



2021 COMMUNITY HEALTH NEEDS ASSESSMENT

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

Prepared for:
Nebraska Medicine

CHNA Sponsored by:
Douglas County Health Department
Pottawattamie County Public Health
Sarpy/Cass Health Department
CHI Health
Methodist Health System

With support from:
Omaha Community Foundation
Charles Drew Health Center, Inc.
OneWorld Community Health Centers, Inc.
The Wellbeing Partners

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2011, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the Omaha metropolitan area (including Douglas, Sarpy, Cass, and Pottawattamie counties). Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

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

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

This assessment was led by a coalition comprised of local public health departments, health systems, federally qualified health centers, and community-based organizations.

SPONSORING ORGANIZATIONS ► **Douglas County Health Department; Pottawattamie County Public Health; Sarpy/Cass Health Department; CHI Health** (CHI Health Creighton University Medical Center–Bergan Mercy, CHI Health Immanuel, CHI Health Lakeside, CHI Health Mercy Council Bluffs, and CHI Health Midlands); **Nebraska Medicine** (Bellevue Medical Center and Nebraska Medical Center); and **Methodist Health System** (Methodist Hospital, Methodist Jennie Edmundson Hospital, and Methodist Women's Hospital).

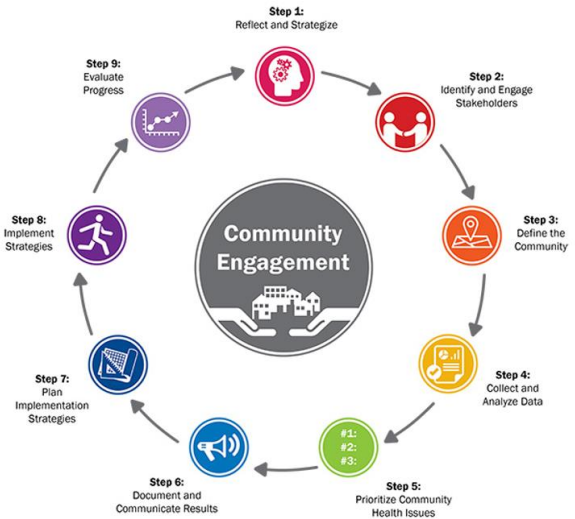
SUPPORTING ORGANIZATIONS ► Omaha Community Foundation; Charles Drew Health Center, Inc.; One World Community Health Centers, Inc.; and The Wellbeing Partners

This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.



Approach

The process for this assessment follows an approach as outlined in the Community Health Assessment Toolkit developed by the Association for Community Health Improvement™ (ACHI). In the ACHI model (at right), collaborating organizations worked through the first three steps in this process, and this assessment document and subsequent communication activities will carry the community engagement model through Step 6. Steps 7 through 9 will be undertaken by the partnering hospitals, health departments, and other organizations over the next three years, at which time the process begins again and this assessment will be updated.



Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community 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 Community Health Survey

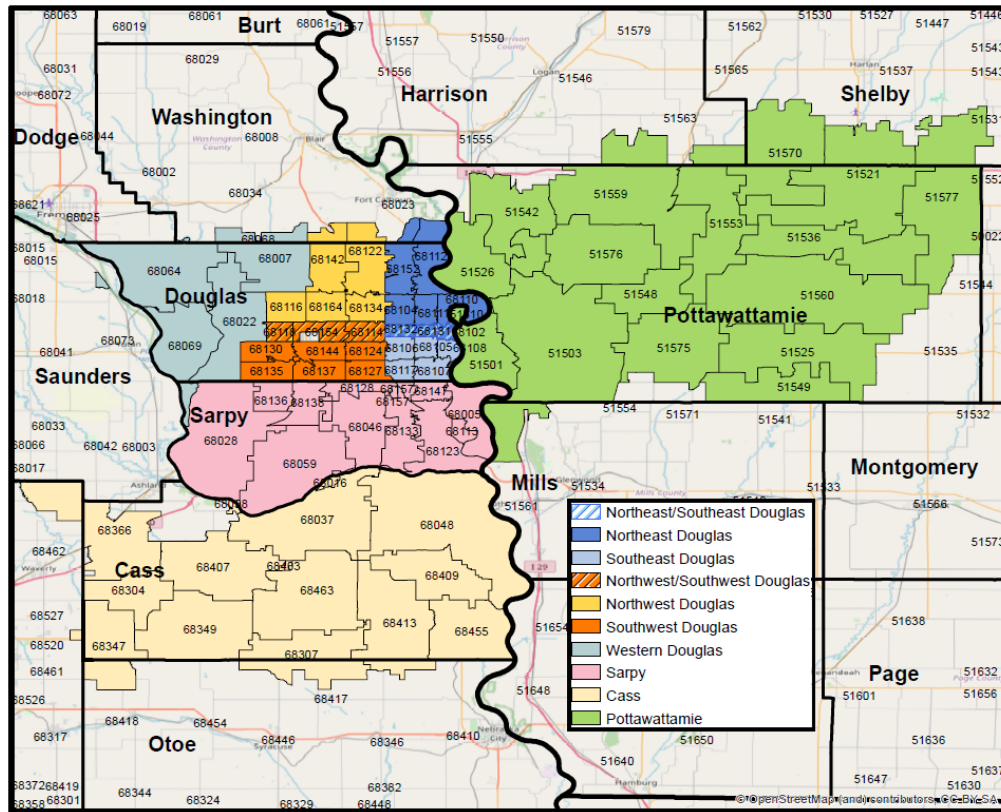
Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the sponsoring and supporting organizations 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) includes Douglas, Sarpy, and Cass counties in Nebraska, as well as Pottawattamie County in Iowa. For this study, Douglas County is further divided into five geographical areas (Northeast Omaha, Southeast Omaha, Northwest Omaha, Southwest Omaha, and Western Douglas County). This community definition is illustrated in the following map.





Sample Approach & Design

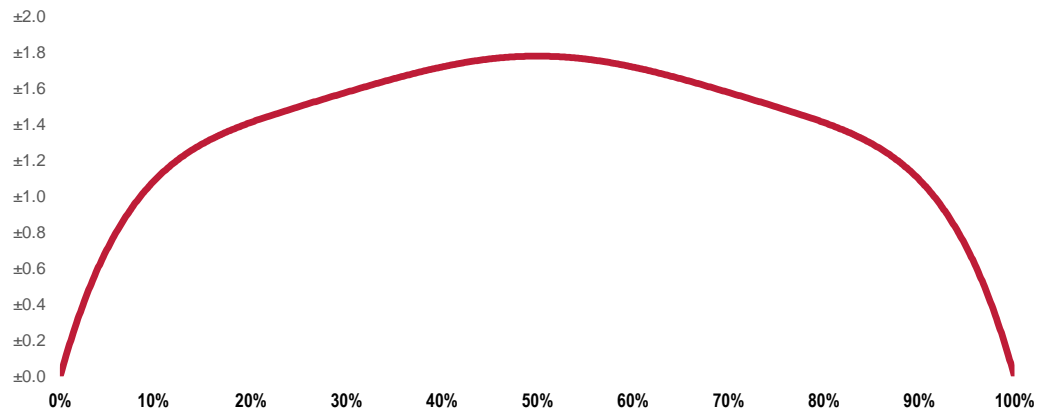
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline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

The sample design used for this effort consisted of a stratified random sample of 2,854 individuals age 18 and older in the Metro Area, including 1,451 in Douglas County, 702 in Sarpy County, 200 in Cass County, and 501 in Pottawattamie County. The higher Douglas County sample reflects a target of 50 surveys per ZIP Code within the county (although some lesser-populated ZIP Codes did not reach this threshold). Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Metro Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 2,854 respondents is $\pm 1.8\%$ at the 95 percent confidence level.



Expected Error Ranges for a Sample of 2,855 Respondents at the 95 Percent Level of Confidence



Note: • The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples: • If 10% of the sample of 2,855 respondents answered a certain question with a "yes," it can be asserted that between 8.9% and 11.1% (10% ± 1.1%) of the total population would offer this response.

• If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 48.2% and 51.8% (50% ± 1.8%) of the total population would respond "yes" if asked this question.

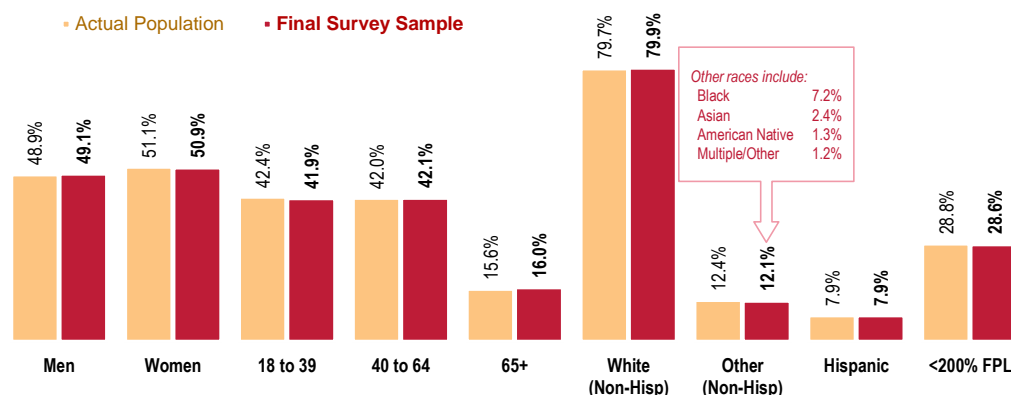
Sample Characteristics

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

The following chart outlines the characteristics of the Metro Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older.]



Population & Survey Sample Characteristics (Metro Area, 2021)



Sources: • US Census Bureau, 2011-2015 American Community Survey.
 • 2021 PRC Community Health Survey, PRC, Inc.
 Notes: • FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

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

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: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level 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 ($\geq 200\%$) of the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents 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 sponsoring organizations; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.



Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 150 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physician	28
Advanced Practice Provider	2
Social Services Provider	32
Public Health Representative	6
Other Health Providers	54
Business Leader	8
Criminal Justice	2
Other Community Leaders	18

Final participation included representatives of the organizations outlined below.

- American Red Cross Heartland Chapter
- City of Bellevue
- Bennington Public Schools
- Charles Drew Health Center, Inc.
- CHI Health
- Child Saving Institute
- City of Omaha
- CityMatCH
- Claire Memorial United Methodist Church
- College of St. Mary
- Completely Kids
- Court Appointed Special Advocate (CASA)
- Creighton Multicultural Community Affairs
- Creighton University
- Douglas County Health Department
- Eastern Nebraska Office of Aging (ENOA)
- Family Housing Advisory Service–North
- Girls Incorporated Of Omaha
- Gretchen Swanson Center for Nutrition
- Health Care Administrator
- Heartland Workforce Solutions
- Iowa West Foundation
- Kountze Memorial Lutheran Church
- Metropolitan Area Planning Agency (MAPA)
- Methodist Health System
- Methodist College
- Metro Area Continuum Care For Health
- Mid-Iowa Family Therapy Clinic & ITPS
- National Safety Council of Nebraska
- Nebraska Medicine
- Nebraska Urban Indian Health Coalition
- Nonprofit Association of the Midlands
- NOVA Treatment Community, Inc.
- Omaha City Council
- Omaha Community Foundation
- Omaha Housing Authority
- Omaha Metro (MAT)
- One World Community Health Center
- Omaha Public Schools
- City of Papillion



- Pottawattamie County Public Health
- Project Harmony
- Ralston Public Schools
- Salem Baptist Church
- Sarpy County Health Department
- Southeast Nebraska Community Action
- City of Springfield
- TEAM (Tobacco Education and Advocacy of the Midlands)
- The Wellbeing Partners
- Together, Inc. Of Metropolitan Omaha
- Tri-City Food Pantry
- University of Nebraska Medical Center (UNMC)
- UNMC College of Public Health
- UNMC College of Dentistry Sealant Program
- University of Nebraska Omaha (UNO)
- Visiting Nurse Association
- YMCA

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 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

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

- Center for Applied Research and 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
- 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
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns



- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Trending

Similar surveys were administered in the Metro Area in 2011, 2015, and 2018 by PRC. 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.

Nebraska & Iowa Risk Factor Data

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

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National 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 US population 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 persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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

Public Comment

Participating hospitals and health systems made their prior Community Health Needs Assessment (CHNA) reports publicly available through their respective websites; through that mechanism, they requested from the public written comments and feedback regarding the CHNA and implementation strategies. At the time of this writing, none 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. Participating hospitals will continue to use their websites as tools to solicit public comments and ensure that these comments are considered in the development of future CHNAs.



SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons 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"> ▪ Insurance Instability ▪ Barriers to Access <ul style="list-style-type: none"> – Appointment Availability – Lack of Transportation ▪ Routine Medical Care (Adults) ▪ Emergency Room Utilization ▪ Health Literacy
CANCER	<ul style="list-style-type: none"> ▪ Leading Cause of Death ▪ Cervical Cancer Screening [Age 21-65]
DIABETES	<ul style="list-style-type: none"> ▪ Diabetes Deaths ▪ Diabetes Prevalence ▪ Blood Sugar Testing [Non-Diabetics]
HEART DISEASE & STROKE	<ul style="list-style-type: none"> ▪ Leading Cause of Death ▪ Stroke Prevalence
INFANT HEALTH & FAMILY PLANNING	<ul style="list-style-type: none"> ▪ Prenatal Care ▪ Infant Deaths
INJURY & VIOLENCE	<ul style="list-style-type: none"> ▪ Prevalence of Falls [Age 45+] ▪ Intimate Partner Violence
MENTAL HEALTH	<ul style="list-style-type: none"> ▪ “Fair/Poor” Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Suicide Deaths ▪ Social Support ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: Mental health ranked as a top concern.

—continued on the following page—



AREAS OF OPPORTUNITY (continued)

<p>NUTRITION, PHYSICAL ACTIVITY & WEIGHT</p>	<ul style="list-style-type: none"> ▪ Fruit/Vegetable Consumption ▪ Leisure-Time Physical Activity ▪ Access to Trails ▪ Overweight & Obesity ▪ Professional Advice on Weight [Overweight Adults] ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
<p>ORAL HEALTH</p>	<ul style="list-style-type: none"> ▪ Regular Dental Care [Adults]
<p>POTENTIALLY DISABLING CONDITIONS</p>	<ul style="list-style-type: none"> ▪ Activity Limitations ▪ High-Impact Chronic Pain ▪ Alzheimer's Disease Deaths ▪ Caregiving
<p>RESPIRATORY DISEASE</p>	<ul style="list-style-type: none"> ▪ Lung Disease Deaths [Chronic Lower Respiratory Disease] ▪ Asthma Prevalence [Adults]
<p>SEXUAL HEALTH</p>	<ul style="list-style-type: none"> ▪ Chlamydia Incidence ▪ Gonorrhea Incidence ▪ HIV Testing [Age 18-44]
<p>SOCIAL DETERMINANTS OF HEALTH</p>	<ul style="list-style-type: none"> ▪ Housing Insecurity ▪ Loss of Utilities ▪ Unhealthy/Unsafe Housing
<p>SUBSTANCE ABUSE</p>	<ul style="list-style-type: none"> ▪ Cirrhosis/Liver Disease Deaths ▪ Key Informants: Substance abuse ranked as a top concern.
<p>TOBACCO USE</p>	<ul style="list-style-type: none"> ▪ Smokers Advised to Quit by a Health Professional



Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment (“Areas of Opportunity” above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Nutrition, Physical Activity & Weight
3. Substance Abuse
4. Diabetes
5. Sexual Health
6. Injury & Violence
7. Heart Disease & Stroke
8. Tobacco Use
9. Infant Health & Family Planning
10. Potentially Disabling Conditions
11. Oral Health
12. Access to Healthcare Services
13. Respiratory Diseases
14. Cancer

Social determinants of health (e.g., housing issues) were not part of this prioritization exercise, but will certainly be viewed as an overarching issue and considered in all actions that sponsoring organizations choose to implement.

Hospital Implementation Strategies

Sponsoring hospitals will use the information from this Community Health Needs Assessment to develop Implementation Strategies to address the significant health needs in the community. While the hospitals 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 action plans to guide community health improvement efforts in the coming years.



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 group of columns furthest to the left provide comparisons among the five subareas within Douglas County, identifying differences for each as “better than” (☀️), “worse than” (🌧️), or “similar to” (☁️) the combined opposing areas of Douglas County.
- The second grouping of columns [to the left of the Metro Area column] provide comparisons among the four counties assessed, identifying differences for each as “better than” (☀️), “worse than” (🌧️), or “similar to” (☁️) the combined opposing counties.
- The columns to the right of the Metro Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 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 2011 (or earliest data available). Note that survey data reflect the ZIP Code-defined Metro Area.

OTHER (SECONDARY) DATA INDICATORS:

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



SOCIAL DETERMINANTS	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
Linguistically Isolated Population (Percent)						4.4	0.8	0.1	1.5	3.2	2.9	2.0	4.4		
Population in Poverty (Percent)						11.6	5.7	7.4	11.8	10.2	11.0	11.2	13.1	8.0	
Children in Poverty (Percent)						17.2	6.2	6.9	15.1	14.2	14.8	14.2	19.5	8.0	
No High School Diploma (Age 25+, Percent)						10.0	4.8	5.1	10.6	8.8	8.9	8.0	12.3		
% Unable to Pay Cash for a \$400 Emergency Expense	33.1	31.3	12.9	14.6	7.5	20.9	9.4	12.3	22.8	18.7			24.6		
% Worry/Stress Over Rent/Mortgage in Past Year	38.7	36.6	21.2	17.2	6.2	25.8	17.3	19.5	24.2	23.9			32.2	20.1	
% Unhealthy/Unsafe Housing Conditions	15.8	12.9	9.0	8.4	6.1	10.8	4.6	4.7	5.8	9.0			12.2	6.1	
% Went Without Electricity, Water, or Heat	8.3	13.3	9.1	10.3	7.1	10.1	8.7	6.8	6.1	9.4				5.2	
% Worried About Food in the Past Year	35.6	35.1	18.1	12.7	6.3	22.8	10.2	17.0	16.4	19.7			30.0	18.8	
% Treated With Less Respect Than Others	32.4	29.7	26.4	19.3	24.3	26.1	22.8	21.8	24.1	25.1					
% Receive Poorer Treatment at Restaurants/Stores	11.1	11.3	7.4	5.8	1.4	8.1	6.8	2.5	8.5	7.7					

SOCIAL DETERMINANTS (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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% Treated as Less Intelligent	18.8	18.2	13.4	9.4	6.5	13.9	11.8	4.7	14.5	13.3					
% Threatened or Harassed	5.9	8.3	3.9	3.6	0.6	5.0	4.1	2.4	5.6	4.8					
% Disagree That the Community Welcomes All Races/Ethnicities	16.4	13.9	13.0	10.4	10.9	13.0	8.6	8.1	6.1	11.3					

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.



OVERALL HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	19.0	18.4	12.2	12.0	7.2	14.4	12.4	11.7	16.7	14.3	14.6	14.4	12.6		12.7

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.



ACCESS TO HEALTH 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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	14.2	15.7	6.0	6.4	5.2	9.8	8.8	3.6	5.8	9.0	17.1	9.6	8.7	7.9	12.1
% [Insured] Went Without Coverage in the Past Year	21.5	19.9	7.7	10.4	7.9	13.7	10.4	7.5	8.1	12.4					5.5
% Difficulty Accessing Health Care in Past Year (Composite)	40.3	50.5	36.4	31.2	31.4	38.3	32.5	24.7	29.3	36.0			35.0		33.4

ACCESS TO HEALTH CARE (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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% Cost Prevented Physician Visit in Past Year	14.6	18.2	15.6	6.5	5.4	12.7	8.3	7.1	7.5	11.2	12.6	8.5	12.9		14.5
% Cost Prevented Getting Prescription in Past Year	10.9	15.9	12.4	8.8	7.5	11.6	9.8	9.7	8.0	10.8			12.8		14.3
% Difficulty Getting Appointment in Past Year	15.0	17.9	16.1	10.2	18.0	14.6	13.3	8.9	10.4	13.8			14.5		10.5
% Inconvenient Hrs Prevented Dr Visit in Past Year	14.0	14.2	12.0	11.1	7.1	12.3	10.1	4.8	6.5	11.1			12.5		12.5
% Difficulty Finding Physician in Past Year	10.2	10.5	6.7	6.5	3.2	7.9	6.0	3.8	9.5	7.7			9.4		6.6
% Transportation Hindered Dr Visit in Past Year	13.0	16.3	6.7	4.5	4.6	9.2	4.2	2.3	8.6	8.0			8.9		4.7
% Language/Culture Prevented Care in Past Year	2.1	4.3	0.5	0.1	0.0	1.5	0.8	0.0	0.7	1.2			2.8		0.9
% Skipped Prescription Doses to Save Costs	15.8	17.3	12.6	9.2	7.3	12.9	11.1	14.8	11.4	12.5			12.7		13.6
Primary Care Doctors per 100,000						109.7	52.3	30.9	46.0	88.3	75.5	72.9	76.6		
% Have a Specific Source of Ongoing Care	73.5	76.7	76.4	79.3	86.1	77.3	80.2	87.4	80.2	78.4			74.2	84.0	66.1
% Have Had Routine Checkup in Past Year	64.2	61.9	63.0	69.5	65.1	65.0	65.7	70.7	74.1	66.3	73.0	78.6	70.5		66.8
% Likely to Participate in Tele- Health	82.4	77.7	81.3	77.6	79.0	79.5	76.5	77.4	67.7	77.6					69.1

ACCESS TO HEALTH 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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% Two or More ER Visits in Past Year	9.2	10.5	4.0	5.5	1.8	6.7	6.5	6.2	9.1	6.9			10.1		4.9
% Low Health Literacy	24.4	22.7	15.9	13.6	7.3	17.8	15.4	10.2	13.2		16.7			27.7	
% Rate Local Health Care "Fair/Poor"	13.0	13.4	6.6	6.0	1.5	8.8	5.4	4.0	9.0	8.0				8.0	
% Treated Worse Than Other Races	5.9	6.9	5.5	5.0	0.0	5.4	2.4	0.8	0.4		4.3			4.7	

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





















CANCER	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)						157.7	141.9	142.2	170.5	155.5	150.2	154.7	149.3	122.7	180.9
Lung Cancer (Age-Adjusted Death Rate)											36.6	33.9	37.8	34.9	25.1
Prostate Cancer (Age-Adjusted Death Rate)										21.6		18.6	20.5	18.6	16.9
Female Breast Cancer (Age-Adjusted Death Rate)											19.1	20.0	18.1	19.7	15.3
Colorectal Cancer (Age-Adjusted Death Rate)										13.8		14.6	14.0	13.4	8.9

CANCER (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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
Cancer Incidence Rate (All Sites)						488.2	470.3	482.8	481.1	483.6	461.9	479.0	448.7		
Female Breast Cancer Incidence Rate						120.0	102.0	121.5	92.6	112.7	116.9	107.7	104.5		
Prostate Cancer Incidence Rate						140.3	145.9	120.0	124.9	138.6	127.4	128.9	125.9		
Lung Cancer Incidence Rate						64.6	63.3	75.0	76.1	66.5	57.2	63.3	58.3		
Colorectal Cancer Incidence Rate						40.4	38.9	40.3	49.7	41.4	42.7	43.7	38.4		
% Cancer	8.7	5.5	11.7	11.2	8.8	9.5	7.6	8.7	9.5	9.1	12.4	12.2	10.0		9.2
% [Women 50-74] Mammogram in Past 2 Years	80.0	70.1	82.5	84.9	84.2	80.5	79.0	74.8	80.0	80.0	75.4	80.8	76.1	77.1	82.3
% [Women 21-65] Cervical Cancer Screening	69.3	69.9	72.9	74.9	82.0	72.6	74.2	64.6	70.2	72.4	80.9	81.1	73.8	84.3	86.7
% [Age 50-75] Colorectal Cancer Screening	75.9	75.1	83.0	78.1	72.9	78.0	78.3	79.0	77.4	78.0	68.7	71.7	77.4	74.4	75.3













































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DIABETES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)						 29.2	 18.4	 21.4	 23.4	26.0	 24.7	 21.6	 21.5		 21.9
% Diabetes/High Blood Sugar	 12.3	 13.7	 11.6	 12.0	 8.1	 12.1	 11.5	 16.8	 14.3	12.4	 10.2	 10.3	 13.8		 10.6
% Borderline/Pre-Diabetes	 8.3	 10.2	 11.4	 4.9	 10.8	 8.6	 8.7	 7.5	 10.2	8.8			 9.7		
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	 43.9	 48.1	 42.6	 45.8	 41.9	 44.9	 45.0	 49.4	 53.6	46.0			 43.3		 49.5

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.



HEART DISEASE & STROKE	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)						 133.9	 134.5	 163.4	 170.7	139.8	 146.6	 168.5	 163.4	 127.4	 152.6
% Heart Disease (Heart Attack, Angina, Coronary Disease)	 8.2	 6.9	 5.4	 5.9	 4.9	 6.4	 4.6	 4.3	 6.6	6.0	 5.9	 6.3	 6.1		 5.2
Stroke (Age-Adjusted Death Rate)						 33.6	 29.8	 24.8	 32.4	32.3	 31.5	 32.6	 37.2	 33.4	 39.5
% Stroke	 6.2	 6.6	 1.3	 2.1	 1.4	 3.6	 1.9	 0.7	 3.5	3.2	 2.9	 3.1	 4.3		 2.3

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INFANT HEALTH & FAMILY PLANNING	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
No Prenatal Care in First Trimester (Percent)						25.5	20.6			24.4	24.9	25.4	17.3		
Low Birthweight Births (Percent)						7.9	6.5	5.9	7.6	7.5	7.0	6.8	8.2		7.6
Infant Death Rate						6.1	3.6		7.9	5.8	5.4	5.1	5.6	5.0	4.9
Births to Adolescents Age 15 to 19 (Rate per 1,000)						24.1	14.3	16.4	28.4	22.4	21.4	19.0	22.7	31.4	

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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INJURY & VIOLENCE	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
Unintentional Injury (Age-Adjusted Death Rate)						35.1	34.2	37.0	42.0	35.8	39.0	41.9	48.9	43.2	34.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)						9.2	8.8		14.6	10.0	12.7	10.7	11.3	10.1	
[65+] Falls (Age-Adjusted Death Rate)						66.8	67.4		68.7	66.3	64.7	83.1	65.1	63.4	
% [Age 45+] Fell in the Past Year	39.2	41.5	33.0	37.4	32.1	37.1	34.7	43.1	35.6	36.7	25.3	24.1	27.5	30.1	
Firearm-Related Deaths (Age-Adjusted Death Rate)						10.5	7.1		10.8	9.7	9.2	8.9	11.9	10.7	

INJURY & VIOLENCE (cont.)	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Homicide (Age-Adjusted Death Rate)										4.0	 2.6	 2.9	 6.1	 5.5	 5.5
Violent Crime Rate						 493.5	 94.7	 108.6	 249.8	369.3	 286.4	 283.0	 416.0		
% Neighborhood Is "Slightly/Not At All Safe"	 42.8	 34.7	 14.5	 9.7	 1.6	 22.0	 3.8	 1.0	 20.9	18.0				 17.4	
% Victim of Violent Crime in Past 5 Years	 5.4	 6.1	 5.1	 1.4	 0.6	 4.0	 1.5	 3.1	 2.0	3.4			 6.2	 2.5	
% Victim of Intimate Partner Violence	 17.3	 17.0	 16.4	 12.7	 15.3	 15.5	 14.7	 17.5	 15.6	15.5			 13.7	 12.0	

























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























































KIDNEY DISEASE	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)						 11.9	 7.6		 10.6	10.8	 10.1	 9.3	 12.9		 12.4

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.



MENTAL 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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	 21.0	 22.6	 16.0	 14.2	 9.6	 17.5	 15.4	 8.9	 18.2	17.0			 13.4	 9.0	
% Diagnosed Depression	 32.0	 28.0	 24.4	 20.3	 22.1	 25.2	 22.4	 16.8	 30.2	25.0	 16.2	 15.4	 20.6	 19.5	

MENTAL HEALTH (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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% Symptoms of Chronic Depression (2+ Years)	 39.8	 41.1	 33.5	 28.1	 21.2	 34.0	 29.4	 22.1	 34.1	32.8			 30.3		 25.1
% Typical Day Is "Extremely/Very" Stressful	 18.9	 15.8	 11.7	 13.2	 8.4	 14.2	 9.6	 7.3	 11.5	12.8			 16.1		 11.5
Suicide (Age-Adjusted Death Rate)						 13.9	 11.1		 18.9	13.7	 14.7	 15.7	 14.0	 12.8	 10.1
% Have Someone to Turn to All/Most of the Time	 72.5	 72.7	 81.1	 85.5	 90.7	 79.5	 86.9	 92.0	 85.1	81.8					 86.1
% Recent Anxiety	 23.1	 24.7	 20.5	 18.3	 13.6	 20.9	 17.9	 10.9	 20.3	20.0					
% Recent Depression	 20.6	 21.2	 16.8	 10.2	 5.3	 15.8	 12.0	 5.3	 18.5	15.1					
% Moderate to Severe Anxiety/Depression (PHQ-4 Score of 6+)	 22.1	 18.5	 17.6	 12.5	 8.5	 16.6	 14.5	 3.8	 14.4	15.6					
Mental Health Providers per 100,000						 210.3	 38.5	 23.2	 102.7	156.8	 71.7	 36.7	 42.6		
% Have Ever Sought Help for Mental Health	 37.3	 34.2	 38.6	 33.2	 33.2	 35.5	 32.8	 28.7	 39.3	35.2			 30.0		 31.6
% Taking Rx/Receiving Mental Health Trtmt	 19.7	 19.9	 23.0	 18.9	 20.2	 20.4	 17.7	 12.9	 25.2	20.2			 16.8		 14.4
% Unable to Get Mental Health Svcs in Past Yr	 7.8	 6.4	 7.9	 3.8	 3.5	 6.1	 7.0	 3.3	 5.2	6.1			 7.8		 2.7

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

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
Population With Low Food Access (Percent)						12.2	32.5	26.6	33.2	19.2	21.3	21.4	22.4		
% "Very/Somewhat" Difficult to Buy Fresh Produce	22.3	23.3	17.5	10.2	6.8	16.9	11.1	12.9	20.0	16.1			21.1		22.8
% 5+ Servings of Fruits/Vegetables per Day	28.6	23.1	24.3	27.5	34.4	26.3	27.9	21.9	18.8	25.7			32.7		35.8
% 7+ Sugar-Sweetened Drinks in Past Week	35.2	38.1	26.9	25.9	15.1	29.9	23.6	29.1	32.5	29.1					28.3
% No Leisure-Time Physical Activity	38.1	42.4	25.3	27.7	20.9	31.9	29.8	28.2	38.4	32.1	26.9	26.5	31.3	21.2	16.7
% Meeting Physical Activity Guidelines	18.8	22.4	20.3	29.2	26.8	23.5	24.4	21.8	9.5	22.1	20.9	20.0	21.4	28.4	22.0
Recreation/Fitness Facilities per 100,000						22.4	17.0	15.8	9.7	19.6					
% Lack of Sidewalks/Poor Sidewalks	27.6	25.3	12.4	15.3	17.7	19.2	10.8	38.5	31.8	19.5					20.1
% Lack of Trails/Poor Quality Trails	27.9	26.6	10.3	10.3	10.3	17.1	10.9	17.4	16.9	16.0					12.9
% Heavy Neighborhood Traffic	22.5	23.5	9.8	10.1	6.6	15.0	6.6	7.8	19.7	13.8					16.7
% Lack of Street Lights/Poor Street Lights	12.8	17.9	7.5	6.4	7.0	10.4	6.7	20.7	16.7	10.7					9.4
% Crime Prevents Exercise in the Neighborhood	24.7	19.5	7.1	2.9	0.7	11.4	4.0	1.6	11.3	9.8					11.0

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (cont.)	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% Overweight (BMI 25+)	71.2	79.6	66.0	67.6	70.2	70.6	73.5	73.2	77.5	71.9	69.0	68.3	61.0		67.5
% Obese (BMI 30+)	40.2	45.8	33.0	35.2	35.9	37.9	35.4	41.4	50.8	38.8	34.1	33.9	31.3	36.0	30.3
% [Overweights] Trying to Lose Weight	44.4	53.1	62.6	59.3	60.6	55.9	54.0	60.0	57.6	55.9			53.7		54.3
% [Overweights] Couseled About Weight in Past Year	21.7	27.1	26.0	23.1	30.7	24.9	20.6	27.6	21.8	23.8			24.7		31.7

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.



ORAL 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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 18+] Dental Visit in Past Year	60.3	53.9	66.9	67.7	79.9	63.8	70.8	64.0	59.4	64.6	67.7	70.8	62.0	45.0	70.4

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.



POTENTIALLY DISABLING CONDITIONS	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030
% Activity Limitations	32.3	25.8	22.3	23.7	15.2	24.9	22.8	23.9	28.1	24.8		24.0		18.4
% With High-Impact Chronic Pain	23.2	19.7	16.1	14.4	10.3	17.4	14.8	15.1	25.3		17.6		14.1	7.0
Alzheimer's Disease (Age-Adjusted Death Rate)						35.0	35.1	35.3	41.6	36.0		28.7	32.1	30.4
% Caregiver to a Friend/Family Member	28.0	28.7	27.3	32.3	30.8	29.4	30.4	37.3	30.7		30.0			22.6

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.



RESPIRATORY DISEASE	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030
CLRD (Age-Adjusted Death Rate)						48.6	41.3	46.7	60.0	48.7	48.8	44.7	39.6	51.9
Pneumonia/Influenza (Age-Adjusted Death Rate)						14.3	15.8		17.3		14.8	15.6	14.0	13.8
% Asthma	9.5	10.3	15.1	10.7	7.4	11.3	10.6	10.4	15.7	11.6		8.0	8.0	12.9
% COPD (Lung Disease)	11.0	8.9	8.5	5.1	3.2	7.8	4.2	8.6	10.9		7.5	5.7	6.1	6.4

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.



SEXUAL 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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
HIV/AIDS (Age-Adjusted Death Rate)										1.0	0.8	0.6	1.9		
HIV Prevalence Rate						50.4	18.9		141.6	53.9	137.3	106.0	372.8		
% [Age 18-44] HIV Test in the Past Year										11.6			22.0		16.1
Chlamydia Incidence Rate						666.6	308.1	158.4	545.0	562.8	418.0	466.7	539.9		
Gonorrhea Incidence Rate						291.3	86.0	38.6	336.2	245.4	140.4	153.8	179.1		

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

SUBSTANCE ABUSE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)						12.3	7.7		15.4	11.5	10.8	9.2	11.1	10.9	7.9
% Excessive Drinker	22.8	23.8	29.9	24.4	31.8	25.7	20.8	28.7	21.4	24.5	21.9	22.5	27.2	26.0	
% Drinking & Driving in Past Month	4.9	4.3	9.9	2.0	8.2	5.3	2.4	2.3	4.2	4.5	5.1	5.2		5.8	
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)						7.9	7.9		7.7	7.8	6.5	8.6	18.8		7.7
% Used an Prescription Opioid in Past Year	15.9	14.0	13.3	13.2	13.7	13.9	13.6	18.5	11.8	13.8			12.9	18.1	

SUBSTANCE ABUSE (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% Ever Sought Help for Alcohol or Drug Problem	2.9	7.1	4.4	4.1	10.7	5.0	4.4	6.2	6.3	5.1			5.4		3.9

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.



TOBACCO USE	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	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% Current Smoker	21.0	16.2	12.8	10.1	10.7	14.1	11.8	12.3	20.2	14.2	14.7	16.4	17.4	5.0	17.0
% Someone Smokes at Home	19.1	13.3	10.2	6.8	2.3	11.1	8.3	5.5	14.8	10.8			14.6		15.1
% [Household With Children] Someone Smokes in the Home	19.4	10.1	13.5	4.9	0.0	10.0	8.9	0.4	9.4	9.4			17.4		
% [Smokers] Have Quit Smoking 1+ Days in Past Year										47.1	52.6	51.6	42.8	65.7	50.7
% [Smokers] Received Advice to Quit Smoking										56.5			59.6	66.6	66.3
% Currently Use Vaping Products	4.5	7.0	8.3	6.8	3.4	6.6	7.3	3.2	5.4	6.5			8.9		5.8

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.





COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The four-county Metro Area, the focus of this Community Health Needs Assessment, encompasses 2,072.44 square miles and houses a total population of 852,548 residents, according to latest census estimates.

Total Population
(Estimated Population, 2014-2018)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Douglas County	554,992	326.41	1,700.29
Sarpy County	178,351	238.15	748.89
Cass County	25,702	557.35	46.11
Pottawattamie County	93,503	950.52	98.37
Metro Area	852,548	2,072.44	411.38
Nebraska	1,904,760	76,823.79	24.79
Iowa	3,132,499	55,856.49	56.08
United States	322,903,030	3,532,068.58	91.42

Sources:
 • US Census Bureau American Community Survey 5-year estimates.
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Population Change 2000-2010

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

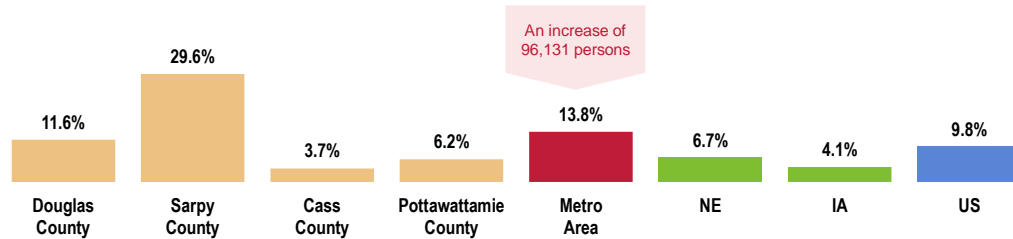
Between the 2000 and 2010 US Censuses, the population of the Metro Area increased by 96,131 persons, or 13.8%.

BENCHMARK ► A much greater proportional increase when compared with state and national percentages.

DISPARITY ► The population growth appears to be predominantly in Sarpy County, followed to a lesser extent by Douglas County.



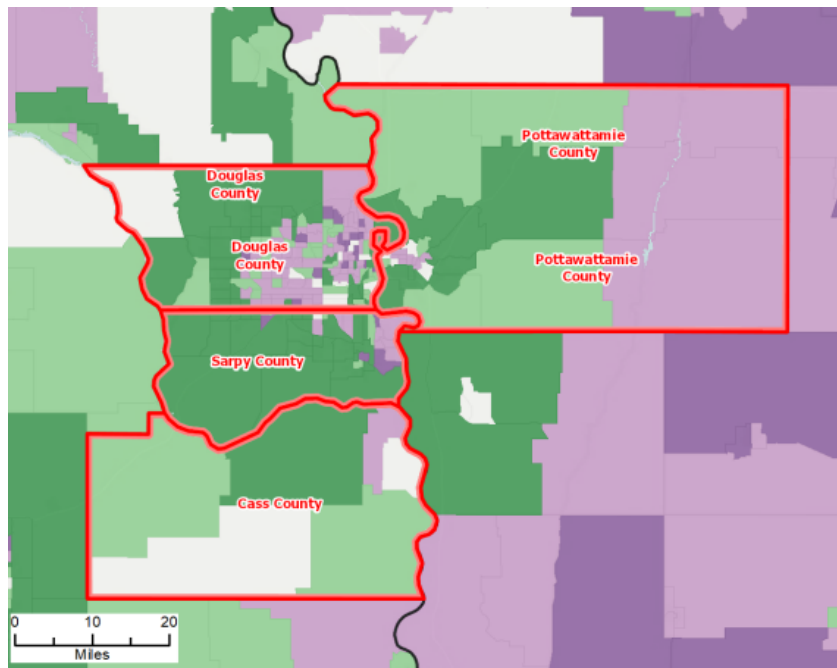
Change in Total Population (Percentage Change Between 2000 and 2010)



An increase of 96,131 persons

Sources: • US Census Bureau Decennial Census (2000-2010).
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
 Notes: • A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

This map shows the areas of greatest increase or decrease in population between 2000 and 2010.



Map Legend

Population Change, Percent by Tract, US Census 2000 - 2010

- Over 10.0% Increase (+)
- 1.0 - 10.0% Increase (+)
- Less Than 1.0% Change (+/-)
- 1.0 - 10.0% Decrease (-)
- Over 10.0% Decrease (-)
- No Population or No Data

Report Location, County



Urban/Rural Population

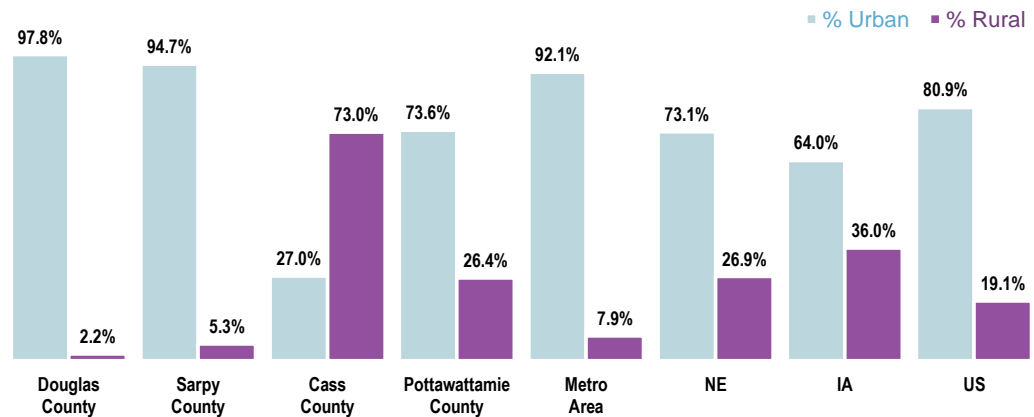
Urban areas are identified using population density, count, and size thresholds, and also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

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

BENCHMARK ▶ Well above the national and (especially) state percentages.

DISPARITY ▶ Note that Cass County is predominantly rural, in contrast to the other three counties.

Urban and Rural Population (2010)

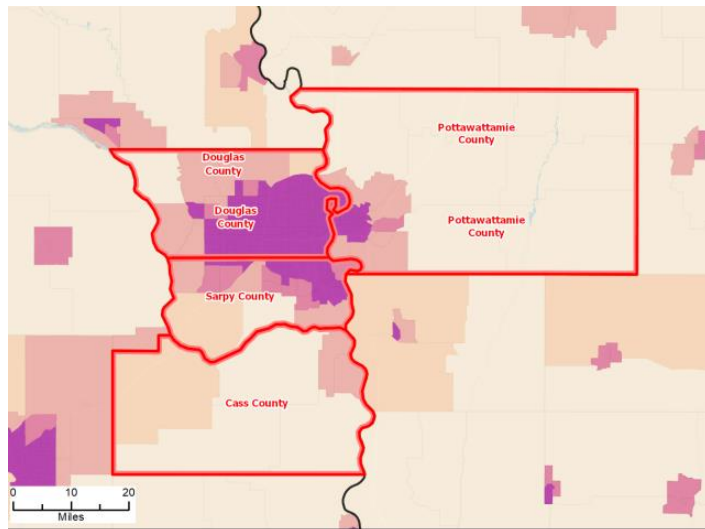


Sources:

- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

 Notes:

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



Map Legend

Urban Population, Percent by Tract, US Census 2010

- 100% Urban Population
- 90.1 - 99.9%
- 50.1 - 90.0%
- Under 50.1%
- No Urban Population
- No Data or Data Suppressed

Report Location, County



Age

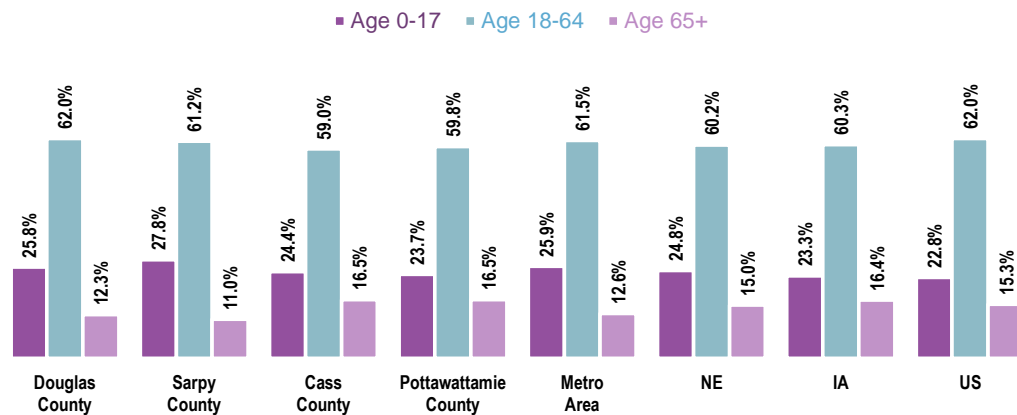
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

In the Metro Area, 25.9% of the population are children age 0-17; another 61.5% are age 18 to 64, while 12.6% are age 65 and older.

BENCHMARK ▶ The proportion of seniors (age 65+) in the Metro Area is smaller than the state and national percentages.

DISPARITY ▶ The proportion of seniors is higher in Cass and Pottawattamie counties when compared with Douglas and Sarpy counties.

Total Population by Age Groups (2014-2018)

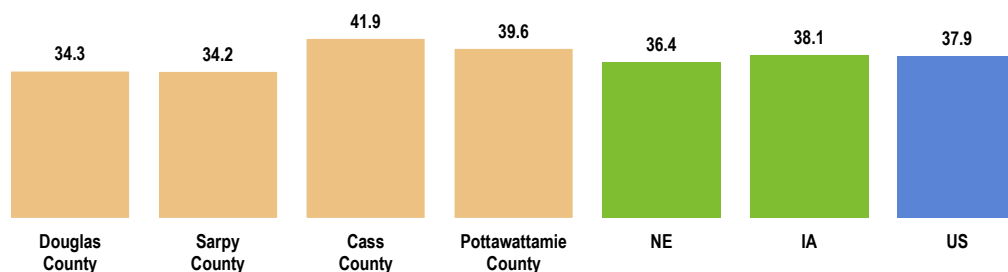


Sources:
 • US Census Bureau American Community Survey 5-year estimates.
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Median Age

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

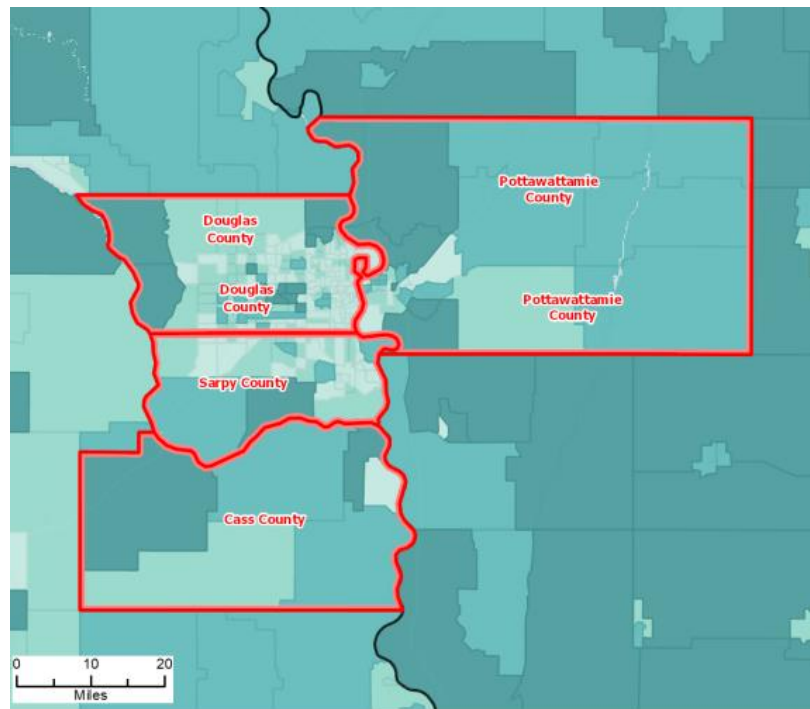
Median Age (2014-2018)



Sources:
 • US Census Bureau American Community Survey 5-year estimates.
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).



The following map provides an illustration of the median age in the Metro Area.



Race & Ethnicity

Race

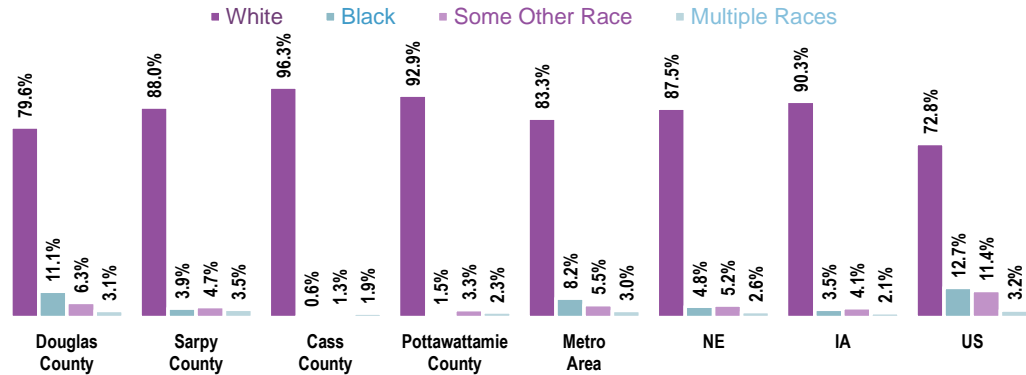
In looking at race independent of ethnicity (Hispanic or Latino origin), 83.3% of residents of the Metro Area are White and 8.2% are Black.

BENCHMARK ▶ A less diverse population than reported for the US overall, although slightly more diverse than the states of Nebraska and Iowa.

DISPARITY ▶ The Douglas County population is the most diverse of the four Metro Area counties.



Total Population by Race Alone (2014-2018)



Sources: • US Census Bureau American Community Survey 5-year estimates.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

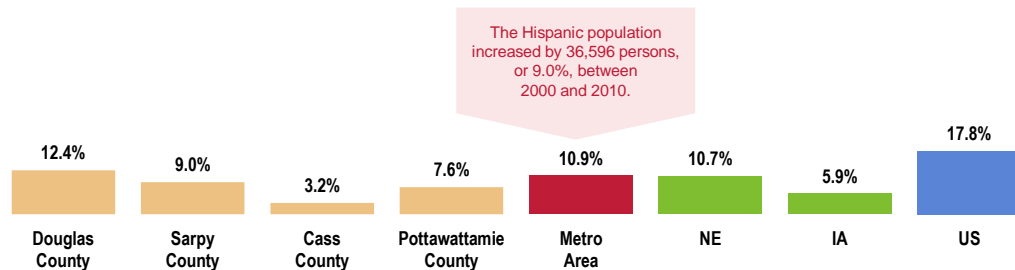
Ethnicity

A total of 10.9% of Metro Area residents are Hispanic or Latino.

BENCHMARK ▶ A lower proportion than reported for the US but much higher than the Iowa proportion.

DISPARITY ▶ Douglas County houses the highest proportion of Hispanic residents in the four-county Metro Area.

Hispanic Population (2014-2018)



Sources: • US Census Bureau American Community Survey 5-year estimates.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes: • Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.



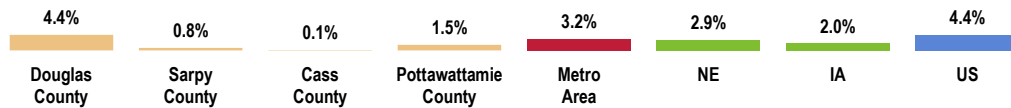
Linguistic Isolation

A total of 3.2% of the Metro Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English “very well”).

BENCHMARK ▶ Below the US percentage but higher than the Iowa prevalence.

DISPARITY ▶ Highest in Douglas County.

Linguistically Isolated Population (2014-2018)

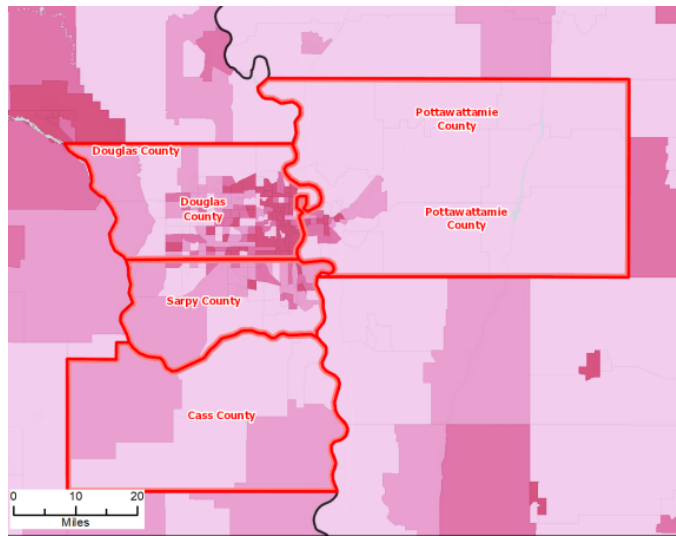


Sources:

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

Notes:

- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English “very well.”



Map Legend

Population in Linguistically Isolated Households, Percent by Tract, ACS 2014-18

- Over 3.0%
- 1.1 - 3.0%
- 0.1 - 1.1%
- No Population in Linguistically Isolated Households
- No Data or Data Suppressed

Report Location, County



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. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

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

Poverty

The latest census estimate shows 10.2% of the Metro Area total population living below the federal poverty level.

BENCHMARK ▶ Lower than the national figure but failing to satisfy the Healthy People 2030 objective.

DISPARITY ▶ Highest in Douglas and Pottawattamie counties.

Among just children (ages 0 to 17), this percentage in the Metro Area is 14.2% (representing nearly 31,000 children).

BENCHMARK ▶ Lower than the national figure but failing to satisfy the Healthy People 2030 objective.

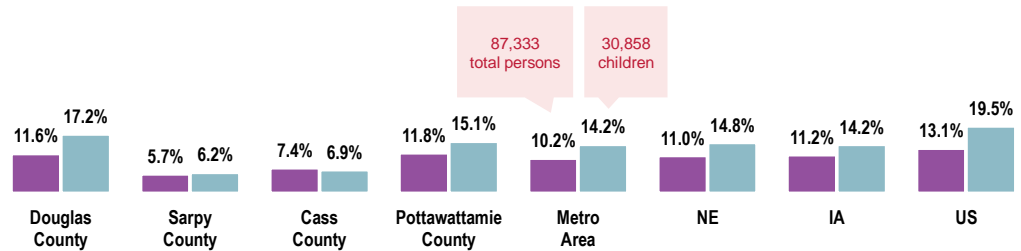
DISPARITY ▶ Child poverty is highest in Douglas and Pottawattamie counties.



Population in Poverty (Populations Living Below the Poverty Level; 2014-2018)

Healthy People 2030 = 8.0% or Lower

■ Total Population ■ Children



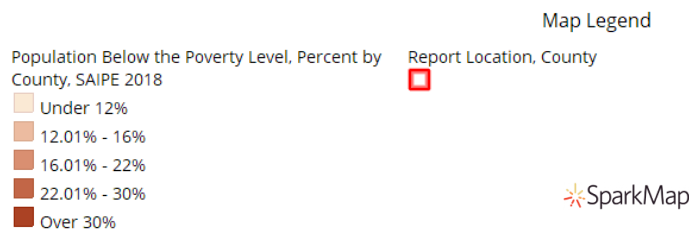
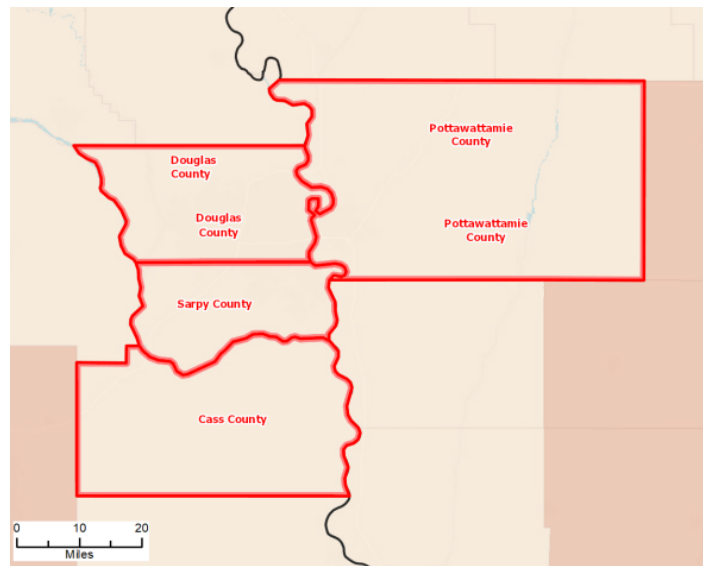
Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030, August 2020. <http://www.healthypeople.gov>

Notes:

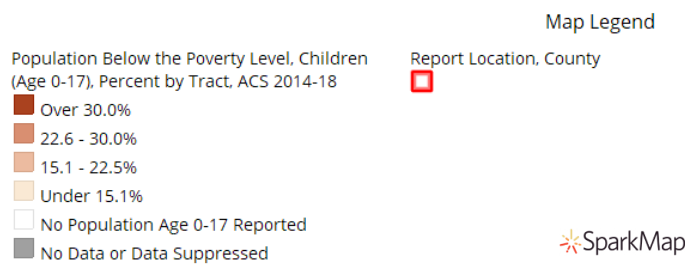
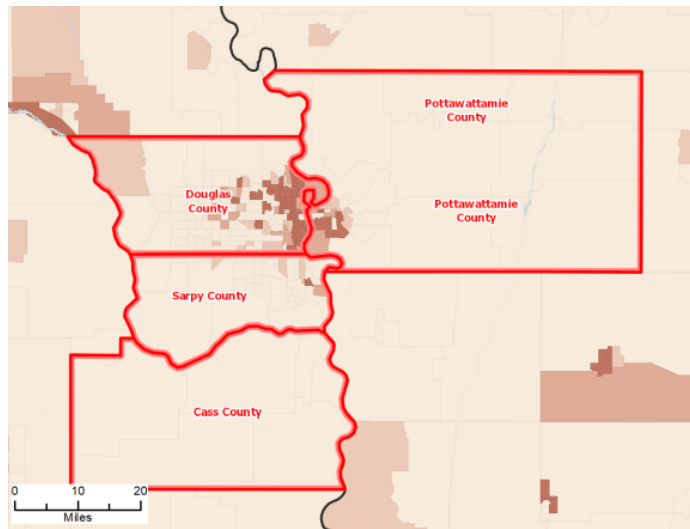
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

The following maps highlight concentrations of persons living below the federal poverty level.



SparkMap





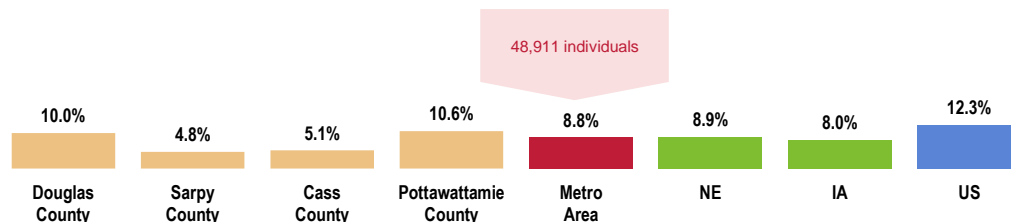
Education

Among the Metro Area population age 25 and older, an estimated 8.8% (nearly 49,000 people) do not have a high school education.

BENCHMARK ▶ Lower than the US prevalence.

DISPARITY ▶ Unfavorably high in Douglas and Pottawattamie counties.

Population With No High School Diploma (Population Age 25+ Without a High School Diploma or Equivalent, 2014-2018)



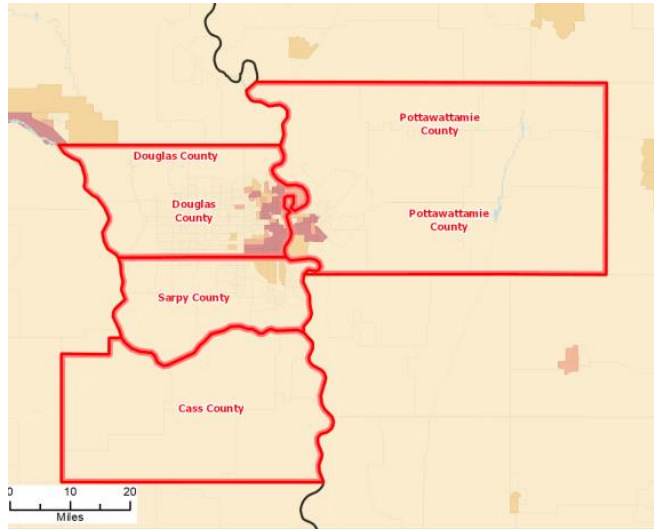
Sources:

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

Notes:

- This indicator is relevant because educational attainment is linked to positive health outcomes.





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 18.7% of Metro Area residents say they would not be able to afford an unexpected \$400 expense without going into debt.

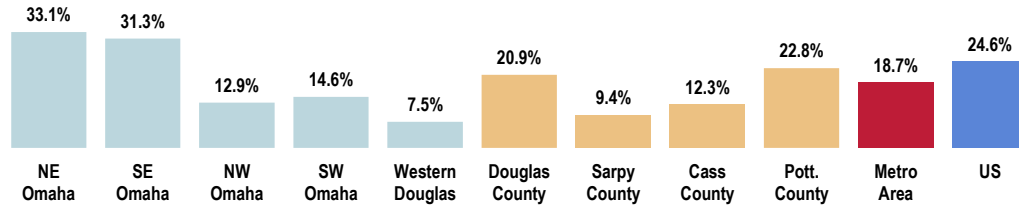
BENCHMARK ► Well below the national prevalence.

DISPARITY ► Unfavorably high in the eastern portions of Omaha. Viewed by county, higher in Douglas and Pottawattamie counties than in Sarpy or Cass. Correlates with age and household income level (especially) and reported more often among women and especially communities of color.



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.

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



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 63]

• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

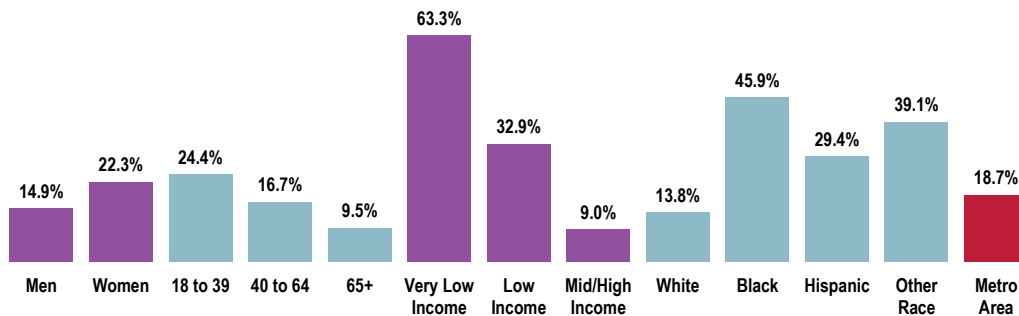
• Includes respondents who say they would not be able to pay for a \$400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

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

Here: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level 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 respondents 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).

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



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 63]

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.

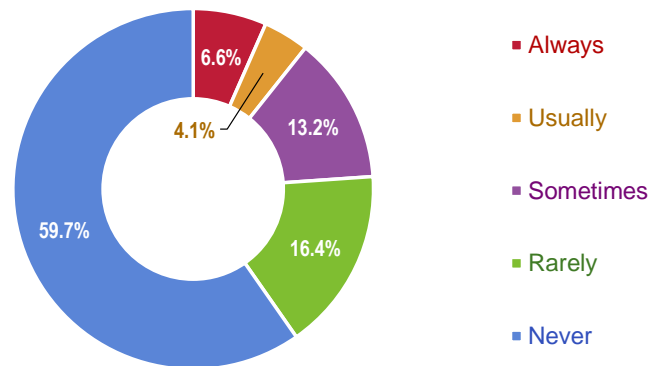


Housing

Housing Insecurity

Most surveyed adults rarely, if ever, worry about the cost of housing.

Frequency of Worry or Stress
Over Paying Rent or Mortgage in the Past Year
(Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: • Asked of all respondents.

However, a considerable share (23.9%) report that they were “sometimes,” “usually,” or “always” worried or stressed about having enough money to pay their rent or mortgage in the past year.

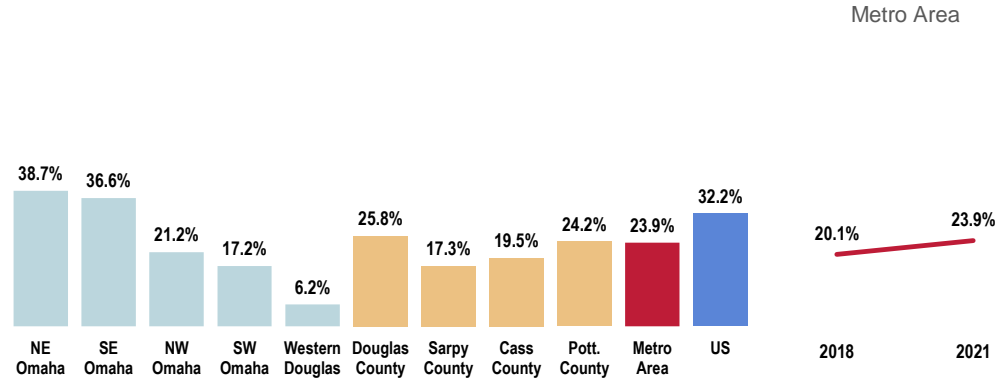
BENCHMARK ► Well below the US percentage.

TREND ► Marks a statistically significant increase from 2018 survey findings.

DISPARITY ► In Douglas County, unfavorably high in the Northeast and Southeast Omaha areas. Viewed by county, the prevalence is highest in Douglas County. Reported more often among women, young adults, and particularly those in lower-income households, communities of color, and renters.

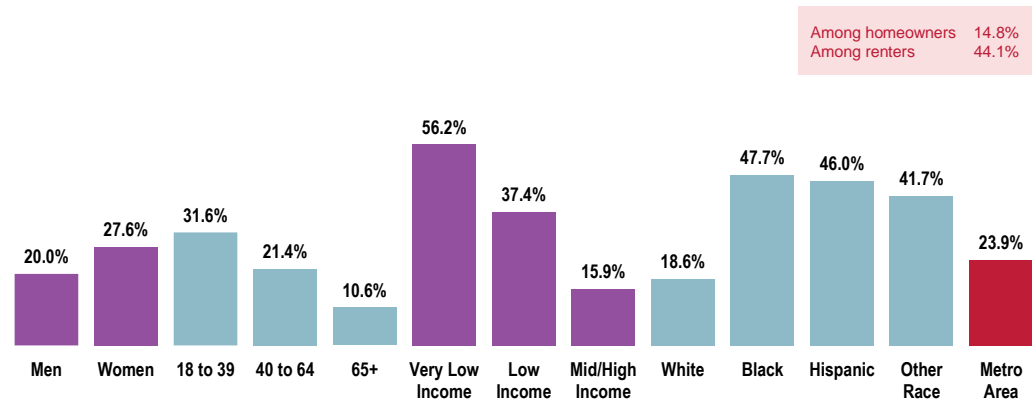


“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
 Notes: • Asked of all respondents.



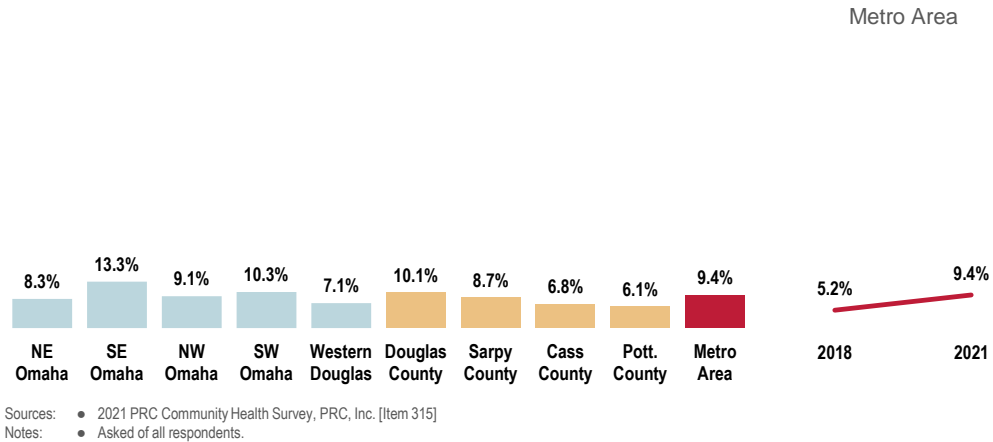
Loss of Utilities

A total of 9.4% of Metro Area residents were without electricity, water, or heat at some point in the past year.

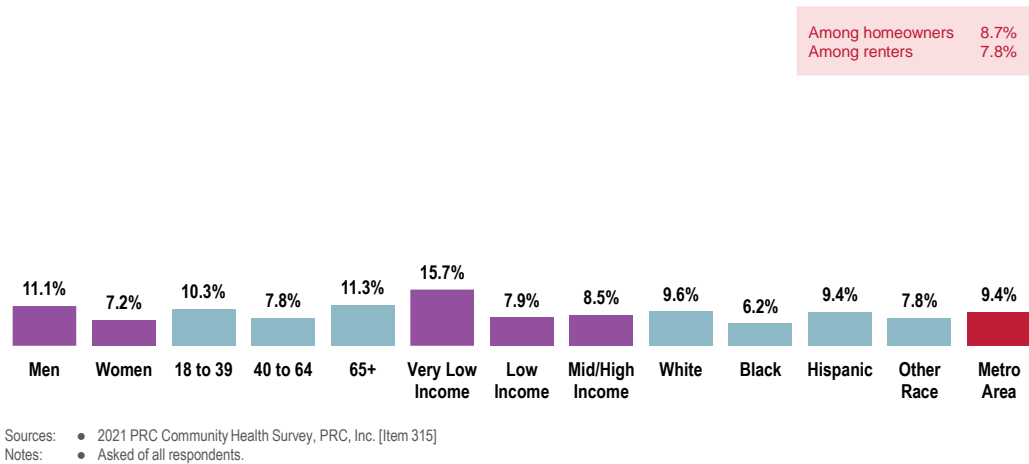
TREND ▶ Denotes a statistically significant increase since 2018.

DISPARITY ▶ Unfavorably high among Douglas County respondents. Particularly high among households below the federal poverty level.

Went Without Electricity, Water, or Heating in the Past Year



Went Without Electricity, Water, or Heating in the Past Year (Metro Area, 2021)



Unhealthy or Unsafe Housing

A total of 9.0% of Metro Area residents report living unhealthy or unsafe housing conditions during the past year.

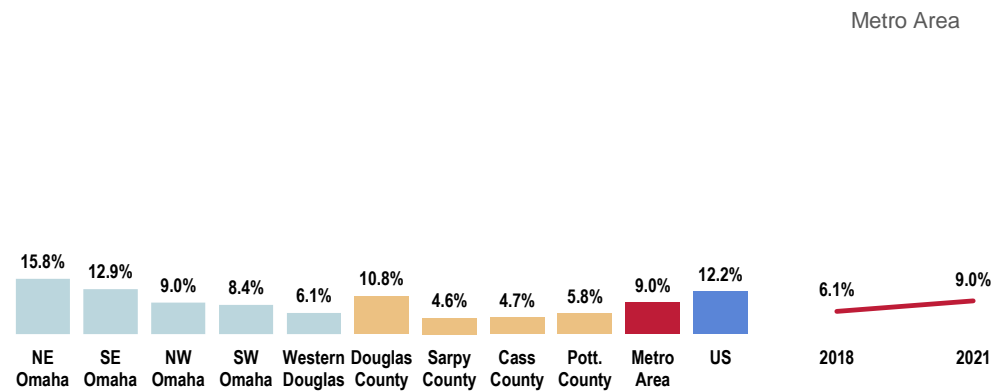
BENCHMARK ▶ Lower than the US prevalence.

TREND ▶ Increasing from 2018 findings.

DISPARITY ▶ In Douglas County, the prevalence is highest in Northeast Omaha. Viewed by county, the prevalence is highest in Douglas County. The prevalence correlates with age and income and is reported more often among communities of color (Hispanic, Black, and other non-White races), and renters.

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?"

Unhealthy or Unsafe Housing Conditions in the Past Year



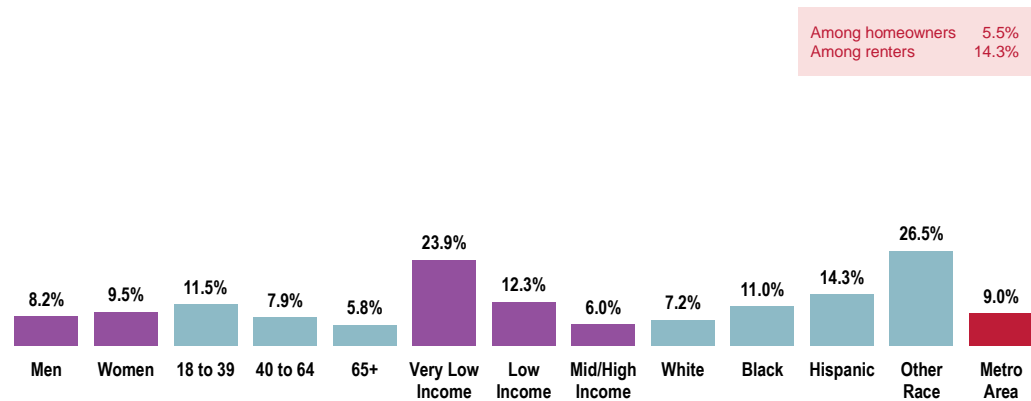
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 65]

• 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 65]

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.

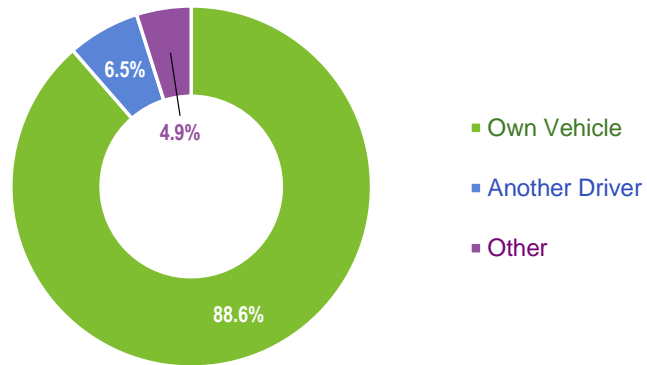


Transportation

While the vast majority of Metro Area adults report owning their own vehicle for transportation purposes, 11.4% rely on other means of transportation.

This includes a total of 6.5% who have **someone else who drives** them around and 4.9% who rely on other modes like **public transportation, walking**, etc.

Primary Form of Transportation
(Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 316]
Notes: • Asked of all respondents.

Food Access

Low Food Access

US Department of Agriculture data show that 19.2% of the Metro Area population (representing over 152,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

BENCHMARK ► Better than the national prevalence.

DISPARITY ► Low food access is more prevalent in the Metro Area outside of Douglas County.

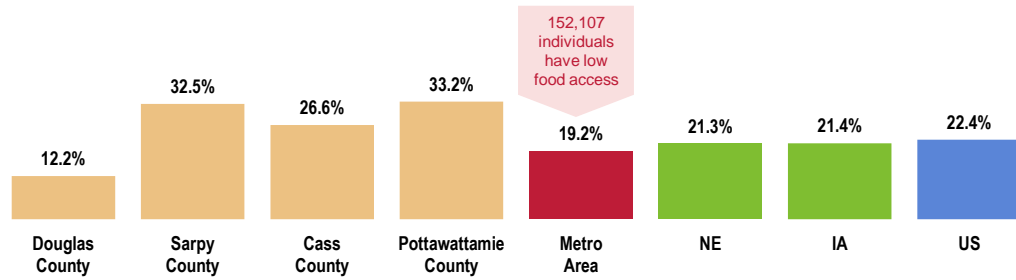
Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* in the **Modifiable Health Risks** section of this report.



Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)

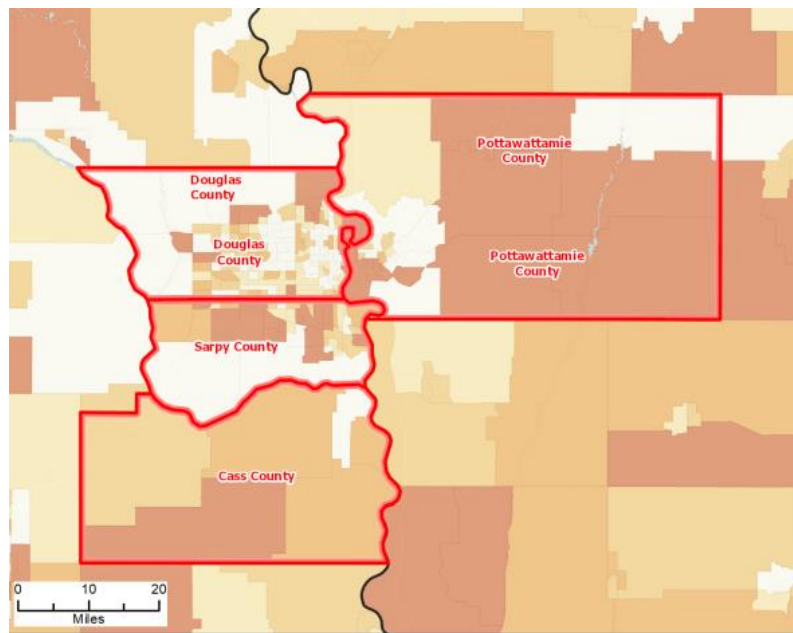


Sources:

- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:

- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than 1/2 mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



Food Insecurity

Over the past year, 19.7% of community residents “often” or “sometimes” worried about running out of food.

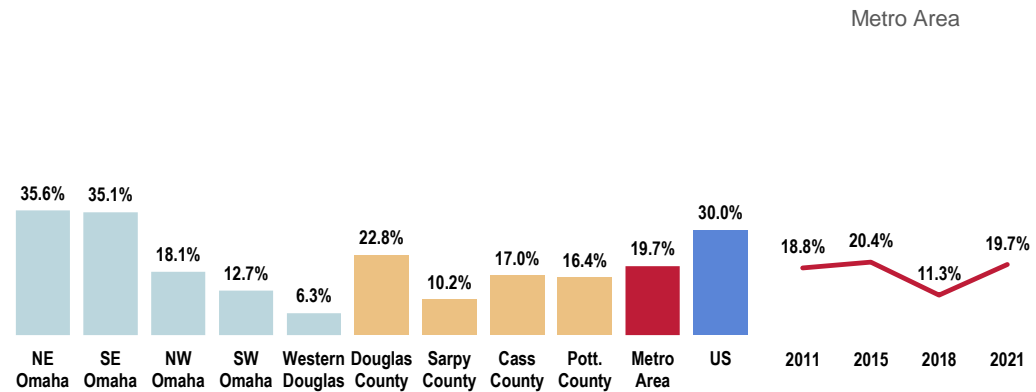
BENCHMARK ▶ Well below the national percentage.

DISPARITY ▶ Highest in Douglas County, particularly in eastern Omaha. The prevalence decreases notably with age and income and is reported more often among women and especially in communities of color.

Surveyed adults were asked whether the following statement was “Often True,” “Sometimes True,” or “Never True” for them in the past 12 months:

I worried about whether our food would run out before we got money to buy more.

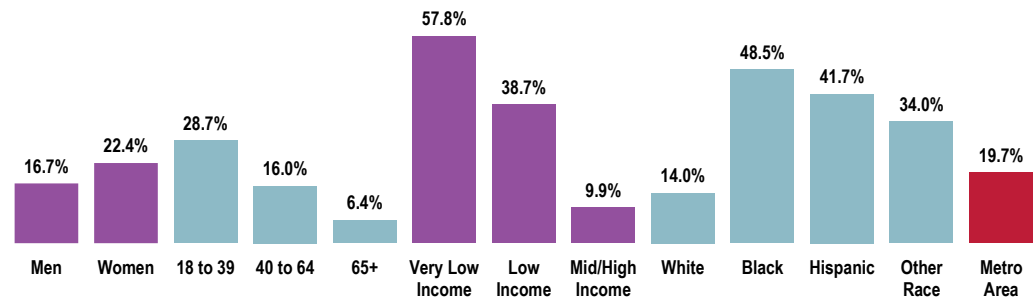
“Often” or “Sometimes” Worry About Food Running Out Before Having Money to Buy More



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 80]
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

“Often” or “Sometimes” Worry About Food Running Out Before Having Money to Buy More (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 80]

Notes: • Asked of all respondents.

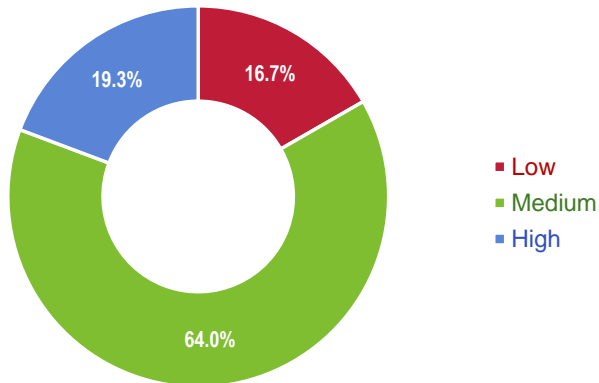


Health Literacy

Most surveyed adults in the Metro Area are found to have a moderate level of health literacy.

Low health literacy is defined as those respondents who "Seldom/Never" find written or spoken health information easy to understand, and/or who "Always/Nearly Always" need help reading health information, and/or who are "Not At All Confident" in filling out health forms.

Level of Health Literacy (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 318-321, 346]
 Notes: • Asked of all respondents.
 • Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

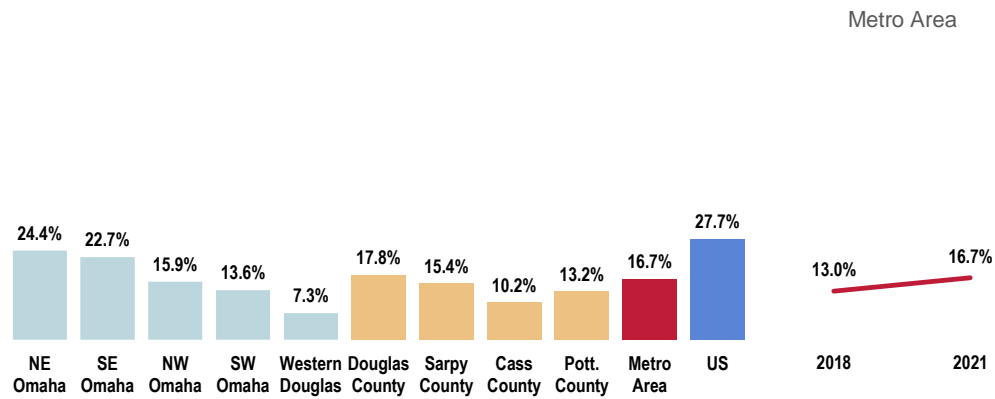
A total of 16.7% are determined to have low health literacy.

BENCHMARK ▶ Well below the national prevalence.

TREND ▶ Increasing since 2018.

DISPARITY ▶ Highest in Douglas County; within the county, notably higher in eastern Omaha. Reported more often among young adults, those living on lower incomes, and communities of color.

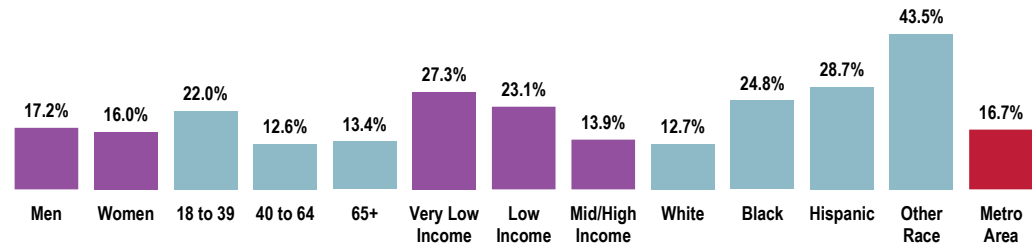
Low Health Literacy



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 346]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.



Low Health Literacy (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 346]
 Notes: • Asked of all respondents.
 • Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Equity

Unfair Treatment

One in four survey respondents (25.1%) reports that in their daily lives, they feel that they are treated with less courtesy or respect than other people a few times per month or more often; another 13.3% report being treated as less intelligent than others.

Fewer respondents (7.7%) report receiving **poorer service** at restaurants and stores, and 7.4% report being treated as a **potential danger** by others. A total of 4.8% of survey respondents have been **threatened or harassed**.

For those who felt they were treated differently, nearly one out of four were unsure of the main reason why. A wide variety of other reasons were given, with *age, gender, race/ethnicity, and height/weight* topping the list. However, in looking at these responses according to these respondent characteristics, notable differences only appeared for age and race/ethnicity.

DISPARITY ► Viewed by **age**, there is a negative correlation between age and the tested aspects of unfair treatment, with adults age 18 to 39 more likely to report each.

Using a short version of the Everyday Discrimination Scale (EDS), respondents were asked about how frequently they encounter treatment they perceive to be unfair.

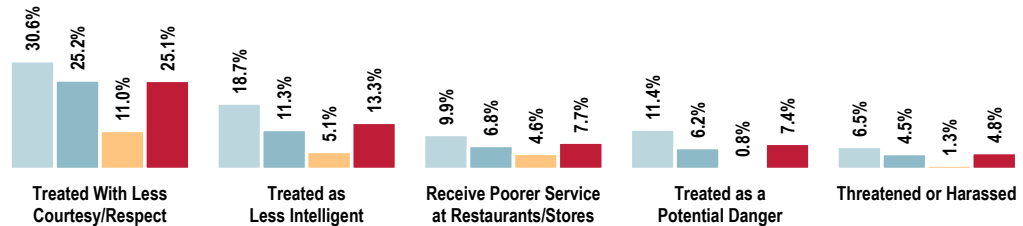
In your day-to-day life, how often do the following things happen to you:

- You are treated with less courtesy or respect than other people?
- You receive poorer service than other people at restaurants or stores?
- People act as if they think you are not smart?
- People act as if they are afraid of you?



Perceptions of Unfair Treatment in Day-to-Day Life (By Age; Metro Area, 2021)

■ 18-39 ■ 40-64 ■ 65+ ■ Total Sample

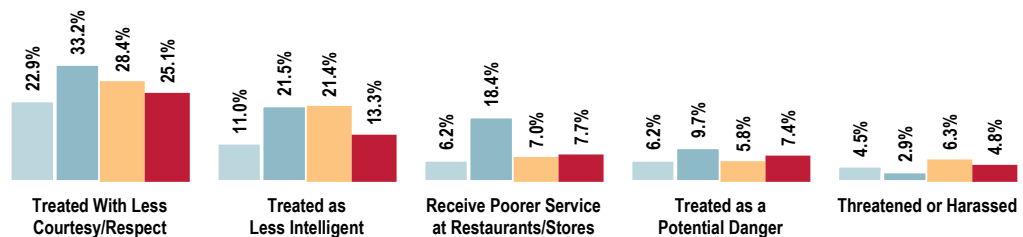


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 338-342]
 Notes: ● Asked of all respondents.
 ● Percentages represent combined "Almost Daily," "At Least Weekly," and "A Few Times a Month" responses.

DISPARITY ► Viewed by **race/ethnicity**, Black respondents gave the highest response for each of the experiences tested except being threatened or harassed. Hispanics were also more likely than Whites to report being treated with less courtesy/respect and being treated as less intelligent.

Perceptions of Unfair Treatment in Day-to-Day Life (By Race/Ethnicity; Metro Area, 2021)

■ White ■ Black ■ Hispanic ■ Total Sample



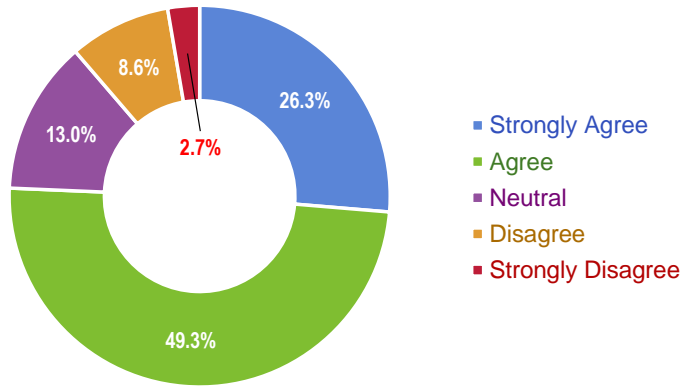
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 338-342]
 Notes: ● Asked of all respondents.
 ● Percentages represent combined "Almost Daily," "At Least Weekly," and "A Few Times a Month" responses.



Community as a Welcoming Place for All Races/Ethnicities

Most Metro Area adults agree that the community is a welcoming place for people of all races and ethnicities, with three in four giving “agree” or “strongly agree” responses.

Level of Agreement About the Community as a Welcoming Place for People of All Races and Ethnicities (Metro Area, 2021)

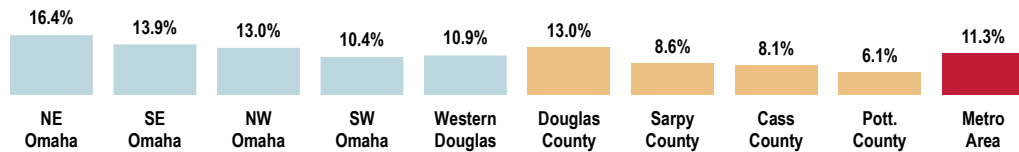


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 312]
 Notes: • Asked of all respondents.

However, 11.3% of residents do not agree that the community is welcoming to all people.

DISPARITY ► The prevalence is unfavorably high among Douglas County respondents. Reported more often among women, young adults, those living on very low incomes, as well as Black and other non-White race respondents.

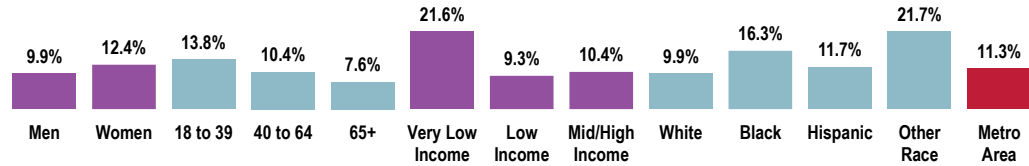
Disagree That the Community is a Welcoming Place for All Races/Ethnicities



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



Disagree That the Community is a Welcoming Place for All Races/Ethnicities (Metro Area, 2021)

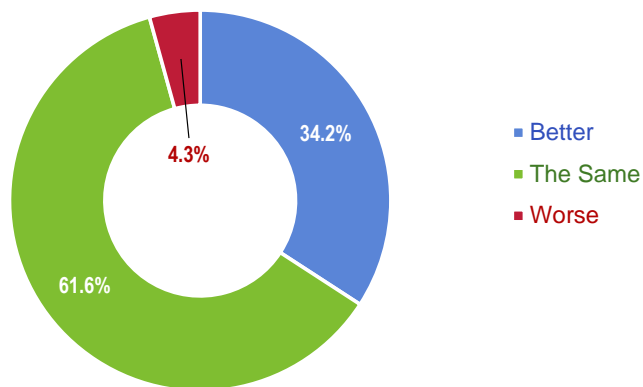


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: • Asked of all respondents.

Treatment Based on Race/Ethnicity in Health Care Settings

A large share of survey respondents (34.2%) feel they were treated “better” than people of other races or ethnicities during recent health care experiences; most (61.6%) felt they were treated “the same.”

How Respondents Feel They Were Treated in Health Care Settings Over the Past Year in Comparison With People of Other Races/Ethnicities (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: • Asked of all respondents.
• As compared to the experiences of people of other races or ethnicities.

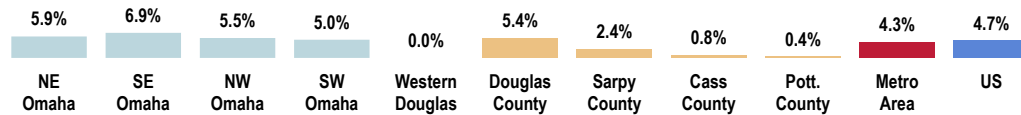
“In the past 12 months, in general, do you feel your health care experiences were “better,” “the same,” or “worse” than those of other races or ethnicities?”



On the other hand, 4.3% of residents perceive their treatment as being “worse” than people of other races during recent health care experiences.

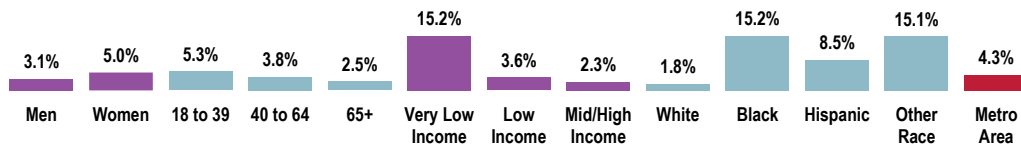
DISPARITY ► Reported most often in Douglas County (though not among any respondents from the county’s western region). Reported more often among women, young adults, and especially those living on very low incomes and in communities of color.

Respondents Who Feel They Were Treated Worse in Health Care Settings Over the Past Year in Comparison With People of Other Races/Ethnicities (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 313]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Respondents Who Feel They Were Treated Worse in Health Care Settings Over the Past Year in Comparison With People of Other Races/Ethnicities (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 313]
 Notes: • Asked of all respondents.



When respondents were asked how their “worse” treatment has affected the way they try to get their health care, the largest share (41.3%) indicated that they **have not changed** their health-seeking behaviors as a result, and 25.6% were unsure. However, 9.3% report being **very particular** about where they seek care, and 5.8% seek out **providers who are people of color**.



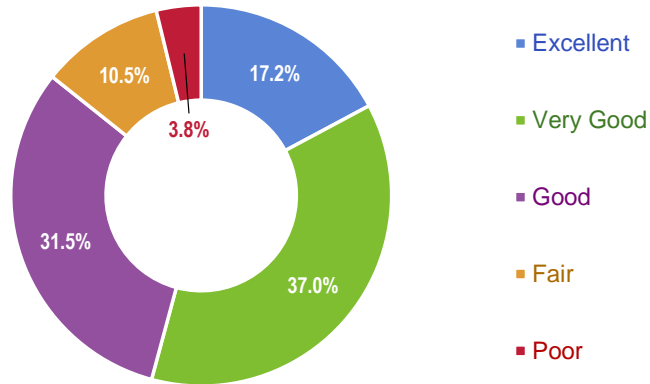
HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"

Most Metro Area residents rate their overall health favorably (responding "excellent," "very good," or "good").

Self-Reported Health Status
(Metro Area, 2021)



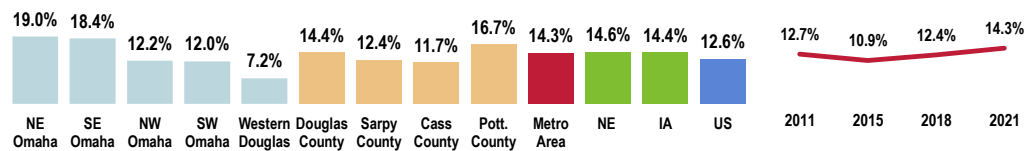
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

However, 14.3% of Metro Area adults believe that their overall health is "fair" or "poor."

DISPARITY ► The response is highest in eastern Omaha. Viewed by demographics, the prevalence is statistically higher among adults age 40+, those living in households with lower incomes, and Hispanics.

Experience "Fair" or "Poor" Overall Health

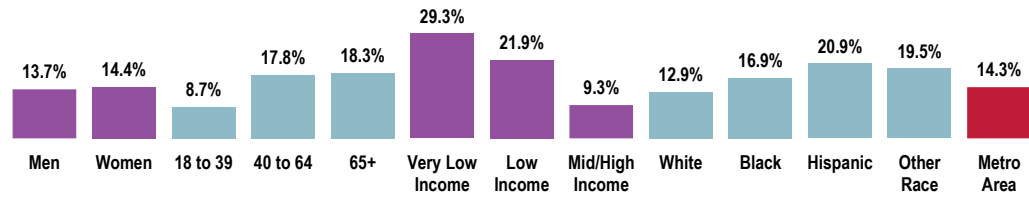
Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.



Experience “Fair” or “Poor” Overall Health (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
 Notes: • Asked of all respondents.



MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. ...Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

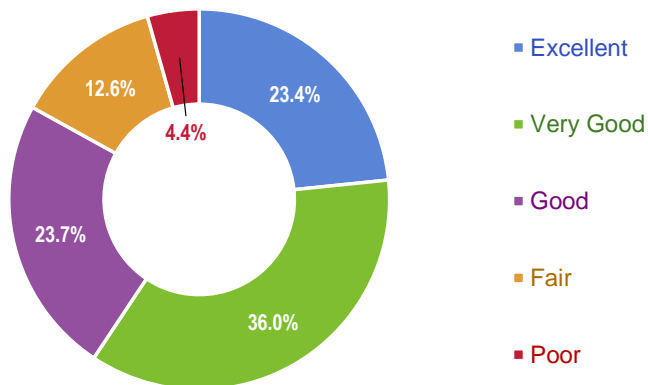
– Healthy People 2030 (<https://health.gov/healthypeople>)

Mental Health Status

Most Metro Area adults rate their overall mental health favorably (“excellent,” “very good,” or “good”).

“Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: Excellent, Very Good, Good, Fair, or Poor?”

Self-Reported Mental Health Status
(Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: • Asked of all respondents.

However, 17.0% believe that their overall mental health is “fair” or “poor.”

BENCHMARK ▶ Worse than the national prevalence.

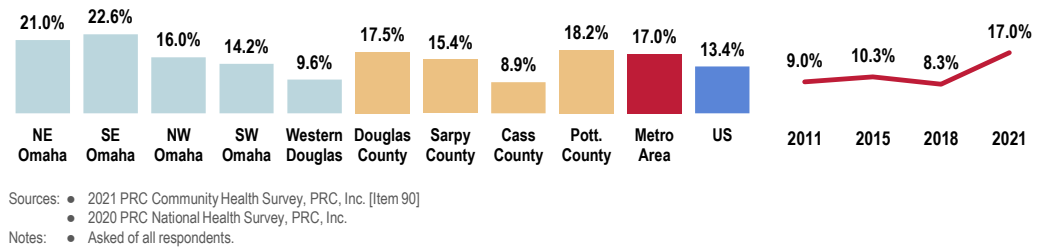
TREND ▶ Marks a statistically significant increase from previous survey results.

DISPARITY ▶ Unfavorably highest among residents of Southeast Omaha.



Experience “Fair” or “Poor” Mental Health

Metro Area



Depression & Anxiety

Diagnosed Depression

A total of 25.0% of Metro Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

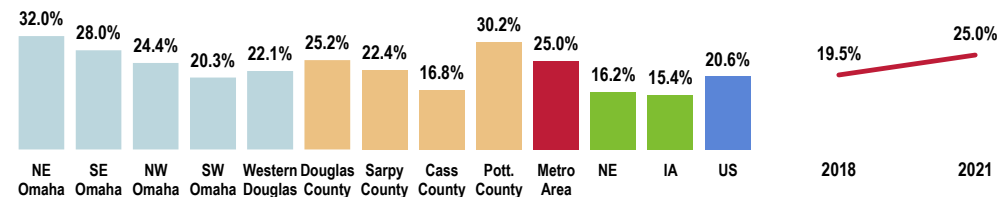
BENCHMARK ▶ Worse than state and US percentages.

TREND ▶ Marks a statistically significant increase since 2018.

DISPARITY ▶ In Douglas County, highest in the Northeast Omaha area. Viewed by county, the prevalence is unfavorably high in Pottawattamie County.

Have Been Diagnosed With a Depressive Disorder

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 93]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • Depressive disorders include depression, major depression, dysthymia, or minor depression.



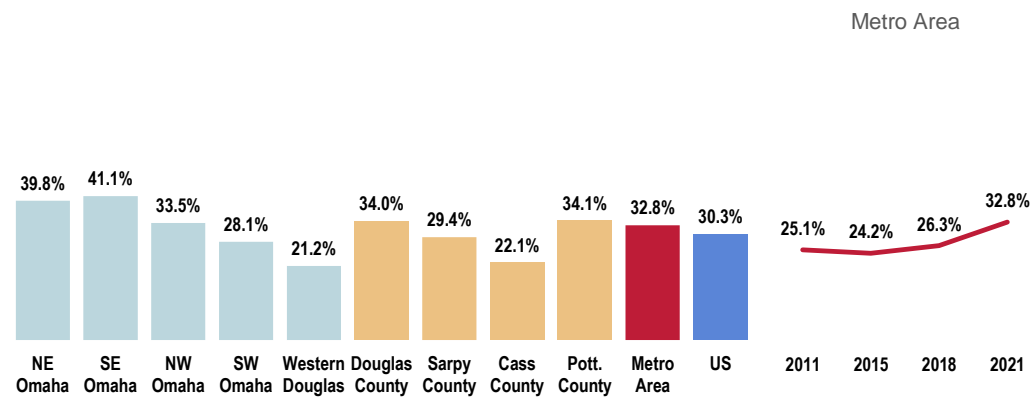
Symptoms of Chronic Depression

A total of 32.8% of Metro Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

TREND ▶ Denotes a statistically significant increase from previous survey results.

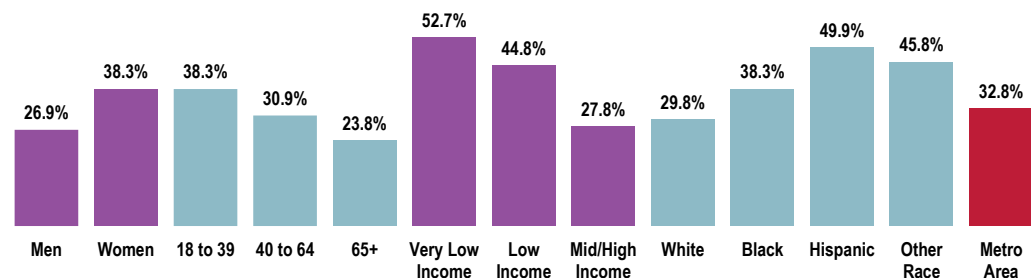
DISPARITY ▶ Higher in Douglas County, especially in the eastern Omaha community. The prevalence decreases with age and income and is reported more often among women and communities of color.

Have Experienced Symptoms of Chronic Depression



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
 Notes: • Asked of all respondents.
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.



Current Anxiety & Depression

The Patient Health Questionnaire-4 (PHQ-4) was developed in order to address anxiety and depression, two of the most prevalent illnesses among the general population and often comorbid in nature.

The PHQ-4 is a four-item questionnaire allowing for ultra-brief and accurate measurement of core symptoms/signs of depression and anxiety. An elevated PHQ-4 score is not diagnostic but is an indicator for further inquiry to establish the presence or absence of a clinical disorder warranting treatment.

Respondents were asked:

During the past two weeks, how often have you been bothered by the following problems:

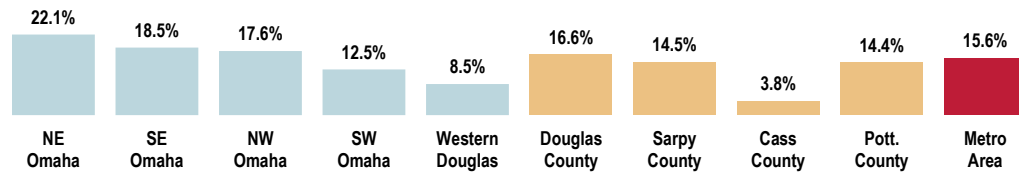
- *Feeling Nervous, Anxious, or On Edge*
- *Not Being Able to Stop or Control Worrying*
- *Feeling Down, Depressed, or Hopeless*
- *Feeling Little Interest or Pleasure in Doing Things*

Responses were scored according to how frequently each was experienced in the previous two weeks (nearly every day, more than half the days, several days, or not at all).

At the time of the survey, 15.6% of Metro Area respondents reported experiencing feelings that signal moderate to severe anxiety and/or depression (reflecting a PHQ-4 score of 6 or higher).

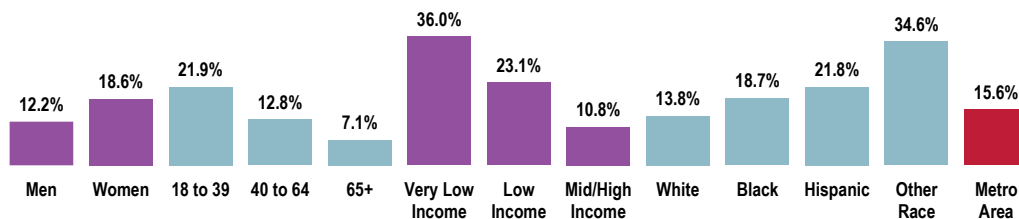
DISPARITY ► Highest in Douglas County, particularly in Northeast Omaha. Reported more often among women, young adults, those in lower-income households, and communities of color.

Moderate to Severe Anxiety/Depression



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 358]
 Notes: • Asked of all respondents.
 • Reflects a PHQ-4 score of 6 or higher.

Moderate to Severe Anxiety/Depression (Metro Area, 2021)



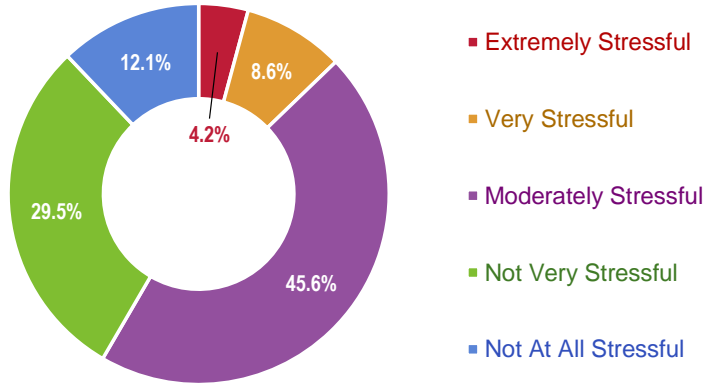
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 358]
 Notes: • Asked of all respondents.
 • Reflects a PHQ-4 score of 6 or higher.



Stress

A majority of surveyed adults characterize most days as no more than “moderately” stressful.

Perceived Level of Stress On a Typical Day
(Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: • Asked of all respondents.

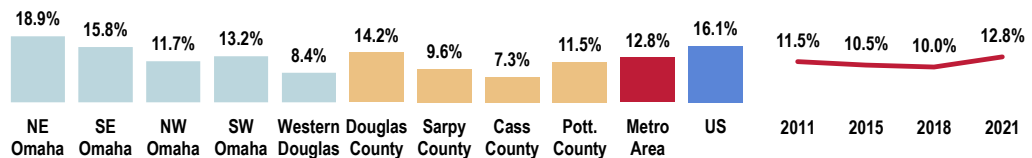
In contrast, 12.8% of Metro Area adults feel that most days for them are “very” or “extremely” stressful.

BENCHMARK ► Lower than the national figure.

DISPARITY ► Highest in Douglas County (and within Douglas County, highest in Northeast Omaha). Correlates with age and income and is more often reported in communities of color.

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

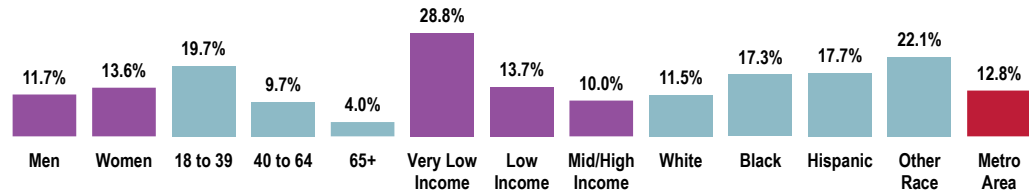
Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.



Perceive Most Days as “Extremely” or “Very” Stressful (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: • Asked of all respondents.

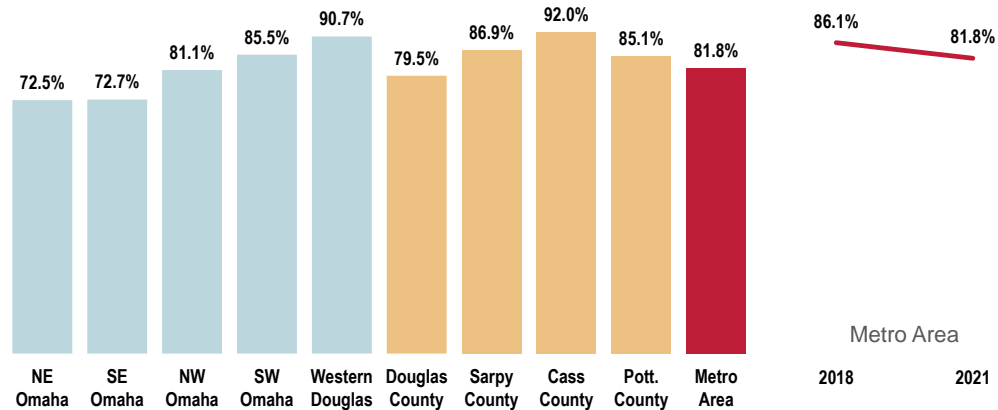
Social Support

Most Metro Area adults (81.8%) report having someone to turn to “all” or “most” of the time, if they needed or wanted help.

TREND ▶ Decreasing significantly from 2018 survey findings.

DISPARITY ▶ Lowest in Douglas County, especially in eastern Omaha. Reported less often among young adults, residents living at lower incomes, and communities of color.

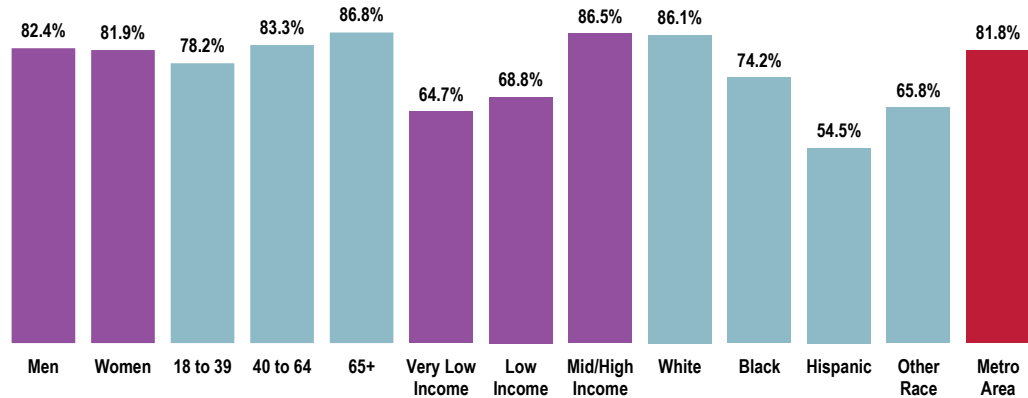
Have Someone to Turn to for Help All/Most of the Time



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 333]
Notes: • Asked of all respondents.



Have Someone to Turn to for Help All/Most of the Time (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 333]
 Notes: • Asked of all respondents.

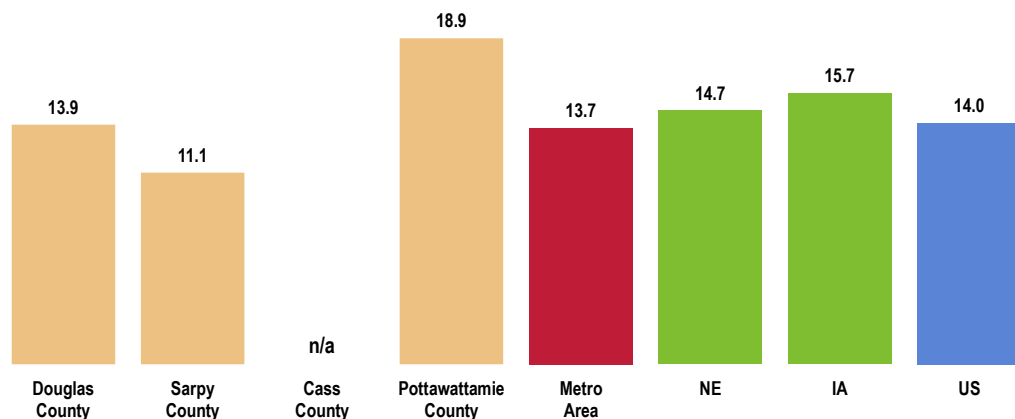
Suicide

In the Metro Area, there were 13.7 suicides per 100,000 population (2017-2019 annual average age-adjusted rate).

TREND ▶ The suicide rate has trended upward over the past decade.

DISPARITY ▶ The rate is highest in Pottawattamie County.

Suicide: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population) Healthy People 2030 = 12.8 or Lower



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



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

Healthy People 2030 = 12.8 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	10.1	10.1	11.0	11.4	12.0	12.0	11.9	13.7
— NE	11.1	11.5	12.5	12.2	12.7	13.2	13.7	14.7
— IA	12.9	13.7	13.3	13.7	13.8	14.5	15.0	15.7
— US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

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

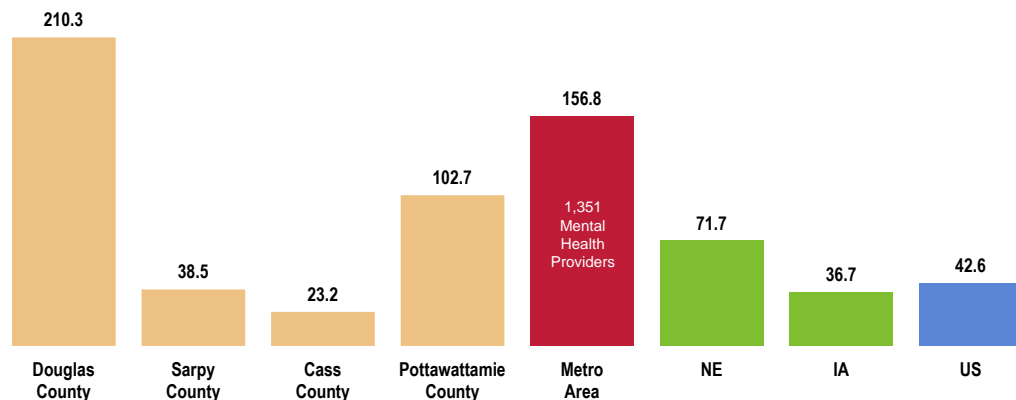
Mental Health Treatment

Mental Health Providers

In the Metro Area in 2020, there were a reported 1,351 mental health providers, translating to a rate of 156.8 providers for every 100,000 population.

- BENCHMARK** ▶ Well above the state and national ratios.
- DISPARITY** ▶ Lowest in Sarpy and Cass counties.

Access to Mental Health Providers (Number of Mental Health Providers per 100,000 Population, 2020)



Sources: • University of Wisconsin Population Health Institute, County Health Rankings.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
Notes: • This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Here, “mental health providers” includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the Metro Area and residents in the Metro Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.



Currently Receiving Treatment

One out of five Metro Area adults (20.2%) is currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

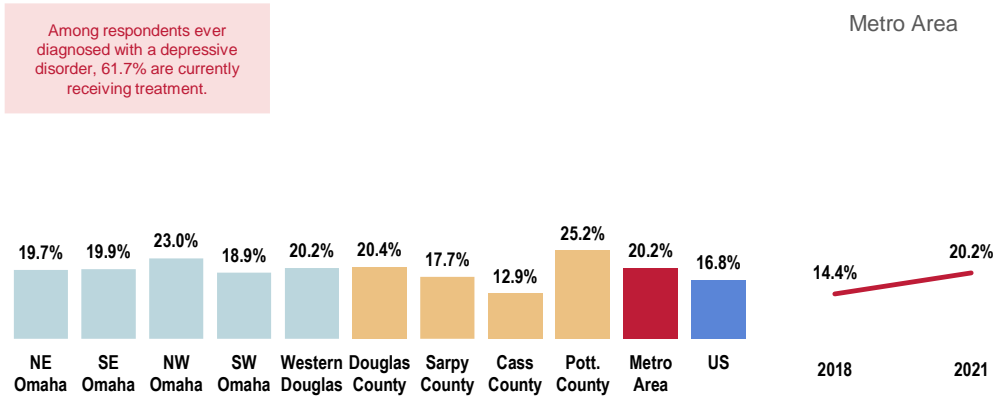
BENCHMARK ▶ Higher than the US percentage.

TREND ▶ Denotes a statistically significant increase since 2018.

DISPARITY ▶ Reported most often among residents of Pottawattamie County.

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 61.7% are currently receiving treatment.



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 94]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • "Treatment" can include taking medications for mental health.

Difficulty Accessing Mental Health Services

A total of 6.1% of Metro Area adults report a time in the past year when they needed mental health services but were not able to get them.

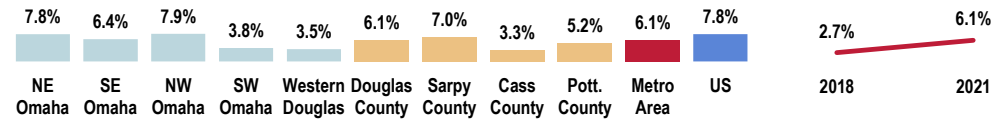
TREND ▶ Increasing significantly from 2018 survey findings.

DISPARITY ▶ The percentage is favorably low in Southwest Omaha and Cass County. The prevalence decreases with age and income, but is reported more often among women, and is notably high among Hispanics.



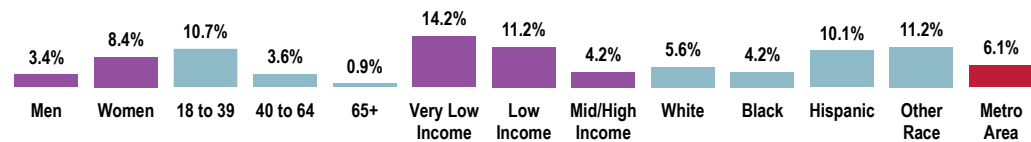
Unable to Get Mental Health Services When Needed in the Past Year

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year (Metro Area, 2021)



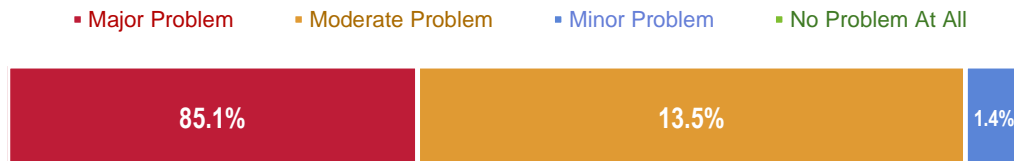
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
 Notes: • Asked of all respondents.



Key Informant Input: Mental Health

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

Perceptions of Mental Health as a Problem in the Community (Key Informants, 2021)



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

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

Access to Care/Services

Timely access. – Other Health Provider

Access to care and more importantly access to immediate and urgent mental health care. Doesn't have to be all inpatient but just in time services is lacking. Access in terms of locations and affordability is key. – Other Health Provider

The lack of community based and residential services. The lack of education and training for long-term care staff in nursing homes. Older adults who cannot find a NF to accept them have no other alternatives than Lincoln Regional Center with little hope of ever discharging to a lower level of care. – Social Services Provider

Access and stigma. I feel like there has been a reduction in stigma with COVID ... it is finally being talked about and encouraged to receive services and help. That said, I think there are not enough providers; when I talk with individuals, they can wait months to find care. Not enough individuals providing medication management as well. Need to really support access, when someone has a heart issue, we don't ask them to wait months to see a doctor. We shouldn't have to do this with someone who has brain issues or mental health concerns. We need more immediate support and to continue to educate those around, integrate into school settings, workplaces etc. – Social Services Provider

Lack of resources and services. Lack of available beds for inpatient and outpatient partial programs delay in getting in to see providers for medical management and therapy, lack of community support. – Social Services Provider

Lack of beds and post-acute resources. – Social Services Provider

There are wait times to be seen, not enough competent providers—there are providers but finding the right one or someone that can help with the right skill set pending what the mental health issue is, lack of psychiatry, we treat them and street them vs. a continuum of care for the those with more complicated issues. Lack of jobs with living wages for those diagnosed, we don't have a preventive approach screening youth and then intervening. – Other Health Provider

Access to services, lack of mental health providers, wait time to get into see a doctor or therapist. Being able to pay for services, lack of coverage by insurance companies. – Other Health Provider

Access to in-patient and outpatient treatment in a timely manner. – Physician

Police as first responders. Fragmented services. Kids and families not having a one stop shop for access. Shortage of psychiatrists and also long-term beds. Mental health shouldn't be accessed through emergency rooms. – Community Leader

Forensic psychiatric facility does not exist for adults. LRC is the only available place for violent patients and yet the wait list is extensive. – Other Health Provider

Immediate access to care. – Business Leader

Access to care and stigma. – Other Health Provider

There are not enough psychiatric beds in the area. Not enough staff to maintain resources. This is leading too many people not getting the help they need. – Social Services Provider



There are not enough inpatient psych beds in the community and surrounding areas. Hospital staff are NOT equipped to take care of aggressive, violent, threatening individuals. These patients need to be a PRIORITY for inpatient psych facilities. If a patient is in a bed and not just in ER they also need to be a priority to open up beds for the medically complex. – Social Services Provider

No beds and the reduction, elimination of psychiatric evaluation nurses, PEC, in the Emergency Room. – Other Health Provider

Access. – Business Leader

Access to both inpatient and outpatient care. – Physician

Access to care, stigma about asking for help. – Social Services Provider

Getting the services needed in a timely fashion. – Community Leader

Lack of available high-quality care. – Other Health Provider

Accessing services. – Social Services Provider

Access to resources, acceptance and stigmas. Major concern with individuals experiencing homeless who suffer from mental health issues without sufficient access to resources and supportive services. – Community Leader

Access to prompt, mental health evaluation, treatment and medication management. Lack of awareness, knowledge among medical professionals about how to refer, treat. – Social Services Provider

Lack of care, long term facilities. – Community Leader

Increased awareness has opened up the doors to getting access to mental health care. As a result, we have outpatient wait lists for eight to ten weeks. Inpatient beds are nonexistent. – Social Services Provider

Lack of access and emphasis on its' importance. – Community Leader

Current CHIP focus. Access to resources, stigma, loneliness and isolation. – Public Health Representative

Lack of resources. – Community Leader

Lack of access, decreased number of trained professionals and insufficient insurance, payment services. – Other Health Provider

Being able to receive services and get culturally competent treatment in a timely fashion. Right now, there are long wait lists for some agencies. – Public Health Representative

Lack of immediate services. – Social Services Provider

There is minimal access to those looking for services and an attached stigma that decreases the chance of them getting help. – Social Services Provider

The biggest issue is the lack of resources and treatment. Not enough beds and, or places for those that need it to receive the care they need. – Business Leader

Access is difficult at all levels. Wait lists, transportation, availability, skilled providers, providers of color and Spanish speaking, cost contribute to the problem. When the need is high the care isn't easily available to meet people's need. – Social Services Provider

Access to psychiatrists in this town is a scandal especially if the patient has Medicaid. There is only one group in town that I am aware of that sees Medicaid. – Physician

Access to care, affordability of sessions, stigma of reaching out for health, transportation getting to appointments, practitioners that are culturally competent. – Social Services Provider

Access. – Other Health Provider

Getting timely appointments and outpatient treatment. – Other Health Provider

Mental health needs are increasing across the country for years while resources and access for these services have either decreased or remained stagnant. – Business Leader

Limited care facilities. – Other Health Provider

Access to care and treatment alone with inpatient beds. – Physician

Not enough long-term residential, non-group home settings to refer to, like six months or longer. No takes, SPMI patients who are combative and assaultive. – Other Health Provider

Lack of high-level mental health care for youth. – Social Services Provider

No funding and very little services. No one seems to want to help these persons and it drives nearly every other social problem in the country. – Criminal Justice

Lack of providers to provide consistent services. Low number of psychiatrists in Iowa and the full waiting rooms at their offices leading to rushed treatment and overmedication. Lack of private insurance or no-insurance children being able to access behavioral health intervention services—only a Medicaid service in Iowa. – Business Leader

Access to service and ability to pay for services. Long-term inpatient psychiatric treatment to allow for sufficient time to manage and treat conditions. Services for people with SMI and significant medical problems who are not allowed or accepted to attend traditional inpatient psychiatric treatment programs. A specialized inpatient treatment program for eating disorders and OCD. – Other Health Provider

Very limited access to treatment due to limited or absent insurance coverage. Lack of providers. Lack of inpatient hospitalization facilities, especially for substance abuse issues. – Physician



Lack of availability and access. – Physician

Without a doubt it is access and treatment of mental illness. It is hard to get people seen. Hospitals and police are dealing with acutely ill patients without the resources or expertise. – Physician

Lack of resources. No available psychiatric beds. – Social Services Provider

Access to care and lack of resources. – Other Health Provider

There are challenges at every level of care on the continuum. The backup for getting patients scheduled for ongoing outpatient (lowest level of care) mental health or substance use therapy sometimes extends out for several months. Psychiatric care is booked out six months in many of the major agencies, sometimes longer. That is not good care. IOP or day treatment options for mental health and/or substance abuse are inadequate in meeting the community demands/needs. Residential/Inpatient treatment options are extremely limited. It's wonderful that the PES opened at UNMC but it came at the expense of Lasting Hope having to close much-needed beds/unit(s) due to staffing shortages. The result, in my opinion, is one more ED and many less available beds for short-term inpatient psychiatric stays. We don't have a forensic unit. We don't have adequate numbers of LRC-type beds/lengths of stay for those with higher level needs. Good people trying hard but not enough patient options. – Other Health Provider

Access to timely referrals and intervention. Not enough nurses to staff inpatient beds in the community, violence against healthcare workers by mental health patients. One system responsible for most of the behavioral care in Omaha. – Other Health Provider

Not enough inpatient psychiatric beds to meet the needs. – Physician

Lack of resources and information about them. – Other Health Provider

Access to care. Difficulty in recruiting mental health providers of all types. Psychiatrists, nurse practitioners, therapists. People are suffering in the community and there is just not enough help for them. – Other Health Provider

Timely access to services. – Other Health Provider

Lack of timely access to psychiatric care, inpatient or outpatient. – Other Health Provider

Access. – Physician

Not enough inpatient care, common to have people wait long time periods to get a bed. Long waits to get seen as an outpatient, leading to acute crisis and need for more inpatient care. Stigma around mental health care.

Non-compliance with treatment. Expense of treatment. – Other Health Provider

Finding help and understanding. – Other Health Provider

Denial/Stigma

Acceptance that mental health is a universal issue. – Community Leader

There is a negative connotation in some communities about accessing and receiving mental health care. In addition, those who want to receive mental health care have limited access and the cost is a barrier. – Physician

Acceptance and awareness. Removing the stigma to create greater access to care. – Other Health Provider

Continued stigma related to mental illness, lack of easily accessible treatment and care options. – Other Health Provider

Stigma. – Other Health Provider

Continue to reduce stigma. Increase funding for mental health provider organizations so as to increase availability of providers. Focus on health inequality. – Other Health Provider

There is still stigma and a lack of understanding of mental health conditions, as well as not enough providers and lack of access especially for those who cannot afford care. – Other Health Provider

Lack of Mental Health Providers

Lack of mental health provider availability and the amount of time it takes to see a provider. Also, the lack of inpatient capacity. – Other Health Provider

Shortage of mental health clinicians. – Physician

Not enough mental health care providers and families struggle to find resources when in an acute emergency situation. COVID has only exacerbated the mental health access to care problem. – Social Services Provider

Shortage of providers causing problems with access. The needs outstrip the resources for both outpatient and inpatient care. With regard to inpatient care, there are plenty of general beds but not enough for the most challenging patients who require "special care" beds). – Physician

Lack of access to culturally competent, trauma informed therapists who are trained to work with individuals and families. – Social Services Provider

Access to mental health care professionals. Not enough in the community particularly for underserved populations leading to long times which makes it difficult for individuals to get needs met. For the Medicare population this is only further compounded by the asinine requirement that they can only work with a social worker or psychologist for therapy. – Other Health Provider



Contributing Factors

Cost of medications and well-trained counselors who do not require payment programs. – Physician
Accessing and affording care, dealing with the fallout, losing employment, housing, relationships from untreated mental illness, stigma. – Social Services Provider
Lack of culturally competent racially diverse mental health providers. stigma. Poor training of faith leaders, teachers, and others who work in minority communities to recognize the signs of mental illness and to help connect with resources. Lack of enough resources in schools to provide mental health services. – Social Services Provider
Flooding from 2019 to COVID. – Social Services Provider
Accurate, timely diagnosis and treatment with therapy and, or medication is lagging well behind demand. Stigma around mental health diagnosis still exists. – Community Leader
Anxiety, depression, and emotional disorders. People are having difficulty dealing with even day-to-day life stressors in healthy ways. Many use drugs, alcohol, tobacco, food, and impulse spending to alleviate stress, which in turn leads to dependency with more health, crime, and mental stress in the future. – Social Services Provider
The biggest issues are access to affordable, culturally, relevant care and the stigma surrounding mental health care. – Other Health Provider

COVID-19

COVID-19 has greatly increased an already large issue for our community. We need more diversity in both race/ethnicity and languages that mental health services are provided. We also have a stigma across the community that is important to continue to address. We also need to look at public funding support for these types of programs and services. – Community Leader
Currently COVID impacted concerns, anxiety, depression, substance dependence. – Social Services Provider
We had an issue before COVID and now it has become worse with the social isolation we all had to endure. People have decreased their ability to positive cope with situations and resources are limited. – Other Health Provider
Higher incidences of anxiety, depression, isolation since pandemic and with racial, social tensions. – Other Health Provider

Incidence/Prevalence

As an educator I see a lot of students, staff, and families that are encountering many mental health challenges. – Community Leader
Functioning with and dealing with depression and anxiety. – Physician
We have increasing amounts of severe mental illness in both adult and pediatric groups. There are limited resources for inpatient and outpatient care. – Physician
More common than people might think. Stigma associated with mental health as well as lack of community programs in this area, could make many people struggling with mental health during the pandemic give up seeking care. – Public Health Representative

Vulnerable Populations

Mental health is the singular largest issue impacting homelessness in our community. Additionally, it is a top issue facing all populations across our community. Specifically, vulnerable or marginalized populations lack access and resources to proper mental health services including therapy, evaluation and diagnosis, medication management, and long-term care. The chronic severe mental health trauma that our homeless population endures is consistently untreated or not treated with the appropriate level of care. – Social Services Provider

Trauma

Trauma can come from individual experiences, childhood, community violence, and so many more areas. Physical and mental health are substantially impacted by trauma. All interventions of a medical or behavioral nature should be grounded in a foundation of trauma-informed care. – Community Leader

Insurance Issues

There is still no parity between physical and mental health services in insurance and in health care providers. – Other Health Provider





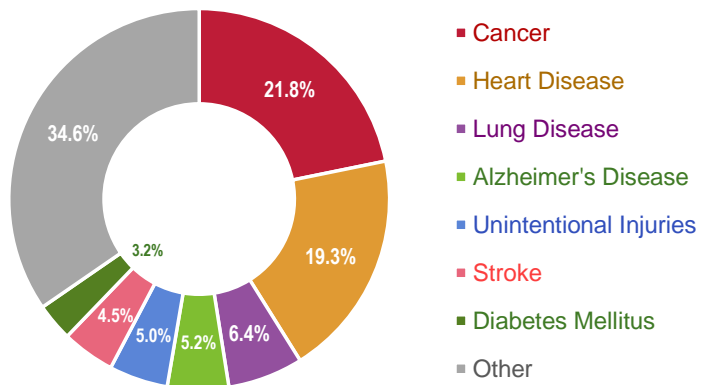
DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for more than 4 in 10 Metro Area deaths in 2019.

Leading Causes of Death
(Metro Area, 2019)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

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

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

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



The following chart outlines 2017-2019 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Metro Area.

Each of these is discussed in greater detail in subsequent sections of this report.

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

Age-Adjusted Death Rates for Selected Causes (2017-2019 Deaths per 100,000 Population)

	Metro Area	NE	IA	US	HP2030
Malignant Neoplasms (Cancers)	155.5	150.2	154.7	149.3	122.7
Diseases of the Heart	139.8	146.6	168.5	163.4	127.4*
Fall-Related Deaths (65+)	66.3	64.7	83.1	65.1	63.4
Chronic Lower Respiratory Disease (CLRD)	48.7	48.8	44.7	39.6	n/a
Alzheimer's Disease	36.0	28.7	32.1	30.4	n/a
Unintentional Injuries	35.8	39.0	41.9	48.9	43.2
Cerebrovascular Disease (Stroke)	32.3	31.5	32.6	37.2	33.4
Diabetes Mellitus	26.0	24.7	21.6	21.5	n/a
Pneumonia/Influenza	14.8	15.6	14.0	13.8	n/a
Intentional Self-Harm (Suicide)	13.7	14.7	15.7	14.0	12.8
Cirrhosis/Liver Disease	11.5	10.8	9.2	11.1	10.9
Kidney Diseases	10.8	10.1	9.3	12.9	n/a
Motor Vehicle Deaths	10.0	12.7	10.7	11.3	10.1
Firearm-Related	9.7	9.2	8.9	11.9	10.7
Drug-Induced	7.8	6.5	8.6	18.8	n/a
Homicide	4.0	2.6	2.9	6.1	5.5

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

• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>.

Note: • *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.



CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. ...Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

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

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

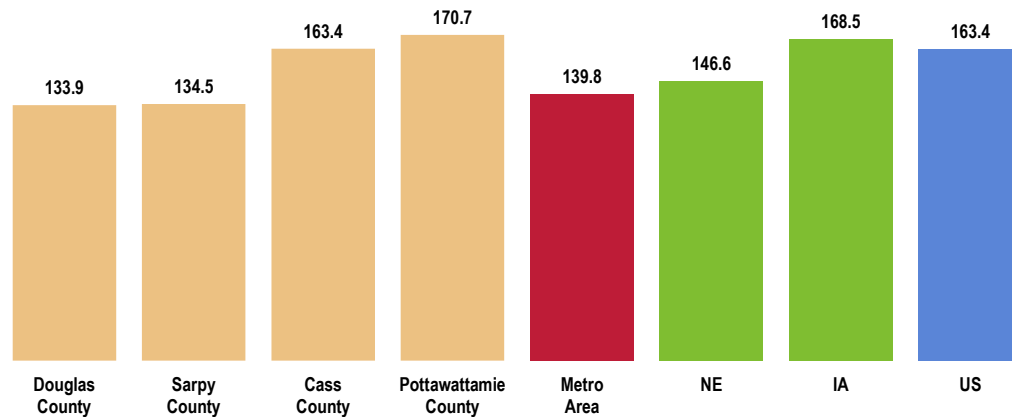
Between 2017 and 2019, there was an annual average age-adjusted heart disease mortality rate of 139.8 deaths per 100,000 population in the Metro Area.

BENCHMARK ▶ Well below the Iowa and US death rates.

DISPARITY ▶ Higher among non-Hispanic Whites and Blacks (especially) in the Metro Area when compared with Hispanics.

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

Heart Disease: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 127.4 or Lower (Adjusted)



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

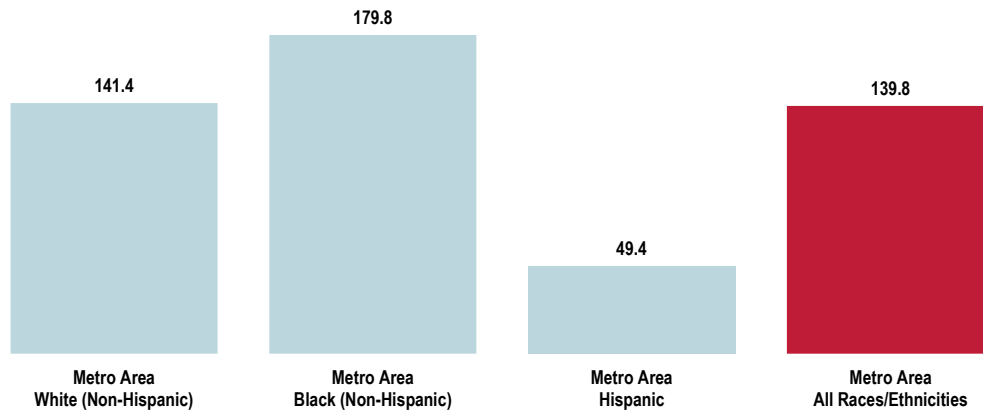
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.



Heart Disease: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



Sources:

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

Notes:

- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

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

Healthy People 2030 = 127.4 or Lower (Adjusted)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	152.6	151.3	150.4	151.2	143.3	141.3	137.1	139.8
— NE	149.3	147.2	145.9	148.5	145.9	148.0	145.1	146.6
— IA	169.9	168.4	165.5	162.3	160.3	163.7	165.1	168.5
— US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

Sources:

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

Notes:

- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.



Stroke Deaths

Between 2017 and 2019, there was an annual average age-adjusted stroke mortality rate of 32.3 deaths per 100,000 population in the Metro Area.

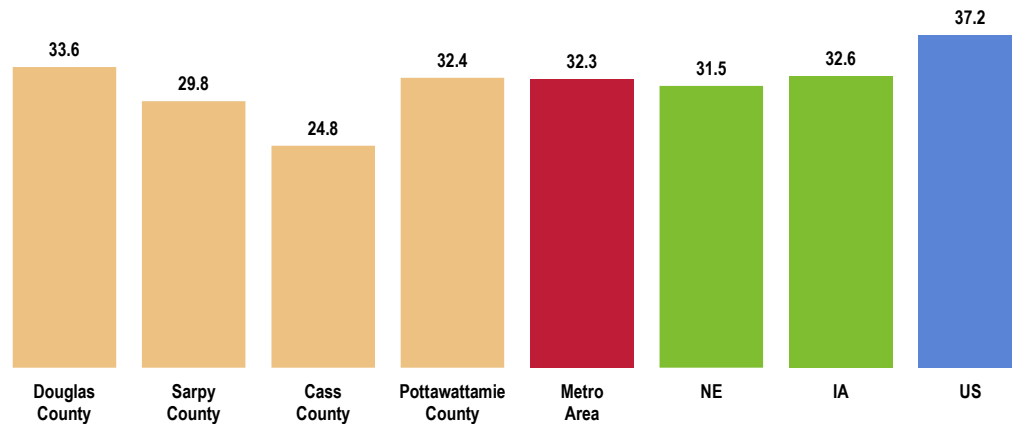
BENCHMARK ▶ Lower than the national death rate.

TREND ▶ Decreasing over time, echoing the Nebraska and Iowa trends.

DISPARITY ▶ Lowest in Cass County. The rate is much higher in the Metro Area's Black community.

Stroke: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

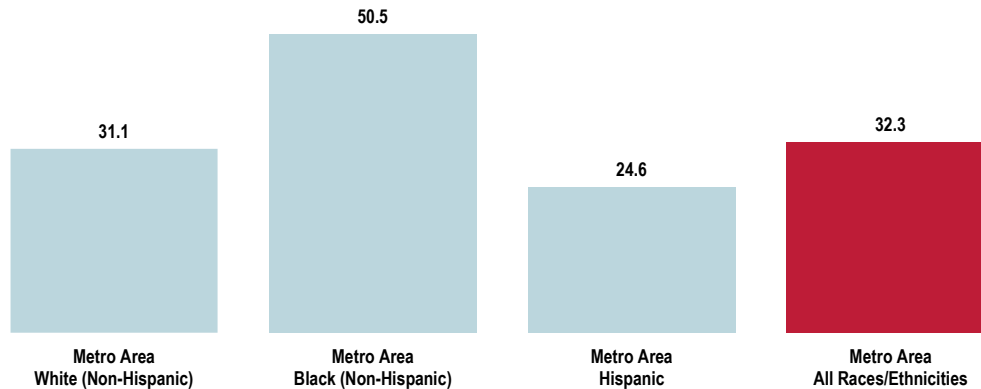


Sources:

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

Stroke: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



Sources:

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



Stroke: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2030 = 33.4 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Metro Area	39.5	38.2	37.9	36.6	35.4	33.7	33.4	32.3
NE	37.4	36.0	35.3	34.8	33.8	32.7	32.1	31.5
IA	35.7	34.3	34.0	33.7	33.2	32.8	32.7	32.6
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

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

Prevalence of Heart Disease & Stroke

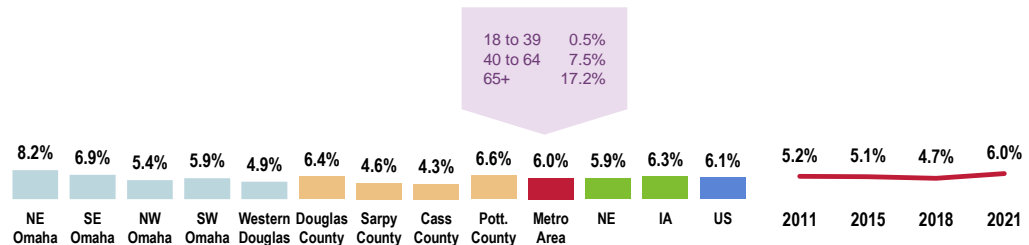
Prevalence of Heart Disease

A total of 6.0% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

DISPARITY ► The prevalence increases with age among Metro Area survey respondents.

Prevalence of Heart Disease

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 307]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
• 2020 PRC National Health Survey, PRC, Inc.

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



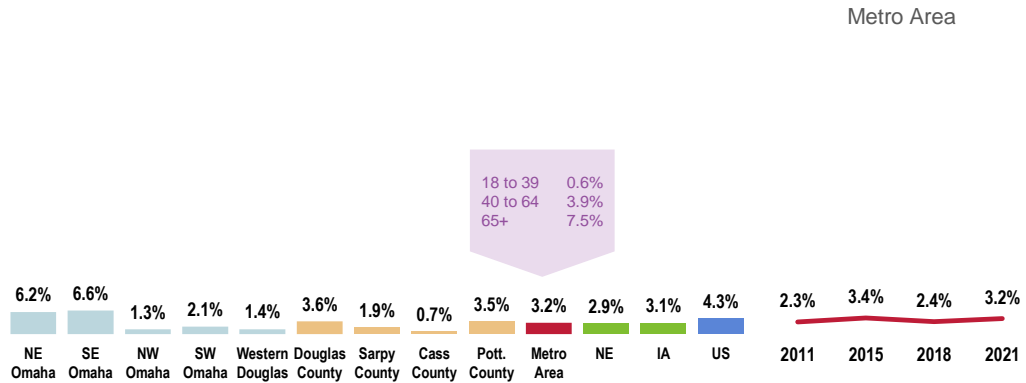
Prevalence of Stroke

A total of 3.2% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

TREND ▶ A significant increase from 2011 and 2018 survey findings.

DISPARITY ▶ Unfavorably high in eastern Omaha. Viewed by county, the prevalence is lowest among Sarpy and Cass County residents. Correlates with age among survey respondents.

Prevalence of Stroke



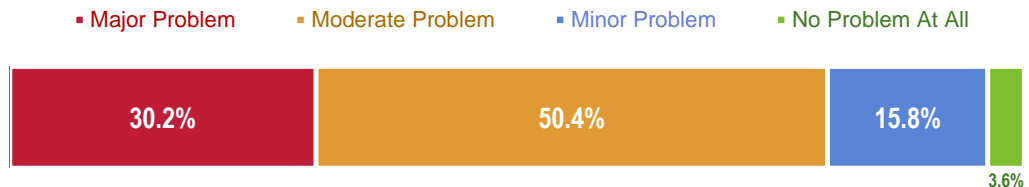
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 29]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Key Informant Input: Heart Disease & Stroke

Half of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a “moderate problem” in the community.

Perceptions of Heart Disease and Stroke as a Problem in the Community (Key Informants, 2021)



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



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

Incidence/Prevalence

High prevalence and leading causes of deaths. Limited efforts in community-based prevention. – Public Health Representative

Number of families impacted, number of employees impacted personally and within their family. – Social Services Provider

The prevalence of heart disease and stroke seem to be increasing. While preventable in some instances with lifestyle changes, prevention doesn't seem to be working as well as it could. Concerns with intentional actions to encourage the consumption of red meat on behalf of elected officials at both State and local levels. – Community Leader

They impact so many people. They are complex issues and are frequently addressed with expensive drugs (such as Eliquis). Like cancer, they are tied to lifestyle and lifestyle isn't easy to address. It also involves addressing equity so that it is easier to medicate after issues occur than to prevent. The gap between the haves and the have-nots is exacerbating the impact of disease in the community. Rich people play tennis, get massages, have access to Whole Foods, take yoga classes, see a dermatologist, get preventative health care—poor people don't. Diets in low-income neighborhoods are tied to heart disease and stroke. – Social Services Provider

One of the leading causes of death in Douglas county. – Community Leader

Newspaper accounts of individuals being affected. – Social Services Provider

Overall health of community. – Business Leader

Given heart disease and stroke are among the top causes of death in our country and we haven't found a cure or as a country we haven't made the health changes required to reduce the risk of heart disease and stroke; it still should be a priority for our health community. Especially, for our vulnerable communities with lack of access and resources for proper care. – Social Services Provider

Due to working in the medical field I hear about the patients with heart disease and stroke. We also tend to see a lot of patients who have substance use issues who also have heart disease. – Social Services Provider

Significant causes of morbidity and mortality. – Other Health Provider

Experience caring for many patients with heart disease and stroke. – Other Health Provider

Although deaths from heart disease are decreasing it is still one of the top causes of death in Nebraska. – Other Health Provider

We are currently seeing a high number of cardiac patients come through emergently. Also, I believe the poor health and nutrition in our community is attributing to heart disease. – Other Health Provider

This was a common problem in my patients. – Physician

Contributing Factors

Chronic conditions overall on the rise. follow-up needed for these patients is higher and there is a risk of non-compliance because of the needed follow-up. patients may choose to refill their needed medications due to cost. These are life-long conditions and when faced with other stressors in life, leading sedentary lifestyles and being overweight can turn this into a vicious cycle. – Other Health Provider

We don't have a plethora of resources for those impacted by this disease and diagnosis rates continue to rise. – Social Services Provider

Poor lifestyle and lack of compliance and follow-up. – Physician

Health care, co-pays and medication cost being the largest issues. – Criminal Justice

Our culture does not support healthy lifestyles or healthy food. We are also a high-stress culture. And for our African American brothers and sisters (and others), living in a milieu that does not always feel safe or accepting affects heart health. – Other Health Provider

Continues to be a problem in the United States including my community. Poor diet and sedentary lifestyles of Americans contribute to this problem. – Other Health Provider

Similar to diabetes, lack of culturally and linguistically competent resources to educate and support their patients and caregivers before, during and immediately after an incident. Poor support to help families modify their homes to accommodate a family member with a disability that has resulted from a stroke or heart attack. Food deserts. Lack of connection to a medical home that could help patients before they experience these things. – Social Services Provider

Comorbidities

The number of persons with hypertension and being overweight. – Community Leader

Large amount of people overweight. – Other Health Provider

Obesity and lack of medical home for continuous proactive management of health conditions. – Business Leader



Nutrition

Because they are known as silent killers, the necessary attention may not be paid to a potential problem, and because the solutions usually require monetary resources, there may not be follow through or consistent follow-through on their resolution. Heart-healthy food is hard to find and expensive, and many foods that are now touted as “healthy” simply means they have some organic component but are still full of sodium. It’s unfortunately impractical to find low-sodium foods when eating on the go or dining out with family. People often resort to salads not realizing the dressings pose a problem with cholesterol. Because we live in the cold-winter state of Nebraska, exercise might be lacking for long stretches of time. So the silent problem often lingers until it becomes a major issue or near-fatal event. – Social Services Provider

Vulnerable Populations

Especially when experienced by people of color, low income and stressed people resulting from heredity, racism, violence, poor food access. – Social Services Provider

Heart disease is a major problem because the same populations I mentioned for diabetes are also effected by heart disease and stroke at a disproportionate rate. Black, African Americans, Latinx, and Native Americans, American Indians. – Physician

Aging Population

Older adults take longer to progress in certain cases therapy ends too soon due to lack of progress and no ongoing monitoring is completed from a rehabilitation standpoint. OT, PT need to educate patients on ways they can continue to regain abilities once they return home. This needs to include common household items that can be used instead of the luxury of state-of-the-art equipment found in rehab centers. – Social Services Provider

Prevention/Screenings

Can be a silent killer. – Other Health Provider



CANCER

ABOUT CANCER

Cancer is the second leading cause of death in the United States. ...The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

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

Age-Adjusted Cancer Deaths

All Cancer Deaths

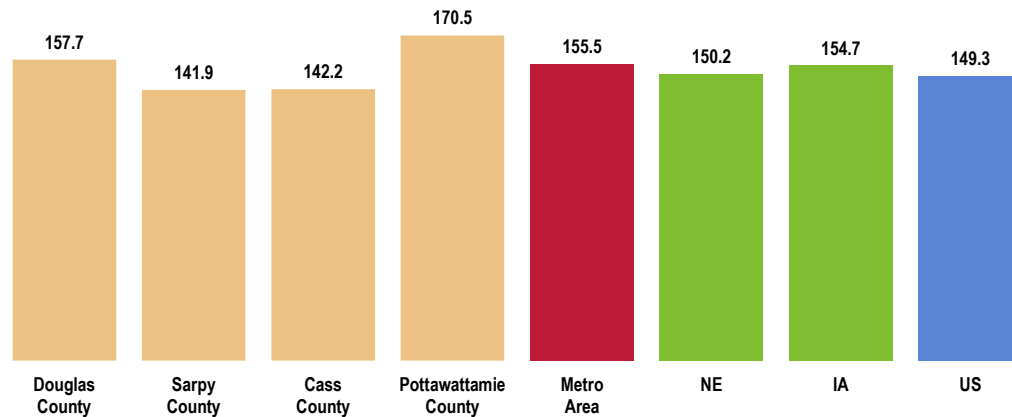
Between 2017 and 2019, there was an annual average age-adjusted cancer mortality rate of 155.5 deaths per 100,000 population in the Metro Area.

BENCHMARK ▶ Fails to satisfy the Healthy People 2030 objective.

TREND ▶ Decreasing steadily over the past decade, in keeping with state and US trends.

DISPARITY ▶ The mortality rate is especially high in the Black community.

Cancer: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower

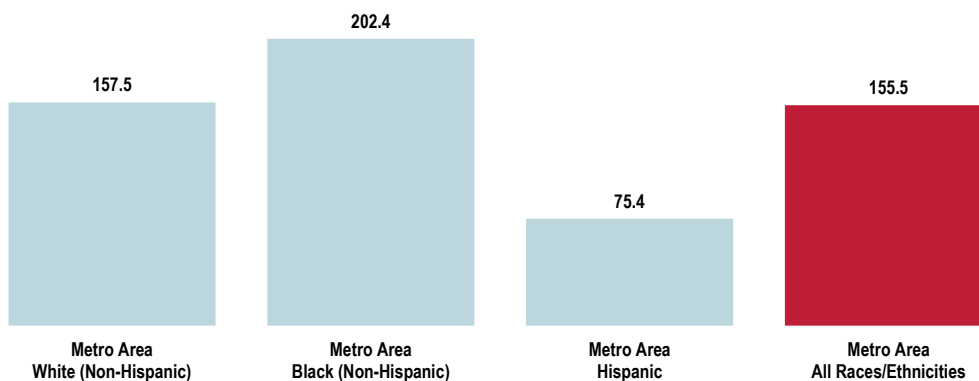


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>



Cancer: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 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 February 2021.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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

Healthy People 2030 = 122.7 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	180.9	178.5	174.8	172.4	166.3	162.5	156.9	155.5
— NE	165.4	163.4	161.9	159.6	157.0	154.7	152.2	150.2
— IA	171.2	170.0	167.7	166.2	163.3	160.6	157.7	154.7
— US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

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



Cancer Deaths by Site

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

Other leading sites include prostate cancer, female breast cancer, and colorectal cancer (both sexes).

BENCHMARK ► Each of the cancer rates by site fails to satisfy the related Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site
(2017-2019 Annual Average Deaths per 100,000 Population)

	Metro Area	NE	IA	US	HP2030
ALL CANCERS	155.5	150.2	154.7	149.3	122.7
Lung Cancer	36.6	33.9	37.8	34.9	25.1
Prostate Cancer	21.6	18.6	20.5	18.6	16.9
Female Breast Cancer	19.1	20.0	18.1	19.7	15.3
Colorectal Cancer	13.8	14.6	14.0	13.4	8.9

Sources:

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

Cancer Incidence

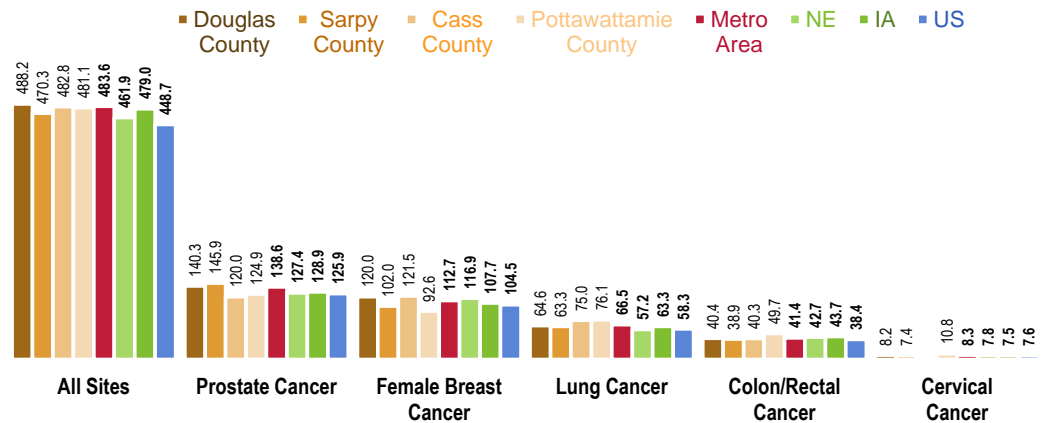
“Incidence rate” or “case rate” is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

The highest cancer incidence rates are for prostate cancer and female breast cancer.

BENCHMARK ► Each of the Metro Area cancer incidence rates is similar to state and US rates.



Cancer Incidence Rates by Site (Annual Average Age-Adjusted Incidence per 100,000 Population, 2013-2017)



Sources: • State Cancer Profiles.
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved 2E-DATE via SparkMap (sparkmap.org).
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

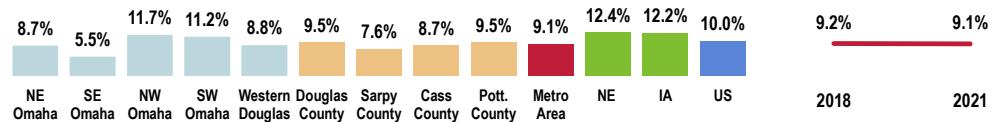
A total of 9.1% of surveyed Metro Area adults report having ever been diagnosed with cancer.

BENCHMARK ► Well below the state percentages.

DISPARITY ► Favorably low among Southeast Omaha respondents. Increases sharply with age and reported more often among women and Whites in the Metro Area.

Prevalence of Cancer

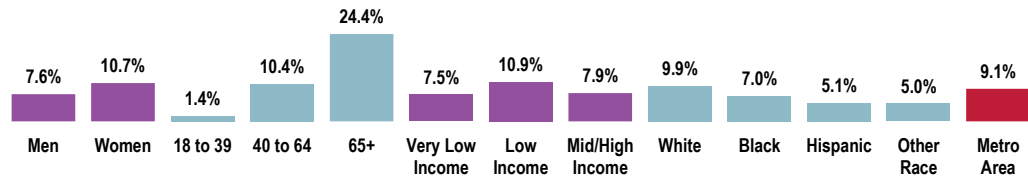
Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 25]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Reflects all respondents.



Prevalence of Cancer (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 25]
 Notes: • Reflects all respondents.

ABOUT CANCER RISK

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

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

RELATED ISSUE
 See also *Nutrition, Physical Activity & Weight and Tobacco Use* in the **Modifiable Health Risks** section of this report.



Cancer Screenings

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

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

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

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

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

Among women age 50-74, 80.0% have had a mammogram within the past 2 years.

BENCHMARK ▶ Higher than the Nebraska percentage and satisfying the Healthy People 2030 objective.

DISPARITY ▶ Lowest in Southeast Omaha (not shown).

Among Metro Area women age 21 to 65, 72.4% have had appropriate cervical cancer screening.

BENCHMARK ▶ Lower than the Nebraska and Iowa percentages. Fails to satisfy the Healthy People 2030 objective.

TREND ▶ Decreasing significantly from previous survey results.

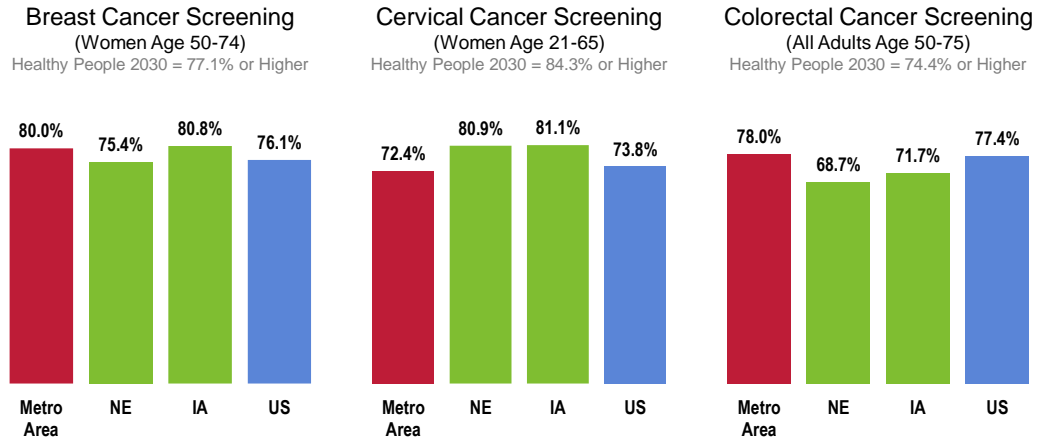
“Appropriate cervical cancer screening” includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.



Among all adults age 50-75, 78.0% have had appropriate colorectal cancer screening.

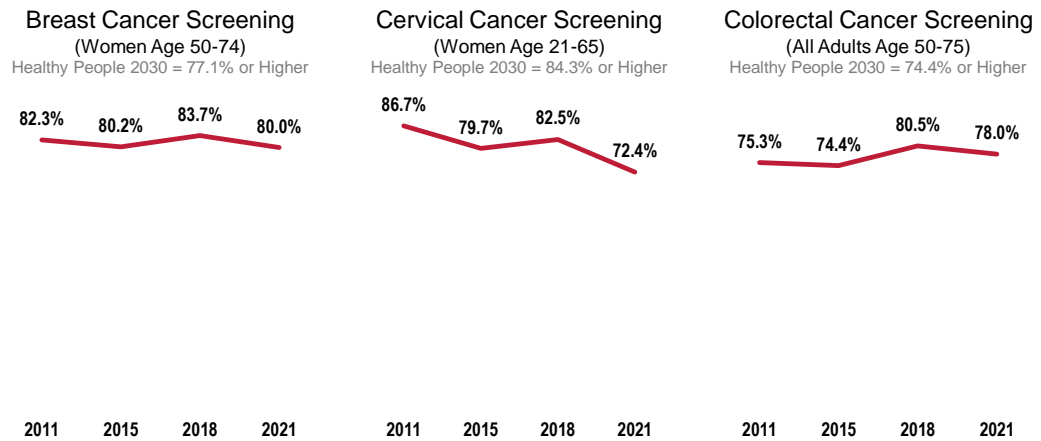
BENCHMARK ▶ Higher than the Nebraska and Iowa percentages. Satisfies the Healthy People 2030 objective.

“Appropriate colorectal cancer screening” includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 116, 117, 118]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Each indicator is shown among the gender and/or age group specified.



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 116, 117, 118]
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

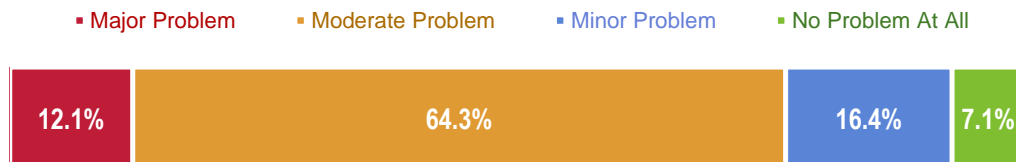
Notes: • Each indicator is shown among the gender and/or age group specified.



Key Informant Input: Cancer

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

Perceptions of Cancer as a Problem in the Community (Key Informants, 2021)



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

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

Contributing Factors

Because there is a high level of pesticides in the food/water in the Midwest. The levels of certain cancers and Parkinson’s in this area are very high. Diets have too much sugar and obesity rates are high. It is difficult for low income folks, especially if they are struggling with mental illness, to make healthy eating a priority. It is hard to afford healthy food and it can be hard to find. There are high rates of asthma in low income communities. Children have a hard time being active without having asthma flare ups. The pandemic added more sedentary time. The overall lifestyle is not conducive to health. There are no beaches for swimming or mountains for climbing. Many neighborhoods are not safe for bike riding (and bikes and helmets are expensive). The city is not friendly for walkers. This all adds up to a chemical soup inside our bodies that is conducive to the growth of cancer cells. – Social Services Provider

Lack of prevention, education and early access to medical care. The environment, water, soil, air are poison. – Social Services Provider

Access to Care/Services

Limited treatment plans and options in Council Bluffs. Patient may have to commute to Omaha. – Business Leader

The cost for treatment is very costly. – Other Health Provider

Access to healthcare. – Criminal Justice

We have many patients who come to us for help who are unable to get post-acute services because no one will take them while on chemo or radiation due to cost. They either go without treatment to get those services or go without services and neither leads to a healthier patient – Social Services Provider

Vulnerable Populations

Lack of culturally competent providers. – Physician

The rate of cancer is disproportionate for certain populations such as Black, African Americans, Latina, and so on. – Physician

It disproportionately is experienced by African Americans and their access to life saving care is not equal. – Community Leader

Incidence/Prevalence

The number of families in crisis regarding a cancer diagnosis in the family. – Social Services Provider

Rates of cancer diagnosis are sky high. We have prevention screenings in place, but these may not be accessible to everyone, everywhere. – Public Health Representative

The array of cancers exist and are still causing death. – Social Services Provider



Impact on Quality of Life

Debilitating nature of cancer, though there are many options in the area for treatment. – Other Health Provider
If untreated, it can kill. – Other Health Provider



RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. ...More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

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

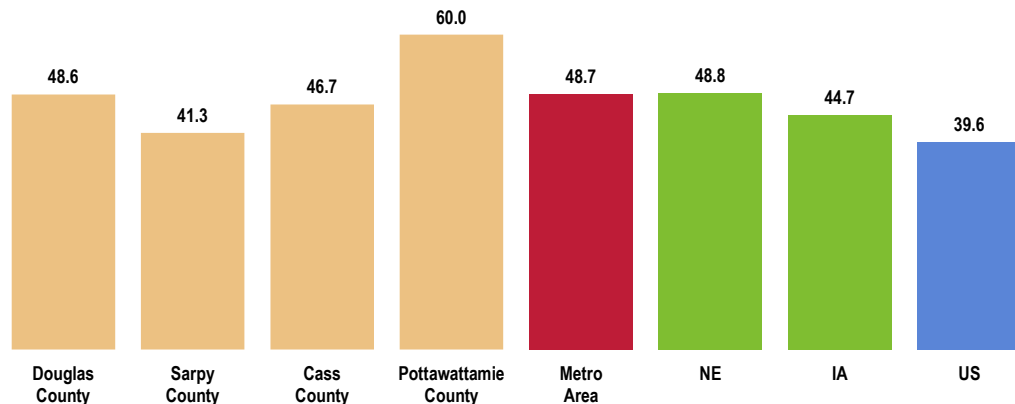
Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2017 and 2019, there was an annual average age-adjusted CLRD mortality rate of 48.7 deaths per 100,000 population in the Metro Area.

BENCHMARK ► Worse than the national mortality rate.

CLRD: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)

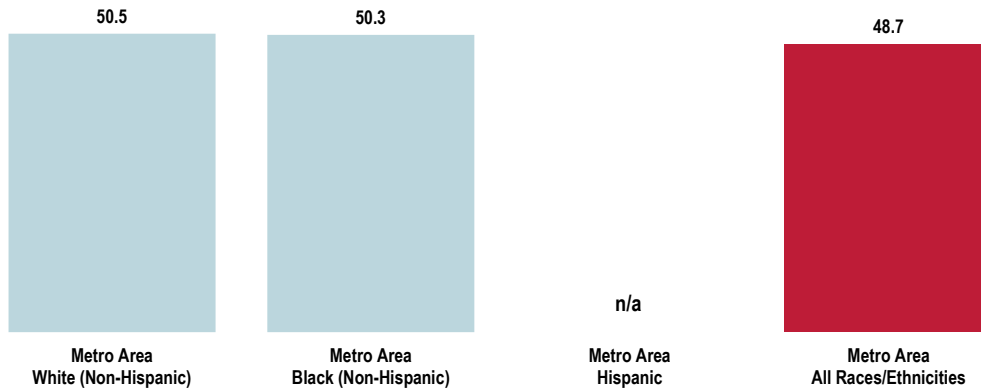


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.

Notes: • CLRD is chronic lower respiratory disease.

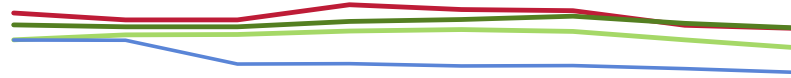


CLRD: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
 Notes: • CLRD is chronic lower respiratory disease.

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	51.9	50.4	50.4	53.6	52.6	52.4	49.4	48.7
— NE	49.4	49.0	49.1	50.2	50.6	51.2	49.7	48.8
— IA	46.4	47.4	47.4	48.2	48.5	48.1	46.3	44.7
— US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
 Notes: • CLRD is chronic lower respiratory disease.



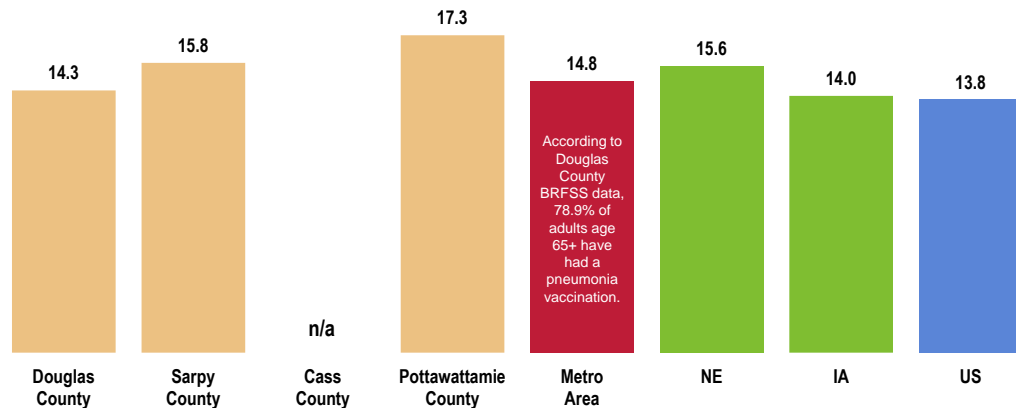
Pneumonia/Influenza Deaths

Between 2017 and 2019, the Metro Area reported an annual average age-adjusted pneumonia influenza mortality rate of 14.8 deaths per 100,000 population.

TREND ▶ Though similar to baseline reports, the mortality rate has decreased in recent years after a period of increase.

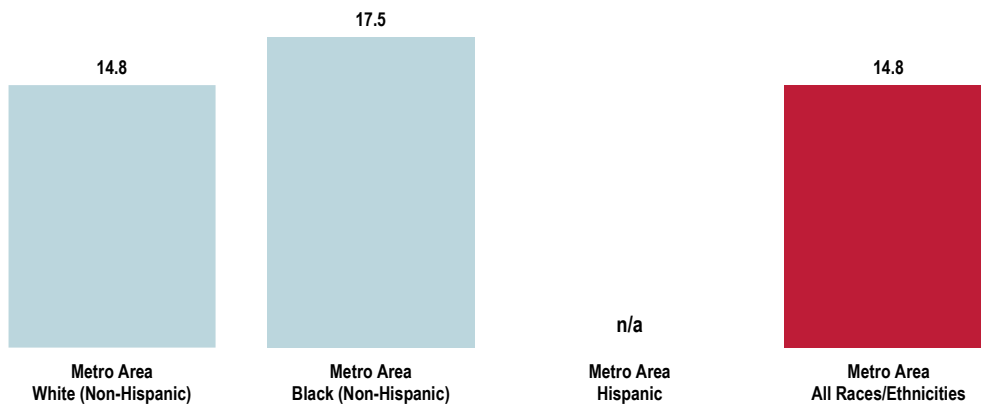
DISPARITY ▶ The mortality rate was higher among Blacks than Whites in the Metro Area.

Pneumonia/Influenza: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
• 2019 Behavioral Risk Factor Surveillance System (BRFSS) Data for Douglas County. Douglas County Health Department

Pneumonia/Influenza: Age-Adjusted Mortality by Race
(2017-2019 Annual Average Deaths per 100,000 Population)



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



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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Metro Area	13.4	14.7	15.8	17.0	16.3	15.8	15.0	14.8
NE	12.9	13.8	14.1	15.5	15.4	15.8	15.5	15.6
IA	15.0	16.4	15.7	15.2	13.2	13.0	13.5	14.0
US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

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

Prevalence of Respiratory Disease

Asthma

A total of 11.6% of Metro Area adults currently suffer from asthma.

BENCHMARK ► Worse than both state percentages.

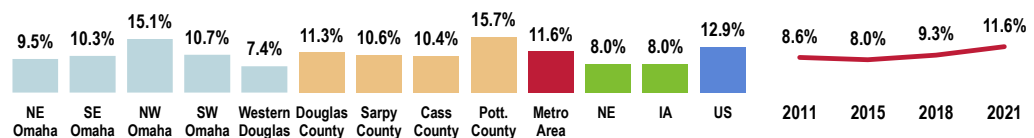
TREND ► Increasing significantly from previous survey findings.

DISPARITY ► In Douglas County, the prevalence is highest in Northwest Omaha. Viewed by county, the percentage is particularly high in Pottawattamie County. Reported most often among younger adults and those living at the lowest income level.

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

Prevalence of Asthma

Metro Area

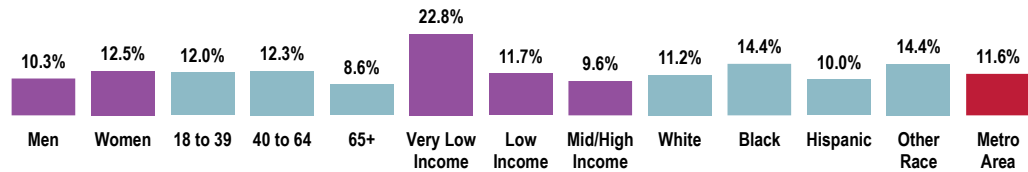


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 308]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • Includes those who have ever been diagnosed with asthma and report that they still have asthma.



Prevalence of Asthma (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 308]
 Notes: • Asked of all respondents.
 • Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

A total of 7.5% of Metro Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

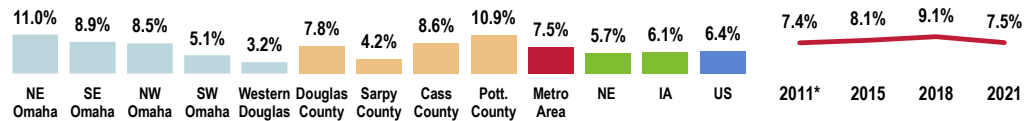
BENCHMARK ► Worse than both state percentages.

DISPARITY ► By county, the prevalence is highest in Pottawattamie County. Also unfavorably high in the Northeast Omaha area of Douglas County.

Note: COPD includes lung diseases such as emphysema and chronic bronchitis.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Metro Area



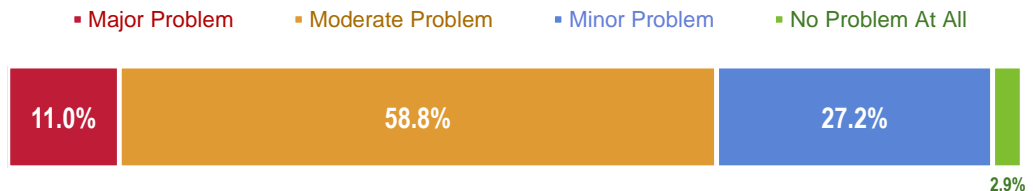
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 23]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
 • *In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.



Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases as a Problem in the Community (Key Informants, 2021)



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

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

Incidence/Prevalence

Asthma appears more prevalent in clients, population in general. – Business Leader

I often hear of children and adults with asthma, allergies or other respiratory issues they must address on an ongoing basis. – Social Services Provider

So many cases of asthma and so many of them are severe. That also prevents folks from being active. It's too hot, too cold, exercise brings it on. It encourages a sedentary lifestyle. – Social Services Provider

It is among the top killers in Nebraska. – Other Health Provider

Tobacco Use

Smoking. – Physician

Smoking. – Other Health Provider

Tobacco use. Atmospherically measurable differences in communities of color and the larger community. – Community Leader

Access to Care/Services

Inadequate referral system for smoking cessation, asthma, COPD. – Physician

Contributing Factors

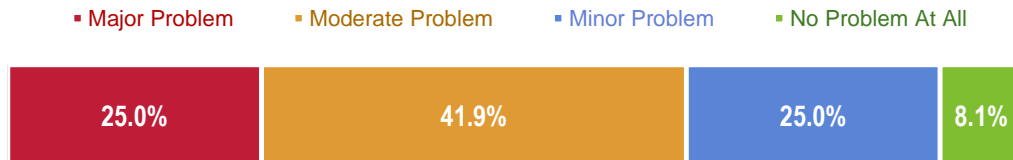
Mold in older homes. High levels of smoking and vaping in the community, COVID. – Social Services Provider



Key Informant Input: Coronavirus Disease/COVID-19

The greatest share of key informants taking part in an online survey characterized *Coronavirus Disease/COVID-19* as a “moderate problem” in the community.

Perceptions of Coronavirus Disease/COVID-19 as a Problem in the Community (Key Informants, 2021)



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

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

Vaccine Hesitancy

People choosing not to get vaccinated. – Social Services Provider

Vaccine hesitancy. – Community Leader

While our positivity rates have been greatly reduced, we are still working to increase our vaccinations rates. Variants are still pervasive. Health disparities are glaringly present, and we have no idea what the long-term impact will be from this virus (i.e. mental health, employment, education, etc.) – Public Health Representative

As of June 10th we still only have 45 percent of Douglas county residents vaccinated and daily vaccinations are slowing down. COVID-19 will continue to be a major issue if we do not get to the 70–80 percent range. – Business Leader

Many older adults are still choosing not to be vaccinated especially in the refugee population. These older adults live in multi-generational home with family members who are employed in areas such as meat packing and other service areas that originally saw high positivity rates. – Social Services Provider

The pandemic won't end until we have enough people vaccinated. Rates of vaccination have tapered off considerably. – Social Services Provider

It is now much better but during pandemic, it was a huge problem. Still a lot of people are not vaccinated for whatever personal choices, but they are not masking or taking precautions. – Social Services Provider

While the overall new cases are reduced, many still are not vaccinated. – Other Health Provider

Vaccination levels are not high enough and more so with BIPOC community. – Other Health Provider

Not enough individuals are getting vaccinated despite efforts by various organizations in the community. – Other Health Provider

Too many people have died and not enough have been vaccinated. – Physician

Vaccine hesitancy in north Omaha. – Business Leader

Contributing Factors

This is a major problem because the vaccines, at one point, were not accessible to specific communities such as North and South Omaha residents. In addition, not having a trusting relationship with health care has exacerbated the barriers to being tested and vaccinated. – Physician

Lots of health disparities with regards to testing and vaccine access. People with limited access to the internet or other technology were left behind. Poor ability to outreach to non-white populations and non-English speaking populations. Poor political leadership at the state and local level regarding masking. Poor coordination and communication with clinicians – Physician

Education. – Other Health Provider

Lack of culturally competent providers. – Physician

People not believing the virus is a problem or not real. – Criminal Justice

New variants, unvaccinated individuals. – Community Leader



Although the pandemic is improving, I worry about those members in our community that are isolated with no transportation, no insurance, or those that don't speak/understand English, those with lower cognitive functioning-being aware of the options they have for getting the COVID-19 vaccination, and that the vaccinations are free. Also the decrease in hours/wages, loss of employment, childcare, etc. affecting so many families. Many families struggling in ways they have never experienced, and the increased issues for those families who were already struggling prior to the onset of the pandemic. Increase in domestic violence and child abuse. – Social Services Provider

Vulnerable Populations

Too many of the homeless have limited access to the vaccine. – Physician

African American and Latino populations are still experiencing COVID at higher rates than white residents of the area, and on average immunization rates are only about 40–50% across the four counties. This lack of immunization leaves thousands at risk and exposed. This fall, experts predict additional viral COVID variants in addition to flu as an impact. – Other Health Provider

Black and brown communities are hit the hardest. – Community Leader

Incidence/Prevalence

Number of families and employees impacted by COVID-19. Also includes mental health impact, anxiety, depression, and dealing with loss. – Social Services Provider

Our state and city were among the highest impacted by COVID-19. It has taken a long time to get to where we are today. – Social Services Provider

Impact on Quality of Life

While it has killed many people and left many others with health challenges, it has impacted the education system, jobs, the economy, relationships, mental health, etc. This pandemic was a trial run. There will be more. We have to learn to de-politicize the pandemic protocols and learn how to reach folks with facts (hard) and services. The pandemic should unify the nation, not divide it. – Social Services Provider

Severity of illness. Morbidity and mortality. Unknown long-term complications. Lack of consensus within community on severity of disease and necessary measures to eradicate, vaccination. – Physician

Compliance With Public Health Recommendations

Lack of voluntary compliance with basic mitigation efforts. Too many unvaccinated citizens and still not good options for quick testing. – Other Health Provider

Significant morbidity and mortality and inconsistent compliance with social distancing and masking in the community. – Physician

Access to Care/Services

Many post-acute services are no longer taking these patients. This is leading to longer hospital stays which ultimately exposes these patients to more risk. – Social Services Provider



INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. ...Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. ...Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2017 and 2019, there was an annual average age-adjusted unintentional injury mortality rate of 35.8 deaths per 100,000 population in the Metro Area.

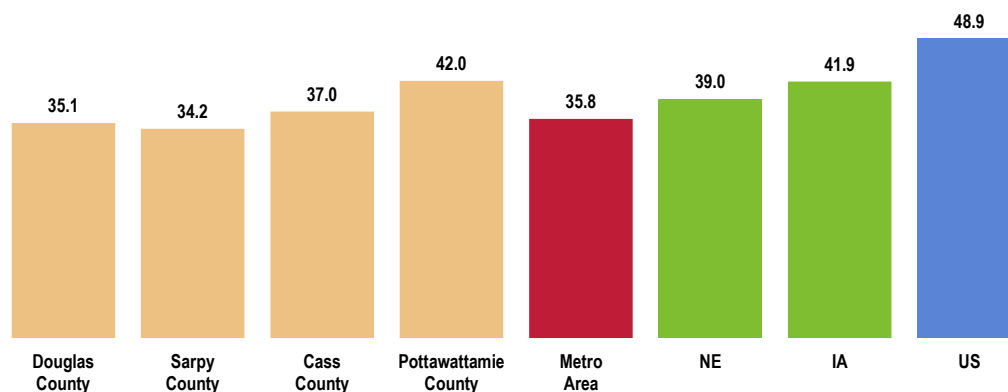
BENCHMARK ► Lower than the Iowa and US mortality rates. Satisfies the Healthy People 2030 objective.

DISPARITY ► The mortality rate is lower in the Hispanic community.



Unintentional Injuries: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower

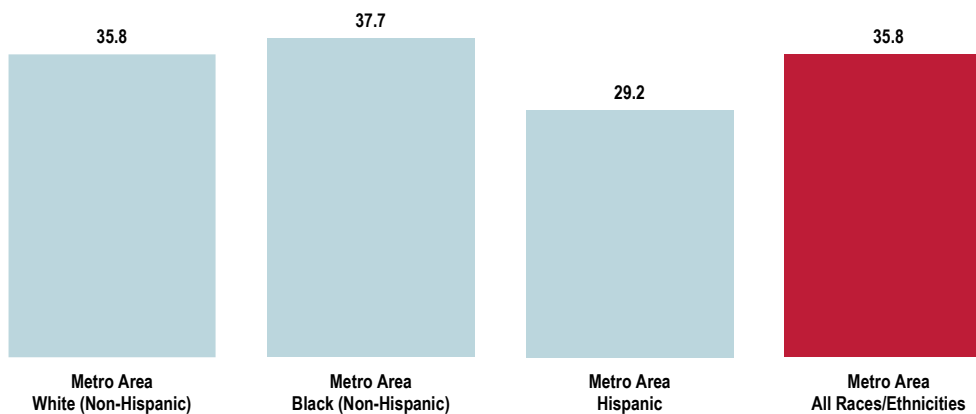


Sources:

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

Unintentional Injuries: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



Sources:

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



Unintentional Injuries: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2030 = 43.2 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	34.3	32.5	33.8	32.4	35.5	36.4	36.1	35.8
— NE	36.4	36.1	37.8	37.5	38.2	38.1	38.0	39.0
— IA	38.8	39.8	40.6	41.4	43.3	43.5	43.1	41.9
— US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

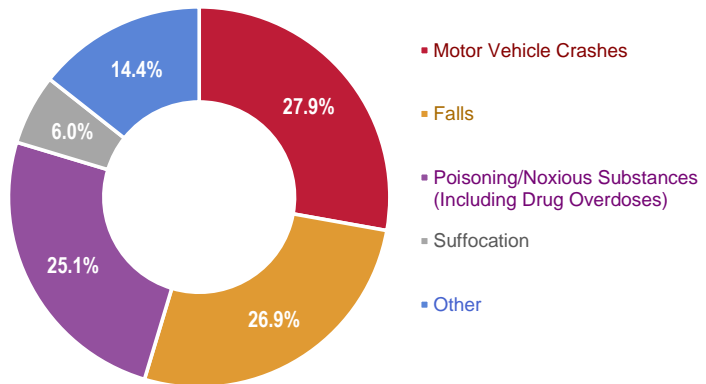
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Leading Causes of Unintentional Injury Deaths

Motor vehicle crashes, falls, poisoning (including unintentional drug overdose), and suffocation accounted for most unintentional injury deaths in the Metro Area between 2017 and 2019.

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading Causes of Unintentional Injury Deaths (Metro Area, 2017-2019)



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



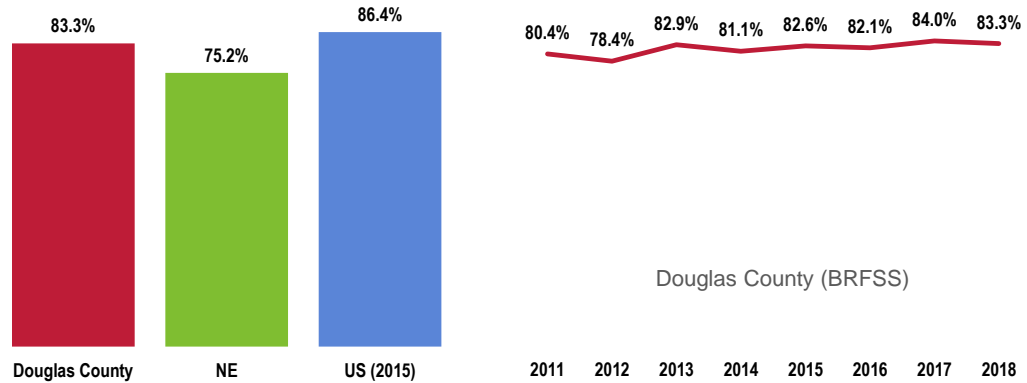
Seat Belts (Douglas County Only)

According to the CDC 2018 Behavioral Risk Factor Surveillance System (BRFSS) data for Douglas County, 83.3% of county residents report “always” wearing a seat belt when driving or riding in a vehicle.

BENCHMARK ▶ Higher than the Nebraska prevalence.

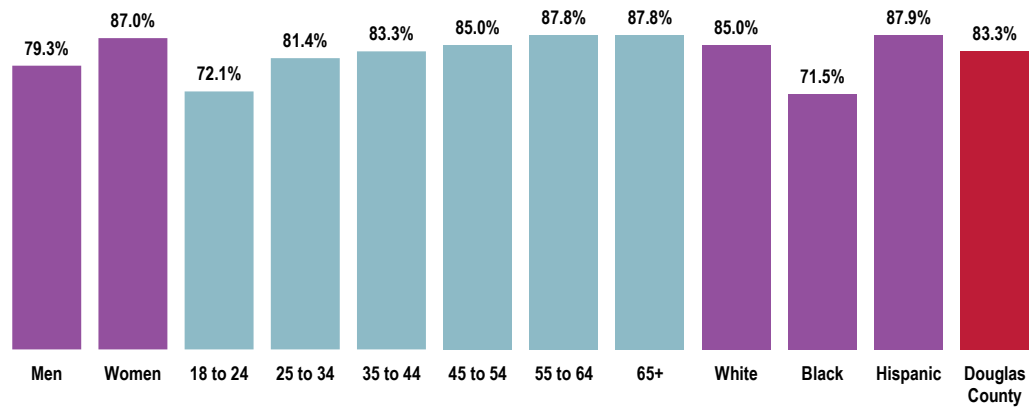
DISPARITY ▶ Lowest among Douglas County men, young adults, and Black residents.

“Always” Wear a Seatbelt When Driving a Vehicle



Sources: • 2018 Behavioral Risk Factor Surveillance System (BRFSS) Data for Douglas County, Douglas County Health Department
 Notes: • Asked of all respondents.
 • US percentage represents 2015 data.

“Always” Wear a Seatbelt When Driving a Vehicle (Douglas County, 2018)



Sources: • 2018 Behavioral Risk Factor Surveillance System (BRFSS) Data for Douglas County, Douglas County Health Department
 Notes: • Asked of all respondents.



Falls

ABOUT FALLS

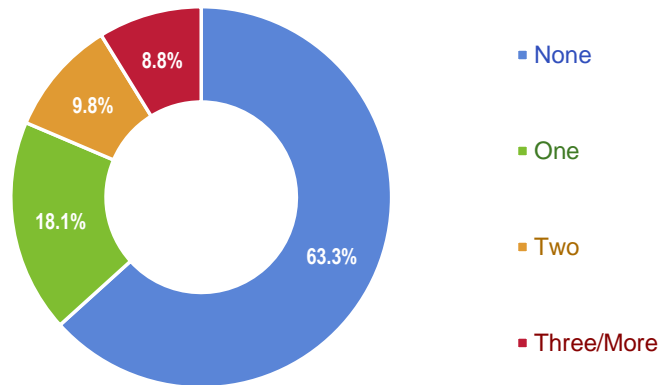
Falls are the leading cause of fatal and nonfatal injuries for persons aged ≥65 years Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

Modifiable fall risk factors include muscle weakness, gait and balance problems, poor vision, use of psychoactive medications, and home hazards. Falls among older adults can be reduced through evidence-based fall-prevention programs that address these modifiable risk factors. Most effective interventions focus on exercise, alone or as part of a multifaceted approach that includes medication management, vision correction, and home modifications.

– Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC

Among surveyed Metro Area adults age 45 and older, most have not fallen in the past year.

Number of Falls in Past 12 Months
(Adults Age 45 and Older; Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 344]
Notes: • Asked of all respondents age 45+.

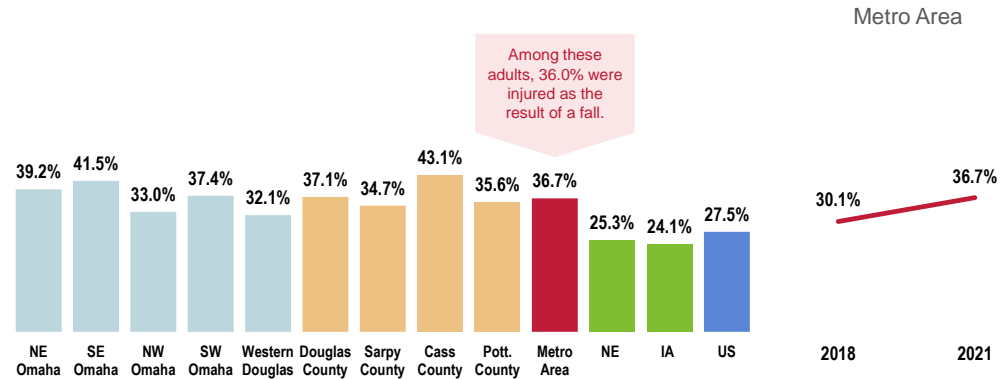
However, 36.7% have experienced a fall at least once in the past year.

BENCHMARK ▶ Well above the state and US percentages.

TREND ▶ Increasing significantly since 2018.



Fell One or More Times in the Past Year (Adults Age 45 and Older)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 344-345]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of those respondents age 45 and older.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

In the Metro Area, there were 4.0 homicides per 100,000 population (2017-2019 annual average age-adjusted rate).

BENCHMARK ▶ Higher than both state figures but lower than the national prevalence and satisfies the Healthy People 2030 objective.

TREND ▶ Decreasing in recent years, echoing the Nebraska trend.

DISPARITY ▶ The homicide rate is six times higher among Metro Area Blacks than Whites.

RELATED ISSUE
 See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Homicide: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population) Healthy People 2030 = 5.5 or Lower

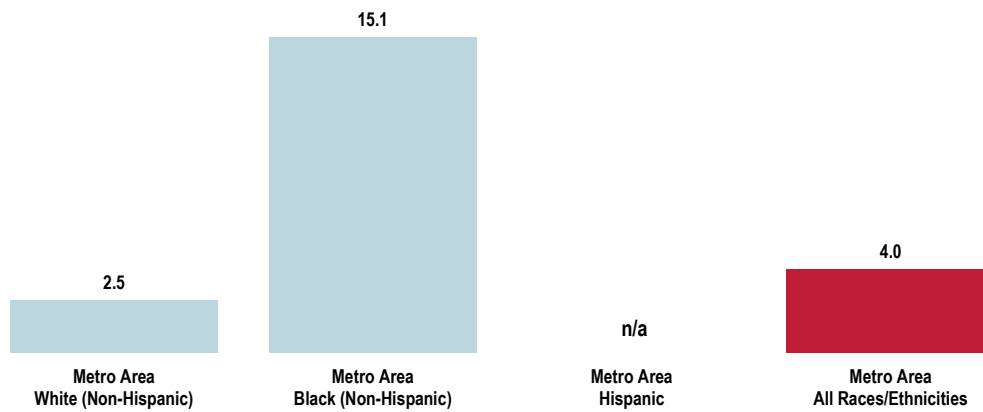


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>



Homicide: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)

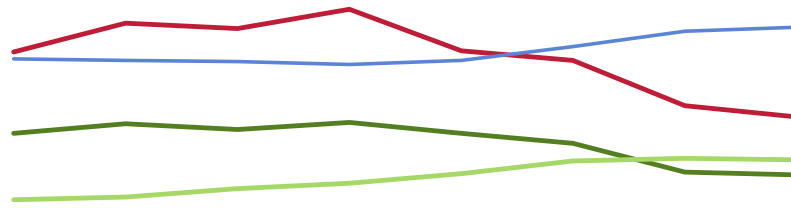
Healthy People 2030 = 5.5 or Lower



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

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

Healthy People 2030 = 5.5 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	5.5	6.2	6.1	6.6	5.6	5.3	4.2	4.0
— NE	3.6	3.8	3.7	3.8	3.6	3.3	2.6	2.6
— IA	2.0	2.0	2.2	2.4	2.6	2.9	3.0	2.9
— US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

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



Violent Crime

Violent Crime Rates

Between 2015 and 2017, there were a reported 369.3 violent crimes per 100,000 population in the Metro Area.

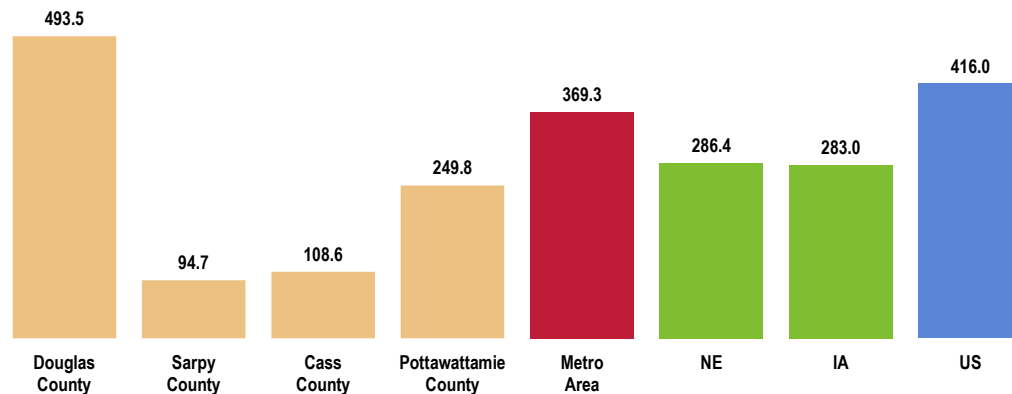
BENCHMARK ► Worse than the Iowa and Nebraska crime rates.

DISPARITY ► Unfavorably high in Douglas County.

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

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

Violent Crime
(Rate per 100,000 Population, 2015-2017)



- Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
 - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
- Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
 - Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Community Violence

A total of 3.4% of surveyed Metro Area adults acknowledge being the victim of a violent crime in the area in the past five years.

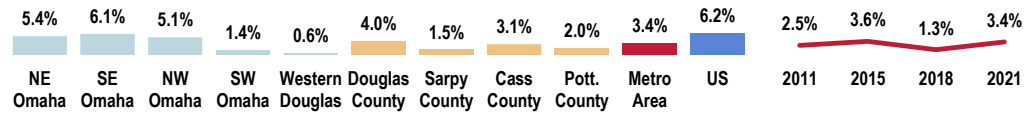
BENCHMARK ► Well below the national prevalence.

DISPARITY ► Highest in Douglas County. Correlates with age and especially income, and significantly higher among Blacks when compared with Whites in the Metro Area.



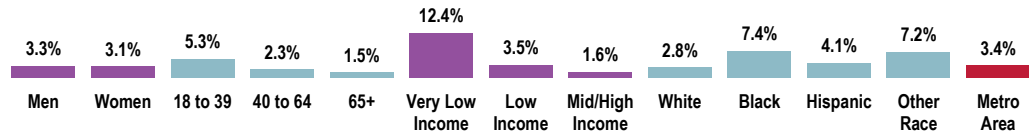
Victim of a Violent Crime in the Past Five Years

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Victim of a Violent Crime in the Past Five Years (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
 Notes: • Asked of all respondents.



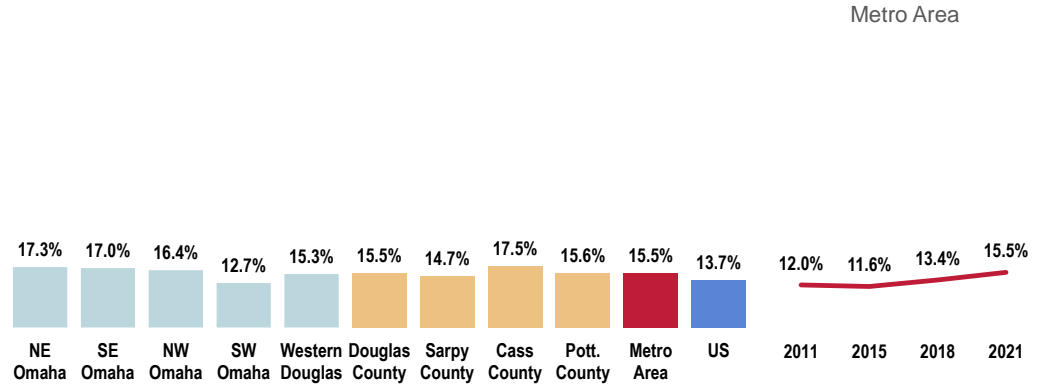
Family Violence

Respondents were read: "By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 15.5% of Metro Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

TREND ► Increasing significantly from previous survey findings.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



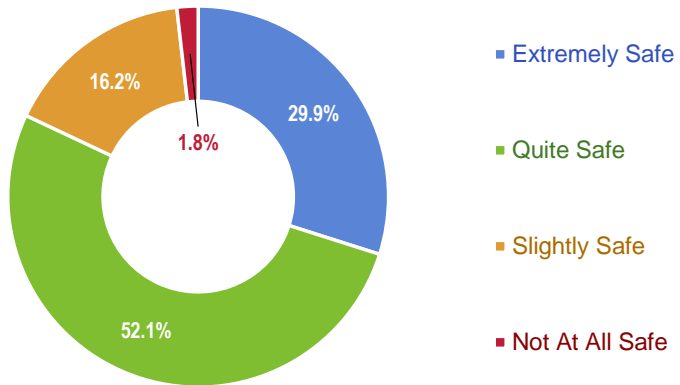
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 39, 309]
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Perceived Neighborhood Safety

While most Metro Area adults consider their own neighborhoods to be “extremely safe” or “quite safe,” 18.0% consider them only “slightly safe” or “not at all safe.”

Perceived Safety of Own Neighborhood (Metro Area, 2021)



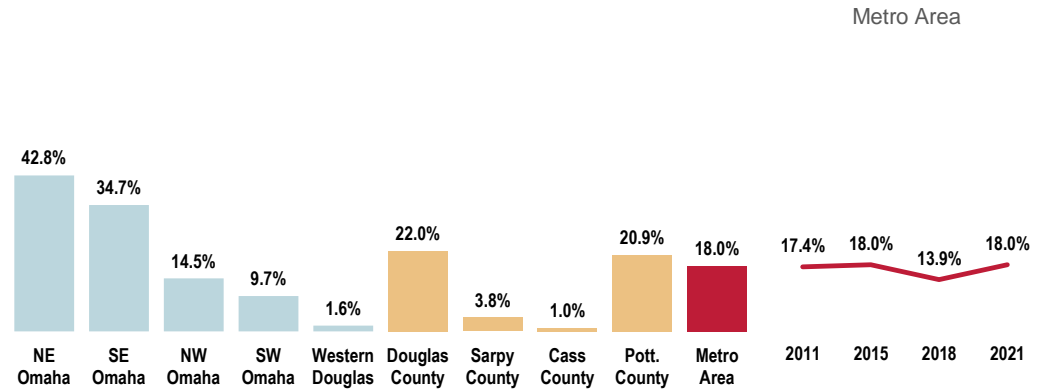
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 331]
 Notes: • Asked of all respondents.



TREND ▶ Similar to 2011 and 2015 survey results (although increasing significantly since 2018).

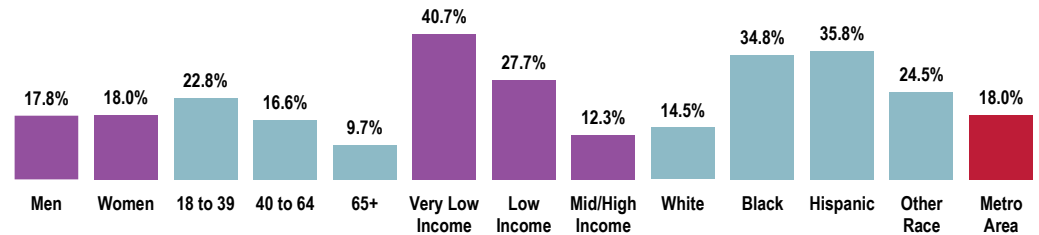
DISPARITY ▶ Unfavorably high in Douglas County, particularly in eastern Omaha. Reported more often among young adults, those in lower-income households, and communities of color.

Perceive Own Neighborhood as “Slightly” or “Not At All” Safe



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 331]
 Notes: • Asked of all respondents.

Perceive Own Neighborhood as “Slightly” or “Not At All” Safe (Metro Area, 2021)



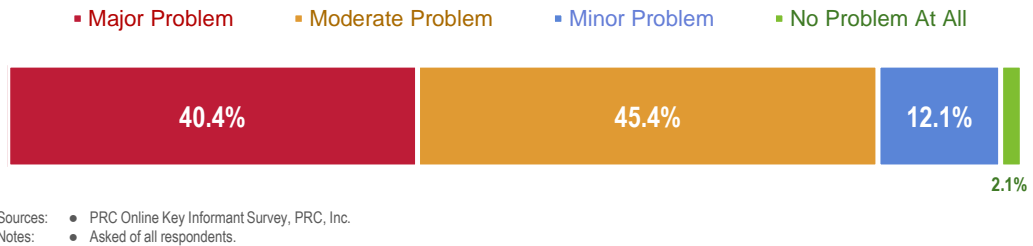
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 331]
 Notes: • Asked of all respondents.



Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a “moderate problem” in the community, followed closely by “major problem” ratings.

Perceptions of Injury and Violence as a Problem in the Community (Key Informants, 2021)



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

Incidence/Prevalence

- Workplace violence events are on the rise in all areas of health care and amongst the community. – Other Health Provider
- There has recently been an uptick in community violence, specifically in north Omaha. – Social Services Provider
- Reports of violence. – Community Leader
- This is self-evident. Neighborhoods are not safe. People are dying. – Social Services Provider
- Reports of injury and violence are all too familiar. – Social Services Provider
- It concerns me when I see the volume and serious nature of violent acts happening in our city. – Community Leader
- The violence dominates the news both national and local. People are hurting each other from shootings and in other ways. Drugs and relationships can lead to violence. – Other Health Provider
- Lots of police violence. Motor vehicle injuries and lack of access to child safety seats for poor children. – Physician
- Television, news and newspaper. – Social Services Provider
- Level of domestic violence in welfare system effecting women and children specifically. – Business Leader
- Increased community and family violence with domestic abuse and child maltreatment increasing over the years. – Social Services Provider
- It feels like the level of violence in the city has increased. Increased violence means increased trauma which is not healthy and leads to other chronic conditions being exacerbated. I think the issue around gangs and drugs is likely the leading contributor to the violence. I know there is quite a lot of great work being done within certain communities around preventions and intervention. – Social Services Provider
- I’ve seen reports on an increase in domestic violence and child abuse, neglect, substance use and so on. – Social Services Provider
- We know that childhood trauma and violence within a community impacts health well into adulthood and we continue to hear instances of family violence, community violence and gang violence in our community. COVID-19 has likely worsened this as families faced increased stress. – Community Leader
- Rates of domestic violence and number of children exposed to ACE’s. – Other Health Provider
- Violent crimes are more prevalent in northeast Omaha than other parts of the city. – Business Leader
- There have been multiple violent deaths just this week. – Other Health Provider
- We have a lot of violent crimes that result in injury. – Other Health Provider
- Watching the news, a lot of shootings. – Physician
- Recidivism of violence, increased violence city wide in the past six months to including shootings and stabbings. – Other Health Provider



Accidents are among the top killers in Nebraska and domestic violence and gun violence are prevalent. – Other Health Provider

Watching the news, working with community organizations. Gangs are a major issue. Domestic violence is a major issue. – Other Health Provider

Continue to have high crime, shooting situations, and so on. Before COVID we had decreased significantly, but now the issues are arising again. – Other Health Provider

Domestic violence, sexual assault, human trafficking, trauma, assaults not domestic continue to rise and the severity of injuries are increasing. – Other Health Provider

Gun Violence

Large number of gunshot wounds and assaults among homeless. – Social Services Provider

Increase gun violence throughout metropolitan Omaha. – Community Leader

Recent daily shootings and killings. – Other Health Provider

Gun violence is drastically up this year. – Business Leader

It is on the news every day, gun violence, child abuse, adult abuse. – Social Services Provider

Lack of targeted responses to gun and domestic violence. – Social Services Provider

Countless gun violence and killing of people in North Omaha, especially black males. Much domestic violence in the community, over run DV shelters, especially for women but lack of resources for men, too. Under-reported violence and rape on college campuses as well. – Social Services Provider

We have had 11 people die of shootings in the last week. I don't know why it's worse but the stress of being shut up during a pandemic may be having some lasting effects. – Other Health Provider

Our rates of adolescent homicide must be addressed. – Other Health Provider

Violence is occurring among those at a young age. This age seems to get younger and younger. – Other Health Provider

Shootings, domestic violence. – Public Health Representative

Contributing Factors

Violence and resultant injury are major problems due to a multitude of reasons, gangs, racism, easy access to guns, poverty, focus of the criminal justice system on punishment rather than rehabilitation. – Other Health Provider

Drugs, addiction, poverty coupled with mental health issues. – Other Health Provider

Poverty driven by low wage jobs leads to what seems like growing crime activity throughout the community. guns are too easily available and used to commit crime and lead to injury or death. domestic violence is far too widespread in our community and has impact of adults and children. – Other Health Provider

Increasing interpersonal violence during the pandemic. Lack of culturally competent mental health providers. Lack of after school and other programming in underserved communities. – Social Services Provider

Coronavirus was a contributing factor. – Criminal Justice

Vulnerable Populations

People of color in north and south Omaha experience injury and violence at a higher rate. – Community Leader

Goes along with poverty and lack of resources. – Other Health Provider

Poverty, broken systems, education, exposure to better quality of life. – Other Health Provider

Significant racial disparity. – Other Health Provider

Follow-Up/Support

I am concerned that there is limited ongoing care for persons and populations with high rates of violence. – Physician



DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. ...Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

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

Age-Adjusted Diabetes Deaths

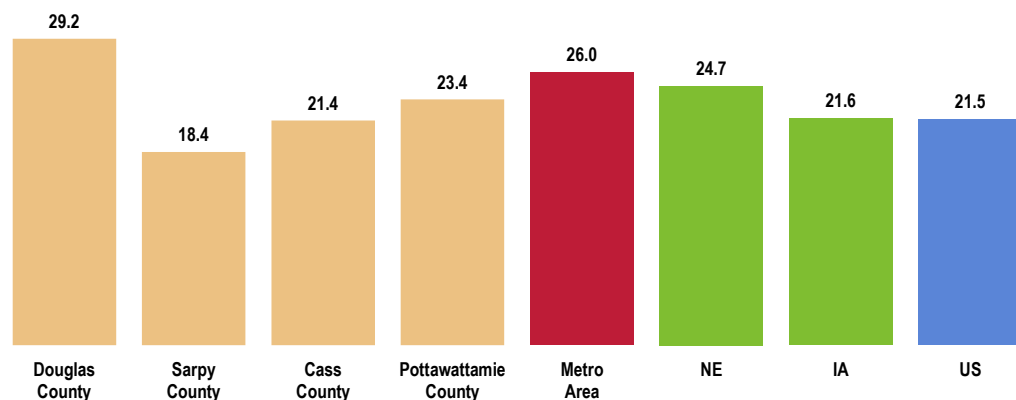
Between 2017 and 2019, there was an annual average age-adjusted diabetes mortality rate of 26.0 deaths per 100,000 population in the Metro Area.

BENCHMARK ▶ Worse than the Iowa and US mortality rates.

TREND ▶ Note the increasing trend over the past decade.

DISPARITY ▶ Unfavorably high in Douglas County. Dramatically higher in the Metro Area's Black community.

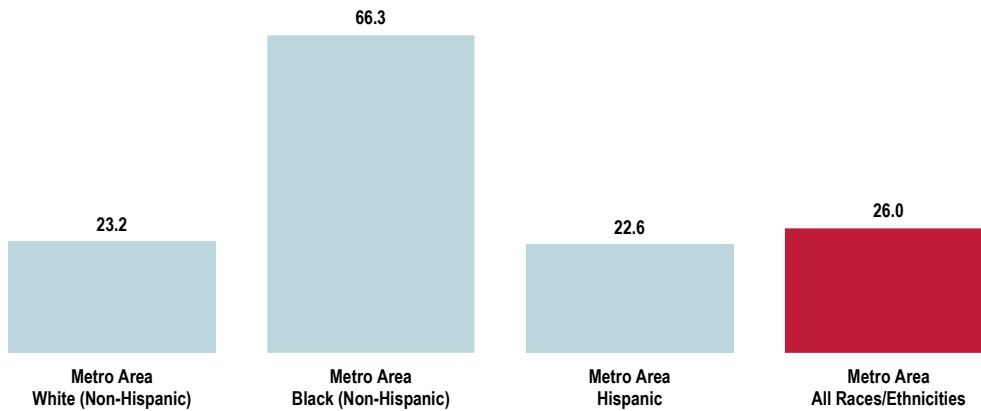
Diabetes: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



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



Diabetes: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)



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

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	21.9	22.7	23.3	24.4	22.9	23.9	24.9	26.0
— NE	21.4	21.4	21.3	22.7	22.7	23.9	24.3	24.7
— IA	18.9	18.8	20.7	23.8	24.4	23.5	21.9	21.6
— US	22.0	22.1	21.1	21.1	21.1	21.3	21.3	21.5

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



Prevalence of Diabetes

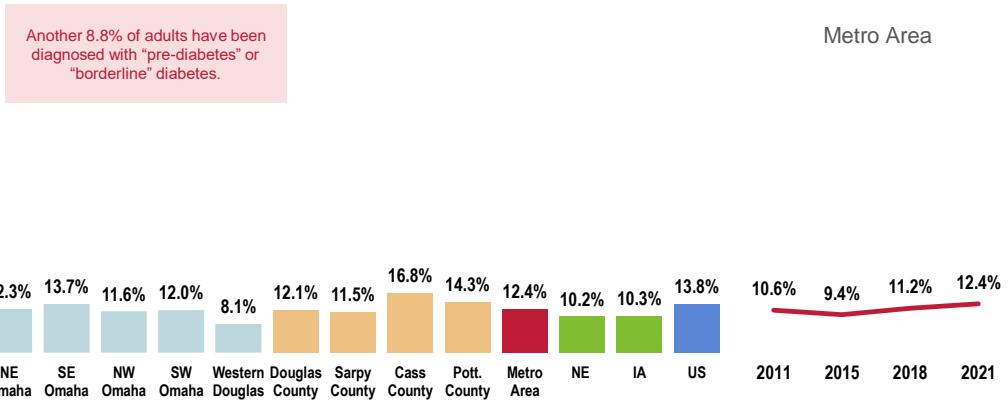
A total of 12.4% of Metro Area adults report having been diagnosed with diabetes.

BENCHMARK ▶ Worse than both state percentages.

TREND ▶ Increasing since 2015.

DISPARITY ▶ Increases with age and is higher among low-income adults, Whites, and Blacks.

Prevalence of Diabetes

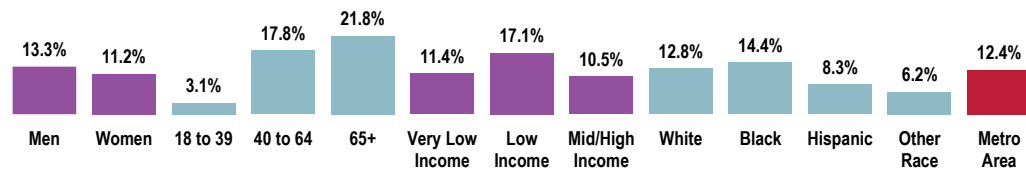


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 32, 121]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Prevalence of Diabetes (Metro Area, 2021)

Note that among adults who have not been diagnosed with diabetes, 46.0% report having had their blood sugar level tested within the past three years.



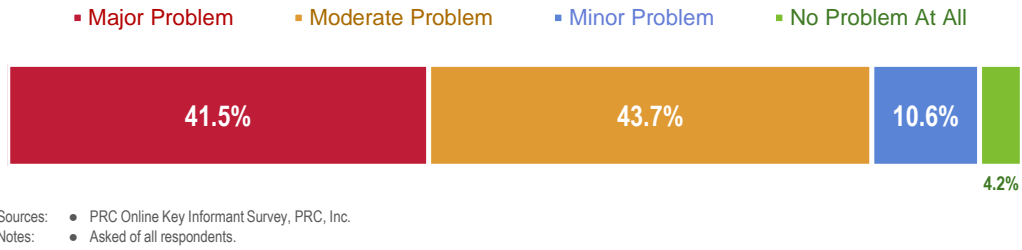
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 33, 121]
 Notes: • Asked of all respondents.
 • Excludes gestational diabetes (occurring only during pregnancy).



Key Informant Input: Diabetes

A high percentage of key informants taking part in an online survey characterized *Diabetes* as a “moderate problem” in the community, followed closely by those who gave “major problem” responses.

Perceptions of Diabetes as a Problem in the Community (Key Informants, 2021)



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

Affordable Medications/Supplies

- Access to medications due to cost, access to care and to get the support they need possibly due to the jobs they work in and the ability for the patient to attend appointments, support groups etc. Lack of safe neighborhoods in certain parts of the city which might limit ability to go for walks and feel safe outdoors. Health literacy. – Social Services Provider
- Denial; cannot afford insulin or supplies. – Physician
- Access to affordable care and treatment. Systemic barriers still exist to the tools to manage, control diabetes. – Other Health Provider
- Lack of funding for cost of insulin leading to multiple hospitalizations. – Social Services Provider
- The cost of health care. – Criminal Justice
- Diabetic medication and supplies. – Other Health Provider
- Cost of medications, especially insulin and inadequate resources such as dieticians, diabetic educational nurses and access to glucometers, lancets, and test strips. – Physician
- Not being able to afford medications, supplies, getting tested, eating healthy and managing it. – Other Health Provider
- Insulin is so expensive. Even with insurance, it can be prohibitive. Especially until deductibles are met. Folks go without. Or try to ration it. Folks don't make dietary changes. They are brought up on a certain diet and those are the foods that are accessible and taste like home or comfort. Good care is expensive. The pharmaceutical industry in the United States is broken. Other countries, some we share borders with, do not charge as much as we do for the drugs. Pharmaceutical companies get richer when people are sicker. It isn't a good model. – Social Services Provider

Contributing Factors

- Access to services when hospitalized, either after first diagnosis, compliance issues that they have to be hospitalized for. The diabetic educators are increasing in the community through physician offices; however, they are not readily available if a patient needs the service in the hospital. While most of this is handled on an outpatient basis, there is something to be said about connecting with someone before leaving the confines of health care and relying on them to return later for consultations. Compliance as a life commitment—poor within our community—patients not always motivated for the follow-up or regimen needed to manage this disease. – Other Health Provider
- Preventing diabetes in the first place with proper diet, and education. Obesity is a huge issue in our community and the lack of knowledge, education, and availability of affordable healthy food has led to an epidemic of diabetes or pre-diabetes conditions. The cost of insulin is outrageous, so we see people making choices about even being able to afford the needed medications. – Other Health Provider
- Healthy eating management of the disease is a struggle, especially for those without insurance or in a lower income bracket. – Other Health Provider



Bad diet, high sugar, high carbs, low vegetables, healthy meat diets. Lack of exercise, active lifestyle. – Community Leader

Access and compliance. – Physician

Access to knowledge of healthy, nutrient, dense foods, access to safe neighborhoods to engage in physical activity, affordability of medications and treatment. – Other Health Provider

Lack of access to healthy food. Unsafe neighborhoods that make exercising difficult. Lack of support for caregivers, limited transportation opportunities. – Social Services Provider

Awareness/Education

Understanding the disease process and long-term consequences of uncontrolled disease. Sub-optimal management with limited access to subspecialist. – Physician

Education and access to healthy foods. – Other Health Provider

Lack of targeted programming. – Social Services Provider

Follow-up with emphasis on non-pharmacologic as well as pharmacologic management. – Physician

Support and motivation for behavior change and weight loss. – Business Leader

Early education and prevention. Children who will grow into adults adapting healthy eating behaviors and physical activity at a young age. – Other Health Provider

Lack of understanding of how diabetes works, how to manage it, and lack of attention to the signs. Many people don't know how to incorporate the dietary needs of diabetes into their daily lives, and can't afford the healthy foods they need, or how to cook the foods that are good for them. – Social Services Provider

Educators available to help them. – Other Health Provider

Health literacy and access to support services to address root causes of diabetes and other chronic conditions. – Other Health Provider

Education about diabetes prevention to intervene before someone has Type II diabetes. Access to affordable nutrition and medications to keep diabetes in check. – Community Leader

Vulnerable Populations

Again, certain populations are disproportionately affected by diabetes. In particular, Black, African Americans, Latina and Native American, American Indian populations. – Physician

Lack of culturally competent providers. – Physician

High prevalence, especially in minority populations such as African American, Native American, and Latino groups. Lack of family and community support for patients. – Public Health Representative

Diagnosis/Treatment

Lack of treatment. – Other Health Provider

Patients not taking care of themselves and condition progresses to the point of not being able to afford medical attention. – Business Leader

Compliance to control blood sugars and lack of follow up. – Physician

Weight Control

Weight and nutrition management. – Other Health Provider

Increasing rates of obesity. – Other Health Provider

Weight control. – Social Services Provider

Lifestyle

Linking the realities of diabetes with what is happening in their home, community, neighborhood. – Public Health Representative

Lifestyle changes including weight loss, healthy diet and exercise. – Physician

Access to Affordable Healthy Food

Affordable food options. – Social Services Provider

Lack of access to fruits and vegetables. Food, desserts. – Community Leader

Quality of Life

Long-term complications, neuropathy, kidney disease, heart disease. – Physician

Prevalent and deadly. – Social Services Provider



KIDNEY DISEASE

ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. ...People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

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

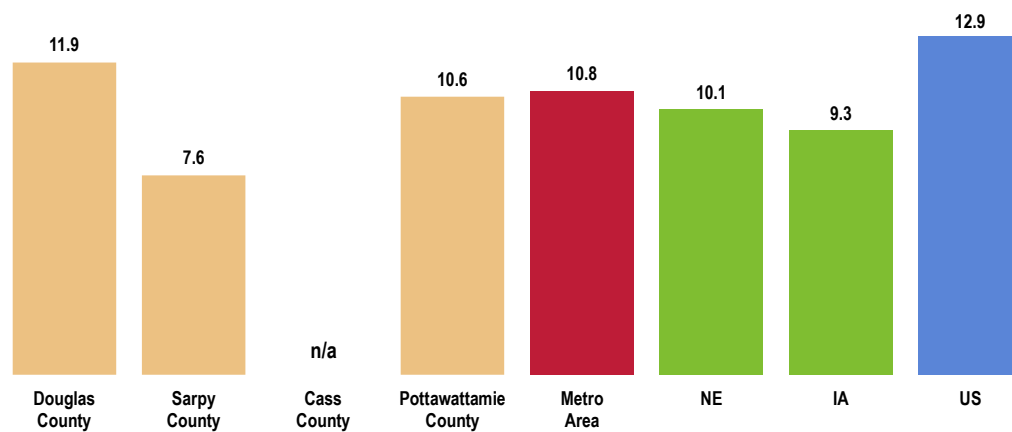
Age-Adjusted Kidney Disease Deaths

Between 2017 and 2019, there was an annual average age-adjusted kidney disease mortality rate of 10.8 deaths per 100,000 population in the Metro Area.

BENCHMARK ▶ Lower than the national figure.

DISPARITY ▶ More than three times higher among Blacks than Whites in the Metro Area.

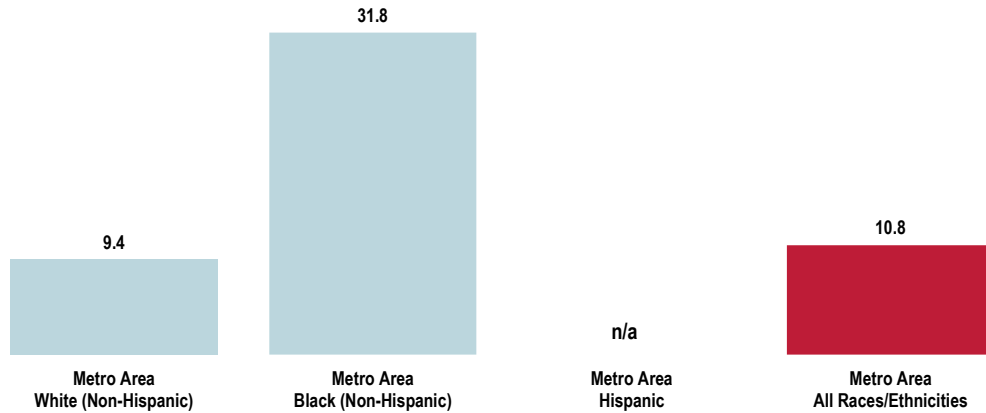
Kidney Disease: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



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

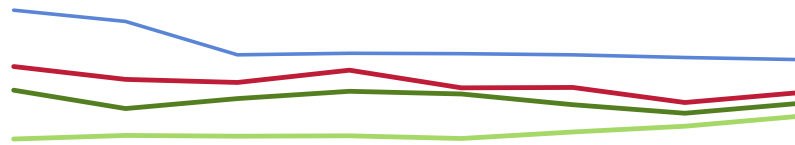


Kidney Disease: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)



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

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



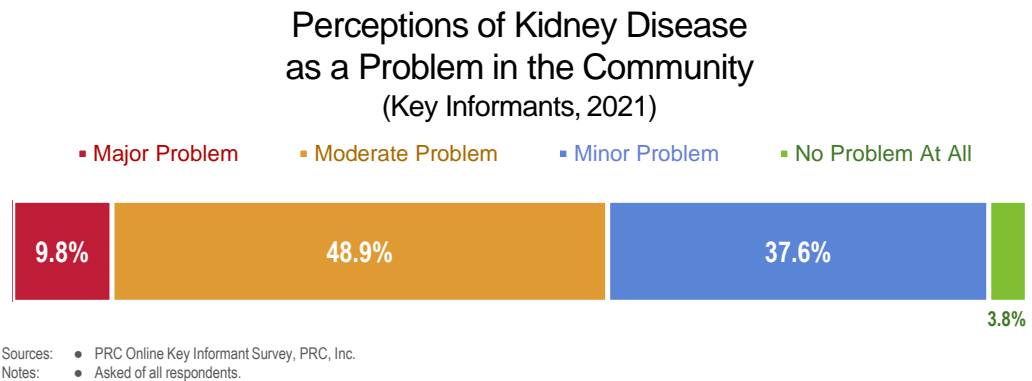
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Metro Area	12.4	11.6	11.4	12.2	11.1	11.1	10.2	10.8
NE	11.0	9.8	10.4	10.9	10.7	10.1	9.5	10.1
IA	7.9	8.2	8.1	8.1	8.0	8.4	8.7	9.3
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

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



Key Informant Input: Kidney Disease

Just less than half of key informants taking part in an online survey characterized *Kidney Disease* as a “moderate problem” in the community.



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

Co-Occurrences

- Level of diabetes. – Business Leader
- It is very likely a product of diabetes. – Community Leader
- Poor health, meth use, high incidence of diabetes. – Other Health Provider

Vulnerable Populations

- Difficulty getting care for especially the poor and homeless populations. – Other Health Provider
- Lack of culturally competent providers. – Physician



POTENTIALLY DISABLING CONDITIONS

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

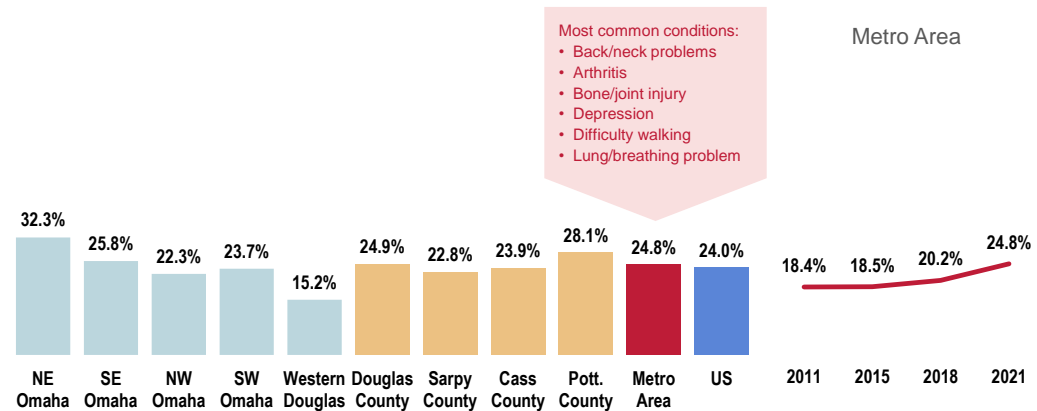
– Healthy People 2030 (<https://health.gov/healthypeople>)

A total of 24.8% of Metro Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

TREND ► Increasing significantly from previous survey findings.

DISPARITY ► Unfavorably high in Northeast Omaha. Reported more often among women, adults age 40 and older, those living at lower income levels, White residents, and Black residents.

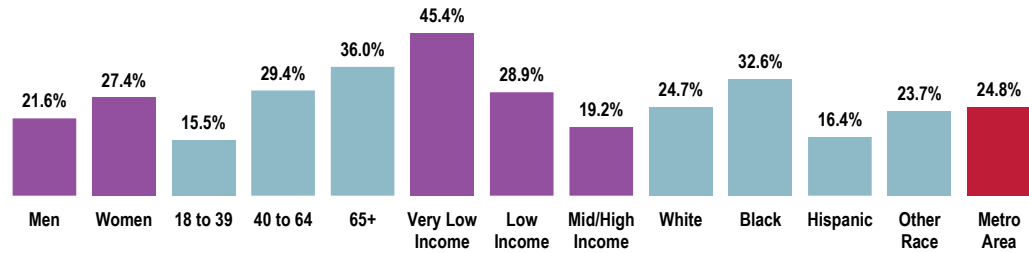
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 96-97]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.



Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: • Asked of all respondents.

Chronic Pain

Prevalence of High-Impact Chronic Pain

A total of 17.6% of Metro Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities “every day” or “most days” during the past six months.

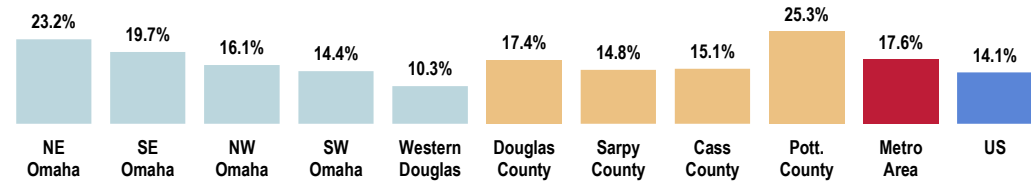
BENCHMARK ► Worse than the US prevalence and more than twice the Healthy People 2030 objective.

DISPARITY ► In Douglas County, the prevalence is highest in the Northeast Omaha area. Viewed by county, the prevalence is considerably higher in Pottawattamie County. Reported more often among adults age 40+, those at lower income levels, and those in the Other Race category.



Experience High-Impact Chronic Pain

Healthy People 2030 = 7.0% or Lower



Sources:

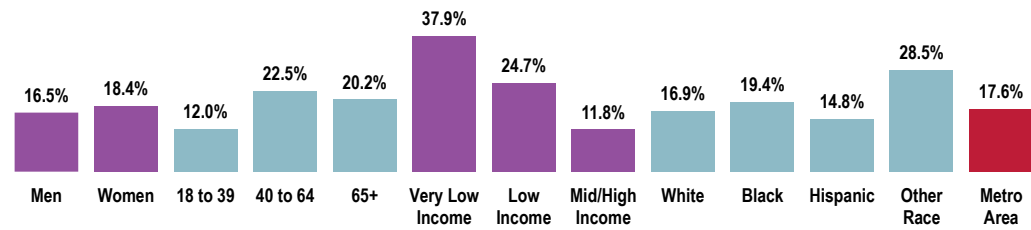
- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

 Notes:

- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain (Metro Area, 2021)

Healthy People 2030 = 7.0% or Lower



Sources:

- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

 Notes:

- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.



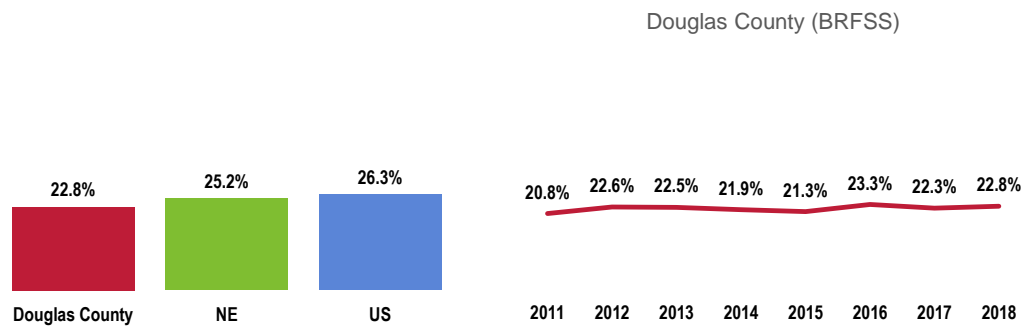
Arthritis (Douglas County Only)

According to the 2018 BRFSS data for Douglas County, 22.8% of residents suffer from arthritis, increasing to over 45% among adults age 55 and older.

BENCHMARK ▶ Somewhat lower than state and national figures.

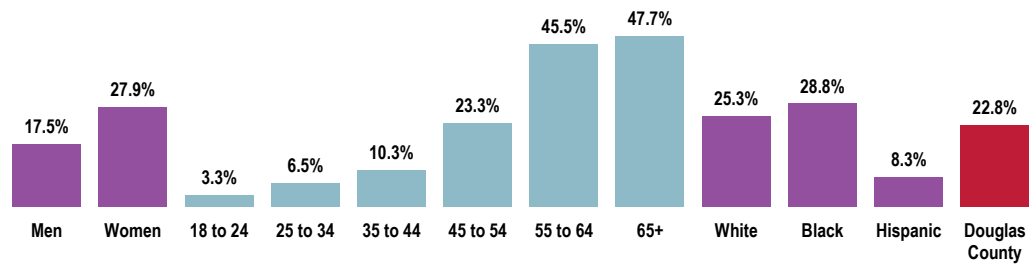
DISPARITY ▶ Reported most often among Douglas County women, older adults, Whites, and Blacks.

Arthritis Among Adults (Douglas County, 2018)



Sources: • 2018 Behavioral Risk Factor Surveillance System (BRFSS) Data for Douglas County, Douglas County Health Department
Notes: • Asked of all respondents.

Arthritis Among Adults (Douglas County, 2018)



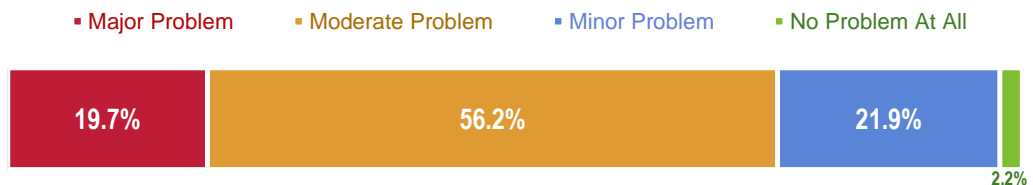
Sources: • 2018 Behavioral Risk Factor Surveillance System (BRFSS) Data for Douglas County, Douglas County Health Department
Notes: • Asked of all respondents.



Key Informant Input: Disability & Chronic Pain

Key informants taking part in an online survey most often characterized *Disability & Chronic Pain* as a “moderate problem” in the community.

Perceptions of Disability & Chronic Pain as a Problem in the Community (Key Informants, 2021)



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

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

Contributing Factors

- Keeps people ill, unemployed, risking employment, tests care of children. – Social Services Provider
- Socioeconomic burden, psychological burden. Decreased productivity and feeling of well-being in the community as a whole. – Physician
- Many older adults suffer with chronic pain issues which is typically only addressed through additional medications instead of using other sources such as physical therapy. – Social Services Provider
- Health literacy and access to support services to address root causes of ongoing disability and chronic pain impacts an individual’s ability to live a full quality of life. – Other Health Provider
- The cost of health care insurance. – Criminal Justice
- People are not as active, and this sedentary lifestyle leads to a vicious cycle that leads to disability and chronic pain. People are also dealing with weight issues that puts extra burden on the body. – Other Health Provider
- I work in the medical field and see so many patients who struggle with chronic pain and pain management. The disability application process is difficult and time-consuming, and it seems that 9/10 times, the client is denied the first time applying. There is also a lack of education for both the general public as well as the medical professionals on who, what, and why someone may qualify for a disability. – Social Services Provider

Vulnerable Populations

- Poor access to physical and occupational services for poor and people of color after injuries, strokes. Lack of support for these same communities to make their homes ADA compliant. Lack of access to rehab care and lack of support of caregivers. – Social Services Provider
- Lack of culturally competent providers. – Physician
- People that are homeless and/or living in poverty lack access and resources to properly address and receive care for chronic and reoccurring pain and disabilities. – Social Services Provider

Access to Care/Services

- Access to pain clinics is limited to those with good insurance coverage. Many misconceptions about disabled individuals. – Other Health Provider
- Access to services is very limited for individuals with chronic pain and disability, because they may not have insurance coverage for treatment that are evidence based and timely. Employers and worksite planning folks may not be aware of their specific needs. Accommodation plans are lacking. Physical buildings and infrastructure do not always seem to be friendly or accessible to people with a physical disability. Disability-friendly designs are needed. – Other Health Provider
- Inadequate access to rheumatologist and orthopedic specialist. – Physician



Opioid Use

Chronic pain is driving the opioid epidemic. – Business Leader

People that have chronic pain and are made to feel like addicts, which oftentimes they become. The only way to get off the opiates is to enter a treatment facility where they may not belong. We don't have any effective, non-addictive medication available for persons with chronic pain. – Other Health Provider

Diagnosis/Treatment

Chronic pain, not much for options for treatment, many people addicted to opioids. – Other Health Provider

No real good pain treatment programs that do not involve opioids. – Other Health Provider

Incidence/Prevalence

I am a retired physician and saw many, many patients with chronic pain. – Physician



Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.¹ Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

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

Age-Adjusted Alzheimer's Disease Deaths

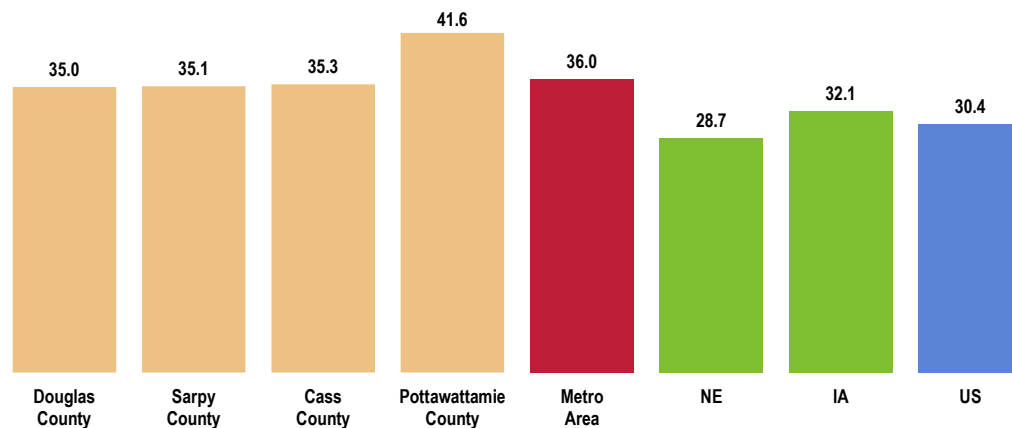
Between 2017 and 2019, there was an annual average age-adjusted Alzheimer's disease mortality rate of 36.0 deaths per 100,000 population in the Metro Area.

BENCHMARK ▶ Worse than Nebraska and US mortality rates.

TREND ▶ Increasing over the past decade.

DISPARITY ▶ Higher among Metro Area Blacks than Whites.

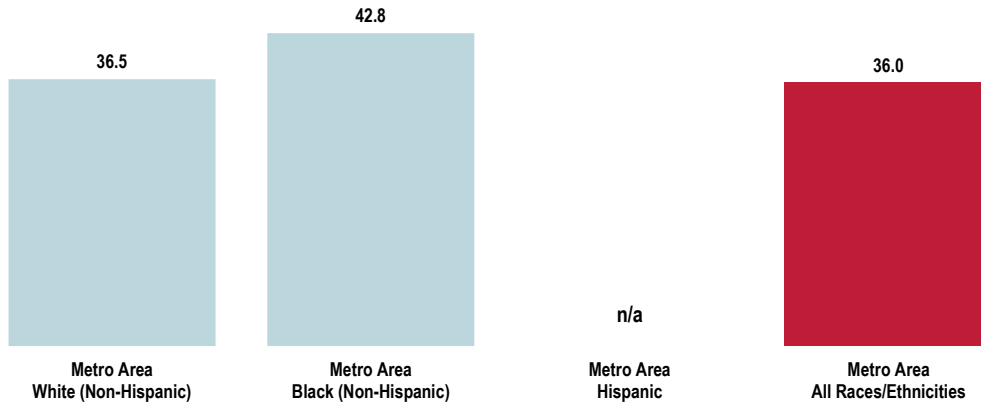
Alzheimer's Disease: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



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

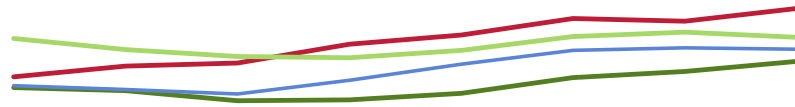


Alzheimer's Disease: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)



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

Alzheimer's Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Metro Area	26.6	28.1	28.5	31.1	32.4	34.6	34.3	36.0
NE	25.1	24.7	23.3	23.4	24.3	26.5	27.4	28.7
IA	31.9	30.3	29.4	29.2	30.3	32.2	32.8	32.1
US	25.4	24.8	24.2	26.1	28.4	30.2	30.6	30.4

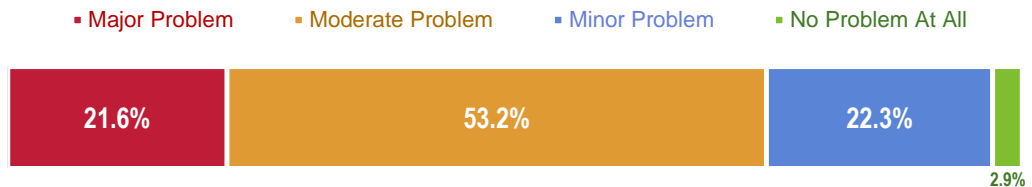
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.



Key Informant Input: Dementia/Alzheimer's Disease

Over half of key informants taking part in an online survey consider *Dementia/ Alzheimer's Disease* to be a “moderate problem” in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2021)



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

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

Incidence/Prevalence

Number of people effected. – Social Services Provider

In recent years, I have personally witnessed several friends deal with dementia/Alzheimer's disease with their parents. It appears we have more and more Memory Care facilities opening up, and most are extremely costly, making it a financial struggle for families. – Social Services Provider

Rates are increasing and will put a strain on caregivers. – Other Health Provider

This is an epidemic that has existed long before COVID hit us. The population is aging and brains are not doing very well. The disease is devastating. The caregiving is draining. Professional care is expensive. Respite can be expensive. It is impacting a large percentage of folks. – Social Services Provider

I hear this it is a problem all too often. – Social Services Provider

Number of employees who are dealing with parents struggling with Dementia, Alzheimer's disease. – Social Services Provider

I know too many people who suffer from it, an increasing number as I age. – Physician

This disease is still killing people. – Social Services Provider

Access to Care/Services

Dementia/Alzheimer's disease continues to be a devastating disease ravaging our community and country with no cure. In our communities where access to medical care is limited or not affordable, the effects of diseases like dementia/Alzheimer's have even more devastating effects than communities with access and availability of resources. – Social Services Provider

Few services available and what is available is very expensive. The system is difficult to navigate. – Other Health Provider

Increased need for units to house clients that are unable to remain in their home. – Public Health Representative

We don't have a plethora of resources for those impacted by this disease and diagnosis rates continue to rise. – Social Services Provider

There are limited community resources for respite for family caregivers and limited resources for affordable assisted living facilities for those with moderate to advanced dementia. – Social Services Provider

Access to neurologist is limited. – Other Health Provider

Affordable Care/Services

Many of these people want to stay in their homes. They are unable to do so without assistance and many cannot afford the care to stay at home. Most memory care or other ALF do not take Medicaid right away. – Social Services Provider

Too few resources for people of lower income to receive respite care and or in home support. – Physician

Memory care is extremely expensive. Qualifying for LTC insurance has become difficult so paying for this kind of care is not feasible for many. The problem is only getting more extensive. – Social Services Provider



Aging Population

- Alzheimer's continues to be a looming problem as the population ages, with perhaps some promising treatments beginning to be developed, but they are also hugely expensive. – Other Health Provider
- Aging population and denial by family members. – Criminal Justice

Lack of Providers

- Not enough trained clinicians, very limited access to skilled nursing units with adequately trained staff. – Other Health Provider
- Limited specialists and access for consumers. – Other Health Provider

Quality of Life

- It's a debilitating disease that presents significant, undesirable disruptions to family systems. – Social Services Provider
- Progressive debilitating disease with significant burden on family caregivers. – Physician

Diagnosis/Treatment

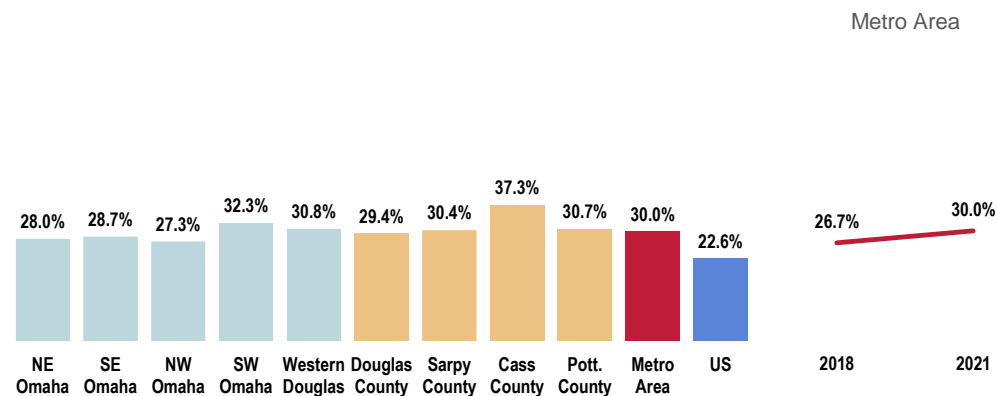
- The ability to know the initial indicators is limited. – Community Leader
- Difficulty accessing testing to determine diagnosis. – Social Services Provider

Caregiving

A total of 30.0% of Metro Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

- BENCHMARK** ▶ Much higher than the national figure.
- TREND** ▶ Increasing significantly since 2018.
- DISPARITY** ▶ Highest among Cass County survey respondents.

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 98]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.





BIRTHS

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.

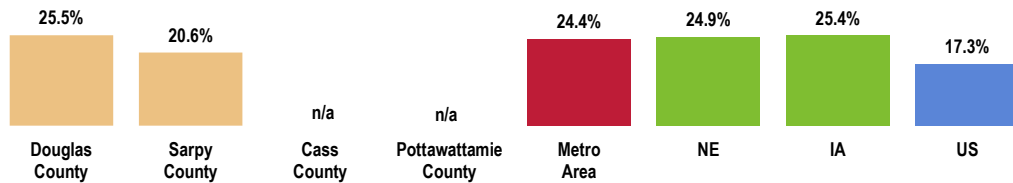
– Healthy People 2030 (<https://health.gov/healthypeople>)

Between 2017 and 2019, 24.4% of all Metro Area births (Douglas and Sarpy counties only) did not receive prenatal care in the first trimester of pregnancy.

Note that county data for Cass and Pottawattamie counties are suppressed or otherwise not available and thus not included in the Metro Area rate.

BENCHMARK ► Worse than the national prevalence.

Lack of Prenatal Care in the First Trimester (Percentage of Live Births, 2007-2010)



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

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



BIRTH OUTCOMES & RISKS

Low-Weight Births

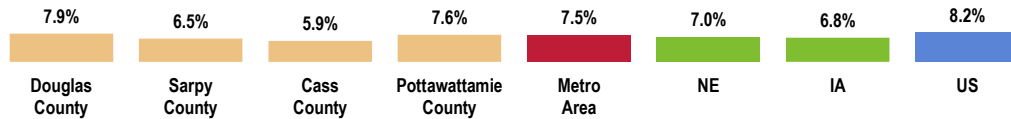
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

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

A total of 7.5% of 2006-2012 Metro Area births were low-weight.

DISPARITY ► Lowest in Cass County.

Low-Weight Births
(Percent of Live Births, 2006-2012)



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

Low-Weight Births
(Percent of Live Births)



	2002-2008	2003-2009	2004-2010	2005-2011	2006-2012
Metro Omaha	7.6%	7.6%	7.7%	7.6%	7.5%
NE	7.0%	7.0%	7.1%	7.0%	7.0%
IA	6.8%	6.8%	6.9%	6.8%	6.8%
US	8.1%	8.1%	8.2%	8.2%	8.2%

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

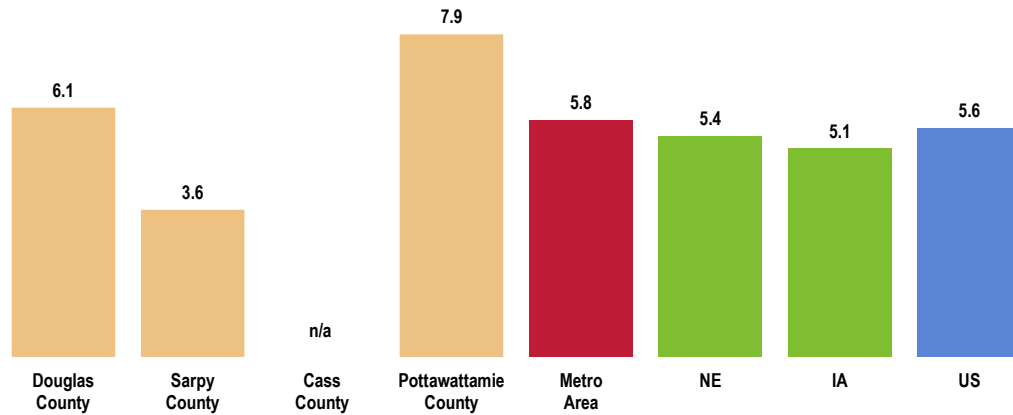
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

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

TREND ► Though decreasing in recent years, the rate is higher than the baseline 2010-2012 rate.

DISPARITY ► Unfavorably high in Pottawattamie County. More than twice as high among births to Black women.

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



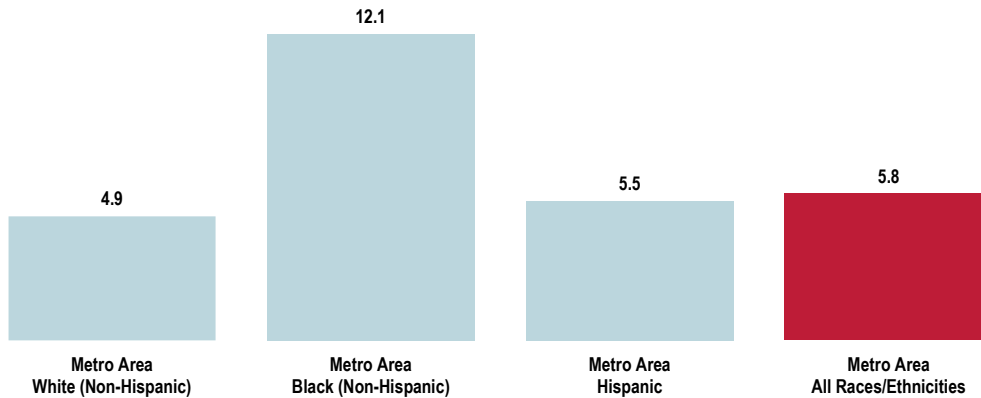
Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 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 by Race/Ethnicity
(Annual Average Infant Deaths per 1,000 Live Births, 2017-2019)
Healthy People 2030 = 5.0 or Lower



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes:

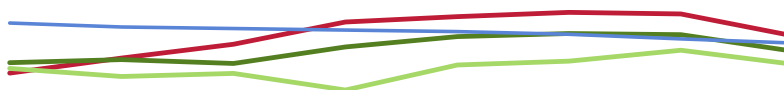
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.



Infant Mortality Trends

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

Healthy People 2030 = 5.0 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— Metro Area	4.9	5.2	5.6	6.1	6.2	6.3	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, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2021.

- Centers for Disease Control and Prevention, National Center for Health Statistics.

- 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.



FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. ...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>)

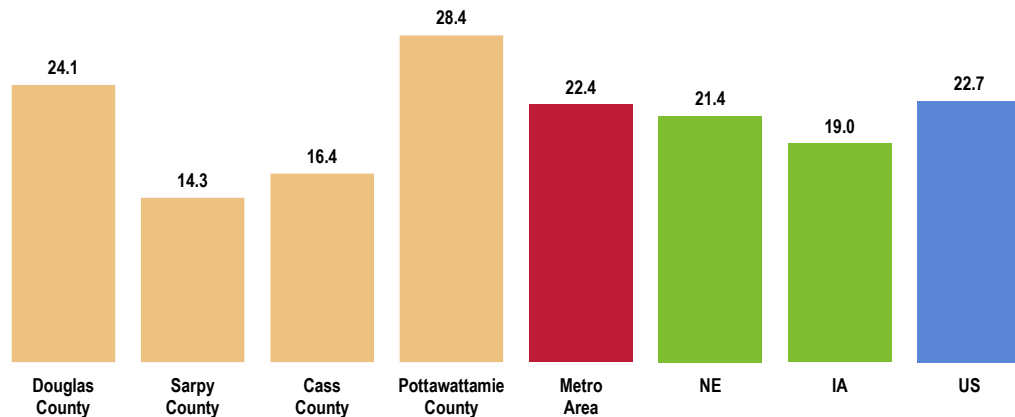
Births to Adolescent Mothers

Between 2006 and 2012, there were 22.4 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 but satisfies the Healthy People 2030 objective.

DISPARITY ▶ Unfavorably high in Douglas and especially Pottawattamie counties.

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 February 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes:

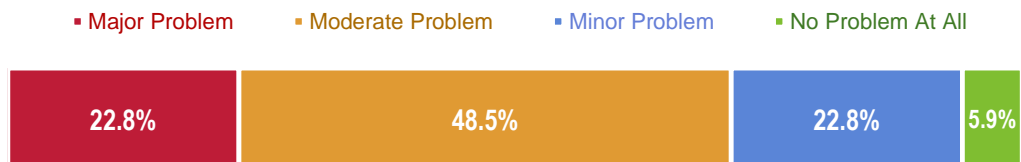
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.



Key Informant Input: Infant Health & Family Planning

Key informants taking part in an online survey largely characterized *Infant Health & Family Planning* as a “moderate problem” in the community.

Perceptions of Infant Health and Family Planning as a Problem in the Community (Key Informants, 2021)



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

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

Vulnerable Populations

Maternal health specifically related to disparities in outcomes. A black woman having a baby is 3-4 times more likely to die in this country than a white woman. We have increased rates of prematurity and c-section rates in our minority population compared to white women. – Other Health Provider

High maternal infant fetal mortality rates in the black community. – Social Services Provider

Infant mortality is higher in northeast Omaha than other parts of Omaha and the nation. – Business Leader

Infant fatalities among African American families are still at a much higher level than white infants, thus underscoring the need for better maternal health coverage and support of both moms and infants throughout pregnancy and the first year. – Other Health Provider

Number of children in our welfare system due to neglect. – Business Leader

We continue to see young mothers that do not receive prenatal care. – Other Health Provider

I have worked in the maternal child field for many years, seeing the increase in teen and young parent pregnancies. Unfortunately, many of these young women didn't finish their high school educations. – Social Services Provider

Second and third generation poverty and reliance on subsidized programs such as welfare. Little or no prenatal care, poor health of the mom, substance abuse and, or high incidence of smoking. – Other Health Provider

Our country ranks near the bottom for Black infant mortality. – Other Health Provider

Incidence/Prevalence

We continue to struggle with our infant mortality rates and oftentimes this has to do with either preconception health or prenatal care. – Public Health Representative

Our infant mortality in certain groups is simply too high. We need to build better systems for health to assist these populations. – Physician

High chlamydia rates compared to other similar communities, especially in north Omaha, people of color. – Social Services Provider

Contributing Factors

Issues are politicized. Sex ed is politicized. Old white men make too many decisions on behalf of women. They don't want the government to control their bodies when it comes to masks, but they have no problem controlling a woman's uterus/vagina. There is too much shame and stigma attached to these services. Black infant death rate is one more indicator of a lack of equity. Equity (and racism) is a piece of every single one of the diseases in this survey. – Social Services Provider

Family planning resources are still considered to be taboo in some segments of our community. Some women still don't have access to comprehensive education that covers all sex education, pregnancy prevention, pregnancy ending, and infant care services. – Community Leader



Unplanned Pregnancy

Unplanned pregnancy rates and infant mortality rates. – Other Health Provider

The number of unplanned pregnancies. – Other Health Provider

Awareness/Education

Available resources for family planning and community education. – Social Services Provider

Parents may be young and may not see health as a priority. – Social Services Provider





MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. ...People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Daily Recommendation of Fruits/Vegetables

A total of 25.7% of Metro Area adults report eating five or more servings of fruits and/or vegetables per day.

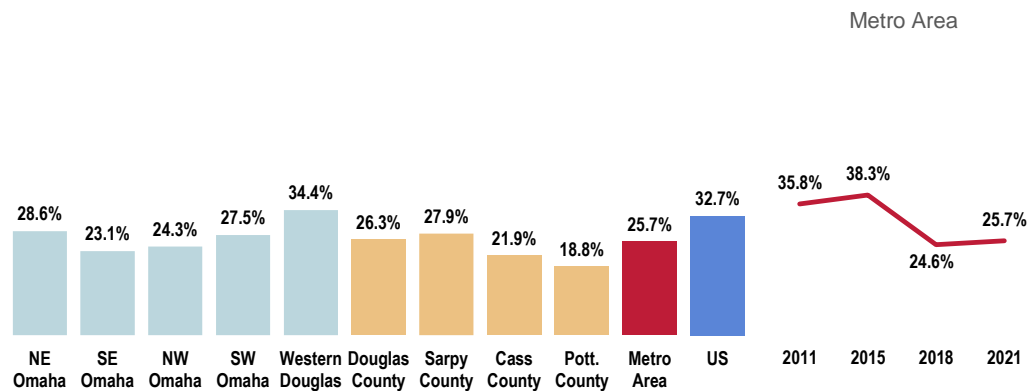
BENCHMARK ▶ Lower than the US prevalence.

TREND ▶ A significant decrease from 2011 and 2015 survey findings.

DISPARITY ▶ Lowest in Pottawattamie County. Reported less often among men, adults age 40 and older, and those at the lowest income level.

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

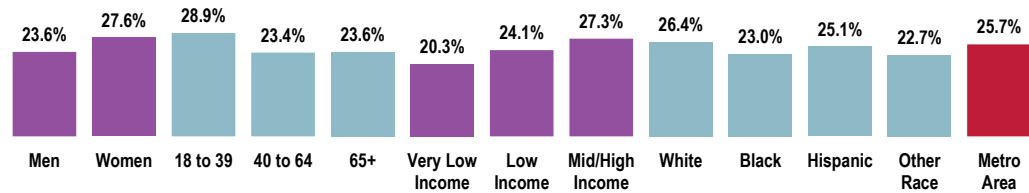
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • For this issue, respondents were asked to recall their food intake on the previous day.



Consume Five or More Servings of Fruits/Vegetables Per Day (Metro Area, 2021)

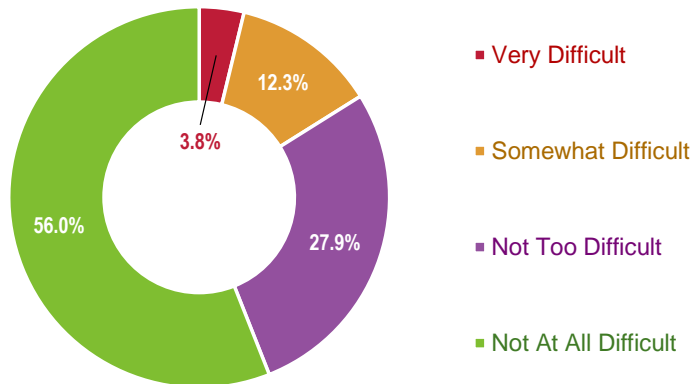


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
 Notes: • Asked of all respondents.
 • For this issue, respondents were asked to recall their food intake on the previous day.

Difficulty Accessing Fresh Produce

Most Metro Area adults report little or no difficulty buying fresh produce at a price they can afford.

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



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
 Notes: • Asked of all respondents.

Respondents were asked: "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

RELATED ISSUE
 See also *Food Access* in the **Social Determinants of Health** section of this report.



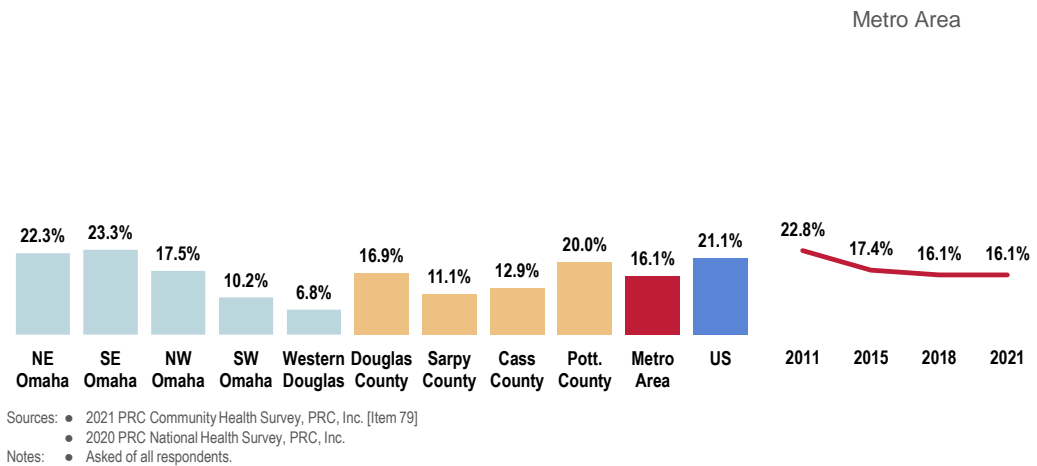
However, 16.1% of Metro Area adults find it “very” or “somewhat” difficult to access affordable fresh fruits and vegetables.

BENCHMARK ▶ Better than the national prevalence.

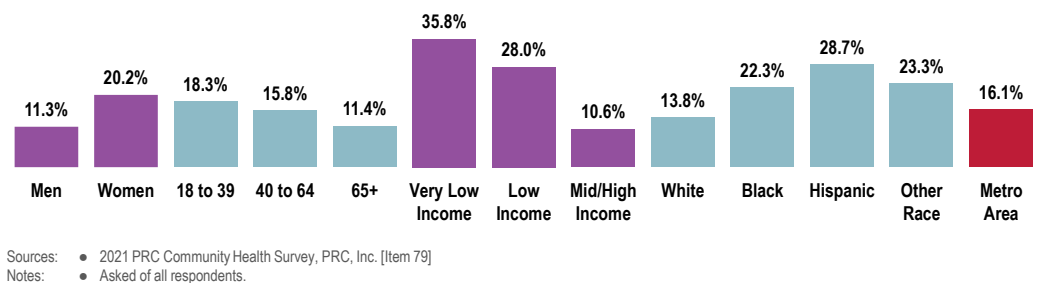
TREND ▶ A significant decrease from 2011 findings but similar to more recent survey administrations.

DISPARITY ▶ In Douglas County, higher in eastern Omaha. By county, the percentage is higher in Douglas and Pottawattamie counties. Decreases with age and income and reported more often among women and in communities of color.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce



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



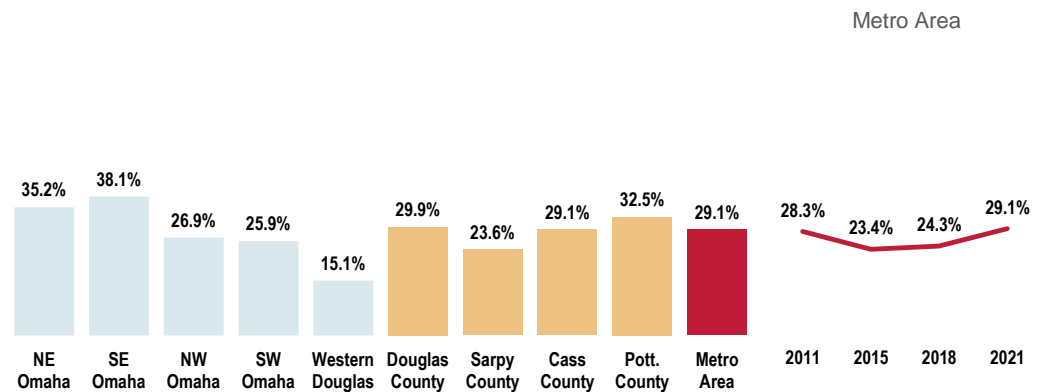
Sugar-Sweetened Beverages

A total of 29.1% of Metro Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

TREND ► Similar to 2011 baseline survey findings but increasing from 2015 and 2018 results.

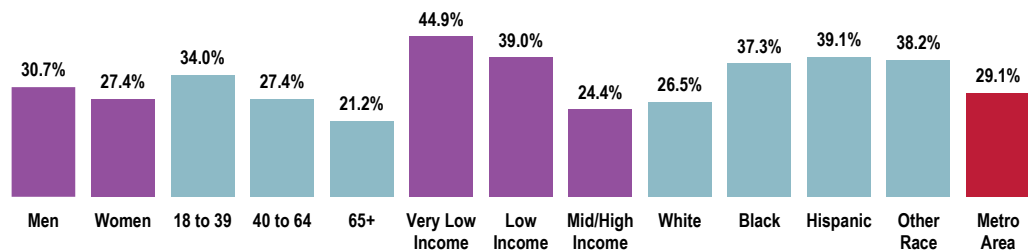
DISPARITY ► In Douglas County, considerably higher in the eastern Omaha region. Viewed by county, the prevalence is lowest in Sarpy County. Decreases with age and income and is reported more often among communities of color.

Had Seven or More Sugar-Sweetened Beverages in the Past Week



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 348]
 Notes: • Asked of all respondents.

Had Seven or More Sugar-Sweetened Beverages in the Past Week (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 348]
 Notes: • Asked of all respondents.



PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

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

Leisure-Time Physical Activity

A total of 32.1% of Metro Area adults report no leisure-time physical activity in the past month.

BENCHMARK ▶ Higher than both state percentages.

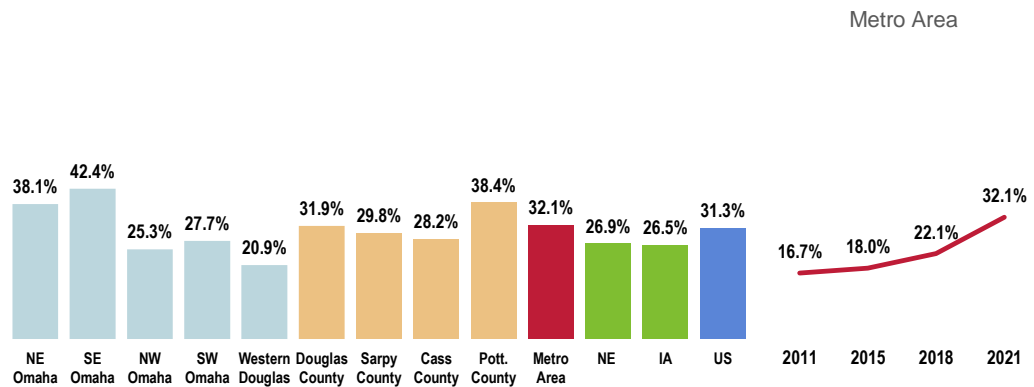
TREND ▶ Denotes a statistically significant increase.

DISPARITY ▶ In Douglas County, highest in eastern Omaha. By county, the percentage is highest among Pottawattamie County respondents.

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 82]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.



Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

A total of 22.1% of Metro Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

BENCHMARK ▶ Above the low prevalence.

DISPARITY ▶ In Douglas County, the prevalence is lowest in Northeast Omaha. By county, the prevalence is dramatically lower in Pottawattamie County. Decreases with age and reported less often among adults in the lower income breakouts, as well as among Other Race respondents.

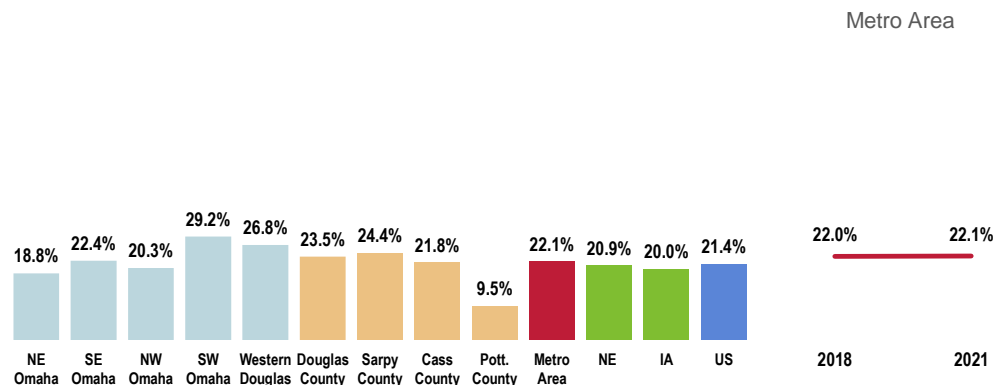
“Meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activities:

Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations

Healthy People 2030 = 28.4% or Higher

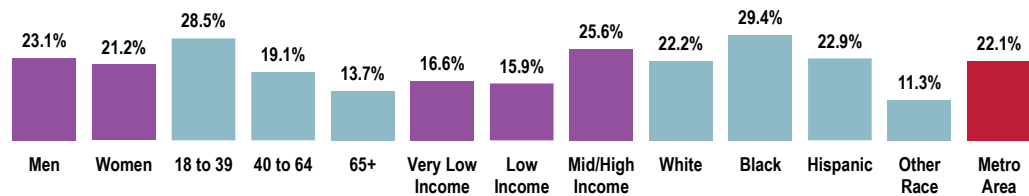


- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2019 Nebraska and Iowa data.
 - 2020 PRC National Health Survey, PRC, Inc.
 - US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
- Notes:
- Asked of all respondents.
 - Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.



Meets Physical Activity Recommendations (Metro Area, 2021)

Healthy People 2030 = 28.4% or Higher



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 126]

• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.

• Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

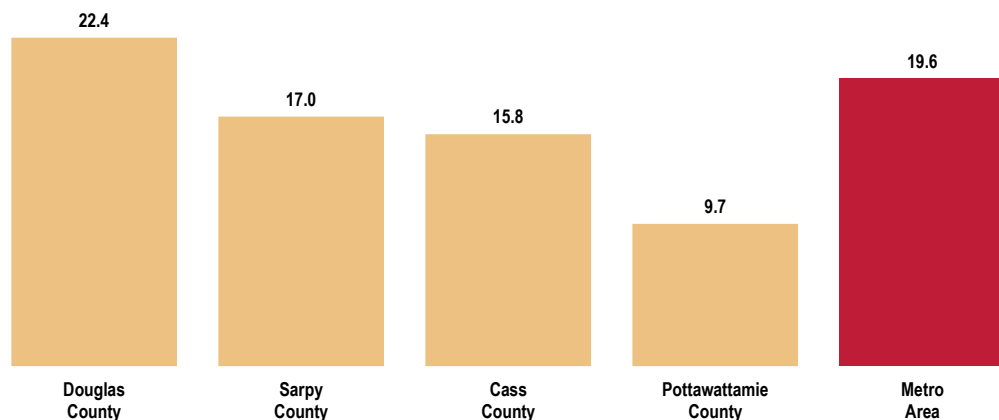
Built Environment

Recreation & Fitness Facilities

In 2018, there were 19.6 recreation/fitness facilities for every 100,000 population in the Metro Area.

BENCHMARK ► The ratio is lowest in Pottawattamie County.

Population With Recreation & Fitness Facility Access (Number of Recreation & Fitness Facilities per 100,000 Population, 2018)



Sources: • US Census Bureau, County Business Patterns. Additional data analysis by CARES.

• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes: • Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."* Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.



Neighborhood Barriers

Survey respondents were next asked about the presence of five neighborhood factors that potentially prevent people from exercising, including lack of sidewalks or sidewalks in poor condition; heavy traffic; lack of trails or trails in poor condition; crime; and lack of streetlights or nonworking streetlights.

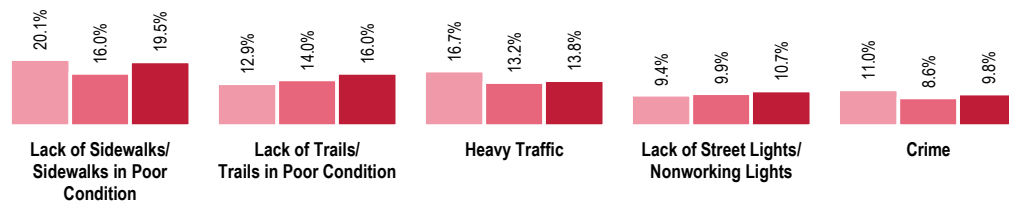
In terms of the presence of these neighborhood barriers, a lack of sidewalks/poor sidewalks received the largest share of responses among survey respondents (mentioned by 19.5%), followed by a lack of trails or poor quality trails (16.0%), heavy neighborhood traffic (13.8%), a lack of street lights or poor quality street lights (10.7%), and crime (9.8%).

TREND ► Over time, respondent perceptions of these barriers have remained fairly stable, with the exception of **traffic** (improved) and **trails** (worsened).

DISPARITY ► Residents of Sarpy County were less likely to mention these potential barriers to outdoor physical activity. Adults in eastern Omaha were far more likely to report these potential barriers.

Presence of Neighborhood Barriers That Prevent Physical Activity (Metro Area)

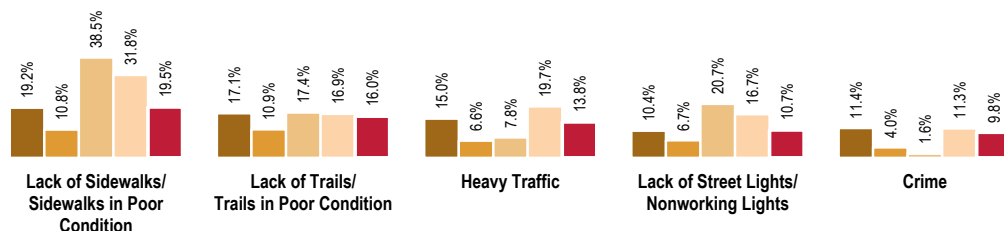
■ 2015 ■ 2018 ■ 2021



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 326-330]
Notes: ● Asked of all respondents.

Presence of Neighborhood Barriers That Prevent Physical Activity (By County; Metro Area, 2021)

■ Douglas Co. ■ Sarpy Co. ■ Cass Co. ■ Pott. Co. ■ Metro Area

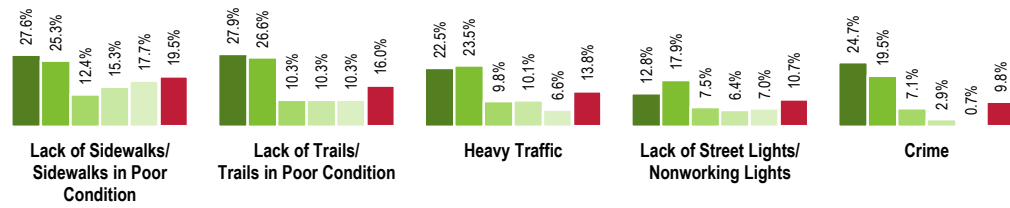


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 326-330]
Notes: ● Asked of all respondents.



Presence of Neighborhood Barriers That Prevent Physical Activity (By Douglas County Subareas; Metro Area, 2021)

■ NE Omaha ■ SE Omaha ■ NW Omaha ■ SW Omaha ■ Western Douglas ■ Metro Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 326-330]
Notes: ● Asked of all respondents.



WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

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

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI $\geq 30 kg/m^2$. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2 . The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI $\geq 30 kg/m^2$, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2 .

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥ 30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.



Overweight Status

More than 7 in 10 Metro Area adults (71.9%) are **overweight**.

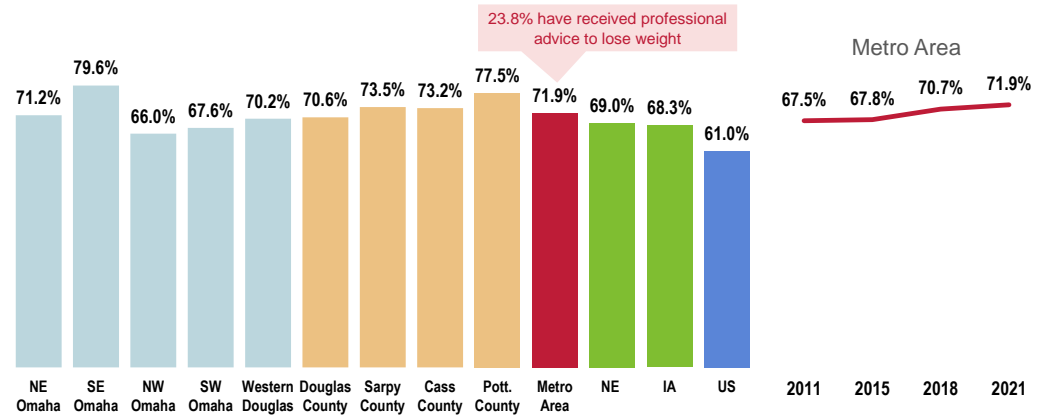
BENCHMARK ▶ Worse than state and national percentages.

TREND ▶ Increasing significantly from 2011 and 2015 survey findings.

DISPARITY ▶ In Douglas County, highest in the Southeast Omaha area. By county, the prevalence is highest in Pottawattamie County.

Here, "overweight" includes those respondents with a BMI value ≥ 25 .

Prevalence of Total Overweight (Overweight and Obese)



- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 128, 325]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

The overweight prevalence above includes 38.8% of Metro Area adults who are **obese**.

BENCHMARK ▶ Well above the state and national percentages. Fails to satisfy the Healthy People 2030 objective.

TREND ▶ Increasing significantly from previous survey findings.

DISPARITY ▶ Highest in Southeast Omaha and Pottawattamie County. Reported more often among adults age 40 to 64, those at the lowest income level, Blacks, and Hispanics.

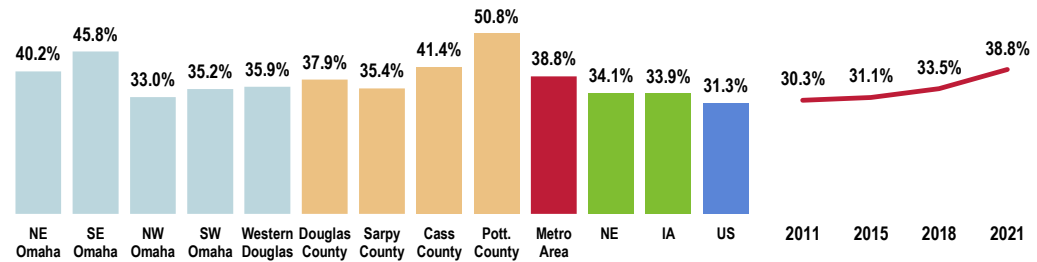
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥ 30 .



Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower

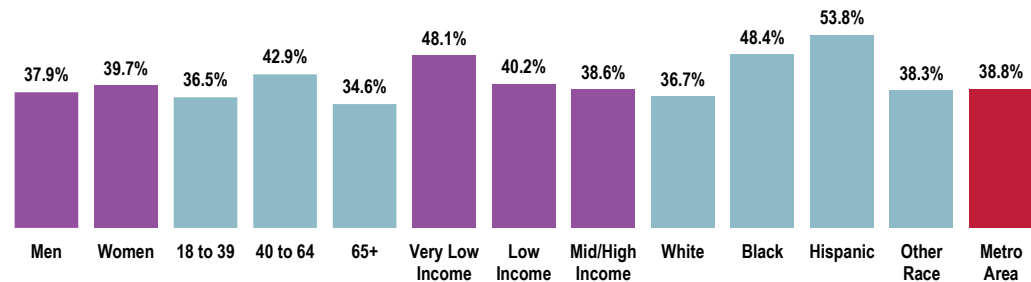
Metro Area



- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 130]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 - 2020 PRC National Health Survey, PRC, Inc.
 - US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity (Metro Area, 2021)

Healthy People 2030 = 36.0% or Lower



- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 130]
 - US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

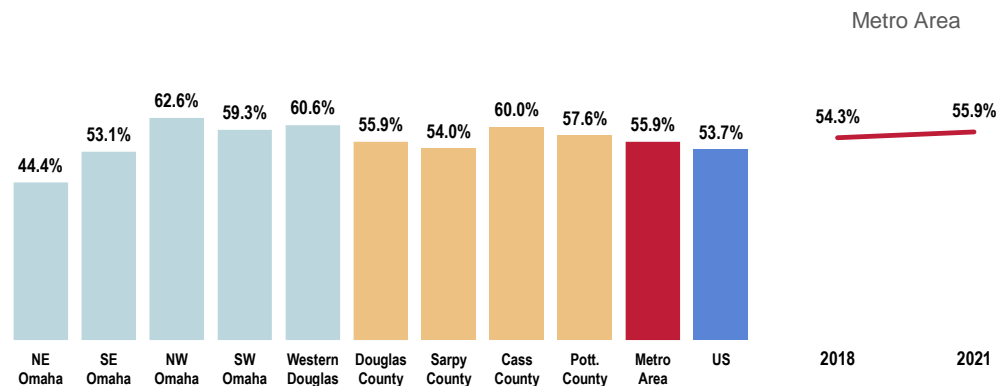


Weight-loss Efforts

Over half (55.9%) of overweight/obese respondents are currently trying to lose weight.

DISPARITY ► Lowest among overweight/obese adults in Northeast Omaha.

Trying to Lose Weight (Among Overweight or Obese Respondents)



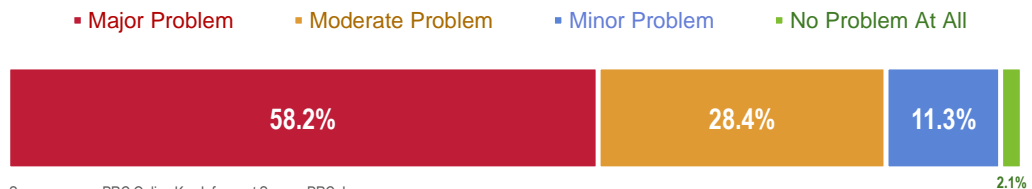
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 349]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Based on reported heights and weights, asked of all respondents.
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a “major problem” in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community (Key Informants, 2021)



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

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

Contributing Factors

- Obesity and balanced meals. Food choices. Lack of mobility. – Other Health Provider
- High levels of obesity. The poor have limited access to healthier foods. Winter with the gyms closed for COVID made physical activity a challenge for all, especially the poor. – Other Health Provider



Undereducated, depressed, poor socioeconomic situations. – Other Health Provider

Obesity and poor nutrition contributing to the development of other health and medical disorders. Challenge, how can we motivate individuals to get more exercise and to eat more healthy foods. – Other Health Provider

Obesity and the chronic diseases that can result. HTN, DM, chronic pain, osteoarthritis. – Physician

Obesity continues to rise and be one of the major contributors to severe health related issues such as diabetes. This is especially true for individuals and families living in poverty that consistently have higher rates of obesity due to lack of access to healthy foods, nutrition education, and healthy cooking skills. – Social Services Provider

Lots of obese and overweight. With the pandemic, few resources or programs for kids. Need to have more options for low income kids and adults. Would love to see more Tai Chi available for elderly again, walking programs – all these have seemed to have disappeared with COVID – Physician

Obesity economic disparities with associated lack of access to healthy foods. Lack of exercise and healthy lifestyles. – Physician

Level of depression and past trauma. Food deserts in some areas of town. – Social Services Provider

This is no longer a sexy or politically correct health issue, but it a major factor in overall risk to other chronic diseases and adult obesity continues to rise each survey period. – Other Health Provider

Culture. – Other Health Provider

Culture, education, access to fresh whole foods. – Other Health Provider

Difficult to compete with electronic entertainment. More trails and pedestrian facilities might make it easier for people to begin walking and getting out of the house. – Community Leader

As both a pediatrician and internist I see that obesity is a health crisis across all ages and disproportionately affects our lower income households. Be that a lack of appropriate nutrition—access to affordable fresh fruits and vegetables, food deserts, education on nutritious food choices; and ability to access or time to participate in exercise. – Physician

Obesity Crisis

Obesity crisis. – Other Health Provider

Overweight population. – Business Leader

Obesity keeps rising. – Public Health Representative

Obesity rates are high in Nebraska and levels of PA and healthy diet are low. – Social Services Provider

Alarming rates of obesity. – Physician

The prevalence of overweight, obesity is high in the county. – Public Health Representative

Too many obese people and not enough exercise. – Physician

Nutrition & Physical Activity

Lack of a culture of exercise and healthy eating in Omaha and surrounding area. Obesity in the poor and especially in children is a growing and significant problem. – Physician

Money for good food, transportation to get to gym. The cyclical issues surrounding families and how their children are raised. – Other Health Provider

Lack of access to healthy foods and lack of support to help people who may be new to the folks. Learn how to cook with them in ways that feel culturally relevant. – Social Services Provider

Generally, children and adults don't seem to get the nutrition or physical activity that is important. Everything is supersized. – Social Services Provider

Lack of good nutrition and activity leads to the other diseases on this survey. – Social Services Provider

As mentioned previously, our culture does not lend itself to healthy nutrition and physical activity. And for people with low incomes it is even more difficult as even if they want fresh fruits and veggies they do not always have access. However, I served a healthy lunch at a meeting one day a couple years ago and a few people left and went to McDonald's instead of eating my free food. And my kids get donuts every Saturday, just like their dad did for them when they were growing up. I'm not telling this group anything you don't know already. Making the healthy choice the easy choice is great—how can we continue to promote that? This is a way bigger problem though. – Other Health Provider

Access to affordable healthy food and education. – Business Leader

Food deserts. Community centers that offer physical activity. – Community Leader

Unequal access to healthy food on a consistent basis, addressing weight gain and the negative impacts of physical inactivity doesn't seem to be working on a broad level. – Community Leader

Access to inexpensive, nutritious food and access to quality K-12 physical education. – Other Health Provider

Cost to eat healthy, lack of education, fast food is cheap and leads to weight gain, lack of resources to help. – Other Health Provider



Awareness/Education

At one point for our medical home we had access to a registered dietician. This service fell off, in my opinion, from being overwhelmed by obesity patients (as opposed to diabetics or heart patients). Big challenges include the weather here, the perceived lack of access to gyms (which is not true, the YMCA does an excellent job as well as the silver sneakers program), and general apathy about physical activity being worth it. I have noticed however, the last year people have become much more attuned to being outside and being active. – Physician

Lack of good quality weight loss programs. Lots of expensive fad programs. Lack of affordability for formal programs in lower income families. Lack of motivation. – Physician

Not enough focus on prevention. – Other Health Provider

Primary care does not provide enough resources. – Physician

Programs willing to help the indigent. – Physician

Lack of affordable resources and unsafe neighborhoods. – Community Leader

There are not many facilities that are affordable for community to utilize to exercise besides outdoor parks. There are no healthy restaurants in Cass county and healthy, clean eating is considered dieting and stigmatized. – Social Services Provider

We do not have a large number of resources to send people to in order to get this education. – Social Services Provider

Lack of awareness about how and where to seek services, whether insurance covers costs. – Social Services Provider

Not enough emphasis, education. Not recognized as the crisis it is. – Other Health Provider

Lack of education about the health consequences of poor decisions. – Physician

Education and willingness to change one's lifestyle choices. – Physician

Built Environment

The built environment is typically inadequate for physical activity. Poor access to quality produce and other healthy food options in grocery stores, restaurants. – Physician

Certain communities live in food swamps and have limited access to parks. – Physician

Single occupancy car-centric culture, poor and inadequate infrastructure to include walking and biking in daily life. Lack of information and understanding about nutrition and its impact on health. – Community Leader

Access and safe areas to bike or walk. – Other Health Provider

Lack of easy access to outdoor exercise facilities in certain neighborhood including sidewalk, trails, and parks in low-income communities. – Public Health Representative

The city area is not designed for us to move naturally throughout the day and food apartheid exists in east Omaha. – Other Health Provider

Lifestyle

Society lifestyle. The food we eat and lack of exercise. – Community Leader

Personal decisions. – Physician

Work life balance. Money to buy quality food. – Social Services Provider

Management of time, uncooperative weather, psychological challenges. – Social Services Provider

Individuals over schedule their lives and run from one activity to the next. Relying on fast food and nights crashed on the couch. – Social Services Provider

Busy lifestyle on the go and fast food is easy. – Other Health Provider

Nutrition

Food access in poorer neighborhoods is difficult, costly, without a welcoming clean grocery. Safety concerns in north Omaha. – Social Services Provider

Poor choices regarding diet, lack of knowledge regarding health eating, access to healthy food. COVID isolated many people including children this year with being at home and on zoom for school and work, leads to sedentary lifestyle. – Other Health Provider

Food insecurity. – Other Health Provider

Comorbidities

Contributes to co-morbid conditions like diabetes, hypertension, and stroke. – Other Health Provider

Vulnerable Populations

This specifically effects the communities of color where there is little access to safe trails, parks, biking and so on. – Social Services Provider



SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. ...Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2017 and 2019, the Metro Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 11.5 deaths per 100,000 population.

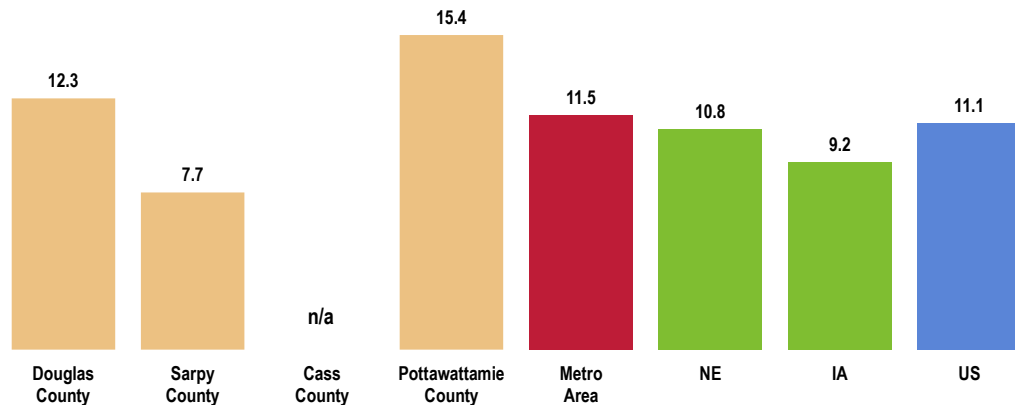
BENCHMARK ▶ Worse than the Iowa mortality rate.

TREND ▶ Increasing in recent years, echoing the Nebraska trend.

DISPARITY ▶ Unfavorably high in Pottawattamie County. Higher among Blacks than Whites in the Metro Area.

Cirrhosis/Liver Disease: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower

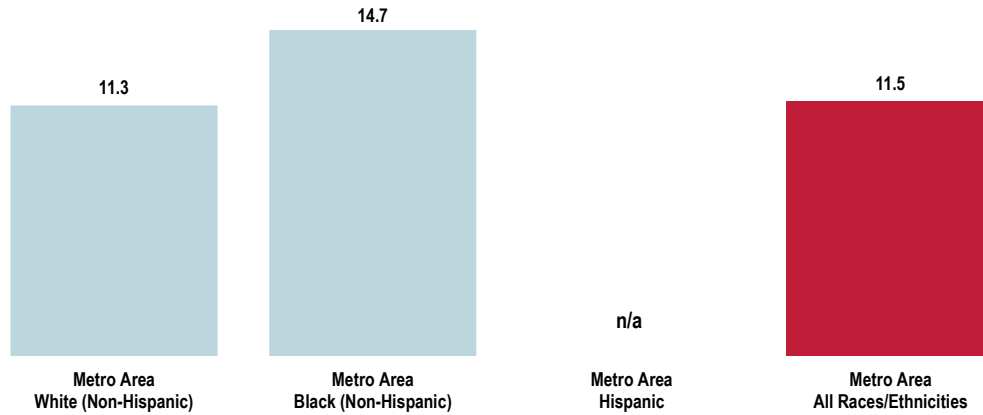


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>



Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race (2017-2019 Annual Average Deaths per 100,000 Population)

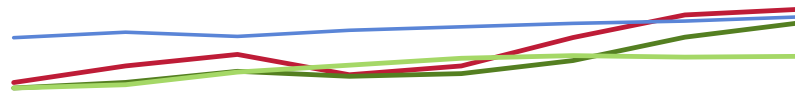
Healthy People 2030 = 10.9 or Lower



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

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Metro Area	7.9	8.7	9.3	8.3	8.7	10.1	11.2	11.5
NE	7.7	7.9	8.5	8.2	8.4	9.0	10.1	10.8
IA	7.7	7.8	8.4	8.8	9.1	9.2	9.2	9.2
US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

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



Alcohol Use

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

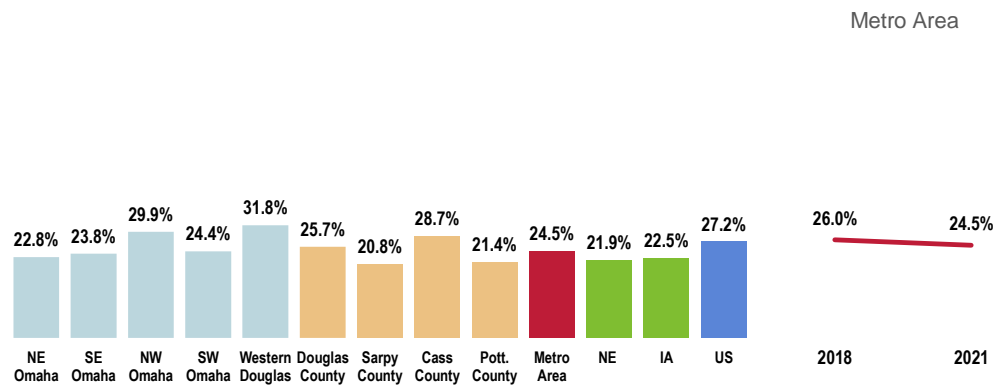
- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

A total of 24.5% of area adults are excessive drinkers (heavy and/or binge drinkers).

BENCHMARK ► Worse than both state percentages.

DISPARITY ► Unfavorably high in Douglas and especially Cass counties. Reported more often among men, young adults, those at the highest income level, and Whites.

Excessive Drinkers



Sources:

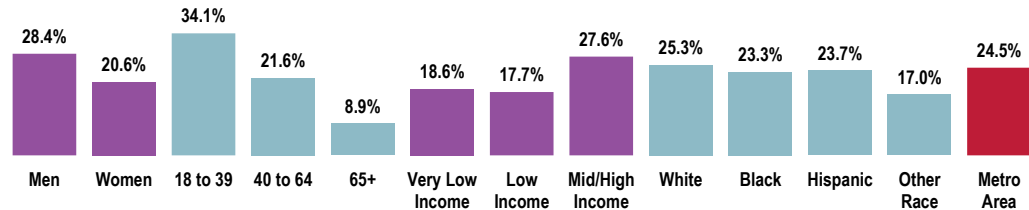
- 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Nebraska and Iowa data.

Notes:

- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.



Excessive Drinkers (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
 Notes: • Asked of all respondents.
 • Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking & Driving

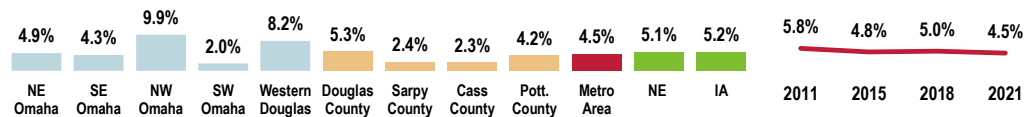
A total of 4.5% of Metro Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

TREND ► The percentage has decreased significantly from 2011 survey results.

DISPARITY ► By county, unfavorably high in Douglas County, with responses concentrated in Northwest Omaha.

Have Driven in the Past Month After Perhaps Having Too Much to Drink

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 310]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Nebraska and Iowa data.
 Notes: • Asked of all respondents.



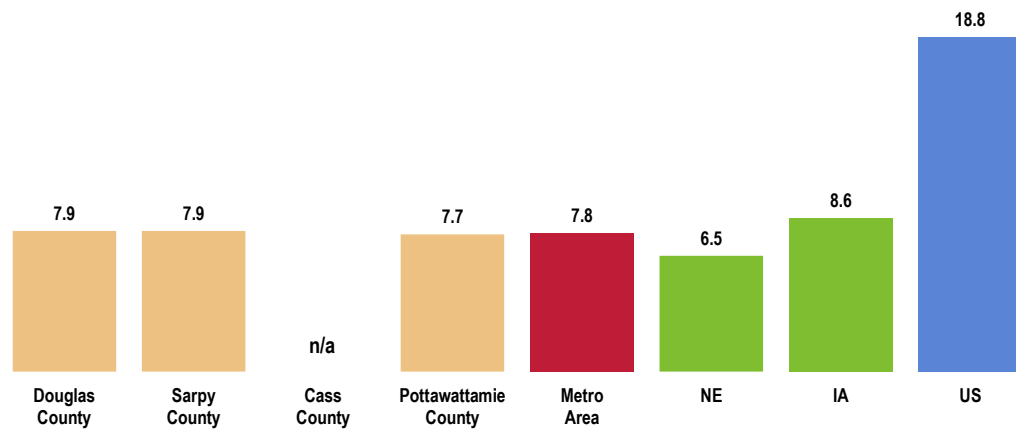
Age-Adjusted Unintentional Drug-Related Deaths

Between 2017 and 2019, there was an annual average age-adjusted unintentional drug-related mortality rate of 7.8 deaths per 100,000 population in the Metro Area.

BENCHMARK ▶ Higher than the Nebraska mortality rate but well below the US rate.

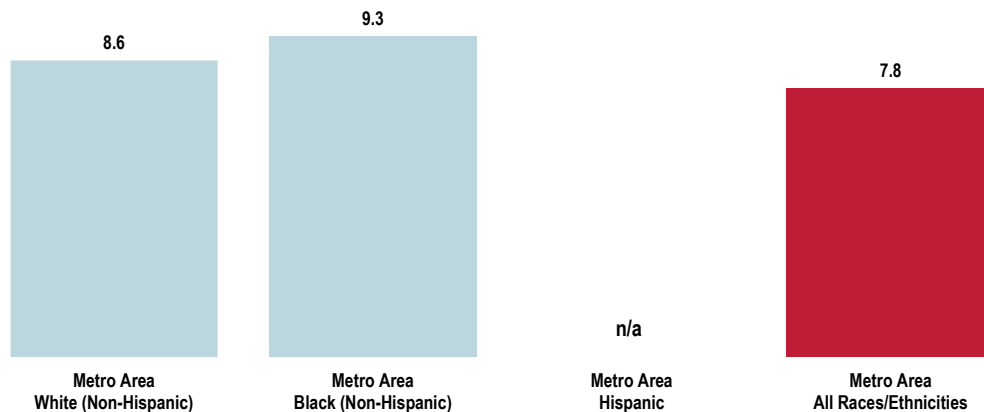
DISPARITY ▶ Slightly higher among Blacks than Whites in the Metro Area.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



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

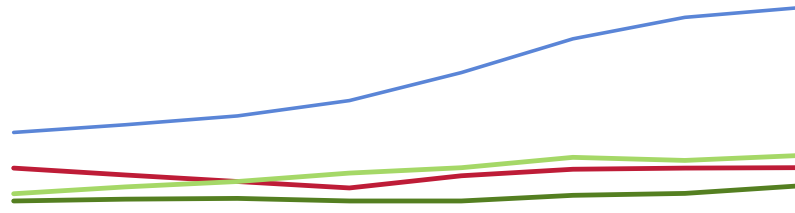
Unintentional Drug-Related Deaths:
Age-Adjusted Mortality by Race
(2017-2019 Annual Average Deaths per 100,000 Population)



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



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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Metro Area	7.7	7.3	6.8	6.4	7.2	7.7	7.7	7.8
NE	5.5	5.6	5.6	5.5	5.5	5.9	6.0	6.5
IA	6.0	6.4	6.8	7.4	7.8	8.5	8.3	8.6
US	10.2	10.7	11.3	12.4	14.3	16.7	18.1	18.8

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

Use of Prescription Opioids

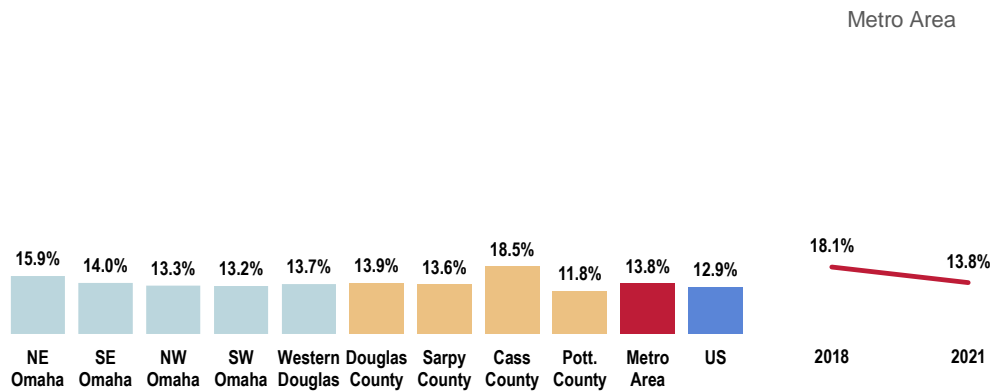
A total of 13.8% of respondents in the Metro Area report using a prescription opioid drug in the past year.

TREND ► Decreasing significantly since first asked in 2018.

DISPARITY ► Reported more often among adults age 40 to 64 and those at lower income levels.

Used a Prescription Opioid in the Past Year

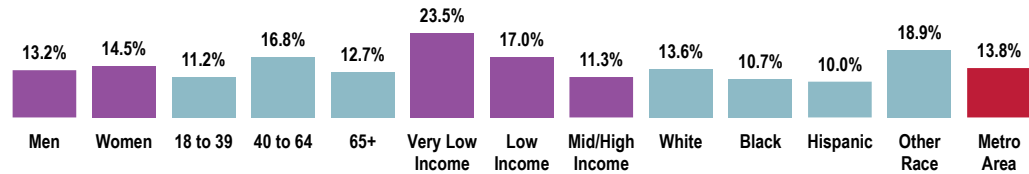
Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.



Used a Prescription Opioid in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Alcohol & Drug Treatment

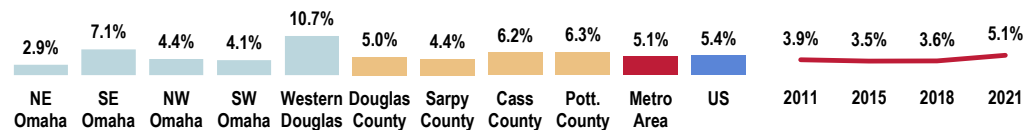
A total of 5.1% of Metro Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

TREND ► Increasing significantly from earlier survey results.

DISPARITY ► In Douglas County, highest in Western Douglas County.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Metro Area



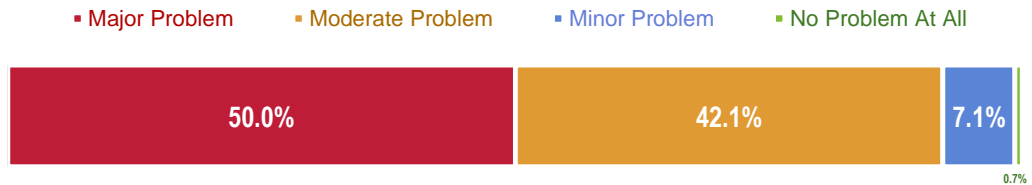
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 51]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.



Key Informant Input: Substance Abuse

Half of key informants taking part in an online survey characterized *Substance Abuse* as a “major problem” in the community.

Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2021)



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

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

Access to Care/Services

There is a lack of treatment facilities and little to no permanent supportive housing upon exit from the treatment programs. Without support of housing, medication and counseling, individuals experience cycles of abuse and other high-risk situations among living on the streets, family violence, or residence within emergency shelters. – Other Health Provider

Need for more nurse navigators and follow-up as well as PEC nurses. – Other Health Provider

Limited options for care, limited options for medication assisted treatment, limited Medicaid payment for medication assisted treatment. – Physician

We don't have enough options for CD evaluations in order to get them timely. – Social Services Provider

Additional facilities and need additional reimbursement to create options. – Business Leader

Treatment in the community options. – Other Health Provider

Easily accessible treatment and care at the time someone seeks services. Wait lists are an ineffective management tool. Inability to address root causes of SA use due to lack of available mental health resources. – Other Health Provider

Access to programming, location, costs, availability. Education is a close second. – Other Health Provider

Little to no treatment programs in this area. All private pay and lack of insurance coverage. – Other Health Provider

Lack of programs. – Community Leader

A timely access and appropriate levels of care. – Other Health Provider

Lack of resources. – Community Leader

Access to providers and lack of insurance coverage. – Public Health Representative

Lack of space for initial evaluation and subsequent treatment recommendations and lack of a payment source to cover the cost of treatment. – Community Leader

Lack of programs to address families. – Social Services Provider

Lack of substance abuse programs in the community. We need inpatient programs. – Social Services Provider

There is a need for more treatment centers and a need for affordable services. – Other Health Provider

Lack of services and addictive behavior which is hard to change. – Community Leader

Lack of treatment facilities require waitlists. Also, facilities have different criteria for admission making it difficult to navigate. There is often a small window of opportunity to assist a person with substance abuse/addictions and the complexity to access services is a huge barrier. – Other Health Provider

Lack of programs. Lack of affordability. Stigma. – Physician

There are no Narcotics Anonymous meetings in the community, there are no treatment facilities in the area. Those suffering from addiction issues are made to go out of Cass County for treatment and when they return they are no supporting services to help them to stay on track. – Social Services Provider

Insurance. – Other Health Provider



Not enough treatment programs and too long wait to get in. – Physician
Limited resources and access to treatment. – Other Health Provider
Access and costs. – Other Health Provider
Not enough inpatient detox and treatment beds, not nearly enough. Rehab is either very expensive, or a long waiting list. Also, need people to want treatment. – Other Health Provider
Not enough treatment programs. – Other Health Provider
This ties directly to the lack of psychiatric services. The lack of inpatient treatment is a barrier. Although, it seems that in or outpatient, addicts have about a 50 percent chance of relapsing. – Physician
Few residential substance abuse treatment centers. Large amount of use and abuse in the community. – Social Services Provider

Contributing Factors

Lack of culturally competent mental health providers. Lack of education of diverse community members, pastors, teachers and so on to recognize the symptoms and know where to send people. – Social Services Provider
Funding. – Physician
Access to care—not enough providers and programs available. Reimbursement for services is not great, leading to a lack of services available. Also, there continues to be a major meth problem in this community, leading to increased crime, child abuse, etc. Alcohol use is also a problem. Opioid use is on the rise here recently as well. – Other Health Provider
Peer and family to support for substance abuser. – Business Leader
COVID results are increased alcohol and drug use. The community lacks high quality inpatient, group treatment. – Social Services Provider
Health literacy and access to support services to address root causes of SUD and other chronic conditions. – Other Health Provider
The legal system. – Social Services Provider
Access to CD evaluations, willingness, often times its their lifestyle that they don't want to give up. When they do make it to treatment and they get out, they go right back to the environment that they drank and did drugs. Need to change places and playmates but that is difficult to do in the poor and underserved communities. – Other Health Provider
Stigma, funding, inadequate inpatient treatment capacity. – Other Health Provider

Affordable Care/Services

Quality services are not financially accessible. – Social Services Provider
Cost, waitlist, effectiveness, access co-occurring capable. – Social Services Provider
Cost and access to detox. – Other Health Provider
Evaluation and treatment cost. Need to keep working to support family, can't leave for an inpatient program, undiagnosed mental health needs, impact of COVID 19. – Social Services Provider
Counseling at a reasonable cost. – Physician

Denial/Stigma

The stigma and lack of resources similar to mental health. – Business Leader
Stigma and insurance. – Physician
Acceptance that we have a problem, be it prescription drug misuse or illegal drug activity. – Community Leader
Stigma that it's not an issue and peer pressure at all ages to drink especially. – Social Services Provider

Lack of Providers

Lack of providers and agencies, especially community-based residential/inpatient and IOP. Sometimes access to obtaining a substance use evaluation can be an issue as well, and providers frequently book out many weeks or longer in advance. I'd say that inconsistencies in how to access treatment across agencies can be a barrier, too. – Other Health Provider
Low number of providers in the community. – Business Leader
Lack of providers, no inpatient services. – Other Health Provider

Income/Poverty

Finances, available treatment facilities in our community. – Social Services Provider
Financial resources. – Community Leader
Capacity and financial barriers. – Other Health Provider



Prevalence/Incidence

It seems to me that amount of alcohol is increasing. Anecdote: One friend in her 20s said that her co-workers go out at least 5 nights/ week and consume large amounts of alcohol. I can only imagine what the imagine what the impact of that kind of habit will be on health if that continues for years. While I drink, I try to keep it in check, but I know that for not a few people drinking becomes alcoholism. I don't know how you shift the culture to discourage binge drinking and encourage moderate responsible drinking, but that should be the goal. – Community Leader

Vulnerable Populations

Tracking homeless people who required substance abuse treatment after discharge from hospital. – Other Health Provider

Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **alcohol** as causing the most problems in the community, followed distantly by **methamphetamine/other amphetamines**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a “Major Problem”)

Alcohol	71.0%
Methamphetamines or Other Amphetamines	19.4%
Marijuana	4.8%
Prescription Medications	3.2%
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	1.6%



TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

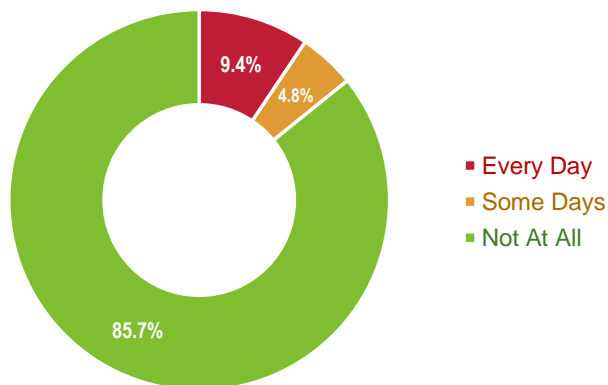
– Healthy People 2030 (<https://health.gov/healthypeople>)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 14.2% of Metro Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).

Cigarette Smoking Prevalence
(Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: • Asked of all respondents.



Note the following findings related to cigarette smoking prevalence in the Metro Area.

BENCHMARK ▶ The prevalence is well below the Iowa and US percentages. Fails to satisfy the Healthy People 2030 objective.

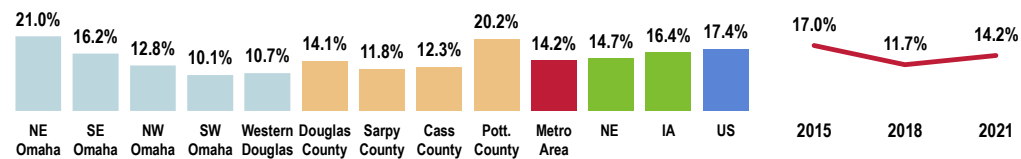
TREND ▶ Decreasing from 2015 findings (but an increase since 2018).

DISPARITY ▶ In Douglas County, highest in the Northeast Omaha area. By county, smoking is most prevalent in Pottawattamie County. Reported more often among adults under 65, those living on very low incomes, and Black residents.

Current Smokers

Healthy People 2030 = 5.0% or Lower

Metro Area



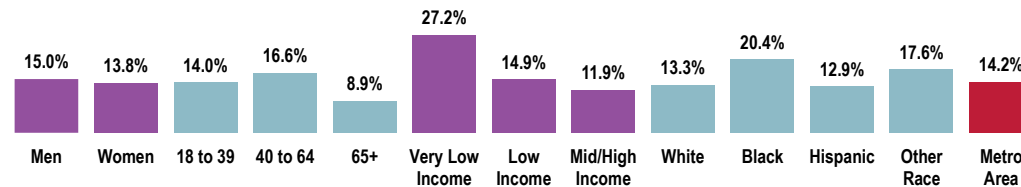
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.
 • Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers

(Metro Area, 2021)

Healthy People 2030 = 5.0% or Lower



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.
 • Includes regular and occasion smokers (every day and some days).



Environmental Tobacco Smoke

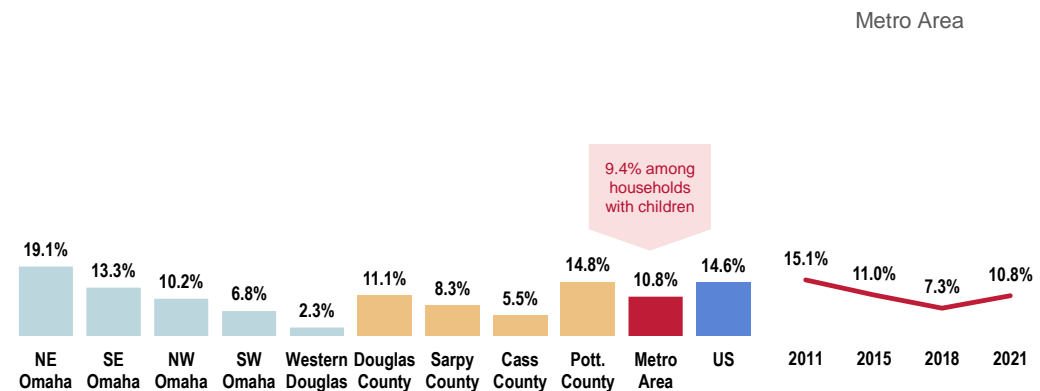
Among all surveyed households in the Metro Area, 10.8% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

BENCHMARK ▶ Lower than the national prevalence.

TREND ▶ Decreasing since 2011 (but increasing from 2018 findings).

DISPARITY ▶ In Douglas County, reported more often in Northeast Omaha. By county, the percentage is highest in Pottawattamie County.

Member of Household Smokes at Home



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

Less than half of regular smokers (47.1%) went without smoking for one day or longer in the past year because they were trying to quit smoking.

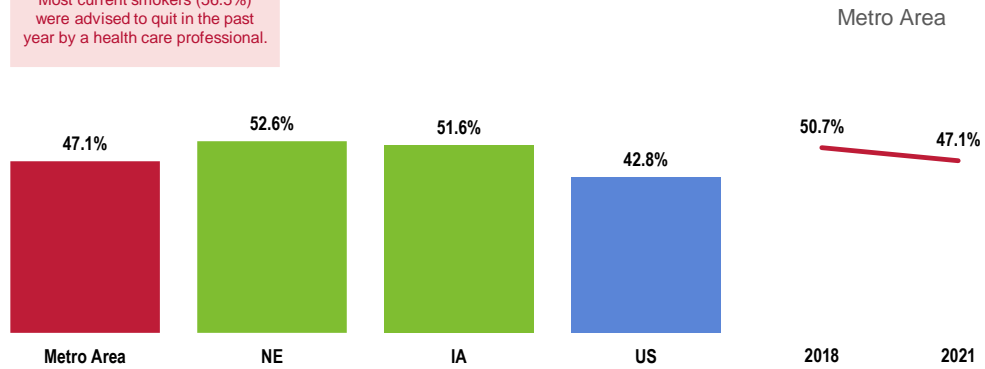
BENCHMARK ▶ Far from satisfying the Healthy People 2030 objective.



Have Stopped Smoking for One Day or Longer in the Past Year (Everyday Smokers)

Healthy People 2030 = 65.7% or Higher

Most current smokers (56.5%) were advised to quit in the past year by a health care professional.



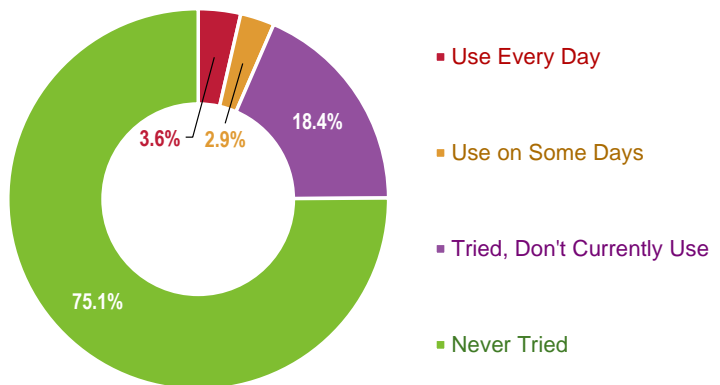
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 41-42]
 • 2020 PRC National Health Survey, PRC, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Nebraska and Iowa data.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of respondents who smoke cigarettes every day.

Use of Vaping Products

Most Metro Area adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.

Use of Vaping Products (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
 Notes: • Asked of all respondents.



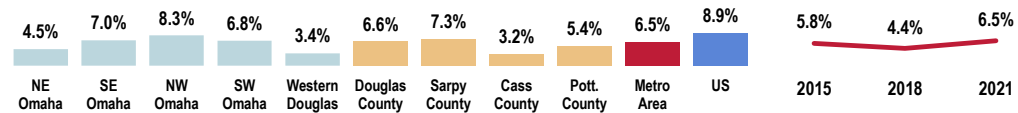
However, 6.5% currently use vaping products either regularly (every day) or occasionally (on some days).

BENCHMARK ▶ Lower than the national figure.

DISPARITY ▶ Lowest in Western Douglas County as well as in Cass County. Reported more often among young adults, those living on very low household incomes, and Whites.

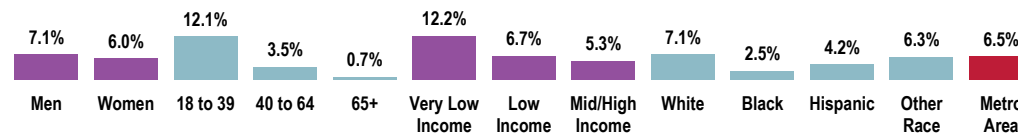
Currently Use Vaping Products (Every Day or on Some Days)

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Currently Use Vaping Products (Metro Area, 2021)

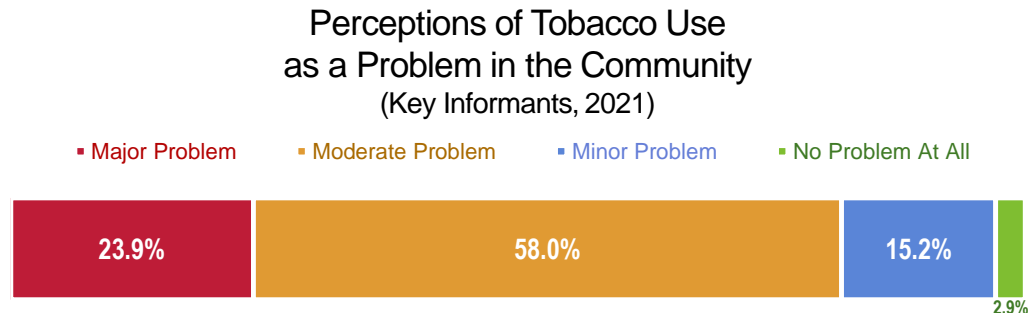


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
 Notes: • Asked of all respondents.
 • Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).



Key Informant Input: Tobacco Use

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



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

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

Incidence/Prevalence

- Prevalence. – Social Services Provider
- Popularity of smoking, vaping, e-cigarettes. – Business Leader
- People are still dying of tobacco related disease. – Social Services Provider
- Still socially acceptable despite the validated health complications. – Other Health Provider Habit. – Other Health Provider
- Lots of people smoke. – Other Health Provider
- Too many people smoke. – Physician
- We have one of the highest prevalence of tobacco use in the US in reproductive age women. – Physician
- Many patients identify as using tobacco or vaping products. – Other Health Provider
- Tobacco use is large in our CHF and COPD populations. – Social Services Provider

Vaping

- The expansion of vaping into the market in addition to the wide availability of tobacco and vaping products. – Community Leader
- Vaping, easy access. – Community Leader
- I believe it is a major problem because adult and adolescent clients where I work attempt to sneak in vapes or some form of tobacco on a regular basis into programming. I also have a teenage son who informs me about all his peers that vape at school. – Social Services Provider

Co-Occurrences

- Because of its wide usage and its long-term influence on a person’s health. – Community Leader
- Leads to many health issues. – Physician
- Tobacco use is a problem in any community. It is addictive and causes many other health problems for the smoker as well as those exposed to secondhand smoke. – Social Services Provider
- Tobacco is a highly addictive drug and causes major health problems. – Community Leader

Vulnerable Populations

- Tobacco in many cases can be the gateway drug to addiction. Although smoking has decreased. It remains prevalent amongst the poor and underserved. – Other Health Provider
- Low income individuals, mental health problems that lead to addiction. – Physician
- It is available and addictive. – Social Services Provider



Teen/Young Adult Usage

Access to tobacco products by minors. – Social Services Provider

Early initiation into smoking. Poor uptake of current quit programs. – Social Services Provider

I believe tobacco use continues to be an issue, especially for young people. – Social Services Provider

Awareness/Education

Perhaps increased screen has brought awareness. – Other Health Provider



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>)

HIV

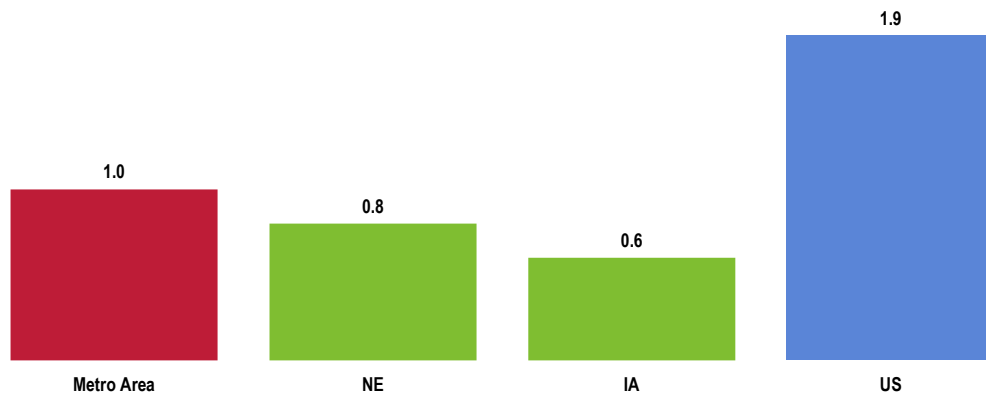
Age-Adjusted HIV/AIDS Deaths

Between 2010 and 2019, there was an annual average age-adjusted HIV/AIDS mortality rate of 1.0 deaths per 100,000 population in the Metro Area.

BENCHMARK ▶ Higher than both state mortality rates but lower than the US rate.

DISPARITY ▶ The mortality rate is over five times higher among Blacks than Whites in the Metro Area.

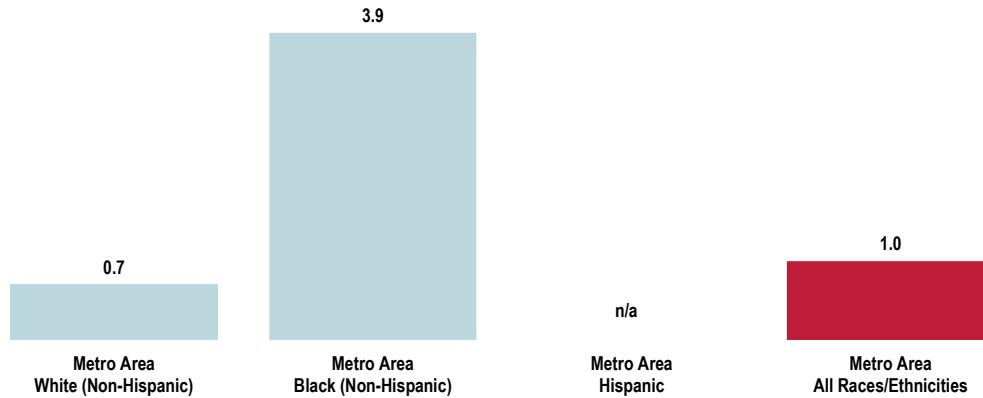
HIV/AIDS: Age-Adjusted Mortality
(2010-2019 Annual Average Deaths per 100,000 Population)



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



HIV/AIDS: Age-Adjusted Mortality by Race (2010-2019 Annual Average Deaths per 100,000 Population)



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

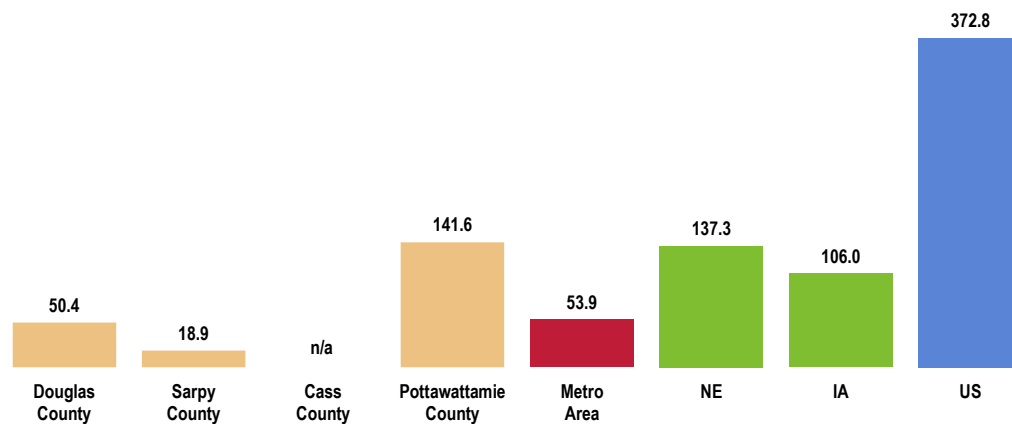
HIV Prevalence

In 2018, there was a prevalence of 53.9 HIV cases per 100,000 population in the Metro Area.

BENCHMARK ► Well below the state and US rates.

DISPARITY ► Within the Metro Area, highest by far in Pottawattamie County.

HIV Prevalence (Prevalence Rate of HIV per 100,000 Population, 2018)



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 February 2021 via SparkMap (sparkmap.org).
Notes: • This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.



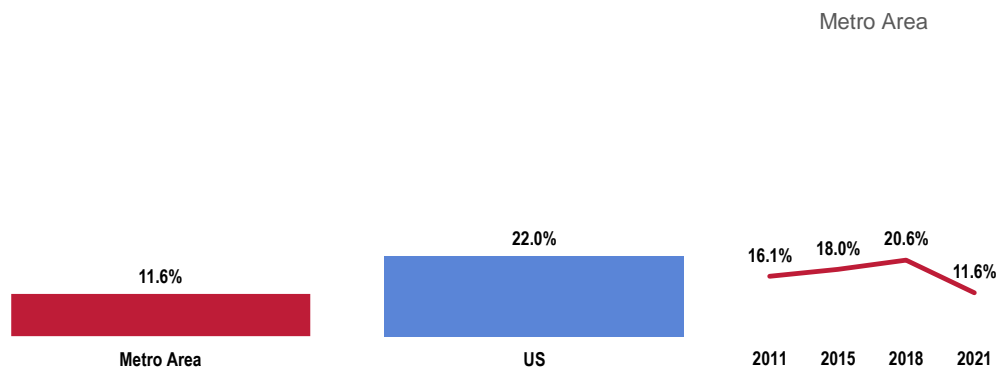
HIV Testing

Among Metro Area adults age 18-44, 11.6% report that they have been tested for HIV in the past year.

BENCHMARK ▶ Lower than the US prevalence.

DISPARITY ▶ Significantly lower than previous survey findings.

Tested for HIV in the Past Year (Adults Age 18-44)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 347]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Reflects respondents age 18 to 44.

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in the Metro Area was 562.8 cases per 100,000 population.

BENCHMARK ▶ Worse than both state rates.

DISPARITY ▶ Highest in Douglas and Pottawattamie counties.

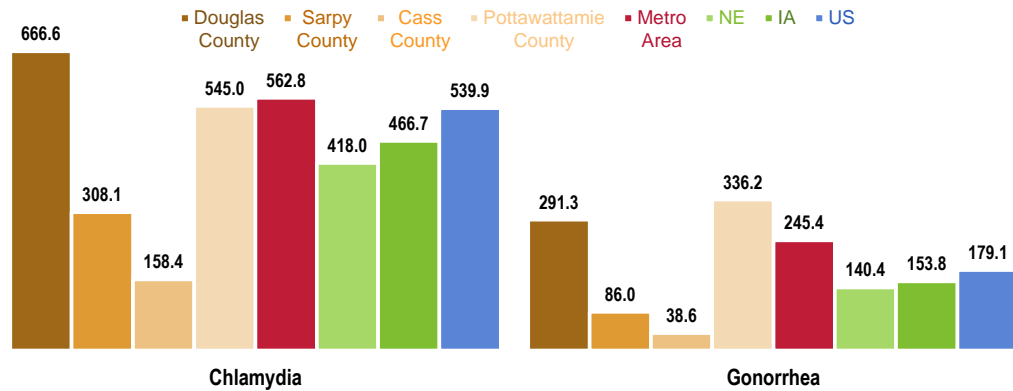
The Metro Area gonorrhea incidence rate in 2018 was 245.4 cases per 100,000 population.

BENCHMARK ▶ Well above the state and US rates.

DISPARITY ▶ Unfavorably high in Douglas and Pottawattamie counties.



Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2018)

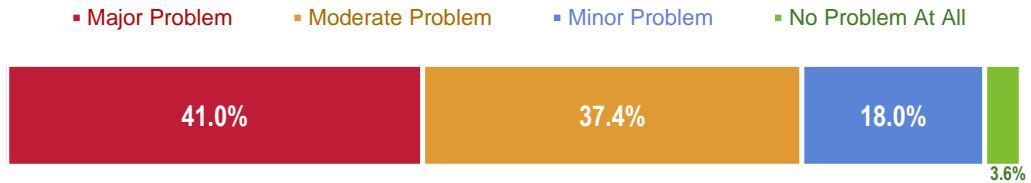


Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
 Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

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

Perceptions of Sexual Health as a Problem in the Community (Key Informants, 2021)



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

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

Incidence/Prevalence

- STD rates are sky high. COVID prevented testing and treatment. – Public Health Representative
- I’m not sure where Douglas county is ranked today, but I know several years ago they ranked extremely high on the STD rate. – Social Services Provider
- High rates. – Other Health Provider
- I have heard we are considered at epidemic level for STDs. – Other Health Provider
- Because of the unbelievable number of cases of STDs in young people. – Community Leader
- Douglas county has had a high rate of STDs for years now. – Social Services Provider
- Level of STDs documented in Douglas county. – Social Services Provider
- High prevalence of STDs. – Physician



I hear we are one of the highest STI per county. – Community Leader
 High incidence of STI. – Business Leader
 Scary statistics in the metro for a very long time. – Social Services Provider
 One of the highest chlamydia rates in the country. Unreported rape. – Social Services Provider
 There is an epidemic of STDs in Douglas county. – Social Services Provider
 STIs in Nebraska are higher than the national average. There is a need for easy and inexpensive birth control. – Other Health Provider
 Our rates of STI are too high and have been for too many years. – Other Health Provider
 Higher than national average of STDs in Douglas county. – Community Leader
 We have had high STD rates for many years and even with significant interventions offered in the last six years they still are high. – Public Health Representative
 Transmission rate is high and see many patients through ED for STD, STI care. – Other Health Provider
 STD rates are very high in Pottawattamie the County Health Department is major provider. – Business Leader
 Much higher than average rates of STIs compared to comparable cities in the US. – Physician
 Douglas county has one of the highest STD rates in the country. – Physician
 High rates of unplanned pregnancies and sexually transmitted infections. – Other Health Provider
 Young adults are having unprotected sex. Certain neighborhoods have high rates of STDs, children having children. – Other Health Provider
 STD rate high. – Other Health Provider
 My understanding is Douglas county has an extremely high rate of STD. HPV is also a growing concern with increasing tonsil and base of tongue cancers being seen. – Physician
 High rate of STDs. – Other Health Provider

Awareness/Education

Lack of knowledge. – Other Health Provider
 High rate of STD and not enough sexual education. – Other Health Provider
 High rates of STIs. Education from area schools not great. – Other Health Provider
 The rate of STIs in Omaha is quite high and the quality of sexual health education is inconsistent and can be lacking in its comprehensive nature. – Community Leader
 Lacking education. – Other Health Provider
 There is no one organization specifically addressing the sexual health of our community. No free clinics to get STD checks. – Social Services Provider
 Education and family counseling. – Criminal Justice
 Lack of importance placed on sexual health in younger populations and access to health providers. Too many limitations on minors accessing services. – Business Leader

Contributing Factors

Douglas County has had very high numbers for years regarding STDs per capita. Human trafficking has become an epidemic. Not sure education is occurring for kids to get facts and thus they want to explore their sexuality, which leads to risky behaviors and sexually transmitted diseases. – Other Health Provider
 We live in a conservative state where it's difficult to incorporate national guidelines for comprehensive sex ed in schools. As providers, we have few options when it comes to referring patients with issues like hypoactive sexual desire disorder or issues with sexual performance – Physician

Access to Care/Services

Many people are using the Emergency Departments for STD testing and pregnancy testing. The economic impact is astounding for hospitals and the patient. Lack of knowledge and options continues to be a problem. – Other Health Provider

Young Adults

STDs have been an ongoing issue in our community especially for residents ages, 15 to 24 years old. – Physician

Vulnerable Populations

High levels of STIs in minority communities. – Social Services Provider





ACCESS TO HEALTH CARE

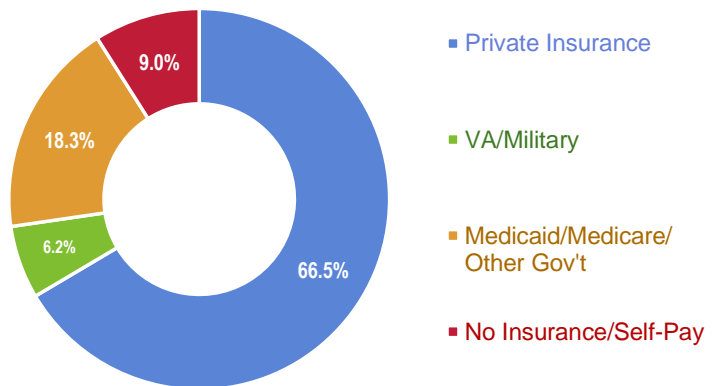
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 66.5% of Metro Area adults age 18 to 64 report having health care coverage through private insurance. Another 24.5% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage
(Adults Age 18-64; Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 9.0% report having no insurance coverage for health care expenses.

BENCHMARK ► Well below the Nebraska prevalence.

TREND ► Decreasing significantly from 2011 survey findings.

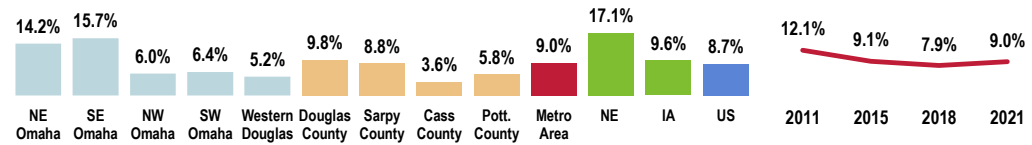
DISPARITY ► Higher in Sarpy and Douglas counties (particularly in eastern Omaha). Reported most often among those living on lower incomes and Hispanics.



Lack of Health Care Insurance Coverage (Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower

Metro Area

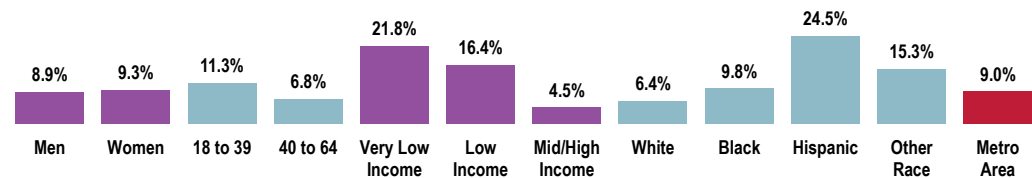


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 138]
 • Behavioral Risk Factor Surveillance System Survey Data, Atlanta, Georgia, United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage (Adults Age 18-64; Metro Area, 2021)

Healthy People 2030 = 7.9% or Lower



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 138]
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents under the age of 65.



Recent Lack of Coverage

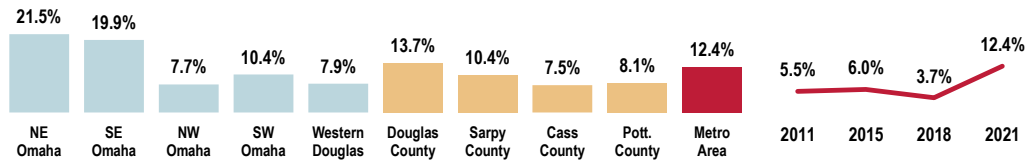
Among currently insured adults in the Metro Area, 12.4% report that they were without healthcare coverage at some point in the past year.

TREND ▶ Denotes a statistically significant increase from previous survey results.

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

Went Without Healthcare Insurance Coverage at Some Point in the Past Year (Among Insured Adults)

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 317]
 Notes: • Asked of all insured respondents.



DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. ...About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

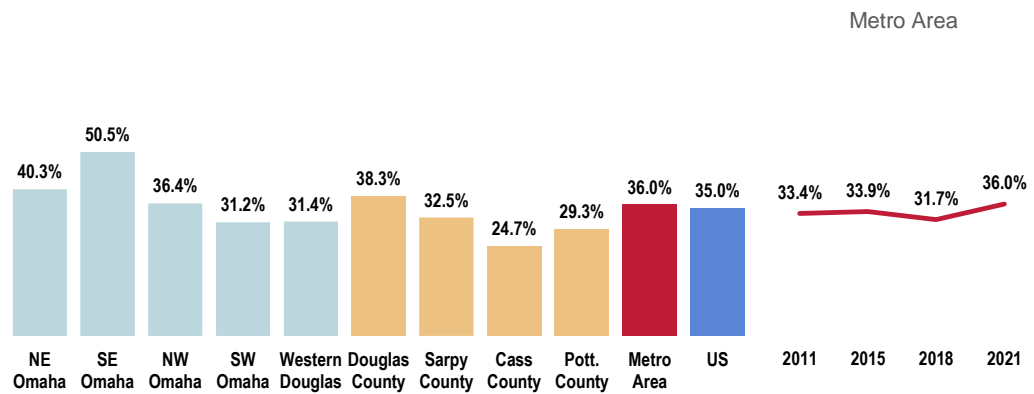
– Healthy People 2030 (<https://health.gov/healthypeople>)

Difficulties Accessing Services

A total of 36.0% of Metro Area adults report some type of difficulty or delay in obtaining health care services in the past year.

DISPARITY ► Highest in Douglas County (especially Southeast Omaha). Correlates with age and income and is reported more often among women and communities of color.

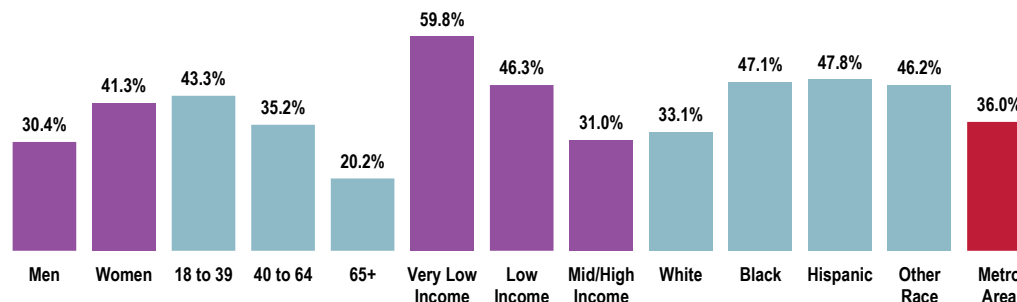
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.



Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
 Notes: • Asked of all respondents.
 • Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Note that, of those experiencing difficulty, 50.4% report that the difficulty was experienced while seeking **primary care** in the past year.

Barriers to Health Care Access

Of the tested barriers, appointment availability impacted the greatest share of Metro Area adults.

BENCHMARK ► The prevalence associated with **cost of doctor visits** was lower than the Nebraska figure but higher than the Iowa figure (not shown). The Metro Area fared better than the national figure with regard to **language/culture** as a barrier to health care.

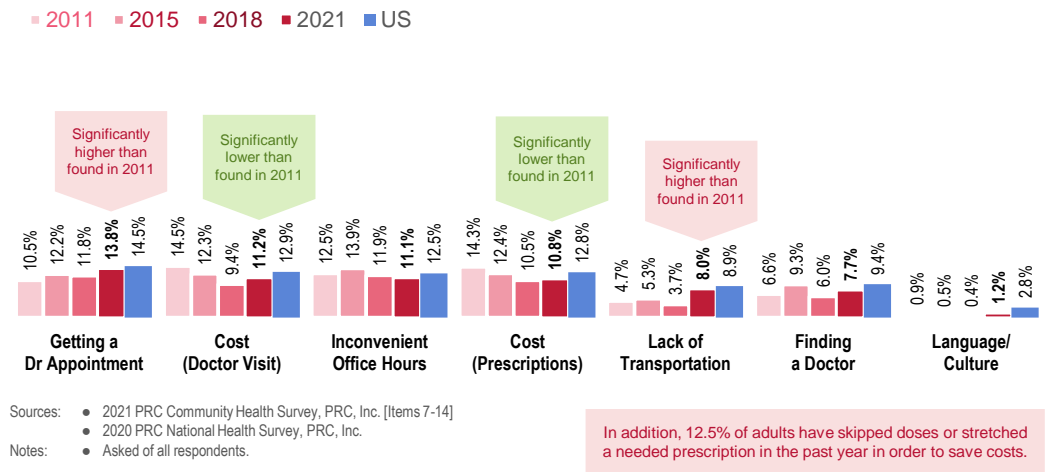
TREND ► Significant improvements have occurred over time for the barrier of **cost** (for both doctor visits and prescriptions), while **doctor availability** and **lack of transportation** have worsened in the Metro Area.

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

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



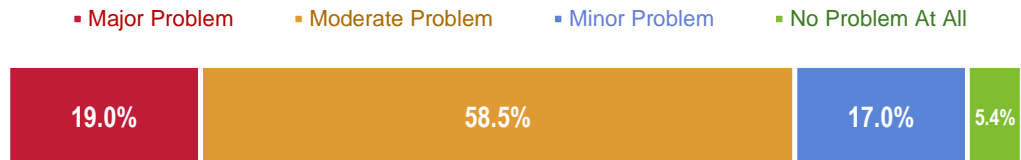
Barriers to Access Have Prevented Medical Care in the Past Year (Metro Area)



Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a “moderate problem” in the community.

Perceptions of Access to Health Care Services as a Problem in the Community (Key Informants, 2021)



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

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

Contributing Factors

- Health literacy, ability for non-English speaking patients to access care, services needed ... all are major concerns in the region. – Other Health Provider
- People without a regular health home, insurance, deductibles, copays, etc. People avoid care due to fear of cost, unclear choices of care and uncoordinated care. Transportation and wait times contribute to the problems. People of color may distrust or be concerned about stigma. – Social Services Provider
- Location, time availability, and insurance. – Community Leader
- Affordability, access for the un and underinsured, mental health. No emergency mental health but after discharge or in general. Need navigators for non-English or limited English speakers, specialist wait times to be seen. – Other Health Provider



Poor public transportation options. Lack of understanding of how to access a medical home. Folks who were not previously insured learning how to navigate the system. Lack of providers who can offer services to people speaking different languages. – Social Services Provider

Frequent utilization of ED by people accessing care in an inappropriate area due to lack of other access, homelessness, wish to be hospitalized for shelter and food. This taxes the health systems, provides inefficient and very expensive care and takes away resources from other more appropriate patients. – Physician

Costs and the ability to pay for healthcare. – Other Health Provider

Medicaid coverage. – Other Health Provider

General preventative health. – Social Services Provider

Cost, education and diverse staff that can relate to the community. – Other Health Provider

Lack of insurance; lack of decent public transportation in a city that has extreme weather (hot, cold, icy, etc.); lack of trust in/relationship with medical providers; even with insurance – copays can be prohibitive and lower/middle income folks will avoid health care, especially preventative. They are more inclined to go to the emergency room with an acute medical condition than seek preventative medicine; lack of access and education about healthy food and nutrition; lack of access to healthy lifestyle activities for low/middle income folks (gym membership, yoga classes, massages, etc.); lack of safe outdoor recreation/physical exercise opportunities. – Social Services Provider

There are still too many “rules” related to healthcare access. I know healthcare workers care, but say you are a person whose blood sugar is really high and you don’t have insurance and the federally qualified clinic just isn’t working out for you, and try getting into a different clinic and they just say, OK you don’t have insurance--go to the federally qualified clinic--and for various reasons that isn’t working. So OK, we’ll see you but you have to pay \$100 copay and we can’t offer you any insulin. We need something more than what we have. – Other Health Provider

Uninsurance, language barriers, transportation, issues with people who live in Southeast and Northeast Omaha having less access – no neighborhood clinics and issues with getting to the clinics, expensive medicines. Lack of diversity in healthcare providers – need to recruit more people of color in the health professional schools. Primary Care providers need access to specialty care for patients out of their scope or who would need diagnostic studies; these are very difficult to access for uninsured patients. – Physician

Affordability, trust and comfort with health care systems and providers. – Other Health Provider

I have a concern that a large group of people do not have adequate access to health care. Students and families in poverty, families with language barriers and such. – Community Leader

Access to oral health care, especially among our most vulnerable populations and the elderly. Oral health and overall health are closely related but our current healthcare system does not include oral health care for many. – Social Services Provider

Lack of access, insurance coverage, and culturally sensitive care. – Public Health Representative

I see the largest issues with people finding a healthcare home so they don’t have to use ERs for non-emergent needs. I also think access where the individuals providing care look, speak and have a similar cultural background as the patients being seen continues to be a need in our community. – Community Leader

Poverty and access to care. – Community Leader

Inequity

Inequity has always existed but was really brought to the forefront during the pandemic. Lack of access to health care for small businesses and nonprofits, ten or less employees is a huge problem. – Community Leader

That low-income communities do not have access to health care, especially exacerbated by COVID. – Social Services Provider

Segregation and lack of culturally competent providers are the biggest challenges facing American Indians in Douglas County. In any discussion involving health/social services, references are made to North Omaha and South Omaha acknowledging the Spanish speaking and Black residents. Seldom is any reference made related to American Indians. – Social Services Provider

The community has described significant access to care barriers related to finding an affordable and nearby mental health care provider who represent and identify with Black, Asian, Native and key refugee nations. This provider shortage impacts the willingness of people of color to access care in future issues. – Other Health Provider

Not enough mental health providers to meet the needs of the community. – Physician

Availability of culturally competent providers. – Physician

It is not directly a health issue. As long as there are financial disparities between communities of color and the larger community there will be health issues. – Community Leader

Transportation Issues

Transportation to health care appointments. – Physician



Access to care issues such as transportation issues for patients without a Nebraska Medicaid plan and vendor. – Other Health Provider

Lack of access to affordable and reliable transportation. The bus system in Omaha only serves a limited are of Omaha. People who live in West Omaha or otherwise outside of the bus route do not have access to affordable transportation to get to medical appointments, jobs grocery store, etc. Ponca transport, Intercultural Senior Center, and Rural transportation Program through Eastern Nebraska Office on Aging can offer limited assistance, but it is not adequate to meet the needs of the Omaha and surrounding area. There needs to be more affordable transportation options available for the community and the bus system needs to be expanded to West Omaha as well as to more areas in metro Omaha. – Other Health Provider

Oral Healthcare

Access to oral health care, especially among our most vulnerable populations and the elderly. Oral health and overall health are closely related but our current healthcare system does not include oral health care for many. – Social Services Provider



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>)

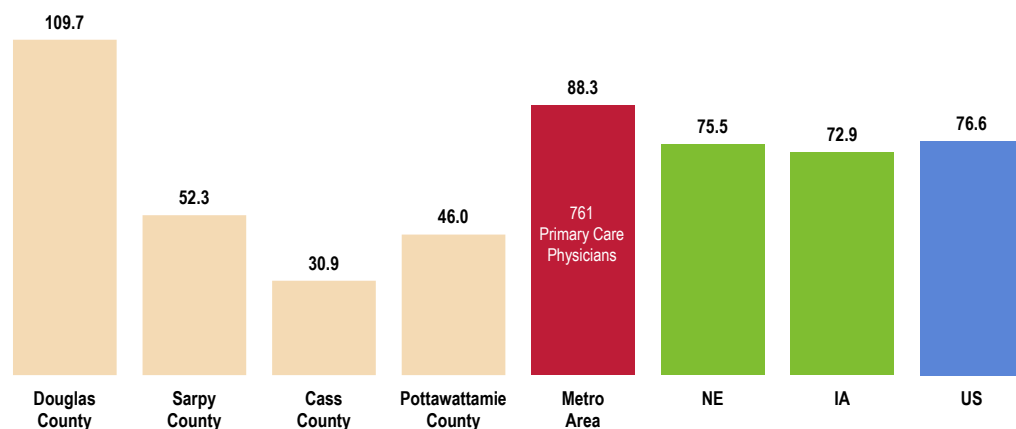
Access to Primary Care

In 2017, there were 761 primary care physicians in the Metro Area, translating to a rate of 88.3 primary care physicians per 100,000 population.

BENCHMARK ▶ Higher than the Iowa rate.

DISPARITY ▶ Highest in Douglas County, lowest in Cass County.

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2017)



Sources: • US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.

• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes: • Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 78.4% of Metro Area adults were determined to have a specific source of ongoing medical care.

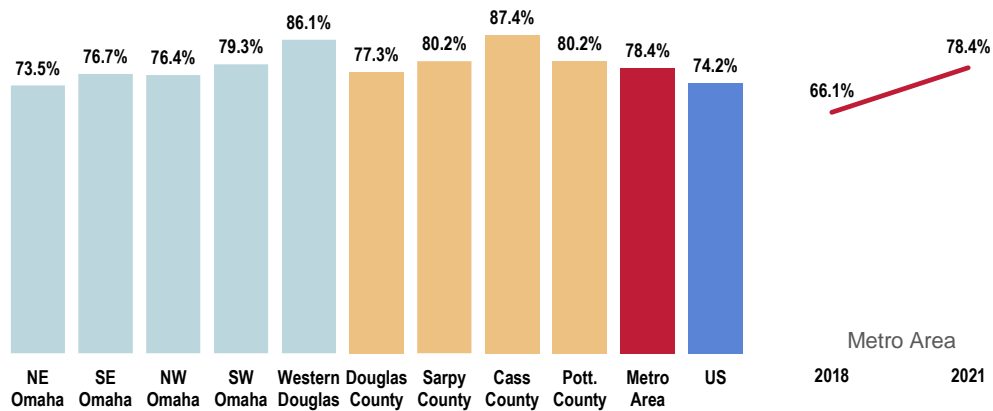
BENCHMARK ▶ Higher than the national prevalence.

TREND ▶ Denotes a statistically significant improvement since 2018.

DISPARITY ▶ Lowest in Douglas County (although quite high in Western Douglas County).

Have a Specific Source of Ongoing Medical Care

Healthy People 2030 = 84.0% or Higher



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 139]
 • 2020 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of all respondents.

Utilization of Primary Care Services

Adults

Two-thirds of adults (66.3%) visited a physician for a routine checkup in the past year.

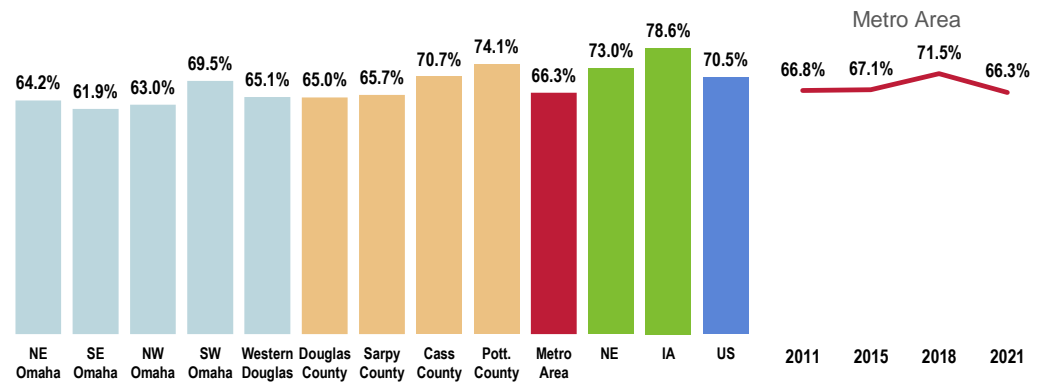
BENCHMARK ▶ Well below the state and national percentages.

TREND ▶ Similar to 2011 and 2015 survey findings but decreasing since 2018.

DISPARITY ▶ Lowest in Douglas County (but higher in Southwest Omaha). Reported less often among men, young adults, and residents in the Other Race grouping.



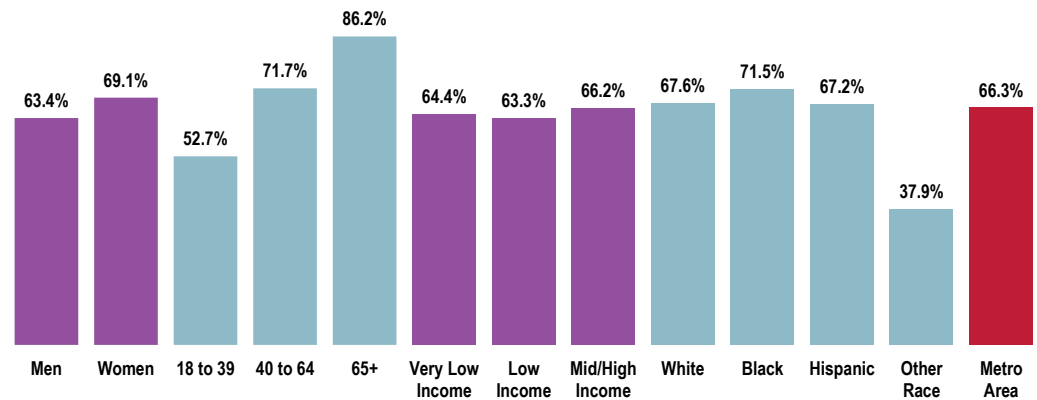
Have Visited a Physician for a Checkup in the Past Year



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
 • Behavioral Risk Factor Surveillance System Survey Data, Atlanta, Georgia, United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
 Notes: • Asked of all respondents.



TELEMEDICINE

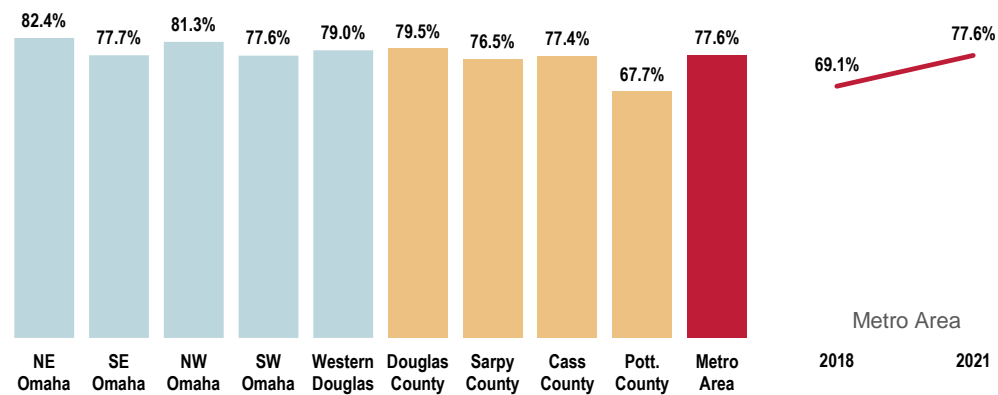
Some doctor's offices offer tele-health visits, in which a patient uses a computer or smartphone to communicate with a physician without being face to face.

Most survey respondents (77.6%) say they would be “very” or “somewhat” likely to participate in a tele-health visit.

TREND ▶ Increasing significantly since 2018.

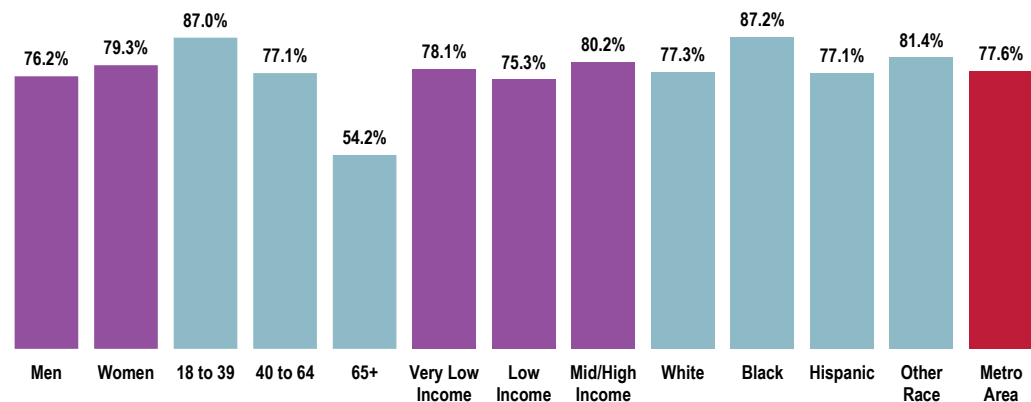
DISPARITY ▶ Least likely among respondents in Pottawattamie County. In general, younger adults and Black residents are more amenable to the tele-health option.

“Very” or “Somewhat” Likely to Participate in a Tele-Health Visit



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.

“Very” or “Somewhat” Likely to Participate in a Tele-Health Visit (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.



EMERGENCY ROOM UTILIZATION

A total of 6.9% of Metro Area adults have gone to a hospital emergency room more than once in the past year about their own health.

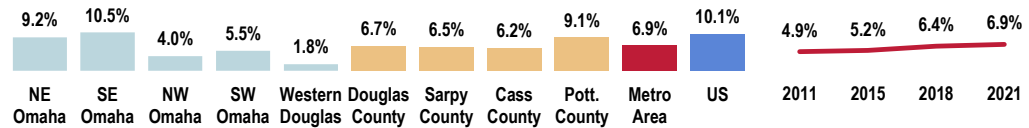
BENCHMARK ▶ Lower than the US prevalence.

TREND ▶ Increasing significantly since 2011.

DISPARITY ▶ In Douglas County, highest in eastern Omaha. The prevalence is particularly high in lower-income households, as well as Black and Other Race respondents.

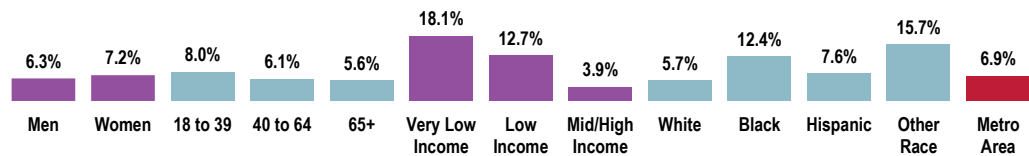
Have Used a Hospital Emergency Room More Than Once in the Past Year

Metro Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 22]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year (Metro Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 22]
 Notes: • Asked of all respondents.



ORAL HEALTH

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>)

Dental Care

Adults

A total of 64.6% of Metro Area adults have visited a dentist or dental clinic (for any reason) in the past year.

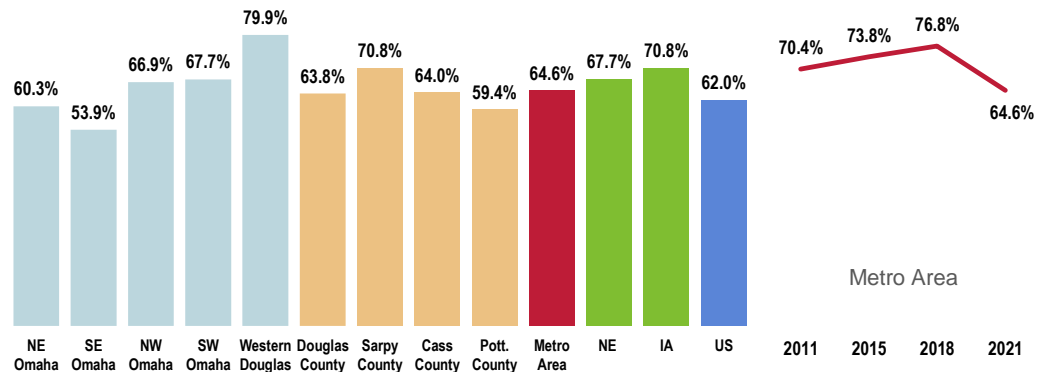
BENCHMARK ▶ Lower than both state percentages but satisfying the Healthy People 2030 objective.

TREND ▶ Decreasing significantly after a steady increase between 2011 and 2018.

DISPARITY ▶ In Douglas County, the prevalence is lowest in Southeast Omaha. By county, the prevalence is lowest in Pottawattamie County. Reported less often among men, young adults, respondents living at lower incomes, Hispanics, and Other Race respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



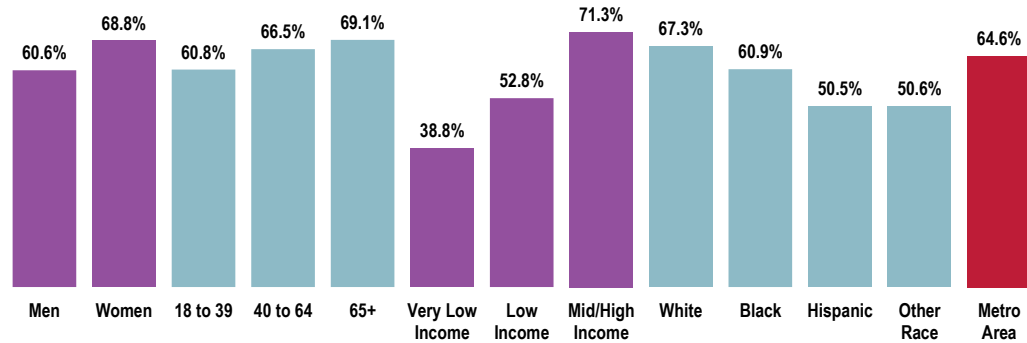
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Nebraska and Iowa data.
 • 2020 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.



Have Visited a Dentist or Dental Clinic Within the Past Year (Metro Area, 2021)

Healthy People 2030 = 45.0% or Higher

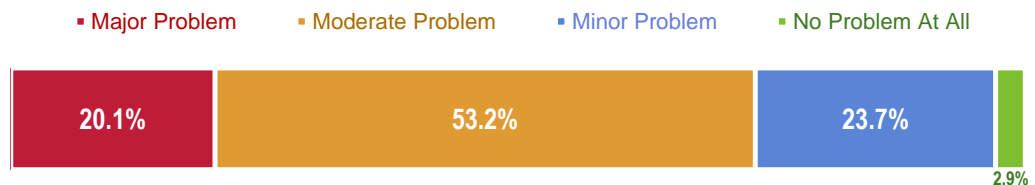


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
 Notes: • Asked of all respondents.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a “moderate problem” in the community.

Perceptions of Oral Health as a Problem in the Community (Key Informants, 2021)



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

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

Access to Care

The majority of the population in Pottawattamie County are enrolled in Medicaid but the overwhelming majority of providers in the county aren't accepting Medicaid patients. Only two in the county will accept adult Medicaid patients and they are booked out for months. Untreated gum disease is linked to infant mortality, heart disease, stroke, diabetes and many more health problems but a huge part of our population is going without any kind of oral health care at all. – Social Services Provider

Lack of providers who take Medicaid for dental insurance or have payment plans. – Other Health Provider

Health insurance lacking benefits. – Other Health Provider

A number of dentists not accepting Medicaid and insured people not being able to afford co-pays. – Business Leader



Lack of insurance coverage. – Other Health Provider
Most people do not have dental coverage. The cost of co-pays if they do have insurance. Dentists not taking Medicaid. – Other Health Provider
Lack of access to care for many. – Other Health Provider
Access to quality dental programs. Parents unwillingness to take advantage of school-based programs. – Community Leader

Affordable Care/Services

Limited access for under resourced populations. – Physician
Need more access to affordable services. – Physician
Dentists are expensive and not covered by most basic insurance. People lose their teeth and their teeth can be indicators of other health issues. – Social Services Provider
At least in the CB community, people seem to need dental care very badly. It is expensive. The wait is long, and these offices are only able to do the bare minimum due to the time and expense. – Other Health Provider
Costly, waitlist, spotty insurance coverage, dentures cost. – Social Services Provider

Cost of Care

Many people without money, insurance to care for oral health. – Community Leader
This is the issue that gets overlooked, and it's a huge one. Dental care is not cheap and those who can't afford regular cleanings certainly can't afford more extensive treatment. – Other Health Provider
People in poverty lack resources for adequate dental care. – Other Health Provider

Co-Occurrences

There is drug usage in the community that leads to poor oral health. Dental coverage is not something all health care plans cover, including Medicaid. Many low-income families cannot afford regular oral health maintenance. – Social Services Provider



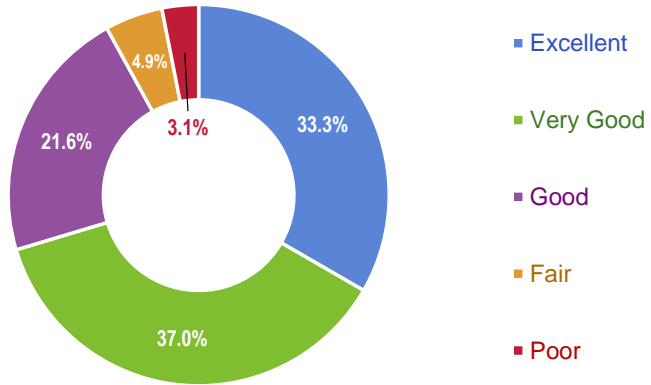


LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

Most Metro Area adults rate the overall health care services available in their community as “excellent” or “very good.”

Rating of Overall Health Care Services Available in the Community (Metro Area, 2021)

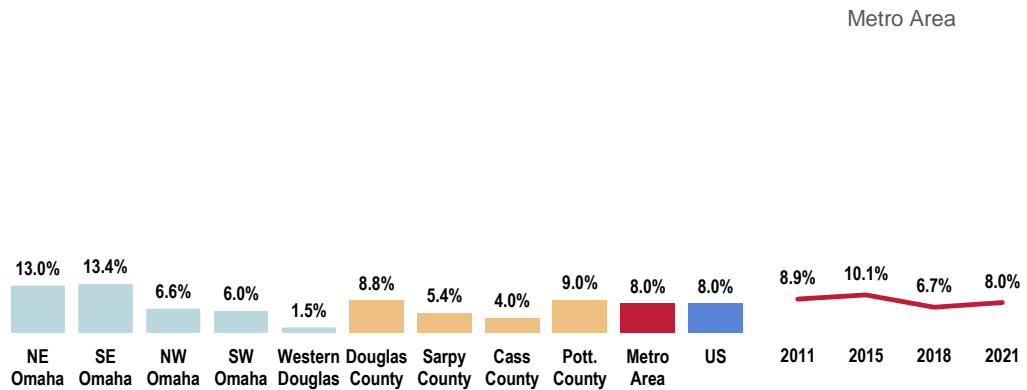


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
 Notes: • Asked of all respondents.

However, 8.0% of residents characterize local health care services as “fair” or “poor.”

DISPARITY ► Statistically highest in Douglas County (within Douglas County, unfavorably high in eastern Omaha). The prevalence correlates with age and income and is reported more often among Blacks, Hispanics, as well as adults with recent access difficulties.

Perceive Local Health Care Services as “Fair/Poor”

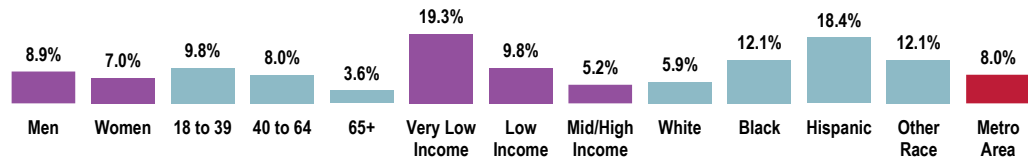


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
 • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.



Perceive Local Health Care Services as “Fair/Poor” (Metro Area, 2021)

With Access Difficulty 17.0%
No Access Difficulty 3.0%



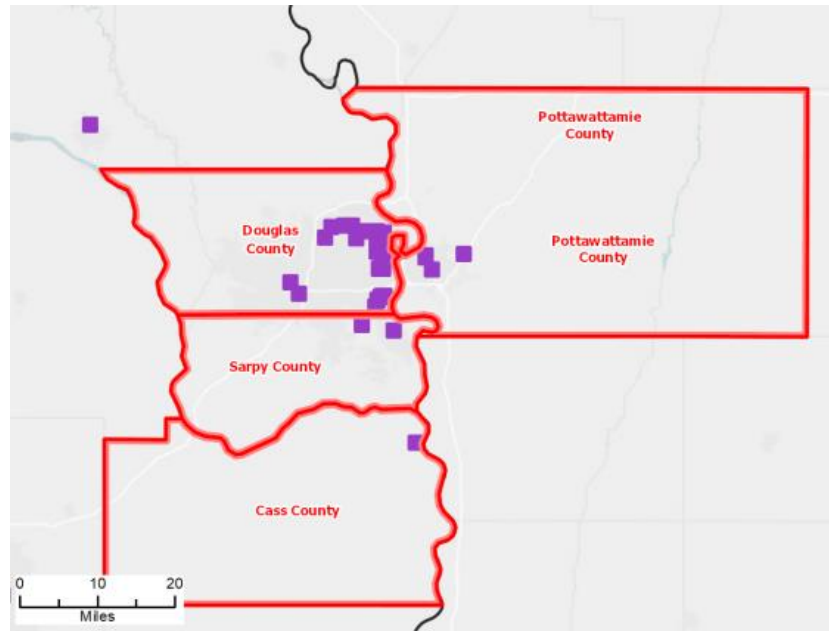
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.



HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the Metro Area as of September 2020.



Map Legend

Federally Qualified Health Centers, POS
September 2020



Report Location, County



SparkMap



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- All Care Health Center
- Behavioral Health Connection Line
- Center for Holistic Care
- Center for Holistic Development
- Charles Drew Health Center
- CHI Health
- CHI Health Behavioral Health Services
- Doctor's Offices
- Douglas County Community Mental Health Center
- Douglas County Health Department
- Faith-Based Organizations
- Federally Qualified Health Centers
- Fred Leroy Health and Wellness
- Free or Reduced-Cost Drug Programs
- Healing Gift Free Clinic
- Heart Ministry Center Medical Clinic
- Hospitals
- I-Smile
- Methodist Health System
- Nebraska Medicine
- Nebraska Urban Indian
- NOAH Clinic
- OneWorld Community Health Center
- Region 6
- Together Inc.
- YMCA
- Youth-Serving Agencies
- YouTurn

Cancer

- A Time to Heal
- American Cancer Society
- Cancer Center
- Charles Drew Health Center
- CHI Health
- CHI Health Henry Lynch Cancer Center
- Children's Hospital
- Department of Health and Human Services
- Eastern Nebraska Community Action Partnership
- Fitness Centers/Gyms
- Fred and Pamela Buffett Cancer Center

- Heartland Oncology
- Hope Lodge
- Josie Harper Programs
- Lift Up Sarpy
- Methodist Estabrook Cancer Center
- National Cancer Institute
- NC2
- Nebraska Cancer Associates
- Nebraska Medicine Cancer Center
- Nebraska Urban Indian
- No More Empty Pots
- NOAH Clinic
- North Omaha Community Care Council
- OneWorld Community Health Center
- Parks and Recreation
- Sarpy County Human Services
- Sarpy/Cass Health and Wellness Department
- UNMC

Coronavirus

- Acute Care Centers
- Bellevue Medical Center
- CDC
- Charles Drew Health Center
- CHI Health
- CHI Health Creighton University Medical Center
- CHI Health Immanuel
- CHI Health Midlands
- Churches
- CVS
- Department of Health and Human Services
- Doctor's Offices
- Douglas County Health Department
- Douglas County Testing Sites
- Federal COVID Relief Program
- Federally Qualified Health Centers
- Food Pantries
- Girls Inc.
- Health Department
- ICAP Program
- Karen Society of Nebraska
- Mental Health Services
- Methodist Health System



- Nebraska Medicine
- North Omaha Community Care Council
- Omaha COVID Free Coalition
- OneWorld Community Health Center
- Pharmacies
- Pottawattamie County Health Department
- Public Health
- Refugee Empowerment Center
- Region 6
- Sarpy/Cass Health and Wellness Department
- State of Nebraska
- Test NE
- Unemployment Benefits
- University Medical Center LaVista
- UNMC
- Vaccination Centers

Chronic Kidney Disease

- American Kidney Foundation
- Charles Drew Health Center
- CHI Health
- Doctor's Offices
- Methodist Health System
- Nebraska Medicine
- OneWorld Community Health Center

Dementia/Alzheimer's Disease

- AANC
- AARP
- Alzheimer's Association
- Alzheimer's Organization
- Area Agency on Aging
- Charles Drew Health Center
- CHI Health
- Country House Memory Care
- Douglas County Long-Term Care
- Eastern Nebraska Office on Aging
- Helping You
- Home Health Care
- Home Instead
- House of Hope
- League of Human Dignity
- Mable Rose Estates
- Memory Care Facilities
- Nebraska Medicine
- Nebraska Office of Aging
- Nursing Homes
- OneWorld Community Health Center
- Parsons House
- Right at Home
- Senior Living Programs
- Skilled Nursing Facilities

- UNMC
- VA
- Via Christi Assisted Living

Diabetes

- All Care Health Center
- American Diabetes Association
- Certified Diabetic Educators
- Charles Drew Health Center
- CHI Health
- Children's Hospital
- Churches
- Community Health Centers
- Creighton REACH Program
- Diabetes Education Center
- Diabetes of the Midlands
- Diabetes Support Group
- Diabetic Educators
- Dialysis Clinic
- Doctor's Offices
- Douglas County Health Department
- Faith-Based Organizations
- Federally Qualified Health Centers
- Fitness Centers/Gyms
- Food Pantries
- Healing Gift Free Clinic
- Health Department
- Healthy Living Classes
- Hospitals
- Hy-Vee
- Juvenile Diabetes Research Fund
- Methodist Diabetic Mobile Program
- Methodist Hospital
- National Diabetes Prevention Program
- Nebraska Medicine
- Nebraska Medicine Diabetes and Endocrinology Center
- Nebraska Methodist College
- NOAH Clinic
- Non-Profits
- North Omaha Community Care Council
- Nutrition Services
- OneWorld Community Health Center
- Pharmacies
- Planet Fitness
- Social Services
- Think Whole Person Healthcare
- UNMC Center for Reducing Health Disparities
- Whispering Roots
- YMCA



Disabilities

Charles Drew Health Center
CHI Health
Community Health Clinics
Doctor's Offices
Health System
Medicaid
Munroe Meyer Institute
Nebraska Medicine
Nebraska Medicine Pain Management Program
OneWorld Community Health Center
Physical Therapy
Social Security Administration

Infant Health and Family Planning

All Care Health Center
Assure Clinic
Boys Town
Charles Drew Health Center
CHI Health
CHI Health Immanuel
Children's Hospital
Community Health Clinics
Department of Health and Human Services
Doctor's Offices
Douglas County Health Department
Essential Pregnancy Services
Faith-Based Organizations
Families First
FAMILY, Inc.
Federally Qualified Health Centers
First Five
Girls Inc.
Headstart
Health Department
I Be Black Girl
Lutheran Family Services
Nebraska AIDS Project
Nebraska Children's Home
Nebraska Medicine
NHHS Programs
NOAH Clinic
Omaha Healthy Start
Omaha Public Schools
OneWorld Community Health Center
Planned Parenthood
Sherwood Foundation
VNA
VNS
WIC
Women's Fund of Omaha

Heart Disease

American Heart Association
ARC
Charles Drew Health Center
CHI Health
CHI Health Immanuel
Clarkson
Community Health Centers
Department of Health and Human Services
Eastern Nebraska Community Action Partnership
Federally Qualified Health Centers
Grocery Stores
Health Department
Hillcrest Home Care
Lift Up Sarpy
Madonna Rehabilitation
Methodist Health System
Methodist Hospital
Methodist Jennie Edmundson Hospital
Nebraska Heart Association
Nebraska Medicine
Nebraska Methodist College
NOAH Clinic
OneWorld Community Health Center
Safety Council
Sarpy County Human Services
Sarpy/Cass Health and Wellness Department
School System
UNMC
VNA
Wellbeing Partners
YMCA

Injury and Violence

100 Black Men
Bellevue Medical Center
Black Police Association
Catholic Charities
Charles Drew Health Center
CHI Health
CHI Health Creighton University Medical Center
CHI Health Midlands
Child Protective Services
City Council
Community Leaders
Court Appointed Self-Advocates
Elected Officials
Empowerment Network
Faith-Based
Fire Department
Fred and Pamela Buffett Cancer Center
Gang Reduction Organizations
Health Department



Heartland Family Services
 Highway Safety
 Hospitals
 Juvenile Probation
 Law Enforcement
 Local News
 Local Newspapers
 Magdalene Omaha
 Mental Health Services
 Methodist Hospital
 Metro Area Youth Services
 Nebraska Medicine
 Nebraska Safety Council
 Neighborhood Associations
 NOAH Clinic
 Non-Profits
 Omaha 360
 Omaha Black Men
 Omaha Healthy Start
 Omaha Police Department
 P.A.C.E.
 Police Athletic League
 Project Extra Mile
 Project Harmony
 Public Health
 SANE Programs
 Sarpy County Legal Services
 School System
 Shelters
 Social Services
 State Legislature
 Step Up Jobs Program
 Trauma Matters Omaha
 UNMC
 Urban League
 Victims Assistance Fund
 Village Zone Pastors and Faith Leaders Collaborative
 Wellbeing Partners
 Women's Advocates
 Women's Center for Advancement
 Workforce Development
 YouTurn
 YWCA

Mental Health

AA/NA
 All Care Health Center
 ARC
 Behaven Kids
 Behavioral Consultants
 Behavioral Health and Education Network
 Behavioral Health Education Center of Nebraska
 Behavioral Health Providers

BNECN
 Boys Town
 Breast Care EAP Hotline
 Campus for Hope
 CARES Act
 Catholic Charities
 Center for Holistic Development
 CenterPointe
 Charles Drew Health Center
 CHI Health
 CHI Health Behavioral Health Services
 CHI Health Heritage Center
 CHI Health Immanuel
 CHI Health Psychiatric Services
 Child Saving Institute
 Children's Square USA
 Churches
 COAD Groups
 Coalition RX
 College of Public Health
 Community Alliance
 Community-Based Service Providers
 Community Counseling
 Community Health Centers
 Compassion in Action
 Connections
 Crisis Hot Line
 Doctor's Offices
 Douglas County
 Douglas County Community Mental Health Center
 Douglas County Health Department
 Douglas County Inpatient Unit
 Douglas Detox
 Eastern Nebraska Office on Aging
 Employee Assistance Programs
 Faith-Based Organizations
 Federally Qualified Health Centers
 Fremont Health
 Fremont Hospital
 Hawks Foundation
 Health Care Community
 Health Department
 Health System
 Heartland Family Services
 Homeless Shelters
 Horizon Group
 Hospitals
 Inpatient Psychiatric Facilities
 Kaneshville Therapy
 Kim Foundation
 Lasting Hope Recovery Center
 Law Enforcement
 Local Newspapers



Lutheran Family Services
 Mental Health Association of Nebraska
 Mental Health Services
 Meridian
 Methodist Health System
 Methodist Hospital
 Methodist Jennie Edmundson Hospital
 NAMI
 Nebraska Medical Association
 Nebraska Medicine
 Nebraska Medicine Psychiatric Services
 Nebraska Mental Health and Aging Coalition
 Nebraska Urban Indian
 NEMA
 NOAH Clinic
 Non-Profits
 North Omaha Community Care Council
 Omaha Police Department
 Omaha Public Schools
 OneWorld Community Health Center
 Peer Support Organizations
 PES
 Private Counselors
 Project Harmony
 Public Health Association of Nebraska
 Region 5
 Region 6
 Richard Young
 Safe Harbor
 Salvation Army
 School System
 Shelters
 South Omaha Community Care Council
 Southeast Nebraska Community Action Council,
 Inc. (SENCA)
 State and County Government
 Support Groups
 SWIA Mental Health and Disability Services
 TEAM
 Telecare
 Think Whole Person Healthcare
 UNMC
 UNMC Center for Reducing Health Disparities
 Wellbeing Partners

Books/Internet
 Bountiful Baskets
 Boys Club
 Center for Nutrition
 Charles Drew Health Center
 Children's Hospital
 Children's Hospital HEROES Program
 City Council
 City Planning
 City Sprouts
 Community Based Organizations
 Community Health Clinics
 Doctor's Offices
 Employers
 Farmer's Market
 Federally Qualified Health Centers
 Fitness Centers/Gyms
 Food Banks
 Food Pantries
 Gardens
 Girls Club
 Grocery Stores
 Healing Gift Free Clinic
 Health Department
 Hy-Vee
 Kroc Center
 Lifetime Fitness
 Live Well Omaha
 Malcolm X Foundation
 Meals On Wheels
 National Diabetes Prevention Program
 Nebraska Medical Association
 Nebraska Medicine Weight Management Clinic
 No More Empty Pots
 Nutrition Services
 Obesity Action Coalition
 Omaha Healthy Kids Alliance
 OneWorld Community Health Center
 Open Door Mission
 Parks and Recreation
 Planet Fitness
 Public Health Association of Nebraska
 School System
 SENCA
 Silver Sneakers
 The Landing
 Together, Big Garden, Whispering Roots
 United Healthcare Community Plan
 UNL Extension
 UNMC
 Walmart
 Weight Watchers
 Wellbeing Partners

Nutrition, Physical Activity, and Weight

5K Fridays
 712 Initiative
 App-Based Resources
 Bakers Grocery
 Bariatric Surgery Programs
 Bike and Walk Nebraska
 Blue Moon



Whispering Roots
WIC
YMCA
Youth-Serving Agencies

Oral Health

All Care Health Center
Anding Family Dental
Charles Drew Health Center
CHI Health Creighton University Medical Center
Community Health Clinics
Creighton Dental School
Dentist's Offices
Heart Ministry Center Medical Clinic
I-Smile
Omaha Public Schools
OneWorld Community Health Center
School System
Shelters
UNMC College of Dentistry
Worthy Dental

Respiratory Diseases

American Cancer Society
American Lung Association
Charles Drew Health Center
CHI Health
Doctor's Offices
Healing Gift Free Clinic
Health Department
Methodist Health System
Metro Omaha Tobacco Action Coalition
Nebraska Medicine
Nicotine Replacement Products
Omaha Therapy and Arts Collaborative (OTAC)
Public Health Association of Nebraska
Smoking Cessation Programs

Sexual Health

Access Granted
Adolescent Health Project/Collaboration
All Available Healthcare in the County
Charles Drew Health Center
CHI Health
Community Health Clinics
Douglas County Health Department
Douglas County STD Clinic
Essential Pregnancy Services
Family Planning
Federally Qualified Health Centers
Girls Inc.
Health System

Hospitals
Licensed Sex Therapists
Methodist Community Health Clinic
Midlands Sexual Health Research Collaborative
Nebraska Cancer Coalition
Nebraska AIDS Project
Nebraska Urban Indian
NOAH Clinic
Omaha Public Schools
OneWorld Community Health Center
Planned Parenthood
Pottawattamie County Health Department
Public Health
Respect Clinic
School System
Sex Education Programs
STD Clinics
UNMC Transgender Clinic
Women's Fund of Omaha

Substance Abuse

AA/NA
All Care Health Center
Boys Town
Bryan Hospital
Campus for Hope
Center for Holistic Development
CenterPointe
Charles Drew Health Center
CHI Health Creighton University Medical Center
CHI Health Immanuel
Coalition RX
Community Alliance
Community Mental Health Providers
Department of Health and Human Services
Douglas County Detox
Emergency Assistance Programs
Emergency Shelters
Faith-Based Organizations
Family Works
Healing Gift Free Clinic
Health Department
Health System
Heartland Family Services
Heritage Health MCOs
Homeless Shelters
Hope Center
Hospitals
Increased Screenings
InRoads
Journeys
Lasting Hope Recovery Center
Lutheran Family Services



- Methadone Clinic
- NAMI
- Nebraska Medicine
- Non-Profits
- NOVA
- OneWorld Community Health Center
- Open Door Mission
- Printed Resources
- Region 6
- Salvation Army
- Santa Monica House
- School System
- Siena Francis
- St. Gabriels
- State and County Government
- Stephen Center
- Substance Abuse Treatment Clinics
- SWIA Mental Health and Disability Services
- Together Inc.
- UNMC
- VA
- Valley Hope
- VNA

Tobacco Use

- American Lung Society
- Charles Drew Health Center
- CHI Health
- Employers
- Healing Gift Free Clinic
- Health System
- Live Well Omaha
- Metro Omaha Tobacco Action Coalition
- Nebraska Medicine
- Nebraska Quit Line Services
- OneWorld Community Health Center
- Quit Iowa
- Smoking Cessation Programs
- State of Nebraska Smoking Cessation Programs
- TEAM (Tobacco Education and Advocacy of the Midlands)
- Tobacco Coalition
- Tobacco Free Hotline



APPENDIX

Progress to Date: 2019 Community Health Needs Assessment and Implementation Plan

The 2019 assessment and planning cycle identified eleven health needs in the community. Those significant health needs were as follows:

Access to Care
Cancer
Dementia, Including Alzheimer's Disease
Diabetes
Heart Disease & Stroke
Injury & Violence
Mental Health
Nutrition, Physical Activity & Weight
Respiratory Diseases
Sexually Transmitted Diseases
Substance Abuse

Table 1. Source: [Douglas County 2019 CHNA](#)

Utilizing an internal prioritization process driven by administrators, community and public health professionals, and healthcare providers with special expertise within each of the identified needs, Nebraska Medicine narrowed the primary community health improvement focus to address three of the significant health needs identified in the 2019 CHNA. The identified three priority focus areas were 1) *Access to Care*, 2) *Injury & Violence Prevention*, and 3) *Mental Health*. Together, the Nebraska Medical Center and Bellevue Medical Center prioritized these focus areas, targeting the at-risk populations served by each hospital.

Focus Area update: Access to Care

To address ongoing access to care issues, Nebraska Medicine transitioned all primary care clinics to the Patient Centered Medical Home (PCMH) model. This model improves healthcare coordination by integrating behavioral health, pharmacy, social work and nutrition staff into each clinic site of care. Nursing Care Coordinators help to coordinate care across the continuum of each patient's life, by focusing on population health management, care transitions, and proactive management of the patient base. Financial counselors assist patients with enrollment in public assistance programs and navigation of the healthcare marketplace.

Connecting patients to community organizations and resources addressing any social determinant of health needs continues to be a focus. During this cycle, Nebraska Medicine started work with Community Relay, a software platform designed for health care providers to create a direct referral between a patient and needed community resources. Streamlining this work will continue to be a priority in the future.

Across the Metro area, convenient, affordable access is made available through the Immediate Care Clinics. Four sites across the Omaha metropolitan area (Chalco, Bellevue Family Medicine, Eagle Run and Midtown) offer extended hours on evenings, weekends, and holidays. Utilization of immediate care provides additional options for the community to seek care after traditional clinic hours while decreasing Emergency Department utilization for less emergent needs. Immediate Care Clinic wait times are made available to Nebraska Medicine patients for increased transparency.

In the past three years, a key component of expanding clinical access involved the availability of telehealth services. Multiple levels of telehealth visits have been made available to patients, including both primary and specialty care. Utilization of telehealth services is a key strategy in supporting patients with identified transportation concerns.

Focus Area update: Injury & Violence

Nebraska Medicine continues to focus on injury and violence prevention through collaboration and education. During this cycle, in-person educational opportunities have been impacted by the COVID-19 pandemic, increasing the need for online or phone resources. The Nebraska Regional Poison Center continues to serve the entire state of Nebraska by providing access to a 24/7 emergency line as well as providing poison education programs and online materials.

Nebraska Medicine continues to build a trauma-informed community through programs such as Dusk to Dawn. This is a hospital-based youth violence prevention program that exposes youth to the physical and emotional consequences of violence as the catalyst for discussion about values, emotions, problem solving and risk and protective factors. This program is a partnership between Nebraska Medicine, the Omaha Police Department, YouTurn and the Boys & Girls Club of the Midlands. Another community-based program, Stop the Bleed, is a trauma intervention program that teaches community members how to stop uncontrolled bleeding in trauma situations.

Additionally, a new collaboration within the Emergency Department, trauma team, and YouTurn works to mitigate potential acts of violence or retaliation for patients and families. ENCOMPASS Omaha is a hospital-based violence intervention program, which aims to help people recover from the physical and emotional trauma caused by violence, ultimately reducing violence within the community. Program participants are connected to resources including housing support, mental health care, legal aid and job training.

Focus Area update: Mental Health

Over this cycle, Nebraska Medicine has continued to increase the number of mental health practitioners available to see patients. The Behavioral Health Intensive Outpatient Program provides integrated care for individuals suffering from both addiction and psychiatric disorders continues to fill a necessary gap for those needing comprehensive treatment without requiring hospitalization. Several Psychiatry subspecialty clinics have been developed, including Women's Reproductive Health, Treatment Resistant Depression, ASPIRE (severe and persistent mental illness), Addictions, Anxiety Disorders and Dialectical Behavior Therapy.

In addition to these expanded services, Nebraska Medicine opened the Adult Psychiatric Emergency Services unit, a separate unit providing support for individuals with psychiatric or substance use issues in a calm, compassionate environment. The goal is to stabilize patients and provide a timely referral to community partners for appropriate treatment. This unit accepts all patients with mental health needs regardless of insurance, history of admissions or a history of violence, and is providing a critical service to the community.

Universal suicide screening and safety planning for hospital admissions have been implemented at both hospital sites. Nebraska Medicine addresses teen suicide prevention strategies through partnership with the Boys Town National Hotline. The Hotline answered over 124,000 calls in 2021. Increased offering and availability of outpatient behavioral health services via telehealth was a key strategy to support community needs during this cycle.

Nebraska Medicine partners with many community organizations that provide psychiatric services to underserved communities. Additionally, the Behavioral Health Connection program was implemented, which connects adults with psychological or substance use disorders to area resources. This free community-based program identifies available services, assists with transportation and creates access to prescription medication programs.

A strong commitment to the surrounding community is also illustrated by annually reported community benefit figures. Nebraska Medicine makes significant investments in financial assistance, health professions education, subsidized health services, community health improvement and community building activities. The table below shows the aggregated total of annual investments for the last three fiscal years.

Fiscal Year 2019	Fiscal Year 2020	Fiscal Year 2021
\$268,912,238	\$302,936,200	\$309,435,679

2021 Survey of Community Health Needs

The following table illustrates the primary areas of need found in the most recently conducted community health survey. For each significant health need, the highlights and areas of opportunity are listed.

Access to Healthcare Services	<ul style="list-style-type: none"> • Insurance Instability • Barriers to Access (appointment availability, lack of transportation) • Routine Medical Care (Adults) • Emergency Room Utilization • Health Literacy
Cancer	<ul style="list-style-type: none"> • Leading Cause of Death • Cervical Cancer Screening (Age 21-65)
Diabetes	<ul style="list-style-type: none"> • Diabetes Deaths • Diabetes Prevalence • Blood Sugar Testing (Non-Diabetics)
Heart Disease & Stroke	<ul style="list-style-type: none"> • Leading Cause of Death • Stroke Prevalence
Injury & Violence	<ul style="list-style-type: none"> • Prevalence of Falls (Age 45+) • Intimate Partner Violence
Mental Health	<ul style="list-style-type: none"> • “Fair/Poor” Mental Health • Diagnosed Depression • Symptoms of Chronic Depression • Suicide Deaths • Social Support • Receiving Treatment for Mental Health • Difficulty Obtaining Mental Health Services • Key Informants: Mental health ranked as a top concern
Nutrition, Physical Activity & Weight	<ul style="list-style-type: none"> • Fruit/Vegetable Consumption • Leisure-Time Physical Activity • Access to Trails • Overweight & Obesity • Professional Advice on Weight (Overweight Adults) • Key Informants: Nutrition, physical activity and weight ranked as a top concern
Oral Health	<ul style="list-style-type: none"> • Regular Dental Care (Adults)

Potentially Disabling Conditions	<ul style="list-style-type: none"> • Activity Limitations • High-Impact Chronic Pain • Alzheimer’s Disease Deaths • Caregiving
Prenatal Health & Infant Mortality	<ul style="list-style-type: none"> • Prenatal Care • Infant Deaths
Respiratory Disease	<ul style="list-style-type: none"> • Lung Disease Deaths (Chronic Lower Respiratory Disease) • Asthma Prevalence (Adults)
Sexual Health	<ul style="list-style-type: none"> • Chlamydia Incidence • Gonorrhea Incidence • HIV Testing (Age 18-44)
Social Determinants of Health	<ul style="list-style-type: none"> • Housing Insecurity • Loss of Utilities • Unhealthy/Unsafe Housing
Substance Abuse	<ul style="list-style-type: none"> • Cirrhosis/Liver Disease Deaths • Key Informants: Substance abuse ranked as a top concern
Tobacco Use	<ul style="list-style-type: none"> • Smokers Advised to Quit by a Health Professional

Table 2. *The 2021 survey identified fifteen significant health needs. Many of these were also identified in the 2018 survey and showed little improvement in the last three years.*

2022-2025 Nebraska Medicine Priorities

Utilizing an internal selection process driven by stakeholders and based on the survey data and community feedback, Nebraska Medicine will prioritize four of the significant health needs identified in the 2021 community health survey for the upcoming three year cycle. In seeking to create sustainable improvements to community health and wellness, based on community collaboration and operational strengths, Nebraska Medicine will place a primary focus on:

Diabetes

Mental Health

Nutrition, Physical Activity and Weight

Prenatal Health and Infant Mortality

The community health needs assessment was adopted by the board of The Nebraska Medical Center and Bellevue Medical Center on June 9, 2022.

Information

To provide feedback on the contents of this report or to request a paper copy, please send a note to community@nebraskamed.com or send a letter to:

Nebraska Medicine
Attn: Community and Patient Engagement
987511 Nebraska Medical Center
Omaha, NE 68198-7511