CHI Health
A member of CommonSpirit

Community Health Needs Assessment

CHI Health Mercy – Council Bluffs, IA

Adopted April 2025

CHI Health Mercy Council Bluffs Community Health Needs Assessment

Table of Contents

Executive Summary

CHNA Purpose Statement

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by CHI Health Mercy Council Bluffs. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment and Mission Statement

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community health program activities is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

CHI Health Overview

CHI Health is a regional health network consisting of 28 hospitals and two stand-alone behavioral health facilities in Nebraska, North Dakota, Minnesota and Western Iowa. Our mission calls us to create healthier communities and we know that the health of a community is impacted beyond the services provided within our wall. This is why we are compelled, beyond providing excellent health care, to work with neighbors, leaders and partner organizations to improve community health. The following community health needs assessment (CHNA) was completed with our community partners and residents in order to ensure we identify the top health needs impacting our community, leverage resources to improve these health needs, and drive impactful work through evidence-informed strategies.

CHI Health Mercy Council Bluffs Overview

CHI Health Mercy Council Bluffs, located in Council Bluffs, Iowa, was founded in 1887 by the Sisters of Mercy and became part of the Alegent Health healthcare system in 1996. In 2014 the Alegent Health system completed a merger to create the market- based organization, CHI Health under the Catholic Health Initiatives umbrella.

CHNA Collaborators

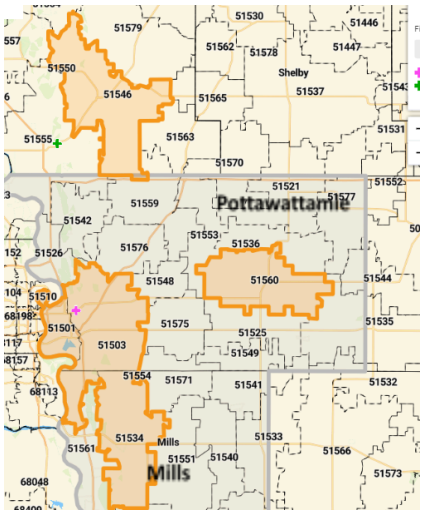
- Professional Research Consultants, Inc. (PRC)
- Mills County Public Health
- Douglas County Health Department
- Pottawattamie County Public Health
- Sarpy/Cass Health Department
- Nebraska Medicine
- Methodist Health System
- Charles Drew Health Center, Inc.

- One World Community Health Centers, Inc.
- All Care Health Center
- The Wellbeing Partners

Community Definition

For the purposes of this CHNA, CHI Health Mercy Council Bluffs identified Pottawattamie and Mills Counties as the primary service area. The Omaha and Council Bluffs Metro Area is made up of four counties: Pottawattamie in Iowa, and Cass, Douglas, and Sarpy in Nebraska. The hospital's primary and secondary service area (based on inpatient and emergency department discharges) includes portions of Pottawattamie, Harrison and Mills Counties. These three counties cover 75% of patients served by CHI Health Mercy Council Bluffs. Another CHI Health entity, CHI Health Missouri Valley, is located in Harrison County, IA, and is concurrently completing a CHNA and related implementation strategy plan, therefore CHI Health Mercy Council Bluffs has selected Pottawattamie and Mills Counties as the focus for this CHNA. The following zip codes correspond to the majority of patients served by CHI Health Mercy Council Bluffs: 51501, 51503, 51534, 51510, 51560, 51555. A map of the Mercy Council Bluffs CHNA service area can be found in figure 1.

Figure 1. CHI Health Mercy Council Bluffs CHNA Service Area Map



Assessment Process and Methods

The process of identifying the community health needs in the two counties served by CHI Health Mercy Council Bluffs was accomplished by using data and community input from two separate processes: the Omaha/Council Bluffs Metro Area process, led by Professional Research Consultants and the Mills County process led by CHI Health Mercy Council Bluffs, in partnership with Mills County Public Health Department (MCPH).

The *Omaha/ Council Bluffs Metro area* process was led by Professional Research Consultants (PRC), a third-party agent contracted by local health systems (including CHI Health) and health departments to conduct the CHNA for a four-county area, including Pottawattamie County, Iowa and

Douglas, Sarpy, and Cass Counties, Nebraska. The CHNA process was composed of primary and secondary data collection and analysis including public health, vital statistics and other data; distribution and analysis of a community health and online key informant survey; and community data presentation.

The *Mills County CHNA* process led by CHI Health Mercy Council Bluffs consisted of a community engagement session including a data presentation and facilitated discussion to determine and validate the top health needs in Mills County with MCPH. The CHI Health Mercy Council Bluffs team compiled secondary data including demographic, socioeconomic, morality and health factors such as healthcare access, educational attainment, poverty, etc., from sources such as Census.gov, County Health Rankings, Centers for Disease Control, Community Commons, American Cancer Society, and the Iowa Cancer Registry.

Process and Criteria to Identify and Prioritize Significant Health Needs

CHI Health Mercy Council Bluffs identified Significant Community Health Needs through the Omaha/ Council Bluffs Metro area process process and Mills County CHNA process. In the Omaha Metro, prioritization was a multi-step process that began with review of the 14 "Areas of Opportunity" included within PRC's CHNA report through the Key Informant Survey (n=118).
In order to prioritize health needs for Mills County, CHI Health Mercy Council Bluffs presented data from the most recent community health assessment conducted by Mills County Public Health and from a review of secondary data to the Healthy Mills Coalition on December 06, 2024 and facilitated a discussion to prioritize community health needs, in alignment with MCPH's Community Health Improvement Plan, which was completed in 2023. After small group discussions were completed a large group discussion was facilitated by CHI Health Mercy Council Bluffs to identify themes, rank top needs, build consensus and vote.

List of Prioritized Health Needs

- **Access to Health Care Services:** 16.0% of Pottawattamie and 25% of Mills residents that cost prevented them from visiting a physician last year. Omaha Metro area residents reported difficulty accessing healthcare services due to cost, transportation, appointment times, and finding physicians.
- **Behavioral Health (including mental health and substance use):** 22.7% of people reported to have Fair/Poor Mental Health in the Omaha Metro Area. 32.3% are diagnosed with depression and 41.8% have symptoms of chronic depression in the Omaha Metro Area. 29% of Mills and 32.1% of Pottawattamie residents reported access to Mental Health treatment. Key informants rated substance use as a top concern with 49.0% stating it is a major problem and 46.9% stating it is a moderate problem. Access to Substance Abuse treatment was cited by 27% of Mills and 8.6% of Pottawattamie County residents as a top concern.
- **Social Determinants of Health:** Metro Area key informants rated social determinants of health as a top concern with 72.2% stating it is a major problem and 22.6% stating it is a moderate problem. A total of 24.3% of Metro Area and 31.1% of Pottawattamie residents would not be able to afford an unexpected $400 expense without going into debt. Mills residents also reported 2% housing and 16% transportation needs.

Resources Potentially Available

In addition to the services provided by CHI Health Mercy Council Bluffs, Pottawattamie and Mills Counties have a number of community assets and resources that are potentially available to address significant health needs. In terms of physical assets and features the communities have parks including Pony Creek Conservation Park, recreational facilities including the Charles E. Lakin YMCA, and museums including Mills County Historical Museum and Indian Creek Historical Society.

Report Adoption, Availability and Comments

This CHNA report was adopted by the CHI Health Board of Directors in April, 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at CHI Health Mercy Council Bluffs. Written comments on this report can be submitted via mail to CHI Health - The McAuley Fogelstrom Center (12809 W Dodge Rd, Omaha, NE 68154 attn. Healthy Communities); electronically at: https://forms.gle/KGRq62swNdQyAehX8 or by calling Ashley Carroll, Market Director, Community and Population Health, at: (402) 343-4548.

Introduction

Hospital Description

CHI Health Mercy Council Bluffs, located in Council Bluffs, Iowa, was founded in 1887 by the Sisters of Mercy and became part of the Alegent Health healthcare system in 1996. In 2014 the Alegent Health system completed a merger to create the market-based organization CHI Health under the Catholic Health Initiatives umbrella.

CHI Health Mercy Council Bluffs provides the following services:

- 3D Mammography
- Behavioral Services/Mental Health
- Cancer Care
- Heart & Vascular Institute
- Maternity
- Orthopedic Care
- Weight Management
- Women's Health

Purpose and Goals of CHNA

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by CHI Health Mercy Council Bluffs. The priorities identified in this report help to guide the hospital's community health improvement programs and

community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

CHI Health and our local hospitals make significant investments each year in our local communities to ensure we meet our Mission of creating healthier communities. A Community Health Needs Assessment (CHNA) is a critical piece of this work to ensure we are appropriately and effectively working and partnering in our communities.

The goals of this CHNA are to:

1. Identify areas of high need that impact the health and quality of life of residents in the communities served by CHI Health.

2. Ensure that resources are leveraged to improve the health of the most vulnerable members of our community and to reduce existing health disparities.

3. Set priorities and goals to improve these high need areas using evidence as a guide for decision making.

4. Ensure compliance with section 501(r) of the Internal Revenue Code for not-for-profit hospitals under the requirements of the Affordable Care Act.

Collaborative Assessment

A community health needs assessment was conducted to cover Douglas, Sarpy, Cass, and Pottawattamie Counties on behalf of the six Omaha/ Council Bluffs Metro CHI Health hospitals (CUMC Bergan Mercy, Immanuel, Lakeside, Mercy Council Bluffs, and Midlands, psychiatric inpatient facility - Lasting Hope Recovery Center, and joint venture specialty hospital, Nebraska Spine Hospital), in partnership with the Health Departments of Douglas and Sarpy/Cass Counties in Nebraska and Pottawattamie County in Iowa, and other local health systems to satisfy regulatory compliance. The process and findings from that assessment are described in this report. Additionally, CHI Health Mercy Council Bluffs led an independent assessment for Mills County (part of the hospital's primary service area), in partnership with Mills County Public Health (MCPH).

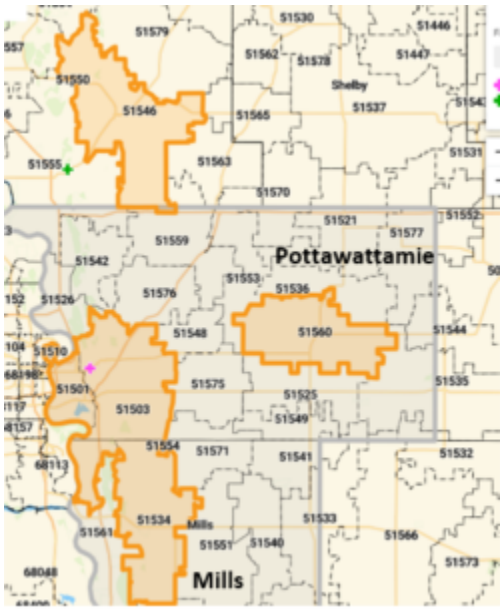
Community Definition

Community Definition

CHI Health Mercy Council Bluffs identified Pottawattamie and Mills Counties as their primary service area for the CHNA. The following zip codes correspond to 80% of patient admissions (51534, 51510, 51560, 51555) as the primary service area. The Omaha and Council Bluffs Metro Area is made up of four counties: Pottawattamie in Iowa, and Cass, Douglas, and Sarpy in Nebraska. The hospital’s primary and secondary service area includes portions of Pottawattamie, Harrison and Mills

Mills Counties. These three counties cover between 75% - 90% of patients served by CHI Health Mercy Council Bluffs. Another CHI Health entity, CHI Health Missouri Valley, is located in Harrison County, IA, and is concurrently completing a CHNA and related implementation strategy, therefore CHI Health Mercy Council Bluffs has selected Pottawattamie and Mills Counties as the focus for this CHNA. Service area map can be found in Figure 1.

Figure 1. CHI Health Mercy-Council Bluffs Service Area Map



Community Description

CHI Health Mercy Council Bluffs is located in Council Bluffs, Iowa, on the western edge of Pottawattamie County, IA bordering the major metropolitan area of Omaha, NE to the west. Pottawattamie County covers approximately 950 square miles with 93,529 residents. Council Bluffs is primarily a metropolitan area and makes up 67% of the Pottawattamie County population while the remaining communities are more rural in nature. There are 14 towns in Pottawattamie County, outside of Council Bluffs: Avoca, Carson, Carter Lake, Crescent, Hancock, Macedonia, McClelland, Minden, Neola, Oakland, Shelby, Treynor, Underwood and Walnut. There are seven incorporated towns in Mills County: Emerson, Glenwood, Hastings, Henderson, Malvern, Pacific Junction, Silver City and a portion of Tabor lies within the County border.

Population

Table 1 below describes the population for Pottawattamie and Mills Counties, Council Bluffs, Iowa and the U.S. The data show a primarily Non-Hispanic White population, however Pottawattamie County also has a slightly higher Hispanic population than Mills County and the State of Iowa. The estimated Hispanic population in Pottawattamie County as of 2022 is 8.70%.

Table 1. Community Demographics

	Council Bluffs	Pottawattamie	Mills	Iowa	United States
Total Population	62,799	93,543	14,605	3,190,369	331,449,281
Population per square mile (density)	1,518.80	98	33	54.5	87.4
Total Land Area (sq. miles)	40.97	951.27	437.43	55,857.13	3,531,905.43
Rural vs. Urban	—	Urban (26.93% live in rural)	Rural 65.42% live in rural)	Urban (35.98% live in rural)	Urban (12.6% live in rural)
Age[3]					
% below 18 years of age	22.8%	23.19%	23%	23%	22.3%
% 65 and older	15.9%	18.36%	19.86%	17.5%	80.89%
Gender[3]					
% Female	50.8%	50.7%	49.7%	50.2%	50.8%
Race[3]					
% White alone	91.1%	88.97%	94.36%	90.6%	76.3%
% Black or African American alone	2.5%	1.83%	0.38%	4.1%	13.4%
% American Indian and Alaskan Native alone	0.5%	0.27%	0.12%	0.5%	1.3%
% Asian alone	1%	0.93%	0.43%	2.7%	5.9%
% Native Hawaiian/Other Pacific Islander alone	0%	0.1%	0.1%	0.2%	0.2%
% Two or More Races	2.1%	2%	1.2%	2%	2.8%
% Hispanic or Latino	10.2%	8.70%	3.61%	6.3%	18.5%
% White alone, not Hispanic or Latino	84.1%	87.3%	93.8%	85%	60.1%

Socioeconomic Factors

Table 2 shows key socioeconomic factors known to influence health including household income, poverty, unemployment rates and educational attainment for the community served by the hospital. Pottawattamie County has a lower graduation rate (high school and bachelor's degree or higher) than both Mills County and the State of Iowa. While poverty rates in both counties are lower than the state of Iowa, child poverty rates in Pottawattamie County are comparable to the state.

Table 2: Socioeconomic Factors

	Pottawattamie	Mills	Iowa	United States
Income Rates				
Median Household Income	$87,810	$71,446	$60,523	$62,843
Poverty Rates				
Persons in Poverty	11.6%	7.2%	10.2%	11.4%
Children in Poverty	14.52%	5.44%	13.79%	18.52%
Employment Rate				
Unemployment Rate	2.9	3.3	2.9	3.7
Education/Graduation Rates				
High School Graduation Rate	91.2%	96.8%	91.4%	87.7%
% of people with less than a HS diploma	12.9%	10.3%	10.5%	11.8%
% of people 5 years and older who are non-English speaking	2.91%	0.58%	3.61%	8.39%
% of Population Age 25+ with Bachelor's Degree or Higher	23.40%	30.50%	28.57%	32.15%
Insurance Coverage				
% of Persons without Health Insurance (under 65)	7.27%	3.97%	6%	10.2%
% of Uninsured Children (under the age of 18)	2.24%	1.68%	2.98%	5.08%
% of people with Medicaid	18.9%	9.7%	20.6%	18.9%

Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA)

Pottawattamie County has four designated Health Professional Shortage Areas (HPSA) including primary care, dental health, mental health disciplines. The four designated HPSA's in Pottawattamie County have scores that range from nine to 23 (17 median score), where the score range is 0-26 (the higher the score, the greater the priority). Mills County has no HPSA designations. Pottawattamie County has one designated Medically Underserved Area with a score of 50.9 where the lowest score (highest need) is zero; the highest score (lowest need) is 100.

Unique Community Characteristics

Aside from the City of Council Bluffs, these two counties are primarily rural, with large portions of agricultural land. Both counties are situated along Interstate 29 and have access to Interstate 80, offering a strong transportation infrastructure. Gaming is also a primary industry in Council Bluffs with three hotel casinos that offer various forms of entertainment and gambling. From this industry grew the Iowa West Foundation which seeks proposals for funding around economic development and healthy families.

In addition to the institutions of higher education located in Omaha (University of Nebraska Omaha, University of Nebraska Medical Center, Creighton University, Nebraska Methodist College, Clarkson College, College of St. Mary, Metro Community College and Bellevue University in Bellevue), Council Bluffs is home to Iowa Western Community College (IWCC).

Other Health Services

Health systems in the area that serve the communities of Pottawattamie and Mills Counties are listed below and a full list of resources within the community can be found in the Appendix A.

- All Care Health Center (Federally Qualified Health Center)
- Charles Drew Health Centers (Federally Qualified Health Center)
- Children's Hospital and Children's Physicians Network
- CHI Health Clinics
- Dimensions, Inc.
- Family Connections Counseling, Glenwood
- Fred LeRoy Health & Wellness Center
- Glenwood Douglas County Health Department (DCHD)
- Methodist Health System, including Methodist Jennie Edmundson hospital located in Council Bluffs
- Mills County Public Health Agency (MCPH)
- Nebraska Medicine/University of Nebraska Medical Center
- One World Health Centers (Federally Qualified Health Center)
- Pottawattamie County Public Health Division (PCPH)
- Psychiatric Medical Institute for Children (PMIC) (Operated by CHI Health), Glenwood
- Sarpy/Cass Department of Health & Wellness
- VA Nebraska – Western Iowa Health Care System

Community Health Needs Assessment Process and Methods

The process of identifying the community health needs in the two counties served by CHI Health Mercy Council Bluffs was accomplished by using data and community input from two separate processes: the Omaha/Council Bluffs Metro Area process, led by Professional Research Consultants and the Mills County process led by CHI Health Mercy Council Bluffs.

Omaha Metro Area CHNA

Professional Research Consultants (PRC) is a third-party agent contracted by local health systems (including CHI Health) and health departments to conduct the CHNA for a four-County area, including Pottawattamie County, Iowa and Douglas, Sarpy, and Cass Counties, Nebraska. PRC is a nationally recognized healthcare consulting firm with extensive experience conducting CHNAs across the United States since 1994. Along with the local health departments and several other community stakeholders, CHI Health was an active key partner working with PRC in planning and designing the CHNA process; identifying key informants to complete the online Key Informant survey; analysis and interpretation of survey findings. The Executive Summary from the PRC Report can be found in the Appendix A.

Methodology

Public Health, Vital Statistics & Other Data
A comprehensive examination of existing secondary data was completed during the CHNA process for the Omaha/Council Bluffs Metro Area by PRC at the direction of the Douglas County Health Department, Sarpy/ Cass Department of Health and Wellness, Pottawattamie County Public Health Department and sponsoring health care organizations. A list of utilized sources can be found in the PRC complete report in the Appendix A. In order to analyze data and determine priorities, standardized data was used for benchmarking, where appropriate. This was accomplished by reviewing trend data provided by PRC from previous Community Health Needs Assessments, Nebraska and Iowa Risk Factor Data, Nationwide Risk Factor Data, and Healthy People 2030.

Community Health Survey
Based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), along with other public health surveys, and customized to address gaps in indicator data relative to health promotion, disease prevention objectives and other recognized health issues, the PRC Community Health Survey was developed by the sponsoring organizations and PRC. The survey was kept similar to a previous survey used in the region, in 2011, 2015, and 2018, and 2021 to allow for trend analysis.

Sponsoring coalition members included:

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

Supporting organizations include:

- All Care Health Center
- Charles Drew Health Center
- One World Community Health Centers, Inc.
- The Wellbeing Partners

The PRC Community Health Survey was conducted via mixed mode methodology, including a telephone survey which incorporated both landline and cell phone interviews, as well as through online questionnaires, and utilized a stratified random sample of individuals age 18 and over across the Metro Area. The sample design consisted of a total of 3651 individuals aged 18 and older in the Metro Area, 583 of which were from Pottawattamie County.

Once completed, results were weighted in proportion to actual population distribution to accurately represent the four County areas. For further information on rates of error, bias minimizations, and sampling process, please refer to the Methodology section located in the PRC report Appendix A.

Online Key Informant Survey

Participants in the Key Informant Survey were individuals who have a broad interest in the health of the community and identified through the sponsoring organizations. The list included physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders who the sponsors felt were able to identify primary concerns within the populations they serve, as well as the community as a whole. Key Informants were contacted via email to introduce the purpose of the survey and were provided a link to complete the survey online. Reminder emails were sent as needed to increase participation. A total of 118 key informants completed the survey. A breakdown of Key Informants can be found in Table 4.

Table 4: Key Informant Participants for PRC CHNA

Online Key Informant Survey Participation	
Key Informant Type	**Number Participated**
Physician	22
Social Services Provider	21
Public Health Representative	4
Other Health Providers	42
Business Leader	12
Other Community Leader	17
Total	**118**

A detailed list of participating stakeholders can be viewed in the PRC Report> Project Summary> Online Key Informant Survey.

Mills County CHNA Process

In order to assess the needs of Mills County, the team at CHI Health Mercy Council Bluffs led a data review and input session on December 6, 2024 at the Healthy Mills Coalition in collaboration with Mills County Public Health (MCPH). As the public health entity for Mills County, MCPH is based out of Glenwood Iowa, and as public health entities are required to complete the CHNA process every five years.

On December 06, 2024 and facilitated a discussion to prioritize community health needs, in alignment with MCPH's Community Health Improvement Plan,which was completed in 2023. After small group discussions were completed a large group discussion was facilitated by CHI Health Mercy Council Bluffs to identify themes, rank top needs, build consensus and vote. The CHI Health Mercy Council Bluffs team compiled secondary data including demographic, socioeconomic, morality and health factors such as healthcare access, educational attainment, poverty, etc. from sources such as Census.gov, County Health

Rankings, Centers for Disease Control, Community Commons, American Cancer Society, and the Iowa Cancer Registry.

Stakeholders in attendance at the community engagement session at the Healthy Mills Coalition meeting represented those who serve **minority**, **at-risk**, **uninsured**, and **aging populations**, as well as **those affected by violence**. Participating agencies included:

- Mills County Public Health
- Mills County Extension
- Heartland Family Service
- Family, Inc.
- Firefly
- Catholic Charities
- Alzheimer's Association
- State of Iowa Tobacco Program
- Financial Advocate

Gaps in information

Although the CHNA is quite comprehensive, it is not possible to measure all aspects of the community's health, nor can we represent all interests of the population. Challenges exist in both counties around reliable data collection due to small sample sizes among different populations and indicators. This assessment was designed to represent a comprehensive and broad look at the health of the overall community. During specific hospital implementation planning, gaps in information will be considered and other data and input will be sought as needed.

CHI Health Mercy Council Bluffs invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received

Assessment Data and Findings

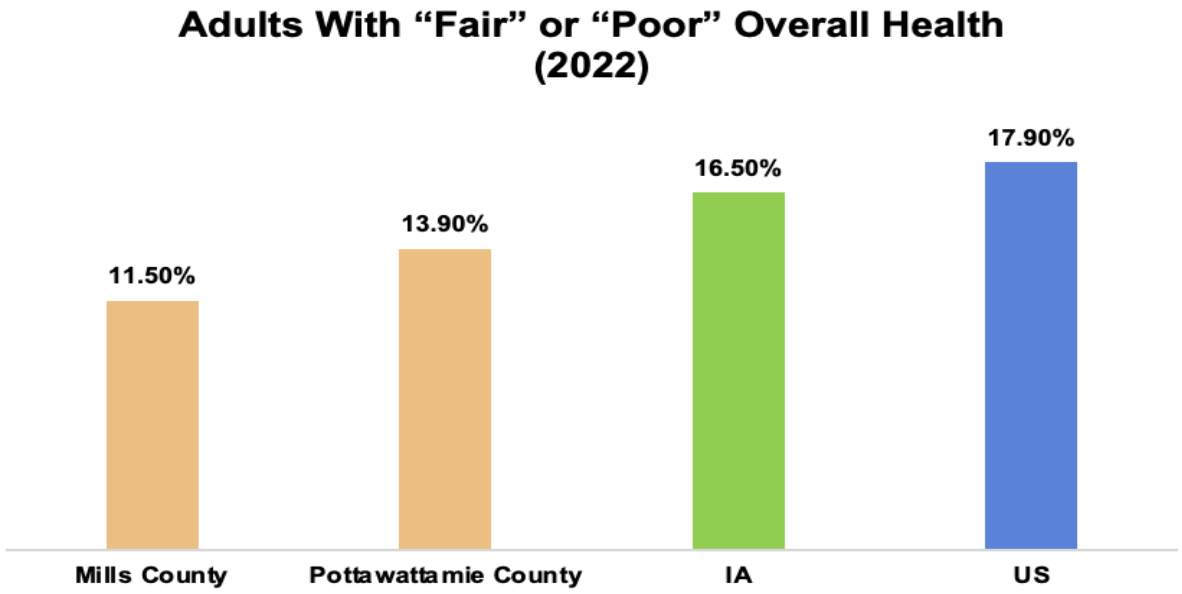
Identified Health Issues

For a complete list of community health indicators reviewed in consideration of the Community Health Needs Assessment for CHI Health Mercy Council Bluffs, please refer to the PRC report attached in Appendix A and the Mills County Data Presentation in Appendix B.

Based upon data gathered for the Mills and Pottawattamie County CHNA, the following "Areas of Opportunity" in Table 5 represent the significant health needs identified within the community of Pottawattamie and Mills Counties.

Table 5: "Areas of Opportunity" Identified by Mills and Pottawattamie County Processes

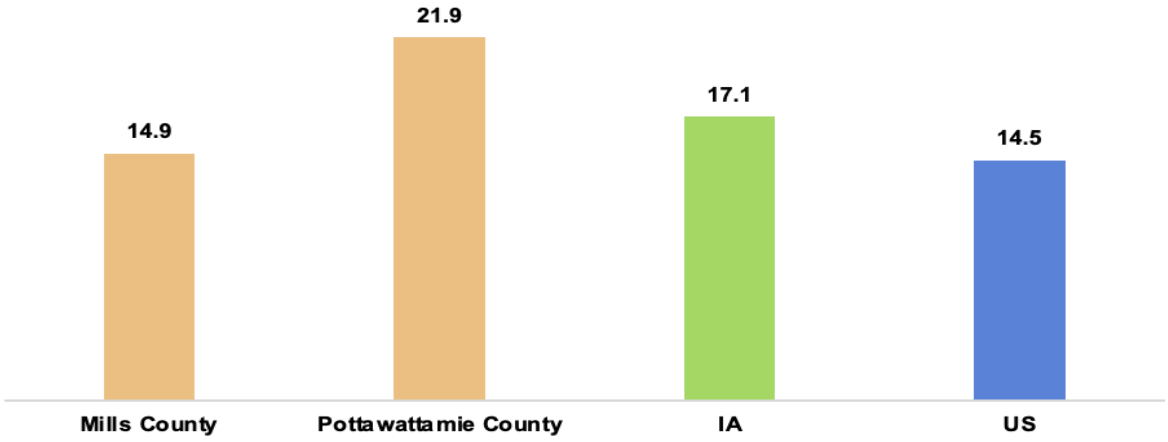
Data and Rationale for High Priority
MENTAL HEALTH



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

- 11.5% believe that their overall health is "fair" or "poor" in Mills County and 13.90% in Pottawattamie County, which is better than the national prevalence.

Suicide Age-adjusted mortality
(2018-2022 Annual Average Deaths per 100,000 Population)



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

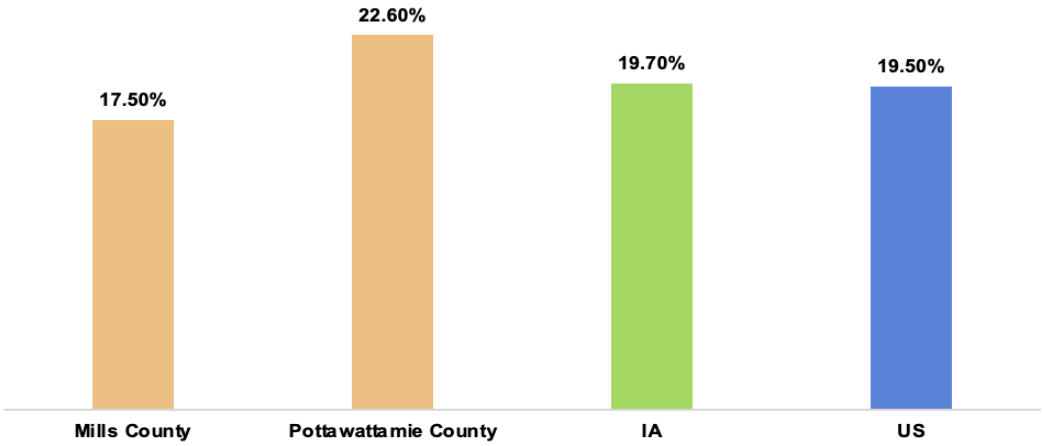
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

- The annual average age-adjusted suicide rate has increased over time in Mills County, from 13.7 from 2017- 2019 to 14.9 from 2018-2022 and 21.9 in Pottawattamie County.

- 15% of Metro Area adults have been diagnosed with a depressive disorder (such as depression, major depression, dysthymia, or minor depression. Viewed by County, the prevalence is unfavorably high in Pottawattamie County 34.40%.

NUTRITION, PHYSICAL ACTIVITY & WEIGHT

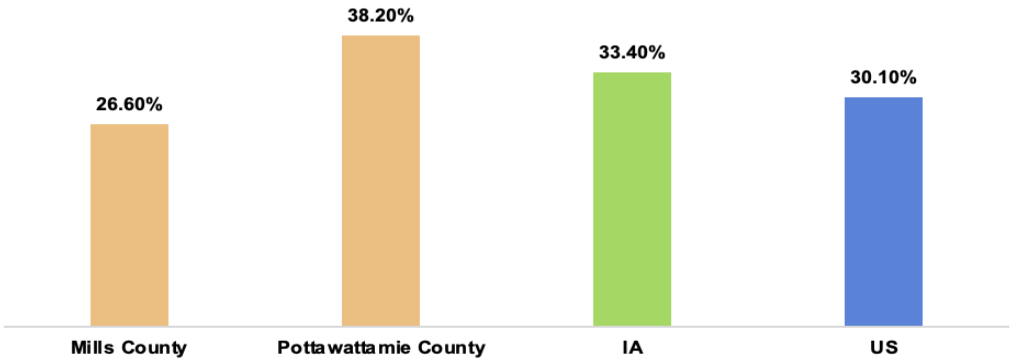
No Leisure-Time Physical Activity in the Past Month
(Among Adults Age 20+, 2021)
Healthy People 2030 = 21.8% or Lower



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

- 17.50% of Mills County and 22.60% of Pottawattamie County adults report no leisure-time physical activity in the past month.

Prevalence of Obesity
(Among Adults Age 20 and Older With a Body Mass Index ≥ 30.0, 2021)
Healthy People 2030 = 36.0% or Lower

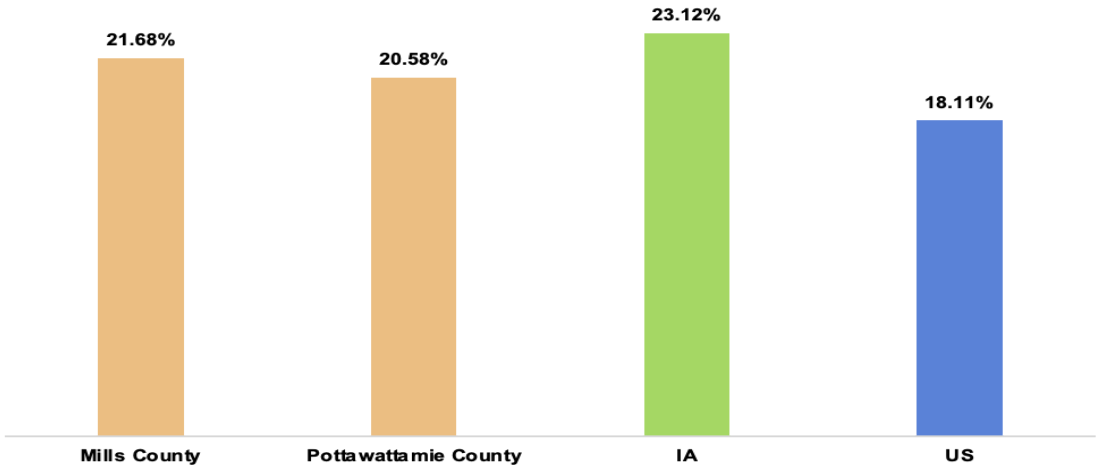


Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

- 26.60% of Mills County adults are obese (2024) which is an improvement from 2018 (39%), and well above the state and national percentages. It fails to satisfy the HP 2030 objective.

SUBSTANCE ABUSE

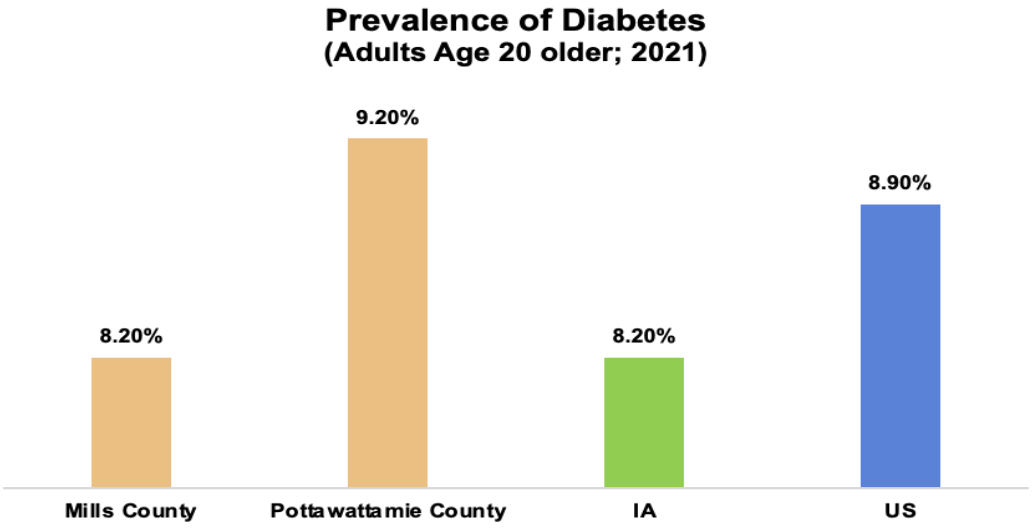


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period.

- A total of 21.68% of Mills County adults and 20.58% of Pottawattamie County adults are excessive drinkers (heavy and/or binge drinkers), worse than national percentages.

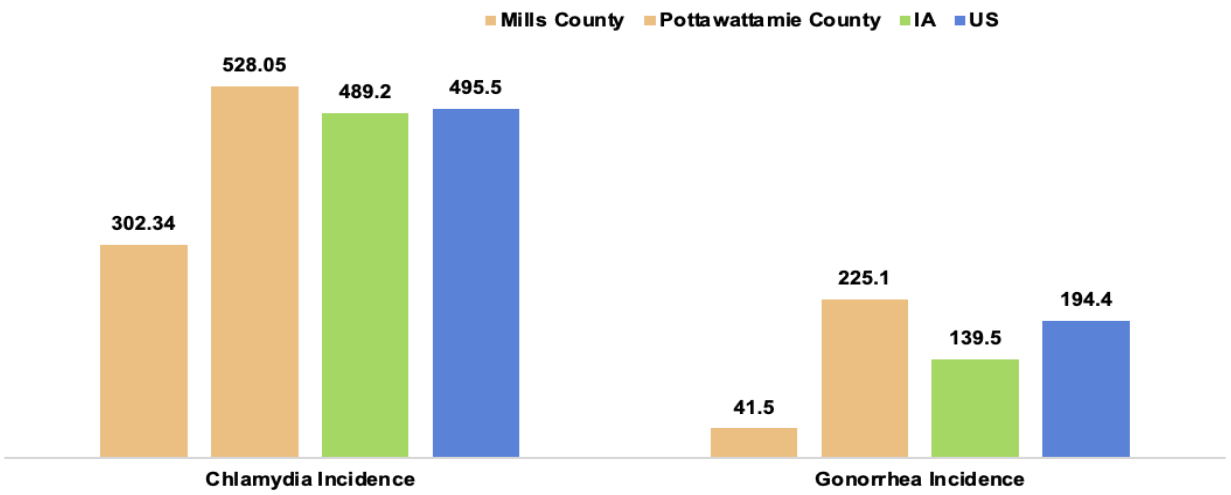
DIABETES



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

- Between 2018 and 2023, there was an annual average age-adjusted diabetes mortality rate of 24.8 deaths per 100,000 population in Mills County and 37.7 deaths per 100,000 population in Pottawattamie County.
- The prevalence of diabetes among Pottawattamie County adults age 20 and older was 9.20% followed by Mills County, 8.20%.

SEXUAL HEALTH

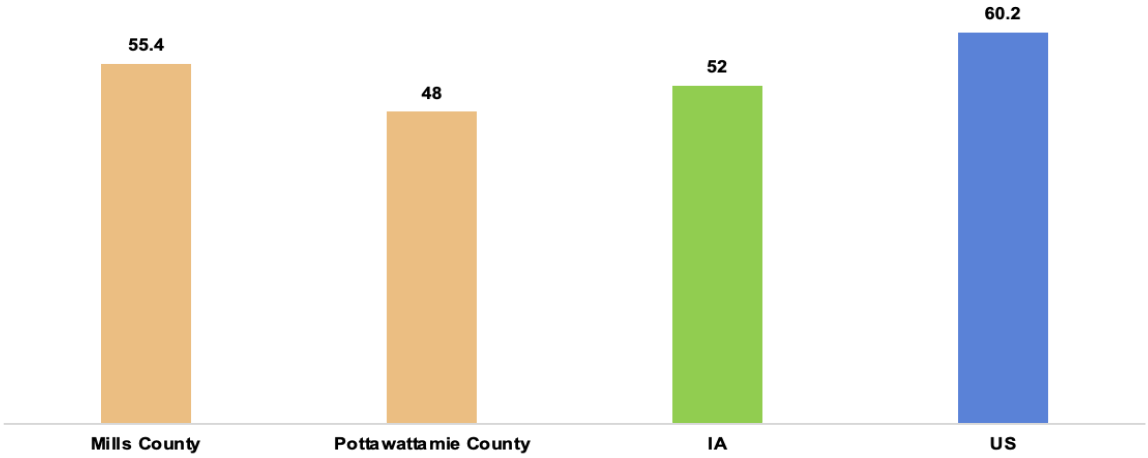


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

- In 2022, the chlamydia incidence rate in Pottawattamie County was 528.05 cases per 100,000 population, notably higher than Mills County (302.34).
- In 2022, the gonorrhea incidence rate in Pottawattamie County was 225.1 cases per 100,000 population, notably higher than Mills County (41.5).

INJURY AND VIOLENCE

Unintentional Injuries Mortality
(2018-2022 Deaths per 100,000 Population)

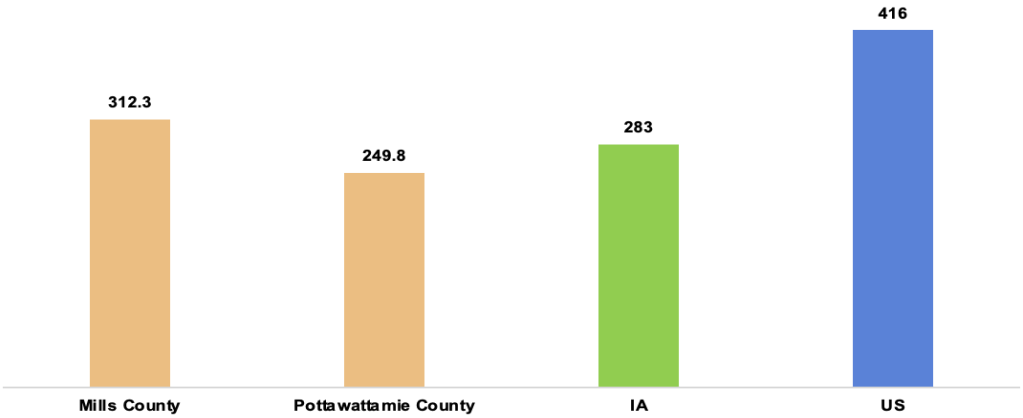


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

- Between 2018 and 2022, there was an annual average age-adjusted unintentional injury mortality rate of 55.4 deaths per 100,000 population in Mills County and 48.0 deaths per 100,000 population in Pottawattamie County.
- Unintentional injury mortality rate in these counties is lower than the Iowa and US mortality rates and satisfies the HP 2030 objective.
- The largest percentage of accidental deaths in the Omaha Metro (27.9%) followed by falls (26.9%) and poisoning/ noxious substances (25.1%). Among respondents aged 45 and old Age-adjusted homicide deaths have decreased in recent years, echoing the Nebraska trend.
- Motor vehicle accidents make up the largest percentage of accidental deaths in the Omaha Metro (27.9%) followed by falls (26.9%) and poisoning/ noxious substances (25.1%). Among respondents aged 45 and older 36.7% have experienced a fall at least once in the past year, well above the state and US percentages.

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



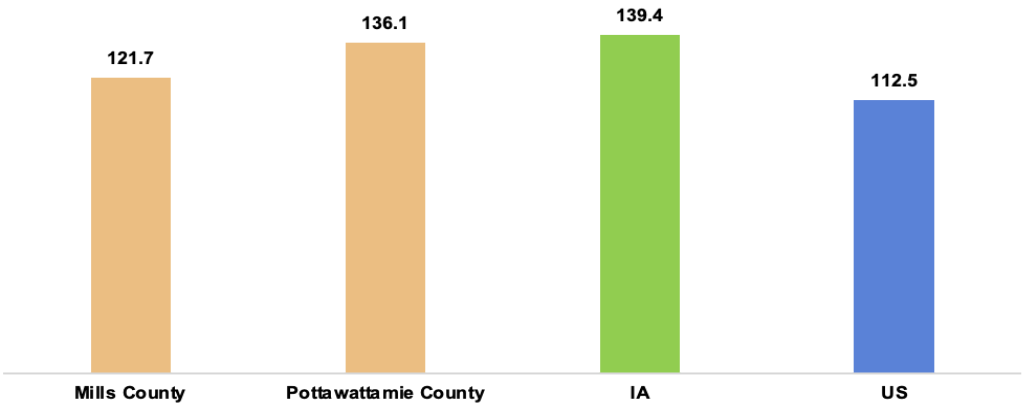
Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

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

- In the Metro Area, there were 4.0 homicides per 100,000 population (2017-2019 annual average age-adjusted rate).
- The rate of violent crime per 100,000 population was 312.3 in Mills County and 249.8 in Pottawattamie County.

HEART DISEASE & STROKE

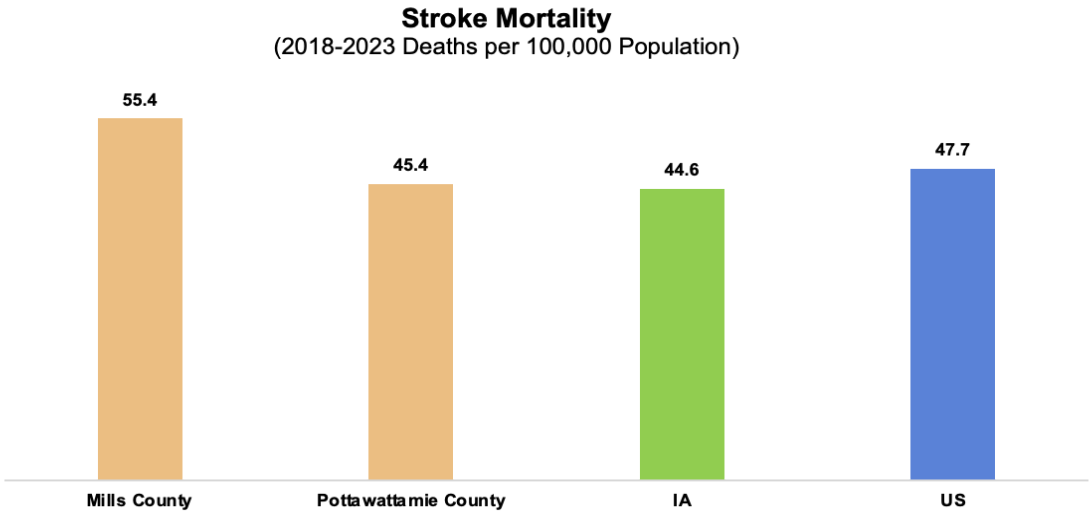
Coronary Heart Disease Mortality
(2018-2022 Deaths per 100,000 Population)



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

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

- The heart disease and stroke mortality rates have increased, between 2018 and 2022, there was an annual average age-adjusted heart disease mortality rate of 121.7 deaths per 100,000 population in Mills County and 136.1 in Pottawattamie County, well similar to Iowa and above the US death rates.

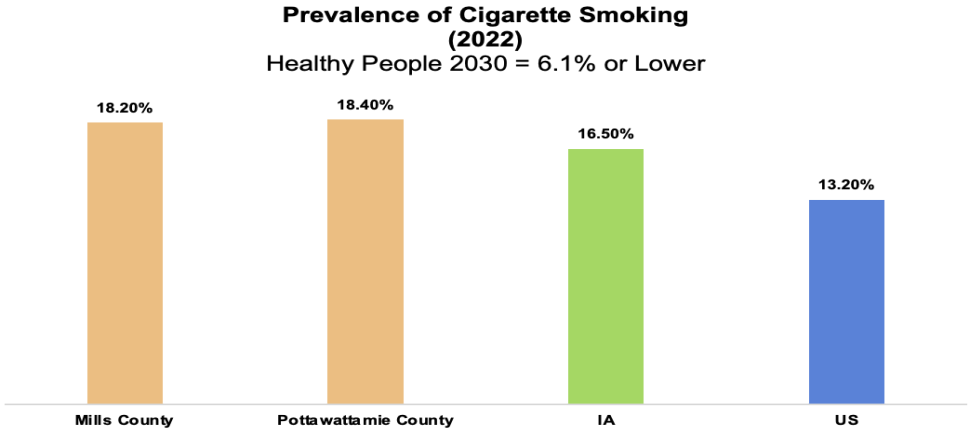


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

- Between 2018 - 2022, there was an annual average age-adjusted stroke mortality rate of 55.4 deaths per 100,000 population in Mills County increasing over time from the Iowa and US trends. The rate is 45.4 in Pottawattamie County similar to Iowa.

TOBACCO USE

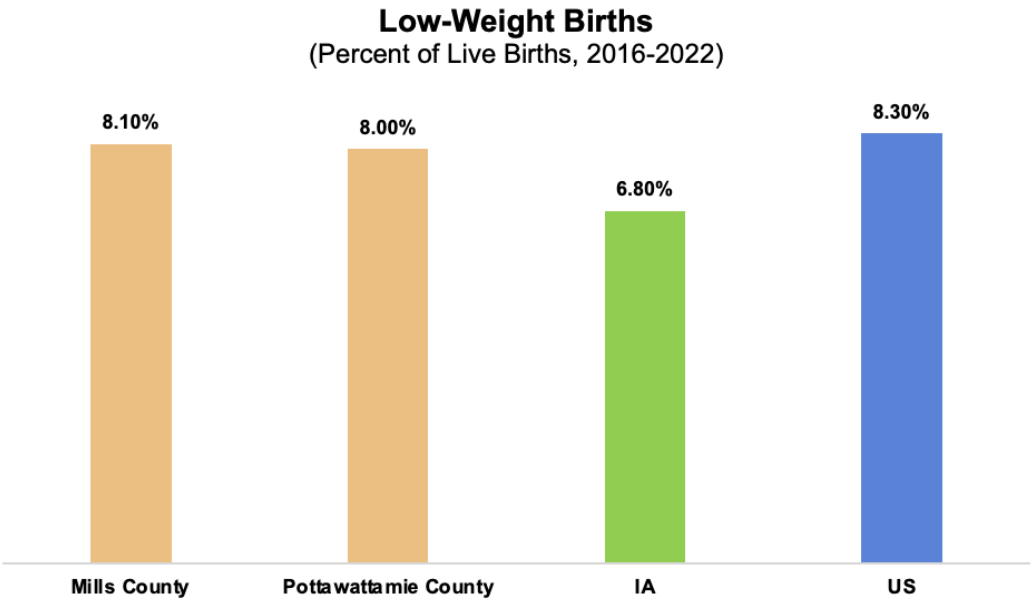


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Includes those who report having smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or on some days.

- 18.20 % of Mills County and 18.40% of Pottawattamie County adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days). The prevalence is much higher than the Iowa and US percentages and fails to satisfy the HP 2030 objective.

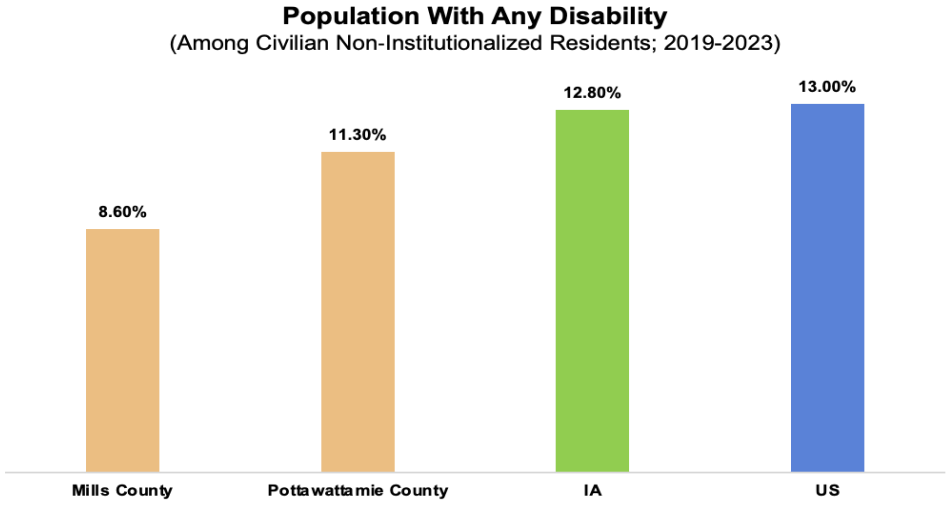
INFANT HEALTH & FAMILY PLANNING



Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

- From 2016-2022 the rate of low weight births is 8.1% in Mills County, and 8% in Pottawattamie County.
- Between 2018 and 2024, there was an annual average of 7 infant deaths per 1,000 live births in Pottawattamie County.

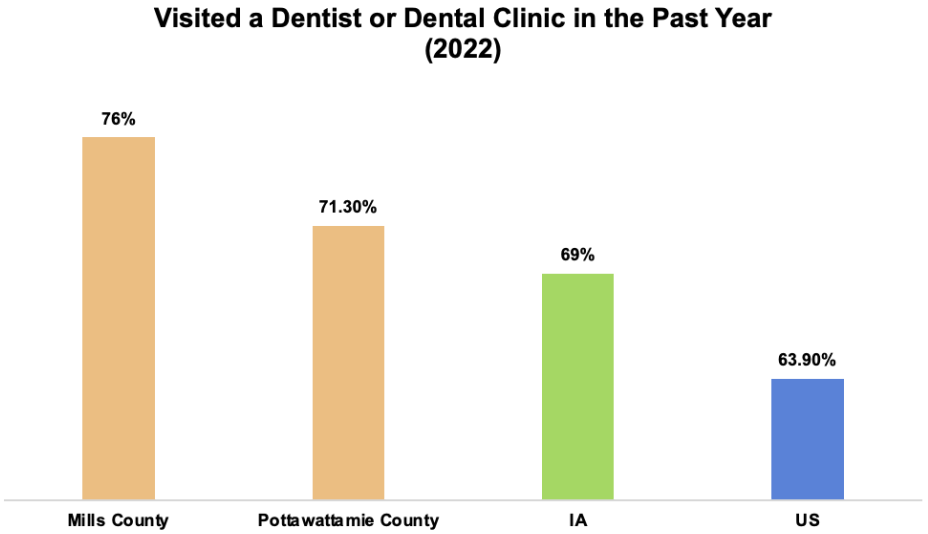
POTENTIALLY DISABLING CONDITIONS



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

- 8.6% of Mills County adults are limited in some way in some activities due to a physical, mental, or emotional problem. Unfavorably high in Pottawattamie County 11.30%.
- The Alzheimer's disease mortality rate has increased over the last decade in the Pottawattamie County from 39.7 (2018- 2020) to 38.8 (2018- 2022) to 47.7 (2018 - 2023).

ORAL HEALTH

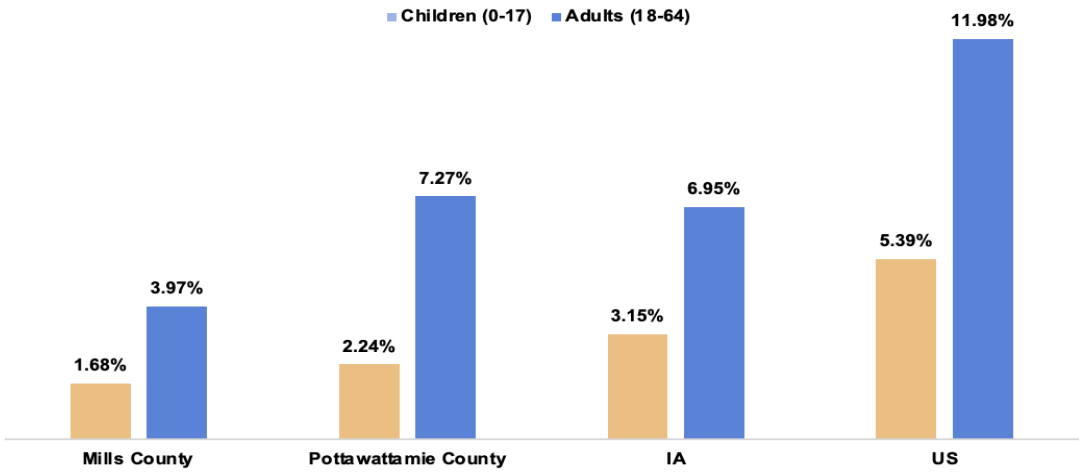


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

- A total of 76% of Mills County adults have visited a dentist or dental clinic (for any reason) in the past year, higher than both state and US percentages, compared to 71.30% of Pottawattamie County adults.

ACCESS TO HEALTHCARE SERVICES

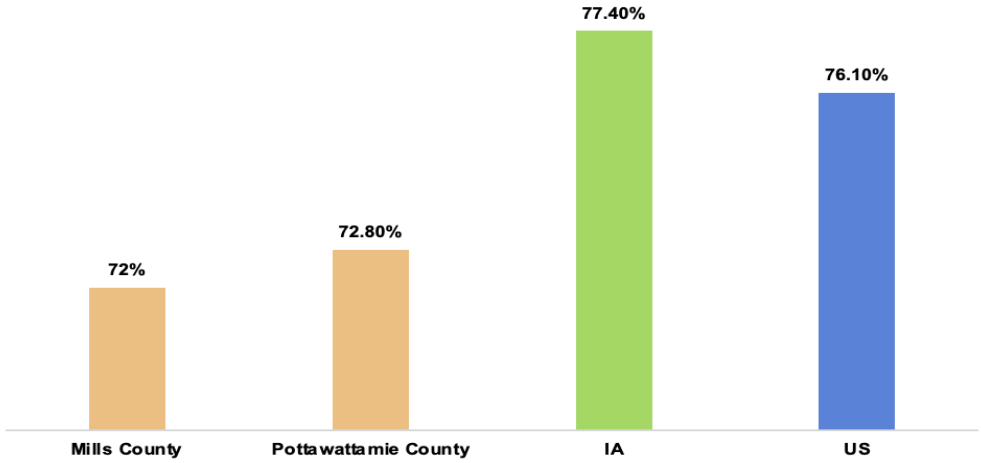
Uninsured Population (2019-2023)
Healthy People 2030 Target = 7.6%



Sources:
- US Census Bureau, American Community Survey, 2019-23,
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

- 3.97% of Mills County and 7.27% of Pottawattamie County residents [Age 18-64] had no insurance coverage for healthcare expenses.

Primary Care Visit in the Past Year (2022)

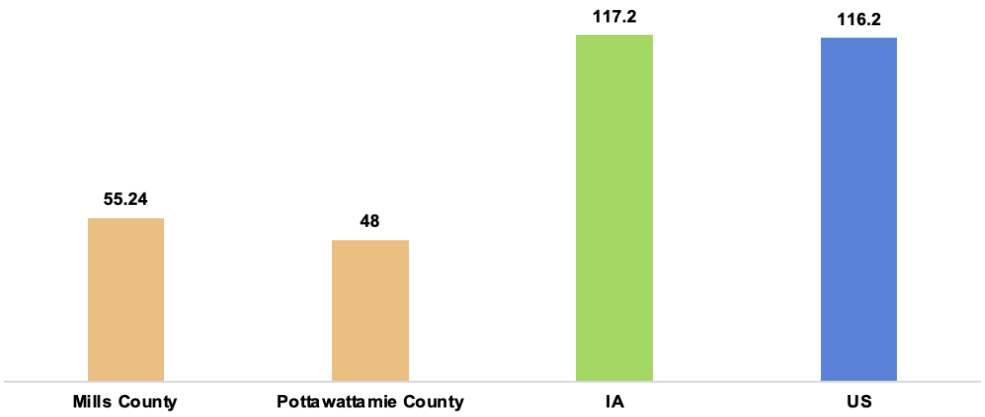


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number and percentage of adults age 18 and older with one or more visits to a doctor for routine checkup within the past one year.

- The percentage of adults who had a primary care visit in the past year (2022) in Mills County was 72% and 72.80% in Pottawattamie County.

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2024)



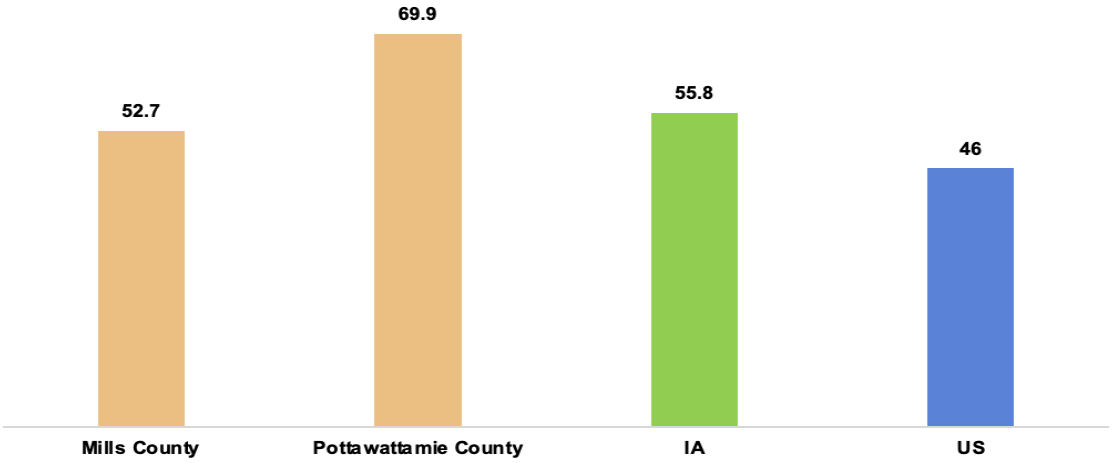
Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

- Number of primary care physicians per 100,000 population was 55.25 in Mills County and 48 in Pottawattamie County.

RESPIRATORY DISEASES

Lung Disease Mortality
(2018-2022 Deaths per 100,000 Population)

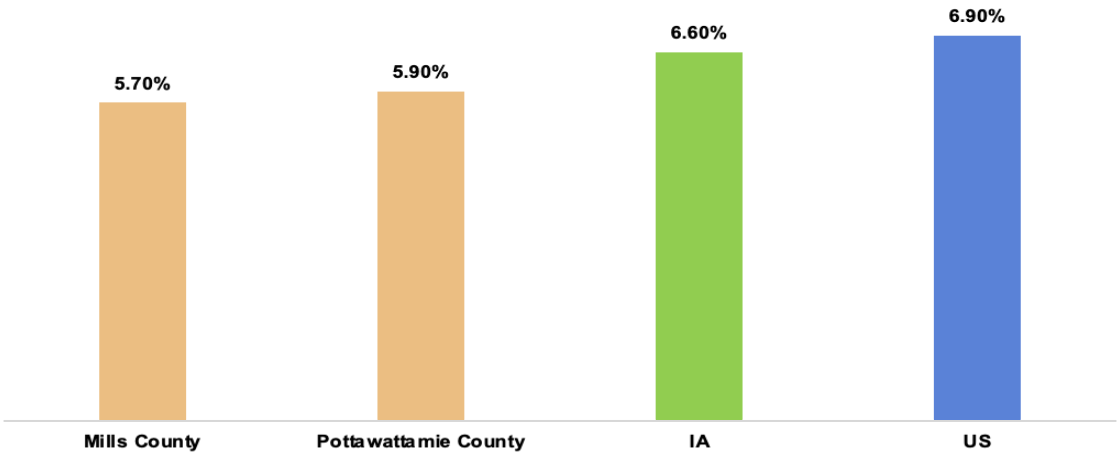


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

- Between 2018 and 2022, there was an annual average age-adjusted CLRD mortality rate of 52.7 deaths per 100,000 population in Mills County and 69.9 deaths per 100,000 population in Pottawattamie County, which is worse than the state and national mortality rate.

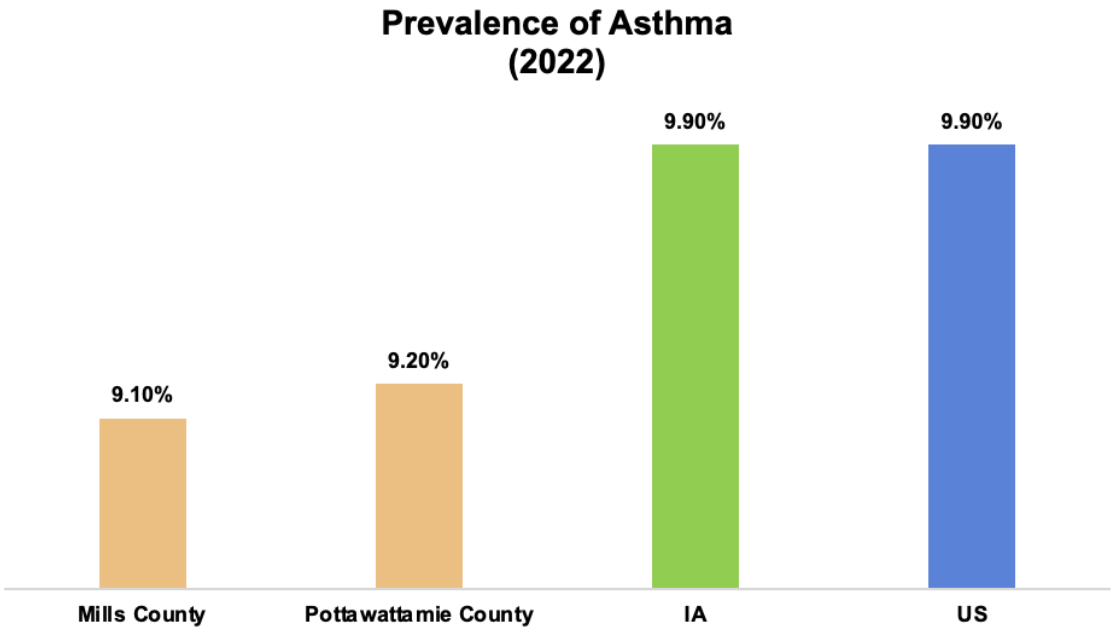
Prevalence of Chronic Obstructive Pulmonary Disease (COPD) (2022)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

- 5.70% of Mills County and 5.90% of Pottawattamie County adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

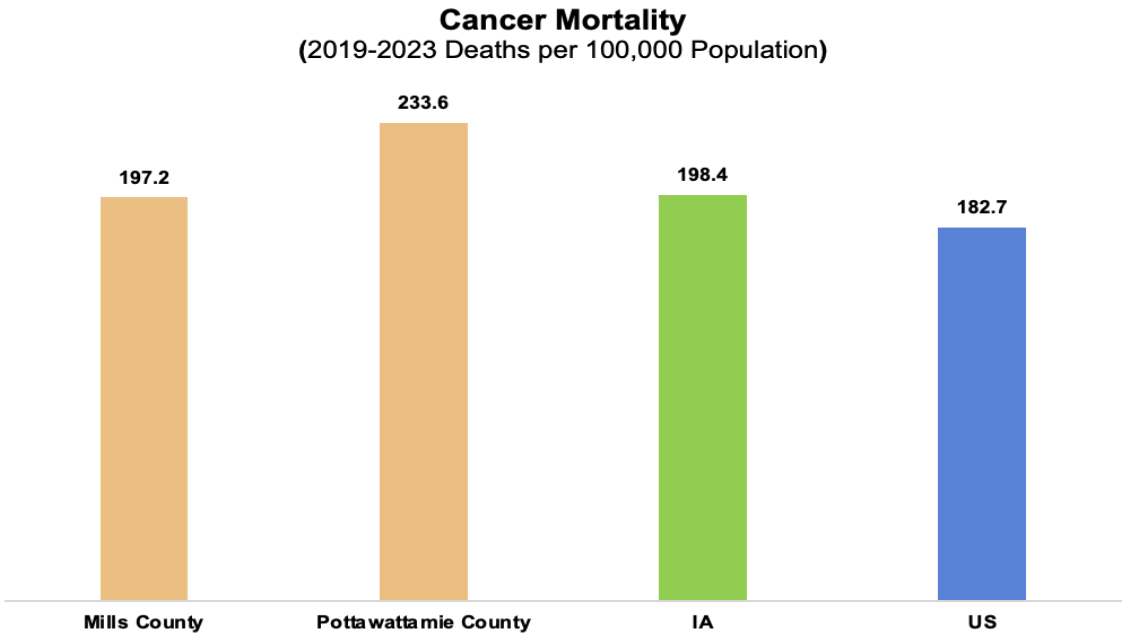


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

- 9.1% and 9.2% of adults in Mills and Pottawattamie County suffer from asthma, similar to state and national percentages.

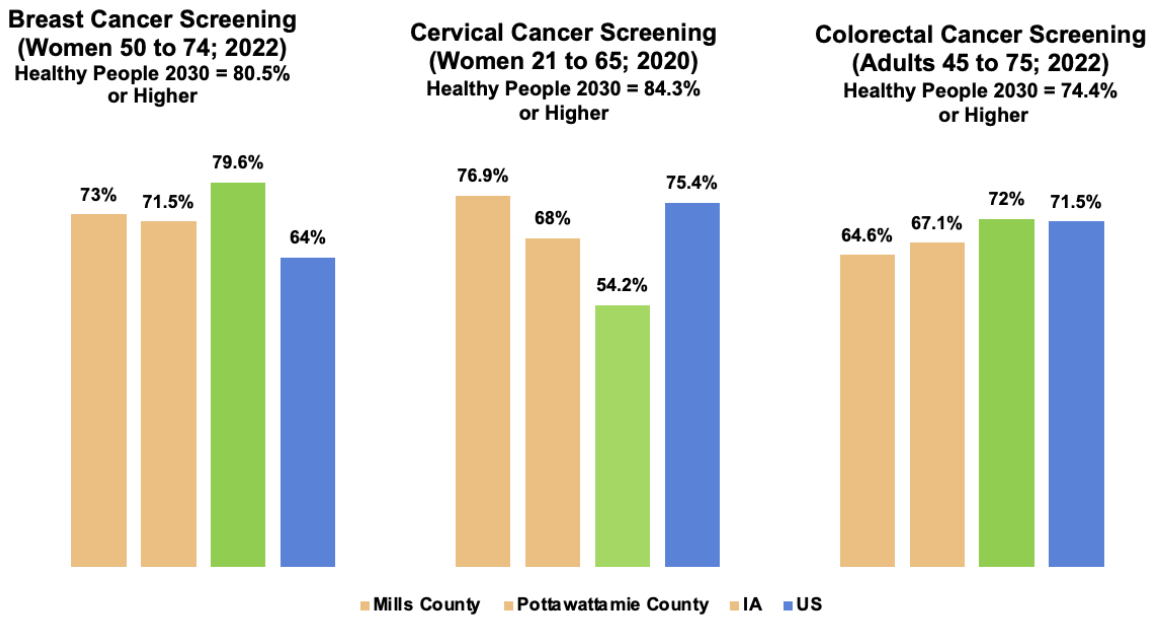
CANCER



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

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

- Leading Cause of Death: Age- adjusted cancer mortality rate is 197.2 deaths/ 100,000 population between 2019 and 2023 for Mills County, and 233.6 in Pottawattamie County, much higher than state and national rates and fails to satisfy the Healthy People 2030 objective.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the age group specified. Breast cancer screenings are mammograms among females age 50-74 in the past 2 years. Cervical cancer screenings are Pap smears among women 21-65 in the past 3 years. Colorectal cancer screenings include the percentage of population age 45-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

- 76.9% of Mills County women aged 21 to 65, and 68% in Pottawattamie County, have had cervical cancer screening, higher than Iowa percentages and failing to satisfy the HP2030 objective.
- The rate of breast cancer screening in both counties is on par with state and HP2030 objective.

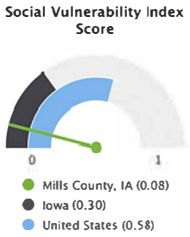
Social Vulnerability Index

Social vulnerability refers to a community's ability to prepare, respond, and adapt to disasters and public health emergencies. SVI is an accepted tool to measure overall community socio-economic well-being. A higher SVI indicates a higher vulnerability to hazard.

Mills County has a social vulnerability index score of 0.08, which is less than the state average of 0.30 for Iowa. Pottawattamie County has a social vulnerability index score of 0.49 which is greater than the average of 0.30 for Iowa

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability. Mills County has a social vulnerability index score of 0.08, which is which is less than the state average of 0.30.

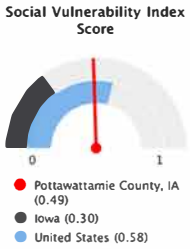
Report Area	Total Population	Socioeconomic Theme Score	Household Composition Theme Score	Minority Status Theme Score	Housing & Transportation Theme Score	Social Vulnerability Index Score
Mills County, IA	14,605	0.07	0.31	0.13	0.17	0.08
Iowa	3,188,836	0.21	0.42	0.40	0.46	0.30
United States	331,097,593	0.54	0.47	0.72	0.63	0.58



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2022. → *Show more details*

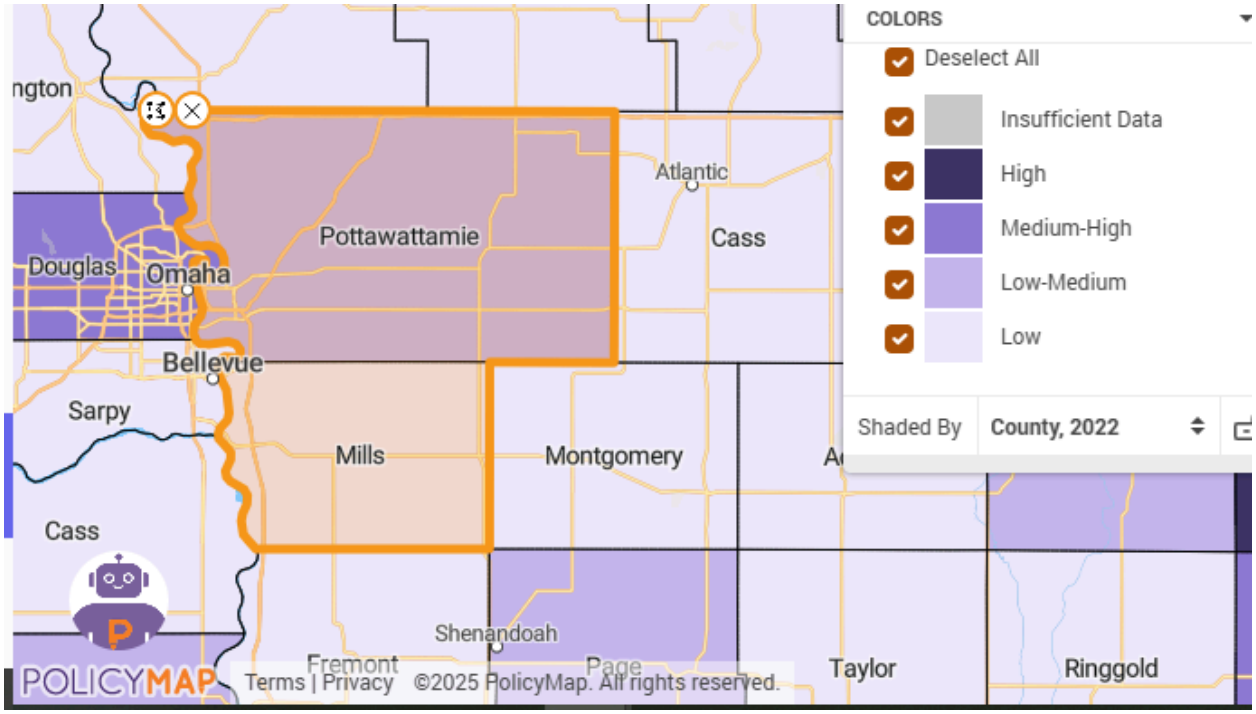
Pottawattamie County has a social vulnerability index score of 0.49, which is which is greater than Mills County and the state average of 0.30.

Report Area	Total Population	Socioeconomic Theme Score	Household Composition Theme Score	Minority Status Theme Score	Housing & Transportation Theme Score	Social Vulnerability Index Score
Pottawattamie County, IA	93,543	0.29	0.74	0.41	0.63	0.49
Iowa	3,188,836	0.21	0.42	0.40	0.46	0.30
United States	331,097,593	0.54	0.47	0.72	0.63	0.58



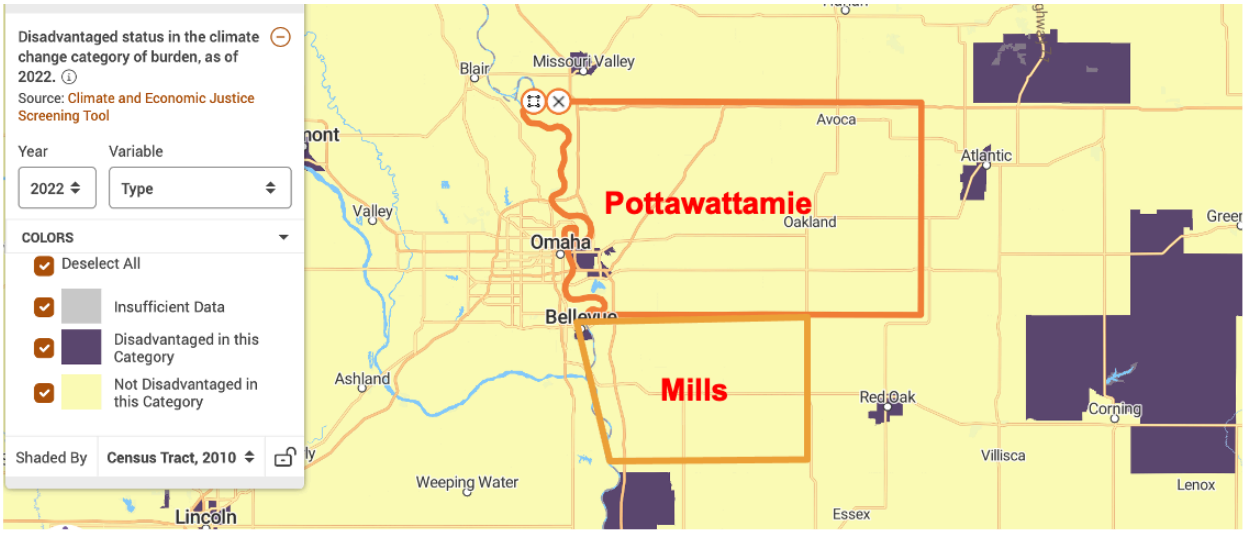
Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2022. → *Show more details*

Social Vulnerability Index- Mills and Pottawattamie Counties



Climate and Health Indicators

Census tracts are classified as disadvantaged if they meet at least one CEJST (Climate and Economic Justice Screening Tool) burden threshold—covering areas like climate, environment, housing, health—or if they fall within Federally Recognized Tribal lands. To qualify, a tract must exceed thresholds for both a burden and a related socioeconomic factor (e.g., low income or education). Additionally, tracts fully surrounded by disadvantaged areas and ranking above the 50th percentile for low income are also considered disadvantaged. In contrast, the following map of Mills and Pottawattamie counties shows these areas as non-disadvantaged, indicating they do not face significant burdens across eight key categories.



Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool (CEJST). Accessed via PolicyMap.

Prioritized Description of Significant Community Health Needs

Prioritization Process

CHI Health Mercy Council Bluffs identified Significant Community Health Needs through consideration of various criteria, including: standing in comparison with benchmark data; identified trends; the magnitude of the issue in terms of the number of persons affected; disparate population impact and equity, severity of the problem, known effective interventions, resource feasibility; and the perceptions among key informants that a given health issue should be a focus area for the community to address collectively.

Omaha/ Council Bluffs Metro area process Prioritization Process & Criteria

Prioritization was a multi-step process that began with review of the 14 “Areas of Opportunity” included within PRC’s CHNA report through the Key Informant Survey (n=118).

Key Informant Survey

Through an online survey, key informants were asked to rank each of the following health needs on a scale ranging from “no problem at all,” “minor problem,” “moderate problem” to “major problem.”
In this process, these key informants were asked to rate the severity of a variety of health issues in the community. In so far as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

- Mental Health
- Social Determinants of Health
- Diabetes
- Nutrition, Physical Activity & Weight

- Substance Use
- Heart Disease & Stroke
- Infant Health & Family Planning
- Injury & Violence
- Disabling Conditions
- Oral Health
- Cancer
- Access to Health Care Services
- Tobacco Use
- Respiratory Diseases

Mills County CHNA Prioritization Process & Criteria

In order to prioritize health needs for Mills County, CHI Health Mercy Council Bluffs presented to Healthy Mills Coalitions in partnership with MCPH on December 6, 2024 and facilitated a discussion to prioritize needs based on:

- severity of the health issue
- population impacted (making special consideration to disparities and vulnerable populations)
- trends in the data
- existing partnerships
- available resources
- hospital's level of expertise
- existing initiatives (or lack thereof)
- potential for impact
- community's interest in the hospital engaging in that health area

Participants were given community health data in the form of handouts and presentations compiled from the publicly- available data sources, including the most recent Mills County Public Health Department Community Health Assessment and Community Health Improvement Plan. Mills County Presentation can be found in Appendix B. Upon the completion of the data presentation stakeholders transitioned to small groups and discussed the following:

- What stood out to you from the information presented? What surprised you?
- Which data points or themes are consistent with what you are seeing/ hearing from the clients/ patients you serve?
- Is there anything we haven't touched on that you feel is an unmet health need?
- What existing assets/ opportunities can we leverage to improve physical/ mental health and wellbeing in our community?
- Using the following criteria provided below, what do you think is the top health need we should focus on in Mills County over the next three years?

After group discussions were completed, Healthy Mills Coalition group participants identified priorities as Access to Care and Social Determinants of Health (Housing, Food, Transportation). Mills County prioritization meeting was then presented to a large group discussion facilitated by CHI Health Mercy Council Bluffs to identify themes, rank top needs, build consensus, and vote.

Considering the identified health needs via both CHNA processes, the final prioritized list of significant health needs for CHI Health Mercy Council Bluffs follows.

Table 7: Top Identified Health Need by CHNA Process

Omaha Metro Identified Health Needs	Mills County Identified Health Needs
Access to Health Care Services	Access to Healthcare
Mental Health	Access to Mental Health Service
Social Determinants of Health	Access to Substance Abuse Treatment
Substance use	Housing
	Transportation

- **Access to Health Care Services:** 16.0% of Pottawattamie and 25% of Mills residents that cost prevented them from visiting a physician last year. Omaha Metro area residents reported difficulty accessing healthcare services due to cost, transportation, appointment times, and finding physicians.
- **Behavioral Health (including mental health and substance use):** 22.7% of people reported to have Fair/Poor Mental Health in the Omaha Metro Area. 32.3% are diagnosed with depression and 41.8% have symptoms of chronic depression in the Omaha Metro Area. 29% of Mills and 32.1% of Pottawattamie residents reported access to Mental Health treatment. Key informants rated substance use as a top concern with 49.0% stating it is a major problem and 46.9% stating it is a moderate problem. Access to Substance Abuse treatment was cited by 27% of Mills and 8.6% of Pottawattamie County residents as a top concern.
- **Social Determinants of Health:** Metro Area key informants rated social determinants of health as a top concern with 72.2% stating it is a major problem and 22.6% stating it is a moderate problem. A total of 24.3% of Metro Area and 31.1% of Pottawattamie residents would not be able to afford an unexpected $400 expense without going into debt. Mills residents also reported 2% housing and 16% transportation needs.

Data provided by CHI Health Mercy Council Bluffs was presented during a Healthy Mills Coalition meeting to a wide range of stakeholders. All parties who reviewed the data found the data to accurately represent the needs of the community.

Resources Available to Address Health Needs

Access to Health Care Services	Mental Health
All Care Community Health Center Bluffs Taxi Caring for Our Communities Casino Cab Charles Drew Health Center CHI Health Center CHI Health Immanuel CHI Health Mercy	988 AEA Services All Care Community Health Center Anywhere Care Behavioral Health Connection Behavioral Health Education Center of Nebraska (BHCEN) Behavioral Health Peer Supports Best Care EAP

City of Omaha Vision Zero Plan Community Alliance Community Health Centers Community Health Workers Connections Area Agency on Aging Council Bluffs Transit Creighton University Doctor's Offices Douglas County Douglas County Detox Center Douglas County Health Department Faith Based Nursing Resources Federal Programs Federally Qualified Health Centers Firefly Mobile Wellness Unit Health Care Facilities Health Fairs Health Systems Heartland Family Services Healing Gift Free Clinic (HGFC) Hospitals Insurance Company Jennie Edmundson Hospital Lutheran Family Services MAPA Safe Streets and Roads Marketplace Insurance Methodist Community Health Clinic (MCHC) Medicare/Medicaid Mental Health Respite Programs Methodist Metro Area Transit Mobile Care Units Nebraska Medicine Nonprofits North Omaha Area Health One World Community Health Center Secret Heart Southwest Iowa Transit System University of Nebraska Medical Center VA	Boys Town Bridge to Mental Health Calvary Church Capstone Behavioral Health Catholic Charities Center for Healing and Hope Center for Holistic Development Charles Drew Health Center CHI Health Center CHI Health Immanuel CHI Health Mercy CHI Heritage CHI McDermott Child and Family Resource Network Community Alliance Community Based Organizations Community Health Centers Community Health Clinics Concord Mediation Counseling Clinics Department of Health and Human Services Doctor's Offices Douglas County Douglas County Community Mental Health Center Douglas County Health Center Douglas County Health Department Douglas County Hospital Durham Outpatient Center Clinic Employee Assistance Program Employers Family Connections Family Services Federally Qualified Health Centers Food Banks/Food Pantries Fresh Hope Full Circle Recovery Group Homes Harbor Pointe Health Care Facilities Health Department Health Systems Heartland Family Services Healing Gift Free Clinic (HGFC) Homeless Shelters Hope Valentine and Melissa Jansen Hospitals Jennie Edmundson Hospital Lasting Hope Recovery Center Lutheran Family Services Managed Care Services

	MentalHealthCourt Meridian MethadoneClinic MethodistCommunityHealthClinic(MCHC) MobileCrisis MunroeMeyer NationalAllianceonMentalIllness NebraskaAssociationofBehavioralHealthOrganizations NebraskaHealthSystems NebraskaMedicine NebraskaMentalHealth&AgingCoalition Nonprofits OmahaForUSLGBTQCenter OmahaPoliceDepartment OneWorldCommunityHealthCenter PESEmergencyRoomServices PrivateMentalHealthTherapists ProjectHarmony PsychiatricImmediateNeedClinic PublicEntitiesDirecting/DevelopingPrograms RegionSix RegionalServices RemedyHealth RuralHealthClinic SafeHarborPeerSupport SalvationArmy SchoolSystem SouthwestIowaMentalHealthandDisabilitiesServiceRegion SouthwestIowaRegion SpenceCounseling Stephen'sCenter SWIARegion SWIAM TeenMentalHealthAlliance TheKimFoundation University of NebraskaMedicalCenter Veteran's Administration WhatMakesUsCampaign

Substance Use	Social Determinants of Health
988 AA/NA Catholic Charities Centerpointe CHI Health Center CHI Health Immanuel CHI Health Mercy Clinical Substance Abuse Treatment Services	211 AEA Services Anawim Behavioral Health Connection Bridge Out of Poverty Canopy South Neighborhood Development Caring for Our Communities Catholic Charities

Community Alliance Community Health Centers Council Bluffs Comprehensive Treatment Center Doctor's Offices Douglas County Community Mental Health Center Douglas County Detox Center Douglas County Outpatient and Inpatient Services Eastern Nebraska Community Action Partnership Employers Family Access Center Family Resource Center Full Circle Recovery Give Recovery Haven Health Heartland Family Services Hospitals InRoads to Recovery Iowa Family Works Jennie Edmundson Hospital Lasting Hope Recovery Center Life Recovery Groups Lutheran Family Services Nebraska Medicine Nonprofits Northpoint NOVA Treatment Community Open Door Mission Public Health Region Six Salvation Army Santa Monica House Sarpy County Drug Court Southwest Iowa Mental Health and Disabilities Service Region Stephen's Center TDC Inpatient Transitional Services of Iowa University of Nebraska Medical Center Valley Hope	Charles Drew Health Center CHI Health Center CHI Health Immanuel City Council Community Alliance Community-Based Organizations Community Health Centers Community Health Services Community Health Workers Community-Oriented Drug Enforcement (CODE) Community Relay Connections Area Agency on Aging Continued Utility Supply Despite Inability to Pay Department of Health and Human Services Doctor's Offices Douglas County Board of Commissioners Douglas County Community Mental Health Center Douglas County Health Department Eastern Nebraska Community Action Partnership Eastern Nebraska Office on Aging Empowerment Network Faith Based Supports Family Housing Advisory Services Food Banks/Food Pantries Francis House Front Porch Investments Habitat for Humanity Health Department Heart Ministry Heartland Family Services Heartland Hope Food Pantry Homeless Shelters Hospitals Housing and Urban Development Housing Continuum Housing Foundation of Sarpy County Insurance Company Intercultural Senior Center Lasting Hope Recovery Center Lied Center Lift Up Sarpy Lutheran Family Services Medicare/Medicaid Methodist Community Health Center Metro Area Continuum of Care for the Homeless Micah House MOBY Nebraska Health Network Nebraska Medicine Nebraska Total Care

	New Visions No More Empty Pots Nonprofits Omaha 100 Omaha ForUS LGBTQ Center Omaha Healthy Kids Alliance Omaha Housing Authority One World Community Health Center Open Door Mission Parks and Recreation Pink For LGBTQ+ Pottawattamie County Sheriff's Office Project Everlast Project Harmony Public Health Refugee Empowerment Network Regions Reimagine Salvation Army Sarpy County Housing Authority School System Sienna Francis Supplemental Nutrition Assistance Program Southwest Iowa Mental Health and Disabilities Service Region Spark Community Development Stephen's Center Subsidized Housing Options Together Inc Unite Us United Way UnitedHealth University of Nebraska Medical Center

Evaluation of FY23-FY25 Community Health Needs Implementation Strategy

The previous CHNA for CHI Health Mercy Council Bluffs was conducted in 2022. Table 8 illustrates the progress and impact made around CHI Health Mercy Council Bluffs's previous implementation strategy to address community health needs.

Table 8: CHI Health Mercy Council Bluffs FY23-FY25 ISP Evaluation

Strategies and Program Activities by Health Need

Health Need #1: Behavioral Health	
Goals & Anticipated Impact	Goals: ● Expand access to behavioral health services for youth and adults ● Expand capacity to identify individuals in mental health crisis and respond appropriately ● Provide access to behavioral health services in Pottawattamie County and encourage greater collaboration between primary care and behavioral health providers ● Support substance abuse recovery and reduce relapse through peer support and coaching Anticipated Impact: ● Decrease in youth feeling sad or hopeless ● Increase in number of individuals who feel confident they can identify signs of mental health crisis and respond appropriately with resources ● Increase number of individuals receiving behavioral health services in Pottawattamie County ● Reduce behavioral health acuity observed in emergency department through earlier clinical intervention ● Increase resilience and support recovery of families affected by substance abuse
Community Indicators	**CHNA 2016** ● Age-adjusted suicide rate per 100,000: 16.5 (Pottawattamie), 11.5 (Mills), 13.20 (Iowa) ● Average number of mentally unhealthy days in last 30: 3.1 (Pott.), 2.8 (Mills), 3.1 (Iowa) **CHNA 2019** ● Age-adjusted suicide rate per 100,000: 17.9 (Pottawattamie), N/A (Mills), 13.20 (Iowa) ● Ratio of population to mental health provider: 580:1 (Pott.), 2,150:1 (Mills), 700:1 (Iowa) ● Percentage of adults reporting binge drinking: 20% (Pott.), 23% (Mills), 22% (Iowa) ● Average age-adjusted number of mentally unhealthy days reported in past 30 days ○ Pottawattamie County 3.4 ○ Mills County 3.0

Health Need #1: Behavioral Health	
	CHNA 2022 ● 3.6 poor mental health days in Mills County, an increase from 2018 (3.0) ● 2,160:1 ratio of population to mental health providers in Mills County, an increase from 2018 (2,140:1) ● 25% of Mills County and Metro Area adults reported excessive drinking, an increase from 2018 (23%)
Strategy	**Key Activities**
1.1 Expand access to mental health services for youth	1.1.1 Explore opportunities to support Council Bluffs Community Schools in meeting the mental health needs of students and provide training and/or resources. FY23 Key Activities Posted Mental Health Therapist position for Transitions Program offered through Council Bluffs Schools. Periodically offer training for the community and schools including Juvenile Court Officers. FY23 Measures Measures: No measures to report. FY24 Key Activities On July 18, 2023, CHI Health Mercy Council Bluffs provided education to Green Hills Area Education Administration

	regarding psychological testing. FY24 Measures There were 250 attendees; we had a booth all three days of the conference and Dr. Larisa Che also provided a breakout session regarding School Anxiety and Avoidance with 40 attendees. FY25 Results Pending
1.2 Partner with the Region to promote adult/youth Mental Health First Aid training	1.2.1 Promote Southwest Iowa Mental Health and Disability Services Region (SWIA MHDS) Mental Health First Aid community trainings and deliver mental health training as staffing capacity allows. FY23 Key Activities: Offered QPR and MHFA training to Pottawattamie County (MHFA can also be obtained through the Region). A one-hour training was provided to Pottawattamie County Department Directors and Elected Officials on October 11 regarding Mental Health Awareness in the Workplace. FY23 Measures # of individuals receiving QPR training: 5 100% trained are confident they can ID signs someone is in mental health crisis and respond with an appropriate resource # of community Mental Health Awareness Presentation: 30 FY24 Key Activities Dr. Che provided education/ mental health awareness as part of a panel discussion at Iowa Western Comm College, for an event hosted by SWI MH Coalition in March 2024. In June 2024, the behavioral health team participated in the AEA Annual Conference at the Mid American Center with a booth all three days and Dr Che presented on 6/12/24.

	FY24 Measures # of community mental health awareness presentations: 25 In addition to activities listed above, CHI Health Mercy Council Bluffs provided Youth Mental Health training to Law Enforcement regarding Youth in MH Crisis ○ # of attendees: 25 Provided education on mental health services to Leadership Council Buffs ○ # of attendees: 30 attendees. Delivered CIT Training for Law Enforcement ○ # of attendees: 25. FY25 Results Pending
1.3 Expand access to and capacity to deliver behavioral health services	1.3.1 Operate an Integrated Behavioral Health primary care model and Psychiatric Immediate Care Clinic on the Mercy Council Bluffs campus. FY23 Key Activities Continued to provide Integrated Behavioral Health providers at both the West Broadway clinic and Valley View clinics, throughout all of FY23. We have also offered the Psychiatric Immediate Care clinic on the CHI Health Mercy Council Bluffs campus the entire fiscal year. The PICC has provided Navigation (Care Management) services for patients throughout the fiscal year. FY23 Measures # of documented psychiatric consultations:1,025 # of separate telephonic interventions: 204 (West Broadway and Valley View) # of patient appointments completed in the Psychiatric Immediate Care Clinic (PICC): 1,700

	FY24 Key Activities We continued to provide Integrated Behavioral Health providers at both the West Broadway clinic and Valley View clinics. We have also offered the Psychiatric Immediate Care clinic on the Mercy campus the entire fiscal year. FY24 Measure # of documented psychiatric consultations: 173 # of separate telephonic interventions: 809 (West Broadway and Valley View) # of patient appointments completed in the Psychiatric Immediate Care Clinic (PICC): 1,500 FY25 Results Pending
1.4 Partner with Mills County Public Health to administer	1.4.1 Support Family Matters Substance Abuse peer support program administered through Mills County Public Health. FY23 Key Activities: Provided $10,000 in support to Family Matters, a peer support service that includes individuals who have common life experiences. People with substance abuse disorders have a unique capacity to help each other based on shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer their support, strength, and hope to their peers, which promotes growth, wellness, and long-term recovery for the whole family. FY23 Measures: # of unduplicated individuals served: 8 # of coaching hours: 12.75 FY24 Key Activities: (July 1, 2023-June 30, 2024)

	CHI awarded Family Matters project $10,000.00. This program is a peer support service that includes individuals who have common life experiences. People with substance abuse disorders have a unique capacity to help each other based on shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer their support, strength, and hope to their peers, which promotes growth, wellness, and long-term recovery for the whole family. Research shows that peer support facilitates recovery. The program provided the following services to help prevent relapse and promote sustaining recovery from substance abuse disorders. FY24 Measures: (July 1, 2023-June 30, 2024) # of unduplicated individuals served: 20 # of coaching hours: 100.5 # of social events: 11 FY25 Results Pending

	**Health Need #1: Behavioral Health**
Related Activities	CHI Health Mercy Council Bluffs continues to participate in the SWIA MHDS Crisis Center Access Network. CHI Health's Behavioral Health Service Line continues to work with educational partners to increase the behavioral health workforce, while implementing and testing novel approaches to retain the existing workforce and meet increased demand for services. In addition, the hospital will explore partnership with additional community organizations.
Planned Resources	The hospital will provide financial and in kind support as well as implement system strategies.

Planned Collaborators	● Council Bluffs Community Schools ● All Care Health Center ● Southwest Iowa Mental Health and Disability Services Region ● Mills County Public Health

 **Health Need #2: Health-Related Social Needs**	
Goals & Anticipated Impact	Goal: ● Reduce unnecessary emergency medical services (EMS) use related to unmet chronic health and social care needs ● Support community efforts to address health-related social needs through effective service referrals and resource navigation ● Support evidence-based programming to support financial literacy and goal setting among individuals

	living in poverty in Pottawattamie County Anticipated Impact: ● Reduce strain on volunteer EMS and increase connection to community resources for individuals with unmet health and social care needs ● Improve patients' health outcomes through remediation of unmet health-related social needs ● Reduce poverty (increase participants' net income/decrease debt) and improve quality of life

Community Indicators	**CHNA 2016** ● Percent of population in poverty: 12.3% (Pottawattamie), 9.7% (Mills), 12.2% (Iowa) ● Percent of children under 18 in poverty: 17.5% (Pottawattamie), 12.7% (Mills), 15.5% (Iowa) **CHNA 2019** ● Percent of population in poverty: 11.8% (Pottawattamie), 8.2% (Mills), 12.3% (Iowa) ● Percent of children under 18 in poverty: 14% (Pottawattamie), 11% (Mills), 13% (Iowa) ● Food Environment Index (0-worst, 10-best): 7.7 (Pott.), 8.7 (Mills), 8.2 (Iowa) ● Rate of food insecurity 11.6% (2015 United Way of the Midlands Food Mapping Paper) **CHNA 2022** ● Percent of population in poverty: 9.2% (Pottawattamie), 8.3% (Mills), 10.2% (Iowa) ● Percent of children under 18 in poverty: 13.77% (Pottawattamie), 8.46% (Mills), 13.79% (Iowa) ● Children Eligible for Free & Reduced Price Lunch: 41% (Pottawattamie), 38% (Mills), 43% (Iowa) ● Housing Cost Burden (% of households where housing costs > 30% of total household income): 24% (Pottawattamie), 22% (Mills), 23% (Iowa)
Strategy	**Key Activities**

Health Need #2: Health-Related Social Needs

2.1 Leverage public health nurses to conduct home- based risk assessments of frequent EMS utilizers and coordinate referrals to community- based services	2.1.1 Partner with Mills County Public Health to provide support for the Mobile Integrated Health Services program FY23 Key Activities: Program is discontinued FY23 Measures: No metrics to report. FY24 Key Activities: Program is currently paused; the health department is exploring grant opportunities to fund position to support this work. FY24 Measures: No metrics to report. FY25 Results Pending
2.2 Connection to community- based services for unmet health needs	2.2.1 Implement social needs screening and referral protocol using Unite Us FY23 Key Activities: Implemented social needs screening and referral system. FY23 Measures: # of clients: 34 #of cases: 36 # of managed cases: 19 # of referred cases 46 FY24 Key Activities: Initiated universal social needs screening for all adults admitted into the hospital. Integrated Unite Us within Epic, the hospital's electronic medical record. FY24 Measures: # of clients: 27 #of cases: 85 # of managed cases: 28 # of referred cases 11

	FY25 Results Pending
2.3 Promote financial literacy	2.3.1 Provide financial and in-kind support for the Bridges out of Poverty Getting Ahead financial literacy program FY23 Key Activities: Provided board leadership and $12,000 to support the Bridges out of Poverty Program in FY23. Initiated partnership with LinkedIn. Partnering with University of Nebraska Medical Center- College of Public Health as co-investigators to investigate the health impact of the Getting Ahead program. Implemented Getting Ahead in the Workplace cohort for entry- level employees that live in some degree of instability. FY23 Measures: # of investigators graduated: 41 % graduation rate: 92% Average increase in monthly income among investigators post- graduation: $1,061 Average increase in net assets among investigators post- graduation: $3,585 Average reduction in monthly public benefits usage: $67 Average decrease in debt to income ratio: 31% FY24 Key Activities: Provided board leadership and $12,000 to support the Bridges out of Poverty Program. FY24 Measures: ● # of investigators graduated: 126 ● % graduation rate: 92% ● Average increase in monthly income among investigators post- graduation: $1,500 ● Average increase in net assets among investigators post- graduation: $7500 ● Average reduction in monthly public benefits usage: $124 ● Average decrease in debt to income ratio: 50% ● Average monthly bill reduction reported among program graduates (assessed post- graduation at three month intervals): $580

	FY25 Results Pending
Related Activities	In addition, the hospital will explore partnership with additional community organizations.
Planned Resources	The hospital will provide financial and in kind support as well as implement system strategies.
Planned Collaborators	● Mills County Public Health ● Mills County EMS ● Methodist- Caring for Our Communities program ● Bridges out of Poverty ● All Care Health Center

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Written Comments

CHI Health invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

Appendices

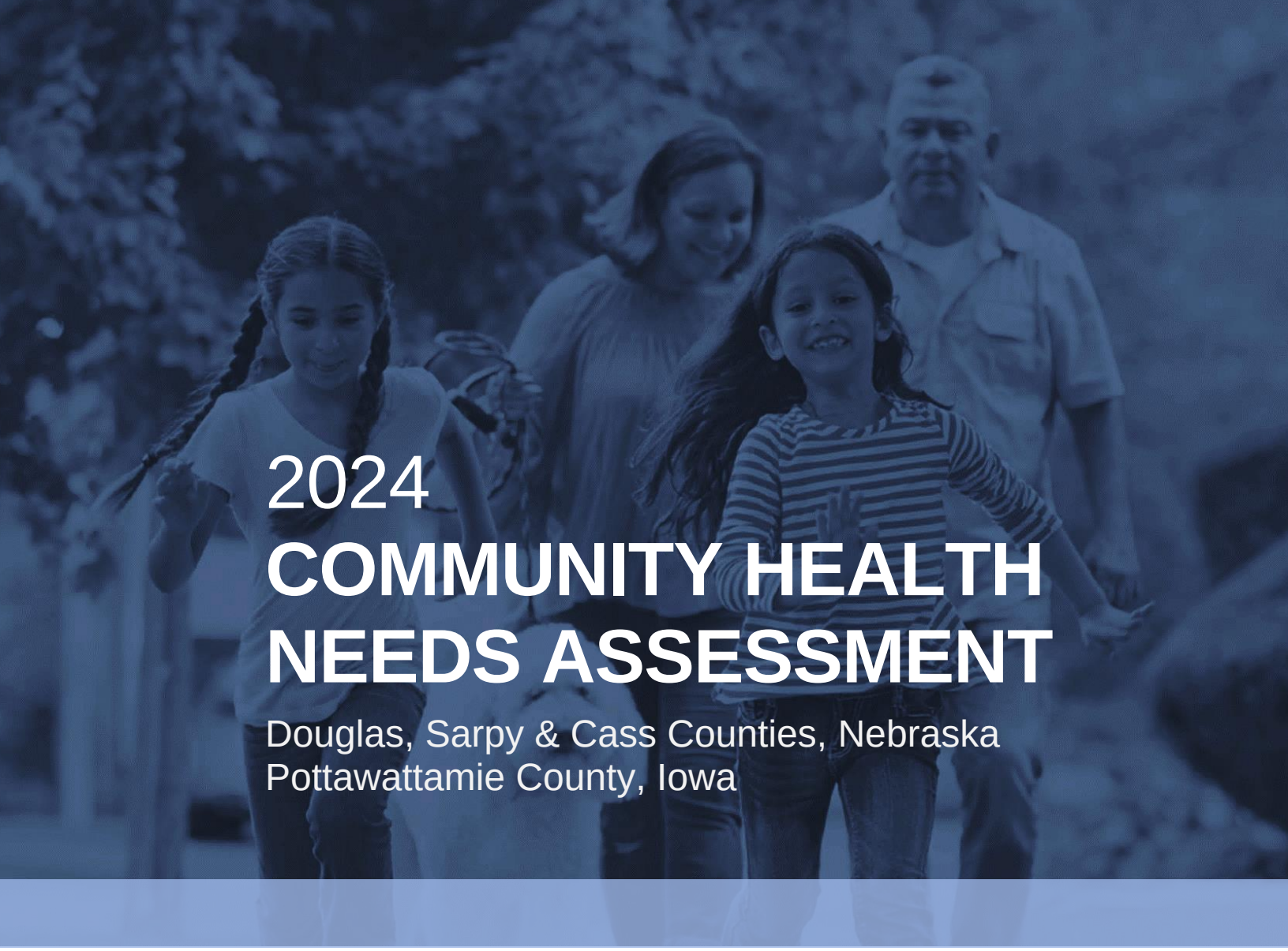
A: PRC Report

Professional Research Consultants (PRC) completed the 2024 Community Health Needs Assessment for Douglas, Sarpy and Cass Counties in Nebraska and Pottawattamie County, Iowa.

B: Mills County Data Presentation

Mills County Public Health hosted a meeting of stakeholders from two local coalitions to review data and have a discussion to identify and validate the top needs in Mills County communities. Data presentation and the handout present the findings discussed during this meeting.

Appendix A



2024 COMMUNITY HEALTH NEEDS ASSESSMENT

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

Sponsored by

Douglas County Health Department
Pottawattamie County Public Health
Sarpy/Cass Health Department
CHI Health
Nebraska Medicine
Methodist Health System
Charles Drew Health Center, Inc.
One World Community Health Centers, Inc.
All Care Health Center

With Support From

The Wellbeing Partners

2023-0321-02

Prepared by
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TABLE OF CONTENTS

INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment — a follow-up to similar studies conducted in 2011, 2015, 2018, and 2021 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Omaha metropolitan area (including Douglas, Sarpy, Cass, and Pottawattamie counties). Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

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

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

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

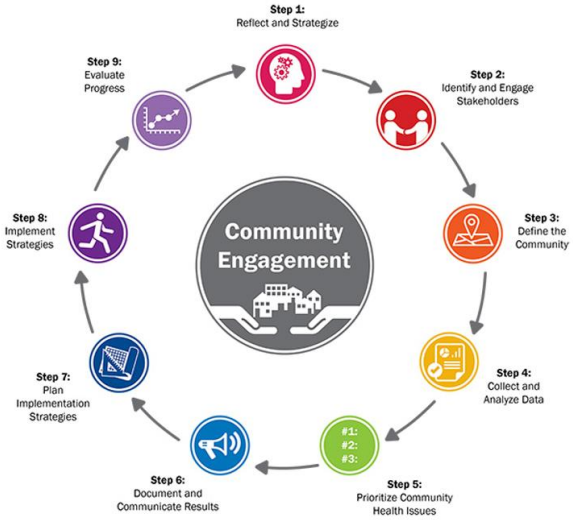
SPONSORING ORGANIZATIONS ► **Douglas County Health Department**; **Pottawattamie County Public Health**; **Sarpy/Cass Health Department**; **CHI Health** (CHI Health Creighton University Medical Center–Bergan Mercy, CHI Health Immanuel, CHI Health Lakeside, CHI Health Mercy Council Bluffs, and CHI Health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

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

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

Approach

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



Methodology

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

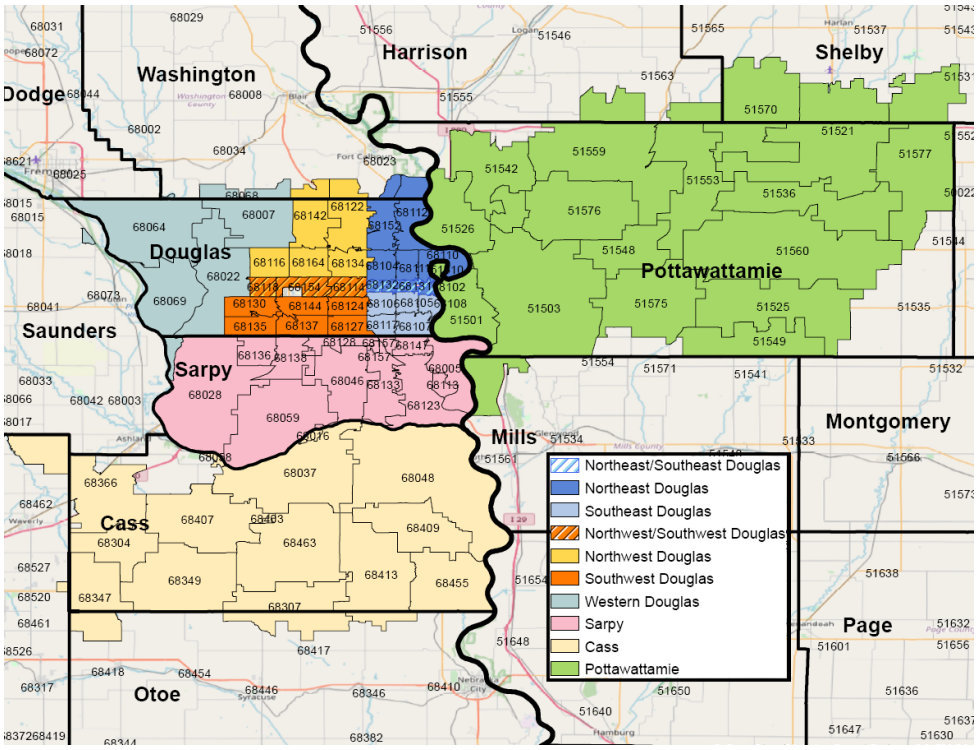
PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

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



Sample Approach & Design

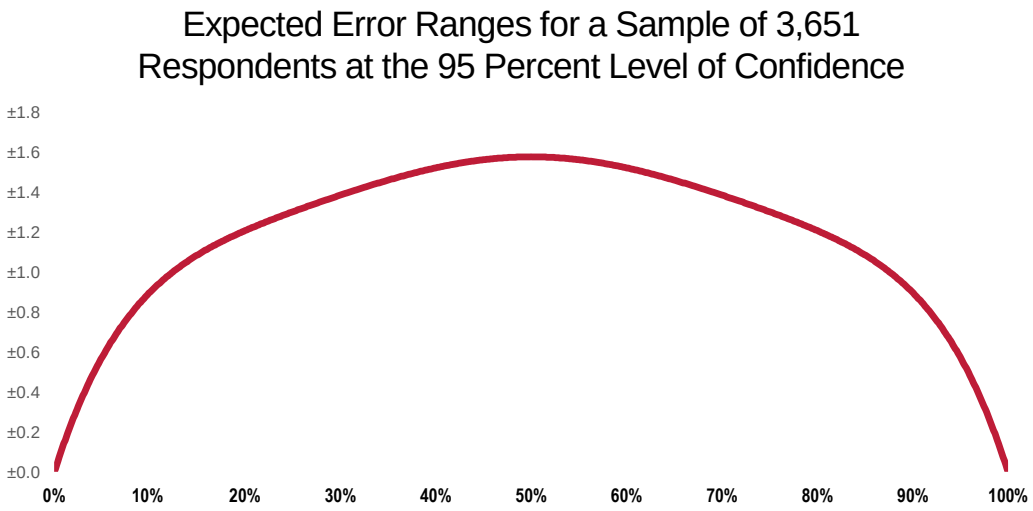
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (landline and cell phone) or through online questionnaires, as well as a community outreach component promoted by the study sponsors through social media posting and other communications.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 2,960 surveys throughout the service area.

COMMUNITY OUTREACH SURVEYS (Sponsoring and Supporting Partners) ► PRC also created a link to an online version of the survey, and the sponsors and supporting partners promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 691 surveys to the overall sample.

In all, 3,651 surveys were completed through these mechanisms, including 1,997 in Douglas County, 844 in Sarpy County, 227 in Cass County, and 583 in Pottawattamie County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Metro Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 3,651 respondents is ±1.6% at the 95 percent confidence level.



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.

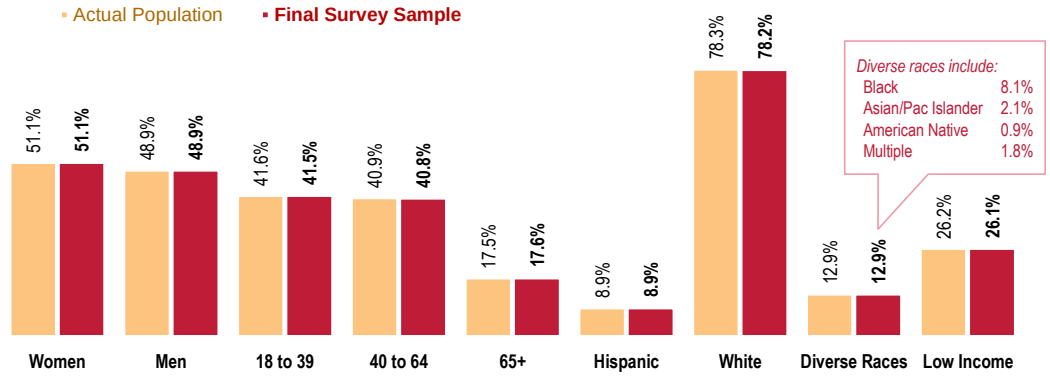
Examples:
- If 10% of the sample of 3,651 respondents answered a certain question with a "yes," it can be asserted that between 9.1% and 10.9% (10% ± 0.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 48.2% and 51.8% (50% ± 1.6%) of the total population would respond "yes" if asked this question.

Sample Characteristics

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

The following chart outlines the characteristics of the Metro Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(Metro Area, 2024)



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2024 PRC Community 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 respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, 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 population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 118 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	22
Public Health Representatives	4
Other Health Providers	42
Social Services Providers	21
Business Leaders	12
Other Community Leaders	17

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

- All Care Health Center
- Board of Health
- Catholic Charities of Omaha
- Center for Holistic Development
- Charles Drew Health Center, Inc.
- CHI Health
- City of Council Bluffs
- City of Omaha Planning
- City of Papillion
- City of Plattsmouth
- Claire Memorial United Methodist Church
- College of St. Mary
- Connections Area Agency on Aging
- Douglas County
- Douglas County Board of Health
- Eastern Nebraska Office on Aging
- FAMILY, Inc.
- Family, MCH Sealant Program
- Goodwill Omaha
- Heartland Family Service
- Housing Foundation for Sarpy County
- I Be Black Girl
- Ignite Nebraska
- Immanuel Pathways Southwest Iowa (PACE)
- Intercultural Senior Center
- Iowa Child Care Resource & Referral
- Iowa West Foundation
- Lift Up Sarpy
- Methodist–EAP
- Methodist Community Health Clinic (MCHC)
- Methodist–MHS
- Methodist–MJE
- Methodist–MWH
- Methodist–NMC
- Methodist–NMH
- Methodist–NMH Admin Services
- Methodist–NMH Cancer Center
- Methodist–Kountze Commons
- Metro Area Transit
- Metropolitan Area Planning Agency
- Nebraska Medicine
- New Life Family Alliance
- No More Empty Pots
- Omaha for Us
- OneWorld Community Health Center
- Pottawattamie County
- Region 6
- ReImagine Omaha
- Santa Monica House
- Sarpy County
- Sarpy/Cass Health
- Serenity Dental
- Southwest Iowa MHDS
- Stephen Center
- UnitedHealth care
- University of Nebraska Medical Center College of Public Health
- Visiting Nurse Association
- Women's Fund of Omaha
- YMCA

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

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Comparisons

Trending

Similar surveys were administered in the Metro Area in 2011, 2015, 2018, and 2021 by PRC. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Nebraska & Iowa Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

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.

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 receiving feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

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

Information Gaps

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

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be individually identifiable or might not comprise a large-enough sample for independent analyses.

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

Public Comment

Participating hospitals and health systems made their prior Community Health Needs Assessment (CHNA) reports publicly available through their respective websites; through that mechanism, they requested from the public written comments and feedback regarding the CHNA and implementation strategies. At the time of this writing, none had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Participating hospitals will continue to use their websites as tools to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Inconvenient Office Hours – Cost of Prescriptions – Cost of Physician Visits – Appointment Availability – Difficulty Finding a Physician – Lack of Transportation – Culture/Language ▪ Skipping/Stretching Prescriptions ▪ Emergency Room Utilization
CANCER	▪ Leading Cause of Death ▪ Prostate Cancer Deaths ▪ Cervical Cancer Screening
DIABETES	▪ Prevalence of Borderline/Pre-Diabetes ▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Activity Limitations ▪ Alzheimer's Disease Deaths
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Prevalence ▪ Stroke Prevalence
INFANT HEALTH & FAMILY PLANNING	▪ Prenatal Care

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
INJURY & VIOLENCE	▪ Falls [45+] ▪ Intimate Partner Violence
MENTAL HEALTH	▪ “Fair/Poor” Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Stress ▪ Current Anxiety & Depression ▪ Suicide Deaths ▪ Lack of Social Support ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Leisure-Time Physical Activity ▪ Meeting Physical Activity Guidelines ▪ Built Environment ▪ Overweight & Obesity ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
ORAL HEALTH	▪ Regular Dental Care
RESPIRATORY DISEASE	▪ Asthma Prevalence
SOCIAL DETERMINANTS OF HEALTH	▪ Financial Resilience ▪ Housing Insecurity ▪ Housing Conditions ▪ Loss of Utilities ▪ Discrimination ▪ Adverse Childhood Experiences (ACEs) ▪ Key Informants: *Social Determinants of Health* ranked as a top concern.
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

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

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

Hospital Implementation Strategy

Sponsoring hospitals will use the information from this Community Health Needs Assessment to develop Implementation Strategies to address the significant health needs in the community. While the hospitals will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of action plans to guide community health improvement efforts in the coming years.

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 group of columns furthest to the left provide comparisons among the five subareas within Douglas County, identifying differences for each as "better than" (☼), "worse than" (☁), or "similar to" (⛅) the combined opposing areas of the county.

The second grouping of columns [to the left of the Metro Area column] provide comparisons among the four counties assessed, identifying differences for each as "better than" (☼), "worse than" (☁), or "similar to" (⛅) the combined opposing counties.

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

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2011 (or earliest available data). Note that survey data reflect the ZIP Code-defined Metro Area.

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

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

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

SOCIAL DETERMINANTS	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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
Linguistically Isolated Population (Percent)						3.1	1.2	0.3	1.5	2.5	2.6	1.9	3.9		
Population in Poverty (Percent)						11.0	5.5	5.6	11.3	9.7	10.4	11.1	12.5	8.0	
Children in Poverty (Percent)						13.2	5.8	5.4	15.6	11.6	12.0	13.0	16.7	8.0	
No High School Diploma (Age 25+, Percent)						8.6	4.3	4.6	9.4	7.7	8.1	7.0	10.9		
Unemployment Rate (Age 16+, Percent)						2.6	2.2	2.3	2.9	2.5	2.3	2.9	3.6		4.0
% Unable to Pay Cash for a $400 Emergency Expense	31.8	38.4	19.6	17.9	15.9	24.9	19.5	20.3	31.1	24.3			34.0		18.7
% Worry/Stress Over Rent/Mortgage in Past Year	38.3	39.5	32.4	29.9	26.4	33.8	29.0	28.9	32.3	32.5			45.8		20.1
% Unhealthy/Unsafe Housing Conditions	21.8	21.2	9.3	10.0	6.4	14.1	8.9	10.1	15.8	13.1			16.4		6.1
% Went Without Electricity, Water, or Heat	12.4	14.9	12.5	6.4	11.6	11.2	6.9	8.3	12.2	10.3					5.2
Population With Low Food Access (Percent)						11.9	36.7	18.4	30.6	19.3	21.9	20.0	22.2		
% Worried About Food in the Past Year	38.6	37.7	20.6	19.6	17.1	27.0	19.8	22.1	29.0	25.6			40.7		18.8
% Ran Out of Food in the Past Year	30.6	33.4	15.2	15.9	10.7	21.7	15.3	17.8	24.7	20.6			32.6		

SOCIAL DETERMINANTS (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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
% Food Insecure	41.2	42.2	21.9	20.8	18.7	29.1	21.8	23.8	31.9	27.8			43.3		
% Treated With Less Respect Than Others	35.4	32.0	25.9	25.7	25.4	28.9	25.5	26.4	29.5	28.2					25.1
% Receive Poorer Treatment at Restaurants/Stores	17.2	12.5	6.7	9.2	7.9	10.8	8.0	6.7	10.6	10.1					7.7
% Treated as Less Intelligent	20.9	23.5	13.2	17.2	15.7	18.0	17.0	13.5	19.6	17.8					13.3
% Threatened or Harassed	8.4	9.0	8.3	8.9	5.2	8.4	5.0	4.7	6.9	7.4					4.8
% Disagree That the Community Welcomes All Races	12.9	13.2	11.3	11.4	12.6	12.1	7.3	12.6	10.4	11.0					11.3
% Treated as Someone to Fear	11.9	10.6	8.2	7.9	4.1	9.1	6.8	9.0	10.2	8.7					7.4
% 4+ Adverse Childhood Experiences (High ACEs Score)	30.4	28.6	24.4	20.4	22.9	25.1	19.9	23.7	29.5	24.4			25.5		15.1

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

better similar worse

OVERALL HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	17.5	20.6	15.7	9.1	12.1	14.9	16.5	11.8	24.9	16.3	15.0	16.2	15.7		12.7

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

better similar worse

ACCESS TO HEALTH CARE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	11.1	16.5	4.7	5.2	4.6	8.5	7.0	7.6	4.9	7.8	10.8	6.7	8.1	7.6	12.1
% Difficulty Accessing Health Care in Past Year (Composite)	43.6	42.8	42.6	43.5	39.1	42.8	41.7	39.4	39.8	42.2			52.5		33.4
% Cost Prevented Physician Visit in Past Year	18.6	19.9	17.1	14.9	11.5	16.9	15.1	15.0	16.0	16.4	10.2	7.2	21.6		14.5
% Cost Prevented Getting Prescription in Past Year	18.8	18.2	18.8	16.3	11.6	17.5	12.4	13.9	18.1	16.4			20.2		14.3
% Difficulty Getting Appointment in Past Year	21.8	21.5	20.5	22.3	20.9	21.5	20.3	17.7	20.9	21.1			33.4		10.5
% Inconvenient Hrs Prevented Dr Visit in Past Year	19.0	16.2	20.7	15.5	15.5	17.7	17.9	19.1	18.0	17.9			22.9		12.5
% Difficulty Finding Physician in Past Year	16.0	16.7	11.1	9.2	5.5	12.2	11.1	10.2	11.8	11.9			22.0		6.6
% Transportation Hindered Dr Visit in Past Year	16.7	17.8	7.8	6.1	5.0	10.8	5.7	4.8	11.3	9.7			18.3		4.7
% Language/Culture Prevented Care in Past Year	3.7	4.4	1.6	1.6	1.7	2.6	0.7	0.5	1.6	2.0			5.0		0.9
% Stretched Prescription to Save Cost in Past Year	21.2	18.5	18.4	15.4	11.4	17.7	15.3	13.8	17.5	17.0			19.4		13.6
% Treated Worse Than Other Races (Health Care)	8.5	5.6	3.7	2.7	3.0	4.8	2.1	2.2	4.0	4.1			6.1		4.3
Primary Care Doctors per 100,000						149.7	52.5	7.5	48.0	114.1	98.3	109.7	113.2		

ACCESS TO HEALTH CARE (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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
% Have a Specific Source of Ongoing Care	71.5	72.1	77.4	79.8	78.6	76.0	77.2	76.8	78.6	76.6			69.9	84.0	66.1
% Routine Checkup in Past Year	70.4	67.2	72.5	73.5	74.7	71.5	70.5	71.1	72.8	71.5	74.7	78.3	65.3		66.8
% Two or More ER Visits in Past Year	18.3	13.9	9.5	8.3	9.0	11.8	11.2	10.3	13.1	11.8			15.6		4.9

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

better similar worse

CANCER	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)						154.1	144.9	147.1	174.7	154.6	148.5	151.3	146.5	122.7	178.5
Lung Cancer Deaths per 100,000 (Age-Adjusted)										34.3	31.8	36.3	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)										19.6	20.8	17.9	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)										21.9	18.7	20.2	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)										13.4	14.9	13.9	13.1	8.9	
Cancer Incidence per 100,000 (Age-Adjusted)						484.5	473.2	490.4	489.0	483.1	459.1	486.8	442.3		

CANCER (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
Lung Cancer Incidence per 100,000 (Age-Adjusted)						59.2	52.6	66.7	72.9	60.1	52.3	60.7	54.0		
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)						144.5	141.0	124.7	127.5	140.9	131.0	134.7	127.0		
Prostate Cancer Incidence per 100,000 (Age-Adjusted)						131.2	130.9	120.5	111.3	128.0	124.8	120.4	110.5		
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)						38.0	36.6	39.3	47.1	39.0	40.5	40.7	36.5		
% Cancer	8.5	8.2	8.3	9.6	4.9	8.4	7.9	13.2	11.7	8.8	11.1	12.3	7.4		9.2
% [Women 50-74] Breast Cancer Screening	77.9	78.1	83.2	85.4	92.5	82.9	82.4	78.2	79.7	82.2	76.9	79.6	64.0	80.5	82.3
% [Women 21-65] Cervical Cancer Screening	75.2	68.0	75.6	75.3	74.0	73.9	73.2	61.9	74.6	73.5			75.4	84.3	86.7
% [Age 50-75] Colorectal Cancer Screening	75.6	71.4	81.4	82.2	74.6	78.4	80.5	83.8	77.4	78.9	68.3	72.0	71.5	74.4	75.3

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

DIABETES	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
Diabetes Deaths per 100,000 (Age-Adjusted)						16.0	28.0	24.2	31.1	25.9	25.1	22.3	22.6		22.7
% Diabetes/High Blood Sugar	15.4	10.7	10.0	9.5	7.4	11.0	11.9	10.1	11.6	11.2	10.8	11.6	12.8		10.6
% Borderline/Pre-Diabetes	13.2	13.3	13.3	9.2	11.3	12.0	11.2	12.1	14.2	12.1			15.0		8.8
Kidney Disease Deaths per 100,000 (Age-Adjusted)						11.4	7.9		9.9	10.2	10.3	9.7	12.8		11.6

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

better similar worse

DISABLING CONDITIONS	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% Activity Limitations	34.1	29.6	24.0	29.2	23.0	28.5	29.1	27.0	37.0	29.6			27.5		18.4
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)						37.7	41.7	31.7	39.7	38.5	30.0	30.9	30.9		28.1

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

better similar worse

HEART DISEASE & STROKE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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
Heart Disease Deaths per 100,000 (Age-Adjusted)						132.6	130.9	167.7	180.3	139.7	144.8	170.3	164.4	127.4	151.3
% Heart Disease	10.7	8.1	6.9	6.9	11.0	8.2	6.9	7.9	10.6	8.2	6.6	6.7	10.3		5.2
Stroke Deaths per 100,000 (Age-Adjusted)						36.8	31.4	29.1	32.3	34.8	33.0	32.3	37.6	33.4	38.2
% Stroke	7.1	3.4	3.6	2.5	1.6	3.8	1.8	3.3	3.2	3.3	2.6	3.1	5.4		2.3

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

INFANT HEALTH & FAMILY PLANNING	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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 (Percent of Births)						5.7	3.3			5.1	4.9	4.3	6.1		4.0
Teen Births per 1,000 Females 15-19						18.4	9.5	10.9	20.0	16.5	16.0	14.4	16.6		
Low Birthweight (Percent of Births)						9.0	7.0	7.0	8.0	8.2	7.5	6.8	8.3		
Infant Deaths per 1,000 Births						6.1	3.8		7.5	5.8	5.4	4.8	5.5	5.0	5.2

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

INJURY & VIOLENCE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
Unintentional Injury Deaths per 100,000 (Age-Adjusted)						35.6	36.0	46.4	40.4	**36.5**	40.3	42.9	51.6	43.2	32.5
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)						8.4	9.4		13.3	**9.5**	12.3	10.5	11.4	10.1	
[65+] Fall-Related Deaths per 100,000 (Age-Adjusted)						59.3	80.0		63.6	**63.6**	67.8	87.4	67.1	63.4	
% [Age 45+] Fell in the Past Year	37.0	33.9	35.7	34.7	34.8	35.3	34.6	31.8	37.2	**35.3**					30.1
Homicide Deaths per 100,000 (Age-Adjusted)										**4.4**	3.0	3.0	6.1	5.5	6.2
Violent Crimes per 100,000						493.5	94.7	108.6	249.8	**369.3**	286.4	283.0	416.0		
% Neighborhood Is “Slightly/Not At All Safe”	42.0	39.6	14.4	8.9	4.7	22.6	8.2	5.3	21.8	**18.9**					17.4
% Victim of Intimate Partner Violence	24.7	24.3	16.2	18.0	18.6	20.2	15.7	16.3	26.5	**19.8**			20.3		12.0

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

MENTAL HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	23.2	27.5	22.9	20.6	17.5	22.7	20.9	20.4	26.2	**22.7**			24.4		9.0
% Diagnosed Depression	33.6	35.9	30.9	34.6	29.4	33.3	28.3	29.0	34.4	**32.3**	17.0	18.5	30.8		19.5
% Symptoms of Chronic Depression	47.4	49.4	39.3	40.2	38.3	43.0	37.1	35.0	44.9	**41.8**			46.7		25.1
% Typical Day Is "Extremely/Very" Stressful	19.1	16.9	17.4	19.7	16.2	18.2	16.4	13.5	22.1	**18.1**			21.1		11.5
Suicide Deaths per 100,000 (Age-Adjusted)						13.8	12.4		19.0	**14.1**	14.8	16.7	13.9	12.8	10.1
% Have Someone to Turn to All/Most of the Time	70.7	59.7	76.3	79.8	81.6	73.5	79.1	77.1	72.9	**74.6**					86.1
% Recent Anxiety	29.7	27.4	25.1	24.6	23.0	26.2	24.4	17.7	28.9	**25.9**					20.0
% Recent Depression	25.1	20.1	17.4	20.0	15.9	20.1	14.9	10.6	21.2	**18.9**					15.1
% Moderate to Severe Anxiety/Depression (PHQ-4 Score of 6+)	25.8	20.4	20.3	19.6	17.1	21.1	15.6	12.4	24.2	**20.0**					15.6
Mental Health Providers per 100,000						280.6	72.4	33.8	143.1	**214.5**	184.5	136.7	183.8		
% Receiving Mental Health Treatment	28.2	25.8	31.7	29.9	22.2	28.7	27.3	23.2	32.1	**28.6**			21.9		14.4

MENTAL HEALTH (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% Unable to Get Mental Health Services in Past Year	16.6	14.1	11.0	12.2	7.0	12.8	7.9	9.6	13.8	11.8			13.2		2.7

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

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% "Very/Somewhat" Difficult to Buy Fresh Produce	29.5	29.5	24.0	17.4	16.6	23.8	19.4	26.0	30.1	23.7			30.0		22.8
% 7+ Sugar-Sweetened Drinks in Past Week	30.9	33.8	23.4	22.3	24.2	26.3	25.3	28.2	31.1	26.8					28.3
% No Leisure-Time Physical Activity	26.3	32.3	22.5	23.2	21.2	25.2	27.1	30.3	32.0	26.5	24.7	25.9	30.2	21.8	16.7
% Meet Physical Activity Guidelines	21.8	25.8	28.8	31.5	33.8	27.9	24.7	21.1	22.1	26.4	20.9	20.1	30.3	29.7	22.0
Recreation/Fitness Facilities per 100,000						20.4	13.1		13.9	17.5	14.2	12.1	14.8		
% Lack of Sidewalks/Poor Sidewalks Prevent Exercise	33.2	25.7	16.1	15.0	16.8	21.2	12.5	40.6	26.3	20.6					20.1
% Lack of Trails/Poor Quality Trails Prevent Exercise	26.6	21.7	14.7	13.9	13.6	18.2	12.5	23.9	18.6	17.2					12.9
% Heavy Neighborhood Traffic Prevents Exercise	29.1	29.4	19.9	16.6	12.7	22.1	9.7	6.7	20.3	18.9					16.7

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% Lack of Street Lights/Poor Street Lights Prevent Exercise	17.6	17.6	10.0	7.0	9.5	12.1	7.0	21.3	17.6	12.0					9.4
% Crime Prevents Exercise in the Neighborhood	34.2	24.8	12.0	7.8	5.1	17.4	4.1	3.9	17.0	14.2					11.0
% Overweight (BMI 25+)	69.7	73.7	70.1	67.2	70.4	69.8	75.4	70.1	80.1	72.2	70.4	71.2	63.3		67.5
% Obese (BMI 30+)	39.8	36.7	35.9	32.6	33.3	35.7	41.9	46.1	45.4	38.4	35.3	37.4	33.9	36.0	30.3
% Have Received Professional Advice to Lose Weight	24.3	25.9	26.8	27.7	24.5	26.2	22.8	24.1	25.4	25.3					24.7

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

better similar worse

ORAL HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% Dental Visit in Past Year	60.5	57.7	68.7	71.2	78.8	66.4	74.1	63.5	61.8	67.4	66.2	68.3	56.5	45.0	70.4

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

better similar worse

RESPIRATORY DISEASE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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
Lung Disease Deaths per 100,000 (Age-Adjusted)						45.4	36.6	49.0	52.3	44.8	45.7	42.3	38.1		50.4
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)						13.2	12.9		18.7	13.7	14.2	13.8	13.4		14.7
% Asthma	18.2	13.7	10.7	11.1	8.5	12.8	10.9	9.2	14.8	12.5	8.1	9.7	17.9		8.6
% COPD (Lung Disease)	7.6	5.9	5.5	5.0	4.3	5.8	3.3	6.3	11.3	5.9	5.6	6.6	11.0		7.4

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.

better similar worse

SEXUAL HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000						83.2	24.9	26.4	152.4	76.3	147.1	114.2	382.2		
Chlamydia Incidence per 100,000						653.2	406.9	174.0	522.0	572.1	453.1	489.2	495.5		
Gonorrhea Incidence per 100,000						289.9	118.9	37.0	225.1	238.8	156.0	200.5	214.0		

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

better similar worse

SUBSTANCE USE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)						18.6	9.8		13.7	15.8	12.0	9.9	11.9		8.5
% Excessive Drinking	26.5	24.0	21.6	25.8	27.9	24.7	18.3	21.3	19.8	22.7	20.5	22.6	34.3		26.0
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)						9.4	7.4		9.5	8.9	7.4	9.4	21.0		7.3
% Used a Prescription Opioid in Past Year	17.2	9.8	14.5	11.4	12.4	13.2	11.5	17.5	16.9	13.4			15.1		18.1
% Ever Sought Help for Alcohol or Drug Problem	9.3	13.0	5.7	7.1	4.4	8.1	4.2	4.3	8.6	7.2			6.8		3.9

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

better similar worse

TOBACCO USE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				Metro Area	METRO 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
% Smoke Cigarettes	20.7	20.1	13.3	12.0	10.7	15.6	10.1	13.3	19.5	14.8	13.0	14.7	23.9	6.1	17.0
% Someone Smokes at Home	19.2	16.4	10.0	7.9	9.2	12.5	5.9	12.6	14.7	11.4			17.7		15.1
% Use Vaping Products	16.5	15.6	9.6	8.4	11.8	12.0	10.0	9.9	10.8	11.3	8.5	6.7	18.5		5.8
% [Smokers] Have Quit Smoking 1+ Days in Past Year										49.3	52.8	52.4	53.1	65.7	50.7

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

better similar worse

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The four-county Metro Area, the focus of this Community Health Needs Assessment, encompasses 2,073 square miles and houses a total population of 895,395 residents, according to latest census estimates.

Total Population
(Estimated Population, 2020)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Douglas County	584,526	326.41	1,791
Sarpy County	190,604	238.10	801
Cass County	26,598	557.34	48
Pottawattamie County	93,667	951.26	98
Metro Area	**895,395**	**2,073.11**	**421**
Nebraska	**1,961,504**	**76,817.44**	**26**
Iowa	**3,190,369**	**55,853.11**	**57**
United States	**331,449,281**	**3,533,018.38**	**94**

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

Population Change 2010-2020

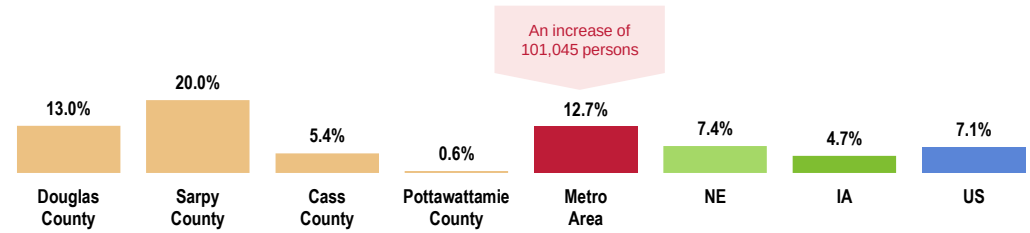
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2010 and 2020 US Censuses, the population of the Metro Area increased by 101,045 persons, or 12.7%.

BENCHMARK ► The growth rate is much higher than recorded statewide and nationally.

DISPARITY ► The largest growth is seen in Sarpy and Douglas counties.

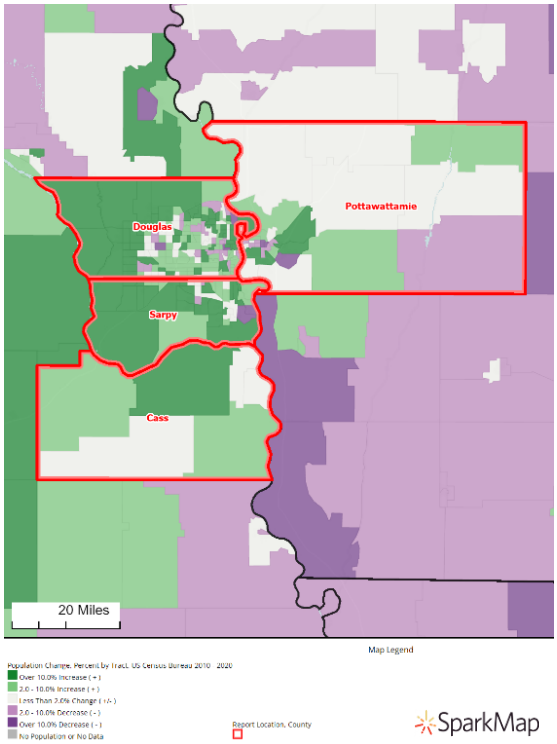
Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

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

This map shows the areas of greatest increase or decrease in population between 2010 and 2020.



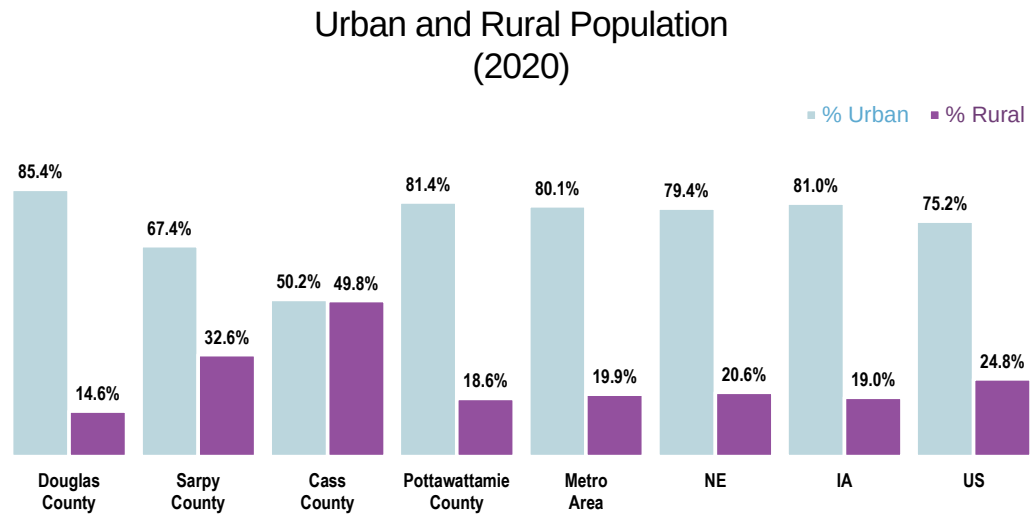
Urban/Rural Population

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

The Metro Area is predominantly urban, with 80.1% of the population living in areas designated as urban.

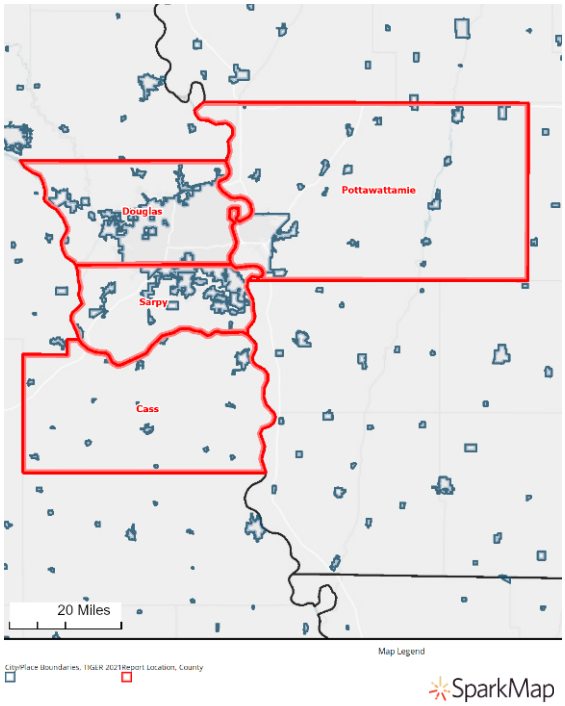
BENCHMARK ► Similar to the states' urban populations and higher than the nation's.

DISPARITY ► Note the disparity in urban/rural classifications between the four counties.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

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



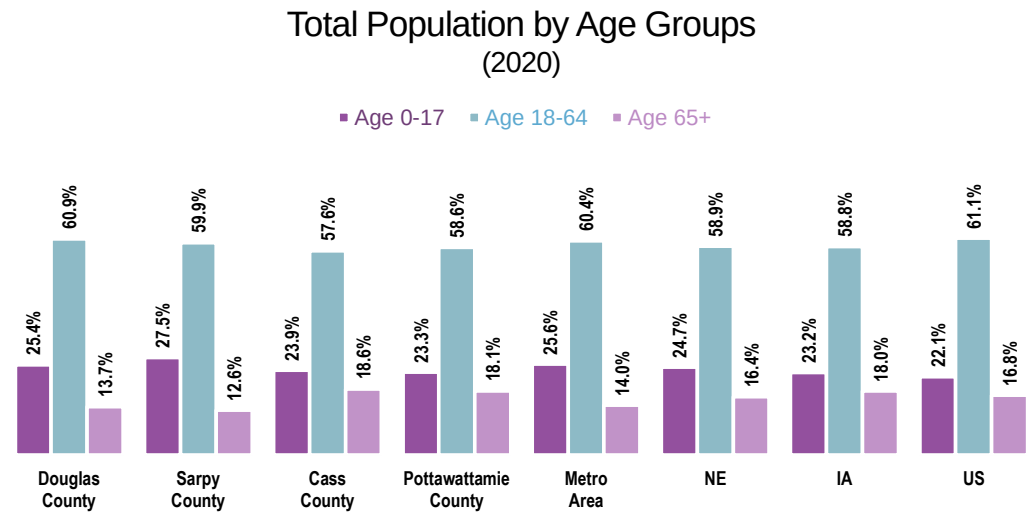
Age

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

In the Metro Area, 25.6% of the population are children age 0-17; another 60.4% are age 18 to 64, while 14.0% are age 65 and older.

BENCHMARK ► The Metro Area overall skews a bit younger than Nebraska, Iowa, and the US.

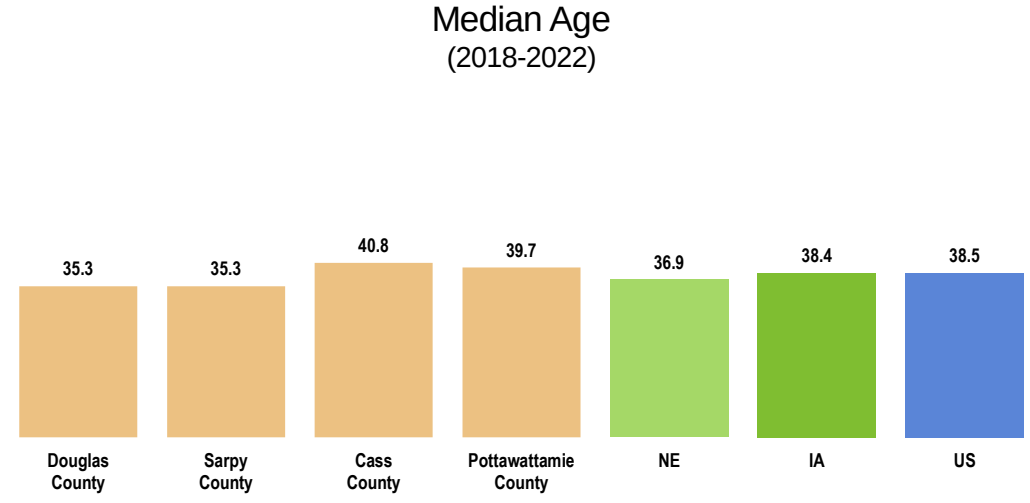
DISPARITY ► By county, Sarpy has the largest proportion of children under 18 and the smallest proportion of adults age 65+.



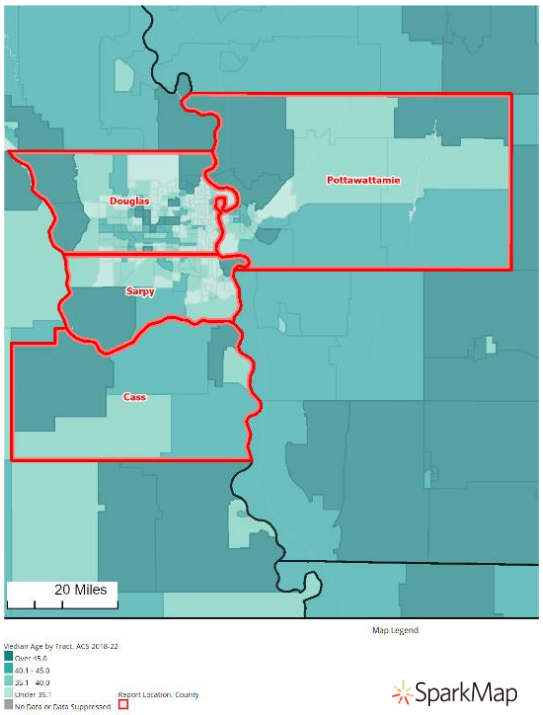
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Median Age

Douglas and Sarpy counties are "younger" than the state and the nation in that the median age is lower. (A composite median is not available for the Metro Area as a whole.)



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



Race & Ethnicity

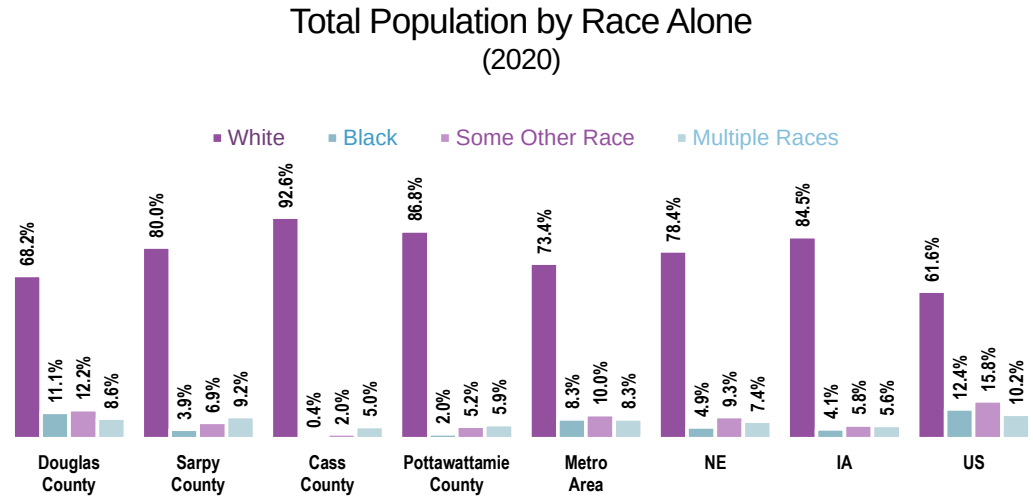
Race

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

In looking at race independent of ethnicity (Hispanic or Latino origin), 73.4% of Metro Area residents are White and 8.3% are Black.

BENCHMARK ► The area is more diverse than either state but less diverse than the US as a whole.

DISPARITY ► Douglas County is the most racially diverse of the four counties.



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

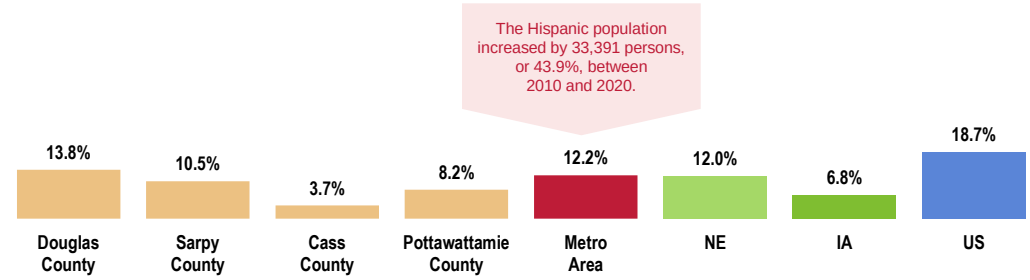
Ethnicity

A total of 12.2% of Metro Area residents are Hispanic or Latino.

BENCHMARK ► Higher than the Iowa proportion but well below the US proportion.

DISPARITY ► The percentage of Hispanic residents is highest in Douglas County.

Hispanic Population
(2020)



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

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

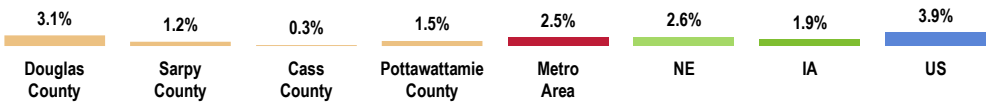
Linguistic Isolation

A total of 2.5% of the area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

BENCHMARK ► Higher than the Iowa figure but lower than the US figure.

DISPARITY ► Highest in Douglas County.

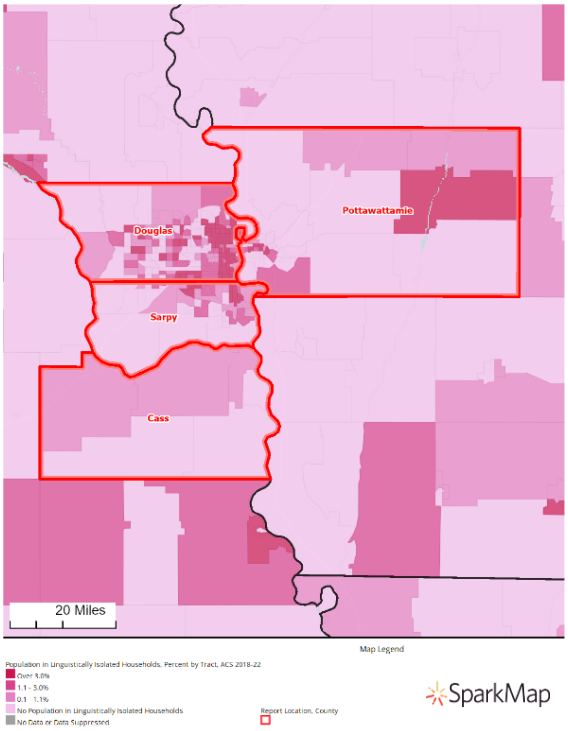
Linguistically Isolated Population
(2018-2022)



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

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

Note the following map illustrating linguistic isolation throughout the Metro Area.



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

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

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

Poverty

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 9.7% of the Metro Area total population living below the federal poverty level.

BENCHMARK ► Lower than the US prevalence but fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Highest in Douglas and Pottawattamie counties.

Among just children (ages 0 to 17), this percentage in the Metro Area is 11.6% (representing an estimated 25,791 children).

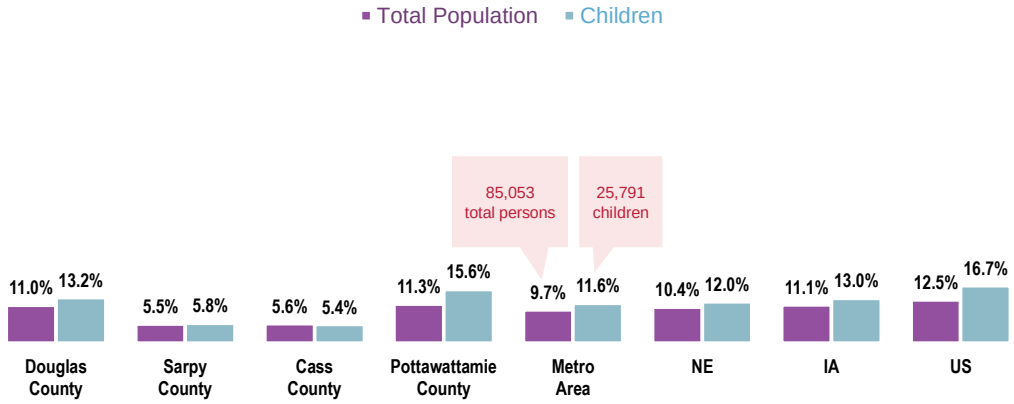
BENCHMARK ► Lower than the US prevalence but fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Highest in Douglas and Pottawattamie counties.

Population in Poverty

(Populations Living Below the Poverty Level; 2018-2022)

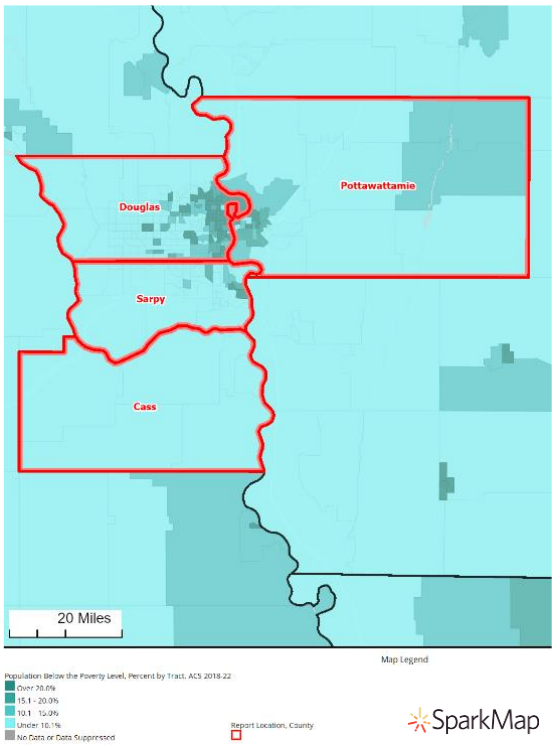
Healthy People 2030 = 8.0% or Lower

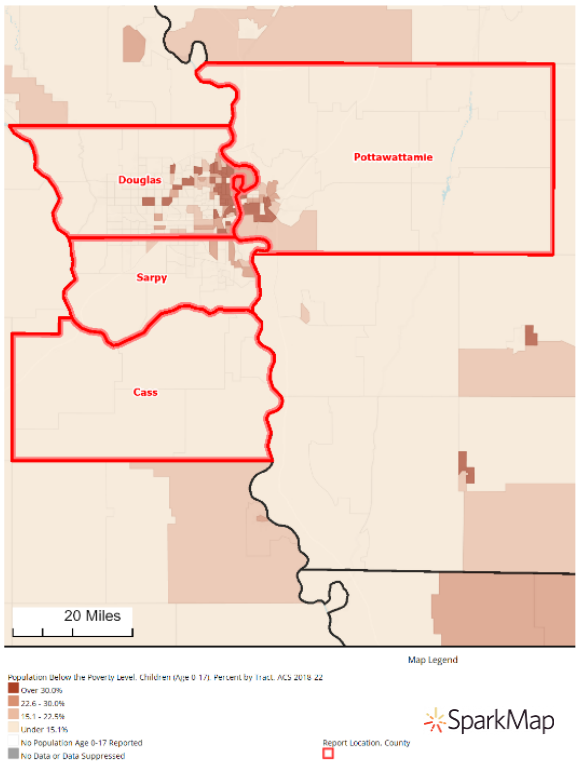


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

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





Education

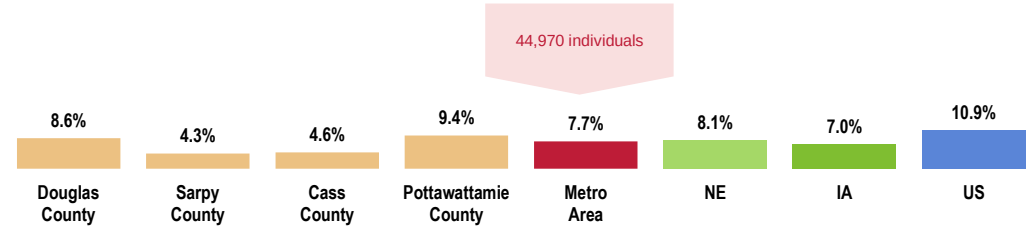
Among the Metro Area population age 25 and older, an estimated 7.7% (nearly 45,000 people) do not have a high school education.

BENCHMARK ► Lower than the national percentage.

DISPARITY ► Highest in Douglas and Pottawattamie counties.

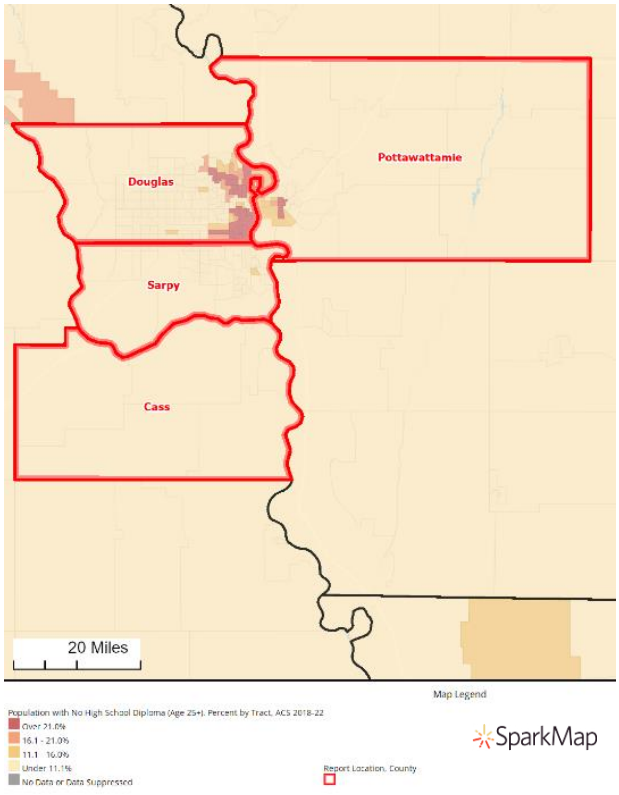
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2018-2022)



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

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

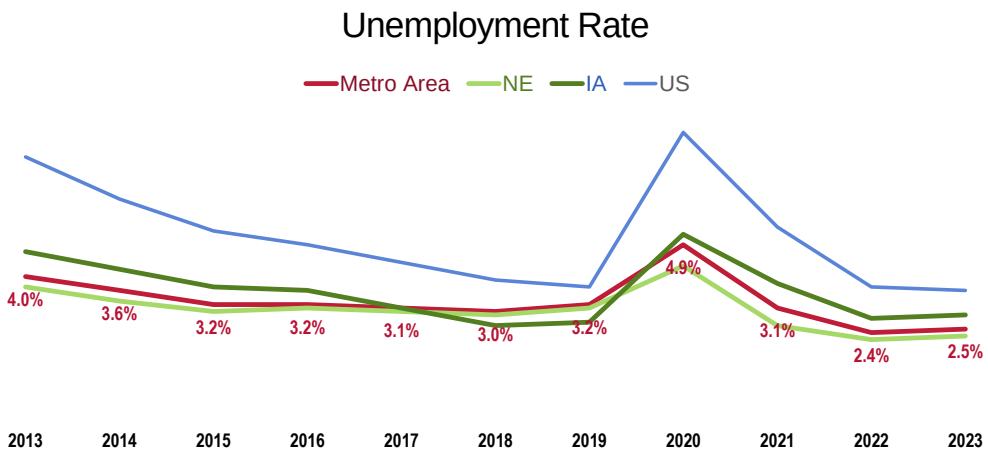


Employment

According to data derived from the US Department of Labor, the 2023 unemployment rate in the Metro Area was 2.5%.

BENCHMARK ► Lower than the Iowa and US unemployment rates.

TREND ► Following significant increases in 2020 (attributed to the COVID-19 pandemic), unemployment has dropped below pre-pandemic levels, and lower than found a decade ago.



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

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 24.3% of Metro Area residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.

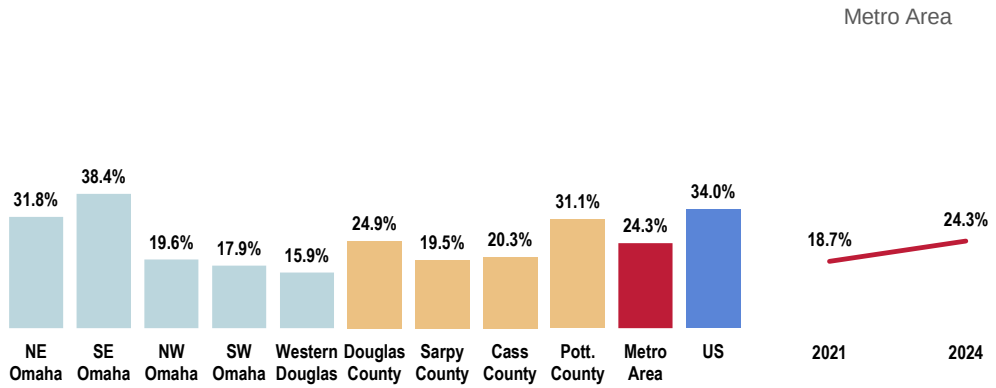
BENCHMARK ► Well below the national prevalence.

TREND ► Marks a statistically significant increase since 2021.

DISPARITY ► In Douglas County, highest among residents east of 72nd Street. By county, highest among Pottawattamie adults. The prevalence decreases with age and household income level, and is reported more often among women, Hispanic residents, White residents, those of Diverse Races, and adults who identify as LGBTQ+.

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

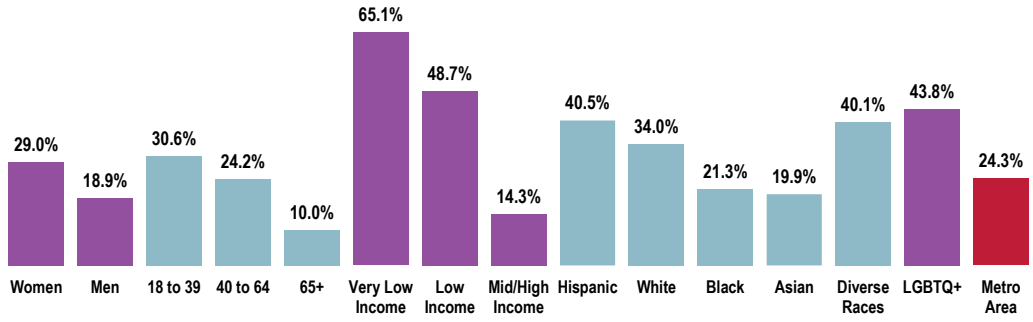
Do Not Have Cash on Hand to Cover a $400 Emergency Expense



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

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

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



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
Notes: ● Asked of all respondents.
● Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

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 2023 guidelines place the poverty threshold for a family of four at $30,000 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.

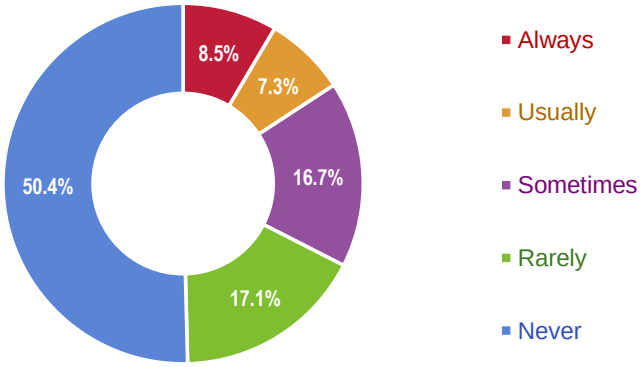
RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Data are also detailed for individuals identifying with a race category, without Hispanic origin. "White" reflects those who identify as White alone, without Hispanic origin. "Diverse Races" includes those who identify as American Indian or Alaska Native, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

Housing

Housing Insecurity

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

Frequency of Worry or Stress
About Paying Rent or Mortgage in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

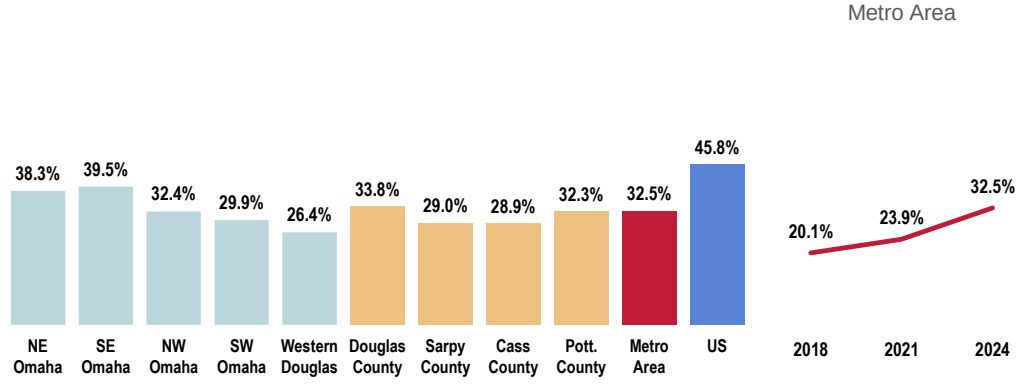
However, nearly one-third (32.5%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

BENCHMARK ► Well below the national figure.

TREND ► Increasing significantly since 2018.

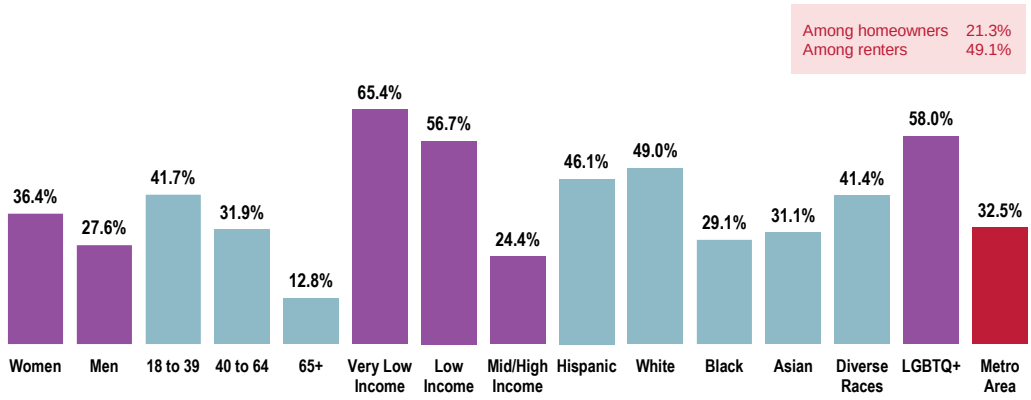
DISPARITY ► Highest in Douglas County (especially east of 72nd Street). Reported more often among women, young adults, those in low-income households, Hispanic respondents, White respondents, LGBTQ+ respondents, and people who rent.

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



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

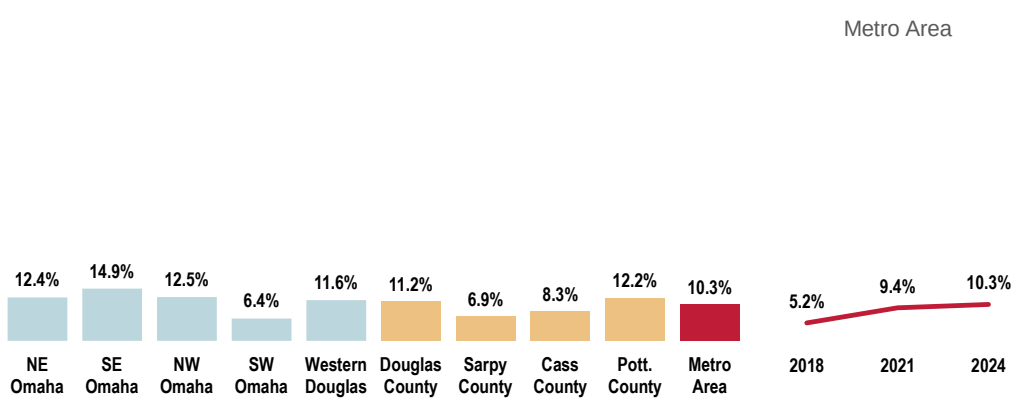
Loss of Utilities

A total of 10.3% of Metro Area residents were without electricity, water, or heat at some point in the past year.

TREND ► Twice the 2018 prevalence (a statistically significant increase).

DISPARITY ► Highest in Douglas County (especially the Southeast Omaha area). Reported more often among men, adults living in low-income households, LGBTQ+ adults, and those who rent.

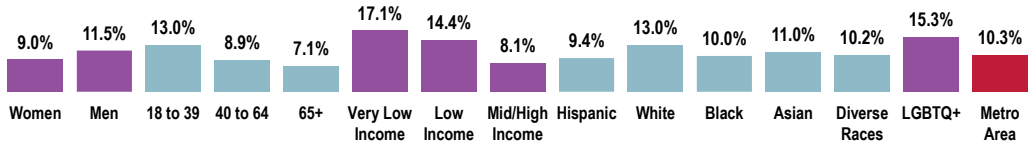
Went Without Electricity, Water, or Heating in the Past Year



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: ● Asked of all respondents.

Went Without Electricity, Water, or Heating in the Past Year
(Metro Area, 2024)

Among homeowners	7.6%
Among renters	14.0%



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: • Asked of all respondents.

Unhealthy or Unsafe Housing

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

A total of 13.1% of Metro Area residents report living in unhealthy or unsafe housing conditions during the past year.

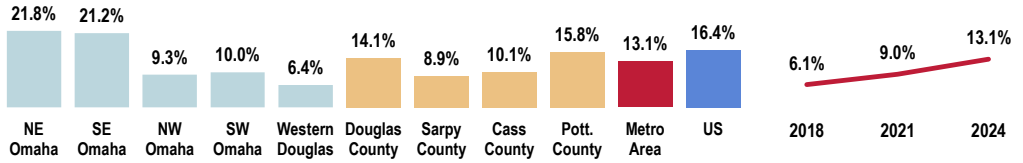
BENCHMARK ► Lower than the US prevalence.

TREND ► Denotes a statistically significant increase since 2018.

DISPARITY ► Higher in Douglas County (especially east of 72nd Street); *due to sample size, the findings for Pottawattamie County are not significant.* The Metro Area prevalence decreases with age and household income level and is reported more often among women, Hispanic adults, Black or African American adults, those who identify as LGBTQ+, and renters.

Unhealthy or Unsafe Housing Conditions in the Past Year

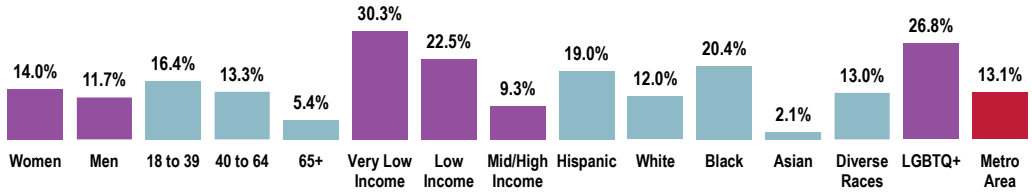
Metro Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Metro Area, 2024)

Among homeowners	8.0%
Among renters	19.7%



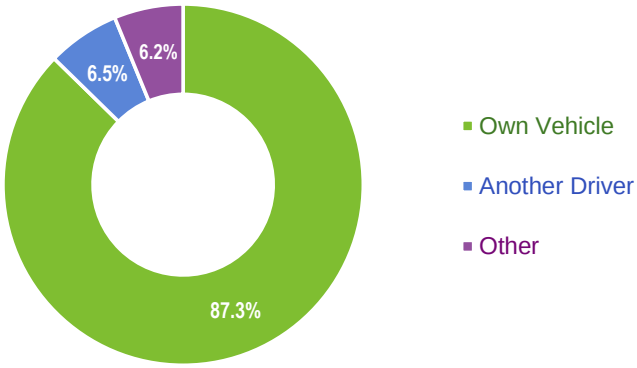
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
Notes: • Asked of all respondents.
• Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Transportation

While the vast majority of survey respondents report owning their own vehicle for transportation purposes, 12.7% rely on other means of transportation.

This includes a total of 6.5% who have **someone else who drives them** and 6.2% who rely on other modes like **public transportation**, **walking**, etc.

Primary Form of Transportation
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: • Asked of all respondents.

Food Access

Low Food Access

Low food access is defined as living more than 1/2 mile (in urban areas, or 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

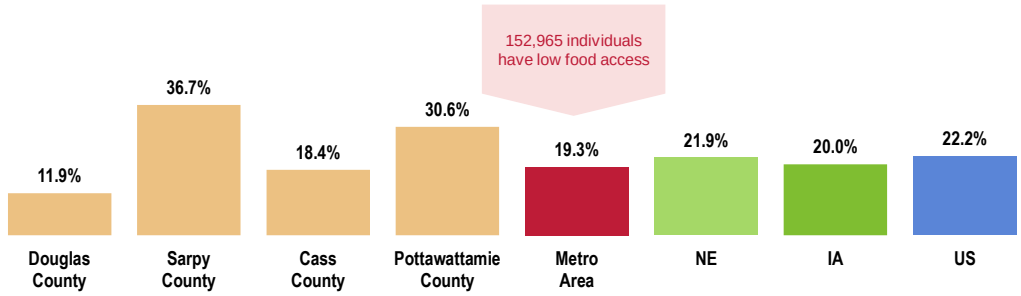
RELATED ISSUE
See also Difficulty Accessing Fresh Produce in the *Nutrition, Physical Activity & Weight* section of this report.

US Department of Agriculture data show that 19.3% of the Metro Area population (representing nearly 153,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

BENCHMARK ► Lower than the US percentage.

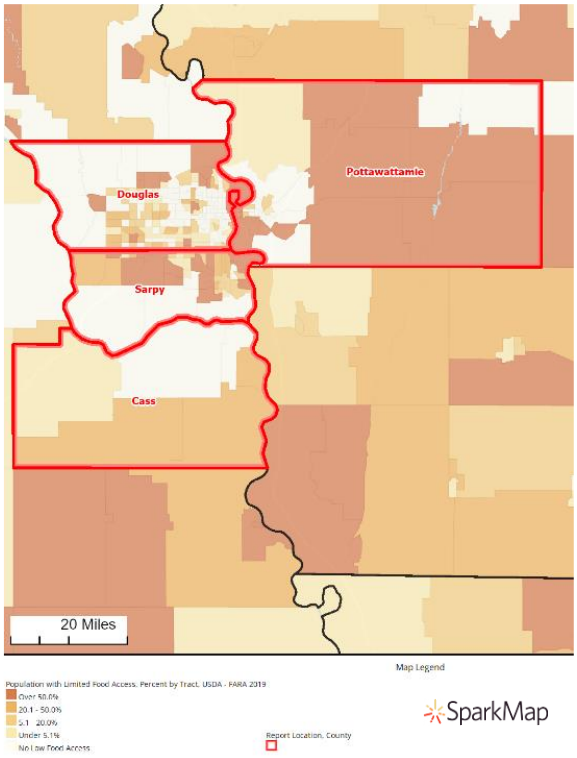
DISPARITY ► Highest in Sarpy and Pottawattamie counties.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



Food Insecurity

Surveyed adults 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" or "sometimes" true for either statement are considered to be food insecure.

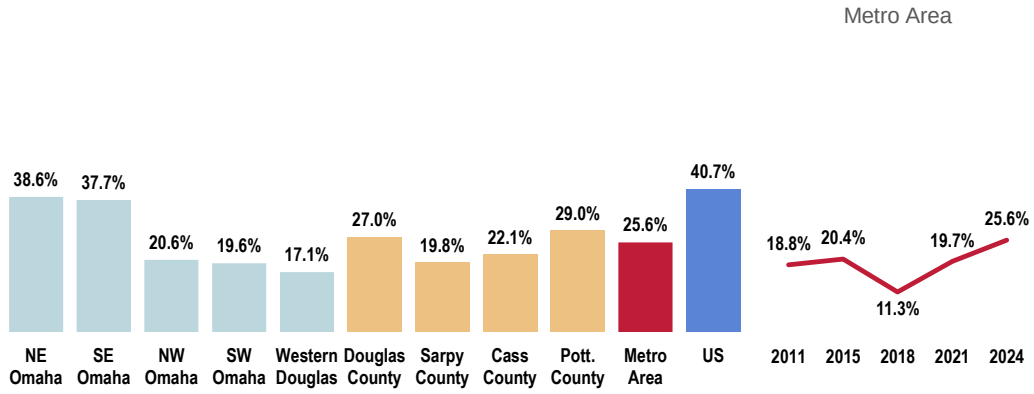
Over the past year, 25.6% of Metro Area residents "often" or "sometimes" worried about running out of food.

BENCHMARK ► Well below national findings.

TREND ► Increasing significantly to the highest percentage recorded to date.

DISPARITY ► Highest in Douglas County (especially the eastern region).

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



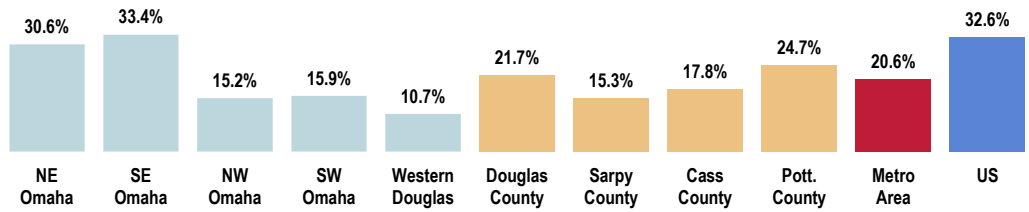
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 67]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

In fact, 20.6% of adults actually ran out of food in the past year before there were funds to buy more.

BENCHMARK ► Well below the US figure.

DISPARITY ► By county, highest in Douglas and Pottawattamie counties. In Douglas County, much higher east of 72nd Street.

Ran Out of Food in the Past Year



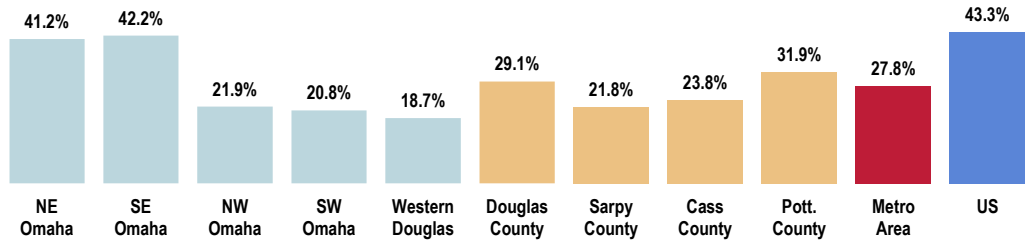
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Overall, 27.8% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

BENCHMARK ► Lower than the national prevalence.

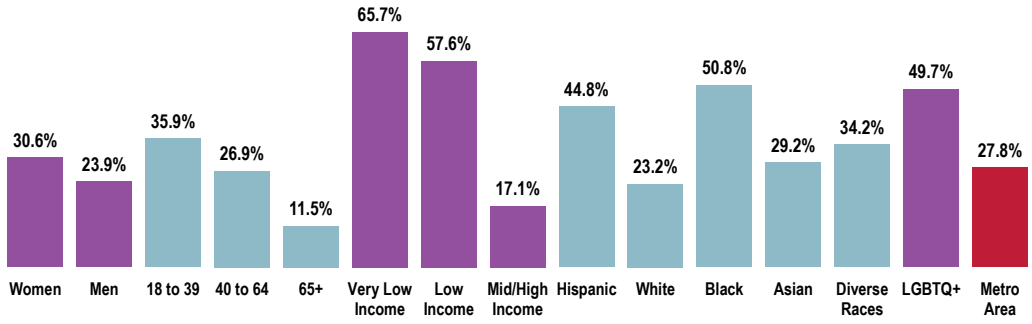
DISPARITY ► By county, highest in Douglas and Pottawattamie counties. Especially high in Omaha east of 72nd Street. The percentage decreases with age and household income level and is reported more often among women, Hispanic adults, Black or African American adults, and LGBTQ+ adults.

Food Insecure



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Food Insecure
(Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: ● Asked of all respondents.

Discrimination

Unfair Treatment

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

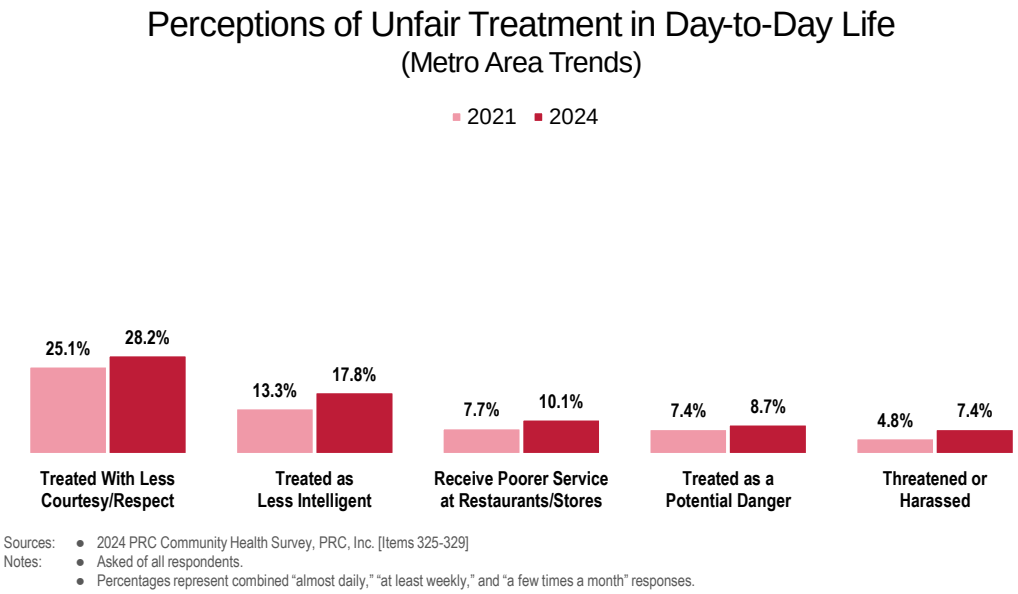
In your day-to-day life, how often do the following things happen to you:

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

Over one in four survey respondents (28.2%) reports that in their daily lives, they feel that they are frequently (a few times per month or more often) treated with less courtesy or respect than other people; another 17.8% report frequently being treated as less intelligent than others.

Fewer respondents (10.1%) report frequently receiving **poorer service** at restaurants and stores, and 8.7% report frequently being treated as a **potential danger** by others. A total of 7.4% of survey respondents have been frequently **threatened or harassed**.

TREND ► With the exception of being treated as a potential danger, each of these indicators has increased significantly since 2021.



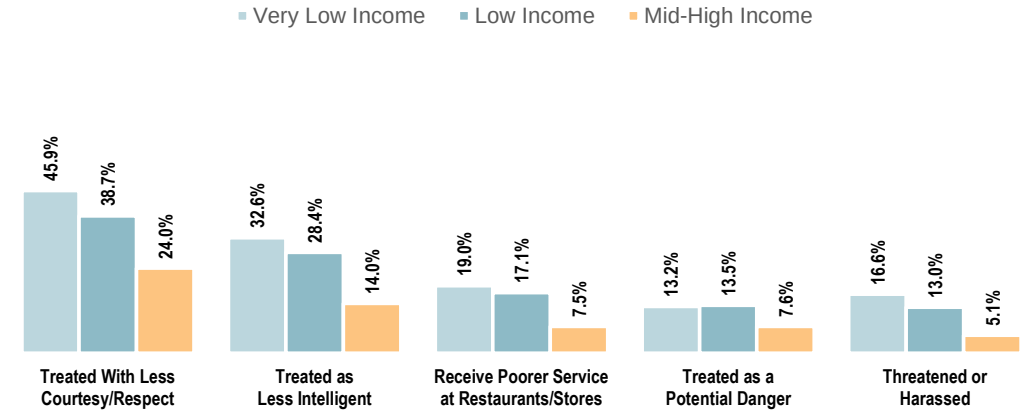
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 325-329]
Notes: ● Asked of all respondents.
● Percentages represent combined "almost daily," "at least weekly," and "a few times a month" responses.

For those who felt they were treated differently, reasons were most often attributed to ***race/ethnicity, gender, age, or height/weight*** (although nearly one out of four was unsure of the main reason why).

Further looking at these responses according to these respondents' characteristics, notable differences also appeared for income.

DISPARITY ► Viewed by **household income level**, note the negative correlation between household income and the tested aspects of unfair treatment, with those in very low income households more likely to report each.

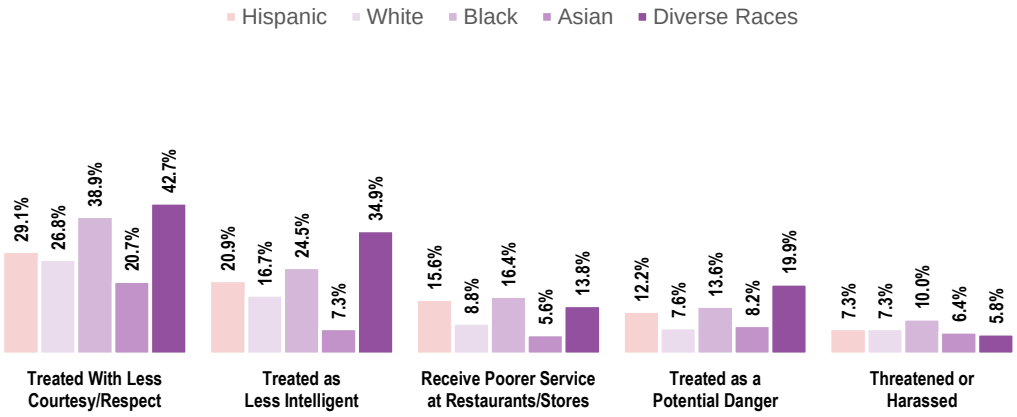
Perceptions of Unfair Treatment in Day-to-Day Life
(By Household Income Level; Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 325-329]
Notes: • Asked of all respondents.
• Percentages represent combined "almost daily," "at least weekly," and "a few times a month" responses.

DISPARITY ► Viewed by **race/ethnicity**, Black or African American adults reported the highest percentage of being *threatened or harassed*. For all others, responses were notably higher for Hispanic respondents, Black or African American respondents, and respondents of Diverse Races.

Perceptions of Unfair Treatment in Day-to-Day Life
(By Race/Ethnicity; Metro Area, 2024)

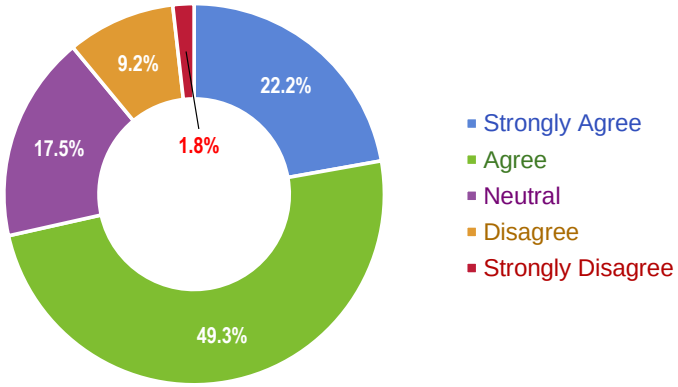


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 325-329]
Notes: • Asked of all respondents.
• Percentages represent combined "almost daily," "at least weekly," and "a few times a month" responses.

Community as a Welcoming Place for All Races/Ethnicities

Most Metro Area adults agree that the community is a welcoming place for people of all races and ethnicities, with over 70% giving "agree" or "strongly agree" responses.

Level of Agreement About the Community as a Welcoming Place for People of All Races and Ethnicities
(Metro Area, 2024)

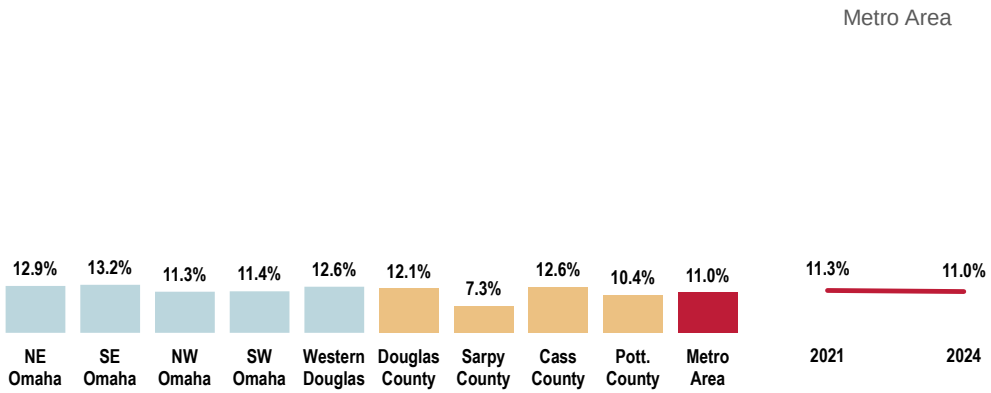


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.

However, 11.0% of residents do not agree that the community is welcoming to all people.

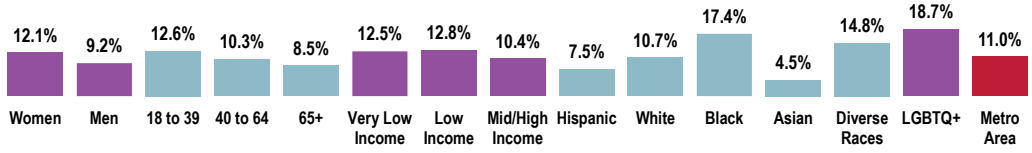
DISPARITY ► Disagreement is lowest in Sarpy County. By race/ethnicity, highest among Black or African American adults and those of Diverse Races. Also higher among women, young adults, and those who identify as LGBTQ+.

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



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.
• Percentages include "disagree" and "strongly disagree" responses.

Disagree That the Community is a Welcoming Place for All Races/Ethnicities
(Metro Area, 2024)



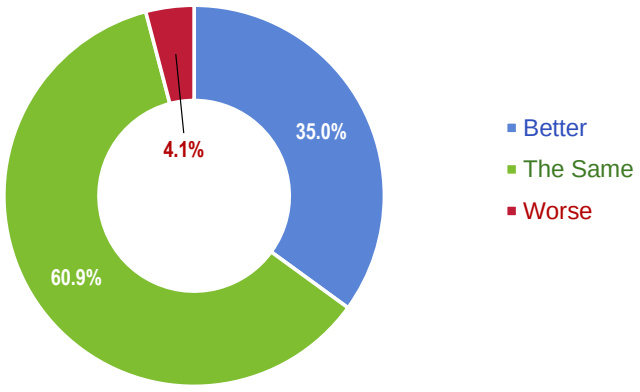
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.
• Percentages include "disagree" and "strongly disagree" responses.

Treatment Based on Race/Ethnicity in Health Care Settings

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

Over one-third (35.0%) of survey respondents feel they were treated "better" than people of other races or ethnicities during their recent health care experiences; most (60.9%) felt they were treated "the same."

Treated in Health Care Settings Over the Past Year in Comparison With People of Other Races/Ethnicities
(Metro Area, 2024)



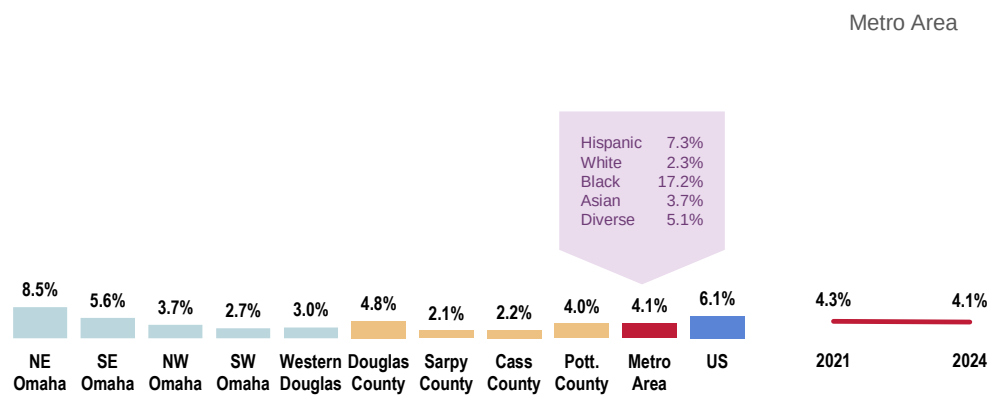
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: • Asked of all respondents.
• As compared to the experiences of people of other races or ethnicities.

On the other hand, 4.1% of residents perceive their treatment as being "worse" than people of other races during recent health care experiences.

BENCHMARK ► Lower than the national prevalence.

DISPARITY ► Reported most often in Douglas County (primarily from the county's northeast region). Reported most often among Black or African American respondents.

Recent Health Care Experiences Were Worse Due to Race



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 307]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

When respondents were asked how their "worse" treatment has affected the way they try to get their health care, the largest share (60.0%) indicated that they **have not changed** their health-seeking behaviors as a result, and 6.9% were unsure. However, 6.7% report **avoiding care** or **putting off** their care as long as possible when in need of health care services.

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 use 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

A series of 11 survey questions was used to identify adults' experiences of adverse childhood events prior to the age of 18 years. These 11 questions align with eight ACEs categories, as outlined in the following table.

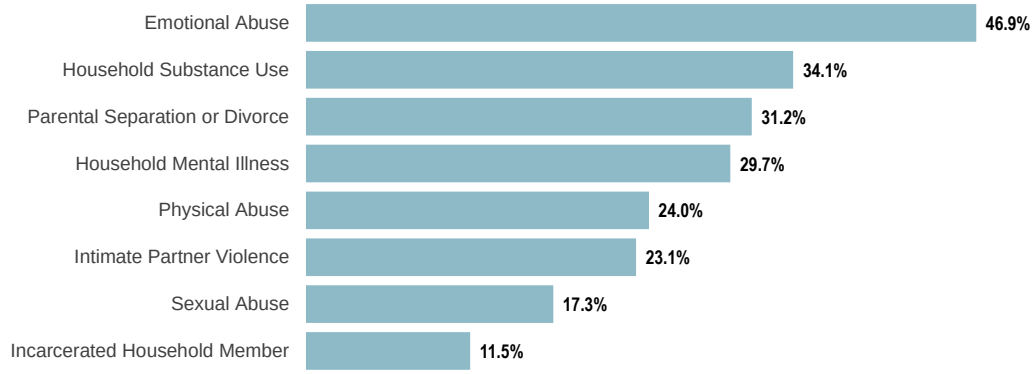
Adverse Childhood Experiences (ACEs)

CATEGORY	QUESTION
HOUSEHOLD MENTAL ILLNESS	Before you were 18 years of age, did you live with anyone who was depressed, mentally ill, or suicidal?
HOUSEHOLD SUBSTANCE USE	Before you were 18 years of age, did you live with anyone who was a problem drinker or alcoholic?
	Before you were 18 years of age, did you live with anyone who used illegal street drugs or who abused prescription medications?
INCARCERATED HOUSEHOLD MEMBER	Before you were 18 years of age, did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?
PARENTAL SEPARATION OR DIVORCE	Before you were 18 years of age, were your parents separated or divorced?
INTIMATE PARTNER VIOLENCE	Before age 18, how often did your parents or adults in your home slap, hit, kick, punch or beat each other up?
PHYSICAL ABUSE	Before age 18, how often did a parent or adult in your home hit, beat, kick, or physically hurt you in any way? Do not include spanking.
EMOTIONAL ABUSE	Before age 18, how often did a parent or adult in your home swear at you, insult you, or put you down?
SEXUAL ABUSE	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you touch you sexually?
	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you try to make you touch them sexually?
	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you force you to have sex?

Sources: • 2024 PRC Community Health Survey, PRC, Inc.
Notes: • Reflects the total sample of respondents.

By category, ACEs were most prevalent in the Metro Area for emotional abuse (experienced by 46.9% of respondents during childhood), followed by household substance use (34.1%) and parental separation or divorce (31.2%).

Adverse Childhood Experiences (ACEs)
(Metro Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 344-351]

Notes:
- Reflects the total sample of respondents.
- 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.

High ACE Scores

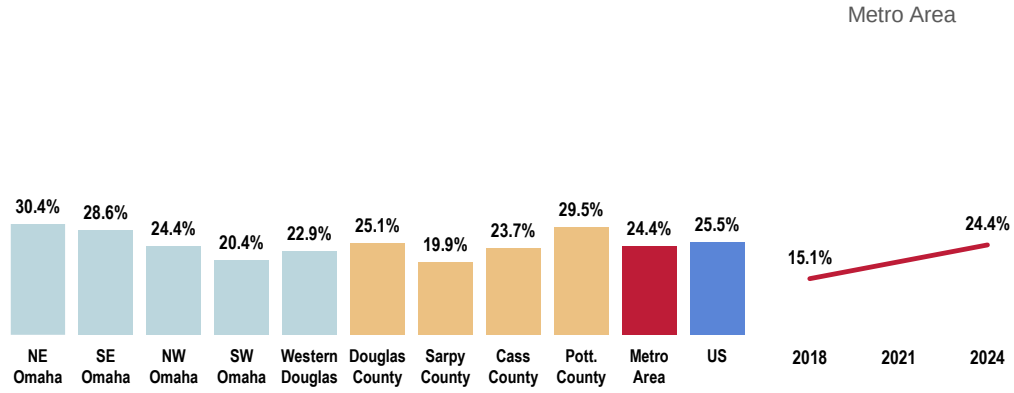
The impact of ACEs on future health and well-being are cumulative. PRC looks at these compounding issues by scoring the ACE series — survey respondents receive one "point" for each of the eight ACEs categories containing an affirmative response; a score of four or higher is determined to be a "high" ACE score.

In all, 24.4% of Metro Area residents reported four or more of the adverse childhood experiences tested (a high ACE score).

TREND ► Increasing significantly since 2018 (the series was not addressed in 2021).

DISPARITY ► Highest in Northeast Omaha and Pottawattamie County. The prevalence decreases with age and household income level and is also reported more often among women, Hispanic adults, Black or African American adults, those of Diverse Races, and people who identify as LGBTQ+.

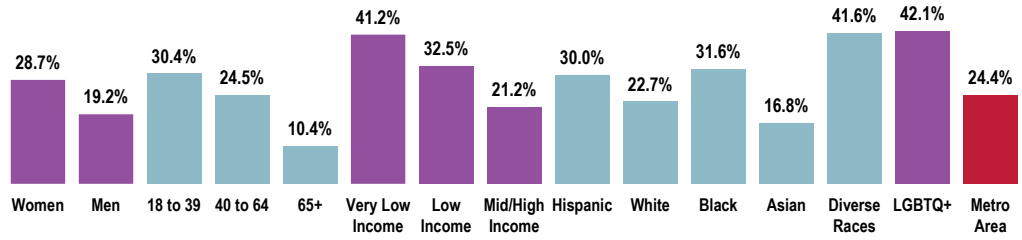
Prevalence of High ACE Scores (Four or More ACEs)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 352]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Adults who report four or more ACEs is categorized as having a high ACE score.

Prevalence of High ACE Scores (Four or More ACEs)
(Metro Area, 2024)



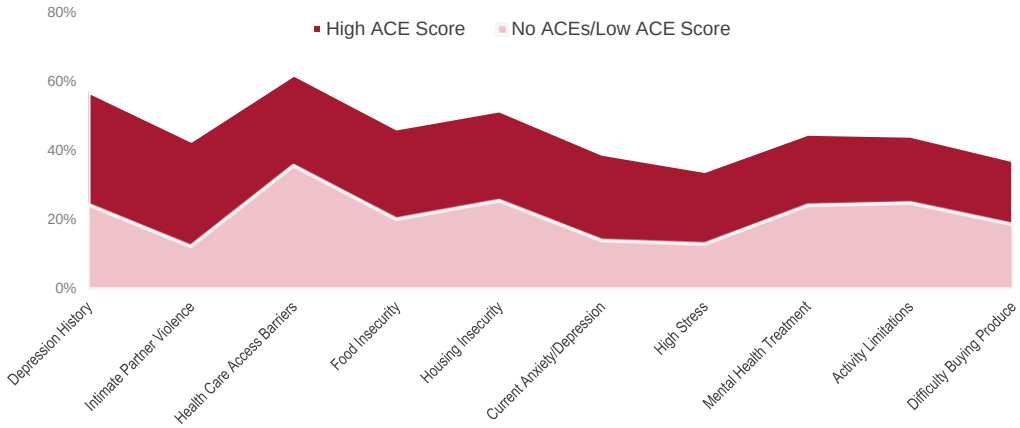
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 352]
Notes: ● Asked of all respondents.
● Adults who report four or more ACEs is categorized as having a high ACE score.

Relationship of ACEs with Other Health Issues

As a person's ACE score increases, so does their risk for disease, social issues, and emotional problems.

Note the following strong correlations of various health indicators in the Metro Area, comparing those reporting no ACEs with those with low (1-3) and high (4+) ACE risk.

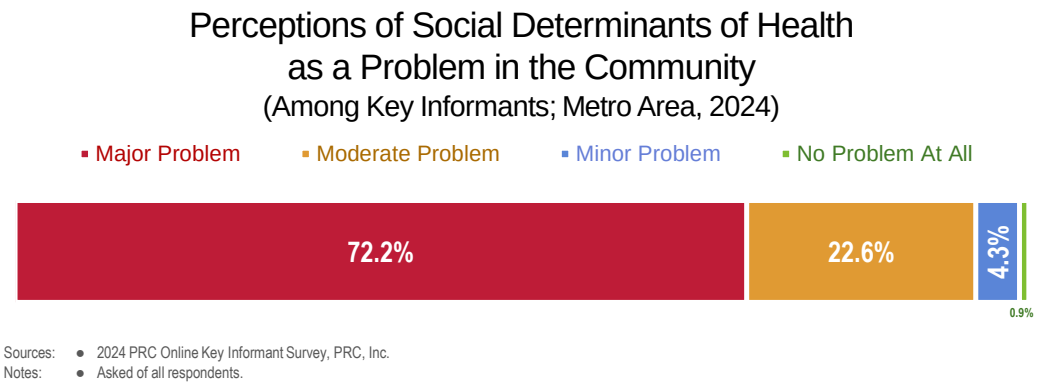
Relationship of ACEs With Other Health Issues
(By ACE Risk Classification; Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 352]
Notes: ● Asked of all respondents.
● Adults with at least one ACE are categorized as having a low score (1 to 3 ACEs) or a high score (4+ ACEs).

Key Informant Input: Social Determinants of Health

The greatest share of key informants taking part in an online survey characterized *Social Determinants of Health* as a "major problem" in the community.



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Housing

Housing is a pretty big issue in the community, especially for low-income families. Education is also a problem in the urban areas of the community. – Community Leader

There is a huge shortage of affordable housing in the metro area, incomes are stagnant, and everything is so expensive. – Social Services Provider

Housing costs (rent, mortgage) are astronomical for average families. The cost of living compared to wages is high. Access to health care, but more so, adequate health coverage or available money for health care. Safe environments for low-income families, especially those of color and refugees. Education is not equal across the city. – Health Provider

There is not enough affordable housing in Omaha. Our most vulnerable populations receive on average $1,000 a month from social security or disability. That is not enough to cover rent, utilities, and food. Homelessness has increased and resources are available; however, the process of accessing resources is too complicated and overwhelming for the population they are meant to serve. – Health Provider

People living in our community have difficulty accessing affordable housing and suffer from health disparities. – Physician

Lack of housing, transportation and food security are a major problem facing my patient population. – Health Provider

Lack of housing causes increased truancy in school/collage attendance, low or lack of income cause an increase in mental and medical issues, environmental concerns health issues such as lead, poor water quality. Discrimination causes low self-esteem, poor choices in basic needs (Maslow hierarchy). No or little knowledge of medical follow-up. Poor lifestyle choices such as smoking, alcohol, drugs, which lead to medical conditions. – Health Provider

We have a 0.9% homeowner vacancy rate and a 1.4% rental vacancy rate. There are almost literally no places to live. – Community Leader

The impact of housing, poverty, and access to healthy food has geocentric limitations. – Physician

Lack of affordable housing, increase in food insecurity, truancy in the schools. – Social Services Provider

The lack of affordable housing and/or acceptance and availability of housing vouchers is out of control. LGBTQ+ unhoused individuals have NO OPTIONS for housing, unless they are 18-26, because most programs are always full, religiously affiliated, or focused on emergent intervention for chronically unhoused. There is a need for primarily transitional and supportive housing, and rapid rehousing rather than interventions in the most emergent interventions. The state legislature continues to invest in corporate tax incentives without thresholds for pay, which allows businesses to pay poorly, not provide benefits, and still receive tax incentives while their employees are forced into state aid program — essentially double-dipping. There is a need for alcohol, tobacco, and gambling density laws or ordinances in qualified census tract or low-income areas, which are routinely targeted by commercial industries marketing unhealthy products to historically marginalized communities. – Community Leader

> According to a recent study, we are short nearly 100,000 units of affordable housing in our community. For people living with untreated serious and persistent mental illness, the likelihood of homelessness is significant and there aren't enough Permanent Supportive Housing units available to meet the need. Poverty, lack of safe housing, and untreated mental illness drives the people impacted by these social problems to become high utilizers of emergency room and other expensive (often unreimbursed) medical care. And, of course, due to our ingrained systemic inequities, the impact is especially toxic for our BIPOC communities. – Social Services Provider
>
> We have a housing shortage. We have increased the cost of living without much of an increase in wages. Hate and bigotry every day play a role in people not being able to get even most basic conditions for human survival met. Red Lining is still happening in our community. The bias that people who are experiencing homelessness face is a very real problem, yet most people understand housing instability. – Community Leader
>
> Housing and food are basic needs. If they are unmet, a person cannot achieve their highest level of health and wellbeing. Lack of transportation and education are barriers to gainful employment and livable wages. – Health Provider
>
> Many of the patients I see hospitalized have housing instability, unemployment, and food instability. Housing specifically needs to be addressed, and we need to have more low-income options that are transitions between the shelters to regular housing. – Physician

Income/Poverty

> They ultimately drive much of the chronic illness and outcomes for the working poor. Housing is a major issue. – Physician
>
> Growing income gap. Wages not keeping up with cost of living. – Community Leader
>
> More people are having difficulties paying their rent, utilities, and other necessities. More people are needing access to food pantries as they do not have access to food sources. An increase in people are living out of their vehicles or surfing from one couch to another. More people are saying they are unable to work, so more people are trying to apply for disability and not being approved. – Health Provider
>
> Poverty, homelessness, lack of affordable housing, family history, education. – Social Services Provider
>
> Wealth disparity in Omaha affects housing, food, and access to care. – Physician
>
> Income equality causes significant challenges with access to housing, education, legal services, etc. – Physician
>
> Too many people struggle to afford housing, food, health and other insurance, transportation, education, health care, etc. – Physician
>
> Poverty. – Physician
>
> Income disparities. – Social Services Provider
>
> Across our country there are more and more working families who are struggling with finances, housing, food insecurity, etc. We have people living on the streets, people standing on corners panhandling across our community, sometimes with their children. There is a lack of affordable housing, so people are going without food, medication etc. in order to make their rent/mortgage payment. The low paying jobs don't have flexibility so parents lose their jobs when they can't find affordable childcare or when they need to stay home with a sick child. Luxury apartments are being built all over town but limited affordable housing is being created. Our shelters are full. – Social Services Provider
>
> Social determinants are foundational to health. Health is bigger than health care and if you do not have the basics such as living wage, transportation, housing, etc. it is near impossible to achieve or sustain good health. – Business Leader
>
> Poverty levels are higher in Latino communities. – Health Provider
>
> We have pockets of poor people with lack of basic living resources. – Health Provider
>
> There are many people living at the poverty level, many homeless, many with inadequate education, etc. – Health Provider
>
> People have to prioritize basic needs, and when juggling on a tight household income, they aren't able to equally support all. – Social Services Provider
>
> My community has the highest poverty rates, lacks adequate and affordable housing, high lead levels, and is subjected to racism and discrimination. – Community Leader

Access to Care/Services

> Because of the lack of mental health services, timely services, housing is an issue, the homeless population, substance use disorders, lack of funding available, not having access to medical insurance, Medicaid eligibility limitations. – Social Services Provider
>
> Hard to get into skilled care or nursing home. Lots of homeless with poor housing options. – Physician

Many of the above problems are direct results and further exacerbated by social determinants of health. Access to care for those without insurance remains difficult. Access to culturally respectful and linguistically appropriate care is limited, especially beyond primary care. Home health, SNF and nursing home care is excessively limited for patients with Medicaid. Medicaid transportation is often not reliable. Limited access to fresh food-access there is often limited to those that speak English and have social security number. Low-income housing is limited and in poor condition. – Physician

It is impossible to go to doctor's appointment if you don't have insurance, or if you have unstable housing, food insecurity, no access to reliable internet services, or if you are working 3 jobs while also going to school and taking care of children or dependent adults in the family. This is particularly impacting non-white people, immigrants, refugees in the community, as well as people in recovery or previously justice involved. – Health Provider

SDOH influence access to care and health equity. Homelessness increases the likelihood of emergency department use. – Advanced Practice Provider

It affects access, follow up, increases recidivism. – Physician

Access to care, health care deserts. – Physician

Racism

Inequality, injustice, poverty, and racism. – Business Leader

Redlining and racism have created wealth inequality and contributed to disinvestment in communities of color and those most impacted by these indicators of health. – Community Leader

Systemic racism and lack of accountability will only continue to perpetuate this issue. – Community Leader

Historical and systemic racism. Socioeconomic disparities. Limited access to health care — the State of Nebraska DHHS does not advertise its program and services that would increase access to health care. Environmental injustice. Cultural and language barriers. Food insecurity and food deserts. Educational disparities. – Community Leader

This system doesn't work for all people who live here. Systemic racism and sexism impact how people can afford safe and quality housing, the communities/neighborhoods where they live, and their overall health. – Business Leader

The main social determinant of health is racial inequality, rooted in racial discrimination. Unfortunately, this is what determines if you are healthy or not in this country. Racial inequality impacts a black or brown child's access to quality opportunities, such as quality food, quality housing, quality jobs, quality health care and education. Racial inequity I believe is the contributor and development of social determinants of health. It has led to education barriers, that lead to income barriers, to lead to housing barriers, to living in toxic environments that impacting the health and wellbeing of a child or person. – Social Services Provider

Homelessness

At the core of numerous, if not all, health issues lie the social determinants of health. For individuals experiencing homelessness, the likelihood of having additional severe underlying conditions that compound their current health challenges is alarmingly high. Consider this: residing in an area with limited access to nutritious food while grappling with a heart condition poses a significant dilemma. How can one be expected to uphold their heart health without access to a diet conducive to it? Furthermore, the glaring gap in affordable housing exacerbates these issues. The lack of stable housing not only perpetuates the cycle of homelessness but also amplifies the risk of deteriorating health conditions and complicates access to essential health care services. This confluence of social determinants creates a formidable barrier to achieving and maintaining optimal health for vulnerable populations. – Health Provider

Over 120 homeless camps in the community, lack of affordable and sustainable housing exist in the community. Landlords and management companies are charging extra fees to live in their properties. Limited resources and long waits for housing. HUD guidelines that identify homeless or near homeless with housing programs and financial assistance programs dictate who gets assistance and how long you must be homeless to get the assistance. – Health Provider

There are too many homeless people in this country for as wealthy as it is, but our government spends money on foreign countries or wastes it wherever Congress decides, and yet they don't want to take care of their own. There is a lack of wanting to get and keep people healthy by helping out in all of these areas. Our government, federal, state and local have no intentions of spending what is our money to help people become, healthy, educated and housed. In my opinion, we should be loading money into programs and assistance on the front end instead of continuing to build hospitals and prisons on the back end. But, Corporate America, and big pharma only make money on the sick and dying. – Health Provider

Impact on Quality of Life

So many can’t meet basic needs which are directly related to overall health. – Health Provider

> Health care does not occur in a silo. Any chronic disease or illness and its management occur in the context of SDOH and the patient's life and community. Douglas County and rural Nebraska present their own unique SDOH for community members. Fear of stigma related to substance overdose leads to under reporting of substance related deaths in rural Nebraska; racial injustices and racial health disparities continue to exist in urban Omaha. – Physician
>
> Everything comes together to impact a person's health. When the basics aren't available and equitable, people struggle. – Social Services Provider
>
> 80% of health is dictated by social determinants of health, can't achieve health without stable needs being met. – Health Provider

Low Education Levels

> Without education, low-income people find it difficult to get affordable housing and cannot afford to eat healthier and make better choices. Food high in calories makes people become overweight and for people of color it becomes more difficult, and many times is discriminated. – Social Services Provider
>
> There is a nucleus of undereducated who believe in the "poor me" mentality. It's everyone else's fault but mine. Some are in the cycle of drugs, arrest, time served with programming, release with programming, monitored with programming, unmonitored, I'm free! Time to celebrate. Drugs, arrest, repeat. – Community Leader

Incidence/Prevalence

> Mental illness and homelessness are on the uprise. – Health Provider
>
> Significant inequities exist throughout the region. – Business Leader

Prevention/Screenings

> Lack of screening, lack of loop closure mechanism for when a referral is made, checkbox mentality of health systems as opposed to addressing the root problem of financial insecurity or unsafe environment. – Health Provider
>
> Lack of consistency in screening for and securing supports for different SDOH across the community. – Health Provider

Diagnosis/Treatment

> This is a complex issue that most health care provides do not give much thought to. Our federally qualified health centers do a good job in their awareness of SDOHs. – Physician

Transportation

> Poor public transit (need more routes in some parts of town, tend to concentrate in areas with better overall transportation resources), need higher minimum wage in NE, poor distribution of health care resources (e.g., no medical specialist and little mental health resources on the north side). – Physician

Follow Up/Support

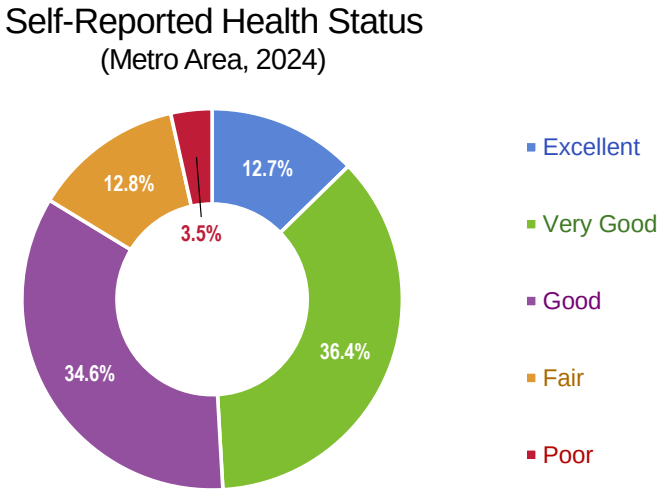
> Our society is currently a mess, with reduction in social supports, funding, and a growing wealth gap. – Business Leader

HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is excellent, very good, good, fair, or poor?"

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

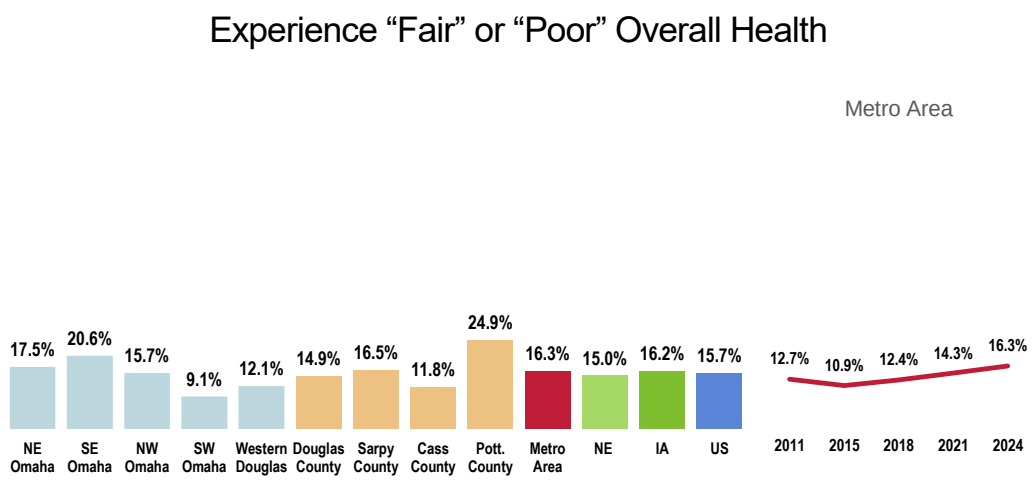


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

However, 16.3% of Metro Area adults believe that their overall health is "fair" or "poor."

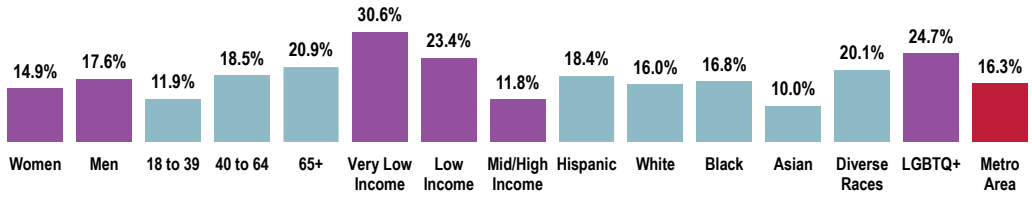
TREND ► Increasing significantly since 2011.

DISPARITY ► Highest in Southeast Omaha and Pottawattamie County. The prevalence increases with age, decreases with household income level, and is reported more often among men, and people who identify as LGBTQ+.



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

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

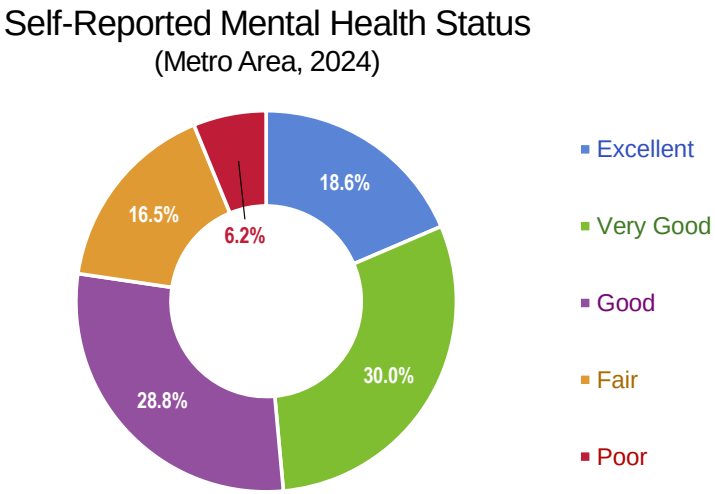
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening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

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

Mental Health Status

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

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



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: • Asked of all respondents.

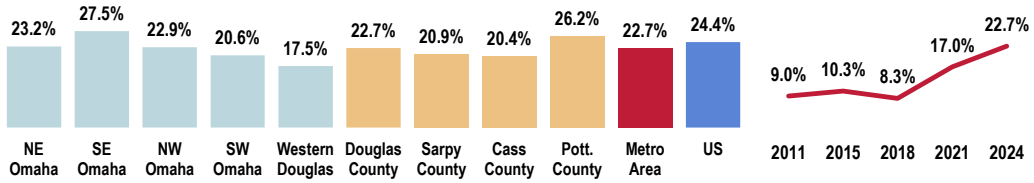
However, 22.7% believe that their overall mental health is "fair" or "poor."

TREND ► Increasing significantly from earlier survey administrations.

DISPARITY ► Highest in Southeast Omaha and Pottawattamie County.

Experience “Fair” or “Poor” Mental Health

Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression & Anxiety

Diagnosed Depression

A total of 32.3% of Metro Area adults have been diagnosed by a physician or other health professional as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

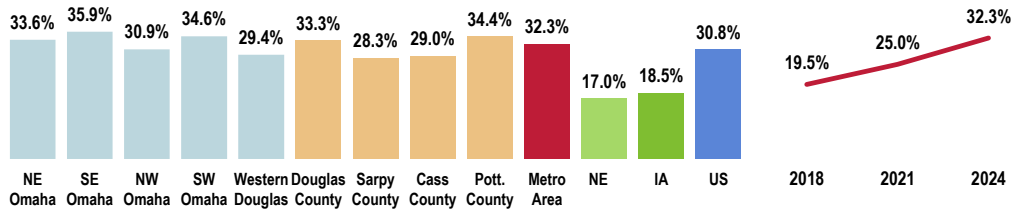
BENCHMARK ► Well above the Nebraska and Iowa percentages.

TREND ► Denotes a statistically significant increase since first asked in 2018.

DISPARITY ► Lowest among Sarpy County respondents.

Have Been Diagnosed With a Depressive Disorder

Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Symptoms of Chronic Depression

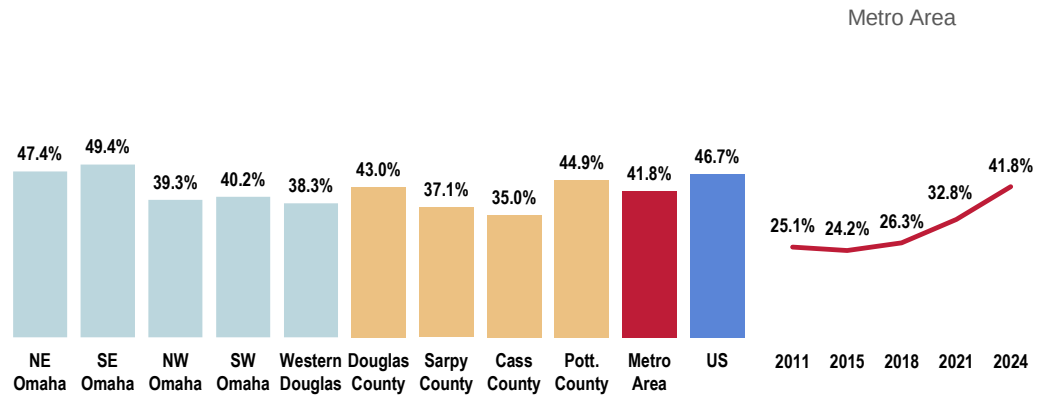
A total of 41.8% of Metro Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

BENCHMARK ► Lower than the national percentage.

TREND ► Increasing significantly since 2011.

DISPARITY ► Highest in Douglas County (especially the eastern region). Reported more often among women, young adults, those living in low-income households, Hispanic residents, Black or African American residents, and LGBTQ+ adults.

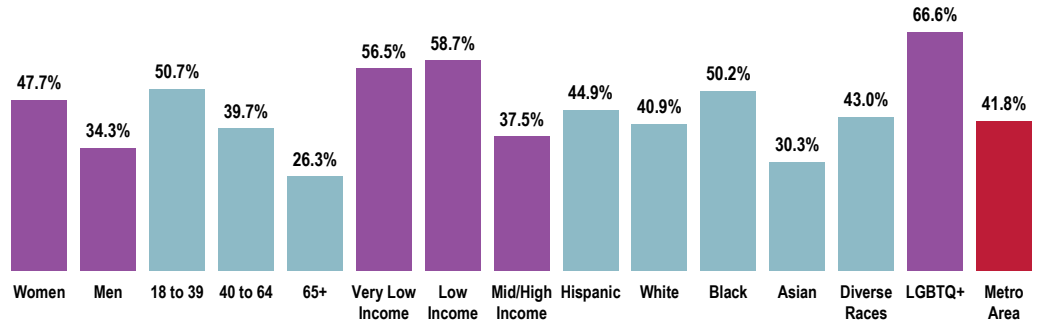
Have Experienced Symptoms of Chronic Depression



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

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

Have Experienced Symptoms of Chronic Depression
(Metro Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]

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

Current Anxiety & Depression

At the time of the survey, 20.0% of Metro Area respondents reported experiencing feelings that signal moderate-to-severe anxiety and/or depression (reflecting a PHQ-4 score of 6 or higher).

TREND ► Denotes a statistically significant increase since 2021.

DISPARITY ► Highest in Douglas County (especially Northeast Omaha) and Pottawattamie County. The prevalence decreases with age and household income and is reported more often among women and LGBTQ+ respondents.

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

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

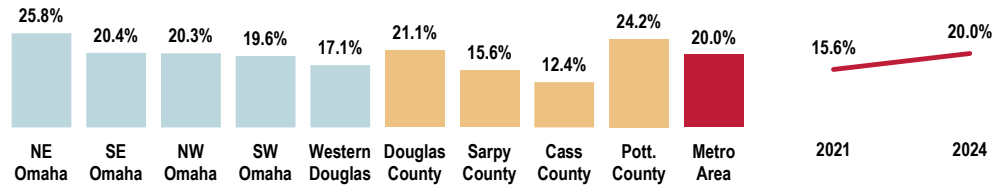
Respondents were asked:

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

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

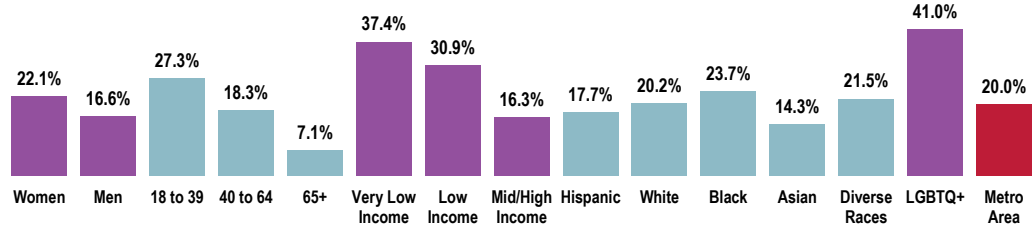
Responses were scored according to how frequently each was experienced in the previous two weeks (nearly every day, more than half the days, several days, or not at all).

Moderate to Severe Anxiety/Depression



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 357]
Notes: • Asked of all respondents.
• Reflects a PHQ-4 score of 6 or higher.

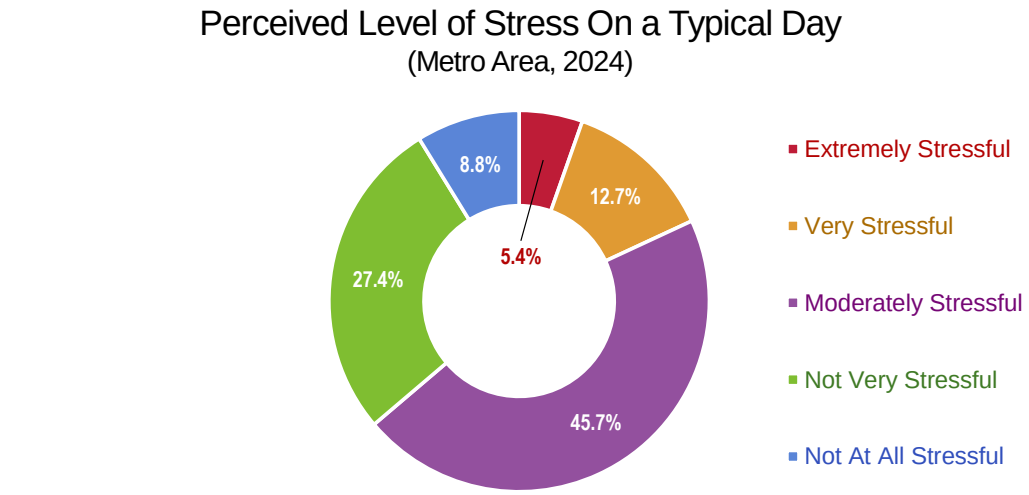
Moderate to Severe Anxiety/Depression
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 357]
Notes: • Asked of all respondents.
• Reflects a PHQ-4 score of 6 or higher.

Stress

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



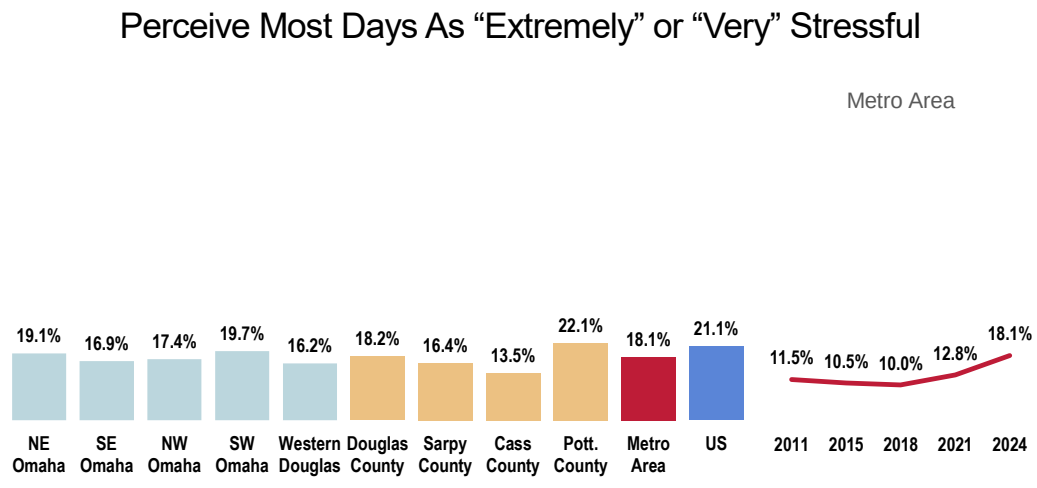
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: • Asked of all respondents.

In contrast, 18.1% of Metro Area adults feel that most days for them are "very" or "extremely" stressful.

BENCHMARK ► Lower than the national percentage.

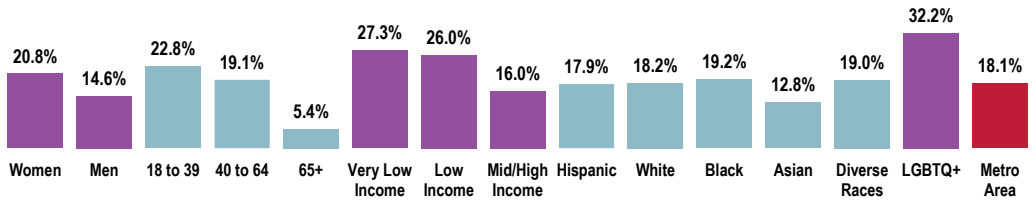
TREND ► Marks a statistically significant increase from previous survey administrations.

DISPARITY ► Most often reported in Pottawattamie County. Higher among women, young adults, those in low-income households, and those who identify as LGBTQ+.



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 79]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful
(Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

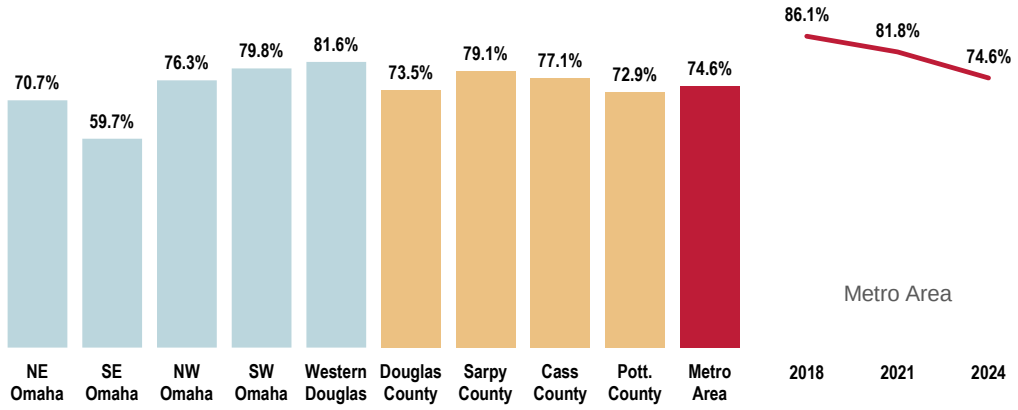
Social Support

Three in four Metro Area adults (74.6%) report having someone to turn to “all” or “most” of the time, if they needed or wanted help.

TREND ► Decreasing significantly since 2018.

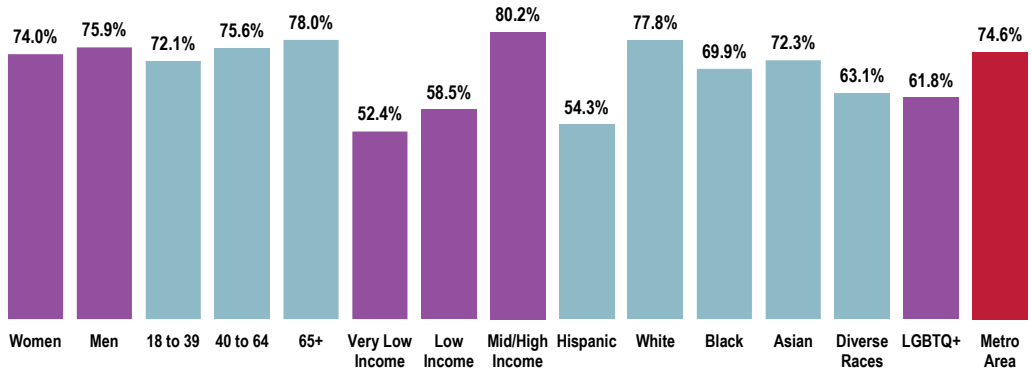
DISPARITY ► Especially low in Douglas County (especially Southeast Omaha), young adults, those in low-income households, Hispanic residents, those of Diverse Races, and LGBTQ+ adults.

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



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 320]
Notes: ● Asked of all respondents.

Have Someone to Turn to for Help All/Most of the Time
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 320]
Notes: • Asked of all respondents.

Suicide

Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.

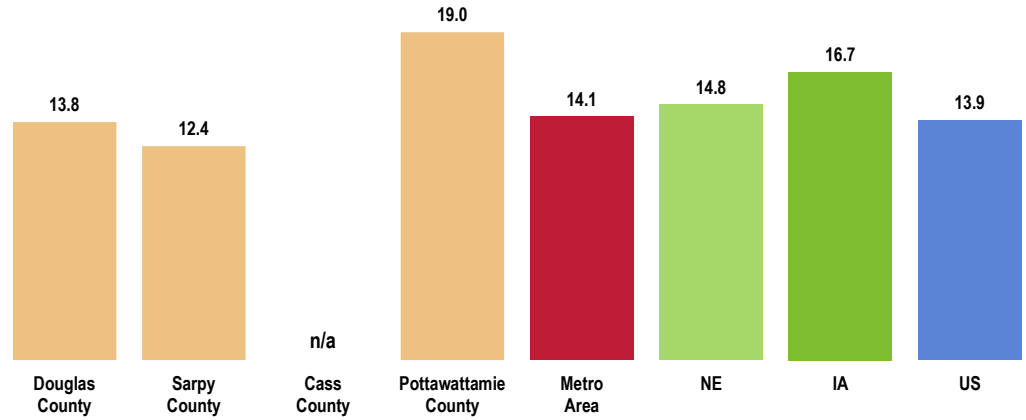
The Metro Area experiences 14.1 suicides per 100,000 population (2018-2020 annual average age-adjusted rate).

BENCHMARK ► Lower than the Iowa suicide rate.

TREND ► The suicide rate has increased over the past decade, echoing state and national trends.

DISPARITY ► Highest in Pottawattamie County and among White residents in the Metro Area.

Suicide: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower

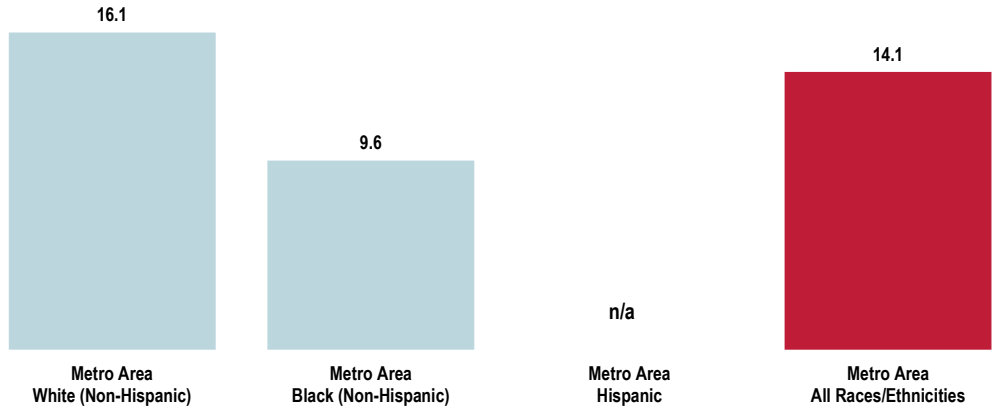


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
• US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Suicide: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



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

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

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	10.1	11.0	11.4	12.0	12.0	11.9	13.7	14.1
NE	11.5	12.5	12.2	12.7	13.2	13.7	14.7	14.8
IA	13.7	13.3	13.7	13.8	14.5	15.0	15.7	16.7
US	12.5	12.8	13.1	13.4	13.6	13.9	14.0	13.9

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

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

Mental Health Treatment

Mental Health Providers

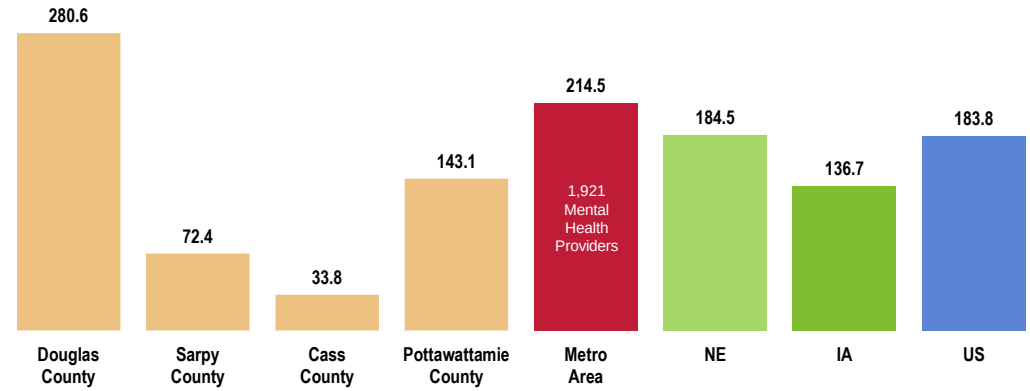
Note that this indicator only reflects providers practicing in the Metro Area and residents in the Metro Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

In 2020, the Metro Area had 214.5 mental health providers (including psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) for every 100,000 population.

BENCHMARK ► Well above the Iowa proportion.

DISPARITY ► Lowest in Sarpy and Cass counties.

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



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

Currently Receiving Treatment

A total of 28.6% are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

BENCHMARK ► Higher than the national prevalence.

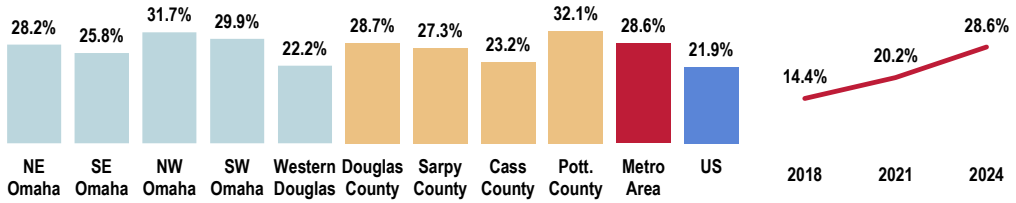
TREND ► Increasing significantly since 2018.

DISPARITY ► Lowest in western Douglas County.

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 65.7% are currently receiving treatment.

Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

Difficulty Accessing Mental Health Services

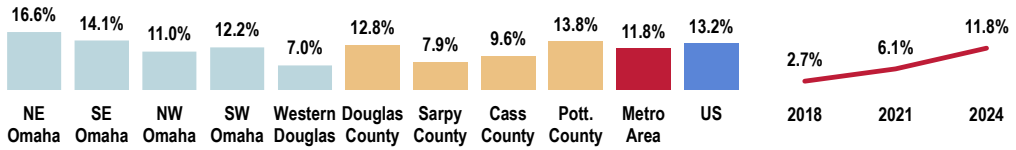
A total of 11.8% of Metro Area adults report a time in the past year when they needed mental health services but were not able to get them.

TREND ► Increasing significantly since 2018.

DISPARITY ► Highest in Douglas County (especially the northeast region). Reported more often among women, young adults, those in low-income households, and LGBTQ+ respondents.

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

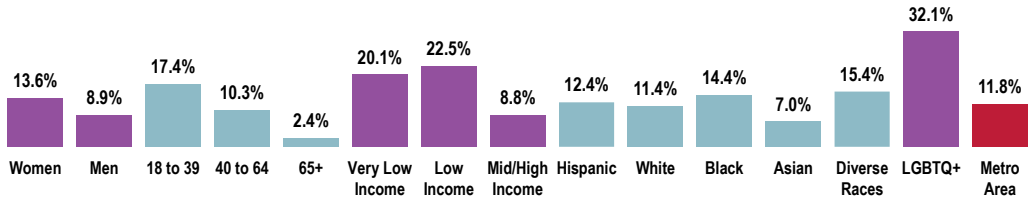
Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(Metro Area, 2024)

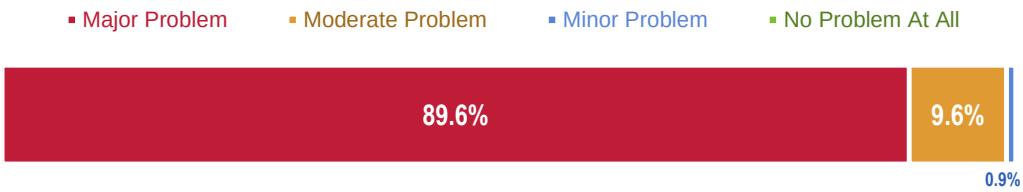


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

Nearly all key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.

Perceptions of Mental Health as a Problem in the Community
(Metro Area, 2024)



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

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

Access to Care/Services

> Access to services and also lack of education on self-care and prevention. – Social Services Provider
>
> University based settings tend to support clinicians to perform public-facing activities more than patient-care activities, so the waiting lists are very long when only very few psychiatrists and therapists are doing the work. Most of these institutions only see patients M-F from 8 to 5, making it hard for working adults and those with caregiving responsibilities to see anyone. Private practice groups do not typically accept Medicare, so it is very difficult for Medicare beneficiaries to receive care. Medicare's reimbursement for MH therapists and MFTs who aren't psychologists and social workers are so low many opt out of it. People with ID/DD and older adults are often unaware of or unable to access culturally sensitive and competent services. Transportation and telehealth technology are not always available or accessible. Lack of long-term inpatient hospitalization options. LTC is not willing to take people with SMI, and certainly not registered sex offenders with SMI. – Health Provider
>
> Access, availability, affordability, space for inpatients, and specialty care. – Health Provider
>
> Access to resources and appropriate therapy treatments. No system exists for efficiently and reliably communicating with primary care providers and the public about how to connect patients to therapists in the community. – Physician
>
> Timely access to care. – Health Provider

Access to outpatient care. Lack of inpatient beds for all patients, but especially for pregnant patients. – Physician

Lack of resources to respond to rising needs. – Health Provider

Access, understanding their needs and meeting basic needs so they can work on themselves. – Health Provider

The death of therapeutic options for those most in need is a glaring concern, leaving many individuals without essential treatment options. Moreover, access to medication presents a formidable obstacle, particularly for individuals experiencing street homelessness, exacerbating an already dire situation. – Health Provider

Access to care and services, cost, and insurance, or lack thereof. – Health Provider

People who care about their wellbeing and having the ability to access services, especially crisis services. There are often long waits for assessments and therapy/psychiatric appointments for all persons. Compassionate people care for people. Trauma training for everyone is lacking in consistency with information. Not enough housing for people to maintain or access with several mental health diagnoses. – Health Provider

There are not close to enough resources, or accessibility is limited. Transportation to even get to mental health appointments can be a challenge as well. Also, the stigma that is associated with mental health is still very real. – Community Leader

The ability to access services in a timely manner pre-crisis is severely limited, with sometimes months of planning or scheduling required. The constellation of providers accepting insurance, self-pay, managed care, or care networks is cumbersome and challenging to navigate for even an informed person. Access to prescribing mental health professionals is severely limited. – Community Leader

Access to care and counseling, especially for kids. – Health Provider

Access to psychiatric services and to evidence-based psychotherapies. – Physician

Providers accepting new patients. – Social Services Provider

Timely appointments, drug costs and escalation due to response in crisis from law enforcement. – Community Leader

Immediate access to mental health services, long term care, crisis intervention, etc. – Social Services Provider

Depression, anxiety, and lack of resources. – Business Leader

Receiving timely services. – Social Services Provider

Access to care, lack of providers, lack of integration with physical health, lack of assessment of social and non-clinical issues that impact mental health. Poor transitions of care. – Health Provider

People cannot access mental health resources in a timely enough manner to make a difference. Whether from being understaffed, or just lack of concern for mental health resources, it just takes too long for anyone to get help and no doubt, many do not because of it. – Health Provider

Lack of access and the number of people with mental health issues that are homeless. – Community Leader

Access to psychiatry and behavioral health services. – Health Provider

Access to mental health professionals. – Business Leader

Access to therapeutic services, times 1,000. Rising incidences of youth suicide and mental illness. Isolation and coping skills post-pandemic. – Business Leader

I think that access to resources is the biggest challenge. The issues regarding access to resources span from not having facilities and professionals who are able to treat mental health issues to individuals who are unable to afford or get to the facilities. It is also incredibly common for us to treat mental health issues by arresting and incarcerating individuals rather than addressing their needs. Our jail is full of people who need help and is not equipped to give them the help they need. – Community Leader

Finding treatments and appropriate placements if needed. – Social Services Provider

Wait times to get an appointment with a professional, lack of resources to handle larger issues. – Social Services Provider

Getting timely appointments. Good inpatient care for crisis. – Physician

The biggest challenge is that there are not enough mental health resources or professionals in our community. – Business Leader

Access to psychiatrists for medication management. – Social Services Provider

Access to services when needed. Continued engagement with services once started. Motivation/ belief that engaging in services will help them long-term. Ability/ understanding how to connect with resources available to them. So many folks have some form of access but fall away from or never access services for a variety of reasons. – Health Provider

Access to mental health services is limited, particularly in the outpatient setting prior to a crisis situation. – Health Provider

Access to care. – Physician

Access to services. Often individuals have to wait months to get into services for mental health care. – Health Provider

People in acute crisis wait for days for beds due to facilities being overloaded. Those who need outpatient care wait months for appointments. – Health Provider

Access to care. – Health Provider

Access to timely care and reimbursement for services. – Health Provider

Their access to services. There are not enough providers and resources to handle the need for services. – Business Leader

Lack of community resources. – Social Services Provider

We have a lack of resources available to meet our communities' mental health crisis. There aren't enough inpatient beds, and getting in to see a therapist or psychiatrist takes months. – Social Services Provider

Not enough acute inpatient beds, and once in, the stay is far too short. Not enough engagement in the support system in discharge planning, if any planning takes place at all. Too many times they are just discharged to a homeless shelter, with a week of medications. – Health Provider

Mental challenges are becoming more normalized, and the stigma is starting to lower which increases the interest in services. However, there is a lack of workforce in this space to meet the increasing demand. In addition to new patients seeking mental health services, the gap in services is exacerbating those with chronic, pre-existing diagnosis and needs. – Business Leader

Access. – Physician

Accessing mental health services, including behavioral health and psychiatry. – Physician

Many people have difficulty finding an outpatient mental health provider to accept their payer source, or it is taking weeks to months to schedule an appointment for outpatient follow-up. – Health Provider

Limited access to mental health providers due to poor reimbursement for mental health services and burnout in mental health providers as a consequence of the pandemic. – Health Provider

My perception is that there are a lot of folks with brain health issues that are not seeking care, or they are people that do not have access to care due to age, employment and benefits status, or income. – Community Leader

Lack of access to adequate care. – Physician

Access to acute and long-term care, access to transitional cares. – Physician

Limited access. Long wait for psychiatry appointments with many offices not accepting new patients. Inadequate community support resources. – Physician

Lack of access to quality and consistent mental health care. Severe lack of inpatient beds. – Physician

Lack of Providers

There are not enough providers to possibly help all the people who need help with mental health issues in our community. In addition, the systems we do have are not easy to navigate for someone not in crisis. If the person is in crisis, the systems we have now are impossible to navigate without help. There is not enough access to get appointments or assessments for not only therapists, but also psychiatrists and prescribers. – Social Services Provider

Rising numbers of depression and anxiety diagnoses, far too few providers, and we need to address the access children have to social media and iPhones. This is the fundamental problem in our area, from both the number of citizens of all walks of life involved as well as the severity of it for the homeless and poor. – Physician

Not enough trained providers, and the cost. – Physician

The lack of mental health providers and the increasing cost of insurance. – Social Services Provider

Limited number of providers and treatment facilities available to take patients without insurance or Medicaid, and long waiting lists and times for the clinics that do take these patients. – Physician

Especially for children, there are few providers and waiting lists to get in for a diagnosis. – Social Services Provider

Not enough mental health providers, not enough insurance coverage, private and federal, and stigma. – Physician

A growing number of children and adults are experiencing mental health challenges but aren't able to access the help they need. For people without insurance or on Medicaid, there aren't enough providers willing to work for the low wages available at the nonprofit organizations that provide free or sliding scale services (reimbursements for these services are woefully inadequate and haven't kept pace with market forces in the private sector). And there's a shortage of psychiatrists and other prescribers. – Social Services Provider

Lack of enough psychiatrists and counselors, need for housing and other supports. – Physician

Limited access to mental health providers due to poor reimbursement for mental health services and burnout in mental health providers as a consequence of the pandemic. – Health Provider

Inadequate provider numbers, inadequate inpatient beds. – Physician

Shortage of services and providers. Lack of providers and services that accept Medicaid. – Advanced Practice Provider

Lack of adequate number of mental health professionals in the community, stigma associated with mental health issues and lack of connection for residents. – Health Provider

Affordable Care/Services

> Accessing and paying for services. Culturally and linguistically concordant services are very limited. Emergency services for youth with mental health crises. – Public Health Representative
>
> Longitudinal counseling services at an affordable cost. – Physician
>
> Resources are difficult to obtain or afford for people in the community. – Health Provider
>
> Access to affordable services. – Social Services Provider

Lack of Diversity in Providers

> Lack of diversity in mental health professionals. – Health Provider
>
> Lack of therapists of color and financial barriers to seeking care. Co-occurring mental health and substance use disorders. – Community Leader
>
> Lack of available diverse mental health therapists and available services for long term treatment. – Community Leader
>
> People don't have access to culturally appropriate therapists. Pastors need additional training to support individuals that are seeking mental health services. Taboo of mental health support. Drug and alcohol addiction is more likely due to unresolved trauma and mental health issues left untreated and or addressed. – Social Services Provider

Denial/Stigma

> Stigma. Access to care. Cost of Care. What social media has done to kids. – Community Leader
>
> Stigma still remains in the community and health care settings. We have a shortage of psychiatric providers for prescribing psychotropic medications. We have many counselors, but the general public does not know where to look to locate these providers. We also need more bilingual providers for our diverse patient populations, we also have need for more substance use disorder programs. Funding for mental health care is also a concern. The highest levels of care (inpatient, partial hospital, IOP) are a challenge to get covered by insurance, thus those most in crisis will continue to struggle due to inability to afford care. Our greatest need is for those living with severe persistent mental illness. We do not have enough resources for them to obtain consistent care and oversight. They struggle from hospitalization to hospitalization and crisis to crisis. – Physician
>
> Stigma in seeking help. – Business Leader

Multiple Factors

> Despair, hopelessness, bigotry, racism, social isolation, and bullying. – Health Provider
>
> Poverty, homelessness, addiction, and family history. – Social Services Provider
>
> Social media, isolation, and lack of support. – Social Services Provider

Awareness/Education

> Understanding where to start to look for support. Recognizing when someone may need help themselves and recognizing challenges in others. Cost barriers. – Public Health Representative
>
> They are doing nothing to promote brain health. We can only help those who help themselves. Money is not the solution without compliance and accessibility to programming. – Community Leader

Access for Medicare/Medicaid Patients

> The explosion with private practices is causing an exclusion of Medicaid, Medicare and low-income populations from being served. The programs available to serve these populations are non-profits who cannot pay staff enough money to stay long term. More integrated health care needs to happen. Research shows people with a mental health dx. are 3 times more likely to have heart disease and other health complications. You cannot treat the body without treating the mind. Many health systems have moved in this direction, but some are still in the dark ages. – Health Provider

Impact on Quality of Life

> I think we continue to see people in a crisis of their mental health, this leads to other medical challenges. For our population I think that it would be beneficial to educate and catch early through primary care, counseling, and tele medicine options so we can meet patients prior to their crisis. With our aging population, undiagnosed or changed mental and behavioral disease to become part of the care plan. – Business Leader

Insurance Issues

> Many people have difficulty finding an outpatient mental health provider to accept their payer source, or it is taking weeks to months to schedule an appointment for outpatient follow-up. – Health Provider

Incidence/Prevalence

> Children and adults struggling with mental health diagnosis, stress that causes depression and anxiety, drug induces mental illness and medical follow up services. – Health Provider

Workforce Challenges

> Lack of stability in workforce due to undiagnosed and misdiagnosed mental health issues. Not enough physicians that are representative of all communities. Not enough holistic options as solutions. – Social Services Provider

Follow Up/Support

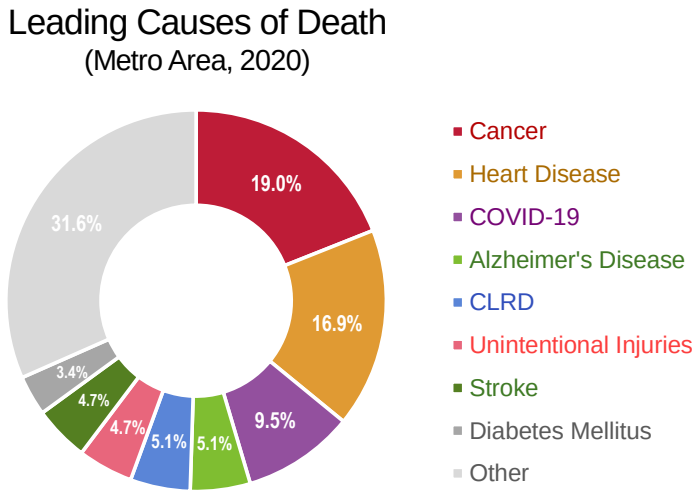
> There is nowhere for them to follow up, or the wait is extremely long when they are discharged from the hospital. – Health Provider

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, cancers and heart disease account for over one-third of all deaths in the Metro Area, with COVID-19 responsible for another 9.5% of deaths in 2020.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

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

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

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

The following chart outlines 2018-2020 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Metro Area.

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

Leading causes of death are discussed in greater detail in subsequent sections of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Metro Area	NE	IA	US	HP2030
Malignant Neoplasms (Cancers)	154.6	148.5	151.3	146.5	122.7
Diseases of the Heart	139.7	144.8	170.3	164.4	127.4*
COVID-19	79.3	84.4	99.0	85.0	—
Fall-Related Deaths (65+)	63.6	67.8	87.4	67.1	63.4
Chronic Lower Respiratory Disease (CLRD)	44.8	45.7	42.3	38.1	—
Alzheimer's Disease	38.5	30.0	30.9	30.9	—
Unintentional Injuries	36.5	40.3	42.9	51.6	43.2
Cerebrovascular Disease (Stroke)	34.8	33.0	32.3	37.6	33.4
Diabetes Mellitus	25.9	25.1	22.3	22.6	—
Alcohol-Induced	15.8	12.0	9.9	11.9	—
Intentional Self-Harm (Suicide)	14.1	14.8	16.7	13.9	12.8
Pneumonia/Influenza	13.7	14.2	13.8	13.4	—
Cirrhosis/Liver Disease	11.7	9.8	9.7	12.5	10.9
Kidney Diseases	10.2	10.3	9.7	12.8	—
Motor Vehicle Deaths	9.5	12.3	10.5	11.4	10.1
Drug-Induced	8.9	7.4	9.4	21.0	—
Homicide	4.4	3.0	3.0	6.1	5.5

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

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

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

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

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

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

Age-Adjusted Heart Disease & Stroke Deaths

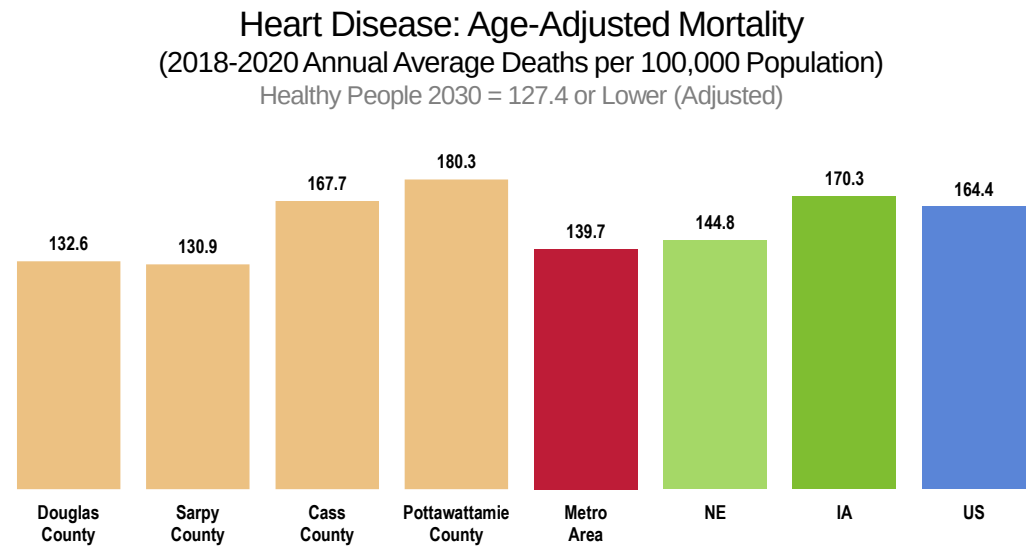
Heart Disease Deaths

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

Between 2018 and 2020, there was an annual average age-adjusted heart disease mortality rate of 139.7 deaths per 100,000 population in the Metro Area.

BENCHMARK ► Lower than the Iowa and US mortality rates.

DISPARITY ► Notably higher in Pottawattamie County and among Black or African American residents.



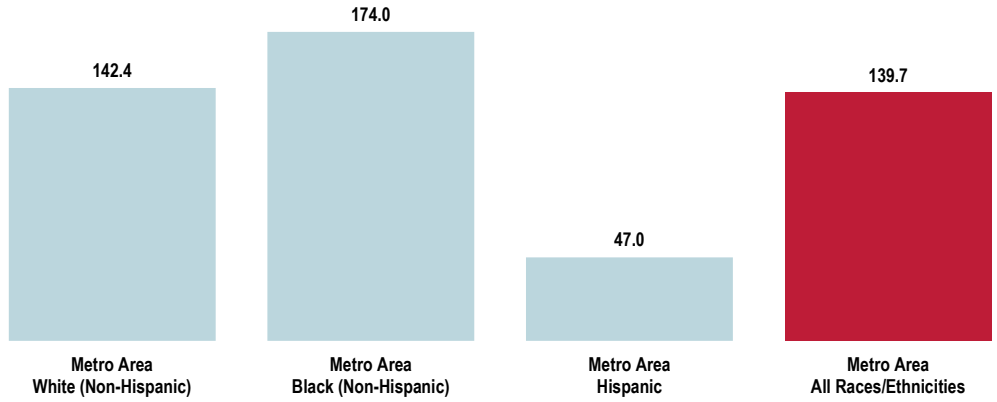
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Heart Disease: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



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

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	151.3	150.4	151.2	143.3	141.3	137.1	139.8	139.7
NE	147.2	145.9	148.5	145.9	148.0	145.1	146.6	144.8
IA	168.4	165.5	162.3	160.3	163.7	165.1	168.5	170.3
US	171.3	169.6	168.9	167.5	166.3	164.7	163.4	164.4

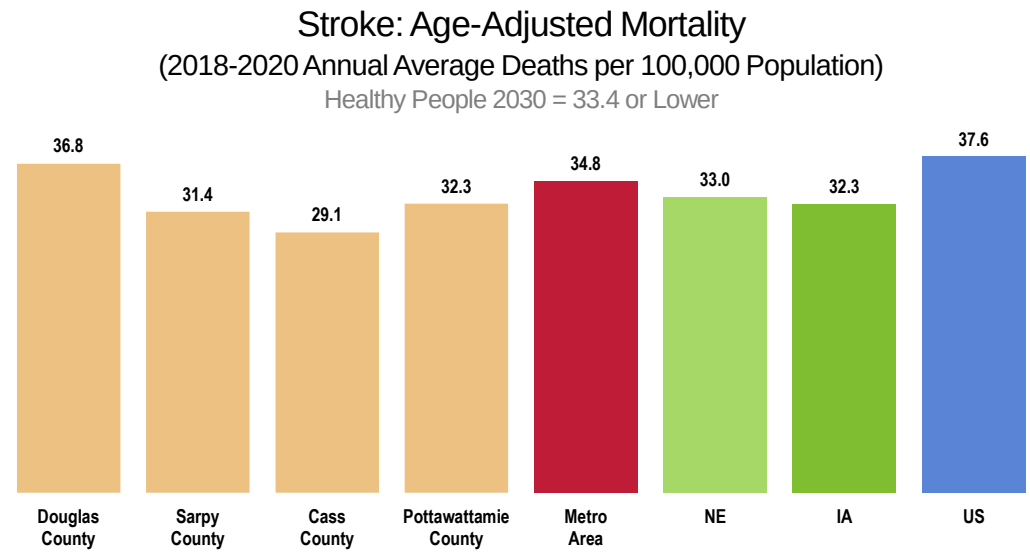
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Stroke Deaths

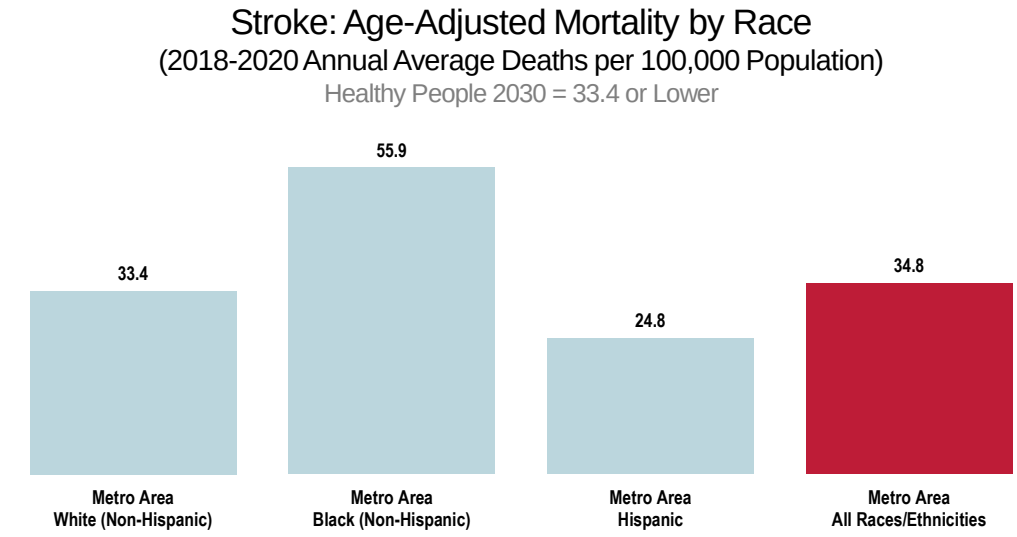
Between 2018 and 2020, there was an annual average age-adjusted stroke mortality rate of 34.8 deaths per 100,000 population in the Metro Area.

DISPARITY ► Affects Metro Area Black residents much more so than White residents or Hispanic residents.



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

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



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

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- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	38.2	37.9	36.6	35.4	33.7	33.4	32.3	34.8
NE	36.0	35.3	34.8	33.8	32.7	32.1	31.5	33.0
IA	34.3	34.0	33.7	33.2	32.8	32.7	32.6	32.3
US	37.0	36.9	37.1	37.5	37.5	37.3	37.2	37.6

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

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

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 8.2% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

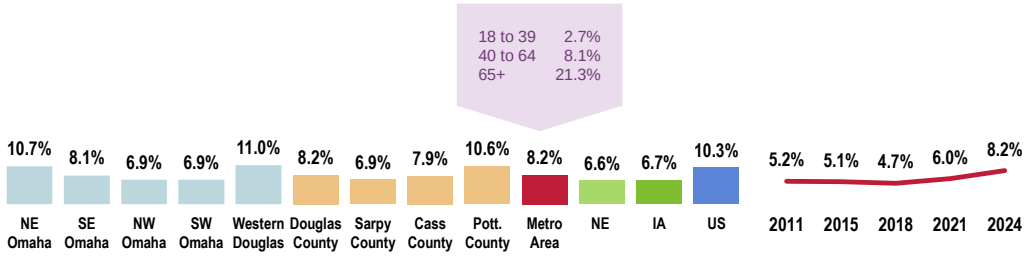
BENCHMARK ► Higher than both state percentages but below the US.

TREND ► Marks a statistically significant increase.

DISPARITY ► Highest in Pottawattamie County. Strong correlation with age.

Prevalence of Heart Disease

Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.

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

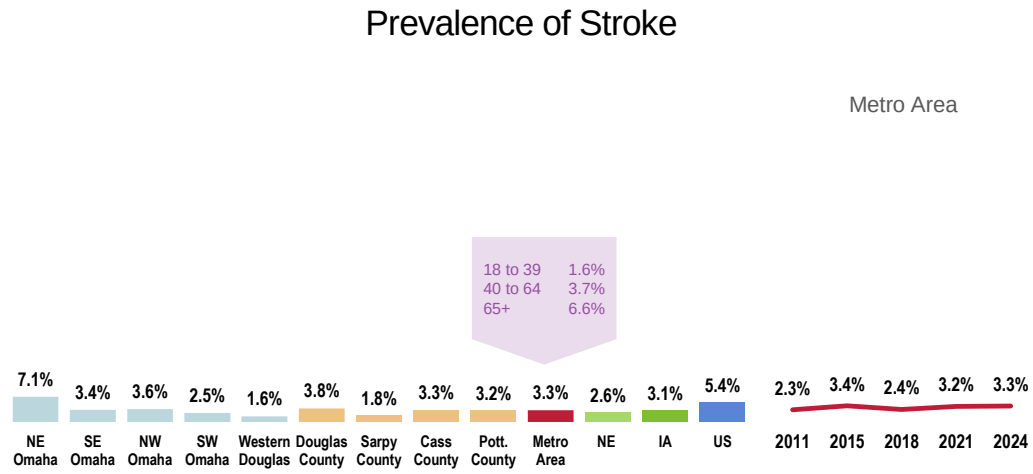
Prevalence of Stroke

A total of 3.3% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

BENCHMARK ► Higher than the Nebraska prevalence but lower than the national prevalence.

TREND ► Increasing since 2011.

DISPARITY ► Highest in Douglas County (especially Northeast Omaha). Increases with age.



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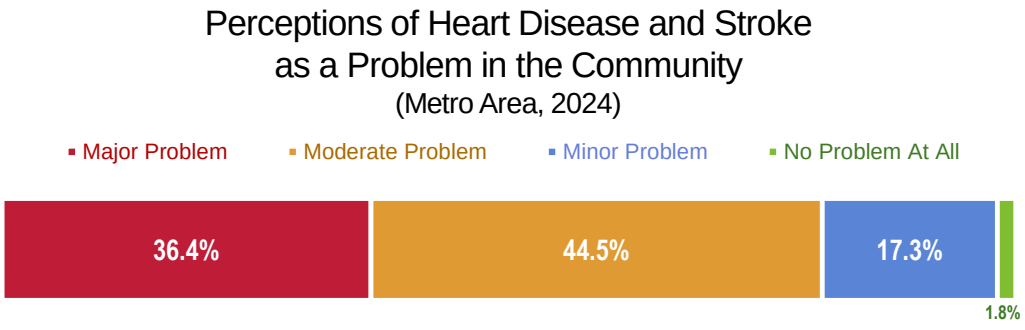
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Heart Disease & Stroke

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



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Incidence/Prevalence

> In my clinical work I am starting to see younger and younger patients hospitalized for heart disease and stroke. – Physician
>
> This is one of the leading causes of morbidity and mortality. – Public Health Representative
>
> Statistics. The CDC, National Institute of Health and American Heart Association. – Social Services Provider
>
> More and more people are having complications from heart disease and stroke at a younger age. – Health Provider
>
> Too prevalent and not enough people seeking care. – Health Provider
>
> Heart disease continues to be a number one cause of death in the United States. – Physician
>
> These are very common in our community and in the hospital. – Physician
>
> It’s the number one cause of death in patients 40 and older. – Physician
>
> Death rates or impairments. – Health Provider
>
> High use of Emergency Departments for heart attacks and stroke. Many risk factors made worse by issues with social determinants of health. – Health Provider
>
> Because of the high prevalence of hypertension and diabetes. – Social Services Provider
>
> I hear a lot about the risks of heart disease and stroke in both men and women. – Social Services Provider

Awareness/Education

> Lack of early and continuous education regarding heart disease and stroke, unsafe walking trails, lack of culturally sensitive food reduction education programming, lack of affordable fruit and vegetables in North Omaha; food deserts; systemic issues related to social determinants of health, and lack of AA providers, nutritionists in health care systems. Lack of affordable medicines that could treat obesity prevalent among minority populations. Finally the death rates associated with heart disease and stroke reveals that these issues are major problems. – Community Leader
>
> Education about prevention and importance of treatment support for adherence with medication and lifestyle changes once diagnosed. – Community Leader
>
> Not understanding signs of stroke in time, or having someone to assist when it is happening. – Health Provider

Obesity

> Heart attack and stroke are closely related to increase in obesity, decreased physical activity and sedentary lifestyle. Access to food and nutrition security play a role in increasing risk. These two vascular conditions remain the majority of health problems and deaths. – Physician
>
> People are fat and they don’t eat well. – Social Services Provider
>
> Obesity and its resulting co-morbidities are a leading problem. Also, even with access to health care, there is a lack of trust in the health care system from our community, which COVID has exacerbated. – Health Provider

Lifestyle

> Lack of mobility, food with high grams of salt or sugar. Lifestyles very sedentary. – Social Services Provider
>
> Poor lifestyle choices. – Physician
>
> Poor diets, lack of exercise and infrequent medical contact. – Community Leader
>
> It is on the rise due to a lack of healthy dieting, exercise, lifestyles. – Health Provider

Aging Population

> With the aging population and the continued diet and weight epidemic, it causes an increase in stroke and heart disease. – Business Leader
>
> I believe we have a higher frequency of heart disease and stroke due to a combination of factors, including an aging community, high level of poverty, and lower educational attainment. – Community Leader

Access to Care/Services

> Heart disease. Prescription medicine cost is outrageous. – Community Leader
>
> Desperate access to health care, disparate health care experiences, unhealthy lifestyle habits, chronic stress and weathering, diseases of despair. – Health Provider

Access to Affordable Healthy Food

> I don't think a person could find/buy healthy food to literally save their life. Corporate America decides what we have access to and its mostly over processed garbage with no health value. The very few foods that might be better for people such as organic and overpriced and unreachable by a great number of our population. There should not be a "Health Food" section in a store. It should all be healthy or at least reasonably. Corporate America and big pharma only make huge profits by keeping people fat and sick. – Health Provider

Racial Disparities

> High rates of CAD within our community with notable ethnic and racial disparities, as well as SES barriers. Access to healthy food. Ability to exercise are contributors. Access to goal directed medical therapy and rehab options after an event are also issues. – Physician

Alcohol/Drug Use

> Alcohol, drugs, tobacco, unhealthy diet and lack of exercise. – Business Leader

Cultural/Personal Beliefs

> Culture and genetics. Lack of intervention and prevention early. – Social Services Provider

Diagnosis/Treatment

> Because of the prevalence of untreated and under treated risk factors for heart disease and stroke. – Physician

Vulnerable Populations

> The Latino community is highly affected by heart disease and has minimal access to education and prevention. – Health Provider

CANCER

ABOUT CANCER

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

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

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

Age-Adjusted Cancer Deaths

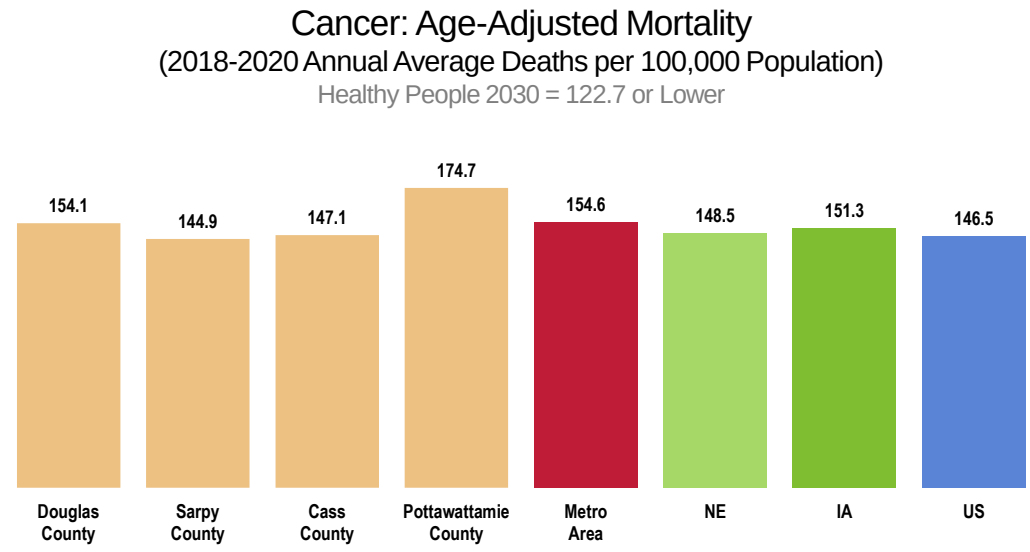
All Cancer Deaths

Between 2018 and 2020, the Metro Area reported an annual average age-adjusted cancer mortality rate of 154.6 deaths per 100,000 population.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► The mortality rate has decreased over time, in keeping with state and national trends.

DISPARITY ► Notably higher among Black residents.



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

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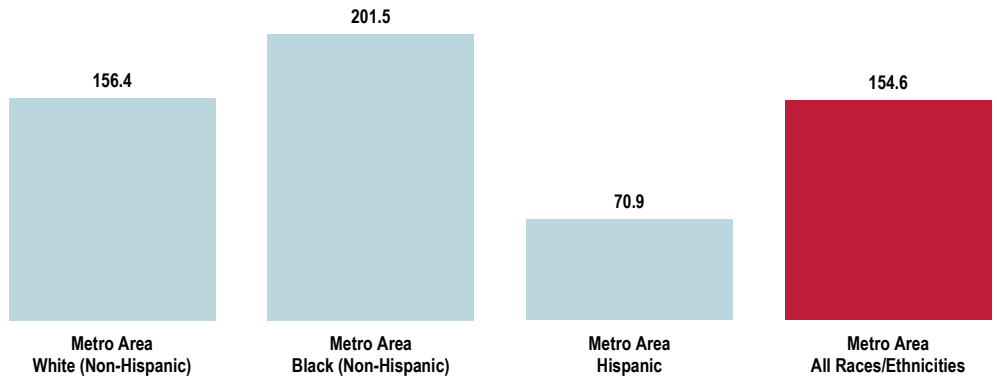
Cancer: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower



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

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	178.5	174.8	172.4	166.3	162.5	156.9	155.5	154.6
NE	163.4	161.9	159.6	157.0	154.7	152.2	150.2	148.5
IA	170.0	167.7	166.2	163.3	160.6	157.7	154.7	151.3
US	166.2	162.7	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
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Notes:
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- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Deaths by Site

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

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

BENCHMARK

Lung Cancer ► Fails to satisfy the Healthy People 2030 objective.

Female Breast Cancer ► Fails to satisfy the Healthy People 2030 objective.

Prostate Cancer ► Higher than the national rate. Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Fails to satisfy the Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

	Metro Area	NE	IA	US	HP2030
ALL CANCERS	**154.6**	**148.5**	**151.3**	**146.5**	**122.7**
Lung Cancer	**34.3**	**31.8**	**36.3**	**33.4**	**25.1**
Prostate Cancer	**21.9**	**18.7**	**20.2**	**18.5**	**16.9**
Female Breast Cancer	**19.6**	**20.8**	**17.9**	**19.4**	**15.3**
Colorectal Cancer	**13.4**	**14.9**	**13.9**	**13.1**	**8.9**

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

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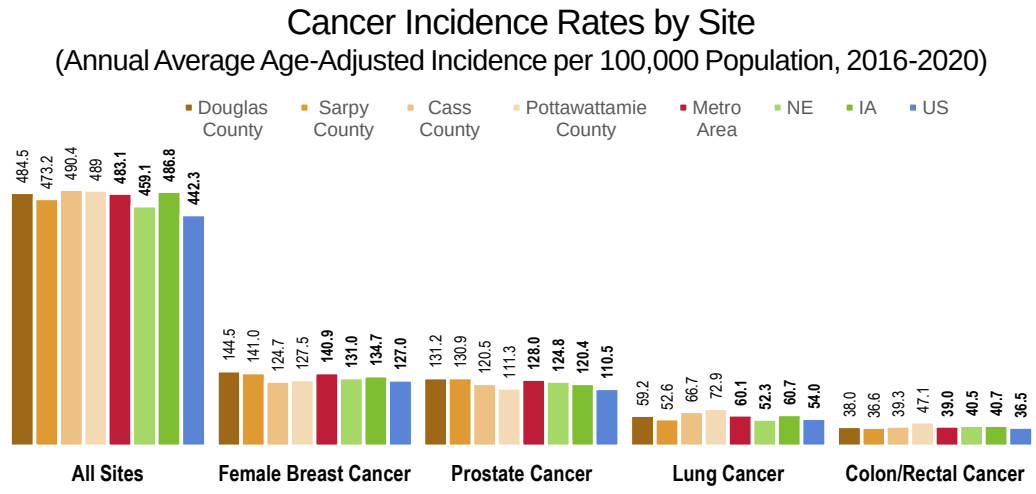
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Incidence

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

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

DISPARITY ► Note that Sarpy County reports a significantly lower incidence rate for lung cancer when compared with the other counties. In contrast, the highest incidence rate for colorectal cancer is in Pottawattamie County.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population.

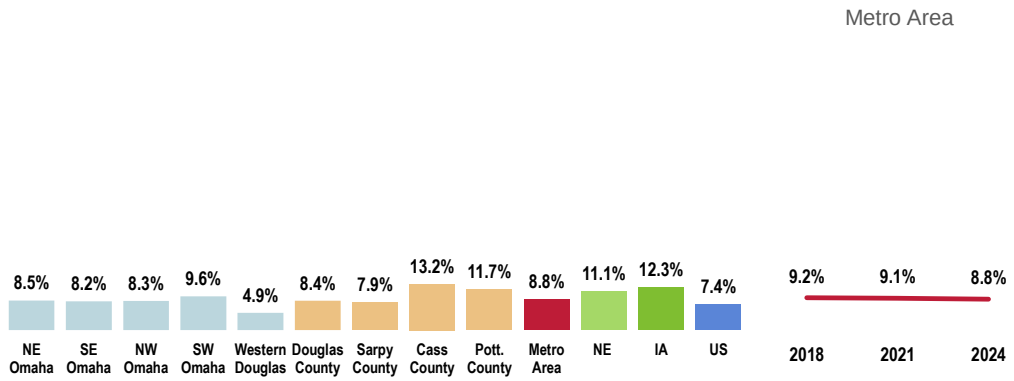
Prevalence of Cancer

A total of 8.8% of surveyed Metro Area adults report having ever been diagnosed with cancer.

BENCHMARK ► Below the Nebraska and Iowa percentages.

DISPARITY ► Statistically high in Pottawattamie County. The prevalence increases with age and is reported more often among White respondents.

Prevalence of Cancer



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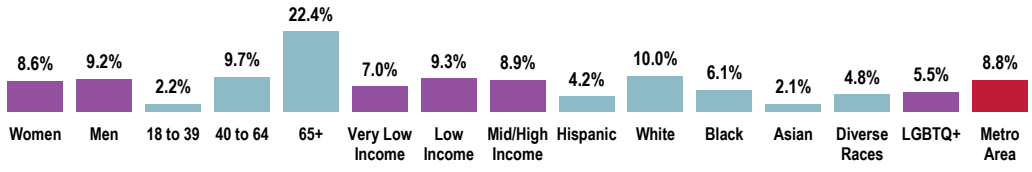
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Prevalence of Cancer
(Metro Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 24]

Notes:
- Reflects all respondents.

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures. Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

FEMALE BREAST CANCER

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

CERVICAL CANCER

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

COLORECTAL CANCER

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

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

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

Among women age 50 to 74, 82.2% have had a mammogram within the past 2 years.

BENCHMARK ► Higher than the Nebraska and US percentages.

DISPARITY ► Reported most often in the Western Douglas County area (not shown).

Among Metro Area women age 21 to 65, 73.5% have had appropriate cervical cancer screening.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every 3 years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Decreasing significantly since 2011.

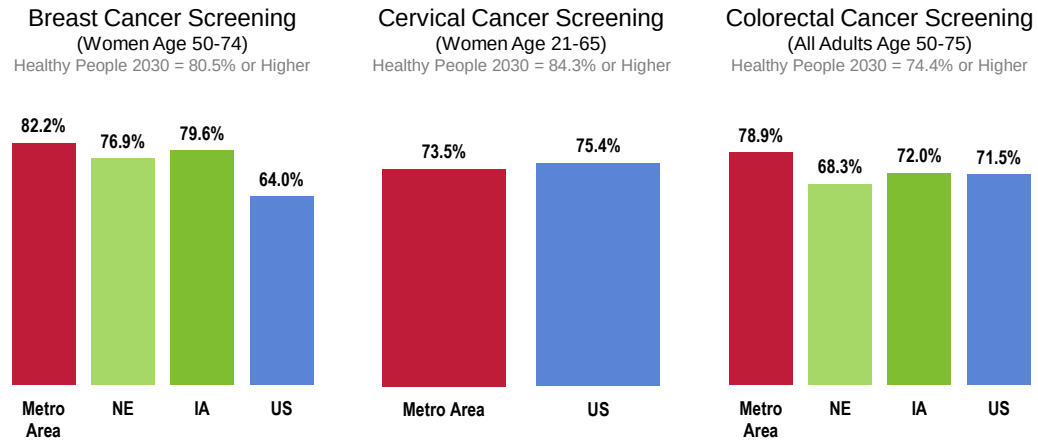
DISPARITY ► Lowest in Southeast Omaha and Cass County (not shown).

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

Among all adults age 50 to 75, 78.9% have had appropriate colorectal cancer screening.

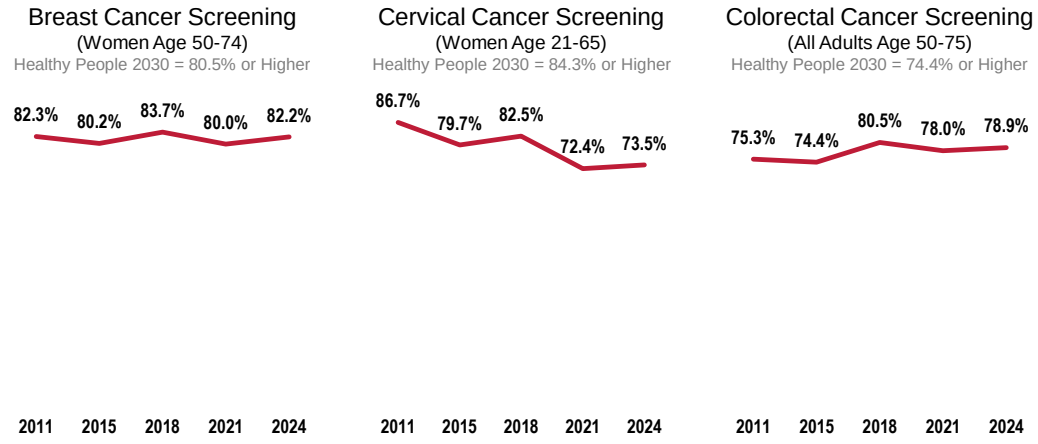
BENCHMARK ► Well above the state and national percentages, and satisfying the Healthy People 2030 objective.

TREND ► Increasing significantly since 2011.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

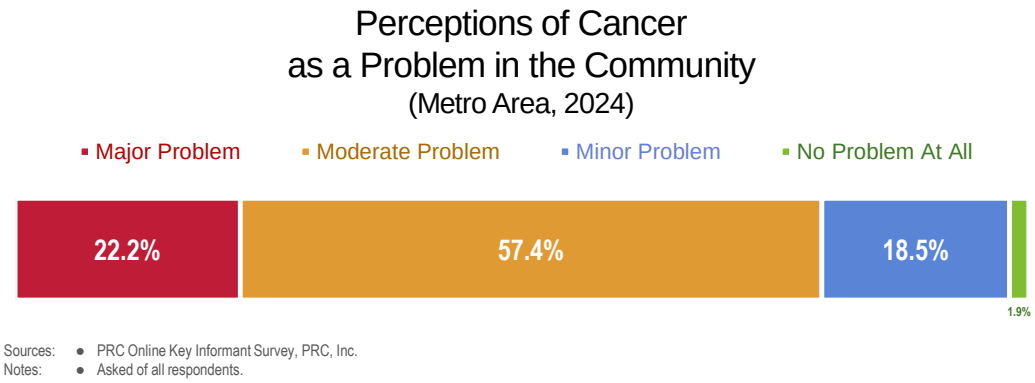


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Key Informant Input: Cancer

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



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

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

Incidence/Prevalence

> So many people have it. – Social Services Provider
>
> Excessively high rates of breast cancer, prostate, colon, and pancreatic cancer. – Community Leader
>
> Cancer is running rampant in all communities. I believe that there are cures out there, but that they are not accessible to all individuals. – Social Services Provider
>
> Many community members have been diagnosed with different types of cancer and eventually some died, while others are battling it with no resources at all. – Business Leader
>
> More and more individuals are diagnosed with cancer and at younger ages. – Community Leader
>
> The numbers are increasing for all age groups, and I have personally experienced loss to cancer in all age groups. – Social Services Provider
>
> It seemed for a decent period of time that treatments were more successful and there were fewer cases of cancer. It seems to have come back with a vengeance in recent times. I fear people can't get in to see a care provider and time is of the essence, especially with cancer. I have lost several friends and a young niece in the last year alone and know or am aware of several people battling for their lives currently. I think that pharmaceuticals' profit comes before everything and there's no money for curing or saving people. – Health Provider
>
> It is rising in incidence and becoming more prevalent. More people are diagnosed at an earlier stage, which means more people are living with or from the consequences of cancer. Additional resources to this survivor population would be beneficial. – Physician
>
> Increasing prevalence rates of many cancers. – Health Provider

Prevention/Screenings

> Patients have limited access to convenient and timely cancer screenings. – Physician
>
> Limited access to health care affects screenings and diagnostic testing for some patients, resulting in later detection. – Advanced Practice Provider
>
> There's limited use of preventive screenings and health education campaigns to reduce cancer risk factors (aside from tobacco use). With many behaviors like smoking, limited physical activity, and poor nutrition, being prevalent in the community, I think more needs to be done focused on prevention of cancer. I think more policy work in this realm would be helpful. – Public Health Representative

Environmental Contributors

> Many young people are developing cancer at an early age. The health of the air, soil and water are in question with major power and energy plants in the north Omaha area. America should quicky adapt regulations from Australia and Europe around contaminate allowed in our environment and our food. – Social Services Provider
>
> Rising rates in rural areas, potentially as a result of agricultural pollution. Rural areas are less likely to have access to preventative or screening resources. – Business Leader

Obesity

> The epidemic of obesity, nitrate content of our water supply due to agricultural inputs, poor diet high in processed sugars and oils, continued tobacco use and alcohol consumption well above any recommended limits. – Physician

Access to Affordable Healthy Food

> Food choices are unhealthy and unaffordable for healthy foods to maintain. – Health Provider

Access to Care for Uninsured/Underinsured

> Many people go untreated for a long period of time due to not having health insurance and or a trusted care physician. – Social Services Provider

Racial Disparities

> There are disparities due to ethnicities and access to care. – Health Provider

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

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

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

Note that this section also includes data relative to COVID-19 (coronavirus disease).

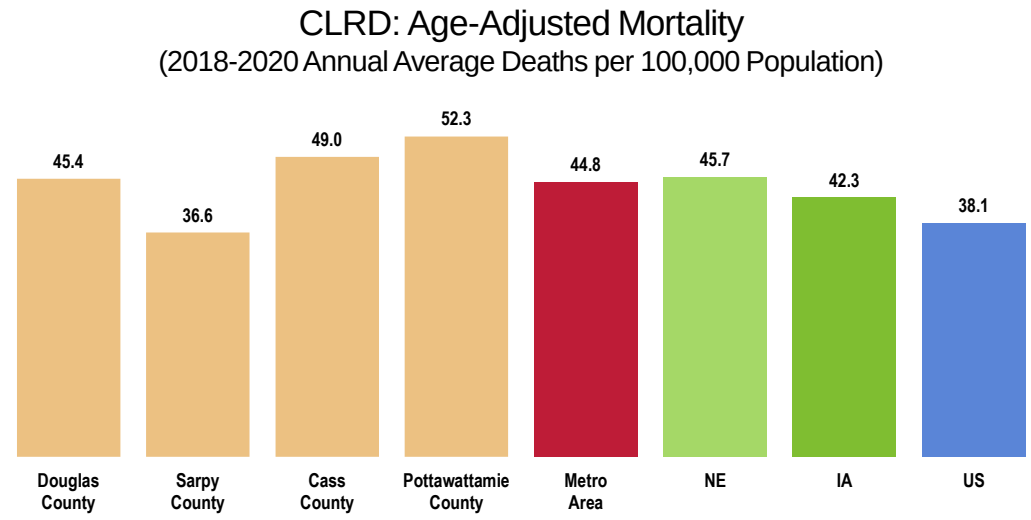
Age-Adjusted Respiratory Disease Deaths

Lung Disease Deaths

Note: Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

Between 2018 and 2020, the Metro Area reported an annual average age-adjusted lung disease mortality rate of 44.8 deaths per 100,000 population.

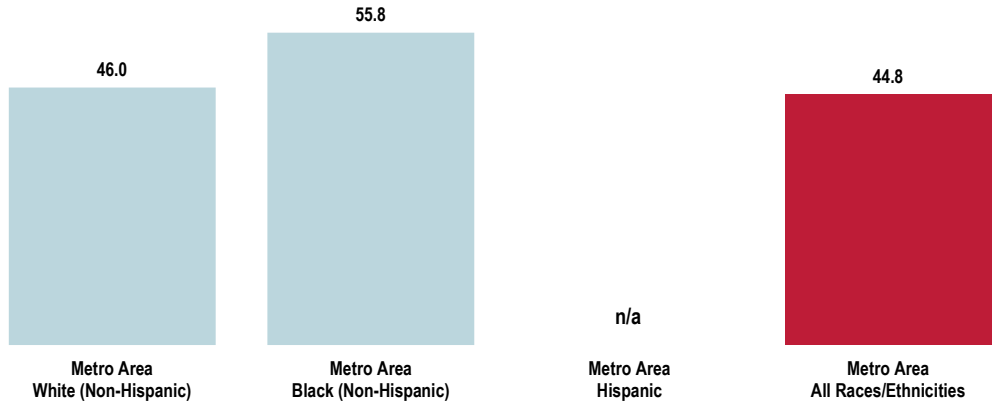
DISPARITY ► Lowest in Sarpy County. Notably higher among Metro Area Black residents.



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

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

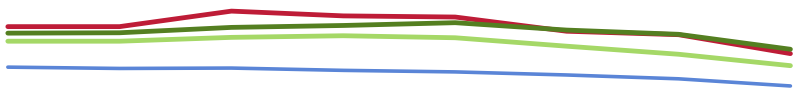
CLRD: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)



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

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	50.4	50.4	53.6	52.6	52.4	49.4	48.7	44.8
NE	49.0	49.1	50.2	50.6	51.2	49.7	48.8	45.7
IA	47.4	47.4	48.2	48.5	48.1	46.3	44.7	42.3
US	42.0	41.7	41.8	41.3	41.0	40.4	39.6	38.1

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

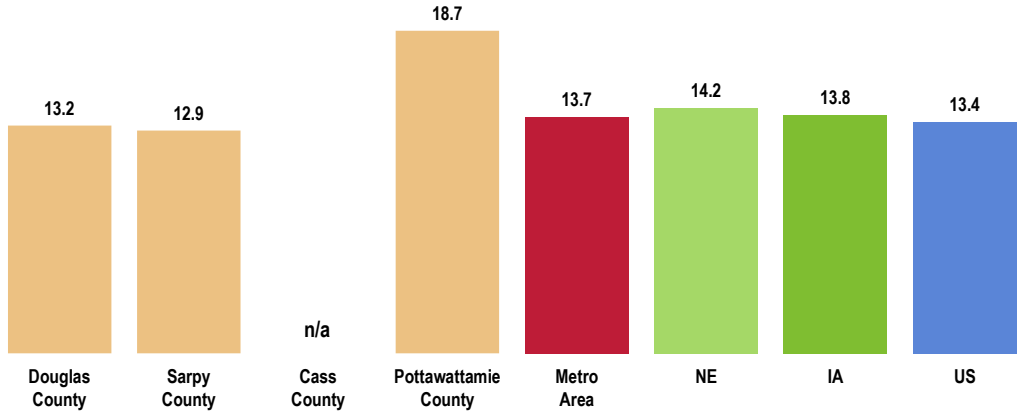
Notes:
- CLRD is chronic lower respiratory disease.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Pneumonia/Influenza Deaths

Between 2018 and 2020, the Metro Area reported an annual average age-adjusted pneumonia/influenza mortality rate of 13.7 deaths per 100,000 population.

DISPARITY ► Particularly high in Pottawattamie County.

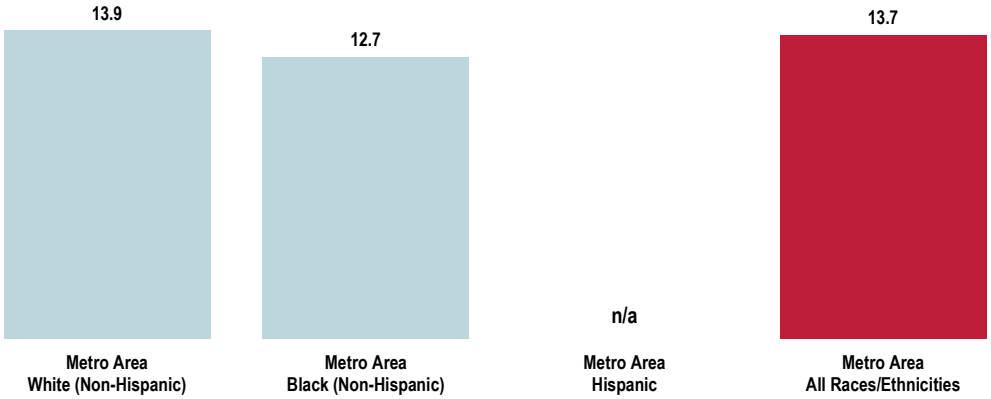
Pneumonia/Influenza: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



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

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

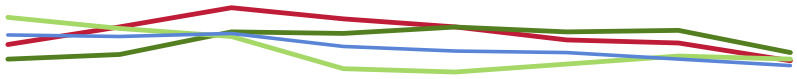
Pneumonia/Influenza: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)



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

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	14.7	15.8	17.0	16.3	15.8	15.0	14.8	13.7
NE	13.8	14.1	15.5	15.4	15.8	15.5	15.6	14.2
IA	16.4	15.7	15.2	13.2	13.0	13.5	14.0	13.8
US	15.3	15.2	15.4	14.6	14.3	14.2	13.8	13.4

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

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

Prevalence of Respiratory Disease

Asthma

A total of 12.5% of Metro Area adults have asthma.

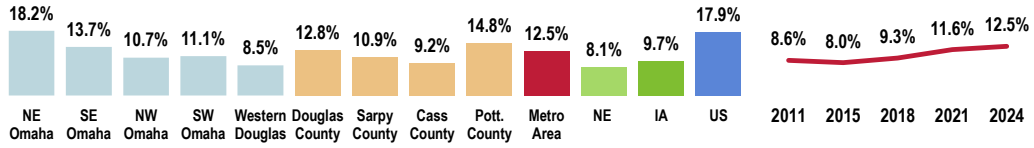
Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

BENCHMARK ► Well above the Nebraska and Iowa percentages but lower than found across the US.

TREND ► Marks a gradual but significant increase from earlier survey administrations.

DISPARITY ► Highest in Northeast Omaha. The prevalence decreases with age and household income level and is reported more often among women, Black or African American residents, and LGBTQ+ residents.

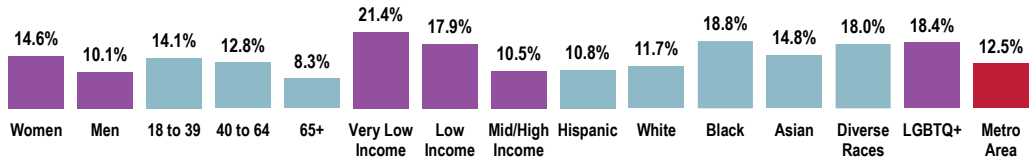
Prevalence of Asthma



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Asthma
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 26]
Notes: • Asked of all respondents.

Chronic Obstructive Pulmonary Disease (COPD)

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

A total of 5.9% of Metro Area adults suffer from chronic obstructive pulmonary disease (COPD).

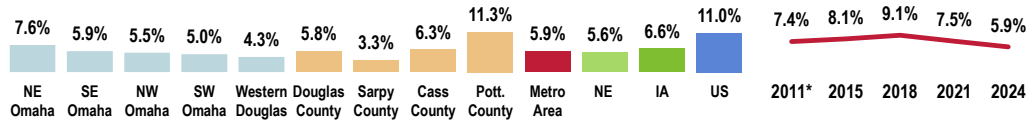
BENCHMARK ► Well below the US figure.

TREND ► Decreasing significantly since 2011 (and especially since 2018).

DISPARITY ► Considerably higher in Pottawattamie County when compared with the other counties.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

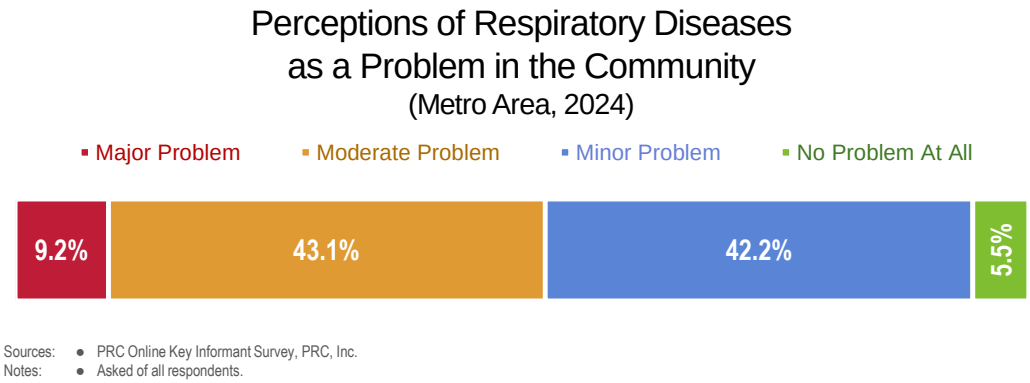
Metro Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 21]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
• *In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a "moderate problem" in the community (followed closely by "minor problem" ratings).



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

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

Incidence/Prevalence

> Asthma and lung disease. – Health Provider
>
> COPD and sleep apnea are prevalent. – Physician
>
> High incidences of COPD. – Community Leader
>
> Respiratory issues, such as asthma. – Health Provider

Tobacco Use

> Smoking and noncompliance. – Physician
>
> Large number of smokers or ex-smokers in the community. Community resistance to getting vaccinated. – Social Services Provider
>
> Tobacco use is high in the community. Not all people received vaccines and or boosters. – Social Services Provider

Awareness/Education

> Lack of awareness and options. – Business Leader

Environmental Contributors

> Significant pollution in Omaha and Nebraska from pesticides and agricultural practices, as well as high rates of smoking. – Physician

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

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

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

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

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

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2018 and 2020, there was an annual average age-adjusted unintentional injury mortality rate of 36.5 deaths per 100,000 population in the Metro Area.

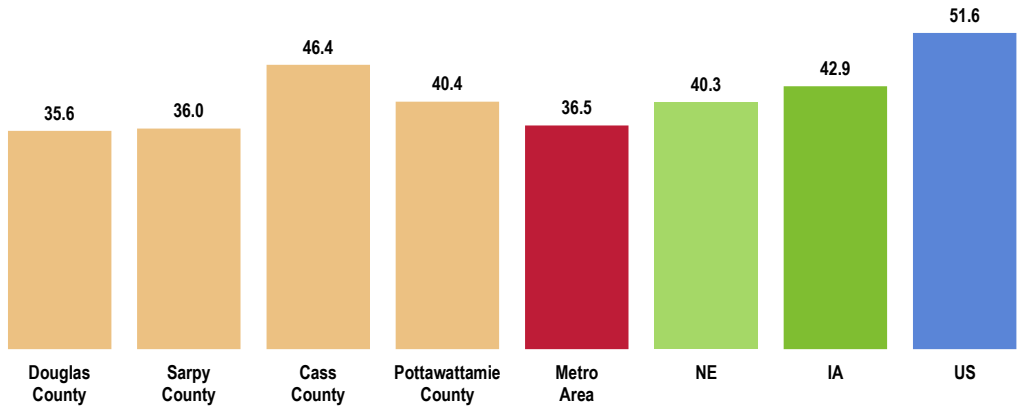
BENCHMARK ► Lower than the Iowa and US mortality rates. Satisfies the Healthy People 2030 objective.

DISPARITY ► Highest in Cass County.

Unintentional Injuries: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



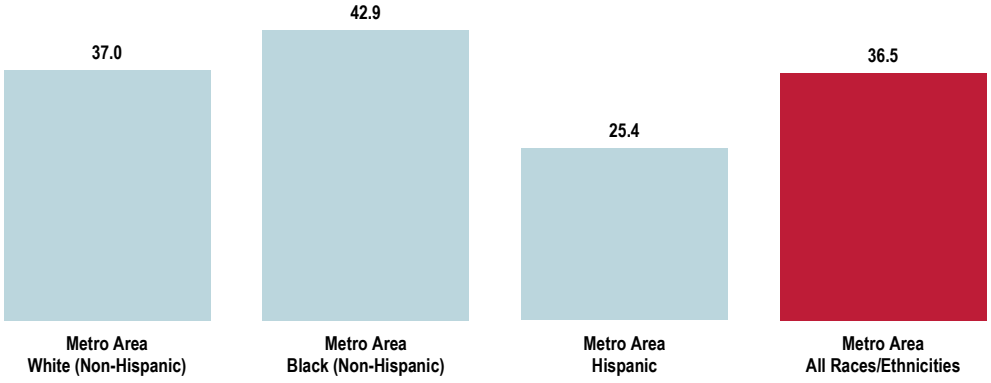
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Unintentional Injuries: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



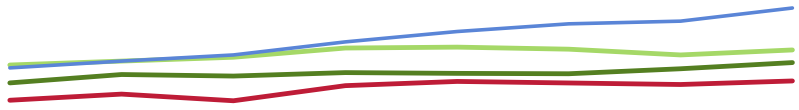
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	32.5	33.8	32.4	35.5	36.4	36.1	35.8	36.5
NE	36.1	37.8	37.5	38.2	38.1	38.0	39.0	40.3
IA	39.8	40.6	41.4	43.3	43.5	43.1	41.9	42.9
US	39.2	40.6	41.9	44.6	46.7	48.3	48.9	51.6

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

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

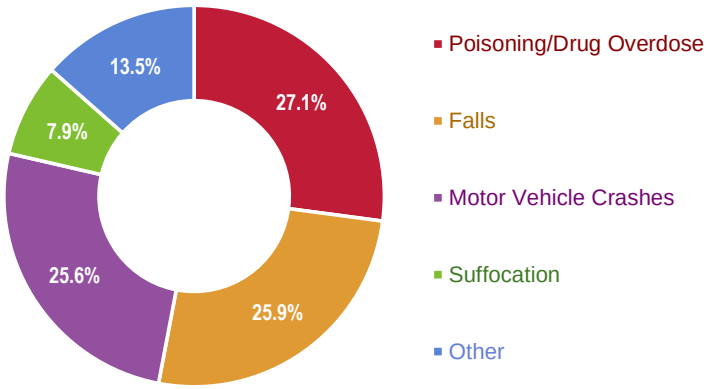
Leading Causes of Unintentional Injury Deaths

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

Poisoning (including unintentional drug overdose), falls, and motor vehicle crashes accounted for most unintentional injury deaths in the Metro Area between 2018 and 2020.

Leading Causes of Unintentional Injury Deaths

(Metro Area, 2018-2020)



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

Falls

ABOUT FALLS

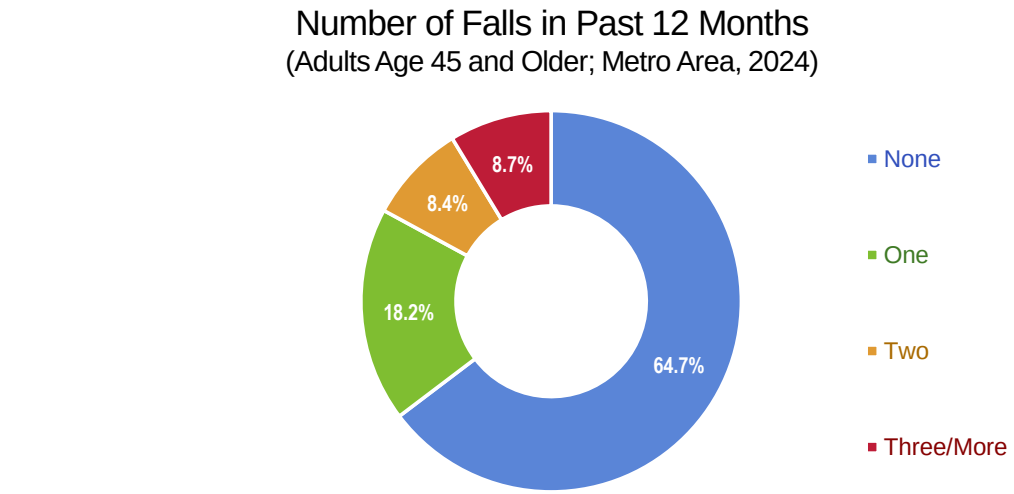
Falls are the leading cause of fatal and nonfatal injuries for persons age 65 and older …. Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

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

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

RELATED ISSUE
For fall-related mortality data, see *Age-Adjusted Death Rates for Selected Causes* in the Leading Causes of Death section of this report.

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

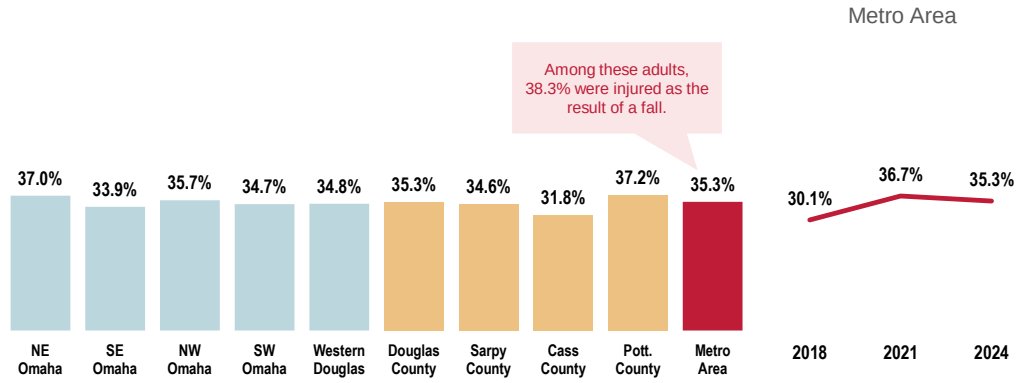


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 331]
Notes: • Asked of all respondents age 45+.

However, 35.3% have experienced a fall at least once in the past year.

TREND ► Increasing significantly from 2018 findings.

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



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 331-332]
Notes: ● Asked of those respondents age 45 and older.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

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

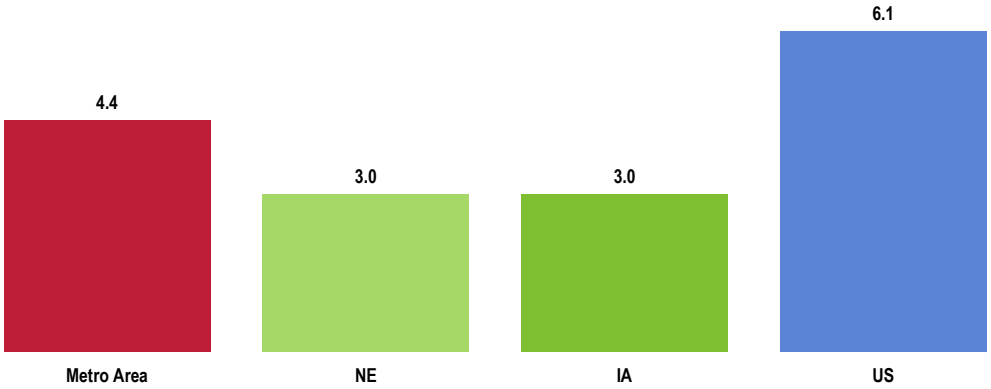
The Metro Area reports 4.4 homicides per 100,000 population (2018-2020 annual average age-adjusted rate).

BENCHMARK ► Worse than both state homicide rates but below the US rate. Satisfies the Healthy People 2030 objective.

TREND ► The rate has decreased over the past decade, mirroring the Nebraska trend.

DISPARITY ► The homicide rate is nine times higher among Black residents than White residents.

Homicide: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower

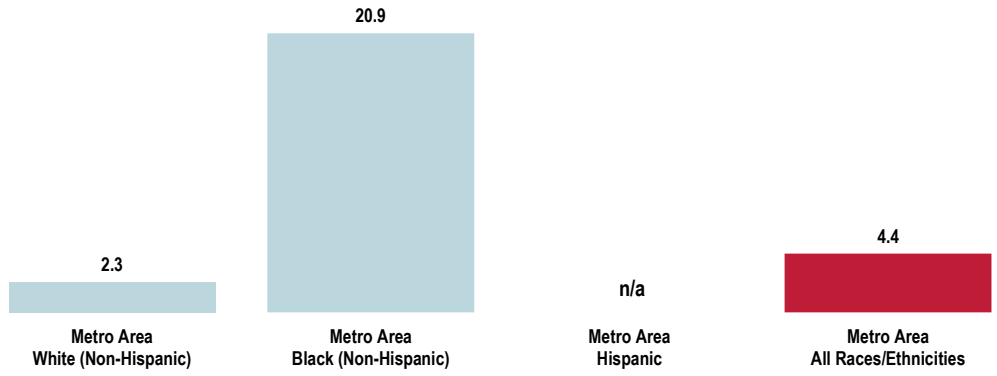


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Homicide: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 5.5 or Lower



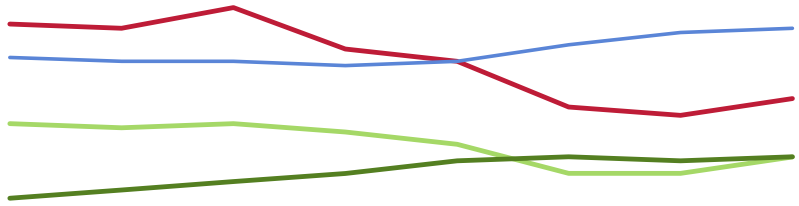
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 5.5 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	6.2	6.1	6.6	5.6	5.3	4.2	4.0	4.4
NE	3.8	3.7	3.8	3.6	3.3	2.6	2.6	3.0
IA	2.0	2.2	2.4	2.6	2.9	3.0	2.9	3.0
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

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

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

Violent Crime

Violent Crime Rates

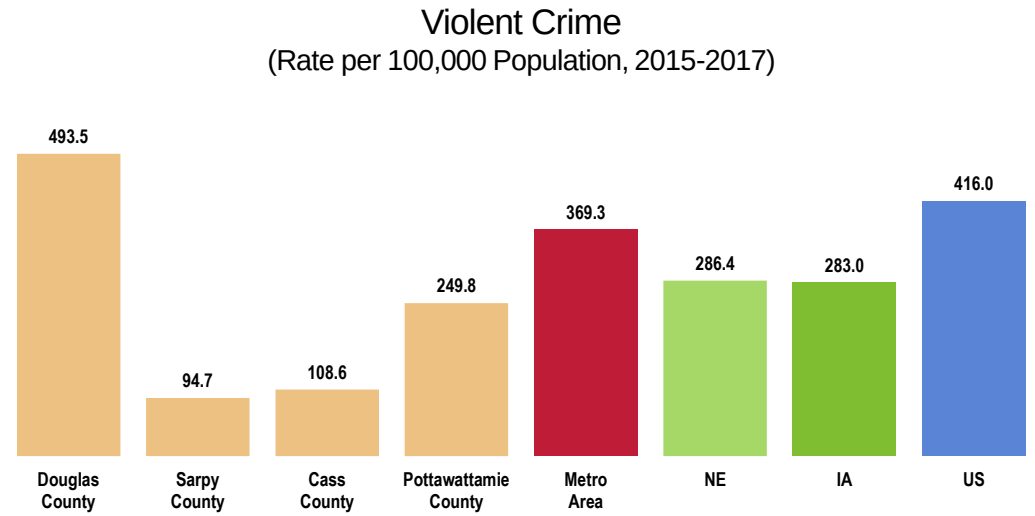
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

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

The Metro Area reported 369.3 violent crimes per 100,000 population (2015-2017).

BENCHMARK ► Well above both state violent crime rates.

DISPARITY ► Highest in Douglas County; particularly low in Sarpy and Cass counties.



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

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

Intimate Partner Violence

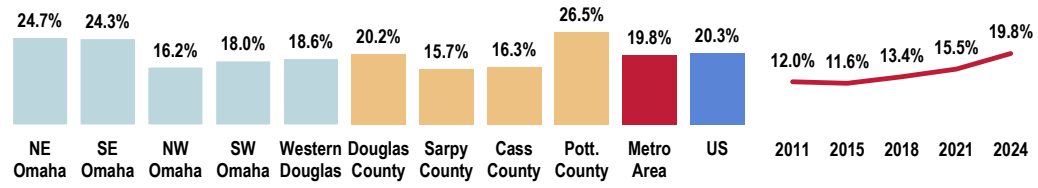
Respondents were read: "By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 19.8% of Metro Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

TREND ► Denotes a statistically significant increase since 2011.

DISPARITY ► Highest in Pottawattamie County and eastern Omaha.

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



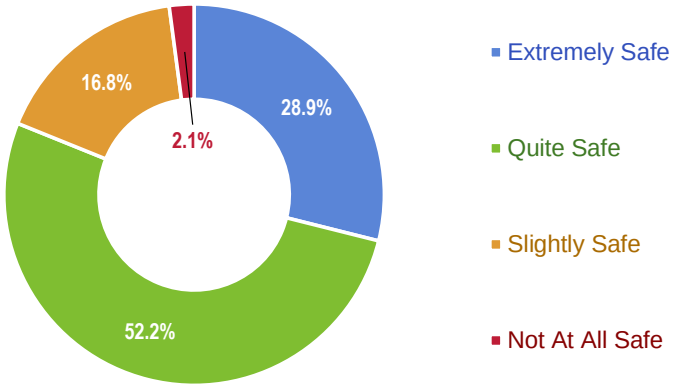
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceived Neighborhood Safety

While most Metro Area adults consider their own neighborhoods to be "extremely safe" or "quite safe," 18.9% consider them only "slightly safe" or "not at all safe."

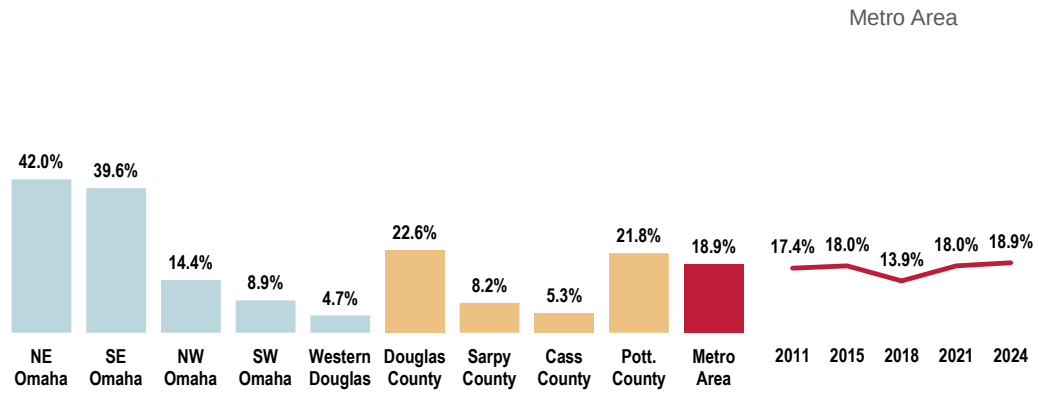
DISPARITY ► Least favorable in Douglas County (especially east of 72nd Street). Less favorable perceptions are also expressed among women, young adults, those in low-income households, Hispanic residents, Black or African American residents, those of Diverse Races, and LGBTQ+ residents.

Perceived Safety of Own Neighborhood
(Metro Area, 2024)



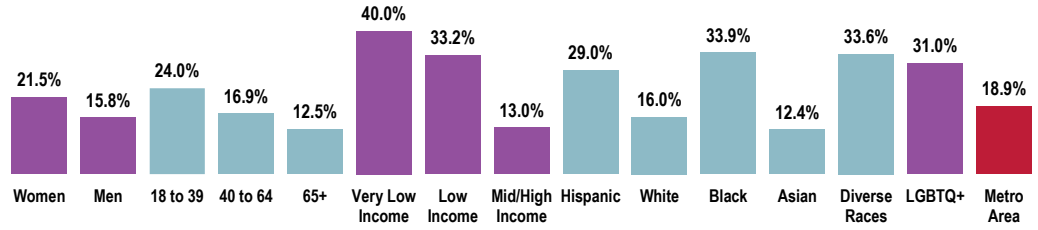
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: ● Asked of all respondents.

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



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: • Asked of all respondents.

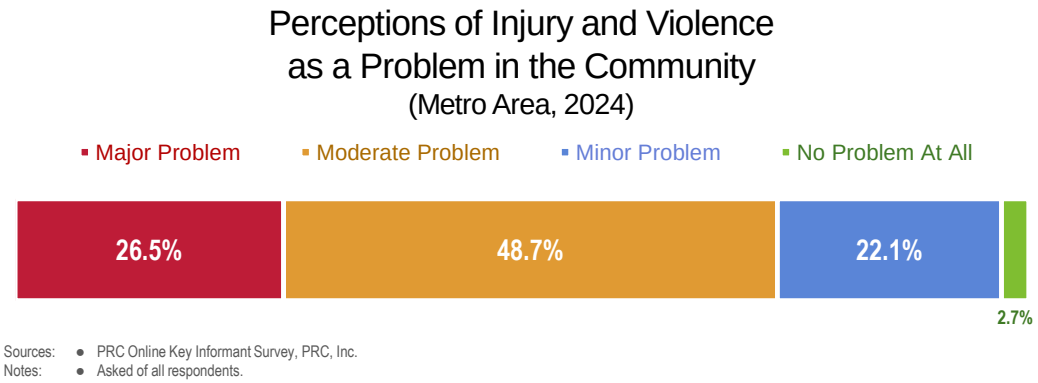
Perceive Own Neighborhood as “Slightly” or “Not At All” Safe
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a "moderate problem" in the community.



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

Incidence/Prevalence

> We treat many patients who are victims of violence at the hospital, and violence has lifelong psychological and social impacts on victims. – Physician
>
> The community is divisive and violent and on the increase. – Social Services Provider
>
> Observed feedback from community groups, like Omaha 360. – Social Services Provider
>
> Our organization focuses on sexual violence and domestic assault. Our recent report of domestic violence in Douglas County indicates an increase. – Business Leader
>
> Crime. – Physician
>
> Assault rates are extremely high. People in the community are prone to resorting to violence for even minor inconveniences. This violence is not only amongst intimate partners, but to those providing community services. – Health Provider
>
> Significant community violence issues. Some areas of the city are distant from trauma centers. Only one level-one trauma center. – Physician
>
> There are always reports on the news of injury or violence happening in our community, shootings, stabbings, drunk driving accidents, robberies, child abuse, human and sex trafficking, etc. – Social Services Provider
>
> High prevalence of people experiencing violence. – Physician
>
> Increased violence with not enough programs or pathways out of circumstances or to address systemic causes. – Business Leader
>
> Turn on the news, it is all over the place. – Health Provider
>
> Based on data from several community partners. – Health Provider

Gun Violence

> The United States has an epidemic of gun violence. – Physician
>
> We have a higher rate of shootings in North and South Omaha. Families are traumatized and looking or mental health support services. Our unhoused population is increasing looking for services. With not enough services or assistance available increases use of drugs and violence. – Social Services Provider
>
> High incidences of shootings and assaults. – Community Leader
>
> Frequent news reports of guns and other violence in Omaha. – Health Provider

Domestic/Family Violence

> Domestic violence and instability in the home cause family displacement. Gun violence, loss of loved ones and if survived, disability, needing caregiver services, family strained relationships. Hit-and-run accidents causes loss of income, in a family, disability, loss of life and not being able to follow up due to the circumstances involved. – Health Provider
>
> Domestic violence, unsafe roads, poor infrastructure, lack of safety regulations and safeguards. – Business Leader

Impact on Quality of Life

> A large portion of the patients I serve list some form of past abuse in their chart, such as physical, emotional, or sexual abuse. We know the impact these adverse events have when experienced or witnessed as children, and as adults on long-term health. – Physician
>
> Poverty, trauma, and mental health issues. – Health Provider

Traffic Fatalities

> Traffic fatalities (particularly those for vulnerable roadway users such as cyclists/pedestrians/motorcyclists) continue to be a persistent problem. High-speeds, impairment from drugs and alcohol, distracted driving, and infrastructure that prioritizes high speeds all contribute to these issues and require cross-sectoral efforts to make progress. – Community Leader

Parental Influence

> Poor parenting skills, single young women, drug abuse, alcohol intake, and domestic violence. – Social Services Provider

Social Media

> News and social media. – Social Services Provider

DIABETES

ABOUT DIABETES

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

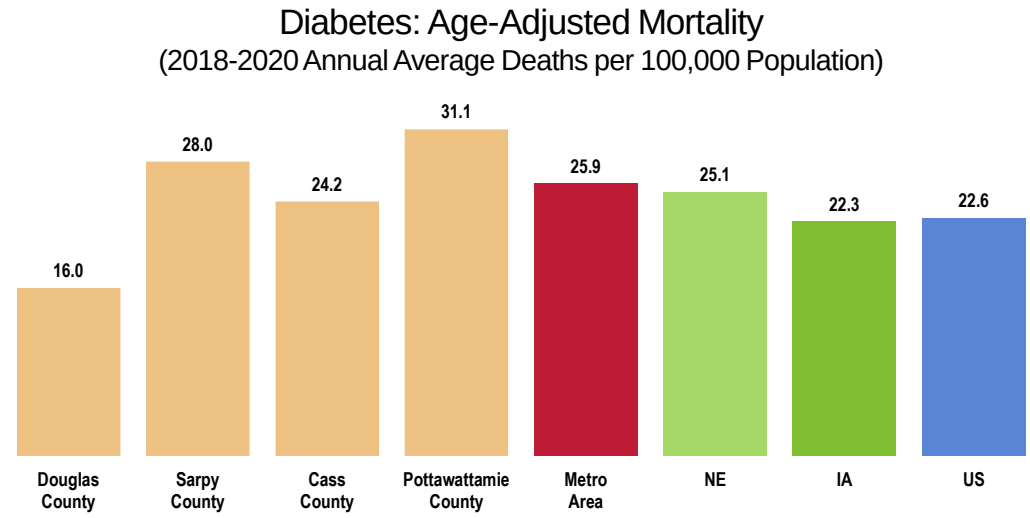
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity,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

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

Age-Adjusted Diabetes Deaths

Between 2018 and 2020, there was an annual average age-adjusted diabetes mortality rate of 25.9 deaths per 100,000 population in the Metro Area.

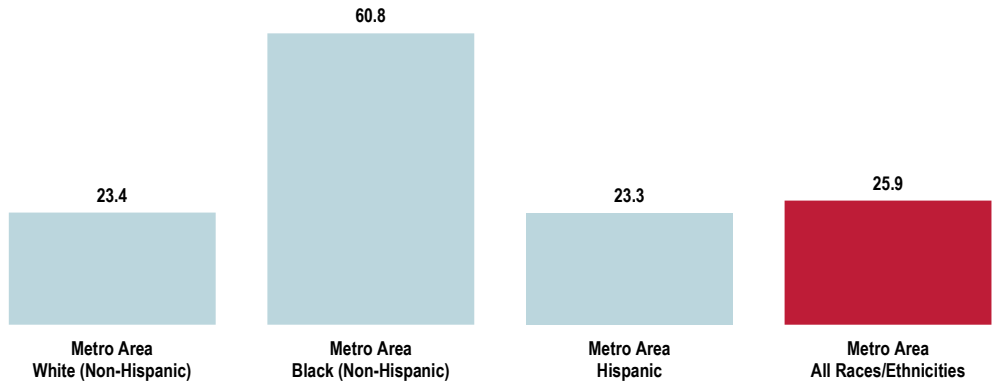
DISPARITY ► Highest in Pottawattamie County. Much higher among Black residents.



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

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

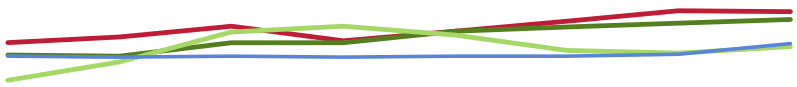
Diabetes: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)



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

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	22.7	23.3	24.4	22.9	23.9	24.9	26.0	25.9
NE	21.4	21.3	22.7	22.7	23.9	24.3	24.7	25.1
IA	18.8	20.7	23.8	24.4	23.5	21.9	21.6	22.3
US	21.3	21.2	21.3	21.2	21.3	21.3	21.5	22.6

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

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

Prevalence of Diabetes

A total of 11.2% of Metro Area adults report having been diagnosed with diabetes.

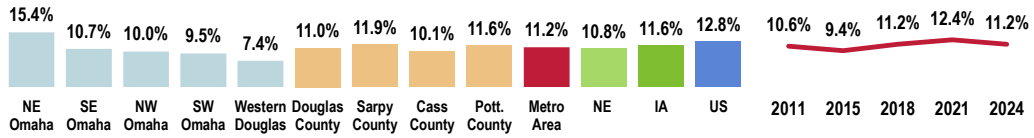
TREND ► While the prevalence of diabetes has remained fairly stable, the prevalence of borderline or pre-diabetes has increased significantly over time (not shown below).

DISPARITY ► Diabetes prevalence is highest in Northeast Omaha. Diabetes increases with age and decreases with household income level, and is reported more often among men and Black or African American respondents.

Prevalence of Diabetes

Another 12.1% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

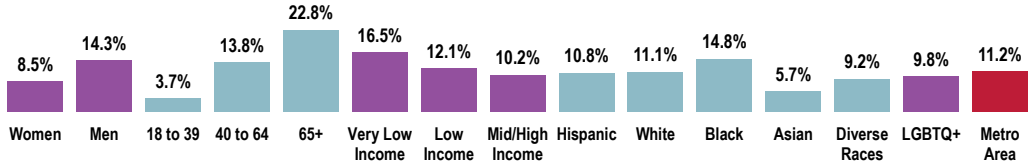
Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(Metro Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Age-Adjusted Kidney Disease Deaths

ABOUT KIDNEY DISEASE & DIABETES

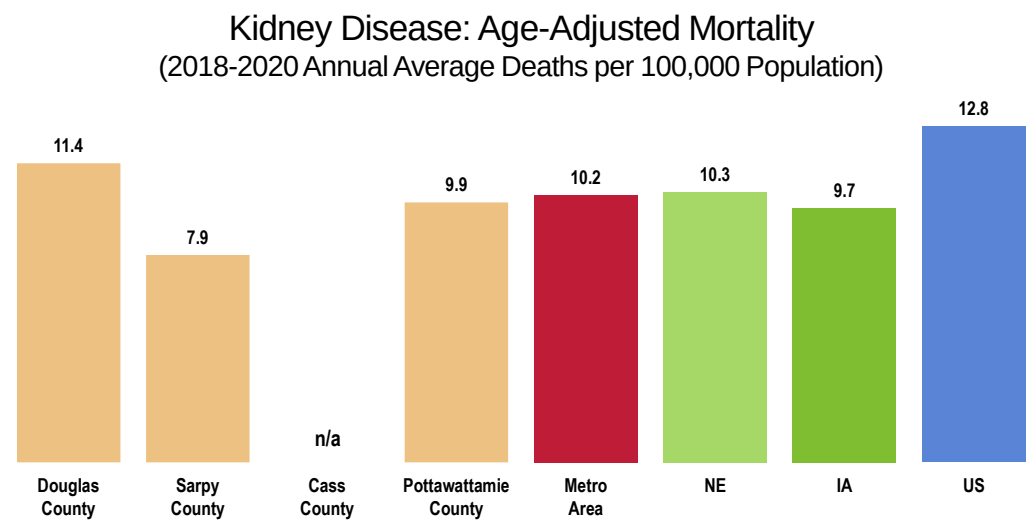
Chronic kidney disease (CKD) is common in people with diabetes. Approximately one in three adults with diabetes has CKD. Both type 1 and type 2 diabetes can cause kidney disease. CKD often develops slowly and with few symptoms. Many people don't realize they have CKD until it's advanced and they need dialysis (a treatment that filters the blood) or a kidney transplant to survive.

– Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html

Between 2018 and 2020, there was an annual average age-adjusted kidney disease mortality rate of 10.2 deaths per 100,000 population in the Metro Area.

BENCHMARK ► Lower than the national mortality rate.

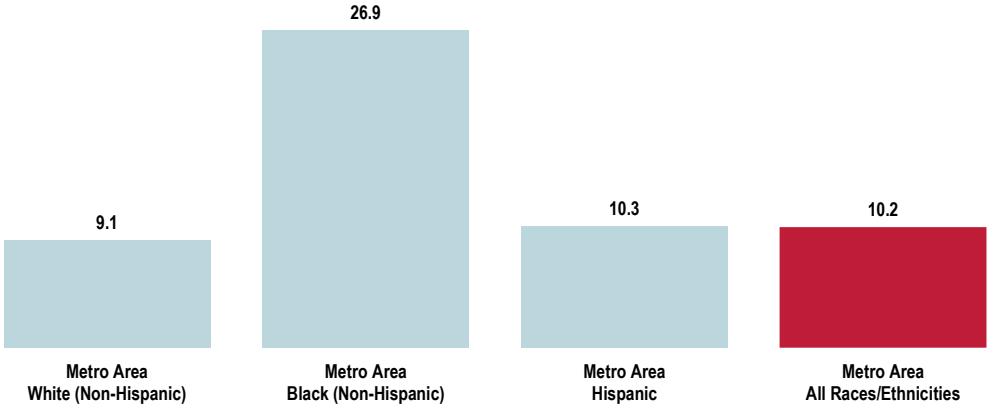
DISPARITY ► Lowest in Sarpy County. By race, the mortality rate is much higher among Black residents than White or Hispanic residents.



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

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

Kidney Disease: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)



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

Notes:
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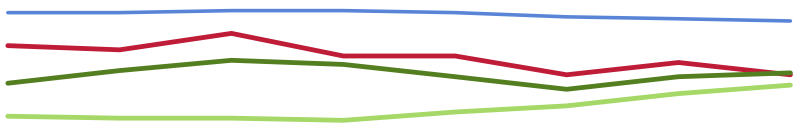
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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



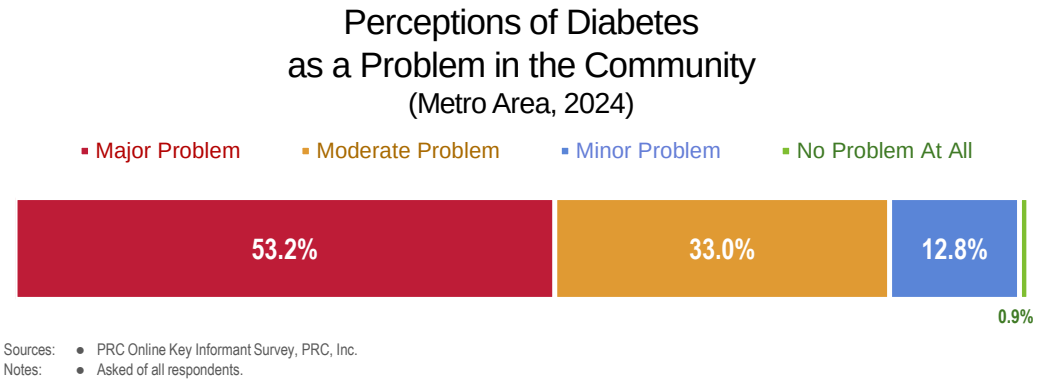
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	11.6	11.4	12.2	11.1	11.1	10.2	10.8	10.2
NE	9.8	10.4	10.9	10.7	10.1	9.5	10.1	10.3
IA	8.2	8.1	8.1	8.0	8.4	8.7	9.3	9.7
US	13.2	13.2	13.3	13.3	13.2	13.0	12.9	12.8

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

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

Key Informant Input: Diabetes

Over half of key informants taking part in an online survey characterized *Diabetes* as a "major problem" in the community.



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

Affordable Medications/Supplies

Lack of access to first line medications, such as GLP1 agonists and SGLT2 inhibitors, due to cost, poor insurance coverage, or just not available in pharmacies. Overabundance of unhealthy foods in grocery stores and fast food. – Physician

Being able to afford diabetic medications. Some newer diabetic medications are not in stock even when insurance will cover the cost, making it difficult for diabetics to get access to their medications. – Health Provider

Affordable medications and access to healthy affordable foods. Medications for diabetes are all separate and have to be ordered individually. Some pharmacies do not carry all diabetic supplies. Rural communities have barriers to accessing their medications, especially if the person is disabled. – Health Provider

Cost of life saving medications. – Social Services Provider

Access to medications, including insulin and type-2 drugs. – Community Leader

Access to affordable medications, and prevention of the disease. – Community Leader

Medication costs both with and without insurance. Significant supply chain issues affecting availability of medications (specifically GLP-1s although some insulin as well). Access to culturally and linguistically appropriate education. Access to healthy foods. Limitation of fresh fruits, vegetables (non-carb heavy) options at food pantries. Access to safe spaces to exercise. – Physician

Costs of medications and testing supplies. Limited access to newer agents for testing, such as continuous glucose monitoring and newer medications, due to lack of formulary coverage by insurers. – Advanced Practice Provider

Access to medications, like GLP-1 and SGLT2, and medication classes. – Physician

Ability to afford CGMs, pumps, and expensive medications and insulin. – Physician

Inability to afford the medication (or access the medications that work best for diabetes and weight management like GLP-1 agonists that were being obtained by people wanting to lose weight). Food insecurity and additional costs of healthier food choices. Lack of access to safe and affordable physical activity options. Lack of diabetes prevention programs in addition to culturally competent diabetes education classes that are conveniently located within the communities most impacted. Lack of podiatrists in north and south Omaha. – Community Leader

Cost of supplies and adherence to care. – Health Provider

From what I have heard, access to medications needed to treat diabetes are being used for other things like weight loss. – Business Leader

Access to Affordable Healthy Food

Accessing healthy foods. – Community Leader

Due to lack of income, no access to fresh food items and healthier items. – Social Services Provider

Access to healthy, less starchy food. – Community Leader

Overall accessibility to healthy food options. – Community Leader

Access to healthy foods. Access to affordable medication, health literacy and prevention. – Health Provider

> Access to fresh healthy foods, eating healthy is more expensive and more work to prepare, we need to educate our community on simple choices they can make to improve their eating habits. I also feel that access to affordable health care is a challenge for our “working” population. Medical coverage as well as medication is expensive as are diabetic supplies. – Social Services Provider
>
> Access to healthy nutrition, exercise, and the cost of diabetes medications. A healthy lifestyle is not the default for many people. – Physician

Awareness/Education

> Education and access to healthy foods and exercise. Lack of intervention early. – Social Services Provider
>
> Early intervention, education, and compliance. – Physician
>
> Health literacy and education on the diagnosis and lifestyle changes, finances for medications. – Social Services Provider
>
> I would say the largest gap is awareness. We know how well we are managing the patients that come to us but do not have a full grasp of all the individuals that need support that aren’t engaged with a health provider. So, awareness is an opportunity, financial support to help manage diabetes and resources to support healthy living and lifestyle options. – Business Leader
>
> Lack of quality education regarding diabetes management. Ability for lower income individuals to afford needed supplies for testing their blood sugar. – Physician

Nutrition

> Nutrition and foot care. – Community Leader
>
> The fact that foods that cause diabetes are allowed on the shelf in the first place. The lack of education of proper nutrition for our children and adults. Access to healthy food options in North Omaha food deserts. – Social Services Provider
>
> A culture in which unhealthy foods are subsidized and marketed to people starting at a young age. Some people do not have access to safe outdoor areas or gyms for exercise, but many Medicaid plans now cover gym access so that is helpful. the cost of newer Diabetes medicines means that people with lower income or wealth may not have the same access to medicine as those who are wealthy. – Physician
>
> Being able to follow directions on making good food choices, being able to afford healthy choices, and following medical guidelines. – Health Provider
>
> Food security, access to treatment, access to the ability to be active and safe, access to medications due to cost. – Physician

Obesity

> Obesity rates, older population, access to affordable drug therapies. – Business Leader
>
> Increasing number of overweight people who are developing diabetes at a very young age. – Physician
>
> Obesity. – Health Provider
>
> Diabetes is secondary to obesity. Healthy food is expensive and people living in poverty must opt for less expensive food that's not good for you. People, in general, are living a sedentary lifestyle as well. – Social Services Provider
>
> I think many people are not diagnosed, but likely have Type 2, especially with the weight epidemic. Scheduling with a care provider can take far too long and I think people give up and just chance it. I don't think people are educated as to where they can get help/insulin and especially if they don't have insurance. I believe there is a federal cap on insulin for $25 or $35 now, but for some people that means not eating that week if they have to buy it, and they likely won’t. – Health Provider

Prevention/Screenings

> Screening, diagnosis, and management of diabetes, particularly culturally and linguistically appropriate care. – Public Health Representative
>
> Testing kits, appropriate diet, and preventative measures. – Business Leader
>
> Tertiary prevention, which is too late. Difficulty accessing and affording medications. Little understanding or evaluation of the environment's impact on diabetes, such as endocrine disrupters and pollution. – Health Provider
>
> I think it is those that are pre-diabetic. We need more assessment and data monitoring to prevent diabetes and screen those individuals that do not know they are pre-diabetic. – Public Health Representative

Access to Care/Services

> Lack of insurance, expense of medications. – Physician
>
> Lack of adequate access to care, education, and treatment. Financial limitations on food choices and optimal medication choices. Issues with weight management for all of the previously noted reasons. – Physician

> Weight loss programs, availability of weight loss medication GLP-1, and access to endocrinologists. – Physician
>
> Lack of access to the latest technology and treatments. – Health Provider

Diagnosis/Treatment

> Lack of integrated services to combine classic medication-based approach with community-based nutrition, activity, and peer support. Medication availability and pricing. Education for those at risk of prediabetes. Access to technology that may help to assist with long term control and prevent diabetes in the first place. – Health Provider
>
> Mental health services are not being offered in conjunction with medical treatment for those on dialysis. Diabetic and pre-diabetic patients should have access to trained and paid community health workers located at support groups outside of medical institutions within their communities. Recent data has revealed that African American diabetes patients on dialysis nationally are not put on kidney transplants lists at the level of white patients and given the racial and ethnic health disparities among diabetes deaths among African Americans in Douglas County, I see this as possibly the biggest challenge. – Community Leader

Disease Management

> Diabetes is not managed well. – Health Provider
>
> Adherence to medication and access to providers of diabetes. Lack of physical activity and obesity. – Physician

Vulnerable Populations

> The Latino community is highly affected by diabetes and prevention education. – Health Provider
>
> For our homeless population it is medication access and making sure that they do not lose their medication. For those that are lower income, it is affording their medications. – Health Provider

Affordable Care/Services

> Insurance coverage for continuous glucose monitoring. Access to healthy, minimally processed foods. Safe places to exercise. – Physician
>
> Cost. – Health Provider

Comorbidities

> Mental health, addiction, and poverty. – Social Services Provider

Inequality

> High maternal and infant mortality, both driven in part by discrimination and access issues. Inability to access mental health services. High rate of syphilis and other STIs. – Physician

Lack of Diversity in Providers

> Access to professionals of color. – Health Provider

Lifestyle

> T2D and unhealthy lifestyles lead to this diagnosis. – Social Services Provider

Parental Influence

> For adults in the community, it is a choice, for children the food by parents who do not pay attention to leading factors as it relates to a restrictive diet or one that includes balance; many have access but may be income challenged or not know what to purchase/prepare. – Business Leader

DISABLING CONDITIONS

Activity Limitations

ABOUT DISABILITY & HEALTH

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

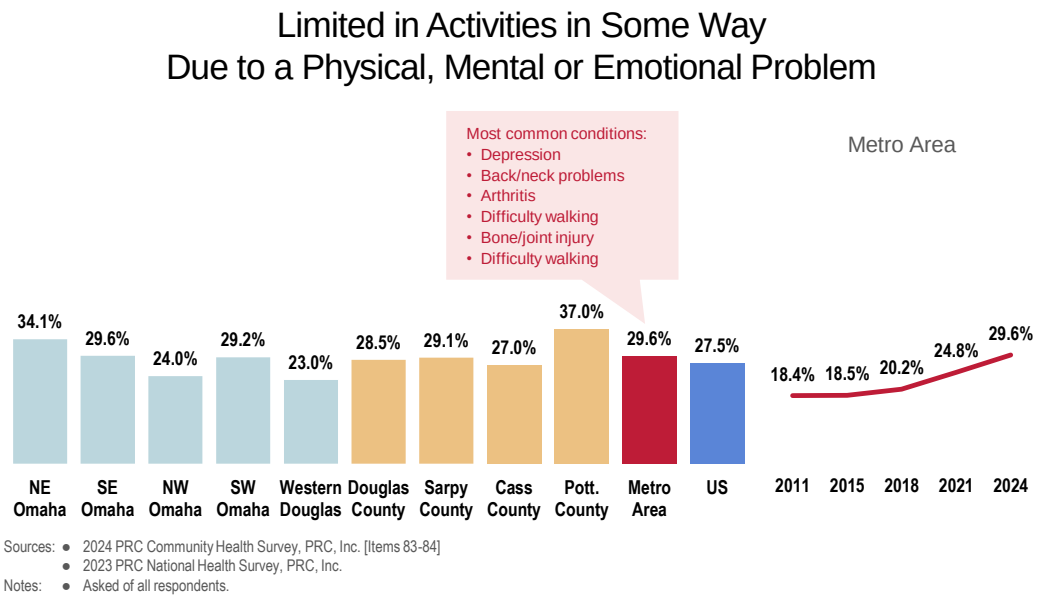
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life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

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

A total of 29.6% of Metro Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

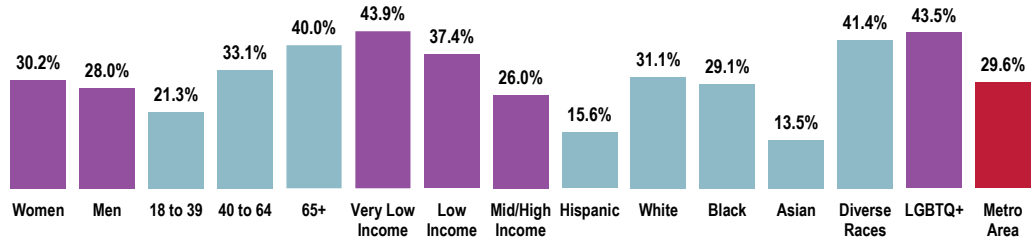
TREND ► Denotes a statistically significant increase since 2011.

DISPARITY ► Highest in Pottawattamie County and Northeast Omaha. The percentage increases with age, decreases with household income levels, and is reported more often among White adults, Black or African American adults, those of Diverse Races, and those who identify as LGBTQ+.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

Alzheimer's Disease

ABOUT DEMENTIA

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

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

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

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

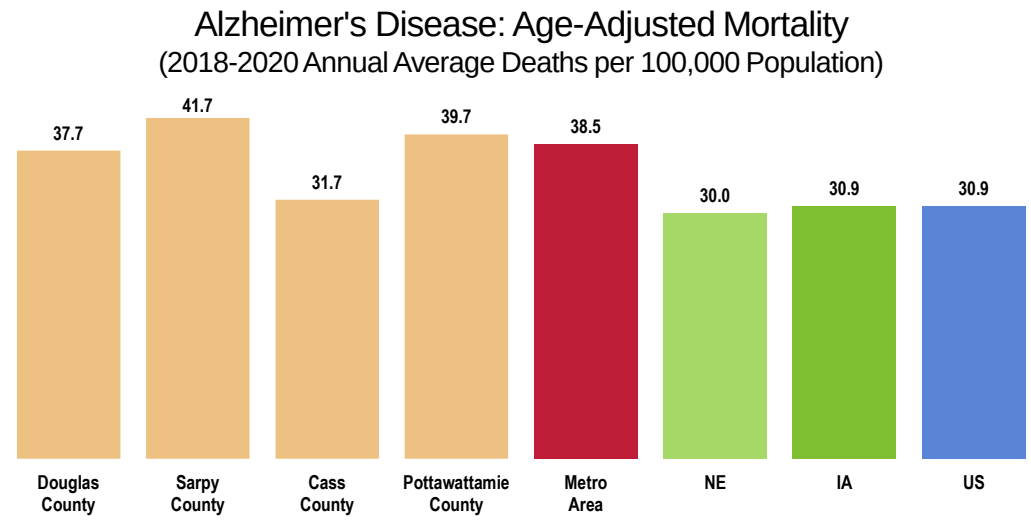
Age-Adjusted Alzheimer's Disease Deaths

Between 2018 and 2020, there was an annual average age-adjusted Alzheimer's disease mortality rate of 38.5 deaths per 100,000 population in the Metro Area.

BENCHMARK ► Much worse than state and national mortality rates.

TREND ► Increasing over the past decade.

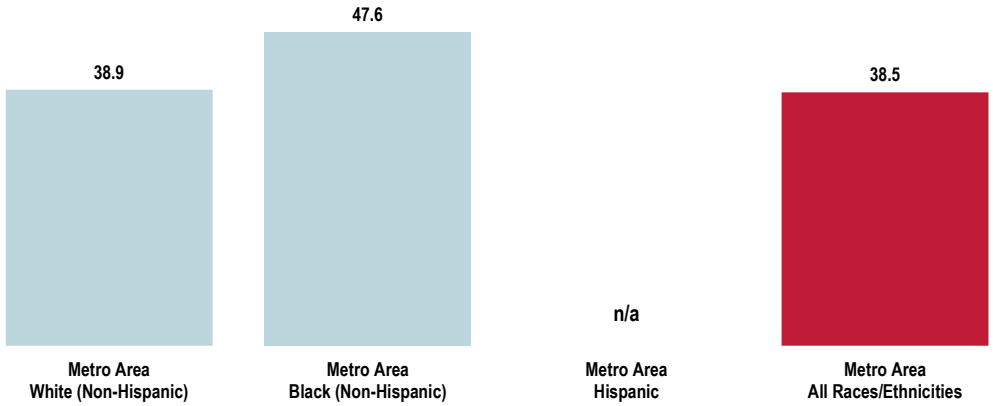
DISPARITY ► Lowest in Cass County. Higher among Metro Area Black residents than White residents.



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

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

Alzheimer's Disease: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)



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

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

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

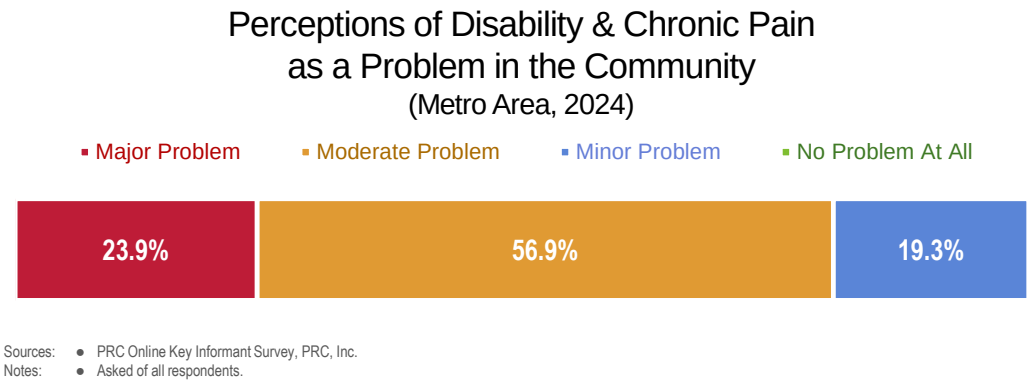
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	28.1	28.5	31.1	32.4	34.6	34.3	36.0	38.5
NE	24.7	23.3	23.4	24.3	26.5	27.4	28.7	30.0
IA	30.3	29.4	29.2	30.3	32.2	32.8	32.1	30.9
US	23.1	24.7	27.4	29.7	30.2	30.6	30.4	30.9

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

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

Key Informant Input: Disabling Conditions

Key informants taking part in an online survey most often characterized *Disabling Conditions* as a "moderate problem" in the community.



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

Aging Population

> Increasing dementia incidence with aging of the population. Many people living with chronic pain and have limited treatment options. – Health Provider
>
> Wider incidences of these conditions are observed with older adults in our community, especially those vulnerable elderly who live alone and need assistance to remain in their homes because they cannot afford an assisted living facility. Also, higher numbers of these conditions among a growing population of elderly in the homeless shelters. – Health Provider
>
> As the population ages, including myself, health changes drastically. All of the above-listed problems along with no longer having a decent balance mean problems and injuries for this demographic. I believe many people, as they age, don't have anyone or anyone who cares to look out for them and help them with their health issues. There are many for-profit care givers for home health care and monitoring, but not many can afford such a service and fall through the cracks. – Health Provider
>
> Baby boomers are aging, and dementia is becoming more predominant. – Health Provider
>
> Aging population and health issues that come with age, such as cognitive, mental, complex chronic conditions. – Social Services Provider
>
> Aging population with increasing number of comorbid chronic health conditions that lead to all of these concerns. This is higher in those with multiple disparities in SDOH. – Physician

Access to Care/Services

> Our neighborhoods, gathering places, and hospital systems are not physically or digitally accessible. Although programs exist, it is not easy for people with physical, sensory, intellectual, and cognitive disabilities and needs to access services. – Health Provider
>
> In my clinical work, I see chronic pain and dementia as severe problems that the health care community and the general public do not have adequate resources or education to manage. These are both complex disease processes that have no simple solutions. The needs of individuals suffering from chronic pain and dementia require multiple resources and medical providers working in coordination. The current medical system is fragmented and there simply isn't the time or personnel to do a thorough job. Not to mention the support that dementia caregivers need. And the opioid crisis's contribution to poor outcomes and unrealistic expectations for quick relief. – Physician
>
> No post-acute facilities to take care of a dementia patient. – Social Services Provider
>
> Not enough beds available at high quality skilled nursing and long-term care facilities. – Physician

Incidence/Prevalence

> Again, it just seems as if disabling conditions, cancer, diabetes, etc. are becoming more and more prevalent than historically. I am also seeing a difference in the availability of resources based on socioeconomic status and a shortage of health care professionals who specialize in these areas. – Social Services Provider

> There is a high proportion of patients in my health care system with disabling conditions, including decreased mobility, dementia, and vision and hearing problems. – Physician
>
> Injuries, illnesses, and sanitary conditions. – Business Leader
>
> I hear about people dealing with dementia more and more every single day, both in my professional as well as my personal life. Doctors don't always know how to address the symptoms patients and their families are presenting with. Memory care facilities typically have a waitlist and so many don't take Medicaid. There is a lack of resources available for those trying to care for their loved ones at home. – Social Services Provider

Impact on Quality of Life

> These challenges can drive the onset of other health issues or exacerbate existing health issues significantly. – Business Leader
>
> Many of the people we see on a daily basis have some sort of medical condition that prevents them from leading a normal life. Many times, people are not able to get their level of care met if they have housing instability nor are actively homeless. This is a situation where one small push can send someone over the edge to then needing higher levels of care and get stuck in a cycle of needing care but then not being to get that care, which spirals out into all aspects of life. – Community Leader
>
> Any of these disability conditions severely impact the ability to manage complex chronic health conditions like hypertension and diabetes from a physical standpoint as well as a mental effort standpoint. Disability conditions take a big toll on mental health, and as mental health declines other chronic conditions suffer. Moreover, these disabling conditions all lead to diminished or complete absence of physical activity. Physical activity by itself is incredibly important in the improvement of chronic conditions both physical and mental. – Physician

Diagnosis/Treatment

> Diets and medications that have side effects which may not be discussed during patient visits. I also believe there are more young people with auditory issues because of the earpieces and headphones that allow significant levels of high decibel sounds directly into the ear. – Business Leader
>
> There are many disabling conditions not seen by the eye that often go undiagnosed. When they involve in-depth diagnoses, it is hard to get appointments or to get clear results and next steps. – Social Services Provider
>
> Conditions are taken care of when they start, and it becomes more difficult to care for. – Social Services Provider

Affordable Care/Services

> Lack of affordable personal care assistance options, lack of support family, friends for those in the community, and the ability to afford hearing and vision care DME. – Health Provider

Comorbidities

> Autism, emotional and mental health, physical conditions, such as diabetes, arthritis, orthopedic, and traumatic brain injury. – Social Services Provider

Follow Up/Support

> The lack of, support for, and insurance coverage for these services, which is especially problematic for low-income persons. – Physician

Lifestyle

> It is secondary to obesity and a sedentary lifestyle. – Social Services Provider

Autoimmune Diseases

> Autoimmune diseases, such as thyroid disease. – Community Leader

Transportation

> Poor transportation systems in town. – Physician

BIRTHS

PRENATAL CARE

ABOUT INFANT HEALTH

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

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

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

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

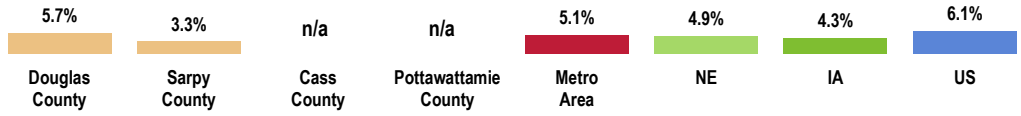
Between 2017 and 2019, 5.1% of all Metro Area births did <u>not</u> receive prenatal care in the first six months of pregnancy.

BENCHMARK ► Higher than the Iowa percentage but lower than the US.

TREND ► Increasing 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 June 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of women who do not obtain prenatal care before their seventh month 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 Omaha	4.0%	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 June 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of women who do not obtain prenatal care before their seventh month of pregnancy (if at all).

BIRTH OUTCOMES & RISKS

Low-Weight Births

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

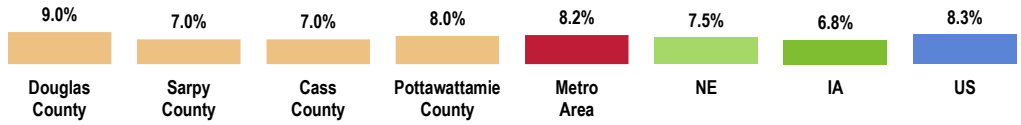
Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 8.2% of 2016-2022 Metro Area births were low-weight.

BENCHMARK ► Higher than the Iowa percentage.

DISPARITY ► Highest among Douglas County births.

Low-Weight Births
(Percent of Live Births, 2016-2022)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one 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.

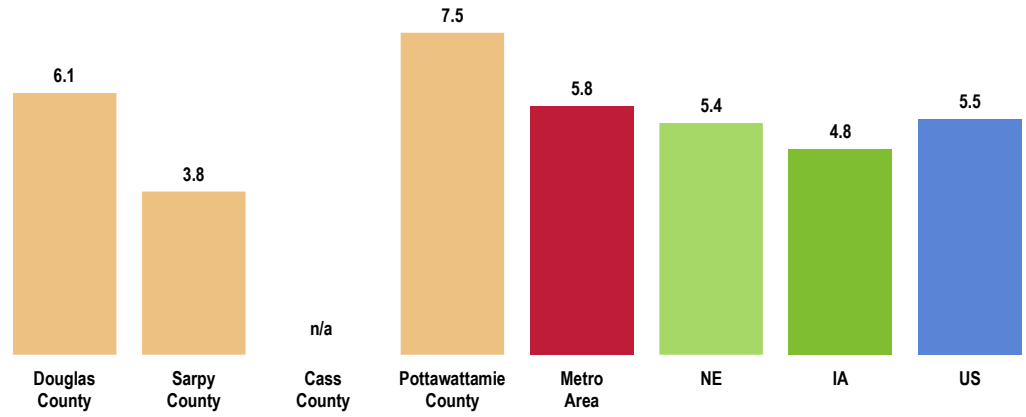
BENCHMARK ► Higher than the Iowa infant mortality rate.

DISPARITY ► Highest in Pottawattamie County. Much higher among Black births than White or Hispanic births in the Metro Area.

Infant Mortality Rate

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

Healthy People 2030 = 5.0 or Lower



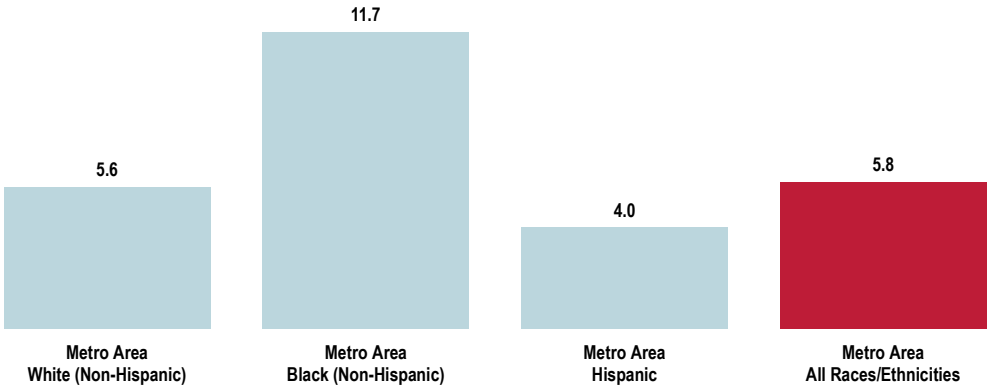
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted June 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Infant Mortality Rate by Race/Ethnicity

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

Healthy People 2030 = 5.0 or Lower



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

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

Healthy People 2030 = 5.0 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	5.2	5.6	6.1	6.2	6.3	6.3	5.8	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, National Center for Health Statistics, Division of Vital Statistics. Data extracted June 2024.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

FAMILY PLANNING

ABOUT FAMILY PLANNING

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

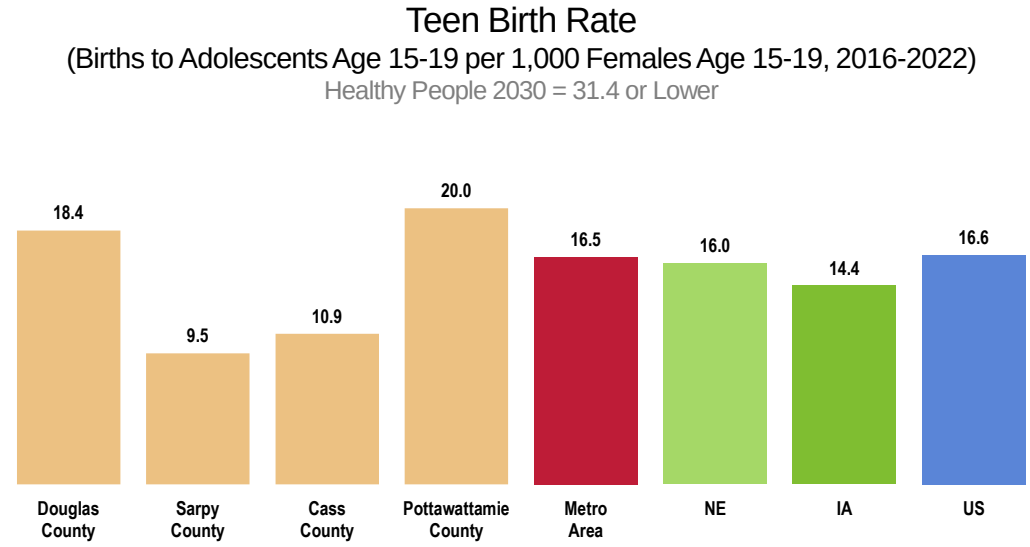
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

Between 2016 and 2022, there were 16.5 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Metro Area.

DISPARITY ► Highest in Pottawattamie and Douglas counties. Much higher among Black or Hispanic females.



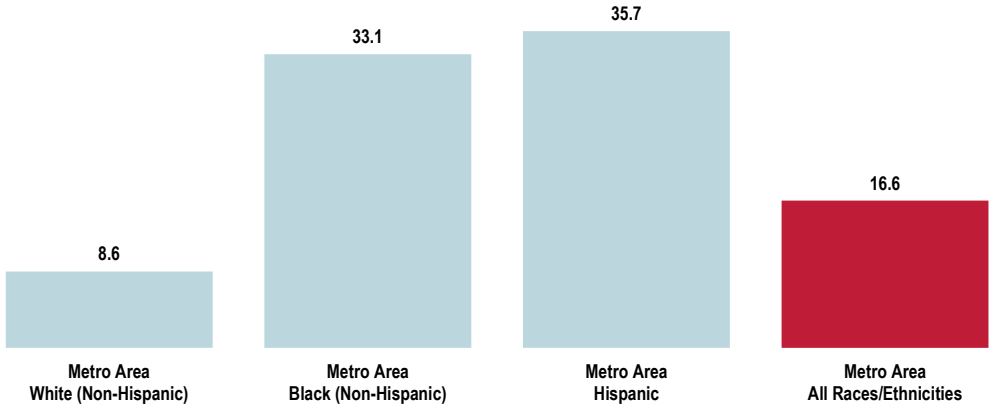
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

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

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2016-2022)

Healthy People 2030 = 31.4 or Lower



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

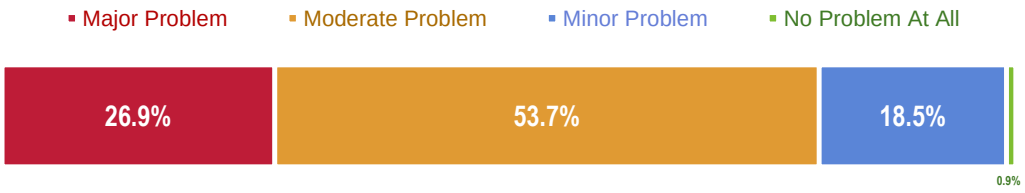
Notes:
- This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19.
- Race categories reflect individuals without Hispanic origin.

Key Informant Input: Infant Health & Family Planning

Over half of key informants taking part in an online survey largely characterized *Infant Health & Family Planning* as a "moderate problem" in the community.

Perceptions of Infant Health and Family Planning as a Problem in the Community

(Metro Area, 2024)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Racial Disparities

> Infant mortality rate shows us that Black and Brown children are dying at birth or shortly after at a higher rate. Proper health and wellness are needed prior to conception and with toxins so high in our food and water, it is causing our babies to die before they are full term, die stillborn, or are born with autism and or major birth defects. – Social Services Provider
>
> The infant mortality rates among Black babies are almost three times the rate of White babies. 70% of all Black births in Douglas County are to single mothers. – Community Leader
>
> Disparities in infant mortality rates for Black families. Lack of equitable infant and maternal health outcomes. Lack of doula coverage and accessibility. Racism and providers not being held accountable for patient experience and poor outcomes. Historical trauma within communities of color contributes to the generations of mistrust. Siloed efforts to address this issue across the state of Nebraska. – Community Leader

> Large African American population where high-risk births are associated. – Health Provider

Awareness/Education

> There is confusion and lack of information/resources regarding abortions. Unwanted pregnancy occurs from assaults, and having a choice is a challenge. We see babies with serious health issues due to mothers not obtaining prenatal care. Medicaid is complicated for low-income and vulnerable populations to navigate regarding family planning and infant health issues. – Health Provider
>
> Lack of education to get healthy foods. – Social Services Provider
>
> Parents that are not aware of the need to follow up with pediatricians. Lack of understanding of resources available to parents in the community. – Health Provider

Government/Policy

> Access to family planning is limited. Increased legislation on women's rights. Limited funding for reliable methods (IUDS, Nexplanon, etc.). Continued racial and ethnic disparities in infant outcomes. Limited access to culturally and linguistically specific resources and providers. – Physician
>
> Because women do not have a right to decide what is best for their body. There is a specific hospital in Omaha that does not have adequate staff to instruct new mothers with what to expect during or after the birth of a child. – Social Services Provider
>
> The political environment which impacts the information and resources available, such as comprehensive sexual health information and contraception. – Business Leader

Infant Mortality

> Infant mortality rates. – Health Provider
>
> Nebraska has a lower or worse than average maternal and infant mortality. We need to improve access and prenatal care to change this horrible statistic. – Physician
>
> High infant mortality and low birth weights. High rates of unintended pregnancies. – Community Leader

Unplanned Pregnancy

> Early age pregnancy, unplanned, access to sex health care, such as pregnancy preventive strategies, routine testing, routine supplies, etc. Social supportive environments and lack of empowerment. – Physician
>
> Due to the number of unplanned births, the number of teen births, and infant mortality rates in our community. – Social Services Provider

Income/Poverty

> Poverty, homelessness, infertility, addiction, and mental health challenges. Social media. – Social Services Provider
>
> Poverty and lack of financial means. – Business Leader

Diagnosis/Treatment

> Not prioritized enough during pregnancy. Lack of short-term and long-term family planning. – Social Services Provider

Lack of Providers

> Insufficient providers. – Physician

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

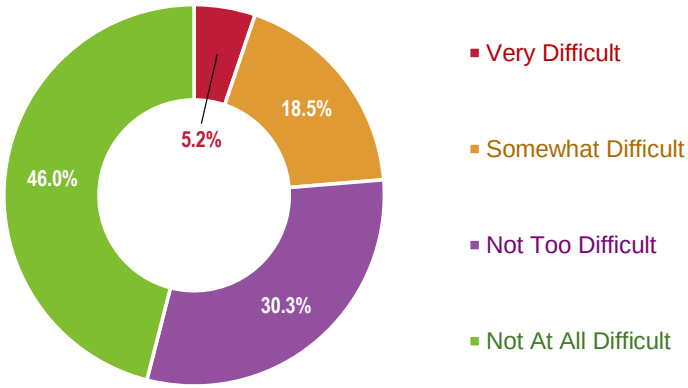
Difficulty Accessing Fresh Produce

Most Metro Area adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked, "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say very difficult, somewhat difficult, not too difficult, or not at all difficult?"

RELATED ISSUE
See also *Food Access* in the **Social Determinants of Health** section of this report.

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



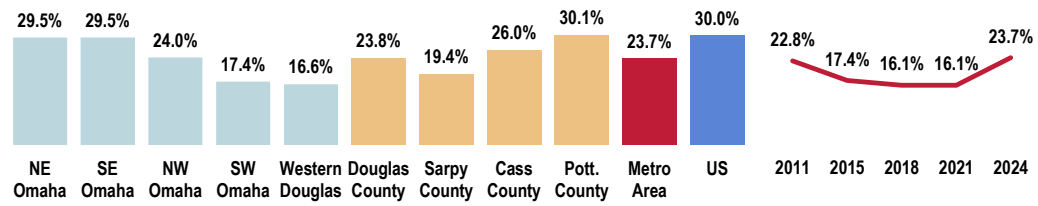
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

However, 23.7% of Metro Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

BENCHMARK ► Lower than the national response.

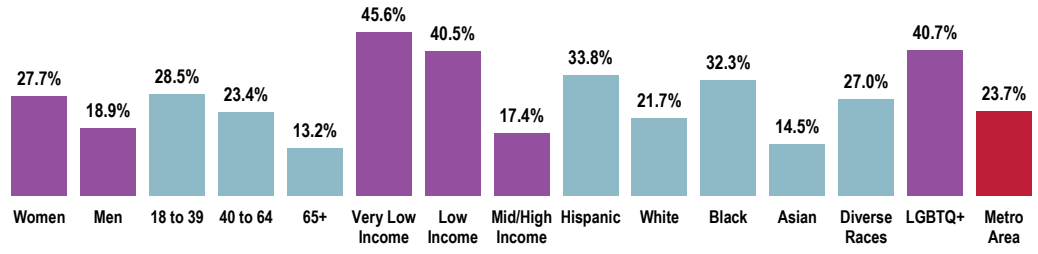
DISPARITY ► Highest in eastern Omaha and in Pottawattamie County. Reported more often among women, young adults, those in low-income households, Hispanic respondents, Black or African American respondents, those of Diverse Races, and LGBTQ+ adults.

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



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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



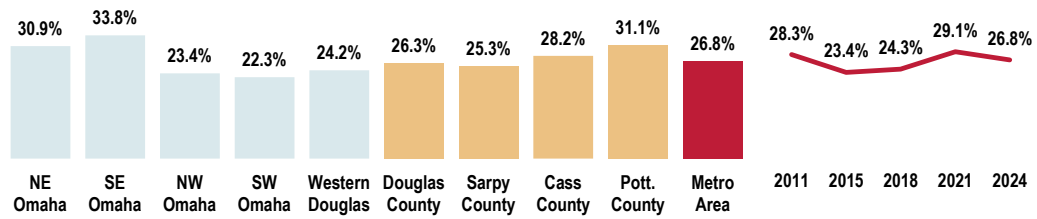
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

Sugar-Sweetened Beverages

A total of 26.8% of Metro Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

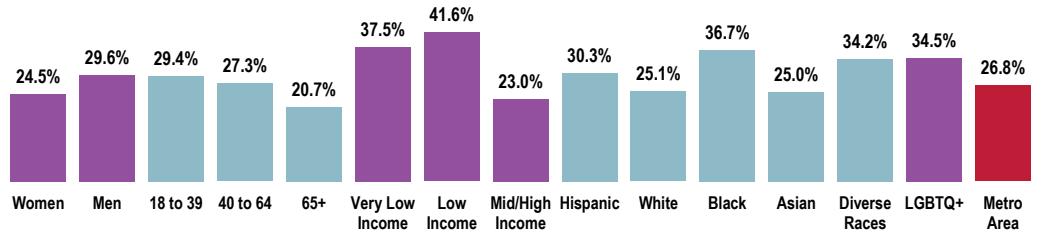
DISPARITY ► Highest in eastern Omaha and Pottawattamie County. Reported more often among men, young adults, those living in low-income households, Hispanic respondents, Black or African American respondents, and LGBTQ+ respondents.

Had Seven or More Sugar-Sweetened Beverages in the Past Week



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.

Had Seven or More Sugar-Sweetened Beverages in the Past Week
(Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

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

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

Just over one in four Metro Area adults (26.5%) reports no leisure-time physical activity in the past month.

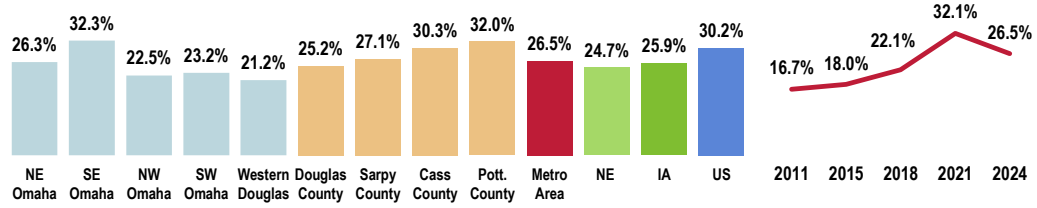
BENCHMARK ► Higher than the Nebraska percentage but lower than the US figure. Satisfies the Healthy People 2030 objective.

TREND ► Despite a drop since 2021, denotes an unfavorable, statistically significant increase since 2011.

DISPARITY ► Least favorable in Southeast Omaha and in Pottawattamie County.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

For adults, “meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activities:

- **Aerobic activity** is one of the following: at least 150 minutes per week of light to moderate activity (such as walking), 75 minutes per week of vigorous activity (such as jogging), or an equivalent combination of both.
- **Strengthening activity** is at least two sessions per week of exercise designed to strengthen muscles (such as push-ups, sit-ups, or activities using resistance bands or weights).

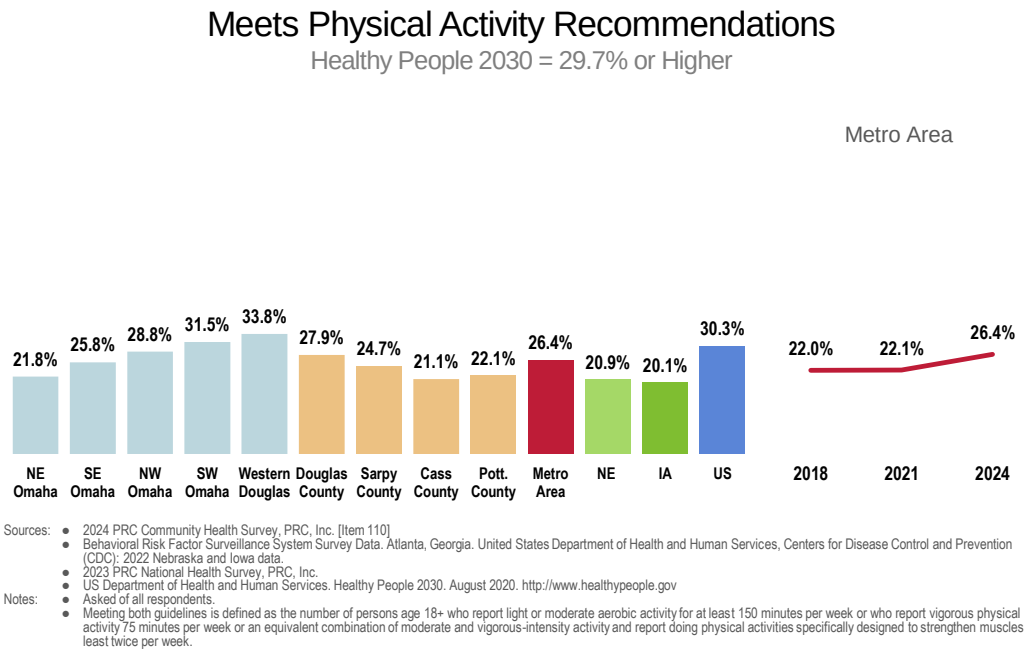
– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

A total of 26.4% of Metro Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

BENCHMARK ► Higher than the state percentages but lower than the US. Fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing significantly since 2018.

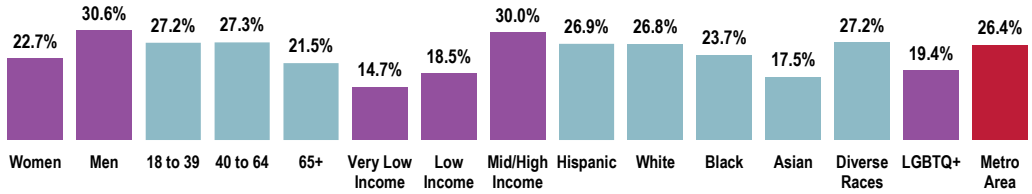
DISPARITY ► Lowest in Northeast Omaha and Pottawattamie County. Reported less often among women, older adults (age 65+), and those living in low-income households.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Meets Physical Activity Recommendations
(Metro Area, 2024)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Built Environment

Recreation & Fitness Facilities

In 2021, there were 17.5 recreation/fitness facilities for every 100,000 population in the Metro Area.

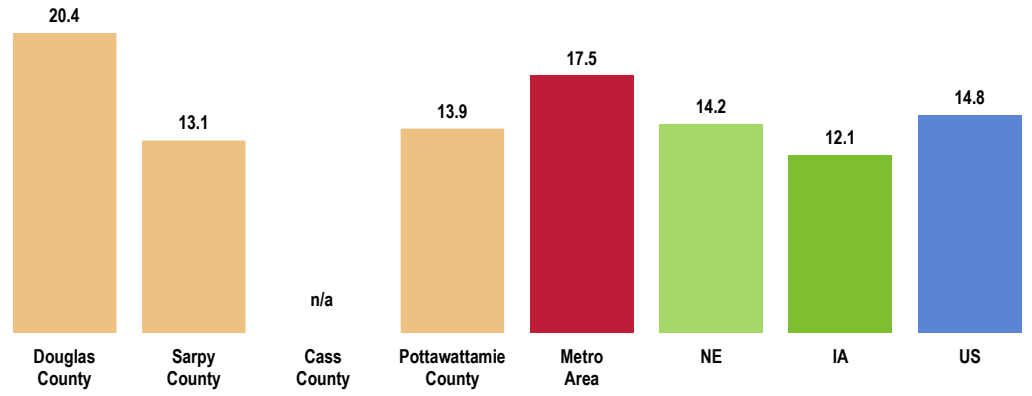
BENCHMARK ► Higher than the state and national ratios.

DISPARITY ► Highest in Douglas County.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access
(Number of Recreation & Fitness Facilities per 100,000 Population, 2021)



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.
- Counts of establishments <3 are suppressed.

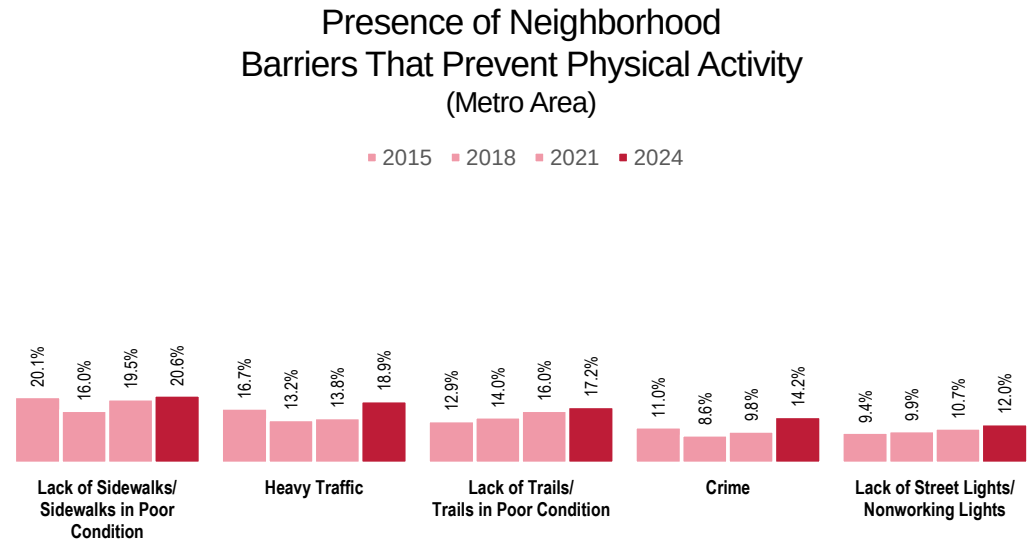
Neighborhood Barriers

Survey respondents were next asked about the presence of five neighborhood factors that potentially prevent people from exercising, including lack (or poor condition) of sidewalks; heavy traffic; lack (or poor condition) of trails; crime; and lack of streetlights or nonworking streetlights.

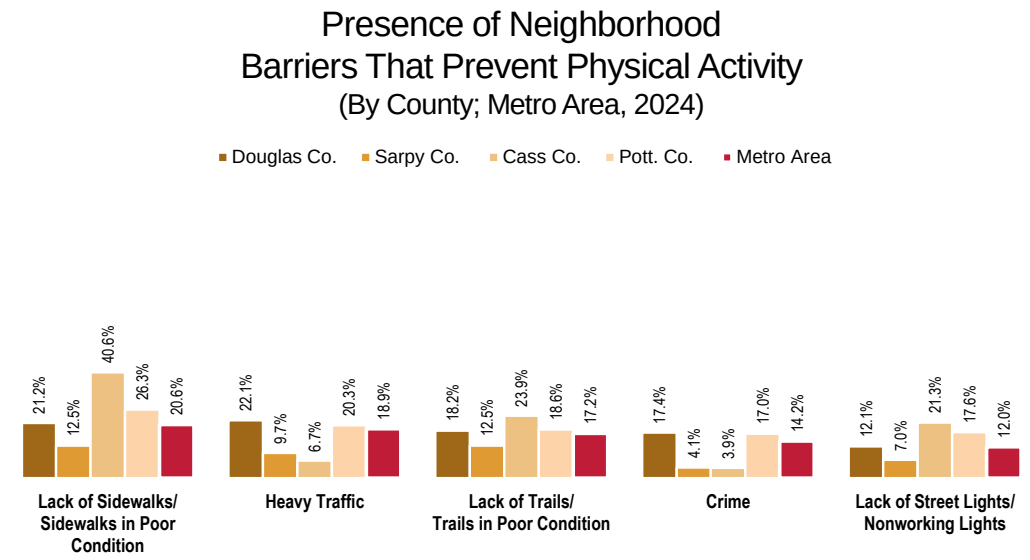
Overall, a lack of sidewalks/poor sidewalks received the largest share of responses among Metro Area adults (mentioned by 20.6%), followed by heavy traffic and lack of (or poor condition) trails.

TREND ► With the exception of sidewalks, each of these barriers has worsened since 2015.

DISPARITY ► Residents of Sarpy County were least likely to mention these potential barriers to outdoor physical activity. Adults in eastern Omaha were far more likely to report these barriers.

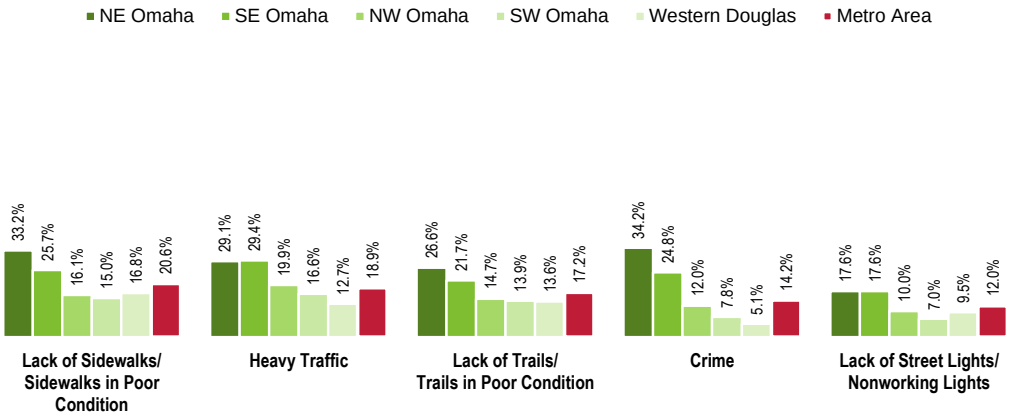


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 314-318]
Notes: ● Asked of all respondents.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 314-318]
Notes: ● Asked of all respondents.

Presence of Neighborhood Barriers That Prevent Physical Activity
(By Douglas County Subareas; Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 314-318]
Notes: • Asked of all respondents.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

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

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Overweight Status

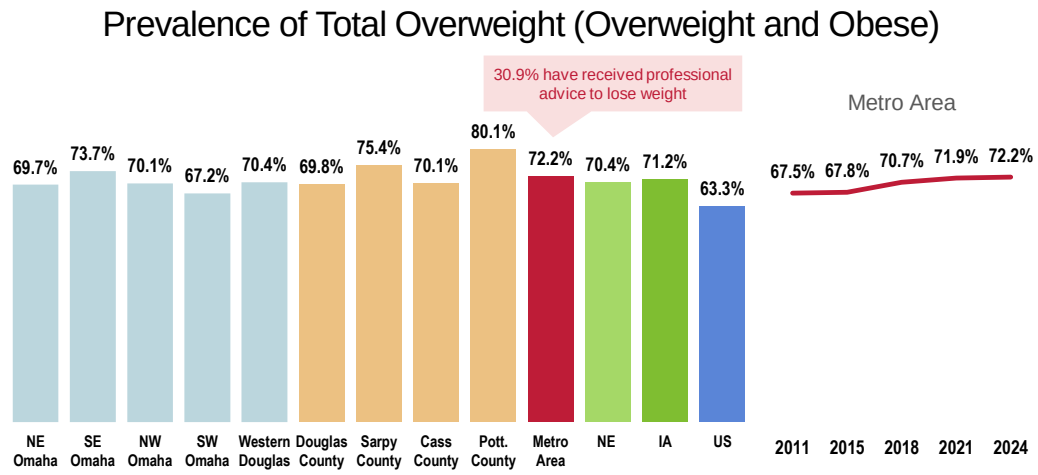
Here, "overweight" includes those respondents with a BMI value ≥25.

Most Metro Area adults (72.2%) are overweight.

BENCHMARK ► Higher than the Nebraska and US figures.

TREND ► Increasing significantly since 2011.

DISPARITY ► Highest in Sarpy and Pottawattamie counties.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 112, 313]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

The overweight prevalence above includes 38.4% of Metro Area adults who are obese.

BENCHMARK ► Worse than the Nebraska and US percentages. Fails to satisfy the Healthy People 2030 objective.

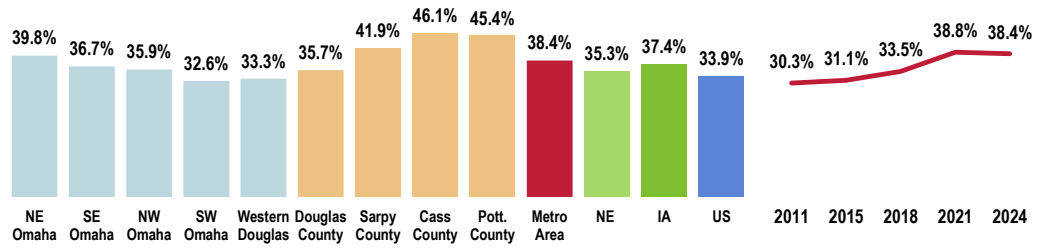
TREND ► Increasing significantly since 2011.

DISPARITY ► Considerably lower in Douglas County when compared to the other three counties. Higher among women, adults age 40 to 64, those in low-income households, and LGBTQ+ adults. Asian respondents are least likely to be obese in the Metro Area.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower

Metro Area



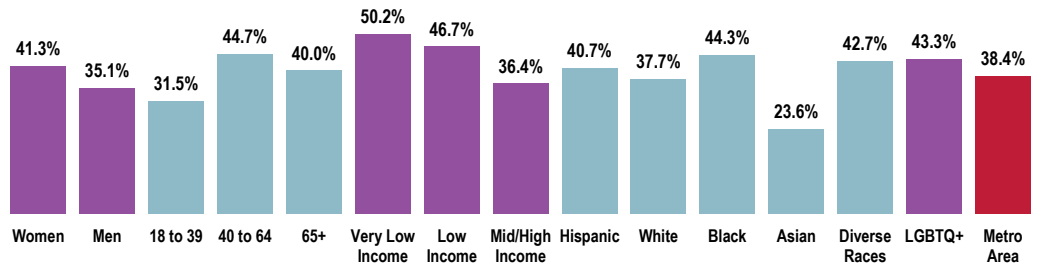
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity

(Metro Area, 2024)

Healthy People 2030 = 36.0% or Lower



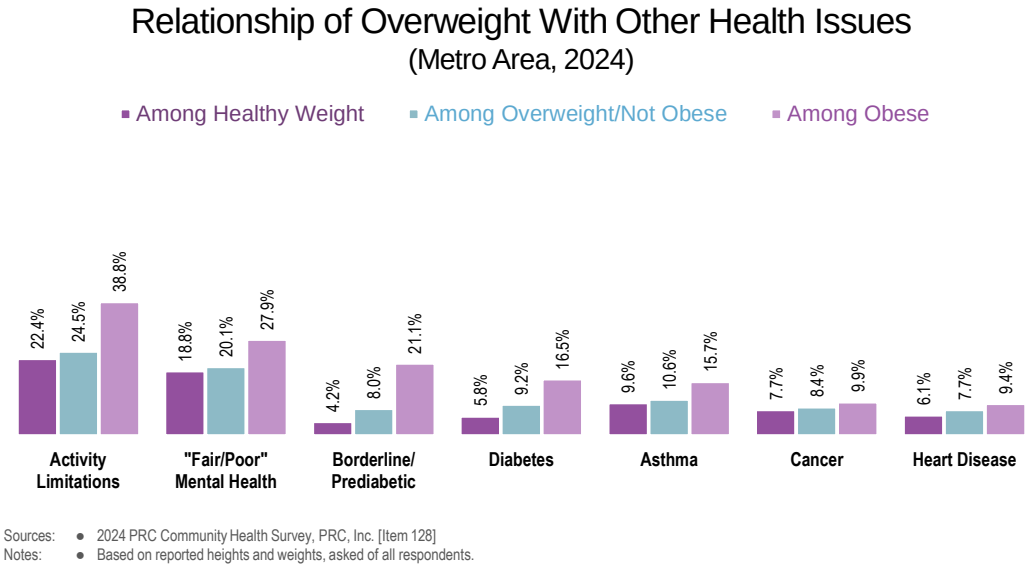
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Relationship of Overweight With Other Health Issues

The correlation between overweight and various health issues cannot be disputed.

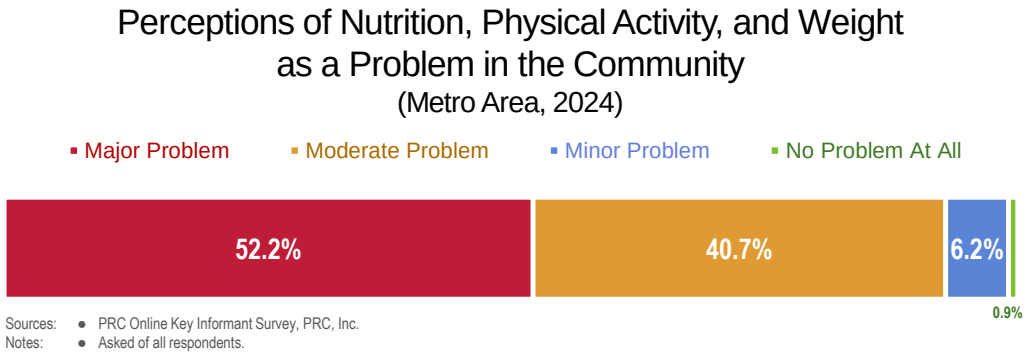
Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 128]
Notes: • Based on reported heights and weights, asked of all respondents.

Key Informant Input: Nutrition, Physical Activity & Weight

Over half of key informants taking part in an online survey characterized *Nutrition, Physical Activity & Weight* as a "major problem" in the community.



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

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

Obesity

> Increasing obesity rates and resulting medical consequences. – Health Provider
> Overweight and obesity continues to affect a large portion of the population. – Health Provider
> Look at the statistics regarding obesity in our country. – Health Provider
> Obesity epidemic and high cost of effective new drugs. – Physician
> Obesity and obesity-related illnesses. – Physician
> Obesity rates, lack of safe walking across the city. – Health Provider

As long as Corporate America and big pharma profit from our population being fat and sick, there will never be the changes necessary in this country to actually help people find/live a healthy life. There's no such thing as nutrition with the products most can afford and have to buy/eat. Private, for-profit gyms and work out centers are overpriced and typically those places are stacked with so many people, most people will not want to continue to fight a crowd, including me, to try to get some exercise. And the for-profit places are good at locking people in for monthly membership that just about takes an act of Congress to get out of. They are banking on the idea that most people will continue paying the monthly membership, instead of "coming in" which they make you do to cancel, even if you can cancel. It's been a scam for many years, and I've been caught in it several times myself. – Health Provider

There is significant obesity and related diseases such as diabetes, hypertension, cancer that could be prevented with a better diet. The connection between how we feel and what we eat seems to be absent. – Health Provider

Lifestyle

People's weight is getting higher and higher, and their activity levels are decreasing. Many people do not know how to eat healthily and/or choose not to. People are becoming more sedentary. – Health Provider

Our community is largely overweight due to the normalization of obesity in our culture, lack of physical activity, and food insecurity for those with lower income. – Physician

A growing number of children and adults are presenting with obesity secondary to a sedentary lifestyle and poor nutrition. Gym memberships can be expensive and/or people are unsure how to use the equipment or don't know how to get started or what sort of exercise/nutrition program would be best suited for them. – Social Services Provider

Inactivity, fast foods, and obesity. – Physician

I personally don't feel we as a community are as active as we should or could be. Social media and video games keep us more stationary. Life for everyone is so busy and most families are on the go which means less nutritious meals and snacks. Joining a local gym is not an option for everyone due to cost, work, etc. – Social Services Provider

Our diet has been getting worse over the years. Fast food is cheaper and faster than food cooked at home. With the increasing use of social media, our young people are not getting as much physical activity. – Health Provider

A culture of unhealthy food and inactivity. – Physician

People are exposed to fat intake foods, sugars, and sodium. Lack of exercise. Not enough fresh food. – Social Services Provider

Food insecurity, cultural influences, socioeconomic disparities, barriers to physical activity, cultural perceptions of body image, health care disparities, stress, and mental health. – Community Leader

Inactivity and poor access to healthy foods. – Health Provider

Access to Affordable Healthy Food

Needs to be attacked from a family and household level. Need easier access to nutritious food in schools and in neighborhoods. Need incentives in communities where this isn't prioritized. – Social Services Provider

Lack of healthy foods, cost of healthy foods. – Physician

Lack of access to healthy foods is affected due to costs and limited supply of healthy food options and ingredients. Processed foods are too abundant and cheap. – Advanced Practice Provider

Poor access to healthy foods. – Physician

Access to good and affordable nutrition and a lack of knowledge. – Physician

Not enough access to healthy foods. – Health Provider

Convenience and time are key contributors to decisions or ability to manage a healthy weight, whether it's the increasing price of food, or the time to prepare healthy meals yourself, it makes it very challenging for many to achieve. – Business Leader

Access to healthier foods and the price of healthier foods. It costs so much more to purchase healthier foods than non-healthy foods. – Business Leader

Awareness/Education

Limited education and promotion of physical activity. Not enough space for low-cost options. Limited multimodal active transit opportunities, such as bike lanes, walking paths, etc. Healthy food is perceived to be expensive. Overweight and obesity is normalized. – Public Health Representative

Education. – Social Services Provider

I think a lot of our issues tie back to educational attainment, age, and poverty. – Community Leader

Education, lack of integrated plans for medication and activity or nutrition. Expense of therapies and behavioral focused weight programs. Lack of a community focus on the issue. – Health Provider

Lack of understanding of physical activity and nutrition. Lack of resources, lack of integrated planning to build vibrant neighborhoods that promote physical activity, instead of needing to be so car centric in daily life. – Business Leader

> Education, access to care, motivation, and financial limitations. – Physician
>
> Education and access to healthy eating options for healthy living. – Community Leader

Income/Poverty

> Lack of financial stability to make healthier lifestyle choices that support healthy food options and regular physical activity. – Community Leader
>
> Poverty, unhealthy diet, lack of choices. – Business Leader
>
> Lack of funds to buy the proper nutritious food, sedentary lifestyles, and too much screen time. – Social Services Provider

Nutrition

> Overabundant access to processed and unhealthy foods. There is not enough access to healthy, nutritious foods, like fruits and vegetables. School lunch programs serve lots of processed foods that are not healthy for our youth. – Social Services Provider
>
> There are too many fast-food restaurants that are open 24 hours and have the ability to deliver food to their house. Physical activity is encouraged but not taken advantage of by all people in the community. – Health Provider

Access to Services

> Lack of facilities and programs. – Community Leader

Built Environment

> Places to safely exercise, as I specifically have patients who are afraid to walk in their neighborhood. Ability to afford healthy food. – Physician

Comorbidities

> Diabetes, poverty, and homelessness. – Social Services Provider

Denial/Stigma

> Stigma around weight. Omaha is not a walkable city, leading to less outdoor exercise. – Physician

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Alcohol Use

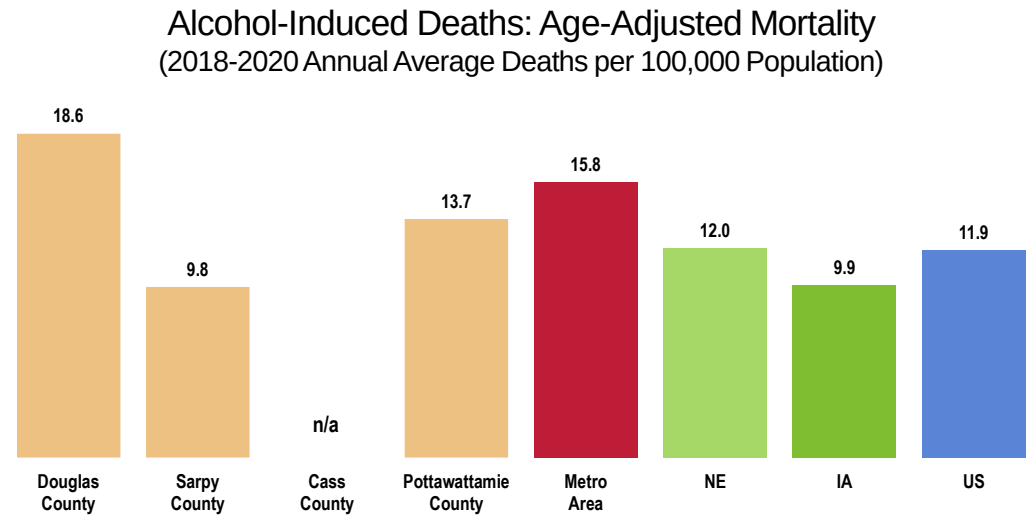
Age-Adjusted Alcohol-Induced Deaths

Between 2018 and 2020, the Metro Area reported an annual average age-adjusted mortality rate of 15.8 alcohol-induced deaths per 100,000 population.

BENCHMARK ► Well above the state and US rates.

TREND ► Increasing considerably over the past decade.

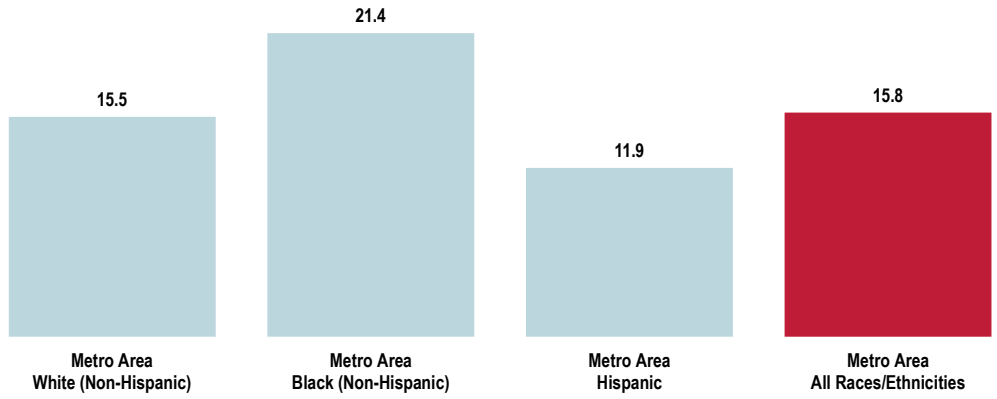
DISPARITY ► Highest in Douglas County and among Black individuals in the Metro Area.



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

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

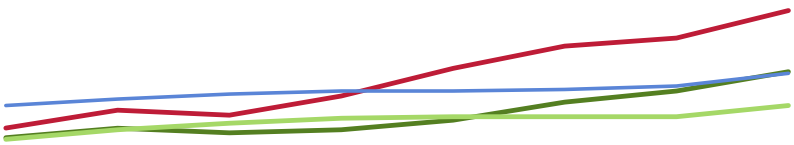
Alcohol-Induced Deaths: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)



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

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	8.5	9.6	9.3	10.5	12.2	13.6	14.1	15.8
NE	7.9	8.5	8.2	8.4	9.0	10.1	10.8	12.0
IA	7.8	8.4	8.8	9.1	9.2	9.2	9.2	9.9
US	9.9	10.3	10.6	10.8	10.8	10.9	11.1	11.9

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

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

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

A total of 22.7% of area adults engage in excessive drinking (heavy and/or binge drinking).

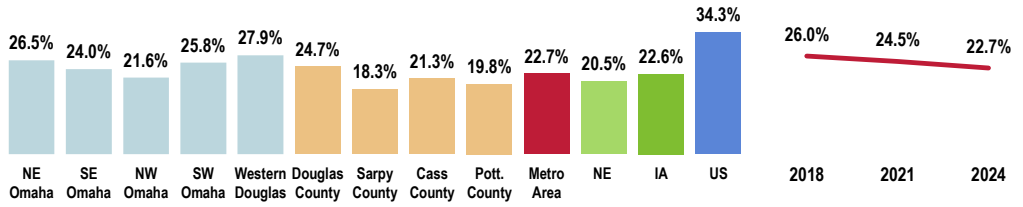
BENCHMARK ► Higher than the Nebraska prevalence but well below the US.

TREND ► Decreasing significantly since 2018.

DISPARITY ► Highest in Douglas County. Reported more often among men, young adults, and those living in higher-income households. Note the low proportion of Asian respondents who engage in excessive drinking.

Excessive Drinking

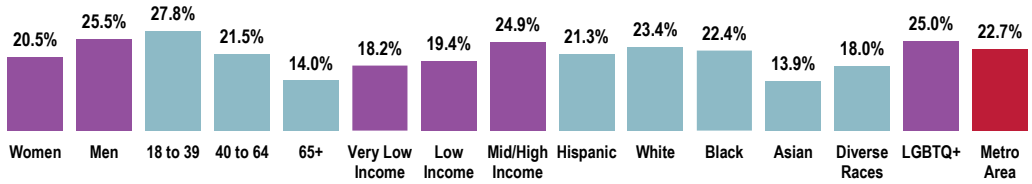
Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinking
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
Notes: • Asked of all respondents.
• Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drug Use

Age-Adjusted Unintentional Drug-Induced Deaths

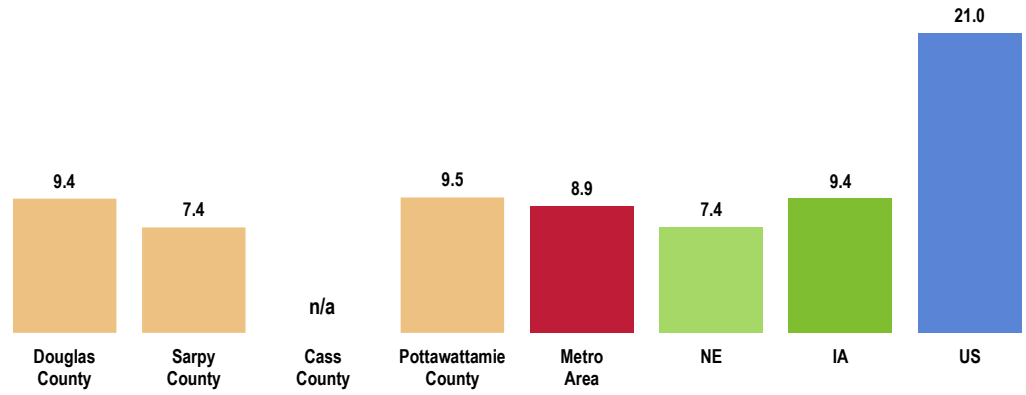
Between 2018 and 2020, there was an annual average age-adjusted mortality rate of 8.9 unintentional drug-induced deaths per 100,000 population in the Metro Area.

BENCHMARK ► Higher than the Nebraska mortality rate but well below that of the US.

TREND ► The mortality rate has increased over the past decade, echoing the state trends (although well below the sharply increasing US trend).

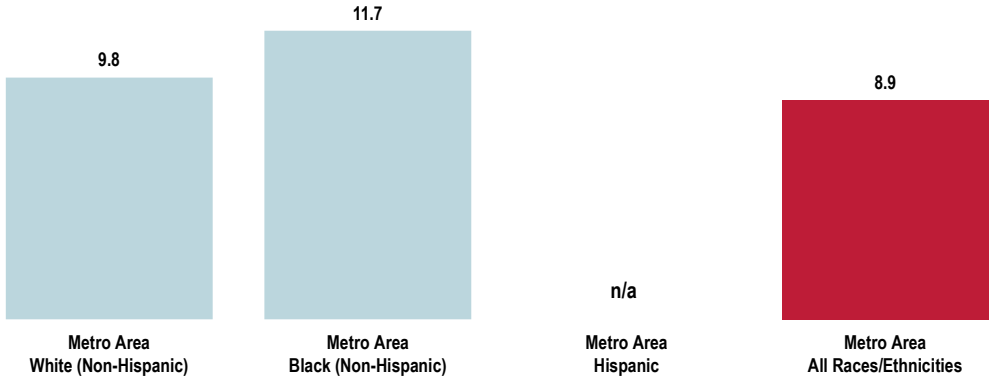
DISPARITY ► Lower in Sarpy County. Slightly higher among Black residents than White residents.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted June 2024.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

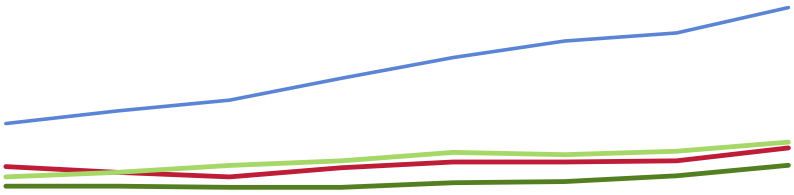
Unintentional Drug-Related Deaths: Age-Adjusted Mortality by Race
(2018-2020 Annual Average Deaths per 100,000 Population)



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

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

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Metro Area	7.3	6.8	6.4	7.2	7.7	7.7	7.8	8.9
NE	5.6	5.6	5.5	5.5	5.9	6.0	6.5	7.4
IA	6.4	6.8	7.4	7.8	8.5	8.3	8.6	9.4
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

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

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

Use of Prescription Opioids

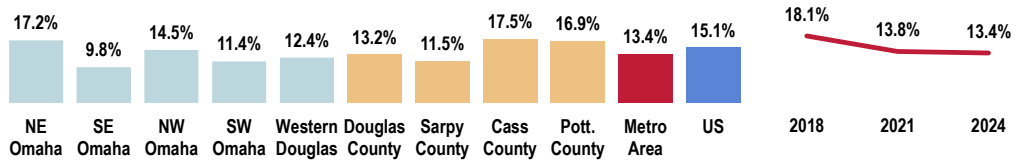
Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

A total of 13.4% of Metro Area adults report using a prescription opioid drug in the past year.

TREND ► Decreasing significantly since 2018.

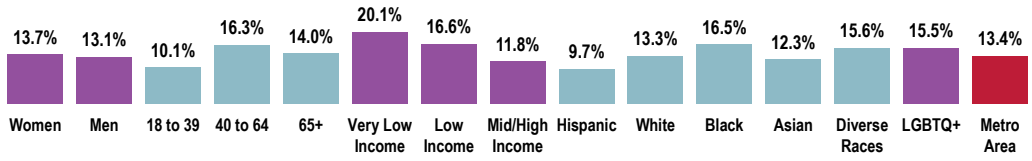
DISPARITY ► Highest in Northeast Omaha and Pottawattamie County. Reported more often among adults age 40 and older, those in low-income households, White adults, and Black or African American adults.

Used a Prescription Opioid in the Past Year



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Used a Prescription Opioid in the Past Year
(Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Alcohol & Drug Treatment

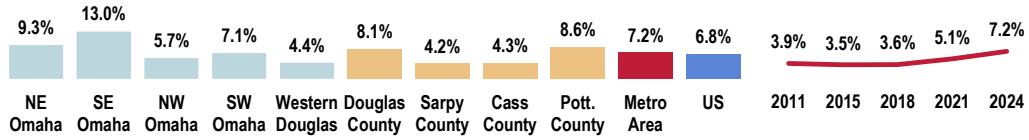
A total of 7.2% of Metro Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

TREND ► The prevalence has increased significantly since 2011.

DISPARITY ► Highest in Douglas County (especially Southeast Omaha).

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Metro Area

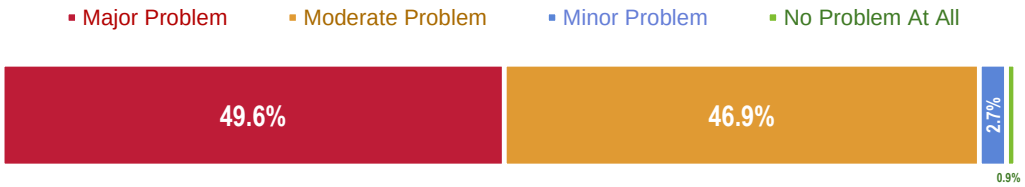


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 42]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Substance Use

The greatest share of key informants taking part in an online survey characterized *Substance Use* as a "major problem" in the community (followed closely by "moderate problem" responses).

Perceptions of Substance Use as a Problem in the Community
(Metro Area, 2024)



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

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

Access to Care/Services

> Not enough places to go for advice or counselling. Without family support, this issue becomes very difficult to deal with. – Social Services Provider
>
> Very limited number of clinics and providers for managing serious substance use disorders. – Health Provider
>
> Residential treatment programs. – Physician
>
> No facilities are available. – Business Leader
>
> Receiving services in a timely manner. The cost of a substance abuse evaluation, shortage of staff and licensed professionals. – Social Services Provider
>
> Lack of access and providers dedicated to this. Education and stigma. – Health Provider
>
> There is a lack of substance abuse treatment options in the area. Many patients are committed to acute psychiatric care in the hospital setting which doesn’t get the patient to the care they need, leading to long waits for treatment and preventing others from getting the services needed in the acute psychiatric unit. – Health Provider
>
> It is difficult to find immediate openings for substance use treatment. There are often waiting lists and delays when attempting to go into a treatment facility. Often times the person relapses or chooses not to go if they have to long of a wait to get into a program. – Health Provider
>
> Not enough 24/7 thirty-day detox, and then recovery programs that accept Nebraska Medicaid. – Health Provider
>
> Lack of insurance. – Health Provider
>
> Accessing substance abuse treatment centers poses a formidable challenge, with individuals often encountering significant hurdles in securing admission and locating available facilities. As a result, many individuals find themselves discharged back into the same environments where their substance abuse issues originated, perpetuating a cycle of dependency and relapse. The scarcity of treatment options exacerbates this predicament, compounding the difficulties faced by those seeking help. Consequently, the barrier posed by insufficient treatment options continues to escalate, leaving many individuals grappling with addiction without the vital support they urgently require. – Health Provider
>
> Affordable evaluations, open beds. No inpatient facilities in the community. The closest inpatient facility that accepts Iowa Medicaid is 45-60 minutes away. Transportation and accessibility are an issue too. – Health Provider
>
> In addition to the financial hurdles, I think that one of the biggest barriers is getting an appointment or getting to the appointment. – Community Leader
>
> Lack of reimbursement. Leads to a lack of resources and levels of care that are needed. Lack or compensation and pay wages for these disciplines to do this work. – Health Provider
>
> Limited resources and limited capacity. – Community Leader
>
> Access to care and treatment, capacity to get out of environments with high substance use. – Physician
>
> Sober living houses and the challenges of those going through drug court not being able to find employment that will allow for the meetings, UA testing, and programming requests. – Social Services Provider
>
> I think the need is exceeding the availability. – Physician

Denial/Stigma

> Stigma and insurance. – Physician
>
> Stigma. – Business Leader
>
> Stigma for accessing care. – Health Provider
>
> Stigmas and fear to admit they need help. – Community Leader
>
> Consumer buy-in that they have a problem and need help to combat it. Transportation to services. Accountability to the substance user. They can’t see a path forward. – Community Leader
>
> Stigma and the financial capability to afford treatment options. – Community Leader

Lack of Providers

> Once again, there is a lack of substance abuse providers. We have a workforce shortage of therapists to address substance misuse in our communities. Many state funded programs cannot afford to pay people to be fully staffed, which reduces accesses and increases wait time. – Social Services Provider
>
> LACK OF EVIDENCE BASED PROVIDERS, stigma, STIGMA!!!!!! People refuse to provide evidence-based treatment with medications. Literally, doctors will refuse to prescribe medication to patients that is needed for their disease. It is completely abhorrent that this is happening, and it is discriminatory to patients. No doctor would refuse to prescribe a medication for their blood pressure- but they refuse to prescribe it for another chronic health condition, their substance use disorder. – Physician

> Shortage of trained clinicians and inadequate reimbursement rates. Lack of long-term residential treatment options in our community available for free, or on a sliding-fee scale. – Social Services Provider
>
> Need more substance abuse providers - very difficult to recruit and retain therapists. We need more options and better community understanding of how to access care and where. Should be noted that Providers do exist in the community, there seems to be some access, however, individuals struggle with motivation to follow-through with evaluation and treatment. And substance abuse still seems to be an accepted norm in society. – Health Provider

Affordable Care/Services

> Cost and availability. – Social Services Provider
>
> Affordable facilities to get treatment, both intensive outpatient and inpatient treatment. Lack of insurance coverage for substance use treatment. – Social Services Provider
>
> Unknown to me, but cost and specific programs are barriers. – Physician

Awareness/Education

> Lack of knowledge of available resources. – Physician
>
> Lack of information about them and too few resources. Unable to afford care. Culture that promotes and glorifies drug use and selling drugs. – Physician
>
> Not adequate access to education and prevention. – Health Provider

Income/Poverty

> Poverty, family history and mental health. – Social Services Provider

Stigma

> Willingness of those in need and support. – Business Leader
>
> The desire to seek out treatment. – Health Provider

Comorbidities

> Mental health, trauma, depression, anxiety, and social isolation. – Health Provider

Cultural Mistrust

> Cultural mistrust, lack of culturally competent care, financial barriers, limited availability of services, language barriers and legal concerns. – Community Leader

Diagnosis/Treatment

> Good urgent withdrawal treatment. Good urgent long term treatment options. – Physician

Easy Access

> Represented by large amounts of availability. Seeing a houselessness increase over the last few years. – Social Services Provider

Hopelessness

> People have no hope, so they don't care about using drugs. Difficult getting people in. – Health Provider

Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **alcohol** as causing the most problems in the community, followed distantly by **methamphetamine/other amphetamines**, **heroin or other opioids**, **marijuana**, **prescription medications**, and **over-the-counter medications**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a “Major Problem”)	
ALCOHOL	73.5%
METHAMPHETAMINE OR OTHER AMPHETAMINES	12.2%
HEROIN OR OTHER OPIOIDS	6.1%
MARIJUANA	4.1%
PRESCRIPTION MEDICATIONS	2.0%
OVER-THE-COUNTER MEDICATIONS	2.0%

TOBACCO USE

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

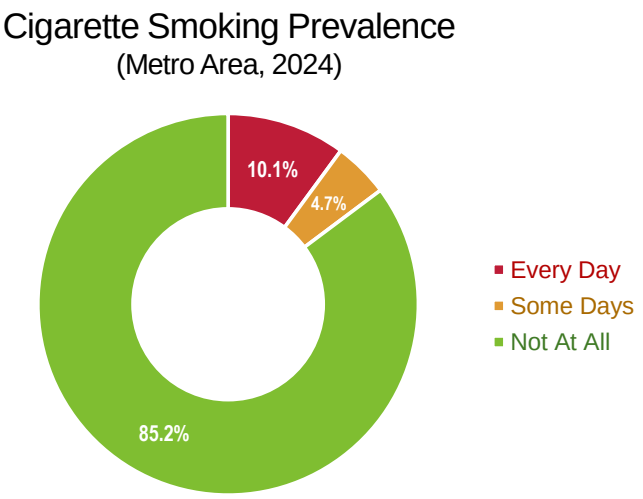
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

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

Cigarette Smoking

Prevalence of Cigarette Smoking

A total of 14.8% of Metro Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the Metro Area.

BENCHMARK ► Higher than the Nebraska findings but lower than the US. Fails to satisfy the Healthy People 2030 objective.

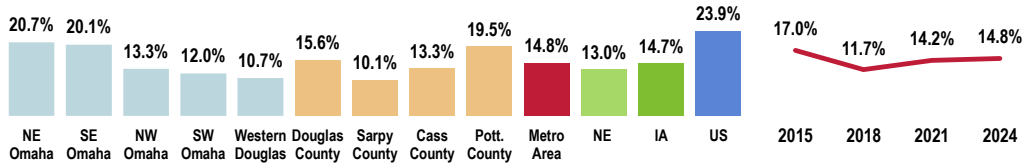
TREND ► Though increasing since 2018, the percentage remains below 2015 findings.

DISPARITY ► Highest in eastern Omaha and Pottawattamie County. Reported more often among men, adults under age 65, those in low-income households, Black or African American residents, those of Diverse Races, and LGBTQ+ adults.

Current Smokers

Healthy People 2030 = 6.1% or Lower

Metro Area



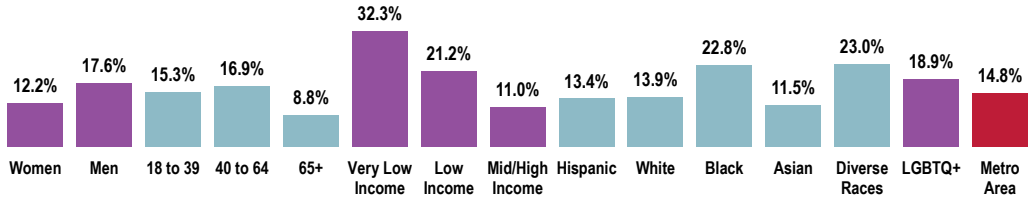
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smoke Cigarettes

(Metro Area, 2024)

Healthy People 2030 = 6.1% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

Among all surveyed households in the Metro Area, 11.4% report that someone has smoked cigarettes, cigars, or pipes anywhere in their home an average of four or more times per week over the past month.

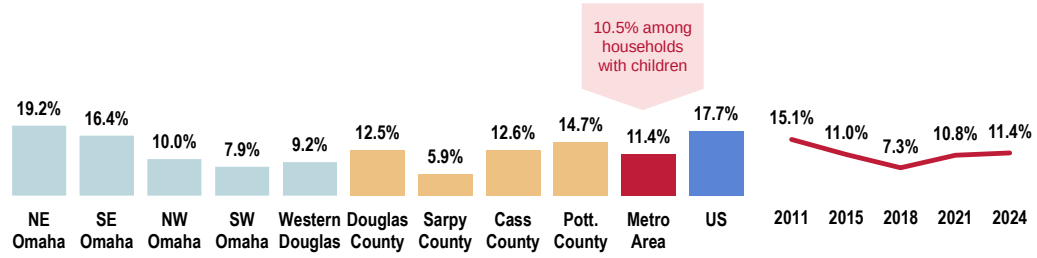
BENCHMARK ► Lower than the national figure.

TREND ► Decreasing significantly since 2011.

DISPARITY ► Highest in Douglas County (especially east of 72nd Street) and Pottawattamie County.

Member of Household Smokes at Home

Metro Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

Just less than one-half of adults who regularly smoke cigarettes (49.3%) went without smoking for one day or longer in the past year because they were trying to quit smoking.

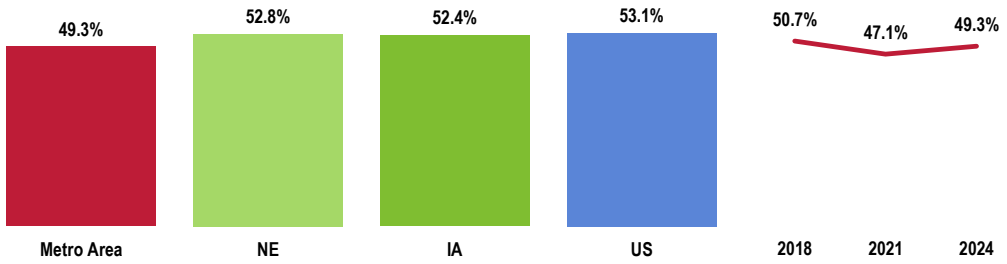
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

Have Stopped Smoking for One Day or Longer in the Past Year

(Everyday Smokers)

Healthy People 2030 = 65.7% or Higher

Metro Area

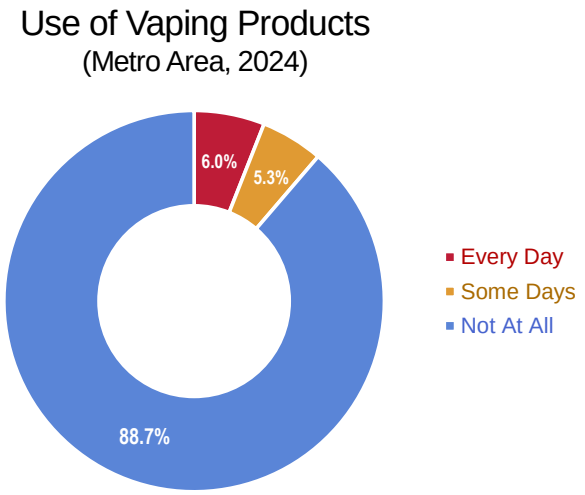


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 305]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Nebraska and Iowa data.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of respondents who smoke cigarettes every day.

Use of Vaping Products

Most Metro Area adults do not use electronic vaping products.



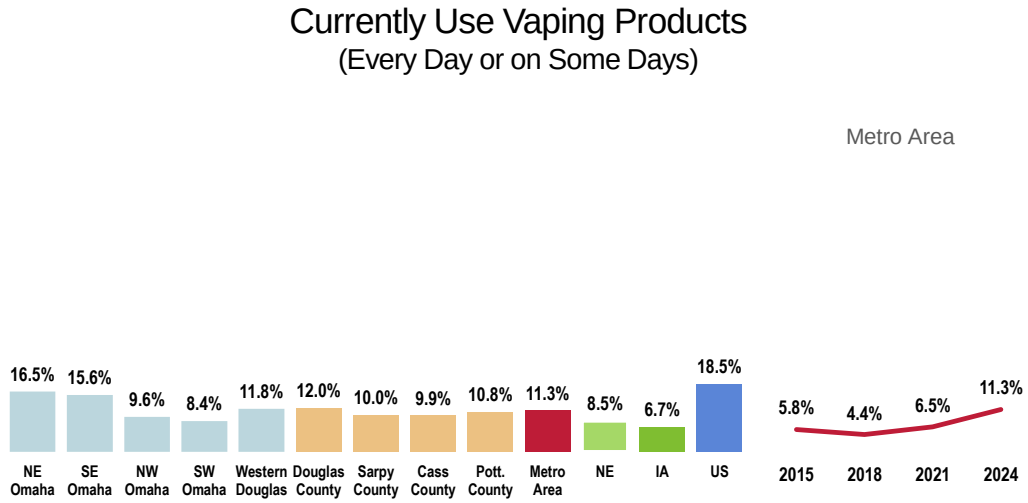
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
Notes: ● Asked of all respondents.

However, 11.3% currently use electronic vaping products either regularly (every day) or occasionally (on some days).

BENCHMARK ► Higher than the state percentages but below that found nationally.

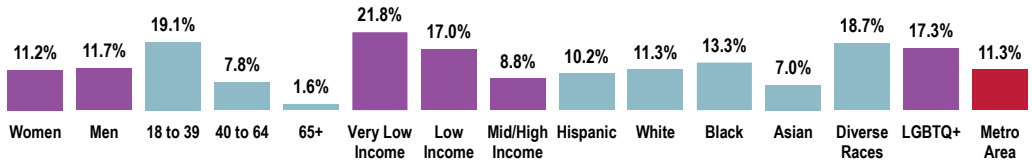
TREND ► Increasing significantly from 2011 findings.

DISPARITY ► Much higher in eastern Omaha. The prevalence decreases with age and household income level and is reported more often among adults of Diverse Races and LGBTQ+ respondents.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Currently Use Vaping Products
(Metro Area, 2024)

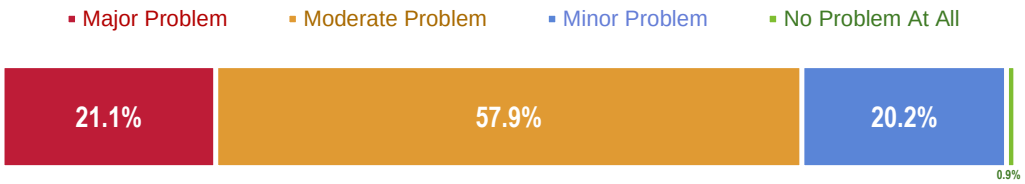


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
Notes: • Asked of all respondents.
• Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a "moderate problem" in the community.

Perceptions of Tobacco Use as a Problem in the Community
(Metro Area, 2024)



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

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

Incidence/Prevalence

> So many people still smoke, even with the negative health effects. – Social Services Provider
>
> Continued significant tobacco use in the community with medical problems secondary to this. – Physician
>
> High rates of smoking. – Health Provider
>
> When I moved to this community seven years ago, I was struck by how many people I saw smoking. I think this is tied to age, educational attainment, and poverty. – Community Leader
>
> Tobacco and vaping are a big problem in our community because there are many people who use tobacco or nicotine and cannot quit using it. We continue to see vape and tobacco shops open in our community, which increases access to the products (including access to youth), but when the stores keep opening, you know that use is a problem, simply because the market for the tobacco / nicotine products are there. If there were not a market, they would not open up new shops to claim some of the market share. – Social Services Provider

> Far too many people smoke or use to smoke, making themselves vulnerable to future diseases. – Social Services Provider

Easy Access

> Easily accessible for minors to obtain with new tobacco products on the market. – Health Provider
>
> Easy access to tobacco stores. – Health Provider
>
> Easy to access. – Social Services Provider

Co-Occurrences

> Often concomitant with other substance use. – Physician
>
> It leads to heart problems, stroke, weight gain or loss, dental diseases, unemployment, and violence and mental illness. – Business Leader

E-Cigarettes

> Vaping among young people. – Social Services Provider
>
> I think tobacco use may be on the decline, but the increase in vaping is concerning. – Health Provider

Income/Poverty

> People say they can't pay their bills or afford necessities such as food, and yet they smoke a pack or more of cigarettes a day. – Health Provider
>
> Tobacco is primarily used by the poor community. – Health Provider

Addiction

> It’s an expensive addictive drug that is the first item of necessity. Often monetary resources first allocation. – Community Leader

Impact on Caregivers/Families

> Tobacco use is a problem because the addiction affects other people that reside with the smoker, causing long term effects. – Health Provider

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

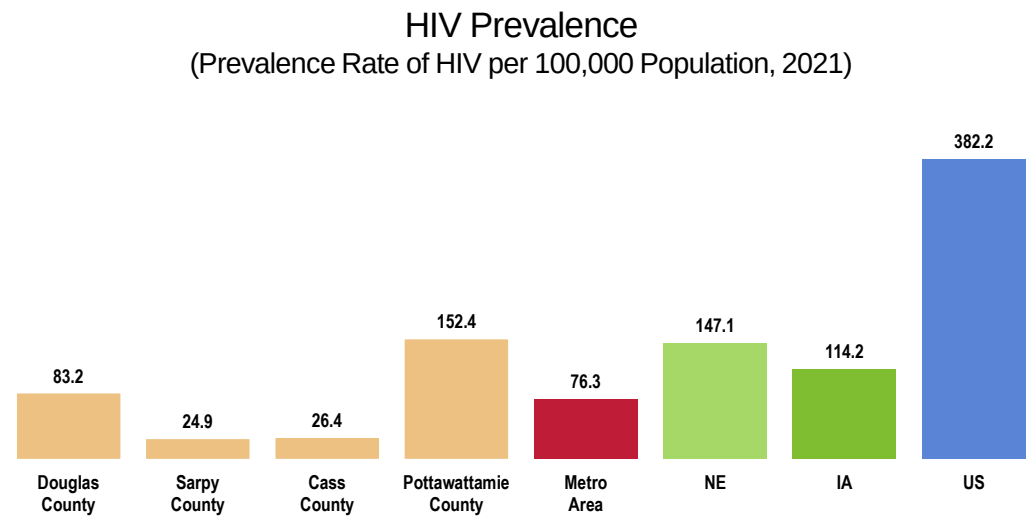
– Healthy People 2030 (https://health.gov/healthypeople)

HIV

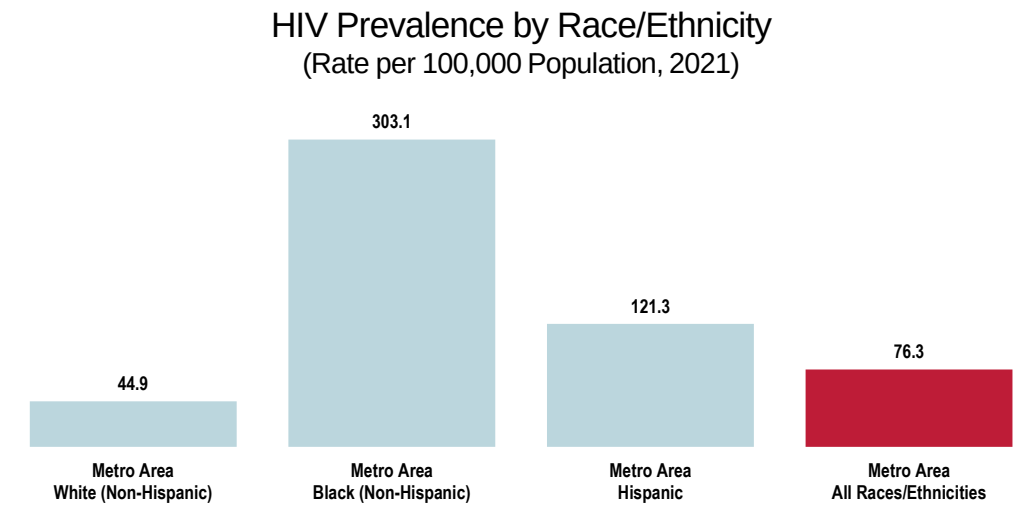
In 2021, the Metro Area reported a prevalence of 76.3 HIV cases per 100,000 population.

BENCHMARK ► Well below the state rates; exceedingly lower than the national rate.

DISPARITY ► Locally highest in Douglas and (especially) Pottawattamie counties. The prevalence rate is much higher among Black residents than White or Hispanic residents.



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 June 2024 via SparkMap (sparkmap.org).



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 June 2024 via SparkMap (sparkmap.org).

Notes:
- Race categories reflect individuals without Hispanic origin.

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

In 2021, the chlamydia incidence rate in the Metro Area was 572.1 cases per 100,000 population.

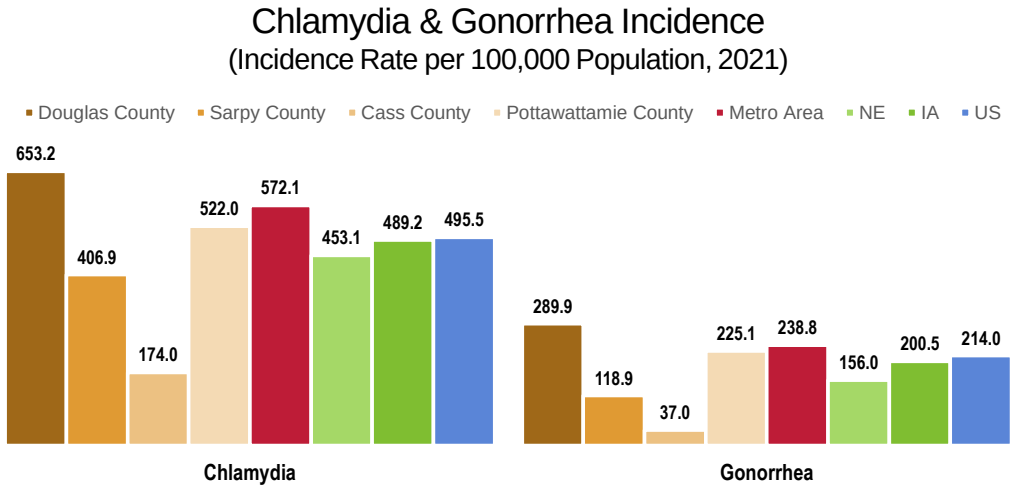
BENCHMARK ► Worse than the Nebraska rate.

DISPARITY ► Highest in Douglas County.

The Metro Area gonorrhea incidence rate in 2021 was 238.8 cases per 100,000 population.

BENCHMARK ► Well above both state incidence rates.

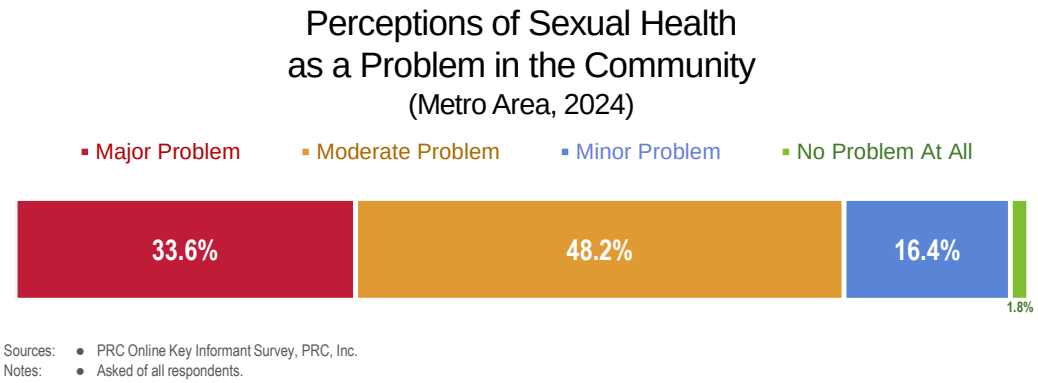
DISPARITY ► Highest in Douglas County.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

A plurality of key informants taking part in an online survey characterized *Sexual Health* as a "moderate problem" in the community.



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

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

Incidence/Prevalence

Data from the Health Department shows STI rates are far above national and state averages. – Business Leader

High rates of STDs. – Community Leader

Large number of STDs in collage age and senior citizens in the community. – Social Services Provider

I believe we have a higher rate of STDs than the state rate in Iowa. Drug use and being impaired contributes to STDs because of sexual assault and the ability to make good decisions while under the influence of all substances. – Social Services Provider

Rates are still high. There is shame associated with practicing healthy sexual behaviors and or getting screened. – Social Services Provider

We have been above the national average for years. – Community Leader

Reports provided by local Emergency Room staff and the local health department. – Social Services Provider

Elevated rates of CVD, syphilis, and other STIs in the community. – Health Provider

Very high rates of chlamydia. – Physician

Omaha is known for their high rate of STDs and being higher than the national average. – Social Services Provider

Increasing HIV, syphilis, high STI rates, ectopic pregnancies. – Physician

My understanding is Douglas County has a large population of STIs. – Health Provider

Rates of STIs are increasing. – Physician

High rates chlamydia, GC, and syphilis. – Physician

High rate of STIs, including GC, chlamydia, and syphilis. – Physician

Douglas County has one of the highest STD rates, per capita, in the nation. – Physician

High rates of STIs, in particular syphilis. Lack of basic comprehensive sex education in the public school system. – Community Leader

Rising number of STD cases in Omaha. Lack of access to Planned Parenthood or other testing facilities. – Social Services Provider

Awareness/Education

Lack of awareness, hygiene, and low morals. – Business Leader

Statistics and lack of information, poverty, mental health, and addiction. – Social Services Provider

Omaha has been horrible for years. Maybe the lack of sexual health education. – Community Leader

Education, lack of access, stigma of access and treatment, lack of centralized anonymous screening and treatment, lack of on-demand screening and treatment possibilities. – Health Provider

STD prevention is not talked about enough with young people. Not talking about it does not keep it from happening, but rather without any safety precautions. – Health Provider

Access to Care

> Politicization of sexual & reproductive health and continued changes in laws targeted by the State Legislature have a chilling effect on those seeking care or contemplating seeking care. Gender-affirming care is restricted to minors under age 19. It is often weeks before community clinics have available slots of HIV/STI testing, and this can radically impact the ability to access post-exposure prophylactic treatment scheduling. Certain STIs are increasing in prevalence (syphilis) or becoming treatment resistant (gonorrhea), primarily due to the widespread use of pre-exposure prophylactic (which should be encouraged and more accessible) but sometimes standard STI panels will omit one or more STIs. A lack of inclusive and updated medical forms at primary care physicians (PCP) don't ask sexual practices/orientation, leaving physicians unable to adequately treat or recommend preventative strategies or testing regimes. Lack of DoxyPEP usage. – Community Leader

Income/Poverty

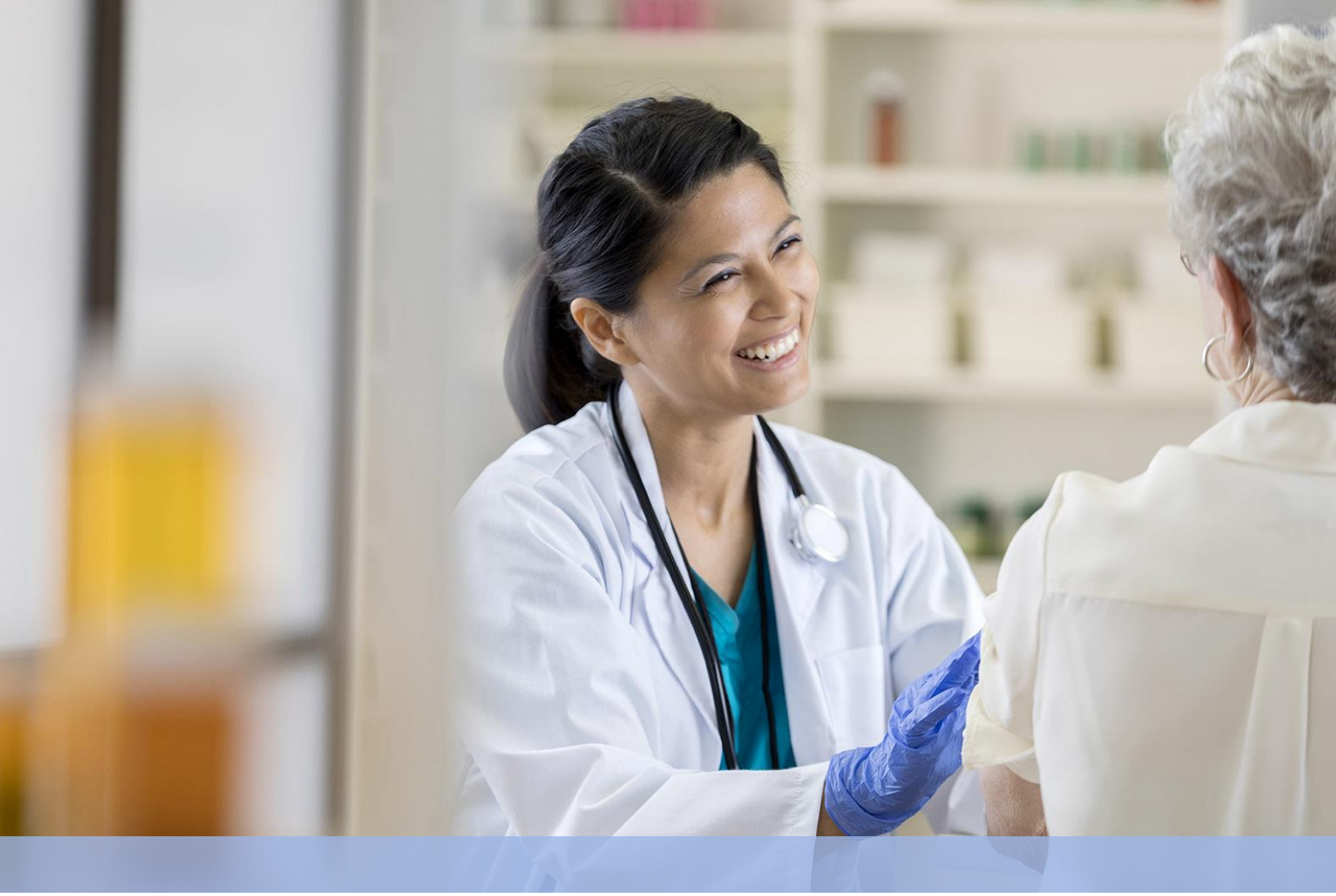
> Compounding social determinants of health that affect access and prevention, such as poverty. – Health Provider

Funding

> Lack of ongoing funding to continuously educate through rigorous campaigns targeting those most at risk. – Community Leader

Culture

> Kids are pushed to grow up. Society rushes kids to become more independent too soon. – Social Services Provider



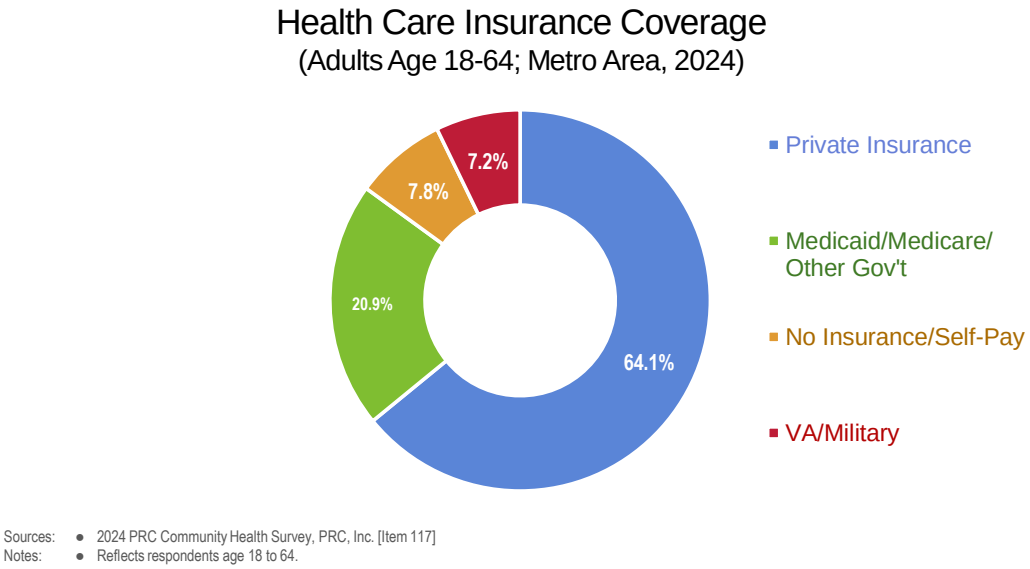
ACCESS TO HEALTH CARE

HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 64.1% of Metro Area adults age 18 to 64 report having health care coverage through private insurance. Another 20.9% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 7.8% report having no insurance coverage for health care expenses.

BENCHMARK ► Lower than the Nebraska response.

TREND ► The prevalence has decreased significantly since 2011.

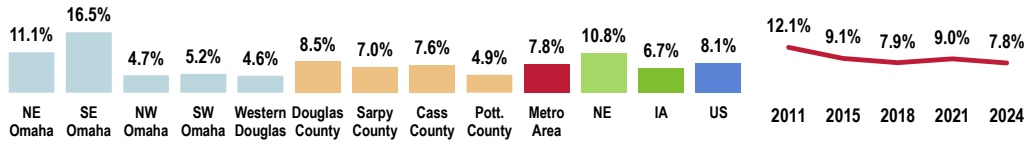
DISPARITY ► Highest in Douglas County (especially Southeast Omaha). Lack of coverage is reported more often among men, young adults, those in low-income households, Hispanic respondents, Black or African American respondents, and those who identify as LGBTQ+.

Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2030 = 7.6% or Lower

Metro Area



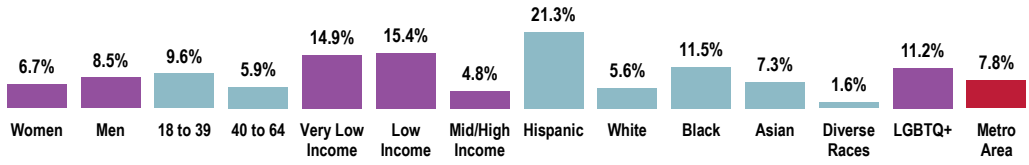
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; Metro Area, 2024)

Healthy People 2030 = 7.6% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

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

Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

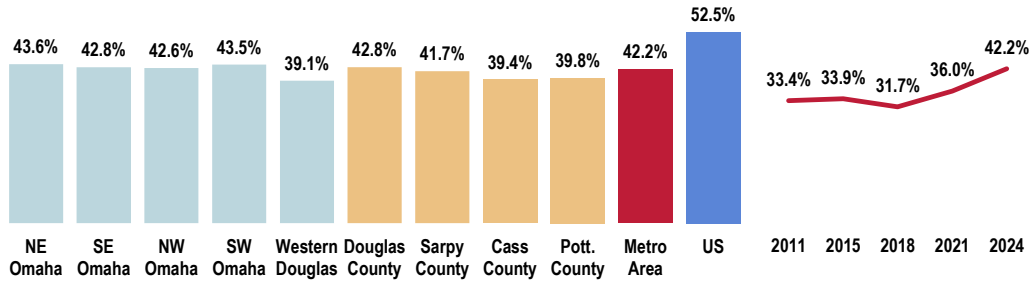
A total of 42.2% of Metro Area adults report some type of difficulty or delay in obtaining health care services in the past year.

BENCHMARK ► Well below the national prevalence.

TREND ► Increasing significantly from early survey administrations.

DISPARITY ► The prevalence decreases with age and household income level and is reported more often among women, Hispanic adults, and LGBTQ+ respondents.

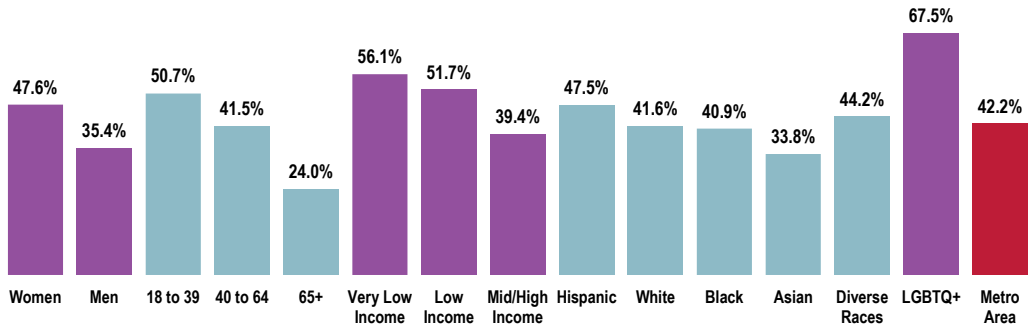
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Metro Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Barriers to Health Care Access

Of the tested barriers, appointment availability impacted the greatest share of Metro Area adults.

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

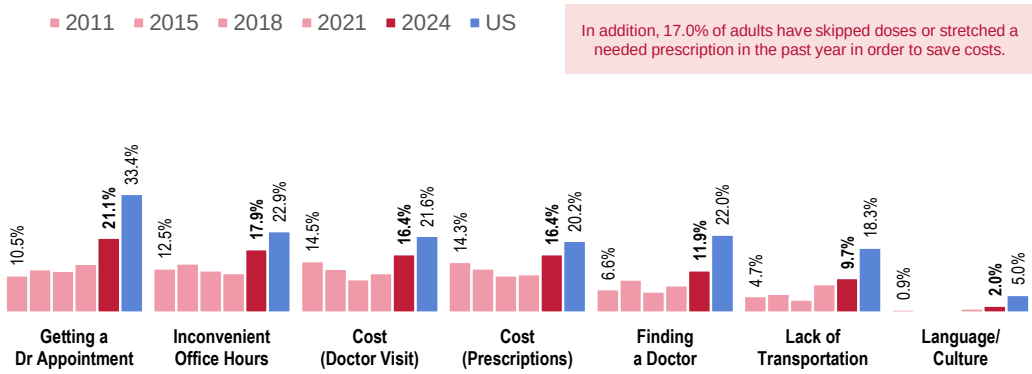
Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

BENCHMARK ► Each of the barriers illustrated fared better than its national counterpart.

TREND ► Each of the barriers below has increased significantly from 2011 findings.

DISPARITY ► Residents of Douglas County (especially east of 72nd Street) are more likely than others to experience many of these barriers to medical care (not shown).

Barriers to Access Have Prevented Medical Care in the Past Year
(Metro Area)

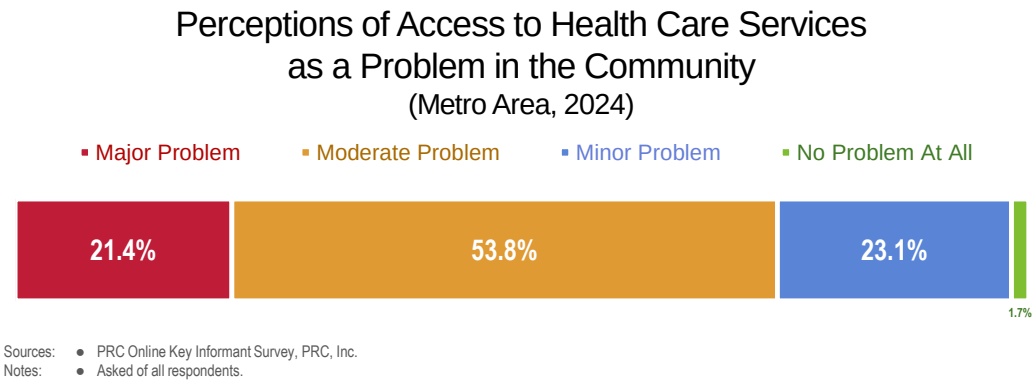


In addition, 17.0% of adults have skipped doses or stretched a needed prescription in the past year in order to save costs.

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 6-13]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.



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

Access to Care/Services

> Options for insurance, which limit health care professionals, and the distance to travel for some services. – Health Provider
>
> Insurance, transportation, and treatment of clients. – Community Leader
>
> Wait times for specialty providers. – Health Provider
>
> Services for older adults. – Social Services Provider
>
> Primarily behavioral health care and dental care here is Council Bluffs. – Health Provider
>
> Availability during hours people can access transportation. Access to therapeutic interventions. Insurance. Geographic access and health care deserts. – Physician
>
> Having providers who take new patients, having the availability to get in, being able to afford it, more access on bus lines. – Health Provider
>
> For individual's dependent on federally qualified health centers for their health care, securing an appointment on the Iowa side can often feel like an insurmountable task. – Health Provider

Affordable Care/Services

> Cost. Many individuals cannot afford to see a health care provider, and then pay for prescriptions. Affordable health care options should be available in every part of the community. – Physician
>
> Higher premium, very complicated rules, and guidelines, out of pocket co-pays, illiteracy, and difficult portal due to technology. – Business Leader
>
> There are not enough services for low-income patients. – Health Provider
>
> Cost, accessibility, especially mental health, getting an appointment takes six to nine months, and many times it is not covered. – Health Provider
>
> Affordable health care services, access to primary care services, timely access to specialty care services. People are concerned about making ends meet with the various health related social needs that sometimes accessing preventative care services or routine care checks are not attainable. – Community Leader

Lack of Providers

> Large driver of access is the low number of primary care physicians resulting in use of emergency or urgent services rather than reliable preventative care. SDOH including transportation access is a significant barrier. For hourly wage earners and many other salaried workers, they have no access to leave to allow for attending health related appointments. Another barrier is underinsured with large deductibles and choosing to avoid or delay care due to large out of pocket cost despite insurance. – Physician

> There are not enough care providers and many care providers, including doctors and dentists and even chiropractors are working a 4-day week. That means having to schedule out months and wait months to see a provider. Personally, I have care providers that I appreciate very much, but even with that relationship of many years, if I have an issue, I have to go to an urgent care clinic or wait 1-3 months to see my own providers. I go every 6 months for a dental checkup and teeth cleaning. Twice last year, the office was closed on the day I was scheduled. Once for snow, and it didn't snow and the other, the dentist, for whatever reason, needed the day off. At face value, that would be tolerable, but you go to the back of the line for rescheduling and the 6-month checkup ends up being 9 months. A lot can happen in 1-3 months waiting to see a care provider and I fear with many people, that lull in time can mean the difference between life or death. – Health Provider
>
> Not enough providers, especially in certain specialty areas, such as psychiatry and neurology. – Physician
>
> There are not enough providers, and the rural areas are significantly lacking resources. – Social Services Provider

Income/Poverty

> Poverty, homelessness, access to affordable housing, and an increase in mental health and physical disability conditions. – Social Services Provider
>
> Finances, even with insurance, the costs of health care influence the decisions of the majority of patients. Compounding the problem are the many patients with no insurance or are underinsured. – Advanced Practice Provider

Transportation

> Transportation access to connect rural people to resources, resulting in delayed or neglected treatment. – Business Leader
>
> Transportation with or without insurance is very difficult to access and very inaccessible at all hours of the day and night. Insurance is a barrier, not a resource anymore. It creates too many obstacles. – Health Provider

Awareness/Education

> Information can be hard to find. Trust between community and health professionals is broken or non-existent. Not all patients are treated equally. Many health providers cannot relate or do not try to relate to patients. Access to some care is difficult because of poor public transportation. – Social Services Provider

Lifestyle

> Obesity is driven by lack of physical activity, nutrition, food access and the built environment. Traffic fatalities and serious injuries, particularly for vulnerable roadway users (pedestrians/cyclists/motorcyclists). Mental health and substance abuse disorders impacting suicide and traffic fatalities and serious injuries. – Community Leader

Insurance Issues

> The main access in accessing health care services is lack of insurance. The state government helped to mitigate this through expanding Medicaid. As of 2021 9.8% of Nebraskans under age 65 did not have insurance which is a higher percentage than Iowa, Minnesota, or North Dakota. Health systems such as Nebraska Medicine could make the process for getting financial assistance simpler which would allow more uninsured people to access care. – Physician

Overuse of Emergency Room

> Too many patients using the emergency departments as their primary care providers, and not getting the follow through that is needed because that is not the role of the emergency department providers. – Health Provider

Value-Based Care Model

> A move towards value-based care would incentivize health systems to improve quality, efficiency and outcomes measurements, while lowering the cost of care by addressing the social determinants of care and behavioral health. – Physician

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

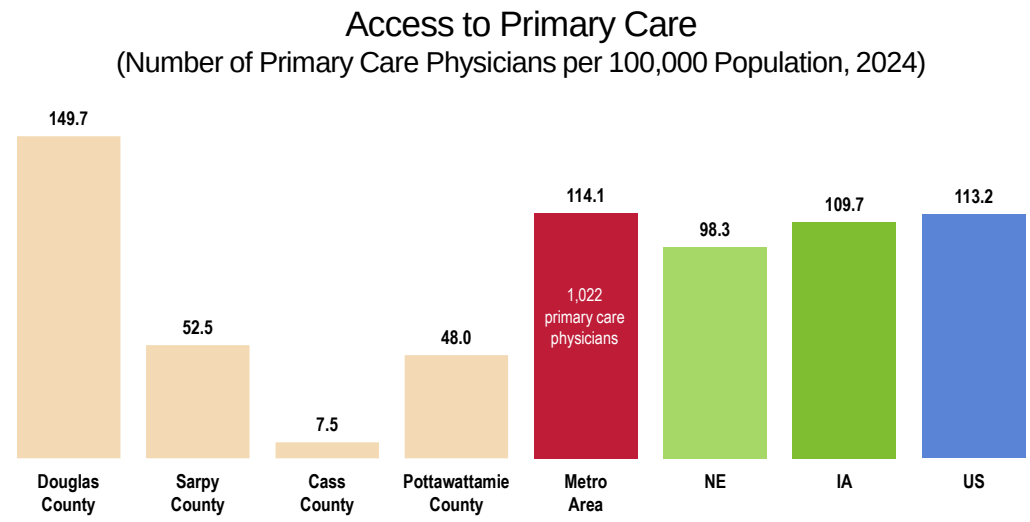
– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

There are currently 1,022 primary care physicians in the Metro Area, translating to a rate of 114.1 primary care physicians per 100,000 population.

DISPARITY ► The proportion is lowest in Cass County.



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2024 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, public health clinic, community health center, urgent care or walk-in clinic, military/VA facility, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

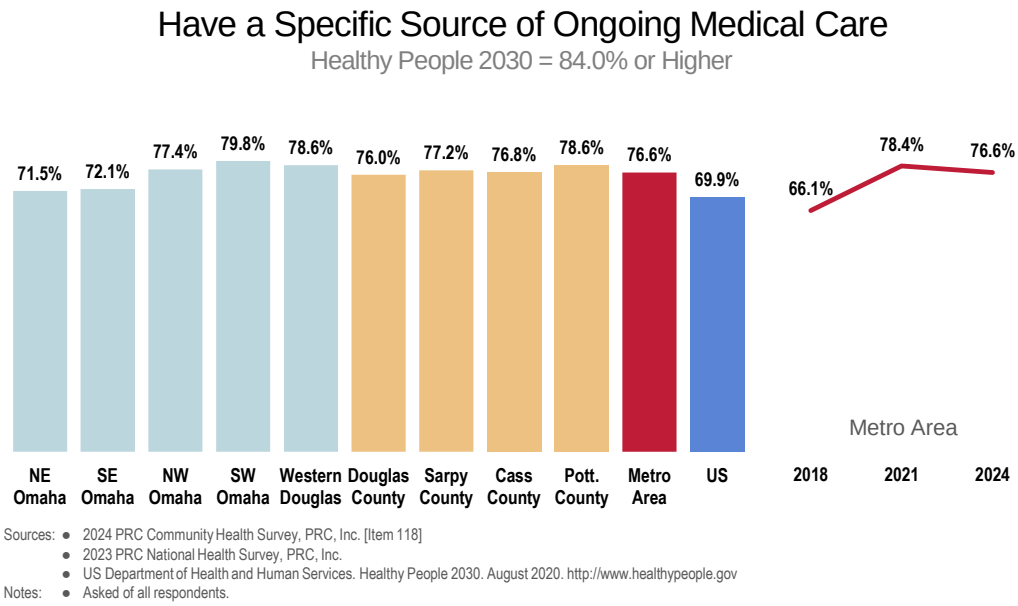
A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 76.6% of Metro Area adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► Higher than the US prevalence but fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing significantly since 2018.

DISPARITY ► Lowest in Northeast Omaha.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 118]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Utilization of Primary Care Services

Adults

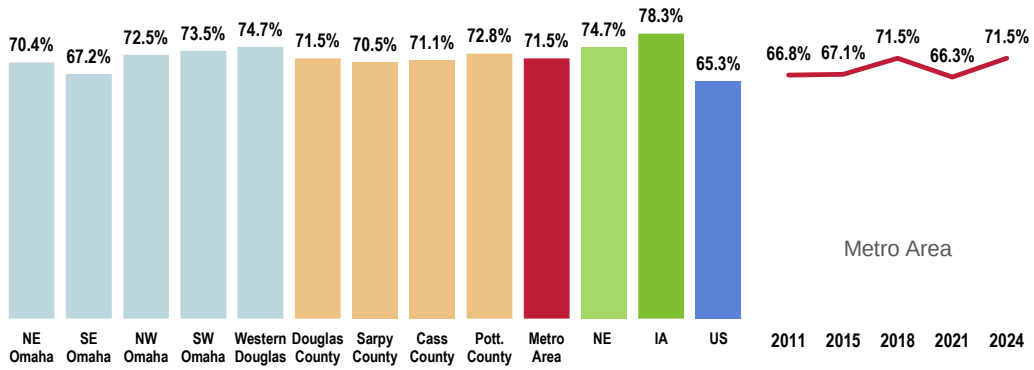
A total of 71.5% of Metro Area adults visited a physician for a routine checkup in the past year.

BENCHMARK ► Well below the state percentages but higher than the US percentage.

TREND ► Marks a statistically significant increase since 2011.

DISPARITY ► Lowest in Southeast Omaha. Reported less often among men, young adults, those in low-income households, Hispanic adults, and LGBTQ+ residents.

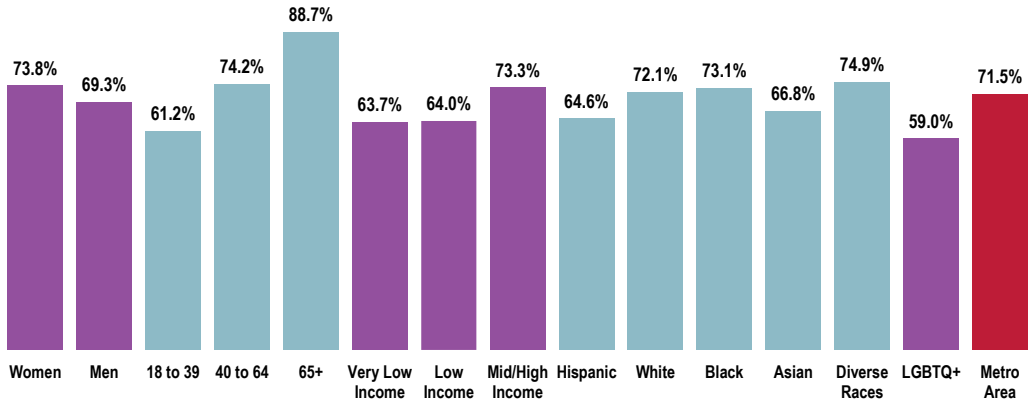
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(Metro Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 16]

Notes:
- Asked of all respondents.

EMERGENCY ROOM UTILIZATION

A total of 11.8% of Metro Area adults have gone to a hospital emergency room more than once in the past year about their own health.

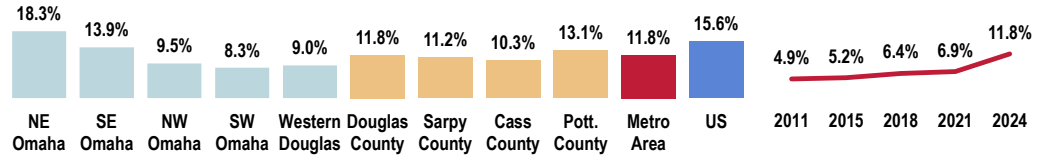
BENCHMARK ► Lower than the national figure.

TREND ► The prevalence has more than doubled since 2011.

DISPARITY ► Highest in Northeast Omaha. Reported more often among young adults, those in low-income households, Black or African American respondents, and LGBTQ+ adults.

Have Used a Hospital Emergency Room More Than Once in the Past Year

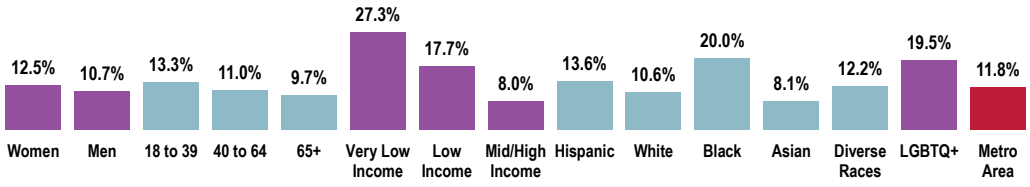
Metro Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 19]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(Metro Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 19]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

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

Dental Care

Adults

Two in three (67.4%) Metro Area adults have visited a dentist or dental clinic (for any reason) in the past year.

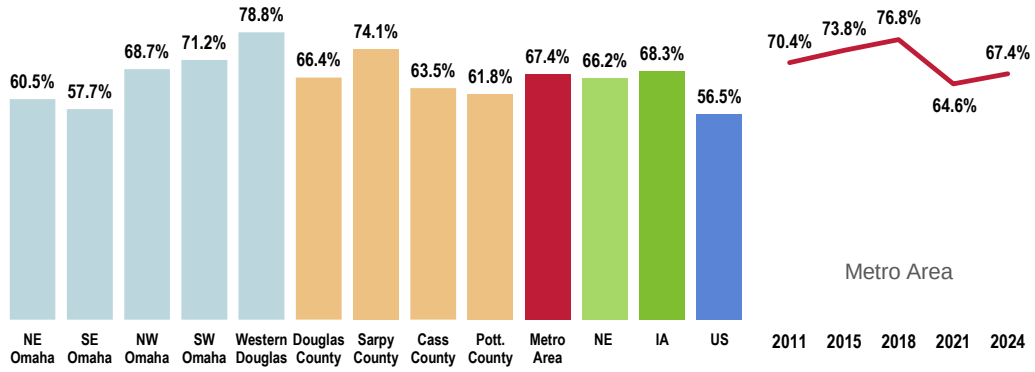
BENCHMARK ► Well above the national prevalence.

TREND ► Except for the low finding in 2021, decreasing significantly from earlier survey administrations.

DISPARITY ► Lowest in eastern Omaha and Pottawattamie County. Reported less often among young adults, those in low-income households, Hispanic adults, Black or African American adults, those of Diverse Races, and those who identify as LGBTQ+.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



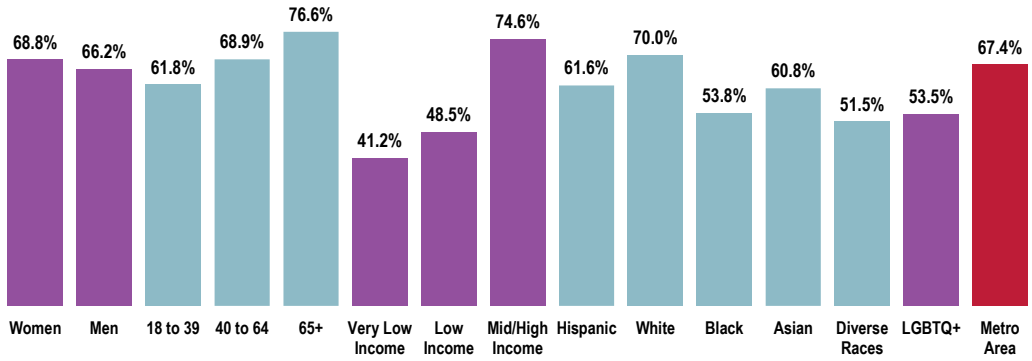
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Nebraska and Iowa data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Metro Area, 2024)

Healthy People 2030 = 45.0% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

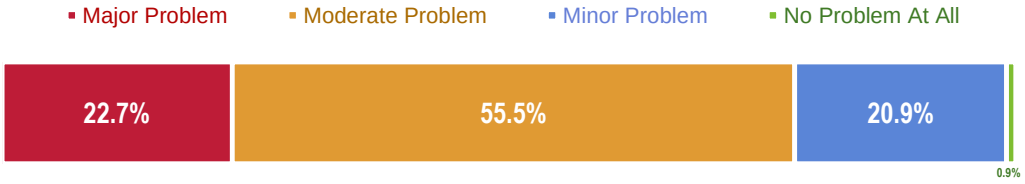
Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.

Perceptions of Oral Health as a Problem in the Community

(Metro Area, 2024)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Access for Medicare/Medicaid Patients

> For families with Medicaid coverage, there are virtually no dentists in Iowa accepting new patients. I had a parent today tell me they are on a waiting list for a dental appointment, but whenever the appointment gets close, the office calls and cancels. – Social Services Provider
>
> No providers accepting patients with Medicaid. – Social Services Provider
>
> It is very difficult to find dentists willing to accept Medicaid as an insurance. There are few providers and the wait time to be seen in the office is often months or more. It is very difficult to find emergency dental care. – Health Provider
>
> The majority of dentists in the community no longer accept Iowa Medicaid. – Health Provider
>
> Lack of services available for Medicaid or uninsured clients, especially youth. – Health Provider
>
> There are not enough dentists to take Medicaid clients. The wait lists are horrible. Research shows poor dental care results in chronic health conditions. – Health Provider

Access to Care/Services

> Dental care access creates long-term health complications. – Physician
>
> Most of my patients lack teeth or lack healthy teeth and lack access to quality and timely dental care and oral surgical care. – Physician
>
> Lack of dental health facilities. – Community Leader
>
> It is very difficult for my patients to find a dentist or dental home, and some have severe tooth decay, affecting their health. – Physician
>
> Lack of access. – Health Provider
>
> Lack of health care access. – Social Services Provider

Affordable Care/Services

> Because no one can afford it, so if you don't have insurance or cash, dental hygiene is the first to go. – Health Provider
>
> It is not available to low resource children and families. – Social Services Provider
>
> It is not affordable. – Social Services Provider
>
> Very expensive, lack of insurance, not a lot of options. – Business Leader
>
> Too costly to get dental care. – Social Services Provider

Access to Care for Uninsured/Underinsured

> Very limited access to dental care for those without insurance, or with financial barriers. Many go without treatment. – Physician
>
> Lack of affordable dental insurance and services. – Advanced Practice Provider

Environmental Contributors

> No fluorinated water in rural communities. Access to dental care and or affordable providers. Delayed dental care for children. – Business Leader

Impact on Quality of Life

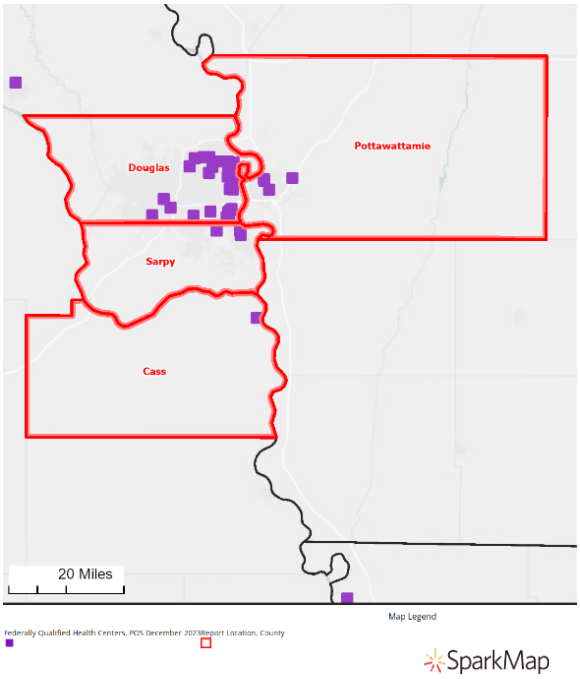
> Poverty, mental health, and addiction. – Social Services Provider

LOCAL RESOURCES

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the Metro Area as of December 2023.



Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- All Care Community Health Center
- Bluffs Taxi
- Caring for Our Communities
- Casino Cab
- Charles Drew Health Center
- CHI Health Center
- CHI Health Immanuel
- CHI Health Mercy
- City of Omaha Vision Zero Plan
- Community Alliance
- Community Health Centers
- Community Health Workers
- Connections Area Agency on Aging
- Council Bluffs Transit
- Creighton University
- Doctor's Offices
- Douglas County
- Douglas County Detox Center
- Douglas County Health Department
- Faith Based Nursing Resources
- Federal Programs
- Federally Qualified Health Centers
- Firefly Mobile Wellness Unit
- Health Care Facilities
- Health Fairs
- Health Systems
- Heartland Family Services
- Healing Gift Free Clinic (HGFC)
- Hospitals
- Insurance Company
- Jennie Edmundson Hospital
- Lutheran Family Services
- MAPA Safe Streets and Roads
- Marketplace Insurance
- Methodist Community Health Clinic (MCHC)
- Medicare/Medicaid
- Mental Health Respite Programs
- Methodist
- Metro Area Transit
- Mobile Care Units
- Nebraska Medicine
- Nonprofits
- North Omaha Area Health
- One World Community Health Center
- Secret Heart
- Southwest Iowa Transit System
- University of Nebraska Medical Center
- VA

Cancer

- A Time to Heal
- American Cancer Association
- American Cancer Society
- American Chemical Society (ACS)
- American Lung Association
- Buffett Cancer Center
- Cancer Shop
- Cancer Support
- Charles Drew Health Center
- CHI Health Center
- Douglas County Health Department
- Estabrook Cancer Center
- Every Woman Matters
- Great Plains Colon Cancer Task Force
- Health Care Facilities
- Hope Lodge
- Hospitals
- Jennie Edmundson Hospital
- Leukemia and Lymphoma Society
- Marketplace Insurance
- Mayo Clinic
- Methodist
- Midwest GI
- Mobile Diabetes Center
- My Sister's Keeper
- NC II Certification
- Nebraska Cancer Specialists
- Nebraska Coalition to End Childhood Cancer
- Nebraska Medicine
- One World Community Health Center
- Project Pink'd
- Smoking Cessation Programs
- Susan G. Komen Foundation
- University of Nebraska Medical Center

Wings of Hope Cancer Support Center
Women's Center for Advancement

Diabetes

American Diabetes Association
American Heart Association
Americans with Disabilities Act (ADA)
Black Men United Food Pantry
Caring for Our Communities
Charles Drew Health Center
CHI Health Center
Children's Hospital and Medical Center
Clair Methodist Garden and Food Distribution
Clinical Pharmacist
Community Health Centers
Community Health Clinics
Community Health Services
Community Health Workers
Connections AEA Services
Creighton University
Dear Diabetes
Diabetes and Education Self Help Center
Diabetes Center
Diabetes Communities of Practice
Diabetes Education
Diabetes Prevention Program
Doctor's Offices
Douglas County Community Health Workers
Douglas County Help Center
Employers
Faith Based Supports
Federally Qualified Health Centers
Fitness Centers/Gyms
Food Banks/Food Pantries
HALT Diabetes Nebraska
Health Department
Health Fairs
Health Systems
Heart Ministry
Healing Gift Free Clinic (HGFC)
Home Health Agencies
Hospitals
HyVee
I Be Black Girl
Insurance Company
Juvenile Diabetes Resource Foundation
Medicare/Medicaid
Medication Assistance Programs
Methodist
Methodist College
Methodist Community Health Clinic (MCHC)
Mobile Diabetes Center
Nebraska Medicine
Nebraska Total Care
Nebraska Urban Indian Health Coalition
No More Empty Pots
North Omaha Area Health
One World Community Health Center
Pharmacy
Ponca Tribe of Nebraska Wellness Center
Pottawattamie County General Assistance
Supplemental Nutrition Assistance Program
Together Inc
U Card Benefits
University of Nebraska Medical Center
YMCA/YWCA

Disabling Conditions

Alzheimer's Association
Assisted Living
CHI Health Center
Circle Theatre Omaha
Community Alliance
Community Health Centers
Creighton University
Department of Health and Human Services
Doctor's Offices
Eastern Nebraska Office on Aging
Federally Qualified Health Centers
Health Department
Health Systems
Home Instead
Hospitals
League of Human Dignity
Meals on Wheels
Memory Care Units
Methodist
MOBY Paratransit
Nebraska Medicine
Nebraska Urban Indian Health Coalition
Nursing Homes
Ponca Tribe of Nebraska Wellness Center
Region Six
Silver Sneakers
Social Security
University of Nebraska Medical Center
VA

Heart Disease & Stroke

American Heart Association
Black Family Health and Wellness
Charles Drew Health Center

CHI Health Center
Community Health Centers
County Services
Doctor's Offices
Federally Qualified Health Centers
Fitness Centers/Gyms
Health Fairs
Health Systems
Heart Ministry
Hospitals
Managed Care Services
Methodist
Methodist Community Health Center
Nebraska Medicine
Nebraska Stroke Association
No More Empty Pots
North Omaha Area Health
Offer in One Language Only
One World Community Health Center
Reading Materials
Restaurants
Supplemental Nutrition Assistance Program
University of Nebraska Medical Center
YMCA/YWCA

Infant Health & Family Planning

Charles Drew Health Center
Children's Hospital and Medical Center
CHIP Program
Community Health Centers
Contraceptive Access Program
Department of Health and Human Services
Diaper Banks
Doctor's Offices
Douglas County Health Department
Douglas County STD Clinic
Doula Passage Program
Early Development Network
Emergency Pregnancy Services
Essential Pregnancy Services
Federally Qualified Health Centers
Girls Inc
Health Start
Help Me Grow Program
Hospitals
I Be Black Girl
Medicare/Medicaid
Methodist
Milk Works
Mothers Love
Nebraska Children's Home
Nebraska Medicine
Nonprofits
NPI-Q Questionnaire
Omaha Black Doula Association
One World Community Health Center
Planned Parenthood
Women, Infants and Children

Injury & Violence

Advocacy
Boys and Girls Club
Charles Drew Health Center
Churches
Community Health Clinics
Completely Kids
Department of Health and Human Services
Doctor's Offices
Douglas County Victim Assistance Program
EMCOMPASS Omaha
Empowerment Network
Girls Inc
Heartland Family Services
Hospitals
Law Enforcement
Nonprofits
Northstart
Omaha 360
Omaha Police Department
Project Harmony
Victim Assistance/Advocacy Program
Women's Center for Advancement
Women's Fund
YMCA/YWCA
YouTurn

Mental Health

988
AEA Services
All Care Community Health Center
Anywhere Care
Behavioral Health Connection
Behavioral Health Education Center of Nebraska (BHCEN)
Behavioral Health Peer Supports
Best Care EAP
Boys Town
Bridge to Mental Health
Calvary Church
Capstone Behavioral Health
Catholic Charities
Center for Healing and Hope
Center for Holistic Development

Charles Drew Health Center
CHI Health Center
CHI Health Immanuel
CHI Health Mercy
CHI Heritage
CHI McDermott
Child and Family Resource Network
Community Alliance
Community Based Organizations
Community Health Centers
Community Health Clinics
Concord Mediation
Counseling Clinics
Department of Health and Human Services
Doctor's Offices
Douglas County
Douglas County Community Mental Health Center
Douglas County Health Center
Douglas County Health Department
Douglas County Hospital
Durham Outpatient Center Clinic
Employee Assistance Program
Employers
Family Connections
Family Services
Federally Qualified Health Centers
Food Banks/Food Pantries
Fresh Hope
Full Circle Recovery
Group Homes
Harbor Pointe
Health Care Facilities
Health Department
Health Systems
Heartland Family Services
Healing Gift Free Clinic (HGFC)
Homeless Shelters
Hope Valentine and Melissa Jansen
Hospitals
Jennie Edmundson Hospital
Lasting Hope Recovery Center
Lutheran Family Services
Managed Care Services
Mental Health Court
Meridian
Methadone Clinic
Methodist Community Health Clinic (MCHC)
Mobile Crisis
Munroe Meyer
National Alliance on Mental Illness
Nebraska Association of Behavioral Health Organizations
Nebraska Health Systems
Nebraska Medicine
Nebraska Mental Health & Aging Coalition
Nonprofits
Omaha ForUS LGBTQ Center
Omaha Police Department
One World Community Health Center
PES Emergency Room Services
Private Mental Health Therapists
Project Harmony
Psychiatric Immediate Need Clinic
Public Entities Directing/Developing Programs
Region Six
Regional Services
Remedy Health
Rural Health Clinic
Safe Harbor Peer Support
Salvation Army
School System
Southwest Iowa Mental Health and Disabilities Service Region
Southwest Iowa Region
Spence Counseling
Stephen's Center
SWIA Region
SWIAM
Teen Mental Health Alliance
The Kim Foundation
University of Nebraska Medical Center
VA
What Makes Us Campaign

Nutrition, Physical Activity & Weight

75 North Highlander Programming
Anytime Fitness
Big Garden
Charles Drew Health Center
CHI Health Center
Children's Hospital and Medical Center
College of Lifestyle Medicine
Community Gardens
Community Health Clinics
Community Health Workers
Creighton University
Doctor's Offices
Douglas County Health Department
Farmer's Markets
Fitness Centers/Gyms
Food Bank for the Heartland
Food Banks/Food Pantries
Government Food Assistance Programs
Health Care Facilities

Health Department
Heart Ministry
Heartland B-Cycle
Heartland Family Services
Homeless Shelters
Hospitals
HyVee
Kroc Center
Libraries
Metro
Nebraska Medicine
Neighbor Good Pantry
No More Empty Pots
Nonprofits
Nutrition Services
Omaha Health Clinic
One World Community Health Center
Parks and Recreation
Planet Fitness
Podcasts
Salvation Army
School System
Senior Farmer's Market Nutrition Program
Summer Food Program
Supplemental Nutrition Assistance Program
Together Inc
University of Nebraska Medical Center
Weight Watchers
Whispering Roots
Women, Infants and Children
YMCA/YWCA

Oral Health

All Care Community Health Center
All Smiles
Charles Drew Health Center
Creighton University
Dentist's Offices
Department of Health and Human Services
Doctor's Offices
Give Kids a Smile Day
Heartland Ministry Dental Clinic
Iowa Mission of Mercy
I-Smile
Managed Care Services
Nebraska Medicine
Nonprofits
One World Community Health Center
Primer Dental Free Dental Care Day
Public Health
School System
Summit Dental
Universities

Respiratory Diseases

Charles Drew Health Center
CHI Health Center
Health Systems
Methodist Community Health Clinic (MCHC)
Nebraska Medicine
One World Community Health Center
Public Health
University of Nebraska Medical Center

Sexual Health

Adolescent Health Project
Charles Drew Health Center
CHI Health Center
Community Health Centers
Doctor's Offices
Douglas County
Douglas County Health Department
Douglas County STD Clinic
Essential Pregnancy Services
Federally Qualified Health Centers
Health Department
Hospitals
Methodist
Nebraska AIDS Project (NAP)
Nonprofits
North Omaha Area Health
Omah Public Library
Omaha ForUS LGBTQ Center
One World Community Health Center
Pharmacy
Planned Parenthood
Pottawattamie County Public Health
Public Health
School System
University of Nebraska Medical Center
Women's Fund

Social Determinants of Health

211
AEA Services
Anawim
Behavioral Health Connection
Bridge Out of Poverty
Canopy South Neighborhood Development
Caring for Our Communities
Catholic Charities

- Charles Drew Health Center
- CHI Health Center
- CHI Health Immanuel
- City Council
- Community Alliance
- Community-Based Organizations
- Community Health Centers
- Community Health Services
- Community Health Workers
- Community-Oriented Drug Enforcement (CODE)
- Community Relay
- Connections Area Agency on Aging
- Continued Utility Supply Despite Inability to Pay
- Department of Health and Human Services
- Doctor's Offices
- Douglas County Board of Commissioners
- Douglas County Community Mental Health Center
- Douglas County Health Department
- Eastern Nebraska Community Action Partnership
- Eastern Nebraska Office on Aging
- Empowerment Network
- Faith Based Supports
- Family Housing Advisory Services
- Food Banks/Food Pantries
- Francis House
- Front Porch Investments
- Habitat for Humanity
- Health Department
- Heart Ministry
- Heartland Family Services
- Heartland Hope Food Pantry
- Homeless Shelters
- Hospitals
- Housing and Urban Development
- Housing Continuum
- Housing Foundation of Sarpy County
- Insurance Company
- Intercultural Senior Center
- Lasting Hope Recovery Center
- Lied Center
- Lift Up Sarpy
- Lutheran Family Services
- Medicare/Medicaid
- Methodist Community Health Center
- Metro Area Continuum of Care for the Homeless
- Micah House
- MOBY
- Nebraska Health Network
- Nebraska Medicine
- Nebraska Total Care
- New Visions
- No More Empty Pots
- Nonprofits
- Omaha 100
- Omaha ForUS LGBTQ Center
- Omaha Healthy Kids Alliance
- Omaha Housing Authority
- One World Community Health Center
- Open Door Mission
- Parks and Recreation
- Pink For LGBTQ+
- Pottawattamie County Sheriff's Office
- Project Everlast
- Project Harmony
- Public Health
- Refugee Empowerment Network
- Regions
- Reimagine
- Salvation Army
- Sarpy County Housing Authority
- School System
- Sienna Francis
- Supplemental Nutrition Assistance Program
- Southwest Iowa Mental Health and Disabilities Service Region
- Spark Community Development
- Stephen's Center
- Subsidized Housing Options
- Together Inc
- Unite Us
- United Way
- UnitedHealth
- University of Nebraska Medical Center

Substance Use

- 988
- AA/NA
- Catholic Charities
- Centerpointe
- CHI Health Center
- CHI Health Immanuel
- CHI Health Mercy
- Clinical Substance Abuse Treatment Services
- Community Alliance
- Community Health Centers
- Council Bluffs Comprehensive Treatment Center
- Doctor's Offices
- Douglas County Community Mental Health Center
- Douglas County Detox Center

- Douglas County Outpatient and Inpatient Services
- Eastern Nebraska Community Action Partnership
- Employers
- Family Access Center
- Family Resource Center
- Full Circle Recovery
- Give Recovery
- Haven Health
- Heartland Family Services
- Hospitals
- InRoads to Recovery
- Iowa Family Works
- Jennie Edmundson Hospital
- Lasting Hope Recovery Center
- Life Recovery Groups
- Lutheran Family Services
- Nebraska Medicine
- Nonprofits
- Northpoint
- NOVA Treatment Community
- Open Door Mission
- Public Health
- Region Six
- Salvation Army
- Santa Monica House
- Sarpy County Drug Court
- Southwest Iowa Mental Health and Disabilities Service Region
- Stephen's Center
- TDC Inpatient
- Transitional Services of Iowa
- University of Nebraska Medical Center
- Valley Hope

Tobacco Use

- Centerpointe
- CHI Health Center
- Doctor's Offices
- Health Systems
- Heartland Family Services
- Lutheran Family Services
- My Life My Quit
- Nebraska Tobacco Quitline
- Public Health
- Women, Infants and Children

Appendix B

Mills County

2024 Community Health Needs Assessment

Meeting Objectives

- Present a community health update (from the 2023 CHA).
- Identify opportunities for collaboration with CHI Health Mercy Council Bluffs, in alignment with Mills County Community Health Improvement Plan priorities.

CHNA/ IS Federal Requirements Overview

Community Health Needs Assessment (CHNA) Due June 2025

- Required for every not-for-profit hospital licensed with the state

conducted every 3 years

- a systematic process involving the community to identify and analyze

community health needs and assets

- to prioritize, plan and act upon unmet community health needs

Implementation Strategy (ISP) Due Nov 2025

- Hospital's plan (3-year) for addressing community health needs
  - includes health needs identified in the community health needs assessment
  - includes evaluation plan to demonstrate impact
  - outlines hospital actions and resources (financial and human)
  - Report annually on tax forms

Access our current & previous CHNA reports at: CHIHealth.com/CHNA

American Hospital Association. (2023). Community Health Assessment Toolkit. Accessed at https://www.healthycommunities.org/resources/community-health-assessment-toolkit

CHI Health Mercy Council Bluffs CHNA Timeline

- Community Health Survey completed June 2024 (Pottawattamie)
- Data review/Prioritizing needs
  - Mills: September 2023
  - Pottawattamie: December - February 2024
- CHI Board Approval of CHI Health Mercy Council Bluffs CHNA: June 2025
- Implementation of new priority health needs July 1 2025, to June 30, 2028

Priority Community Health Needs Identified in Mills County

Areas of Opportunities Identified	
ACCESS TO HEALTH CARE SERVICES ★	▪ Barriers to Access – Inconvenient Office Hours – Cost of Care – Lack of local urgent care/emergency department – Lack of Transportation
ACCESS TO MENTAL HEALTH SERVICES	*Barriers to Access -Lack of providers in the county – Inconvenient office hours – cost – Accessibility to appointments – Urgent care access
ACCESS TO STUBSTANCE ABUSE TREATMENT	*Barriers to Access -Lack of providers – lack of facilities – Transportation – Education – lack of Community Awareness
TRANSPORTATION ★	*Barriers to Access -Lack of options – Cost – Timeliness – Frustration over MCO transports
HOUSING	*Barriers to Access -expensive to rent / buy in Mills County – Lack of options – Low quality houses – Waiting lists/ access

Sept 2023

Guiding Principles

- **Use Evidence to Drive Impact**
- **Address Disparities**
- **Prioritize Root Causes**
- **Integrate Community**
- **Improve Community Capacity**
- **Enhance Care Continuum**
- **Consider Education and Research**

Considerations for Selecting Hospital Priorities

- Severity of health issue
- Population impacted (making special considerations to disparities and vulnerable populations)
- Trends in the data
- Existing partnerships
- Readiness
- Political Will
- Available resources
- Hospital’s level of expertise
- Existing initiatives (or lack there of)
- Potential for impact
- Community’s interest in the hospital engaging in that health area

Previously Prioritized Health Needs for CHI Health Mercy Council Bluffs

FY17-19	FY20-22	FY23-25
Behavioral Health ● Crisis care ● Cross-system care coordination ● Expand detox services	Behavioral Health ● Support SWIA MHDS efforts to maximize crisis stabilization ● Offer training to community members (e.g. MHFA, crisis deescalation) ● Fund Family Matter substance misuse program	Behavioral Health ● Expand access to youth mental health services ● Promote MHFA training ● Support Family Matters program
Injury prevention ● Outreach and education	Social Determinants of Health ● Explore opportunities to support MCPH's efforts to address transportation and healthy food access	Social Determinants of Health ● Support the MCPH Mobile Integrated Health Svcs program ● Implement HRSN screening and referral using Unite Us
Nutrition, physical activity and weight status		
Maternal and Child Health ● Family Matters		

2024 Community Health Update

Total Population

A total of 14,605 people live in the 437.43 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2018-22 5-year estimates. The population density for this area, estimated at 33 persons per square mile, is less than the national average population density of 94 persons per square mile.

Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Mills County, IA	14,605	437.43	33
Iowa	3,188,836	55,853.39	57
United States	331,097,593	3,533,269.34	94

Data Source: US Census Bureau, American Community Survey. 2018-22. ➞ *Show more details*

View larger map

Population, Density (Persons per Sq Mile) by Tract, ACS 2018-22

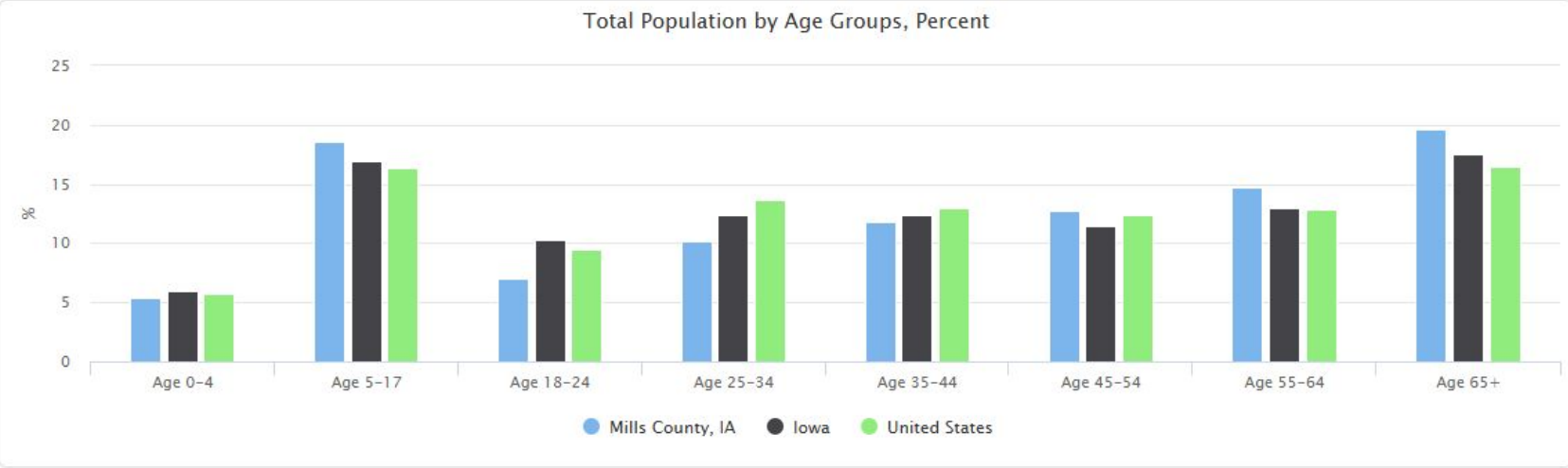
- Over 5,000
- 1,001 - 5,000
- 501 - 1,000
- 51 - 500
- Under 51
- No Data or Data Suppressed
- Mills County, IA

Total Population by Age Groups, Percent

This indicator reports the percentage of age groups in the population of the report area.
The percentage values could be interpreted as, for example, *"Of the total population in the report area, the percentage of population age 0-4 is (value)."*

Report Area	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+
Mills County, IA	5.34%	18.58%	7.06%	10.11%	11.83%	12.78%	14.67%	19.63%
Iowa	5.95%	16.95%	10.26%	12.40%	12.43%	11.45%	12.99%	17.57%
United States	5.74%	16.37%	9.45%	13.71%	12.93%	12.41%	12.86%	16.53%

Data Source: US Census Bureau, American Community Survey. 2018-22. ➞ *Show more details*

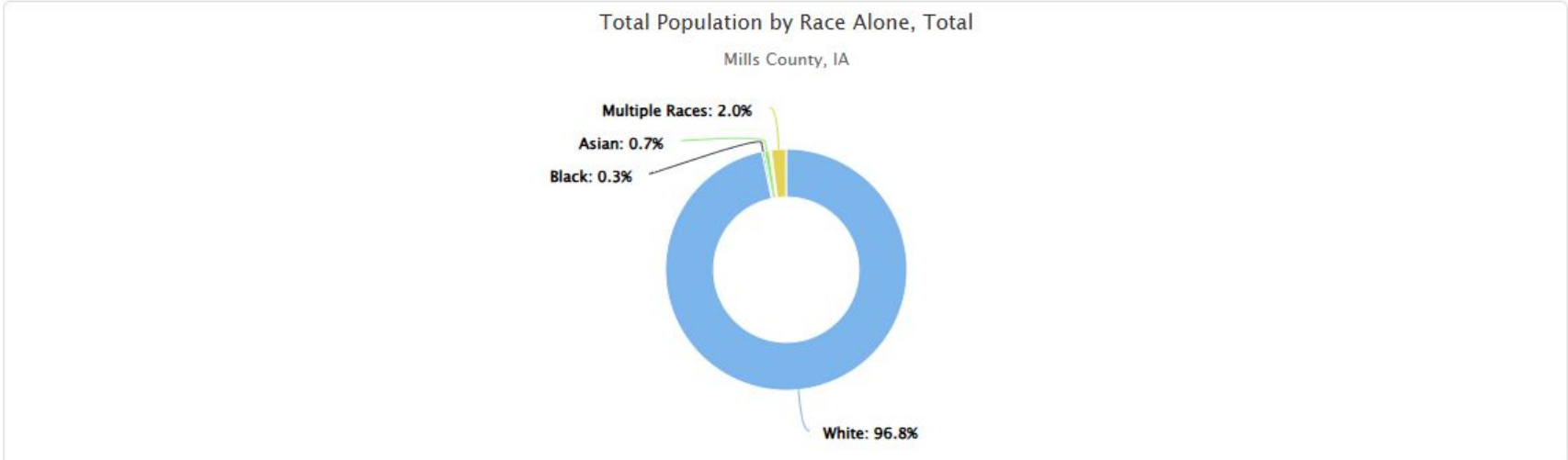


Total Population by Race Alone, Total

This indicator reports the total population of the report area by race alone.

Report Area	White	Black	Asian	American Indian / Alaska Native	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Races
Mills County, IA	14,137	38	103	18	0	21	288
Iowa	2,769,619	120,619	78,940	10,111	4,582	54,569	150,396
United States	218,123,424	41,288,572	19,112,979	2,786,431	624,863	20,018,544	29,142,780

Data Source: US Census Bureau, American Community Survey. 2018-22. → *Show more details*

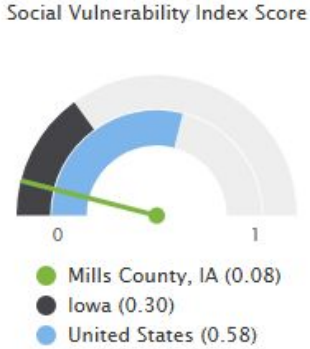


Social Vulnerability Index (SoVI)

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability. The report area has a social vulnerability index score of 0.08, which is which is less than the state average of 0.30.

Report Area	Total Population	Socioeconomic Theme Score	Household Composition Theme Score	Minority Status Theme Score	Housing & Transportation Theme Score	Social Vulnerability Index Score
Mills County, IA	14,605	0.07	0.31	0.13	0.17	0.08
Iowa	3,188,836	0.21	0.42	0.40	0.46	0.30
United States	331,097,593	0.54	0.47	0.72	0.63	0.58



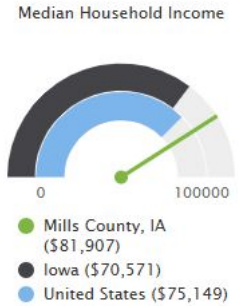
Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2022. ➞ *Show more details*

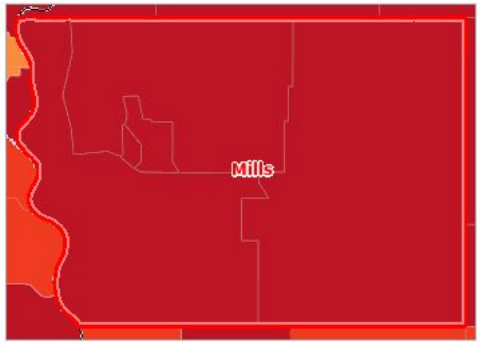
Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 5,261 households in the report area, with an average income of $105,654 and a median income of $81,907.

Report Area	Total Households	Average Household Income	Median Household Income
Mills County, IA	5,261	$105,654	**$81,907**
Iowa	1,290,139	$92,053	$70,571
United States	125,736,353	$105,833	$75,149

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22. ➞ *Show more details*





View larger map

Median Household Income by Tract, ACS 2018-22

- Over $70,000
- $60,000 - $70,000
- $50,000 - $59,999
- Under $50,000
- No Data or Data Suppressed
- Mills County, IA

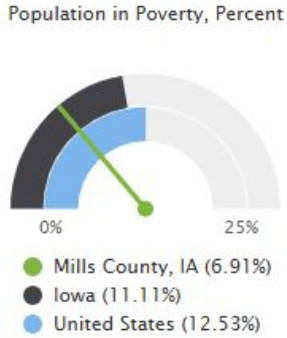
Poverty - Population Below 100% FPL

Poverty is considered a *key driver* of health status.

Within the report area 6.91% or 996 individuals for whom poverty status is determined are living in households with income below 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.
Note: The total population measurements for poverty reports are lower than population totals for some other indicators, as poverty data collection does not include people in group quarters. See "Show more details" for more information.

Report Area	Total Population	Population in Poverty	Population in Poverty, Percent
Mills County, IA	14,423	996	6.91%
Iowa	3,088,999	343,141	11.11%
United States	323,275,448	40,521,584	12.53%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22. → *Show more details*



Poverty- Cont.

Poverty - Poverty Profile

This indicator reports the percentage of the total population living in households with incomes at various thresholds relative to the Federal Poverty Level (FPL). The Federal Poverty Level is updated each year and varies by household size and state (there is one set of thresholds for the contiguous states - Alaska and Hawaii thresholds are determined independently). For further information, please see the latest poverty guidelines .

Report Area	50% or Less	51% - 100%	101%-150%	151% - 200%	201% - 500%	Over 500%
Mills County, IA	2.64%	4.27%	8.95%	5.47%	43.57%	35.10%
Iowa	5.15%	5.96%	7.67%	8.36%	45.31%	27.55%
United States	5.83%	6.70%	7.96%	8.31%	40.31%	30.89%

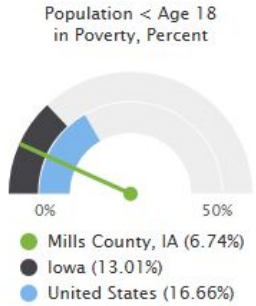
Data Source: US Census Bureau, American Community Survey. 2018-22. → *Show more details*

Poverty - Children Below 100% FPL

In the report area 6.74% or 234 children aged 0-17 are living in households with income below 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.

Report Area	Total Population	Population < Age 18	Population < Age 18 in Poverty	Population < Age 18 in Poverty, Percent
Mills County, IA	14,423	3,473	234	6.74%
Iowa	3,088,999	718,457	93,453	13.01%
United States	323,275,448	72,035,358	12,002,351	16.66%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22. → *Show more details*



View larger map

Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2018-22

- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- Mills County, IA

Attainment - Overview

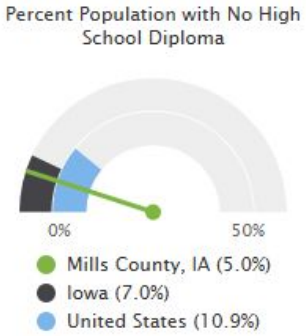
Educational Attainment shows the distribution of the highest level of education achieved in the report area, and helps schools and businesses to understand the needs of adults, whether it be workforce training or the ability to develop science, technology, engineering, and mathematics opportunities. Educational attainment is calculated for persons over 25 years old, and is an estimated average for the period from 2018 to 2022.

For the selected area, 21.0% have at least a college bachelor's degree, while 29.0% stopped their formal educational attainment after high school.

Report Area	No High School Diploma	High School Only	Some College	Associate's Degree	Bachelor's Degree	Graduate or Professional Degree
Mills County, IA	5.0%	29.0%	23.4%	12.2%	21.0%	9.5%
Iowa	7.0%	30.6%	20.1%	12.0%	20.3%	10.0%
United States	10.9%	26.4%	19.7%	8.7%	20.9%	13.4%

Note: This indicator is compared to the state average.

Data Source: US Census Bureau, American Community Survey. 2018-22. → *Show more details*

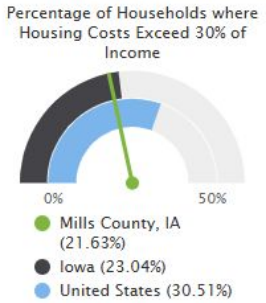


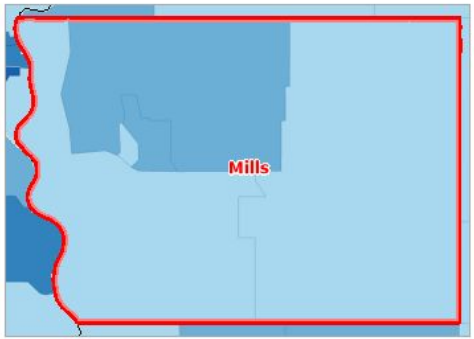
Housing Costs - Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. Of the 5,261 total households in the report area, 1,138 or 21.63% of the population live in cost burdened households.

Report Area	Total Households	Cost-Burdened Households	Cost-Burdened Households, Percent
Mills County, IA	5,261	1,138	21.63%
Iowa	1,290,139	297,226	23.04%
United States	125,736,353	38,363,931	30.51%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22. ➞ *Show more details*





View larger map

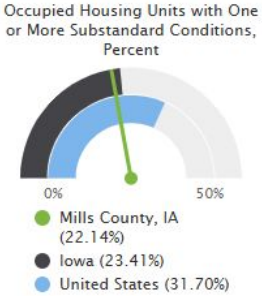
Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2018-22

- Over 35.1%
- 28.1 - 35.0%
- 21.1 - 28.0%
- Under 21.1%
- No Data or Data Suppressed
- Mills County, IA

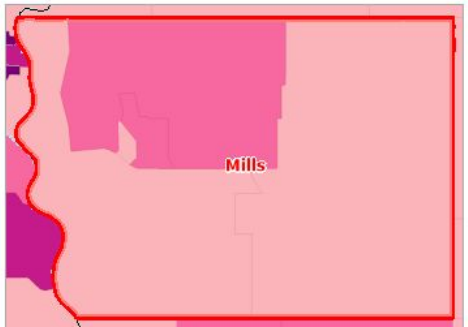
Housing Quality - Substandard Housing

This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard. Of the 5,261 total occupied housing units in the report area, 1,165 or 22.14% have one or more substandard conditions.

Report Area	Total Occupied Housing Units	Occupied Housing Units with One or More Substandard Conditions	Occupied Housing Units with One or More Substandard Conditions, Percent
Mills County, IA	5,261	1,165	22.14%
Iowa	1,290,139	301,989	23.41%
United States	125,736,353	39,858,044	31.70%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22. ➞ *Show more details*



Substandard Housing Units, Percent of Total by Tract, ACS 2018-22

- Over 34.0%
- 28.1 - 34.0%
- 22.1 - 28.0%
- Under 22.1%
- No Data or Data Suppressed
- Mills County, IA

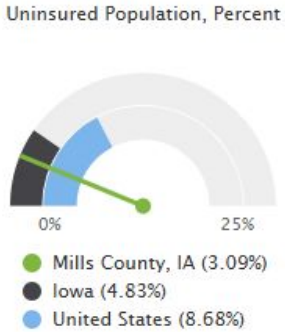
Insurance - Uninsured Population (ACS)

The lack of health insurance is considered a *key driver* of health status.

In the report area 3.09% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less than the state average of 4.83%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Mills County, IA	14,257	441	3.09%
Iowa	3,142,658	151,750	4.83%
United States	326,147,510	28,315,092	8.68%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22. → *Show more details*



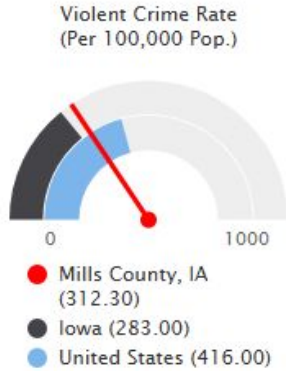
Violent Crime - Total

Violent crime includes homicide, rape, robbery, and aggravated assault.

Within the report area, the 2015-2017 three-year total of reported violent crimes was 139, which equates to an annual rate of 312.30 crimes per 100,000 people, higher than the statewide rate of 283.00.

Report Area	Total Population	Violent Crimes, 3-year Total	Violent Crimes, Annual Rate (Per 100,000 Pop.)
Mills County, IA	14,832	139	**312.30**
Iowa	3,162,071	26,851	283.00
United States	366,886,849	4,579,031	416.00

Note: This indicator is compared to the state average.
Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2015-2017. → *Show more details*

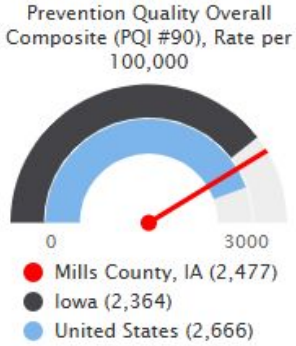


Hospitalizations - Preventable Conditions

This indicator reports the unsmoothed age-adjusted rate of Prevention Quality Overall Composite (PQI #90) for Medicare FFS population in 2022. Data were obtained from the CMS Mapping Medicare Disparities tool.

Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 (rate displayed as zero for such counties.)

Report Area	FFS Beneficiaries	Prevention Quality Overall Composite (PQI #90), Total	Prevention Quality Overall Composite (PQI #90), Rate per 100,000
Mills County, IA	2,422	60	**2,477**
Iowa	432,488	10,224	2,364
United States	30,900,366	823,804	2,666



Note: This indicator is compared to the state average.

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022. → *Show more details*

Maternal & Child Health

Health Care - FQHC Maternal and Child Health

This indicator provides an overview of the prenatal and perinatal health measures among prenatal care patients seen in Federally Qualified Health Centers or FQHC Look-alikes that operate one or more service delivery sites within the report area.
Note: Data are based on the location of the health center and may include patients who reside outside of the report area.

Report Area	Total Prenatal Care Patients	Early Entry into Prenatal Care	Low and Very Low Birth Weight
Iowa	4,878	70.96%	8.27%
United States	557,069	79.82%	8.62%

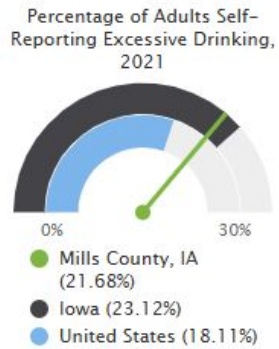
Data Source: US Department of Health & Human Services, Health Resources and Services Administration. 2023. → *Show more details*

Alcohol - Heavy Alcohol Consumption

In the report area, 2,429, or 21.68% adults self-report excessive drinking in the last 30 days, which is less than the state rate of 23.12%. Data for this indicator were based on survey responses to the 2021 Behavioral Risk Factor Surveillance System (BRFSS) annual survey and are used for the 2024 County Health Rankings.

Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period. Alcohol use is a behavioral health issue that is also a risk factor for a number of negative health outcomes, including: physical injuries related to motor vehicle accidents, stroke, chronic diseases such as heart disease and cancer, and mental health conditions such as depression and suicide. There are a number of evidence-based interventions that may reduce excessive/binge drinking; examples include raising taxes on alcoholic beverages, restricting access to alcohol by limiting days and hours of retail sales, and screening and counseling for alcohol abuse (Centers for Disease Control and Prevention, Preventing Excessive Alcohol Use, 2020).

Report Area	Population Age 18+	Adults Reporting Excessive Drinking	Percentage of Adults Reporting Excessive Drinking
Mills County, IA	11,207	2,429	21.68%
Iowa	2,470,275	571,088	23.12%
United States	259,746,218	47,041,079	18.11%



Note: This indicator is compared to the state average.

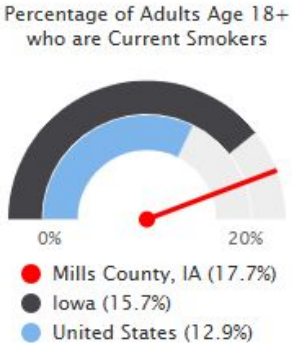
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings. 2021. → *Show more details*

Tobacco Usage - Current Smokers

This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

Within the report area there are 17.7% adults age 18+ who have smoked and currently smoke of the total population age 18+.

Report Area	Total Population	Adults Age 18+ as Current Smokers (Crude)	Adults Age 18+ as Current Smokers (Age-Adjusted)
Mills County, IA	14,553	**17.7%**	18.2%
Iowa	3,200,517	15.7%	16.5%
United States	333,287,557	12.9%	13.2%

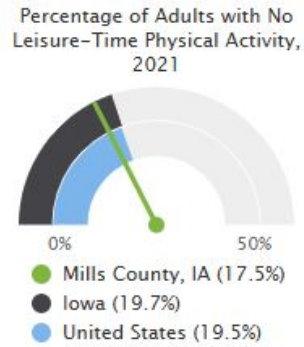


Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 . → *Show more details*

Physical Inactivity

Within the report area, 2,054 or 17.5% of adults aged 20 and older self-report no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.
Note: In 2021, the CDC updated the methodology used to produce estimates for this indicator. Estimated values for prior years (2004 - 2017) have been updated in this platform to allow comparison across years. Use caution when comparing with saved assessments generated prior to November 10, 2021.

Report Area	Population Age 20+	Adults Age 20+ with No Leisure Time Physical Activity	Adults Age 20+ with No Leisure Time Physical Activity, Percent
Mills County, IA	10,811	2,054	17.5%
Iowa	2,366,312	489,670	19.7%
United States	232,759,569	47,072,403	19.5%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2021. → *Show more details*

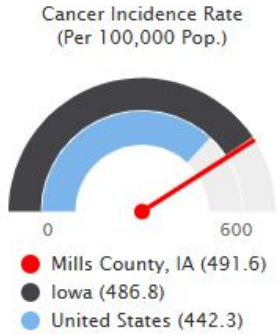
Cancer Incidence - All Sites

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older).

Within the report area, there were 100 new cases of cancer reported. This means there is a rate of 491.6 for every 100,000 total population.

Report Area	Estimated Total Population	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Population)
Mills County, IA	20,341	100	**491.6**
Iowa	3,943,508	19,197	486.8
United States	383,976,486	1,698,328	442.3

Note: This indicator is compared to the state average.
Data Source: State Cancer Profiles. 2016-20. ➞ *Show more details*



Top Five Most Commonly Diagnosed Cancers

The table below shows counts and age-adjusted incidence rates of the five most common newly diagnosed cancers by site for the 5-year period 2016-2020.

Area Name	Cancer Site	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Population)
Mills County, Iowa	1 - Breast (All Stages^), 2016-2020	17	159.3
Mills County, Iowa	2 - Lung & Bronchus (All Stages^), 2016-2020	15	69
Mills County, Iowa	3 - Prostate (All Stages^), 2016-2020	13	115.8
Mills County, Iowa	4 - Colon & Rectum (All Stages^), 2016-2020	9	48.2
Mills County, Iowa	5 - Bladder (All Stages^), 2016-2020	6	26.9
Iowa	1 - Breast (All Stages^), 2016-2020	2,642	134.7
Iowa	2 - Lung & Bronchus (All Stages^), 2016-2020	2,518	60.7
Iowa	3 - Prostate (All Stages^), 2016-2020	2,432	120.4
Iowa	4 - Colon & Rectum (All Stages^), 2016-2020	1,578	40.7
Iowa	5 - Melanoma of the Skin (All Stages^), 2016-2020	1,108	30.1
US	1 - Breast (All Stages^), 2016-2020	249,750	127
US	2 - Lung & Bronchus (All Stages^), 2016-2020	215,307	54
US	3 - Prostate (All Stages^), 2016-2020	212,734	110.5
US	4 - Colon & Rectum (All Stages^), 2016-2020	138,021	36.5
US	5 - Melanoma of the Skin (All Stages^), 2016-2020	83,836	22.5

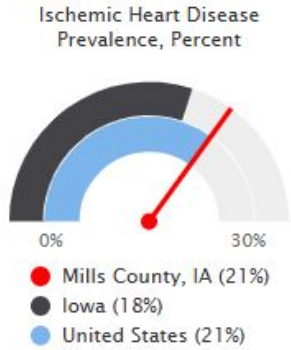
Data Source: State Cancer Profiles. 2016-20. → *Show more details*

Chronic Conditions - Heart Disease (Medicare Population)

This indicator reports the unsmoothed age-adjusted rate of ischemic heart disease prevalence for Medicare FFS population in 2022. Data were obtained from the CMS Mapping Medicare Disparities tool.

Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 (rate displayed as zero for such counties.)

Report Area	FFS Beneficiaries	Ischemic Heart Disease Prevalence, Total	Ischemic Heart Disease Prevalence, Percent
Mills County, IA	2,422	509	21%
Iowa	432,488	77,848	18%
United States	30,900,366	6,489,077	21%



Note: This indicator is compared to the state average.

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022. → *Show more details*

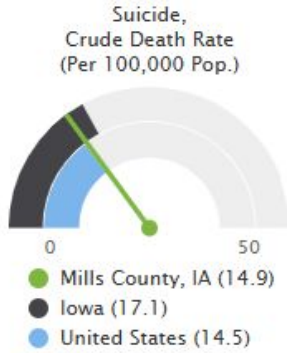
Mortality - Suicide

This indicator reports the 2018-2022 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

Within the report area, there are a total of 11 deaths due to suicide. This represents a crude death rate of 14.9 per every 100,000 total population.

Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Mills County, IA	14,791	11	14.9
Iowa	3,173,674	2,709	17.1
United States	330,014,476	239,493	14.5



Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2018-2022. → *Show more details*

Data Health Outcomes

		Mills, IA	Pottawattamie, IA	United States
		Remove Location ☐	Remove Location ☐	Remove Location ☐
Health Outcomes				
Length of Life		Mills, IA	Pottawattamie, IA	United States
Premature Death		8,000	8,800	8,000
Quality of Life		Mills, IA	Pottawattamie, IA	United States
Poor or Fair Health		12%	14%	14%
Poor Physical Health Days		2.9	3.3	3.3
Poor Mental Health Days		4.5	4.8	4.8
Low Birthweight		8%	8%	8%

Data Health Behaviors

Health Behaviors	Mills, IA	Pottawattamie, IA	United States
Adult Smoking	16%	18%	15%
Adult Obesity	37%	38%	34%
Food Environment Index	9.1	8.1	7.7
Physical Inactivity	22%	25%	23%
Access to Exercise Opportunities	63%	82%	84%
Excessive Drinking	22%	21%	18%

Data Health Behaviors

Health Behaviors		Mills, IA	Pottawattamie, IA	United States
Alcohol-Impaired Driving Deaths		63%	17%	26%
Sexually Transmitted Infections		242.0	521.9	495.5
Teen Births		10	20	17

Data Clinical Care

Clinical Care		Mills, IA	Pottawattamie, IA	United States
Uninsured		5%	6%	10%
Primary Care Physicians		1,810:1	2,220:1	1,330:1
Dentists		2,910:1	1,690:1	1,360:1
Mental Health Providers		1,320:1	430:1	320:1
Preventable Hospital Stays		3,384	2,660	2,681
Mammography Screening		52%	50%	43%
Flu Vaccinations		62%	58%	46%

Data Social and Economic Factors

Social & Economic Factors		Mills, IA	Pottawattamie, IA	United States
High School Completion		95%	91%	89%
Some College		78%	64%	68%
Unemployment		2.3%	2.8%	3.7%
Children in Poverty		11%	15%	16%
Income Inequality		3.7	4.3	4.9
Children in Single-Parent Households		14%	27%	25%
Social Associations		9.0	10.9	9.1
Injury Deaths		66	73	80

Data Physical Environment

Physical Environment		Mills, IA	Pottawattamie, IA	United States
Air Pollution - Particulate Matter		7.3	7.8	7.4
Drinking Water Violations		No	No	
Severe Housing Problems		10%	12%	17%
Driving Alone to Work		79%	82%	72%
Long Commute - Driving Alone		43%	25%	36%

Discussion

1. What stood out to you from the information presented? What surprised you?

2. Which data points or themes are consistent with what you are seeing/ hearing from the clients/ patients you serve?

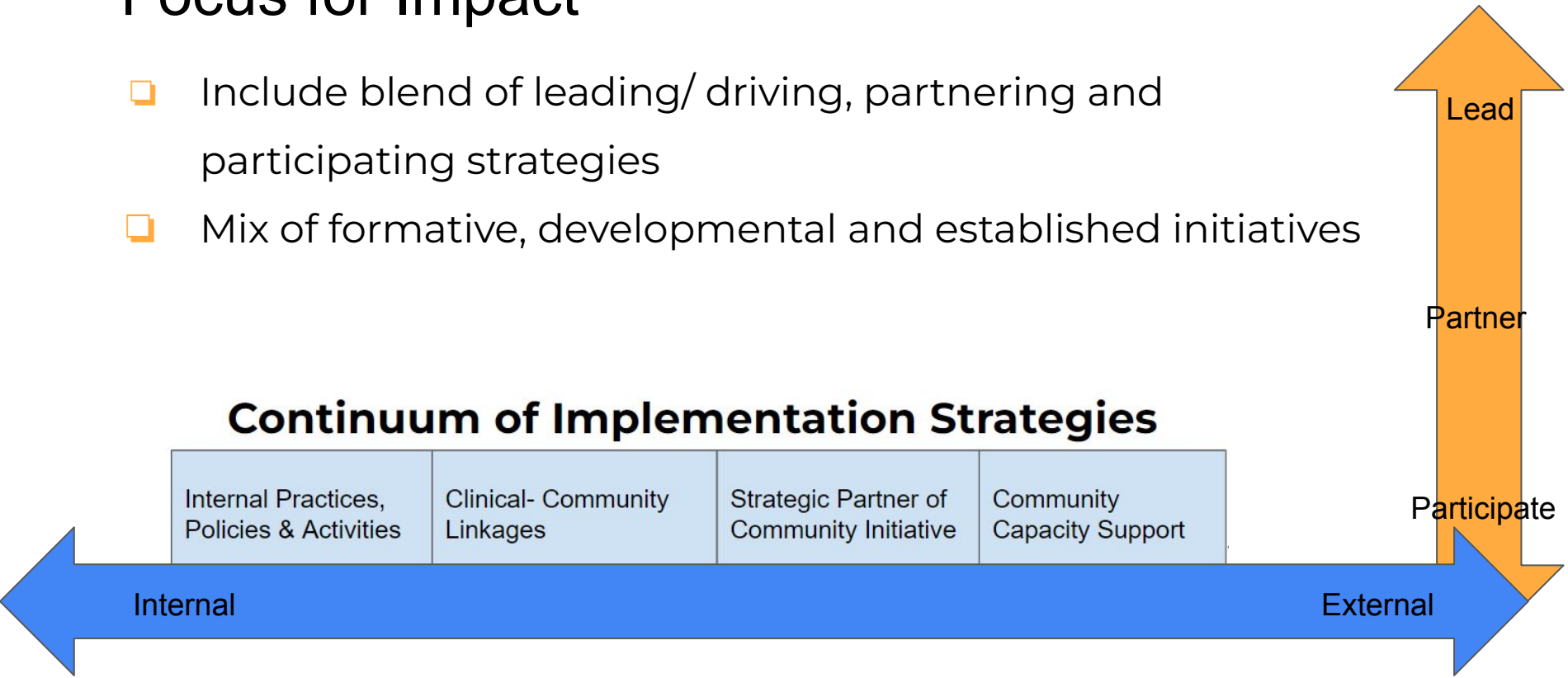
3. How can the hospital partner to close resource gaps and provide greater impact?What's working well? (What services/ partnerships/ programs can be expanded on?)Where are we encountering challenges?

4. Are there any emerging issues that we should consider elevating as a priority for collective action?

5. Is there any other data we should take into consideration in determining hospital priorities for action/ partnership?

Focus for Impact

- Include blend of leading/ driving, partnering and participating strategies
- Mix of formative, developmental and established initiatives



CHI Health Behavioral Health Care Services

For more than three decades, CHI Health Behavioral Care has led the region in providing specialized psychiatric and chemical dependency services. Our programs and services are specially tailored to provide effective, individualized care.

Information and Referral Line - (402) 717-HOPE

Problems don't always occur on a 9 to 5 schedule. That's why CHI Health Psychiatric Associates has experienced staff available 24 hours a day, seven days a week.

The Information and Referral Line, (402) 717-HOPE (4673), and the Psychiatric Assessment Center are always available for individuals seeking psychiatric services or information. Our clinical staff will help the caller identify and access the appropriate psychiatric services.

An initial assessment of the caller's needs will be conducted over the phone and assistance is given to the caller.

In the Kearney, NE area, call 1 (800) 930-0031 for the 24/7 Access Center.

Mental Health Care for All Ages

- Child and Adolescent Care
- Adult Care
- Senior Care

Comprehensive Levels of Mental Health Care

- Outpatient
- Integrated
- Intensive Outpatient
- Partial Hospitalization
- Inpatient
- Residential Treatment
- Employee Assistance Program

Setting Priorities

- General Guidelines:
  - severity of the health issue
  - population impacted (making special consideration to **disparities and vulnerable populations**)
  - trends in the data
  - existing partnerships
  - available resources
  - hospital's level of expertise
  - existing initiatives (or lack thereof)
  - potential for impact
  - community's interest in the hospital engaging in that health area

Questions?

Thank you!