Executive Report

2015 Community Health Needs Assessment

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

Sponsored by:

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

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Introduction

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Project Overview

Project Goals

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

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

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

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

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

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

Methodology

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

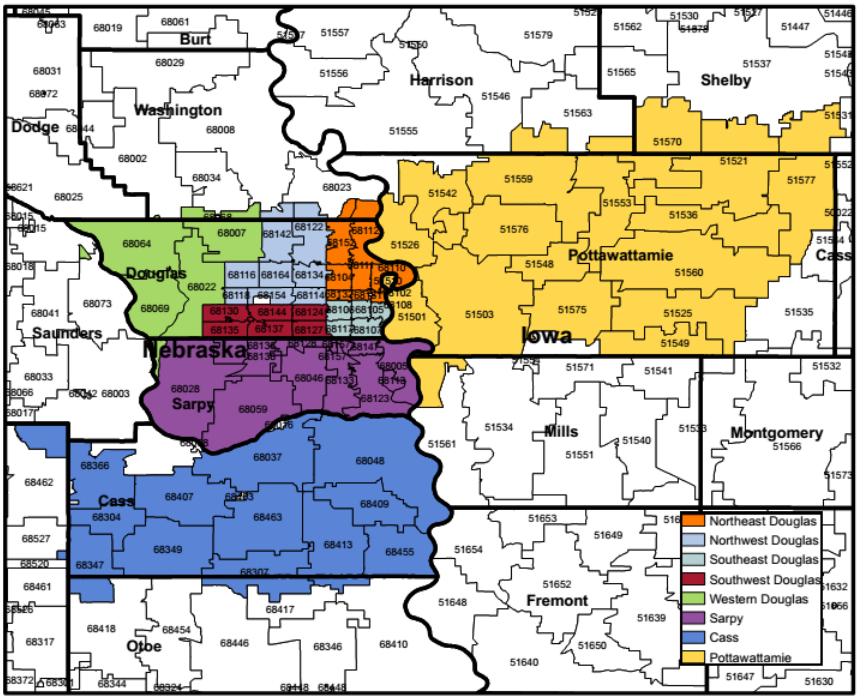
PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

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



Sample Approach & Design

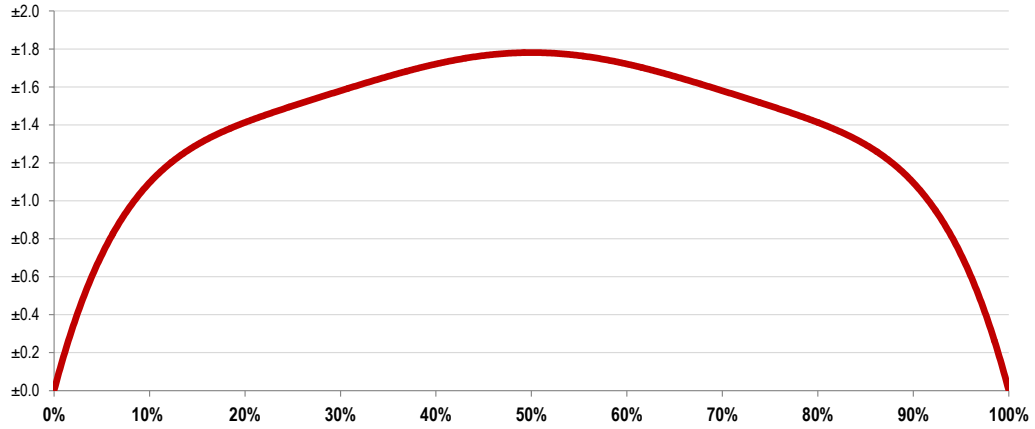
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews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

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

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

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

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



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

Examples:
- If 10% of the sample of 2,622 respondents answered a certain question with a "yes," it can be asserted that between 8.9% and 11.1% (10% ± 1.1%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 48.2% and 51.8% (50% ± 1.8%) of the total population would respond "yes" if asked this question.

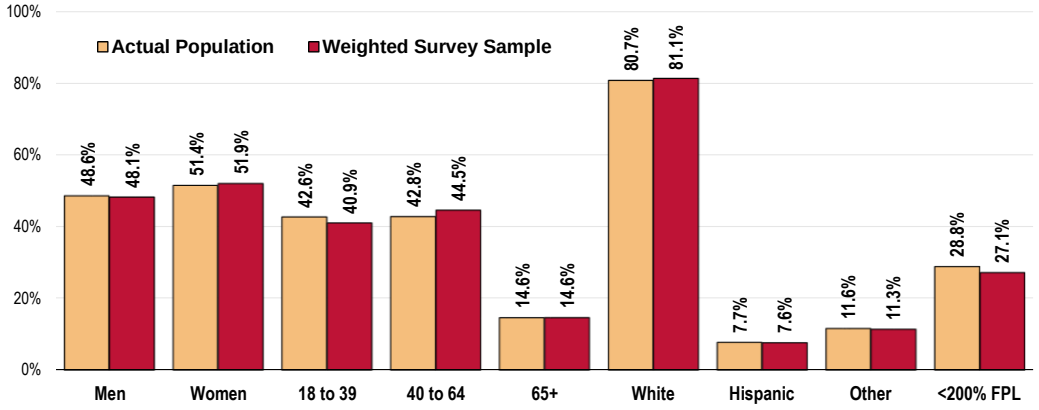
Sample Characteristics

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

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

Population & Survey Sample Characteristics

(Metro Area, 2015)



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

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

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

Online Key Informant Survey

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

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

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

Final participation included representatives of the organizations outlined below.

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

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

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

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

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

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

Public Health, Vital Statistics & Other Data

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

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

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

Benchmark Data

Trending

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

Nebraska & Iowa Risk Factor Data

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

Nationwide Risk Factor Data

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

Healthy People 2020

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

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

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

Determining Significance

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

Information Gaps

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

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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

Summary of Findings

Significant Health Needs of the Community

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

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	• Barriers to Access: Difficultly Finding a Physician

Cancer	• Cancer Deaths
	  ○ Including Lung Cancer, Prostate Cancer, Colorectal Cancer Deaths
	• Cancer Incidence
	  ○ Including Female Breast Cancer, Lung Cancer, Colorectal Cancer Incidence
	• Cervical Cancer Screening

Dementia, Including Alzheimer's Disease	• Alzheimer's Disease Deaths
Diabetes	• Diabetes Deaths • *Diabetes ranked as a top concern in the Online Key Informant Survey.*
Heart Disease & Stroke	• Stroke Prevalence • *Heart Disease & Stroke ranked as a top concern in the Online Key Informant Survey.*
Injury & Violence	• Safety Seat/Seat Belt Usage [Children] • Firearm-Related Deaths • Homicide Deaths • Violent Crime Rate & Victimization • *Injury & Violence ranked as a top concern in the Online Key Informant Survey.*
Mental Health	• *Mental Health ranked as a top concern in the Online Key Informant Survey.*
Nutrition, Physical Activity & Weight	• Overweight Prevalence [Adults] • Use of Local Trails • Children's Physical Activity • Access to Recreation/Fitness Facilities • *Nutrition, Weight, and Physical Activity ranked as a top concern in the Online Key Informant Survey.*

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Areas of Opportunity *(continued)*	
Respiratory Diseases	• Chronic Lower Respiratory Disease (CLRD) Deaths
Sexually Transmitted Diseases	• Gonorrhea Incidence • Chlamydia Incidence • Multiple Sexual Partners • *Sexually Transmitted Diseases ranked as a top concern in the Online Key Informant Survey.*
Substance Abuse	• Cirrhosis/Liver Disease Deaths • Drug-Induced Deaths • Seeking Help for Alcohol/Drug Issues

Summary Tables: Comparisons With Benchmark Data

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

Reading the Summary Tables

TREND SUMMARY (Current vs. Baseline Data)

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

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

In the following charts, Metro Area results are shown in the larger, blue column.

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

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

The columns to the right of the Metro Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the Metro Area compares favorably (☼), unfavorably (☁), or comparably (⛅) to these external data.

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

Social Determinants	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Linguistically Isolated Population (Percent)						4.2	1.9	0.2	1.9	3.3	1.8	3.0	4.8		
Population in Poverty (Percent)						14.3	6.6	6.4	13.8	12.4	12.4	12.8	15.4		
Population Below 200% FPL (Percent)						31.9	19.4	19.6	30.8	28.8	30.4	31.6	34.2		
Children Below 200% FPL (Percent)						40.6	26.1	25.9	40.9	37.0	37.9	40.2	43.8		
No High School Diploma (Age 25+, Percent)						10.5	5.1	6.0	10.7	9.3	9.0	9.6	14.0		
Unemployment Rate (Age 16+, Percent)										3.2	3.5	3.0	5.6		4.4

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

better similar worse

Overall Health	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% "Fair/Poor" Physical Health	15.6	17.6	7.1	7.9	7.0	11.2	6.7	15.6	14.8	10.9	14.4	13.9	15.3		12.7
% Activity Limitations	22.2	18.6	13.8	17.2	13.6	17.5	17.5	16.1	26.1	18.5	19.1	18.8	21.5		18.4

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

better similar worse

Access to Health Services	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% [Age 18-64] Lack Health Insurance	21.6	19.6	4.5	2.6	6.1	10.8	5.3	8.2	6.5	9.1	12.7	17.6	15.1	0.0	12.1
% [Insured] Went Without Coverage in Past Year	10.7	9.2	5.5	4.2	1.7	6.5	5.4	3.3	5.4	6.0			8.1		5.5
% Difficulty Accessing Healthcare in Past Year (Composite)	42.2	39.3	34.2	34.2	25.2	36.4	26.4	31.4	33.4	33.9			39.9		33.4
% Inconvenient Hrs Prevented Dr Visit in Past Year	17.3	12.2	12.9	16.8	5.1	14.4	11.6	12.1	15.2	13.9			15.4		12.5
% Cost Prevented Getting Prescription in Past Year	20.4	14.2	12.6	11.5	9.3	14.1	7.0	6.0	13.8	12.4			15.8		14.3
% Cost Prevented Physician Visit in Past Year	22.0	9.7	8.9	13.6	6.4	13.1	8.4	12.4	14.3	12.3			18.2		14.5
% Difficulty Getting Appointment in Past Year	16.3	16.3	10.4	11.9	9.0	13.2	8.0	14.4	13.1	12.2			17.0		10.5
% Difficulty Finding Physician in Past Year	13.0	11.3	9.0	10.1	2.3	10.3	6.1	11.0	8.6	9.3			11.0		6.6
% Cultural/Language Differences Prevented Med Care/Past Yr	0.8	1.5	0.6	0.6	0.0	0.8	0.0	0.0	0.2	0.5					
% Transportation Hindered Dr Visit in Past Year	13.8	9.1	1.8	3.0	1.3	6.1	1.9	6.0	5.9	5.3			9.4		4.7
% [Sarpy/Cass/Pott.] Traveled 30+ Min for Medical Appt/Past Yr							7.8	39.7	19.0	14.6					19.6

Access to Health Services (continued)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Skipped Prescription Doses to Save Costs	23.2	12.4	12.3	12.9	5.7	14.5	8.6	13.7	17.8	13.7			15.3		13.6
Primary Care Doctors per 100,000						98.4	51.9	31.8	46.3	81.0	72.7	71.2	74.5		
% Have a Particular Place for Medical Care	87.6	80.3	85.1	84.7	90.9	84.9	86.7	84.0	89.5	85.8			76.3		86.3
% Difficulty Getting Child's Healthcare in Past Year	11.8	2.8	0.9	1.4	0.0	3.5	2.6	1.0	4.5	3.3			6.0		1.9
% Have Had Routine Checkup in Past Year	64.7	67.9	65.3	64.4	57.1	65.0	71.2	67.4	72.1	67.1	69.6	61.6	65.0		66.8
% Child Has Had Checkup in Past Year	85.0	84.1	85.9	83.5	90.2	85.0	88.3	89.9	88.0	86.3			84.1		87.8
% Two or More ER Visits in Past Year	10.2	6.8	2.5	2.4	4.8	5.1	2.5	2.7	10.9	5.2			8.9		4.9
% Rate Local Healthcare "Fair/Poor"	18.6	13.2	6.9	5.0	4.4	9.9	7.4	14.8	13.4	10.1			16.5		8.9

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

better similar worse

Arthritis, Osteoporosis & Chronic Back Conditions	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% [50+] Arthritis/Rheumatism	37.2	30.1	28.1	24.5	27.5	29.4	27.3	20.9	39.2	30.1			37.3		32.5
% [50+] Osteoporosis	12.1	9.4	8.9	5.2	5.4	8.4	8.3	9.4	10.2	8.7			13.5	5.3	9.6
% Sciatica/Chronic Back Pain	22.7	13.0	18.5	14.7	19.7	17.3	12.2	14.0	17.0	16.2			18.4		15.1

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better similar worse

Cancer	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Cancer (Age-Adjusted Death Rate)						180.5	167.6	176.4	184.2	178.5	170.0	163.4	166.2	161.4	189.6
Lung Cancer (Age-Adjusted Death Rate)										51.4	46.6	42.7	44.7	45.5	
Prostate Cancer (Age-Adjusted Death Rate)										22.3	20.0	21.6	19.8	21.8	
Female Breast Cancer (Age-Adjusted Death Rate)										21.9	19.6	20.2	21.3	20.7	
Colorectal Cancer (Age-Adjusted Death Rate)										16.7	16.3	16.0	14.9	14.5	
Prostate Cancer Incidence per 100,000						140.1	136.7	117.6	115.7	135.0	133.3	136.6	142.3		

Cancer (continued)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Female Breast Cancer Incidence per 100,000						132.5	124.8	121.3	139.7	131.8	124.8	121.8	122.7		
Lung Cancer Incidence per 100,000						72.5	64.9	67.5	90.4	73.8	66.8	60.0	64.9		
Colorectal Cancer Incidence per 100,000						47.6	46.3	50.0	54.3	48.5	48.4	48.4	43.3		
Cervical Cancer Incidence per 100,000						6.7	5.7		6.5	6.5	6.8	7.2	7.8		
% Skin Cancer	3.2	2.0	5.2	6.8	5.0	4.6	5.3	10.6	6.2	5.1	6.1	5.9	6.7		5.3
% Cancer (Other Than Skin)	6.2	3.3	2.9	4.9	6.7	4.5	5.5	8.5	8.0	5.2	7.1	6.8	6.1		5.8
% [Women 50-74] Mammogram in Past 2 Years	76.5	79.3	86.3	78.0	86.9	80.2	85.4	78.0	73.6	80.2	78.2	72.9	83.6	81.1	82.3
% [Women 21-65] Pap Smear in Past 3 Years	69.4	82.6	80.0	81.6	82.3	78.8	85.3	77.6	75.7	79.7	78.0	76.6	83.9	93.0	86.7
% [Age 50-75] Colorectal Cancer Screening	73.5	61.7	84.9	78.6	75.3	75.6	72.8	72.1	71.6	74.4			75.1	70.5	75.3

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better similar worse

Chronic Kidney Disease	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Kidney Disease (Age-Adjusted Death Rate)						12.2	11.8		9.9	11.6	8.2	9.8	13.2		13.0
% Kidney Disease	3.0	4.5	1.0	1.5	3.8	2.4	1.6	3.8	2.8	2.3	2.2	2.0	3.0		

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better similar worse

Dementias, Including Alzheimer's Disease	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Alzheimer's Disease (Age-Adjusted Death Rate)						26.3	25.3	33.9	36.9	28.1	30.3	24.7	24.0		23.9

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

better similar worse

Diabetes	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Diabetes Mellitus (Age-Adjusted Death Rate)						23.3	18.6		26.5	22.7	18.8	21.4	21.3	20.5	23.4
% Diabetes/High Blood Sugar	13.4	12.7	7.3	6.2	8.9	9.5	7.9	11.2	11.0	9.4	9.3	9.2	11.7		10.6
% Borderline/Pre-Diabetes	5.0	5.0	7.7	4.5	6.2	5.6	3.6	4.9	5.8	5.2			5.1		
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	45.2	51.0	51.1	48.6	61.4	49.7	48.6	48.4	50.3	49.5			49.2		

Diabetes (continued)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% [Diabetics] Taking Insulin/Medication										82.4			80.4		83.4

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better similar worse

Educational & Community-Based Programs	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Attended Health Event in Past Year	27.1	24.8	23.6	20.9	32.9	24.3	27.7	18.5	22.4	24.6			23.8		23.8
% "Frequently/Sometimes" Use Email/Text w/Dr or Hospital	22.7	22.5	28.3	24.2	22.5	24.4	25.6	25.3	20.3	24.2					11.6
% Have a Completed Advance Directive/Living Will	28.5	21.5	33.9	36.5	46.0	31.7	33.0	29.7	31.8	31.9					29.2
% Health Info is Seldom/Never Easy to Understand	10.4	10.2	4.5	2.9	1.6	6.3	5.4	6.1	4.4	6.0					
% Always/Nearly Always Need Someone to Help Read Health Info	3.2	4.0	6.6	2.3	0.5	3.8	1.4	3.8	3.5	3.3					
% Health Info is Seldom/Never Spoken in an Easily Understood Way	10.4	10.2	4.5	2.9	1.6	6.3	5.4	6.1	4.4	5.9					
% "Not At All Confident" About Filling Out Health Forms	1.4	2.8	3.9	2.0	1.0	2.4	2.1	5.9	1.8	2.4					

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better similar worse

Family Planning	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Births to Teenagers (Percent)						6.3	4.0			5.6	6.5	6.4	7.8		8.2

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Hearing & Other Sensory or Communication Disorders	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Deafness/Trouble Hearing	8.1	7.5	5.8	7.9	6.7	7.3	8.4	9.3	15.9	8.6			10.3		9.8

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Heart Disease & Stroke	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)						151.5	139.5	150.1	165.7	151.3	168.4	147.2	171.3	156.9	184.5
Stroke (Age-Adjusted Death Rate)						40.8	38.7	29.2	29.3	38.2	34.3	36.0	37.0	34.8	47.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	4.8	4.8	3.7	5.9	4.1	4.8	5.2	4.1	6.9	5.1			6.1		5.2
% Stroke	3.1	5.4	3.8	3.1	3.1	3.7	1.3	0.3	5.5	3.4	2.8	2.5	3.9		2.3

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better similar worse

HIV	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
HIV/AIDS (Age-Adjusted Death Rate)										1.3	0.7	0.9	2.2	3.3	1.9
HIV Prevalence per 100,000						238.3	81.7	61.8	96.5	184.9	68.1	115.1	340.4		
% [Age 18-44] HIV Test in the Past Year	33.1	25.9	14.9	13.4	12.1	20.5	10.6	7.7	17.7	18.0			19.3		16.1

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Immunization & Infectious Diseases	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Have Completed Hepatitis B Vaccination Series	40.5	41.9	45.7	37.9	51.3	41.9	50.9	40.8	37.6	43.0			44.7		28.9

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

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Injury & Violence Prevention	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Unintentional Injury (Age-Adjusted Death Rate)						32.1	29.3	42.3	38.2	32.5	39.8	36.1	39.2	36.4	31.2
Motor Vehicle Crashes (Age-Adjusted Death Rate)						6.6	5.5		9.9	7.1	11.1	11.4	10.7	12.4	9.6

Injury & Violence Prevention (continued)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Perceive Neighborhood as "Slightly/Not At All Safe"	40.3	35.8	18.5	7.3	2.7	22.4	5.4	3.5	17.9	18.0					17.4
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	91.7	80.0	83.8	92.9	95.9	88.3	97.0	88.1	93.3	91.0			92.2		93.9
% Child [Age 5-17] "Always" Wears Bicycle Helmet	33.2	35.3	47.1	51.6	50.6	44.6	50.2	24.0	24.3	42.9			48.7		43.5
Firearm-Related Deaths (Age-Adjusted Death Rate)						11.2	5.1		10.4	10.0	7.4	9.0	10.4	9.3	8.3
% Firearm in Home	21.3	15.5	28.3	32.3	44.9	26.2	33.8	60.9	39.0	30.2			34.7		33.7
% [Homes With Children] Firearm in Home	12.1	8.2	29.4	32.1	37.8	23.2	34.3	64.8	42.9	29.2			37.4		32.3
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	27.0	8.2	5.5	12.0	8.3	12.1	7.3	11.6	17.0	11.8			16.8		10.4
Homicide (Age-Adjusted Death Rate)										6.2	2.0	3.8	5.3	5.5	4.1
Violent Crime per 100,000						477.7	66.9	72.3	789.9	418.8	266.0	273.6	395.5		
% Victim of Violent Crime in Past 5 Years	9.2	5.9	3.6	3.1	0.2	4.9	0.7	0.8	1.7	3.6			2.8		2.5
% Intimate Partner Was Controlling/Harassing in Past 5 Yrs	5.8	7.6	1.6	2.0	0.5	3.7	3.6	4.8	8.7	4.4					6.4

Injury & Violence Prevention (continued)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks					
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Victim of Domestic Violence (Ever)	16.9	12.8	11.7	9.3	3.2	11.9	8.1	11.0	15.6	11.6			15.0		12.0

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better similar worse

Maternal, Infant & Child Health	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks					
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
No Prenatal Care in First Trimester (Percent)						27.5	21.8			26.2	23.5	26.4		22.1	29.6
Low Birthweight Births (Percent)						7.5	6.1			7.2	6.6	6.6	8.0	7.8	7.6
Infant Death Rate						5.5	4.4		5.4	5.2	4.8	5.2	6.0	6.0	6.4

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

better similar worse

Mental Health & Mental Disorders	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks					
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% "Fair/Poor" Mental Health	12.7	12.8	9.7	8.3	2.6	10.1	7.0	9.0	17.1	10.3			11.9		9.0
% Symptoms of Chronic Depression (2+ Years)	26.9	26.7	21.5	25.2	12.9	24.3	21.4	16.1	30.4	24.2			30.4		25.1

Mental Health & Mental Disorders (cont.)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Suicide (Age-Adjusted Death Rate)						9.1	8.5		18.1	10.1	13.7	11.5	12.5	10.2	10.6
% Major Depression	11.1	11.0	12.4	9.2	4.9	10.5	5.5	6.2	11.8	9.5					10.1
% [Those w/Major Depression] Seeking Help										89.9					88.7
% Typical Day Is "Extremely/Very" Stressful	8.6	13.1	12.2	11.0	10.3	11.1	8.2	12.2	10.1	10.5			11.9		11.5

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better similar worse

Nutrition, Physical Activity & Weight	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Eat 5+ Servings of Fruit or Vegetables per Day	36.7	36.7	42.4	37.4	43.1	38.7	40.5	34.8	33.9	38.3			39.5		35.8
% Had 7+ Sugar-Sweetened Drinks in the Past Week	29.6	22.2	22.6	21.5	16.8	23.4	22.0	31.1	23.5	23.4					28.3
% [Child 0-17] Had 7+ Sugar-Sweetened Drinks/Past Week	17.2	31.2	24.7	12.4	16.6	20.0	27.6	31.6	30.6	23.2					
% "Very/Somewhat" Difficult to Buy Fresh Produce	24.3	23.3	12.8	12.0	11.7	17.0	16.4	19.5	20.0	17.4			24.4		22.8
Population With Low Food Access (Percent)						15.6	42.8	30.0	34.8	23.7	22.7	25.9	23.6		

Nutrition, Physical Activity & Weight (cont.)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Medical Advice on Nutrition in Past Year	36.6	41.8	37.7	35.6	43.8	38.0	40.4	41.6	39.3	38.7			39.2		38.4
% Healthy Weight (BMI 18.5-24.9)	25.0	35.4	31.3	32.2	32.4	31.1	33.6	26.9	22.9	30.4	31.6	32.5	34.4	33.9	31.0
% Overweight (BMI 25+)	70.9	61.1	67.4	67.2	65.9	66.8	66.0	71.7	75.4	67.8	67.0	65.5	63.1		67.5
% Obese (BMI 30+)	32.6	30.9	33.4	21.7	35.2	29.4	29.8	35.3	41.0	31.1	31.3	29.6	29.0	30.5	30.3
% "Often/Sometimes" Worry That Food Will Run Out	34.5	33.3	21.7	12.6	3.8	23.0	13.8	12.2	19.5	20.4					18.8
% Medical Advice on Weight in Past Year	23.8	26.3	20.5	21.8	35.3	23.5	26.8	25.4	27.5	24.7			23.7		26.2
% [Overweights] Counseled About Weight in Past Year	27.6	38.4	26.9	28.6	48.0	30.8	36.9	30.9	29.5	31.7			31.8		
% [Obese Adults] Counseled About Weight in Past Year	43.2	53.3	36.3	44.8	52.8	44.3	55.7	42.1	43.3	46.2			48.3		
% [Overweights] Trying to Lose Weight Both Diet/Exercise	36.3	36.8	42.5	50.8	46.9	42.8	44.9	40.9	42.6	43.1			39.5		
% Child [Age 5-17] Healthy Weight	53.5	62.4	55.2	73.4	58.1	62.5	53.6	66.7	57.5	59.8			56.7		
% Children [Age 5-17] Overweight (85th Percentile)	34.5	23.4	24.2	13.1	32.8	22.6	34.9	20.9	29.5	26.3			31.5		29.4

Nutrition, Physical Activity & Weight (cont.)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Children [Age 5-17] Obese (95th Percentile)	22.9	14.6	13.2	6.0	10.6	12.3	20.0	12.3	17.0	14.7			14.8	14.5	13.2
% [Employed] Job Entails Mostly Sitting/Standing	56.4	57.0	59.9	70.2	69.5	62.6	65.3	66.2	53.6	62.2			63.8		65.4
% No Leisure-Time Physical Activity	19.5	22.6	20.3	14.6	13.2	18.5	13.6	17.4	22.5	18.0	28.5	25.3	20.7	32.6	16.7
% Meeting Physical Activity Guidelines	48.8	51.4	55.0	57.3	56.9	53.8	53.9	49.3	46.4	52.7			50.3		52.4
% Moderate Physical Activity	31.9	33.6	28.3	34.6	35.6	32.4	26.3	33.1	27.8	30.6			30.6		30.7
% Vigorous Physical Activity	37.1	41.6	41.7	45.8	45.0	42.1	45.2	35.7	35.1	41.6			38.0		43.7
Recreation/Fitness Facilities per 100,000						15.7	9.4	4.0	9.7	13.3	11.8	11.9	9.7		
% Have Access to Indoor Exercise Equipment	68.8	67.6	85.7	80.8	84.1	77.0	86.6	68.9	75.2	78.4					75.0
% Medical Advice on Physical Activity in Past Year	37.6	48.2	39.5	43.5	49.2	42.5	42.8	44.6	40.8	42.4			44.0		43.1
% [Child 0-4] Ever Breastfed/Fed Breast Milk										86.6					84.3
% [Child 5-17] Compliance w/All "5-4-3-2-1 Go!" Guidelines	9.1	0.9	4.4	5.0	5.7	5.0	3.3	1.9	5.4	4.6					3.4

Nutrition, Physical Activity & Weight (cont.)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area	Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% [Child 5-17] Eats 5+ Fruits/Vegetables Daily	31.9	29.7	32.1	26.0	27.7	29.4	34.4	33.7	35.6	31.4					22.9
% [Child 5-17] Drinks 4+ Glasses of Water Daily	76.0	56.7	68.0	66.7	72.1	67.4	67.0	66.0	65.5	67.0					61.7
% [Child 5-17] Eats 3+ Servings of Low-Fat Dairy Daily	34.7	62.8	56.6	51.1	58.7	52.1	47.0	65.8	46.9	50.7					52.8
% [Child 5-17] Spends <2 Hrs on Screen Time Daily	9.1	8.0	12.6	12.8	13.1	11.3	13.5	18.2	13.1	12.2					10.2
% [Child 5-17] Exercises for 1+ Hours Daily	53.9	50.6	53.9	49.8	64.9	52.9	57.7	65.4	67.4	56.0					64.0
% [Child 5-17] Walks/Bikes to School Most Days	11.5	24.1	8.2	16.7	12.5	14.4	14.8	10.7	14.1	14.4					10.2
% Child [Age 2-17] Physically Active 1+ Hours per Day	53.9	50.6	53.9	49.8	64.9	52.9	57.7	65.4	67.4	56.0			48.6		
% Use Local Parks/Recreation Centers at Least Weekly	43.4	42.4	44.0	45.3	40.2	43.7	49.7	27.4	33.1	43.1					40.5
% Use Local Trails at Least Monthly	33.4	44.0	44.6	50.4	44.5	43.7	51.6	39.4	40.7	44.8					49.8
% Believe Schools Should Require PE for All Students	96.9	96.5	97.4	96.4	93.6	96.6	97.9	93.6	96.9	96.8					96.6
% Lack of Sidewalks/Poor Sidewalks Prevent Exercise	37.8	20.8	12.2	16.6	20.4	21.1	10.0	31.8	27.8	20.1					

Nutrition, Physical Activity & Weight (cont.)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Lack of Trails/Poor Quality Trails Prevent Exercise	29.1	15.2	7.1	9.8	17.6	14.8	5.0	19.8	13.7	12.9					
% Heavy Traffic in Neighborhood Prevents Exercise	29.7	19.7	23.5	10.7	8.9	19.6	8.1	14.0	15.9	16.7					
% Lack of Street Lights/Poor Street Lights Prevent Exercise	19.0	6.1	5.4	6.1	10.0	8.9	4.2	24.9	16.7	9.4					
% Crime Prevents Exercise in Neighborhood	33.9	20.4	9.2	2.4	3.5	14.5	2.4	0.9	8.6	11.0					

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

better similar worse

Oral Health	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% [Age 18+] Dental Visit in Past Year	61.4	66.4	75.3	80.9	83.6	72.7	80.1	70.1	70.5	73.8	71.1	67.6	65.9	49.0	70.4
% Child [Age 2-17] Dental Visit in Past Year	88.4	89.8	87.0	86.2	89.7	87.7	91.7	91.4	87.5	88.7			81.5	49.0	86.2
% Have Dental Insurance	63.0	62.6	75.9	71.5	76.8	69.3	84.0	69.4	73.4	72.7			65.6		70.1

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

better similar worse

Respiratory Diseases	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
CLRD (Age-Adjusted Death Rate)						51.3	42.6	44.6	57.5	50.4	47.4	49.0	42.0		53.2
Pneumonia/Influenza (Age-Adjusted Death Rate)						14.9	15.9		14.3	14.7	16.4	13.8	15.3		20.8
% COPD (Lung Disease)	9.2	6.0	6.4	12.2	3.7	8.4	6.9	4.0	9.4	8.1	6.3	5.3	8.6		7.4
% [Adult] Currently Has Asthma	12.5	5.3	10.8	7.1	3.3	8.6	5.1	6.8	9.6	8.0	7.8	7.3	9.4		8.6
% Child [Age 0-17] Asthma (Ever Diagnosed)	7.1	8.6	11.7	5.9	12.8	8.7	8.0	8.8	9.7	8.6			12.5		7.9

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

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Sexually Transmitted Diseases	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Gonorrhea Incidence per 100,000						149.9	43.1	31.8	101.6	119.1	65.5	77.0	107.5		
Chlamydia Incidence per 100,000						588.3	326.0	218.4	425.6	505.0	371.5	366.2	456.7		
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	4.4	12.8	2.2	0.0	0.0	5.0	7.3	3.1	8.9	5.8			11.7		3.3

Sexually Transmitted Diseases (continued)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% [Unmarried 18-64] Using Condoms	36.9	48.2	48.5	21.2	34.3	38.5	40.3	47.2	31.2	38.0			33.6		19.5

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

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Substance Abuse	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)						10.3	5.7		7.9	8.7	7.8	7.9	9.9	8.2	6.6
% Keep Medications Locked Up	22.6	18.8	16.8	12.4	11.4	16.9	15.9	9.6	18.3	16.6					
% Have Ever Shared Prescription Medication	4.6	8.9	5.5	6.2	5.2	6.2	4.0	10.6	4.5	5.7					
% Took Someone Else's Prescription Meds in the Past Month	1.3	3.5	1.2	0.7	1.2	1.5	0.9	1.0	1.5	1.4					
% Used an Illegal Drug in the Past Month	6.5	4.7	7.0	2.8	0.0	4.9	0.9	3.9	3.4	3.9					
% Drinking & Driving in Past Month	2.7	3.3	7.2	4.0	5.1	4.4	5.3	8.2	5.1	4.8			5.0		5.8
Drug-Induced Deaths (Age-Adjusted Death Rate)						9.5	6.8		14.6	9.6	9.2	7.9	14.1	11.3	7.1

Substance Abuse (continued)	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Ever Sought Help for Alcohol or Drug Problem	5.0	5.3	3.1	2.1	2.4	3.6	1.9	2.1	6.2	3.5			4.9		3.9

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

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Tobacco Use	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)									Metro Area vs. Benchmarks				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County	Metro Area	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
% Current Smoker	22.5	18.3	14.6	14.2	9.6	16.6	12.1	18.0	26.5	17.0	19.5	18.5	14.9	12.0	
% Someone Smokes at Home	16.1	13.4	11.9	6.1	6.0	11.1	5.5	14.2	18.5	11.0			12.7		15.1
% [Non-Smokers] Someone Smokes in the Home	4.3	3.6	5.6	0.9	3.2	3.4	3.2	8.6	4.1	3.6			6.3		
% [Household With Children] Someone Smokes in the Home	13.6	8.4	5.3	5.0	0.9	7.1	2.9	19.8	12.4	7.2			9.7		9.3
% [Smokers] Received Advice to Quit Smoking										70.6			67.8		
% Currently Use Electronic Cigarettes (E-Cigarettes)	7.3	7.6	6.1	6.5	3.4	6.5	3.7	2.8	5.0	5.8					
% Use Smokeless Tobacco	1.5	0.3	4.6	3.0	1.7	2.5	2.3	8.0	4.9	3.0	4.9	5.3	4.0	0.3	

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

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Vision	Each County vs. Others (Douglas County Sub-County Areas vs. Other Sub-County Areas)								
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County
% Eye Exam in Past 2 Years	55.0	49.7	60.0	58.9	49.0	56.0	57.1	54.2	55.6

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

Metro Area	Metro Area vs. Benchmarks				
	vs. IA	vs. NE	vs. US	vs. HP2020	TREND
56.1			56.8		55.9

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Community Description

Professional Research Consultants, Inc.

Population Characteristics

Total Population

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

Total Population
(Estimated Population, 2009-2013)

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

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

Population Change 2000-2010

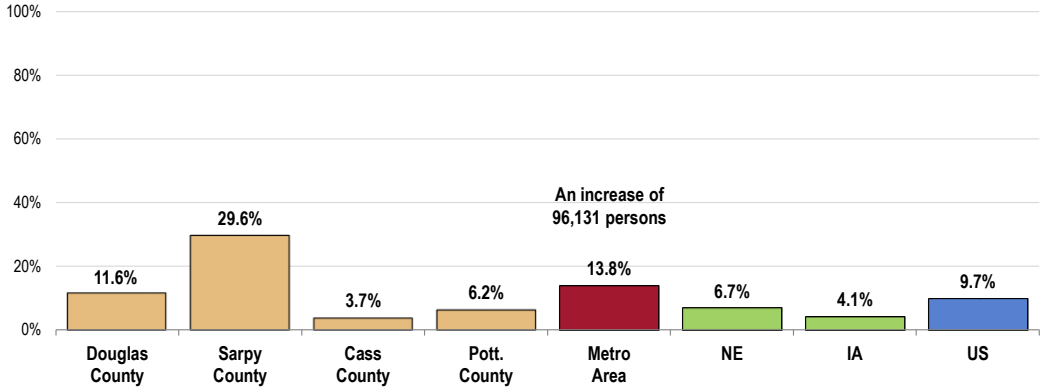
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

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

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

Change in Total Population

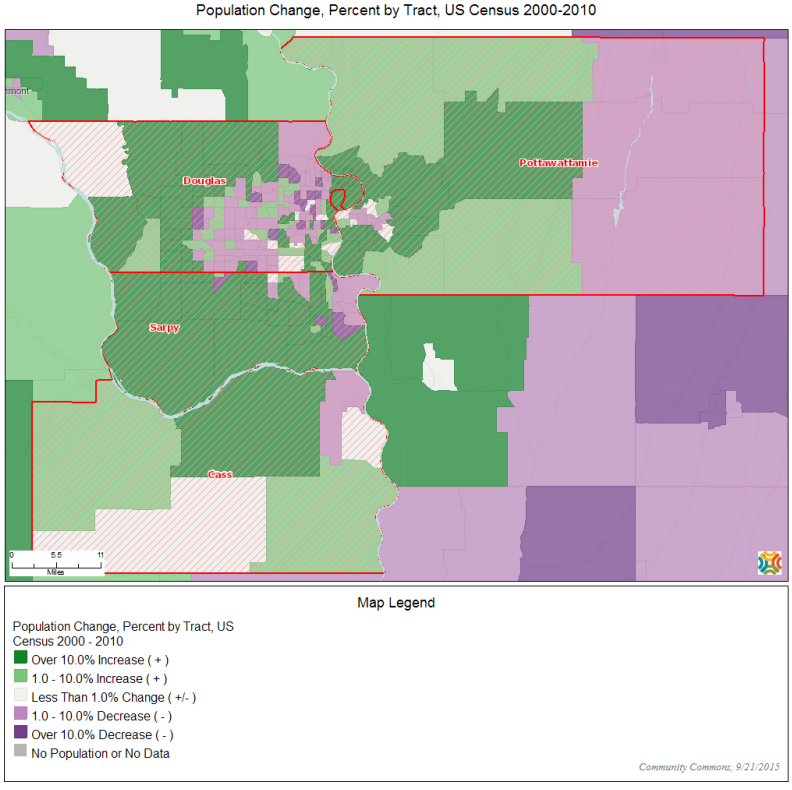
(Percentage Change Between 2000 and 2010)



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

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

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



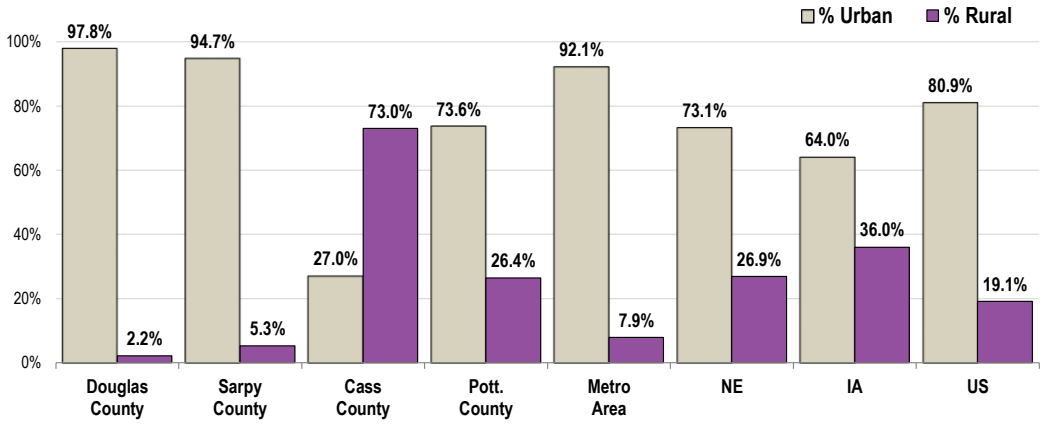
Urban/Rural Population

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

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

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

Urban and Rural Population
(2010)

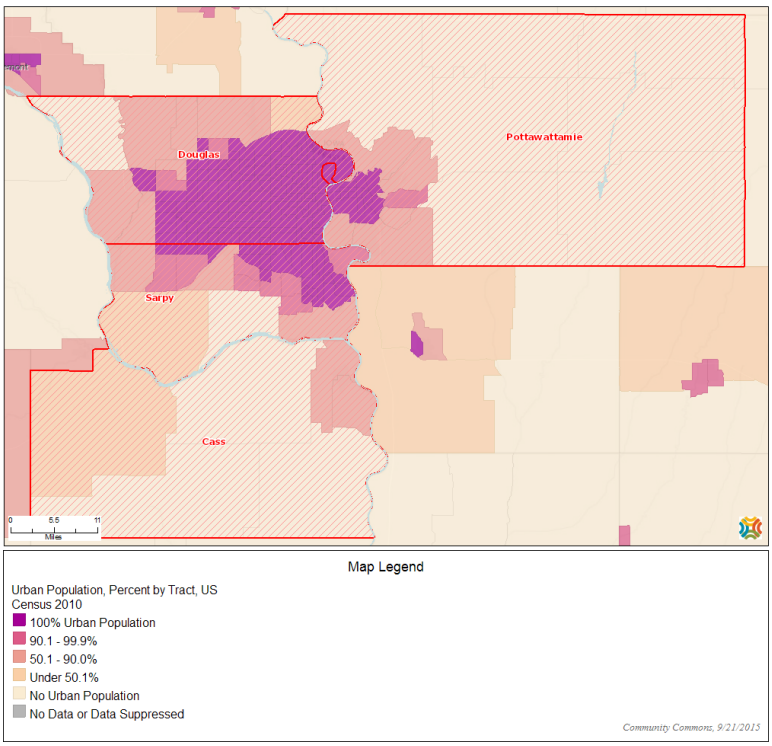


Sources:
- US Census Bureau Decennial Census (2010).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

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

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

Urban Population, Percent by Tract, US Census 2010



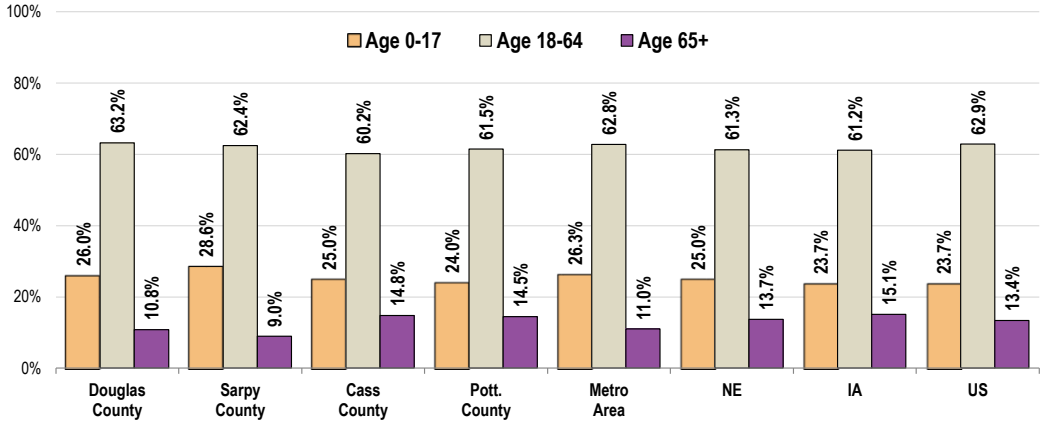
Age

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

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

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

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

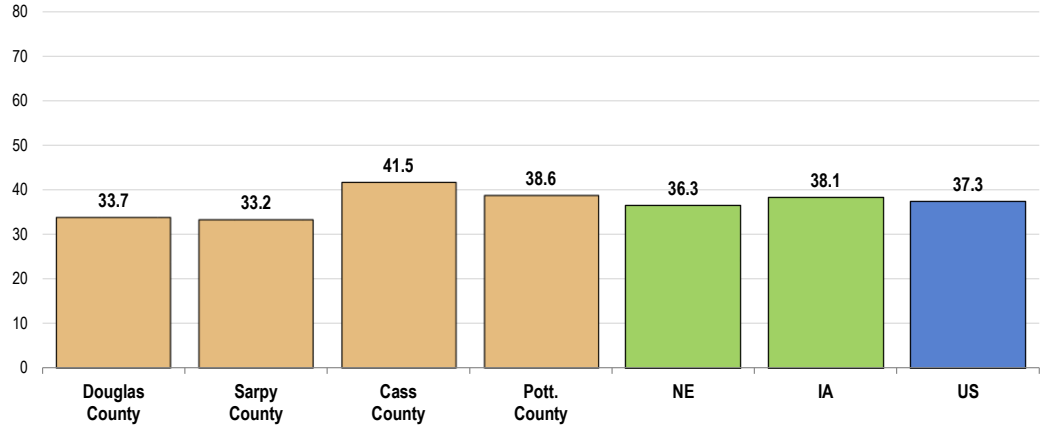


Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

Median Age

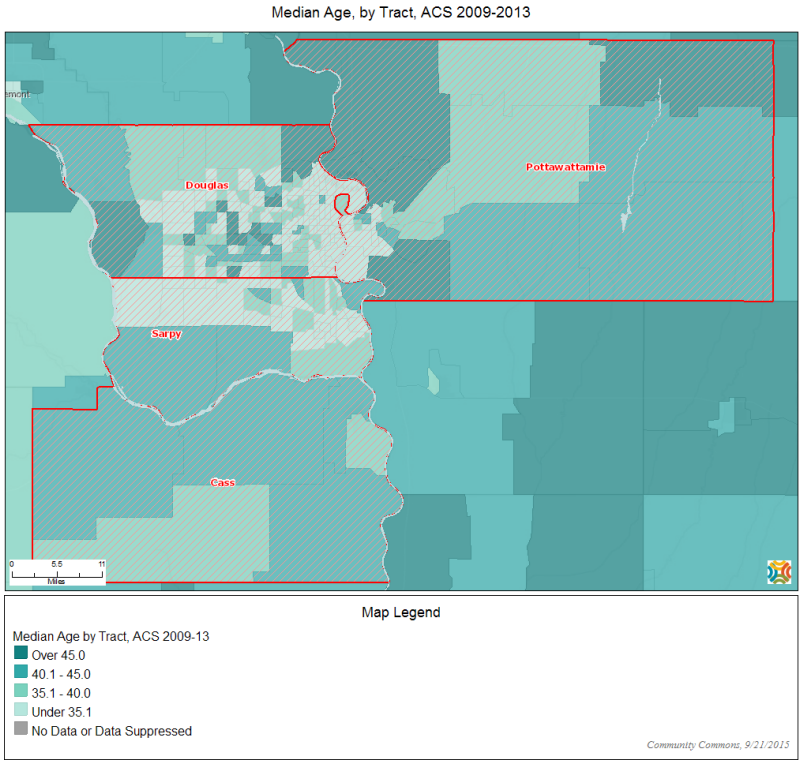
Douglas and Sarpy counties are "younger" than the states and the nation in that their median ages are lower; in contrast, Cass and Pottawattamie counties are "older."

Median Age
(2009-2013)



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

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



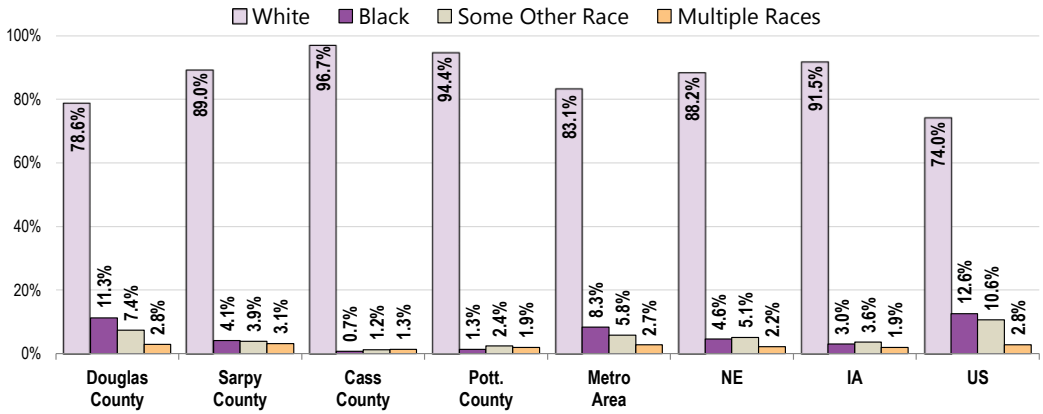
Race & Ethnicity

Race

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

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

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



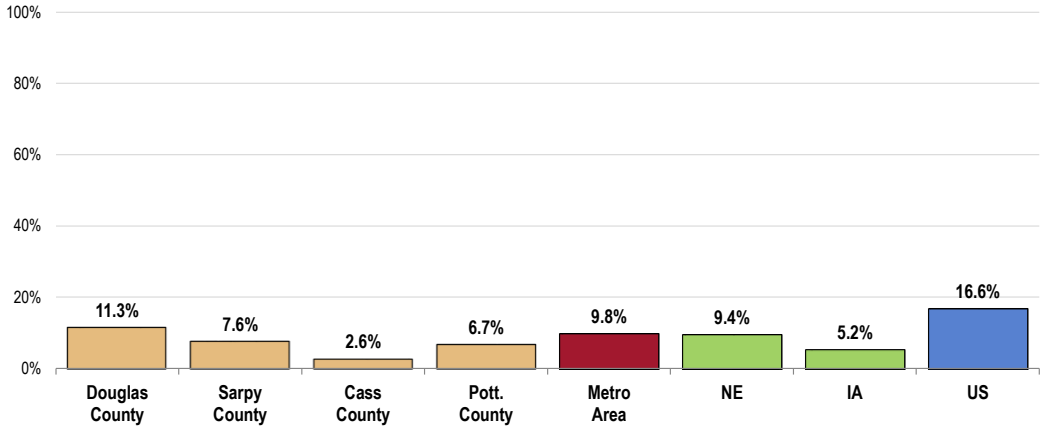
Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

Ethnicity

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

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

Percent Population Hispanic or Latino
(2009-2013)

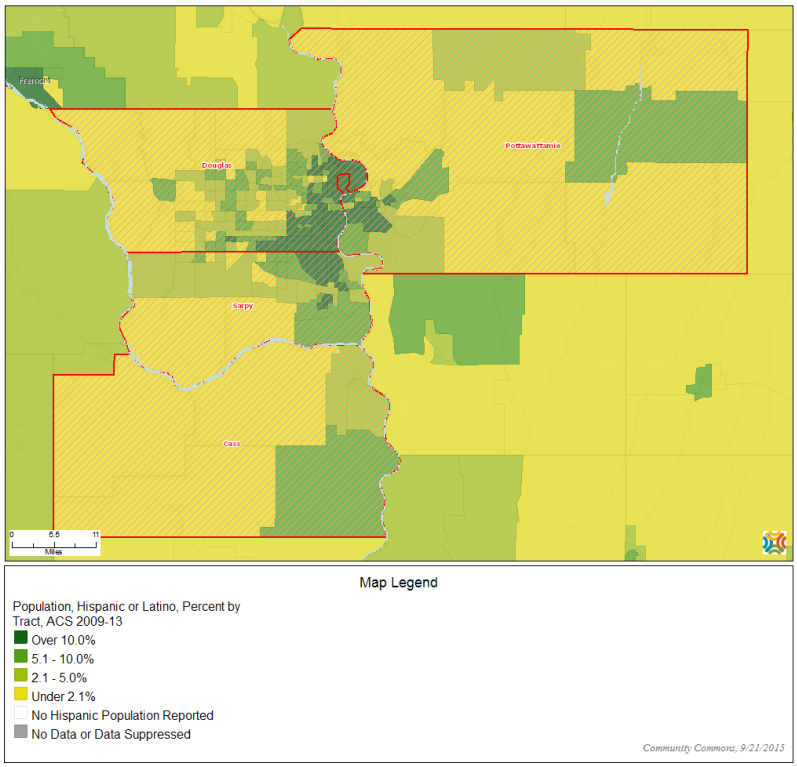


Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

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

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

Population Hispanic or Latino, Percent by Tract, ACS 2009-2013

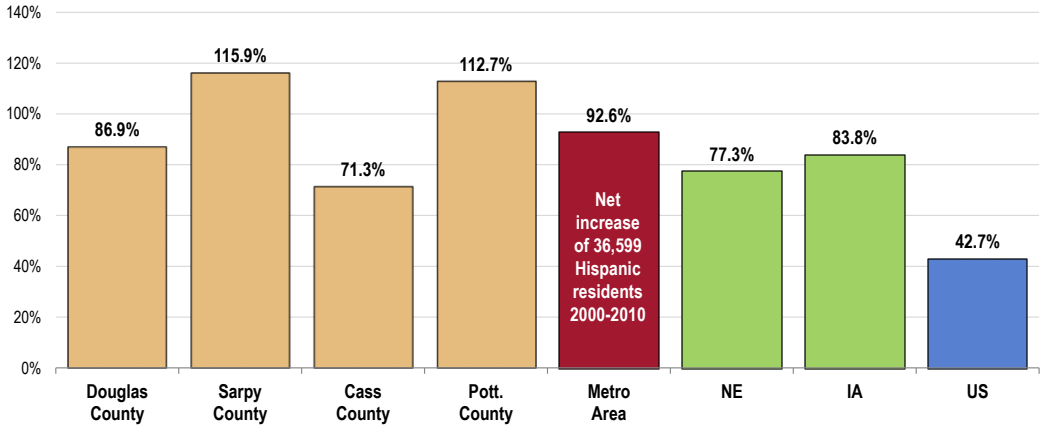


Between 2000 and 2010, the Hispanic population in the Metro Area increased by 36,599 residents, or 92.6%.

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

Hispanic Population Change

(Percentage Change in Hispanic Population Between 2000 and 2010)



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

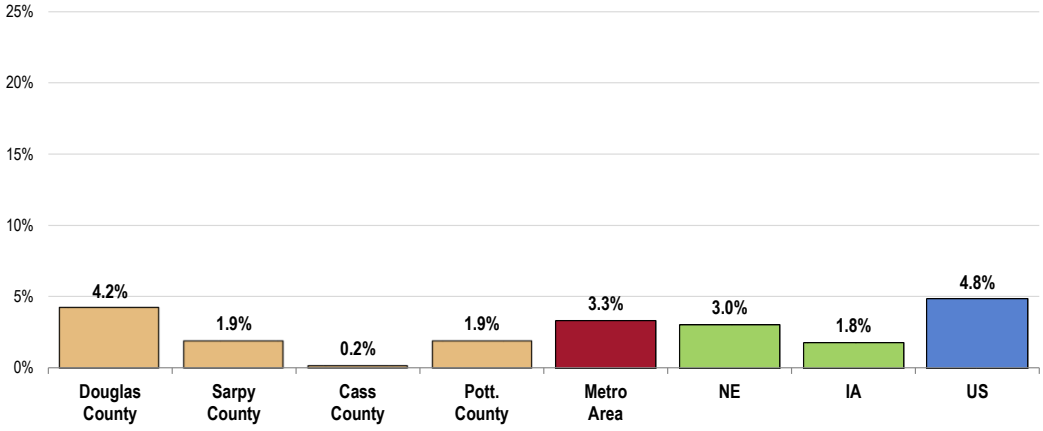
Linguistic Isolation

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

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

Linguistically Isolated Population

(2009-2013)

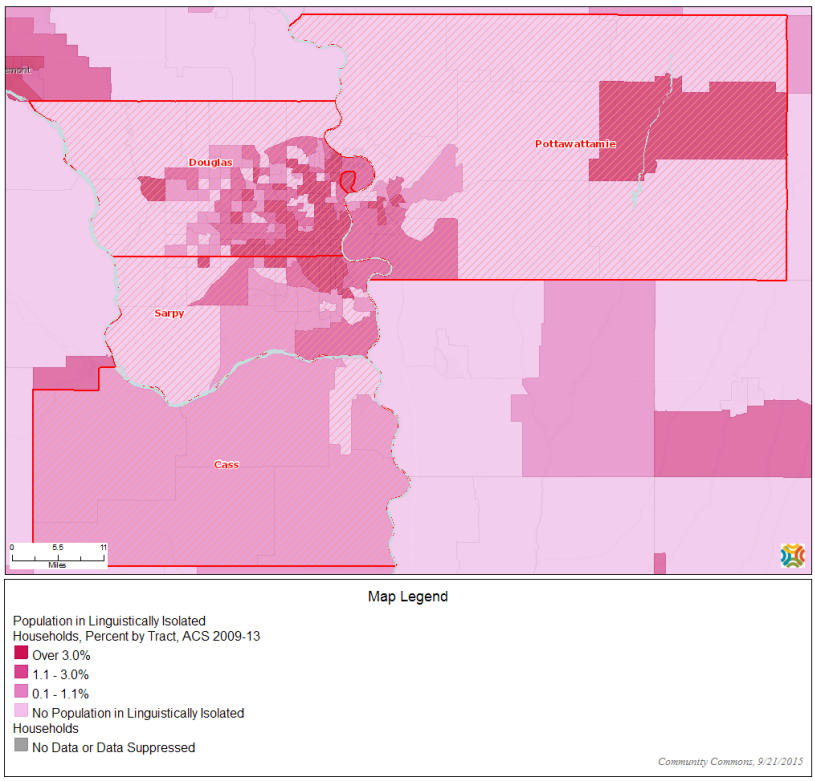


Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

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

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

Population in Linguistically Isolated Households, Percent by Tract, ACS 2009-2013



Social Determinants of Health

About Social Determinants

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

- Healthy People 2020 (www.healthypeople.gov)

Poverty

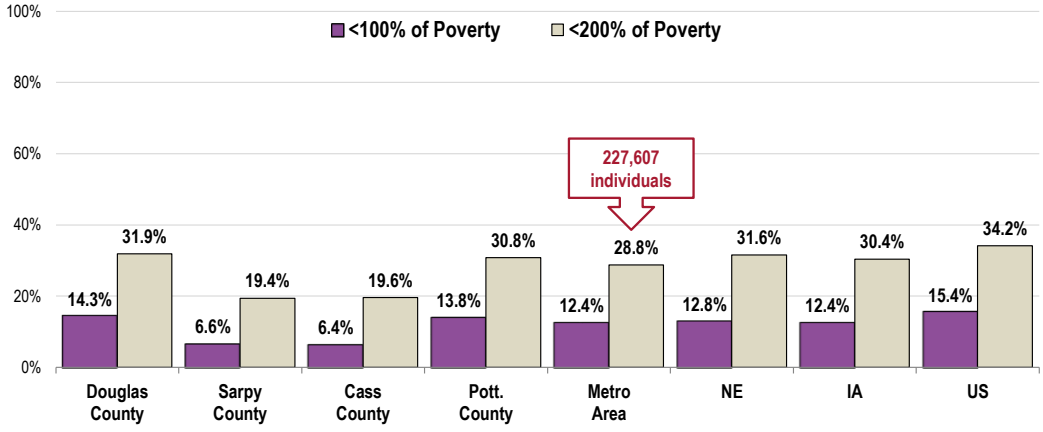
The latest census estimate shows 12.4% of the Metro Area population living below the federal poverty level.

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

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

Population in Poverty

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

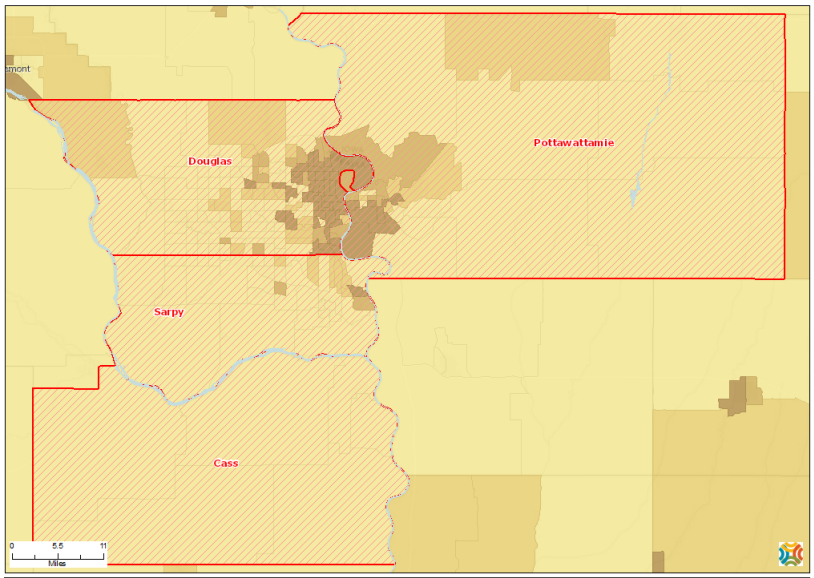


Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

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

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

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

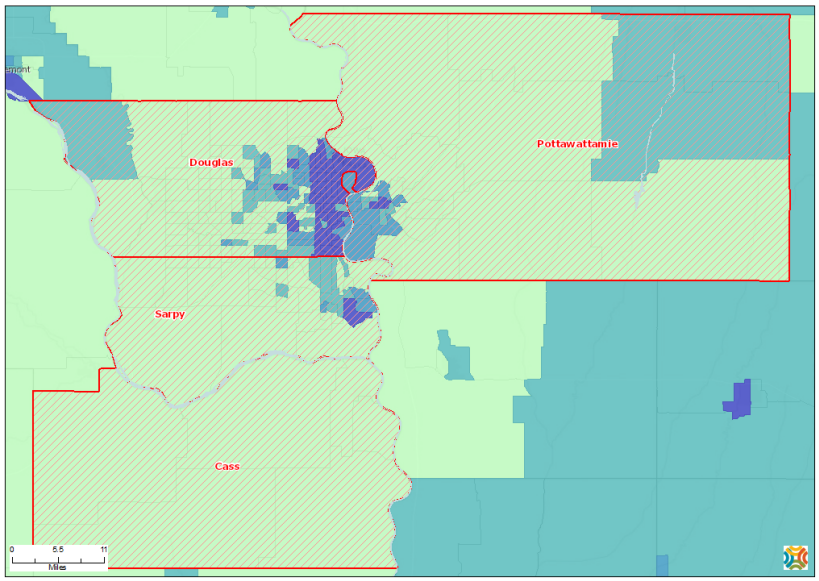


Map Legend

Population Below the Poverty Level, Percent by Tract, ACS 2009-13
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

Community Commons, 9/21/2015

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



Map Legend

Population Below 200% Poverty Level, Percent by Tract, ACS 2009-13
- Over 50.0%
- 38.1 - 50.0%
- 26.1 - 38.0%
- Under 26.1%
- No Data or Data Suppressed

Community Commons, 9/21/2015

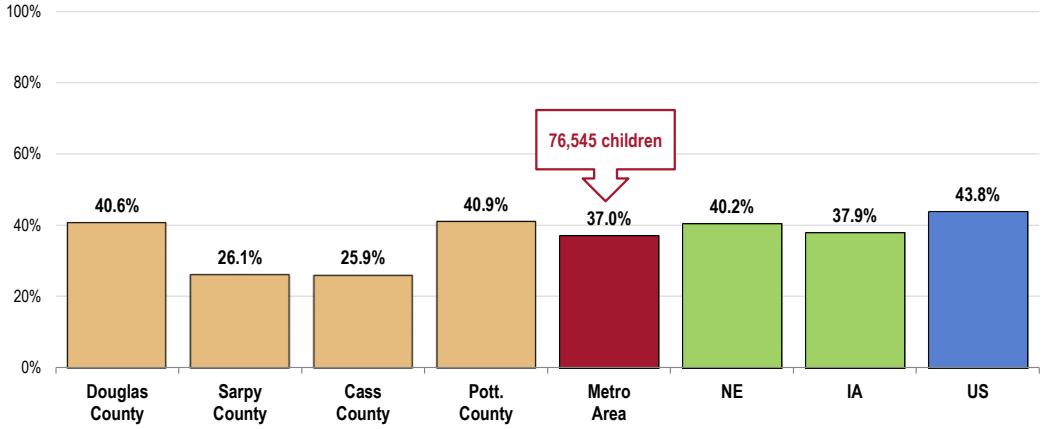
Children in Low-Income Households

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

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

Percent of Children in Low-Income Households

(Children 0-17 Living Below 200% of the Poverty Level, 2009-2013)

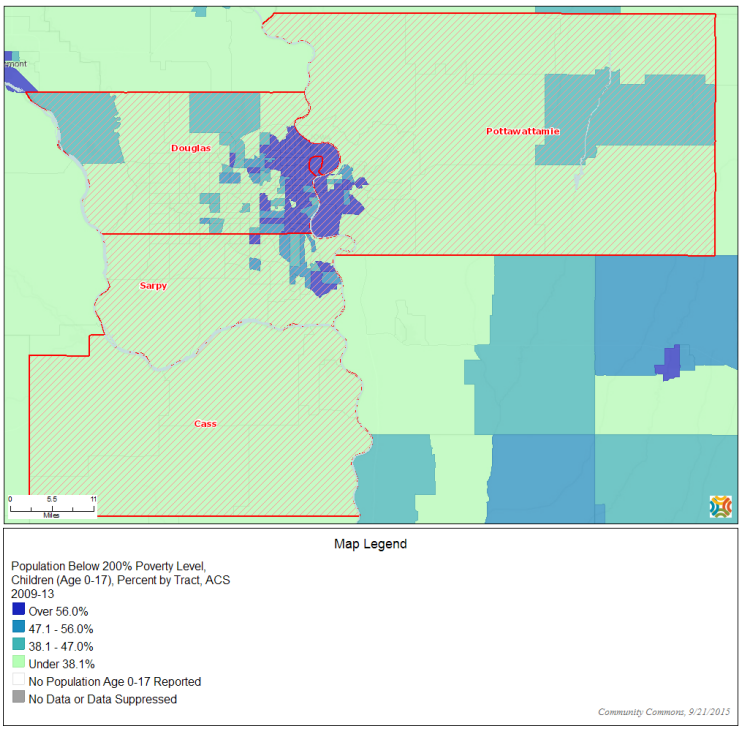


Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

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

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

Children (0-17) Living Below 200% of Poverty, Percent by Tract, ACS 2009-2013



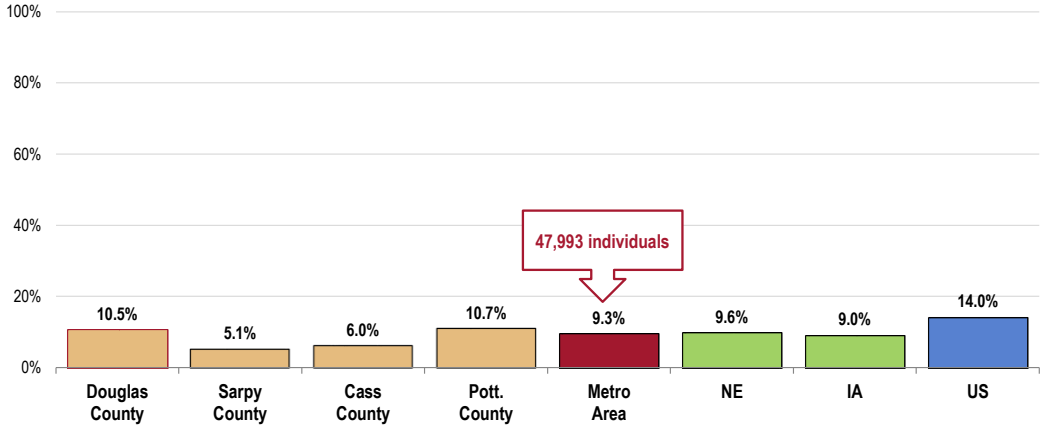
Education

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

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

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2009-2013)

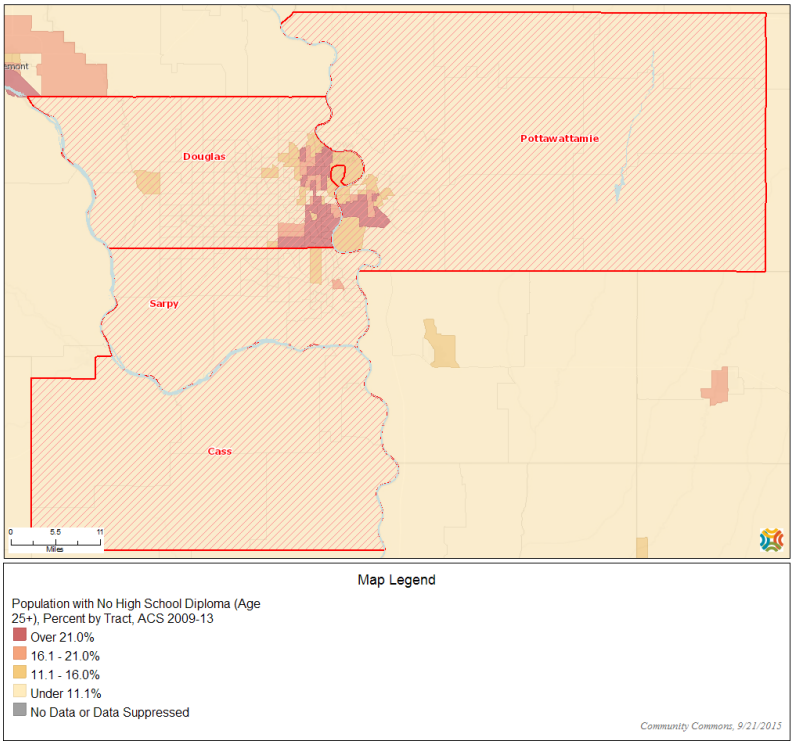


Sources:
- US Census Bureau American Community Survey 5-year estimates (2009-2013).
- Retrieved August 2015 from Community Commons at http://www.chna.org.

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

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

Population With No High School Diploma, Percent by Tract, ACS 2009-2013



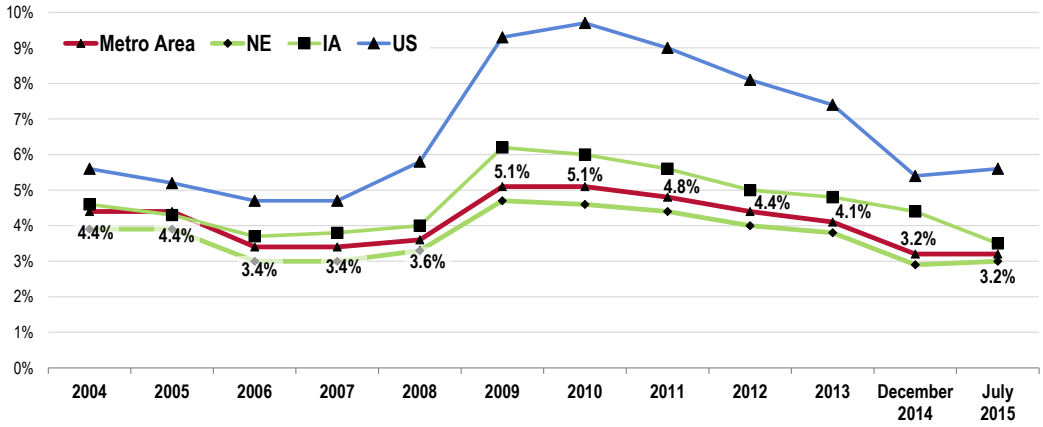
Employment

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

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

Unemployment Rate

(Percent of Non-Institutionalized Population Age 16+ Unemployed, Not Seasonally-Adjusted)



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

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

General Health Status

Professional Research Consultants, Inc.

Overall Health Status

Self-Reported Health Status

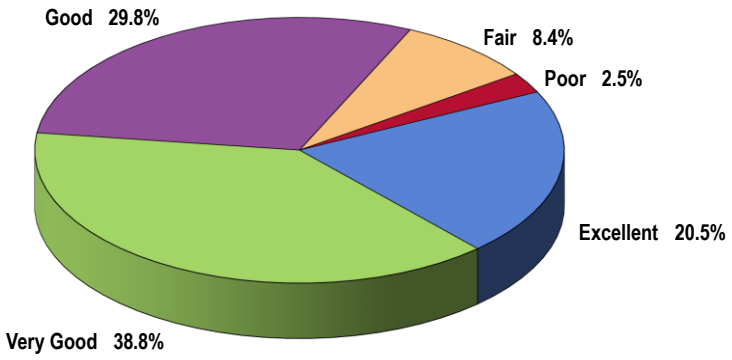
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

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

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

Self-Reported Health Status
(Metro Area, 2015)



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

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

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

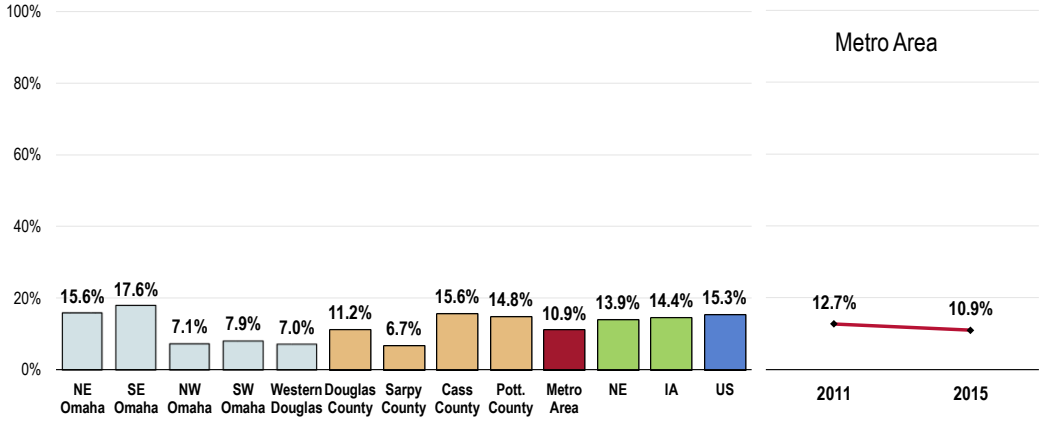
NOTE:

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

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

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

Experience "Fair" or "Poor" Overall Health



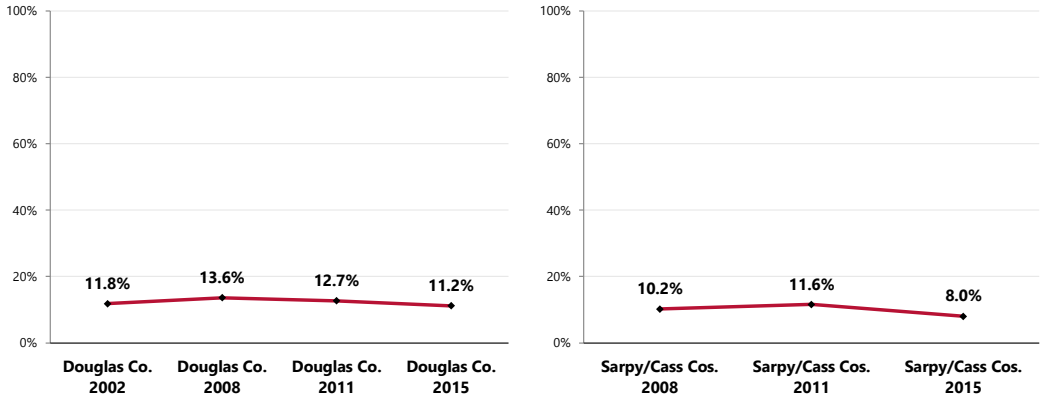
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.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

Notes:
- Asked of all respondents.

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

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

Experience "Fair" or "Poor" Overall Health



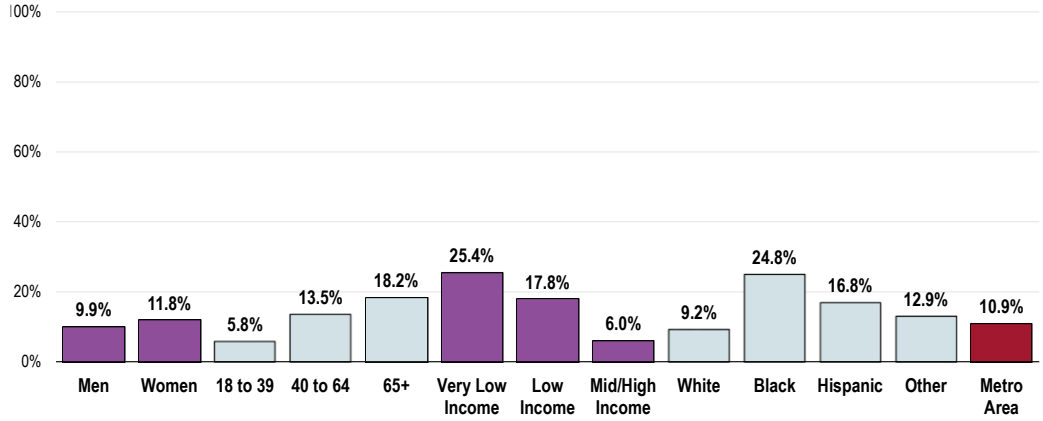
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]

Notes:
- Asked of all respondents.

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

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

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



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

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

Activity Limitations

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

About Disability & Health

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

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

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

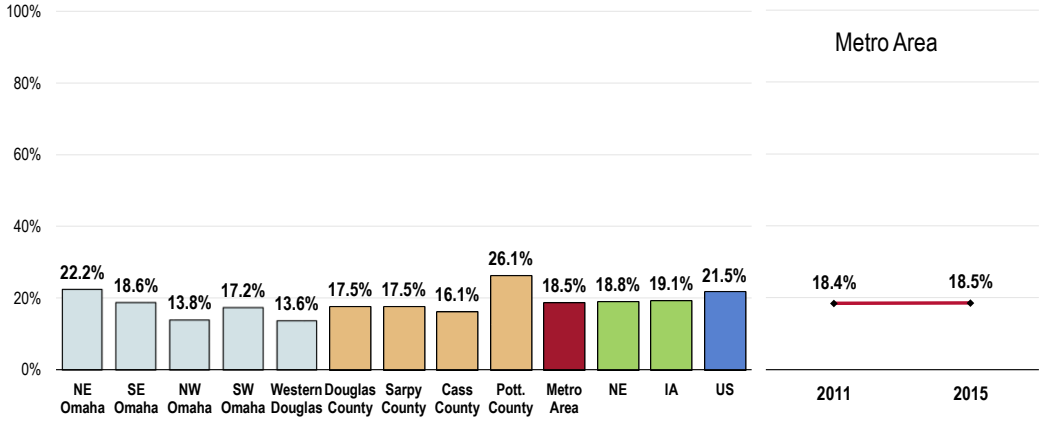
- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.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

- Healthy People 2020 (www.healthypeople.gov)

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

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

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

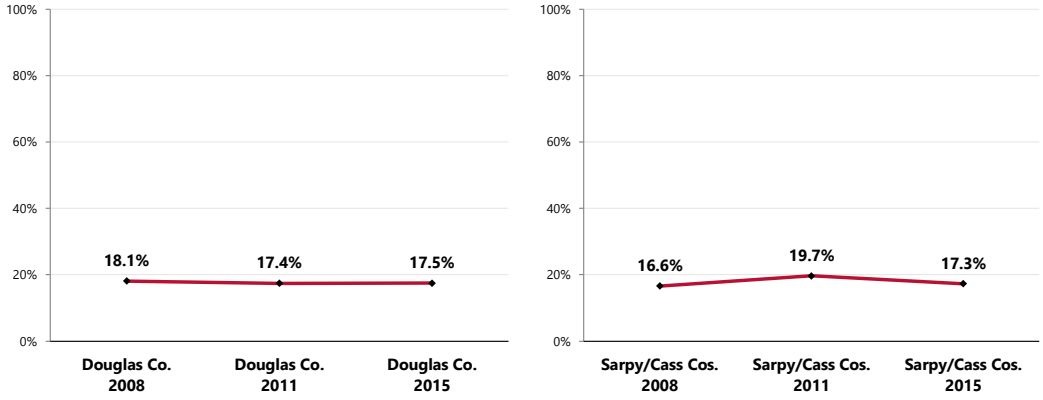


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 105]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.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

Notes:
- Asked of all respondents.

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

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



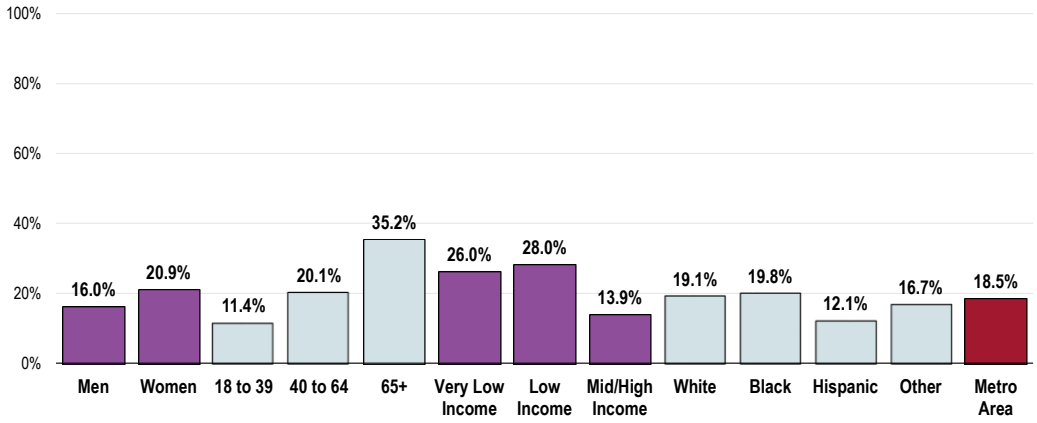
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 105]

Notes:
- Asked of all respondents.

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

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

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



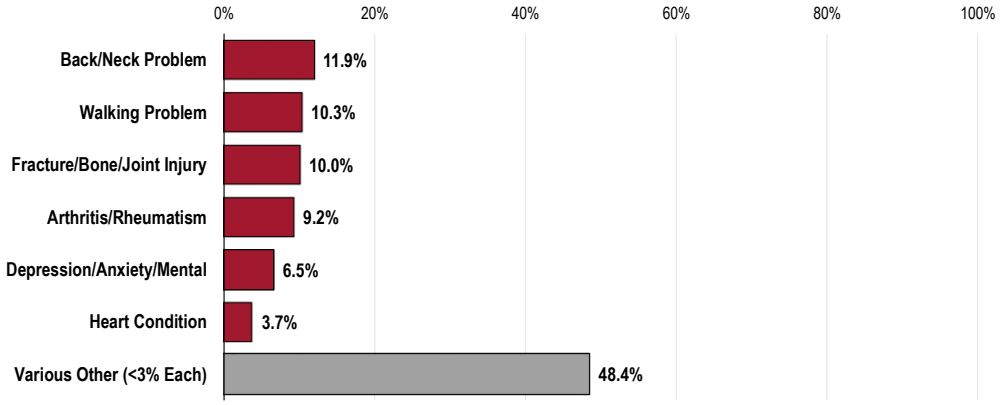
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect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

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

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

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; Metro Area, 2015)



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

Mental Health

RELATED ISSUE:

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

About Mental Health & Mental Disorders

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

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

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

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)

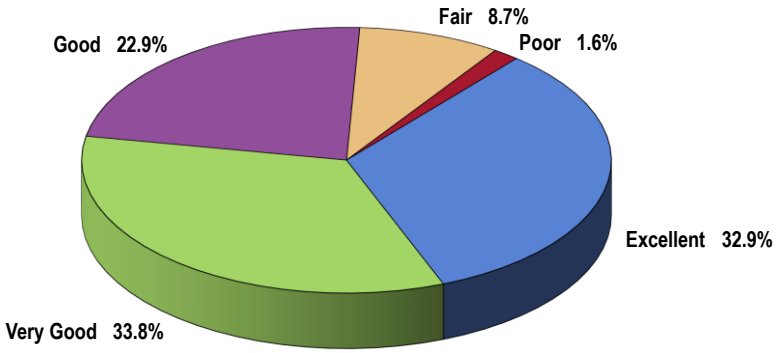
Self-Reported Mental Health Status

"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?"

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

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

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

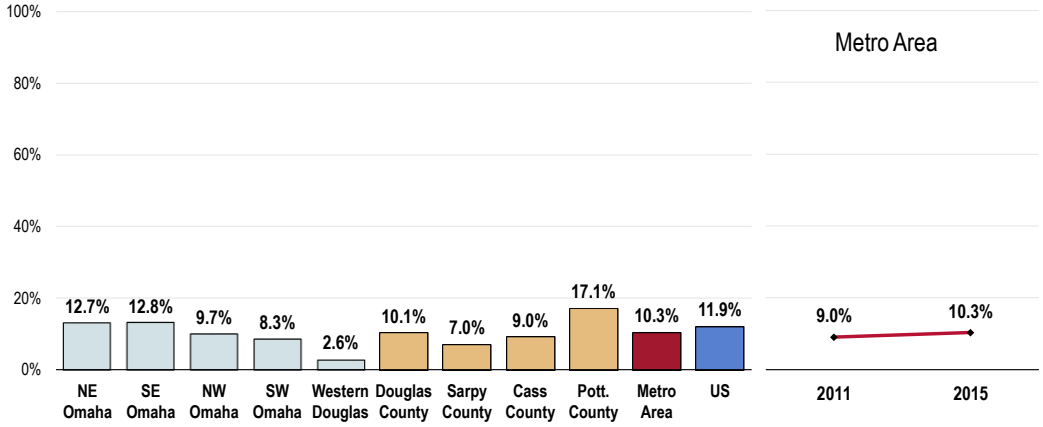


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
Notes: • Asked of all respondents.

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

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

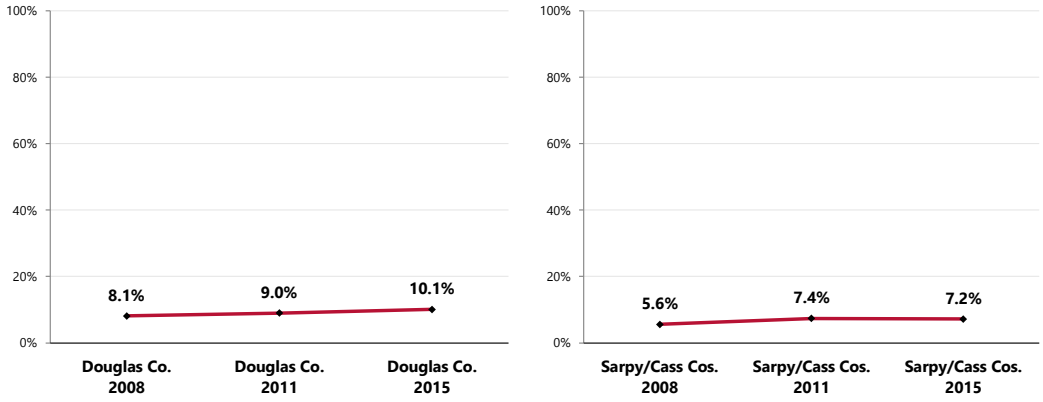
Experience "Fair" or "Poor" Mental Health



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

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

Experience "Fair" or "Poor" Mental Health

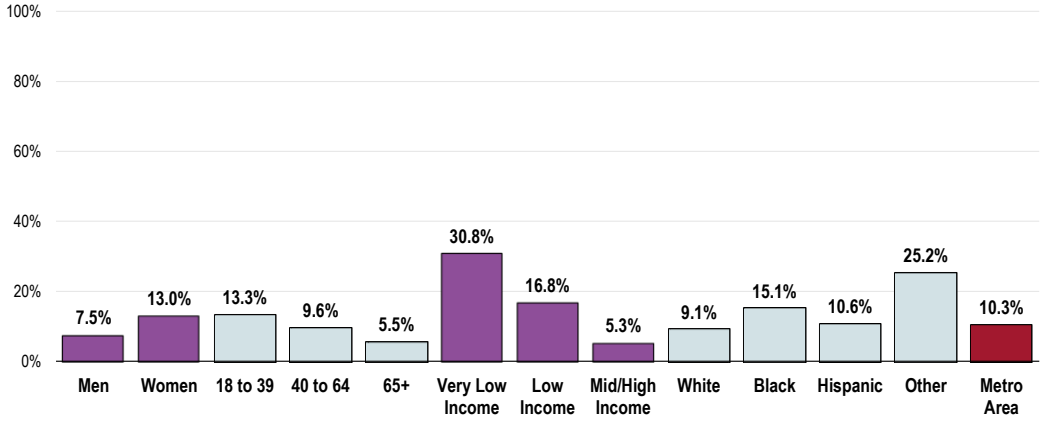


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 100]
Notes: ● Asked of all respondents.

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

Experience "Fair" or "Poor" Mental Health

(Metro Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]

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

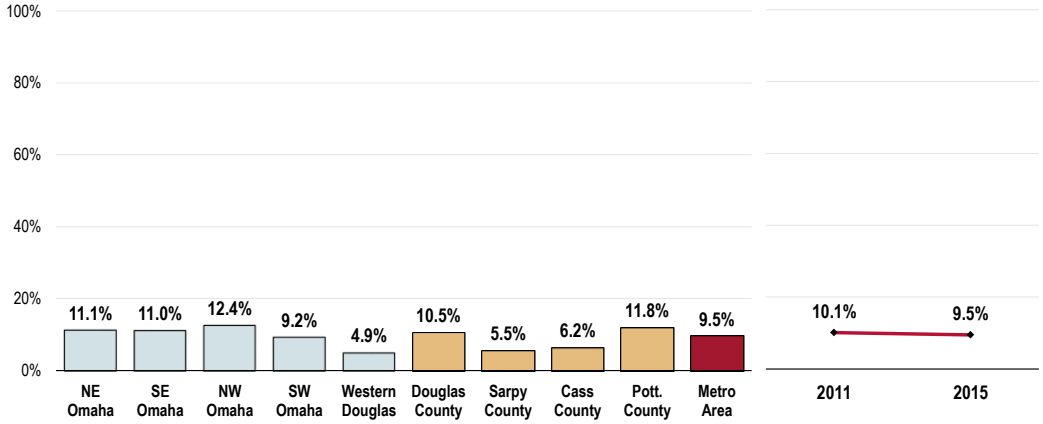
Depression

Major Depression

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

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

Have Been Diagnosed With Major Depression

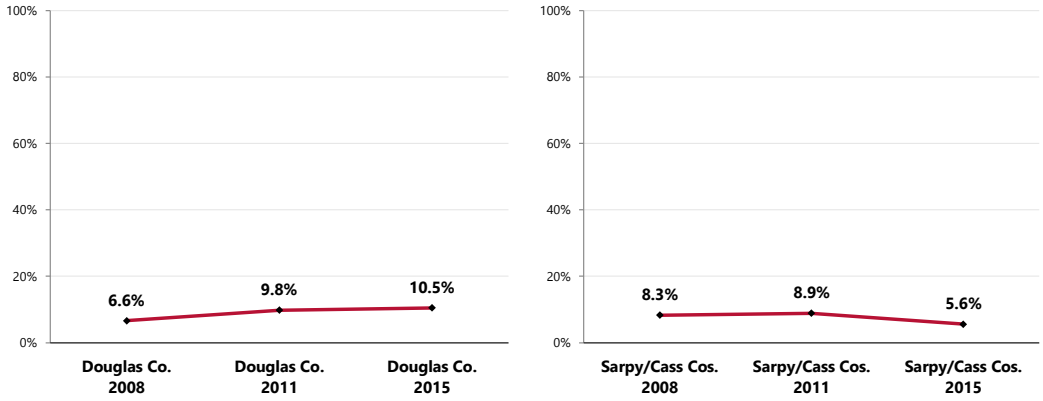


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 308]

Notes:
- Asked of all respondents.

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

Have Been Diagnosed With Major Depression

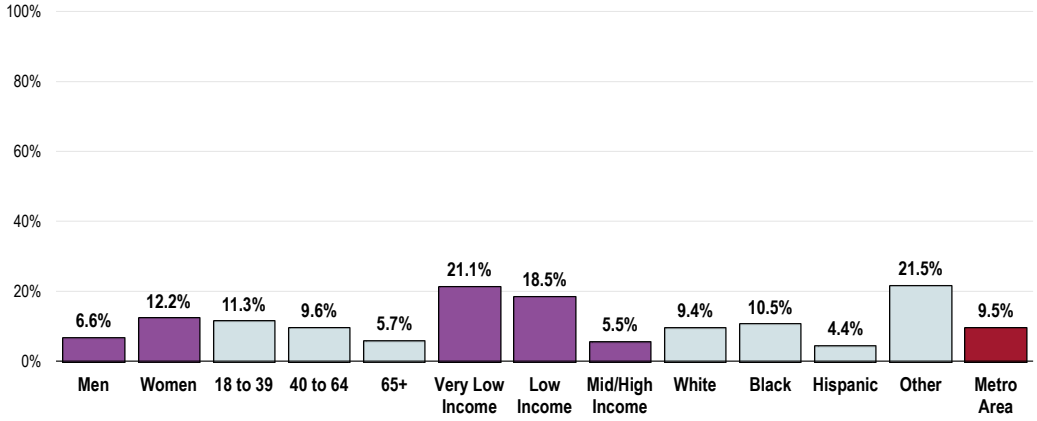


Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]
Notes: ● Asked of all respondents.

The prevalence of diagnosed depression is notably higher among:

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

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



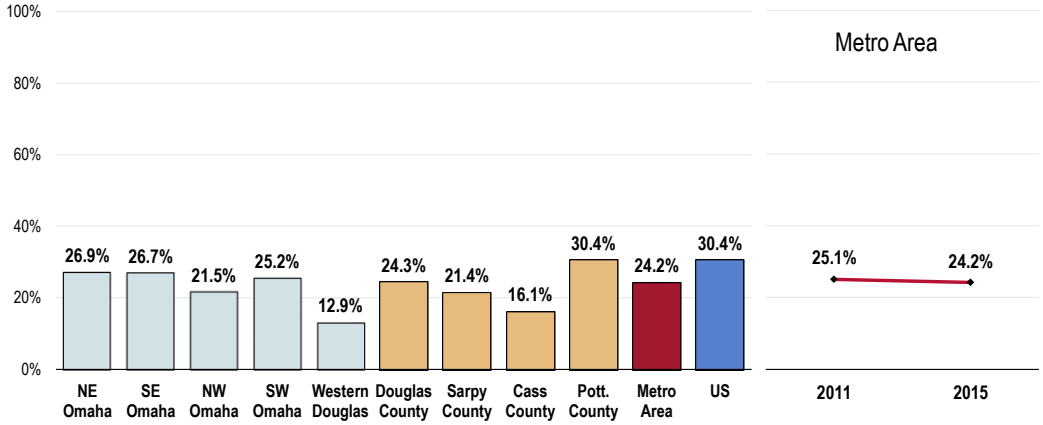
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect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

Symptoms of Chronic Depression

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

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

Have Experienced Symptoms of Chronic Depression

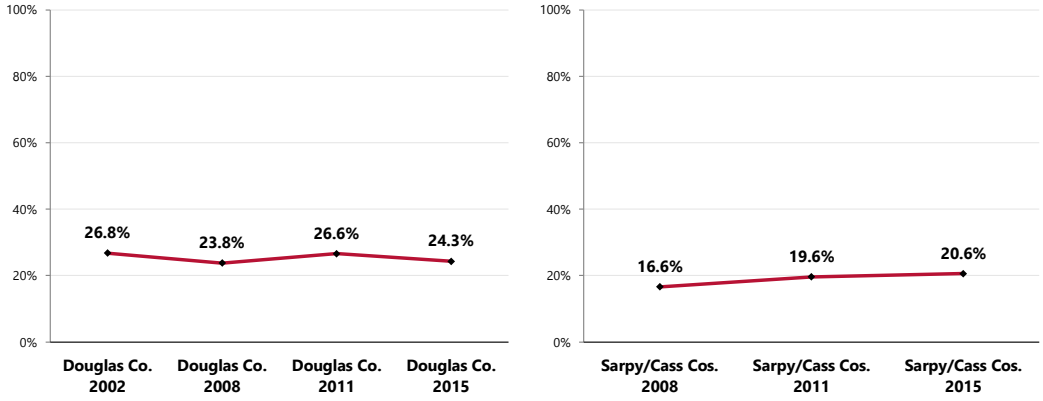


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 101]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

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

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

Have Experienced Symptoms of Chronic Depression



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

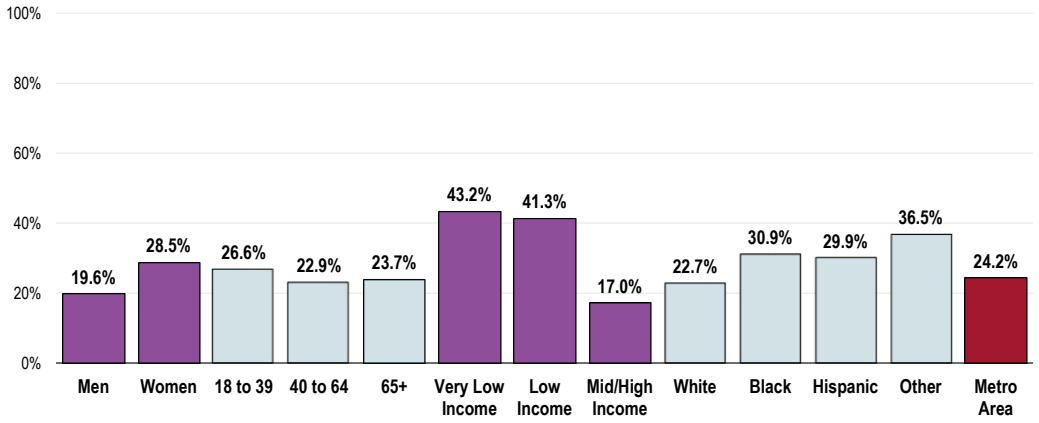
Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

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

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

Have Experienced Symptoms of Chronic Depression

(Metro Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]

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

Stress

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

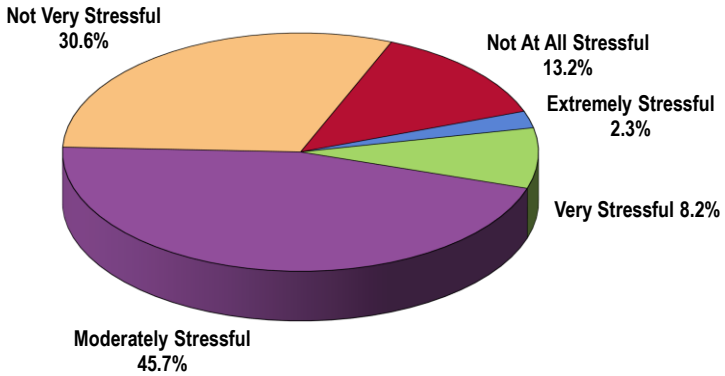
- Another 45.7% of adults characterize their typical day as "moderately stressful."

RELATED ISSUE:

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

Perceived Level of Stress On a Typical Day

(Metro Area, 2015)



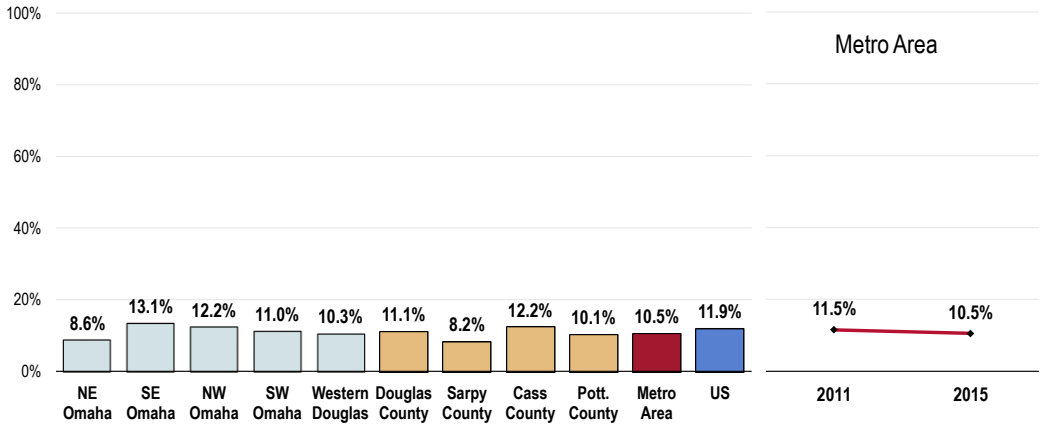
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]

Notes:
- Asked of all respondents.

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

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

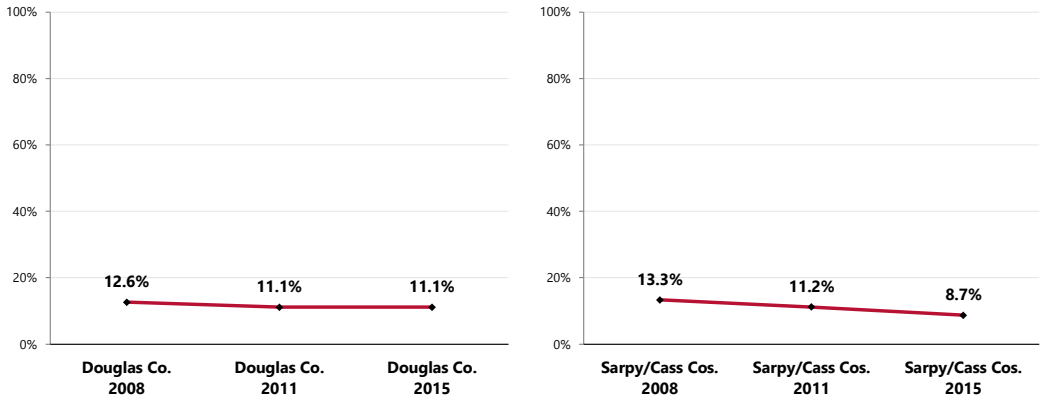
Perceive Most Days As "Extremely" or "Very" Stressful



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

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

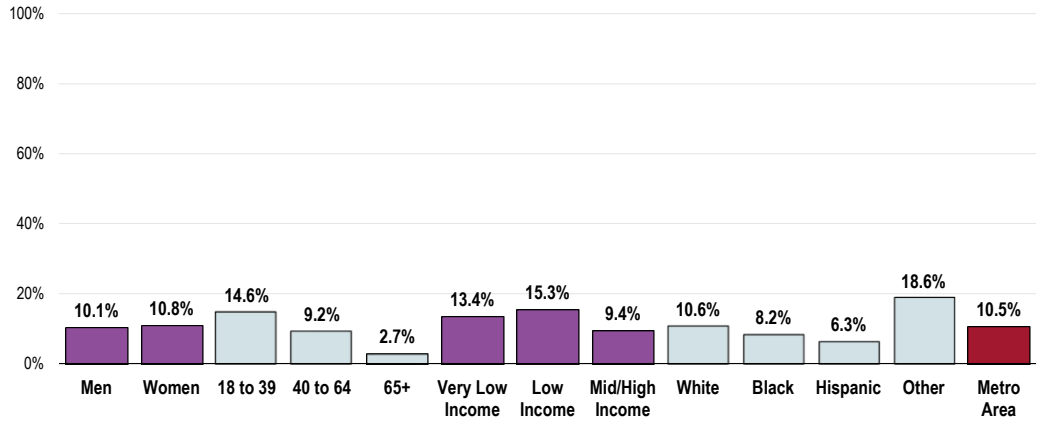
Perceive Most Days As "Extremely" or "Very" Stressful



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

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

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



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]

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

Suicide

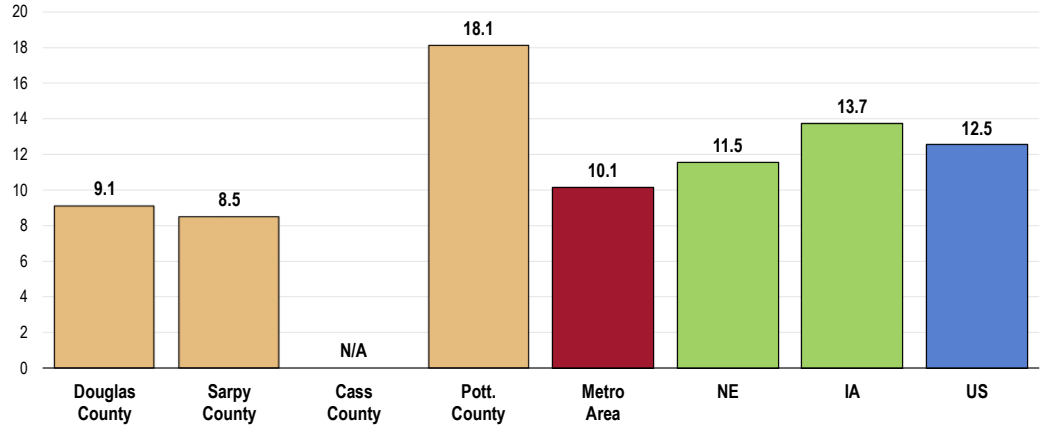
Between 2011 and 2013, there was an annual average age-adjusted suicide rate of 10.1 deaths per 100,000 population in the Metro Area.

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

Suicide: Age-Adjusted Mortality

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

Healthy People 2020 Target = 10.2 or Lower



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

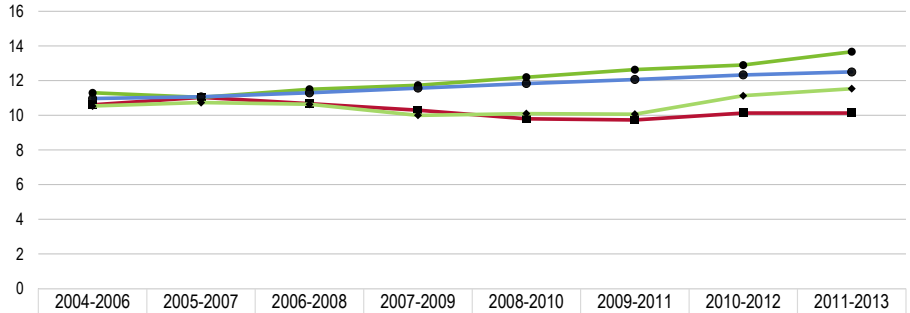
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	10.6	11.0	10.7	10.3	9.8	9.7	10.1	10.1
Nebraska	10.5	10.7	10.6	10.0	10.1	10.1	11.1	11.5
Iowa	11.3	11.0	11.5	11.7	12.2	12.6	12.9	13.7
United States	11.0	11.1	11.3	11.6	11.8	12.1	12.3	12.5

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

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

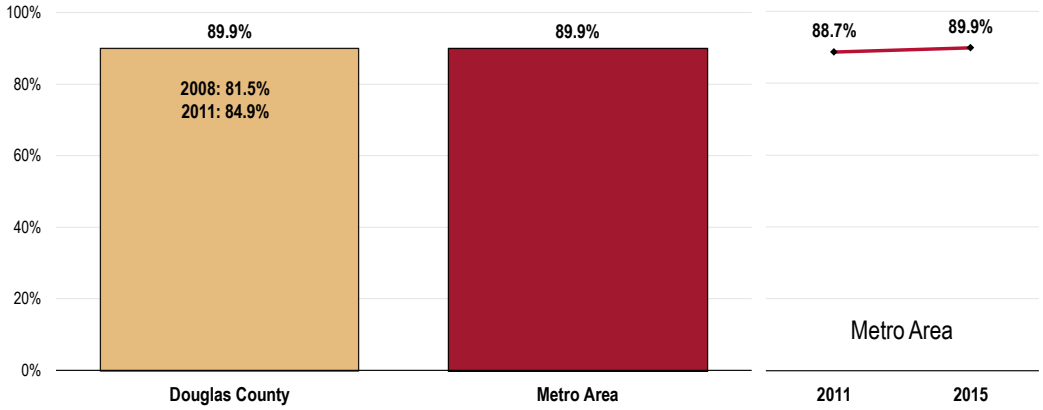
Mental Health Treatment

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

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

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

(Among Adults With Major Depression)



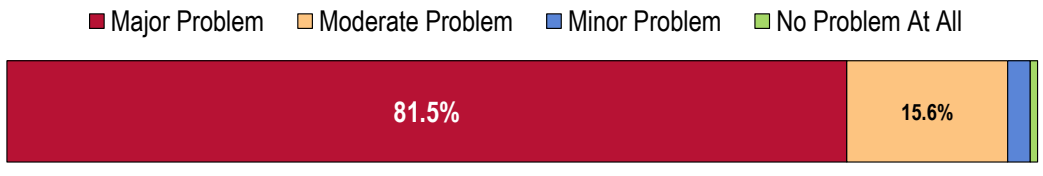
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 123]
Notes: ● Reflects those respondents with major depression.

Key Informant Input: Mental Health

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

Perceptions of Mental Health as a Problem in the Community

(Key Informants, 2015)



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

Challenges

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

Access to Care/Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Access to care. Stigma. – Community/Business Leader

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

Access to therapy or medications. – Healthcare Provider

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

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

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

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

Lack of treatment and affordable care. – Social Service Provider

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

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

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

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

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

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

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

Lack of Providers

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

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

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

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

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

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

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

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

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

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

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

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

Lack of practitioners in the field. – Healthcare Provider

No providers and no facilities. – Social Service Provider

Lack of providers. – Physician

Lack of Resources

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

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

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

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

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

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

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

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

necessary. – Healthcare Provider

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

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

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

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

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

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

Not enough inpatient beds and not enough psychiatrists. – Physician

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

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

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

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

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

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

Inadequate resources. – Community/Business Leader

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

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

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

Stigma

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

Stigma of needing mental health services. – Social Service Provider

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

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

Funding

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

No money! - Community/Business Leader

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

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

Co-occurring Morbidities

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

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

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

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

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

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

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

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

Education

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

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

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

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

Coordination Between Services

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

I think there is a big connection with mental health issues and homelessness. In Council Bluffs there are two homeless shelters and more transitional housing so I would consider this a major problem. Mental health programming and payment are a problem for many. – Community/Business Leader

Continuity of care and medication compliance. – Healthcare Provider

Risk Factors

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

Death, Disease & Chronic Conditions

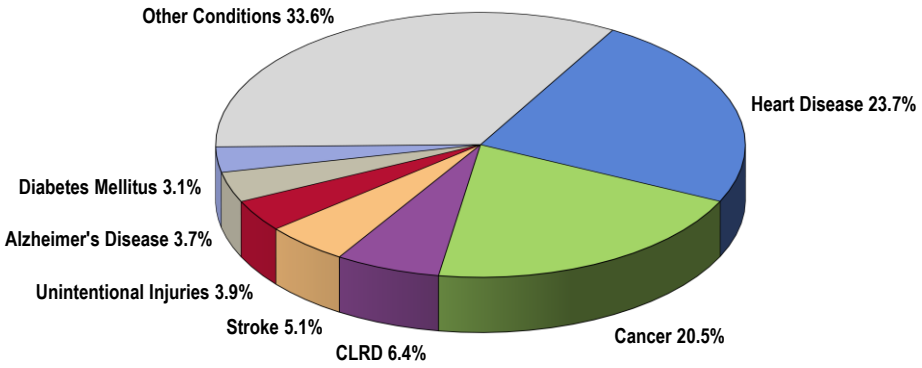
Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

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

Leading Causes of Death
(Metro Area, 2013)



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

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

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

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

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

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

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

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

Age-Adjusted Death Rates for Selected Causes

(2011-2013 Deaths per 100,000 Population)

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

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

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

Cardiovascular Disease

About Heart Disease & Stroke

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

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

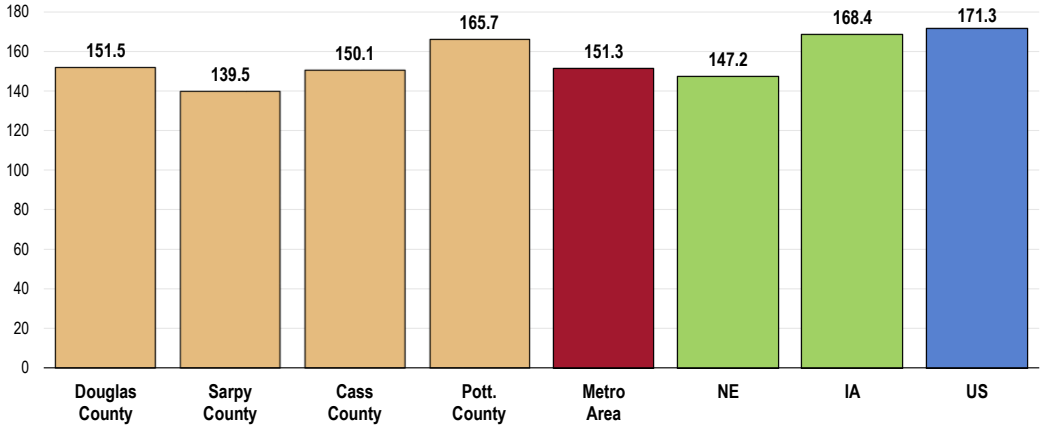
Between 2011 and 2013 there was an annual average age-adjusted heart disease mortality rate of 151.3 deaths per 100,000 population in the Metro Area.

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

Heart Disease: Age-Adjusted Mortality

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

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



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

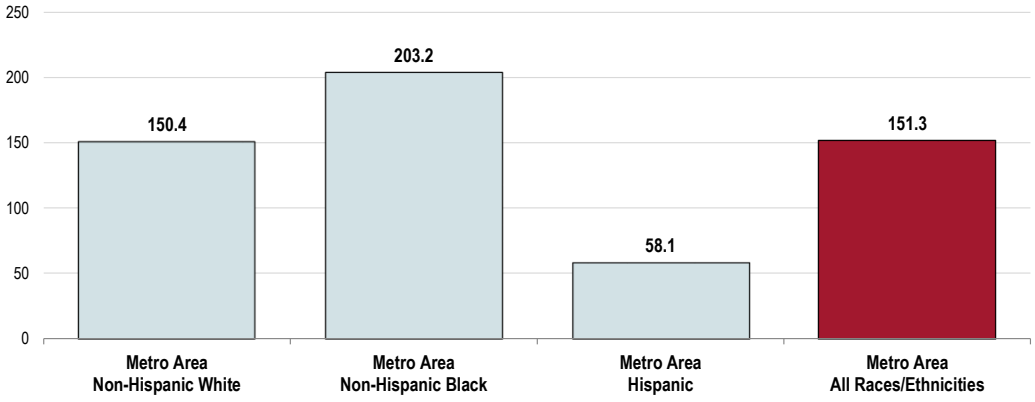
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account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

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

Heart Disease: Age-Adjusted Mortality by Race

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

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



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- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

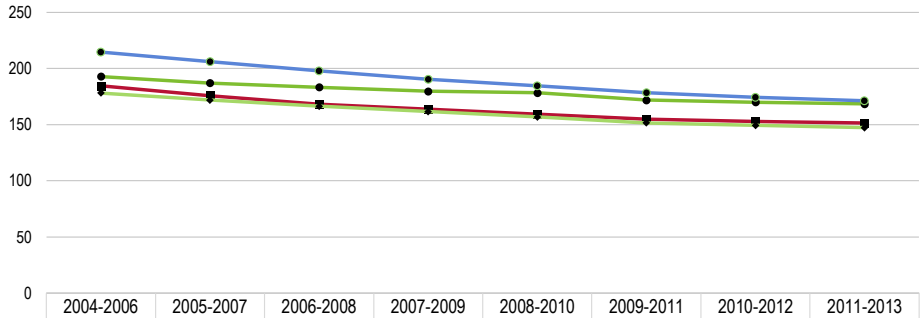
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account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

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

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	184.5	175.7	168.0	163.6	159.3	154.8	152.6	151.3
Nebraska	178.2	171.8	166.4	161.5	156.9	151.4	149.3	147.2
Iowa	192.9	186.9	183.2	179.6	178.3	171.8	169.9	168.4
United States	214.6	206.1	197.9	190.3	184.7	178.5	174.4	171.3

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

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

Stroke Deaths

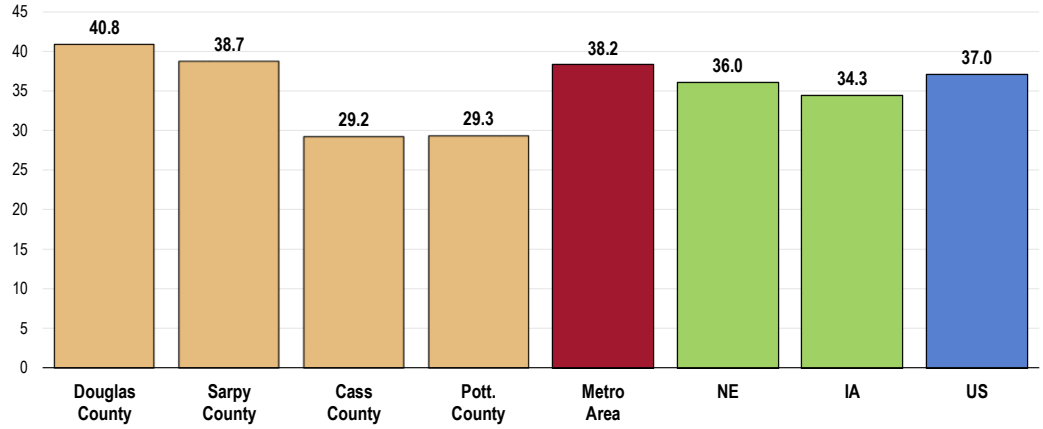
Between 2011 and 2013, there was an annual average age-adjusted stroke mortality rate of 38.2 deaths per 100,000 population in the Metro Area.

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

Stroke: Age-Adjusted Mortality

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

Healthy People 2020 Target = 34.8 or Lower



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

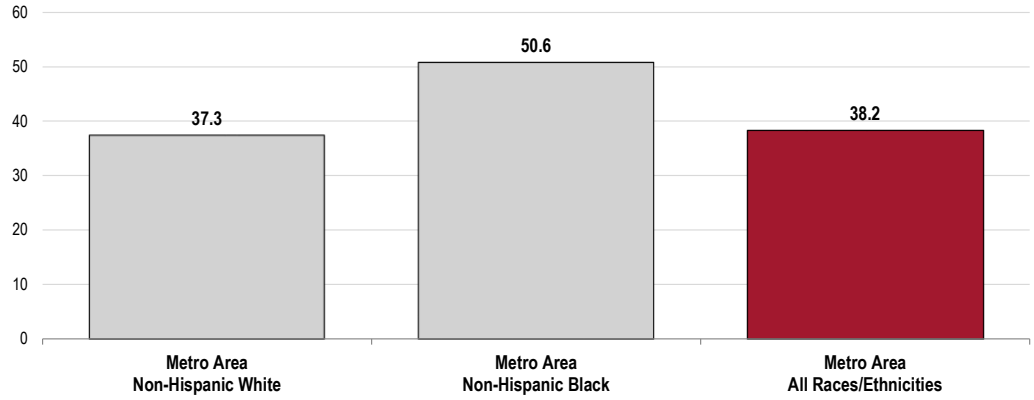
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Stroke: Age-Adjusted Mortality by Race

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

Healthy People 2020 Target = 34.8 or Lower



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

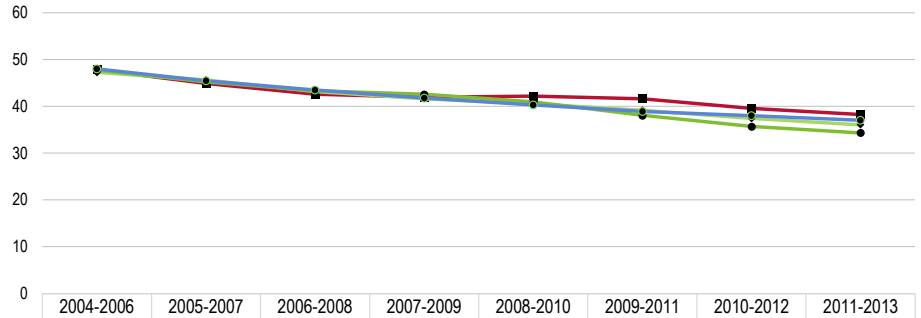
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	47.8	44.9	42.6	41.9	42.2	41.6	39.5	38.2
Nebraska	47.2	45.6	43.1	41.6	40.5	39.2	37.4	36.0
Iowa	47.8	45.2	43.3	42.5	40.9	38.0	35.7	34.3
United States	48.0	45.4	43.5	41.7	40.3	38.9	38.0	37.0

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

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

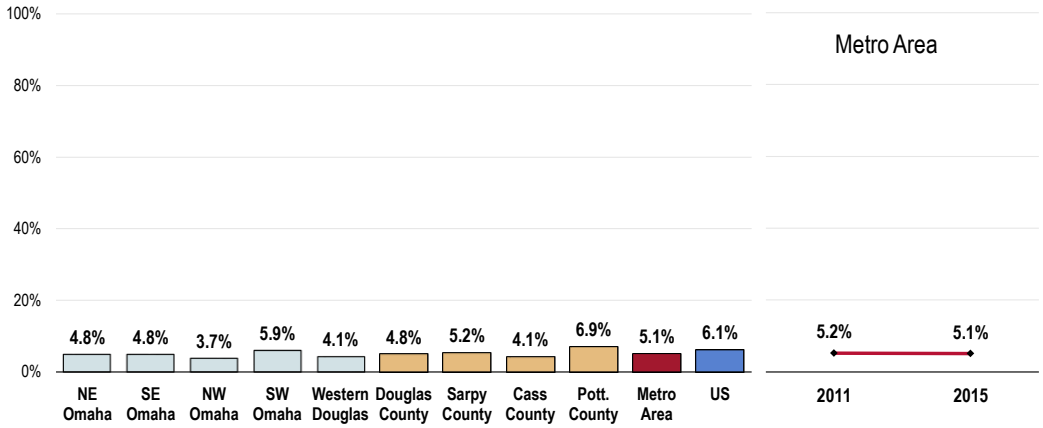
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

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

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

Prevalence of Heart Disease

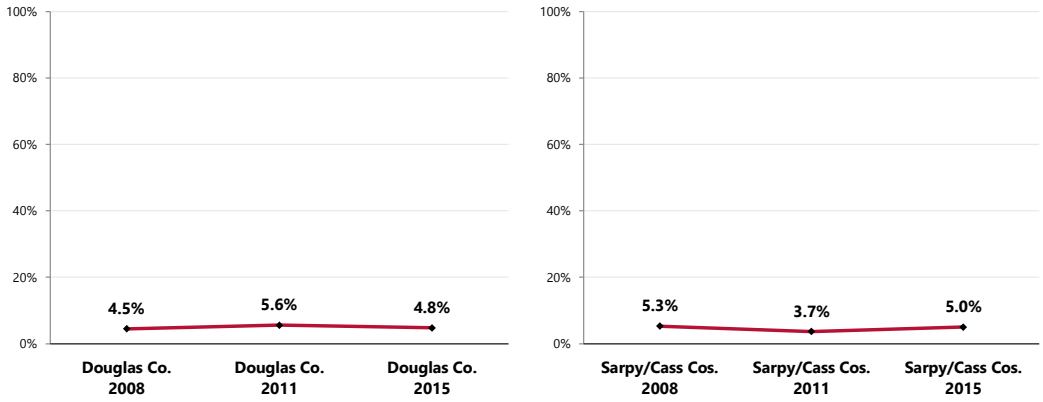


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 309]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

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

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

Prevalence of Heart Disease

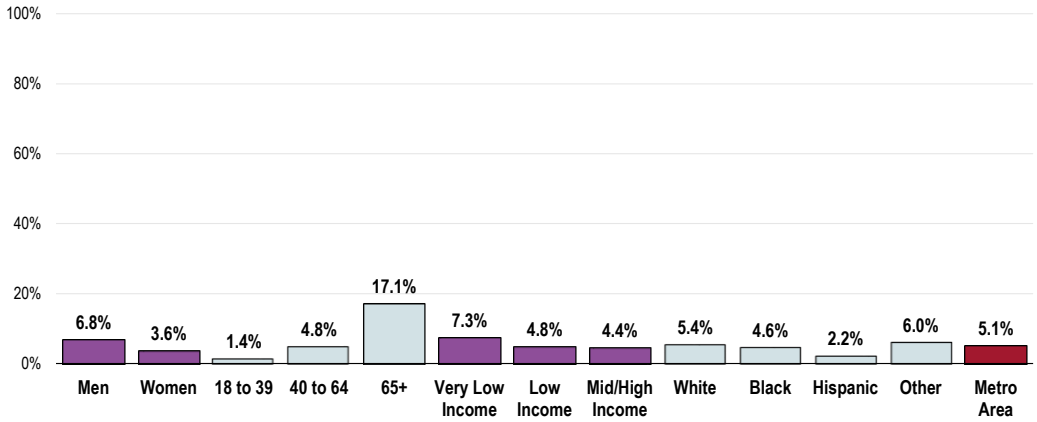


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 309]
Notes: ● Asked of all respondents.
● Includes diagnoses of heart attack, angina or coronary heart disease.

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

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

Prevalence of Heart Disease
(Metro Area, 2015)



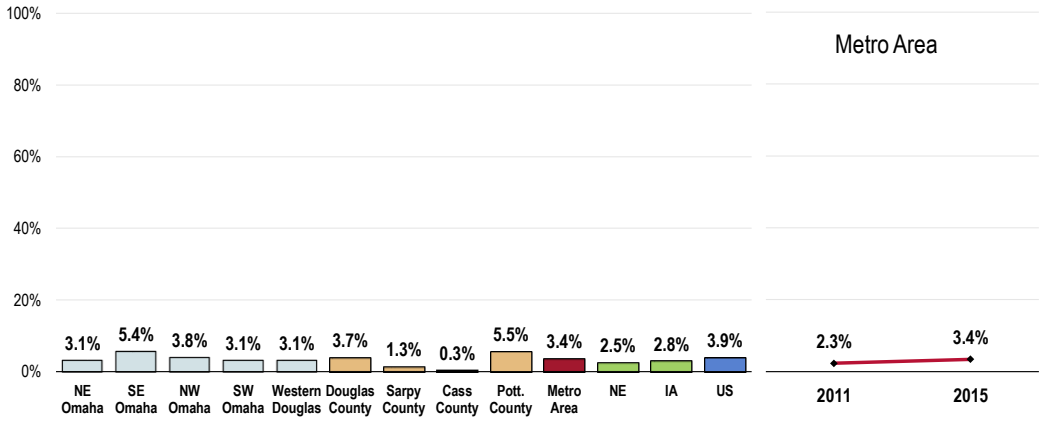
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]
Notes: ● Asked of all respondents.
● Includes diagnoses of heart attack, angina or coronary heart disease.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White"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

Prevalence of Stroke

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

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

Prevalence of Stroke

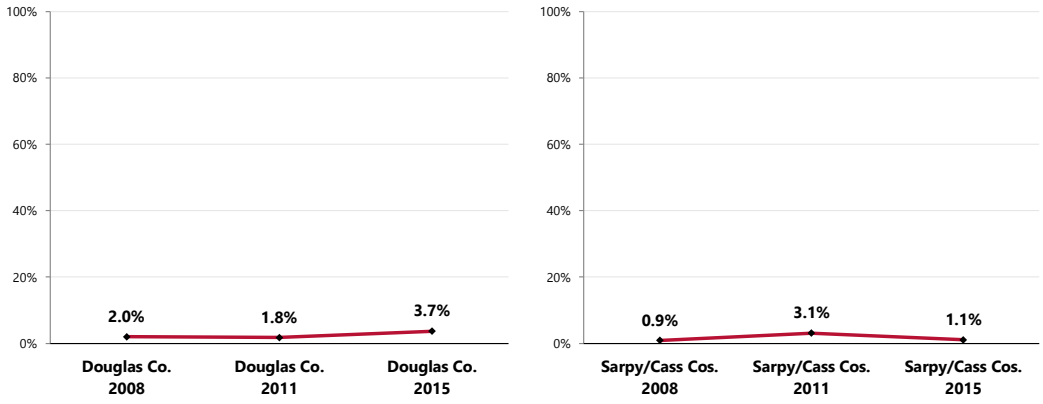


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers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

Notes:
- Asked of all respondents.

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

Prevalence of Stroke



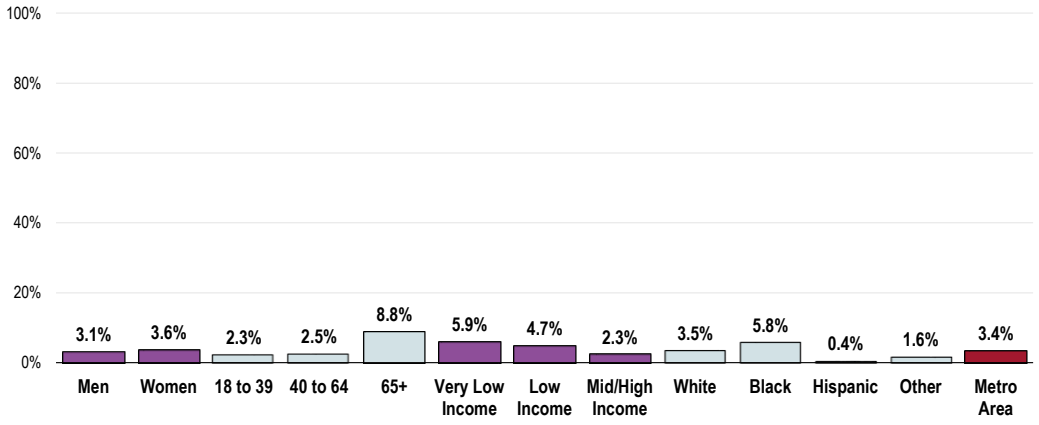
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]

Notes:
- Asked of all respondents.

Adults more likely to have been diagnosed with stroke include:

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

Prevalence of Stroke
(Metro Area, 2015)



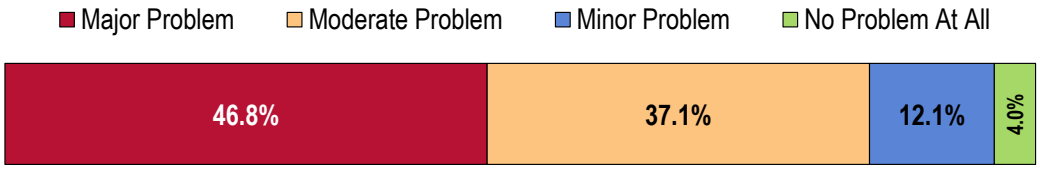
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]

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

Key Informant Input: Heart Disease & Stroke

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

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



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

Top Concerns

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

Associated Risk Factors

Obesity, need more preventative care strategies. – Healthcare Provider

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Leading Cause of Death

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

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

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

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

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

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

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

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

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

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

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

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

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

High Rate of Occurrence

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

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

It affects so many people. – Physician

High prevalence. – Physician

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

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

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

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

Racial & Ethnic Disparities

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

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

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

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

Family history/heredity. – Healthcare Provider

Health disparities. – Social Service Provider

Resources

Poor primary healthcare access. – Healthcare Provider

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

Cancer

About Cancer

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

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

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

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

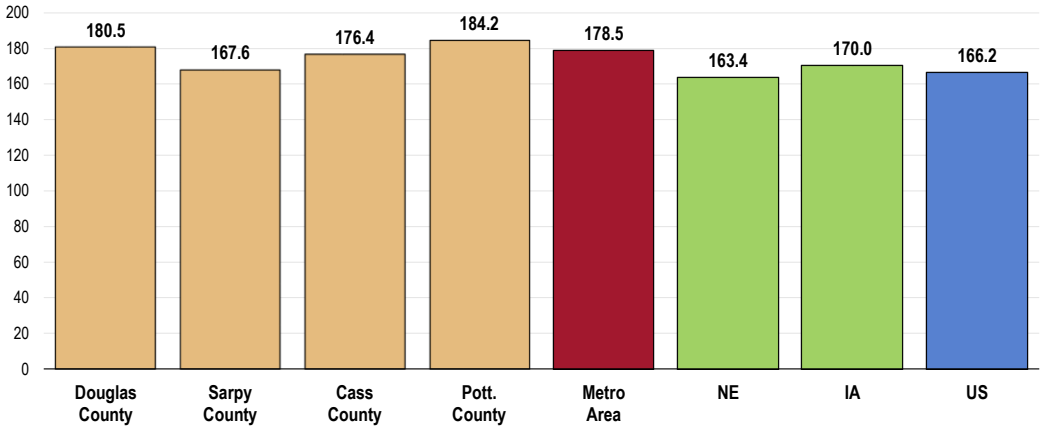
Between 2011 and 2013, there was an annual average age-adjusted cancer mortality rate of 178.5 deaths per 100,000 population in the Metro Area.

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

Cancer: Age-Adjusted Mortality

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

Healthy People 2020 Target = 161.4 or Lower



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

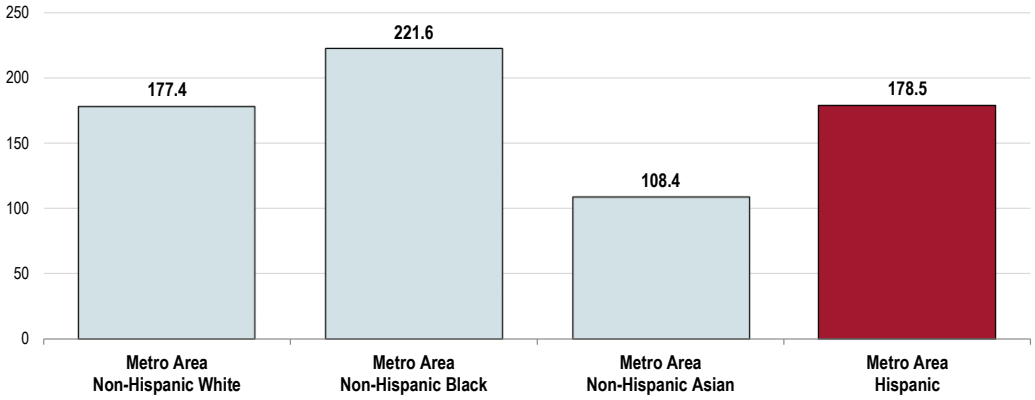
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Cancer: Age-Adjusted Mortality by Race

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

Healthy People 2020 Target = 161.4 or Lower

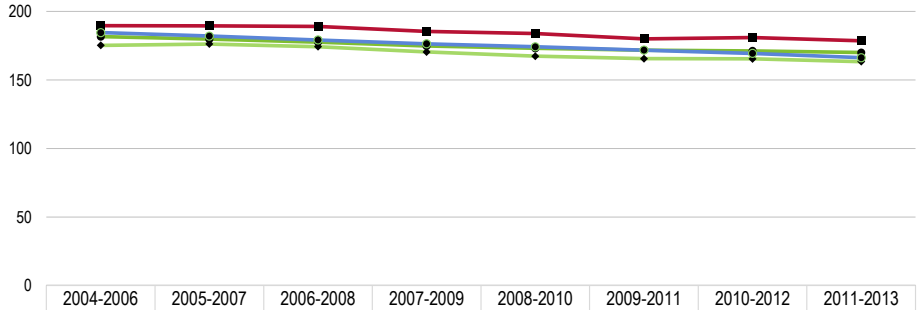


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov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

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

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

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



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	189.6	189.4	189.1	185.5	183.9	179.9	180.9	178.5
Nebraska	175.3	176.2	174.3	170.5	167.4	165.5	165.4	163.4
Iowa	181.6	179.8	177.6	174.8	173.1	171.8	171.2	170.0
United States	184.6	182.1	179.2	176.4	174.2	171.8	169.4	166.2

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

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

Cancer Deaths by Site

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

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

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

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

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

Age-Adjusted Cancer Death Rates by Site

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

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

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

Cancer Incidence

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

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

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

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

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

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

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

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

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

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

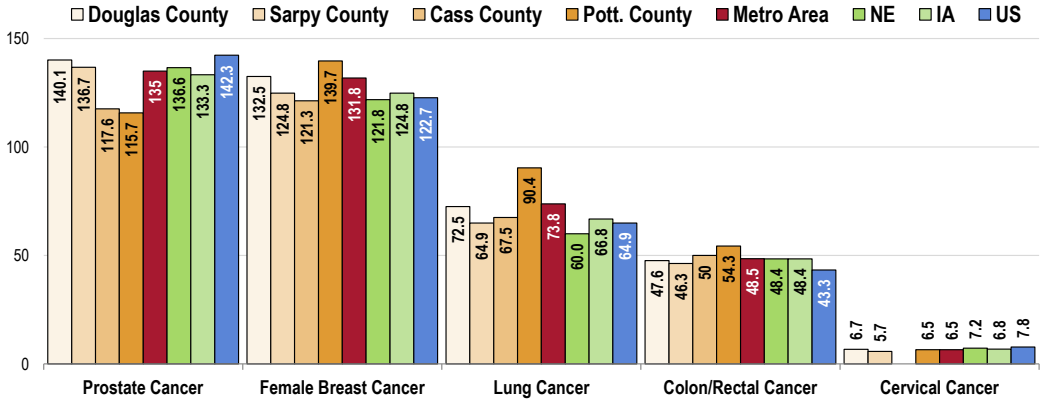
- Close to both state rates.
- Worse than the national incidence rate.
- Unfavorably high in Pottawattamie County.

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

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

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2007-2011)



Sources:
- State Cancer Profiles: 2007-11.
- Retrieved August 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

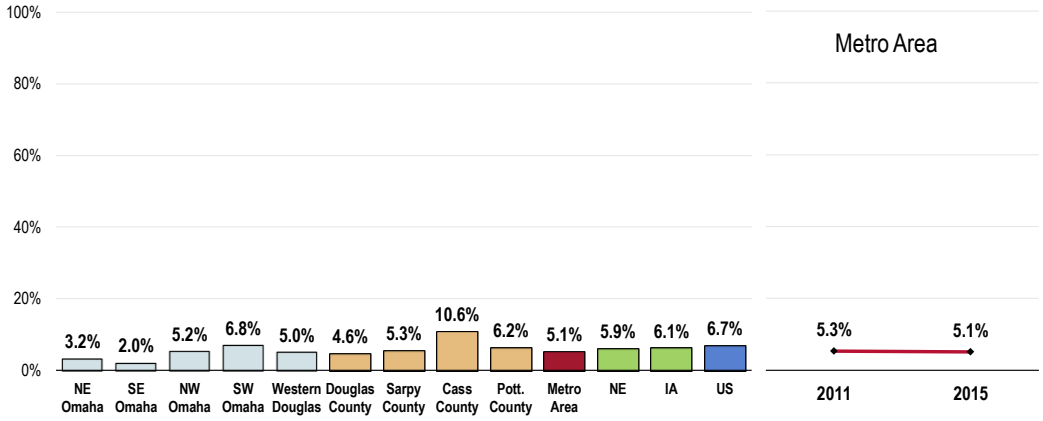
Prevalence of Cancer

Skin Cancer

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

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

Prevalence of Skin Cancer

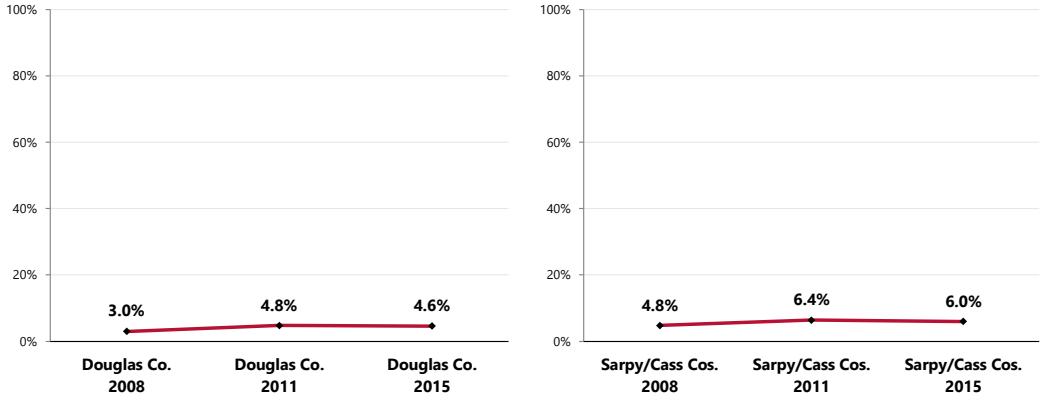


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.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

Notes:
- Asked of all respondents.

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

Prevalence of Skin Cancer



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]

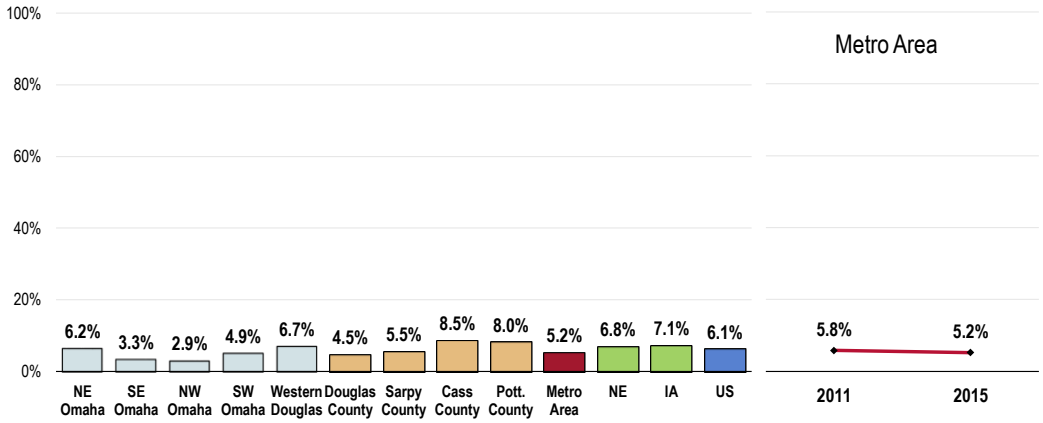
Notes:
- Asked of all respondents.

Other Cancer

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

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

Prevalence of Cancer (Other Than Skin Cancer)

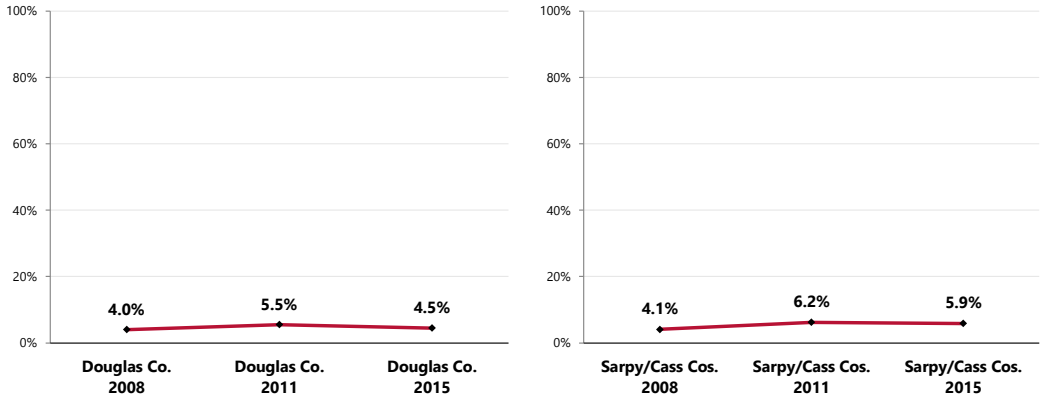


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.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

Notes:
- Asked of all respondents.

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

Prevalence of Cancer (Other Than Skin Cancer)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]

Notes:
- Asked of all respondents.

Cancer Risk

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

About Cancer Risk

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

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

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

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

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

Female Breast Cancer Screening

About Screening for Breast Cancer

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

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

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

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

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

Mammography

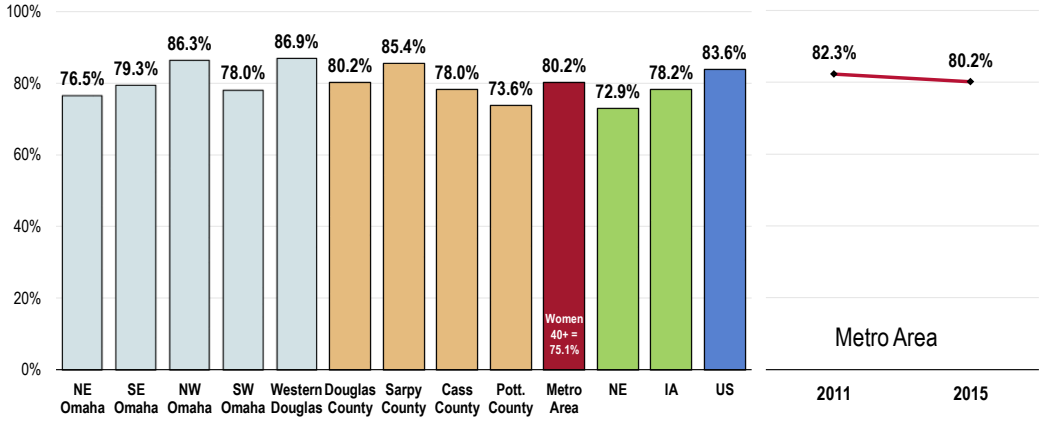
Among women age 50-74, 80.2% have had a mammogram within the past two years.

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

Have Had a Mammogram in the Past Two Years

(Among Women Age 50-74)

Healthy People 2020 Target = 81.1% or Higher



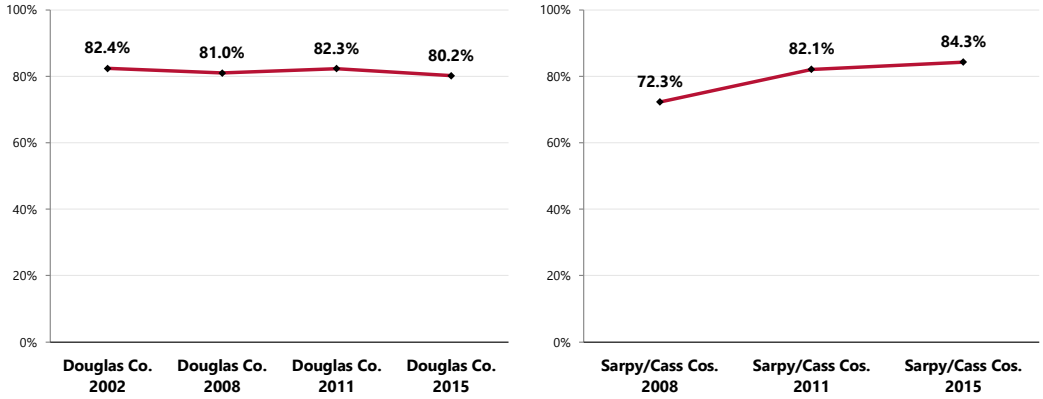
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 128-129]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2012 Nebraska and Iowa data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes:
- Reflects female respondents 50-74.
- *Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).

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

Have Had a Mammogram in the Past Two Years

(Among Women Age 50-74)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 128-129]

Notes:
- Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

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

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

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

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

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

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

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

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

Pap Smear Testing

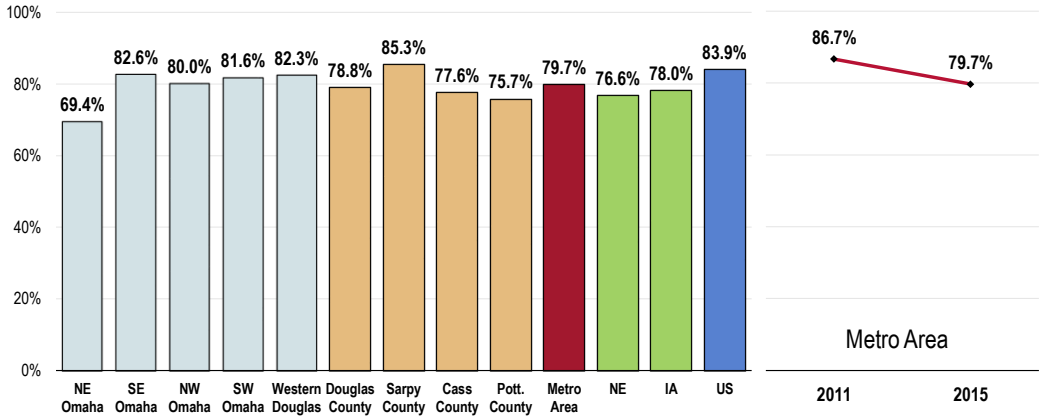
Among women age 21 to 65, 79.7% have had a Pap smear within the past three years.

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

Have Had a Pap Smear in the Past Three Years

(Among Women Age 21-65)

Healthy People 2020 Target = 93.0% or Higher



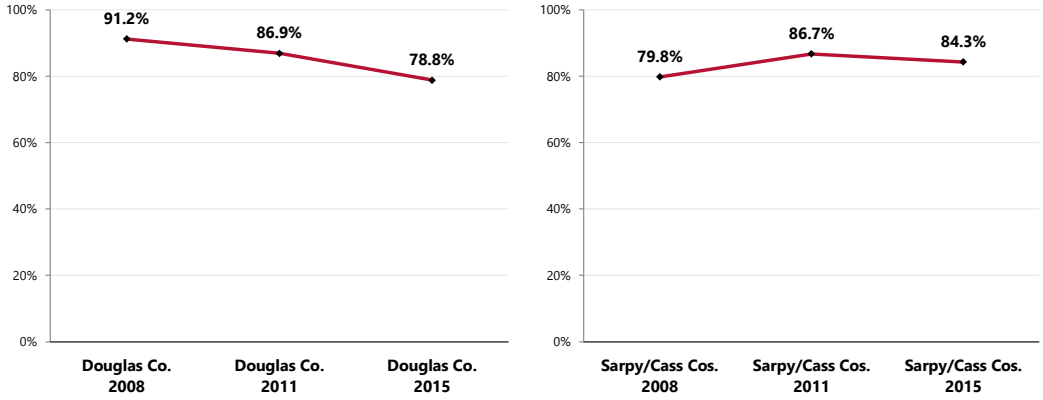
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 130]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2012 Nebraska and Iowa data.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

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

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

Have Had a Pap Smear in the Past Three Years

(Among Women Age 21-65)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 130]

Notes:
- Reflects female respondents age 21 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

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

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

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

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

Colorectal Cancer Screening

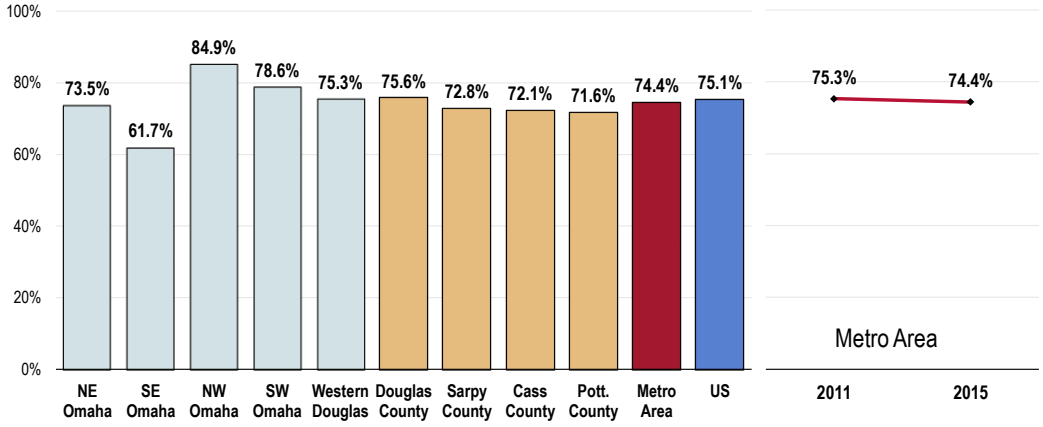
Among adults age 50–75, 74.4% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years).

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

Have Had a Colorectal Cancer Screening

(Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 133]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

Notes:
- Asked of all respondents age 50 through 75.
- In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

Lower Endoscopy

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

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

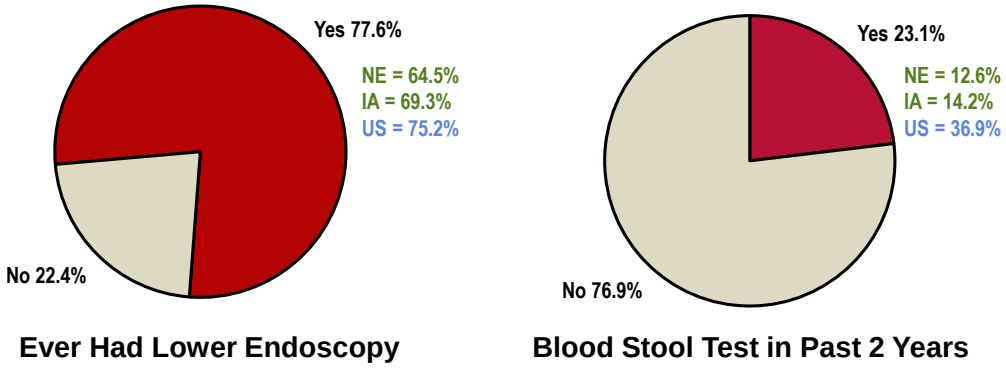
Blood Stool Testing

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

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

Colorectal Cancer Screenings

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



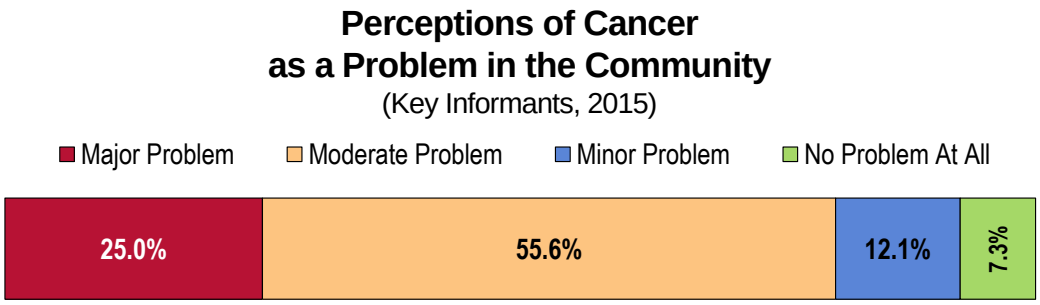
Ever Had Lower Endoscopy | **Blood Stool Test in Past 2 Years**

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

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

Key Informant Input: Cancer

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



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

Top Concerns

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

High Rate of Occurrence

There is so much of it. – Physician

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

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

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

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

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

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

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

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

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

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

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

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

Access to Screenings

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

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

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

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

Lack of Resources

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

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

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

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

Associated Risk Factors

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

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

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

Respiratory Disease

About Asthma & COPD

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

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

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

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

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

Risk factors for asthma currently being investigated include:

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

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

Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

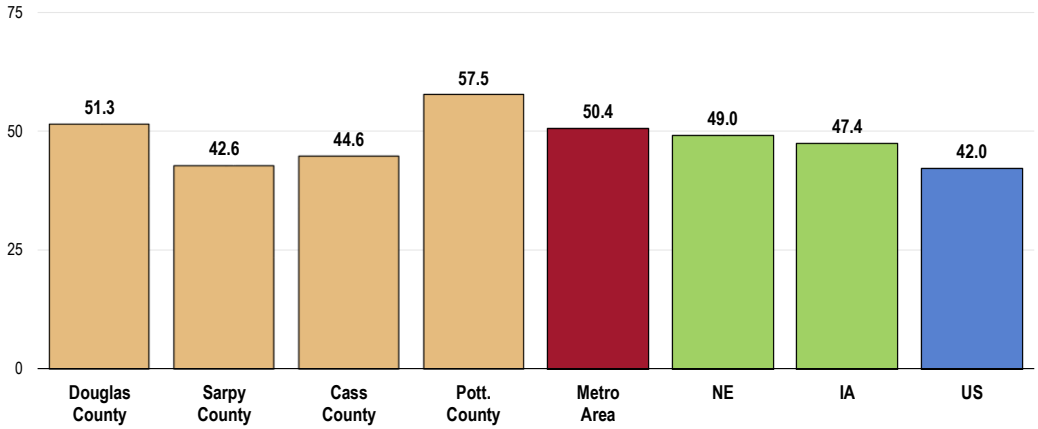
Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

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

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

CLRD: Age-Adjusted Mortality

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



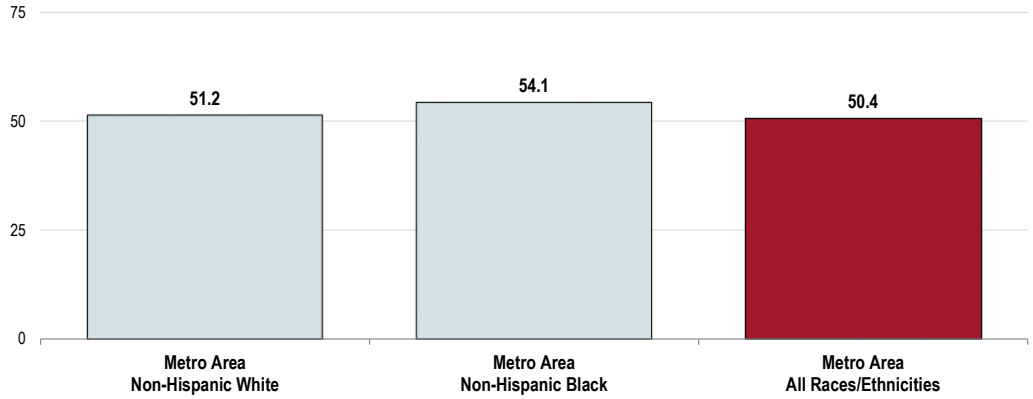
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.

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

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

CLRD: Age-Adjusted Mortality by Race

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



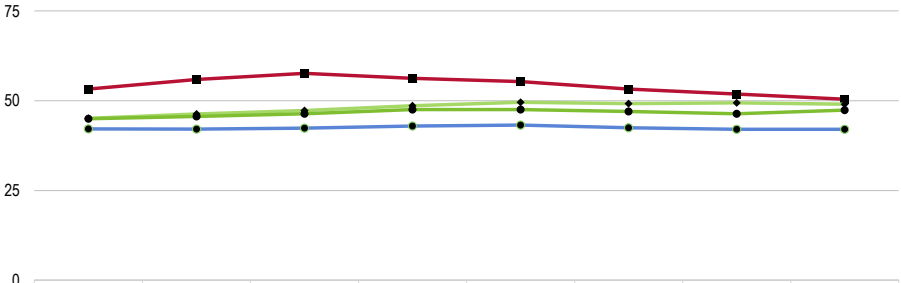
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.

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

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

CLRD: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	53.2	55.9	57.6	56.3	55.3	53.2	51.9	50.4
Nebraska	45.1	46.3	47.3	48.6	49.6	49.2	49.4	49.0
Iowa	45.0	45.6	46.4	47.5	47.6	47.0	46.4	47.4
United States	42.2	42.1	42.4	42.9	43.2	42.5	42.1	42.0

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

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

Pneumonia/Influenza Deaths

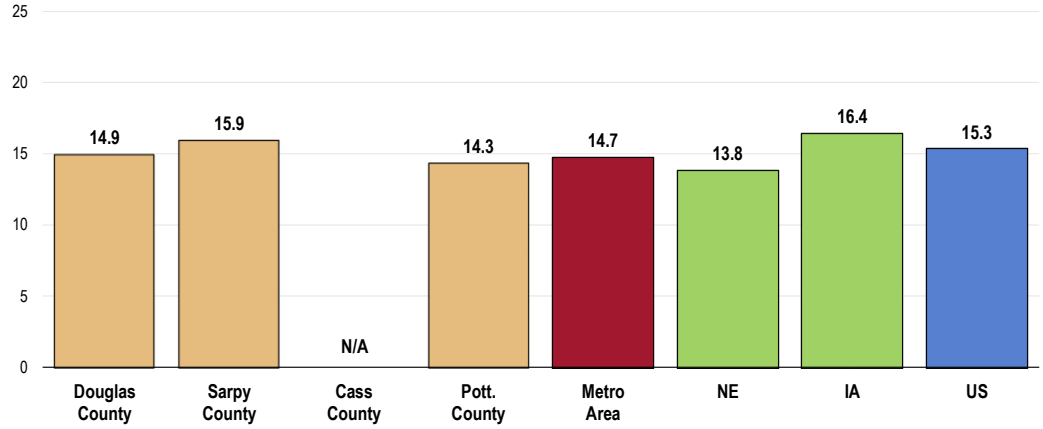
Between 2011 and 2013, there was an annual average age-adjusted pneumonia influenza mortality rate of 14.7 deaths per 100,000 population in the Metro Area.

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

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

Pneumonia/Influenza: Age-Adjusted Mortality

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



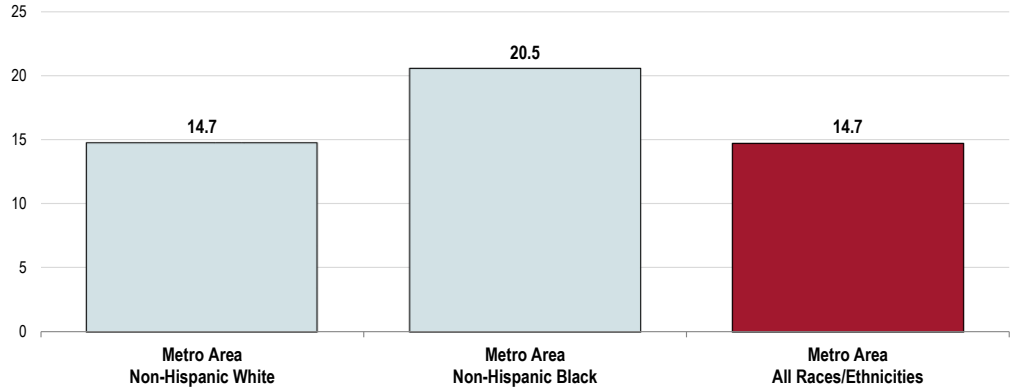
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.

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

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

Pneumonia/Influenza: Age-Adjusted Mortality by Race

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



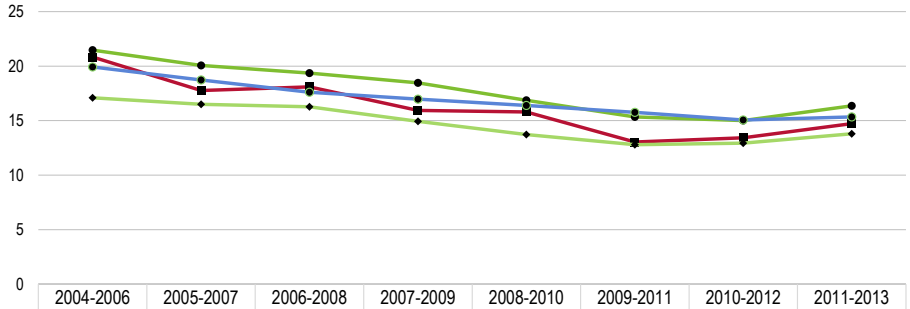
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.

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

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

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	20.8	17.8	18.1	15.9	15.8	13.0	13.4	14.7
Nebraska	17.1	16.5	16.3	14.9	13.7	12.8	12.9	13.8
Iowa	21.5	20.1	19.4	18.5	16.9	15.3	15.0	16.4
United States	19.9	18.7	17.6	17.0	16.4	15.8	15.1	15.3

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

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

Chronic Obstructive Pulmonary Disease (COPD)

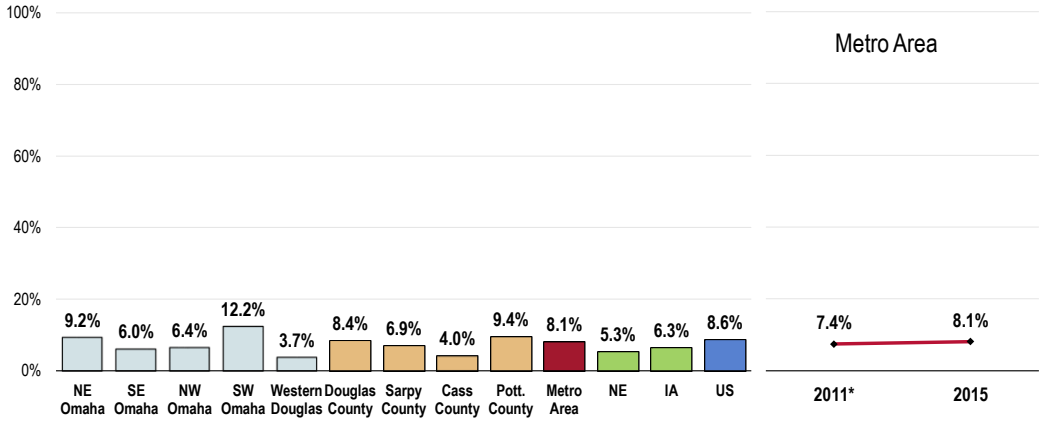
A total of 8.1% of Metro Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

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

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

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

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

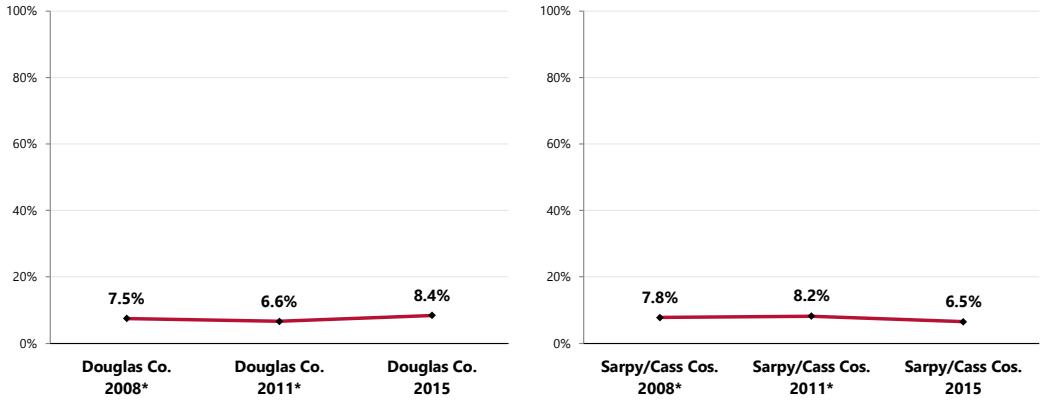


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.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

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

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

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]

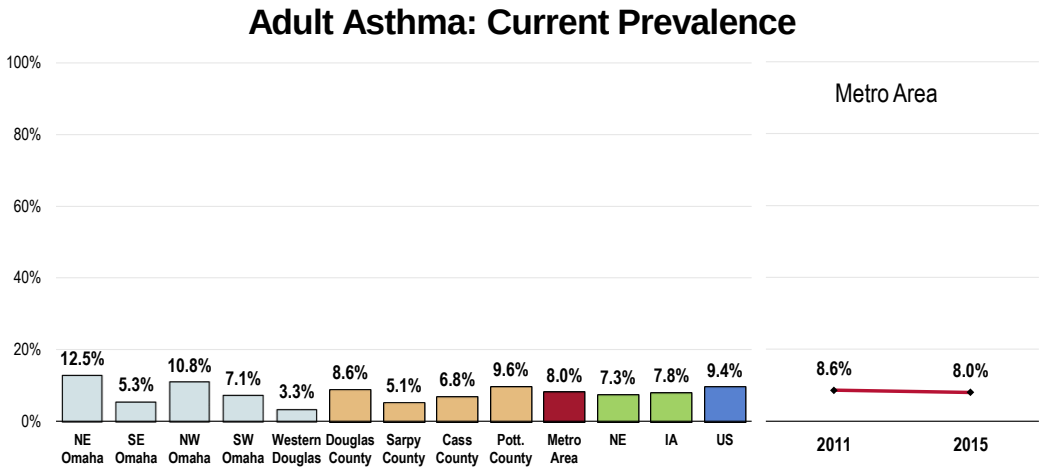
Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
- *In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Asthma

Adults

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

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

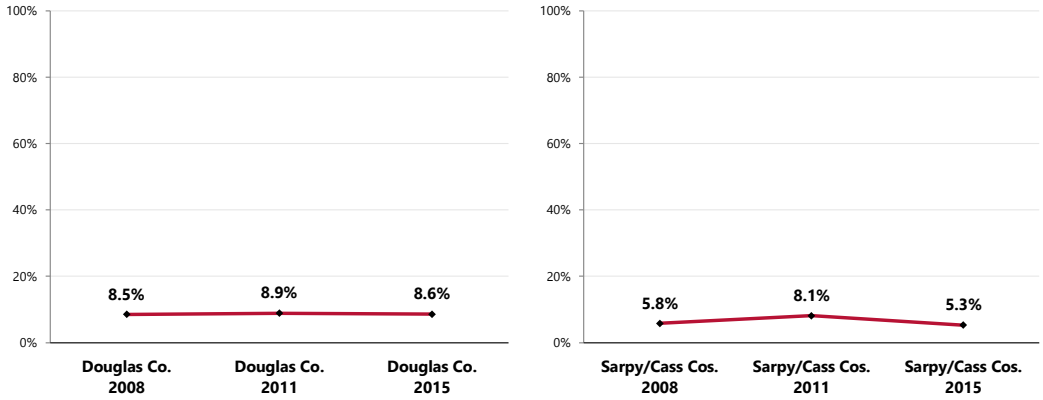


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 310]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Nebraska. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nebraska and Iowa data.

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

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

Adult Asthma: Current Prevalence



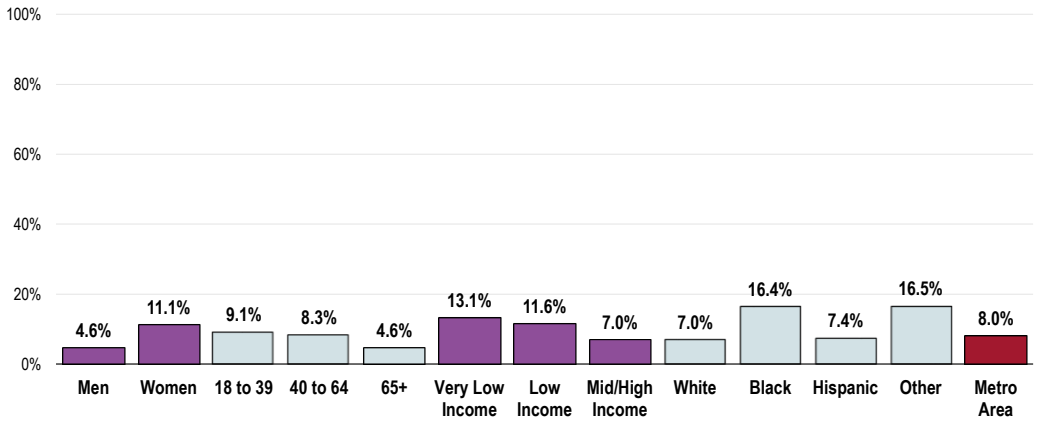
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 310]
Notes: ● Asked of all respondents.
● Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

The following adults are more likely to suffer from asthma:

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

Currently Have Asthma

(Metro Area, 2015)



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

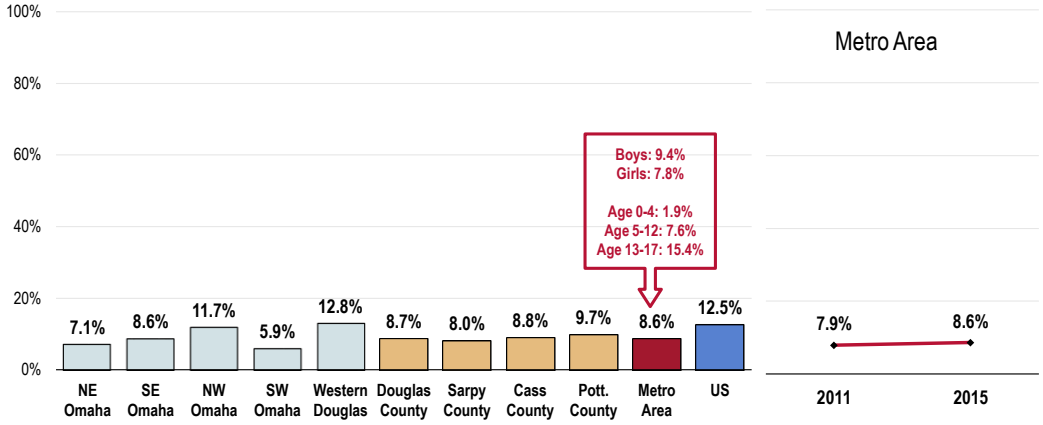
Children

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

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

Child Has Ever Been Diagnosed With Asthma

(Among Parents of Children Age 0-17)

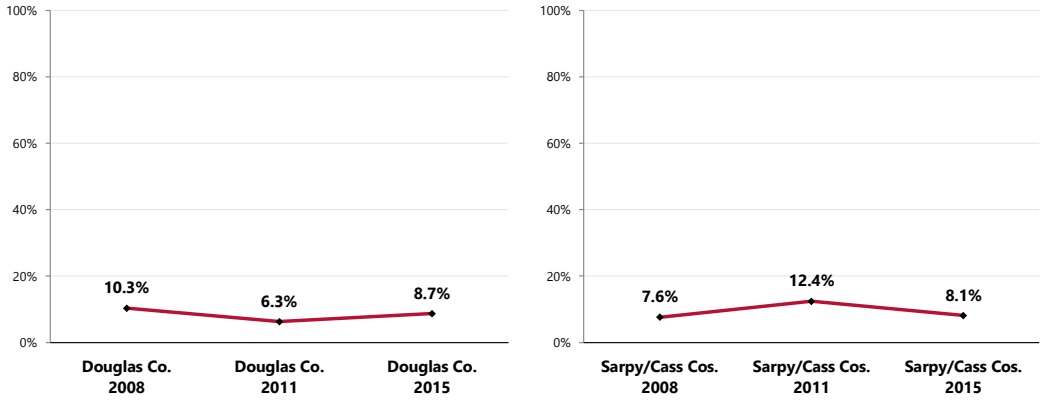


Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 114]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

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

Child Has Ever Been Diagnosed With Asthma

(Among Parents of Children Age 0-17)



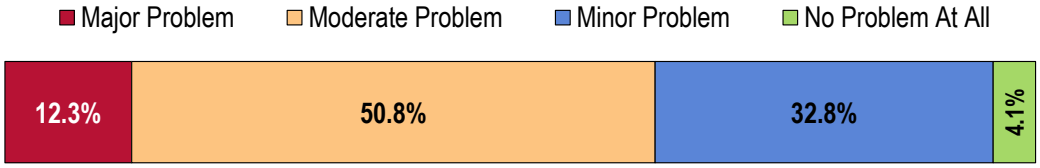
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 114]
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2015)



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

Top Concerns

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

Associated Risk Factors

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

Smokers. – Healthcare Provider

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

Smoking. – Community/Business Leader

Asthma

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

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

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

Injury & Violence

About Injury & Violence

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

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

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

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

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

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

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

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

Efforts to prevent violence may focus on:

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

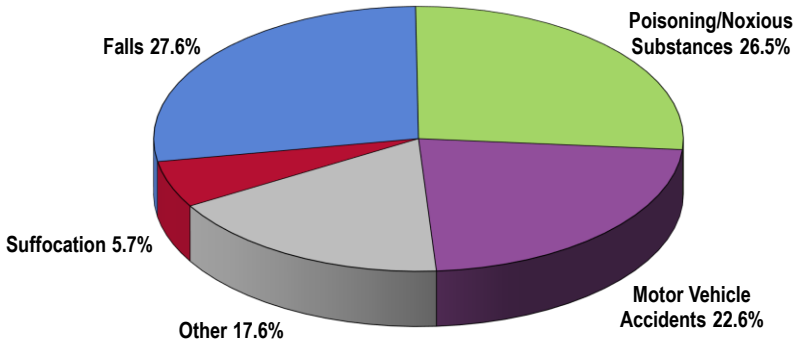
- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

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

Leading Causes of Accidental Death

(Metro Area, 2011-2013)



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

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

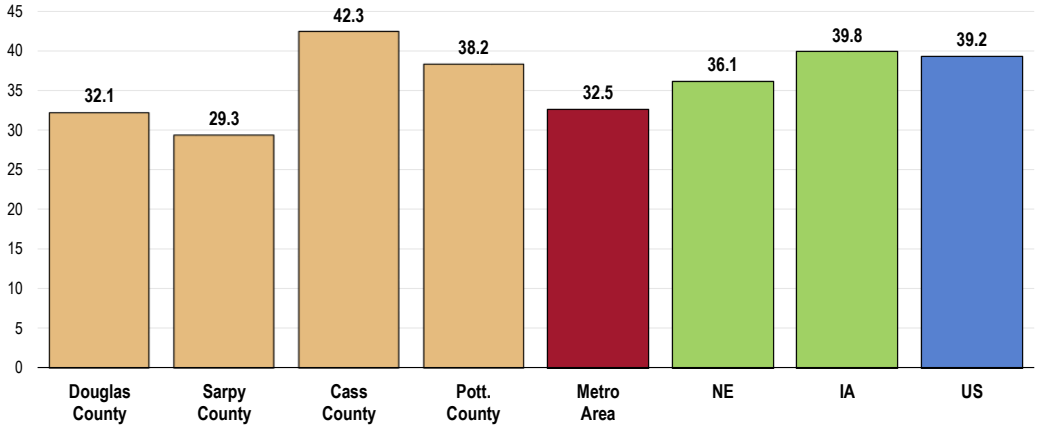
Between 2011 and 2013, there was an annual average age-adjusted unintentional injury mortality rate of 32.5 deaths per 100,000 population in the Metro Area.

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

Unintentional Injuries: Age-Adjusted Mortality

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

Healthy People 2020 Target = 36.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

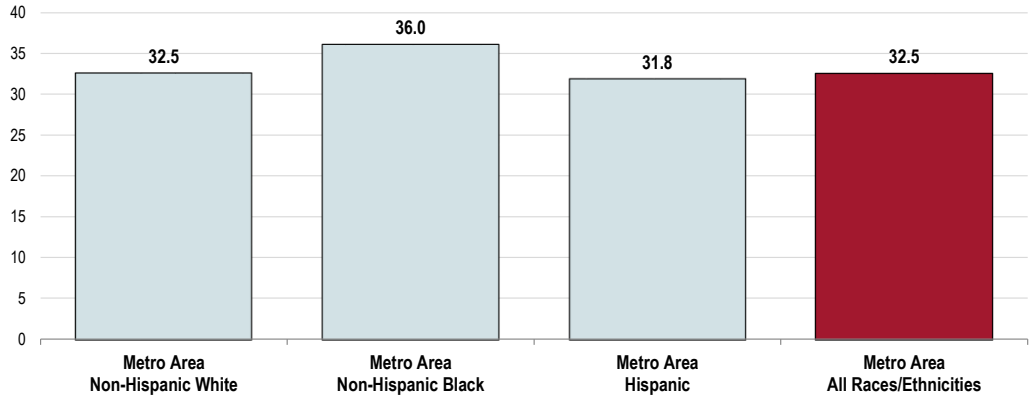
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Unintentional Injuries: Age-Adjusted Mortality by Race

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

Healthy People 2020 Target = 36.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

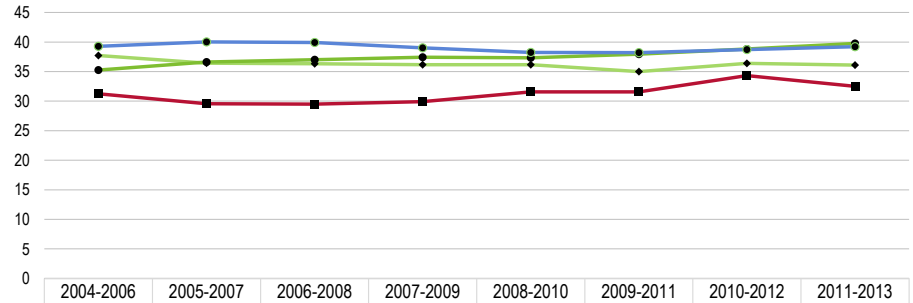
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 or Lower



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	31.2	29.6	29.5	29.9	31.6	31.6	34.3	32.5
Nebraska	37.7	36.4	36.3	36.2	36.2	35.0	36.4	36.1
Iowa	35.3	36.6	37.0	37.4	37.3	37.9	38.8	39.8
United States	39.3	40.0	39.9	39.0	38.2	38.2	38.7	39.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

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

Motor Vehicle Safety

Age-Adjusted Motor-Vehicle Related Deaths

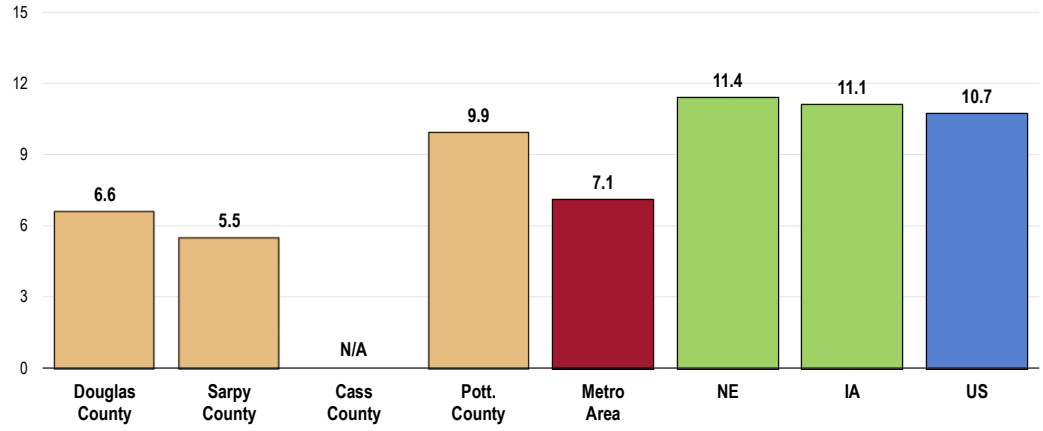
Between 2011 and 2013, there was an annual average age-adjusted motor vehicle crash mortality rate of 7.1 deaths per 100,000 population in the Metro Area.

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

Motor Vehicle Crashes: Age-Adjusted Mortality

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

Healthy People 2020 Target = 12.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

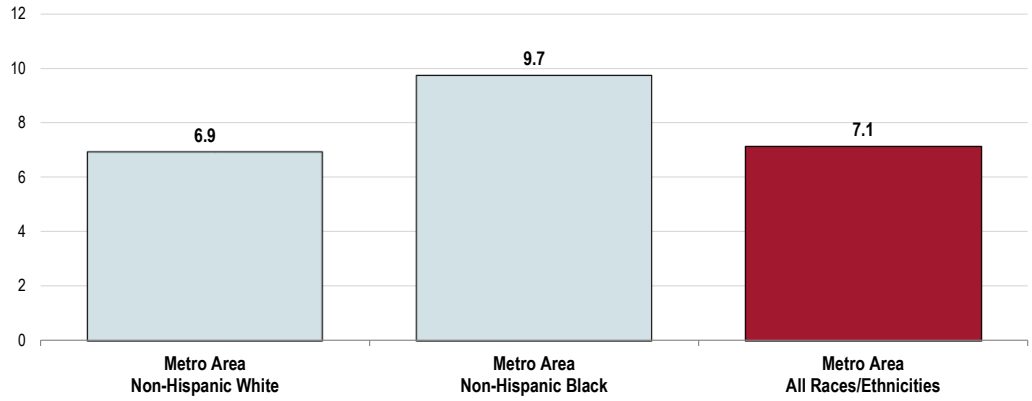
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Motor Vehicle Crashes: Age-Adjusted Mortality by Race

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

Healthy People 2020 Target = 12.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

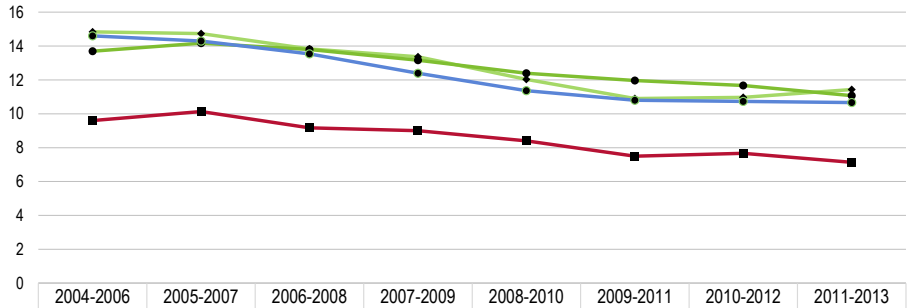
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 12.4 or Lower



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Metro Area	9.6	10.1	9.2	9.0	8.4	7.5	7.7	7.1
Nebraska	14.8	14.7	13.8	13.4	12.0	10.9	11.0	11.4
Iowa	13.7	14.2	13.8	13.2	12.4	12.0	11.7	11.1
United States	14.6	14.3	13.5	12.4	11.4	10.8	10.7	10.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

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