

2021 CHILD & ADOLESCENT HEALTH NEEDS ASSESSMENT

Douglas & Sarpy Counties, Nebraska
Pottawattamie County, Iowa

Sponsored by:

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

With support from:

OneWorld Community Health Centers
Douglas County Health Department
The Wellbeing Partners
Charles Drew Health Center, Inc.
Lozier Foundation

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Child & Adolescent Health Needs Assessment, a follow-up to similar studies conducted in 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of children and adolescents in the Omaha Metropolitan Area.

This assessment was conducted by PRC, Inc., on behalf of Children’s Hospital & Medical Center, Boys Town National Research Hospital, and Building Healthy Futures, with support from OneWorld Community Health Centers, Douglas County Health Department, The Wellbeing Partners, Charles Drew Health Center, Inc., and Lozier Foundation.

PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Child & Adolescent Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Child & Adolescent Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

PRC Child & Adolescent Health Survey

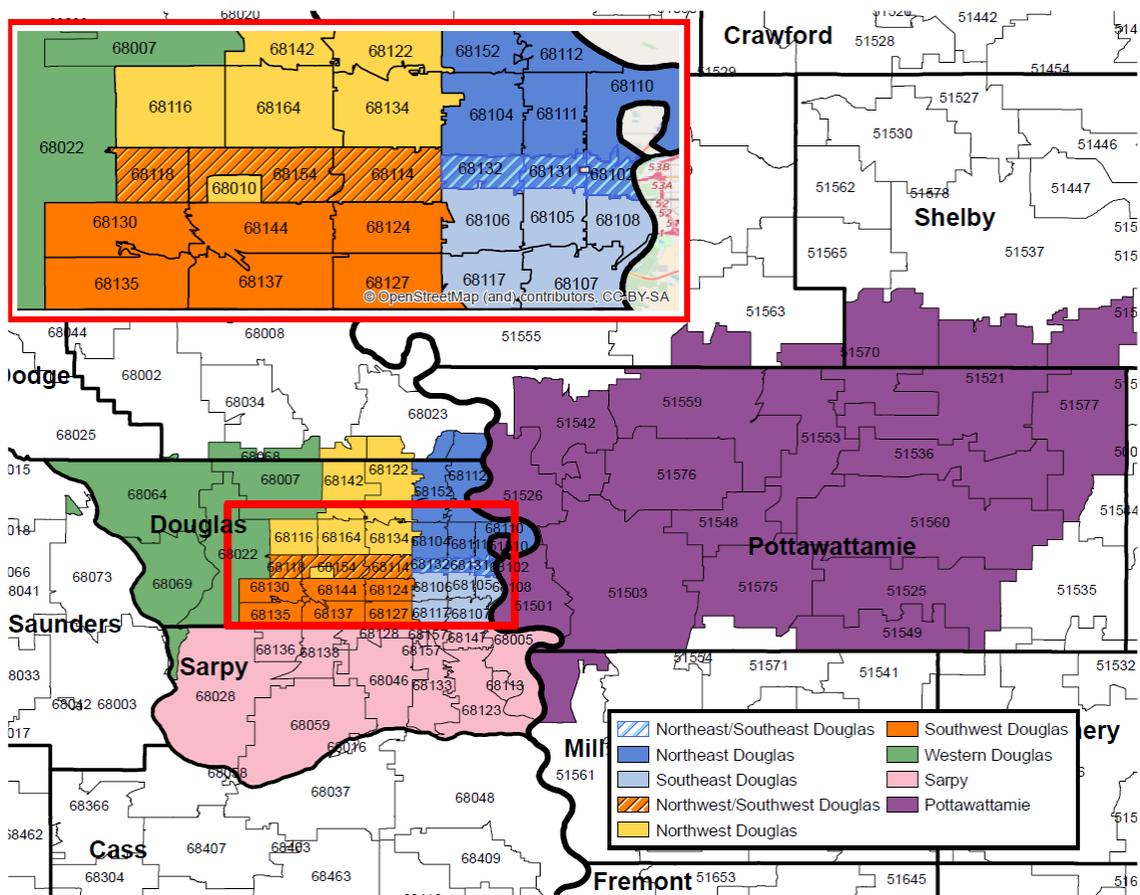
Survey Instrument

The final survey instrument used for this study was developed by the study sponsors and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Metro Area” in this report) is defined as each of the residential ZIP Codes comprising Douglas and Sarpy counties in Nebraska, as well as Pottawattamie County in Iowa. This community definition was determined by the sponsors of this study. Douglas County is further divided in this report into five segments (Northeast Omaha, Southeast Omaha, Northwest Omaha, Southwest Omaha, and Western Douglas County). This geographic definition is further illustrated in the following map.





Sample Approach & Design

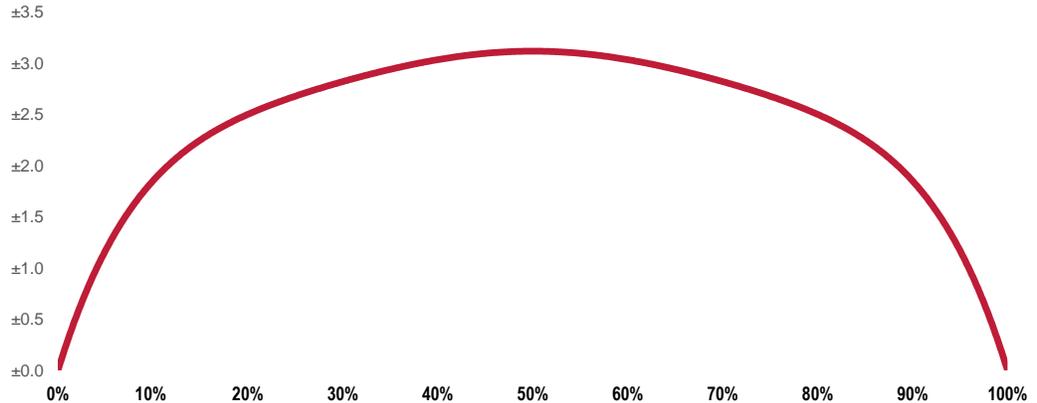
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Child & Adolescent Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone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

The sample design used for this effort consisted of a stratified random sample of 1,000 parents of children under the age of 18 in the Metro Area. By geography, a total of 695 surveys were conducted in Douglas County, 215 in Sarpy County, and 90 in Pottawattamie County. Once the interviews were completed, these were weighted in proportion to the actual child population distribution to appropriately represent the Metro Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 1,000 respondents is $\pm 3.1\%$ at the 95 percent confidence level. By county: the maximum error rate is $\pm 3.7\%$ for Douglas County, $\pm 6.9\%$ for Sarpy County, and $\pm 9.8\%$ for Pottawattamie County.



Expected Error Ranges for a Sample of 1,000 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 1,000 respondents answered a certain question with a "yes," it can be asserted that between 8.1% and 11.9% ($10\% \pm 1.9\%$) of the total population would offer this response.
 - If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.9% and 53.1% ($50\% \pm 3.1\%$) of the total population would respond "yes" if asked this question.

Respondent Selection

Survey respondents were adults age 18 and older who are a health care decision maker for children residing in the household. For households with more than one child under the age of 18, most questions were asked about the child with the most recent birthday. This random selection process allows for the best representation of children by age and gender.

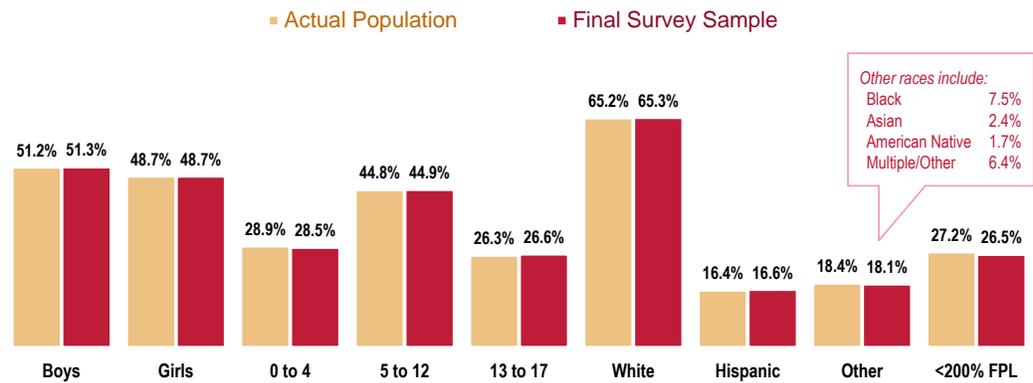
Sample Characteristics

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

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



Population & Survey Sample Characteristics (Metro Area, 2021)



Sources: • US Census Bureau, 2011-2015 American Community Survey.
 • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

INCOME & RACE/ETHNICITY

INCOME ► 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 2020 guidelines place the poverty threshold for a family of four at \$26,200 annual household income or lower). In sample segmentation: “low income” refers to respondents living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more ($\geq 200\%$ of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used and represent the race/ethnicity of the randomly selected child. Hispanic children are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).



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 also was implemented as part of this process. A list of recommended participants was provided by the sponsors; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns among the families and children/adolescents with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 143 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	27
Public Health Representatives	21
Other Health Providers	31
Social Services Providers	22
Other Community Leaders	42

Final participation included representatives of the organizations outlined below.

- Abide Network, Inc.
- American Red Cross—Omaha Council Bluffs Metro Chapter
- Arbor Family Counseling
- Boy Scouts of America—Mid-America
- Boys & Girls Clubs of the Midlands
- Boys Town Hospital and Clinics
- Buffett Early Childhood Institute
- Catholic Charities of Omaha
- Center for Holistic Development
- Charles Drew Health Center
- CHI Health
- Child Saving Institute
- Children’s Hospital & Medical Center
- City MatCH
- City Sprouts
- Council Bluffs Community School District
- Creighton Dental - Care Coordination
- Creighton University
- Creighton University College of Nursing
- Douglas County Board of Commissioners
- Douglas County Health Department
- Educare of Omaha
- Family Inc.
- Father Flanagan Boys Home
- Girl Scouts—Spirit of Nebraska
- Girls Inc.
- Goodwill Industries Inc.



- Greater Omaha Attendance and Learning Services
- Gretchen Swanson Center for Nutrition
- Gretna Public Schools
- Head Start
- Heart Ministries
- Housing Foundation for Sarpy County
- International Council for Refugees and Immigrants Inc
- Kroc Center
- Lasting Hope Recovery Center
- Legal Aid of Nebraska
- Lift Up Sarpy County
- MilkWorks
- Millard Public Schools
- Millard Public Schools Foundation
- Munroe-Meyer Institute (UNMC)
- Nebraska Alliance of Child Advocacy Centers
- Nebraska Children's Home Society
- Nebraska Early Childhood Collaborative
- Nebraska Extension
- Nebraska State Legislature
- Nebraska Total Care
- New Visions Homeless Services
- Omaha City Parks and Recreation
- Omaha City Planning
- Omaha Community Foundation
- Omaha Home for Boys
- OneWorld Community Health Centers, Inc.
- Omaha Public Schools
- OPS Board of Education
- Papillion–La Vista High School
- Project Harmony
- Raise Me to Read
- Ralston Public Schools
- Refugee Empowerment Network
- Region 6
- RISE
- Sarpy & Cass County Health Department
- Springfield Platteview Community Schools
- Stephen Center
- The Collective for Hope
- The Wellbeing Partners
- ThriveVentures
- UNITE Nebraska
- United Way of the Midlands
- University of Nebraska Medical Center
- UNMC College of Public Health
- Visiting Nurse Association (VNA)
- VNA Project WIN–Welcoming Infants into Neighborhoods
- Weitz Family Foundation
- WIC
- Women's Fund of Omaha
- YouTurn Omaha

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

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

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.



Public Health, Vital Statistics & Other Data

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

- [Center for Applied Research and Engagement Systems \(CARES\), University of Missouri Extension, SparkMap \(sparkmap.org\)](#)
- [Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division for Adolescent and School Health](#)
- [Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance \(DHIS\)](#)
- [Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics](#)
- [Douglas County Health Department](#)
- [ESRI ArcGIS Map Gallery](#)
- [Geolytics Demographic Estimates & Projections](#)
- [OpenStreetMap \(OSM\)](#)
- [US Census Bureau, Decennial Census](#)
- [US Department of Health & Human Services](#)

Note that secondary data reflect county-level data.

Benchmark Data

Trending

Similar surveys were administered in the Metro Area in 2012, 2015, and 2018 by PRC on behalf of the sponsors. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Nationwide Risk Factor Data

National survey data, which are provided in comparison charts, are taken from the *2020 PRC National Child & Adolescent Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the population of American children and youth with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.



Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% 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 children, or children of parents who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, undocumented residents, and children of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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



Public Comment

Participating hospitals made the prior Child & Adolescent Health Needs Assessment (CHNA) report publicly available through their websites; through that mechanism, the hospitals requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Children's Hospital & Medical Center and Boys Town National Research Hospital had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Children's Hospital & Medical Center and Boys Town National Research Hospital will continue to use their websites to solicit public comments and ensure that these comments are considered in the development of future CHNAs.



IRS FORM 990, SCHEDULE H COMPLIANCE

For non-profit hospitals, a Child & Adolescent Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H		See Report Page
Part V Section B Line 3a	A definition of the community served by the hospital facility	6
Part V Section B Line 3b	Demographics of the community	9
Part V Section B Line 3c	Existing health care facilities and resources within the community that are available to respond to the health needs of the community	195
Part V Section B Line 3d	How data was obtained	6
Part V Section B Line 3e	The significant health needs of the community	16
Part V Section B Line 3f	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g	The process for identifying and prioritizing community health needs and services to meet the community health needs	18
Part V Section B Line 3h	The process for consulting with persons representing the community's interests	10
Part V Section B Line 3i	The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	198



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 Child & Adolescent Health Needs Assessment. From these data, opportunities for children’s health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data; identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of children affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	<ul style="list-style-type: none"> ▪ Difficulty Accessing Children’s Healthcare <ul style="list-style-type: none"> – Appointment Availability – Lack of Transportation ▪ Reliance on the Internet for Health Care Information
INJURY & SAFETY	<ul style="list-style-type: none"> ▪ Mortality <ul style="list-style-type: none"> – Age 5-9 – Age 10-14 ▪ Bicycle Helmet Usage ▪ Child Has Had a Brain Injury/Concussion ▪ Children Feeling Unsafe at School or Going To/From School ▪ Child Has Been Exposed to Neighborhood Violence
MENTAL & BEHAVIORAL HEALTH	<ul style="list-style-type: none"> ▪ Depression & Anxiety <ul style="list-style-type: none"> – Diagnosed Depression – Symptoms of Depression – Suicide Attempts [High Schoolers] – Diagnosed Anxiety – Chronic Worrying – Child Has Difficulty Sleeping ▪ Child Lived with Someone Who Had Mental Health Issues ▪ Children Needing Mental Health Services ▪ Children Receiving Treatment/Counseling ▪ Key Informants: Mental and behavioral health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	<ul style="list-style-type: none"> ▪ Frequency of Eating Fast Food ▪ Eating Meals as a Family ▪ Screen Time ▪ Overweight & Obesity ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
ORAL HEALTH	<ul style="list-style-type: none"> ▪ Regular Dental Care ▪ Difficulty Accessing Dental Care

—continued on the following page—



AREAS OF OPPORTUNITY (continued)

<p>PARENTING EDUCATION & FAMILY SUPPORT</p>	<ul style="list-style-type: none"> ▪ Family Strength ▪ Family Teamwork ▪ Family Resilience ▪ Child Has an Adult for Guidance Outside the Household [Age 5-17] ▪ Key Informants: Lack of Family Support/Services ranked as a top concern. ▪ Key Informants: Lack of Parenting Education/Readiness ranked as a top concern.
<p>PEDIATRIC CHRONIC CONDITIONS</p>	<ul style="list-style-type: none"> ▪ Prevalence of Diabetes/High Blood Sugar ▪ Condition Requiring Therapy
<p>PHYSICAL ENVIRONMENT</p>	<ul style="list-style-type: none"> ▪ Neighborhood Has Rundown Housing ▪ Neighborhood Has Signs of Vandalism ▪ Exposure to Environmental Tobacco Smoke ▪ Children's Use of Neighborhood Parks
<p>PRENATAL & INFANT HEALTH</p>	<ul style="list-style-type: none"> ▪ Infant Mortality ▪ Acceptance of Recommended Childhood Vaccines
<p>SEXUAL HEALTH</p>	<ul style="list-style-type: none"> ▪ Gonorrhea Incidence [Children/Adults] ▪ Chlamydia Incidence [Children/Adults] ▪ Key Informants: Sexual health ranked as a top concern.
<p>TOBACCO, ALCOHOL & OTHER DRUGS</p>	<ul style="list-style-type: none"> ▪ Household Member Smokes ▪ Drinking & Driving [High Schoolers] ▪ Lifetime Illicit Drug Use [High Schoolers] <ul style="list-style-type: none"> – Prescription Drugs (not Rx) – Inhalants – Methamphetamines – Heroin – Injection Drugs ▪ Key Informants: Tobacco, alcohol, and other drugs ranked as a top concern.
<p>VISION, HEARING & SPEECH CONDITIONS</p>	<ul style="list-style-type: none"> ▪ Hearing Problems ▪ Recent Eye Exams



Community & Stakeholder Feedback on Prioritization of Health Needs

Children’s Hospital & Medical Center began a five-year strategic planning effort in 2019. Feedback from key internal and external stakeholders was gathered from over 1500 participants through surveys and stakeholder sessions. Individuals that provided input included board representatives, physician and nursing leaders, medical staff, management, employees, community leaders, partners and patients and families. Children’s mission was affirmed: To improve the life of every child through exceptional Care, Advocacy, Research and Education (CARE) with a continued vision to be a global leader for children’s health. The values of Innovation, Collaboration, Accountability, Respect and Excellence were also updated to reflect the values needed to fulfill the mission and vision.

Children’s 2021 – 2025 Strategic Plan was released in 2020 and detailed five goals and 17 key strategies. One of the goals focused on the work to be done in the community to “Champion the needs and welfare of children.” This goal has three strategies: 1) promote child and youth advocacy; 2) impact each stage of the child’s life in collaboration with families, child serving agencies and other external partners; 3) ensure health equity for under-represented population.

While the Pediatric Community Health Needs Assessment Data was being gathered in the community, Children’s Center for the Child & Community began an internal strategic alignment process. A programmatic inventory and SWOT analysis were conducted, primary and secondary populations were established, and department roles were defined. Along with cross-department input, a community health landscape analysis revealed seven potential impact areas to focus on based on Children’s Strategic Plan and current programming capacity. Each area was ranked based on criteria and the priority list was approved by leadership.

New Impact Areas were identified as: 1) Pediatric Mental Health; 2) Food Insecurity; 3) Financial Stability; and 4) Healthy Housing. Additionally, Legacy Programs or programs currently in place were identified as: 1) Healthy Schools Programs and 2) Early Childhood Programs. Crosscutting themes will be applied to the organization’s new Impact Areas (priorities) and Legacy Programs:

- Focus on underrepresented populations as defined by National Institutes of Health (NIH)
- Using early childhood settings and schools as access points for intervention and service delivery
- Utilize Children’s Access to Care framework¹, adopted during the 2019-2021 ISP

Data and Community Input from the 2021 P-CHNA confirmed these new Impact Areas and continued work for the Legacy Programs as follows:

	DATA NOTES	STAKEHOLDER INPUT
PEDIATRIC MENTAL HEALTH	<ul style="list-style-type: none"> ▪ Parents of adolescents perceive mental health as a top health issue ▪ Significant disparities and increasing rates of diagnosed depression, anxiety, suicide attempts and chronic worrying exist and trended up since 2018 ▪ Children living with someone who has a mental health issue increased ▪ 1 in 5 Children needed mental health services in the past year 	<ul style="list-style-type: none"> ▪ Stakeholders ranked the following as top problems for Children and Adolescents in our community: <ul style="list-style-type: none"> – Mental and behavioral health (#1) – Lack of Family Support/Services (#2) – Lack of parenting education/readiness – Tobacco, alcohol and other drugs ▪ Exposure to Crime, Violence and Social Disorder ranked as the #3 “Most Important Contributors to Health Problems Among Local Children and Youth”

¹ An adaptation of Jean-Frederic Levesque, Mark F. Harris and Grant Russell (2013). Patient-Centered Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations. *International Journal for Equity in Health* 12(18).



		<ul style="list-style-type: none"> ▪ <i>“Access to services for mental and behavioral health is limited for many our families. Some families don’t quite understand exactly what mental health issues are or are reluctant to accept the notion that there could be some mental health issues or behavioral issues for fear of labeling. – Community Leader”</i> ▪ <i>“Utter lack of sufficient mental health services for the need. – Physician”</i> ▪ <i>“Not enough dollars available to be spent in more flexible ways to meet the needs, especially for people of color. – Other Health Provider”</i>
FOOD INSECURITY	<ul style="list-style-type: none"> ▪ Worried about food in the past year ▪ Population with low food access ▪ Difficulty accessing fresh produce ▪ Frequency of eating Fast Food ▪ Eating Meals as a Family ▪ Significant increase in children who are overweight and obese ▪ Parents perceive nutrition, physical activity and obesity as a top health issue for children under 12-years-old 	<ul style="list-style-type: none"> ▪ Nutrition, physical activity and obesity ranked as a top concern among stakeholders ▪ <i>“Food insecurity is an ever-increasing need in our community because of economic insecurity. Related: cheap food leads to poor nutrition and the resulting weight and health issues that follow. – Community Leader”</i> ▪ <i>“Access to nutritious food is limited outside of school. Even with access to local grocery stores, the cost to purchase nutritional foods are too expensive for many of our families. Due to this and having greater access to fast foods and the affordability of non-nutritious food, results in weight issues for our families. Also, physical activity is impacted tremendously by the use of devices for fun versus playing outside, limiting physical activity. – Community Leader”</i>
FINANCIAL STABILITY	<ul style="list-style-type: none"> ▪ Unable to pay for an emergency expense of \$400 ▪ Children in poverty* ▪ Worry/Stress over rent/mortgage in past year* ▪ Went without electricity, water, or heat in the past year* ▪ Worried about food in the past year* ▪ Disparities for most health issues are significantly higher for low-income and very low-income families 	<ul style="list-style-type: none"> ▪ Poverty and Economic Status ranked as the #1 “Most Important Contributors to Health Problems Among Local Children and Youth” ▪ <i>“Caregivers/parents need support from the community to raise healthy children. When we don’t pay people a living wage, offer quality housing, and make nourishing foods accessible, we cannot expect parents/families to be able to be their best role model/coach to kids. – Public Health Representative”</i> ▪ <i>“We have seen an increasing need for emergency economic assistance related to housing, utilities, transportation and mental health supports during the pandemic. – Community Leader”</i>



<p>HEALTHY HOUSING</p>	<ul style="list-style-type: none"> ▪ Worry/Stress over rent/mortgage in past year* ▪ Went without electricity, water or heat in the past year* ▪ Unhealthy or unsafe housing conditions in the past year ▪ Neighborhood has rundown housing ▪ Neighborhood has signs of vandalism ▪ Exposure to environmental tobacco smoke ▪ Household member smokes 	<ul style="list-style-type: none"> ▪ Availability of Safe Housing ranked as the #2 “Most Important Contributors to Health Problems Among Local Children and Youth” ▪ Tobacco, alcohol and other drugs ranked as a top concern ▪ <i>“Parents and families report the presence of unhealthy living spaces, such as a leaking roof, rodents, cockroaches, dysfunctional heating and cooling in their homes. – Other Health Provider”</i> ▪ <i>“Unaffordable housing and evictions are creating unstable environments for children and families, essentially deteriorating the strong foundations and security we know children and adolescents need to thrive. We know housing is a basic need and when it is not met, or when families are faced with losing their housing, stress increases, and attention is diverted to survival and immediate needs rather than prevention and engaging with community resources and supports. – Community Leader”</i>
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*Indicators from the 2021 Community Health Needs Assessment (adult) for Douglas, Sarpy & Cass Counties, Nebraska and Pottawattamie County, Iowa

On October 6, 2021, findings from the 2021 Pediatric Community Health Needs Assessment were presented in partnership with The Wellbeing Partners XChange Summit to over 90 community stakeholders. The XChange Summit is the region’s largest multi-sector health conference which gathers leaders from across Douglas, Sarpy, Cass and Pottawattamie counties to celebrate the milestones of our collective work and advance future work while learning from local, regional and national experts. At this event, Professional Research Consultants (PRC) highlighted data reflecting significant health issues identified from the research (see Areas of Opportunity above).

To gain deeper understanding of the data, five small group discussions were formed and facilitated. Population-specific data presentations were crafted and shared, followed by group discussion across the following five themes: Mental Health Disparity Data for Black Children; Mental Health Disparity Data for Latino Children; Geographic Mental Health Disparities in Pottawattamie County; Gaps in the Community’s Child and Youth Mental Health Continuum; and the Role of Health Systems in Mental Health. Questions addressed during the breakout sessions included messaging & awareness, access to care, intervention approaches and focus, contributing factors, and integration opportunities. Feedback gathered will inform Implementation Strategy Plans submitted in 2022.

Hospital Implementation Strategy

Children’s Hospital & Medical Center will use the information from this Child & Adolescent Health Needs Assessment to develop an Implementation Strategy to address the significant children’s health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital’s action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of Children’s Hospital & Medical Center’s past activities to address the needs identified in the prior CHNA can be found as an appendix to this report.



Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, Metro Area results are shown in the larger, gray column.
- The columns to the left of the Metro Area column provide comparisons among the three counties and among the five subareas of Douglas County, identifying differences for each as “better than” (☀), “worse than” (☹), or “similar to” (☺) the combined opposing areas.
- The columns to the right of the Metro Area column provide trending, as well as comparisons between local data and any available national findings and Healthy People 2030 objectives. 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.

Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY

(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2012 (or earliest available data).

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).



HEALTH STATUS	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child's Activities/Abilities Limited Due to Health Condition	7.9	2.8	4.5	5.9	1.3	4.9	5.6	5.8	5.2			7.9		8.2
% [Age 5-17] Missed 10+ School Days Last Yr Due to Illness/Injury	6.1	6.2	6.9	4.7	2.1	5.7	9.0	11.1	6.8			6.6		7.3
% [Age 0-17] Condition Requiring Therapy	14.7	10.0	12.7	15.2	12.9	13.2	12.6	10.2	12.7			12.5		9.4
% [Age 5-17] Child's Mental Health Is "Fair/Poor"	21.5	6.9	10.2	5.2	1.7	9.9	8.8	9.2	9.6			9.7		7.9
% [Age 5-17] Child Has Depression	11.3	10.6	9.4	7.5	11.8	9.7	7.2	15.0	9.7			9.1		6.1
% [Age 5-17] Child Had Symptoms of Depression in Past Year	11.5	8.2	3.9	4.9	8.3	6.8	4.8	9.3	6.6			5.1		2.0
[High Schoolers] Attempted Suicide in Past Year (Percent)									13.1			8.9	2.4	12.4
% [Age 5-17] Child Has Anxiety	17.2	16.9	19.7	12.4	16.5	16.6	10.8	21.1	15.7			13.4		10.1
% [Age 5-17] Child Worries A Lot	34.9	30.4	43.8	27.9	24.3	33.8	29.4	45.2	34.0			29.6		21.9
% [Age 0-17] Child Has Respiratory Allergies	17.1	7.3	11.5	9.5	28.4	12.5	9.0	12.3	11.7			16.8		18.3
% [Age 0-17] Child Has Food/Digestive Allergies	7.7	4.6	7.5	6.0	21.7	7.6	5.1	11.3	7.4			9.8		7.5
% [Age 0-17] Child Currently Has Asthma	14.3	7.8	3.9	5.6	7.0	7.5	3.0	2.9	7.0	7.2	6.4	9.4		8.7

HEALTH STATUS (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child Has ADD/ADHD	 18.3	 12.3	 12.2	 10.0	 7.1	 12.6	 8.7	 13.0	11.7			 13.5		 9.4
% [Age 0-17] Child Has Learning Disability	 15.0	 6.5	 6.9	 7.8	 3.8	 8.5	 9.6	 6.3	8.5			 11.1		 8.2
% [Age 0-17] Child Has Developmental Delays	 11.6	 6.6	 6.3	 8.2	 4.4	 7.7	 6.3	 9.5	7.6			 9.8		 6.5
% [Age 0-17] Child Is Developmentally On Track	 86.5	 88.8	 95.7	 93.3	 94.3	 91.7	 87.1	 95.2	91.0					 91.9
% [Age 5-17] Child Has Behavioral/Conduct Problems	 5.4	 5.2	 3.1	 4.3	 8.3	 4.7	 5.8	 3.9	4.9			 4.4		 5.1
% [Age 5-17] Child Has Autism/Spectrum Disorder	 4.8	 3.8	 4.2	 7.8	 1.9	 5.0	 4.8	 8.5	5.4			 3.9		 4.1
% [Age 0-17] Child Has Diabetes/High Blood Sugar	 3.1	 2.7	 0.7	 0.0	 4.7	 1.7	 1.4	 3.4	1.8			 1.8		 0.4
% [Age 0-17] Child Has Epilepsy/Seizure Disorder	 2.7	 0.0	 1.4	 2.2	 0.0	 1.4	 1.8	 3.7	1.8			 1.3		 1.5
% [Age 1-17] Child Had Frequent Issues w/Cavities or Tooth Decay/Past Year	 10.7	 13.3	 6.0	 7.4	 13.0	 9.3	 8.5	 8.9	9.1	 11.8	 11.6	 14.0		
% [Age 0-17] Child Has Speech/Language Problems	 17.3	 8.4	 9.2	 17.4	 18.1	 13.3	 14.9	 10.8	13.4			 13.0		 10.8
% [Age 0-17] Child Has Hearing Problems	 10.0	 3.2	 7.6	 4.5	 9.2	 6.5	 3.5	 8.9	6.1			 7.0		 3.5
% [Age 0-17] Child Has Vision Problems	 34.5	 33.9	 21.5	 22.3	 30.8	 27.6	 23.9	 21.3	26.0					 26.2

HEALTH STATUS (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% [Age 5-17] Child Is Overweight or Obese	 51.0	 52.7	 41.7	 29.7	 27.5	 41.1	 39.4	 31.7	39.6			 36.9		 30.2
% [Age 5-17] Child Is Obese	 33.7	 29.9	 19.0	 18.7	 17.9	 23.7	 20.9	 18.1	22.4			 17.8	 15.5	 17.1
% [Age 0-17] Child Has Sustained Injury Requiring Treatment in Past Year	 12.0	 5.7	 9.7	 11.2	 16.8	 10.2	 8.7	 11.5	10.0			 8.8		 15.1
% [Age 0-17] Child Has Brain Injury/Concussion	 5.1	 1.3	 3.1	 4.8	 4.2	 3.6	 7.2	 7.0	4.8			 4.6		 2.5
Infant Death Rate						 6.1	 3.6	 7.9	5.8	 5.4	 5.1	 5.6	 5.0	 4.9
[Age 1-4] Mortality Rate per 100,000									20.2	 21.9	 20.1	 23.8	 18.4	
[Age 5-9] Mortality Rate per 100,000									14.2	 12.8	 12.1	 11.6	 18.4	
[Age 10-14] Mortality Rate per 100,000									21.1	 18.0	 18.1	 15.2	 18.4	
[Age 15-19] Mortality Rate per 100,000									49.1	 50.2	 48.7	 49.8	 18.4	
[All Ages 1-19] Mortality Rate per 100,000									26.0	 25.9	 25.3	 25.4	 18.4	
No Prenatal Care in First Trimester (Percent, Douglas County)									24.9					 29.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

 better  similar  worse

BIOLOGICAL INFLUENCES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Low Birthweight Births (Percent)						7.9	6.5	7.6	7.7	7.0	6.8	8.2		
% [Age 0-17] Child Was Ever Breastfed	70.9	76.6	79.4	78.0	76.4	76.6	80.9	79.1	77.8			70.5		74.8
% Exclusively Breastfed Until 6 Months	28.1	39.5	34.0	41.0	29.4	35.3	36.2	30.4	35.0			27.7	42.4	30.6

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SOCIAL ENVIRONMENT INFLUENCES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% 2+ Household Adults Involved in Child's Care	67.8	78.5	89.0	92.7	88.2	83.4	88.1	88.8	85.1					86.0
% [Age 0-17] Child Lived With Someone Who Had Mental Health Issues	23.1	9.3	15.6	12.0	8.6	14.4	12.7	18.4	14.4	8.0	11.3	8.1		13.4
% [Age 0-17] Child Has Been Exposed to Neighborhood Violence	17.5	6.5	5.0	3.4	2.9	7.2	2.8	13.4	6.9	3.7	4.2	4.1		8.5
% [Age 6-17] Child "Always/Usually" Stays Calm When Challenged	68.3	72.3	80.0	82.8	82.0	76.8	73.6	81.8	76.6					77.3
% [Age 5-17] Child Has an Adult for Guidance Outside Household	91.2	86.9	96.5	96.2	100.0	93.7	93.6	96.6	94.0					96.2
% [Parents] Extremely Confident in Meeting Child's Physical Needs	81.9	81.9	95.1	93.4	94.7	89.3	82.7	84.7	87.2					84.4

SOCIAL ENVIRONMENT INFLUENCES (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Parents] Extremely Confident in Meeting Child's Emotional Needs	 60.2	 66.7	 78.1	 74.4	 78.0	 71.2	 68.4	 72.6	70.7					 74.6
% [Parents] Extremely Confident in Meeting Child's Social Needs	 67.2	 65.6	 78.1	 69.7	 78.6	 71.3	 71.5	 62.9	70.4					 72.1
% [Parents] Extremely Confident in Accessing Info to Keep Child Healthy	 79.2	 71.3	 91.6	 83.3	 93.9	 83.0	 88.4	 86.8	84.7					 81.2
% [Parents] Family Always Talks Together About What to Do	 45.1	 52.6	 53.8	 56.8	 47.8	 52.1	 55.3	 48.4	52.4	 50.2	 48.8	 52.3		 54.2
% [Parents] Family Always Works Together to Solve Problems	 30.5	 53.9	 45.8	 50.3	 49.4	 45.8	 50.8	 42.0	46.5	 50.2	 48.2	 52.3		 50.5
% [Parents] Family Always Knows They Have Strength to Draw On	 47.8	 55.7	 55.5	 49.6	 70.1	 53.6	 54.5	 50.9	53.5	 53.4	 50.8	 56.1		 58.4
% [Parents] Family Always Stays Hopeful Even In Difficult Times	 35.4	 53.1	 47.2	 47.5	 54.6	 46.7	 45.2	 29.2	44.5	 54.1	 49.6	 57.8		 50.0
Linguistically Isolated Population (Percent)						 4.3	 0.8	 1.8	3.2	 2.8	 2.1	 4.3		
Children Below 200% FPL (Percent)						 37.4	 23.6	 36.2	34.1	 36.0	 34.7	 40.1		
% Unable to Pay Cash for a \$400 Emergency Expense	 34.4	 26.4	 9.4	 6.4	 10.5	 17.3	 10.4	 14.2	15.4			 24.6		 20.6

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SOCIAL DETERMINANTS OF HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	 34.3	 23.0	 13.3	 7.1	 17.0	 18.3	 13.1	 21.0	17.4			 22.7		 28.2
% Unhealthy/Unsafe Housing Conditions	 24.0	 11.8	 3.3	 2.8	 9.0	 9.5	 2.4	 11.7	8.1			 12.2		 9.7
% Neighborhood Has Poorly Kept or Rundown Housing	 49.0	 27.0	 9.2	 4.2	 7.4	 19.6	 5.9	 25.9	17.1	 13.3	 14.0	 13.3		 19.4
% Neighborhood Has Signs of Vandalism	 28.5	 25.6	 6.1	 1.1	 7.6	 13.6	 2.0	 11.8	10.7	 4.4	 3.3	 7.7		 10.8
% [Age 0-17] Household Member Smokes	 34.1	 24.9	 16.2	 15.8	 4.4	 20.7	 16.8	 40.0	21.9	 14.4	 15.0	 14.4		 19.4
% [Age 0-17] Child "Never" Uses Neighborhood Playgrounds/Parks	 19.9	 9.9	 9.9	 3.4	 12.4	 10.4	 3.8	 14.7	9.4					 5.5
% [Age 0-17] Neighborhood Is "Slightly" or "Not At All" Safe	 49.0	 21.5	 5.1	 4.4	 0.0	 16.7	 3.3	 9.1	12.7			 15.8		 10.2
% [Age 5-17] Child Was Bullied in the Past Year	 27.2	 16.1	 17.0	 11.6	 16.4	 17.4	 11.3	 31.4	17.6					 21.2
% [Age 5-17] Child Missed School in Past Year Because Felt Unsafe	 15.1	 11.9	 3.7	 3.8	 8.2	 8.0	 3.9	 9.8	7.3			 8.4		 1.8
% [Age 0-17] Child Uses a Safety Restraint When Riding in a Vehicle						 96.4	 98.1	 97.4	96.9					 96.6
% [Age 5-17] Child "Always" Wear a Bike Helmet	 40.0	 39.2	 47.5	 47.7	 56.7	 45.3	 50.7	 22.9	44.3			 50.1		 40.3

SOCIAL DETERMINANTS OF HEALTH (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Have Discussed Water Safety With a Health Professional	52.3	47.1	48.7	48.7	40.5	48.5	42.3	48.3	47.1					45.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better
 similar
 worse

BEHAVIORAL INFLUENCES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 2-17] Child Has 5+ Servings of Fruits/Vegetables per Day	32.2	33.0	33.4	34.0	17.3	32.0	35.5	30.5	32.7			36.9		34.9
% [Age 2-17] Child Ate 3+ Fast Food Meals in Past Week	29.7	29.6	24.6	25.5	10.5	25.7	21.6	33.0	25.3			19.1		19.9
% [Age 2-17] 7+ Servings of Sugar-Sweetened Drinks per Week	24.9	25.3	17.4	22.3	29.4	22.8	18.2	33.3	22.6					21.2
% [Age 2-17] Ate 7+ Meals Together as a Family in Past Week	47.3	53.6	52.4	51.3	54.2	51.5	47.2	59.6	51.3	42.7	39.8	64.6		49.8
% [Age 2-17] Child Was Physically Active One Hour/Day in Past Week	40.6	49.4	56.0	56.6	48.6	51.2	49.4	60.2	51.8			44.9	30.4	52.7
% [Age 5-17] Child Spends 2+ Hours per Day on Screen Time	51.7	52.2	53.4	65.2	47.8	55.4	46.8	52.0	53.1					44.5
% [Age 5-17] Child Has Difficulty Sleeping	23.5	18.9	27.5	20.8	30.2	23.5	20.3	27.0	23.1			20.4		10.2
[High Schoolers] Smoked Cigarettes in Past Month (Percent)									4.9			6.0	3.4	11.0

BEHAVIORAL INFLUENCES (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
[High Schoolers] Drank Alcohol in Past Month (Percent)									21.4			29.2	6.3	24.0
[High Schoolers] Drove When Drinking in Past Month (Percent)									6.1			5.4		9.1
[High Schoolers] Ever Used Marijuana (Percent)									28.7			36.8		30.4
[High Schoolers] Ever Used Prescription Drugs (Not Rx) (Percent)									16.3			14.3		15.5
[High Schoolers] Ever Used Inhalants (Percent)									10.4			6.4		8.1
[High Schoolers] Ever Used Ecstasy (Percent)									3.5			3.6		4.5
[High Schoolers] Ever Used Cocaine (Any Form) (Percent)									3.5			3.9		4.2
[High Schoolers] Ever Used Methamphetamines (Percent)									2.3			2.1		4.3
[High Schoolers] Ever Used Heroin (Percent)									3.1			1.8		1.7
[High Schoolers] Ever Used Injection Drugs (Percent)									2.9			1.6		3.3
[High Schoolers] Used Marijuana in Past Month (Percent)									16.0			21.7	5.8	16.2

BEHAVIORAL INFLUENCES (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
[All Ages] Gonorrhea Incidence per 100,000						291.3	86.0	336.2	251.8	140.4	153.8	179.1		115.4
[All Ages] Chlamydia Incidence per 100,000						666.6	308.1	545.0	575.3	418.0	466.7	539.9		468.6
Births to Adolescents Age 15 to 19 (Rate per 1,000)						22.3	12.6	25.4	20.6	19.8	17.6	20.9		
[High Schoolers] Currently Sexually Active (Percent)									21.3			27.4		20.8
[Sexually Active High Schoolers] Did Not Use Condom (Percent)									38.5			45.7		38.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO CARE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child Has Had Routine Checkup in Past Year	84.3	86.1	84.9	83.0	88.2	84.8	84.7	85.7	84.8			87.3		84.2
% Would Not Want New Baby to Have All Recommended Vaccines	9.5	6.9	8.7	6.0	6.4	7.7	7.3	8.4	7.6			15.5		5.3
% [Age 1-17] Child Has Dental Insurance	89.2	86.4	90.2	94.5	88.3	90.1	89.1	96.4	90.6					89.3
% [Age 1-17] Child Visited a Dentist/Oral Health Provider in Past Year	66.4	70.6	83.7	79.5	78.9	76.1	79.9	78.2	77.2	82.6	88.4	85.0		83.0
% [Age 1-17] Difficulty Accessing Child's Dental Care in the Past Year	17.4	12.3	5.9	11.5	18.8	11.9	10.8	20.6	12.5					6.2

ACCESS TO CARE (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child Has Had an Eye Exam in the Past 3 Years	80.9	78.0	72.9	78.6	80.0	77.5	82.6	78.4	78.7			83.4		84.0
% [Age 0-17] Difficulties Accessing Vision Care in the Past Year	11.1	5.0	3.6	1.6	0.0	4.7	2.6	4.0	4.1					4.0
% [Age 0-17] Child Has Had Hearing Tested in the Past 5 Years	80.3	82.3	85.6	86.9	95.0	84.7	88.8	87.2	85.9			86.7		72.1
% [Age 0-17] Child Has Had 2+ ER Visits in Past Year	12.5	10.0	4.3	2.6	10.8	7.2	2.9	6.8	6.2			8.2		10.0
% [Age 0-17] Child Used Some Type of Urgent Care Center in the Past Year	27.6	31.1	27.2	27.3	34.3	28.6	31.0	48.2	31.3			35.7		32.4
% [Age 0-17] Child Is Uninsured	3.2	7.7	2.9	1.3	1.3	3.4	5.0	1.0	3.5	6.2	3.5	4.8		4.4
% [Age 0-17] Child Has Been Without Insurance At Some Point	14.0	16.1	6.1	4.8	6.7	9.5	6.6	6.3	8.5			10.5		7.4
% [Age 0-17] Difficulty Finding Physician for Child in Past Year	8.9	5.0	6.2	5.0	0.0	5.7	4.8	4.0	5.3			10.7		3.5
% [Age 0-17] Difficulty Getting Appointment for Child in Past Year	15.0	11.2	7.5	9.1	11.5	10.4	8.2	14.3	10.4			13.9		5.8
% [Age 0-17] Cost Prevented Child's Dr Visit in Past Year	9.8	7.4	4.3	0.5	13.7	5.8	2.6	3.1	4.8			6.0		4.8
% [Age 0-17] Transportation Hindered Child's Dr Visit in Past Year	13.9	6.3	4.8	2.2	13.7	7.0	3.1	6.8	6.0			6.1		2.6

ACCESS TO CARE (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES			Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Cost Prevented Getting Child's Prescription in Past Year	7.4	5.0	0.6	3.2	7.8	4.0	2.4	3.7	3.6			6.2		3.6
% [Age 0-17] Culture Difference Prevented Child's Dr Visit in Past Year	2.8	1.5	1.6	1.2	2.9	1.8	0.5	4.6	1.8			3.9		1.5
% [Parents] Could Use Help With Healthcare Service Coordination	26.9	17.7	12.5	12.0	4.1	15.7	7.1	15.3	13.7					14.5
% Child Needed to See a Specialist in the Past Year	31.8	33.7	35.2	31.0	35.7	33.2	25.7	31.5	31.3			33.1		29.5
% [Child Needing Care] "Major/Moderate" Problem Getting Specialty Care									20.2			33.2		19.9
% [Age 5-17] Parent Aware of Community Mental Health Resources	70.3	62.0	87.9	82.6	70.8	76.6	73.9	82.4	76.6			70.2		67.2
% [Age 5-17] Needed Mental Health Svcs in the Past Yr	25.6	14.7	18.8	17.8	9.4	18.4	15.2	27.5	18.7			17.1		13.6
% [Age 5-17] Child Has Ever Taken Rx for Mental Health	9.9	15.8	16.4	6.3	7.6	11.8	10.4	16.0	11.9			12.5		13.7
% [Age 5-17] Child Rec'd Professional Treatment/Counseling in Past Yr	18.5	13.2	16.7	15.3	9.4	15.5	14.7	23.4	16.2					12.7
% Rely on the Internet for Healthcare Information	10.1	9.4	13.3	10.6	8.6	10.8	13.1	12.2	11.5			13.7		7.5

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

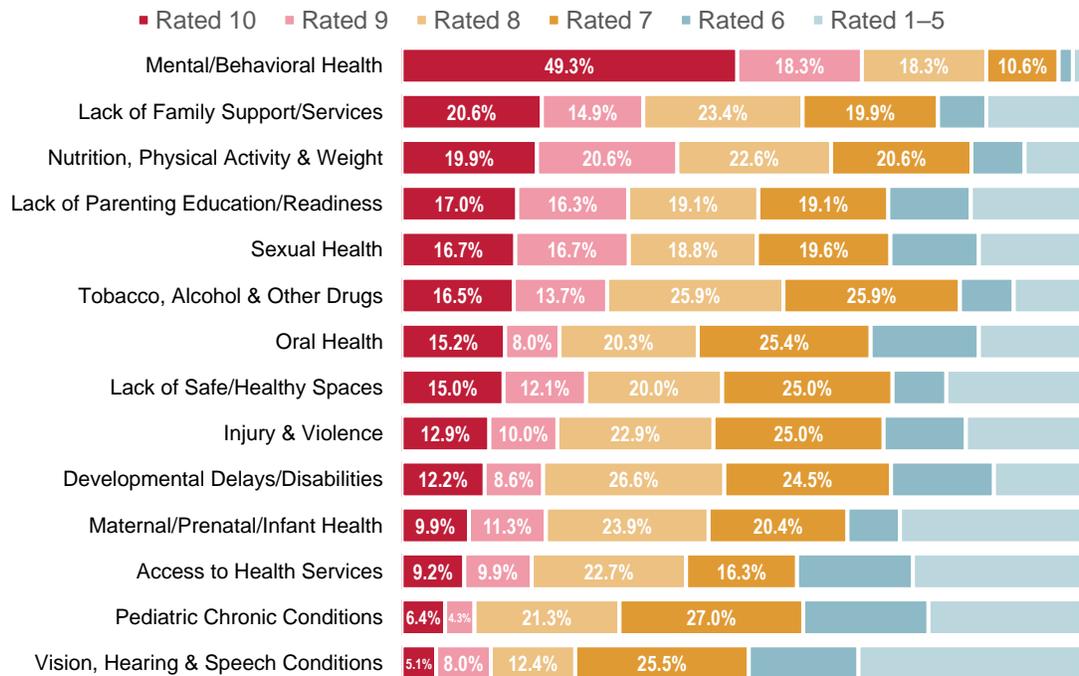
better similar worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 14 health issues is a problem for children and/or adolescents in their own community, using a 10-point scale where a rating of “1” is not an issue and “10” is a major issue.

The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process.)

Key Informants: Relative Position of Health Topics as Problems in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue)





PERCEPTIONS OF TOP HEALTH ISSUES

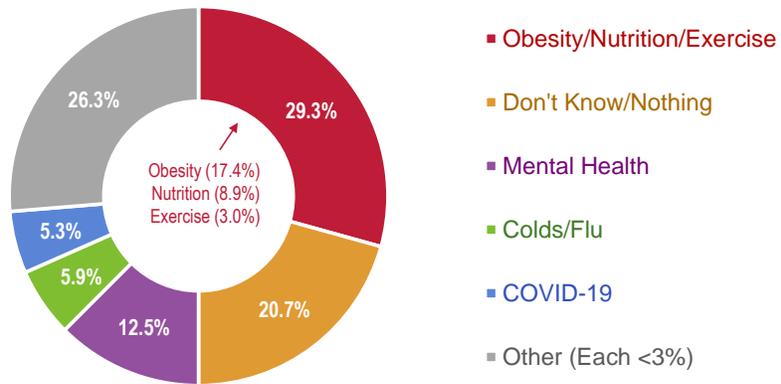
CHILD HEALTH

Perceived Top Health Issues

Among surveyed families, the interrelated issues of obesity, nutrition, and exercise received the largest share of responses (29.3%) as the perceived number-one health issue for children under the age of 12.

Mental health was mentioned by 12.5% of responses.

Perceived Number-One Health Issue Affecting Children Under 12 in the Community (Among Metro Area Parents With a Child Age 0-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Reflects total sample of respondents.



ADOLESCENT HEALTH

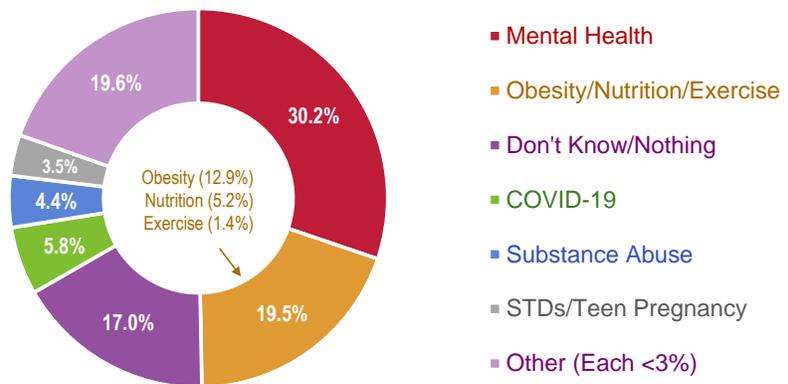
Perceived Top Health Issues

Mental health issues received the largest share of responses (30.2%) when parents were asked to name the number-one health issue for adolescents (age 12-17).

Other frequent responses included combined obesity/nutrition/exercise (mentioned by 19.5%), COVID-19 (5.8%), substance abuse (4.4%), and STDs/teen pregnancy (3.5%).

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

Perceived Number-One Health Issue Affecting Adolescents (12-17) in the Community (Among Metro Area Parents With a Child Age 0-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 7]
Notes: • Reflects the total sample of respondents.





HEALTH STATUS

OVERALL HEALTH STATUS

Activity Limitations

A total of 5.2% of Metro Area children are limited or prevented in some way in their ability to do things most children of the same age can do because of a medical, behavioral, or other health condition.

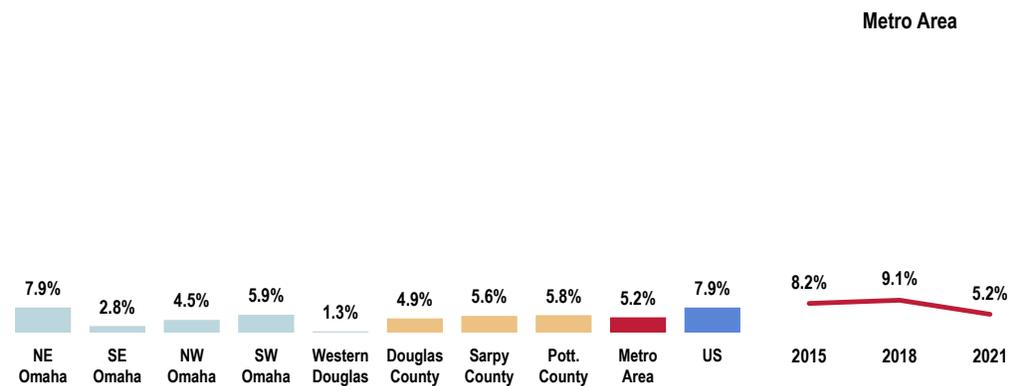
BENCHMARK ▶ Lower than the national prevalence.

TREND ▶ Decreasing significantly from 2015 and 2018 survey results.

DISPARITY ▶ Lowest among children in Western Douglas County. The prevalence of activity limitations correlates with age among Metro Area children.

NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

Prevalence of Activity Limitations



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 66]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

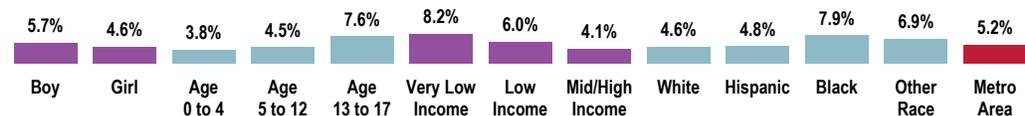
Notes: • Asked of all respondents about a randomly selected child in the household.

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

Here: “very low income” refers to children living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

In addition, all Hispanic children are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White children).

Prevalence of Activity Limitations (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 66]

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

Activity limitations among Metro Area children are most often attributed to **autism**, followed distantly by conditions such as **Down's syndrome, anxiety/depression, ADD/ADHD, cerebral palsy, and tuberous sclerosis**.

Description of Activity Limitations (Among Children With Activity Limitations; Metro Area, 2021)



Activity Limitation Is the Result of a Long-Term Condition

Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 67-68]
 Notes: • Asked of respondents for whom the randomly selected child in the household has some type of activity limitation (n=52).
 • Conditions noted reflect only those respondents who could name the problem.

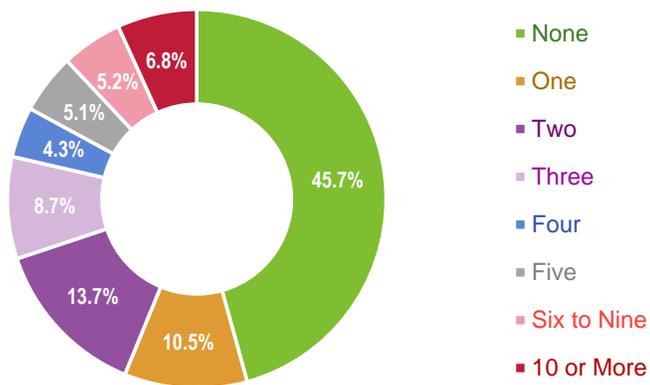
School Days Missed Due to Illness or Injury

While most Metro Area school-age children (age 5-17) missed two or fewer school days in the past year due to illness or injury, 6.8% are reported to have missed 10 or more.

DISPARITY ► 10+ missed school days are reported more often among parents of teens and those living in households with very low incomes.

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

Number of School Days Missed in the Past Year Due to Illness or Injury (Metro Area Children Age 5-17, 2021)

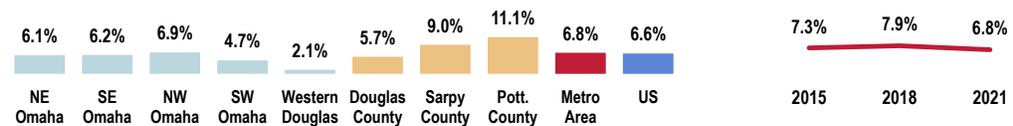


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.



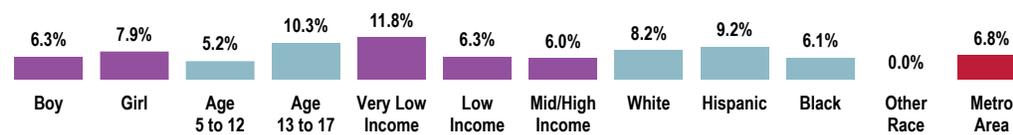
Child Missed 10 or More School Days in the Past Year Due to Illness or Injury (Metro Area Children Age 5-17, 2021)

Metro Area



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.

Child Missed 10 or More School Days in the Past Year Due to Illness or Injury (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 94]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.



Condition Requiring Therapy

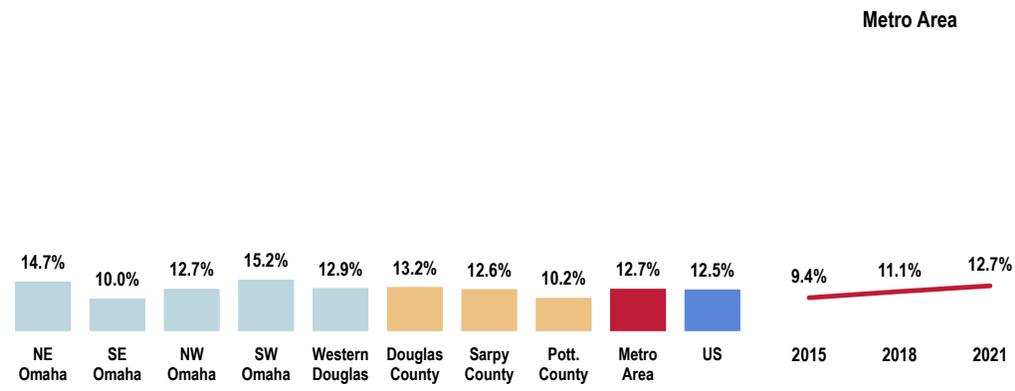
Therapy might include physical, occupational, or speech therapy.

Among surveyed parents in the Metro Area, 12.7% indicate that their child (under 18) has a condition that requires therapy.

TREND ▶ Increasing significantly from 2015 survey findings.

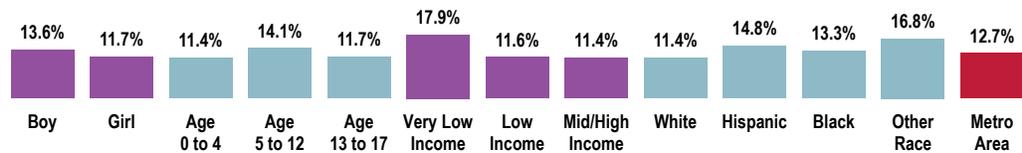
DISPARITY ▶ Unfavorably high among children in households at the lowest income level.

Child Has a Condition That Requires Therapy (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 32]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Has a Condition That Requires Therapy (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 32]
 Notes: • Asked of all respondents about a randomly selected child in the household.



MENTAL HEALTH

ABOUT MENTAL HEALTH

Childhood and adolescence are critical stages of life for mental health. This is a time when rapid growth and development take place in the brain. Children and adolescents acquire cognitive and social-emotional skills that shape their future mental health and are important for assuming adult roles in society.

The quality of the environment where children and adolescents grow up shapes their well-being and development. Early negative experiences in homes, schools, or digital spaces, such as exposure to violence, the mental illness of a parent or other caregiver, bullying and poverty, increase the risk of mental illness.

Mental health conditions ... are major causes of illness and disability among young people.... The consequences of not addressing mental health and psychosocial development for children and adolescents extend to adulthood and limit opportunities for leading fulfilling lives.

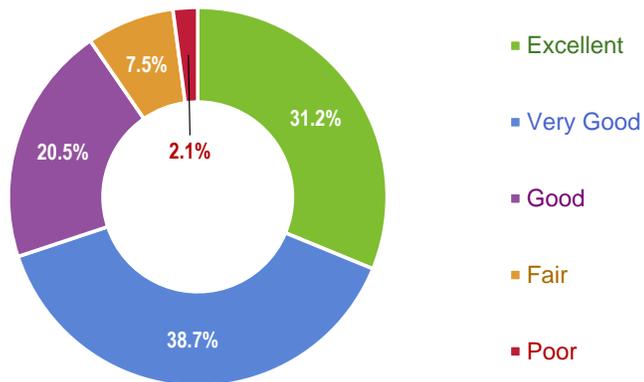
- World Health Organization (<https://www.who.int/activities/Improving-the-mental-and-brain-health-of-children-and-adolescents>)

Child's Mental Health Status

Seven in 10 Metro Area parents of children age 5-17 rate their child's mental health — which includes stress, depression, and problems with emotions — as “excellent” (31.2%) or “very good” (38.7%).

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

Child's Mental Health Status
(Metro Area Children Age 5-17, 2021)



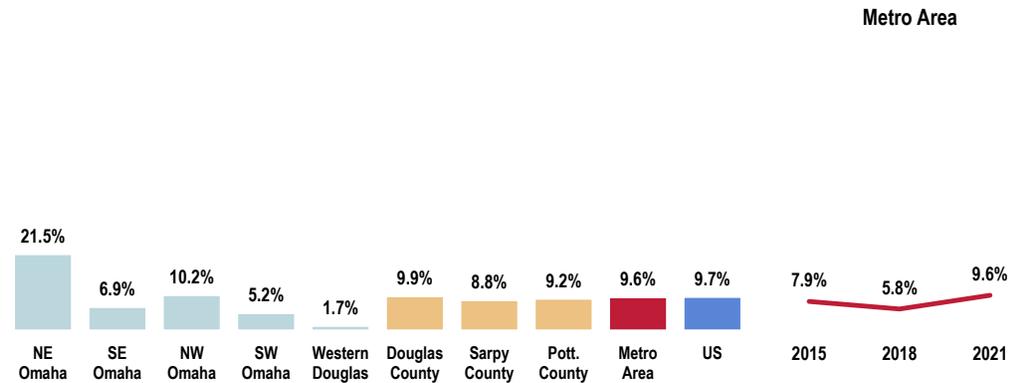
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 77]
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



However, 9.6% of Metro Area parents believe that their school-age child’s mental health is “fair” or “poor.”

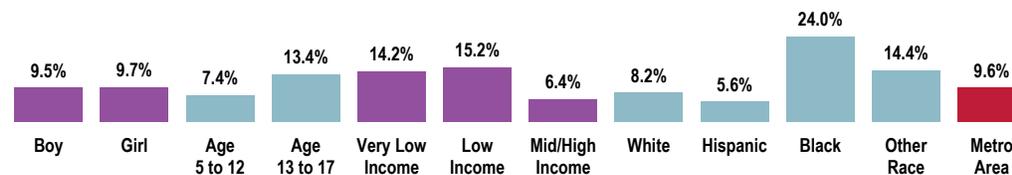
DISPARITY ► Unfavorably high among respondents in Northeast Omaha. Reported more often among parents of teens, those living on lower incomes, and parents of Black children.

Child Experiences “Fair” or “Poor” Mental Health (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 77]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Experiences “Fair” or “Poor” Mental Health (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 77]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects



Depression

Diagnosed Depression

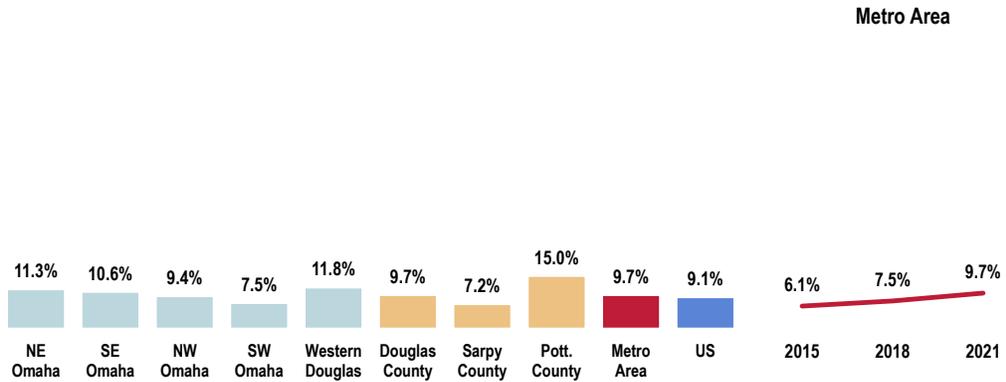
A total of 9.7% of Metro Area parents report that they have been told by a doctor or other healthcare provider that their school-age child had depression.

TREND ▶ Increasing significantly since 2015.

DISPARITY ▶ Reported more often among parents of teens, those in lower-income households, and parents of Black children.

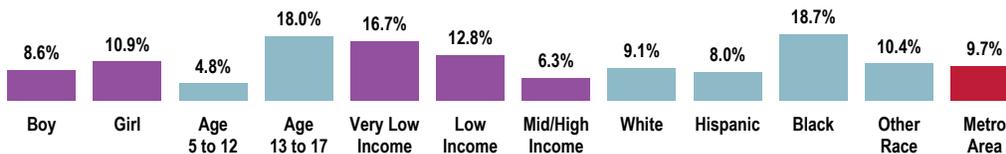
See also Mental Health Services & Treatment in the *Access to Care* section of this report.

Child Has Been Diagnosed with Depression (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 86]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has Been Diagnosed with Depression (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 86]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



Signs of Depression

A total of 6.6% of Metro Area parents indicate that their school-age child felt so sad or hopeless almost every day for two weeks or more in the past year that the child stopped doing some usual activities.

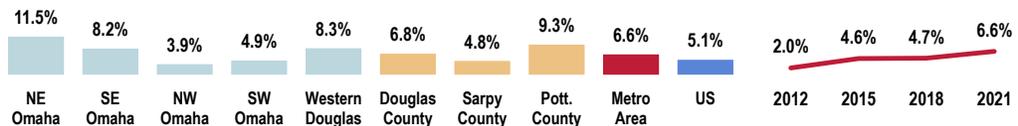
TREND ▶ Marks a significant increase since 2012.

DISPARITY ▶ Reported more often for Metro Area teens and non-White children age 5-17.

Child Felt Sad or Hopeless for Two or More Weeks in the Past Year and Stopped Performing Usual Activities (Metro Area Children Age 5-17, 2021)

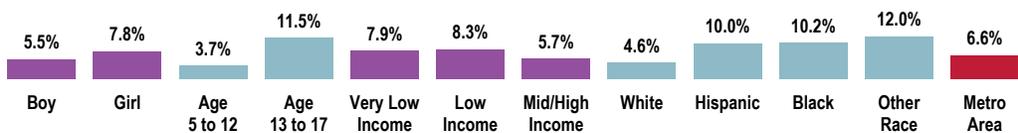
Among parents of those children feeling sad or hopeless, 76.6% sought professional treatment for their child.

Metro Area



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 84-85]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Felt Sad or Hopeless for Two or More Weeks in the Past Year and Stopped Performing Usual Activities (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 84]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



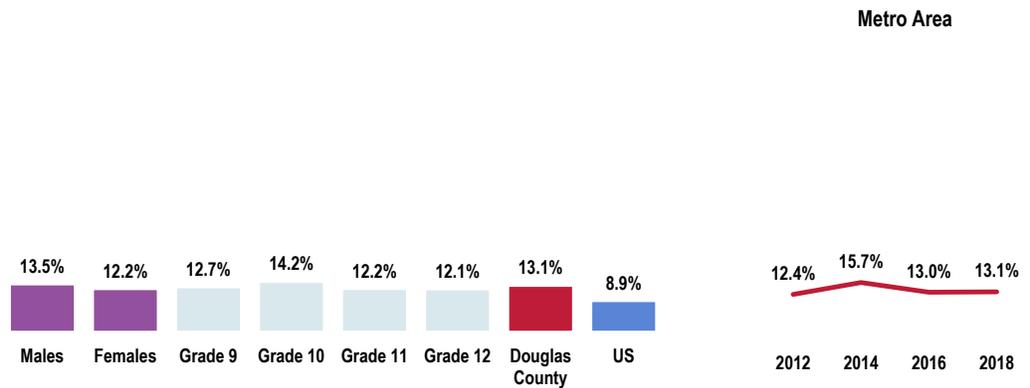
Suicide Attempts (Adolescents)

Among high school students in Douglas County, 13.1% report attempting suicide in the past year (2018-2019 Youth Risk Behavior Survey).

BENCHMARK ▶ Worse than the national prevalence. Fails to satisfy the Healthy People 2030 objective.

TREND ▶ Fluctuating over time.

Attempted Suicide in the Past Year (Among High School Students; Douglas County Youth Risk Behavior Surveys, 2018-2019) Healthy People 2030 Target = 2.4% or Lower



Sources:

- Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
- Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes:

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



Anxiety

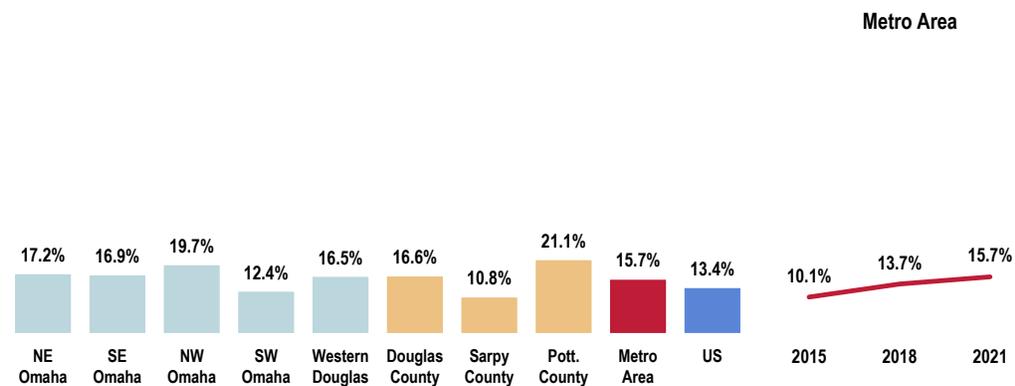
Anxiety Disorders

A total of 15.7% of Metro Area parents report that they have been told by a doctor or other health care provider that their school-age child had anxiety.

TREND ► Increasing significantly since 2015.

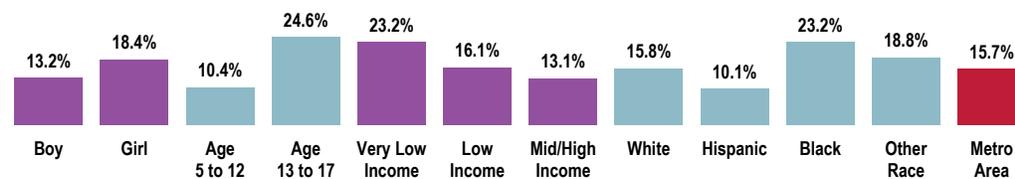
DISPARITY ► The prevalence is lowest in Sarpy County. Reported more often among parents of girls, teens, those living on lower incomes, and non-Hispanic communities of color.

Child Has Been Diagnosed with Anxiety (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 89]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has Been Diagnosed with Anxiety (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 89]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



Worry

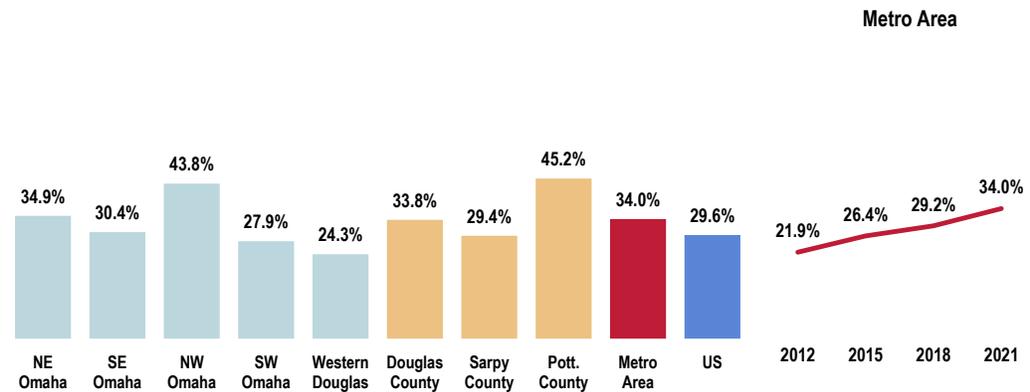
Just over one in three Metro Area parents (34.0%) indicates that their school-age child worries a lot.

TREND ▶ Marks a steady, significant increase since 2012.

DISPARITY ▶ Unfavorably high in Northwest Omaha and Pottawattamie County. Statistically higher among girls than boys in the Metro Area.

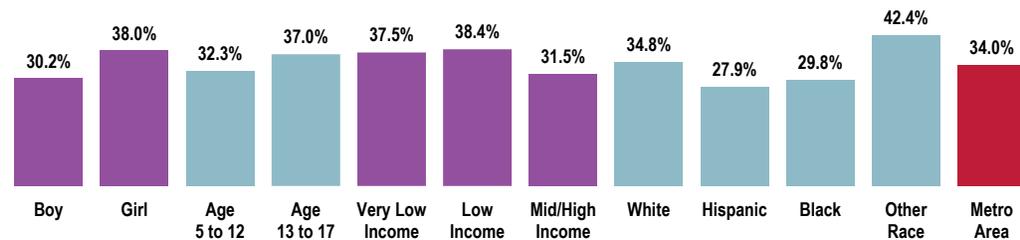
“Would you say that this child worries a lot?”

Child Worries a Lot
(Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 82]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Worries a Lot
(Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 82]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



CHRONIC CONDITIONS

Allergies

Respiratory Allergies

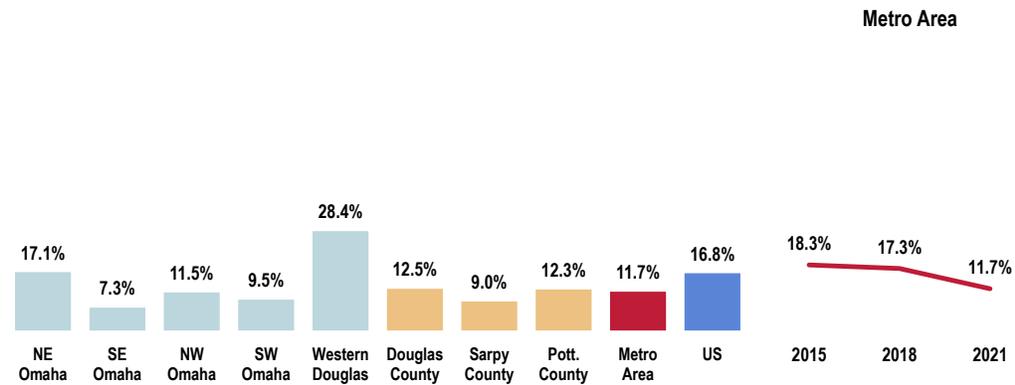
A total of 11.7% of Metro Area children suffer from respiratory allergies.

BENCHMARK ▶ Lower than the national prevalence.

TREND ▶ Decreasing significantly from previous survey findings.

DISPARITY ▶ Unfavorably high in Western Douglas County. Correlates with child's age and is especially high among Black children in the Metro Area.

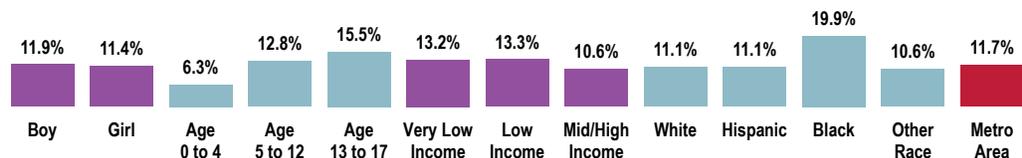
Child Has Respiratory Allergies
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 54]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

Child Has Respiratory Allergies
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 54]
Notes: • Asked of all respondents about a randomly selected child in the household.

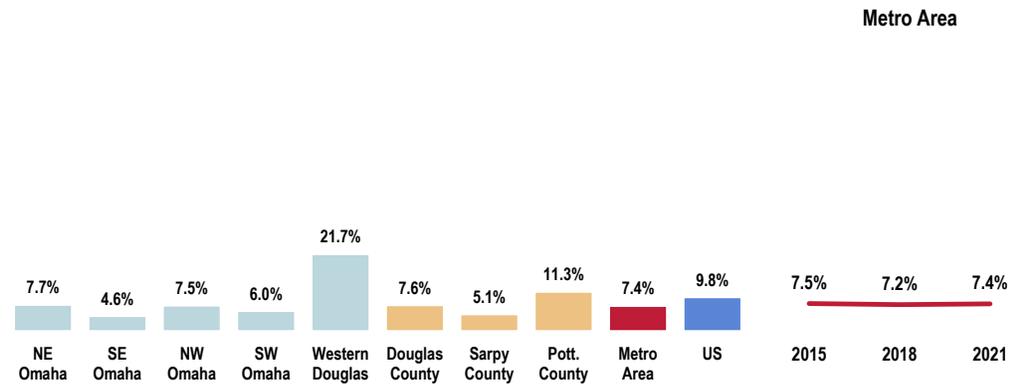


Food/Digestive Allergies

A total of 7.4% of Metro Area children have some type of food or digestive allergy.

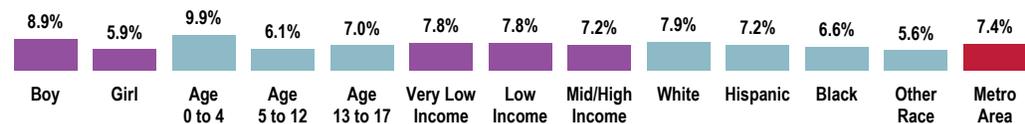
DISPARITY ► Highest in Western Douglas County.

Child Has Food/Digestive Allergies (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 55]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Has Food/Digestive Allergies (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 55]
 Notes: • Asked of all respondents about a randomly selected child in the household.



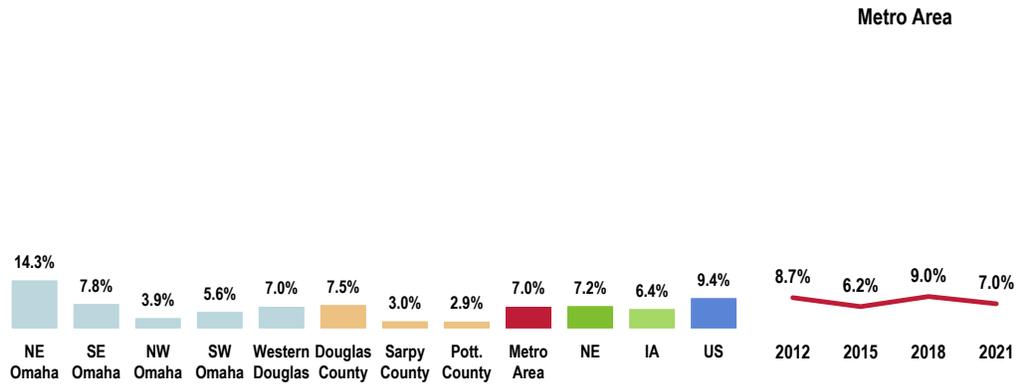
Asthma

Prevalence of Asthma

A total of 7.0% of Metro Area children age 0 to 17 currently have asthma.

DISPARITY ► Unfavorably high in Northeast Omaha. Reported more often among parents of teens, those living in lower-income households, and parents of Black children.

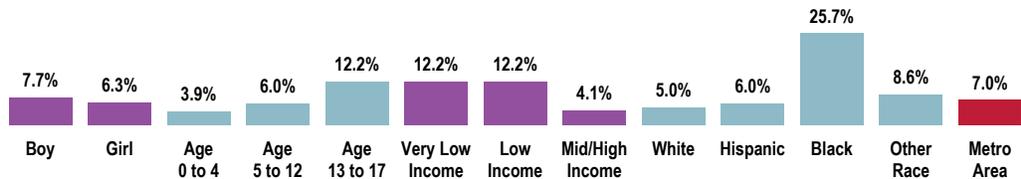
Child Currently Has Asthma (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 125]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.

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

Child Currently Has Asthma (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 125]
 Notes: • Asked of all respondents about a randomly selected child in the household.



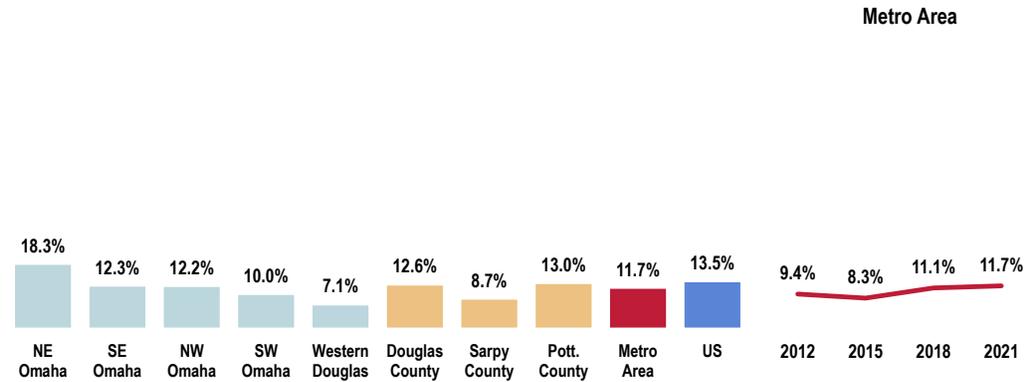
Cognitive & Behavioral Disorders

Attention Deficit Hyperactivity Disorder (ADHD)

A total of 11.7% of Metro Area children are reported to have ever suffered from or been diagnosed with attention deficit hyperactivity disorder or ADHD (also sometimes referred to as attention deficit disorder or ADD).

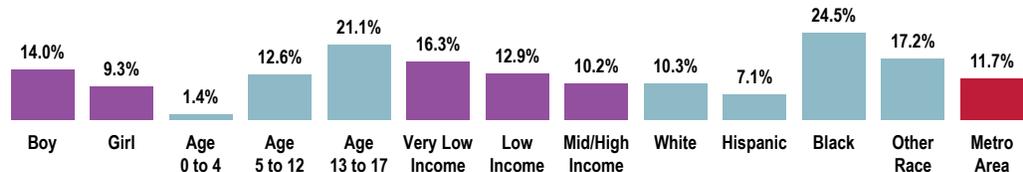
DISPARITY ► Unfavorably high among children in Northeast Omaha. The prevalence increases with age, decreases with household income, and is reported more often among parents of boys and parents of non-White/non-Hispanic children.

Child Has ADD/ADHD (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 65]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Has ADD/ADHD (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 65]
 Notes: • Asked of all respondents about a randomly selected child in the household.

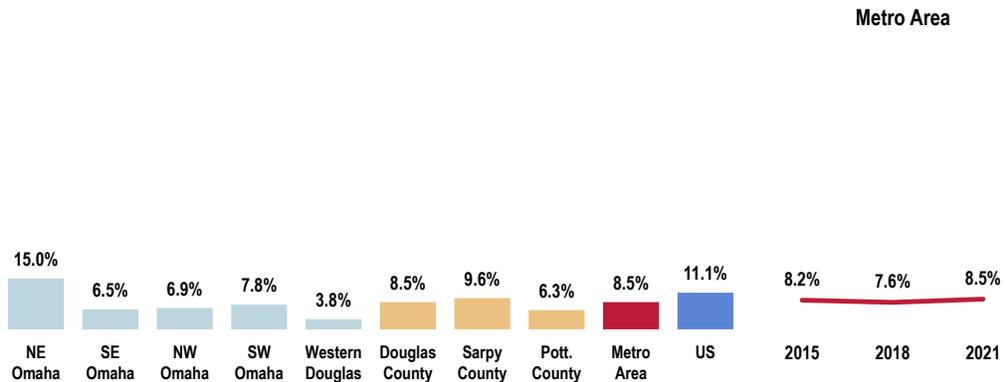


Learning Disabilities

A total of 8.5% of Metro Area children are reported to have some type of learning disability.

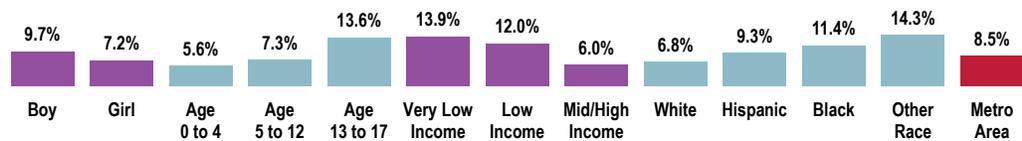
DISPARITY ► Highest in Northeast Omaha. Correlates with age and household income level.

Child Has a Learning Disability (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 62]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Has a Learning Disability (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 62]
 Notes: • Asked of all respondents about a randomly selected child in the household.

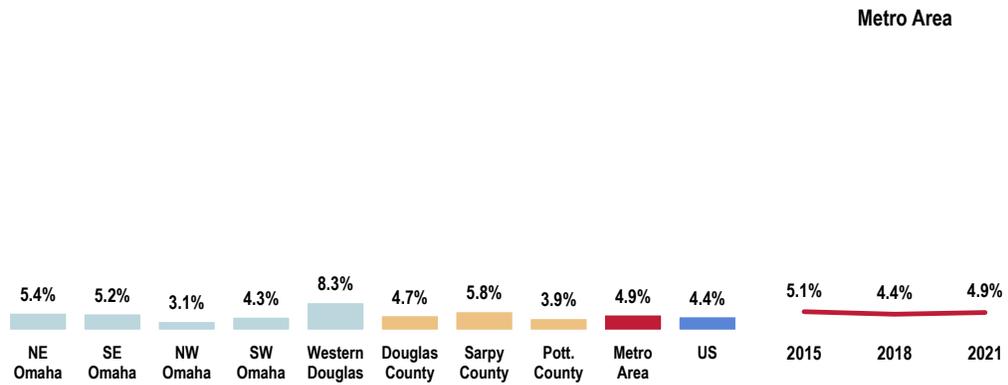


Behavioral/Conduct Disorders

Among Metro Area parents of children age 5-17, 4.9% indicate that a doctor or other health care provider has ever told them that their child has some type of behavioral or conduct disorder, such as oppositional defiant disorder or conduct disorder.

DISPARITY ► Especially high among Black children in the Metro Area.

Child Has a Behavioral/Conduct Disorder (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 87]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has a Behavioral/Conduct Disorder (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 87]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

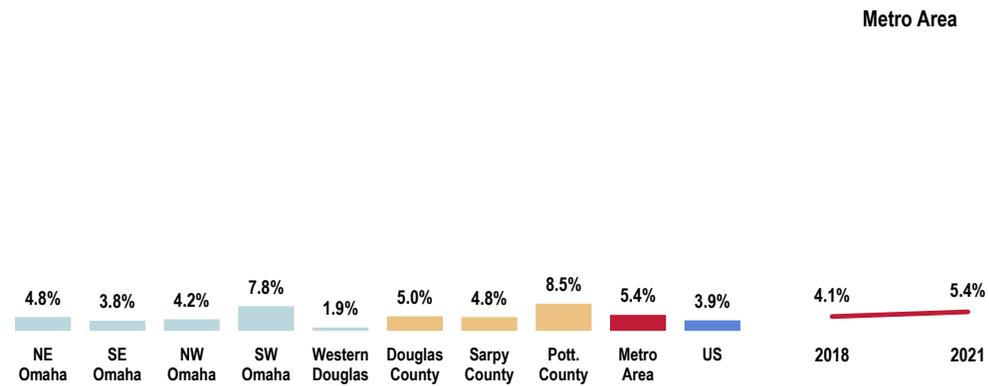


Autism Spectrum Disorders

Among Metro Area parents of children age 5-17, 5.4% indicate that their child has been diagnosed with autism, Asperger's disorder, pervasive developmental disorder, or autism spectrum disorder.

DISPARITY ▶ The prevalence is statistically higher among Metro Area boys when compared with girls.

Child Has Child Has Autism, Asperger's Disorder, Pervasive Developmental Disorder, or Autism Spectrum Disorder (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 88]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has Autism, Asperger's Disorder, Pervasive Developmental Disorder, or Autism Spectrum Disorder (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 88]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



Key Informant Input: Developmental Delays and Disabilities

Nearly half of key informants taking part in an online survey rated *Developmental Delays and Disabilities* as an “8,” “9,” or “10” in the community (10-point scale where 10 is a “major issue”).

Perceptions of Developmental Delays or Disabilities as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Access to Care/Services

The waitlist at Munroe-Meyer Institute is over 300 families long. – Community Leader

I believe there are services available but accessing those services can be very difficult. There is also a very long waitlist for those to receive state services. Private nonprofit providers that provide services are lacking staff and appropriate resources. – Community Leader

The lack of access to integrated care, for health and education, with experienced providers and educators. – Other Health Provider

I work with refugees specifically, and many of these diagnoses are new concepts for families due to a lack of resources and diagnostic capability prior to arrival in the U.S. Parents and guardians are often not fully supported by CLAS (Culturally and Linguistically Appropriate Services). In Omaha, Spanish is commonly an option, but very little inclusion of the other 120 primary languages living in our city. Newer arrivals may not even realize their special needs kids can attend school, let alone that there are additional support services and resources available to them—then accessing, navigating, etc. difficulties come in ... they often don't know that there is even something to ask for, let alone what to ask for from their schools and community agencies. – Social Services Provider

I see the problem in finding medical/mental support that is continuing and consistent, and the kind of resources that school districts need to put in to place to support children with such needs. For schools, the identification process is thorough and proper, but also takes time. I have experienced miserly decision making as to providing resources (equipment/supplies) and human resources (paraprofessionals, counselors, Special Education Teachers) for children with special needs. Additionally, there have been times when problems could have been solved with early intervention. – Social Services Provider

Services for families to get diagnosis for developmental and intellectual delays and disabilities are difficult to access; either waits for appointments are very long and systems are difficult to navigate. In my experience these systems are especially difficult to navigate for non-English speaking families. – Community Leader

Children in our state (especially those with disability or special healthcare need) NEED access to Medicaid. The lack of affordable health insurance is negatively impacting children's access to services. Especially these children who are high utilizers of healthcare. Their families are going into debt or delaying providing care, which means that early intervention is being delayed. Not good policy for our state. We need a Medicaid buy-in or to utilize the Family Opportunity Act through Medicaid. – Social Services Provider

Services readily available to meet the needs of the population are not available in a timely fashion. – Other Health Provider

Many children have these issues, but public resources are insufficient. The number of developmental pediatricians is too small, and the waiting list for ABA therapy is unbearably long. – Physician



Prevention/Screenings

Some families do not follow through on testing. Once identified, some parents and guardians do not follow up with recommendations. Services are limited to serve this population. – Other Health Provider

Because many kids have been partially or completely at home, they have not gotten the needed screening and treatments they have needed and their caregivers were unlikely to have gotten the support they needed, so I anticipate a lot of learning loss and missed opportunities for diagnoses. Also the lack of in school socialization is probably also an issue. – Public Health Representative

Parents enter into medical care late into their pregnancy, if at all. Lack of proper foods. – Social Services Provider

They are a major problem because when undetected early, these lead to more significant challenges later. The earlier we identify and intervene with developmental and intellectual delays, the better off our children will be. – Community Leader

Diagnosis/Treatment

Children who struggle academically, but who may not have an official IEP/504 do not have the resources that students who have these diagnoses have. Children with DD are not prepared for the real world. More resources should be devoted to job readiness/career development for PWD. – Community Leader

Many go undiagnosed or unrecognized and students continue to struggle. For those who are diagnosed, there are limited resources. – Social Services Provider

I feel that these issues continue to be under-recognized and under-addressed and that it has a significant impact on those children's ability to be successful in school and life. – Physician

Without proper care and attention, small problems become large ones. – Other Health Provider

Incidence/Prevalence

I believe the numbers keep rising and caregivers lack knowing what to do about them. – Community Leader

I think that a lot of children struggle with developmental delays—whether it is social learning, speech delays, actual delays—that contribute to low achievement in schools. Many times, schools don't have the resources (or are unwilling) to provide the level of support that is needed for the child to be successful in school. Additionally, it is very difficult for parents with children with disabilities to get supportive services unless their child has the "right" diagnoses to qualify for a Medicaid waiver or other state-based support. – Other Health Provider

Affordable Care/Services

There is a lack of affordable, accessible providers in medical care and behavioral health. There are also very few people providing education and health care in the sexuality field that are trained in this area and trauma informed. How do we have broader Medicaid coverage for educational assistance and a healthcare navigator? – Public Health Representative

Contributing Factors

Stigma, education, and accessibility impact the services provided to people of color in the Omaha community. – Other Health Provider

Funding

There are insufficient funds available to serve and support youth and their families that are impacted by ID/DD issues. – Other Health Provider

Family Support

No quality family time or access to resources. – Community Leader



Diabetes

Prevalence of Diabetes

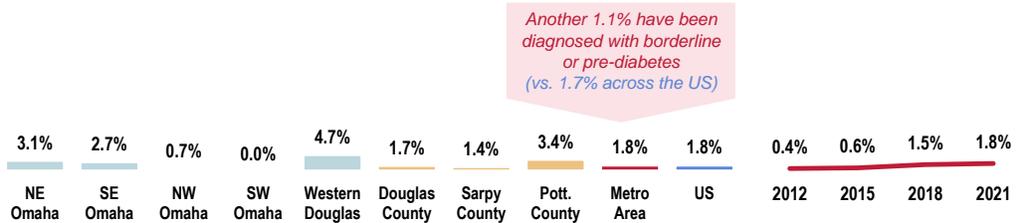
A total of 1.8% of Metro Area children age 0 to 17 have been diagnosed with diabetes.

TREND ► Denotes a steady, statistically significant increase since 2012.

DISPARITY ► Correlates with income and is highest among teens and especially Black children.

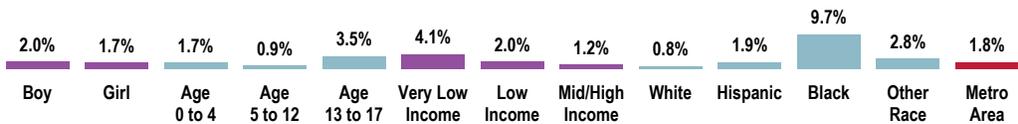
Child Has Diabetes (Metro Area, 2021)

Metro Area



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 126]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Has Diabetes (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 126]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Chronic Dental Issues

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

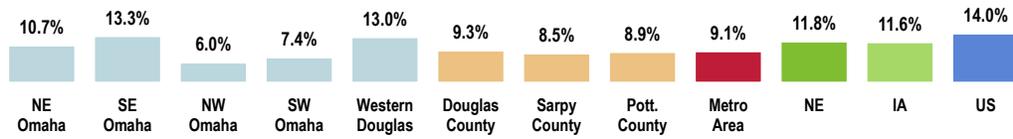
“Would you please tell me if this child has ever suffered from or been diagnosed with any of the following medical conditions”

A total of 9.1% of Metro Area parents with children age 1-17 report frequent or chronic difficulty with decayed teeth or cavities in the past year.

BENCHMARK ▶ Lower than the Nebraska and US percentages.

DISPARITY ▶ Lowest in Northwest Omaha. Reported more often among parents of children age 5 to 12 and parents of Hispanic children.

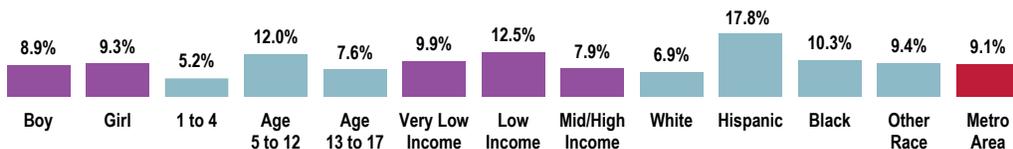
Child Had Frequent Issues with Cavities or Tooth Decay in the Past Year (Metro Area Children Age 1-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 305]
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes: • Asked of all respondents about a randomly selected child aged 1-17 in the household.

Child Had Frequent Issues with Cavities or Tooth Decay in the Past Year (Metro Area Children Age 1-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 305]
 Notes: • Asked of all respondents about a randomly selected child in the household.



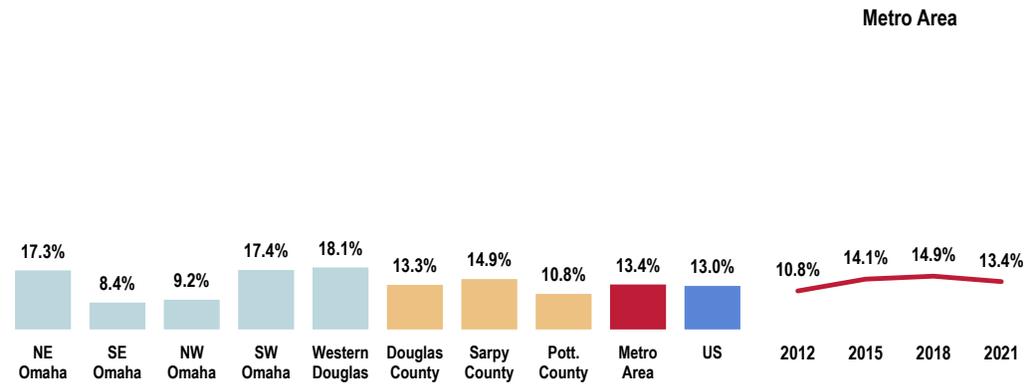
Speech/Language, Hearing & Vision

Speech/Language Issues

A total of 13.4% of Metro Area children have some type of speech or language problem.

DISPARITY ► Lowest in Southeast and Northwest Omaha.

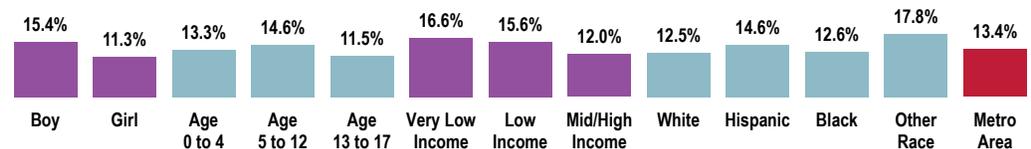
Child Has Speech/Language Problems (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 63]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

Child Has Speech/Language Problems (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 63]
 Notes: • Asked of all respondents about a randomly selected child in the household.



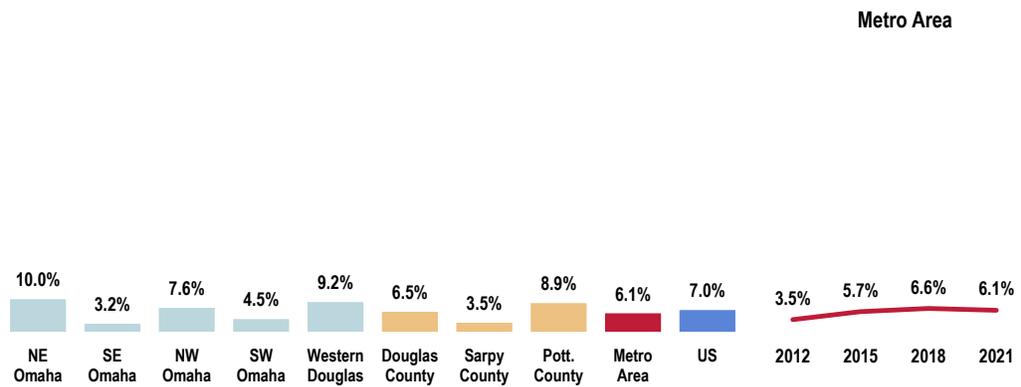
Hearing Problems

A total of 6.1% of Metro Area children have been diagnosed with hearing problems.

TREND ▶ Marks a statistically significant increase from 2012 survey findings.

DISPARITY ▶ Favorably low in Southeast Omaha and Sarpy County. Reported more often about a child age 5 to 12.

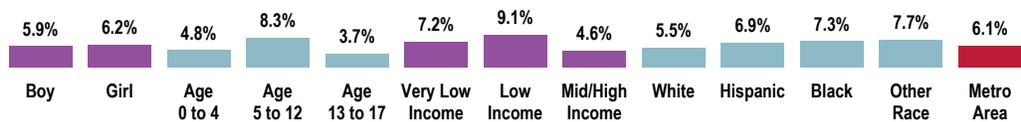
Child Has Hearing Problems (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 37]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

Child Has Hearing Problems (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 37]
 Notes: • Asked of all respondents about a randomly selected child in the household.

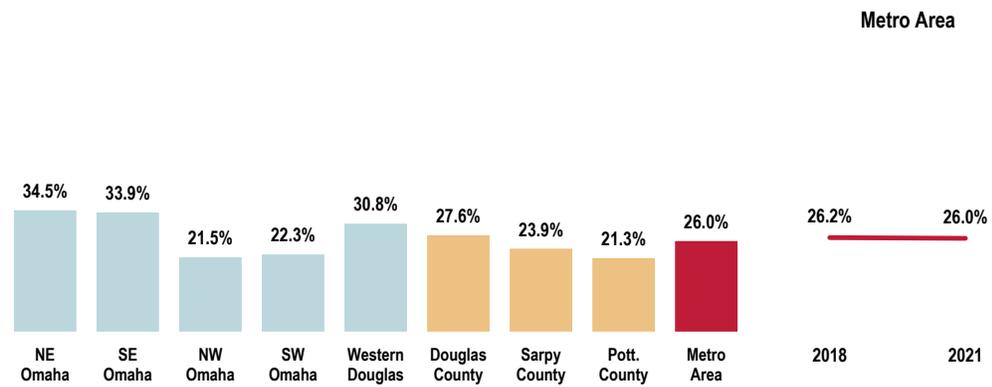


Vision Problems

A total of 26.0% of Metro Area children have vision problems.

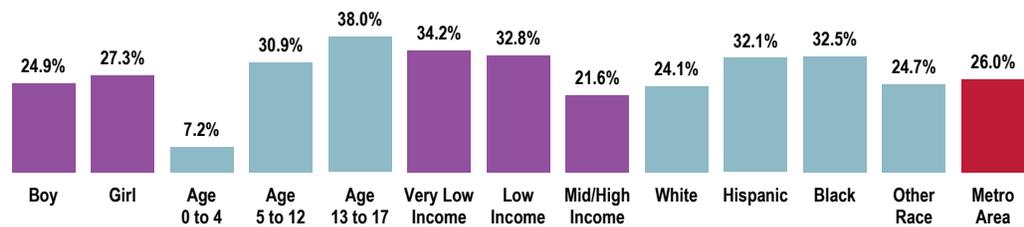
DISPARITY ► Unfavorably high in Southeast Omaha. The prevalence increases with age, decreases with household income level, and is reported more often among parents of Hispanic children and parents of Black children.

Child Has Vision Problems (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 303]
Notes: • Asked of all respondents about a randomly selected child in the household.

Child Has Vision Problems (Metro Area, 2021)



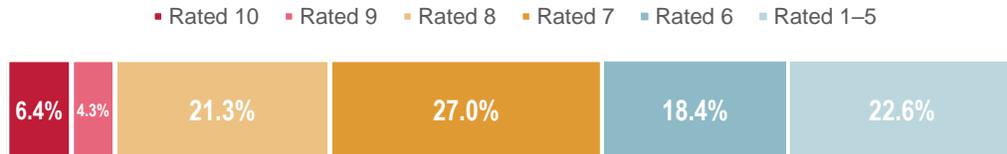
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 303]
Notes: • Asked of all respondents about a randomly selected child in the household.



Key Informant Input: Pediatric Chronic Conditions

Nearly one-third of key informants taking part in an online survey rated *Pediatric Chronic Conditions* as an “8,” “9,” or “10” in the community (10-point scale where 10 is a “major issue”).

Perceptions of Pediatric Chronic Conditions as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Contributing Factors

In some of the underserved communities in North and South Omaha, we are still seeing high rates of obesity and asthma. Again, due to COVID, kids were less able to participate in physical activity, less able to access healthy lunches (or any nutrition) through school, and due to the economic and family instability, families were less likely to leave unhealthy/substandard housing (connected to asthma) during this past year. – Public Health Representative

Omaha has too much substandard housing. Lack of access to affordable transportation to many parts of the city impacts seeing medical providers and early detection. Limited availability of social determinants of health for many (food, shelter, transportation, phone communication, broadband) in pockets of the city. – Other Health Provider

The ability to get to health agencies, food desserts and having people who serve the community look like the community. – Social Services Provider

Asthma control in the metro area is not available to all. Excellent medical control for type 1 diabetes and chronic seizures are not available for all. Autism resources are not available to all. – Physician

Infant Health

I work with infants and one of the major conversations in this space is chronic conditions related to feeding and chronic conditions. For infants with feeding difficulties, the providers are not coordinated and parents are struggling to find resources. – Public Health Representative

Workforce Development

This is a workforce development opportunity with having access to experienced providers who treat chronic mental health conditions for children, especially with complex medical needs such as autism spectrum disorder. – Other Health Provider

Access to Care/Services

Affordable and accessible care is not available in all areas of the community. Specialty services are not located in areas where people of color reside and the providers do not look like the individuals who are served. – Other Health Provider

Diagnosis/Treatment

Unrecognized, untreated or undertreated chronic conditions, especially asthma, continue to have a significant impact on the health and well-being of our children and adolescents. – Physician

Co-Occurrences

Many factors have led to an increase in diabetes and obesity in children. – Social Services Provider



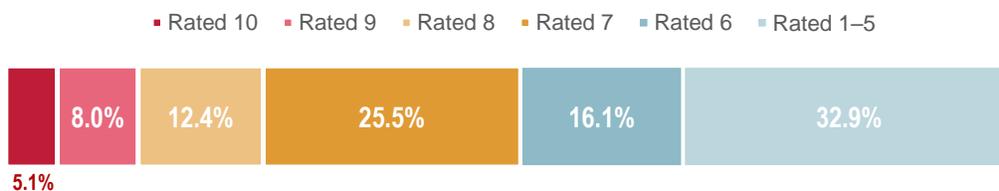
Social Determinants

Urban setting with high poverty rates, resulting in generational poverty. – Other Health Provider
Air quality and poor living environment. – Community Leader

Key Informant Input: Vision, Hearing & Speech Conditions

The largest share of key informants taking part in an online survey gave *Vision, Hearing & Speech Conditions* a rating of between 1 and 5 (on a 10-point scale where “1” is not an issue at all) for children/adolescents in the community.

Perceptions of Vision, Hearing & Speech Conditions as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Prevention/Screenings

The school setting catches this during the mandated health screenings. – Other Health Provider
Ongoing issue, plus since kids were out of school, they were out of the reach of the supportive services that could treat and screen for these. – Public Health Representative
Again, social factors drive the decision to get the medical assessment needed. – Other Health Provider
Families that do not routinely take their child to the doctor will never know if they can hear or see. Many times kids are just on a smart device watching with no other human interactions. Kids are not having to speak and have conversations. – Other Health Provider
Early screening prevents these conditions from getting worse but there is not a universal screening for all children related to vision, hearing, and especially speech conditions. Pediatricians are the first line of defense but if a family is not utilizing the health care system or is not aware of factors that impact a child’s development, their children might not receive services until they enter a school building. – Community Leader

Impact on Quality of Life

Vision loss is a silent condition among many children, resulting in many struggling to do well in school and/or experience behavior problems. If a child struggles to see, the child does not experience any pain and few recognize they see the world differently; therefore, they go on believing they must not be as smart as their peers and/or everyone’s world is a little fuzzy. Additionally, parent often associate poor vision with age, and do not prioritize vision screening or comprehensive vision exams for their children, leaving many children in our community with untreated vision problems that could easily be remedied if diagnosed. – Community Leader
As we move toward total health and wellness, all conditions related to vision, hearing, and speech have an impact on the developmental needs of children and adolescents. Affordable, accessible, and culturally appropriate providers are important in the education and utilization of services which have not been a priority for communities of color. – Other Health Provider

Lack of Providers

No doctors in the neighborhood. – Social Services Provider
While vision care and services is part of physical health, I believe it is important to ensure we are intentional about the gaps in vision care and services within our community. – Public Health Representative



Affordable Care/Services

Accessibility to affordable vision and dental care for students without health insurance is an issue in West Omaha. One World does have a clinic, for which we are grateful, but it isn't in a walkable area and public transportation is very limited. Wonderful partners like the Vision Van are able to schedule screenings but can't offer free eye exams or glasses to students without Medicaid. – Community Leader

Vision insurance is not accessible to all. Children needing a referral for a comprehensive eye exam does not occur. – Physician

Child Overweight & Obesity

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

Childhood obesity is associated with a higher chance of obesity, premature death and disability in adulthood. But in addition to increased future risks, obese children experience breathing difficulties, increased risk of fractures, hypertension, early markers of cardiovascular disease, insulin resistance and psychological effects.

- World Health Organization (<https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight>)

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

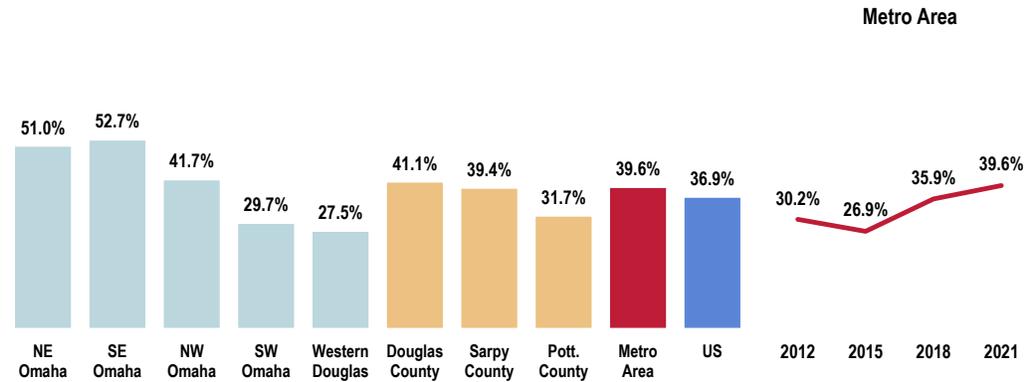
Based on the heights/weights reported by surveyed parents, 4 in 10 Metro Area children age 5 to 17 (39.6%) are overweight or obese (≥85th percentile).

TREND ► Increasing significantly since 2012 (and especially 2015).

DISPARITY ► Affecting over half of children in eastern Omaha. Reported more often among parents of boys, parents of children age 5 to 12, and among communities of color.

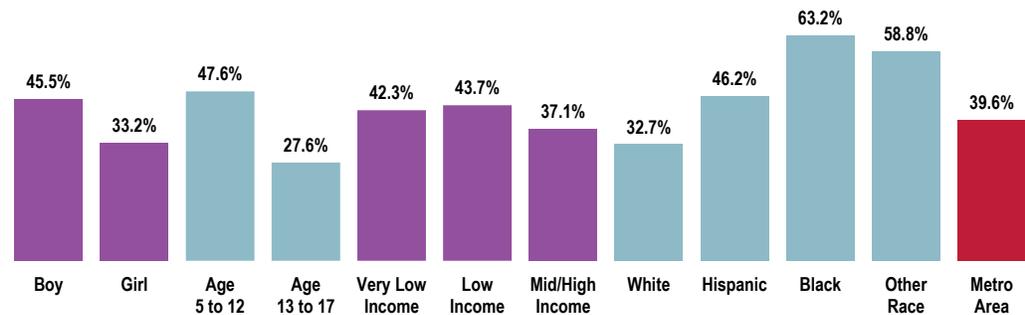


Child Is Overweight or Obese (Metro Area Children Age 5-17 With a BMI in the 85th Percentile or Higher)



Sources: ● 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 135]
 ● 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: ● Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 ● Overweight among children 5-17 is determined by child's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

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



Sources: ● 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 135]
 Notes: ● Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 ● Overweight among children is determined by children's Body Mass Index status equal to or above the 85th percentile of US growth charts by gender and age.



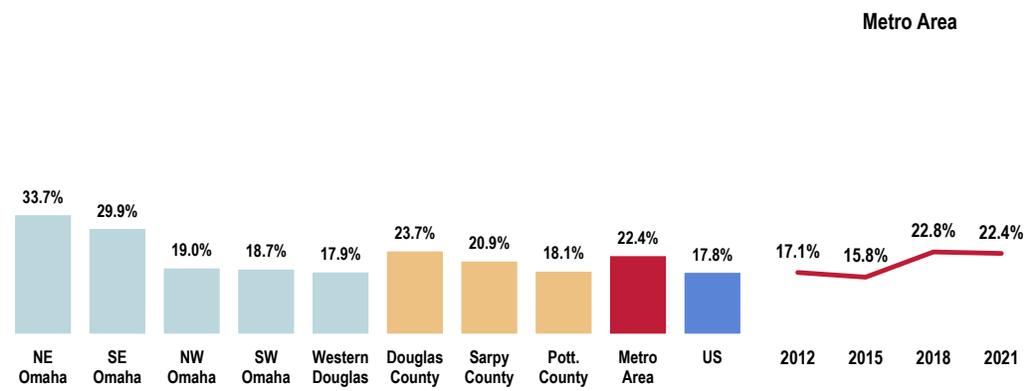
The childhood overweight prevalence above includes 22.4% of area children age 5 to 17 who are **obese** (≥95th percentile).

BENCHMARK ▶ Worse than the national prevalence. Far from satisfying the Healthy People 2030 objective.

TREND ▶ Increasing significantly from 2012 and 2015 survey results.

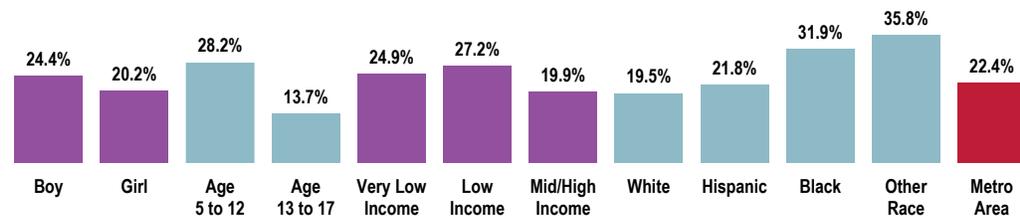
DISPARITY ▶ Reported among roughly 30% or more of parents in Northeast and Southeast Omaha. Highest among children age 5 to 12 and non-Hispanic communities of color.

Child Obesity Prevalence (Metro Area Children Age 5-17 with a BMI in the 95th Percentile or Higher) Healthy People 2030 Target = 15.5% or Lower



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 135]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 • Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Child Obesity Prevalence (Metro Area Children Age 5-17 with a BMI in the 95th Percentile or Higher) Healthy People 2030 Target = 15.5% or Lower



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 135]
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
 • Overweight among children is determined by children's Body Mass Index status equal to or above the 85th percentile of US growth charts by gender and age.



Serious Injury

Prevalence of Serious Injuries

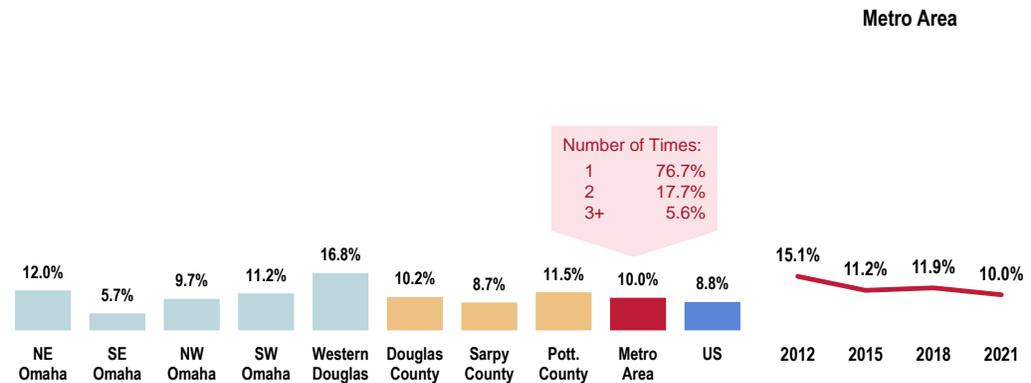
While most Metro Area children were not seriously injured in the past year, 10.0% sustained injuries serious enough to require medical treatment.

TREND ▶ Decreasing significantly since 2012.

DISPARITY ▶ Lowest in Southeast Omaha. The prevalence increases with age and is reported more often among non-Hispanic communities of color.

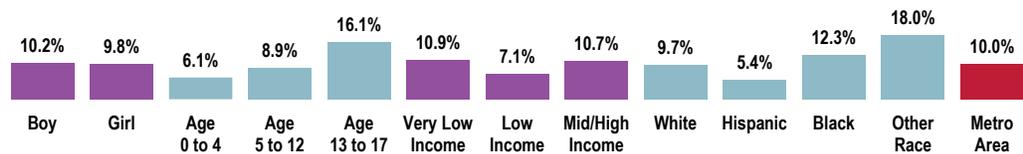
“In the past two years, has this child been injured seriously enough to need treatment from a doctor or a nurse?”

Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 69-70]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year (Metro Area, 2021)

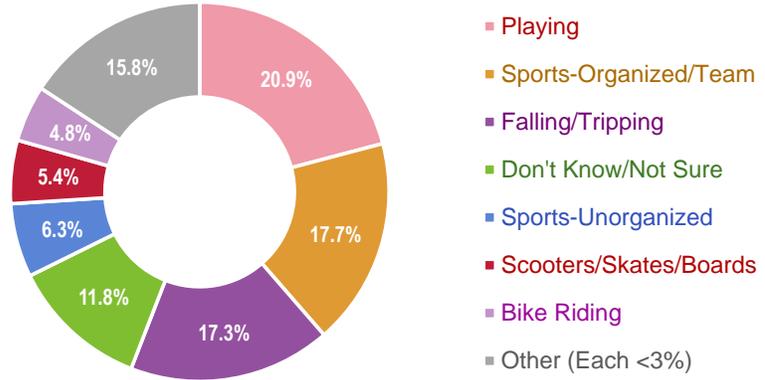


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 69]
 Notes: • Asked of all respondents about a randomly selected child in the household.



When asked what the child was doing when the injury occurred, parents of these children most often mentioned activities like **playing, organized sports, and falling/tripping**. Other contributors included **unorganized sports, scooters/skateboards and bike riding**.

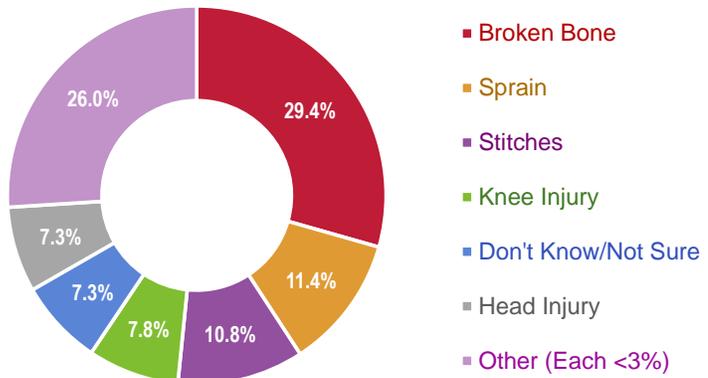
Child's Activity When Most Seriously Injured in Past Year (Metro Area Children Seriously Injured in the Past Year, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 71]
 Notes: • Asked of all respondents for whom the randomly selected child in the household was seriously injured in the past year.

When asked about the type of injury sustained, these parents frequently mentioned **broken bones, sprains,** and injuries requiring **stitches**. Injuries mentioned with less frequency included **knee** and **head injuries**.

Type of Injury Sustained (Metro Area Children Seriously Injured in the Past Year, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 72]
 Notes: • Asked of all respondents for whom the randomly selected child in the household was seriously injured in the past year.



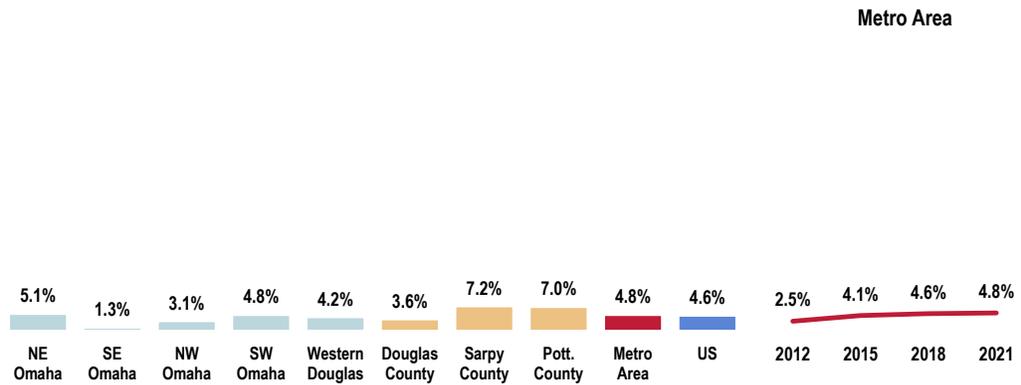
Brain Injury/Concussion

A total of 4.8% of Metro Area children have suffered a brain injury or concussion.

TREND ► Increasing significantly since 2012.

DISPARITY ► Lowest in Douglas County (and especially Southeast Omaha). Reported more often among parents of boys and teens.

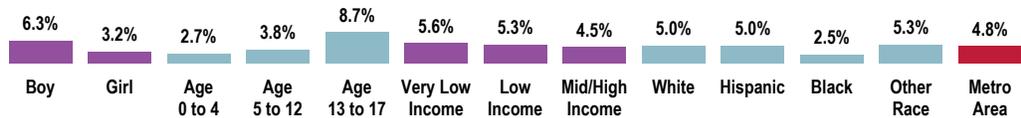
Child Has Had a Brain Injury/Concussion (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 59]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

Child Has Had a Brain Injury/Concussion (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 59]

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



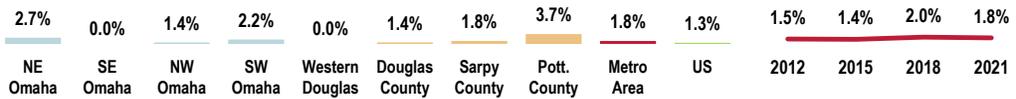
NEUROLOGICAL CONDITIONS

Epilepsy

A total of 1.8% of Metro Area children have epilepsy or a seizure disorder.

Child Has Seizure Disorder/Epilepsy (Metro Area, 2021)

Metro Area



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 58]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Has Seizure Disorder/Epilepsy (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 58]
 Notes: • Asked of all respondents about a randomly selected child in the household.

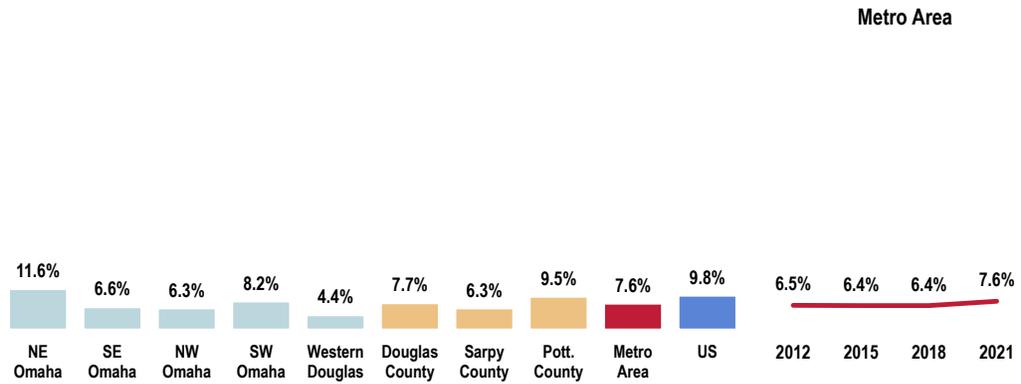


Developmental Delays

A total of 7.6% of Metro Area children have been diagnosed with some type of developmental delay that affects his/her ability to learn.

DISPARITY ► Reported more often among parents of Hispanic children and parents of Black children.

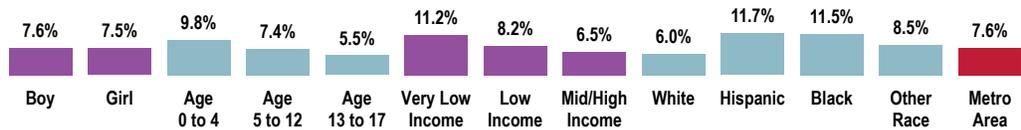
Child Has a Developmental Delay (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 64]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

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

Child Has a Developmental Delay (Metro Area, 2021)



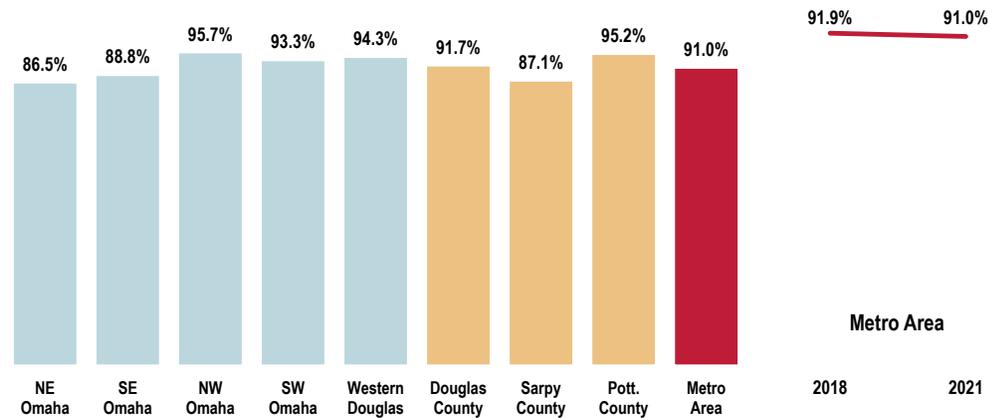
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 64]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Most Metro Area parents (91.0%) report that their child is developmentally on track compared to other children.

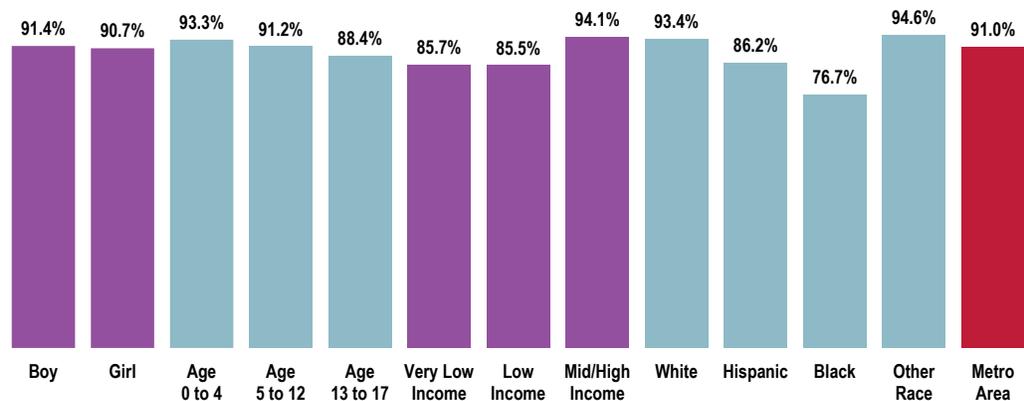
DISPARITY ▶ Lowest in Northeast Omaha and Sarpy County. Reported less often among parents of teens, those in lower-income households, parents of Hispanic children, and parents of Black children.

**Child Is Developmentally On Track
(Metro Area, 2021)**



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 320]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

**Child Is Developmentally On Track
(Metro Area, 2021)**



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 320]
 Notes: • Asked of all respondents about a randomly selected child in the household.



MORTALITY

Infant Mortality

Between 2017 and 2019, there was an annual average of 5.8 infant deaths per 1,000 live births.

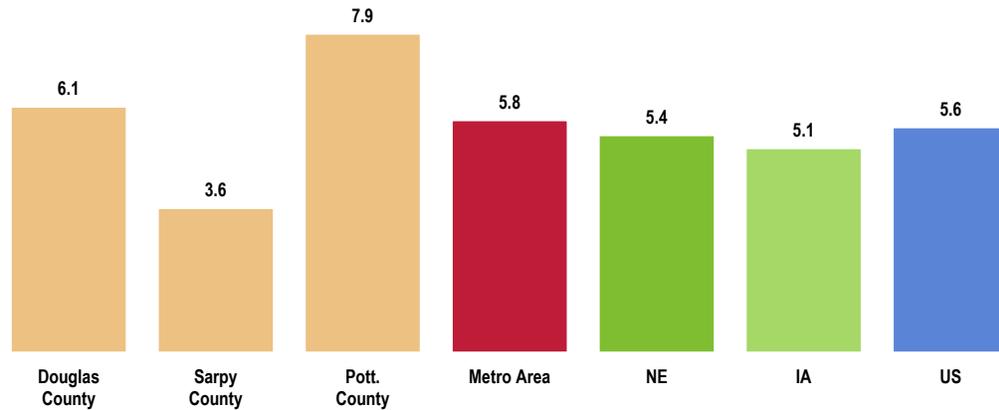
BENCHMARK ► Worse than both state death rates. Fails to satisfy the Healthy People 2030 objective.

TREND ► Though decreasing in recent year, the infant mortality rate has increased over the past decade overall.

DISPARITY ► Highest in Pottawattamie County. Considerably higher in the Metro Area's Black community.

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

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2017-2019)
Healthy People 2030 Target = 5.0 or Lower

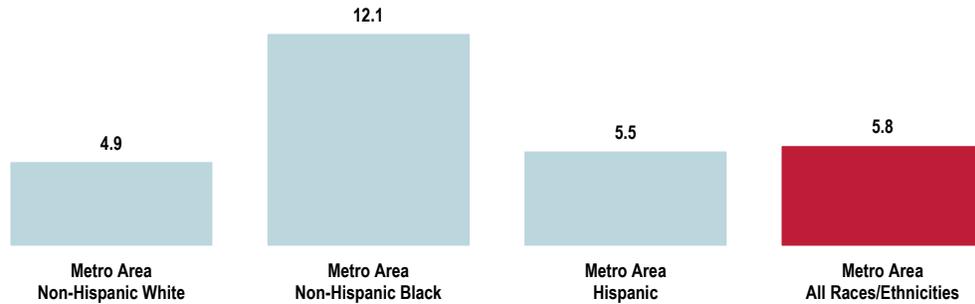


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2021.
 - US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
- 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.



Infant Mortality by Race/Ethnicity

(Annual Average Infant Deaths per 1,000 Live Births, 2017-2019)
Healthy People 2030 Target = 5.0 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 July 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 Target = 5.0 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	4.9	5.3	5.5	6.1	6.2	6.4	6.3	5.8
— NE	5.1	5.2	5.1	5.5	5.8	5.8	5.8	5.4
— IA	5.0	4.8	4.9	4.5	5.1	5.2	5.4	5.1
— US	6.1	6.0	5.9	5.9	5.9	5.8	5.7	5.6

Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes:

- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.



Child & Adolescent Deaths

ABOUT CHILD & ADOLESCENT DEATHS

Injuries (including road traffic injuries, drowning, burns, and falls) rank among the top causes of death and lifelong disability among children aged 5-14 years. The patterns of death in older children and young adolescents reflect the underlying risk profiles of the age groups, with a shift away from infectious diseases of childhood and towards ... injuries, notably drowning and road traffic injuries for older children and young adolescents.

The rise of injury deaths, particularly, road traffic injuries and drowning, demonstrate that the risk exposure is different for those over the age of 5 years. As a result, the nature of interventions needed to prevent poor health outcomes have shifted away from health sector actions to prevent and treat the infectious diseases of early childhood towards other sectors needed to take action to prevent mortality from road traffic injuries, violence and mental health problems. Actions across a range of government sectors including education, transportation and road infrastructure, water and sanitation and law enforcement are needed to prevent premature mortality in older children and young adolescents.

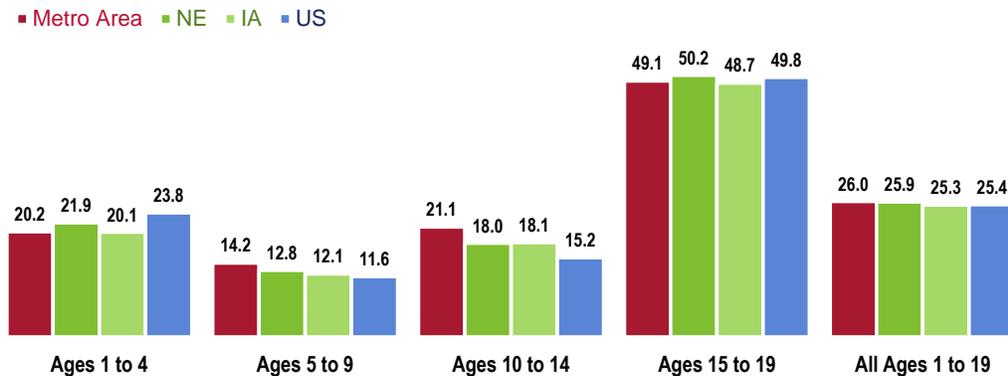
- World Health Organization (<https://www.who.int/news-room/fact-sheets/detail/mortality-among-children-aged-5-14-years>)

Death Rates by Age Groups

The following chart outlines mortality rates among Metro Area children and adolescents in various age groups, expressed as the number of deaths per 100,000 population in those age groups.

BENCHMARK ► The Metro Area mortality rates among children age 5-9 and age 10-14 are worse than Nebraska, Iowa, and US rates. With the exception of children age 5-9, the Metro Area death rates fail to meet the related Healthy People 2030 objective.

Child & Adolescent Mortality Rates by Age Group
 (Annual Average Child Mortality per 100,000 Population; 2017-2019)
 Healthy People 2030 Target = 18.4 or Lower (All Ages 1 to 19 Years)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 Notes: • Rates are crude rates, representing the number of deaths of children in each age group per 100,000 population.



Leading Causes of Child Death

Perinatal conditions (such as low birthweight, preterm births, and complications of labor/delivery) are the number-one leading cause of death for Metro Area infants under 1 year of age.

For all other age groups of children and adolescents, **unintentional injuries** are the leading cause of death.

See also *Injury & Safety* in the Physical Environment Influences section of this report.

Leading Causes of Child Deaths by Age Group (Metro Area, 2021)

	Under 1 Year	Ages 1 to 4	Ages 5 to 9	Ages 10 to 14	Ages 15 to 19
NUMBER-ONE LEADING CAUSE	Perinatal Conditions*	Unintentional Injuries	Unintentional Injuries (Motor Vehicle)	Unintentional Injuries (Motor Vehicle)	Unintentional Injuries (Motor Vehicle, Poisoning/Overdose)
NUMBER-TWO LEADING CAUSE	Congenital Conditions**	Congenital Conditions**	Cancer (Brain/CNS)	Cancer	Suicide (Firearms, Suffocation)
NUMBER-THREE LEADING CAUSE	Unintentional Injuries (Suffocation)	Cancer	Congenital Conditions**	Suicide	Homicide (Firearms)

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2021.

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





BIOLOGICAL INFLUENCES

PRENATAL CARE

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

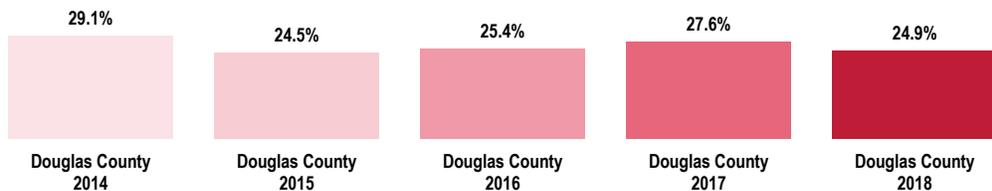
– Healthy People 2030 (<https://health.gov/healthypeople>)

In 2018, 24.9% of all Douglas County births did not receive prenatal care in the first trimester of pregnancy.

TREND ▶ An improvement since 2014.

Early and continuous prenatal care is the best assurance of infant health.

Trend Lack of Prenatal Care in the First Trimester
(Percentage of Live Births; Douglas County, 2014-2018)



Sources: • Maternal Child Health (MCH) Tables, Douglas County Health Department. Data extracted August 2021.

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.



LOW-WEIGHT BIRTHS

A total of 7.7% of 2013-2019 Metro Area births were low-weight.

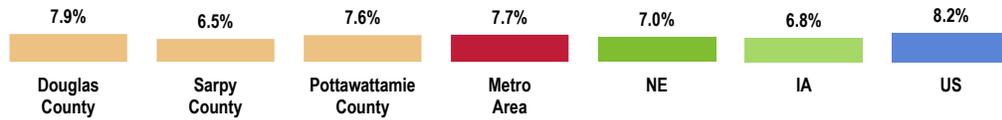
BENCHMARK ▶ Above both state percentages but lower than the US percentage.

DISPARITY ▶ Lowest in Sarpy County.

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.

Low-Weight Births (Percent of Live Births, 2013-2019)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted July 2021.

Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.



INFANT HEALTH

Breastfeeding & Breast Milk

ABOUT BREASTFEEDING

Exclusive breastfeeding for 6 months has many benefits for the infant and mother. Chief among these is protection against gastrointestinal infections which is observed not only in developing but also industrialized countries. Early initiation of breastfeeding, within 1 hour of birth, protects the newborn from acquiring infections and reduces newborn mortality. The risk of mortality due to diarrhea and other infections can increase in infants who are either partially breastfed or not breastfed at all.

Breastmilk is also an important source of energy and nutrients in children aged 6-23 months. It can provide half or more of a child's energy needs between the ages of 6 and 12 months, and one-third of energy needs between 12 and 24 months. Breast milk is also a critical source of energy and nutrients during illness and reduces mortality among children who are malnourished.

Children and adolescents who were breastfed as babies are less likely to be overweight or obese. Additionally, they perform better on intelligence tests and have higher school attendance. Breastfeeding is associated with higher income in adult life.

Longer durations of breastfeeding also contribute to the health and well-being of mothers: it reduces the risk of ovarian and breast cancer and helps space pregnancies – exclusive breastfeeding of babies under 6 months has a hormonal effect which often induces a lack of menstruation.

- World Health Organization (<https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding>)

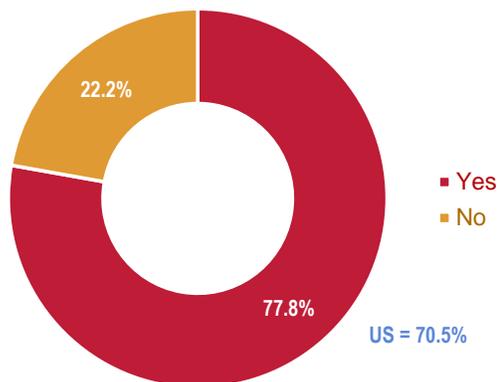
Ever Breast-Fed

Over three in four Metro Area children age 0 to 17 (77.8%) were ever breast-fed or fed using breast milk (regardless of duration).

BENCHMARK ▶ Higher than the national prevalence.

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

Child Was Ever Fed Breast Milk
(Metro Area, 2021)



- Sources:
- 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 113]
 - 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents about a randomly selected child in the household.



Exclusive Breastfeeding

In total, just over one-third (35.0%) of all Metro Area children were fed breast milk exclusively for the first 6 months of life.

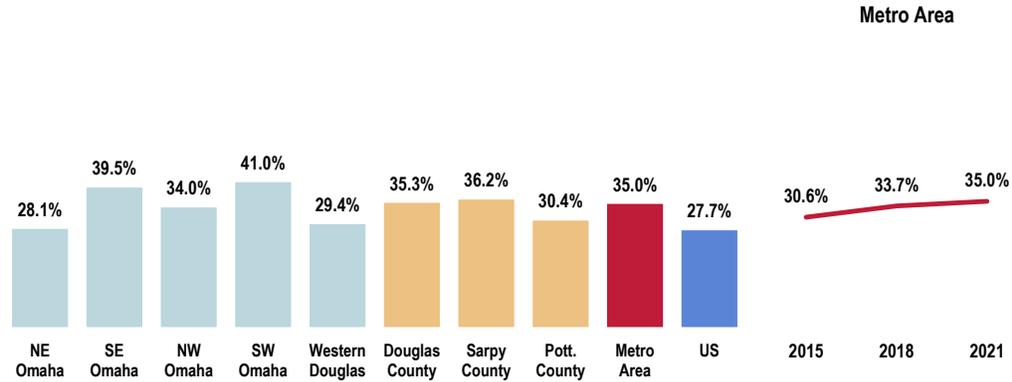
BENCHMARK ▶ Well above the US prevalence but fails to meet the Healthy People 2030 objective.

TREND ▶ Increasing significantly from 2015 survey findings.

DISPARITY ▶ Lowest in Northeast Omaha. The prevalence decreases with child's age (suggesting an improvement over time), and increases with household income level. Reported less often in non-Hispanic communities of color.

Child Was Exclusively Breastfed for at Least 6 Months (Metro Area, 2021)

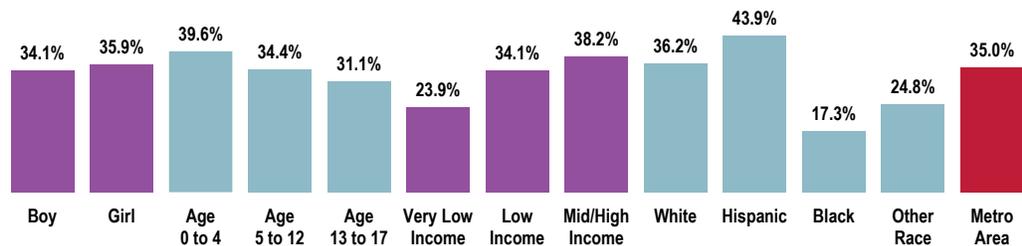
Healthy People 2030 Target = 42.4% or Higher



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 130]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2030, August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Was Exclusively Breastfed for at Least 6 Months (Metro Area, 2021)

Healthy People 2030 Target = 42.4% or Higher



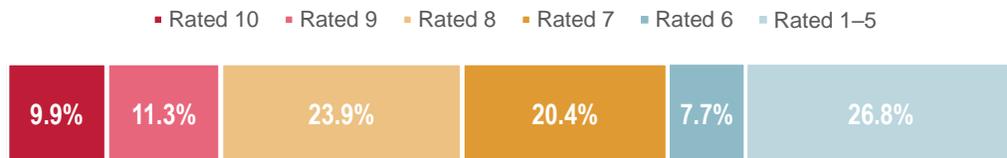
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 130]
 • US Department of Health and Human Services. Healthy People 2030, August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of all respondents about a randomly selected child in the household.



Key Informant Input: Infant Health

A plurality of key informants taking part in an online survey gave *Maternal, Prenatal, or Infant Health* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children in the community.

Perceptions of Maternal, Prenatal, or Infant Health as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Health Disparities

The data concerning maternal, prenatal and infant health indicate the disparities in health outcomes for black women and babies. Affordable, accessible, and culturally appropriate care is necessary to improve the numbers. – Other Health Provider

High rate of infant mortality in the black community. – Physician

Infant mortality in African-Americans is much greater than whites. Prevention is the key. – Physician

Infant mortality rates are rising and this disproportionately affects black infants. The black maternal mortality rate is nearly double that of other races. And, this is not an economic only concern. Black college graduates are far more likely to die in childbirth than white women on welfare. We have disparities in health in our community.

Supporting mothers and infants from birth is necessary to strengthen outcomes for all children. – Other Health Provider

Our black infant mortality rates rank among the worst in the nation. – Community Leader

Black women are most disproportionately affected with a maternal mortality rate of 37.1 deaths per 100,000 live births, compared to 14.7 deaths per 100,000 live births for white women and 11.8 deaths per 100,000 live births for Hispanic women. For the first time, a woman, in the USA is twice as likely to die from pregnancy related complications as her mother was a generation ago. Black women have to work seven extra months, just to earn the same pay as a male coworker. This is the reality for the majority of Black woman in the United States.

According to the U.S. Census, on average, Black women were paid 63% of what non-Hispanic white men were paid in 2019. That means it takes the typical Black woman 19 months to be paid what the average white man takes home in 12 months. – Community Leader

People of color continue to have higher rates of maternal and infant death, due to biases systemic to the healthcare system and our society. – Public Health Representative

Mostly concerned about black maternal health and the systemic racism that is baked into the health care field. We also need financial support for doulas for everyone. – Public Health Representative

Disparities need to be addressed. – Public Health Representative

Disparities in infant mortality and maternal mortality. – Community Leader

Disparities make Nebraska an unsafe place to be born. We have poor perinatal health outcomes. – Physician

Contributing Factors

Lack of prenatal and infant health access, service locations, lack of transportation, COVID-impacted individuals, and families' willingness to seek services when needed, as well as immigration concerns. – Public Health Representative

Moms need lots of support to foster a safe, healthy pregnancy, with even more help once the infant is born. A lack of safe housing, high cost of medical care and lack of paid maternity leave all contribute to the problem. – Public Health Representative



Increasing NICU rates, high maternal morbidity, lack of prenatal care caused by a myriad of other things, including, but not limited to, substance abuse, social determinants of health, lack of parenting preparedness, lack of family social supports, and isolation. – Community Leader

Awareness/Education

Due to a lack of education on the topic, many new parents do not know about safe sleep and medication safety. More resources in this area are critical. – Community Leader

Maternal/postpartum mental health needs are a huge need, especially now. New moms have been cut off from many celebrations and supports that they previously had access to and I frequently speak with moms who have no informal sources of support, at all. I think helping to develop the informal networks for moms is a major opportunity. Mom's health affects baby's health. Additionally, for moms who were provided with Medicaid during their pregnancy, that is normally removed after two-months postpartum, which I think affects the long-term health outcomes of the mom. – Other Health Provider

Vulnerable Populations

Some of our undocumented families do not feel comfortable with using maternal and prenatal services. – Community Leader

This has always been an issue in our area, particularly for underserved communities. With the pandemic, with the loss of the social, personal connections, and limited access to support services, I believe that there will be some poor outcomes for families. – Public Health Representative

Access to Care/Services

Non-existing or readily available and accessible. – Community Leader

Access to maternal and prenatal health is not always covered within typical insurance, or the extra costs for it are detrimental to families. This is one of the most important areas I see a need for. – Social Services Provider

Prevention/Screenings

Positive early childhood development has proven to have a positive impact on our youth. – Community Leader

We can prevent long-term and life-long issues if there is better engagement. – Other Health Provider

Co-Occurrences

Asthma and low birth weight. – Community Leader

Alcohol/Drug Use

Mortality is still high and substance abuse is a huge problem. – Physician





SOCIAL ENVIRONMENT INFLUENCES

PARENTING

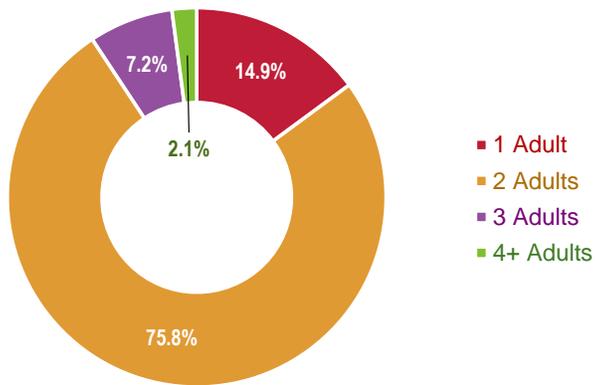
Household Adults Involved in Child's Care

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

A total of 14.9% of Metro Area children have just one adult in the household involved in their care.

Three in four (75.8%) Metro Area children have two household adults, while 9.3% have three or more household adults involved in their care.

Number of Household Adults Involved in Care of Child
(Metro Area Parents, 2021)

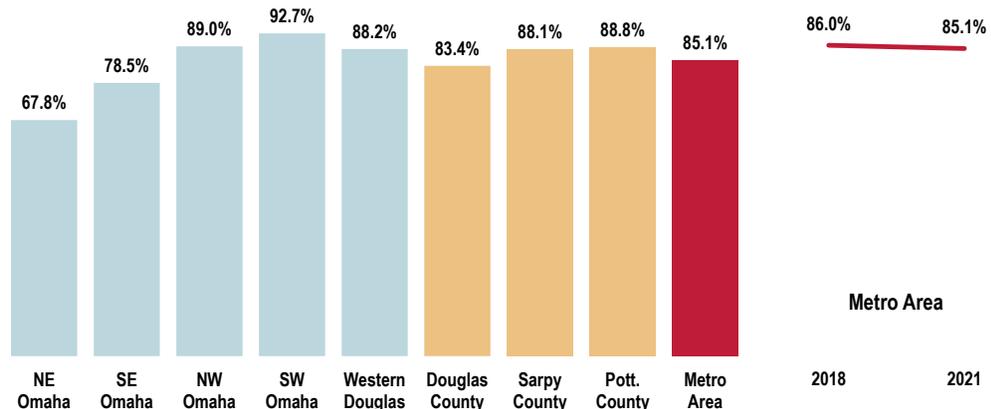


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 339]
Notes: • Asked of all respondents.

In total, 85.1% of area children have two or more household adults involved in their care.

DISPARITY ▶ Lowest in Douglas County (and especially Northeast Omaha). The prevalence decreases with child's age, increases with household income level, and is reported less often among parents of Black children.

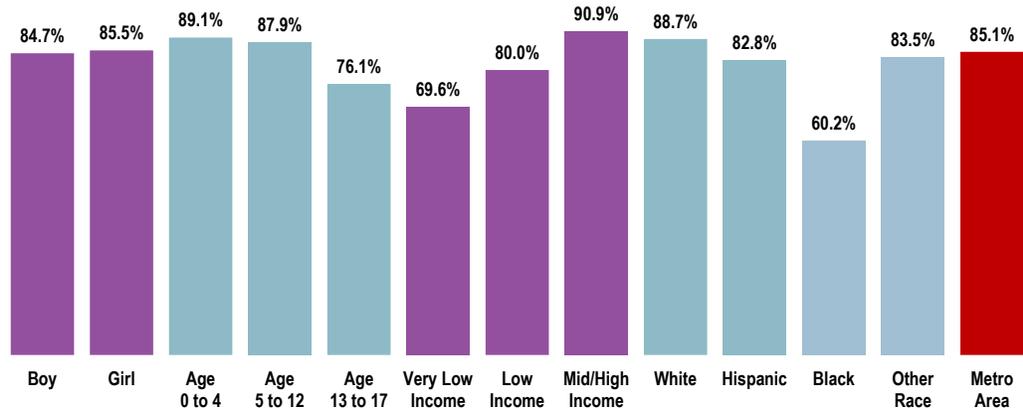
2+ Household Adults Involved in Child's Care
(Metro Area Parents, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 339]
Notes: • Asked of all respondents.



2+ Household Adults Involved in Child's Care (Metro Area Parents, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 339]
 Notes: • Asked of all respondents.



ADVERSE CHILDHOOD EXPERIENCES (ACEs)

ABOUT ACEs

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They are a significant risk factor for substance abuse disorders and can impact prevention efforts. ACEs include:

- Physical abuse or neglect
- Emotional abuse or neglect
- Sexual abuse
- Intimate partner violence
- Household substance misuse
- Household mental illness
- Parental separation/divorce
- Incarcerated household member

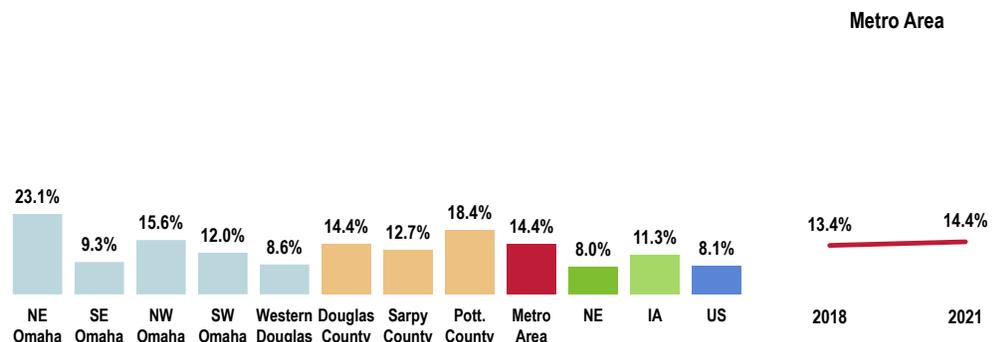
Exposure to Serious Mental Health Issues

A total of 14.4% of Metro Area parents report that their child has lived with someone with serious mental health issues.

BENCHMARK ► Worse than the state and national percentages.

DISPARITY ► Unfavorably high in Northeast Omaha. Reported more often among parents of girls, parents of children age 5 to 17, and those in lower-income households.

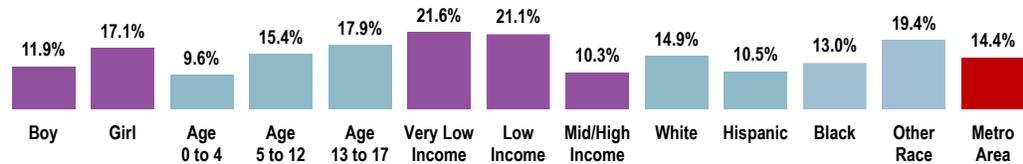
Child Ever Lived With Someone With Serious Mental Health Issues (Metro Area Children, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 322]
 Notes: • Asked of all respondents.
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.



Child Ever Lived With Someone With Serious Mental Health Issues (Metro Area Children, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 322]
Notes: • Asked of all respondents.

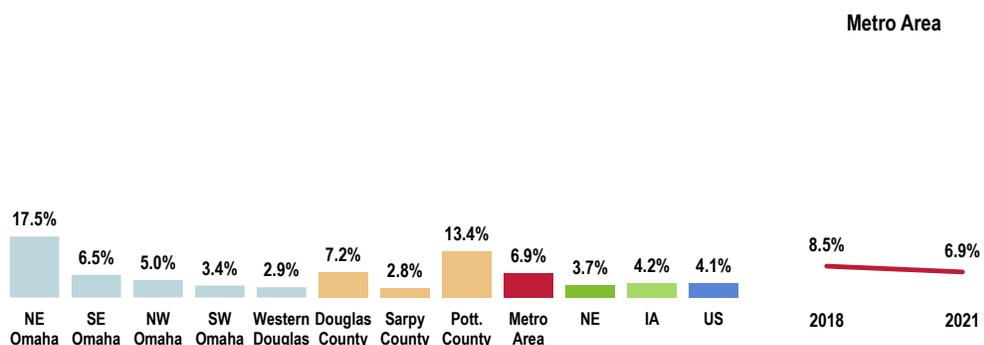
Exposure to Neighborhood Violence

A total of 6.9% of Metro Area parents report that their child has ever been exposed to violence in their neighborhood.

BENCHMARK ► Worse than both state figures as well as the US percentage.

DISPARITY ► Particularly high in Northeast Omaha and Pottawattamie County. Correlates with child's age and is reported more often among low-income households and non-Hispanic communities of color.

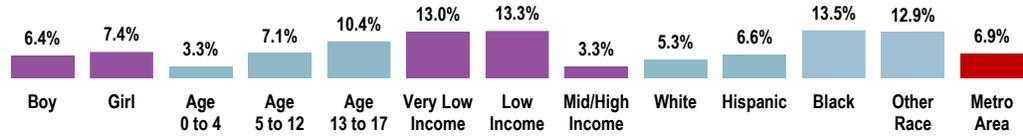
Child Ever Exposed to Neighborhood Violence (Metro Area Children, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: • Asked of all respondents.
• Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.



Child Ever Exposed to Neighborhood Violence (Metro Area Parents, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 312]
 Notes: • Asked of all respondents.



RESILIENCE FACTORS

Childhood Resilience

“How often does this child (age 5 and under) bounce back when things don’t go his/her way?”

A total of 84.8% of parents with children age 6 months to 5 years report that their child “always” or “usually” bounces back when things do not go his/her way.

- ▶ The remaining 15.2% of these children “sometimes” or “never” bounce back.

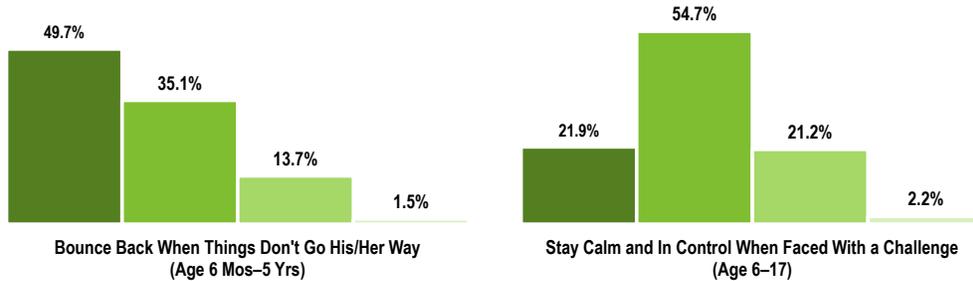
“How often does this child (age 6-17) stay calm and in control when faced with a challenge?”

For children age 6-17, 76.6% of parents report that they “always” or “usually” stay calm and in control when faced with a challenge.

- ▶ The remaining 23.4% of children in this age group “sometimes” or “never” stay calm when challenged.

How Often Does This Child ...
(Metro Area, 2021)

■ Always ■ Usually ■ Sometimes ■ Never

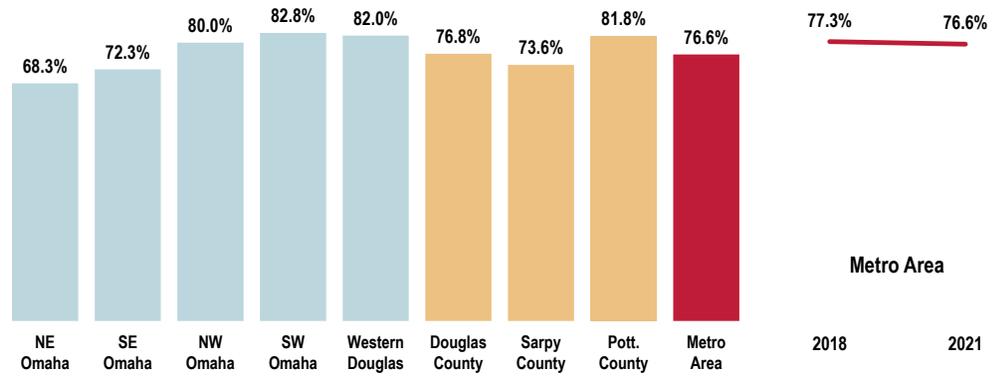


Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 317-318]
Notes: ● Asked of all respondents about a randomly selected child in the household.

DISPARITY ▶ For school-age children in Douglas County, the prevalence of those who “always/usually” stay calm when faced with a challenge is lowest in Northeast Omaha. Reported less often among those living just above the federal poverty level as well as non-White, non-Hispanic residents.

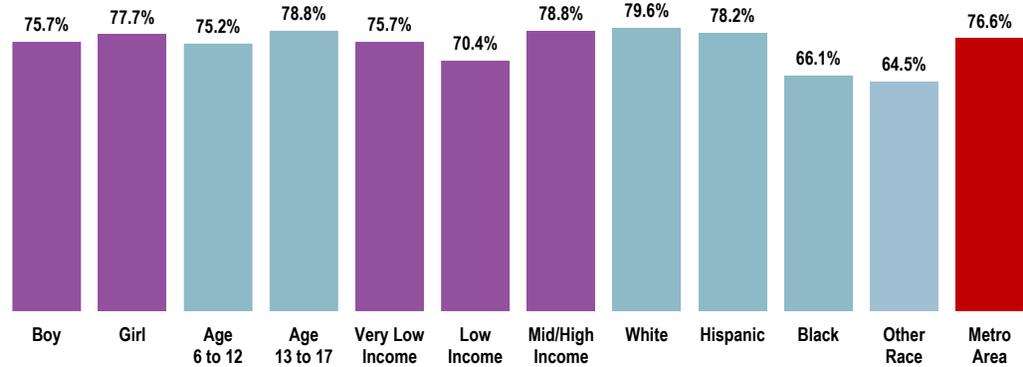


Child “Always/Usually” Stays Calm When Faced With a Challenge (Metro Area Children Age 6-17, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents.

Child “Always/Usually” Stays Calm When Faced With a Challenge (Metro Area Child Age 6-17, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents.



Adults Available for Advice/Guidance

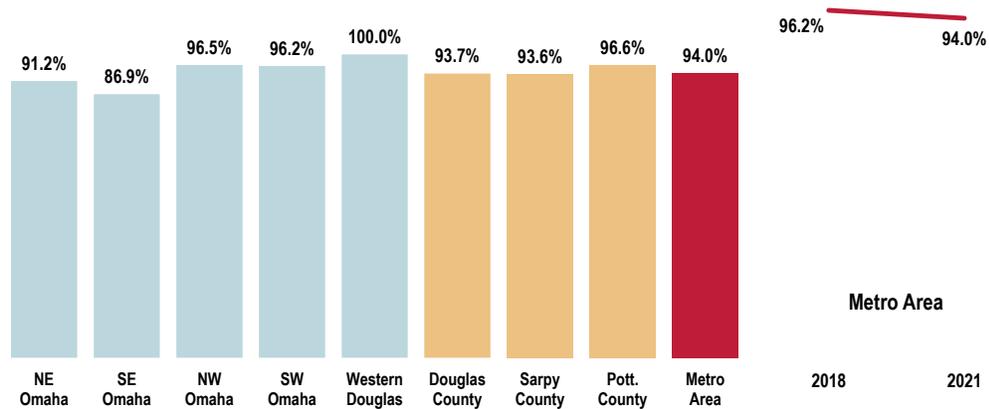
“Other than you or the other adults in your home, is there at least one other adult in this child’s school, neighborhood, or community who knows this child well and who he/she can rely on for advice or guidance?”

The vast majority (94.0%) of parents of school-age children in the Metro Area report that their child can rely on at least one adult outside the household for advice or guidance.

TREND ▶ Just below that reported in 2018.

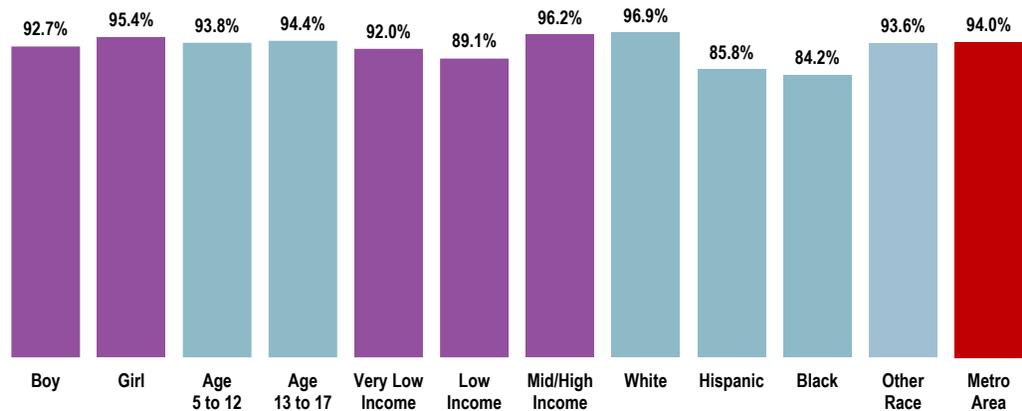
DISPARITY ▶ Lowest in Southeast Omaha. Reported less often in low-income households and among parents of Hispanic children and parents of Black children.

Child Has an Adult for Advice/Guidance (Outside Household)
(Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: • Asked of all respondents about a randomly selected child age 5-17 in the household.

Child Has an Adult for Advice/Guidance (Outside Household)
(Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: • Asked of all respondents about a randomly selected child age 5-17 in the household.



Family Resilience

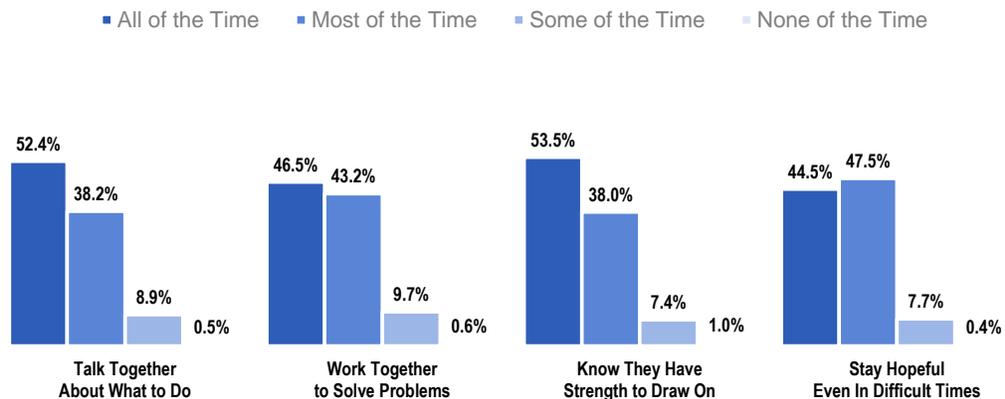
Parents were asked a series of questions related to family resilience, including how often the family:

- ▶ Talks together about what to do;
- ▶ Works together to solve problems;
- ▶ Knows they have strength to draw on; and;
- ▶ Stays hopeful even in difficult times.

For each question, most parents responded that the family does these things “all of the time” or “most of the time.”

“When your family faces problems, how often are you likely to do each of the following? Would you say: all of the time, most of the time, some of the time, or none of the time?”

Family Resilience (Metro Area, 2021)



Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 334-337]
 Notes: ● Asked of all respondents about a randomly selected child in the household.

BENCHMARK ▶ The Metro Area percentages of families who **work together** to solve problems and those who **stay hopeful** in difficult times are well below the national benchmarks (and state benchmarks for staying hopeful).

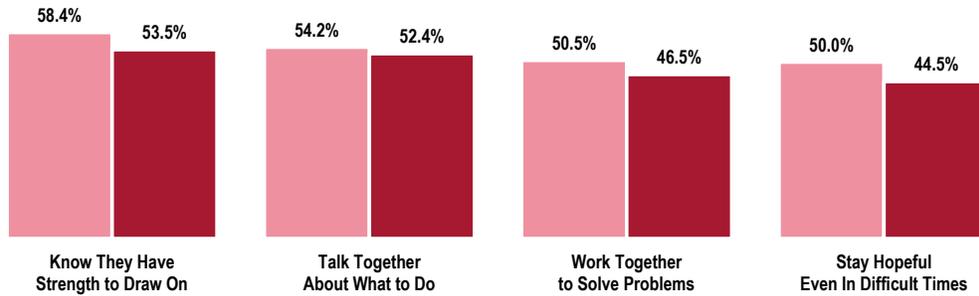
TREND ▶ Since 2018, the percentages of parents who gave “all of the time” responses about **family strength** and **family hope** have decreased significantly.

DISPARITY ▶ Parents in Northeast Omaha gave the lowest share of “always” responses for families working together and staying hopeful (those in Pottawattamie County gave even lower responses for staying hopeful).



Trends in Family Resilience: “All of the Time” Responses (Metro Area, 2021)

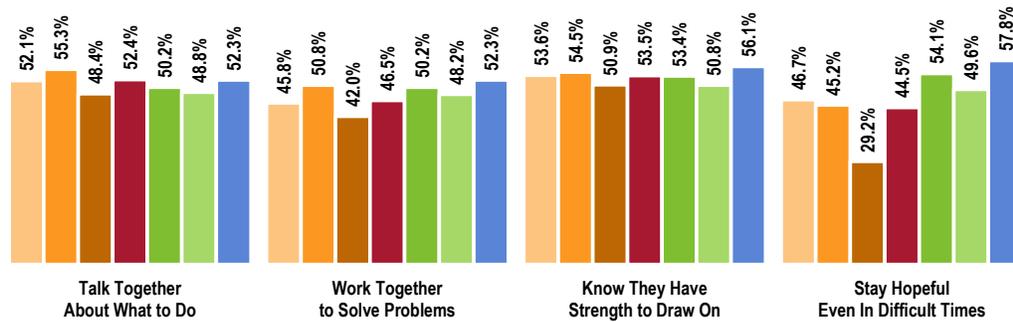
■ Metro Area 2018 ■ Metro Area 2021



Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 334-337]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Family Resilience: “All of the Time” Responses (Metro Area, 2021)

■ Douglas County ■ Sarpy County ■ Pott. County ■ Metro Area ■ NE ■ IA ■ US



Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 334-337]
Notes: ● Asked of all respondents about a randomly selected child in the household.
● Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children’s Health (NSCH) data query, Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration’s Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.



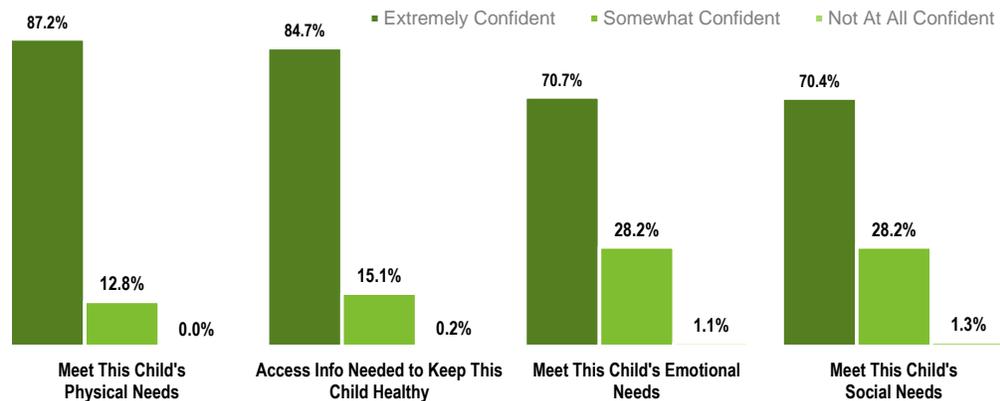
Meeting Child's Needs

Parents were asked a series of questions related to meeting their child's needs, including how confident the parent is:

- ▶ Accessing the information they need to keep their child healthy;
- ▶ Meeting their child's emotional needs;
- ▶ Meeting their child's physical needs; and;
- ▶ Meeting their child's social needs.

Responses ranged from 70.4% being “extremely confident” about meeting their child's social needs to 87.2% feeling “extremely confident” in meeting the child's physical needs.

Parent's Confidence In Ability to ... (Metro Area, 2021)



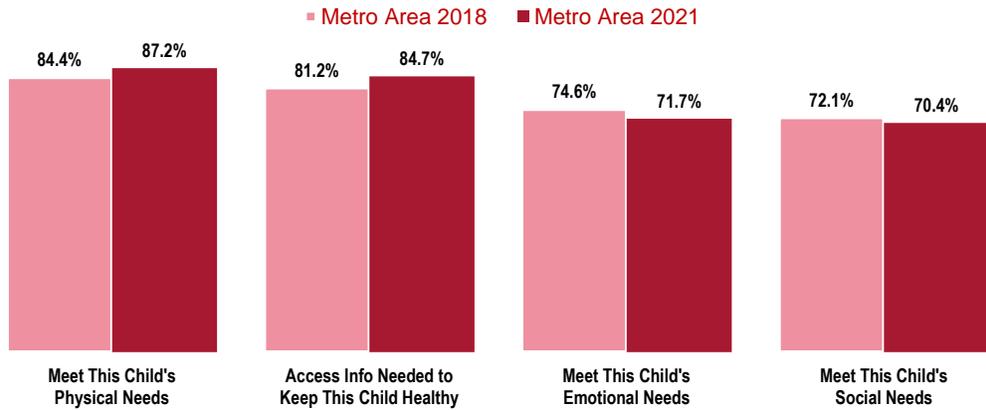
Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 330-333]
Notes: ● Asked of all respondents about a randomly selected child in the household.

TREND ▶ Parental confidence in **accessing information** to keep their child healthy has increased significantly since 2018.

DISPARITY ▶ Parents in eastern Omaha and those in Sarpy County were least likely to express confidence in meeting their child's **physical needs**. Those in Douglas County (especially Southeast Omaha) were least likely to feel confident about **accessing health information**, and Northeast Omaha parents gave the lowest rating of confidence in meeting their child's **emotional needs**.

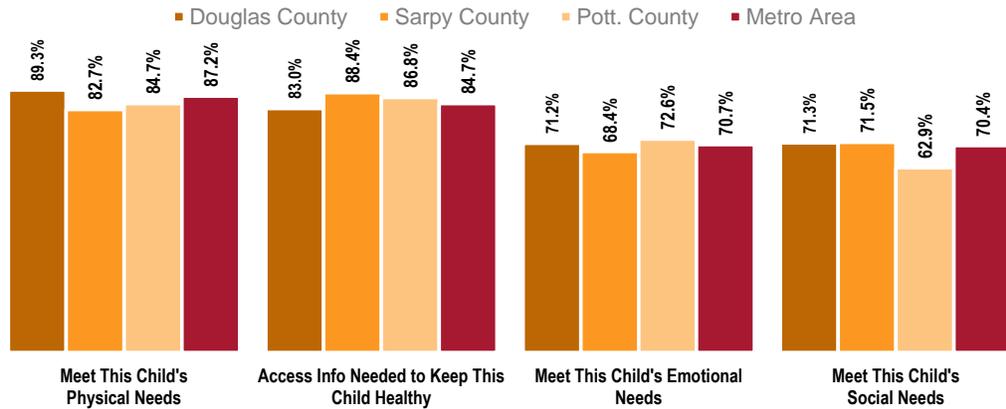


Trends: Parent “Extremely” Confident In Ability to ... (Metro Area, 2021)



Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 330-333]
 Notes: ● Asked of all respondents about a randomly selected child in the household.

Parent “Extremely” Confident In Ability to ... (Metro Area, 2021)



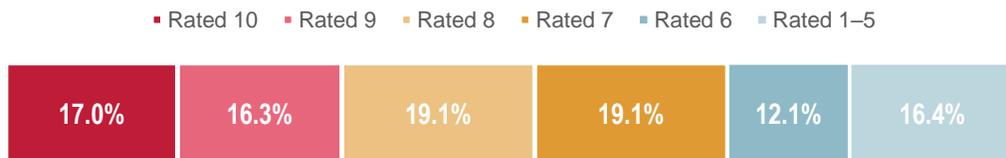
Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 330-333]
 Notes: ● Asked of all respondents about a randomly selected child in the household.



Key Informant Input: Lack of Parenting Education/Readiness

A plurality of key informants taking part in an online survey gave *Lack of Parenting Education/Readiness* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of a Lack of Parenting Education/Readiness as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Awareness/Education

Parents aren't educated and it is hard to try to help with homework with all of this virtual teaching. It has been very hard on some parents. Plus, they have to work, and children are left on their own. – Social Services Provider

Raising children at this point of history is unlike anything past generations have faced. Most parents cannot use the guidance of their parents or grandparents. – Physician

Many parents lack the knowledge of household routines that are of benefit and those of detriment to their child. – Physician

We have about 8,000 opportunity youth in our community. These young adults age 16 to 24 who are disconnected from school, work or family. A pretty high percentage of these young adults have children of their own. We generally leave to parent from our parents—if this group is disconnected from their parents how will they learn to be good parents. – Community Leader

Many parenting programs are focused on certain populations, teen parents for example. Universal parenting education would be ideal. – Community Leader

We have no standard parenting education available to all community members. This type of education is very important for prevention of mental health issues and abuse. – Physician

This is an ongoing issue and some of the families who likely needed education and support were also folks who were front line workers and/or folks with limited internet access, so they were likely not benefiting from any existing support options during the pandemic. – Public Health Representative

We want parents and families to be held accountable, but our system actually keeps them out. I am not sure of all the reasons, but it seems like parents today do not have an idea of how to parent thus causing children to not be ready for school. This carries on through adolescents. We need more willingness for our systems to engage and welcome in parents. – Public Health Representative

I don't believe it is totally lacking. One learns as they go, providing for children and changes in adolescents. – Community Leader

Many parents are clearly not prepared for the sacrifices necessary to care for children. Children are frequently perceived as a commodity—when a child doesn't fit a parent's world he or she gets left behind or left out. Many individuals thrust into parenthood through irresponsible sexual behavior experienced a lack of good parenting examples in their own lives. The problems snowball generationally. Childhood neglect by self-centered parents leads to loneliness, obesity, emotional underdevelopment, over-stimulation from video games and technology, and attachment issues that permeate every relationship in an affected child's life. – Community Leader

I work in the school systems and children's behaviors are becoming more and more violent. It is evident that parents aren't educated for how to handle their children and get them ready for school. – Community Leader

Awareness is the first step to prevention. You don't know what you don't know. – Other Health Provider



Parents of all backgrounds continue to request more parenting education and support. – Community Leader

Readiness is a major issue because it is connected to grade level reading, graduation, & life success. Students come to kindergarten classrooms & are, literally, unable to take a seat or take a turn. For all too many their young lives have been chaotic & without structure. For some, there have not been positive interactions with adults including calm conversation, reading to/with, listening, seeing new things, feeling safe. Incidents in adolescents increase when students are not on grade level for reading because they cannot read the materials. Parents are doing the best that they can with what they know, but it does not seem that there is a community wide understanding of the crucial importance of pre-birth to five. Research supports parenting education & working with communities to increase awareness, understanding, & practice of good parenting. Supports exist, but the most important people with regard to reading, behaviors, staying in school, being on grade level are the parents. – Social Services Provider

I think that many parents were raised in households that didn't have a lot of knowledge about parenting strategies and techniques. When those parents have children, that lack of knowledge is present—by expanding parenting supports and educational opportunities, it will create healthier families. – Other Health Provider

Again, a large portion of parents don't have the skills to raise children. They are allowing devices and teachers to raise their children. Parents don't know how to discipline children, therefore don't. – Community Leader

Many parents lack the navigation and advocacy skills for our community's educational, health care and support systems. Silos created between agencies, sectors and services only complicate a parent's ability to provide the care and services needed by children. – Community Leader

Parental Support/Influence

I see parents struggle with providing positive influences of life and living education for their children in the environment where I work. – Other Health Provider

I have relatives and friends in the education sector. I hear stories everyday of children left to fend for themselves and no parental interaction with schools. – Other Health Provider

Adolescents out of control and parents routinely in need of help with their students. Parents making the choice of not parenting as children are in trouble in school and in the community. – Community Leader

The family unit is the primary unit in society. That means that parents need to parent well and that includes education. Parenting must include both a commitment to parenting, but also requires skills. Good intentions alone does not guarantee success in parenting. – Community Leader

We see issues with youth that tie back to the parents' abilities. – Other Health Provider

Parent support is always an issue when they have to work two to three jobs to put food on the table and stay in survival crisis mode. Again, all the social determinants of health are at play here. – Public Health Representative

Generational

It's a generational challenge. It leads to raising young people who aren't prepared for life in a healthy way. – Social Services Provider

Parenting is hard and many of the families did not have a good example to follow. Helping parents as early as possible, before their child is even born, allows them to gain the skills they needs to set their child up for success. – Community Leader

People tend to parent the way they were parented, even if they don't want to, due to lack of information on better ways to parent. This includes not knowing how to prepare their children for school, so children are behind when they start school. – Other Health Provider

Contributing Factors

This has been a problem for some time. I feel that many young people are having children and more and more grandparents are raising them. I have also worked with families that struggle with untreated mental health and substance abuse, using together. The lack of parenting from one generation to another. – Social Services Provider

Many parents, biological and foster, are struggling with their own mental health, in addition to understanding how to support their children. – Other Health Provider

Many parents have challenges that prevent them from participating in opportunities to learn the importance of parenting. Generational challenges, early parenting, cost, availability, cultural appropriateness are all challenges in creating a system of prevention and education to those who are or wish to become parents. – Other Health Provider

Many moral decisions play into pregnancy and childbirth and everyone should make their own choice when it comes to these decisions, but often there are not supports in place to help young parents, parents with developmental disabilities, families in poverty, etc. to understand child development and the magnitude of the responsibilities they will be undertaking. – Other Health Provider



Teen Pregnancy

Too many children having children, the cycle just repeats through the generations. If the parent lacked good parenting skills, then their offspring continue the same types of behavior. – Public Health Representative

Many parents become pregnant while very young and do not seem ready to have children. This results in children being brought up in suboptimal conditions, which often places them at a disadvantage as they progress through life. – Physician

Lots of kids are becoming parents. These kids were never parented and this leads to a cycle that we see with this population. Also, lots of parents work and have no time to parent. – Other Health Provider

Denial/Stigma

Resistance, not being involved in the process results in unwillingness to work with providers. – Social Services Provider

Lack of Trust Between Parents and Schools

Building trust between schools and parents is a challenge, especially if the parent didn't have a good school experience growing up. Many resources, like Parent University, aren't offered in West Omaha. – Community Leader





SOCIAL DETERMINANTS OF HEALTH

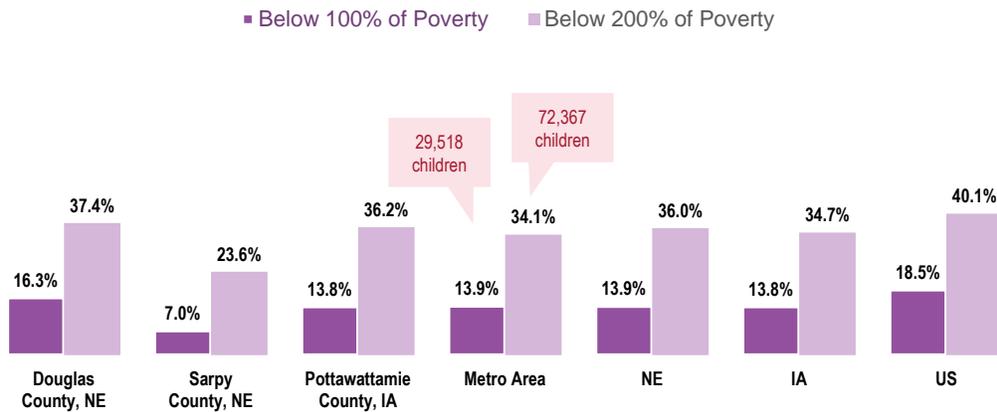
POVERTY

The latest census estimate shows 13.9% of Metro Area children living below the federal poverty level, and 34.1% living below 200% of poverty.

BENCHMARK ▶ The percentage of those living below 200% of poverty is lower than the Nebraska and US percentages.

DISPARITY ▶ Lowest in Sarpy County.

Percent of Children in Low-Income Households
(Children 0-17 Living Below 100% and Below 200% of the Poverty Level, 2015-2019)

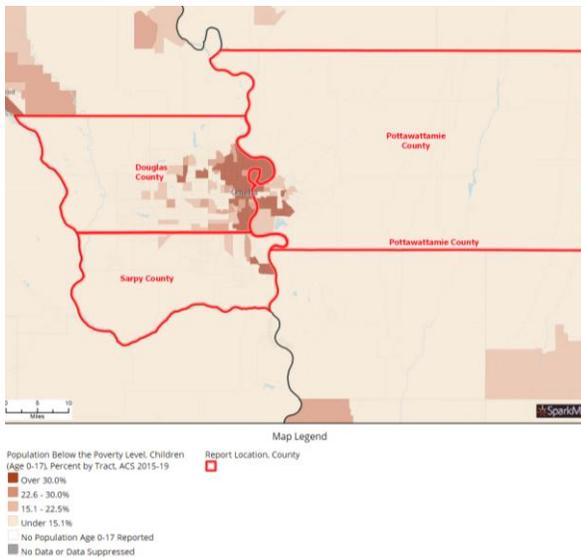


Sources:

- US Census Bureau American Community Survey, 5-year data (2015-2019).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).

Notes:

- This indicator reports the percentage of children aged 0-17 living in households with income below 100% and 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.



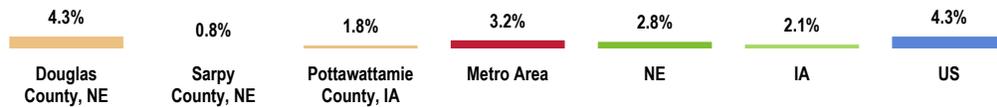
LINGUISTIC ISOLATION

A total of 3.2% 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”).

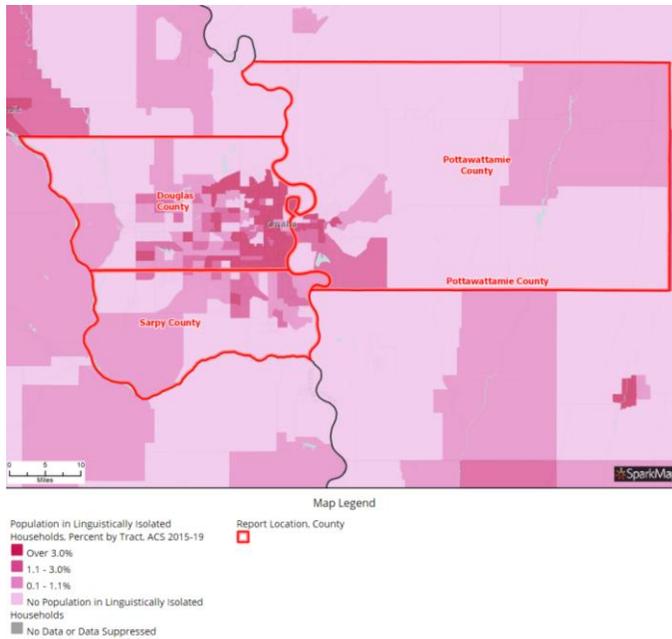
BENCHMARK ▶ Higher than the Nebraska and Iowa percentages but lower than the US figure.

DISPARITY ▶ Unfavorably high in Douglas County.

Linguistically Isolated Population (2015-2019)



- Sources:
- US Census Bureau American Community Survey, 5-year data (2015-2019).
 - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.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."



FINANCIAL RESILIENCE

Respondents were asked: "Suppose that you have an emergency expense that costs \$400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

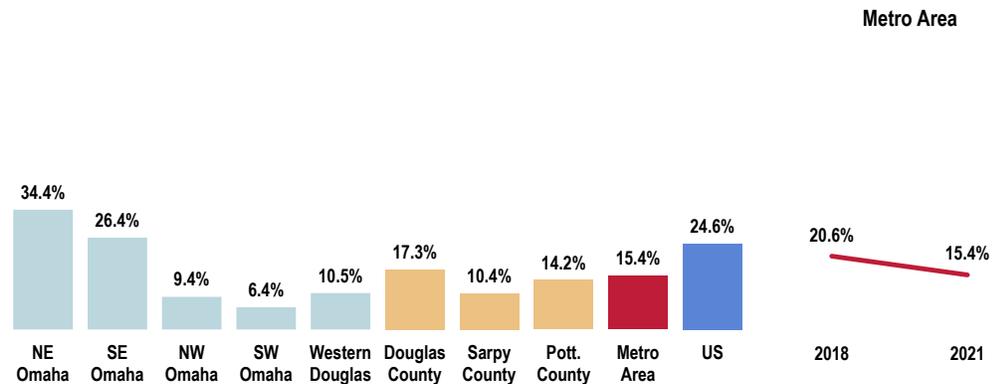
A total of 15.4% of Metro Area parents would not be able to afford an unexpected \$400 expense without going into debt.

BENCHMARK ▶ Well below the US prevalence.

TREND ▶ Improving since 2018.

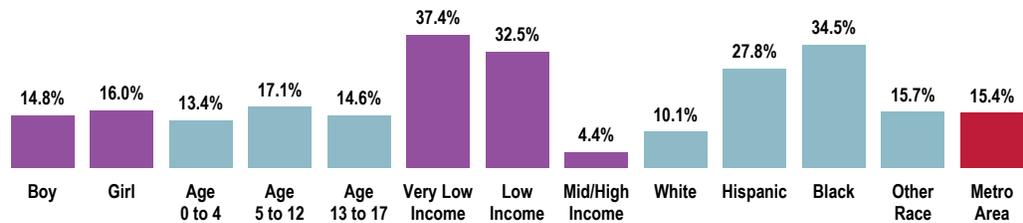
DISPARITY ▶ Unfavorably high in Douglas County (especially eastern Omaha). Reported more often among those in low- and very low-income households as well as parents of Hispanic children and parents of Black children.

Do Not Have Cash on Hand to Cover a \$400 Emergency Expense



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 342]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • Includes respondents who say they would not be able to pay for a \$400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Do Not Have Cash on Hand to Cover a \$400 Emergency Expense (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 342]
 Notes: • Asked of all respondents.
 • Includes respondents who say they would not be able to pay for a \$400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.



DIFFICULTY ACCESSING FRESH PRODUCE

While most report little or no difficulty, 17.4% of Metro Area parents report that it is “very” or “somewhat” difficult for them to access affordable fresh fruits and vegetables.

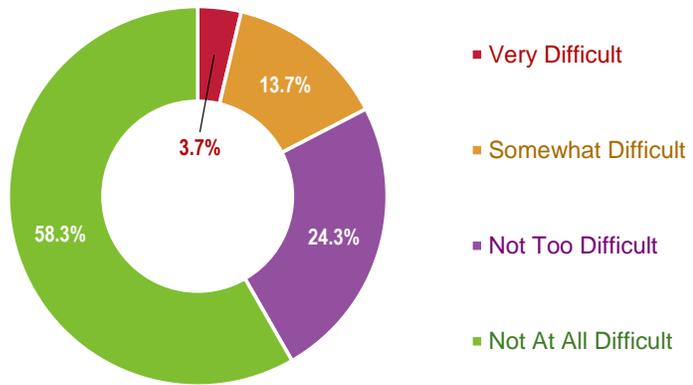
“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford?”

BENCHMARK ▶ Lower than the national prevalence.

TREND ▶ Improving significantly since 2015.

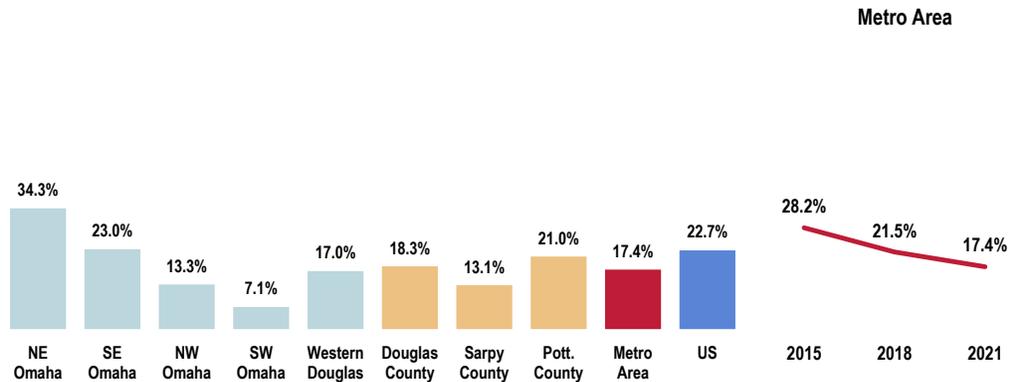
DISPARITY ▶ Unfavorably high in Northeast Omaha. The prevalence correlates with age and household income level and is reported more often among parents of Hispanic children and Black children.

Level of Difficulty Finding Fresh Produce at an Affordable Price
(Metro Area Parents, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 112]
Notes: • Asked of all respondents.

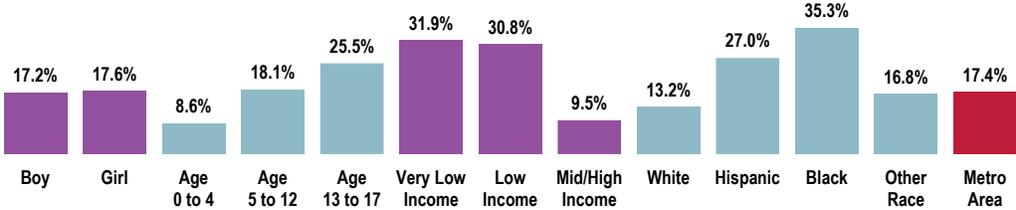
Find It “Very” or “Somewhat”
Difficult to Buy Affordable Fresh Produce
(Metro Area Parents, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 112]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.



Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Metro Area Parents, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 112]
 Notes: • Asked of all respondents.

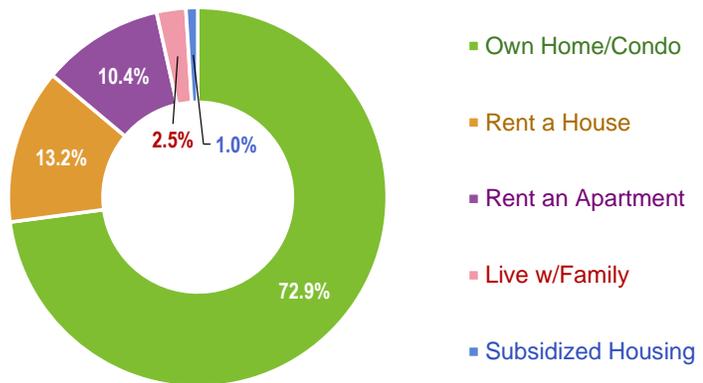


LIVING CONDITIONS & SAFE SPACES

Current Living Situation

Asked to describe their current living situation, most respondents (72.9%) own a home or condo and 23.6% rent a house or apartment. The remaining respondents live with family or in subsidized housing.

Housing Situation
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 121]
Notes: • Asked of all respondents.

Exposure to Environmental Tobacco Smoke

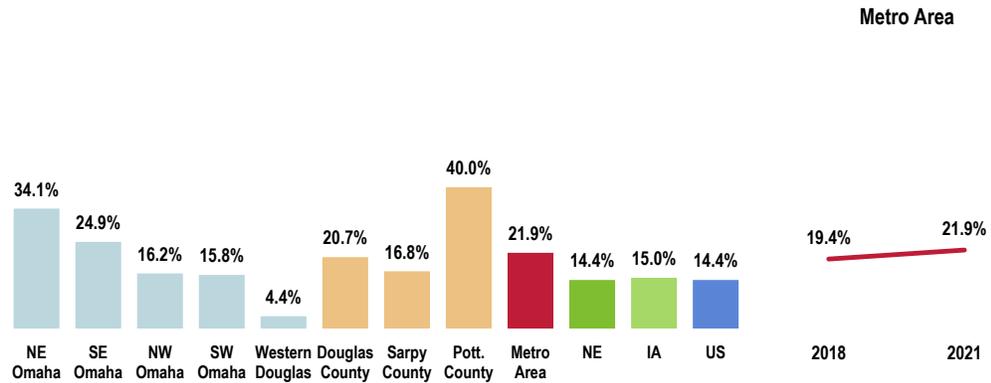
A total of 21.9% of Metro Area parents report that someone in the household smokes inside the home (even occasionally).

BENCHMARK ► Much higher than state and national percentages.

DISPARITY ► Unfavorably high in Northeast Omaha and Pottawattamie County. The prevalence decreases with household income level and is reported more often among parents of children age 5-17 and those in non-Black, non-Hispanic communities of color.



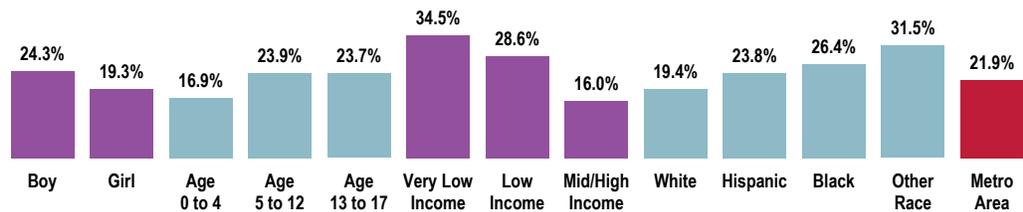
Someone In the Household Smokes (Even Occasionally) (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 325]
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes: • Asked of all respondents.

Someone In the Household Smokes (Even Occasionally) (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 325]
 Notes: • Asked of all respondents.



Unhealthy or Unsafe Housing

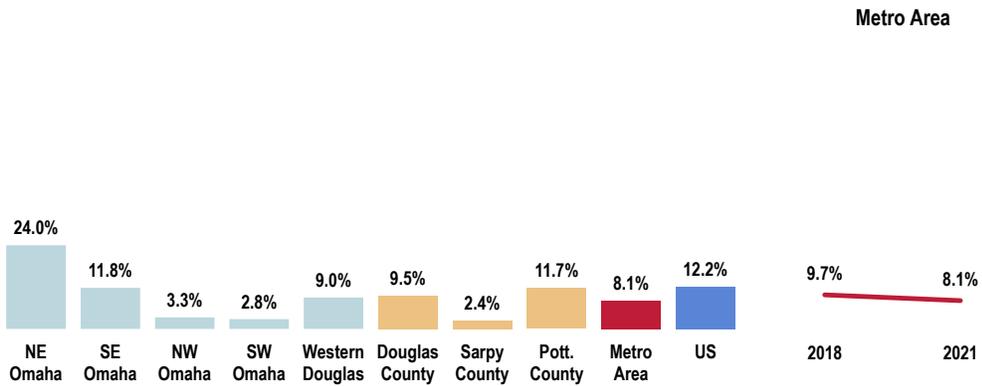
Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

A total of 8.1% of Metro Area residents report living in unhealthy or unsafe housing conditions during the past year.

BENCHMARK ▶ Lower than the national prevalence.

DISPARITY ▶ Statistically highest in Douglas County (especially Northeast Omaha). Reported more often among respondents in low-income households and parents of Hispanic children and Black children, as well as renters.

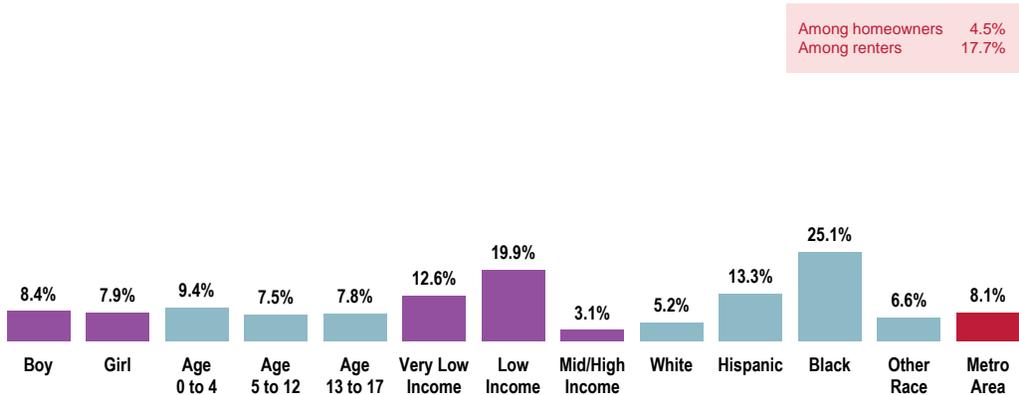
Unhealthy or Unsafe Housing Conditions in the Past Year



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 341]
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 341]

Notes: • Asked of all respondents.
• Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.



Neighborhood Blight

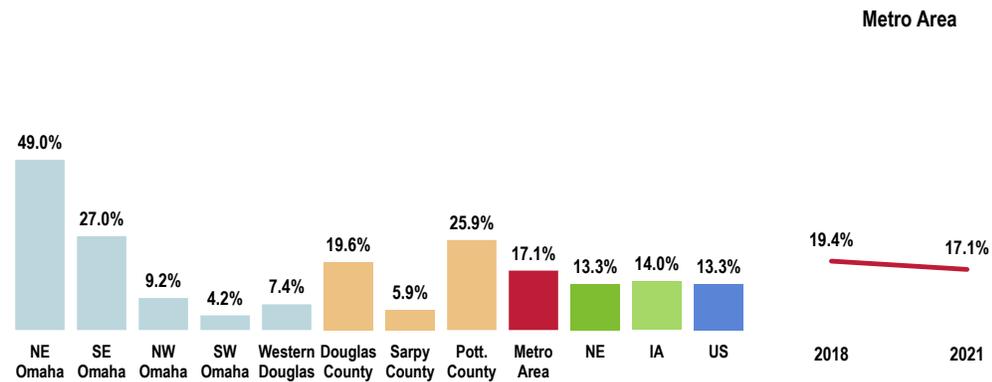
Rundown Housing

A total of 17.1% of Metro Area residents say that they live in a neighborhood with poorly kept or rundown housing.

BENCHMARK ▶ Well above the state and national percentages.

DISPARITY ▶ Highest in Pottawattamie County and in Douglas County (especially eastern Omaha).

Neighborhood Has Poorly Kept or Rundown Housing



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 315]
 Notes: • Asked of all respondents.
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.

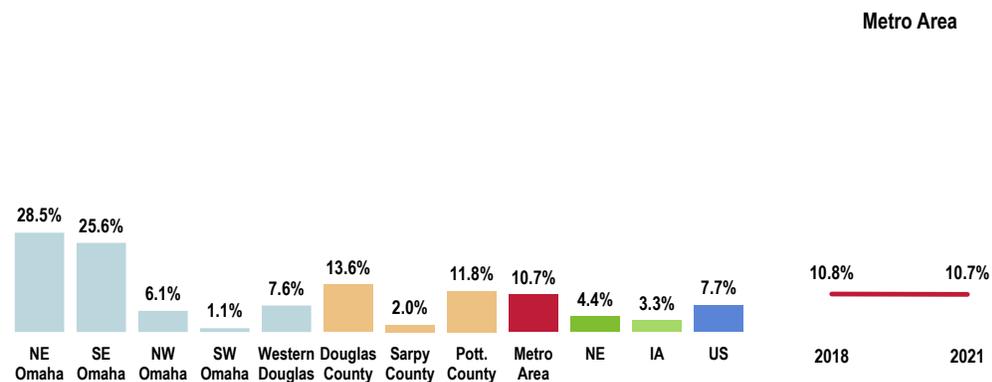
Vandalism

Among survey respondents, 10.7% report living in a neighborhood with signs of vandalism.

BENCHMARK ▶ Well above the state and national figures.

DISPARITY ▶ Highest in Douglas County (especially eastern Omaha).

Neighborhood Has Signs of Vandalism



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 316]
 Notes: • Asked of all respondents.
 • Signs of vandalism include things like broken windows or graffiti.
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.

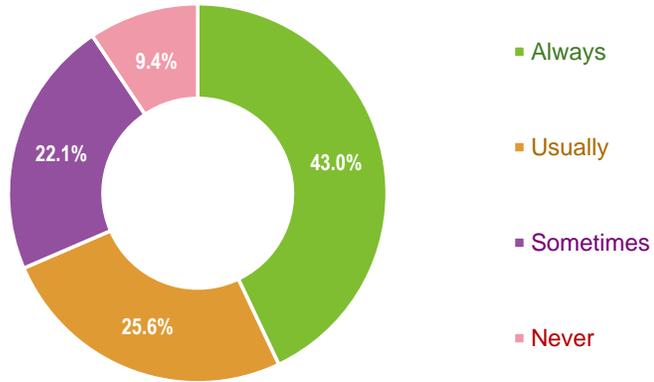


Playgrounds & Parks

Respondents were asked: "How often do children play in playgrounds or parks in your neighborhood?"

Just over two in three (68.6%) survey respondents report that children "always" or "usually" use playgrounds or parks in the neighborhood.

Child's Use of Neighborhood Playgrounds/Parks (Metro Area, 2021)

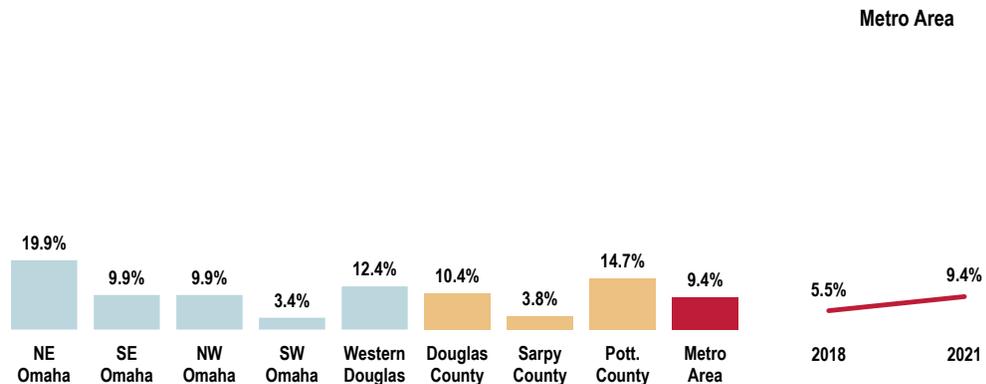


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 314]
 Notes: • Asked of all respondents.

TREND ► The prevalence of those whose child "never" uses playgrounds or parks in the neighborhood has increased significantly since 2018.

DISPARITY ► Unfavorably high in Northeast Omaha and Pottawattamie County. Reported more often among low-income households and parents of Hispanic children and Black children.

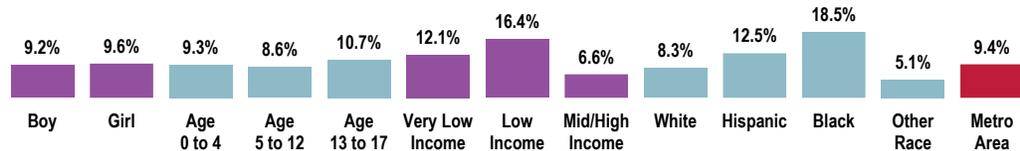
Child "Never" Uses Neighborhood Playgrounds/Parks (Metro Area Children Under 18)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 314]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Child “Never” Uses Neighborhood Playgrounds/Parks (Metro Area Children Under 18)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 314]
Notes: • Asked of all respondents.

Key Informant Input: Lack of Safe, Healthy Spaces

A plurality of key informants taking part in an online survey gave *Lack of Safe/Healthy Spaces* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of a Lack of Safe, Healthy Spaces as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)

■ Rated 10 ■ Rated 9 ■ Rated 8 ■ Rated 7 ■ Rated 6 ■ Rated 1–5



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Housing

In my experience, working with low income families, there is a lack of safe and healthy housing and play spaces in the neighborhoods where they are able to access affordable housing. – Community Leader

Environmental health: it’s part of other topics, but actually having green spaces as well as a way to get to them is important to people, especially children. Safe housing in terms of clean air, lead-free building materials, and pest free (rodents, roaches, bed bugs, etc.) is a major factor in child development. – Other Health Provider

Parents and families report the presence of unhealthy living spaces, such as a leaking roof, rodents, cockroaches, dysfunctional heating and cooling in their homes. – Other Health Provider

Safe and healthy places are where children can grow and not be victims. – Community Leader



Affordable housing and evictions are creating unstable environments for children and families, essentially deteriorating the strong foundations and security we know children and adolescents need to thrive. We know housing is a basic need and when it is not met, or when families are faced with losing their housing, stress increases and attention is diverted to survival and immediate needs rather than prevention and engaging with community resources and supports. – Community Leader

Safe and affordable, quality housing is a problem for all of Omaha. When you can only afford a tiny apartment in a "dangerous" neighborhood, guardians may not feel safe allowing their children to play outside—even IF a playground or park was within walking distance, which it all too often isn't. Immigrants and refugees may not know about youth programs with positive activities in their neighborhood, let alone how to access and pay for them. Transportation to youth programs can be an issue, as well as paying for uniforms and equipment, etc. So kids get stuck inside on their phones, computers, TVs, etc. – Social Services Provider

Housing constantly comes up as a primary stressor for families. They can't afford their current housing, their current housing doesn't meet the family's needs, they can't afford to move to a new apartment. Low-income and income-controlled housing developments needs to be a priority for all cities in the Omaha metro. – Other Health Provider

Among our children living in poverty, the availability of healthy, affordable housing is extremely limited. Great efforts are underway in the community to address the issue; however, resources are limited to families and their landlords for improving home environments and mitigation of hazards in the home. – Community Leader

Safe, affordable quality housing is a MAJOR issue in our region. Youth spend most of their time in their homes and neighborhoods. We need to recognize that this affects everything else, from foods they eat, how well they sleep, the social connections they make, to whether they show up to school ready to learn. – Public Health Representative

Affordable safe housing has become a big issue in our community. Parks have become unsafe for children, small amusement parks no longer exist, indoor activities are costly. – Social Services Provider

Poor housing conditions and lack of jobs. – Social Services Provider

Built Environment

There are not places for our young people to go in our community that are not tied to a school or income or transportation. – Social Services Provider

Safe, fun, educational spaces like the zoo or children's museum are expensive and make it hard to access. – Other Health Provider

We don't have enough safe spaces that build self-worth, that families can afford to send their children to. The safe spaces the children want to attend are at capacity. – Community Leader

There are always barriers involved to get to or into locations that are safe for them. – Community Leader

Many youth report that they don't believe they have safe and healthy spaces to go or events to attend. – Community Leader

There are neighborhoods that do not have safe and healthy spaces to play or even walk. – Community Leader

Safety is key in the promotion of healthy spaces for all. – Public Health Representative

Urban communities are challenged to find safe and healthy spaces because there is no master plan to intentionally address the need for these types of facilities or businesses. – Other Health Provider

We are starting to see more safe places in the city for kids to participate in, but we have a ways to go. – Other Health Provider

So many kids are latch-key kids, spending time by themselves with devices unsupervised. There has to be safe spaces for kids during these times that engages them. – Community Leader

Not available throughout city. – Other Health Provider

Some neighborhoods in Omaha are not safe for children and adolescents. Some parks are not complete parks. In North and South Omaha, where can you walk? where are the trails that you can walk that don't require a car to get there? – Community Leader

Many adolescents and children live in areas that do not feel safe to them which increases their stress and decreases the time they spend outside. Even if there is a park nearby, families sometimes do not feel safe using it. Many families live in substandard housing due to lack of money for a better place or lack of residential status which makes them hesitant to complain. – Other Health Provider

COVID-19

Cases of abuse are increasing, especially following COVID-19. Kids don't have safe places to live. – Community Leader

Restrictions during the pandemic have limited access to safe and healthy places, such as the YMCA, Kroc Center, and schools. – Other Health Provider



Contributing Factors

Same issues of unsafe communities, bullying and not enough parents being parents. – Public Health Representative

Systemic Racism

Environmental racism and lack of city government understanding equitable distribution of resources. – Public Health Representative

Incidence/Prevalence

This is an ongoing issue in the community. – Public Health Representative

Self-Actualization

It's the foundation for self-actualization. – Social Services Provider



INJURY & SAFETY

ABOUT VIOLENCE & SAFETY

Most violence against children involves at least one of six main types of interpersonal violence that tend to occur at different stages in a child's development.

- **Maltreatment** (including violent punishment) involves physical, sexual and psychological/emotional violence; and neglect of infants, children and adolescents by parents, caregivers and other authority figures, most often in the home but also in settings such as schools
- **Bullying** (including cyber-bullying) is unwanted aggressive behavior by another child or group of children who are neither siblings nor in a romantic relationship with the victim. It involves repeated physical, psychological or social harm, and often takes place in schools and other settings where children gather, and online.
- **Youth violence** is concentrated among children and young adults aged 10–29 years, occurs most often in community settings between acquaintances and strangers, includes bullying and physical assault with or without weapons (such as guns and knives), and may involve gang violence.
- **Intimate partner violence** (or domestic violence) involves physical, sexual and emotional violence by an intimate partner or ex-partner. Although males can also be victims, intimate partner violence disproportionately affects females. It commonly occurs against girls within child marriages and early/forced marriages. Among romantically involved but unmarried adolescents it is sometimes called "dating violence".
- **Sexual violence** includes non-consensual completed or attempted sexual contact and acts of a sexual nature not involving contact (such as voyeurism or sexual harassment); acts of sexual trafficking committed against someone who is unable to consent or refuse; and online exploitation.
- **Emotional or psychological violence** includes restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment.

When directed against girls or boys because of their biological sex or gender identity, any of these types of violence can also constitute gender-based violence.

Violence against children has lifelong impacts on health and well-being of children, families, communities, and nations. Violence against children can:

- Result in death
- Lead to severe injuries
- Impair brain and nervous system development
- Result in negative coping and health risk behaviors
- Lead to unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV
- Contribute to a wide range of non-communicable diseases as children grow older (e.g., cardiovascular disease, cancer, diabetes) due to the negative coping and health risk behaviors associated with violence
- Impact opportunities and future generations

Violence against children can be prevented. Preventing and responding to violence against children requires that efforts systematically address risk and protective factors at all four interrelated levels of risk (individual, relationship, community, society).

- World Health Organization (<https://www.who.int/news-room/fact-sheets/detail/violence-against-children>)



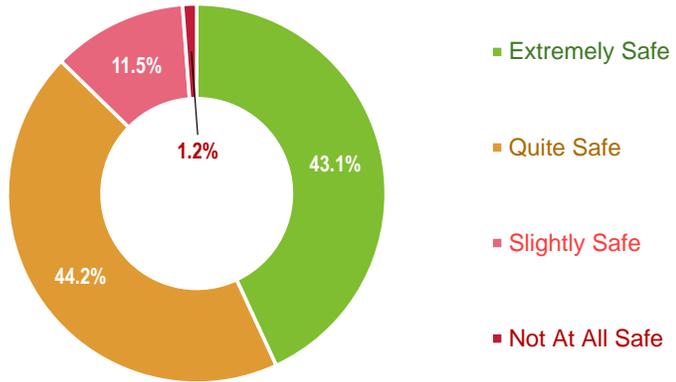
Violence & Safety

Neighborhood Safety

While most Metro Area families live in “extremely safe” or “quite safe” neighborhoods, 12.7% of parents live in neighborhoods they consider only “slightly safe” or “not at all safe.”

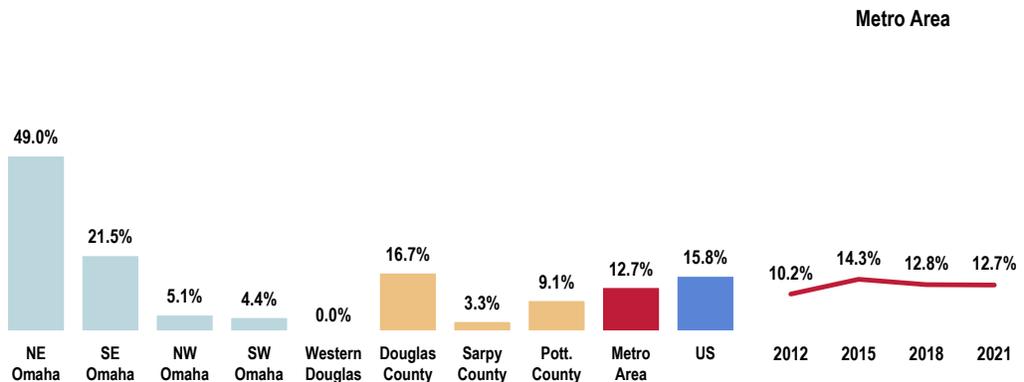
DISPARITY ► Highest in Douglas County (especially Northeast Omaha). Reported more often among those in lower-income households and communities of color.

Perceived Safety of Neighborhood
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 76]
Notes: • Asked of all respondents.

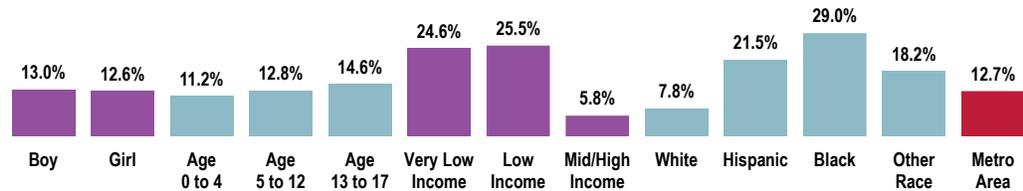
Neighborhood Perceived to be “Slightly/Not At All” Safe
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 76]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.



Neighborhood Perceived to be “Slightly/Not At All” Safe (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 76]
Notes: • Asked of all respondents.

Bullying

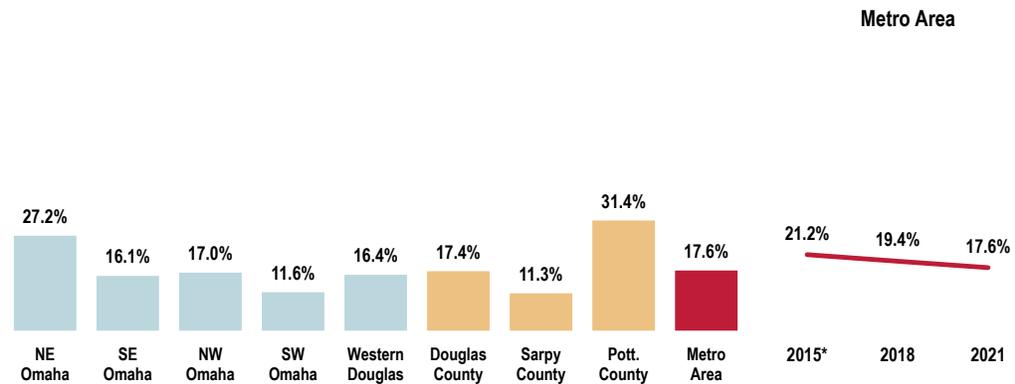
Among parents of school-age children (age 5-17), 17.6% report that their child has been bullied in the past year, whether online or in person.

TREND ► The decrease over time is not yet statistically significant.

DISPARITY ► Unfavorably high in Northeast Omaha and Pottawattamie County. Reported more often among parents of girls.

NOTE: It is important to recognize that incidences of bullying are reported by parents and are limited to incidents of which parents are aware; it is reasonable to presume that the true incidence for these measures is potentially quite a bit higher.

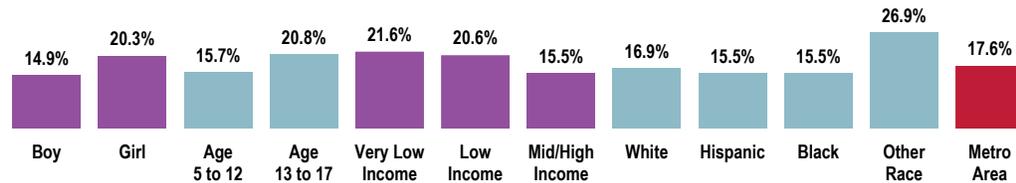
Child Was Bullied in the Past Year (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: • Asked of all respondents.
• *2015 was asked as two questions (online bullying and bullying on school property).



Child Was Bullied in the Past Year (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: • Asked of all respondents.

Feeling Safe at School or Going to/From School

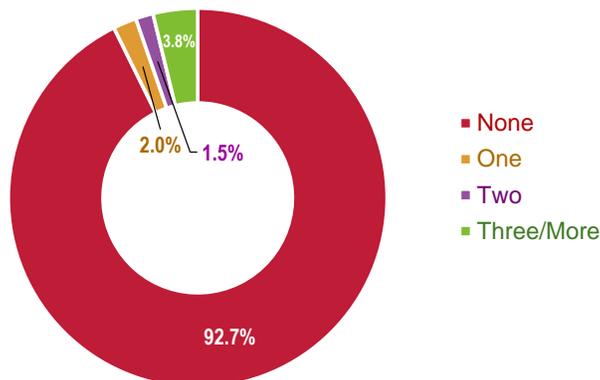
A total of 7.3% of Metro Area children age 5-17 missed school at least once in the past year because the child felt unsafe either at school or on the way to/from school.

TREND ▶ Marks a statistically significant increase from 2012 and 2015 survey findings.

DISPARITY ▶ Unfavorably high in Northeast Omaha. The prevalence decreases with income level and is reported more often among parents of Hispanic children and parents of Black children.

“During the past year, how many days did this child not go to school because he/she felt unsafe at school or on the way to or from school?”

School Days Missed in the Past Year Because Child Felt Unsafe at School or on the Way to/From School (Metro Area Children Age 5-17, 2021)

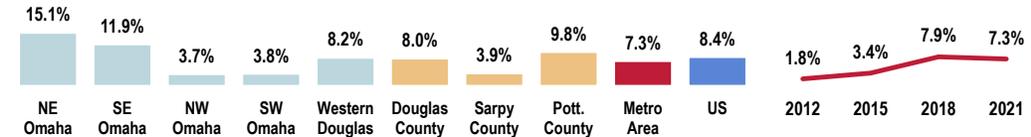


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 73]
Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.



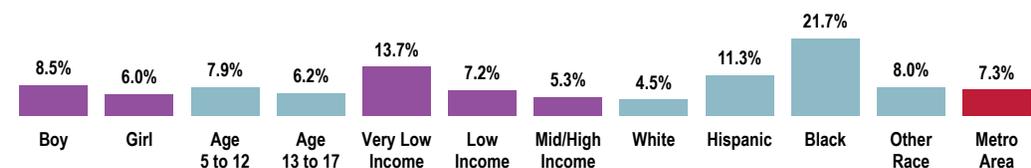
Child Missed School in the Past Year Due to Feeling Unsafe (Metro Area Children Age 5-17, 2021)

Metro Area



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 73]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.

Child Missed School in the Past Year Due to Feeling Unsafe (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 73]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17.

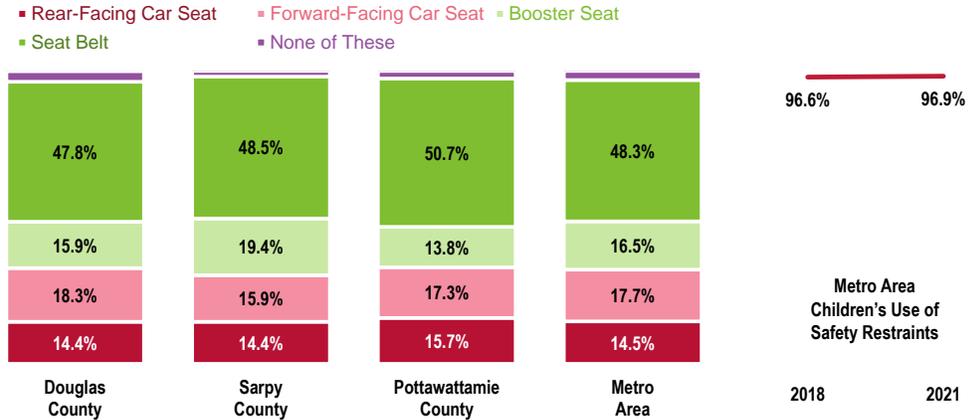


Injury Control

Car Seats & Seat Belts

Metro Area parents were asked about the type of restraint used by their child when riding in a vehicle. The responses by county are below.

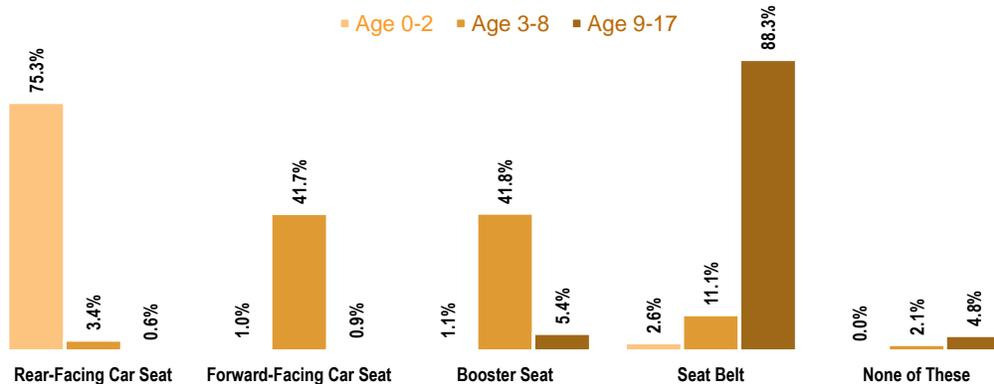
Child Restraint Used When Riding in a Vehicle (Metro Area Children, 2021)



Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 311]
 Notes: ● Asked of all respondents about a randomly selected child in the household.

Recommendations for the type of restraint to be used are largely based on age, height, and weight. This is especially true for the younger ages, where recommendations are dependent on the specific car seat being used and the manufacturer's specifications. The following charts outline usage by age and weight.

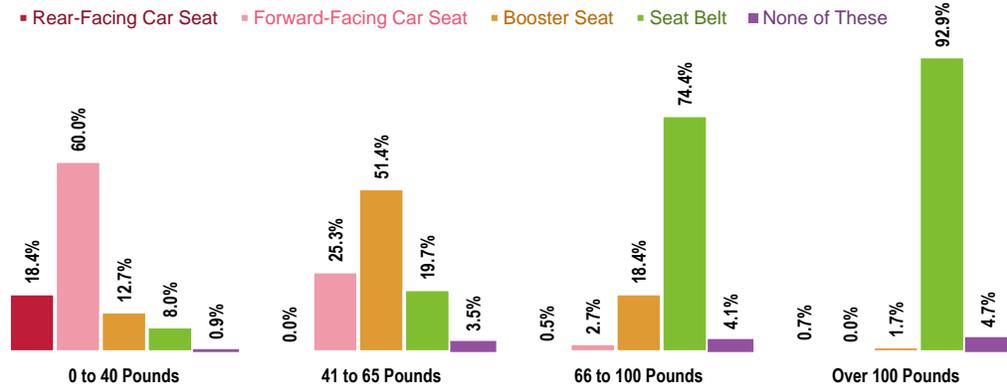
Child Restraint Used When Riding in a Vehicle (Metro Area Children by Age, 2021)



Sources: ● 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 311]
 Notes: ● Asked of all respondents about a randomly selected child in the household.



Child Restraint Used When Riding in a Vehicle (Metro Area Children by Weight, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 311]
 Notes: • Asked of all respondents about a randomly selected child in the household.

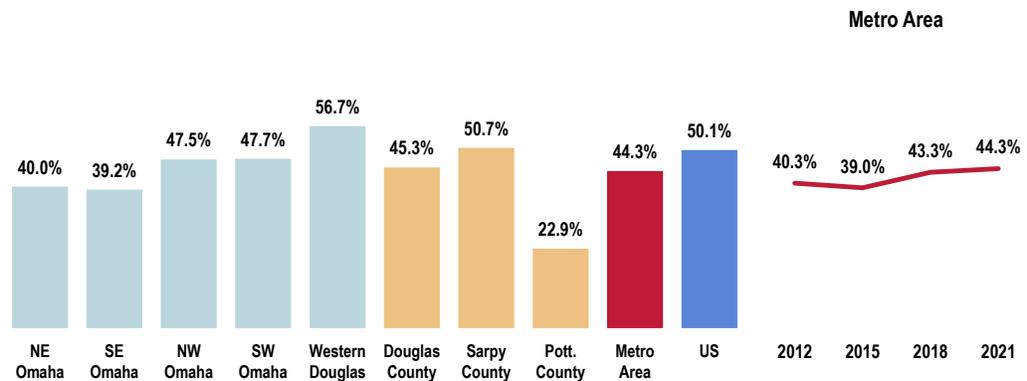
Bicycle Helmet Use

A total of 44.3% of Metro Area children age 5 to 17 are reported to “always” wear a helmet when riding a bicycle (denominator reflects only those who engage in these activities).

BENCHMARK ▶ Lower than the US percentage.

DISPARITY ▶ Lowest among children in Pottawattamie County. Reported less often among parents of boys and teens, among Hispanic and Black children, and among those living on very low incomes.

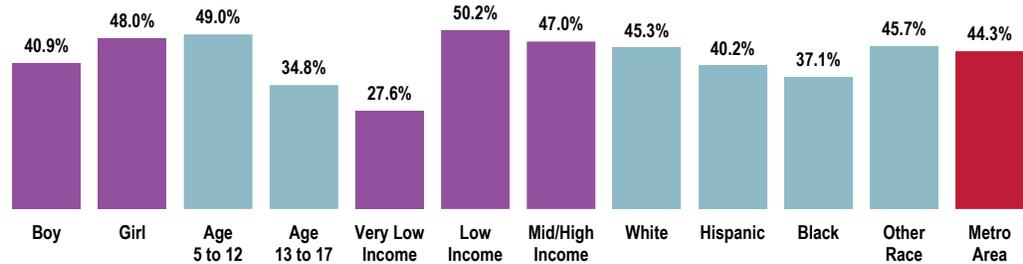
Child “Always” Wore a Helmet When Riding a Bicycle in the Past Year (Metro Area Children Age 5-17 Who Rode a Bike in the Past Year, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 310]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a bike in the past year.



Child “Always” Wore a Helmet When Riding a Bicycle in the Past Year (Metro Area Children Age 5-17 Who Rode a Bike in the Past Year, 2021)



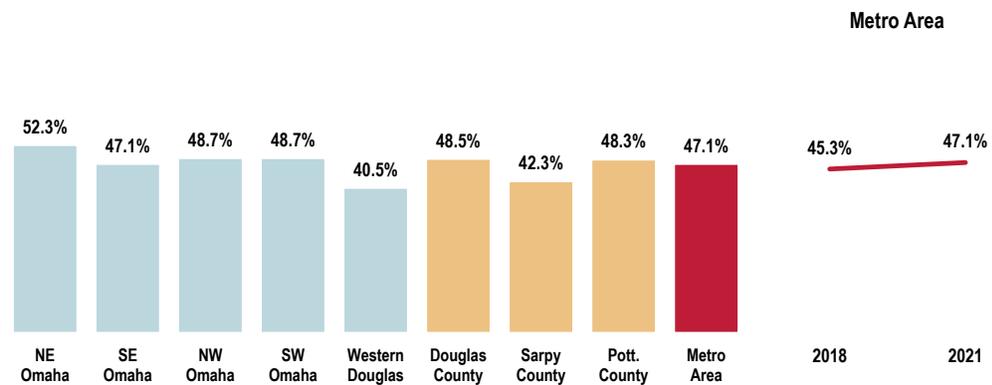
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 310]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a bike in the past year.

Water Safety

Almost half (47.1%) of Metro Area parents have discussed water safety with a health professional or someone at their child’s school.

DISPARITY ► The prevalence is notably lower among parents of children age 5 to 17.

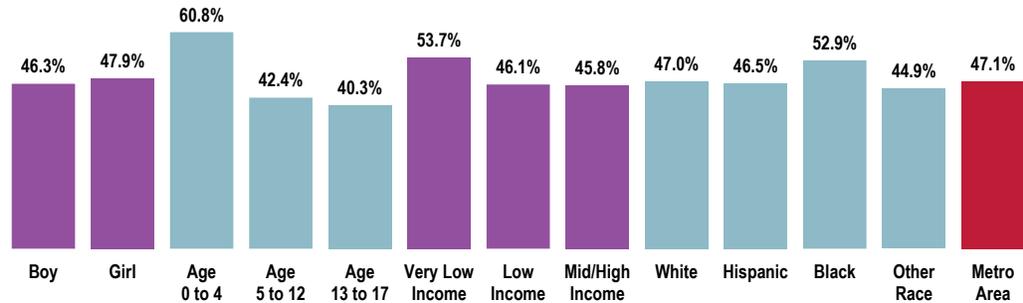
Discussed Water Safety With a Health Professional (Metro Area Parents, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 309]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Discussed Water Safety With a Health Professional (Metro Area Parents, 2021)

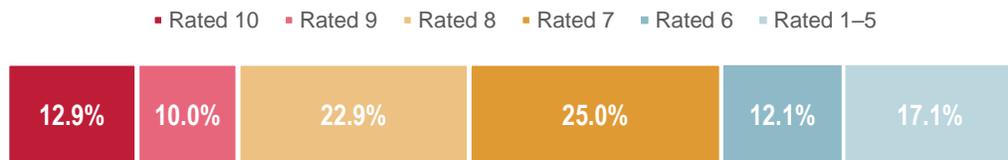


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 309]
Notes: • Asked of all respondents about a randomly selected child in the household.

Key Informant Input: Injury & Violence

A plurality of key informants taking part in an online survey gave *Injury & Violence* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of Injury and Violence as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Incidence/Prevalence

Increase in ED visits with these diagnoses. – Other Health Provider

Because we keep hearing and seeing a rise in the numbers of younger people involved in violence and being injured. – Public Health Representative

Violence is growing in our community and even if not caused by a child, they are impacted. – Other Health Provider

Statistically, Omaha has a high rate of violent crime. That would impact children in the communities where the rate is high. – Community Leader

This is evidenced by increased volume of abuse and neglect reporting, as well as increased incidents of gun violence committed by adolescents in our community. – Other Health Provider



The leading cause of mortality and morbidity for people age 1 to 44 years old. Very preventable. Lack of resources to address. – Physician

Because of the frequent violence going on in our community, such as drive-by shootings, gang and drug activities in the neighborhoods and schools, increase in bullying, access to guns and children raising themselves at home, without parental guidance. – Public Health Representative

Violence is continuously on the rise in our community. Violent deaths, shootings, etc. are happening more frequently. – Community Leader

During the pandemic, globally, there was an increase in interpersonal violence. – Public Health Representative

Children are experiencing physical, emotional, and sexual abuse and this is not acceptable. – Public Health Representative

Each area in the definition is a major challenge in our community. – Public Health Representative

Violence continues to be a major issue within the Omaha metro and appears to have risen since the pandemic. – Community Leader

Impact on Quality of Life

The trauma that results from these incidences is so grave for children and adolescents, that whenever and wherever it occurs, there are far reaching and permanent consequences. – Other Health Provider

Intimate partner violence is a source of stress for children and adolescents which impacts them for the rest of their lives. This is a daily reality that too many teens and children live with every day. Children who grow up with violence often repeat it in their adult relationships which perpetuates the problem. Violence in teen dating relationships is often seen as normal; of course he/she is jealous, he/she loves me, etc. – Other Health Provider

I see little commitment to address injury and violence involving youth in my community. These cause trauma with our youth. – Other Health Provider

Children are directly and indirectly exposed to incidents of shootings and violence in Omaha. These exposures result in immeasurable outcomes for a child's ongoing wellness, emotional well-being, self-identity. – Other Health Provider

The incidents of trauma and violence have a detrimental impact on the lives of children and adolescents. Racism is a major concern for people of color and COVID is a continuing concern in the lives of children and adolescents. – Other Health Provider

Vulnerable Populations

Children who come from families of poverty do not have access or education of all needed resources. – Community Leader

They are angry because of how they live. They tend to take it out on one another. Who else is there? – Social Services Provider

Lack of parental or adult physical supervision. – Community Leader

Violence is a public health issue. Youth residing in some neighborhoods in our community have a significantly greater risk of being a perpetrator and/or victim of violence. Opportunity is not equal and health and economic disparity disproportionately affect people of color. Further, over 60% of adults in our community reported experiencing ACEs in childhood. – Other Health Provider

Gun Violence

We have a significant issue with guns and weapons in our community, including access to. – Social Services Provider

Many youth are involved or affected by violence within the North Omaha community. Shootings have devastating effects on minority populations in both North and South Omaha. – Social Services Provider

Funding

Until our child welfare system is adequately funded and staffed to meet reasonable caseloads without operating as a for profit department in state government, and until children and families have access to health and mental health care, this will remain a problem in our community. – Community Leader

Motor Vehicle Crashes

Young drivers. There have been deaths due to reckless driving and/or inexperience. – Public Health Representative



KEY INFORMANT PERCEPTIONS: SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities.

- Healthy People 2030 (<https://health.gov/healthypeople>)

When key informants in the community were asked about the greatest contributor to health problems among children and youth in the Metro Area, the greatest share first mentioned poverty/economic status, followed by the availability of safe housing, and exposure to crime and violence.

Key informants also mentioned systemic oppression, access and quality of education, access to fresh food, economic opportunity, and social support.



Most Important Contributors to Health Problems Among Local Children and Youth

SOCIAL DETERMINANT	% FIRST MENTION	% SECOND MENTION	% THIRD MENTION	# TOTAL MENTION
Poverty/Economic Status	31.1%	29.2%	10.5%	75
Availability of Safe Housing	13.2%	4.7%	13.3%	33
Exposure to Crime, Violence, and Social Disorder	11.3%	12.3%	14.3%	40
Systemic Prejudice, Discrimination, and Oppression	10.4%	19.8%	9.5%	42
Access and Quality of All Education	10.4%	4.7%	10.5%	27
Access to Fresh Food and Food Markets	7.5%	4.7%	6.7%	20
Access to Economic and Job Opportunities	6.6%	10.4%	10.5%	29
Social Support	3.8%	6.6%	6.7%	18
Transportation Options	2.8%	2.8%	5.7%	12
Language/Literacy	1.9%	1.9%	3.8%	8
Access to Media and Emerging Technology Including Internet	0.9%	1.9%	2.9%	6
Residential Segregation	0.0%	0.9%	1.9%	3
Opportunities for Recreational and Leisure-Time Activities	0.0%	0.0%	3.8%	4





BEHAVIORAL INFLUENCES

NUTRITION

Fruits & Vegetables

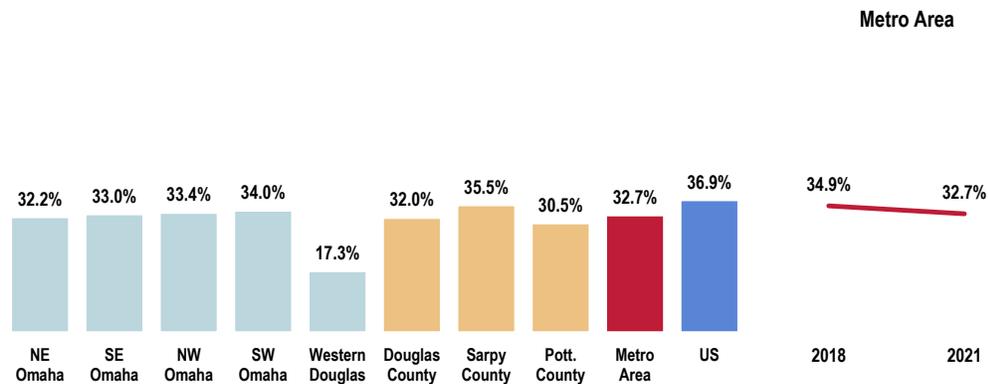
Fruit & Vegetable Consumption

A total of 32.7% of Metro Area parents report that their child eats five or more servings of fruits and/or vegetables per day.

DISPARITY ► Lowest in Western Douglas County. The percentage decreases with child's age.

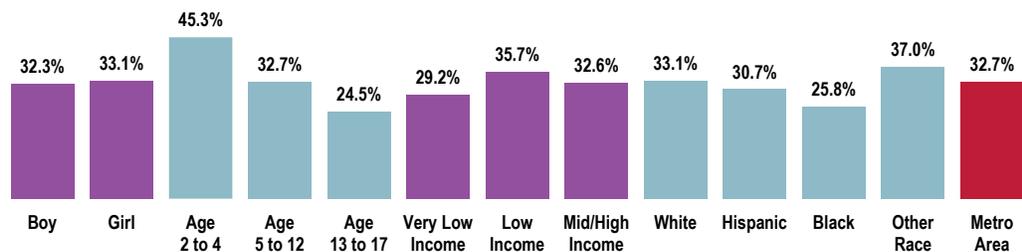
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods their child eats on a typical day.

Child Has Five or More Servings of Fruits/Vegetables per Day
(Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 328]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Child Has Five or More Servings of Fruits/Vegetables per Day
(Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 328]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.



Fast Food

Most Metro Area children age 2-17 have had a “fast food” meal in the past week; in fact, one in four parents (25.3%) report that their child has had three or more meals from “fast food” restaurants in the past week.

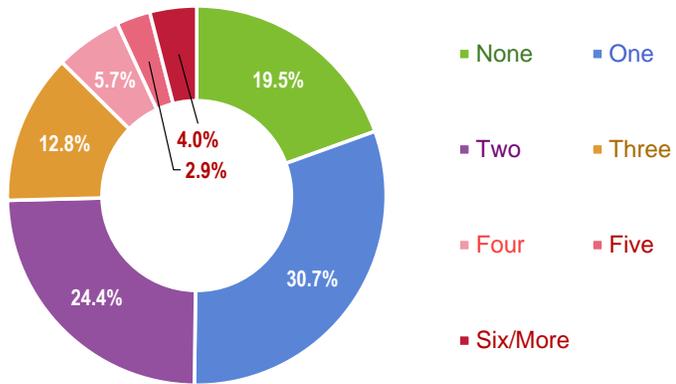
“In the past 7 days, how many meals would you say this child has eaten from ‘fast food’ restaurants? Please include breakfasts, lunches, and dinners.”

BENCHMARK ▶ Higher than the national prevalence.

TREND ▶ Marks a statistically significant increase since 2012.

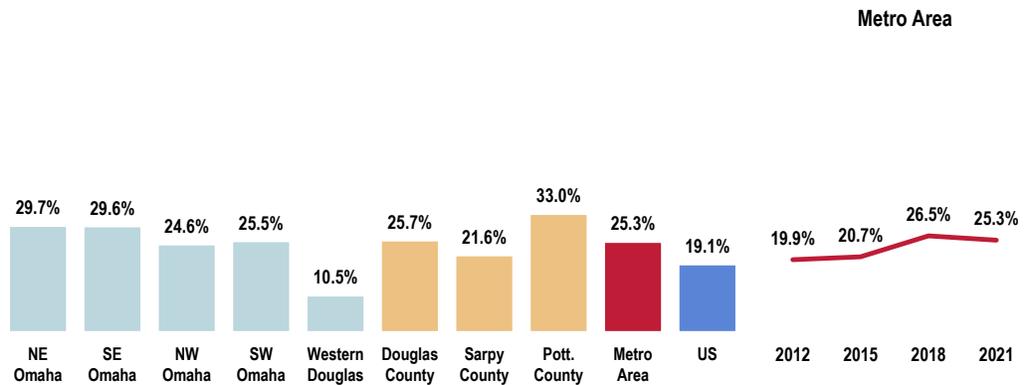
DISPARITY ▶ Lowest in Western Douglas County. Reported more often among parents of teens and parents of Black children.

Number of Fast Food Meals for Child in the Past Week
(Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 108]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

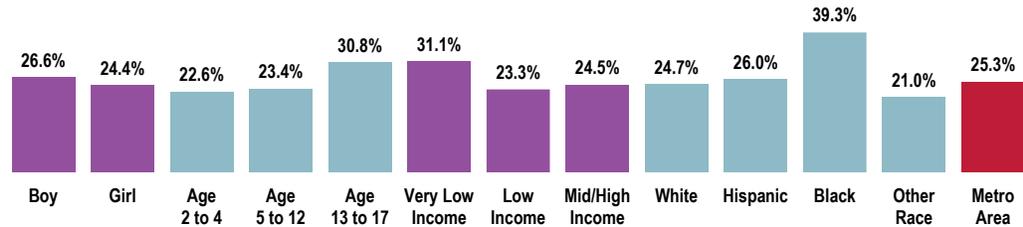
Child Had Three or More Fast Food Meals in the Past Week
(Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 108]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.



Child Had Three or More Fast Food Meals in the Past Week (Metro Area Children 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 108]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Family Meals

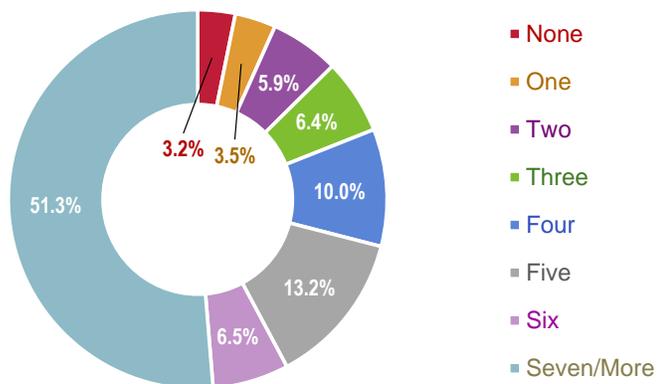
Just over half of Metro Area parents (51.3%) report sharing meals as a family an average of at least once a day (seven or more times in the past week).

BENCHMARK ▶ Higher than both state percentages but below the national figure.

DISPARITY ▶ Correlates with child's age and is reported less often among parents of boys.

"In the past 7 days, how many meals did you eat together as a family? Please include breakfasts, lunches, and dinners."

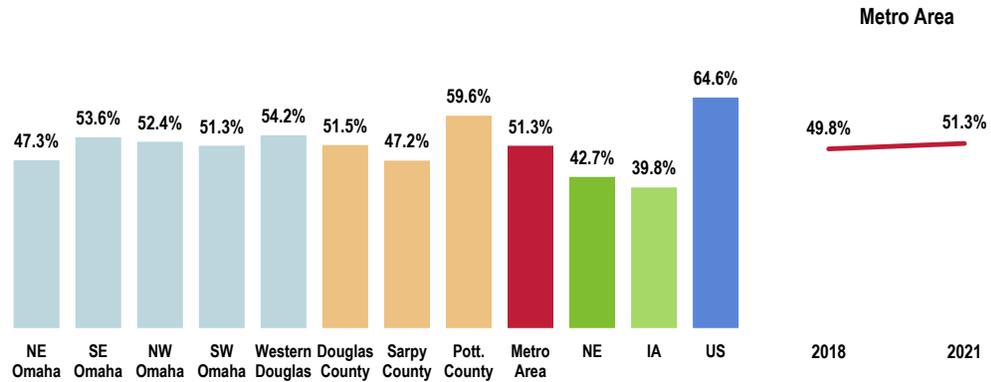
Number of Meals Eaten as a Family in the Past Week (Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 109]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.



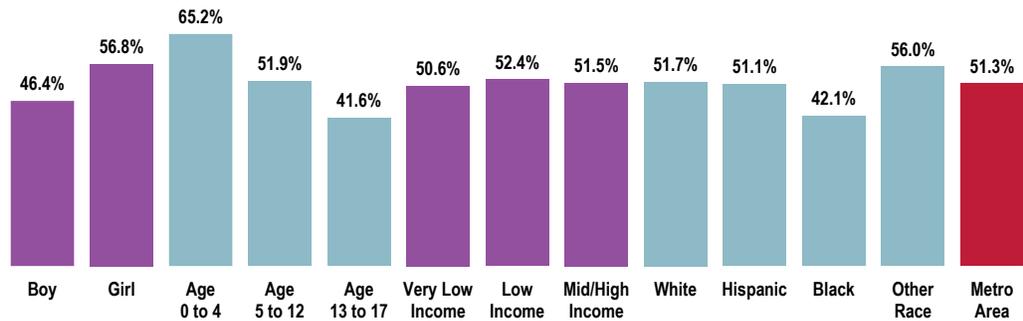
Shared Seven or More Meals as a Family in the Past Week (Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 109]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Shared Seven or More Meals as a Family in the Past Week (Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 109]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

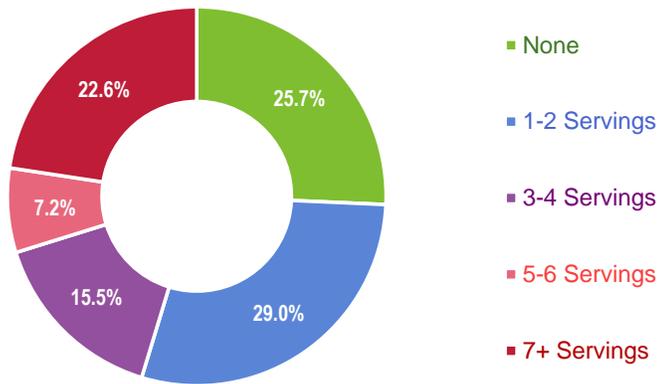


Sugar-Sweetened Beverages

A total of 22.6% of Metro Area parents report that their child (age 2-17) drinks an average of at least one sugar-sweetened beverage per day in the past week.

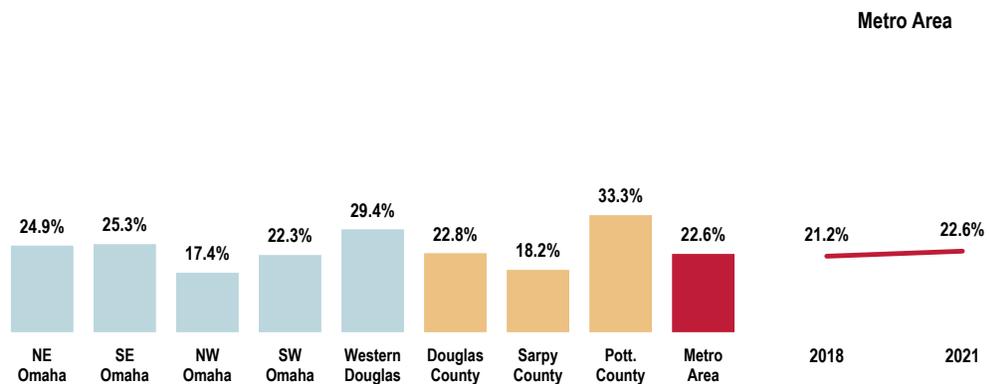
DISPARITY ► Highest in Pottawattamie County. Reported more often among parents of teens, those in low-income households, and parents of Hispanic children or those in the Other Race category.

Servings of Sugar-Sweetened Beverages Per Week
(Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 327]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

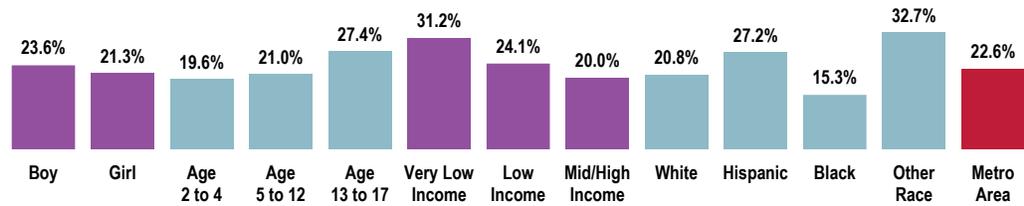
Average One or More Sugar-Sweetened Drinks per Day
(Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 327]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.



Average One or More Sugar-Sweetened Drinks per Day (Metro Area Children Age 2-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 327]
 Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.



PHYSICAL ACTIVITY

Recommended Physical Activity

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Preschool-aged children (ages 3 through 5 years) should be physically active throughout the day to enhance growth and development. Children and adolescents ages 6 through 17 years should do 60 minutes (1 hour) or more of moderate-to-vigorous physical activity daily.

- 2018 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

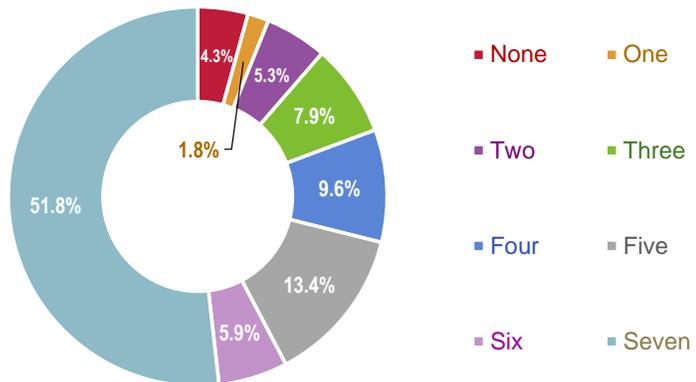
Among Metro Area children age 2 to 17, 51.8% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

BENCHMARK ► Higher than the US prevalence. Satisfies the Healthy People 2030 objective.

DISPARITY ► Lowest among children in Northeast Omaha. The prevalence decreases considerably with age and is reported less often among parents of girls, those living just above the federal poverty level, and parents of Hispanic children and (especially) Black children.

“The next questions are about physical activity. During the past 7 days, on how many days was the child physically active for a total of at least 60 minutes per day?”

Number of Days in the Past Week on Which Child Was Physically Active for One Hour or Longer (Metro Area Children Age 2-17, 2021)

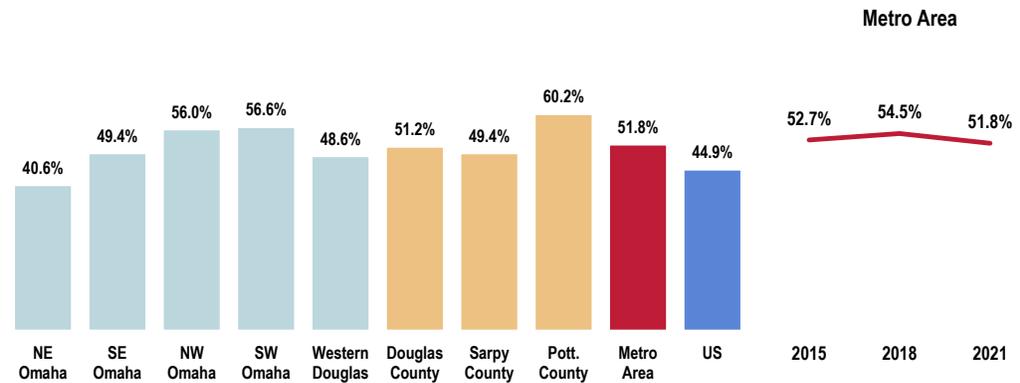


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 107]
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.



Child Was Physically Active for One Hour or Longer on Every Day of the Past Week (Metro Area Children Age 2-17, 2021)

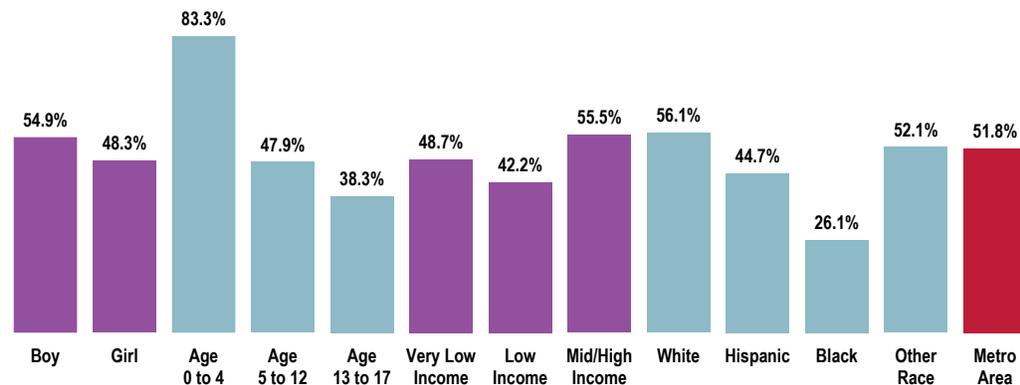
Healthy People 2030 Target = 30.4% or Higher



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 107]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Child Was Physically Active for One Hour or Longer on Every Day of the Past Week (Metro Area Children Age 2-17, 2021)

Healthy People 2030 Target = 30.4% or Higher



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 107]
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov> (adjusted to reflect all children and adolescents)
 Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.



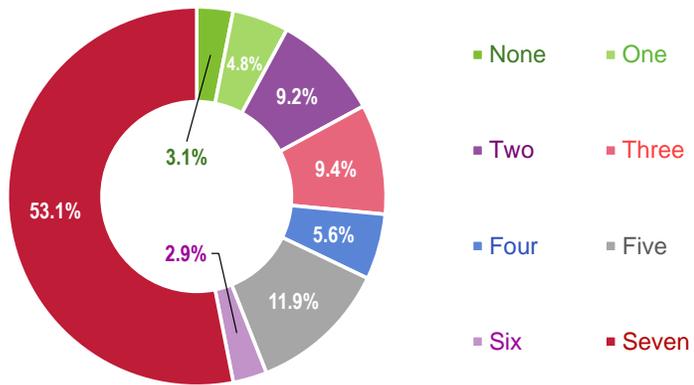
Screen Time

“During the past seven days, on how many days did this child spend two or more hours in front of a screen, including TV, video games, computer, or a cell phone?”

Total Screen Time

Among children age 5 through 17, over half (53.1%) are reported to watch two or more hours of screen time (whether television, computer, video games, cell phone, handheld device, etc.) on every day of the seven days preceding the survey.

Children’s Screen Time in the Past Week: Days of 2+ Hours
(Metro Area Children Age 5-17, 2021)

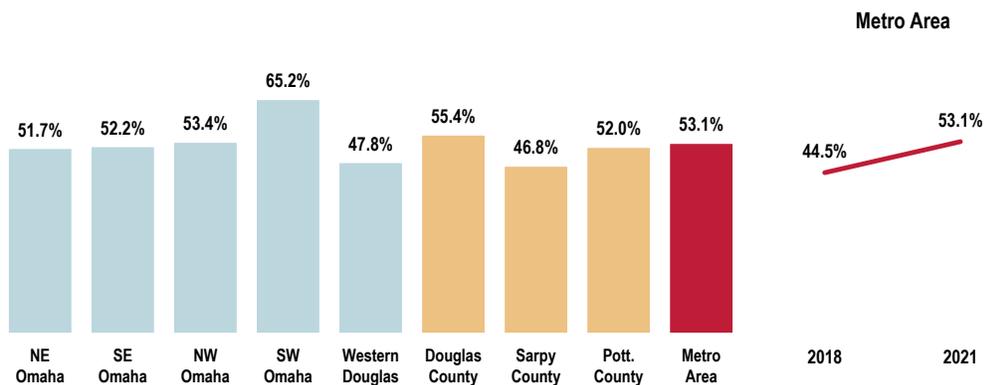


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 326]
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

TREND ► Increasing significantly from 2018 survey results.

DISPARITY ► Highest in Southwest Omaha. Reported less often among parents of children age 5 through 12 and parents of Hispanic children.

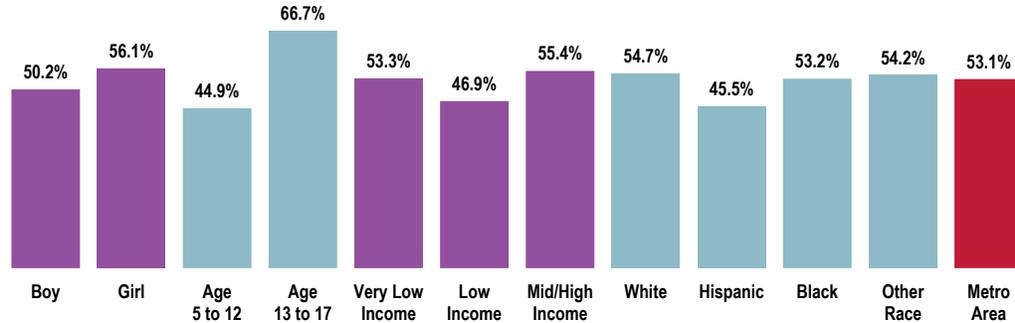
Children With 2+ Hours per Day of Screen Time
(TV, Computer, Video Games, Phone, Device, etc.)
(Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 326]
Notes: • Asked of respondents for whom the randomly selected child in the household is age 5 to 17.



Children With 2+ Hours per Day of Screen Time (TV, Computer, Video Games, Phone, Device, etc.) (Metro Area Children Age 5-17, 2021)

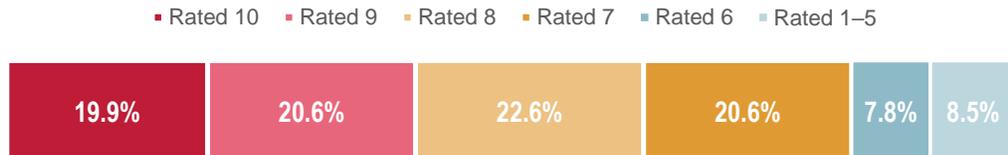


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 326]
Notes: • Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Key Informant Input: Nutrition, Physical Activity & Weight

Four in 10 key informants taking part in an online survey gave **Nutrition, Physical Activity & Weight** a rating of “9” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Weight Status

- Increasing BMI; the last year of remote learning, lack of physical activity and stress has created a worsened obesity problem. – Physician
- Obesity is an epidemic and contributes to so many major health issues. – Physician
- Childhood obesity and lack of physical activity is rising. Disparities are evident in this realm. – Physician
- Obesity and lack of physical activity, especially with the pandemic. – Physician
- Obesity in childhood is rampant, which leads to poor adult health. The treatment is challenging and expensive. Prevention is the key. – Physician



If you just look around, you will see many children who are significantly overweight or obese even at a young age. Children are less physically active than in the past. They spend less time outdoors and more time on screen-time. Many families lack knowledge of even basic nutritional information. – Other Health Provider

Chronic obesity begins early in life. Obesity as an adult not only is the major factor in adult medical conditions but is a primary driver in overall healthcare costs. – Community Leader

Obesity is a challenge. Things got worse during the pandemic with free access to the kitchen while at home learning. Few opportunities for exercise. – Physician

Obese students, the need for food for students, students eating junk food instead of nutritious foods. – Community Leader

Obesity and being overweight is a major concern for our youth. Real nutrition is not shared with families that can rid our community of diseases. We need to get real nutritional advice out to all individuals. – Community Leader

Obesity is a major problem, and weight management clinics at Children's and Boys Town have been ineffective at helping. – Physician

Obesity continues to be a large problem within the Omaha metro. – Community Leader

High incidence of obesity. – Physician

Obesity epidemic: there are weight management clinics that can be helpful; however, insurance coverage for this is not guaranteed and it takes a lot of effort on the family's part, which can be difficult to maintain. – Physician

Specifically, obesity rates are high in our community, particularly among children of color and those living in poverty. For these families, a lack of access to affordable, healthy foods and safe places to play and exercise are created by the geographic segregation in our community and is rooted in the social determinants of health. Families in poverty are more likely to live in older communities with older housing stock that is challenged for well-lit and maintained sidewalks and parks. Access to grocery stores is limited for many, especially if transportation is limited; therefore, fast food and convenient stores serve as the families source of food. – Community Leader

Access to Affordable Healthy Food

Access to nutritious food is limited outside of school. Even with access to local grocery stores, the cost to purchase nutritional foods are too expensive for many of our families. Due to this and having greater access to fast foods and the affordability of non-nutritious food, results in weight issues for our families. Also, physical activity is impacted tremendously by the use of devices for fun versus playing outside, limiting physical activity. – Community Leader

Nourishing foods and lots of movement help decrease the affects of so many other health issues. This cannot be forgotten as we address access to care, chronic conditions, and mental health. – Public Health Representative

If one is not receiving a healthy nutritional diet, then they are not growing properly or receiving physical exercise. – Community Leader

Decrease reports of healthy family meals either due to parents working long hours, or kids being over extended. – Community Leader

I think that lack of access to healthy foods, lack of knowledge about how to incorporate healthy foods into a family's life, and lack of exercise are rampant in Omaha. I think that the underlying reasons why families turn to fast food over homecooked meals needs to continue to be addressed through community programs. Having a child be overweight can have lifelong negative health and social impacts. – Other Health Provider

Cost of food, inability to qualify for SNAP, moms are overwhelmed and feed the kids foods that are not of the greatest quality because of cost. – Public Health Representative

Lack of nutritional food, cost of healthy options for families. COVID has eliminated jobs for parents, which has had a trickle-down effect in getting food for the family. – Other Health Provider

Fast food is convenient and less expensive. – Other Health Provider

COVID-19

I think especially during the pandemic we have seen a decrease in physical activity and issues with food security that normally translates into consumption of less nutrient dense options. I do believe in Council Bluffs that particularly in the far Western side of the city and in Carter Lake there is a food desert and likely issues related to food apartheid. – Public Health Representative

Increased screen time with technology devices during the pandemic has negatively impacted children/adolescents' eating habits and lack of physical activity. – Other Health Provider

With job loss, lack of access to supportive services, and school closures due to the pandemic, there are national trends indicating that there are going to be upticks in obesity type 2 diabetes and other obesity related conditions. – Public Health Representative

Dramatic increase in BMI since the pandemic. Fewer opportunities for sports and physical activity, more sitting in front of screens, more snacking as kids spend time at home. – Physician

Higher incidence with pandemic inactivity, as well as the sedentary nature of a lifestyle with screen time. – Physician



The COVID-19 pandemic has exacerbated already low levels of physical activity, lack of access to healthful foods (especially for lower income families that rely on school breakfast and lunch, and increasing levels of obesity due to restrictions that are necessary to slow the spread of COVID-19 but also reduce opportunities for moderate to vigorous intensity in physical activity and increase the opportunities for energy intake-expenditure imbalance. – Public Health Representative

With the pandemic, a lot of youth had to stay inside. Families do not have access to fruit, vegetables, etc. and do not understand nutrition needs. – Social Services Provider

Contributing Factors

All health outcomes are connected and lack of appropriate nutrition in food deserts, lack of green space in urban communities contribute to weight concerns. Most urban areas in Omaha do not have playgrounds, variety in restaurants, and other safe space opportunities to impact the challenges for children and adolescents. – Other Health Provider

They live in food deserts and they can't play in their neighbors because of all the violence, so they stay in house and eat if there is food. – Social Services Provider

The lack of knowledge and connection between nutrition and physical activity also contributes. Educating families together including parents would assist in making changes. – Community Leader

Single-parent homes where the parent is often working and the children are left to prepare meals for themselves and younger siblings. Parents afraid to allow children outside due to the violence in their communities. Too much TV and electronic time, especially, if a parent is not around to place limitations. Neighborhood stores tend to have higher costs for their products and healthier items often can cost more than nonhealthy food choices. – Public Health Representative

Single-parent as well two-parent households are busy, and I feel that these three important health issues are put on the backburner. It is much easier to get a meal from fast food, let them play video games, and relax for the night. I feel that once a child is overweight this is when the concern comes in and many times it is difficult for the parent and even more for the child to hear this. Nutrition and facts should be presented early on, simple resources, meals, snacks, etc. Children need exercise and outdoor time. – Social Services Provider

Insufficient Physical Activity

Children have had less physical activity over the past year due to spending more time at home. Much of the free and low-cost food available to families isn't as healthy as fresh, homemade food. Separately, neighborhoods in west Omaha aren't walkable contributing to more time in the car. – Community Leader

Less emphasis on healthy hobbies these days as a direct result of gaming and cell phone platforms. – Other Health Provider

With technology becoming more of a focus, activity has become less. – Other Health Provider

With our electronic culture, children are sitting in front of screens more. Childhood obesity is higher than it ever has been. – Community Leader

So much of the time youth spend on activities is in a stationary position. With opportunities to be active becoming less in school the chances for these helpful situations are becoming less and less. Physical activity, fresh air, and the release of endorphins all have positive outcomes with other areas such as physical health, mental health, education and more. – Community Leader

Built Environment

Having safe, organized play areas are limited in the city. Also, many parents cannot afford sports programs. This has impacted physical fitness and weight problems in our youth. Also, our poor areas are food deserts. – Social Services Provider

Some neighborhoods do not have safe places to play and healthy food is more expensive than junk food. This is an issue in Omaha, but also nationally. – Community Leader

Co-Occurrences

Leads to all sorts of health issues. We don't have a culture of health and wellness in our community. – Social Services Provider

These three areas set the individual's life-long health trajectory and greatly affected by the social determinants of health. – Public Health Representative

Social Determinants

Food insecurity is an ever-increasing need in our community because of economic insecurity. Related: cheap food leads to poor nutrition and the resulting weight and health issues that follow. – Community Leader

Incidence/Prevalence

True for the entire country. – Community Leader



SLEEP

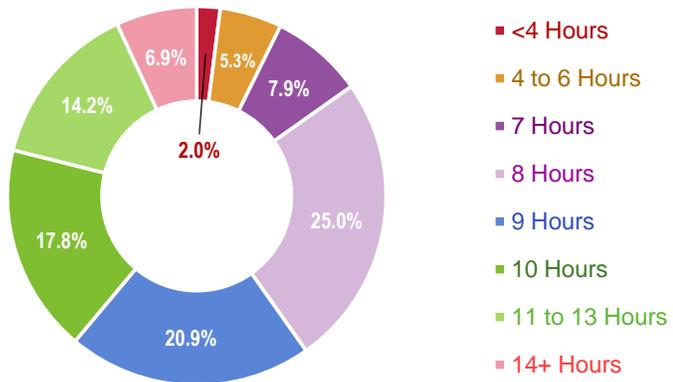
Sleep Recommendations

Across all age ranges, 63.7% of Metro Area children average 8-10 hours of sleep per night.

Parents of children under 6 were asked: "During the past week, how many hours of sleep did this child get during an average 24-hour period, counting both nighttime sleep and naps?"

Parents of children age 6-17 were asked: "During the past week, how many hours of sleep did this child get on an average weeknight?"

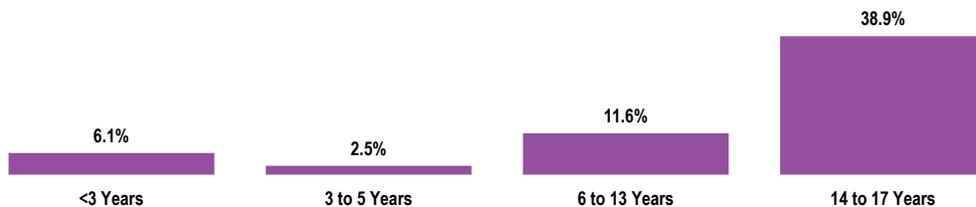
Average Daily Hours of Child's Sleep
(Metro Area Children, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 321]
Notes: • Asked of respondents about a randomly selected child in the household.

When looking at sleep habits by age group, a significant proportion of children are not receiving enough sleep (on average).

Child Gets Less Than 8 Hours of Sleep Per Night
(Metro Area Children by Age Group, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 321]
Notes: • Asked of respondents about a randomly selected child in the household.



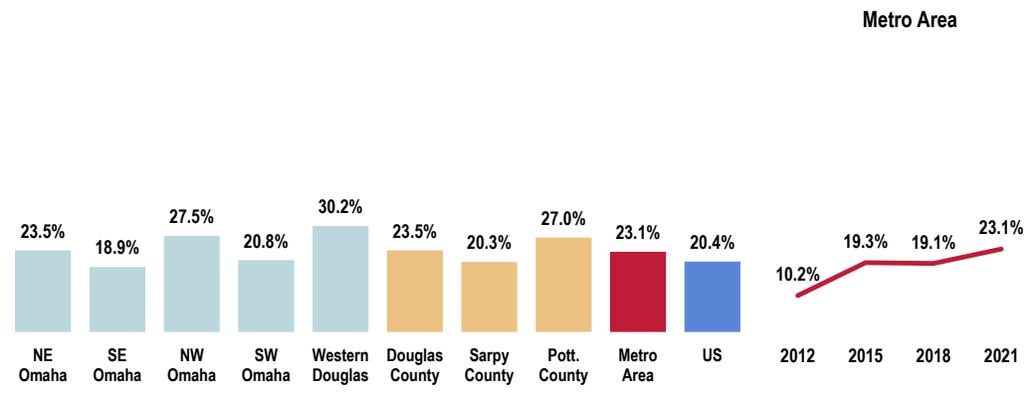
Sleep Difficulties

A total of 23.1% of Metro Area parents indicate that their school-age child has difficulty falling asleep and/or sleeping through the night.

TREND ▶ The prevalence has more than doubled from 2012 survey results.

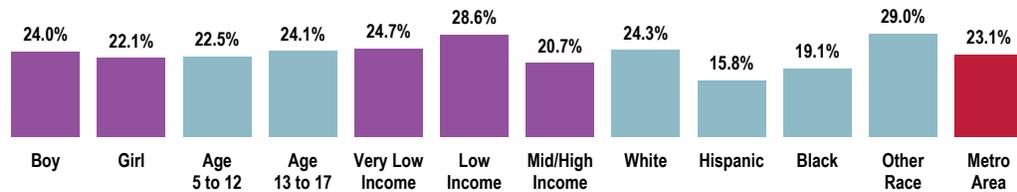
DISPARITY ▶ Highest among non-Hispanic, non-Black communities of color.

Child Has Difficulties Falling Asleep and/or Sleeping Through the Night (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 83]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has Difficulties Falling Asleep and/or Sleeping Through the Night (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 83]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



TOBACCO, ALCOHOL & OTHER DRUGS

Current Tobacco Use (Adolescents)

Among Douglas County high school students, 4.9% report smoking at least one cigarette on at least one day during the 30 days preceding the administration of the 2018-2019 Youth Risk Behavior Survey.

BENCHMARK ▶ Lower than the US prevalence but failing to satisfy the Healthy People 2030 objective.

TREND ▶ Decreasing significantly from 2012 and 2014 reports.

DISPARITY ▶ Reported more often among Douglas County high school juniors.

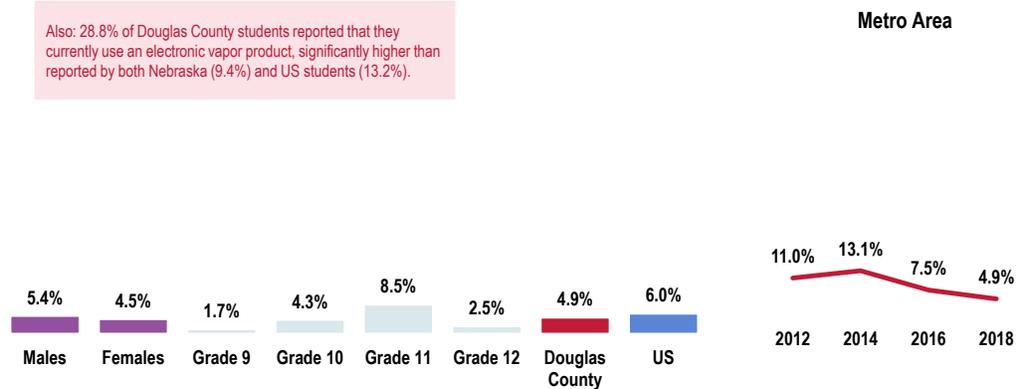
This indicator is derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students by county. For more information, visit: www.cdc.gov/healthy-youth/yrbs.

Smoked Cigarettes in Past Month

(Among High School Students; Douglas County Youth Risk Behavior Surveys, 2018-2019)

Healthy People 2030 Target = 3.4% or Lower

Also: 28.8% of Douglas County students reported that they currently use an electronic vapor product, significantly higher than reported by both Nebraska (9.4%) and US students (13.2%).



Sources: • Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
• Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Smoked cigarettes on at least 1 day during the 30 days before the survey.

Alcohol Use (Adolescents)

Current Alcohol Use

Among high school students in Douglas County, 21.4% report having at least one drink of alcohol on at least one day during the 30 days preceding the administration of the 2018-2019 Youth Risk Behavior Survey.

BENCHMARK ▶ Lower than the national figure but failing to meet the Healthy People 2030 objective.

TREND ▶ Marking a statistically significant decrease since 2012 (and especially 2014).

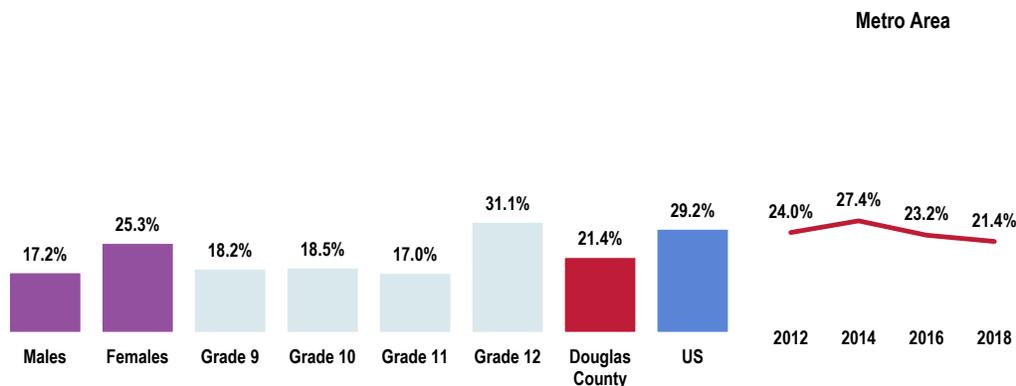
DISPARITY ▶ Reported more often among females and high school seniors.



Drank Alcohol in Past Month

(Among High School Students; Douglas County Youth Risk Behavior Surveys, 2018-2019)
Healthy People 2030 Target = 6.3% or Lower

These indicators are derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students by county. For more information, visit: www.cdc.gov/healthy-youth/yrbs.



Sources: • Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
• Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Had at least one drink of alcohol on at least one day during the 30 days before the survey.

Drinking & Driving

A total of 6.1% of Douglas County high school students report having driven a car or other vehicle when drinking alcohol on one or more occasion during the 30 days preceding the administration of the 2018-2019 Youth Risk Behavior Survey.

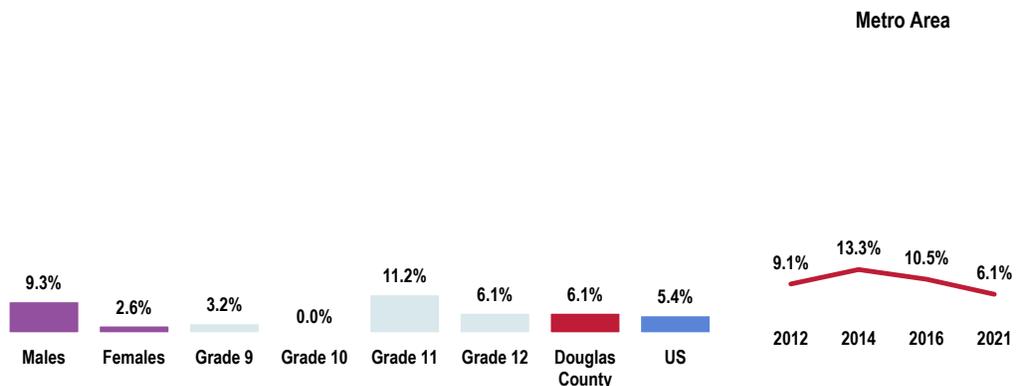
BENCHMARK ▶ Above the US prevalence.

TREND ▶ Decreasing significantly from 2012 (and especially 2014) reports.

DISPARITY ▶ Reported more often among Douglas County high school males and juniors.

Drove When Drinking Alcohol in the Past Month

(Among High School Students; Douglas County Youth Risk Behavior Surveys, 2018-2019)



Sources: • Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
• Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.

Notes: • Drove a car or other vehicle when drinking alcohol one or more times during the 30 days before the survey.



Drug Use (Adolescents)

Lifetime Use of Drugs

Douglas County high school students' use of drugs include marijuana (28.7% have ever used), prescription drugs (16.3% have ever used drugs not prescribed to them), and inhalants (10.4% have ever used).

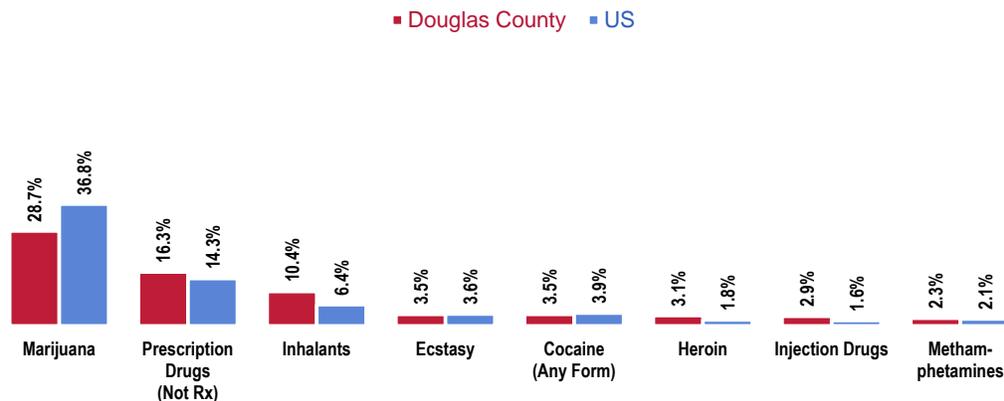
BENCHMARK ▶ The local prevalence is worse than the national prevalence for prescription drugs, inhalants, methamphetamines, heroin, and injection drugs (but better than the US prevalence for marijuana and cocaine).

TREND ▶ Over time, the use of inhalants and heroin has increased significantly among Douglas County high school students; on the other hand, use of marijuana, ecstasy, cocaine, methamphetamines, and injection drugs has decreased (not shown).

These indicators are derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students by county. For more information, visit: www.cdc.gov/healthy-youth/yrbs.

Ever Used Specific Drugs

(Among High School Students; Douglas County Youth Risk Behavior Surveys, 2018-2019)



- Sources:
- Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
 - Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.
- Notes:
- Prescription drugs include drugs such as Oxycontin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax.
 - Inhalants include sniffing glue, breathing the contents of aerosol spray cans, or inhaling any paints or sprays to get high.
 - Ecstasy is also called "MDMA."
 - Cocaine includes powder, crack or freebase forms of cocaine.
 - Methamphetamine is also called "speed," "crystal," "crank," or "ice."
 - Heroin also called "smack," "junk," or "China white."

Current Marijuana Use

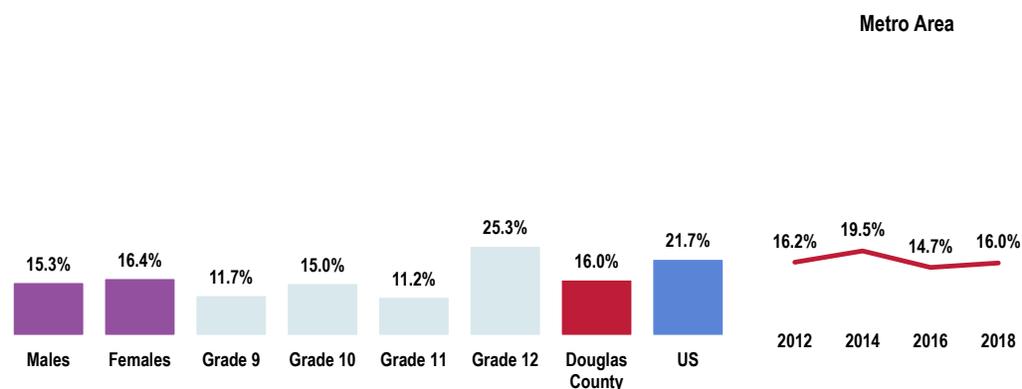
A total of 16.0% of Douglas County high school students report having used marijuana one or more times during the 30 days preceding the administration of the 2018-2019 Youth Risk Behavior Survey.

BENCHMARK ▶ Below the national prevalence but failing to satisfy the Healthy People 2030 objective.

DISPARITY ▶ Reported more often among high school seniors.



Used Marijuana in Past Month (Among High School Students; Douglas County Youth Risk Behavior Surveys, 2018-2019) Healthy People 2030 Target = 5.8% or Lower



Sources:

- Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
- Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

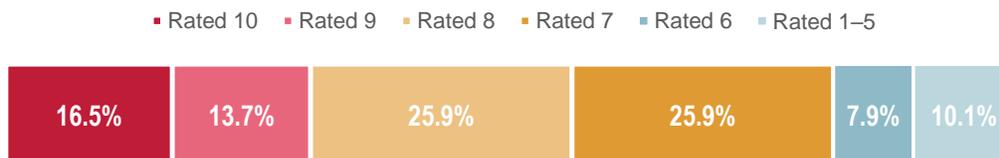
Notes:

- Used marijuana one or more times during the 30 days before the survey.

Key Informant Input: Tobacco, Alcohol & Other Drugs

Over half of key informants taking part in an online survey gave *Tobacco, Alcohol & Other Drugs* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of Tobacco, Alcohol, and Other Drugs as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



Sources:

- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:

- Asked of all respondents.

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Easy Access

- Too available for kids. – Other Health Provider
- It is sold everywhere, and that is often who they see being successful in the neighborhood. – Social Services Provider
- High prevalence of use among kids and they seem to have easy access to these things. – Other Health Provider
- Access, inability to cope with problems, generational use. – Social Services Provider
- Easily accessible and not stressing the harm. Stricter laws needed to prevent children and adolescent use. – Community Leader



Easily available and without parental supervision, a child is open to experiment. – Other Health Provider

One of the top places to obtain substances is in our schools. We are limiting our youth by taking a primarily behavior approach to penalize youth through the court system versus increase prevention strategies and offer access to experienced providers who can treat substance use. – Other Health Provider

Easy access, home alone too often and no parental controls. Pick up habits they see their parents do. Peer pressure and bullying. – Public Health Representative

Access and use and abuse in the high schools is significant. – Physician

Drug use is an epidemic, and drugs of every kind, prescription and recreational, are easily available in school hallways. – Physician

Contributing Factors

The abuse of these substances go hand in hand with poverty. Lack of behavioral and mental health services, peer pressure. – Other Health Provider

Prevention and education that relates to the harm created from tobacco, alcohol, and other drugs has never used a holistic lens to provide information on not just saying "NO" but why is it important to refrain beginning in the early years. Tobacco, Alcohol, and other drugs are coping mechanisms for trauma and mental health concerns. – Other Health Provider

Meth in particular is ravaging immigrant and refugee communities. Not only does it impact that individual's health, but they often mistreat family and friends to maintain their high, and often wind up with other criminal complications as a result of use (theft, etc.). Substance abuse and addiction requires professional intervention; it's more than a family or friend can fix. Finding CLAS effective professional interventions in Omaha is basically impossible. People have resorted to "sending the person back" to dangerous home countries to protect the rest of the family because it feels like the only option when things get really bad. – Social Services Provider

Exposure to marketing. – Physician

The lack of safe healthy places in the community for children/adolescents is one problem. Peer pressure, parents using, easy access, no accountability, lack of parenting, lack of consequences, and the lack of resources for children/adolescents to get help with mental health/substance abuse. – Social Services Provider

E-Cigarettes

Rates of vaping and drinking are too high. Students don't have the support they need to not start and to quit if they started. – Physician

Vaping has seemed to replace much of this in younger students. – Social Services Provider

We have seen a rise in vaping in our student population. In the past few years, a number of students have died in alcohol related incidents. – Community Leader

Vaping is the number-one issue right now. Students are terribly addicted to this chronic bad habit. Juul company has made their product addicting and students cannot kick the habit. Staff having to patrol the restrooms because students use the area to vape. Students being suspended for vaping on a routine basis. Alcohol is easily available for some students, they share with others as they do with vaping products. Share Juuls. – Community Leader

Incidence/Prevalence

Children are initiating such behaviors at young ages, which likely leads to continuing use as they age. – Public Health Representative

Multiple substance use among many young people. – Physician

Binge drinking. – Community Leader

Doesn't allow people to reach their potential. It's a crippling problem in the community. – Social Services Provider

Ongoing issue. Also, see the mental health question. People self-medicating with these things. – Public Health Representative

We are seeing more children, and at a younger age, using chemicals. It seems that marijuana is being used more and some people don't think that there is a problem with it. – Community Leader

Reports of increased use since the pandemic. This was already an issue and remains. – Community Leader

Increase in availability with being home during pandemic. – Other Health Provider

Coping Mechanism

These often begin as coping strategies related to trauma and mental and behavioral health challenges. – Public Health Representative

Relates to mental health challenges and students looking for alternative ways to cope. – Other Health Provider

When youth are stressed or being harmed, they may turn to substance use. We have to protect youth, teach him healthy coping behaviors, and make substances harder to use and abuse. – Public Health Representative



Parental Influence

Parents and guardians who are clients at my place of work have arrived with their children and are high or under the influence. – Other Health Provider

Drug and alcohol use are common among parents who children go into foster care, their use also causes so much heartache and irrational decision-making among the users. Some of which leave permanent scars. – Other Health Provider

Discrimination/Racism

People of color experience discrimination at every stage of the criminal legal system and are more likely to be stopped, searched, arrested, convicted, harshly sentenced and saddled with a lifelong criminal record. This is particularly the case for drug law violations. Nearly 80% of people in federal prison and almost 60% of people in state prison for drug offenses are Black or Latino. Research shows that prosecutors are twice as likely to pursue a mandatory minimum sentence for Black people as for white people charged with the same offense. Among people who received a mandatory minimum sentence in 2011, 38% were Latino and 31% were Black. Black people and Native Americans are more likely to be killed by law enforcement than other racial or ethnic groups. They are often stereotyped as being violent or addicted to alcohol and other drugs. Experts believe that stigma and racism may play a major role in police–community interactions. – Community Leader

Vulnerable Populations

Too many youths are drinking and taking drugs at younger ages in low-income neighborhoods. Many experiment by the time they are in middle school and have full blown addictions by early adulthood. I know that it goes underreported within North Omaha. I personally believe that statistics and surveys will not account for young people that are not involved in the criminal justice system. – Social Services Provider

Environmental Tobacco Smoke

Children are still exposed to secondhand smoke and that is a problem. I am not sure about the statistics regarding drug and alcohol addiction for Omaha. – Community Leader



SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (<https://health.gov/healthypeople>)

Births to Adolescent Mothers

ABOUT FAMILY PLANNING

Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (<https://health.gov/healthypeople>)

Between 2012 and 2018, there were 20.6 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Metro Area.

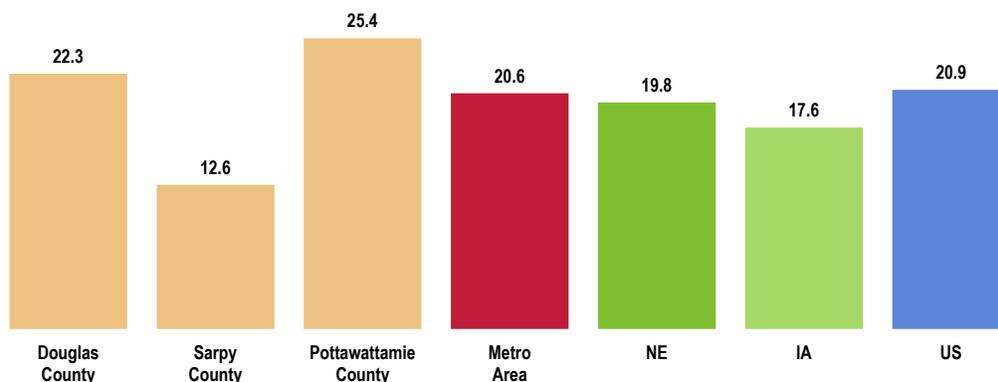
BENCHMARK ► Higher than the Iowa rate.

DISPARITY ► Unfavorably high in Pottawattamie county.



Teen Birth Rate

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2012-2018)
Healthy People 2030 = 31.4 or Lower



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes:

- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. 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.

Sexual Activity Among Adolescents

Recent Sexual Activity

Among Douglas County high school students, 21.3% report having had sexual intercourse with at least one person during the three months preceding the administration of the 2018-2019 Youth Risk Behavior Survey.

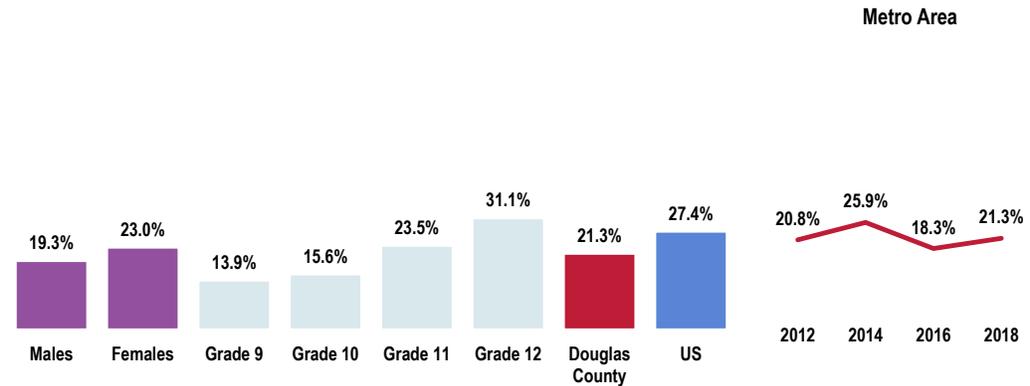
BENCHMARK ▶ Lower than the national percentage.

DISPARITY ▶ Reported more often among females, juniors, and seniors.

These indicators are derived from the CDC's Youth Risk Behavior Survey (YRBS), a school-based survey administered to high school students by county. For more information, visit: www.cdc.gov/healthyyouth/yrbs.



Had Sexual Intercourse in Past Three Months (Among High School Students; Douglas County Youth Risk Behavior Surveys, 2018-2019)



Sources: • Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
 • Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Reporting sexual activity within the three months preceding the survey.

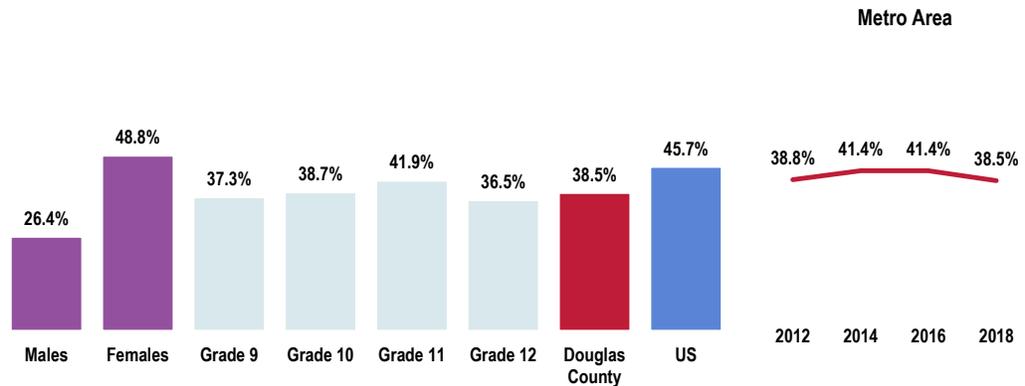
Risky Sexual Behaviors

Among Douglas County high school students who are sexually active, 38.5% report not using a condom during their last experience of sexual intercourse.

BENCHMARK ▶ A lower percentage than reported across the US.

DISPARITY ▶ The prevalence is much higher among Douglas County high school females.

Did Not Use a Condom During Most Recent Sexual Experience (Among Sexually Active High School Students; Youth Risk Behavior Surveys, 2018-2019)



Sources: • Douglas County Health Department. 2018/2019 Douglas County Youth Behavior Survey Report.
 • Centers for Disease Control and Prevention (CDC). 1991–2019 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed August 2021.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Condom was not used during most recent sexual experience.



Chlamydia & Gonorrhea

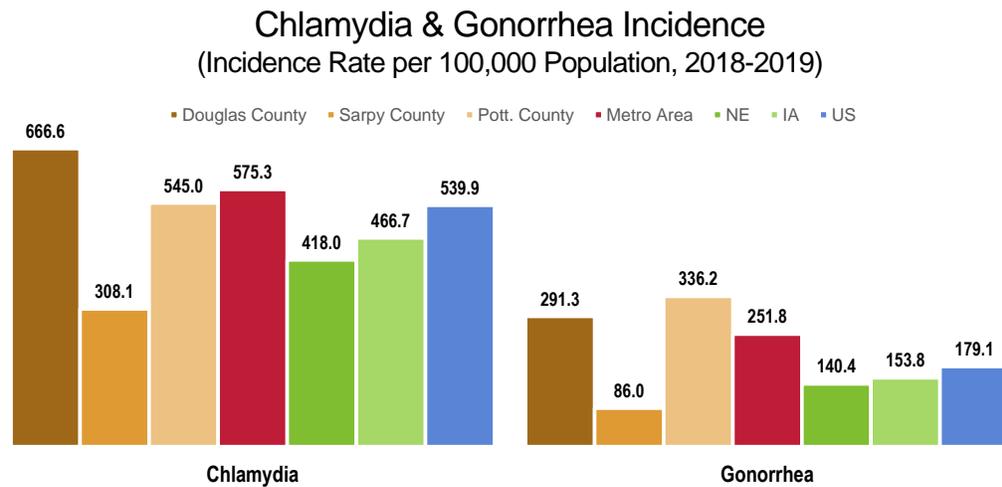
During the 2018-2019 reporting period, there were 575.3 diagnosed chlamydia infections per 100,000 population in the Metro Area. *Note that this rate includes diagnoses in all ages (both children and adults).*

During this same time, the Metro Area reported 251.8 diagnosed gonorrhea infections per 100,000 population. *Note that this rate includes diagnoses in all ages (both children and adults).*

BENCHMARK ▶ Both rates are worse than Nebraska and Iowa rates as well as the national rate.

TREND ▶ Both rates have increased over time (not shown).

DISPARITY ▶ Chlamydia incidence is highest in Douglas County while gonorrhea incidence is highest in Pottawattamie County.



Sources:

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).

Notes:

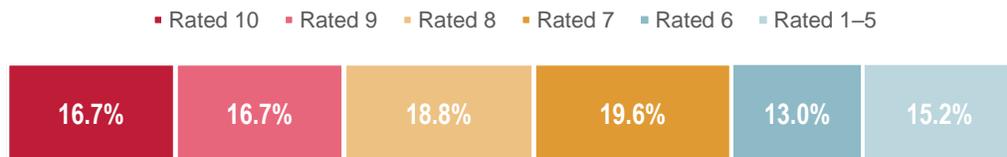
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.



Key Informant Input: Sexual Health

Over half of key informants taking part in an online survey gave *Sexual Health* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of Sexual Health as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Awareness/Education

It is a subject not often talked about. Children are left home alone a lot to be preyed on. Teens start looking for someone to love, which drives them to early sex and/or gangs. – Social Services Provider

So many confusing messages coming from school, homes, community leaders and media. – Social Services Provider

According to CDC, the age group at most risk for sexual transmitted infections is between ages 15 to 25. Yet as health care providers and educators, we have not systematically provided the education and awareness to youth who are at most risk for them to understand how to make healthy choices. Leaving it to families to provide sexual health is not only limiting but also a detriment to the youth who do not have family support. We can teach youth how to manage a checkbook in school but not how to manage their sexual health? Not acceptable. – Other Health Provider

There is still very little sexual health education that encompasses true sexual health questions and answers facing children and teens today. – Physician

Limited resources in schools, too much opportunity to opt out of valuable curriculum. Rates of STIs are not improving after decades of knowing that this is an issue. – Physician

Lack of education and resources. – Other Health Provider

Sex education should be taught at age appropriate levels. – Community Leader

Students without access to medically accurate, evidence-based sexual health curriculum aren't able to make informed decisions. Students who receive abstinence only education aren't prepared for real world situations. – Community Leader

The absence of high quality sex education that is medically accurate, age appropriate, inclusive, trauma informed, and culturally affirming in our schools is a major problem for children and adolescents in our community. – Community Leader

STD rates are still high. Sex is happening and our children and teens don't know enough. We don't need to take the parental role, but they need to understand the issues. Especially in the 19 to 26 age range, young people are finding themselves and are more active. There is not enough info about where to go to get info—need more publicity about the teen clinics in the city. – Community Leader

As demonstrated by the massive debate recently over the state health education standards, many children grow up in households where parents believe that not providing them with science-based, accurate information about their bodies, sexual health and development is a way of protecting them. Withholding this information actually sets children and adolescents up for increased risk for contracting STIs, risky sexual practices and lack of participation in preventative activities. Not to mention, the rates of STIs in Douglas County are outrageous. – Other Health Provider

We must teach children to understand their bodies, understand consent, and be realistic that knowledge means prevention. The shame and guilt approach is not working. – Public Health Representative



They are not always receiving science-based education to make informed decisions on choice, and they need more trusted adults in the community to provide resources to aid them in educating them on such matters. – Community Leader

STD rates in Nebraska are some of the highest in the nation. Lack of funding and buy-in for comprehensive sexual health curriculum. – Social Services Provider

Age appropriate education for all adults included. – Public Health Representative

Youth (especially refugee and immigrant youth who may have arrived after "sex ed" was offered to their grade level) frequently are not provided with honest, real information about how their bodies function. From puberty, to periods, to pregnancy and STIs—they have a million questions and are all too often without a trusted and well-informed source to answer them. Many immigrant and refugee communities are highly religious, which also creates an atmosphere of secrecy and shame around these questions. A major, major, major unfortunate result is that porn becomes the default "education" ... and porn is a public health crisis unto itself. It shapes ideas of what sex and relationships should look like in unhealthy ways; exposing minors to predators and potentially unhealthy fetishes at too young an age to process the difference; may even experience erectile dysfunction when faced with real-life sex. – Social Services Provider

Incidence/Prevalence

This is an ongoing issue in our conservative state. – Public Health Representative

Promiscuity is high and early sexual activity. – Physician

Based on the data of STIs and pregnancy rates. – Community Leader

Douglas County has high rates of STIs. – Physician

STI rates continue to be an epidemic in Omaha. – Other Health Provider

Last number I have seen are pretty poor for Nebraska's sexual health. – Other Health Provider

STD statistics. – Community Leader

STIs are an ongoing epidemic in our communities. The Contraceptive Access Project and Get Checked Omaha/ Access Granted is really working to effect change in this area but I'm not sure we are there yet. In Pottawattamie County we continue to have an increased teen birth rate as well. While Nebraska is working through health standards required in their school settings, this conversation is not on the same page in Iowa. – Other Health Provider

Douglas County still has one of the highest rates of chlamydia in the country. – Physician

Continue to see high numbers of STIs in the community and increasing cases of syphilis. – Public Health Representative

STDs are consistently on the rise and sexual health is an ever-changing field. It isn't just disease prevention that needs to be addressed but also sexual health. Sexual health needs to have standards based on science that include gender identity and sexual orientation. These things all influence sexual health and the services that a young person may need. – Public Health Representative

High rates of STDs and teen pregnancy, with limited resources. – Physician

High STD rates in the community and teens having babies. – Other Health Provider

Contributing Factors

In the societal push for sexual freedom and uninhibited sexual expression, children are at high risk for abuse and development of (very) unhealthy sexual attitudes at very young ages. Healthy sexual boundaries are violated, never to be reestablished. Look at skyrocketing incidence of sexually transmitted disease for starters. The ready availability of pornography is also a source of impairment of sexual health for children and adolescents, contributing to degradation of healthy sexual awareness. The solution lies not in teaching children about sex at an earlier age or exposing them to unhealthy examples of sexuality. It lies in modeling healthy relationships complete with healthy boundaries at all stages of a child's life and eliminating exposure to toxic influence. – Community Leader

High STI rates, cost of getting into somewhere for birth control. – Public Health Representative

Policy Barriers

Political barriers make it difficult to educate students on facts and options. – Other Health Provider

There are a significant amount of resources being poured into the Omaha health care and education community to address sexual health. However, institutional barriers and policy barriers remain. Only 2 schools districts in NE even closely align with national standards on sex education. Without consistent, age-appropriate, inclusive, medically accurate information our young people are not able to make informed decisions and plan for their futures. The policy infrastructure is not yet supportive in NE for improved sexual health outcomes (i.e. restrictions on access to birth control and condoms and abortion info for school-based health centers). Community based organizations need to commit to providing sexual health information too. A movement for reproductive justice needs to be funded and supported for long-term success as well. – Public Health Representative



Teen Pregnancy

At work I encounter young people with unplanned pregnancies. – Other Health Provider

We have a high number of pregnant and parenting teens, as well as STDs. More education and support is necessary. – Social Services Provider

Easy/Early Access

Children see and hear about sex everywhere; in their homes, on TV, radio and social media. Children are allowed to grow up too fast; cell phones, provocative clothing, dating at younger ages, home alone too often, etc. Some children seek love because they don't get it at home and they connect sex to love. Limitations on educating students in the school systems. – Public Health Representative

Co-Occurrences

Leads to disease and pregnancy, which they aren't ready for, which leads to unhealthy children and/or abortion, which is unhealthy and leads to other challenges. – Social Services Provider

Denial/Stigma

Stigma for addressing sexual health is still prevalent. Most all child providers are testing and treating adolescents for this disease. High rates of STIs still present. – Physician





ACCESS TO CARE

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

— Healthy People 2030 (<https://health.gov/healthypeople>)

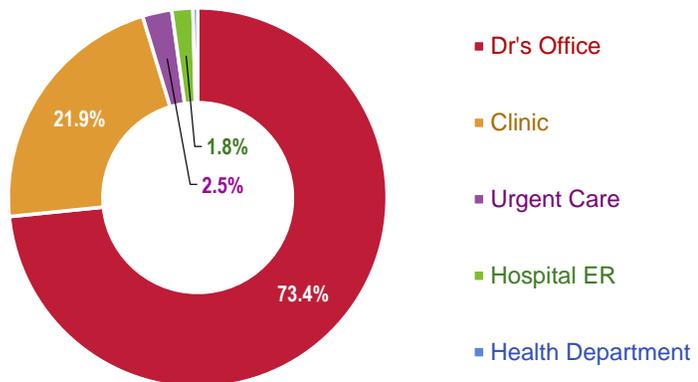
Routine Medical Care

Type of Place Used for Medical Care

When asked where they take their child if they are sick or need advice about his/her health, the greatest share of respondents (73.4%) identified a particular doctor's office.

A total of 21.9% say they usually go to some type of clinic, while 2.5% use an urgent care center and 1.8% rely on a hospital emergency room for their child's medical care.

Particular Place Utilized for Child's Medical Care
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 26]
Notes: • Asked of all respondents about a randomly selected child in the household.



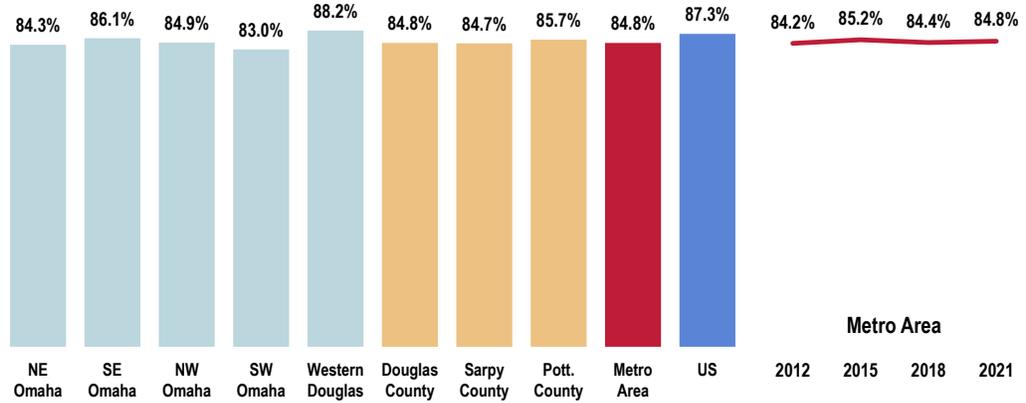
Receipt of Routine Medical Care

Among surveyed parents, 84.8% report that their child has had a routine checkup in the past year.

DISPARITY ► The prevalence decreases with age among Metro Area youth.

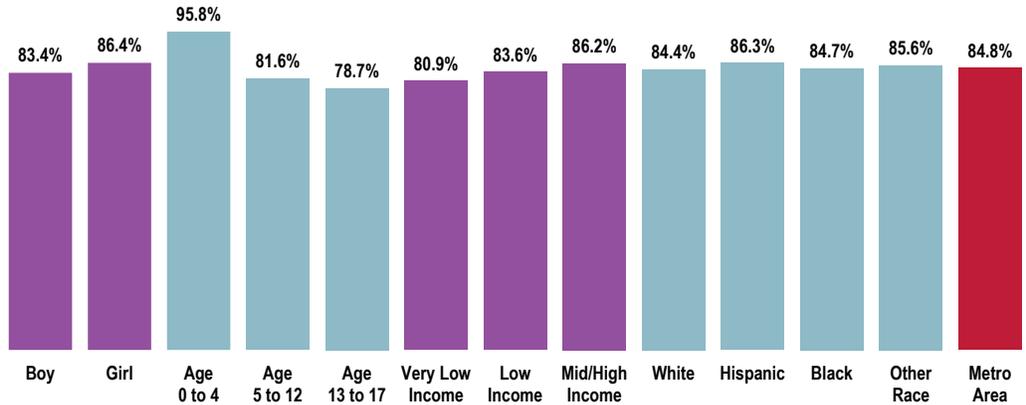
A routine checkup can include a well-child checkup or general physical exam, but it does not include exams for a sports physical or visits for a specific injury, illness, or condition.

Child Visited a Physician for a Routine Checkup in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 27]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Visited a Physician for a Routine Checkup in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 27]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Vaccinating Newborns

While nearly all surveyed Metro Area parents say they would want their (hypothetical) newborn to receive all recommended vaccinations, a total of 7.6% would not.

BENCHMARK ▶ Half the US prevalence.

TREND ▶ The prevalence has increased significantly since 2015.

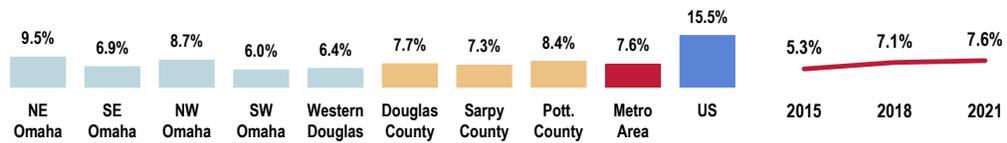
Vaccination is a primary defense against some of the most deadly and debilitating known diseases.

If Respondent Had a Newborn, Would Not Want Him/Her to Get All Recommended Vaccinations (Metro Area Parents, 2021)

Reasons:

- Safety concerns (32.4%)
- Perceived as unnecessary (27.9%)
- Prefer to delay (14.7%)

Metro Area



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 115-116]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.



Dental Care

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. ...Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (<https://health.gov/healthypeople>)

Receipt of Dental Care

In all, 77.2% of Metro Area children age 1-17 have visited a dentist or dental clinic (for any reason) in the past year.

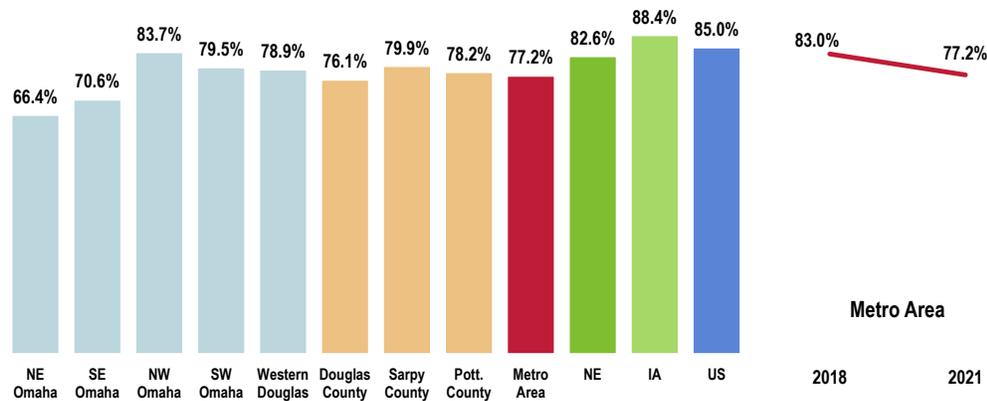
BENCHMARK ▶ Lower than the state and US percentages.

TREND ▶ Decreasing significantly from 2018 survey findings.

DISPARITY ▶ Lowest in Northeast Omaha. Reported less often among parents of children age 1-4, those living on low incomes, and non-Hispanic communities of color (especially Black children).

Child Visited a Dentist/Oral Health Care Provider Within the Past Year (Metro Area Children Age 1-17, 2021)

Healthy People 2030 Objective = 45.0% or Higher (Age 2-17)

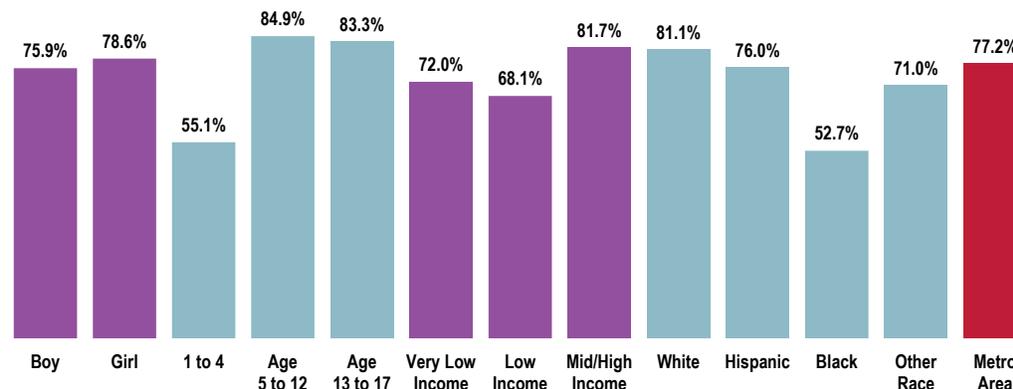


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 306]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 • Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.



Child Visited a Dentist/Oral Health Care Provider Within the Past Year (Metro Area Children Age 1-17, 2021)

Healthy People 2030 Objective = 45.0% or Higher (Age 2-17)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 306]
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 2 to 17.

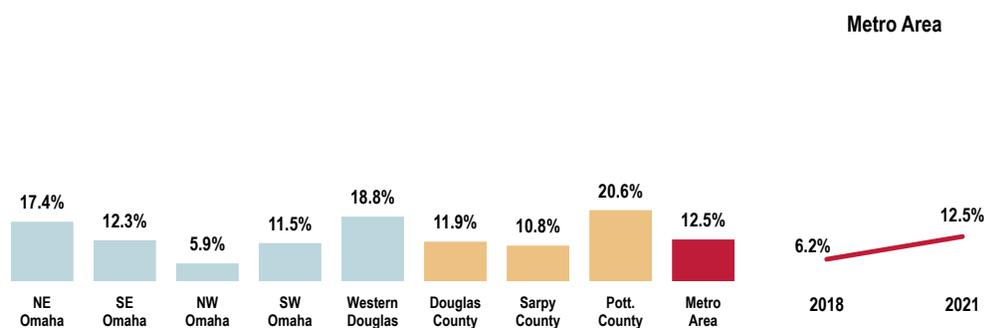
Difficulties Accessing Dental Care

A total of 12.5% of parents report that they have experienced difficulties accessing dental care for their child (age 1 to 17) in the past year.

TREND ► Reports of difficulty increased significantly from 2018 survey findings.

DISPARITY ► Unfavorably high in Pottawattamie County. The prevalence increases with child's age and is reported more often among parents living just above the federal poverty level and non-Hispanic, non-Black communities of color.

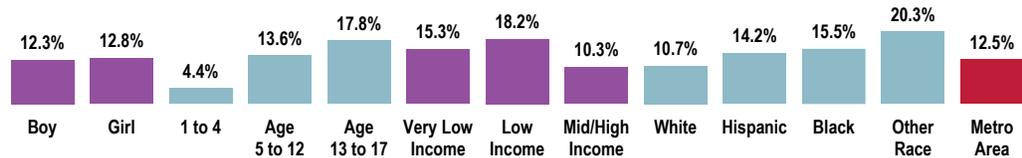
Difficulty Accessing Dental Care in Past Year (Metro Area Children Age 1-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 307]
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
 • This question was asked about all children, regardless if they needed or sought care.



Difficulty Accessing Dental Care in Past Year (Metro Area Children Age 1-17, 2021)



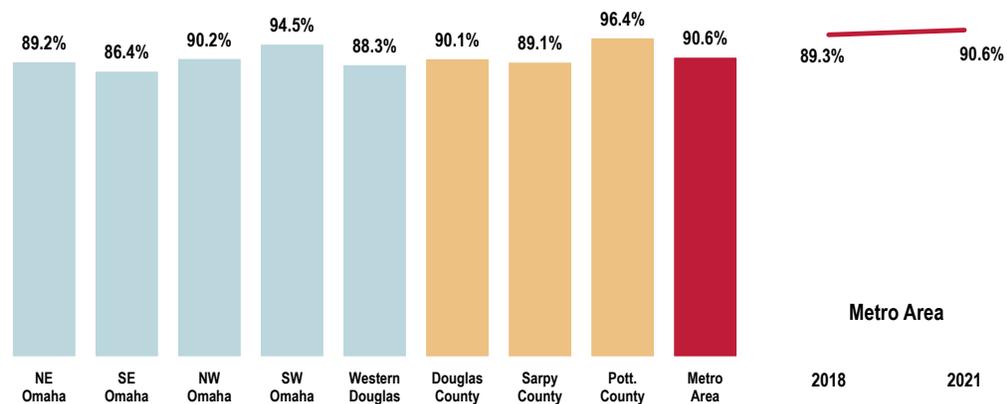
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 307]
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 2 to 17.
 • This question was asked about all children, regardless if they needed or sought care.

Dental Insurance

Most (90.6%) Metro Area children age 1-17 have insurance that covers all or part of their dental expenses (including private or government-sponsored coverage like Medicaid, Medicare, or CHIP).

DISPARITY ► Coverage is highest in Southwest Omaha and Pottawattamie County. Reported less often among parents of children age 1 to 4, parents of Hispanic children, and parents of Black children.

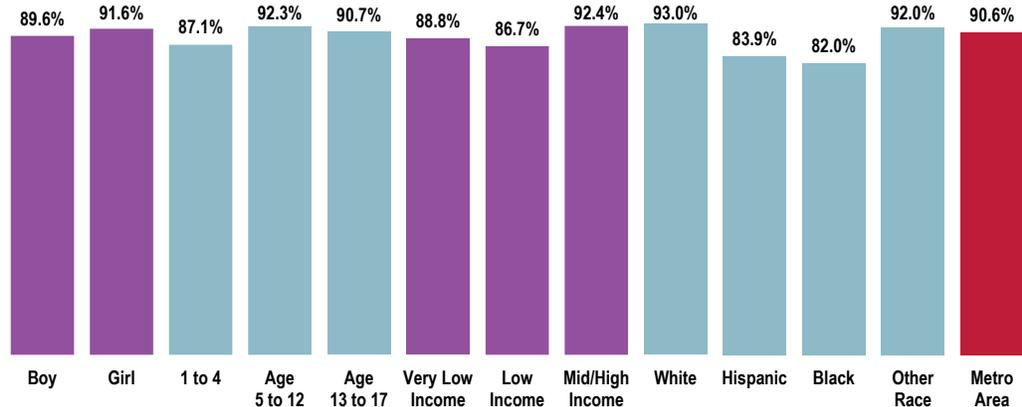
Child Has Dental Insurance (Metro Area Children Age 1-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 308]
 Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.



Child Has Dental Insurance (Metro Area Children Age 1-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 308]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.

Key Informant Input: Oral Health

A plurality of key informants taking part in an online survey gave *Oral Health* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of Oral Health as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)

■ Rated 10 ■ Rated 9 ■ Rated 8 ■ Rated 7 ■ Rated 6 ■ Rated 1–5



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Contributing Factors

In Iowa, we are moving to a managed care model for children on Medicaid for dental services. There are already too many administrative barriers for dental providers to bill and receive payment for Medicaid and Hawk-I services currently. Adding the barriers of MCO insurance options will limit the availability of providers even further. Currently there are only three dental provider offices accepting new Medicaid clients in Pottawattamie and Mills counties. Furthermore, less than 50% of children on Medicaid in those counties have seen a dentist in the past year leaving hundreds of children without essential preventive services. Transportation to dental providers is also a barrier in rural communities as well as language barriers for individuals whose primary language is not English. It is also much easier to be fired as a patient in the dental world than it is in the medical world which means many families have already exhausted their clinical options that accept their insurance provider. – Other Health Provider

Since everything is connected, the lack of healthy foods will impact the quality of oral health. Many communities of color have few oral health professionals and no insurance to cover many of the procedures necessary for good oral health. – Other Health Provider

There are no dentists in the community. The cost is a big factor, and fear. – Social Services Provider



The standard American diet lends itself to oral issues. If a parent doesn't know when or where to take a child to the dentist, issues can go undetected and become large financial burdens quickly. – Other Health Provider

Lack of access to, ability to afford, and transportation. – Social Services Provider

If we are working parents with health coverage through our place of employment first we must take time off (possibly not being able to afford to), dental plans do not cover much (leaving another bill), nutrition, many people do not understand that teeth are very important and preventative care is not priority today. – Social Services Provider

Dental health is an essential part of our overall health. While working with our Healthy Smiles program, we are finding many children with urgent dental needs. Children present with pain, infection and lack of self-esteem due to the appearance of their teeth. I have a strong passion for dental public health and our program works hard on case management to make sure that every child with urgent dental need finds a dental home. This is a challenge due to the barriers discussed earlier, such as financial, language, transportation, guardianship and access to care. There is plenty of dental need in our community to keep all dental professionals busy. I once walked into a pre-K classroom and 14 children out of 15 had urgent dental need. We need help fighting oral health in our community, so children spend less time in the nurse's office with dental pain and more time in the classroom learning. – Social Services Provider

It has a lower priority for parents than food, shelter and clothing, safety and security. Financially inaccessible, not being covered by insurance for many. – Other Health Provider

Many families do not have the resources to make oral health a priority. There are fewer and fewer dental providers that accept Medicaid. We know that poor oral health can lead to other chronic health conditions and is correlated with poor academic performance. – Community Leader

Access for Medicare/Medicaid Patients

In Iowa, we are moving to a managed care model for children on Medicaid for dental services. There are already too many administrative barriers for dental providers to bill and receive payment for Medicaid and hawk-i services currently. Adding the barriers of MCO insurance options will limit the availability of providers even further. Currently there are only three dental provider offices accepting new Medicaid clients in Pottawattamie and Mills Counties. Furthermore, less than 50% of children on Medicaid in those counties have seen a dentist in the past year leaving hundreds of children without essential preventive services. Transportation to dental providers is also a barrier in rural communities as well as language barriers for individuals whose primary language is not English. It is also much easier to be fired as a patient in the dental world than it is in the medical world which means many families have already exhausted their clinical options that accept their insurance provider. – Other Health Provider

Many families do not have the resources to make oral health a priority. There are fewer and fewer dental providers that accept Medicaid. We know that poor oral health can lead to other chronic health conditions and is correlated with poor academic performance. – Community Leader

Fewer dentists in Pottawattamie County are accepting Medicaid patients. This is most likely due to low reimbursement rates and poor show rates for Medicaid patients. – Public Health Representative

There are so few Medicaid oral health care providers in our community. We need more dentists who will accept Medicaid patients. – Community Leader

Medicaid reimbursement rates are not adequate to encourage dentists to provide care. – Public Health Representative

Affordable Care/Services

The number one referral in school nursing is dental. Families living in poverty often times make this the last health priority for seeking services. – Other Health Provider

Dental expenses are costly and families with limited or no insurance put off regular treatment. – Social Services Provider

Payment is often carved out of regular insurance. Great surgical expenses in childhood is due to dental decay in childhood, which is very preventable. – Physician

Awareness/Education

Lots of kids and families do not understand the importance of oral health and its effects. Access is also a problem. – Other Health Provider

Not enough education of the importance. – Other Health Provider

Oral health is important for all human beings, especially kids with growing teeth. – Community Leader

Vulnerable Populations

Undocumented families might be less likely to take advantage of programs that offer free oral health services. Oral health is not covered for many working families and is an expense that is not budgeted for. – Community Leader



For immigrants and refugees coming from underdeveloped countries or refugee camps, adequate dental care just isn't available in many cases. People arrive in the U.S. without having ever seen a dental specialist in their entire life. Additionally, they may not have had access to high amounts of sugary foods and/or nutrition education on the new foods they'll encounter here in the U.S. so are unaware of the damage that these foods can wreak on oral health. – Social Services Provider

Access to Care

Despite access to school dental programs, some students just don't see the dentist regularly, whether that be due to insurance, or parents just not being able to commit to appointments due to work schedules. – Community Leader

The historical limitations due to access, availability and affordability has created gaps in oral health literacy and how to navigate the system. – Public Health Representative

Prevention/Screenings

The data indicates oral health care among early childhood populations is worsening in our community. Without appropriate care and prevention practices, large percentages of children 1 to 5 years old develop decay, and many go untreated. Untreated decay causes significant pain, impacts their ability to eat, and eventually impacts their permanent teeth that emerge ... continuing the cycle of decay and pain. – Community Leader

Impact on Quality of Life

Typically, oral health is taught and held accountable in the home. Oral issues affect so much of an individual's health. – Social Services Provider

Incidence/Prevalence

This is an ongoing issue. – Public Health Representative



Vision & Hearing

Vision

Recent Eye Exams

A total of 78.7% of Metro Area parents indicate that their child has had an eye exam within the past three years.

BENCHMARK ▶ Lower than the national percentage.

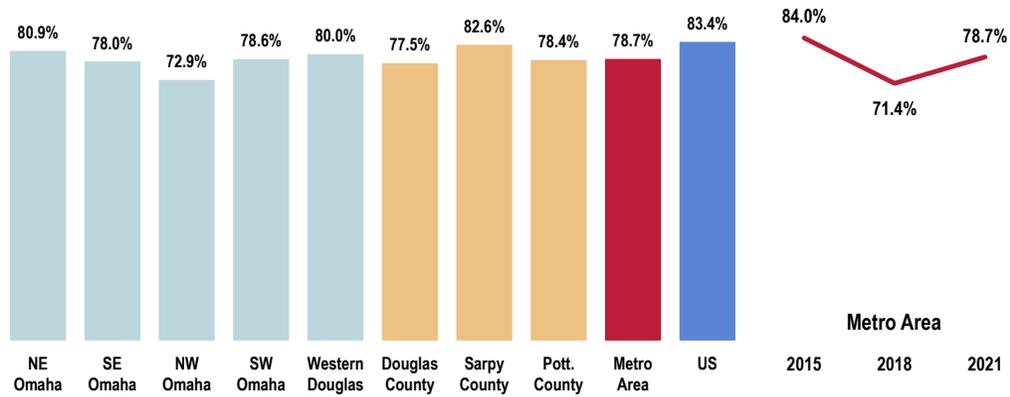
TREND ▶ Decreasing from 2015 survey results (but higher than that reported in 2018).

DISPARITY ▶ Reported less often among parents of children age 1-4 and those at the highest income level.

RELATED ISSUE:

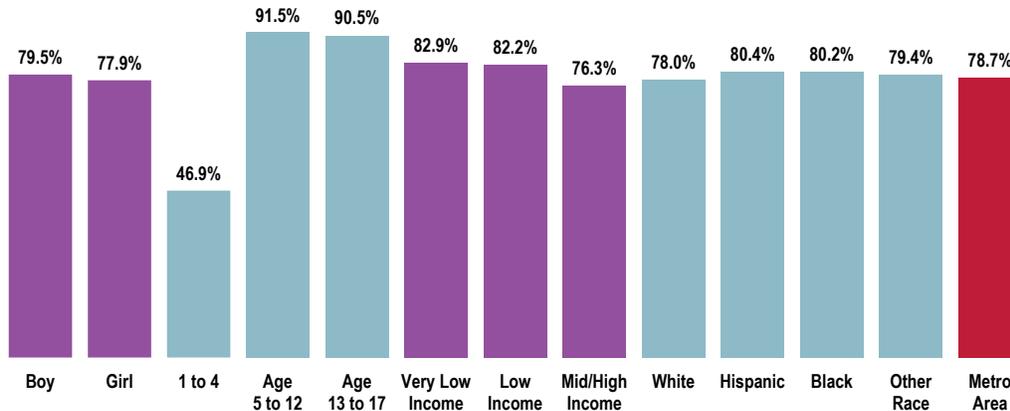
See also Vision Problems and Hearing Problems in the Chronic Disease & Special Health Needs: Prevalence of Selected Medical Conditions section of this report.

Child Had an Eye Exam in the Past Three Years (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 36]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Had an Eye Exam in the Past Three Years (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 36]
 Notes: • Asked of all respondents about a randomly selected child in the household.

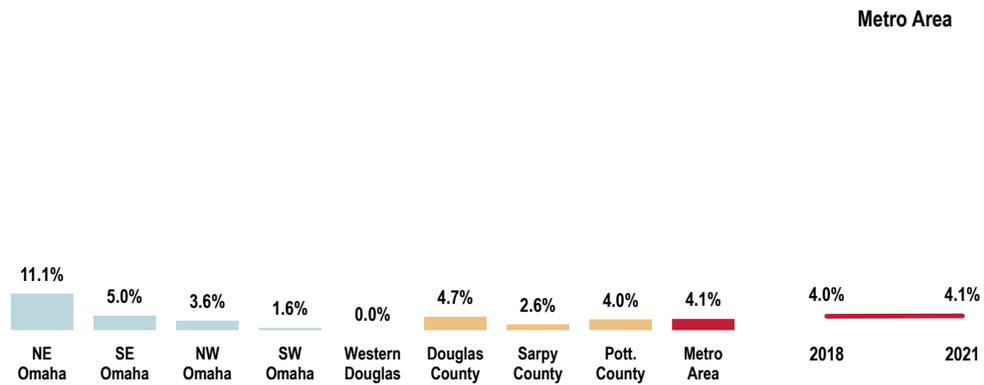


Difficulties Accessing Vision Care

A total of 4.1% of Metro Area parents report difficulties accessing vision care for their child in the past year.

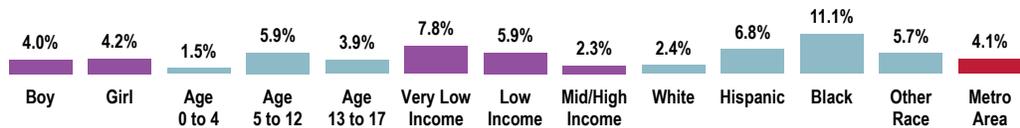
DISPARITY ► Unfavorably high in Northeast Omaha. Reported more often among parents of children age 5-12, those living in lower-income households, parents of Hispanic children, and parents of Black children.

Difficulties Accessing Child's Vision Care in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 304]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • This question was asked about all children, regardless if they needed or sought care.

Difficulties Accessing Child's Vision Care in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 304]
 Notes: • Asked of all respondents about a randomly selected child in the household.
 • This question was asked about all children, regardless if they needed or sought care.



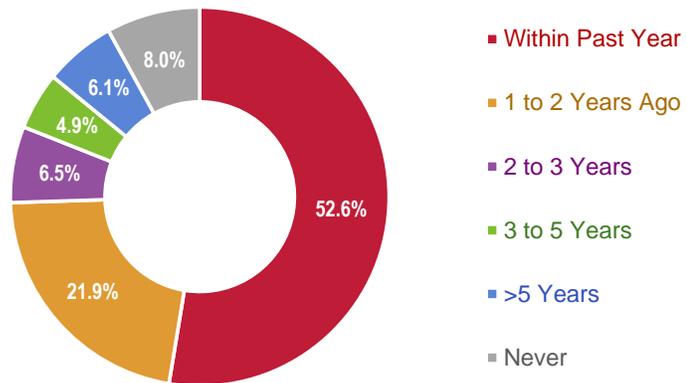
Hearing Tests

A total of 85.9% of Metro Area children have had a hearing test within the past five years.

TREND ▶ Increasing significantly since 2012.

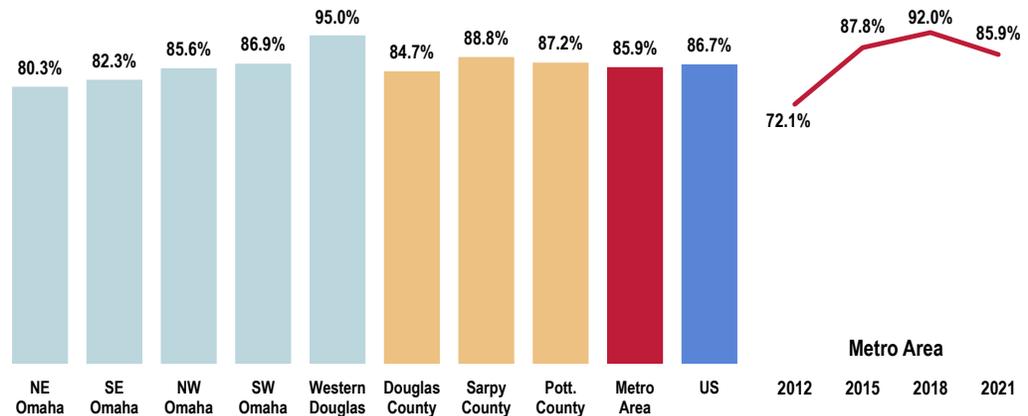
DISPARITY ▶ Highest in Western Douglas County. Reported less often among Metro Area parents of teens.

Child's Most Recent Hearing Test
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]
Notes: • Asked of all respondents about a randomly selected child in the household.

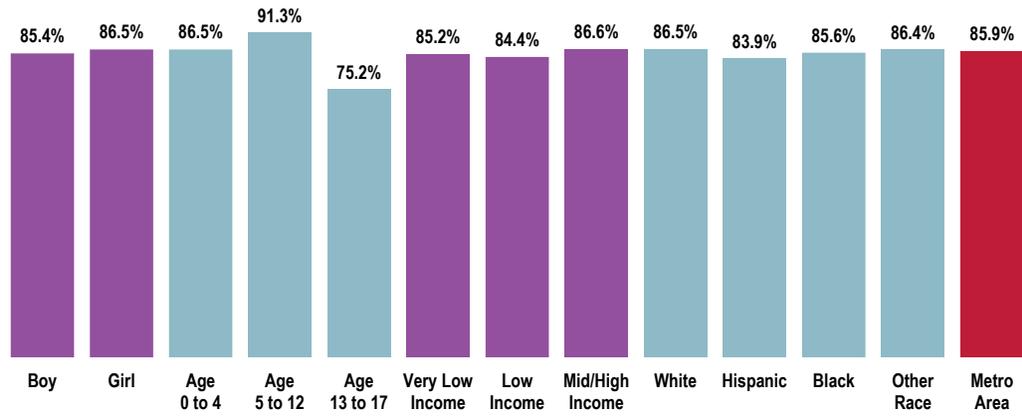
Child Had a Hearing Test in the Past Five Years
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents about a randomly selected child in the household.



Child Had a Hearing Test in the Past Five Years (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 38]
 Notes: • Asked of all respondents about a randomly selected child in the household.



EMERGENT & URGENT CARE

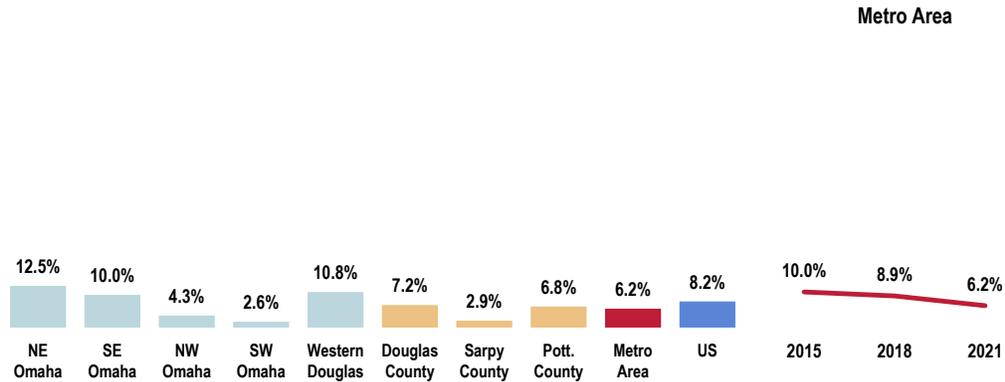
Emergency Room Utilization

A total of 6.2% of Metro Area parents report taking their child to a hospital emergency room (ER) more than once in the past year.

TREND ▶ Decreasing significantly since 2015.

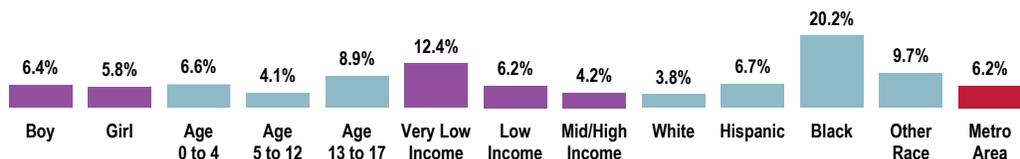
DISPARITY ▶ Unfavorably high in Douglas County (especially Northeast Omaha). Use of the ER correlates with income level and is higher among teens and non-Hispanic communities of color.

Child Used a Hospital
Emergency Room More Than Once in the Past Year
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 39]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents about a randomly selected child in the household.

Child Used a Hospital
Emergency Room More Than Once in the Past Year
(Metro Area, 2021)

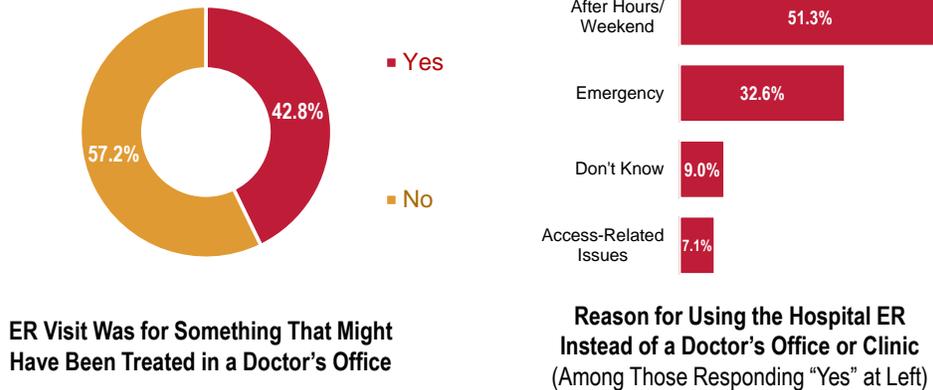


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 39]
Notes: • Asked of all respondents about a randomly selected child in the household.



Many parents report that their child's emergency room visit was something that could not have been treated in a doctor's office, often because the event occurred **after hours or on the weekend**.

Emergency Room Visits (Among Metro Area Children With Any ER Visits in the Past Year, 2021)



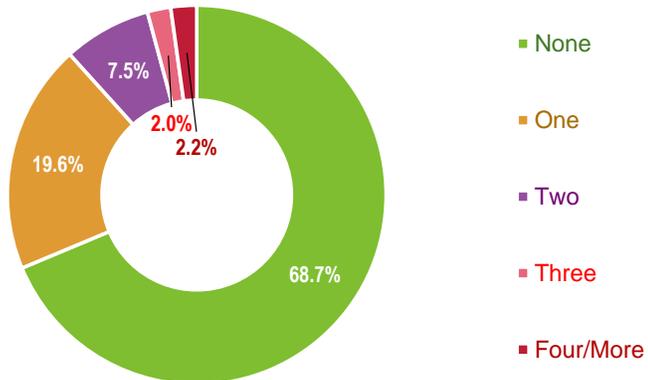
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 41-42]
 Notes: • Asked of respondents for whom the randomly selected child in the household used a hospital ER in the past year.

Urgent Care Centers/Walk-In Clinics

A total of 31.3% of Metro Area children visited an urgent care center or other walk-in clinic at least once in the past year.

DISPARITY ► Use is dramatically higher in Pottawattamie County.

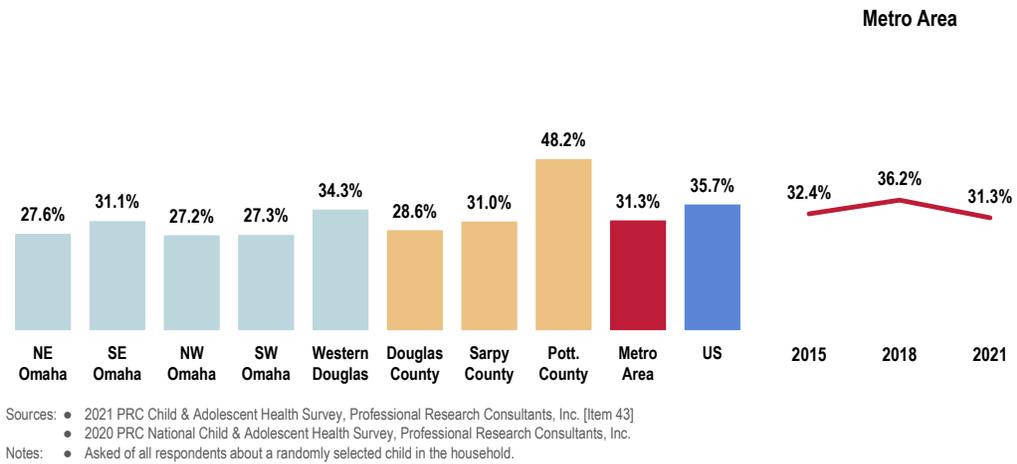
Number of Visits to an Urgent Care Center or Other Walk-in Clinic in the Past Year (Metro Area, 2021)



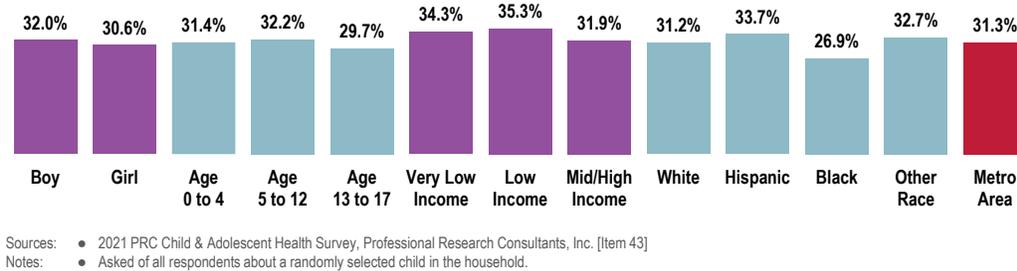
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 43]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Child Used an Urgent Care Center, QuickCare Clinic, or Other Walk-In Clinic in the Past Year (Metro Area, 2021)



Child Used an Urgent Care Center, QuickCare Clinic, or Other Walk-In Clinic in the Past Year (Metro Area, 2021)



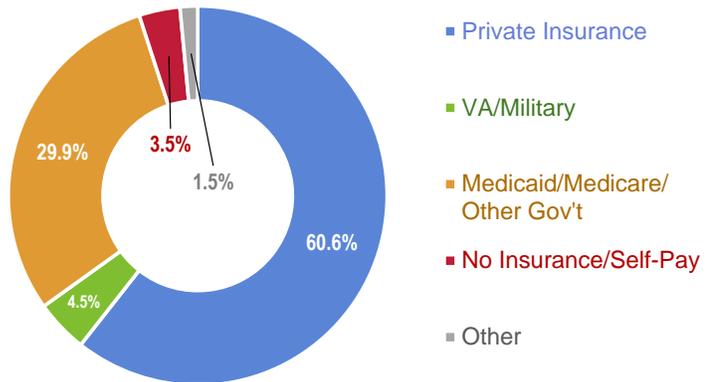
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their child's healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 6 in 10 (60.6%) parents report having healthcare coverage for their child through private insurance. Another 34.4% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, state-sponsored CHIP, military benefits).

Healthcare Insurance Coverage for Child
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 137]
Notes: • Asked of all respondents.

Lack of Health Insurance Coverage

Prevalence of Uninsured Children/Adolescents

On the other hand, 3.5% of Metro Area parents report having no insurance coverage for their child's healthcare expenses, through either private or public sources.

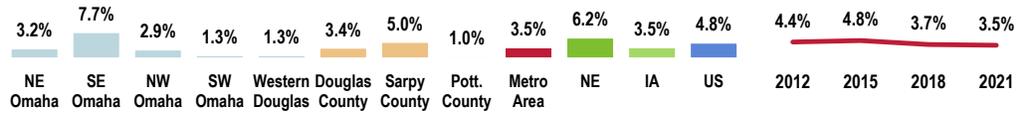
BENCHMARK ► Lower than the Nebraska prevalence.

DISPARITY ► Unfavorably high in Southeast Omaha. Reported more often among low-income respondents and parents of Hispanic children.



Lack Healthcare Insurance Coverage for Child (Metro Area, 2021)

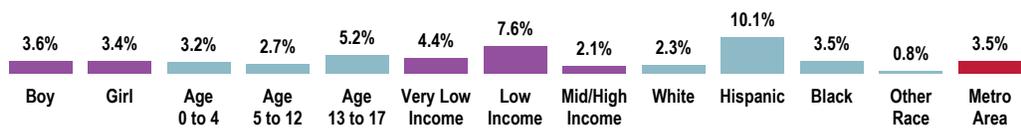
Metro Area



Sources: ● 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 137]
 ● 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 ● Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 2021 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes: ● Asked of all respondents.

Lack Healthcare Insurance Coverage for Child (Metro Area, 2021)



Sources: ● 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 137]
 Notes: ● Asked of all respondents.

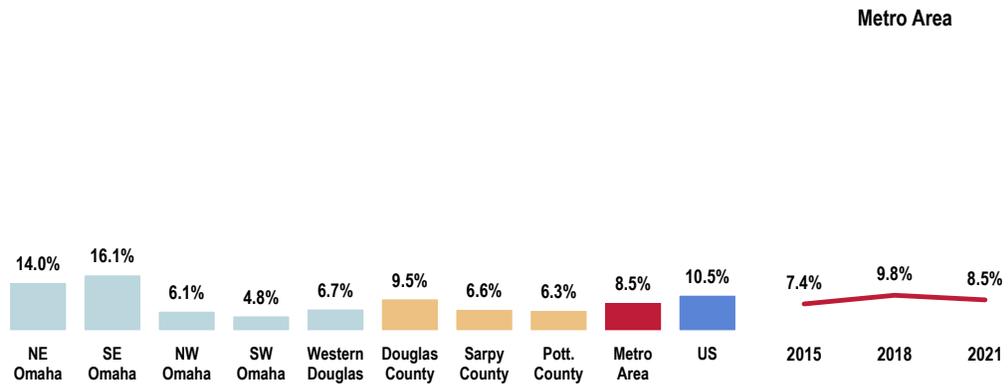


Recent Lack of Coverage

Among parents with insurance for their child, 8.5% report that their child was without healthcare coverage at some point in the past year.

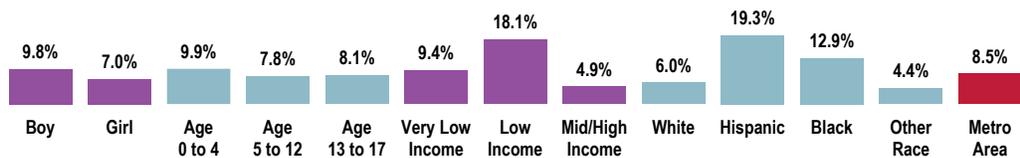
DISPARITY ► Notably high in the eastern part of Omaha. Reported more often among parents living just above poverty, parents of Hispanic children, and parents of Black children.

Child Has Been Without Coverage at Some Point (Metro Area Children 0-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 101]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children under 18 at home.

Child Has Been Without Coverage at Some Point (Metro Area Children 0-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 101]
 Notes: • Asked of all respondents with children under 18 at home.



DIFFICULTIES ACCESSING HEALTH CARE

Barriers to Health Care Access

Of the tested access barriers, **difficulty getting a doctor's appointment** impacted the greatest share of Metro Area children (10.4% of parents say that lack of appointment availability prevented them from obtaining a visit to a physician for their child in the past year).

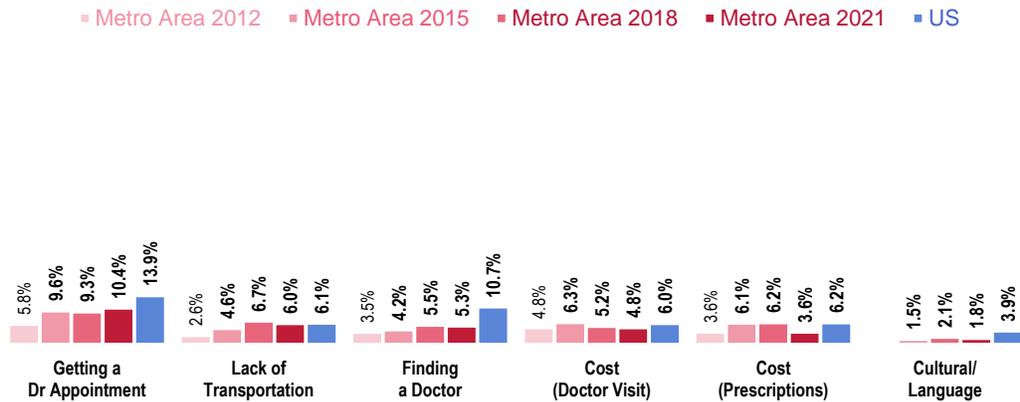
Lack of **transportation** impacted 6.0%, followed by difficulty **finding a physician** (5.3%), **cost of a doctor visit** (4.8%), **cost of prescription medication** (3.6%), and **culture/language** as a barrier (1.8%).

BENCHMARK ▶ These barriers are lower in the Metro Area than they are across the US as a whole: **finding a physician, appointment availability, cost of prescriptions, and culture/language.**

TREND ▶ Since 2012, **appointment availability** and **transportation** barriers have increased significantly.

DISPARITY ▶ Douglas County residents were most likely to say that **cost** prevented them from seeking a doctor's visit for their child in the past year; parents in Northeast Omaha were notably more likely to report that **transportation** was a barrier for their child's medical care in the past year.

Barriers to Access Have Prevented Child's Medical Care in the Past Year (Metro Area, 2021)

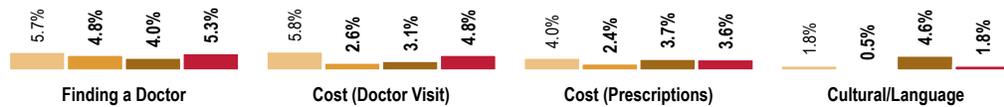


Sources: ● PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 17-20, 22-23]
 ● 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: ● Asked of all respondents about a randomly selected child in the household.



Barriers to Access Have Prevented Child's Medical Care in the Past Year (By County, 2021)

■ Douglas County
 ■ Sarpy County
 ■ Pottawattamie County
 ■ Metro Area



Sources:

- PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Items 17-20, 22-23]
- 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.

 Notes:

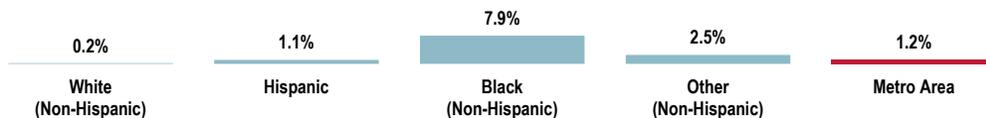
- Asked of all respondents about a randomly selected child in the household.

Bias in Treatment

Among surveyed Metro Area parents, 1.2% feel that their child's health care experience in the past year was worse because of race.

DISPARITY ▶ Reported more often among parents of Black children.

Child's Health Care Experiences Were Worse In the Past Year, Based on Race (Metro Area Parents, 2021)



Sources:

- 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 323]

 Notes:

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

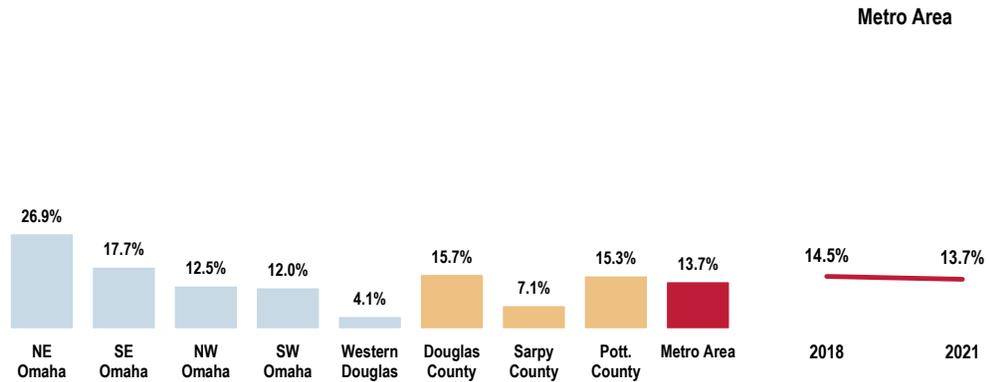


Care Coordination

A total of 13.7% of Metro Area parents report that they could have used extra help arranging or coordinating their child’s medical care in the past year.

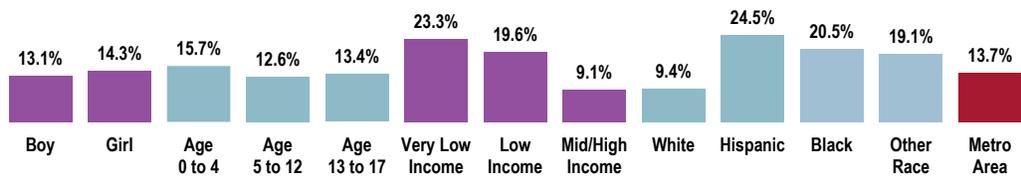
DISPARITY ► Highest in Douglas County (especially Northeast Omaha). The prevalence decreases with household income and is much higher among communities of color.

Could Have Used Help Coordinating Child’s Health Care Services or Providers in the Past Year (Metro Area Parents, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 340]
 Notes: • Asked of all respondents about a randomly selected child in the household.

Could Have Used Help Coordinating Child’s Health Care Services or Providers in the Past Year (Metro Area Parents, 2021)



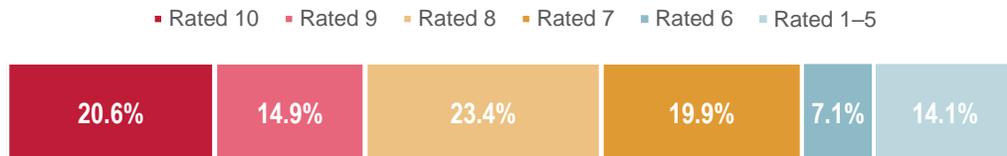
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 340]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Family Support Services

Over half of key informants taking part in an online survey gave *Lack of Family Support/ Services* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of a Lack of Family Support or Services as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Access to Care/Services

Very little exists and there are significant difficulties accessing what does exist. – Physician

Mental health services for the individual, as well as the individual’s support system (family), are significantly lacking. – Community Leader

Many families are never referred to the support that are available in the community. Often this is because providers they do see do not know what is available, how to refer and/or criteria for enrollment in each program. Many services that are provided are offered in English only or English and Spanish which does not meet the needs of people who do not speak those languages. Another issue is transportation. Few programs provide transportation. This is often a barrier especially for low income families who may not have any or reliable transportation. – Other Health Provider

I think that children are experiencing major mental health issues right now (with pandemic stress, family stress, school stress and underlying mental health needs) and there is a huge gap in services available for children and families in crisis. It takes a very long time for child welfare / juvenile probation services to kick in and the families that need the support urgently struggle to obtain it. Additionally, preventive case management services are available, but I would advocate that they be expanded. – Other Health Provider

Systems are difficult to navigate for even those who have resources. Navigating systems of assistance is challenging as well as getting family support that are trauma-informed, accessible and not ableist, etc. – Public Health Representative

Family supports and services for marginalized communities are not convenient, affordable or accessible for those most in need. Funding to organizations in the communities of color is insufficient to meet the needs. – Other Health Provider

Accessibility of services, lack of quality childcare and transportation to the site, need for culturally sensitive services. – Public Health Representative

The services change frequently, case managers with DHHS change frequently, getting people to answer the phones and speak to someone is difficult at times. – Other Health Provider

It less the lack of services and more about the ability for families to access the services. There are a lot of resources in our community, however families do not always know how to navigate the complicated system of accessing services. Often they have to repeat their story over and over before they find the right place that meets their needs and that they qualify for. – Community Leader

The need outweighs the available resources in the community. Many of the services available are located in the East part of the city. – Community Leader



Awareness/Education

I believe there are many good supports in our community, but that families may not be familiar with them and/or the services may not be included in the type of insurance they have. Wait lists are a major barrier to getting much needed help for mental and behavioral health. There is a lack of connectivity between all of the services in the metro, and I believe that any collective impact which might fill this need of supports and students has not yet reached its full potential. We also have a marvelous Midwest work ethic and an individualistic nature as a community. We could do better at noticing who needs help, understanding the "why" and connecting families with support they need. A family's need might be served from some entity or individual right around the corner, but they don't know the need exists and the family may be reticent to ask. Breaking down those barriers and pushing protective factors that lift people up is a necessary community practice. – Social Services Provider

I have worked with many families and rarely do they know where to go when their children are experiencing mental health challenges and the system is not always easy to navigate, particularly for families with limited resources and knowledge. We also many times have children placed out of home, when a strong program to support families so children can safely stay with people that they love in imperative. We need better policies that truly support families where they are. – Other Health Provider

Not enough family supports, i.e. parent education support groups and services are available. The services that are available are excellent (CHI Health/Boys Town) however wait times and capacity are a major concern due to increased access especially during the pandemic. – Other Health Provider

There are resources, but families do not know where to turn. – Physician

Refugee and immigrant guardians are often told what they CAN'T do in the U.S. (discipline, for example), but are almost never provided with specific, clear strategies of what they CAN and should do instead. A lack of adequate CLAS standards is a problem in this area as well. Guardians would greatly benefit from a 'parent mentor' program, much like youth get plugged into when navigating a new culture and systems. – Social Services Provider

Family Structure

Lots of children are being raised by older grandparents, older siblings and foster parents where the child moves from one place to the other and cannot build a connection and trust with anyone. Adolescents need stability and structure. – Other Health Provider

I see so many families struggling with their children because of a lack of parenting skills or willingness to be engaged in their child's life. – Community Leader

We see families in our clinic who are frequently facing challenges with single parenting and finding good childcare, safe transport to school, time off for appointments, transportation to appointments when they have multiple children and no one to watch the ones at home because transportation won't allow more than 1 child (or COVID not allowing everyone at visit), families with care givers working 2 jobs or night jobs and difficulty finding safe, consistent option for childcare. – Physician

I believe children do better in a two-parent household. Children and students from single parent households and children being raised by their grandparents or other family relative often are not sure of what and how to access available resources. I see parents struggling to thrive during the pandemic; if parents are struggling, so are their children. – Community Leader

Many single-family homes or broken homes, financial struggles, safety. – Physician

Family Support

Not all families have equal access for family supports. there is a heavy focus on low SES and minority populations, leaving a gap in supports for middle- and upper-class families. – Other Health Provider

There is so much abuse within family structures. Most families report not having anyone in their family to turn to. Many don't know any services available for them. – Community Leader

Families are not engaged as a partner in the medical field. Families report they often don't feel connected or see themselves in the practitioners. – Community Leader

We are living in unprecedented times, and while a number of NGOs (funded in part by PPP loans) have stepped in to help families, I believe that a number of families—thanks in part to the digital divide—missed out on opportunities for support that were advertised online and other places. finding ways to help those families make up for what they have lost and closing that divide will be key to equity. – Public Health Representative

In the metro area, supports vary by community. – Community Leader

Even the slightest barrier can be what keeps a child from getting care. Supports are needed to help parents understand what they need to do and how to get it done. – Other Health Provider

Income/Poverty

We have seen an increasing need for emergency economic assistance related to housing, utilities, transportation and mental health supports during the pandemic. – Community Leader

Resources of social health, such as poverty, housing, transportation, etc. for all children to maximize the health and well-being is not a priority in our community. – Physician



Again, working two-parent households are juggling a lot. I know, I did it. If you have the money, you can get the support. – Community Leader

Caregivers/parents need support from the community to raise healthy children. When we don't pay people a living wage, offer quality housing, and make nourishing foods accessible, we cannot expect parents/families to be able to be their best role model/coach to kids. – Public Health Representative

Contributing Factors

Limited resources for housing stability, childcare resources, and before and after school sports and activities that are accessible to all families. – Physician

Generational poverty. – Other Health Provider

I believe the lack of family support and services can lead to a variety of physical and mental illnesses (article). Children, adolescents, adults and the elderly who have a strong support system may develop healthy habits that can promote better self-esteem, relationships and confidence. It is important to surround ourselves with people who show empathy, compassion, positivity and confidence as these characteristics encourage us to be our best for ourselves and others. – Social Services Provider

Incidence/Prevalence

The growth of kids with autism isn't being met anywhere. – Community Leader

Because it's come up as a priority in the last two DHHS Title V Needs Assessments over the last 10 years for children and youth with special healthcare needs. Because it's been identified as a priority in the NE Developmental Disabilities Council current needs assessment, has been prioritized by the Arc of NE. And consultants for NE DHHS have indicated it as a concern in their report after they conducted a statewide listening session. Further, I work with families and see firsthand the disconnects. Families need more navigational supports, but they also need access to more programs such as Medicaid, especially for their child with disability/special healthcare needs. – Social Services Provider

Culturally Competent Providers

Parents don't seek medical help until the last minute. They don't like going to agencies because there is no one that looks like them. Plus, lack of money. – Social Services Provider

No one that looks like them or who they can trust is available, nonexistence. – Community Leader

Denial/Stigma

A lot of families are resistant to accepting help and/or are not involved in the selection process, so they are resistant to services. – Social Services Provider

Funding

There are limited resources available to fund family supports and services. these supports and services can help keep youth and families out of system involvement. – Other Health Provider



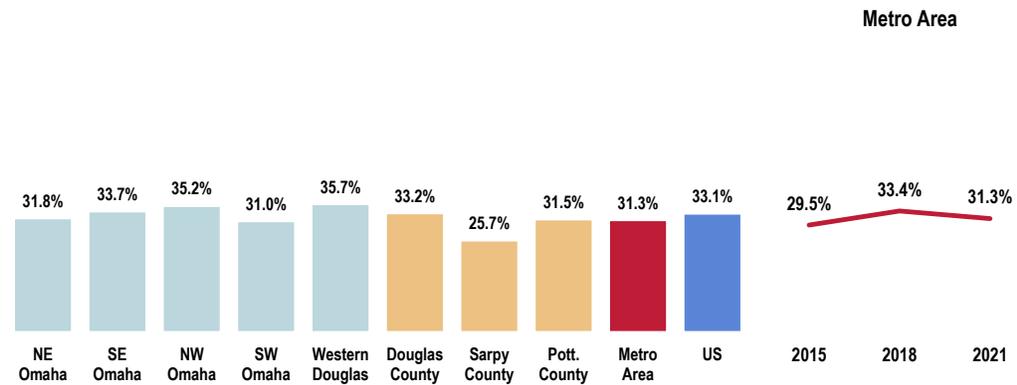
Access to Specialty Care

Need for Specialty Care

A total of 31.3% of Metro Area children are reported to have needed to see a specialist at some point in the past year.

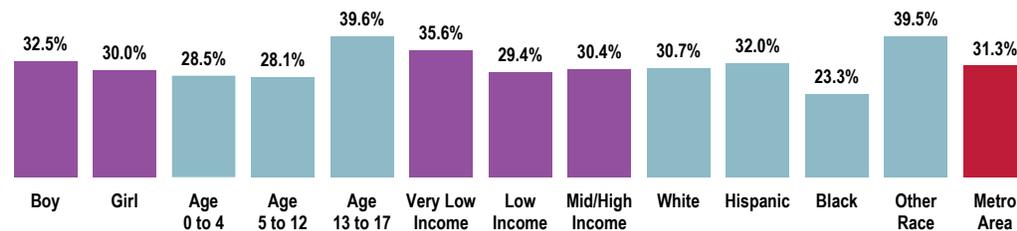
DISPARITY ► Lowest in Sarpy County. Reported more often among parents of teens.

Child Needed a Specialist in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 28]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents about a randomly selected child in the household.

Child Needed a Specialist in the Past Year (Metro Area, 2021)



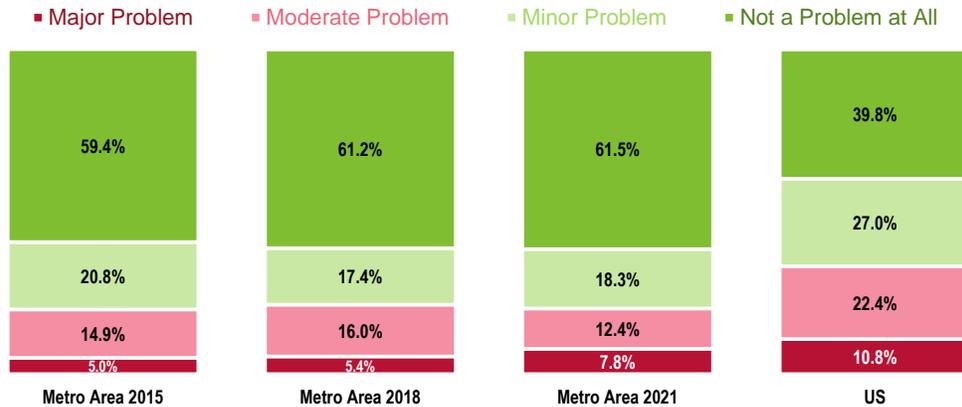
Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 28]
 Notes: • Asked of all respondents about a randomly selected child in the household.



Difficulty Accessing Specialty Care

Parents of children needing specialty medical care in the past year were further asked to evaluate the difficulty of getting the needed care. In the Metro Area, 38.5% expressed some level of difficulty, characterizing it as a “major,” “moderate,” or “minor problem.”

Evaluation of Difficulty Getting Specialty Care for Child in the Past Year (Metro Area Parents of Children Needing to See a Specialist in the Past Year, 2021)



Sources: • PRC Child & Adolescent Health Surveys, Professional Research Consultants, Inc. [Item 29]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of respondents for whom the randomly selected child in the household has needed to see a specialist in the past year.

Key Informant Input: Access to Health Care

A plurality of key informants taking part in an online survey gave *Access to Health Services* a rating of “8,” “9,” or “10” (10-point scale where “10” is a major issue) for children/adolescents in the community.

Perceptions of Access to Health Services as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)



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



Among those rating this issue as a “9” or a “10,” reasons related to the following:

Contributing Factors

Transportation to and from, as well as inability to pay co-pays or other associated costs. – Social Services Provider

Transportation, lack of Medicaid providers, follow through by parents, language barriers. – Community Leader

Transportation barriers. Neighborhoods aren't walkable and public transportation is severely limited. One World has a clinic in West Omaha, for which we are grateful, but it's difficult to get to without a car. – Community Leader

I believe cost, proximity to home, and having adults in the home to take them for care are the greatest barriers to accessing health care. – Public Health Representative

Affordable, accessible, and culturally appropriate providers. – Other Health Provider

Children and adolescents have to rely on parents or guardians to get them to the physician's office. In two parent household this is an issue when parents work or only have one care or cannot take time off. It is even more pronounced in low income and minority families. Families are also caring for their elders and as a result have a hard time getting away. The move to technology i.e. portals and other electronics makes care not accessible for this population as well. For mental health, there is a severe gap in care for young people and after care—lots of emergency triage and centers but what is needed is more places for young people to live with mental health and social supports. – Community Leader

Location of services, lack of transportation, undocumented can't afford and aren't eligible for services through Medicaid, language barriers for non-English speakers. – Public Health Representative

People want providers within a five to ten-minute drive or walk. Specialist availability seems low, and long wait times to get an appointment. – Public Health Representative

To all, culturally appropriate, geographically available and insurance or payment available. – Physician

1) Cultural competency of health institutions and lack of professionals of color that mirror the community in need of their care. 2) Geographic barriers to care, particularly specialty care services; many providers are located in west Omaha with limited bus access, so residents of east Omaha experience barriers to transportation to appointments. 3) Lack of knowledge and skills among many parents for navigating the health system - inability to advocate for their child because they are not aware of other options and/or services, barriers in scheduling appointments and following all the 'rules' required. 4) Language barriers for parents trying to access care for their child. – Community Leader

I have five barriers that I see as the biggest challenges related to accessing health care for children and adolescents in our community: financial, language, transportation, guardianship, and access to care. – Social Services Provider

Barriers like insurance, parent consent, and the pandemic restrictions on walk-in's due to safety. – Community Leader

Social determinants of health—transportation, affordable health care, lack of insurance, systemic racism/medical mistrust in the healthcare world, providers without training on autism and youth-friendly care, providers trained in implicit bias, health care should not be tied to employment in this country. – Public Health Representative

Access to excellent care with providers who have the experience and support to treat child/adolescent/transition age (19 to 25) for mental health care. Integrated services have improved access in primary care settings and schools however there are continued limited provider availability with an average wait time for a first-time appointment of two to four months in outpatient settings. – Other Health Provider

Availability and transportation. – Community Leader

Awareness/Education

Awareness, cost, and ease. – Other Health Provider

I see a lot of lack of knowledge of how to enter into systems to obtain mental health care. There are A LOT of parents that make too much to obtain Medicaid but cannot afford the health care plan through their employer or aren't offered health care through their employer and can't afford anything available through the ACA at this point. Lack of knowledge about the importance of yearly physicals for children of all ages to assess for developmental needs, undiagnosed chronic conditions and mental health needs. Oral care / eye care that isn't addressed due to costs and lack of assistance. – Other Health Provider

Adolescent Healthcare

Lack of the adolescent well visit. We know that preconception care is important to improve reproductive outcomes and improved overall health. These patterns of engagement with medical and dental homes are established during the adolescent years. As the adolescent well visit is low, it means there is not opportunity for engagement on health topics, check ins about relationship safety and consent, preconception care, and a whole host of other topics. – Other Health Provider



COVID-19

Due to the pandemic, there are a number of families experiencing job loss and really changed family structures. This disruption, and grief, and increased health issues means that caretakers are more overwhelmed. People are also anxious about going to health care providers and changing protocols—due to the prioritization of COVID—has created changes in some access to services. – Public Health Representative

Vulnerable Populations

Immigration issues, DACA no longer available, families split apart by deportation. Stress related to fear of family separation. Lack of Medicaid coverage due to not being a citizen. – Physician

Transportation

Safe and decent transportation. – Social Services Provider



MENTAL HEALTH SERVICES & TREATMENT

Awareness of Mental Health Services

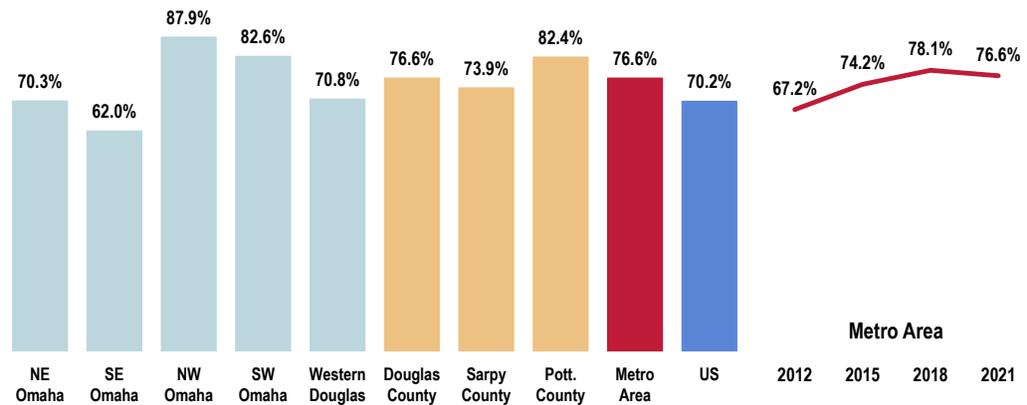
Three in four Metro Area parents (76.6%) say that they are aware of local community resources for mental health.

BENCHMARK ▶ A higher prevalence of awareness than reported nationally.

TREND ▶ A statistically significant increase from 2012 survey findings (similar to later administrations).

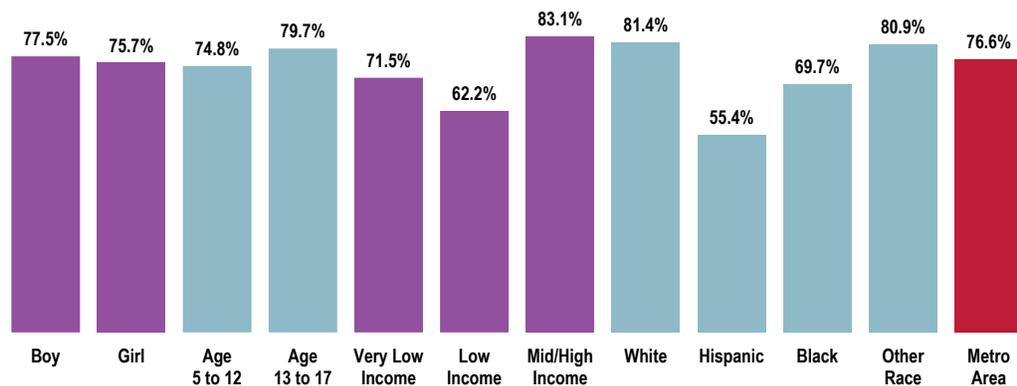
DISPARITY ▶ Awareness is lowest among Southeast Omaha respondents. Also reported less often among low-income households, parents of Hispanic children, and parents of Black children.

Aware of Mental Health Resources in the Community
(Among Parents of Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 90]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Aware of Mental Health Resources in the Community
(Among Parents of Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 90]
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



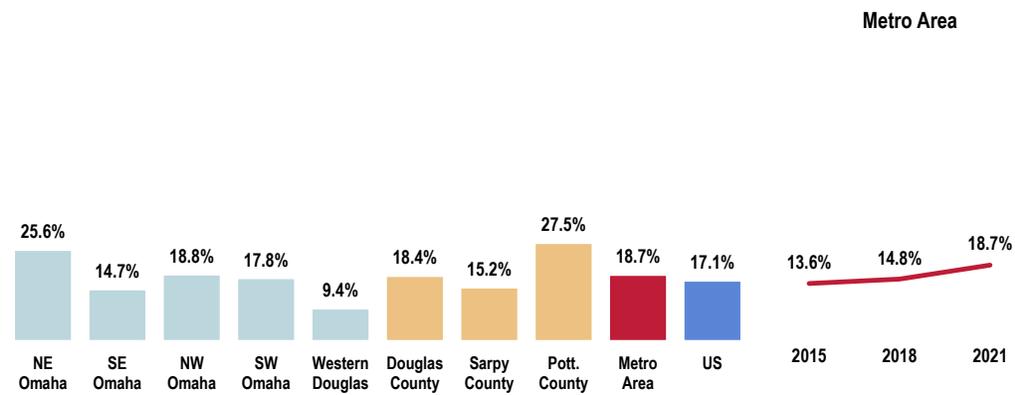
Need for Mental Health Services

Nearly one in five Metro Area parents of children age 5-17 (18.7%) reports that their child needed mental health services at some point in the past year.

TREND ► Increasing significantly from 2015 survey findings.

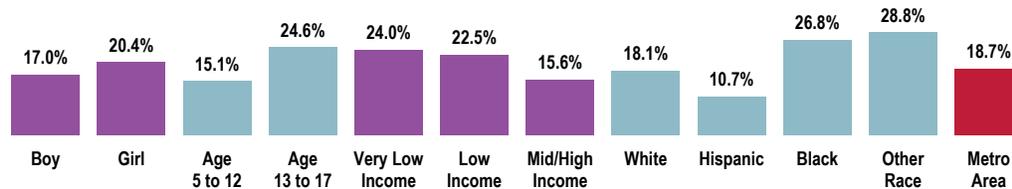
DISPARITY ► Unfavorably high among Northeast Omaha respondents. The prevalence correlates with household income and is reported more often among parents of teens and parents of non-Hispanic children.

Child Needed Mental Health Services in the Past Year (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 78]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Needed Mental Health Services in the Past Year (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 78]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



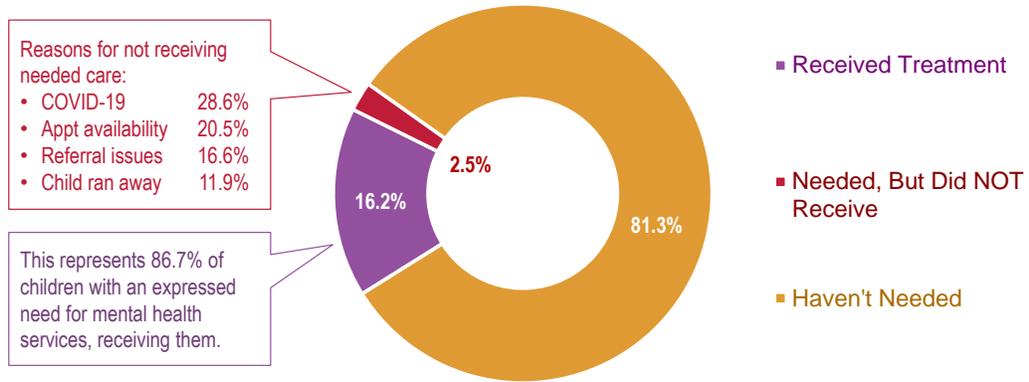
Receipt of Mental Health Services

A total of 16.2% of Metro Area parents report that their child (age 5-17) has received mental health services in the past year (this includes 86.7% of those with an expressed need for services).

TREND ▶ Marks a statistically significant increase since 2015.

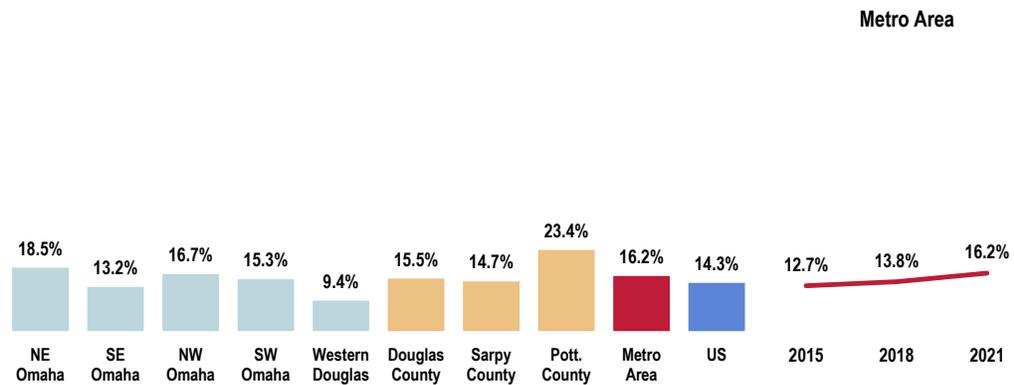
DISPARITY ▶ Reported more often among parents of teens, those in lower-income households, and parents with children of other races.

Child's Receipt of Mental Health Treatment in Past Year (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Items 79-80]
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

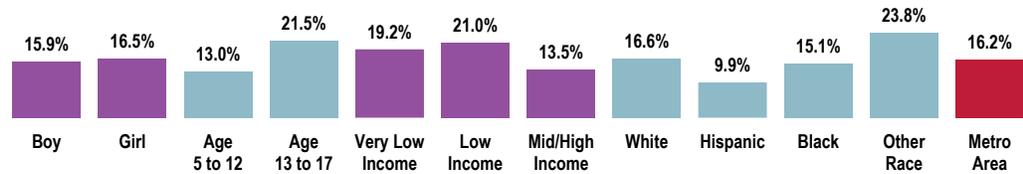
Child Received Treatment or Counseling in the Past Year (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 79]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



Child Received Treatment or Counseling in the Past Year (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 79]
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

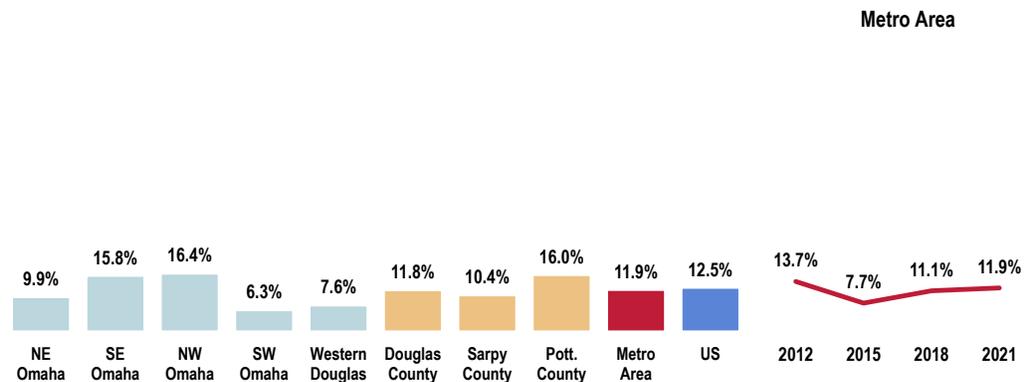
Prescriptions for Mental Health

A total of 11.9% of Metro Area parents report that their child (age 5-17) has ever taken prescribed medication for his/her mental health.

TREND ► Increasing from 2015 survey findings (similar to 2012 and 2018 results).

DISPARITY ► The prevalence is lowest in Southwest Omaha. Higher among teens, children in very low income households, and Black children.

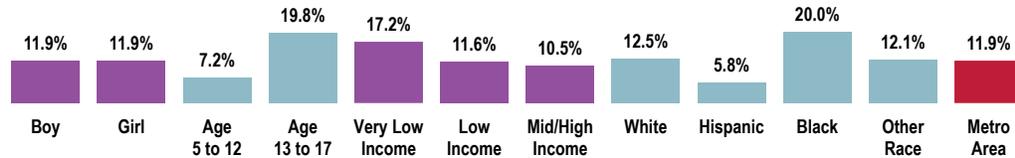
Child Has Ever Taken Prescription Medication for Mental Health (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 81]
 • 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.



Child Has Ever Taken Prescription Medication for Mental Health (Metro Area Children Age 5-17, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 81]
Notes: • Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Key Informant Input: Mental & Behavioral Health

The greatest share of key informants taking part in an online survey rated *Mental & Behavioral Health* as a “10” for children/adolescents in the community (10-point scale where 10 is a “major issue”).

Perceptions of Mental or Behavioral Health as a Problem for Children/Adolescents in the Community (Where “1” Is Not an Issue and “10” Is a Major Issue; Key Informants, 2021)

■ Rated 10 ■ Rated 9 ■ Rated 8 ■ Rated 7 ■ Rated 6 ■ Rated 1–5



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

Among those rating this issue as a “9” or a “10,” reasons related to the following:

Access to Care/Services

Lack of access to resources and an overall lack of providers available. – Community Leader

There are a lot of youth who have school failure, behavioral problems or suicide, as a result of behavioral health issues. Very challenging to access behavioral health services. Not enough behavioral health services. OPS resistant to screening high school students for risk. – Physician

Wait lists, unable to get children in for immediate care. Children are waiting in the ED for a bed in an inpatient setting after a suicide attempt. Not enough providers and not enough inpatient beds. – Other Health Provider

Needs for mental health services continue to rise. Many therapists are booked out for weeks. Suicide attempts among teenagers continues to rise. – Other Health Provider



Again, individuals and families in need of mental and behavioral health resources often get turned away or run into barriers when trying to care for their loved ones. – Community Leader

There is a mental health epidemic in our children. Wait times are long and families and children are suffering. – Physician

Utter lack of sufficient mental health services for the need. – Physician

There is a woeful lack of mental health services in our community. It can be difficult for adults to receive the care they need. There is even less available for children and teens. The wait to see a psychiatrist is often several months. If they do not have insurance, they may be unsure how to access services. If they have Medicaid or private insurance, they may still have difficulty finding services that do not require a long wait. By the time the services are available, the crisis has often decreased and they may no longer want services. Until the next crisis when it starts all over again. Parents are sometimes reluctant to pursue mental health treatment for their children and teens for a variety of reasons. Again, transportation to access services is often a problem. – Other Health Provider

Many children suffer from these conditions, and it takes far too long to get into behavioral health. The number of psychiatrists is insufficient, and the number of inpatient beds is far too small. – Physician

Young folks do not have the access to mental health services. Mental health is typically not seen as a priority to young adults and is considered a stigma. – Public Health Representative

Access to services for mental and behavioral health is limited for many our families. Some families don't quite understand exactly what mental health issues are or are reluctant to accept the notion that there could be some mental health issues or behavioral issues for fear of labeling. – Community Leader

Access to services is difficult to navigate and too expensive for many. – Public Health Representative

Difficult to get young people into a therapist. Behavioral health impacts learning and schools aren't adequately equipped to serve children in the schools. – Social Services Provider

High prevalence and significant lack of access and resources, such as inpatient and outpatient. – Physician

Long waits to get into the therapist. – Public Health Representative

Lack of mental health resources, as well as lack of inpatient beds available to kids. – Other Health Provider

Very difficult to find timely appointments for new behavioral health referrals to psychiatry and even psychologists. Can be nearly impossible to get an inpatient bed for a child or adolescent in behavioral health crisis. – Physician

The lack of resources and the time it takes to actually get a child in to be seen is a problem. – Social Services Provider

Time frames to see a therapist are long. Parents and guardians may not access due to cost and availability. Negative stigma of mental health and behavioral health therapy. – Other Health Provider

Long wait times for inpatient beds for kids that need immediate help. – Other Health Provider

Lack of access and lack of providers. – Physician

Not enough resources for immediate care. – Other Health Provider

Access to affordable, LGBTQ-inclusive, trauma-informed mental and behavioral health is a major issue. Therapists that are trusted have full caseloads and are not accepting new patients. There is also an overreach of ministries that function in this area and with homelessness. – Public Health Representative

Access to care, financial barriers, lack of compensation for providers, the need for community-based service delivery. – Other Health Provider

COVID-19

Increased suicide rate with the current pandemic. The mental health stigma is extensive. – Physician

Because of the effects of the pandemic. I believe resources were in short supply prior to the pandemic and the situation has dramatically worsened as a result of the pandemic and current environment. – Community Leader

Huge increase in depression, anxiety, eating disorders, and self-harm since the start of the pandemic. – Physician

Nebraska ranks near the bottom of states for mental and behavioral health resources. We are seeing critical needs in children, especially in light of COVID. – Social Services Provider

We have seen nationally an uptick in suicidal ideation in even very young children, and an increase in depression during the pandemic. Caregivers are also dealing with depression and grief, due to the pandemic and things like the George Floyd case, and most are ill-equipped to manage their own issues, much less the issues of the kids. And, with the pandemic taking away the opportunity for support through school and houses of worship for some, I believe that there will be a continued impact of this for years to come. – Public Health Representative

Mental health is the current regional priority health issue and it's only growing with the pandemic. Children need support to cope and build resiliency and address any mental health conditions at their primary care doctor, school, and within the community. – Public Health Representative

Children, especially during the pandemic, have more mental and behavioral health needs than ever before. There are lots of supports available, but not enough to meet the needs of children and families. – Community Leader



Mental and behavioral health has always been under-utilized and supported within the Omaha metro. Now with the pandemic, it is even more of a need, especially for youth who have lost caregivers during the pandemic. – Community Leader

Rates of anxiety, depression, and suicidal ideation have been increasing. With the pandemic, it is only increasing more. – Physician

Chronic psychiatric and mental health concerns with caregivers. If caregivers do not have access to prompt, high quality psychiatric care, it negatively impacts children. – Other Health Provider

The pandemic has taken its toll on everyone. Mental and behavioral health is a priority for post-pandemic life within the next two years. – Community Leader

Especially with the COVID pandemic, mental health diagnoses are on the rise. Caregivers and healthcare providers may not be able to, or are comfortable with treating these conditions, and access to psychiatry and psychology is difficult. – Physician

Incidence/Prevalence

There is an increasing volume of behavioral health needs—more patients with depression, anxiety and lack of outpatient services to provide timely treatment, lack of inpatient psychiatric beds when needed. I do not feel that there is enough/proper education and training for teachers regarding ADHD in the classroom and likely not enough resources to help implement behavioral programs for children in the classroom. – Physician

Hearing and seeing the issues that families, schools and our judicial system are dealing with. – Public Health Representative

Higher incidence, especially with the pandemic. – Physician

The trauma kids see and live with on a daily basis. – Community Leader

Social emotional concerns are increasing based on feedback from preschool and kindergarten teachers in the communities we serve. One of our programs specifically receives referrals from primary care providers and at least one third of the referrals have a social emotional or behavioral concern. We also have seen very high social emotional delays on standardized evidenced based surveys we use within our programs. We know that the early childhood foundation is essential to building strong and healthy futures and if mental/behavioral/social emotional health isn't established in the early years it will be much harder to do later. – Other Health Provider

This is evidenced by increased volumes of mental health concerns with children/adolescents in our health systems, as well as in our schools. – Other Health Provider

There is what seems to be an ever-growing burden of depression and anxiety issues with the children and adolescents in our community. – Physician

Again. It's been prioritized by the state Title V Children & Youth with Special healthcare needs committee and cross-cutting committees for the last two iterations of the Title V Needs assessments and also by the Nebraska DD Council. It's also been identified as a problem by Nebraska Kids Count where they report a disproportionate number of children with mental health are being served in our child welfare program. The lack of programming in this area is driving out-of-home placements. Families cannot pay for services or continue the battle. If they give up custody, the state has to pay. Significant problems exist for children/youth that have both an intellectual disability and mental health condition. We need a mental/behavioral health Medicaid waiver program like Iowa. Funding is a problem but so is adequacy of providers. – Social Services Provider

Multiple student visits for anxiety, depression, and medication delivery. – Community Leader

Lack of Providers

Iowa has a huge shortage of practicing psychiatrists and even more so pediatric psychiatrists. Much of the treatment for mental health especially, is being done by the primary provider. – Public Health Representative

There is a significant lack of good behavioral health providers and services for children and adolescents. There are long wait lists at all agencies. Poor or no insurance coverage is another barrier. – Physician

Limited providers in areas of need, transportation, resistance to working with providers. – Social Services Provider

Not enough providers. – Physician

We do not have enough behavioral health providers to meet the mental health needs of youth. Even when a provider can be located, many families lack resources including transportation, challenges with work/school schedule, finances and insurance to access services. We are making improvements with integrated mental/behavioral health into schools and primary care. We need more general wellness programs integrated into our schools for all youth to develop health approaches to stress. This has been exacerbated by COVID. – Other Health Provider

Not enough providers to provide adequate services. – Other Health Provider

Lack of mental health providers well-versed in pediatrics, wait times, access for low income and English as a second language families. – Physician

There are just simply not enough mental health providers available for all the individuals that really need help. – Community Leader



Denial/Stigma

The stigma around mental health. – Other Health Provider

This has to do with the stigma of stepping up and saying I'm struggling. Children need to have access to assessments and supports in a confidential manner. I recently read a quote, people fake being ok but they don't fake experiencing depression. People have to feel comfortable stepping up and saying they need help. – Community Leader

Mental and behavioral health is a major problem for children and adolescents due to the stigma, lack of utilization, lack of providers of color, funding to support prevention, and no plan for capacity building for professionals in the urban communities. – Other Health Provider

The degree of trauma is great and far reaching in children and their families. The stigma and lack of trust are barriers in addressing it. Lack of services for young children, 0 to 3 years old. – Public Health Representative

The historical stigma of seeking behavioral health support, along with lack of diversity and representation of people of color in the field. – Public Health Representative

The stigma around mental health unfortunately still keep families and adolescents from getting the help they need. The workforce is under paid and there are not enough prevention and early interventions services, so children become system involved so families can get some relief. – Other Health Provider

Social Determinants

Adversity, toxic stress, poverty, & poverty of spirit are all things many children & adolescents face every day. Parents are doing the best that they can, but they do not seem to realize the extreme importance of their early interactions with their own children, how that builds brain architecture, & that waiting for schools or physicians to solve a problem when children are 4 or 5 is not the answer. As a community we must do better in celebrating the worth of parents so that THEY know it. Parents also must understand that their stress is their child's stress. We must help build buffers for the parents too, so that they are supported & then can support their children. Schools do not have the personnel resources to support all the mental/behavioral health needs they encounter. I heard just months ago that one district is allowing 5 minutes per child with counselors. That is not enough time to even build rapport for meaningful conversation. – Social Services Provider

The grief experienced due to exposure to the social determinants. – Social Services Provider

Because they fall into the category of the 'have nots' on all levels. – Social Services Provider

Gangs, drugs, suicides, you name it. The need is 1000% self-evident. – Social Services Provider

Parents' mental health. – Community Leader

This is somewhat referred to in the social determinants, but social isolation and bullying are two factors that can impact children's health and well-being. – Other Health Provider

Parents suffering from addiction, early trauma, parental incarceration, undiagnosed and untreated mental health, discomfort with counseling. – Social Services Provider

Stresses of living in a high-stress environment. The state of Nebraska has insufficient support services. – Other Health Provider

Not enough dollars available to be spent in more flexible ways to meet the needs, especially for people of color. – Other Health Provider

Suicide Rates

Rates for suicide and attempted suicide are considerably higher in our community when compared to national figures. Once a behavioral or mental health issue is identified, families then encounter another host of barriers to accessing the services they need including: 1) limited professionals of color and/or professionals available that speak their language and/or match their cultural background; 2) lack of understanding what level of care is appropriate and how best to advocate for that level of care; 3) difficulty making appointments due to wait-times, limited availability, lack of compatibility with payers (providers not accepting Medicaid), not understanding who to call/what to ask for; 4) fear and/or stigma they may experience within their own family and/or community that may impact their desire to follow-through with appointments and treatments. – Community Leader

Significant rise in suicide attempts and suicide risk based on assessments. Large number of students with anxiety and depression in schools as seen by school nurses in health offices. – Other Health Provider

High rates of suicidal ideations and lack of providers cause delays in access to services. – Community Leader

Number one concern often cited by residents, increasing suicide in young people, impact of the pandemic. – Community Leader

The isolation and remote learning have contributed to depression, anxiety, and in some cases, worsened bad situations at a child's home. Additionally, children have been spending more time on screens which has also contributed to an increase in anxiety. We are seeing suicidal ideation go up as well. – Community Leader

We have seen a rise in suicide and behavioral health issues, and we are without space for kids. – Community Leader



Vulnerable Populations

Two-thirds of women in jail are women of color, 44% are Black, 15% are Hispanic, and 5% are of other racial/ethnic backgrounds compared to 36% of women who identified as White. Black women have a 1 in 9 chance of developing breast cancer; for White women the odds are 1 in 8, according to the American Cancer Society. But Black women are more likely to die from the disease: White women's probability of dying from breast cancer is 1 in 37, while Black women's is 1 in 31. – Community Leader

Immigration system, until it is fixed, families live in fear all the time of deportation, or student visas that have expired fear the same. Adequate incomes equal safer housing, equals happier, healthier families. Stigma around mental health. – Community Leader

Mental health and wellness is not seen as a priority in the African American community. Youth within the criminal justice system lack the mental and behavioral supports needed to function as a contributing member of society. Trauma from childhood carries on as we have young parents with mental health and behavioral issues have children and are raising families while coping with their own unresolved issues. – Social Services Provider

We have experienced an increased need for mental health services and access to such services, particularly for racial and ethnic minorities. Access to culturally responsive and culturally competent care is critically important for populations deeply impacted by racial, ethnic, and economic disparities. – Community Leader

Awareness/Education

Having access to licensed therapists is critical, and families do not always know where to go to access this resource, especially within their budget. – Social Services Provider

They have been through so much lately and have very little experience to help navigate the roads. – Community Leader

This probably can go under the mental health umbrella but learning what healthy relationships and conflict resolution looks like is incredibly important. Often this is not modeled sufficiently in the youth's own personal lives, both in real life and online. – Social Services Provider

Gender Identity

Gender identity. Children are confused about who they are. They are not told that it is okay to be confused about who you are right now. This is not necessarily a time to make a change of your identity all at once, they are just figuring out who they are day to day. – Community Leader

Gender identity. Approximately 75% of my clinical practice treats children/adolescents/transition age, 19- to 25-year-olds, for gender dysphoria. There are a lack of trusted providers and educators who are experienced to support the LBGTQIA+ community. – Other Health Provider

Co-Occurrences

The incidence of anxiety and depression in children and adolescents is often an underlying condition of behavioral issues in the classroom, as well as the more serious issue of suicide. The issue of behavior in the classroom is an issue that needs to be addressed. – Community Leader

Prevention/Screenings

The children we serve often present multiple mental and behavioral health concerns that could be addressed at their root cause, early in life, which would prepare them for better navigation/lifelong coping of the concerns and/or help them escape altogether potential lingering, compounding concerns. – Social Services Provider

Coordination of Care

Currently resources are segmented. We continue to add supports without building on what is already in place, so we have many well intended people working in isolation and not making progress. – Other Health Provider

Affordable Care/Services

Lack of affordable mental health services for families. – Other Health Provider

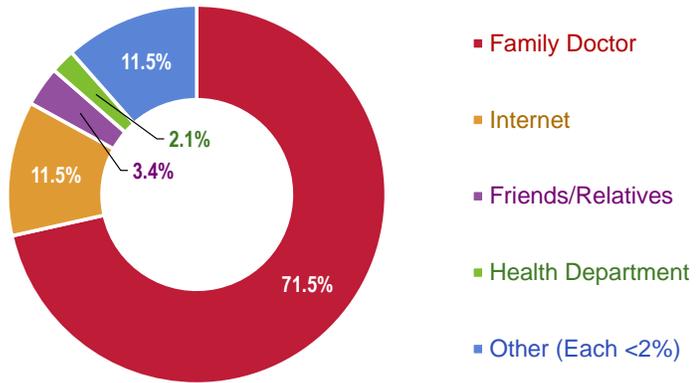


RESOURCES

Health Care Information

For a plurality of Metro Area parents (71.5%), family physicians are the primary source of children’s health care information.

Primary Source of Healthcare Information for Child
(Metro Area, 2021)

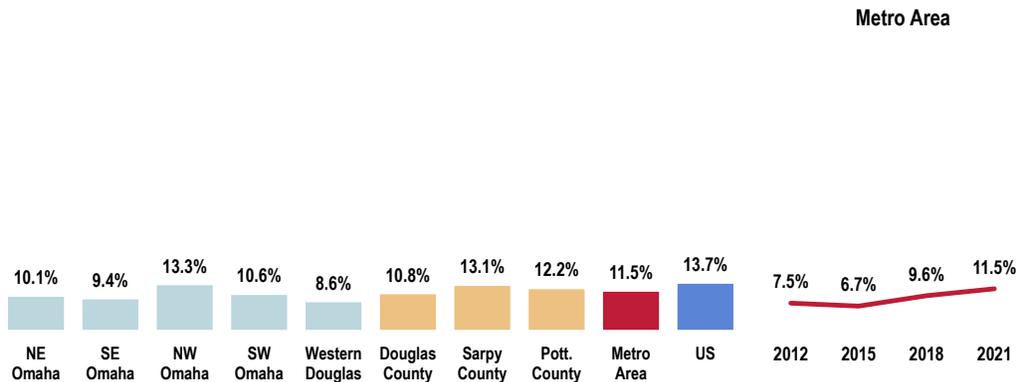


Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 329]
Notes: • Asked of all respondents.

In all, 11.5% of parents identified the internet as their primary source of health care information for their child.

TREND ► The prevalence has increased significantly from 2012 and 2015 survey findings.

Internet Is the Primary Source of Healthcare Information
(Metro Area, 2021)



Sources: • 2021 PRC Child & Adolescent Health Survey, Professional Research Consultants, Inc. [Item 329]
• 2020 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.



Resources Available to Address the Significant Health Needs

Children’s Hospital & Medical Center joins health care systems around Nebraska and recognizes that caring for children goes beyond the walls of the clinics and hospital. Nearly 80% of health outcomes are driven by factors outside of traditional health care and there is a recognized need to work with community partners to address social needs to better support the health of children.

Children’s acknowledges that many community resource lists exist, and we cannot provide a comprehensive list within the confines of this document. To that end, we would like to highlight United Way of the Midland’s 211 Helpline. The 211 Helpline works to connect residents in Omaha and across Nebraska to local programs that can help them access the assistance they need.

In addition to the 211 Helpline, Children’s is proud to be a participant in Unite Nebraska. Unite Nebraska is Nebraska’s first statewide coordinated care network designed to address social determinants of health. Through this new network, health and social service care providers communicate and track outcomes together through bi-directional referrals. Unite Nebraska combines person-centered care coordination and community engagement for health systems, social service organizations and government agencies.

In addition to the many resources available across the state, Children’s Hospital & Medical Center offers a wealth of resources, services and programs to help meet the needs of the children and families we serve.

For patients in our care and their families, Children’s provides a unique team of professionals in the fields of nursing and social work to deliver Care Coordination services across the Children’s continuum – from primary care to emergency room to home health to specialty pediatric clinics to inpatient stays. Care Coordinators work with all who are involved in a patient’s care, including schools, insurance companies, community groups and the health care team, to help make sure a patient gets what he or she needs. Care Coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient’s care to achieve safer and more effective services. Children’s Care Coordinators are crucial to ensuring medical adherence, providing concrete resources for needs such as transportation, food, housing, and finances, completing assessments that assist mental and emotional health, and serving as longitudinal supports for the patient family.

The following table summarizes resources and programs managed by Children’s and key community resources and programs in which Children’s takes a leadership role. We fully anticipate our “Key Resource” list will build and expand substantially over the next three years as our Impact Areas are fully developed. Additional information may be found on our website, www.childrensomaha.org.

PRIORITY IMPACT AREA	KEY RESOURCES
PEDIATRIC MENTAL HEALTH	Caring Contacts, Westside Community Schools School Outreach, Autism Outreach, Psychiatric consultative service, FQHC partnership, MH/BH Project ECHO sessions, Region VI Continuum of Care Analysis, Help Me Grow Nebraska, Nebraska Healthy Schools Program, BUILD Health Challenge, Telepsychiatry, Social Work availability across the Children’s continuum, integration of psychologists at select Children’s Physicians primary care clinics in partnership with Munroe Meyer Institute
FOOD INSECURITY	Food Bank for the Heartland, Nebraska Extension Regional Food System, Unite NE bidirectional referral system, TeleLactation services, Breastfeeding outreach and promotion, donated breast milk depot, Formula Assistance, CHMC Food Pantry/Rainbow House, Double Up Food Bucks, Provider Nutrition Education Series, Community Grants to address food insecurity through Preventing Childhood Obesity Grants, The Wellbeing Partners’ Share Our Table Community Workgroup, BUILD Health Challenge, food boxes for inpatient families, social work and financial counselor assistance in public benefit program applications



FINANCIAL STABILITY

Unite NE bidirectional referral system, Nebraska Healthy Schools Program SDOH Learning Collaborative and Resource Guide, Medicaid enrollment and supports, Wishing Well financial assistance, Financial Assistance Program for Children's Patients, Food Insecurity screening and referrals, SNAP Outreach, Double Up Food Bucks.

HEALTHY HOUSING

Unite NE bidirectional referral system, Nebraska Healthy Schools Program SDOH Learning Collaborative and Resource Guide, Healthy Home referrals to Omaha Healthy Kids Alliance, Nebraska Asthma Coalition Environmental Workgroup, lead testing in partnership with local health departments





APPENDIX

CHILDREN’S HOSPITAL & MEDICAL CENTER: 2019-2021 IMPLEMENTATION STRATEGY PLAN EVALUATION OVERVIEW

Children’s Hospital & Medical Center created a 3-year implementation strategy plan (ISP) to be carried out from 2019 through 2021. This ISP was developed with dedicated and intentional collaboration between our community’s pediatric and adult hospital systems and was designed to serve the specific needs of the pediatric population. The ISP addressed each strategic priority across the continuum of care and identified appropriate resources to be included to address the needs identified in the priority areas.

Children’s Center for the Child & Community serves as the outreach hub of Children’s Hospital & Medical Center and provided oversight and management of the ISP. The Center provided infrastructure and leadership for both internal and external partnerships associated with the Pediatric CHNA planning and implementation process.

ISP priority specific workgroups were convened quarterly within Children’s, and community partnerships were fostered to advance the four child health priorities. Below is a brief summary of accomplishments and key evaluation outcomes to date.

ACCESS TO HEALTH SERVICES	
Overarching Goal: To improve access to children’s health care services, especially for those in underserved communities	
STRATEGY	OUTCOMES
Identify the root causes of access to care problems and specific population(s) in which to intervene.	<ul style="list-style-type: none"> ▪ A definition and framework of “Access to Care” was adopted in 2019. ▪ Community Engaged Analysis Process conducted in 2020 resulted in three priority indicators for focus: Need for Care Coordination, unaware of community mental health resources, and no preventive dental care in the last year.
Improve access to care for specific patient populations across Children’s enterprise.	<ul style="list-style-type: none"> ▪ A landscape analysis and mapping of mental health services available to support children and families with social/emotional, behavioral and/or mental health needs was completed in partnership between Children’s and Region 6. As a result of the work, the “Continuum of Care for Children & Youth” includes 87 different services across five levels of care and five sectors (health, education, mental health, community, and justice) were categorized and mapped. Additionally, seven organizations providing referral and navigation support were identified, and two open-source websites were assessed. ▪ Early Dental Health Starter Kit project was launched with a goal to package and distribute 25,000 kits through pediatric primary care offices throughout the state in partnership with the University of Nebraska Medical Center’s Pediatric Dental Program.
Increase access to care through clinic-to-community strategies.	<ul style="list-style-type: none"> ▪ Implementation of Unite Nebraska’s bi-directional referral platform in the Care Coordination Department beginning in August 2021 achieving 17 referrals in the first two months of operation.



- Children’s Vision Screening Program and Visionmobile continued to improve access to vision services for underserved populations. Over 30,000 students received vision screenings in the last three years. The Visionmobile provided over 3,500 comprehensive eye exams during 2019, 2020 and 2021.
- Through Project ECHO, an innovative model of inter-professional education and case-based learning, which aims to share clinical knowledge and deliver best-practice care to people in communities that lack ready access to specialists, Children’s provided a ten session School Health Series for continuing education targeted to school nurses statewide. Each session, 70 to 120 nurses attended.
- 40 Hastings Public School students diagnosed with asthma are participating in the School Health Asthma Intervention Pilot during school year 2021/22.
- Five School Health Learning Collaborative sessions were conducted addressing issues specific to COVID-19 reaching over 140 unique participants.

MENTAL AND BEHAVIORAL HEALTH

Overarching Goal: To improve access to quality child and adolescent behavioral health care services, especially for those in underserved communities

STRATEGY	OUTCOMES
<p>Expand integrated behavioral health care model across Children’s enterprise.</p>	<ul style="list-style-type: none"> ▪ The Patient Assistance Team at Children’s Hospital & Medical Center (PATCH) program was piloted in 2019 and expanded in 2020 creating individualized care plans for over 400 patients most of whom are on the autism spectrum. Due to the success of the pilot, PATCH will be expanded to all Speciality Clinics beginning January 2022. ▪ Capacities for telehealth services and telementoring supports were developed and expanded significantly throughout 2019 and 2020: <ul style="list-style-type: none"> – Telepsychiatry appointments in the Kearney Children’s Physicians clinic were consistently filled 75% of the time, many times reaching 100%. – Patients with insulin-dependent Diabetes Mellitus and Cystic Fibrosis were identified (n=182) and provided telepsychology services, resulting in reduced stressors. – A tele-presenter was hired through Children’s Physicians to create more options for mental health providers to support primary care providers and facilitate mental health care. ▪ Two Child & Adolescent Psychiatrists within the Behavioral Health Department are providing 10-12 real-time psychiatric consults to 15 Children’s Physicians providers each month. The model is still in its pilot phase and is being completed without any additional funding.



Foster and support community health/behavioral health outreach efforts and partnerships.

- Project ECHO is an innovative model of inter-professional education and case-based learning that aims to share clinical knowledge and deliver best-practice care to people in communities that lack ready access to specialists. In 2020 and 2021, a series regarding anxiety and depression was conducted with providers in the primary care setting, resulting in the training of 32 and 42 unique providers respectively.
- To promote on-going Autism screening in the community prior to age two, a PSA was created regarding the 16 early signs of the condition for parents and an awareness video for primary care providers was released.
- The “Continuum of Mental Health Care for Children & Youth” tool (see Access to Health Services priority for more detail) was used by the University of Nebraska Medical Center and Creighton University during on boarding of the Child & Adolescent Psychiatry residents and fellows, class 2021.

NUTRITION, PHYSICAL ACTIVITY & OBESITY

Overarching Goal: To develop programs, partnerships and policies to prevent, assess and treat children who are overweight or obese, focusing on addressing disparities and inequities

STRATEGY	OUTCOMES
<p>Expand community environmental supports for healthy eating and physical activity through community systems.</p>	<ul style="list-style-type: none"> ▪ Mapped BMI data from Children’s Electronic Health Record (EHR) database and disseminated in various community forums to inform interventions and local programming. ▪ Preventing Childhood Obesity Community Grant Program completed the 2019/20 cycle providing \$25,000 grants to ten community organizations. The 2021/22 cycle includes a focus on underserved populations and health equity resulting in ten additional community-based organizations receiving funding to conduct prevention activities for underrepresented populations ▪ Over 22 million school minutes and 1 million family activity minutes were completed on GoNoodle in 2020 representing a 75% increase in activity on GoNoodle from the prior year. ▪ 529 early care and education professionals received Go NAP SACC training and technical assistance in 2019, 2020 and 2021. ▪ Nebraska Double Up Food Bucks received two USDA GusNIP awards supporting expansion of the program to underserved populations. ▪ Partnered with four YMCA branches in Lincoln to offer ENERGY Fitness to overweight/obese youth ages 6-12 years old. Completed facilitation guide for ENERGY Fitness.



<p>Engage and provide resources to primary care physicians and providers on nutrition, physical activity and obesity best practices.</p>	<ul style="list-style-type: none"> Adopted a continuum of care model for pediatric weight management, highlighting the staged approaches. Weight & Wellness Clinic was rebranded and reorganized to better serve families. ENERGY nutrition workbook and videos were created and disseminated in English and Spanish. A 3-part Nutrition Education and Resource Webinar Series and nutrition education packets were sent to Children’s primary care and specialty care providers.
<p>Advocate for policies and practices that support healthy eating, physical activity and obesity prevention.</p>	<ul style="list-style-type: none"> Published quarterly For Every Child e-newsletters to a statewide audience with over 1250 contacts, an average 30% open rate. Served as a core partner to promote the Nebraska Healthy Schools Program and the Whole School, Whole Community, Whole Child Model to improve nutrition, physical activity, chronic condition management in schools and during out-of-school time. In 2021, Children’s Governmental Affairs advocated for LB 108 in the Nebraska Legislature increasing the gross income limit allowed for families to qualify for SNAP. The 2021 Nebraska Healthy Kids Summit was held virtually for a statewide cross-sector audience focusing on health equity and included a research fair highlighting local and state research & evaluation projects for nutrition, physical activity and obesity.

SEXUAL HEALTH

Overarching Goal: To improve adolescent sexual health care and education through clinic-to-community collaboration

STRATEGY	OUTCOMES
<p>Continue to support and participate in the Adolescent Health Project, primary care and community collaboration.</p>	<ul style="list-style-type: none"> Since the Adolescent Health Project Pilot began, over 4,200 chlamydia/gonorrhea tests were administered within Children’s Physician’s clinics increasing the annual rate by over 1,100 tests. In 2020, Children’s Physicians implemented the Access Granted platform, connecting adolescents to providers for reproductive health care and providing valuable feedback regarding the adolescent patient experience. Two Adolescent Health specialists were recruited and hired to address the complex need of teens and young adults; thereby serving as the state’s first Board Certified Adolescent Health specialists The Adolescent and Young Adult Clinic was opened in 2021.
<p>Continue to implement the AAP ICARE 2.0 Project with an identified group of Children’s Physicians Providers.</p>	<ul style="list-style-type: none"> In 2019, the adolescent health questionnaire risk assessment formally became a routine part of well-youth visits for patients 14-years and older.

