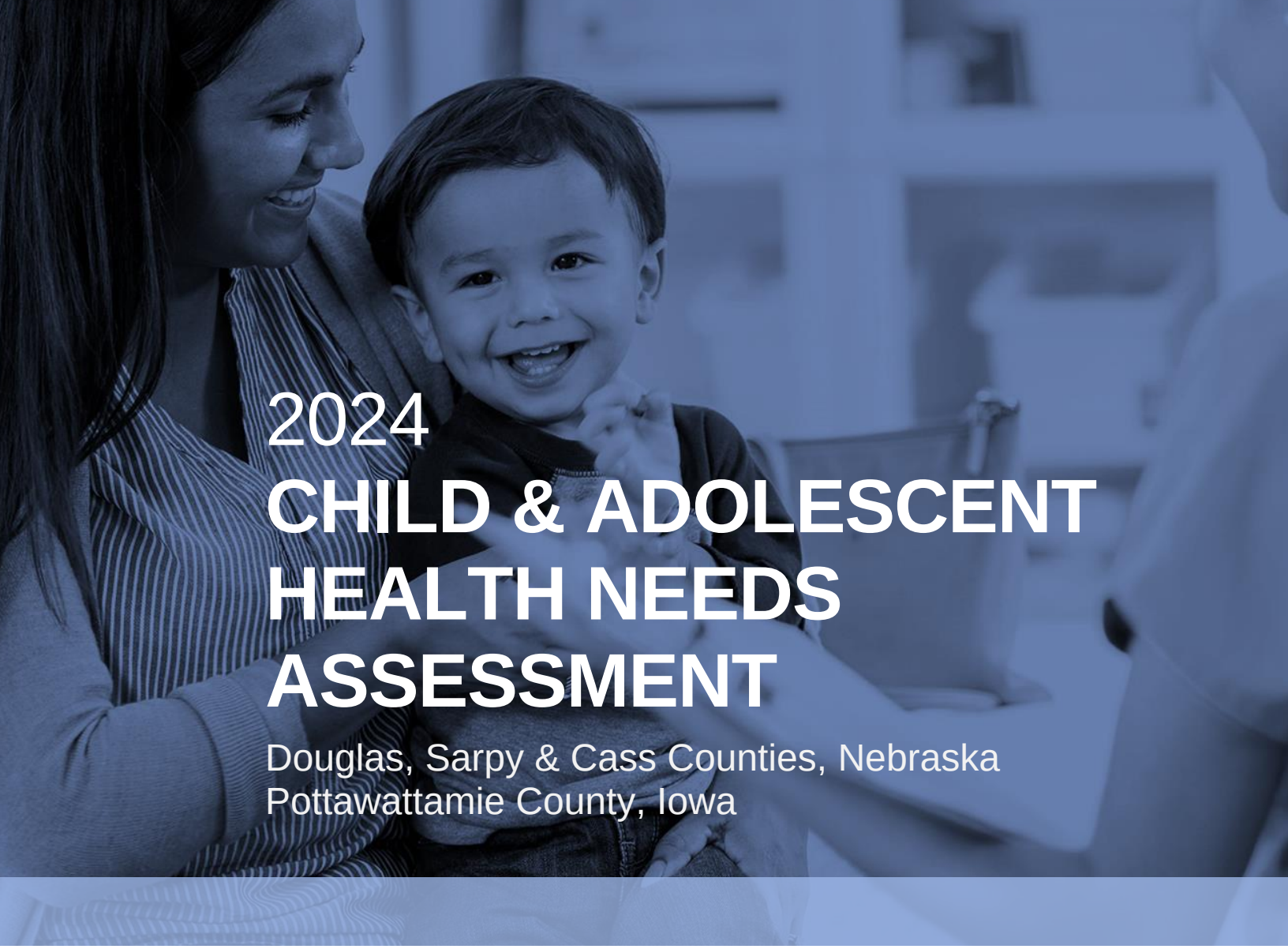

2024 CHILD & ADOLESCENT HEALTH NEEDS ASSESSMENT

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

Sponsored by:
Children's Nebraska

In collaboration with:
Boys Town National Research Hospital
Building Healthy Futures

With support from:
Charles Drew Health Center
Creighton Institute for Population Health
Douglas County Health Department
Lozier Foundation
OneWorld Community Health Center
Sarpy/Cass Counties Health Department

Prepared by
www.PRCCustomResearch.com

Children's NEBRASKA

2023-0314-02

Letter to the Community

On behalf of Children's Nebraska, I am proud to present our community's 2024 Child & Adolescent Community Health Needs Assessment. Our dedicated team and network of care providers know every child's wellbeing is deeply connected to the health and wellness of their community. For children to thrive, they need thriving communities, and we want to ensure they have them.

Children have many influences in their lives, and we recognize every adult who comes into contact with a child has a unique perspective on what that child needs to thrive. To help us understand how to best serve our community, we have been working hard with our partners this past year collecting public health and demographic data, surveying public health experts, healthcare providers and community leaders, and gathering input from more than 1,100 parents and caregivers.

These collective insights were invaluable to this work and ensured a wide range of diverse voices were represented in this process. As a result, the 2024 Child & Adolescent Community Health Needs Assessment provides us with a better understanding of the challenges facing children and families in our community.

This health needs assessment will guide the ways in which Children's continues to support health and wellness in homes, communities and schools, while informing how we provide healthcare in our clinics and hospital. Following the publication of this report, we will develop an implementation plan to address the priority needs that have been identified around access to care, mental health and the social determinants of health. The plan will serve as a roadmap for our community partnerships, programs and advocacy work for the next three years.

We sincerely thank those who contributed to, sponsored and funded this report, and we look forward to ongoing collaboration with our community partners. Together, we will continue working to fulfill our mission of improving the life of every child.

Sincerely,

Chanda Chacón, MPH, FACHE
President & CEO

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This PRC Child & Adolescent Health Needs Assessment — a follow-up to similar studies conducted in 2012, 2015, 2018, and 2021 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of children and adolescents in Omaha Metropolitan Area.

This assessment was conducted by PRC, Inc., on behalf of Children's Nebraska, Boys Town National Research Hospital, and Building Healthy Futures, with support from Charles Drew Health Center, Creighton Institute for Population Health, Douglas County Health Department, Lozier Foundation, OneWorld Community Health Center, and Sarpy/Cass Counties Health Department.

PRC is a nationally recognized health care consulting firm with extensive experience conducting community health research in hundreds of communities across the United States since 1994.

Methodology

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

PRC Child & Adolescent Health Survey

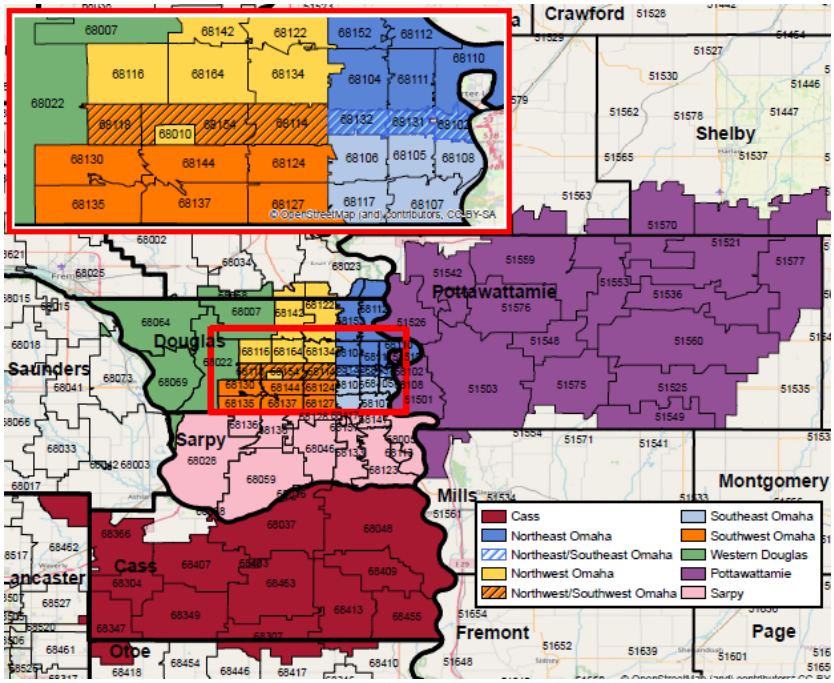
Survey Instrument

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

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Metro Area" in this report) is defined as each of the residential ZIP Codes comprising Douglas, Sarpy, and Cass counties in Nebraska, as well as Pottawattamie County in Iowa.

This community definition was determined by the sponsors of this study. For more granular assessment, Douglas County is further divided into five geographical areas (Northeast Omaha, Southeast Omaha, Northwest Omaha, Southwest Omaha, and Western Douglas County). A description is illustrated in the adjacent map.

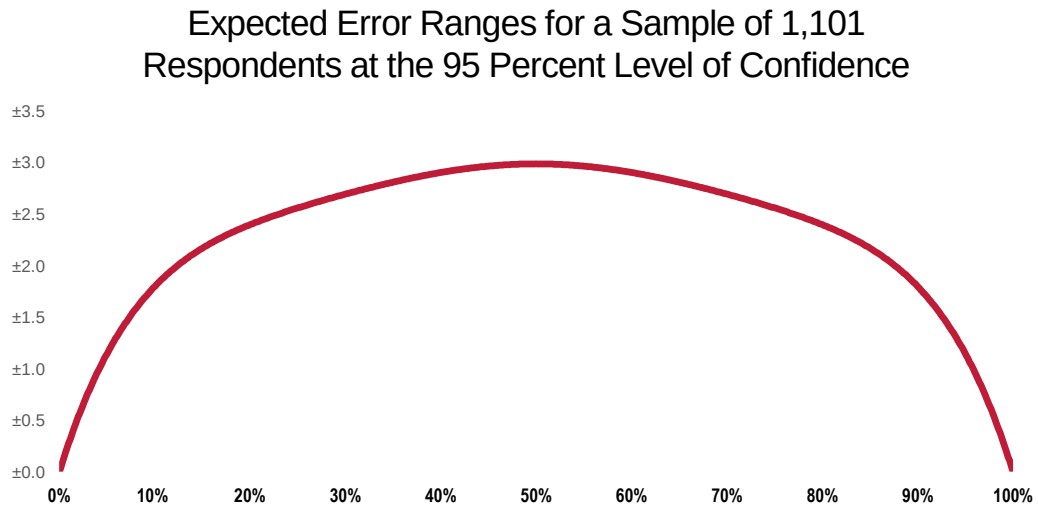


Sample Approach & Design

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

The sample design used for this effort consisted of a stratified random sample of 1,101 parents of children under the age of 18 in the Metro Area. By geography, a total of 715 surveys were conducted in Douglas County, 200 in Sarpy County, 86 in Cass County, and 100 in Pottawattamie County. Once the interviews were completed, these were weighted in proportion to the actual child population distribution so as to appropriately represent the Metro Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 1,101 respondents is ±3.0% at the 95 percent confidence level. By county: the maximum error rate is ±3.7% for Douglas County, ±6.9% for Sarpy County, ±10.6% for Cass County, and ±9.8% for Pottawattamie County.



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

Examples:
- If 10% of the sample of 1,101 respondents answered a certain question with a "yes," it can be asserted that between 8.2% and 11.8% (10% ± 1.8%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 47.0% and 53.0% (50% ± 3.0%) of the total population would respond "yes" if asked this question.

Respondent Selection

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

For purposes of this assessment, keep in mind the following terminology guidelines:

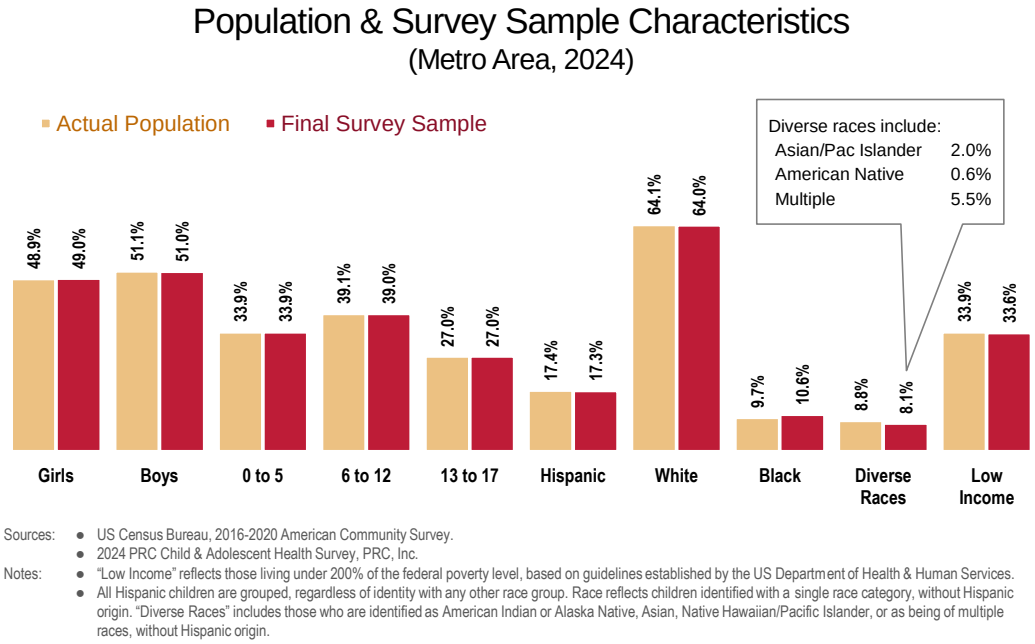
PARENTS ► When the term “parents” is used, it may include parents, grandparents, guardians, or other health care decision-makers.

CHILDREN & ADOLESCENTS ► This term, as well as references to “children” only, refers to anyone under the age of 18.

Sample Characteristics

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

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



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic children are grouped, regardless of identity with any other race group. Race reflects children identified with a single race category, without Hispanic origin. "Diverse Races" includes those who are identified as American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

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

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 220 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	18
Public Health Representatives	35
Other Health Providers	21
Social Services Providers	45
Other Community Leaders	101

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- American Heart Association
- Applied Information Management Institute
- Arbor Family Counseling
- Bellevue Public Schools
- Blue Cross and Blue Shield of Nebraska
- Boys & Girls Clubs of the Midlands
- Boys Town Hospital and Clinics
- Bright Minds, Brighter Futures
- Buffett Early Childhood Institute
- Carole's House of Hope
- CASA for Douglas County
- Catholic Charities of Omaha
- Center for Holistic Development
- CHAD Nebraska
- Charles Drew Health Center
- CHI Health Midlands
- Child Saving Institute
- Children's Nebraska
- Children's Respite Care Center
- Children's Square U.S.A.
- City Sprouts
- Code Black
- Completely KIDS
- Conestoga Public Schools
- Council Bluffs Community School District
- Creighton University
- Douglas County Board of Health
- Douglas County Health Department
- Douglas/Sarpy County WIC program
- Eastern Nebraska Community Action Partnership
- Educational Service Unit #3
- Elkhorn Public Schools
- Family Housing Advisory Services, Inc.
- FAMILY, Inc.
- Financial Beginnings
- Financial Hope Collaborative, Creighton University
- First Five Nebraska
- Food Bank for the Heartland
- Generation Diamond
- Girls Inc. of Omaha
- Greater Omaha Chamber
- Gretchen Swanson Center for Nutrition
- Gretna Public Schools
- Habitat for Humanity of Council Bluffs
- Habitat for Humanity of Omaha
- Head Start, Omaha Public Schools
- Health Center Association of Nebraska

- Heartland Family Services
- Heartland Workers Center
- Immigrant Legal Center
- inCOMMON
- Kids Can Community Center
- Kim Foundation
- Learning Community
- Legal Aid of Nebraska
- Lending Link
- Lift Up Sarpy County
- Louisville Public Schools
- Mercy Housing Midwest
- Methodist Community Counseling Program
- Metropolitan Omaha Educational Consortium
- MICAH House
- Mid-America Council, Boy Scouts of America
- MilkWorks
- Millard Public Schools
- Munroe-Meyer Institute
- Nebraska Foundation for Children's Vision
- Nebraska Department of Health and Human Services
- Nebraska Early Childhood Collaborative
- Nebraska Extension
- Nebraska Family Helpline
- Nebraska Medical Foundation
- Nebraska Methodist Health System
- Nebraska Regional Poison Center
- Nebraska State Legislature
- NeighborGood
- Nelson Mandela Elementary
- North Omaha Area Health (NOAH)
- Omaha City Parks and Recreation
- Omaha City Planning
- Omaha Community Broadcasting
- Omaha Community Foundation
- Omaha ForUs
- Omaha Home for Boys
- Omaha Public Schools
- OneWorld Community Health Centers
- Papillion La Vista Community Schools
- Plattsmouth Community Schools
- Pottawattamie County
- Pottawattamie County Board of Health
- Project Harmony
- Project Houseworks
- PTI Nebraska (Parent Training and Information)
- Raise Me to Read
- Ralston Public Schools
- Refugee Empowerment Center
- Region 6
- Restoring Dignity
- RISE
- Sarpy/Cass Health Department
- Simple Foundation
- Southside Redevelopment Corporation/Canopy South
- Springfield Platteview Community Schools
- The BRIDGE Family Resource Connector Network
- The Lazoritz Group
- The Wellbeing Partners
- Touch of Gold
- Tri-Faith Initiative
- United Way of the Midlands
- UNMC College of Public Health
- Urban League of Nebraska
- Visiting Nurse Association
- Voices for Children in Nebraska
- Weeping Water Public Schools
- Weitz Family Foundation
- Westside Community Schools
- Women's Fund of Omaha
- Woodhaven Counseling Associates
- YMCA of Greater Omaha
- Youth Emergency Services (YES)
- YouTurn

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

Public Health, Vital Statistics & Other Data

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

- 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, National Center for Health Statistics
- US Census Bureau, Decennial Census
- US Department of Health & Human Services

Note that secondary data reflect county-level data.

Benchmark Data

Trending

Similar surveys were administered in the Metro Area in 2012, 2015, 2018, and 2021 by PRC on behalf of the sponsors. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Nationwide Risk Factor Data

National survey data, which are provided in comparison charts, are taken from the *2023 PRC National Child & Adolescent Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the population of American children and youth with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

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

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.

- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

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

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized children, or children of parents who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, undocumented residents, and children of certain racial/ethnic or immigrant groups — while represented in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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

Public Comment

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

IRS FORM 990, SCHEDULE H COMPLIANCE

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

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	87
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	186
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	14
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	15
Part V Section B Line 3h The process for consulting with persons representing the community's interests	8
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	190

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Insurance Instability ▪ Difficulty Accessing Children's Health Care ○ Finding a Physician ○ Appointment Availability ○ Lack of Transportation ○ Cost of Prescriptions ○ Culture/Language Difference ▪ Lack of Financial Resilience ▪ Child Needed Specialty Care ▪ Access to Specialty Care ▪ Outmigration ▪ Utilization of Emergency Rooms ▪ Utilization of Urgent Care Centers ▪ Reliance on the Internet for Health Care Information
INJURY & SAFETY	▪ Mortality ○ Age 5-9 ○ Age 10-14 ▪ Brain Injuries/Concussions ▪ Children Feeling Unsafe at School or Going to/from School
MENTAL & BEHAVIORAL HEALTH	▪ "Fair" or "Poor" Mental Health ▪ Depression ○ Symptoms of Depression ○ Diagnosed Depression ▪ Anxiety ○ Chronic Worrying ○ Diagnosed Anxiety ○ Child Has Difficulty Sleeping ▪ Learning Disabilities ▪ Behavioral/Conduct Problems ▪ ADD/ADHD ▪ Child Lived with Someone Who Had Mental Health Issues ▪ Key Informants: *Mental & Behavioral Health* ranked as a top concern.

— *continued on the following page* —

AREAS OF OPPORTUNITY (continued)	
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Fruit/Vegetable Consumption ▪ Screen Time ▪ Overweight & Obesity ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
ORAL HEALTH	▪ Difficulty Accessing Dental Care
PARENTING EDUCATION & FAMILY SUPPORT	▪ Child Has an Adult for Guidance Outside Household [Age 5-17] ▪ Key Informants: *Lack of Parenting Education/Readiness* ranked as a top concern.
PEDIATRIC CHRONIC CONDITIONS	▪ Diabetes ▪ Conditions Requiring Therapy
PRENATAL & INFANT HEALTH	▪ Lack of Prenatal Care ▪ Infant Mortality ▪ Attitudes Toward Childhood Vaccines ▪ Key Informants: *Prenatal & Infant Health* ranked as a top concern.
SEXUAL HEALTH	▪ Gonorrhea Incidence [Children/Adults] ▪ Chlamydia Incidence [Children/Adults] ▪ Key Informants: *Sexual Health* ranked as a top concern.
TOBACCO, ALCOHOL & OTHER DRUGS	▪ Household Member Smokes (Tobacco, Marijuana, or Vaping)
VISION, HEARING & SPEECH CONDITIONS	▪ Vision Problems ▪ Recent Eye Exams ▪ Hearing Problems ▪ Chronic Ear Infections ▪ Speech/Language Problems

Community & Stakeholder Feedback on Prioritization of Health Needs

In 2024, Children's Nebraska updated its Strategic Plan. One of the five organizational goals is to "Champion the needs and welfare of children" and has three priorities:

1. Promote child and youth advocacy.
2. Impact each stage of a child's life in collaboration with families, child-serving agencies and other external partners.
3. Ensure health equity for underrepresented populations.

Children's Community Health & Advocacy team works with community partners to achieve these aims. While the Child & Adolescent Community Health Needs Assessment (CHNA) data was being gathered in the community, the Community Health & Advocacy leadership team conducted an internal strategic alignment process involving mapping current capacities, strategies, and alignment with Children's Strategic Plan. Preliminary data from the CHNA was used to identify priority areas, highlighting ongoing and

worsening disparities compared to previous years and presenting opportunities for upstream intervention at the prevention level in the following areas:

- Access to Care
- Social Determinants of Health
- Pediatric Mental Health

Quantitative and qualitative data from the CHNA in these three areas were shared with community stakeholders and members to identify community priorities and health needs through Data Gallery Walks. The Data Gallery Walks presented data in an accessible format, allowing for a better understanding of the communities' perception of the problem and community interest to address that need. Data Gallery Walks and the prioritization process are detailed below.

Feedback from community stakeholders confirmed the Impact Areas for the 2025-2027 Implementation Strategy Plan (ISP). Additionally, Children's Nebraska's School Health program strategies and growth will be integrated across the Impact Areas with the goal of serving as the trusted school health expert. Crosscutting approaches will be integrated into the organization's Impact Areas as follows:

- Focus on underrepresented populations, as defined by the National Institutes of Health (NIH).
- Use community partner sites and schools as access points for intervention and service delivery.
- Utilize the Children's Access to Care framework[1], adopted during the 2019-2021 Implementation Strategic Plan (ISP).

ACCESS TO CARE	**CHNA Supporting Data** • Families could have used help coordinating their child's health care services or providers. • Increase in parents not wanting to get a new baby all recommended vaccines. • Children lacking health insurance coverage in the past year. • Parents had difficulty getting a doctor's appointment for their child. • Parents felt the need to leave the area in order to get certain children's health care services. • 5 of 7 barriers to access to care have increased significantly since 2012.
Stakeholder & Listening Session Input *"[Immigrants and refugees] are very conscious of how they speak, because they're not able to be understood, they're not able to understand. And even myself, I have called on behalf of my clients, and the receptionist, to schedule an appointment, they're not very welcoming. So just imagine somebody who is intimidated, doesn't know the language, and you're just throwing words at them basically, because they don't understand it, they cannot retain it, and moving fast...So training people who are interacting with [immigrants and refugees] firsthand on recognizing when to bring an interpreter, ask for help, that's going to make it very easy for some of them." - Immigrant/Refugee Listening Session Attendee* *"The same for our community, most of us go to Charles Drew because of the interpretation available there... Even though it's far up north, a lot of people are buying houses nowadays towards the West…[Charles Drew] is more convenient because of the language barriers. My mom would rather do that when I'm not available, she would go to Charles Drew and she would drive 30 minutes to come over here and get her checkup and everything with a reliable translator, everything. But some people that are in the Northwest area, they've been going to CHI Immanuel, even though they're no translators or interpreters there, they rely on their kids, or some of them in their 30s, who has limited English, they try their best to go there. And so maybe have more interpretation available on hand or something." - Immigrant/Refugee Listening Session Attendee*	

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

"Access to a pediatric practitioner that knows the family and child, uses screening and conversation to identify needs for referral, follows up on environmental risks and trauma, and provides a safe space for child health and well-being. Many families do not have regular providers and use alternative systems (e.g. emergency room) for health care. Relatedly, many families do not have or do not know how to access medical insurance." - Community Leader

"Minority children and adolescents may be more likely to be uninsured or underinsured, which can limit their access to preventive services, primary care, and specialty care. Many families in North Omaha have low income, which can limit their ability to afford health care services or health insurance. This can result in delayed or foregone medical care. There is a shortage of health care providers, including pediatricians and mental health professionals, in North Omaha. This can lead to long wait times for appointments and reduced availability of services. Minority children and adolescents may face disparities in health outcomes and may experience discrimination within the health care system, which can affect their willingness to seek care and their overall health. A historical mistrust of the health care system." – Public Health Representative

"Health disparity, health systems fee-for-service structures and access to care issues make connections to care fragmented and too complex. There is limited lived experience data from a family perspective to help understand what and why challenges exist. This limits the ability to create solutions. Need broader population perspective and upstream approaches." – Other Health Provider

MENTAL HEALTH	**CHNA Supporting Data** • Parents rated mental health as the top health concern for adolescents • School-age children diagnosed with anxiety • Child worries a lot • Children have lived with someone who had a serious mental health issue • Parent awareness of mental health resources in the community • Child has difficulties sleeping • School-age children with 2+ hours of screen time per weekday

Stakeholder & Listening Session Input

Mental Health is the top concern for children and adolescents among stakeholders.

This issue has finally gotten more awareness but has significantly compounded since 2020. Schools lack resources for mental and behavioral support. Often, children with high needs are sent home when schools can't meet their needs, which creates a bigger issue for working parents. The community needs more options for families prior to crisis situations. – Social Services Provider

Though the amount of resources for mental and behavioral health is growing, there is still a big need for parents, caregivers, and people who are in contact with children to receive these types of resources. Many families, especially refugee or immigrant families, carry a stigma on mental and behavioral health, other families get overwhelmed with caring for a child that is dealing with a condition and may not know where to turn to or lose hope on the child. Treating and caring for children with various mental or behavioral health conditions can be expensive, limiting access to medications and treatments. – Public Health Representative

Especially when I compare myself with my kid, they're growing as a king and queen, because I grew up in a refugee camp, very limited food, education, everything. When I compare, even the house, I used to live in a bamboo house. So comparatively how they stay, the food that they eat, the clothes that they wear, everything is so in a high level. So the parents are like, "Oh, okay, they're okay," but they don't know what's going on. — Immigrant/Refugee Listening Session Attendee

We can see our children when they get sick, physical[ly], but we can't see when our kids are having mental sickness. That's kind of challenging, because parents, they are not able to differentiate their kids how they're doing. [B]ecause of their busy schedule...parents [are] not able to know when the kids are having all those symptoms building…and it's very hard unless they really give their time and focus to the kid. I think that's the biggest issue happening, because you know when the child is having fever or stomach ache or something, but you never know how the child is growing mentally, and if they're having any kind of mental sickness like depression, or anxiety. — Immigrant/Refugee Listening Session Attendee

Mental health is a big issue...With the young folks, what we're seeing actually, we're seeing a spike in terms of suicide ideation, substance abuse, and dependency. — Immigrant/Refugee Listening Session Attendee

SOCIAL DETERMINANTS OF HEALTH	CHNA Supporting Data
	• Children in low-income households • Families experiencing food insecurity • Families find it difficult to buy affordable fresh produce • Children living in unhealthy or unsafe housing conditions • Families do not have enough cash on hand to cover a $400 emergency expense • Families living in neighborhoods with rundown housing and sign of vandalism

Stakeholder & Listening Session Input

Poverty and Economic Status ranked as the #1 "Most Important Contributors to Health Problems Among Local Children and Youth"

Due to today's economy and workforce challenges, families are struggling to provide basic necessities, and our community resources are stretched very thin. Referrals to agencies that provided support in the past are no longer taking new clients, so families are going without. Need is far exceeding the amount of support our social support agencies can provide, thereby creating even greater strain on families. – Public Health Representative

It's a major problem for families in general, especially in areas of the county where the built environment has not been designed to accommodate safe spaces. For instance, there is not a lot of walking/running space in North Omaha, and the areas marked as "trails" are next to dangerously busy streets (i.e., trail off Sorenson Parkway), which can make it unsafe for children and adolescents interested in using the trail. In addition, most of the healthy activities cost money, which not all families can afford, especially if their focus is on basic needs (which are barely met). Therefore, the city should consider offering more programs that are free for low-income families OR free in general for all families to participate in. The promotion of these programs will need to be enhanced, as I hear many times from community residents that they "didn't know" about a program or event to promote health and well-being, mainly because it was poorly promoted. – Public Health Representative

Housing, housing, housing … we have a big gap in healthy housing options for families, and our children are suffering as a result. Without stable, healthy housing options, children will continue to experience trauma related to frequent upheaval from school and family environments, and many of their health conditions will worsen due to living in aging homes that expose them to pollutants, bed bugs, and mold. The cumulative effect are unhealthy children that lack connection to community, children that become disengaged in school, and children experiencing illnesses over and over. – Public Health Representative

The challenges that we are seeing is that as immigrants, we are not raised to go for yearly checkups, so vaccines. So when parents come over here, that is something that's very new to them. So with education and having health fairs, bringing service providers to them, that does make it easier for them to understand the importance of either vaccines or yearly checkups, or dental appointments like every six weeks, all those kinds of stuff, it comes with education. So the other thing is when parents come, they're focused on survival. So with work schedule, juggling the kids, sometimes it's a one-income household, so all their energy goes to providing those things. If we are looking at Maslow's hierarchy of needs, the basics, that's what they're focused on. So as you go up, "Do I go to work, or do I take time off unpaid just to take a child who's not sick to the doctor?" To them it makes more sense to go to work and get paid than take a well child to the doctor. — Immigrant/Refugee Listening Session Attendee

The workload, I think is something that hampers the health of the refugee children and all refugees themselves, even if they're adults. So they work a lot, and they're going to not find enough time to give it to their children, to go to hospitals for their general checkup, even if there not a bigger issue. And that small issue can lead to the bigger one, but they will ignore it because they can't take their work and they cannot find time — Immigrant/Refugee Listening Session Attendee

Data Gallery Walks

A selection of data from the CHNA was presented to community partners and members during an interactive Data Gallery Walk. Quantitative data revealing health disparities among different population groups and geographical regions in the Omaha metro was showcased on two posters for each topic, inspiring discussions on Social Determinants of Health, Access to Care, and Mental Health. An additional poster featured qualitative insights from Community Listening Sessions and the Online Key Informant Survey, adding depth and context from lived experiences. A total of five in-person Data Gallery Walks were hosted by the Community Health & Advocacy team at Children's Nebraska, United Way of the Midlands, Yates Illuminates, Creighton University at Highlander, and the Babrbara Weitz Community Engagement Center in October 2024. An asynchronous virtual event was also conducted to provide a mode of input for those unable to attend the in-person events.

Sharing CHNA data with community partners and members provides many advantages. It promotes community engagement by giving people access to information about their health needs, enhances understanding of local health issues, and fosters trust in healthcare systems by demonstrating that their concerns are recognized. This approach encourages collaboration to address complex health challenges within the community.

A prioritization survey was developed to collect feedback and affirm Children's Nebraska's priority areas from the Data Gallery Walk. As participants explored the gallery, they were asked to identify community-level priorities and strategies using an online or paper survey. They evaluated the relevance of three topic areas, pinpointed the most critical data, and suggested where Children's Nebraska could concentrate its efforts and resources.

In total, 154 people participated in the in-person Data Gallery Walks, with the virtual Data Gallery Walk having 353 reads, and 138 completed the prioritization survey.

Hospital Implementation Strategy

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

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, Metro Area results are shown in the larger, gray column.

The columns to the left of the Metro Area column provide comparisons among the four counties and the five subareas of Douglas County, identifying differences for each as "better than" (☼), "worse than" (☁), or "similar to" (⛅) the combined opposing areas in each section.

The columns to the right of the Metro Area column provide trending, as well as comparisons between local data and any available national findings and Healthy People 2030 objectives. Again, symbols indicate whether the Metro Area compares favorably (☼), unfavorably (☁), or comparably (⛅) to these external data.

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

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Child & Adolescent Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY
(Current vs. Baseline Data)

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

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

HEALTH STATUS	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child's Physical Health Is "Fair/Poor"	3.9	5.0	2.0	3.1	0.0	3.1	1.4	4.2	1.0	2.5			3.0		3.2
% [Age 0-17] Child's Activities/Abilities Limited Due to Health Condition	12.5	12.2	13.2	12.5	0.8	11.6	7.1	5.3	9.4	10.2			16.1		8.2
% [Age 5-17] Missed 10+ School Days Last Yr Due to Illness/Injury	9.0	6.4	6.4	8.1	5.6	7.2	5.6	14.3	5.3	7.0			8.5		7.3
% [Age 0-17] Child Has Brain Injury/Concussion	6.6	2.4	4.7	7.1	5.5	5.4	2.9	4.8	7.9	5.1			5.5		2.5
% [Age 0-17] Child Has a Condition Requiring Therapy	14.8	13.2	14.2	14.5	0.6	13.0	11.9	12.0	13.5	12.8					9.4
% [Age 5-17] Child's Mental Health Is "Fair/Poor"	14.3	11.5	10.5	15.7	1.9	12.1	8.0	9.4	14.3	11.3			14.4		7.9
% [Age 5-17] Child Has Depression	23.7	12.7	11.7	16.5	1.9	14.7	7.2	12.6	10.2	12.5			11.7		6.1
% [Age 5-17] Child Had Symptoms of Depression in Past Year	11.5	9.0	8.0	9.6	1.9	8.8	4.6	5.2	8.3	7.7			14.2		2.0
% [Age 5-17] Child Has Anxiety	34.0	18.9	23.0	28.2	9.9	24.7	18.1	22.5	18.9	22.5			22.5		10.1
% [Age 5-17] Child Worries A Lot	43.5	22.4	40.7	39.7	34.6	37.1	33.2	33.2	34.9	35.9			38.7		21.9
% [Age 0-17] Child Has Had Any Type of Allergy	33.3	22.1	30.2	29.6	18.8	28.1	29.5	20.7	16.4	27.0					

HEALTH STATUS (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child Has Ever Had Asthma	23.4	14.5	11.1	12.3	6.9	14.2	14.1	5.0	10.7	**13.6**			18.4		11.2
% [Age 0-17] Child Has ADD/ADHD	18.7	11.5	15.2	14.4	8.7	14.4	14.8	16.5	20.3	**15.2**			19.0		9.4
% [Age 0-17] Child Has Learning Disability	16.1	9.1	11.7	10.8	4.8	11.3	9.8	10.7	10.5	**10.8**			13.0		8.2
% [Age 5-17] Child Has Behavioral/Conduct Problems	13.0	5.9	5.5	10.6	1.9	8.2	5.1	5.7	10.6	**7.6**			10.2		5.1
% [Age 5-17] Child Has Autism/Spectrum Disorder	6.4	11.6	5.6	3.9	0.0	5.9	3.9	4.7	4.9	**5.3**			9.4		4.1
% [Age 0-17] Child Has Diabetes/High Blood Sugar	6.1	1.6	0.3	1.3	0.0	2.0	1.0	1.0	0.0	**1.5**			4.4		0.4
% [Age 0-17] Child Has Epilepsy/Seizure Disorder	4.4	1.5	1.5	2.4	0.0	2.2	1.7	1.5	2.3	**2.1**			4.4		1.5
% [Age 0-17] Child Has Migraines/Severe Headaches	14.6	5.5	3.9	11.0	3.7	8.2	7.0	5.3	3.3	**7.4**			7.9		5.4
% [Age 1-17] Child Had Cavities/Tooth Decay in Past Year	11.7	15.9	10.5	8.8	4.3	10.8	9.3	8.0	8.4	**10.1**	8.5	11.0			9.1
% [Age 0-17] Child Has Speech/Language Problems	18.3	12.1	16.4	14.7	1.5	14.2	13.8	15.3	10.4	**13.8**			16.1		10.8
% [Age 0-17] Child Has Vision Problems	23.9	18.9	21.2	28.1	15.6	22.6	21.0	17.2	16.2	**21.4**			11.4		26.2

HEALTH STATUS (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child Has Hearing Problems	10.0	4.1	8.5	4.5	4.7	6.6	7.3	8.7	4.6	6.6			9.3		3.5
% [Age 0-17] Child Has Had 3+ Ear Infections (Ever)	20.3	15.9	17.2	21.8	19.8	19.0	27.3	20.3	24.4	21.5			14.7		28.7
% [Age 5-17] Child Is Overweight or Obese	31.7	38.2	27.2	40.4	28.5	33.6	32.3	34.7	33.9	33.4			44.1		30.2
% [Age 5-17] Child Is Obese	23.1	23.8	19.2	26.7	19.6	22.8	21.8	21.3	24.2	22.7			27.2	15.5	17.1
% [Age 0-17] Child Has Sustained Injury Requiring Treatment in Past Year	13.1	9.2	15.0	11.4	10.8	12.2	10.7	13.9	9.6	11.6			15.7		15.1
Infant Deaths per 1,000 Births						6.1	3.8		7.5	5.8	5.4	4.8	5.5	5.0	4.9
[Age 1-4] Mortality Rate per 100,000										23.2	22.7	21.1	23.3		
[Age 5-9] Mortality Rate per 100,000										15.9	12.8	12.5	11.3		
[Age 10-14] Mortality Rate per 100,000										20.4	18.2	18.1	15.5		
[Age 15-19] Mortality Rate per 100,000										47.2	47.8	50.3	52.2		
[Age 1-19] Mortality Rate per 100,000										26.5	25.5	26.0	25.9	18.4	

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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BIOLOGICAL INFLUENCES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
No Prenatal Care in First 6 Months of Pregnancy (Percent of Births)						5.7	3.3			5.1	4.9	4.3	6.1		4.1
Low Birthweight (Percent of Births)						8.0	7.0	7.0	8.0	7.8	7.2	6.8	8.2		
% [Age 0-17] Child Was Ever Breastfed	68.7	80.2	77.4	79.8	91.3	78.1	85.8	89.4	70.7	79.4			70.4		74.8
% Exclusively Breastfed Until 6 Months	24.7	33.0	31.7	45.2	61.8	36.8	34.9	38.1	29.6	35.7			31.4	42.4	30.6

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

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SOCIAL ENVIRONMENT INFLUENCES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Child Lived With Someone Who Had Mental Health Issues	32.0	16.2	21.0	21.8	0.8	20.7	16.0	17.3	22.8	19.8					13.4
% [Age 0-17] Child Has Been Exposed to Neighborhood Violence	19.6	8.9	7.1	4.5	1.3	8.8	3.3	7.4	7.1	7.3					8.5
% [Age 6-17] Child "Always/Usually" Stays Calm When Challenged	70.2	70.3	69.4	76.7	81.7	72.9	81.8	68.0	62.5	73.7					77.3
% [Age 5-17] Child Has an Adult for Guidance Outside Household	93.3	85.4	92.6	96.3	94.4	92.6	95.3	94.6	99.3	94.0					96.2

SOCIAL ENVIRONMENT INFLUENCES (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Parents] Extremely Confident in Accessing Info to Keep Child Healthy	75.4	77.3	81.4	81.6	82.4	79.6	85.2	83.4	88.1	81.8					81.2
Linguistically Isolated Population (Percent)						3.6	1.3	0.3	1.6	2.8	2.8	1.9	4.0		
Children Below 200% FPL (Percent)						34.3	21.0	33.6	36.0	31.4	33.9	33.6	37.8		
% Unable to Pay Cash for a $400 Emergency Expense	46.4	39.4	28.6	23.4	7.0	31.0	23.4	22.3	37.9	29.8			34.0		20.6

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

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SOCIAL DETERMINANTS OF HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	38.7	38.0	27.0	21.9	16.5	29.1	26.0	34.1	36.0	29.3			31.7		28.2
% Food Insecure	55.2	52.6	31.3	25.8	13.0	37.2	26.0	29.6	38.1	34.6			51.2		
% Unhealthy/Unsafe Housing Conditions	24.4	10.9	7.0	4.2	1.5	10.0	7.4	9.6	10.8	9.5			21.2		9.7
% Neighborhood Has Rundown Housing or Signs of Vandalism	34.4	13.2	7.1	6.2	0.0	12.9	5.7	6.7	14.3	11.3	22.6	21.1			
% [Age 0-17] Household Member Smokes	30.7	22.7	29.4	25.3	7.8	25.4	19.1	26.5	26.4	24.1					19.4

SOCIAL DETERMINANTS OF HEALTH (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 0-17] Children “Never” Use My Neighborhood Playgrounds/Parks	13.9	8.2	9.5	4.9	7.1	8.7	1.6	13.1	9.6	7.3					5.5
% [Age 0-17] Neighborhood Is "Slightly" or "Not At All" Safe	34.5	11.6	7.5	2.9	1.3	12.0	1.9	5.1	10.2	9.3			21.7		10.2
% [Age 5-17] Child Was Bullied in the Past Year	31.0	16.6	24.1	19.8	18.7	22.5	17.7	30.0	27.2	22.2					21.2
% [Age 5-17] Child Missed School in Past Year Because Felt Unsafe	15.2	13.7	6.6	12.2	3.2	10.7	6.2	2.0	12.2	9.6			24.3		1.8
% [Age 0-17] Child Uses a Safety Restraint When Riding in a Vehicle	94.4	96.9	97.9	96.6	97.2	96.6	95.7	97.4	95.1	96.3					96.6
% [Age 5-17] Child "Always" Wears a Bike Helmet	42.1	47.2	46.4	63.6	36.5	49.4	52.1	53.2	28.6	47.9					40.3

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

better similar worse

BEHAVIORAL INFLUENCES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 2-17] Child Has 5+ Servings of Fruits/Vegetables per Day	35.2	41.7	34.8	22.2	29.7	32.4	27.8	34.7	25.0	30.6					34.9
% [Age 2-17] 7+ Servings of Sugar-Sweetened Drinks per Week	23.1	21.7	16.8	12.0	5.7	16.8	19.2	14.4	16.3	17.3					21.2

BEHAVIORAL INFLUENCES (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 2-17] Ate 7+ Meals Together as a Family in Past Week	58.0	59.1	43.2	39.5	34.8	47.7	37.5	41.5	58.4	**46.4**			38.4		49.8
% [Age 2-17] Child Was Physically Active One Hour/Day in Past Week	53.1	59.0	55.6	41.5	45.3	51.1	41.2	48.3	60.0	**49.7**			44.5	30.4	52.7
% [Age 5-17] Child Has Own Smartphone	63.3	52.2	48.5	60.6	41.5	54.8	54.7	44.8	54.6	**54.4**			62.1		
% [Age 5-17] Child Has 2+ Hours of Total Screen Time per Day	74.7	67.7	70.9	67.2	66.9	69.7	70.3	68.4	72.7	**70.2**			84.2		44.5
% [Age 5-17] Child Has Difficulty Sleeping	28.7	36.6	20.9	28.5	9.7	26.3	21.0	28.2	29.0	**25.5**			26.4		10.2
[All Ages] Gonorrhea Incidence per 100,000						318.0	133.5	72.4	245.7	**263.7**	177.5	219.3	206.5		111.6
[All Ages] Chlamydia Incidence per 100,000						662.0	398.5	186.7	476.4	**571.9**	457.2	478.5	481.3		456.5
Teen Births per 1,000 Females 15-19						20.8	11.4	13.8	22.9	**18.8**	18.3	16.3	19.3		

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

better similar worse

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 0-17] Child Has Had Routine Checkup in Past Year	89.4	96.3	90.9	91.9	93.9	92.2	92.8	86.0	93.5	92.3			90.8		84.2
% Would Not Want New Baby to Have All Recommended Vaccines	16.6	9.1	13.4	16.4	3.2	13.1	16.9	16.5	20.7	14.8			16.8		5.3
% [Age 1-17] Child Visited a Dentist/Oral Health Provider in Past Year	76.9	78.1	85.3	90.2	85.7	83.4	91.0	87.0	85.3	85.5	82.0	82.1	80.8	45.0	83.0
% [Age 1-17] Difficulty Accessing Child's Dental Care in the Past Year	13.6	11.3	7.9	10.1	3.2	9.9	6.2	11.3	12.2	9.4					6.2
% [Age 0-17] Difficulties Accessing Child's Health Care (Composite)	36.5	26.8	33.4	24.2	20.6	29.2	25.4	28.1	27.7	28.2			45.8		20.9
% [Age 0-17] Difficulty Finding Physician for Child in Past Year	12.5	9.1	9.2	3.6	2.0	7.8	7.4	8.7	4.8	7.4			18.8		3.5
% [Age 0-17] Difficulty Getting Appointment for Child in Past Year	16.2	16.4	17.6	13.3	5.9	14.9	14.5	10.2	16.2	14.8			27.5		5.8
% [Age 0-17] Cost Prevented Child's Dr Visit in Past Year	12.3	6.5	8.1	4.8	0.8	7.1	5.4	4.5	4.6	6.4			9.4		4.8
% [Age 0-17] Transportation Hindered Child's Dr Visit in Past Year	15.3	9.7	6.0	6.2	2.3	8.3	5.5	0.6	6.5	7.3			16.2		2.6
% [Age 0-17] Inconvenient Hrs Prevented Child's Dr Visit in Past Year	18.2	13.6	12.8	12.3	15.5	14.2	13.0	16.7	11.9	13.7			22.0		12.1
% [Age 0-17] Cost Prevented Getting Child's Prescription in Past Year	9.1	4.9	6.7	5.1	0.2	5.9	3.6	5.0	6.2	5.4			9.7		3.6

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
% [Age 0-17] Culture Difference Prevented Child's Dr Visit in Past Year	7.8	2.3	1.2	2.3	0.0	2.9	2.8	1.4	2.2	2.8			6.4		1.5
% [Age 0-17] Child Has Had an Eye Exam in the Past 3 Years	85.6	74.4	78.0	80.6	80.2	79.8	80.4	81.5	85.0	80.5			81.0		84.0
% [Age 0-17] Difficulties Accessing Vision Care in the Past Year	9.1	7.4	3.7	6.6	2.6	6.2	3.2	2.8	4.8	5.3					4.0
% [Age 0-17] Child Has Had Hearing Tested in the Past 5 Years	87.7	84.2	81.0	86.6	86.7	85.0	89.6	89.7	86.9	86.5			86.1		72.1
% [Age 0-17] Child Has Had 2+ ER Visits in Past Year	22.8	14.6	12.3	11.5	4.9	14.1	9.4	11.8	12.2	12.8			19.0		10.0
% [Age 0-17] Child Used Urgent Care in the Past Year	42.3	51.0	43.0	46.3	42.0	45.2	44.4	42.5	53.4	45.8			55.9		32.4
% [Age 0-17] Child Is Uninsured	3.0	8.5	2.0	4.3	11.1	4.9	3.2	3.3	6.9	4.7			4.5		4.4
% [Age 0-17] Child Has Been Without Insurance At Some Point	14.4	17.0	11.0	11.7	11.8	13.1	10.9	6.6	12.0	12.3			14.9		7.4
% [Parents] Could Use Help With Health Care Service Coordination	21.8	17.0	13.1	10.2	1.3	13.8	12.6	13.2	19.6	14.1					14.5
% Child Needed to See a Specialist in the Past Year	36.8	40.0	39.9	36.8	20.2	36.7	44.0	42.4	31.1	37.9			44.7		29.5
% [Child Needing] "Major/Moderate" Problem Getting Specialty Care	31.6	25.9	29.6	28.7		27.9	37.3			29.4			57.0		19.9

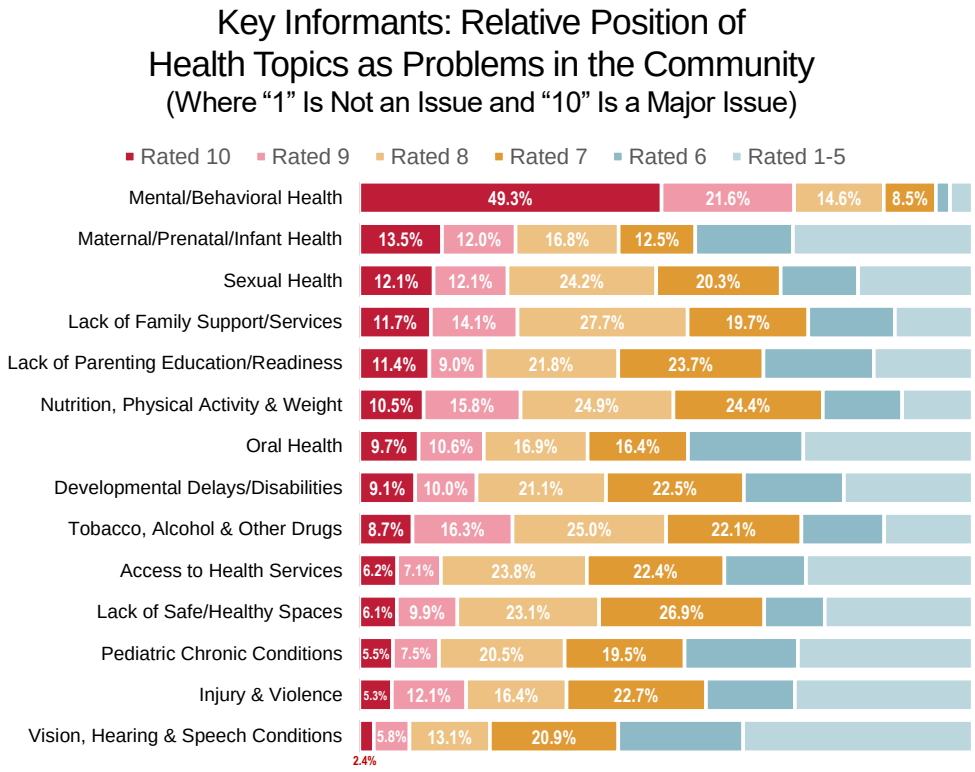
ACCESS TO HEALTH CARE (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG COUNTIES				Metro Area	METRO AREA vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 5-17] Parent Aware of Community Mental Health Resources	70.3	71.7	66.1	68.3	79.0	69.8	74.0	79.3	74.8	71.5			67.5		67.2
% [Age 5-17] Child Receiving Mental Health Treatment	26.7	18.2	23.0	22.2	3.9	20.9	16.1	19.3	23.2	20.0			19.5		
% Unable to Get Child's Mental Health Services in Past Year	11.4	8.8	9.9	10.2	8.1	9.9	4.3	4.6	3.6	7.8			11.4		
% [Parents] Feel Need to Leave the Area for Children's Health Svcs	21.1	11.8	11.1	11.1	6.0	12.9	13.8	34.5	24.9	14.9			36.3		11.7
% [Parents] Child's Health Care Experiences Were Worse Due to Race	2.9	2.4	1.4	1.5	0.0	1.8	1.0	1.5	0.0	1.4					1.2
% Rely on the Internet for Health Care Information	12.6	13.6	13.3	10.5	10.9	12.3	12.3	19.2	13.1	12.6					7.5

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

better similar worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 14 health issues is a problem for children and/or adolescents in their own community, using a 10-point scale where a rating of "1" is not an issue and "10" is a major issue. The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



PERCEPTIONS OF TOP HEALTH ISSUES

PERCEIVED TOP HEALTH ISSUES

Child Health

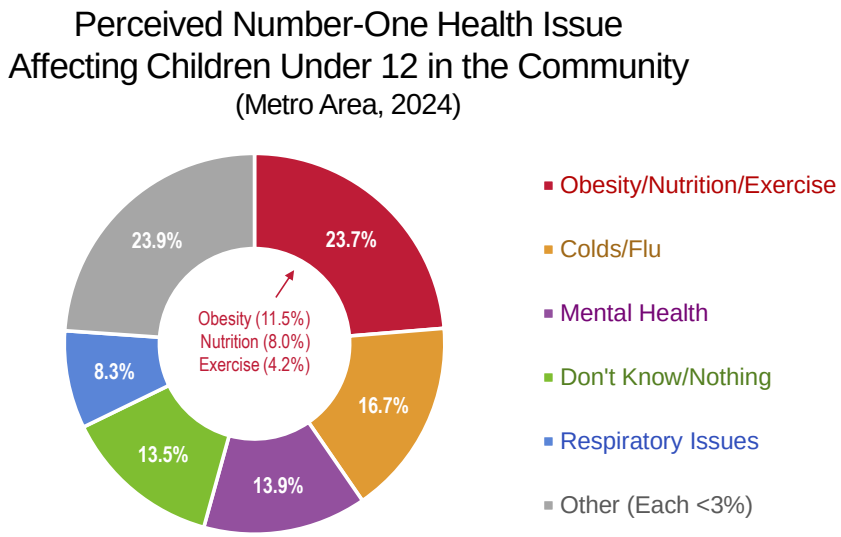
The initial inquiry of the PRC Child & Adolescent Health Survey asked respondents the following:

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

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

The interrelated issues of obesity, nutrition, and exercise received the largest share of responses (23.7%) as the perceived number-one health issue for children under the age of 12.

Colds/flu was second, with 16.7% of responses, followed by mental health (13.9%) and respiratory issues (8.3%).



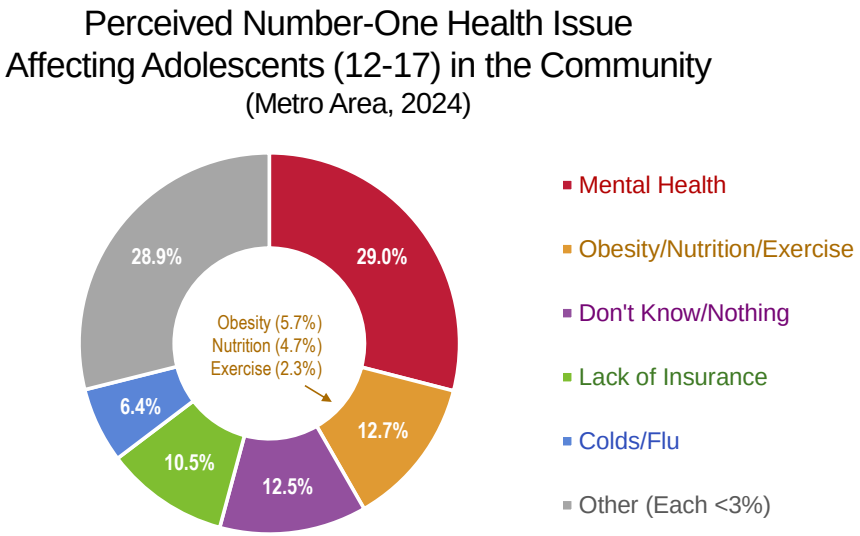
Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 303]
Notes: • Reflects total sample of respondents.

Adolescent Health

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

Mental health received the largest share of responses (29.0%) when parents were asked to name the number-one health issue for adolescents (age 12-17).

Other frequent responses included obesity/nutrition/exercise (mentioned by 12.7%), lack of insurance (10.5%), and colds/flu (6.4%).



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 304]
Notes: • Reflects total sample of respondents.

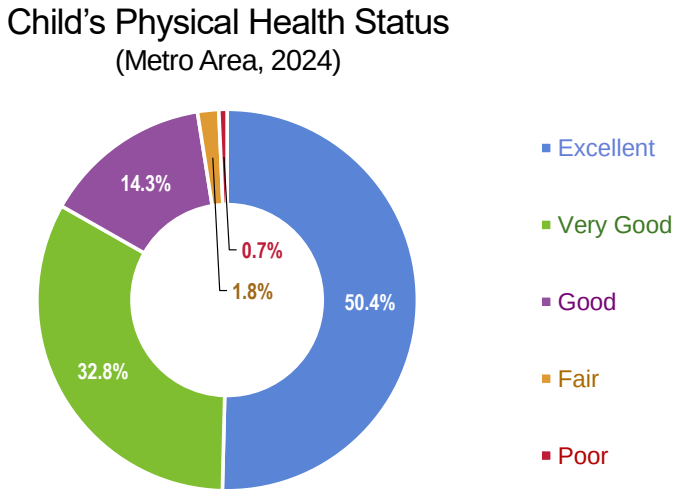
HEALTH STATUS

OVERALL PHYSICAL HEALTH

Child's Physical Health Status

"Would you say that, in general, your child's physical health is: excellent, very good, good, fair, or poor?"

Most Metro Area parents rate their child's physical health favorably (responding "excellent," "very good," or "good").



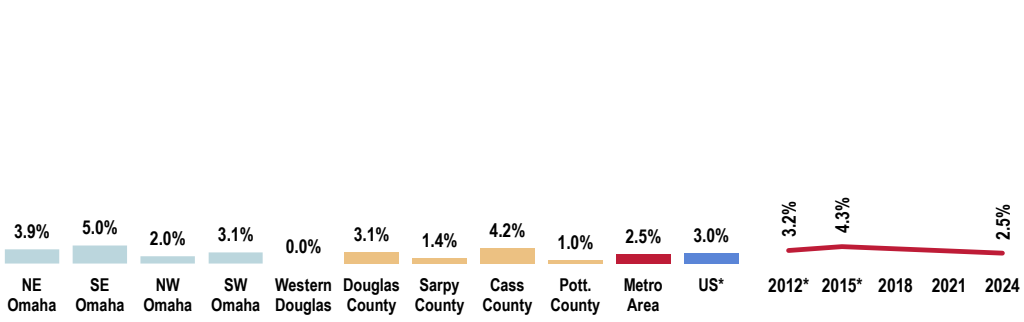
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 305]
Notes: ● Asked of all respondents about a randomly selected child in the household.

However, 2.5% of Metro Area adults believe that their child's physical health is "fair" or "poor."

NOTE: When the term "parents" is used, it may include parents, grandparents, guardians, or other health care decision-makers.

When the term "children and adolescents" is used (or simply "children"), it refers to anyone under the age of 18.

DISPARITY ► Lowest in Western Douglas County. More often reported among parents of adolescents (age 13 to 17) and those with very low incomes.

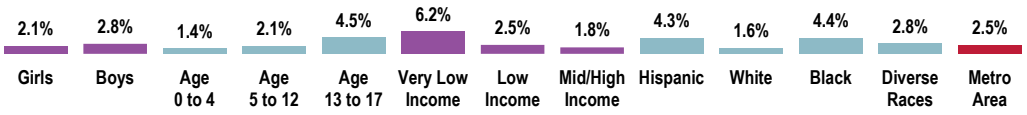


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 305]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.
● * Measure of child's overall health.

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.

Experience “Fair” or “Poor” Physical Health

(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 305]
Notes: ● Asked of all respondents about a randomly selected child in the household.

INCOME & RACE/ETHNICITY

INCOME ► Income categories used to segment survey data 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 2022 guidelines place the poverty threshold for a family of four at $27,750 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 (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used and represent the race/ethnicity of the randomly selected child. All Hispanic children are grouped, regardless of identity with any other race group. Data are also detailed for children identified (by the responding parent) with a race category, without Hispanic origin. “White” reflects those who are identified as White alone, without Hispanic origin; “Black” reflects those who are identified as Black or African American alone, without Hispanic origin. “Diverse Races” includes those who are identified as American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

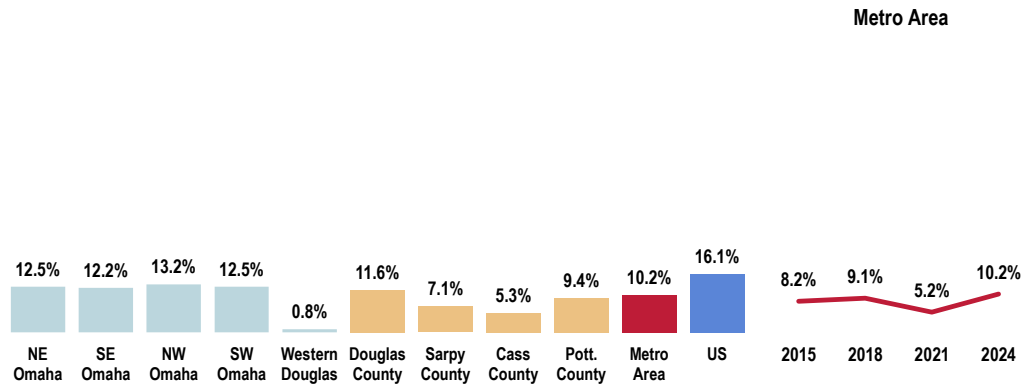
Activity Limitations

A total of 10.2% of Metro Area children are limited or prevented in some way in their ability to do things most children of the same age can do because of a medical, behavioral, or other health condition.

BENCHMARK ► Lower than the US percentage.

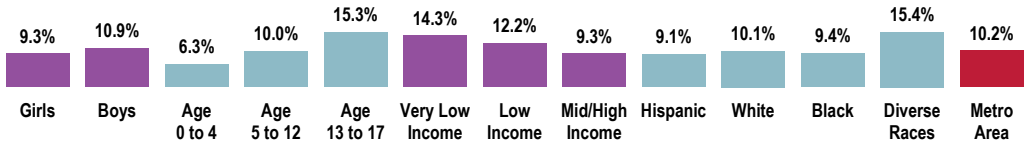
DISPARITY ► Highest in Douglas County. Increases with age.

Prevalence of Activity Limitations



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 47]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Prevalence of Activity Limitations
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 47]
Notes: ● Asked of all respondents about a randomly selected child in the household.

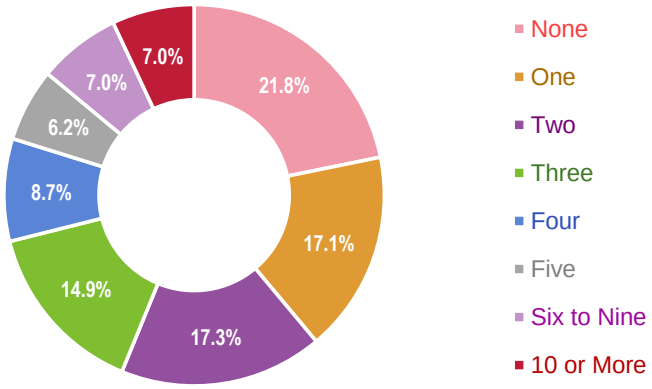
School Days Missed Due to Illness or Injury

While most Metro Area school-age children (age 5-17) missed few, if any, school days in the past year due to illness or injury, 7.0% are reported to have missed 10 or more.

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

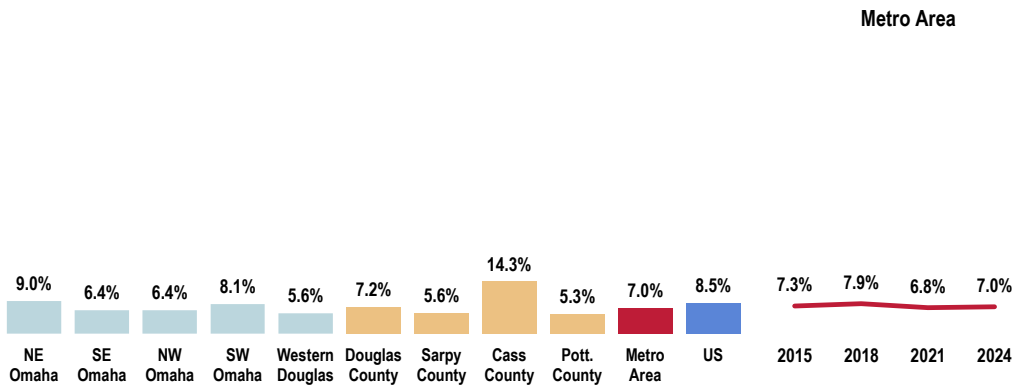
DISPARITY ► More often reported among parents of adolescents (age 13 to 17) and those with lower incomes.

Number of School Days Missed in the Past Year Due to Illness or Injury
(Metro Area Children Age 5-17, 2024)



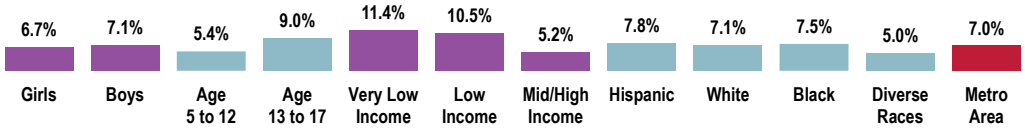
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 67]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 67]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.

Child Missed 10 or More School Days in the Past Year Due to Illness or Injury
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 67]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5 to 17.

Conditions Requiring Therapy

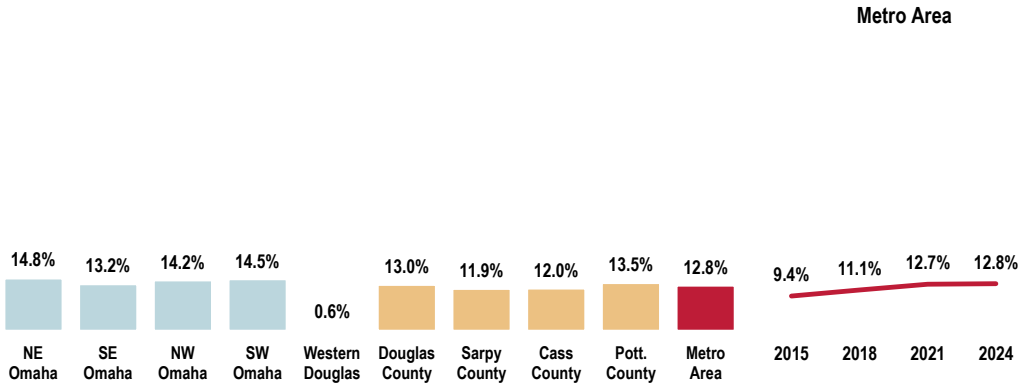
Among surveyed parents in the Metro Area, 12.8% indicate that their child (under age 18) has a condition that requires special therapy.

Therapy might include physical, occupational, or speech therapy.

TREND ► Trending higher over time.

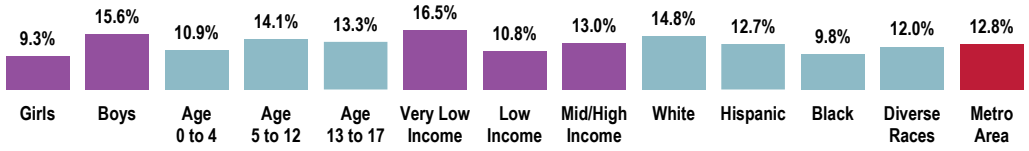
DISPARITY ► Lowest (null response) in Western Douglas County. More often reported among parents of boys.

Child Has a Condition That Requires Therapy



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has a Condition That Requires Therapy
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents about a randomly selected child in the household.

MENTAL HEALTH

ABOUT MENTAL HEALTH

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

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

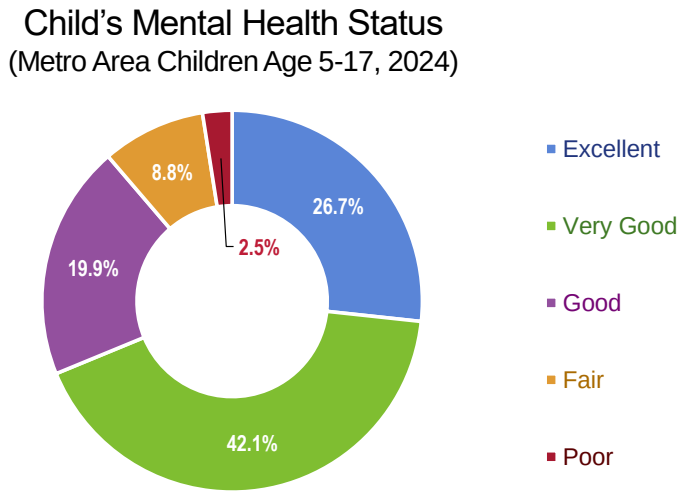
Mental health conditions … are major causes of illness and disability among young people. … The consequences of not addressing mental health and psychosocial development for children and adolescents extend to adulthood and limit opportunities for leading fulfilling lives.

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

Child's Mental Health Status

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

Most Metro Area parents of children age 5-17 rate their child's mental health — which includes stress, depression, and problems with emotions — favorably (responding "excellent," "very good," or "good").



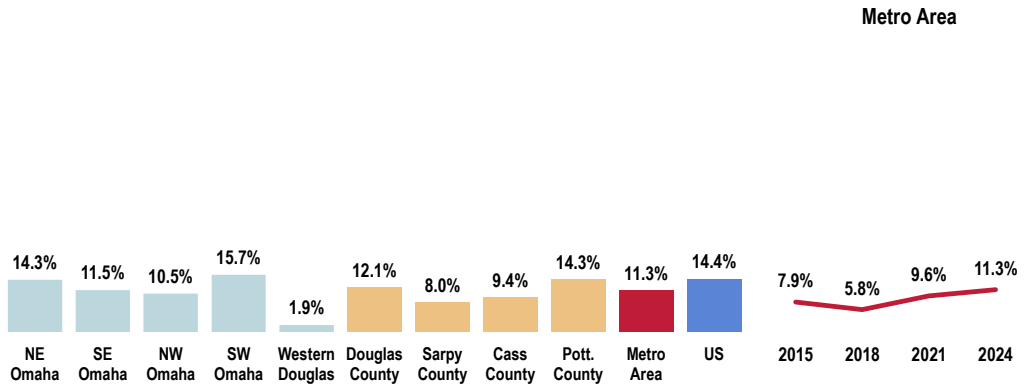
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 55]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

However, 11.3% of Metro Area parents of school-age children (ages 5 to 17) believe that their child's mental health is "fair" or "poor."

TREND ► Rising significantly higher over time.

DISPARITY ► Lowest in Western Douglas County. More often reported among girls and adolescents (age 13 to 17). Especially high among those living at or below the federal poverty level.

Child Experiences "Fair" or "Poor" Mental Health
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 55]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Experiences "Fair" or "Poor" Mental Health
(Metro Area Children Age 5-17, 2024)

Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 55]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Depression

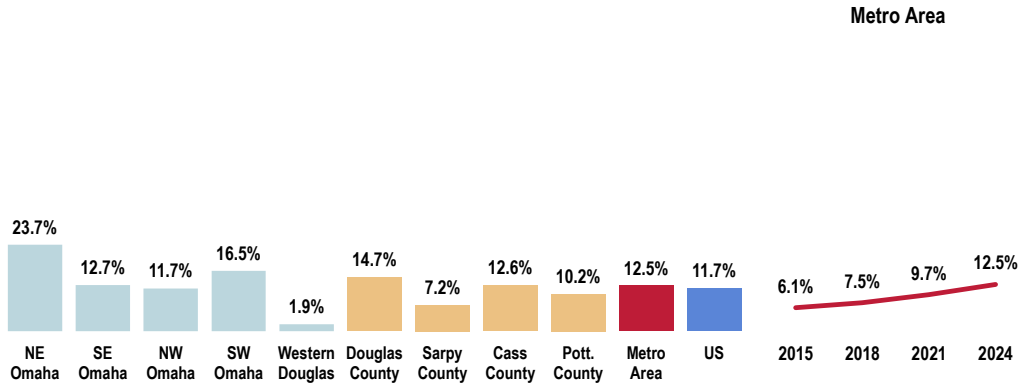
Diagnosed Depression

A total of 12.5% of Metro Area parents report that they have been told by a doctor or other health care provider that their school-age child had depression.

TREND ► Rising significantly higher over time.

DISPARITY ► Highest in Northeast Omaha. More often reported among girls, adolescents (age 13 to 17), and those in households with very low incomes.

Child Has Been Diagnosed with Depression
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 61]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has Been Diagnosed with Depression
(Metro Area Children Age 5-17, 2024)

Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 61]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Signs of Depression

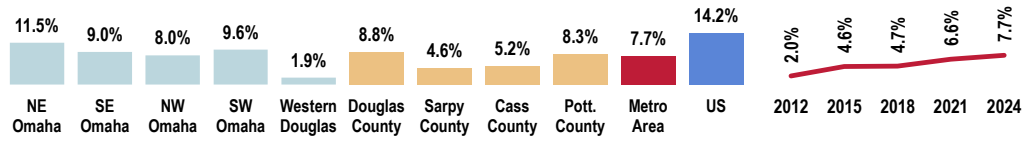
A total of 7.7% of Metro Area parents indicate that their school-age child felt so sad or hopeless almost every day for two weeks or more in the past year that the child stopped doing some usual activities.

BENCHMARK ► Well below the US percentage.

TREND ► Trending significantly higher over time.

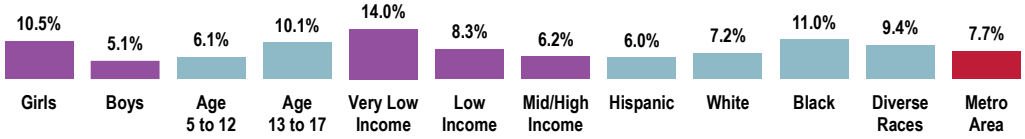
DISPARITY ► Particularly low in Western Douglas County. More often reported among girls, adolescents (age 13 to 17), and children in households with very low incomes.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Items 60]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Felt Sad or Hopeless for Two or More Weeks in the Past Year and Stopped Performing Usual Activities
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 60]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Anxiety

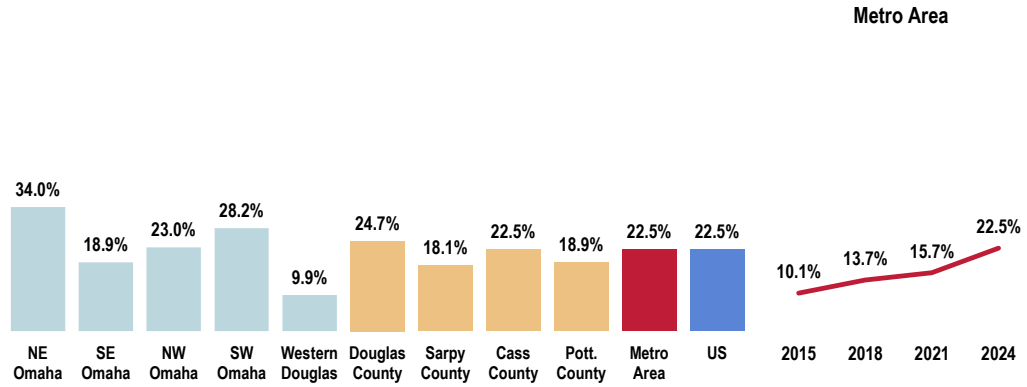
Anxiety Disorders

A total of 22.5% of Metro Area parents report that they have been told by a doctor or other health care provider that their school-age child had anxiety.

TREND ► Represents a dramatic increase over time.

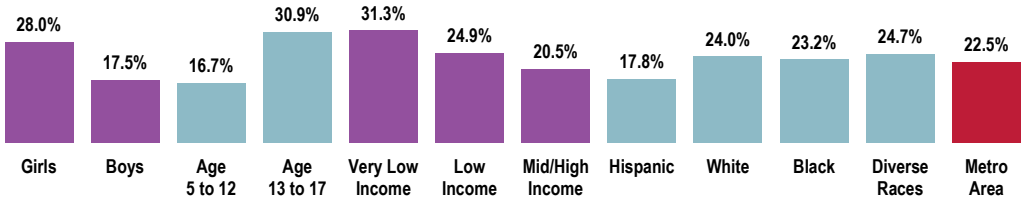
DISPARITY ► Highest in Northeast Omaha. More often reported among girls, adolescents (age 13 to 17), and children in very low income households.

Child Has Been Diagnosed with Anxiety
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 64]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has Been Diagnosed with Anxiety
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 64]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Worry

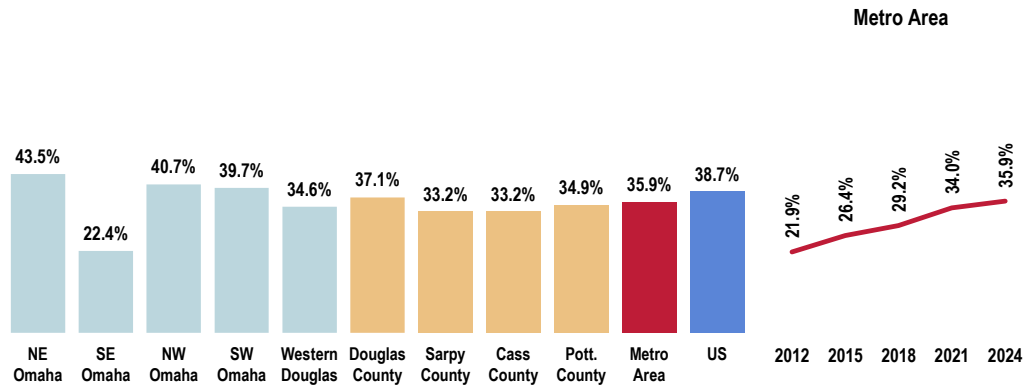
More than one-third (35.9%) of Metro Area parents indicates that their school-age child worries a lot.

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

TREND ► Rising significantly over time.

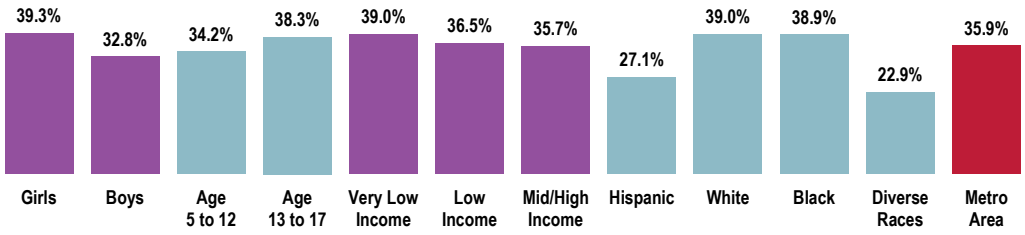
DISPARITY ► Lowest in Southeast Omaha. More often reported among parents of girls, White children, and Black children.

Child Worries a Lot
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 58]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Worries a Lot
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 58]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

CHRONIC CONDITIONS

Allergies

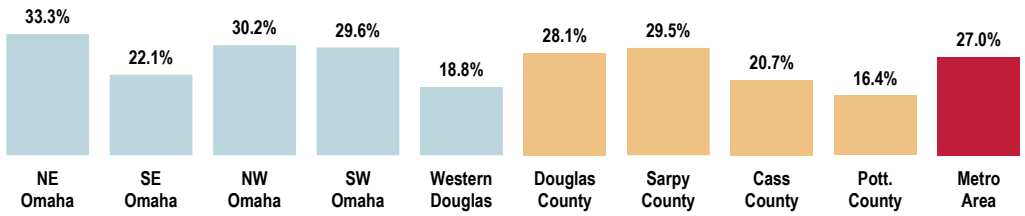
Respondents were asked to report on the prevalence of a number of different chronic conditions and illnesses afflicting children.

"Has this child ever suffered from or been diagnosed with any of the following …"

A total of 27.0% of Metro Area children suffer from some type of allergy, including respiratory, food, and skin allergies.

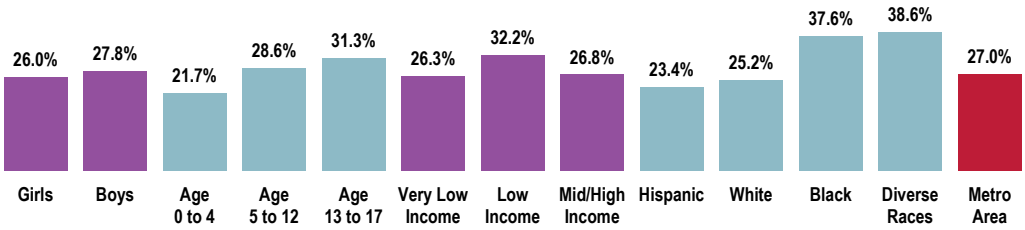
DISPARITY ► Lowest in Pottawattamie County. Within Douglas County, statistically low in Southeast Omaha. Increases with age and is more often reported in Black children and children of diverse races.

Child Has Had Any Type of Allergy



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 313]
Notes: • Asked of all respondents about a randomly selected child in the household.
• Includes any type of allergy, such as respiratory, food, skin, etc.

Child Has Had Any Type of Allergy
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 313]
Notes: • Asked of all respondents about a randomly selected child in the household.
• Includes any type of allergy, such as respiratory, food, skin, etc.

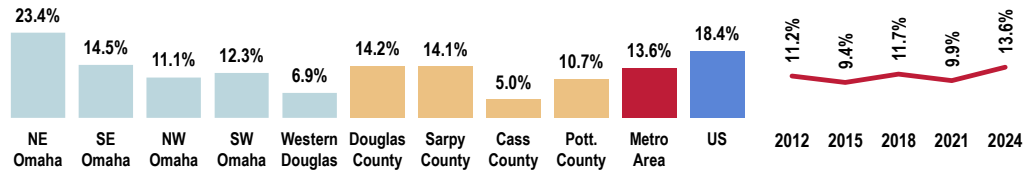
Asthma

A total of 13.6% of Metro Area children age 0 to 17 have been diagnosed with asthma.

BENCHMARK ► Lower than the national percentage.

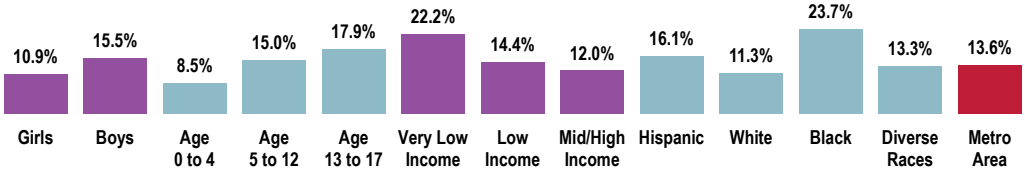
DISPARITY ► Particularly high in Northeast Omaha. More often reported among boys and children age 5 and older. Especially high among those in very low income households and in Black children.

Child Has Ever Been Diagnosed With Asthma



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Ever Been Diagnosed With Asthma
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 33]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Cognitive & Behavioral Disorders

Attention Deficit Hyperactivity Disorder (ADHD)

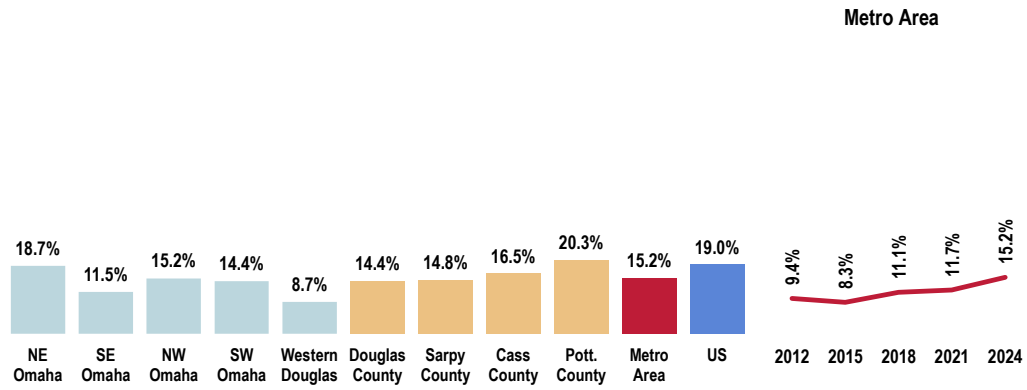
A total of 15.2% of Metro Area children are reported to have ever suffered from or been diagnosed with ADHD (also sometimes referred to as attention deficit disorder, or ADD).

BENCHMARK ► Lower than the US finding.

TREND ► Represents a significant increase from previous surveys.

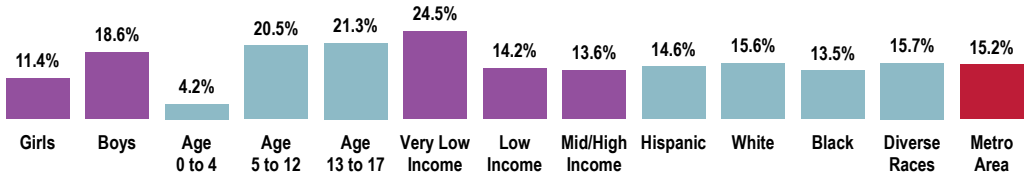
DISPARITY ► More often reported among boys, children age 5 and older, and children in very low income households.

Child Has ADD/ADHD



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 46]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has ADD/ADHD
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 46]
Notes: ● Asked of all respondents about a randomly selected child in the household.

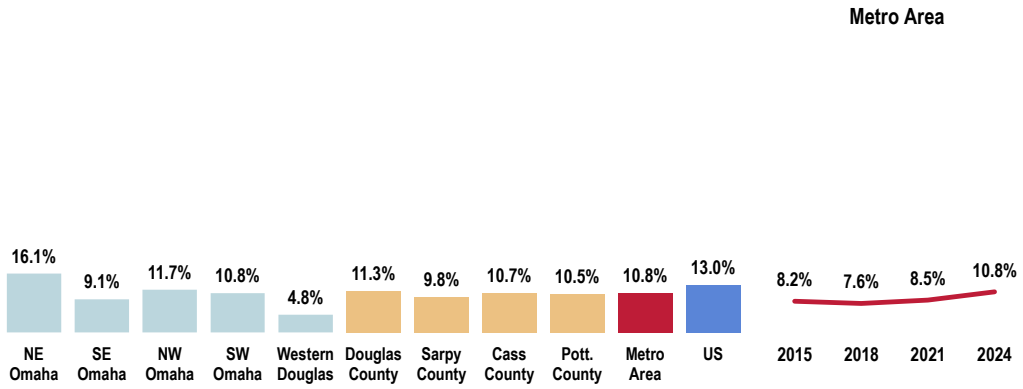
Learning Disabilities

A total of 10.8% of Metro Area children are reported to have some type of learning disability.

TREND ► Marks a significant increase over time.

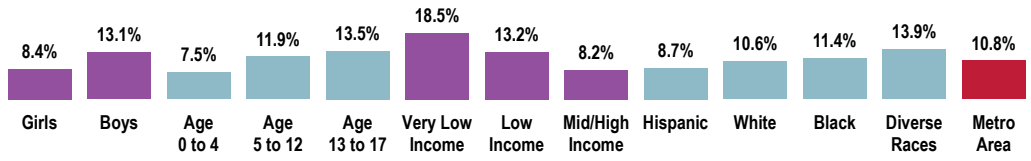
DISPARITY ► Highest in Northeast Omaha. More often reported among boys, children age 5 and older, and those in households with very low incomes.

Child Has a Learning Disability



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 44]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has a Learning Disability
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 44]
Notes: ● Asked of all respondents about a randomly selected child in the household.

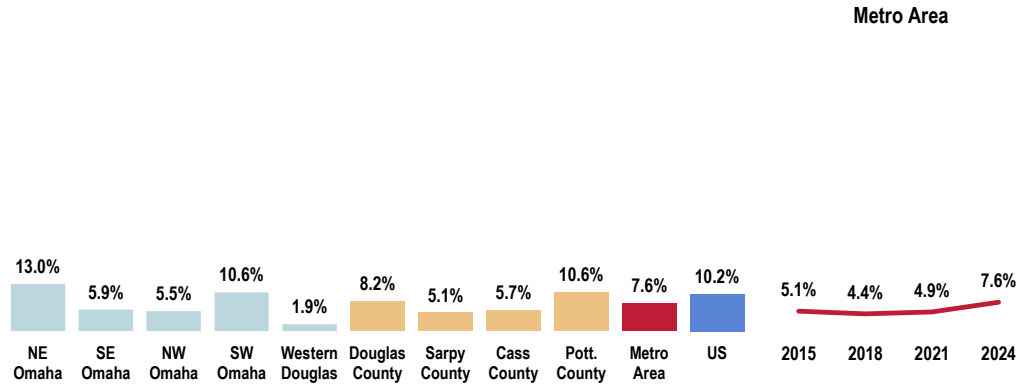
Behavioral/Conduct Disorders

Among Metro Area parents of children age 5-17, 7.6% indicate that a doctor or other health care provider has ever told them that their child has some type of behavioral or conduct disorder, such as oppositional defiant disorder or conduct disorder.

TREND ► Denotes a significant increase from previous surveys.

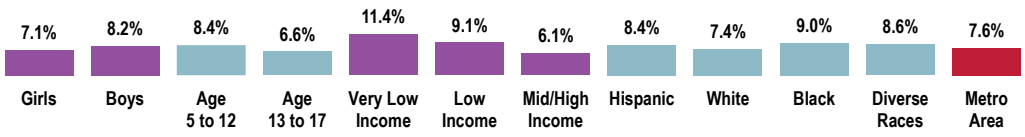
DISPARITY ► Lowest in Western Douglas County.

Child Has a Behavioral/Conduct Disorder
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 62]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has a Behavioral/Conduct Disorder
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 62]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

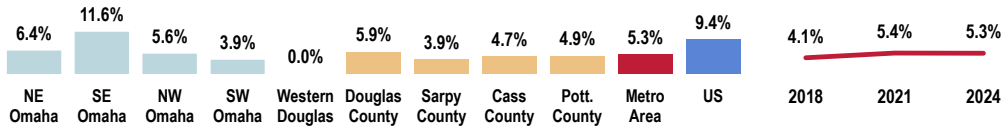
Autism Spectrum Disorders

Among Metro Area parents of children age 5-17, 5.3% indicate that their child has been diagnosed with autism, Asperger's disorder, pervasive developmental disorder, or autism spectrum disorder.

BENCHMARK ► Lower than the US percentage.

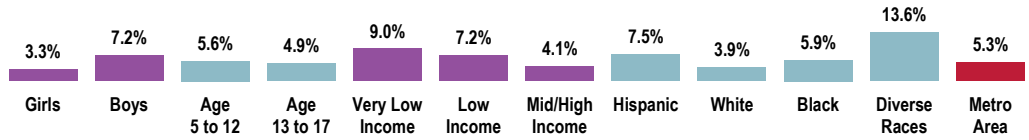
DISPARITY ► Particularly high in Southeast Omaha. More often reported in boys, children in very low income households, and children of diverse races.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 63]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

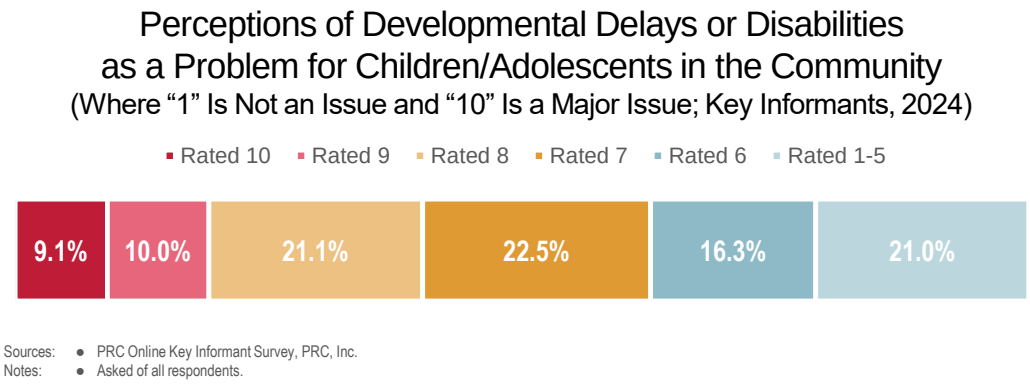
Child Has Autism, Asperger's Disorder, Pervasive Developmental Disorder, or Autism Spectrum Disorder
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 63]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Key Informant Input: Developmental Delays and Disabilities

Four in 10 key informants taking part in an online survey characterized *Developmental Delays and Disabilities* as an "8," "9," or "10" for children/adolescents in the community (10-point scale where "10" is a major issue).



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

Access to Care/Services

Limited access to health care services can mean that developmental delays and intellectual disabilities are not identified or addressed early. Early intervention is critical for managing these issues and improving outcomes for children. There may be a lack of awareness and understanding about developmental and intellectual delays, leading to stigma and reluctance to seek help. This can delay diagnosis and intervention. Addressing these challenges requires a comprehensive approach that includes improving access to quality education, healthcare, and support services, as well as addressing socioeconomic factors and raising awareness about the importance of early intervention for children with developmental and intellectual delays. – Public Health Representative

Lack of resources to serve children and adolescents that are not eligible in the ID/DD system. – Other Health Provider

Access to the Early Development Network through substantiated findings and adequate services to address needs is a growing challenge. What are the data behind referrals and substantiated findings? Additionally, what services are being offered and what are the associated impacts and outcomes? Do these data exist? – Community Leader

Our resources are stretched thin. – Community Leader

Wait lists for evaluation can be over 1 year and then typically another 6 months wait for ABA services. We know early intervention works but it often takes 1.5 years to access it and we miss out on valuable time for intervention. Very few services for young adults with I/DD and it's hard to find a medical home that understands how to work with young adults/adults with I/DD after they transition from pediatric care. – Other Health Provider

Not enough resources to assess and then support children and families. Wait lists that go multiple months and then access to needed services is disjointed and difficult to follow through with the plan. – Social Services Provider

Very, very, very long waiting lists for children with developmental and intellectual delays to see a provider. – Community Leader

Families need resources and they aren't always accessible. – Community Leader

Waiting too long to get in to see a doctor. – Community Leader

Developmental and Intellectual delays and disabilities are influenced by biological conditions as well as environmental conditions that are impacted by the family's access to appropriate medical and educational resources. In communities of color, these resources are nonexistent or unavailable. – Other Health Provider

Long waiting lists for services, specifically as adolescents/young adults reach adulthood. Having a pool of mental health therapists educated and trained to work with children and youth with developmental and intellectual delays and disabilities is needed. Employment opportunities are limited; housing is scarce; other services to help young people with developmental and intellectual delays/disabilities. – Other Health Provider

Because there is such a lag time when referring them until they can be seen. – Physician

Awareness/Education

> There is a growing number of children with developmental and intellectual delays and disabilities. Parents are not educated as to where to receive information and support. Parents are often left to research on their own and systems of care are hard to navigate on your own. There is also a huge gap in support for those transitioning from pediatrics to adult care. – Community Leader
>
> I think there's a lack of education for parents. Often parents don't want a child to be labeled with a disability, but this then causes a lack of available support for the child. There is also a lack of resources within schools for children with these needs. – Social Services Provider
>
> Children will have better educational and health care outcomes in all areas of their lives, from infants to old age. – Community Leader
>
> Generally, people with I/DD are othered and separated so when it comes to puberty, bodily autonomy, consent and healthy relationships, this population is often left out of the conversation. Yet, they also have relationships and bodies that go through these changes. – Public Health Representative
>
> I hear parents and families complain that have no idea where to turn to for help. – Community Leader
>
> Not all parents have available resources to understand the need to get their children the assistance they need at an early age. Navigating the health system is complex and can be intimidating. – Community Leader

Incidence/Prevalence

> My organization has seen an increase in children with developmental and intellectual delays. – Social Services Provider
>
> I've been working with a coalition of early childhood education and health care providers who have identified this as a frequent concern. – Social Services Provider
>
> Many children are being diagnosed with delays, however, with programming that focuses on early identification and intervention, we are moving in the right direction. – Social Services Provider
>
> I think that the prevalence of these delays and disabilities are under-identified, and the resources are expensive and less available to lower-resourced families. – Public Health Representative
>
> Autism spectrum disorder diagnoses appear to be up. Wait lists for ABA therapy services are long and care is incredibly expensive. It is difficult to get appointments with specialists, and wait times and follow-ups take forever. – Social Services Provider

Lack of Providers

> Utilizing services through the school district is challenging because there is a severe shortage in staff across all the districts. Additionally, there are not enough specialists in the area, so finding a specialist that is accepting new patients/clients is rare. It is not accessible through insurance because a lot of specialists do not take all insurance plans. – Social Services Provider
>
> There are few providers who are trained and able to provide appropriate assessments (and treatment) to identify disabilities and developmental delays. Those that are experts have a long waitlist. Munroe-Meyer is an excellent example, they can perform assessments, however there is a 6-month or longer waitlist. Services cannot start until after the child has testing completed, then the child may go on another waitlist to see a provider for the disability they have. In the meantime, the child goes without proper care, and behaviors escalate. If the child is in foster care, they are often placed with families that can't provide proper care to the developmentally delayed child, and the child is moved, which adds more trauma. – Other Health Provider

Prevention/Screenings

> Early detection and intervention for all is not happening. – Social Services Provider
>
> I believe we can do a better job at early detection and also at avoiding overdiagnosis of what seems like the diagnosis of the day. – Community Leader

Co-Occurrences

> Developmental and intellectual delays are one of the most common causes of referrals to primary physicians. Delays can significantly impact a child's ability to reach milestones and can impact learning, social interactions, and family dynamics. – Community Leader

Cultural/Personal Beliefs

> Culturally frowned upon, so some simply ignore it. – Social Services Provider

Refugee Population

> We have received a much larger number of refugee children with this problem this past year, and although CHI has been very helpful, it has been hard to get the assessments done by OPS in time for the kids to start attending school, and there are long delays to start receiving help for the family. – Social Services Provider

Impact on Quality of Life

> Developmental and intellectual delays and disabilities create additional challenges for the children and add a layer of complexities for parents who are also trying to maintain a job to financially support their families. These diagnoses can be devastating for the children, for the parents, and for the families who can already barely afford basic expenses. – Social Services Provider

Vulnerable Populations

> I have a great number of autistic children in my practice. They are mostly Karen. They have speech delay and ADHD. They are very similar. They are able to follow commands. Some of my other patient populations are children that have been exposed to drugs and alcohol while in utero, but I don't believe this to be the case with the Karen population unless it is betel gum. – Physician

Diabetes

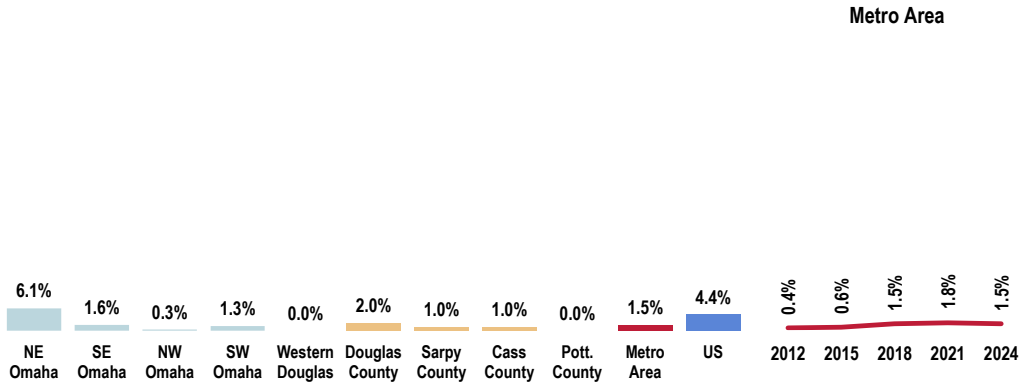
A total of 1.5% of Metro Area children age 0 to 17 have been diagnosed with diabetes.

BENCHMARK ► Lower than the national finding.

TREND ► Marks a significant increase from the 2012 benchmark, although similar to more recent findings.

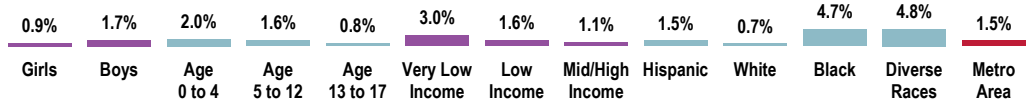
DISPARITY ► Highest in Northeast Omaha.

Child Has Diabetes



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 35]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Diabetes
(Metro Area, 2024)



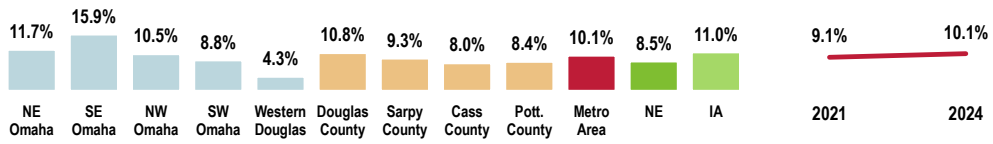
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 35]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Chronic Dental Issues

A total of 10.1% of Metro Area parents with children age 1-17 report frequent or chronic difficulty with cavities or decay in their child's teeth in the past year.

DISPARITY ► Highest in Southeast Omaha. More often reported in children age 5 and older, those with lower incomes, and Hispanic children.

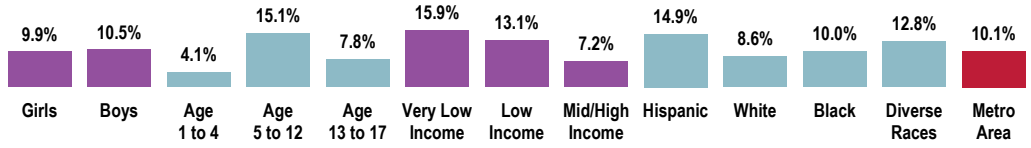
Child Had Frequent Issues With Cavities or Tooth Decay in the Past Year
(Children Age 1-17)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 310]
- Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved January 2024 from www.childhealthdata.org. CAHMI: www.cahmi.org.

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

Child Had Frequent Issues With Cavities or Tooth Decay in the Past Year
(Metro Area Children Age 1-17, 2024)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 310]

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

Speech/Language, Hearing & Vision

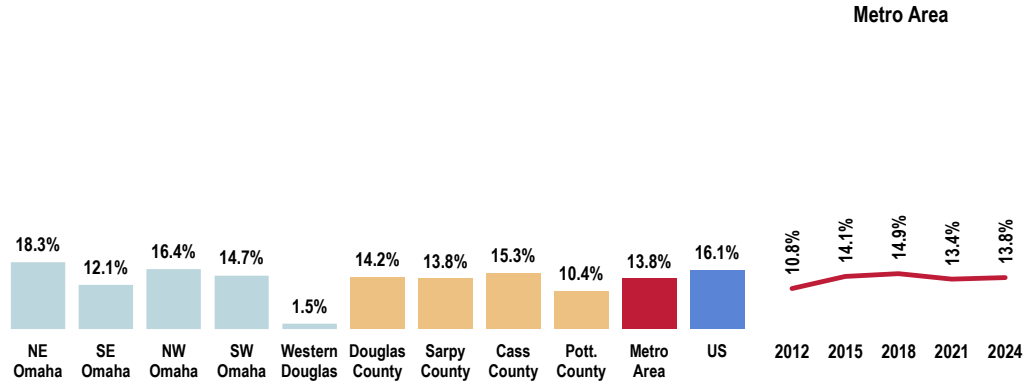
Speech/Language Issues

A total of 13.8% of Metro Area children have some type of speech or language problem.

TREND ► Marks a significant increase from the 2012 benchmark (similar to more recent findings).

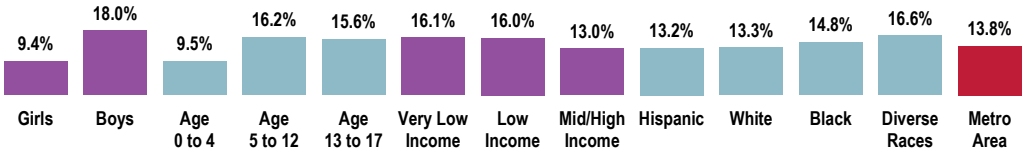
DISPARITY ► Lowest in Western Douglas County. More often reported in boys and children age 5 and older.

Child Has Speech/Language Problems



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 45]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Speech/Language Problems
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 45]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Hearing Problems

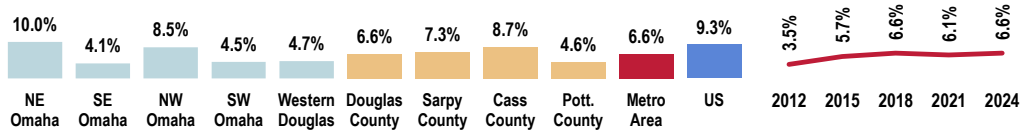
RELATED ISSUE:
See also Vision & Hearing in the *Access to Care* section of this report.

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

BENCHMARK ► Lower than the national percentage.

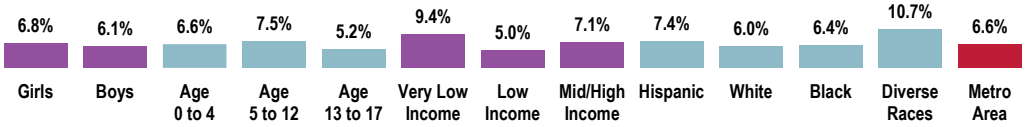
TREND ► Denotes a significant increase from the 2012 baseline.

Child Has Hearing Problems



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 26]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Hearing Problems
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 26]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Ear Infections

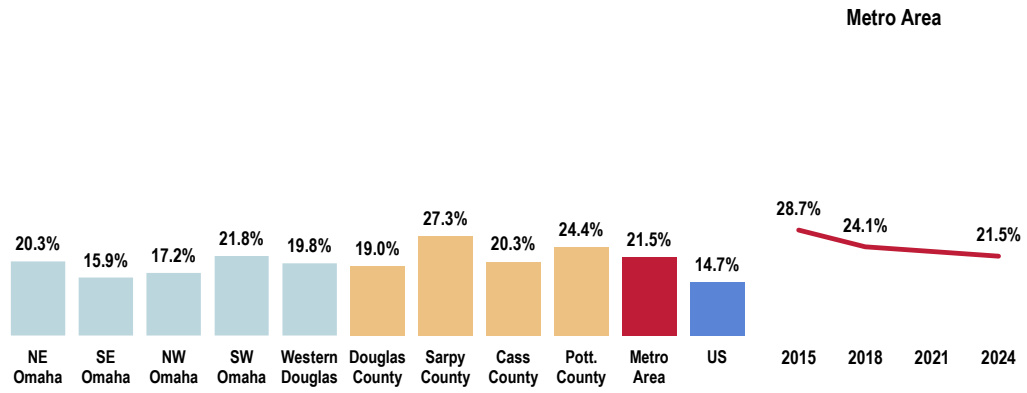
Among Metro Area children, 21.5% have had three or more ear infections.

BENCHMARK ► Higher than the US finding.

TREND ► Trending significantly lower over time.

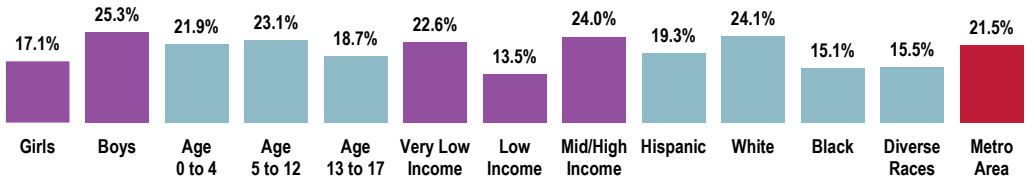
DISPARITY ► Highest in Sarpy County. More often reported in boys, those in very low income households, those in mid/high income households, and White children.

Child Has Had Three or More Ear Infections



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 43]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Had Three or More Ear Infections
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 43]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Vision Problems

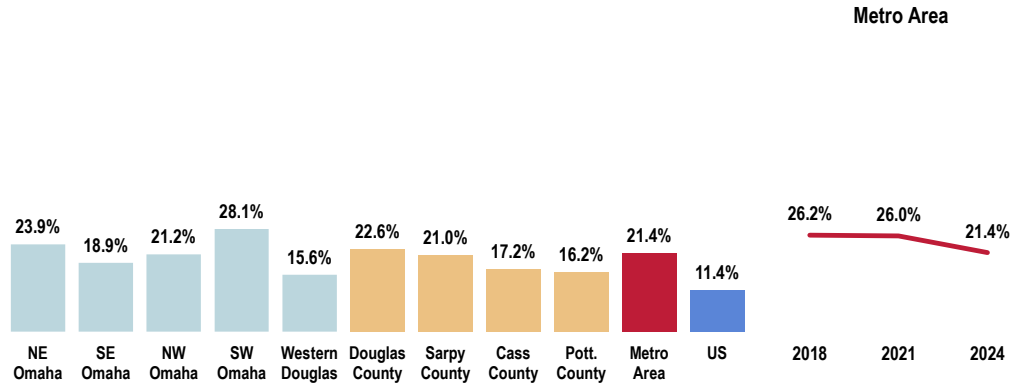
A total of 21.4% of Metro Area children have vision problems.

BENCHMARK ► Nearly two times the national percentage.

TREND ► Marks a significant decline from previous surveys.

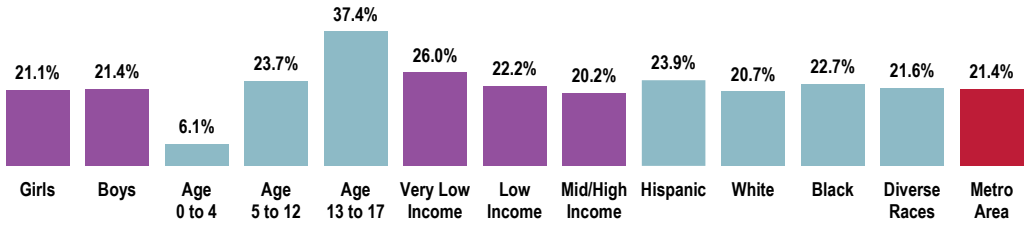
DISPARITY ► Note the positive correlation with age.

Child Has Vision Problems



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 307]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

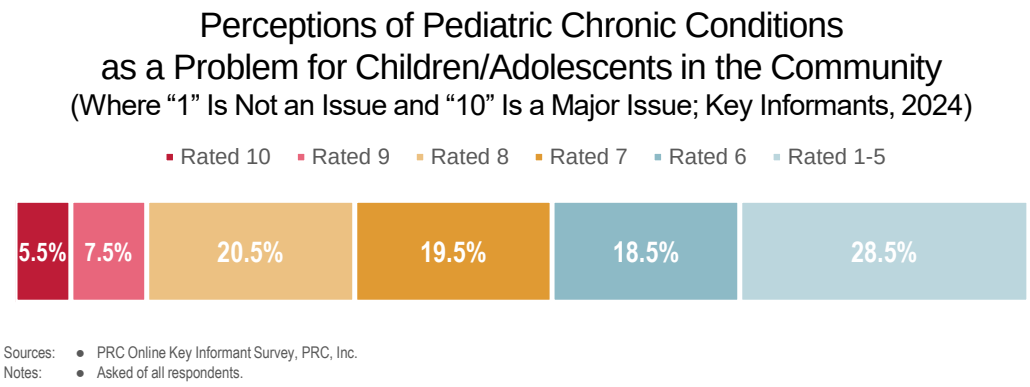
Child Has Vision Problems
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 307]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Key Informant Input: Pediatric Chronic Conditions

One-third of key informants taking part in an online survey characterized *Pediatric Chronic Conditions* as an "8," "9," or "10" for children/adolescents in the community (10-point scale where "10" is a major issue).



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

Access to Care/Services

> Access and availability are a major issue. Families wait and their access when they have Medicaid or are unable to travel to Omaha is restricted. – Community Leader
>
> Families need resources, and they aren't easily accessible. – Community Leader
>
> Access to prenatal care in North and South Omaha. – Community Leader
>
> Access to specialists is limited. – Community Leader
>
> I think one major issue we have is with emergency needs for pediatric chronic conditions. Oftentimes these are managed by emergency room visits that expose children to so many other illnesses while waiting to see a doctor in a general emergency room waiting area. Fear of additional exposure limits families in getting care. – Social Services Provider

Impact on Quality of Life

> Limits quality of life and productivity. Lack of complex care programs. – Physician
>
> For families, having a child who has a chronic health condition can lead to the potential of neglected siblings, major expense and time commitment for parents, confusion caused by conflicting systems of health care management, work issues, and social isolation. – Community Leader
>
> High absentee levels as reported by parents due to illness from chronic conditions. – Social Services Provider
>
> Children who suffer from asthma, allergies, mental health, and poor oral health do not come to school able to learn. We must have great access to great care for our children and that starts with parents knowing and understanding the health care system and how to access its resources. – Social Services Provider

Awareness/Education

> There is very little education for parents on chronic conditions. Not having regular pediatric providers creates a context in which chronic conditions are not detected and treated and followed up on. – Community Leader
>
> There is a lack of parental education and support. Parents receive a lot of conflicting information. – Community Leader
>
> Parent education on conditions. – Social Services Provider

Lack of Providers

> Not enough providers and representation of the community. – Social Services Provider
>
> Basically, because there are only a certain number of pediatric specialists in the region. – Community Leader
>
> Lack of specialized medical providers to treat pediatric chronic conditions. – Other Health Provider

Incidence/Prevalence

> Asthma, we have a large population of children and adults who have asthma. Not everyone is educated about the effects this has on their family and that it can lead to death. – Community Leader

> Asthma and autism spectrum disorder diagnoses seem to be more frequent and more prevalent. These conditions exacerbate challenges related to learning and independence and means parents will have more frequent absences from their jobs to meet the additional heath care needs of their children and may need to pay for more medicines to support their children. – Social Services Provider
>
> Our health outcomes are bad and getting worse. – Physician

Income/Poverty

> Children and adolescents growing up in poverty do not have access to a consistent "family pediatrician"; therefore, they are not diagnosed in time. There are many variables as to why parents do not take their children to the doctor with a consistent matter. – Community Leader

Lifestyle

> Healthy lifestyles are needed to live longer, healthier lives, and act as a preventative to our future children being healthy or unhealthy. – Community Leader

Nutrition

> Unhealthy diet and lack of daily safe places to exercise. Obesity is a major issue and type 2 diabetes and fatty liver disease. Also, I work in North Omaha, and I have a great number of autistic children in my Karen population. These children were born here. – Physician

Vulnerable Populations

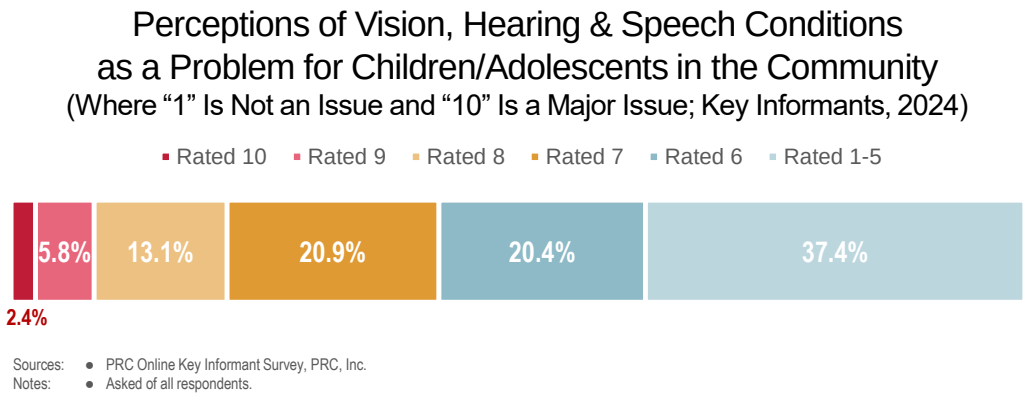
> Due to disparities in communities of color, access to quality of care is delayed until conditions become chronic. Lack of parental education regarding pediatric health conditions is also a contributor to the problems for children and adolescents. – Other Health Provider

COVID-19

> Support and awareness around COVID-19, long COVID, and vaccines. – Social Services Provider

Key Informant Input: Vision, Hearing & Speech Conditions

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



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

Access to Care/Services

> Again, it is hard to get them in in a timely manner. – Physician
>
> These are the extra services that are not offered unless someone notices the child is struggling. Most insurances add these services as add-ons, and people in poverty may not have access to support their children. – Community Leader

> Access to the appropriate screenings and services, speech therapy is a challenge. If the resources are attached to the school year, that has obvious limitations. – Social Services Provider
>
> Again, wait lists for services are out of control. Insurance limitations on therapies are a barrier to receiving adequate services. There are not enough services to meet needs – particularly within school systems. The free services provided by the district are band-aids and often don't actually meet the needs of the child. – Social Services Provider
>
> Services are not readily accessible throughout our community and/or at an affordable rate. – Social Services Provider

Vulnerable Populations

> The health of our at-risk, low-income children and adolescents continues to be a problem. This is part of their overall health. – Community Leader
>
> Lack of medical services in communities of color leads to chronic conditions that require resources. – Other Health Provider

Awareness/Education

> Early childhood education can assist with some speech conditions. Children don't have many opportunities for screenings for hearing. – Community Leader

Post-Pandemic Concerns

> I believe there are a lot of speech delays in pandemic babies, based on my experience of working with young children over the years. – Social Services Provider

Income/Poverty

> Parents with limited incomes and/or who may be working multiple jobs to care for their families and make ends meet may not give the needed attention to vision, hearing, and speech until they believe there is a serious problem, which may be all too late. – Social Services Provider

Social Media/Technology

> Screen time is at an all-time high. Recent news reports show that people are experiencing body pain due to the amount of time spent looking at phone or handheld devices. Not only vision but bodily pain due to the tilt of the neck or slumping of the back. Limited staffing to provide resources such as speech. – Social Services Provider

Child Overweight & Obesity

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

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

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

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

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

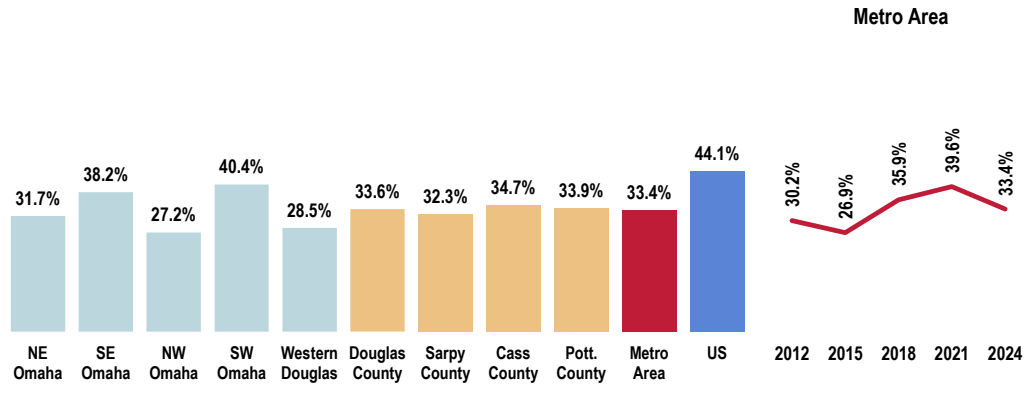
– Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 33.4% of Metro Area children age 5 to 17 are overweight or obese (≥85th percentile).

BENCHMARK ► Lower than the US finding.

DISPARITY ► More often reported in children age 5 to 12 and those in households just above the federal poverty level.

Child Is Overweight or Obese (BMI ≥ 85th Percentile)
(Children Age 5-17)

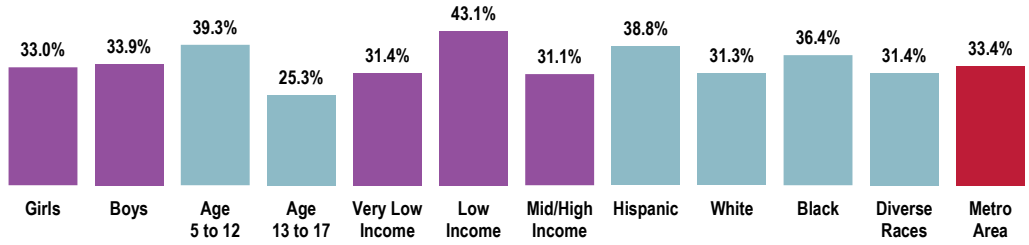


Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 102]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
- Overweight among children 5-17 is determined by child's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Child Is Overweight or Obese (BMI ≥ 85th Percentile)

(Metro Area Children Age 5-17, 2024)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 102]

Notes:
- Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
- Overweight among children is determined by children's Body Mass Index status equal to or above the 85th percentile of US growth charts by gender and age.

The childhood overweight prevalence above includes 22.7% of area children age 5 to 17 who are obese (≥95th percentile).

BENCHMARK ► Fails to satisfy the Healthy People 2030 target.

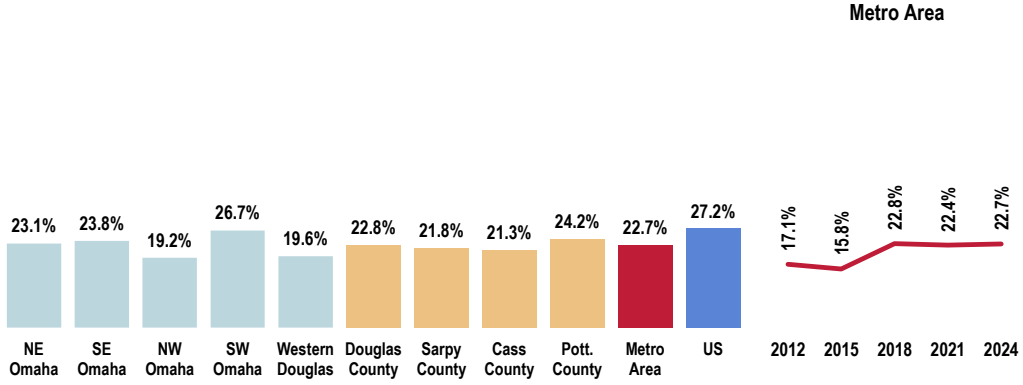
TREND ► Represents a significant increase from the 2012 baseline (similar to more recent findings).

DISPARITY ► More often reported in children age 5 to 12 and those living in households with incomes just above the federal poverty level.

Child Is Obese (BMI ≥ 95th Percentile)

(Children Age 5-17)

Healthy People 2030 Target = 15.5% or Lower (Goal for Ages 2 to 19)



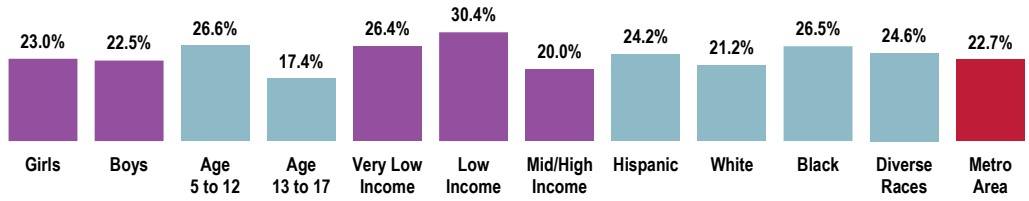
Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 102]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov

Notes:
- Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Child Is Obese (BMI ≥ 95th Percentile)

(Metro Area Children Age 5-17, 2024)

Healthy People 2030 Target = 15.5% or Lower (Goal for Ages 2 to 19)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 102]
- US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov

Notes:
- Asked of those respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Serious Injury

"In the past year, has this child been injured seriously enough to need treatment from a doctor or a nurse?"

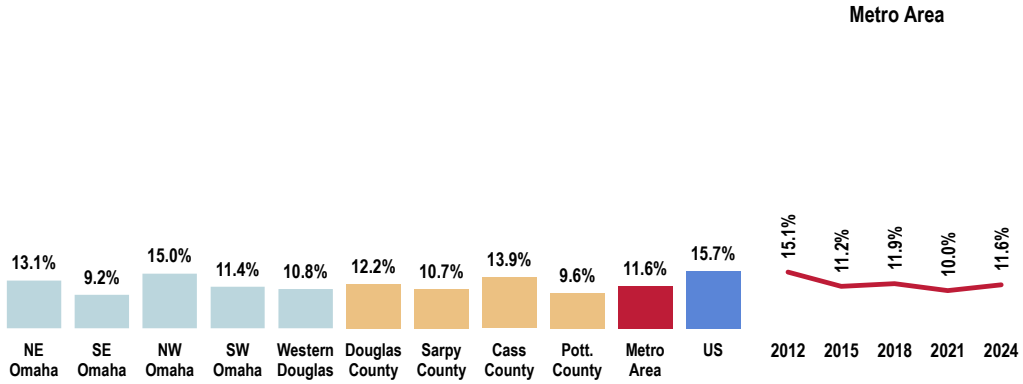
While most Metro Area children were not seriously injured in the past year, 11.6% sustained injuries serious enough to require medical treatment.

BENCHMARK ► Lower than the national percentage.

TREND ► Denotes a significant decrease from 2012 baseline findings.

DISPARITY ► More often reported in boys, those in higher income households, and in White children.

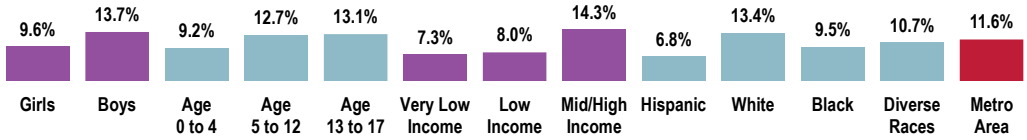
Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 49]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

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

Child Was Injured Seriously Enough to Need Medical Treatment in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 49]
Notes: ● Asked of all respondents about a randomly selected child in the household.

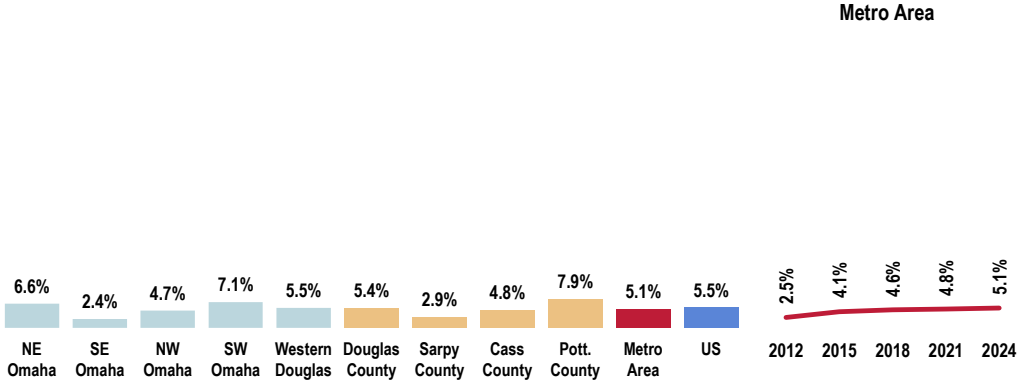
Brain Injury/Concussion

A total of 5.1% of Metro Area children have experienced a brain injury or concussion.

TREND ► Marks a significant increase from the 2012 baseline (similar to more recent findings).

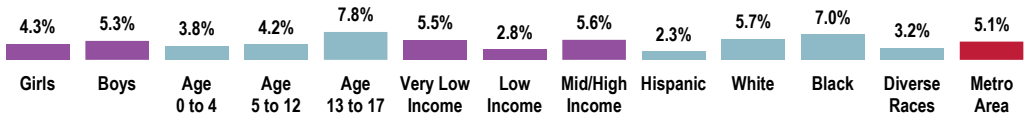
DISPARITY ► Lowest in Southeast Omaha; lower in Sarpy County than in the other counties. More often reported in adolescents (age 13 to 17) and White children.

Child Has Had a Brain Injury/Concussion



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 41]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Had a Brain Injury/Concussion
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 41]
Notes: • Asked of all respondents about a randomly selected child in the household.

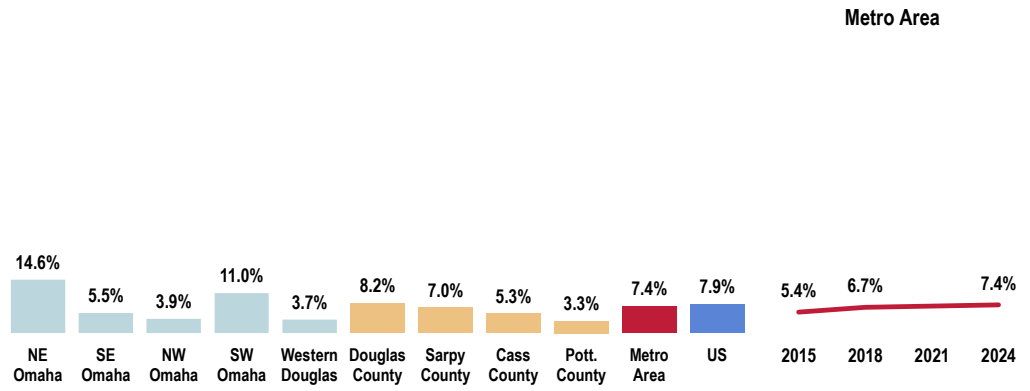
NEUROLOGICAL CONDITIONS

Migraines/Severe Headaches

Among survey respondents, 7.4% report that their child suffers from migraines or severe headaches.

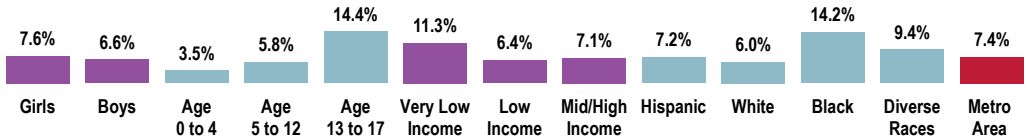
DISPARITY ▶ Highest in Northeast Omaha. More often reported in adolescents (age 13 to 17) and in Black children.

Child Has Migraines/Severe Headaches



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 42]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Migraines/Severe Headaches
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 42]
Notes: ● Asked of all respondents about a randomly selected child in the household.

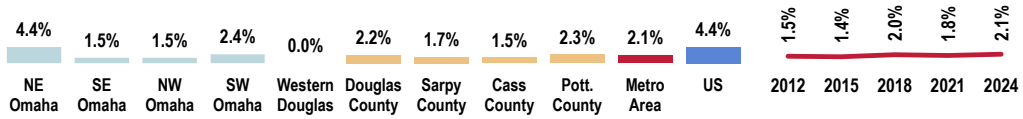
Epilepsy

A total of 2.1% of Metro Area children have epilepsy or a seizure disorder.

BENCHMARK ► Lower than the US finding.

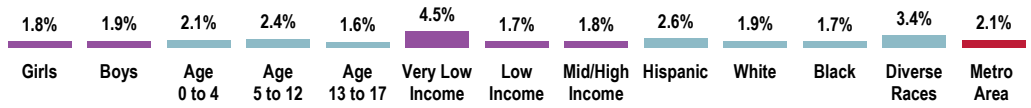
DISPARITY ► Lowest (null response) in Western Douglas County.

Child Has Seizure Disorder/Epilepsy



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 40]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Has Seizure Disorder/Epilepsy
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents about a randomly selected child in the household.

MORTALITY

Infant Mortality

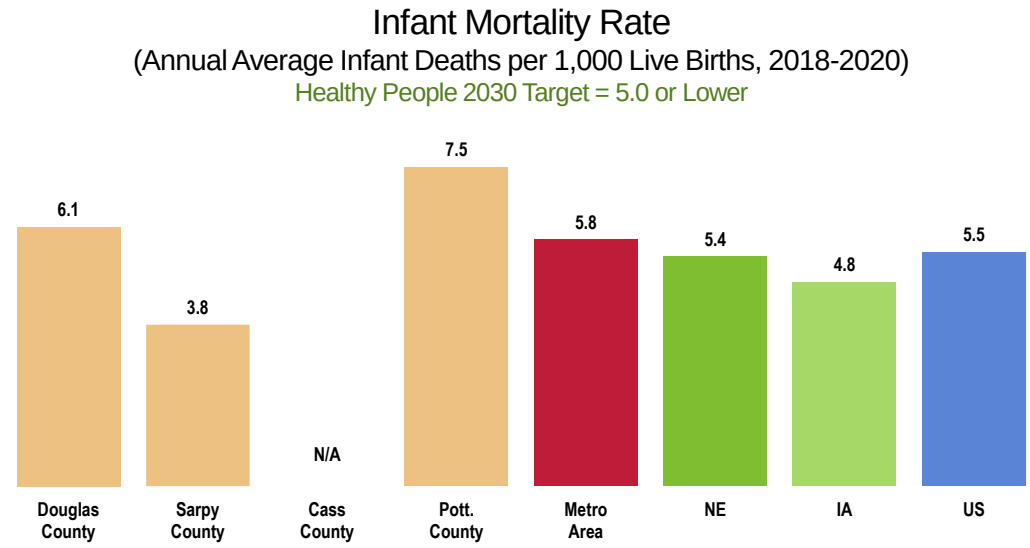
Infant mortality rates reflect deaths of children less than 1 year old per 1,000 live births.

Between 2018 and 2020, there was an annual average of 5.8 infant deaths per 1,000 live births.

BENCHMARK ► Less favorable than Nebraska, Iowa, and US rates. Fails to satisfy the Healthy People 2030 target.

TREND ► Despite slight declines in recent years, this has trended upward for much of the past decade in the Metro Area.

DISPARITY ► Particularly high in Pottawattamie County. Considerably higher among Black infants.



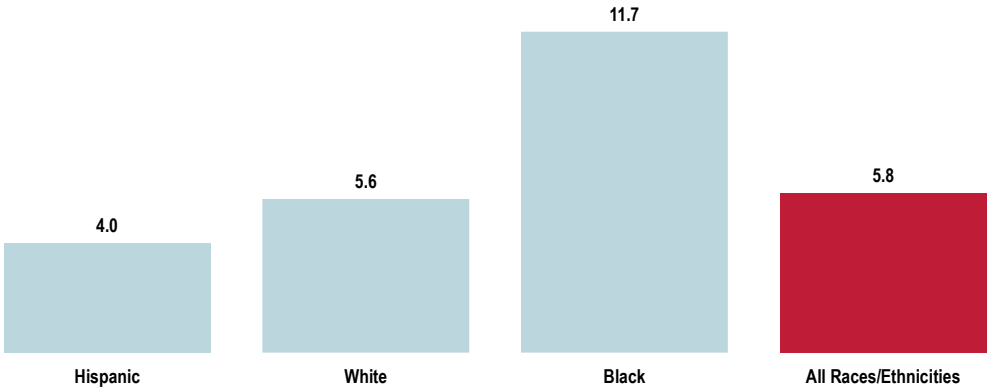
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted January 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Infant deaths include deaths of children under 1 year old.

Infant Mortality Rate by Race/Ethnicity

(2018-2020 Annual Average Infant Deaths per 1,000 Live Births; Metro Area)

Healthy People 2030 Target = 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 January 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Infant deaths include deaths of children under 1 year old.
- Race categories reflect individuals without Hispanic origin.

Infant Mortality Rate

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

Healthy People 2030 Target = 5.0 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	4.9	5.3	5.5	6.1	6.2	6.4	6.3	5.8
NE	5.2	5.1	5.5	5.8	5.8	5.8	5.4	5.4
IA	4.8	4.9	4.5	5.1	5.2	5.4	5.1	4.8
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	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 January 2024.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Child & Adolescent Deaths

ABOUT CHILD & ADOLESCENT DEATHS

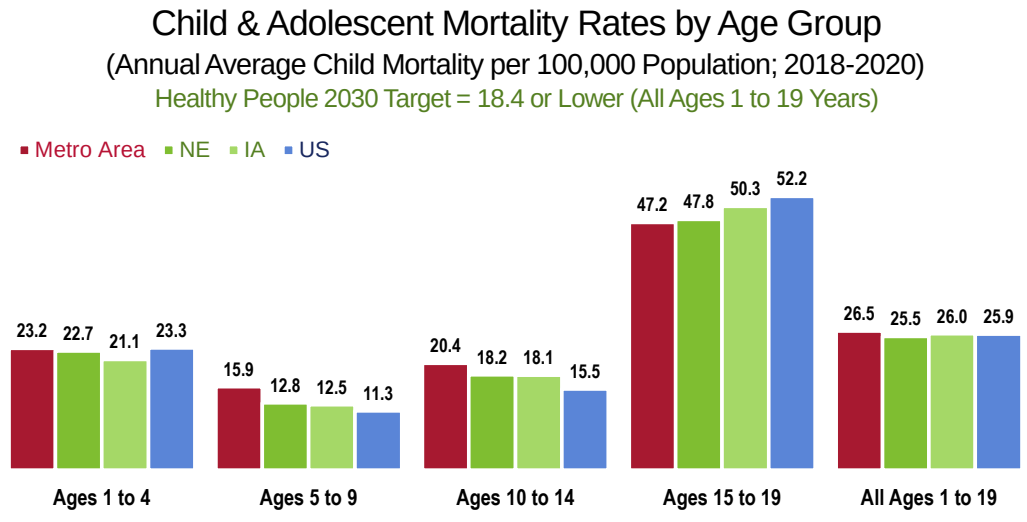
Injuries (including road traffic injuries, drowning, burns, and falls) rank among the top causes of death and lifelong disability among children aged 5-14 years. The patterns of death in older children and young adolescents reflect the underlying risk profiles of the age groups, with a shift away from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

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

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

Death Rates by Age Groups

The following chart outlines mortality rates among Metro Area children and adolescents in various age groups, expressed as the number of deaths per 100,000 population in those age groups. Note how these differ from state and national rates, as well as the Healthy People 2030 target.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2024.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Rates are crude rates, representing the number of deaths of children in each age group per 100,000 population.

Leading Causes of Child Death

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

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

See also *Injury & Safety* in the Modifiable Health Risks section of this report.

Leading Causes of Child Deaths by Age Group
(Metro Area, 2011-2020)

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

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2024.

Notes:
- *Perinatal conditions include certain conditions occurring in the perinatal period, usually low birthweight, preterm birth, and complications of pregnancy, labor and delivery.
- **Congenital conditions include congenital malformations, deformations and chromosomal abnormalities.
- Information in parentheses indicate majority types reported, if available.

BIOLOGICAL INFLUENCES

PRENATAL CARE

ABOUT INFANT HEALTH

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

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

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

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

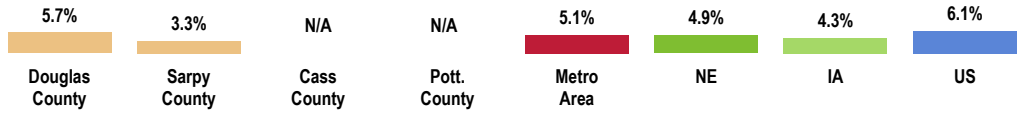
Between 2017 and 2019, 5.1% of all Metro Area births to mothers living in the Metro Area did <u>not</u> receive prenatal care in the first trimester of pregnancy.

BENCHMARK ► Lower than the US percentage. Higher than the Iowa percentage.

TREND ► Increasing overall over the past decade.

DISPARITY ► Highest in Douglas County.

Lack of Prenatal Care in the First Six Months of Pregnancy
(Percentage of Live Births, 2017-2019)



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of women who do not obtain prenatal care in the first six months of pregnancy (if at all).

Lack of Prenatal Care in the First Six Months of Pregnancy

(Percentage of Live Births)

	2008-2010	2011-2013	2014-2016	2017-2019
Metro Area	4.1%	4.0%	5.0%	5.1%
NE	4.3%	4.6%	5.2%	4.9%
IA	4.1%	3.8%	4.0%	4.3%
US	4.3%	5.0%	5.7%	6.1%

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of women who do not obtain prenatal care in the first six months of pregnancy (if at all).

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.

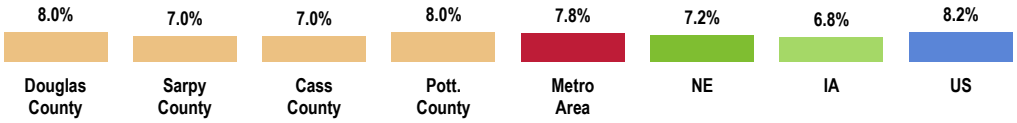
Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 7.8% of 2014-2020 Metro Area births were low-weight.

BENCHMARK ► Higher than found across Nebraska and Iowa but lower than found across the US.

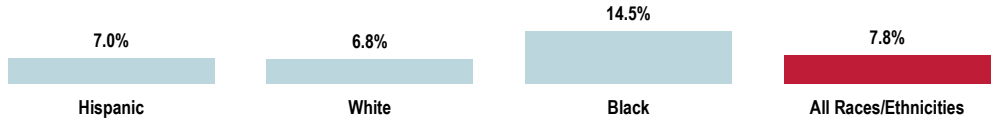
DISPARITY ► Highest in Douglas and Pottawattamie counties. Considerably higher among Black infants.

Low-Weight Births
(Percent of Live Births, 2014-2020)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted January 2024.
Note: ● This indicator reports the percentage of total births that are low birthweight (Under 2500g).

Low-Weight Births
(Percent of Live Births, 2014-2020)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted January 2024.
Note: ● This indicator reports the percentage of total births that are low birthweight (Under 2500g).

INFANT HEALTH

ABOUT BREASTFEEDING

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

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

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

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

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

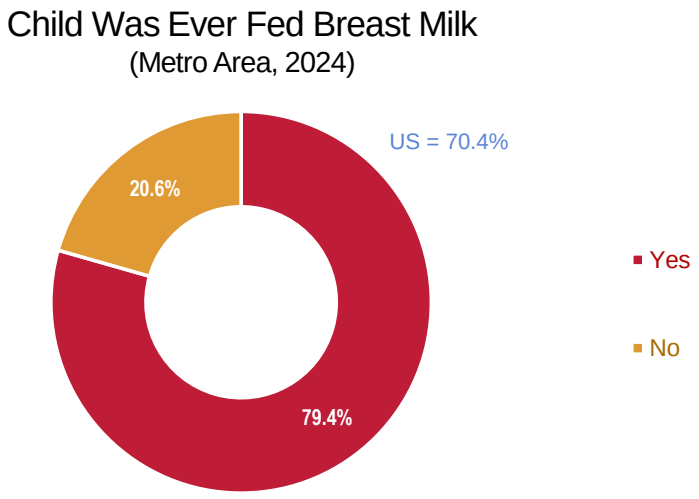
Breastfeeding & Breast Milk

Ever Fed Breast Milk

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

Among Metro Area children age 0 to 17, 79.4% were ever breastfed or fed using breast milk (regardless of duration).

BENCHMARK ► Higher than found nationally.



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 85]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

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

Exclusive Breastfeeding

Just over one-third (35.7%) of all Metro Area children were fed breast milk <u>exclusively</u> for the first 6 months of life.

To determine the percentage of children exclusively breastfed, those parents who ever breastfed were further asked at what age the child was introduced to cereal, formula, or any food other than breast milk.

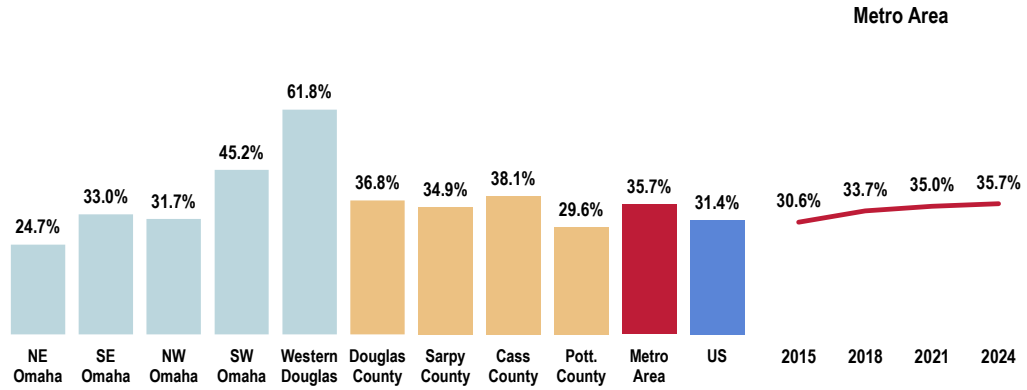
BENCHMARK ► Fails to satisfy the Healthy People 2030 target.

TREND ► Trending significantly higher over time.

DISPARITY ► Lowest in Northeast Omaha. Reported less often in boys, younger children (age 0 to 4), adolescents (age 13 to 17), and Black children. In particular, note the strong correlation with income.

Child Was Exclusively Breastfed for at Least 6 Months

Healthy People 2030 Target = 42.4% or Higher



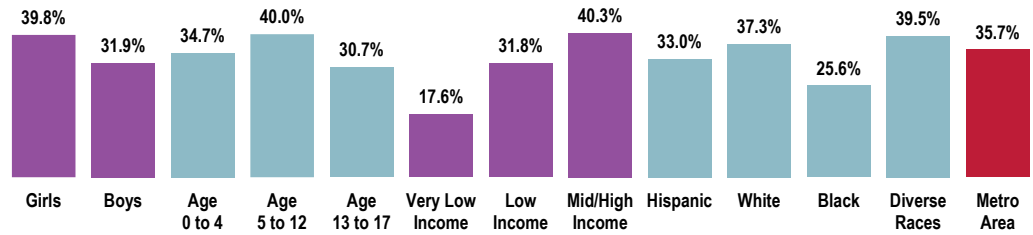
Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 104]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov

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

Child Was Exclusively Breastfed for at Least 6 Months

(Metro Area, 2024)

Healthy People 2030 Target = 42.4% or Higher

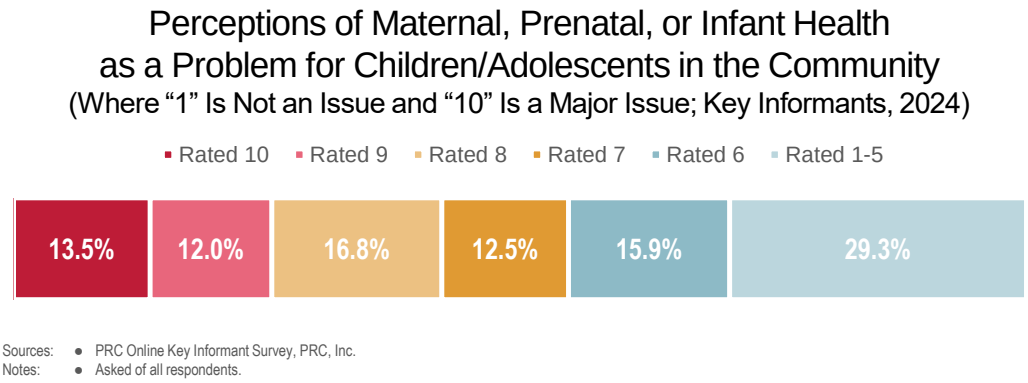


Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 104]
- US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov

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

Key Informant Input: Maternal/Prenatal & Infant Health

The greatest share of key informants taking part in an online survey gave *Maternal/Prenatal & Infant Health* a rating of "8," "9," or "10" (10-point scale where "10" is a major issue in the community).



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

Racial Disparities

The disparities in infant, maternal, birth outcomes across race and ethnicity are a key driver of this issue. Systemic racism. – Community Leader

This is a huge source of racial disparities and also is a huge contributor to differences in life expectancy. – Public Health Representative

Attention and action to maternal health care racial disparities is necessary to address preterm and low birth weights. Can we ever overdo access to prenatal and postnatal care? – Community Leader

Omaha has a long history of racial injustices and the state's largest population of black mothers. Black mothers experience significant disparities in birth outcomes. – Public Health Representative

There are several ethnic and cultural groups that do not have access to care. – Community Leader

Health conditions during pregnancy and at the time of birth are challenged by available medical service professionals and contribute to high infant deaths in the black community. – Other Health Provider

Health disparity, health systems fee-for-service structures and access to care issues make connections to care fragmented and too complex. There is limited lived experience data from a family perspective to help understand what and why challenges exist. This limits the ability to create solutions. Need broader population perspective and upstream approaches. – Other Health Provider

Large immigration population, high rates of poverty, and undocumented families, none of these are likely or able to access prenatal care without serious help. – Public Health Representative

We have significant and persistent disparities in birth outcomes in our communities particular among Black/African American community members and those living in poverty. In order to have healthy births, healthy babies, and healthy kids, we needs to improve access to prenatal, effective support for wraparound services to address the social drivers of health, ensure ongoing support through the postpartum period, address bias and other systemic issues in health care, ensure effective screening and support for mental health needs, ensure access to dental care, and more. A key driver of understanding the health of our community is how many babies celebrate their 1st birthday, we need to do better to make sure all babies reach their 1st birthday. – Community Leader

The statistics in the paper recently highlighted this as a major issue, specifically in underrepresented populations and the black community. – Social Services Provider

Maternal mortality rates among African American and black women. It is ridiculously high in a community that has so many resources. – Public Health Representative

BIPOC mothers experience significantly higher rates of birth complications, including mother and infant death, than white mothers. It's a fact. – Social Services Provider

Black maternal health rates should not be disproportionate to other races with so many resources. – Social Services Provider

We know nationally that maternal and child health is an issue and those of color are at an even greater risk. I think this is due to racism. – Public Health Representative

As stated in many recent research, minorities are drastically affected by infant mortality compared to other communities. We need to do better with educating our communities of color in maternal and prenatal care. – Public Health Representative

This is a major problem, again, because the data demonstrates it as such. Black babies die two times more than White babies, which is a preventable issue that must be addressed. There were strong efforts to address in the late '90s/early 2000s which showed a narrowing of the gap in this disparity but for whatever reasons, those efforts halted, and we are back to where we started with the disparity. Action must happen to get this addressed! – Public Health Representative

Parts of our community are experiencing significant health disparities and poorer health outcomes related to maternal child health. African American/Black women are experiencing much higher rates of preterm labor, low-birth weights and less than ideal postpartum care – often leading to higher rates of maternal depression. Some great strides were made in the past to reduce these disparities, but we as a community have slipped back into complacency and our Black moms and babies are suffering. – Public Health Representative

We continue to see negative maternal, infant, and birth outcomes. The fact that women of color are more likely to experience mortality or morbidity highlights the need to prioritize this. – Public Health Representative

Black women are experiencing poor maternal health outcomes at higher rates than others. – Public Health Representative

Incidence/Prevalence

Just look at the data. – Community Leader

Maternal and neonatal death rates are embarrassing. – Physician

Maternal/infant mortality is high nationwide. Due to the lack of data, Nebraska does not know where we stand. However, verbal accounts show that Nebraska likely rates up there with the nation. – Community Leader

NICUs are full across the community. – Physician

DCDH and DHHS statistics. – Community Leader

We have horrible maternal child health outcomes in Omaha and Douglas County. – Physician

Access to Care/Services

Access to high quality prenatal care in East Omaha neighborhoods is very limited. There is not a full-service hospital. – Social Services Provider

Overall, women in Nebraska have a very high vulnerability to adverse outcomes due to the availability of reproductive health care services. 12.7 percent of birthing people received no or inadequate prenatal care, less than the U.S. rate of 14.8 percent. Restrictions on the ability of pregnant persons to partner with a physician to discontinue a pregnancy has also been further restricted and increases negative health outcomes for potential healthy pregnancy, natal, and postnatal health. Black birth givers experience far greater negative health outcomes compared with their non-Black fellow birth givers. The lack of available physicians with lived experience as a Black person and lack of insurance coverage for Douglas or advocates in situations where a power imbalance exists between birth giver and physician perpetuates negative health outcomes. – Community Leader

Disproportional access to care. – Community Leader

Data exists that demonstrates this. Worry about the rural communities not as close to Omaha and Lincoln and lack of providers. I'd like to see the state obtain a 1115 waiver like other states (Colorado, Hawaii, New York, Minnesota, Florida, Georgia, etc.) that guarantees continuous Medicaid eligibility for children on Medicaid and CHIP. In many cases, there is an annual review that causes churn. – Social Services Provider

Access to health care should be easy, but we continue to see high numbers of neonatal hospital admissions and patients with complex medical needs in that population. – Community Leader

Infant Morality

Infant mortality rates are high. – Social Services Provider

Infant mortality rates in my community are higher than average, especially in the black community. – Community Leader

In southwest Iowa, infant and maternal mortality has been on the rise, especially for minority populations. That is concerning. – Social Services Provider

Nationally, maternal infant mortality rates are terrible. Even worse in communities of color. – Public Health Representative

Data has repeatedly shown that we have high rates of maternal and infant mortality. This is especially true for non-white communities. Lack of adequate support, both prenatal and postpartum is also a barrier. – Community Leader

Affordable Care/Services

> Financial access and lack of knowledge can mean mothers and children do not receive the health care services they may desperately need. – Social Services Provider
>
> I do not feel like disadvantaged women are getting the prenatal care they need, maybe because of a lack of funds or, in the case of a teen, not knowing any better. – Other Health Provider

Income/Poverty

> Low-income, racial and ethnic minorities, and those that do not speak English have challenges in accessing prenatal and postpartum care. Postpartum care is not offered by Medicaid, nor is dental or behavioral health as a result. – Community Leader
>
> Socioeconomic Factors: North Omaha has higher rates of poverty compared to other parts of the city, which can impact access to quality health care, nutritious food, and safe housing. These factors can contribute to poor maternal and infant health outcomes. Preexisting Health Conditions: The prevalence of preexisting health conditions, such as obesity, hypertension, and diabetes, can be higher in economically disadvantaged communities, leading to increased risks during pregnancy and childbirth. Environmental Factors: Exposure to environmental toxins and stressors, such as pollution or violence, can also impact maternal and infant health. – Public Health Representative

Awareness/Education

> I believe that some parents need better education and guidance before and during pregnancy in order to avoid maternal/prenatal complications to begin with. Avoid a problem and don't create more problems. Once someone is pregnant, then we could do a better job of educating them on what is the healthiest path forward. Unfortunately, many people don't know the basics of taking care of themselves, let alone taking care of two. – Community Leader

Cultural/Personal Beliefs

> Cultural nuances and engaging the health system for guidance. – Social Services Provider

Diagnosis/Treatment

> Too many mothers dying during delivery and during pregnancy. Need earlier OB/GYN treatment. – Community Leader

Employment

> Without adequate maternity leave and enough sick days to use prenatal, maternal, and infant health is a major problem. – Public Health Representative

Follow Up/Support

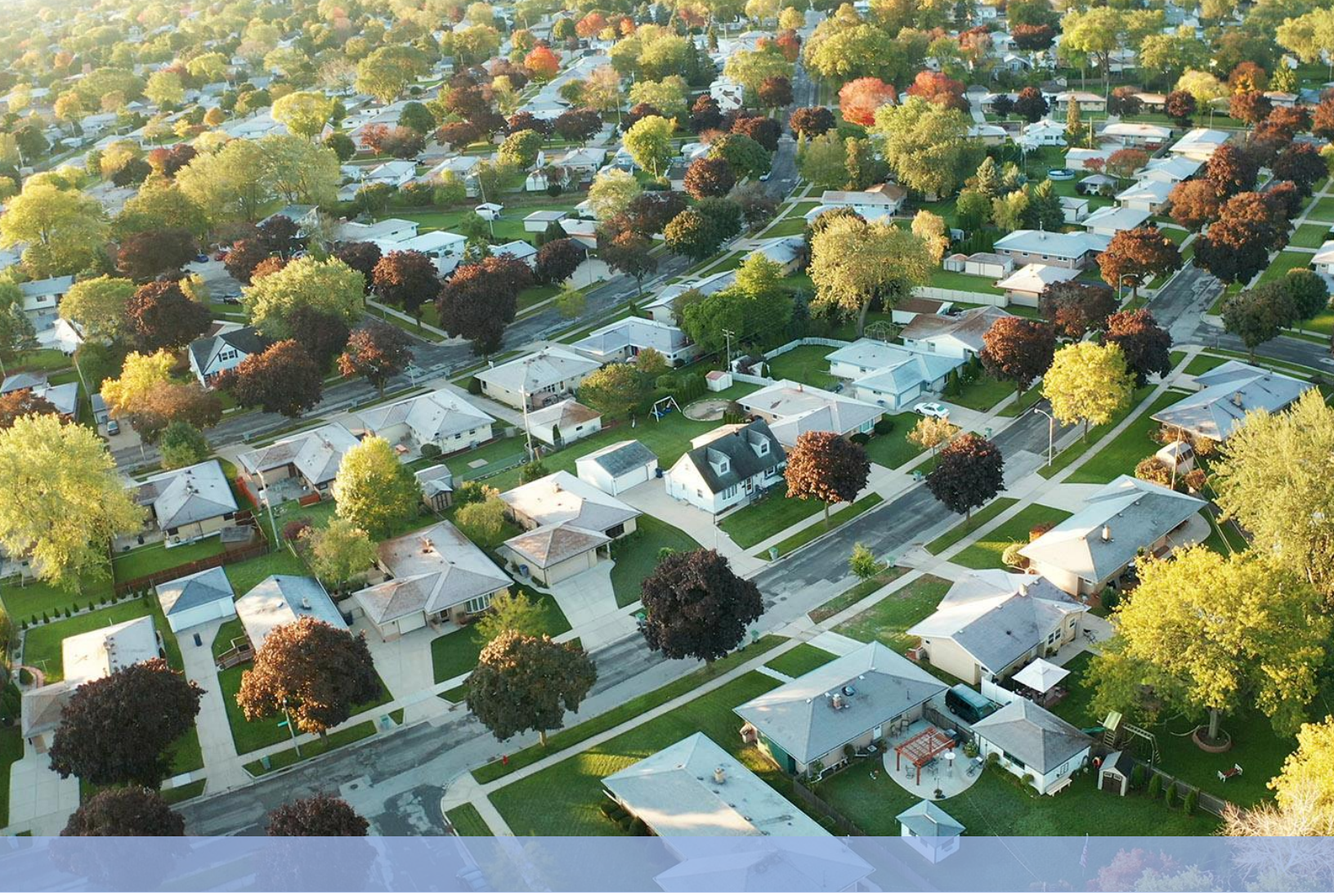
> Not enough support for mothers navigating the complexities. – Social Services Provider

Lack of Providers

> The Fetal Infant Mortality Review (FIMR) program is not currently available due to an open nurse coordinator position. There could be more coordination support for maternal/infant health across the community, which is currently spotty and siloed. – Public Health Representative

Breastfeeding Rates

> Lack of breastfeeding, not high enough initiation or duration rates and not enough exclusivity. Children would be more healthy, less obese, diabetes type 1 and 2, and childhood cancer. – Physician



SOCIAL ENVIRONMENT INFLUENCES

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

ABOUT ACEs

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

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

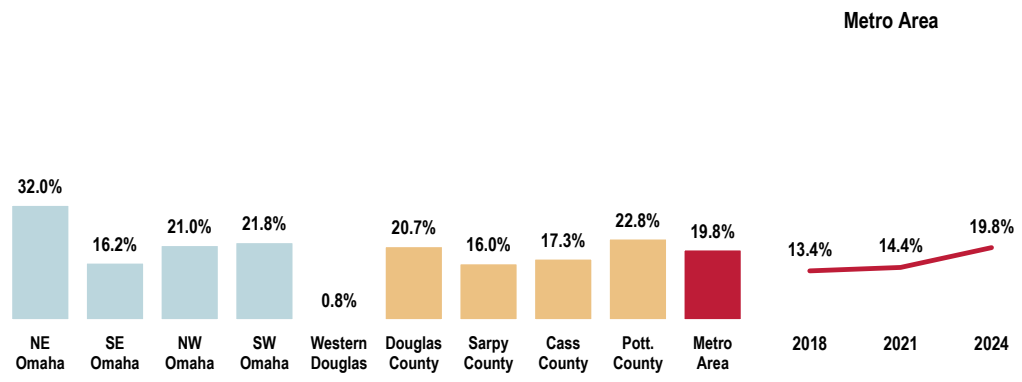
Exposure to Serious Mental Health Issues

A total of 19.8% of Metro Area parents report that their child has ever lived with someone with serious mental health issues.

TREND ► Denotes a significant increase from previous surveys.

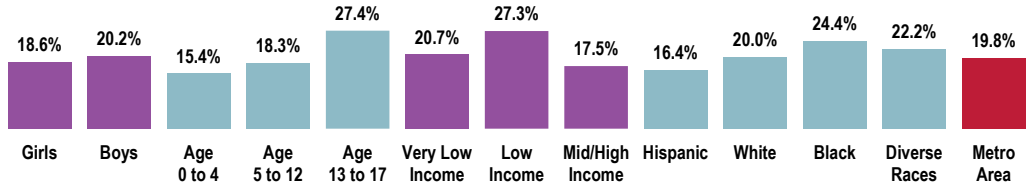
DISPARITY ► Considerably high in Northeast Omaha. More often reported among adolescents (age 13 to 17) and children living just above the federal poverty level.

Child Ever Lived With Someone
Who Had Serious Mental Health Issues



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 323]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Ever Lived With Someone Who Had Serious Mental Health Issues
(Metro Area, 2024)



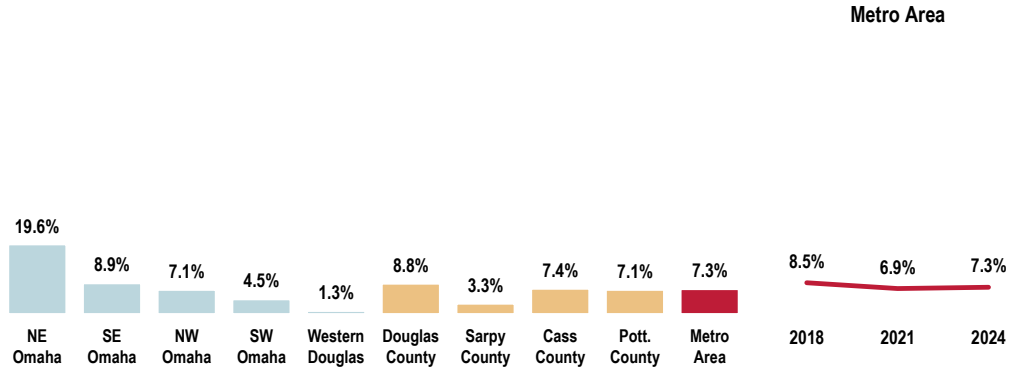
Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 323]
Notes: • Asked of all respondents about a randomly selected child in the household.

Exposure to Neighborhood Violence

A total of 7.3% of Metro Area parents report that their child has ever been the victim of violence or witnessed any violence in the neighborhood.

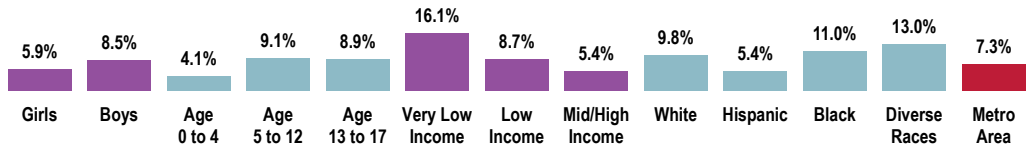
DISPARITY ► Especially high in Northeast Omaha. More often reported among children age 5 to 17 and those in very low income households.

Child Ever Exposed to Neighborhood Violence



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 316]
Notes: • Asked of all respondents about a randomly selected child in the household.

Child Ever Exposed to Neighborhood Violence
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 316]
Notes: • Asked of all respondents about a randomly selected child in the household.

RESILIENCE

Resiliency Characteristics

"How often does this child (age 1 to 5) bounce back when things don't go his/her way?"

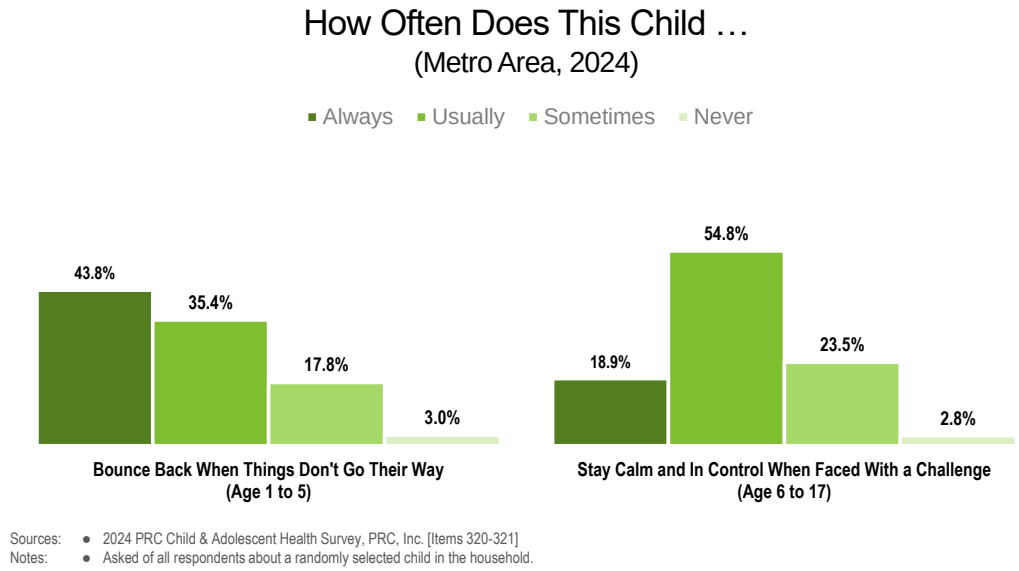
A total of 79.2% of parents with children age 1 to 5 years report that their child "always" or "usually" bounces back when things do not go their way.

The remaining 20.8% of these children "sometimes" or "never" bounce back.

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

For children age 6-17, 73.7% "always" or "usually" stay calm and in control when faced with a challenge.

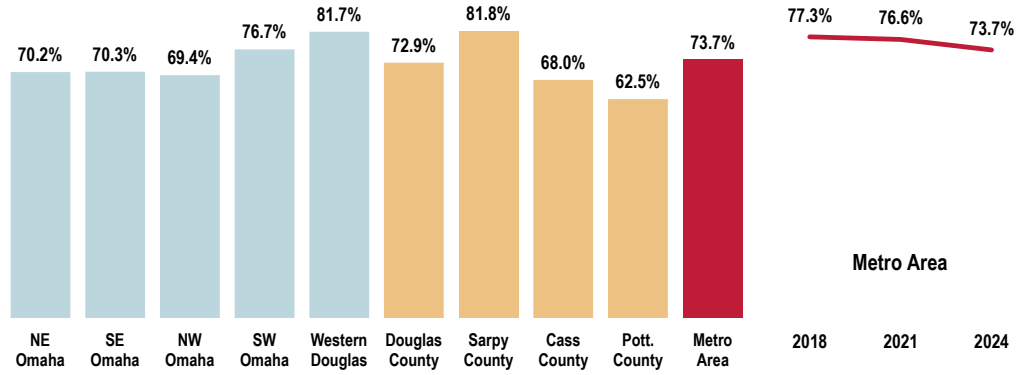
The remaining 26.3% of children in this age group "sometimes" or "never" stay calm when challenged.



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Items 320-321]
Notes: • Asked of all respondents about a randomly selected child in the household.

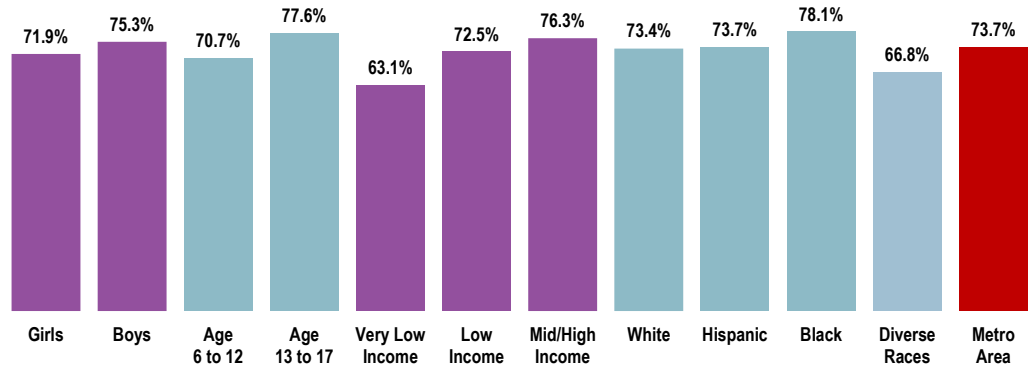
DISPARITY ► For school-age children in Douglas County, the prevalence of those who "always/usually" stay calm when faced with a challenge is 72.9%. This is lowest in Pottawattamie County and is less often reported among children age 6 to 12 and those in households with very low incomes.

Child "Always/Usually" Stays Calm When Faced With a Challenge
(Children Age 6-17)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 321]
Notes: • Asked of all respondents about a randomly selected child age 6-17 in the household.

Child "Always/Usually" Stays Calm When Faced With a Challenge
(Metro Area Children Age 6-17, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 321]
Notes: • Asked of all respondents about a randomly selected child age 6-17 in the household.

Support Outside the Household

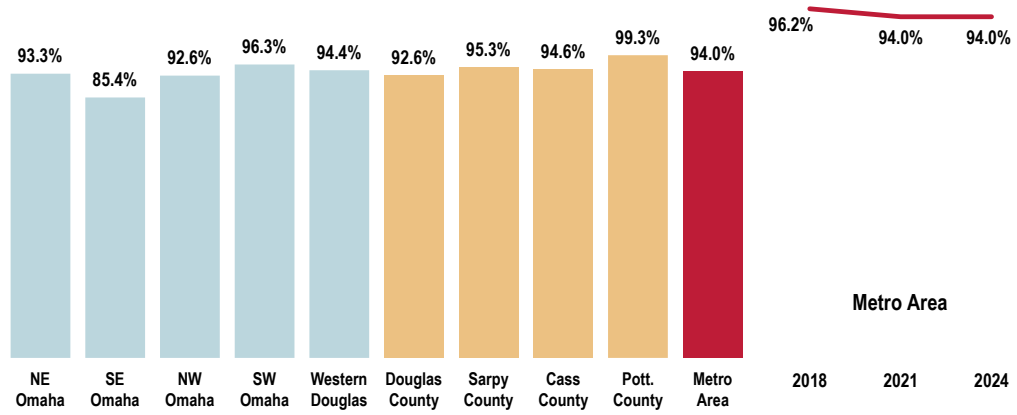
"Other than you or the other adults in your home, is there at least one other adult in this child's school, neighborhood, or community who knows this child well and who can be relied on for advice or guidance?"

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

TREND ► Represents a decrease from the 2018 baseline finding.

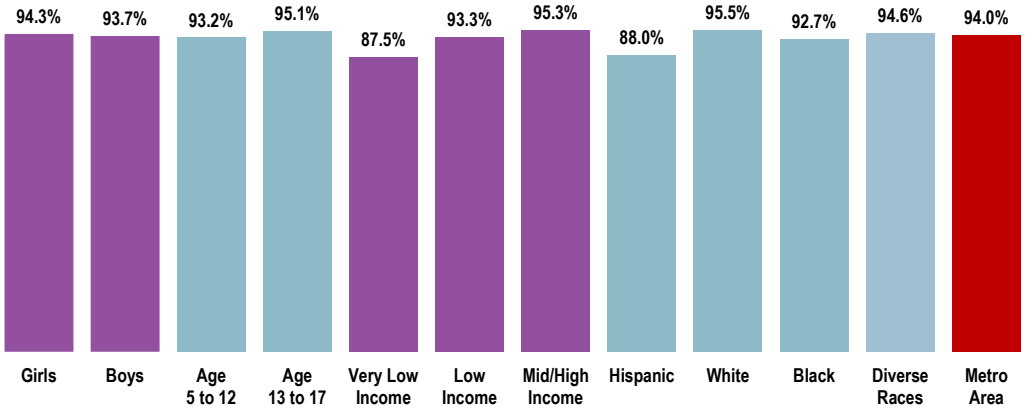
DISPARITY ► Lowest in Southeast Omaha. Reported less often among children in households with very low incomes and among Hispanic children.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 322]
Notes: ● Asked of all respondents about a randomly selected child age 5-17 in the household.

Child Has an Adult for Advice/Guidance (Outside Household)
(Metro Area Children Age 5-17, 2024)

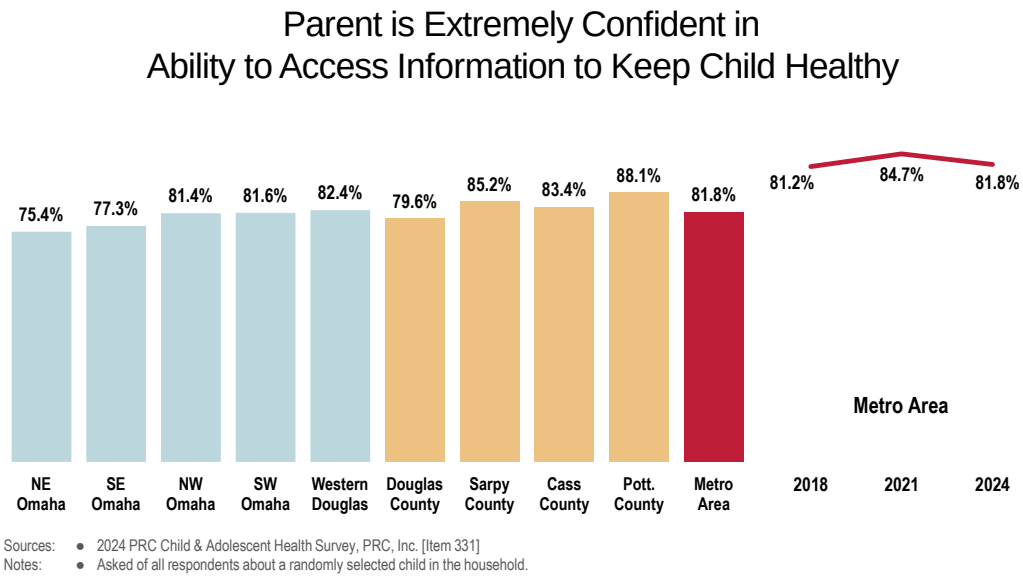


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 322]
Notes: ● Asked of all respondents about a randomly selected child age 5-17 in the household.

Meeting Child's Health Care Needs

Asked how confident they are in accessing the information they need to keep their child healthy, 81.8% of parents gave "extremely confident" responses.

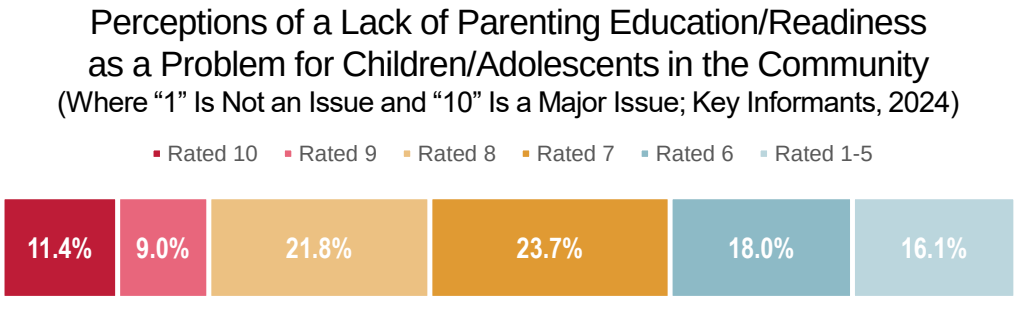
DISPARITY ► Lower in Douglas County (especially Northeast and Southeast Omaha).



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 331]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Key Informant Input: Lack of Parenting Education/ Readiness

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



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

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

Awareness/Education

> Parents don't know where to look for help in safe places that can be trusted. – Community Leader

Parents do the best they can, but a lack of evidence-based parenting practices impacts the ability of children to be ready to learn in school and supported in learning all through school. – Social Services Provider

The subcategories of social determinants of health each are very different. Some I see zero influence, others are significant concerns in the community. One is equal access to education. The additional issue I believe is directly related to health issues is chronic school absenteeism due to illness, sometime for multiple days, weeks or months. Health clinics, in my opinion, do not inquire as to a child's school attendance record ... how many days they have been absent from school due to illness. Sometimes, parents visit different providers who cannot communicate per HIPAA. Other times, physicians provide school notes and do not APPEAR to share with families how sick is too sick to attend school, nor is it clear how somatic complaints (stomach aches), sleepiness, access to screen time are screened as a contributor to school absences. – Other Health Provider

Anyone can have a child; they don't come with instructions. Parenting education should be offered in high schools and community colleges. Family units are living more separately than ever before – the idea of "it takes a village" is lost. Parents really need consistent support and a resource they can use when in need. – Social Services Provider

This is an issue from infancy. Parents don't know what they don't know, and parenting is hard. How do we educate and engage parents, especially those who did not receive a positive parenting experience in their own childhood? – Community Leader

Lack of parenting education affects many generations in my community, creating a barrier for children to achieve a healthier lifestyle. – Public Health Representative

I believe that there is a lack of parenting education and readiness because of the need for two incomes to support the family and children. Because the cost of living is so high, a single parent must work multiple jobs, and even if they are in a two-parent household, typically both parents must work to provide, thus leaving the child rearing to screens or outside child care. Leaving family values to be distributed by others. There is little access to parenting education either because the parent is not aware of the resources available or time constraints. It seems to me there are only educational classes available in the very early stages. Lack of consistency in the early years can cause problems, and many only seek help when things are so out of hand that it is hard to come back from. Think uncontrolled teenagers and no parent accountability if there are problems in the classrooms, leaving it up to the teachers who are understaffed, underpaid, and underappreciated. – Public Health Representative

Parenting education is not valued until a child is removed from the home and placed in foster care. All prospective parents should be required to participate in parenting education prior to the birth of a child. – Other Health Provider

Immigrant parents and parents of low-income areas need to be made aware of the opportunities. They know nothing about the resources, even though these may be very scarce. – Social Services Provider

Parenting education and readiness can help our communities by offering guidance on what it means to provide emotional support and nurturing relationships with children. I have seen parents who are not adequately prepared or struggle to provide the emotional support and validation that children need for healthy development. This lack of emotional support can contribute to low self-esteem, anxiety, and depression in children and adolescents. I also believe that effective communication between parents and children is essential for building trust, resolving conflicts, and fostering healthy relationships. I've witnessed parents who lack parenting education and have difficulty communicating effectively with their children, leading to misunderstandings, resentment, and strained relationships. The lack of parenting education can perpetuate cycles of ineffective parenting practices and poor outcomes across generations. – Social Services Provider

There are very few parent education programs in Omaha. – Social Services Provider

In my opinion, being a parent is life's biggest commitment. You can divorce a spouse, you can disown parents/siblings/other family members, but you cannot do that with a child (unless you put it up for adoption and legally relinquish parental rights or are an abhorrently neglectful parent). Just because a person has the biological ability to bear children doesn't mean they should. If they do decide to have a child, it is completely up to the parent to seek out education and ready themselves for the role. You must pass a test to obtain a driver's license, you have to be 18 to vote, you have to be 21 to consume alcohol – in other words, you must demonstrate some form of personal accountability, responsibility, and readiness in order to participate in these activities. Because nothing equivalent exists for parenting, in my opinion, too many people are ill-prepared to be parents. – Community Leader

I'm seeing in many cases that people don't understand the basics of living, and yet they become parents who are expected to guide their children. Many people shouldn't become parents. But if they do become parents, then they should be better educated to meet their own needs and those needs of their children. Right now, this is a major concern of mine. – Community Leader

Parental Influence

While a shift to more conscious or gentle parenting is trending, the traditional route is still widely followed for most black households. If our community hosted more opportunities for education in what conscious parenting is and fostered understanding of child psychology and development, we would/could see a shift in homes and across the community. – Community Leader

> Parents can only teach and model what they know, so their children's lives are limited by their parents. Education can help open doors to better opportunities and higher elevations from income to employment to housing and future wealth. – Social Services Provider
>
> I observe many parents on a daily basis that have no clue about most things happening in their child's life on daily basis and how to help, intervene or react. I observe many adults on a daily basis who don't have sensible control over their own lives. That makes them ill-equipped to properly parent. – Community Leader
>
> In recent years, even our educated parents seem to be wary of disappointing their child with corrections. We have parents who are content with having their elementary aged students be on age-inappropriate social media platforms with NO monitoring ("I don't check their messages") while their child is telling others to GKYS (go kill yourself). – Other Health Provider
>
> Too often we see that issues with children and adolescents are linked to poor parenting skills. – Other Health Provider
>
> I believe childhood obesity and behavioral health crisis in children demonstrate that parents need more support to ensure babies get a healthy start. Quality early childhood programming is hard to come by, especially for some families. – Community Leader

Access to Care/Services

> Parents tell us they would like assistance dealing with teen and adolescent parenting issues. This goes hand in hand with mental and behavioral health support. – Social Services Provider
>
> Many or most families don't have access to quality early care and education for their children. – Community Leader
>
> Limited resources unless you fall within a certain socioeconomic status, which is usually well below poverty level. Even then, resources are not abundant enough to meet the need and often have extensive waiting lists. – Public Health Representative
>
> Access. – Social Services Provider
>
> There are not enough resources in the community to set families up for success. – Community Leader

Teen Parents

> We are currently in the place of kids having kids and kids raising kids. The lack of parental guidance given to the youth during this time is not relevant. – Community Leader
>
> Many of our struggling students come to us from homes with young parents that were not prepared to handle kids. It is very easy for some of these homes to want to pass their kids on to others. These kids are coming to us broken and in need of love and support. – Other Health Provider

Generational

> I feel this is a problem because of the way children are acting. Possibly generational. – Other Health Provider

Affordable Care/Services

> Support is lacking, and if there is support, it comes at a fee that families cannot afford. – Social Services Provider

Refugee Population

> The child removals from families among refugees are so often due to a lack of cultural understanding of parenting norms in the USA. – Social Services Provider

Language Barriers

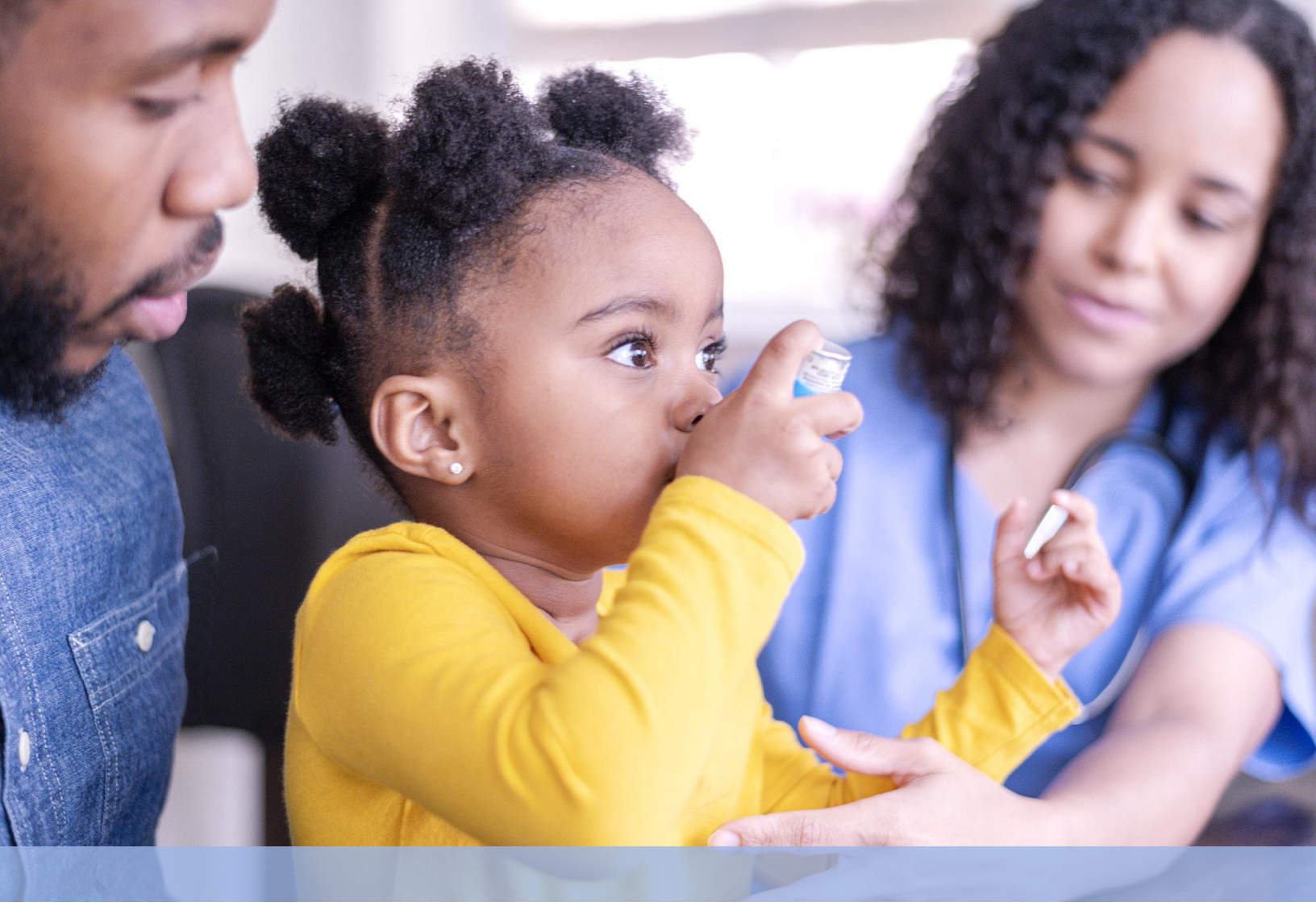
> Language barrier. – Social Services Provider

Social Constructs

> Social constructs have degraded the family unit, CPS, and foster care. – Physician

Trauma

> We have a lot of parents with unhealed trauma that increases barriers for them to be able to meet the needs of their children. I believe parents need more demographic support based on the complexities of different communities in the Omaha Metro. A lot of parents do not know that 90% of their child's brain will develop before the age of 5, significantly increasing the need for quality care givers and strong bonds in the early years. – Social Services Provider



SOCIAL DETERMINANTS OF HEALTH

POVERTY

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to overall health.

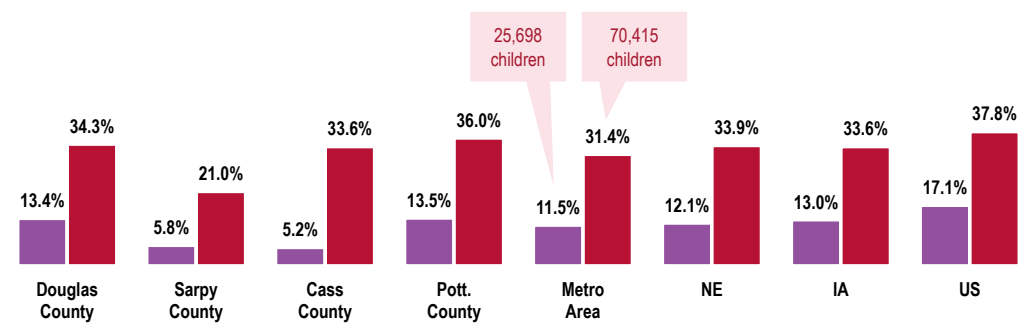
The latest census estimate shows 11.5% of Metro Area children living below the federal poverty level, and 31.4% living below 200% of poverty.

BENCHMARK ► The percentage of those living below 200% of poverty is lower than found across Nebraska, Iowa, and the US.

DISPARITY ► Highest in Pottawattamie County.

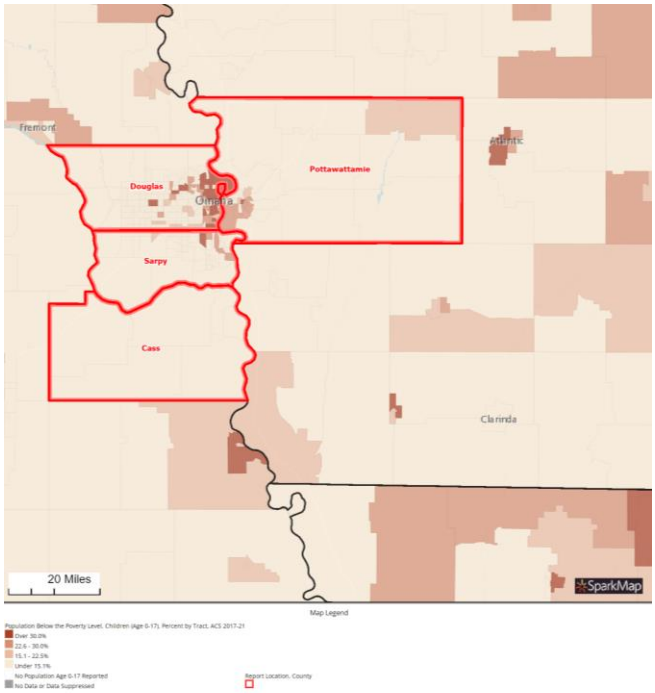
Percent of Children in Low-Income Households

(Children 0-17 Living Below 100% and Below 200% of the Poverty Level, 2017-2021)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of children aged 0-17 living in households with income below 100% and below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.



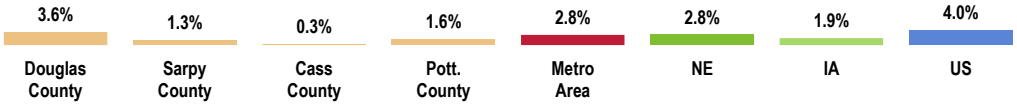
LINGUISTIC ISOLATION

A total of 2.8% of the Metro Area population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

BENCHMARK ► Lower than the national percentage but higher than the Iowa percentage.

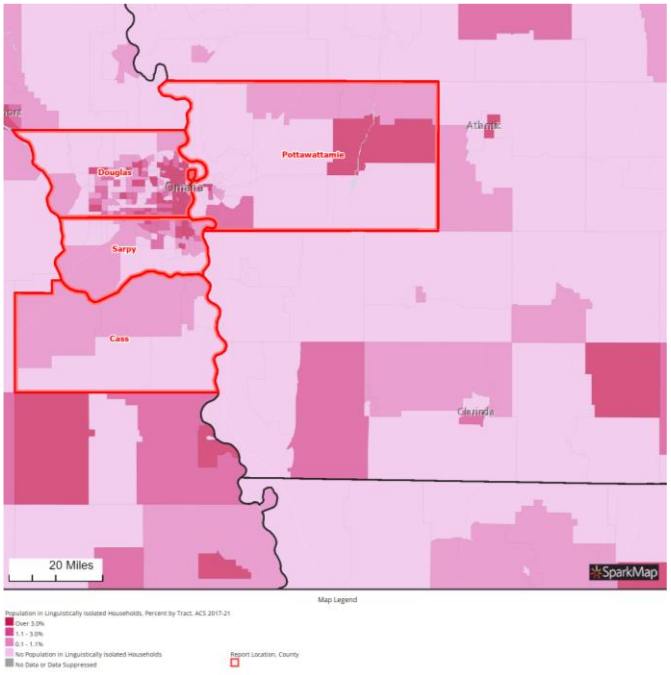
DISPARITY ► Highest in Douglas County.

Linguistically Isolated Population
(2017-2021)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2024 via SparkMap (sparkmap.org).

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



FINANCIAL RESILIENCE

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

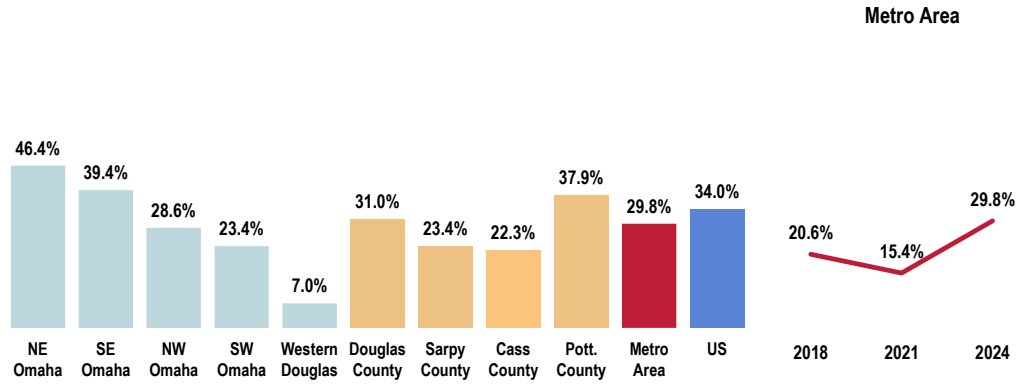
A total of 29.8% of Metro Area parents would not be able to afford an unexpected $400 expense without going into debt.

BENCHMARK ► Lower than the national finding.

TREND ► Marks a significant increase from previous surveys.

DISPARITY ► Highest in Northeast Omaha and Southeast Omaha. Those more likely to report difficulty include parents of children who are: age 12 and younger, Hispanic, Black, or of diverse races. As might be expected, the strongest correlation is with income.

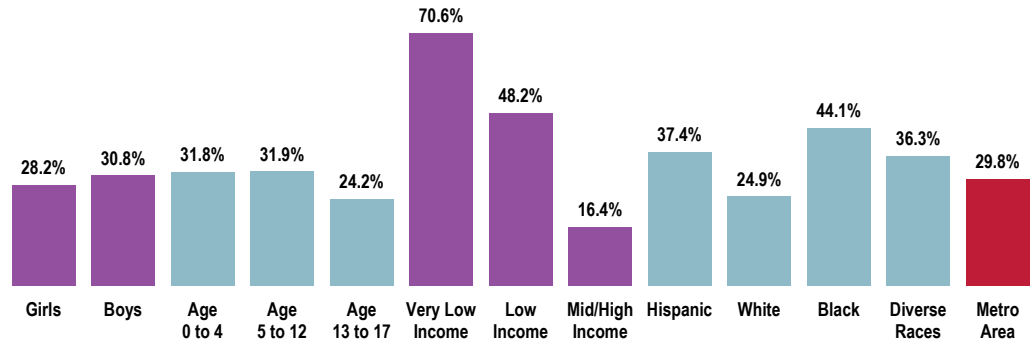
Do Not Have Cash on Hand to Cover a $400 Emergency Expense



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 334]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with a child age 0 to 17 in the home.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Metro Area, 2024)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 334]

Notes:
- Asked of all respondents with a child age 0 to 17 in the home.
- 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.

FOOD ACCESS

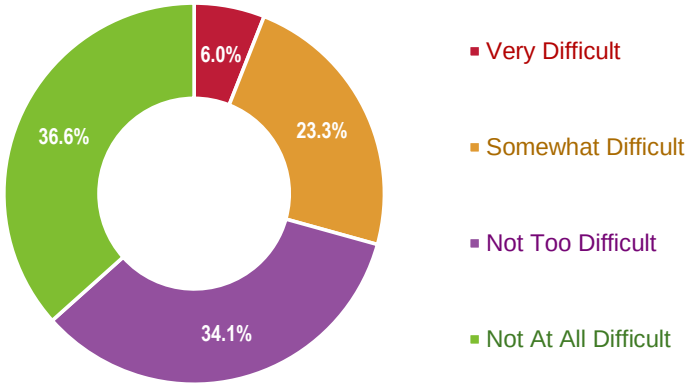
Difficulty Accessing Fresh Produce

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

While most report little or no difficulty, 29.3% of Metro Area parents report that it is "very" or "somewhat" difficult for them to access affordable fresh fruits and vegetables.

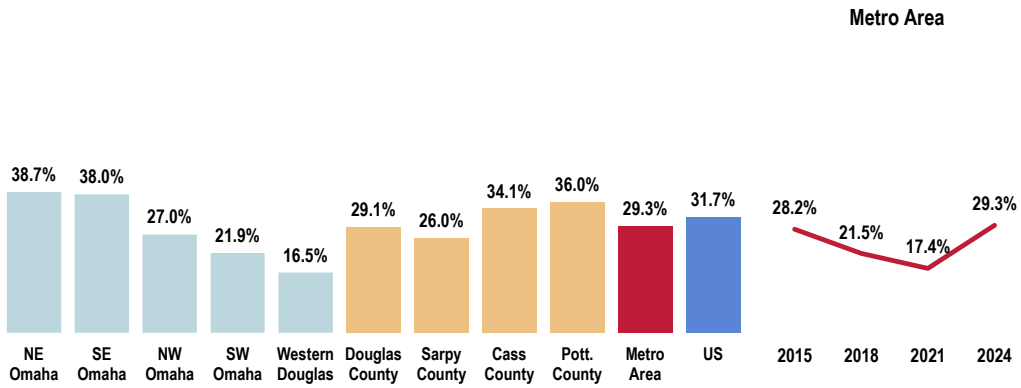
DISPARITY ▶ Highest in Northeast Omaha and Southeast Omaha. More often reported among households with lower incomes and among parents of Hispanic children.

Level of Difficulty Finding Fresh Produce at an Affordable Price
(Metro Area, 2024)



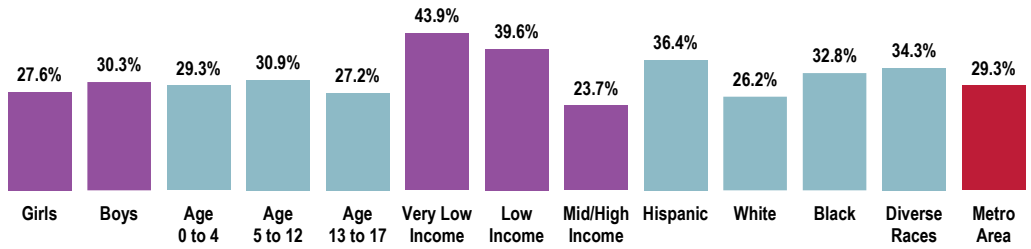
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 82]
Notes: ● Asked of all respondents with a child age 0 to 17 in the home.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 82]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with a child age 0 to 17 in the home.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 82]
Notes: ● Asked of all respondents with a child age 0 to 17 in the home.

Food Insecurity

Overall, 34.6% of surveyed families are determined to be “food insecure,” having run out of food in the past year and/or been worried about running out of food.

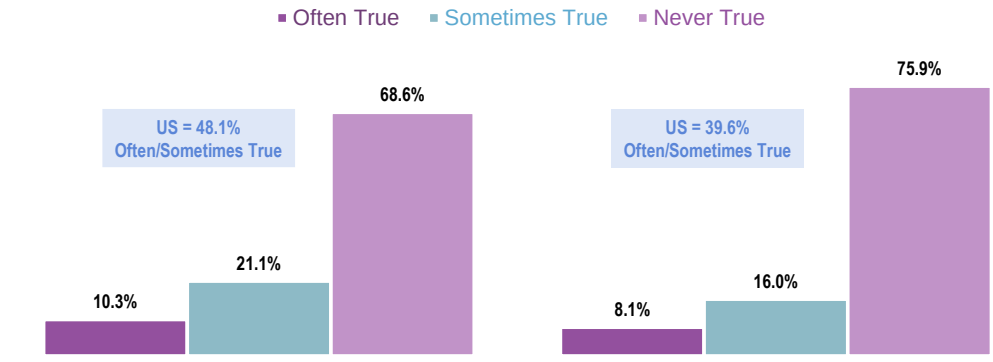
Surveyed parents were asked: “Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "often true," "sometimes true," or "never true" for you in the past 12 months:

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

The food that we bought just did not last, and we did not have money to get more.”

Those answering “often true” or “sometimes true” for either statement are considered to be food insecure.

Food Insecurity
(Metro Area, 2024)

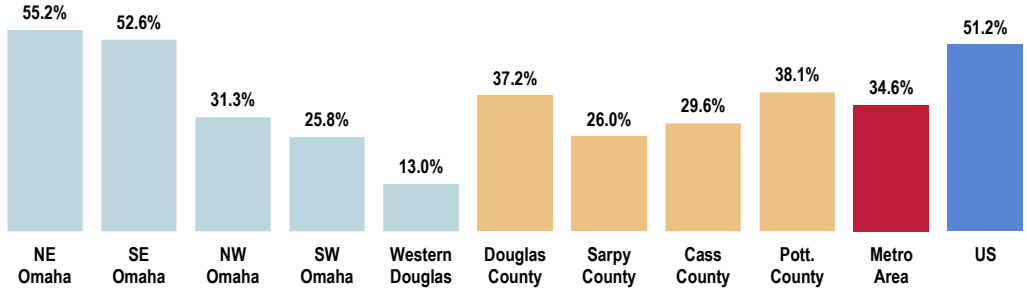


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Reflects the total sample of respondents.

BENCHMARK ► Considerably lower than the national percentage.

DISPARITY ► Highest in Northeast Omaha and Southeast Omaha. More often reported among households with children age 12 and younger, Hispanic children, and Black children. Primarily correlated with income.

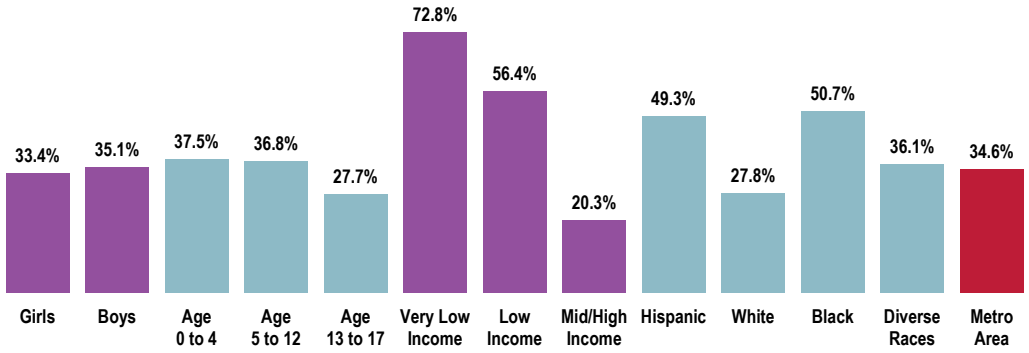
Food Insecurity



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 124]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(Metro Area, 2024)



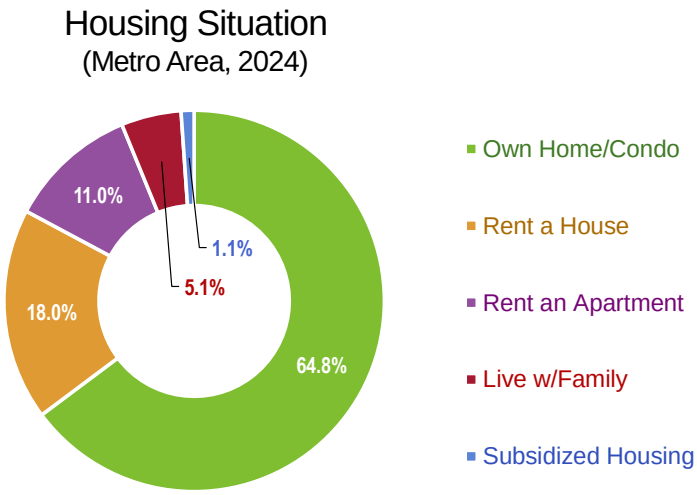
Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 124]

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

LIVING CONDITIONS & SAFE SPACES

Current Living Situation

When asked to describe their current living situation, 64.8% of respondents said they own a home or condo, while 29.0% said they rent a house or apartment. The remaining respondents said they live with family or in subsidized housing.



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 90]
Notes: • Asked of all respondents with a child age 0 to 17 in the home.

Unhealthy or Unsafe Housing

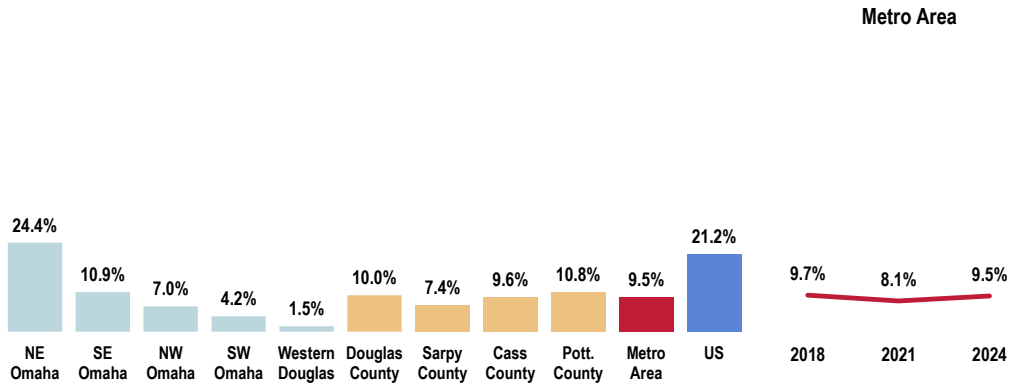
A total of 9.5% of Metro Area residents report living in unhealthy or unsafe housing conditions during the past year.

BENCHMARK ► Considerably lower than found nationally.

DISPARITY ► Particularly high in Northeast Omaha. More often reported among lower-income households, parents of Hispanic children, parents of Black children, and those who rent their home.

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

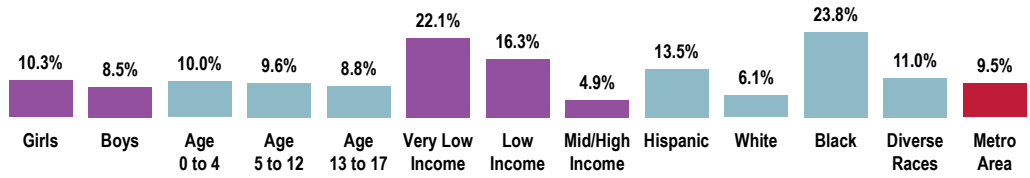


Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with a child age 0 to 17 in the home.
- 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, 2024)

Among homeowners	5.9%
Among renters	18.1%



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 92]

Notes:
- Asked of all respondents with a child age 0 to 17 in the home.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Neighborhood Blight

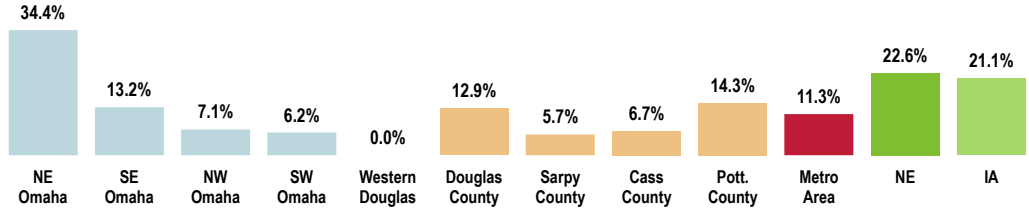
"In your neighborhood, is there poorly kept or rundown housing, or are there signs of vandalism, such as broken windows or graffiti?"

A total of 11.3% of Metro Area residents say they live in a neighborhood with signs of vandalism or poorly kept/rundown housing.

BENCHMARK ▶ Lower than found across Nebraska and Iowa.

DISPARITY ▶ Particularly high in Northeast Omaha.

Neighborhood Has Rundown Housing or Signs of Vandalism



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 319]
- Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved January 2024 from www.childhealthdata.org. CAHMI: www.cahmi.org.

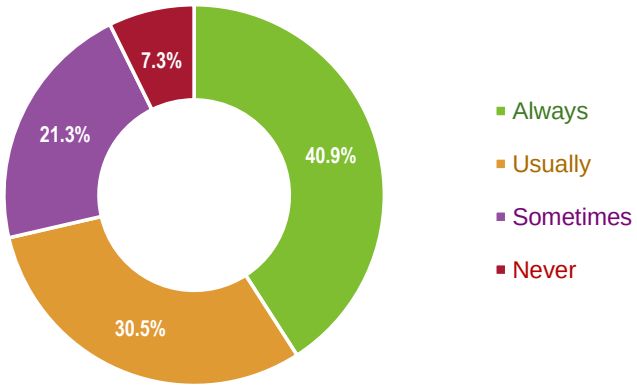
Notes:
- Asked of all respondents with a child age 0 to 17 in the home.
- The CAHMI state percentages include a reference to litter, which was not included in the PRC survey.

Playgrounds & Parks

"How often do children play in playgrounds or parks in your neighborhood?"

Seven in 10 survey respondents (71.4%) report that children "always" or "usually" use playgrounds or parks in the neighborhood.

Local Children's Use of Neighborhood Playgrounds/Parks
(Metro Area, 2024)



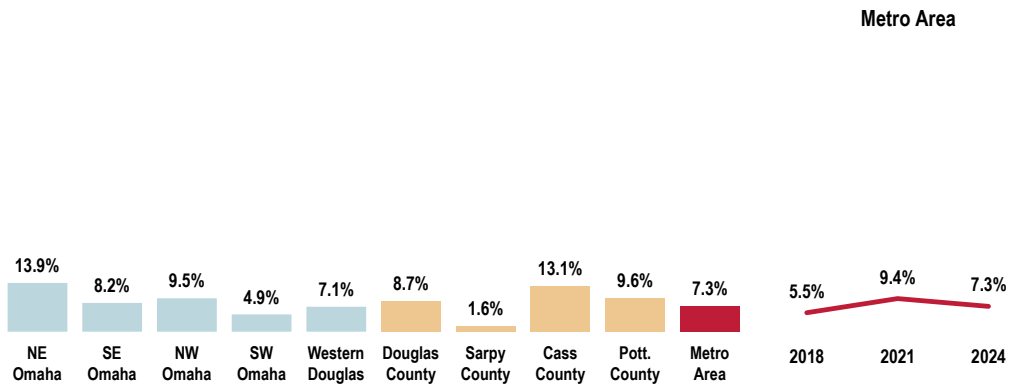
Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 318]

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

However, 7.3% indicate that children "never" use the playgrounds or parks in the respondent's neighborhood.

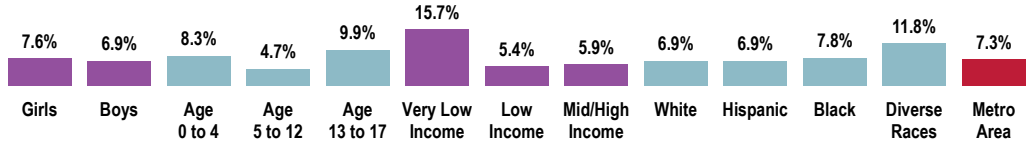
DISPARITY ► "Never" responses are most prevalent in Northeast Omaha. More often reported for adolescents (age 13 to 17) and especially for children in households at or below the federal poverty level.

Children "Never" Use My Neighborhood Playgrounds/Parks



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents about a randomly selected child in the household.

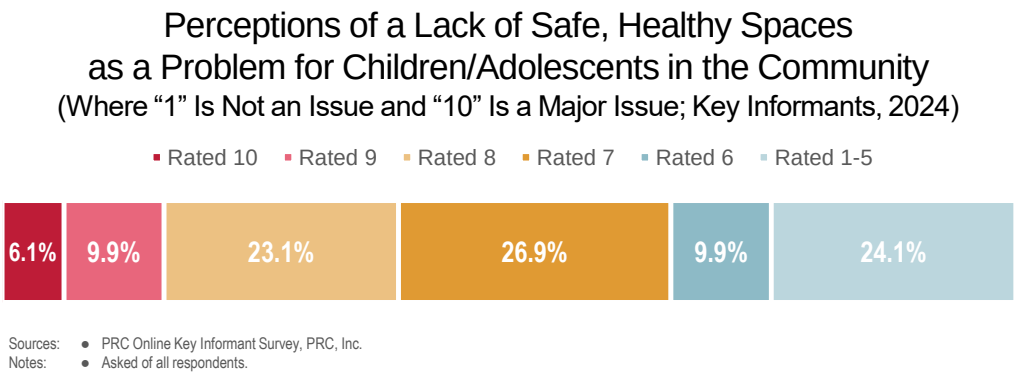
Children "Never" Use My Neighborhood Playgrounds/Parks
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents about a randomly selected child in the household.

Key Informant Input: Lack of Safe, Healthy Spaces

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



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

Built Environment

Children are products of their environments, and being in unhealthy spaces breeds major problems, whether in home, hanging around the neighborhood, or in the school. We have to have safe and healthy spaces for children to thrive. – Social Services Provider

Local parks are lacking. This area doesn't have enough pathways to allow for more biking and walking. Major intersections don't have bridges over them that are conducive to safe transportation. – Social Services Provider

The number of safe and healthy places in the city is improving. However, traditional areas of North and South Omaha are still lacking these spaces. – Public Health Representative

There aren't safe places for kids to gather for fun that aren't expensive. There is no gathering place for children, so they gather in unsafe places. – Community Leader

I was thinking about access to safe and healthy spaces for infants, toddlers, and preschoolers. A shortage of access to early care and learning opportunities while parents work exists in our community. – Community Leader

Some areas within the Omaha area do not allow for safe environments for children and adolescents due to violence, gangs, and drugs being so prevalent in the community. – Social Services Provider

Children have nowhere to go that is clean and safe. – Community Leader

We cater to cars and haven't designed places and spaces to be calm, fun, and safe for our community. – Public Health Representative

Structural environment in some geographies within the city could be better. Societal issues overall increase parent concerns for safety. The idea of sending children outside to play has multiple considerations – is there adult supervision, is the playground equipment well maintained, etc. Schools are safe places to play, however learning is the primary responsibility. Children are easily engaged in screen-time vs. active play. – Other Health Provider

When we have conducted informal surveys of our students, they complain that there is nothing to do and no safe place to do it. – Community Leader

There is a lack of community spaces for kids to play, learn, and grow. Parks and walking trials, I should not have to travel outside my community to walk on a sidewalk or visit a park. – Social Services Provider

Many communities in North and South Omaha do not have safe places, parks, and/or recreational facilities that offer safety. Many areas do not have adequate lighting to create safe environments. – Other Health Provider

In many neighborhoods, there are no green spaces, or the green spaces are not safe. – Social Services Provider

The lack of healthy, safe, and clean spaces for children in my community is very limited. We have a great need to develop more safe spaces for families to engage in social gatherings in a healthy environment. – Public Health Representative

Kids don't know where to go. Don't have access to activities. There is a lot of idle time in impoverished communities where kids are home or in unsafe spaces. – Social Services Provider

> It's a major problem for families in general, especially in areas of the county where the built environment has not been designed to accommodate safe spaces. For instance, there is not a lot of walking/running space in North Omaha, and the areas marked as "trails" are next to dangerously busy streets (i.e., trail off Sorenson Parkway), which can make it unsafe for children and adolescents interested in using the trail. In addition, most of the healthy activities cost money, which not all families can afford, especially if their focus is on basic needs (which are barely met). Therefore, the city should consider offering more programs that are free for low-income families OR free in general for all families to participate in. The promotion of these programs will need to be enhanced, as I hear many times from community residents that they "didn't know" about a program or event to promote health and well-being, mainly because it was poorly promoted. – Public Health Representative

Housing

> More and more families are being pushed out of their homes, and that leaves a gap for them to have the space, place, and environment for them to grow. – Community Leader
>
> Housing, housing, housing … we have a big gap in healthy housing options for families, and our children are suffering as a result. Without stable, healthy housing options, children will continue to experience trauma related to frequent upheaval from school and family environments, and many of their health conditions will worsen due to living in aging homes that expose them to pollutants, bed bugs, and mold. The cumulative effect are unhealthy children that lack connection to community, children that become disengaged in school, and children experiencing illnesses over and over. – Public Health Representative
>
> Low-income homes for refugees are often crowded with many maintenance issues, and yet refugees will rarely have the linguistic and cultural confidence to advocate for themselves with landlords. Also, refugee youth are so desperate to belong to a group outside of the core family that they are very vulnerable to gangs and trafficking. – Social Services Provider

Incidence/Prevalence

> I see children wandering the streets acting out. – Community Leader
>
> I don't know that I have a good answer to this, as I live in a safe neighborhood, but I do know that's not necessarily true across our larger county communities. – Community Leader
>
> OPD data. – Community Leader

LGBTQ+ Populations

> Omaha ForUs is the only LGBTQ+ center located between Chicago, IL & Denver, CO from east to west, and Sioux Falls, SD & Kansas City, MO north to south. The organization maintains restrictive hours due to lack of funding to support sufficient staff for weekend and some weekday hours. LGBTQ+ social spaces only include bars, and as a result contribute to the community's disproportionate use/abuse of legal/illegal substances. Officials inside/outside K-12 educational systems work to erase LGBTQ+ identities from literature, lesson plans, and social components of the school experience. Collectively, this intensifies existing challenges. As a result of historic marginalization, lack of infrastructure investment, and shrinking "safe spaces," LGBTQ+ youth (particularly adolescents) are at risk. 18-34-year-olds growing apart from their families as they mature have no external social root systems in the state and are incentivized to leave, contributing to brain drain and state outmigration. – Community Leader
>
> In Nebraska and much of the United States, I am currently highly concerned about LGBTQ+ youth. We are seeing laws being debated and passed targeting young people just like them, or in many cases, them. It can't be an easy time to grow up LGBTQ+ youth. It never has been an easy time with acceptance and lack of role models. But now adults are targeting LGBTQ+ youth and their health with anti-LGBTQ+ laws. – Community Leader

Violence

> Violence is everywhere in our community, and people do not feel safe taking their children places. Also, many healthy spaces cost money that people cannot afford. – Social Services Provider

Environmental Contributors

> Exposure to environmental factors and having minimum ability to control it. – Social Services Provider

Homelessness

> Shelters that take families with children are full, and not leaving in the periods of time expected. – Community Leader

Parental Influence

> With a lack of parenting, youth do not have consistency in their lives, which is needed. Therefore, causing unsafe spaces and youth left to their own devices. – Community Leader

INJURY & SAFETY

ABOUT VIOLENCE & SAFETY

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

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

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

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

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

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

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

Violence & Safety

Bullying

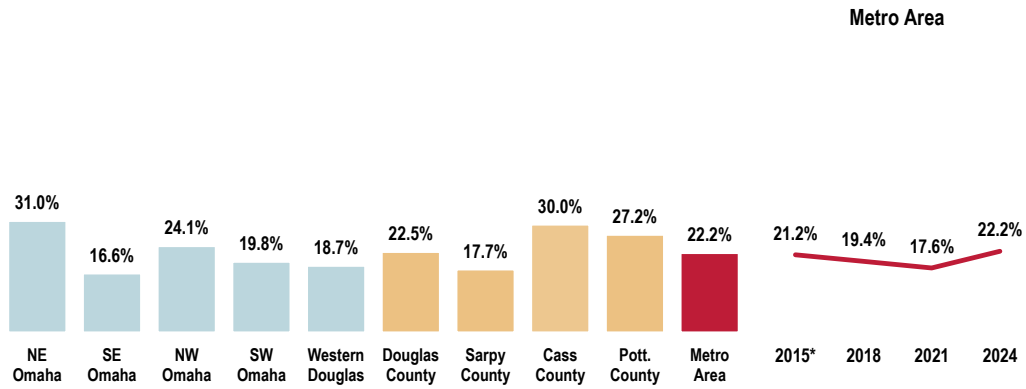
NOTE: It is important to recognize that incidences of bullying are reported by parents and are limited to incidents of which parents are aware; it is reasonable to presume that the true incidence for these measures is potentially quite a bit higher.

Among parents of school-age children (age 5-17), 22.2% report that their child has been bullied in the past year, whether online or in person.

TREND ► Returning to the baseline level after recording a significant decline in recent years.

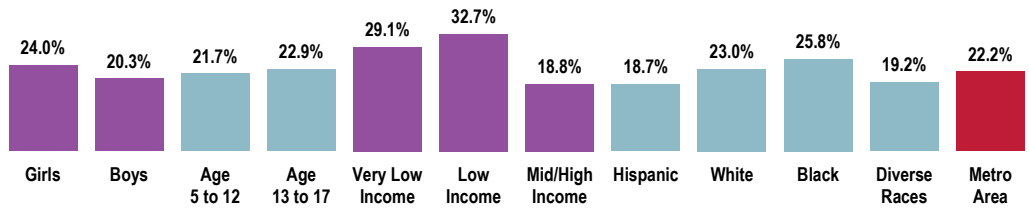
DISPARITY ► Highest in Northeast Omaha. More often reported among lower-income households.

Child Was Bullied in the Past Year
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 317]
Notes: ● Asked of respondents for whom the randomly selected child in the household is age 5 to 17.
● *2015 was asked as two questions (online bullying and bullying on school property).

Child Was Bullied in the Past Year
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 317]
Notes: ● Asked of respondents for whom the randomly selected child in the household is age 5 to 17.

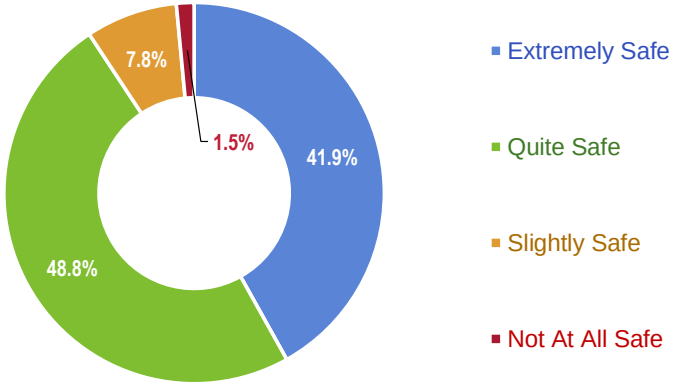
Neighborhood Safety

While most Metro Area families feel that they live in safe neighborhoods, 9.3% of parents live in neighborhoods they consider only "slightly safe" or "not at all safe."

BENCHMARK ► Considerably better than the US percentage.

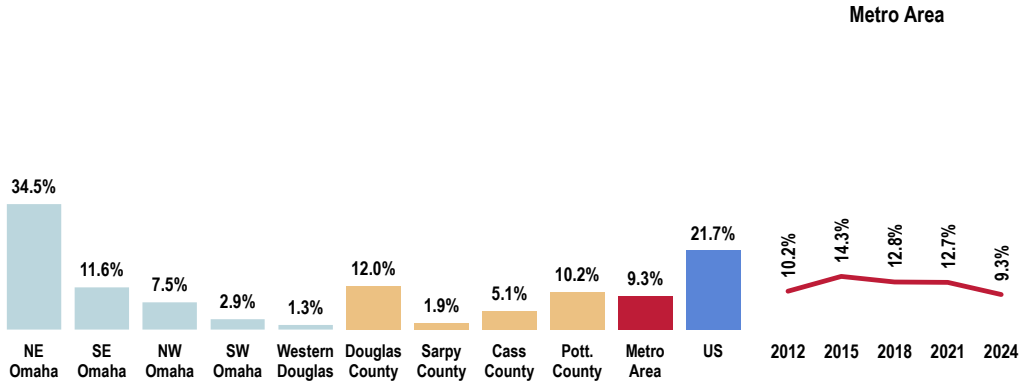
DISPARITY ► Considerably higher in Northeast Omaha. More often reported among households with lower incomes, parents of Black children, and parents of children of diverse races.

Perceived Safety of Neighborhood
(Metro Area, 2024)



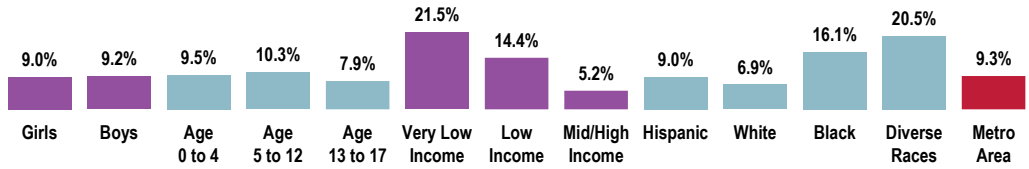
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 54]
Notes: ● Asked of all respondents.

Neighborhood Perceived to be "Slightly/Not At All" Safe



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 54]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Neighborhood Perceived to be "Slightly/Not At All" Safe
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 54]
Notes: ● Asked of all respondents.

Feeling Safe at School or Going to/from School

A total of 9.6% of Metro Area children age 5-17 missed school at least once in the past year because the child felt unsafe either at school or on the way to or from school.

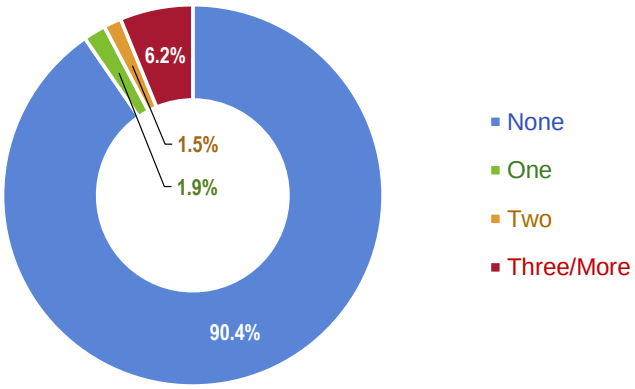
"During the past year, how many days did this child not go to school because he/she/they felt unsafe at school or on the way to or from school?"

BENCHMARK ► Much lower than the national finding.

TREND ► Trending significantly higher over time.

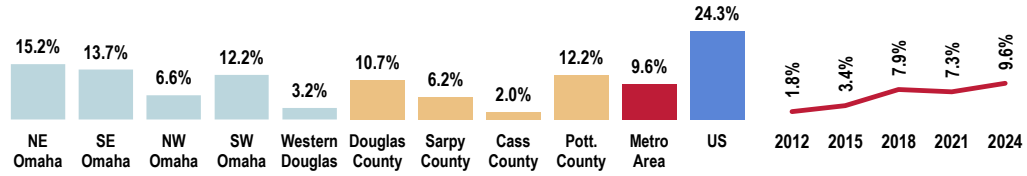
DISPARITY ► Lowest in Western Douglas County. Lower in Cass County compared to the other counties. More often reported among lower-income households.

School Days Missed in the Past Year Because Child Felt Unsafe at School or on the Way to/From School
(Metro Area Children Age 5-17, 2024)



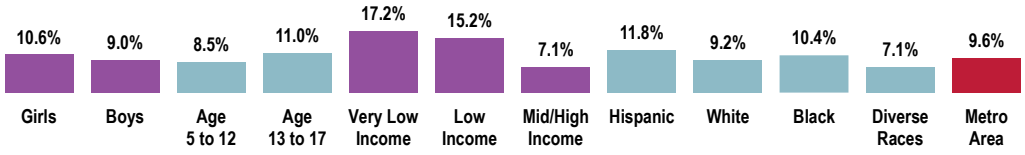
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 51]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5-17.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 51]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5-17.

Child Missed School in the Past Year Due to Feeling Unsafe
(Metro Area Children Age 5-17, 2024)

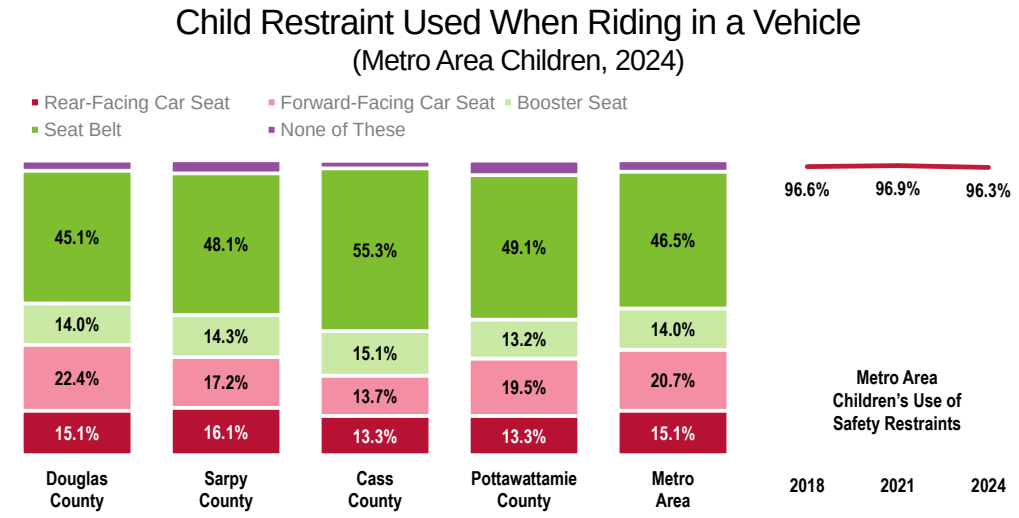


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 51]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5-17.

Injury Control

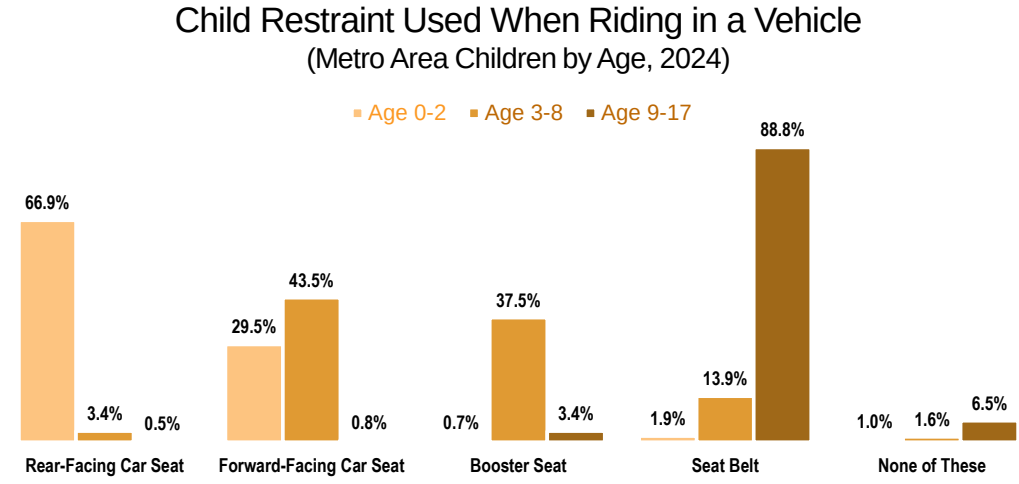
Car Seats & Seat Belts

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



Source: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 315]
Notes: • Asked of all respondents about a randomly selected child in the household.

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



Source: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 315]
Notes: • Asked of all respondents about a randomly selected child in the household.

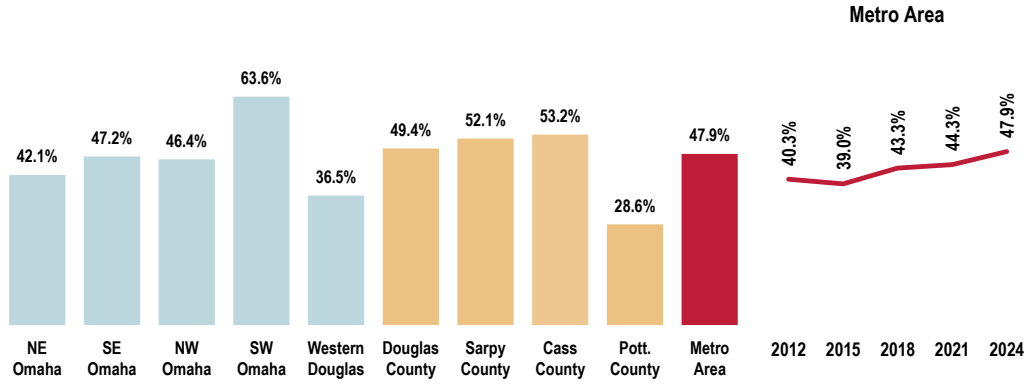
Bicycle Helmet Use

A total of 47.9% of Metro Area children age 5-17 are reported to "always" wear a helmet when riding a bicycle (denominator reflects only those who engage in these activities).

TREND ► Rising significantly higher over time.

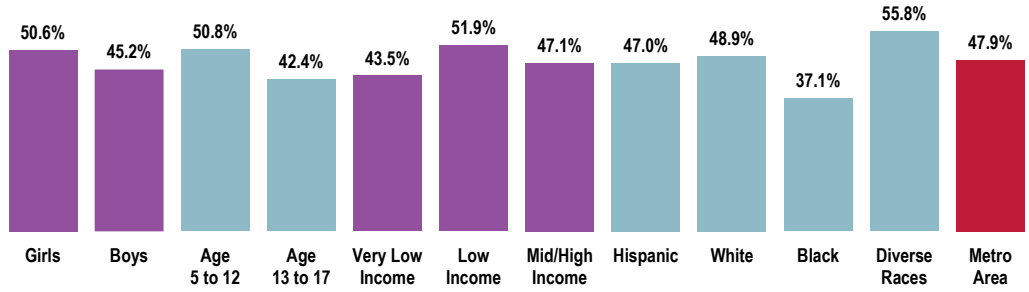
DISPARITY ► Lower in Western Douglas County than in other parts of the county. Lowest in Pottawattamie County when compared to the other counties overall. Also reported less often in adolescents (age 13 to 17) and Black children.

Child "Always" Wore a Helmet When Riding a Bicycle in the Past Year
(Children Age 5-17 Who Rode a Bike in the Past Year, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 314]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a bike in the past year.

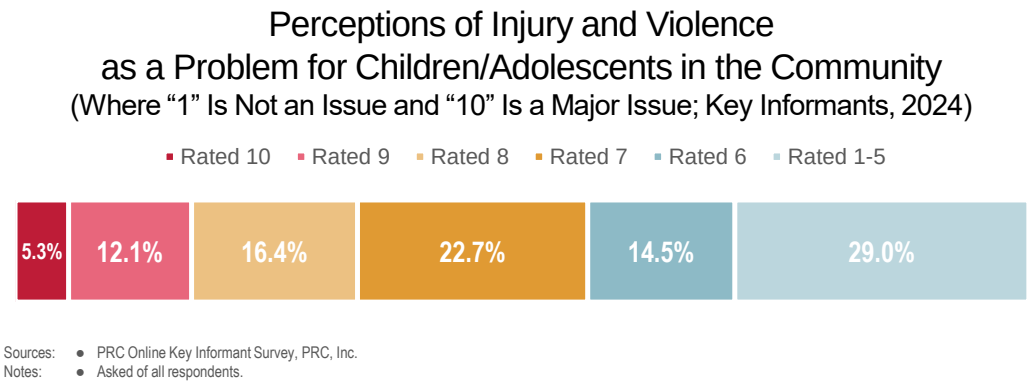
Child "Always" Wore a Helmet When Riding a Bicycle in the Past Year
(Metro Area Children Age 5-17 Who Rode a Bike in the Past Year, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 314]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5-17 and who rode a bike in the past year.

Key Informant Input: Injury & Violence

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



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

Incidence/Prevalence

> The public schools are filled with children that think they are in charge. I hear the stories from parents of the violent issues that are happening in the schools. – Community Leader
>
> I see a lot of sports injuries and domestic violence and abuse in various realms. Stats also show an increase in child abuse and neglect. – Social Services Provider
>
> Violence in certain communities is persistent, and exposure to violence in the home or neighborhood environment perpetuates traumatic experiences. – Other Health Provider
>
> Community violence, interpersonal/domestic violence, as well as teen dating violence seems to be increasing, both from observation of news reporting and reports from clients we work with. – Social Services Provider
>
> Violence is pervasive, especially when you evaluate ACE scores as it relates to the impact on young children. Not all violence is making it on the news (DV, child neglect, etc.) – Social Services Provider
>
> There has been an influx of community violence in South and North Omaha. I do know SOVIP and Omaha 360 are partnering to help address the problem. – Other Health Provider
>
> Motor vehicle injuries and gun violence are the leading causes of death among young people. – Public Health Representative
>
> Children and adolescents are exposed to violence in their communities. What is easily, readily available now to lessen the impact of physical and mental issues later in life? – Other Health Provider
>
> Violence throughout the community is a constant concern. Children are unwittingly privy to the aftermath of violent criminal and law enforcement activities. – Community Leader
>
> Because homicide is the third-leading cause of death for young people ages 10-24. – Social Services Provider
>
> It is a leading cause of death for this age group, especially when you take into account suicide, homicide, and car crashes. – Public Health Representative
>
> Youth in care today have higher acuity and violence tendencies. – Social Services Provider
>
> It is a major problem because the data for the county demonstrates it as such, especially in the northeast quadrant of the county. – Public Health Representative

Gun Violence

> Gun violence is a constant issue for Omaha youth. – Physician
>
> Too many guns and people using them. Continued non-accidental trauma. – Physician
>
> Too many people shooting each other leads to unsafe communities and can contribute to early deaths. – Community Leader
>
> There is a lot of gun violence. – Community Leader

Gang Violence

> Gang activities – prevalence of guns. Lead-based paint in homes, lack of safe places to play, playing fields (softball, soccer, etc.) are not available, stressed-out parents whose 'bandwidth tax' is often maxed out due to financial stress & other stresses. Lack of facilities for dancing and other activities – Social Services Provider
>
> Community violence is getting worse. Adolescents are being pulled into gang activity, drugs are rampant, and access to any of these is very easy. Mental and behavioral health issues among children and adolescents are skyrocketing. – Public Health Representative
>
> Gang violence and crime. – Community Leader

Impact on Quality of Life

> Children may be introduced to violence and be impacted by injury that may impact them way too young, often way too deeply and may linger throughout their lives. Violence may have a multiplying effect that may plague families and communities. The spread needs to stop. – Social Services Provider
>
> This impacts children not only when they are the victims of injury and violence, but also when they witness it in action, or as a result of an action against a loved one. They are highly impacted and discouraged, often, from disclosing these occurrences to school team members. – Social Services Provider
>
> Family and community violence, exposure to violence in the home or community can normalize aggressive behavior and increase the likelihood of youth perpetrating or becoming victims of violence. – Public Health Representative

Housing

> Injury of children comes in many forms, from unhealthy housing conditions that exacerbate asthma, to children accidentally ingesting harmful substances and the abuse children experience as caretakers become stressed and do not have the coping skills to handle their mental health challenges. Then, compound the issue with the trauma caused as a result of the stressors and conditions in which many children live, and our community has a major problem on its hands. – Public Health Representative
>
> Many families feel unsafe where they live. – Community Leader

Income/Poverty

> Violence and crimes disproportionately impact low-income, minority communities, which is an important risk factor for health inequities. – Public Health Representative
>
> Disproportionate levels of violence in communities with high poverty. – Social Services Provider

Access to Care/Services

> Lack of resources and equitable resources. – Social Services Provider

Awareness/Education

> Our community has a lot of violence, and there are no education or support programs that start at an early age. In the community, by members of the community who look like our community and have the inside knowledge of what they are going through. – Social Services Provider

Cultural/Personal Beliefs

> Violence is culturally acceptable and plays out not only in homes and neighborhoods across our communities but shows up in the way we interact with each other on roadways, in public, in health care settings and schools. The fact that "safety" is a major concern in many community-based spaces and places suggests we may have cultural/social opportunities to address how we value each other. – Community Leader

Funding

> Violence is a public health issue, and our community needs to fund more wraparound services for families that experience violence and multiple SDOH. We can't keep working downstream and addressing violence after it already happens when we have serious issues with inequity in our schools and community that lead to violence. – Other Health Provider

Incarceration

> Racism, disparate number of children entering the juvenile justice system. – Community Leader

Government/Policy

> Increased politization, partisanship, aggressive public policy, and media grandstanding which seek to mobilize opposition to those with historically marginalized identities, such as LGBTQ+ individuals, become targets for increased harassment, intimidation, threats, and physical violence. Our community's largest treating provider institution's lack of support to reject policy (like LB574) which perpetuated myths about harmful care supposedly provided to sexual and gender minority youth further exacerbated public outcry to limit access to youth medical health supports, and empowered individuals to make LGBTQ+ minors increasingly unsafe as adult behaviors and attitudes are echoed by their own children, sometimes with less restraint. We have received increased reports of suicidality, self-harm, threats, intimidation, assaults, and other violence. Reportedly, calls to LGBTQ+ crisis hotlines in Nebraska also spiked during public policy discussions and votes on these issues. – Community Leader

KEY INFORMANT PERCEPTIONS: SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

SDOH also contribute to wide health disparities and inequities. 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)

When key informants in the community were asked about the greatest contributor to health problems among children and youth in the Metro Area, the greatest share first mentioned poverty/economic status and access to affordable housing.

Key informants also frequently mentioned economic opportunity, systemic oppression, access to affordable food, and access and quality of education.

Most Important Contributors to Health Problems Among Local Children and Youth				
SOCIAL DETERMINANT	**% FIRST MENTION**	**% SECOND MENTION**	**% THIRD MENTION**	**# TOTAL MENTION**
Poverty/Economic Status	**32.3%**	13.3%	13.4%	93
Access to Affordable Housing	**24.1%**	15.8%	9.6%	78
Access to Economic and Job Opportunities	**8.2%**	12.0%	7.6%	44
Systemic Prejudice, Discrimination, and Oppression	**7.6%**	8.9%	8.3%	39
Access to Affordable Food	**6.3%**	8.9%	8.9%	38
Access and Quality of All Education	**5.7%**	6.3%	5.7%	28
Availability of Safe Housing	**4.4%**	7.6%	3.8%	25
Exposure to Crime, Violence, and Social Disorder	**3.2%**	9.5%	8.3%	33
Transportation Options	**2.5%**	1.3%	6.4%	16
Social Support	**1.9%**	6.3%	10.2%	26
Access to Media and Emerging Technology, Including Internet	**1.9%**	1.9%	6.4%	16
Language/Literacy	**1.3%**	3.2%	2.5%	11
Access to Fresh Food and Food Markets	**0.6%**	4.4%	3.8%	14
Residential Segregation	**0.0%**	0.6%	2.5%	5
Opportunities for Recreational and Leisure-Time Activities	**0.0%**	0.0%	2.5%	4

BEHAVIORAL INFLUENCES

NUTRITION

Fruits & Vegetables

Fruit & Vegetable Consumption

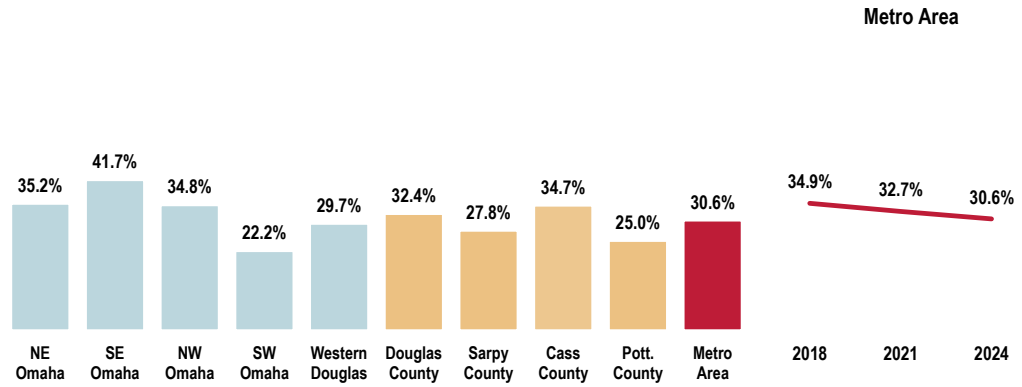
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods their child eats on a typical day.

A total of 30.6% of Metro Area parents report that their child eats five or more servings of fruits and/or vegetables per day.

TREND ► Marks a significant decrease over time.

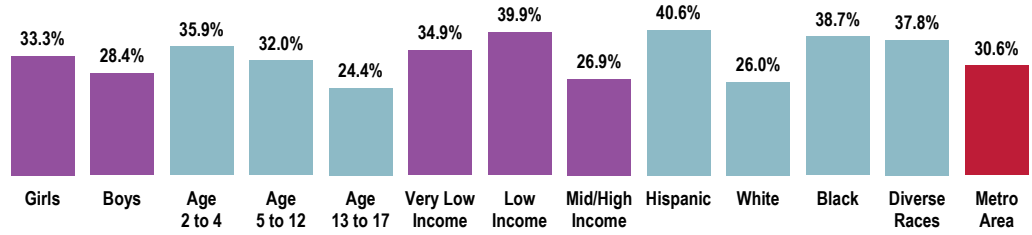
DISPARITY ► Lowest in Southwest Omaha. Less often reported for adolescents (age 13 to 17), those in higher-income households, and White children.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 329]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Child Has Five or More Servings of Fruits/Vegetables per Day
(Metro Area Children Age 2-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 329]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Family Meals

"During the past 7 days, on how many days did all the family members who live in this household eat at least one meal together?"

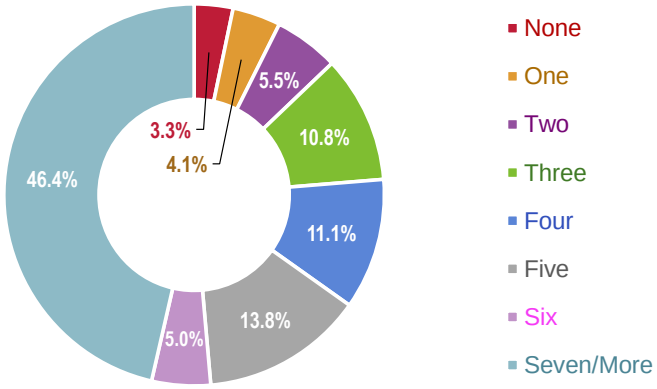
Less than one-half (46.4%) of Metro Area parents of children age 2-17 report sharing meals as a family an average of at least once a day (seven or more times in the past week).

BENCHMARK ► More favorable than the US percentage.

TREND ► Marks a significant decrease from previous surveys.

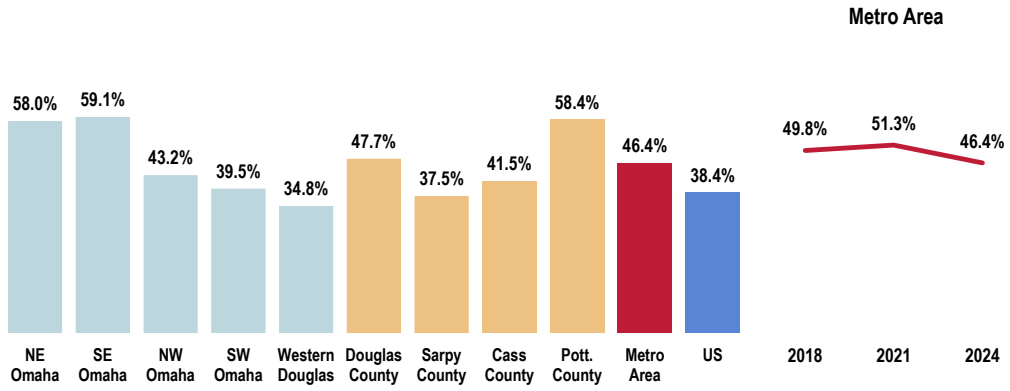
DISPARITY ► Lower in Southwest and Western portions of Douglas County, and in Sarpy County overall. Less often reported among boys, adolescents (age 13 to 17), White children, and Black children. Also note the negative correlation with income.

Number of Meals Eaten as a Family in the Past Week
(Metro Area Children Age 2-17, 2024)



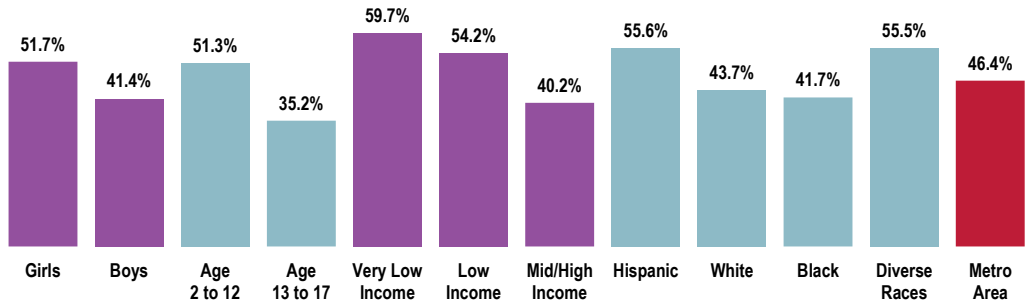
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 81]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 81]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Shared Seven or Meals as a Family in the Past Week
(Metro Area Children Age 2-17, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 81]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

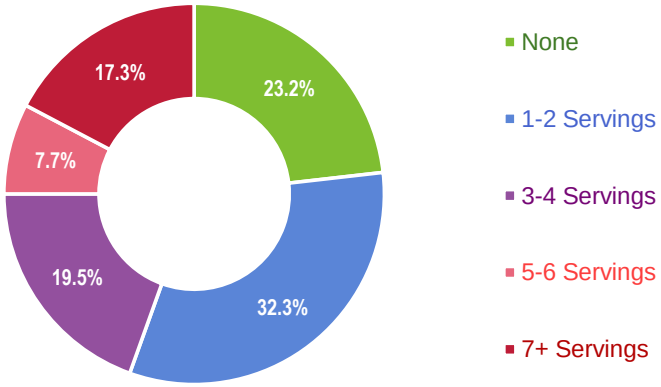
Sugar-Sweetened Beverages

A total of 17.3% of Metro Area parents report that their child (age 2-17) drinks an average of at least one sugar-sweetened beverage per day.

TREND ► Denotes a significant decrease from previous surveys.

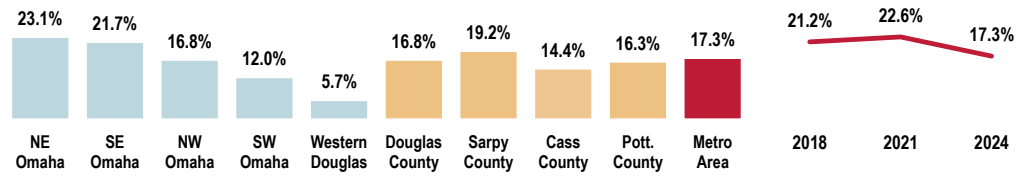
DISPARITY ► Highest in Northeast Omaha. More often reported in households living just above the federal poverty level and by parents of Black children.

Servings of Sugar-Sweetened Beverages Per Week
(Metro Area Children Age 2-17, 2024)



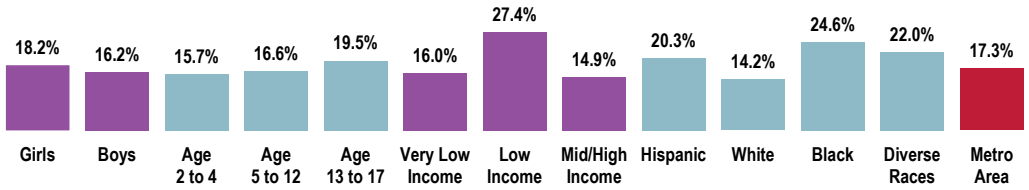
Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 328]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.
• Includes beverages such as soda pop, Kool-Aid, sweetened fruit juice, sports drinks, or energy drinks. Does not include diet drinks.

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



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 335]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.
• Includes beverages such as soda pop, Kool-Aid, sweetened fruit juice, sports drinks, or energy drinks. Does not include diet drinks.

Average One or More Sugar-Sweetened Drinks per Day
(Metro Area Children Age 2-17, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 335]
Notes: • Asked of all respondents for whom the randomly selected child in the household is between the ages of 2 and 17.
• Includes beverages such as soda pop, Kool-Aid, sweetened fruit juice, sports drinks, or energy drinks. Does not include diet drinks.

PHYSICAL ACTIVITY

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Recommended Physical Activity

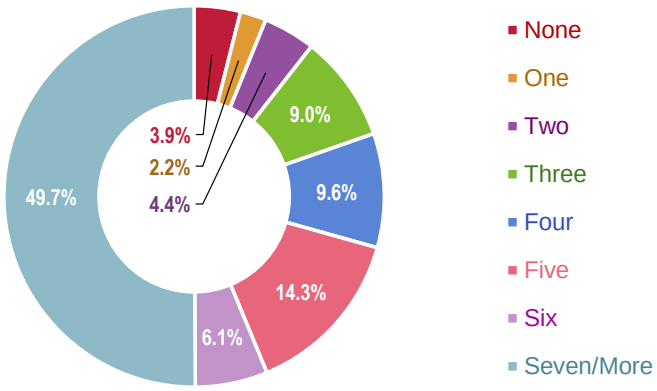
Among Metro Area children age 2 to 17, 49.7% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

"During the past 7 days, on how many days was the child physically active for a total of at least 60 minutes per day?"

BENCHMARK ► Higher than found nationally. Satisfies the Healthy People 2030 target.

DISPARITY ► Lowest in Sarpy County, as well as in the Southwest Omaha portion of Douglas County. Less often reported for girls, adolescents (age 13 to 17), and those in higher-income households.

Number of Days in the Past Week on Which Child Was Physically Active for One Hour or Longer
(Metro Area Children Age 2-17, 2024)

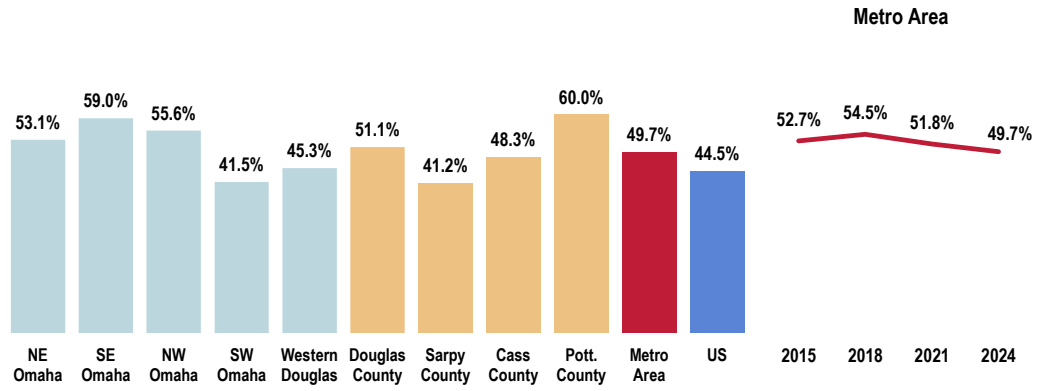


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of those respondents for whom the randomly selected child in the household is between the ages of 2 and 17.

Child Was Physically Active for One Hour or Longer on Every Day of the Past Week

(Children Age 2-17)

Healthy People 2030 Target = 30.4% or Higher (Goal for Ages 6 to 13)



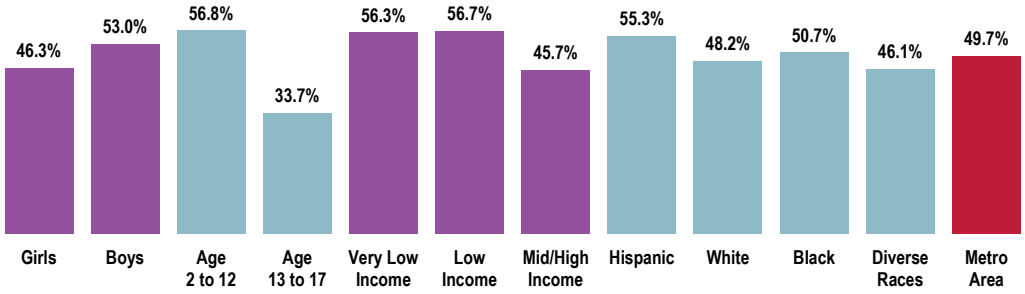
Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 79]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov

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

Child Was Physically Active for One Hour or Longer on Every Day of the Past Week

(Metro Area Children Age 2-17, 2024)

Healthy People 2030 Target = 30.4% or Higher (Goal for Ages 6 to 13)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 79]
- US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople. gov (adjusted to reflect all children and adolescents)

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

Screen Time

Total Screen Time

"On an average week day, about how many hours or minutes does this child usually spend in front of a screen—watching TV programs or videos, playing video games, on a computer, a cell phone, or other electronic device?"

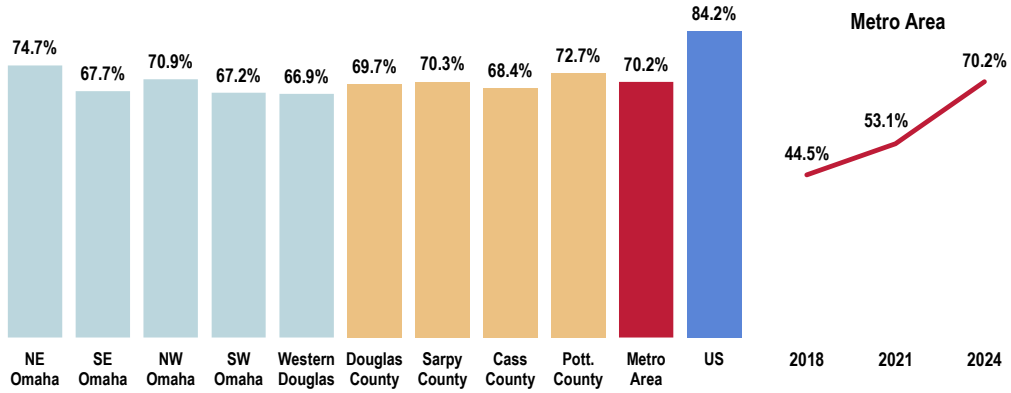
Among Metro Area children age 5 through 17, 70.2% are reported to have watched two or more hours of screen time (whether television, computer, video games, cell phone, handheld device, etc.) on every day of the seven days preceding the survey.

BENCHMARK ► Lower than the US percentage.

TREND ► Marks a dramatic increase over time.

DISPARITY ► More often reported for boys, adolescents (age 13 to 17), and Black children.

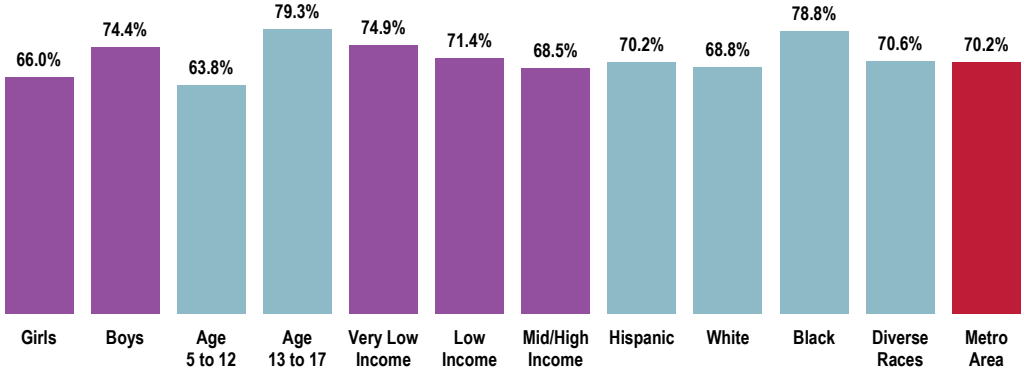
Children With Two or More Hours per Weekday of Total Screen Time (TV, Computer, Video Games, Phone, Device, etc.)
(Children Age 5-17)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of respondents for whom the randomly selected child in the household is age 5 to 17.
- Excludes screen time for school or spent doing homework.
- "Two or more hours" includes reported screen time of 120 minutes or more per day.

Children With Two or More Hours per Weekday of Total Screen Time (TV, Computer, Video Games, Phone, Device, etc.)
(Metro Area Children Age 5-17, 2024)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 100]

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

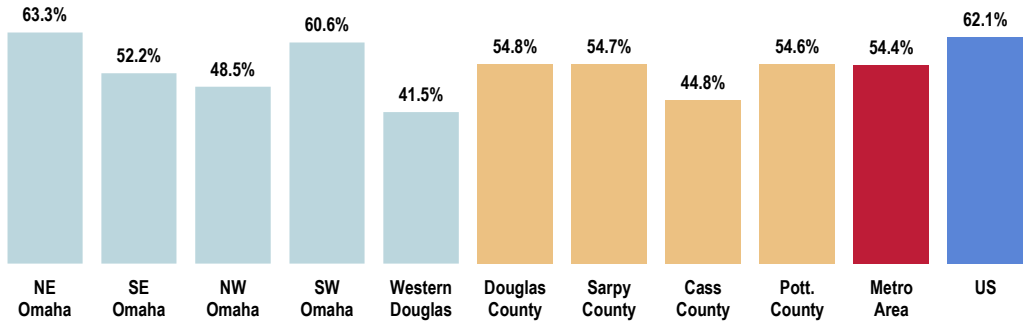
Smartphones

Among parents of school-age children (age 5 to 17), over one-half (54.4%) indicate that their child has a smartphone on which they can download apps or games and visit social media sites.

BENCHMARK ► Lower than the US finding.

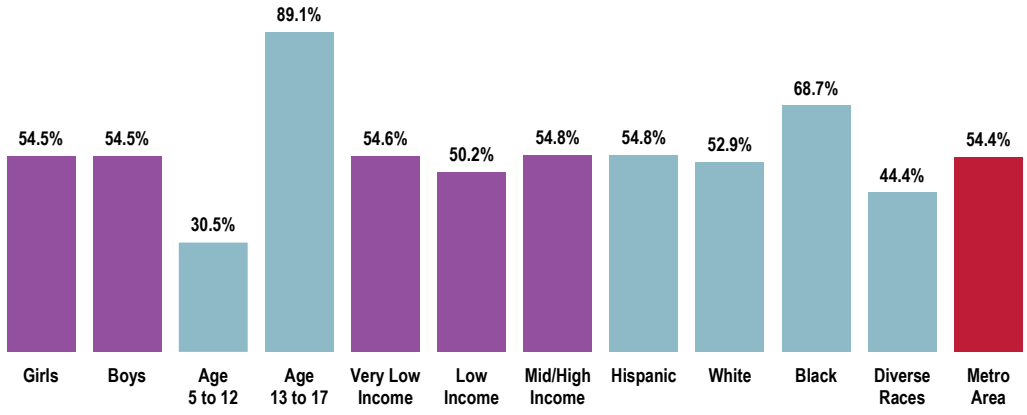
DISPARITY ► Highest in Northeast Omaha. More often reported for adolescents (age 13 to 17) and Black children.

Child Has Own Smartphone
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 78]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5-17.

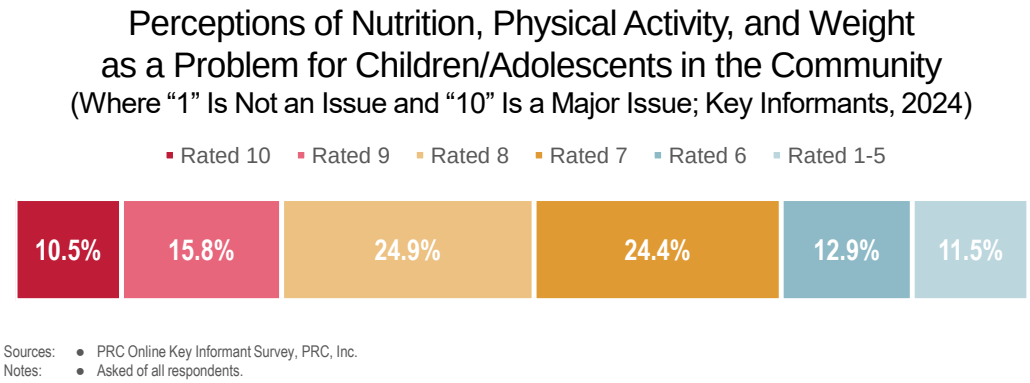
Child Has Own Smartphone
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 78]
Notes: ● Asked of all respondents for whom the randomly selected child in the household is age 5-17.

Key Informant Input:
Nutrition, Physical Activity & Weight

More than one-half of key informants taking part in an online survey gave *Nutrition, Physical Activity & Weight* a rating of "8," "9," or "10" (10-point scale where "10" is a major issue for children/adolescents in the community).



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

Obesity

Our community is overweight, and food insecurity is real. More primary care doctors need to intergrate nutritional components, even if BMI or the bell curve are within normal range. Asking families if they have access to food can help. – Social Services Provider

Childhood obesity. – Physician

I see children and adults with weight issues and can trace it to all of the above. We also have seen infants using tablets and phones, further reducing physical play as an expectation or practice. – Social Services Provider

Obesity is rampant. – Physician

So many children are overweight or with a high BMI and parents not having the right resources to help them and the child without making the child feel bad or fat. – Community Leader

Our society in general could be much better at addressing overall health and nutrition. It seems to be more common for kids to deal with weight and nutrition issues at an early age. – Community Leader

It's somewhat situational, encountering many children who are already larger than their parents from a young age, 5-7 and up. I only remember encountering this occasionally 30 years ago. – Community Leader

Weight in pediatrics is concerning, and there are limited resources to change the culture of direction of this need. – Community Leader

Childhood obesity and the long-term sequelae continue to increase despite current efforts to impact its prevalence. – Physician

Just walking around Omaha, you are seeing kids that are obese and are constantly on their phones or playing video games. I would assume diabetes is an issue. – Community Leader

I feel this is a problem because of the increase in overweight and obese children. – Other Health Provider

Too many children are overweight or obese before they even start school, which increases the likelihood that they will remain overweight/obese in adulthood, leading to increased incidences of chronic disease, not to mention the toll it takes on their self-esteem and mental health. This will also affect their access to needed health care due to increased health care needs, as well as health care costs. – Community Leader

Obesity is rampant in our youth. Balanced eating habits, access to proper nutrition, and lack of physical activity are all issues not only for youth, but adults as well. – Public Health Representative

20% of the adolescents in the US have childhood obesity. Adolescents who have obesity are at higher risk for developing health conditions like high blood pressure, heart disease, and diabetes. Kids who have obesity are also at greater risk for depression, social isolation, and bullying. – Public Health Representative

Lifestyle

Children and adolescents repeatedly are reported to not meet dietary intake recommendations despite community intervention and focus on the topic for many years. Children are largely inactive or only participate in organized sports that often provide limited amounts of truly moderate to vigorous physical activity time. Weight of youth remain higher than recommended for age and this contributes to comorbidities impacting overall health, ability to adequality move to meet physical activity needs. – Public Health Representative

Kids who start with poor nutrition, low activity levels, and are overweight continue to have progressively worsening health conditions as they get older. Access to healthy, affordable food impacts families living in poverty, esp. BIPOC families, is severely limited. – Social Services Provider

My patient population eats a lot of rice. Need more variety of fruits and vegetables and meats. Others eat too much junk food and fast food. Need more safe places and indoor places to exercise. – Physician

The nutritional quality of the readily accessible food types is subpar. Due to either heightened recognition of certain chronic diseases, or the increase in those diseases, there seems to be a concerning trend in children and adolescents in preventable conditions. – Community Leader

Nuclear family structures are not the norm. When they exist, families are overworked and overscheduled. A standard, balanced, homecooked meal is not a reality for a lot of folks. Our kids are bigger, play outside less, and we are seeing the impact from that. – Community Leader

Again, this is a pervasive problem not only in the state, but across the country. There is not enough access to healthy and quality foods in areas where food deserts exist and even in areas where grocery stores exist, but they do not provide access to quality food. Physical activity is a problem because there is not enough access in some parts of town to outdoor spaces to encourage physical activity. Also, when winter hits, not everyone can afford to hit the gym, so offering ways for people to stay active when it's cold is also a problem. Obviously, nutrition and activity compound the weight issue because people not eating healthy, and being more sedentary than active will lead to weight issues. This is a pervasive problem for adults AND children. – Public Health Representative

In my community, we have found many food desert zones and little to no green areas for families to practice in healthy physical activities. Education in nutrition and fitness needs to be offered to parents as part of the food assistance program. – Public Health Representative

Access to Affordable Healthy Food

Healthy and nutritious meals are more costly for families and more time-consuming for families on the go. Children may be limited in their ability to participate in sports due to parents working multiple jobs to support their households, associated costs, or transportation. Gaming and electronics are so prevalent and may keep children occupied and inactive for hours. Concerned parents may keep children at home to avoid entanglements with gang activity and violence. Together, these can lead to major health and weight problems. – Social Services Provider

In our impoverished areas, there is little access to healthy foods that are affordable, as well as safe places for physical activity. Sports and activities cost money, and many do not have the money to pay the fees to join. – Social Services Provider

A lot of children do not have access to healthy food sources or safe places to play for physical activity. – Community Leader

Lack of fresh products within walking distance. Access to cheap and unhealthy items. – Social Services Provider

Families are struggling to have access to fresh produce, healthy groceries, and great outdoor spaces to take part in. – Social Services Provider

Access to healthy and affordable foods can be limited, especially in rural areas of our community. Additionally, youth lack access to safe, regular physical activity options. – Public Health Representative

Like most places, it's easier to get less healthy food at lower cost than healthier food options. Additionally, we have several food deserts in the metro. Not many areas are walkable and bikeable throughout the metro, and PE and recess are reduced at school compared to a decade or two ago. Finally, there is a growing number of overweight and obese children in the area. – Community Leader

Families have complained about access to healthy foods and places to eat in this community. Childhood obesity is a common concern expressed by the people we serve. – Community Leader

Nutrition and healthy meals are less accessible to some families due to the cost of living and housing cost. Unhealthy weight caused by unhealthy eating habits and little physical activity results in health issues in children and adults. – Social Services Provider

Insufficient Physical Activity

This is a societal issue. Kids play less, are sedentary, and are lured by the constant availability of unhealthy foods. Lack of education on making healthy choices and the fact that parents seek convenience over nutrition due to high demands on time and schedules. – Social Services Provider

More kids are sedentary, and that is not healthy. So many foods are processed. – Social Services Provider

> In general, lifestyles are becoming increasingly sedentary; youth are less inclined to play and move around outside when they can be entertained indoors by electronic devices for hours; nutrient-rich foods tend to be much more costly than less nutritious food; fast food restaurants are ubiquitous and convenient. – Community Leader
>
> Physical activity is not prioritized. Some parts of the city do not have ready access to nutritional foods. – Community Leader

Built Environment

> Certain families have barriers to access the community amenities to support betterment. This could be related to food deserts or simply not feeling safe enough to allow your children to play in their neighborhood. – Social Services Provider
>
> Poor communities lack grocery stores, green space and walking paths; fast food and healthy food options are all challenges to communities that lack funds to pay for the more expensive food choices. – Other Health Provider
>
> Access to safe, creative, physical spaces is limited. Children are spending more time on electronics and technology than engaging in physical activity. In my community, indoor facilities that promote physical activity are limited. – Public Health Representative

Prevention/Screenings

> In general, I don't feel that preventative care is prioritized in our society at the level it should be. We are spending so much money treating disease after symptoms begin when if we invested more in helping families with nutrition and physical activity early on, we would have a much healthier community long-term. – Social Services Provider
>
> We focus so much on illness and don't think of those things as wellness and preventative measures for illness. – Community Leader

Income/Poverty

> Nutrition, physical activity, and weight are not embedded in our regular school education. For people living in poverty, it is a luxury to talk about food because it is tied to income. Most markets available to people who live in poverty do not offer healthy options for meals; there are a lot of processed meals eaten and not enough educational programs to educate our community. – Community Leader
>
> When we live in survival mode, making healthy choices isn't accessible. Poverty and violence also impact these areas. – Public Health Representative

Access to Care/Services

> No resources for families, and if there are any, they are too far away or too costly. – Physician

Awareness/Education

> Lack of education and resources. – Physician

Cultural/Personal Beliefs

> This aligns with our focus on productivity and sports and what we value. We aren't valuing being active and nutrition for general well-being and making it okay to make these things a priority at school and at work. – Community Leader

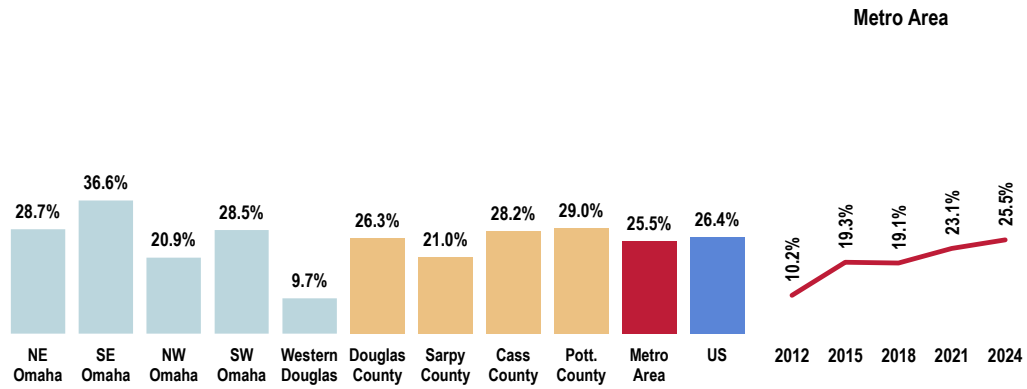
SLEEP

One-fourth (25.5%) of Metro Area parents indicate that their school-age child has difficulty falling asleep and/or sleeping through the night.

TREND ► Trending significantly higher over time.

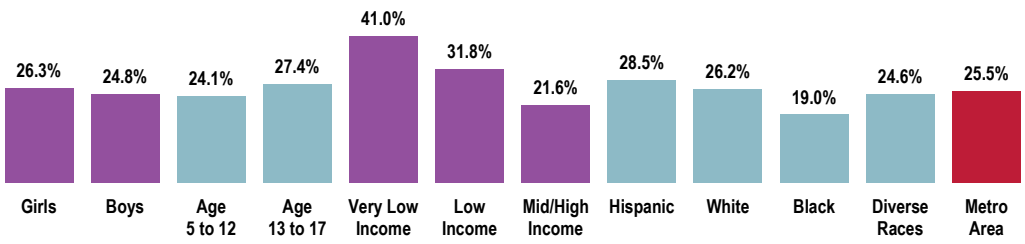
DISPARITY ► Highest in Southeast Omaha. More often reported among lower-income households.

Child Has Difficulties Falling Asleep and/or Sleeping Through the Night
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 59]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Child Has Difficulties Falling Asleep and/or Sleeping Through the Night
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 59]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

TOBACCO, ALCOHOL & OTHER DRUGS

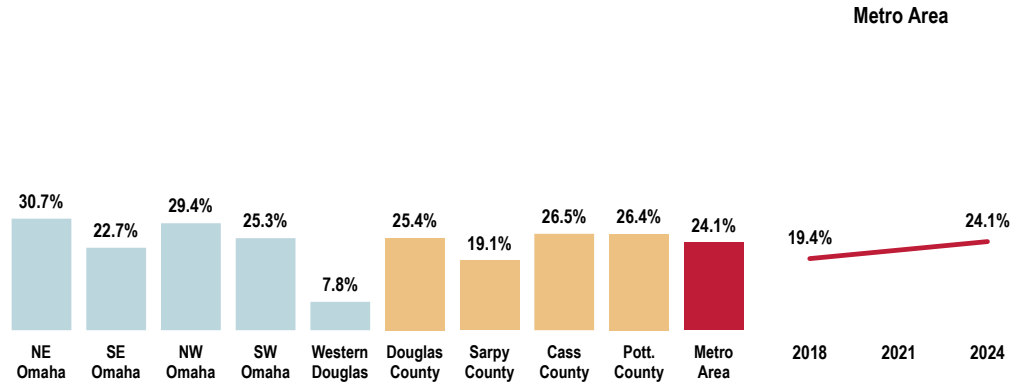
Household Members Who Smoke

Nearly one-fourth (24.1%) of Metro Area parents report that someone in the household smokes, whether tobacco, marijuana, or vaping/electronic vapor products.

TREND ► Marks a significant increase since the 2018 survey.

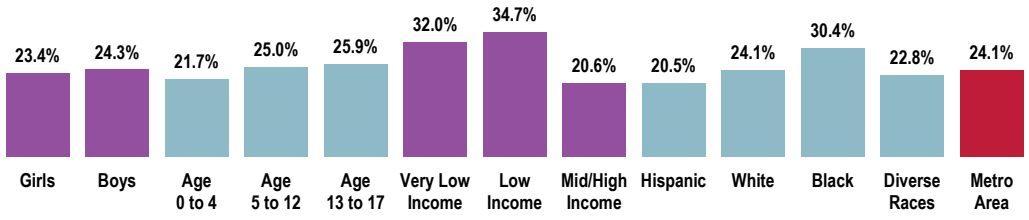
DISPARITY ► Lowest in Western Douglas County; also lower in Sarpy County than in the other counties overall. More often reported among lower-income households.

Someone in the Household Smokes, Even Occasionally



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 326]
Notes: ● Asked of all respondents.
● Smoking here includes tobacco, marijuana, and/or vaping/electronic cigarettes.

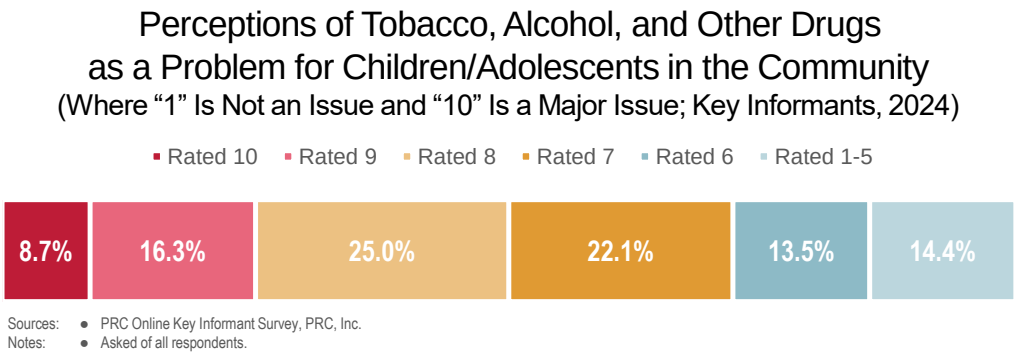
Someone in the Household Smokes, Even Occasionally
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 326]
Notes: ● Asked of all respondents.
● Smoking here includes tobacco, marijuana, and/or vaping/electronic cigarettes.

Key Informant Input: Tobacco, Alcohol & Other Drugs

One-half of key informants taking part in an online survey gave *Tobacco, Alcohol & Other Drugs* a rating of "8," "9," or "10" (10-point scale where "10" is a major issue for children/adolescents in the community).



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

Easy Access

> Easy to access, social media challenges are also increasing the issue. – Social Services Provider
>
> Tobacco and other drugs are symptoms of untreated mental health issues. Access is too easy to mask deeper issues. – Community Leader
>
> Access is everywhere, and kids are using it to cope. They don't know what to do otherwise. – Social Services Provider
>
> Access to tobacco, alcohol, and drugs is unbelievably easy, especially in public schools and in public settings. With the rise of mental and behavioral health issues, many kids are turning to these things in lieu of self-regulation skills. – Public Health Representative
>
> Fentanyl is a problem. We need more resources and more communication on this. Vaping, too. Ketamine is becoming more widely used. How do we educate and protect? CBD stores are here, but how can we educate on this as well? – Social Services Provider
>
> There is more access than ever to tobacco (including vape products) alcohol, and other drugs. But please, let's not make marijuana the target. Is early use of it a concern? Yes, but drunk driving, opioids and other prescription drugs, and smoking/vaping tobacco has documented serious health impacts, including death. – Social Services Provider
>
> The products are more accessible than the resources to help families. – Physician
>
> Client reports of their children using tobacco and marijuana have increased, along with the use of legal substances, such as gas station heroin. This combined with the increased need for Narcan in shelters and schools. – Social Services Provider
>
> It is easily accessible to youth, and not enough education is provided to prevent it. – Community Leader
>
> Those are widely available to anybody, and no authorities or even common citizens would like to start a controversy by opposing the use. – Social Services Provider
>
> Marijuana and THC liquid are becoming the drug of choice for self-medication. The potency and easy availability of these products puts our students at greater risk. Students and some of our parents don't see anything wrong with using it. – Other Health Provider
>
> Access seems to be easy enough that too many of our youth are using tobacco, alcohol, marijuana, and other substances. It is harming their brain development and disrupting their educational attainment. – Social Services Provider

E-Cigarettes

> Especially since vaping is so widely accepted and accessible, many teens are resorting this as an introduction to nicotine and cannabis, it has gotten to the point where you see it everywhere. ETOH is so widely accepted and glamorized on screen that it is seen as a normal way of life when it is so much more dangerous than many other vices. – Public Health Representative

> Vaping seems to be a trend that nobody has their hands around. Overall, it appears that alcohol misuse may be decreasing, but if tobacco use or vaping increase, then those gains overall will be negligible. – Social Services Provider
>
> Vaping a popular thing among youth. – Social Services Provider
>
> The clandestine use of vaping products is not being stopped by retail store measures, which I believe are as highly secure as possible, just as much as alcohol. Children are getting access, circumventing all postal mail order and retail store security measures. There are also measurable amounts of these products infused with THC or other chemicals. Schools have put in place extreme consequences, multiple days out of school suspension ... equivalent to suspended time for assault and fights. The problem continues to increase. – Other Health Provider
>
> The cigarette and vape litter around the community is worse. Children are not only exposed to this habit in their homes, but advertising is also targeted at youth and on social media and movies. – Community Leader
>
> Kids are vaping at an alarming rate. I do think there is less alcohol consumption, but increased marijuana use. – Community Leader
>
> Vaping is increasing. – Physician
>
> The prevalence of vaping, hemp products, and cannabis oil have made these products an everyday use for many teens. This problem is affecting all teens regardless of money, parent involvement, or school performance. There are few supports for parents who are trying to get help for their teens prior to full-blown addiction. There are no providers of substance abuse treatment for these kids in our community. – Social Services Provider

Alcohol/Drug Use

> It might be bias of what is heard in the news, but it seems that there are frequently stories of kids being involved with drugs or alcohol, which then sometimes lead to other issues like driving under the influence, etc. I think usage of tobacco, alcohol, and other drugs are sometimes also instigated by mental health issues, which also need to be addressed. – Community Leader
>
> Too many situations where drugs and/or alcohol are found in the schools or other situations. – Other Health Provider
>
> Drug addiction is a major problem, and it is not being dealt with. Parents are in denial about it. Much more education needs to be done to prevent this in our kids. – Other Health Provider
>
> Tobacco, alcohol, and drug use are major issues in children and adolescents in my community. I've witnessed and experienced how systemic inequalities, including limited access to education, health care, employment opportunities, and socioeconomic resources contribute to higher levels of stress, trauma, and social disadvantage, which can increase the risk of substance use as a coping mechanism. Our children witness that, and the cycle continues. – Social Services Provider
>
> Tobacco, alcohol, and other drugs are a major problem due to unaddressed trauma and other mental health conditions. Also, the availability of these items in communities exceeds the availability of health grocery stores. – Other Health Provider

Incidence/Prevalence

> Prevalence. – Community Leader
>
> Teen use of nicotine products is up. Additionally, we hear from young people that the school bathrooms are frequently unsafe spaces, as it relates to drug use. – Social Services Provider
>
> I work in North Omaha. Marijuana and alcohol and other drugs are all too common. Also, vaping and tobacco use. – Physician
>
> As reported in community meetings by professionals in this arena, I feel that substance use is a major problem for children, adolescents, and adults. – Public Health Representative
>
> Talk to kids. It is a problem. – Community Leader

Awareness/Education

> There is not enough education and awareness campaigns about the dangers of tobacco, alcohol, and drug misuse. – Public Health Representative
>
> Low perceived risk associated with use of tobacco, alcohol, and other drugs in area teens. – Public Health Representative

Built Environment

> There are more smoke shops and liquor stores in the community than safe spaces for youth in the community to have productive, healthy activities. – Social Services Provider
>
> Major problems arise in my community when we have a difficult time accessing healthy food markets, but on the other hand, we have alcohol and tobacco stores on every corner. – Public Health Representative

Co-Occurrences

> Most of the youth that enter care at Boys Town have tobacco, alcohol, and other drug abuse issues that seemingly accompany physical and mental issues. Surveys at local high schools indicated large availability of these drugs. Illegal substances can be found at almost any high school in the metro area. – Community Leader
>
> The burden of tobacco, alcohol, and other drugs includes chronic disease and addictions, cancer, negative impacts on economy, productivity, and communities overall. Over 2,500 Nebraskans die every year from tobacco and smoking-related causes, and over 500 adolescents each year in our state will become new daily smokers. The vast majority of adult smokers started before they were 18 years old. Addressing these issues during adolescence would positively impact the community. – Public Health Representative

Diagnosis/Treatment

> We lack effective assessment and treatment for adolescents with substance addictions, especially alcohol and drugs, and we have not effectively addressed the increase in vaping among our youth. – Other Health Provider
>
> Nowhere to refer them to. – Physician

Refugee Populations

> Refugee youth come to the USA with a lot of trauma that is not addressed. This, coupled with their vulnerability to gangs and other groups for a sense of belonging, makes them prone to tobacco, alcohol, and other drug problems. – Social Services Provider

Generational

> A lifestyle of substance use/abuse spanning across generations is very prevalent in communities around the Omaha metro. Children and adolescents are not afforded opportunities to change their environments for the short term, like after school activities, or long-term, like affordable housing, due to poverty barriers. – Social Services Provider

Prevention/Screenings

> This is certainly not a new issue. Good progress has been made over time. If these efforts are to be maintained, strong prevention and intervention activities that are relevant and current are needed. – Other Health Provider

SEXUAL HEALTH

ABOUT FAMILY PLANNING

Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

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

Births to Adolescent Mothers

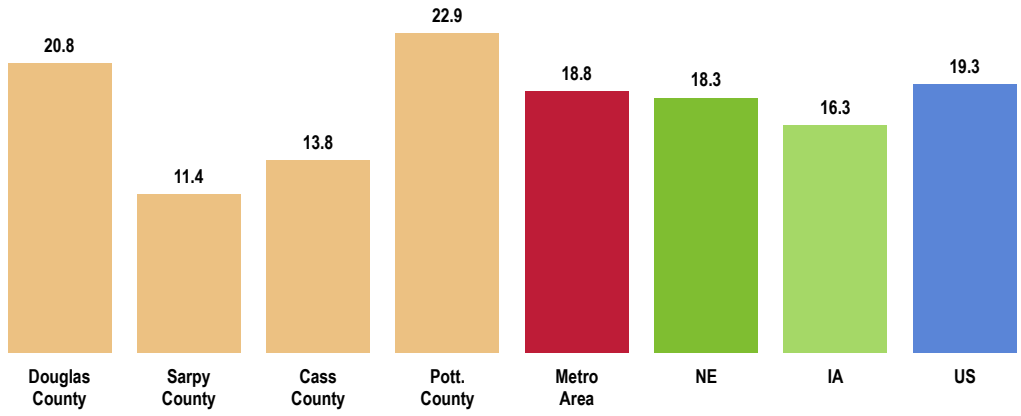
Between 2014 and 2020, there were 18.8 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Metro Area.

BENCHMARK ► Higher than the Iowa rate.

DISPARITY ► Higher in Douglas and Pottawattamie counties. The rate is also notably higher among Hispanic and Black female adolescents.

Teen Birth Rate

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2014-2020)

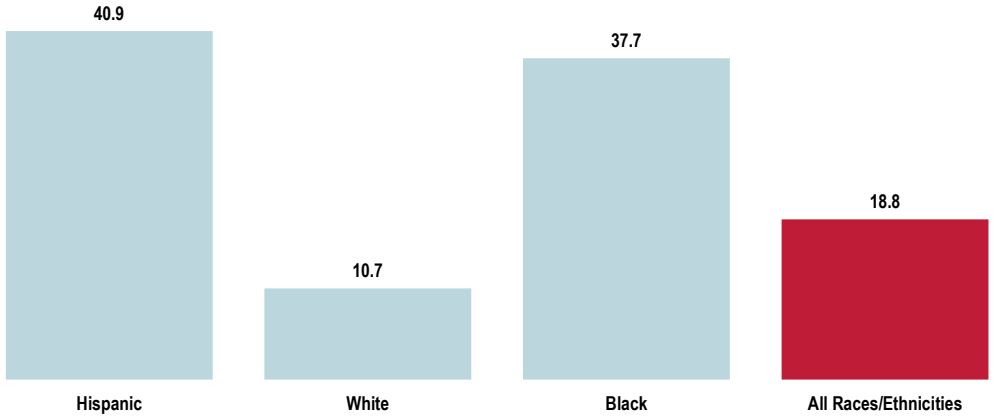


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2024 via SparkMap (sparkmap.org).

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.

Teen Birth Rate by Race/Ethnicity

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19; Metro Area, 2014-2020)



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2024 via SparkMap (sparkmap.org).

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.
- Race categories reflect individuals without Hispanic origin.

Chlamydia & Gonorrhea

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)

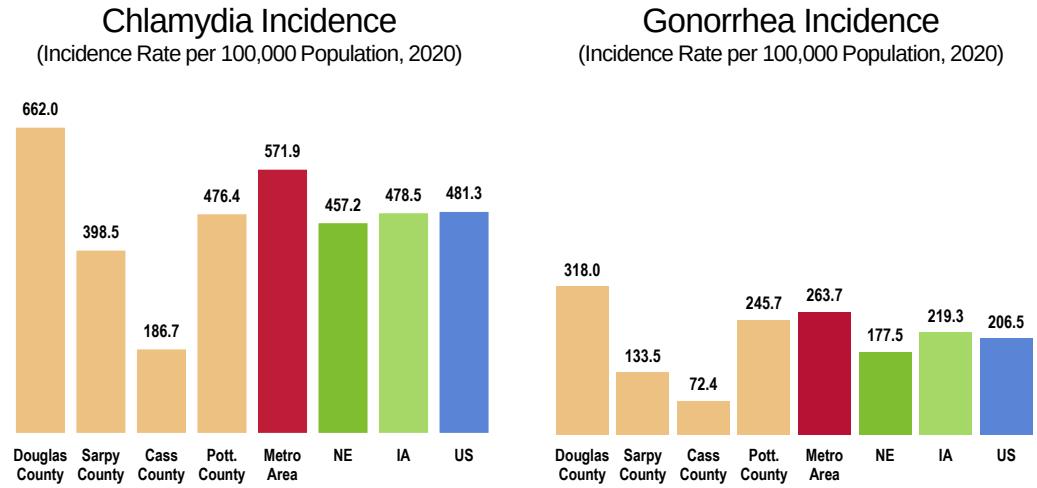
In 2020, there were 571.9 diagnosed chlamydia infections per 100,000 population in the Metro Area. *Note that this rate includes diagnoses in all ages (both adolescents and adults).*

Also in 2020, there were 263.7 diagnosed gonorrhea infections per 100,000 population in the Metro Area. *Note that this rate includes diagnoses in all ages (both adolescents and adults).*

BENCHMARK ► Each rate is higher than the corresponding Nebraska, Iowa, and US rates.

TREND ► Both rates are trending significantly higher over time (not shown).

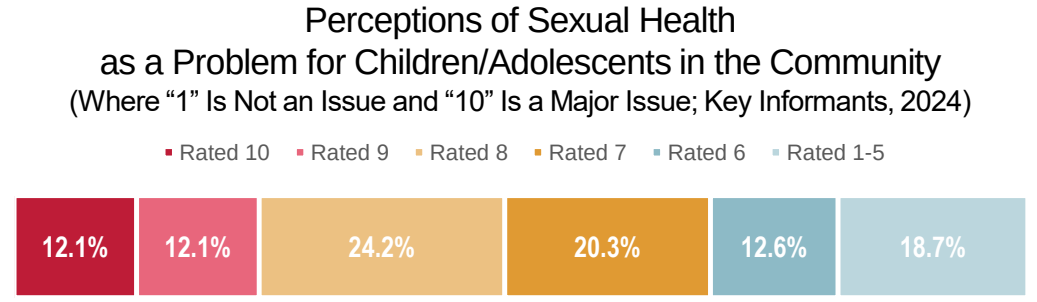
DISPARITY ► Both rates are higher in Douglas and Pottawattamie counties.



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 January 2024 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

Nearly one-half of key informants taking part in an online survey gave *Sexual Health* a rating of "8," "9," or "10" (10-point scale where "10" is a major issue for children/adolescents in the community).



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

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

Awareness/Education

> Children and adolescents are vulnerable to sexual violence, exploitation, and abuse. Perpetrators may be family members, peers, or strangers. Without education and awareness and safe spaces, I've seen how the fear of stigma, shame, or retaliation may prevent children from seeking help or disclosing abuse. Also, societal gender norms and expectations can influence adolescents' attitudes and behaviors related to sexuality. Pressure to conform to traditional gender roles, stereotypes, and expectations may limit adolescents' autonomy and ability to make informed choices about their sexual health. There is widespread use of digital technology and social media, so children in my community are more exposed to online risks, and these online experiences can have serious consequences for their sexual health and well-being. – Social Services Provider
>
> STDs and high pregnancy rates. Groups are trying to remove education from schools where it is desperately needed since many children aren't getting it at home. – Social Services Provider
>
> There are a lot of inaccurate messages in the culture right now, particularly among young people that use social media platforms as a source of information. Ensuring access to accurate information is a challenge for all communities. – Public Health Representative

There is so much misinformation out there about sex and sexual health. It is such a taboo topic that even parents are not comfortable talking to their children about it. Many are even confused about human anatomy even as adults. The amount of misinformation about the female anatomy is truly shocking. Reproduction and birth control is a policed topic among parents. – Public Health Representative

Sexual health can be a significant issue for children and adolescents in many communities, including North Omaha, due to various factors such as limited access to sexual education, socioeconomic disparities, and higher rates of sexually transmitted infections (STIs). In communities like North Omaha, where there may be economic challenges and limited resources, access to comprehensive sexual education and health care services can be limited. This can lead to a lack of knowledge about safe sexual practices, contraception, and the risks associated with unprotected sex. – Public Health Representative

Most school districts, not all, don't teach a comprehensive sex education curriculum. Access to information, contraceptives, and testing isn't readily available in school health classes or health offices. – Social Services Provider

Lack of proper sexual education in schools is a large problem in Nebraska. – Community Leader

Receiving minimal and basic knowledge from school. – Social Services Provider

Without comprehensive, accurate sex education in schools, we've leaving young people in the dark. This leads to unplanned pregnancy, risk of STI transmission, relationship violence, etc., all of which create health risks and put the futures of young people at risk. – Social Services Provider

Nebraska does a terrible job of education and access for sexual health education and treatment. STDs and STIs are too common. – Social Services Provider

Limited access to pragmatic sexual education. Lack of faith and hope for a good future, so it doesn't matter to them. Parents are preoccupied with meeting basic needs due to high poverty rates in north Omaha. The majority of single parents – too many demands, not enough time. – Social Services Provider

Better and more comprehensive sex education is necessary to reduce unwanted pregnancies, STI rates, and improve sexual health. In addition, even basic classes like understanding our anatomy would be useful. – Community Leader

Our schools need sexual health programs that start in the schools in elementary. – Social Services Provider

Sex education and reproductive medicine has become political. – Public Health Representative

In an effort to “protect” children from learning about sex and sexual health, they can be left to their own devices and engage in reckless behavior that could be prevented with factual information, proper education, and guidance. – Community Leader

Not enough information is available without being judged. – Public Health Representative

Sexual health needs to be addressed in my community. Access to sexual education and services are the main reason why we see rising numbers of sexually transmitted diseases in our community. – Public Health Representative

Inadequate availability of sound, scientific information about sexual health. – Other Health Provider

Incidence/Prevalence

STDs are steadily increasing. – Social Services Provider

STIs. – Community Leader

Douglas County has had higher rates of chlamydia and gonorrhea than the national average for years. Adolescents and young adults account for a large percentage of the totals reported. – Community Leader

We are seeing a substantive increase in children with problem sexual behaviors. – Social Services Provider

Sexual health has been a pervasive problem, and there is plenty of local data to demonstrate this. Also, there has been an uptick in syphilis cases across the country, including here in the county. – Public Health Representative

HIV and syphilis are on the rise. Gonorrhea and chlamydia are rampant. Pregnancy at a young age is too common. – Physician

STIs at high rates. – Physician

Children are introduced to sex way too young and are grappling with their sexual identity while they should be focusing on their education and before they even receive a diploma. This is often too much for a child and leads to anxiety, depression, and increased suicides. – Social Services Provider

Our STD rate is not decreasing, our syphilis and gonorrhea rates are increasing. We live in a politically conservative area, and access to sexual health information and reproductive health services are decreasing. – Community Leader

Rates of STI's have been on the rise in the last several years. Lack of access to appropriate education and preventative resources are also barriers. Changes in how sexual health is taught in our schools have limited access to timely and appropriate resources. – Community Leader

Access to Care/Services

> Since the closure of the Council Bluffs Planned Parenthood office, access to services is more difficult. The incidence of STIs in our community is high. – Public Health Representative
>
> Access, stigma, and the polarization of the issue at the state level. – Social Services Provider
>
> Lack of appropriate medical care and educational opportunities are not available in all communities. – Other Health Provider

Government/Policy

> I'm always hearing that STIs are on the rise. With legislators targeting LGBTQ+ and abortion laws nearly every day of the week, I'm concerned that our youth don't know where to turn for health care solutions or answers to their questions. – Community Leader
>
> Conservative political and religious agendas interfere with the provision of sexual health education and services. As a result, educators, health providers, and social service professionals are reluctant to openly address sexual health needs for children and adolescents for fear of backlash. – Other Health Provider
>
> Politization of LGBTQ+ identities, inclusive literature, and sexual health have increasingly limited access to adolescents to seek care. Increased barriers or parental involvement for preventative sexual health strategies like education, prophylactics, or testing have a chilling effect on access to resources which directly contribute to increased negative health outcomes, including higher rates of HIV/STI infection, unwanted pregnancy, etc. Education systems are facing increasing attacks for evidence-based, medically accurate, developmentally appropriate, and LGBTQ+ inclusive health curricula. Successful attacks have increasingly limited access for LGBTQ+ youth and any youth who may be sexually active, consider becoming sexually active, or struggling to understand one's gender identity and sexual orientation, e.g. backlash against Nebraska DOE and State Board of Education for optional school district inclusive health standards, and nationally. – Community Leader

Denial/Stigma

> It's still taboo, even though sexual health is an important part of someone's well-being. It is not safe for everyone to understand and express their sexual identity and preferences, nor seek affirming care. – Public Health Representative

Refugee Populations

> Refugees are very vulnerable to their welcoming communities without any community members that they know, and they have a hard time reading when a situation is dangerous, and so issues of trafficking are quite common among this group. – Social Services Provider

Generational

> Generational barriers and lack of education across the board are the major challenges affecting sexual health. Not enough education from parents, support systems (formal or informal), or schools to address sexual health, though it is detrimental to every person. – Social Services Provider

Prevention/Screenings

> We continue to see challenges with STIs that are preventable. We also need to support sexual health literacy to reduce teen and young adult pregnancies, and these have impacts on the health and well-being for both the mother and the child (also relates to maternal/prenatal health needs). – Community Leader

Unprotected Sex

> Unprotected sex, diseases, and unplanned pregnancies. Fear of educational programs with religious beliefs. – Other Health Provider

ACCESS TO CARE

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

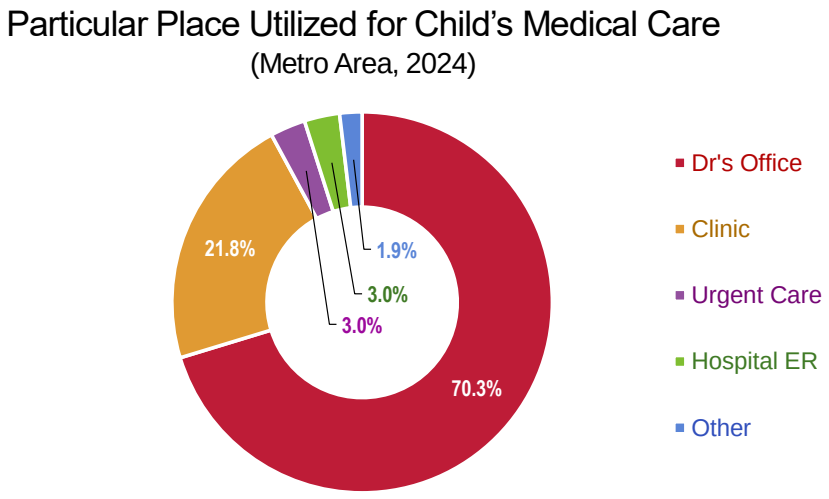
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

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

Routine Medical Care

Type of Place Used for Medical Care

When asked where they take their child if they are sick or need advice about the child's health, the greatest share of respondents (70.3%) identified a particular doctor's office.



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 19]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Receipt of Routine Medical Care

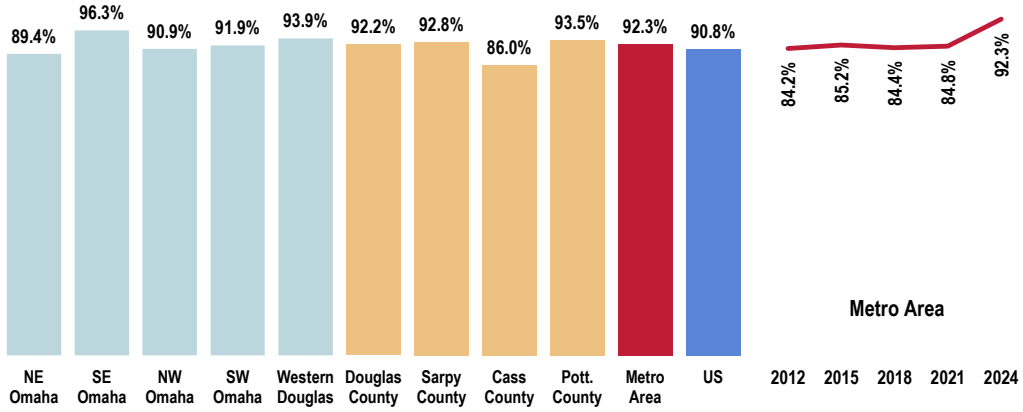
A routine checkup can include a well-child checkup or general physical exam, but it does not include exams for a sports physical or visits for a specific injury, illness, or condition.

Among surveyed parents, 92.3% report that their child has had a routine checkup in the past year.

TREND ► Represents a significant increase from previous surveys.

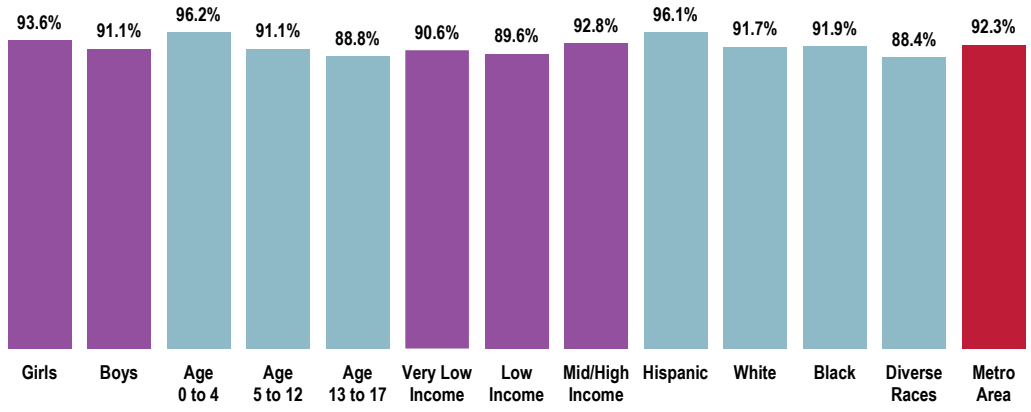
DISPARITY ► Reported less often for children age 5 and older and for White children.

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



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 20]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Visited a Physician for a Routine Checkup in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 20]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Vaccinating Newborns

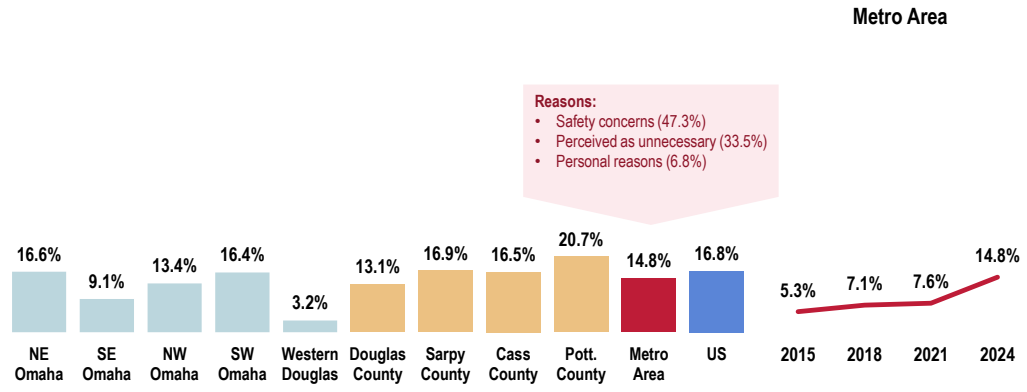
Vaccination is a primary defense against some of the most deadly and debilitating known diseases.

While 85.2% of surveyed Metro Area parents say they would want their (hypothetical) newborn to receive all recommended vaccinations, a total of 14.8% would not.

TREND ► Marks a dramatic increase in vaccine hesitancy from previous surveys.

DISPARITY ► Vaccine hesitancy is lowest in Western Douglas County. Lower in Douglas County overall when compared to other counties in the Metro Area.

If Respondent Had a Newborn, Would Not Want All Recommended Vaccinations



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Items 87-88]
• 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Dental Care

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

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

Receipt of Dental Care

In all, 85.5% of Metro Area children age 1-17 have visited a dentist or dental clinic (for any reason) in the past year.

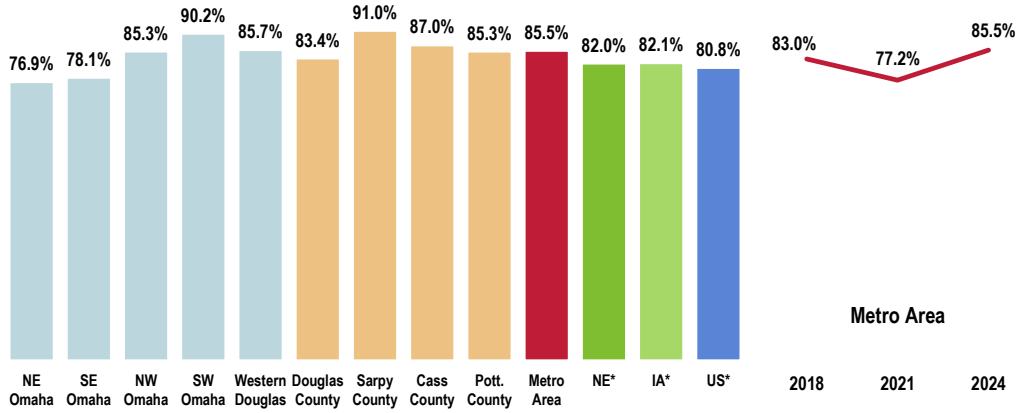
BENCHMARK ► More favorable than the Nebraska, Iowa, and US findings. Satisfies the Healthy People 2030 target.

DISPARITY ► Lowest in Northeast Omaha. Reported less for children age 1 to 4, those in lower-income households, and Black children.

Child Visited a Dentist/Oral Health Care Provider Within the Past Year

(Children Age 1-17)

Healthy People 2030 Objective = 45.0% or Higher (Age 2-17)



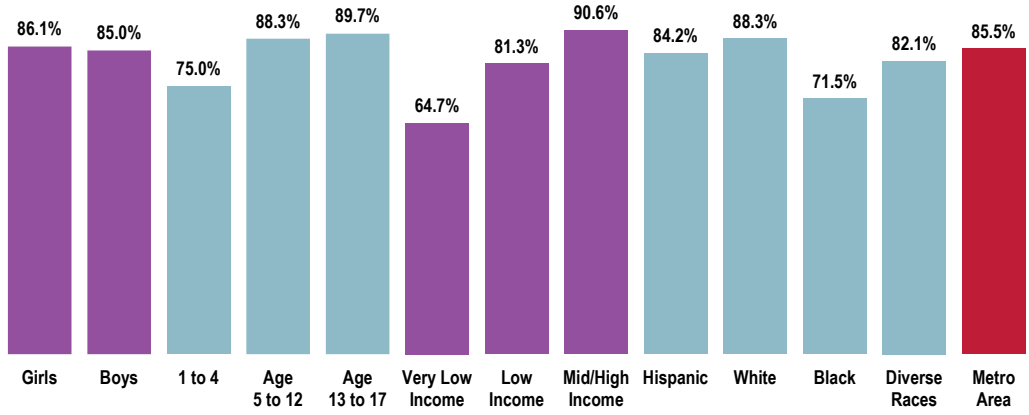
Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 311]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
- Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health, US Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved January 2024 from www.childhealthdata.org. CAHMI: www.cahmi.org.

Notes:
- Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
- *Percentages are for children age 2-17.

Child Visited a Dentist/Oral Health Care Provider Within the Past Year

(Metro Area Children Age 1-17, 2024)

Healthy People 2030 Objective = 45.0% or Higher (Age 2-17)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 311]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

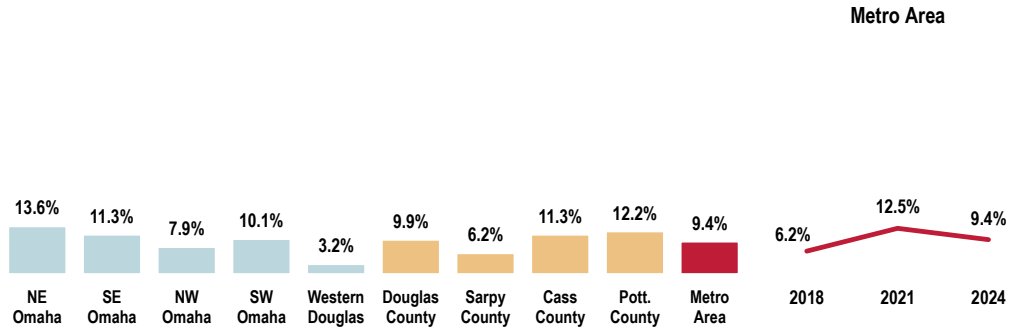
Difficulties Accessing Dental Care

A total of 9.4% of parents report that they have experienced difficulties accessing dental care for their child (age 1 to 17) in the past year.

TREND ► Marks a significant increase from 2018 but a significant decrease from 2021.

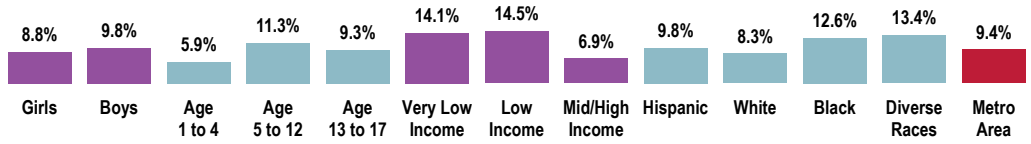
DISPARITY ► Lowest in Western Douglas County and Sarpy County. More often reported among parents of children age 5 to 12 and households with lower incomes.

Difficulty Accessing Dental Care in Past Year
(Children Age 1-17)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 312]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
• This question was asked about all children, regardless if they needed or sought care.

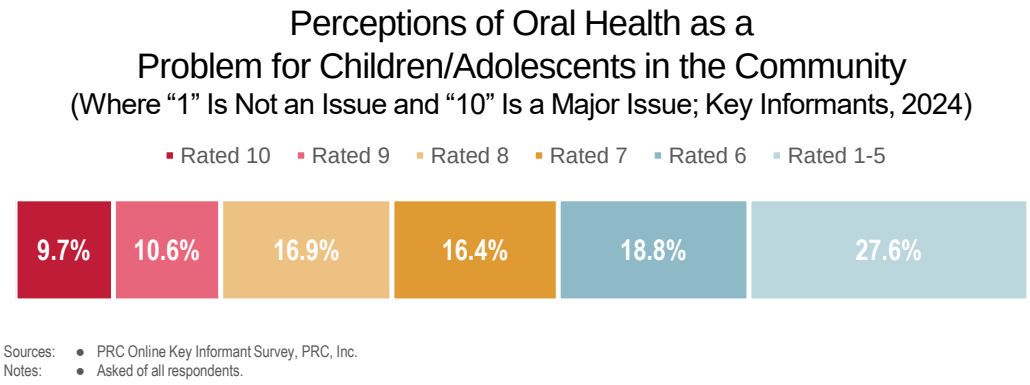
Difficulty Accessing Dental Care in Past Year
(Metro Area Children Age 1-17, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 312]
Notes: • Asked of those respondents for whom the randomly selected child in the household is age 1 to 17.
• This question was asked about all children, regardless if they needed or sought care.

Key Informant Input: Oral Health

More than one-third of key informants taking part in an online survey gave *Oral Health* a rating of "8," "9," or "10" (10-point scale where "10" is a major issue for children/adolescents in the community).



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

Access for Medicare/Medicaid Patients

> Very few providers are willing to take Medicaid. – Community Leader
>
> Lack of providers who take Medicaid as a payment. – Public Health Representative
>
> No dentists in Council Bluffs and surrounding communities take Medicaid, so there are no providers to help those on Medicaid. – Public Health Representative
>
> I believe there is a lack of services for those children who have Medicaid or CHIP. – Public Health Representative
>
> The metro has less than five providers who accept Medicaid. If someone accepts Medicaid, the wait lists are months long. – Social Services Provider
>
> Many dentists do not take Medicaid. – Physician
>
> There are limited providers that accept patients on Medicaid. – Social Services Provider
>
> Few dentists accept Medicaid. – Physician
>
> There are no dentists taking new Medicaid patients in Iowa that serve our families. – Public Health Representative
>
> Limited number of dentists and especially ones that will accept Medicaid. – Public Health Representative
>
> Limited dental services for Medicaid recipients and long wait times for all dental providers. – Other Health Provider

Access to Care for Uninsured/Underinsured

> Oral health is often not covered through insurance. It is expensive, and there is no education embedded in educational programs like schools, day cares, or centers. – Community Leader
>
> Lack of insurance, low priority when dealing with other crises. – Social Services Provider
>
> There are few dentists located in poor communities, and insurance is not always available to communities of color. – Other Health Provider
>
> Access to oral health care can take months, especially for low-income families. Many oral health providers will not see Medicaid or uninsured patients. – Community Leader

Insurance Issues

> I am being told of oral health issues in the school down the street from my house. Your teeth need their own insurance policy. Health insurance doesn't cover them. The state government doesn't want to expand programs to help the most vulnerable get dental help they need. – Community Leader
>
> Limited access to dental insurance and dental providers keeps families from preventive dental care. Parent education is needed on connection between dental health and physical health. Barriers for families in getting children to providers (transportation) and creating trust with dental professionals – difficult to establish primary dental care where children are seen over time rather than during an acute episode. – Other Health Provider

> I believe, in general, that dental health insurance is problematic for everyone. It tends to pay less than physical health care and frequently two insurance plans complicate things even more than just one. It seems like dental insurance, if everyone has it, results in paying more and receiving less. – Community Leader
>
> Dental services aren't included in health care insurance and often are an afterthought, although dental issues can signal greater health needs. – Public Health Representative

Access to Care/Services

> Many families do not have access. I also believe there is a lack of education about its importance. – Community Leader
>
> Lack of access. Families in poverty essentially get two strikes and you're out with providers that do accept Medicaid. This ultimately is a punishment directed at children, and their oral health issues could contribute to long-term downstream issues. – Social Services Provider

Co-Occurrences

> Lack of oral health will cause physical health issues. – Other Health Provider
>
> Poor oral health can lead to many physical health concerns. – Social Services Provider

Impact on Quality of Life

> If you do not feel well, you cannot concentrate on school and learn. – Social Services Provider
>
> We have learned that students frequently miss school due to oral pain. – Social Services Provider

Affordable Care/Services

> Many families find dental services expensive, even with insurance. Along with families not being able to afford care, there is also the problem with availability and long wait periods between each appointment or being scheduled. – Public Health Representative

Awareness/Education

> Lack of education for parents on the need for consistent oral health care. Often, adults in the household don't have good oral health practices and then don't prioritize for children, either. – Social Services Provider

Diagnosis/Treatment

> Dentists and oral care are looked at as painful. Minimum access to oral professionals for residents. – Social Services Provider

Homelessness

> Dental and oral care are one of the first things to fall by the wayside, especially for those experiencing homelessness. There is not enough attention paid to oral health. I have encountered young adults with braces on with no oral care in several years. Medical needs are dental health care needs, and this needs to be addressed. – Social Services Provider

Incidence/Prevalence

> I see a lot of kids with decaying teeth. – Other Health Provider

Lack of Providers

> We need more dentists and hygienists at the Charles Drew Health Center. – Physician

Refugee Population

> We do not have free dentistry available for refugees that can be scheduled within their first 3 months of arrival when they are working with the resettlement agency. Many have not been educated on the need for dental health and will not make appointments for themselves after the 3 months. – Social Services Provider

Nutrition

> Poor nutrition and poor oral hygiene contribute to dental issues. Lack of dental care insurance and dental care providers compound the issue. – Public Health Representative

Parental Influence

> Parents may not have had the background that brings oral health to their radar and may carry the same habits forward to their children. Oral care becomes another cost that can further devastate their already overtaxed budgets. – Social Services Provider

Prevention/Screenings

> Ongoing preventative care is difficult to maintain due to job schedules and transportation. – Social Services Provider

Vision & Hearing

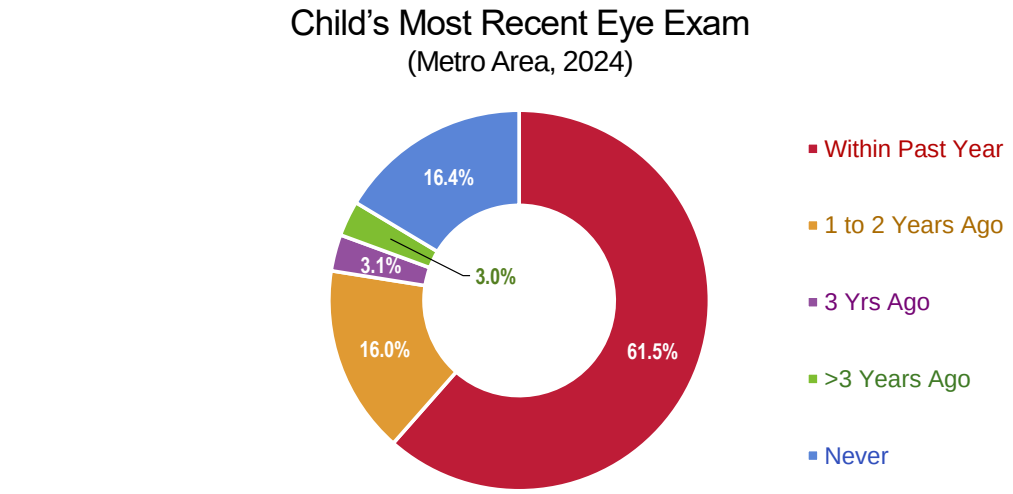
Recent Eye Exams

RELATED ISSUE:
See also Vision Problems and Hearing Problems in the *Chronic Disease & Special Health Needs* section of this report.

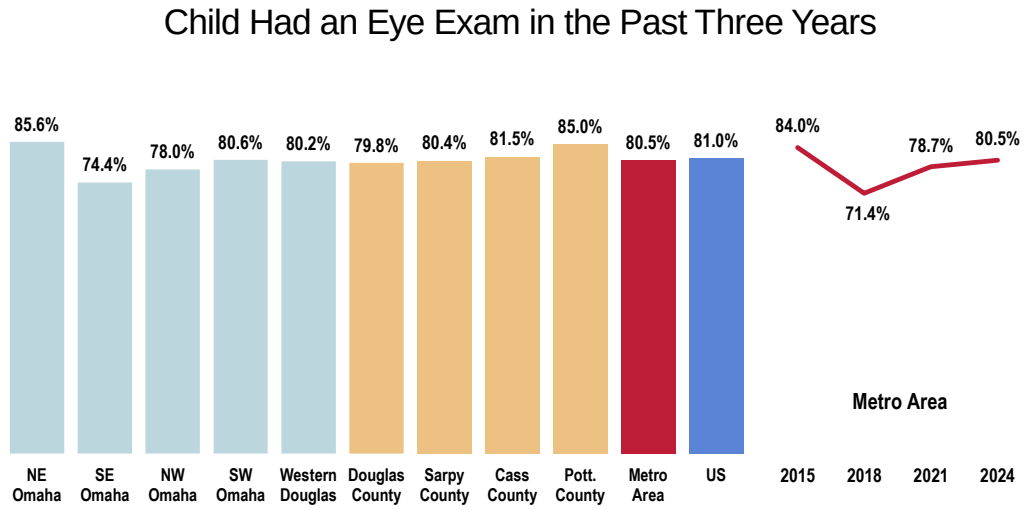
A total of 80.5% of Metro Area parents report that their child has had an eye exam in the past three years.

TREND ► Continuing to trend higher from a low in 2018 but remaining below the 2015 baseline finding.

DISPARITY ► Highest in Northeast Omaha. Reported less often for boys, children age 0 to 4, and White children.



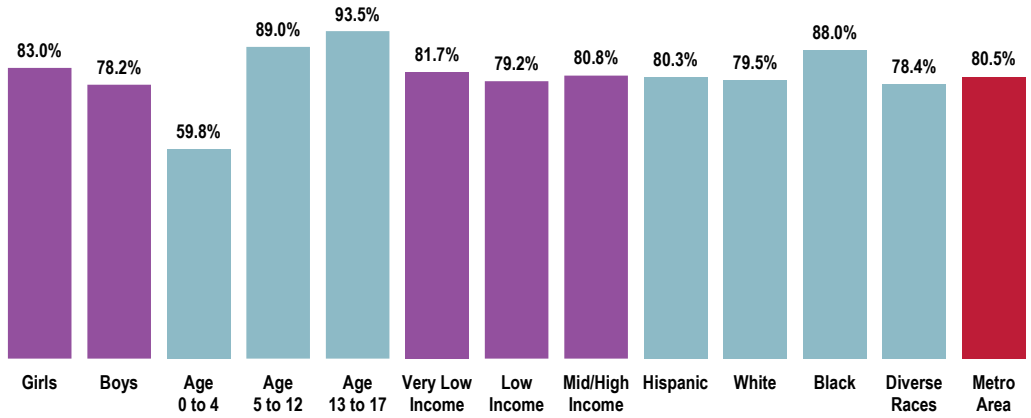
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 25]
Notes: ● Asked of all respondents about a randomly selected child in the household.



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 25]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Had an Eye Exam in the Past Three Years

(Metro Area, 2024)



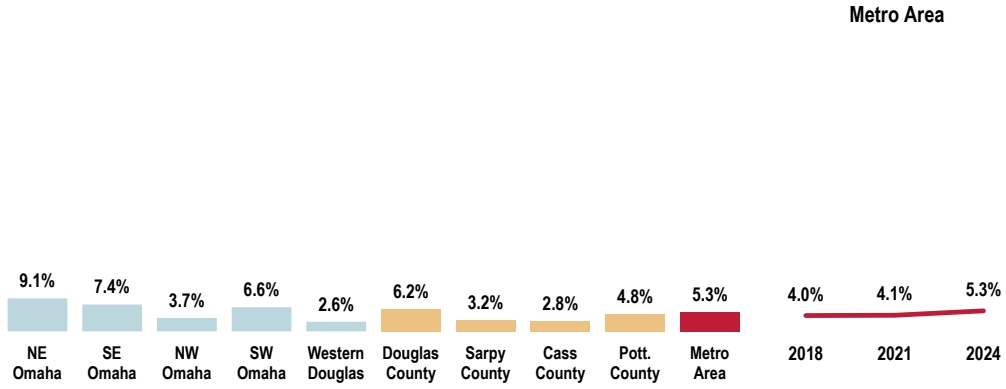
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 25]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Difficulty Accessing Vision Care

Among Metro Area parents, 5.3% report difficulties accessing vision care for their child in the past year.

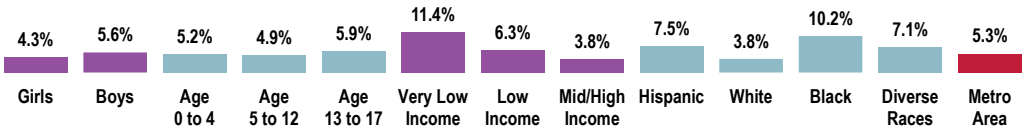
DISPARITY ► Higher in Douglas County than in the other counties. Especially high among children in households at or below the federal poverty level.

Difficulty Accessing Child's Vision Care in the Past Year



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents about a randomly selected child in the household.
● This question was asked about all children, regardless if they needed or sought care.

Difficulty Accessing Child's Vision Care in the Past Year
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 308]
Notes: • Asked of all respondents about a randomly selected child in the household.
• This question was asked about all children, regardless if they needed or sought care.

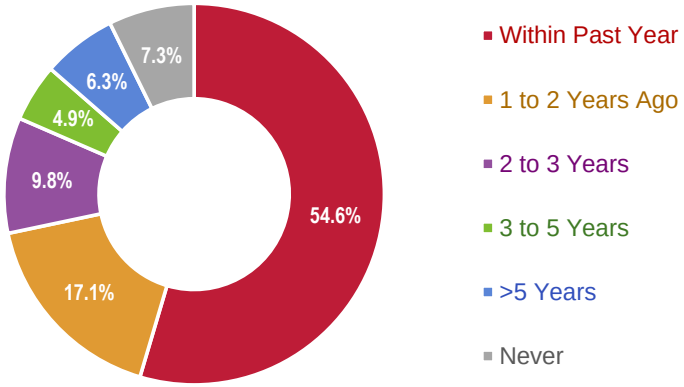
Hearing Tests

A total of 86.5% of Metro Area children have had a hearing test within the past five years.

TREND ► Represents a significant increase from the 2012 baseline.

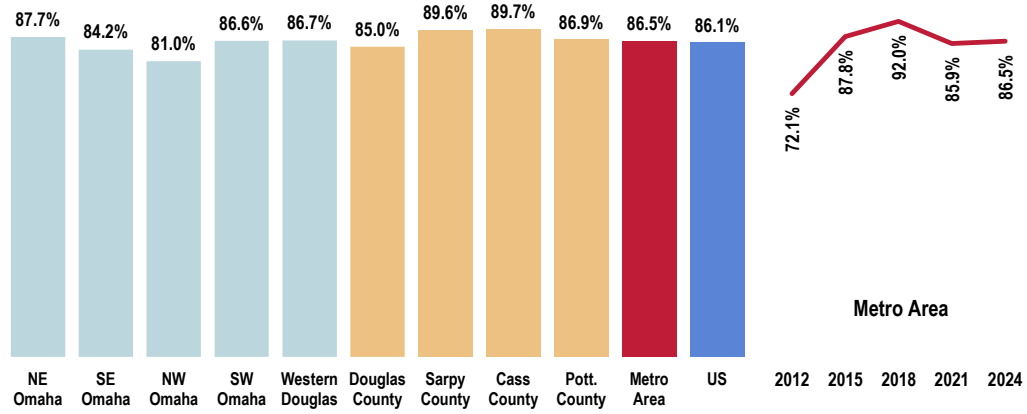
DISPARITY ► Reported less often among parents of Hispanic children.

Child's Most Recent Hearing Test
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 27]
Notes: • Asked of all respondents about a randomly selected child in the household.

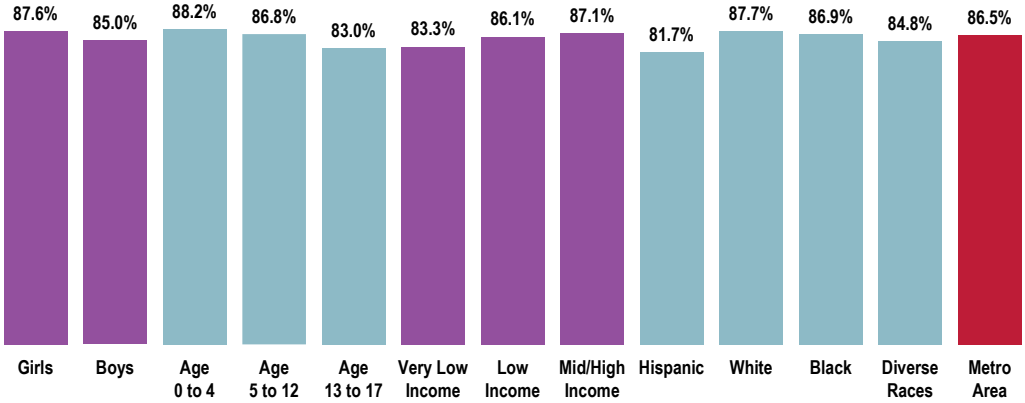
Child Had a Hearing Test in the Past Five Years



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 27]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

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

Child Had a Hearing Test in the Past Five Years
(Metro Area, 2024)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 27]

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

EMERGENT & URGENT CARE

Emergency Room Utilization

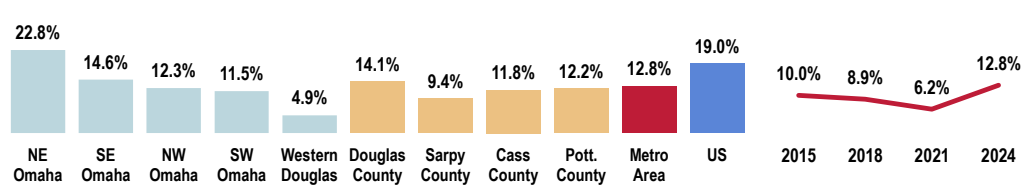
A total of 12.8% of Metro Area parents report taking their child to a hospital emergency room more than once in the past year.

BENCHMARK ► Lower than the US percentage.

TREND ► Denotes a significant increase from previous surveys.

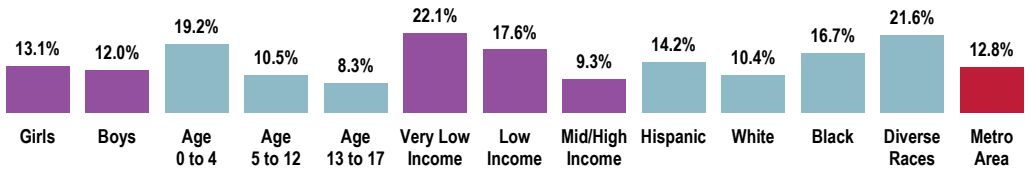
DISPARITY ► Highest in Northeast Omaha. More often reported among parents of children age 0 to 4, those with lower incomes, and parents of children of diverse races.

Child Used a Hospital Emergency Room More Than Once in the Past Year



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 28]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

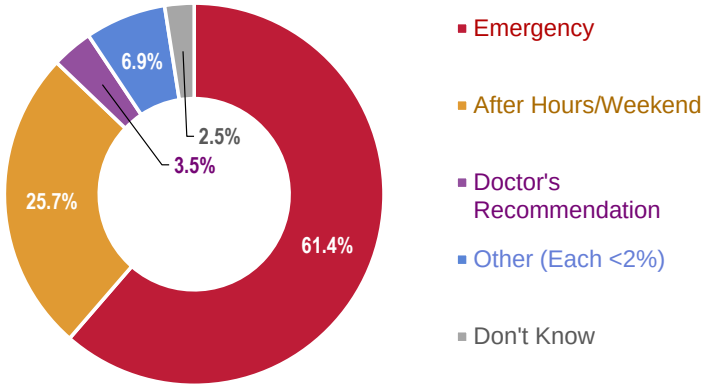
Child Used a Hospital Emergency Room More Than Once in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 28]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Many parents report that their child's emergency room visit was something that could not have been treated in a doctor's office, often because the event was an emergency.

Reason for Using the Hospital ER
Instead of a Doctor's Office or Clinic
(Metro Area Children With Any ER Visit in the Past Year, 2024)

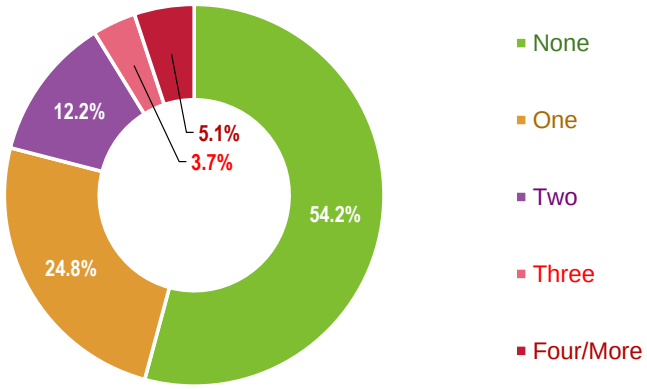


Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 309]
Notes: • Asked of respondents for whom the randomly selected child in the household used a hospital ER in the past year.

Use of Urgent Care Centers & Walk-In Clinics

A total of 45.8% of Metro Area children visited an urgent care center or a walk-in clinic at least once in the past year.

Number of Visits to an Urgent Care Center
or Other Walk-in Clinic in the Past Year
(Metro Area, 2024)



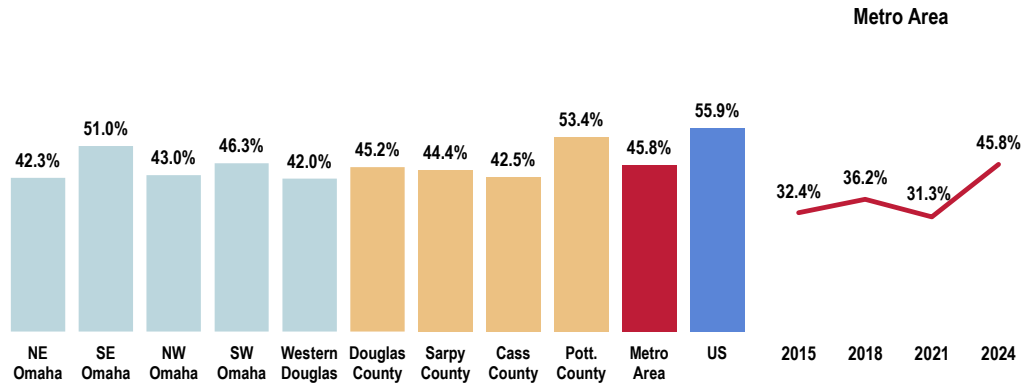
Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 30]
Notes: • Asked of all respondents about a randomly selected child in the household.

BENCHMARK ► Lower than found nationally.

TREND ► Represents a significant increase from previous surveys.

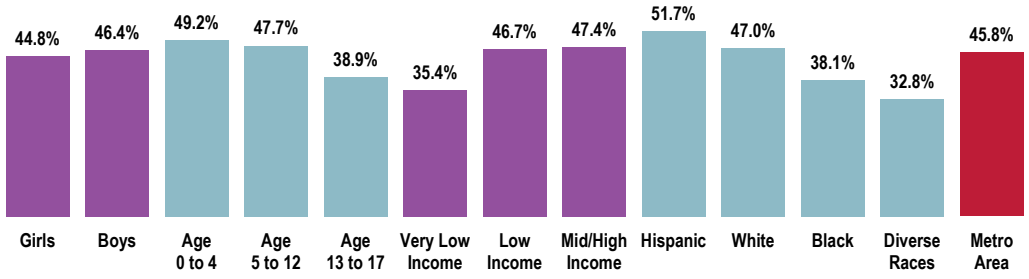
DISPARITY ► More often reported in children age 12 and younger, those living above the federal poverty level, Hispanic children, and White children.

Child Used an Urgent Care Center or Other Walk-In Clinic in the Past Year



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 30]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Used an Urgent Care Center or Other Walk-In Clinic in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 30]
Notes: ● Asked of all respondents about a randomly selected child in the household.

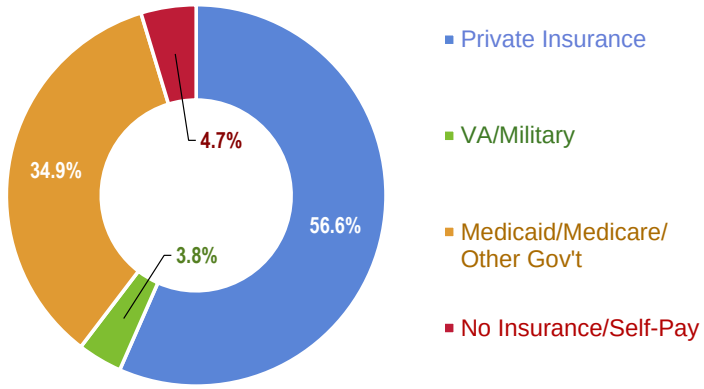
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their child's health care insurance coverage, if any, from either private or government-sponsored sources.

More than one-half (56.6%) of parents report having health care coverage for their child through private insurance. Another 38.7% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, state-sponsored CHIP, military benefits).

Health Care Insurance Coverage for Child
(Metro Area, 2024)



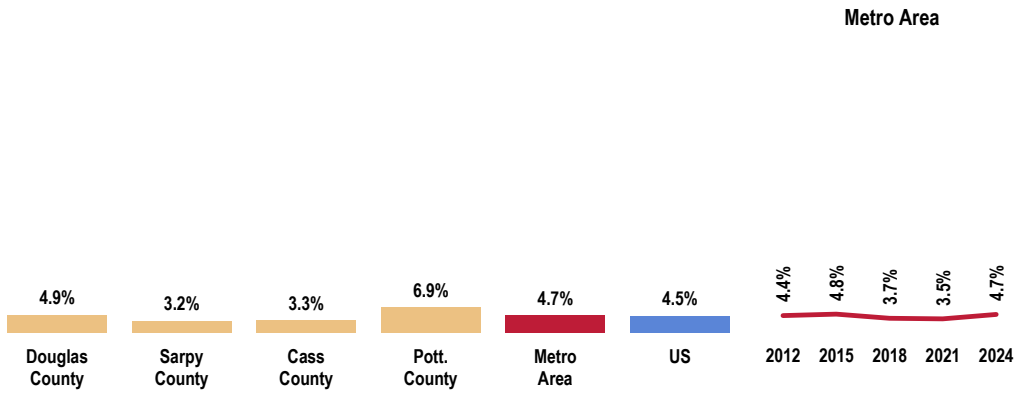
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 105]
Notes: ● Asked of all respondents.

Lack of Health Insurance Coverage

Prevalence of Uninsured Children/Adolescents

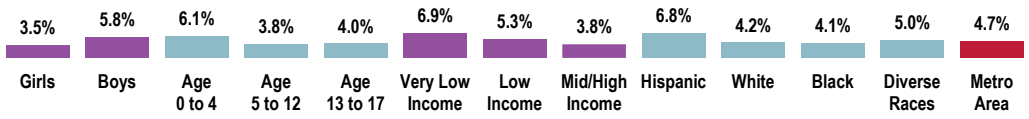
On the other hand, 4.7% of Metro Area parents report having no insurance coverage for their child's health care expenses, through either private or public sources.

Lack Health Care Insurance Coverage for Child



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 105]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Lack Health Care Insurance Coverage for Child
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 105]
Notes: • Asked of all respondents.

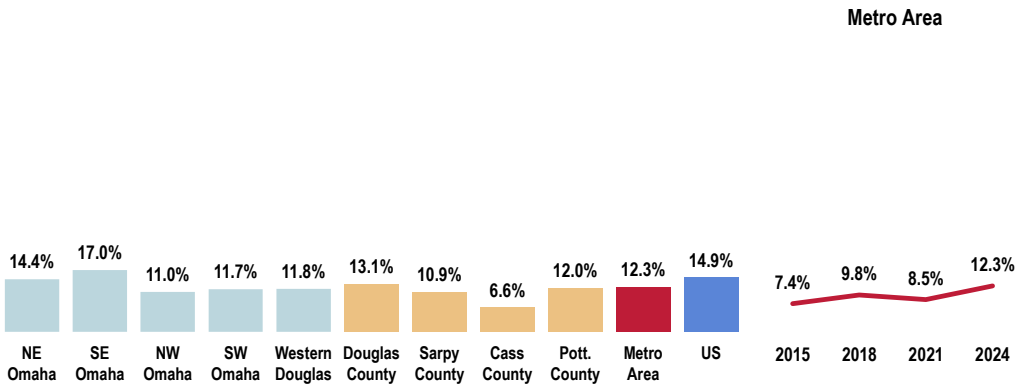
Recent Lack of Coverage

Among parents with insurance for their child, 12.3% report that their child was without health care coverage at some point in the past year.

TREND ► Trending higher over time.

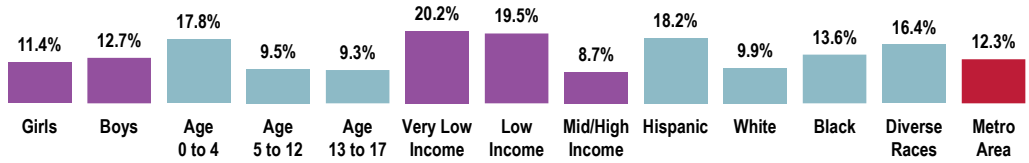
DISPARITY ► This type of insurance instability is lowest in Cass County. More often reported for children age 0 to 4, those in lower-income households, and Hispanic children.

Child Has Been Without Health Insurance Coverage at Some Point in the Past Year



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 74]
• 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children under 18 at home.

Child Has Been Without Health Insurance Coverage at Some Point in the Past Year
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 74]
Notes: • Asked of all respondents with children under 18 at home.

DIFFICULTIES ACCESSING HEALTH CARE

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented their child from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect all children, regardless of whether medical care was needed or sought.

Of the tested access barriers, difficulty getting a doctor's appointment impacted the greatest share of Metro Area children (14.8% of parents say that lack of appointment availability prevented them from obtaining a visit to a physician for their child in the past year).

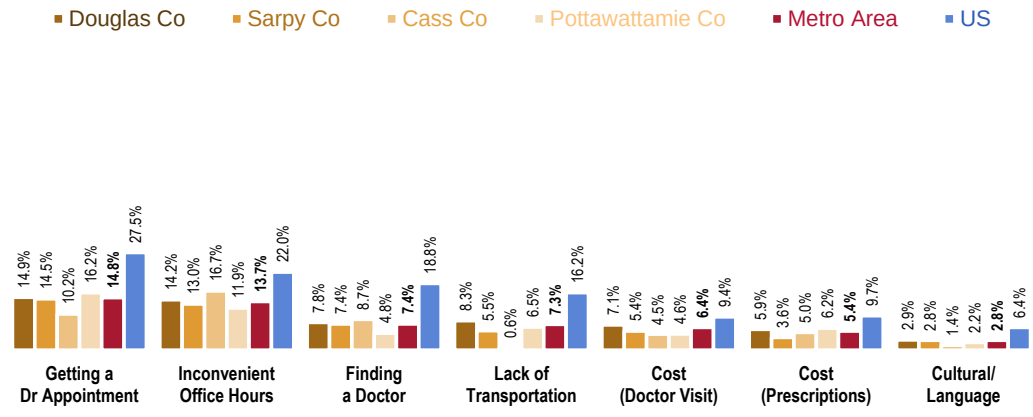
Inconvenient office hours impacted 13.7%, followed by difficulty finding a physician (7.4%), lack of transportation (7.3%), cost of a doctor visit (6.4%), cost of prescription medication (5.4%), and culture/language as a barrier (2.8%).

BENCHMARK ► All seven barriers were found to have less of an impact in the Metro Area than across the US.

TREND ► Since 2012, mention of five barriers in the Metro Area has increased significantly: appointment availability, finding a physician, lack of transportation, cost of prescriptions, and culture/language differences.

DISPARITY ► Mention of four barriers was unfavorably high in Northeast Omaha (not shown): finding a physician, cost of a doctor visit, lack of transportation, and culture/language differences.

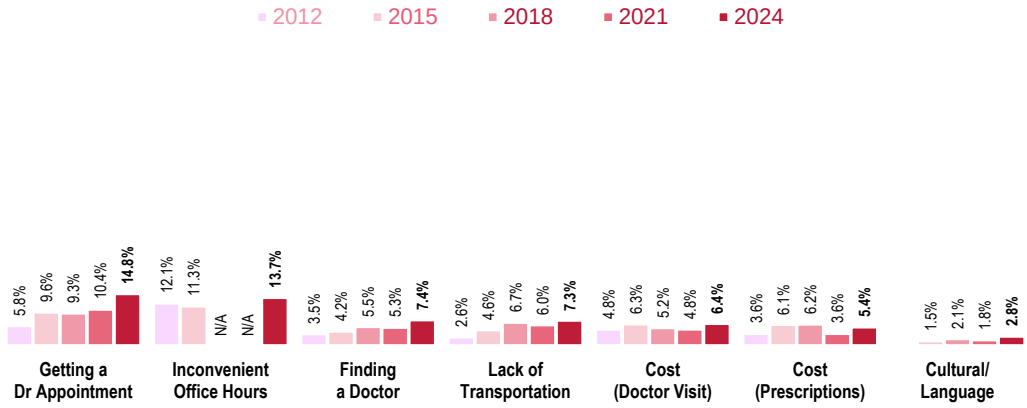
Barriers to Access Have
Prevented Child's Medical Care in the Past Year
(Metro Area, 2024)



Sources: • 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Items 11-17]
Notes: • Asked of all respondents about a randomly selected child in the household.

Barriers to Access Have Prevented Child's Medical Care in the Past Year

(Metro Area)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Items 11-14, 16-17]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Bias in Treatment

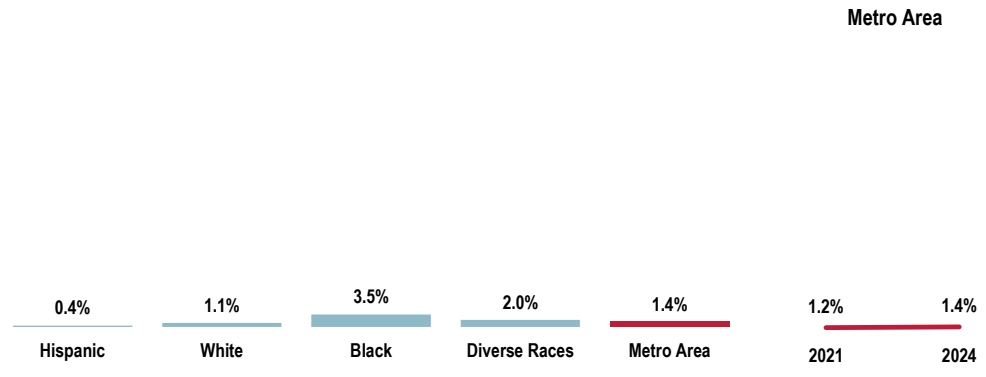
"And now thinking about all of this child's health care experiences in the past 12 months, in general, do you feel that this child's experiences were "better," "the same," or "worse" than those of children of other races or ethnicities?"

Among surveyed Metro Area parents, 1.4% feel that their child's health care experience in the past year was worse because of racial bias.

DISPARITY ► Lower in Western Douglas County and in Pottawattamie County overall (not shown). No statistically significant difference found by race and ethnicity.

Child's Health Care Experiences Were Worse In the Past Year, Based on Race

(Metro Area, 2024)



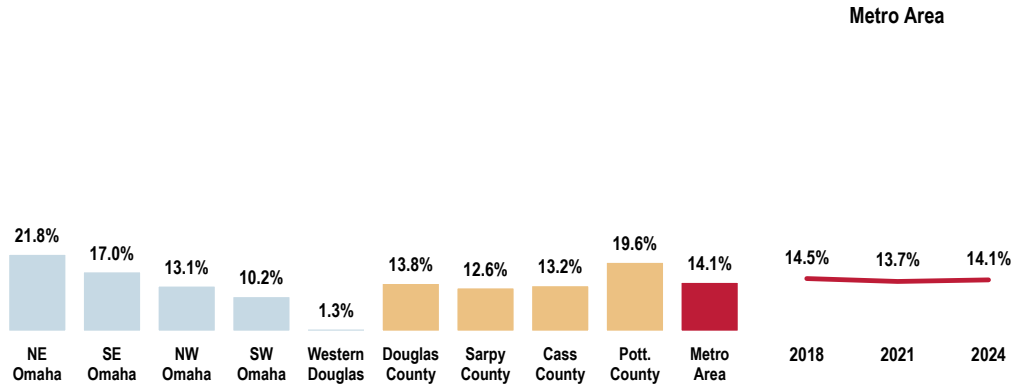
Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 324]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Care Coordination

A total of 14.1% of surveyed parents report that they could have used extra help arranging or coordinating their child's medical care in the past year.

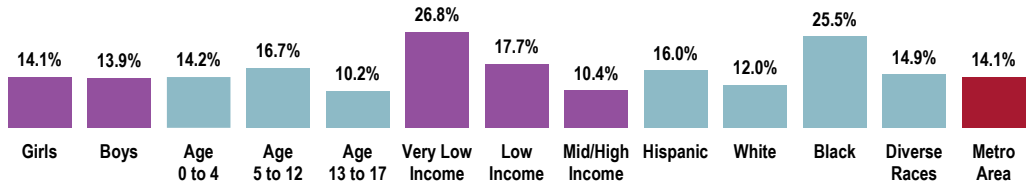
DISPARITY ► Highest in Northeast Omaha. More often reported among parents of children age 5 to 12, those with lower incomes, and parents of Black children.

Could Have Used Help Coordinating Child's Health Care Services or Providers in the Past Year



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 333]
Notes: ● Asked of all respondents about a randomly selected child in the household.

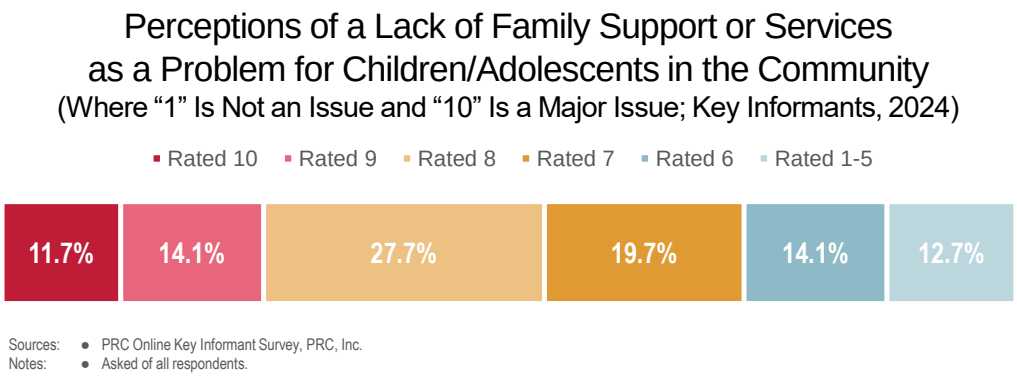
Could Have Used Help Coordinating Child's Health Care Services or Providers in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 333]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Key Informant Input: Family Support Services

Over half of key informants taking part in an online survey gave *Lack of Family Support/ Services* a rating of "8," "9," or "10" (10-point scale where "10" is a major issue for children/adolescents in the community).



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

Access to Care/Services

> Family supports can help parents access opportunities they may not know are available and navigate systems that can seem out of reach or unclimbable, limiting the lives, aspirations and progression of the families and children. – Social Services Provider
>
> Family supports and services are typically temporary, have tight eligibility criteria, and have limited availability. Sustained engagement is necessary to help families turn their lives and health in a positive direction. – Social Services Provider
>
> Resources available to working families, in the languages they speak, and at convenient times for them. – Social Services Provider
>
> Lack of resources to support and mentor family members beyond what is needed and provided for their children and adolescents. – Other Health Provider
>
> The community is overall very aware and supportive; however, bridging to or actually connecting families to the service or support is challenging. Referrals may not be completed due to minor details or disconnected handoffs. – Other Health Provider
>
> There are so many families that need these services due to system involvement that it does not allow self-referrals to access this service affordably. Insurance does not cover this cost, and a lot of families cannot afford to pay out-of-pocket. – Social Services Provider
>
> There are many nonprofits and agencies that offer support and services, but many are not realistically accessible to family (i.e. time and place). I also question whether the services offered meet the actual need of what the family/parents need or want. For example, there are many places offering GED courses, but maybe the need for parents is job readiness. Sometimes as a community, we TELL parents/families what they need rather than ask. – Other Health Provider
>
> When families look for help, services are overwhelmed. – Community Leader
>
> We work with many parents that know that their kids are struggling and are desperate for help. Many times, there are not services available that can support them. – Other Health Provider
>
> I work in a small community and if we identify a need, we don't have a lot of resources to offer. – Physician
>
> Social determinants of health for families restrict the available support and services for individuals who live in the North and South sections of Omaha. Diversity in professionals is limited, thereby creating gaps in services. – Other Health Provider

Follow Up/Support

> I work with new families every day. They often have little to no support in helping them adjust to parenthood. This makes the chances they will ultimately reach their breastfeeding goals less, which then decreases the health potential of the mother and child for the rest of their lives. – Physician
>
> Many families do not have access to support they need to be well and do well for their children, child care, access to healthy food and safe housing. – Community Leader
>
> There are siloed support systems for families across the community. – Public Health Representative

I am not sure if the parents are refusing the support that they may have been given, or the doctors in our community are not sure where to refer families to get the support they need. Speaking for Council Bluffs I WIC tends to be a first line, along with the doctors. Hopefully, they are referring to Family Inc. or to the VNA for further support. I feel like it is also difficult to be able to provide services to families that deny the need for help. – Community Leader

Families often don't know what to do to get services after a diagnosis. Refugees definitely need more support. We need to reimburse community health workers. – Social Services Provider

I am not confident that families are referred to or connected to resources for support. Many families have to serve as their own navigators to resources. – Public Health Representative

Families, especially in the low- to moderate-income areas, have no access to any type of support system. The community clinics advertise their services, but in reality, access is very limited, or the agencies do not have the resources available to help. Families, especially immigrant families, are left alone. – Social Services Provider

More and more, child care providers are sharing their need for support to help support the families they serve. The needs range from housing and transportation to postpartum support, food, and parenting education. – Community Leader

Awareness/Education

The families we serve don't know how to navigate the health care system. Many lack insurance and don't know where to go to get support for their children. – Social Services Provider

There is a lack of free public information that is unbiased. There is a lack of providers to provide care for the growing population of children with special health care needs. – Community Leader

I think that the support and services are there, but they are not being fully utilized. – Community Leader

There are so many supports available. I think sometimes families may not know how to access family support if they are not in school or day care. – Social Services Provider

I see and hear parents that are at their rope's end. They don't know where to go, and they have no idea how to access help. – Community Leader

Affordable Care/Services

Lack of affordable, quality day care so that parents can work. If a child requires more complex care, there is even more difficulty finding child care. Home nursing is nearly impossible to find. – Physician

Specifically thinking on mental health support, there is a lack of affordable options, and often those that are available take weeks or months to get into. We need better options for families that need support – often families want it but can't get what they need until they are in crisis. – Social Services Provider

Our community does not have access to family support and services that are free or provided at a low cost. – Social Services Provider

We lack demographic specific resources for families, we do not have affordable, quality child care options, which forces families to stay in lower-paying jobs to receive assistance but also prevents them from improving quality of life. Minorities and lower-income communities continue to lack education on the importance of early childhood development. Hard to meet basic needs such as housing, laundry, healthy food options, etc. – Social Services Provider

Income/Poverty

Many families reach out to our organization looking for resources around access to help with utilities, rental assistance, emergency expenses, transportation issues, housing insecurity, etc. – Community Leader

Families are struggling due to inflation, mental health issues, political instability, and so much more weighing people down. Home visits and in-home support are difficult to access. – Social Services Provider

Due to today's economy and workforce challenges, families are struggling to provide basic necessities, and our community resources are stretched very thin. Referrals to agencies that provided support in the past are no longer taking new clients, so families are going without. Need is far exceeding the amount of support our social support agencies can provide, thereby creating even greater strain on families. – Public Health Representative

Family Support

It feels like parents are told, "Your kid has xxx problem" but are never given resources (or at least realistic resources) to help improve them. Parents are out here floating on life rafts trying to figure out how to improve the lives of their children but don't have any direction on where to go. If they are given resources, there are usually very long wait times. – Public Health Representative

Caring adults and adults with time to give their children because so many parents and guardians work. – Community Leader

Parents need to work, and some positions allow no time off, or very few. If a parent does not have support, financial, transportation, PTO, etc., their children do not have access to the same benefits or services as their peers. – Public Health Representative

> I believe the lack of family support and services can have far-reaching negative consequences for the physical, emotional, and social development of children and adolescents, impacting their overall well-being and future. It is so important to invest in family support programs, social services, and community resources to ensure that all children have the opportunity to thrive in a supportive environment. Families need more support to be able to provide for the basic needs of their children, including food, shelter, clothing, and in some cases medicine/health care. Without adequate family support, children lack access to these essentials, which can negatively impact their physical health and growth (mental as well). – Social Services Provider
>
> Providers want to treat children when it's the parents that need the support to safely raise their children. – Community Leader

Refugee Populations

> The major problem is that if the refugee parent arrives with a disability that makes it hard to find employment, the children are at risk of homelessness after the resettlement agency closes the case at 3 months. With SSI taking up to a year to process, the family is left with no rental assistance for a very long time. – Social Services Provider
>
> Large immigrant population, undocumented families, families in poverty or working poor – services & supports (or the knowledge/need of tools to access them) are just out of reach. They don't qualify for aid but are unable to navigate or find it on their own. – Public Health Representative

Transportation

> Many of the individuals who need it most have issues obtaining it due to transportation, language, and finances. – Community Leader
>
> In our area, there are not a lot of resources. We are just outside the Omaha metro, and the lack of transportation affects our families in getting to appointments and various services. – Other Health Provider

Housing

> I know several families who are struggling to maintain their households. These individuals have reached out for support but are often told they don't meet the requirements for assistance or are placed on waiting lists. – Public Health Representative

Cultural/Personal Beliefs

> Many providers and real or perceived religious affiliation prevent parents from receiving or seeking effective support from our largest identifiable family support agencies, especially in the case of LGBTQ+ youth. Programs with culturally responsive capacity to serve this community are often un/underfunded, and lack the staffing and robust, sustainable funds to grow and market programs to those in need. While parents/families may receive referrals, support is often limited by capacity – not expertise. Programs are, many times, run by a single staff person or volunteers, leading to high peaks and low valleys of quality service delivery and program fidelity. Family supports and services for marginalized youth, who face most risk due to intersection identities, minority, stress, etc., must receive support from public and private funding streams and/or from large providers themselves to access supports, if the goal is to address youth social determinants of health and general health outcomes. – Community Leader

Technology

> Devices with social media are raising a generation of children; parents want others to solve their children’s problems instead of them dealing with behavior and other issues. – Community Leader

Racial Disparities

> Representation is lacking in this area. – Social Services Provider

Funding

> This is truly the front end of the system, not enough investments at this end because there is no consistent payer. – Social Services Provider

Lack of Providers

> There is a shortage of mental health providers in the area, and insurance, or lack thereof, affects many families. – Community Leader

Access to Specialty Care

Need for Specialty Care

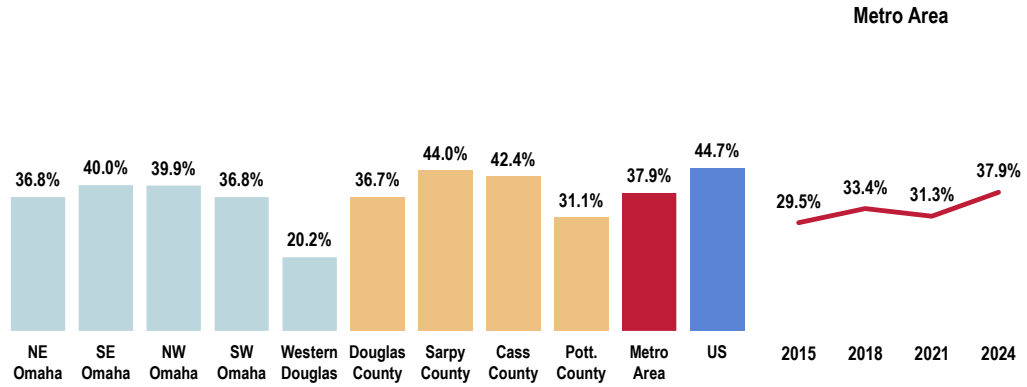
A total of 37.9% of Metro Area children are reported to have needed to see a specialist at some point in the past year.

BENCHMARK ► Lower than the national finding.

TREND ► Rising significantly higher over time.

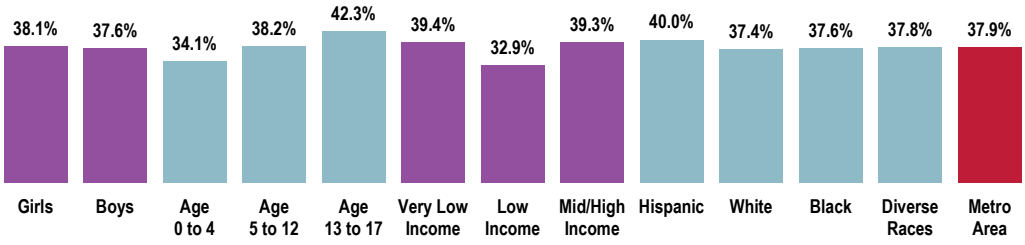
DISPARITY ► Highest in Sarpy County. More often reported for adolescents (age 13 to 17).

Child Needed a Specialist in the Past Year



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 21]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Child Needed a Specialist in the Past Year
(Metro Area, 2024)

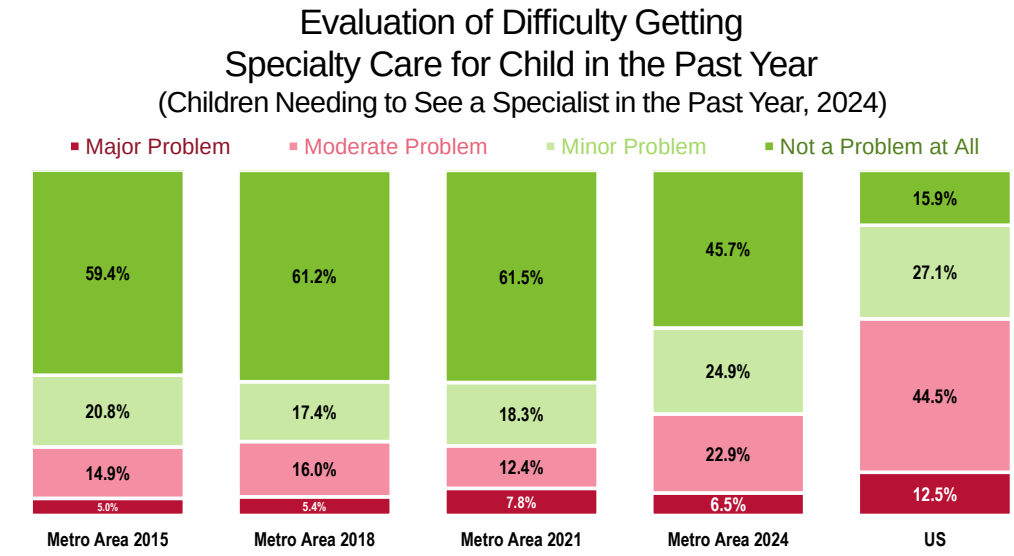


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 21]
Notes: ● Asked of all respondents about a randomly selected child in the household.

Difficulty Accessing Specialty Care

Parents of children needing specialty medical care in the past year were further asked to evaluate the difficulty of getting the needed care — more than one-half (54.3%) expressed some level of difficulty, characterizing it as a "major," "moderate," or "minor problem."

BENCHMARK ► Much more favorable than found nationally.



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 22]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of respondents for whom the randomly selected child in the household has needed to see a specialist in the past year.

Outmigration for Children's Health Care

A total of 14.9% of Metro Area parents report that they feel the need to leave their local areas in order to get certain children's health care services.

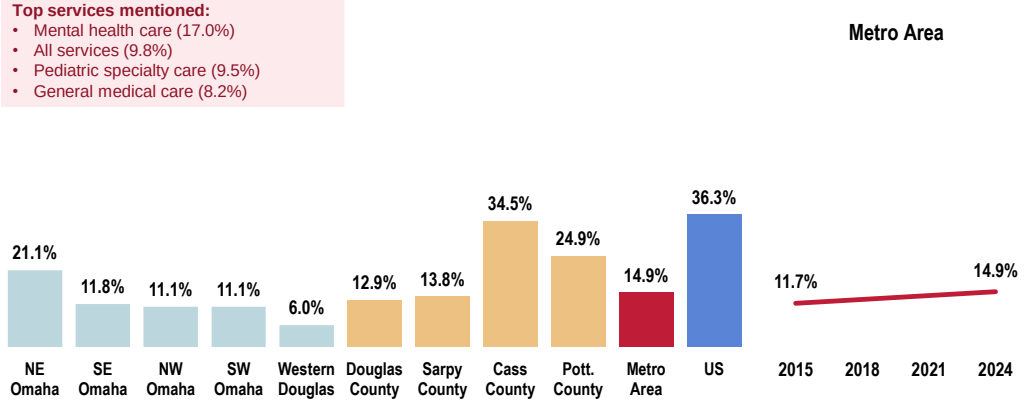
BENCHMARK ► Less than half the national percentage.

TREND ► Represents a significant increase since the 2015 survey.

DISPARITY ► Highest in Cass County and Pottawattamie County. Within Douglas County, highest in Northeast Omaha. More often reported among parents of children age 5 to 12 and those with very low incomes.

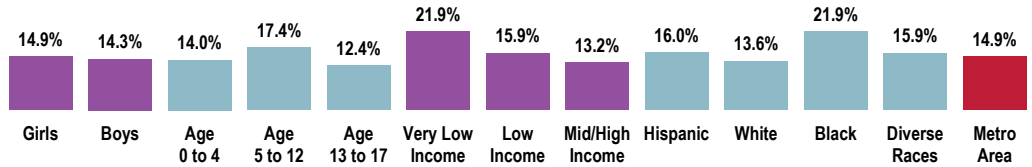
Feel the Need to Leave the Area for Children's Health Care Services

Top services mentioned:
- Mental health care (17.0%)
- All services (9.8%)
- Pediatric specialty care (9.5%)
- General medical care (8.2%)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Items 4-5]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a randomly selected child in the household.

Feel the Need to Leave the Area for Children's Health Care Services
(Metro Area, 2024)

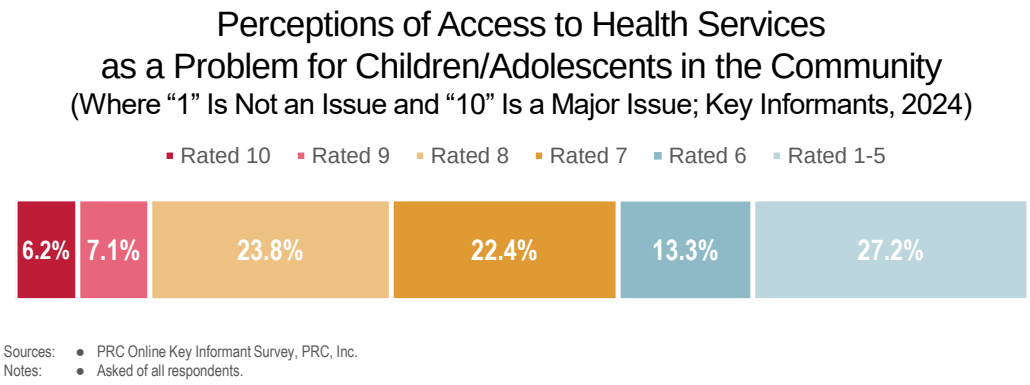


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents about a randomly selected child in the household.

When asked to state the main reason they feel the need to leave the area for pediatric care, these parents most often said **the service is not available locally** (29.5%), they believe there is **better care elsewhere** (29.2%), and there are **long waits for appointments** (6.6%).

Key Informant Input: Access to Health Care

More than one-third of key informants taking part in an online survey gave *Access to Health Services* a rating of "8," "9," or "10" (10-point scale where "10" is a major issue for children/adolescents in the) community.



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

Access to Care/Services

> Access to a pediatric practitioner that knows the family and child, uses screening and conversation to identify needs for referral, follows up on environmental risks and trauma, and provides a safe space for child health and well-being. Many families do not have regular providers and use alternative systems (e.g. emergency room) for health care. Relatedly, many families do not have or do not know how to access medical insurance. – Community Leader
>
> I think that it is hard to get in to see a provider on a fast basis. Also, I am not sure that families are able to access after-hours care that is with a primary provider, rather than having to access an urgent care or emergency department. – Public Health Representative
>
> Getting people connected with services that are a good fit for them. If someone makes a referral, there's still often a gap between the suggestion and the beginning of services. – Public Health Representative
>
> There is a mental health desert in our area. There are few emergency placements, and those that we did have seem to be closing due to horrible Medicaid reimbursement rates. There are very few places for inpatient treatment that are pediatric-focused. There is no place for minor substance abuse treatment or parent support for adolescents with substance abuse issues. – Social Services Provider
>
> Not enough mental health services available. – Social Services Provider
>
> Literally physically accessing services is an issue. Provider availability during hours families need services. Number of providers that take underinsured. – Social Services Provider
>
> Wait times and cost. – Community Leader
>
> Availability of and access to mental health care for a range of mental health concerns that do not require disclosure to unsafe adults, could be parents. – Public Health Representative

Affordable Care/Services

> Lack of access to affordable, culturally responsive health care is an issue for uninsured and underinsured individuals. – Community Leader
>
> Many people cannot afford to pay for health insurance and cannot qualify for it. – Social Services Provider
>
> Working parents often make too much to receive public assistance but too little to pay for health care costs on their own. The cliff effect challenges health care for our children. Even those that may have health care through their work may still worry about the out-of-pocket costs they may not be able to cover. – Social Services Provider
>
> Cost of care. Family deductibles are rising. Individuals who need to access care put it off as it's cost-prohibitive. Lack of providers. Need to train more health care providers – especially those who provide mental and behavioral health and diagnose and treat autism. Interpreters who are onsite to provide translation support. Not the same level of understanding on phone or iPad-better than none. – Social Services Provider

Income/Poverty

> "Financial health" – they usually include this issue on poverty and economic development where it is its own problem, and I'd say it is a determinant by its own. There are no providers or coaching and development opportunities to include financial education and the access to low-cost capital to individuals and families. – Social Services Provider

> While I could only choose 3 social determinants of health, there is often a multiplicity of issues that converge to devastate a family's health and life. Poverty and economics are major and are often carried forward to future generations. We don't realize the choices people make that might have been influenced by the ONLY choices they had and could have resulted from systemic or a single person's act of prejudice that could have made a difference in opportunities available. – Social Services Provider

> Low-income families do not have access to adequate health care, health care education, and necessary support services based on where they live, how much they make, their insurance status, and stigmas attached to poverty. The system is not equitable. – Social Services Provider

Awareness/Education

> Although there are places like Charles Drew and OneWorld, I believe there are still barriers for youth to access health care. It may be attributed to the parents' lack of awareness of what the kids need or their struggle to get them there. – Other Health Provider

> Information access, lack of knowing options and resources. – Social Services Provider

> Parents' lack of understanding how to apply. We also have parents who make just over the threshold for income but are not able to afford health care on their own. – Other Health Provider

Access to Care for Uninsured/Underinsured

> Minority children and adolescents may be more likely to be uninsured or underinsured, which can limit their access to preventive services, primary care, and specialty care. Many families in North Omaha have low income, which can limit their ability to afford health care services or health insurance. This can result in delayed or foregone medical care. There is a shortage of health care providers, including pediatricians and mental health professionals, in North Omaha. This can lead to long wait times for appointments and reduced availability of services. Minority children and adolescents may face disparities in health outcomes and may experience discrimination within the health care system, which can affect their willingness to seek care and their overall health. A historical mistrust of the health care system. – Public Health Representative

> Lack of health insurance coverage and family support, health care system can be more user-friendly. – Public Health Representative

Transportation

> Transportation is a major issue for many in my community to be able to go to food stores, doctor's appointments, and recreation areas. We need to do better for our children to help them grow in a healthy environment. – Public Health Representative

> Lack of transportation, lack of providers taking Medicaid, lack of providers in communities that need the most help. – Community Leader

Insurance Issues

> Insurance, access to health professionals of color, convenient locations, and quality of services. – Other Health Provider

> Insurance, parents' availability, conflicts with parents' work. – Public Health Representative

Lack of Coordinated Care

> Lack of systems that coordinate to make Omaha a safe place to grow for all children. We have activity and obesity issues, safety issues, sexual health issues, maternal/child health disparities, and poverty and racism driving disparities. – Physician

Lack of Providers

> Number of specialty providers. – Physician

Specialty Care

> Pediatric cardiac care. – Physician

Vulnerable Populations

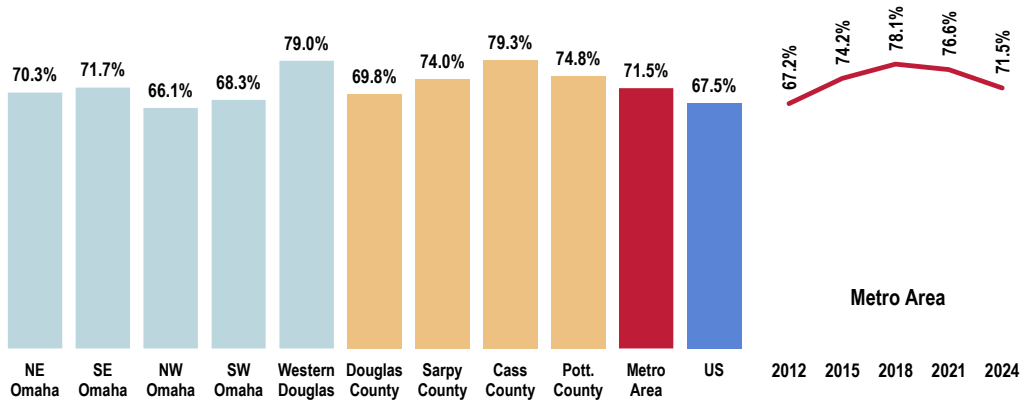
> Children & adolescents in our community with historically marginalized identities, specifically LGBTQ+ individuals and families, experience higher rates of both real and perceived obstacles to gain access to culturally responsive care, including physical, mental, and behavioral health. Additionally, few local resources exist to support parents/caregivers of youth with historically marginalized identities. Outside of service provision, increasing politization of these marginalized identities increasingly predispose these youth to increased risk of violence, risky behaviors (including at-risk sexual practices, drugs, alcohol, and tobacco use & abuse, etc.). While many providers exist to serve youth, few offer real and perceived safety for many youths, especially those who live in low-income households. Many are referred to underfunded programs which have expertise but lack financial resources/staffing. Large institutional providers and state programs must support such specialized care. – Community Leader

MENTAL HEALTH SERVICES & TREATMENT

Awareness of Mental Health Services

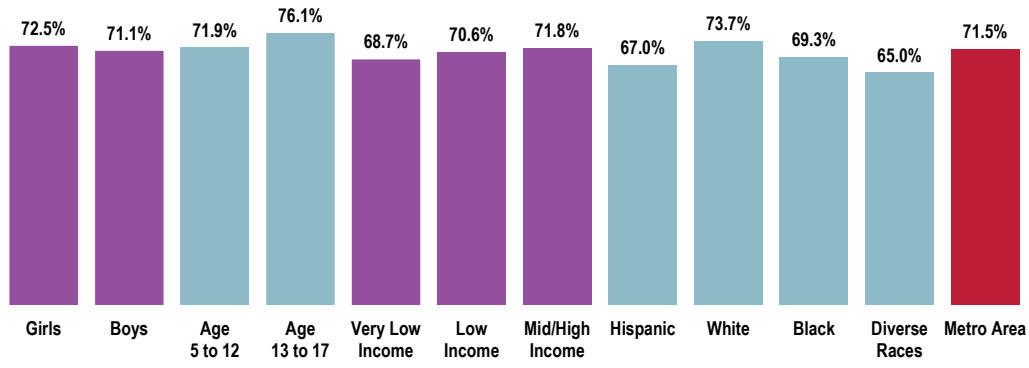
Seven in 10 Metro Area parents (71.5%) say they are aware of local community resources for mental health.

Aware of Mental Health Resources in the Community
(Parents of Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 65]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Aware of Mental Health Resources in the Community
(Parents of Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 65]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

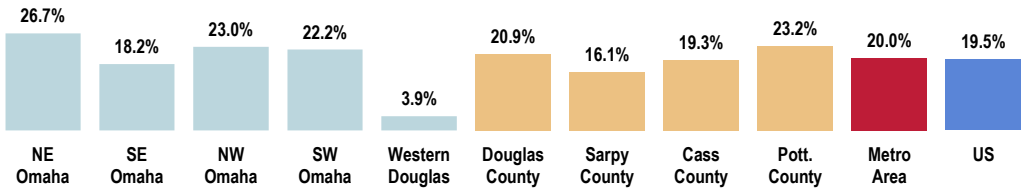
Mental Health Treatment

"Is this child now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

A total of 20.0% of Metro Area parents report that their child (age 5-17) is currently receiving mental health treatment.

DISPARITY ► Lowest by far in Western Douglas County. More often reported by parents of adolescents (age 13 to 17), those with very low incomes, and parents of Hispanic children.

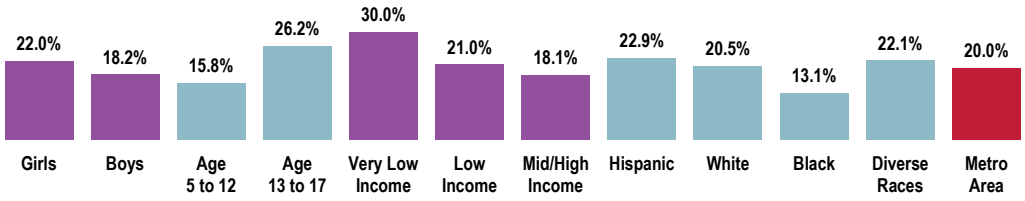
Child Is Currently Receiving Mental Health Treatment
(Children Age 5-17)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 56]
- 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

Child Is Currently Receiving Mental Health Treatment
(Metro Area Children Age 5-17, 2024)



Sources:
- 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 56]

Notes:
- Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

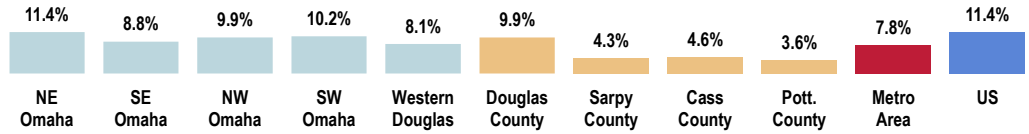
Difficulty Accessing Mental Health Services

A total of 7.8% of Metro Area parents report a time in the past 12 months when their child (age 5-17) needed mental health services but they were unable to get them.

BENCHMARK ► Lower than the national percentage.

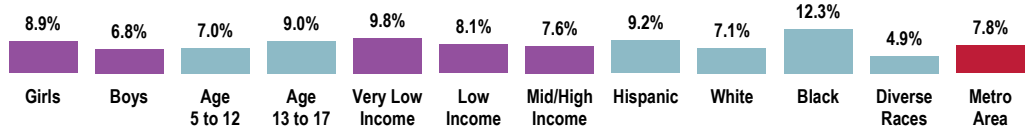
DISPARITY ► Highest in Douglas County.

Unable to Get Needed Mental Health Services for Child in the Past Year
(Children Age 5-17)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 57]
● 2023 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

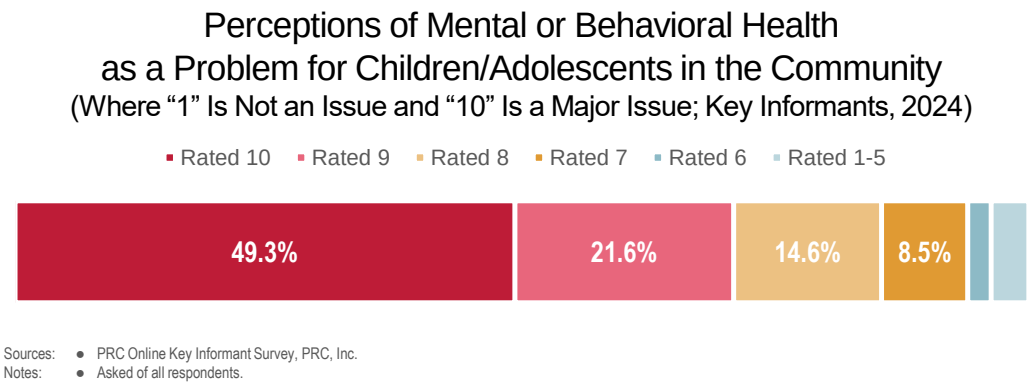
Unable to Get Needed Mental Health Services for Child in the Past Year
(Metro Area Children Age 5-17, 2024)



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 57]
Notes: ● Asked of respondents for whom the randomly selected child in the household is between the ages of 5 and 17.

Key Informant Input: Mental & Behavioral Health

The greatest share of key informants taking part in an online survey rated *Mental & Behavioral Health* as a "10" for children/adolescents in the community (10-point scale where "10" is a major issue).



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

Access to Care/Services

> The lack of services and timely diagnosis are creating problems in our schools. – Community Leader
>
> Trying to get children in for counseling takes weeks and months when they need help now. – Community Leader
>
> There is a lack of quality mental health services in rural areas surrounding the Metro area. Often, families do not have the resources to get children to Omaha on a regular basis for therapy. Major behavioral health issues are still undiagnosed, and the ability to find resources to deal with major issues in the schools is scarce. – Community Leader
>
> Lack of access to high quality care along the full continuum. – Community Leader
>
> We have families that have to wait weeks to be seen by a therapist and months to be seen by a psychiatrist. – Other Health Provider
>
> Significant lack of access. Waiting lists are long. If not savvy, it is nearly impossible to access the system. – Physician
>
> Accessibility and affordability are the main barriers preventing good mental and behavioral health. Not enough providers, causing no one to take on new clients, and providers that have openings do not take all insurances such as Medicaid or TRICARE. – Social Services Provider
>
> Behavioral health. Boys Town has a waiting list for youth in need of behavioral modification services. This goes hand-in-hand with issues of mental health. Proliferation of education for parenting and how to manage school behaviors is needed in order to prevent more serious issues later. – Community Leader
>
> In our work, the need surpasses our capacity to provide therapy in a quick response. We have seen a substantial increase in the number of referrals to services, resulting in increased wait times. We have to find a way to get to therapeutic outcomes without having to rely on licensed therapists to be the only service provider. – Community Leader
>
> Everywhere has such long wait lists for support and services. We lack funding. – Community Leader
>
> Not enough access to care. – Public Health Representative
>
> Availability of appointments is a major concern, especially for those with mental health issues, or immediate respite care needs. Our urban core has not been fully and equitably developed, and many little ones and children lack access to safe places to play. Parents need to understand the importance of play and conversation with their children for their best development. – Social Services Provider
>
> This issue has finally gotten more awareness but has significantly compounded since 2020. Schools lack resources for mental and behavioral support. Often, children with high needs are sent home when schools can't meet their needs, which creates a bigger issue for working parents. The community needs more options for families prior to crisis situations. – Social Services Provider
>
> Mental health referrals have been on the rise for years. It can take as long as six months to get access to a psychologist or psychiatrist. We do not have enough mental health consultants and practitioners to work in schools and community support organizations. – Community Leader
>
> Lack of resources available for all the needs. – Community Leader
>
> Behavioral health access has been an ongoing community need for many years. – Physician

We know that mental and behavioral health continues to be a growing need. We need to continue to expand on work that drives comprehensive services, community, and social support. Mental Health is a foundation for physical health and overall well-being. There is good work underway that needs to continue to be prioritized. – Community Leader

Mental health issues are on the rise and not enough help available. – Social Services Provider

The wait lists are long, access is hard. There are stereotypes and stigmas that have to be overcome. The support is hard to find, and navigating this for families with needs is very challenging. – Community Leader

Wait lists are too long, and there are not enough providers to get youth and families into mental health services in a timely manner. Nearly 40% of providers that have a PLMHP never get the LMHP. They leave the field or leave the state because there are so many barriers to obtaining the supervised hours. Most insurance companies do not credential the PLMHP. Other states have started legislation to require insurance companies to credential PLMHPs while they get supervised hours. This would keep providers in our state to address MH health needs for youth and increase access to MH for youth and families. We also have very few diverse and Spanish-speaking providers, and families have a right to identify and find providers they feel like they can connect with. Few providers are trained to work with I/DD, trauma, and in evidence-based treatment, and right now kids need a lot more than supportive, talk therapy. – Other Health Provider

Though the amount of resources for mental and behavioral health is growing, there is still a big need for parents, caregivers, and people who are in contact with children to receive these types of resources. Many families, especially refugee or immigrant families, carry a stigma on mental and behavioral health, other families get overwhelmed with caring for a child that is dealing with a condition and may not know where to turn to or lose hope on the child. Treating and caring for children with various mental or behavioral health conditions can be expensive, limiting access to medications and treatments. – Public Health Representative

Mental health is now finally being talked about within the past couple of years. It doesn't make you a social pariah to suffer from a mental health condition, but it doesn't help improve the conditions, because there are very few resources available for people suffering. The resources available are overworked and underpaid, which doesn't make others want to go into the field. – Public Health Representative

There are a number of youths within my familial community experiencing issues with behavior and emotional management. Each of them is having difficulty at home and in school and receiving limited resources and support. Even those that have been seen by a professional and prescribed medication have difficulty getting the needed medication regularly. – Public Health Representative

Workforce shortages have made timely access to mental and behavioral health services a major problem. Families are waiting months for appointments. – Community Leader

Personal experience in accessing care. We also see signs of issues in the community – depression, anxiety, and more cause young people to act. Hopelessness, income stressors, family stressors, and geography play a key role in outcomes for children and teens. – Community Leader

Lack of specialized resources to assess and evaluate their needs. Not enough prevention and intervention efforts. – Other Health Provider

There are longer wait times for support, especially for those that need specialized or culturally sensitive support. We also see a need for those in the workforce pipeline. Rates of anxiety and depression are rising. – Community Leader

As I intersect with professionals in the community, this problem is always at the top of the list. The concerns are usually related to a lack of services. May be time to renew preventive approaches in hopes of creating protective factors for all children and adolescents. – Other Health Provider

Access to mental and behavioral health services is a concern. Self-awareness, regulating, and coping all need community resources. Social media and mental health needs attention to shine a light on the issue with resources to help parents. – Community Leader

Scheduling lag for seeking mental health appointments is more than 14 days in most cases. While same or next-day availability isn't always possible, that is what is needed to keep our kids safe with the mental health needs they have. – Community Leader

There is a waiting list for psychiatric residential treatment facilities. Post-pandemic youth are struggling with social issues. There is a long wait time to see psychologists and psychiatrists. – Community Leader

Too few resources, too many barriers to this care. – Social Services Provider

Mental and behavioral health became virtually a health care desert a few years back with the closing of the traditional facilities and a lack of future options left those needing mental health care in limbo. Adolescents need trained people to talk to and receive care from in this area because, in many cases, their parents lack basic skill sets of life. Additionally, many parents and teachers aren't equipped to deal with the unique needs of some LGBTQ+ youth needing assistance. – Community Leader

There are limited resources throughout our state for mental and behavioral health resources. Patients often wait several weeks or months to see a provider. They often see a provider that isn’t appropriate for their needs because it is the best option. – Physician

I believe there is a lack of services and also many risk factors around the communities in which children live that impact their mental health, such as violence, poverty, racism, segregation, and social media. – Public Health Representative

Limited resources for care within our community. This would be all levels of care. FP, peds providers skilled in medication management for children, urgent or emergent access to care during crisis episodes, IP level of care and intensive OP services. We simply do not have beds or spots available without wait times that put the child at further or heightened risk. Lack of support for families waiting for placement. When I think about the workforce and limited spots in our advanced practice programs, specifically around adolescent psych, I wonder how we could address this? Capacity for oversight for training in this specialty could be a contributing factor. – Community Leader

There is limited access to experienced providers in a timely fashion. Waiting several months to see someone for an issue perpetuates the anxiety around it and increases acute need to go to the ER for services. In addition, as an ER employee, it appears we are seeing some of the same patients over and over with the same crisis. It is disheartening to feel like we are unable to meet their needs and support them with resources for healing and recovery from crisis. – Community Leader

Too many people who need help are put on waitlists instead of providers referring to other providers who have openings. The important thing should be getting children and adolescents the service they need and not keeping a waitlist to show how much the services are needed. – Social Services Provider

There are few services, and the wait times are months for help. It seems like more and more children are having these issues. Everyone is talking about it. I witness children/adolescents struggling every day. I have no children. I just know what I witness on the topics in this survey as I move about my neighborhood, the Omaha community, and the state. – Community Leader

Lack of Providers

Lack of licensed providers. – Community Leader

There are nowhere near enough providers available, and if they are available, they do not accept Medicaid insurance. The providers in our area are so full it takes months to be seen even for an evaluation, all the while families and children continue to struggle to function. – Community Leader

The number of providers is very low, and the need is high. The waiting list to see a provider to even establish a diagnosis is too long. – Public Health Representative

There are not enough providers, insurance makes it difficult to access services, and there is a need for intensive services, such as residential treatment. – Community Leader

Lack of providers and lack of resources in our community. Parents' unaddressed mental health needs affect their ability to get their child's mental health needs met. Lack of understanding and belief in mental health among parents and caregivers. – Other Health Provider

There are not enough therapists to meet the level of need. Additionally, accessing support before the issues rise to the level of needing higher levels of care is very difficult. – Social Services Provider

We are still experiencing a workforce shortage, even if Omaha no longer falls on the behavioral health workforce shortage list. There are long waits to get in; the Omaha-metro area is burdened to support surrounding areas that do have a significant workforce shortage. Access to mental and behavioral health care through an insurance lens is lacking, as well. Most major plans are spotty at best with coverage, or are high deductibles that are extremely burdensome to families, especially those who may not qualify for other benefits, such as Medicaid. Additionally, there are limited resources for high levels of care, such as residential or partial care options for families whose child may need that level of support. Again, these scarce resources are taxed by families outside the metro area as well, given the sparse availability of these services outside the Omaha/Lincoln/Council Bluffs area. – Other Health Provider

There is an unequal balance of need versus resources. There are not enough practitioners. – Public Health Representative

Lack of providers, and when someone is able to access a provider, the wait times are long. – Social Services Provider

The lack of available providers who specialize in children and adolescents is a problem. Those that do practice are overwhelmed. There are no group treatment options, very limited inpatient, no emergency placement for mental health, and no substance abuse treatment programs for adolescents, inpatient, outpatient, group, or meeting supports. There is no parent support for teens with serious mental health issues or substance abuse issues. – Social Services Provider

There are so few qualified practitioners. – Physician

The numbers have been increasing, and there is a lack of providers to treat. – Physician

There are not enough providers to serve the need. – Community Leader

Lack of providers. Equitable services. Quality of care, and just plain disregard for the three areas mentioned. – Social Services Provider

We have a shortage of mental health providers and resources for children and youth. – Physician

Our society has changed, and there are different stressors than in the past. Substance use, social media, and social norms have changed, resulting in increased mental health issues for our youth. There has been an increase in outpatient. services, especially private practice; however, there is an increase in provisionally licensed therapists in our community, as the seasoned professionals are leaving/retiring. This means we have a market of professionals with less experience and training. Training for provisionals in private practice is also questionable. So increased mental health needs with a lower skilled workforce. There also was a shift to decrease inpatients and residential care – which has benefits unless a child truly needs inpatient care, and now they can obtain it due to low capacity of higher levels of care. Higher levels of care in our community also need to use evidenced based practices. – Other Health Provider

I think it is due to the lack of mental health therapists. There are a variety of issues that are creating this, which include stigma of mental health needs and social media. – Community Leader

Not enough providers to serve those in need; mental and behavioral health care tends to be more expensive to treat than other medical conditions; behavioral and mental health continues to be stigmatized, misunderstood, or trivialized/downplayed; it is often difficult to identify if a child/adolescent needs behavioral and mental health care. – Community Leader

Not enough providers, long wait lists, families don't know how to access these services, and when they do, they can't get in. – Social Services Provider

There are not enough mental health providers. We are building two huge facilities in Omaha and CB. Mental health practitioners are burned out, and many have moved to private practice for a better work/life balance and because of pay. There is not a pipeline being built to ensure these facilities will be properly staffed. Also, there is a huge emphasis on behavioral health for children, but what happens when they become 19 – there are limited treatment options for adults, further exacerbating the problem. Mental health doesn't stop when you are an adult. More primary care options need to be available for parents that are coming to medical appointments. Reduce the negative stigma of accessing mental health. – Social Services Provider

There are not enough behavioral health providers. – Community Leader

Mental and behavioral health has become and remains one of the top areas of concerns brought to our attention. We have good therapists in the area, but not enough. We are also lacking these resources in the rural areas just outside the metro. – Community Leader

Part of the issue is even identifying the level of mental and behavioral health issues for our children, as there not enough providers to begin with. There is no question the kids are going through a lot these days, and those parents that do seek help often have to wait weeks or even months for an appointment. Simply not enough providers or accessibility. – Social Services Provider

Incidence/Prevalence

We are seeing students come to school with severe behavioral issues and, more than ever, violent behaviors. Students talk about hurting others or themselves at a really high rate. We have experienced students punching staff and even becoming physical with our resource officer. These extreme behaviors are with students as young as 3 and 4, but mostly we are seeing it manifest in our primary grades. – Community Leader

Mental and behavioral health. I responded to this earlier but want to emphasize the challenge. – Community Leader

Mental health. – Community Leader

We are seeing an enormous increase in demand for services for children and adolescents needing mental and behavioral health services, along with a substantial increase in suicide ideation. – Social Services Provider

Families who seek assistance from our organization and our community partners indicate that this is a high-priority need. – Social Services Provider

Mental health disorders, such as anxiety, depression, attention-deficit/hyperactivity disorder (ADHD), and conduct disorders, are relatively common among children and adolescents. I've witnessed how mental and behavioral problems can significantly impact a child's development across various domains, including cognitive, emotional, social, and academic functioning. Untreated mental health issues can hinder a child's ability to reach their full potential and lead to long-term consequences in adulthood. I also believe that children in my community may face various risk factors that contribute to the development of mental and behavioral problems. These risk factors can include exposure to trauma, adverse childhood experiences (ACEs), poverty, violence, substance abuse within the family, lack of access to quality education and health care, and social stigma. – Social Services Provider

So much anxiety and depression. – Physician

Our organization has seen a 30-40% increase in behavioral health visits in the emergency department year after year since 2017. Our community's children and youth need care, support, and treatment in a timely manner, but our system does not have the bandwidth currently to meet the need. As a result, the mental and behavioral health of kids continues to deteriorate until it becomes a crisis, and they show up in our emergency departments. We need to make a real effort to change the system by identifying issues earlier and providing adequate resources to families and children needing help. We keep responding in the same way, but the problem is not going away – it's getting worse. – Public Health Representative

Trends in adolescent mental health are increasing in areas of depression, anxiety, rates of emergency department visits related to diagnosis of mental health issues, and death from suicide. Adolescence is a critical time for the development of physical and mental health. There is a connection between physical and mental health; shorter life expectancy in those with severe mental health disorders, comorbidities like cardiovascular disease, infectious diseases, and cancer. – Public Health Representative

All the challenges over the last couple of years. – Community Leader

Mental health is the 21st century's public health challenge when physical health challenges were for the 20th century. It shows up repeatedly in our CHA and CHIP work because we don't have it figured out and it contributes to so many other issues. – Public Health Representative

The number of children needing mental health is increasing, and the age of onset is decreasing. Our health care payment system poorly supports mental health services, and we don't have a flow of new providers to keep up with the demand. Mental health is a primary driver of juvenile delinquency, and our system doesn't have effective resources to rehabilitate them. Unmanaged mental health in children has led to sub-optimally functioning adults and parents that will be less equipped to raise mentally well children. – Community Leader

DCDH and DHHS statistics. – Community Leader

A lot of kids these days are admittedly struggling with anxiety and depression. Additionally, there seems to be a higher number of kids being diagnosed with ADHD. – Community Leader

Poor mental health among children continues to be a major public health concern. – Community Leader

Suicidal ideations are up from the students we serve in my organization. – Community Leader

It is appearing in every facet of our lives and careers. I don't know what is causing it, but kids are struggling, families are struggling, and we have a revolving door of kids needing help. Parents don't know what to do and struggle to survive within our current system. Parents seem to have low coping skills, and some are using available treatment facilities as respite care instead of the crisis care currently offered. – Community Leader

Seeing increased depression and anxiety in our youth. Preschoolers are being diagnosed with anxiety disorders. Resources are not very accessible for families who do not have the flexibility to be off work during "regular business hours." There has been a stigma around mental health for so long that it is seen as a weakness (especially to older generations). – Social Services Provider

Increasing numbers of youth experiencing mental and behavioral health problems. Resources or remediation options are lacking. – Public Health Representative

The number of students struggling with mental health issues continues to grow. We can provide connections with therapists, but there may be a four-week or more wait time for an appointment. – Other Health Provider

Too many children and adolescents need emergency services. Need to get into schools and support them. – Physician

Post-Pandemic

From what I have heard and read, there has been an increase, especially since COVID, in mental health and behavioral issues among the pediatric population. It is also my understanding that the community as a whole does not have the amount of resources needed to address these issues. – Community Leader

These were always issues, but post-pandemic, the issues have exploded. Wait lists for mental health services are ridiculous. It is difficult to get appointments, and costs can be prohibitive. Limits on services are also a major problem. Access to services in multiple languages is often lacking. I have seen more suicidal ideation, adjustment disorders, and ASD than ever in my experience. – Social Services Provider

I believe there are several factors contributing to the mental and behavioral health problem for adolescents. We are still seeing effects from the isolation created by the COVID pandemic shutdown. Isolation among youth has continued to grow as a result of technology. Students are spending a great deal of time on social media on devices by themselves instead of interacting socially with other adolescents. A great deal of what students are seeing and hearing on social media is also creating negative self-images among adolescents. We also continue to see a decline in the family structure. Essential social, emotional, and behavioral skills are not being taught at home at a young age. – Community Leader

We work in the mental health space. It has always been a concern in our community (and elsewhere), but post-pandemic has been even worse. With not only increased rates of depression and anxiety, but youth suicide deaths in our community were the highest year on record in 2020 and 2021, and still have remained higher than pre-pandemic years since. – Community Leader

Huge increase in mental health concerns since the pandemic. – Community Leader

COVID-19 has exacerbated mental health issues for children and adolescents in Omaha and beyond. There is a lack of resources at school, family, or the community to address this challenge. We cannot only rely upon health care systems for addressing this serious issue. – Public Health Representative

Behaviors and mental of families in the post-COVID era are evident in schools and directly relates to behaviors displayed. – Social Services Provider

I think we are still recovering from the impact of COVID, and we see in schools that children are not ready for kindergarten, both academically and socially/emotionally. Mental and behavioral health of children impacts them directly AND the other children in the school because attention is diverted from instruction to address the mental/behavioral needs of another child. – Social Services Provider

Mental and behavioral health issues among children and adolescents is skyrocketing. Coming out of the pandemic years, children don't have the appropriate social skills, regulation skills, or early education to catch up to grade levels in school. This only leads to greater behavioral issues. Many are recruited into gangs for that need to belong. Others may resort to tobacco, alcohol, or substance use. Parents have no idea what to do and blame themselves. As inappropriate behaviors increase, the help and/or support programs seem to not be able or willing to help due to lack of insurance, or lack of bed space. – Public Health Representative

Mental and behavioral health is a pervasive problem. It has been exacerbated by the COVID-19 pandemic and highlighted the areas we were lacking prior to the pandemic. For instance, the access to mental health services and the shortage of health professionals to provide care, especially with the uptick in need post-pandemic. We need to not only address the rising rates of suicide, depression, and anxiety, but we also need to address the workforce issue that exists which will maintain these disparities if it is not addressed. Part of the issue of addressing the disparity is to address the workforce. – Public Health Representative

Mental health needs continue to be prevalent in post-COVID and political climates. There is not enough access to affordable services in the community. An increase in private practice has made it hard for nonprofits to hire and retain therapists to increase accessibility to youth. – Other Health Provider

Since the pandemic, we have witnessed an increase in depression and feelings of isolation by a segment of our student population. We provide a counseling service, but unfortunately it is not accessed by every student experiencing mental health issues. – Community Leader

Still dealing with ramifications of COVID. Teachers indicate difficulty controlling children. Higher rates of suicide and depression. I also think that there is TOO much pressure from some school districts who are forcing students into Advanced Placement courses, which may not be in the student's best interest but rather makes the school look good. – Social Services Provider

The impacts of COVID on the mental health of children. – Social Services Provider

Mental and behavioral health resources are limited in our community. Additionally, the increase in individuals accessing mental and behavior health supports has increased post-pandemic, making the limited number of resources even sparser. – Public Health Representative

Suicide Rates

I have had more patients attempt or complete suicide since March 2020, than in 20 years preceding combined. – Physician

We track data and are seeing a rise in suicides, suicidal ideation, depression, anxiety, and other mental health concerns. In our juvenile justice system, kids need substance abuse treatment, therapeutic interventions, and trauma-informed care that all too frequently are waitlisted and/or cannot find a culturally competent provider. – Community Leader

As previously mentioned, rates of suicidality and self-harm are up, ability to provide gender-affirming care for youth under 19 is dangerously restricted and poorly managed, while access to culturally responsive mental health providers often require long waits or are in small agencies with less flexibility or credentialing to accept Medicaid or certain insurance providers. Public policy has further restricted available supports and removed access to evidence-based care in accordance with WPATH and other widely accepted standards of care for LGBTQ (specifically queer and trans) youth while exacerbating already existing disparate outcomes. These restrictions have compounded the problem, as the restrictions to care which has become politicized has not been answered with targeted care, increased financial support, or comparable care in terms of successful outcomes. – Community Leader

High rate of suicide. Long wait times to see a therapist. – Community Leader

The rates of suicide ideation and behavior are increasing with minimal resources to provide real-time support. – Community Leader

Social Media/Technology

Expanded reach of social media platforms. Coordination of services is difficult for families and providers. Lack of workforce to address needs. – Social Services Provider

Too many kids need mental health services. I believe a big part is because of social media and parents allowing them to be on their phones all the time. – Community Leader

Social and emotional development due to technology. Families do not understand how to have balance, and this is also a cause for you to separate from healthy social gatherings. – Community Leader

Dependency on electronics as a babysitter. – Community Leader

It was mentioned in passing, but I think it is important to call out the impacts of technology on health. Teaching parents how to keep their kids safe online, cyberbullying, etc that contribute to a child's health are extremely important to be part of the strategy, in my opinion. – Social Services Provider

Trauma

> Generational trauma, current events, lack of parental understanding can all contribute to adverse mental and behavioral health issues. Children are often diagnosed late or not at all in our community due to the stigma of being labeled. – Community Leader
>
> Unaddressed trauma has been bubbling under the surface of our community for some time. When a child or family needs services, they need it immediately. When the check engine light comes on your car, no mechanic would say keep driving around and we'll see you in two months. – Social Services Provider
>
> Urban areas with higher crime rates can expose children to traumatic experiences, which can have long-lasting effects. Family instability, substance abuse, and other community issues can also contribute to the mental and behavioral health challenges faced by children and youth in the areas of their mental health and behavior. There may be a lack of mental health resources in the community, including fewer mental health professionals, limited access to therapy or counseling, and stigma surrounding mental health issues. – Public Health Representative
>
> The intergenerational transfer of childhood trauma. – Social Services Provider
>
> Trauma continues to impact children and families. Impacted people struggle with coping skills and resources to address trauma and behaviors. Agencies are struggling with attracting and retaining a qualified workforce. – Other Health Provider

Diagnosis/Treatment

> There are too many situations where it has come down to the child/adolescent having a mental health problem. Usually finding out too late. – Other Health Provider
>
> This is an ongoing issue, and questions regularly arise related to what does this care look like. Individual therapy, group therapy, other alternatives. What are the best action steps we can take as a community? – Community Leader
>
> Lack of attention to mental and behavioral health causes challenges within families and can lead to devastating actions happening within the home and spreading to families and school. – Social Services Provider

Bullying

> The frequency of bullying in schools, kids with autism, ADHD, gender issues, etc. receiving proper diagnosis, treatment, and management in the mainstream educational system. – Public Health Representative
>
> Children are struggling with mental health disorders, and bullying is a major contributor. With the rise of social media access, students have no way of getting away from bullies. Most schools are struggling with how to draw the line between home issues and school issues while it's not blurred. – Social Services Provider

Denial/Stigma

> There is still a major stigma around mental health in so many households and communities. There are also few emergency options and resources for families during a mental health crisis. – Social Services Provider
>
> The stigma, cost, lack of trust, and lack of service providers who have life experiences that match the client are all hindrances to utilization of behavioral health services. – Other Health Provider

Parental Influence

> I believe children's minds are not developed to the level necessary compared to the access of the amount and type information they have available to them. There is a lack of monitoring to the appropriate levels and type of information commensurate to age. – Community Leader
>
> Residual impact from parents and look at weakness and sometimes laziness. – Social Services Provider

Vulnerable Populations

> A variety of reports indicate this issue is at crisis levels, and Omaha is no different. LGBTQ, POC, and other marginalized communities are particularly susceptible to these issues. – Public Health Representative
>
> Mental health is one of the top needs in communities of color. It is a subject that has to be explored and brought forward as health care. Access to bilingual and multicultural practitioners is very important in the success of treatment for my community. – Public Health Representative

Lack of Resiliency

> Lack of resiliency and hope. – Community Leader
>
> Hopelessness. Research clearly shows hope is the best predictor of well-being outcomes. Gallup data shows fewer than half of American youth are hopeful. Hope is easy to define, easy to measure, and easy to teach and practice. – Community Leader

Access for Medicare/Medicaid Patients

> Our community doesn't have enough providers that take Medicaid or offer appointments after 5 p.m. or weekends. There are not enough providers to help with in-school services. – Community Leader

Affordable Care/Services

> Access to affordable mental and behavioral health services seems to be a big challenge. Equity and stigma in this area is top of mind. – Community Leader

Cultural/Personal Beliefs

> Our society and culture values productivity, achievement, and social status over mental well-being and human connectedness. Kids are taught to strive for both good grades and standout performance in sports, while watching adults connect with each other through electronics. We are growing into a generation of stressed, disconnected kids. – Community Leader

Refugee Population

> Refugee children come in having come from severely traumatic situations. The process of becoming a refugee and receiving that status clearly indicates severe danger to the individual. This trauma is not addressed until later, when it starts manifesting as behavior issues at school. – Social Services Provider

Funding

> Mental and behavioral health is a huge (and growing) issue across the country, and Omaha is no exception. Providers' efforts to offer adequate interventions and prevention will be helpful, no doubt, but further investment is needed. Parental education and awareness will be key in helping our children through this crisis. – Community Leader

Income/Poverty

> Mental and behavioral health is an issue in our community due to generational poverty, racism, and generational trauma. – Public Health Representative

Increase in Outside Factors

> The increase in outside factors. – Community Leader

Sleep Hygiene

> Sleep hygiene. Our youth are not getting sleep at the recommended hours that is uninterrupted (technology use). This, anecdotally, seems to be a factor in almost every health issue I have experienced in my role (whether behavioral health, mental health, safety/well-being, etc.) – Other Health Provider

Stress

> The effect of toxic stress and adverse experiences individually and generationally is a problem in the community. – Social Services Provider

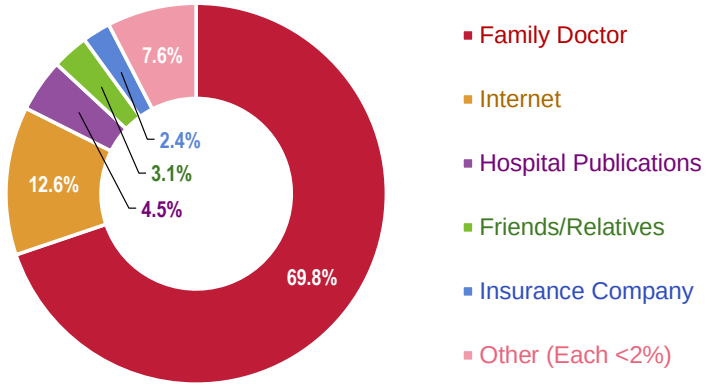
RESOURCES

HEALTH CARE INFORMATION SOURCES

For more than two-thirds (69.8%) of Metro Area households, family physicians are the primary source of children's health care information.

"Where do you get most of your health care information for this child?"

Primary Source of Health Care Information for Child
(Metro Area, 2024)

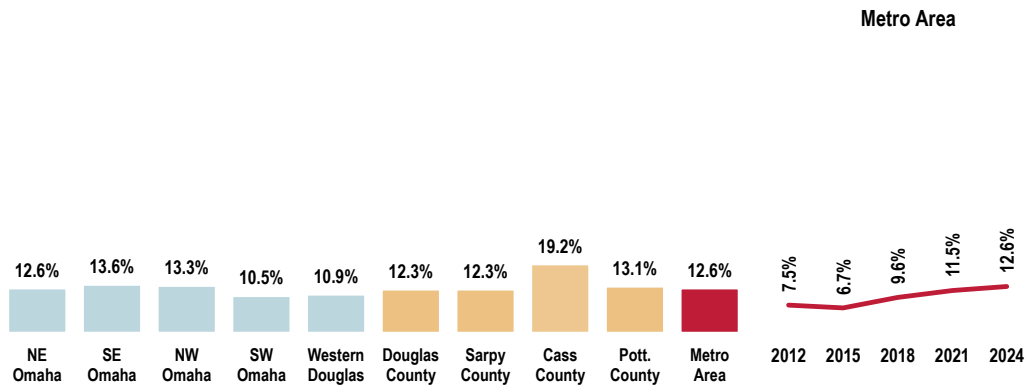


Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 330]
Notes: ● Asked of all respondents about a randomly selected child in the household.

A total of 12.6% of parents identified the internet as their primary source of health care information for their child.

TREND ► Increasing over time.

Rely on the Internet for Information About Child's Health Care



Sources: ● 2024 PRC Child & Adolescent Health Survey, PRC, Inc. [Item 330]
Notes: ● Asked of all respondents with a child age 0 to 17 in the home.

COMMUNITY RESOURCES

Children's Nebraska recognizes that caring for children goes beyond the walls of the clinics and hospital. It has been widely documented that 80% of health outcomes are driven by factors outside of traditional health care. Children's joins hospitals across the state and region in investing in community resources and partnerships to address Social Determinants of Health (SDOH) to better support the health of children.

Children's acknowledges that many community resource lists exist, and we cannot provide a comprehensive list within the confines of this document. To that end, we would like to highlight **United Way of the Midland's 211 Helpline**. The 211 Helpline works to connect residents in Omaha and across Nebraska to local programs that can help them access the assistance they need.

In addition to the 211 Helpline, Children's is proud to be a participant in Unite Nebraska. **Unite Nebraska is Nebraska's first statewide coordinated care network** designed to address social drivers of health. Using this network, health and social service care providers communicate and track outcomes together through bi-directional referrals. Unite Nebraska combines person-centered care coordination and community engagement for health systems, social service organizations and government agencies.

In addition to the many resources available across the state, Children's Nebraska offers a wealth of resources, services and programs to help meet the needs of the children and families we serve.

For patients in our care and their families, Children's provides a unique team of professionals in the fields of nursing and social work to deliver **Care Coordination** services across the Children's continuum – from primary care to emergency room to home health to specialty pediatric clinics to inpatient stays. Care Coordinators work with all who are involved in a patient's care, including schools, insurance companies, community groups and the health care team, to help make sure a patient gets what he or she needs. Care Coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective services. Children's Care Coordinators are crucial to ensuring medical adherence, providing concrete resources for needs such as transportation, food, housing, and finances, completing assessments that assist mental and emotional health, and serving as longitudinal supports for the patient family.

The following table summarizes Hospital-based resources and programs managed by Children's Nebraska and key Community-based resources and programs in which Children's takes a leadership role. Additional information may be found on our website, www.childrensnebraska.org

Priority Impact Area	Key Resources and Assets
Pediatric Mental Health and Wellness	**Hospital-Based Resources:** • Caring Contacts • Autism Outreach/PATCH Program • Mental/Behavioral Health Project ECHO sessions • Telepsychiatry and Project HALO (holographic meeting technology) • Integration of psychologists at select Children's Physicians primary care clinics in partnership with Munroe Meyer Institute • Child Advocacy Team and Foster Care Clinic • Children's Outreach and Provider Education (COPE) • Behavioral Health & Wellness Center (opening 2026) • School Health Program • Westside Community Schools, School Nursing **Community-Based Resources:** • FQHC partnership • Region VI Continuum of Care Analysis • Project Harmony

Access to Care	**Hospital-Based Resources:** • FQHC and School-Based Health Centers partnership, including leased providers for Specialty care • Westside Community Schools School Outreach • Visionmobile and Vision Outreach Program • Project AUSTIN • School Health Program • EMS Tier Program • School and Sports Physical outreach clinics • Sports Medicine Outreach for School Athletics Programs **Community-Based Resources:** • UBER Health and other medical transportation services • Douglas County Youth Center (DCYC) intake medical assessments • Legal Aid of Nebraska and Immigrant Legal Center
Social Determinants of Health (SDOH) *Including:* • Food Security • Financial Stability • Healthy Housing • Transportation • Education and Workforce Development	**Hospital-Based Resources:** • SDOH Screening for all inpatient and outpatient visits • Unite NE bidirectional referral system • Breastfeeding outreach and promotion • Donated breast milk depot • Formula Assistance • Community Impact Grants to support organizations addressing SDOH needs • Social work and financial counselor assistance in public benefit program applications – including Medicaid, WIC and SNAP • School Health Program • Wishing Well financial assistance for patient SDOH needs • Food boxes for inpatient families • Project SEARCH • Career Quest for high school students • Injury Prevention – Car Seats and Car Seat Safety **Community-Based Resources:** • United Way of the Midlands – 211 Help Line and Help Me Grow • Douglas County Health Department • Sarpy/Cass Health Department • Double Up Food Bucks • Healthy Housing Omaha • Nebraska Asthma Coalition • Lead testing in partnership with local health departments • Omaha Bridges out of Poverty

APPENDIX

EVALUATION OF PAST ACTIVITIES

2022-2024 Implementation Strategy Plan Evaluation Overview

Children's Nebraska created a 3-year implementation strategy plan (ISP) to be carried out from 2022 through 2024. This ISP was designed to serve the specific needs of the pediatric population, prioritizing underrepresented child populations as defined by the National Institutes of Health. The ISP addressed each strategic priority across three activity areas and identified appropriate resources to be included to address the needs identified in the priority areas.

Children's Community Health & Advocacy serves as the outreach hub of Children's Nebraska and provided oversight and management of the ISP. Community Health & Advocacy provided infrastructure and leadership for both internal and external partnerships associated with the Pediatric CHNA planning and implementation process.

ISP steering committee and priority specific workgroups were convened within Children's, and community partnerships were fostered to advance the four child health priorities. Below is a brief summary of accomplishments and key evaluation outcomes to date.

DISCOVERY & RESEARCH	
PURPOSE: To collect data regarding populations impacted, inventorying current policies, practices and workflows that support related work internally and in the community, and understanding the local and national landscape to identify best and emerging practices.	

Social Determinants of Health:
Financial Stability
Food Security
Healthy Housing
	• Children's Nebraska devoted 1.75 FTE to Impact Area coordination in the areas of Social Determinants of Health.
	• Promising practice research was completed describing the work in the Social Determinants of Health by peer hospitals, community organizations and best practice. 34 Promising Options were identified.
	  ○ Promising Options were then narrowed through bidirectional planning with key internal and external stakeholders including:
	  ▪ 24 external organizations,
	  ▪ 63 Children's team members from 43 departments.
	  ○ Additional learning was conducted with 6 peer hospitals and 18 community organizations.
	  ○ Following these conversations Promising Options were narrowed to seven and Lean Business Plans were developed detailing the Promising Options.
	  ○ Plans were socialized and introduced to multiple internal stakeholders to build capacity to move toward implementation.
	• An internal anonymous social needs survey was conducted with Children's team members to identify what resources Children's should investigate making available to team members to address their social needs.

Pediatric Mental Wellness	• **Assessed Need to Inform Programming:**
	  ○ 80+ Nebraska secondary students were surveyed to help identify a need for the CALM Project - a program connecting health care providers and schools to empower teens to get the mental health help and support they need.
	  ○ Over 330 school social workers and counselors were surveyed to identify their most prevalent needs in addressing the social, emotional and behavioral health needs of Nebraska students.
	• **Caring Contacts: An Emerging Practice Established**
	  ○ Children's launched Caring Contacts in 2020, and provides hand-written notes to children being seen in the Emergency Department for suicidal ideation. Since its launch, nearly 1000 children and youth have been enrolled.
	  ○ The program has been peer reviewed and published with the following findings:
	  ▪ Only 7% of those enrolled experience repeat incidence of suicide ideation or gesture – compared to 27% among this population nationally.
	  ▪ Staff Social Worker retention has increased.
	  ▪ No patient deaths of enrolled patients to-date.

EDUCATION & TRAINING

PURPOSE: Evaluating staff awareness, knowledge and sensitivity to each Impact area, and identifying education and training opportunities and modes for delivery.

Social Determinants of Health: Financial Stability Food Security Healthy Housing	• Conducted 10 Community Learning tours taking Children's Nebraska team members to visit 21 organizations working to address the Social Determinants of Health in our community to increase team member awareness of resources in the community and challenges faced by those we serve. ○ Events were attended by 86 attendees. • Children's Nebraska's Paid Volunteer Time Off program – BeInvolved was launched in Summer 2022. Over 4,300 volunteer hours have been completed by Children's team members since program inception. • The Community Health & Advocacy team completed Health Equity training through the Racial Equity Institute.

Pediatric Mental Wellness	• **Educating Professionals:**
	  ○ COPE Program:
	  ▪ 94 Primary Care Providers each completed 20 hours of training in the management of mild to moderate mental health conditions within their patients.
	  ▪ 1,927 CMEs awarded to through COPE's training programs.
	  ○ Neurosequential Training for Schools: Teamed up with ESU10 and the Neurosequential Network to fund the Neurosequential Model in Education Bootcamp training for 2 School-based mental health therapists serving the ESU 10 educational region.

	• **Zero Suicide Framework:** Following completion of the first 18-month of a learning collaborative, the Zero Suicide principles were fully socialized throughout the organization. Significant progress was made regarding implementation and operationalization including:
	  ○ Standardized language and description to better identify and support youth experiencing suicide ideation.
	  ○ Enhanced screening and protocols aligning with evidence-based practices and made all tool widely available.
	  ○ Expanded data collection to better identify and monitor children experiencing depression, anxiety and suicide ideation.
	  ○ Provided additional training for all Social Workers, and adjusted roles, placement and FTE to meet need.
	• **Trauma Informed Care Training**
	  ○ Provided training to over 300 staff including nursing leadership on the Trauma Informed Care framework with practical application to health care.

ADVOCACY

PURPOSE: Assessing current and proposed policies and legislation impacting each Impact Area, and identifying key partners and champions for the work.

Social Determinants of Health:
Financial Stability
Food Security
Healthy Housing
	• In 2022, Community Program Contributions were made to 13 community organizations working in our Impact Areas.
	  ○ 5 Financial Stability Organizations
	  ○ 3 Food Security Organizations
	  ○ 4 Healthy Housing Organizations
	  ○ 2 Pediatric Mental Wellness Organizations
	• Additional Community Program Contributions will be made year-end 2024.
	• 10 Community Impact Grants were awarded to community organizations in July 2023 to fund projects addressing Children's Impact Areas.
	• Implementation work began on three strategies:
	  ○ Child Care Survey was initiated and disseminated to Children's Nebraska team members to understand our workforce's need and barriers in the area of child care. Over 380 responses were gathered.
	  ○ An internal group of stakeholders was convened, and a Healthy Housing Physician Champion was named in partnership with the Mid-American Pediatric Environmental Health Specialty Unit (MAPEHSU).
	  ○ Children's Board Placement project was launched aiming at preparing team members for placement on a community Board and assisting with placement.
	• An internal Health Equity Steering Committee was formed and includes a Community Health Equity Workgroup led by Community Health & Advocacy.
	• Partnered with Nebraska Medicine/UNMC to host a Food Resource Fair held in Spring 2024 at the new Community Wellness Center.

	• A partnership with Habitat for Humanity Omaha was established to provide education and case management for Children's team members to become mortgage ready. 13 Children's team members have completed the program. • Beginning in Summer 2024 financial literacy courses were provided to Children's team members through a partnership with Bridges Out of Poverty. 6 Children's team members have completed the program.

Pediatric Mental Wellness	• **Increasing Access to Care & Capacity:** With the help of ARPA funding and support of the Nebraska Legislature:
	  ○ Children's Nebraska announced the opening of the Behavioral Health & Wellness Center, broke ground, and is scheduled to open in 2026.
	  ○ The Behavioral Health Urgent Care was opened in Kearney, Nebraska in July 2024 – providing walk-in services for children and families in crisis.
	• **Strengthening School Mental Health Programs & Services:**
	  ○ Collaborated with the Nebraska Department of Education to increase school mental Health infrastructure by facilitating Tier 2 evidence-based school-based group intervention training for school social workers, counselors, psychologists, and other school mental health service providers. Approximately 100 school-based staff from across the state were trained to facilitate these interventions with students. Trainings were conducted for the following interventions: STRONG for Schools (Supporting Transition Resilience of Newcomer Groups) Cognitive Behavioral Intervention for Schools (CBITS), Bounce Back and Supporting Students Exposed to Trauma (SSET).
	  ○ Partnered with the School Social Work Association of NE (SSWAN) and the Nebraska School Counselor Association to increase membership and support school mental health training and professional development opportunities. Free memberships for 25 new members of each association were offered through the partnership.
	• **Caring Contacts Replication Kits:** Caring Contacts, a program that provides hand-written notes to kids seen in the Emergency Department and experiencing suicidal ideation over 1-year following their discharge. Replication kits were created and have shared with over 50 other healthcare systems nationally.
	• **Reaching Underserved Students:**
	  ○ Partnered with the Northeast Nebraska Public Health Department and Nebraska Department of Education to sponsor the 2023 Nebraska Native Youth Gathering (NNYG) which is designed to engage 8th-12th grade students, who identify as Nebraska American Indian youth. This annual gathering aims to enhance the individual and collective understanding of spiritual, emotional, mental, and physical well-being. In 2023, there were approximately 240 Native students in attendance representing 12 School Districts across the state. 2024 saw an increase with 435 participants from over 25 school buildings across Nebraska.
	  ○ In preparation for 2024 Pediatric Community Health Needs Assessment, facilitate focus group discussions with underrepresented populations to ensure their health needs were identified and included. Focus groups included parents/caregivers of foster youth, immigrant/refugee families and children/youth identifying as LGBTQ+.

SUGGESTED CITATION:
Professional Research Consultants. (2024). (rep.). *2024 Child & Adolescent Community Health Needs Assessment: Douglas, Sarpy & Cass Counties, Nebraska, Pottawattamie County, Iowa*. Omaha, NE.

WRITTEN COMMENTS
We welcome comments and feedback on this report. For questions, comments, opportunities for partnership or to request data, send an email to community@childrensnebraska.org.

ELECTRONIC ACCESS:
Children's Nebraska:
https://childrensnebraska.org/CHNA

Douglas County Health Department:
https://www.douglascountyhealth.com/community-health-needs-assessment

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