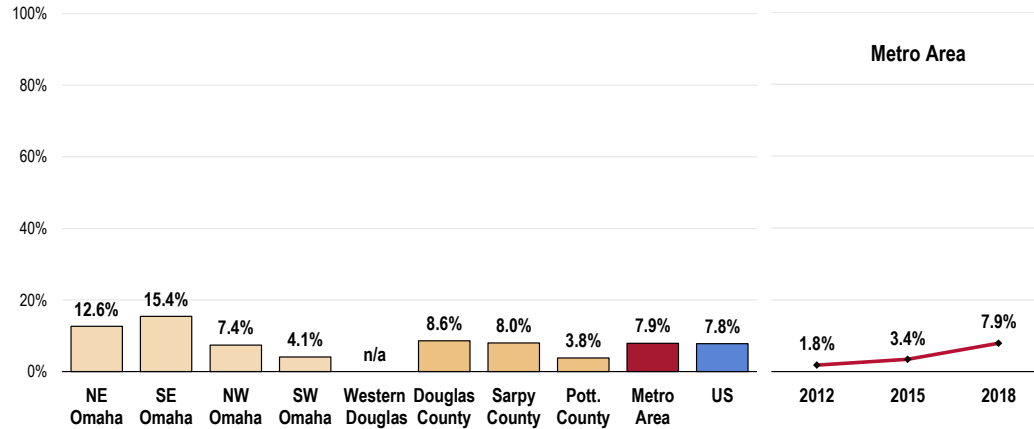
School Days Missed in the Past Year Because Child Felt Unsafe at School or on the Way to/From School (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 73]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.

- Almost identical to the national proportion.
- Within Douglas County, children in Southeast Omaha are more likely to have missed school due to safety concerns.
- Statistically comparable among the three Metro Area counties.
- TREND: Represents a notable increase over time.

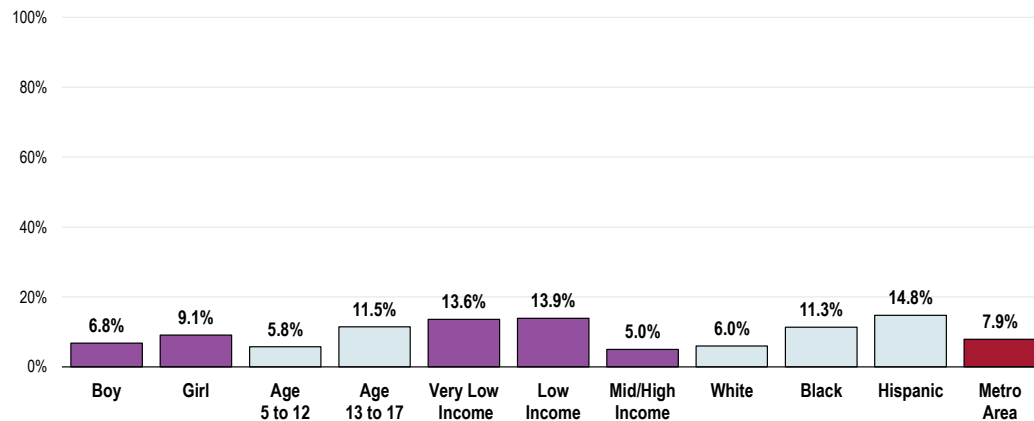
Child Missed School in the Past Year Due to Feeling Unsafe (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 73]
 • 2018 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.

- Teens, children in lower-income households, and Hispanic children are more likely to have missed school due to safety reasons than their demographic counterparts.

Child Missed School in the Past Year Due to Feeling Unsafe (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 73]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Housing Conditions

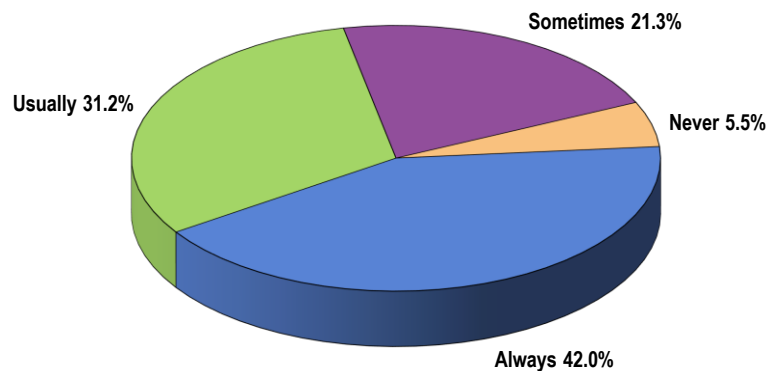
“How often do children play in playgrounds or parks in your neighborhood? Would you say: always, usually, sometimes, or never”

Neighborhood Playgrounds & Parks

The majority (73.2%) of survey respondents report that children “always” or “usually” use playgrounds or parks in their neighborhood.

Another 21.3% report that children “sometimes” use these resources.

Child Use of Neighborhood Playgrounds/Parks
(Metro Area, 2018)

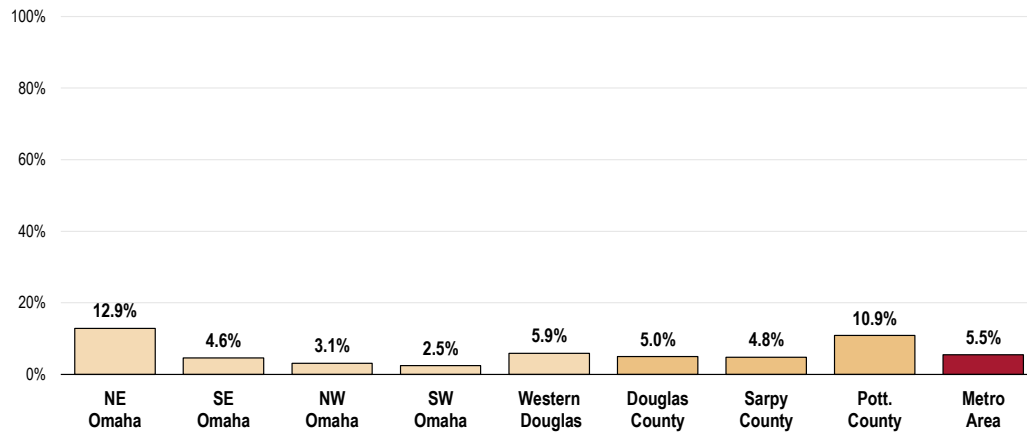


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 321]
Notes: • Asked of all respondents about a randomly selected child in the household.

Conversely, 5.5% of respondents report that children “never” use playgrounds or parks in their neighborhood.

- Within Douglas County, children in Northeast Omaha are less likely to utilize neighborhood playgrounds or parks.
- Differences among the three Metro Area counties are not statistically significant.

Children “Never” Use Neighborhood Playgrounds/Parks (Metro Area, 2018)



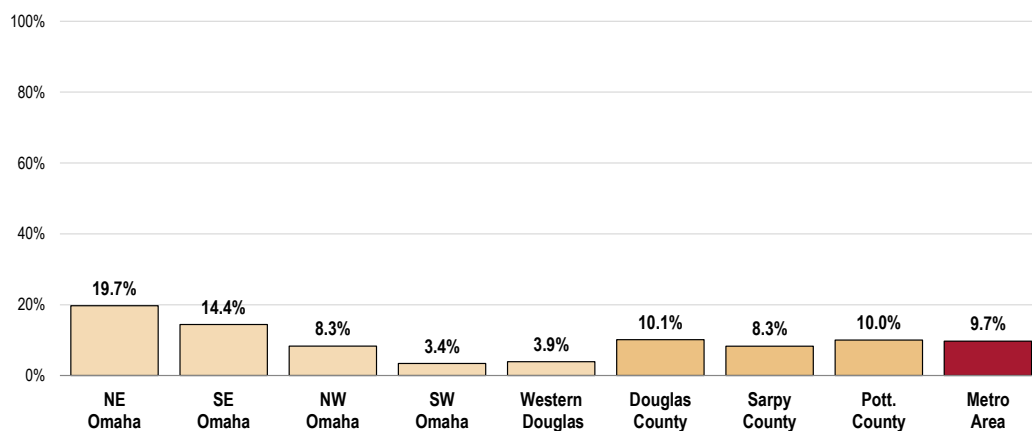
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 321]
 Notes: • Asked of all respondents about a randomly selected child in the household.

Unhealthy Housing Conditions

A total of 9.7% of Metro Area parents report having ongoing problems in the past year with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

- In Douglas County, this prevalence is highest in Northeast Omaha.
- No significant differences among the three counties.

Unhealthy Housing Conditions in Past Year (Metro Area Parents, 2018)

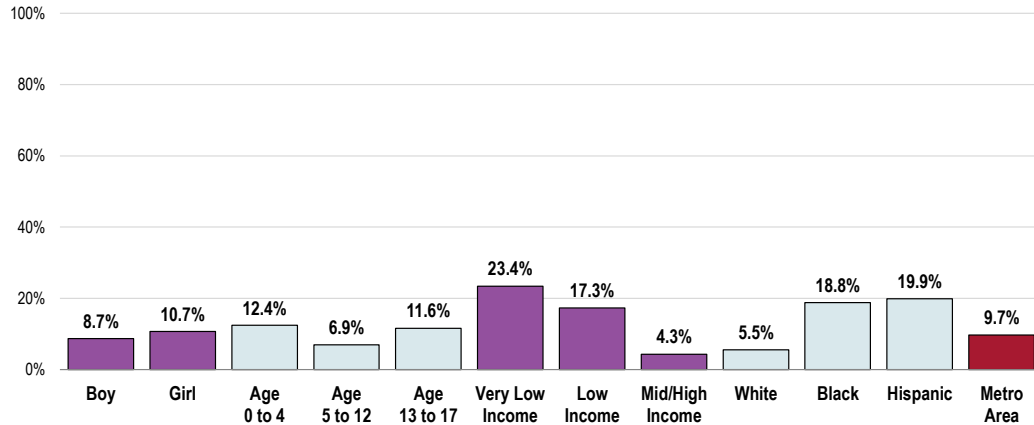


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 358]
 Notes: • Asked of all respondents with a randomly selected child in the household.
 • Unhealthy housing conditions include ongoing problems with water leaks, rodents, insects, mold, lead paint, or other housing conditions that might make living there unhealthy or unsafe.

Reports of unhealthy housing conditions are more prevalent for the following:

- Households with younger or older children.
- Those living in lower-income households (negative correlation with income).
- Households with Black or Hispanic children.

Unhealthy Housing Conditions in Past Year (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 358]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

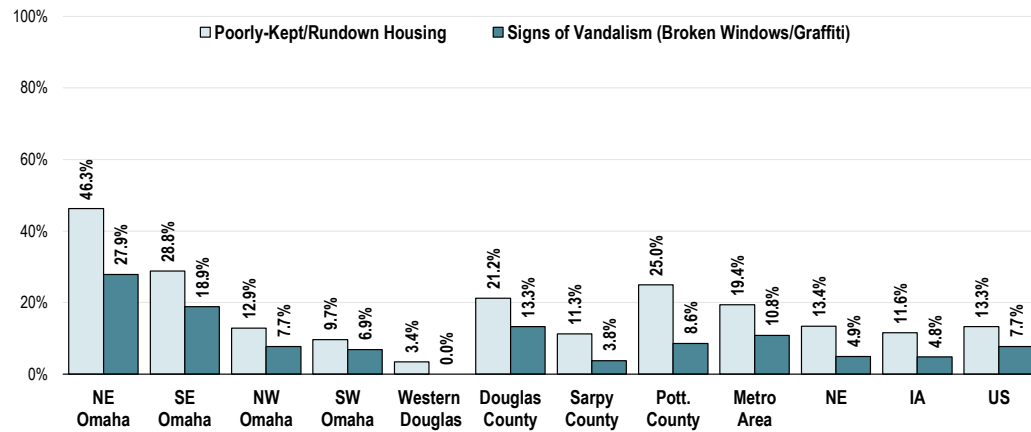
Detracting Elements of Neighborhood

A total of 19.4% of Metro Area respondents reported poorly-kept or rundown housing in their neighborhood, while a lesser but notable 10.8% reported signs of vandalism.

- Metro Area findings for each is significantly higher than state or national findings.
- Within Douglas County, the prevalences for both neighborhood elements were highest in Northeast and Southeast Omaha.
- Douglas County, overall, also displays a statistically higher prevalence of each element when compared against the other two counties (differences for Pottawattamie County were not significant).

Respondents were also asked about the presence of certain aspects in their neighborhood, including poorly-kept or rundown housing and signs of vandalism (such as broken windows or graffiti).

Aspects of Neighborhood (Metro Area, 2018)



Sources:

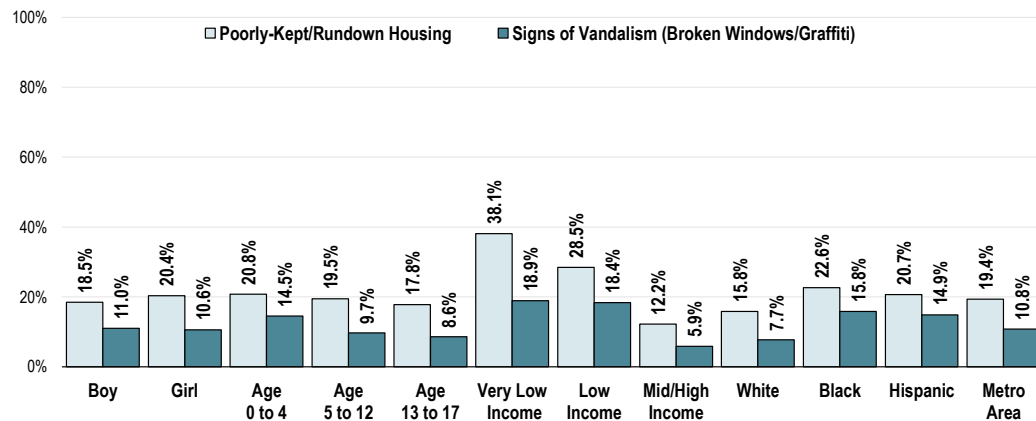
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 322-323]
- Child and Adolescent Health Measurement Initiative. 2016 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes:

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

- Each of these neighborhood aspects is negatively correlated with income.
- Parents of children age 0-4 also report a higher prevalence of vandalism in their neighborhood.

Aspects of Neighborhood (Metro Area, 2018)



Sources:

- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 322-323]

Notes:

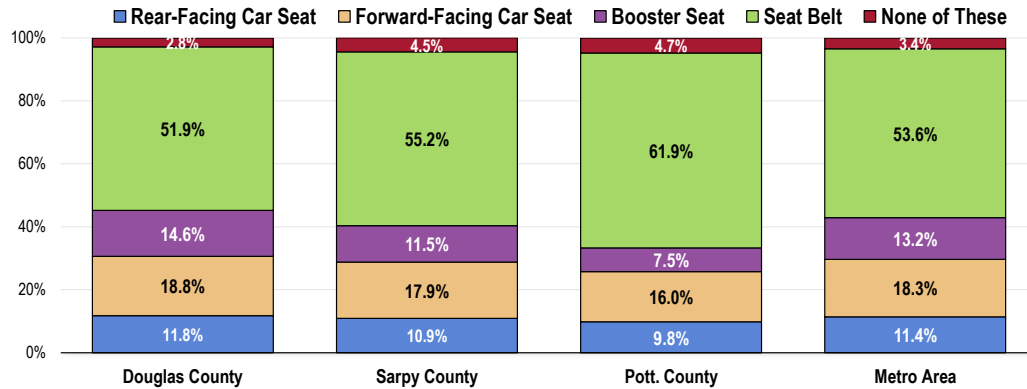
- Asked of all respondents about a randomly selected child in the household.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal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

Injury Control

Car Seats & Seat Belts

Metro Area parents were asked about the type of restraint used by their child when riding in a vehicle. The responses by county are below.

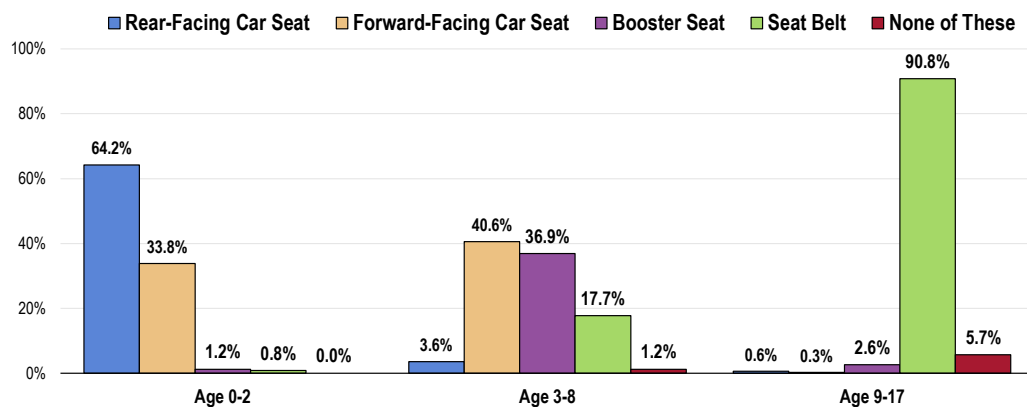
Child Restraint Used When Riding in a Vehicle (Metro Area Children, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 317]
Notes: • Asked of all respondents about a randomly selected child in the household.

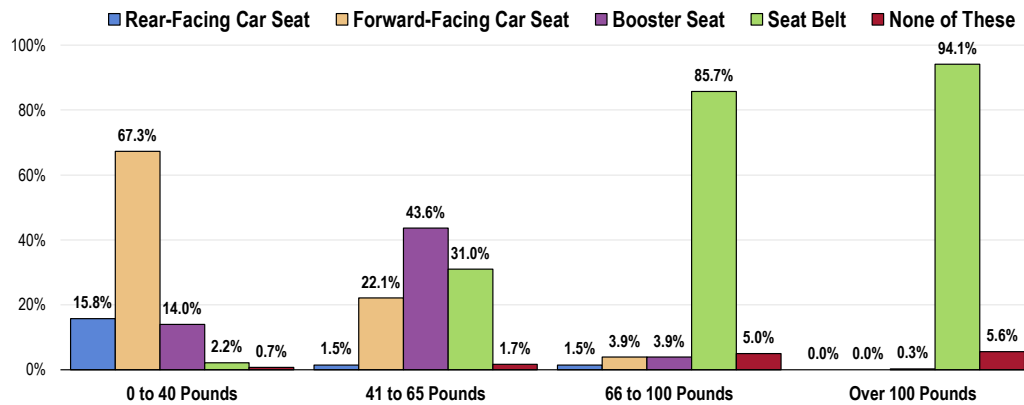
Recommendations for the type of restraint to be used are largely based on age, height and weight. This is especially true for the younger ages, where recommendations are dependent on the specific car seat being used and the manufacturer's specifications. The following charts outline usage by age and weight.

Child Restraint Used When Riding in a Vehicle (Metro Area Children by Age, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 317]
Notes: • Asked of all respondents about a randomly selected child in the household.

Child Restraint Used When Riding in a Vehicle (Metro Area Children by Weight, 2018)



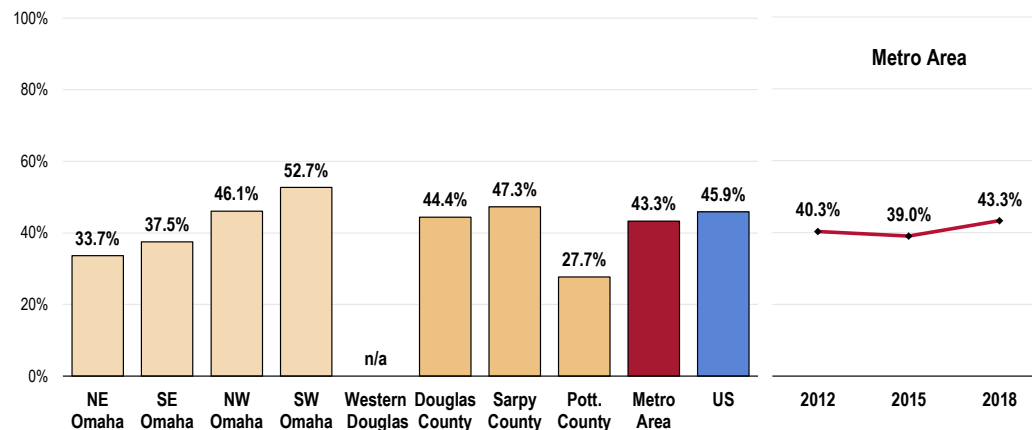
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 317]
Notes: • Asked of all respondents about a randomly selected child in the household.

Bicycle Helmet Use

A total of 43.3% of Metro Area children age 5 to 17 are reported to “always” wear a helmet when riding a bicycle.

- Statistically similar to the US proportion.
- Within Douglas County, this level of helmet safety is least prevalent in Northeast Omaha.
- By county, children in Pottawattamie County are least likely to “always” wear a helmet when riding a bicycle.
- TREND: Statistically similar to 2012 and 2015 findings.

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, 2018)

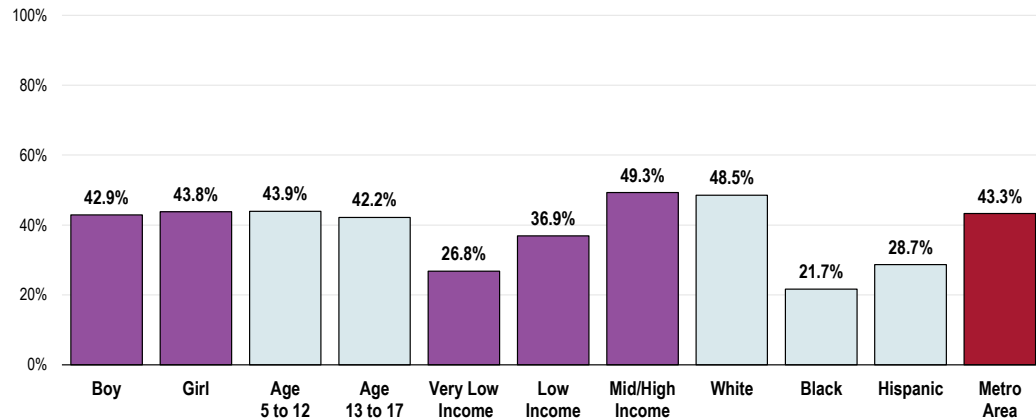


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 316]
• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a bike in the past year.

Helmet use is less prevalent among:

- Those in very low-income households.
- Black children.

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, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 316]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Water Safety

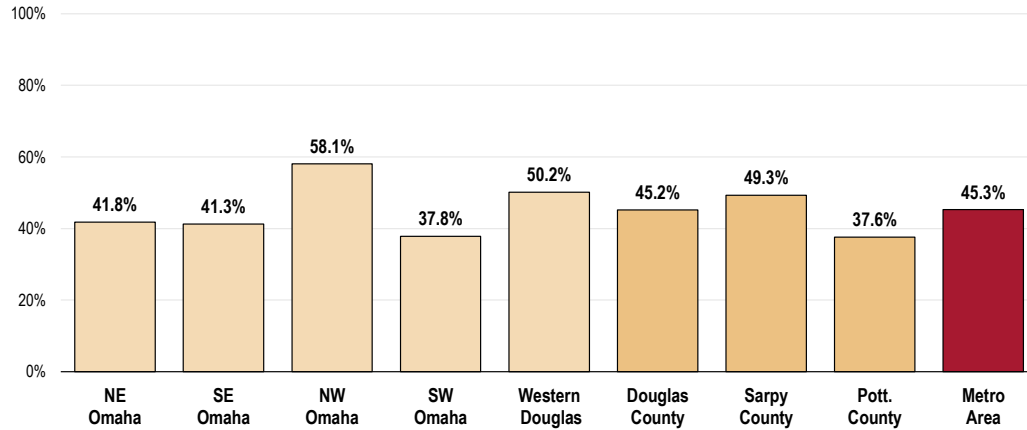
Over four in 10 parents (45.3%) have discussed water safety with a health professional or someone at their child's school.

- Within Douglas County, these discussions are most prevalent in Northwest Omaha and least prevalent in Southwest Omaha.
- Comparable by county.

"Water safety includes checking to make sure that the water temperature in the bath is safe, not leaving children unattended near water, understanding basic swimming safety, and so on.

Has a health professional or someone at this child's school ever talked with you about how to keep your child safe in and around water?"

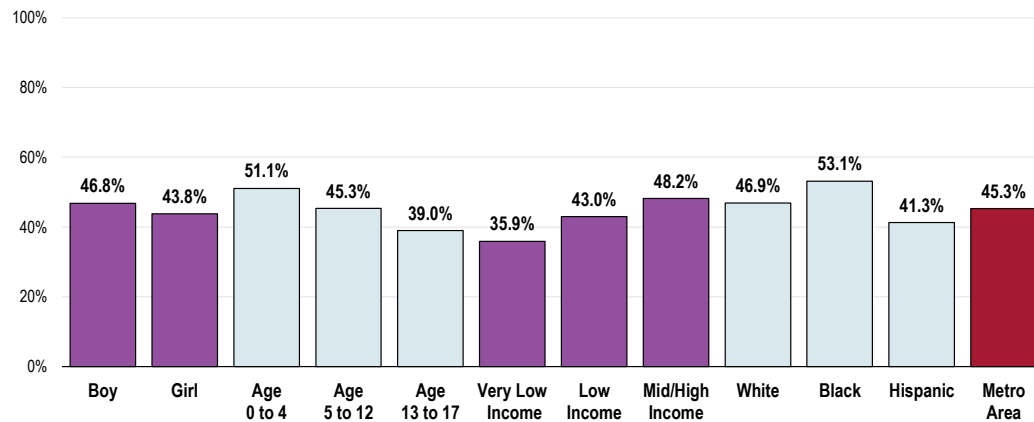
Discussed Water Safety With a Health Professional (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 315]
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Parents of teens and those with very low incomes are less likely to report having had this type of conversation.

Discussed Water Safety With a Health Professional (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 315]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Key Informant Input: Injury & Violence

Almost half of the key informants taking part in an online survey characterized Injury & Violence as a “moderate problem” for children/adolescents in the community.

Perceptions of Injury & Violence as a Problem for Children/Adolescents in the Community (Key Informants, 2018)

■ 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 about a randomly selected child in the household.

Top Concerns

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

Prevalence/Incidence

Many children in this area either suffer from violence themselves or are affected by violence in their area. This includes gang-related violence and domestic violence. I also work with many refugee families, who may be unaware of resources, and undocumented families who may feel unable to report violence. - Community/Business Leader

In Iowa, the IowaACES360 data suggests that Pottawattamie County has the highest percentage of adults that has 4+ Adverse Childhood Experiences in all of Iowa. While it is an extrapolation, it can be assumed that it also has high rates of ACEs for children in the county. Further, looking at data regarding child abuse and neglect, the data supports that violence and injury is a concern for Pottawattamie County children. - Other Health Provider

We admit and treat children on an almost daily basis that are the victims of violence, neglect. We treat and admit children daily as a result of unintentional injury accidents. - Other Health Provider

Violence continues to be a major problem with the child/adolescent population in our community as evidenced by increased rate of Emergency Department visits and also according ESU data. - Other Health Provider

Both are issues, as they result in emotional and sense of purpose issues amongst children and adolescents. As a result, many young people may have issues with trust and respect for self and others, as these are core values for creating healthy relationships. - Community/Business Leader

It's common among the culture. Crime, violence and gangs are a way of life. Kids are caught in the middle and forced to choose sides. - Social Services Provider

There is violence occurring every day in our schools, on our streets, in our video games and in homes. Little seems to be done to curb society's acceptance of violence. - Community/Business Leader

The high crime rate that is occurring in our city. Single parent homes, where children are left home to fend for themselves. The violence seen on television and video games. - Community/Business Leader

Violence both within the home and outside affects children and youth's ability to thrive as students and future employees. Domestic violence, school violence, and gang violence are all serious and chronic threats to the youth I serve. - Social Services Provider

Local and national environment makes this topic a pervasive issue for mental and physical health. Leading cause of death in kids and teens. - Physician

Injury and violence have always been a problem. What we are seeing is that they are not being reported by the kids, mainly because of retaliation. - Community/Business Leader

Exposure to violence and PTSD that follows occurs far too often in our community. - Social Services Provider

Omaha's crime rate, violence is concerning, and adolescents are impacted. - Other Health Provider

Adverse Childhood Experiences (ACEs)

Many of the children served by programs at my agency are exposed to violence in their homes. Due to fear of children being removed and fear of the abuser, domestic violence is under-reported.

Additionally, we have seen an increase in children entering the child welfare system due to abuse and neglect. Our community reports a decline in gun violence in our community; however, far too many children are exposed to and often victims of violence in their neighborhoods. - Social Services Provider

Injury and violence are critical issues because of how widespread Adverse Childhood Experiences are and because of how they shape health outcomes (and other forms of personal success) over the course of someone's whole life. Additionally, we have significant racial and economic disparities when it comes to injuries and violence. - Public Health Representative

Many children in our community are impacted by violence either in their home or in their community. Generations of families have experienced trauma, have stressors that impact quality of life, have high ACE scores, and/or impacted by generational poverty. Each of these factors put them at risk for exposure to violence; thereby continuing the cycle. - Community/Business Leader

Recognition of ACES, in-home and community violence impacts across the lifespan. - Community/Business Leader

We know exposure to violence is a major determinant of long term quality of life and health status. We have children experiencing high levels of ACEs on which we need to both prevent and intervene. - Public Health Representative

ACE's study shows that our children are directly impacted by exposure to injury and violence, real or perceived. - Public Health Representative

Many children have experienced childhood trauma. Some children that I see are from other countries and are fleeing violence. - Physician

Domestic/Child Abuse

Children need safe sleeping spaces, safe living spaces, safe transportation and safe neighborhoods. Not all children have the same safety measures being taken in their lives. Violence in our city is a major issue. - Community/Business Leader

Child abuse and violence against children in daycares and from gangs is commonplace in our community. - Physician

Home life, street violence and peer pressure are all hot buttons to observe and become involved in personal violence lifestyle. - Community/Business Leader

In the home, social aspects with divorce, abuse, etc. Some families struggle with food and transportation. - Other Health Provider

Many different household dynamics, and the children are caught in them. - Other Health Provider

Many see domestic violence in the home. - Physician

Gun Violence

Omaha has a distressingly high rate of gun violence and homicide. The effects ripple throughout the community and affect children who witness as well as experience such violence. - Other Health Provider

There are a lot of reports on the news regarding gun violence in our community. Injury is also one of the highest risks for a young child over the age of 2. Children need supervision and we need to child proof homes for safety. There is also a lot of domestic violence in our community which puts children at risk. - Public Health Representative

Many children that we work with experience violence in their neighborhoods and, or homes. Gun violence, domestic violence, gangs and such are prevalent. - Community/Business Leader

The number of incidents of gun-related and other physical assaults in the community. - Community/Business Leader

When I have a teacher tell me that two of her 1st graders are talking about who got shot earlier than the other - one was 3 and the other was 4 - that tells me we have a major problem. Also, as we have looked at and are becoming a trauma-informed schools we have realized that most of our children and parents are dealing with a multiple amount of issues. - Community/Business Leader

Shootings, gang violence are still prevalent in our community even though progress has been made. - Community/Business Leader

Socioeconomic Status

In areas of concentrated disadvantage, children and adolescents live with community violence as well as violence in the home and bullying at school. Violence perpetuates disparities in health overall. - Public Health Representative

Injury and violence are unfortunately a part of everyday life when a family lives in low-income areas, due to lack of education or criminal charges. This places children in positions of seeing more abuse and violence than other children. This also places a child at higher risk of injury. - Community/Business Leader

Many of the children in the community come from areas of poverty and high crime areas which can leave children in an unsafe environment. If a child feels unsafe they cannot reach their full potential. - Other Health Provider

Many children live in unsafe neighborhoods, where they fear for their life or lives of family members on a regular basis. Streets are not safe for pedestrian, bike traffic parks. Need better lighting. - Community/Business Leader

Children in our community are exposed to violence in the media and in their day-to-day lives, depending on the area of town they live in. Injury to their own selves is a risk they deal with frequently. - Physician

In our most impoverished areas, violence remains at an all-time high. - Social Services Provider

Gangs

Gang violence impacts a number of neighborhoods and the children and young people in the community. Engaging gang experts at UNO would be helpful to addressing the problems in other ways rather than just police profiling and intervention. Domestic violence and child abuse are significant, and a number of children will have long-term effects from the Adverse Childhood Experiences (ACE) issues. More community cooperation and education would be helpful. Violence is an interesting topic not only for Omaha but also for our country. The casualness of violence in language, media, entertainment, and political posturing is impactful on children. - Other Health Provider

Gang activity makes me believe injury and violence is a major problem for children and adolescents in our community. - Community/Business Leader

Gangs contribute to violence. Alcohol and drug use would also influence violence and injury due to types of behavior related to being impaired. - Other Health Provider

Gang violence is prevalent in my community. - Social Services Provider

Parenting

In my community, I believe that most families units are made up of working parent(s) or guardians, often having more than one job to make ends meet. Unfortunately, this can often cause children to be left alone, which can sometimes result in children engaging in bad behaviors or being acquainted with the wrong groups. This lack of supervision can lead to criminal behavior, often involving violence. Violence can also be seen in the home in the form of domestic violence, which is present in all communities and can often go unnoticed and is usually difficult for victims to ask for assistance. - Community/Business Leader

Children are raising themselves, hanging around the wrong people, lack structure in home life. - Physician

Lack of structure, generational violence, lack of things for adolescents to do. - Community/Business Leader

Low parental skills and education, and lack of money. - Community/Business Leader

Bullying

Refugee youth are often bullied by their American peers - and they often cannot fight back with language so must fight back physically. Also, many refugee adults suffer from PTSD and other mental health issues that they are unaware how to seek treatment - so they self-medicate. Drinking and abuse can become an issue in some homes. - Social Services Provider

Although less than what may be seen nationally, responses to the YRBS survey indicate that violence and bullying are occurring in our schools and that some children have not gone to school because of feeling unsafe. Also, youth in the area are reporting sexual violence - Public Health Representative

Increase in online bullying and youth involved in gang activity. - Other Health Provider

Prevention Programs

There is a need for proper mentoring and systems to support the members of the community that for whatever reason are disengaged and are without the necessary resources to become successful. Adolescents that exit the school system with deficient/limited skills in academic areas face challenges that they are not prepared to navigate. This can become compounded when the problems are generational. - Community/Business Leader

The community does not focus enough on prevention of injury and violence therefore the problems continue to escalate. - Other Health Provider

Co-Occurrences

Abuse and trauma history contribute to behavioral healthcare needs. - Community/Business Leader

Leading Cause of Mortality in Children

Major cause of mortality and morbidity in childhood and youth and yet viewed as "accidents" that cannot be prevented, which is NOT true. Limited resources- finance, trained personnel and programs to address all in need. Need better community data to highlight the issues and to mobilize evidence-based practice. Fractionated efforts. - Physician

Suicide

Suicide and depression are huge; self-injury and minimal services available. - Community/Business Leader

Behavioral Influences



Professional Research Consultants, Inc.

Healthy Routines

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 over time 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)

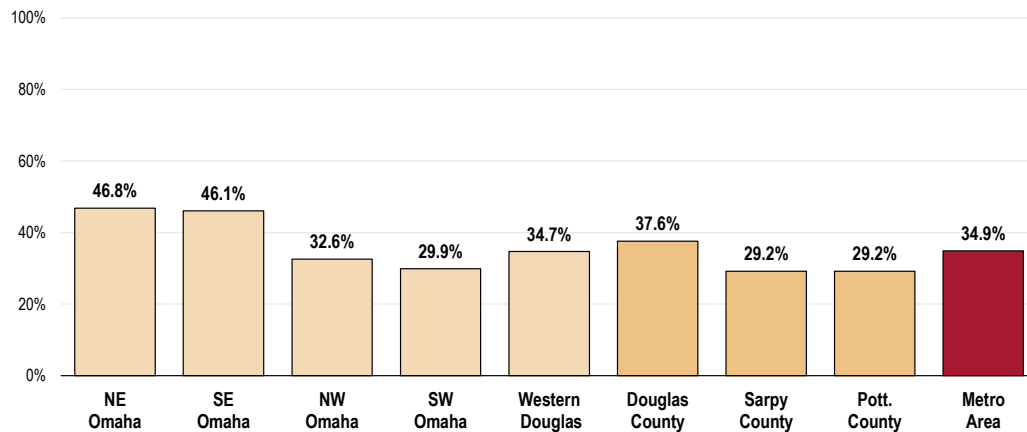
Fruit & Vegetable Consumption

Just over one-third (34.9%) of Metro Area parents report that their child eats five or more servings of fruits and/or vegetables per day.

"During the past 7 days, on how many days did this child eat or drink 5 or more servings of fruits and vegetables?"

- In Douglas County, this prevalence is lowest in Southwest Omaha.
- By county, lowest (statistically) in Sarpy County.

Child Has Five or More Servings of Fruits/Vegetables per Day (Metro Area Children Age 2-17, 2018)

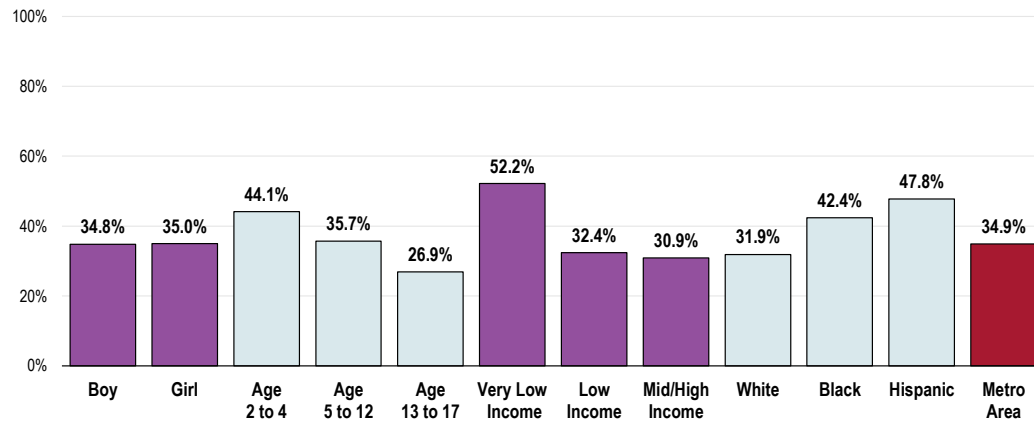


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 336]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

The following are less likely to get the daily recommended servings of fruits and vegetables:

- Teens (note the negative correlation between age and fruit/vegetable consumption).
- Children living in households above 100% of the federal poverty level.
- White children.

Child Has 5+ Fruits/Vegetables per Day (Metro Area Children Age 2-17, 2018)



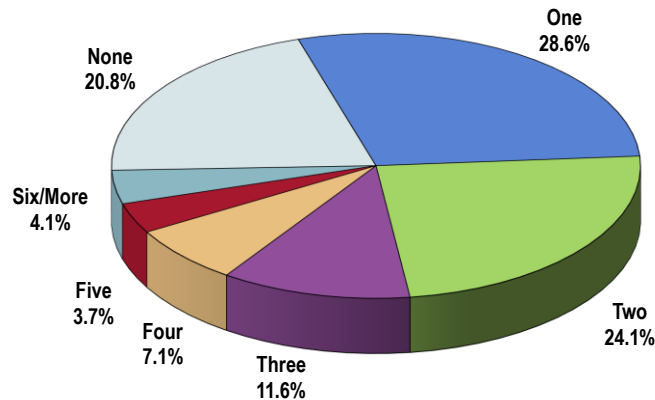
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 336]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Fast Food

Nearly eight in 10 Metro Area children age 2-17 (79.2%) have had at least one "fast food" meal in the past week.

"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."

Number of Fast Food Meals for Child in the Past Week (Metro Area Children Age 2-17, 2018)

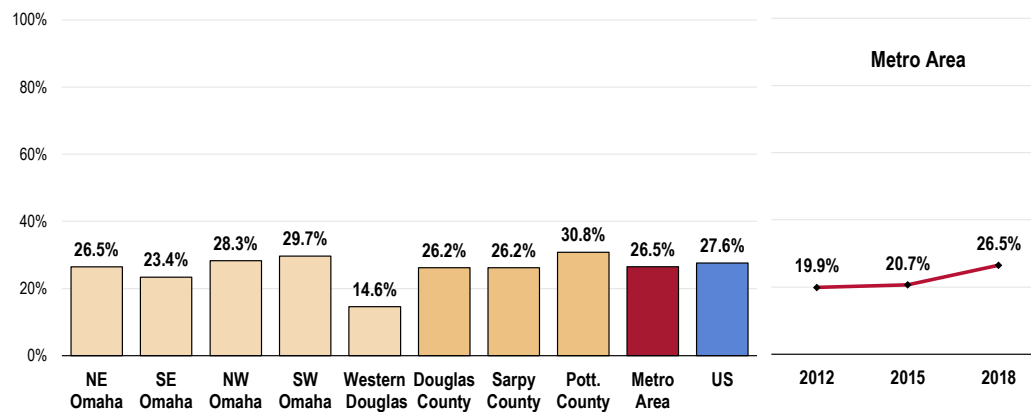


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 108]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

In fact, more than one-quarter (26.5%) of parents report that their child has had three or more meals from “fast food” restaurants in the past week.

- Close to US findings.
- Within Douglas County, children in Western Douglas are least likely to consume fast food this often.
- Statistically, no difference among individual counties.
- TREND: Represents a significant increase over 2012 findings.

Child Had Three or More Fast Food Meals in the Past Week (Metro Area Children Age 2-17, 2018)

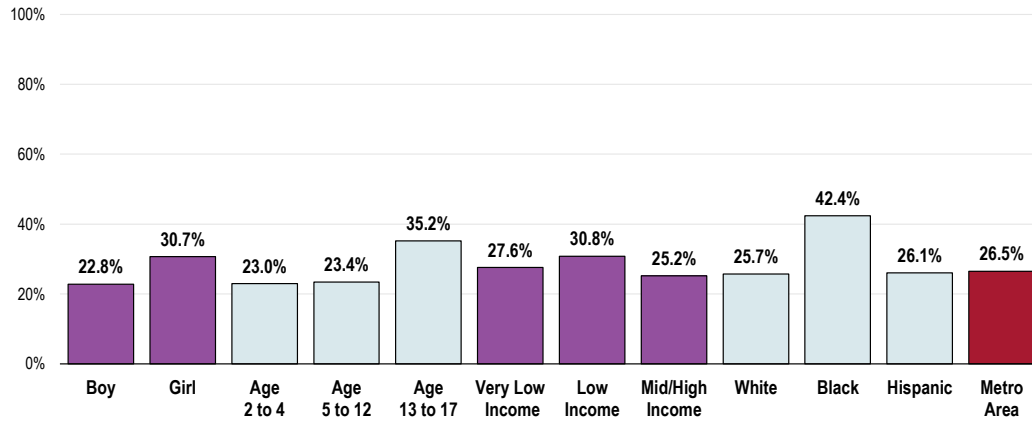


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 108]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Fast food consumption is more prevalent among:

- Girls.
- Teens.
- Black children.

Child Has Three or More Fast Food Meals in the Past Week (Metro Area Children 2-17, 2018)



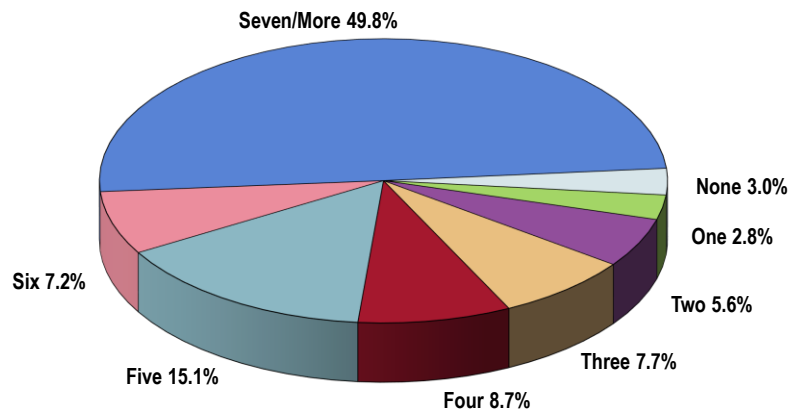
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 108]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Family Meals

Almost half of Metro Area parents (49.8%) average at least one family meal per day in the past week.

"In the past 7 days, how many meals did you eat together as a family? Please include breakfasts, lunches, and dinners."

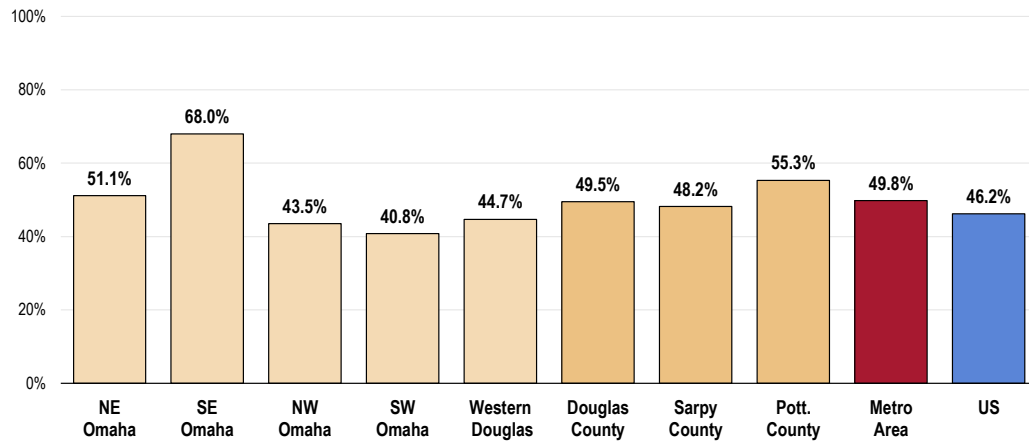
Number of Meals Eaten as a Family in the Past Week (Metro Area Children Age 2-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 109]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

- No significant difference from national findings.
- In Douglas County, family meals are most prevalent in Southeast Omaha and least prevalent in Southwest Omaha.
- Statistically comparable by county.

Shared 7+ Meals as a Family in the Past Week (Metro Area Children Age 2-17, 2018)



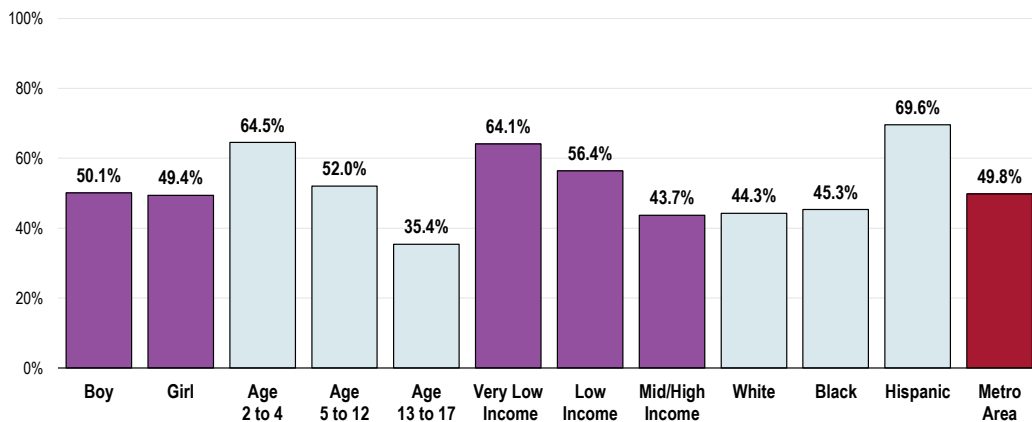
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 109]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Note the following:

- Family meals display a strong negative correlation with age.
- There is also a negative correlation with income.
- Almost seven in 10 Hispanic children share in frequent family meals.

Shared 7+ Meals as a Family in the Past Week (Metro Area Children Age 2-17, 2018)



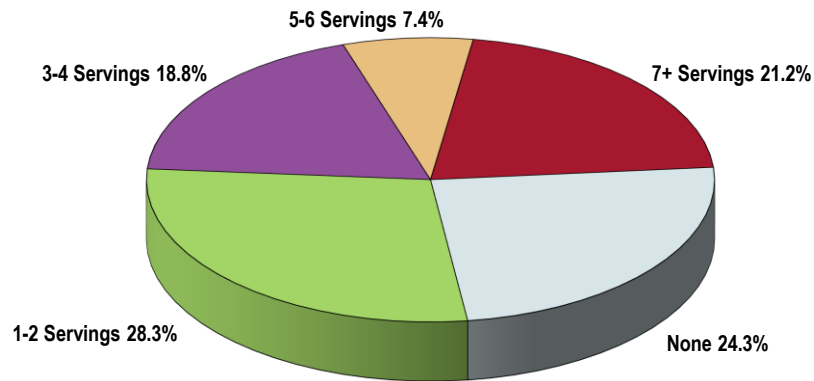
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 109]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

"During the past 7 days, how many cans, glasses, or servings of sugar-sweetened beverages did this child have? Please include beverages such as soda pop, Kool-Aid, sweetened fruit juice, sports drinks, or energy drinks. Do not include "diet" drinks."

Sugar-Sweetened Beverages

One-quarter (24.3%) Metro Area children age 2-17 have had at least three servings of a sugar-sweetened beverage in the past week, while 28.3% had one or two servings, and the remaining 24.3% had none.

Servings of Sugar-Sweetened Beverages Per Week
(Metro Area Children Age 2-17, 2018)

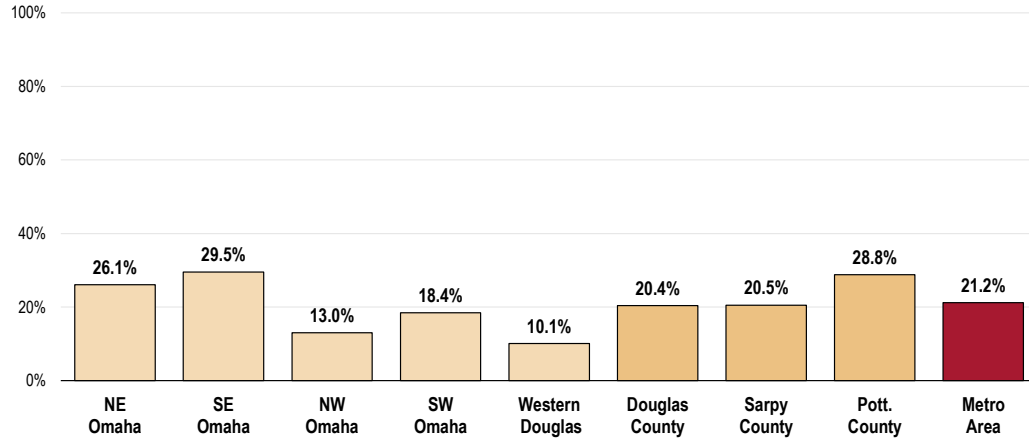


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 335]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

In terms of daily consumption, 21.2% of children average at least one serving of a sugar-sweetened beverage per day (7 or more in the past week).

- Within Douglas County, highest in Southeast Omaha.
- Differences in sugar-sweetened beverage consumption by county are not statistically significant.

Average One or More Servings of Sugar-Sweetened Beverages Per Day (Metro Area Children Age 2-17, 2018)

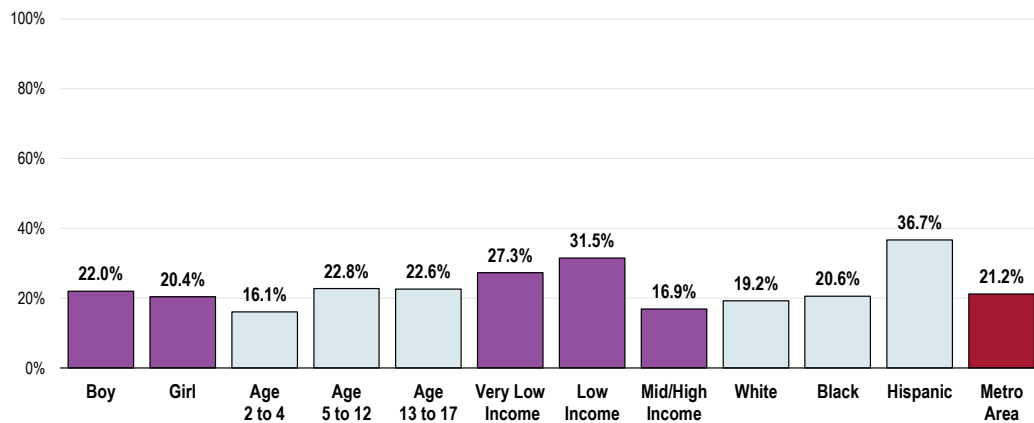


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 335]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Drinking sugar-sweetened beverages is more common among:

- Older children (age 5-17).
- Children living lower-income households.
- Hispanic children.

Average One or More Servings of Sugar-Sweetened Beverages Per Day (Metro Area Children Age 2-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 335]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

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)

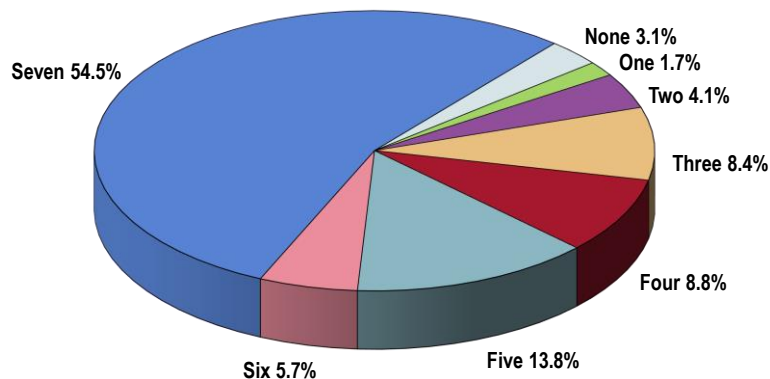
Recommended Physical Activity

A total of 54.5% 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 8.9% had two or fewer days with adequate physical activity in the past week.

"The next questions are about physical activity. During the past 7 days, on how many days was the child physically active for a total of at least 60 minutes per day?"

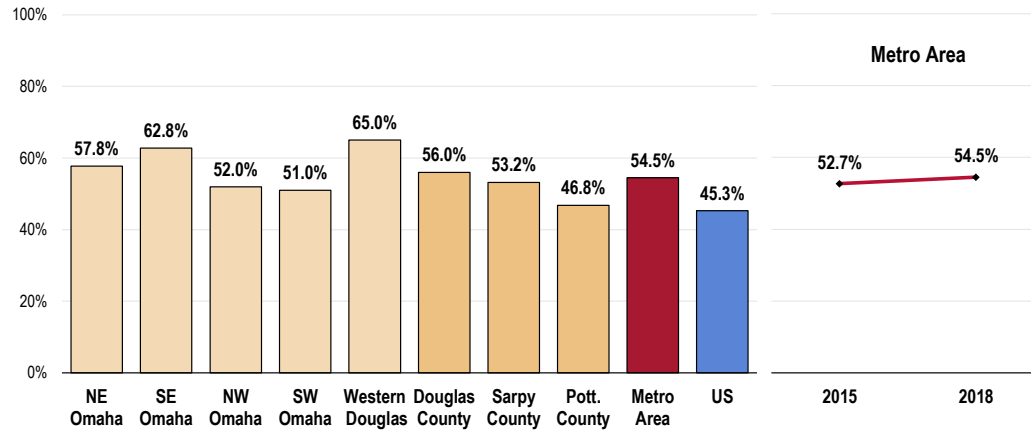
Number of Days in the Past Week on Which Child Was Physically Active for One Hour or Longer
(Metro Area Children Age 2-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 107]
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

- Daily physical activity in the Metro Area is above the proportion reported nationally.
- Statistically no difference by area.
- TREND: No significant change in physical activity since first measured in 2015.

Child Was Physically Active for One Hour or Longer on Every Day of the Past Week (Metro Area Children Age 2-17, 2018)



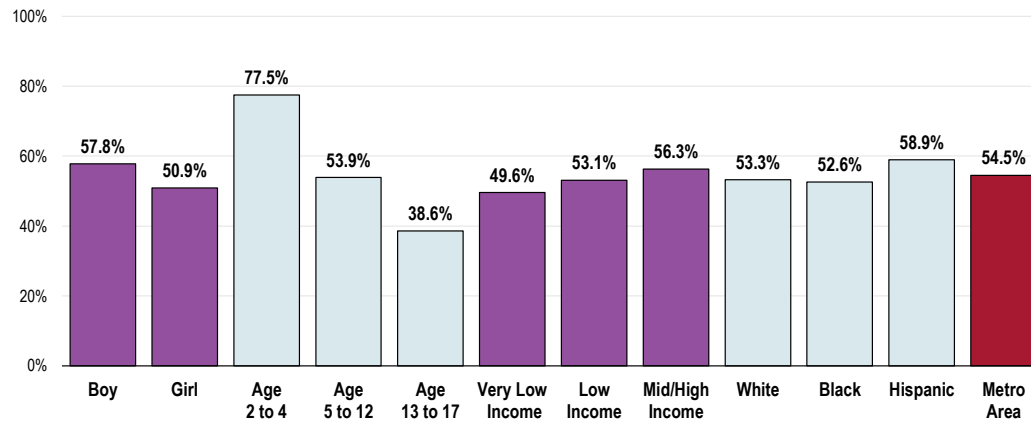
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 107]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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).

Child Was Physically Active for One Hour or Longer on Every Day of the Past Week (Metro Area Children Age 2-17, 2018)



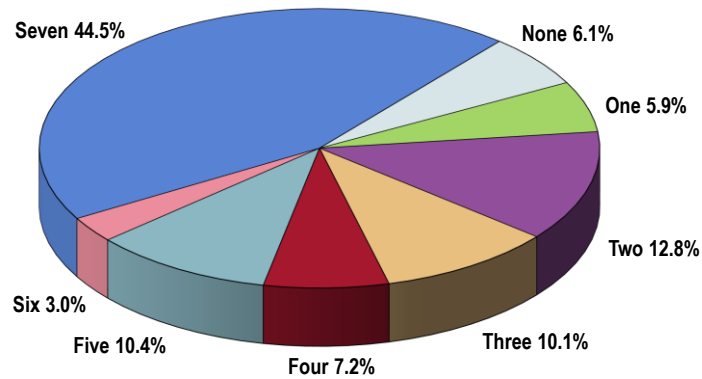
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 107]
 Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Screen Time

"During the past 7 days, on how many days did this child spend two or more hours in front of a screen including TV, video games, computer, or a cell phone?"

Among children age 5 through 17, 44.5% are reported to watch two or more hours on screen time (whether television, computer, video games, cell phone, handheld device, etc.) on every day of the seven days preceding the survey.

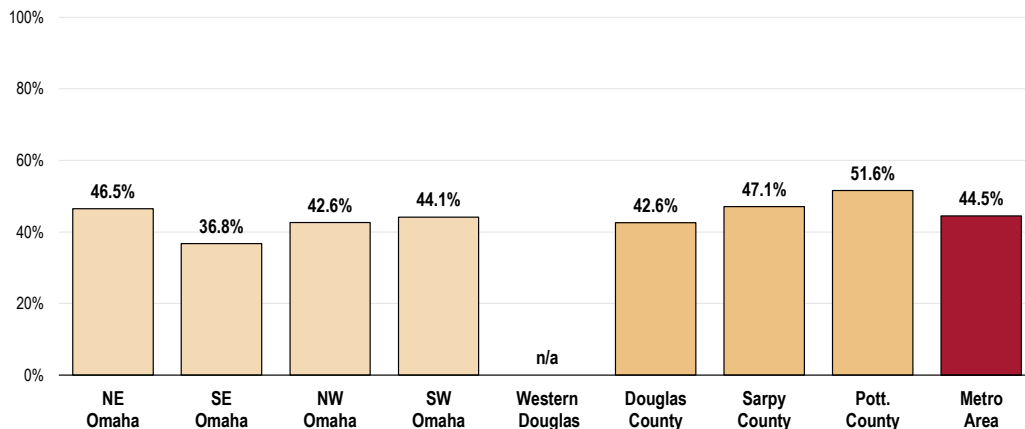
Children's Screen Time in the Past Week – Days of 2+ Hours (Metro Area Children Age 5-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 334]
Notes: • Asked of respondents for whom the randomly selected child in the household is age 5 to 17.

- The proportions by area are statistically comparable.

Children With 2+ Hours per Day of Screen Time (TV, Video Games, Computer, Phone, etc.) (Metro Area Children Age 5-17, 2018)

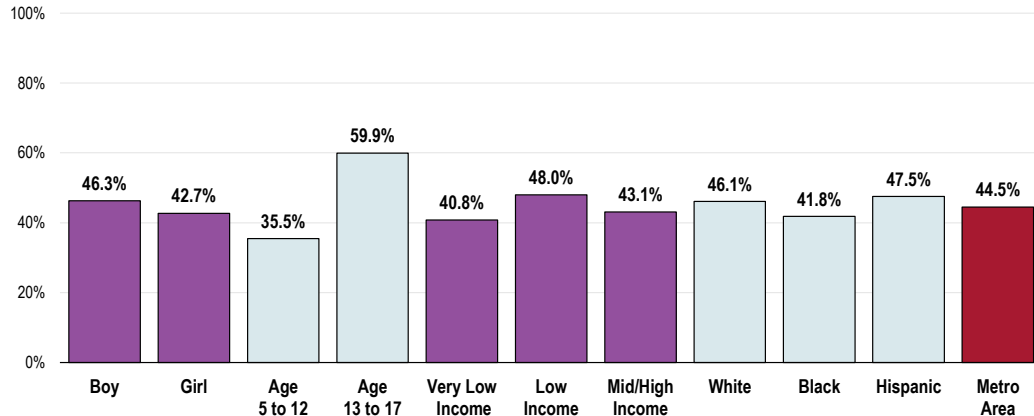


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 334]
Notes: • Asked of respondents for whom the randomly selected child in the household is age 5 to 17.

- Teens are especially more likely to spend 2+ hours per day on screens.

Children With 2+ Hours per Day of Screen Time (TV, Video Games, Computer, Phone, etc.)

(Metro Area Children Age 5-17, 2018)

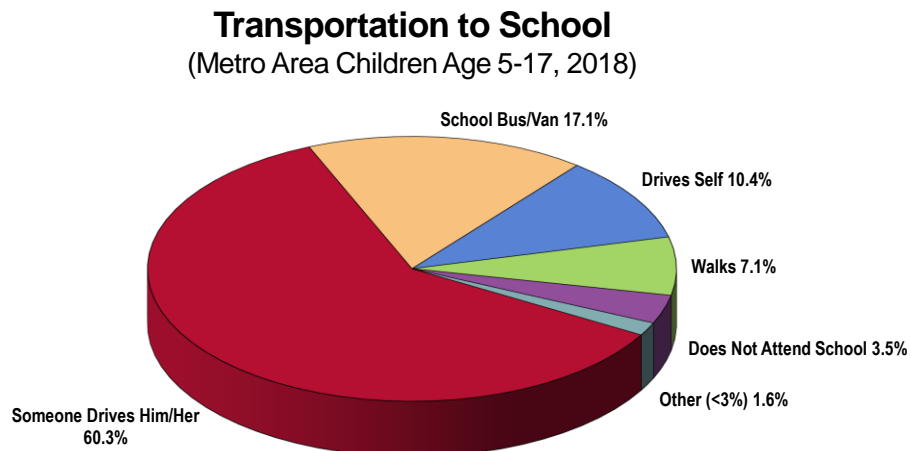


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 334]
 Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Transportation to School

The majority (60.3%) of school-age children in the Metro Area are driven to school.

Another 17.1% take a school bus/van, 10.4% drive themselves, and 7.1% walk.



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 318]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Key Informant Input: Nutrition, Physical Activity, and Weight

More than half of 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 & Weight as a Problem for Children/Adolescents in the Community

(Key Informants, 2018)

■ 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 about a randomly selected child in the household.

Top Concerns

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

Obesity/Overweight

Obesity is on the rise, and an understanding of whole food nutrition is lacking. Recess is being cut from the school day. Processed food (both at school and at home) creates poor access to nutrition and can cause excess weight gain. Electronics have negatively impacted physical activity. - Public Health Representative

Increase in overweight and obesity rates in the Metro, increase in diabetes and other chronic diseases linked to weight and health habits. Issues with access to food and barriers that lead to food insecurity (transportation, money, healthy options provided in their community). Lack of sidewalks and safe places for physical activity in certain neighborhoods. - Other Health Provider

There is a high prevalence of overweight and obesity within the child and adolescent population. Limited access, either due to no stores nearby that sell healthy foods or limited resources to purchase them, effects the nutritional status and weight of children. Additionally, limited breastfeeding education and support is a factor as well. - Public Health Representative

Due to the high obesity rate in our city and our community. This particularly affects the children in low-income homes. Physical activity may be limited due to no safe area to walk or exercise in their community. Education is often necessary to assist families in understanding how to increase the amount of fresh fruit(s) and vegetables and whole grains. Also increasing awareness of portion control and limiting high calorie intake of beverages in families - Other Health Provider

I see this every day, the number of children that are considered obese is tragic. Along with this, nutrition and physical activity must be included. It is important to address this because they can lead to some of the other serious items, diabetes, mental health, etc. - Community/Business Leader

Rising obesity. Sedentary lifestyle. Increase screen time. High fructose corn syrup in many foods. Easy access to processed foods. - Community/Business Leader

As a dietitian and WIC coordinator, when looking at the most recent prevalence data, Pottawattamie County incidence of overweight and obesity in children 24 to 60 months exceeded the state average. - Public Health Representative

Obesity is a huge issue all over our world. Poor choices, education, demographics, financial issues, violence, lack of physical activity. - Community/Business Leader

Childhood obesity is increasing in our area. Hypertension, diabetes and other weight related illnesses are following our children into adulthood. - Physician

See lots of overweight children and youth. Assume poor diets, lack of exercise. - Community/Business Leader

Lots of obese kids, little access to physical activity, horrible school lunches, little access to good quality and culturally appropriate nutrition services. - Physician

Obesity and overweight kids and families is an epidemic. Culture of healthy weight is needed for behavior change. Policy changes to encourage health- in physical activity and nutrition needed at all ages. Lack of registered dietitians in the schools and health systems activities. - Physician

Surveys, assessments, statistics indicate that childhood obesity is an issue in our community along with decreased activity levels and poorer nutrition. Less whole food and more processed foods. - Public Health Representative

All you have to do is look at the research regarding childhood obesity. The numbers continue to increase. Again, our community isn't immune to the trends that are seen across the country. - Public Health Representative

Both adults and children are fatter as a consequence of bad food choices and limited physical activity. Lack of money to buy nutritional foods. - Community/Business Leader

Increased obesity and decrease in exercise ability. See kids every day with poor diets and no exercise as they eat fast food and sit on the computer or phone. - Physician

Health measurements currently support a rapid rise in childhood obesity and accompanying health conditions. - Community/Business Leader

Childhood obesity, as well as mental health, is a huge indicator of overall health and symptomatic of so many other health issues. Obesity rates are very high in Nebraska. - Community/Business Leader

Obesity has become a problem for this generation due to lower activity. The easy availability of more calorie dense low nutritional value foods, and sugary drinks. - Other Health Provider

Childhood obesity and decreased activity on the rise. Will lead to epidemic of DM and HTN if unchecked. - Physician

Many people are overweight and lack appropriate access and knowledge on nutrition and exercise. - Social Services Provider

Many children are qualifying for the diagnosis of overweight or obese. - Physician

Higher incidence of obesity, lack of access to physical activity, nutritional education. - Community/Business Leader

Too many overweight and obese kids, causes heart disease and diabetes and contributes to shortened life expectancy. - Community/Business Leader

High rate of obesity and overweight in children. - Public Health Representative

Childhood obesity continues to be a significant concern for our community. - Public Health Representative

Increasing number of children at unhealthy or at-risk BMI. - Other Health Provider

Obesity. - Community/Business Leader

Obesity is a concern. - Other Health Provider

Access to Healthy Food

Children and adolescents in this area often do not have easy access to fresh/nutritious food. This is due to transportation concerns, lack of resources, financial concerns/lack of insurance, work commitments or scheduling concerns, cultural/language barriers, and/or lack of education. - Community/Business Leader

In North Omaha, there are a lack of grocery stores. There is a lack of education from inside the community on healthy nutrition and access to healthy food is limited. Sidewalks, crime and families in survival mode contribute to the lack of physical activity by many families. - Community/Business Leader

Unhealthy and limited food choices for those in urban or low-income households and areas. - Community/Business Leader

Cost of healthy food versus highly processed food, which is cheaper to get for families to feed their children, which leads to obesity. Lack of knowledge in food prep and services for families within our community. - Other Health Provider

Lack of or expense of fresh fruits and vegetables. Family patterns of using food as rewards/comfort. Uninvolved parents who rely on TV/videogames/technology to entertain their children. Neighborhoods where it is not safe for children to play outside - Other Health Provider

Cultural differences and lack of healthy food. Expensive or difficult to get to activities for children to keep active. After school care with television or other electronic devices. - Other Health Provider

Family priority to provide nutritious food access to equipment, sports leagues and outdoor spaces. - Community/Business Leader

Lack of fresh food, lack of resources to purchase this food. - Community/Business Leader

Insufficient Physical Activity

Kids are not getting the recommended minutes of physical activity or recommended servings of fruit and vegetables. They are sitting too much in school and at home. Parents tell us it's difficult to be active as a family because of their busy schedules. Fast food is more common than cooking and preparing meals at home. Stress and trauma contribute to over-eating. - Community/Business Leader

Children and adolescents in the community lack recess opportunities in school. Parents allow youth to play video games, which encourage snack foods and reduce physical activity, thereby increasing weight concerns. - Other Health Provider

As a society, while many people want to be healthy and eat well, they lack critical components to navigate this successfully. Some people lack balance with an active and inactive lifestyle. - Community/Business Leader

Physical education in schools has dwindled, the number of extracurricular activities has been cut and video games. - Community/Business Leader

Inactivity and too much screen-time continue to fight for kids' attention and time. Unsafe neighborhoods contribute to the inability for kids to be outside playing. - Community/Business Leader

It is a common concern of parents, especially with excessive electronic use, which negatively affects exercise. - Social Services Provider

Lack of activity options outside of school, poverty. - Community/Business Leader

Poverty

The economic and poverty issue is extremely prevalent throughout my community, which obviously leads to many children not having access to three healthy, balanced meals each day, including good snacks. Much of this can also lead to poor health, weight issues and a lack of physical activity needed for children to thrive. Again, several factors contribute to these issues, but full circle I believe the causing factors are lack of family unit, poverty and socio/economics issue. - Community/Business Leader

Families are food insecure. Kids get all meals at school for the day sometimes. Fast food is convenient and cheaper according to families but if educated they will find eating healthy can be much cheaper. Kids are watching more and more TV because they don't live in safe neighborhoods - Physician

Children living in poverty have a higher BMI and higher rate of obesity, particularly in early childhood as compared to children who live in a higher SES bracket. In addition, early childhood programs (aside from Head Start) do not have intentional emphasis on nutrition, healthy eating and direct instruction regarding physical activity. Parents do not receive training and coaching, and they may struggle with navigating the health care system to access preventive care for their children. Families may also struggle with healthy eating due to a lack of resources and SNAP restrictions (they may not understand the restrictions and may not be skilled at making healthy decisions when shopping for food). - Community/Business Leader

I work with mostly minority and low-income youth. These tend to be the children who suffer most with nutrition and weight problems. - Physician

Many of the families we serve live in poverty, which leads to poor nutrition and limited physical activity. - Community/Business Leader

Impact on Overall Health

These health behaviors are key drivers of health and chronic disease prevention. Our rates of obesity continue to rise and therefore efforts have not been successful at slowing this trend. Instead of burning out from these efforts we need renewed attention and innovation to address these issues. - Public Health Representative

This is a systemic issue across the US. Despite previous interventions, the main causes have not been addressed. - Physician

Probably the number one health issue of this generation, pathetic resources with nationally poor outcomes. Obesity due to poor diet and lack of activity. - Physician

It's important and plays a role in everything else. - Community/Business Leader

Obviously, if diabetes is on the rise in young people, nutrition habits have to change. Kids need more emphasis on healthy foods and more knowledge about why sugar/high fats are trouble, so they can better equip themselves later in life with healthy habits. - Community/Business Leader

This issue has the greatest impact on overall health. - Physician

Diet/Nutrition

It is a known fact that many children are not getting the proper nutrition in this community, as evidenced by the need to have programs in and out of school (backpacks with food for families) to help families in need. In addition, many children are not getting enough exercise as they have cut recess in some schools; and afterschool, many kids are sitting in front of the television playing video games. - Social Services Provider

Healthy nutrition, physical activity and weight are the foundation for health now and in later life. - Social Services Provider

Lack of proper nutrition and physical activity has resulted in an increase of youth who are obese and/or suffer from chronic illness like diabetes. - Community/Business Leader

Prevention

Our data still indicate we have a long way to go to resolve these challenges. Failure to build good habits around nutrition and physical activity (and the neighborhood and community environments that would prioritize these behaviors) greatly increase the amount of chronic disease burden experienced by our community. - Public Health Representative

Our culture is one in which prevention is not a priority. Children and families need to be taught how to promote their own physical health. This is not a focus in our community at all. - Physician

Few programs in the Plattsmouth community. - Physician

Health Awareness/Education

Education to parents and children about healthy eating habits seems to be on the rise due to the knowledge of the obesity epidemic, but access and cost to healthy eating options is lacking. - Physician

Not all families have appropriate education related to healthy nutrition choices & age-appropriate intake. Even those that do may not follow such recommendations, for various reasons. The expense of healthy food & time needed to create healthy meals/snacks can be challenges. Society promotes excess/unhealthy snacks through schools encouraging students to bring daily snacks, teachers using candy as a frequent prize, coaches assigning snacks/treats to players on sports teams, etc. It's difficult to ensure adequate physical activity for many kids/teens -- It's not safe in most settings to let kids play outside unsupervised. It's expensive to belong to a gym, put kids on sports teams, etc.; and getting to these things can be a stress for working & single parents. PE class is isn't even required at all school levels. Screen time is way too high!! - Physician

Lifestyles

There is no vision for a healthy lifestyle. Why would someone pay more and work so hard for something that doesn't seem to be vital to living? There is no real sense of need for a healthy lifestyle because they don't see anyone living that way. - Social Services Provider

Too many kids are overbooked and are eating on-the-go between practices and games. Too much time spent on electronics. - Other Health Provider

Parenting Issues

Single parent homes where children have to fix their own meals or fast food is purchased because there is not time to cook a meal. It is not always safe for children to play in their neighborhoods, so they sit inside and watch TV or play video games. Not enough health foods served in the low-income areas and/or the cost of the healthy foods are too high. - Community/Business Leader

There is too much screen time among children and not enough parent involvement, with both parents working in the homes these days. - Physician

Unsafe Neighborhoods

Neighborhoods are not safe, and until we can get a handle on them, our kids will not play outside. - Community/Business Leader

Sleep Practices

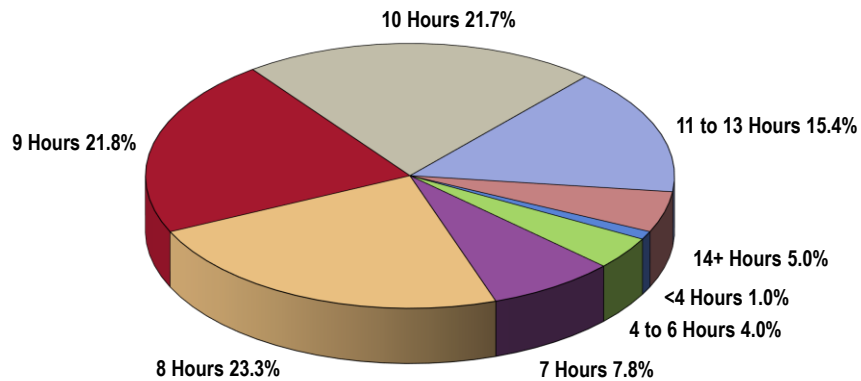
Sleep Recommendations

Across all age ranges, two-thirds (66.8%) of Metro Area children average 8-10 hours of sleep per night.

Parents of children age 0-6 were asked: "During the past week, how many hours of sleep did this child get during an average 24-hour period, counting both nighttime sleep and naps?"

Parents of children age 6-17 were asked: "During the past week, how many hours of sleep did this child get on an average weeknight?"

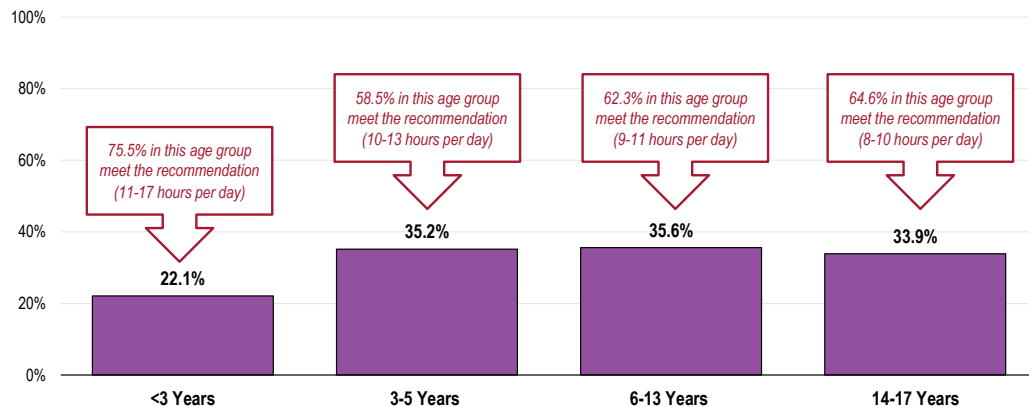
Average Daily Hours of Child's Sleep
(Metro Area Children, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 330]
Notes: • Asked of all respondents about a randomly selected child in the household.

When looking at sleep recommendations by age group, a significant proportion of children are not receiving enough sleep (on average).

Child Gets Less Than the Recommended Amount of Sleep Per Night
(Metro Area Children by Age Group, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 330]
Notes: • Asked of all respondents about a randomly selected child in the household.

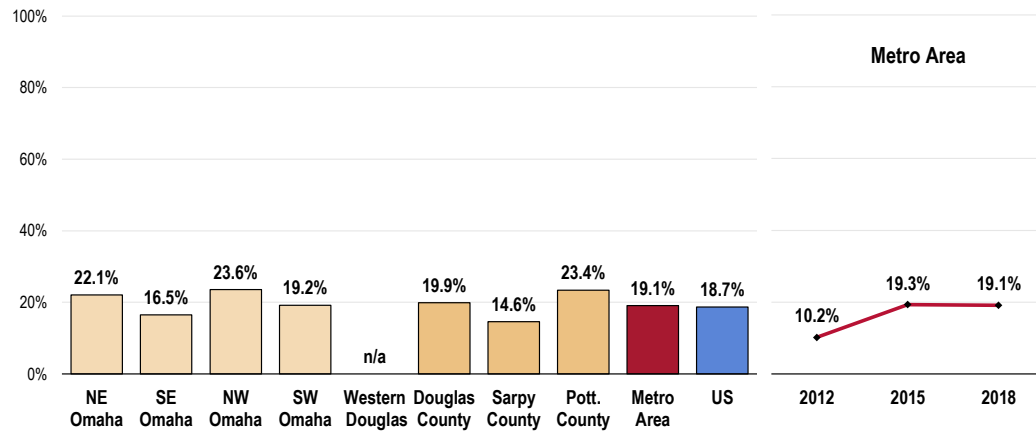
Sleep Difficulties

A total of 19.1% of Metro Area parents indicate that their school-age child has difficulty falling asleep and/or sleeping through the night.

- Comparable to that reported nationwide.
- Similar by area.
- TREND: A significant increase since 2012 findings (though statistically unchanged from 2015).

Child Has Difficulties Falling Asleep and/or Sleeping Through the Night

(Metro Area Children Age 5-17, 2018)



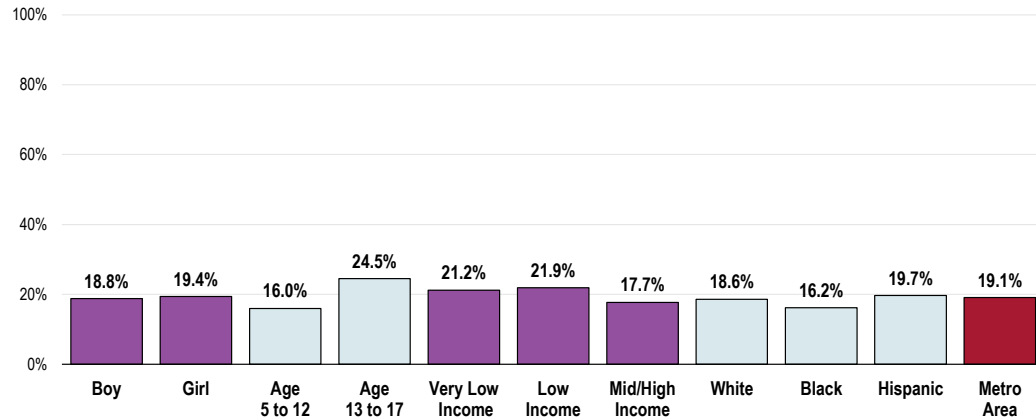
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 83]

• 2018 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 sleep difficulties are more prevalent among teens.

Child Has Difficulties Falling Asleep and/or Sleeping Through the Night (Metro Area Children Age 5-17, 2018)



- Sources:
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 83]
- 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Tobacco, Alcohol, & Other Drugs

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).

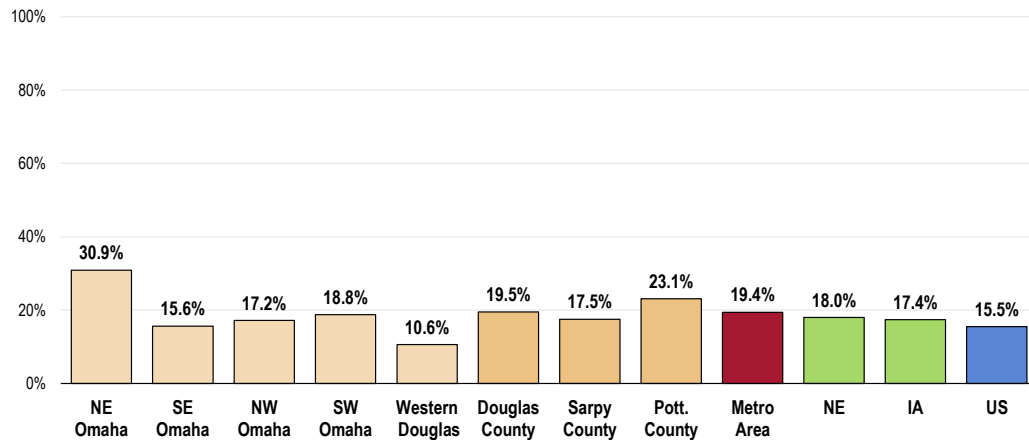
— Healthy People 2020 (www.healthypeople.gov)

Household Member Smoking

A total of 19.4% of Metro Area parents report that someone in the household smokes tobacco, marijuana, or electronic vapor products.

- This prevalence is above that seen nationally.
- Similar to state rates.
- In Douglas County, smoking is highest in Northeast Omaha.
- Statistically comparable by county.

Someone In The Household Smokes (Metro Area, 2018)



Sources:

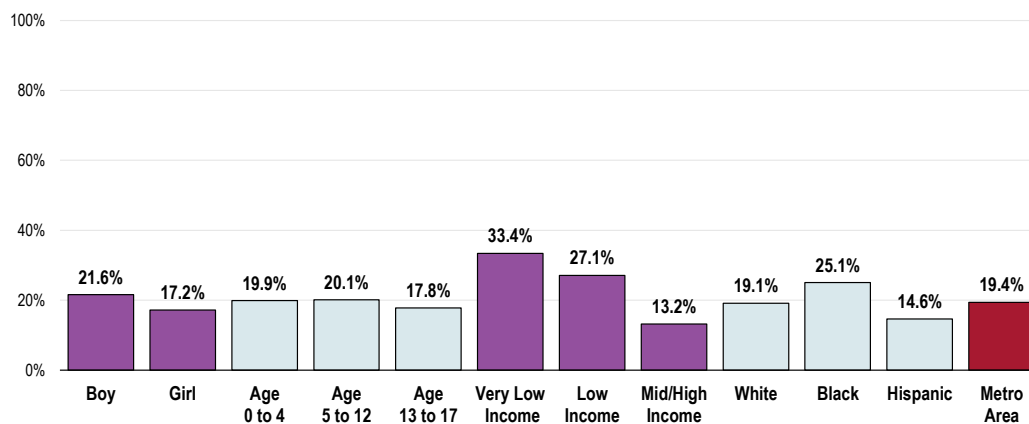
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 333]
- Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes:

- Asked of all respondents with a randomly selected child in the household.
- Includes tobacco, marijuana, and vaping/electronic vapor products.

- Metro Area children living in lower-income households are more likely to be exposed to smoke from tobacco, marijuana, or vaping products (note the negative correlation with income).

Someone In The Household Smokes (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 333]

Notes: • Asked of all respondents with 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Smoking During Pregnancy

According to 2016 data from Douglas County Vital Statistics, Maternal and Child Health Indicators, 7.4% of Douglas County mothers reported tobacco use during pregnancy.

Tobacco Use (Adolescents)

Among high school students in Douglas County, 7.5% report smoking at least one cigarette during the 30 days preceding the administration of the 2016 Youth Risk Behavior Survey.

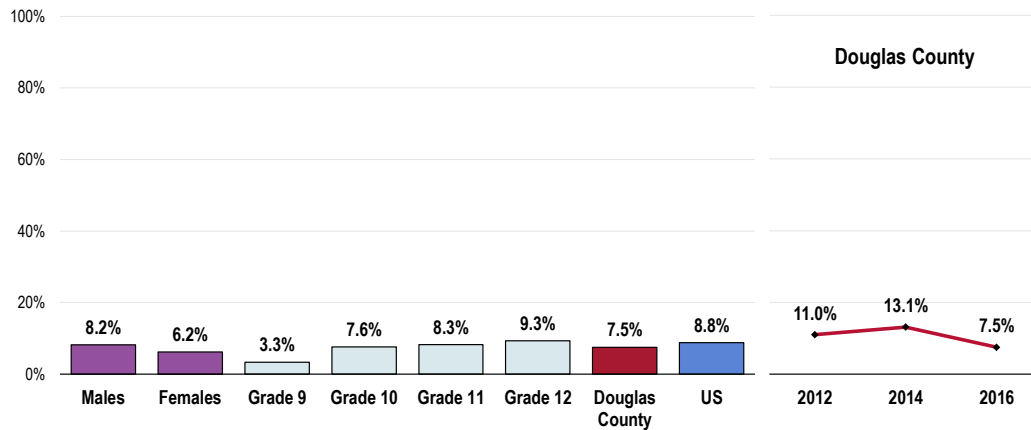
- Under the US prevalence.
- Smoking prevalence is statistically higher among males than females.
- Increases significantly by Grade 10.
- TREND: Tobacco use among Douglas County high schoolers has significantly decreased over time.

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

For more information, visit: www.cdc.gov/healthyyouth/yrebs.

Smoked Cigarettes in Past Month

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2016)



Sources: • Douglas County Health Department. 2016/17 Douglas County Youth Risk Behavior Survey Report.
 • Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed September 2018.

Notes: • Smoked cigarettes on at least 1 day during the 30 days before the survey.

Alcohol Use (Adolescents)

Current Alcohol Use

Among high school students in Douglas County, 23.2% report having at least one drink of alcohol during the 30 days preceding the administration of the 2016 Youth Risk Behavior Survey.

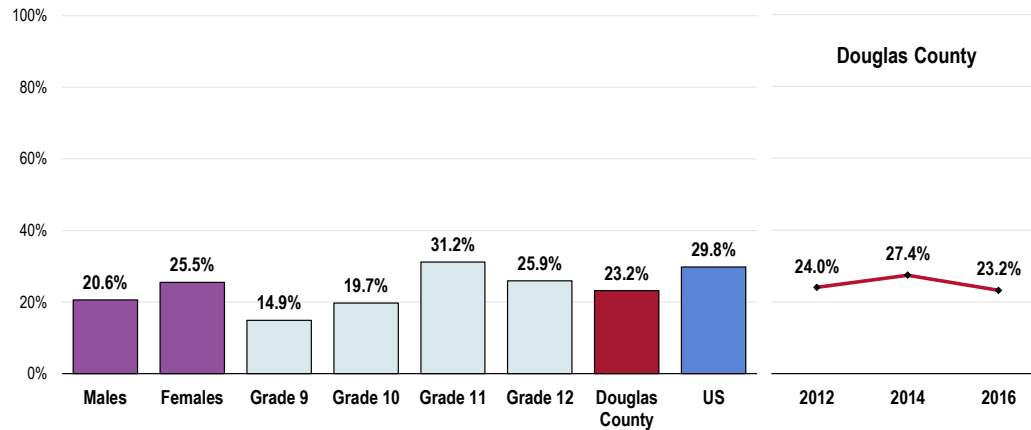
- Lower than national findings.
- Higher among females.
- Increases significantly by grade level, particularly in Grade 11.
- TREND: Represents a significant decrease over 2014 findings (though statistically similar to 2012).

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

For more information, visit: www.cdc.gov/healthyyouth/yrbs.

Drank Alcohol in Past Month

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2016)



Sources: • Douglas County Health Department. 2016/17 Douglas County Youth Risk Behavior Survey Report.
 • Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://hccdc.cdc.gov/youthonline/>. Accessed September 2018.

Notes: • Had at least one drink of alcohol on at least one day during the 30 days before the survey.

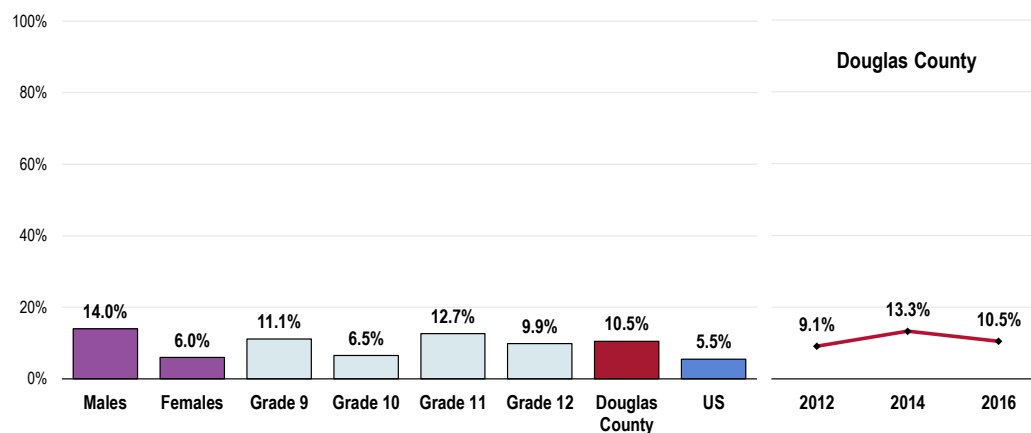
Current Drinking & Driving

A total of 10.5% of Douglas County high school students report having driven a car or other vehicle when drinking alcohol on one or more occasion during the 30 days preceding the administration of the 2016 Youth Risk Behavior Survey.

- Statistically less favorable than national findings.
- Far more prevalent among males.
- Highest in Grades 9 and 11.
- TREND: Represents a significant decrease since 2014, though statistically higher than 2012 findings.

Drove When Drinking Alcohol in the Past Month

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2016)



Sources: • Douglas County Health Department. 2016/17 Douglas County Youth Risk Behavior Survey Report.
 • Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://hccdc.cdc.gov/youthonline/>. Accessed September 2018.

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

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

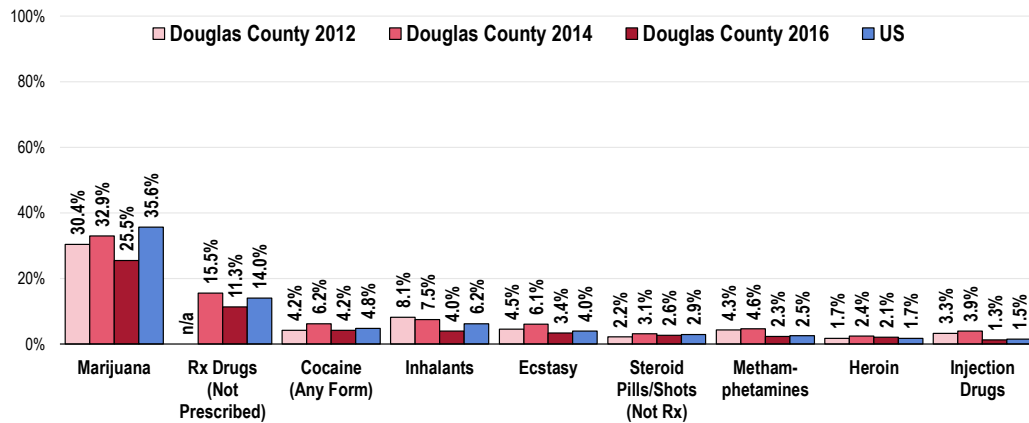
For more information, visit: www.cdc.gov/healthyyouth/yrbs.

Douglas County high school students report the highest lifetime usage of marijuana (25.5% have ever used) and illicit prescription drugs (11.3% have ever used drugs not prescribed to them).

- Findings are significantly below national findings for each indicator except heroin (which is higher).
- TREND: Use of marijuana, prescription drugs, inhalants, ecstasy, methamphetamines, and injection drugs have each decreased significantly since first measured, while steroids and heroin have increased (use of cocaine has not changed significantly).

Ever Used Specific Drugs

(Among High School Students; Douglas County Youth Risk Behavior Surveys)



Sources:

- Douglas County Health Department, 2016/17 Douglas County Youth Risk Behavior Survey Report.
- Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://ncod.cdc.gov/youthonline/>. Accessed September 2018.

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 is also called "MDMA."
- Cocaine includes powder, crack or freebase forms of cocaine.
- Methamphetamine is also called "speed," "crystal," "crank," or "ice."
- Heroin also called "smack," "junk," or "China white."

Current Marijuana Use

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

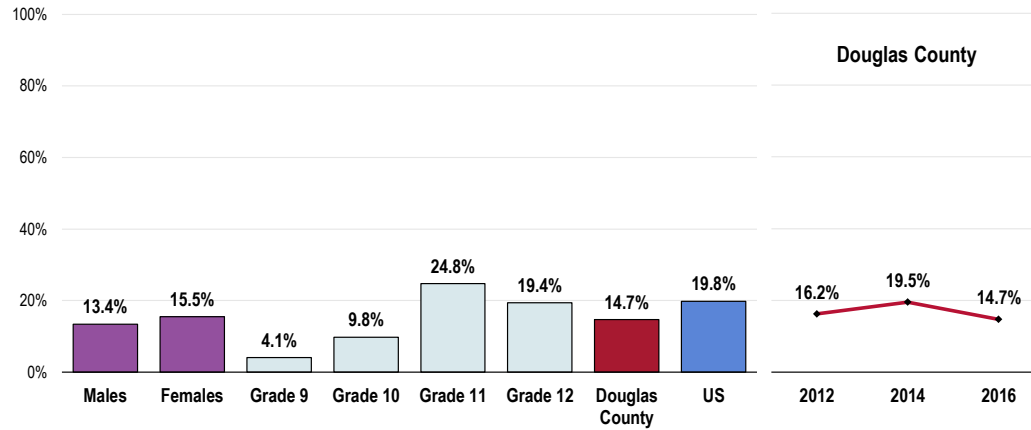
For more information, visit: www.cdc.gov/healthyyouth/yrbs.

A total of 14.7% of Douglas County high school students report having used marijuana one or more times during the 30 days preceding the administration of the 2016 Youth Risk Behavior Survey.

- Lower than national findings.
- Higher among females.
- Marijuana use appears to increase with grade until Grade 11.
- TREND: Adolescent marijuana use in Douglas County has decreased over time.

Used Marijuana in Past Month

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2016)

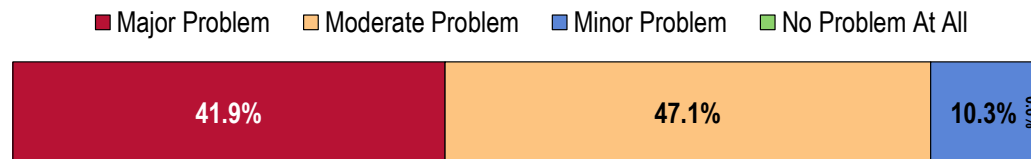


Sources: • Douglas County Health Department. 2016/17 Douglas County Youth Risk Behavior Survey Report.
 • Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed September 2018.
 Notes: • Used marijuana one or more times during the 30 days before the survey.

Key Informant Input: Tobacco, Alcohol, & Other Drugs

The greatest share of key informants taking part in an online survey characterized **Tobacco, Alcohol, & Other Drugs** as a “moderate problem” for children/adolescents in the community.

Perceptions of Tobacco, Alcohol & Other Drugs as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Barriers to Treatment

Among those rating this issue as a “major problem,” the greatest barriers to accessing substance abuse treatment are viewed as:

Prevalence/Incidence

Alcohol and drug abuse in adolescents, specifically, are hurting our community. I see specifically in the refugee community how many young people are using drugs and alcohol, which affects performance at school and employability. - Social Services Provider

More and more kids are using marijuana without being aware of possible consequences. When families do seek treatment, there are very limited resources for kids. - Physician

High number of arrests for drugs in the county, large number of youths using alcohol and tobacco. - Public Health Representative

Opioid use and street drugs, as well as alcohol continue to disrupt young lives and those of their families. - Community/Business Leader

Continued persistence in prescription drug use, opioid use, meth and contracted community supports targeted to address effectively. - Community/Business Leader

High rates of binge drinking in Nebraska. Increases in vaping in high school. - Community/Business Leader

I fear that we see more alcohol and other drug abuse issues in our student population. - Community/Business Leader

Tobacco and alcohol are the highest risk factors influencing longevity in Nebraska. - Public Health Representative

Increased emergency department visits that are substance use related. ESU data reflect substance use in child, adolescent population continues to increase. - Other Health Provider

Again, data suggests we have high rates of substance use in our community. - Physician

I am so far removed from this within our community, but I know the problem exists. I know of those children born to parents who are using. - Other Health Provider

Drug and alcohol use prevalent in community. - Community/Business Leader

Data from YRBS indicates concerns specific to these risky behaviors. - Public Health Representative

Increasing opioid epidemic. - Physician

The increasing number of opioid overdoses. - Other Health Provider

Vaping, smoking, drug use, alcohol and narcotics are all problems in our teen population. - Physician

Culture/Social Norms

Generational. It's been a problem for generations. It's easy to become addicted at young ages, and kids are being exposed to it at younger ages. It becomes a coping mechanism for the realities of life. It also becomes something that is a part of a lifestyle kids are aspiring to live. This is the vision of what a "cool" life looks like. Until kids see a new vision, they will see no need to change. - Social Services Provider

Students see what their parents or significant adults do in their lives, they model themselves after them. Peer pressure to belong to a group. Alcohol is cheap. It can take away the pain for a period of time for some students. You do get a buzz from tobacco and or alcohol or from vaping. - Community/Business Leader

I had a kindergarten student tell me that "beer and weed are not for kindergartners". Thank goodness, but how sad that our kids are subject to this type of language and activity. Also, the vaping in high schools is an epidemic and the kids can access this very easily. - Community/Business Leader

After all the years of public education, I am amazed at the number of teens who choose to start smoking cigarettes (at a much higher cost per pack). I see young parents asking for assistance with food or transportation but always have cigarettes and money to spend on them. - Other Health Provider

Like obesity, another health issue where choices in childhood and adolescence have negative health consequences into adulthood. Parents and health care providers are often not the best example, as they also often have these problems. Alcohol, in particular, leads to decreased judgement and bad choices that may contribute to violence, accidents, STD and unplanned pregnancy and physical illness. - Physician

It's become accepted in our community for youth to be drinking, and it's frustrating as a community member and parent to watch. Schools should be addressing this more- private schools are what I can speak to- and approach it as a community issue. - Community/Business Leader

Often these are used as self-medication or coping when kids are overwhelmed with stress and violence. In this way, adverse experiences are exacerbated and tend to be transmitted intergenerationally. - Other Health Provider

Young people are exposed to the drug culture early and often. The use of tobacco and alcohol products at a young age are all factors to beginning in the hard drug culture. - Community/Business Leader

Drugs and alcohol make people feel different. Teens want to feel differently. It's easy to access drugs and alcohol. - Social Services Provider

The onset of smoking is not unusual at age 12. Now we have the e-cigarettes and JUUL type. - Other Health Provider

The culture promotes use of alcohol and drugs by young people. - Social Services Provider

Many adolescents are starting to use substances earlier. - Social Services Provider

Many parents and children smokers. - Physician

Generational, coping skills, lack of education. - Community/Business Leader

Easy Access to Substances

Kids have easy access to drugs and alcohol. Kids are bored and want to try something new.

Sometimes it is a cycle: parent at home smokes, drinks and/or does drugs, so they think it is okay. – Physician

Adults make it okay for kids to binge drink when watching sporting events. Resources to intervention. - Community/Business Leader

They are so common and easy to get a hold of. And the consequences can be serious. - Community/Business Leader

Access to these substances and lack of parental supervision. - Community/Business Leader

Easy access. Our community is targeted. - Community/Business Leader

School Issues

Children are being used to sell drugs to children in the schools. Lack of parental monitoring and, or positive role modeling. Peer pressure and need to be accepted by others who have these bad habits. - Community/Business Leader

Limited education in schools. - Physician

Drugs are prevalent in the schools. - Physician

Vulnerable Populations

In some segments, tobacco use is decreasing except within the LGBTQ community, where they are disproportionately affected in comparison to the heterosexual community. Not enough is being done in regard to prevention programs directly related to the LGBTQ population. - Public Health Representative

Places some infants at high risk prenatally, and use throughout the life span impacts individual's ability to be a productive individual and impacts those near them. - Social Services Provider

Tobacco, alcohol, and other drugs are still a major concern, particularly in communities of color. - Other Health Provider

It thrives in low-income communities. Easy to get. - Community/Business Leader

Co-Occurrences

The increase in asthma cases is related to tobacco consumption in the home. Drug and alcohol use are prevalent among youth engaged in gang activity, much of which results in violence and injury. - Community/Business Leader

The use of legal and illegal substance goes hand-in-hand with mental illness. Therefore, our lack of ability to treat mental illness has created a larger drug epidemic. In schools it is not seen as a bad thing just seen as something to do. - Community/Business Leader

E-Cigarettes

Young adolescents are initiating the use of alcohol at an early age... Addiction leads to life-long problems, including lifelong social issues. - Public Health Representative

E-cigarettes are becoming more popular across teens. - Other Health Provider

Access to Care/Services

Need prevention and treatment programs for youth that address alcohol, marijuana, and for young adults. There is a lack of treatment programs in the metro area. - Community/Business Leader

Lack of programs to help young people who become addicted. Availability is a problem too. - Physician

Most Problematic Substances

Key informants (who rated this as a “major problem”) most often identified **alcohol**, **marijuana**, **tobacco/vaping products**, **prescription medications**, and **methamphetamines/other amphetamines** as the most problematic substances abused by youth in the community.

Problematic Substances				
	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	45.1%	27.5%	14.0%	44
Marijuana	23.5%	19.6%	14.0%	29
Tobacco/Vaping Products	11.8%	7.8%	28.0%	24
Prescription Medications	5.9%	21.6%	12.0%	20
Methamphetamines or Other Amphetamines	3.9%	15.7%	10.0%	15
Heroin or Other Opioids	5.9%	0.0%	6.0%	6
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	3.9%	4.0%	4
Over-The-Counter Medications	0.0%	2.0%	4.0%	3
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	0.0%	6.0%	3
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	0.0%	2.0%	2.0%	2
Inhalants	2.0%	0.0%	0.0%	1
Cocaine or Crack	2.0%	0.0%	0.0%	1

Sexual Behaviors

Sexual Activity Among Adolescents

Among Douglas County high school students, 18.3% report having had sexual intercourse with at least one person during the three months preceding the administration of the 2016 Youth Risk Behavior Survey.

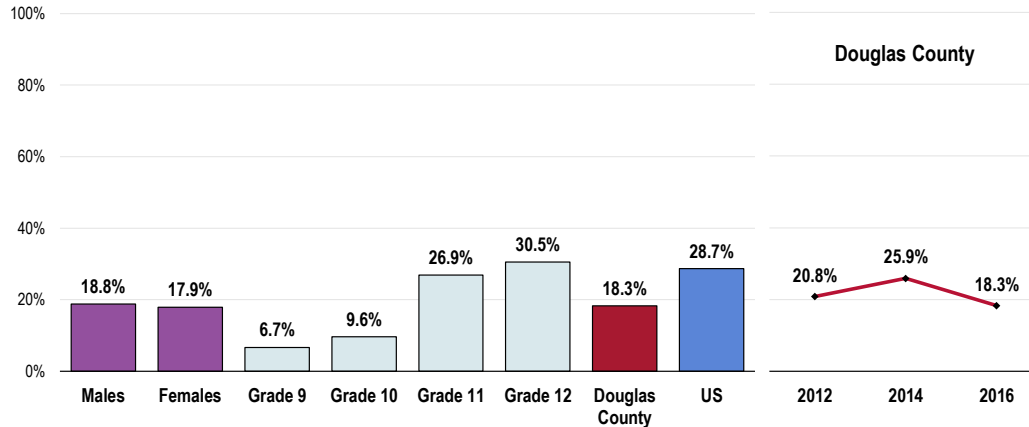
This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students by county.

For more information, visit: www.cdc.gov/healthyyouth/yrbs.

- Well below national findings.
- Shows a dramatic increase by Grade 11.
- TREND: Reported sexual intercourse among Douglas County adolescents has declined significantly over time, particularly over 2014 findings.

Had Sexual Intercourse in Past Three Months

(Among High School Students; Douglas County Youth Risk Behavior Survey, 2016)



Sources: • Douglas County Health Department. 2016/17 Douglas County Youth Risk Behavior Survey Report.
 • Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed September 2018.

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 15.8% report not using any method to prevent pregnancy.

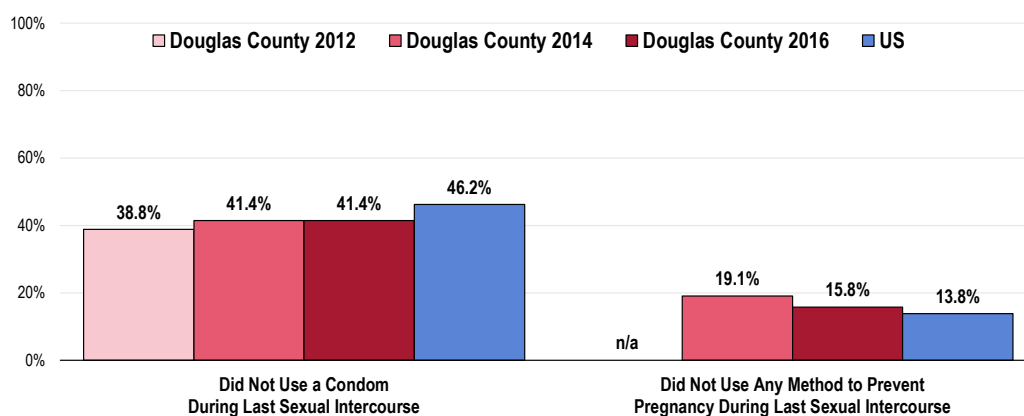
This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students by county.

For more information, visit: www.cdc.gov/healthyyouth/yrbs.

- Condom use in Douglas County is less favorable than US findings, while birth control is more favorable.
- TREND: Use of condoms has decreased over 2012 findings (though matching 2015 findings), while use of birth control has increased since available 2015 data.

Risky Sexual Behavior

(Among Sexually Active High School Students; Douglas County Youth Risk Behavior Surveys)



- Sources:
- Douglas County Health Department. 2016/17 Douglas County Youth Risk Behavior Survey Report.
 - Centers for Disease Control and Prevention (CDC). 2017 National High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed September 2018.
- 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.

Chlamydia & Gonorrhea

In 2014, there were 546.8 diagnosed chlamydia infections per 100,000 population in the Metro Area. *Note that this rate includes diagnoses in all ages (both children and adults).*

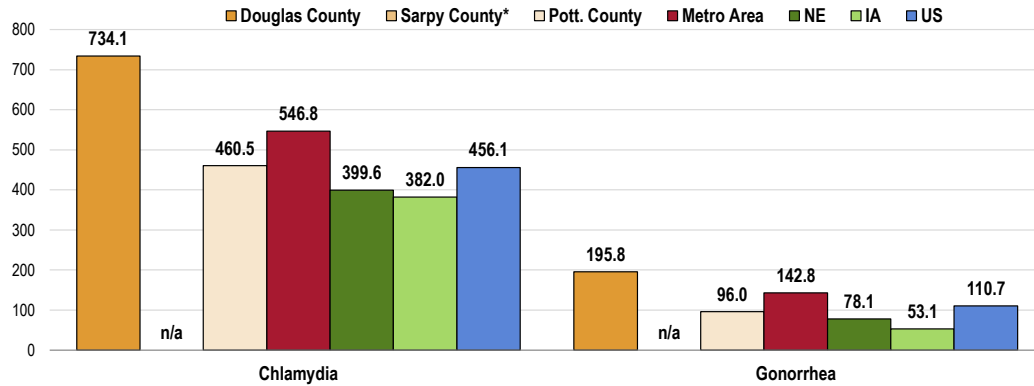
- Much higher than the state and national rates.
- Notably higher in Douglas County than Pottawattamie.

In 2014, there were 142.8 diagnosed gonorrhea infections per 100,000 population in the Metro Area. *Note that this rate includes diagnoses in all ages (both children and adults).*

- Higher than the state and national rates.
- Incidence of gonorrhea is much higher in Douglas County than in Pottawattamie County.

Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2014)



Sources:

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2011.
- Retrieved September 2018 from Community Commons at <http://www.chna.org>.

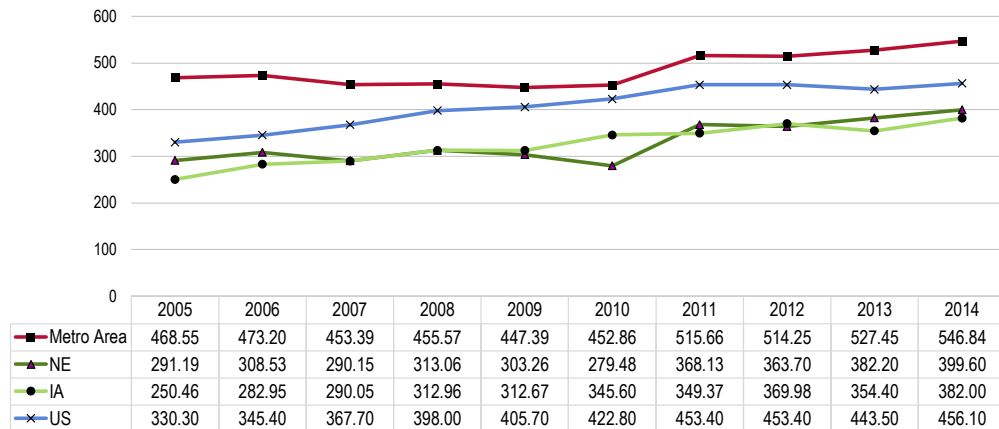
Notes:

- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.
- *The incidence for Sarpy County is not available for these indicators.

- TREND:** Chlamydia incidence has followed a general upward trend in the Metro Area and has remained above state and national trends.

Chlamydia Incidence

(Annual Average Cases per 100,000 Population)



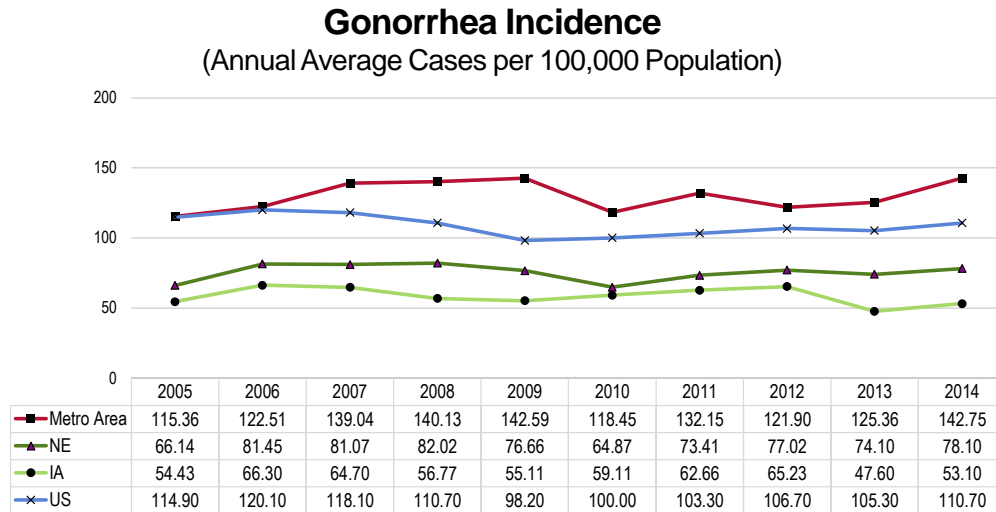
Sources:

- US Census Bureau American Community Survey.
- Retrieved September 2018 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.
- Rates are annual averages new cases per 100,000 population.

- **TREND:** The gonorrhea incidence in the Metro Area has not shown a clear trend over the past decade, though it has remained above state and national trends throughout that time.



Sources:

- US Census Bureau American Community Survey.
- Retrieved September 2018 from Community Commons at <http://www.chna.org>.

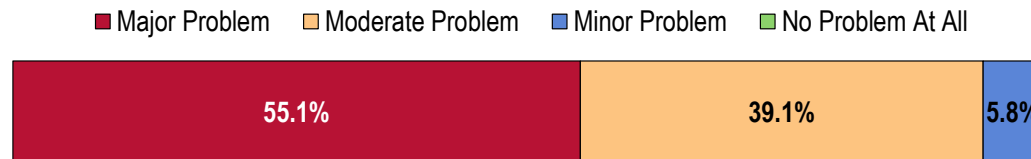
 Notes:

- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.
- Rates are annual averages new cases per 100,000 population.

Key Informant Input: Sexual Health

Over half of key informants taking part in an online survey characterized *Sexual Health* as a “major problem” for children/adolescents in the community.

Perceptions of Sexual Health as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources:

- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

 Notes:

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

Top Concerns

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

Prevalence/Incidence

STD rates in Douglas County are troublesome; all you need to do is evaluate the current report on the State of Public Health in Douglas County and see that this is a difficult health behavior to successfully intervene and change behaviors. There are significant barriers to appropriately educate our youth regarding sexual health and parents aren't doing enough at home regarding this topic. Again, this is a topic that should begin at home where open-communication is supported and anything about sexual health is allowed to be discussed at the table without judgment or shame. - Public Health Representative

Douglas County continues to have one of the highest rates of STD's. Teen pregnancy rates seem to have dropped but are still too high. There needs to be good education and access to care for adolescents. - Public Health Representative

The agencies that are offering sexual health education are limited, and often do not work together. The resources are limited, and agencies feel competition to win grants to do the work, which results in less collaboration. Kids need access to free education, resources, and confidential treatment/health care. - Social Services Provider

Douglas County certainly has a history of chlamydia and gonorrhea infection rates being high. This has not yet changed drastically. Evidence shown by the Adolescent Health Project further and better identifies this need than I am able to. - Other Health Provider

The STD rates in Omaha far exceed the national average, with more than 60% of all new cases in the 15-24 age group. While the teen pregnancy rate has declined, there are glaring racial and ethnic disparities. - Community/Business Leader

Douglas County has very high STD rates. Younger people need to understand the overall implications of STD's better and learn prevention that works. - Community/Business Leader

STD numbers are not decreasing. Too much focus on testing and treating but not enough funds and focus on prevention, healthy relationships. - Other Health Provider

Douglas County has one if not the highest number of STDs in America, yikes. - Other Health Provider

We have a very high rate of STD's and an outmoded system of sex education in the schools. No coincidence. Sexual health means safer kids who finish school and who postpone childbearing until they are ready. - Other Health Provider

Increase or sustaining of high prevalence in STD's and births to teen mothers. Disparity across ethnicity with births to teen mothers. - Other Health Provider

We continue to have an STD epidemic in our community that also includes a significant racial, economic disparity. - Public Health Representative

STDs remain high among 15-19-year-olds. The number and percentage of 15-19-year-old Hispanic pregnancies. - Community/Business Leader

Douglas County has some of the highest STD rates in the nation. Higher than state and national averages. - Other Health Provider

Douglas County is still very high on the prevalence of STI's and STD's. Teen pregnancy rates among children with foster care experience is very high. - Community/Business Leader

The numbers of STD's and teen pregnancies are extremely high. Better education and practical resources can be used to introduce healthy sexual health awareness. - Community/Business Leader

According to CDC data, our Douglas County continues to have one of the highest rates of STD's in the country, specifically in the age population between 15 to 25. - Other Health Provider

Rate of STD's among teens is decreasing, but is still higher than national averages. - Community/Business Leader

I think that Omaha has incredibly high rates of STDs and that many of the school districts still use outmoded, abstinence-focused health education rather than attempting to give teenagers truthful information about how to protect themselves. - Other Health Provider

Omaha and surrounding communities have a high rate of STD's in the young adult population. - Other Health Provider

Nebraska has one of largest rates of STD's in the country. The rate of teen pregnancies is still high in our community. Parents are younger, having babies as a teen, and the trend just continues through generations. - Community/Business Leader

We have some of the highest rates of STD's in the country, yet we don't seem to be making much progress talking about this or comfort with treating it. Lack of resources in West Omaha for teens. - Other Health Provider

Chlamydia and gonorrhea are at record high levels. Sexual and reproductive health should be a normal conversation at routine medical checkups. Young adults should not feel ashamed. The threat of resistant gonorrhea is getting closer and closer to us and we must be prepared. - Public Health Representative

From community meetings, I know that we have one of the highest STD rates in the nation. While teen pregnancy has actually decreased slightly over the last few years we see many teen moms at WIC clinic and many teen moms with more than one child. - Public Health Representative

High rates of STD's, particularly chlamydia and gonorrhea among youth. - Public Health Representative

The amount of STI's is high and the age range is getting lower. - Physician

High teen pregnancy rates, and a high number of STI's. - Public Health Representative

The last reports I have seen rank Nebraska one of the highest states in STD's - Other Health Provider

Still see too many with STD's and teen pregnancy. - Physician

Douglas County has the highest rate of STD's in Nebraska. - Social Services Provider

Increased level of STI's in our youth and young adults per data. - Physician

Because of the high STD rate. - Community/Business Leader

We have a high rate of STI's in our community. - Physician

The high percentage of teens with STI's in Omaha. - Community/Business Leader

Nebraska has one of the highest rates of STD's in teens. Teen pregnancy is lower than in the past. - Physician

STD's continue to be a problem in Omaha. - Other Health Provider

High prevalence of chlamydia and gonorrhea. - Community/Business Leader

High rates of STD's in the Omaha area. - Other Health Provider

High rate of STD's. - Public Health Representative

The high rates of STDs in our community. - Community/Business Leader

STD rates continue to be a problem in our community. - Community/Business Leader

STD rates in Douglas County are high. - Community/Business Leader

Increasing rates of chlamydia in Omaha. - Physician

High STD rate. - Other Health Provider

High rates of STD/STI and disparities that exist across race/ethnicity. - Public Health Representative

The high STD rates in our community. - Social Services Provider

STD rates continue to be alarmingly high. - Public Health Representative

Douglas County experiences a high rate of STI's. - Other Health Provider

Health Awareness/Education

We have school-based health centers in schools but aren't able to talk about preventing STDs and pregnancies - and can't distribute condoms - to these young adults? We are making progress but still haven't created a new "norm" where we talk openly about sexual health - Community/Business Leader

Anyone who has access to school data understands the need for increased education with regard to sexual health, teen pregnancy and STD knowledge and prevention. These are issues that face our young adults, the numbers do not dispute this. Prevention is key here, but unfortunately, there is again not enough funding to support programs providing help for our teens. - Community/Business Leader

Lack of education both related to sexual health, birth control and prenatal, postnatal care. Cultural attitudes, cultural and language barriers, lack of access to proper resources, healthcare, nutrition, financial concerns, lack of insurance. - Community/Business Leader

State law makes it hard to keep kids informed in school. As a provider in a school, I can test for STD's and pregnancy but cannot talk about birth control. Kids lack the education about STD's and the harmful effects that can come from being untreated. - Physician

While progress has been made, continued focus should be on making sure young people have the ability to access reproductive and sexual health resources in an environment and way in which they are comfortable and empowered. - Community/Business Leader

Young people are provided little factual and empowering information in the education system that results in empowerment and responsibility about their sexual and reproductive lives. - Public Health Representative

Many refugee and immigrant cultures do not talk about sex education at home, so many of our youth don't know the first thing about their own bodies and how to protect themselves. - Social Services Provider

Lack of realistic sex education in some school districts, Millard. - Community/Business Leader

Lack of education, lack of prevention, generational. - Community/Business Leader

Limited education for children at school in some districts. - Physician

Lack of knowledge related to sexual health. - Community/Business Leader

Culture/Social Norms

The culture promotes unhealthy sex. Kids are watching the people before them engage in unhealthy sexual relationships. Many teen pregnancy and STD cases are due to lack of real vision or understanding. - Social Services Provider

Community not willing to talk about and support the issue. Parents not feeling comfortable talking with their kids about the issue. - Community/Business Leader

Hormones! Pressure from peers on social media. I wonder if there is a lack of personal faith in a higher being. Do children go to church anymore? Do they believe? Casual attitude about the sexual world.

Constant presence of sex in all things that sell product, yet we still cannot pass out condoms in a school setting, but students can watch shows on cable TV with explicit sexual themes. - Community/Business Leader

The onset of sexual activity has been found to have onset as young as age 12. - Other Health Provider

One word: social media. - Public Health Representative

Children engage in risky sexual behavior. - Community/Business Leader

I believe kids are having sex at younger ages. - Public Health Representative

Use of Health Care & Preventive Services

Primary Care Services

About Primary Care

Improving health care 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 health care 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).

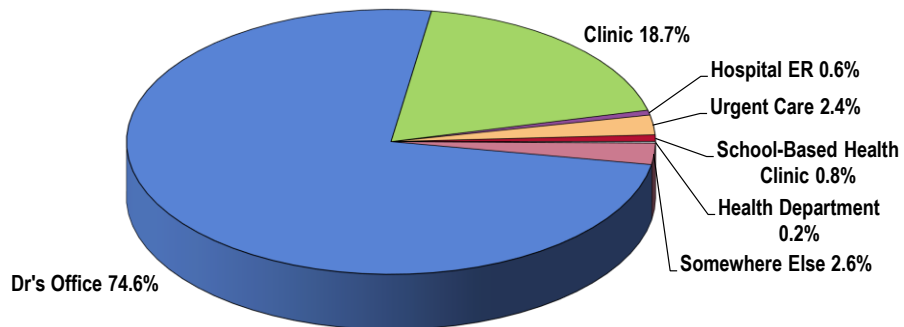
— Healthy People 2020 (www.healthypeople.gov)

Particular Place Utilized for Ongoing Care

When asked where they take their child if they are sick or need advice about his/her health, almost three-quarters (74.6%) of respondents identified a particular doctor's office.

A total of 18.7% say they usually go to some type of clinic, while 0.6% rely on a hospital emergency room, and 2.4% use an urgent care center for their child's medical care.

Particular Place Utilized for Child's Medical Care
(Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 26]
Notes: • Asked of all respondents about a randomly selected child in the household.

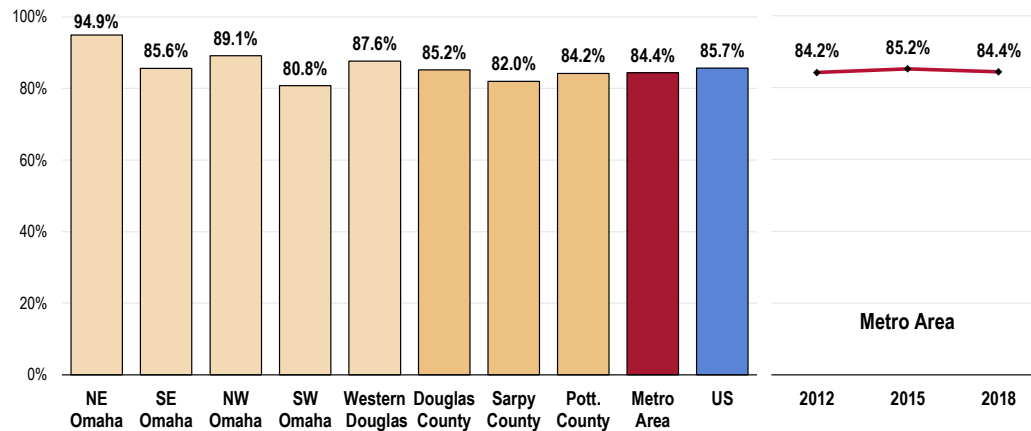
A routine checkup can include a well-child checkup or general physical exam, but it does not include exams for a sports physical or visits for a specific injury, illness, or condition.

Receipt of Routine Medical Care

A total of 84.4% of Metro Area children have had a routine checkup in the past year.

- Comparable to US findings.
- Within Douglas County, routine checkups are most common in Northeast Omaha.
- Statistically, no difference among the three counties.
- TREND: Statistically unchanged since 2012.

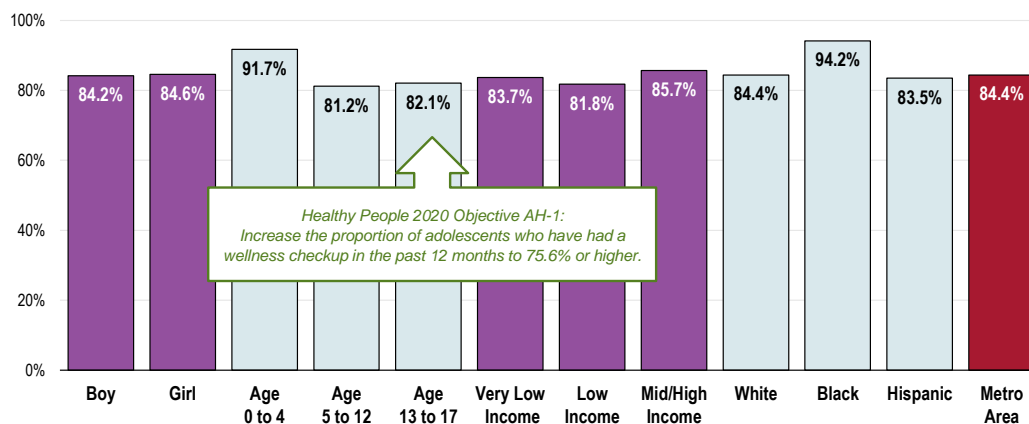
Child Visited a Physician for a Routine Checkup in the Past Year (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 27]
 • 2018 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 lowest among children age 5-17, though the proportion of Metro Area adolescents (age 13-17) with routine checkups satisfies the Healthy People 2020 target (75.6% or higher) for their age group.
- White and Hispanic children are also statistically less likely to have had a routine checkup in the past year.

Child Visited a Physician for a Routine Checkup in the Past Year (Metro Area, 2018)



Sources:

- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 27]
- 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Perceptions of Childhood Vaccinations

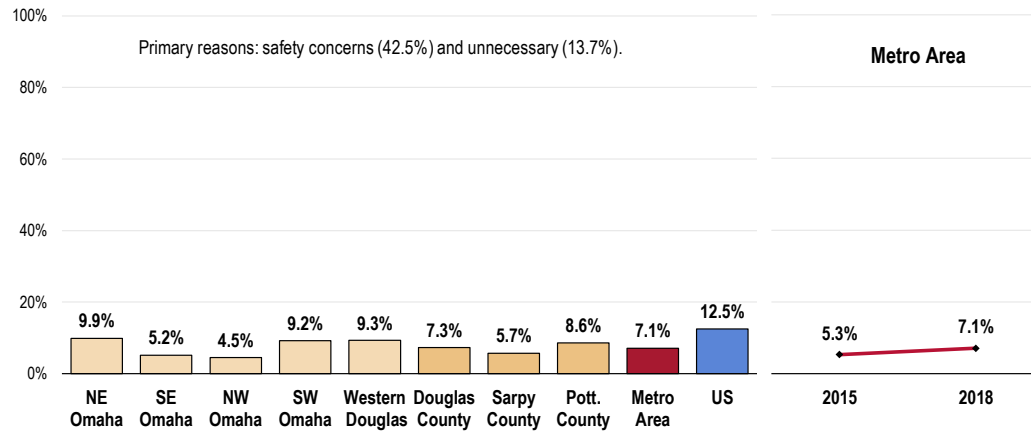
While 92.9% of surveyed Metro Area parents say they would want their (hypothetical) newborn to receive all recommended vaccinations, a total of 7.1% would not.

- The proportion of parents who would refuse recommended vaccinations is much lower than the percentage reported nationwide.
- In Douglas County, this is low (most favorable) in Northwest Omaha.
- Similar by county.
- TREND: Anti-vaccination sentiment has not statistically changed over the past three years.

Reasons given for not getting all of the recommended vaccines primarily included **safety concerns** (mentioned by 42.5%) and perceiving that **some or all vaccines are unnecessary** (13.7%).

Vaccination is a primary defense against some of the most deadly and debilitating known diseases.

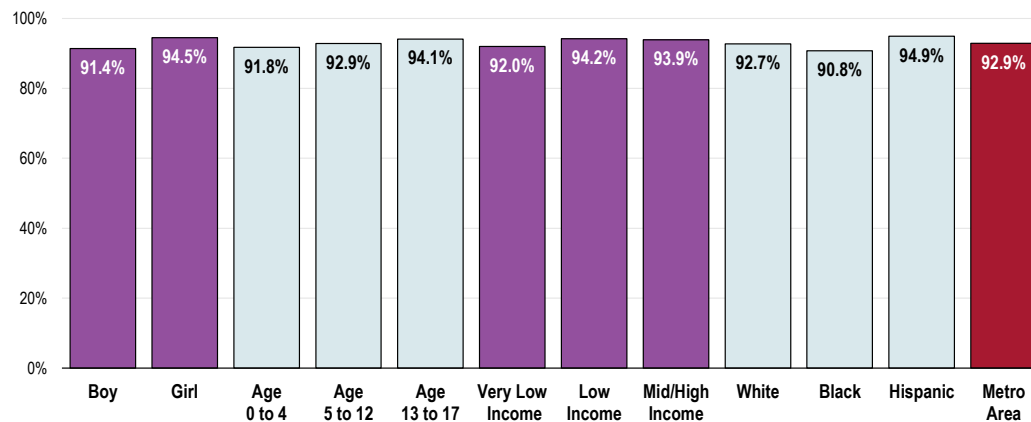
If Respondent Had a Newborn, Would Not Want Him/Her to Get All Recommended Vaccinations (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 115-116]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Statistically, there were no differences in newborn vaccination perceptions among the following demographic breakouts.

If Respondent Had a Newborn, Would Not Want Him/Her to Get All Recommended Vaccinations (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 115]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

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)

Receipt of Dental Care

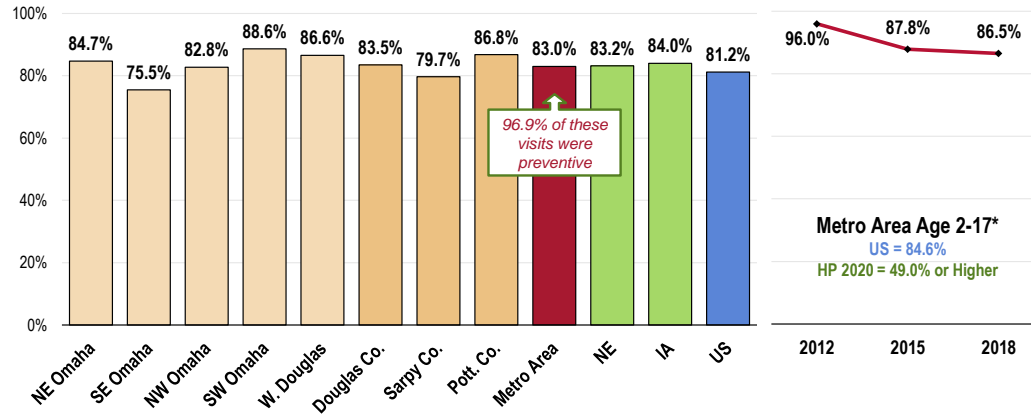
Most Metro Area children age 1-17 (83.0%) have visited a dentist or other oral health care provider (for any reason) in the past year.

- No significant differences when compared against state and national findings.
- Within Douglas County, this is highest in Southwest Omaha and lowest in Southeast Omaha.
- Comparable among the three Metro Area counties.
- TREND: When limited to age 2-17, there is a significant decrease in dental care since first measured in 2012. *Note that previous data for this indicator measured ages 2-17.*

A total of 96.9% of these visits for children age 1-17 were preventive.

Child Visited a Dentist/Oral Health Care Provider Within the Past Year

(Metro Area Children Age 1-17, 2018)

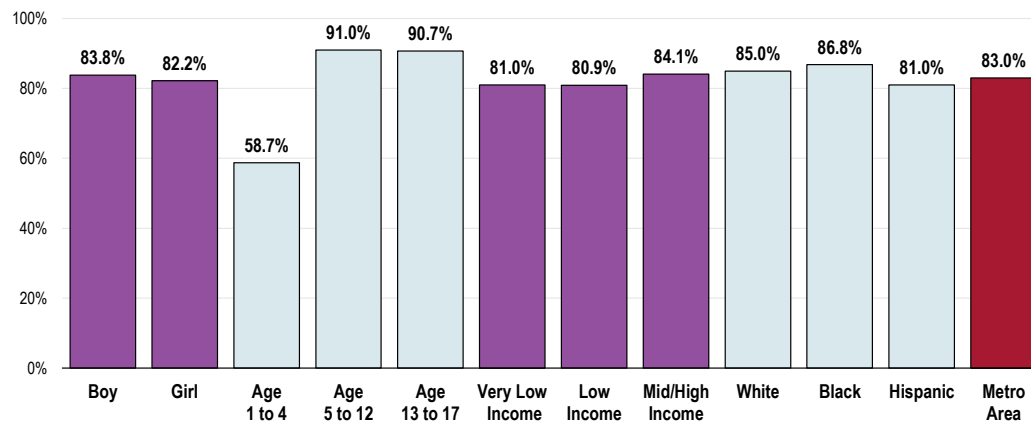


- Sources:
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 310-311]
 - Child and Adolescent Health Measurement Initiative. 2016 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 10/05/18 from www.childhealthdata.org. CAHMI: www.cahmi.org.
 - 2018 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-2.1]
- Notes:
- Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
 - * In prior years and the Healthy People 2020 benchmark, this indicator reflects ages 2-17.

- Note that less than 60% of children age 1-4 are likely to have visited a dentist or dental clinic in the past year.

Child Visited a Dentist/Oral Health Care Provider Within the Past Year

(Metro Area Children Age 1-17, 2018)



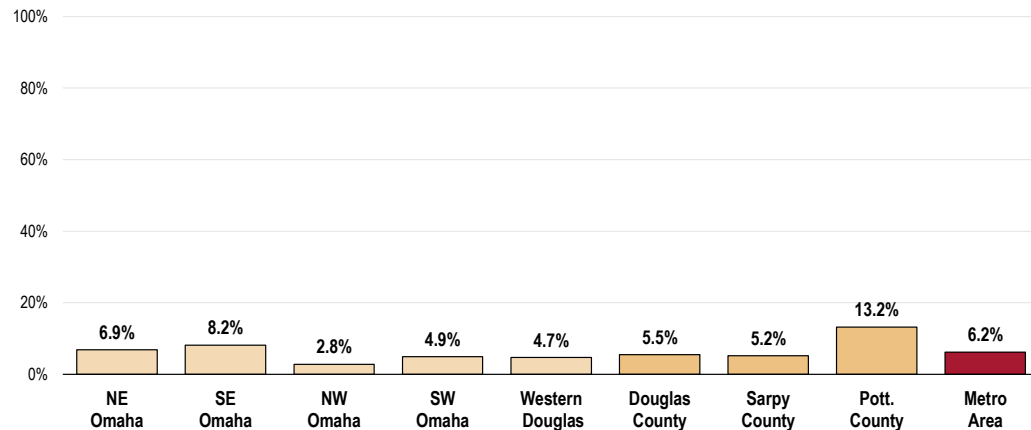
- Sources:
- 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 310]
- Notes:
- Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Difficulties Accessing Dental Care

A total of 6.2% of parents report that they have experienced difficulties accessing dental care for their child (age 1 to 17) in the past year.

- Of the Douglas County areas, access difficulties are lowest in Northwest Omaha.
- By county, highest in Pottawattamie County.

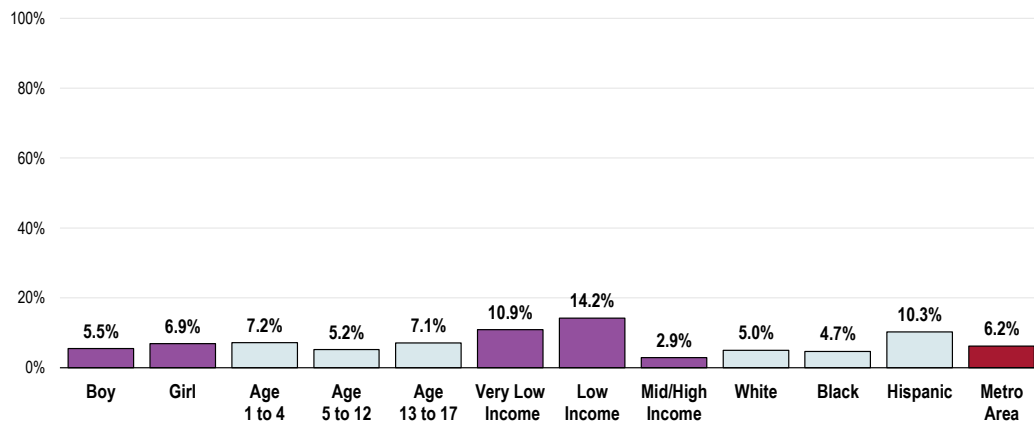
Difficulties Accessing Dental Care in Past Year (Metro Area Children Age 1-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 312]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.

- Difficulties accessing dental care is more common among children living in lower-income households.

Difficulties Accessing Dental Care in Past Year (Metro Area Children Age 1-17, 2018)



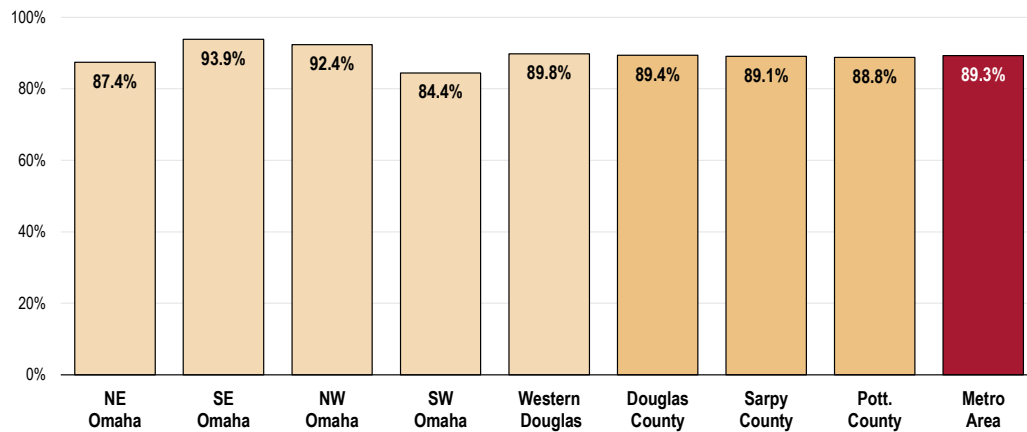
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 312]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Dental Insurance

Nearly nine in 10 Metro Area children age 1-17 (89.3%) have coverage that covers all or part of their dental expenses.

- Within Douglas County, highest in Southeast Omaha and lowest in Southwest Omaha.
- No significant difference among the Metro Area counties.

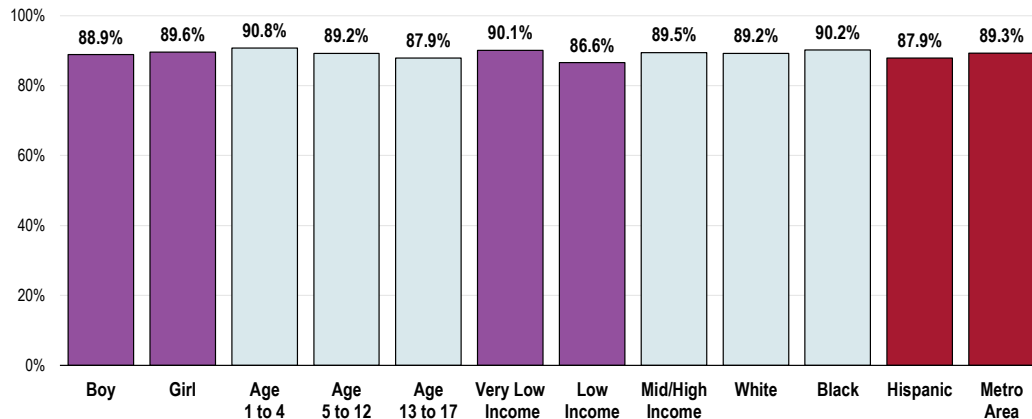
Child Has Dental Insurance (Metro Area Children Age 1-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.

- No significant differences among the following child demographics.

Child Has Dental Insurance (Metro Area Children Age 1-17, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

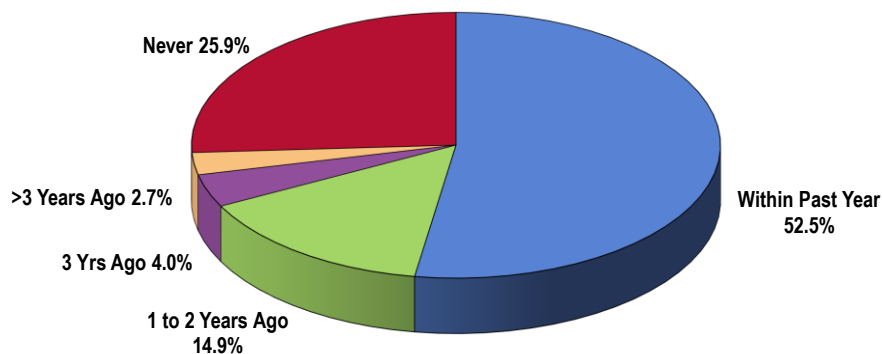
Vision & Hearing Care

Recent Eye Exams

Note the following frequency of eye exams among Metro Area children age 0-17; as shown, over one-quarter (25.9%) have never had an eye exam.

RELATED ISSUE:
See also *Vision, Hearing,
& Speech Conditions* in
the **Current Health**
Status: Chronic Disease
section of this report.

Child's Most Recent Eye Exam
(Metro Area, 2018)

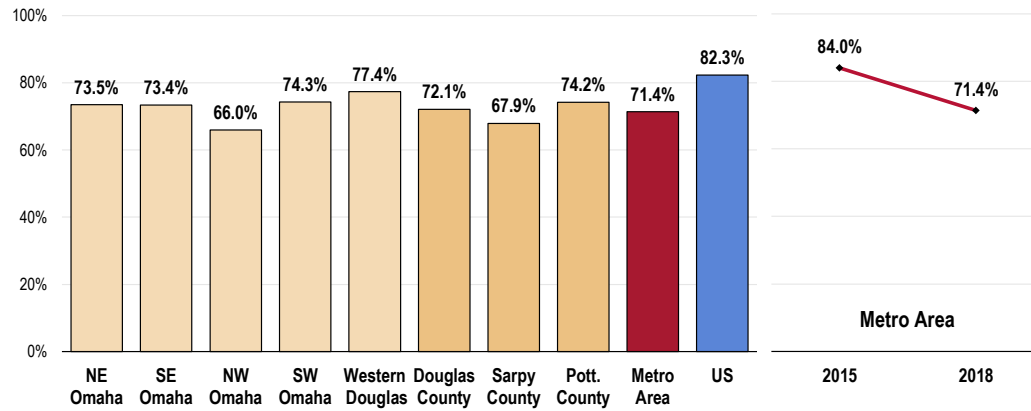


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 36]
Notes: • Asked of all respondents about a randomly selected child in the household.

On the other hand, a total of 71.4% of Metro Area parents indicate that their child has had an eye exam within the past three years.

- Well below the US prevalence.
- In Douglas County, recent eye exams are least common in Northwest Omaha.
- Statistically comparable findings when viewed by county.
- TREND: Marks a notable decrease since first measured in 2015

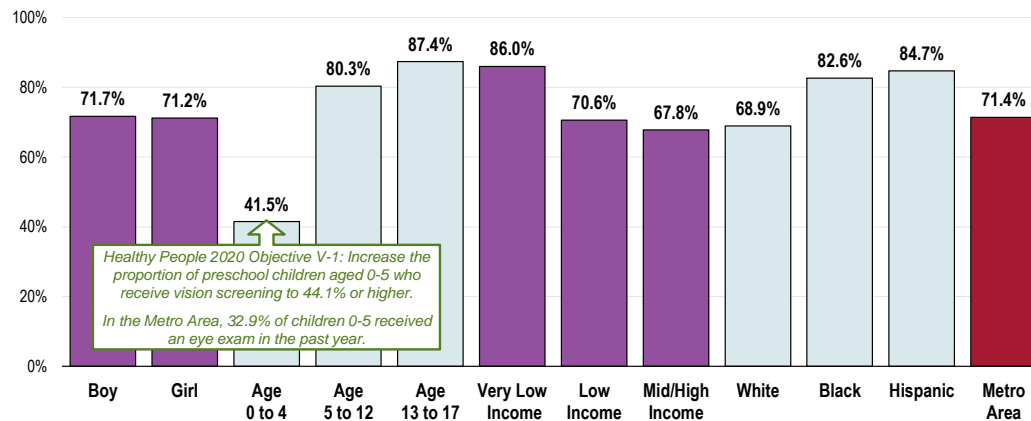
Child Had an Eye Exam in the Past Three Years (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 36]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • *2015 data did not specify an eye exam from a vision care provider.

- Children under age 5 are much less likely to have received an eye exam in the **past 3 years** (strong positive correlation with age).
- Note that the prevalence of Metro Area children age 0 to 5 who have had an eye exam in the **past year** (32.9%) fails to satisfy the Healthy People 2020 target (44.1% or higher) for this age group.
- Children living in households above 100% FPL are also less likely to have had an eye exam in the past 3 years, as are White children.

Child Had an Eye Exam in the Past Three Years (Metro Area, 2018)

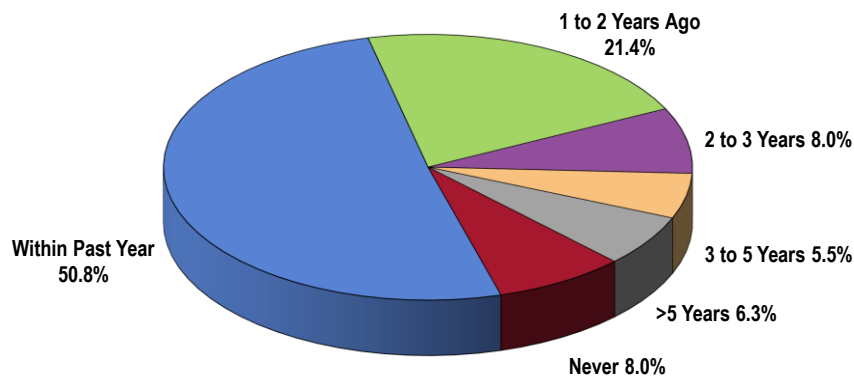


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 36]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective V-1]
 Notes: • Asked of all respondents about a randomly selected child 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Hearing Tests

Note that 8.0% of Metro Area parents indicate that their child has never had a hearing test.

Child's Most Recent Hearing Test
(Metro Area, 2018)

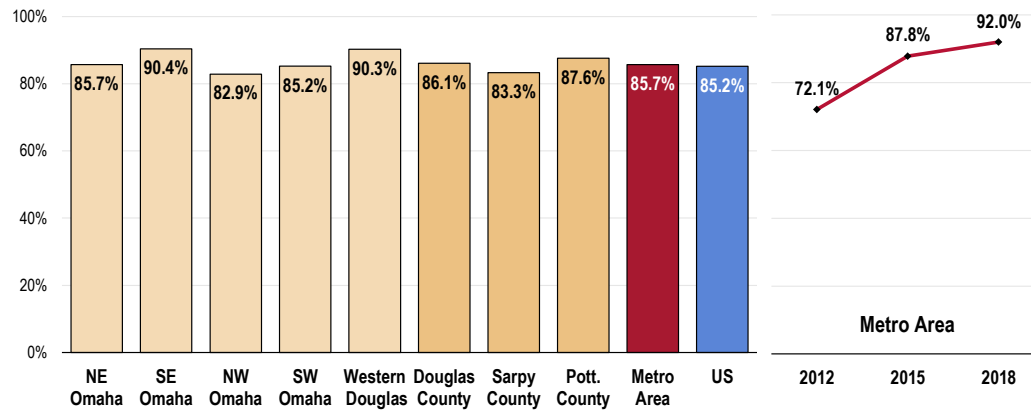


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]
Notes: • Asked of all respondents about a randomly selected child in the household.

On the other hand, 85.7% of Metro Area children have had a hearing test within the past five years.

- Close to US findings.
- No significant differences by area.
- TREND: This prevalence had markedly increased since 2012 findings (though statistically similar to 2015).

Child Had a Hearing Test in the Past Five Years (Metro Area, 2018)



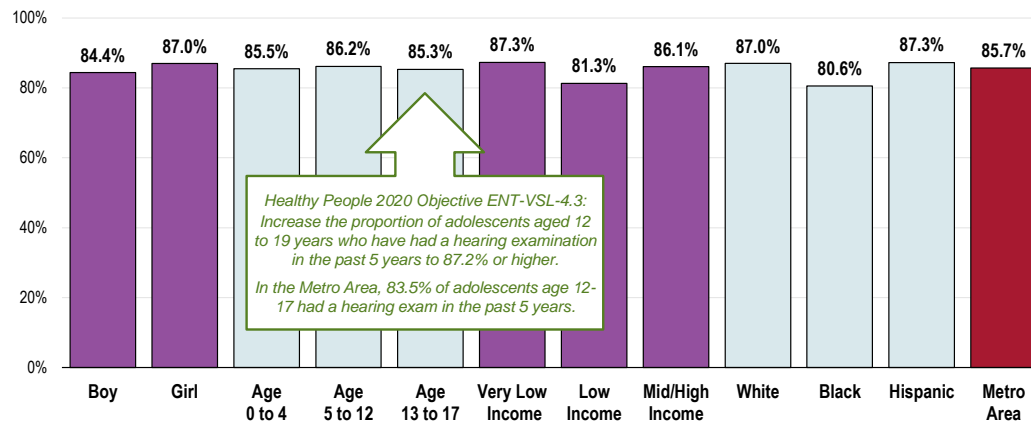
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]

• 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

- No significant differences by demographics.
- Note that the prevalence of hearing tests among Metro Area adolescents age 12 to 17 (83.5%) fails to satisfy the Healthy People 2020 target (87.2% or higher) set for those age 12 to 19.

Child Had a Hearing Test in the Past Five Years (Metro Area, 2018)



Sources: • 2018 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 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

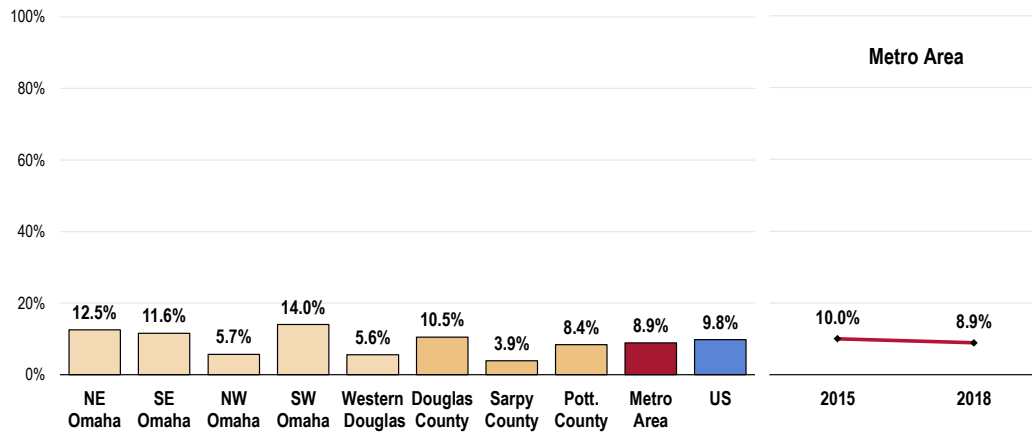
Emergent & Urgent Care

Emergency Room Utilization

A total of 8.9% of Metro Area parents report taking their child to a hospital emergency room (ER) more than once in the past year.

- Similar to the US figure.
- Among the areas within Douglas County, ER use is statistically lowest in Northwest Omaha.
- By county, highest in Douglas County.
- TREND: Statistically unchanged over the past three years.

Child Used a Hospital Emergency Room More Than Once in the Past Year (Metro Area, 2018)

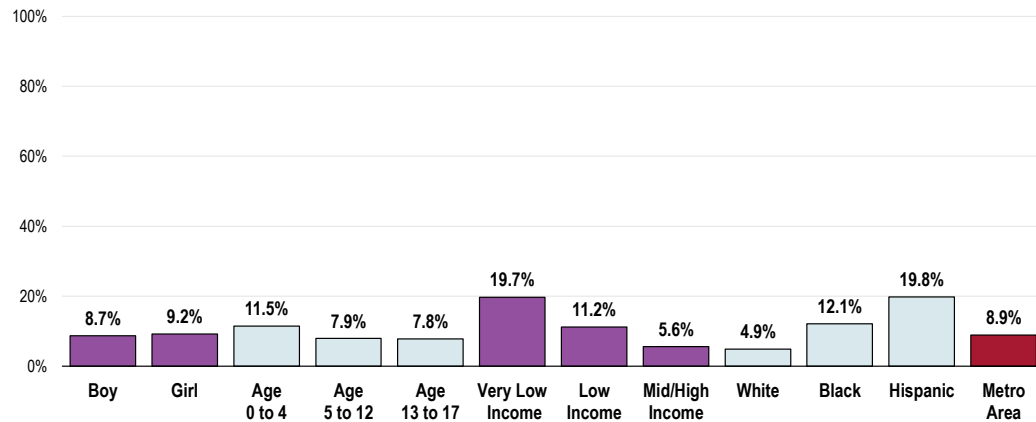


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 39]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Children more likely to have used a hospital emergency room for care more than once in the past year include:

- Those in lower-income households (negative correlation with income).
- Hispanic children.

Child Used a Hospital Emergency Room More Than Once in the Past Year (Metro Area, 2018)

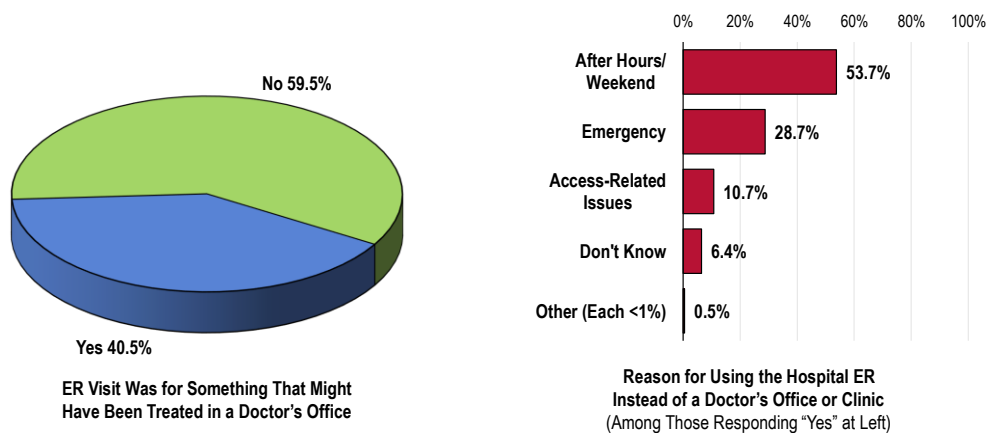


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 39]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Among Metro Area parents of children with any ER visit in the past year, 40.5% say 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, 53.7% indicated that they needed the care **after hours or on the weekend**, and 28.7% said the visit was to treat an actual **emergency situation**.
- Another 10.7% of Metro Area parents took their child to a hospital ER in the past year because of **access-related issues**.

Emergency Room Visits (Among Metro Area Children With Any ER Visits in the Past Year, 2018)



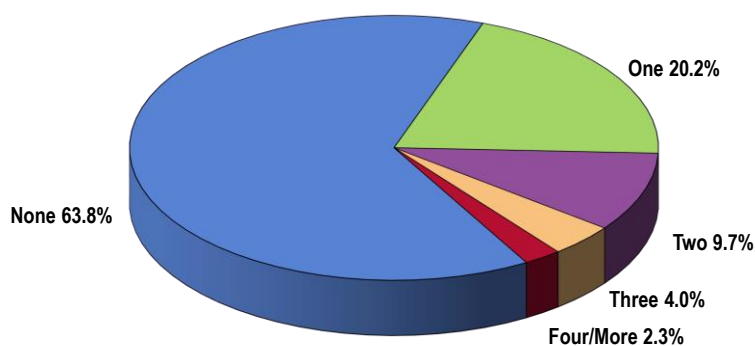
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 41-42]
 Notes: • Asked of respondents for whom the randomly selected child in the household used a hospital ER in the past year.

Urgent Care Centers/Walk-In Clinics

A total of 36.2% of Metro Area children visited an urgent care center or other walk-in clinic at least once in the past year.

- The prevalence includes 6.3% of Metro Area children who visited an urgent care center 3+ times in the past year.

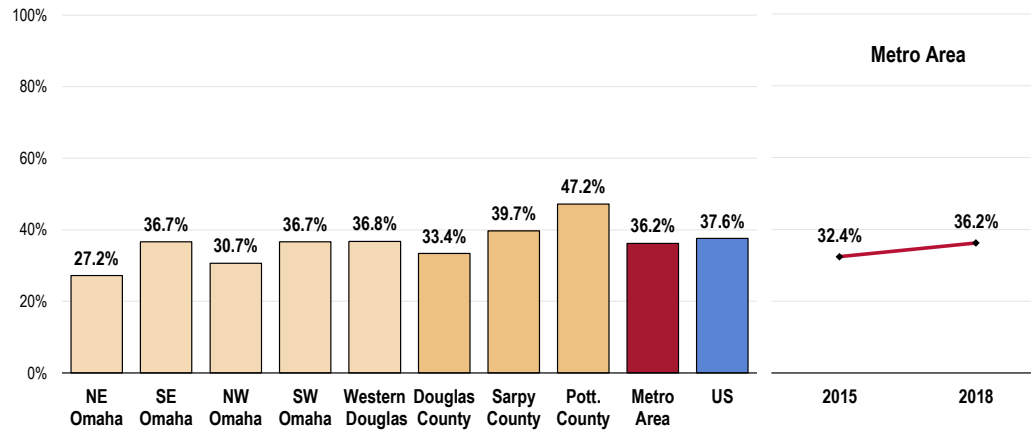
**Number of Visits to an Urgent Care Center
or Other Walk-in Clinic in the Past Year**
(Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 43]
Notes: • Asked of all respondents about a randomly selected child in the household.

- The prevalence of children using an urgent care center in the past year is comparable to national findings.
- No significant differences in prevalence among the Douglas County areas.
- By county, highest in Pottawattamie County.
- TREND: Statistically similar to 2015 findings.

Child Used an Urgent Care Center, QuickCare Clinic, or Other Walk-In Clinic in the Past Year (Metro Area, 2018)

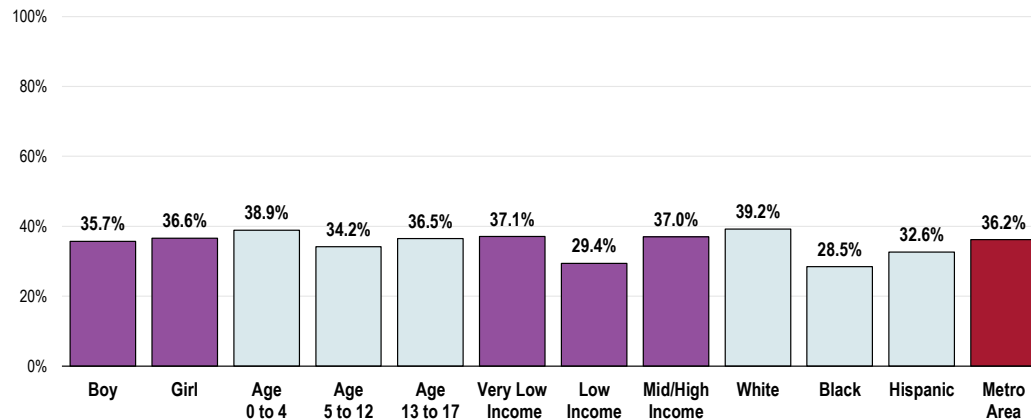


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 43]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

- Differences by demographics are not statistically significant.

Child Used an Urgent Care Center, QuickCare Clinic, or Other Walk-In Clinic in the Past Year (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 43]
 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Services



Professional Research Consultants, Inc.

Difficulties Accessing Healthcare

Health Insurance Coverage

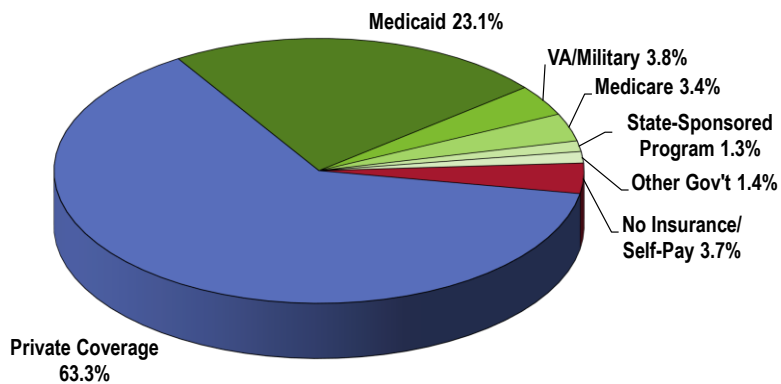
Type of Health Insurance Coverage

Nearly two-thirds (63.3%) of parents report having healthcare coverage for their child through private insurance.

Another 33.0% 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, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 137]
Notes: • Asked of all respondents about a randomly selected child in the household.

Lack of Health Insurance Coverage

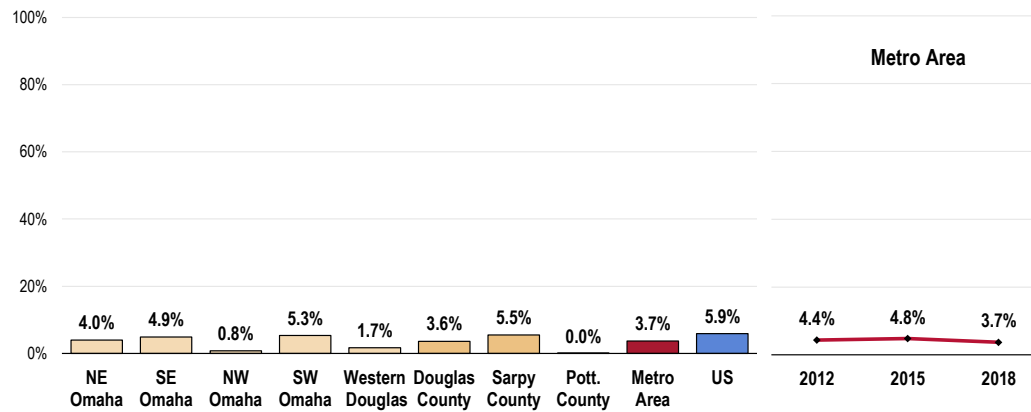
On the other hand, 3.7% of Metro Area parents report having no insurance coverage for their child's healthcare expenses, through either private or public sources.

- Statistically lower than the US figure.
- The Healthy People 2020 target is universal coverage (100% insured).
- Within Douglas County, uninsurance is lowest in Northwest Omaha.
- By county, lowest in Pottawattamie County (where no parents noted a lack of coverage for their child).
- TREND: The prevalence of uninsured children is statistically similar to findings from prior years.

Lack Healthcare Insurance Coverage for Child

(Metro Area, 2018)

Healthy People 2020 Target = 0% (Universal Coverage)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 137]
 • 2018 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 about a randomly selected child in the household.

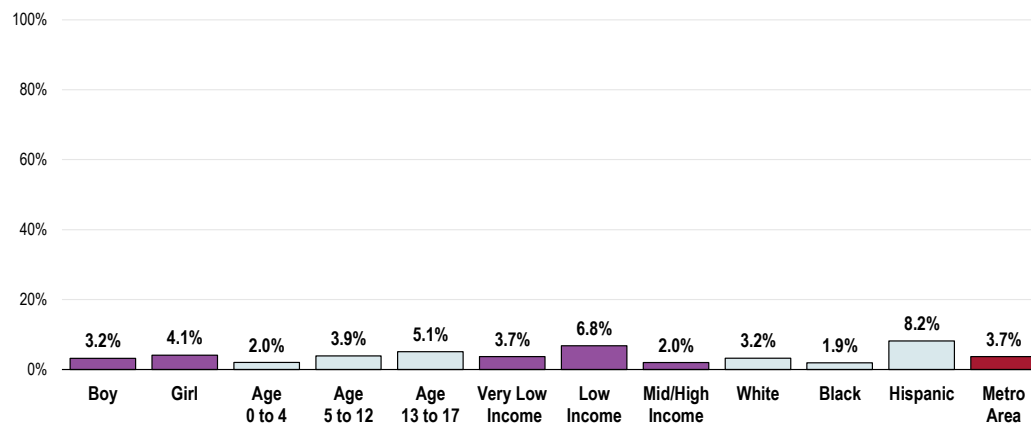
The following child segments are less likely to have healthcare coverage:

- **Teens.**
- **Children living in households between 100% and 199% of the federal poverty level.**

Lack Healthcare Insurance Coverage for Child

(Metro Area, 2018)

Healthy People 2020 Target = 0% (Universal Coverage)



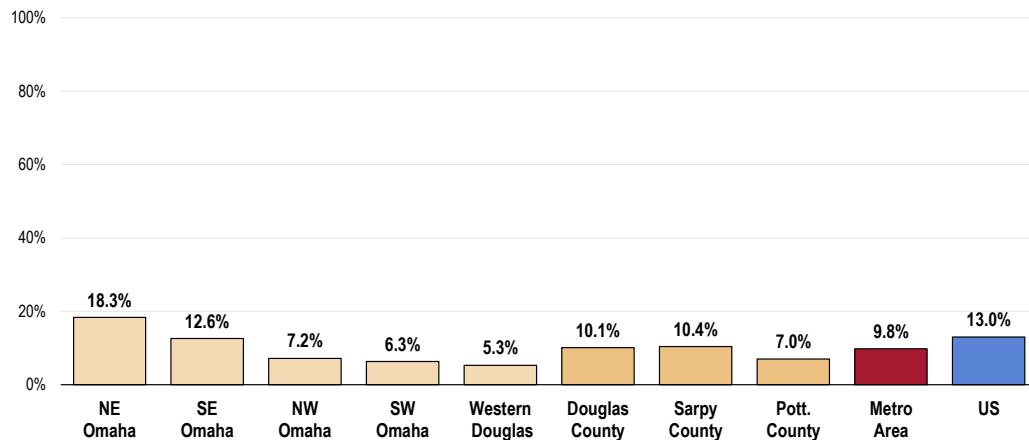
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 137]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
 Notes: • Asked of all respondents about a randomly selected child 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Without Coverage in the Past Year

Among all Metro Area parents, 9.8% report that their child was without healthcare coverage at some point in the past year (including the 3.7% who are currently without insurance coverage).

- Statistically similar to the US proportion.
- In Douglas County, children in Northeast Omaha are most likely to have been without coverage in the past year.
- Statistically comparable among the three Metro Area counties.

Child Went Without Coverage at Some Point in the Past Year (Metro Area, 2018)

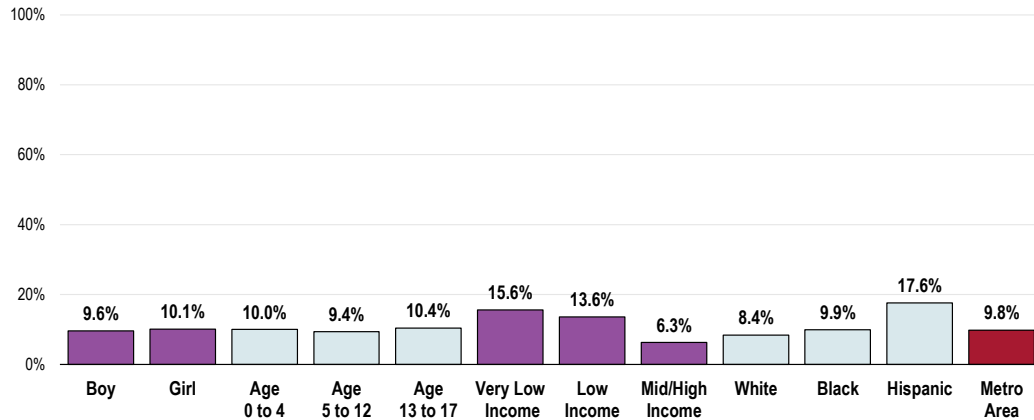


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 101]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

The following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Children living in lower-income households (negative correlation with income).
- Hispanic children.

Child Went Without Coverage at Some Point in the Past Year (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 101]

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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Barriers to Care

About Access to Healthcare

Access to comprehensive, quality health care 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 health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

— Healthy People 2020 (www.healthypeople.gov)

Barriers to Healthcare Access

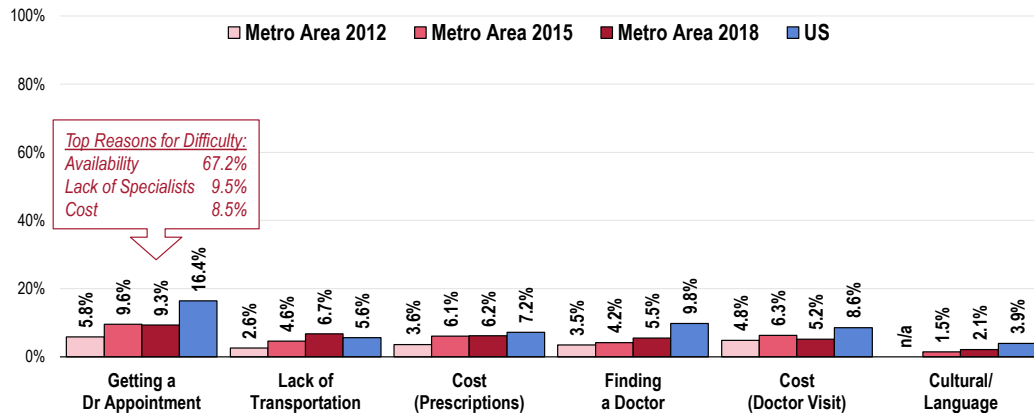
Of the tested access barriers, difficulty getting a doctor's appointment impacted the greatest share of Metro Area children (9.3% of parents say that lack of appointment availability prevented them from obtaining a visit to a physician for their child in the past year).

Lack of transportation impacted 6.7%, followed by prescription cost (6.2%).

- Except for transportation and prescription cost (which are similar), the proportion of Metro Area children impacted for each of the tested barriers was lower than nationwide findings.
- TREND: For most of the tested barriers, the proportion of Metro Area children impacted was statistically worse (higher) than first measured; however, the prevalences of **cost of a doctor visit** and **cultural differences** remained statistically unchanged.

For parents reporting difficulty getting an appointment for their child, the top reason given was availability (67.2%), followed by lack of specialists (9.5%) and cost (8.5%).

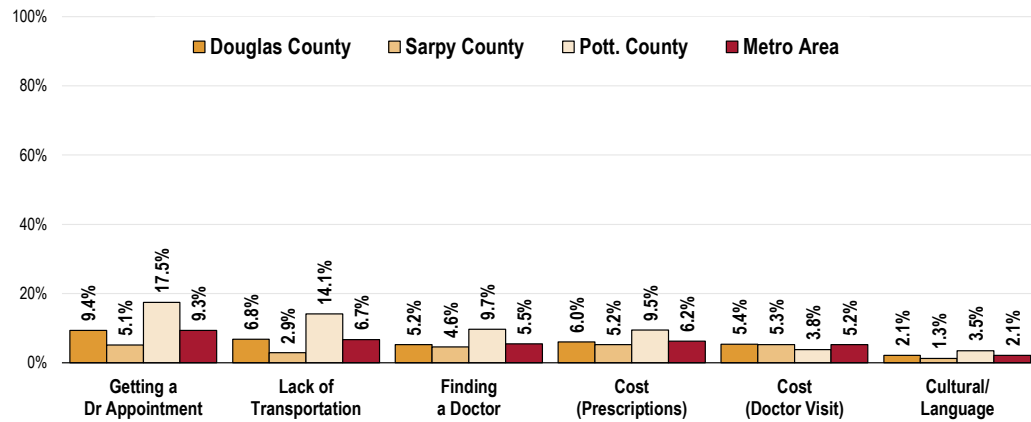
Barriers to Access Have Prevented Child's Medical Care in the Past Year (Metro Area, 2018)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 17-20, 22-23, 304]
 • 2018 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 parents living in Pottawattamie County reported the highest prevalences of **difficulty getting an appointment** and **lack of transportation** for their child.

Barriers to Access Have Prevented Child's Medical Care in the Past Year (By County, 2018)



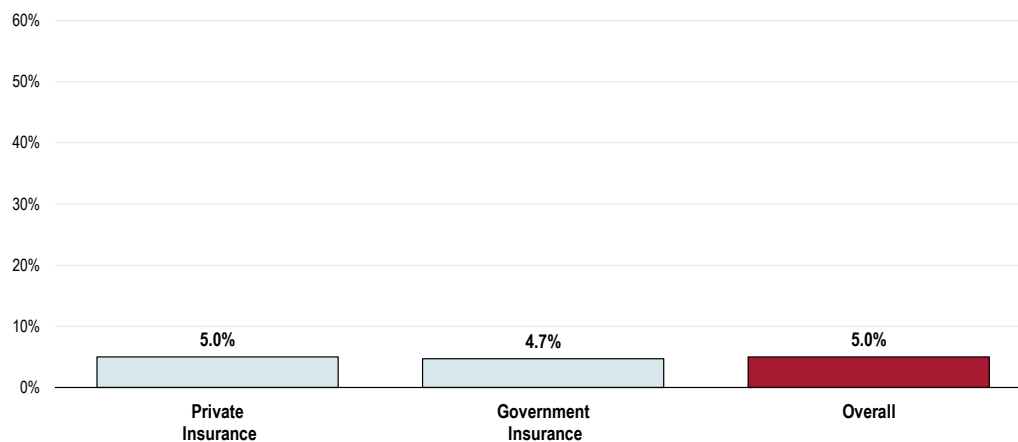
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 17-23]
Notes: • Asked of all respondents about a randomly selected child in the household.

Deductible Prevented Care

Overall, 5.0% of children with insurance (government or private) have gone without healthcare at some point in the past year due to the size of their insurance deductible.

- Note that responses among 11 insured respondents with unknown insurance type are not shown.

Size of Deductible Prevented Child's Health Care in Past Year (Metro Area Children by Insurance Type, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 332]
Notes: • Asked of all respondents with whom the randomly selected child in the household is insured.
• Note that responses among 11 insured respondents with unknown insurance type are not shown.

"A health insurance deductible is the amount you owe for covered health care services before your health insurance plan begins to pay.

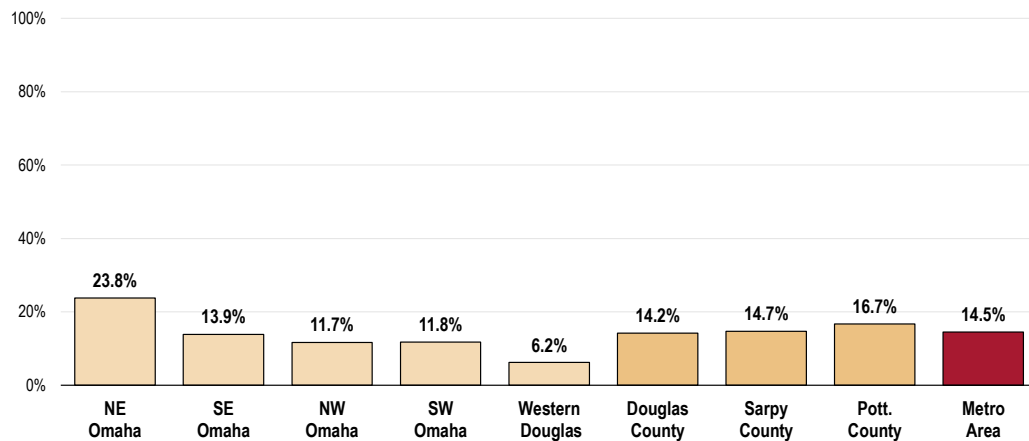
In the past 12 months, has the size of the health insurance deductible for this child prevented him/her from receiving needed health care?

Care Coordination

A total of 14.5% of Metro Area parents report that they could have used extra help arranging or coordinating their child's medical care in the past year.

- Within Douglas County, this need is highest in Northeast Omaha and lowest in Western Douglas.
- No significant differences by county.

Could Have Used Help Coordinating Child's Care in Past Year (Metro Area Parents, 2018)

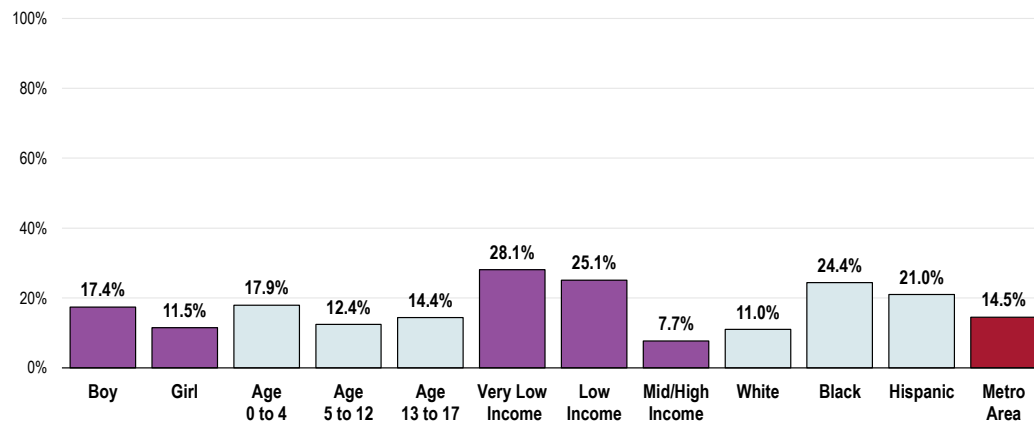


Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 355]
Notes: • Asked of all respondents with a child in the household.

Parents report a higher need for help coordinating care for children in the following demographic groups:

- Boys.
- Those living in lower-income households.
- Black children.
- Hispanic children.

Could Have Used Help Coordinating Child's Care in Past Year (Metro Area Parents, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 355]

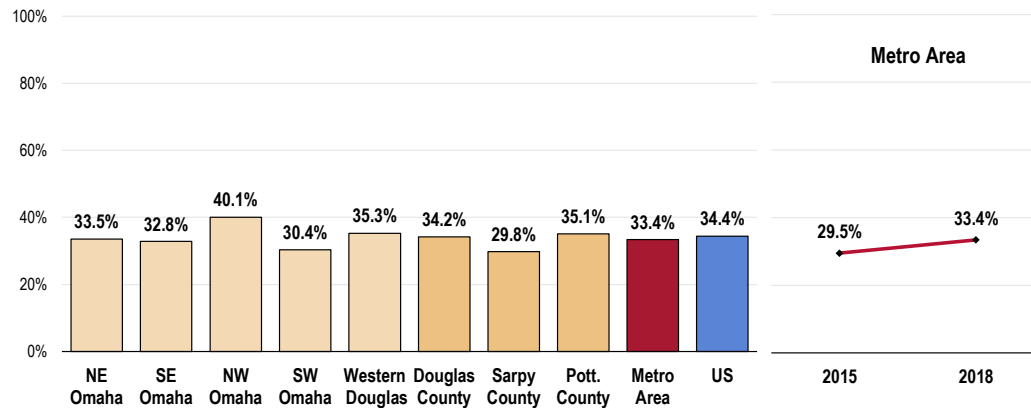
Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to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

Access to Specialty Care

One-third (33.4%) of Metro Area children are reported to have needed to see a specialist at some point in the past year.

- Similar to the US proportion.
- Differences by area are not statistically significant.
- TREND: No significant change within the past three years.

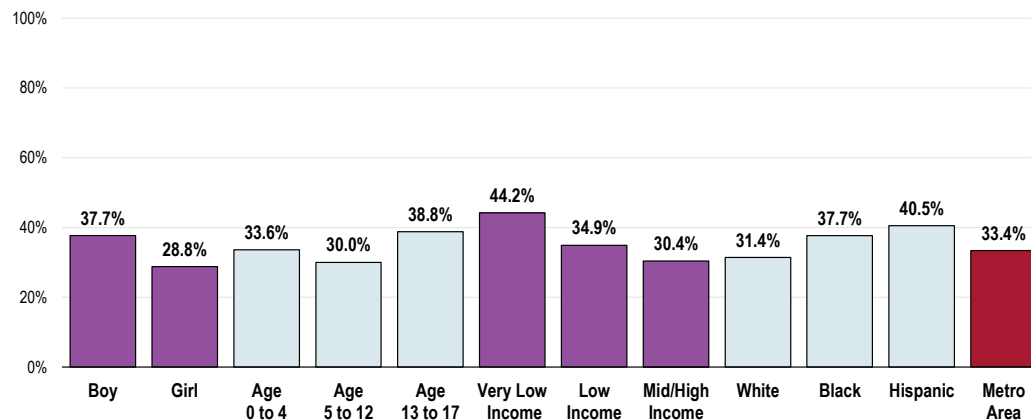
Child Needed a Specialist in the Past Year (Metro Area, 2018)



Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 28]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

- Boys, teens, and those living in very low-income households are more likely to have needed to see a specialist in the past year.

Child Needed a Specialist in the Past Year (Metro Area, 2018)



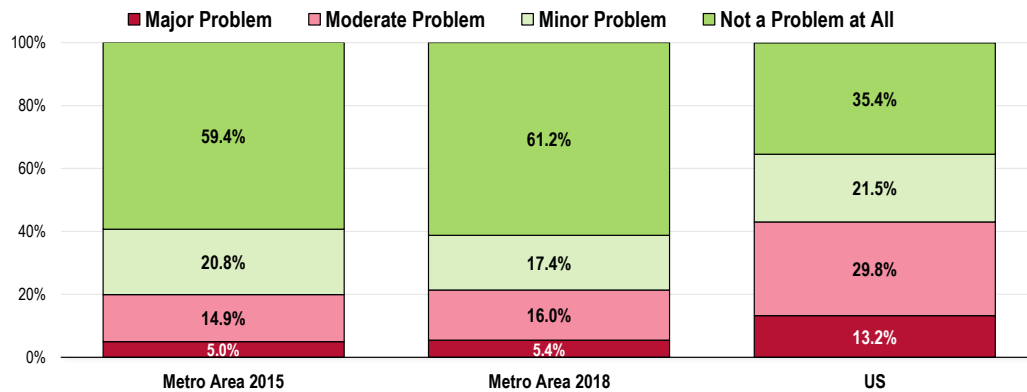
Sources: • 2018 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 28]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects 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% FPL; "Low Income" includes households with incomes between 100% and 199% FPL; "Mid/High Income" includes households with incomes at 200% or more of the FPL.

Parents of children needing specialty medical care in the past year were further asked to evaluate the difficulty of getting the needed care. Over one-third (38.8%) expressed some level of difficulty, characterizing it as a “major,” “moderate,” or “minor problem.”

- In particular, 16.0% of these parents had “moderate problems” getting their child’s specialty care, and 5.4% had “major problems.”
- “Major/moderate problem” responses in Metro Area are notably lower than US findings.
- By county, there is statistically no difference in the prevalence of “major/moderate problem” responses (not shown).
- TREND: Since first measured in 2015, “major/moderate problem” ratings have not changed significantly in the Metro Area.

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, 2018)



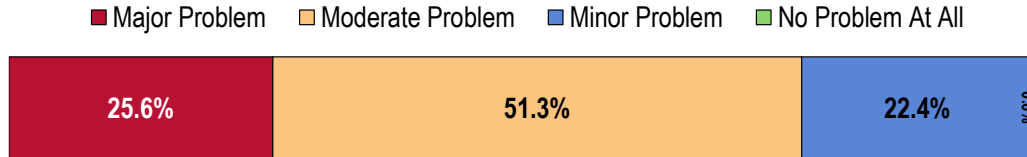
Source: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 29]
 • 2018 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of respondents for whom the randomly selected child in the household has needed to see a specialist in the past year.

Key Informant Input: Access to Health Services

Over half of key informants taking part in an online survey characterized **Access to Health Services** as a “moderate problem” for children/adolescents in the community.

Perceptions of Access to Health Services as a Problem for Children/Adolescents in the Community (Key Informants, 2018)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents about a randomly selected child in the household.

Top Concerns

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

Affordable Care/Services

People struggle with access to affordable health care. They aren't able to cover the cost of what is left as options for the ACA, and they may make just enough to not qualify for Medicaid. They may pay out-of-pocket for services at our clinic, since they trust their pediatrician, but it is a struggle. Or they don't have reliable transportation, and IntelliRide is not very helpful if you have more than one child. Or they have really high premiums and they don't want to bring their child in until they truly need to. - Other Health Provider

Availability of quality health care services that are affordable and linguistically/culturally appropriate for children from diverse backgrounds is limited. Additionally, accessing support for health care coverage enrollment for children, and their low-income parents for that matter, is also extremely limited. - Social Services Provider

Affordability and accessibility. If it takes a lot of time to see a doctor - families, teens, and children may not make the time/have the time and same with money. I also believe that better prevention for health issues should start in schools and continue on at after school programs and at home. - Community/Business Leader

Cost and accessing routine well-checks are the biggest challenges related to accessing health services for children and adolescents in my community. - Community/Business Leader

Cost. We see families who cannot afford the sliding scale fees, do not eat as healthy as they should due to cost, lack access and knowledge. - Community/Business Leader

The expense and lack of access. - Community/Business Leader

They can't pay for the services. - Community/Business Leader

Lack of Specialized Services

Access to inpatient psychiatric care is not adequate in our community to meet current needs. Also struggle with finding appropriate outpatient psychiatric/eating disorder programs, especially for boys. Struggle with children whose families make too much for Medicaid but do not have adequate resources to pay for appointments, hospitalizations, and medications. - Other Health Provider

We have access to services for regular health maintenance visits. However, access for specialty care like neurosurgery, neurology, nephrology behavioral health services have a long waiting list, and it is difficult to get appointments in a timely manner. - Other Health Provider

Spanish-speaking providers. Parents of children, adolescents feeling heard, understood, valued. - Community/Business Leader

Children and adolescents who need psychiatric services must wait months to be able to see a psychiatrist. This is unacceptable. - Community/Business Leader

Limited child, adolescent providers and lack of services offered in convenient locations, schools. - Other Health Provider

Medicaid providers, access in close proximity to families, hours of operations, and health literacy for families as it relates to access concerns. - Public Health Representative

Insurance Issues

Fractionated care, not all have insurance coverage, hours that are not helpful to working parents, lack of coordination and collaboration between health systems, lack of coordination and collaboration between schools and health systems, difficulty navigating health systems, limited providers in mental health, limited resources in youth violence and alcohol and drugs. – Physician

Access is limited for families without insurance and or a without a social security card. The Federally Qualified Health Centers are often their only option, but they ask for payment on a sliding scale. I feel families have limited options when a specialist is needed for their child. The FQHC will sometimes refer to specialists but it is still difficult to see these providers for long term management due to cost. Mental Health Care is totally not accessible for people in poverty and or without health insurance. The School Based Health Centers and schools offer preventive mental health services and limited counseling, but these services are needed by an overwhelming number of children and cost and access is limited. - Other Health Provider

The cost of insurance and the ability to gain transportation to sites where the services are free or on a sliding scale. - Community/Business Leader

Cost of care for those uninsured, available hours clinics are open, location of clinics to family homes. - Community/Business Leader

Lack of insurance coverage and lack of transportation. - Community/Business Leader

Hard for families to access specialist because of implementation of rules like you need to be seeing a PCP from the same institution. - Physician

Access to health insurance. - Community/Business Leader

Transportation

I feel there are very distinct differences in access to health care for individuals in north and south Omaha. This centers around transportation to physicians and/or having a specialist in various illnesses. The location and hours are also barriers. - Community/Business Leader

Transportation and open hours. Many of our families are single families or refugee/migrant families, and they have a hard time getting to an appointment, much less making one. We, as a school, have set up many appointments, etc. at the school so our families can get the services! - Community/Business Leader

Transportation and awareness. It's hard to get to some places without a car, and I think people don't even know which places they can go for basic preventative services. - Public Health Representative

Transportation, culturally competent professionals. - Community/Business Leader

Transportation. - Community/Business Leader

Transportation. - Community/Business Leader

Barriers to Care

How to get to the doctor, knowing when to go to doctor versus the ER, cost and lack of insurance. - Community/Business Leader

No readily available services in the community as major health care is either moved west or will not see patients unless they have insurance. - Other Health Provider

Hours and days, insurance, parental priority. - Community/Business Leader

Vulnerable Populations

Thousands of Omaha's children do not access health care through "traditional" means, due to barriers such as low health literacy/health awareness within parents, transportation, an inability to navigate our health systems, fear of connecting to an "institution" due to immigration status, cost, lack of insurance, etc. Access to care is a broad concept that have both demand and supply-side factors that need to be addressed. - Community/Business Leader

Our major health systems are often not ready to serve individuals of limited income and limited English proficiency in ways that are effective and create trust. - Public Health Representative

Major issue for the undocumented and the working poor. - Other Health Provider

Obesity

Pediatric obesity and pediatric mental illness, both of which require substantial behavior health interventions. - Other Health Provider

Parenting

Parental follow-through. Lack of understanding and priority of the parent/guardian to seek preventive care, especially from the primary care doctor. - Community/Business Leader

Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified **mental health care, dental care, substance abuse treatment, and specialty care** as the most difficult to access in the community.

Medical Care Difficult to Access Locally				
	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	64.5%	32.2%	3.6%	31
Dental Care	16.1%	19.4%	21.4%	17
Substance Abuse Treatment	6.5%	25.8%	17.9%	15
Specialty Care	3.2%	9.7%	28.6%	12
Primary Care	6.5%	6.5%	10.7%	7
Chronic Disease Care	3.2%	6.5%	3.6%	4
Prenatal Care	0.0%	0.0%	7.1%	2
Eating Disorders	0.0%	0.0%	3.6%	1
Vision Care	0.0%	0.0%	3.6%	1

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 Problems

211
Boys Town
Building Healthy Futures
Charles Drew Health Center
CHI Health
CHI-Immanuel Medical Center
Children's Health Insurance Program
Children's Hospital and Medical Center
Children's Physicians
Connections at Project Harmony
Creighton Dental School/Clinic
Douglas County
Douglas County Health Department
Families in Action
Federally Qualified Health Centers
Girls Inc.
Health Department
Health Systems
Heartland Family Services
Heartland Hope Mission
Hy-Vee
Kinship Cross Fit for Kids
Lutheran Family Services
Metro Area Transit (MAT)
Medicaid
Mobile Dental Services
NOAH Clinic
North Omaha Area Health Free Clinics
Omaha Healthy Start
OneWorld Community Health Center
Porto Medical Clinic
Project Harmony
SCHIP (State Children's Health Insurance Program)
School System
School-Based Health Centers
Sherwood Foundation

University of Nebraska Medical Center (UNMC)

Allergies

Air Nebraska
American Lung Association
Charles Drew Health Center
Children's Developmental Clinic (CDC)
Children's Hospital and Medical Center
Doctor's Offices
Douglas County
Federally Qualified Health Centers
Health Department
Healthy Kids Alliance
Midwest Asthma and Allergy Clinic
Omaha Food Allergy Support Group
Omaha Health Kids Alliance - OHKA
Omaha Treatment Center (OTC)
OneWorld Community Health Center
School System
School-Based Health Centers
University of Nebraska Medical Center (UNMC)

Asthma

Air Nebraska
Asthma Educators
Case Management for Managed Care Companies
Charles Drew Health Center
CHI Health
Children's Developmental Clinic (CDC)
Children's Hospital and Medical Center
Children's Physicians
Children's Specialty Pediatric Center (SPC)
City Planning
Doctor's Offices
Douglas County
Douglas County Health Department
Emergency Medical Services (EMS)

Family Support Workers
 Federally Qualified Health Centers
 Health Department
 Legal Aid
 Live Well Omaha
 Medicaid
 Omaha Health Kids Alliance (OHKA)
 OneWorld Community Health Center
 Project Air
 School System
 School-Based Health Centers
 University of Nebraska Medical Center (UNMC)
 US Department of Housing and Urban Development (HUD)

Cognitive and Behavioral Problems

1st Five Healthy Mental Development Program
 Arbor Family Counseling
 Area Education Association
 Autism Center of Nebraska
 Behaven Kids
 Behavioral Health Services
 Big Brother/Big Sister
 Boys and Girls Club
 Boys Town
 Brain Balance
 Bridge Church
 Buffett Early Childhood Institute
 Center for Holistic Development
 Charles Drew Health Center
 CHI Health
 CHI-Creighton
 CHI-Immanuel Medical Center
 Child and Family Resource Network
 Child Saving Institute
 Child Specialty Clinic Iowa
 Childhood Autism Services
 Children's Behavioral Health
 Children's Hospital and Medical Center
 Churches
 CMH Behavioral Health
 Collective for Youth
 Community Alliance
 Community Health Centers
 Completely KIDS
 Connections at Project Harmony
 Council Bluffs Preschool Program
 CRCC (Children's Respite Care Center)
 Cultural Liaisons

Daybreak
 DHHS (Department of Health and Human Services)
 Doctor's Offices
 Early Childhood Development
 Early Development Network
 Early Headstart
 Early Intervention Services
 ESUs (Education Service Units)
 Federally Qualified Health Centers
 Girls Inc.
 Green Hills Area Education Agency
 H & J Counseling
 Head Start
 Heartland Family Services
 Hope Center
 Kid Squad
 Legal Aid
 Living Hope
 Lutheran Family Services
 McDermott
 Medical Personnel
 Mental Health Services
 Mercy Psychiatric Associates
 MORE Program
 Munroe Meyer Institute
 Nebraska Department of Health and Human Services
 Nebraska Family Help Line
 Nebraska Medicine
 NorthStar Foundation
 Ollie Webb Center, Inc.
 Omaha Public Schools
 Omaha Refugee Health Collaborative
 Omni Center
 OneWorld Community Health Center
 Pediatric Therapy Center
 Private Community Resources
 Project Harmony
 Psychiatric Crisis Line
 Pediatric Therapy Center (PTC)
 PTI Nebraska (Parent Training and Information)
 Refugee Specialists
 Region 6
 Safe Harbor Crisis Line
 School System
 School-Based Health Centers
 Secular Community Groups
 Social Services

Spence Counseling Center
 Sylvan Learning Center
 University of Nebraska Medical Center (UNMC)
 Voices
 Westside Community Schools

Diabetes

American Diabetes Association
 Boys Town
 Charles Drew Health Center
 CHI Health
 Children's Endocrinology
 Children's HEROES Program
 Children's Hospital and Medical Center
 Children's Physicians
 Cooking Matters
 Doctor's Offices
 Food Pantry
 Healthy Families
 Juvenile Diabetes Research Foundation (JDRF)
 Methodist Health System
 Nebraska Department of Health and Human Services
 OneWorld Community Health Center
 School System
 School-Based Health Centers
 University of Nebraska Medical Center (UNMC)

Hearing and Vision Problems

Boys Town
 Building Healthy Futures
 Charles Drew Health Center
 Children's Hospital and Medical Center
 Children's Vision Collaborative
 Doctor's Offices
 Early Development Network
 Head Start
 Lion's Club
 Lutheran Family Services
 Nebraska Foundation for Children's Vision
 OneSight
 OneWorld Community Health Center
 School System
 School-Based Health Centers

Infant and Child Health

Adolescent Health Project
 Baby Blossoms Collaborative

Boys Town
 Buffett Early Childhood Institute
 Certified Nurse Midwives
 Charles Drew Health Center
 CHI Health
 Child and Family Resource Network
 Children's Hospital and Medical Center
 CityMatch
 County Clinic
 Doctor's Offices
 Douglas County
 Douglas County Health Department
 Early Childhood Services
 Essential Pregnancy Services (EPS)
 FAMILY, Inc.
 Federally Qualified Health Centers
 Fetal Infant Mortality Review Board
 Girls Inc.
 Healthy Families
 Heartland Family Services
 Hospitals
 Immunization Task Force
 Kindred Hearts
 Lutheran Family Services
 Lydia House and Bethlehem House
 Methodist Health System
 MilkWorks
 Nebraska Breastfeeding Coalition
 Nebraska Children's Home Society
 Nebraska Medicine
 Nebraska Perinatal Quality Improvement Collaborative
 Omaha Healthy Start
 Omaha Police Department
 OneWorld Community Health Center
 Planned Parenthood
 Pottawattamie County WIC
 Safe Sleep Nebraska
 School-Based Health Centers
 Southwest Iowa Breastfeeding Coalition
 Visiting Nurses Association

Injury and Violence

After School Programs
 Big Brother/Big Sister
 Boys and Girls Club
 Boys Town
 Catholic Charities
 Center for Holistic Development
 Center for Women's Advancement

Charles Drew Health Center
 CHI-Immanuel Medical Center
 Child Saving Institute
 Children's Child Advocacy Team
 Children's Hospital and Medical Center
 Children's Square
 City of Omaha
 City of Omaha's Vision Zero Taskforce
 City Planning
 CMS (Centers for Medicare & Medicaid Services)
 Community Development Organizations
 Community Policing
 Completely KIDS
 Connections at Project Harmony
 CRCC (Children's Respite Care Center)
 DHHS (Department of Health and Human Services)
 Doctor's Offices
 Domestic Violence Resource Centers
 Douglas County Community Response Resource Group
 Dusk to Dawn
 Faith-Based Organizations
 FAMILY, Inc.
 Federally Qualified Health Centers
 Girls Inc.
 Health Systems
 Healthy Families
 Heartland Family Services
 Home Health Services
 Immigrant Legal Center/Justice for our Neighbors
 Impact One
 Law Enforcement
 Live Well Omaha
 Lutheran Family Services
 Mental Health Services
 Methodist Community Counseling
 Nebraska Department of Health and Human Services
 Neighborhood Associations
 NorthStar Foundation
 Omaha 360
 Omaha Parks and Recreation
 Omaha Police Department
 Omaha Public Schools
 Omaha Refugee Task Force
 OneWorld Community Health Center
 Operation Youth Success (OYS)
 Partners With Kids

Poison Control
 Project Harmony
 Promise Partners Prevent Child Abuse Committee
 Region 6
 Religious Community Centers
 SAFEKIDS Coalition
 School System
 Social Services
 SOVIP (South Omaha Violence Intervention and Prevention)
 Spence Counseling Center
 State Agencies
 Step Up Omaha
 Stephen's Center
 The Accountable Health Community
 The Kim Foundation
 THRIVE
 Trauma Centers
 Trauma Matters Omaha
 Urban League
 Visiting Nurses Association
 Women's Center for Advancement
 Women's Shelters

Mental Health Issues

1st Five Healthy Mental Development Program
 Arbor Family
 Behaven Kids
 Behavioral Health Education Center of Nebraska
 Behavioral Health Services
 Boys and Girls Club
 Boys Town (BT)
 Bryan High School
 Building Healthy Futures
 Catholic Charities
 Center for Healing and Hope
 Center for Holistic Development
 Charles Drew Health Center
 CHI Behavioral Health Services
 CHI Health
 CHI-Creighton
 CHI-Immanuel Medical Center
 Child Saving Institute
 Children's Behavioral Health
 Children's Hospital and Medical Center
 Children's Physicians
 Children's Psychiatry
 Children's Society

Children's Square
 Churches
 CMH Behavioral Health
 Community Alliance
 Community Health Improvement Plan
 Completely KIDS
 Connections at Project Harmony
 Court-Ordered Therapy and Counseling
 CRCC (Children's Respite Care Center)
 Daybreak
 Doctor's Offices
 Douglas County Health Department
 Early Childhood Care and Education
 Early Headstart
 Family and Friends
 Federally Qualified Health Centers
 Full Circle Therapy
 Grief's Journey
 H & J Counseling
 Health Systems
 Heartland Family Services
 Horizon Therapy Group
 Hospitals
 Integrated Primary Care and Behavioral Health Services
 Lasting Hope Recovery Center
 Learning Community Centers
 Lift Up Sarpy
 Lutheran Family Services
 McDermott
 Mental Health Services
 Mercy
 Mercy Psychiatric Associates
 Methodist Health System
 Munroe Meyer Institute
 Nebraska Children's Home Society
 Nebraska Department of Health and Human Services
 Nebraska Medicine
 Omaha Integrative Care
 Omaha Public Schools
 Omaha Refugee Task Force
 Omni Center
 OneWorld Community Health Center
 Porto Medical Clinic
 Project Harmony
 Refugee Specialists
 Region 6
 SCHIP (State Children's Health Insurance Program)

School System
 School-Based Health Centers
 Social Services
 Southwest IA Mental Health and Disability Services Region
 Spence Counseling Center
 Stephen's Center
 Tele-Psychiatry
 The Kim Foundation
 Transitional Services
 University of Nebraska Medical Center (UNMC) Behavioral Health Education Center of Nebraska (BHECN)
 University of Nebraska Medical Center (UNMC) Psychiatry
 Westside Community Schools

Neurological Problems

Boys and Girls Club
 Boys Town
 Children's Hospital and Medical Center
 Children's Physicians
 Doctor's Offices
 Girls Inc.

Nutrition, Physical Activity, and Weight

Action for Healthy Kids
 After School Programs
 Alegent Health
 Backpack Programs
 Boys and Girls Club
 Boys Scouts of America and Girl Scouts USA
 Boys Town
 Brain Blasters
 CACFP (Child and Adult Care Food Program)
 Charles Drew Health Center
 Children's Behavioral Health
 Children's HEROES Program
 Children's Hospital and Medical Center
 Children's Programs
 Churches
 City Planning
 Community Gardens
 Cooking Matters
 Coordinated School Health
 Doctor's Offices
 Douglas County Health Department
 Douglas County WIC Program
 Families in Action
 Family and Friends

Farmer's Markets
 Federally Qualified Health Centers
 Food Bank of the Heartland
 Food Pantry
 Fuel Up to Play 60
 Girls Club
 Girls Inc.
 Go NAPSACC
 Gretchen Swanson Center for Nutrition
 Grocery Stores
 Gyms
 HALOS Program
 Head Start
 Health Advisory Committee
 Healthy Families
 Healthy Neighborhood Stores
 Healthy Self With Larry Waters
 Heartland Family Services
 HMC Pantry
 Hope Center
 Hospitals
 Hy-Vee
 Kroc Center
 League/Club Sports
 Live Well Omaha
 Lutheran Family Services
 MilkWorks
 Nebraska Department of Health and Human Services
 Nebraska Extension Office
 No More Empty Pots
 NorthStar Foundation
 Nutrition Services
 Omaha Parks and Recreation
 Omaha Public Schools
 OneWorld Community Health Center
 PACE (Police Athletics for Community Engagement)
 Parks and Recreation
 Project ECHO
 REACH
 Sarpy/Cass Health Department
 Maternity/Child Health Program
 Sarpy/Douglas Department of Health and Wellness
 School System
 School-Based Health Centers
 Soup Kitchens
 Stephen's Center
 The Accountable Health Community
 The Big Garden

Training Programs Teaching Healthy Lifestyles
 United Way
 UNL Extension
 UNO (University of Nebraska- Omaha)
 Visiting Nurses Association
 Volunteering/Mentoring in Youth Centers
 Weight Watchers
 WELLCOM
 WIC

Oral Health/Dental Care

AllCare Health Center
 Anding Family Dental
 Building Healthy Futures
 Charles Drew Health Center
 CHI-Creighton
 Children's Dentistry of Council Bluffs
 Creighton Dental School/Clinic
 Dentist's Offices
 Doctor's Offices
 FAMILY, Inc.
 Federally Qualified Health Centers
 Head Start
 Heart Ministry
 HMC Dental Clinic
 I Smile Dental Program
 Managed Care
 MARTI Interpreter System
 Medicaid
 Medicare
 Mobile Dental Services
 OneWorld Community Health Center
 Sarpy/Douglas Department of Health and Wellness
 Small Smiles
 Tooth Mobile
 University of Nebraska Medical Center (UNMC) Dental Clinic

Sexual Health

AAA Pregnancy Services
 Adolescent Health Project
 Assure Women's Center
 Boys Town
 Brenda's Council Program for STD Prevention
 Charles Drew Health Center
 CHI Health
 Children's Hospital and Medical Center
 Children's Physicians

Community Alliance
 Community Health Centers
 Condom Distribution Throughout the City
 Council Bluffs Health Department
 Doctor's Offices
 Douglas County
 Douglas County Health Center
 Douglas County Health Department
 Douglas County Health Department - STD Clinic
 Family and Friends
 Federally Qualified Health Centers
 Girls Inc.
 Health Care
 Health Department
 Health Systems
 Home Health Services
 Libraries
 Lutheran Family Services
 Methodist Women's Adolescent Gynecology
 Metro Community College
 Nebraska AIDS Project (NAP)
 Nebraska AIDS Project
 Nebraska Children's Home Society
 Nebraska Medicine
 NOAH Clinic
 Non-Profits
 Omaha Public Schools
 OneWorld Community Health Center
 Planned Parenthood
 Project Harmony
 School System
 School-Based Health Centers
 Teen and Youth Advocacy
 University of Nebraska Medical Center (UNMC)
 Women's Center of Omaha

Churches
 Criminal Justice System
 Doctor's Offices
 Douglas County
 Douglas County Health Center
 Douglas County Health Department
 Drug Rehab Programs
 ENCAP (Eastern Nebraska Community Action Partnership)
 Heartland Family Services
 Hospitals
 Inroads Counseling
 Lasting Hope Recovery Center
 Lutheran Family Services
 Mental Health Services
 Metro Omaha Tobacco Action Coalition (MOTAC)
 Nebraska Department of Health and Human Services
 Nebraska Quit Now
 Nebraska Urban Indian Health Coalition
 Nova
 OneWorld Community Health Center
 Porto Medical Clinic
 Programs With Dually Licensed Staff
 Project Extra Mile
 Region 6
 School System
 Standard Treatment Centers
 Substance Abuse Counselors
 Tobacco Alliance Group

Substance Abuse

AA/NA
 Addiction and Behavioral Health Services
 American Cancer Society
 Arbor Family
 Boys Town
 Catholic Charities
 Center for Holistic Development
 Charles Drew Health Center
 CHI-Immanuel Medical Center
 Children's Developmental Clinic (CDC)
 Children's Hospital and Medical Center

Appendix



Professional Research Consultants, Inc.

Evaluation of Implementation Plan

2016-2018 Implementation Plan highlights focus on hospital-based programs and services, community-based programs and partnerships, and the development of the Center for the Child & Community to serve as the infrastructure for community outreach activities.

Children's Center for the Child & Community is a statewide community outreach hub of Children's Hospital & Medical Center. The Center for the Child & Community was launched in 2016 to serve as the infrastructure leading both internal and external partnerships around the Pediatric Community Health Needs Assessment planning and implementation.

ACCESS TO HEALTH SERVICES

Strategy #1: Increase appointment availability for families seeking pediatric primary care.

- Children's Physicians continues to focus on its "Never Say No" policy to accommodate families needing same-day appointments. Every Children's Physicians office offers extended hours.
- Relocated the Children's Physicians offices at Creighton to provide more space to accommodate more patient visits in 2017. Opened Children's Physicians, Fremont office in August 2017 and the Kearney office in July 2018. Plans are underway to relocate Spring Valley in Fall 2019 or early 2020.
- Held two walk-in sports physical clinics in August 2017. Conducted more than 200 sports physicals in those two days. Held four walk-in sports physical clinics in July/August 2018 (two locations each day). Conducted more than 280 in those two days.
- Implemented more evening clinic hours, as well as walk-in flu vaccine clinics every Saturday at each office for the 2017 and 2018 flu seasons.
- Children's Physicians, UNMC hired a dedicated provider to handle walk-in visits every day.
- Expanded walk-in availability at Children's Physicians, Plattsmouth office in June 2018.
- In 2018, the Care Transitions team (social work and nurse case managers) began tracking interventions with patients and their families across the entire Children's continuum.
- Nurse case management expanded to cover Eagle Run and West Village Pointe offices with existing staff in May 2018.

Strategy #2: Implement a pediatric specialist recruitment plan.

- Completed a pediatric specialist recruitment plan. In 2018, monthly scheduled updates between physician recruitment and specialty operations team have increased communication and led to smoother transitions.
- Implemented extended appointment hours within Children's outpatient specialty clinics to incorporate early morning, day, evening and/or weekend times: 2016 for Infusion Services; 2017 for Gastroenterology, Hematology/Oncology, Orthopedics, Endocrinology, Urology, Sleep Lab. Further expanded hours for Infusion.
- In April 2018, outpatient clinics in Children's Specialty Pediatric Center started 12-hour days, three days per week
- Added rotating specialty services to the Spring Ridge location in the summer of 2016. In 2018, five specialties now provide services there.
- Added Cardiology specialty services full-time in Sioux City in December 2016.
- Opened the expanded Lincoln Specialty Clinic in October 2017 to provide 10 specialty clinics and triple the capacity of the old location. Additional specialties offered with this expansion include child advocacy, GI, Genetics, ID as well as the following services: cardiac and pulmonary diagnostics, x-ray, ultrasound and lab draws. In 2018, services grew to include 15 specialty clinics and added dietitian services.
- In 2017, Children's specialty clinics reported 108,917 specialty billed visits, which is a 7 percent increase over 2016.
- Children's Specialty Physicians teams hired a consultant (Huron) in 2018 to increase efficiencies within outpatient specialty clinic throughput and scheduling processes, including focusing on early morning and evening visit times to accommodate busy families.

Strategy #3: Explore options to help reduce misuse of emergency department services

- Opened additional Urgent Care facility at Dundee in March 2017
- Educated families on when to use emergency room services versus urgent care services through our website and Just Kids publication in the summer of 2017, via doctor chats on local radio stations, and added content to patient brochures.
- Created handout of when to use ED versus UC and gave to all case managers to use – resulting in a 5 percent reduction in ED visits among Children's Physicians patients from offices with nursing case managers. Added messaging on Facebook, resulting in 388 shares.
- Installed case management and social work functions in Emergency Department to facilitate direction to a patient-centered medical home.
- Hired a Director of Care Transitions to oversee case management and social work functions throughout the organization, including Emergency.

- The Care Transitions and Children's Physicians teams worked with United Health Care to explore interventions to reduce high utilization of Emergency Departments by families via Social work and nurse case management in 2018.

Strategy #4: Implement virtual visits

- Scheduled as part of Phase II launch: 1,614 virtual care visits performed as of November 2018, including 1,560 Behavioral Health visits, 10 Children's Physicians ADHD follow-up visits, 7 post-operative visits, 3 tele-lactation visits, 6 virtual rounding visits at Ambassador and 3 tele-medicine follow up visits through Children's Specialty Pediatric Clinic in Lincoln.
- Conducted a gap analysis in October 2018 and presented to Children's executive leadership. Revised strategic plan for virtual presented to executive leadership in December 2018. Will revise strategic plan and operational support for 2019.

Strategy #5: Improve access to pediatric health services for Spanish-speaking families

- In 2016, hired live interpreter at Children's Physicians, Creighton University location.
- In 2017, Children's Physicians placed full-time Spanish interpreters at its Creighton University, Spring Valley and UNMC locations.
- Children's Physicians, Fremont clinic opened in August 2017 with two Spanish-speaking interpreter staff members.
- Creighton relocation completed in February 2017 and Spring Valley relocation underway to serve high number of Spanish-speaking patients/families.

INJURY PREVENTION & VIOLENCE

Strategy #1: Expand Period of PURPLE Crying education into more hospitals statewide.

- Working to identify new hospital sites statewide.
- Working with the Nebraska Department of Health and Human Services to develop a campaign about abusive head trauma to bring about a change in attitudes and behaviors about normal infant crying.

Strategy #2: Provide free helmets and head trauma/brain injury education at events and locations.

- All events were held in 2016-2018, with helmets, and bike safety education and helmet fitting provided.
- 2018 marked the first year of combining education and free helmets at the annual Healthy Kids Day in April. Each child and parent received a brief educational offering prior to receiving a helmet. Helmets and education provided during Healthy Kids Day, West Village Pointe Open House, Wellness Fair and other events in 2018.

- Total of 1,901 children received free helmets and bike safety education in 2017 at community events (e.g., Omaha Public Schools resource fair, Omaha Police Department Safety Fest, Ponca Tribe Health Fair, etc.). This was an increase of 25 percent from 2016.

Strategy #3: Increase reach of child passenger safety seat checks.

- Children's Injury Prevention team provided 500 car seat checks in Children's fitting station in 2017 and increased its later hours of operation. Children's provided another 509 car seat checks at community events, and gave out 228 safe car seats to families.
- To expand reach, Children's actively promoted and explored increasing the number of community fitting stations with community partners. The Nebraska Department of Transportation and Omaha Fire have begun car seat fitting checks, and Wellcare Medicaid office now has new car seat technicians available.
- Children's added car seat information into the admission questions so that the discharge planning for safe car ride can be more efficient and timely.
- Optimized inpatient processes by working with nursing staff to identify patients through Epic earlier than discharge to better accommodate families' needs.
 - Checked car seats for 40 children leaving inpatient areas since the implementation of EPIC consult capabilities.
 - Added 7 new child passenger safety technicians for Children's, bringing the organization-wide total to 22.

Strategy #4: Promote water safety/drowning prevention in the Omaha metro area.

- Children's promoted water safety/drowning prevention through a partnership with the Joshua Collingsworth Memorial Foundation and Omaha Parks & Recreation. This initiative recognized a 24 percent reduction of total lifeguard rescues after life vest education was provided to all Omaha public pools.
- Used grant funding to purchase life vests. Visited all 18 Omaha public pools to provide life-vest education with Josh the Otter educational presentations.

Strategy #5: Provide education on home safety, specifically falls and poisonings.

- In 2016, held educational outreach sessions in high schools for students, counselors and teachers, as well as in day cares and community events where families were present. This partnership completed its goals for 2016 – reaching 2,146 individuals and developed two press releases.
- In 2017, Safe Kids Douglas County, led by Children's, continued to support the Nebraska Poison Control Center with distribution of press releases, promoting drug take back days and event partnership at Baby Love, Omaha's semi-annual baby fair

- Home safety outreach education efforts implemented through Parenting U and Lamaze birthing class opportunities. In 2017, Children's also provided education via social media on medication safety and how to prevent poisoning in the home.

Strategy #6: Provide the highest quality of trauma care to injured and abused children.

- In 2017, 652 patients received trauma services through Children's (sustained volume from 2016).
- Children's continues to provide the region's only Level II Pediatric Trauma Center.
- One new trauma outreach initiative launched statewide has been Project Austin, a program that prepares rural hospitals and EMS providers to develop an emergency plan for each child and to have skill and knowledge training for the care of a medically complex child in their community. Through 2017, 211 children in a four-state region have been served by this program.

MENTAL HEALTH

Strategy #1: Expand Behavioral Health's use of Children's Virtual Visit.

- Established 6 hub sites (5 in Nebraska and 1 in Iowa). At inception (September 2015), treated 6 patients via Virtual Visit. Increased virtual visits to accommodate 992 patients through 2016.
- Children's Behavioral Health expanded use of Virtual Visit services, improving access to care. More than 1,000 patients were seen in 2017 due to the additional access hub sites. This is projected to eclipse 2,000 patients in 2018. Added two new Children's Physicians sites for Virtual Visit (Fremont and Council Bluffs). Also added Virtual Visit services for psychiatry to a clinic in Beatrice, Nebraska. Launched psychology visits for patients with chronic medical condition and psychological comorbidities.
- Established Virtual Visit service for HEROES weight-management clinic patients in July 2016. Treated 3 patients in the first month and 56 patients throughout 2016. This is established, yet flexes weekly due to changes in provider availability.

Strategy #2: Integrate Behavioral Health care within specialty clinics and primary care offices.

- Children's expanded behavioral health service into all Children's Physicians primary care offices, resulting in more than 200 new patients. Children's also integrated behavioral health service into the Endocrinology FOCUS, Cystic Fibrosis and Ulcerative Colitis/Crohn's outpatient clinics, resulting in over 220 new patients.
 - These efforts and more allowed Children's Behavioral health providers to log approximately 22,149 patient visits in 2016, 22,619 in 2017 and project 23,522 in 2018. The 2018 number is a 4 percent increase over 2017.

- Children's Emergency Department/Short Stay Unit expansion plans called for an increase from one behavioral health room to six total. As of Nov. 2017, four behavioral health rooms in the new Short Stay Unit have been added.
- PATCH (Patient Assistance Team at Children's Hospital & Medical Center pilot program was launched in April 2018. PATCH creates specialized adaptive care plans for patients on the autism spectrum. More than 24 patients have been a part of the PATCH pilot program and all have had outstanding results. Program will roll out system-wide in 2019.

Strategy #3: Work with area schools to address preventative mental health practices.

- Children's continues to partner with Westside Schools to continue the Student Assistance Program—a school-based mental health service that connects district families with Children's behavioral health team. This program saw 156 student referrals from the district during the 2016-17 school year and 180 students in 2017-18 school year. For the 2018-2019 school year, student volumes have remained constant, and 8 hours were added on site clinical hours per week for the middle school.

Strategy #4: Be a catalyst for mental health collaboration in the community.

- A representative from Children's Behavioral Health serves on a community suicide coalition with the Kim Foundation. Two representatives from Children's participate in the Nebraska Association of Behavioral Health Organizations mental health advocacy group.
- Collaborated with the Kim Foundation to be a sponsor of the "13 Minutes" suicide awareness and prevention campaign (<http://www.thekimfoundation.org/13-minutes.html>).
- Co-hosted the 9th Annual Nebraska Child Health & Education Summit on Dec. 11, 2018 with multiple community partners. Keynote speaker addressed mental health prevention and policy best practices to a wide audience of education and health leaders across Nebraska. More than 100 individuals in attendance.

Strategy #5: Explore partnerships to train future mental health professionals.

- A representative from Children's Behavioral Health appointed as an inaugural member of the Children's Hospitals Association PLS Advisory Committee. This is a national committee of 10 children's hospitals addressing educational needs surrounding behavioral and mental knowledge for health care providers.
- Project ECHO Behavioral Health series, led by Children's Behavioral Health in collaboration with Children's Center for the Child & Community, launched in September 2018 to work with more than 70 physicians and community providers

statewide to improve access to, as well as quality of, behavioral health services within communities.

NUTRITION, PHYSICAL ACTIVITY & WEIGHT

Strategy #1: Create Children's Center for the Child & Community to promote health and childhood obesity prevention statewide.

- Foster local and state partnerships (University of Nebraska Medical Center (UNMC) College of Public Health, Nebraska Department of Health and Human Services (DHHS), Live Well Omaha Kids, University of Nebraska Lincoln (UNL) Extension) to enhance current and future prevention initiatives.
 - Launched in March 2016, Children's Center is a formal University of Nebraska partner with the opening of the dedicated space at Nebraska Innovation Campus.
 - Building Health Futures, Boys Town and Children's Center are partnering on the 2018 Pediatric Community Health Needs Assessment (P-CHNA). The Center will lead both internal and external partnership work around the P-CHNA planning and implementation.
 - The Childhood Obesity Learning Collaborative with UNMC College of Public Health, UNL Clinical Psychology and Gretchen Swanson Center for Nutrition, provides training and evaluation support for the Preventing Childhood Obesity Grants, working with community-based organizations serving children most affected by the obesity epidemic.
 - A partnership with DHHS is ongoing with the Go NAP SACC initiative. Go NAP SACC stands for Nutrition and Physical Activity Self-Assessment for Child Care. Formalized a partnership with UNL Extension and Nebraska Department of Agriculture to collaborate on the Supplemental Nutrition Assistance Program (SNAP) Double-UP Food Bucks program addressing food insecurity in Lincoln and Omaha pilots.
 - Center staff have secured a leadership role with the Prosper Lincoln early childhood initiative to be the conveners for the Early Childhood Comprehensive Health Mobilizing for Action through Planning and Partnerships (MAPP) Project.
 - Other notable partnerships the Center is developing further: YMCAs in Lincoln; UNL Children, Youth and Families Department and Building Healthy Futures (Omaha).
 - In 2017, Children's reached more than 150,786 children through programming focused on improving nutrition and physical activity.

- Define & Enhance a Continuum of Care Model for Childhood Obesity Prevention & Treatment.
 - The Continuum of Care Model is a priority, and progress has been made in developing educational/training opportunities for community stakeholders and providers. Project ECHO launched in October 2017, and 15 sessions were held to address childhood obesity. 2018 sessions focused on mental health.
 - Children's Center has secured a partnership with Lincoln YMCA to develop and pilot the ENERGY Playbook, a group fitness class designed for children who are overweight or obese. UNMC College of Public Health and University of Nebraska Omaha are partnering on the development and evaluation of the Playbook. The pilot launched in January 2018.
 - Six learning sessions were held with the 10 Preventing Childhood Obesity grant project teams to build their organizational capacity around childhood obesity prevention.

Strategy #2: Engage and invest in community organizations and individuals to impact more children and establish broad, collaborative approach.

- Award \$250,000 in annual grants to non-profit partners to support programs dedicated to preventing childhood obesity. Children's awarded grants totaling \$225,000 in 2016 with an additional \$25,000 invested toward evaluation analysis to increase the grant program's impact and sustainability. In 2017, awarded 10 grants to community non-profit organizations. Each partner received \$25,000 to implement its program from July 2017 – December 2018. The Center for the Child & Community regularly meets with partners to improve program execution and evaluation.
- Awarded annual, renewable \$1,000 scholarships to five college-bound high school students from the metro area that plan to pursue a career that improves the health status of children. Children's awarded five, renewable \$1,000 scholarships in 2016, and five more at the June awards presentation in 2017.

Strategy #3: Champion healthy eating and fitness education through the Healthy Kohl's Kids partnership with Kohl's department stores.

- Plan and execute school outreach and community events that promote healthy nutrition and physical activity.
 - Healthy Kohl's Kids outreach events reached 36,501 children in 2016. In 2017, Children's was awarded a \$160,000, two-year Kohl's Cares grant to expand GoNoodle into Lancaster County, targeting 76 schools and more than 25,000 kids by the end of the 2018-19 school year. With this change in direction, the Healthy Kohl's Kids program (funded by previous Kohl's grants) ended in August 2017.

- Promote health messages via Healthy Kohl's Kids website, social media content and paid media campaign. Children's continued to promote health messages via web, social media and advertising in 2016, and promoted the GoNoodle expansion to Lancaster County in 2017-18.

Strategy #4: Sponsor GoNoodle online resource to bring physical activity into area classrooms and homes.

- Sponsor GoNoodle program for schools, teachers and families throughout the Omaha metro area.
- Children's GoNoodle sponsorship continued in 2016, reaching 143,449 children in area schools. With the Kohl's Cares grant for 2017-18, the sponsorship expanded to Lancaster County.
- Promote resource via internal channels, social media and twice-annual e-newsletters to school leaders. GoNoodle messaging was shared through internal and external communication channels throughout 2016, 2017 and 2018.

Strategy #5: Continue programs for weight management, including bariatric surgery, for clinically obese children and teens.

- Offer intervention, education, lifestyle modification and clinical and behavioral support for youth and families struggling with obesity in both Omaha and Lincoln clinics. In 2017, Children's HEROES pediatric weight management clinic treated 621 unique patients, including 78 new patients. These patients made 1,668 visits to clinic, which is 14 percent increase over 2016.

Strategy #6: Offer at least one Parenting U session per year centered on childhood obesity prevention.

- Children's offered a full schedule of Parenting U classes in 2016, with a course on Oct. 2, 2016 specifically focused on Healthy Nutrition for Toddlers. Classes continued into 2017-18, with the same nutrition-focused session taught on Oct. 1, 2017 and Oct. 23, 2018.

Strategy #7: Promote childhood obesity prevention education across Children's communication channels.

- Children's continues to communicate its strategic focus on childhood obesity prevention via various channels, including paid TV and radio placements, social media, multiple publications and websites.

ORAL HEALTH

Strategy #1: Partner with Children's Physicians primary care providers to address oral health with the parent population.

- Incorporated discussion regarding oral health and importance of regular dentist during 12-month and 24-month well-check visit.
- Added oral health content in newborn book distributed to parents of infant patients.

Strategy #2: Provide education to parents about the importance of pediatric oral health.

- Included annual content in Just Kids publication (e.g., "Mind Your Mouth" – Spring 2017)
- Provided Parenting U educational session on oral health annually.
- Provided oral health information annually within social media strategies.

Strategy #3: Continue to provide space within Children's Specialty Pediatric Center for the UNMC College of Dentistry to treat children throughout the area with oral health needs

- Space provided throughout 2016 and currently.

VISION, HEARING & SPEECH CONDITIONS

Strategy #1: Partner with Children's Physicians primary care providers to improve vision care for children.

- Test for vision issues at every 3-year well-check and refer 100 percent of patients with an abnormal result to a vision specialist.
- Test for hearing issues at every 4-year well-check visit and refer patients with abnormal results to the appropriate specialist.

Strategy #2: Provide education to parents about the importance of pediatric hearing and vision testing.

- Include annual content in Just Kids publication. (e.g., "How Loud is It" - Spring 2017 and "A Closer Look: When should children receive vision exams, and is the school exam enough" – Fall 2017)
- Provide hearing and vision information annually on Facebook. (e.g., August 2017 video on how to safely view the solar eclipse and an article on mobile vision van and September 2017 video on smart phone-compatible hearing aids that are available through Children's Audiology department)

Strategy #3: Increase the reach of Children's Ophthalmology Clinic.

- In 2016, Children's Ophthalmology Clinic saw 5,990 visits, a 40 percent increase over 2015.

- In 2017, Children's Ophthalmology Clinic saw 5012 unique patients who made 5,722 visits. There were 937 new patients seen.

Strategy #4: Serve as a catalyst for access to vision care/education in the community.

- Children's Visionmobile mobile vision unit, began serving Omaha Public Schools (OPS) students in late summer 2018, providing comprehensive eye exams and prescription/dispensing of glasses.
- Through November 2018, Visionmobile visited 10 schools and provided a comprehensive eye exam for 389 students. Of the children screened, 218 received glasses. The program team includes a full-time optometrist, an optician, optic technician and care coordinator.
- School vision screening partnership with Omaha Public Schools and five local Colleges of Nursing and Allied Health and Interdisciplinary studies initiated by Building Healthy Futures has continued under the Ophthalmology Department's new Children's vision screening coordinator in the 2018-2019 school session. In the fall of 2018, the vision screening teams have screened 9,395 OPS students, resulting in 3,674 referrals for a comprehensive eye exam.
- The Child Vision Collaboration's first reconvening with a joint leadership of OPS and Children's effort is planned in late December 2018.

ASTHMA & OTHER RESPIRATORY CONDITIONS

Strategy #1: Partner with Children's Physicians primary care providers to better manage patients diagnosed with asthma.

- Worked with patients and families to ensure patients who have been diagnosed with asthma receive an annual asthma evaluation.
- Worked with patients and families to ensure patients who have been diagnosed with asthma have a written asthma management plan for both home and school.
- Developed asthma outpatient pathway committee in February 2018. In the fall of 2018, they completed and implemented an outpatient acute exacerbation pathway. Their next efforts will be to develop an outpatient chronic management pathway.

Strategy #2: Implement Healthy Planet Asthma Project

- Worked across the continuum of care with the goal of reducing emergency room visits and hospital admissions due to asthma.

- Implemented electronic health record improvements to enable better tracking of patients diagnosed with asthma. Placed a dedicated asthma case manager throughout the outpatient specialty clinics to better manage patient care. Revised patient materials to standardize across the entire continuum of care, so asthma patients receive consistent messaging throughout Children's. Implemented the electronic registry and editing for accuracy. Work flow is in place. Refinement of the asthma metrics utilizing the asthma registry in EPIC continued through 2018 with multiple measures developed.
- Since November 2017, QI project with the Emergency Department and Pulmonology has been in place, with the goal of identifying children who have used the Emergency Department three or more times within 12 months. 96 children were identified. 41 children scheduled appointments for follow up with the pulmonology team (respiratory therapist reviews and educates, with social worker/nurse case manager assisting with follow up and barriers). Seventy-five percent of the children attended the clinic appointment.

Strategy #3: Partner with Omaha Healthy Kids Alliance on Project Air to asthma-proof homes of selected children who have severe cases of asthma.

- Provided grant dollars to assist with project.
- Selected patients for partnership to assist with the project. This began January 1, 2017. As of October 27, 2017, 18 patients enrolled in the program. Sixteen are from Children's Physicians and two through the outpatient Pulmonology department. Four cases are complete, 2 are in progress, 4 new referrals are pending and 8 have been lost to follow-up. Through 2018, 20 patients have been referred. 11 patient interventions are on-going or completed by Omaha Healthy Kids Alliance.

SEXUAL HEALTH

Strategy #1: Partner with The Women's Fund of Omaha to help combat epidemic infection rates of gonorrhea and chlamydia among adolescents in the greater Omaha metro area.

- A representative from Children's serves on the Women's Fund Board of Directors.
- Provided education to Children's providers about issues and treatment options related to adolescent sexual health (nurses in January 2017 and physicians in April 2017).
- Children's Physicians' offices incorporated sexual health education and testing as part of teen well-check visits; this protocol was first piloted in 5 offices and then rolled out to all offices in the fall 2017. As of December 2017, all Children's Physicians' offices utilize a risk behavior screening questionnaire during well visits ages 15-21 (individual providers may utilize this questionnaire at other visits they deem appropriate as well).

- All Children's Physicians offices located in Douglas, Sarpy and Cass counties provide free testing to patients for gonorrhea and chlamydia funded through the Women's Grant. Since December 2017, more than 1,500 chlamydia/gonorrhea tests have been ordered from Children's Physicians clinics. Of these, 1,149 of the test (76 percent) have been funded by the Adolescent Health Project through the Women's fund of Omaha. Participation in the grant has increase sexually transmitted infection testing in Children's Physicians offices by almost 900 tests a year compared to lab volumes prior to participation.
- Sexually transmitted infection (STI) algorithm of orders and documentation for screening, testing and treating for STIs are now easily available and utilized within the electronic health record system.

Strategy #2: Provide education to parents and adolescents regarding topics related to sexuality and sexual health

- Included annual content in Just Kids publication (e.g., "HPV Vaccine: What You Need to Know" – Fall 2016)
- Promoted annual content via Children's Facebook platform.

Strategy #3: Serve as a catalyst for adolescent sexual health care/education in the community.

- Identify appropriate community partners and organizations. Joined the adolescent Health Project and are actively participating in all training, implementation and reporting efforts of this project.
- Exploring more collaborative opportunities to improve access to sexual health care/education for underserved populations.

SUBSTANCE ABUSE

Children's did not address the Substance Abuse health priority identified through the CHNA process and has limited resources and services available to specifically address alcohol, tobacco and drug use in adolescents. Other community organizations have infrastructure and programs in place to more effectively meet this need. For these reasons, we've excluded this as an area chosen for action.

Children's regularly surveys adolescent patients and their families about these issues in our primary care offices and directs them to other community resources (e.g. substance abuse counseling/rehab services offered by Boys Town, Lasting Hope Recovery Center and private providers) as needed. In the hospital setting, Children's providers observe a specific triage protocol for patients with a substance abuse-related medical issue/diagnosis. The protocol helps to delineate the level of concern, and often involves Children's Behavioral Health team. Children's provides necessary medical care and refers patients to community partners and agencies for more comprehensive intervention.