

Executive Report

2015 Community Health Needs Assessment

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

Sponsored by:

CHI Health
Douglas County Health Department
Live Well Omaha
Methodist Health System
Nebraska Medicine
Pottawattamie County Public Health Department/VNA
Sarpy/Cass County Department of Health and Wellness

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2015-0342-02
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Introduction



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Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2011, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Omaha metropolitan area (including Douglas, Sarpy, Cass, and Pottawattamie counties). Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was sponsored by a coalition comprised of local health systems and local health departments. Sponsors include: **CHI Health** (CHI Health Bergan Mercy, CHI Health Creighton University Medical Center, CHI Health Immanuel, CHI Health Lakeside, CHI Health Mercy Council Bluffs, and CHI Health Midlands); **Douglas County Health Department**; **Live Well Omaha**; **Methodist Health System** (Methodist Hospital, Methodist Jennie Edmundson Hospital, and Methodist Women's Hospital); **Nebraska Medicine** (Nebraska Medicine–Nebraska Medical Center and Nebraska Medicine–Bellevue); **Pottawattamie County Public Health Department/VNA**; and **Sarpy/Cass County Department of Health and Wellness**.

This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting

Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

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

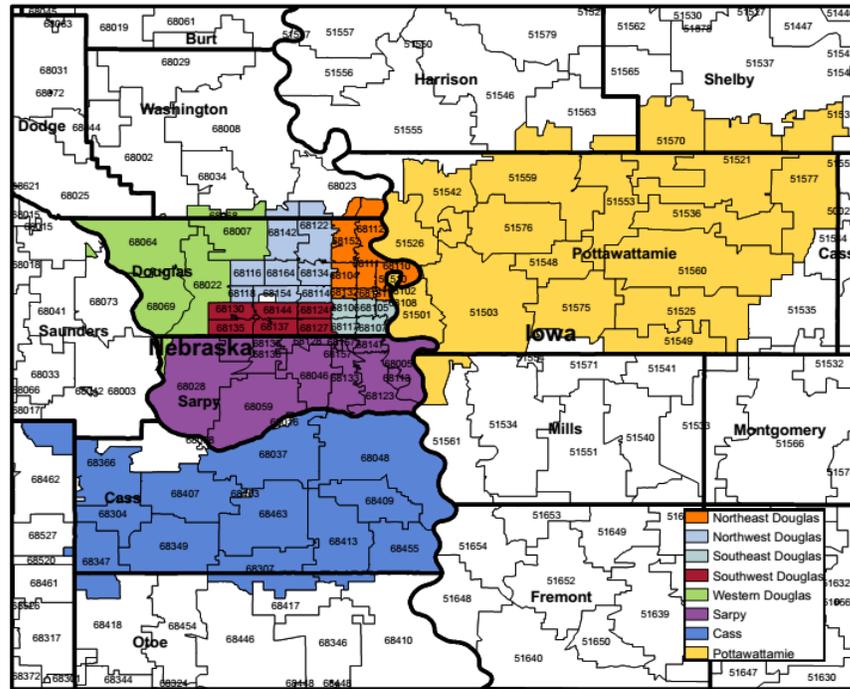
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the sponsoring organizations and PRC and is similar to the previous survey used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Metro Area” in this report) includes Douglas, Sarpy, and Cass counties in Nebraska, as well as Pottawattamie County in Iowa. Douglas County is further divided into 5 geographical areas (Northeast Omaha, Southeast Omaha, Northwest Omaha, Southwest Omaha, and Western Douglas County). This community definition is illustrated in the following map.



Sample Approach & Design

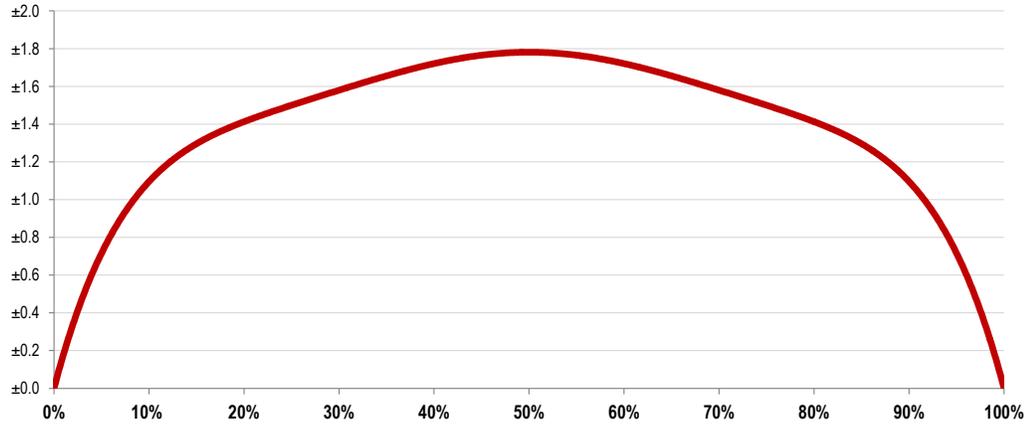
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a stratified random sample of individuals age 18 and older in the Metro Area. Initially, stratified targets were established for each county or subcounty area: 1,000 surveys in Douglas County (200 in each of the five subcounty areas); 200 in Cass County; and 400 in each of Sarpy and Pottawattamie counties. In addition, multiple oversamples were implemented in Douglas County to: 1) increase samples among Black and Hispanic residents; and 2) increase samples to target a minimum of 50 surveys in each ZIP Code in the county. With these oversampling measures, the final sample included 2,622 Metro Area residents, including 1,621 in Douglas County, 400 in Sarpy County, 201 in Cass County, and 400 in Pottawattamie County.

Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Metro Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 2,622 respondents is $\pm 1.8\%$ at the 95 percent level of confidence.

Expected Error Ranges for a Sample of 2,622 Respondents at the 95 Percent Level of Confidence



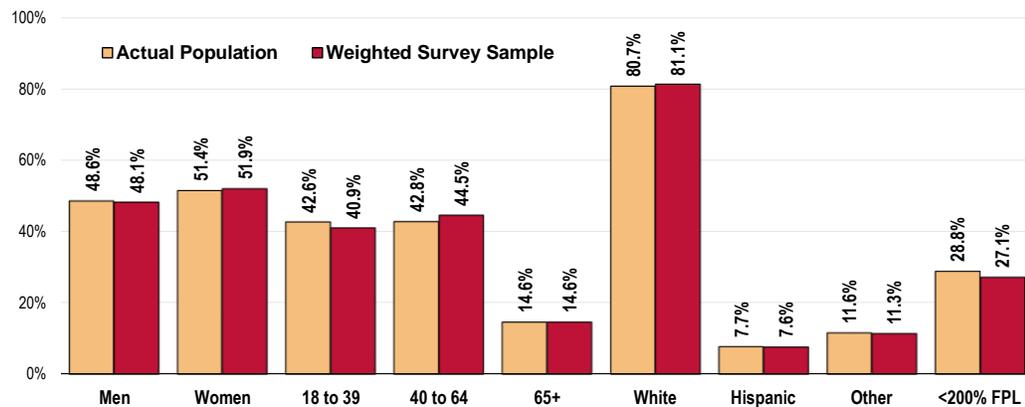
- Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.
- Examples:
- If 10% of the sample of 2,622 respondents answered a certain question with a "yes," it can be asserted that between 8.9% and 11.1% ($10\% \pm 1.1\%$) 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 48.2% and 51.8% ($50\% \pm 1.8\%$) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, 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, 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 gender, age, race, ethnicity, and 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 demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics (Metro Area, 2015)



Sources:
 • Census 2010, Summary File 3 (SF 3). US Census Bureau.
 • 2015 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g., the 2014 guidelines place the poverty threshold for a family of four at \$23,850 annual household income or lower*). In sample segmentation: “**very low income**” refers to community members living in a household with defined poverty status; “**low income**” refers to households with incomes just above the poverty level, earning up to twice the poverty threshold; and “**mid/high income**” refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 138 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

| Online Key Informant Survey Participation | | |
|---|----------------|----------------------|
| Key Informant Type | Number Invited | Number Participating |
| Community/Business Leader | 94 | 24 |
| Other Health | 87 | 38 |
| Physician | 49 | 14 |
| Public Health Representative | 13 | 10 |
| Social Service Provider | 113 | 52 |

Final participation included representatives of the organizations outlined below.

- Alegent Creighton Health
- Alegent Creighton L Street Clinic
- All Care Health Center
- American Cancer Society
- Bethany Lutheran Home
- Broadway United Methodist Church
- Building Healthy Futures
- CASA
- Catholic Charities of the Archdiocese of Omaha
- Center for Health Policy and Ethics at Creighton University
- Center for Holistic Development
- Charles Drew Health Center Intercultural Senior Center
- CHI Alegent Creighton Health Clinic-Bellevue
- CHI Clinics
- CHI Health
- CHI Health Immanuel Medical Center
- CHI Health Mercy Council Bluffs
- Children's Hospital and Medical Center
- Children's Square USA
- City of Omaha
- Connections Area Agency on Aging
- Council Bluffs Senior Center, Inc.
- Council Bluffs YMCA
- Creighton University
- Creighton University Health Sciences - MCAD
- Creighton University School of Dentistry
- Douglas County
- Douglas County Commissioner

- Douglas County General Assistance
- Douglas County Health Department
- Douglas County Health Department
- Douglas County Health Department
- Eastern Nebraska Office on Aging
- Food Bank for the Heartland
- Fred Leroy Health and Wellness Center
- Heartland Family Service
- Hope Medical Outreach Coalition
- Iowa Department of Human Services
- Lamp Rynearson and Associates
- Livewise
- Local Government
- Lutheran Family Services of Nebraska, Inc.
- Methodist Health System
- Methodist Jennie Edmundson Hospital
- Methodist Physicians Clinic
- Methodist Renaissance Health Clinic
- Metro Area Continuum of Care for the Homeless
- Nebraska Center for Healthy Families
- Nebraska Children's Home Society
- Nebraska Extension in Douglas-Sarpy Counties
- Nebraska Medicine
- Nebraska Medicine Clinics
- Nebraska Medicine Family Medicine Bellevue
- Nebraska Medicine Plattsmouth Internal Medicine Clinic
- Nebraska Medicine/Diabetes Center
- Nebraska Methodist Heidi Wilke SANE/SART Program
- Nebraska Urban Indian Health Coalition
- North Omaha Area Health Inc.
- Omaha Fire Department
- Omaha Housing Authority
- Omaha Metropolitan Medical Response System
- Omaha Police Department
- OneWorld Community Health Centers
- Pottawattamie County Board of Health
- Pottawattamie County Community Services
- Pottawattamie County WIC Program
- Project Everlast Omaha
- Project Harmony

- Refugee Empowerment Center
- Refugee Health Collaborative
- Salem Baptist Church
- Sarpy County Cooperative Head Start
- Siena/Francis House
- Stephen Center, Inc.
- Ted E. Bear Hollow
- The Sherwood Foundation
- Tobacco Free Sarpy
- Together
- Tri-City Food Pantry
- University of NE Med Center College of Public Health
- UNMC
- UNMC/Center for Reducing Health Disparities
- Visiting Nurse Association
- VNA of Pottawattamie County
- VODEC
- Voices for Children in Nebraska
- West Central Community Action
- YMCA of Greater Omaha
- Zion Recovery Services

Through this process, input was gathered from several individuals whose organizations work with **low-income, minority populations** (*including African-American, American Indian, Asian, asylees, Bhutanese, Burmese, Caucasian/White, child welfare system, children, disabled, elderly, ESL, hearing-impaired, Hispanic, homeless, immigrants/refugees, interracial families, Karen, LGBT, low-income, Medicaid, mentally ill, Middle Eastern, minorities, Muslim refugees, Nepali refugees, non-English speaking, North and South Omaha, residents of the suburbs, retired, rural, single-parent families, Somalian, Southeast Asian, Sudanese, teen pregnancy, underserved, undocumented, uninsured/ underinsured, veterans, Vietnamese, women and children, working professionals*), or other **medically underserved populations** (*including African-Americans, AIDS/HIV, autistic, Caucasian/white, children (including those with incarcerated parents and those of parents with mental illness), disabled, domestic abuse and sexual assault victims, elderly, ex-felons and recently incarcerated, Hispanic, homeless, immigrants/refugees, lack of transportation, LGBT, low-income, Medicaid/Medicare, mentally ill, minorities, non-English speaking, North and South Omaha, prenatal, substance abusers, undocumented, uninsured/underinsured, veterans, WIC clients, women and children, young adults*).

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

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

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this 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):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that the secondary data presented reflect a compilation of county-level data.

Benchmark Data

Trending

A similar survey was administered in the Metro Area in 2011 by PRC on behalf of the sponsoring organizations. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. In addition, county-specific trending has been provided for Douglas County as well as Sarpy/Cass Counties (combined) based on similar surveys administered in 2002 and 2008. Historical data for secondary data indicators are also included for the purposes of trending.

Nebraska & Iowa Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2013 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

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

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



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

Determining Significance

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

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of 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, pregnant women, lesbian/gay/bisexual/transgender residents, 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 terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Summary of Findings

Significant Health Needs of the Community

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

| Areas of Opportunity Identified Through This Assessment | |
|---|--|
| Access to Healthcare Services | <ul style="list-style-type: none"> • Barriers to Access: Difficulty Finding a Physician |
| Cancer | <ul style="list-style-type: none"> • Cancer Deaths <ul style="list-style-type: none"> ◦ Including Lung Cancer, Prostate Cancer, Colorectal Cancer Deaths • Cancer Incidence <ul style="list-style-type: none"> ◦ Including Female Breast Cancer, Lung Cancer, Colorectal Cancer Incidence • Cervical Cancer Screening |
| Dementia, Including Alzheimer's Disease | <ul style="list-style-type: none"> • Alzheimer’s Disease Deaths |
| Diabetes | <ul style="list-style-type: none"> • Diabetes Deaths • <i>Diabetes ranked as a top concern in the Online Key Informant Survey.</i> |
| Heart Disease & Stroke | <ul style="list-style-type: none"> • Stroke Prevalence • <i>Heart Disease & Stroke ranked as a top concern in the Online Key Informant Survey.</i> |
| Injury & Violence | <ul style="list-style-type: none"> • Safety Seat/Seat Belt Usage [Children] • Firearm-Related Deaths • Homicide Deaths • Violent Crime Rate & Victimization • <i>Injury & Violence ranked as a top concern in the Online Key Informant Survey.</i> |
| Mental Health | <ul style="list-style-type: none"> • <i>Mental Health ranked as a top concern in the Online Key Informant Survey.</i> |
| Nutrition, Physical Activity & Weight | <ul style="list-style-type: none"> • Overweight Prevalence [Adults] • Use of Local Trails • Children’s Physical Activity • Access to Recreation/Fitness Facilities • <i>Nutrition, Weight, and Physical Activity ranked as a top concern in the Online Key Informant Survey.</i> |

-- continued next page --

| Areas of Opportunity (<i>continued</i>) | |
|---|--|
| Respiratory Diseases | <ul style="list-style-type: none"> • Chronic Lower Respiratory Disease (CLRD) Deaths |
| Sexually Transmitted Diseases | <ul style="list-style-type: none"> • Gonorrhea Incidence • Chlamydia Incidence • Multiple Sexual Partners • <i>Sexually Transmitted Diseases ranked as a top concern in the Online Key Informant Survey.</i> |
| Substance Abuse | <ul style="list-style-type: none"> • Cirrhosis/Liver Disease Deaths • Drug-Induced Deaths • Seeking Help for Alcohol/Drug Issues |

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Metro Area, including comparisons among the individual communities, as well as trend data. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables

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

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

TREND SUMMARY (Current vs. Baseline Data)

Survey Data Indicators: Trends for survey-derived indicators represent significant changes since 2011.

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

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Social Determinants | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| Linguistically Isolated Population (Percent) | | | | | | 4.2 | 1.9 | 0.2 | 1.9 |
| Population in Poverty (Percent) | | | | | | 14.3 | 6.6 | 6.4 | 13.8 |
| Population Below 200% FPL (Percent) | | | | | | 31.9 | 19.4 | 19.6 | 30.8 |
| Children Below 200% FPL (Percent) | | | | | | 40.6 | 26.1 | 25.9 | 40.9 |
| No High School Diploma (Age 25+, Percent) | | | | | | 10.5 | 5.1 | 6.0 | 10.7 |
| Unemployment Rate (Age 16+, Percent) | | | | | | | | | |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------------------------|--------|--------|--------|------------|-------|
| 3.3 | 1.8 | 3.0 | 4.8 | | |
| 12.4 | 12.4 | 12.8 | 15.4 | | |
| 28.8 | 30.4 | 31.6 | 34.2 | | |
| 37.0 | 37.9 | 40.2 | 43.8 | | |
| 9.3 | 9.0 | 9.6 | 14.0 | | |
| 3.2 | 3.5 | 3.0 | 5.6 | | 4.4 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Overall Health | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % "Fair/Poor" Physical Health | 15.6 | 17.6 | 7.1 | 7.9 | 7.0 | 11.2 | 6.7 | 15.6 | 14.8 |
| % Activity Limitations | 22.2 | 18.6 | 13.8 | 17.2 | 13.6 | 17.5 | 17.5 | 16.1 | 26.1 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------------------------|--------|--------|--------|------------|-------|
| 10.9 | 14.4 | 13.9 | 15.3 | | 12.7 |
| 18.5 | 19.1 | 18.8 | 21.5 | | 18.4 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Access to Health Services | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % [Age 18-64] Lack Health Insurance | 21.6 | 19.6 | 4.5 | 2.6 | 6.1 | 10.8 | 5.3 | 8.2 | 6.5 |
| % [Insured] Went Without Coverage in Past Year | 10.7 | 9.2 | 5.5 | 4.2 | 1.7 | 6.5 | 5.4 | 3.3 | 5.4 |
| % Difficulty Accessing Healthcare in Past Year (Composite) | 42.2 | 39.3 | 34.2 | 34.2 | 25.2 | 36.4 | 26.4 | 31.4 | 33.4 |
| % Inconvenient Hrs Prevented Dr Visit in Past Year | 17.3 | 12.2 | 12.9 | 16.8 | 5.1 | 14.4 | 11.6 | 12.1 | 15.2 |
| % Cost Prevented Getting Prescription in Past Year | 20.4 | 14.2 | 12.6 | 11.5 | 9.3 | 14.1 | 7.0 | 6.0 | 13.8 |
| % Cost Prevented Physician Visit in Past Year | 22.0 | 9.7 | 8.9 | 13.6 | 6.4 | 13.1 | 8.4 | 12.4 | 14.3 |
| % Difficulty Getting Appointment in Past Year | 16.3 | 16.3 | 10.4 | 11.9 | 9.0 | 13.2 | 8.0 | 14.4 | 13.1 |
| % Difficulty Finding Physician in Past Year | 13.0 | 11.3 | 9.0 | 10.1 | 2.3 | 10.3 | 6.1 | 11.0 | 8.6 |
| % Cultural/Language Differences Prevented Med Care/Past Yr | 0.8 | 1.5 | 0.6 | 0.6 | 0.0 | 0.8 | 0.0 | 0.0 | 0.2 |
| % Transportation Hindered Dr Visit in Past Year | 13.8 | 9.1 | 1.8 | 3.0 | 1.3 | 6.1 | 1.9 | 6.0 | 5.9 |
| % [Sarpy/Cass/Pott.] Traveled 30+ Min for Medical Appt/Past Yr | | | | | | | 7.8 | 39.7 | 19.0 |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|--------|--------|------------|-------|
| 9.1 | 12.7 | 17.6 | 15.1 | 0.0 | 12.1 |
| 6.0 | | | 8.1 | | 5.5 |
| 33.9 | | | 39.9 | | 33.4 |
| 13.9 | | | 15.4 | | 12.5 |
| 12.4 | | | 15.8 | | 14.3 |
| 12.3 | | | 18.2 | | 14.5 |
| 12.2 | | | 17.0 | | 10.5 |
| 9.3 | | | 11.0 | | 6.6 |
| 0.5 | | | | | |
| 5.3 | | | 9.4 | | 4.7 |
| 14.6 | | | | | 19.6 |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Access to Health Services (continued) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % Skipped Prescription Doses to Save Costs | 23.2 | 12.4 | 12.3 | 12.9 | 5.7 | 14.5 | 8.6 | 13.7 | 17.8 |
| Primary Care Doctors per 100,000 | | | | | | 98.4 | 51.9 | 31.8 | 46.3 |
| % Have a Particular Place for Medical Care | 87.6 | 80.3 | 85.1 | 84.7 | 90.9 | 84.9 | 86.7 | 84.0 | 89.5 |
| % Difficulty Getting Child's Healthcare in Past Year | 11.8 | 2.8 | 0.9 | 1.4 | 0.0 | 3.5 | 2.6 | 1.0 | 4.5 |
| % Have Had Routine Checkup in Past Year | 64.7 | 67.9 | 65.3 | 64.4 | 57.1 | 65.0 | 71.2 | 67.4 | 72.1 |
| % Child Has Had Checkup in Past Year | 85.0 | 84.1 | 85.9 | 83.5 | 90.2 | 85.0 | 88.3 | 89.9 | 88.0 |
| % Two or More ER Visits in Past Year | 10.2 | 6.8 | 2.5 | 2.4 | 4.8 | 5.1 | 2.5 | 2.7 | 10.9 |
| % Rate Local Healthcare "Fair/Poor" | 18.6 | 13.2 | 6.9 | 5.0 | 4.4 | 9.9 | 7.4 | 14.8 | 13.4 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------------------------|--------|--------|--------|------------|-------|
| 13.7 | | | 15.3 | | 13.6 |
| 81.0 | 72.7 | 71.2 | 74.5 | | |
| 85.8 | | | 76.3 | | 86.3 |
| 3.3 | | | 6.0 | | 1.9 |
| 67.1 | 69.6 | 61.6 | 65.0 | | 66.8 |
| 86.3 | | | 84.1 | | 87.8 |
| 5.2 | | | 8.9 | | 4.9 |
| 10.1 | | | 16.5 | | 8.9 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Arthritis, Osteoporosis & Chronic Back Conditions | Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas) | | | | | | | | |
|--|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
| % [50+] Arthritis/Rheumatism | 37.2 | 30.1 | 28.1 | 24.5 | 27.5 | 29.4 | 27.3 | 20.9 | 39.2 |
| % [50+] Osteoporosis | 12.1 | 9.4 | 8.9 | 5.2 | 5.4 | 8.4 | 8.3 | 9.4 | 10.2 |
| % Sciatica/Chronic Back Pain | 22.7 | 13.0 | 18.5 | 14.7 | 19.7 | 17.3 | 12.2 | 14.0 | 17.0 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 30.1 | | | 37.3 | | 32.5 |
| 8.7 | | | 13.5 | 5.3 | 9.6 |
| 16.2 | | | 18.4 | | 15.1 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Cancer | Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas) | | | | | | | | |
|--|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
| Cancer (Age-Adjusted Death Rate) | | | | | | 180.5 | 167.6 | 176.4 | 184.2 |
| Lung Cancer (Age-Adjusted Death Rate) | | | | | | | | | |
| Prostate Cancer (Age-Adjusted Death Rate) | | | | | | | | | |
| Female Breast Cancer (Age-Adjusted Death Rate) | | | | | | | | | |
| Colorectal Cancer (Age-Adjusted Death Rate) | | | | | | | | | |
| Prostate Cancer Incidence per 100,000 | | | | | | 140.1 | 136.7 | 117.6 | 115.7 |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 178.5 | 170.0 | 163.4 | 166.2 | 161.4 | 189.6 |
| 51.4 | 46.6 | 42.7 | 44.7 | 45.5 | |
| 22.3 | 20.0 | 21.6 | 19.8 | 21.8 | |
| 21.9 | 19.6 | 20.2 | 21.3 | 20.7 | |
| 16.7 | 16.3 | 16.0 | 14.9 | 14.5 | |
| 135.0 | 133.3 | 136.6 | 142.3 | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Cancer (continued) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| Female Breast Cancer Incidence per 100,000 | | | | | | 132.5 | 124.8 | 121.3 | 139.7 |
| Lung Cancer Incidence per 100,000 | | | | | | 72.5 | 64.9 | 67.5 | 90.4 |
| Colorectal Cancer Incidence per 100,000 | | | | | | 47.6 | 46.3 | 50.0 | 54.3 |
| Cervical Cancer Incidence per 100,000 | | | | | | 6.7 | 5.7 | | 6.5 |
| % Skin Cancer | 3.2 | 2.0 | 5.2 | 6.8 | 5.0 | 4.6 | 5.3 | 10.6 | 6.2 |
| % Cancer (Other Than Skin) | 6.2 | 3.3 | 2.9 | 4.9 | 6.7 | 4.5 | 5.5 | 8.5 | 8.0 |
| % [Women 50-74] Mammogram in Past 2 Years | 76.5 | 79.3 | 86.3 | 78.0 | 86.9 | 80.2 | 85.4 | 78.0 | 73.6 |
| % [Women 21-65] Pap Smear in Past 3 Years | 69.4 | 82.6 | 80.0 | 81.6 | 82.3 | 78.8 | 85.3 | 77.6 | 75.7 |
| % [Age 50-75] Colorectal Cancer Screening | 73.5 | 61.7 | 84.9 | 78.6 | 75.3 | 75.6 | 72.8 | 72.1 | 71.6 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|--|--------|--------|--------|------------|-------|
| 131.8 | 124.8 | 121.8 | 122.7 | | |
| 73.8 | 66.8 | 60.0 | 64.9 | | |
| 48.5 | 48.4 | 48.4 | 43.3 | | |
| 6.5 | 6.8 | 7.2 | 7.8 | | |
| 5.1 | 6.1 | 5.9 | 6.7 | | 5.3 |
| 5.2 | 7.1 | 6.8 | 6.1 | | 5.8 |
| 80.2 | 78.2 | 72.9 | 83.6 | 81.1 | 82.3 |
| 79.7 | 78.0 | 76.6 | 83.9 | 93.0 | 86.7 |
| 74.4 | | | 75.1 | 70.5 | 75.3 |
| <div style="display: flex; justify-content: space-around; align-items: center;"> <div> better</div> <div> similar</div> <div> worse</div> </div> | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Chronic Kidney Disease | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|--|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | Kidney Disease (Age-Adjusted Death Rate) | | | | | | 12.2 | 11.8 | |
| % Kidney Disease | 3.0 | 4.5 | 1.0 | 1.5 | 3.8 | 2.4 | 1.6 | 3.8 | 2.8 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 11.6 | 8.2 | 9.8 | 13.2 | | 13.0 |
| 2.3 | 2.2 | 2.0 | 3.0 | | |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Dementias, Including Alzheimer's Disease | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | Alzheimer's Disease (Age-Adjusted Death Rate) | | | | | | 26.3 | 25.3 | 33.9 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 28.1 | 30.3 | 24.7 | 24.0 | | 23.9 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Diabetes | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|---|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | Diabetes Mellitus (Age-Adjusted Death Rate) | | | | | | 23.3 | 18.6 | |
| % Diabetes/High Blood Sugar | 13.4 | 12.7 | 7.3 | 6.2 | 8.9 | 9.5 | 7.9 | 11.2 | 11.0 |
| % Borderline/Pre-Diabetes | 5.0 | 5.0 | 7.7 | 4.5 | 6.2 | 5.6 | 3.6 | 4.9 | 5.8 |
| % [Non-Diabetes] Blood Sugar Tested in Past 3 Years | 45.2 | 51.0 | 51.1 | 48.6 | 61.4 | 49.7 | 48.6 | 48.4 | 50.3 |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 22.7 | 18.8 | 21.4 | 21.3 | 20.5 | 23.4 |
| 9.4 | 9.3 | 9.2 | 11.7 | | 10.6 |
| 5.2 | | | 5.1 | | |
| 49.5 | | | 49.2 | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Diabetes (continued) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | % [Diabetics] Taking Insulin/Medication | | | | | | | | |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|------------|------------|------------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 82.4 | | | ☁️ 80.4 | | ☁️ 83.4 |
| | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Educational & Community-Based Programs | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|--------------------------------------|------------|------------|------------|-----------------|----------------|--------------|-------------|--------------|
| | % Attended Health Event in Past Year | ☁️ 27.1 | ☁️ 24.8 | ☁️ 23.6 | ☁️ 20.9 | ☀️ 32.9 | ☁️ 24.3 | ☁️ 27.7 | 🌧️ 18.5 |
| % "Frequently/Sometimes" Use Email/Text w/Dr or Hospital | ☁️ 22.7 | ☁️ 22.5 | ☁️ 28.3 | ☁️ 24.2 | ☁️ 22.5 | ☁️ 24.4 | ☁️ 25.6 | ☁️ 25.3 | 🌧️ 20.3 |
| % Have a Completed Advance Directive/Living Will | ☁️ 28.5 | 🌧️ 21.5 | ☁️ 33.9 | ☀️ 36.5 | ☀️ 46.0 | ☁️ 31.7 | ☁️ 33.0 | ☁️ 29.7 | ☁️ 31.8 |
| % Health Info is Seldom/Never Easy to Understand | 🌧️ 10.4 | 🌧️ 10.2 | ☁️ 4.5 | ☀️ 2.9 | ☀️ 1.6 | ☁️ 6.3 | ☁️ 5.4 | ☁️ 6.1 | ☁️ 4.4 |
| % Always/Nearly Always Need Someone to Help Read Health Info | ☁️ 3.2 | ☁️ 4.0 | 🌧️ 6.6 | ☀️ 2.3 | ☀️ 0.5 | 🌧️ 3.8 | ☀️ 1.4 | ☁️ 3.8 | ☁️ 3.5 |
| % Health Info is Seldom/Never Spoken in an Easily Understood Way | 🌧️ 10.4 | 🌧️ 10.2 | ☁️ 4.5 | ☀️ 2.9 | ☀️ 1.6 | ☁️ 6.3 | ☁️ 5.4 | ☁️ 6.1 | ☁️ 4.4 |
| % "Not At All Confident" About Filling Out Health Forms | ☁️ 1.4 | ☁️ 2.8 | ☁️ 3.9 | ☁️ 2.0 | ☀️ 1.0 | ☁️ 2.4 | ☁️ 2.1 | 🌧️ 5.9 | ☁️ 1.8 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|------------|------------|------------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 24.6 | | | ☁️ 23.8 | | ☁️ 23.8 |
| 24.2 | | | | | ☀️ 11.6 |
| 31.9 | | | | | ☀️ 29.2 |
| 6.0 | | | | | |
| 3.3 | | | | | |
| 5.9 | | | | | |
| 2.4 | | | | | |
| | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Family Planning | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| Births to Teenagers (Percent) | | | | | | 6.3 | 4.0 | | |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 5.6 | 6.5 | 6.4 | 7.8 | | 8.2 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Hearing & Other Sensory or Communication Disorders | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % Deafness/Trouble Hearing | 8.1 | 7.5 | 5.8 | 7.9 | 6.7 | 7.3 | 8.4 | 9.3 | 15.9 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 8.6 | | | 10.3 | | 9.8 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Heart Disease & Stroke | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| Diseases of the Heart (Age-Adjusted Death Rate) | | | | | | 151.5 | 139.5 | 150.1 | 165.7 |
| Stroke (Age-Adjusted Death Rate) | | | | | | 40.8 | 38.7 | 29.2 | 29.3 |
| % Heart Disease (Heart Attack, Angina, Coronary Disease) | 4.8 | 4.8 | 3.7 | 5.9 | 4.1 | 4.8 | 5.2 | 4.1 | 6.9 |
| % Stroke | 3.1 | 5.4 | 3.8 | 3.1 | 3.1 | 3.7 | 1.3 | 0.3 | 5.5 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 151.3 | 168.4 | 147.2 | 171.3 | 156.9 | 184.5 |
| 38.2 | 34.3 | 36.0 | 37.0 | 34.8 | 47.8 |
| 5.1 | | | 6.1 | | 5.2 |
| 3.4 | 2.8 | 2.5 | 3.9 | | 2.3 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| HIV | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| HIV/AIDS (Age-Adjusted Death Rate) | | | | | | | | | |
| HIV Prevalence per 100,000 | | | | | | 238.3 | 81.7 | 61.8 | 96.5 |
| % [Age 18-44] HIV Test in the Past Year | 33.1 | 25.9 | 14.9 | 13.4 | 12.1 | 20.5 | 10.6 | 7.7 | 17.7 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------------------------|--------|--------|--------|------------|-------|
| 1.3 | 0.7 | 0.9 | 2.2 | 3.3 | 1.9 |
| 184.9 | 68.1 | 115.1 | 340.4 | | |
| 18.0 | | | 19.3 | | 16.1 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Immunization & Infectious Diseases | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % Have Completed Hepatitis B Vaccination Series | 40.5 | 41.9 | 45.7 | 37.9 | 51.3 | 41.9 | 50.9 | 40.8 | 37.6 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------------------------|--------|--------|--------|------------|-------|
| 43.0 | | | 44.7 | | 28.9 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Injury & Violence Prevention | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|---|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| Unintentional Injury (Age-Adjusted Death Rate) | | | | | | 32.1 | 29.3 | 42.3 | 38.2 |
| Motor Vehicle Crashes (Age-Adjusted Death Rate) | | | | | | 6.6 | 5.5 | | 9.9 |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|--------|--------|------------|-------|
| 32.5 | 39.8 | 36.1 | 39.2 | 36.4 | 31.2 |
| 7.1 | 11.1 | 11.4 | 10.7 | 12.4 | 9.6 |

| Injury & Violence Prevention (continued) | Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas) | | | | | | | | | |
|--|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|--|
| | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County | |
| % Perceive Neighborhood as "Slightly/Not At All Safe" | 40.3 | 35.8 | 18.5 | 7.3 | 2.7 | 22.4 | 5.4 | 3.5 | 17.9 | |
| % Child [Age 0-17] "Always" Uses Seat Belt/Car Seat | 91.7 | 80.0 | 83.8 | 92.9 | 95.9 | 88.3 | 97.0 | 88.1 | 93.3 | |
| % Child [Age 5-17] "Always" Wears Bicycle Helmet | 33.2 | 35.3 | 47.1 | 51.6 | 50.6 | 44.6 | 50.2 | 24.0 | 24.3 | |
| Firearm-Related Deaths (Age-Adjusted Death Rate) | | | | | | 11.2 | 5.1 | | 10.4 | |
| % Firearm in Home | 21.3 | 15.5 | 28.3 | 32.3 | 44.9 | 26.2 | 33.8 | 60.9 | 39.0 | |
| % [Homes With Children] Firearm in Home | 12.1 | 8.2 | 29.4 | 32.1 | 37.8 | 23.2 | 34.3 | 64.8 | 42.9 | |
| % [Homes With Firearms] Weapon(s) Unlocked & Loaded | 27.0 | 8.2 | 5.5 | 12.0 | 8.3 | 12.1 | 7.3 | 11.6 | 17.0 | |
| Homicide (Age-Adjusted Death Rate) | | | | | | | | | | |
| Violent Crime per 100,000 | | | | | | 477.7 | 66.9 | 72.3 | 789.9 | |
| % Victim of Violent Crime in Past 5 Years | 9.2 | 5.9 | 3.6 | 3.1 | 0.2 | 4.9 | 0.7 | 0.8 | 1.7 | |
| % Intimate Partner Was Controlling/Harassing in Past 5 Yrs | 5.8 | 7.6 | 1.6 | 2.0 | 0.5 | 3.7 | 3.6 | 4.8 | 8.7 | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 18.0 | | | | | 17.4 |
| 91.0 | | | 92.2 | | 93.9 |
| 42.9 | | | 48.7 | | 43.5 |
| 10.0 | 7.4 | 9.0 | 10.4 | 9.3 | 8.3 |
| 30.2 | | | 34.7 | | 33.7 |
| 29.2 | | | 37.4 | | 32.3 |
| 11.8 | | | 16.8 | | 10.4 |
| 6.2 | 2.0 | 3.8 | 5.3 | 5.5 | 4.1 |
| 418.8 | 266.0 | 273.6 | 395.5 | | |
| 3.6 | | | 2.8 | | 2.5 |
| 4.4 | | | | | 6.4 |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Injury & Violence Prevention (continued) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|--------------------------------------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | % Victim of Domestic Violence (Ever) | 16.9 | 12.8 | 11.7 | 9.3 | 3.2 | 11.9 | 8.1 | 11.0 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|---------|--------|------------|-------|
| 11.6 | | | 15.0 | | 12.0 |
| | better | similar | worse | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Maternal, Infant & Child Health | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | No Prenatal Care in First Trimester (Percent) | | | | | | 27.5 | 21.8 | |
| Low Birthweight Births (Percent) | | | | | | 7.5 | 6.1 | | |
| Infant Death Rate | | | | | | 5.5 | 4.4 | | 5.4 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|---------|--------|------------|-------|
| 26.2 | 23.5 | 26.4 | | 22.1 | 29.6 |
| 7.2 | 6.6 | 6.6 | 8.0 | 7.8 | 7.6 |
| 5.2 | 4.8 | 5.2 | 6.0 | 6.0 | 6.4 |
| | better | similar | worse | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Mental Health & Mental Disorders | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|---|-----------------------------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | % "Fair/Poor" Mental Health | 12.7 | 12.8 | 9.7 | 8.3 | 2.6 | 10.1 | 7.0 | 9.0 |
| % Symptoms of Chronic Depression (2+ Years) | 26.9 | 26.7 | 21.5 | 25.2 | 12.9 | 24.3 | 21.4 | 16.1 | 30.4 |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|--------|--------|------------|-------|
| 10.3 | | | 11.9 | | 9.0 |
| 24.2 | | | 30.4 | | 25.1 |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Mental Health & Mental Disorders (cont.) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| Suicide (Age-Adjusted Death Rate) | | | | | | 9.1 | 8.5 | | 18.1 |
| % Major Depression | 11.1 | 11.0 | 12.4 | 9.2 | 4.9 | 10.5 | 5.5 | 6.2 | 11.8 |
| % [Those w/Major Depression] Seeking Help | | | | | | | | | |
| % Typical Day Is "Extremely/Very" Stressful | 8.6 | 13.1 | 12.2 | 11.0 | 10.3 | 11.1 | 8.2 | 12.2 | 10.1 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 10.1 | 13.7 | 11.5 | 12.5 | 10.2 | 10.6 |
| 9.5 | | | | | 10.1 |
| 89.9 | | | | | 88.7 |
| 10.5 | | | 11.9 | | 11.5 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Nutrition, Physical Activity & Weight | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % Eat 5+ Servings of Fruit or Vegetables per Day | 36.7 | 36.7 | 42.4 | 37.4 | 43.1 | 38.7 | 40.5 | 34.8 | 33.9 |
| % Had 7+ Sugar-Sweetened Drinks in the Past Week | 29.6 | 22.2 | 22.6 | 21.5 | 16.8 | 23.4 | 22.0 | 31.1 | 23.5 |
| % [Child 0-17] Had 7+ Sugar-Sweetened Drinks/Past Week | 17.2 | 31.2 | 24.7 | 12.4 | 16.6 | 20.0 | 27.6 | 31.6 | 30.6 |
| % "Very/Somewhat" Difficult to Buy Fresh Produce | 24.3 | 23.3 | 12.8 | 12.0 | 11.7 | 17.0 | 16.4 | 19.5 | 20.0 |
| Population With Low Food Access (Percent) | | | | | | 15.6 | 42.8 | 30.0 | 34.8 |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 38.3 | | | 39.5 | | 35.8 |
| 23.4 | | | | | 28.3 |
| 23.2 | | | | | |
| 17.4 | | | 24.4 | | 22.8 |
| 23.7 | 22.7 | 25.9 | 23.6 | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Nutrition, Physical Activity & Weight (cont.) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % Medical Advice on Nutrition in Past Year | 36.6 | 41.8 | 37.7 | 35.6 | 43.8 | 38.0 | 40.4 | 41.6 | 39.3 |
| % Healthy Weight (BMI 18.5-24.9) | 25.0 | 35.4 | 31.3 | 32.2 | 32.4 | 31.1 | 33.6 | 26.9 | 22.9 |
| % Overweight (BMI 25+) | 70.9 | 61.1 | 67.4 | 67.2 | 65.9 | 66.8 | 66.0 | 71.7 | 75.4 |
| % Obese (BMI 30+) | 32.6 | 30.9 | 33.4 | 21.7 | 35.2 | 29.4 | 29.8 | 35.3 | 41.0 |
| % "Often/Sometimes" Worry That Food Will Run Out | 34.5 | 33.3 | 21.7 | 12.6 | 3.8 | 23.0 | 13.8 | 12.2 | 19.5 |
| % Medical Advice on Weight in Past Year | 23.8 | 26.3 | 20.5 | 21.8 | 35.3 | 23.5 | 26.8 | 25.4 | 27.5 |
| % [Overweights] Counseled About Weight in Past Year | 27.6 | 38.4 | 26.9 | 28.6 | 48.0 | 30.8 | 36.9 | 30.9 | 29.5 |
| % [Obese Adults] Counseled About Weight in Past Year | 43.2 | 53.3 | 36.3 | 44.8 | 52.8 | 44.3 | 55.7 | 42.1 | 43.3 |
| % [Overweights] Trying to Lose Weight Both Diet/Exercise | 36.3 | 36.8 | 42.5 | 50.8 | 46.9 | 42.8 | 44.9 | 40.9 | 42.6 |
| % Child [Age 5-17] Healthy Weight | 53.5 | 62.4 | 55.2 | 73.4 | 58.1 | 62.5 | 53.6 | 66.7 | 57.5 |
| % Children [Age 5-17] Overweight (85th Percentile) | 34.5 | 23.4 | 24.2 | 13.1 | 32.8 | 22.6 | 34.9 | 20.9 | 29.5 |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|--------|--------|------------|-------|
| 38.7 | | | 39.2 | | 38.4 |
| 30.4 | 31.6 | 32.5 | 34.4 | 33.9 | 31.0 |
| 67.8 | 67.0 | 65.5 | 63.1 | | 67.5 |
| 31.1 | 31.3 | 29.6 | 29.0 | 30.5 | 30.3 |
| 20.4 | | | | | 18.8 |
| 24.7 | | | 23.7 | | 26.2 |
| 31.7 | | | 31.8 | | |
| 46.2 | | | 48.3 | | |
| 43.1 | | | 39.5 | | |
| 59.8 | | | 56.7 | | |
| 26.3 | | | 31.5 | | 29.4 |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Nutrition, Physical Activity & Weight (cont.) | Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas) | | | | | | | | |
|--|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
| % Children [Age 5-17] Obese (95th Percentile) | 22.9 | 14.6 | 13.2 | 6.0 | 10.6 | 12.3 | 20.0 | 12.3 | 17.0 |
| % [Employed] Job Entails Mostly Sitting/Standing | 56.4 | 57.0 | 59.9 | 70.2 | 69.5 | 62.6 | 65.3 | 66.2 | 53.6 |
| % No Leisure-Time Physical Activity | 19.5 | 22.6 | 20.3 | 14.6 | 13.2 | 18.5 | 13.6 | 17.4 | 22.5 |
| % Meeting Physical Activity Guidelines | 48.8 | 51.4 | 55.0 | 57.3 | 56.9 | 53.8 | 53.9 | 49.3 | 46.4 |
| % Moderate Physical Activity | 31.9 | 33.6 | 28.3 | 34.6 | 35.6 | 32.4 | 26.3 | 33.1 | 27.8 |
| % Vigorous Physical Activity | 37.1 | 41.6 | 41.7 | 45.8 | 45.0 | 42.1 | 45.2 | 35.7 | 35.1 |
| Recreation/Fitness Facilities per 100,000 | | | | | | 15.7 | 9.4 | 4.0 | 9.7 |
| % Have Access to Indoor Exercise Equipment | 68.8 | 67.6 | 85.7 | 80.8 | 84.1 | 77.0 | 86.6 | 68.9 | 75.2 |
| % Medical Advice on Physical Activity in Past Year | 37.6 | 48.2 | 39.5 | 43.5 | 49.2 | 42.5 | 42.8 | 44.6 | 40.8 |
| % [Child 0-4] Ever Breastfed/Fed Breast Milk | | | | | | | | | |
| % [Child 5-17] Compliance w/All "5-4-3-2-1 Go!" Guidelines | 9.1 | 0.9 | 4.4 | 5.0 | 5.7 | 5.0 | 3.3 | 1.9 | 5.4 |

Metro Area vs. Benchmarks

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 14.7 | | | 14.8 | 14.5 | 13.2 |
| 62.2 | | | 63.8 | | 65.4 |
| 18.0 | 28.5 | 25.3 | 20.7 | 32.6 | 16.7 |
| 52.7 | | | 50.3 | | 52.4 |
| 30.6 | | | 30.6 | | 30.7 |
| 41.6 | | | 38.0 | | 43.7 |
| 13.3 | 11.8 | 11.9 | 9.7 | | |
| 78.4 | | | | | 75.0 |
| 42.4 | | | 44.0 | | 43.1 |
| 86.6 | | | | | 84.3 |
| 4.6 | | | | | 3.4 |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Nutrition, Physical Activity & Weight (cont.) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % [Child 5-17] Eats 5+ Fruits/Vegetables Daily | 31.9 | 29.7 | 32.1 | 26.0 | 27.7 | 29.4 | 34.4 | 33.7 | 35.6 |
| % [Child 5-17] Drinks 4+ Glasses of Water Daily | 76.0 | 56.7 | 68.0 | 66.7 | 72.1 | 67.4 | 67.0 | 66.0 | 65.5 |
| % [Child 5-17] Eats 3+ Servings of Low-Fat Dairy Daily | 34.7 | 62.8 | 56.6 | 51.1 | 58.7 | 52.1 | 47.0 | 65.8 | 46.9 |
| % [Child 5-17] Spends <2 Hrs on Screen Time Daily | 9.1 | 8.0 | 12.6 | 12.8 | 13.1 | 11.3 | 13.5 | 18.2 | 13.1 |
| % [Child 5-17] Exercises for 1+ Hours Daily | 53.9 | 50.6 | 53.9 | 49.8 | 64.9 | 52.9 | 57.7 | 65.4 | 67.4 |
| % [Child 5-17] Walks/Bikes to School Most Days | 11.5 | 24.1 | 8.2 | 16.7 | 12.5 | 14.4 | 14.8 | 10.7 | 14.1 |
| % Child [Age 2-17] Physically Active 1+ Hours per Day | 53.9 | 50.6 | 53.9 | 49.8 | 64.9 | 52.9 | 57.7 | 65.4 | 67.4 |
| % Use Local Parks/Recreation Centers at Least Weekly | 43.4 | 42.4 | 44.0 | 45.3 | 40.2 | 43.7 | 49.7 | 27.4 | 33.1 |
| % Use Local Trails at Least Monthly | 33.4 | 44.0 | 44.6 | 50.4 | 44.5 | 43.7 | 51.6 | 39.4 | 40.7 |
| % Believe Schools Should Require PE for All Students | 96.9 | 96.5 | 97.4 | 96.4 | 93.6 | 96.6 | 97.9 | 93.6 | 96.9 |
| % Lack of Sidewalks/Poor Sidewalks Prevent Exercise | 37.8 | 20.8 | 12.2 | 16.6 | 20.4 | 21.1 | 10.0 | 31.8 | 27.8 |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|--------|--------|------------|-------|
| 31.4 | | | | | 22.9 |
| 67.0 | | | | | 61.7 |
| 50.7 | | | | | 52.8 |
| 12.2 | | | | | 10.2 |
| 56.0 | | | | | 64.0 |
| 14.4 | | | | | 10.2 |
| 56.0 | | | 48.6 | | |
| 43.1 | | | | | 40.5 |
| 44.8 | | | | | 49.8 |
| 96.8 | | | | | 96.6 |
| 20.1 | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Nutrition, Physical Activity & Weight (cont.) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % Lack of Trails/Poor Quality Trails Prevent Exercise | 29.1 | 15.2 | 7.1 | 9.8 | 17.6 | 14.8 | 5.0 | 19.8 | 13.7 |
| % Heavy Traffic in Neighborhood Prevents Exercise | 29.7 | 19.7 | 23.5 | 10.7 | 8.9 | 19.6 | 8.1 | 14.0 | 15.9 |
| % Lack of Street Lights/Poor Street Lights Prevent Exercise | 19.0 | 6.1 | 5.4 | 6.1 | 10.0 | 8.9 | 4.2 | 24.9 | 16.7 |
| % Crime Prevents Exercise in Neighborhood | 33.9 | 20.4 | 9.2 | 2.4 | 3.5 | 14.5 | 2.4 | 0.9 | 8.6 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 12.9 | | | | | |
| 16.7 | | | | | |
| 9.4 | | | | | |
| 11.0 | | | | | |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Oral Health | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| % [Age 18+] Dental Visit in Past Year | 61.4 | 66.4 | 75.3 | 80.9 | 83.6 | 72.7 | 80.1 | 70.1 | 70.5 |
| % Child [Age 2-17] Dental Visit in Past Year | 88.4 | 89.8 | 87.0 | 86.2 | 89.7 | 87.7 | 91.7 | 91.4 | 87.5 |
| % Have Dental Insurance | 63.0 | 62.6 | 75.9 | 71.5 | 76.8 | 69.3 | 84.0 | 69.4 | 73.4 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 73.8 | 71.1 | 67.6 | 65.9 | 49.0 | 70.4 |
| 88.7 | | | 81.5 | 49.0 | 86.2 |
| 72.7 | | | 65.6 | | 70.1 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Respiratory Diseases | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| CLRD (Age-Adjusted Death Rate) | | | | | | 51.3 | 42.6 | 44.6 | 57.5 |
| Pneumonia/Influenza (Age-Adjusted Death Rate) | | | | | | 14.9 | 15.9 | | 14.3 |
| % COPD (Lung Disease) | 9.2 | 6.0 | 6.4 | 12.2 | 3.7 | 8.4 | 6.9 | 4.0 | 9.4 |
| % [Adult] Currently Has Asthma | 12.5 | 5.3 | 10.8 | 7.1 | 3.3 | 8.6 | 5.1 | 6.8 | 9.6 |
| % Child [Age 0-17] Asthma (Ever Diagnosed) | 7.1 | 8.6 | 11.7 | 5.9 | 12.8 | 8.7 | 8.0 | 8.8 | 9.7 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|------------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 50.4 | 47.4 | 49.0 | 42.0 | | 53.2 |
| 14.7 | 16.4 | 13.8 | 15.3 | | 20.8 |
| 8.1 | 6.3 | 5.3 | 8.6 | | 7.4 |
| 8.0 | 7.8 | 7.3 | 9.4 | | 8.6 |
| 8.6 | | | 12.5 | | 7.9 |
| | better similar worse | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Sexually Transmitted Diseases | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|---|----------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| Gonorrhea Incidence per 100,000 | | | | | | 149.9 | 43.1 | 31.8 | 101.6 |
| Chlamydia Incidence per 100,000 | | | | | | 588.3 | 326.0 | 218.4 | 425.6 |
| % [Unmarried 18-64] 3+ Sexual Partners in Past Year | 4.4 | 12.8 | 2.2 | 0.0 | 0.0 | 5.0 | 7.3 | 3.1 | 8.9 |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 119.1 | 65.5 | 77.0 | 107.5 | | |
| 505.0 | 371.5 | 366.2 | 456.7 | | |
| 5.8 | | | 11.7 | | 3.3 |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Sexually Transmitted Diseases (continued) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|-----------------------------------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | % [Unmarried 18-64] Using Condoms | 36.9 | 48.2 | 48.5 | 21.2 | 34.3 | 38.5 | 40.3 | 47.2 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|---------|--------|------------|-------|
| 38.0 | | | | | 19.5 |
| | better | similar | worse | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Substance Abuse | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|---|---|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | Cirrhosis/Liver Disease (Age-Adjusted Death Rate) | | | | | | 10.3 | 5.7 | |
| % Keep Medications Locked Up | 22.6 | 18.8 | 16.8 | 12.4 | 11.4 | 16.9 | 15.9 | 9.6 | 18.3 |
| % Have Ever Shared Prescription Medication | 4.6 | 8.9 | 5.5 | 6.2 | 5.2 | 6.2 | 4.0 | 10.6 | 4.5 |
| % Took Someone Else's Prescription Meds in the Past Month | 1.3 | 3.5 | 1.2 | 0.7 | 1.2 | 1.5 | 0.9 | 1.0 | 1.5 |
| % Used an Illegal Drug in the Past Month | 6.5 | 4.7 | 7.0 | 2.8 | 0.0 | 4.9 | 0.9 | 3.9 | 3.4 |
| % Drinking & Driving in Past Month | 2.7 | 3.3 | 7.2 | 4.0 | 5.1 | 4.4 | 5.3 | 8.2 | 5.1 |
| Drug-Induced Deaths (Age-Adjusted Death Rate) | | | | | | 9.5 | 6.8 | | 14.6 |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|--------|--------|--------|------------|-------|
| 8.7 | 7.8 | 7.9 | 9.9 | 8.2 | 6.6 |
| 16.6 | | | | | |
| 5.7 | | | | | |
| 1.4 | | | | | |
| 3.9 | | | | | |
| 4.8 | | | 5.0 | | 5.8 |
| 9.6 | 9.2 | 7.9 | 14.1 | 11.3 | 7.1 |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Substance Abuse (continued) | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|--|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | % Ever Sought Help for Alcohol or Drug Problem | 5.0 | 5.3 | 3.1 | 2.1 | 2.4 | 3.6 | 1.9 | 2.1 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 3.5 | | | 4.9 | | 3.9 |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Tobacco Use | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|------------------|----------|----------|----------|-----------------|----------------|--------------|-------------|--------------|
| | % Current Smoker | 22.5 | 18.3 | 14.6 | 14.2 | 9.6 | 16.6 | 12.1 | 18.0 |
| % Someone Smokes at Home | 16.1 | 13.4 | 11.9 | 6.1 | 6.0 | 11.1 | 5.5 | 14.2 | 18.5 |
| % [Non-Smokers] Someone Smokes in the Home | 4.3 | 3.6 | 5.6 | 0.9 | 3.2 | 3.4 | 3.2 | 8.6 | 4.1 |
| % [Household With Children] Someone Smokes in the Home | 13.6 | 8.4 | 5.3 | 5.0 | 0.9 | 7.1 | 2.9 | 19.8 | 12.4 |
| % [Smokers] Received Advice to Quit Smoking | | | | | | | | | |
| % Currently Use Electronic Cigarettes (E-Cigarettes) | 7.3 | 7.6 | 6.1 | 6.5 | 3.4 | 6.5 | 3.7 | 2.8 | 5.0 |
| % Use Smokeless Tobacco | 1.5 | 0.3 | 4.6 | 3.0 | 1.7 | 2.5 | 2.3 | 8.0 | 4.9 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

| Metro Area | Metro Area vs. Benchmarks | | | | TREND |
|------------------------------|---------------------------|--------|--------|------------|-------|
| | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| 17.0 | 19.5 | 18.5 | 14.9 | 12.0 | |
| 11.0 | | | 12.7 | | 15.1 |
| 3.6 | | | 6.3 | | |
| 7.2 | | | 9.7 | | 9.3 |
| 70.6 | | | 67.8 | | |
| 5.8 | | | | | |
| 3.0 | 4.9 | 5.3 | 4.0 | 0.3 | |
| better similar worse | | | | | |

Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)

| Vision | NE Omaha | SE Omaha | NW Omaha | SW Omaha | Western Douglas | Douglas County | Sarpy County | Cass County | Pott. County |
|--|---|---|---|---|---|---|---|---|---|
| % Eye Exam in Past 2 Years |  55.0 |  49.7 |  60.0 |  58.9 |  49.0 |  56.0 |  57.1 |  54.2 |  55.6 |
| Note: In the green section, each county is compared against all others combined (sub-county areas compared to other sub-county areas). Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results. | | | | | | | | | |

Metro Area vs. Benchmarks

| Metro Area | vs. IA | vs. NE | vs. US | vs. HP2020 | TREND |
|------------|---|--|--|------------|---|
| 56.1 | | |  56.8 | |  55.9 |
| |  better |  similar |  worse | | |

Community Description



Professional Research Consultants, Inc.

Population Characteristics

Total Population

The four-county Metro Area surrounding Omaha, Nebraska, the focus of this Community Health Needs Assessment, encompasses 76,803.37 square miles and houses a total population of 805,609 residents, according to latest census estimates.

Total Population
(Estimated Population, 2009-2013)

| | Total Population | Total Land Area (Square Miles) | Population Density (Per Square Mile) |
|----------------------|------------------|--------------------------------|--------------------------------------|
| Douglas County | 524,697 | 328.37 | 1,597.89 |
| Sarpy County | 162,728 | 238.93 | 681.08 |
| Cass County | 25,222 | 557.30 | 45.26 |
| Pottawattamie County | 92,962 | 950.03 | 97.85 |
| Metro Area | 805,609 | 2,074.62 | 388.32 |
| Nebraska | 1,841,625 | 76,803.37 | 23.98 |
| Iowa | 3,062,553 | 55,842.35 | 54.84 |
| United States | 311,536,591 | 3,530,997.6 | 88.23 |

Sources:

- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at <http://www.chna.org>.

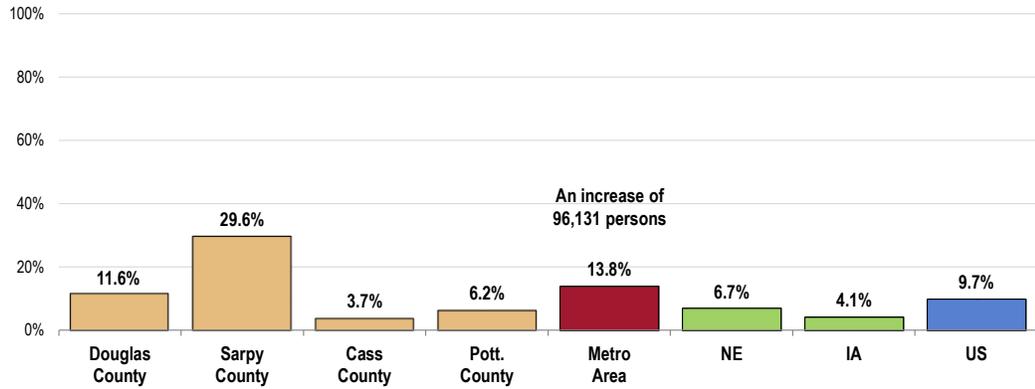
Population Change 2000-2010

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the Metro Area population increased by 96,131 persons, or 13.8%.

- A greater proportional increase than seen across either state.
- A greater proportional increase than seen nationwide.
- Note the large increase in Sarpy County population during this time.

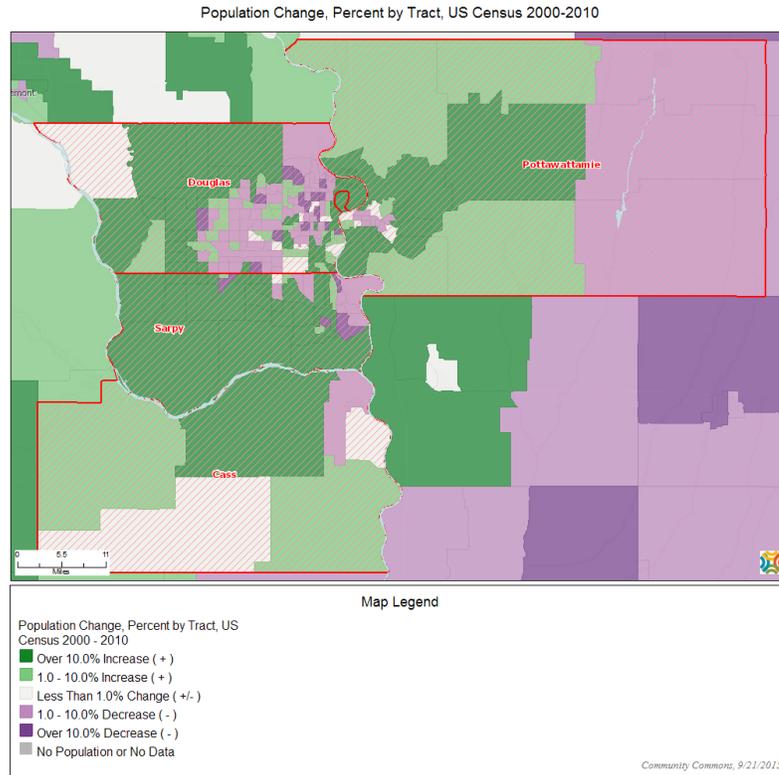
Change in Total Population (Percentage Change Between 2000 and 2010)



Sources:
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.
 • US Census Bureau Decennial Census (2000-2010).

Notes:
 • A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Note the pockets of *decreasing* population as well in the following map.



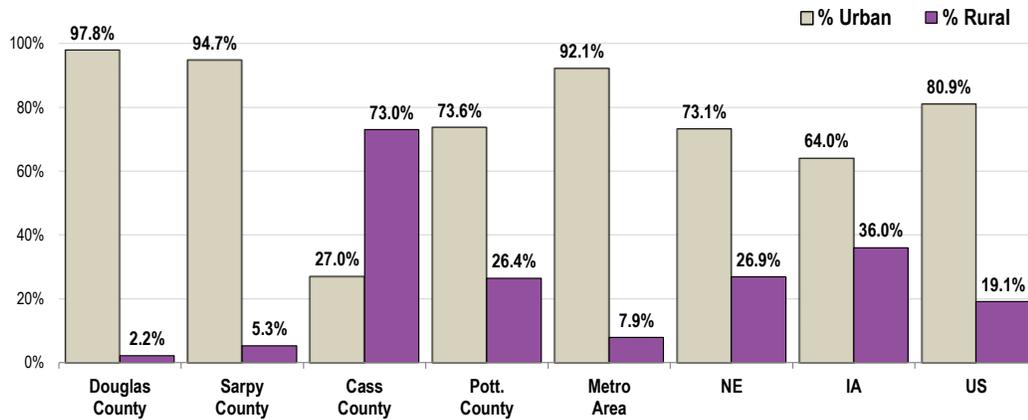
Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

The Metro Area is predominantly urban, with 92.1% of the population living in areas designated as urban.

- Note that a majority of state and national populations live in urban areas.
- In contrast, Cass County appears to be predominantly rural.

Urban and Rural Population
(2010)



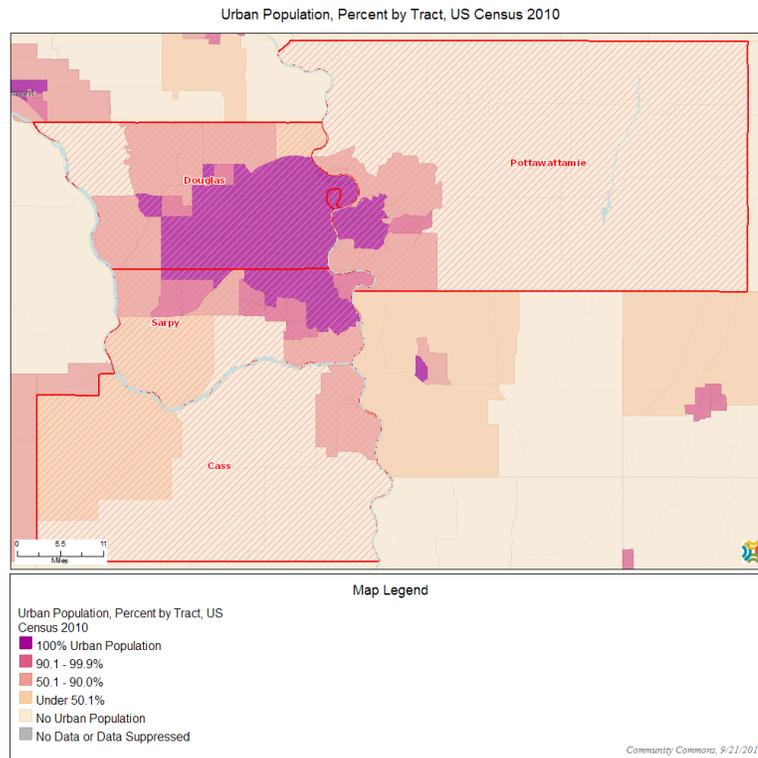
Sources:

- US Census Bureau Decennial Census (2010).
- Retrieved August 2015 from Community Commons at <http://www.chna.org>.

 Notes:

- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

- Note the following map outlining the urban population in the Metro Area census tracts as of 2010.



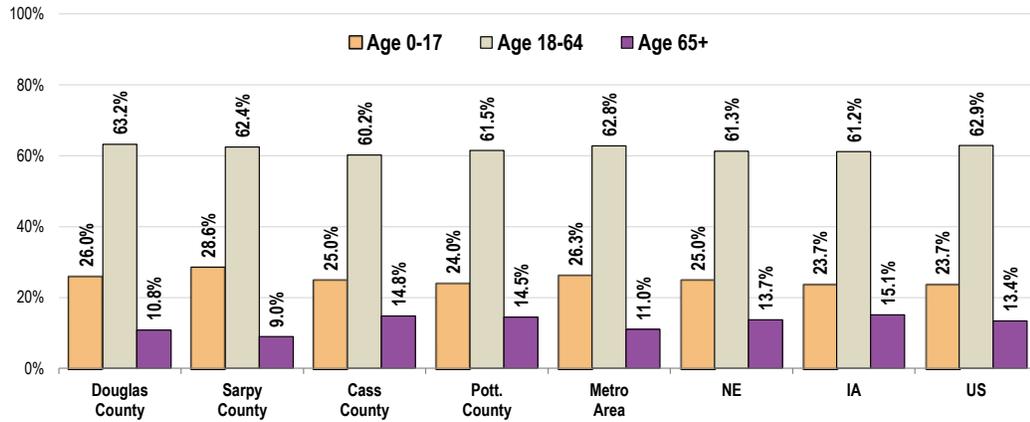
Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

In the Metro Area, 26.3% of the population are infants, children or adolescents (age 0-17); another 62.8% are age 18 to 64, while 11.0% are age 65 and older.

- The percentage of older adults (65+) is lower than both statewide ratios.
- The percentage of older adults (65+) is also lower than the US figure.
- Viewed by county, Cass and Pottawattamie counties house larger populations of seniors (age 65+).

Total Population by Age Groups, Percent (2009-2013)

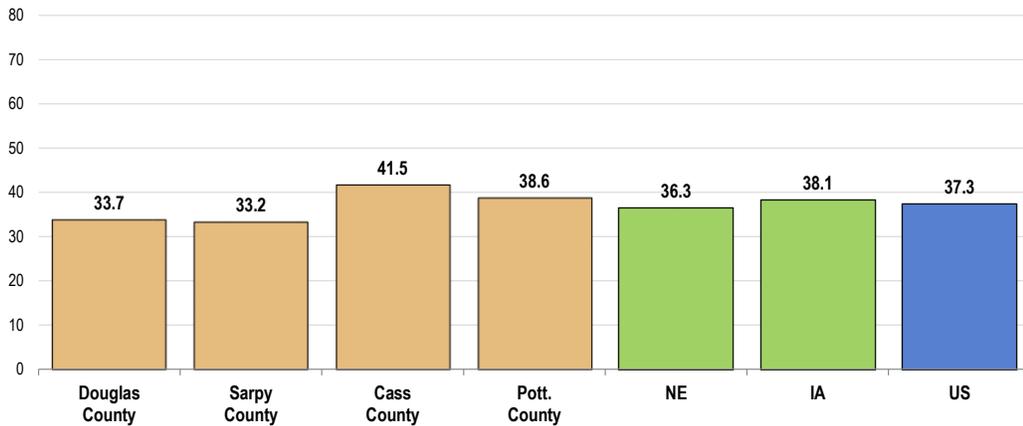


Sources: • US Census Bureau American Community Survey 5-year estimates (2009-2013).
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Median Age

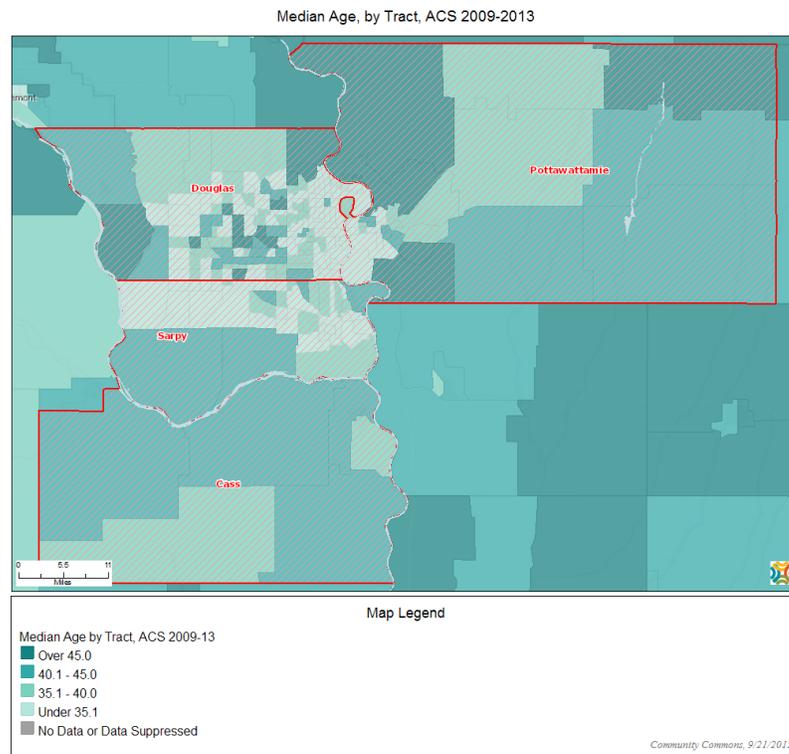
Douglas and Sarpy counties are “younger” than the states and the nation in that their median ages are lower; in contrast, Cass and Pottawattamie counties are “older.”

Median Age (2009-2013)



Sources: • US Census Bureau American Community Survey 5-year estimates (2009-2013).
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.

- The following map provides an illustration of the median age in the Metro Area, segmented by census tract.



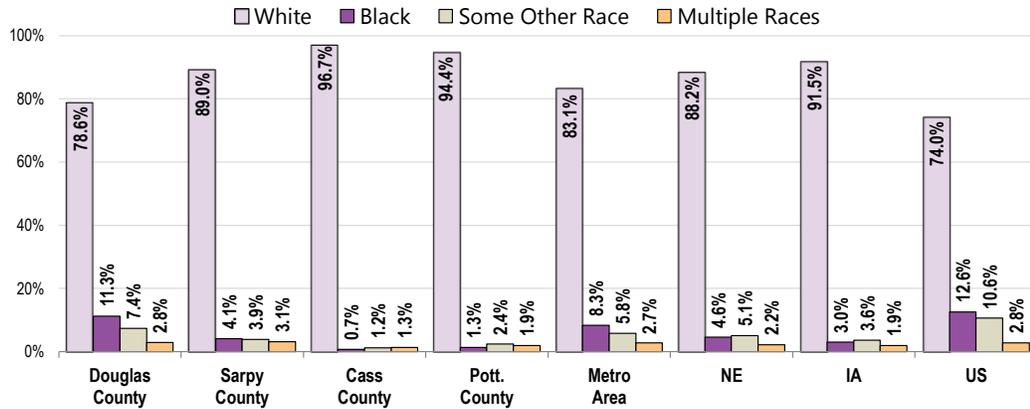
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 83.1% of Metro Area residents are White and 8.3% are Black.

- This is a more diverse racial distribution than found in either state, but less diverse than found nationally.
- By county, Cass and Pottawattamie are the least diverse.

Total Population by Race Alone, Percent (2009-2013)



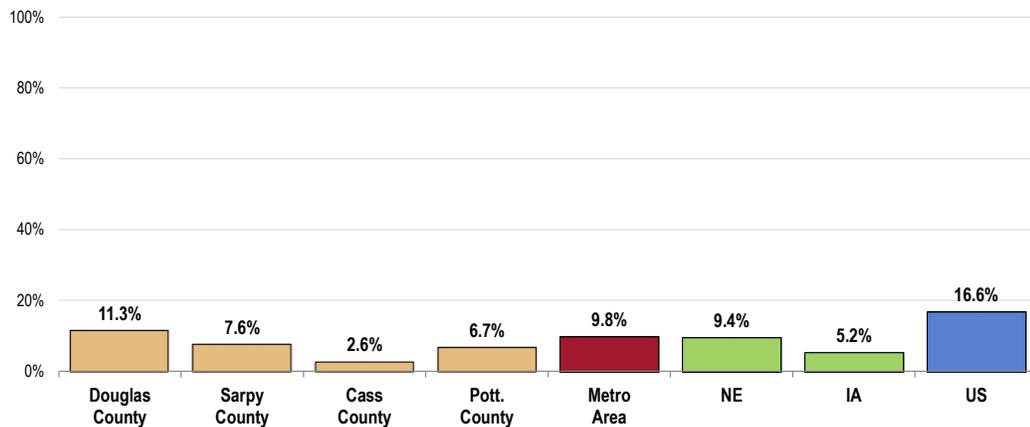
Sources: • US Census Bureau American Community Survey 5-year estimates (2009-2013).
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Ethnicity

A total of 9.8% of Metro Area residents are Hispanic or Latino.

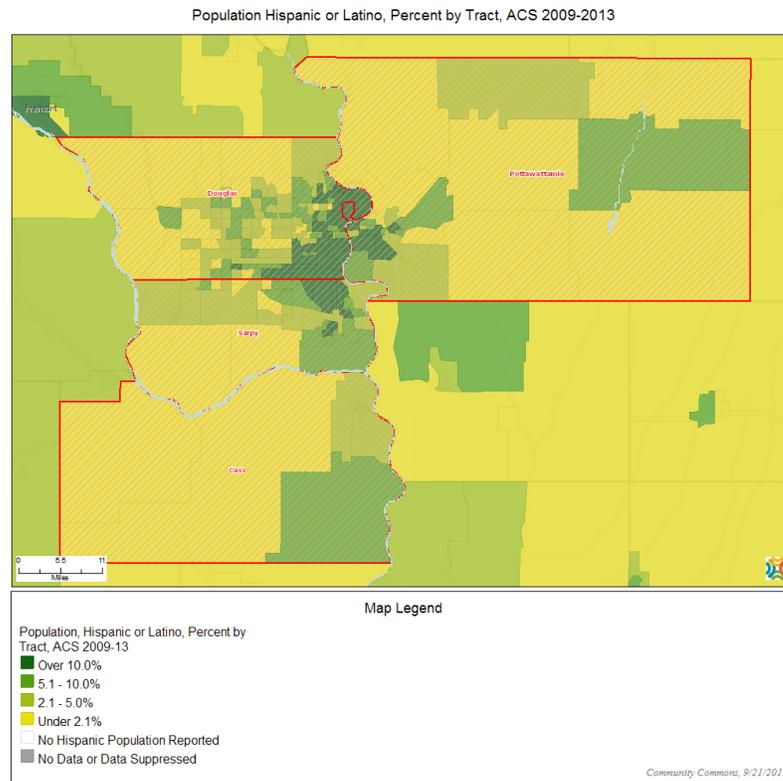
- Higher than the Nebraska proportion (and much higher than the Iowa proportion).
- Lower than found nationally.
- Viewed by county: highest in Douglas County, lowest in Cass County.

Percent Population Hispanic or Latino (2009-2013)



Sources: • US Census Bureau American Community Survey 5-year estimates (2009-2013).
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.
 Notes: • Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

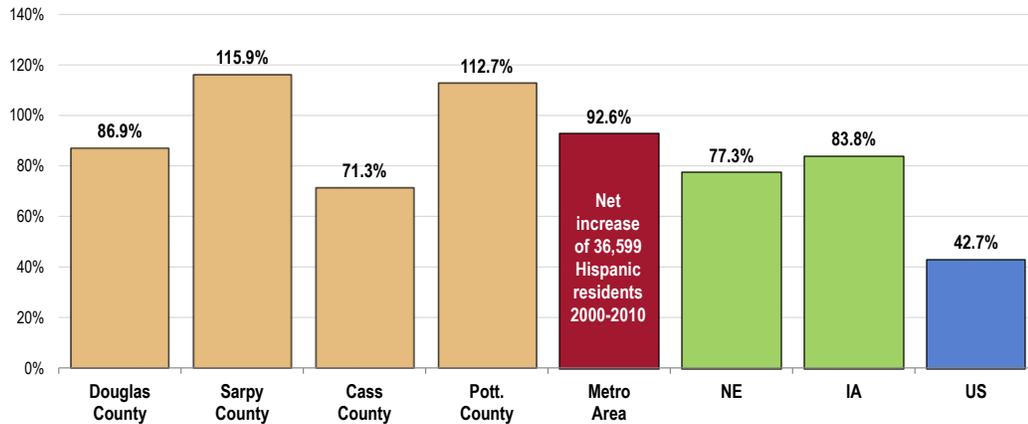
- The Hispanic population appears to be most concentrated in the central portion of the Metro Area.



Between 2000 and 2010, the Hispanic population in the Metro Area increased by 36,599 residents, or 92.6%.

- Higher (in terms of percentage growth) than found in either state.
- More than twice (in terms of percentage growth) that found nationally.
- Much larger increases were recorded in Sarpy and Pottawattamie counties than in Douglas or Cass counties.

Hispanic Population Change (Percentage Change in Hispanic Population Between 2000 and 2010)



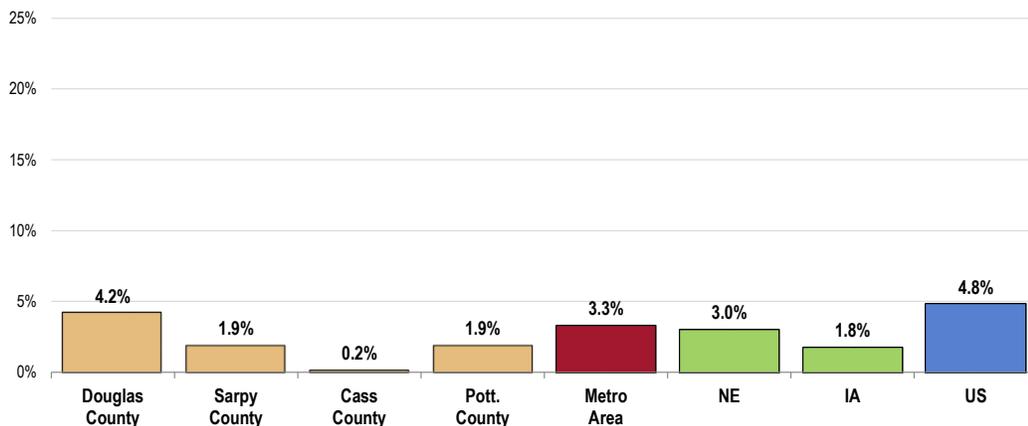
Sources: • US Census Bureau Decennial Census (2000-2010).
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Linguistic Isolation

A total of 3.3% of the Metro Area population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English “very well”).

- Higher than both statewide proportions.
- Lower than found nationally.
- By county, ranging from 4.2% in Douglas County to just 0.2% in Cass County.

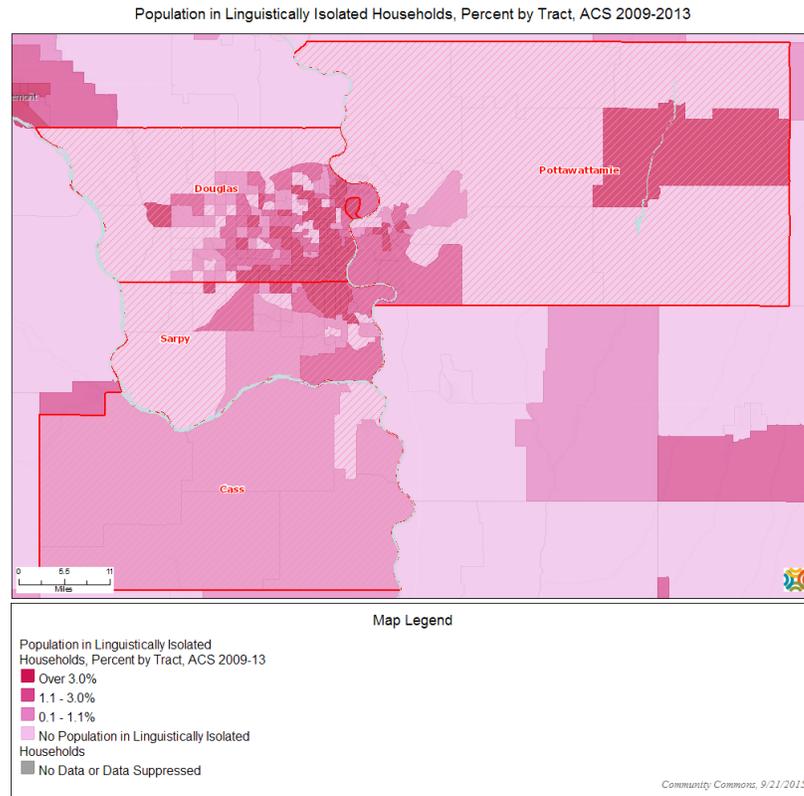
Linguistically Isolated Population (2009-2013)



Sources: • US Census Bureau American Community Survey 5-year estimates (2009-2013).
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of the population aged 5 and older who live in a home in which no person 14 years old and over speaks only English, or in which no person 14 years old and over speak a non-English language and speak English “very well.”

- Note the following map illustrating linguistic isolation in the Metro Area.



Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 (www.healthypeople.gov)

Poverty

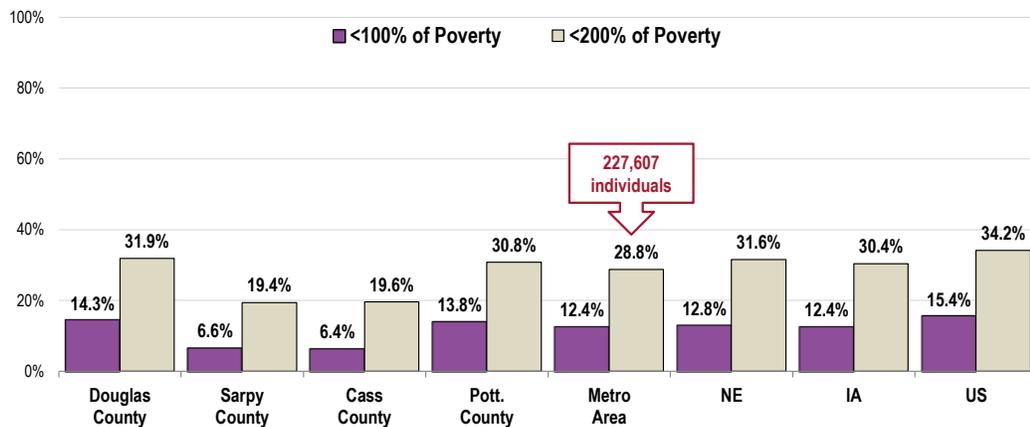
The latest census estimate shows **12.4%** of the Metro Area population living below the federal poverty level.

In all, **28.8%** of Metro Area residents (an estimated **227,607 individuals**) live below 200% of the federal poverty level.

- Below the statewide proportions.
- Lower than found nationally.
- Much lower in Sarpy and Cass counties.

Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2009-2013)



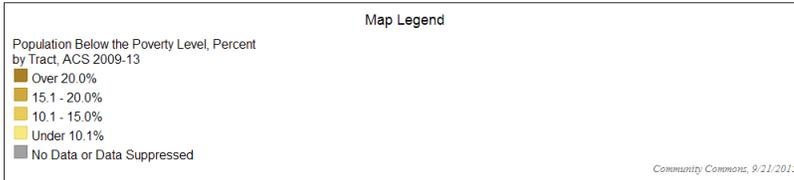
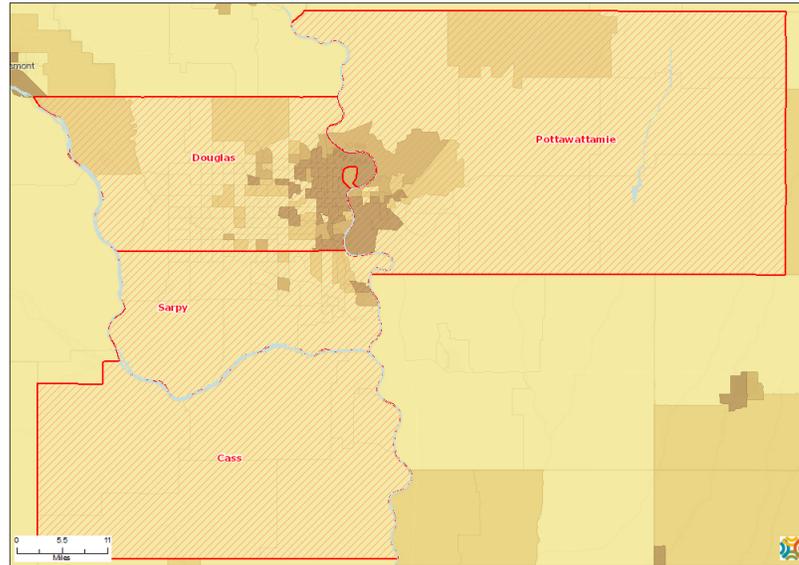
Sources: • US Census Bureau American Community Survey 5-year estimates (2009-2013).

• Retrieved August 2015 from Community Commons at <http://www.chna.org>.

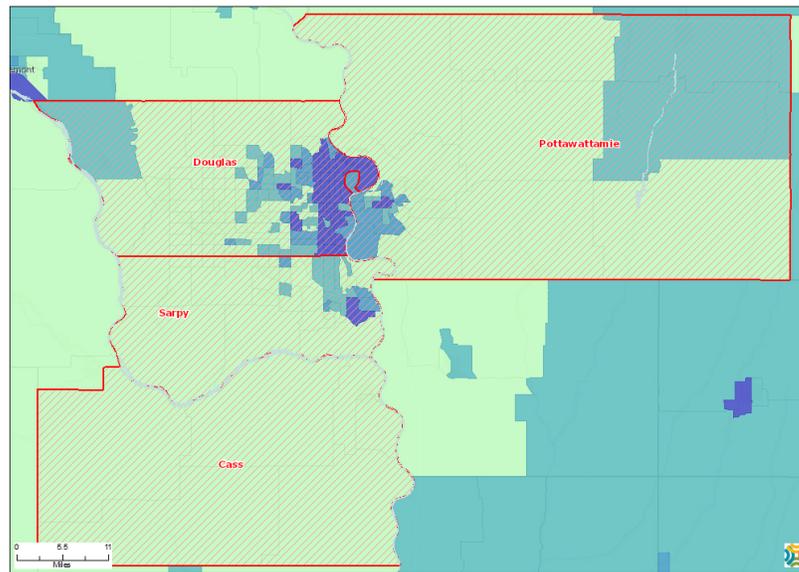
Notes: • Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- A higher concentration of persons living in poverty is found in eastern Douglas County and southwest Pottawattamie County.

Population Below the Poverty Level, Percent by Tract, ACS 2009-2013



Population Below 200% of Poverty, Percent by Tract, ACS 2009-2013

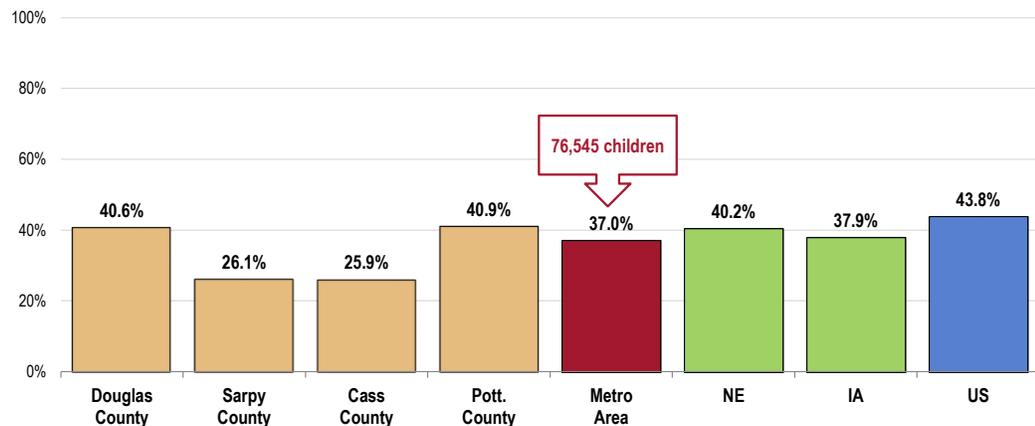


Children in Low-Income Households

Additionally, 37.0% of Metro Area children age 0-17 (representing an estimated 76,545 children) live below the 200% poverty threshold.

- Below the Nebraska proportion and similar to the Iowa proportion.
- Below the proportion found nationally.
- Much higher in Douglas and Pottawattamie counties than in Sarpy or Cass counties.

Percent of Children in Low-Income Households (Children 0-17 Living Below 200% of the Poverty Level, 2009-2013)

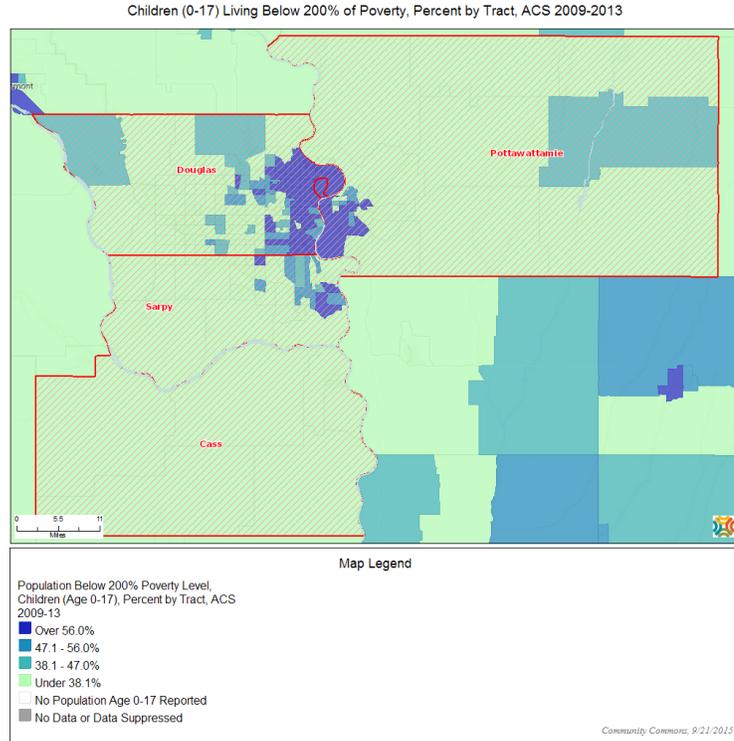


Sources: • US Census Bureau American Community Survey 5-year estimates (2009-2013).

• Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- Again, a notably higher concentration of children in lower-income households is found in eastern Douglas County and southwest Pottawattamie County.

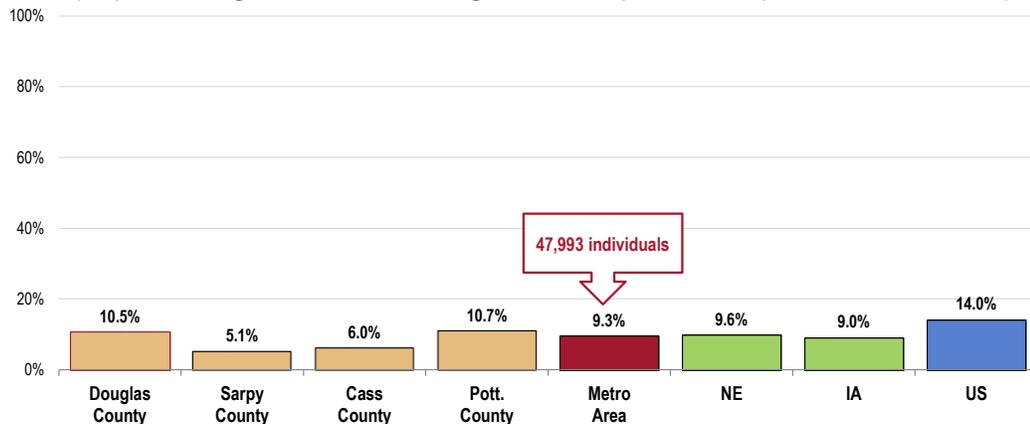


Education

Among the Metro Area population age 25 and older, an estimated 9.3% (nearly 48,000 people) do not have a high school education.

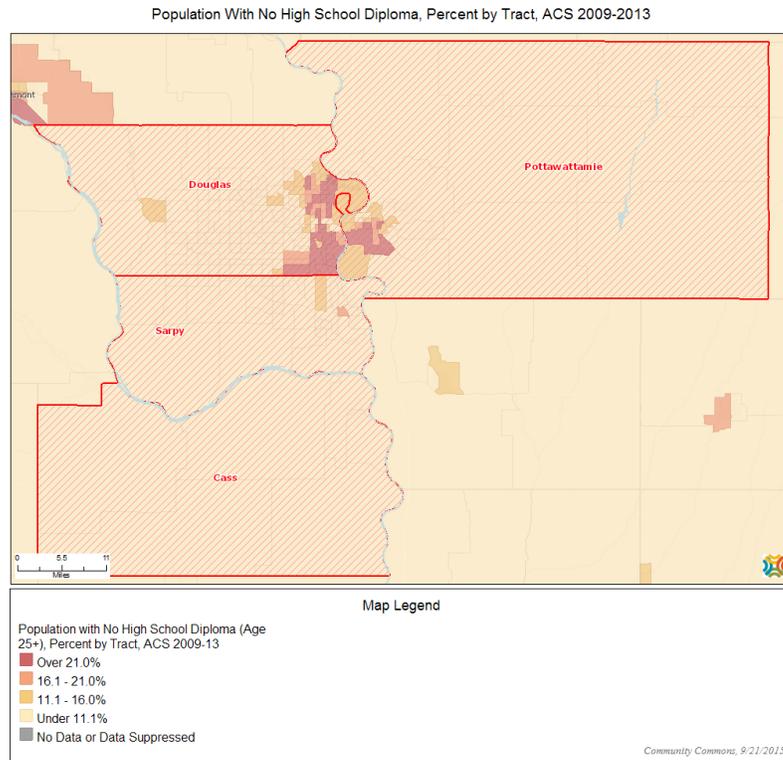
- Similar to the statewide figures.
- More favorable than found nationally.
- More favorable in Sarpy and Cass counties.

Population With No High School Diploma (Population Age 25+ Without a High School Diploma or Equivalent, 2009-2013)



- Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
 - Retrieved August 2015 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

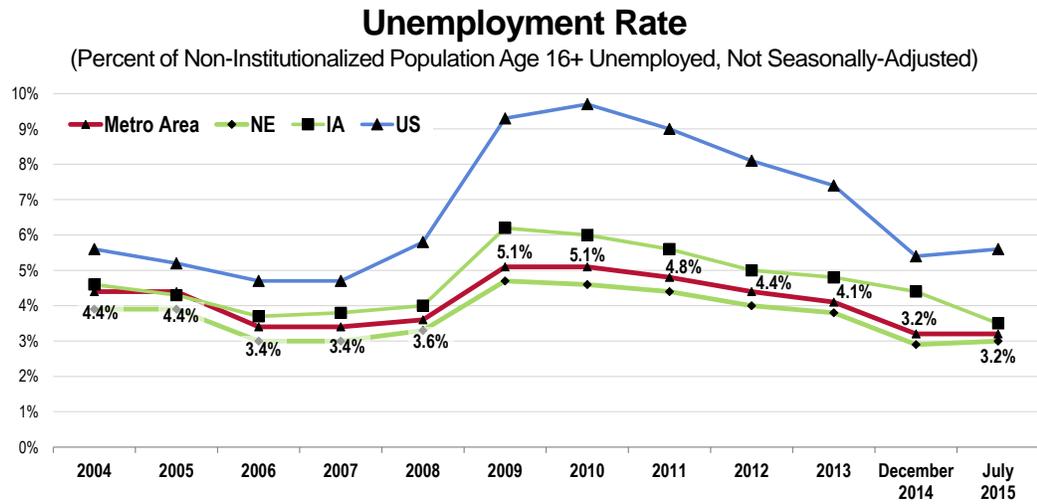
- Geographically, this indicator is more concentrated in eastern Douglas and southwestern Pottawattamie counties.



Employment

According to data derived from the US Department of Labor, the unemployment rate in the Metro Area in July 2015 was 3.2%.

- Less favorable than the Nebraska unemployment rate but more favorable than Iowa.
- More favorable than the national unemployment rate.
- TREND: Unemployment for Metro Area has trended downward since peaking in 2010, echoing the state and national trends.



Sources:

- US Department of Labor, Bureau of Labor Statistics.
- Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

General Health Status



Professional Research Consultants, Inc.

Overall Health Status

Self-Reported Health Status

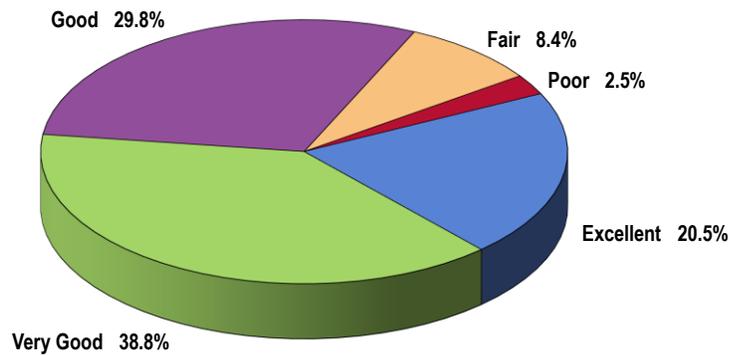
A total of 59.3% of Metro Area adults rate their overall health as “excellent” or “very good.”

- Another 29.8% gave “good” ratings of their overall health.

The initial inquiry of the PRC Community Health Survey asked respondents the following:

“Would you say that in general your health is: excellent, very good, good, fair or poor?”

Self-Reported Health Status
(Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

However, 10.9% of Metro Area adults believe that their overall health is “fair” or “poor.”

NOTE:

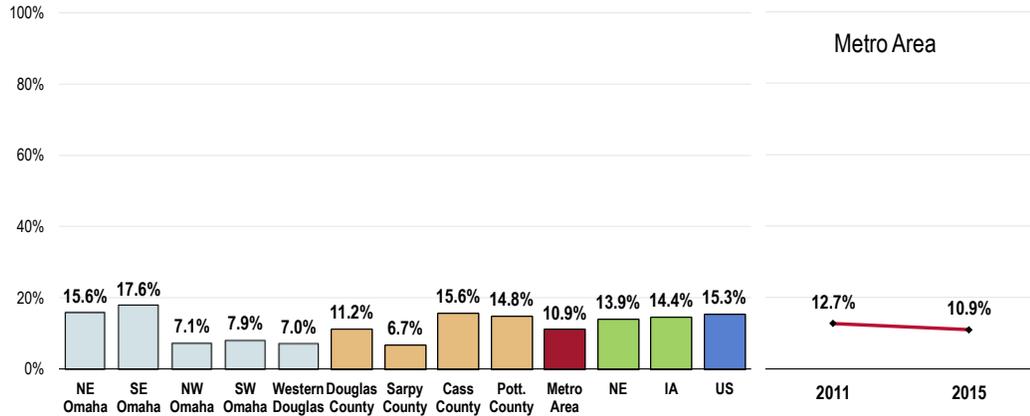
Differences noted in the text represent significant differences determined through statistical testing.

Where sample sizes permit, community-level data are provided.

Trends are measured against baseline data – i.e., the earliest year that data are available or that is presented in this report.

- Better than statewide findings.
- Better than the national percentage.
- Viewed by county, most favorable in Sarpy County.
- Within Douglas County, much less favorable in the east.
- TREND: No statistically significant change has occurred when comparing “fair/poor” overall health reports to previous (2011) survey results.

Experience “Fair” or “Poor” Overall Health



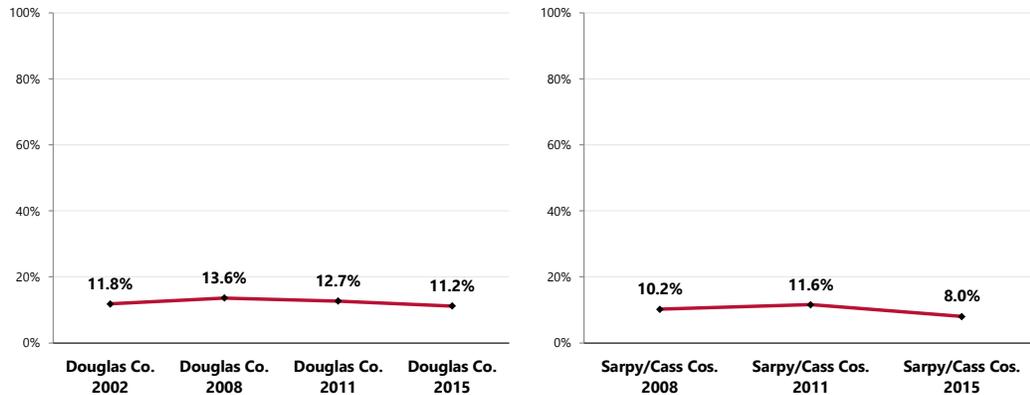
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Because similar surveys were completed in Douglas and Sarpy/Cass counties prior to 2011, the following chart shows the longer trends for these areas.

- TREND: No statistically significant change has occurred for either Douglas or Sarpy/Cass counties when comparing “fair/poor” overall health reports to previous survey results.

Experience “Fair” or “Poor” Overall Health



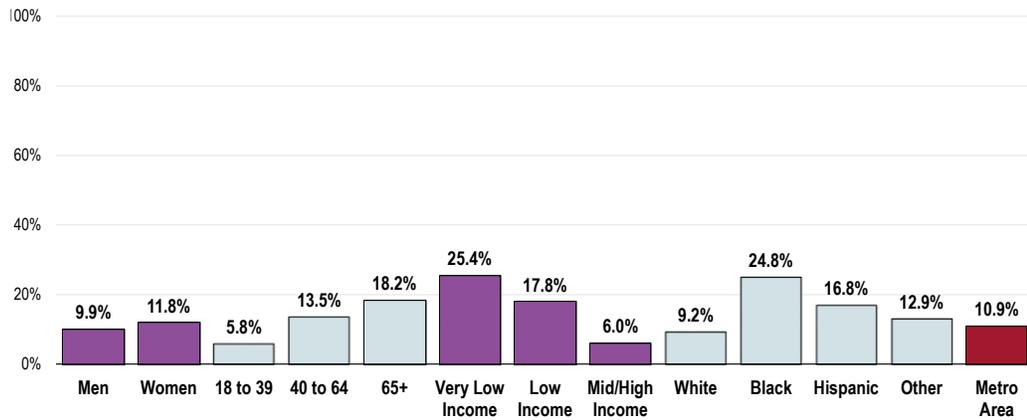
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]
 Notes: • Asked of all respondents.

Adults more likely to report experiencing “fair” or “poor” overall health include:

- Seniors (note the positive correlation with age).
- Residents living at lower incomes (negative correlation with income).
- Blacks and Hispanics.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

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

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



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households living with defined poverty status; “Low Income” includes households with incomes just above the FPL, earning up to twice the poverty threshold; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

RELATED ISSUE:
See also
*Potentially Disabling
Conditions in the
Death, Disease &
Chronic Conditions*
section of this report.

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

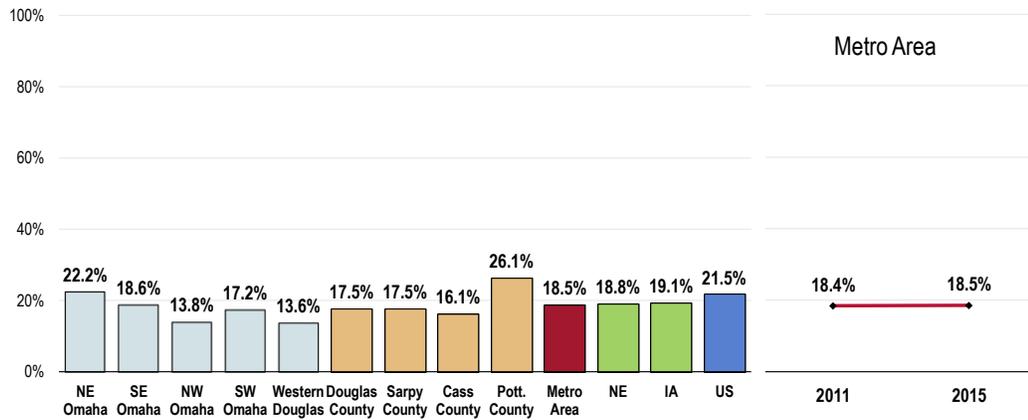
- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

- Healthy People 2020 (www.healthypeople.gov)

A total of 18.5% of Metro Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Similar to both statewide figures.
- More favorable than the national prevalence.
- Unfavorably high in Pottawattamie County.
- In Douglas County, unfavorably high in the Northeast.
- TREND: No significant change in activity limitations since 2011.

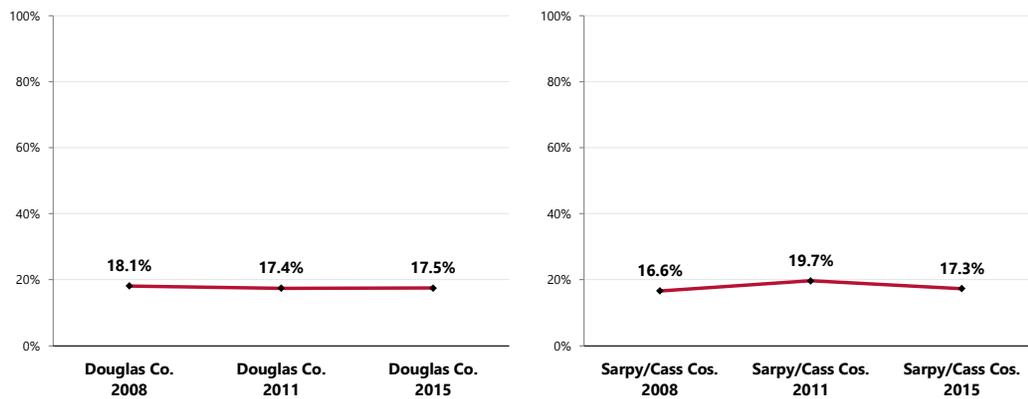
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 105]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: No statistically significant change for either area over time.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

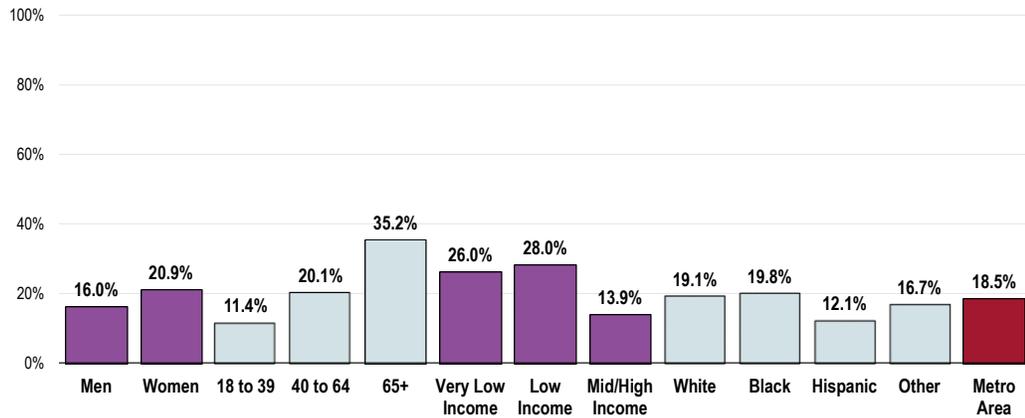


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 105]
 Notes: • Asked of all respondents.

In looking at responses by key demographic characteristics, note the following:

- Women are more likely than men to report activity limitations.
- Adults age 40 and older are much more often limited in activities (note the positive correlation with age).
- Residents living at or near the federal poverty level are twice as likely to report activity limitations as those with higher incomes.
- Whites and Blacks are more likely than Hispanics and Other races to report activity limitations.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (Metro Area, 2015)

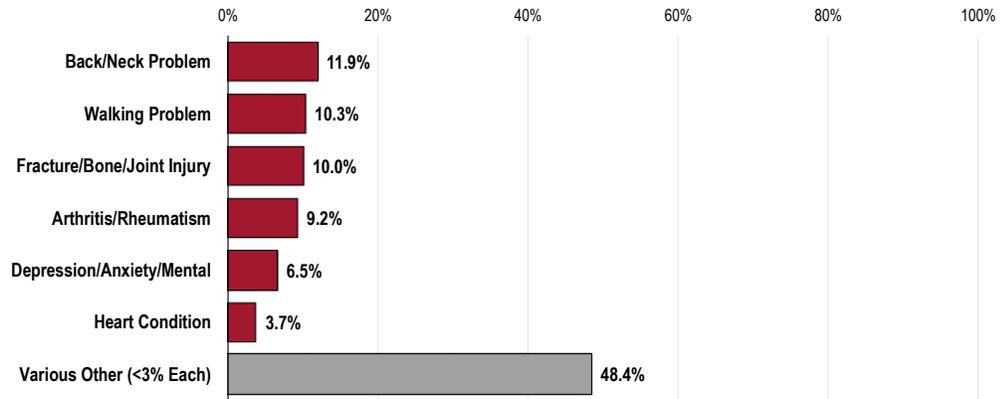


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among persons reporting activity limitations, these are most often attributed to musculoskeletal issues, such as back/neck problems, difficulty walking, fractures or bone/joint injuries, or arthritis/rheumatism.

Other problems mentioned with some frequency include depression/anxiety/mental health issues and heart conditions.

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



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
 Notes: • Asked of those respondents reporting activity limitations.

Mental Health

RELATED ISSUE:

See also
*Potentially Disabling
Conditions in the
Death, Disease &
Chronic Conditions
section of this report.*

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

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

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant 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 in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)

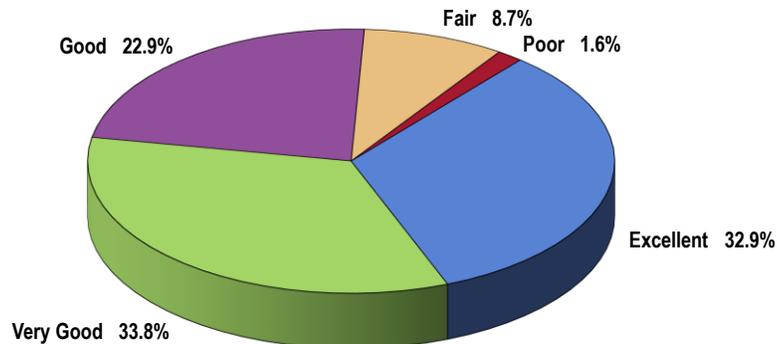
Self-Reported Mental Health Status

Two in three Metro Area adults (66.7%) rate their overall mental health as “excellent” or “very good.”

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

- Another 22.9% gave “good” ratings of their own mental health status.

Self-Reported Mental Health Status (Metro Area, 2015)

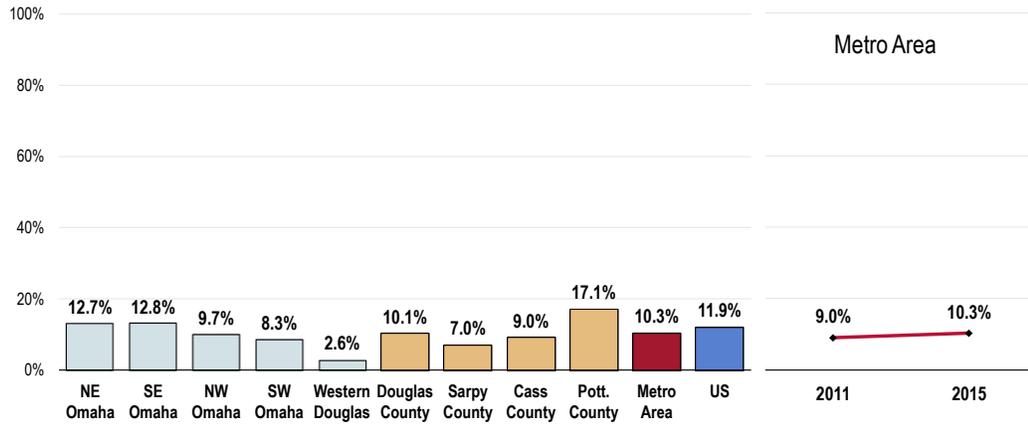


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
Notes: • Asked of all respondents.

A total of 10.3% of Metro Area adults, however, believe that their overall mental health is “fair” or “poor.”

- Similar to the “fair/poor” response reported nationally.
- Lowest in Sarpy County; unfavorably high in Pottawattamie County.
- Favorably low in Western Douglas County.
- TREND: Statistically unchanged since 2011.

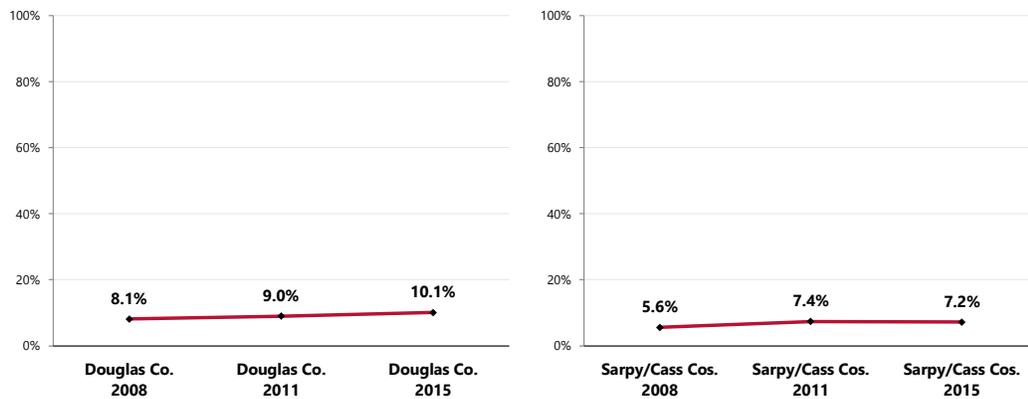
Experience “Fair” or “Poor” Mental Health



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 100]
 ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: ● Asked of all respondents.

- TREND: Statistically unchanged since 2008 for both Douglas and Sarpy/Cass counties.

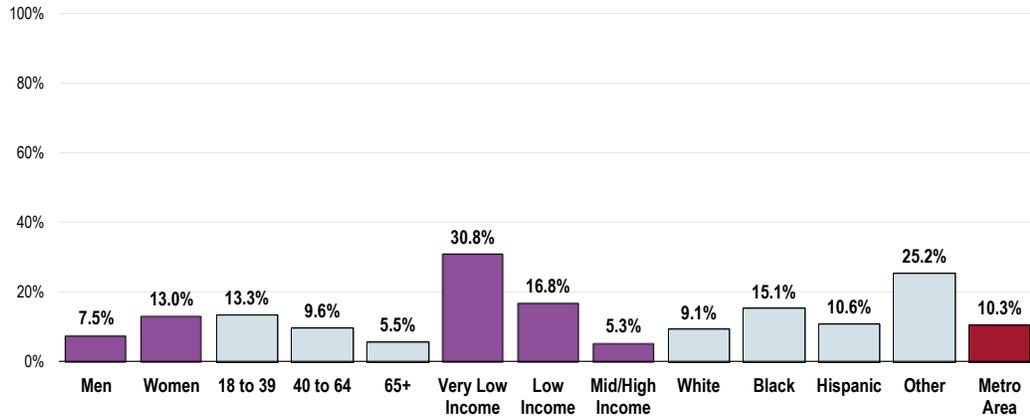
Experience “Fair” or “Poor” Mental Health



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 100]
 Notes: ● Asked of all respondents.

- Note the negative correlations between poor mental health and both age and income.
- Women, Blacks, and Other races are much more likely to report experiencing “fair/poor” mental health than their demographic counterparts.

Experience "Fair" or "Poor" Mental Health (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

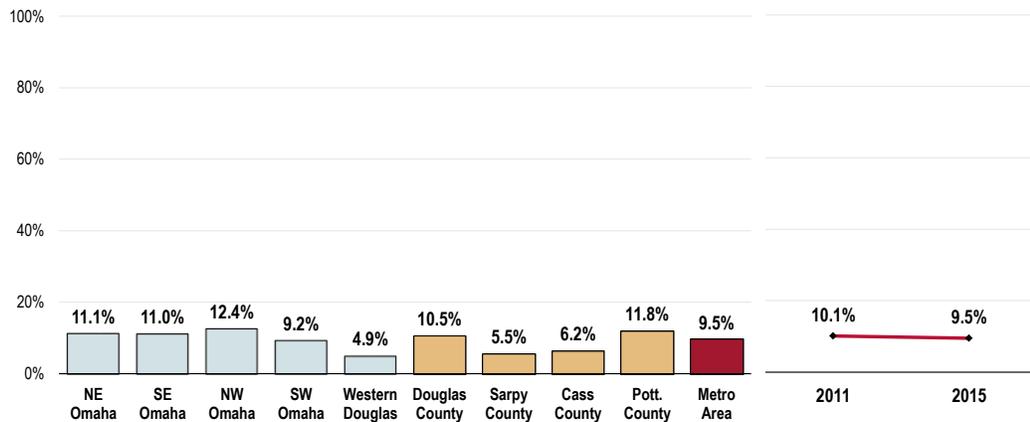
Depression

Major Depression

A total of 9.5% of Metro Area adults have been diagnosed by a physician as having major depression.

- Among the four Metro Area counties, lowest in Sarpy County.
- Lowest in Western Douglas County.
- TREND: Statistically unchanged over time.

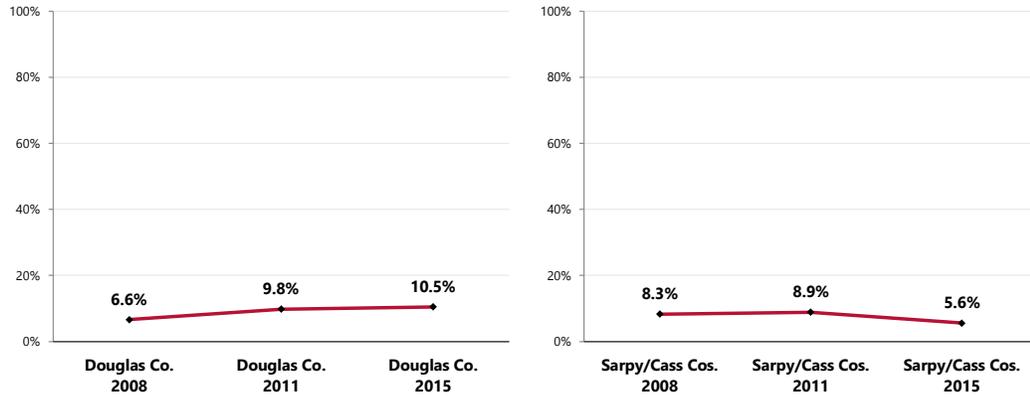
Have Been Diagnosed With Major Depression



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 308]
 Notes: • Asked of all respondents.

- TREND: Marks a statistically significant increase over time in Douglas County; statistically unchanged in Sarpy/Cass counties.

Have Been Diagnosed With Major Depression

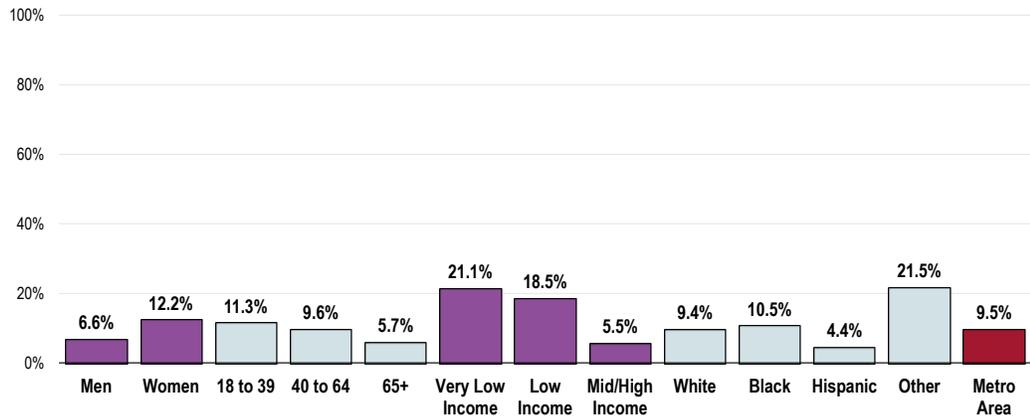


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]
 Notes: • Asked of all respondents.

The prevalence of diagnosed depression is notably higher among:

- Women.
- Younger adults (negative correlation with age).
- Community members living at lower incomes (negative correlation with income).
- Other races.

Have Been Diagnosed With Major Depression (Metro Area, 2015)



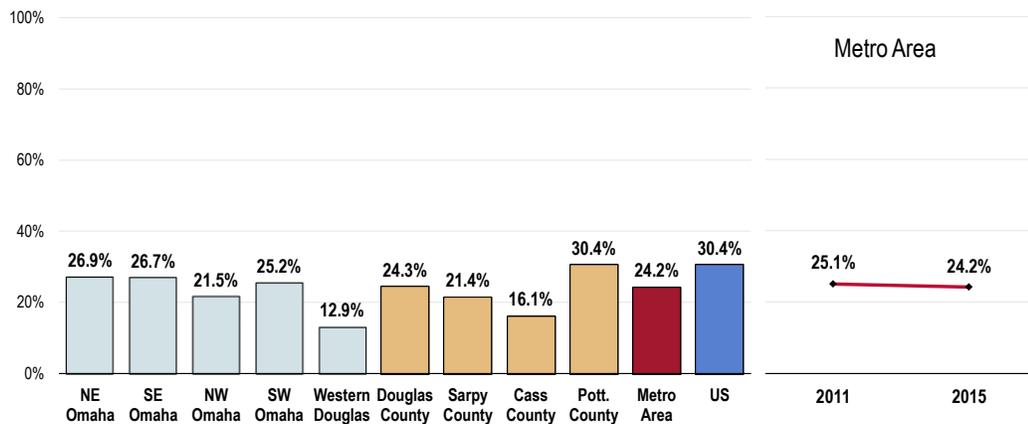
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Symptoms of Chronic Depression

A total of 24.2% of Metro Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

- More favorable than national findings.
- Highest in Pottawattamie County; lowest in Cass County.
- Favorably low in Western Douglas County.
- TREND: Similar to that reported in the Metro Area in 2011.

Have Experienced Symptoms of Chronic Depression

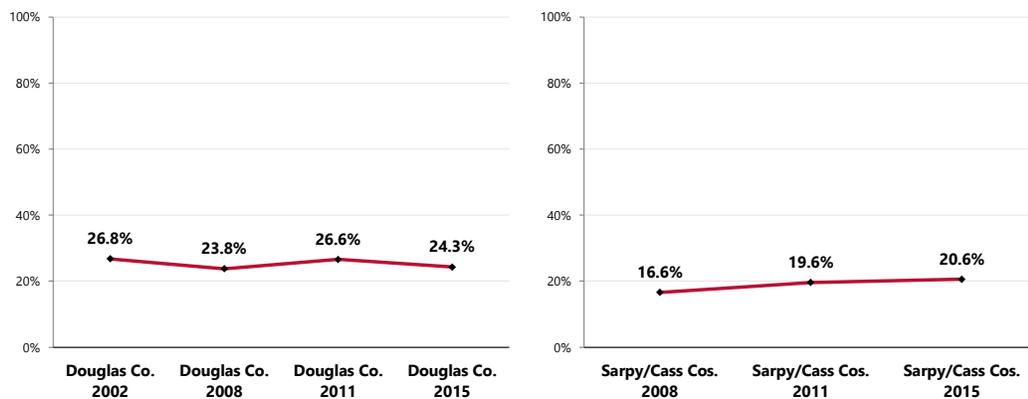


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 101]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

- TREND: No significant changes over time in either area.

Have Experienced Symptoms of Chronic Depression



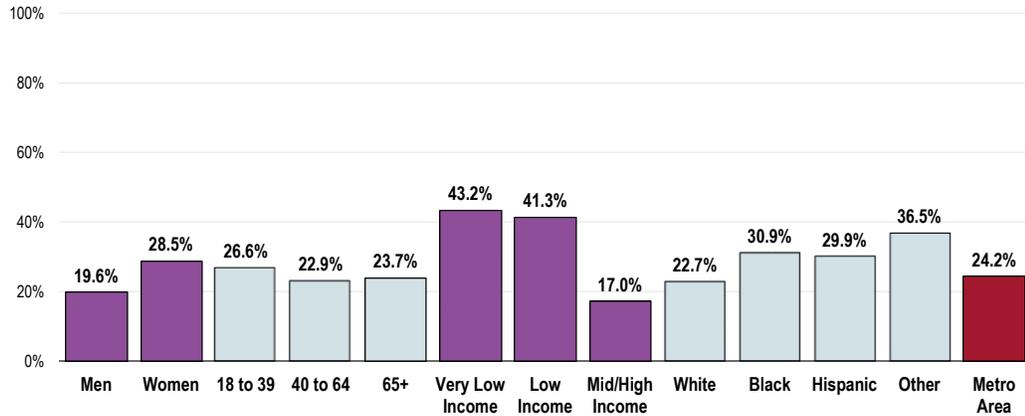
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 101]

Notes: • Asked of all respondents.
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Note that the prevalence of chronic depression is notably higher among:

- Women.
- Adults with lower incomes.
- Blacks, Hispanics, and Other adults.

Have Experienced Symptoms of Chronic Depression (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
 Notes: • Asked of all respondents.
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

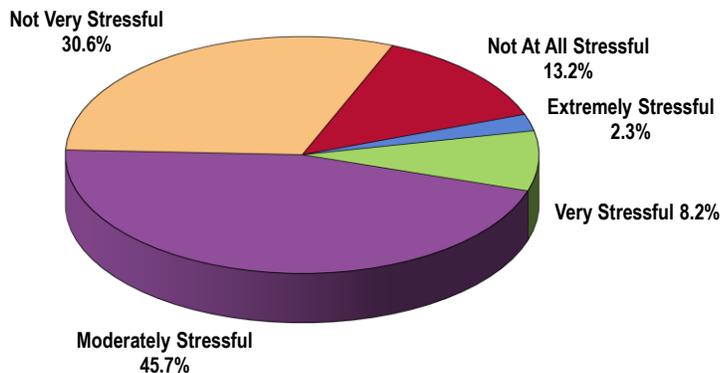
More than 4 in 10 Metro Area adults consider their typical day to be "not very stressful" (30.6%) or "not at all stressful" (13.2%).

RELATED ISSUE:

- Another 45.7% of adults characterize their typical day as "moderately stressful."

See also *Substance Abuse in the Modifiable Health Risks* section of this report.

Perceived Level of Stress On a Typical Day (Metro Area, 2015)

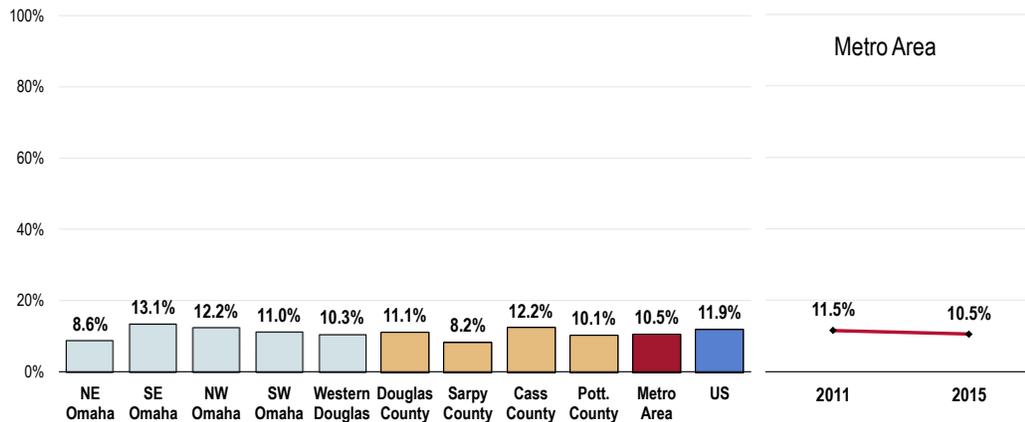


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
 Notes: • Asked of all respondents.

In contrast, 10.5% of Metro Area adults experience “very” or “extremely” stressful days on a regular basis.

- Comparable to national findings.
- Comparable findings by county.
- In Douglas County, favorably low in Northeast Omaha.
- TREND: Statistically similar to the 2011 findings.

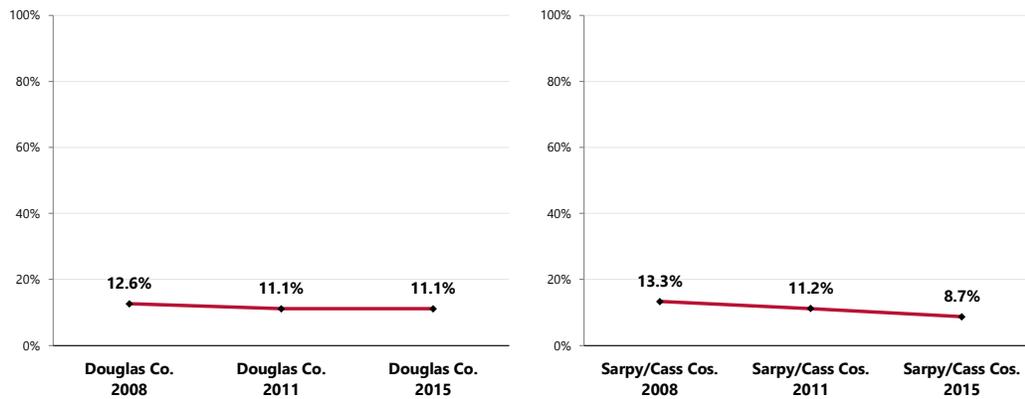
Perceive Most Days As “Extremely” or “Very” Stressful



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 102]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged in Douglas County but marking a statistically significant decrease over time in Sarpy/Cass counties.

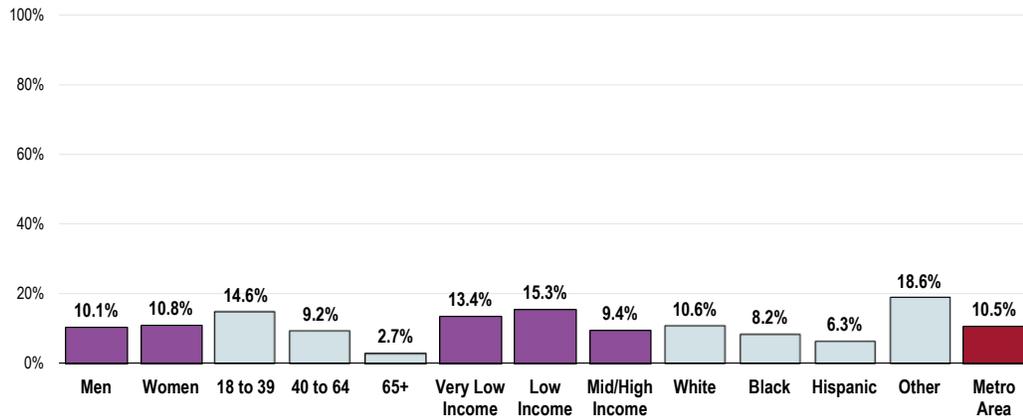
Perceive Most Days As “Extremely” or “Very” Stressful



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 102]
 Notes: • Asked of all respondents.

- Note that high stress levels are more prevalent among adults under 65 (negative correlation with age), lower-income residents, Whites, and Other race adults.

Perceive Most Days as “Extremely” or “Very” Stressful (Metro Area, 2015)



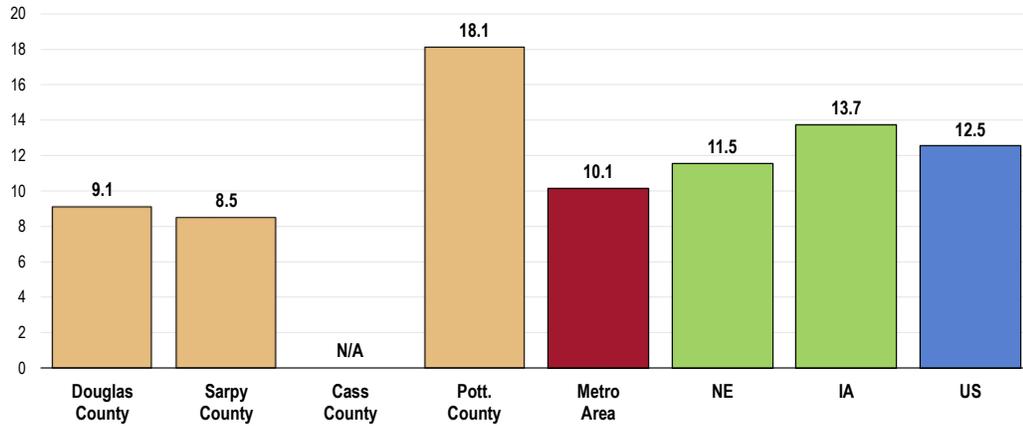
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households living with defined poverty status; “Low Income” includes households with incomes just above the FPL, earning up to twice the poverty threshold; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Suicide

Between 2011 and 2013, there was an annual average age-adjusted suicide rate of 10.1 deaths per 100,000 population in the Metro Area.

- Lower than the statewide rates.
- Lower than the national rate.
- Similar to the Healthy People 2020 target of 10.2 or lower.
- Unfavorably high in Pottawattamie County.

Suicide: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 10.2 or Lower



Sources:

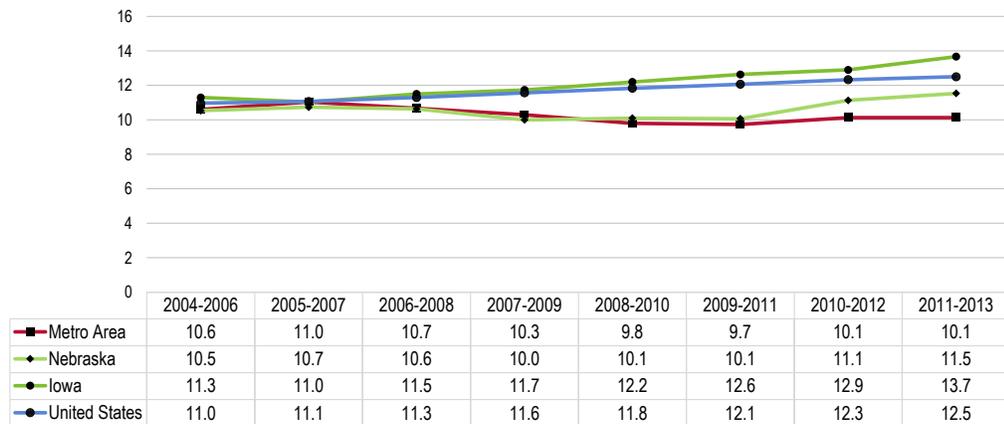
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- **TREND:** The area suicide rate has overall trended downward slightly, in contrast to the increasing trends across Nebraska, Iowa, and the US overall.

Suicide: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 10.2 or Lower



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]

Notes:

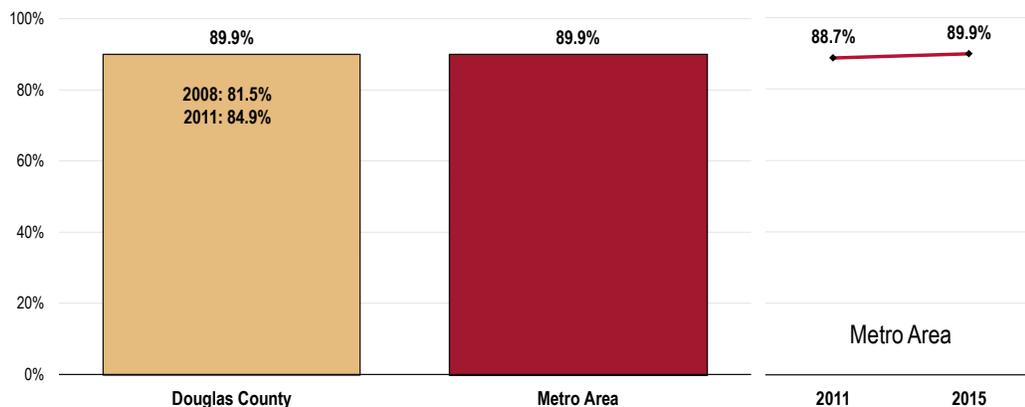
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

Mental Health Treatment

Among adults with a diagnosis of major depression, 89.9% acknowledge that they have sought professional help for a mental or emotional problem.

- TREND: There has been no statistically significant change over time among Metro Area adults with major depression.
- TREND: In Douglas County, the increase since 2008 is not statistically significant.

Adults With Major Depression Who Have Ever Sought Professional Help for a Mental or Emotional Problem (Among Adults With Major Depression)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 123]
Notes: • Reflects those respondents with major depression.

Key Informant Input: Mental Health

The vast majority of key informants taking part in an online survey characterized *Mental Health* as a “major problem” in the community.

Perceptions of Mental Health as a Problem in the Community (Key Informants, 2015)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, August 2015.

Challenges

Among those rating this issue as a “major problem,” the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care/Services

Limited access to care, almost no ability to have inpatient care, services for children are limited. – Public Health Representative

Not enough access or resources, not enough education for people to know what to do. – Healthcare Provider

Access. These patients often board in the Emergency Department for days if there are no beds available in the community. – Physician

Access to care, cost of medication. – Public Health Representative

Access to services in a timely manner, not enough inpatient beds or emergency services. – Social Service Provider

Finding a mental health bed when needed. There are waiting lists that are months long. CHI Health is currently the only system that provides mental health beds in the area. – Healthcare Provider

Access to care and choices in care. If no insurance and no funding, it is hard to access care in a timely manner. If you don't have insurance you are limited to handful of agencies that can serve you. There are limited inpatient psych beds. – Healthcare Provider

Mental health issues are common and it can be difficult to get in to see a practitioner and also can be difficult to afford needed medications. – Community/Business Leader

Access to services. Particularly when needed outside of normal business hours. – Social Service Provider

Availability of services and limited financial coverage. – Public Health Representative

Access and availability of appropriate levels of care. Following up with care. Providers lack of knowledge regarding diverse populations. Cost of care and inability to pay for services so some do not engage in services. Stigmas. – Social Service Provider

Affordability and access to quality mental health practitioners is a key issue in Omaha. We lack accessible drug/alcohol programs for adults and youth. Our interventions don't follow research and best practice. We are behind 10 years. – Community/Business Leader

Few services and extremely long wait periods. – Social Service Provider

Affordable, high quality facilities and professionals. – Social Service Provider

Access to care. Stigma. – Community/Business Leader

Having access to counseling services and assistive support for meeting daily needs. – Healthcare Provider

Access to therapy or medications. – Healthcare Provider

Access and quality care, medication management, ability to pay for medication, transportation to office for visits/medication checks, over diagnosed children and not providing alternatives vs. a quick and easy diagnosis with medication. – Social Service Provider

Lack of access is the biggest problem related to mental health in our county. Mental health services are very expensive and scarce so the programs that offer services on a sliding scale are overwhelmed and may take up to six weeks to be able to book an appointment. – Healthcare Provider

It is difficult to get into a treatment program/facility. Many times one has to wait. Not enough mental health counselors. – Healthcare Provider

Access to residential treatment when needed. The waiting lists are unacceptable. – Social Service Provider

Lack of treatment and affordable care. – Social Service Provider

Lack of access to crisis intervention and inpatient care. – Social Service Provider

Insufficient access for persons experiencing severe mental health crises. State laws are focused on civil rights and do not adequately address the needs of individuals; the bar is set too high for Board of Mental Health commitments, too few professionals. – Social Service Provider

Lack of access to care. Stigma. Lack of resources, including trained counselors in Spanish and other languages. – Public Health Representative

Access to care both short and long term. – Healthcare Provider

Access to care, cost of care, continuity of care. – Healthcare Provider

There is currently a four-month wait for an outpatient to get an appointment with Douglas County. I am not aware of any other mental health provider that will see patients without insurance. Since Nebraska did not expand Medicaid, that leaves a rather large population. – Physician

Not having rapid access to services, not having longer-term services to follow up acute episodes. – Social Service Provider

Lack of Providers

There are not enough providers in Omaha. There are even less in outstate and rural NE. Co-pays are expensive and often insurance doesn't cover the care. Mental healthcare can be expensive and time consuming and overall is very difficult to access. – Physician

Lack of service providers and convenient appointment times for individuals. – Social Service Provider

Lack of healthcare providers or mental health facilities. – Healthcare Provider

There are not enough providers and there is not a clear and easy pathway for people who need to access services. – Social Service Provider

I see the biggest challenge in finding appropriate providers who have the skill to treat those with mental health issues, then the wait time for evaluation, therapy and approval for medication often causes delay in treatment and/or continuity. – Community/Business Leader

Lack of adequate number of mental health providers in the area. Not enough psychiatric beds in the community. Fragmented system of care. No full-service psychiatric ED. – Healthcare Provider

Access to mental health services. Magellan is a barrier to care, not enough BH therapists or psychiatrists. Poorly coordinated care. Documentation burden makes BH care inefficient. No show rates among BH providers make it inefficient. Limited payments. – Public Health Representative

Access to mental health providers. Shortage of providers. Difficult for patients to make appointments and then get to appointments. – Physician

Not enough psychiatrists in the area. Takes a long time to get into an appointment. – Healthcare Provider

Access to an inadequate number of professionals and insurance coverage for treatment. – Community/Business Leader

Not enough affordable mental health professionals in our community. – Physician

Lack of providers. Reimbursements from insurance companies, Medicaid, Medicare, government contracts, etc. are insufficient. As a result, salaries are low and the field is not attractive to, or unable to retain, talent. – Social Service Provider

Lack of practitioners in the field. – Healthcare Provider

No providers and no facilities. – Social Service Provider

Lack of providers. – Physician

Lack of Resources

Lack of resources and inpatient beds for mental health admissions. – Healthcare Provider

People don't have the resources to access care, seems to be a lot of therapists but very few that want Medicaid or low fees. Language capacity is also an issue. Not enough services for children and young adults. – Healthcare Provider

Not enough resources in the community, limited spaces for inpatient evaluations. – Healthcare Provider

Lack of resources, lack of psychiatrists, counselors, residential facilities and after care programs, also poor reimbursement for services. – Social Service Provider

Access to in-hospital bed, access to follow-up visits with health practitioners and even community level awareness of how to access an underfunded, overwhelmed system for mental health services. – Social Service Provider

Getting people into treatment and helping them be successful. Often times this treatment will need to happen multiple times before the individual succeeds in staying on top of their illness. Access to ongoing medication management is lacking as well. – Social Service Provider

Not enough facilities/housing, even if it's temporarily needed. People not able to afford counseling/rehab if needed. We try to triage "who is really bad off," they get some help while others who may be hanging on by a shred will not be receiving any help. – Healthcare Provider

Limited long-term stay beds available in the community. Insurance does not cover the level of services

necessary. – Healthcare Provider

There is no Hispanic psychiatrist in the whole state of Nebraska. There are two Hispanic certified psychologists in Omaha, few bilingual therapists. To address appropriately mental health conditions, we need bilingual/bicultural providers capable of understanding. – Community/Business Leader

People use ED for their mental health primary care. Region 6 has limited effectiveness, strategies, etc. – Healthcare Provider

No navigator for ongoing guidance, no affordable counseling. Very few experienced counselors available to non-insured people. – Social Service Provider

Not sufficient support for mental health in Nebraska. – Healthcare Provider

There are not enough beds in mental health units to care for the number of patients. – Social Service Provider

Lack of mental health services and after-treatment facilities that can provide some sort of counseling. There is also a lack of mental health practitioners and especially those that are willing to take Medicaid patients. – Public Health Representative

Not enough inpatient beds and not enough psychiatrists. – Physician

There are not enough inpatient mental health facilities. Patients have to wait hours to days in the ED or days to weeks in the hospital for a psychiatric bed to open up. – Physician

Lack of culturally competent therapists with knowledge of historical trauma. Also access to psychiatrists is challenging. – Social Service Provider

Affordable treatment and follow-up care. – Community/Business Leader

There are not enough service providers for people with limited English. Additionally, traditional methods of counseling are not culturally appropriate and do not work as well as in home therapy sessions and trust building first. – Social Service Provider

Access to culturally competent services, lack of insurance and the Medicaid expansion, available mental health professionals who are culturally diverse. – Social Service Provider

Lack of inpatient services. Often patients with mental health problems become entangled in the criminal justice system so we have many people with serious, untreated mental illness in our jails and prison. – Social Service Provider

Inadequate resources. – Community/Business Leader

Lack of services provided, lack of use of the few providers available, lack of culturally appropriate mental health treatment for individuals. – Social Service Provider

We have a resource rich community for mental health, however individuals struggle to navigate the resources and finding access. There are often transportation issues and/or issues with follow through. – Social Service Provider

Limited resources, i.e. professionals and limited financial support blended with poor population understanding of and support for behavioral health issues. Too few inpatient services or emergency services for youth in mental health crisis. – Public Health Representative

Stigma

There is a stigma regarding mental health. Services and help are not available and most people who need the services are either too proud to get help or don't know where to get help. – Social Service Provider

Stigma of needing mental health services. – Social Service Provider

Stigma associated with mental health prevents proper identification and diagnosis. Lack of coordination among programs/agencies/schools that work with people with mental health, resulting in an overwhelming and confusing system that is difficult to navigate. – Social Service Provider

Stigma of disease, lack of screening and treatment, inpatient and outpatient. Poor insurance coverage. – Public Health Representative

Funding

Getting the support they need both financially, psychologically and social support so they get connected with a psychiatrist, can afford their medications, and stay on their treatment regimen. – Healthcare Provider

No money! - Community/Business Leader

Funding for services that are available. Insurances not paying for very long psychiatric hospitalizations. Closing of Mental Health Institutions in the state. Limited group homes and RCF for people who are unable to live in community. Long waiting list. – Healthcare Provider

Due to the nature of most mental health diagnosis it leads many people into a lifestyle where there isn't health insurance or the money available to pay for therapy and prescriptions. There isn't enough state funding to go around to help in paying for services. – Social Service Provider

Co-occurring Morbidities

We know that more people are struggling with mental health and substance abuse problems. We need to integrate our healthcare systems so we are treating the whole person 100 percent of the time and not just when someone comes in specifically for this issue. – Social Service Provider

With the de-institutionalization of mental health services there are now more mentally ill individuals in the community. There are, at times, no places for violent individuals to be treated and lack of community support for non-violent consumers. – Community/Business Leader

There are a lot of people that hang out downtown and don't want to get services for mental health. I think it stems from other issues like substance abuse. – Community/Business Leader

It leads to poverty and all of the negative other issues covered here. – Community/Business Leader

I believe that the first obstacle is convincing people that they need the services. I also think having access to services as well as transportation can be a problem. Many of our parents do not have insurance and therefore can't afford services. – Social Service Provider

Not seeking treatment or not knowing where to go for treatment. – Healthcare Provider

Being able to be productive citizens and mainstream into the community. – Healthcare Provider

Mental Health has to be one of the biggest challenges that our community faces. Mental health and the lack of access to services and stable housing or support is contributing to large increases in crime, homelessness, and poverty. – Social Service Provider

Education

There continues to be a lack of understanding of the issue of mental health. As a community we struggle with access and urgent care needs. – Social Service Provider

Don't think we talk about this enough. – Social Service Provider

Supportive wrap-around services, homeless. – Social Service Provider

Undiagnosed mental health and lack of funding to access mental health services; including lack of services available to address chronically mentally ill. – Healthcare Provider

Coordination Between Services

Communication between ID and BH service systems. – Community/Business Leader

I think there is a big connection with mental health issues and homelessness. In Council Bluffs there are two homeless shelters and more transitional housing so I would consider this a major problem.

Mental health programming and payment are a problem for many. – Community/Business Leader

Continuity of care and medication compliance. – Healthcare Provider

Risk Factors

Kids and families who live in neighborhoods with high risk factors, i.e. poverty, gang violence, no transportation, stigma, and lack of trust with organizations/agencies, this population does not access mental health in our clinics. – Healthcare Provider

Death, Disease & Chronic Conditions



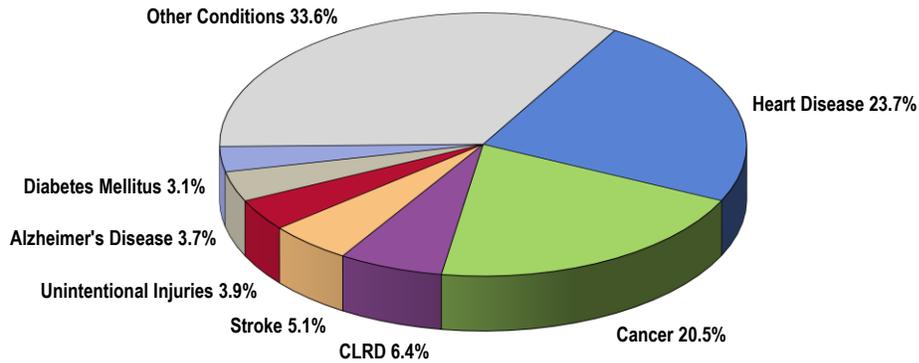
Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for nearly one-half of all deaths in the Metro Area in 2013.

Leading Causes of Death
(Metro Area, 2013)



- Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, Nebraska, Iowa and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines 2011-2013 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Metro Area.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Note that age-adjusted mortality rates in the Metro Area are worse than national rates for cancer, chronic lower respiratory disease (CLRD), Alzheimer’s disease, homicide, and diabetes mellitus.

Of the causes outlined in the following chart for which Healthy People 2020 objectives have been established, Metro Area rates fail to satisfy the related goals for cancer, stroke, homicide, firearms, diabetes mellitus, and cirrhosis.

Age-Adjusted Death Rates for Selected Causes (2011-2013 Deaths per 100,000 Population)

| | Metro Area | Nebraska | Iowa | US | HP2020 |
|--|------------|----------|-------|-------|--------|
| Malignant Neoplasms (Cancers) | 178.5 | 163.4 | 170.0 | 166.2 | 161.4 |
| Diseases of the Heart | 151.3 | 147.2 | 168.4 | 171.3 | 156.9* |
| Chronic Lower Respiratory Disease (CLRD) | 50.4 | 49.0 | 47.4 | 42.0 | n/a |
| Cerebrovascular Disease (Stroke) | 38.2 | 36.0 | 34.3 | 37.0 | 34.8 |
| Unintentional Injuries | 32.5 | 36.1 | 39.8 | 39.2 | 36.4 |
| Alzheimer's Disease | 28.1 | 24.7 | 30.3 | 24.0 | n/a |
| Diabetes Mellitus | 22.7 | 21.4 | 18.8 | 21.3 | 20.5* |
| Pneumonia/Influenza | 14.7 | 13.8 | 16.4 | 15.3 | n/a |
| Kidney Diseases | 11.6 | 9.8 | 8.2 | 13.2 | n/a |
| Intentional Self-Harm (Suicide) | 10.1 | 11.5 | 13.7 | 12.5 | 10.2 |
| Firearm-Related | 10.0 | 9.0 | 7.4 | 10.4 | 9.3 |
| Drug-Induced | 9.6 | 7.9 | 9.2 | 14.1 | 11.3 |
| Cirrhosis/Liver Disease | 8.7 | 7.9 | 7.8 | 9.9 | 8.2 |
| Motor Vehicle Deaths | 7.1 | 11.4 | 11.1 | 10.7 | 12.4 |
| Homicide/Legal Intervention | 6.2 | 3.8 | 2.0 | 5.3 | 5.5 |
| HIV/AIDS | 1.3 | 0.9 | 0.7 | 2.2 | 3.3 |

Sources:

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

- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.

Note:

- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

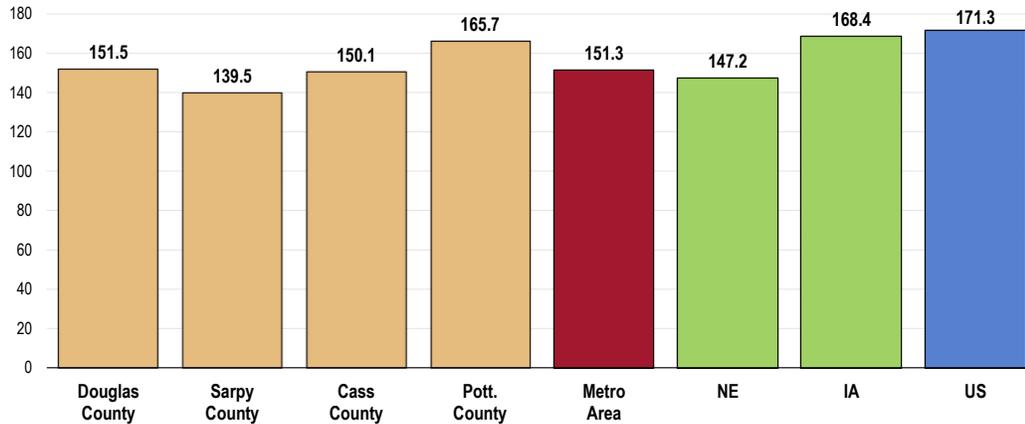
Heart Disease Deaths

Between 2011 and 2013 there was an annual average age-adjusted heart disease mortality rate of 151.3 deaths per 100,000 population in the Metro Area.

- Similar to the Nebraska rate but lower than the Iowa rate.
- Lower than the national rate.
- Similar to the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).
- Unfavorably high in Pottawattamie County; lowest in Sarpy County.

The greatest share of cardiovascular deaths is attributed to heart disease.

Heart Disease: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 156.9 or Lower (Adjusted)



Sources:

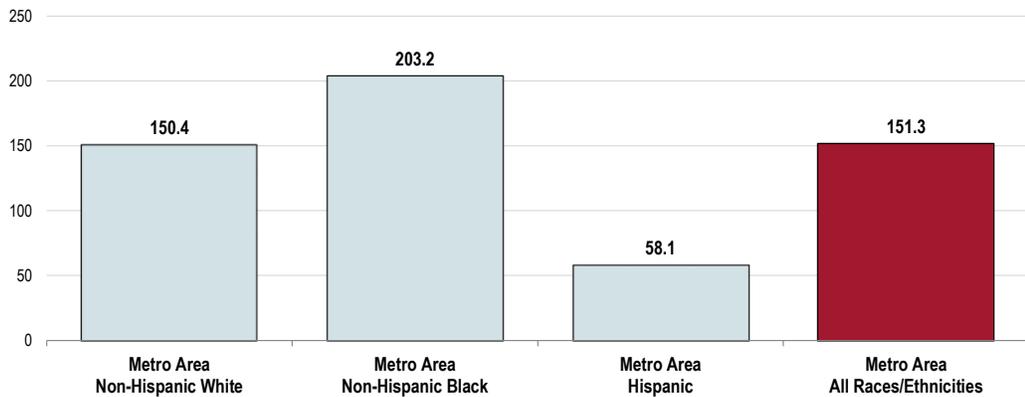
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

- By race, the heart disease mortality rate is notably higher among Non-Hispanic Whites and especially Non-Hispanic Blacks when compared with Hispanics in the Metro Area.

Heart Disease: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 156.9 or Lower (Adjusted)



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]

Notes:

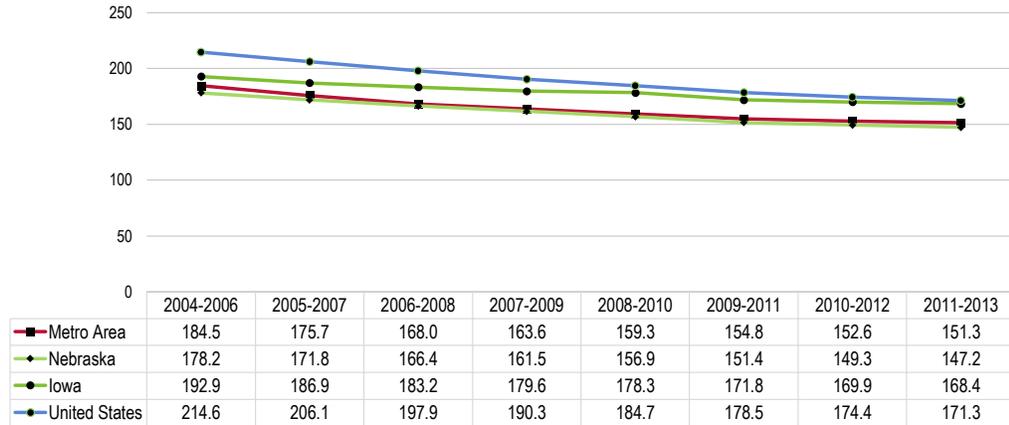
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

- **TREND:** The heart disease mortality rate has decreased in the Metro Area, echoing the decreasing trends across Nebraska, Iowa, and the US overall.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



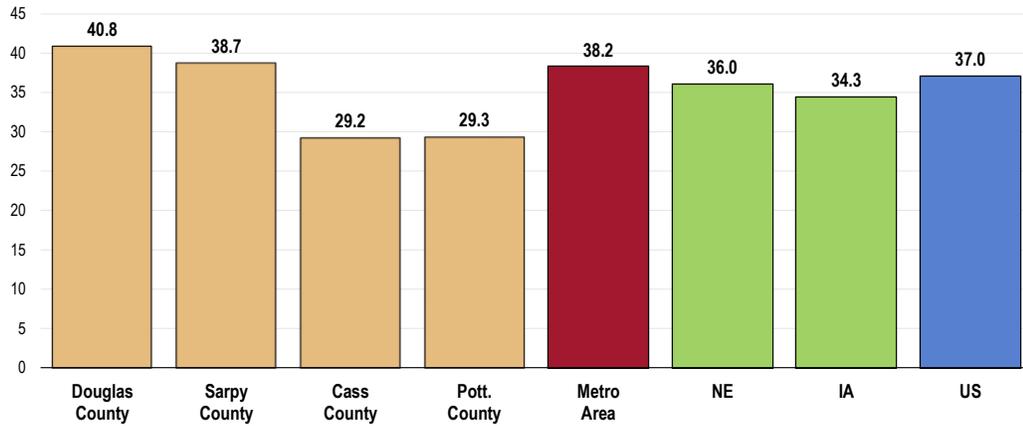
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.
 - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

Between 2011 and 2013, there was an annual average age-adjusted stroke mortality rate of 38.2 deaths per 100,000 population in the Metro Area.

- Higher than both state rates.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 34.8 or lower.
- Much higher in Douglas and Sarpy counties than in Cass and Pottawattamie counties.

Stroke: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 34.8 or Lower



Sources:

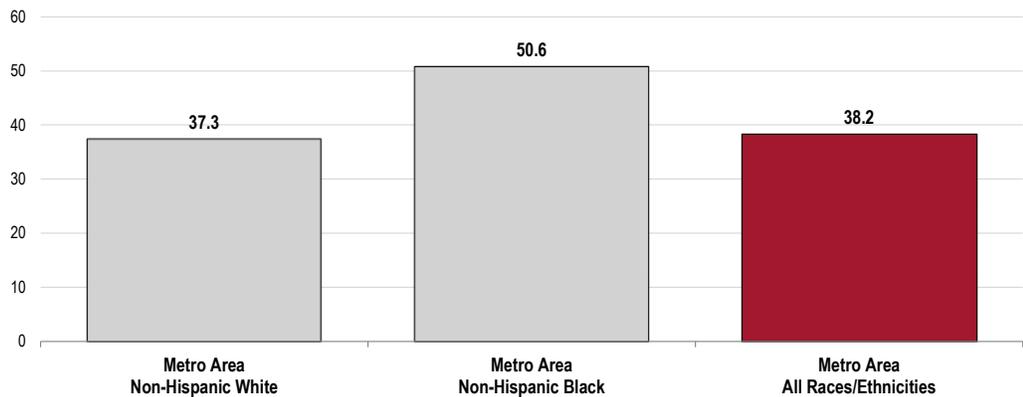
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]

 Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- Stroke mortality is much higher among Blacks than Whites in the Metro Area.

Stroke: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 34.8 or Lower



Sources:

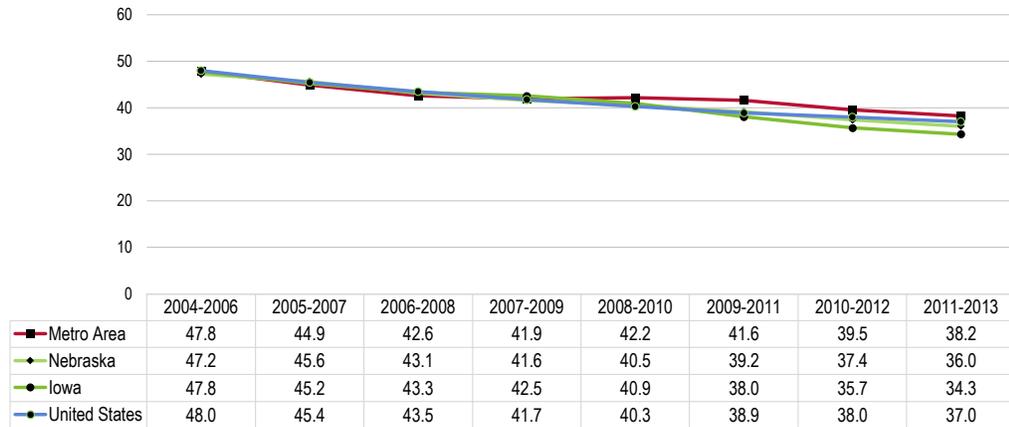
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]

 Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The stroke rate has declined in recent years, echoing the trends reported across both states and the US overall.

Stroke: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 34.8 or Lower



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 ● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 ● Local, state and national data are simple three-year averages.

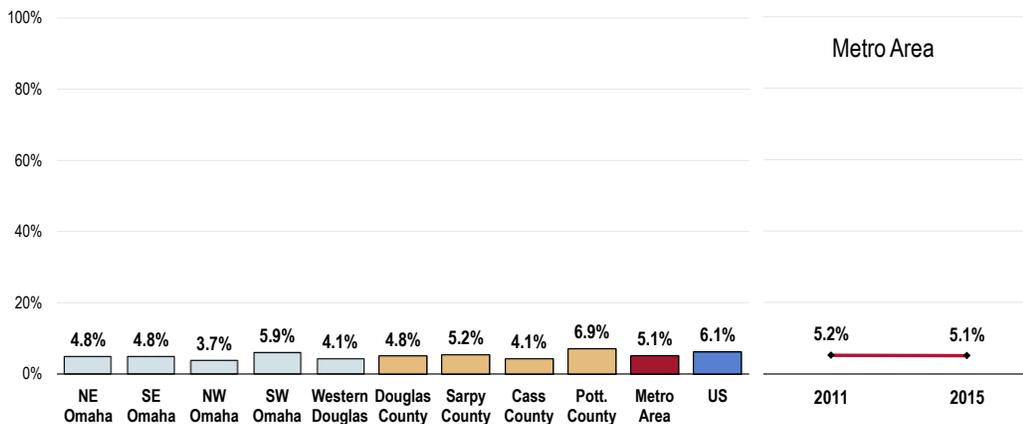
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 5.1% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Similar to the national prevalence.
- Similar findings by county.
- In Douglas County, similar findings by subarea.
- TREND: Statistically unchanged since 2011.

Prevalence of Heart Disease

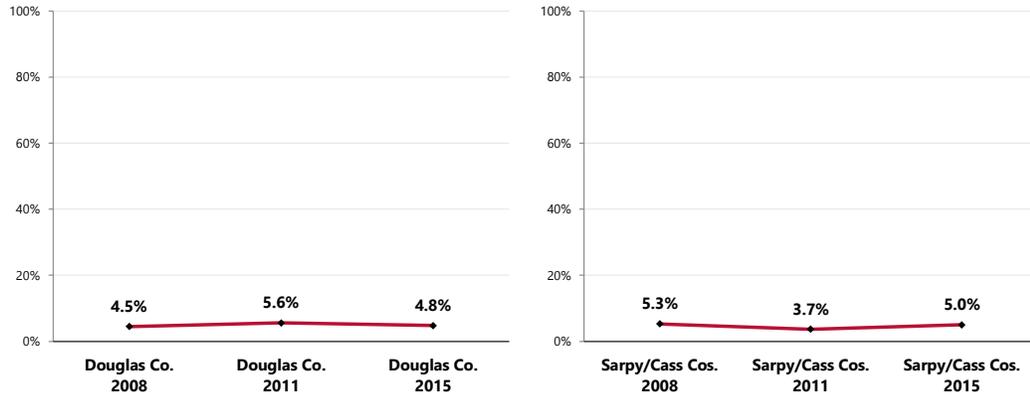


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 309]
 ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents.
 ● Includes diagnoses of heart attack, angina or coronary heart disease.

- TREND: Statistically unchanged over time in both Douglas and Sarpy/Cass County areas.

Prevalence of Heart Disease

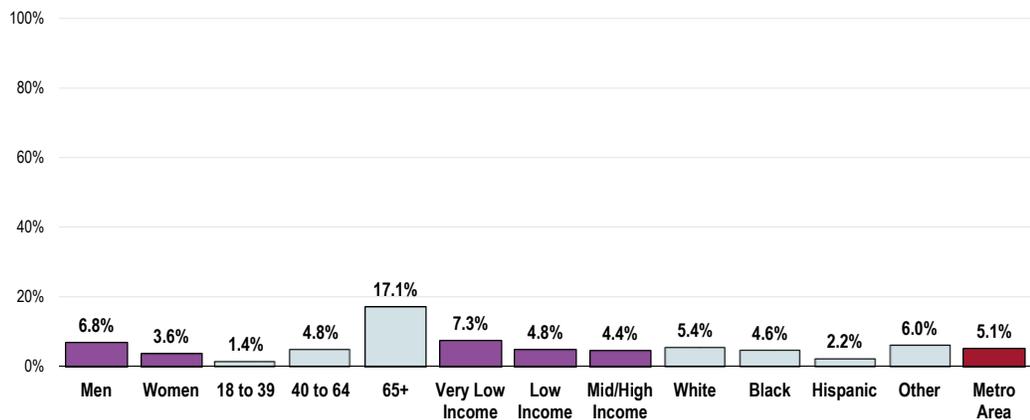


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 309]
 Notes: • Asked of all respondents.
 • Includes diagnoses of heart attack, angina or coronary heart disease.

Adults more likely to have been diagnosed with chronic heart disease include:

- Men.
- Seniors (positive correlation with age).
- The prevalence is favorably low, on the other hand, in the Hispanic population.

Prevalence of Heart Disease (Metro Area, 2015)



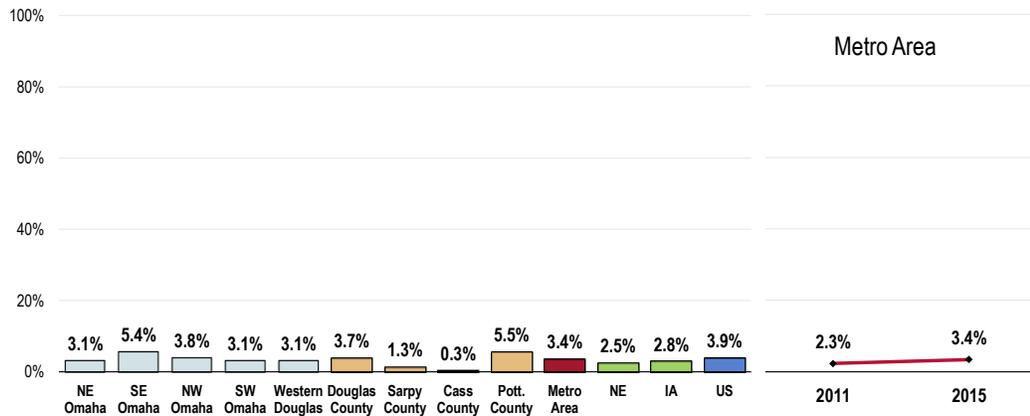
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]
 Notes: • Asked of all respondents.
 • Includes diagnoses of heart attack, angina or coronary heart disease.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prevalence of Stroke

A total of 3.4% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Higher than the Nebraska percentage but similar to that in Iowa.
- Similar to national findings.
- Unfavorably high in Pottawattamie County.
- In Douglas County, statistically similar by subarea.
- TREND: Denotes a statistically significant increase in stroke prevalence over time.

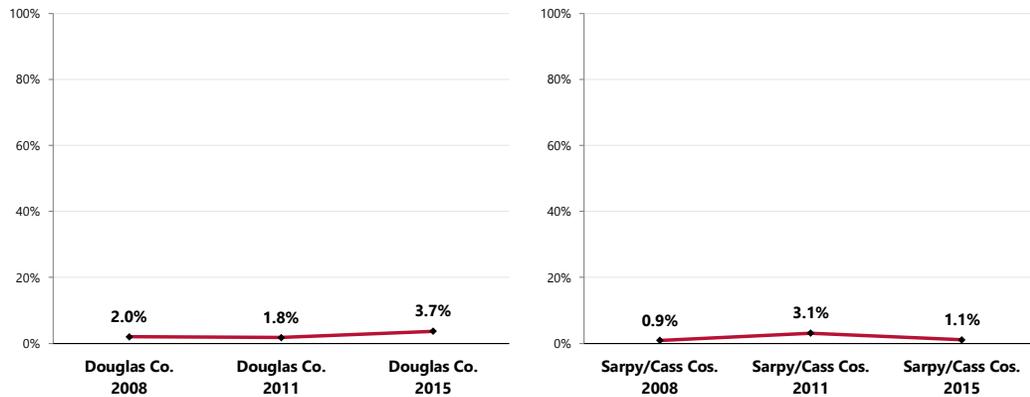
Prevalence of Stroke



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 Notes: • Asked of all respondents.

- TREND: Denotes a statistically significant increase in stroke prevalence over time in Douglas County; in Sarpy/Cass, the prevalence is similar to the 2008 baseline figure.

Prevalence of Stroke

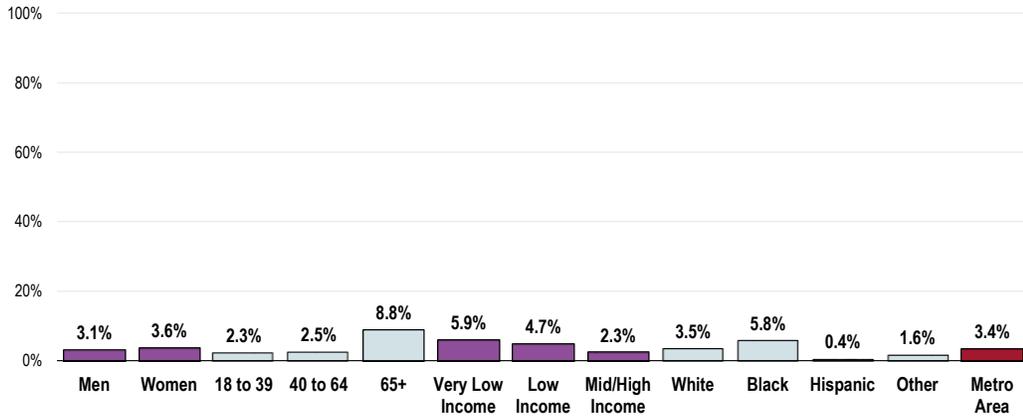


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]
 Notes: • Asked of all respondents.

Adults more likely to have been diagnosed with stroke include:

- Older adults (positive correlation with age).
- Whites and Blacks.

Prevalence of Stroke (Metro Area, 2015)

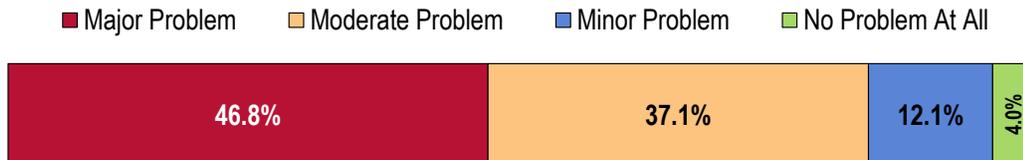


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "major problem" in the community.

Perceptions of Heart Disease and Stroke as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Associated Risk Factors

Obesity, need more preventative care strategies. – Healthcare Provider

Given the obesity levels in society and the sedentary lifestyles of too many adults and children, the incident of these diseases will only increase over time. – Social Service Provider

Obesity and lack of exercise, I believe, are primary causes of heart disease. – Community/Business Leader

Adults continue to smoke, are overweight and don't exercise. – Healthcare Provider

Uncontrolled hypertension due to lack of resources for medications as well as patient non-adherence to plan due to poor education. – Healthcare Provider

Stress caused by financial burden, immigration, domestic violence, family separation, isolation, unemployment, discrimination and other determinants affecting their lifestyle. Inability to afford treatments or medications prescribed. Fatalism, the belief. – Community/Business Leader

As our population ages and because Pottawattamie County has a high rate of smokers and overweight/obese residents, the problems with heart disease and stroke become increased. – Community/Business Leader

Same reason as diabetes, lots of people at risk for or have this disease and don't know. There is limited access to healthy food and exercise in some communities. Specialty care is hard to access in North and South Omaha. – Social Service Provider

Long term impact resulting in death and disability. Issues with obesity will likely increase this. – Social Service Provider

This has been a long time need of the community. Heart disease and stroke are also complications of diabetes, which is another community need. – Community/Business Leader

I think we have a large number of people who smoke, drink and have other chronic illnesses that lead to heart disease. – Healthcare Provider

We have an obesity issue in Omaha, which leads to heart disease. Also, we have the most restaurants per capita than any other city, therefore eating out and eating unhealthy food is more likely to take place. Also, there is a lack in physical activity. – Social Service Provider

Diet, lack of activity as a part of our culture. – Healthcare Provider

The unhealthy lifestyles seems to stem more heart disease and stroke in our community. – Community/Business Leader

This is linked to lifestyle factors (e.g. unhealthy diet and insufficient exercise) that are problems in the community. – Public Health Representative

Leading Cause of Death

It is the number one cause of death. – Social Service Provider

Still highest mortality rate tied to heart disease. – Community/Business Leader

It is one of the leading killers. – Social Service Provider

Heart disease is the number one cause of death of women and men in our community. They are conditions which appropriate lifestyle and preventative health interventions can prevent or delay the onset, but many individuals do not have access to care. – Physician

One of the leading causes of death. Significant impact financially, socially, community-wide. Heart disease and stroke are one of the number one killers of men and women in the US. – Social Service Provider

Loss of life or physical/mental deficits created reduce family functioning and stability. Impacts wage earning capacity for the family. – Social Service Provider

Heart disease is the number two and stroke number four leading cause of death in Douglas County. – Public Health Representative

Per CDC, heart disease is the leading cause of death. – Social Service Provider

Heart disease is always the number one killer and causes huge medical, individual and family costs. – Social Service Provider

Major abuse of death, weight and inactivity plays a role. – Public Health Representative

Cardiac disease is a major cause of death in the US and particularly in Nebraska. Risk factors include diet and exercise. – Social Service Provider

Still a leading cause of morbidity and mortality though rates are dropping with improved management. Stroke is so debilitating and early intervention key. Much more can be done to improve diet and lifestyle changes to decrease risk. Increasing obesity. – Healthcare Provider

Still leading cause of death nationwide, obesity, HTN, inactivity, high cholesterol, smoking. – Healthcare Provider

High Rate of Occurrence

Volume of patient care in the community for these conditions. – Physician

I see a number of patients that are hospitalized due to these diagnoses. I have a number of family members, friends and other individuals that have high blood pressure or other predisposing factors to these diseases. – Healthcare Provider

It affects so many people. – Physician

High prevalence. – Physician

High blood pressure is really prevalent in my community, which often leads to HD. – Social Service Provider

This is a major problem everywhere and stats are no different here. We need more preventive services also. – Healthcare Provider

Statistics. This is a health disparities issue as well. – Public Health Representative

It is a major problem in our community and across the United States. The cost of healthcare prohibits many in our community from seeking good preventative care. Sedentary lifestyle, poor diet, smoking, stress and heredity all play a role. – Social Service Provider

Racial & Ethnic Disparities

The racial and ethnic health disparities associated with heart disease and stroke is extremely high for AA, Hispanic and Native Americans. – Social Service Provider

The measurable difference in the fatal effects of these diseases between African Americans and almost all other ethnicities. – Community/Business Leader

The issue of heart disease and stroke represents a health disparity and affects African Americans at an alarming rate and across the life span. It becomes an issue for pregnant women with high blood pressure as they are more likely to experience premature babies. – Public Health Representative

Prevalence of diabetes in Hispanic population with more subsequent vascular complications. Hispanics have more limited access to secondary prevention services due to lack of disease understanding and high cost of healthcare. – Physician

Family history/heredity. – Healthcare Provider

Health disparities. – Social Service Provider

Resources

Poor primary healthcare access. – Healthcare Provider

Because we have certified stroke centers and heart centers in our area hospitals. – Healthcare Provider

Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
 - Cervical cancer (using Pap tests)
 - Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

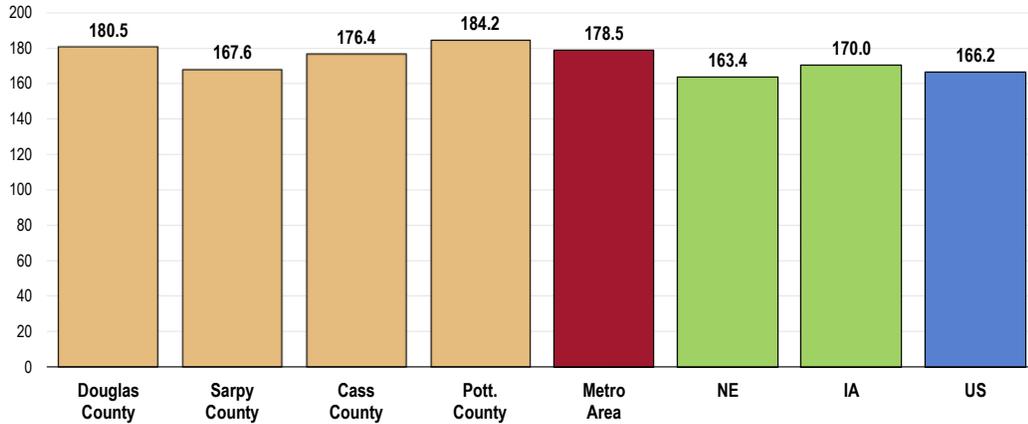
All Cancer Deaths

Between 2011 and 2013, there was an annual average age-adjusted cancer mortality rate of 178.5 deaths per 100,000 population in the Metro Area.

- Less favorable than the Nebraska state rate, similar to Iowa's rate.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 161.4 or lower.
- Favorably low in Sarpy County.

Cancer: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 or Lower



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

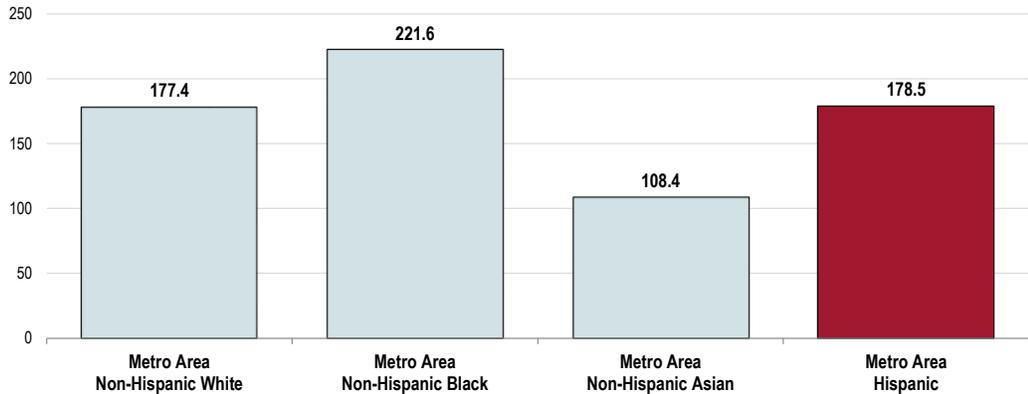
Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The cancer mortality rate is notably higher among Whites and (especially) Blacks when compared with Asians in the Metro Area.

Cancer: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 or Lower



Sources:

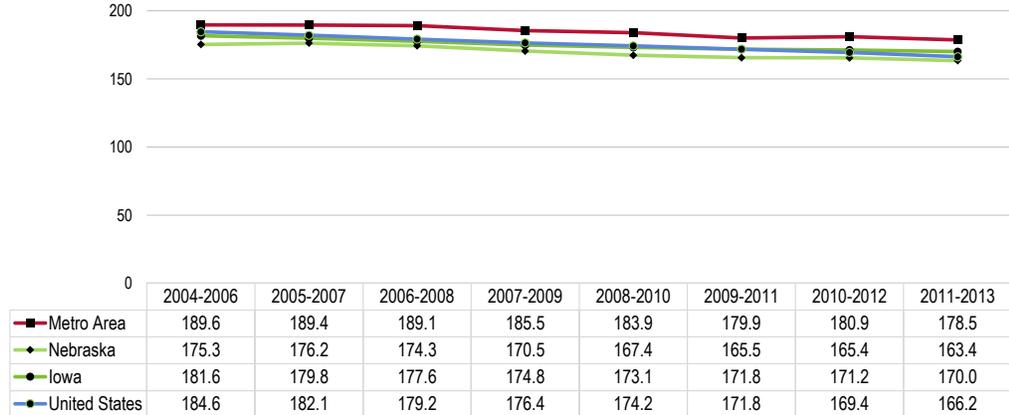
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Cancer mortality has decreased over the past decade in the Metro Area; the same trend is apparent across both states and the US overall.

Cancer: Age-Adjusted Mortality Trends
 (Annual Average Deaths per 100,000 Population)
 Healthy People 2020 Target = 161.4 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 • State and national data are simple three-year averages.

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the Metro Area.

Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both genders).

As can be seen in the following chart (referencing 2011-2013 annual average age-adjusted death rates):

- The Metro Area **lung cancer** death rate is higher than both state rates, as well as the national rate.
- The Metro Area **prostate cancer** death rate is similar to the Nebraska rate, but worse than both the Iowa and US rates.
- The Metro Area **female breast cancer** death rate is worse than both the Nebraska and Iowa rates, but comparable to the US rate.
- The Metro Area **colorectal cancer** death rate is comparable to both state rates, but worse than the national rate.

Note that **each** of the Metro Area cancer death rates detailed below fails to satisfy the related Healthy People 2020 target, with the exception of prostate cancer (the Metro Area rate is comparable to its related target).

Age-Adjusted Cancer Death Rates by Site (2011-2013 Annual Average Deaths per 100,000 Population)

| | Metro Area | NE | IA | US | HP2020 |
|----------------------|------------|------|------|------|--------|
| Lung Cancer | 51.4 | 42.7 | 46.6 | 44.7 | 45.5 |
| Prostate Cancer | 22.3 | 21.6 | 20.0 | 19.8 | 21.8 |
| Female Breast Cancer | 21.9 | 20.2 | 19.6 | 21.3 | 20.7 |
| Colorectal Cancer | 16.7 | 16.0 | 16.3 | 14.9 | 14.5 |

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

Cancer Incidence

Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. Here, these rates are also age-adjusted.

“Incidence rate” or “case rate” is the number of new cases of a disease occurring during a given period of time.

It is usually expressed as cases per 100,000 population per year.

Between 2007 and 2011, Metro Area had an annual average age-adjusted incidence rate of prostate cancer of 135.0 cases per 100,000 population.

- Comparable to both state incidence rates.
- Better than the national incidence rate.
- Much higher in Douglas and Sarpy counties than in Cass and Pottawattamie counties.

There was an annual average age-adjusted incidence rate of 131.8 female breast cancer cases per 100,000 in the Metro Area.

- Worse than either statewide rate.
- Worse than the national incidence rate.
- Unfavorably high in Pottawattamie County.

There was an annual average age-adjusted incidence rate of 73.8 lung cancer cases per 100,000 in the Metro Area.

- Worse than the statewide incidence rates.
- Worse than the national incidence rate.
- Unfavorably high in Pottawattamie County.

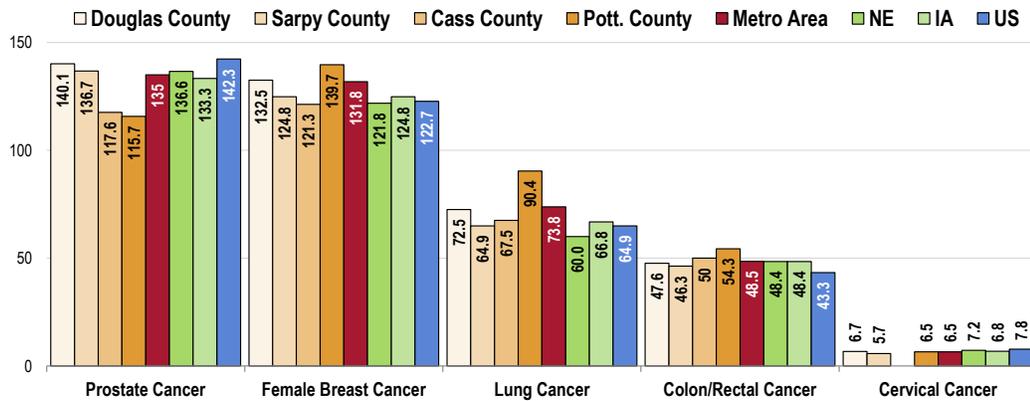
There was an annual average age-adjusted incidence rate of **colorectal cancer** of 48.5 cases per 100,000 in the Metro Area.

- Close to both state rates.
- Worse than the national incidence rate.
- Unfavorably high in Pottawattamie County.

There was an annual average age-adjusted incidence rate of **cervical cancer** of 6.5 cases per 100,000 in the Metro Area.

- Better than the Nebraska rate and similar to Iowa.
- Better than the national incidence rate.
- Favorably low in Sarpy County.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2007-2011)



Sources: • State Cancer Profiles: 2007-11.
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

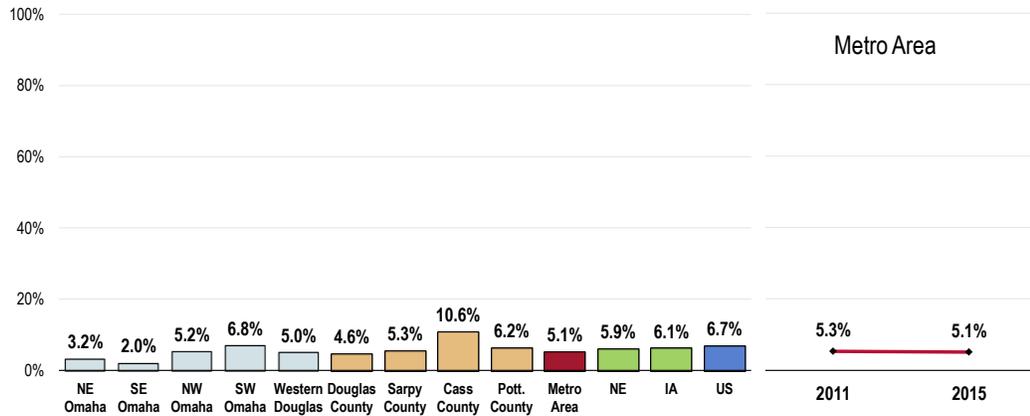
Prevalence of Cancer

Skin Cancer

A total of 5.1% of surveyed Metro Area adults report having been diagnosed with skin cancer.

- Similar to what is found in Nebraska; better than the Iowa prevalence.
- Similar to the national average.
- Particularly high in Cass County.
- In Douglas County, unfavorably high in Southwest Omaha.
- TREND: The prevalence of skin cancer has remained statistically unchanged over time.

Prevalence of Skin Cancer

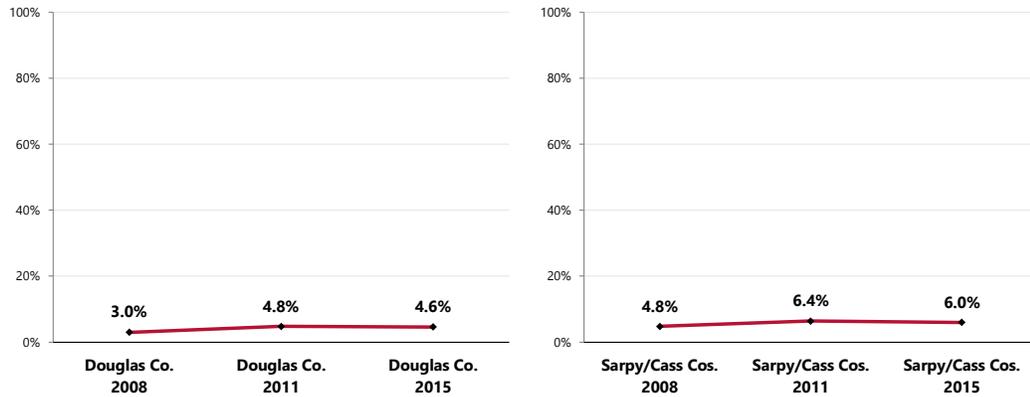


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

- TREND: The prevalence of skin cancer has increased significantly over time in Douglas County (no significant change over time in Sarpy/Cass).

Prevalence of Skin Cancer



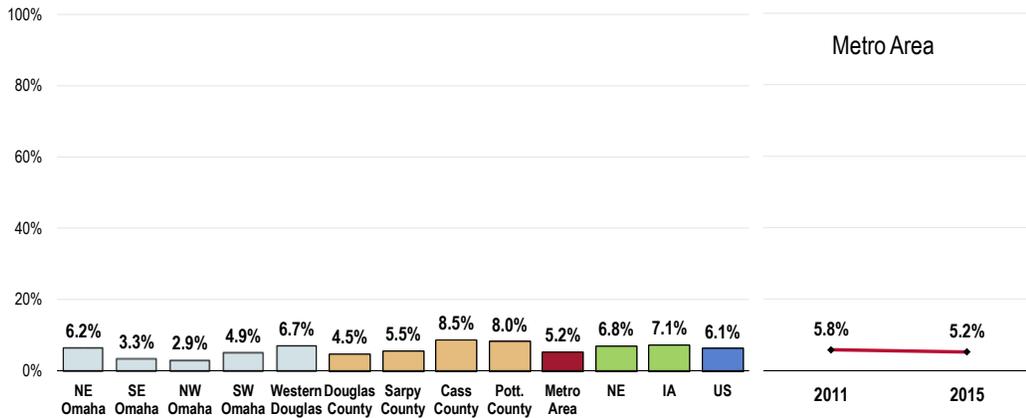
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]
 Notes: • Asked of all respondents.

Other Cancer

A total of 5.2% of adults have been diagnosed with some type of (non-skin) cancer.

- Lower than either statewide prevalence.
- Similar to the national prevalence.
- Particularly high in Pottawattamie County.
- In Douglas County, findings are statistically similar.
- TREND: The prevalence of cancer has remained unchanged over time.

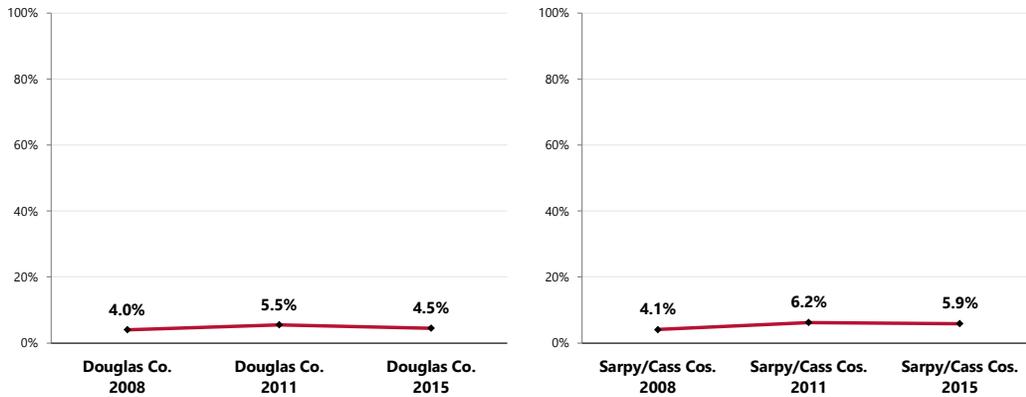
Prevalence of Cancer (Other Than Skin Cancer)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: The prevalence of cancer is statistically unchanged in Douglas and Sarpy/Cass counties.

Prevalence of Cancer (Other Than Skin Cancer)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]
 Notes: • Asked of all respondents.

Cancer Risk

RELATED ISSUE:

See also
Nutrition & Overweight,
Physical Activity &
Fitness and Tobacco
Use in the **Modifiable**
Health Risk section of
this report.

About Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

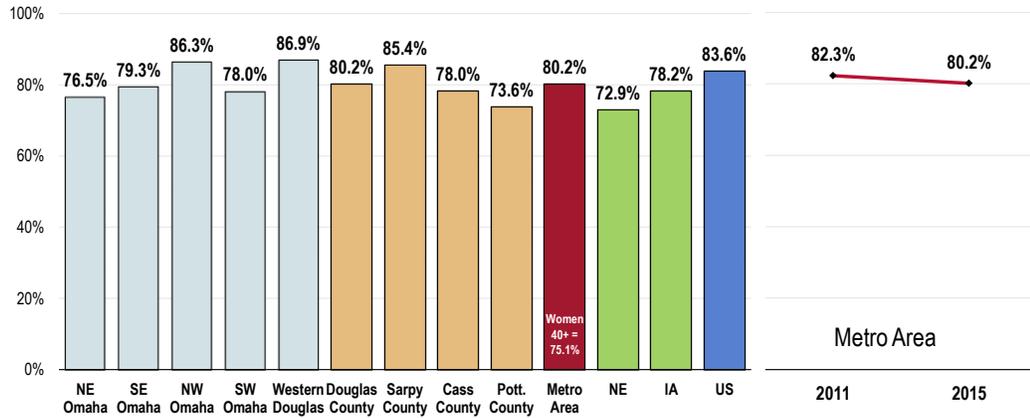
Mammography

Among women age 50-74, 80.2% have had a mammogram within the past two years.

- Better than Nebraska findings, similar to Iowa (both of which represent all women 50+).
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- Statistically similar by county in the Metro Area.
- Within Douglas County, ranging from 76.5% in Northeast Omaha to 86.9% in the west.
- Among women 40+, 75.1% have had a mammogram in the past two years.
- TREND: Statistically unchanged since 2011.

Have Had a Mammogram in the Past Two Years (Among Women Age 50-74)

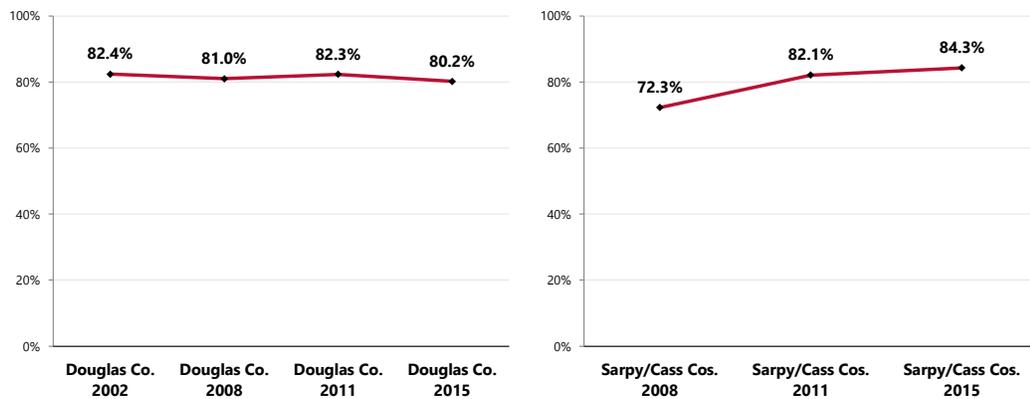
Healthy People 2020 Target = 81.1% or Higher



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 128-129]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2012 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-17]
 Notes: • Reflects female respondents 50-74.
 • *Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).

- TREND: Statistically unchanged over time in Douglas County, but marking a statistically significant increase over time in the combined Sarpy/Cass counties.

Have Had a Mammogram in the Past Two Years (Among Women Age 50-74)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 128-129]
 Notes: • Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

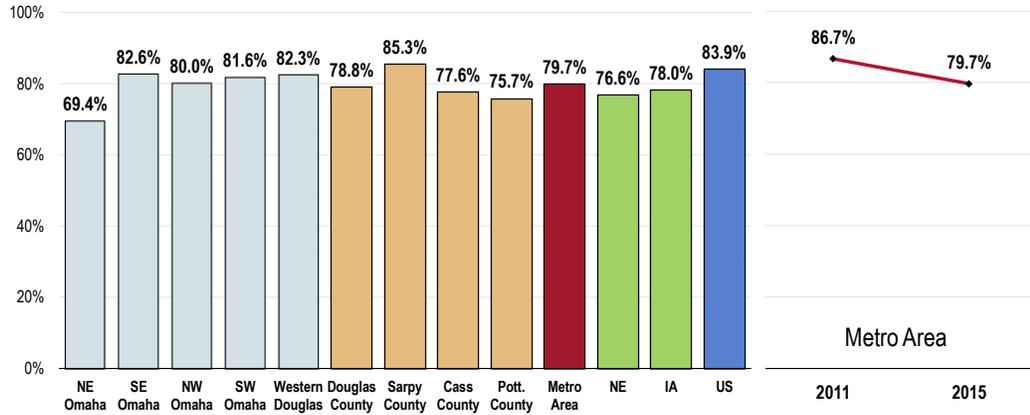
Pap Smear Testing

Among women age 21 to 65, 79.7% have had a Pap smear within the past three years.

- Higher than the Nebraska findings and similar to Iowa (both of which represent all women 18+).
- Lower than national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- Favorably high in Sarpy County.
- In Douglas County, the testing prevalence is much lower in Northeast Omaha.
- TREND: Denotes a statistically significant decrease over time.

Have Had a Pap Smear in the Past Three Years (Among Women Age 21-65)

Healthy People 2020 Target = 93.0% or Higher

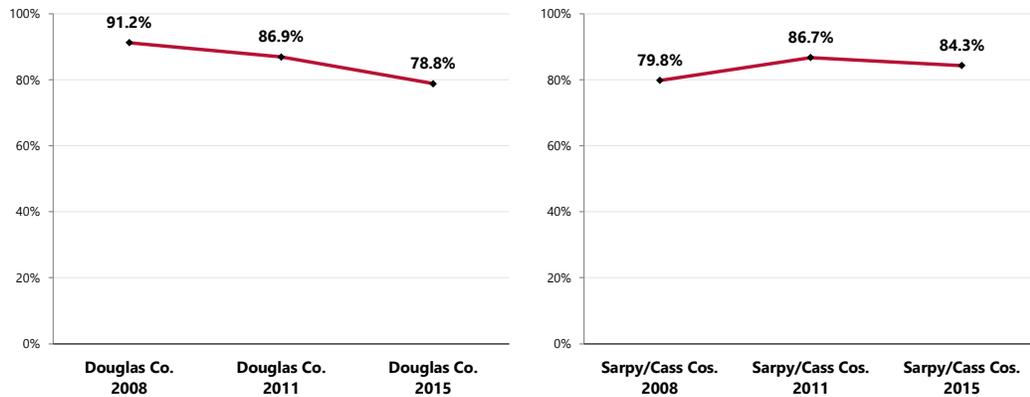


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 130]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2012 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-15]

Notes: • Reflects female respondents age 21 to 65.
 • *Note that the Nebraska percentage represents all women age 18 and older.

- TREND: Decreasing significantly over time in Douglas County; statistically unchanged in Sarpy/Cass counties.

Have Had a Pap Smear in the Past Three Years (Among Women Age 21-65)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 130]
 Notes: • Reflects female respondents age 21 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screening

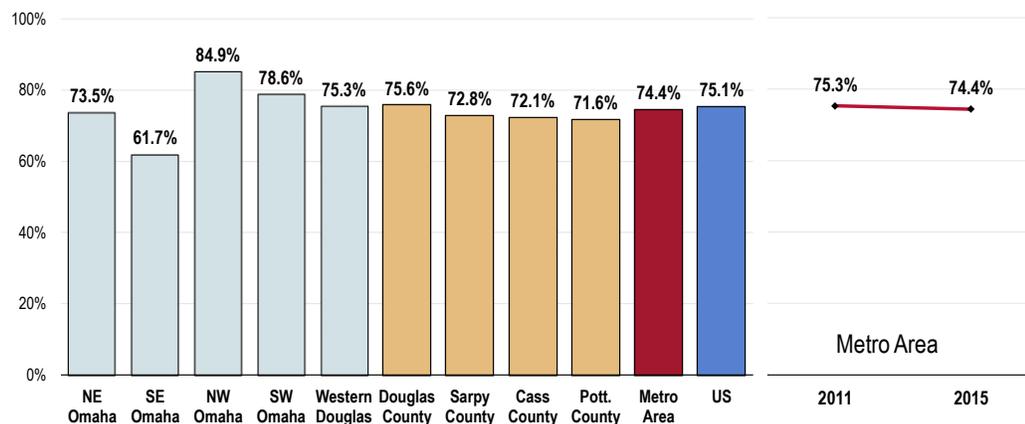
Among adults age 50–75, 74.4% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years).

- Similar to national findings.
- Satisfies the Healthy People 2020 target (70.5% or higher).
- Statistically similar findings by county.
- In Douglas County: highest in Northwest Omaha, lowest in Southeast Omaha.
- TREND: Statistically unchanged since 2011.

Have Had a Colorectal Cancer Screening

(Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher



- Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 133]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-16]
- Notes:
- Asked of all respondents age 50 through 75.
 - In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

Lower Endoscopy

Among adults age 50 and older, more than 3 in 4 (77.6%) have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.

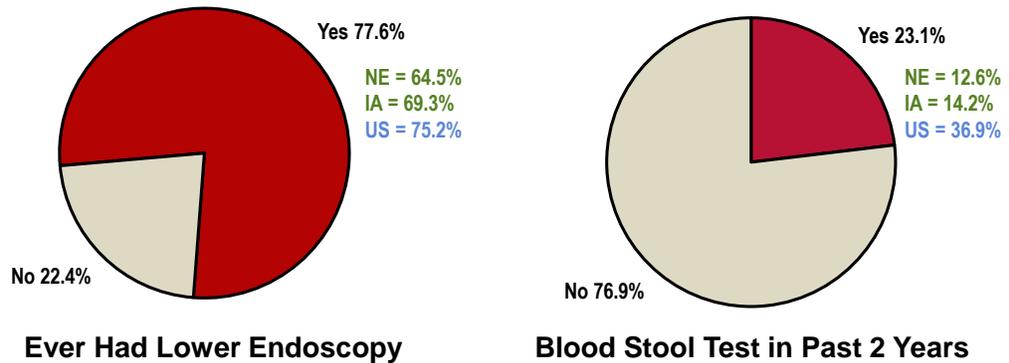
- More favorable than both state proportions.
- Similar to national findings.

Blood Stool Testing

Among adults age 50 and older, 23.1% have had a blood stool test (aka “fecal occult blood test”) within the past two years.

- Better than Nebraska and Iowa findings.
- Worse than national findings.

Colorectal Cancer Screenings
(Among Metro Area Adults Age 50 and Older, 2015)



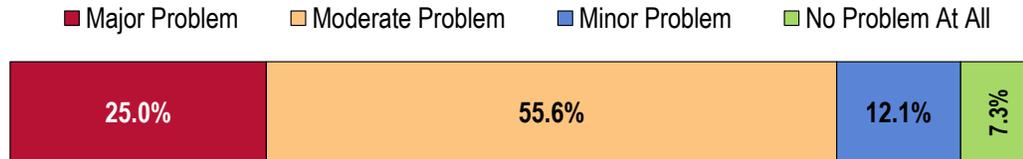
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 131-132]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2012 Nebraska and Iowa data.

Notes: • Asked of respondents age 50 and older.
 • Lower endoscopy includes either sigmoidoscopy or colonoscopy.

Key Informant Input: Cancer

A plurality of key informants taking part in an online survey characterized **Cancer** as a “moderate problem” in the community.

Perceptions of Cancer as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

High Rate of Occurrence

There is so much of it. – Physician

Many individuals are being diagnosed with cancer. There are many resources available to treat cancer, it is still a very expensive disease and causes many issues with patients, mental health, employment, family, housing, etc. – Healthcare Provider

Increasingly high incidence of disease affecting wide base of population. – Community/Business Leader

The number of those effected by the disease seems to be going up each year, as does the cost of care. The overall cost to society in terms of lost productivity and financial hardship is a huge burden to so many families, certainly beyond the personal loss. – Social Service Provider

Cancer still seems to be an illness that many people suffer. – Community/Business Leader

Number of people diagnosed with cancer. Healthcare costs associated with the disease. Impact to the familial unit and community on loss of wage earner, parent, community member. – Social Service Provider

Pottawattamie County seems to have a higher than average population with different types of cancer. Our population doesn't participate in screenings to catch it at an early stage. Due to high incidence of smoking we have numerous people with lung cancer. – Healthcare Provider

Prostate cancer among African American men seems to be extremely high. – Social Service Provider

It is the second leading cause of death and is predicted to surpass heart disease as the number one killer. – Social Service Provider

It continues to kill people in the community and the treatments are often as harsh as the cancer itself. – Healthcare Provider

The cancer death rates in Nebraska are high. – Community/Business Leader

Because of the increase in diagnosis and cost of healthcare and access to care issues. – Social Service Provider

Most every family that I know has had a family member with one or another type of cancer. Per CDC, cancer is the second leading cause of death. – Social Service Provider

Access to Screenings

Being diagnosed in late stages due to no preventive care. – Healthcare Provider

Methodist Jennie Edmundson holds three cancer screenings a year. Skin, prostate, breast and cervical. At times we need to turn people away because of the increase in numbers. Alegent Mercy does not hold free cancer screenings. Both need to work together in our community. – Healthcare Provider

While there is some good breast cancer work being done by My Sisters Keeper in North O, they only do awareness. Screening is still a little tough to access for women between ages of 20-50 (ages not covered by every woman matters). – Social Service Provider

Inability to get cancer screening for uninsured patients, this leads to disparities in stage at diagnosis. – Public Health Representative

Lack of Resources

There are a lack of specialists in the rural communities. – Healthcare Provider

There is no outreach in Spanish for the Hispanic community other than the one provided by UNMC/CRHD. Non-documented female immigrants do not have access to EWM. Because of this they do not get any preventive assistance when they come to see a doctor. – Community/Business Leader

Omaha has become a major cancer treatment center at all the major hospitals. – Healthcare Provider

Because of the costs associated with diagnosis, testing, and treatment for the underserved limit access to care. Plus a difficult disease mentally. Decreases work days. – Healthcare Provider

Associated Risk Factors

Pottawattamie County has a high percentage of smokers and incidence of lung cancer. – Community/Business Leader

The environment is poison. People lead stressful lives. People smoke. Diets are poor. Too many preservatives in food and liquids. – Social Service Provider

The varying types of diseases that could be prevented but run a course towards death because they are not addressed in a timely manner. – Community/Business Leader

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 (www.healthypeople.gov)

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

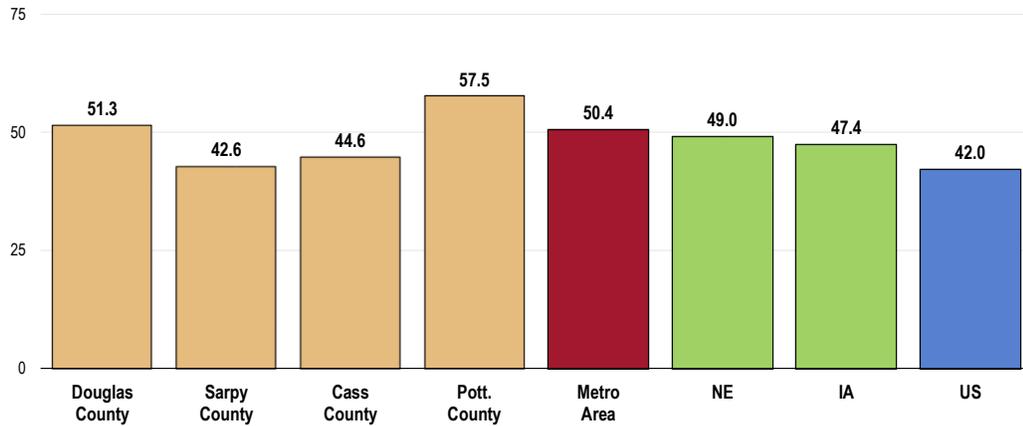
Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2011 and 2013, there was an annual average age-adjusted CLRD mortality rate of 50.4 deaths per 100,000 population in the Metro Area.

Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

- Similar to the Nebraska rate but worse than the Iowa rate.
- Worse than the national rate.
- Unfavorably high in Douglas and Pottawattamie counties.

CLRD: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)

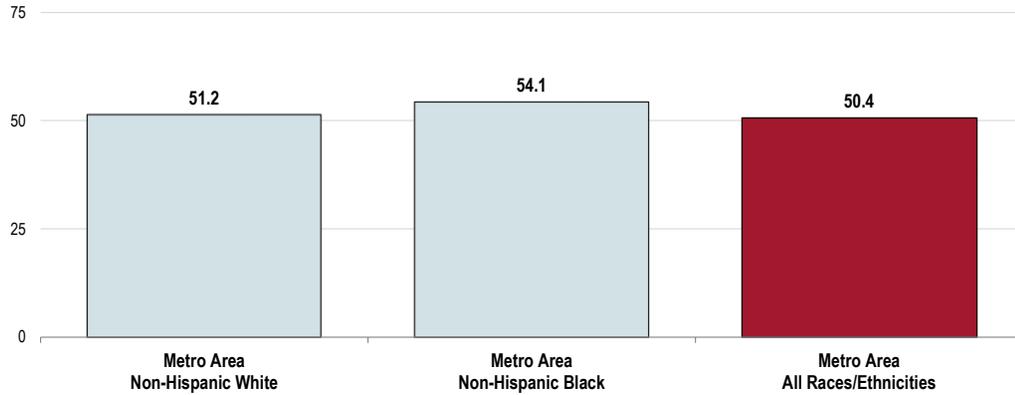


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• CLRD is chronic lower respiratory disease.

- CLRD mortality appears slightly higher among Blacks than among Whites in the Metro Area.

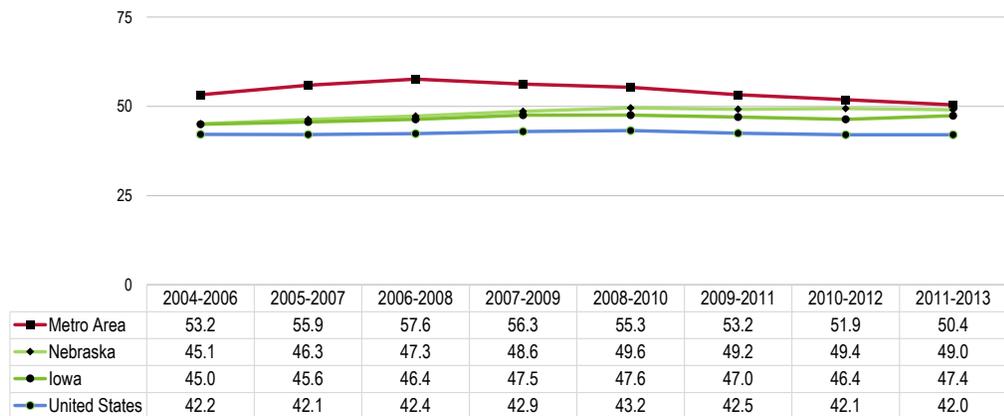
CLRD: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - CLRD is chronic lower respiratory disease.

- **TREND:** Despite fluctuations, CLRD mortality in the Metro Area has decreased over time; in contrast, state rates have increased (the US rate was stable over the past decade).

CLRD: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - CLRD is chronic lower respiratory disease.

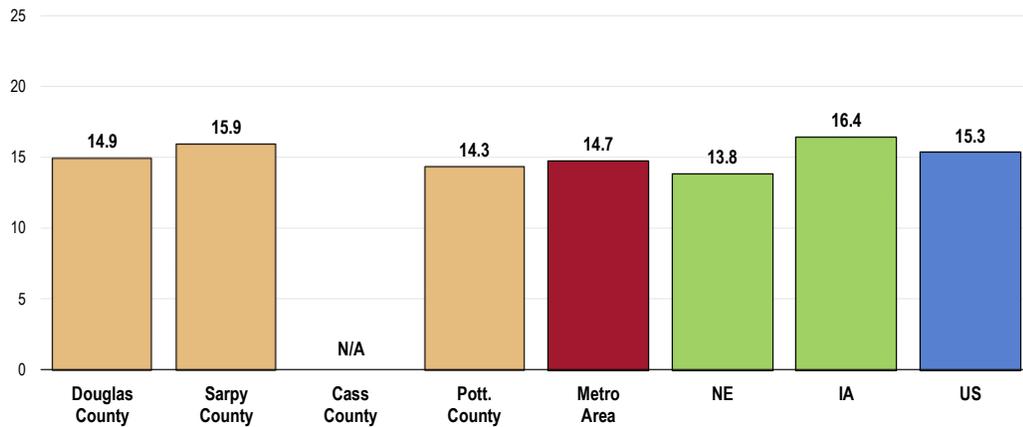
Pneumonia/Influenza Deaths

Between 2011 and 2013, there was an annual average age-adjusted pneumonia influenza mortality rate of 14.7 deaths per 100,000 population in the Metro Area.

- Worse than the Nebraska rate, better than the Iowa rate.
- Similar to the national rate.
- Highest in Sarpy County.

For prevalence of vaccinations for pneumonia and influenza, see also *Immunization & Infectious Disease*.

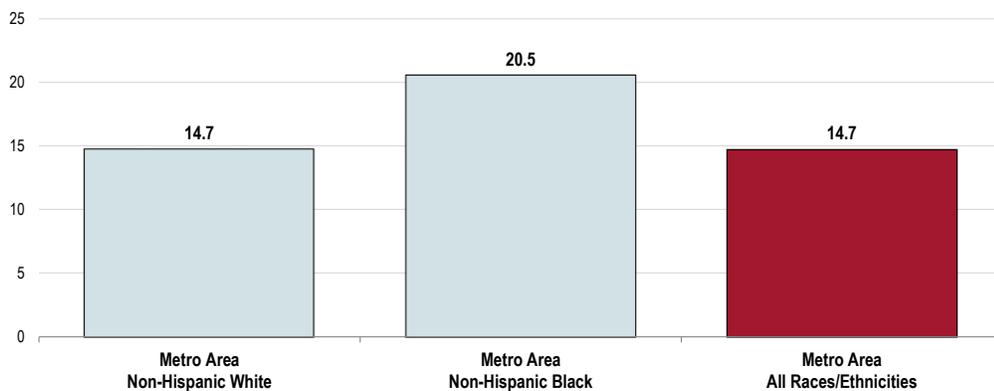
Pneumonia/Influenza: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The pneumonia/influenza mortality rate in the Metro Area is higher among Blacks than Whites.

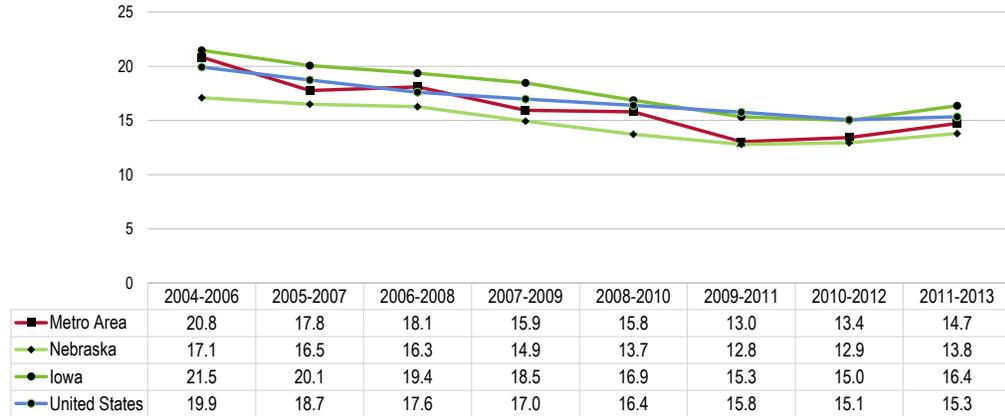
Pneumonia/Influenza: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Note the decreasing trends in pneumonia/influenza mortality.

Pneumonia/Influenza: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 ● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 ● State and national data are simple three-year averages.

Chronic Obstructive Pulmonary Disease (COPD)

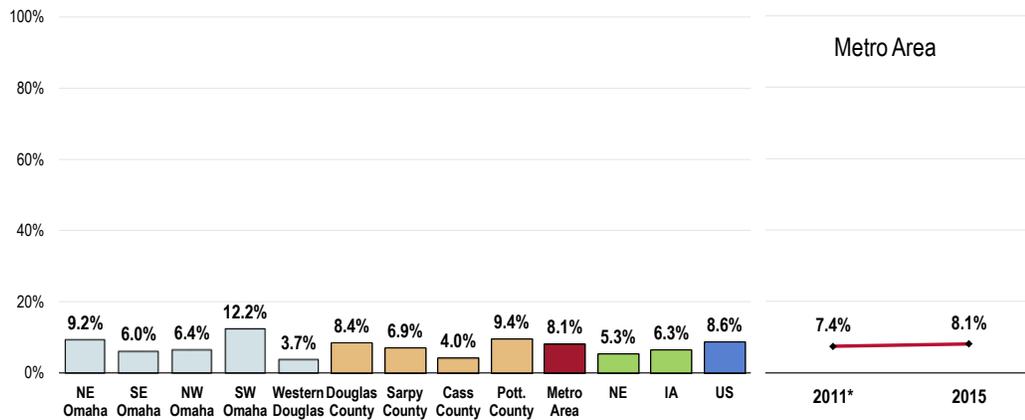
A total of 8.1% of Metro Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

- Less favorable than either state proportion.
- Similar to the national prevalence.
- Favorably low in Cass County.
- In Douglas County, unfavorably high in Southwest Omaha.
- NOTE: in prior data, this question was asked slightly differently; respondents in 2011 were asked if they had ever been diagnosed with “chronic lung disease, including bronchitis or emphysema,” rather than “COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema” as is asked currently.

TREND: In comparing to 2011 data, the change in prevalence is not statistically significant.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

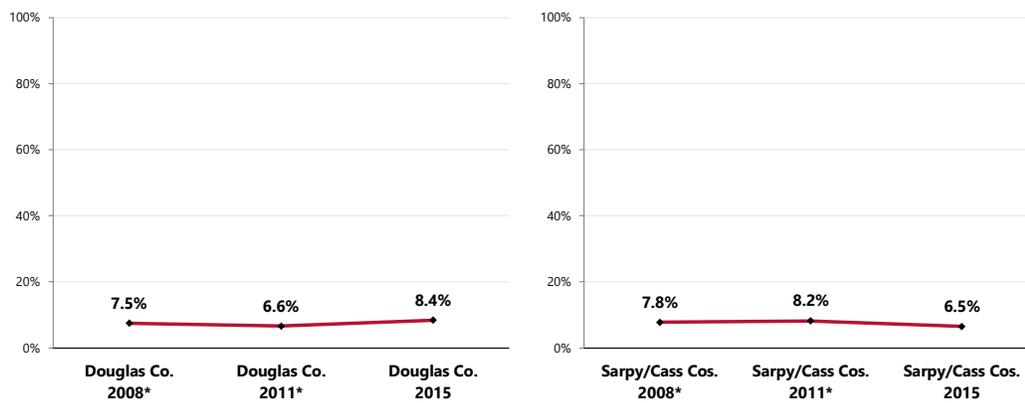


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
 • Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
 • *In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]
 Notes: • Asked of all respondents.
 • Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
 • *In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

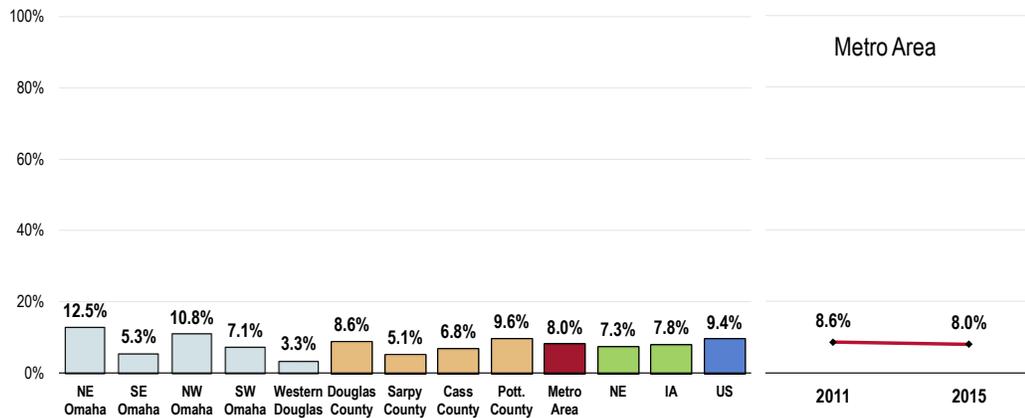
Asthma

Adults

A total of 8.0% of Metro Area adults currently suffer from asthma.

- Similar to both state figures.
- Similar to the national prevalence.
- Among the 4 counties, lowest in Sarpy County.
- In Douglas County, unfavorably high in Northeast Omaha.
- TREND: The prevalence of adults with asthma has not changed significantly since 2011.

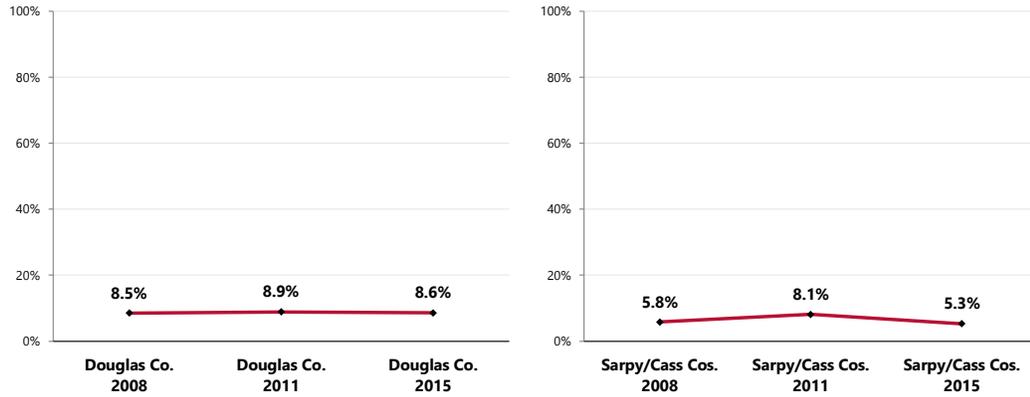
Adult Asthma: Current Prevalence



- Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 310]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
- Notes:
- Asked of all respondents.
 - Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

- TREND: Current asthma prevalence has not changed significantly over time in Douglas or Sarpy/Cass counties.

Adult Asthma: Current Prevalence

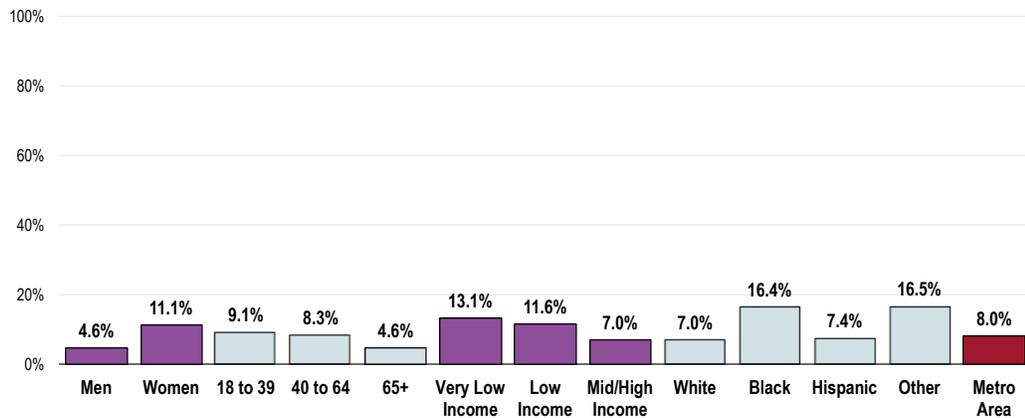


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 310]
 Notes: ● Asked of all respondents.
 ● Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

The following adults are more likely to suffer from asthma:

- Women.
- Younger adults (negative correlation with age).
- Low-income residents (negative correlation with income).
- Blacks and Other adults.

Currently Have Asthma (Metro Area, 2015)



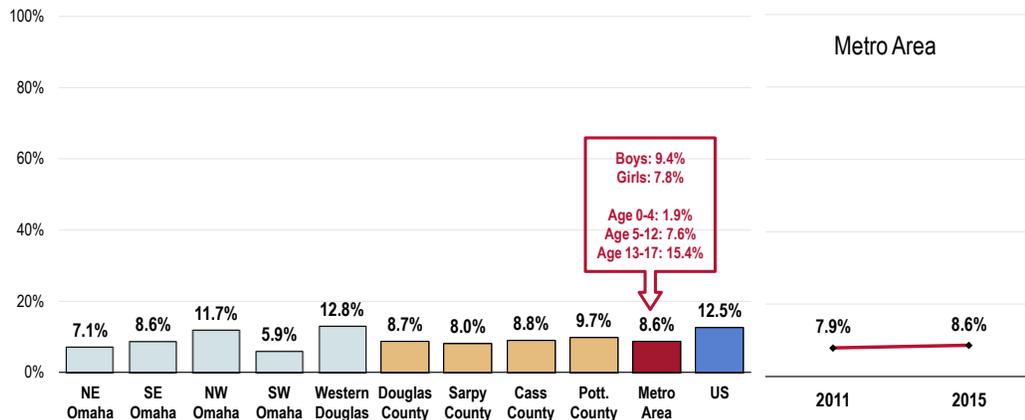
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 310]
 Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

Among Metro Area children under age 18, 8.6% currently have asthma.

- Much lower than national findings.
- Similar findings by county in the Metro Area.
- Statistically similar findings by subarea in Douglas County.
- TREND: The prevalence of children who have ever been diagnosed with asthma has not changed significantly over time.
- Similar by child’s gender; note the positive correlation with age and asthma among Metro Area children.

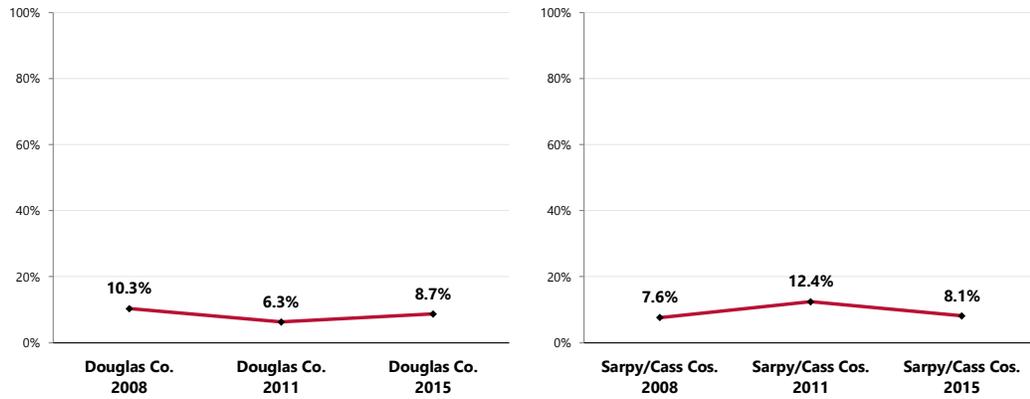
Child Has Ever Been Diagnosed With Asthma
(Among Parents of Children Age 0-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 114]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

- TREND: Diagnoses of asthma have not changed significantly over time in Douglas or Sarpy/Cass counties.

Child Has Ever Been Diagnosed With Asthma (Among Parents of Children Age 0-17)

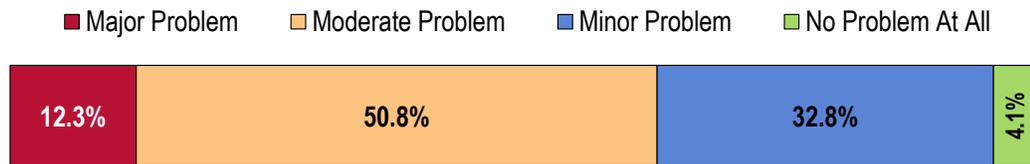


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 114]
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Respiratory Disease

One-half of key informants taking part in an online survey characterized *Respiratory Disease* as a “moderate problem” in the community.

Perceptions of Respiratory Diseases as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Associated Risk Factors

- Smoking rates are high and asthma in adults and children seems to be a very common problem. – Community/Business Leader
- Smoking is very prevalent. – Healthcare Provider
- Increased smoking among the poorer populations. – Healthcare Provider
- Kids not being active early in life, living with parents who smoke or use substances, and air pollutants. – Healthcare Provider
- Problems with lead and other things in older housing in Omaha. – Social Service Provider

Smokers. – Healthcare Provider

Families exposed to chemicals at home/work environment. Lack of education on preventive measures. – Community/Business Leader

Smoking. – Community/Business Leader

Asthma

Childhood asthma is still a big problem in Douglas County. – Community/Business Leader

There is a lot of asthma in North Omaha especially. – Healthcare Provider

Higher than national average for asthma deaths in Douglas County. – Social Service Provider

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

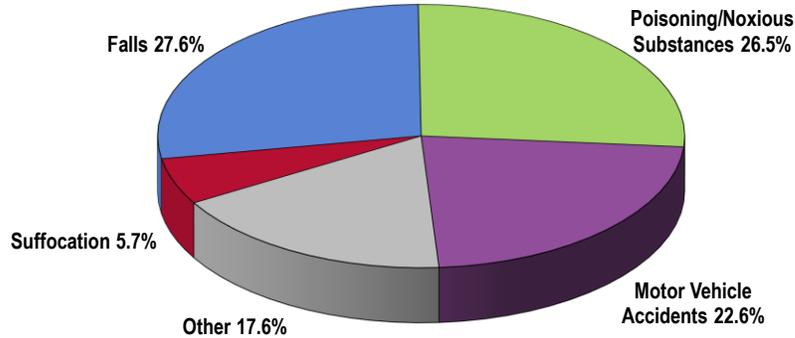
- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Falls, poisoning (including accidental drug overdose), motor vehicle accidents, and suffocation for over 8 in 10 accidental deaths in the Metro Area between 2011 and 2013.

Leading Causes of Accidental Death (Metro Area, 2011-2013)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

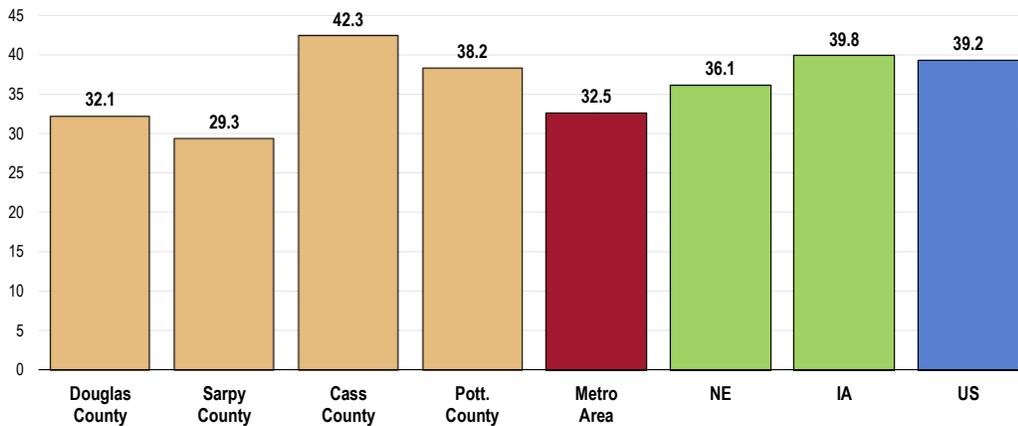
Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2011 and 2013, there was an annual average age-adjusted unintentional injury mortality rate of 32.5 deaths per 100,000 population in the Metro Area.

- More favorable than both state rates.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target (36.4 or lower).
- Unfavorably high in Cass and Pottawattamie counties.

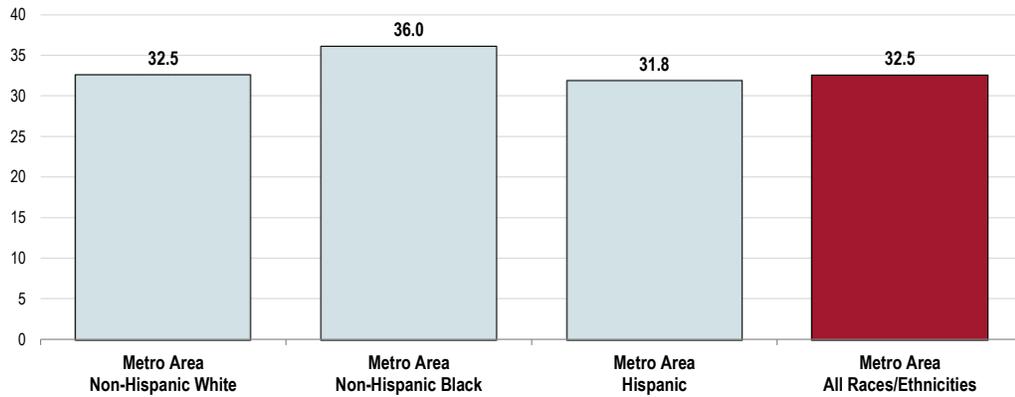
Unintentional Injuries: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The mortality rate is notably higher among Blacks when compared with Whites and Hispanics in the Metro Area.

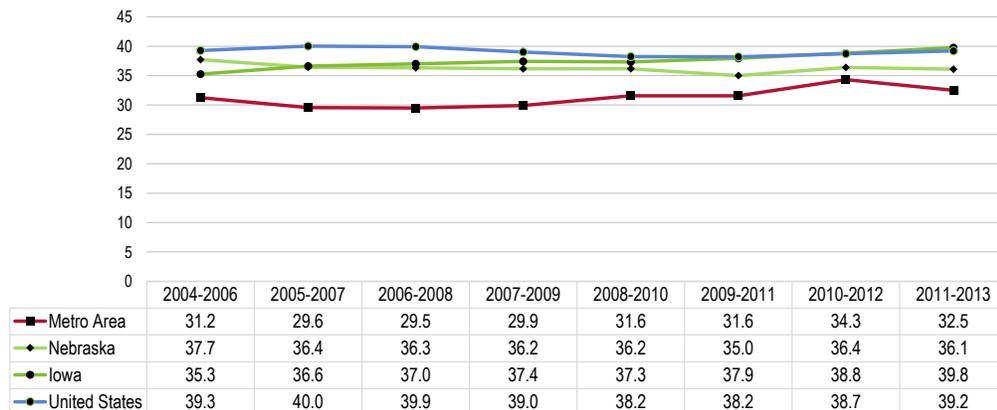
Unintentional Injuries: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The area's unintentional injury mortality rate has not changed significantly from baseline data.

Unintentional Injuries: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.

Motor Vehicle Safety

Age-Adjusted Motor-Vehicle Related Deaths

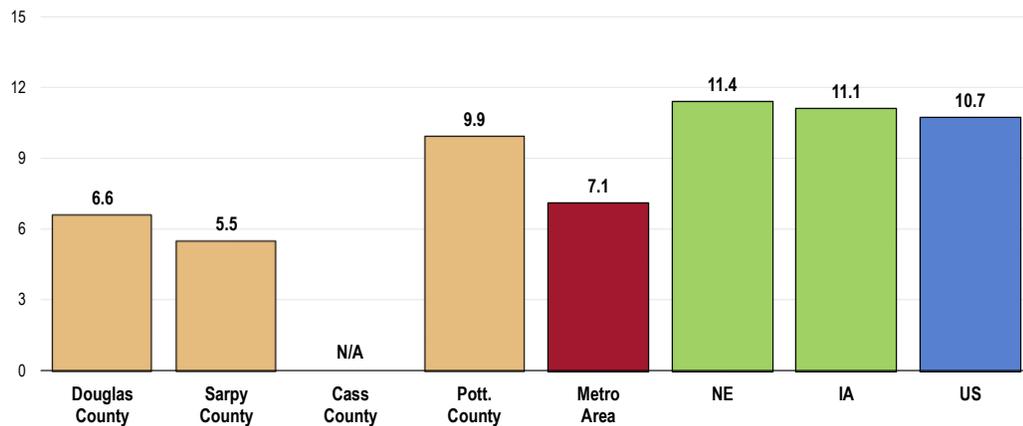
Between 2011 and 2013, there was an annual average age-adjusted motor vehicle crash mortality rate of 7.1 deaths per 100,000 population in the Metro Area.

- Much lower than found statewide.
- Much lower than found nationally.
- Satisfies the Healthy People 2020 target (12.4 or lower).
- Unfavorably high in Pottawattamie County.

Motor Vehicle Crashes: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 12.4 or Lower



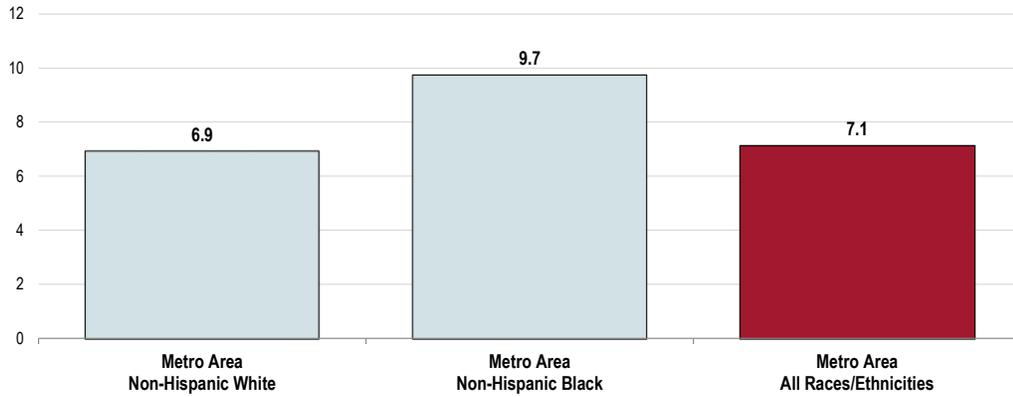
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The Metro Area motor vehicle crash mortality rate is higher among Blacks than among Whites.

Motor Vehicle Crashes: Age-Adjusted Mortality by Race

(2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 12.4 or Lower



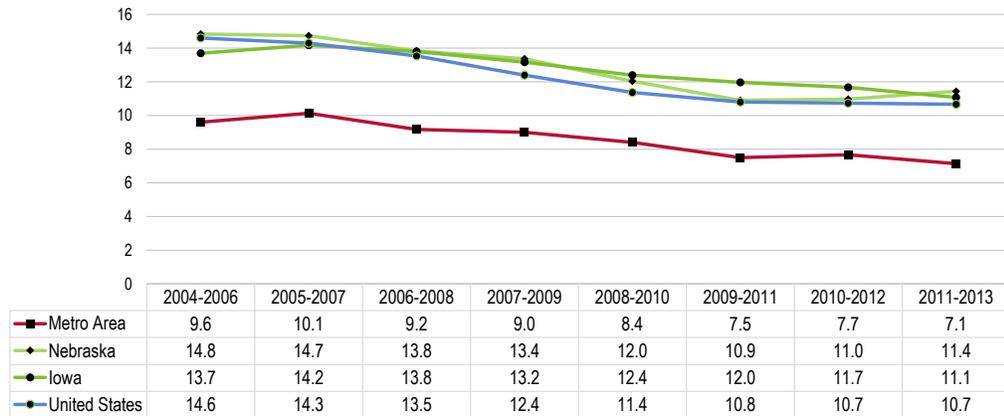
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- **TREND:** The mortality rate in the Metro Area decreased over the past decade, echoing the state and national trends.

Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 12.4 or Lower



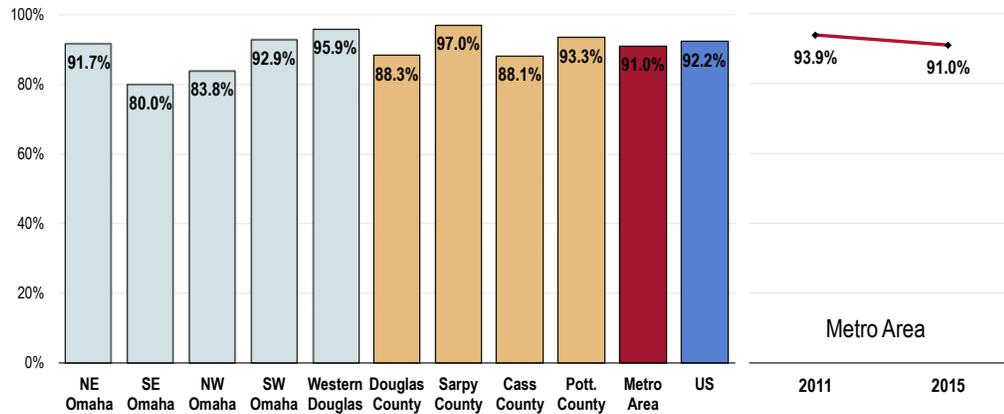
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.

Seat Belt Usage - Children

A full 91.0% 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.

- Statistically similar to what is found nationally.
- By county, favorably high in Sarpy County.
- In Douglas County, lowest in Southeast Omaha.
- TREND: Marks a statistically significant decrease since 2011.

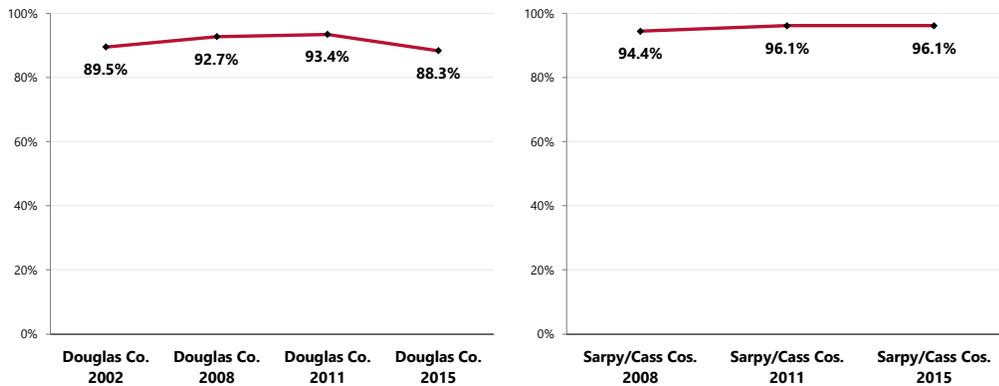
Child “Always” Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle
(Among Parents of Children Age 0-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 122]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Child “Always” Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle
(Among Parents of Children Age 0-17)



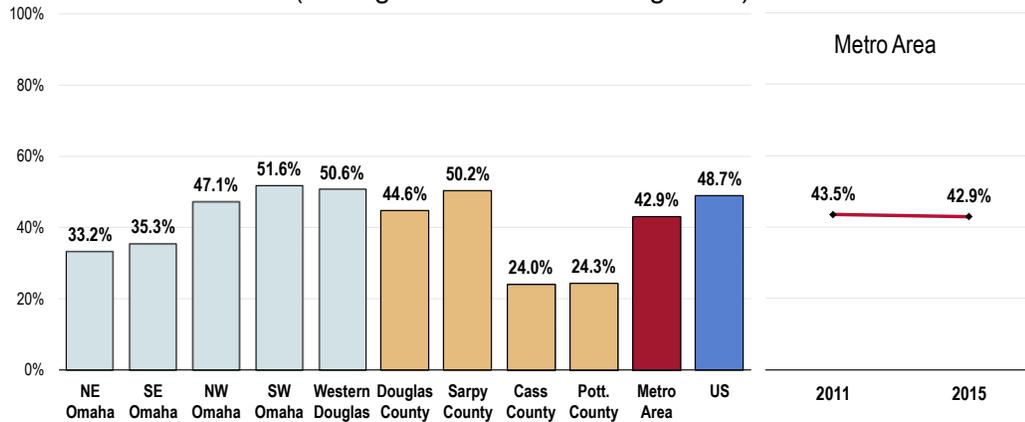
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 122]
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Bicycle Safety

Just over 4 in 10 Metro Area children age 5 to 17 (42.9%) are reported to “always” wear a helmet when riding a bicycle.

- Statistically comparable to the national prevalence.
- Unfavorably low in Cass and Pottawattamie counties.
- Helmet use is much higher in the western portion of Douglas County.
- TREND: Statistically unchanged over time.

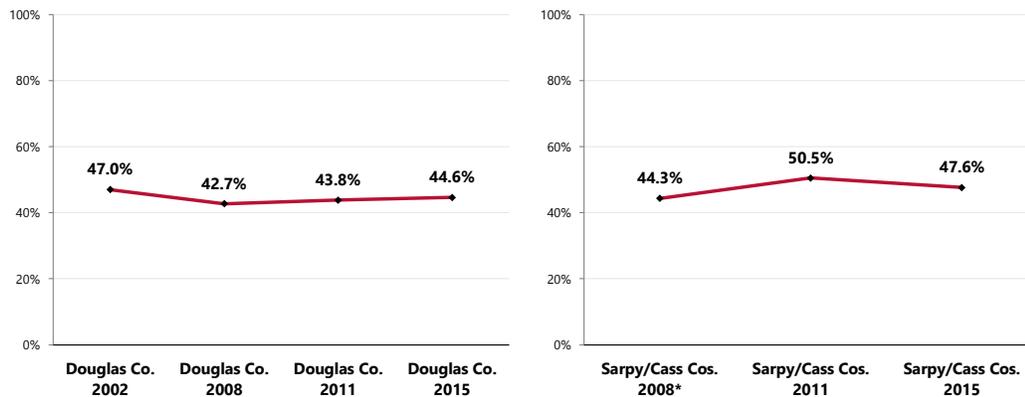
Child “Always” Wears a Helmet When Riding a Bicycle (Among Parents of Children Age 5-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 121]
Notes: • Asked of all respondents with children age 5 to 17 at home.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Child “Always” Wears a Helmet When Riding a Bicycle (Among Parents of Children Age 5-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 121]
Notes: • Asked of all respondents with children age 5 to 17 at home.

Firearm Safety

Age-Adjusted Firearm-Related Deaths

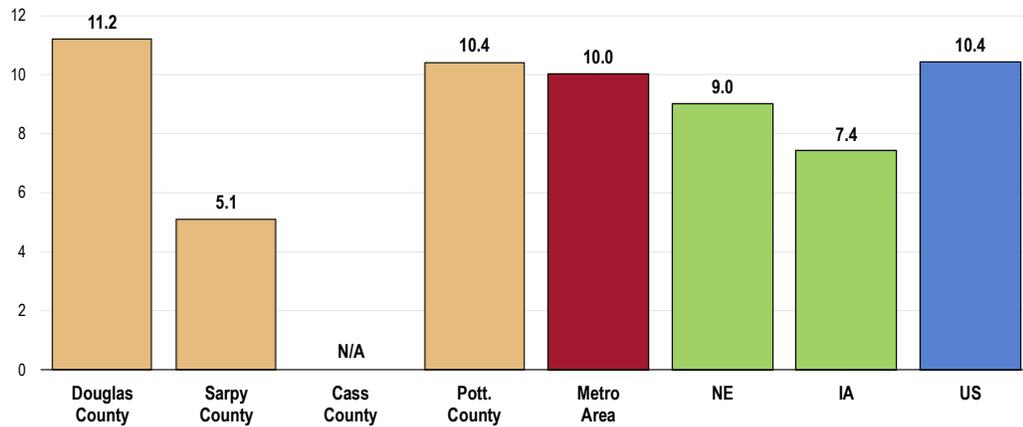
Between 2011 and 2013, there was an annual average age-adjusted rate of 10.0 deaths per 100,000 population due to firearms in the Metro Area.

- Higher than found statewide.
- Comparable to the national rate.
- Fails to satisfy the Healthy People 2020 objective (9.3 or lower).
- Favorably low in Sarpy County.

Firearms-Related Deaths: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 or Lower

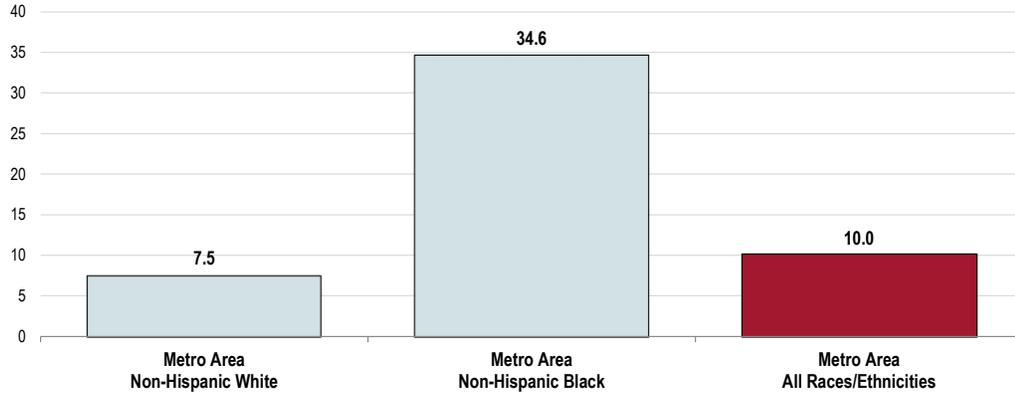


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The Metro Area firearm-related mortality rate is dramatically higher among Blacks than among Whites.

Firearms-Related Deaths: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 or Lower

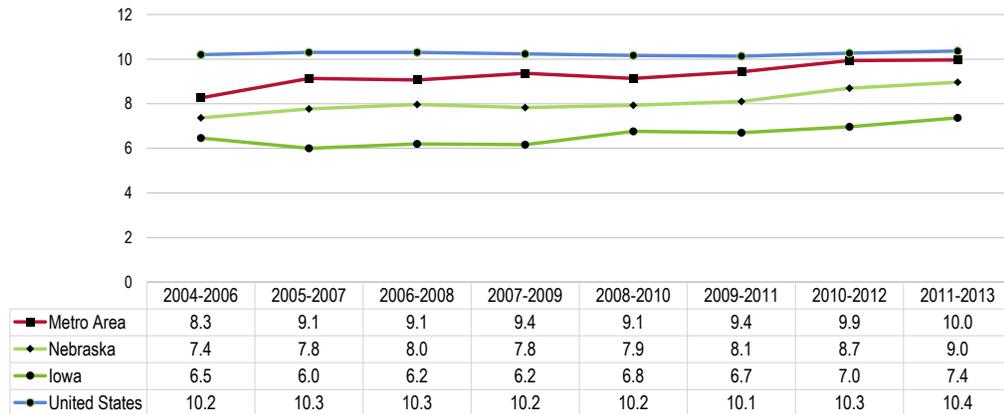


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Firearm-related mortality increased over the past decade.

Firearms-Related Deaths: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.

Presence of Firearms in Homes

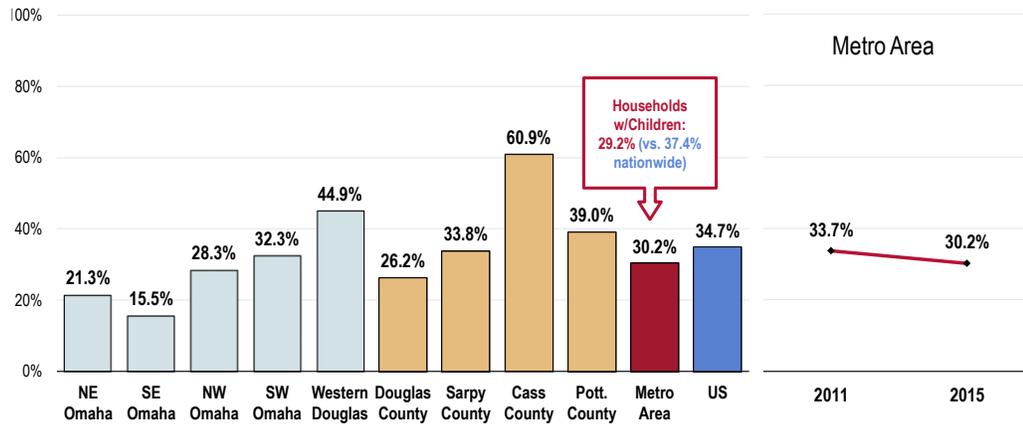
Survey respondents were further asked about the presence of weapons in the home:

“Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, ‘firearms’ include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire.”

Overall, 3 in 10 Metro Area adults (30.2%) have a firearm kept in or around their home.

- Lower than the national prevalence.
- Unfavorably high in Cass and Pottawattamie counties.
- Within Douglas County, higher in the western portion.
- TREND: Marks a statistically significant decrease from that reported in 2011.
- Among Metro Area households with children, 29.2% have a firearm kept in or around the house (more favorable than reported nationally).
- TREND: The prevalence of firearms in households with children has not changed significantly over time (not shown).

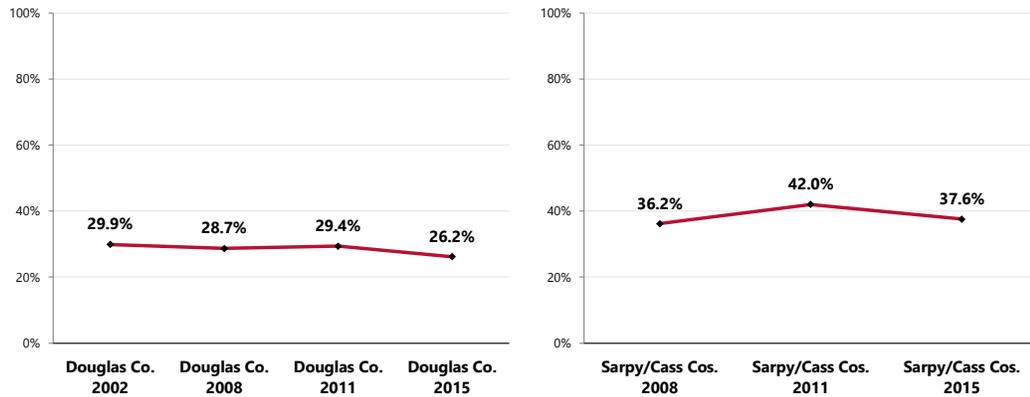
Have a Firearm Kept in or Around the Home



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 52, 137]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

- TREND: The prevalence of firearms in area households decreased significantly in Douglas County (no significant change over time in Sarpy/Cass).

Have a Firearm Kept in or Around the Home

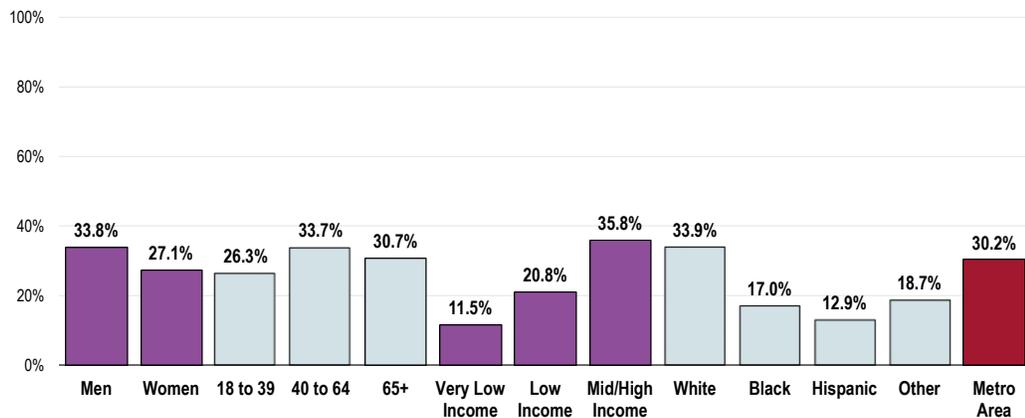


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 52, 137]
 Notes: • Asked of all respondents.
 • In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

Reports of firearms in or around the home are more prevalent among the following respondent groups:

- Men.
- Residents age 40 to 64.
- Higher-income households (positive correlation with income).
- White respondents.

Have a Firearm Kept in or Around the House (Metro Area, 2015)

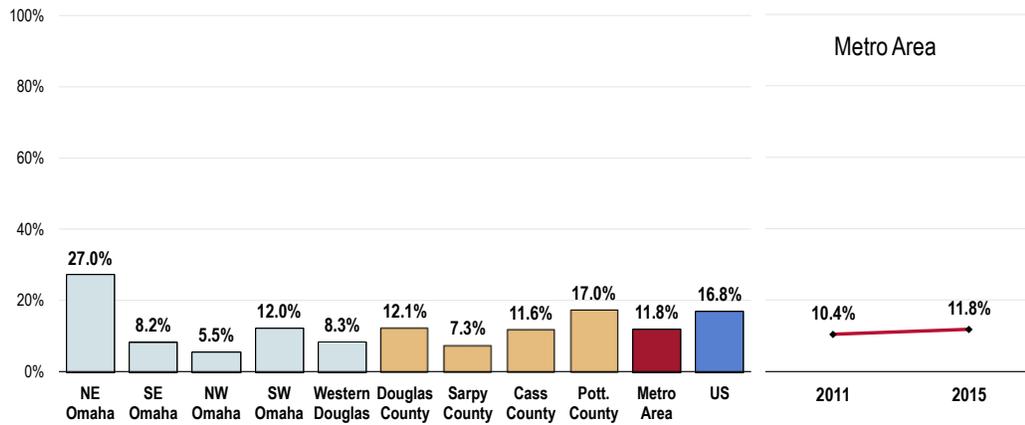


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
 Notes: • Asked of all respondents.
 • In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among Metro Area households with firearms, 11.8% report that there is at least one weapon that is kept unlocked and loaded.

- Better than that found nationally.
- Favorably low in Sarpy County.
- In Douglas County, note the 27.0% prevalence in Northeast Omaha.
- TREND: Statistically similar to that reported in 2011.

Household Has An Unlocked, Loaded Firearm (Among Respondents Reporting a Firearm in or Around the Home)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 138]

• 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents with a firearm in or around the home.

• In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

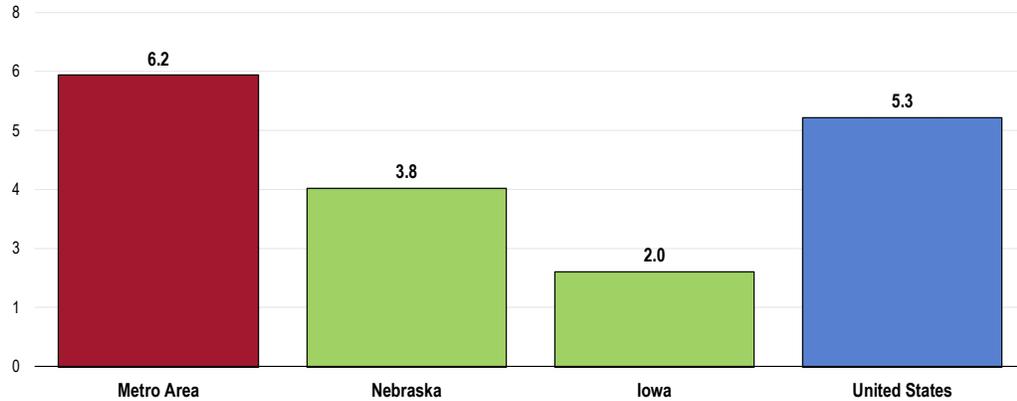
Between 2011 and 2013, there was an annual average age-adjusted homicide rate of 6.2 deaths per 100,000 population in the Metro Area.

- Worse than the rates found statewide.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target of 5.5 or lower.

RELATED ISSUE:

See also *Suicide* in the **Mental Health** section of this report.

Homicide: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 5.5 or Lower



Sources:

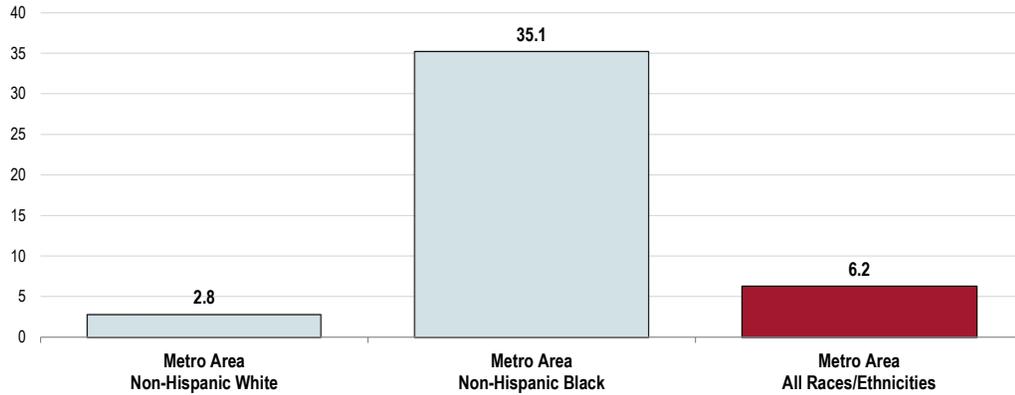
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The homicide rate is notably higher in the Metro Area's Black community.

Homicide: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 5.5 or Lower



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]

Notes:

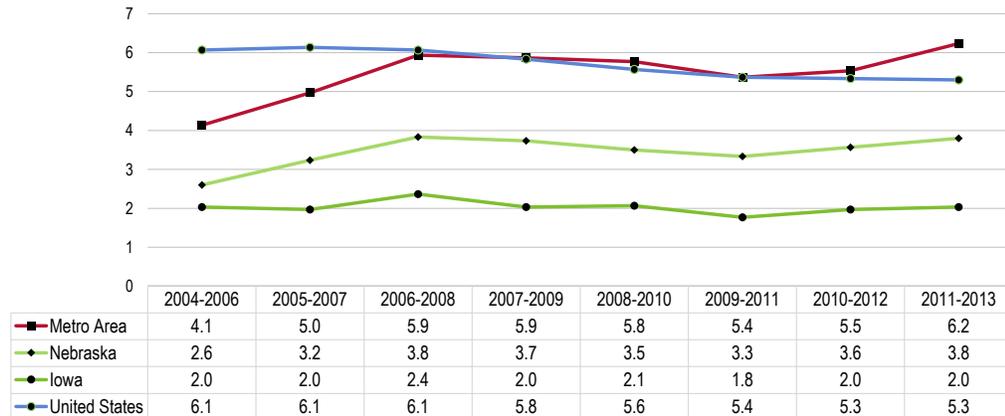
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- **TREND:** The homicide rate has increased in the Metro Area, echoing the Nebraska trend over the past decade.

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 5.5 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.

Violent Crime

Violent Crime Rates

Between 2010 and 2012, there were a reported 418.8 violent crimes per 100,000 population in the Metro Area.

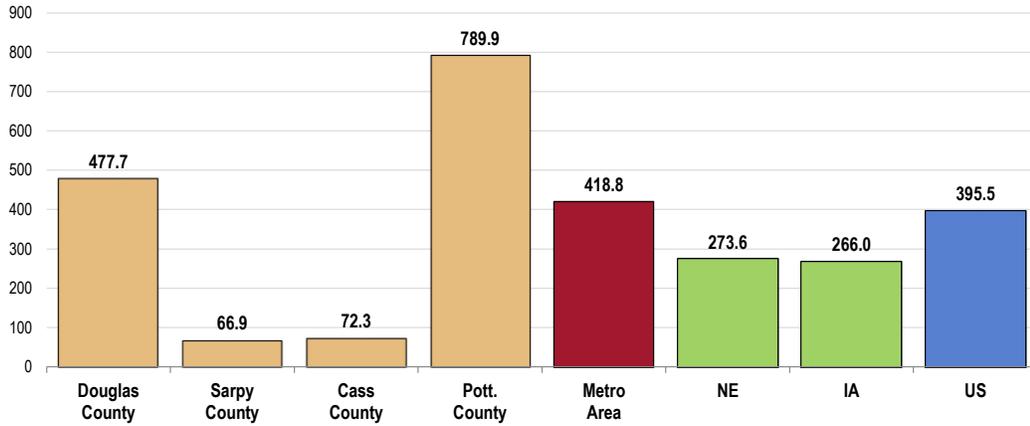
- Much higher than either state rate for the same period.
- Higher than the national rate.
- Unfavorably high in Douglas and Pottawattamie counties.

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime

(Rate per 100,000 Population, 2010-2012)



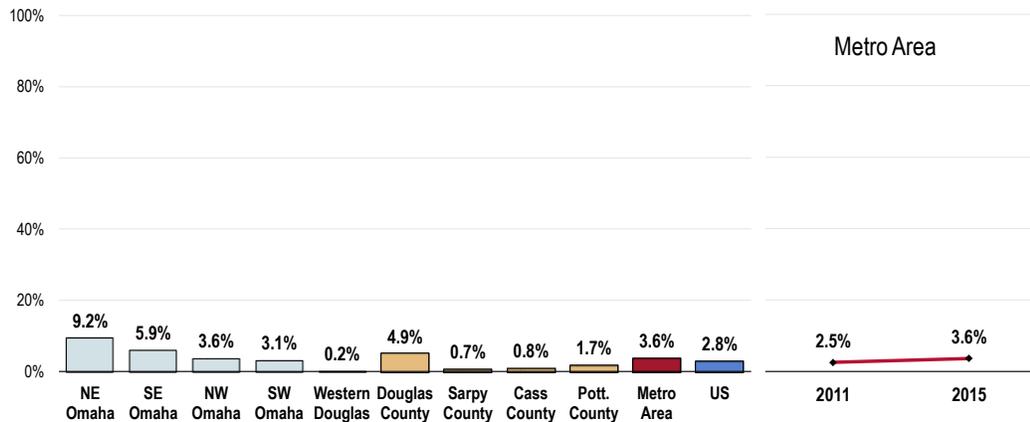
Sources: • Federal Bureau of Investigation, FBI Uniform Crime Reports: 2010-2012.
 Notes: • This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
 • Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Experience With Violence

A total of 3.6% of Metro Area adults acknowledge being the victim of a violent crime in the past five years.

- Statistically similar to national findings.
- Unfavorably high in Douglas County.
- Highest in Northeast Omaha, lowest in Western Douglas County.
- TREND: Marks a statistically significant increase over time.

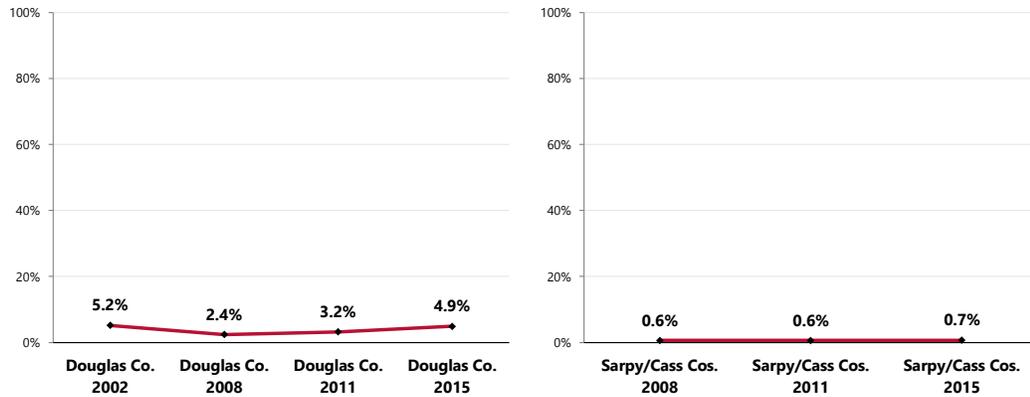
Victim of a Violent Crime in the Past Five Years



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 50]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Victim of a Violent Crime in the Past Five Years

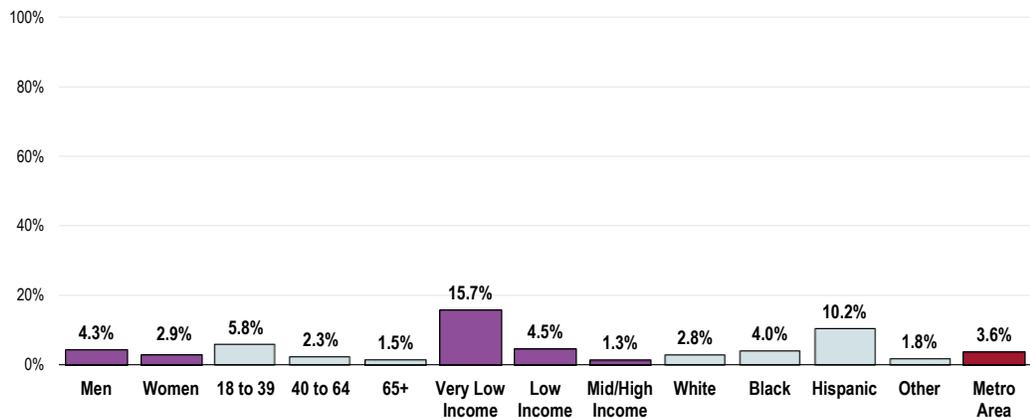


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 50]
 Notes: • Asked of all respondents.

These population segments are more likely to report crime victimization in the past 5 years:

- Younger residents (negative correlation with age).
- Lower-income residents (negative correlation with income).
- Hispanics.

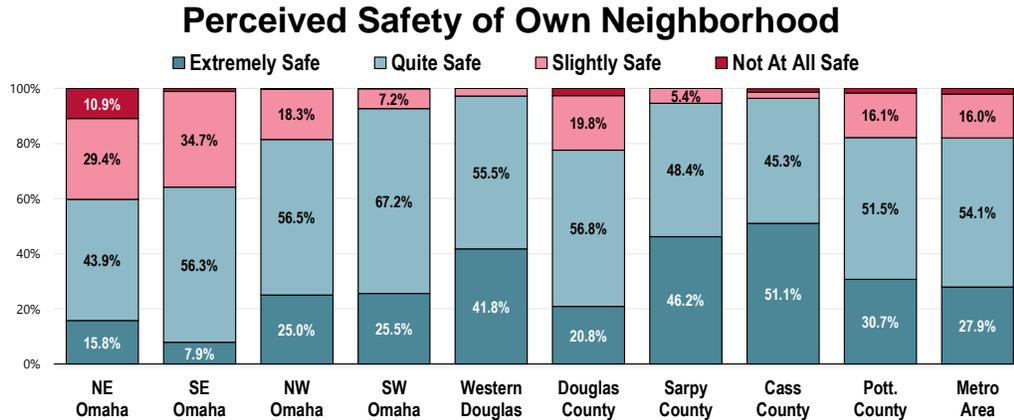
Victim of a Violent Crime in the Past Five Years (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Perceptions of Neighborhood Safety

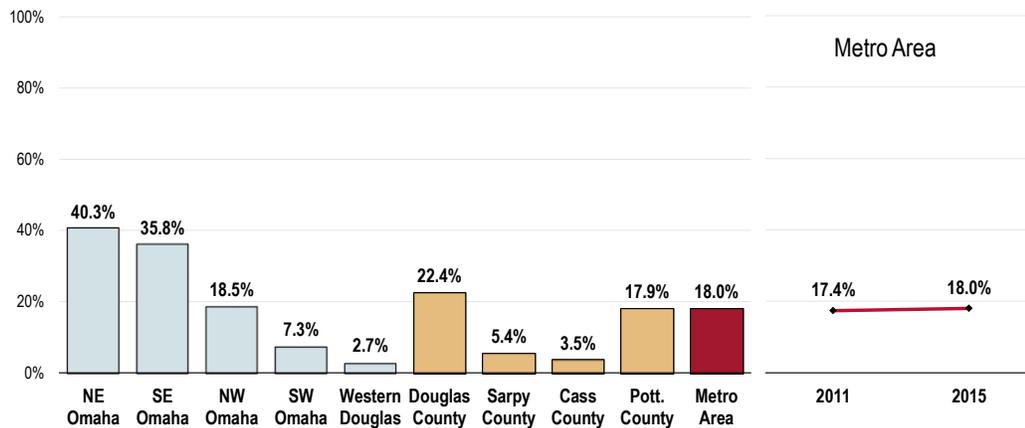
Most Metro Area adults (82.0%) consider their neighborhood to be “extremely” or “quite” safe; however, 18.0% consider their neighborhood to be “slightly safe” or “not at all safe.”



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 332]
 Notes: • Asked of all respondents.

- Among the four Metro Area counties, “slightly/not at all safe” ratings were favorably low in Sarpy and Cass counties.
- Within Douglas County, the prevalence was much higher in eastern Omaha.
- TREND: Statistically unchanged from 2011 survey results.

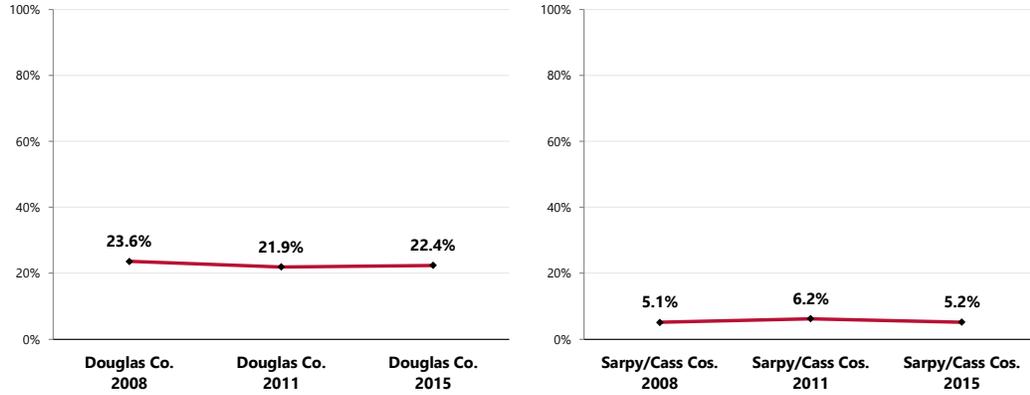
Perceive Own Neighborhood as “Slightly” or “Not At All” Safe



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 332]
 Notes: • Asked of all respondents.

- TREND: No significant change over time in Douglas or Sarpy/Cass counties.

Perceive Own Neighborhood as “Slightly” or “Not At All” Safe



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 332]
 Notes: • Asked of all respondents.

Family Violence

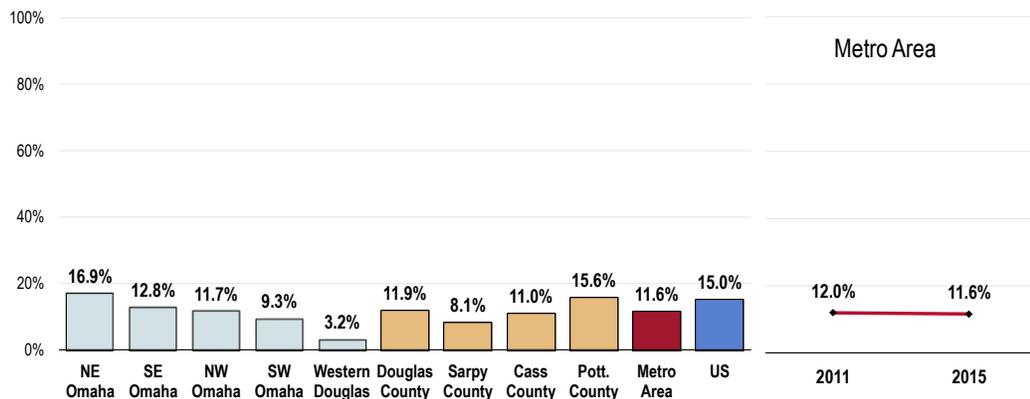
A total of 11.6% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

Respondents were told:

“By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner.”

- More favorable than national findings.
- Highest in Pottawattamie County.
- Ranging from 16.9% in Northeast Omaha to 3.2% in Western Douglas County.
- TREND: Statistically unchanged over time.

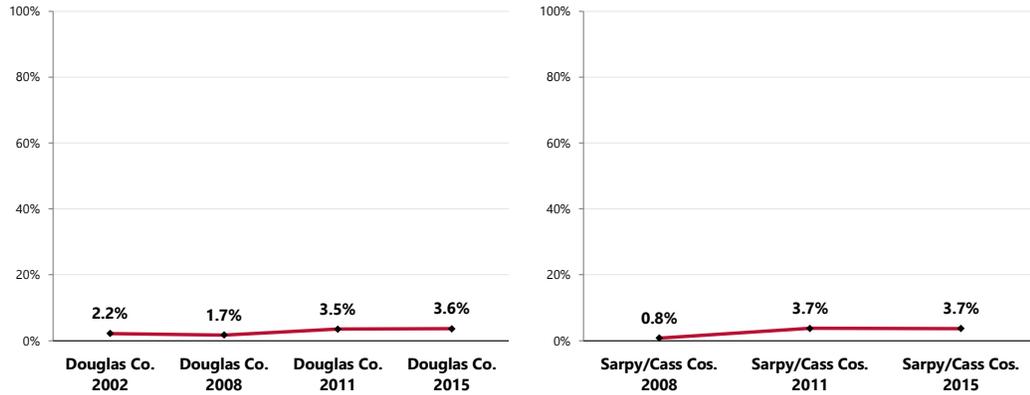
Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 51]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- **TREND:** The prevalence of area residents who have experienced domestic violence *in the past 5 years* has increased significantly over time in Douglas and Sarpy/Cass counties.

Have Experienced Domestic Violence in the Past 5 Years

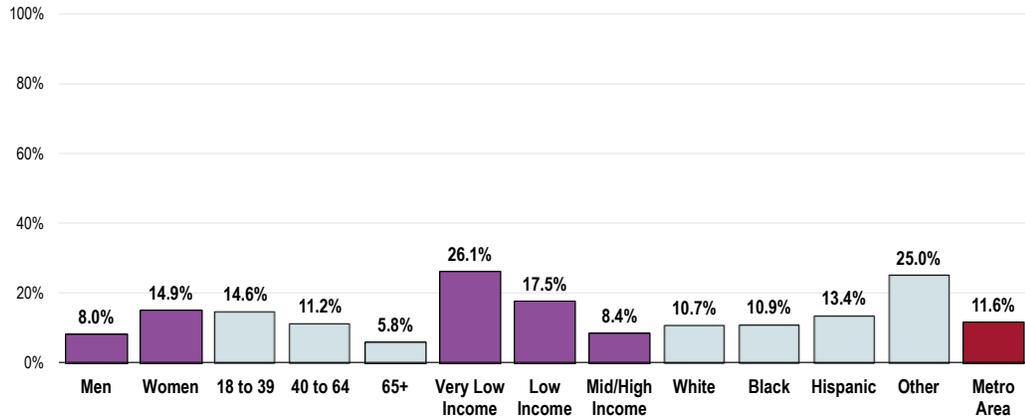


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 312]
 Notes: • Asked of all respondents.

Reports of domestic violence are also notably higher among:

- Women.
- Younger adults (negative correlation with age).
- Those with lower incomes (negative correlation with income).
- Other races.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 51]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

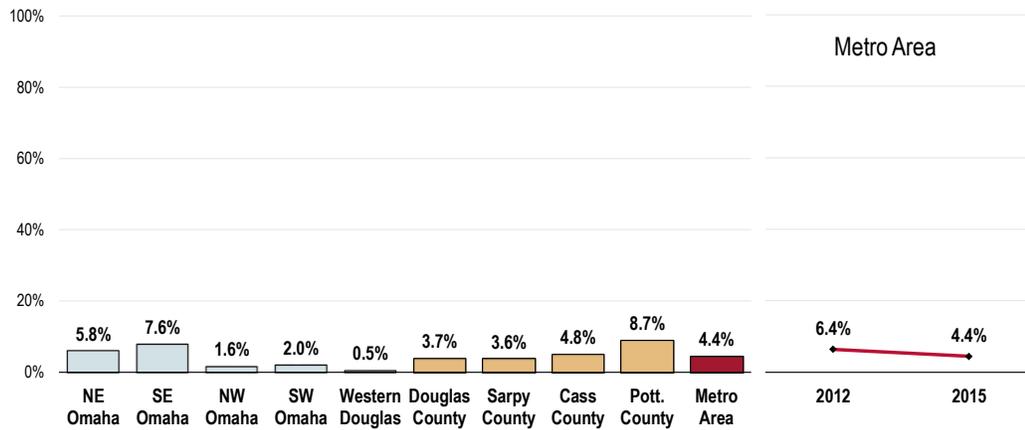
Another 4.4% of survey respondents acknowledge that an intimate partner has been controlling, degrading, harassing, or disruptively jealous in the past 5 years.

Respondents were asked:

“In the last 5 years, has an intimate partner ever tried to control most of your daily activities, constantly put you down in front of others, harassed you or been disruptively jealous of you?”

- Among the four Metro Area counties, unfavorably high in Pottawattamie County.
- Highest in the eastern portion of Douglas County.

An Intimate Partner Has Been Controlling, Degrading, Harassing, or Disruptively Jealous in the Past 5 Years

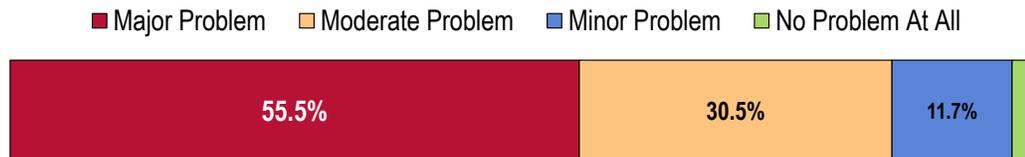


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 313]
 Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

More than half of key informants taking part in an online survey characterized *Injury & Violence* as a “major problem” in the community.

Perceptions of Injury & Violence as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Violent Crime

Omaha has a high rate of violence per capita. – Community/Business Leader

Violence is a regular occurrence in our community. There are high murder, robbery, assault, and other crime rates. This is particularly true in low-income neighborhoods, but are regular occurrences in all neighborhoods. – Social Service Provider

Increase in Omaha of violent crime in all communities. – Social Service Provider

Violence is a major project in the community. – Social Service Provider

Omaha has high rates of violence and has been named the most dangerous place to live for blacks. – Social Service Provider

Violence is pervasive in the community and this does not support a healthy environment and this is truly detrimental to children, especially those in neighborhoods where it is most prevalent, since it is becoming the norm. – Social Service Provider

Omaha has among highest rates of homicide for its size. Violence and injury are number one cause of death for young people. Suicides, domestic and workplace violence continues to be in the news and reported to agencies. – Healthcare Provider

Many deaths from gunshot wounds and gang violence. I believe that the access to jobs and support in the areas where this occurs is suboptimal. I also believe racially motivated. – Healthcare Provider

Gang violence is significant. – Healthcare Provider

Rate of gun violence and violent crime in the community. – Physician

Gangs and drugs. – Healthcare Provider

Gang violence, drug use, poverty in certain neighborhoods. – Social Service Provider

When Omaha is listed as "one of the most dangerous places for a black man to live in the country" you know you have a problem. – Social Service Provider

The violence in this city, particularly against young black men, is terribly high. – Community/Business Leader

The number of shootings/homicides that occur in Omaha. – Community/Business Leader

Homicide rates continue to escalate. – Social Service Provider

Increased number of shootings in the North Omaha area/gang violence. – Healthcare Provider

There is an ever-increasing incidence of violent crimes, particularly in North Omaha, often involving guns. – Social Service Provider

Regardless of the fact that statistically we aren't worse off than any other major city, our young black men and boys are killing each other. – Community/Business Leader

Increased gang violence in areas of low income and poverty. Recently Voices for Children of Nebraska hosted a Race Matters Conference at UNO. National speakers from Washington and Baltimore stated what will happen if our community does not take action soon. – Healthcare Provider

Lack of parenting, access to guns, no family support system, no values. – Community/Business Leader

The rate of violence against African Americans in North Omaha is staggering and needs improvement. I believe our community needs to be focused on how we can lift up this area. I also see many sexual assault victims, many of which have not received any information. – Healthcare Provider

Gang activity in North and South Omaha, poverty, lack of education and domestic violence. – Social Service Provider

Violence, murder, and gang threats seem to continue to rise in our community. The value of human life seems to be slipping away from the grasp of our younger generations. – Social Service Provider

Number of arrests due to violence. – Public Health Representative

High shooting and gang violence in North Omaha persists. – Healthcare Provider

Increase in the number of gangs operating on the north side. The number of confiscated weapons has increased, which shows there is a problem with gun control. The number of people going into the ER for gun related injuries is up. – Social Service Provider

Domestic Violence & Child Abuse

Children across our community and more so in the Eastern 1/3 of our community experience more adverse childhood experiences and have higher rates of behavioral health issues and concerns. These events stem from the fact that too many children live in poverty. – Public Health Representative

Child abuse reports are at record levels, increase in gang shootings, exposure of children to violence. Domestic assaults/violence continues to be a major issue and concern. – Social Service Provider

Families and children are experiencing a significant amount of trauma and violence. This has huge impacts on a person's overall health and wellbeing. If individuals in our community do not feel safe, health is not going to be a priority. – Social Service Provider

We don't have enough resources allocated to the prevention of domestic violence in place within the city and the universities. We don't have prevention methods in place to keep urban youth from being involved in destructive behaviors. – Social Service Provider

One third of women are victims of domestic violence/intimate partner violence in our community. It is also the number one cause of death of adolescents and young adults in our community, male and female. Women who die during their pregnancy or within one year. – Physician

We see a lot of violence, including gang affiliation and domestic violence within the populations we serve. – Social Service Provider

Children and families continue to be traumatized by violence and injury in our community. With each exposure to trauma, the child's ability to function and thrive is challenged. With inadequate understanding of trauma's impact on the brain. – Social Service Provider

Domestic violence, child abuse and dependent adult abuse and gang violence, continue to affect all in the community. Gang violence and shootings continue to rise. – Healthcare Provider

Gun Violence

Gun violence is taking away caretakers and children. Loss of life and loss of earning potential. Loss of presence in the community due to persons being shot and killed. Trauma caused by those directly and indirectly impacted by violence. – Social Service Provider

Gun violence is causing problems and paralyzing development. – Community/Business Leader

Certain parts of our community are experiencing gun violence too frequently. – Public Health Representative

At least one shooting per day and on several days there have been in excess of five shootings per day. We have a gang problem in Douglas County. – Healthcare Provider

Gun violence and homicides are very high in neighborhood in which our clinic is located. – Physician

There is a shooting or assault reported on almost daily in the news. We see approximately two to three sexual assault victims monthly. – Healthcare Provider

Guns, lack of a curfew. – Community/Business Leader

Omaha ranks as one of the highest cities nationally for the rate of gun violence. Also the amount of domestic violence is very high for a city our size. These problems will be passed down for generations if more is not done to resolve. – Social Service Provider

Gun violence seems to be on the rise and domestic violence continues to be a big problem. – Physician

There are shootings on a regular basis. – Public Health Representative

There are shootings and stabbings nearly every week if not more frequently. – Healthcare Provider

Associated Risk Factors

Substance abuse/homelessness/mental health leads to injury and violence. No long term treatment or after care opportunities. Cycle continues. – Social Service Provider

Gang violence, poverty. – Healthcare Provider

Statistics. Health disparities issue. – Public Health Representative

Poverty and high youth unemployment rate contribute to a climate where violence becomes a way of life. Gang activity and gun availability both are major factors in encouraging violent behavior. – Social Service Provider

The various environmental influences of trauma, racism, unresolved grief, inadequate parenting skills, suicide and other types of self-harm. – Social Service Provider

Injuries are a big problem for Hispanics working under unsafe conditions (meat plants, construction, hospitality industry and others). Violence, domestic violence is also a major problem that can't be

addressed effectively due to the lack of adequate service. – Community/Business Leader

Illegal drug use. Revenge, uncontrollable anger, educating public. – Community/Business Leader

There is only one forensic nurse examiner program in the community. Violence rates and repeat offenders are extremely high. There is a need for prevention but also adequately trained healthcare providers to address the situation. – Healthcare Provider

Increasing Problem

If you listen to the news there are numerous shootings, acts of domestic violence and vehicular accidents daily. I also believe that the gang activity has increased in our community. – Social Service Provider

Everyday newscasts and newspaper articles report gang and gun violence and assaults in our city. – Social Service Provider

Many deaths in youth and others all over the city. – Public Health Representative

Stats show this is a major problem and people agonize over this. – Healthcare Provider

Listening to the nightly news for Council Bluffs in the past weekend has been overwhelming in regards to shootings occurring at all times of the day and night. I'm unaware of how to assist victims of shooting violence. – Social Service Provider

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

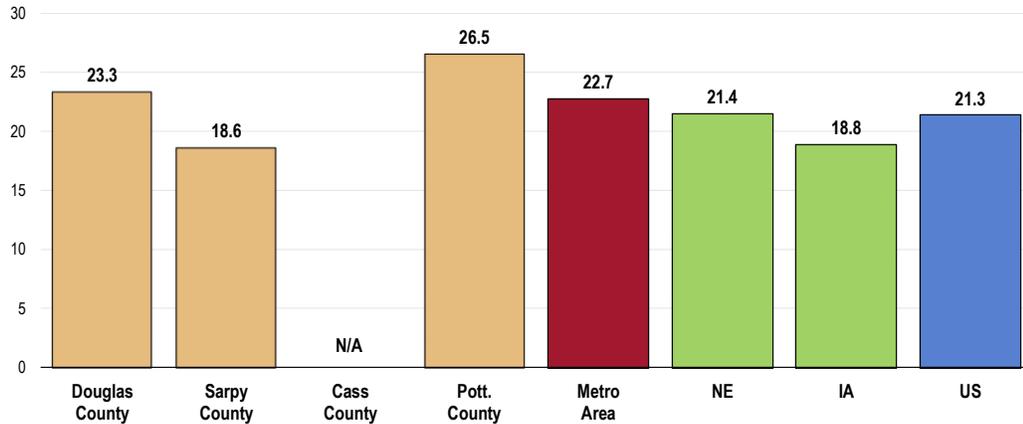
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Between 2011 and 2013, there was an annual average age-adjusted diabetes mortality rate of 22.7 deaths per 100,000 population in the Metro Area.

- Less favorable than the statewide rates.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).
- Higher in Pottawattamie County.

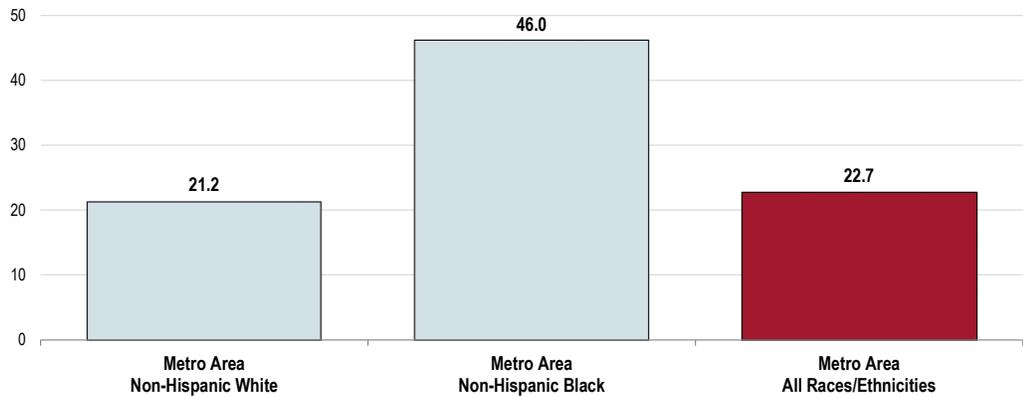
Diabetes: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 20.5 or Lower (Adjusted)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

- The diabetes mortality rate in the Metro Area is notably higher among Blacks than among Whites.

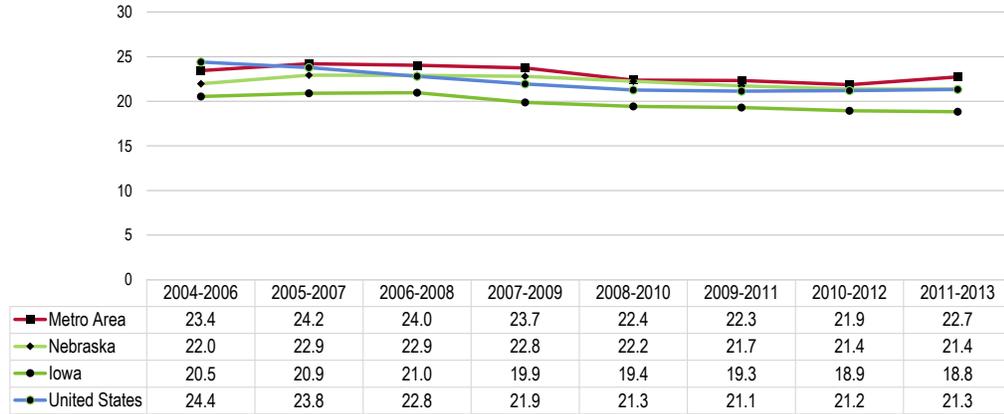
Diabetes: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 20.5 or Lower (Adjusted)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

- TREND: Diabetes mortality has been largely stable over the past decade.

Diabetes: Age-Adjusted Mortality Trends
 (Annual Average Deaths per 100,000 Population)
 Healthy People 2020 Target = 20.5 or Lower (Adjusted)



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]

 Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

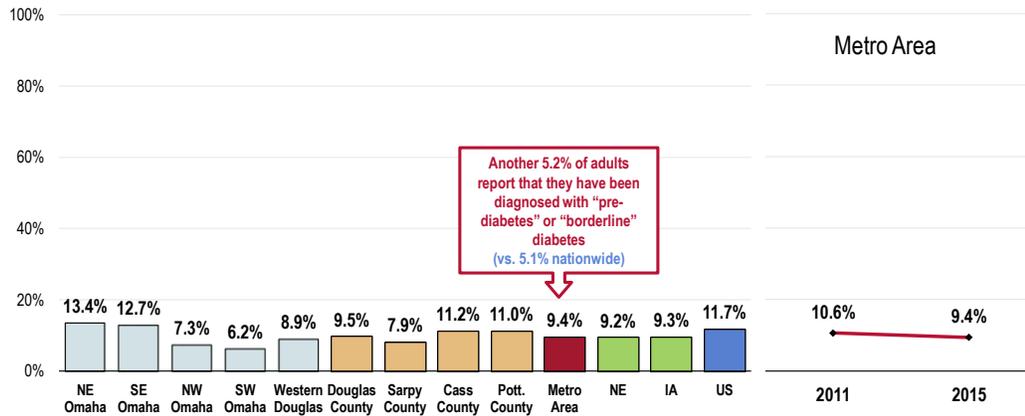
A total of 9.4% of Metro Area adults report having been diagnosed with diabetes.

- Similar to both statewide proportions.
- Better than the US prevalence.
- Similar findings among the 4 Metro Area counties.
- In Douglas County, unfavorably high in Northeast Omaha.
- TREND: Statistically unchanged since 2011.

In addition to the prevalence of diagnosed diabetes referenced above, another 5.2% of Metro Area adults report that they have “pre-diabetes” or “borderline diabetes.”

- Comparable to the US prevalence.

Prevalence of Diabetes

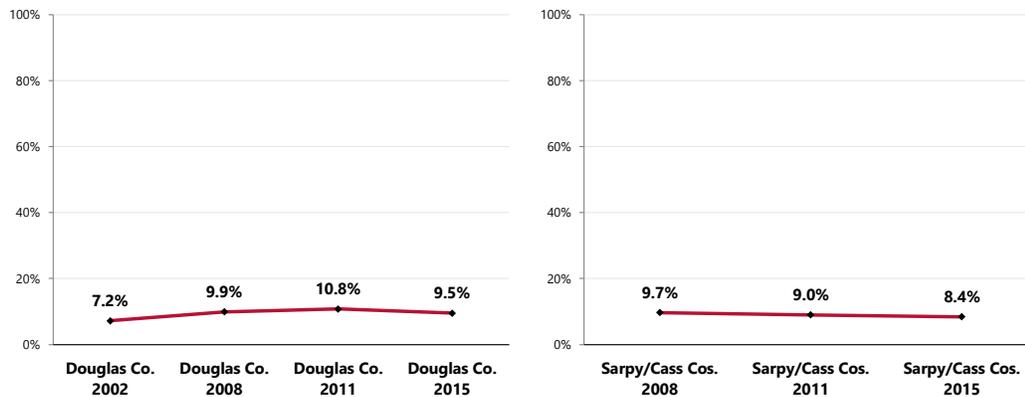


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 136]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.

Notes: • Asked of all respondents.
 • Local and national data exclude gestation diabetes (occurring only during pregnancy).

- **TREND:** Note the statistically significant increase in diabetes over time for Douglas County respondents (the Sarpy/Cass prevalence is statistically unchanged).

Prevalence of Diabetes

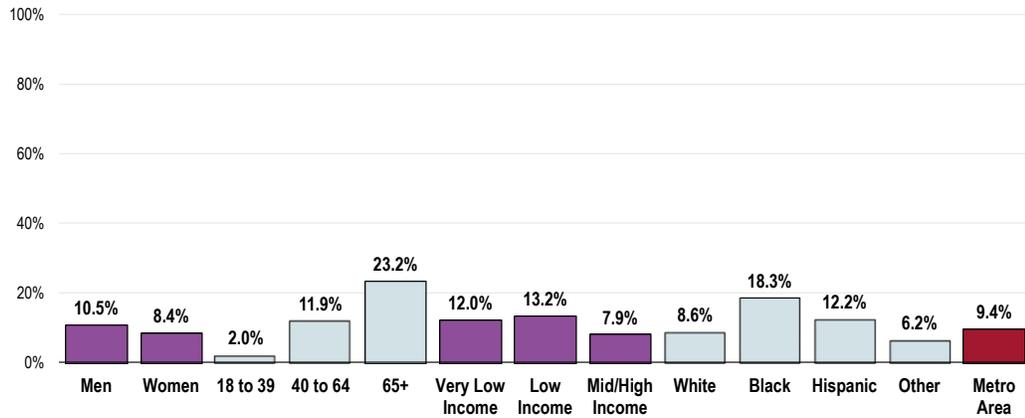


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 136]
 Notes: • Asked of all respondents.

A higher prevalence of diagnosed diabetes (excluding pre-diabetes or borderline diabetes) is reported among:

- Older adults (note the strong positive correlation between diabetes and age, with 23.2% of seniors with diabetes).
- Residents in households with lower incomes.
- Blacks and Hispanics.

Prevalence of Diabetes (Metro Area, 2015)



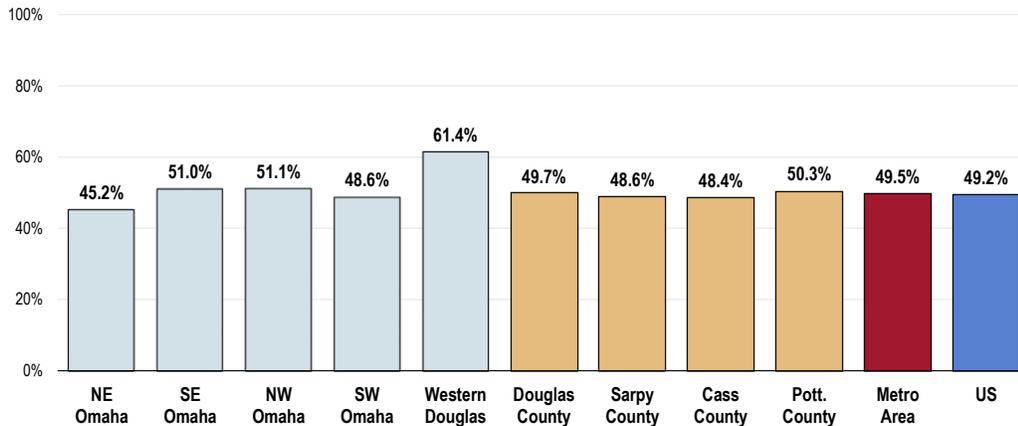
- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 136]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - Excludes gestation diabetes (occurring only during pregnancy).

Diabetes Testing

Of Metro Area adults who have not been diagnosed with diabetes, one-half (49.5%) reports having had their blood sugar level tested within the past three years.

- Similar to the national proportion.
- Statistically similar among the 4 Metro Area counties.
- Testing prevalence is highest in Western Douglas County.

Have Had Blood Sugar Tested in the Past Three Years (Among Non-Diabetics)



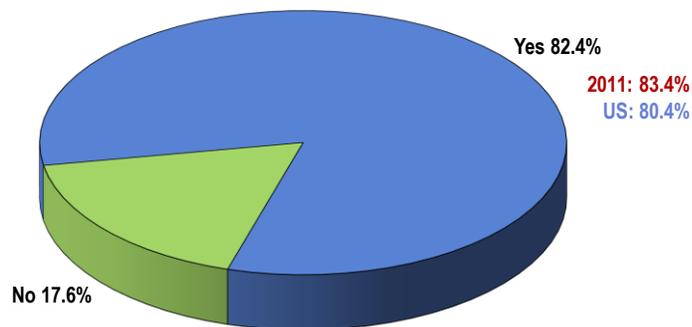
- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of respondents who have not been diagnosed with diabetes.

Diabetes Treatment

Among adults with diabetes, most (82.4%) are currently taking insulin or some type of medication to manage their condition.

- Close to the US prevalence among diabetics.
- TREND: Statistically unchanged over time.

Taking Insulin or Other Medication for Diabetes (Metro Area Diabetics, 2015)

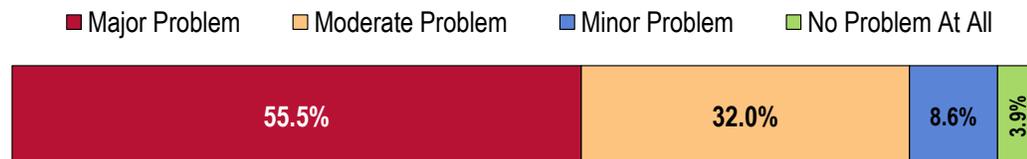


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 311]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all diabetic respondents.

Key Informant Input: Diabetes

Over half of key informants taking part in an online survey characterized *Diabetes* as a “major problem” in the community.

Perceptions of Diabetes as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Challenges

Among those rating this issue as a “major problem,” the biggest challenges related to diabetes in the community are seen as:

Awareness/Education

Education and motivation. – Social Service Provider

Education about diabetes and cost of medication and supplies. – Physician

Lack of awareness and prevention initiatives. – Social Service Provider

Knowledge and awareness. Increase in number of children being diagnosed. – Social Service Provider

Education, education, education. Access to knowledge about exercise and places to exercise safely (some places in Omaha it is not safe to walk outside). Many of these individuals also have problems accessing or knowing how to obtain healthy food. – Physician

The biggest challenge for diabetics is a lack of health literacy. Not all people understand how to prevent, recognize, or manage diabetes. Another major barrier is a lack of access to healthy foods in many of the low income areas of the city. – Community/Business Leader

Often undiagnosed. Lack of information on how best to manage in their daily lives. Lack of access to medical care to get treatment and advice. – Public Health Representative

Regular medical care and education. – Physician

I think that Pottawattamie County still doesn't see the importance of healthy eating in relationship to diabetes. It seems like people continue to make the unhealthy choices because that is the way it has always been. We need to continue to educate. – Community/Business Leader

Access to support and continuing education about managing their diabetes. Also because exercise and diet are so critical to managing or preventing diabetes, it is essential that people have safe places to exercise and access to healthy, affordable food. – Social Service Provider

The community's lack of willingness to receive education. – Community/Business Leader

As someone that works with individuals and families near homelessness, diabetes can be triggered by poor nutrition and eating habits as well as poor health and access to healthcare. – Social Service Provider

Making the lifestyle changes, weight loss, exercise, necessary to improve their diabetes. – Healthcare Provider

Affordable Medications, Testing Strips, Healthy Food

Access to low cost diabetic supplies and medications. – Physician

The biggest challenge is access to diabetes testing supplies and insulin. Patients also face the challenge of access to healthy foods and knowledge regarding what foods are good for diabetes. – Healthcare Provider

Lack of resources to pay for diabetes testing supplies and insulin. – Healthcare Provider

Access to affordable medication and testing strips. – Social Service Provider

Access to health foods and exercise. – Social Service Provider

There are a lot of people with limited access to healthy foods and vigorous physical activity. There are a number of people walking around with pre-diabetes and diabetes who don't have a regular source of care. – Social Service Provider

Nebraska Medicaid does not cover diabetes education. This is a major problem for most at risk population to get the help they need to self-manage their diabetes. – Healthcare Provider

Cost of continuing care. Health information not readily available for self-care. Educational materials and truly helping persons with diabetes or pre-diabetes understand the risk factors, physical and mental care strategies and follow up care. – Social Service Provider

Cost of healthcare, patient education, proper nutrition, physical activity. – Social Service Provider

Access to healthcare, financial difficulties in relation to buying needed medications and ability to pay for needed nutritional items. – Public Health Representative

Lack of access to care, lack of resources, lack of understanding as to how this disease really affects us. – Healthcare Provider

Access to drugs. – Healthcare Provider

Buying healthy foods often exceed people's budget. Most healthy foods are expensive and the foods with high sugar content have lower prices. – Social Service Provider

Access to quality foods and grocery stores that offer organic foods and free range meats (grass fed beef, etc.), food deserts, over medicating and lack of holistic health treatment, safe and appropriate youth and adult exercise equipment at parks, unkempt. – Social Service Provider

Price of medications and new devices available to other populations. Cultural eating and physical activity habits in spite of all the educational efforts. – Community/Business Leader

Obtaining their medications, the cost. – Healthcare Provider

Associated Risk Factors

Obesity and eating habits are poor, especially in the poorer neighborhoods. – Community/Business Leader

Type 2 diabetes due to weight concerns. – Public Health Representative

Overweight and obesity continue to be a problem in our community and along with that type II diabetes. – Social Service Provider

Obesity, high blood pressure, more education needed on diabetes in general. – Social Service Provider

Obesity rates are higher than ever, which leads to diabetes. Doctors are not addressing the root causes for weight issues. – Healthcare Provider

Diet, exercise, understanding diabetes, employment concerns. – Community/Business Leader

Socioeconomic, education, and lack exercise/diet. – Healthcare Provider

The long-term impact on their health status. – Social Service Provider

Chronic nature of the disease and the physical effects. Lifestyle changes are hard to make. – Social Service Provider

This goes hand in hand with the concern I have for lack of exercise, nutrition and weight issues that are prevalent in our community. I would imagine that it also goes hand in hand with issues related to access to care. Ultimately, the biggest challenge. – Healthcare Provider

Many overweight, unhealthy individuals in our community that have diabetes as a result of their chronic conditions and high rate of obesity. – Healthcare Provider

Obesity and being compliant with their treatment regimen. – Healthcare Provider

Prevention and Compliance

Compliance to treatment. Affording medications. Lifestyle changes. – Physician

Prevention and being compliant with their treatment. – Community/Business Leader

Consistent disease management and prevention. – Social Service Provider

I think one of the biggest challenges is related to prevention of diabetes and weight management.

Healthy lifestyle. I think we need to do more on the preventative side. – Social Service Provider

Prevention, i.e. for those who are at risk for pre-diabetes, healthcare reimbursement for prevention.

The Y has an evidence-based diabetes prevention program that has a third party payment option through Uninet, but some insurers will not work with it. – Social Service Provider

Frequent monitoring. – Physician

Motivation for compliance for care. – Physician

Not compliant with insulin, oral medications, and diet. – Healthcare Provider

Lack of Resources

Lack of diabetes prevention programs. – Public Health Representative

Access to ongoing care and managing this chronic disease and its many serious complications. – Public Health Representative

Lack of clinics to treat and diagnose. – Social Service Provider

We only have one Endocrinologist in CB, need additional. Need more education in schools to decrease weight and increase activity. – Healthcare Provider

Limited preventative care. – Healthcare Provider

Increasing Numbers

The increasing number of pre-diabetics occurring because of the combination of genetics and personal habit is creating a generation of individuals at risk for compromised lives. Access to healthy foods and daily, safe active living are critical. – Public Health Representative

Numbers diagnosed. – Healthcare Provider

Increasing numbers of children with diabetes and related health concerns. – Social Service Provider

Alzheimer's Disease

About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

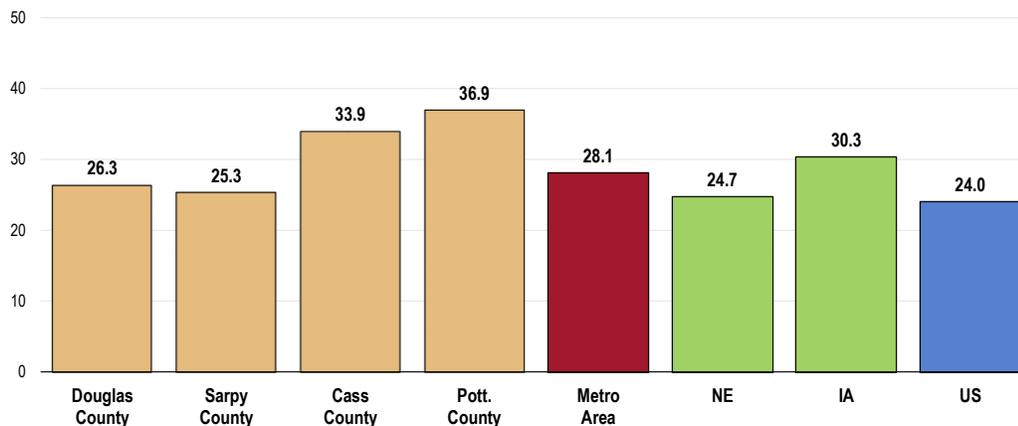
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2011 and 2013, there was an annual average age-adjusted Alzheimer's disease mortality rate of 28.1 deaths per 100,000 population in the Metro Area.

- Less favorable than the Nebraska rate but more favorable than Iowa.
- Less favorable than the national rate.
- Unfavorably high in Cass and Pottawattamie counties.

Alzheimer's Disease: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population)

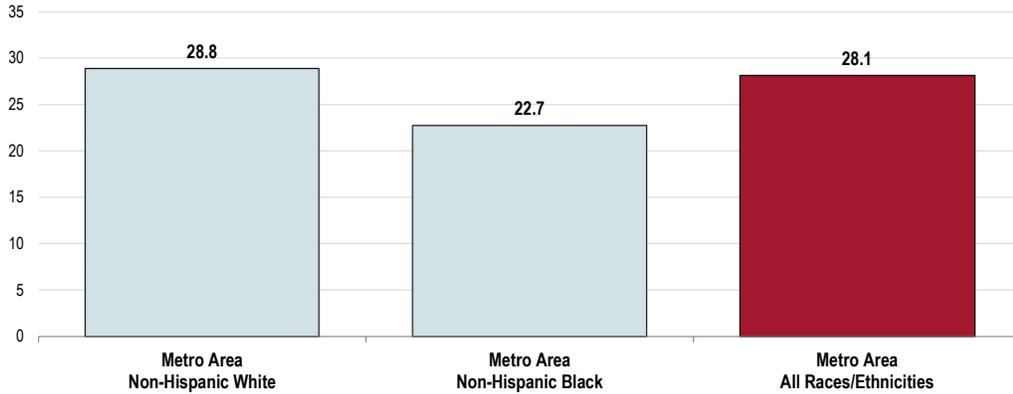


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The Alzheimer's disease mortality rate is higher among Metro Area Whites when compared with Blacks.

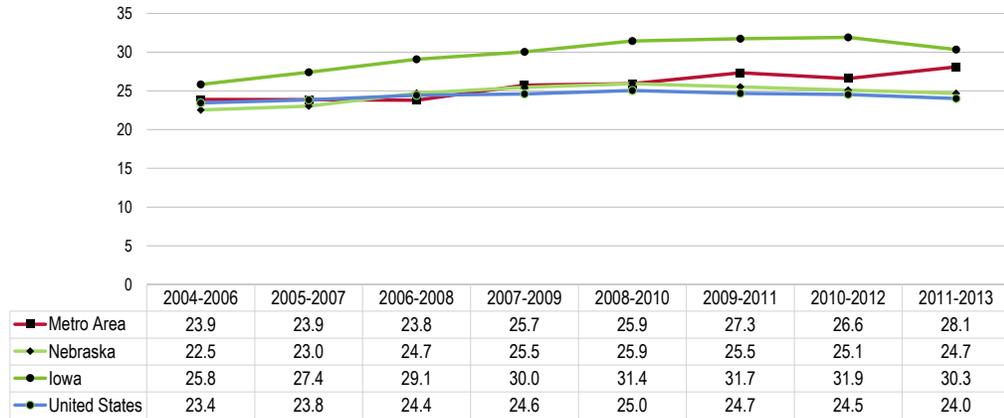
Alzheimer's Disease: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Alzheimer's disease mortality has increased over time in the Metro Area.

Alzheimer's Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

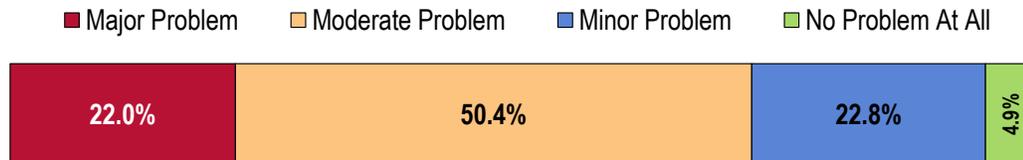


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Dementias, Including Alzheimer's Disease

Half of key informants taking part in an online survey consider *Dementias, Including Alzheimer's Disease* to be a “moderate problem” in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Aging Population

This has not been in the forefront for years but as the baby boomers age the need is much greater now. The number of families affected by this disease is much greater now. – Social Service Provider

The population of those 65 and older is increasing, therefore we will begin to see higher rates of dementia/Alzheimer's. – Social Service Provider

With longevity increasing, there are more individuals/families impacted by Dementia/Alzheimer's Disease. Resources for providing care and support are not adequate to meet the need and often are not affordable. These diseases also taking a toll on the men. – Social Service Provider

Aging of the population is leading to an increase in the prevalence of dementia related disease. – Social Service Provider

The population is aging with inadequate resources to meet the coming needs. – Community/Business Leader

We are seeing an aging population with increasing numbers of people with Alzheimer's and limited resources specialized to deal with this issue. – Social Service Provider

Resources

We have problems finding resources for individuals in our care. – Community/Business Leader

Limited resources for outpatient skilled nursing and residential placement. This problem will grow as the population ages. – Public Health Representative

Little has been done to address the cost, needs for those affected by the different dementias. Facilities are limited. Many cost well over \$6,000 a month. Home care is \$20 per hour and if a family wants to keep them home and work that is \$3,200 plus. – Healthcare Provider

There are not enough Alzheimer's units. – Physician

I have seen the number of Alzheimer's/dementia care facilities grow tremendously over the past nine years. I have personal experience with being unable to find placement for family members as well. – Healthcare Provider

Number of memory care facilities and professional experience in this area. – Public Health Representative

High Rate of Occurrence

There is so much of it. – Physician

Because of the increase in diagnosis and the effect on the patient, family and caregivers. – Social Service Provider

Increase in patient numbers with often having long wait lists for affordable bed options. – Community/Business Leader

This is a growing problem everywhere and our healthcare system is going to be overwhelmed by this disease alone if we can't figure out preventive measures for it. – Healthcare Provider

Statistics show this to be a problem. – Public Health Representative

Because African American women are stricken at such a high rate at such a young age. – Community/Business Leader

Education

It goes undiagnosed as other ailments. – Community/Business Leader

It is a major problem because of the public's lack of knowledge of the disease. – Social Service Provider

The stress on the caregivers and a lack of support for the caregiver's needs. The impact on families and the individual and the cost of the care. The elderly population being the fastest growing population, their numbers alone predict a growing problem. – Social Service Provider

Because there have been no outreach efforts to educate the Hispanic community with sensitive and culturally tailored tools. – Community/Business Leader

Kidney Disease

About Chronic Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

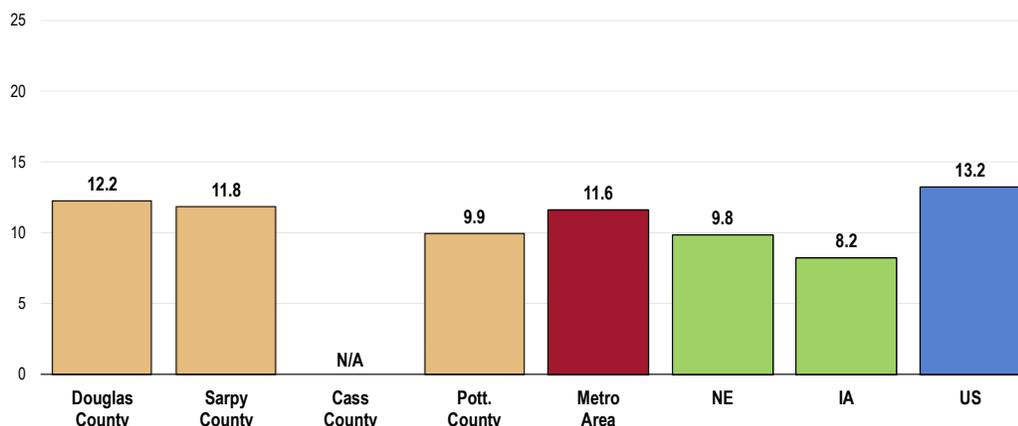
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2011 and 2013 there was an annual average age-adjusted kidney disease mortality rate of 11.6 deaths per 100,000 population in the Metro Area.

- Higher than the rates found statewide.
- Lower than the US rate.
- Lowest in Pottawattamie County.

Kidney Disease: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population)

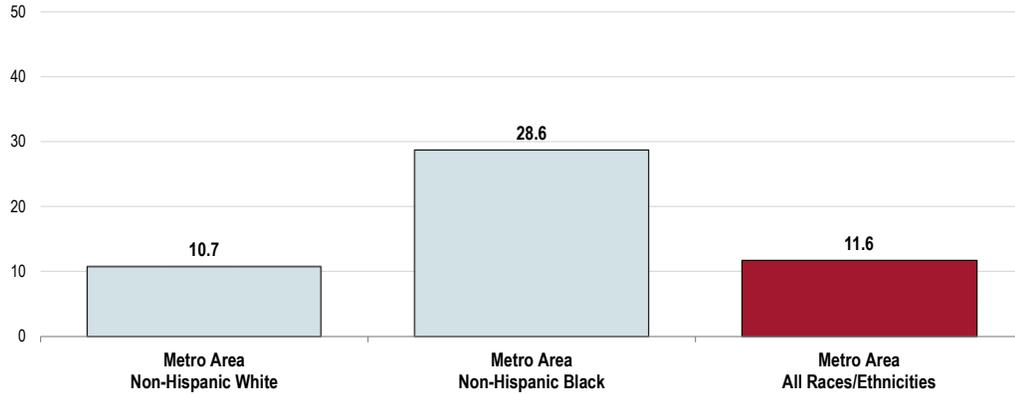


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The kidney disease mortality rate in the Metro Area is much higher in the Black community.

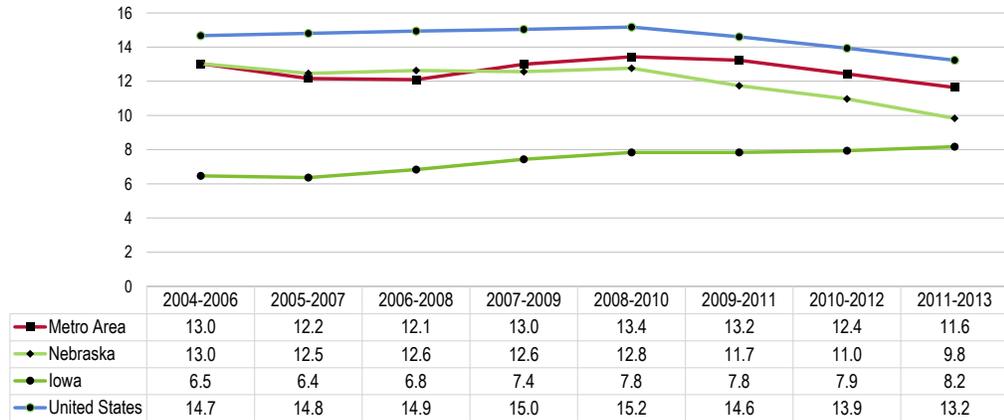
Kidney Disease: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The death rate has risen and fallen over the past decade in the Metro Area.

Kidney Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



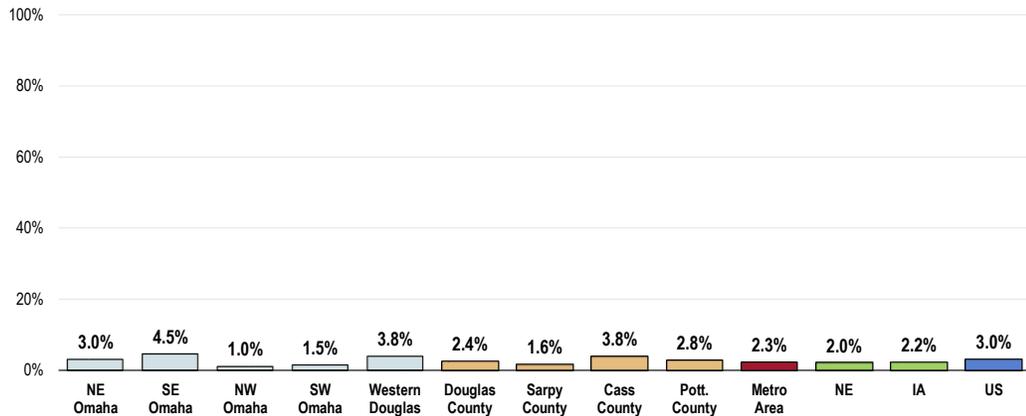
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - State and national data are simple three-year averages.

Prevalence of Kidney Disease

A total of 2.3% of Metro Area adults report having been diagnosed with kidney disease.

- Similar to the Nebraska and Iowa proportions.
- Similar to the national proportion.
- Statistically similar by county.
- In Douglas County, unfavorably high in Southeast Omaha (lowest in Northwest Omaha).

Prevalence of Kidney Disease

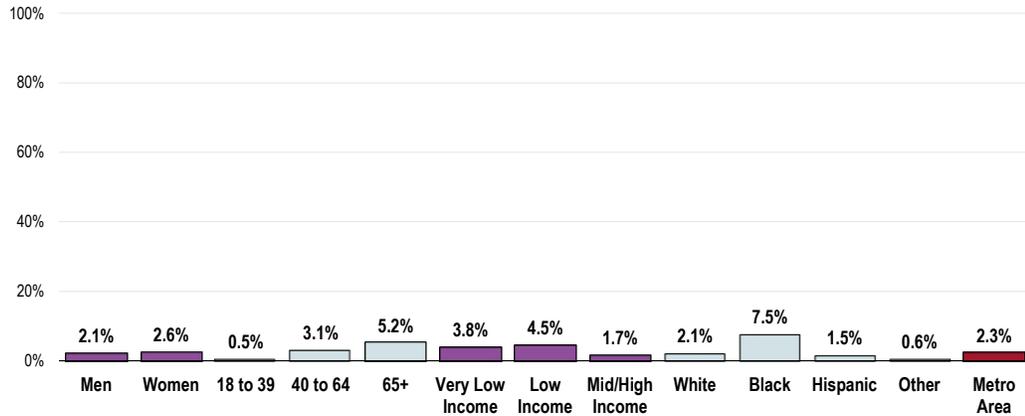


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

- Note the positive correlation between age and kidney disease in the Metro Area.
- Lower-income residents are more likely to report kidney disease than those in the highest income category.
- A higher prevalence of kidney disease is reported among Black respondents in the Metro Area.

Prevalence of Kidney Disease (Metro Area, 2015)

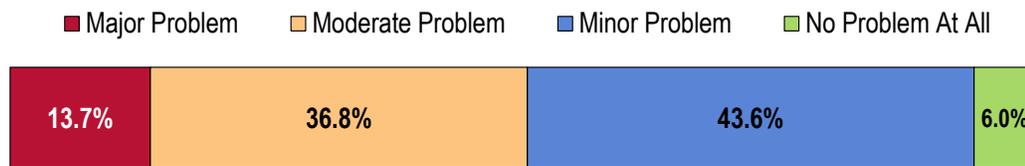


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Chronic Kidney Disease

The greatest share of key informants taking part in an online survey characterized *Chronic Kidney Disease* as a "minor problem" in the community.

Perceptions of Chronic Kidney Disease as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Co-occurring Morbidities

Because it is a complication of diabetes. – Community/Business Leader

Due to other major health issues, such as diabetes, can create issues with the kidneys. – Social Service Provider

There are several kidney dialysis facilities popping up in the community, which means the need is there. More chronic disease is prevalent, which if not controlled leads to kidney disease. – Social Service Provider

Diabetes and hypertension is related to kidney disease. – Social Service Provider

Uncontrolled diabetes leading to kidney disease. – Healthcare Provider

The rates of diabetes in the community as well as alcohol and drug issues. – Social Service Provider

Many patients who have diabetes develop chronic kidney disease that increases the number of people who suffer from this disorder. Chronic kidney disease often leads to renal failure and the need for dialysis, which is in short supply to non-documented members. – Social Service Provider

Poorly controlled diabetes, poorly controlled hypertension and concentrated population of African Americans. – Healthcare Provider

Education, Prevention and Information Needed

With education, prevention and information this disease could be avoided and preventive. – Social Service Provider

It is not often assessed or monitored until it becomes a major health issue. – Healthcare Provider

Related Costs

Cost, dialysis is expensive. Days lost from work. Transplant list is limited. – Healthcare Provider

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than \$128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least \$50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

Prevalence of Arthritis/Rheumatism

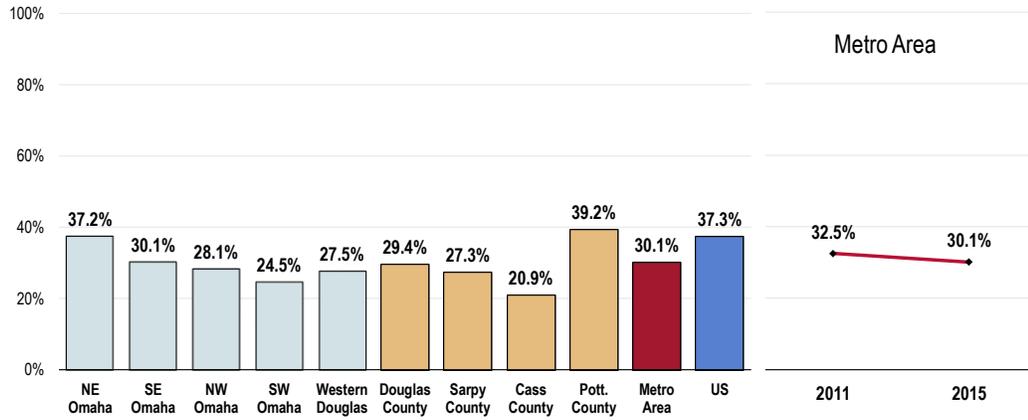
A total of 3 in 10 Metro Area adults age 50 and older (30.1%) report suffering from arthritis or rheumatism.

- More favorable than that found nationwide.
- Favorably low in Cass County, highest in Pottawattamie County.
- In Douglas County: unfavorably high in Northeast Omaha.
- TREND: The prevalence of arthritis/rheumatism is similar to that reported in 2011.

RELATED ISSUE:

See also *Activity Limitations* in the **General Health Status** section of this report.

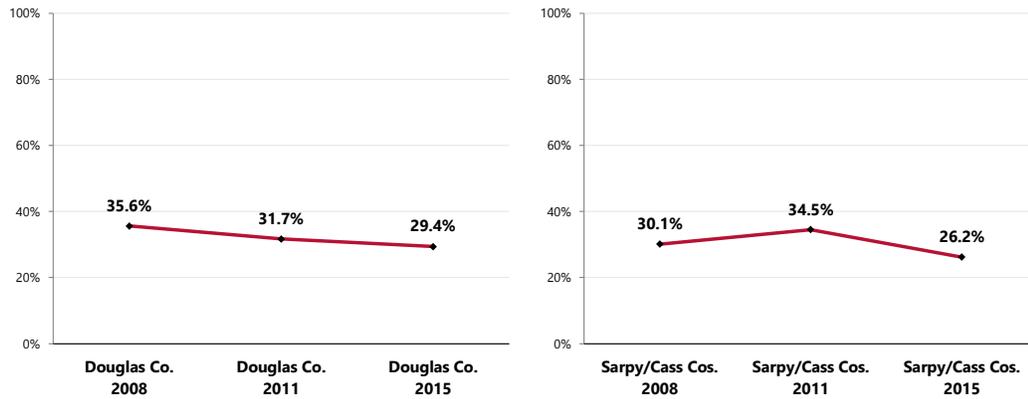
Prevalence of Arthritis/Rheumatism (Among Adults Age 50 and Older)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 139]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Reflects respondents age 50 and older.

- **TREND:** Note the statistically significant increase over time in Douglas County (the Sarpy/Cass prevalence is statistically unchanged).

Prevalence of Arthritis/Rheumatism (Among Adults Age 50 and Older)



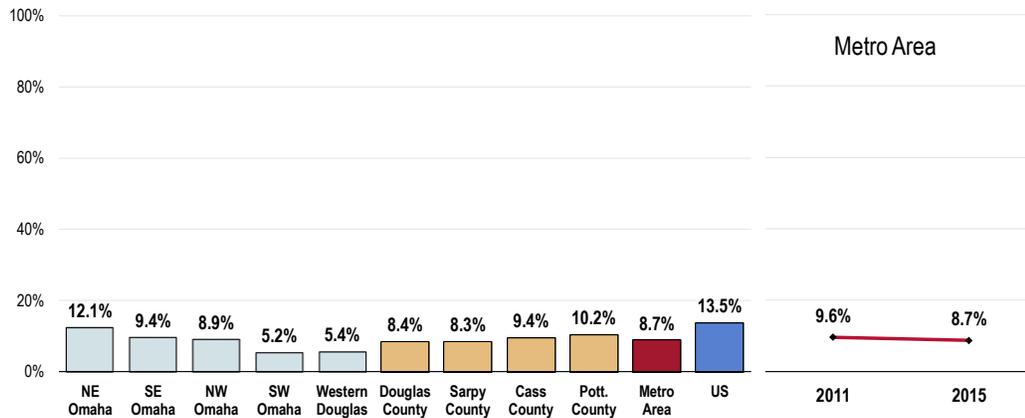
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 139]
 Notes: • Reflects respondents age 50 and older.

Prevalence of Osteoporosis

A total of 8.7% of survey respondents age 50 and older have osteoporosis.

- Better than that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.
- Similar findings among the 4 Metro Area counties.
- In Douglas County, unfavorably high in Northeast Omaha.
- TREND: Statistically unchanged over time.

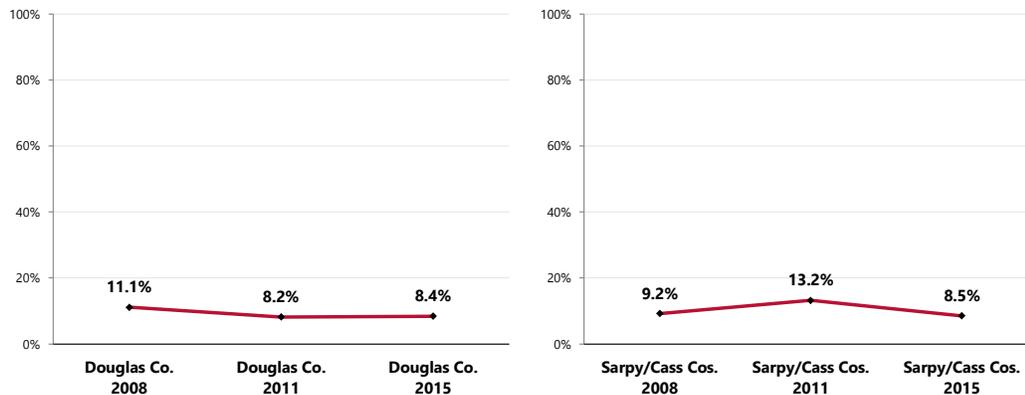
Prevalence of Osteoporosis (Among Adults Age 50 and Older) Healthy People 2020 Target = 5.3% or Lower



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 140]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]
 Notes: • Reflects respondents age 50 and older.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Prevalence of Osteoporosis (Among Adults Age 50 and Older)



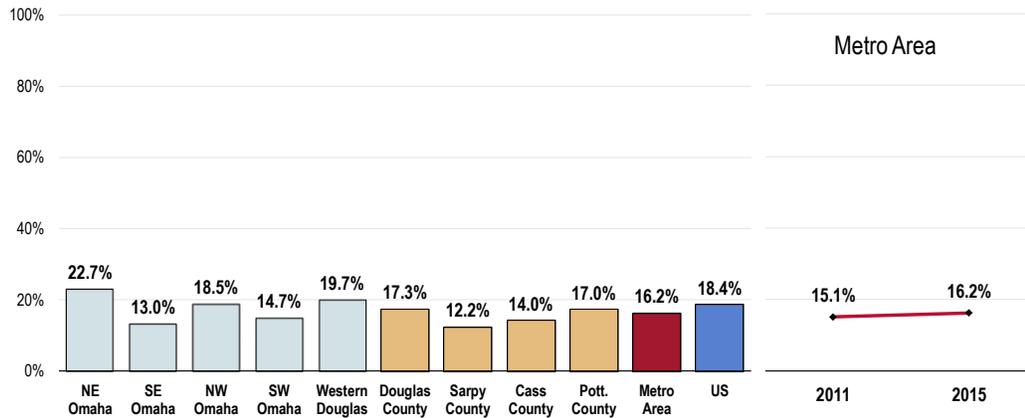
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 140]
 Notes: • Reflects respondents age 50 and older.

Prevalence of Sciatica/Chronic Back Pain

A total of 16.2% of survey respondents suffer from chronic back pain or sciatica.

- Similar to that found nationwide.
- Highest in Douglas County, lowest in Sarpy County.
- Unfavorably high in Northeast Omaha.
- TREND: Statistically unchanged over time.

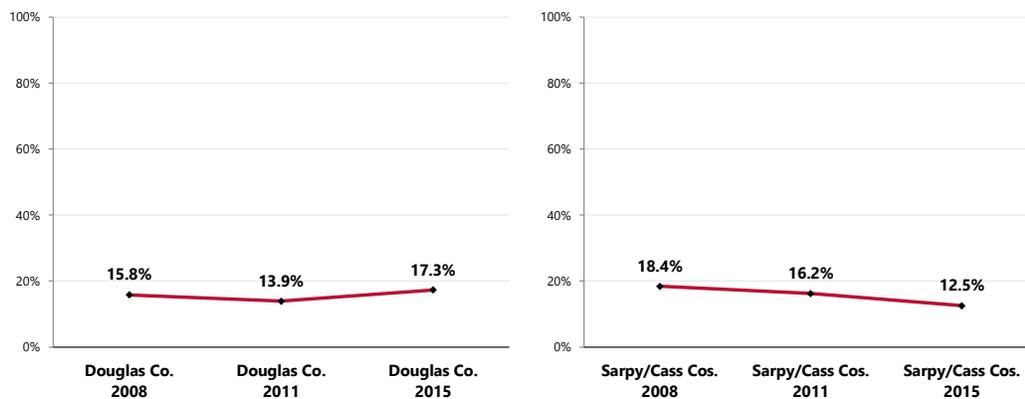
Prevalence of Sciatica/Chronic Back Pain



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Denotes a statistically significant decrease over time in Sarpy/Cass counties (the Douglas County prevalence has not changed significantly).

Prevalence of Sciatica/Chronic Back Pain

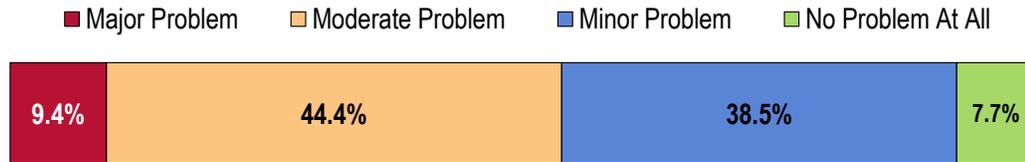


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
 Notes: • Asked of all respondents.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

A plurality of key informants taking part in an online survey characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a “moderate problem” in the community.

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

High Rate of Occurrence

- Advancing age of the population with increasing pain issues related to arthritis. – Physician*
- With an aging population and being an agricultural community with hard labor, it follows that such inflictions would plague our residents. – Social Service Provider*
- The aging population has a lot of problems with arthritis and we see a lot of this with those persons active in sports as they age. There are also pediatric issues with arthritis. – Social Service Provider*
- I work in a clinic in which we have a number of patients with back related complaints with limited ability to refer for treatment. We also have a number of patients with rheumatoid arthritis/osteoporosis that have difficulty getting access to a rheumatologist. – Healthcare Provider*
- Patient exposure in the community. – Physician*

Access to Resources

- Not enough specialty MDs. – Healthcare Provider*
- I have many uninsured patients that experience severe back pain and we do not have the referral resources needed to give proper care. The majority of my patients do not have insurance and do not have the ability to see a neurosurgeon. – Healthcare Provider*
- Due to the lack of access, inferior quality of services, language barrier and discrimination, immigrants do not receive appropriate preventive treatment. Inability to afford treatments and or medications due to immigrant status. – Community/Business Leader*

Addiction

- Major treatment is pain medication, which is highly addictive. – Healthcare Provider*

Hearing Impairment

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

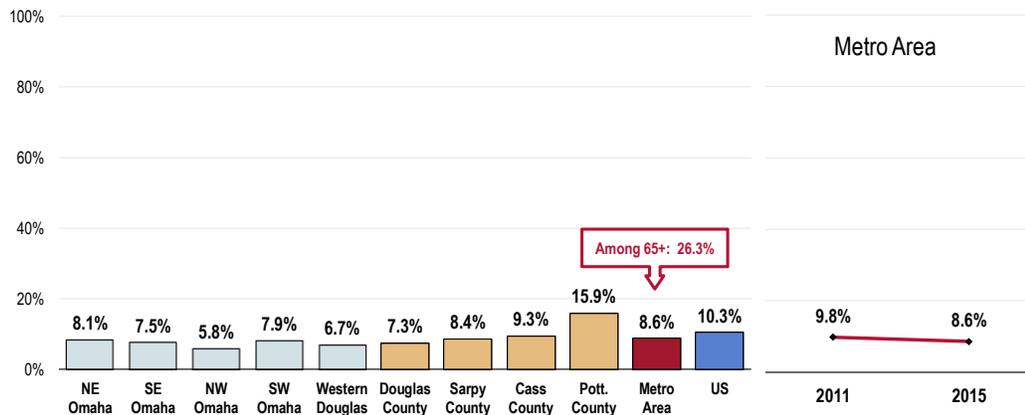
As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

- Healthy People 2020 (www.healthypeople.gov)

In all, 8.6% of Metro Area adults report being deaf or having difficulty hearing.

- Similar to that found nationwide.
- Unfavorably high in Pottawattamie County.
- Similar findings by Douglas County subarea.
- TREND: Unchanged over time.
- Among Metro Area adults age 65 and older, 26.3% have partial or complete hearing loss.

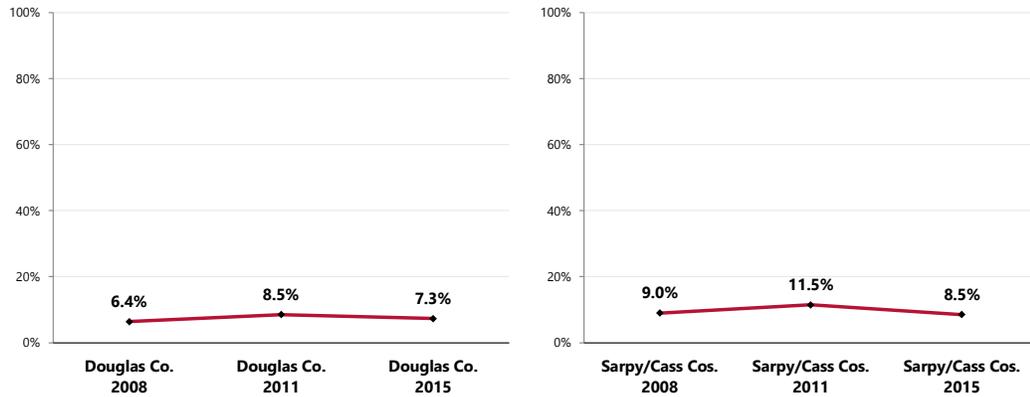
Prevalence of Deafness/Trouble Hearing



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 27]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: The prevalence is unchanged over time in Douglas and Sarpy/Cass counties.

Prevalence of Deafness/Trouble Hearing



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 27]
 Notes: • Asked of all respondents.

Key Informant Input: Vision & Hearing

The greatest share of key informants taking part in an online survey characterized *Vision & Hearing* as a “minor problem” in the community.

Perceptions of Hearing and Vision as a Problem in the Community

(Key Informants, 2015)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Access to Resources

Inability to access services due to immigrant status, inability to afford devices. – Community/Business Leader

Lack of providers to see patients at a discounted rate. Lack of free screenings. – Healthcare Provider

Although there is mandatory testing for hearing in newborns, there is not much assistance for helping with the purchase of hearing aids. Also interpretive services is a challenge to get in the clinic setting. – Physician

Not covered by insurance, many people not covered by insurance, glasses broken or not covered. – Public Health Representative

For those with no insurance or funding it is almost impossible to get hearing aids and eyewear. No place to get testing let alone treatment. This has had a huge impact on their functioning and participation in our community as well as being successful. – Healthcare Provider

Co-occurring Morbidities

Complication of diabetes. – Community/Business Leader

Infectious Disease



Professional Research Consultants, Inc.

HIV

About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

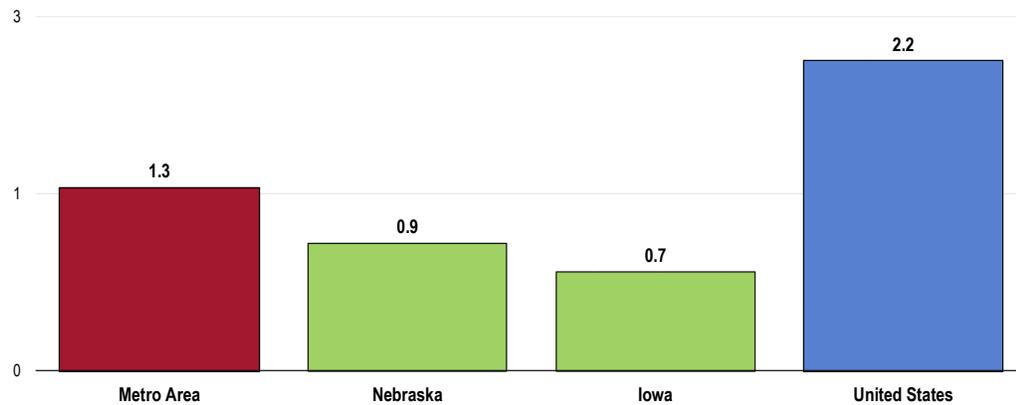
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted HIV/AIDS Deaths

Between 2011 and 2013, there was an annual average age-adjusted HIV/AIDS mortality rate of 1.3 deaths per 100,000 population in the Metro Area.

- Worse than both statewide rates
- Better than the rate reported nationally.
- Satisfies the Healthy People 2020 target (3.3 or lower).

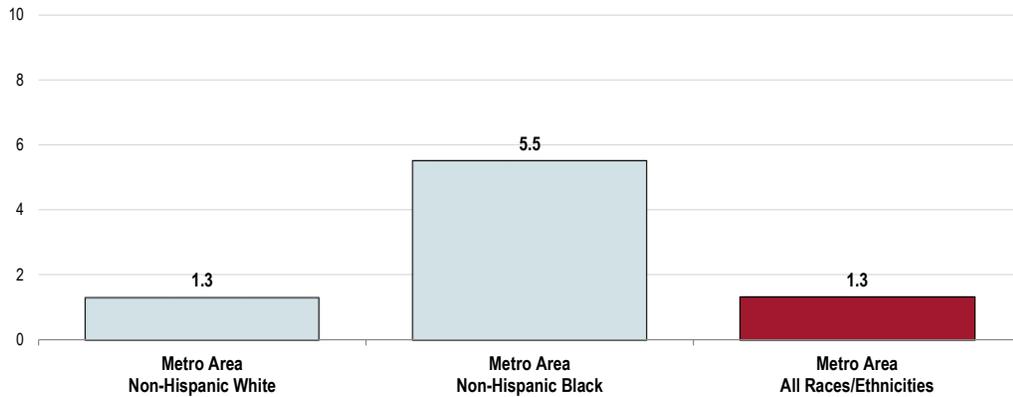
HIV/AIDS: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 3.3 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The HIV mortality rate among Blacks is more than 4 times as high as that reported among Whites in the Metro Area.

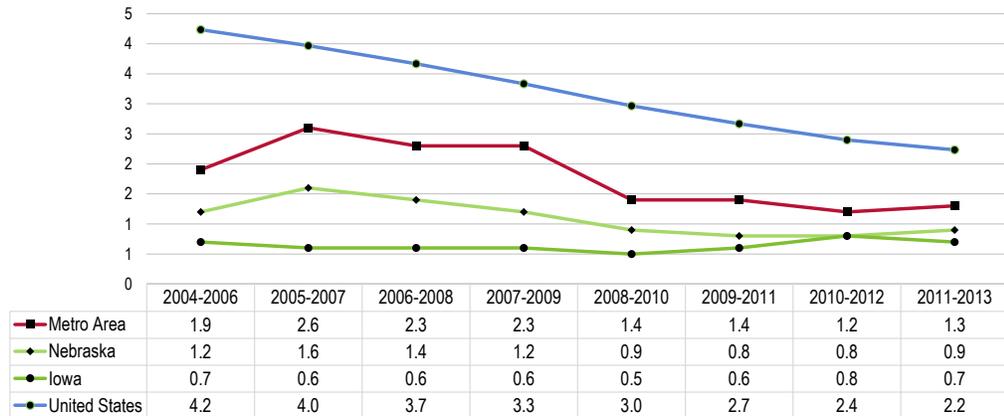
HIV/AIDS: Age-Adjusted Mortality by Race (2004-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 3.3 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- **TREND:** HIV/AIDS mortality decreased over the past decade in the Metro Area and in Nebraska and the US overall.

HIV/AIDS: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 3.3 or Lower

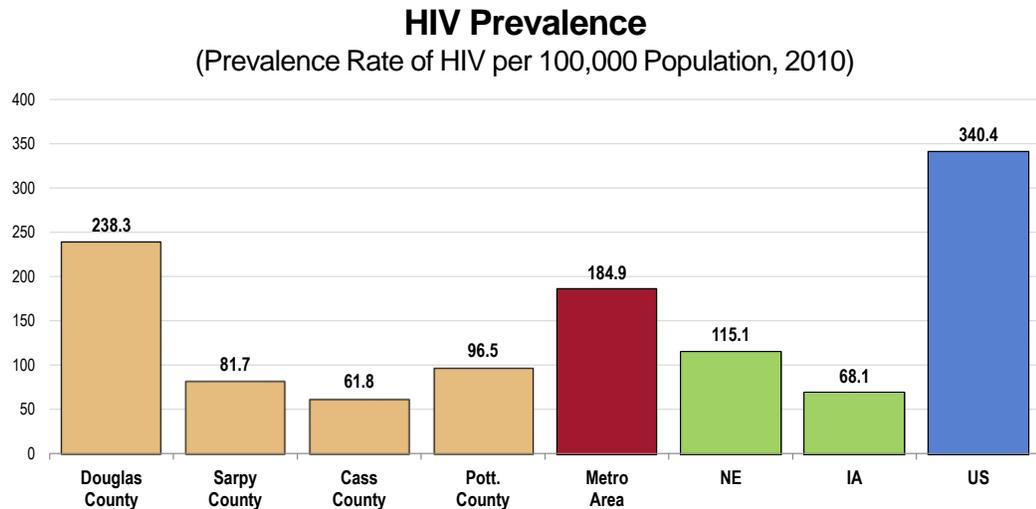


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - State and national data are simple three-year averages.

HIV Prevalence

In 2010, there was a prevalence of 184.9 HIV cases per 100,000 population in the Metro Area.

- Much less favorable than the statewide prevalence rates.
- Much more favorable than the national prevalence.
- Favorably low in Sarpy and Cass counties.

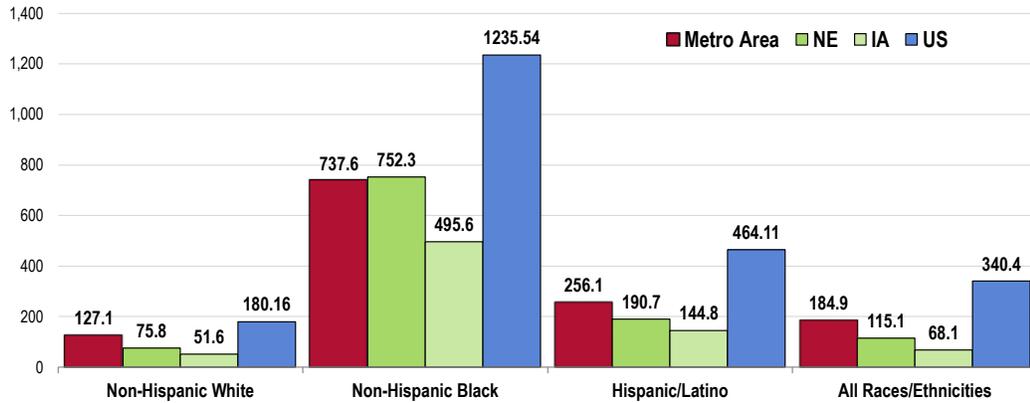


Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.
• Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Notes: • This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

- By race and ethnicity, HIV/AIDS prevalence in the Metro Area is particularly high among Blacks, although to a lesser degree than found across Iowa or nationally.

HIV Prevalence Rate by Race/Ethnicity (Prevalence Rate of HIV per 100,000 Population, 2010)



Sources:

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.
- Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Notes:

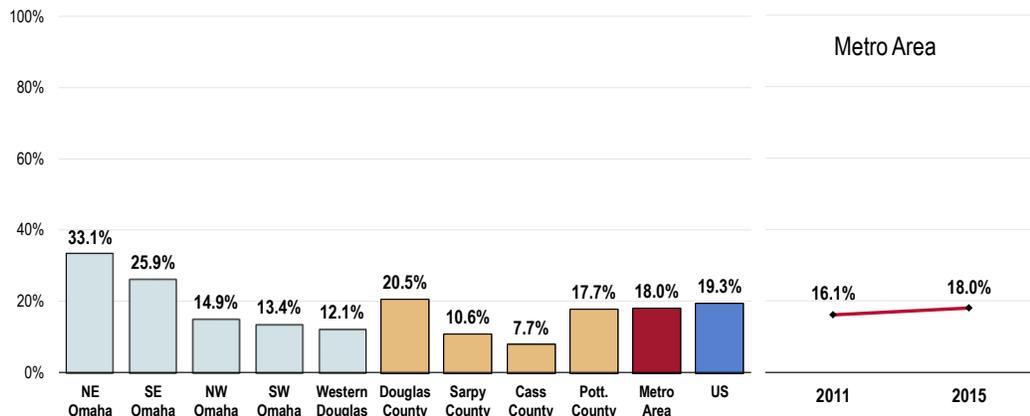
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

Among Metro Area adults age 18-44, 18.0% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Comparable to the proportion found nationwide.
- Relatively low in Sarpy and Cass counties.
- Testing prevalence is highest in eastern Omaha.
- TREND: Testing has remained stable since 2011.

Tested for HIV in the Past Year (Among Adults Age 18-44)



Sources:

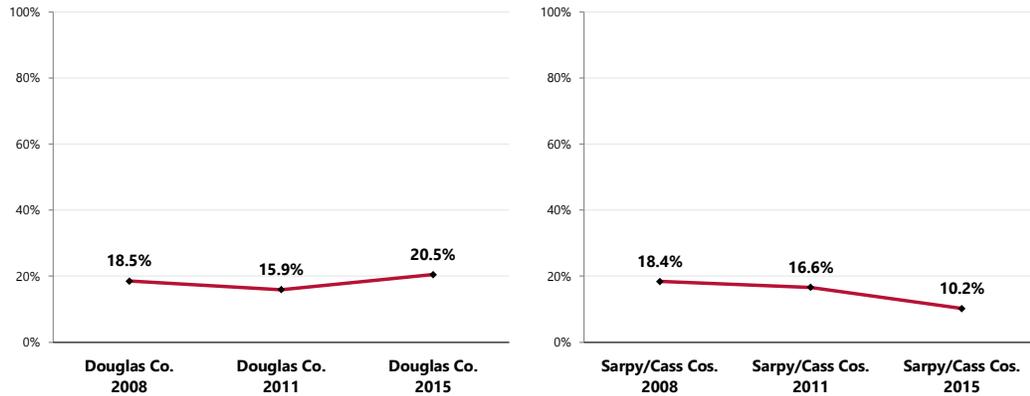
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 145]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:

- Reflects respondents age 18 to 44.

- **TREND:** The testing prevalence has remained stable in Douglas and Sarpy/Cass counties.

Tested for HIV in the Past Year (Among Adults Age 18-44)

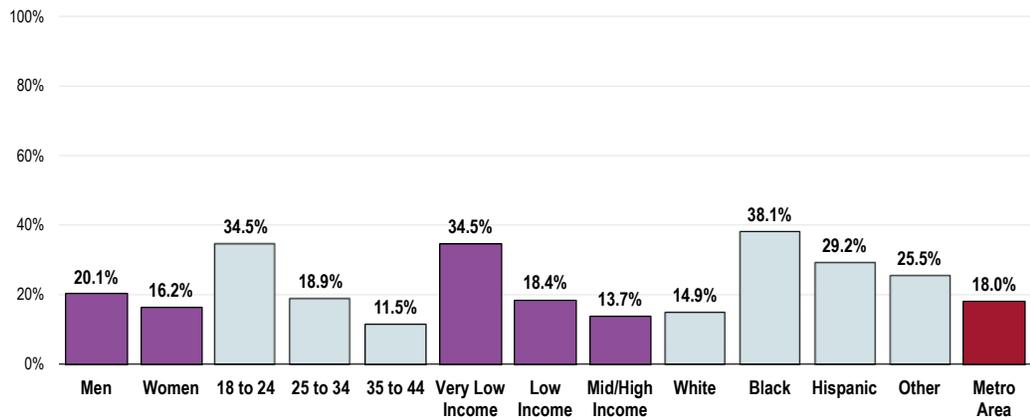


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 145]
 Notes: • Reflects respondents age 18 to 44.

These populations are more likely to have been tested:

- Men.
- Young adults (negative correlation with age).
- Lower-income residents (negative correlation with income).
- Blacks, Hispanics, and Other adults.

Tested for HIV in the Past Year (Among Adults Age 18-44)

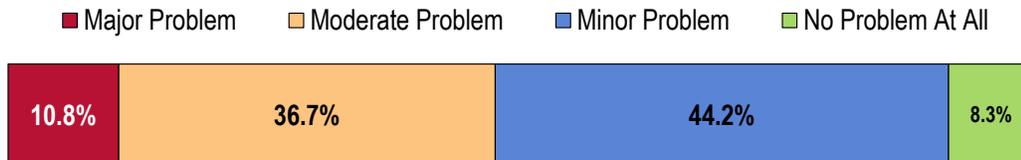


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 145]
 Notes: • Reflects respondents age 18 to 44.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: HIV/AIDS

The largest share of key informants taking part in an online survey characterized *HIV/AIDS* as a “minor problem” in the community.

Perceptions of HIV/AIDS as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

High Rate of Occurrence

- Statistics indicate HIV/AIDS is prevalent among AA women. – Social Service Provider*
- Because there are a disproportionate number of African women infected with HIV and the major agencies are not addressing this problem. This disease directly affects the families health in our community and services are not readily available. – Social Service Provider*
- I don't know the stats, I believe North Omaha has a high number of people living with HIV/AIDS. – Healthcare Provider*
- The rate per 1,000 population seems high. – Social Service Provider*
- High STD rates in Omaha. – Social Service Provider*
- Included in STDs and we are above national average, especially for African Americans. – Community/Business Leader*

Associated Issues

- HIV/AIDS contributes to housing instability and the incidence of homelessness. – Social Service Provider*
- Stigma, lack of specialists, medications are extremely expensive, more and more people 15-25 are being infected due to lack of testing and understanding of how HIV is transmitted. – Healthcare Provider*
- Creates significant hardships for those directly and indirectly impacted. Health decreases, impacts availability and ability of person to provide for their families, parent, etc. Cost of healthcare for patients is extremely high. Social stigma still. – Social Service Provider*

Unprotected Sex

- People, youth and young adults fail to be tested. Continued failure to use contraception. – Community/Business Leader*
- Unprotected sex and high percentage of STD in Douglas County. – Healthcare Provider*

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

In 2012, the chlamydia incidence rate in the Metro Area was 505.0 cases per 100,000 population.

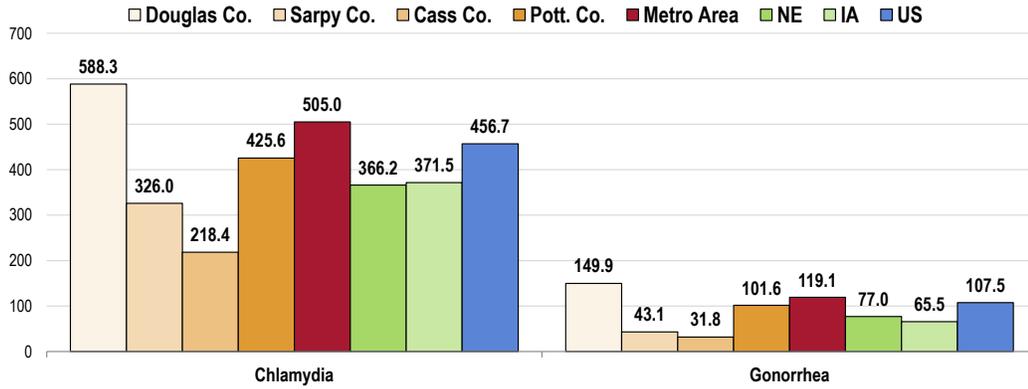
- Notably higher than the Nebraska and Iowa incidence rates.
- Notably higher than the national incidence rate.
- Unfavorably high in Douglas and Pottawattamie counties.

The gonorrhea incidence rate in the Metro Area was 119.1 cases per 100,000 population in 2012.

- Notably higher than the Nebraska and Iowa incidence rates.

- Notably higher than the national incidence rate.
- Unfavorably high in Douglas and Pottawattamie counties.

Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2012)



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2012.
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

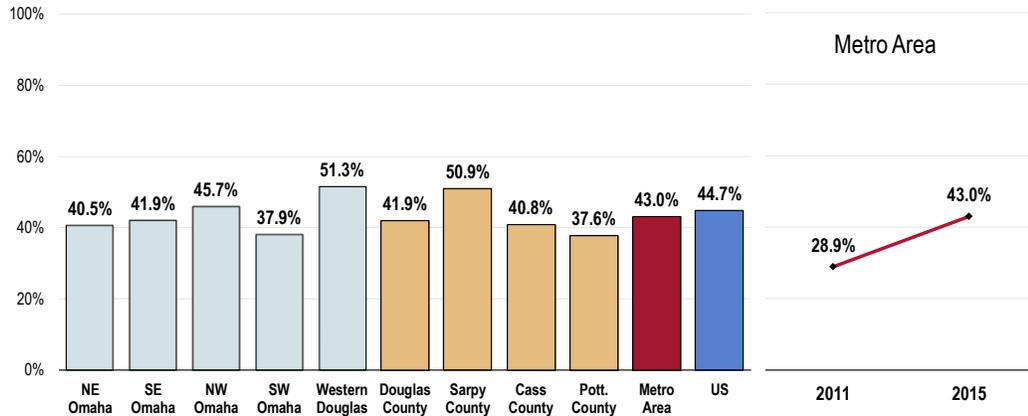
Hepatitis B Vaccination

Based on survey data, just over 4 in 10 Metro Area adults (43.0%) report having received the hepatitis B vaccination series.

Respondents were told that, to be vaccinated against hepatitis B, a series of three shots must be administered, usually at least one month between shots. They were then asked if they had completed this vaccination series.

- Similar to what is reported nationwide.
- Lowest in Pottawattamie County.
- Favorably high in Western Douglas County.
- TREND: Note the statistically significant increase over time in the Metro Area.

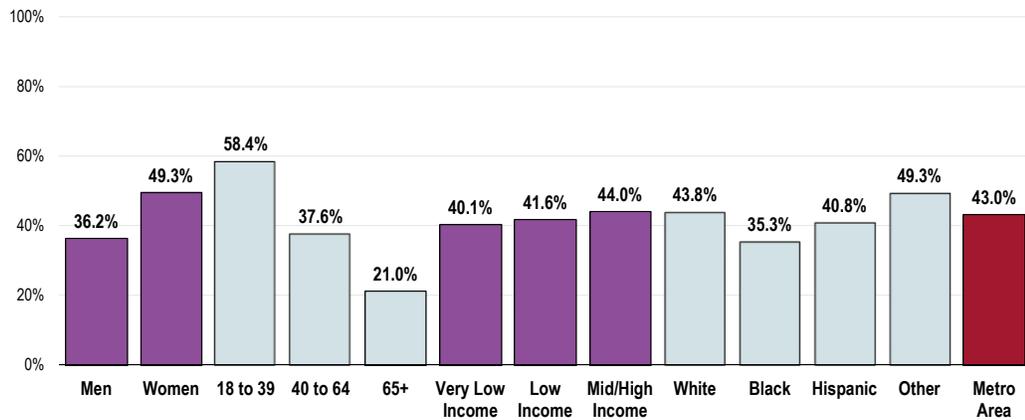
Have Completed the Hepatitis B Vaccination Series



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 70]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • Includes a series of three shots, usually administered at least one month between shots.

- Note the negative correlation between age and hepatitis B vaccination.
- In addition, men, Blacks, and Hispanics are much less likely to have received the hepatitis B vaccine.

Have Completed the Hepatitis B Vaccination Series (Metro Area, 2015)



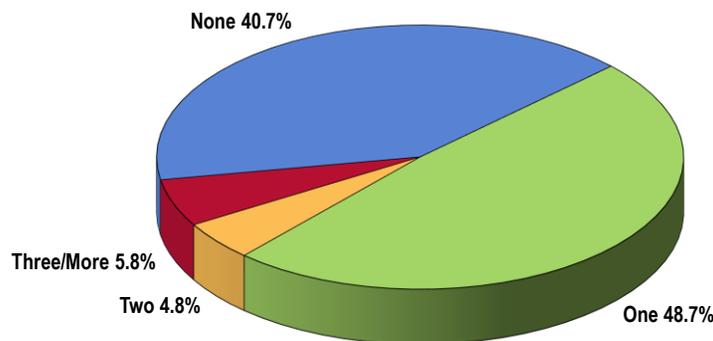
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 70]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Safe Sexual Practices

Sexual Partners

Among unmarried Metro Area adults under 65, the vast majority cites having one (48.7%) or no (40.7%) sexual partners in the past 12 months.

Number of Sexual Partners in Past 12 Months (Among Unmarried Adults Age 18-64; Metro Area, 2015)

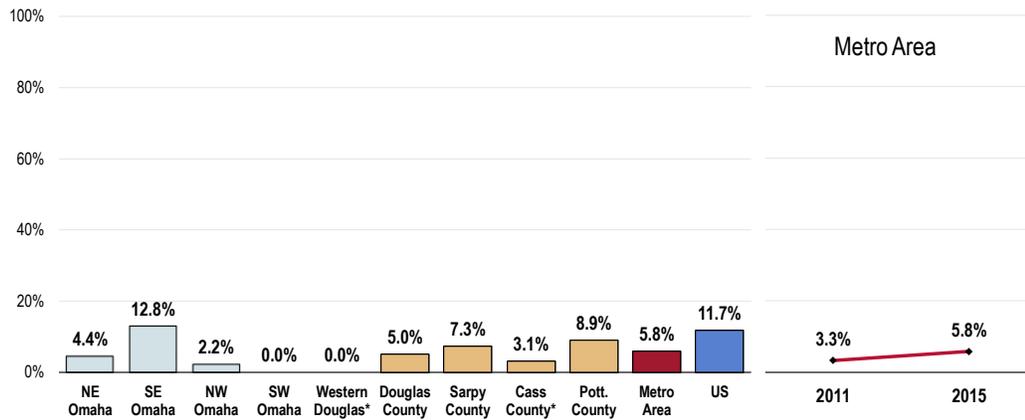


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
 Notes: • Asked of all unmarried respondents under the age of 65.

However, 5.8% report three or more sexual partners in the past year.

- Half the percentage reported nationally.
- Similar findings by county.
- Unfavorably high in Southeast Omaha.
- TREND: Marks a statistically significant increase since 2011.

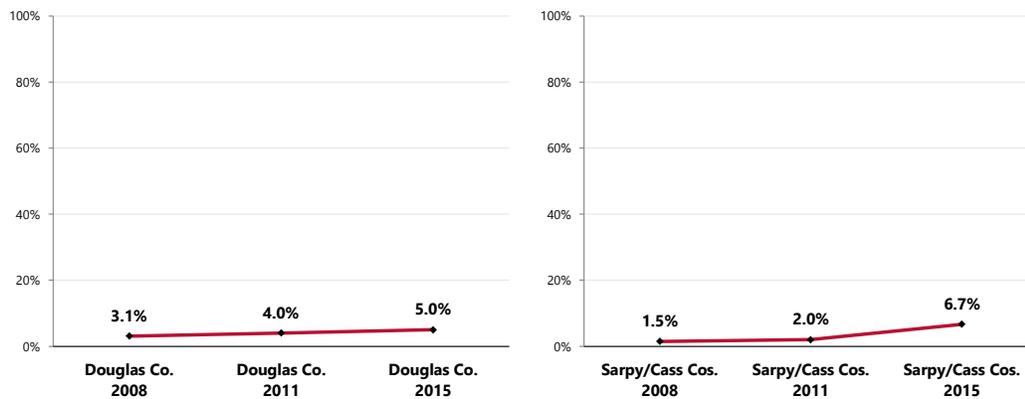
Had Three or More Sexual Partners in the Past Year (Among Unmarried Adults Age 18-64)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 86]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all unmarried respondents under the age of 65.
 • *Use caution when interpreting these percentage results as the sample size falls below 50.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Had Three or More Sexual Partners in the Past Year (Among Unmarried Adults Age 18-64)

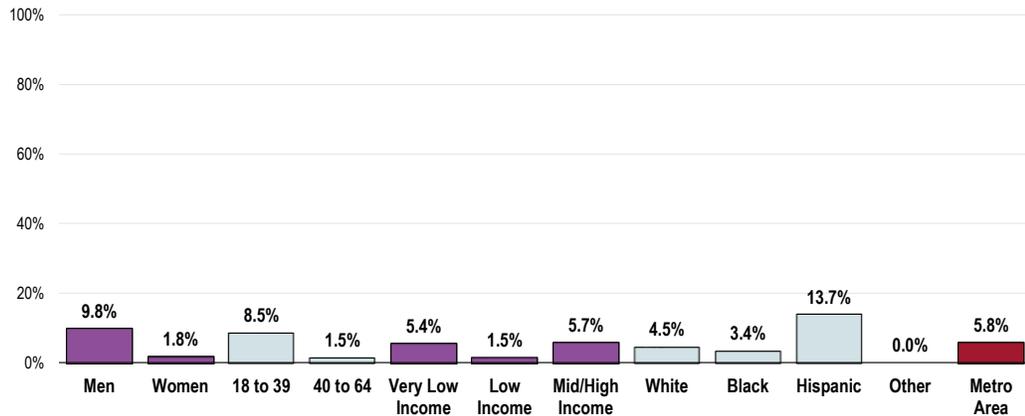


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 86]
 Notes: • Asked of all unmarried respondents under the age of 65.

Unmarried respondents (age 18 to 64) more likely to report three or more sexual partners in the past year include:

- Men.
- Residents age 18 to 39.
- Those at either end of the income spectrum.
- Hispanics.

Had Three or More Sexual Partners in the Past Year (Among Unmarried Adults Age 18-64; Metro Area, 2015)



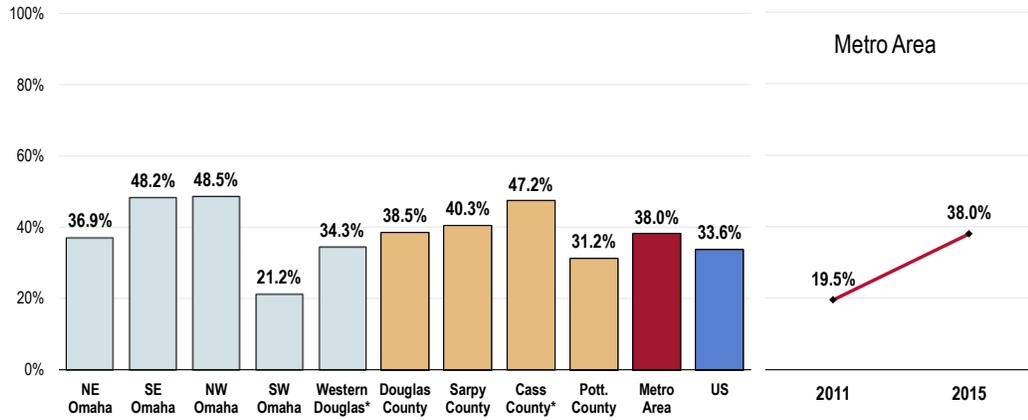
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
 Notes: • Asked of all unmarried respondents under the age of 65.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Condom Use

Among Metro Area adults who are under age 65 and unmarried, 38.0% report that a condom was used during their last sexual intercourse.

- Statistically similar to national findings.
- Similar findings by county in the Metro Area.
- In Douglas County, lowest in Southwest Omaha.
- TREND: Marks a statistically significant increase over time in the Metro Area.

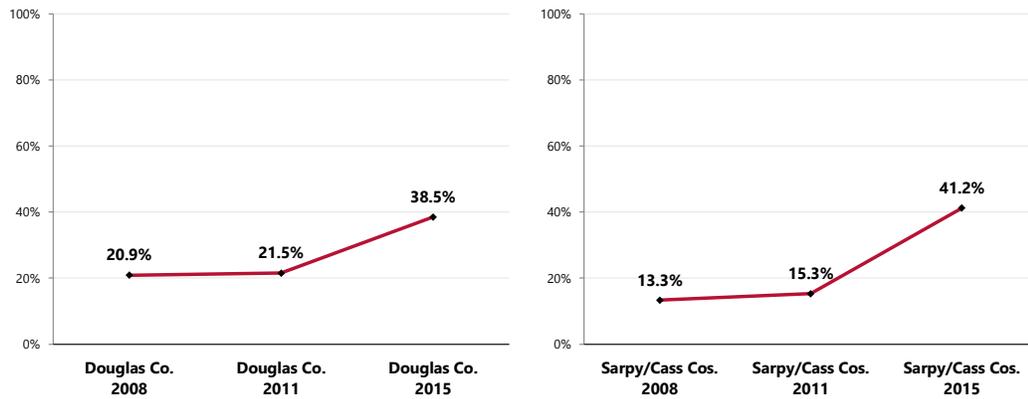
Condom Was Used During Last Sexual Intercourse (Among Unmarried Adults Age 18-64)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 87]
 ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: ● Asked of all unmarried respondents under the age of 65.
 ● *Use caution when interpreting these percentage results as the sample size falls below 50.

- **TREND:** The prevalence of reported condom use has increased significantly in Douglas and Sarpy/Cass counties.

Condom Was Used During Last Sexual Intercourse (Among Unmarried Adults Age 18-64)

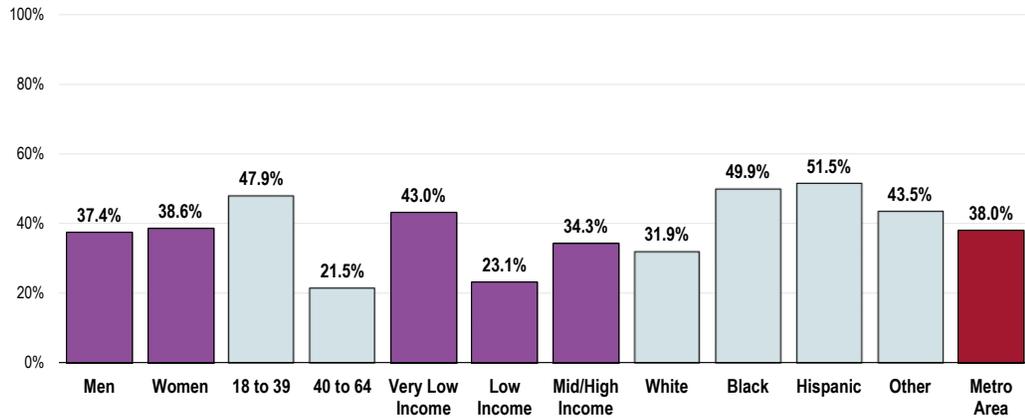


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 87]
 Notes: ● Asked of all unmarried respondents under the age of 65.

Those less likely to report that a condom was used during their last sexual intercourse include:

- Residents age 40 through 64.
- Respondents with higher incomes.
- Whites.

Condom Was Used During Last Sexual Intercourse (Among Unmarried Adults Age 18-64; Metro Area, 2015)

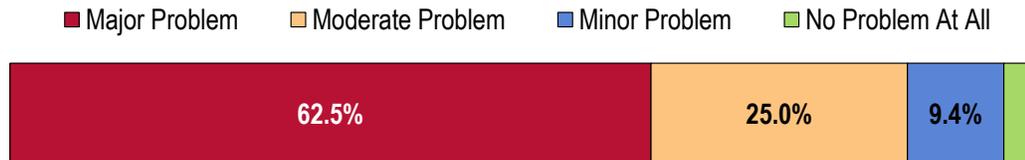


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 87]
 Notes: • Asked of all unmarried respondents under the age of 65.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Sexually Transmitted Diseases

Most key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a "major problem" in the community.

Perceptions of Sexually Transmitted Diseases as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

High Rate of STD Occurrence

Douglas County consistently has high STD rates. Likely due to low health literacy, small dating pools, and lack of access to preventative measures and education. – Community/Business Leader

Nationally this area is documented as having the highest sexually transmitted disease numbers in the country. – Healthcare Provider

Stats on number of STDs in Pottawattamie County and Douglas County (just across river). – Public Health Representative

Statistics for Douglas County. – Social Service Provider

Omaha has one of the highest rates in the United States. – Community/Business Leader

STD rates remain well above state and national averages and little has been successful in leading to change. – Public Health Representative

DC Health Department statistics billboards/PSA's. – Social Service Provider

Reading the statistics. – Community/Business Leader

STDs in Douglas County are extremely high. Lack of education with risky behavior and the potential consequences. Healthcare costs. – Social Service Provider

See HIV/AIDS. – Healthcare Provider

Same as previous question about HIV. – Social Service Provider

We have a high rate of STDs in our community. A main concern is that parents do not want to talk to their children about STDs. – Social Service Provider

High levels of STD in our population. – Healthcare Provider

High STD rates in Omaha area. – Social Service Provider

Prevalence and incidence greater than national average. – Community/Business Leader

Statistics. Health disparities issue. – Public Health Representative

Omaha has twice the national average of STD rates. It is at epidemic proportions and left untreated can cause serious damage, especially to women. – Healthcare Provider

Highest in the nation for certain sexually transmitted diseases, especially in under age 20 population. – Social Service Provider

We have one of the highest rates of STDs among teens in the country. – Community/Business Leader

Our rates are off the chart. – Social Service Provider

Douglas county has the highest STDs. – Social Service Provider

Douglas Country ranked highest for STD rate. – Healthcare Provider

We have some of the highest rates on newly infected people in the nation. – Social Service Provider

STD rates are extremely high. – Social Service Provider

The rates speak for themselves, three zip codes that make up the greatest part of North Omaha (68104, 68111, 68110) have the highest STD rates in the state of Nebraska, yet we have the least amount of agencies to offer affordable screening and treatment. – Social Service Provider

Douglas County has one of the highest rates of chlamydia and gonorrhea in the country. – Healthcare Provider

They are reported to be at epidemic levels. – Community/Business Leader

Above average for African Americans. – Community/Business Leader

Douglas County has some of the highest rates of chlamydia in the country. It is not that uncommon to encounter someone with syphilis here. I regularly encounter people who do not understand that STDs can be spread with oral sex. HIV and Hepatitis C. – Physician

The statistical data from DCHD. – Healthcare Provider

Douglas County has some of the highest rates of chlamydia and gonorrhea in the state and country. I am not sure how much this is discussed in primary care OB/GYN offices. – Social Service Provider

Still high percentage of teens with STDs. – Social Service Provider

Teens increase with sexual activity at a younger age. – Social Service Provider

Highest rate of STI in teens and young adults. Community very conservative and does not address opening sex, no sex education in schools. – Public Health Representative

Data demonstrates Douglas County has some of the highest STD rates in the country. – Social Service Provider

Douglas County has very high rates of STDs compared not only to the rest of NE but to the country as a whole. – Physician

I believe we have close to the highest rate or chlamydia in the nation. – Physician

The rates of chlamydia and gonorrhea are above the national average and above the state of

Nebraska average. Testing and treatment is not easily accessible and physicians are not doing uniform testing. Schools and many parents are reluctant to talk about this. – Public Health Representative

The higher than national average for chlamydia and gonorrhea. – Community/Business Leader

Very high rate of sexually transmitted diseases, especially chlamydia in the metro area. – Community/Business Leader

Lack of Education

Lack of community education, high rate of communicable diseases according to CDE and public health. – Healthcare Provider

Lack of awareness and knowledge about extent of the problem and lack of education regarding transmission/prevention. – Social Service Provider

Lack of education related to STDs. – Healthcare Provider

Lack of education, high rates of STDs in our community. – Social Service Provider

Our chlamydia and gonorrhea rates have been much higher than state and national rates since 1998. – Public Health Representative

Wow! There is so much resistance to sex education in our community! - Community/Business Leader

People are having unprotected sex. Young adults do not think it will happen to them and don't connect STD with protection. – Healthcare Provider

Most people express to me that they do not see the importance of prevention. – Healthcare Provider

Lack of education on cultural beliefs/myths. – Community/Business Leader

Lack of skills, comfort and knowledge among adults to address the issue with their children. Stigma prevents screening/diagnosis. Lack of navigation skills and access to services. Problem is primarily among teens and young adults, their brains work differently. – Social Service Provider

Unprotected sex. – Social Service Provider

I think sexually transmitted diseases are a major problem in many communities. Mostly due to a lack of education and prevention. HPV is also on the rise. – Social Service Provider

Inadequate sexual education at home and school regarding STDs. – Healthcare Provider

Number one in the US, limited school education, limited community resources applied. – Healthcare Provider

Increased STDs, little education in middle schools and high schools. – Healthcare Provider

Associated Issues

It is a major issue affecting those living in poverty and those who are homeless. – Social Service Provider

Major problem with STDs with special focus in minority communities. Lack of community response to address the issue. – Social Service Provider

I think that it is a behavior that is culturally infused. – Social Service Provider

No parenting, no family values, no discipline. – Community/Business Leader

I feel there is a great stigma surrounding STDs for the age group in which the number of cases is largest, those between 16 and 30 years of age. A lack of education as to what STDs are and how they are contracted contributes to our numbers also. – Healthcare Provider

They are being passed back and forth. – Community/Business Leader

Younger Population

Increased infections in persons age 15 to 25. – Healthcare Provider

Too much in 15-24 year olds. Youth do not understand the consequences of the disease and too few are getting screened and treated. The resurgence of syphilis is frightening. Youth do not understand the significance of having diseases. – Public Health Representative

Children are becoming sexually active younger and younger and are not educated or do not feel comfortable accessing care and precautions for avoiding disease. – Social Service Provider

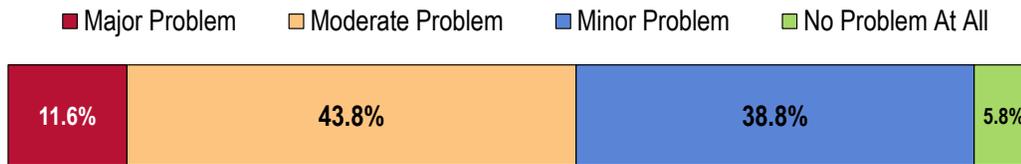
Early sexual activity by teens. – Social Service Provider

Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

A plurality of key informants taking part in an online survey characterized *Immunization & Infectious Diseases* as a “moderate problem” in the community.

Perceptions of Immunization and Infectious Diseases as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Education

There have been cases of outbreaks of infectious diseases in our community that are preventable with immunizations. We also take for granted that TB is not common here in Omaha, but with the influx of more immigrants, better infrastructure and training. – Physician

Young mothers misunderstand the importance of immunizations for their children. – Community/Business Leader

More people ages 15-25 are being infected; lack of education and understanding of risk factors/behaviors to include prevention, testing, and treatment. Specific populations at risk are African American and Latino groups. – Healthcare Provider

Cultural Beliefs

Infectious disease as it relates to STDs reveal high rates among African Americans residing in Omaha. – Social Service Provider

Cultural beliefs. – Community/Business Leader

Spread of the diseases. Impact to family structures and community structures. Cost of care. – Social Service Provider

Individuals opposed to vaccinations present a social barrier. – Social Service Provider

Access to Care

Access and affordability for low income families. – Community/Business Leader

MRSA VRE and other super bugs are being diagnosed and becoming barriers for patients to get treatments. Placements in communities are denying people due to having these diagnoses. – Healthcare Provider

Lack of Immunizations

Too many babies are not being immunized. – Community/Business Leader

Births



Professional Research Consultants, Inc.

Prenatal Care

About Infant & Child Health

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

Early and continuous prenatal care is the best assurance of infant health.

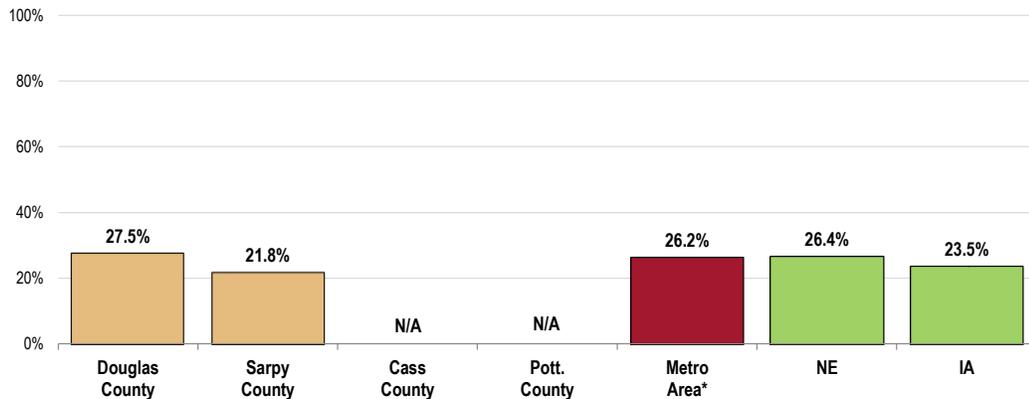
Between 2011 and 2013, 26.2% of all Metro Area births did not receive prenatal care in the first trimester of pregnancy (note that this only includes data for Douglas and Sarpy counties, as counts were too low to be calculated in Cass and Pottawattamie counties).

- Similar to the Nebraska proportion but higher than Iowa.
- Fails to satisfy the Healthy People 2020 target (22.1% or lower).
- Higher in Douglas County than in Sarpy County.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2011-2013)

Healthy People 2020 Target = 22.1% or Lower



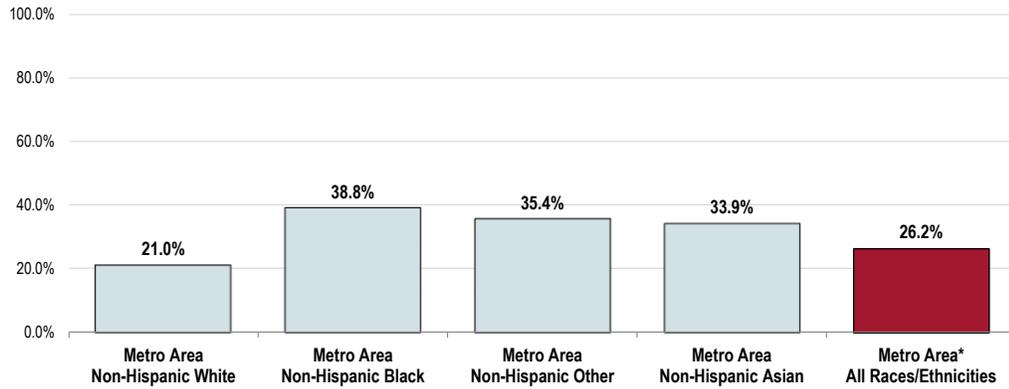
- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage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

- Lack of prenatal care is notably more prevalent among Blacks, Others, and Asians.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2011-2013)

Healthy People 2020 Target = 22.1% or Lower



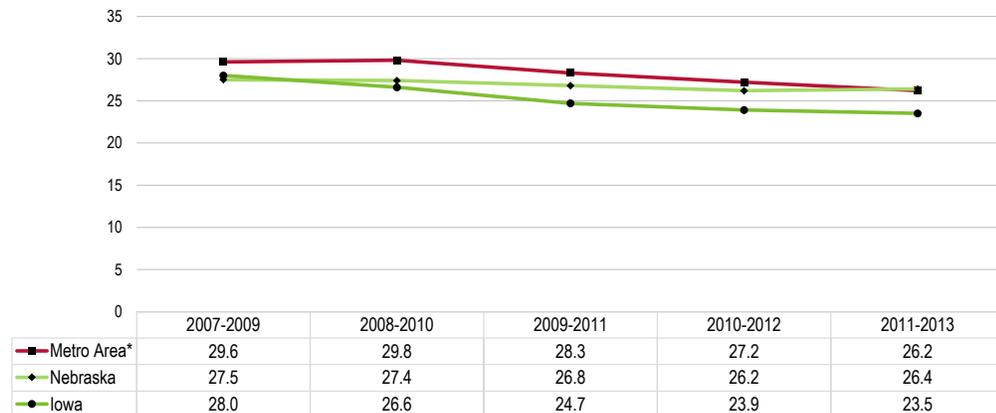
- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
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 - *Does not include Cass or Pottawattamie counties, for which birth counts were too low for calculations.

- TREND: Receipt of prenatal care has improved overall in the Metro Area, echoing recent trends reported in Nebraska and Iowa.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2011-2013)

Healthy People 2020 Target = 22.1% or Lower



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

Birth Outcomes & Risks

Low-Weight Births

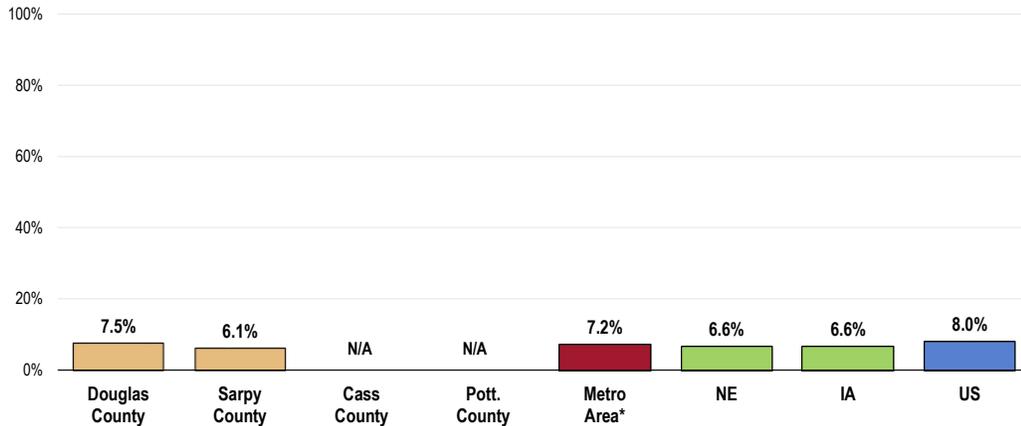
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

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

A total of 7.2% of 2011-2013 Metro Area (Douglas/Sarpy counties only) births were low-weight.

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

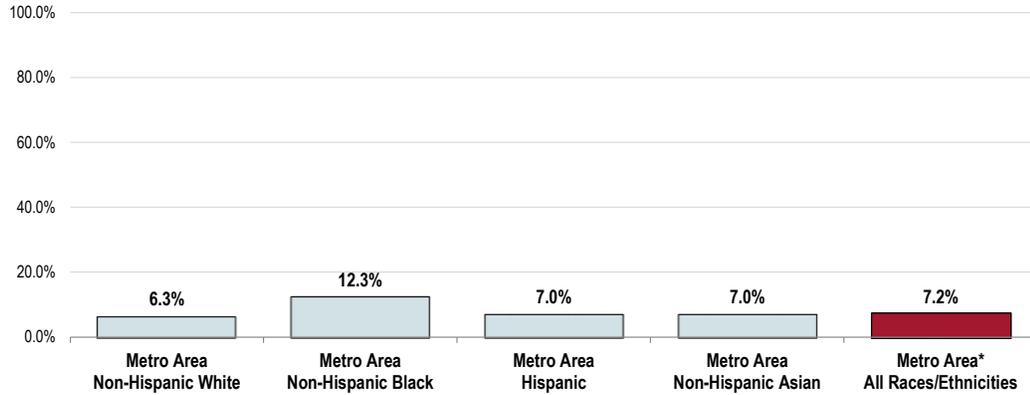
Low-Weight Births
(Percent of Live Births, 2011-2013)
Healthy People 2020 Target = 7.8% or Lower



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

- Low-weight births are more prevalent among Blacks in the area.

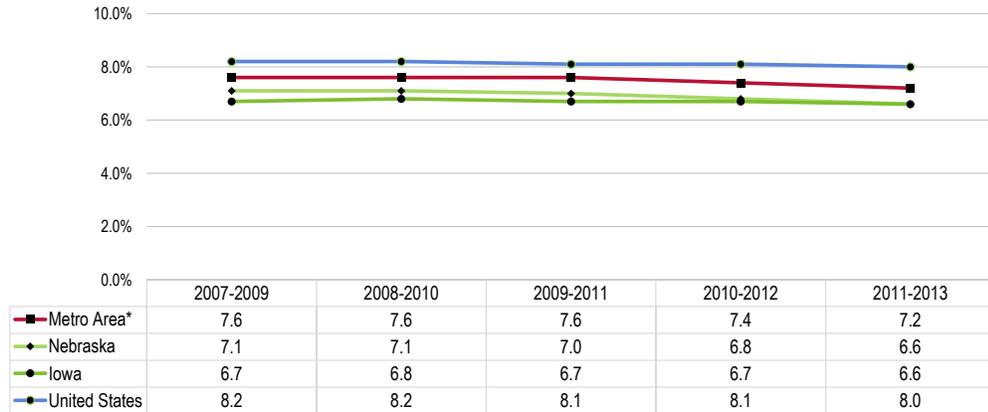
Low-Weight Births by Race/Ethnicity (Percent of Live Births, 2011-2013) Healthy People 2020 Target = 7.8% or Lower



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

• **TREND:** The proportion of low-weight births has decreased in the region in recent years.

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



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

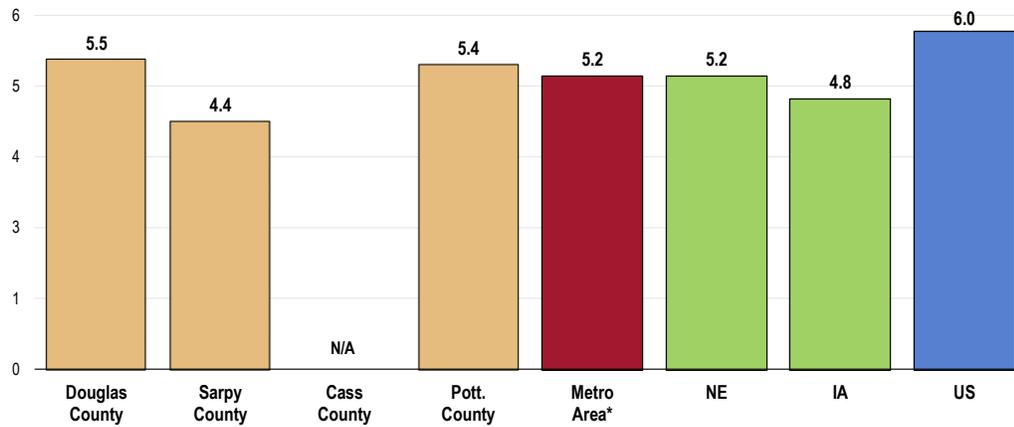
Infant Mortality

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

Between 2011 and 2013, there was an annual average of 5.2 infant deaths per 1,000 live births.

- Identical to the Nebraska rate, worse than the Iowa rate.
- Better than the national rate.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.
- Favorably low in Sarpy County.

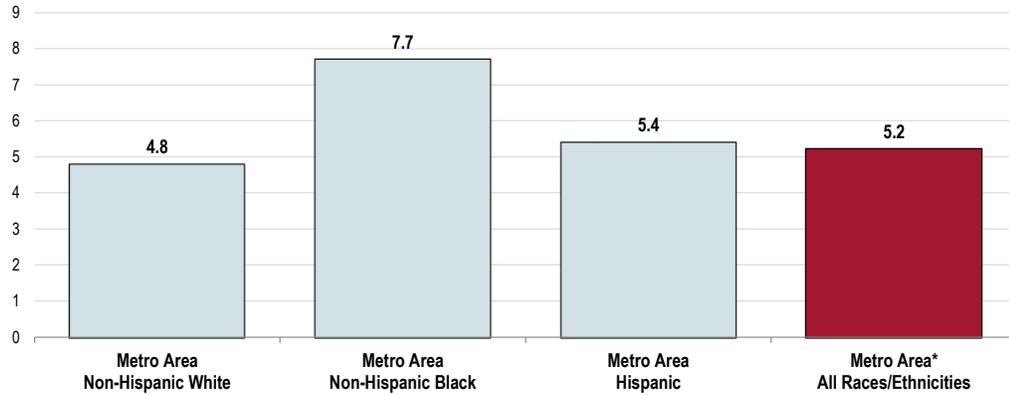
Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2011-2013)
Healthy People 2020 Target = 6.0 or Lower



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Infant deaths include deaths of children under 1 year old.
 - This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.
 - *Does not include Cass County, for which birth counts were too low for calculations.

- The infant mortality rate is notably higher among births to Black mothers in the area.

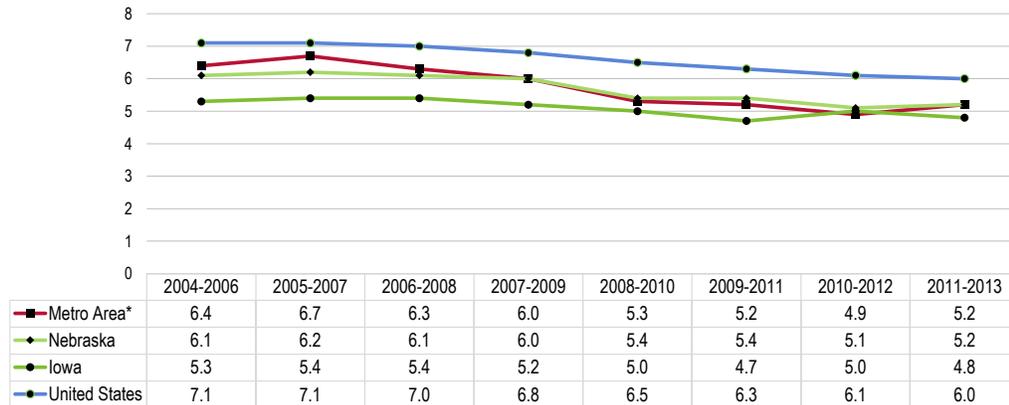
Infant Mortality by Race/Ethnicity (Annual Average Infant Deaths per 1,000 Live Births, 2011-2013) Healthy People 2020 Target = 6.0 or Lower



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Infant deaths include deaths of children under 1 year old.
 - This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.
 - *Does not include Cass County, for which birth counts were too low for calculations.

- TREND: Infant mortality decreased over the past decade.

Infant Mortality Rate (Annual Average Infant Deaths per 1,000 Live Births) Healthy People 2020 Target = 6.0 or Lower



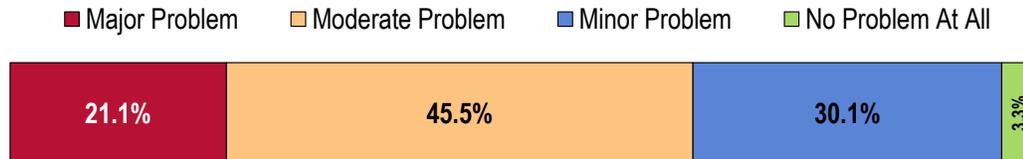
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
 - Centers for Disease Control and Prevention, National Center for Health Statistics.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.
 - *Does not include Cass County, for which birth counts were too low for calculations.

Key Informant Input: Infant & Child Health

Key informants taking part in an online survey generally characterized *Infant & Child Health* as a “moderate problem” in the community.

Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Infant Mortality

The infant mortality rate is again disproportionate to that of other communities in Omaha. – Social Service Provider

We have high infant mortality rates and many children living in poverty, so there are issues with infant and child health. – Community/Business Leader

Infant mortality among babies born to AA women is nearly three times that of their white counterparts. – Social Service Provider

Infant deaths have slowed down over the past years but immunizations and lead exposure still need to be addressed. There are high levels of lead in many low income parents which put many infants at risk. – Social Service Provider

Though infant mortality rates have fallen, a health disparity still exists and too many African American pregnancies end in either death or disability. Though access to healthcare is key, reducing racism and addressing risk factors early and often are necessary. – Public Health Representative

Infant mortality still reflects a health disparity despite great progress that has been made in our community. – Public Health Representative

Access to Care

Access and affordability for early childhood health and wellbeing is essential to our success as a community. Quality childcare, health and mental health services for infants and children continues to be out of reach for low income families. – Community/Business Leader

Prenatal care is hard to access for women who are poor or non-documented. Also, access to early child care is difficult to access for the same reasons as well as geography since most designated child care clinics and hospitals are west of 72nd Street. – Social Service Provider

Continued health concerns which result from poverty, low income not having access and adequate care for young children. – Social Service Provider

I think education and lifestyle are factors. Uninsured and underinsured have access to care issues, including prenatal care. – Social Service Provider

I have a lot of children who have young parents with limited resources. Many of these families are single-parent families. If the families don't qualify for Medicaid or if for some reason they lose their Medicaid coverage the children do without. – Physician

Socioeconomic Factors

Obesity issues with children from a very early age. Concerns about poverty and lack of appropriate nutrition and healthy food in general. Lack of education about healthy eating habits and proper physical activity (exercise). Lack of parenting skills. – Social Service Provider

Lack of education on cultural beliefs and values. Inability to afford healthy food. – Community/Business Leader

Ensuring the health of women and children in a community is crucial for good health and economic standing of the entire community. In Omaha, there are significant disparities in the health outcomes between whites and blacks. This divide continues to widen. – Physician

Increase with immigrant population here in Nebraska over past 5-10 years. Newly immigrated families do not understand how to navigate our health systems. School based health centers have improved healthcare access instead of clinics. – Healthcare Provider

Teen Pregnancy

Professional experience in this area, number of teenage pregnancies. – Public Health Representative

Maternal Mortality

Maternal mortality is high in this area. – Social Service Provider

Family Planning

Births to Teen Mothers

About Teen Births

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

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

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

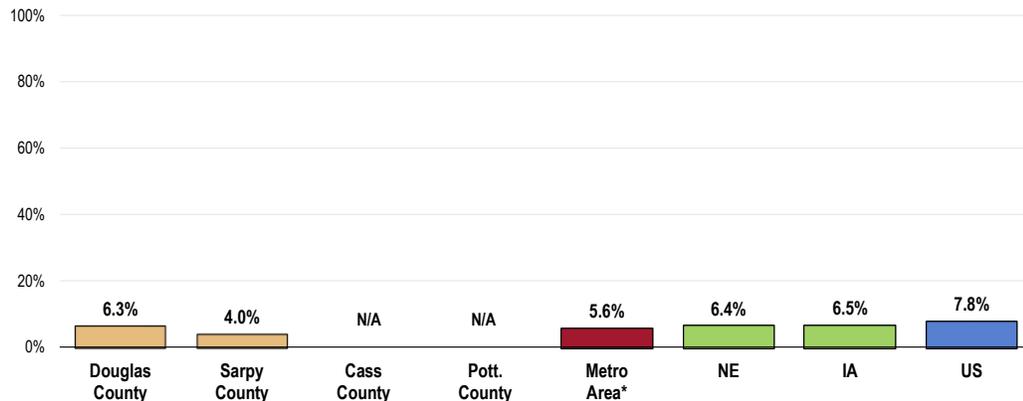
- Healthy People 2020 (www.healthypeople.gov)

Between 2011 and 2013, 5.6% of live births were to females under the age of 20 in the Metro Area (Douglas and Sarpy counties only).

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

Births to Teen Mothers (Under 20)

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



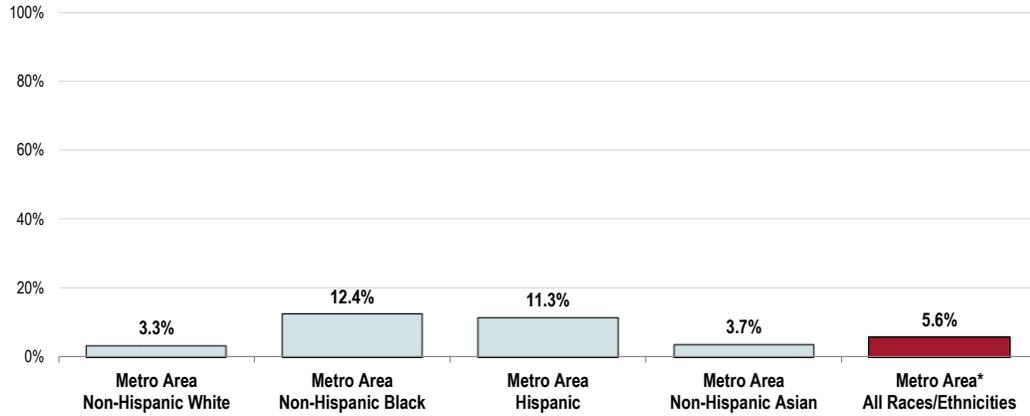
Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.

Note: • Numbers are a percentage of all live births within each population.

- *Does not include Cass or Pottawattamie counties, for which birth counts were too low for calculations.

- By race and ethnicity, Blacks and Hispanics/Latinas exhibit the highest percentage of teen births in the area.

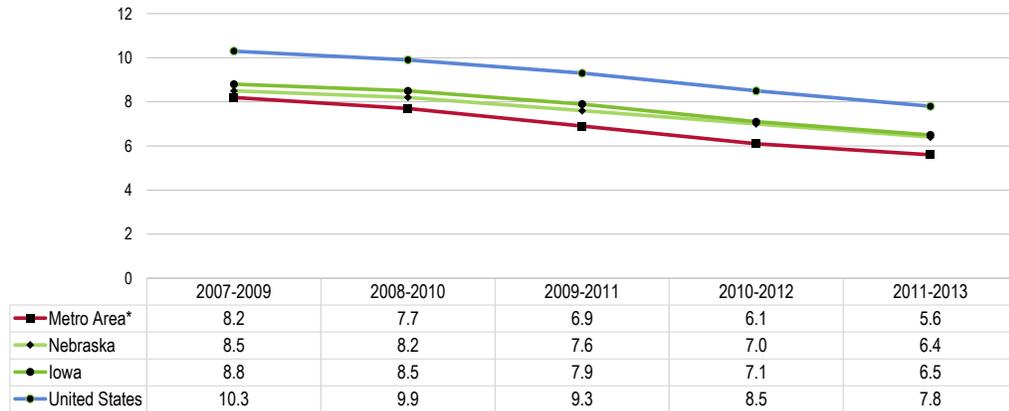
Births to Teen Mothers (Under 20) (Births to Women Under 20 as a Percentage of Live Births, 2011-2013)



Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System: 2011-20123 Accessed using CDC WONDER.
 Note: ● Numbers are a percentage of all live births within each population.
 ● *Does not include Cass or Pottawattamie counties, for which birth counts were too low for calculations.

- **TREND:** Note the steady improvement in the percentage of teen births in recent years.

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



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

Key Informant Input: Family Planning

The largest share of key informants taking part in an online survey characterized *Family Planning* as a “moderate problem” in the community.

Perceptions of Family Planning as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Access to Resources

People, male and female, need to have family planning services. We have opposition to these services because some services, minimal, involve abortion. – Community/Business Leader

There are many conservatives in this area and I believe for women, especially uninsured, there is a lack of adequate family planning clinics. – Healthcare Provider

Patients without resources have few options. – Physician

Many women in this community, including employees of the University of Nebraska system, have insurance that is grandfathered under the ACA and still have to pay a co-pay for effective contraceptive methods. Many women lose their Medicaid coverage. – Physician

Fewer and fewer full service providers available. More and more teen mothers not looking at any options except keeping their babies as if they were pets. – Social Service Provider

Lack of funding to access services. – Healthcare Provider

There are many women who lack access to birth control or lack the awareness and health literacy to know how to prevent pregnancy. – Community/Business Leader

There is a lack of access and education for teens and young adults. – Community/Business Leader

Lack of clinics/programs providing comprehensive and accurate family planning services. Very difficult to access birth control methods and clinics for pregnant mothers do not offer information on all available options. Only one abortion clinic. – Social Service Provider

Teen/Unplanned Pregnancy

Increase in teenage pregnancy. – Healthcare Provider

Lots of teen parents and unplanned births. – Public Health Representative

Though teen pregnancy is decreasing, we still have high rates of teen pregnancy in African American and Hispanic population. – Healthcare Provider

There is a high teen pregnancy rate in Douglas County, particularly among African Americans. – Public Health Representative

CHI limits the types of family planning it offers. It is difficult for teens to access LARC. There are a lot of unplanned teen pregnancies in South Omaha especially. – Public Health Representative

Rate of unplanned pregnancies. – Social Service Provider

Too many young single females giving birth in the area. Education and affordable birth control should be options for under-insured and no insurance populations. – Healthcare Provider

Increase in teen pregnancy. – Social Service Provider

Percentage of teenage pregnancies. – Public Health Representative

Education

Lack of education and options that appeal to the culture of the area. – Healthcare Provider

I am concerned over the lack of apparent education for young people on the use of contraception. I also see unplanned pregnancies. I am not sure why family planning is not utilized. – Community/Business Leader

Lack of sex education and health education services, which leads to increase of STD and unplanned pregnancies. – Social Service Provider

Not a Priority

I have not seen a push in family development in teenage/youth organizations and programs or for any existing adults needing assistance. Most programs I see are geared toward individuality and self-sufficiency. There aren't any organized groups or discussions. – Social Service Provider

I do not believe that access to family planning is a problem in Douglas County, rather I think that socially family planning is not prioritized and having children at a young age has been glorified. – Healthcare Provider

Lack of Support

Too many babies being born with inadequate family support. – Community/Business Leader

Family planning is a major problem in our community as it relates to single parent households and their ability to support their families. Working with the near homeless population every day we see the struggles families face not having the family structure. – Social Service Provider

High Rate of STDs

The high rate of STDs. Pregnancies have leveled off for young unwed women but clearly a complete use of contraceptives is lacking. – Community/Business Leader

The high rates of STDs in the community tells me that people are not using protection and probably need this help. – Social Service Provider

Religion

Lack of education on cultural/moral, family and religious values. – Community/Business Leader

Religious values surrounding family planning is an obstacle. – Social Service Provider

Modifiable Health Risks



Professional Research Consultants, Inc.

Actual Causes Of Death

About Contributors to Mortality

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

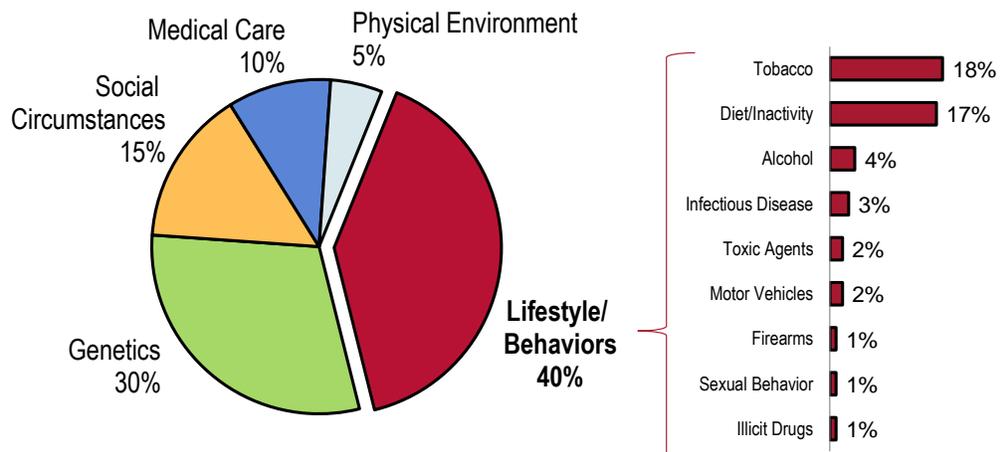
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual behavior** (20,000), and **illicit use of drugs** (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

- Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States



Sources: • "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002.
 • "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

| Leading Causes of Death | Underlying Risk Factors (Actual Causes of Death) | |
|--------------------------------|--|---|
| Cardiovascular Disease | Tobacco use Elevated serum cholesterol High blood pressure | Obesity Diabetes Sedentary lifestyle |
| Cancer | Tobacco use Improper diet | Alcohol Occupational/environmental exposures |
| Cerebrovascular Disease | High blood pressure Tobacco use | Elevated serum cholesterol |
| Accidental Injuries | Safety belt noncompliance Alcohol/substance abuse Reckless driving | Occupational hazards Stress/fatigue |
| Chronic Lung Disease | Tobacco use | Occupational/environmental exposures |

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88-1232.

Nutrition

About Healthful Diet & Healthy Weight

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

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

Americans with a healthful diet:

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

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

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

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

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

Social factors thought to influence diet include:

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

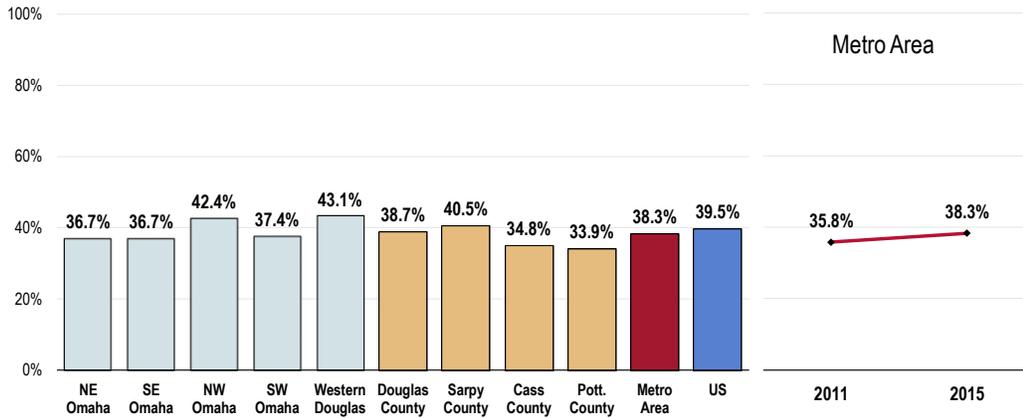
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 38.3% of Metro Area adults report eating five or more servings of fruits and/or vegetables per day.

- Similar to national findings.
- Lowest in Pottawattamie County.
- Statistically similar findings by subarea in Douglas County.
- TREND: Fruit/vegetable consumption has not changed significantly since 2011.

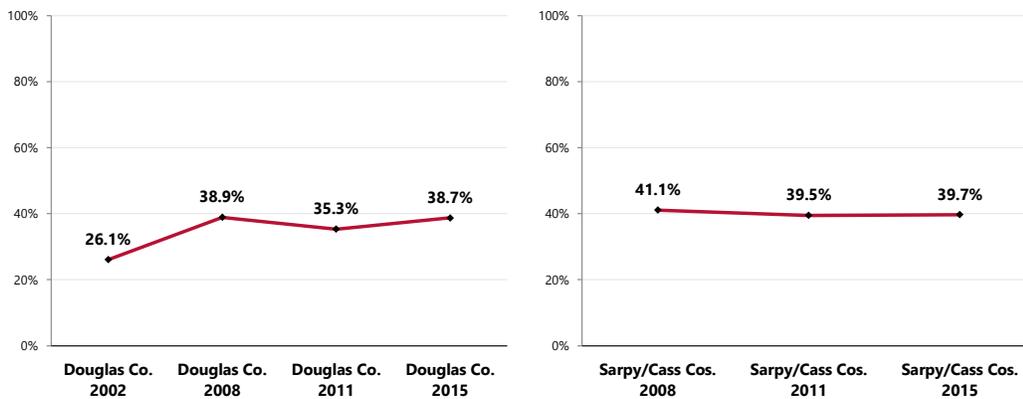
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 146]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • For this issue, respondents were asked to recall their food intake on the previous day.

- TREND: Note the statistically significant increase over time in Douglas County (the Sarpy/Cass prevalence remained stable).

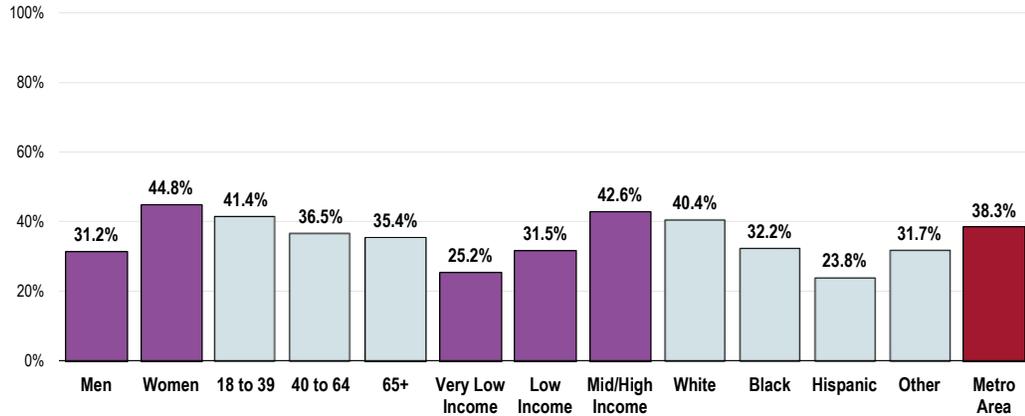
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 146]
 Notes: • Asked of all respondents.

- Area men are less likely to get the recommended servings of daily fruits/vegetables, as are low-income adults (positive correlation with income), Blacks, Hispanics, and Other adults.

Consume Five or More Servings of Fruits/Vegetables Per Day (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
 Notes: • Asked of all respondents; respondents were asked to recall their food intake on the previous day.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Sugar-Sweetened Beverages

Adults

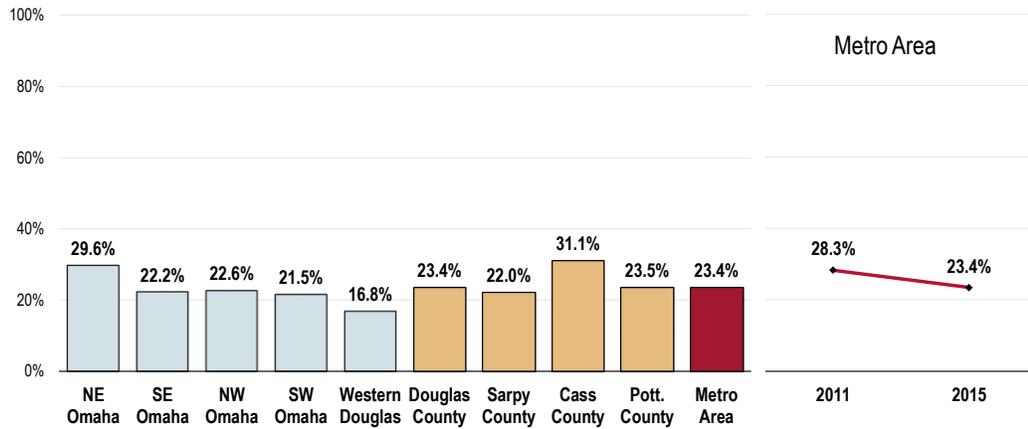
A total of 23.4% of Metro Area adults report drinking at least one sugar-sweetened beverage daily in the past week.

- Highest among Cass County respondents.
- Highest in Northeast Omaha, lowest in Western Douglas County.
- TREND: Marks a statistically significant improvement over time.

Respondents were asked:

"During the past 7 days, how many servings of sugar-sweetened beverages did you have? Please include beverages such as soda, Kool-Aid, sweetened fruit juice, sports drinks, or energy drinks. Do not include 'diet' drinks."

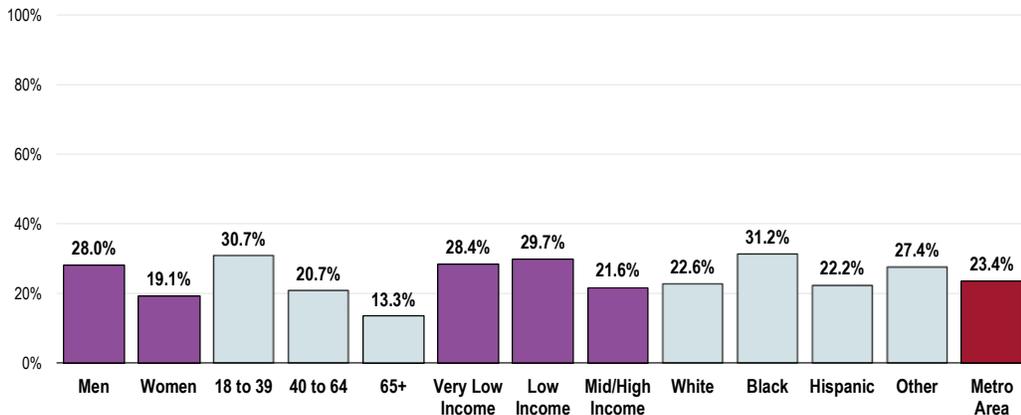
Had 7+ Sugar-Sweetened Beverages in the Past Week



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 181]
 Notes: • Asked of all respondents.

- Residents more likely to have at least one sugar-sweetened beverage per day include men, younger adults (negative correlation with age), lower-income residents, and Black respondents.

Had 7+ Sugar-Sweetened Beverages in the Past Week (Metro Area, 2015)



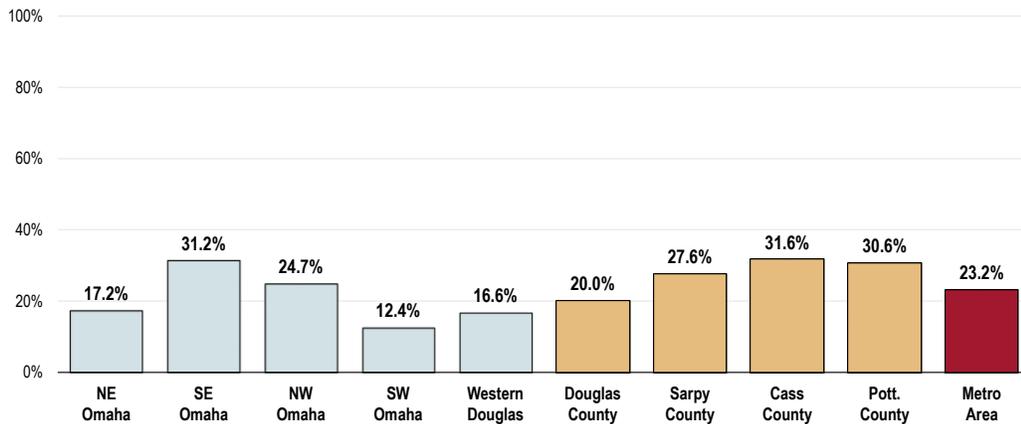
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

A similar prevalence of Metro Area adults parents (23.2%) report that their child drank at least one sugar-sweetened beverage per day over the past week.

- Lowest among Douglas County parents.
- In Douglas County, highest in Southeast Omaha, lowest in Southwest Omaha.

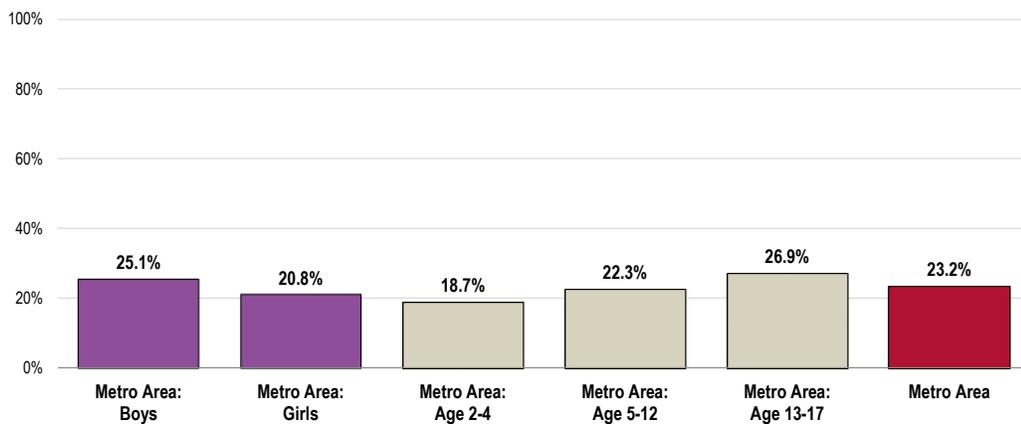
Child Had 7+ Sugar-Sweetened Beverages in the Past Week (Metro Area Parents of Children <18, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 346]
 Notes: • Asked of all respondents with children under 18 at home.

- By children’s demographic, boys and teens are more likely to have at least one sugar-sweetened drink per day (positive correlation with age).

Child Had 7+ Sugar-Sweetened Beverages in the Past Week (Metro Area Parents of Children <18, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 346]
 Notes: • Asked of all respondents with children under 18 at home.

Access to Food

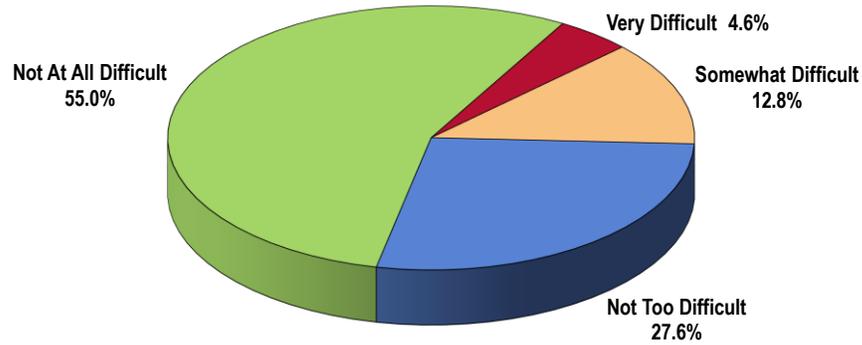
Fresh Produce

Respondents were asked:

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?”

While most report little or no difficulty, 17.4% of Metro Area adults report that it is “very” or “somewhat” difficult for them to access affordable, fresh fruits and vegetables.

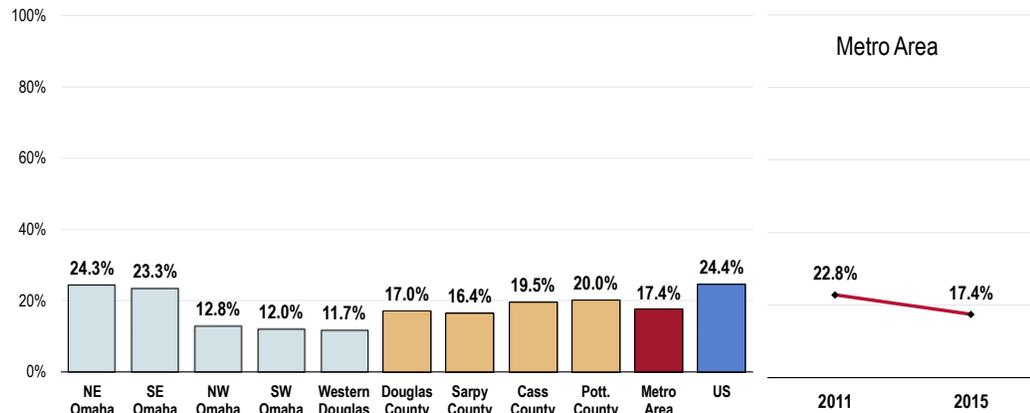
Level of Difficulty Finding Fresh Produce at an Affordable Price (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
 Notes: • Asked of all respondents.

- More favorable than national findings.
- Comparable findings by county in the Metro Area.
- Within Douglas County: unfavorably high in eastern Omaha.
- TREND: Marks a statistically significant improvement over time.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce

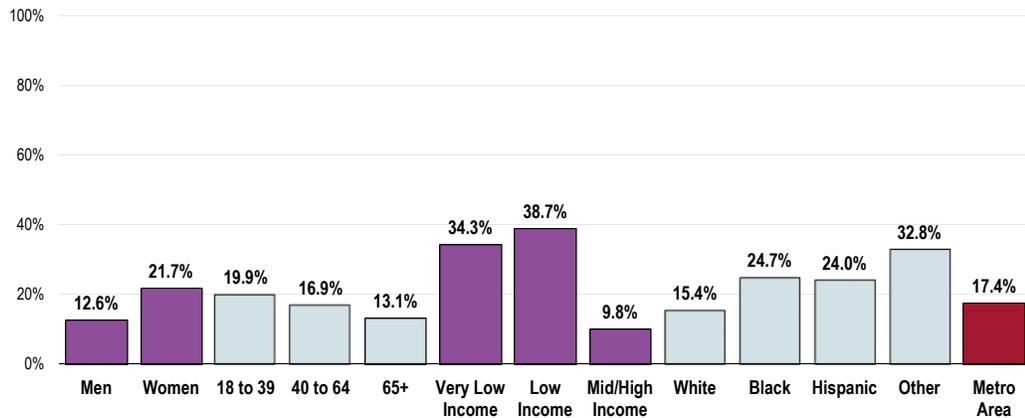


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 91]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

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

- Women.
- Younger residents (negative correlation with age).
- Lower-income residents.
- Blacks, Hispanics, and Other residents.

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



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households living with defined poverty status; “Low Income” includes households with incomes just above the FPL, earning up to twice the poverty threshold; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Food Insecurity

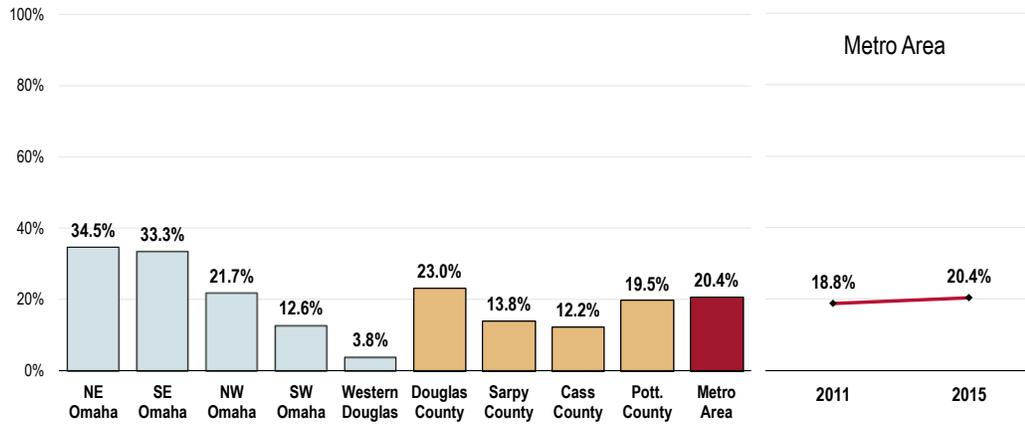
Respondents were asked to indicate their agreement with the following statement:

“I worried about whether our food would run out before we got money to buy more.”

While most respondents “never” worry about their food running out before there is money for more, 20.4% of Metro Area residents “often” or “sometimes” experience this concern.

- Unfavorably high in Douglas County (lowest in Sarpy and Cass).
- In Douglas County, the prevalence of concern is highest in the east.
- TREND: Has not changed significantly since 2011.

“Often” or “Sometimes” Worry About Food Running Out Before Having Money to Buy More

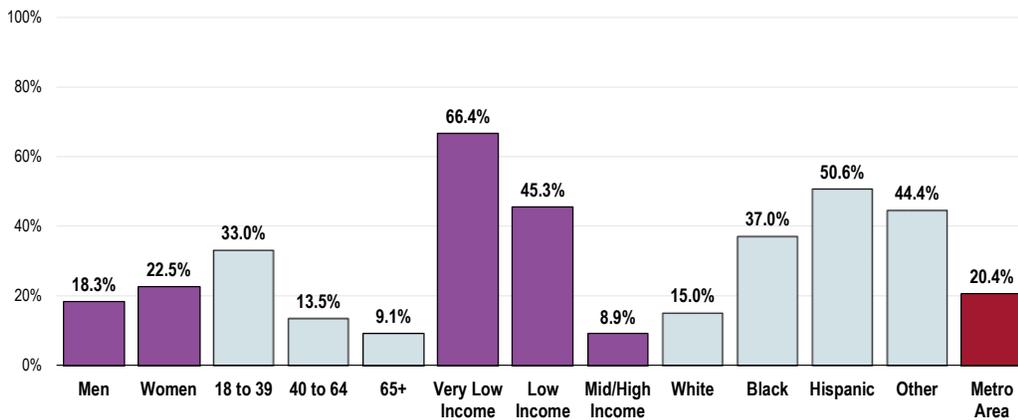


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 321]
 Notes: ● Asked of all respondents.

Metro Area populations more likely to worry that their food will run out before there is money for more include:

- Women.
- Young adults (negative correlation with age).
- Lower-income residents (negative correlation with income).
- Blacks, Hispanics, and Other adults.

“Often” or “Sometimes” Worry About Food Running Out Before Having Money to Buy More (Metro Area, 2015)



Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 321]
 Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 ● Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households living with defined poverty status; “Low Income” includes households with incomes just above the FPL, earning up to twice the poverty threshold; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

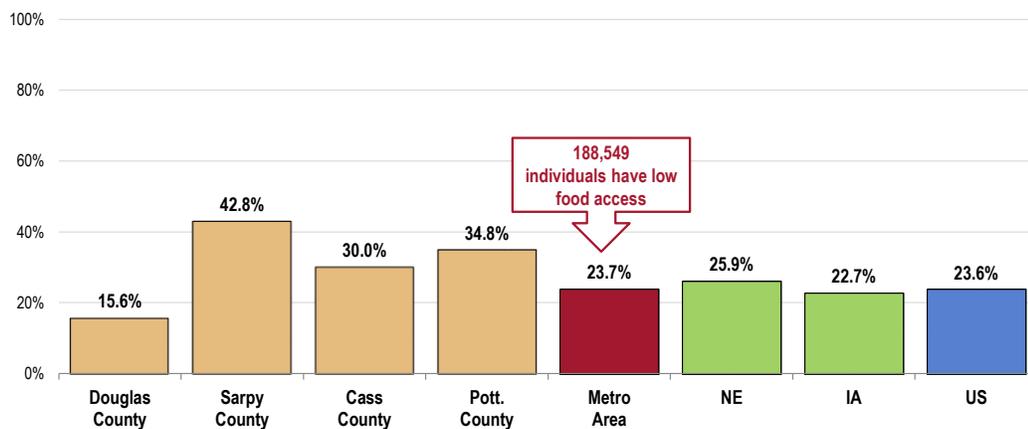
Food Deserts

US Department of Agriculture data show that 23.7% of the Metro Area population (representing over 188,000 residents) have low food access or live in a “food desert,” meaning that they do not live near a supermarket or large grocery store.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where “far” is more than 1 mile in urban areas and more than 10 miles in rural areas.

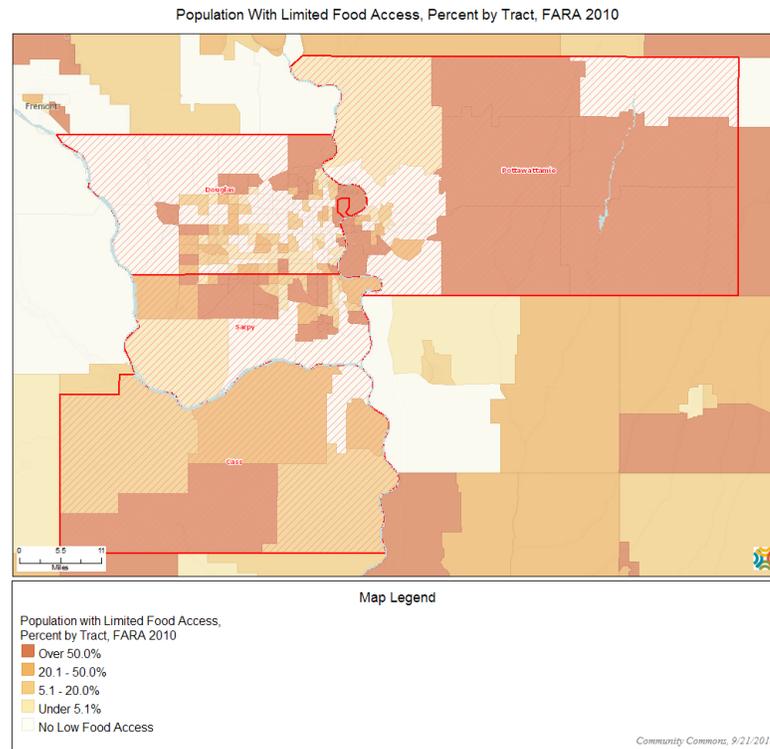
- More favorable than Nebraska findings, similar to Iowa.
- Similar to national findings.
- Favorably low in Douglas County; highest in Sarpy and Pottawattamie counties.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)



Sources: • US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA): 2010.
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where “far” is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts by census tract.

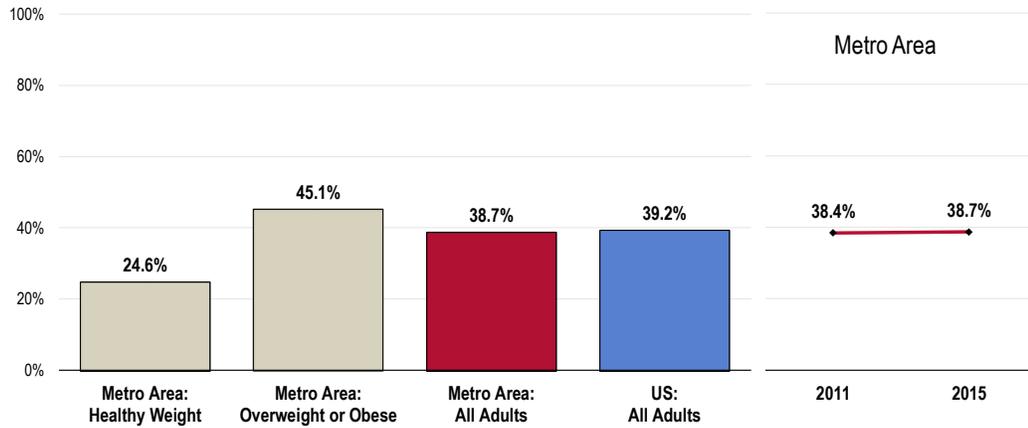


Health Advice About Diet & Nutrition

A total of 38.7% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Close to national findings.
- Among overweight/obese residents, the percentage is 45.1% (meaning more than one-half of these adults have not been given professional advice about diet and nutrition).
- TREND: Statistically unchanged since 2011.

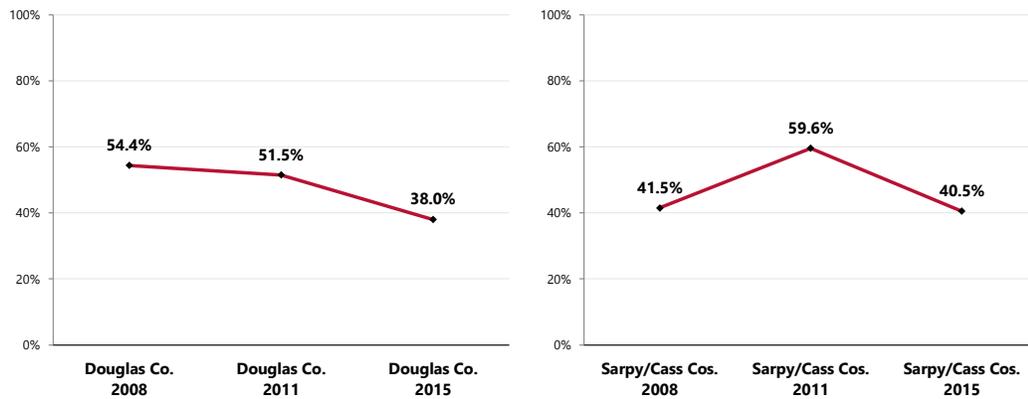
Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 18]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Note the statistically significant decrease over time in Douglas County (the Sarpy/Cass prevalence is statistically unchanged from 2008 baseline data *but denotes a significant decrease from the 2011 prevalence*).

Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 18]
 Notes: • Asked of all respondents.

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 (www.healthypeople.gov)

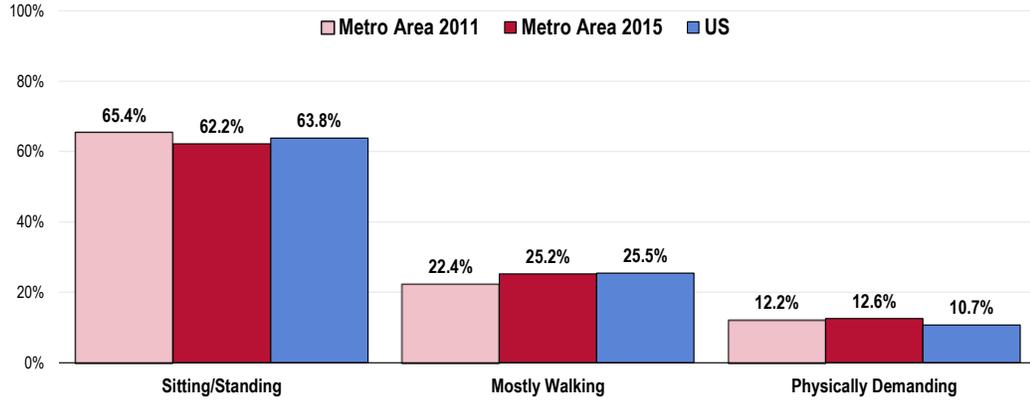
Level of Activity at Work

A majority of employed respondents reports low levels of physical activity at work.

- Just over 6 in 10 employed respondents (62.2%) report that their job entails mostly sitting or standing, similar to the US figure.
- 25.2% report that their job entails mostly walking (similar to that reported nationally).

- 12.6% report that their work is physically demanding (lower than reported nationally).
- TREND: Levels of physical activity at work are statistically unchanged over time.

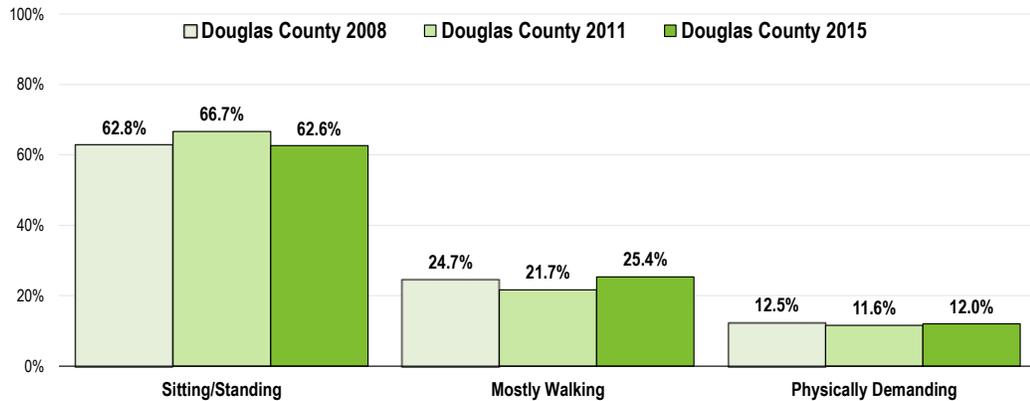
Primary Level of Physical Activity At Work (Among Employed Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 323]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of those respondents who are employed for wages.

- TREND: In Douglas County, the prevalence of sedentary employment is statistically unchanged since 2008.

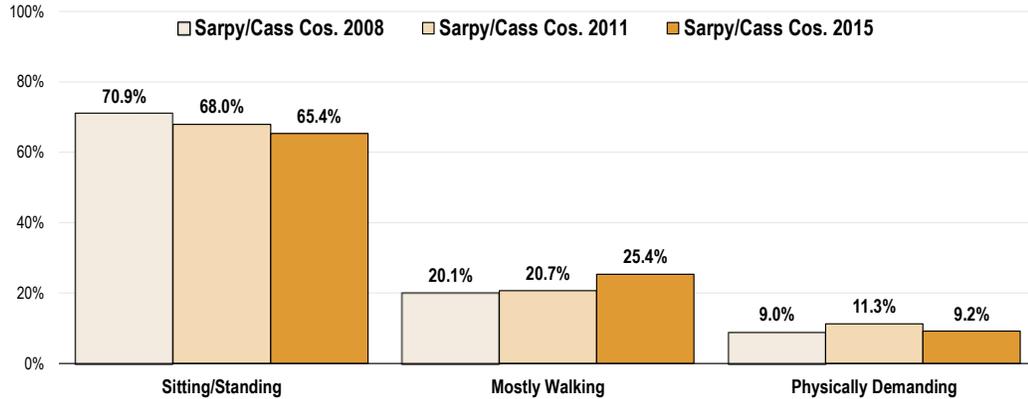
Primary Level of Physical Activity At Work (Douglas County; Among Employed Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 323]
 Notes: • Asked of those respondents who are employed for wages.

- TREND: In Sarpy/Cass counties, the prevalence of sedentary employment is statistically unchanged since 2008.

Primary Level of Physical Activity At Work (Sarpy/Cass Counties; Among Employed Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 323]
 Notes: • Asked of those respondents who are employed for wages.

Leisure-Time Physical Activity

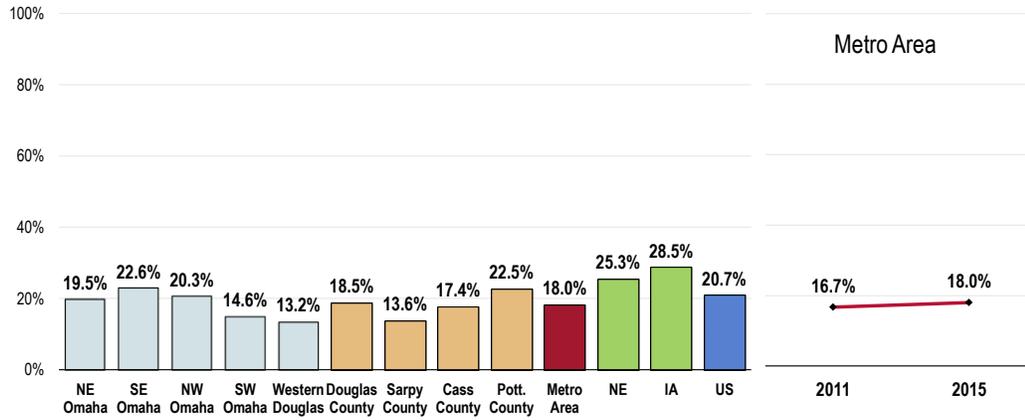
A total of 18.0% of Metro Area adults report no leisure-time physical activity in the past month.

- More favorable than statewide findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).
- Less favorable in Pottawattamie County.
- Favorably low in Southwest Omaha and Western Douglas County.
- TREND: Statistically unchanged since 2011.

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower

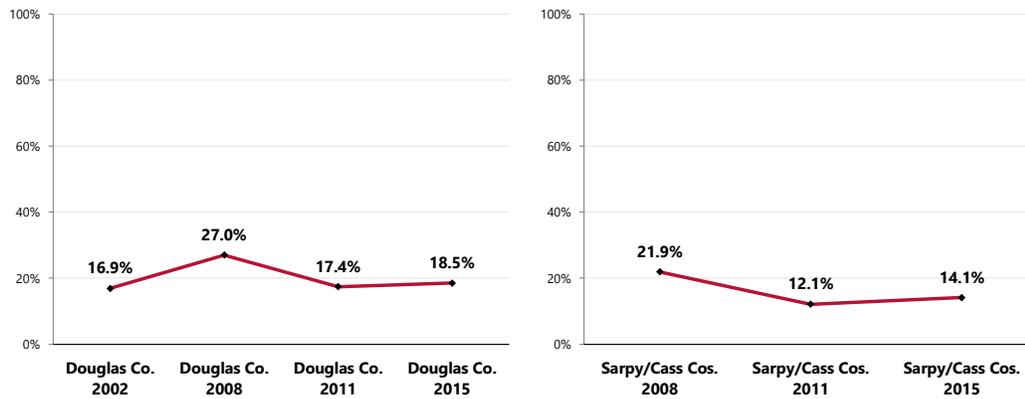


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 92]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]

Notes: • Asked of all respondents.

- **TREND:** Statistically unchanged over time in Douglas County but marking a statistically significant improvement in Sarpy/Cass counties.

No Leisure-Time Physical Activity in the Past Month



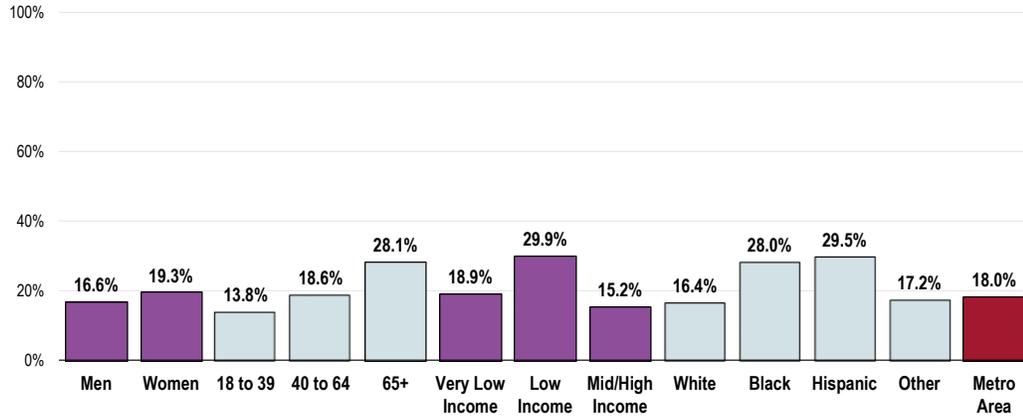
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 92]
 Notes: • Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

- Adults age 40 and older (positive correlation with age).
- Residents living just above the federal poverty level (a.k.a. the “working poor”).
- Blacks and Hispanics.

No Leisure-Time Physical Activity in the Past Month (Metro Area, 2015)

Healthy People 2020 Target = 32.6% or Lower



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 92]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Levels

Recommended Levels of Physical Activity

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

- 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

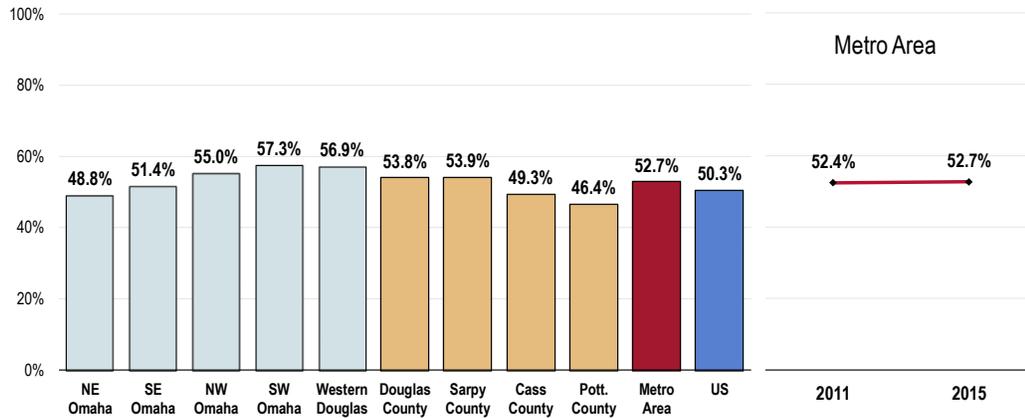
Recommended Levels of Physical Activity

A total of 52.7% of Metro Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- Comparable to national findings.
- Lower in Pottawattamie County.
- In Douglas County, lowest in Northeast Omaha.

- TREND: Statistically unchanged over time.

Meets Physical Activity Recommendations

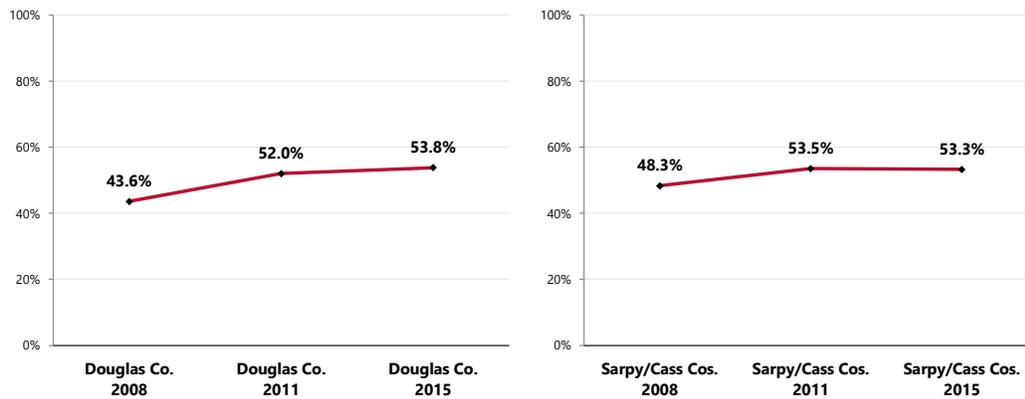


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 147]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
 • In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

- TREND: Marks a statistically significant increase over time in Douglas County (no significant change for Sarpy/Cass counties).

Meets Physical Activity Recommendations



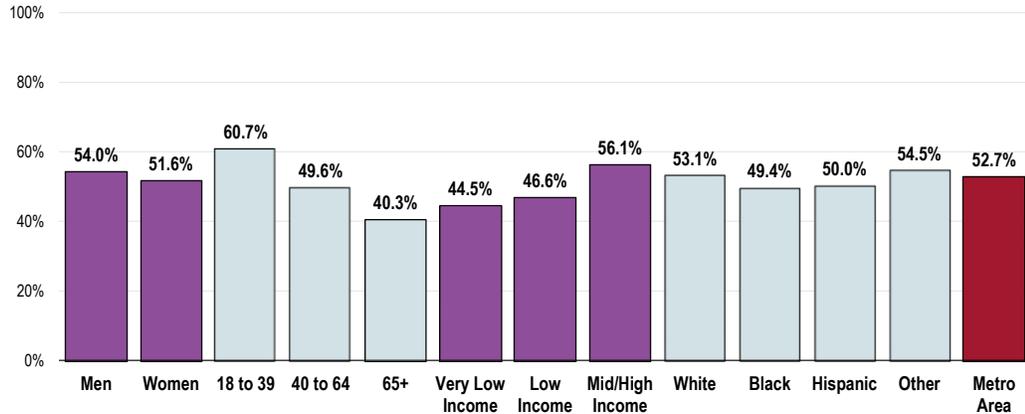
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 147]
 • Asked of all respondents.

Notes: • In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Those less likely to meet physical activity requirements include:

- Seniors (negative correlation with age).
- Lower-income residents (positive correlation with income).

Meets Physical Activity Recommendations (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Moderate & Vigorous Physical Activity

In the past month:

A total of 30.6% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

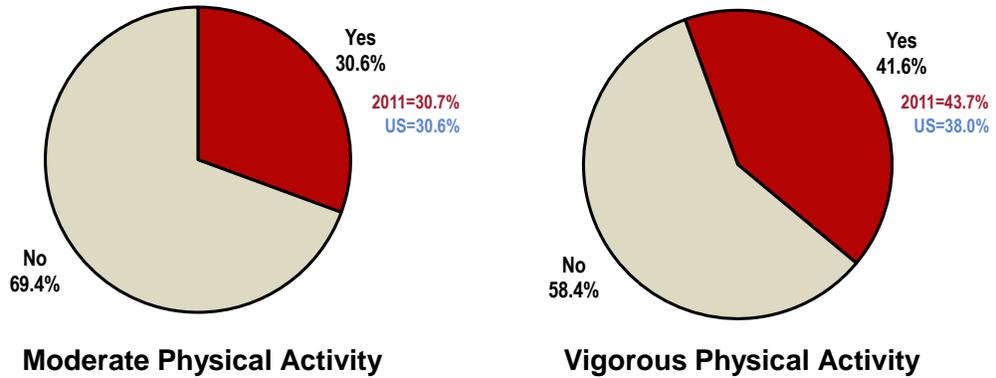
- Identical to the national level.
- TREND: Statistically unchanged since 2011.

A total of 41.6% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- More favorable than the nationwide figure.
- TREND: Statistically similar to 2011 findings.

The individual indicators of moderate and vigorous physical activity are shown here.

Moderate & Vigorous Physical Activity (Metro Area, 2015)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 148-149]
 • 2013 PRC National Health Surveys, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • Moderate Physical Activity: Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times per week for at least 30 minutes per time.
 • Vigorous Physical Activity: Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for at least 20 minutes per time.

Access to Physical Activity

Access to Recreation & Fitness Facilities

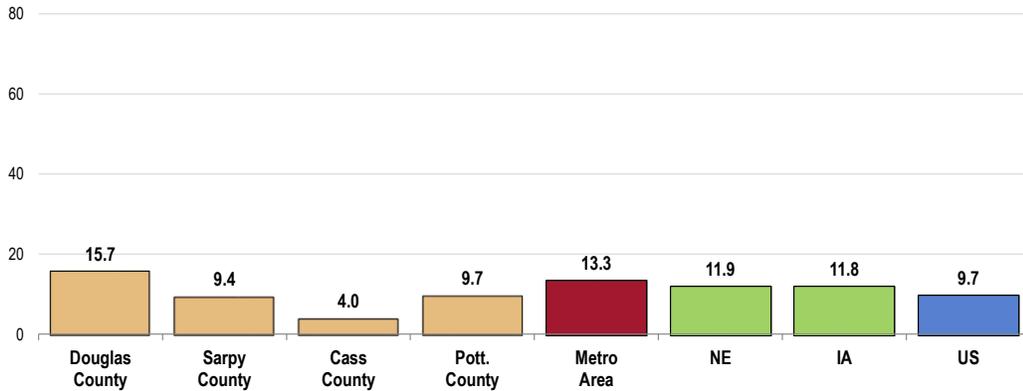
In 2013, there were 13.3 recreation/fitness facilities for every 100,000 population in the Metro Area.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

- Above what is found in both states.
- Above what is found nationally.
- Favorably high in Douglas County; lowest in Cass County.

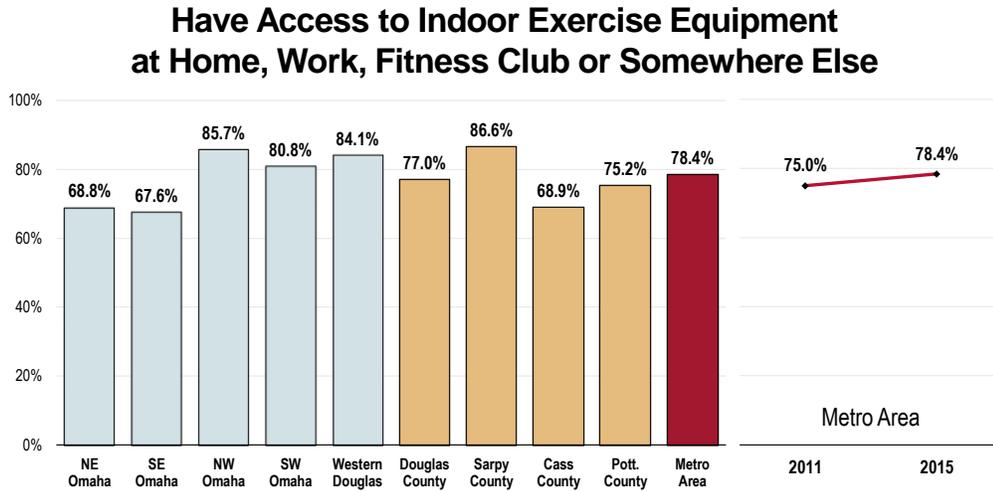
Population With Recreation & Fitness Facility Access (Number of Recreation & Fitness Facilities per 100,000 Population, 2013)



Sources: • US Census Bureau, County Business Patterns: 2013. Additional data analysis by CARES.
 • Retrieved August 2015 from Community Commons at <http://www.chna.org>.
 Notes: • Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which include Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities". Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Most Metro Area adults (78.4%) have access to some type of indoor exercise equipment (including at home, work, a fitness club, or elsewhere).

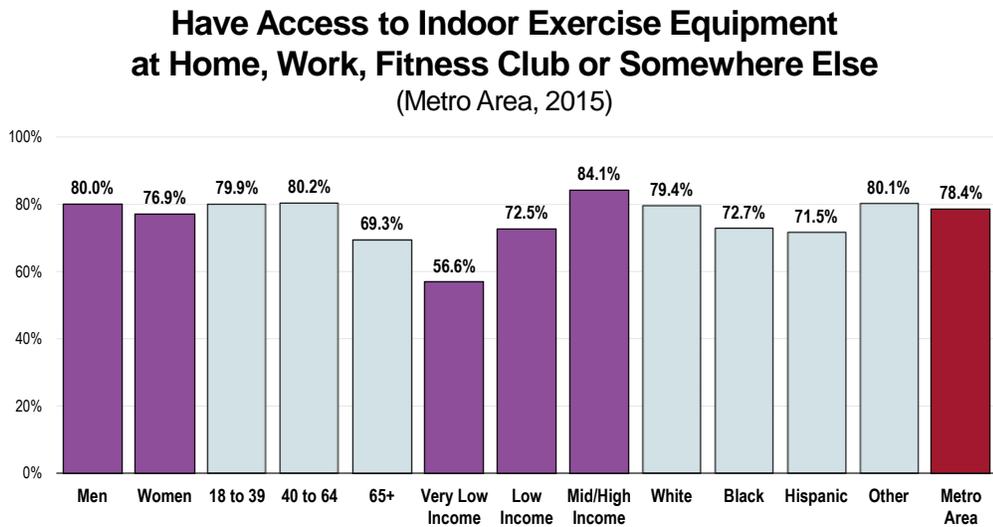
- Favorably high in Sarpy County.
- In Douglas County, access to indoor equipment is lowest in the east.
- TREND: Marks a statistically significant increase over time.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 324]
 Notes: • Asked of all respondents.

Residents less likely to report having access to indoor exercise equipment include:

- Seniors (65+), low-income residents, Blacks, and Hispanics.



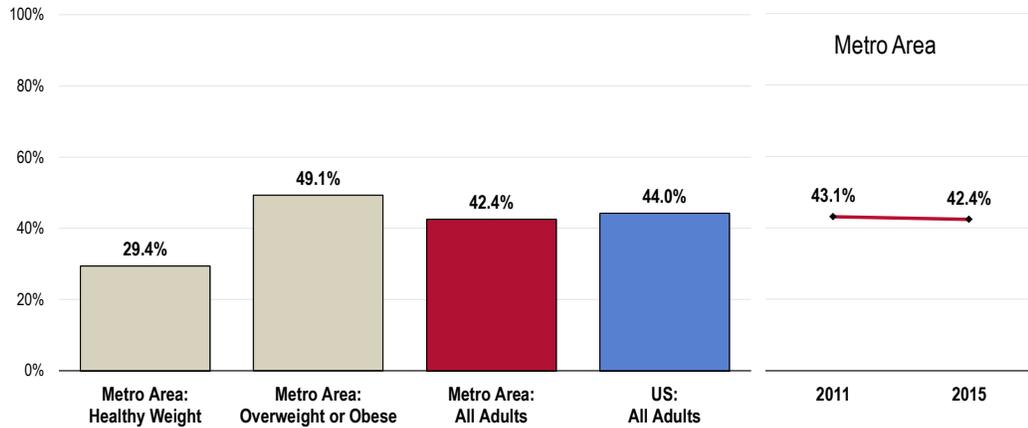
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 324]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Health Advice About Physical Activity & Exercise

A total of 42.4% of Metro Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Close to the national average.
- TREND: Similar to 2011 survey findings.
- Note: 49.1% of overweight/obese Metro Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)

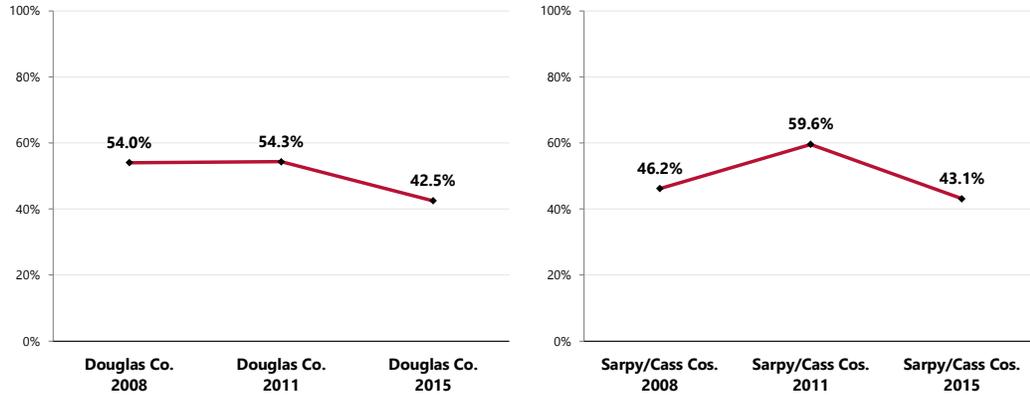


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 19]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

- TREND: Denotes a statistically significant decrease over time in Douglas County; while the Sarpy/Cass prevalence is statistically unchanged from baseline 2008 findings, note the significant decrease from more recent survey results (2011).

Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional (Among Obese Adults)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 19]
 Notes: ● Asked of all respondents.

Physical Education in the Schools

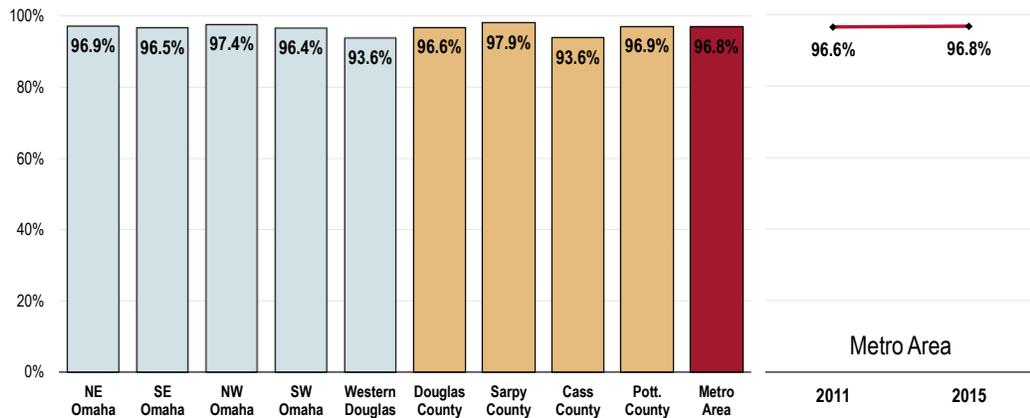
The vast majority of survey respondents in the Metro Area (96.8%) believe that schools should require physical education for all students.

Respondents were next asked:

“Thinking about physical activity for youth in this community, do you feel local schools should require physical education for ALL students?”

- Comparable findings by Metro Area county.
- Comparable findings within the 5 Douglas County subareas.
- TREND: Statistically unchanged over time.

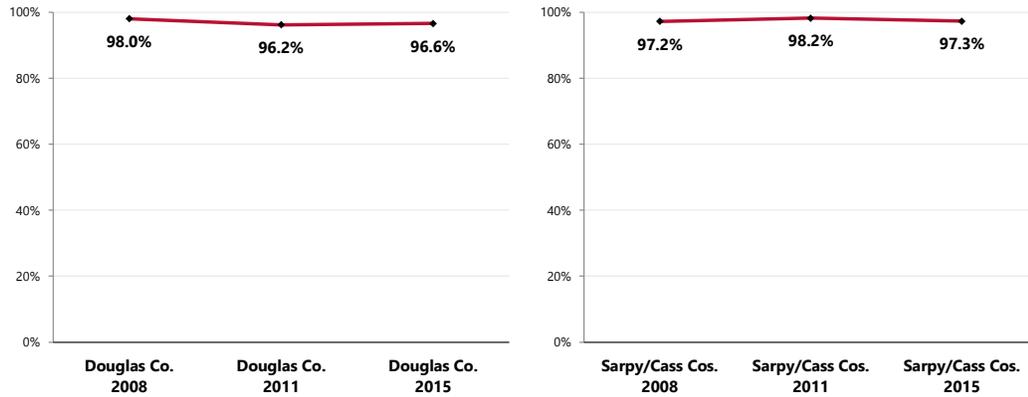
Believe That Schools Should Require Physical Education for All Students



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 333]
 Notes: ● Asked of all respondents.

- **TREND:** Denotes a statistically significant decrease over time (while remaining a vast majority) in Douglas County; in Sarpy/Cass, statistically unchanged over time.

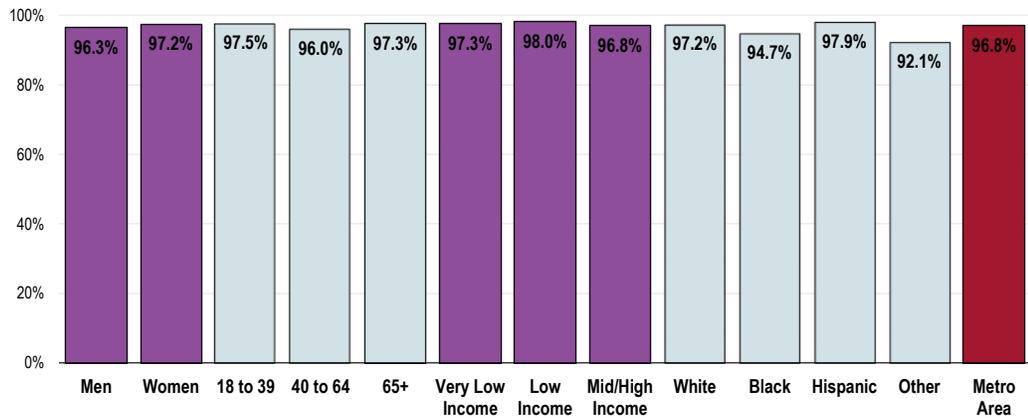
Believe That Schools Should Require Physical Education for All Students



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 333]
 Notes: • Asked of all respondents.

- No significant differences by demographic characteristics.

Believe That Schools Should Require Physical Education for All Students (Metro Area, 2015)



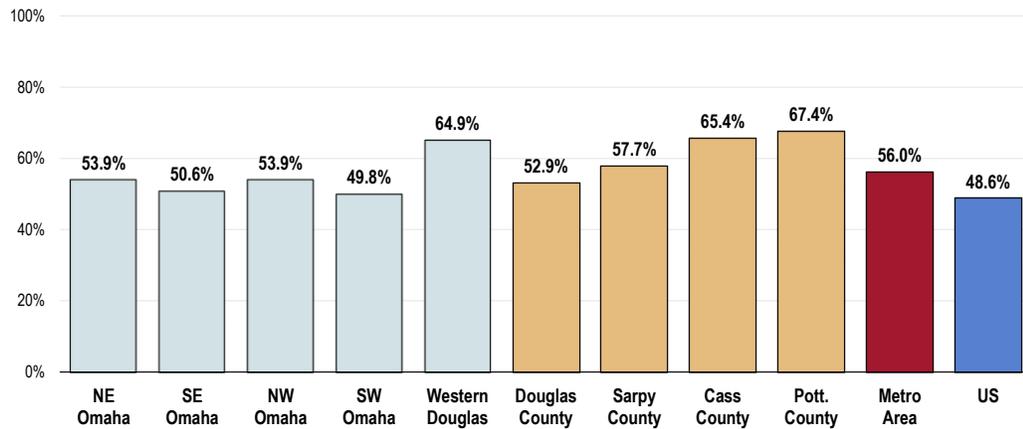
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 333]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children’s Physical Activity

Among Metro Area children age 2 to 17, 56.0% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- More favorable than found nationally.
- Favorably high in Pottawattamie County; lowest in Douglas County.
- Favorably high in Western Douglas County.

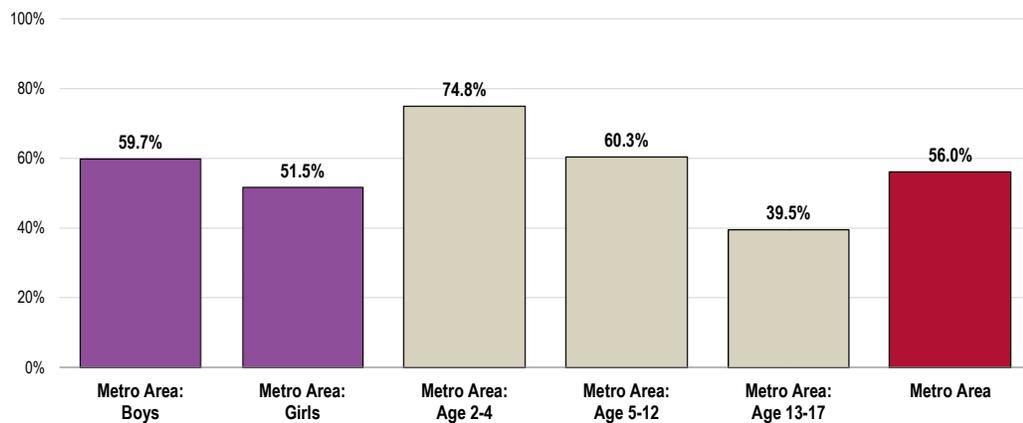
Child Is Physically Active for One or More Hours per Day (Among Metro Area Children Age 2-17)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children age 2-17 at home.
 • Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

- Higher among Metro Area boys; note the negative correlation with age.

Child Is Physically Active for One or More Hours per Day (Among Metro Area Children Age 2-17)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
 Notes: • Asked of all respondents with children age 2-17 at home.
 • Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

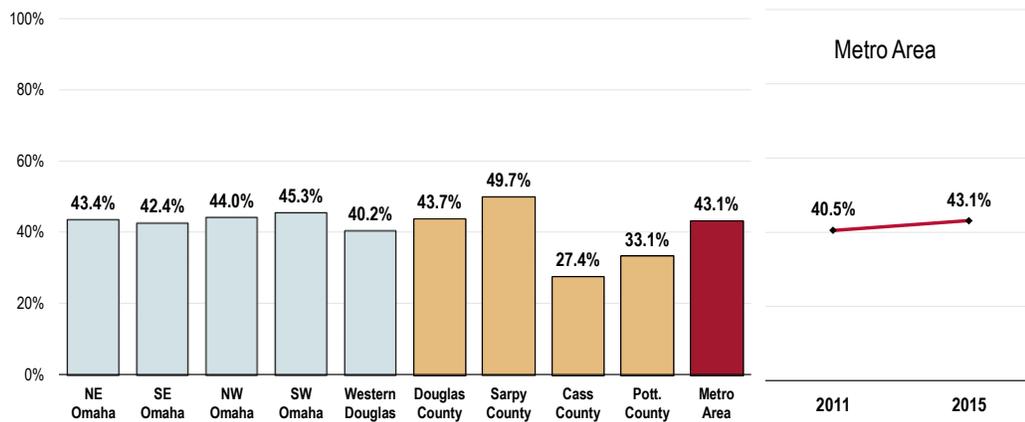
Built Environment

Use of Local Parks & Recreation Centers

While most Metro Area adults use local parks or recreational centers for exercise less than once a week, 43.1% of report using local parks or recreational centers at least weekly.

- Weekly use is lowest in Cass and Pottawattamie counties.
- Weekly use is comparable across the 5 Douglas County subareas.
- TREND: Weekly use of local parks or recreational centers is statistically unchanged over time in the Metro Area.

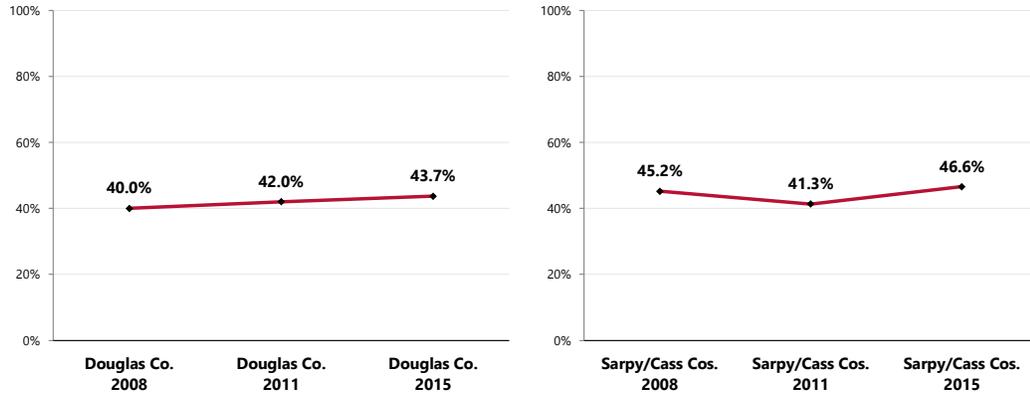
Typically Use Local Parks or Recreation Centers for Exercise at Least Once a Week



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 179]
 Notes: • Asked of all respondents.

- TREND: Denotes a statistically significant increase over time in Douglas County (statistically unchanged in Sarpy/Cass).

Typically Use Local Parks or Recreation Centers for Exercise at Least Once a Week

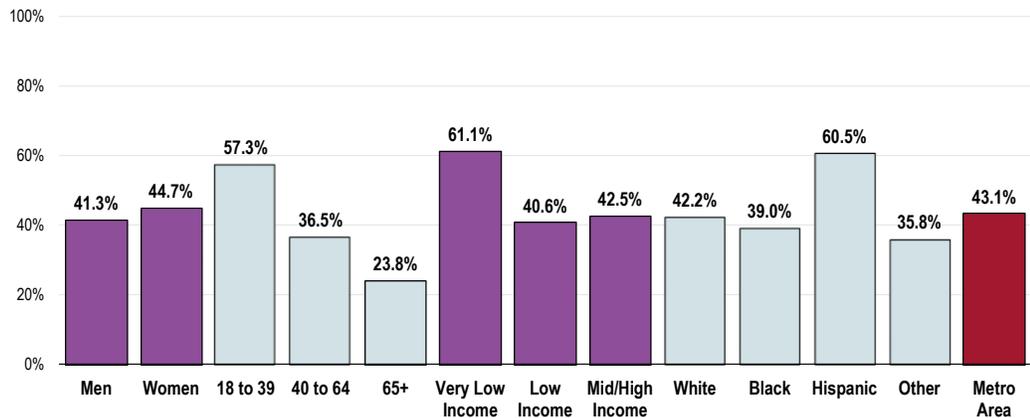


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 179]
 Notes: ● Asked of all respondents.

Viewed by demographic characteristics, these population samples are less likely to report weekly use of local parks or recreation centers:

- Older residents (negative correlation with age).
- Residents living above the federal poverty level.
- Whites, Blacks, and Other races.

Typically Use Local Parks or Recreation Centers for Exercise at Least Once a Week (Metro Area, 2015)



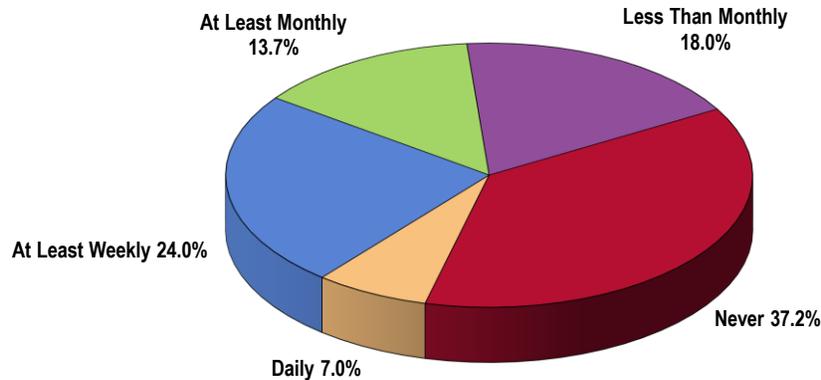
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 179]
 Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Use of Local Paved or Dirt Trails

When asked how often they use a local paved or dirt trail for walking in good weather, over-half of community members said “never” (mentioned by 37.2%) or “less than one month” (18.0%).

- On the other hand, 13.7% of survey respondents use a paved or dirt trail for walking in good weather at least **monthly**, while 24.0% use one at least **weekly**, and 7.0% use one **daily**.

Frequency of Using Local Paved or Dirt Trails for Walking, Hiking, or Biking in Good Weather (Metro Area, 2015)

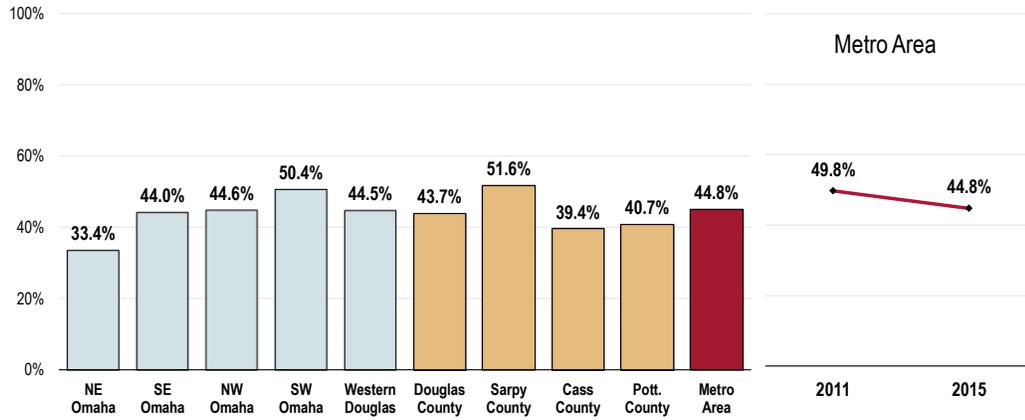


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 326]
Notes: • Asked of all respondents.

A total of 44.8% of Metro Area adults report using local trails at least monthly.

- Highest in Sarpy County.
- In Douglas County: highest in Southwest Omaha, lowest in Northeast Omaha.
- TREND: Denotes a statistically significant decrease over time.

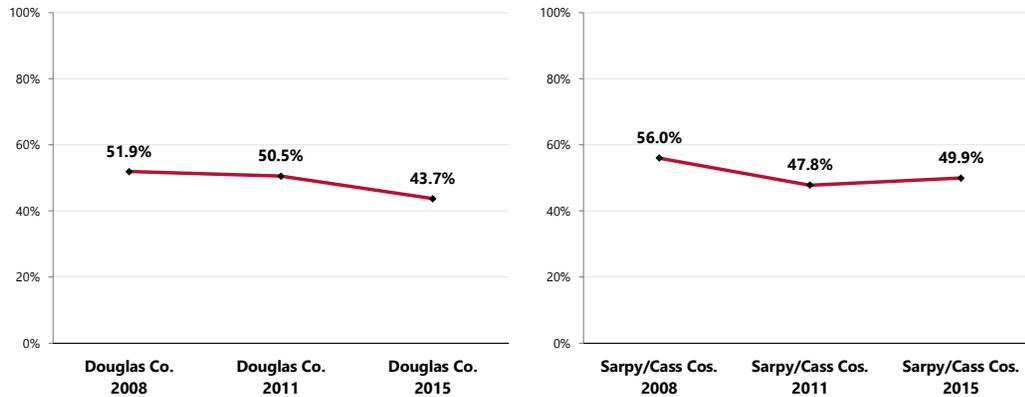
Typically Use Local Paved or Dirt Trails for Walking, Hiking, or Biking at Least Once a Month in Good Weather



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 180]
 Notes: • Asked of all respondents.

- **TREND:** Note the statistically significant decrease over time in Douglas County; statistically unchanged from baseline findings in Sarpy/Cass counties.

Typically Use Local Paved or Dirt Trails for Walking, Hiking, or Biking at Least Once a Month in Good Weather

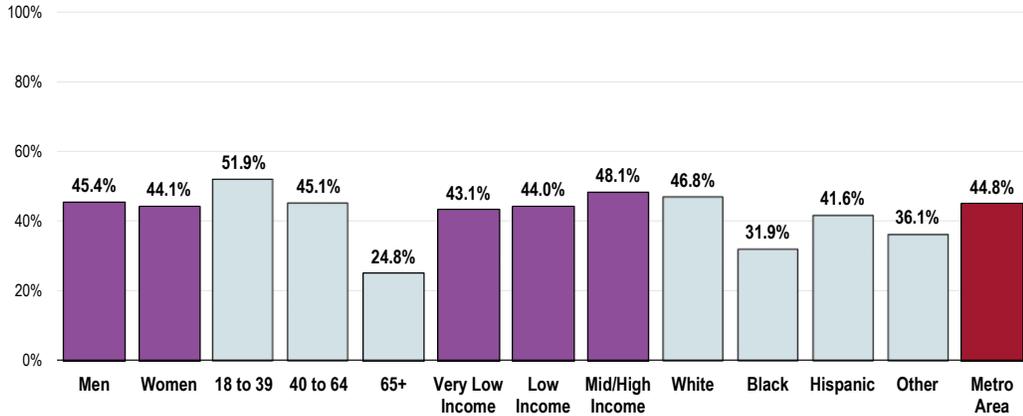


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 180]
 Notes: • Asked of all respondents.

Metro Area residents less likely to report monthly use of local trails include:

- Adults age 40 and older (negative correlation with age).
- Black adults.

Typically Use Local Paved or Dirt Trails for Walking, Hiking, or Biking at Least Once a Month in Good Weather
(Metro Area, 2015)



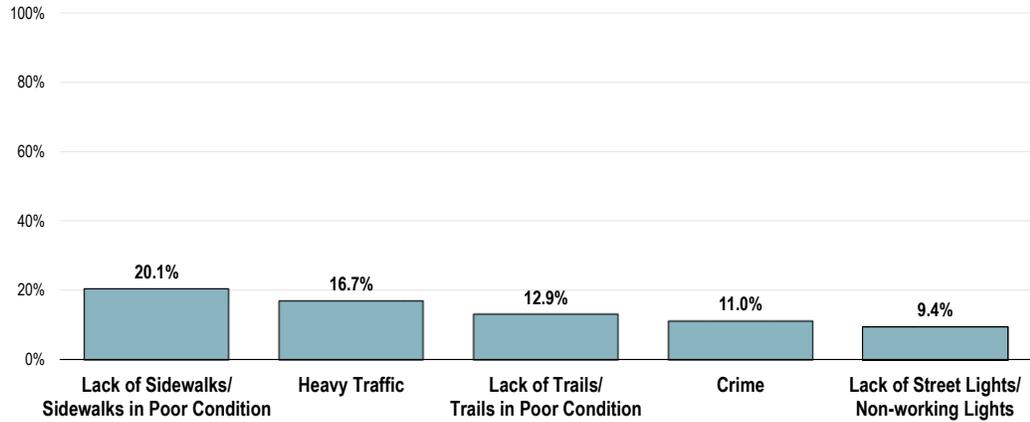
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Neighborhood Barriers

Survey respondents were next asked about the presence of five neighborhood factors that potentially prevent people from exercising, including lack of sidewalks or sidewalks in poor condition; heavy traffic; lack of trails or trails in poor condition; crime; and lack of street lights or non-working street lights.

As can be seen, a lack of sidewalks/poor sidewalks received the largest share of responses among community members (mentioned by 20.1%), followed by heavy traffic (16.7%), lack of trails/poor trails (12.9%), crime (11.0%), and lack of street lights/non-working street lights (9.4%).

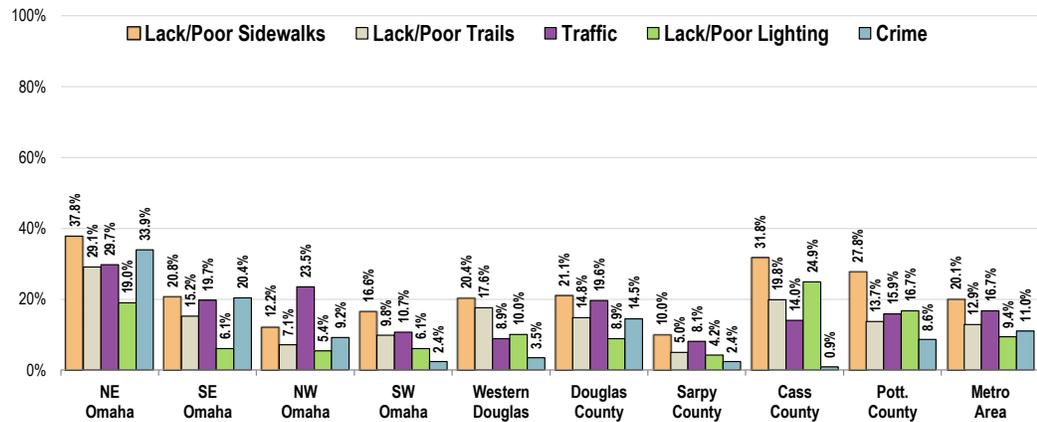
Presence of Neighborhood Barriers That Prevent Physical Activity (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 327-331]
 Notes: • Asked of all respondents.

For further analysis, the following chart provides an illustration of respondents' perceptions of neighborhood barriers, segmented by geographic areas of residence.

Presence of Neighborhood Barriers That Prevent Physical Activity (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 327-331]
 Notes: • Asked of all respondents.

Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥ 30 kg/m^2 . The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2 . The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥ 30 kg/m^2 , mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2 .

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

| Classification of Overweight and Obesity by BMI | BMI (kg/m^2) |
|---|------------------|
| Underweight | <18.5 |
| Normal | 18.5 – 24.9 |
| Overweight | 25.0 – 29.9 |
| Obese | ≥ 30.0 |

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

“Healthy weight” means neither underweight, nor overweight (BMI = 18.5-24.9).

Healthy Weight

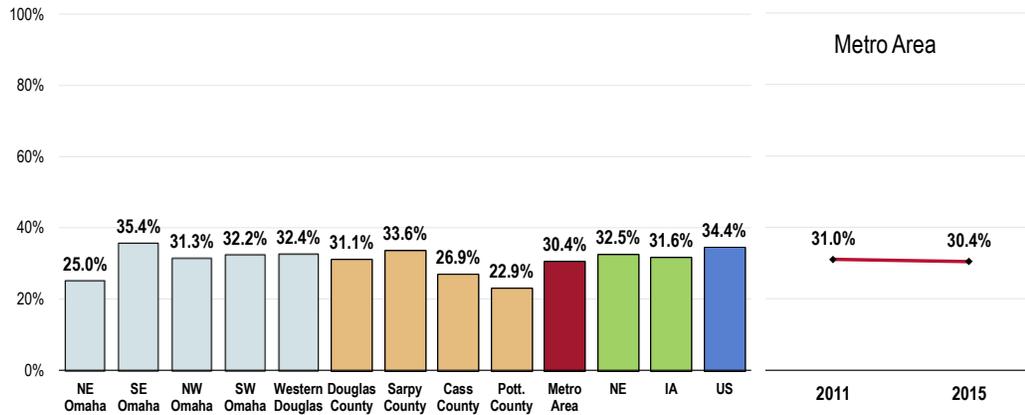
Based on self-reported heights and weights, 30.4% of Metro Area adults are at a healthy weight.

- Less favorable than the Nebraska figure, similar to Iowa.
- Less favorable than national findings.
- Fails to satisfy the Healthy People 2020 target (33.9% or higher).
- Unfavorably low in Pottawattamie County.
- In Douglas County, lowest among Northeast Omaha residents.
- TREND: Statistically unchanged since 2011.

Healthy Weight

(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)

Healthy People 2020 Target = 33.9% or Higher



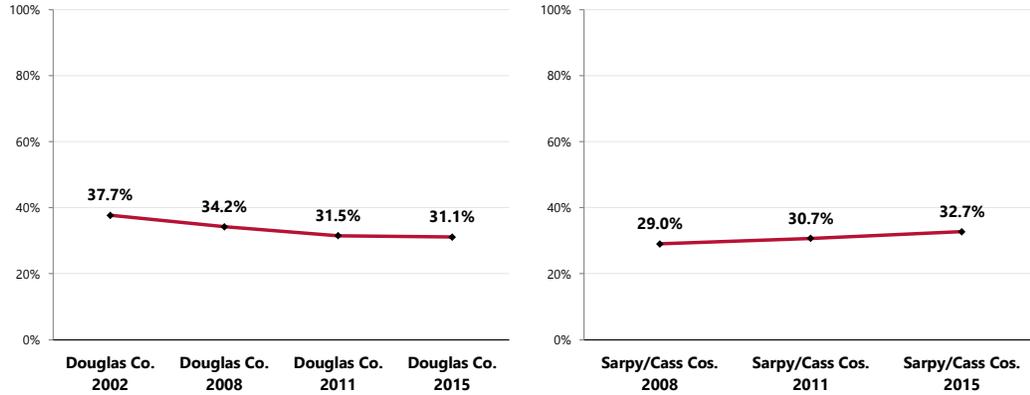
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-8]

Notes: • Based on reported heights and weights, asked of all respondents.
 • The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

- TREND: Note the significant decrease in healthy weight in Douglas County over time (the Sarpy/Cass prevalence is statistically unchanged).

Healthy Weight

(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
 Notes: ● Based on reported heights and weights, asked of all respondents.
 ● The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

Overweight Status

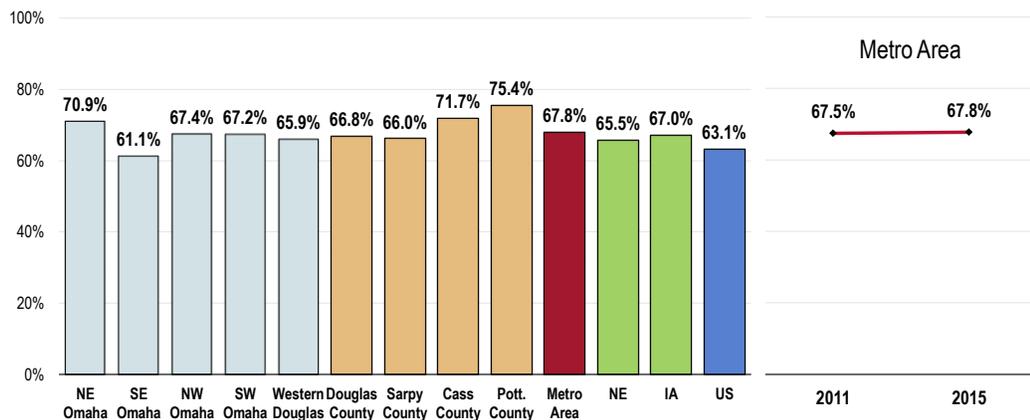
A total of 2 in 3 Metro Area adults (67.8%) are overweight.

Here, "overweight" includes those respondents with a BMI value ≥ 25 .

- Higher than the Nebraska prevalence, similar to the Iowa prevalence.
- Higher than the US overweight prevalence.
- Least favorable in Pottawattamie County.
- Least favorable in Northeast Omaha.
- TREND: Statistically unchanged since 2011.

Prevalence of Total Overweight

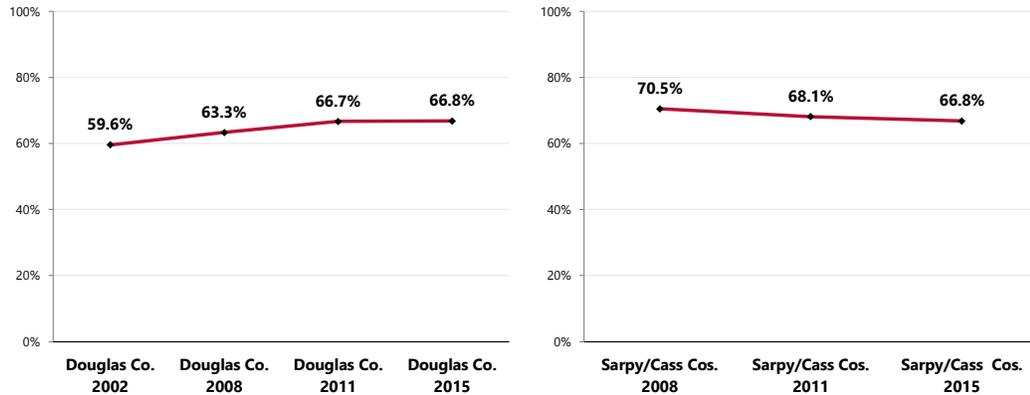
(Percent of Adults With a Body Mass Index of 25.0 or Higher)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
 ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 ● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 Notes: ● Based on reported heights and weights, asked of all respondents.
 ● The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

- TREND: Note the statistically significant increase over time in Douglas County (the decrease in Sarpy/Cass is not statistically significant).

Prevalence of Total Overweight
(Percent of Adults With a Body Mass Index of 25.0 or Higher)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]

Notes: ● Based on reported heights and weights, asked of all respondents.

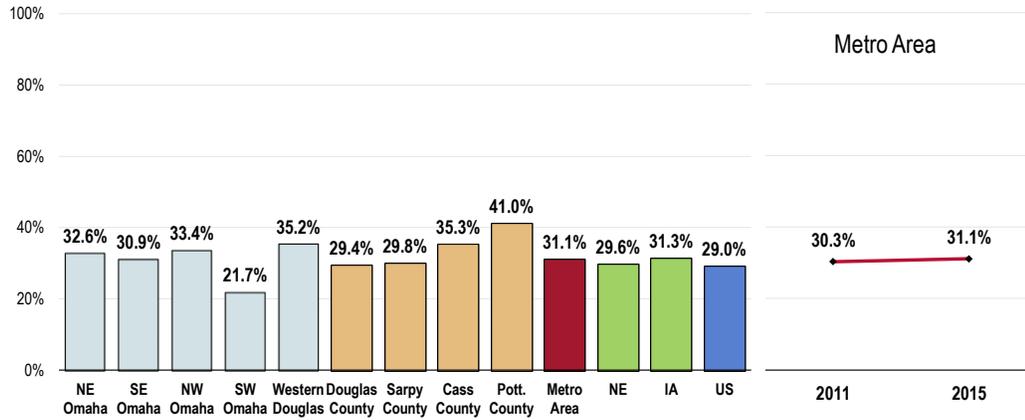
● The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Further, 31.1% of Metro Area adults are obese.

“Obese“ (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥ 30 .

- Comparable to both state figures.
- Comparable to the US figure.
- Comparable to the Healthy People 2020 target (30.5% or lower).
- Highest in Pottawattamie County, lowest in Douglas County.
- In Douglas County, favorably low in Southwest Omaha.
- TREND: Statistically unchanged since 2011.

Prevalence of Obesity (Percent of Adults With a Body Mass Index of 30.0 or Higher) Healthy People 2020 Target = 30.5% or Lower

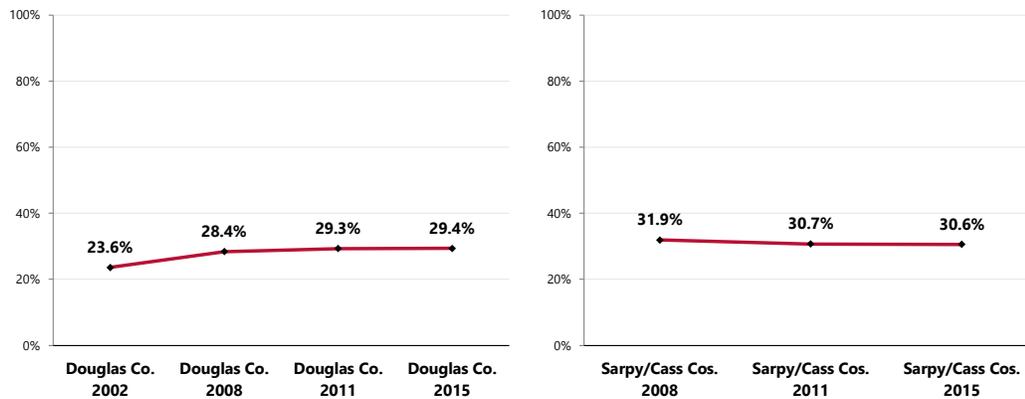


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.

Notes: • Based on reported heights and weights, asked of all respondents.
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

- TREND: Note the statistically significant increase in obesity for Douglas County since 2008; the Sarpy/Cass prevalence is statistically unchanged.

Prevalence of Obesity (Percent of Adults With a Body Mass Index of 30.0 or Higher)

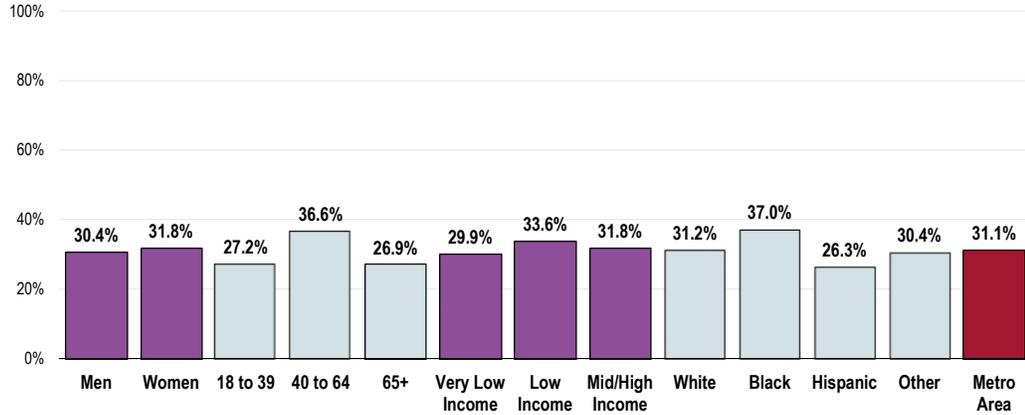


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
 Notes: • Based on reported heights and weights, asked of all respondents.
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Obesity is notably more prevalent among:

- Those between the ages of 40 and 64.
- Black respondents.

Prevalence of Obesity
 (Percent of Adults With a BMI of 30.0 or Higher; Metro Area, 2015)
 Healthy People 2020 Target = 30.5% or Lower



Sources:

- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]

 Notes:

- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

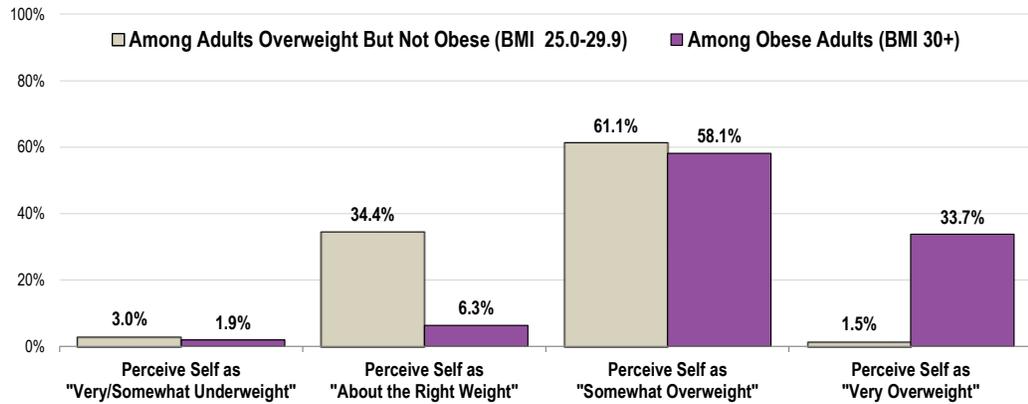
Actual vs. Perceived Body Weight

A total of 6.3% of obese adults and 34.4% of overweight (but not obese) adults feel that their current weight is "about right."

- 61.1% of overweight (but not obese) adults see themselves as "somewhat overweight."
- 33.7% of obese adults see themselves as "very overweight."

Actual vs. Perceived Weight Status

(Among Overweight/Obese Adults Based on BMI; Metro Area, 2015)



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

Notes: • BMI is based on reported heights and weights, asked of all respondents.

• The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Relationship of Overweight With Other Health Issues

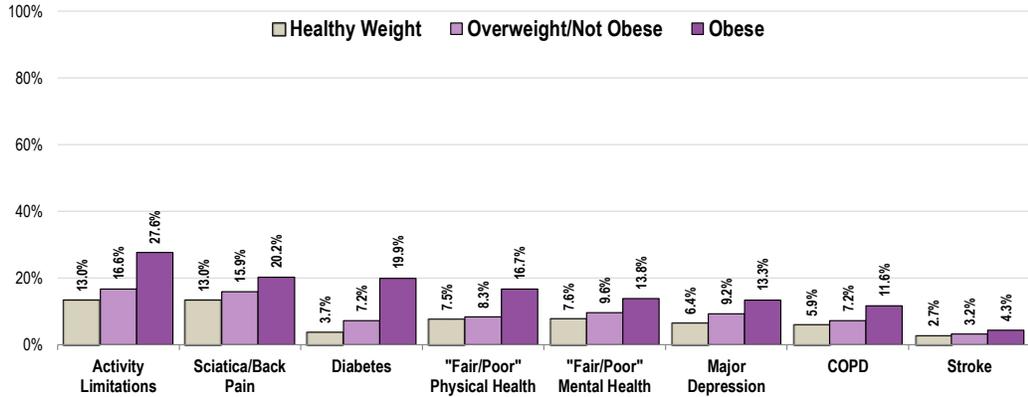
Overweight and obese adults are more likely to report a number of adverse health conditions.

Among these are:

- Activity limitations.
- Sciatica/chronic back pain.
- Diabetes.
- "Fair" or "poor" physical health.
- "Fair" or "poor" mental health.
- Major depression.
- COPD.
- Stroke.

The correlation between overweight and various health issues cannot be disputed.

Relationship of Overweight With Other Health Issues (By Weight Classification; Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 25, 29, 36, 39, 100, 105, 308]
 Notes: • Based on reported heights and weights, asked of all respondents.

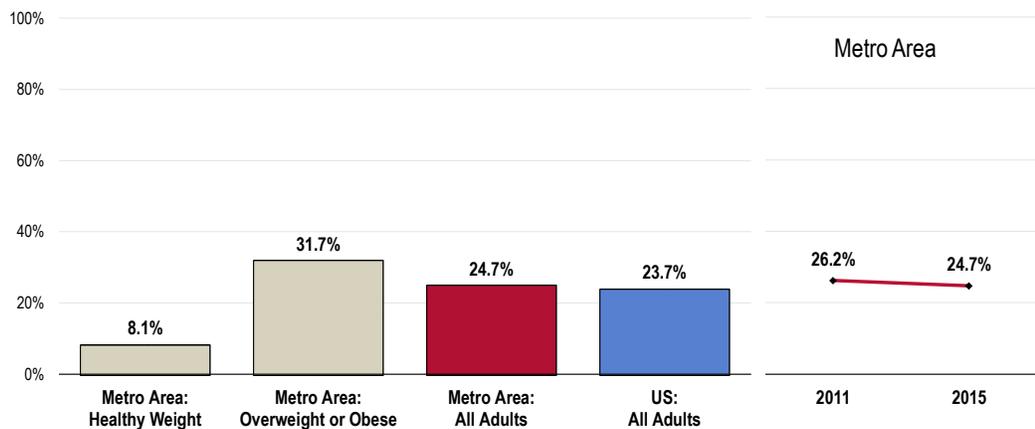
Weight Management

Health Advice

A total of 24.7% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Statistically similar to the national findings.
- TREND: Statistically unchanged from that reported in 2011.
- Note that just 31.7% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while nearly 7 in 10 have not).

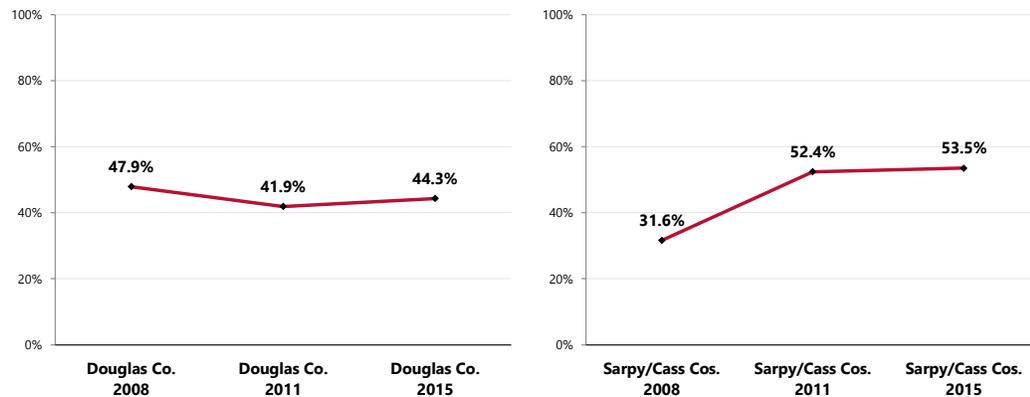
Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 98, 153]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas County but marking a statistically significant increase in Sarpy/Cass counties.

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional (Among Obese Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 154]

Notes: • Based on reported heights and weights, asked of all respondents.

- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Weight Control

About Maintaining a Healthy Weight

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

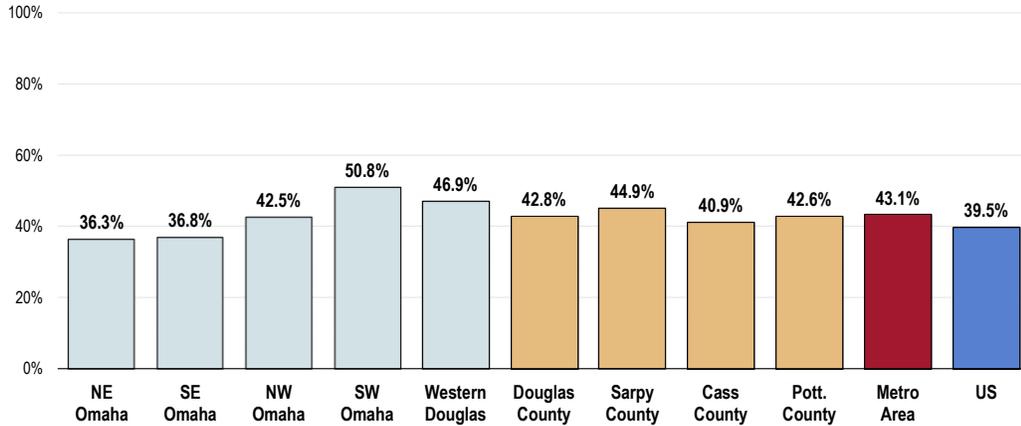
All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

- Healthy People 2020 (www.healthypeople.gov)

A total of 43.1% of Metro Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

- Similar to national findings.
- Similar findings by county in the Metro Area.
- In Douglas County, highest in Southwest Omaha, lowest in the east.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity (Among Overweight or Obese Respondents)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Reflects respondents who are overweight or obese based on reported heights and weights.

Childhood Overweight & Obesity Prevention

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

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

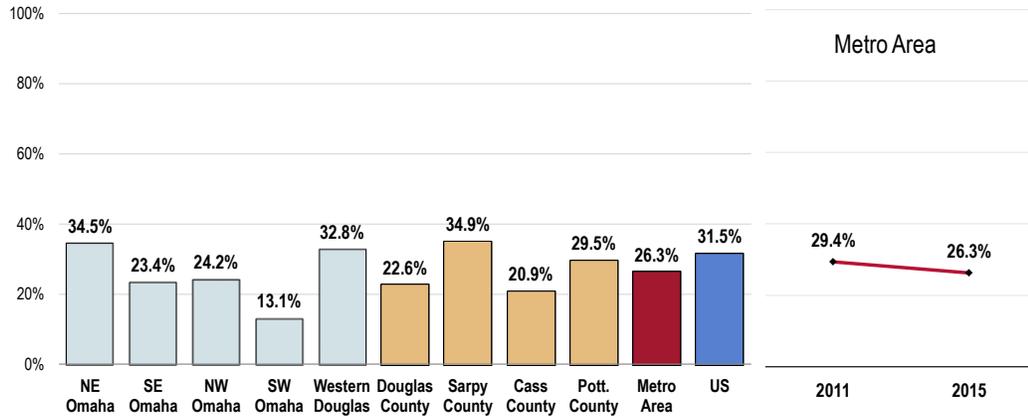
• Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 26.3% of Metro Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Statistically similar to that found nationally.
- Unfavorably high in Sarpy County.
- In Douglas County: highest in Northeast Omaha, lowest in the southwest.
- TREND: Statistically unchanged since 2011.

Child Total Overweight Prevalence

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



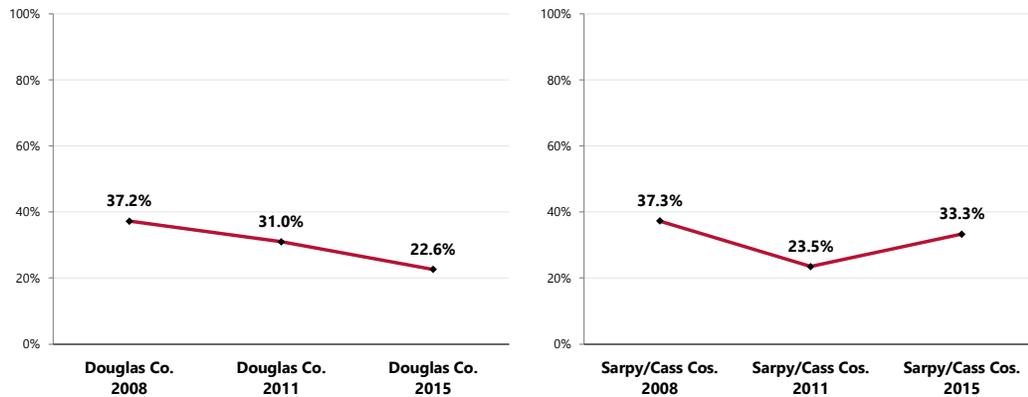
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents with children age 5-17 at home.
 • Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

- **TREND:** Marks a statistically significant improvement over time in Douglas County; the Sarpy/Cass prevalence is statistically unchanged from baseline data but marks a statistically significant increase from 2011 findings.

Child Total Overweight Prevalence

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



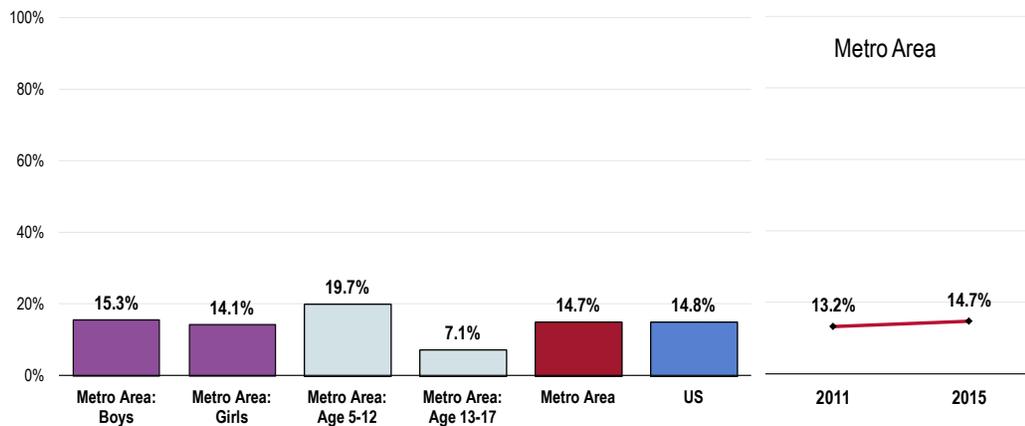
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]

Notes: • Asked of all respondents with children age 5-17 at home.
 • Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Further, 14.7% of Metro Area children age 5 to 17 are obese (≥95th percentile).

- Nearly identical to the national percentage.
- Close to the Healthy People 2020 target (14.5% or lower for children age 2-19).
- TREND: Statistically unchanged since 2011.
- Statistically similar by child’s gender; higher among children age 5-12 than among teens.

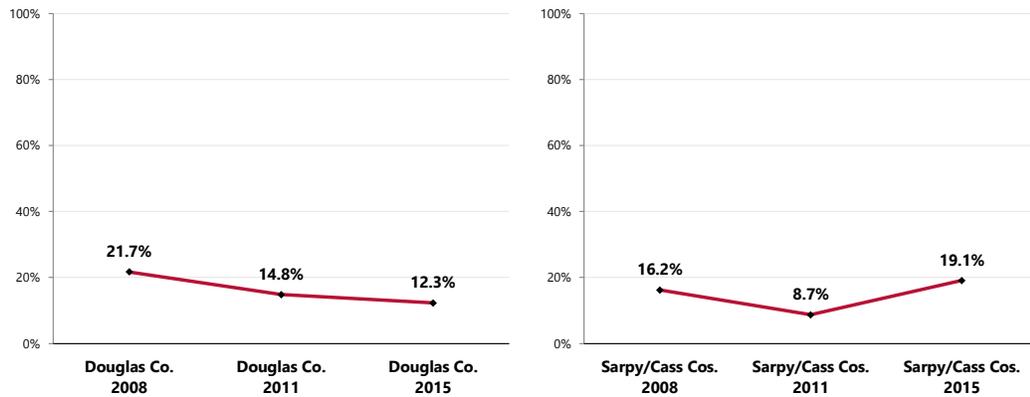
Child Obesity Prevalence
 (Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)
 Healthy People 2020 Target = 14.5% or Lower



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]
 Notes: • Asked of all respondents with children age 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.

- TREND: In Douglas County, note the statistically significant decrease over time (the Sarpy/Cass prevalence is statistically similar to baseline data).

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



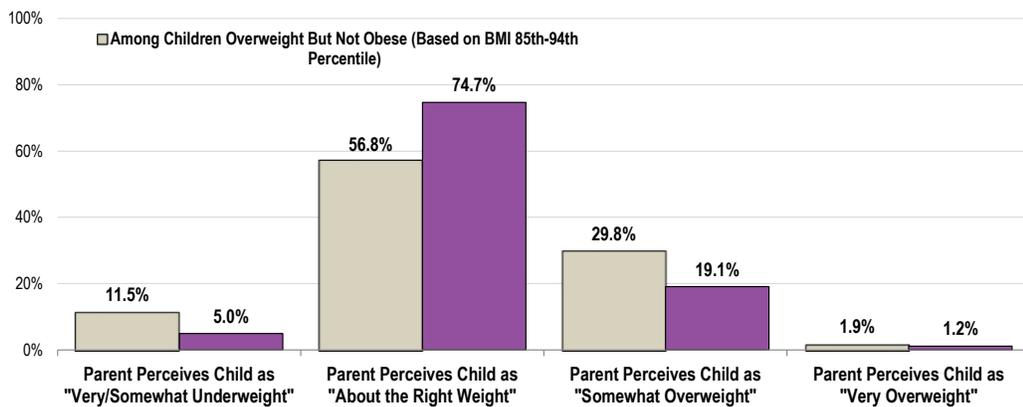
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Obesity among children is determined by children’s Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Actual vs. Perceived Body Weight

Interestingly, among parents of children age 5-17 who are overweight or obese, see their child as being at “about the right weight.”

- Just 29.8% perceive their overweight child as “somewhat overweight,” and only 1.2% of parents with obese children see that child as “very overweight.”

Children’s Actual vs. Perceived Weight Status (Among Overweight/Obese Children Age 5-17; Metro Area, 2015)

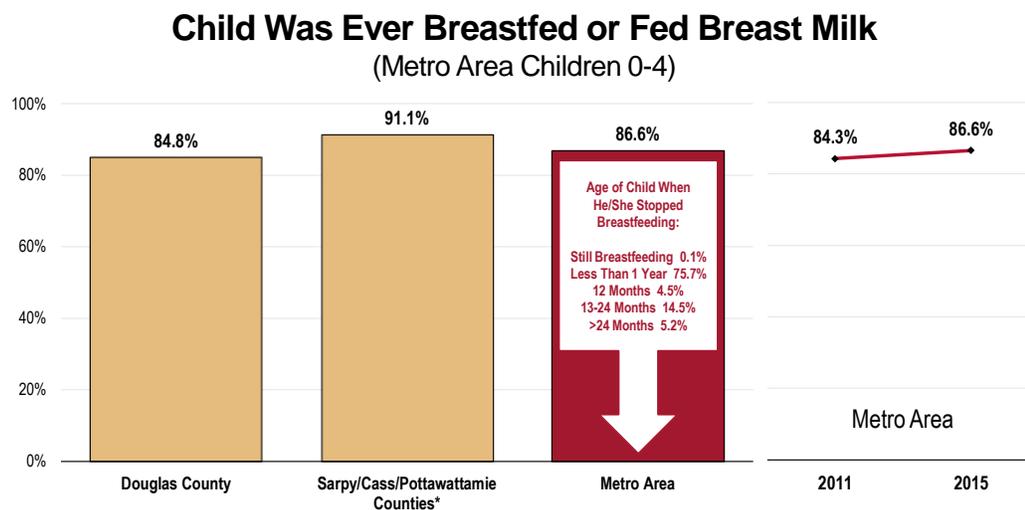


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Overweight in children is defined as a Body Mass Index (BMI) value at or above the 85th percentile of US growth charts by gender and age; obesity in children is defined as a BMI value at or above the 95th percentile.

Breastfeeding

Among parents of children age 0 to 4, 86.6% indicate that their child was breastfed or fed breast milk.

- TREND: Statistically unchanged from 2011 survey results.
- When asked about the age of the child at the end of breastfeeding, 75.7% of these adults reported that the child was **under one** year of age, while 4.5% stopped breastfeeding when the child was **one year old**. Another 14.5% stopped **after his/her first birthday but prior to his/her second birthday**, and 5.2% breastfed until the child was **two years** of age or older.



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 341-342]

Notes: ● Asked of all respondents with children under 5.

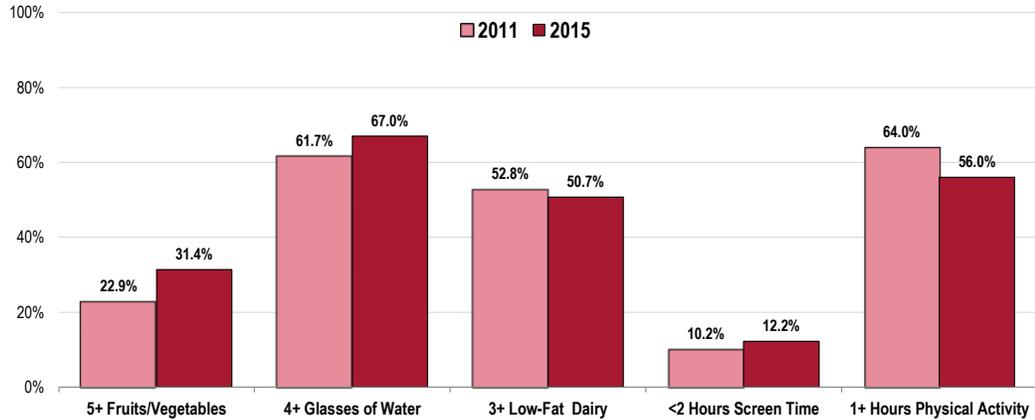
● *Sample size falls below 50; use caution when interpreting percentage results.

“5-4-3-2-1 Go!” Guidelines

As a health initiative geared toward school-aged children in the Metro Area, Live Well Omaha has established the “5-4-3-2-1 Go!” daily guidelines: 5+ servings of fruits/vegetables; 4+ glasses of water; 3 servings of low-fat dairy; <2 hours of screen time; and 1+ hours of physical activity.

Viewing the guidelines individually, area parents are more likely to report that their school-aged child (age 5 to 17) fulfilled the physical activity, water, and dairy guidelines each day in the week preceding the survey. They are less likely to report their child’s compliance with screen time and fruit/vegetable guidelines.

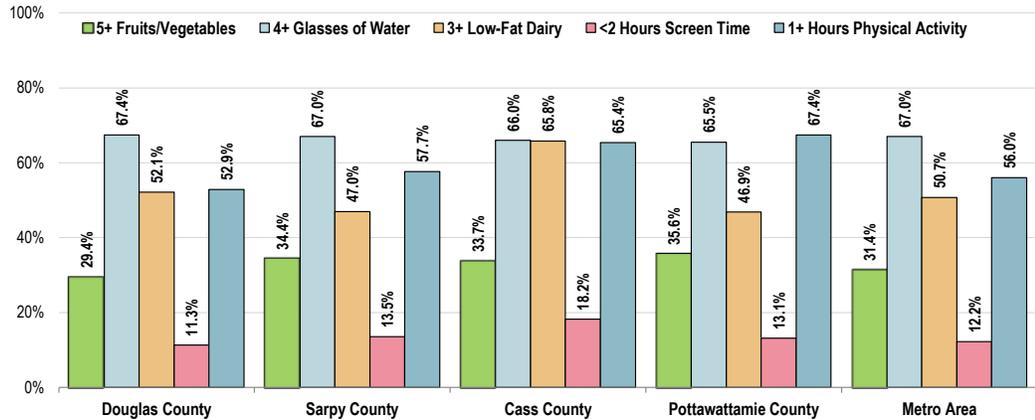
Compliance With Individual “5-4-3-2-1 Go!” Guidelines on Each Day of the Previous Week (Metro Area Children 5-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 117, 182, 343-345, 347]
 Notes: • Asked of all respondents about a child age 5-17 at home.

- The following chart provides an illustration of compliance with the individual guidelines, viewed by county within the Metro Area.

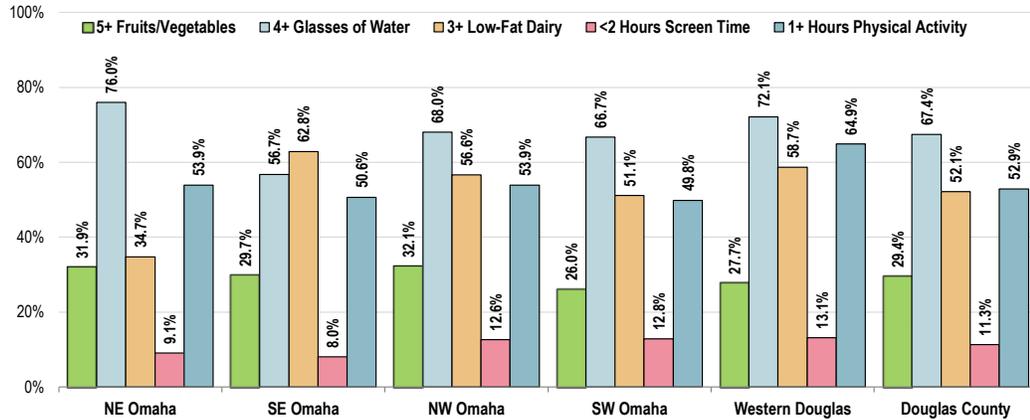
Compliance With Individual “5-4-3-2-1 Go!” Guidelines on Each Day of the Previous Week (Metro Area Children 5-17, by County; 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 117, 182, 343-345, 347]
 Notes: • Asked of all respondents about a child age 5-17 at home.

- The following chart provides an illustration of compliance with the individual guidelines, viewed by county within Douglas County.

Compliance With Individual “5-4-3-2-1 Go!” Guidelines on Each Day of the Previous Week (Metro Area Children 5-17, Douglas County; 2015)

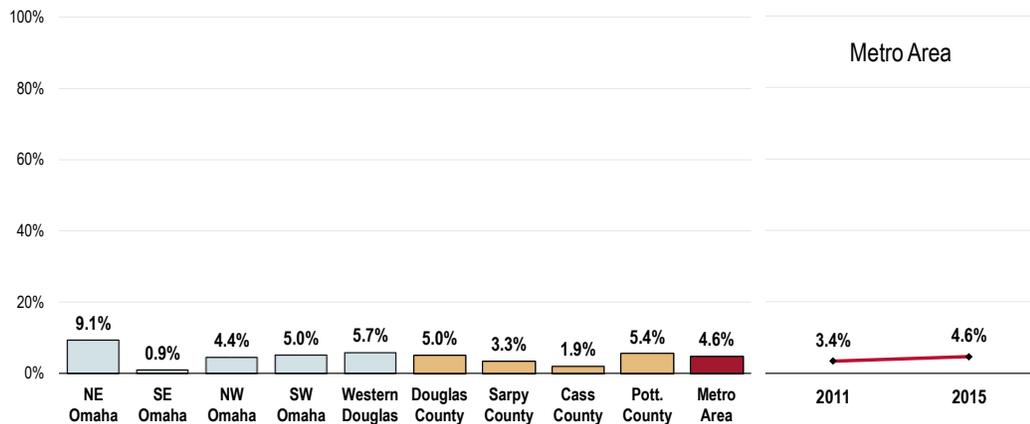


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 117, 343-345, 347]
 Notes: • Asked of all respondents about a child age 5-17 at home.

Overall, just 4.6% of school-aged children in the Metro Area were in compliance with all of the “5-4-3-2-1 Go!” guidelines on each of the 7 days preceding the survey.

- Statistically similar by county within the Metro Area.
- Within Douglas County, lowest in Southeast Omaha.
- TREND: Statistically unchanged from 2011 survey results.

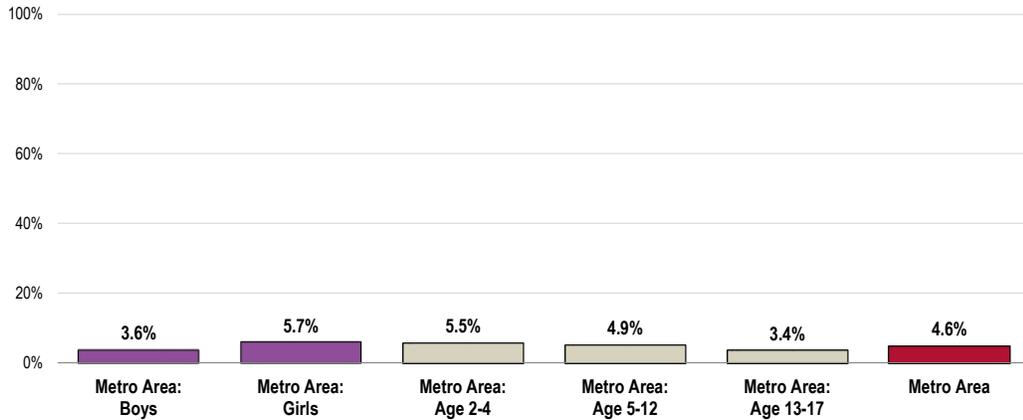
Compliance With All “5-4-3-2-1 Go!” Guidelines on Each Day of the Previous Week (Metro Area Children 5-17, Douglas County; 2015)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 182]
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Percentages represent parents reporting that their child exhibited all desired “5-4-3-2-1 Go!” behaviors on seven of the past seven days.

- No statistically significant difference when viewed by the child’s demographic characteristics.

Compliance With All “5-4-3-2-1 Go!” Guidelines on Each Day of the Previous Week (Metro Area Children 5-17, Douglas County; 2015)



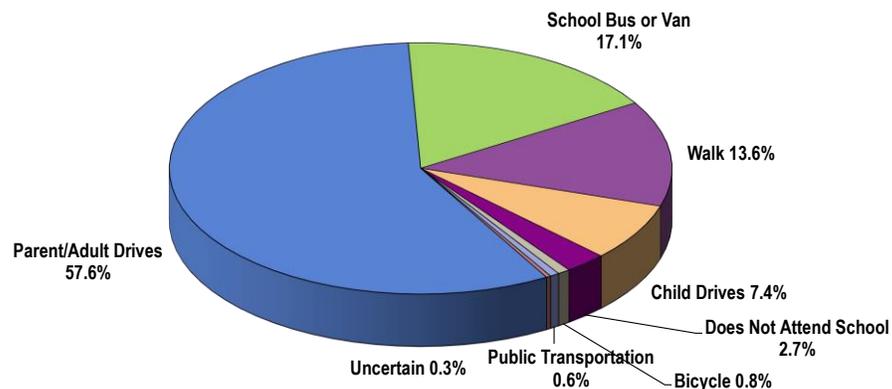
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 182]
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Percentages represent parents reporting that their child exhibited all desired “5-4-3-2-1 Go!” behaviors on seven of the past seven days.

Walking or Riding a Bicycle to School

When parents of Metro Area school-aged children were asked to indicate how their child gets to school, 57.6% report that they (or another adult) drive their child; another 7.4% indicate that the child drives him/herself.

- Another 17.1% of school-aged children ride a school bus or van, while 13.6% walk to school (just 0.8% bike to school).

Means of Transportation to School on Most Days (Metro Area Children 5-17, 2015)

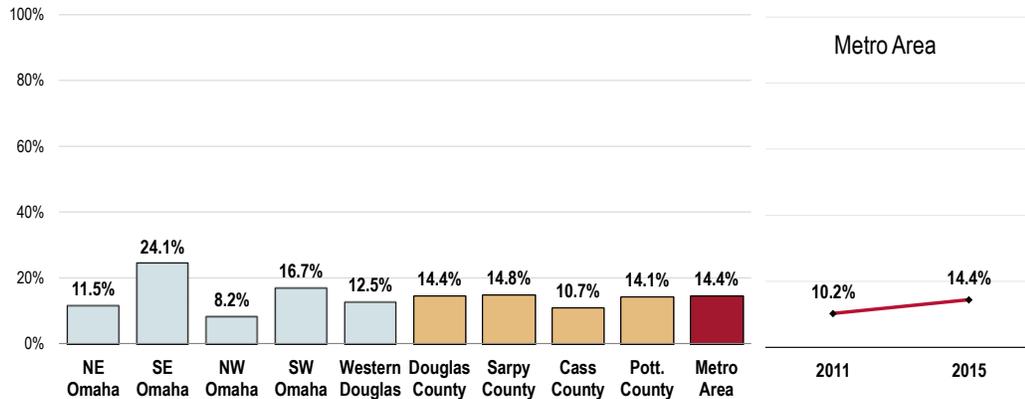


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 348]
 Notes: • Asked of all respondents about a child age 5-17 at home.

Overall, 14.4% of Metro Area school-aged children walk or bike to school.

- Among the four Metro Area counties, statistically similar survey results.
- Within Douglas County, lowest in Northwest Omaha.
- TREND: Denotes a statistically significant increase over time.

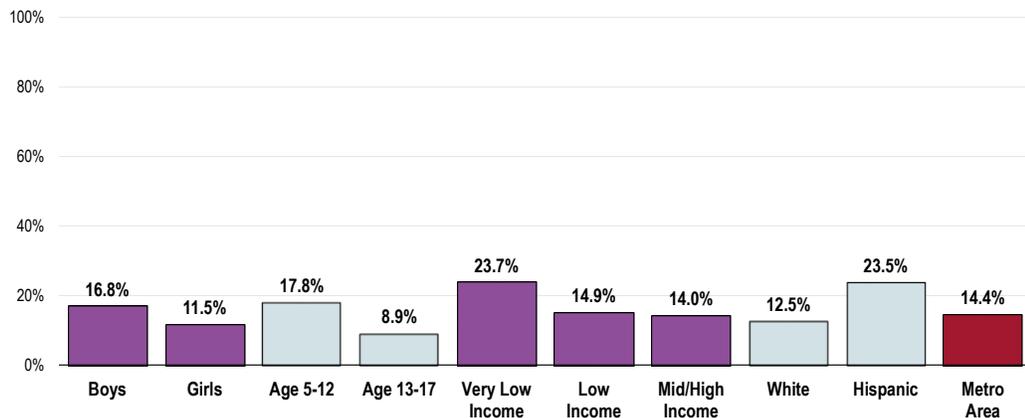
Child Walks/Bikes to School on Most Days (Metro Area Children Age 5-17, 2015)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 348]
 Notes: • Asked of all respondents with children age 5-17 at home.

- Viewed demographically, Metro Area boys, children aged 5-12, those living in poverty, and Hispanics are more likely to walk or bike to the school.

Child Walks/Bikes to School on Most Days (Metro Area Children 5-17, 2015)

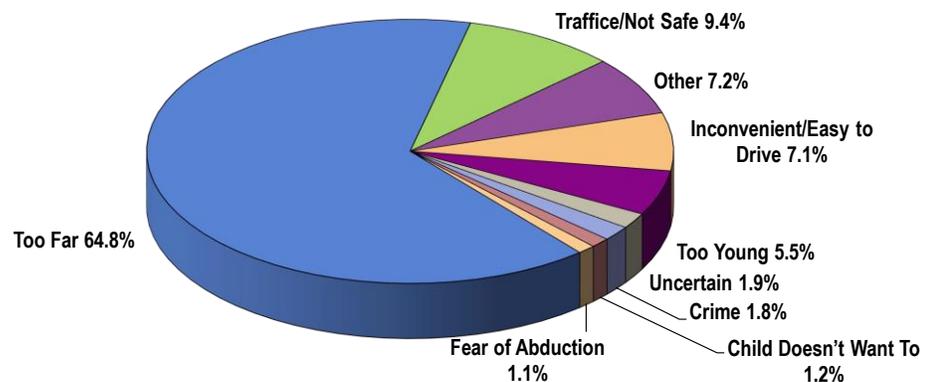


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 348]
 Notes: • Asked of respondents with children age 5-17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

The majority of parents whose children do not walk or bike to school indicate that this is because the distance is too far (64.8%).

- Another 9.4% report that **traffic/no safe route** is the main barrier, while 7.1% feel that having the child walk/bike would be **inconvenient**.
- 5.5% of these parents feel their child is **too young** to walk/bike to school, and 2.9% cited **crime or fear of abduction** as the reason their children to not walk/bike to school.

Reasons Child Does Not Walk/Bike to School on Most Days (Metro Area Children 5-17 Who Do Not Usually Walk/Bike to School, 2015)

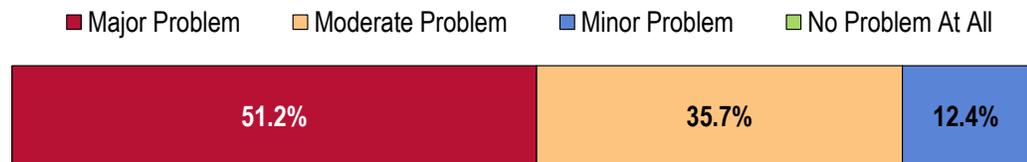


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 349]
 Notes: • Asked of all respondents.

Key Informant Input: Nutrition, Physical Activity & Weight

Just over half of key informants taking part in an online survey characterized *Nutrition, Physical Activity & Weight* as a “major problem” in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Access to Affordable Healthy Foods

Lower income families do not always make the most positive food choices and struggle with issues of health and weight. Youth are reliant on devices, apps, and screen time. – Social Service Provider

Easy access to unhealthy foods. High price for healthy foods. – Social Service Provider

The biggest challenges are a lack of access to healthy food, a lack of health literacy, poverty, and lack of access to safe neighborhoods to get exercise. – Community/Business Leader

The problem is obvious! Fast food, snack food and huge portions at home and at restaurants! - Community/Business Leader

There are areas in Pottawattamie County that would be considered food deserts. Rural areas as well as the west side of Council Bluffs, including Carter Lake, do not have easy access to full service grocery stores. This leaves many families with limited access. – Community/Business Leader

We have active lives, single parents, women working outside the home, availability of fast food establishments, and kids in numerous activities. Easy to stop and grab rather than plan a healthy meal. – Social Service Provider

Food toxic environment. Poor nutritional quality food that is affordable and accessible, especially in poor communities. – Public Health Representative

Access to affordable fruits and vegetables and a built environment that makes it easy for individuals to walk and get regular exercise. – Public Health Representative

Lack of healthy and organic foods, lack of stores that provide those healthier foods, food deserts, not enough community gardens and smaller stores, not enough free standing exercise equipment at parks for adult recreation, too many TV distractions. – Social Service Provider

Our culture makes it difficult for us to get good nutritious food, physical activity. – Healthcare Provider

High cost of healthy food and lack of activity promoted by parents. Parents aren't active to model for their children. Poor representation of a healthy body image instead of just overweight or "skinny." - Other Health

Lack of Education

Lack of education about proper food consumption and type of foods to be eating. Lack of availability of good quality food versus the convenience of fast food. Lack of cooking skills with many persons. Lack of understanding the impact of unhealthy food. – Social Service Provider

Education about healthy lifestyle. – Healthcare Provider

Biggest challenge is teaching someone how to eat healthy when their choices are limited to food bank options. Designed so people go less hungry, loaded with carbs, physical activity is down as people are working longer and harder and do not have energy. – Healthcare Provider

Knowledge about how to be active. The infrastructure of the community advocates for a sedentary lifestyle over a physically active one. There are often a lack of safe places to exercise in many communities in Omaha. Nutrition is a complex topic. – Physician

Lack of knowledge regarding proper nutrition and fitness. – Social Service Provider

Understanding the need for a healthy lifestyle and the willingness to put forth the effort to make those changes. – Healthcare Provider

Nutrition knowledge, cost of nutritious foods, cultural choices, lack of routine activity. – Healthcare Provider

Lack of food for poor and the amount of food stamps they receive. No food stamps for felons. – Social Service Provider

High Rate of Overweight & Obesity

High percentage of overweight children, teens, and adults. – Healthcare Provider

The "overweight" rate and obesity rate seems high for our population. – Social Service Provider

Childhood obesity, poverty, lack of low-cost gyms. – Healthcare Provider

Childhood obesity on the rise. – Social Service Provider

With the rising amount of children being obese from lack of activity and increased time in front of a

screen of some type, as well as the large increases we are seeing in homelessness and impoverished families, nutrition, physical activity and weight. – Social Service Provider

National surveys suggest Douglas County residents are not meeting national recommendations. – Public Health Representative

Children in the community with record levels of obesity. Adults with very poor eating habits. All of this leads to a very unhealthy community. – Social Service Provider

Obesity is on the rise. It affects so many other health issues. – Physician

I see a lot of overweight kids, parents in CB and surrounding communities. Income constraints, generational patterns. – Healthcare Provider

Family weight problems, food insecurity. – Public Health Representative

Weight is the biggest issue. Clearly Omaha has a high rate of obesity in its population. It also has a high rate of binge drinking. – Social Service Provider

Infrastructure

Lack of safe, accessible recreational areas in parts of Omaha, such as North and South Omaha. Less nutritious foods are less expensive, easy to prepare. – Healthcare Provider

Safe walking trails in high risk communities, lack of ongoing education regarding preventive care. – Social Service Provider

Lack of sidewalks in many neighborhoods. Lack of access to fresh produce in many neighborhoods. – Healthcare Provider

Lack of time and money for healthy meal planning. Lack of places to exercise safely. – Physician

Leisure time focus on sedentary activities, streets that are not pedestrian or bike friendly, pervasive advertisements for junk foods and fast food, proliferation of fast food options. – Social Service Provider

Socioeconomic Factors

Money and safe neighborhoods. – Social Service Provider

Money. – Public Health Representative

For some the problem is related to poverty and access. For many it is lifestyle and poor choices. – Social Service Provider

The lack of these things contributes to other major chronic health conditions. – Social Service Provider

It costs money to join an exercise club or gym, nothing is free. Need free nutrition classes for overweight adults and children in CB. – Healthcare Provider

Behavioral Risk Factors

Education on nutrition and exercise and self-motivation to follow the correct practices. – Healthcare Provider

People in general are less active. Doctors are not addressing the emotional issues around food and eating as an addiction. – Healthcare Provider

Patient motivation to change lifestyle. Food deserts in urban settings. Soda and fast food addiction. Sedentary lifestyle. – Physician

Our indicators for physical activity and nutrition do not meet the Healthy People goals. The biggest challenge is sedentary lifestyle and poor eating habits. – Social Service Provider

Culture

Education, cultural attitudes and lack of low cost/free facilities for physical activities. – Physician

There seems to be a trend in Council Bluffs that we are from the Midwest and it's ok to be overweight. Live Well Council Bluffs is trying to help guide the healthy choice as the best choice and physical activity is important. – Community/Business Leader

Cultural eating and physical activity habits. Lack of education on genetics, diabetes. – Community/Business Leader

Lack of Support

For patients without resources, I am not aware of any options. Many third-party payers don't pay for weight loss. – Physician

Parents failure to ensure children have activities. – Community/Business Leader

Healthcare providers being adept at having the difficult client conversations and having adequate

preventive and supportive services, especially for those beyond the preventive stage. – Social Service Provider

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

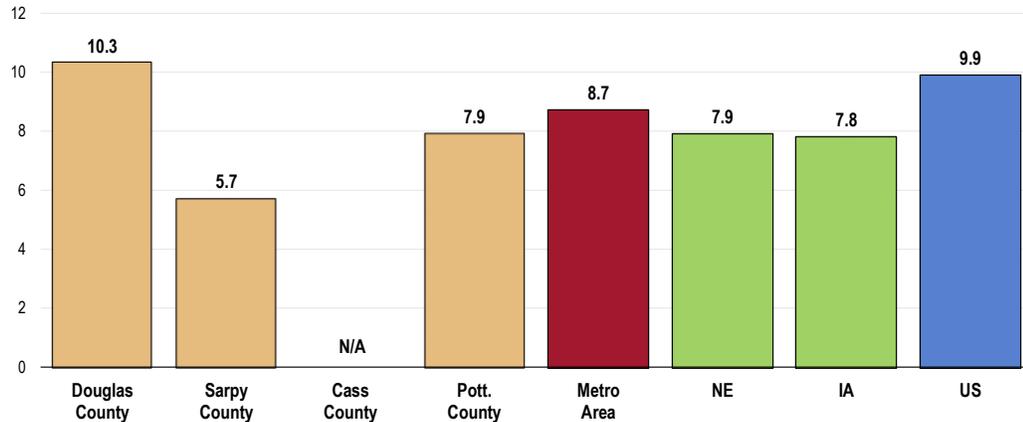
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2011 and 2013, there was an annual average age-adjusted cirrhosis/liver disease mortality rate of 8.7 deaths per 100,000 population in the Metro Area.

- Higher than the statewide rates.
- Lower than the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).
- Unfavorably high in Douglas County.

Cirrhosis/Liver Disease: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



Sources:

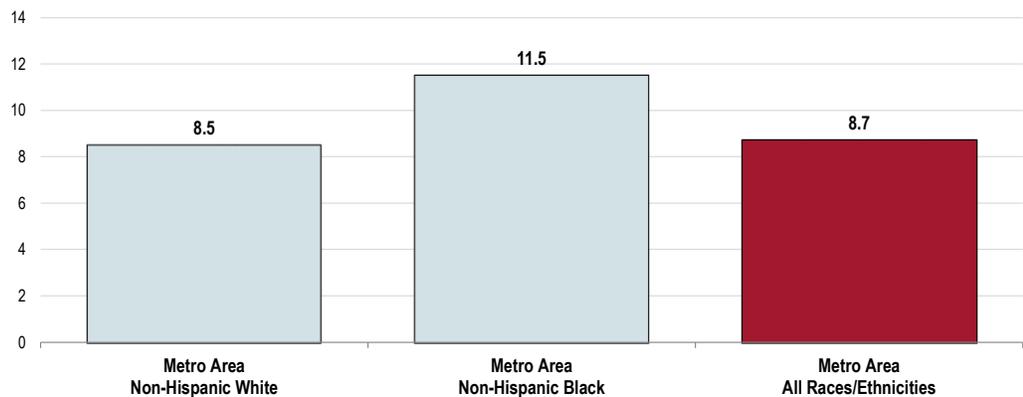
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The cirrhosis mortality rate is higher among Blacks when compared with Whites in the Metro Area.

Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



Sources:

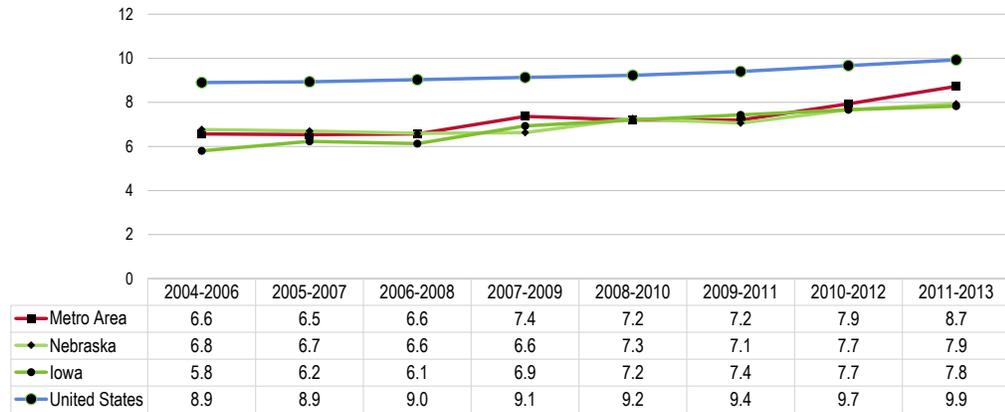
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The mortality rate has increased over time in the Metro Area, echoing the state and US trends.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● State and national data are simple three-year averages.

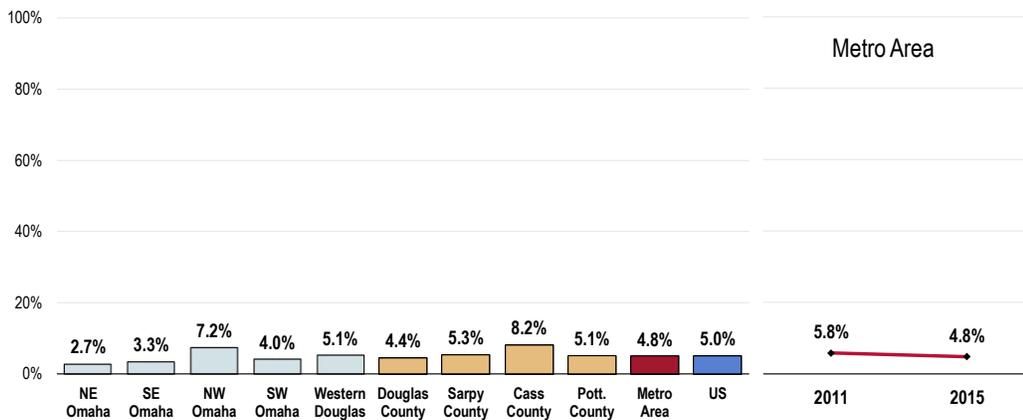
Drinking & Driving

A total of 4.8% of Metro Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

- Similar to the national findings.
- Similar by county in the Metro Area.
- In Douglas County, unfavorably high in Northwest Omaha.
- TREND: Statistically unchanged over time.

Have Driven in the Past Month After Perhaps Having Too Much to Drink

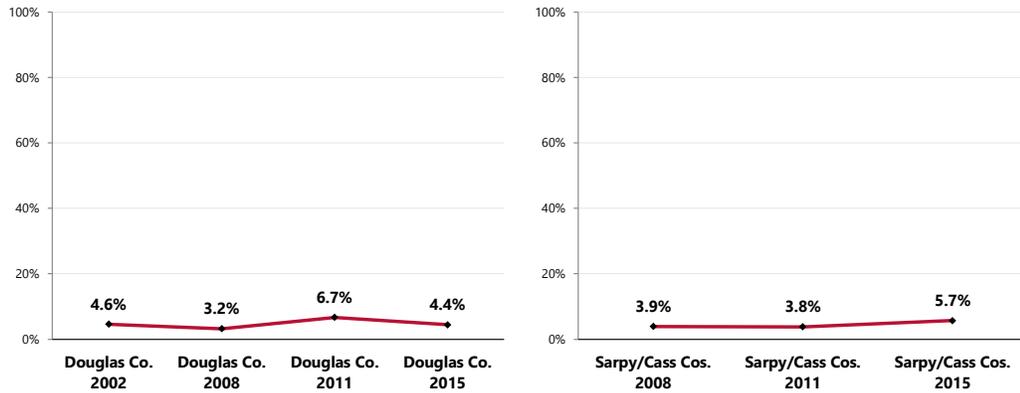


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 65]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents.

- TREND: The prevalence has not changed significantly over time in either area.

Have Driven in the Past Month After Perhaps Having Too Much to Drink



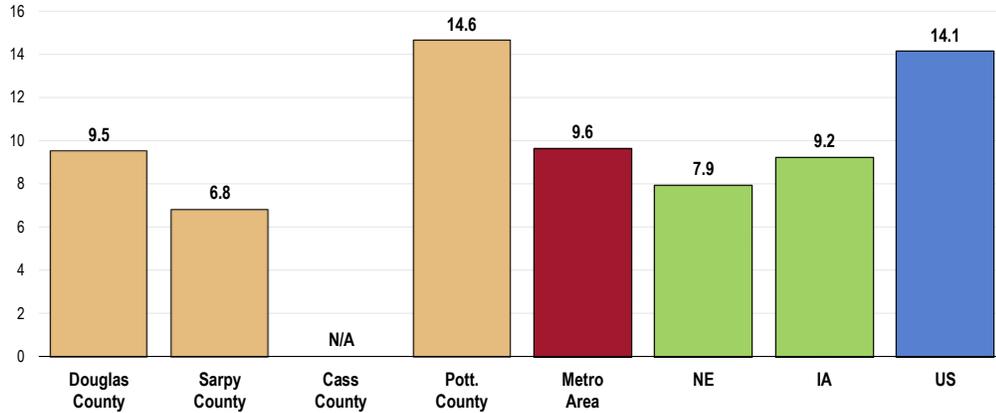
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 65]
 Notes: • Asked of all respondents.

Age-Adjusted Drug-Induced Deaths

Between 2011 and 2013, there was an annual average age-adjusted drug-induced mortality rate of 9.6 deaths per 100,000 population in the Metro Area.

- Worse than the Nebraska rate but similar to the Iowa rate.
- Well below the national rate.
- Satisfies the Healthy People 2020 target (11.3 or lower).
- Highest in Pottawattamie County.

Drug-Induced Deaths: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 11.3 or Lower



Sources:

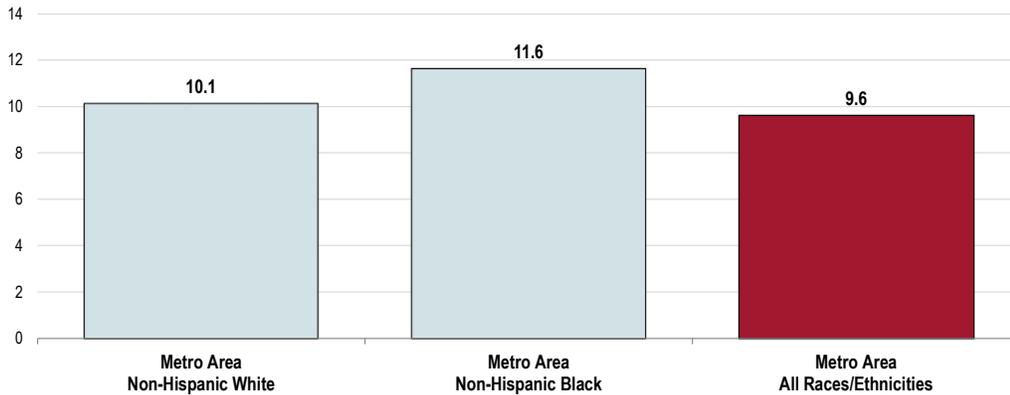
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The drug-induced mortality rate is higher in the Metro Area's Black population.

Drug-Induced Deaths: Age-Adjusted Mortality by Race (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 11.3 or Lower



Sources:

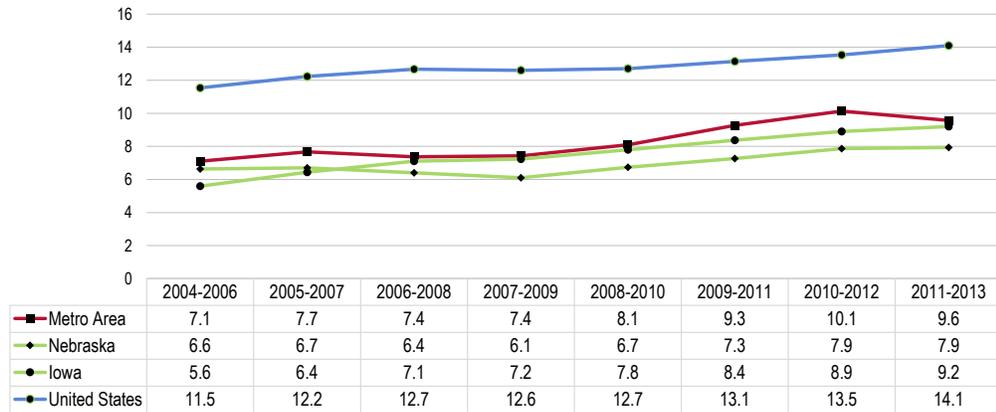
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The mortality rate has increased over time, in keeping with state and national trends.

Drug-Induced Deaths: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 11.3 or Lower



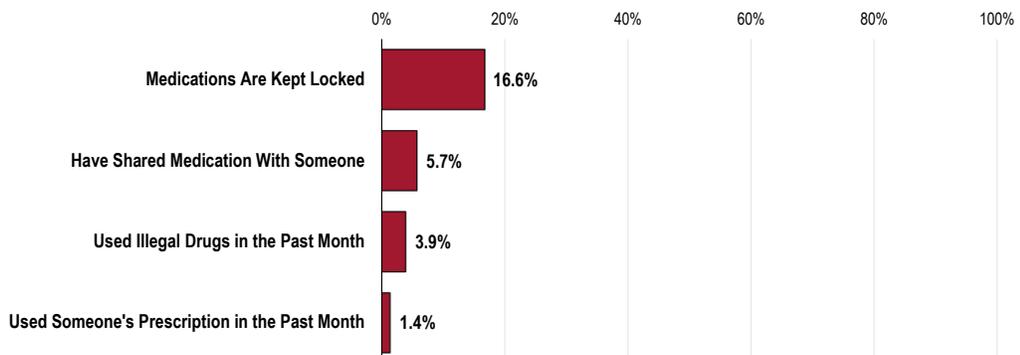
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● County, state and national data are simple three-year averages.

Drug Misuse

Respondents were next asked a series of questions about prescription and illegal drug use, including use of illegal drugs as well as the sharing and safekeeping of prescription drugs.

The largest share of responses (16.6%) was by respondents who report locking up their prescription medications. Fewer local adults (5.7%) have shared a prescription medication with someone, and 3.9% report using an illegal drug in the past month. Just 1.4% used someone else’s prescription medication in the past month.

Drug Storage & Drug Misuse (Metro Area, 2015)

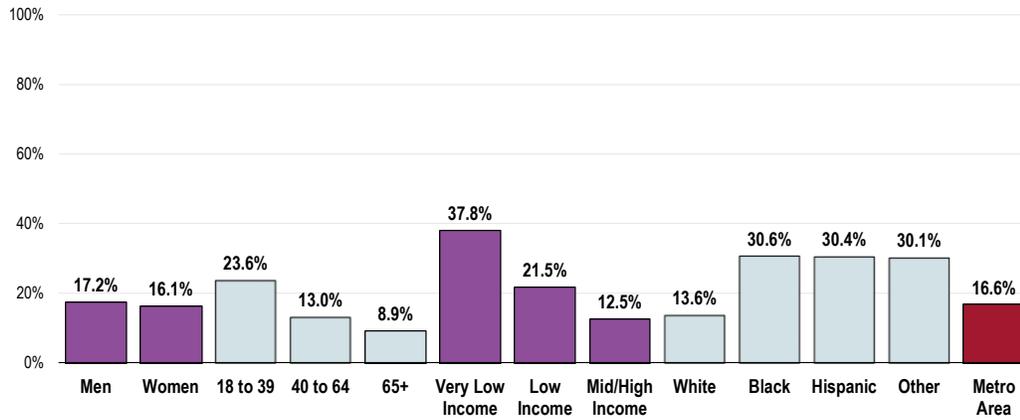


Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 316-319]
Notes: ● Asked of all respondents.

Locked Medications

- Whites are much less likely than other races/ethnicities to lock up their medications.
- Note also the negative correlations with age and income.

Keep Medications Locked Up
(Metro Area, 2015)

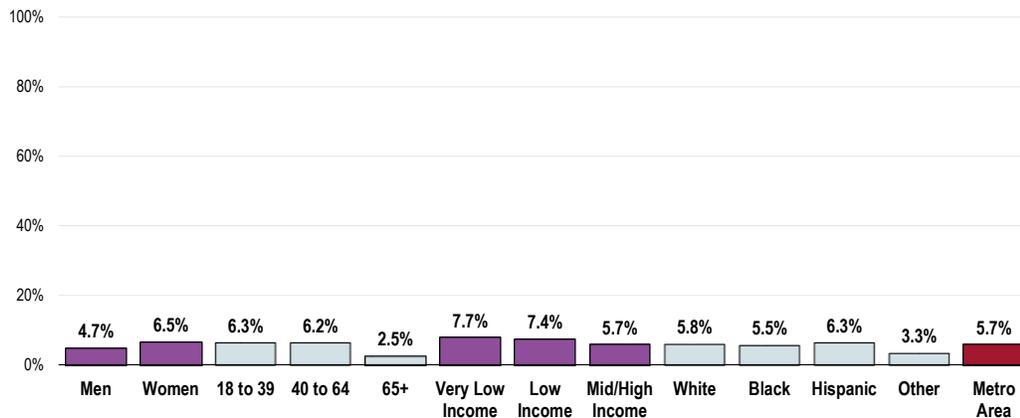


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 316]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Shared Prescriptions

- Residents under 65 are much more likely than seniors to have ever shared a prescription medication with another person.

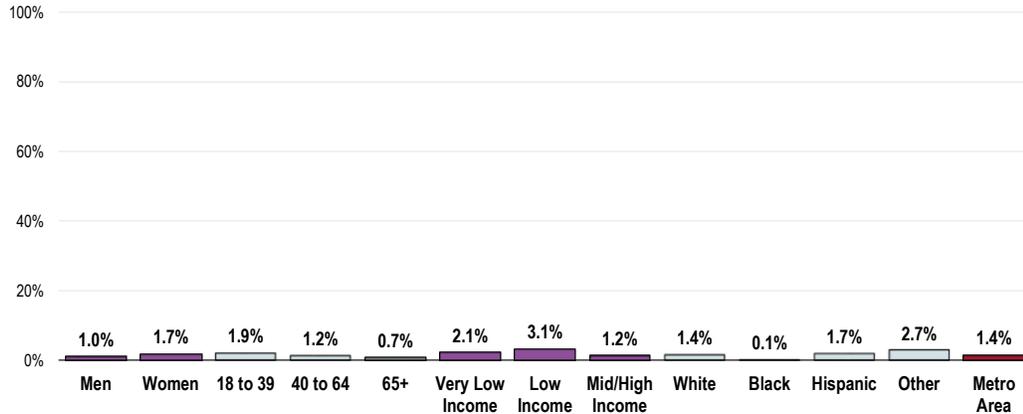
Have Ever Shared Prescription Medication With Someone Else
(Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 317]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

- With regard to taking someone else’s prescription medication, note that Blacks are least likely to report doing so.

Have Taken Someone Else’s Prescription in the Past Month (Metro Area, 2015)

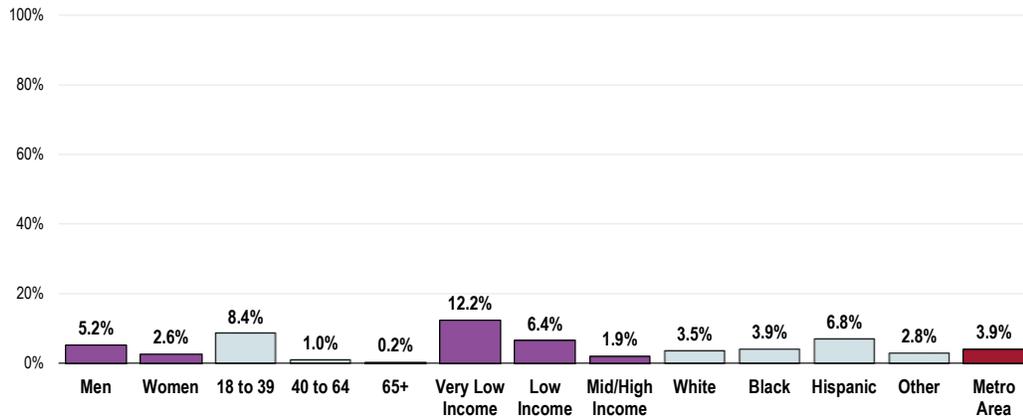


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 318]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Illegal Drugs

- These adults are more likely to report using an illegal drug in the past month: men, young adults (negative correlation), and low-income residents (negative correlation).

Used an Illegal Drug in the Past Month (Metro Area, 2015)



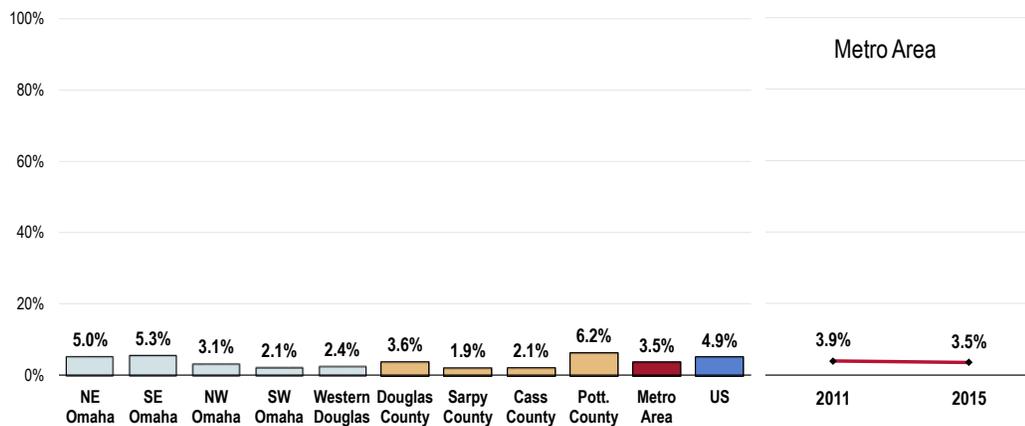
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 319]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Alcohol & Drug Treatment

A total of 3.5% of Metro Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Significantly lower than national findings.
- Lowest in Sarpy County, highest in Pottawattamie County.
- In Douglas County, lowest in Southwest Omaha.
- TREND: Statistically unchanged over time.

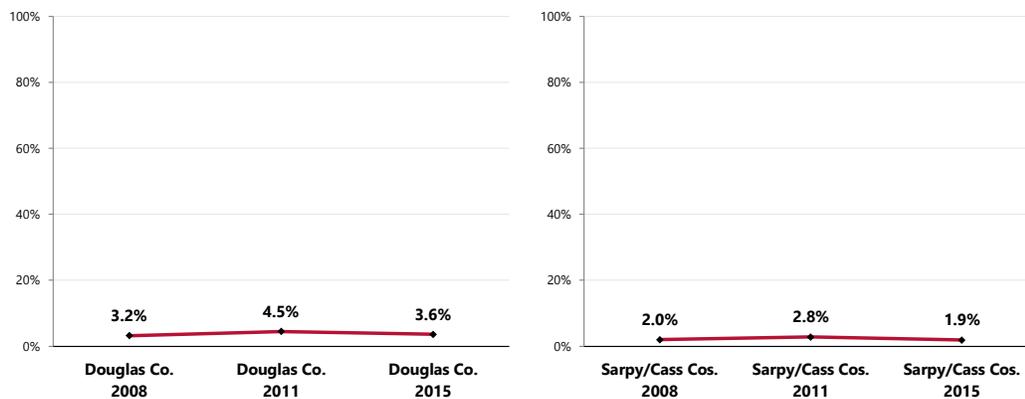
Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 67]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

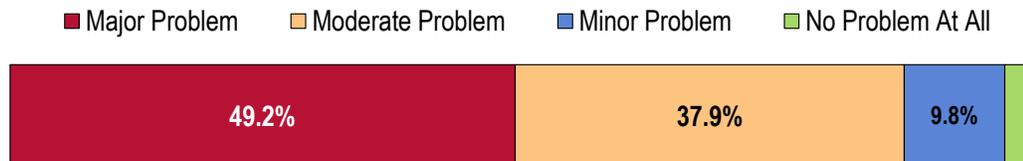


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 67]
 Notes: • Asked of all respondents.

Key Informant Input: Substance Abuse

Just less than half of key informants taking part in an online survey characterized *Substance Abuse* as a “major problem” in the community.

Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Barriers to Treatment

Among those rating this issue as a “major problem,” the greatest barriers to accessing substance abuse treatment are viewed as:

Lack of Resources

Lack of access to practitioners, lack of resources to get needed treatments or medications, poverty, lack of transportation. – Community/Business Leader

Lack of practitioners in the field. – Healthcare Provider

Lack of providers. Reimbursement rates are too low. This leads to low salaries and an inability to attract and/or retain talent. In addition, substance abuse treatment needs to be integrated with mental healthcare. – Social Service Provider

Not enough providers for inpatient substance abuse or long term substance abuse treatment. – Healthcare Provider

Programs located in their catchment area. – Social Service Provider

Too few high quality treatment centers. – Physician

There is a great shortage of any type of substance abuse treatment programs (other than the VA). – Physician

Awareness and number of available resources. Financial difficulty of obtaining needed services. – Public Health Representative

Lack of treatment facilities, financial issues. – Social Service Provider

Few services are available, inpatient treatment is not available. – Public Health Representative

Lack of facilities. – Social Service Provider

Lack of facilities/beds and numbers too great finances. – Healthcare Provider

No inpatient treatment! No navigation through the system. No navigation in post treatment. Little or no aftercare. Little new research is being used. – Social Service Provider

Knowledge of resources, access to resources, affordability of services. – Social Service Provider

Lack of appropriate mental health services and people self-medicate with drugs. Lack of appropriate substance abuse treatment programs, especially for pregnant and parenting women is hugely lacking in our community. – Physician

Numbers of available beds and costs associated with. – Social Service Provider

No inpatient treatment program in Council Bluffs. Closest is Manning of Fort Dodge or people have to go to Omaha where funding is not available. – Healthcare Provider

Adequate insurance is one. Another is willingness to seek treatment as it often takes many times for the treatment to be successful. – Social Service Provider

Many people who abuse substances may not have insurance coverage or resources to pay for treatment. – Healthcare Provider

No culturally appropriate treatment facility or programs in the community. Incarceration seen as a way to address the problem, dehumanizing it. – Community/Business Leader

Culturally appropriate services and professionals, adequate insurance coverage and Medicaid expansion. – Social Service Provider

Lack of local resources to assist with treatment, lack of good role models, particularly parents, relatives, friends and neighbors. – Healthcare Provider

I'm not sure it's about people not being able to access treatment but more about people not utilizing treatment options. – Social Service Provider

Because there isn't any in the area. – Healthcare Provider

Lack of services in our community and lack of a variety of levels of care, long wait lists and wait periods, stigma, transportation. – Social Service Provider

Affordable Care

Costs of care. Access availability of the appropriate level of care. Feeling helpless and mental health issues may distract or prevent care for substance use addictions. – Social Service Provider

Affordable healthcare. – Social Service Provider

Access is limited for urgent care, there is limited funding and a community stigma that does not support treatment. – Social Service Provider

Lack of payment resources for residential treatment, denial of extent of the problem. – Social Service Provider

Cost of treatment, lack of desire to commit to treatment, lack of education concerning substance abuse, poverty, lack of healthcare insurance, Medicaid or Medicare. Persons with mental illness lacking the ability to address substance abuse, low-income. – Social Service Provider

Funding/insurance. – Community/Business Leader

If you don't have funding it is hard to obtain CD evaluation and a slot in treatment facility. You have to be on long wait lists to obtain them and by then they have relapsed and miss opportunities due to being sucked back into their addiction. – Healthcare Provider

The cost, self-awareness, and ability to fight the issue as a disease, not a personality flaw. – Social Service Provider

Denial & Stigma

Stigma and limited services. Very limited services for inpatient and medication assisted detox in Omaha. More in Lincoln and Grand Island. – Social Service Provider

Denial that they have a problem, low self-esteem, lonely and depressed. Feel that it will make their pain go away. Per Boys Town survey it is one of the top five key health concerns for children and adolescents. – Social Service Provider

Denial and how to pay for treatment. – Healthcare Provider

The greatest barrier for people accessing needed treatment is motivation, available programs and payment. – Community/Business Leader

The will to quit. – Community/Business Leader

Not wanting help. – Community/Business Leader

Cost and stigma. – Social Service Provider

The willingness to seek help and fight the addiction. The next challenge is programs that are effective in dealing with the underlying issues of the abuse. – Community/Business Leader

The desire to be drug and alcohol free is the greatest barrier. Often mothers fear the loss of parental rights if they access treatment. Child care is another barrier. – Social Service Provider

High Rate of Abuse

Many abusing S.A. – Healthcare Provider

Still too many children and parents using illegal substances. Facilities have closed so treatment for SA is not readily available and not covered by insurance. – Healthcare Provider

Increased use with persons age 11-25. – Healthcare Provider

High rates of both non-prescription and prescription substance abuse. – Physician

Very high rate of prescription drug usage, illegal drugs, and ease of alcohol abuse. – Public Health Representative

Easy Access & Addiction

Lots of drugs and access to drugs. – Healthcare Provider

Availability, stigma, cost, hours of services, non-recognition of the issue. – Healthcare Provider

The meth problem in CB seems to keep growing. Easy access and cost keep people doing this drug. – Community/Business Leader

Substance abuse leads to so many of our problems. I think the barrier is addiction. – Community/Business Leader

Addiction, cost of treatment, motivation. – Social Service Provider

Most Problematic Substances

Key informants (who rated this as a “major problem”) most often identified alcohol, methamphetamine, and prescription medication as the most problematic substances abused in the community.

| | Most Problematic | Second-Most Problematic | Third-Most Problematic | Total Mentions |
|---|------------------|-------------------------|------------------------|----------------|
| Alcohol | 54.4% | 26.3% | 12.3% | 53 |
| Methamphetamines or Other Amphetamines | 24.6% | 31.6% | 22.8% | 45 |
| Prescription Medications | 12.3% | 12.3% | 36.8% | 35 |
| Marijuana | 7.0% | 12.3% | 5.3% | 14 |
| Cocaine or Crack | 1.8% | 7.0% | 12.3% | 12 |
| Over-The-Counter Medications | 0.0% | 5.3% | 3.5% | 5 |
| Synthetic Drugs (e.g. Bath Salts, K2/Spice) | 0.0% | 1.8% | 3.5% | 3 |
| Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly) | 0.0% | 3.5% | 0.0% | 2 |
| Heroin or Other Opioids | 0.0% | 0.0% | 1.8% | 1 |
| Inhalants | 0.0% | 0.0% | 1.8% | 1 |

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

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).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

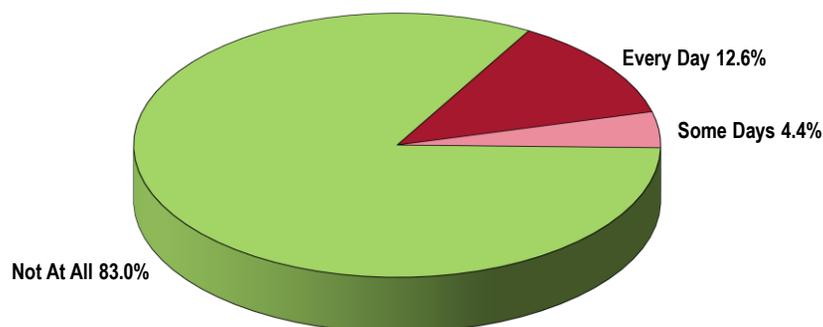
- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 17.0% of Metro Area adults currently smoke cigarettes, either regularly (12.6% every day) or occasionally (4.4% on some days).

Cigarette Smoking Prevalence
(Metro Area, 2015)



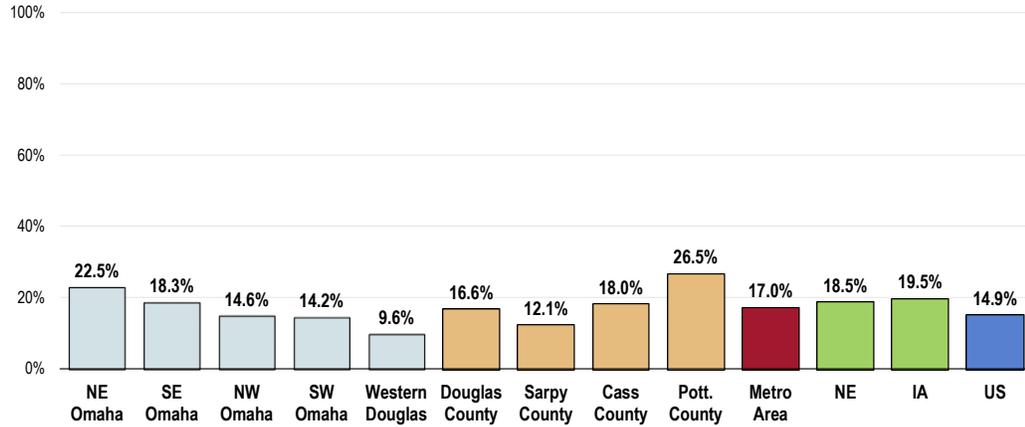
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
Notes: • Asked of all respondents.

- Similar to the Nebraska percentage but more favorable than the Iowa percentage.
- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (12% or lower).
- Least favorable in Pottawattamie County.

- In Douglas County, highest in Northeast Omaha.

Current Smokers

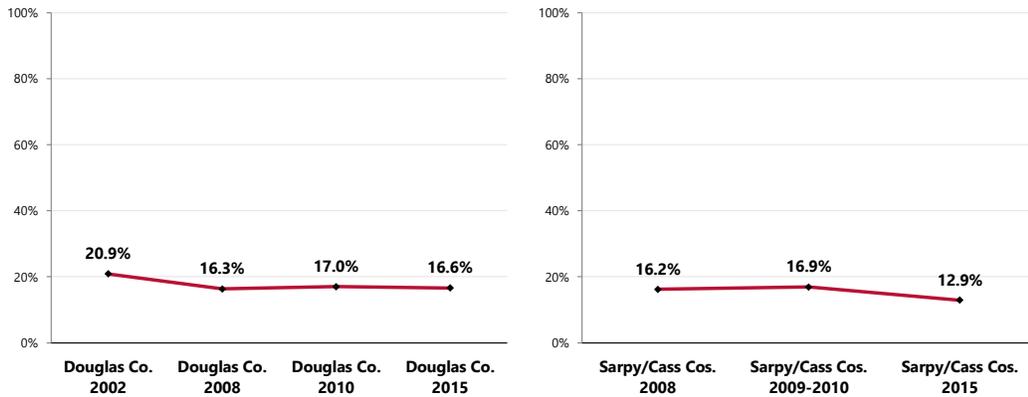
Healthy People 2020 Target = 12.0% or Lower



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Includes regular and occasional smokers (those who smoke cigarettes everyday or on some days).

- TREND: Note the statistically significant decrease over time in Douglas County (the Sarpy/Cass prevalence is statistically unchanged).

Current Smokers



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
- Notes:
- Asked of all respondents.
 - Includes regular and occasional smokers (those who smoke cigarettes everyday or on some days).

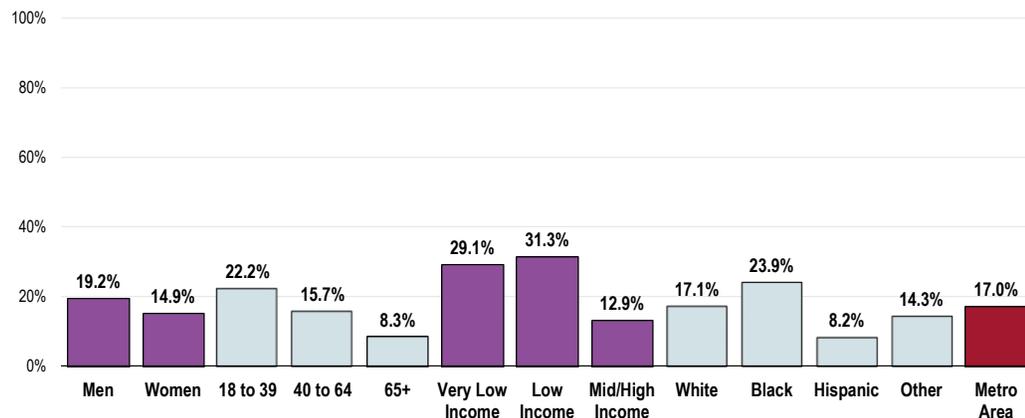
Cigarette smoking is more prevalent among:

- Men.
- Adults under 65 (negative correlation with age).
- Lower-income residents.
- Blacks.

Current Smokers

(Metro Area, 2015)

Healthy People 2020 Target = 12.0% or Lower



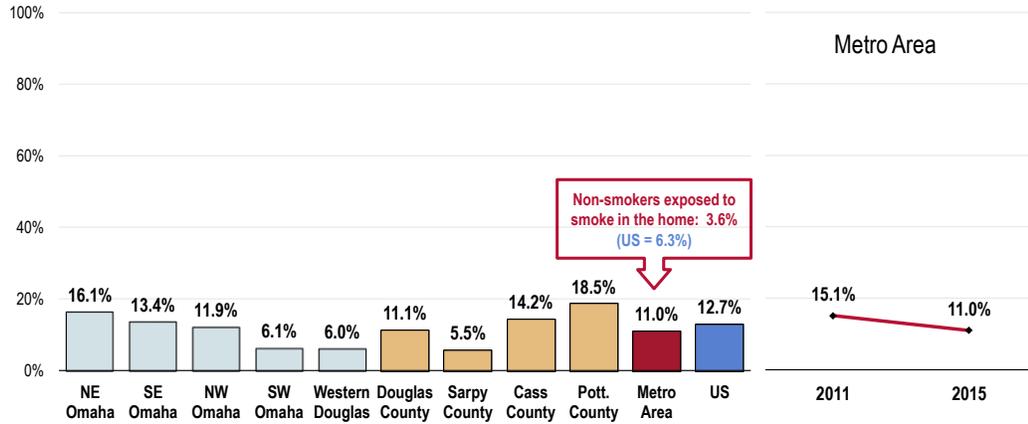
- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - Includes regular and occasion smokers (everyday and some days).

Environmental Tobacco Smoke

A total of 11.0% of Metro Area adults (including smokers and non-smokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Comparable to national findings.
- Least favorable in Pottawattamie County.
- In Douglas County, unfavorably high in Northeast Omaha.
- TREND: Marks a statistically significant decrease over time.
- Note that 3.6% of Metro Area non-smokers are exposed to cigarette smoke at home, more favorable than what is found nationally.

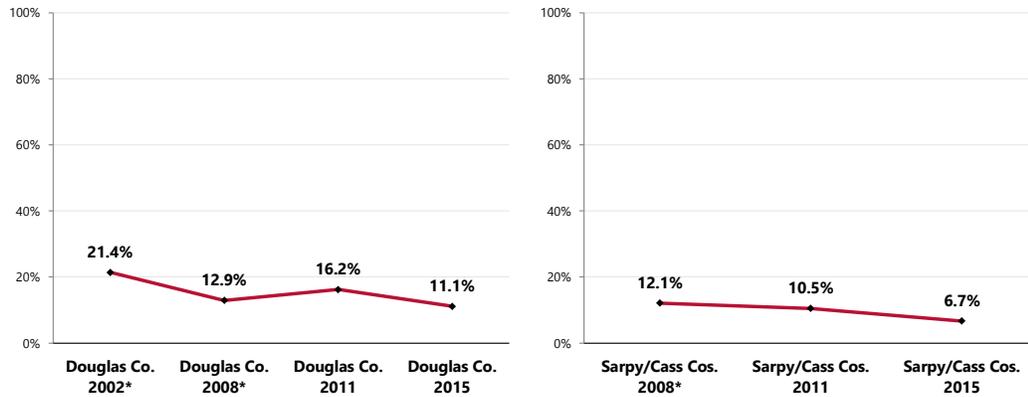
Member of Household Smokes at Home



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 59, 158]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- TREND: Marks a statistically significant decrease over time for Douglas County as well as Sarpy/Cass counties.

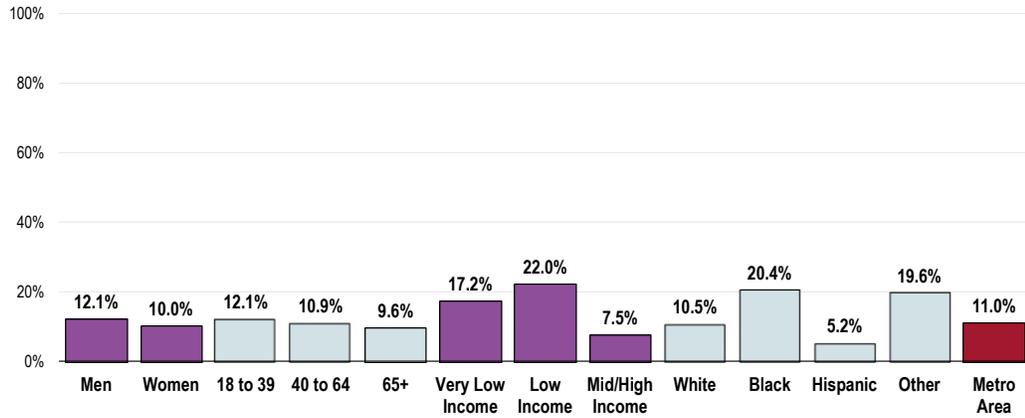
Member of Household Smokes at Home



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 59, 158]
 Notes: • Asked of all respondents.
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among residents with lower incomes, Blacks, and Other races.

Member of Household Smokes At Home (Metro Area, 2015)

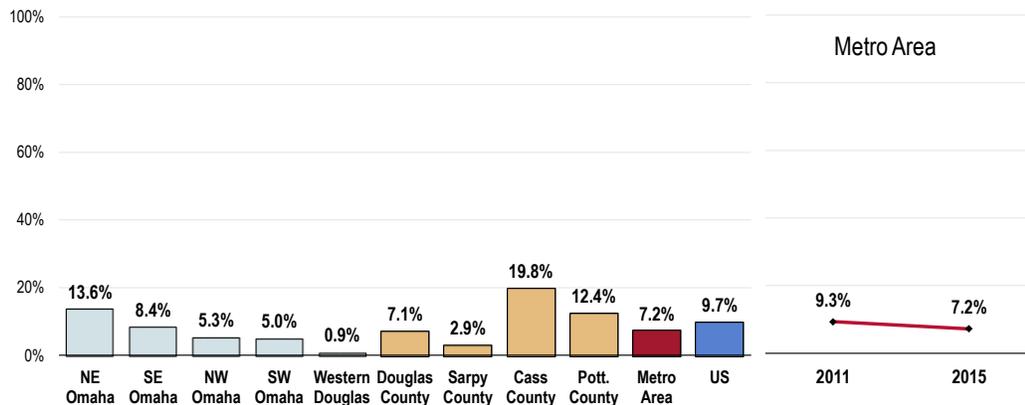


Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
 Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 ● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Among homes with children, 7.2% have someone who smokes cigarettes inside.

- Comparable to national findings.
- Higher in Cass and Pottawattamie counties.
- Highest in Northeast Omaha; lowest in Western Douglas County.
- TREND: Statistically unchanged over time.

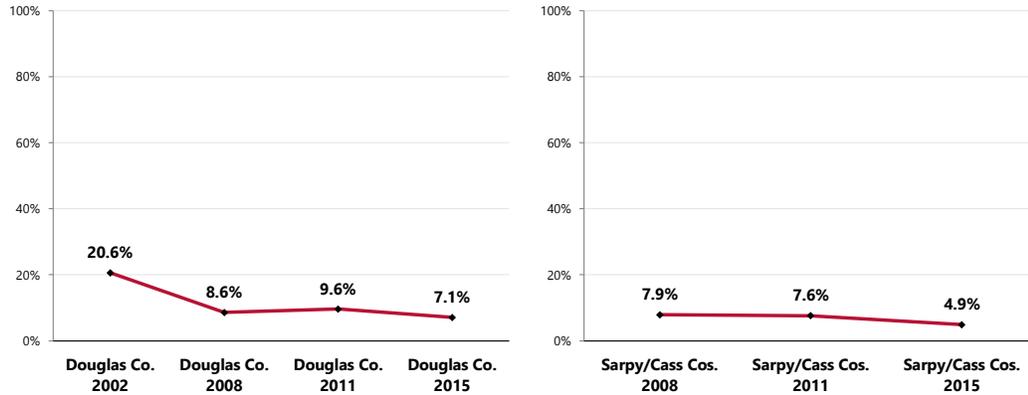
Percentage of Households With Children In Which Someone Smokes in the Home (Among Households With Children)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 159]
 ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: ● Reflects respondents with children 0 to 17 in the household.
 ● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- TREND: Note the statistically significant decrease from baseline data in Douglas County (the Sarpy/Cass prevalence is statistically unchanged).

Percentage of Households With Children In Which Someone Smokes in the Home (Among Households With Children)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 159]

Notes: • Reflects respondents with children 0 to 17 in the household.

• "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

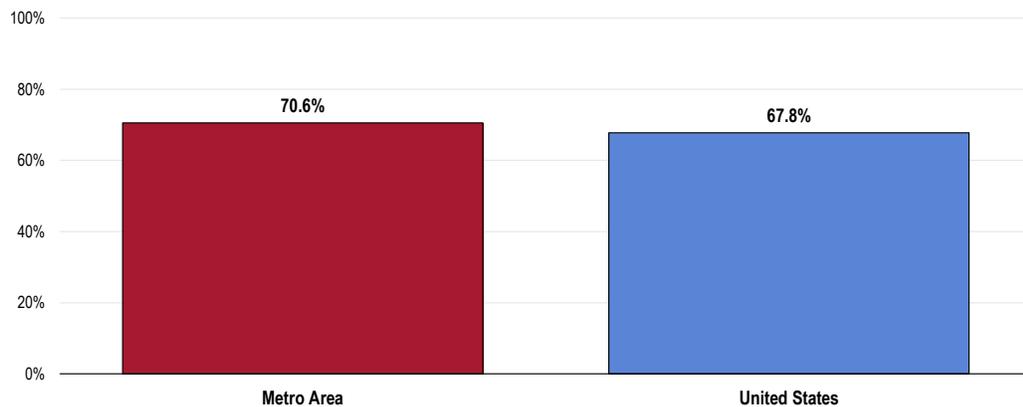
- Healthy People 2020 (www.healthypeople.gov)

Health Advice About Smoking Cessation

A total of 70.6% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Comparable to the national percentage.

Advised by a Healthcare Professional in the Past Year to Quit Smoking (Among Current Smokers)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all current smokers.

Other Tobacco Use

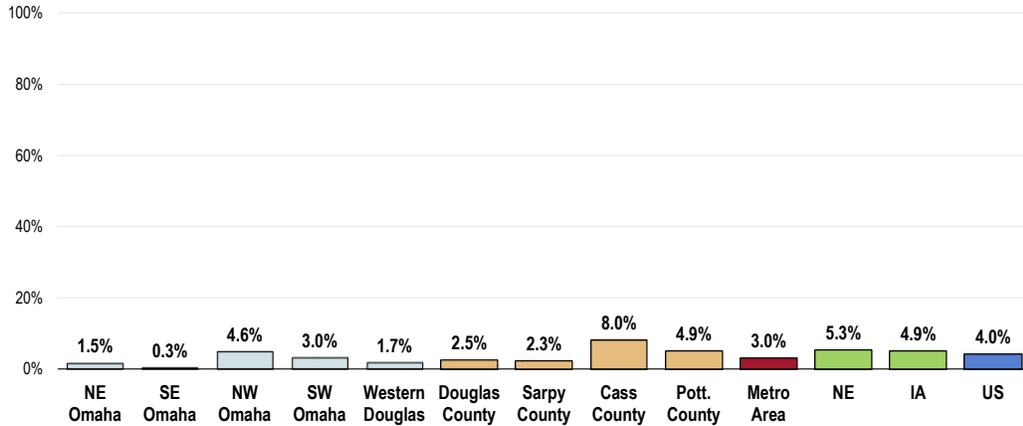
Smokeless Tobacco

A total of 3.0% of Metro Area adults use some type of smokeless tobacco every day or on some days.

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

- More favorable than the state percentages.
- Comparable to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- Unfavorably high in Cass County.
- In Douglas County, highest in Northwest Omaha.

Use of Smokeless Tobacco Healthy People 2020 Target = 0.3% or Lower



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 60]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.2]

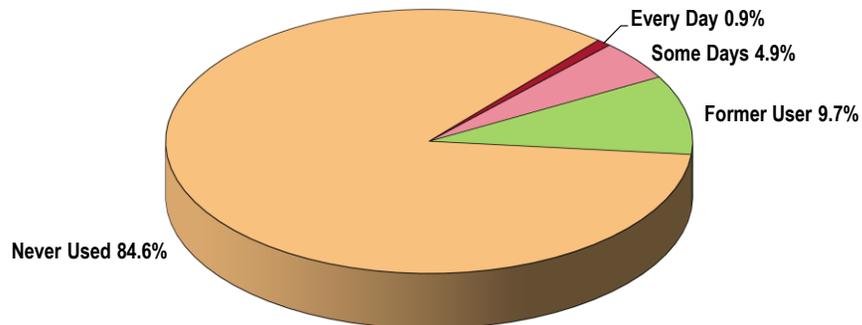
Notes: • Asked of all respondents.
 • Smokeless tobacco includes chewing tobacco or snuff.

Use of Electronic Cigarette (E-Cigarettes)

Asked about their use of electronic cigarettes (“e-cigarettes”), most survey respondents have never used them before (84.6%).

On the other hand, 9.7% of survey respondents are former users of e-cigarettes, and 5.8% are current users (whether every day or on some days).

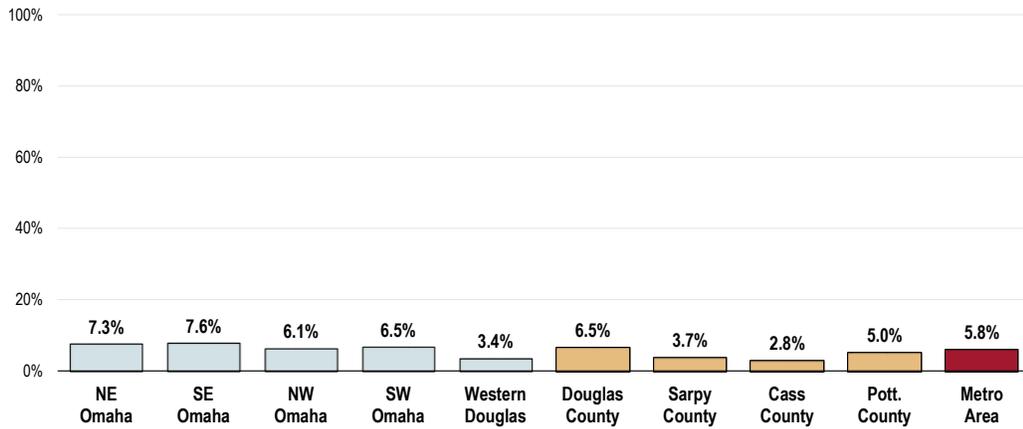
Electronic Cigarette (E-Cigarette) Smoking Prevalence (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
 Notes: • Asked of all respondents.

- Current usage is highest in Douglas County.
- The prevalence is lowest in Western Douglas County.

Currently Use Electronic Cigarettes (E-Cigarettes)

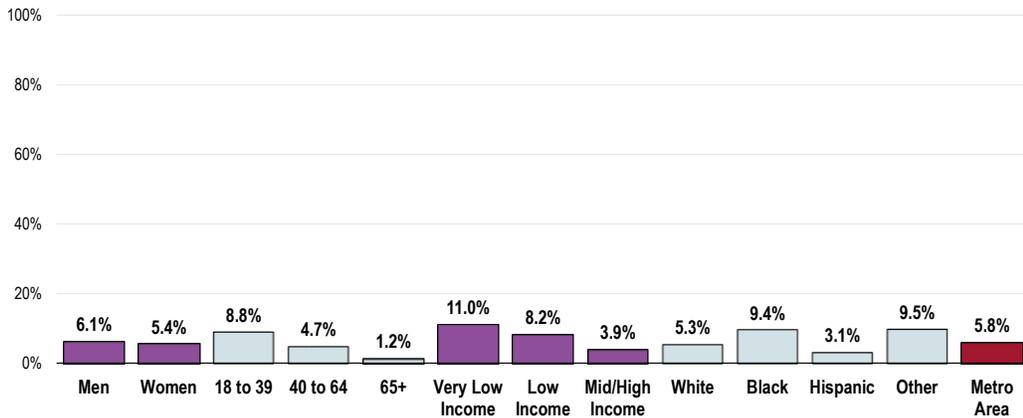


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
 Notes: • Asked of all respondents.

Electronic cigarette smoking is more prevalent among:

- Young adults (negative correlation with age).
- Lower-income residents (negative correlation with income).
- Blacks and Other race residents.

Currently Use Electronic Cigarettes (Metro Area, 2015)

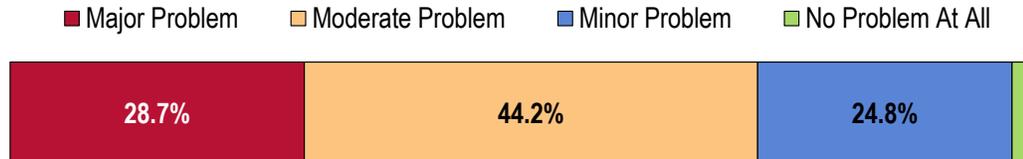


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Current drinkers had at least one alcoholic drink in the past month.

Key Informant Input: Tobacco Use

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

Perceptions of Tobacco Use as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

High Rate of Occurrence

We still have a higher than average smoking rate. We need to continue to educate people on how to quit. – Community/Business Leader

Statistics. Lack of awareness of the harmful effects of tobacco use. – Public Health Representative

Too many smokers and many have no desire to quit. – Healthcare Provider

Even one smoker is one too many. – Social Service Provider

High use. – Healthcare Provider

It is a major killer of Americans. – Social Service Provider

I think that rates of tobacco use are still high despite reductions in the past few years. The latest "County Health Ranking" has Pottawattamie County at 22 percent for adult smoking compared to the state average of 18 percent. – Community/Business Leader

People still smoke. – Social Service Provider

I see many smokers all over the community. – Social Service Provider

Stats on number of active tobacco use in Pottawattamie County. – Public Health Representative

Just using tobacco is a problem, especially pregnant mothers. Using tobacco to deal with mental health symptoms instead of accessing mental healthcare. – Healthcare Provider

High rates of tobacco usage. – Community/Business Leader

Many people continue to smoke despite knowing the negative health risks of doing so. Additionally, e-cigs are all the rage, and while they do not involve tobacco, I believe there are likely still health risks involved in vaping. – Social Service Provider

Young Smokers

PSAs, many young people are smoking. – Social Service Provider

High usage in teens, e-cigs not regulated, much chewing tobacco usage in teen sports. – Public Health Representative

Seems like the strong push to decrease the number of smokers is on the rise again in the younger ages. What damages will e-cigarettes cause? Addiction issues to tobacco. Cost of tobacco when people choose to feed their addiction versus feeding their family. – Social Service Provider

Tobacco use in the community and among youth ages 16-24 is high according to past news articles. – Social Service Provider

Peer pressure. – Community/Business Leader

Young people smoking that cause health related issues such as lung cancer, etc. – Social Service Provider

Lots of teenage and young adults that smoke, seen at public events, or young people that I know. – Healthcare Provider

Co-occurring Morbidities

There is a lot of disease related to smoking. – Physician

Tobacco abuse is a common problem with major health effects. – Physician

Many people still do smoke, but this number is decreasing. However, for those who do smoke there are, obviously, significant health concerns, heart disease, lung disease, etc. – Physician

Cultural Factors

With the casinos being in our community, they are the last public establishment who allows smoking indoors, I think this perpetuates tobacco use. I feel as though I see more people smoking in our community than others. – Social Service Provider

Socioeconomic, rural area. – Healthcare Provider

Access to Health Services



Professional Research Consultants, Inc.

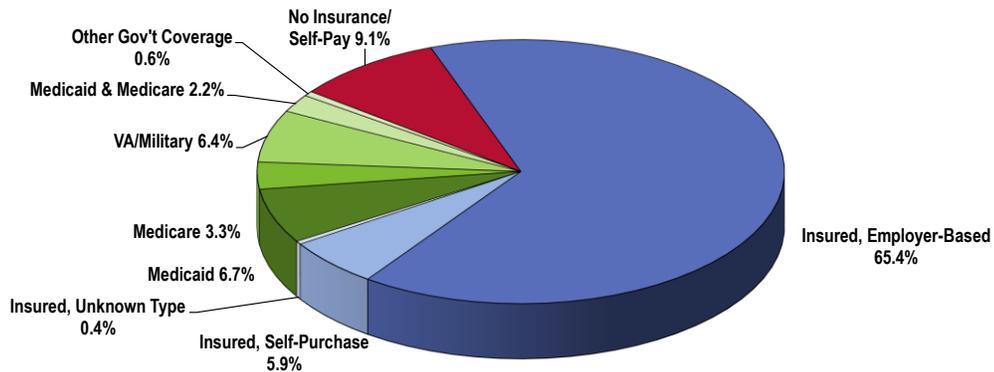
Health Insurance Coverage

Type of Healthcare Coverage

A total of 71.7% of Metro Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 19.2% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

Healthcare Insurance Coverage
(Among Adults Age 18-64; Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
Notes: • Reflects respondents age 18 to 64.

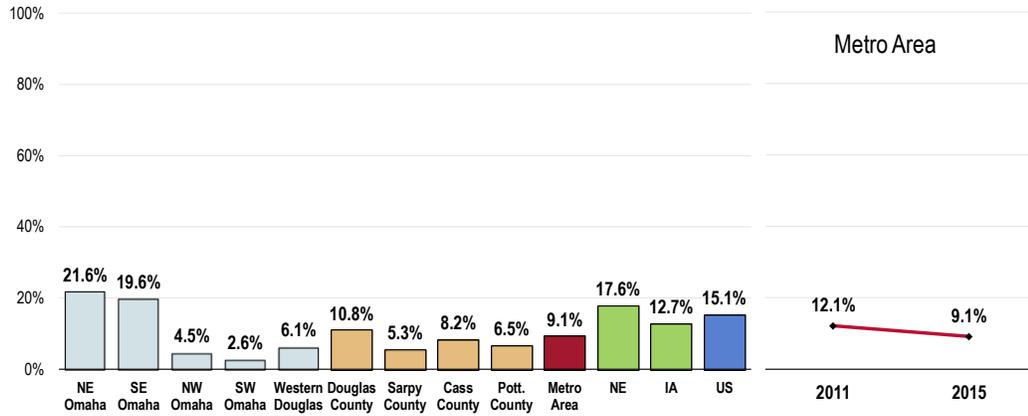
Lack of Health Insurance Coverage

Among adults age 18 to 64, 9.1% report having no insurance coverage for healthcare expenses.

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

- Well below the Nebraska and Iowa findings.
- Well below the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Worst in Douglas County, best in Sarpy County.
- Within Douglas County, unfavorably high in the east.
- TREND: Marks a statistically significant decrease over time.

Lack of Healthcare Insurance Coverage (Among Adults Age 18-64) Healthy People 2020 Target = 0.0% (Universal Coverage)

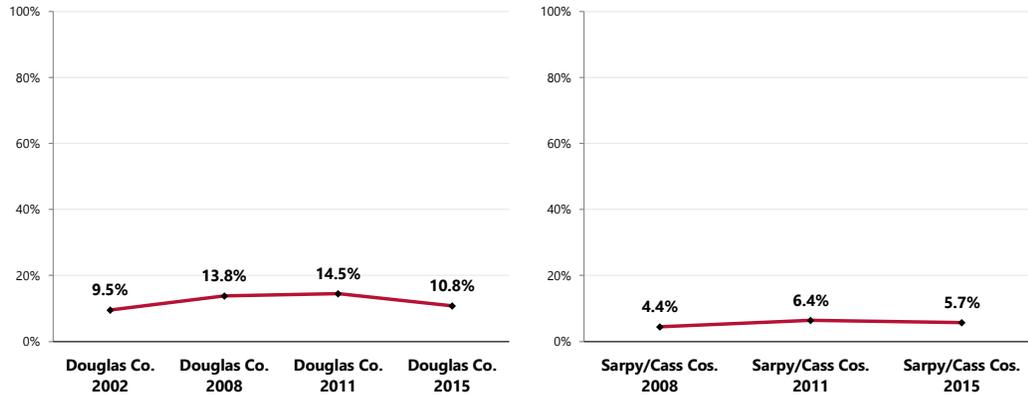


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 165]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]

Notes: • Asked of all respondents under the age of 65.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Lack of Healthcare Insurance Coverage (Among Adults Age 18-64)

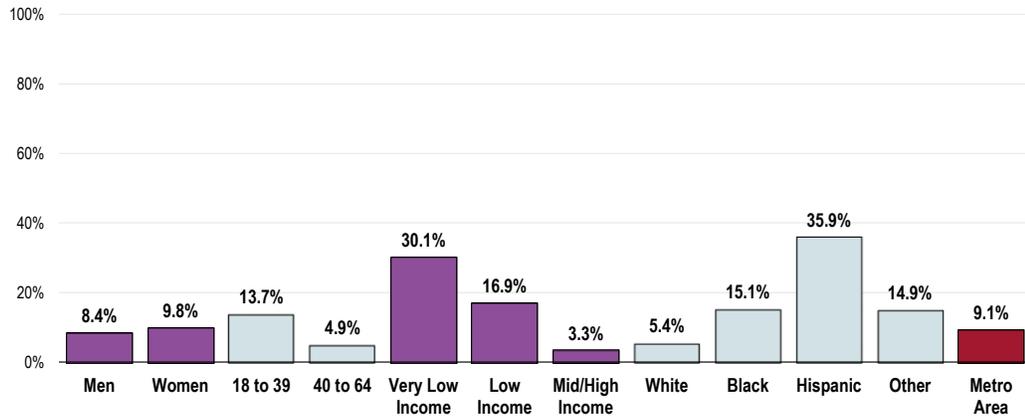


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 165]
 Notes: • Asked of all respondents under the age of 65.

The following population segments are more likely to be without healthcare insurance coverage:

- Young adults.
- Residents living at lower incomes (negative correlation with income).
- Blacks, Other races, and especially Hispanics.

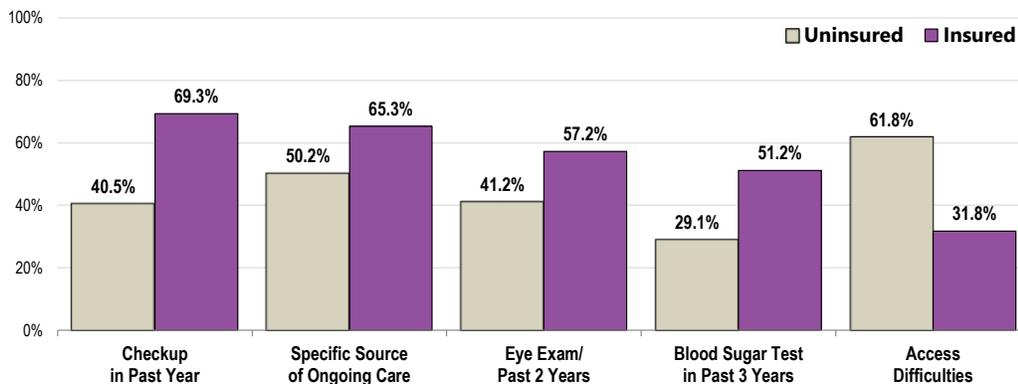
Lack of Healthcare Insurance Coverage (Among Adults Age 18-64; Metro Area, 2015) Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
 Notes: • Asked of all respondents under the age of 65.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

- As might be expected, uninsured adults in the Metro Area are less likely to receive routine care and preventive health screenings and are more likely to have experienced difficulties accessing healthcare.

Preventive Healthcare (By Insured Status; Metro Area, 2015)



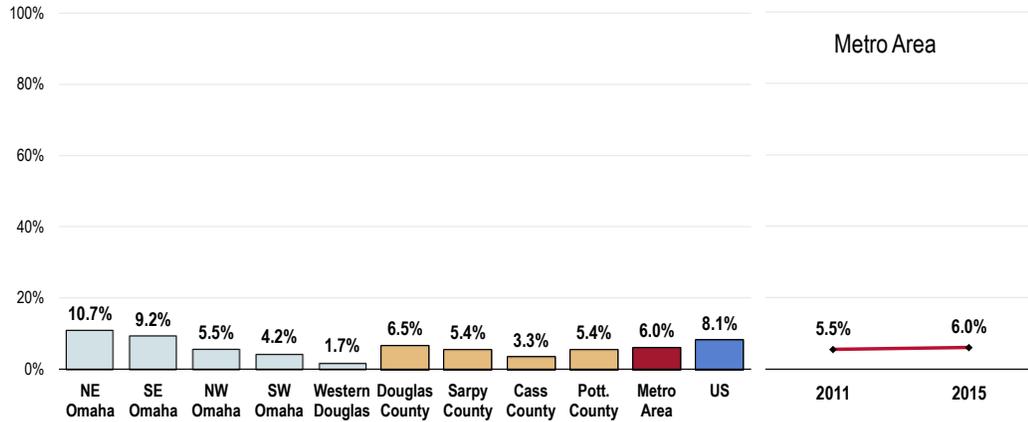
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 20, 23, 40, 166, 169]
 Notes: • Asked of all respondents.

Recent Lack of Coverage

Among currently insured adults in the Metro Area, 6.0% report that they were without healthcare coverage at some point in the past year.

- Better than US findings.
- Favorably low in Cass County.
- Highest in Northeast Omaha.
- TREND: Insurance instability is statistically unchanged since 2011 in the Metro Area.

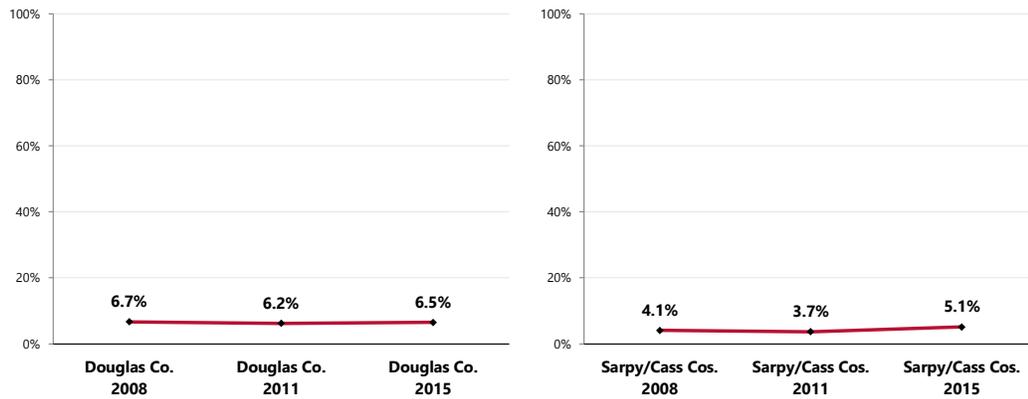
Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 79]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all insured respondents.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults)

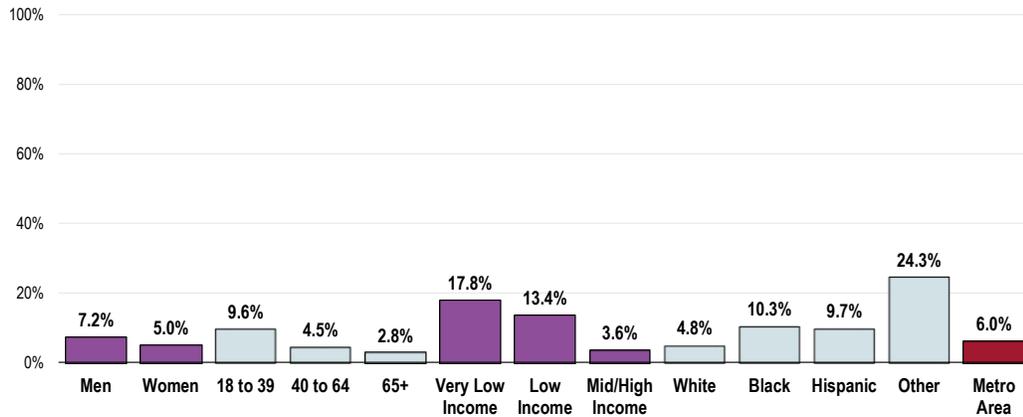


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 79]
 Notes: • Asked of all insured respondents.

Among insured adults, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Men.
- Adults under age 40 (negative correlation).
- Lower-income residents (negative correlation).
- Blacks, Hispanics, and especially Other races.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults; Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 79]
 Notes: • Asked of all insured respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality 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)

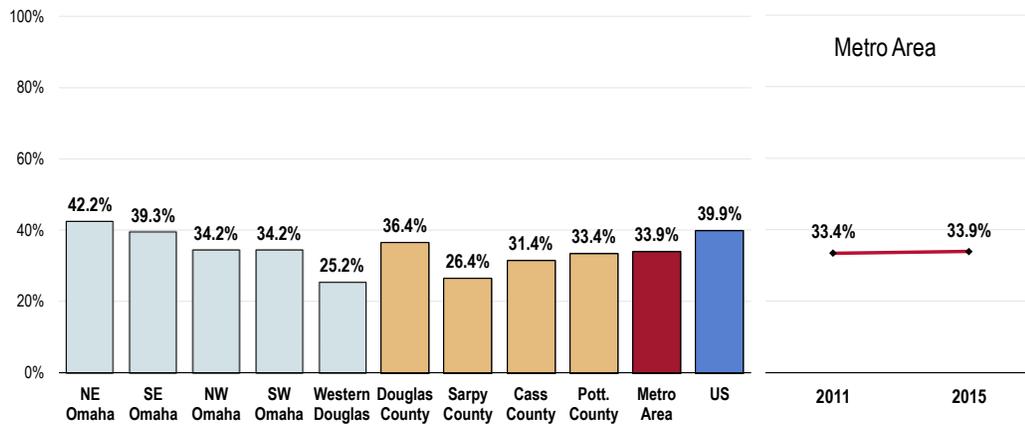
Difficulties Accessing Services

A total of 33.9% of Metro Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

- More favorable than national findings.
- Highest in Douglas County, lowest in Sarpy County.
- Unfavorably high in Northeast Omaha.
- TREND: Similar to the percentage reported in 2011.

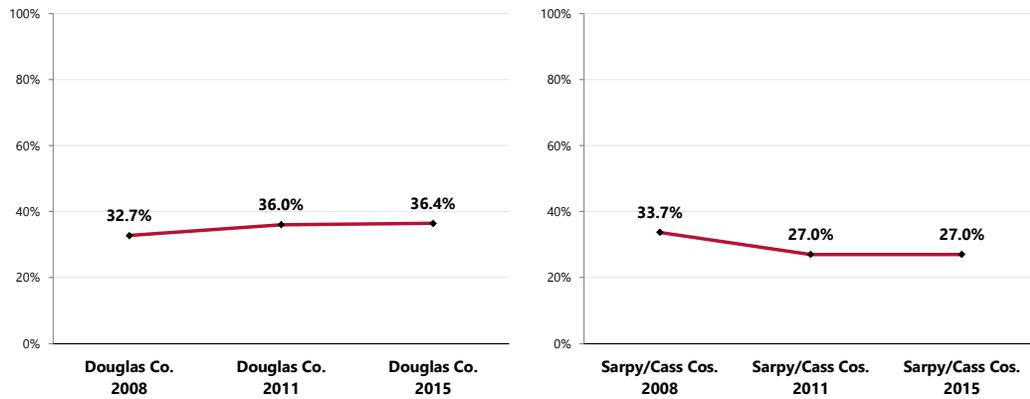
Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



- Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 169]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
 - Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

- TREND: Statistically unchanged over time in Douglas County but marking a statistically significant improvement in Sarpy/Cass counties.

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

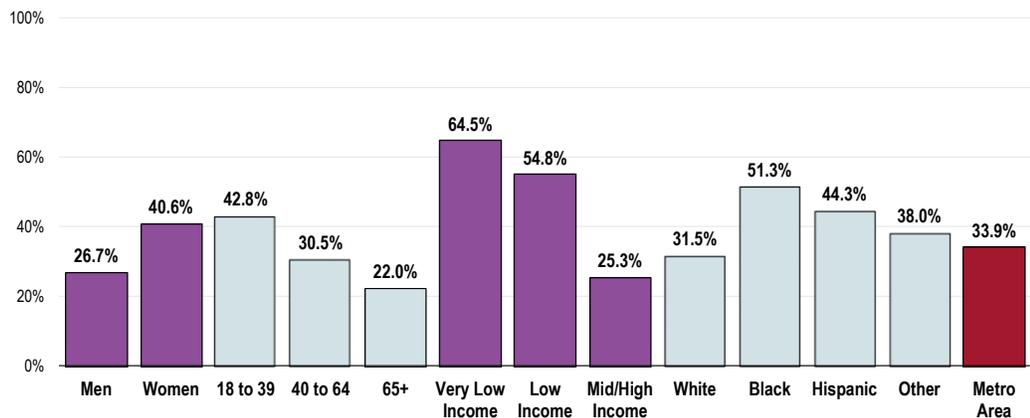


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 169]
 Notes: ● Asked of all respondents.
 ● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults under the age of 65 (negative correlation).
- Lower-income residents (negative correlation).
- Blacks, Hispanics, and Other adults.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (Metro Area, 2015)



Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
 Notes: ● Asked of all respondents.
 ● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Barriers to Healthcare Access

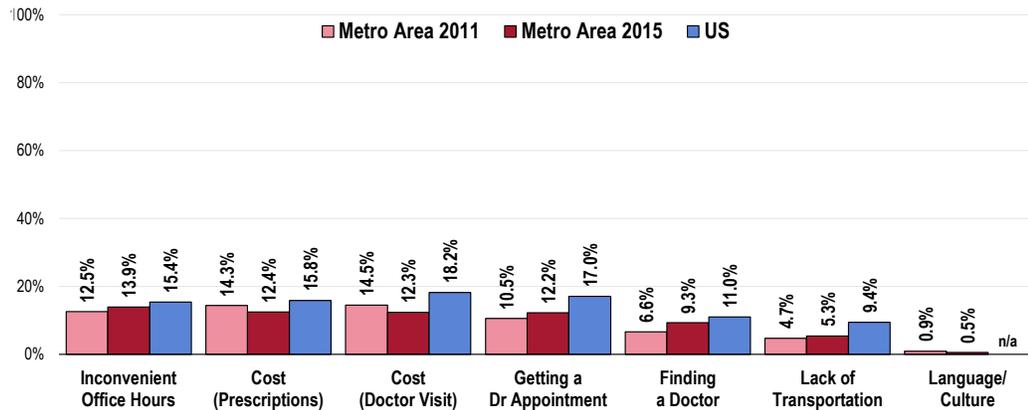
Of the tested barriers, inconvenient office hours impacted the greatest share of Metro Area adults (13.9% say that inconvenient hours prevented them from obtaining a visit to a physician in the past year).

To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them 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.

- The proportion of Metro Area adults impacted was statistically comparable to or better than that found nationwide for each of the tested barriers.
- **TREND:** Compared to baseline 2011 data, the Metro Area has seen a significant decrease with regard to the barrier of **cost of doctor visits** but a significant increase in the barrier of difficulty **finding a physician**.

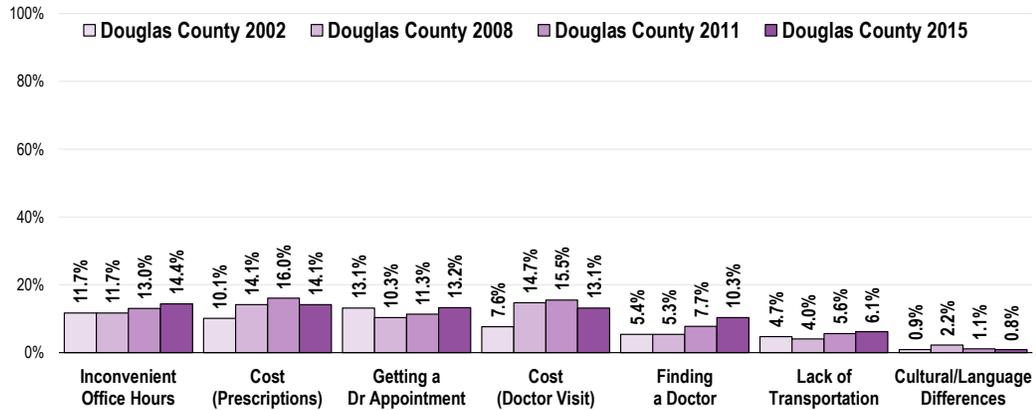
Barriers to Access Have Prevented Medical Care in the Past Year



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12, 305]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- **TREND:** Compared to baseline 2002 data, Douglas County has seen significant increases with regard to the barriers of difficulty **finding a physician**, **cost of physician visits**, **inconvenient office hours**, and **cost of prescription medications**.

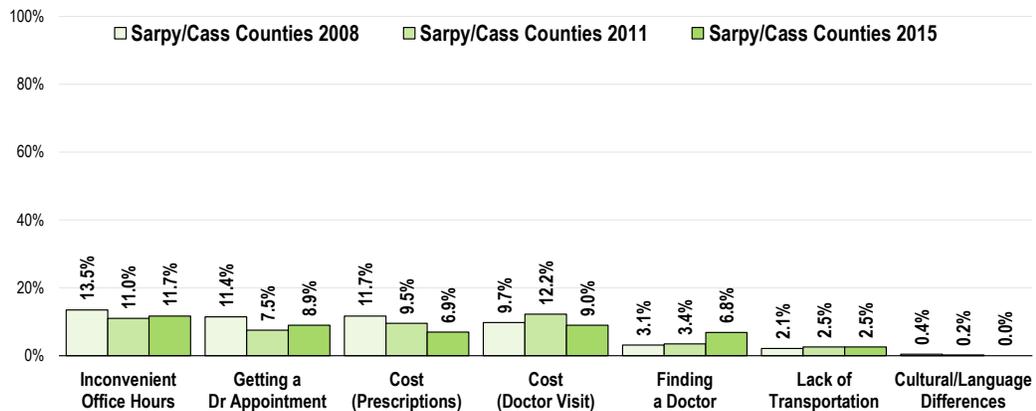
Barriers to Access Have Prevented Medical Care in the Past Year (Douglas County)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12, 305]
 Notes: ● Asked of all respondents.

- **TREND:** Compared to baseline 2008 data, Sarpy/Cass counties have seen a significant increase with regard to the barrier of difficulty **finding a physician**; on the other hand, the area has also experienced a significant decrease in regard to the barrier of **cost of prescription medications**.

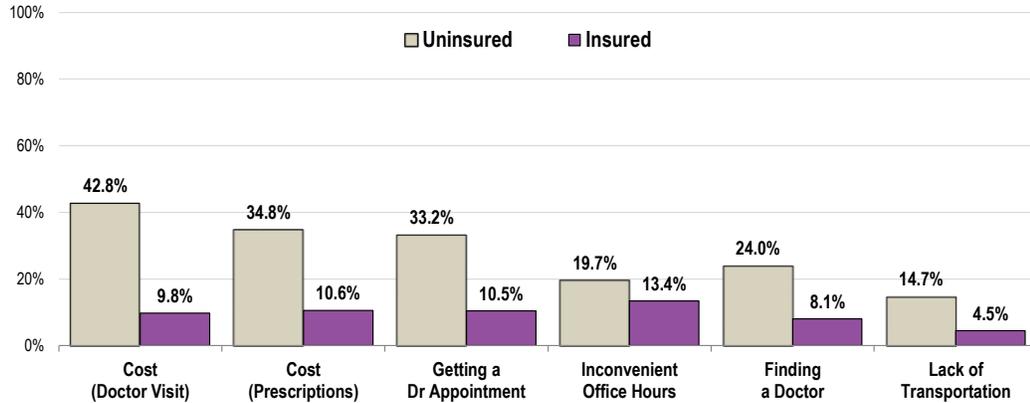
Barriers to Access Have Prevented Medical Care in the Past Year (Sarpy/Cass Counties)



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12, 305]
 Notes: ● Asked of all respondents.

- As might be expected, Metro Area adults without health insurance are much more likely to report access barriers when compared to the insured population, particularly those related to cost.

Barriers to Healthcare Access (By Insured Status; Metro Area, 2015)



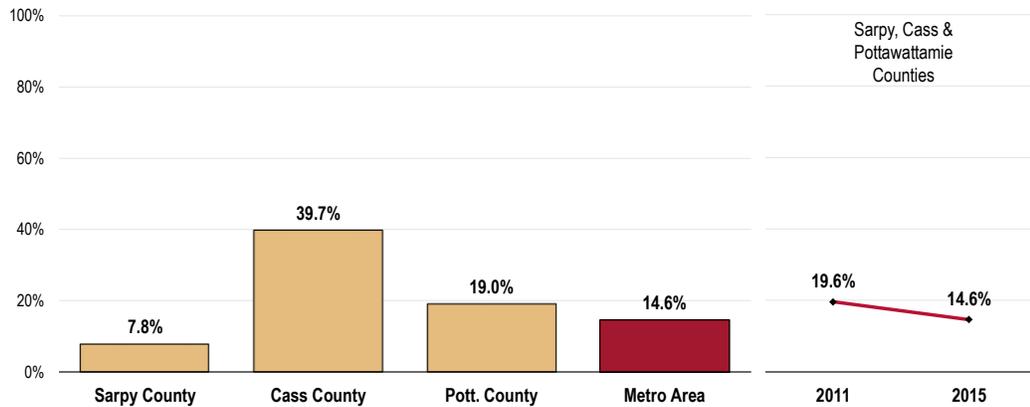
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12, 305]
 Notes: • Asked of all respondents.

Outmigration for Care (Sarpy, Cass & Pottawattamie Counties)

When residents of Sarpy, Cass and Pottawattamie counties were asked whether they have traveled more than 30 minutes for a medical appointment in the past year, 14.6% answered affirmatively.

- Particularly high in Cass County, higher in Pottawattamie County than in Sarpy County.
- TREND: In the combined area, this prevalence has decreased significantly since 2011.

Have Had to Travel 30 Minutes or More for a Medical Appointment in the Past Year (Sarpy, Cass & Pottawattamie Counties Only)



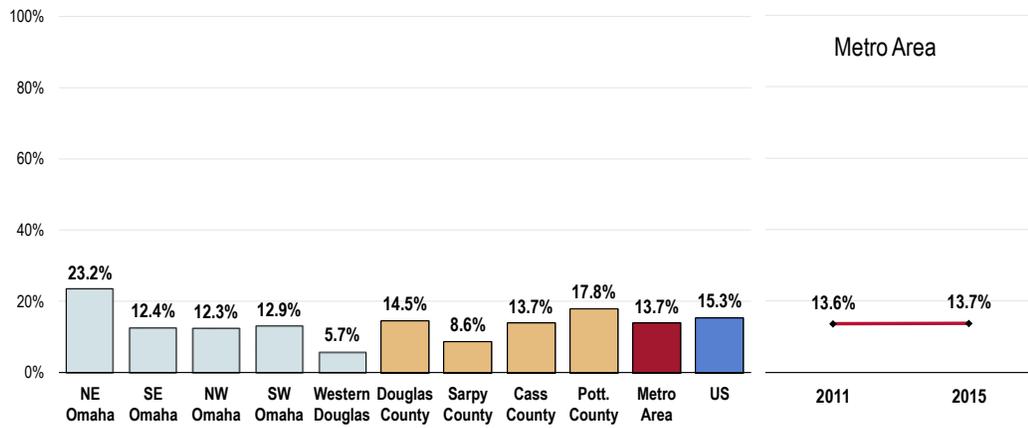
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 306]
 Notes: • Asked of all respondents (excluding those in Douglas County).

Prescriptions

Among all Metro Area adults, 13.7% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Comparable to national findings.
- Highest in Pottawattamie County, lowest in Sarpy County.
- Unfavorably high in Northeast Omaha.
- TREND: Statistically similar to 2011 findings.

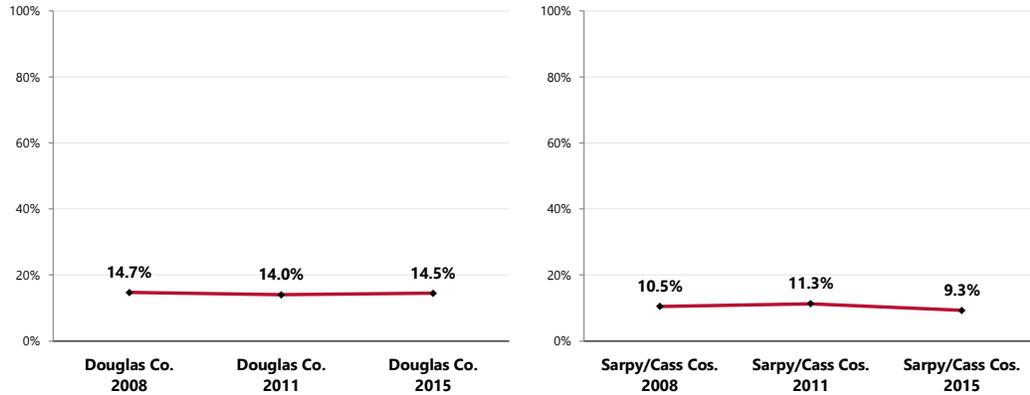
Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 13]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

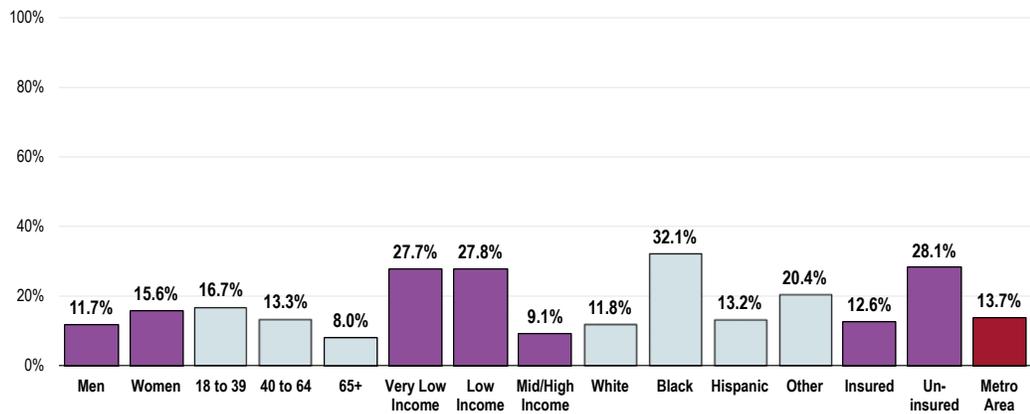


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 13]
 Notes: ● Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Women.
- Younger residents (negative correlation with age).
- Respondents with lower incomes.
- Blacks and Other races.
- Uninsured adults.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money (Metro Area, 2015)



Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
 Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

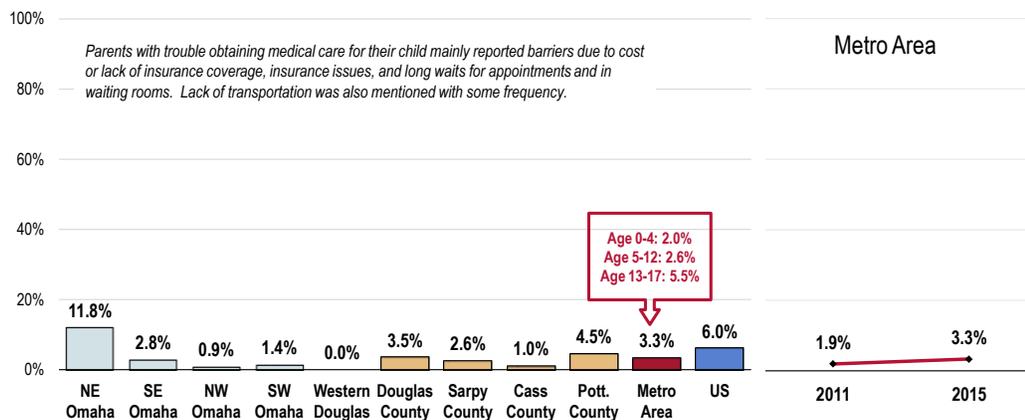
Accessing Healthcare for Children

A total of 3.3% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

- More favorable than what is reported nationwide.
- Comparable findings by county in the Metro Area.
- In Douglas County, unfavorably high in Northeast Omaha.
- TREND: Statistically unchanged since 2011.
- Highest (5.5%) among parents of teens.

Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)

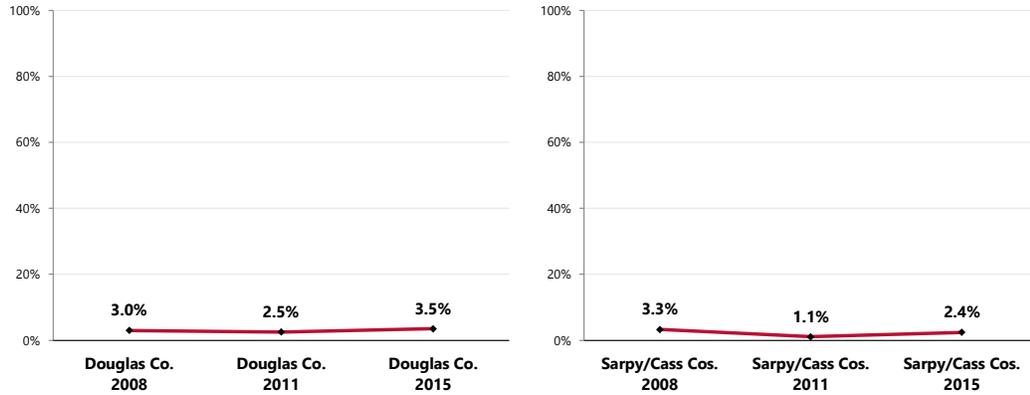


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 111-112]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Among the parents experiencing difficulties, the majority cited **cost or a lack of insurance** as the primary reason; others cited insurance issues, long waits for appointments and in waiting rooms, and lack of transportation.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)

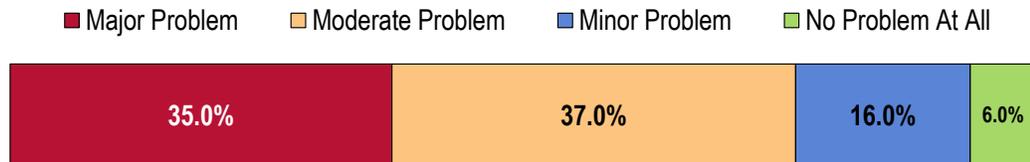


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 111-112]
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Healthcare Services

Key informants taking part in an online survey more often characterized **Access to Healthcare Services** as a “moderate problem” in the community.

Perceptions of Access to Healthcare Services as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Healthcare Insurance Coverage

- Lack of insurance or means to pay. Wait times and keeping appointments for many, transportation for many. – Social Service Provider*
- No health insurance or PCP. – Healthcare Provider*
- Lack of insurance remains a problem. American Indians continue to access healthcare through Emergency Rooms. Continuity of care is also a problem. Elderly who live alone often don't fare well after leaving the hospital. Also transportation for medical. – Social Service Provider*

No or under-insured lack of transportation, lack of knowledge about where to seek care. – Physician
Most working adults either cannot afford healthcare or must work two jobs to pay for it. For example, a couple making \$2,000 per month, family insurance \$300 per month, with a 7,000 out of pocket deductible. – Social Service Provider

Adequate and consistent insurance coverage for those who receive Medicaid. High deductibles and cost of private insurance. No Medicaid expansion for the state of Nebraska. – Social Service Provider

The greatest challenge currently is the fact that Medicaid has not been expanded, especially for low income Nebraskans, this is a huge obstacle. – Social Service Provider

Individuals being able to afford health insurance and/or paying for services. – Social Service Provider

Insurance rates and lack of Medicaid Expansion. There are only limited places where uninsured patients can go for care. – Public Health Representative

Part is lack of insurance, but even for those with insurance and PCPs, when they call the office, they are often told to "go to the Emergency Room." - Physician

We still have a large group of people who don't have insurance and don't qualify for Obamacare. Medicaid expansion would help but it doesn't look like our politicians will support it. In addition, access to mental healthcare and addictions treatment. – Social Service Provider

Access to Resources

Access to healthcare, mental health, violence issues, coordinated care, and preventive services. – Healthcare Provider

Services not close to most vulnerable population. Cost. Times available for office/clinic visits. – Community/Business Leader

Lack of providers in some areas and lack of quality discharge planning. Also medication management can be an issue. – Community/Business Leader

Lack of resources to access quality healthcare. – Public Health Representative

The lack of services in their community. – Social Service Provider

Unable to schedule appointments. When patients call, they have to wait months to be seen. Then they use Emergency Departments as primary care centers. – Healthcare Provider

Long wait lists/periods for community health centers, transportation, schedules, cultural barriers and misunderstandings. – Social Service Provider

Not enough psychiatrists available in Council Bluffs. The wait time to get an appointment is quite a long wait. – Healthcare Provider

The lack of any specialty clinics (ENT, GI) in the South Omaha area. Transportation is always a problem, it is difficult for families to get time off work or find someone who can take child to appointment. – Physician

Knowledge of exciting resources, affordability, and transportation. – Public Health Representative

We work with the homeless, addicted and poor. All services are in short supply from my perspective. Particularly mental health services. – Social Service Provider

Access to healthcare is largely dependent on geography and the ability to pay, so poorer patients have much greater problems accessing healthcare in a timely and appropriate manner. – Social Service Provider

There are areas in the community where people do not have access to medical services after hours and therefore have no other choice than to go to the Emergency Room, which is the most expensive care. – Public Health Representative

Affordability

The biggest challenge is lack of funding. If a person does not have insurance it is impossible to get appointments and to obtain medications/treatments for disorder. – Healthcare Provider

Access to affordable services. Mental health services, coordinated chronic disease management, social services and social workers. – Physician

Lack of ability to pay and lack of transportation for parents with small children or people who cannot get to bus stops. – Healthcare Provider

The biggest access barrier in this community is related to poverty, people who cannot afford their co-pays to see a doctor and not enough free clinics to absorb the people who need medical care. – Community/Business Leader

The cost, even the small co pay at community health centers can be prohibiting to some patients. Plus

the clinics are booked out a ways. Many times the patients are not seen by the same provider or by students. – Healthcare Provider

Limited access or lowest quality of all kind of healthcare for Hispanics who are non-documented, language barriers, major discriminatory practices, lack of cultural sensitivity (providers, assistants, front desk attendee), unwilling to come out of comfort zone. – Community/Business Leader

Transportation/Location

In North Omaha, there are still transportation issues to specialty care outside of the services that NOAH or Drew offer. Same thing in South Omaha. – Social Service Provider

Working with the senior adult population for the past 15 years I have seen affordable transportation as a huge issue among most seniors. – Community/Business Leader

Locations of federally qualified health centers, need more clinics in more locations, hours and days of service. Need more urgent care locations, dental, behavioral health as well as primary care. – Healthcare Provider

Transportation to and from the hospital and doctor's appointments. – Healthcare Provider

Another issue is transportation to get to appointments for those who have limited funding. – Healthcare Provider

Transportation, location, availability, ability to pay for services with or without insurance (co-pays), trust of providers, and comprehending the recommendations or follow up services needed. – Social Service Provider

Cultural Barriers

There is a large refugee population in Omaha. There are huge issues with lack of appropriate translation/interpretation services, alternative clinic hours, poor clinician/staff training to work with refugees. Physically accessing services. – Physician

A continued distrust of healthcare institutions. – Community/Business Leader

Lack of cultural competency. Transportation and insufficient public transportation. Health literacy and ability to navigate the health system. – Social Service Provider

Lack of Funding

The biggest challenge is lack of funding. If a person does not have insurance it is impossible to get appointments and to obtain medications/treatments for disorder. Another issue is transportation to get to appointments for those who have limited funding. – Healthcare Provider

Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified mental health, substance abuse treatment, primary care, and dental care as the most difficult to access in the community.

| | Most Difficult to Access | Second-Most Difficult to Access | Third-Most Difficult to Access | Total Mentions |
|---------------------------|--------------------------|---------------------------------|--------------------------------|----------------|
| Mental Healthcare | 52.4% | 26.8% | 7.5% | 36 |
| Substance Abuse Treatment | 16.7% | 26.8% | 12.5% | 23 |
| Dental Care | 7.1% | 4.9% | 17.5% | 12 |
| Chronic Disease Care | 4.8% | 12.2% | 5.0% | 9 |
| Specialty Care | 4.8% | 9.8% | 7.5% | 9 |
| Primary Care | 7.1% | 7.3% | 5.0% | 8 |
| Pain Management | 2.4% | 2.4% | 15.0% | 8 |
| Urgent Care | 2.4% | 2.4% | 10.0% | 6 |
| Elder Care | 2.4% | 2.4% | 7.5% | 5 |
| Palliative Care | 0.0% | 4.9% | 2.5% | 3 |
| Prenatal Care | 0.0% | 0.0% | 7.5% | 3 |
| Family Planning | 0.0% | 0.0% | 2.5% | 1 |

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

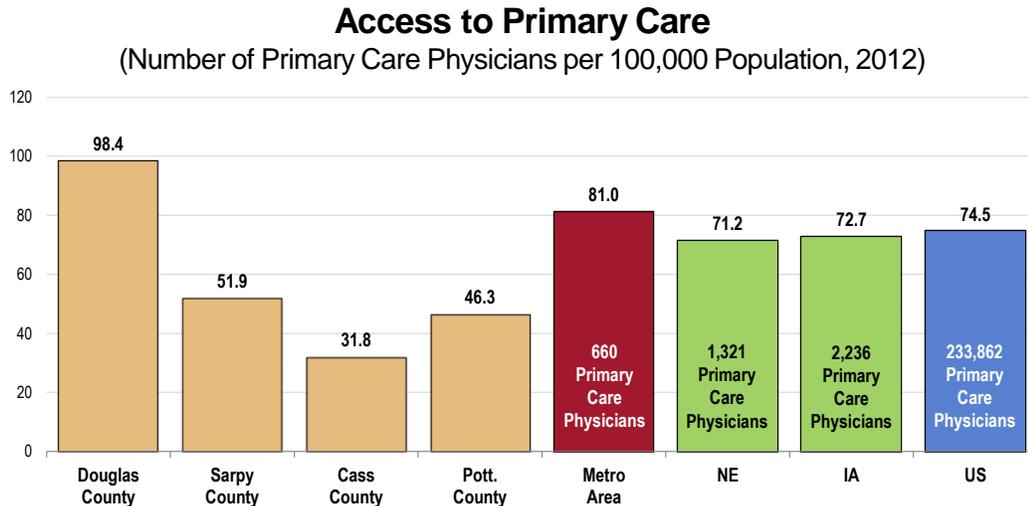
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

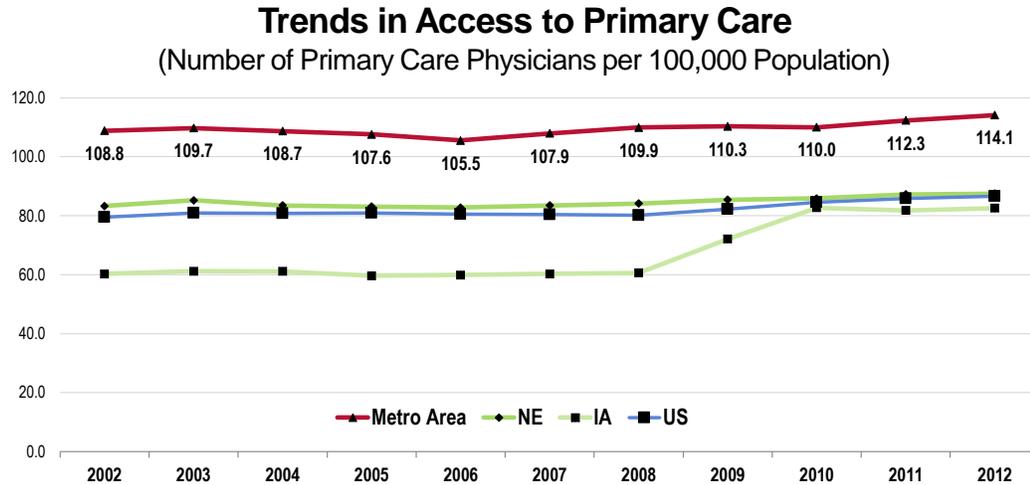
In the Metro Area in 2012, there were 660 primary care physicians, translating to a rate of 81.0 primary care physicians per 100,000 population.

- Above the primary care physician-to-population ratios found statewide.
- Above the ratio found nationally.
- Much higher in Douglas County; lowest in Cass and Pottawattamie counties.



- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2012.
 - Retrieved August 2015 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

- TREND: Access to primary care (in terms of the ratio of primary care physicians to population) has improved somewhat over the past decade in the Metro Area.



Sources:

- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2012.
- Retrieved August 2015 from Community Commons at <http://www.chna.org>.

Notes:

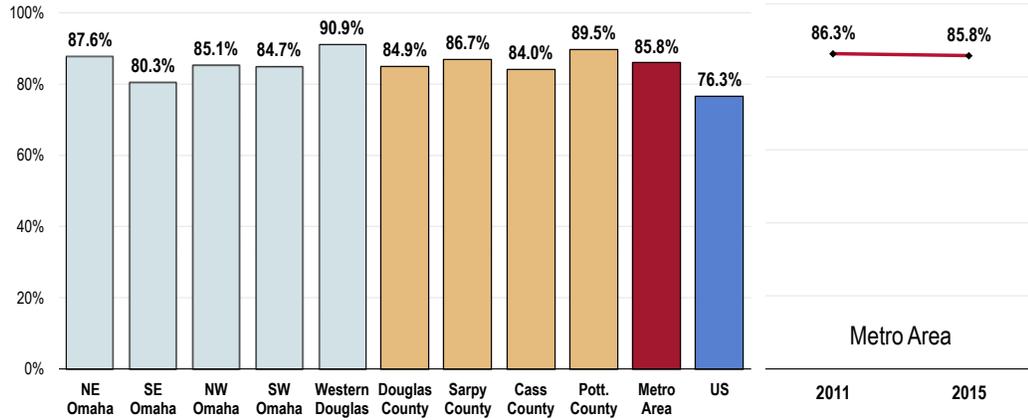
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.
- These figures represent all primary care physicians practicing patient care, including hospital residents. In counties with teaching hospitals, this figure may differ from the rate reported in the previous chart.

Particular Place for Medical Care

A total of 85.8% of Metro Area adults have a particular place they visit for their medical care.

- Higher than the national figure.
- Favorably high in Pottawattamie County.
- In Douglas County, least favorable in Southeast Omaha.
- TREND: Statistically unchanged over time.

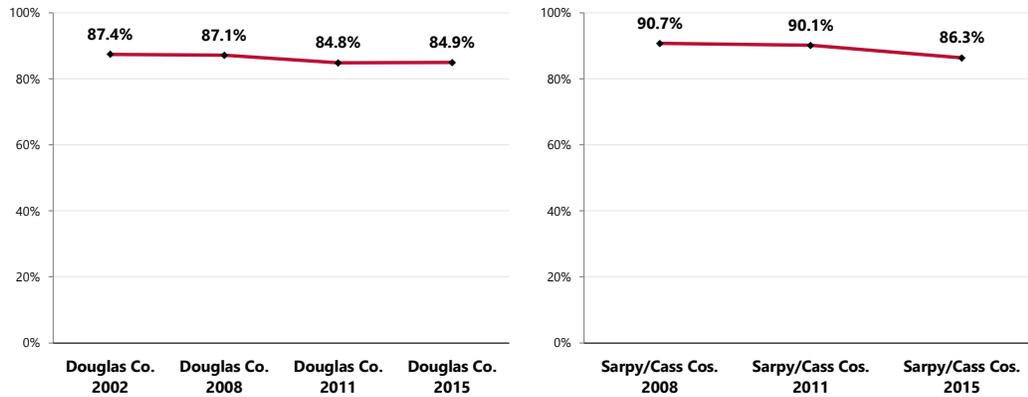
Have a Particular Place for Medical Care



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 15]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- **TREND:** Statistically unchanged over time in Douglas County; marks a statistically significant decrease over time in Sarpy/Cass counties.

Have a Particular Place for Medical Care

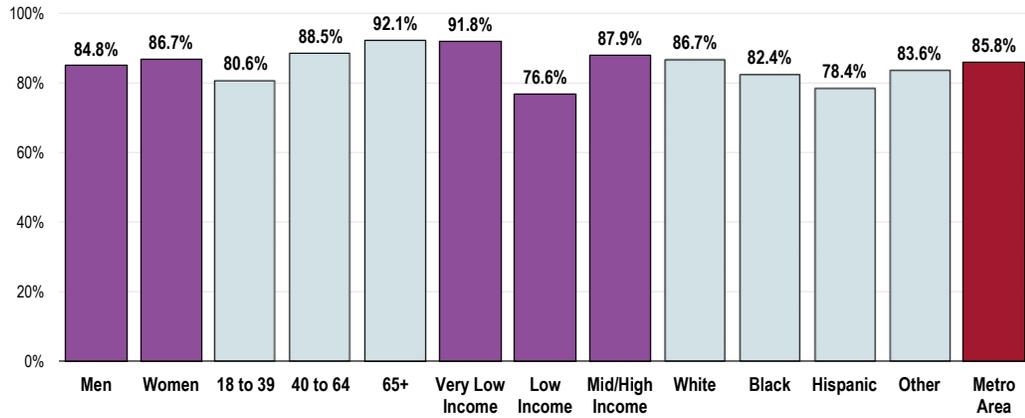


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 15]
 Notes: • Asked of all respondents.

When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- Adults under age 40 (positive correlation with age).
- Adults living just above the federal poverty level.
- Blacks and Hispanics.

Have a Particular Place for Medical Care (Metro Area, 2015)

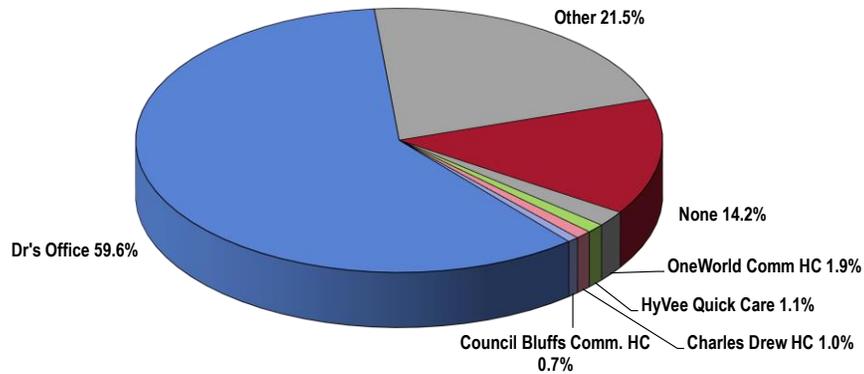


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 15]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (59.6%) identified a particular doctor's office. Some respondents cited specific facilities, including OneWorld Community Health Center, HyVee Quick Care, Charles Drew Health Center, and Council Bluffs Community Health Center.

Particular Place Utilized for Medical Care (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]
 Notes: • Asked of all respondents.

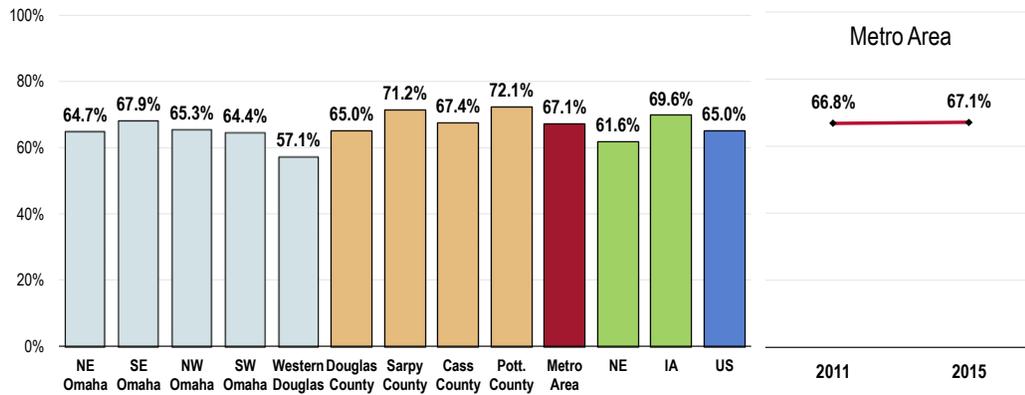
Utilization of Primary Care Services

Adults

Two-thirds of adults (67.1%) visited a physician for a routine checkup in the past year.

- Higher than the Nebraska figure, lower than Iowa.
- Comparable to national findings.
- Lowest in Douglas County.
- Unfavorably low in Western Douglas County.
- TREND: Statistically similar to 2011 findings.

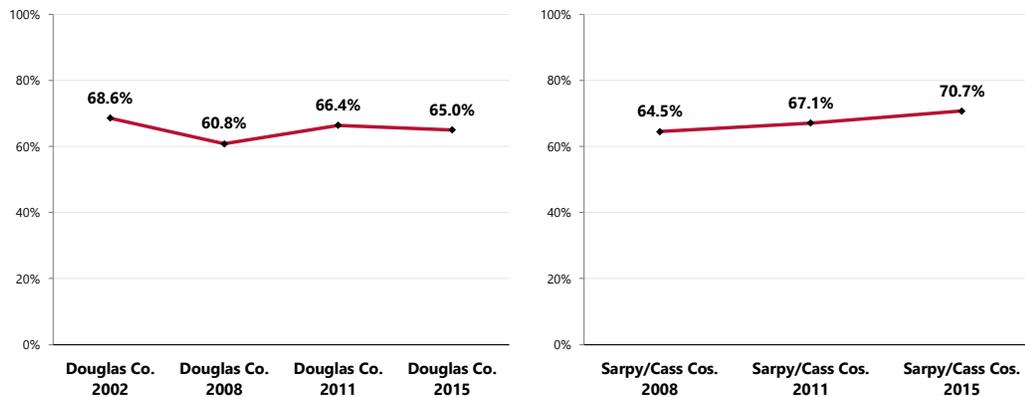
Have Visited a Physician for a Checkup in the Past Year



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 17]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Nebraska and Iowa data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

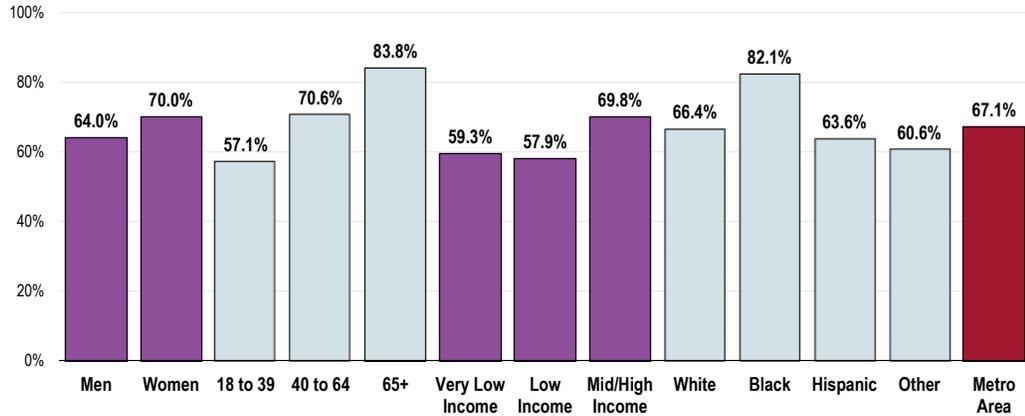
Have Visited a Physician for a Checkup in the Past Year



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 17]
 Notes: • Asked of all respondents.

- Adults under age 65 are less likely to have received routine care in the past year (note the positive correlation with age), as are Metro Area men, low-income residents, Whites, Hispanics, and Other races.

Have Visited a Physician for a Checkup in the Past Year
(Metro Area, 2015)



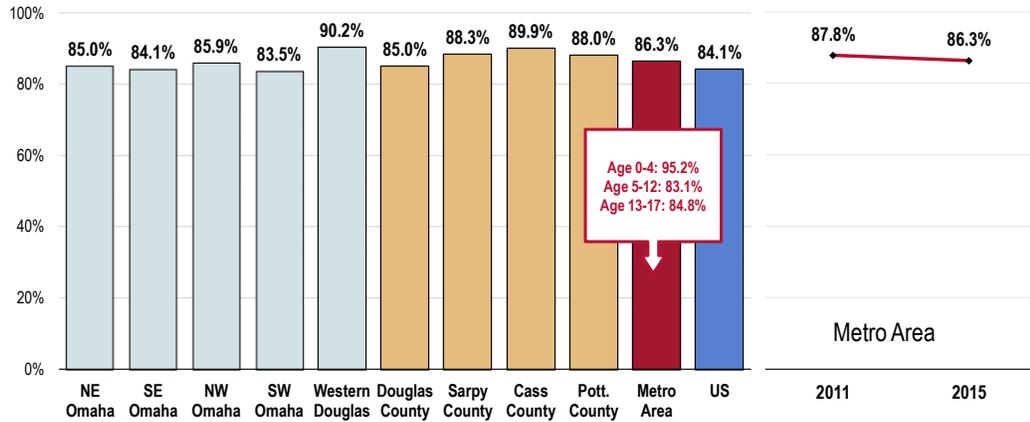
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

Among surveyed parents, 86.3% report that their child has had a routine checkup in the past year.

- Similar to national findings.
- Similar findings among the 4 Metro Area counties.
- Similar findings within Douglas County.
- TREND: Statistically similar to 2011 findings.
- As may be expected, routine checkups are highest in the Metro Area among children under age 5.

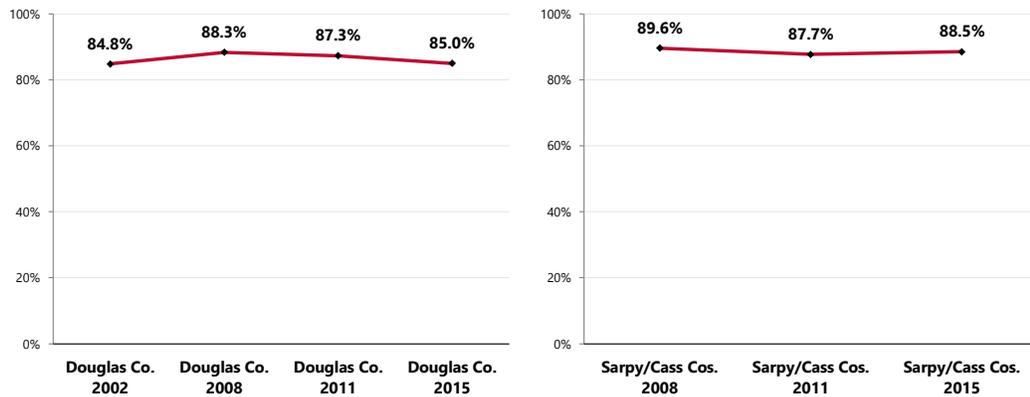
Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 113]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 113]
 Notes: • Asked of all respondents with children 0 to 17 in the household.

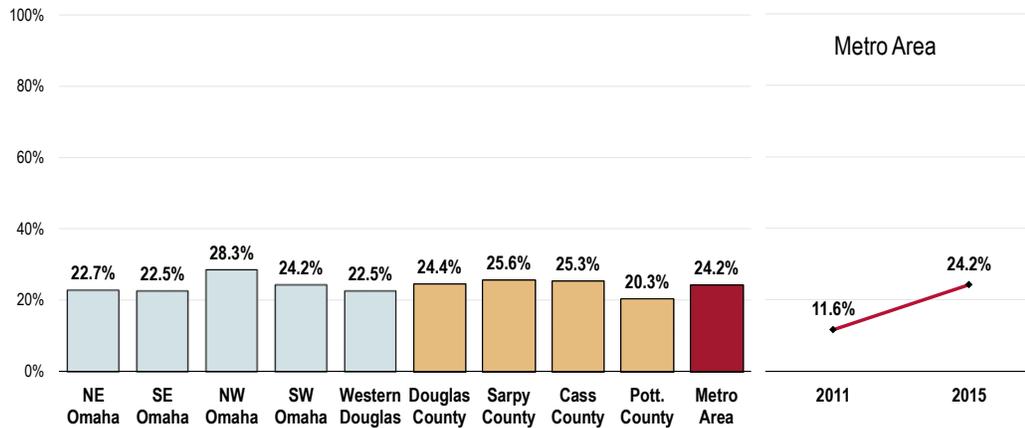
Electronic Communication

The majority (75.8%) of Metro Area adults reports that they “seldom” or “never” communicate electronically (e.g., via email or text) with a physician or hospital.

However, 24.2% “frequently” or “sometimes” do so.

- Lowest in Pottawattamie County.
- Similar findings across the 5 Douglas County subareas.
- TREND: Marks a statistically significant increase over time.

“Frequently” or “Sometimes” Use Electronic Communication to Communicate with a Doctor or Hospital

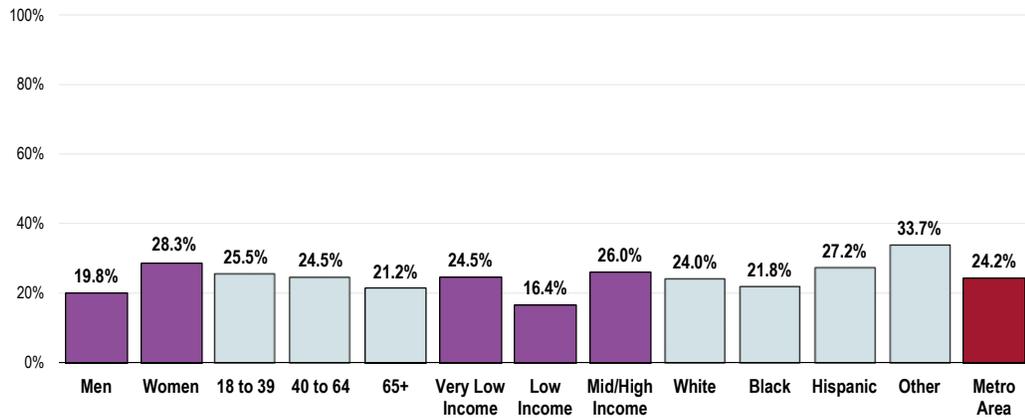


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 307]
 Notes: • Asked of all respondents.

The following demographic samples are more likely to use electronic communication with a doctor or hospital:

- Women.
- Adults at either end of the income spectrum.

“Frequently” or “Sometimes” Use Electronic Communication to Communicate with a Doctor or Hospital (Metro Area, 2015)



Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 307]

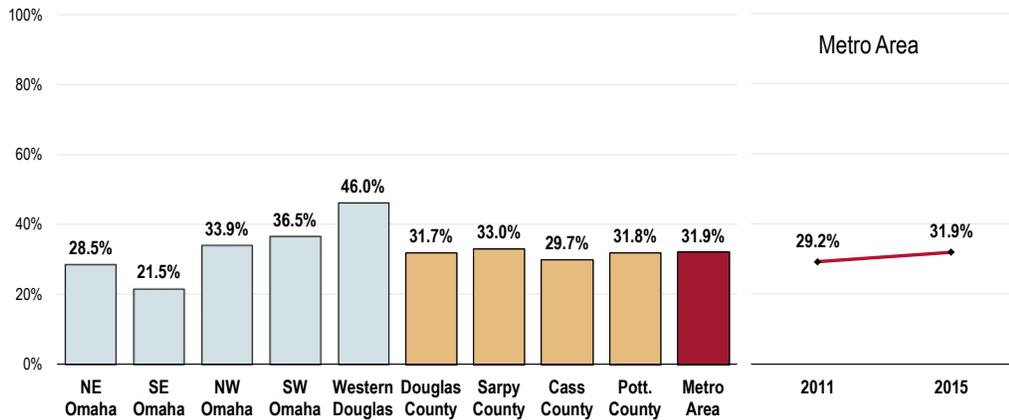
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households living with defined poverty status; “Low Income” includes households with incomes just above the FPL, earning up to twice the poverty threshold; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Advance Directives

31.9% of Metro Area adults have a completed Advanced Directive (or Living Will) in place.

- Among the four Metro Area counties: no significant difference in findings.
- Within Douglas County, much lower in the east.
- TREND: Denotes a statistically significant increase over time.

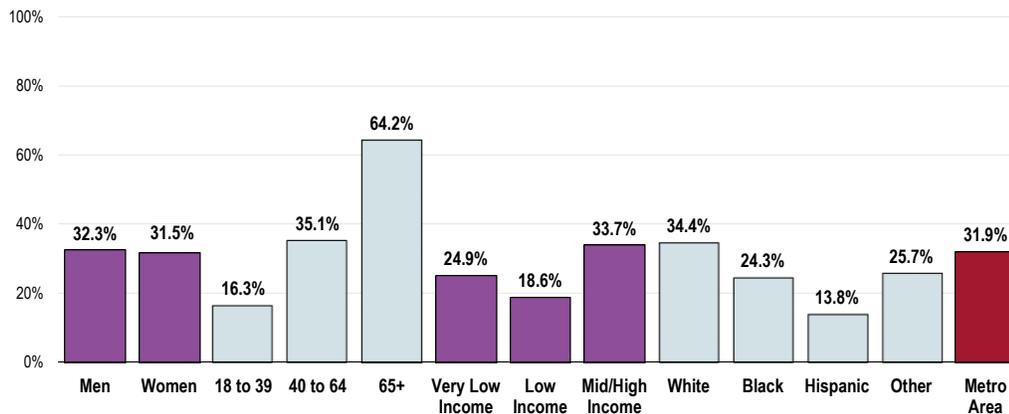
Currently Have a Completed Advance Directive or Living Will



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 320]
 Notes: • Asked of all respondents.

- Younger residents (as may be expected), low-income residents, Blacks, Hispanics, and Other races are less likely to have a completed Advanced Directive/Living Will.

Currently Have a Completed Advance Directive or Living Will (Metro Area, 2015)



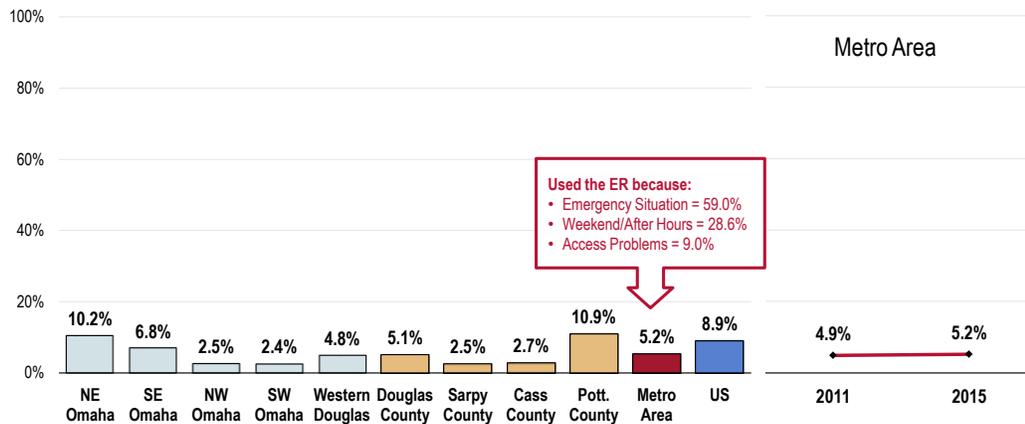
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 320]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Emergency Room Utilization

A total of 5.2% of Metro Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Well below the national findings.
- Unfavorably high in Pottawattamie County.
- Highest in Northeast Omaha; lowest in the northwest.
- TREND: Statistically unchanged over time.

Have Used a Hospital Emergency Room More Than Once in the Past Year

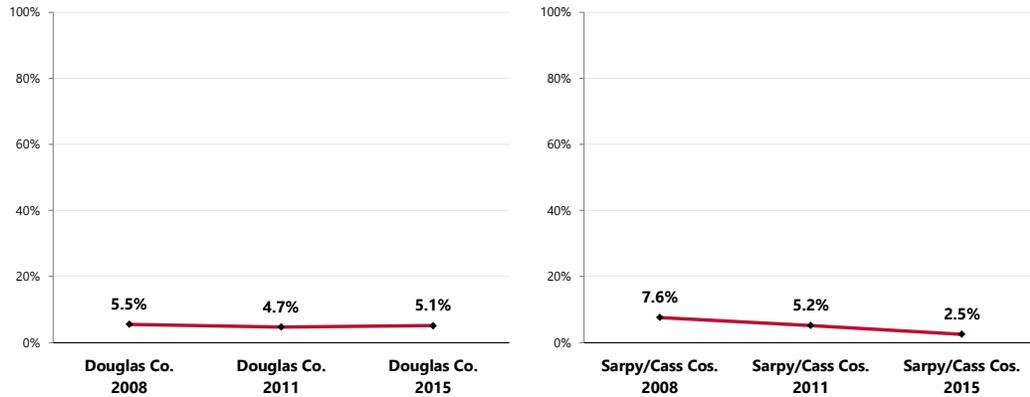


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 23-24]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Of those using a hospital ER, 59.0% say this was due to an **emergency or life-threatening situation**, while 28.6% indicated that the visit was during **after-hours or on the weekend**. A total of 9.0% cited **difficulties accessing primary care** for various reasons.

- TREND: Statistically unchanged over time in Douglas County but marking a statistically significant decrease in Sarpy/Cass counties.

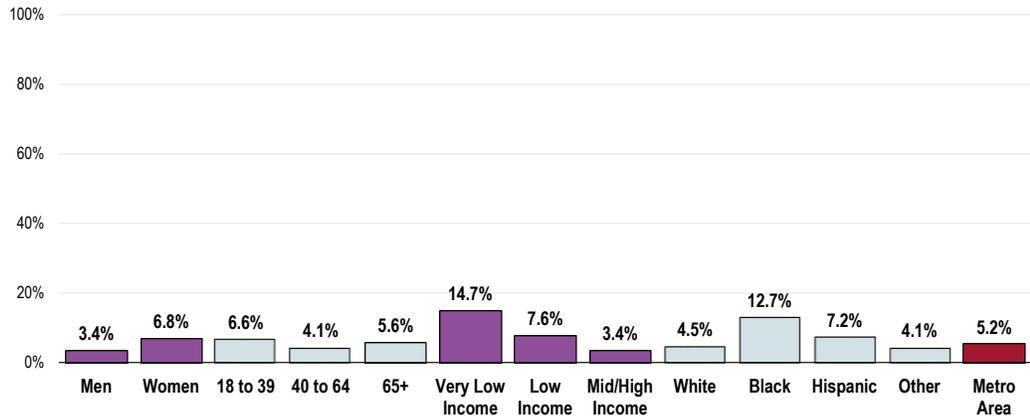
Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 23-24]
 Notes: ● Asked of all respondents.

- ER use is more prevalent among Metro Area women, lower-income residents (negative correlation with income), Blacks, and Hispanics.

Have Used a Hospital Emergency Room More Than Once in the Past Year (Metro Area, 2015)



Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
 Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use**; **excessive alcohol use**; and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

• Healthy People 2020 (www.healthypeople.gov)

Dental Care

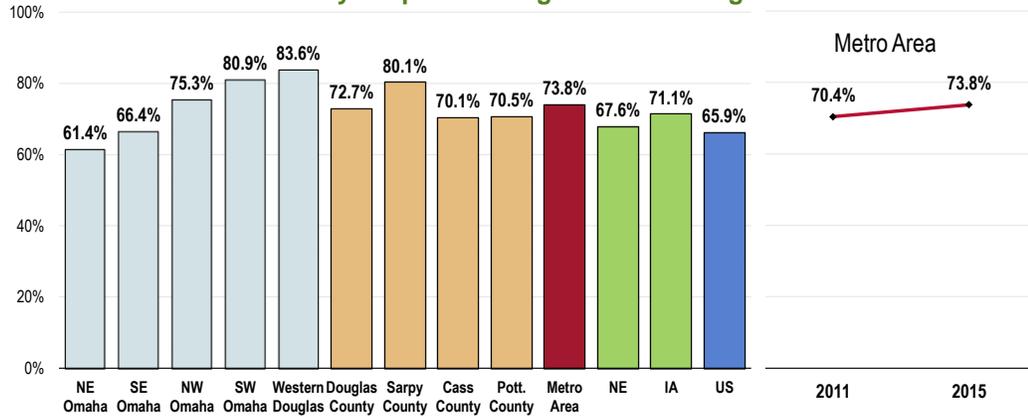
Adults

A total of 73.8% of Metro Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- Higher than both state proportions.
- Higher than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Favorably high in Sarpy County.
- Much lower in the eastern portion of Douglas County.
- TREND: Marks a statistically significant increase over time.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 Target = 49.0% or Higher

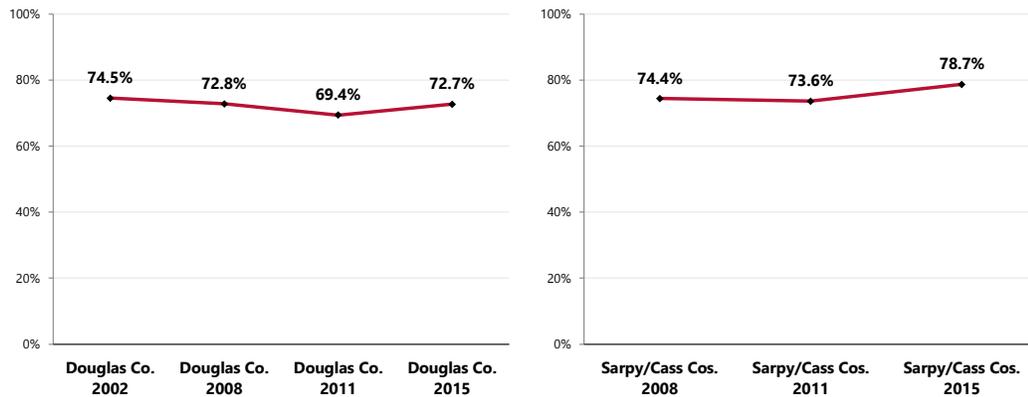


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 21]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2012 Nebraska and Iowa data.

Notes: • Asked of all respondents.

• TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Have Visited a Dentist or Dental Clinic Within the Past Year



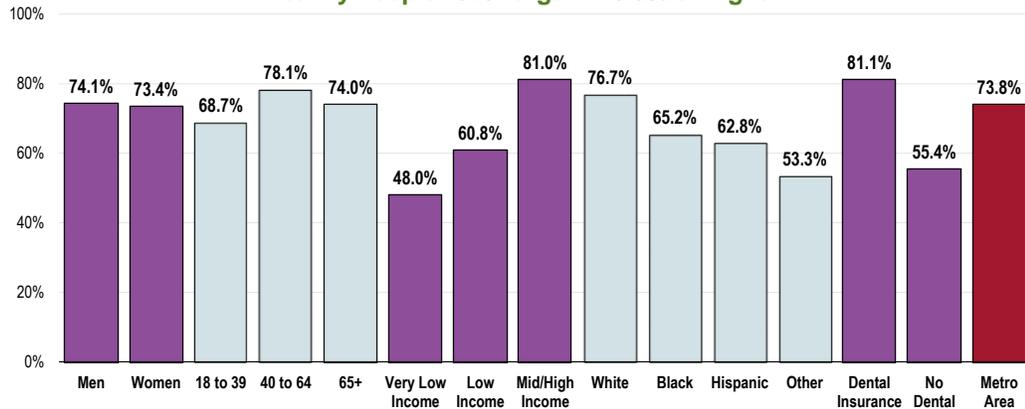
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 21]
 Notes: • Asked of all respondents.

Note the following:

- Adults under 40 are much less likely to report recent dental care than are their demographic counterparts.
- Persons living in the higher income categories report much higher utilization of oral health services (positive correlation with income).
- Whites are much more likely than Blacks, Hispanics, or Other races to report recent dental care.
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year (Metro Area, 2015)

Healthy People 2020 Target = 49.0% or Higher



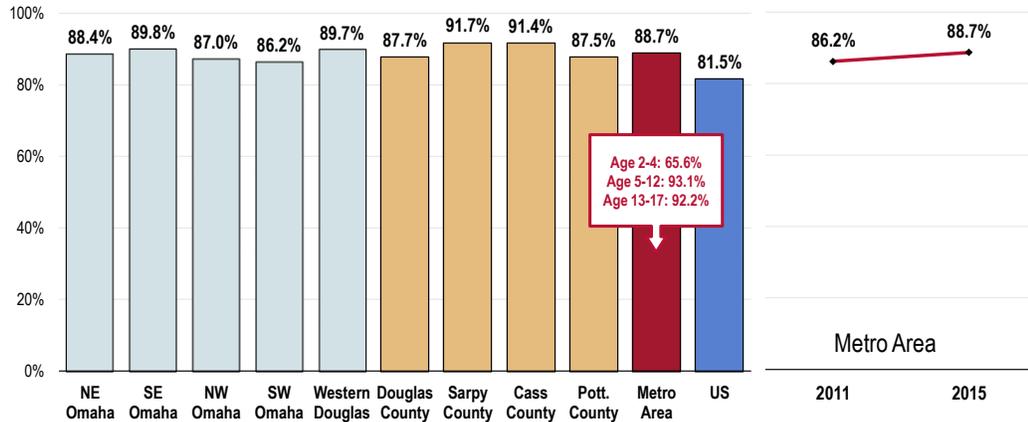
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

A total of 88.7% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- More favorable than national findings.
- Easily satisfies the Healthy People 2020 target (49% or higher).
- Comparable findings by Metro Area county.
- Comparable findings by subarea within Douglas County.
- TREND: Statistically unchanged over time.
- As expected, regular dental care is notably lower among children age 2 to 4.

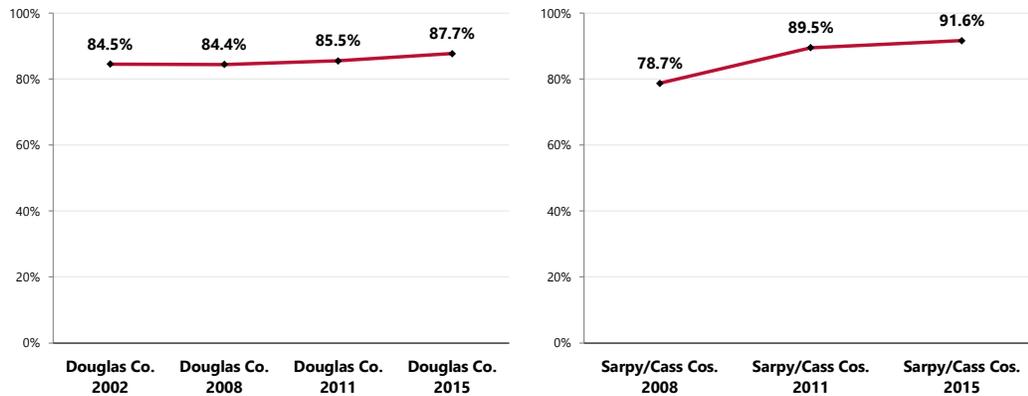
Child Has Visited a Dentist or Dental Clinic Within the Past Year (Among Parents of Children Age 2-17) Healthy People 2020 Target = 49.0% or Higher



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 116]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
 Notes: • Asked of all respondents with children age 2 through 17.

- TREND: Statistically unchanged over time in Douglas but marking a statistically significant increase in children’s dental care for Sarpy/Cass counties.

Child Has Visited a Dentist or Dental Clinic Within the Past Year (Among Parents of Children Age 2-17)



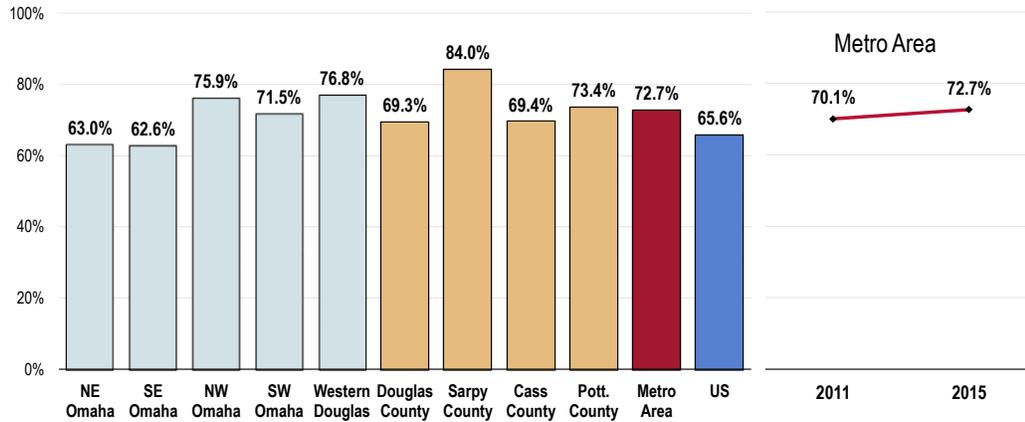
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 116]
 Notes: • Asked of all respondents with children age 2 through 17.

Dental Insurance

Most Metro Area adults (72.7%) have dental insurance that covers all or part of their dental care costs.

- Higher than the national finding.
- Highest in Sarpy County, lowest in Douglas County.
- Much lower in the eastern portion of Douglas County.
- TREND: Denotes a statistically significant increase in coverage over time.

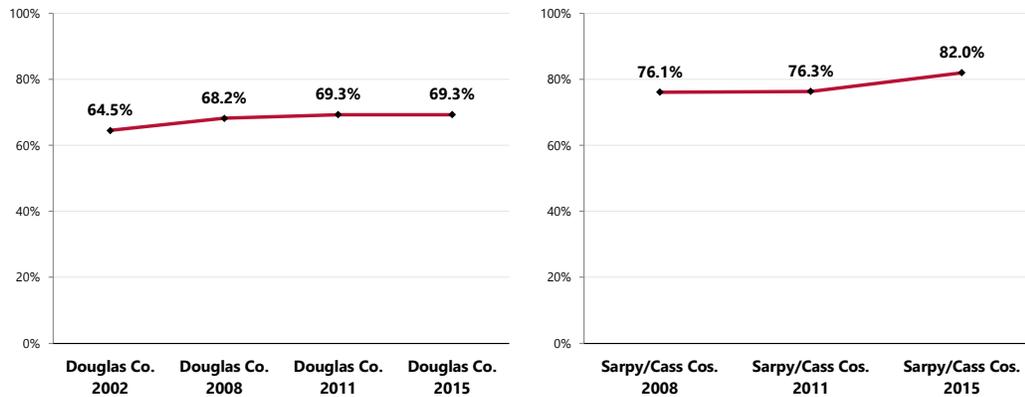
Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 22]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Marks a statistically significant increase in coverage over time for Douglas as well as Sarpy/Cass counties.

Have Insurance Coverage That Pays All or Part of Dental Care Costs

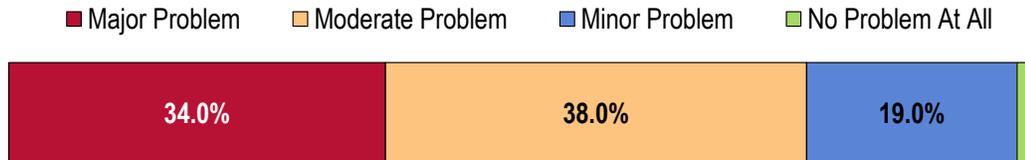


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 22]
 Notes: • Asked of all respondents.

Key Informant Input: Oral Health

Key informants taking part in an online survey more often characterized *Oral Health* as a “moderate problem” in the community.

Perceptions of Oral Health as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, August 2015.

Top Concerns

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

Dental Coverage

Rare insurance coverage, much dental disease not treated except in Emergency Department. – Public Health Representative

If you do not have insurance you can't get care. If you are able to get in the free/sliding scale clinics they pull teeth. If you need dentures it is forever until you can get into a clinic to start the long process of getting dentures. – Healthcare Provider

Lack of resources for patients without insurance. – Healthcare Provider

Increased cost of dental insurance. – Healthcare Provider

Everyone brings attention to physical health. ACA didn't really address adult dental care. Families are working and can't get to the dentist. Dentists don't accept Medicaid, they say they do but try to get an appointment, then try harder if you have it. – Healthcare Provider

Drug use, ineffective or negligent oral care insurance. – Healthcare Provider

Fewer providers accepting Medicaid. – Healthcare Provider

Dentists do not want to serve low income families and it is too expensive for working families, even with insurance to pay for major dental care. – Social Service Provider

Lack of providers willing to serve Medicaid or uninsured individuals. – Social Service Provider

It is harder to get insurance for dental care, harder to find dentists to volunteer their time for low income persons. – Healthcare Provider

I know many 20 somethings that work in lower paying jobs that are not provided dental insurance. Most have not visited a dentist in years. Also retirees do not have dental insurance because it is not provided through Medicare. – Healthcare Provider

Affordability of Services

Most low income people do not have dental insurance and can't afford to have oral maintenance. – Social Service Provider

Lack of insurance and low Medicaid rates for dental care impede access to dental care. – Social Service Provider

There are not enough free or reduced cost or sliding scale dental clinics to accommodate the patients who need care, so many wait until the situation becomes emergent and end up in the Emergency

Rooms to manage dental needs. – Community/Business Leader

One World and Charles Drew are the only options I am aware of that will accept patients on a sliding fee basis. – Physician

The cost of dental care, particularly restorative, is prohibitive. – Social Service Provider

Dental is expensive for patients. Expensive for CHS to run. Have to wait many times months for routine care. Lack of care for the elderly with issues, i.e. dementia. Major disease of childhood is dental care. Diabetics, patients with cancer. – Healthcare Provider

Cost of care, access to care if no insurance. – Healthcare Provider

There is little access to affordable dental services for low income patients and as with mental health, those that do offer services at a reduced cost are overwhelmed and unable to provide timely service. – Healthcare Provider

Lack of awareness. Too expensive. Lack of access to routine care for the underserved. – Public Health Representative

Education

I believe it is lack of education on the part of parents. They do not see the importance of preventative care and dental treatment when a problem exists. Parents lack the funding and insurance for their own oral health, so it may influence their beliefs. – Social Service Provider

Lack of preventative care (regular dental visits). – Social Service Provider

Professional experience with young adults and adults. – Public Health Representative

Access to Care

Fewer people have access to this. – Social Service Provider

Diet, young parents, few dentists. – Physician

I think there is poor ability to access good dental care. – Healthcare Provider

Lack of access due to immigrant status. Cost of services. – Community/Business Leader

Vision Care

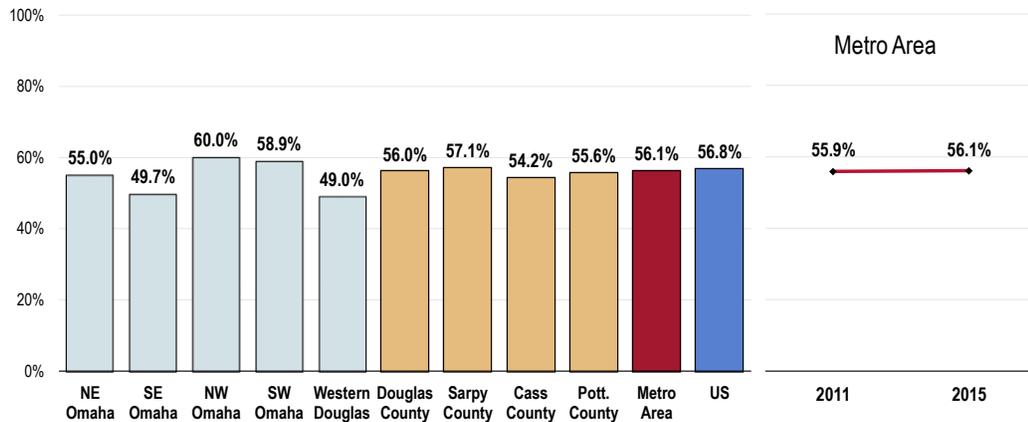
A total of 56.1% of residents had an eye exam in the past two years during which their pupils were dilated.

RELATED ISSUE:

See also [Vision & Hearing in the Death, Disease & Chronic Conditions](#) section of this report.

- Close to the national percentage.
- Comparable findings among Metro Area counties.
- Lowest in Southeast Omaha and Western Douglas County.
- TREND: Statistically unchanged over time.

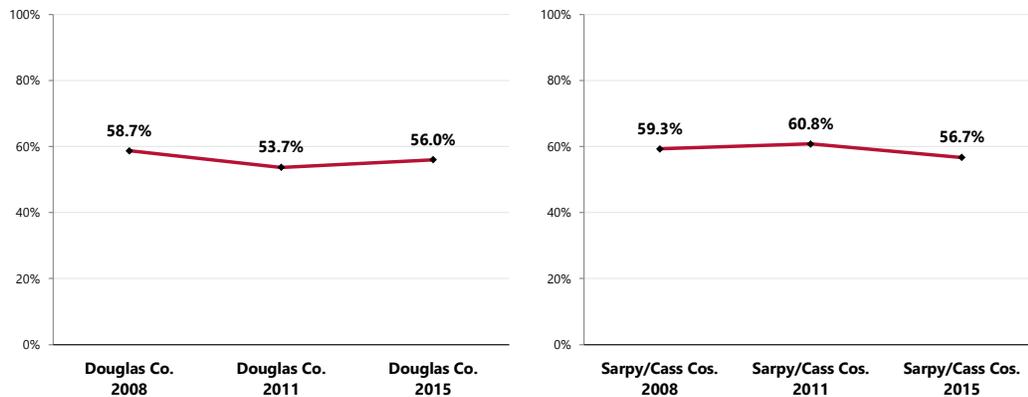
Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

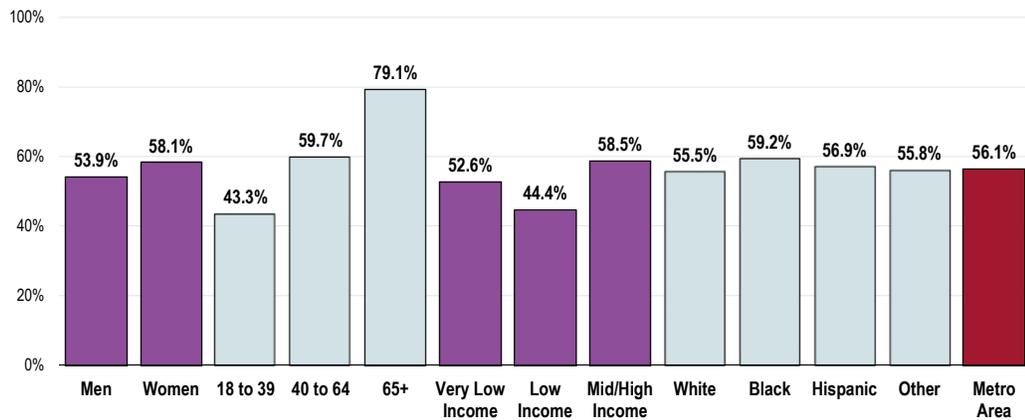


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20]
 Notes: • Asked of all respondents.

Recent vision care in the Metro Area is more often reported among:

- Women.
- Older residents (positive correlation with age).
- Residents at either end of the income spectrum.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Health Education & Outreach



Professional Research Consultants, Inc.

Healthcare Information Sources

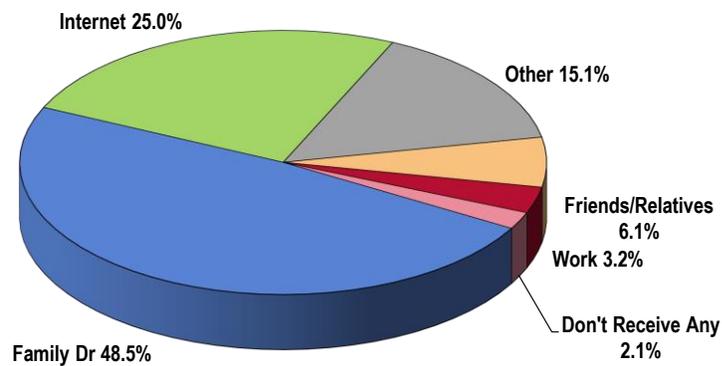
Family physicians and the Internet are residents' primary sources of healthcare information.

- 48.5% of Metro Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 25.0%.

Other sources mentioned include friends and relatives (6.1%) and work (3.2%).

- A total of 2.1% of survey respondents say that they do not receive any healthcare information.

Primary Source of Healthcare Information
(Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 334]
Notes: • Asked of all respondents.

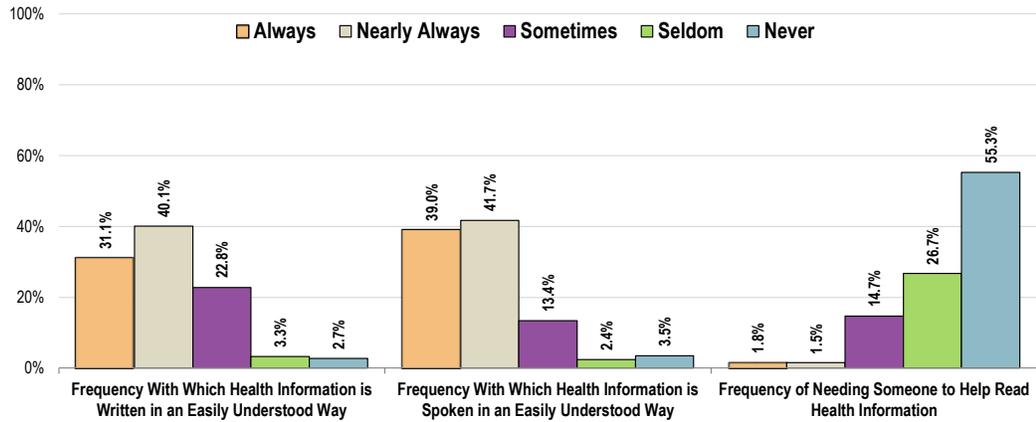
Health Literacy

Survey respondents were next asked about their level of ease in understanding health information, whether written or spoken.

While most Metro Area residents do not appear to have problems with reading or hearing about health information, note that 6.0% report that health information is “seldom” or “never” written in an easily understood way, and a similar proportion (5.9%) feels health information is “seldom/never” spoken in an easily understood way.

- Among survey respondents, 3.3% “always” or “nearly always” need someone to help them read health information.

Understanding Health Information (Metro Area, 2015)

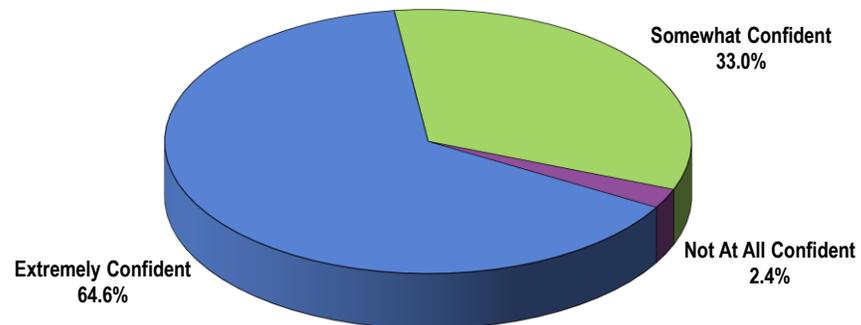


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 335-337]
 Notes: • Asked of all respondents.

Asked about their level of confidence in filling out health forms appropriately, most Metro Area residents (64.6%) gave “extremely confident” responses, and 33.0% are “somewhat confident” about their ability to fill out health forms.

- Note that 2.4% of respondents are “not at all confident” about filling out health forms.

Self-Perceived Confidence in Ability to Fill Out Health Forms (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 338]

Notes: • Asked of all respondents.

• In this case, health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

Participation in Health Promotion Events

About Educational & Community-Based Programs

Educational and community-based programs play a key role in preventing disease and injury, improving health, and enhancing quality of life.

Health status and related-health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Education and community-based programs and strategies are designed to reach people outside of traditional healthcare settings. These settings may include schools, worksites, healthcare facilities, and/or communities.

Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

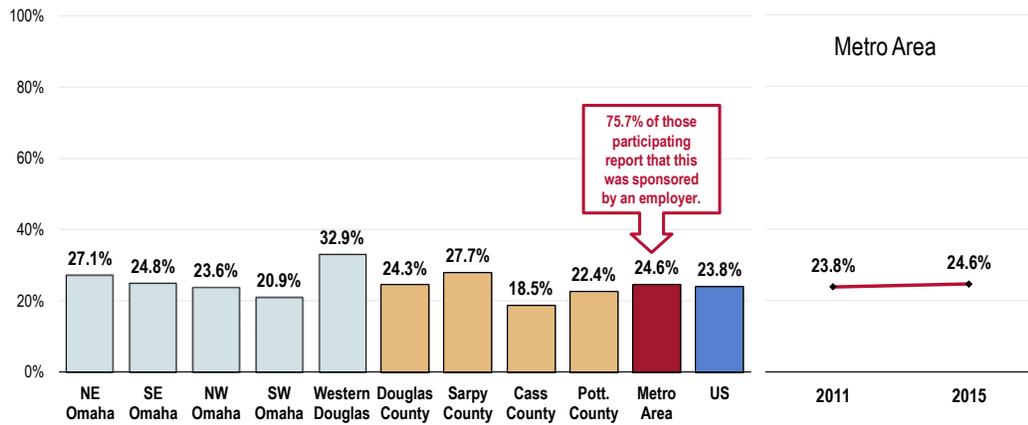
Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

- Healthy People 2020 (www.healthypeople.gov)

A total of 24.6% of Metro Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.

- Comparable to the national prevalence.
- Lowest in Cass County.
- Favorably high in Western Douglas County.
- TREND: Unchanged since the 2011 survey was conducted.
- Note that 75.7% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer.

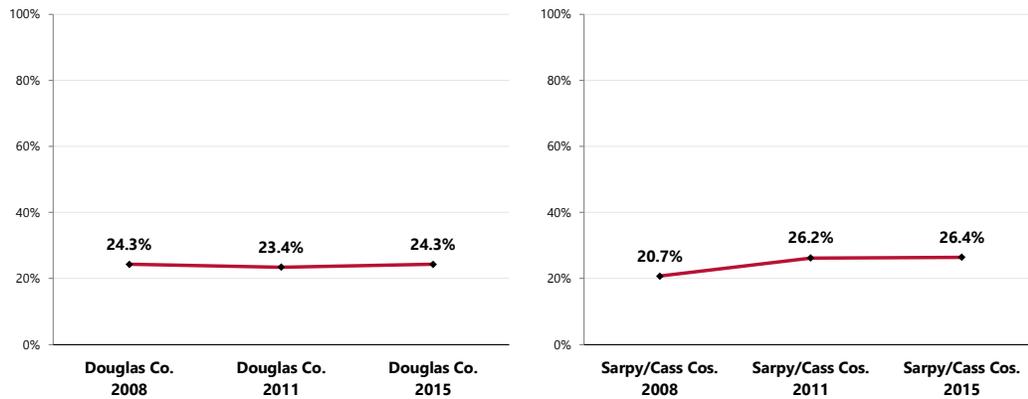
Participated in a Health Promotion Activity in the Past Year



Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 339-340]
 ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: ● Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas County but marking a statistically significant increase over time in Sarpy/Cass counties.

Participated in a Health Promotion Activity in the Past Year

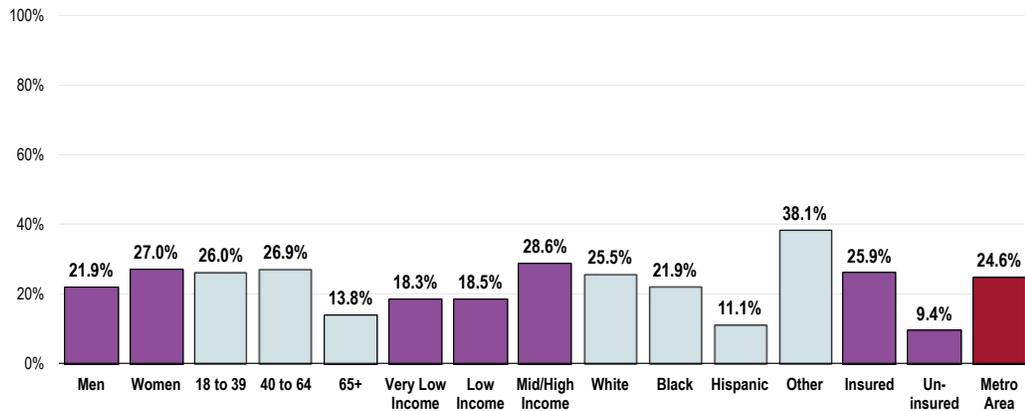


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 339-340]
 Notes: ● Asked of all respondents.

These population segments are less likely to have participated in a health promotion event during the past year:

- Men.
- Seniors.
- Lower-income residents.
- Blacks and Hispanics.
- The uninsured.

Participated in a Health Promotion Activity in the Past Year (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 339]

- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Local Resources



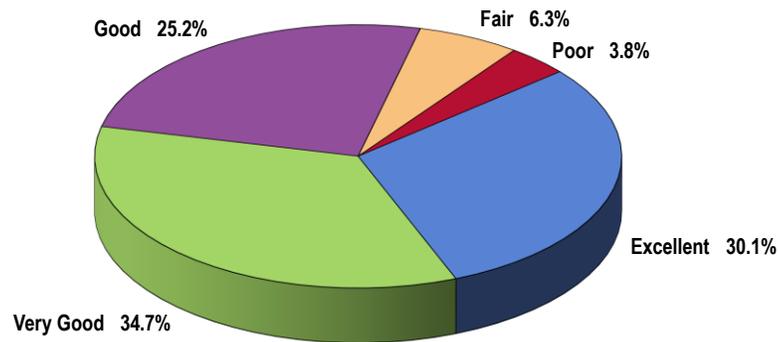
Professional Research Consultants, Inc.

Perceptions of Local Healthcare Services

Nearly 2 in 3 Metro Area adults (64.8%) rate the overall healthcare services available in their community as “excellent” or “very good.”

- Another 25.2% gave “good” ratings.

Rating of Overall Healthcare Services Available in the Community (Metro Area, 2015)

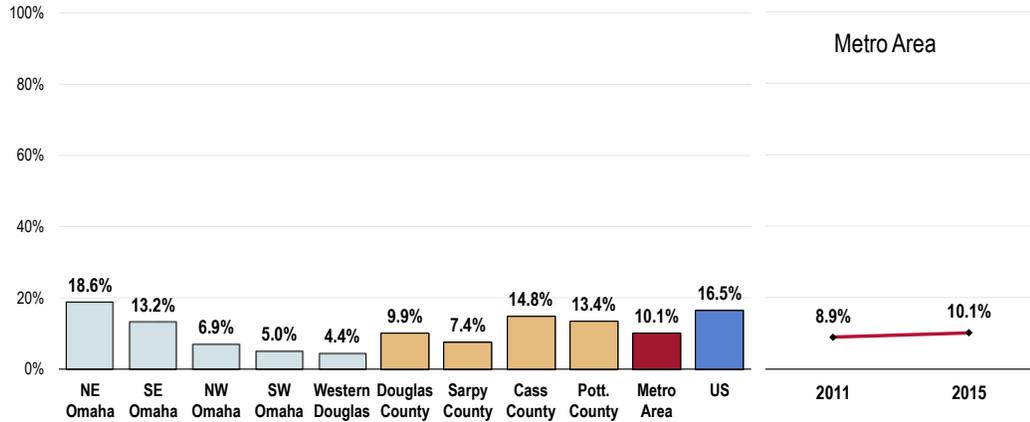


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 10.1% of residents characterize local healthcare services as “fair” or “poor.”

- More favorable than reported nationally.
- Favorably low in Sarpy County.
- In Douglas County, the prevalence is much higher in the east.
- TREND: Statistically unchanged over time.

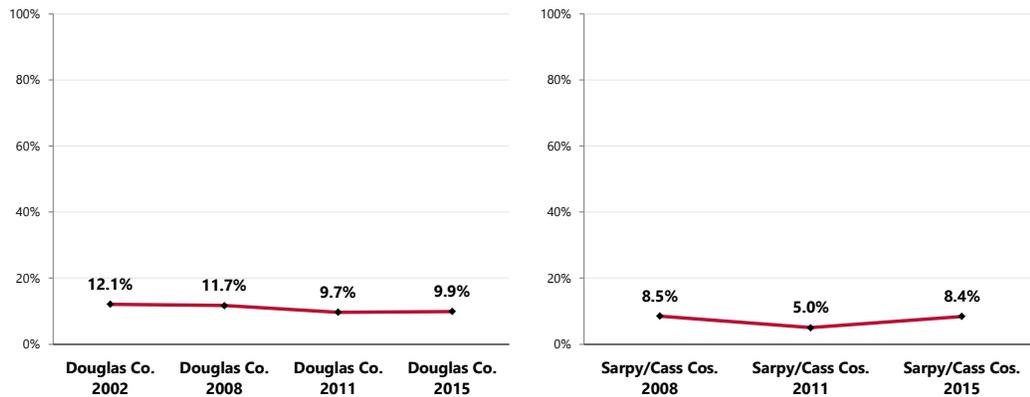
Perceive Local Healthcare Services as “Fair/Poor”



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

- TREND: Statistically unchanged over time in Douglas and Sarpy/Cass counties.

Perceive Local Healthcare Services as “Fair/Poor”

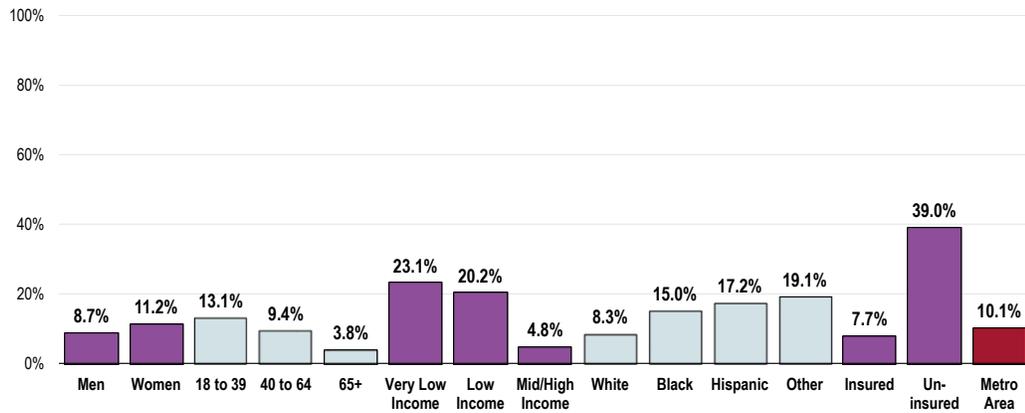


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]
 Notes: • Asked of all respondents.

The following residents are more critical of local healthcare services:

- Women.
- Adults under age 65 (negative correlation with age).
- Residents with lower incomes (negative correlation with income).
- Blacks, Hispanics, and Other adults.
- Uninsured adults.

Perceive Local Healthcare Services as “Fair/Poor” (Metro Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

Notes: • Asked of all respondents.

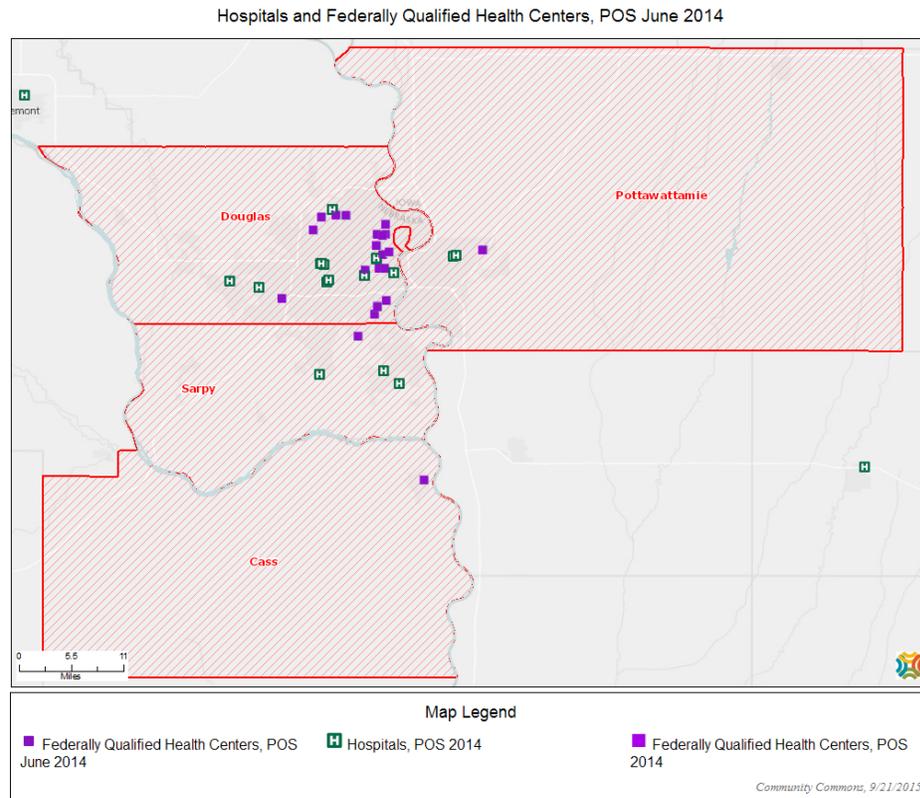
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households living with defined poverty status; "Low Income" includes households with incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map provides an illustration of the hospitals and Federally Qualified Health Centers (FQHCs) within the Metro Area as of June 2014.

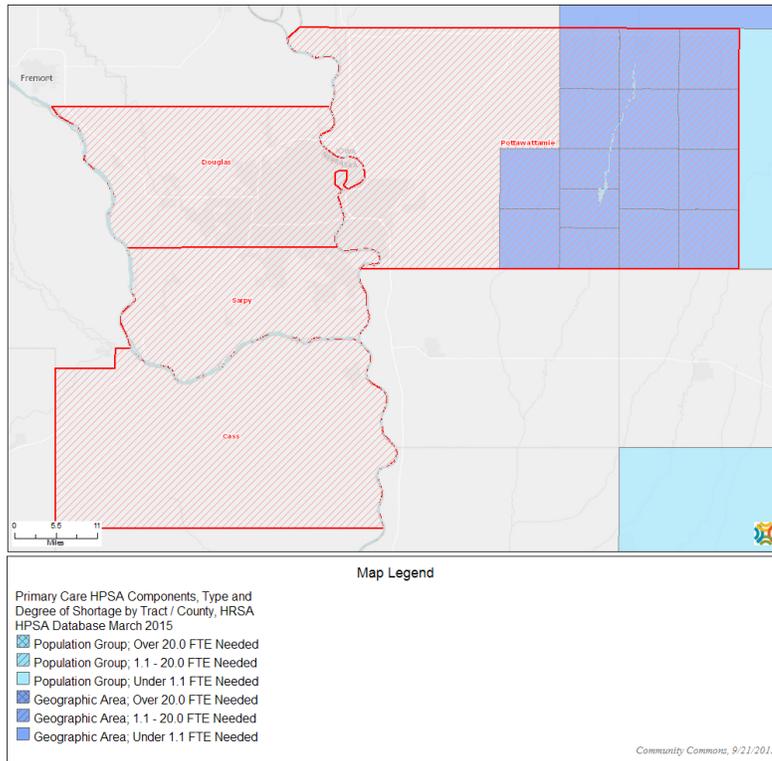


Health Professional Shortage Areas (HPSAs)

The following map provides an illustration of those areas within the Metro Area that have been designated by the US Department of Health and Human Services as a health professional shortage area (HPSA) as of March 2015.

A "health professional shortage area" (HPSA) is defined as having a shortage of primary medical care, dental or mental health professionals.

Population Living in a HPSA, Percent , HRSA HPSA Database March 2015



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

| | |
|--|---|
| ACA | Heartland Family Services |
| Alegent Psychiatric Associates | Hope Medical Outreach Coalition |
| All Care | Hospitals |
| Ambulatory Clinics | Inroads to Recovery |
| Area Agency on Aging | Insurance Covered Transportation |
| Boys Town | Intelliride |
| Bus | Interpretive Services |
| Carl T. Curtis Health Center | Live Well Omaha |
| Catholic Charities | Lutheran Family Services |
| Center for Holistic Development | Lutheran Family Services and Southern Sudan Community |
| Charles Drew Health Center | Magis Clinic Creighton |
| CHI Health | Medicaid |
| Clinics | Methodist Jennie Edmundson Hospital |
| Community Alliance | Metro Area Transportation |
| Community Health Center | More Partnership Between Clinical and Public Sides |
| Creighton | Nebraska Department of Health and Human Services (DHHS) |
| Creighton Dental School | Nebraska Urban Indian Health |
| Cultural/Diversity Training | North Omaha Area Health |
| Department of Health and Human Services | One World Community Health Center |
| Diabetes Discharge Kit Nebraska Medicine | PACE Programs |
| Douglas County Health Department | Pottawattamie County Community Services |
| Douglas County Mental Health Center | Private Health Providers |
| Douglas County Outpatient Psych Clinic | Quick Care |
| Douglas County Primary Health Clinic | Renaissance Clinic |
| Eastern Nebraska Office on Aging | Salvation Army |
| Emergency Room | School Based Health Centers |
| Endeveren Family Medicine | Schools |
| Faith Community Nurses | Social Workers |
| Federally Qualified Health Centers | Southwest Iowa Transit Agency |
| Financial Assistance Programs | Special Transit System |
| Florence Clinic | SWITA |
| Fred Leroy Health and Wellness Center | Taxi |
| Free Clinic at Kounze Memorial Church | Transitional Services |
| Friend Drive | Transportation Assistance |
| Goodlife | UNMC |
| Health Fairs, Screenings | Visiting Nurses Association |
| Heart Ministry Center | Winnebago Hospital |

Arthritis, Osteoporosis & Chronic Back Conditions

Arthritis Foundation
 Charles Drew Health Center
 CHI Health
 CHI Psychiatry
 Chiropractic Care
 Eastern Nebraska Office on Aging
 Hospitals
 Methodist Pain Clinic
 Methodist Physicians Clinic
 MHS Physical Therapy
 Midwest Pain Clinic
 Miller Ortho
 Nebraska Arthritis Partnership
 One World Community Health Center
 Orthopedic Care
 Orthopedic Physician Specialist
 Pain Clinic
 Physical Therapy Programs
 Private Health Providers
 Rheumatology Consultants
 The Spine Center
 Wellness Centers

Cancer

American Cancer Society
 Bryan LGH
 Cancer Center at UNMC
 Cancer Center of America
 Charles Drew Health Center
 CHI Alegent Creighton and Bergan
 CHI Health
 Children's Hospital
 Creighton
 Creighton University
 EPA Attempt to Clean up North Omaha
 Every Woman Matters
 Health Advocacy Organizations
 Health Department
 Heartland Oncology
 Hope Medical Outreach Coalition
 Hospitals
 Lung Cancer Non-Profit
 Methodist
 Methodist Estabrook Cancer Center
 Methodist Jennie Edmundson Hospital
 My Sister's Keeper
 Nebraska Cancer Coalition

Nebraska Cancer Specialists
 Nebraska Comprehensive Cancer
 Control Program
 Nebraska Medicine
 Nebraska Urban Indian Health
 No More Empty Pots
 Olson Clinic
 One World Community Health Center
 Our Family Resource Center
 OWHC
 Private Health Providers
 Project Pink
 Public Health Department
 Quitline Iowa
 Survivor Support Groups
 Susan G. Komen Foundation
 Three Accredited Cancer Centers
 Tomato Collaborates With NUIHC and
 NMEP
 UNMC
 Visiting Nurses Association
 Wings of Hope

Chronic Kidney Disease

Charles Drew Health Center
 CHI Health
 Creighton University
 Dialysis Centers
 Dialysis Units in North Omaha
 Dialysis Units, Davita
 Emergency Room
 Hospitals
 National Kidney Foundation
 Nebraska Kidney Association
 Nebraska Medicine
 North Omaha Area Health
 Outpatient Dialysis Centers
 RAI Care Center Omaha at Home
 Program
 UNMC
 VAMC

Dementias, Including Alzheimer's Disease

Alzheimer's Association
 Assisted Living Facilities
 Douglas County Health Center
 Eastern Nebraska Office on Aging
 Eldercare Physicians
 For Profit Organizations that Provide Day

Care
 Geriatric Clinics
 Home Healthcare
 Home Instead Center for Successful Aging
 Hospitals
 Locked Units in Nursing Homes
 Long Term Care Facilities With Dementia/Secured Units
 Memory Care Homes
 Methodist
 Nursing Homes
 OWHC
 Respite Resource Center
 Support Groups
 Three Health Systems
 UNMC

Diabetes

After School Programs
 American Diabetes Association
 Charles Drew Health Center
 CHI Alegent Creighton
 CHI Health
 CHI Weight Management Program
 Children's Hospital
 Churches
 Clinics
 Community Health Fairs
 Community Health Nurse
 Community-Based Prevention Programs
 CPPHE-REACH Program
 Creighton University
 Department of Health and Human Services
 Diabetes Alliance
 Diabetes Education Center of the Midlands
 Diabetes Education CHI Health
 Diabetes Foundation
 Diabetes Non-Profit
 Diabetes Prevention Programs at YMCA and UNMC
 Diabetes Resource Center
 Diabetes Specialist Practices
 Diabetes Supply Center of the Midlands
 Diabetic Centers and Educators
 Diabetic Education Classes at NE Medicine
 Diabetic Educators at Hospitals

Diabetic Support Groups
 Douglas County Health Center
 Douglas County Health Department
 Eastern Nebraska Office on Aging
 Employer Wellness Programs Incentive Based
 Faith-Based Communities
 Farmer's Market
 Federally Qualified Health Centers
 Foot Care Clinics
 Foreman Foundation
 General Assistance if You Meet Income Guidelines
 Generic Medications
 Goodlife
 Government Offices and County Extension Offices
 Grocery Stores
 Health Coaches
 Health Department
 Health Fairs, Screenings
 Healthy Families
 Healthy Neighborhood Stores
 Home Healthcare
 Hope Center
 Hospitals
 Hy-Vee
 Internet
 Live Well Council Bluffs
 Local Diabetes Chapter
 Local Garden Programs
 Malcolm X Foundation
 Methodist
 Methodist Physicians Clinic
 MHS Diabetes Center
 Midtown Clinic at Nebraska Medicine
 Nebraska Medicine
 Nebraska Medicine Bellevue
 No More Empty Pots
 North Omaha Area Health
 NUJHC
 One World Community Health Center
 OWHC
 Pharmaceutical Company Medication Assistance Program
 Primary Care Providers
 Private Health Providers
 Public and Private Health Providers
 Public Health Department
 Schools

Sharing Clinic
 The Diabetes Center on 84th and Center
 The Healing Gift Clinic
 Three Health Systems
 TOPS
 Uninet Diabetes Education and Support
 Groups
 United Healthcare Community Health
 Worker Program
 UNMC
 Visiting Nurses Association
 Weight Watchers
 Winnebago Hospital
 YMCA

Family Planning

Abortion and Contraception Clinic of
 Nebraska
 Archdiocese of Omaha
 Association of Reproductive Health
 Professionals
 Charles Drew Health Center
 College of Public Health
 Creighton
 Department of Health and Human
 Services
 Douglas County Health Department
 Emergency Pregnancy Service
 Federally Qualified Health Centers
 Fred Leroy Health and Wellness Center
 Hospitals
 North Omaha Area Health
 One World Community Health Center
 OWHC
 Planned Parenthood
 Primary Care Providers
 Private Health Providers
 School Based Health Centers
 Schools
 Sherwood Foundation
 Social Workers
 UNMC
 Visiting Nurses Association
 Wal-Mart

Hearing & Vision

Building Healthy Futures
 Charles Drew Health Center
 Creighton University
 Lions

OWHC
 Primary Care Providers
 Schools

Heart Disease & Stroke

Adult and Elderly Home Visiting
 Programs
 American Heart Association
 Business Wellness Programs Such as
 Union Pacific
 Cardiac Center at Creighton
 Cardiac Prevention Programs at Local
 Hospitals
 Cardiac Rehab Programs
 Charles Drew Health Center
 CHI Alegent Creighton and Bergan
 CHI Health
 CHI Heart Centers
 Clinics
 Community Center Fitness Programs
 Community Health Fairs
 Community Wide Stroke Team
 Community-Based Prevention Programs
 CPPHE-REACH Program
 Creighton
 Department of Health and Human
 Services
 Diabetic Centers and Educators
 Douglas County Health Department
 Eastern Nebraska Office on Aging
 Engage Wellness Center UNMC
 Faith Community Nurses
 Faith-Based Communities
 Federally Qualified Health Centers
 Fitness Centers/Gyms
 Fred Leroy Health and Wellness Center
 Health Coaches MPC
 Health Department
 Health Fairs, Screenings
 Healthy Families
 Healthy Heart Program
 Healthy Neighborhood Stores
 Hospital Diet Office
 Hospitals
 Hy-Vee
 Live Well Omaha
 Long Term Care Options
 Methodist
 Methodist Heart Center
 Methodist Jennie Edmundson Hospital

Methodist Physicians Clinic
 Nebraska Heart Association
 Nebraska Medicine
 North Omaha Area Health
 North Omaha Community Care Council
 One World Community Health Center
 OWHC
 Prevention Programs at the Fitness Clubs
 Primary Care Providers
 Private Health Providers
 Public Health Department
 Quitline Iowa
 Red Dress Program for Women
 Specialty Care
 The Center
 Three Health Systems
 Trained Pharmacists and Protocols
 Tuition Support Offered by YMCA
 UNMC
 UNO
 Visiting Nurses Association
 Worksite Wellness Programs
 YMCA

HIV/AIDS

Charles Drew Health Center
 Churches
 Creighton University
 Department of Health and Human Services
 Douglas County Health Department
 Douglas County Medical Center
 Extension Offices
 Health Department
 Infectious Disease Medicine at Bergan Mercy
 Nebraska AIDS Project
 Nebraska Medicine
 North Omaha Area Health
 One World Community Health Center
 Planned Parenthood
 Private Health Providers
 School Based Health Centers
 UNMC

Immunization & Infectious Diseases

Charles Drew Health Center
 College of Public Health
 Department of Health and Human Services

Douglas County Health Department
 Douglas County Medical Center
 Douglas County Primary Health Clinic
 Federally Qualified Health Centers
 Health Department
 Hospitals
 Nebraska AIDS Project
 Nebraska Medicine
 One World Community Health Center
 OWHC
 Planned Parenthood
 Primary Care Providers
 Private Health Providers
 School Based Health Centers
 UNMC
 Women's Fund of Omaha

Infant & Child Health

Ambulatory Clinics
 Baby Blossom Collaborative
 Charles Drew Health Center
 CHI Health
 Children's Hospital
 CityMatch
 Daycare Centers
 Department of Health and Human Services
 Douglas County Health Department
 Early Childhood Services
 Educare and the Learning Community
 EPA Douglas County Health Dept & Charles Drew Health Cntr
 Faith-Based Communities
 Federally Qualified Health Centers
 Fetal Infant Mortality Efforts
 Health Department
 Home Healthcare
 Home Visitation Programs, Headstart, Evenstart Programs
 Live Well Omaha
 Maternal and Child Health Bureau HRSA
 Maternal Health Clinics
 Omaha Healthy Start
 Omaha Public Schools
 One World Community Health Center
 OWHC
 Private Health Providers
 Project Harmony
 Quick Care
 School Based Health Centers

Schools
 The Connections Program
 UNMC
 Visiting Nurses Association
 WIC

Injury & Violence

360 Community Group
 75 North
 ABIDE Ministries
 Adult Protective Services
 After School Programs
 Anger Management Classes at MH Organizations
 Big Brothers and Big Sisters
 Black Men United
 Boy Scouts
 Boys and Girls Club
 Catholic Charities
 Center for Holistic Development
 Child Saving Institute
 Children's Square
 Churches
 Collective for Youth
 Community Groups in North and South Omaha
 Community Policing
 Community-Based Prevention Programs
 Compassion in Action
 Crime Commission
 Crisis Response Team
 DHS and Multiple Family and Children Organizations
 Domestic Violence Coordinating Council
 Douglas County
 Douglas County Corrections
 Douglas County District Court
 DV Task Force
 DVCC and WCA
 Education
 Emotional CPR From CHI Immanuel
 Empowerment Network
 Faith-Based Communities
 Family Network
 Federally Qualified Health Centers
 Gang Prevention Units
 Gang Unit of Omaha Police Department
 Girls, Inc.
 Grass Root Neighborhood Organizations
 Green Dot Program at UNO Campus

Heartland Family Services
 Hope Center
 Hospitals
 Impact One
 Jobs
 Juan Diego Center
 Kroc Center
 Law Enforcement
 Lutheran Family Services
 Lydia House
 Malcolm X Foundation
 Methodist
 Methodist Forensic Nurse Examiner Program
 Methodist SANE/SART Program
 Midlands Mentoring
 National Safety Council
 Nebraska Families Collaborative
 Neighbors Helping Neighbors
 NICE Program in OPS
 NUIHC
 Omaha 360
 Omaha Alliance of Churches
 Omaha Empowerment Network
 Omaha Police Department
 Omaha Public Schools
 Omaha Youth Engagement System
 Outpatient Treatment
 Phoenix House Domestic Violence Shelter
 Programs for at Risk Youth
 Programs Through Police Resources
 Project 360
 Project Everlast
 Project Harmony
 Public and Private Entities Working Together
 Safety Council
 School Based Health Centers
 Schools
 Stopping Violence
 Team Mates Mentoring Program
 Think Before You Act
 Trauma Center
 Universities
 Upward Bound Programs at all Universities
 Urban League
 Voices for Children of Nebraska
 Wellness Centers

Women's Center for Advancement
YMCA

Mental Health

Act Team - HFS
All Care
Antonia Correa - UNMC/COPH/CRHD
APA
Behavioral Health at MMI and Children's
Behavioral Health Parity Act
Boys Town
Campus for Hope
Catholic Charities
Center for Holistic Development
Charles Drew Health Center
CHI Health
CHI Health Immanuel
CHI Health Mercy
CHI Health School Based Mental Health Program
Child Protective Services
Child Saving Institute
Children's Hospital Behavioral Health
Children's Square
Churches
Clinics
Community Alliance
Community Based Providers
Connections Project
County Mental Health
Creighton
Department of Health and Human Services
Douglas County
Douglas County Board of Mental Health
Douglas County Corrections
Douglas County Health Center
Douglas County Health Department
Douglas County Hospital
Douglas County Mental Health Center
Douglas County Outpatient
EAP
Early Home Visitation Prgm Funded by Promise Partners
Emergency Room
Family Connections
Family Enrichment
Family Network
Federally Qualified Health Centers
Fitness Centers/Gyms

Fred Leroy Health and Wellness Center
Friendship Program
Glenwood Resource Center
Greater Omaha Center in City of Omaha Detox Center
HAB and SCL
Heartland Family Services
Homeless Shelters
Hospitals
IHH, HFS and CHI
Inroads to Recovery
Insurance Company
Integrated Health Homes
Jewish Family Services
Juan Diego Center
Kim Foundation
Lasting Hope Recovery Center
Legislature
LFS
Lincoln Regional Center
Living Hope
Lutheran Family Services
Magellan
McDermott
Medicaid
Mental Health and Substance Abuse Network
Mental Health Folk at Centrepont
Mental Health Partnership
Methodist Counseling Program
Methodist Foundation
Methodist Jennie Edmundson Hospital
MICAH House
Munroe-Meyer Institute
NAMI
Nebraska Children's Home Society
Nebraska Medicine
Nebraska Urban Indian Health
New Horizon Therapy
NMC Psychiatry
Nonprofit Agencies Offering Outpatient Services
Omaha Campus for Hope and Catholic Charities
Omaha Public Schools
One World Community Health Center
OWHC
Personal Referrals
Pottawattamie Case Management Services

Pottawattamie County Mental Hlth and
 Substance Abuse
 Private Health Providers
 Private Institutions
 Private Mental Health Service Agencies
 Project Harmony
 Psych Associates
 Psych Services
 Region 6
 Regionalization of Mental Health Services
 RESPECT Clinic
 Richard Young
 Safe Haven
 Salvation Army
 School-Based Health Centers
 Schools
 Small Number of Beds at Nebraska
 Medicine
 SW IA Mental Health
 Three Health Systems
 United Way 211
 VA Hospital
 Visiting Nurses Association
 Voices for Children of Nebraska
 Youth Emergency Services

Nutrition, Physical Activity & Weight

After School Programs
 B Cycles
 Backpack Program That Supplies Food
 for the Weekend
 Bike and Walking Trails
 Boys and Girls Club
 Boys Town
 Charles Drew Health Center
 CHI Health
 Children's Hospital
 Community Centers
 Community Health Fairs
 Cooking Matters
 Council Bluffs Health Department
 CPPHE-REACH Program
 Creighton University
 Department of Health and Human
 Services
 Douglas County Community Center
 Douglas County Health Department
 Eat Healthy Programs
 Extension, NEP and Nutrition/Health
 Programs

Faith-Based Communities
 Familia Saludables (Healthy Families)
 Alegent
 Family Network
 Farmer's Market
 Fitness Centers/Gyms
 Food Banks, Pantries and Meals on
 Wheels for Elderly
 Free Run/Walk a Thons
 Girls, Inc.
 Grocery Stores
 Health Department
 Health Fairs, Screenings
 Healthy Families
 Healthy Neighborhood Stores
 Heartland Family Services
 HEROES
 Hospitals
 Hy-Vee
 Hy-Vee Dietitians
 Kroc Center
 Live Well Council Bluffs
 Live Well Omaha
 Multiple Nutrition/Supplement Stores
 Nebraska Medicine Bellevue
 Nebraska Urban Indian Health
 No More Empty Pots
 Nutrition Programs Through VNA, WIC
 and Hy-Vee
 Nutritional Classes Offered in the
 Community
 Nutritionist Referral
 Omaha Nutrition Center
 Omaha Public Schools
 One World Community Health Center
 Overeaters Anonymous
 OWHC
 Parks and Recreation
 Primary Care Providers
 Private Health Providers
 Public Health Department
 Salvation Army
 Schools
 Senior Center
 Silver Sneakers Program
 The Center
 Three Health Systems
 Transportation Assistance
 UNMC
 Weight Loss Center

Weight Watchers
Wellness Centers
Wellness Council of the Midlands
WIC
YMCA
Youth Sports Activities in Schools

Oral Health

All Care
Building Healthy Futures
Charles Drew Health Center
Community Events Providing Free Services
Community Health Nurse
Creighton Dental School
Creighton University
Dental Schools
Department of Health and Human Services
Federally Qualified Health Centers
Fred Leroy Health and Wellness Center
Free Dental Care
Hawk I for Low Income
Heart Ministry Center
I-MOM
Iowa Mission
I-Smile
One World Community Health Center
OWHC
Private Health Providers
Schools
Sliding Scale Dental Clinic at UNMC
SMILE Program
UNMC
Winnebago Hospital

Respiratory Diseases

Advocacy Group
American Lung Association
Douglas County Health Department
Emergency Room
OWHC
Primary Care Providers
Private Health Providers
Quitline Iowa

Sexually Transmitted Diseases

Adolescent Health Project
Charles Drew Health Center

CHI Health
Churches
Clinics
Community Organized Events
Council Bluffs Health Department
County Health Screening Programs
Creighton
DCHD STD Clinics
Department of Health and Human Services
Douglas County
Douglas County Health Center
Douglas County Health Department
Douglas County Medical Center
Douglas County STD Clinic
Early Education
Federally Qualified Health Centers
Fred Leroy Health and Wellness Center
Gabriel's Corner
Get Checked Omaha
Girls, Inc.
Health Department
HIV Prevention Programs
Hospitals
Lutheran Family Services
Nebraska AIDS Project
Nebraska Medicine
Nontraditional Testing Sites
North Omaha Area Health
NUIHC
Omaha Public Library
One World Community Health Center
OWHC
Planned Parenthood
Primary Care Providers
Private Health Providers
Public Health Department
Public Libraries Provide Free STD Screenings
Renaissance Clinic
RESPECT Clinic
School Based Health Centers
Schools
Sex Education in OPS
STD Clinic
Three Health Systems
TOP Programs in Schools
UNMC
UNO

Women's Fund of Omaha

Substance Abuse

211
 Addiction Centers/Programs
 Alcoholic Anonymous
 Behavioral Health
 Boys Town
 Campus for Hope
 Catholic Charities
 Catholic Social Services
 Center for Holistic Development
 Charles Drew Health Center
 CHI Health
 CHI Health Mercy
 Child and Young Adult Treatment Programs Through CHI
 Coalition for Treatment of Drug Abuse
 Community Alliance
 Counseling
 Courts and Department of Human Services
 Department of Health and Human Services
 Detox in Downtown Omaha
 Douglas County Corrections
 Drug Dependency Unit in Winnebago
 Family Health Services
 Fred Leroy Health and Wellness Center
 Gabriel's Corner
 GOCA of Greater Omaha
 Heartland Family Services
 Hospitals
 Inroads Counseling
 Inroads to Recovery
 Insurance Company
 Journey's Program
 Lasting Hope Recovery Center
 Law Enforcement
 LFS
 Lower Cost Services
 Lutheran Family Services
 Mental Health and Substance Abuse Network
 Methodist Jennie Edmundson Hospital
 NOVA
 NUIHC
 One World Community Health Center
 Open Door Mission
 PMIC in Glenwood

Pottawattamie County Mental Hlth and Substance Abuse
 Primary Care Providers
 Private Health Providers
 Private Institutions
 Private Substance use and Metal Health Counselors
 Psych Associates
 Psych Services
 Region 6
 Salvation Army
 Siena Francis House
 Sliding Scale CD Evaluations Offered by CHI
 Sober Houses
 Stephen Center
 Teen Challenge of the Midlands
 Transitional Services
 United Way 211
 UNMC
 VA Hospital
 Valley Hope
 Various Non-Profits in the Community

Tobacco Use

Addiction Centers/Programs
 American Cancer Society
 American Lung Association
 Behavioral Health
 Cardiac Center at Creighton
 Churches
 Clinics
 Community Health Nurse
 Community Poster Education
 Department of Health and Human Services
 Family Network
 Health Department
 Heartland Family Services
 Home Education Parenting
 Hospitals
 Insurance Company
 Live Well Omaha
 MD Cessation Counseling and Treatment
 Methodist Jennie Edmundson Hospital
 MOTAC
 Nebraska Statewide Compliance
 Tobacco Checks
 NUIHC
 Primary Care Providers

Private Health Providers
Pulmonology and Cancer Center
Quit NE
Quitline
Quitline Iowa

Schools
Self Help Programs
Smoking Cessation Programs
UNMC

Appendices



Professional Research Consultants, Inc.

Appendix A: Douglas County Summary

| Overall Health | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|-------------------------------|----------------|--|---|---|---|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % "Fair/Poor" Physical Health | 11.2 |  14.4 |  13.9 |  15.3 |  11.8 | |
| % Activity Limitations | 17.5 |  19.1 |  18.8 |  21.5 |  18.1 | |
| | |  better |  similar |  worse | | |

| Access to Health Services | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|---|---|---|--|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Age 18-64] Lack Health Insurance | 10.8 |  12.7 |  17.6 |  15.1 |  0.0 |  9.5 |
| % [Insured] Went Without Coverage in Past Year | 6.5 | | |  8.1 | |  6.7 |
| % Difficulty Accessing Healthcare in Past Year (Composite) | 36.4 | | |  39.9 | |  32.7 |
| % Inconvenient Hrs Prevented Dr Visit in Past Year | 14.4 | | |  15.4 | |  11.7 |
| % Cost Prevented Getting Prescription in Past Year | 14.1 | | |  15.8 | |  10.1 |
| % Cost Prevented Physician Visit in Past Year | 13.1 | | |  18.2 | |  7.6 |
| % Difficulty Getting Appointment in Past Year | 13.2 | | |  17.0 | |  13.1 |
| % Difficulty Finding Physician in Past Year | 10.3 | | |  11.0 | |  5.4 |
| % Transportation Hindered Dr Visit in Past Year | 6.1 | | |  9.4 | |  4.7 |

| Access to Health Services (continued) | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|-------------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Cultural/Language Differences Prevented Med Care/Past Yr | 0.8 | | | | | 0.9 |
| % Skipped Prescription Doses to Save Costs | 14.5 | | | 15.3 | | 14.7 |
| % Difficulty Getting Child's Healthcare in Past Year | 3.5 | | | 6.0 | | 3.0 |
| % Have a Particular Place for Medical Care | 84.9 | | | 76.3 | | 87.4 |
| % Have Had Routine Checkup in Past Year | 65.0 | 69.6 | 61.6 | 65.0 | | 68.6 |
| % Child Has Had Checkup in Past Year | 85.0 | | | 84.1 | | 84.8 |
| % Two or More ER Visits in Past Year | 5.1 | | | 8.9 | | 5.5 |
| % Rate Local Healthcare "Fair/Poor" | 9.9 | | | 16.5 | | 12.1 |
| | | better | similar | worse | | |

| Arthritis, Osteoporosis & Chronic Back Conditions | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|-------------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [50+] Arthritis/Rheumatism | 29.4 | | | 37.3 | | 35.6 |
| % [50+] Osteoporosis | 8.4 | | | 13.5 | 5.3 | 11.1 |
| % Sciatica/Chronic Back Pain | 17.3 | | | 18.4 | | 15.8 |
| | | better | similar | worse | | |

| Cancer | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|---|---|---|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Skin Cancer | 4.6 |  6.1 |  5.9 |  6.7 | |  3.0 |
| % Cancer (Other Than Skin) | 4.5 |  7.1 |  6.8 |  6.1 | |  4.0 |
| % [Women 50-74] Mammogram in Past 2 Years | 80.2 |  78.2 |  72.9 |  83.6 |  81.1 |  82.4 |
| % [Women 21-65] Pap Smear in Past 3 Years | 78.8 |  78.0 |  76.6 |  83.9 |  93.0 |  91.2 |
| | |  |  |  | | |
| | | better | similar | worse | | |

| Diabetes | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|---|---|---|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| Diabetes Mellitus (Age-Adjusted Death Rate) | 22.7 |  18.8 |  21.4 |  21.3 |  20.5 |  23.4 |
| % Diabetes/High Blood Sugar | 9.5 |  9.3 |  9.2 |  11.7 | |  7.2 |
| | |  |  |  | | |
| | | better | similar | worse | | |

| Educational & Community-Based Programs | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|---|---|---|------------|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Attended Health Event in Past Year | 24.3 | | |  23.8 | |  24.3 |
| | |  |  |  | | |
| | | better | similar | worse | | |

| Hearing & Other Sensory or Communication Disorders | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|-------------------------------|--------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Deafness/Trouble Hearing | 7.3 | | | 10.3 | | 6.4 |
| <div style="display: flex; justify-content: space-around; align-items: center;">  better  similar  worse </div> | | | | | | |

| Heart Disease & Stroke | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|-------------------------------|--------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Heart Disease (Heart Attack, Angina, Coronary Disease) | 4.8 | | | 6.1 | | 4.5 |
| % Stroke | 3.7 | 2.8 | 2.5 | 3.9 | | 2.0 |
| <div style="display: flex; justify-content: space-around; align-items: center;">  better  similar  worse </div> | | | | | | |

| HIV | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|-------------------------------|--------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Age 18-44] HIV Test in the Past Year | 20.5 | | | 19.3 | | 18.5 |
| <div style="display: flex; justify-content: space-around; align-items: center;">  better  similar  worse </div> | | | | | | |

| Injury & Violence Prevention | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|-------------------------------|--------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Child [Age 0-17] "Always" Uses Seat Belt/Car Seat | 88.3 | | | 92.2 | | 89.5 |
| % Child [Age 5-17] "Always" Wears Bicycle Helmet | 44.6 | | | 48.7 | | 47.0 |
| % Firearm in Home | 26.2 | | | 34.7 | | 29.9 |

| Injury & Violence Prevention (continued) | Douglas County | Douglas County vs. Benchmarks | | | |
|---|----------------|---|---|--|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 |
| % Victim of Violent Crime in Past 5 Years | 4.9 | | |  2.8 |  5.2 |
| % Perceive Neighborhood as "Slightly/Not At All Safe" | 22.4 | | | |  23.6 |
| % Victim of Domestic Violence/Past 5 Years | 3.6 | | | |  2.2 |
| | |  |  |  | |
| | | better | similar | worse | |

| Mental Health & Mental Disorders | Douglas County | Douglas County vs. Benchmarks | | | |
|---|----------------|---|---|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 |
| % "Fair/Poor" Mental Health | 10.1 | | |  11.9 |  8.1 |
| % Symptoms of Chronic Depression (2+ Years) | 24.3 | | |  30.4 |  26.8 |
| % Major Depression | 10.5 | | | |  6.6 |
| % [Those w/Major Depression] Seeking Help | 89.9 | | | |  81.5 |
| % Typical Day Is "Extremely/Very" Stressful | 11.1 | | |  11.9 |  12.6 |
| | |  |  |  | |
| | | better | similar | worse | |

| Nutrition, Physical Activity & Weight | Douglas County | Douglas County vs. Benchmarks | | | |
|--|----------------|-------------------------------|--------|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 |
| % Eat 5+ Servings of Fruit or Vegetables per Day | 38.7 | | |  39.5 |  26.1 |
| % Medical Advice on Nutrition in Past Year | 38.0 | | |  39.2 |  54.4 |

| Nutrition, Physical Activity & Weight (continued) | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|-------------------------------|--------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Healthy Weight (BMI 18.5-24.9) | 31.1 | 31.6 | 32.5 | 34.4 | 33.9 | 37.7 |
| % Overweight (BMI 25+) | 66.8 | 67.0 | 65.5 | 63.1 | | 59.6 |
| % Obese (BMI 30+) | 29.4 | 31.3 | 29.6 | 29.0 | 30.5 | 23.6 |
| % [Obese Adults] COUNSELED About Weight in Past Year | 44.3 | | | 48.3 | | 47.9 |
| % Children [Age 5-17] Overweight (85th Percentile) | 22.6 | | | 31.5 | | 37.2 |
| % Children [Age 5-17] Obese (95th Percentile) | 12.3 | | | 14.8 | 14.5 | 21.7 |
| % [Employed] Job Entails Mostly Sitting/Standing | 62.6 | | | 63.8 | | 62.8 |
| % No Leisure-Time Physical Activity | 18.5 | 28.5 | 25.3 | 20.7 | 32.6 | 16.9 |
| % Meeting Physical Activity Guidelines | 53.8 | | | 50.3 | | 43.6 |
| % Medical Advice on Physical Activity in Past Year | 42.5 | | | 44.0 | | 54.0 |
| % Believe Schools Should Require PE for All Students | 96.6 | | | | | 98.0 |
| % Use Local Parks/Recreation Centers at Least Weekly | 43.7 | | | | | 51.9 |
| % Use Local Trails at Least Monthly | 43.7 | | | | | 40.0 |
| | | better similar worse | | | | |

| Oral Health | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|-------------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Age 18+] Dental Visit in Past Year | 72.7 | 71.1 | 67.6 | 65.9 | 49.0 | 74.5 |
| % Child [Age 2-17] Dental Visit in Past Year | 87.7 | | | 81.5 | 49.0 | 84.5 |
| % Have Dental Insurance | 69.3 | | | 65.6 | | 64.5 |
| | | better | similar | worse | | |

| Respiratory Diseases | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|-------------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % COPD (Lung Disease) | 8.4 | 6.3 | 5.3 | 8.6 | | 7.5 |
| % [Adult] Currently Has Asthma | 8.6 | 7.8 | 7.3 | 9.4 | | 8.5 |
| % Child [Age 0-17] Asthma (Ever Diagnosed) | 8.7 | | | 12.5 | | 10.3 |
| | | better | similar | worse | | |

| Sexually Transmitted Diseases | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|---|----------------|-------------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Unmarried 18-64] 3+ Sexual Partners in Past Year | 5.0 | | | 11.7 | | 3.1 |
| % [Unmarried 18-64] Using Condoms | 38.5 | | | 33.6 | | 20.9 |
| | | better | similar | worse | | |

| Substance Abuse | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|--|---|---|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Drinking & Driving in Past Month | 4.4 | | | ☁ 5.0 | ☁ 4.6 | |
| % Ever Sought Help for Alcohol or Drug Problem | 3.6 | | | ☁ 4.9 | ☁ 3.2 | |
| | |  better |  similar |  worse | | |

| Tobacco Use | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|--|----------------|--|---|---|--|--|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Current Smoker | 16.6 |  19.5 | ☁ 18.5 | ☁ 14.9 |  12.0 |  20.9 |
| % Someone Smokes at Home | 11.1 | | | ☁ 12.7 | |  21.4 |
| % [Household With Children] Someone Smokes in the Home | 7.1 | | | ☁ 9.7 | |  20.6 |
| | |  better |  similar |  worse | | |

| Vision | Douglas County | Douglas County vs. Benchmarks | | | | TREND |
|----------------------------|----------------|--|---|---|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Eye Exam in Past 2 Years | 56.0 | | | ☁ 56.8 | ☁ 58.7 | |
| | |  better |  similar |  worse | | |

Appendix B: Sarpy/Cass Counties Summary

| Overall Health | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|-------------------------------|------------|---|---|---|------------|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % "Fair/Poor" Physical Health | 8.0 |  14.4 |  13.9 |  15.3 | |  10.2 |
| % Activity Limitations | 17.3 |  19.1 |  18.8 |  21.5 | |  16.6 |
| | |  |  |  | | |
| | | better | similar | worse | | |

| Access to Health Services | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|---|---|--|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Age 18-64] Lack Health Insurance | 5.7 |  12.7 |  17.6 |  15.1 |  0.0 |  4.4 |
| % [Insured] Went Without Coverage in Past Year | 5.1 | | |  8.1 | |  4.1 |
| % Difficulty Accessing Healthcare in Past Year (Composite) | 27.0 | | |  39.9 | |  33.7 |
| % Inconvenient Hrs Prevented Dr Visit in Past Year | 11.7 | | |  15.4 | |  13.5 |
| % Cost Prevented Getting Prescription in Past Year | 6.9 | | |  15.8 | |  11.7 |
| % Cost Prevented Physician Visit in Past Year | 9.0 | | |  18.2 | |  9.7 |
| % Difficulty Getting Appointment in Past Year | 8.9 | | |  17.0 | |  11.4 |
| % Difficulty Finding Physician in Past Year | 6.8 | | |  11.0 | |  3.1 |
| % Transportation Hindered Dr Visit in Past Year | 2.5 | | |  9.4 | |  2.1 |
| % Cultural/Language Differences Prevented Med Care/Past Yr | 0.0 | | | | |  0.4 |

| Access to Health Services (continued) | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|--|---|--|---|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Skipped Prescription Doses to Save Costs | 9.3 | | |  15.3 |  10.5 | |
| % Difficulty Getting Child's Healthcare in Past Year | 2.4 | | |  6.0 |  3.3 | |
| % Have a Particular Place for Medical Care | 86.3 | | |  76.3 |  90.7 | |
| % Have Had Routine Checkup in Past Year | 70.7 |  69.6 |  61.6 |  65.0 |  64.5 | |
| % Child Has Had Checkup in Past Year | 88.5 | | |  84.1 |  89.6 | |
| % Two or More ER Visits in Past Year | 2.5 | | |  8.9 |  7.6 | |
| % Rate Local Healthcare "Fair/Poor" | 8.4 | | |  16.5 |  8.5 | |
| | |  better  similar  worse | | | | |

| Arthritis, Osteoporosis & Chronic Back Conditions | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|---|------------|--|--------|---|---|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [50+] Arthritis/Rheumatism | 26.2 | | |  37.3 |  30.1 | |
| % [50+] Osteoporosis | 8.5 | | |  13.5 |  5.3 | |
| % Sciatica/Chronic Back Pain | 12.5 | | |  18.4 |  18.4 | |
| | |  better  similar  worse | | | | |

| Cancer | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|---|------------|---------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Skin Cancer | 6.0 | 6.1 | 5.9 | 6.7 | 81.1 | 4.8 |
| % Cancer (Other Than Skin) | 5.9 | 7.1 | 6.8 | 6.1 | 81.1 | 4.1 |
| % [Women 50-74] Mammogram in Past 2 Years | 84.3 | 78.2 | 72.9 | 83.6 | 81.1 | 72.3 |
| % [Women 21-65] Pap Smear in Past 3 Years | 84.3 | 78.0 | 76.6 | 83.9 | 93.0 | 79.8 |
| | | better | similar | worse | | |

| Diabetes | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|-----------------------------|------------|---------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Diabetes/High Blood Sugar | 8.4 | 9.3 | 9.2 | 11.7 | 9.7 | 9.7 |
| | | better | similar | worse | | |

| Educational & Community-Based Programs | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Attended Health Event in Past Year | 26.4 | | | 23.8 | 20.7 | 20.7 |
| | | better | similar | worse | | |

| Hearing & Other Sensory or Communication Disorders | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---------------------------|---------|--------|------------|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Deafness/Trouble Hearing | 8.5 | | | 10.3 | 9.0 | 9.0 |
| | | better | similar | worse | | |

| Heart Disease & Stroke | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|--|--|--|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Heart Disease (Heart Attack, Angina, Coronary Disease) | 5.0 | | |  6.1 |  5.3 | |
| % Stroke | 1.1 |  2.8 |  2.5 |  3.9 |  0.9 | |
| | |  better |  similar |  worse | | |

| HIV | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|---|------------|---|--|--|---|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Age 18-44] HIV Test in the Past Year | 10.2 | | |  19.3 |  18.4 | |
| | |  better |  similar |  worse | | |

| Injury & Violence Prevention | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|---|------------|---|--|--|---|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Child [Age 0-17] "Always" Uses Seat Belt/Car Seat | 96.1 | | |  92.2 |  94.4 | |
| % Child [Age 5-17] "Always" Wears Bicycle Helmet | 47.6 | | |  48.7 |  44.3 | |
| % Firearm in Home | 37.6 | | |  34.7 |  36.2 | |
| % Domestic Violence/Past 5 Years | 3.7 | | | |  0.8 | |
| % Victim of Violent Crime in Past 5 Years | 0.7 | | |  2.8 |  0.6 | |
| % Perceive Neighborhood as "Slightly/Not At All Safe" | 5.2 | | | |  5.1 | |
| | |  better |  similar |  worse | | |

| Mental Health & Mental Disorders | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|---|------------|---|---|---|---|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % "Fair/Poor" Mental Health | 7.2 | | |  11.9 |  5.6 | |
| % Major Depression | 5.6 | | | |  8.3 | |
| % Symptoms of Chronic Depression (2+ Years) | 20.6 | | |  30.4 |  16.6 | |
| % Typical Day Is "Extremely/Very" Stressful | 8.7 | | |  11.9 |  13.3 | |
| | |  |  |  | | |
| | | better | similar | worse | | |

| Nutrition, Physical Activity & Weight | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|---|---|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Eat 5+ Servings of Fruit or Vegetables per Day | 39.7 | | |  39.5 |  41.1 | |
| % Medical Advice on Nutrition in Past Year | 40.5 | | |  39.2 |  41.5 | |
| % Healthy Weight (BMI 18.5-24.9) | 32.7 |  31.6 |  32.5 |  34.4 |  33.9 |  29.0 |
| % Overweight (BMI 25+) | 66.8 |  67.0 |  65.5 |  63.1 | |  70.5 |
| % Obese (BMI 30+) | 30.6 |  31.3 |  29.6 |  29.0 |  30.5 |  31.9 |
| % [Obese Adults] Counseled About Weight in Past Year | 31.6 | | |  48.3 |  53.5 | |
| % Children [Age 5-17] Overweight (85th Percentile) | 33.3 | | |  31.5 |  37.3 | |
| % Children [Age 5-17] Obese (95th Percentile) | 19.1 | | |  14.8 |  14.5 |  16.2 |
| % [Employed] Job Entails Mostly Sitting/Standing | 65.4 | | |  63.8 |  70.9 | |

| Nutrition, Physical Activity & Weight (continued) | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|---|---|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % No Leisure-Time Physical Activity | 14.1 |  28.5 |  25.3 |  20.7 |  32.6 |  21.9 |
| % Meeting Physical Activity Guidelines | 53.3 | | | |  50.3 |  48.3 |
| % Medical Advice on Physical Activity in Past Year | 43.1 | | | |  44.0 |  46.2 |
| % Believe Schools Should Require PE for All Students | 97.3 | | | | |  97.2 |
| % Use Local Parks/Recreation Centers at Least Weekly | 46.6 | | | | |  45.2 |
| % Use Local Trails at Least Monthly | 49.9 | | | | |  56.0 |
| | |  |  |  | | |
| | | better | similar | worse | | |

| Oral Health | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|---|---|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Age 18+] Dental Visit in Past Year | 78.7 |  71.1 |  67.6 |  65.9 |  49.0 |  74.4 |
| % Child [Age 2-17] Dental Visit in Past Year | 91.6 | | | |  81.5 |  49.0 |
| % Have Dental Insurance | 82.0 | | | |  65.6 |  76.1 |
| | |  |  |  | | |
| | | better | similar | worse | | |

| Respiratory Diseases | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|--|--|--|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % COPD (Lung Disease) | 6.5 |  6.3 |  5.3 |  8.6 |  7.8 | |
| % [Adult] Currently Has Asthma | 5.3 |  7.8 |  7.3 |  9.4 |  5.8 | |
| % Child [Age 0-17] Asthma (Ever Diagnosed) | 8.1 | | |  12.5 |  7.6 | |
| | |  better |  similar |  worse | | |

| Sexually Transmitted Diseases | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|---|------------|---|--|--|--|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % [Unmarried 18-64] 3+ Sexual Partners in Past Year | 6.7 | | |  11.7 |  1.5 | |
| % [Unmarried 18-64] Using Condoms | 41.2 | | |  33.6 |  13.3 | |
| | |  better |  similar |  worse | | |

| Substance Abuse | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|--|--|--|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Drinking & Driving in Past Month | 5.7 | | |  5.0 |  3.9 | |
| % Ever Sought Help for Alcohol or Drug Problem | 1.9 | | |  4.9 |  2.0 | |
| | |  better |  similar |  worse | | |

| Tobacco Use | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|--|------------|---|--|--|---|---|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Current Smoker | 12.9 |  19.5 |  18.5 |  14.9 |  12.0 |  16.2 |
| % Someone Smokes at Home | 6.7 |  12.7 | | |  12.1 | |
| % [Household With Children] Someone Smokes in the Home | 4.9 |  9.7 | | |  7.9 | |
| | |  better |  similar |  worse | | |

| Vision | Sarpy-Cass | Sarpy-Cass vs. Benchmarks | | | | TREND |
|----------------------------|------------|--|---|---|---|-------|
| | | vs. IA | vs. NE | vs. US | vs. HP2020 | |
| % Eye Exam in Past 2 Years | 56.7 |  56.8 | | |  59.3 | |
| | |  better |  similar |  worse | | |