2012 PRC
Child & Adolescent
Community Health
Needs Assessment

DOUGLAS & SARPY COUNTIES, NEBRASKA
POTTAWATTAMIE COUNTY, IOWA

Sponsored by

BOYS TOWN
National Research Hospital

Children's Hospital & Medical Center

Professional Research Consultants, Inc.
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INTRODUCTION
Project Overview

Project Goals

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

Methodology

PRC Community Health Survey

Survey Instrument

The final survey instrument used for this study was developed by Boys Town National Research Hospital, Children’s Hospital & Medical Center, and PRC.

Community Defined for This Assessment

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

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

The sample design used for this effort consisted of a stratified random sample of 902 parents of children under 18 in the Metro Area (701 conducted via landline telephone or cell phone, and 201 collected through online surveys). By geography, a total of 626 surveys were conducted in Douglas County, 158 in Sarpy County and 118 in Pottawattamie County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Metro Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 902 respondents is ±3.3% at the 95 percent level of confidence. By county: the maximum error rate is ±4.0% for Douglas County results, ±6.9% for Sarpy County, and ±9.8% for Pottawattamie County.

![Expected Error Ranges for a Sample of 902 Respondents at the 95 Percent Level of Confidence](image)

**Expected Error Ranges for a Sample of 902 Respondents at the 95 Percent Level of Confidence**

<table>
<thead>
<tr>
<th>County-Level Maximum Error:</th>
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<tr>
<td>Douglas County: ±4.0%</td>
</tr>
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<td>Sarpy County: ±6.9%</td>
</tr>
<tr>
<td>Pottawattamie County: ±9.8%</td>
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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 902 respondents answered a certain question with a “yes,” it can be asserted that between 8.0% and 12.0% (10% ± 2.0%) of the total population would offer this response.
- If 50% of respondents said “yes,” one could be certain with a 95 percent level of confidence that between 46.7% and 53.3% (50% ± 3.3%) of the total population would respond “yes” if asked this question.

Sample Characteristics

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

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

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the 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 2012 guidelines place the poverty threshold for a family of four at $23,050 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of Metro Area children and adolescents with a high degree of confidence.
Key Informant Focus Groups

As part of the community health needs assessment process, there were five focus groups held February 29 to March 1, 2012. The participants in these focus groups included 46 key informants, including physicians, other health professionals, social service providers, business leaders, and other community leaders with input and expertise regarding the community’s youth.

A list of recommended participants for the focus groups was provided by the sponsors of this study. 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. Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

Focus group candidates were first contacted by letter to request their participation. Follow-up phone calls were then made to ascertain whether or not they would be able to attend. Confirmation calls were placed the day before the groups were scheduled to insure a reasonable turnout.

Audio from the focus groups sessions was recorded, from which verbatim comments in this report are taken. There are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

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

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community 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
- GeoLytics Demographic Estimates & Projections
- National Center for Health Statistics
- Iowa Department of Public Health
- Nebraska Department of Health Services
- statehealthfacts.org
- countyhealthrankings.org
- US Census Bureau
- US Department of Health and Human Services

Note that secondary data are compared to state and national data where available.
Certain indicators in this assessment relate to national disease prevention and health promotion goals established by 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.

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 persons, or those 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 members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses. In particular, it is recognized that little data are available specific to the Native American population (although this group is included in the survey findings in a representative proportion).

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

The following “health priorities” represent recommended areas of intervention, based on the information gathered through this Child & Adolescent Community Health Needs Assessment. From these data, opportunities for health improvement exist in the region with regard to the following health areas:

Access to Healthcare

One out of five Metro Area families reports difficulties or delays in accessing healthcare services for their child in the past year.

- A total of 20.9% of Metro Area parents report some type of difficulty or delay in obtaining healthcare services for their child in the past year.
- Of the tested barriers, inconvenient office hours impacted the greatest share of Metro Area respondents (12.1% say that inconvenient office hours prevented them from taking a child for medical care in the past year).

Other related survey findings:

- A total of 7.6% of Metro Area parents do not have a particular place for their child’s medical care (“medical home”).
- A total of 35.2% of Metro Area children/adolescents have gone to a hospital emergency room, urgent care, Quick Care or walk-in clinic in the past year.
  - Note that 71.2% of parents whose child received urgent or emergency care in the past year acknowledge that the injury or illness might have been treatable in a doctor’s office or clinic.

Access to healthcare services was identified among focus group participants as one of the Top 5 key health concerns for Metro Area children and adolescents.

- When asked to write down what they individually perceive as the top five health priorities for the community based on the group discussion as well as on their own experiences and perceptions, responses related to accessing healthcare services ranked #3 overall among key informant focus group participants.
- Some of the key issues discussed in the key informant focus groups: barriers to healthcare services (geography, uninsured and under-insured families, cost, transportation, office hours, culture, homeless children); a need to meet families where they live, work, and play; and availability of specialists and technology.
- Mentioned resources available to help address this issue: local hospitals; urgent care centers; school-based clinics; Creighton University Pediatric Clinic; University of Nebraska Medical Center Pediatric Clinic; Nebraska health departments; Medicaid; faith-based organizations.
Key informants believe that barriers to healthcare access remain considerable hurdles for parents in the Metro Area. For example, in focus group discussions, participants mentioned a lack of facilities in the northern region:

“The Omaha community has grown west, so they built hospitals out there. University has one, Methodist has one, Alegent has one; brand new, nice, beautiful hospitals, but in north Omaha all the hospitals and clinics have closed down.” — Douglas County Social Service Provider

Asthma

A total of 8.7% of school-age children in the Metro Area currently have asthma.

Other related survey findings:

- Metro Area asthma prevalence is particularly high in:
  - African American children (25.9%).
  - Northeast Omaha (19.4%).
- Among children/adolescents with asthma:
  - 12.2% had 3+ urgent/emergent care visits in the past year due to asthma.
  - 11.8% had 2 overnight hospitalizations due to asthma.
  - 16.7% do not have an asthma action plan in place.

A total of 20.9% of children with asthma missed three or more school days in the past year due to their asthma.

- In addition, 34.6% of parents with asthmatic children missed at least one day of work in the past year because of the child’s asthma.

Injury & Safety

In the Metro Area, unintentional injury is the number-one leading cause of death of children and adolescents past the age of one year.

Related Metro Area survey findings included:

- A total of 15.1% of area children were injured seriously enough to require treatment at some point in the past year.
  - Among these children, 22.6% were seriously injured more than once.
- Among survey respondents, 10.2% consider their neighborhood to be “slightly” or “not at all” safe from crime.
- In their own homes, 19.2% of respondents do not always feel safe.
  - Highest (28.1%) in Northeast Omaha.
- Among children 5-17 who ride bicycles, 40.3% wear helmets; among those riding skateboards, scooters, skates and rollerblades, only 27.1% wear helmets.
- When asked about a series of behavioral concerns that some adolescents and families face, respondents expressed the greatest concern about bullying (17.3% say this is a serious concern they have for their own child).
Many focus group participants are concerned about injury and violence in the community.

- The main issues discussed included firearms and the impact of trauma on children.

Desensitization to trauma was a concern to some focus group members, as was the disparity of crime in different regions of the Metro Area. Note the following:

“One of the things that really irritates me is you’ll see in the news, let’s say some teen in west Omaha has a car wreck. Right away the news media says there will be grief counselors at the school, but in north Omaha there’s a school lockdown because there was a shooting outside the school and the grade school kids are there to experience it and have to walk past that bloody spot on the sidewalk where the person was shot, and grief counselors are hardly ever mentioned... There was a doctor that said, ‘Well it seems like these kids got used to it.’ How do you get used to it?”— Douglas County Social Service Provider

**Mental Health**

Mental health issues received the fourth-highest mention among surveyed parents when asked to identify what they see as the number-one health issue affecting adolescents in the Metro Area.

- Many respondents identified mental health issues (including mental disorders and conditions such as ADHD) as the top health issue affecting adolescents in the community (mentioned by 9.0%, the fourth highest response).

Other related survey findings among school-aged Metro Area children:

- 21.9% of Metro Area parents report that their school-aged child worries a lot.
- 10.2% of Metro Area parents report that their school-aged child has difficulties falling asleep and/or sleeping through the night.
- 2.0% of Metro Area parents indicate that their school-aged child felt so sad or hopeless almost every day for two weeks or more that he/she stopped doing some usual activities.

Mental health was most often identified among focus group participants as the top health concern for Metro Area children and adolescents.

- The main issues discussed include: access; shortage of child psychiatrists; stigma; and over-medicating.

- Mentioned resources available to address this issue: social service agencies; Immanuel Medical Center; Lutheran Family Services; Creighton University & Medical Center; Boys Town National Research Hospital; Children’s Hospital and Medical Center; University of Nebraska Medical Center; law enforcement; Douglas County Health Department; Heartland Family Services; Women’s Center for Advancement; Council Bluffs Community Health Center; OneWorld Community Health Center; Charles Drew Community Health Center; Eastern Nebraska Community Action Partnership; Building Bright Futures; Children’s Square; Family Connection.
Focus group participants cited mental health as a leading issue in the quest for healthy youth in the Metro Area. As one participant reported:

“Our counselors would tell you in our high schools that there are kids with suicidal thoughts or even attempts every week. It happens. And that’s not unusual. That would be true in every high school in the metro area, more so in some than others.” Sarpy County Participant

Obesity & Nutrition

Three out of 10 school-age children/adolescents in the Metro Area are overweight or obese.

- Based on the heights/weights reported by surveyed parents, 30.2% of Metro Area children age 5 to 17 are overweight or obese (≥85th percentile). More specifically, 17.1% of Metro Area children age 5 to 17 are obese (≥95th percentile).

Other related survey findings among parents of school-aged Metro Area children include the following:

- A total of 19.9% of parents acknowledge that their child had three or more meals from “fast food” restaurants in the past week.
- Less than one-half (46.4%) of Metro Area parents reports that their child eats five or more servings of fruits and/or vegetables per day.

Obesity was most often identified among surveyed parents as the number-one health issue affecting both children and adolescents in the Metro Area.

- Obesity received the largest share of responses (38.8%) when respondents were asked to name the number-one health issue among children under the age of 12.
- In addition, obesity received the largest share of responses (26.2%) when respondents were asked to name the number-one health issue among adolescents.

Obesity/nutrition was identified among focus group participants as one of the Top 5 key health concerns for Metro Area children and adolescents.

- When asked to write down what they individually perceive as the top five health priorities for the community based on the group discussion as well as on their own experiences and perceptions, responses related to obesity and nutrition ranked #4 overall among key informant focus group participants.
- Key issues related to obesity and nutrition discussed in the focus groups: food deserts; fast food establishments; nutrition and cooking education; and hunger.
- Mentioned resources available to help address this issue: YMCA; YWCA; local schools; Boys & Girls Club; Girls Inc.; private healthcare providers; OneWorld Community Health Center; Charles Drew Community Health Center; Omaha Public Schools; the food bank; Live Well Omaha; HEROES Program; Healthy Families Program; after-school programs; recreation centers; WIC program; local hospitals.
A relevant focus group comment:

“I really think to effectively treat the obesity epidemic you’ve got to start educating these families when the kids are less than a year of age and starting to set the groundwork for the understanding of good choices. We’ve also got to promote home-cooked meals, which goes back to most of these young adults don’t know how to cook.” — Douglas County Physician

Sexual Activity

Douglas County in particular experiences exceptionally high rates of sexually transmitted diseases, such as chlamydia trachomatis.

- The Douglas County chlamydia rate (545.1) is dramatically higher than state (303.0) and US rates (405.3).
- Of the 3,063 total chlamydia cases reported in Douglas County in 2011, a full 31.0% were among adolescents age 15-19 (an additional 1.4% were in younger children, age 10-14).

Sexually transmitted diseases (STDs) received the third-highest mention among surveyed parents when asked to identify what they see as the number-one health issue affecting adolescents in the Metro Area.

- STDs received 10.3% of responses among parents when asked to name the number-one health issue among adolescents (ranking third overall after obesity and substance abuse).

Other related survey findings:

- When asked about a series of behavioral concerns that some adolescents and families face, 6.3% of respondents said that sexual activity is a serious concern they have for their own child.

Sexually transmitted infections/sexual health was identified among focus group participants as one of the Top 5 key health concerns for Metro Area children and adolescents.

- When asked to write down what they individually perceive as the top five health priorities for the community based on the group discussion as well as on their own experiences and perceptions, responses related to sexually transmitted infection and sexual health ranked #5 overall among key informant focus group participants.
- The main issues included: epidemic proportions of sexually transmitted diseases (STDs); access to sexual education and reproductive services; and victims of sexual abuse or assault.
- Mentioned resources available to help address this issue: Planned Parenthood; Girls Inc.; Douglas County Health Department; private healthcare providers; University of Nebraska Medical Center - College of Public Health; Nebraska AIDS Project; OneWorld Community Health Center; Charles Drew Community Health Center.
One local physician noted:

“The sexual risk behaviors have to be in my mind number one because a lot of kids’ lives are changed forever by choices that they make. I’ve never seen them change positively. So I think that that’s a real issue. Again the community’s had such a hard problem trying to even deal with this issue.” — Douglas County Physician

**Substance Abuse**

Substance abuse received the second-highest mention among surveyed parents when asked to identify what they see as the number-one health issue affecting adolescents in the Metro Area.

- When respondents were asked to name the number-one health issue among adolescents, references to alcohol and drugs received 17.1% of responses, second only to the health issue of obesity.

Substance abuse was identified among focus group participants as one of the Top 5 key health concerns for Metro Area children and adolescents.

- When asked to write down what they individually perceive as the top five health priorities for the community based on the group discussion as well as on their own experiences and perceptions, responses related to substance abuse ranked #2 overall among key informant focus group participants.

- The main issues discussed surrounding substance abuse included: limited treatment facilities; effects of substance abuse; and parental knowledge/complicity.

- Mentioned resources available to help address this issue: local hospitals; group homes; NOVA Treatment Community; Catholic Social Services; Lutheran Family Services; Alcoholics Anonymous; Region VI; faith-based organizations; Coalition for the Prevention of Drug Abuse; PRIDE Omaha; Sarpy/Cass Health Department; Tobacco Free Sarpy; DARE; Gang Resistance Education And Training (GREAT) program; law enforcement; Bellevue Medical Center; Sarpy County drug court; Addiction and Behavioral Health Services, Inc.; Midlands Hospital.

One participant noted:

“And what happens to a child who is caught with drugs or drug paraphernalia: they’re immediately suspended. They have to go through an alcohol counseling and awareness class before they can reenter. It can take up to 10 days. Most of the kids, not all, but some of those kids are already absent very frequently; they’re already behind. That child is not going to finish. Then they’re depressed, back to using drugs. So if we don’t start thinking about an over-addicted society and the availability of drugs from all various standpoints, I think we’re going see a lot of trouble. And a lot of kids are self-medicating, which is scary.” — Douglas County Community Leader
PERCEPTIONS OF HEALTH ISSUES
**Top Health Issues for Children**

Obesity received the largest share of responses (38.8%) when respondents were asked to name the number-one health issue among children under the age of 12.

- Respondents also frequently identified colds/flu (15.6%) as the number-one health issue affecting children, followed by nutrition (7.1%), exercise (4.6%), abuse or neglect (3.8%) and access to healthcare (3.8%).
- Note that 113 parents were uncertain or could not identify a health issue and are not included in the following chart.

**Perceived Number-One Health Issue Affecting Children Under 12 in the Community**
(Metro Area, 2012)

Next, respondents were asked the following:

“For that issue, do you feel existing community resources or services are more than sufficient, sufficient, insufficient or not available?”

**Perception of Existing Community Resources or Services for Number-One Health Issue Affecting Children Under 12**
(By Perceived Primary Health Issue; Metro Area, 2012)

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents. Does not include respondents who were uncertain or could not give an answer.
Top Health Issues for Adolescents

Similarly, obesity received the largest share of responses (26.2%) when respondents were asked to name the number-one health issue among adolescents.

- Respondents also frequently identified alcohol and drugs (mentioned by 17.1%), sexually transmitted diseases (10.3%). and mental health issues (9.0%).
- Note that 171 parents were uncertain or could not give an answer.

Perceived Number-One Health Issue Affecting Teens (13-19) in the Community
(Metro Area, 2012)

Respondents who mention obesity, substance abuse, or mental health as the number-one adolescent health issues largely see community resources as insufficient (or nonexistent) to address these problems.

Perception of Existing Community Resources or Services for Number-One Health Issue Affecting Teens
(By Perceived Primary Health Issue; Metro Area, 2012)
HEALTH STATUS
Physical Health

Evaluations of Child’s Overall Health Status

Most Metro Area parents rate their child’s overall health as “excellent” (56.5%) or “very good” (30.0%).

- Another 10.2% gave “good” ratings of their child’s overall health.

**Child’s Health Status**
(Metro Area, 2012)

- Excellent: 56.5%
- Very Good: 30.0%
- Good: 10.2%
- Fair: 2.9%
- Poor: 0.3%

**However, 3.2% of Metro Area parents believe that their child’s overall health is “fair” or “poor.”**

- In Douglas County, lowest (most favorable) in Northwest Omaha.
- No significant difference between Douglas, Sarpy and Pottawattamie counties.

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

NOTE:
- Differences noted in the text represent significant differences determined through statistical testing.
- Where sample sizes permit, community-level data are provided.
No statistical difference to report when viewed by child’s demographic characteristics.

**Child Experiences “Fair” or “Poor” Overall Health**
(Metro Area, 2012)

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<th>Low Income</th>
<th>Mid/High Income</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
<th>Metro Area</th>
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<tbody>
<tr>
<td>Boy</td>
<td>3.1%</td>
<td>3.4%</td>
<td>4.7%</td>
<td>2.1%</td>
<td>3.6%</td>
<td>1.9%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Girl</td>
<td>6.5%</td>
<td>3.9%</td>
<td>3.2%</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 13]

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. “Low Income” includes households with incomes up to 200% of the federal poverty level. “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

---

**Days of Poor Health in the Past Month**

According to Metro Area parents, just over one-half (51.3%) of children in the community did not experience any days of poor physical health in the past month.

- In contrast, 16.5% of children had **one day** of poor physical health in the past month, while 11.9% had **two days** and 20.3% of parents report that their child had **3+ days** of poor physical health in the past month.

**Number of Days When Child’s Physical Health Was Not Good in the Past Month**
(Metro Area, 2012)

- None 51.3%
- One 16.5%
- Two 11.9%
- 3+ days 20.3%

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 14]

Notes: ● Asked of all respondents about a randomly-selected child in the household.
In Douglas County, children more likely to experience 3+ days of poor physical health in the past month were more often found in Northeast Omaha; on the other hand, Northwest Omaha parents were least like to report that their child experienced 3+ days of poor health last month.

No significant difference to report when viewed by county.

The following groups of children are more likely to have experienced 3+ days of poor physical health in the past month:

- Boys.
- Children under the age of 5.
- Hispanic children and those of “Other” races.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.
Mental Health

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 understanding of how the brain functions under normal conditions and in response to stressors, combined with knowledge of how the brain develops over time, has been essential to that progress. 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 women 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 among 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 Status

Most Metro Area parents (92.4%) report that their child’s mental health was good “most of the time” in the past month.

- Another 3.6% report that their child’s mental health was good “some of the time” in the past 30 days.
A total of 4.0% of Metro Area respondents, however, believe that their child’s mental health was good “little” or “none of the time” in the past month.

- In Douglas County: highest in Northeast Omaha; lowest in Northwest Omaha.
- By county: highest in Douglas County; lowest in Sarpy County.
Boys, children under 5 and teens are more likely to report experiencing good mental health “little/none of the time” than their demographic counterparts.

---

**Child Experienced Good Mental Health “Little/None of the Time” in the Past Month**

(Metro Area, 2012)

---

**Prevalence of Mental Health Issues**

**Anxiety/Worry**

When asked, a total of 21.9% of Metro Area parents report that their school-aged child worries a lot.

- In Douglas County, no significant difference to report by area.
- No difference when viewed by county.

**Child Worries a Lot**

(Metro Area Children Ages 5-17, 2012)
According to their parents, children of “Other” races are more likely to worry often, although it is important to keep in mind the relatively small sample size of school-aged children when making comparisons by race.

### Child Worries a Lot
(Metro Area Children Ages 5-17, 2012)

#### Difficulties Sleeping

A total of 10.2% of Metro Area parents report that their school-aged child has difficulties falling asleep and/or sleeping through the night.

- In Douglas County, no significant difference by area.
- Viewed by county, highest (least favorable) in Pottawattamie County.

### Child Has Difficulties Falling Asleep and/or Sleeping Through the Night
(Metro Area Children Ages 5-17, 2012)
Those school-aged children more likely to experience sleep difficulties include Whites and children of "Other" races.

Child Has Difficulties Falling Asleep and/or Sleeping Through the Night
(Metro Area Children Ages 5-17, 2012)

When asked, 11.1% of parents with school-aged children who have problems sleeping report that the problems are due to a chronic disease.

Sleeping Difficulties Are Due to a Chronic Illness
(Among Parents Whose School-Aged Child Has Sleep Difficulties; Metro Area, 2012)
Signs of Depression

A total of 2.0% of Metro Area parents indicate that their school-aged child felt so sad or hopeless almost every day for two weeks or more that he/she stopped doing some usual activities.

- Favorably low in Western Douglas County.
- No statistical difference when viewed by county.

**Child Felt Sad or Hopeless for Two or More Weeks in the Past Year and Stopped Performing Usual Activities**

(Metro Area Children Ages 5-17, 2012)

The prevalence of depression among school-aged Metro Area children is notably higher among:

- Teens.

**Child Felt Sad or Hopeless for Two or More Weeks in the Past Year and Stopped Performing Usual Activities**

(Metro Area Children Ages 5-17, 2012)

Sources:
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 89]

Notes:
- Asked of all respondents about a randomly selected child aged 5-17 in the household.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
- *Indicates a small sample size (<50) and should be kept in mind when making comparisons.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level. “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
More than one-half (53.0%) of Metro Area parents whose school-aged children exhibited signs of depression in the past year have not sought mental health services for the child.

**Sought Treatment for Depressed Child**  
(Among School-Aged Children With Feelings of Sadness/Hopelessness; Metro Area, 2012)

```
No 53.0%
Yes 47.0%
```

**Emotional Support**

The majority of Metro Area parents (93.6%) indicates that their school-aged child has 3+ friends or relatives on whom he/she could depend for help with emotional problems or feelings.

- On the other hand, 1.8% of parents report that their school-aged child has only one (or no) friend/relative for emotional support.

**Number of Close Friends or Relatives Who Would Help Child With Emotional Problems or Feelings if Needed**  
(Metro Area Children Ages 5-17, 2012)

```
None 0.6%
One 1.2%
Two 4.7%
Three/More 93.6%
```
• No statistical difference by area within Douglas County.
• No difference to report among the three counties.

Child Has Three or More Close Friends or Relatives for Support if Needed
(Metro Area Children Ages 5-17, 2012)

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>96.1%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>92.6%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>93.0%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>94.7%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>97.0%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>94.4%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>90.8%</td>
</tr>
<tr>
<td>Pottawattamie County</td>
<td>94.5%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

Awareness & Availability of Mental Health Services

Just over 2 in 3 (67.2%) Metro Area parents indicate that they’re aware of local community resources for mental health.

• Awareness does not vary significantly within Douglas County.
• Viewed by county, no significant difference to report.

Aware of Mental Health Resources in the Community

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>72.6%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>62.7%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>63.7%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>65.8%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>63.6%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>66.0%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>68.6%</td>
</tr>
<tr>
<td>Pottawattamie County</td>
<td>71.4%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>67.2%</td>
</tr>
</tbody>
</table>

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. (Item 91, 92)
Notes: Asked of all respondents about a randomly-selected child aged 5-17 in the household.

“If this child’s mental health got to a point where you felt he/she was at risk of hurting himself/herself or others, would you know where to go to get this help?”
If they were concerned that their children might be at risk for harming themselves or others, most Metro Area parents (86.2%) would know where to seek help.

- In Douglas County, awareness is highest in Northeast Omaha.
- Viewed by county, highest in Pottawattamie County.

Would Know Where to Seek Help if Child Was at Risk of Hurting Self or Others

When asked, most of these parents were likely to indicate that they would seek help at a **physician’s office** (mentioned by 51.2%) or **hospital** (28.0%). Specific hospitals mentioned with greater than 3% response share included **Boys Town National Research Hospital** (5.0%), **Children’s Hospital and Medical Center** (3.4%) and **Immanuel Medical Center** (3.4%).

Likely Place for Seeking Mental Health Services for At-Risk Child
(Metro Area Parents Who Know Where to Seek Mental Health Services, 2012)

Note that 43.0% of parents reported that their child has never needed mental health services. These children are not included in the following charts and data.
Among Metro Area parents who have needed mental health services for their child, 90.8% have been able to access these services.

- In Douglas County, highest in the Western region but unfavorably low in Northwest Omaha.
- By county, no significant differences to report.

### Have Been Able to Access Mental Health Services When Needed for Child
(Parents Who Have Needed Mental Health Services for Child; Metro Area, 2012)

![Chart showing percentage of parents able to access mental health services by county.]

<table>
<thead>
<tr>
<th>County</th>
<th>Access Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>95.0%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>90.0%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>84.3%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>94.9%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>97.3%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>91.2%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>87.8%</td>
</tr>
<tr>
<td>Pottawattamie County</td>
<td>94.8%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 81]
Notes: Asked of all respondents who have needed mental health services for their child.

When asked why they were unable to receive the necessary mental health services for their children, 48.5% of these parents had not tried and 19.7% were uncertain how to answer the inquiry.

However, 13.5% indicated that cost prevented them from obtaining the necessary mental health services for their child and 7.8% were denied services.

### Reason for Inability to Access Child’s Mental Health Services When Needed
(Among Parents Unable to Access Mental Health Services for Child; Metro Area, 2012)

![Pie chart showing reasons for inability to access mental health services.]

- Never Tried: 48.5%
- Uncertain: 19.7%
- Cost: 13.5%
- Was Denied: 7.8%
- Other: 3.3%
- Don’t Know Who to Call: 7.2%

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 82]
Notes: Asked of those respondents who have been unable to access mental health services for their child when needed.
Prescriptions for Mental Health

Among parents indicating that they were able to obtain mental health services for their children, 13.7% report that their child has taken prescribed medication for their mental health.

Note the positive correlation with age among Metro Area children.

Child Has Taken Prescribed Medications for Mental Health
(Among Parents Who Have Needed Child’s Mental Health Services; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>8.4</td>
<td>91.6</td>
</tr>
<tr>
<td>5-12</td>
<td>12.9</td>
<td>87.1</td>
</tr>
<tr>
<td>13-17</td>
<td>20.3</td>
<td>79.7</td>
</tr>
</tbody>
</table>

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 83]
Notes: ● Asked of those respondents who have needed mental health services for their child.

Related Focus Group Findings: Mental Health

Many focus group participants discussed mental health care in the community. The main issues discussed include:

- Access
- Shortage of child psychiatrists
- Stigma
- Over-medicating

Focus group members perceive mental health to be a serious health concern for children and adolescents in their community. Participants worry about the pervasiveness of suicidal inclinations that begin as early as elementary school as well as some parents’ denial about their child’s suicidal thoughts. A participant describes:

> I mean our counselors would tell you in our high schools that there are kids with suicidal thoughts or even attempts every week. It happens. And that’s not unusual. That would be true in every high school in the metro area, more so in some than others.” Sarpy County Participant

Throughout the focus groups, issues surrounding access to behavioral health services came up. The participants feel there are not enough mental health resources available for children and adolescents in the community. Similar to overall healthcare, accessing the appointments can be difficult for families who do not have transportation or who work multiple jobs.
"I don’t think the access is because we don’t have the providers, with the exception of the mental health stuff. Pediatric psych is the hardest referral for us to get." — Douglas County Physician

There is currently also a shortage of child psychiatrists and appointments may be scheduled for a date many months beyond the initial phone call. For children on Medicaid, accessing mental healthcare can be near impossible. Unprepared and ill-equipped parents are often left to manage the ill child. The number of inpatient hospital units has decreased in recent years as well, which means youth are often taken to the emergency room because there is no other option and then must wait for hours. Insurance coverage is limited and youth generally only receive inpatient care for a few days, barely enough time to move past the crisis stage. A participant recalls:

“Usually it’s 72 hours. And then the parent drives ‘em right back to the juvenile center and I go, ‘Well, did they give you any plan? A treatment plan?’ And sometimes they do but the parents can’t access that and they don’t know what to do with them and they bring the child back. And the child doesn’t need to be in the correctional system at all. They need mental health services.”
— Sarpy County Participant

Families also may face stigma when attempting to access services and this stigma may limit the ability, or willingness, for families to access behavioral healthcare services.

“There’s a stigma for mental health anyways, and it’s not being promoted at all, that only increases the stigma. You see a lot of billboards advertising the free healthcare. You don’t see anything advertising where there’s mental health services. Make it more commonplace and okay and acceptable to go.” — Pottawattamie County Participant

Participants also have concern about the phenomenon of over-medicating that may be occurring among young children and adolescents. These children are not forced to learn anger or stress management skills. The child’s coping mechanisms therefore are not developed. A participant explains:

“I also firmly believe that we are dealing with a highly overmedicated youth. I think that a lot of these kids are getting meds, and they’re getting strong meds, and then they’re getting even stronger meds, but they’re not being given the opportunity to learn behavior modification. I actually had one child tell me once, after he hit somebody, that he can’t control his anger because that’s the way God made him. Somewhere in the description of what his issues are, nobody has taught him how to cope with them, because if I’m not mistaken, traditionally God makes us screaming, naked, and bald.” — Pottawattamie County Participant
SPECIAL HEALTH NEEDS
Of the tested medical conditions, the most prevalent in the Metro Area were nasal/hay fever allergies (affecting 23.8% of children/adolescents) and other allergies (affecting 16.2%).

- More than one out of 10 Metro Area children/adolescents have speech or language problems (10.8% among children aged 1-17).
- Attention deficit/hyperactivity disorder (ADHD), asthma, developmental or learning delays, and orthopedic/skeletal problems affect 5%-10% of Metro Area children/adolescents.
- Note that less than one percent of Metro Area parents report that their child has suffered from or been diagnosed with mental retardation, sickle-cell anemia, spina bifida, diabetes and/or cancer.

In a follow-up inquiry, 6.3% of Metro Area parents noted that their child has been diagnosed with some type of condition or special health need other than the ones addressed specifically. Other special needs mentioned primarily included various mental and learning disorders.
Childhood Asthma

Prevalence

As noted previously, 8.7% of Metro Area children under age 18 currently have asthma.

- Statistically similar to national findings among children under 18.
- In Douglas County, unfavorably high in Northeast Omaha; lowest in Northwest Omaha and the Western Douglas region.
- No significant difference by county.

Child Currently Has Asthma

(Among Parents of Children Age 1-17; Metro Area, 2012)

Viewed by demographics, the asthma prevalence in the Metro Area children is highest among African American children.

Child Currently Has Asthma

(Metro Area, 2012)

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 141]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of respondents about a randomly selected child aged 1-17 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. “Low Income” includes households with incomes up to 200% of the federal poverty level. “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
Among Metro Area children with asthma, more than one-half (55.3%) did not experience any emergency or urgent care visits due to their asthma in the past year.

- On the other hand, 12.2% of asthmatic children in the Metro Area had 3+ asthma-related emergency medical visits over the past year.

### Number of Asthma-Related Emergent/Urgent Care Visits in the Past Year
(Parents of Children w/Asthma; Metro Area, 2012)

- Three/More: 12.2%
- Two: 10.8%
- One: 21.8%
- None: 55.3%

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 41]

**Notes:**
- Asked of all respondents about a randomly-selected child in the household who currently suffers from asthma.
- Emergency visits include trips to the emergency room, Urgent Care, Quick Care or a walk-in clinic for asthma in the past year.

Among Metro Area children with asthma, 15.3% were hospitalized overnight in the past year because of their asthma, including 11.8% who were hospitalized more than once.

### Number of Overnight Hospitalizations for Child’s Asthma in the Past Year
(Parents of Children w/Asthma; Metro Area, 2012)

- Two: 11.8%
- One: 3.5%
- None: 84.7%

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 42]

**Notes:**
- Asked of all respondents about a randomly-selected child in the household who currently suffers from asthma.
Among Metro Area school-aged children with asthma, most (62.1%) did not miss any school because of asthma-related problems in the past year.

- On the other hand, 20.9% of school-aged asthmatic children in the Metro Area missed 3+ school days because of their asthma in the past year.

**Number of Schooldays Missed in the Past Year Due to Asthma**
(Parents of School-Aged Children w/Asthma; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Days Missed</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>62.1%</td>
</tr>
<tr>
<td>One</td>
<td>12.6%</td>
</tr>
<tr>
<td>Two</td>
<td>4.4%</td>
</tr>
<tr>
<td>Three/More</td>
<td>20.9%</td>
</tr>
</tbody>
</table>

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 43]
Notes: Asked of all respondents about a randomly-selected, school-aged child in the household who currently suffers from asthma.

In a related issue, more than one-third (34.6%) of Metro Area parents with asthmatic children missed at least one day of work in the last year because of their child’s asthma.

**Number of Respondent Workdays Missed in the Past Year Due to Child’s Asthma**
(Parents of Children w/Asthma; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Days Missed</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>65.4%</td>
</tr>
<tr>
<td>One</td>
<td>11.7%</td>
</tr>
<tr>
<td>Two</td>
<td>8.2%</td>
</tr>
<tr>
<td>Three/More</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 44]
Notes: Asked of all respondents about a randomly-selected child in the household who currently suffers from asthma.
A total of 83.3% of Metro Area children with asthma have an action plan in place.

**Child With Asthma Has an Action Plan**  
(Parents of Children w/Asthma; Metro Area, 2012)

- Yes 83.3%
- No 16.7%

Sources: *2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc.*  
Notes: *Asked of all respondents about a randomly-selected child in the household who currently suffers from asthma.

Related Focus Group Findings: Chronic Disease & Environmental Health

All participants agree that chronic disease conditions exist in the community. Focus group participants discussed several chronic health conditions that persist in the community, including issues ranging from asthma and diabetes to lead poisoning and obesity.

Focus group members express great concern about environmental contaminants, like lead, second-hand smoke, and insect infestation. There is much concern about the high levels of lead found in homes in North and South Omaha, which can contribute to learning disabilities and other health conditions. A participant explains her concern for children in eastern Omaha:

“If you take a census map and your boundaries would be to the south Cummings, to the north 680, to the west say 72nd and to the river to the east, and you overlay that with three years of homicides, ’09, ’10, and ’11, you also then put in that that’s the site of the largest lead contaminated area in the country, maybe even in the world, that’s concentrated in that small area, and you put the number of children, approximately 28,000 children in those census tracks, you will get a good view of what our children are exposed to, the risk factors, because of lead, if you are exposed to lead, lead stays with you from the womb to the tomb and some of the behaviors that we know result from exposure to lead, has to do with low school achievement, criminal activity, depression, and on and on, all the things that we see that our kids are experiencing today.” — Douglas County Social Service Providers
Managing Children’s Special Health Needs

Among parents of Metro Area children with special needs (those reported to have any of the chronic disease conditions tested in the survey), **19.6% reported a need for particular specialists for the child**, while **15.5% mentioned a need for affordable healthcare**, and **9.5% have a need for help with the child’s allergies**.

- Other needs mentioned by parents included nutrition, education and equipment. Note that these data exclude the 15.8% of respondents who said “nothing.”

**Respondents’ Greatest Need for Child With Special Needs**  
(Parents of Children w/Special Needs; Metro Area, 2012)

With regard to the needs of parents with children having special needs, the largest share of responses was for classes or education (18.1%), followed by affordable healthcare (15.4%), support groups (8.7%) and time (8.7%).

- Other needs mentioned by these parents of children with special needs included financial help and insurance assistance. Note that these data exclude the 22.4% of respondents who said “nothing.”

**Respondents’ Greatest Need for Self When Helping to Care for Child With Special Needs**  
(Parents of Children w/Special Needs; Metro Area, 2012)
PRENATAL & INFANT 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)

In 2010, 25.9% of all Douglas County births did not receive prenatal care in the first trimester of pregnancy.

- More favorable than the Nebraska proportion but less favorable than the Iowa proportion.
- Fails to satisfy the Healthy People 2020 target (22.1% or lower).

**Lack of Prenatal Care in the First Trimester**
(Percentage of Live Births; Douglas County, 2010)

![Bar chart showing lack of prenatal care percentages for Douglas County, Nebraska, and Iowa.](chart)

- **Douglas County**: 25.9%
- **Nebraska**: 28.0%
- **Iowa**: 13.6%

Sources:
- statehealthfacts.org
- NE Department of Health Services.

Note:
- Numbers are a percentage of all live births within each population.
Lack of prenatal care has increased overall in Douglas County in the past several years, echoing the statewide trend.

**Lack of Prenatal Care in the First Trimester**

(Percentage of Live Births)

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>22.1%</td>
<td>22.1%</td>
<td>22.1%</td>
<td>22.1%</td>
<td>22.1%</td>
<td>22.1%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>15.7%</td>
<td>21.5%</td>
<td>24.5%</td>
<td>25.9%</td>
<td>26.2%</td>
<td>25.1%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>17.3%</td>
<td>24.7%</td>
<td>24.6%</td>
<td>26.8%</td>
<td>27.9%</td>
<td>28.0%</td>
<td>25.9%</td>
</tr>
</tbody>
</table>

Sources: ● NE Department of Health Services.

Note: ● Numbers are a percentage of all live births within each population.
Low-Weight Births

A total of 8.4% of 2010 Douglas County births were low-weight.

- Just above the state proportion.
- Similar to the national proportion.
- Fails to satisfy the Healthy People 2020 target (7.8% or lower).
- Highest in Douglas and Pottawattamie counties; lowest in Sarpy County.

The proportion of low-weight births has trended upward slightly in Douglas County over the past decade; the same can be said for both Nebraska and the US overall.

Low-Weight Births
(Percentage of Live Births)
CHILD & ADOLESCENT MORTALITY
Mortality Rates

Infant Mortality

In 2010, there was an annual average of 5.7 infant deaths per 1,000 live births in Douglas County.

- Higher than the Nebraska and Iowa rates.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.
- Highest in Douglas and Pottawattamie counties; lowest in Sarpy County.

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

Infant mortality rates have decreased in Douglas County over the past decade, echoing the trends reported for Nebraska and the US overall.

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births)
Children & Adolescents

Between 2006-2008, the Metro Area reported an annual average of 30.9 child deaths (age 1 to 4) per 100,000 population.

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

With regard to children age 5 to 9, the Metro Area crude death rate was 13.1 per 100,000 population (2004-2008 data).

- Comparable to the Nebraska rate but higher than the Iowa rate.
- Comparable to the national rate.
- Fails to satisfy the Healthy People 2020 goal of 12.3 deaths per 100,000 population.

Among Metro Area youth age 10 to 14, the 2006-2008 crude death rate was 18.1 per 100,000 population.

- More favorable than the Nebraska rate but higher than the Iowa rate.
- Less favorable than the national rate.
- Fails to satisfy the related Healthy People 2020 goal of 15.2 deaths per 100,000 population.

Among Metro Area teens (age 15 to 19), the 2006-2008 crude death rate was 61.3 per 100,000 population.

- More favorable than the Nebraska rate but higher than the Iowa rate.
- Similar to the national rate.
- Fails to satisfy the related Healthy People 2020 goal of 55.7 deaths per 100,000 population.

Child & Adolescent Mortality Rates by Age Group
(Annual Average Child Mortality per 100,000 Population; 2006-2008)

Sources: CDC WONDER Online Query System, Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2012.
Leading Causes of Child Deaths

The predominant cause of death between 1999-2008 for Metro Area children under one year of age was perinatal conditions (certain conditions occurring in the perinatal period, usually low birthweight, preterm birth, and complications of pregnancy, labor and delivery).

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

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

### Leading Causes of Child Deaths by Age Group

(Metro Area, 1999-2008)

<table>
<thead>
<tr>
<th>Omaha Metro Area</th>
<th>Under 1 Year</th>
<th>Ages 1 to 4</th>
<th>Ages 5 to 9</th>
<th>Ages 10 to 14</th>
<th>Ages 15 to 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number-One Leading Cause</td>
<td>Perinatal Conditions*</td>
<td>Accidents</td>
<td>Accidents</td>
<td>Accidents</td>
<td>Accidents (especially Motor Vehicle Crashes)</td>
</tr>
<tr>
<td>Number-Two Leading Cause</td>
<td>Congenital Conditions**</td>
<td>Homicide</td>
<td>Cancer</td>
<td>Cancer</td>
<td>Suicide</td>
</tr>
<tr>
<td>Number-Three Leading Cause</td>
<td>SIDS***</td>
<td>Cancer</td>
<td>n/a</td>
<td>n/a</td>
<td>Homicide</td>
</tr>
</tbody>
</table>

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2012.

Notes: ● Perinatal conditions include certain conditions occurring in the perinatal period, usually low birthweight, preterm birth, and complications of pregnancy, labor and delivery.
● Congenital conditions include congenital malformations, deformations and chromosomal abnormalities.
● SIDS is Sudden Infant Death Syndrome.

See also Injury & Safety in the Modifiable Health Risks section of this report.
MODIFIABLE HEALTH RISKS
Nutrition

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

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

- In Douglas County, no significant difference by sub-area.
- By county, most favorable in Douglas County and least favorable in Sarpy County.

**Child Has 5+ Servings of Fruits/Vegetables per Day**
(Metro Area, 2012)

---

Metro Area teenagers are reported to be less likely to get the recommended daily servings of fruits and vegetables.

**Child Has 5+ Servings of Fruits/Vegetables per Day**
(Metro Area, 2012)
Fast Food

While 26.5% of survey respondents report that their child had no “fast food” meals in the past week, a total of 19.9% of parents acknowledge that their child had three or more meals from “fast food” restaurants in the past week.

### Number of Fast Food Meals for Child in the Past Week
(Metro Area, 2012)

- None: 26.5%
- One: 32.9%
- Two: 20.7%
- Three/More: 19.9%

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 124]

**Notes:** Asked of all respondents about a randomly-selected child in the home.

- The prevalence of children who had at least 3 “fast food” meals in the past week does not vary significantly by sub-area in Douglas County.
- Viewed by county, no statistical differences to report.

### Child Ate 3+ Fast Food Meals in the Past Week

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 124]

**Notes:** Asked of all respondents about a randomly-selected child in the household.
The prevalence is highest among teenagers (age 13-17) in the Metro Area.

**Child Ate 3+ Fast Food Meals in the Past Week**
(Metro Area, 2012)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age Range</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
<th>Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boy</td>
<td>0 to 4</td>
<td>20.8%</td>
<td>19.1%</td>
<td>10.3%</td>
<td>19.0%</td>
<td>28.1%</td>
<td>23.6%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Girl</td>
<td>5 to 12</td>
<td>20.8%</td>
<td>19.1%</td>
<td>10.3%</td>
<td>19.0%</td>
<td>28.1%</td>
<td>23.6%</td>
<td>19.5%</td>
</tr>
<tr>
<td></td>
<td>13 to 17</td>
<td>20.8%</td>
<td>19.1%</td>
<td>10.3%</td>
<td>19.0%</td>
<td>28.1%</td>
<td>23.6%</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

**Related Focus Group Findings**

**Nutrition & Obesity**

Many focus group participants discussed nutrition and obesity. The main findings include:

- Food deserts
- Fast food establishments
- Nutrition and cooking education
- Hunger

Childhood obesity is a major concern for the community. Focus group participants worry that children are not receiving appropriate nutrition and the rise in the number of overweight and obese children is of primary concern. Poor eating habits stem from a variety of sources in the community. Participants describe many portions of the community as “food deserts.” In some neighborhoods, grocery stores are scarce, but convenience marts are abundant. These convenience marts may not sell produce or fresh food items, and represent the easy (if not only) choice for residents. One participant recalls:

“**Their idea of a family meal is carry-in pizza. There are parts of town where there’s no grocery store within walking distance that sells produce, and so you can walk in north Omaha for miles before you come to a grocery store where you can buy produce. That’s more expensive than to get the junk food.**” — Douglas County Physician

**Fast food establishments** are also a common choice as a quick and easy option. Many community residents are overscheduled and on the run, so fast food restaurants become the obvious choice. Focus group participants feel that eating three meals a day is unusual, as is the whole family sitting around the dinner table. One member notes:
“The parents are running so much they don’t have time for any of that. So drive through the drive-in quick, grab ’em something to shut ’em up and off we go type deal.” — Sarpy County Participant

Focus group participants believe nutrition and cooking classes would benefit community residents greatly because residents do not know how to cook healthy meals for their families. Cooking classes could occur in a variety of settings including grocery stores, schools, and social service agencies. A participant explains:

“I really think to effectively treat the obesity epidemic you’ve got to start educating these families when the kids are less than a year of age and starting to set the groundwork for the understanding of good choices. We’ve also got to promote home-cooked meals, which goes back to most of these young adults don’t know how to cook.” — Douglas County Physician

There is much concern about hunger in the Omaha metropolitan area. Participants feel that many area children may eat only one daily meal during the school week and that weekends remain questionable. Schools currently offer breakfast meal programs, but whether or not a child receives dinner is generally unknown. Current programs to combat hunger include a backpack program in which children receive additional food items for evenings and weekends. There is great collaboration occurring between local food banks and school districts, as one respondent describes:

“The food bank has the Kids Cafes, which I know a lot of places work with. As far as provision of healthy food, Kids Café, after school snack program, they have a backpack program, so I feel like there are some people working really hard on that, and then also the summer feeding. The concern for children who are in summer school when summer school ends they still have access to breakfast and lunch like they get every day through OPS. I feel like there’s some good work in that area, some good collaborations and people working together on food issues for children.” — Douglas County Social Service Provider
Physical Activity

Physical Activity Levels

In this instance:

- The term “moderate physical activity” includes 30 minutes of activity that does not make a child breathe hard, such as fast walking, slow bicycling, skating, or pushing a lawn mower.
- The term “vigorous physical activity,” includes exercise for 20 minutes that makes a child breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities.

Note that while 15.3% of area children age 2-17 did not get any moderate physical activity in the past week, 31.3% participated in moderate activity on six or seven days last week.

With regard to vigorous physical activity, 26.8% of children age 2-17 participated on six or seven days last week.

Average Days of Moderate or Vigorous Physical Activity for Child in the Past Week
(Metro Area Children 2-17, 2012)

<table>
<thead>
<tr>
<th>Days</th>
<th>Moderate Physical Activity</th>
<th>Vigorous Physical Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day</td>
<td>8.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>2 Days</td>
<td>4.6%</td>
<td>13.1%</td>
</tr>
<tr>
<td>3 Days</td>
<td>10.6%</td>
<td>14.4%</td>
</tr>
<tr>
<td>4 to 5 Days</td>
<td>21.3%</td>
<td>31.0%</td>
</tr>
<tr>
<td>6 to 7 Days</td>
<td>31.3%</td>
<td>26.8%</td>
</tr>
<tr>
<td>None</td>
<td>9.7%</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

Sources:
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 122-123]

Notes:
- Asked of parents about a randomly selected child age 2-17 at home.
- Vigorous activity occurs for at least 20 minutes (3 times weekly) and includes exercise which causes the child to breathe hard such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities.
- Moderate activity occurs for at least 30 minutes (5 times weekly) and includes exercise which does not make the child breathe hard, such as fast walking, slow bicycling, skating or pushing a lawn mower.
In the past month:

A total of 46.1% of Metro Area children/adolescents participated in moderate physical activity (5 times a week, 30 minutes at a time).

- In Douglas County, no difference by sub-area.
- Viewed by county, no statistical difference to report.

The prevalence is lowest among girls, teens and children in lower-income households in the Metro Area.
A total of 71.3% of Metro Area children/adolescents (2-17) participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- In Douglas County, highest in Northwest Omaha.
- No significant difference when viewed by county.

The prevalence is lowest among children age 2-4, teenagers, and particularly those living in lower-income households in the Metro Area.

**Child Participates in Vigorous Physical Activity**

(Metro Area, 2012)

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 161]
Notes: Asked of all respondents about a randomly selected child aged 2-17 in the household.

- Vigorous activity occurs for at least 20 minutes (3 times per week) and includes exercise which causes the child to breathe hard such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities.

---

"On how many of the past 7 days did this child exercise or participate in vigorous physical activity for at least 20 minutes that made him/her breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing or similar aerobic activities?"
Screen Time

Television Watching & Other Screen Time

Among children aged 5 through 17, 15.0% are reported to watch three or more hours of television per day; 12.8% are reported to spend three or more hours on other types of screen time for entertainment (video games, Internet, etc.).

Children’s Screen Time
(Among Parents of School-Aged Children; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Hours per Day of Television</th>
<th>None</th>
<th>1 Hour</th>
<th>2 Hours</th>
<th>3+ Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 Hour</td>
<td>19.3%</td>
<td>26.0%</td>
<td>35.5%</td>
<td>15.0%</td>
</tr>
<tr>
<td>1 Hour</td>
<td>9.9%</td>
<td>31.5%</td>
<td>22.6%</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

Hours per Day of Other Screen Time
(i.e., video games, computer/Internet entertainment)

<table>
<thead>
<tr>
<th>Hours per Day of Other Screen Time</th>
<th>None</th>
<th>1 Hour</th>
<th>2 Hours</th>
<th>3+ Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 Hour</td>
<td>31.5%</td>
<td>22.6%</td>
<td>35.5%</td>
<td>9.9%</td>
</tr>
<tr>
<td>1 Hour</td>
<td>15.0%</td>
<td>26.0%</td>
<td>35.5%</td>
<td>19.3%</td>
</tr>
<tr>
<td>2 Hours</td>
<td>12.8%</td>
<td>23.2%</td>
<td>1 Hour</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

Total Screen Time

Further, 42.6% of children aged 5 to 17 spend three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

- Similar to the prevalence reported nationally.
- Unfavorably high in Northeast Omaha; much lower in western Douglas County.
- Viewed by county, no significant differences to note.
- By age, a higher prevalence is reported by parents of Metro Area teens.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]
(Among Parents of Children Ages 5-17; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Age 5-12:</th>
<th>33.7%</th>
<th>Age 13-17:</th>
<th>58.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>56.4%</td>
<td>SE Omaha</td>
<td>43.0%</td>
</tr>
<tr>
<td>HW Omaha</td>
<td>41.5%</td>
<td>SW Omaha</td>
<td>32.5%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>29.0%</td>
<td>Douglas County</td>
<td>41.3%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>42.1%</td>
<td>Pottawattamie County</td>
<td>43.4%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>42.6%</td>
<td>US</td>
<td>48.6%</td>
</tr>
</tbody>
</table>

Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 118-119, 144-145]
- 2012 Professional Research Consultants, Inc. PRC Community Health Survey. [Item 146]

Notes:
- Asked of all respondents with children 5-17 at home.
- For this issue, respondents with children who are not in school were asked about “weekdays,” while parents of children in school were asked about typical “school days.”
- “Three or more hours” includes reported screen time of 180 minutes or more per day.
Related Focus Group Findings

Physical Activity

Many focus group participants discussed the lack of physical activity in the community. The main discussion centered on:

- Inactivity
- Cost of organized athletics

There is much concern amongst focus group participants about the inactivity of today’s children and adolescents. Physical activity is no longer a normal part of a child’s lifestyle. A sedentary lifestyle can lead to many health conditions, including obesity, heart disease, and poor mental health.

Focus group members feel that children watch more television and play more video games than ever before, coupled with limited physical education and recesses during the school day. In addition, kids no longer walk home from school, but instead go directly to daycare or an after-school activity. Currently there are programs available aimed at increasing physical activity, including after-school programs, YMCA, Boys and Girls Clubs, neighborhood parks, trail systems, skate parks, and recreation centers. A participant describes:

“I think the Movin’ After School thing is important because they’re trying to basically streamline all after-school programs to make a commitment to not serve sugar-sweetened beverages and to provide a certain number of minutes of physical activity every week. I think it comes with incentives, so if you get a certain score then you get funds to buy additional physical activity equipment. I know it doesn’t solve everything, but it’s a good start.” — Douglas County Social Service Provider

Organized athletics also represent an option for physical activity; however, some participants view the cost as a burden to many families.

“I’ll get them the contact information for Council Bluffs Youth Soccer, and then they discover that they can’t afford it, or they can afford to pay the tuition but they can’t afford to pay for the cleats and the shin guards or the uniform.” — Pottawattamie County Participant

Pottawattamie County’s COBRA’s RC program seeks to eliminate the cost barrier by covering the cost of fees and uniforms for a child for one year, with the option to participate in unlimited sports for just $15 dollars. Other participants feel that eliminating the need for matching uniforms may make a difference and one participant offers the following solution:

“I would like to see, as a community, that we change that concept of having to have new uniforms every year. I think we put parents in a real bind financially, as well as this stigma where everybody has to match and everything has to be new. And I think it’s both in the community and at schools, we have eliminated a lot of kids from being able to play these sports ‘cause the parents simply can’t afford all the uniforms. But you put the fee with these uniforms and the matching bag, and they gotta have matching warm-up uniforms, and it’s just gotten so competitive, it’s just out of control and parents can’t afford it.” — Pottawattamie County Participant
Body Weight

Childhood Overweight & Obesity

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/weights reported by surveyed parents, 30.2% of Metro Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Nearly identical to that found nationally.
- In Douglas County, highest in Northeast Omaha and lowest in the Western portion of the county.
- No statistical difference to note when viewed by county.

Child Overweight Prevalence

(Percent of Children Ages 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)

Note that weight status could not be determined for 15.0% of children age 5-17 because respondents were unable to provide their child's height and/or weight; these children are therefore not represented in these charts and data.
Overweight is notably high among boys, children age 5-12, those living in lower-income households, and Non-Whites.

Child Overweight Prevalence
(Percent of Children Ages 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)

<table>
<thead>
<tr>
<th>Age</th>
<th>Boy</th>
<th>Girl</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>White</th>
<th>Black*</th>
<th>Hispanic</th>
<th>Other*</th>
<th>Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to 12</td>
<td>34.6%</td>
<td>25.9%</td>
<td>34.3%</td>
<td>24.2%</td>
<td>46.1%</td>
<td>24.5%</td>
<td>26.9%</td>
<td>33.8%</td>
<td>41.6%</td>
</tr>
<tr>
<td>13 to 17</td>
<td>24.2%</td>
<td>25.9%</td>
<td>24.2%</td>
<td>24.2%</td>
<td>24.2%</td>
<td>24.2%</td>
<td>24.2%</td>
<td>24.2%</td>
<td>24.2%</td>
</tr>
</tbody>
</table>

Further, 17.1% of Metro Area children age 5 to 17 are obese (≥95th percentile).

- Statistically comparable to that found nationally.
- Comparable to the Healthy People target (14.6% or lower).
- In Douglas County, highest in Northeast Omaha; lowest in Northwest Omaha and the Western portion of the county.
- By county: least favorable in Douglas County and most favorable in Sarpy County.

Child Obesity Prevalence
(Percent of Children Ages 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

<table>
<thead>
<tr>
<th>NE Omaha</th>
<th>SE Omaha</th>
<th>NW Omaha</th>
<th>SW Omaha</th>
<th>Western Douglas</th>
<th>Douglas County</th>
<th>Sarpy County</th>
<th>Pottawattamie County</th>
<th>Metro Area</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.0%</td>
<td>25.4%</td>
<td>12.1%</td>
<td>14.9%</td>
<td>11.2%</td>
<td>19.4%</td>
<td>9.1%</td>
<td>19.8%</td>
<td>17.1%</td>
<td>18.9%</td>
</tr>
</tbody>
</table>

Sources: • 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 148]  
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.  

Notes: • Asked of all respondents about a randomly-selected child aged 5-17 at home.
• 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.
Obesity is notably high among boys, children living in lower-income households, and Non-Whites.

### Child Obesity Prevalence

(Percent of Children Ages 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

```

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age 5 to 12</th>
<th>Age 13 to 17</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>White</th>
<th>Black*</th>
<th>Hispanic</th>
<th>Other*</th>
<th>Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boy</td>
<td>21.9%</td>
<td>18.6%</td>
<td>15.0%</td>
<td>34.4%</td>
<td>10.5%</td>
<td>11.3%</td>
<td>31.8%</td>
<td>22.0%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Girl</td>
<td>12.2%</td>
<td>16.0%</td>
<td>15.0%</td>
<td>28.7%</td>
<td>10.5%</td>
<td>11.3%</td>
<td>31.8%</td>
<td>22.0%</td>
<td>17.1%</td>
</tr>
</tbody>
</table>
```

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 148]

Notes:
* Represents a small sample size (<50) and should be considered when making comparisons.
* 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.

Among Metro Area parents of overweight (not obese) school-aged children, a total of 7.4% indicate that a health professional or someone at the child’s school told the parent that the child is overweight.

This prevalence is 8.8% among parents of children who are obese.

### Parent Has Been Told in the Past Year by a School or Health Professional That Their Child Is Overweight

(Among Children Ages 5-17 Who Are Overweight/Obese Based on BMI; Metro Area, 2012)

```

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight/Not Obese Children (Based on BMI)</td>
<td>7.4%</td>
</tr>
<tr>
<td>Obese Children (Based on BMI)</td>
<td>8.8%</td>
</tr>
</tbody>
</table>
```

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 128]

Notes:
* Asked of all respondents about a randomly-selected child aged 5-17 at home.
* 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.
Perceptions of Overweight

Interestingly, parents of overweight/obese children are inclined to see their child as being at “about the right weight.” This includes 68.7% of parents with overweight (not obese) children and 43.4% of parents with obese children.

- Only 9.7% perceive their obese child to be “very overweight.”

Children’s Actual vs. Perceived Weight Status
(Among Children Ages 5-17 Who Are Overweight/Obese Based on BMI; Metro Area, 2012)

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 127]
Notes: Asked of all respondents about a randomly-selected child aged 5-17 at home.
- 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.

Body image appears to be fairly high among Metro Area children/adolescents (as reported by parents), regardless of the child’s/adolescent’s weight.

Children’s Personal Body Image
(Among Children Ages 5-17 Who Are Overweight/Obese Based on BMI; Metro Area, 2012)

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 129]
Notes: Asked of all respondents about a randomly-selected child aged 5-17 at home.
- 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.
Household Tobacco Use

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)

Exposure to Environmental Tobacco Smoke

A total of 4.3% of Metro Area parents report that a member of their household smokes in the home.

- In Douglas County, least favorable in Northeast Omaha; no reports of smoking in the home for Northwest Omaha or Western Douglas respondents.
- Viewed by county, no significant difference to report.

Member of Household Smokes Inside the Home

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 115]
Notes: ● Asked of all respondents.
Smoking in the home is notably higher among households with teens and respondents in lower-income homes.

**Member of Household Smokes Inside the Home**  
(Metro Area, 2012)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Low Income</th>
<th>Mid/High Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4</td>
<td>4.7%</td>
<td>3.9%</td>
</tr>
<tr>
<td>5 to 12</td>
<td>3.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>13 to 17</td>
<td>8.6%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Other</td>
<td>2.7%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.5%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Other Race</td>
<td>4.3%</td>
<td></td>
</tr>
</tbody>
</table>

**Other Tobacco Use**

A total of 23.2% of Metro Area parents report that a member of their household smokes outside the home.

- In Douglas County, lowest in the Western region.
- No difference when viewed by county.

**Member of Household Smokes Outside the Home**

<table>
<thead>
<tr>
<th>County</th>
<th>NE Omaha</th>
<th>SE Omaha</th>
<th>NW Omaha</th>
<th>SW Omaha</th>
<th>Western Douglas</th>
<th>Douglas County</th>
<th>Sarpy County</th>
<th>Pottawattamie County</th>
<th>Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27.3%</td>
<td>30.3%</td>
<td>19.1%</td>
<td>19.0%</td>
<td>15.0%</td>
<td>22.8%</td>
<td>23.1%</td>
<td>25.8%</td>
<td>23.2%</td>
</tr>
</tbody>
</table>
A total of 6.0% of Metro Area respondents indicate that a member of the household uses some type of chewing tobacco.

- Lowest in Northeast Omaha.
- Viewed by county, highest (least favorable) in Sarpy County; lowest in Douglas County.

### Member of Household Uses Chewing Tobacco

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>1.1%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>4.4%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>2.6%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>5.0%</td>
</tr>
<tr>
<td>Western Douglas County</td>
<td>5.6%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>3.5%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>11.1%</td>
</tr>
<tr>
<td>Pottawattamie County</td>
<td>10.1%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 117]

**Notes:** Asked of all respondents.
Related Focus Group Findings

Focus group participants are concerned with substance abuse in the community. The main issues discussed surrounding substance abuse included:

- Limited treatment facilities
- Effects of substance abuse
- Parental knowledge

A number of focus group participants are concerned with substance abuse in the community, specifically among adolescents. Focus group members feel that substance use is high in the Omaha metropolitan area. The drugs of most concern include marijuana, alcohol, prescription drugs, inhalant, and K2. The over-riding perception is that it is not “cool” to be drug-free in today’s world and adolescents are no longer intimidated by drugs’ side effects.

Many respondents believe that youth are self-medicating with drugs and there are limited programs available to address this issue. There are currently **limited treatment facilities** in Eastern Nebraska and Western Iowa for adolescents. One 90-day treatment facility is located in Glenwood, Iowa. Several long-standing social service agencies in the Omaha metropolitan area will have to close their doors in 2012 because of decreased funding. Participants fear that the closing of these agencies (which supported education and drug prevention) may cause an increase in drug use.

Focus group participants also worry about the **effect** that substance use and abuse has on other behaviors and adolescents’ overall health. There is great worry that substance use leads to other risky behaviors, including increased chance of accidents and injuries, tobacco use, poor mental health, diet, physical inactivity and participation in risky sexual behavior. In conjunction with negative health effects, the students caught using drugs at school receive suspensions; however, these students are generally already truant so missing more school may perpetuate the cycle. A respondent describes:

> “And what happens to a child who is caught with drugs or drug paraphernalia: they’re immediately suspended. They have to go through an alcohol counseling and awareness class before they can reenter. It can take up to 10 days. Most of the kids, not all, but some of those kids are already absent very frequently; they’re already behind. That child is not going to finish. Then they’re depressed, back to using drugs. So if we don’t start thinking about an over-addicted society and the availability of drugs from all various standpoints, I think we’re going see a lot of trouble. And a lot of kids are self-medicating, which is scary.” — Douglas County Community Leader

Although substance abuse is prevalent throughout the metropolitan area, participants believe that certain drugs have higher rates of use in differing communities. For example: in more affluent neighborhoods, prescription drug use is on the rise, whereas adolescents in rural areas consume more alcohol. One member explains:
“So I see drug use as a real concern and I’m convinced it’s the tip of the iceberg. It’s there much more frequently than we’re able to monitor and to regulate. So it’s easy access. We have an affluent community where the majority of the kids have the resources to get the drugs. It’s easier to get marijuana than to get alcohol. It’s a battle that I think we’ve got to come to grips with because we’re not – we’re no Utopia and we’re no better than any other high school in the state really when it comes to that type of a risk that our kids are taking.” — Sarpy County Participant

Another component in the pervasive use of illegal substances is parental knowledge, or lack thereof. Many focus group members believe that parents’ ability to guide their child has declined in previous years (parents are more focused on being a friend than a parent). The participants cited examples of parties where a parent is actually home when alcohol is available. Additionally, there is concern about the number of parents who may be drug users themselves. Parents also could be uninformed about substance use, or even naïve to the idea. Education targeting parental awareness is a must, as this participant describes:

“There are all these things out there and most parents have no clue. When you say who can help, maybe doctors and hospitals could. If a doctor on that 7th grade exam talked a little more to Mom or Dad about what to expect as far as the environment their kids are going into, asked more questions of kids earlier, that we could maybe get some help in that corner.” — Douglas County Social Service Provider
Injury & Safety

Injuries

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)

“A total of 15.1% of Metro Area parents report that their child was injured seriously enough to need medical treatment at some point in the past two years.

- Within Douglas County, no significant differences to report.
- No difference by county.”
The prevalence of serious injury among Metro Area children is highest among boys and children age 5 and older.
Among parents of children who were seriously injured in the past two years, 22.6% report that the child was seriously injured on more than one occasion, including 4.3% who were injured three or more times.

**Number of Times Child Was Seriously Injured in Past Two Years**  
(Parents of Children Who Were Seriously Injured in the Past Two Years; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once</td>
<td>77.4%</td>
</tr>
<tr>
<td>Twice</td>
<td>18.3%</td>
</tr>
<tr>
<td>Three/More Times</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

Of the Metro Area children who were seriously injured in the past two years, 25.3% were playing when the injury occurred and 19.6% were participating in organized sports.

- Another 11.2% of these parents indicate their child fell or tripped when the injury occurred.

**Child’s Activity When Most Seriously Injured in Past Two Years**  
(Parents of Children Who Were Seriously Injured in the Past Two Years; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing</td>
<td>25.3%</td>
</tr>
<tr>
<td>Organized Sports</td>
<td>19.6%</td>
</tr>
<tr>
<td>Fell/Tripped</td>
<td>11.2%</td>
</tr>
<tr>
<td>Scooter/Rollerblades/Skatboarding</td>
<td>4.3%</td>
</tr>
<tr>
<td>Bike Riding</td>
<td>4.1%</td>
</tr>
<tr>
<td>Slipped on Ice</td>
<td>3.0%</td>
</tr>
<tr>
<td>Other</td>
<td>32.5%</td>
</tr>
</tbody>
</table>
With regard to the type of injury sustained, the largest share of responses was for broken bones (mentioned by 23.1%), followed by wounds needing stitches (17.9%), sprains (10.3%) and head injuries (9.4%).

- Other injuries mentioned less often include cuts, muscle injuries, and back and knee injuries.

### Type of Injury Sustained

(Parents of Children Who Were Seriously Injured in the Past Two Years; Metro Area, 2012)

- Broken Bone 23.1%
- Stitches 17.9%
- Sprain 10.3%
- Head Injury 9.4%
- Cut 7.3%
- Muscle Injury 6.3%
- General Medical 4.7%
- Back Injury 4.6%
- Knee Injury 4.3%
- Other 12.1%

When asked where they sought help for their injured child, 52.5% of Metro Area parents with recently-injured children mentioned a hospital and/or emergency room.

- Other sites for medical care included family physicians (mentioned by 30.5%), specialists (8.5%) and urgent care centers (5.2%).

### Source for Help After the Injury

(Parents of Children Who Were Seriously Injured in the Past Two Years; Metro Area, 2012)

- Hospital/ER 52.5%
- Family Dr 30.5%
- Urgent Care 5.2%
- Specialist 8.5%
- Other 3.3%
In the past year, 1.8% of school-aged Metro Area children missed school because they felt unsafe at school or on the way to/from school.

- On the other hand, the vast majority (98.2%) of school-aged children did not miss school in the past year because of safety concerns.

**Number of School Days Missed in the Past Month Because Child Felt Unsafe**
(Metro Area School-Aged Children, 2012)

- Respondents in Southeast Omaha and Western Douglas did not report any children missing school due to safety concerns.
- Viewed by county, no significant difference to report.

**Child Missed at Least One School Day in the Past Month Because He/She Felt Unsafe**
(Metro Area Children Age 5-17, 2012)
Viewed by the child’s demographic characteristics, there are no significant differences to report.

Child Missed at Least One School Day in the Past Month Because He/She Felt Unsafe
(Metro Area Children 5-17, 2012)

Neighborhood Safety

Most Metro Area survey respondents report that they feel “extremely” (39.2%) or “quite” (50.6%) safe from crime in their neighborhood.

- On the other hand, many (10.2%) Metro Area respondents feel “slightly” or “not at all” safe in their neighborhood.
The prevalence of respondents who feel “slightly/not at all safe” in their neighborhoods is unfavorably high in Northeast Omaha; however, notably low percentages were reported in the western portions of Douglas County.

Also quite low in Sarpy County.

### Perceive Neighborhood as “Slightly/Not At All” Safe from Crime

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>36.4%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>19.6%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>4.3%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>2.9%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>2.1%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>13.7%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>1.2%</td>
</tr>
<tr>
<td>Pottawattamie</td>
<td>8.3%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 74]

**Notes:** Asked of all respondents.

A total of 80.8% of Metro Area survey respondents report that they feel safe in their own home “all the time.”

On the other hand, 19.2% of survey respondents do not always feel safe in their own homes.

### Frequency of Feeling Safe at Home

(Metro Area, 2012)

- All the Time 80.8%
- Often 16.8%
- Sometimes 1.9%
- Almost Never 0.1%
- Never 0.4%

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 75]

**Notes:** Asked of all respondents.
The prevalence of Metro Area parents who do not always feel safe in their homes is unfavorably high in Northeast Omaha but lowest in Southwest Omaha and the Western Douglas region.

No difference among the three counties.

Do Not Always Feel Safe at Home

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>28.1%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>24.0%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>20.8%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>14.9%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>11.9%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>20.7%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>16.1%</td>
</tr>
<tr>
<td>Pottawattamie</td>
<td>17.2%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>19.2%</td>
</tr>
</tbody>
</table>

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 75]

Notes: Asked of all respondents.

Car Seats & Seat Belts

A full 95.1% of Metro Area parents report that their child (age 0 to 17) “always” wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

More favorable than what is found nationally.

In Douglas County: lowest in Northeast Omaha, highest in Northwest Omaha and Western Douglas County.

No statistical difference by county.

As may be expected, the prevalence is higher among younger children.

Child “Always” Wears a Seatbelt or Appropriate Restraint When Riding in a Vehicle
(Metro Area, 2012)

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>89.1%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>93.7%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>99.4%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>96.2%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>98.3%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>95.0%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>94.3%</td>
</tr>
<tr>
<td>Pottawattamie</td>
<td>97.2%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>95.1%</td>
</tr>
<tr>
<td>US</td>
<td>91.6%</td>
</tr>
</tbody>
</table>

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 71, 142-143]

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

Bicycles

Among Metro Area school-aged children who rode a bicycle in the past year, 40.3% “always” wore a helmet.

- Statistically comparable to the national prevalence.
- Unfavorably low in Northeast Omaha.
- Viewed by county, lowest in Pottawattamie.

Child “Always” Wore a Helmet When Riding a Bicycle Last Year
(Among Parents of Children Age 5-17 Who Rode a Bike in Past Year; Metro Area, 2012)

Skateboards, Scooters, Skates & Rollerblades

Among Metro Area school-aged children who rode a skateboard, scooter, skates or rollerblades in the past year, 27.1% “always” wore a helmet.

- In Douglas County the sample size did not support data analysis for this question.
- No significant difference by county.

Child “Always” Wore a Helmet on Skateboards, Scooters, Skates or Rollerblades Last Year
(Among Parents of Children 5-17 Who Engaged in These Activities in Past Year; Metro Area, 2012)
Related Focus Group Findings

Injury & Violence

Many focus group participants are concerned with injury and violence in the community. The main issues included:

- Firearms
- Impact of trauma

There is great concern about violence in the community, ranging from the impact of school bullying to homicide. Focus group participants believe that additional prevention programs need to be put into place in order to combat injury and violence. Respondents also believe that gang activity in Douglas County is widespread geographically, although there is greater incidence in North and South Omaha. Easy access to firearms is also a large concern.

“For children to come to school with a gun there has to be a means for them to obtain it, and I think we’ve not done much to prevent that.” — Douglas County Physician

Focus group participants spoke at length about the impact of trauma on children. There is great concern for youth living in high crime neighborhoods because of the perceived lack of available grief counselors. Some focus group members believe that community members think children get de-sensitized to the violence, but this is not the case. The outcomes from this trauma or stress are multi-fold and may manifest in a variety of ways. A participant describes:

“One of the things that really irritates me is you’ll see in the news, let’s say some teen in west Omaha has a car wreck. Right away the news media says there will be grief counselors at the school, but in north Omaha there’s a school lockdown because there was a shooting outside the school and the grade school kids are there to experience it and have to walk past that bloody spot on the sidewalk where the person was shot, grief counselors are hardly ever mentioned… There was a doctor that said, ‘Well it seems like these kids got used to it.’ How do you get used to it?” — Douglas County Social Service Provider
Sexual Activity

Chlamydia

In 2011, there were 592.3 diagnosed chlamydia infections per 100,000 population in Douglas County.

- Dramatically higher than the Nebraska and Iowa rates.
- Dramatically higher than the national incidence rate.
- Rates are notably lower in Sarpy and Pottawattamie counties.

Chlamydia Incidence Rate
(Annual Cases per 100,000 Population)

Chlamydia incidence has followed a general upward trend in Douglas County over the past decade, remaining consistently higher than statewide rates (which also appear to be on the rise).

Chlamydia Incidence
(Annual Average Cases per 100,000 Population)
Of the 3,063 total chlamydia cases reported in Douglas County in 2011, nearly one-third (32.4%) were among adolescents and preteens age 10-19.

- Additionally, just over one-half of cases appear in young adults in their 20s.

### Chlamydia by Age Group
(Douglas County, 2011)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9 Yrs</td>
<td>0.0%</td>
</tr>
<tr>
<td>10-14 Yrs</td>
<td>1.4%</td>
</tr>
<tr>
<td>15-19 Yrs</td>
<td>31.0%</td>
</tr>
<tr>
<td>20-24 Yrs</td>
<td>36.3%</td>
</tr>
<tr>
<td>25-29 Yrs</td>
<td>16.4%</td>
</tr>
<tr>
<td>30-34 Yrs</td>
<td>7.7%</td>
</tr>
<tr>
<td>35-44 Yrs</td>
<td>5.6%</td>
</tr>
<tr>
<td>&gt;44 Yrs</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

Sources: Douglas County Health Department
Notes: Percentages are based on 3,063 total cases.

### Related Focus Group Findings

**Sexually Transmitted Infections & Unplanned Pregnancy**

Many focus group participants discussed sexually transmitted infections, reproductive health and unplanned pregnancy. The main issues included:

- Epidemic proportions of sexually transmitted infections (STIs)
- Access to sexual education and reproductive services
- Victims of sexual abuse or assault

Focus group participants worry about the **epidemic proportions of sexually transmitted infections (STIs)** in the community. The overall health consequences and mental health repercussions of STIs and unplanned pregnancy can be exponential to a young person. As a physician describes:

> “The sexual risk behaviors have to be in my mind number one because a lot of kids’ lives are changed forever by choices that they make. I’ve never seen them change positively. So I think that’s a real issue. Again the community’s had such a hard problem trying to even deal with this issue.” — Douglas County Physician

**Access to sexual education classes and reproductive services** are seen as opportunities to empower teenagers to make informed decisions about their sexual health. Participants believe that state legislation limits access and treatment for reproductive health, which is an unfortunate reality. Focus group participants reinforce the idea that education does not only need to occur in the schools, but that faith-based organizations and social service agencies can play a role as well. A participant explains:
“There is a way to even introduce it [STIs] through the faith institutions. But it has to be done with respect so that you don’t rip the fabric of an individual’s faith apart trying to introduce. We’re not oblivious to the fact that every Sunday there are people sitting in congregations before us with HIV and AIDS but to say it over the pulpit then brings credence, credibility, validity so that a person doesn’t suffer in silence. Then how do you leverage that once you bring it public without identifying the individual themselves?” — Douglas County Community Leader

Pregnancy prevention messaging also needs to occur often to have an impact on adolescents. The concept of having a “trusted adult” to speak with is an important aspect to consider in this realm as well.

**Victims of sexual abuse or assault** (including both genders) are important to consider when considering reproductive health, STIs and unplanned pregnancy. Focus group respondents believe that a large amount of sexual abuse is occurring in the community and that the stigma surrounding this crime keeps victims from coming forward. Additionally, victims of sexual abuse may engage in risky sexual behaviors more often, as one community leader describes:

“There are so many unreported cases of rape, molestation, incest...And that issue also feeds into the STI/STD, teen pregnancy, because those children tend to act out sexually. They see that or - I’m speaking on behalf of girls at this point - as a way to take control. ‘I will choose and I will – I make that decision. Someone is not going to decide for me.’ You see – or ‘I was not protected and loved the way I should have been as a child but I have a child. I will love my child. I will take care of my child,’ and dream and hope to do that.” — Douglas County Community Leader
BEHAVIORAL CONCERNS
Obeying Rules

“Compared to this child’s friends, how often does this child go against the rules set by adults?”

When asked to consider how often their child goes against the rules set by adults when compared with peers, most (59.9%) respondents said “less often.”

- Another 31.5% of Metro Area parents feel that their child disobeys the established rules about as often as his or her peers.

Frequency of Child Disobeying Rules Compared With Friends as Perceived by Parent
(Metro Area, 2012)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Often</td>
<td>59.9%</td>
</tr>
<tr>
<td>Same Amount</td>
<td>31.5%</td>
</tr>
<tr>
<td>More Often</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

However, 8.6% of parents consider their child to disobey their rules “more often” than his or her peers.

Significantly higher among Metro Area children under age 5, as well as among non-White/non-Hispanic children.

Parent Perceives That Child Disobeys the Rules “More Often” Than Friends
(Metro Area, 2012)

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. (Item 95)
Notes: Asked of all respondents about a randomly-selected child in the household.
Parents’ Behavioral Concerns for Children

When asked about a series of behavioral concerns that some adolescents and families face, the largest share of responses among Metro Area parents with adolescents was for being bullied by another child in the past year (17.3% of respondents say this is a serious concern they have for their own child).

- Another 6.3% of Metro Area parents have a serious concern about their child in the past year regarding sexual activity, followed by serious concerns regarding alcohol (3.9%).

Parent Has Had Serious Concerns for Their Adolescent in the Past Year Regarding:

- Being Bullied by Another Child: 17.3%
- Sexual Activity: 6.3%
- Drinking Alcohol: 3.9%
- Considering Suicide: 2.4%
- Harming, Threatening or Bullying Another: 1.9%
- Illegal or Illicit* Drug Use: 1.8%
- Physically Harm ing Themselves: 1.5%
- Gang Membership: 0.0%

Sources:
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. (Items 96-103)

Notes:
- *Illicit drug use refers to the adolescent’s use of prescription medication which was not prescribed to him/her.
DAILY LIFE
In general, the largest share of Metro Area children (52.0%) spends most of their time with both parents.

- 29.1% of children spend most of their time with their mothers.
- 5.6% of children spend most of their time with their fathers.

Most parents gave “excellent” (67.0%) or “very good” (24.2%) ratings of their relationship with their child.

- Another 7.3% gave “good” evaluations of their relationship.
However, 1.4% of Metro Area respondents consider themselves to have a “fair” or “poor” relationship with this child.

No significant differences when viewed by demographic characteristics.

**Child Has a “Fair/Poor” Relationship With Respondent**
(Metro Area, 2012)

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boy</strong></td>
<td>0.9%</td>
<td>1.3%</td>
<td>0.6%</td>
<td>1.1%</td>
<td>2.9%</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Girl</strong></td>
<td>0.4%</td>
<td>1.8%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>3.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Age 0 to 4</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Age 5 to 12</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Age 13 to 17</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Low Income</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Mid/High Income</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>White</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Black</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Metro Area</strong></td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]

**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. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
After-School Activities

While three-fourths of Metro Area school-aged children participate in some type of organized after-school activities, a total of 23.9% do not participate in any.

- Sports are the most common after-school activity, followed by various clubs, dance, Scouting and school programs.

In Douglas County: children in eastern Omaha are less likely to participate in an after-school activity, while those in Southwest Omaha and Western Douglas are more likely.

- No significant difference by county.

Child Does Not Participate in After-School Activities

(Metro Area Children Ages 5-17, 2012)
The following Metro Area children are least likely to participate in an after-school program or activity:

- Residents of lower-income households.
- African American or Hispanic children (note the small sample size among African American children in this case).

**Child Does Not Participate in After-School Activities**
(Metro Area School-Aged Children, 2012)

Among parents with children who do not participate in an organized after-school program or activity, the largest share (41.0%) reported that their child has **no interest**, while others mentioned a **lack of time** for activities (mentioned by 16.8%), **transportation** as a barrier (9.3%), a specific **disability or illness** (8.3%) which prevents the child’s after-school activities, and **cost** as a barrier to activities (7.2%).
Among Metro Area parents of teens age 14 to 17, 18.8% report that their child currently works for pay at a job.

- Among these teens, 20.5% work 5 hours or less per week, while 32.2% work between 6 and 10 hours and 40.9% work between 11 and 20 hours per week.
- Note that 6.4% of these employed teens work more than 20 hours per week.

**Child Currently Works for Pay at a Job**
(Parents of Children Age 14-17; Metro Area, 2012)

**Adolescent Currently Works at a Job for Pay**

<table>
<thead>
<tr>
<th>Hours Worked Per Week</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Hrs/Less</td>
<td>20.5%</td>
</tr>
<tr>
<td>6-10 Hrs</td>
<td>40.9%</td>
</tr>
<tr>
<td>11-20 Hrs</td>
<td>32.2%</td>
</tr>
<tr>
<td>&gt;20 Hours</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

**Average Hours Worked Per Week**

- Yes: 18.8%
- No: 81.2%

**Sources:**
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 110-111]

**Notes:**
- Asked of all respondents about a randomly-selected child aged 14-17 at home.
ACCESS TO HEALTHCARE SERVICES
Insurance Coverage

Medical Coverage

A total of 69.1% of Metro Area parents report having private healthcare coverage for their child. Another 26.5% report coverage through a government-sponsored program (e.g., KidCare, Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage for Child
(Metro Area, 2012)

No Insurance/ Self-Pay 4.4%
Medicaid & Medicare 0.4%
VA/Military 5.2%
Medicare 2.1%
Medicaid 17.8%
KidCare 1.0%
Private Coverage 69.1%

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 150]
Notes: ● Asked of all respondents about a randomly-selected child under 18 in the household.

However, 4.4% report having no insurance coverage for their child’s healthcare expenses.

- The Healthy People 2020 target is universal coverage (0% uninsured).
- Worst in Southeast Omaha; best in Southwest Omaha and Western Douglas.
- No difference when examined by county.

Lack Healthcare Insurance Coverage for Child
(Metro Area, 2012)

Healthy People 2020 Target = 0.0% (Universal Coverage)

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 150]
Notes: ● Asked of all respondents about a randomly-selected child in the home.
Those living in lower-income households are more likely to be without healthcare insurance coverage.

Dental Coverage

Among Metro Area parents, 72.4% report having dental coverage for their child’s dental care.

- Favorably high in Northwest and Southwest Omaha; lower in the Northeast and Southeast regions of the city.
- By county: highest in Sarpy County, lowest in Douglas County.

Child Has Private Coverage That Pays All or Part of Dental Care Costs
Difficulties Accessing Healthcare

A total of 20.9% of Metro Area parents report some type of difficulty or delay in obtaining healthcare services for their child in the past year.

- In Douglas County, highest in Northeast Omaha and lowest in Northwest Omaha.
- No difference by county.

Experienced Difficulties or Delays of Some Kind in Receiving Child’s Needed Healthcare in the Past Year

Note that the following demographic groups more often report difficulties accessing their child’s healthcare services:

- Residents in lower-income households.
- African American children and those of "other" races.

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc.  
Notes: Asked of all respondents.

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 barriers, inconvenient office hours impacted the greatest share of Metro Area families (12.1% of parents say that inconvenient office hours prevented them from taking a child for medical care in the past year).

- Other barriers preventing Metro Area children from receiving medical care include getting appointments (mentioned by 5.8% as a barrier in the past year), cost of a physician visit (4.8%), cost of prescription medication (3.6%), finding a physician (3.5%) and lack of transportation (2.6%).

To better understand healthcare access barriers, Metro Area parents were asked whether any of six types of barriers to access prevented their child from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.
Related Focus Group Findings

Access to Healthcare

Many focus group participants are concerned with area parents’ ability to access healthcare services for their children. The discussion centered on the following issues:

- Barriers to healthcare services
- Geography
- Uninsured and under-insured families
- Cost
- Transportation
- Office hours
- Culture
- Homeless children
- Need to meet families where they live, work, and play
- Specialists and technology

Focus group participants believe there are several barriers that children and families encounter when trying to access healthcare services in the community. Throughout the focus groups, the concept that geography impacts one’s ability to access healthcare services came up several times. Participants feel that certain geographic locations within the community (including North and South Omaha, Bellevue, and parts of Council Bluffs) have limited healthcare facility options. In general, these same communities have a higher proportion of minority residents and lower-income levels. As one respondent recalls:

“The Omaha community has grown west, so they built hospitals out there. University has one, Methodist has one, Alegent has one; brand new, nice, beautiful hospitals, but in north Omaha all the hospitals and clinics have closed down.” — Douglas County Social Service Provider

Pottawattamie County residents also face a unique situation: it is not uncommon for families to live in Iowa but to seek healthcare in Nebraska.

Focus group members have concern for those families who are under-insured or uninsured in the community. The under-insured population includes the working poor: those parents who may qualify for employer insurance, but the deductibles are too high or the monthly employee cost is too great, so they elect to go without. Uninsured families may qualify for Medicaid, but finding a provider who accepts that insurance can be difficult. Respondents feel the number of physicians who accept Medicaid has decreased in recent years due to a low reimbursement rate. Even getting on Medicaid is filled with obstacles, as one participant explains:

“Medicaid has moved to online applications through Access Nebraska...for some of the individuals who are really in need they do not have access to computers or do not feel comfortable completing applications online. Now there’s a call center for the state. Before you had a primary caseworker assigned to each case for an application. You wait for 45 minutes and don’t speak with an individual. It’s an automated system. So I think there’s a lot of system issues.” — Sarpy County Participant
The cost of office visits and prescription drugs may also impact a family’s ability to access critical healthcare services. A participant notes:

“A family we have now, the child needs – the child has a serious disorder, requires a medication that’s very expensive. They can get the healthcare but they can’t get the medication they need for him. They only way they can get that medication at a reduced price is to go to either OneWorld or Charles Drew. Well, they can’t get in. So it’s that situation where the resources are there, but sometimes it’s the medications that are very expensive. Sometimes it’s not the resources there but the capacity.” — Douglas County Community Leader

There are three community health centers (Charles Drew, OneWorld, and the Council Bluffs Community Health Center) which operate on a sliding fee scale. These facilities offer both preventative and urgent care services. They are located in high need areas to service under-insured and uninsured residents. These community health centers have wait lists due to the high demand for services.

Getting to the physician’s office or community health center is another obstacle to accessing care. Families may have access to one (or no) personal vehicle, and the public transportation system in the Omaha metropolitan area is limited in routes and times. The extreme weather conditions in the heartland also may impact a family’s ability to utilize public transportation.

Many families have parents who work multiple jobs or shift work which makes getting to a doctor appointment during normal office hours difficult. There is much fear over losing a job if an employee misses work. These families may forgo preventative healthcare and a child may not have a medical home.

“Children’s Hospital has a rotating evening clinic, but it’s primarily urgent care, not primary care, so you really can’t access that system to come in and get your routine vaccinations and that type of thing.” — Douglas County Physician

Culture also affects how a family may access healthcare services. All of the community health centers are culturally-sensitive facilities, but wait times can be long as these facilities are inundated with patients. Certain ethnic groups in the community also have different health beliefs, as one participant describes:

“Well you look at Sudanese population. I’ll talk about it. The different dialects and the different customs they have to medicine and stuff, it don’t appeal to them as– a need that they need to get taken care of. You can send a note home that say your kid needs to go have a physical or whatever it is, they don’t understand. They’re just gonna say, ‘No. They don’t need to have one. They’re fine.’ ” — Sarpy County Participant

Focus group respondents also believe that this new generation of adolescents views healthcare differently than years past and may not necessarily view primary or preventative care as important. Recognizing this viewpoint is critical when trying to make an impact with youth.

The concept of “homeless children” also came up in the focus groups. Families may have lost a home to foreclosure and a child might now live at a friend or relative’s home. These children have additional mental healthcare needs and their physical health may go unnoticed due to the situation. A Sarpy County participant explains:
“Someone from the school told me not too long ago that we have more homeless children in this county than we ever want to know about. And that homeless is not they’re living in shacks underneath the South Omaha bridge. It’s that their parents have lost the house from foreclosure and they can’t afford to take care of these kids. ‘Well you go stay with Curtis and you go stay with Brad. And you go stay with Joan.’ And so now these kids are just sleeping on your couch or on a spare bed and there’s nobody there to help.” — Sarpy County Participant

A number of respondents feel it is critical to provide medical services to families where they live, work, and play. If this is done correctly it can eliminate many of the above barriers. Additionally, if providers can help children have an appreciation for (not fear of) physicians, dentists and social service agencies, the child’s long-term health outcomes may improve. One respondent notes:

“Whatever way it takes to get the most number of kids served effectively, take the services to where the kids are, going to Children’s Square and providing service, going to Boys & Girls Clubs and providing services. Going to the schools and having those positive experiences with healthcare providers ...If we go to the kids and we bring dentists and hygienists in there and introduce them to how positive an experience healthcare can be, we’ll have more educated adults in 10, 15 years, and I guess that’s that whole ‘old dog, new trick.’ It doesn’t always work so well. But if you start with a puppy, you’re gonna have a well-trained dog.” — Pottawattamie County Participant

Focus group participants believe community residents have access to a number of specialists and technology. Children with acute care needs have great resources located within the immediate region. The number of pediatricians and family practice physicians is adequate for the population; however, many barriers exist. Increasing the number of adolescent specialists and psychiatrists are two areas where the majority of participants see immediate needs.
Primary Care Services

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)

Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (74.6%) identified a particular doctor’s office. A total of 3.6% identified OneWorld Community Health Center.

However, 7.6% of children/adolescents do not have a particular place for care (“medical home”).

### Particular Place Utilized for Child’s Medical Care

(Metro Area, 2012)

- Dr’s Office 74.6%
- None 7.6%
- OneWorld Comm Hlth Ctr 3.6%
- Other 2.2%

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 22-23]
Notes: ● Asked of all respondents about a randomly-selected child in the home.
Most (77.1%) Metro Area children have seen a doctor (for any reason) in the past 6 months.

- Asked to specify the reason for their child’s most recent medical care, 40.5% of parents mentioned a routine **checkup or physical** while 20.0% cited an **illness** as the reason for their child’s most recent medical visit.

### Child’s Most Recent Doctor Visit for Any Reason

(Metro Area, 2012)

<table>
<thead>
<tr>
<th>Reason for Most Recent Visit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checkup/Physical</td>
<td>40.5%</td>
</tr>
<tr>
<td>Illness</td>
<td>20.0%</td>
</tr>
<tr>
<td>Cold/Flu</td>
<td>5.2%</td>
</tr>
<tr>
<td>Immuniz.</td>
<td>4.8%</td>
</tr>
<tr>
<td>Injury</td>
<td>3.8%</td>
</tr>
<tr>
<td>Ear Infection</td>
<td>3.3%</td>
</tr>
<tr>
<td>Other</td>
<td>22.4%</td>
</tr>
</tbody>
</table>

### Most Recent Dr’s Visit For Any Reason

- Past 6 Months: 77.1%
- 6-12 Months: 17.4%
- 1-2 Years: 4.0%
- > 2 Years: 1.5%

### Overall, 84.2% of Metro Area children had a routine checkup in the past year.

- Similar to national findings.
- In Douglas County, no difference by sub-area.
- No difference between the three counties.

### Child Has Visited a Physician for a Routine Checkup in the Past Year

(Metro Area, 2012)

- NE Omaha: 82.1%
- SE Omaha: 88.7%
- NW Omaha: 88.2%
- SW Omaha: 83.7%
- Western Douglas: 80.4%
- Douglas County: 85.1%
- Sarpy County: 83.2%
- Pott. County: 81.4%
- Metro Area: 84.2%
- US: 87.0%

**Sources:**
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 25-26]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of respondents about a randomly-selected child in the household.
Note that routine checkups are highest in Metro Area children who are under age 5, African American or Hispanic.

### Child Has Visited a Physician for a Routine Checkup in the Past Year
(Metro Area, 2012)

<table>
<thead>
<tr>
<th>Category</th>
<th>Boy</th>
<th>Girl</th>
<th>Age 0 to 4</th>
<th>Age 5 to 12</th>
<th>Age 13 to 17</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
<th>Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>84.8%</td>
<td>83.6%</td>
<td>95.6%</td>
<td>83.3%</td>
<td>72.4%</td>
<td>85.7%</td>
<td>84.0%</td>
<td>82.5%</td>
<td>90.3%</td>
<td>91.7%</td>
<td>77.9%</td>
<td>84.2%</td>
</tr>
</tbody>
</table>

Sources:  ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc.  (Item 24)
Notes:  ● Asked of all respondents about a randomly-selected child under 18 at home.
  ● 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. “Low Income” includes households with incomes up to 200% of the federal poverty level. “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

### Immunizations

When asked where their child received his or her most recent immunizations, the largest share of Metro Area parents with children under 6 (79.3%) mentioned a doctor’s office.

- Other sites for recent immunizations included clinics (mentioned by 6.7%), hospitals (5.7%) and government or military sites (3.0%).
- Note that 2.0% of Metro Area parents with children under 6 indicate that their child has not been vaccinated.

### Site for Child’s Most Recent Immunization
(Parents of Children Under 6, Metro Area, 2012)

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr’s Office</td>
<td>79.3%</td>
</tr>
<tr>
<td>Hospital</td>
<td>5.7%</td>
</tr>
<tr>
<td>Clinic</td>
<td>6.7%</td>
</tr>
<tr>
<td>Gov’t/VA</td>
<td>3.0%</td>
</tr>
<tr>
<td>Uncertain</td>
<td>2.3%</td>
</tr>
<tr>
<td>Hasn’t Been Immunized</td>
<td>2.0%</td>
</tr>
<tr>
<td>Other</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Sources:  ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc.  (Item 33)
Notes:  ● Asked of all respondents about a randomly-selected child under 6 in the home.
Related Focus Group Findings: Immunizations

Many focus group participants discussed the importance of all children receiving their age-appropriate immunizations. The main discussion centered on:

- School district requirement
- Accessibility

Focus group participants believe the immunization level across the Omaha metropolitan area is high because **schools districts require** students to have certain vaccines before they can enroll. The school district requirement really helps to create parental action. Immunizations are also very **accessible** to all families through the health department, immunization clinics, and family practice providers. A physician explains:

> “Vaccine numbers are excellent. I think they’re very accessible. There are many places you can go in town. Douglas County Health Department has a good main clinic, but they have outreach and the prices are phenomenal, so there’s no excuse in this city not to be vaccinated.” — Douglas County Physician
Dental Care

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers.

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.

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
- Poor dietary choices

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
- 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.

Community water fluoridation and school-based dental sealant programs are 2 leading evidence-based interventions to prevent tooth decay.

Major improvements have occurred in the nation’s oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent CDC publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased.

Lack of access to dental care for all ages remains a public health challenge. This issue was highlighted in a 2008 Government Accountability Office (GAO) report that described difficulties in accessing dental care for low-income children. In addition, the Institute of Medicine (IOM) has convened an expert panel to evaluate factors that influence access to dental care.

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)
Regular Source of Dental Care

A total of 90.1% of Metro Area parents report that their child has a particular place for dental care.

- In Douglas County, favorably high in the Western region.
- By county: most favorable in Sarpy County, least favorable in Douglas County.

### Child Has a Particular Place for Dental Care
(Metro Area Children 2-17, 2012)

<table>
<thead>
<tr>
<th>Location</th>
<th>% of Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Omaha</td>
<td>91.0%</td>
</tr>
<tr>
<td>SE Omaha</td>
<td>90.2%</td>
</tr>
<tr>
<td>NW Omaha</td>
<td>84.7%</td>
</tr>
<tr>
<td>SW Omaha</td>
<td>85.5%</td>
</tr>
<tr>
<td>Western Douglas</td>
<td>97.9%</td>
</tr>
<tr>
<td>Douglas County</td>
<td>88.3%</td>
</tr>
<tr>
<td>Sarpy County</td>
<td>94.8%</td>
</tr>
<tr>
<td>Pott. County</td>
<td>92.2%</td>
</tr>
<tr>
<td>Metro Area</td>
<td>90.1%</td>
</tr>
</tbody>
</table>

Sources:  
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 34]

Notes:  
- Asked of all respondents about a randomly-selected child aged 2-17 in the home.

As asked to specify their site for dental care, 79.8% of Metro Area parents with a regular site for their child’s dental care mentioned a dental office.

- Another 18.8% of these parents mentioned specific dentists, and 1.4% seek dental care for their child in a hospital setting.

### Particular Place Utilized for Child’s Dental Care
(Metro Area Children 2-17, 2012)

- Dentist’s Office: 79.8%
- Hospital: 1.4%
- Specifically-Named Dentists: 18.8%

Sources:  
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 35]

Notes:  
- Asked of all respondents who indicate that their child (age 2-17) has a particular place for dental care.
Most (75.4%) Metro Area children have received dental care (for any reason) in the past 6 months.

- Asked to specify the reason for their child’s most recent dental visit, 88.4% of parents mentioned a routine cleaning while 3.4% specified a cavity filling.

### Child’s Most Recent Dental Visit
(Metro Area, 2012)

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 Years</td>
<td>3.2%</td>
</tr>
<tr>
<td>&gt; 2 Years</td>
<td>0.8%</td>
</tr>
<tr>
<td>Past 6 Months</td>
<td>75.4%</td>
</tr>
<tr>
<td>6-12 Months</td>
<td>20.6%</td>
</tr>
</tbody>
</table>

### Reason for Most Recent Dental Visit

- Routine Cleaning: 88.4%
- Cavity Filling: 3.4%
- Other: 8.2%

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 36-37]

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

The vast majority of Metro Area children (age 2-17) visited a dentist or dental clinic at some point in the past year.

- More favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- In Douglas County, statistically similar by sub-area.
- No difference by county.

### Child Has Visited a Dentist or Dental Clinic Within the Past Year
(Among Parents of Children Age 2-17; Metro Area, 2012)

- Healthy People 2020 Target = 49.0% or Higher

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. (Item 36)
2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents about a randomly-selected child aged 2 through 17 at home.
Regular dental care is lower among boys, children age 2 to 4, teens and Hispanic children.

### Child Has Visited a Dentist or Dental Clinic Within the Past Year
(Among Parents of Children Age 2-17; Metro Area, 2012)

<table>
<thead>
<tr>
<th></th>
<th>Boy</th>
<th>Girl</th>
<th>Age 2 to 4</th>
<th>Age 5 to 12</th>
<th>Age 13 to 17</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
<th>Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>94.4%</td>
<td>97.7%</td>
<td>94.5%</td>
<td>98.3%</td>
<td>93.1%</td>
<td>95.5%</td>
<td>95.9%</td>
<td>96.8%</td>
<td>96.0%</td>
<td>91.6%</td>
<td>98.7%</td>
<td>96.0%</td>
</tr>
</tbody>
</table>

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 36]

**Notes:**
- Asked of all respondents about a randomly-selected child aged 2-17 at home.
- 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. “Low Income” includes households with incomes up to 200% of the federal poverty level. “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

**Dental Sealants**

More than one-half of Metro Area parents (53.3%) indicates that their child (age 6-17) has received sealants on his or her permanent molars.

- In Douglas County, no difference by sub-area.
- No difference by county.

### Child Has Received Dental Sealants on His/Her Permanent Molars
(Among Parents of Children 6-17; Metro Area, 2012)

<table>
<thead>
<tr>
<th></th>
<th>NE Omaha</th>
<th>SE Omaha</th>
<th>NW Omaha</th>
<th>SW Omaha</th>
<th>Western Douglas</th>
<th>Douglas County</th>
<th>Sarpy County</th>
<th>Pottawattamie County</th>
<th>Metro Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>48.0%</td>
<td>62.2%</td>
<td>45.1%</td>
<td>58.8%</td>
<td>51.6%</td>
<td>53.5%</td>
<td>58.2%</td>
<td>42.8%</td>
<td>53.3%</td>
</tr>
</tbody>
</table>

**Sources:** 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]

**Notes:**
- Asked of all respondents about a randomly-selected child aged 6 through 17 at home.
Many focus group participants discussed oral health in the community. The main issues included:

- Limited number of pediatric dentists
- Preventative dentistry
- Culture

Focus group participants feel oral health has an effect on a child’s overall health and that it is critical to get regular dental care. However, many families face barriers to accessing dental treatment. Many respondents believe that families with dental insurance as well as those without face barriers to care due to the limited number of pediatric dentists in the Omaha metropolitan area. Access for children on Medicaid can be an even greater hurdle due to the low reimbursement rate. A focus group respondent notes:

“There are a few pediatric dentists, so the parents have to kind of call around. They probably have to be a little bit aggressive. The second, some of us pediatricians are doing fluoride treatments and identify early decay, and instead of them seeing the pediatric dentist earlier they’re getting repair under general anesthesia a little later, and that access could be improved by better reimbursement for the dentist.” — Douglas County Physician

Another physician describes how geography can act a barrier to access:

“You get further and further east in Omaha, the dentists are less likely to take Medicaid because they’re already filled. They’ve got to hit their maximum, and so then you get to this point where yeah, there might be someone, but they’re in Papillion or Bellevue or west Omaha.” — Douglas County Physician

One option for uninsured children includes a dental clinic at Creighton University. The community health center in Council Bluffs also has one dentist on-site, but the wait list is extensive and it has become more crisis care than preventative dentistry. Respondents believe that preventative dentistry is very important to children’s long-term oral health.

In addition to access barriers, there are cultural barriers to overcome when educating some ethnic groups on proper oral healthcare. Sarpy County respondents describe the Sudanese population and the cultural barriers in their community:

“Well you look at Sudanese population and dental health is on the very bottom of the list. That is the first thing – and I was a school nurse for many years. That’s the first thing that goes. They just won’t take care of their teeth and, gosh, if you’ve ever had a – needed a root canal or if you’ve ever had a cavity, that hurts. And those kids are sitting there just putting up with the pain. And I see – when I do my medical assessments, I – probably one out of every – maybe every 20 or 25 needs dental care. They’ve got just horrible decay going on.” — Sarpy County Participant
A total of 61.2% of Metro Area parents indicate that their child had an eye exam in the past year.

- On the other hand, 15.9% of Metro Area children have not ever had an eye exam.

The prevalence of vision exams in the past two years does not vary by sub-area in Douglas County.

- By county: highest in Sarpy County, lowest in Douglas County.

RELATED ISSUE:
See also Blindness/Deafness in the Prevalence of Selected Medical Conditions section of this report.
As might be expected, Metro Area children under 5 are least likely to have had an eye exam in the past two years.

Child Had an Eye Exam in the Past Two Years  
(Metro Area, 2012)

Hearing Testing

Further, a total of 54.9% of Metro Area parents indicate that their child had a hearing test in the past year.

- On the other hand, 7.6% of Metro Area children have never had a hearing exam.
- Hearing tests in the past two years are notably high in Southeast Omaha but notably low in Northwest Omaha.
- No difference when viewed by county.

**Child Had a Hearing Test in the Past Two Years**

Children least likely to have had their hearing tested in the past year include girls, those under 5, teenagers, and non-White/non-Hispanic children.

**Child Had a Hearing Test in the Past Two Years (Metro Area, 2012)**

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. (Item 28)

Notes:
- Asked of all respondents about a randomly-selected child at home.
- 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. “Low Income” includes households with incomes up to 200% of the federal poverty level, “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
A total of 35.2% of Metro Area children have gone to a hospital emergency room, urgent care, Quick Care or walk-in clinic in the past year.

- In Douglas County, lowest in Southeast Omaha.
- By county, unfavorably high in Sarpy County.

Of these urgent/emergent visits, 9.6% resulted in a hospital admission.

Viewed by demographic characteristics, children of “Other” races are more likely to have been to an emergency room, urgent care, Quick Care or walk-in clinic for care in the past year.
Note that 71.2% of parents whose child received urgent or emergency care in the past year acknowledge that the injury or illness might have been treatable in a doctor’s office or clinic.

**Urgent/Emergent Care Visit Could Have Been Treated in a Doctor’s Office or Clinic**
(Child Used Urgent/Emergency Services in the Past Year; Metro Area, 2012)

<table>
<thead>
<tr>
<th>Yes</th>
<th>71.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>28.8%</td>
</tr>
</tbody>
</table>

Sources:  
- 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. (Item 31)

Notes:  
- Asked of all respondents about a randomly-selected child in the home who used some type of urgent or emergent care services in the past year.

As asked the reason they sought care urgent or emergent care instead of visiting a clinic or doctor’s office, 64.8% of these Metro Area parents mentioned after-hours or weekend visits, while 16.0% reported emergency or life-threatening situations and 8.9% cited some type of access barrier.
HEALTH EDUCATION & OUTREACH
Health Education

Healthcare Information Sources

Family physicians and the Internet are residents’ primary sources of healthcare information for their child.

- 71.9% of Metro Area respondents cited their family physician as their primary source of healthcare information for their child.
- The Internet received the second-highest response, with 7.5%.
  - Other sources mentioned include hospital publications (2.8%) and friends or relatives (2.7%).
- Just 0.9% of survey respondents say that they do not receive any healthcare information for their child.

Primary Source of Healthcare Information for Child
(Metro Area, 2012)

- Family Doctor 71.9%
- Internet 7.5%
- Hospital Publications 2.8%
- Friends/Relatives 2.7%
- Other 15.1%

Sources: 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 130]
Notes: Asked of all respondents about a randomly-selected child in the home.
Most (93.7%) Metro Area parents have access to the Internet.

- The prevalence is lowest in Southeast Omaha, highest in Southwest Omaha and Western Douglas County.
- By county: highest in Sarpy County, lowest in Douglas County.

The following populations are less likely to have Internet access:

- Lower-income households.
- Hispanics.

Related Focus Group Findings
Many focus group participants view health education as a critical component to having healthy children and adolescents. The discussion focused on:

- Health literacy
- Focus on the family
- Communication
- Trusted adult

Focus group participants feel that health education is an important aspect of prevention and improving the overall health for children and adolescents. Focus group members believe health educators are missing from the equation and could increase health literacy levels in the community. Children and adults need health education to improve health outcomes and take better care of their child. Some parents even lack basic health knowledge and may be embarrassed to ask physicians for clarification or additional information. One participant explains:

“I think that the parents lack the education to comprehend a lot of the direction that’s given to them by the medical community. I think sometimes they either simply don’t ask the questions, because they’re afraid they’re not gonna know what the answer put it in terms that they can understand.” — Pottawattamie County Participant

Participants think that a variety of agencies, including the school districts, healthcare providers, hospitals and social service agencies need to work together to increase health literacy in the community.

Education needs to focus on the family because kids learn behaviors from their parents and social norms are developed at home. Parents must serve as positive role models for their children. Parents themselves need to be motivated to change and can really only do this when they are aware and believe in the services available. Continuing to educate families about the available services is a top priority.

Current health education classes occur at Building Bright Futures, the Child Savings Institute, schools and local hospitals. Health education programs need to consider class times and location in order to reach the most at-risk families. Children’s Hospital and Medical Center offers parenting classes, but many at-risk families do not attend. One participant describes:

“I gave a parent talk a few weekends ago, but the people who most need to worry either don’t have the availability to get there, they didn’t even hear about it, they don’t have the childcare, it’s not close enough to home. We could do a great job with family education if we were in the right corridors of town.” — Douglas County Physician

Communicating health education and prevention messaging with children and adolescents has changed in the past decade with the advent of social media like Facebook and Twitter. Focus group participants feel there are a variety of communication channels that can be utilized to reach their targeted audience. Facebook pages, Twitter, email blasts and text messaging are some of the newest avenues. The participants note that it is also very important to speak directly with youth and obtain their perspective. In addition, informal and formal networking still occurs and youth may hear of services through their social network. A respondent explains that the actual educational
component is perhaps better served face-to-face, but social media can grab youth's attention:

“"I mean I think that it gets their attention. Where you go from there, it can't be the only thing... There’s a whole component missing [in social media] sometimes the social skills are lacking and the verbiage you get on texting may not be what you mean to say.” — Sarpy County Participant

Another important aspect of communication involved the idea of a trusted adult. Several focus group participants spoke at length about the need for children and adolescents to believe that they can have a confidential conversation with an adult. This person might be located in a variety of settings, as one participant describes:

“"I think you hit it right with trusted adult. We were trying to figure out why kids don’t go to the traditional centers that we grew up with and the spaces – and I don’t want to call any by name but they were not showing up there and a lot of the programming was going on. And they said, ‘We don’t go to a program. Put the right person in front of us, we’ll sit outside.’ That changed the whole perspective. It was never about a building. How slick the walls were. How creative we put stuff. ‘Put the right person in front of me, I’ll sit out in the grass.’ So that changes everything. If you don’t have that trusted individual to be able to navigate through life with them. They’re not coming.” — Douglas County Community Leader
Parenting Education

Among Metro Area survey respondents, 6 in 10 (60.0%) are aware of parenting education programs offered in the community.

- In Douglas County, no difference in awareness by sub-area.
- Further, no difference when viewed by county.

**Aware of Local Parenting Education Programs**

When asked to specify which program they are aware of, the largest share of these respondents (18.5%) mentioned school programs, followed by Boys Town National Research Hospital (16.6%) and Children’s Hospital and Medical Center (5.5%).

- Among respondents who are aware of local parenting education programs, 38.0% have utilized these resources.

**Awareness of Local Parenting Education Programs**
(Metro Area, 2012)

Sources: ● 2012 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 131]
Notes: ● Asked of all respondents.
Cultural Competency

Related Focus Group Findings

Many focus group participants discussed culture and its relationship to healthcare. The issue highlighted was the need for:

- Cultural competency

Focus group members agree that the community is home to a variety of different ethnicities and that medical providers service a range of cultures. The focus group participants think that both physicians and service providers need to possess **cultural competence** in order to make an impact on an individual’s health. Culturally competent providers can recognize how culture affects a patient’s attitudes and tailor their communication accordingly. An example of how critical culturally-appropriate messaging is with the Sudanese population in Sarpy County:

"I educate on secondhand smoke at apartments where there’s a large Sudanese population and things like that where I have mothers that really understand that if they’re smoking that the secondhand smoke is very much hurting and endangering their child. But when they bring the fathers down they’re mocking me. I mean it’s very sad how they don’t want to understand why their kid is always – has an ear infection or why their kid is asthmatic and all of the situations that come around from secondhand smoke. And it’s such a cultural barrier." — Sarpy County Participant
Collaboration

Related Focus Group Findings

Participants spent time discussing the varying levels of collaboration occurring in the community between non-profit organizations, schools, and healthcare providers. The themes surrounding collaboration were:

- Excellent collaboration
- Time and trust
- Coordinated effort

Many of the focus group respondents feel there is excellent collaboration happening in the community between businesses, social service agencies, law enforcement, the school system and healthcare providers in promoting child and adolescent health. The current financial climate has created some strain on organizations, which makes these efforts even more critical. The Omaha Public School District has begun collaborating with a local hospital to place healthcare clinics in schools and thus far the results have been promising.

There is some concern about the ability of hospital facilities to collaborate with one another, although physician-to-physician relationships are generally positive. Administrative barriers and politics can be inadvertent road blocks for collaboration, and social service agencies feel these constraints.

Focus group participants note that collaborative efforts take time and trust and may take years to build. Several Douglas County focus group participants believe it is important for organizations to recognize that there are excellent existing programs in place and that organizations do not need to “reinvent the wheel.” In Pottawattamie County, the social service agencies have been around for a long time and things flow smoothly. Their social service agencies work diligently to complement one another without duplicating services, as a Pottawattamie County social service provider describes:

“We work diligently not to duplicate services. It happens. Sometimes it absolutely needs to happen, but for the most part, we work alongside each other and complement each other’s services. We don’t generally compete. Some of that has to do with the relationships and the trust that’s been built over the years. There are people in this room that I’ve worked with for many, many years, and when you don’t have a revolving door of service providers, you can begin to build some relationships.” — Pottawattamie County Participant

The focus group attendees believe that a coordinated effort could help streamline the collaboration processes, aid in organization and eliminate repetitive meetings. A coordinated effort would benefit the operating-over-capacity agencies and provide the best care for the children in the community. A participant explains:

“I know that this week I’m going to two different school-based mental health meetings that are being hosted by totally different funders and pathways. And everybody – I mean there are lots of groups- don’t you think? I mean we live in meetings where this one is a truancy initiative sponsored by this group. And then another doesn’t call it truancy but now they’re starting to call it absenteeism.” — Douglas County Community Leader
APPENDICES
Appendix: Public Health & Community Stakeholder Input

Focus groups held as part of this Community Health Needs Assessment incorporated input from 46 key informants (or community stakeholders), with special emphasis on persons who work with or have special knowledge about vulnerable populations in the Metro Area, including low-income individuals, minority populations, those with chronic conditions, and other medically underserved residents. A list of these participants is provided in the following pages.

<table>
<thead>
<tr>
<th>Focus Group Participant</th>
<th>Organization</th>
<th>Populations Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medically Underserved</td>
</tr>
<tr>
<td>Dr. Eduardo Delgado</td>
<td>Downtown Pediatric Clinic</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Gina Direnzo-Coffey</td>
<td>Bergan Medical Building Pediatric Clinic</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Debra Esser</td>
<td>Coventry Health Care Of Nebraska</td>
<td>x</td>
</tr>
<tr>
<td>Dr. David Filipi</td>
<td>Blue Cross Blue Shield Of Nebraska</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Michelle R. Horton Brown</td>
<td>Endeveren Family Medicine</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Ed Kolb</td>
<td>Downtown Pediatric Clinic</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Kari Simonsen</td>
<td>UNMC Medical Advisor To Douglas Country Health Dept.</td>
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<td>Dr. Chuck Sprague</td>
<td>Lakeside Pediatric Clinic</td>
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<td>Mr. Ira Combs</td>
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<td>Ms. Hefferman Dorothy</td>
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<td>Ms. Kay Farrel</td>
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<td>Ms. Nancy Hemesath</td>
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<tr>
<td>Ms. Ann Lawless</td>
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<td>Ms. Donna Polk-Primm</td>
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<td>Ms. Sharon Wade</td>
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<td>PRIDE Omaha</td>
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<td>Mr. Steven Martin</td>
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<td>Ms. Carolina Quezada</td>
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<td>Ms. Carolyn Rooker</td>
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<td>Ms. Roberta Wilhelm</td>
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<td>Ms. Karen Authier</td>
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<td>Ms. Ruth Henrichs</td>
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<td>Dr. Brad Conner</td>
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<td>Ms. Bridgette Laney</td>
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<td>Ms. Valerie Galing</td>
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<td>Mr. Curtis Rainge</td>
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<td>Ms. Kathy Roehrig</td>
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<td>Ms. Rebecca Tamayo</td>
<td>OneWorld</td>
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<td>Mr. Russ Zeeb</td>
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<td>Mr. Brian Fuller</td>
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<td>Mr. Tom Hanafan</td>
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<td>Mr. Geoff Hubbard</td>
<td>Council Bluffs Parks &amp; Recreation</td>
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<td>Ms. Ejay Jack</td>
<td>Planned Parenthood of the Heartland</td>
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<td>Ms. Deb Kissel</td>
<td>Green Hills AEA /Community Youth Corrections Dept</td>
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<td>Ms. Susan Roarty</td>
<td>Pottawattamie Juvenile Justice</td>
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<td>Ms. Angie Sada</td>
<td>Boys &amp; Girls Club</td>
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<td>Mr. Ryan Willer</td>
<td>Neighborhood Center</td>
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<tr>
<td>Ms. Kris Wood</td>
<td>Pottawattamie County WIC Program</td>
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Note that two of these participants have special knowledge of and expertise in public health:

Dr. Kari Simonsen is Assistant Professor of Pediatrics, Division of Infectious Diseases at University of Nebraska Medical Center and the UNMC Advisor to the Douglas County Public Health Department. She is formerly Fellow, Pediatric Infectious Diseases at Brown University. She received her medical degree from UNMC in 2001 and completed her residency in pediatrics at Indiana University in 2004.

Ms. Kris Wood is Program Coordinator for the Pottawattamie County WIC program, a position she has held since 2009. She is also a current member of the Human Service Advisory Council, and a 2009-2010 member of the Iowa Dietetic Association Board. Ms. Wood was previously employed at Mid-Iowa Community Action and is a graduate of the University of Nebraska – Lincoln.