2012 PRC Community Health Needs Assessment Report

Primary Service Area Findings —
South Lake Tahoe & Surrounding Communities

Sponsored by

Barton Health

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INTRODUCTION

Project Overview

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area (PSA) of Barton Health and Barton Memorial Hospital. 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 conducted on behalf of Barton Health 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 a series of Key Informant Focus Groups.

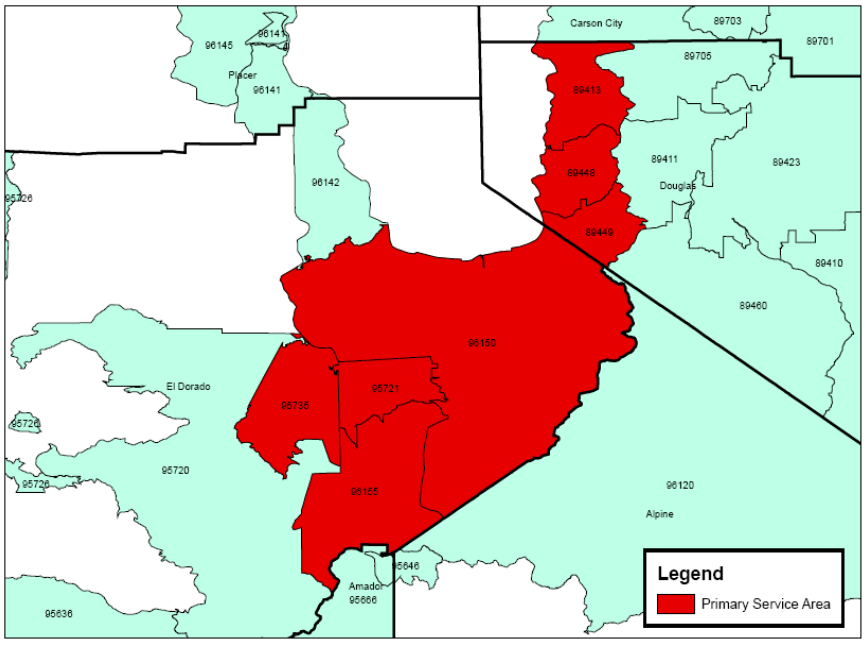
PRC Community Health Survey

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 Barton Health and PRC, with input from the Barton Health Community Health Needs Assessment Advisory Steering Committee.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Primary Service Area" in this report) includes these residential ZIP Codes: 95375, 95721, 95735, 96150, 96155, 96156, 96158, 89413, 89448 and 89449. A geographic description is illustrated in the following map.



Sample Approach & Design

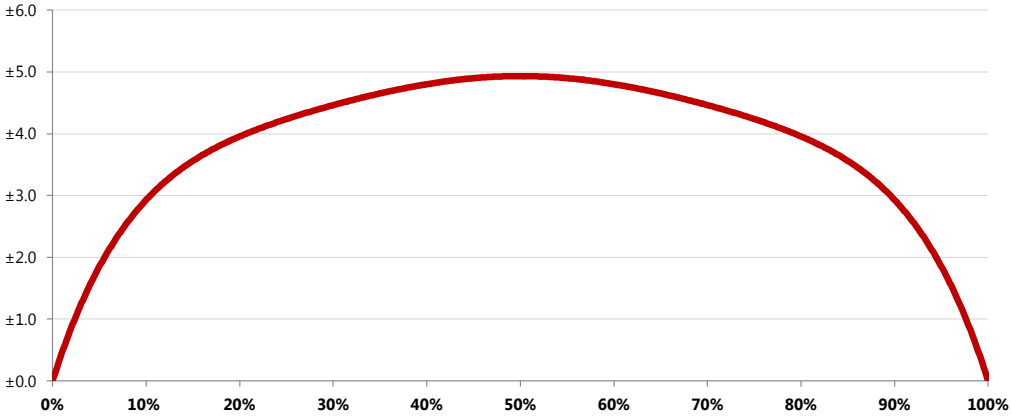
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — 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 random sample of 400 individuals age 18 and older in the Primary Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Primary Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is ±4.9% at the 95 percent level of confidence.

Expected Error Ranges for a Sample of 400 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 400 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% (10% ± 2.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% (50% ± 4.9%) of the total population would respond "yes" if asked this question.

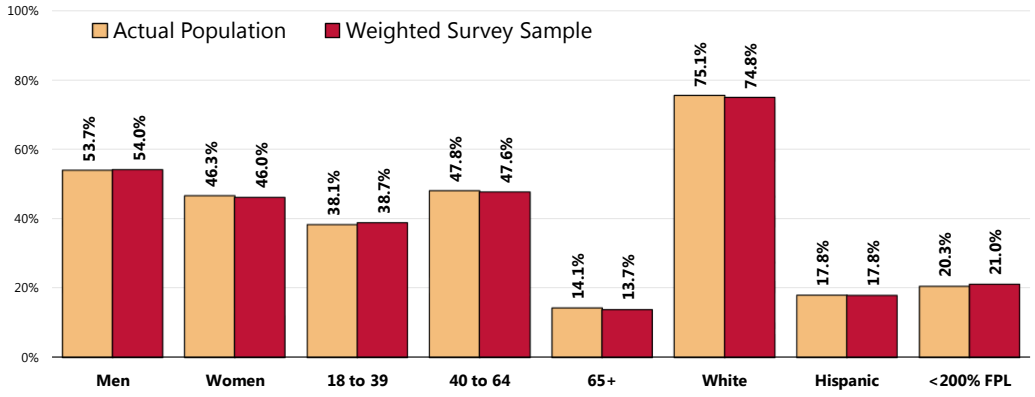
Sample Characteristics

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 charts outline the characteristics of the Primary Service 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 & Sample Characteristics

(Primary Service Area, 2012)



Sources:
- Census 2010, Summary File 3 (SF 3). U.S. Census Bureau.
- 2012 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 2012 guidelines place the poverty threshold for a family of four at $23,050 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; "**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.

Key Informant Focus Groups

As part of the community health assessment, there were two focus groups held on March 29, 2012, one with members of the Barton Health Community Health Needs Assessment Advisory Steering Committee, and one with other key informants from the community. In all, 21 individuals took part in these focus groups, including physicians, other health professionals, social service providers and other community leaders.

A list of recommended participants for the focus groups was provided by Barton Health with input from members of the Advisory Steering Committee. 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. Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

Focus group candidates were first contacted by letter to request their participation. Follow-up phone calls were then made to ascertain whether or not they would be able to attend. Confirmation calls were placed the day before the groups were scheduled to insure a reasonable turnout.

Audio from the focus groups sessions was recorded, from which verbatim comments in this report are taken. There are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

NOTE: These findings represent qualitative rather than quantitative data. The groups were 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. These secondary data are only available at the county level; to best match the Primary Service Area, data from El Dorado County in California and Douglas County in Nevada were used. These were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Centers for Disease Control & Prevention
- National Center for Health Statistics
- California Department of Public Health
- Nevada Department of Health and Human Services, Nevada State Health Division
- California Uniform Crime Report
- Crime in Nevada
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Benchmark Data

California and Nevada 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 *2011 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 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.

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

Areas of Opportunity for Community Health Improvement

The following "health priorities" represent recommended areas of intervention, 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 region with regard to the following health areas (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	
Access to Health Services	• Lack of Health Insurance Coverage • Insurance Instability • Cost of Physician Visits • Routine Checkups [Adults] (Including Screening for Blood Pressure/Cholesterol) • Lack of Dental Insurance Coverage • Routine Eye Exams • Ratings of Local Healthcare
Cancer	• Cancer Deaths (Prostate Cancer, Lung Cancer)
Dementias, Including Alzheimer's Disease	• Alzheimer's Disease Deaths
Housing	• Displacement • Exposure to Mold, Radon, Lead
Immunization & Infectious Diseases	• Seasonal Flu Shots (65+)
Injury & Violence Prevention	• Unintentional Injury Deaths (Poisonings/Accidental Overdoses, Motor Vehicle Crashes, Falls) • Family Violence (Domestic Violence, Child Abuse)
Mental Health & Mental Disorders	• Suicides
Substance Abuse	• Cirrhosis/Liver Disease Deaths • High-Risk Alcohol Use • Drug-Induced Deaths • Illicit Drug Use
Tobacco Use	• Cigarette Smoking • Chronic Lower Respiratory Disease (CLRD) Deaths

Prioritization

These areas of concern are subject to the discretion of area providers, the steering committee, or other local organizations and community leaders as to actionability and priority. A prioritization process will be pursued by Barton Health, and the prioritized description of community health needs, as well as a description of the process and criteria used in prioritizing, will be shared with community members.

Top Community Health Concerns Among Community Key Informants

At the conclusion of each key informant focus group, participants were asked to write down what they individually perceive as the top five health priorities for the community, based on the group discussion as well as on their own experiences and perceptions. Their responses were collected, categorized and tallied to produce the top-ranked priorities as identified among key informants. These should be used to complement and corroborate findings that emerge from the quantitative dataset.

1. Mental Health

- Mentioned resources available to address this issue: El Dorado County Mental Health Office; Barton Health Telemedicine Resources; NAMI; public health; psychiatrists; Barton Health Emergency Room; South Lake Tahoe law enforcement; family physicians; private providers; Tahoe Youth & Family Services; Women's Center

2. Substance Abuse

- Mentioned resources available to address this issue: rehabilitation programs; Tahoe Turning Point; Tahoe Youth & Family Services; Vitality Lake Tahoe; Sierra Recovery; Youth Task Force; Alcoholics Anonymous; Tahoe Turning Point

3. Access

- Mentioned resources available to address this issue: Barton Health; Cancer League; First Firs Dental van; Barton Community Clinic; public health; BlueGo Transit

4. Education/Prevention

- Mentioned resources available to address this issue: Barton Health; public health offices; Lake Tahoe Unified School District; community clinics; gyms; private providers; Lake Tahoe Community College

5. Housing

- Mentioned resources available to address this issue: El Dorado County Human Services; City of South Lake Tahoe; Tahoe Magic; Tahoe Area Coordinating Council for the Disabled

Summary Tables: Comparisons With Benchmark Data

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

Reading the Summary Tables

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

The columns to the right of the Primary Service Area column provide comparisons between the Primary Service Area and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the Primary Service 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.

Access to Health Services	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	**26.2**	20.9	23.1	14.9	0.0
% [65+] With Medicare Supplement Insurance	**76.9**			75.5	
% [Insured] Insurance Covers Prescriptions	**92.4**			93.9	
% [Insured] Went Without Coverage in Past Year	**8.3**			4.8	
% Difficulty Accessing Healthcare in Past Year (Composite)	**40.1**			37.3	
% Inconvenient Hrs Prevented Dr Visit in Past Year	**10.6**			14.3	
% Cost Prevented Getting Prescription in Past Year	**18.5**			15.0	
% Cost Prevented Physician Visit in Past Year	**19.3**			14.0	
% Difficulty Getting Appointment in Past Year	**16.4**			16.5	
% Difficulty Finding Physician in Past Year	**10.6**			10.7	
% Transportation Hindered Dr Visit in Past Year	**9.8**			7.7	
% Skipped Prescription Doses to Save Costs	**15.4**			14.8	
% Difficulty Getting Child's Healthcare in Past Year	**3.7**			1.9	
% [Age 18+] Have a Specific Source of Ongoing Care	**77.0**			76.3	95.0
% Have Had Routine Checkup in Past Year	**54.3**			67.3	
% Child Has Had Checkup in Past Year	**84.3**			87.0	
% Two or More ER Visits in Past Year	**8.6**			6.5	

Access to Health Services (continued)	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Rate Local Healthcare "Fair/Poor"	29.3			15.3	
			better	similar	worse

Arthritis, Osteoporosis & Chronic Back Conditions	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	24.7			35.4	
% [50+] Osteoporosis	10.9			11.4	5.3
% Sciatica/Chronic Back Pain	22.8			21.5	
% Migraine/Severe Headaches	9.9			16.9	
% Chronic Neck Pain	10.0			8.3	
			better	similar	worse

Cancer	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	180.1	160.3	180.8	178.1	160.6
Lung Cancer (Age-Adjusted Death Rate)	48.6	39.2	54.4	50.5	45.5
Prostate Cancer (Age-Adjusted Death Rate)	25.5	22.2	23.8	23.1	21.2
Female Breast Cancer (Age-Adjusted Death Rate)	20.7	22.0	22.5	23.0	20.6
Colorectal Cancer (Age-Adjusted Death Rate)	15.2	15.1	18.0	16.8	14.5
% Skin Cancer	7.5			8.1	
% Cancer (Other Than Skin)	7.3			5.5	

Cancer (continued)	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% [Men 50+] Prostate Exam in Past 2 Years	74.8			70.5	
% [Women 50-74] Mammogram in Past 2 Years	74.7	81.4	69.9	79.9	81.1
% [Women 21-65] Pap Smear in Past 3 Years	78.5	80.8	78.4	84.7	93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	72.4	61.5	61.5	72.0	
% [Age 50+] Blood Stool Test in Past 2 Years	24.2	27.0	17.2	28.3	
% [Age 50-75] Colorectal Cancer Screening	73.3				70.5
			better	similar	worse

Chronic Kidney Disease	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Kidney Disease (Age-Adjusted Death Rate)	8.7	8.1	20.7	14.6	
			better	similar	worse

Diabetes	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Diabetes Mellitus (Age-Adjusted Death Rate)	15.0	21.7	13.7	22.5	19.6
% Diabetes/High Blood Sugar	5.3	8.6	8.5	10.1	
			better	similar	worse

Dementias, Including Alzheimer's Disease	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Alzheimer's Disease (Age-Adjusted Death Rate)	27.0	25.4	13.4	23.2	
			better	similar	worse

Educational & Community-Based Programs	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Attended Health Event in Past Year	19.6			22.2	
			better	similar	worse

Environmental Health	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Exposed to Mold at Home/Work	12.7				
% Exposed to Lead at Home/Work	8.7				
% Exposed to Radon at Home/Work	16.8				
			better	similar	worse

Family Planning	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Births to Teenagers	6.9	9.3	16.0	10.3	
			better	similar	worse

General Health Status	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% "Fair/Poor" Physical Health	13.6	18.1	17.0	16.8	
% Activity Limitations	20.4	18.1	21.0	17.0	
			better	similar	worse

Hearing & Other Sensory or Communication Disorders	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Deafness/Trouble Hearing	11.9			9.6	
			better	similar	worse

Heart Disease & Stroke	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	179.2	180.2	207.5	192.5	152.7
Stroke (Age-Adjusted Death Rate)	34.8	42.3	39.0	42.2	33.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	3.6			6.1	
% Stroke	1.1	2.3	3.1	2.7	
% Blood Pressure Checked in Past 2 Years	91.1			94.7	94.9
% Told Have High Blood Pressure (Ever)	30.2	25.7	27.5	34.3	26.9
% [HBP] Taking Action to Control High Blood Pressure	91.1			89.1	
% Cholesterol Checked in Past 5 Years	84.0	74.5	76.0	90.7	82.1
% Told Have High Cholesterol (Ever)	30.6	36.5	38.6	31.4	13.5
% [HBC] Taking Action to Control High Blood Cholesterol	87.4			89.1	
% 1+ Cardiovascular Risk Factor	77.6			86.3	
			better	similar	worse

HIV	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
HIV/AIDS (Age-Adjusted Death Rate)	1.4	3.8	3.6	4.5	3.3
% [Age 18-44] HIV Test in the Past Year	13.3			19.9	16.9
			better	similar	worse

Homelessness	Primary Service Area	PSA vs. Benchmarks vs. CA	vs. NV	vs. US	vs. HP2020
% Was Homeless at Some Point in the Past 2 Years	1.2				
% Lived w/Friend or Relative Due to Housing Emergency	7.3			10.7	
			better	similar	worse

Immunization & Infectious Diseases	Primary Service Area	PSA vs. Benchmarks vs. CA	vs. NV	vs. US	vs. HP2020
Pertussis per 100,000	0.6	2.1	1.1	4.5	
Hepatitis C, non-A non-B Incidence per 100,000	0.2	0.1	0.4		0.2
% [Age 65+] Flu Shot in Past Year	54.8	63.0	59.3	71.6	90.0
% [High-Risk 18-64] Flu Shot in Past Year	44.9			52.5	90.0
% [Age 65+] Pneumonia Vaccine Ever	60.6	62.6	66.6	68.1	90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever	36.2			32.0	60.0
% Ever Vaccinated for Hepatitis B	39.8			38.4	
			better	similar	worse

Injury & Violence Prevention	Primary Service Area	PSA vs. Benchmarks vs. CA	vs. NV	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	47.3	30.9	45.7	39.5	36.0
Motor Vehicle Crashes (Age-Adjusted Death Rate)	13.6	11.2	15.7	14.1	12.4
% "Always" Wear Seat Belt	91.2			85.3	92.4
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	96.7			91.6	

Injury & Violence Prevention (continued)	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Child [Age 5-17] "Always" Wears Bicycle Helmet	**55.7**			35.3	
Firearm-Related Deaths (Age-Adjusted Death Rate)	**10.3**	8.8	16.1	10.2	9.2
% Firearm in Home	**27.8**			37.9	
% [Homes With Children] Firearm in Home	**19.6**			34.4	
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	**18.6**			16.9	
Homicide (Age-Adjusted Death Rate)	**2.5**	6.4	7.6	6.1	5.5
Violent Crime per 100,000 [El Dorado County]	**271.5**	482.1		454.1	
% Victim of Violent Crime in Past 5 Years	**2.2**			1.6	
% Ever Threatened With Violence by Intimate Partner	**15.6**			11.7	
% Victim of Domestic Violence (Ever)	**19.4**			13.5	
Child Abuse Offenses per 1,000 Children [El Dorado County]	**62.8**	48.4			
			better	similar	worse

Maternal, Infant & Child Health	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% No Prenatal Care in First Trimester [Douglas County]	**26.5**		36.4		22.1
% Received Late or No Prenatal Care [El Dorado County]	**2.7**	3.2			
% of Low Birthweight Births	**6.9**	6.8	12.3	8.2	7.8

Maternal, Infant & Child Health (continued)	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Infant Death Rate	3.7	5.1	6.1	6.7	6.0
			better	similar	worse

Mental Health & Mental Disorders	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	8.0			11.7	
% Major Depression	10.1			11.7	
% Symptoms of Chronic Depression (2+ Years)	29.5			26.5	
Suicide (Age-Adjusted Death Rate)	14.6	9.8	19.3	11.3	10.2
% Have Ever Sought Help for Mental Health	27.9			24.4	
% Typical Day Is "Extremely/Very" Stressful	9.7			11.5	
% Child [Age 5-17] Takes Prescription for ADD/ADHD	4.5			6.5	
			better	similar	worse

Nutrition & Weight Status	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	53.6			48.8	
% Medical Advice on Nutrition in Past Year	36.5			41.9	
% Healthy Weight (BMI 18.5-24.9)	44.8			31.7	33.9
% Overweight	53.0	61.6	60.2	66.9	
% Obese	15.2	24.7	23.1	28.5	30.6

Nutrition & Weight Status (continued)	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% [Overweights] Perceive Self "About the Right Weight"	36.4				
% Medical Advice on Weight in Past Year	18.1			25.7	
% [Overweights] Counseled About Weight in Past Year	22.6			30.9	
% [Obese Adults] Counseled About Weight in Past Year	39.8			47.4	31.8
% [Overweights] Trying to Lose Weight Both Diet/Exercise	37.9			38.6	
% Children [Age 5-17] Overweight	34.6			30.7	
% Children [Age 5-17] Obese	20.4			18.9	14.6
			better	similar	worse

Oral Health	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	62.8	69.6	67.2	66.9	49.0
% Child [Age 2-17] Dental Visit in Past Year	81.3			79.2	49.0
% Have Dental Insurance	54.5			60.8	
			better	similar	worse

Physical Activity	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% [Employed] Job Entails Mostly Sitting/Standing	55.8			63.2	
% No Leisure-Time Physical Activity	13.8	20.4	23.0	28.7	32.6
% Meeting Physical Activity Guidelines	58.6	51.3	51.4	42.7	

Physical Activity (continued)	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Moderate Physical Activity	**38.0**			23.9	
% Vigorous Physical Activity	**48.1**	32.9	29.9	34.8	
% Have 24-Hour Access to Fitness Equipment	**75.4**				
% Medical Advice on Physical Activity in Past Year	**40.0**			47.8	
% Child [Age 5-17] Watches TV 3+ Hours per Day	**12.0**			19.7	
% Child [Age 5-17] Uses Computer 3+ Hours per Day	**12.1**			9.9	
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time	**39.2**			43.4	
			better	similar	worse

Respiratory Diseases	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
CLRD (Age-Adjusted Death Rate)	**44.4**	38.5	50.4	41.8	
Pneumonia/Influenza (Age-Adjusted Death Rate)	**14.8**	19.7	19.8	17.0	
% Nasal/Hay Fever Allergies	**17.8**			27.3	
% Sinusitis	**9.2**			19.4	
% Chronic Lung Disease	**7.6**			8.4	
% [Adult] Currently Has Asthma	**6.3**	7.7	9.2	7.5	
% [Child 0-17] Currently Has Asthma	**3.2**			6.8	
			better	similar	worse

Sexually Transmitted Diseases	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000	**7.2**	65.4	69.5	103.2	
Primary & Secondary Syphilis Incidence per 100,000	**0.7**	5.4	3.7	4.5	
Chlamydia Incidence per 100,000	**128.7**	387.9	361.8	409.8	
Hepatitis B Incidence per 100,000	**0.6**	0.8	1.6	1.3	
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	**12.5**			7.1	
% [Unmarried 18-64] Using Condoms	**37.3**			18.9	
			better	similar	worse

Substance Abuse	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	**10.2**	11.2	11.1	9.0	8.2
% Current Drinker	**69.4**	53.3	56.7	58.8	
% Chronic Drinker (Average 2+ Drinks/Day)	**13.2**	5.7	5.8	5.6	
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	**28.6**	15.8	17.2	16.7	24.3
% Drinking & Driving in Past Month	**2.1**			3.5	
% Driving Drunk or Riding with Drunk Driver	**6.1**			5.5	
Drug-Induced Deaths (Age-Adjusted Death Rate)	**17.3**	11.1	19.5	12.6	11.3
% Illicit Drug Use in Past Month	**6.7**			1.7	7.1

Substance Abuse (continued)	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Ever Sought Help for Alcohol or Drug Problem	8.1			3.9	
			better	similar	worse

Tobacco Use	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Current Smoker	18.2	12.1	21.4	16.6	12.0
% Someone Smokes at Home	12.8			13.6	
% [Non-Smokers] Someone Smokes in the Home	5.1			5.7	
% [Household w/Children] Someone Smokes in the Home	6.6			12.1	
% [Smokers] Received Advice to Quit Smoking	62.2			63.7	
% [Smokers] Have Quit Smoking 1+ Days in Past Year	49.4			56.2	80.0
% Smoke Cigars	4.8			4.2	0.2
% Use Smokeless Tobacco	3.9			2.8	0.3
			better	similar	worse

Vision	Primary Service Area	PSA vs. Benchmarks			
		vs. CA	vs. NV	vs. US	vs. HP2020
% Blindness/Trouble Seeing	5.5			6.9	
% Eye Exam in Past 2 Years	50.9			57.5	
			better	similar	worse

GENERAL HEALTH STATUS

Overall Health Status

Self-Reported Health Status

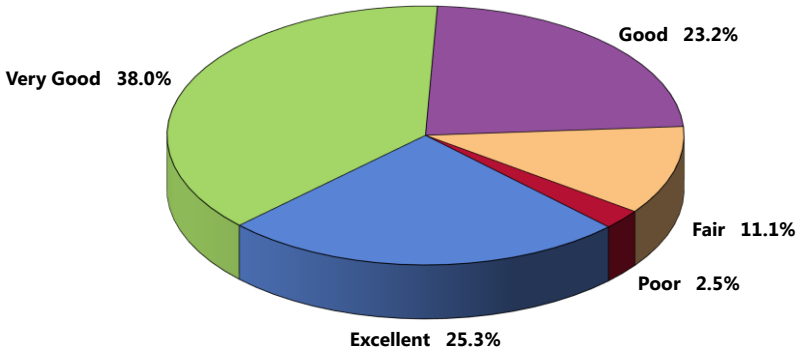
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

A total of 63.3% of Primary Service Area adults rate their overall health as "excellent" or "very good."

- Another 23.2% gave "good" ratings of their overall health.

Self-Reported Health Status
(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

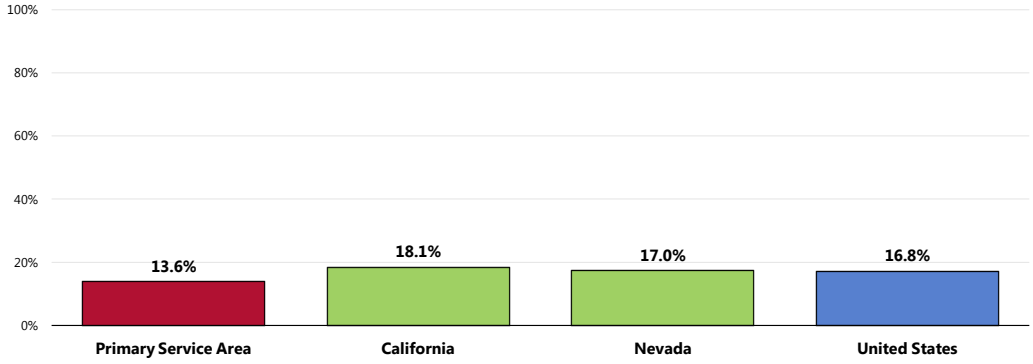
However, 13.6% of Primary Service Area adults believe that their overall health is "fair" or "poor."

- Better than the California percentage, statistically similar to the Nevada finding.
- Statistically similar to the national percentage.

NOTE:

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

Experience "Fair" or "Poor" Overall Health



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

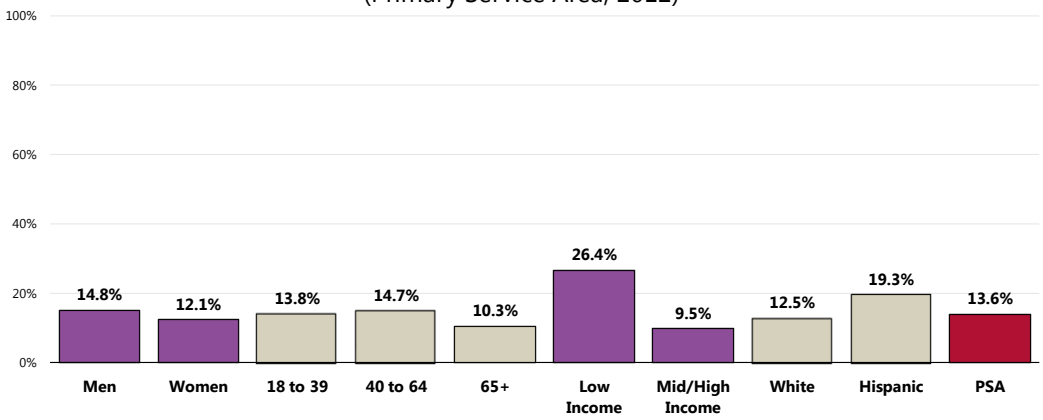
Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by gender, age groupings, income (based on poverty status), and race/ethnicity.

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

- Residents living at lower incomes.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

Experience "Fair" or "Poor" Overall Health

(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

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.

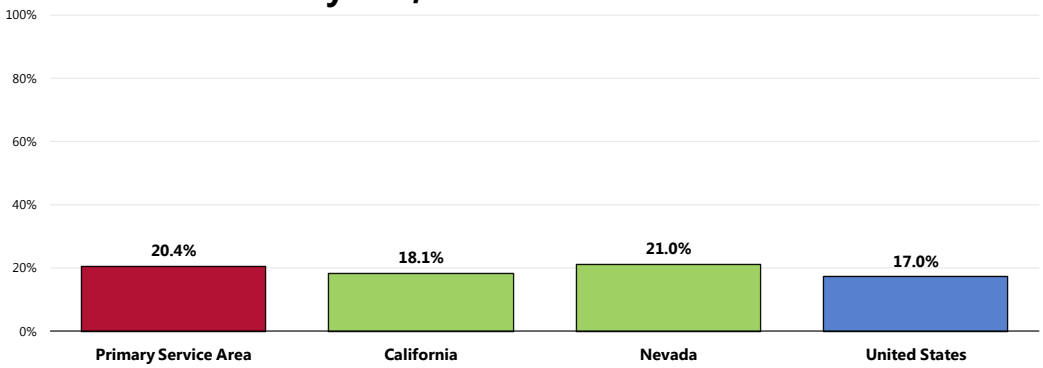
– Healthy People 2020 (www.healthypeople.gov)

A total of 20.4% of Primary Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Similar to both statewide percentages.
- Similar to the national prevalence.

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

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



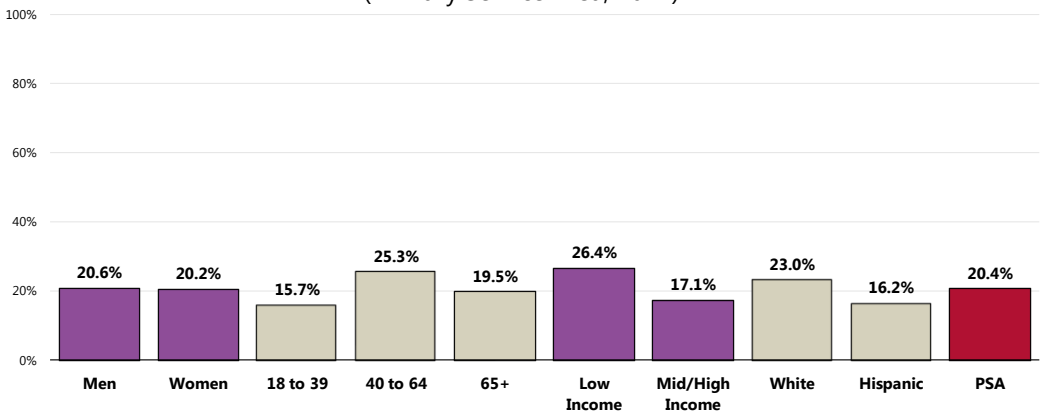
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

In looking at responses by key demographic characteristics, there are no statistically significant differences to report.

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

(Primary Service Area, 2012)



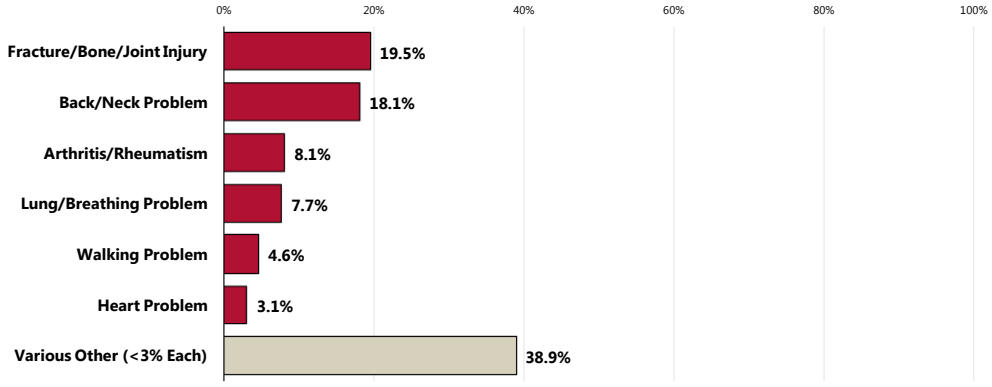
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "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 fractures or bone/joint injuries, back/neck problems, arthritis/rheumatism or difficulty walking. Lung/breathing problems were also frequently mentioned.

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
Notes: • Asked of those respondents reporting activity limitations.

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. According to the national Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

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 understanding of how the brain functions under normal conditions and in response to stressors, combined with knowledge of how the brain develops over time, has been essential to that progress. 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 among 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, and 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)

Mental Health Status

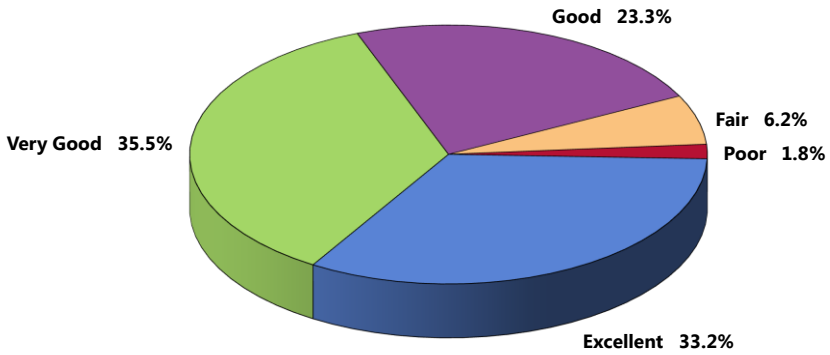
Self-Reported Mental Health Status

"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?"

A total of 68.7% of Primary Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 23.3% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status
(Primary Service Area, 2012)

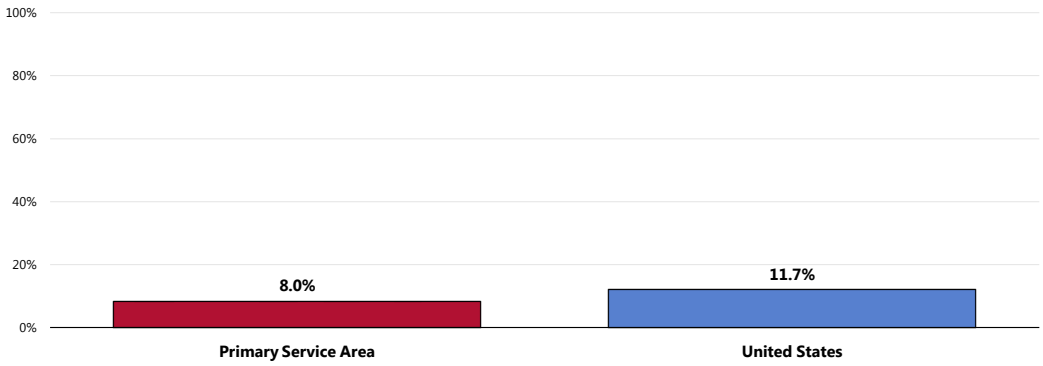


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
Notes: • Asked of all respondents.

A total of 8.0% of Primary Service Area adults, however, believe that their overall mental health is "fair" or "poor."

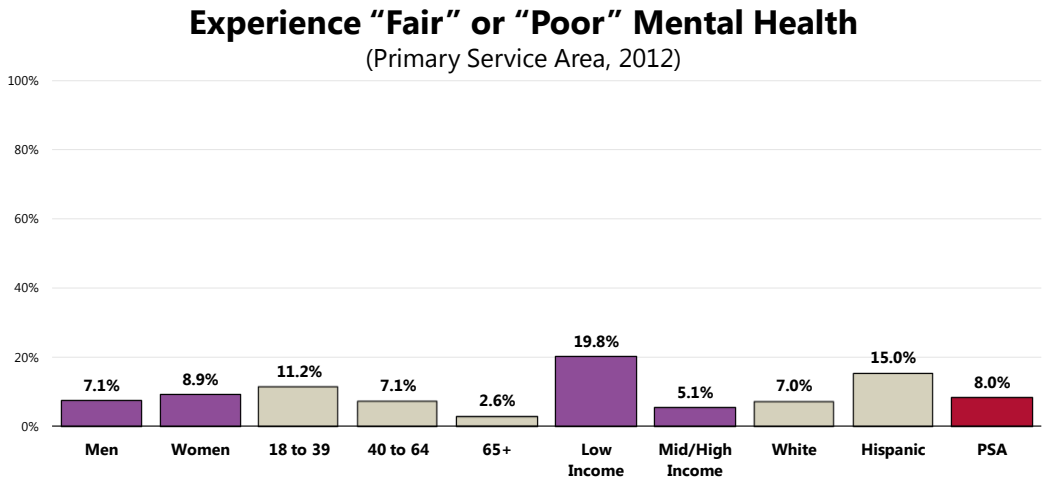
- More favorable than the "fair/poor" response reported nationally.

Experience "Fair" or "Poor" Mental Health



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Young adults, and especially low-income residents, are more likely to report experiencing "fair/poor" mental health than are their demographic counterparts.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
Notes: • Asked of all respondents.
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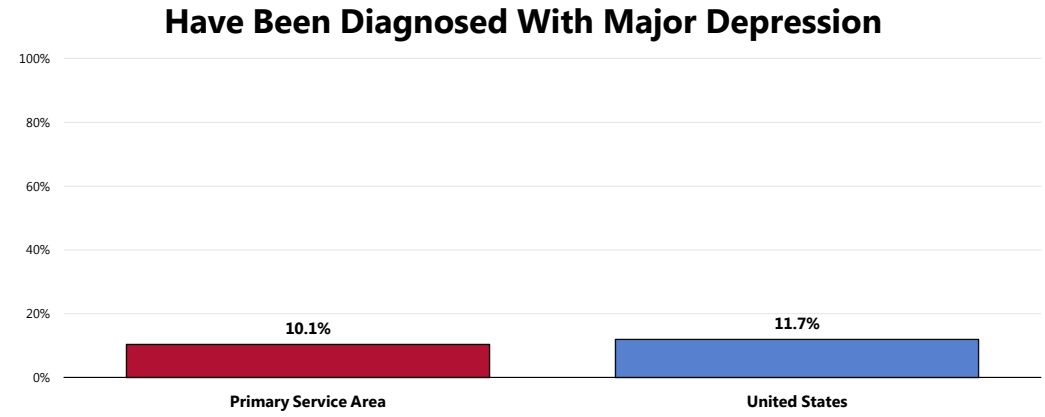
Depression

Major Depression

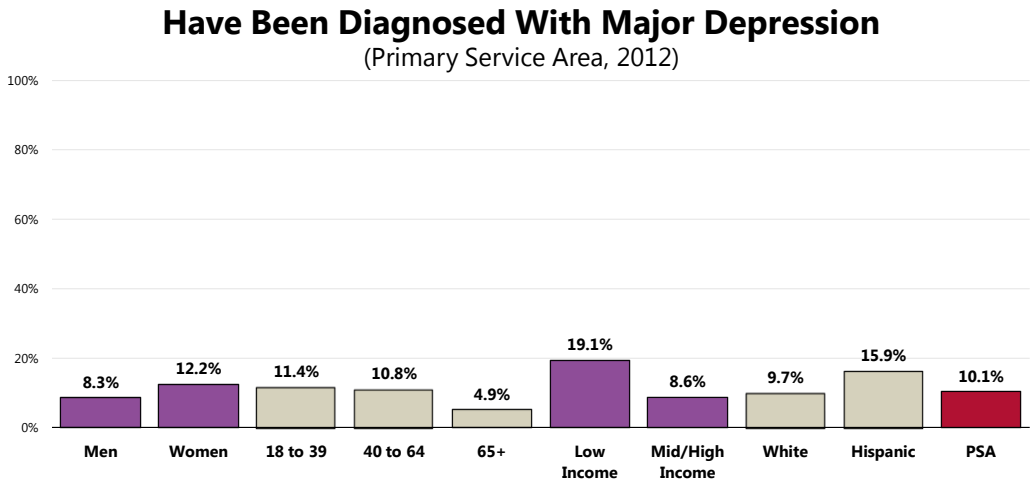
A total of 10.1% of Primary Service Area adults have been diagnosed with major depression by a physician.

- Similar to the national finding.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- The prevalence of major depression is notably higher among community members living at lower incomes.

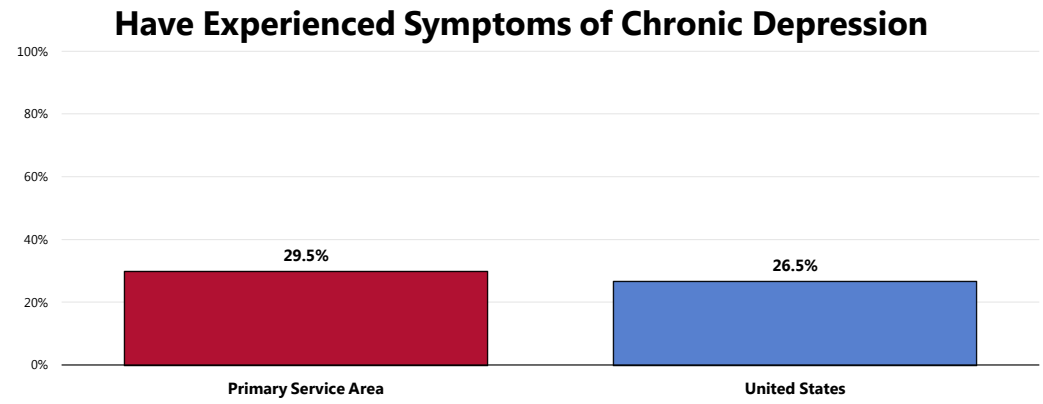


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
Notes: • Asked of all respondents.
• Hispanics can be of any race (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Symptoms of Chronic Depression

A total of 29.5% of Primary Service 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 (chronic depression).

- Comparable to national findings.



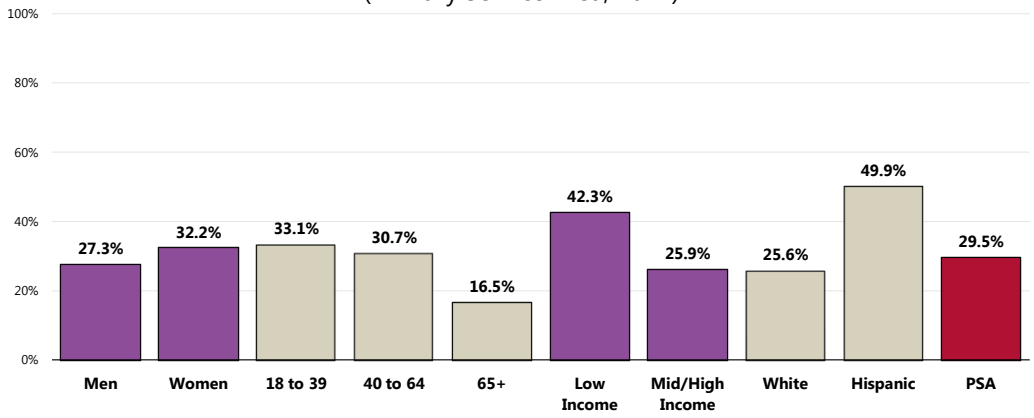
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

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

- Adults under age 65.
- Adults with lower incomes.
- Hispanics.

Have Experienced Symptoms of Chronic Depression

(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]
Notes: • Asked of all respondents.
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• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

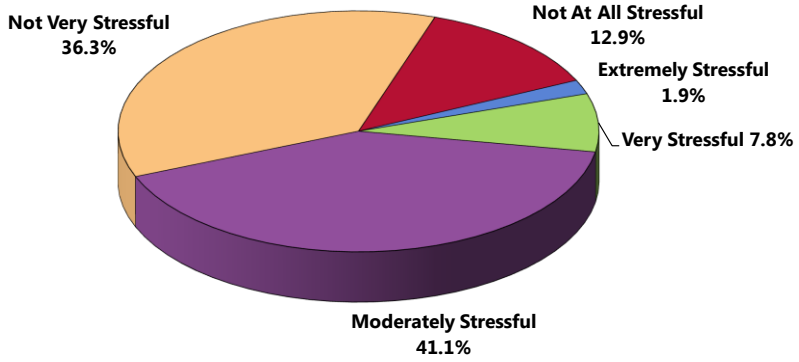
RELATED ISSUE: See also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Nearly one-half of Primary Service Area adults considers their typical day to be "not very stressful" (36.3%) or "not at all stressful" (12.9%).

- Another 41.1% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day

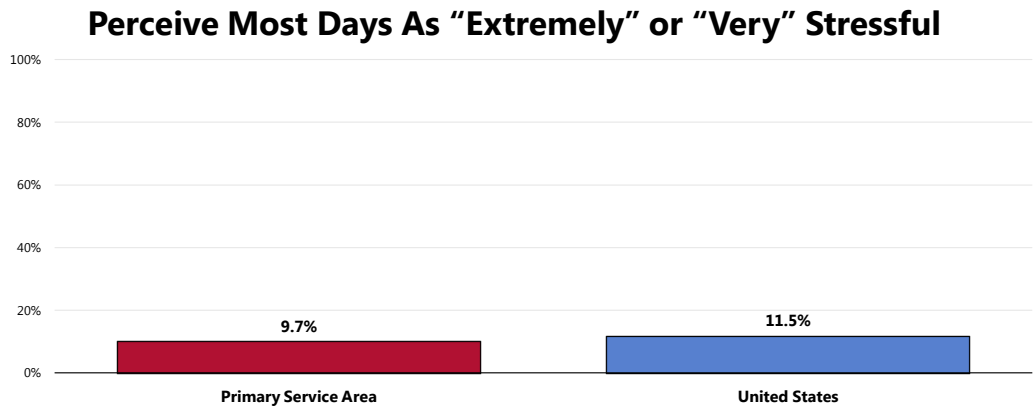
(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.

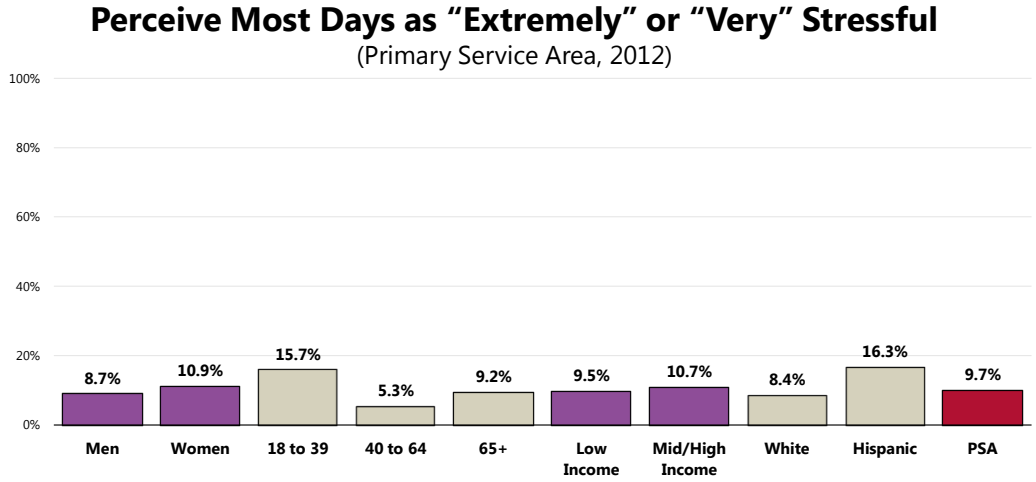
In contrast, 9.7% of Primary Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Similar to national findings.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Note that high stress levels are more prevalent among young adults (those under age 40) in the Primary Service Area.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
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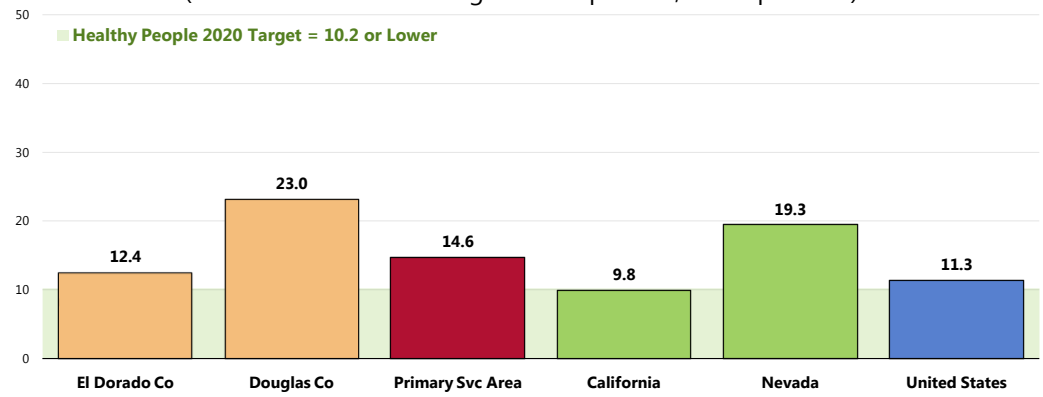
Suicide

Between 2006 and 2008, there was an annual average age-adjusted suicide rate of 14.6 deaths per 100,000 population in the Primary Service Area (here, reflecting the combined area of El Dorado and Douglas counties).

- Higher than the California rate but lower than the Nevada rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.
- Much higher in Douglas County.

Suicide: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



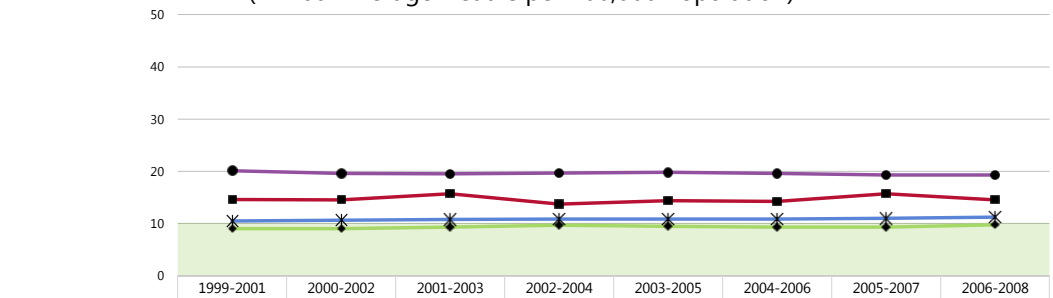
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The area suicide rate has been relatively stable over the past decade.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2
Primary Svc Area	14.6	14.5	15.7	13.7	14.4	14.2	15.7	14.6
California	9.1	9.1	9.3	9.7	9.5	9.3	9.4	9.8
Nevada	20.1	19.6	19.6	19.7	19.8	19.6	19.3	19.3
United States	10.5	10.7	10.8	10.9	10.9	10.9	11.0	11.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
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- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

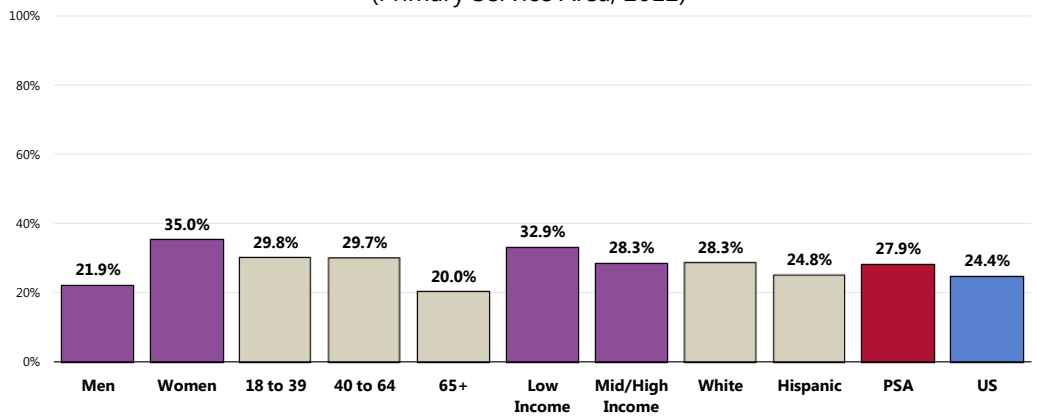
Mental Health Treatment

Among surveyed adults, 27.9% acknowledge that they have sought professional help for a mental or emotional problem.

- Similar to national findings.
- Viewed by demographics, men and seniors are statistically less likely to report seeking professional treatment for mental health problems.

Have Sought Professional Help for a Mental or Emotional Problem

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

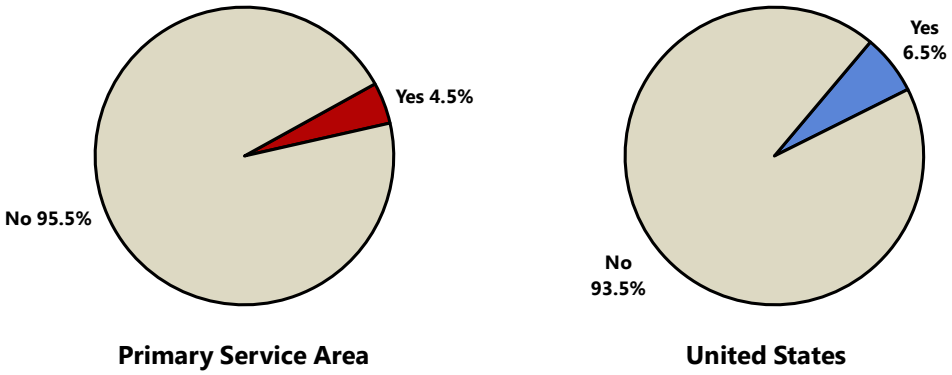
Children & ADD/ADHD

Among Primary Service Area adults with children age 5 to 17, 4.5% report that their child takes medication for ADD/ADHD.

- Statistically similar to the national prevalence.

Child Takes Medication for ADD/ADHD

(Among Parents of Children 5-17)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5 to 17.

Related Focus Group Findings: Mental Health

Many focus group participants discussed mental health in the community. The main issues discussed include:

- Shortage of psychiatrists and treatment facility options
- Stress management
- Stigma
- Individuals living with disabilities

During the focus groups, issues surrounding mental healthcare coverage came up several times. The participants feel the community suffers due to a **limited number of psychiatrists, counselors, and treatment facilities** available for behavioral healthcare. Psychiatrists have month-long waiting periods before initial appointments.

> *"What I find when I'm dealing with the mental ill is they are a group that really nobody wants to deal with. It's just there are no beds. There's no place to put anybody." — Social Service Provider*

Participants feel South Lake Tahoe needs to have a 23-hour [less than one day] urgent psychiatric center in town. This type of holding space could help alleviate the burden on the hospitals and law enforcement. Focus group members have concern for homeless persons with mental illness and want transitional housing made available for mentally ill patients after discharge.

> *"Those who act out because they are mentally ill, there's no place to put them. We have no transitional housing as they come out of jail or they come out of the hospital, where they can be treated until they can get back on their feet and realize that they may need help and then come back into the community." — Social Service Provider*

Stigma surrounding behavioral health can also hamper a person's ability to access services. The National Alliance on Mental Illness (NAMI) supports family members of the mentally ill in navigating the behavioral health system and also provides education.

Participants believe residents lack basic **stress management** skills. Educating families about stress management is critical to empowering families. South Lake Tahoe residents may encounter additional stresses because many families do not have extended family nearby to help with day-to-day needs. A participant explains the importance of parents taking care of their mental health so that they can set a good example for their children:

> *"If you ask how many parents are stressed or what someone's stress levels are on a scale of one to ten, most people would come in at an eight. So what – so they're setting the examples for their children of how they're managing their lives because they're not taking time for themselves to exercise, eat right, and to make healthy choices." — Healthcare Professional*

Services for disabled residents also remain limited in the community. Communication for this population needs to be improved so that everyone knows what services are available. Participants believe individuals with disabilities may feel uncomfortable in a physician waiting room, so they leave and do not receive care. Participants think these

residents prefer providers and agencies that can provide services in a more private environment.

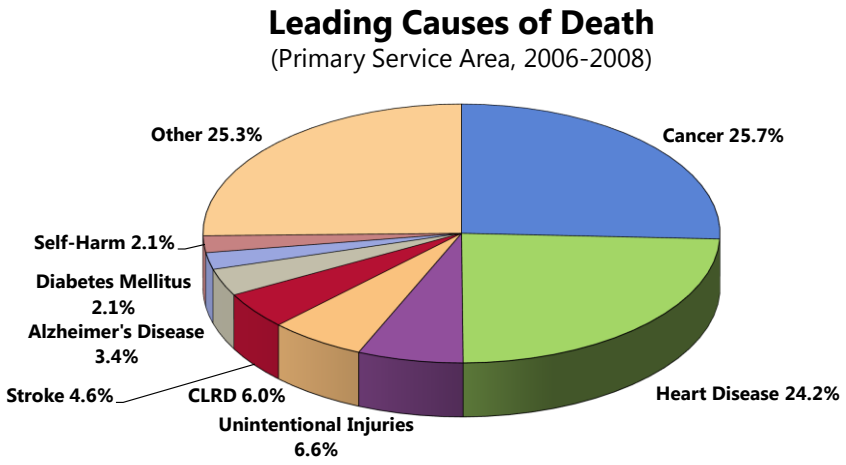
> *"Well, they're already in a position of feeling uncomfortable because of their disability, because of their mental status, because of their age, and they're here with children running around and other folks … It just makes them feel very uncomfortable, so they leave." — Social Service Provider*

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for more than one-half of all deaths in the Primary Service Area between 2006 and 2008.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
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.
• Primary Service Area findings reflect both El Dorado County (CA) and Douglas County (NV).

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, California, Nevada 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 2006-2008 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Primary Service Area.

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

Age-adjusted mortality rates in the Primary Service Area are worse than national rates for suicide, CLRD (chronic lower respiratory disease), unintentional injuries, Alzheimer's disease, cirrhosis/liver disease and drug-induced deaths.

Of the causes outlined in the following chart for which Healthy People 2020 objectives have been established, Primary Service Area rates fail to satisfy the related goals for suicide, heart disease, cancer, unintentional injuries (including motor vehicle accidents), firearm-related deaths, cirrhosis/liver disease and drug-induced deaths.

Age-Adjusted Death Rates for Selected Causes

(2006-2008 Deaths per 100,000)

	Primary Service Area	CA	NV	US	HP2020
Malignant Neoplasms (Cancers)	**180.1**	**160.3**	**180.8**	**178.1**	**160.6**
Diseases of the Heart	**179.2**	**180.2**	**207.5**	**192.5**	**152.7***
Unintentional Injuries	**47.3**	**30.9**	**45.7**	**39.5**	**36.0**
Chronic Lower Respiratory Disease (CLRD)	**44.4**	**38.5**	**50.4**	**41.8**	n/a
Cerebrovascular Disease (Stroke)	**34.8**	**42.3**	**39.0**	**42.2**	**33.8**
Alzheimer's Disease	**27.0**	**25.4**	**13.4**	**23.2**	n/a
Drug-Induced	**17.3**	**11.1**	**19.5**	**12.6**	**11.3**
Diabetes Mellitus	**15.0**	**21.7**	**13.7**	**22.5**	**19.6***
Pneumonia/Influenza	**14.8**	**19.7**	**19.8**	**17.0**	n/a
Intentional Self-Harm (Suicide)	**14.6**	**9.8**	**19.3**	**11.3**	**10.2**
Motor Vehicle Crashes	**13.6**	**11.2**	**15.7**	**14.1**	**12.4**
Firearm-Related	**10.3**	**8.8**	**16.1**	**10.2**	**9.2**
Cirrhosis/Liver Disease	**10.2**	**11.2**	**11.1**	**9.0**	**8.2**
Kidney Disease	**8.7**	**8.1**	**20.7**	**14.6**	n/a
Homicide/Legal Intervention	**2.5**	**6.4**	**7.6**	**6.1**	**5.5**
HIV/AIDS	**1.4**	**3.8**	**3.6**	**4.5**	**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 April 2012.
- 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.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Cardiovascular Disease

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

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

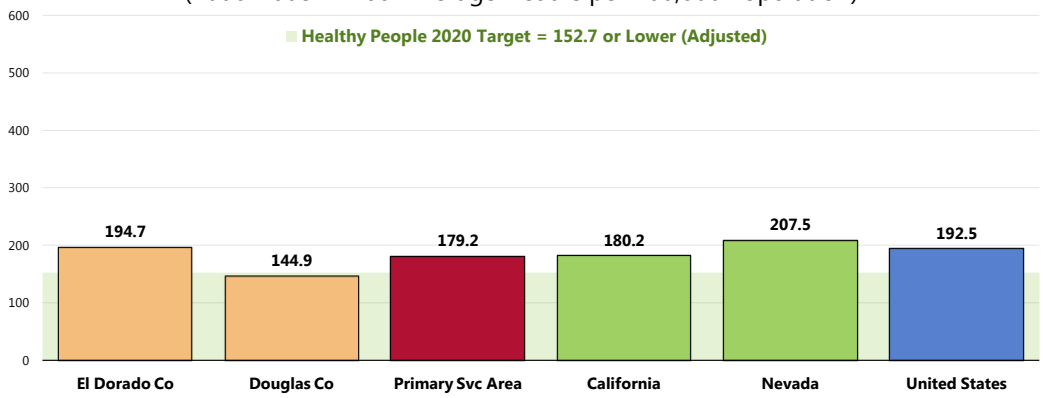
Heart Disease Deaths

Between 2006 and 2008, there was an annual average age-adjusted heart disease mortality rate of 179.2 deaths per 100,000 population in the Primary Service Area.

- Similar to the California rate and lower than the Nevada rate.
- Lower than the national rate.
- Fails to satisfy the Healthy People 2020 target (as adjusted to account for all diseases of the heart).
- Notably higher in El Dorado County.

Heart Disease: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



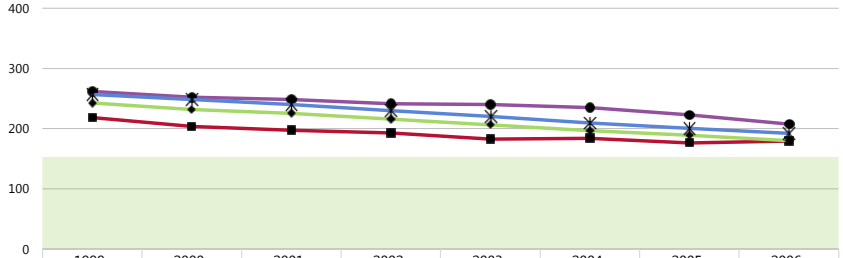
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [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 U.S. 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.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The heart disease mortality rate has <u>decreased</u> in the Primary Service Area, echoing the decreasing trends across California, Nevada and the US overall.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020 (Adjusted)	152.7	152.7	152.7	152.7	152.7	152.7	152.7	152.7
Primary Svc Area	218.3	203.8	197.1	193.2	183.0	183.8	176.2	179.2
California	242.5	232.0	225.3	215.9	206.1	197.0	188.9	180.2
Nevada	262.2	252.5	248.3	241.4	240.4	235.1	222.9	207.5
United States	257.0	248.4	240.0	230.0	220.1	209.4	200.7	192.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- 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 U.S. 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.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

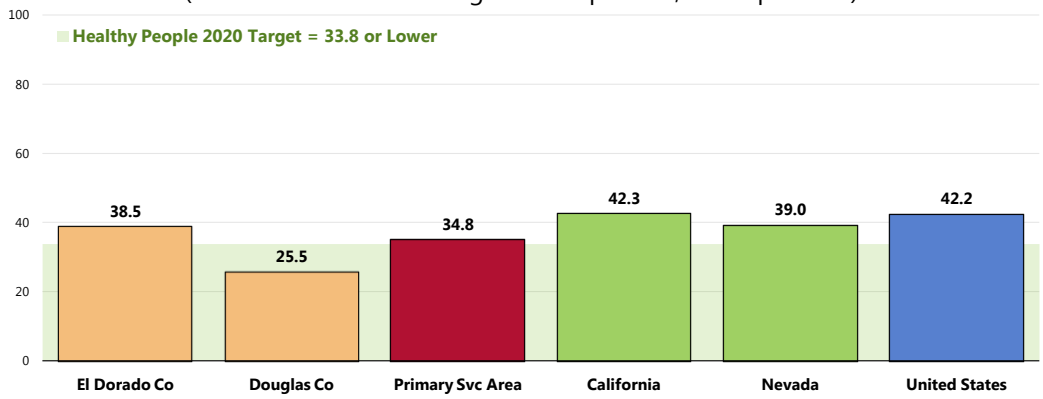
Stroke Deaths

Between 2006 and 2008, there was an annual average age-adjusted stroke mortality rate of 34.8 deaths per 100,000 population in the Primary Service Area.

- More favorable than both state rates.
- More favorable than the national rate.
- Similar to the Healthy People 2020 target of 33.8 or lower.
- Higher in El Dorado County.

Stroke: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



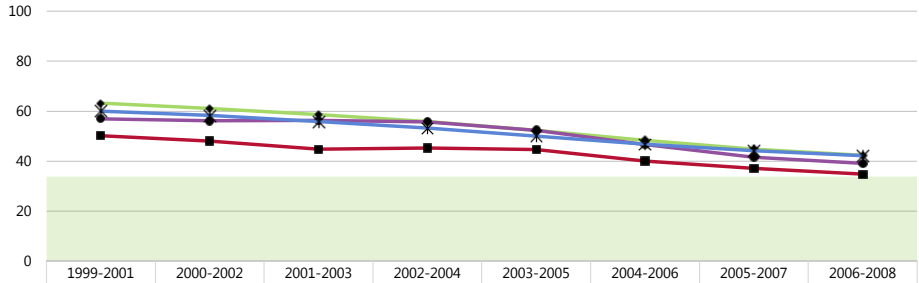
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The stroke rate has declined in recent years, mirroring the trends reported across both states and the country as a whole.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	33.8	33.8	33.8	33.8	33.8	33.8	33.8	33.8
Primary Svc Area	50.2	48.1	44.8	45.2	44.6	40.1	37.1	34.8
California	63.2	61.1	58.7	55.8	52.3	48.3	44.8	42.3
Nevada	57.0	56.1	56.3	55.7	52.4	46.6	41.6	39.0
United States	60.1	58.3	55.8	53.2	50.0	46.7	44.1	42.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

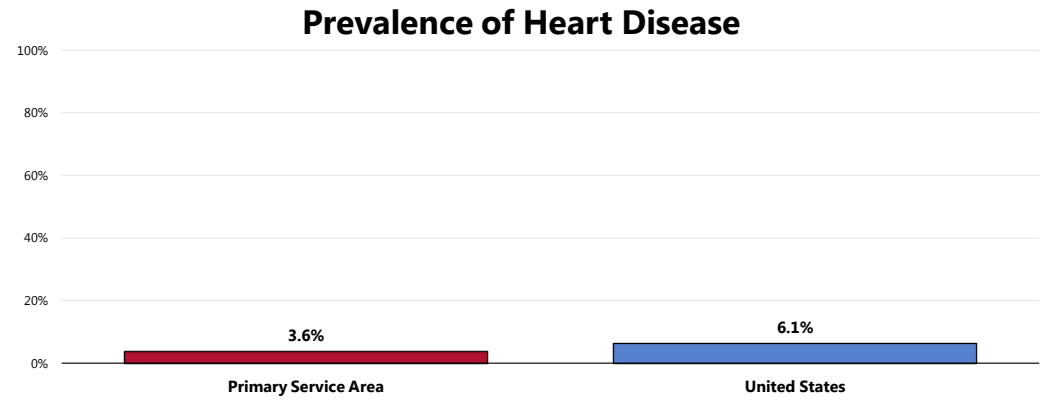
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 3.6% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

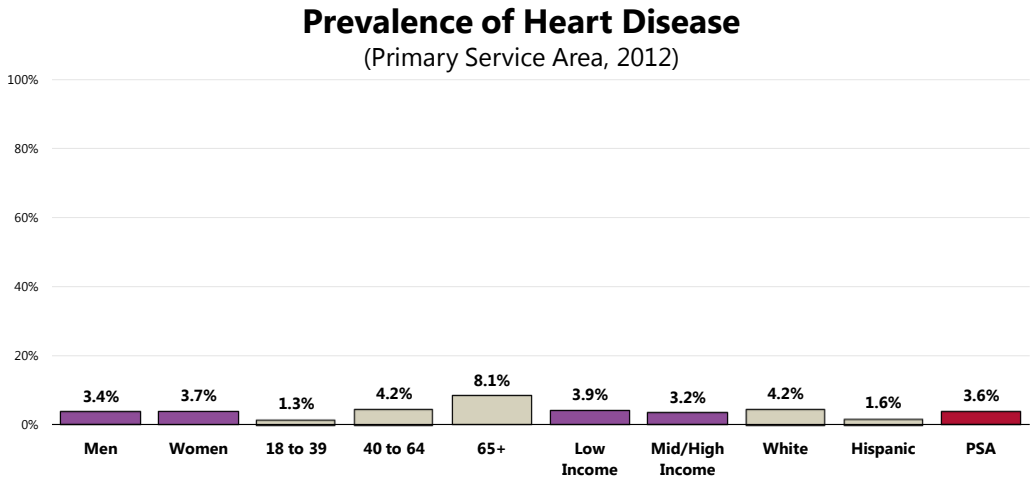
- Lower than the national prevalence.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- Seniors (age 65+) are more likely to have been diagnosed with chronic heart disease.

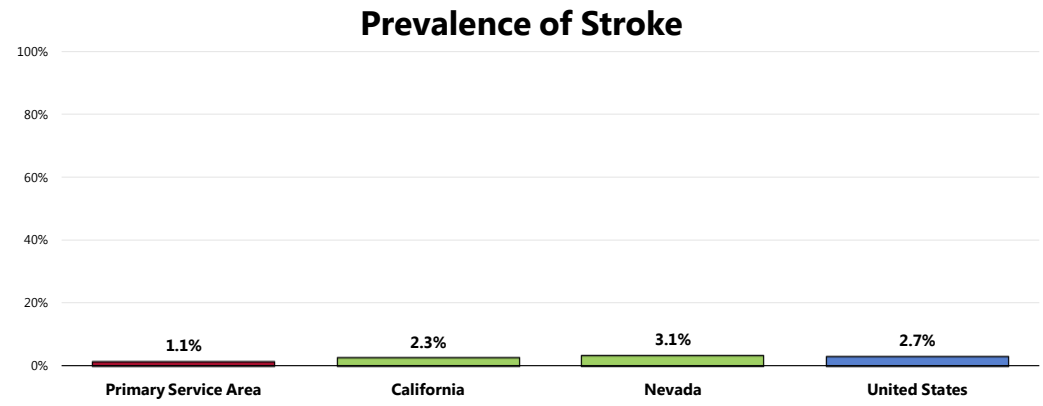


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Just 1.1% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

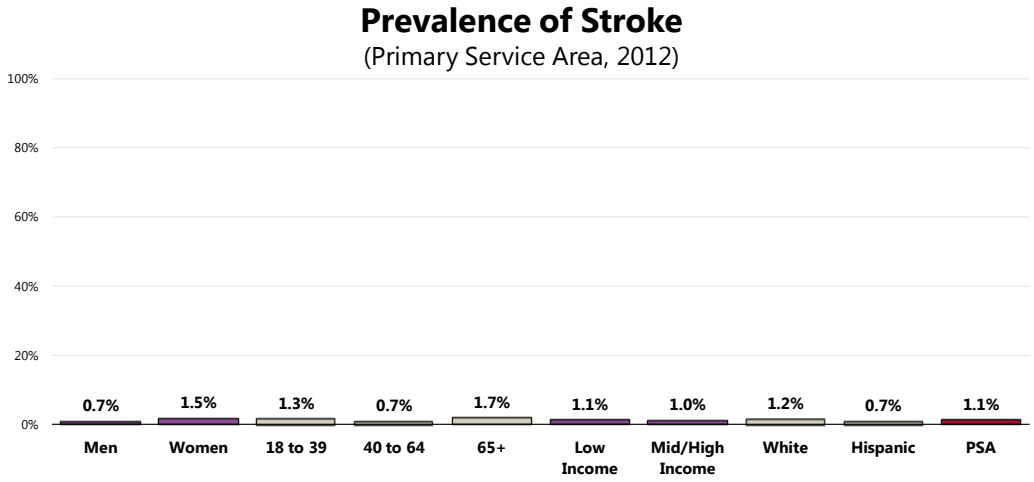
- Lower than both statewide findings.
- Lower than national findings.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.

Notes:
- Asked of all respondents.

No significant difference to note when viewed by demographics.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Cardiovascular Risk Factors

Hypertension (High Blood Pressure)

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

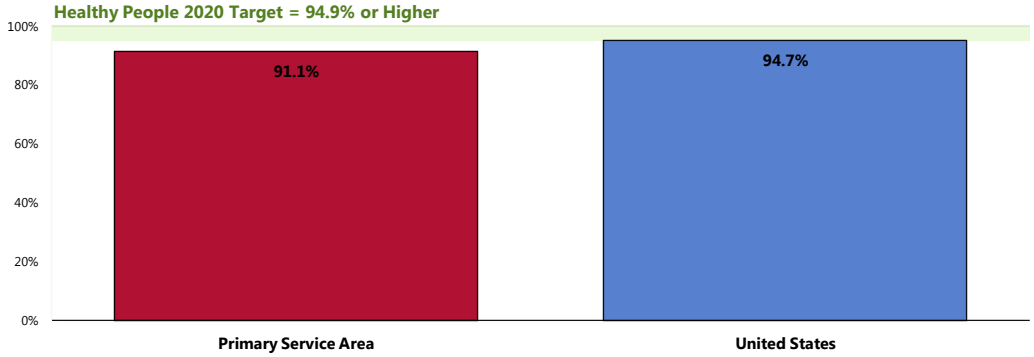
– Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure Testing

A total of 91.1% of Primary Service Area adults have had their blood pressure tested within the past two years.

- Less favorable than national findings.
- Fails to satisfy the Healthy People 2020 target (94.9% or higher).

Have Had Blood Pressure Checked in the Past Two Years



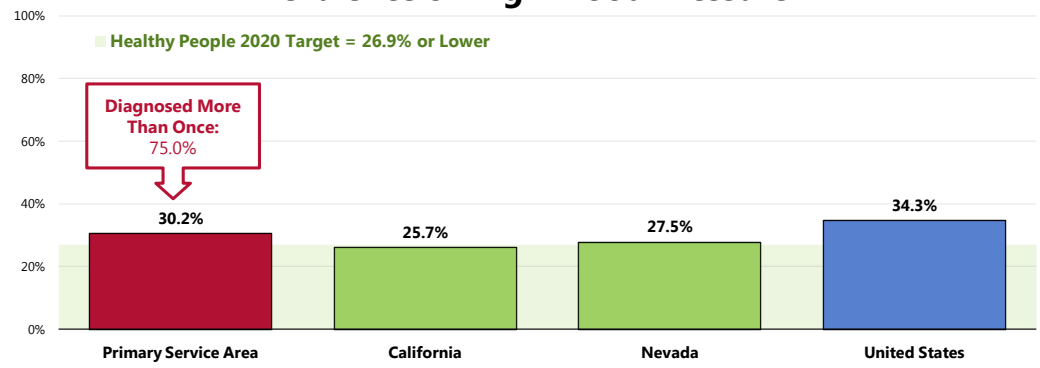
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]

Notes:
- Asked of all respondents.

A total of 30.2% of adults have been told at some point that their blood pressure was high.

- Comparable to the California and Nevada figures.
- Comparable to the national prevalence.
- Comparable to the Healthy People 2020 target (26.9% or lower).
- Among hypertensive adults, 75.0% have been diagnosed with high blood pressure more than once.

Prevalence of High Blood Pressure



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 47, 149]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 California and Nevada data.
- 2011 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 HDS-5.1]

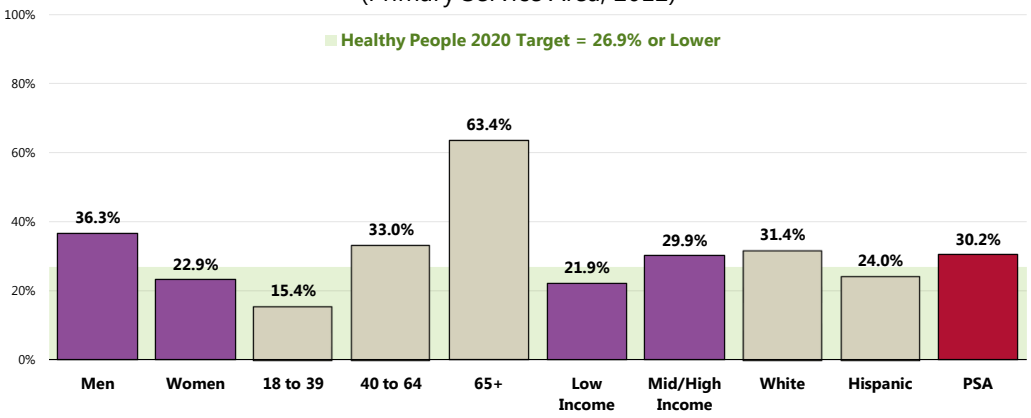
Notes:
- Asked of all respondents.

Hypertension diagnoses are higher among:

- Men.
- Adults age 40 and older, and especially those age 65+.

Prevalence of High Blood Pressure

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

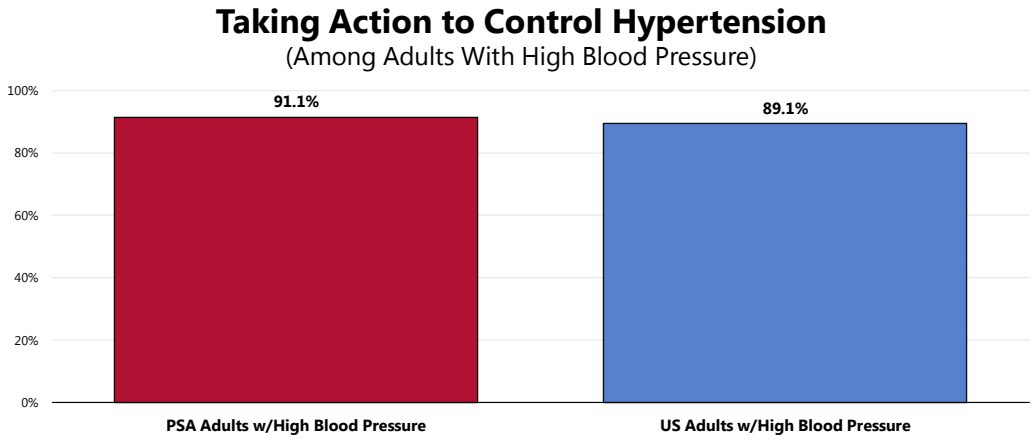
Hypertension Management

Respondents reporting high blood pressure were further asked:

"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"

Among respondents who have been told that their blood pressure was high, 91.1% report that they are currently taking actions to control their condition.

- Similar to national findings.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

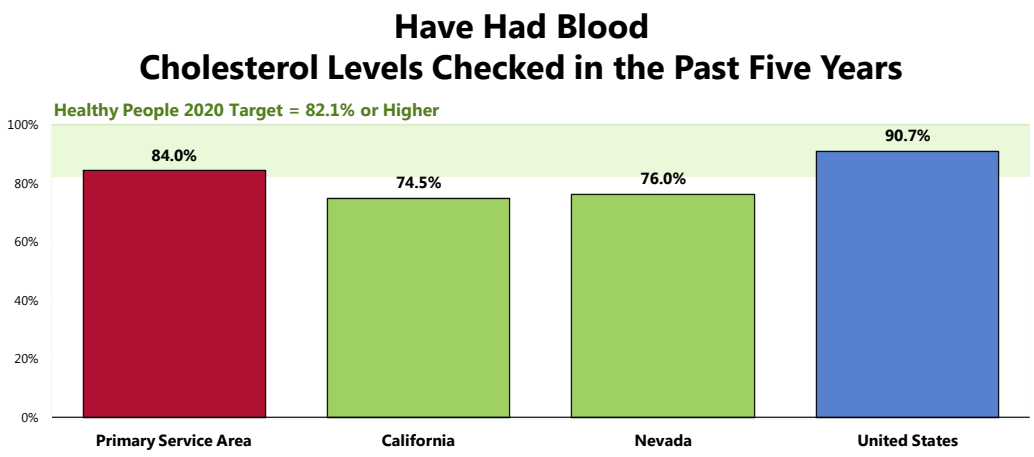
Notes:
- Asked of all respondents who have been diagnosed with high blood pressure.
- In this case, the term "action" refers to medication, change in diet, and/or exercise.

High Blood Cholesterol

Blood Cholesterol Testing

A total of 84.0% of Primary Service Area adults have had their blood cholesterol checked within the past five years.

- More favorable than California and Nevada findings.
- Less favorable than the national findings.
- Similar to the Healthy People 2020 target (82.1% or higher).



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 California and Nevada data.
- 2011 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 HDS-6]

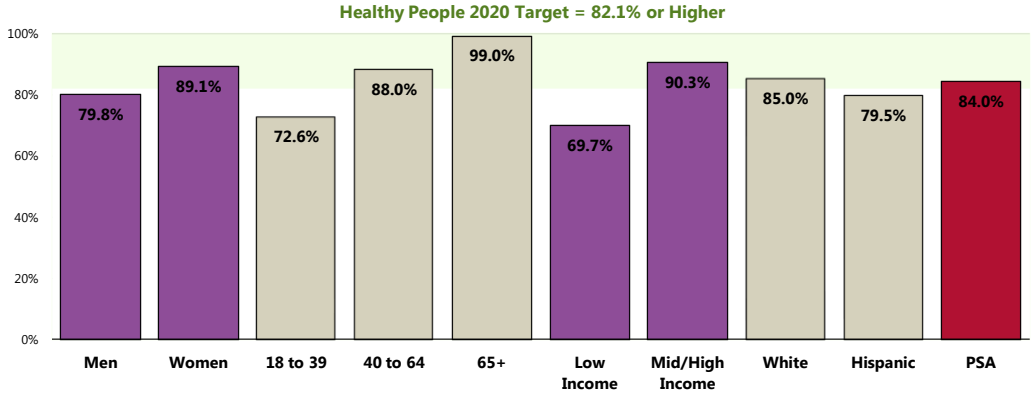
Notes:
- Asked of all respondents.

The following demographic segments report lower screening levels:

- Men.
- Adults under 40 (note the positive correlation with age).
- Residents with lower incomes.

Have Had Blood Cholesterol Levels Checked in the Past Five Years

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

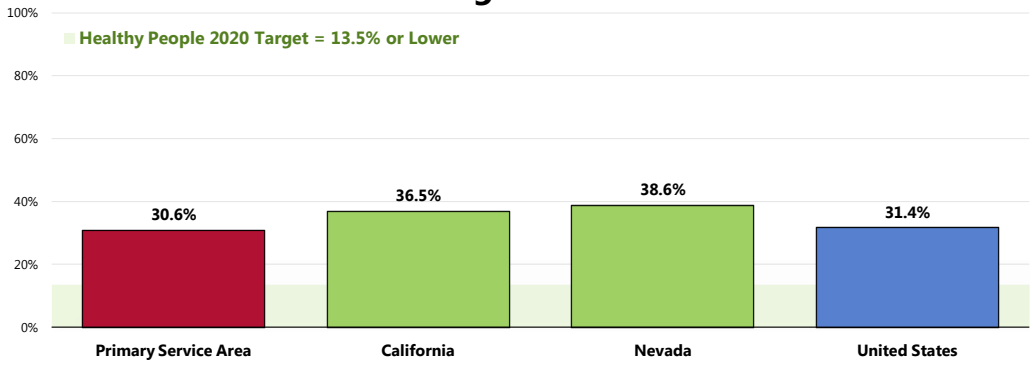
Notes:
- Asked of all respondents.
- Hispanics can be of any race (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up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

Self-Reported High Blood Cholesterol

A total of 30.6% of adults have been told by a health professional that their cholesterol level was high.

- More favorable than the California and Nevada findings.
- Similar to the national prevalence.
- More than twice the Healthy People 2020 target (13.5% or lower).

Prevalence of High Blood Cholesterol



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 150]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 California and Nevada data.
- 2011 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 HDS-7]

Notes:
- Asked of all respondents.
- *The California data reflects those adults who have been tested for high cholesterol and who have been diagnosed with it.

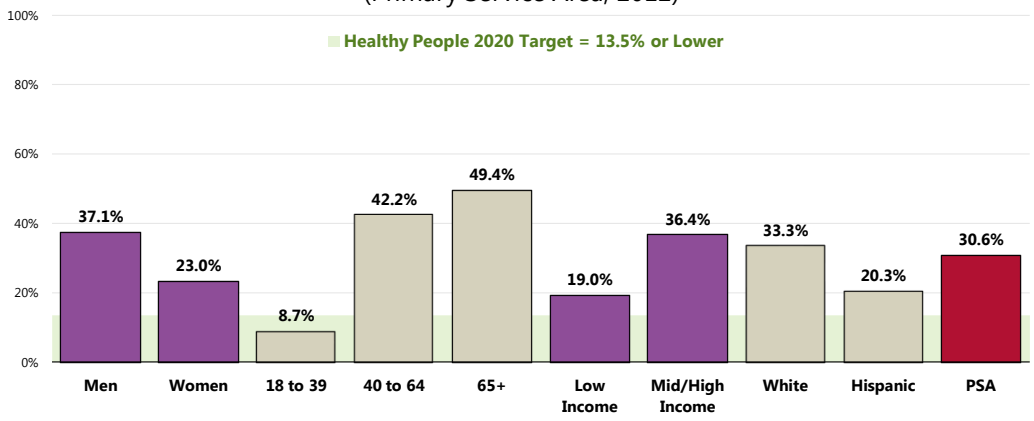
Note that 21.8% of Primary Service Area adults report not having high blood cholesterol, but: 1) have never had their blood cholesterol levels tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

The following population segments are more likely to report high cholesterol levels:

- Men.
- Adults aged 40 and older.
- Higher-income residents.
- Non-Hispanic White respondents.
- Keep in mind that "unknowns" are relatively high in men, young adults, lower-income residents and Hispanics.

Prevalence of High Blood Cholesterol

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 150]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Respondents reporting high cholesterol were further asked:

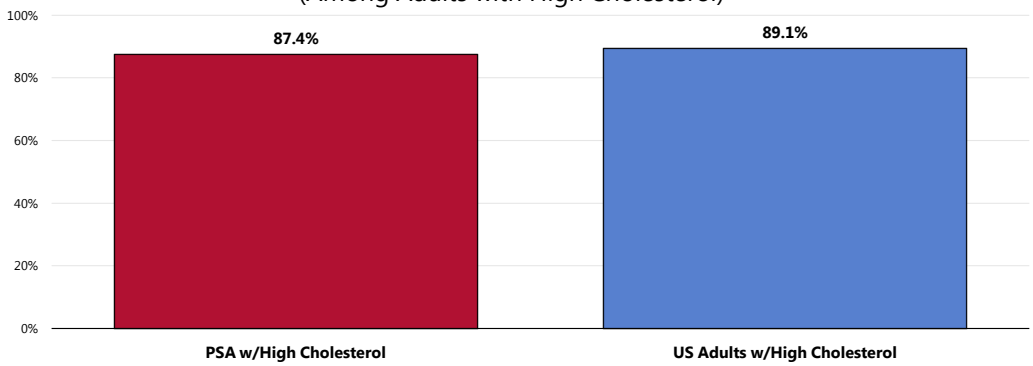
"Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"

Among adults who have been told that their blood cholesterol was high, 87.4% report that they are currently taking actions to control their cholesterol levels.

- Comparable to that found nationwide.

Taking Action to Control High Blood Cholesterol Levels

(Among Adults with High Cholesterol)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 51]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents who have been diagnosed with high blood cholesterol levels.
- In this case, the term "action" refers to medication, change in diet, and/or exercise.

Total Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

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

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

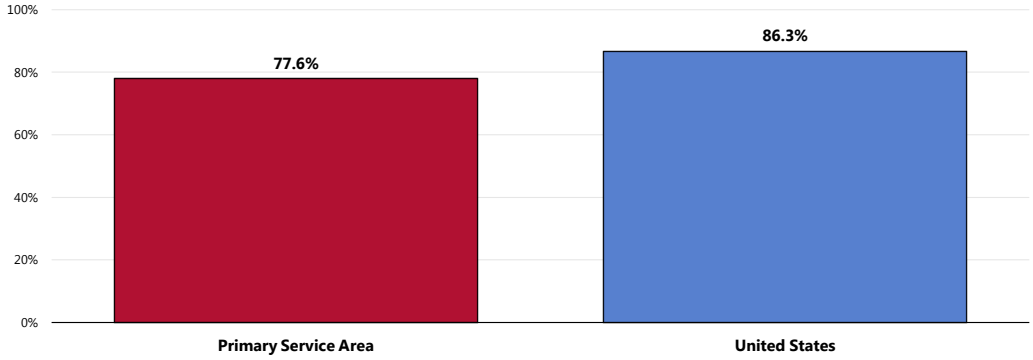
Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

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

A total of 77.6% of Primary Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- More favorable than national findings.

Present One or More Cardiovascular Risks or Behaviors



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

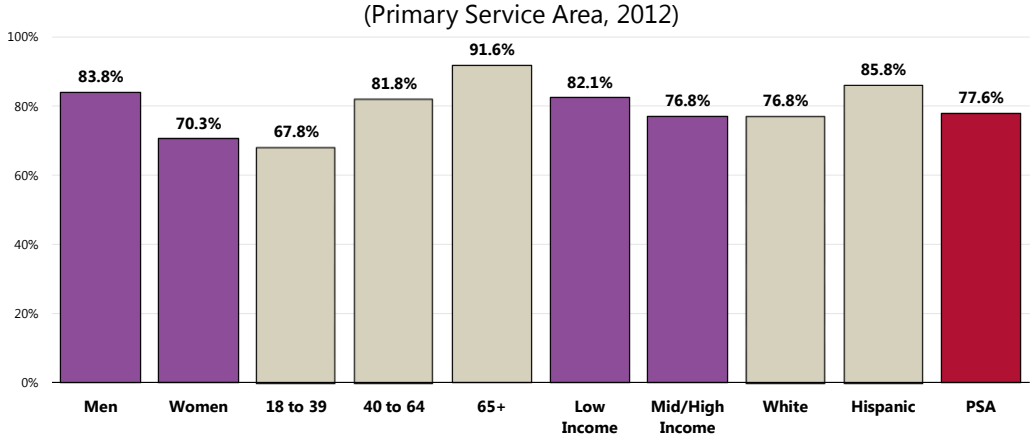
Adults more likely to exhibit cardiovascular risk factors include:

- Men.
- Adults age 40 and older, and especially seniors.

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

Present One or More Cardiovascular Risks or Behaviors

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]

Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

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)

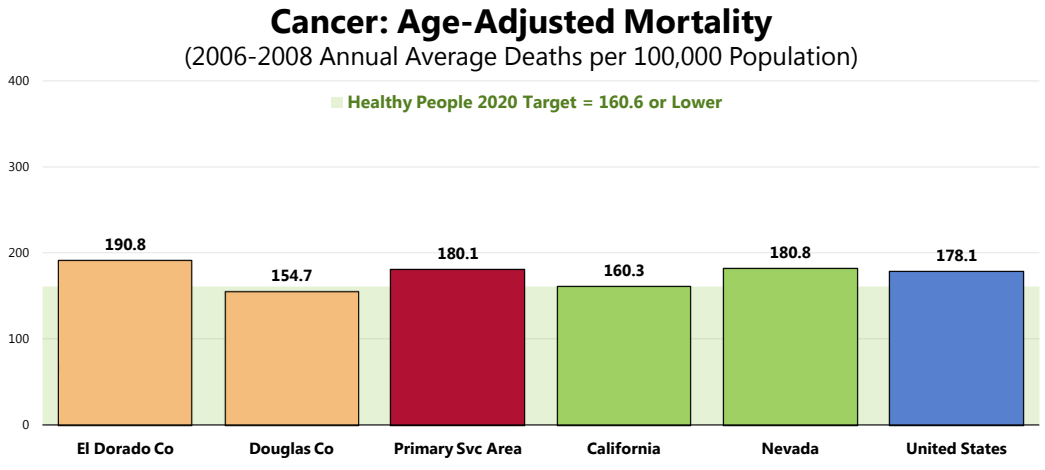
– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2006 and 2008, there was an annual average age-adjusted cancer mortality rate of 180.1 deaths per 100,000 population in the Primary Service Area.

- Less favorable than the California rate but similar to the Nevada rate.
- Similar to the national rate.
- Fails to satisfy the Healthy People 2020 target of 160.6 or lower.
- Much higher in El Dorado County.



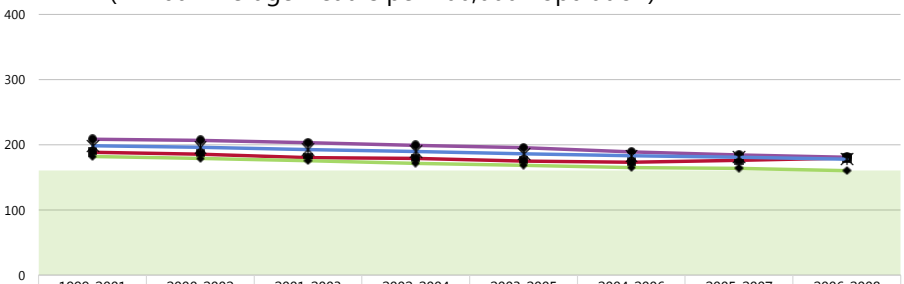
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

- Cancer mortality has decreased overall in the Primary Service Area; the same trend is apparent across both states and the nation overall.

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	160.6	160.6	160.6	160.6	160.6	160.6	160.6	160.6
Primary Svc Area	188.8	185.7	180.3	179.4	175.0	173.4	176.5	180.1
California	182.1	179.1	175.8	171.6	168.6	165.4	163.7	160.3
Nevada	208.7	207.2	203.5	199.3	195.7	189.2	184.8	180.8
United States	198.7	196.2	193.1	189.8	186.6	183.4	181.0	178.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- 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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the Primary Service 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 2006-2008 annual average age-adjusted death rates):

- The Primary Service Area **lung cancer** death rate is higher than the California rate, lower than the Nevada rate and similar to the national rate.
- The Primary Service Area **prostate cancer** death rate is higher than both state rates as well as the national rate.
- The Primary Service Area **female breast cancer** death rate is lower than both state rates and the US rate overall.
- The Primary Service Area **colorectal cancer** death rate is similar to the California rate and lower than the Nevada and US rates.

Note that while the Primary Service Area female breast and colorectal cancer rates are similar to their related Healthy People 2020 targets, the lung and prostate cancer rates fail to satisfy their 2020 goals.

Age-Adjusted Cancer Death Rates by Site

(2006-2008 Annual Average Deaths per 100,000 Population)

	Primary Service Area	CA	NV	US	HP2020
Lung Cancer	**48.6**	**39.2**	**54.4**	**50.5**	**45.5**
Prostate Cancer	**25.5**	**22.2**	**23.8**	**23.1**	**21.2**
Female Breast Cancer	**20.7**	**22.0**	**22.5**	**23.0**	**20.6**
Colorectal Cancer	**15.2**	**15.1**	**18.0**	**16.8**	**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 April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Prevalence of Cancer

Skin Cancer

A total of 7.5% of surveyed Primary Service Area adults report having been diagnosed with skin cancer.

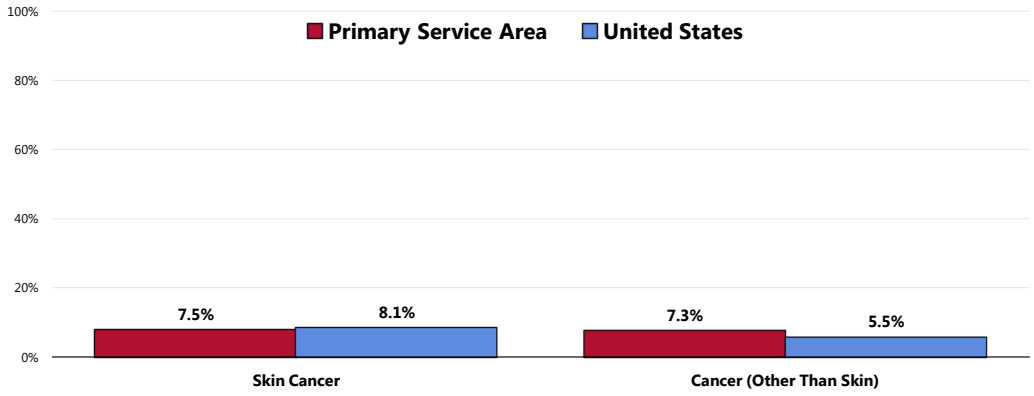
- Similar to the national prevalence.

Other Cancer

A total of 7.3% of respondents have been diagnosed with some type of (non-skin) cancer.

- Similar to the national prevalence.

Prevalence of Cancer



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 30-31]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

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

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 four cancer sites: prostate cancer (prostate-specific antigen testing and digital rectal examination); female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Prostate Cancer Screenings: PSA and/or Digital/Rectal Examinations

The US Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years.

Rationale: Prostate cancer is the most common nonskin cancer and the second-leading cause of cancer death in men in the United States. The USPSTF found convincing evidence that prostate-specific antigen (PSA) screening can detect some cases of prostate cancer.

In men younger than age 75 years, the USPSTF found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes compared with treatment after clinical detection.

The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate-to-substantial harms, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime.

There is also adequate evidence that the screening process produces at least small harms, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results.

The USPSTF recommends against screening for prostate cancer in men age 75 years or older.

Rationale: In men age 75 years or older, the USPSTF found adequate evidence that the incremental benefits of treatment for prostate cancer detected by screening are small to none.

Given the uncertainties and controversy surrounding prostate cancer screening in men younger than age 75 years, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment. Men should be informed of the gaps in the evidence and should be assisted in considering their personal preferences before deciding whether to be tested.

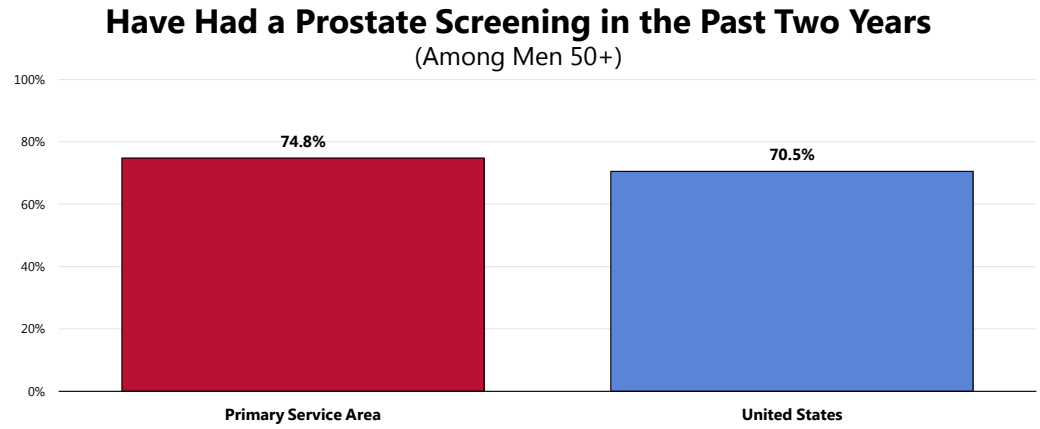
– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

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.

Note: Due to recent (2008) changes in clinical recommendations against routine PSA testing, it is anticipated that testing levels will begin to decline.

Among men age 50 and older, three-fourths (74.8%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

- Statistically similar to national findings.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all male respondents 50 and older.

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.

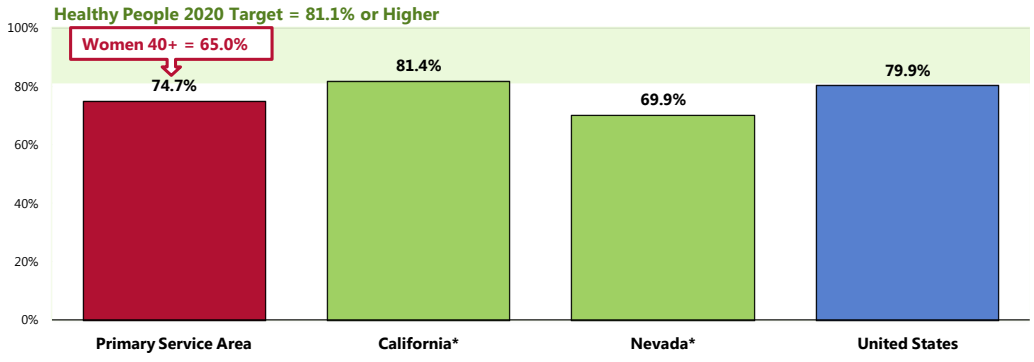
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Among women age 50-74, 74.7% have had a mammogram within the past two years.

- Similar to statewide findings (which represent all women 50+).
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- Among women 40+, 65.0% had a mammogram in the past two years.

Have Had a Mammogram in the Past Two Years

(Among Women 50-74)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 152-153]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 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 to 74.
- *Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).

Cervical Cancer Screenings: Pap Smear Testing

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.

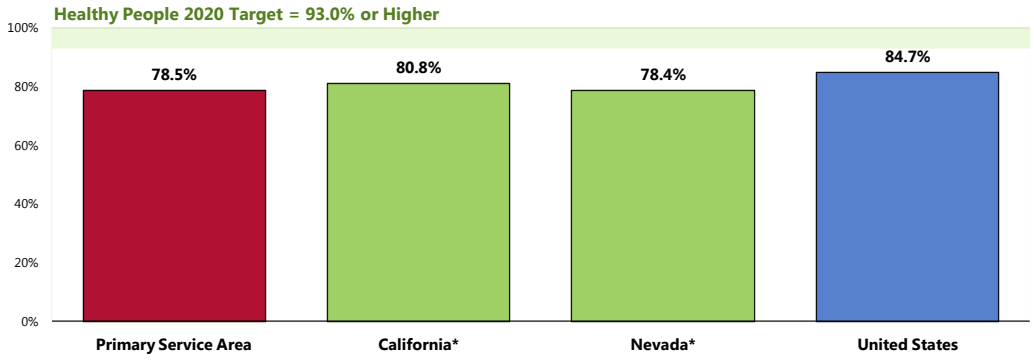
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Among women age 21 to 65, 78.5% had a Pap smear within the past three years.

- Comparable to California and Nevada findings (which represents all women 18+).
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).

Have Had a Pap Smear in the Past Three Years

(Among Women 21-65)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 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 21-65.
- *Note that the California percentage represents all women 18 and older.

Colorectal Cancer Screenings

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.

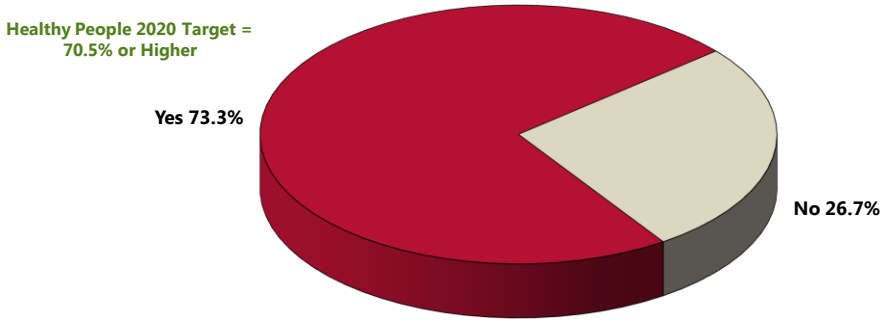
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screening

Among adults age 50-75, 73.3% 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 the Healthy People 2020 target (70.5% or higher).

Have Had a Colorectal Cancer Screening
(Among Primary Service Area Adults 50-75)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- 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.

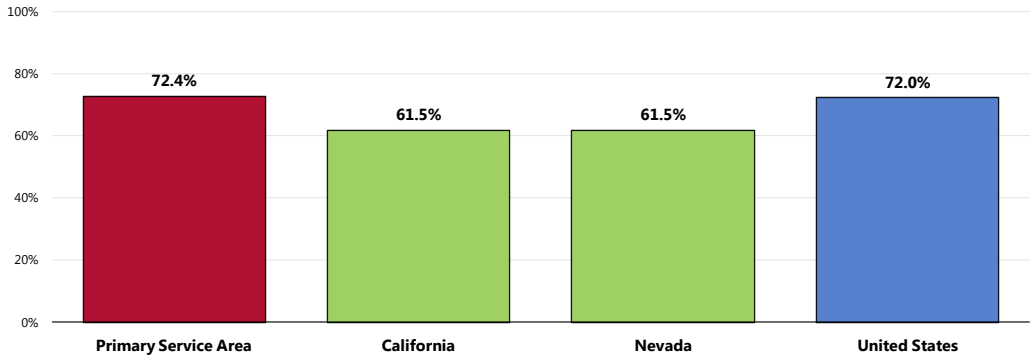
Lower Endoscopy

Among adults age 50 and older, 72.4% have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.

- More favorable than California and Nevada findings.
- Similar to national findings.

Have Ever Had a Lower Endoscopy Exam

(Among Adults 50+)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents 50+.
- Lower endoscopy includes either sigmoidoscopy or colonoscopy.

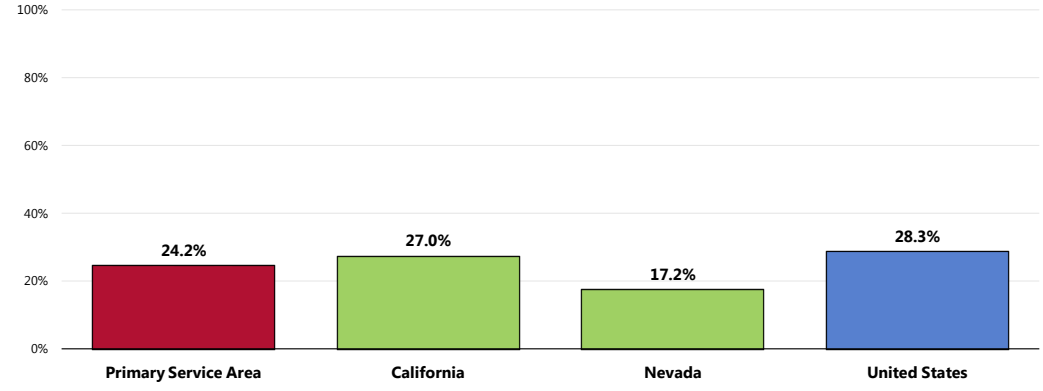
Blood Stool Testing

Among adults age 50 and older, 24.2% have had a blood stool test (aka "fecal occult blood test") within the past two years.

- Comparable to California findings, more favorable than Nevada findings.
- Comparable to national findings.

Have Had a Blood Stool Test in the Past Two Years

(Among Adults 50+)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents 50+.

Respiratory Disease

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.

Several additional respiratory conditions and respiratory hazards, including infectious agents and occupational and environmental exposures, are covered in other areas of Healthy People 2020. Examples include tuberculosis, lung cancer, acquired immunodeficiency syndrome (AIDS), pneumonia, occupational lung disease, and smoking. Sleep Health is now a separate topic area of Healthy People 2020.

Currently in the United States, more than 23 million people have asthma. Approximately 13.6 million adults have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed. 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

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.

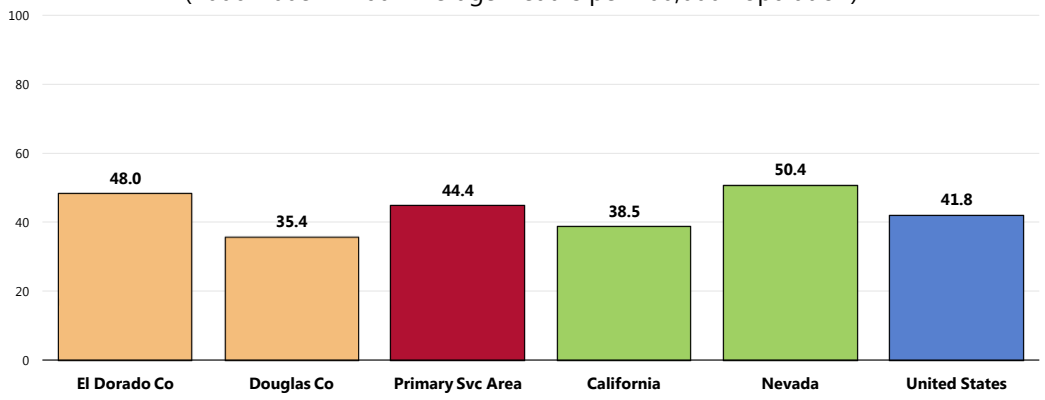
Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2006 and 2008, there was an annual average age-adjusted CLRD mortality rate of 44.4 deaths per 100,000 population in the Primary Service Area.

- Higher than the California rate but lower than found in Nevada.
- Higher than the national rate.
- Higher in El Dorado County.

CLRD: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



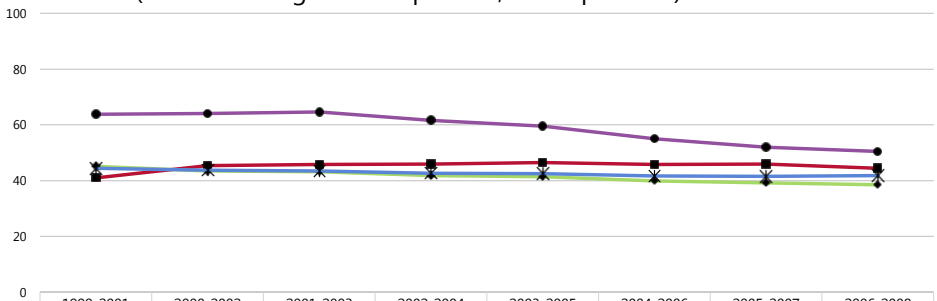
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- CLRD is chronic lower respiratory disease.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

CLRD mortality in the Primary Service Area has remained relatively stable for most of the past decade; in contrast, rates have decreased across California, Nevada and the US overall.

CLRD: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Primary Svc Area	41.0	45.4	45.8	45.9	46.5	45.7	46.0	44.4
California	45.1	43.5	43.1	41.7	41.4	39.9	39.1	38.5
Nevada	63.9	64.1	64.6	61.6	59.6	55.1	52.0	50.4
United States	44.4	43.8	43.5	42.6	42.5	41.6	41.5	41.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- CLRD is chronic lower respiratory disease.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Pneumonia/Influenza Deaths

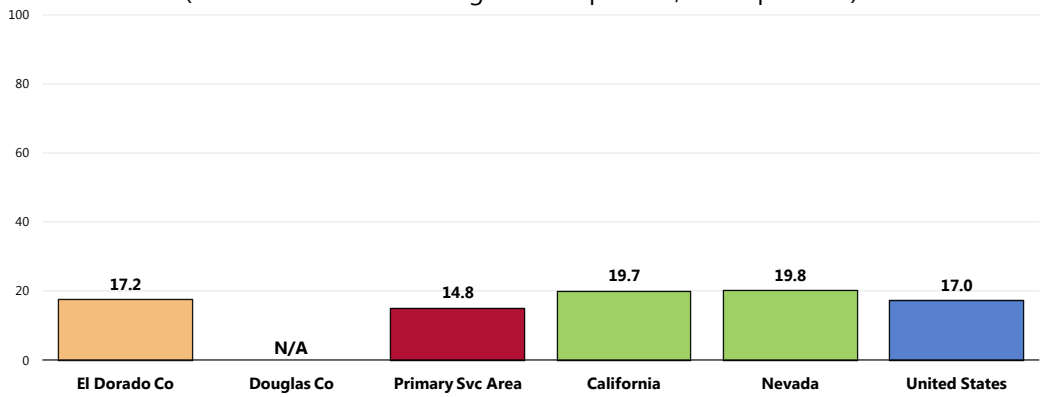
For prevalence of vaccinations for pneumonia and influenza, see also "Immunization & Infectious Disease."

Between 2006 and 2008, there was an annual average age-adjusted mortality rate of 14.8 deaths per 100,000 population for pneumonia/influenza in the Primary Service Area.

- More favorable than both state rates.
- More favorable than the national rate.
- Not available in Douglas County.

Pneumonia/Influenza: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



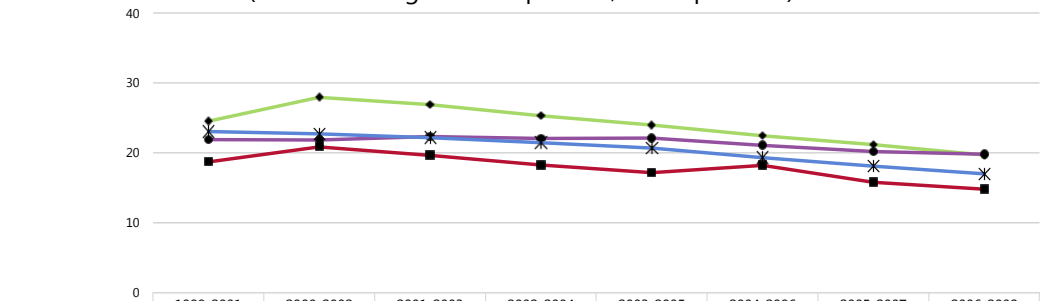
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Area pneumonia/influenza mortality has decreased over time, echoing the state and US trends.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Primary Svc Area	18.7	20.9	19.6	18.2	17.1	18.2	15.8	14.8
California	24.5	28.0	26.9	25.3	24.0	22.5	21.2	19.7
Nevada	21.9	21.8	22.3	22.0	22.1	21.1	20.2	19.8
United States	23.0	22.7	22.2	21.5	20.7	19.3	18.1	17.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Prevalence of Respiratory Conditions

Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma, nasal/hay fever allergies, sinusitis, and/or chronic lung disease.

Nasal/Hay Fever Allergies

Less than one-fifth (17.8%) of Primary Service Area adults currently suffers from or have been diagnosed with nasal/hay fever allergies.

- Much lower than the national prevalence.

Sinusitis

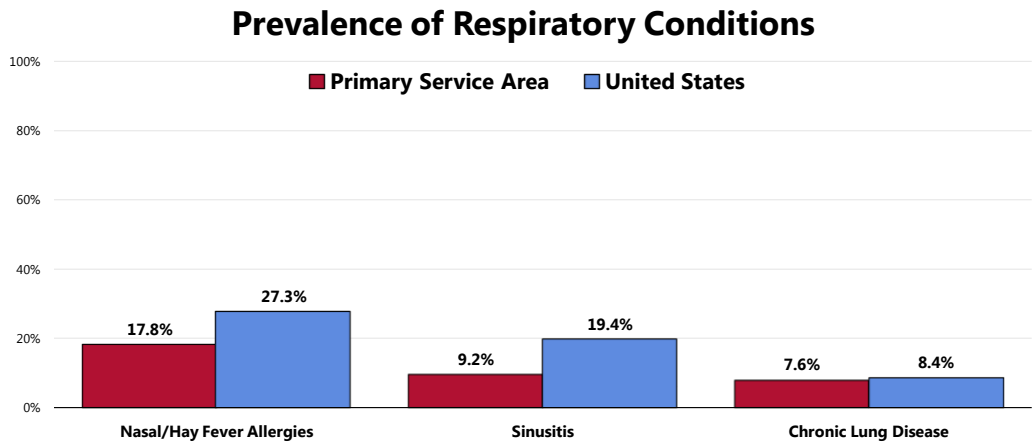
A total of 9.2% of Primary Service Area adults suffer from sinusitis.

- Much lower than the national prevalence.

Chronic Lung Disease

A total of 7.6% of Primary Service Area adults suffer from chronic lung disease.

- Similar to the national prevalence.



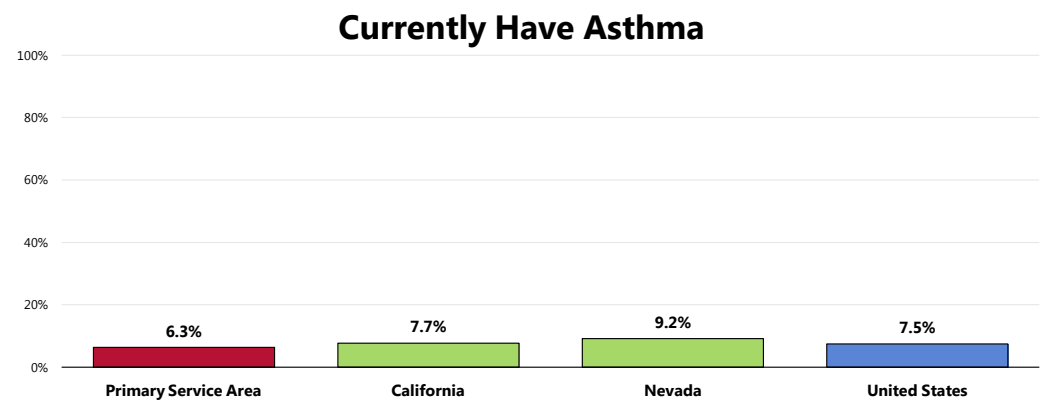
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25, 34-35]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Adults

A total of 6.3% of Primary Service Area adults currently suffer from asthma.

- Similar to the California prevalence, more favorable than the Nevada prevalence.
- Similar to the national prevalence.

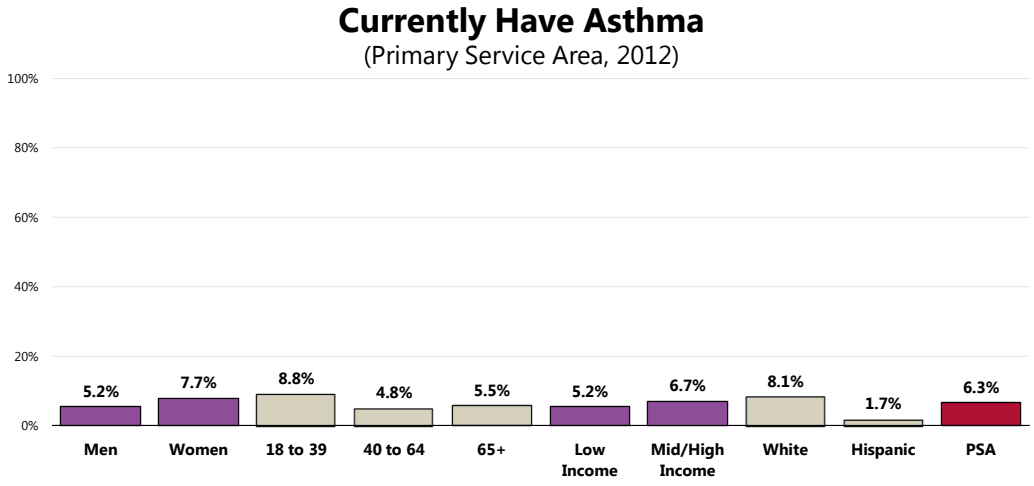


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 159]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.

Notes:
- Asked of all respondents.

The following adults are more likely to suffer from asthma:

- Young adults.
- Non-Hispanic White respondents.

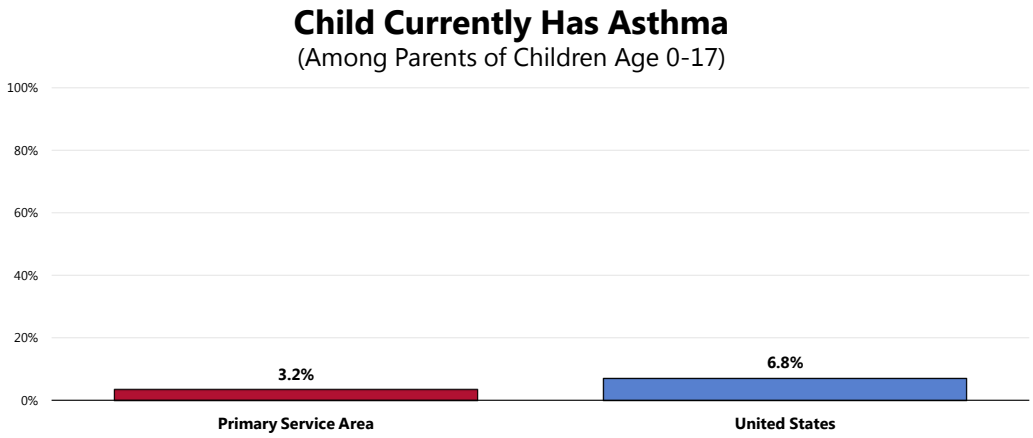


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 159]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among Primary Service Area children under age 18, 3.2% currently have asthma.

- Statistically similar to national findings.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 160]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

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

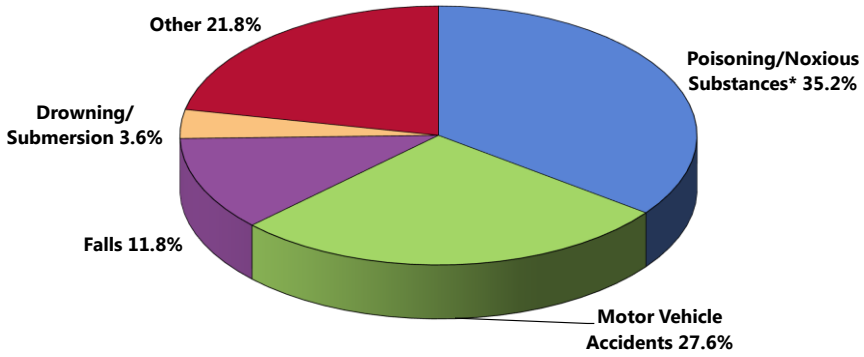
– Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Poisoning (including accidental overdose in adults), motor vehicle accidents, falls and drowning/submersion accounted for nearly 8 in 10 accidental deaths in the Primary Service Area between 2006 and 2008.

Leading Causes of Accidental Death

(Primary Service Area, 2006-2008)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- *Includes accidental overdose in adults and poisoning in children.
- Primary Service Area findings include El Dorado County (CA) and Douglas County (NV) findings.

Unintentional Injury

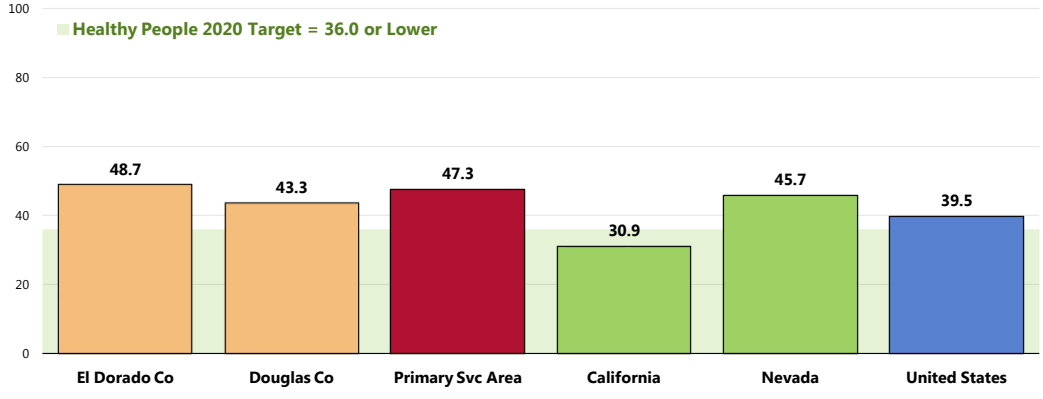
Age-Adjusted Unintentional Injury Deaths

Between 2006 and 2008, there was an annual average age-adjusted unintentional injury mortality rate of 47.3 deaths per 100,000 population in the Primary Service Area.

- Less favorable than the California rate but comparable to the Nevada rate.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target (36.0 or lower).
- Higher in El Dorado County.

Unintentional Injuries: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



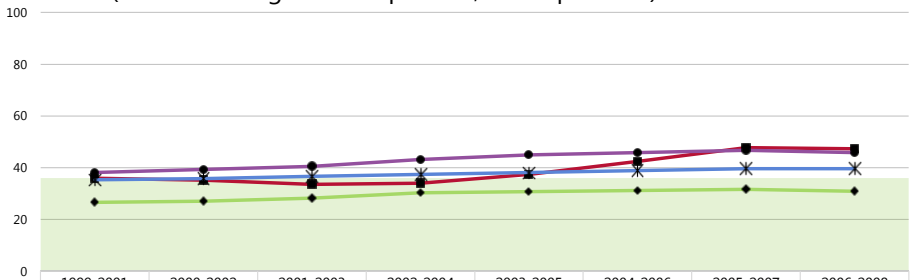
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

There is an overall upward trend in the unintentional injury mortality rate in the Primary Service Area, echoing the slowly increasing trends reported in California, Nevada and the US overall.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0
Primary Svc Area	35.9	35.1	33.5	34.0	37.4	42.4	47.8	47.3
California	26.5	26.9	28.2	30.2	30.7	31.1	31.6	30.9
Nevada	38.1	39.3	40.4	43.2	45.0	45.7	46.7	45.7
United States	35.2	35.8	36.6	37.3	38.0	38.9	39.6	39.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- 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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Motor Vehicle Safety

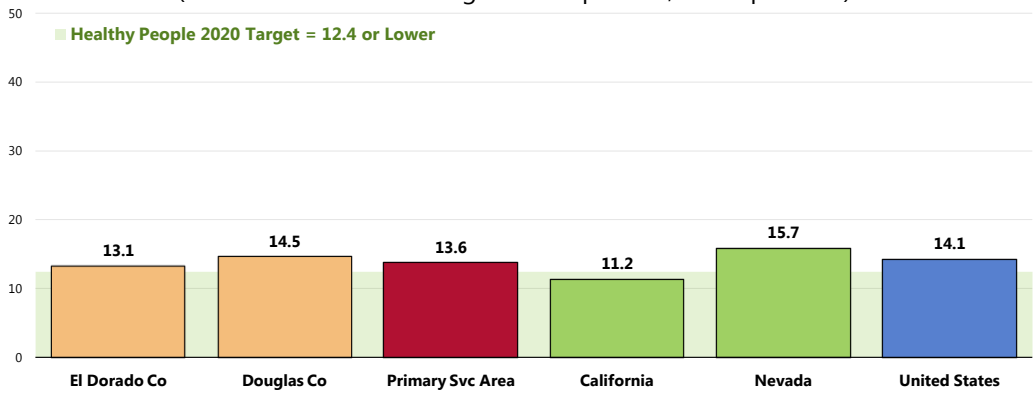
Age-Adjusted Motor-Vehicle Related Deaths

Between 2006 and 2008, there was an annual average age-adjusted motor vehicle crash mortality rate of 13.6 deaths per 100,000 population in the Primary Service Area.

- Higher than found in California but lower than the Nevada rate.
- Comparable to that found nationally.
- Fails to satisfy the Healthy People 2020 target (12.4 or lower).
- Lower in El Dorado County.

Motor Vehicle Crashes: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



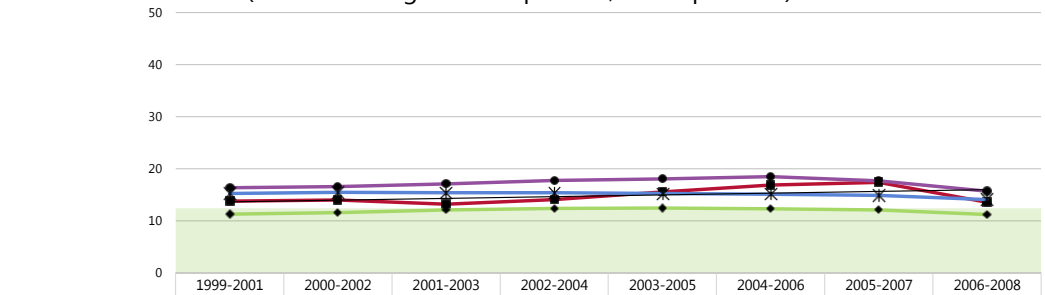
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The mortality rate in the Primary Service Area fluctuated over the past decade; the California rate was stable during this time, while Nevada and the US rates decreased.

Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	12.4	12.4	12.4	12.4	12.4	12.4	12.4	12.4
Primary Svc Area	13.8	14.0	13.2	14.1	15.6	16.9	17.4	13.6
California	11.3	11.6	12.1	12.4	12.5	12.3	12.1	11.2
Nevada	16.4	16.6	17.1	17.8	18.1	18.5	17.7	15.7
United States	15.3	15.5	15.4	15.4	15.2	15.1	14.9	14.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

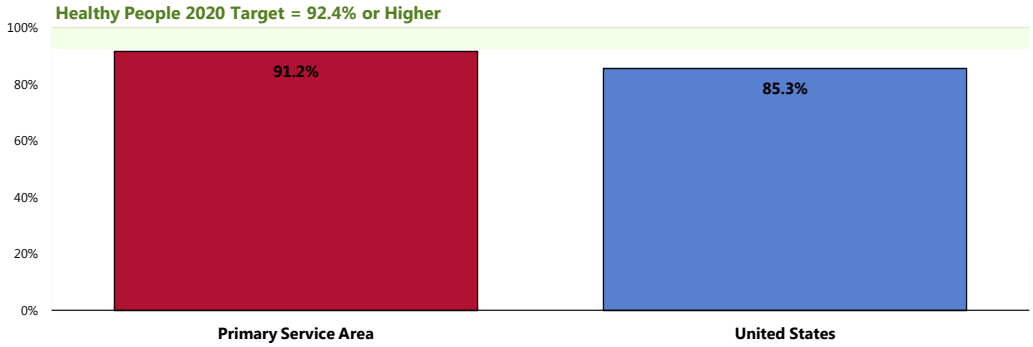
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Seat Belt Usage - Adults

Most Primary Service Area adults (91.2%) report "always" wearing a seat belt when driving or riding in a vehicle.

- More favorable than the percentage found nationally.
- Similar to the Healthy People 2020 target of 92.4% or higher.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle



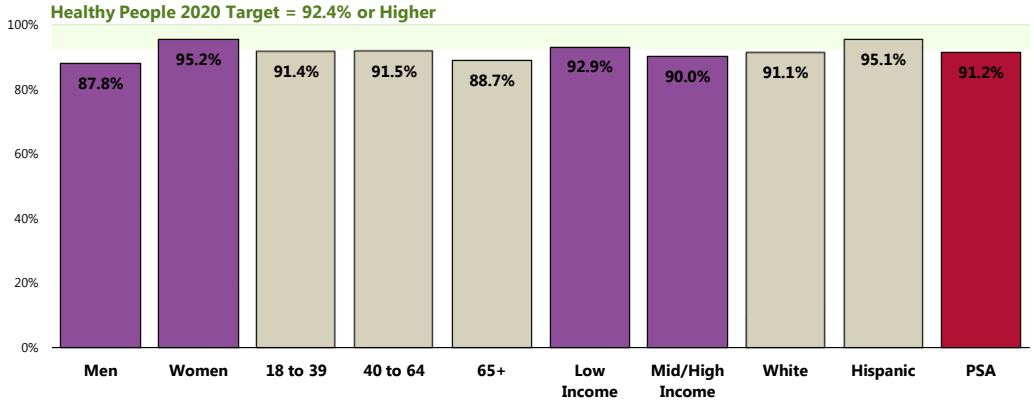
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-15]

Notes:
- Asked of all respondents.

- Men are less likely to report consistent seat belt usage in the Primary Service Area.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-15]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

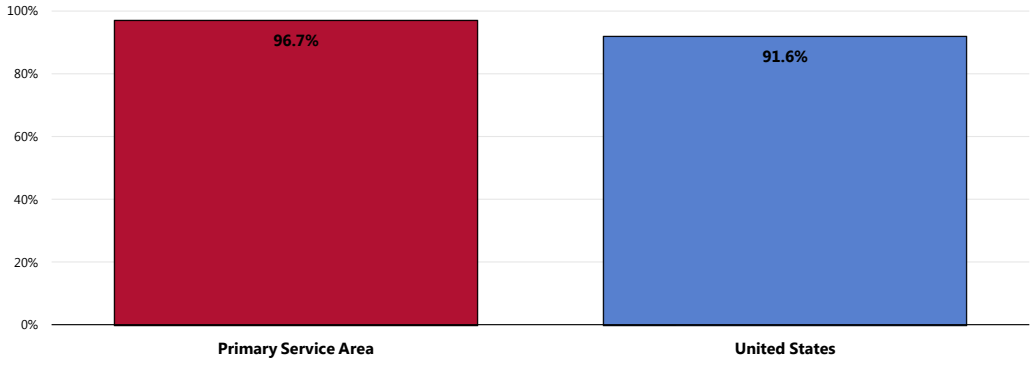
Seat Belt Usage - Children

A full 96.7% of Primary Service Area parents report that their child (age 0 to 17) "always" wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

- More favorable than what is found nationally.

Child "Always" Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle

(Among Parents of Children Age 0-17)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 139]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

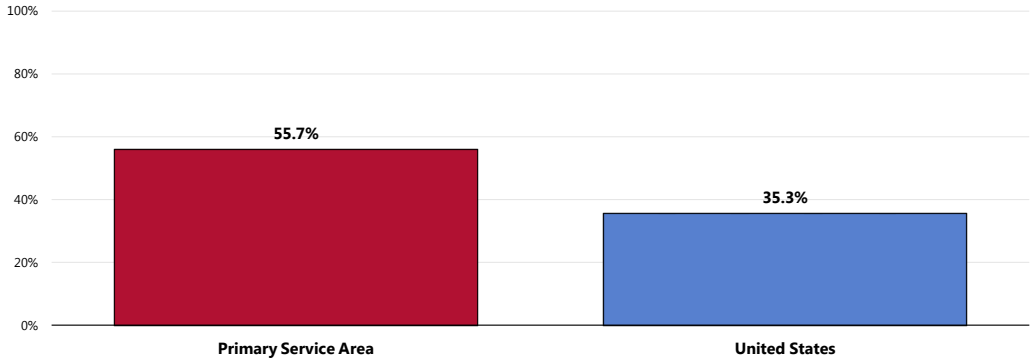
Bicycle Safety

Just over one-half (55.7%) of Primary Service Area children age 5 to 17 are reported to "always" wear a helmet when riding a bicycle.

- Much higher than the national prevalence.

Child "Always" Wears a Helmet When Riding a Bicycle

(Among Parents of Children Age 5-17)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 144]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5 to 17 at home.

Firearm Safety

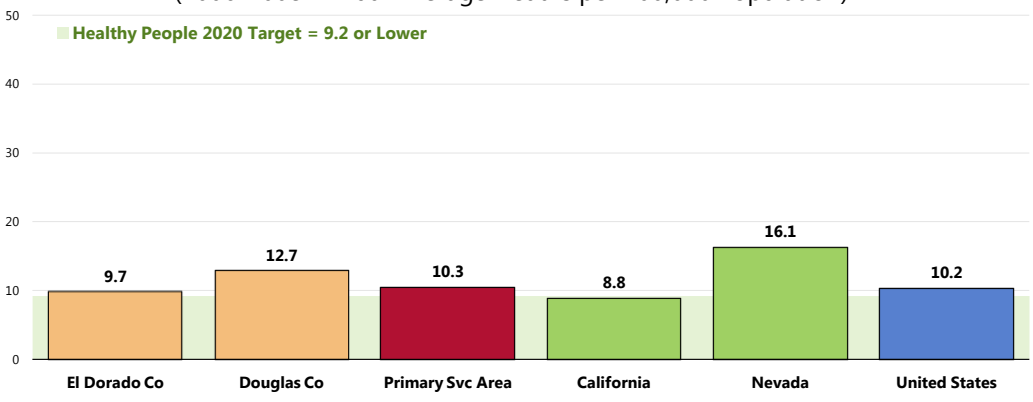
Age-Adjusted Firearm-Related Deaths

Between 2006 and 2008, there was an annual average age-adjusted rate of 10.3 deaths per 100,000 population due to firearms in the Primary Service Area.

- Higher than the California rate but lower than the Nevada rate.
- Nearly identical to the national rate.
- Fails to satisfy the Healthy People 2020 objective (9.2 or lower).
- Higher in Douglas County.

Firearms-Related Deaths: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



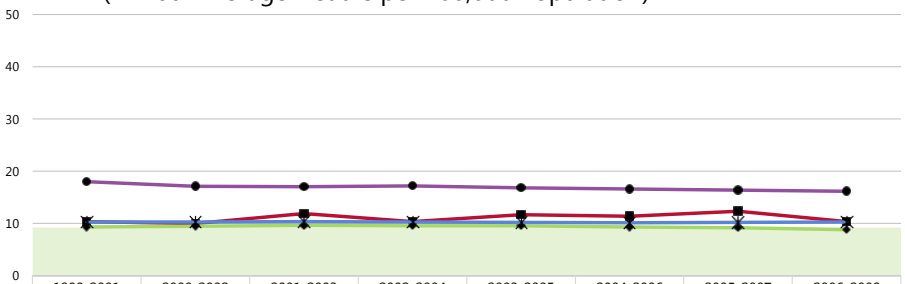
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

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.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Despite fluctuations, the mortality rate in the Primary Service Area is relatively unchanged from the 1999-2001 reporting period.

Firearms-Related Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	9.2	9.2	9.2	9.2	9.2	9.2	9.2	9.2
Primary Svc Area	10.4	10.0	11.9	10.4	11.7	11.4	12.3	10.3
California	9.3	9.4	9.6	9.6	9.5	9.3	9.2	8.8
Nevada	18.0	17.1	17.1	17.2	16.8	16.6	16.4	16.1
United States	10.3	10.3	10.3	10.2	10.2	10.1	10.2	10.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

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.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Presence of Firearms in Homes

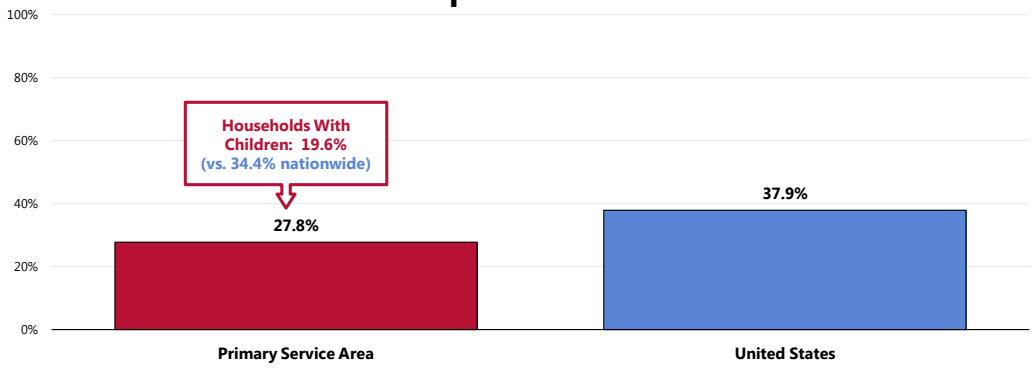
Overall, 27.8% of Primary Service Area adults has a firearm kept in or around their home.

- Much lower than the national prevalence.
- Among Primary Service Area households with children, 19.6% have a firearm kept in or around the house (lower than reported nationally).

Survey respondents were further asked about the presence of weapons in the home:

"Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, 'firearms' include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire."

Have a Firearm Kept in or Around the Home



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 57, 161]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

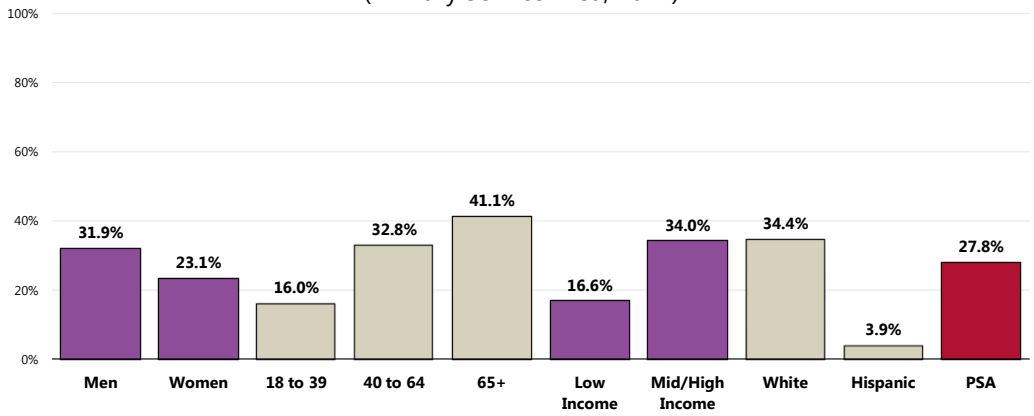
Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

Reports of firearms in or around the home are more prevalent among the following respondent groups:

- Men.
- Adults aged 40+.
- Higher-income households.
- Non-Hispanic White respondents.

Have a Firearm Kept in or Around the House

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 57]

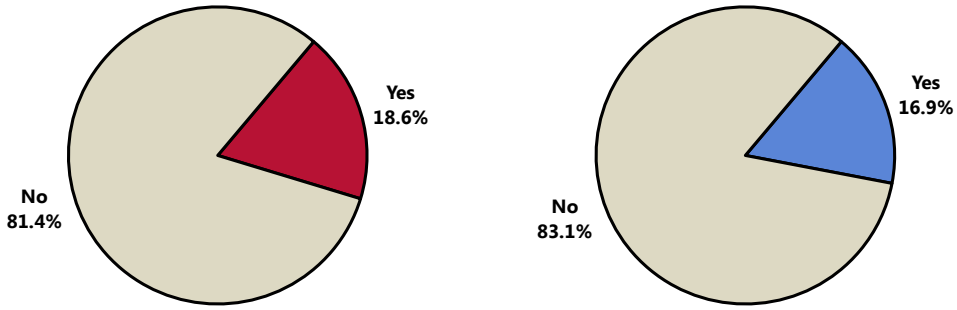
Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
- Hispanics can be of any race (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among Primary Service Area households with firearms, 18.6% report that there is at least one weapon that is kept unlocked and loaded.

- Statistically similar to that found nationally.

Household Has An Unlocked, Loaded Firearm

(Among Respondents Reporting a Firearm in or Around the Home)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 162]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with a firearm in or around the home.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

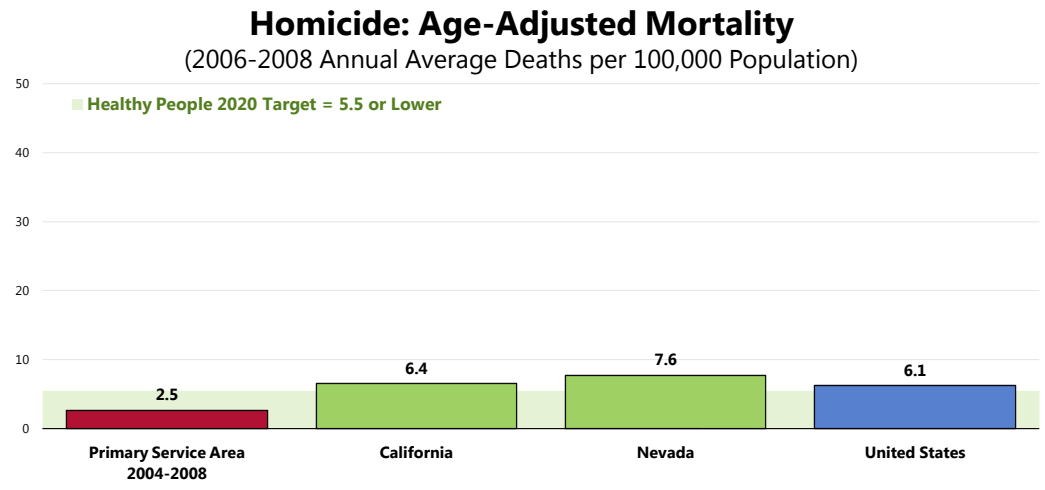
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE:
See also *Suicide* in the **Mental Health & Mental Disorders** section of this report.

Between 2006 and 2008, there was an annual average age-adjusted homicide rate of 2.5 deaths per 100,000 population in the Primary Service Area.

- More favorable than the rates found in California and Nevada.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 5.5 or lower.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-29]

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Violent Crime

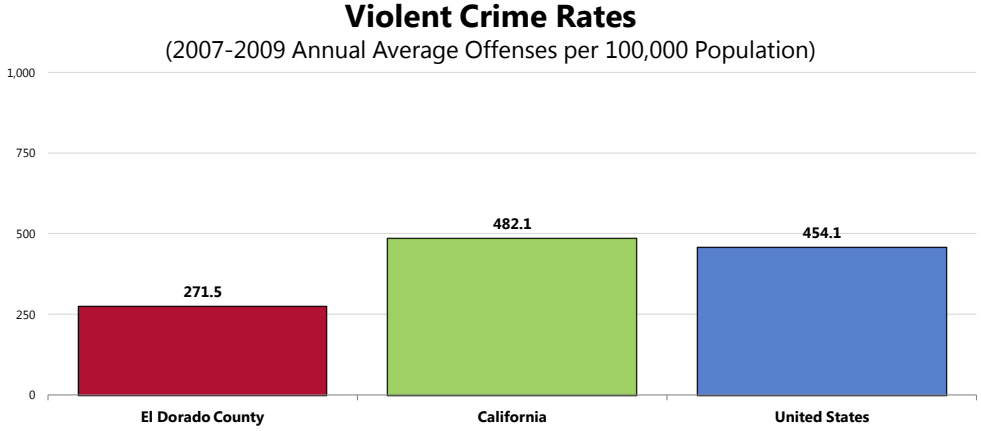
Violent Crime Rates

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

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

Between 2007 and 2009, there was a violent crime rate of 271.5 offenses per 100,000 population in El Dorado County (Douglas County data not available).

- Much lower than the California rate for the same period.
- Lower than the national rate.



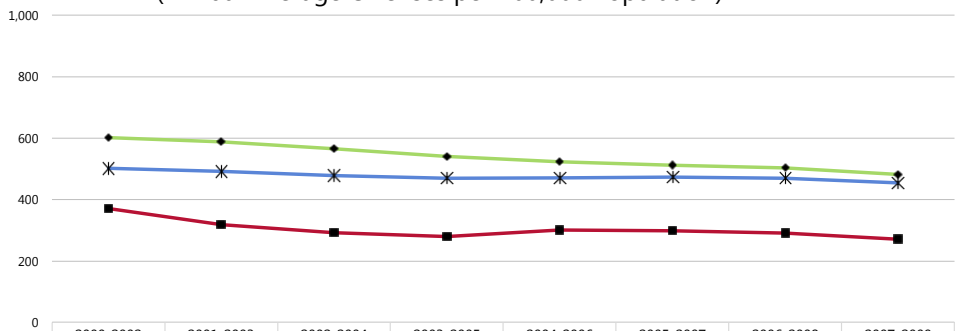
Sources:
- California Uniform Crime Report.
- Crime in Nevada.
- US Department of Justice, Federal Bureau of Investigation.

Notes:
- Rates are offenses per 100,000 population among agencies reporting.

- The reported crime rate has declined in recent years, echoing the California and national trends. Across Nevada, violent crime increased over the past decade.

Violent Crime Rates

(Annual Average Offenses per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
El Dorado Co	370.7	318.1	292.9	279.6	301.2	298.9	291.0	271.5
California	601.8	588.1	566.1	540.4	523.4	512.6	503.7	482.1
United States	501.8	491.6	477.8	469.3	470.5	473.4	469.9	454.1

Sources:
- California Uniform Crime Report.
- Crime in Nevada.
- US Department of Justice, Federal Bureau of Investigation.

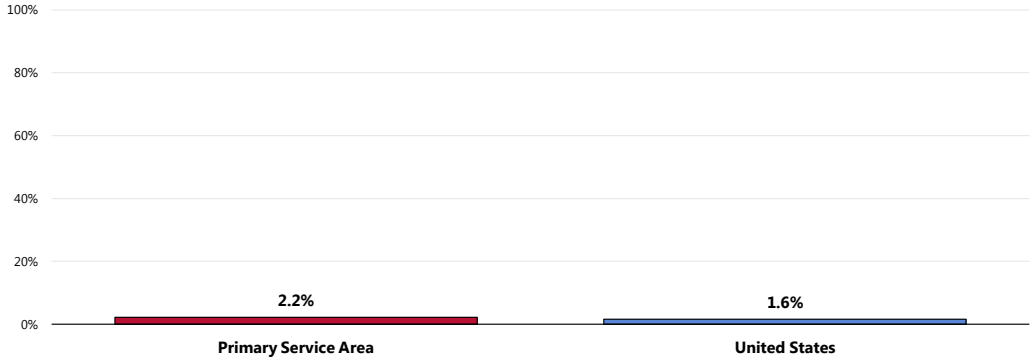
Notes:
- Rates are offenses per 100,000 population among agencies reporting.

Self-Reported Violence

A total of 2.2% of Primary Service Area adults acknowledge being the victim of a violent crime in the past five years.

- Statistically similar to national findings.

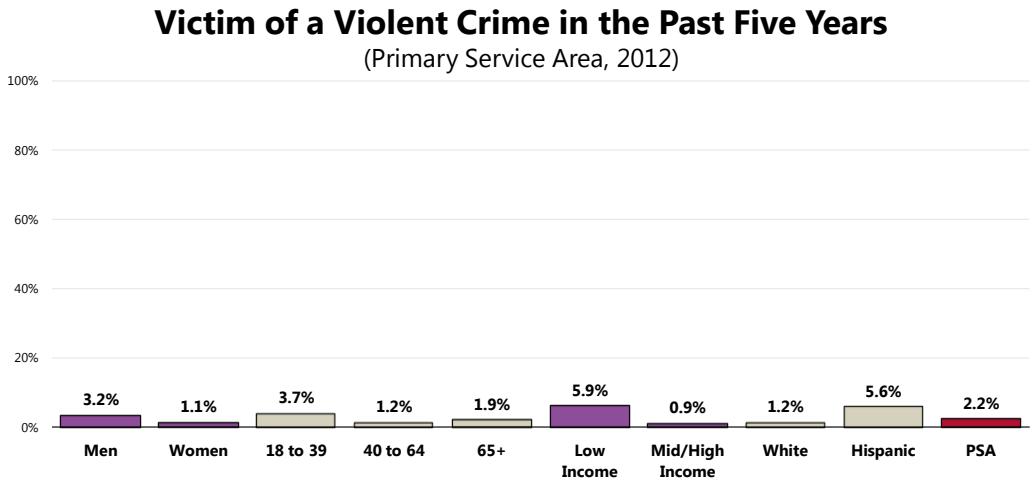
Victim of a Violent Crime in the Past Five Years



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Reports of violence are notably higher among residents living in the lower income category.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Self-Reported Family Violence

Respondents were told:

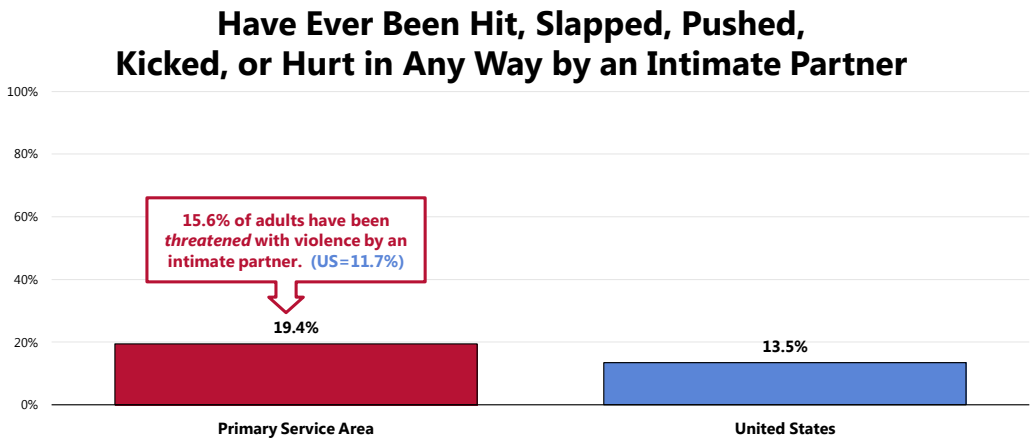
"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 15.6% of Primary Service Area adults report that they have ever been threatened with physical violence by an intimate partner.

- Comparable to that reported nationally.

A total of 19.4% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- Less favorable than national findings.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 55-56]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

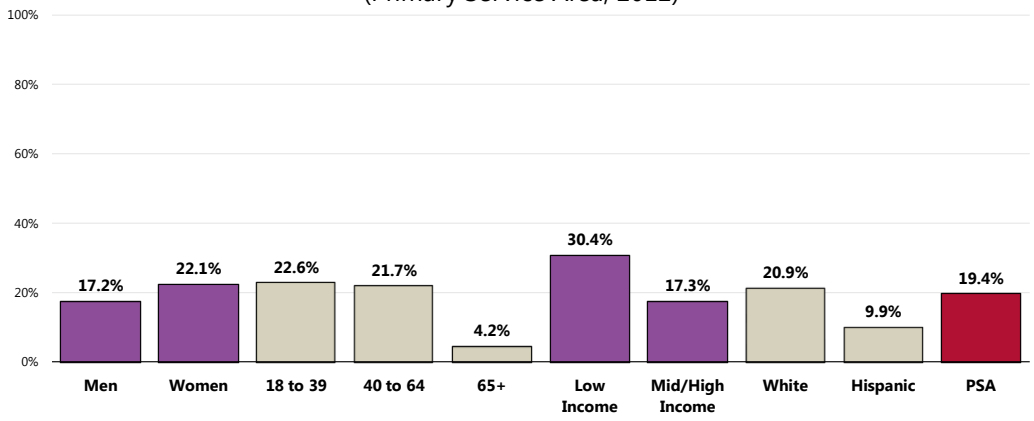
Notes:
- Asked of all respondents.

Reports of domestic violence are also notably higher among:

- Adults under 65.
- Those with lower incomes.
- Non-Hispanic White respondents.

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

(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
Notes: • Asked of all respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Child Abuse Rates

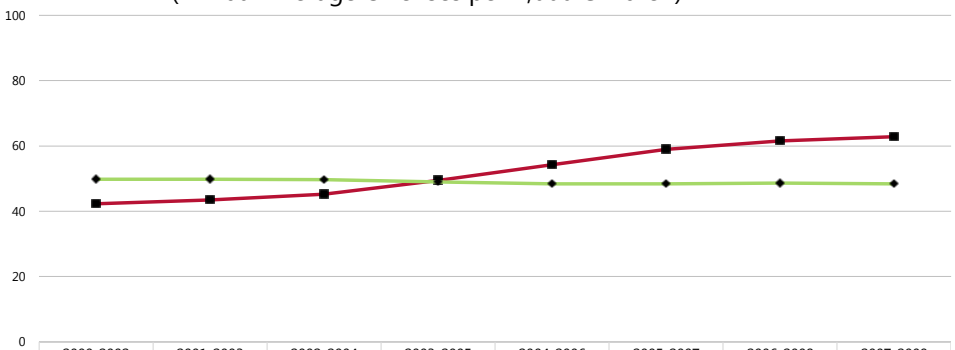
Keep in mind that these data only reflect those incidents reported to law enforcement.

Between 2007 and 2009, there was an annual average child abuse offense rate of 62.8 offenses per 1,000 children in El Dorado County (comparable Douglas County data not available)**.**

- Higher than the California rate for the same period.
- The reported child abuse rate has increased in the county over time, while the California rate decreased slightly.

Reported Child Abuse Rates

(Annual Average Offenses per 1,000 Children)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
El Dorado Co	42.2	43.5	45.2	49.4	54.3	58.9	61.5	62.8
California	49.8	49.8	49.7	49.0	48.4	48.4	48.7	48.4

Sources: • California Uniform Crime Report.
Notes: • Rates are based on unduplicated counts of children with allegations, substantiations, and entering care during the time period.

Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes.

Effective therapy can prevent or delay diabetic complications. However, almost 25% of Americans with diabetes mellitus are undiagnosed, and another 57 million Americans have blood glucose levels that greatly increase their risk of developing diabetes mellitus in the next several years. Few people receive effective preventative care, which makes diabetes mellitus an immense and complex public health challenge.

Diabetes mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

In addition to these human costs, the estimated total financial cost of diabetes mellitus in the US in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

– Healthy People 2020 (www.healthypeople.gov)

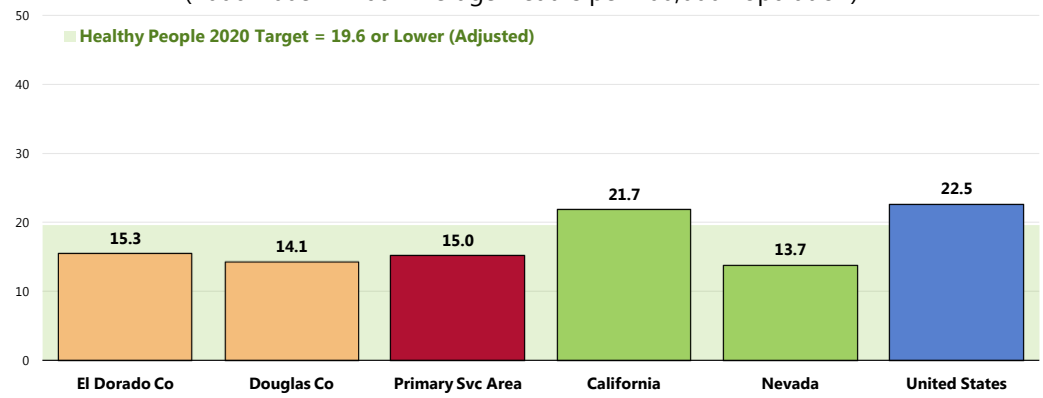
Age-Adjusted Diabetes Deaths

Between 2006 and 2008, there was an annual average age-adjusted diabetes mortality rate of 15.0 deaths per 100,000 population in the Primary Service Area.

- More favorable than that found in California but less favorable than the Nevada rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target (19.6 or lower).
- County rates are statistically similar.

Diabetes: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



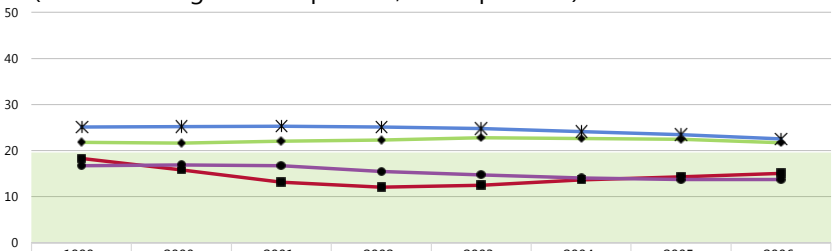
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Although there have been some increases in recent years in the Primary Service Area, diabetes mortality has overall declined in the past decade.

Diabetes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020 (Adjusted)	19.6	19.6	19.6	19.6	19.6	19.6	19.6	19.6
Primary Svc Area	18.2	15.8	13.1	12.0	12.5	13.6	14.3	15.0
California	21.7	21.6	22.0	22.3	22.7	22.6	22.5	21.7
Nevada	16.7	16.8	16.7	15.5	14.7	14.0	13.7	13.7
United States	25.1	25.2	25.3	25.1	24.8	24.1	23.5	22.5

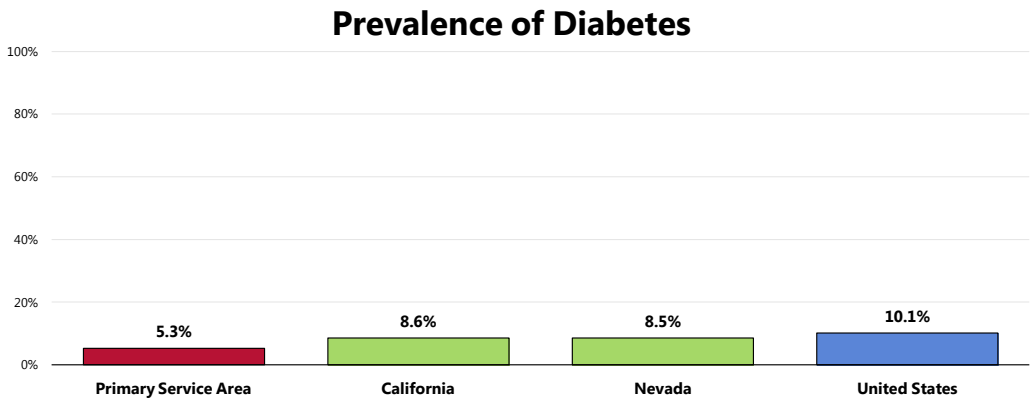
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Prevalence of Diabetes

A total of 5.3% of Primary Service Area adults report having been diagnosed with diabetes.

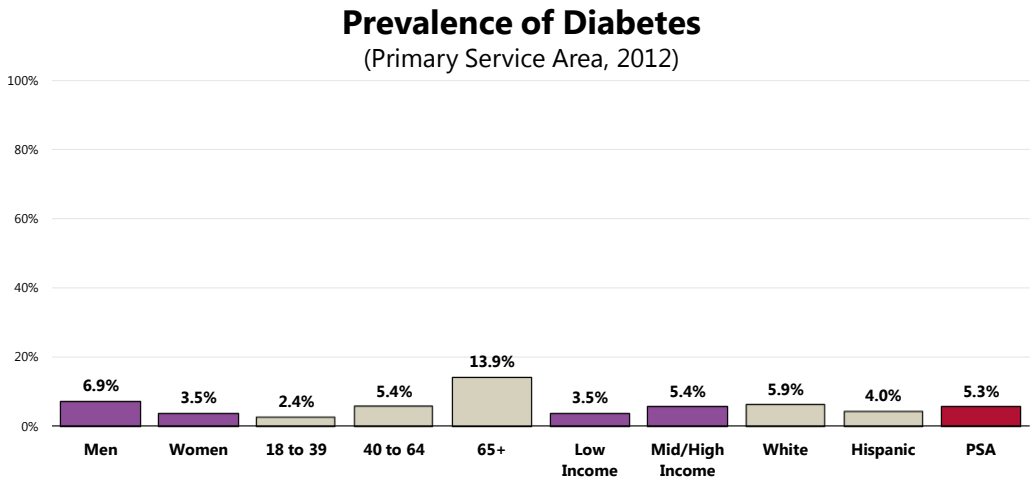
- More favorable than the proportions statewide.
- More favorable than the national proportion.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.

Notes:
- Asked of all respondents.
- Local and national data exclude gestation diabetes (occurring only during pregnancy).

Note the positive correlation between diabetes and age (with 13.9% of seniors with diabetes).



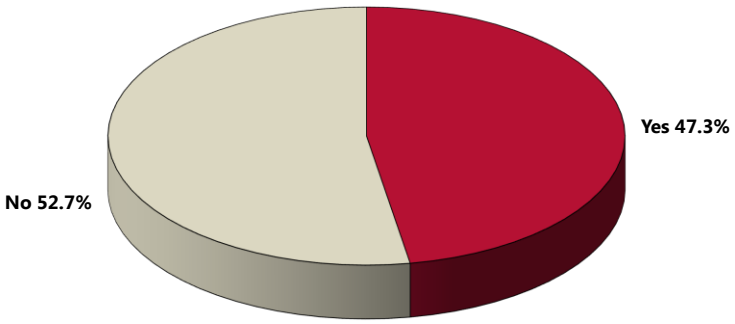
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestation diabetes (occurring only during pregnancy).

Among adults with diabetes, just under one-half (47.3%) is currently taking insulin or some type of medication to manage their condition.

Taking Insulin or Other Medication for Diabetes

(Among Primary Service Area Diabetics; n=25)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 45]
Notes: • Asked of all diabetic respondents (note that the percentage represents a small sample size of 25 people).

Alzheimer's Disease

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

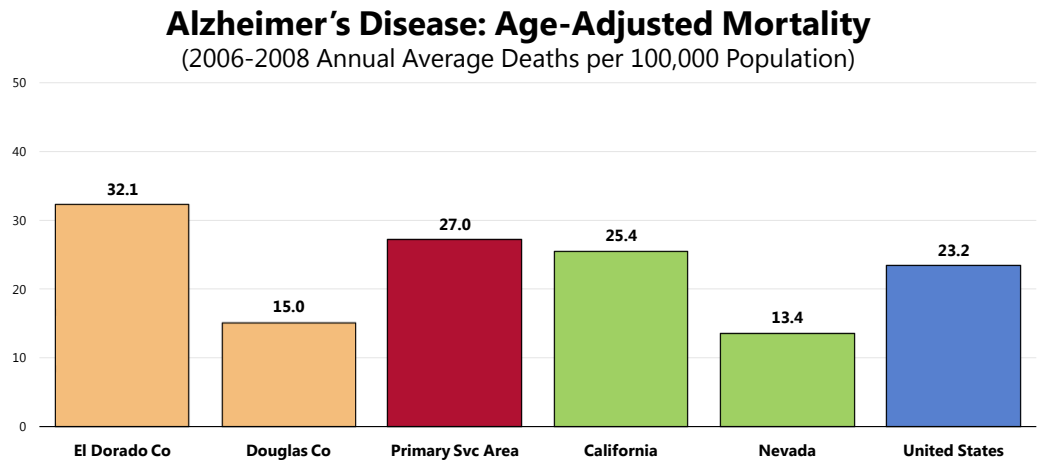
Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2006 and 2008, there was an annual average age-adjusted Alzheimer's disease mortality rate of 27.0 deaths per 100,000 population in the Primary Service Area.

- Less favorable than both statewide rates.
- Less favorable than the national rate.
- More than twice as high in El Dorado County as in Douglas County.



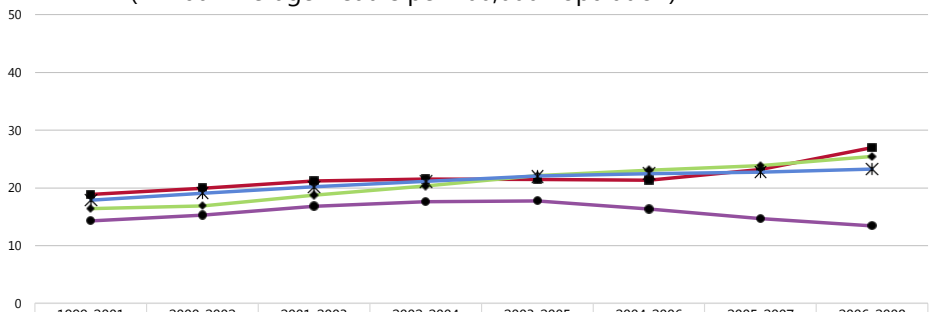
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

- The Alzheimer's disease mortality rate has increased over time in the Primary Service Area; the same is true for California and the US overall. In contrast, Nevada mortality decreased during this time.

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Primary Svc Area	18.9	19.9	21.2	21.5	21.5	21.3	23.2	27.0
California	16.4	16.9	18.7	20.4	22.1	23.0	23.9	25.4
Nevada	14.3	15.3	16.8	17.6	17.8	16.3	14.7	13.4
United States	17.9	19.1	20.2	21.1	22.0	22.4	22.7	23.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

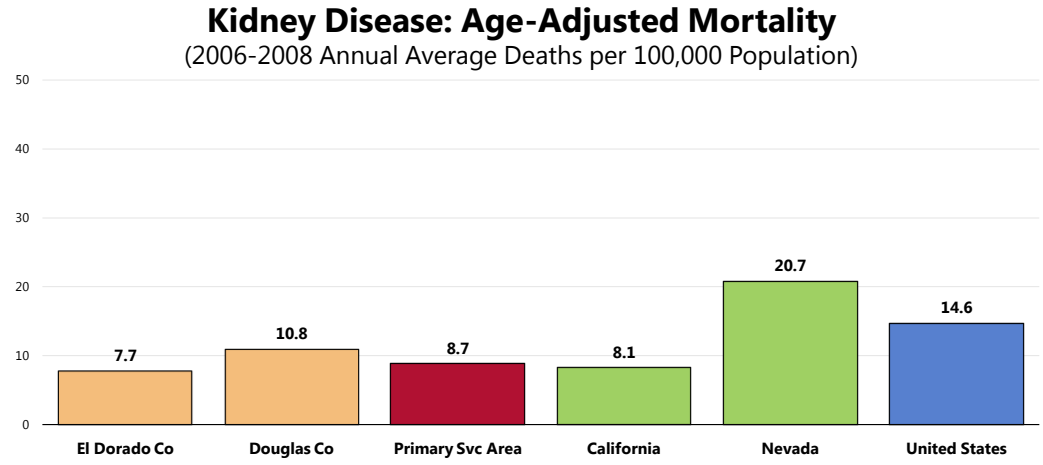
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2006 and 2008 there was an annual average age-adjusted kidney disease mortality rate of 8.7 deaths per 100,000 population in the Primary Service Area.

- Higher than the rate found in California but much lower than the Nevada rate.
- Lower than the national rate.
- Higher in Douglas County.



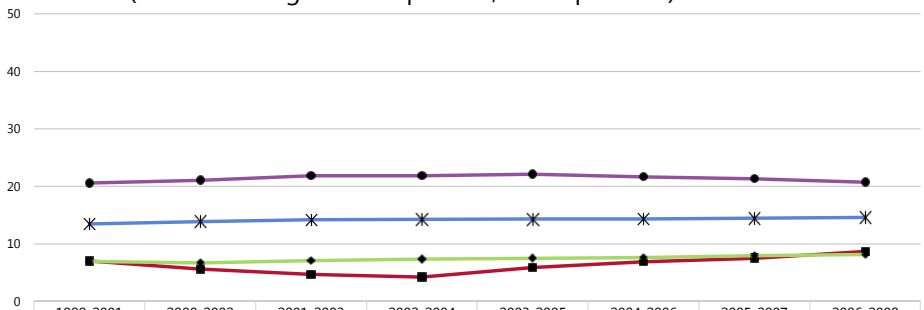
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Kidney disease mortality in the Primary Service Area has increased in recent years, as did the California and US rates.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Primary Svc Area	7.0	5.6	4.7	4.2	5.9	6.9	7.5	8.7
California	7.0	6.7	7.1	7.3	7.5	7.6	7.9	8.1
Nevada	20.6	21.1	21.9	21.8	22.1	21.6	21.3	20.7
United States	13.5	13.9	14.2	14.3	14.3	14.3	14.4	14.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.

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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Potentially Disabling Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

RELATED ISSUE:
See also *Activity Limitations* in the **General Health Status** section of this report.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

– Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Pain

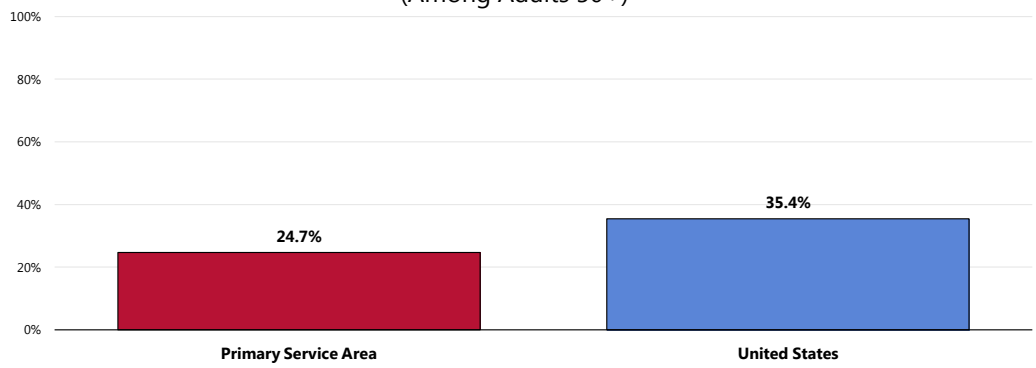
Prevalence of Arthritis/Rheumatism

A total of one-fourth (24.7%) of Primary Service Area adults age 50 and older reports suffering from arthritis or rheumatism.

- More favorable than that found nationwide.

Prevalence of Arthritis/Rheumatism

(Among Adults 50+)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents 50 and older.

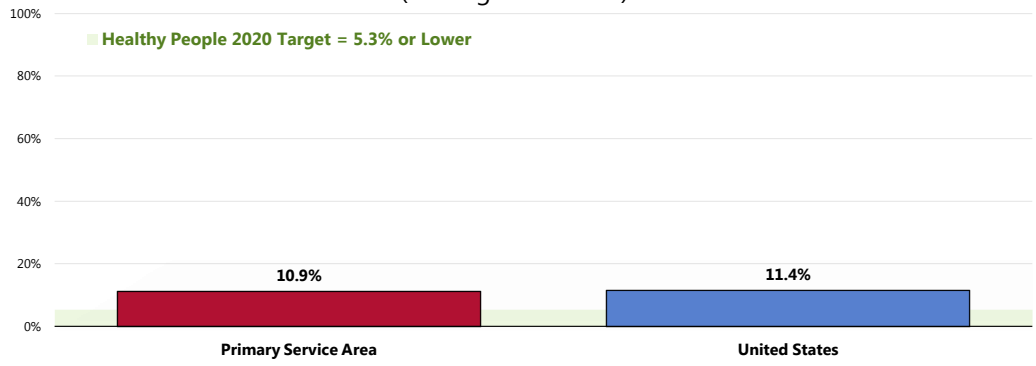
Prevalence of Osteoporosis

A total of 10.9% of survey respondents age 50 and older have osteoporosis.

- Similar to that found nationwide.
- Twice the Healthy People 2020 target of 5.3% or lower.

Prevalence of Osteoporosis

(Among Adults 50+)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 166]
- 2011 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 AOCBC-10]

Notes:
- Reflects respondents 50 and older.

Prevalence of Sciatica/Chronic Back Pain

A total of 22.8% of survey respondents suffer from chronic back pain or sciatica.

- Comparable to that found nationwide.

Prevalence of Chronic Neck Pain

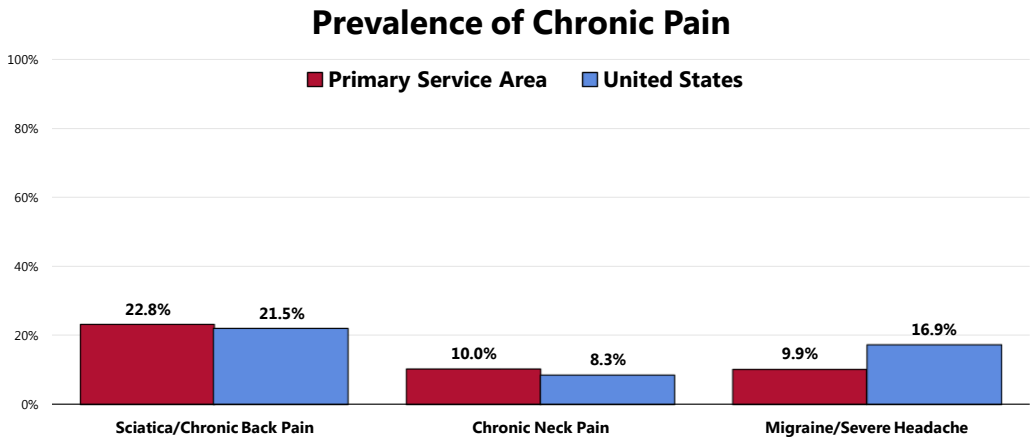
One in 10 survey respondents (10.0%) currently suffers from chronic neck pain.

- Similar to that found nationwide.

Prevalence of Migraines/Severe Headaches

A total of 9.9% of survey respondents report suffering from migraines or severe headaches.

- More favorable than that found nationwide.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 29, 36-37]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Vision & Hearing Impairment

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

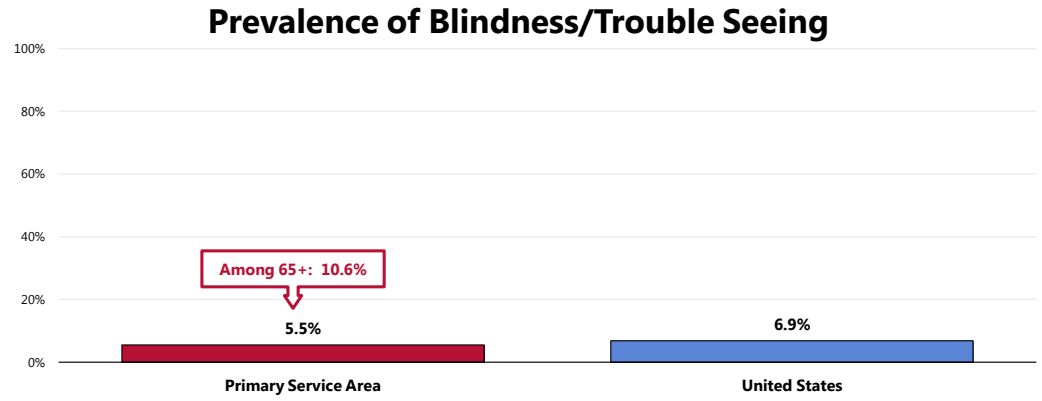
– Healthy People 2020 (www.healthypeople.gov)

Vision Trouble

A total of 5.5% of Primary Service Area adults are blind, or have trouble seeing even when wearing corrective lenses.

- Similar to that found nationwide.
- Among Primary Service Area adults age 65 and older, 10.6% have vision trouble.

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



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 26]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Hearing Trouble

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

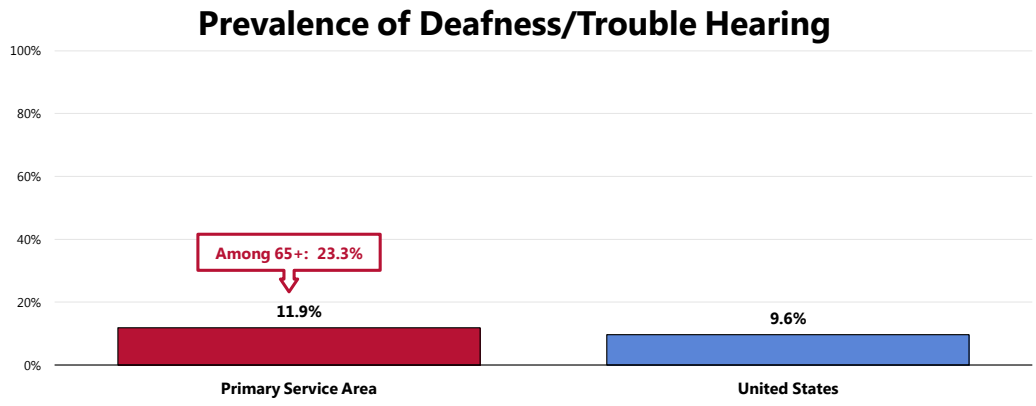
Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

– Healthy People 2020 (www.healthypeople.gov)

In all, 11.9% of Primary Service Area adults report being deaf or having difficulty hearing.

- Similar to that found nationwide.
- Among Primary Service Area adults age 65 and older, 23.3% have partial or complete hearing loss.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 27]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

INFECTIOUS DISEASE

Vaccine-Preventable Conditions

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by $9.9 billion.
- Saves $33.4 billion in indirect costs.

– Healthy People 2020 (www.healthypeople.gov)

Measles, Mumps, Rubella

"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

Between 2007 and 2009, there were no reported cases of measles, mumps or rubella in the Primary Service Area.

Reported Case Rates for Vaccine-Preventable Diseases

(2007-2009 Annual Average Cases per 100,000 Population)

	Primary Service Area	CA	NV	US
Measles	**0.0**	**0.0**	**0.0**	**0.0**
Mumps	**0.0**	**0.0**	**0.2**	**0.4**
Rubella	**0.0**	**0.0**	**0.0**	**0.0**

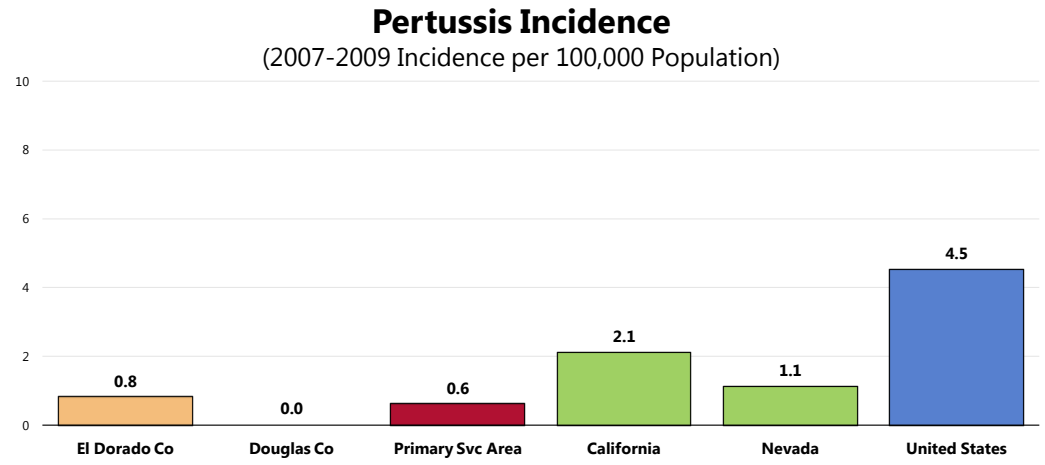
Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

Notes:
- US measles cases include only those infected while in the United States.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Pertussis

Between 2007 and 2009, the annual average pertussis incidence rate (new cases per year) was 0.6 cases per 100,000 population in the Primary Service Area.

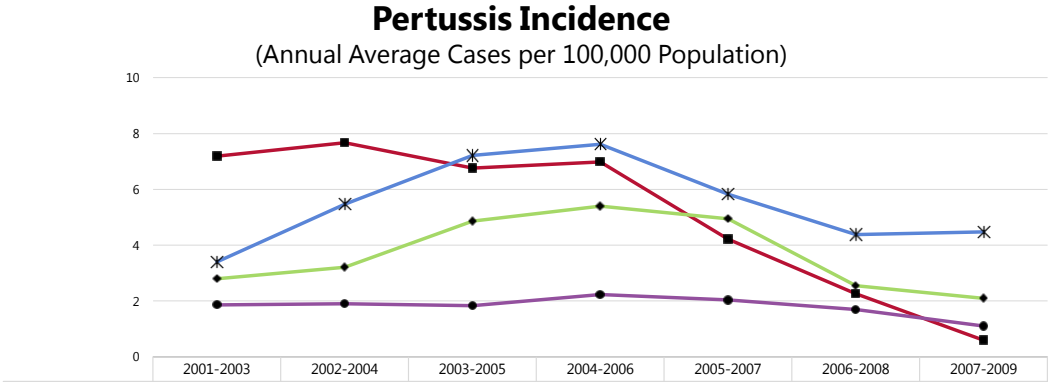
- Below the California and Nevada incidence rates.
- Well below the national rate.
- No cases were reported in Douglas County.



Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The incidence rate has decreased in the Primary Service Area, particularly since the 2004-2006 reporting period; the same is true for both states and the US overall.



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Primary Svc Area	7.2	7.7	6.8	7.0	4.2	2.3	0.6
California	2.8	3.2	4.9	5.4	5.0	2.5	2.1
Nevada	1.9	1.9	1.8	2.2	2.0	1.7	1.1
United States	3.4	5.5	7.2	7.6	5.8	4.4	4.5

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

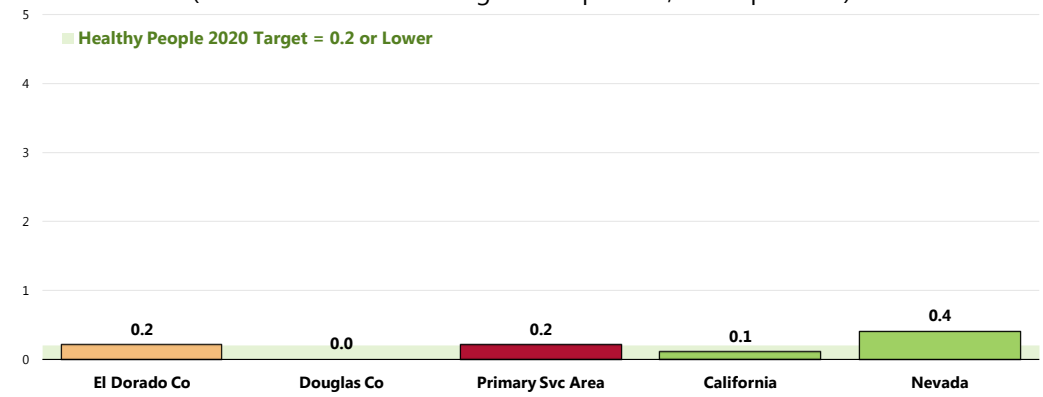
Acute Hepatitis C

The Primary Service Area experienced an incidence rate of less than one case of hepatitis C per 100,000 population between 2007 and 2009.

- Above the California rate but below the Nevada rate.
- Identical to the Healthy People 2020 target of 0.2 or lower.
- No cases reported in Douglas County.

Hepatitis C (Acute) Incidence

(2007-2009 Annual Average Cases per 100,000 Population)



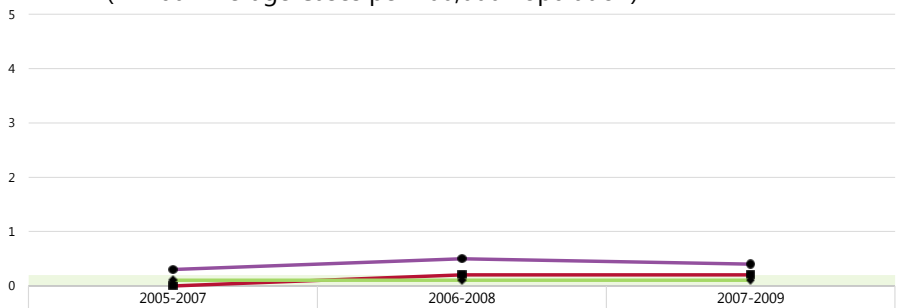
Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-26]

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Incidence has increased slightly from the zero case rate during the 2005-2007 reporting period in the Primary Service Area.

Hepatitis C (Acute) Incidence

(Annual Average Cases per 100,000 Population)



	2005-2007	2006-2008	2007-2009
Healthy People 2020	0.2	0.2	0.2
Primary Svc Area	0.0	0.2	0.2
California	0.1	0.1	0.1
Nevada	0.3	0.5	0.4

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-26]

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Influenza & Pneumonia Vaccination

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

– Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

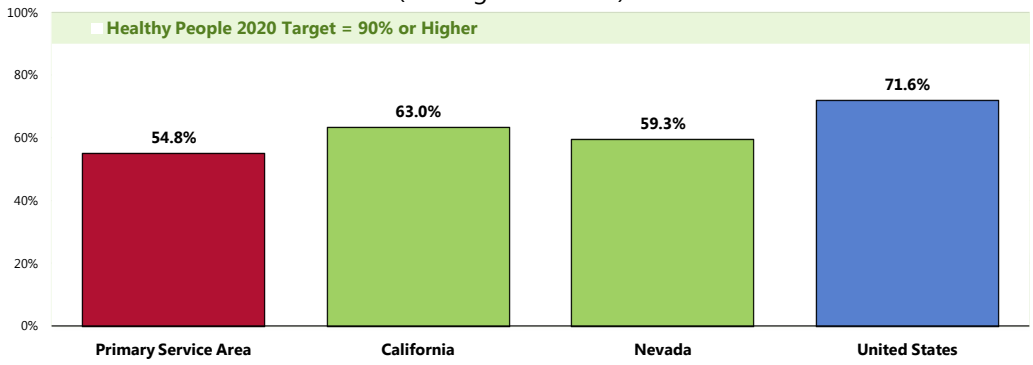
FluMist® is a vaccine that is sprayed into the nose to help protect against influenza; it is an alternative to traditional flu shots.

Among Primary Service Area seniors, 54.8% received a flu shot (or FluMist®) within the past year.

- Statistically comparable to the California and Nevada findings.
- Lower than the national finding.
- Fails to satisfy the Healthy People 2020 target (90% or higher).

Have Had a Flu Vaccination in the Past Year

(Among Adults 65+)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.7]

Notes:
- Reflects respondents 65 and older.
- Includes FluMist as a form of vaccination.

High-Risk Adults

"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 44.9% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

- Statistically similar to national findings.
- Fails to satisfy the Healthy People 2020 target (90% or higher).

Have Had a Flu Vaccination in the Past Year

(Among High-Risk Adults 18-64)

Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
- 2011 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 IID-12.6]

Notes:
- Reflects high-risk respondents age 18-64.
- Includes FluMist as a form of vaccination.

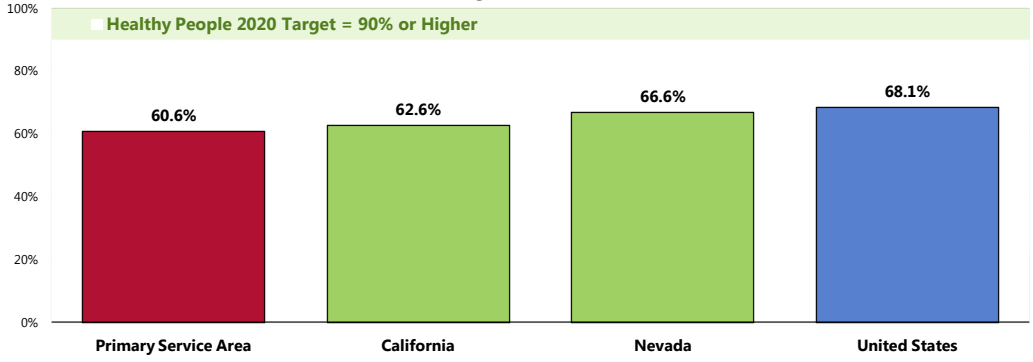
Pneumonia Vaccination

Among adults age 65 and older, 60.6% have received a pneumonia vaccination at some point in their lives.

- Similar to the California and Nevada figures.
- Similar to the national finding.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.

Have Ever Had a Pneumonia Vaccine

(Among Adults 65+)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-13.1]

Notes:
- Reflects respondents 65 and older.

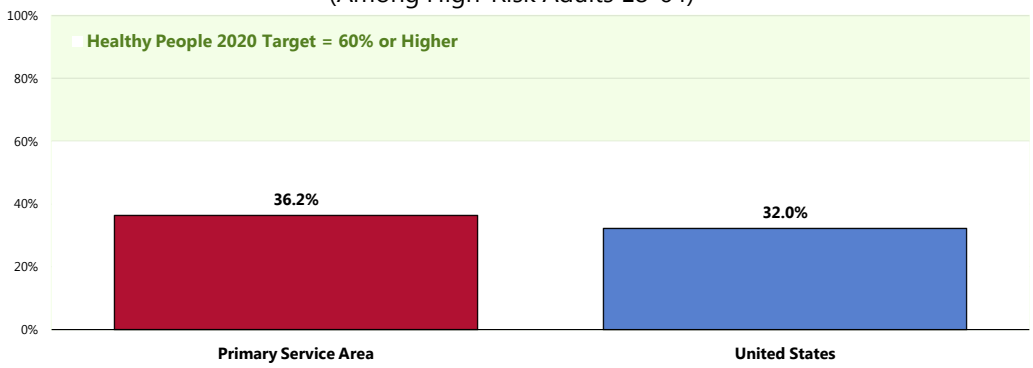
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 36.2% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (60% or higher).

Have Ever Had a Pneumonia Vaccine

(Among High-Risk Adults 18-64)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]
- 2011 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 IID-13.2]

Notes:
- Asked of all high-risk respondents under 65.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

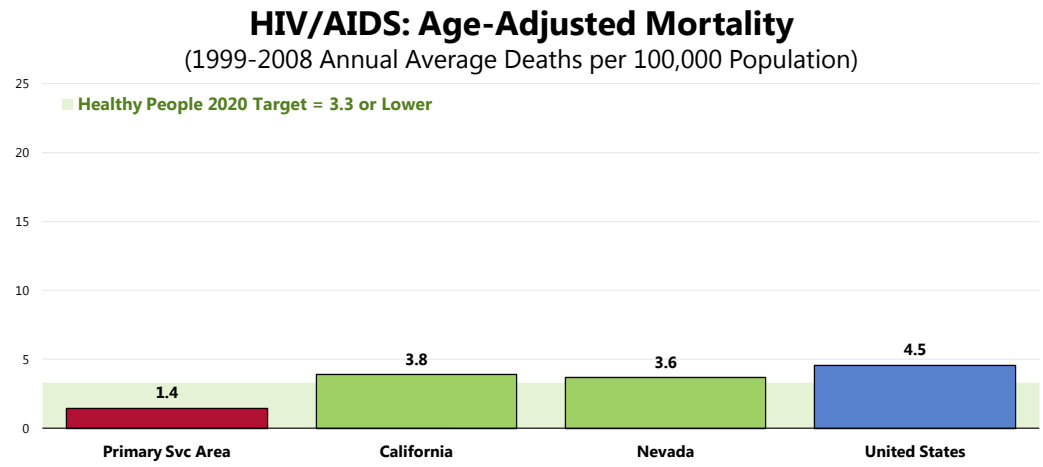
Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted HIV/AIDS Deaths

Between 1999 and 2008, there was an annual average age-adjusted HIV/AIDS mortality rate of 1.4 deaths per 100,000 population in the Primary Service Area.

- Lower than the rate found in either state.
- Much lower than the rate reported nationally.
- Satisfies the Healthy People 2020 target (3.3 or lower).



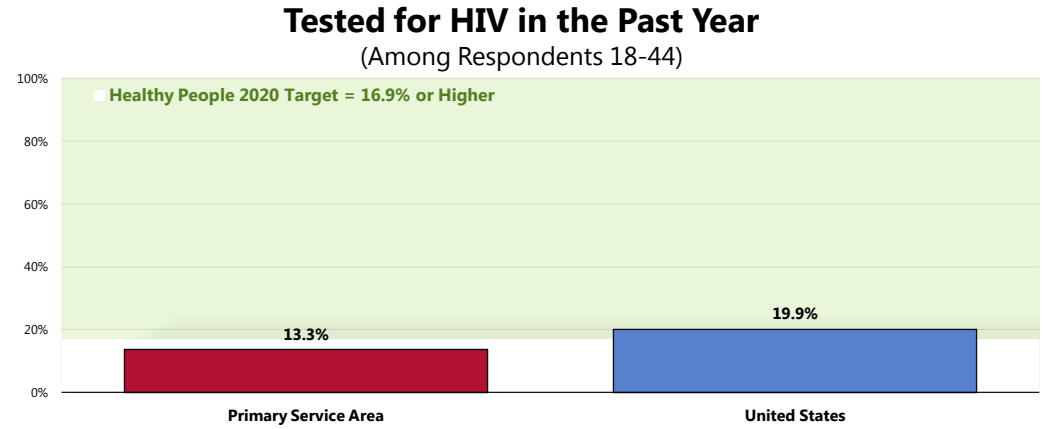
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

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 U.S. Standard Population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

HIV Testing

Among Primary Service Area adults age 18-44, 13.3% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Statistically comparable to the proportion found nationwide.
- Similar to the Healthy People 2020 target of 16.9% or higher.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 173]
- 2011 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 HIV-14.1]

Notes:
- Reflects respondents age 18 to 44.
- Note that the Healthy People 2020 objective is for ages 15-44.

Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs**. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities**. Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities**. Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications**. Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates the influence of these factors. Social, economic, and behavioral factors that affect the spread of STDs include:

- **Racial and ethnic disparities**. Certain racial and ethnic groups (mainly African American, Hispanic, and American Indian/Alaska Native populations) have high rates of STDs, compared with rates for whites.
- **Poverty and marginalization**. STDs disproportionately affect disenfranchised people and people in social networks where high-risk sexual behavior is common, and either access to care or health-seeking behavior is compromised.
- **Access to health care**. Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for whom access to or use of health services is most limited.
- **Substance abuse**. Many studies document the association of substance abuse with STDs. The introduction of new illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the epidemic spread of STDs.
- **Sexuality and secrecy**. Perhaps the most important social factors contributing to the spread of STDs in the United States are the stigma associated with STDs and the general discomfort of discussing intimate aspects of life, especially those related to sex. These social factors separate the United States from industrialized countries with low rates of STDs.
- **Sexual networks**. Sexual networks refer to groups of people who can be considered "linked" by sequential or concurrent sexual partners. A person may have only 1 sex partner, but if that partner is a member of a risky sexual network, then the person is at higher risk for STDs than a similar individual from a nonrisky network.

– Healthy People 2020 (www.healthypeople.gov)

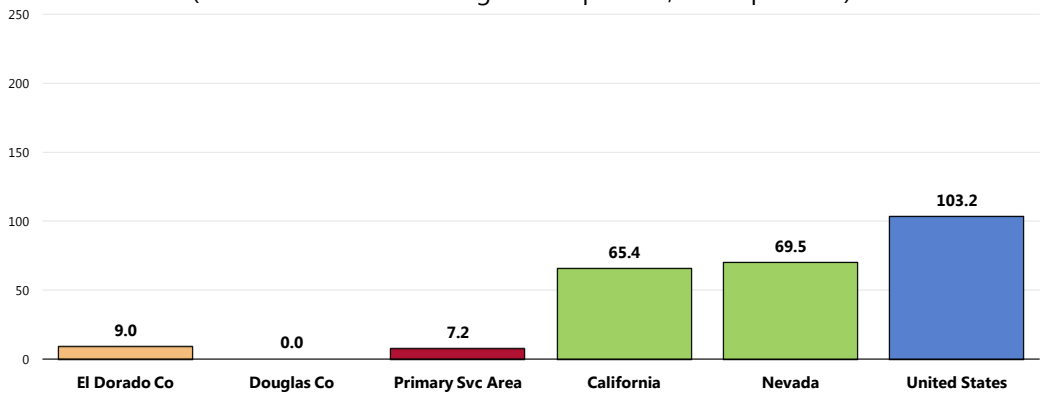
Gonorrhea

Between 2008 and 2010, the annual average gonorrhea incidence rate was 7.2 cases per 100,000 population in the Primary Service Area.

- A fraction of the California and Nevada incidence rates.
- Much lower than the national incidence rate.

Gonorrhea Incidence

(2008-2010 Annual Average Cases per 100,000 Population)



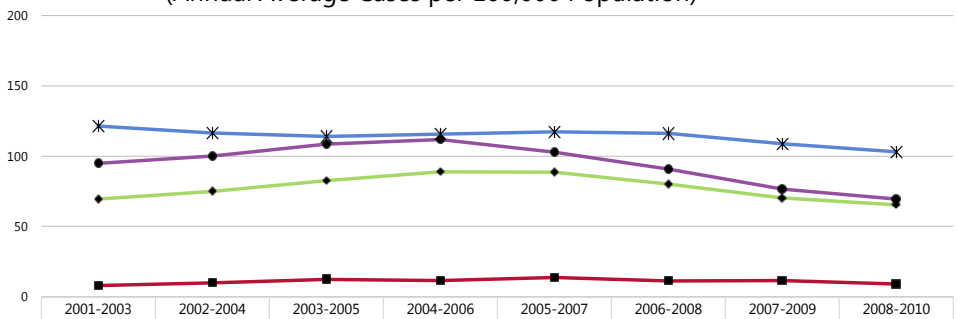
Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

- The El Dorado County gonorrhea rate has shown no clear trend over the past decade. In contrast, California, Nevada and US rates (still much higher) decreased.
- Note that Douglas County trend data are not available due to low counts.

Gonorrhea Incidence

(Annual Average Cases per 100,000 Population)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
El Dorado Co	7.7	9.7	12.1	11.5	13.6	11.2	11.5	9.0
California	69.3	74.9	82.5	88.9	88.6	80.0	70.1	65.4
Nevada	94.9	100.2	108.5	111.8	102.8	90.8	76.6	69.5
United States	121.3	116.5	114.1	115.6	117.4	116.1	108.9	103.2

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

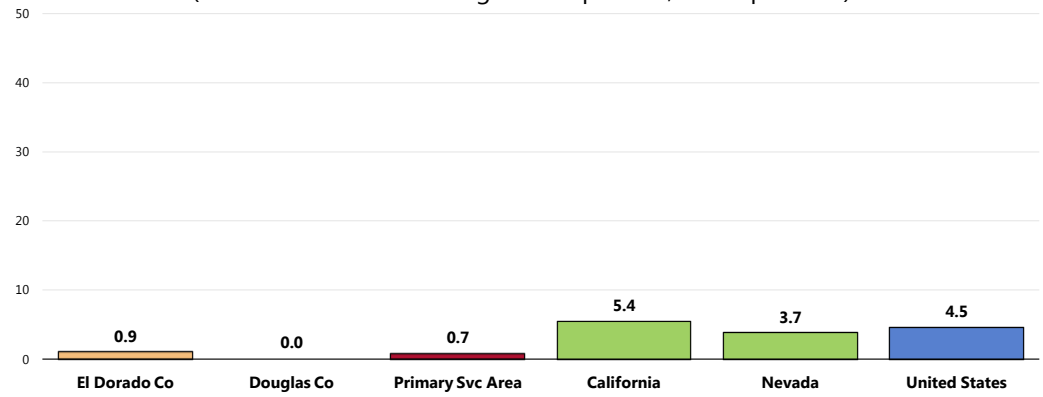
Syphilis

Between 2008 and 2010, the annual average primary/secondary syphilis incidence rate was 0.7 cases per 100,000 population in the Primary Service Area.

- Much lower than the California and Nevada incidence rates.
- Much lower than the national incidence rate.
- No cases reported in Douglas County.

Primary/Secondary Syphilis Incidence

(2008-2010 Annual Average Cases per 100,000 Population)



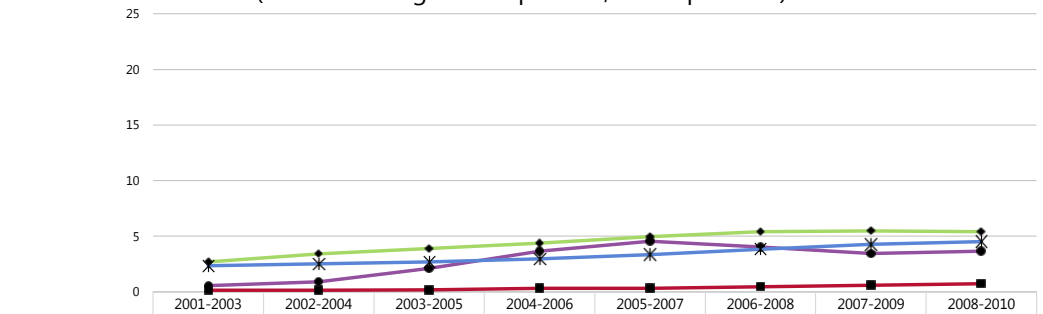
Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Syphilis incidence trended upward slightly in the Primary Service Area during the past decade. An upward trend is also reported for California, Nevada and the US overall.

Primary/Secondary Syphilis Incidence

(Annual Average Cases per 100,000 Population)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Primary Svc Area	0.2	0.2	0.2	0.3	0.3	0.5	0.6	0.7
California	2.7	3.4	3.9	4.4	5.0	5.4	5.5	5.4
Nevada	0.6	0.9	2.1	3.7	4.5	4.0	3.4	3.7
United States	2.3	2.5	2.7	3.0	3.3	3.8	4.3	4.5

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

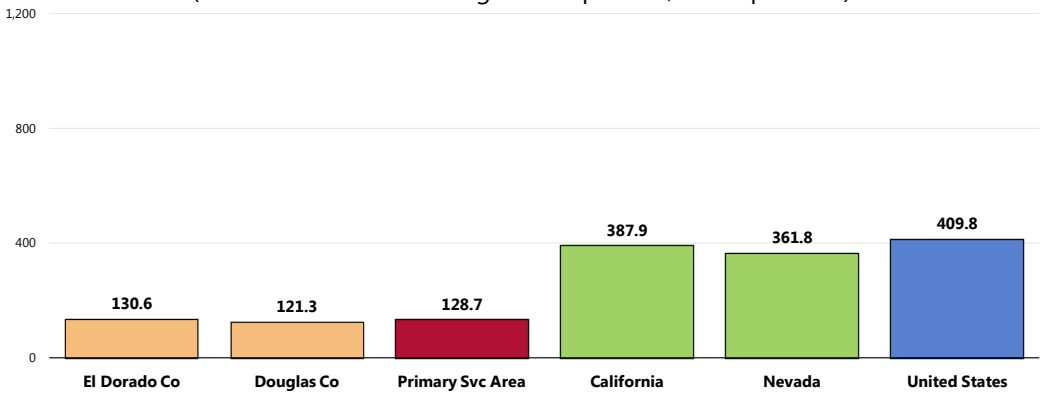
Chlamydia

Between 2008 and 2010, the annual average chlamydia incidence rate was 128.7 cases per 100,000 population in the Primary Service Area.

- More favorable than the California and Nevada rates.
- More favorable than the national incidence rate.
- No statistical difference by county.

Chlamydia Incidence

(2008-2010 Annual Average Cases per 100,000 Population)



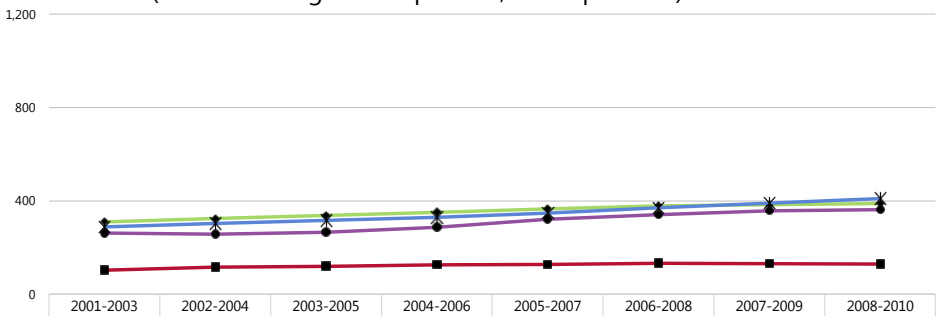
Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Chlamydia incidence increased over the past decade in the Primary Service Area, as did the state and national incidence rates.

Chlamydia Incidence

(Annual Average Cases per 100,000 Population)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Primary Svc Area	103.4	116.6	119.0	125.7	127.8	132.4	130.1	128.7
California	309.5	324.8	337.6	351.5	365.0	378.6	382.9	387.9
Nevada	262.0	257.2	264.8	286.6	320.8	340.9	357.9	361.8
United States	288.5	302.5	315.9	330.1	347.1	370.0	390.3	409.8

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

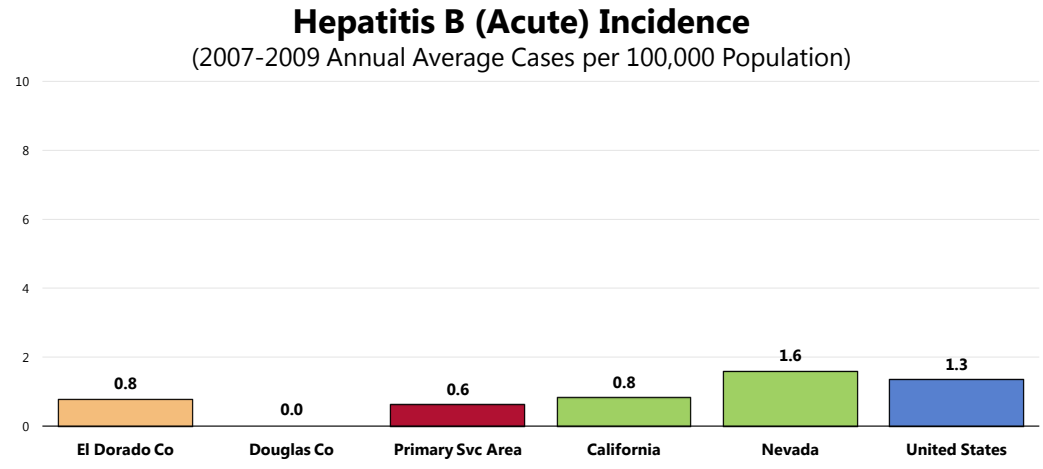
Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Acute Hepatitis B

Hepatitis B Incidence

Between 2007 and 2009, the Primary Service Area experienced a rate of less than one case of hepatitis B per 100,000 population.

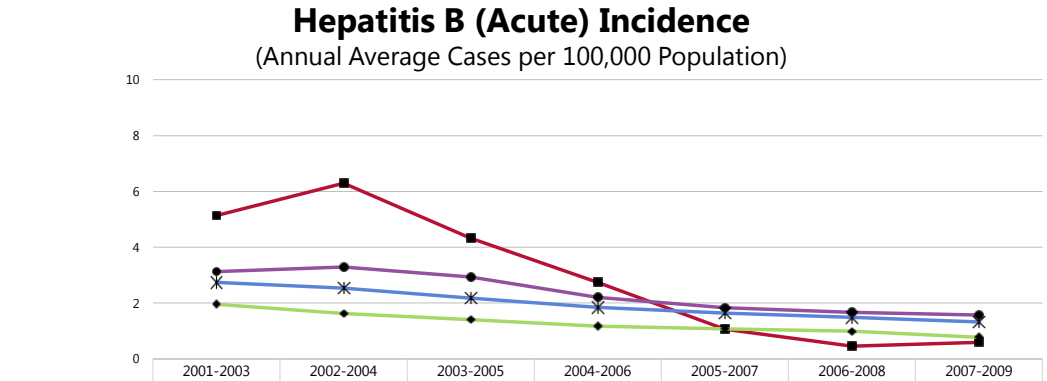
- More favorable than the statewide rates.
- More favorable than the national rate.
- No cases reported in Douglas County for this period.



Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Hepatitis B has decreased considerably in recent years, echoing the downward trend reported in California, Nevada and the US as a whole.



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Primary Svc Area	5.1	6.3	4.3	2.7	1.1	0.5	0.6
California	2.0	1.6	1.4	1.2	1.1	1.0	0.8
Nevada	3.1	3.3	2.9	2.2	1.8	1.7	1.6
United States	2.7	2.5	2.2	1.8	1.6	1.5	1.3

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

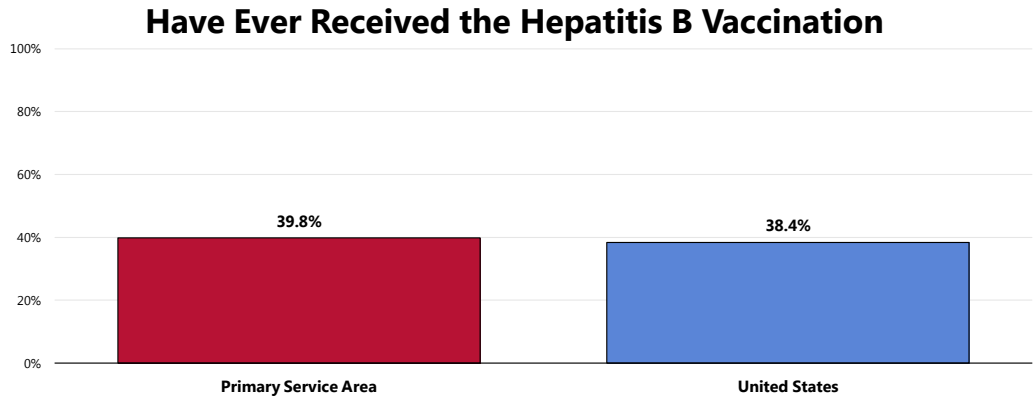
Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Hepatitis B Vaccination

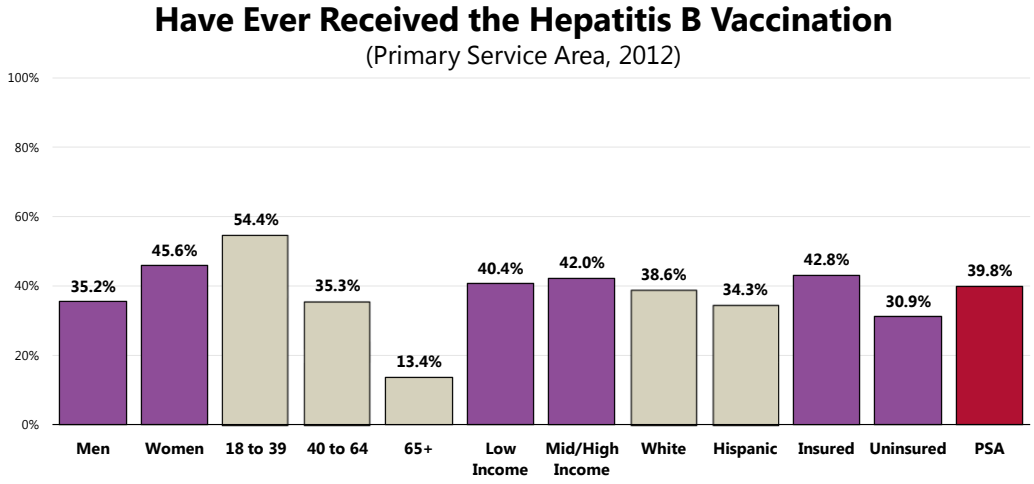
Based on survey data, 4 in 10 residents (39.8%) report having received the hepatitis B vaccine.

- Similar to what is reported nationwide.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 77]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Men and adults aged 40 and older are less likely to have received the hepatitis B vaccine.



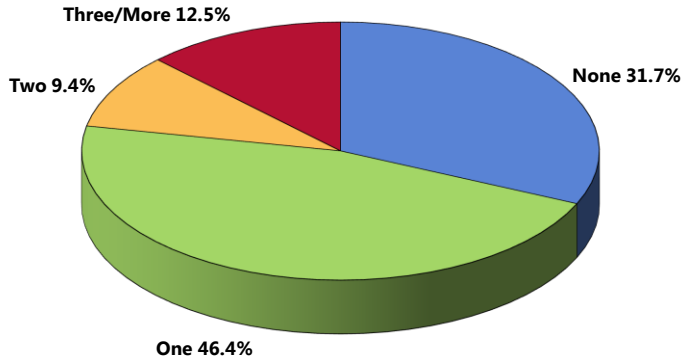
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 77]
Notes: • Asked of all respondents.
• Hispanics can be of any race (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Sexual Partners

Among unmarried Primary Service Area adults under 65, the vast majority cites having one (46.4%) or no (31.7%) sexual partners in the past 12 months.

Number of Sexual Partners in Past 12 Months

(Among Unmarried Adults 18-64; Primary Service Area, 2012)



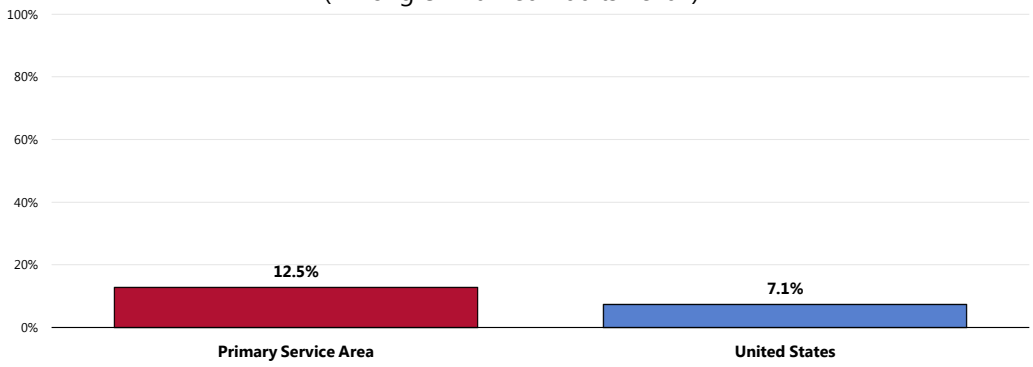
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 97]
Notes: • Asked of all unmarried respondents under the age of 65.

However, 12.5% report three or more sexual partners in the past year.

- Statistically comparable to that reported nationally.

Had Three or More Sexual Partners in the Past Year

(Among Unmarried Adults 18-64)

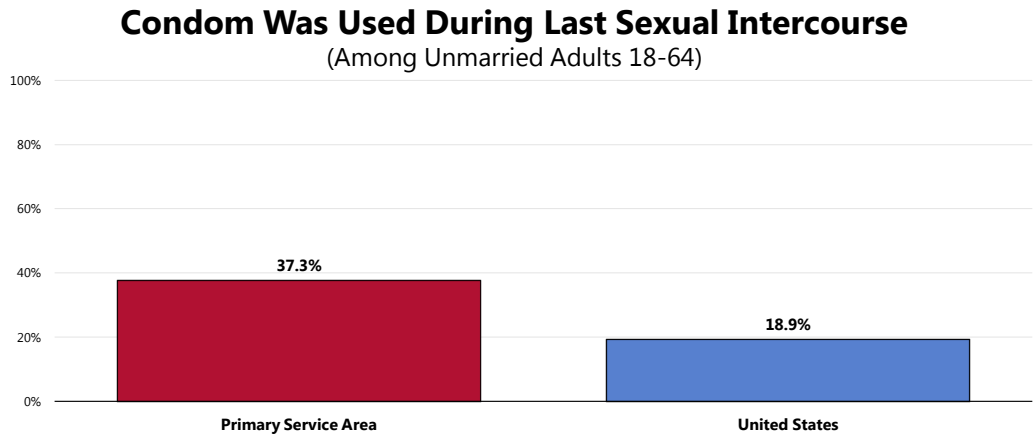


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 97]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all unmarried respondents under the age of 65.

Condom Use

Among Primary Service Area adults who are under age 65 and unmarried, 37.3% report that a condom was used during their last sexual intercourse.

- Twice the national prevalence.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 98]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all unmarried respondents under the age of 65.

BIRTHS

Prenatal Care

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

– Healthy People 2020 (www.healthypeople.gov)

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

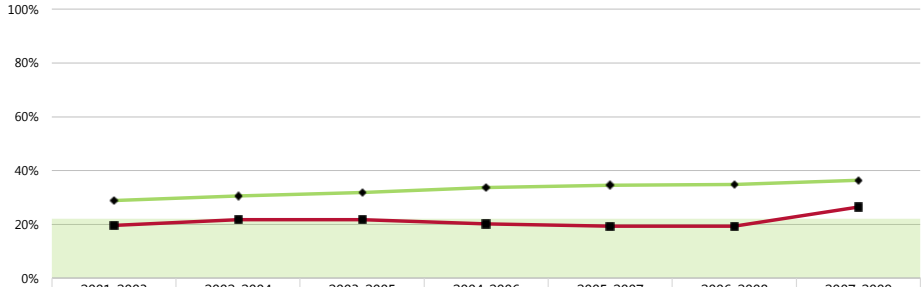
Note that different measures of lack of prenatal care were reported for the two counties/states.

DOUGLAS COUNTY: Between 2007 and 2009, 26.5% of all Douglas County births did not receive prenatal care in the first trimester of pregnancy.

- More favorable than the Nevada proportion.
- Fails to satisfy the Healthy People 2020 target (22.1% or lower).
- Receipt of prenatal care has worsened overall in Douglas County, echoing the trend reported in Nevada.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births; Douglas County)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%
Douglas Co	19.6%	21.8%	21.8%	20.2%	19.3%	19.3%	26.5%
Nevada	28.9%	30.6%	31.8%	33.7%	34.6%	34.8%	36.4%

Sources:
- Nevada Department of Health and Human Services, Nevada State Health Division
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

Note:
- Numbers are a percentage of all live births within each population.

EL DORADO COUNTY: Between 2007 and 2009, just 2.7% of all El Dorado County births received late (beginning in the third trimester) **or no prenatal care.**

- More favorable than the California proportion.
- The county percentage increased over the past decade; the same increasing trend is reported for California.

Mothers Receiving Late or No Prenatal Care

(Percentage of Live Births; El Dorado County)

	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
El Dorado Co	1.8%	1.8%	2.2%	2.3%	2.5%	2.4%	2.7%
California	2.7%	2.6%	2.6%	2.7%	2.9%	3.1%	3.2%

Sources: • California Department of Public Health
Note: • Numbers are a percentage of all live births within each population.
• Late prenatal care is defined as care begun in the third trimester of pregnancy.

Birth Outcomes & Risks

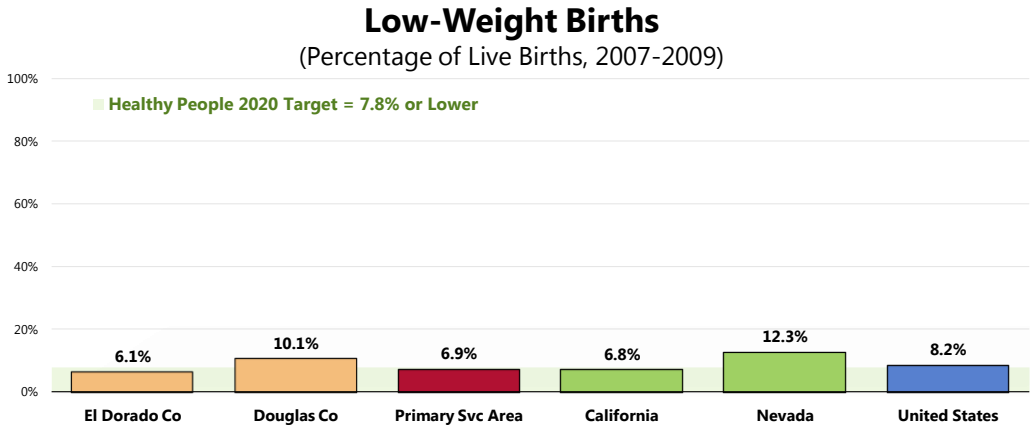
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

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

Low-Weight Births

A total of 6.9% of 2007-2009 Primary Service Area births were low-weight.

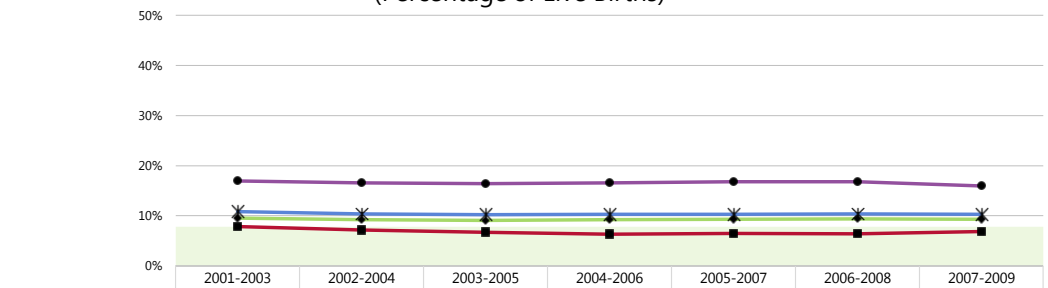
- Similar to the California proportion, more favorable than the Nevada proportion.
- Better than the national proportion.
- Satisfies the Healthy People 2020 target (7.8% or lower).
- Higher in Douglas County.



Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division
- Centers for Disease Control and Prevention, National Vital Statistics System.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.
- Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.
- Primary Service Area findings reflect El Dorado County (CA) and Douglas County (NV) births.

The proportion of low-weight births decreased slightly in the Primary Service Area in recent years; rates for California, Nevada and the US overall have been stable.



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Primary Svc Area	7.9%	7.2%	6.7%	6.3%	6.5%	6.4%	6.9%
California	9.5%	9.2%	9.1%	9.2%	9.3%	9.4%	9.3%
Nevada	17.0%	16.6%	16.4%	16.6%	16.8%	16.8%	16.0%
United States	10.8%	10.4%	10.2%	10.3%	10.3%	10.4%	10.3%

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division
- Centers for Disease Control and Prevention, National Vital Statistics System.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.
- Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.
- Primary Service Area findings reflect El Dorado County (CA) and Douglas County (NV) births.

Infant Mortality

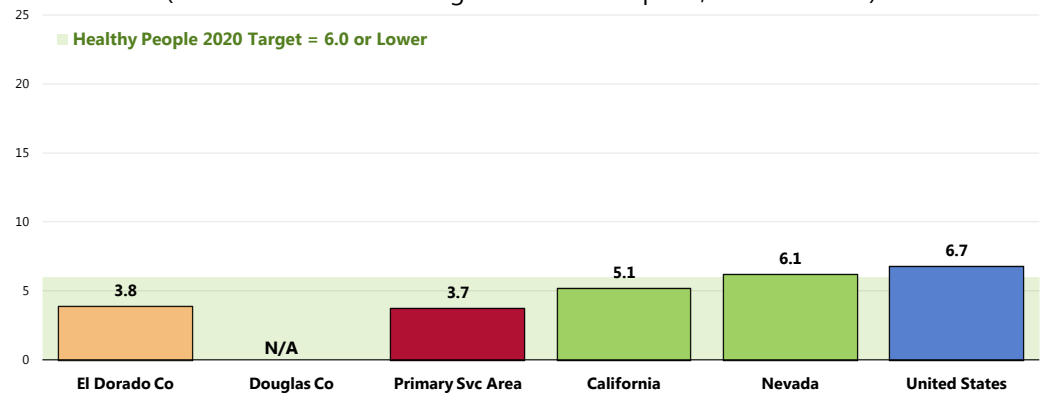
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2006 and 2008, there was an annual average of 3.7 infant deaths per 1,000 live births.

- More favorable than the California and Nevada rates.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births.
- Note that the individual Douglas County rate is not available due to low counts.

Infant Mortality Rate

(2006-2008 Annual Average Infant Deaths per 1,000 Live Births)



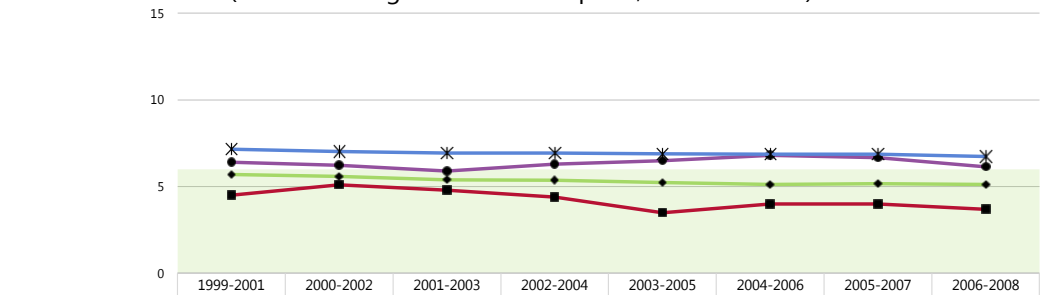
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The infant mortality rate has decreased overall in the Primary Service Area, echoing the trends reported for California, Nevada and the US overall.

Infant Mortality Rate

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



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0
Primary Svc Area	4.5	5.1	4.8	4.4	3.5	4.0	4.0	3.7
California	5.7	5.6	5.4	5.4	5.2	5.1	5.2	5.1
Nevada	6.4	6.2	5.9	6.3	6.5	6.8	6.7	6.1
United States	7.2	7.0	6.9	6.9	6.9	6.9	6.9	6.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

Family Planning

Family planning is one of the 10 great public health achievements of the 20th century. The availability of family planning services allows individuals to achieve desired birth spacing and family size and contributes to improved health outcomes for infants, children, and women. Family planning services include contraceptive and broader reproductive health services (patient education and counseling), breast and pelvic examinations, breast and cervical cancer screening, sexually transmitted infection (STI) and HIV prevention education/counseling/testing/referral, and pregnancy diagnosis and counseling. For many women, a family planning clinic is their entry point into the healthcare system and is considered to be their usual source of care. This is especially true for women with incomes below the poverty level, women who are uninsured, Hispanic women, and Black women.

Unintended pregnancies (those reported by women as being mistimed or unwanted) are associated with many negative health and economic outcomes. In 2001, almost one-half of all pregnancies in the US were unintended. For women, negative outcomes associated with unintended pregnancy include:

- Delays in initiating prenatal care
- Reduced likelihood of breastfeeding
- Poor maternal mental health
- Lower mother-child relationship quality
- Increased risk of physical violence during pregnancy

Children born as a result of an unintended pregnancy are more likely to experience poor mental and physical health during childhood and poor educational and behavioral outcomes.

– Healthy People 2020 (www.healthypeople.gov)

Births to Teen Mothers

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

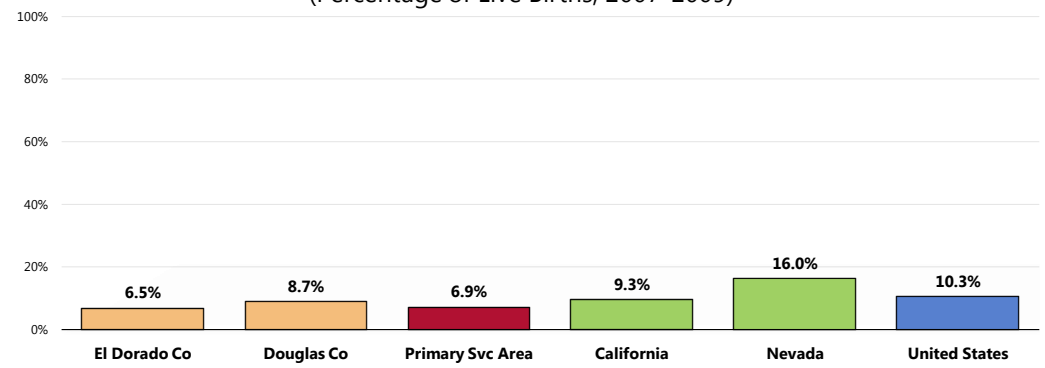
– Healthy People 2020 (www.healthypeople.gov)

A total of 6.9% of 2007-2009 Primary Service Area births were to teenage mothers.

- Below the California and Nevada figures.
- Below the national proportion.
- Higher in Douglas County.

Births to Teen Mothers

(Percentage of Live Births, 2007-2009)



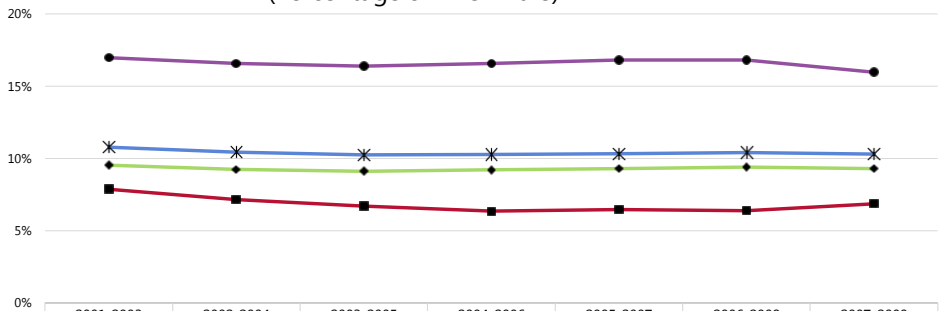
Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division
- Centers for Disease Control and Prevention, National Vital Statistics System.

Note:
- Numbers are a percentage of all live births within each population.
- Primary Service Area findings reflect El Dorado County (CA) and Douglas County (NV) births.

This percentage decreased overall in the Primary Service Area over the past decade; the same can be said across Nevada, while California and US rates were stable.

Births to Teen Mothers

(Percentage of Live Births)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Primary Svc Area	7.9%	7.2%	6.7%	6.3%	6.5%	6.4%	6.9%
California	9.5%	9.2%	9.1%	9.2%	9.3%	9.4%	9.3%
Nevada	17.0%	16.6%	16.4%	16.6%	16.8%	16.8%	16.0%
United States	10.8%	10.4%	10.2%	10.3%	10.3%	10.4%	10.3%

Sources:
- California Department of Public Health.
- Nevada Department of Health and Human Services, Nevada State Health Division
- Centers for Disease Control and Prevention, National Vital Statistics System.

Note:
- Numbers are a percentage of all live births within each population.
- Primary Service Area findings reflect El Dorado County (CA) and Douglas County (NV) births.

MODIFIABLE HEALTH RISKS

Actual Causes Of Death

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were tobacco (an estimated 435,000 deaths), diet and activity patterns (400,000), alcohol (85,000), microbial agents (75,000), toxic agents (55,000), motor vehicles (43,000), firearms (29,000), sexual behavior (20,000), and illicit use of drugs (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

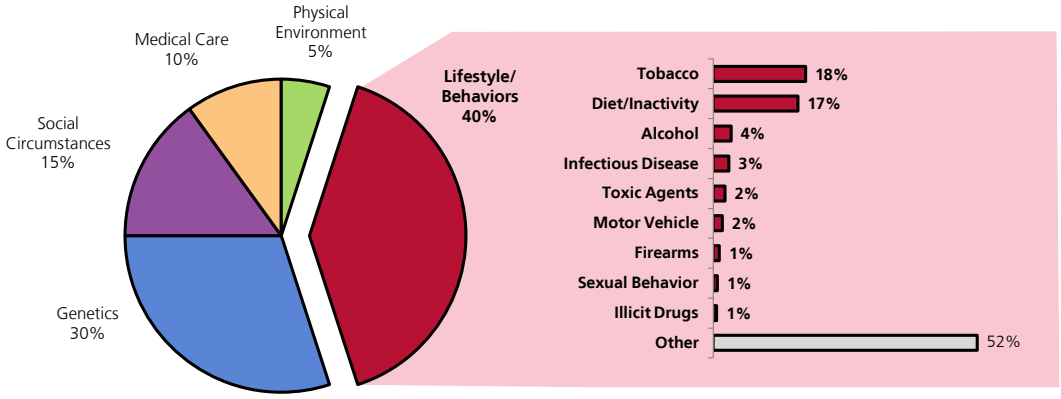
– Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic lung disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88–1232.

Factors Contributing to Premature Deaths in the United States



Sources: "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs, Vol. 21, No. 2, March/April 2002. "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH) JAMA, 291(2000):1238-1245.

Nutrition

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

– Healthy People 2020 (www.healthypeople.gov)

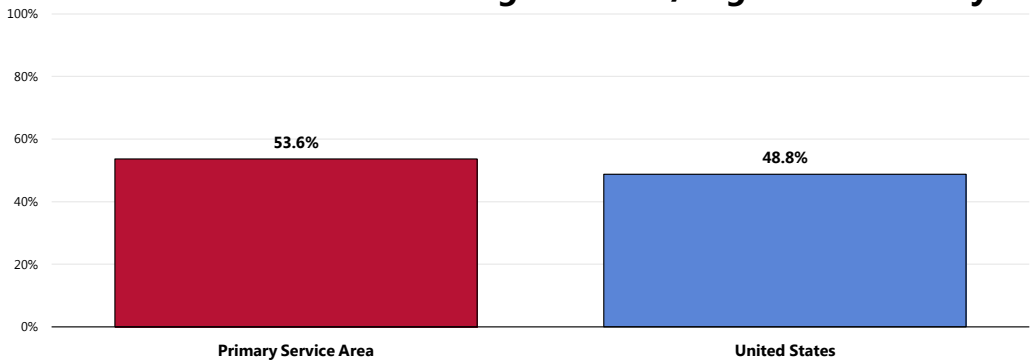
Daily Recommendation of Fruits/Vegetables

A total of 53.6% of Primary Service Area adults report eating five or more servings of fruits and/or vegetables per day.

- Similar to national findings.

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

Consume Five or More Servings of Fruits/Vegetables Per Day



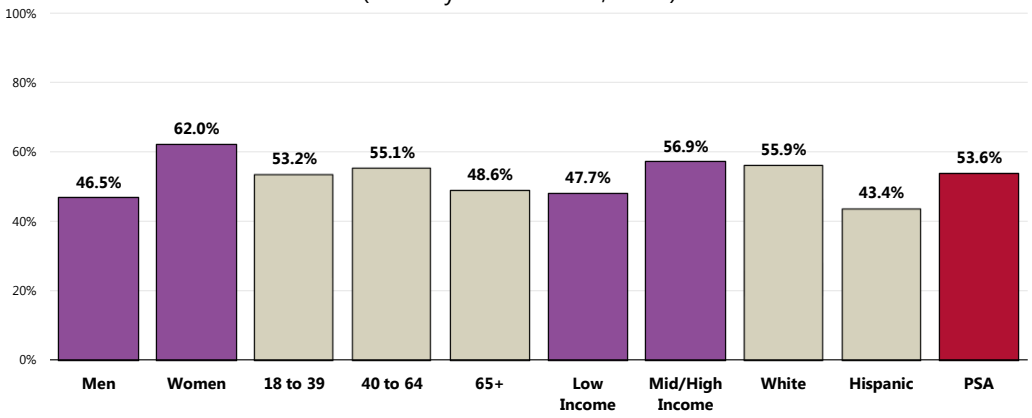
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 175]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Area men are less likely to get the recommended servings of daily fruits/ vegetables.

Consume Five or More Servings of Fruits/Vegetables Per Day

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 175]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- For this issue, respondents were asked to recall their food intake on the previous day.

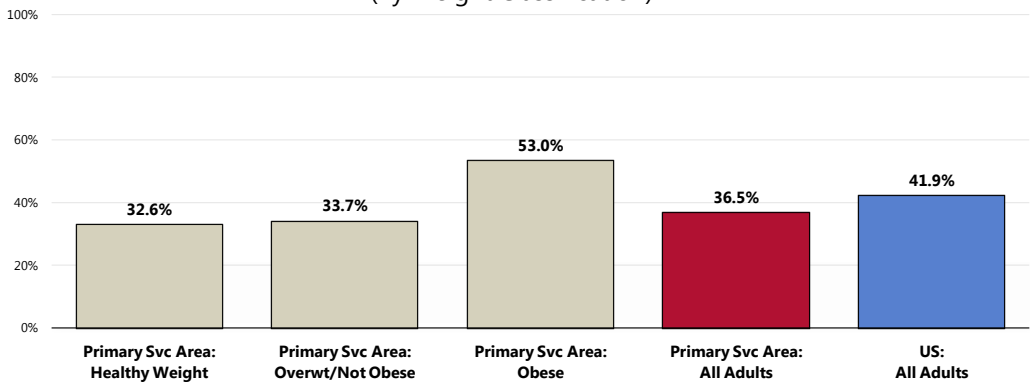
Health Advice About Diet & Nutrition

A total of 36.5% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Comparable to national findings.
- Note: Among obese respondents, 53.0% report receiving diet/nutrition advice (meaning that nearly one-half did not).

Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Related Focus Group Findings: Nutrition and Obesity

Many focus group participants discussed nutrition and physical activity. The main findings include:

- Poor eating habits
- Cooking and nutrition education
- Hunger

Many South Lake Tahoe families have **poor eating habits**. Many times family members consume fast food because it is cheap and easy. Some parents work multiple jobs or shift work and cannot eat together as a family. Kids are left to cook their own meals. Participants express concern for "motel families," those families that rent rooms by the week in local motels. These people do not have access to a kitchen, as one participant explains:

> *"We have a lot of hotels that rent out weekly, so we have a lot of families that have no cooking options – if you're living in a hotel from week to week – where is their food? School, fast-foods – those are the realities." — Healthcare Professional*

Focus group participants feel residents lack nutrition and obesity prevention **knowledge**. Parents do not recognize that their child's overweight, or even obese; weight and overeating is a cultural norm. Advertising also sends parents mixed messages. A participant describes:

> *"I was doing a nutrition class with them, and one of the young moms said, 'But they tell me on TV Gatorade's good for you,' and so again that is a huge impact: the media." — Healthcare Professional*

Members think **nutrition education** should target the entire family. Residents do not know how to cook healthy meals, so they need to learn basic cooking skills (e.g. how to properly store/freeze foods and cook nutritious meals). The WIC program produced a very successful bilingual cookbook, so additional products like that would benefit residents. Focus group participants would also like to have classes which demonstrate to families how to shop for healthy options on a budget. A participant explains:

> *"I observed a lot of poor grocery shopping choices. I think that education in how your dollar will go farther will be really beneficial in this community. Buying the little set that has the tiny little cheese and four crackers, you're paying $1.25 for four crackers and a little thing of cheese. You want to say, 'Oh, my gosh. You could buy a block of cheese and a huge box of crackers,' but those are also generational. If you haven't been taught ..." — Social Service Provider*

Participants express concern about the level of **malnutrition and hunger** in the basin. Participants worry for the entire community, but especially senior citizens and children. The senior center only provides one meal a day and the Meals-On-Wheels program no longer services South Lake Tahoe. Because of the high unemployment rate some families cannot afford to purchase food for their families, or they have to choose between prescriptions and food. Many school-aged children receive free or reduced-cost lunches, but some of these children may eat only one meal a day during the school week.

> *"Almost 70 percent of our kids qualify for a free or reduced lunch. They come to school without having breakfast, so often their only nutritious meal might be that lunch that they're getting through the school." — Social Service Provider*

Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity:

- Gender (boys)
- Belief in ability to be active (self-efficacy)
- Parental support

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity:

- Parental education
- Gender (boys)
- Personal goals
- Physical education/school sports
- Belief in ability to be active (self-efficacy)
- Support of friends and family

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

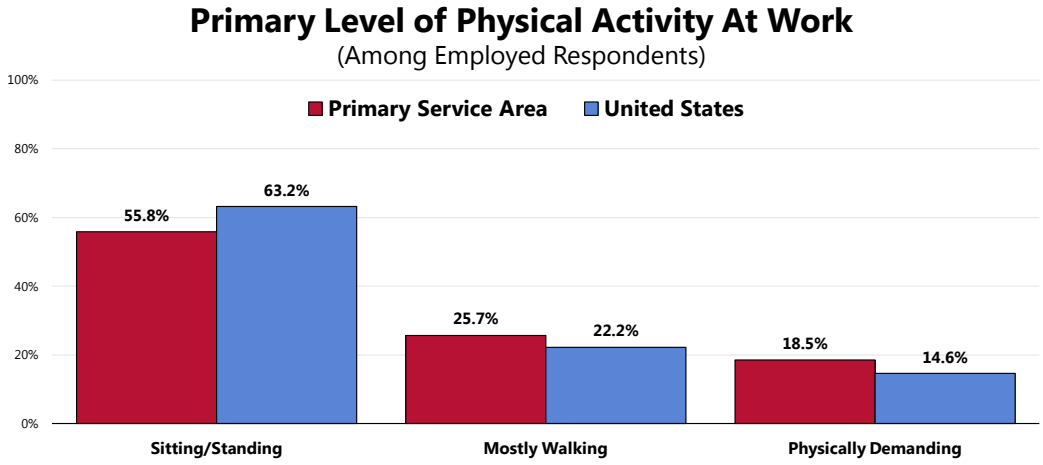
People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

– Healthy People 2020 (www.healthypeople.gov)

Level of Activity at Work

A majority of employed respondents reports low levels of physical activity at work.

- Just over 1 in 2 employed respondents (55.8%) report that their job entails mostly sitting or standing, statistically similar to the US figure.
- 25.7% report that their job entails mostly walking (similar to the national figure).
- 18.5% report that their work is physically demanding (similar to that reported nationally).



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

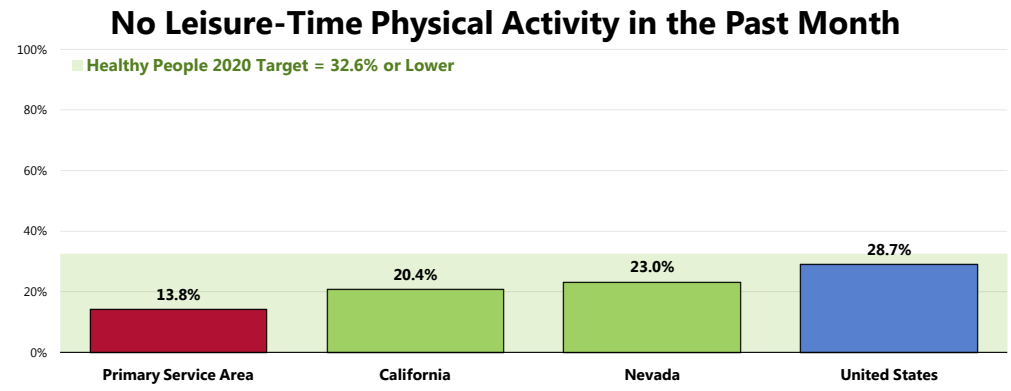
Notes:
- Asked of those respondents who are employed for wages.

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

A total of 13.8% of Primary Service Area adults report no leisure-time physical activity in the past month.

- More favorable than both statewide figures.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).

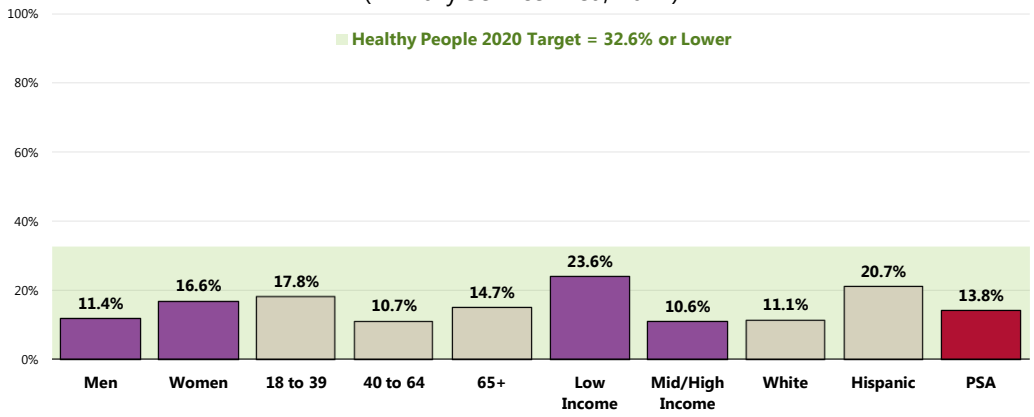


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 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 PA-1]

Notes:
- Asked of all respondents.

Lack of leisure-time physical activity in the area is more prevalent among lower-income residents.

No Leisure-Time Physical Activity in the Past Month
(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Levels

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

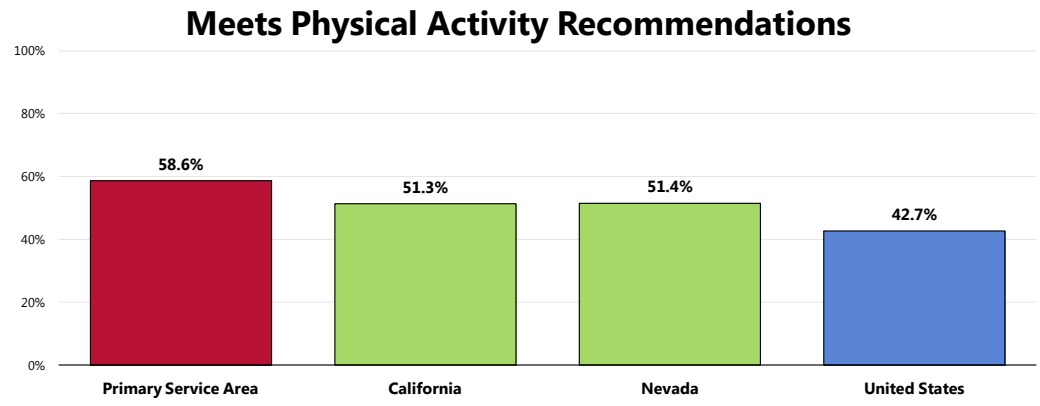
For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

– 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

Recommended Levels of Physical Activity

A total of 58.6% of Primary Service Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- More favorable than statewide findings.
- More favorable than national findings.

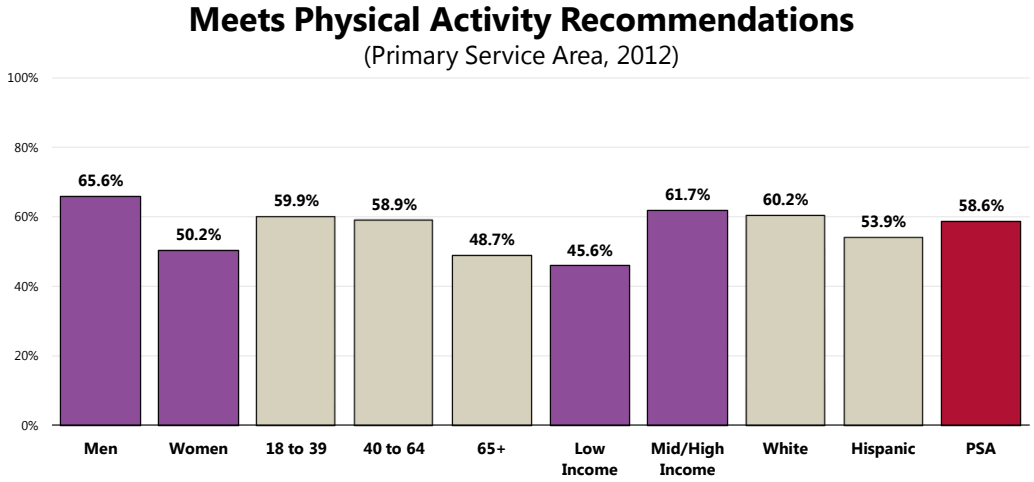


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 California and Nevada data.

Notes:
- Asked of all respondents.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Those less likely to meet physical activity requirements include:

- Women.
- Lower-income residents.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Moderate & Vigorous Physical Activity

In the past month:

A total of 38.0% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

- More favorable than the national level.

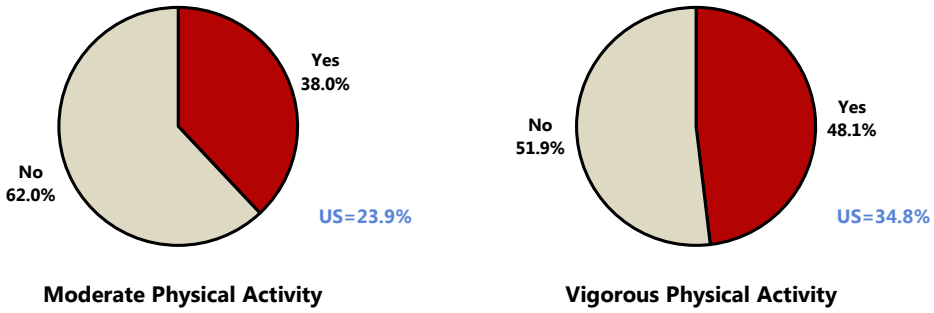
The individual indicators of moderate and vigorous physical activity are shown here.

A total of 48.1% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- More favorable than both statewide figures (not shown).
- More favorable than the nationwide figure.

Moderate & Vigorous Physical Activity

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 180-181]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Moderate Physical Activity: Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times per week for at least 30 minutes per time.
- Vigorous Physical Activity: Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for at least 20 minutes per time.

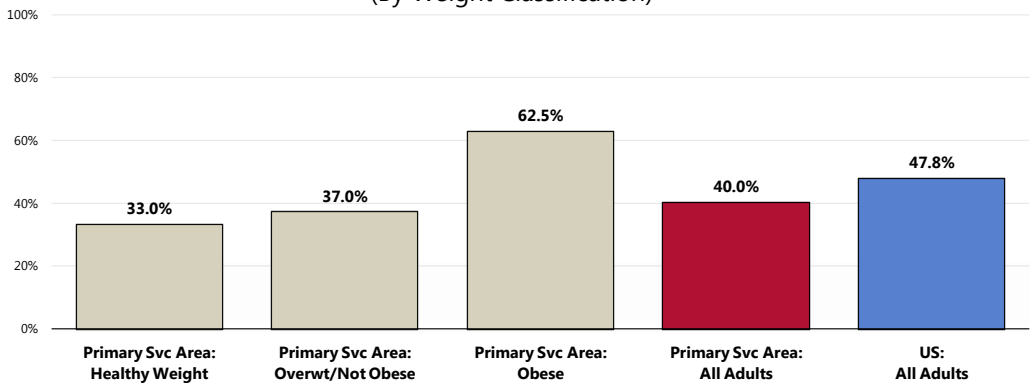
Health Advice About Physical Activity & Exercise

A total of 40.0% of Primary Service Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Less favorable than the national average.
- Note: 62.5% of obese Primary Service Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Access to Indoor Fitness Equipment

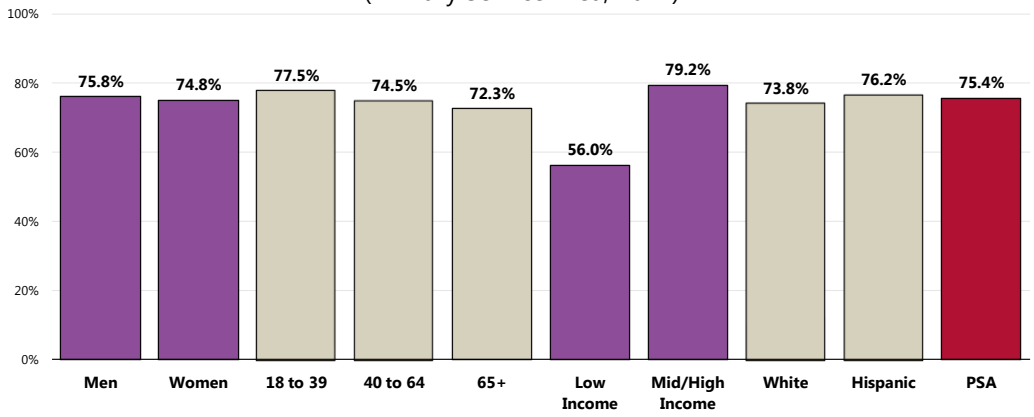
"Do you have access to any indoor exercise equipment that you can use when you wish, either at home, at work, at a fitness club, or somewhere else?"

A total of three in four Primary Service Area adults (75.4%) have access to indoor exercise equipment which they can use whenever they wish.

- As may be expected, lower-income residents are least likely to have access to indoor fitness equipment.

Have Access to Indoor Exercise Equipment

(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 107]
Notes: • Asked of all respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
• Access might include fitness equipment at home, work, a fitness club or elsewhere.

Interest in a Wellness Center

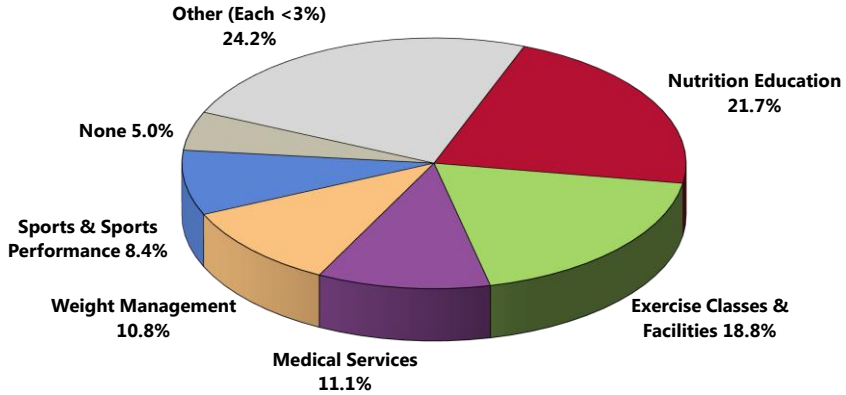
"If a wellness center, designed to help people live a healthier life, were to open in the South Lake Tahoe area, what type of health and wellness service or program would you most like to see offered?"

When asked what type of health and wellness service/program they would like to see if a wellness center were to open in the area, most identified services relating to nutrition, physical activity and weight management.

- A total of 11.1% identified medical services (e.g., cardiology, pulmonology, women's services, indigent care, physical therapy, lab tests, dental services etc.)
- Note that the distribution below excludes roughly one-third of respondents who responded "don't know."

Type of Health/Wellness Service or Program Desired

(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 108]
Notes: • Asked of all respondents. Excludes those who were uncertain or unwilling to provide a response.

Children's Screen Time

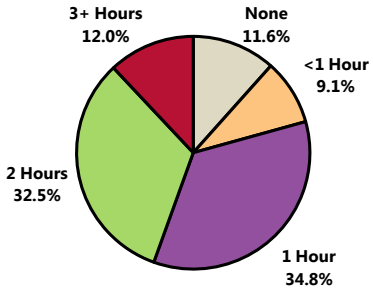
Television Watching & Other Screen Time

Among children aged 5 through 17, 12.0% are reported to watch three or more hours of television per day; 12.1% are reported to spend three or more hours on other types of screen time for entertainment (video games, Internet, etc.).

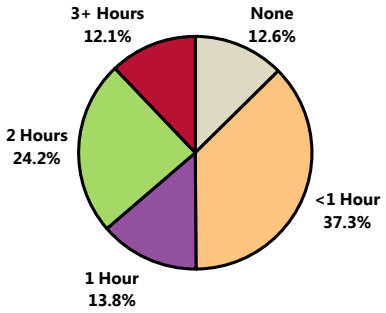
- Comparable to the percentages reported nationally.

Children's Screen Time

(Among Parents of Children Ages 5-17; Primary Service Area, 2012)



Hours per Day of Television



Hours per Day of Other Screen Time
(i.e., video games, computer/Internet entertainment)

Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 145-146, 182-183]
Notes: • Asked of respondents with a child aged 5 to 17 in the household.

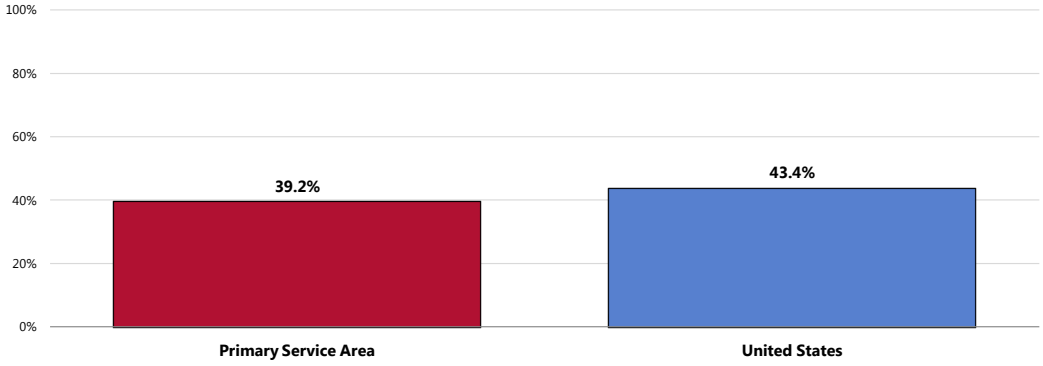
Total Screen Time

When combined, 39.2% of Total Area children aged 5 to 17 spend three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

- Comparable to the national figure.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]

(Among Parents of Children 5-17)



Sources: • 2012 Professional Research Consultants, Inc. PRC Community Health Survey. [Item 184]
Notes: • Asked of all respondents with children 5-17 at home.
• For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."
• "Three or more hours" includes reported screen time of 180 minutes or more per day.

Related Focus Group Findings: Physical Activity

Many focus group participants discussed physical activity in the community. The main discussions centered on:

- Safety
- Winter weather

While opportunities for residents to exercise outdoors exist, some participants have concerns about **safety**. Many neighborhoods lack sidewalks and some do not have proper street lighting. Participants would like to see more bike paths to facilitate safe outdoor activity and also police enforcement of the helmet laws.

Participants feel that **winter weather** can limit residents' ability to exercise outside and although winter sports are prevalent, the cost can be prohibitive for some residents. One participant explains:

> *"I mean, in the summer, yes, you can have all the activity you want, but the winter, not everybody can afford the winter activities. So we go back to being sedentary a good six months for some of our residents." — Healthcare Professional*

Participants also worry that many families do not participate in regular outdoor activities and that youth spend much time indoors. However, the school districts work hard to provide a variety of physical activity options:

> *"You know, within the schools, we have a swim program, and we have a ski program for the entire grade level. There's lots of hiking, the Rim Trail Association. There are athletic events that go on, but in that same sense, you go to certain pockets of our schools, and some of those kids have never gone hiking until their classes went on a field trip." — Healthcare Professional*

Weight Status

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

– Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

Healthy Weight

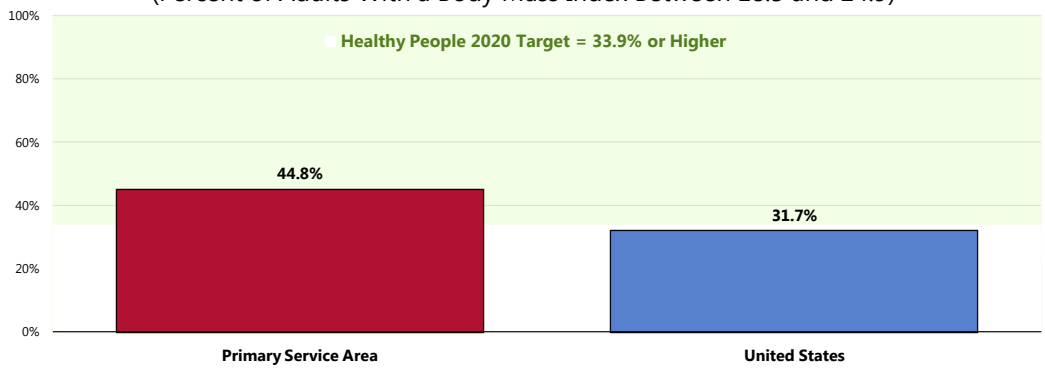
"Healthy weight "means neither underweight, nor overweight (BMI = 18.5-24.9).

Based on self-reported heights and weights, 44.8% of Primary Service Area adults are at a healthy weight.

- More favorable than national findings.
- Satisfies the Healthy People 2020 target (33.9% or higher).

Healthy Weight

(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-8]
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

Overweight Status

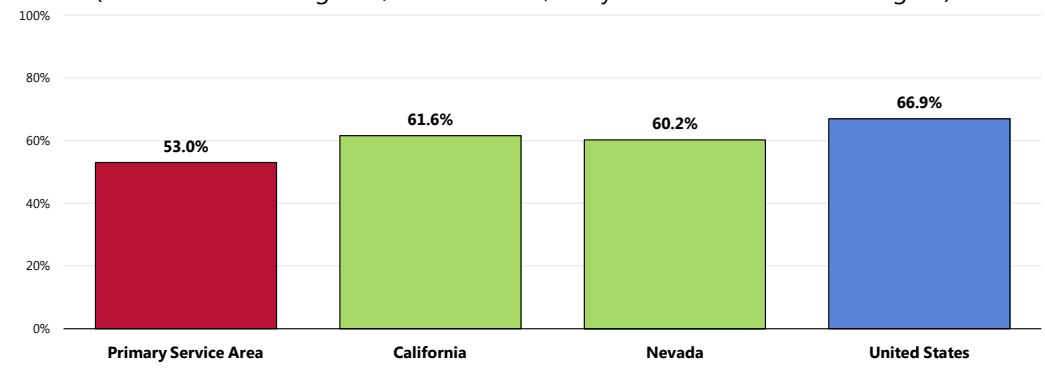
Here, "overweight" includes those respondents with a BMI value ≥25.

More than one in two Primary Service Area adults (53.0%) is overweight.

- Much lower than the California and Nevada proportions for overweight.
- Much lower than the US overweight prevalence.

Prevalence of Total Overweight

(Percent of Overweight or/Obese Adults; Body Mass Index of 25.0 or Higher)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

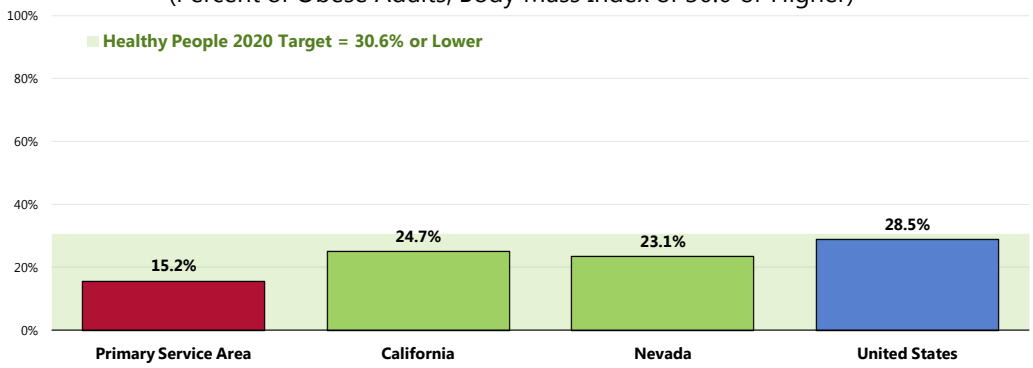
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

Further, 15.2% of Primary Service Area adults are obese.

- More favorable than California and Nevada findings.
- More favorable than US findings.
- Satisfies the Healthy People 2020 target (30.6% or lower).

Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
- 2011 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 NWS-9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.

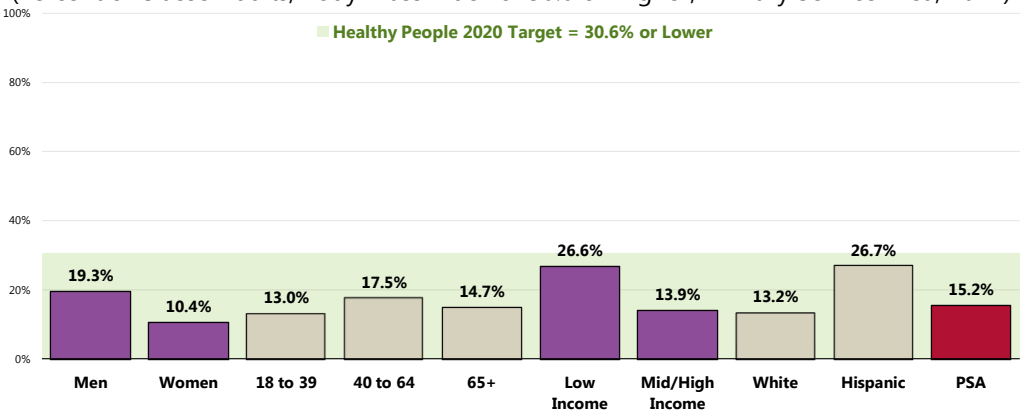
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Obesity is notably more prevalent among:

- Men.
- Respondents with lower incomes.
- Hispanics.

Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher; Primary Service Area, 2012)



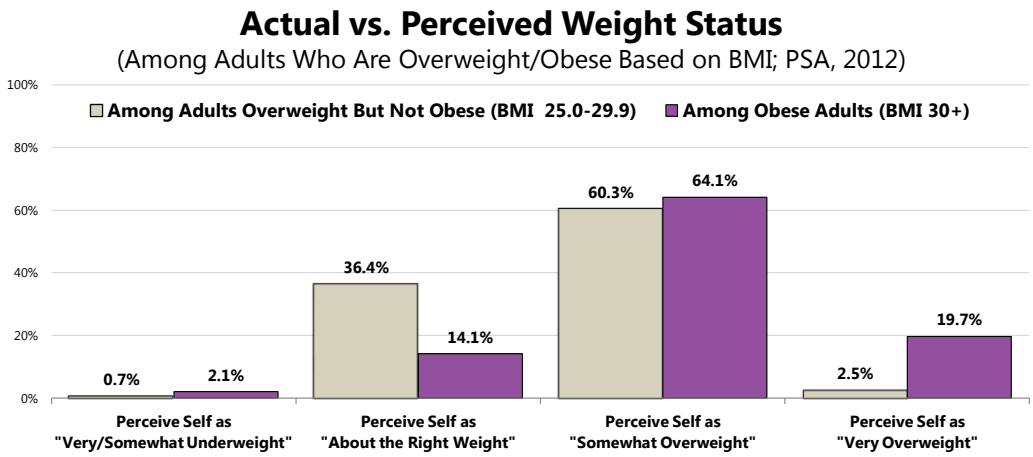
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Actual vs. Perceived Body Weight

A total of 14.1% of obese adults and 36.4% of overweight (but not obese) adults feel that their current weight is "about right."

- 60.3% of overweight (but not obese) adults see themselves as "somewhat overweight."
- 19.7% of obese adults see themselves as "very overweight."



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 113]

Notes:
- BMI is based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Relationship of Overweight With Other Health Issues

The correlation between overweight and various health issues cannot be disputed.

Obese adults are more likely to report a number of adverse health conditions.

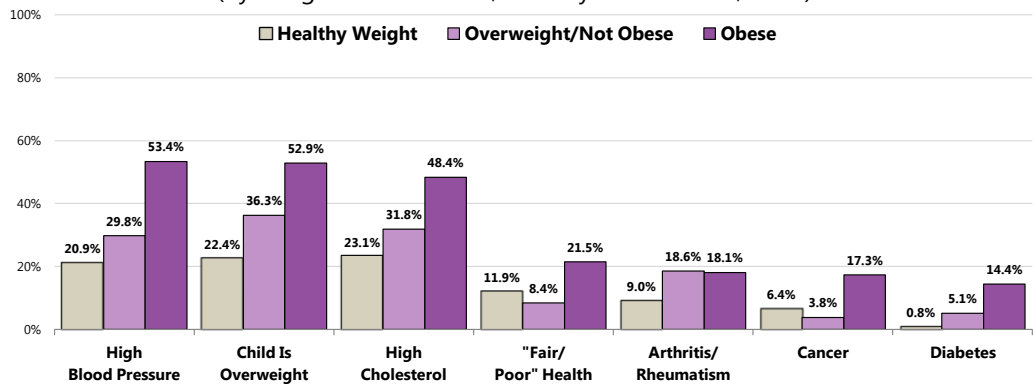
Among these are:

- Hypertension (high blood pressure).
- High cholesterol.
- "Fair" or "poor" physical health.
- Arthritis/rheumatism.
- Cancer.
- Diabetes.

Overweight/obese residents are also more likely to have overweight children.

Relationship of Overweight With Other Health Issues

(By Weight Classification; Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 28, 30, 44, 149, 150, 190]
Notes: • Based on reported heights and weights, asked of all respondents.

Weight Management

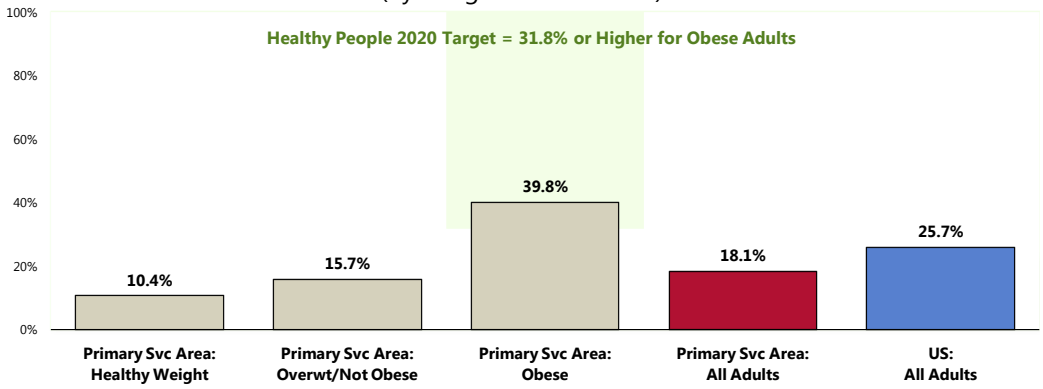
Health Advice

A total of 18.1% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Lower than the national findings.
- Note that 39.8% of obese adults have been given advice about their weight by a health professional in the past year (while 6 in 10 have not).
  - This is statistically similar to the US prevalence as well as the Healthy People 2020 target of 31.8% or higher.

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 112, 188-189]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Weight Control

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

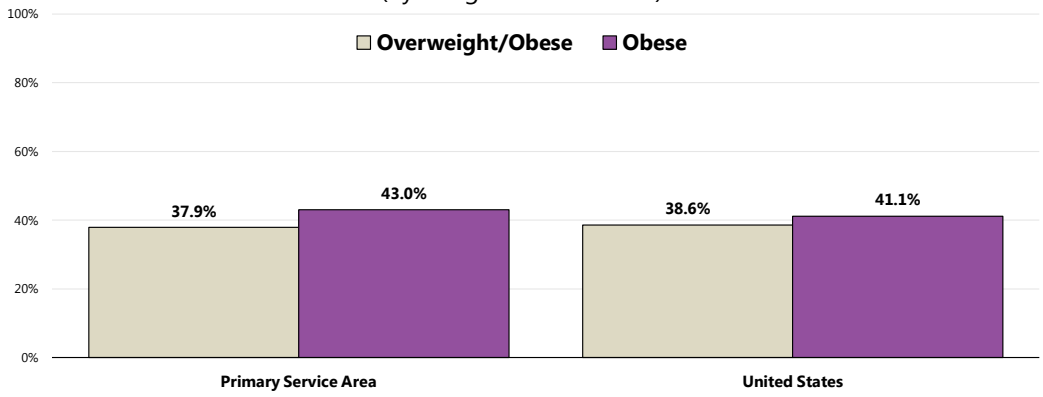
All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

– Healthy People 2020 (www.healthypeople.gov)

A total of 37.9% of Primary Service Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

- Similar to national findings.
- Note: 43.0% of <u>obese</u> Primary Service Area adults report that they are trying to lose weight through a combination of diet and exercise, similar to what is found nationally.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity
(By Weight Classification)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 187]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.

Childhood Overweight & Obesity

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

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

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

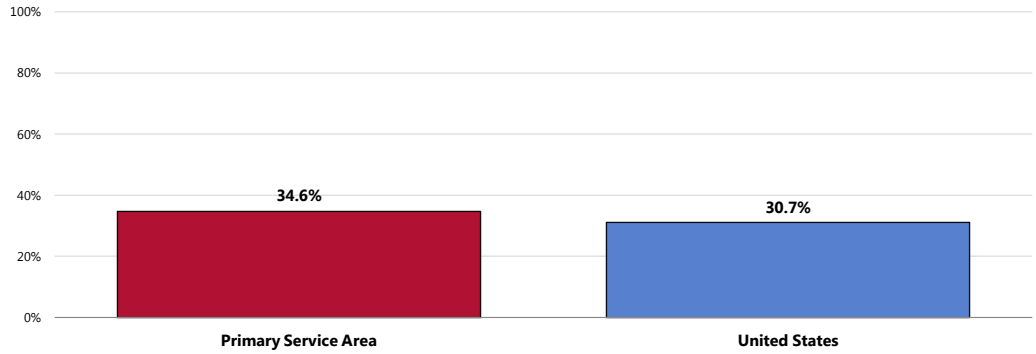
– Centers for Disease Control and Prevention.

Based on the heights/weights reported by surveyed parents, more than one in three (34.6%) Primary Service Area children age 5 to 17 is overweight or obese (≥85th percentile).

- Statistically similar to that found nationally.

Child Total Overweight Prevalence

(Percent of Children 5-17 Who Are Overweight/Obese; Body Mass Index in the 85th Percentile or Higher)

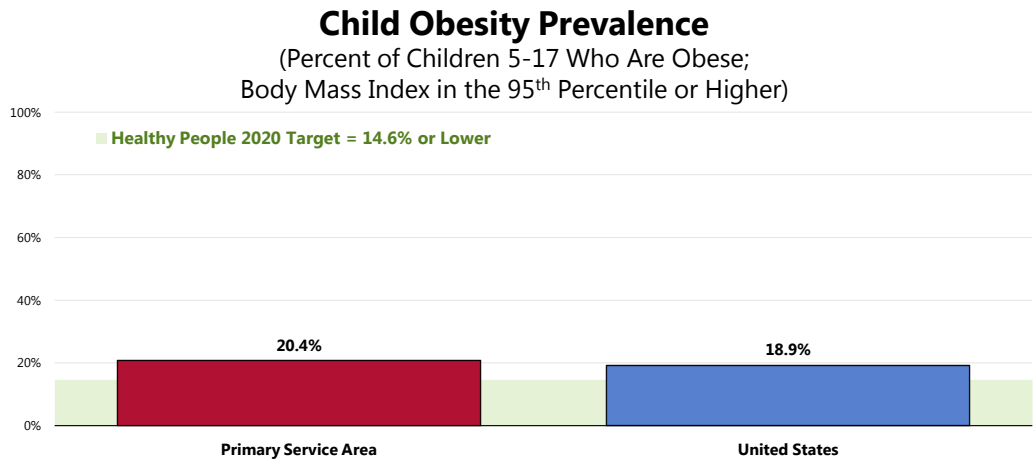


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is estimated based on children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Further, one in five (20.4%) Primary Service Area children age 5 to 17 is obese (≥95th percentile).

- Similar to the national percentage.
- Similar to the Healthy People 2020 target (14.6% or lower for children age 2-19).



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- 2011 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 NWS-10.4]

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Substance Abuse

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

The field has made progress in addressing substance abuse, particularly among youth. According to data from the national Institute of Drug Abuse (NIDA) Monitoring the Future (MTF) survey, which is an ongoing study of the behaviors and values of America's youth between 2004 and 2009, a drop in drug use (including amphetamines, methamphetamine, cocaine, hallucinogens, and LSD) was reported among students in 8th, 10th, and 12th grades. Note that, despite a decreasing trend in marijuana use which began in the mid-1990s, the trend has stalled in recent years among these youth. Use of alcohol among students in these three grades also decreased during this time.

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

– Healthy People 2020 (www.healthypeople.gov)

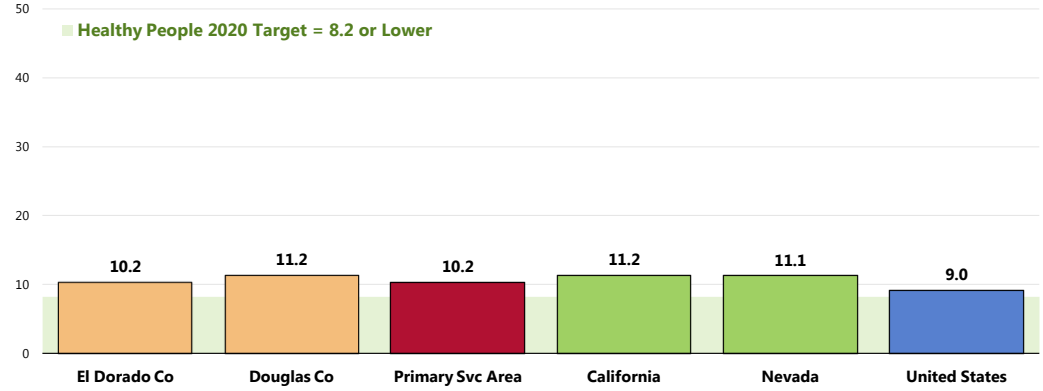
Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2006 and 2008, there was an annual average age-adjusted cirrhosis/liver disease mortality rate of 10.2 deaths per 100,000 population in the Primary Service Area.

- Lower than both state rates.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).
- Statistically similar by county.

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2006-2008 Annual Average Deaths per 100,000 Population)



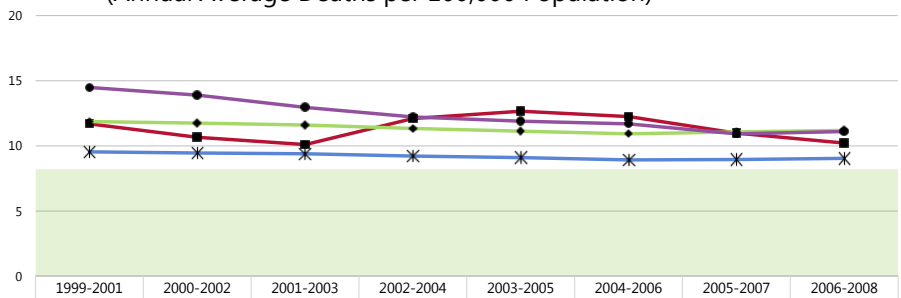
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-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 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The mortality rate has fluctuated in the region but decreased steadily from the 2003-2005 reporting period. Across both states and the US overall, rates decreased over the past decade.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2
Primary Svc Area	11.7	10.7	10.1	12.1	12.7	12.3	11.0	10.2
California	11.9	11.8	11.6	11.3	11.1	10.9	11.1	11.2
Nevada	14.5	13.9	13.0	12.2	11.9	11.7	10.9	11.1
United States	9.5	9.5	9.4	9.2	9.1	8.9	9.0	9.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

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- Local, state and national data are simple three-year averages.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

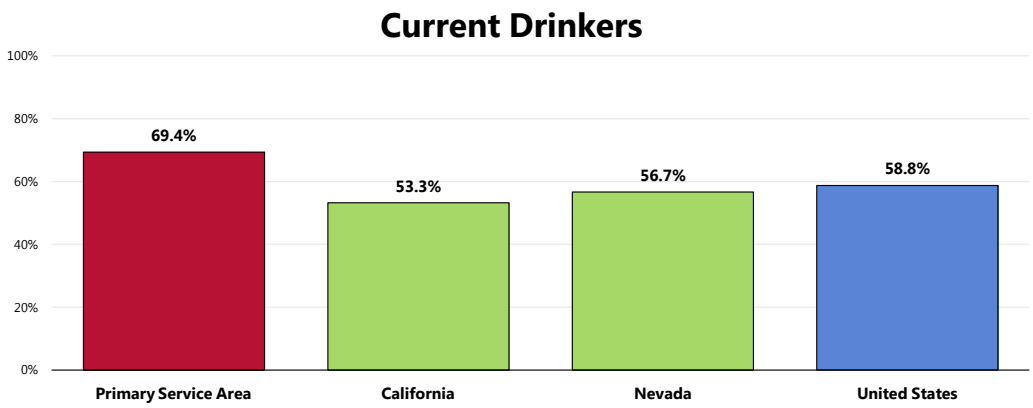
High-Risk Alcohol Use

Current Drinking

"Current drinkers" include survey respondents who had at least one drink of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

A total of 69.4% of area adults had at least one drink of alcohol in the past month (current drinkers).

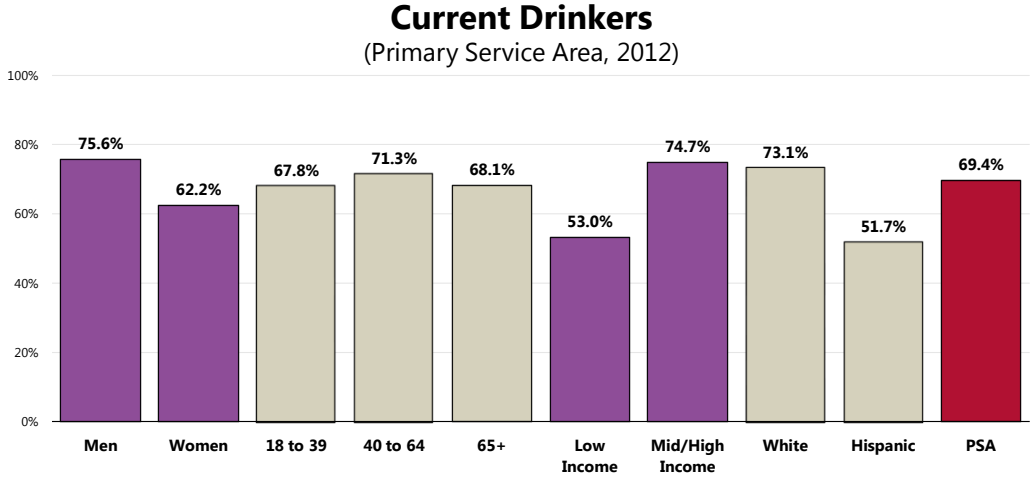
- Much higher than both statewide proportions.
- Much higher than the national proportion.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Current drinkers had at least one alcoholic drink in the past month.

Current drinking is more prevalent among men, higher-income residents and non-Hispanic White respondents.



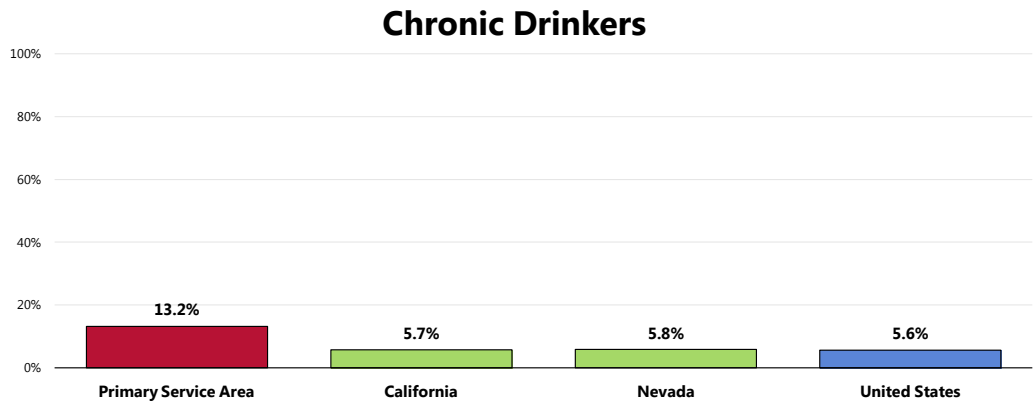
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Current drinkers had at least one alcoholic drink in the past month.

"Chronic drinkers" include survey respondents reporting 60 or more drinks of alcohol in the month preceding the interview.

A total of 13.2% of area adults averaged two or more drinks of alcohol per day in the past month (chronic drinkers).

- Less favorable than the statewide figures.
- Less favorable than the national proportion.

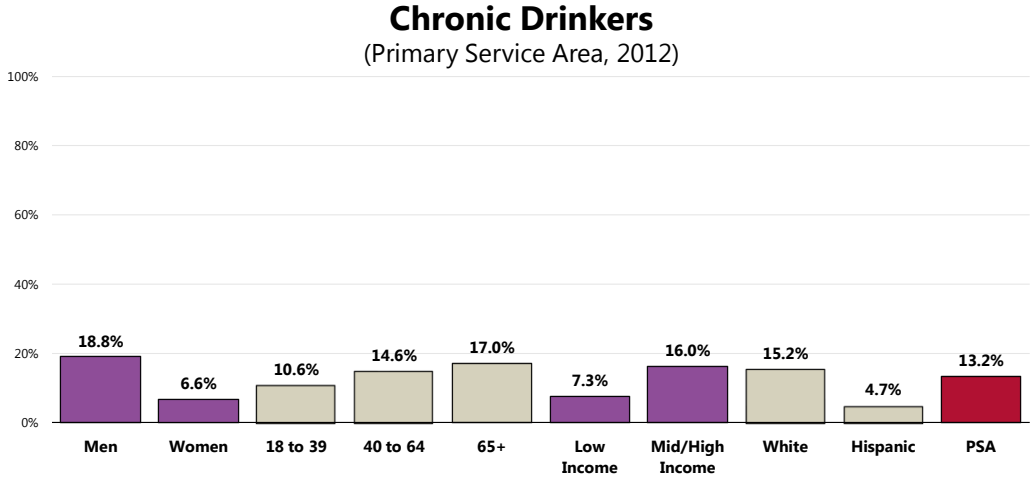


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 196]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Chronic drinkers are defined as having 60+ alcoholic drinks in the past month.
- *The state definition for chronic drinkers is males consuming 2+ drinks per day and females consuming 1+ drink per day.

Chronic drinking is more prevalent among men, residents in the higher income category and non-Hispanic White respondents.

RELATED ISSUE: See also *Stress* in the **Mental Health & Mental Disorders** section of this report.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 196]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Chronic drinkers are defined as those having 60+ alcoholic drinks in the past month.

Binge Drinking

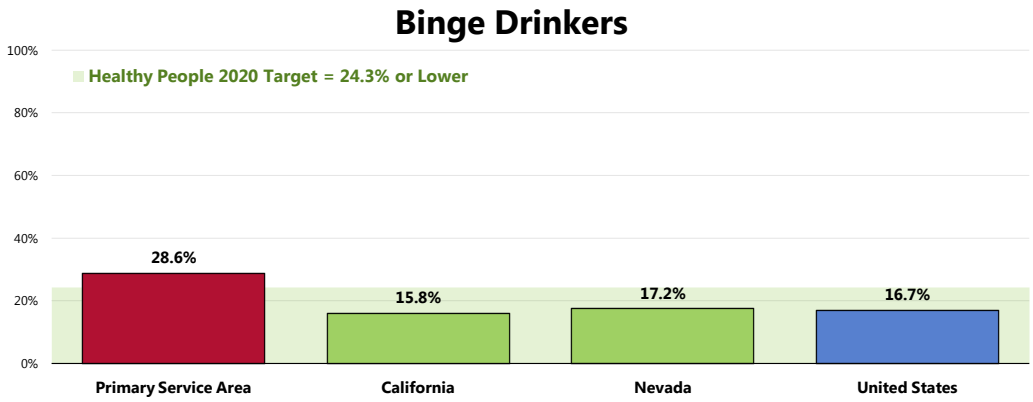
"Binge drinkers" include:

1) MEN who report drinking 5 or more alcoholic drinks on any single occasion during the past month; and

2) WOMEN who report drinking 4 or more alcoholic drinks on any single occasion during the past month.

A total of 28.6% Primary Service Area adults are binge drinkers.

- Much higher than California and Nevada figures.
- Much higher than national findings.
- Similar to the Healthy People 2020 target (24.3% or lower).

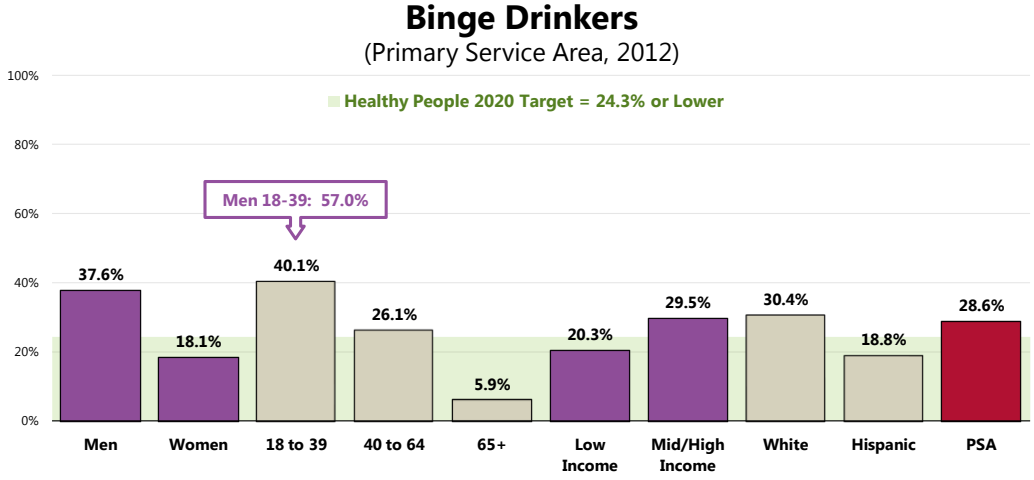


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 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 SA-14.3]

Notes:
- Asked of all respondents.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.

Binge drinking is more prevalent among:

- Men (especially those under age 40).
- Adults under age 40.
- Non-Hispanic White respondents.



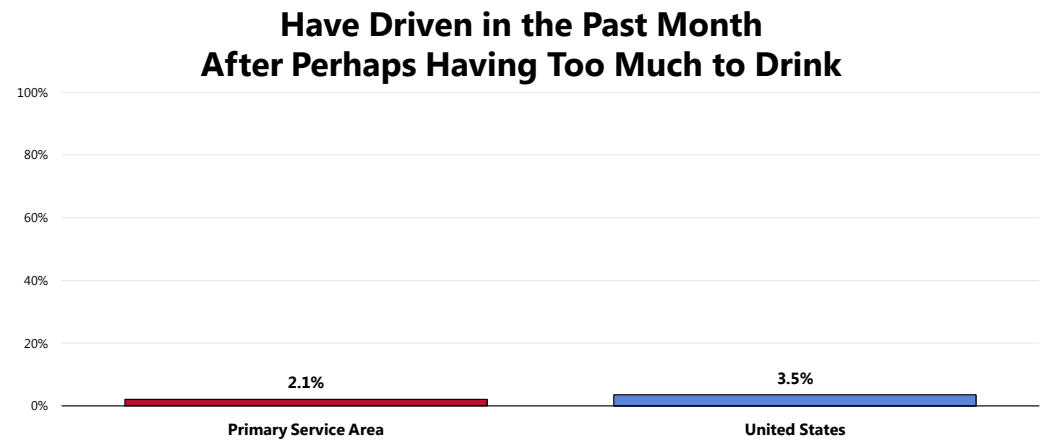
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-14.3]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

A total of 2.1% of Primary Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- Similar to the national findings.

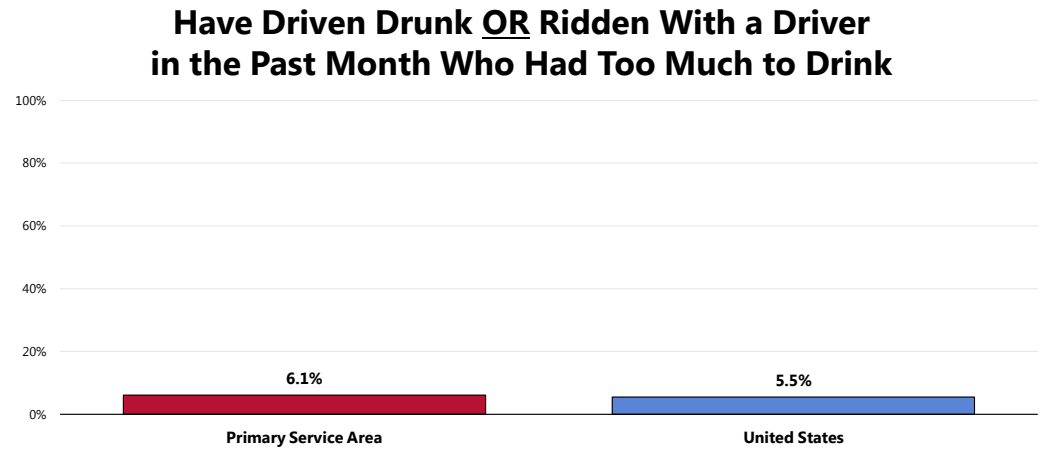


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 70]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

A total of 6.1% of Primary Service Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- Comparable to the national prevalence.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 198]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

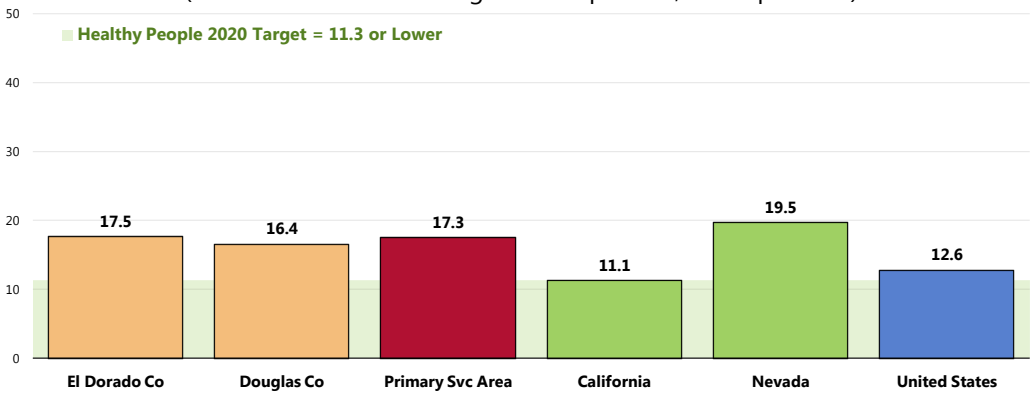
Age-Adjusted Drug-Induced Deaths

Between 2006 and 2008, there was an annual average age-adjusted drug-induced mortality rate of 17.3 deaths per 100,000 population in the Primary Service Area.

- Less favorable than the California rate but more favorable than the Nevada rate.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target (11.3 or lower).
- Similar by county.

Drug-Induced Deaths: Age-Adjusted Mortality

(2005-2007 Annual Average Deaths per 100,000 Population)



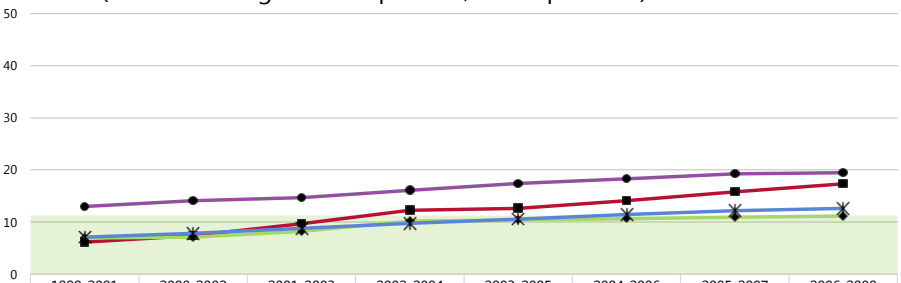
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

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.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

The mortality rate has increased steadily in the region, echoing the state and national trends.

Drug-Induced Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	11.3	11.3	11.3	11.3	11.3	11.3	11.3	11.3
Primary Svc Area	6.2	7.4	9.7	12.3	12.6	14.1	15.8	17.3
California	6.9	7.1	8.2	10.2	10.4	10.6	11.0	11.1
Nevada	13.0	14.1	14.7	16.1	17.4	18.3	19.3	19.5
United States	7.1	7.9	8.8	9.8	10.5	11.5	12.2	12.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

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.
- Primary Service Area findings are a weighted average of El Dorado County (CA) and Douglas County (NV) rates.

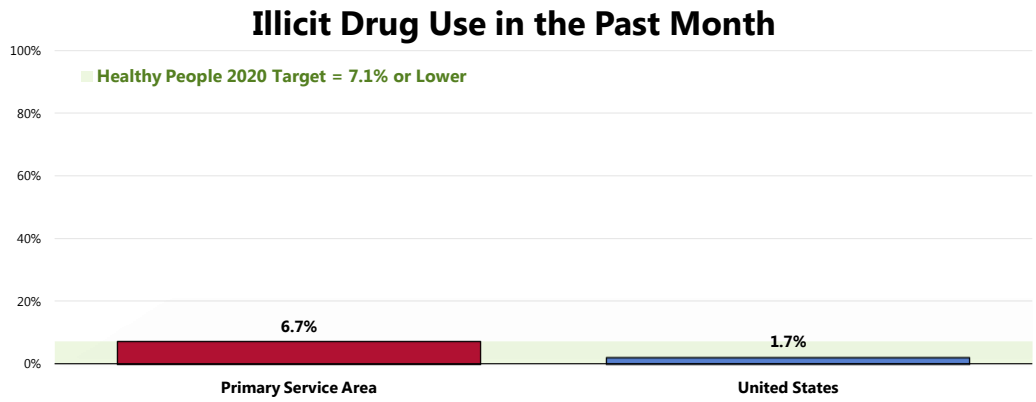
Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 6.7% of Primary Service Area adults acknowledge using an illicit drug in the past month.

- Nearly four times the prevalence found nationally.
- Similar to the Healthy People 2020 target of 7.1% or lower.



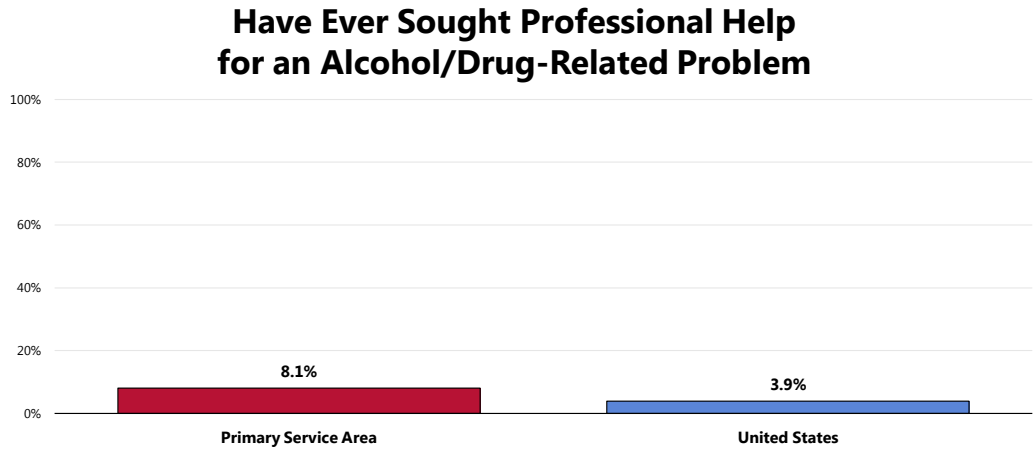
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 72]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.

Alcohol & Drug Treatment

A total of 8.1% of Primary Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- More than twice national findings.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 73]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Related Focus Group Findings: Substance Abuse

The focus group participants are concerned with substance abuse in the community. The main issues discussed surrounding substance abuse included:

- Prevalence of drug use
- Limited treatment facilities
- Marijuana collectives

A number of focus group participants express concern with the **prevalence of substance abuse** in the community, specifically prescription drugs, marijuana, heroin, opiates, synthetic drugs and alcohol abuse. Drug use occurs across all ages and areas of the community. The 24/7 drinking culture across the state line in the casinos perpetuates this behavior. Participants have concerns that parents who abuse substances have children who model the behavior. Additionally, parents may ignore or encourage teen drug use and offer little support when schools catch the teen using illegal substances. As one participant explains:

> *"You have children that see very poor modeling and begin using substances at a young age. There are parents that either ignore that or encourage that, so when these young kids then are caught or expected to follow the law, there is very little support from the parental unit. And we have a unique challenge here too because Tahoe is a place where people come to party and have a good time and so how do you say, 'Well, that behavior is okay for the visitor, but the residents, no'? That's a difficult thing." — Social Service Provider*

There are **limited treatment facilities** for individuals with substance abuse problems. The two public treatment centers only accept insured or private-pay patients. The majority of residents cannot afford those facilities and South Lake Tahoe does not have a public center. Many times local residents must travel to Reno or Placerville for treatment.

The participants feel the **marijuana collectives** have a negative impact on residents in South Lake Tahoe. Residents can now legally grow marijuana at home and some of these families have young children. These children come to school and smell of marijuana, as one participant recalls:

> *"We're really even seeing down to elementary – families who are growing in their homes. Kids may not be smoking at that age, but they come in reeking of marijuana smell, and there's nothing we can do – I mean those kids' families will be reported, but the whole legal system about the collectives is difficult. It will be interesting to see over the next 10-15 years what the impact is on those kids who grew up in homes that were growing." — Healthcare Professional*

In addition to youth having easier access to marijuana than ever before, participants worry about the effects that growing marijuana can have on a home's structure. These "grow homes" have an increased chance for mold which can seriously impact a person's health and quality of life.

> *"I get many calls about home grows, where people are growing marijuana in other people's homes, which by then is causing water intrusion and mold and health problems. When we say they're growing marijuana, it's not just a plant. It's a lot. It's like a rain garden."*
> *— Social Service Provider*

Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the US $193 billion annually in direct medical expenses and lost productivity.

Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

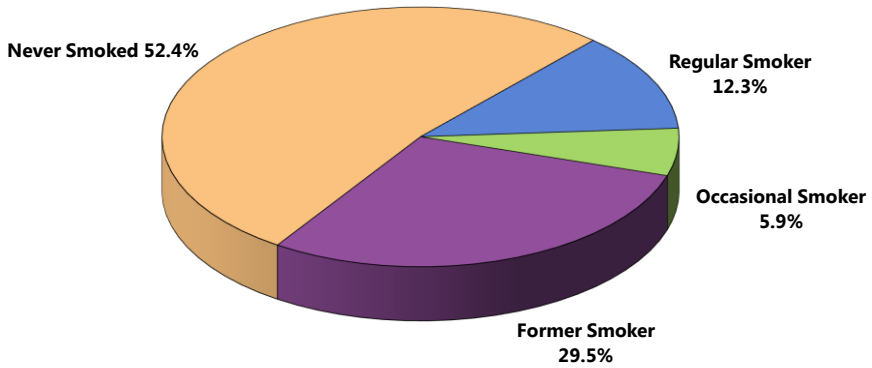
– Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 18.2% of Primary Service Area adults currently smoke cigarettes, either regularly (12.3% every day) **or occasionally** (5.9% on some days)**.**

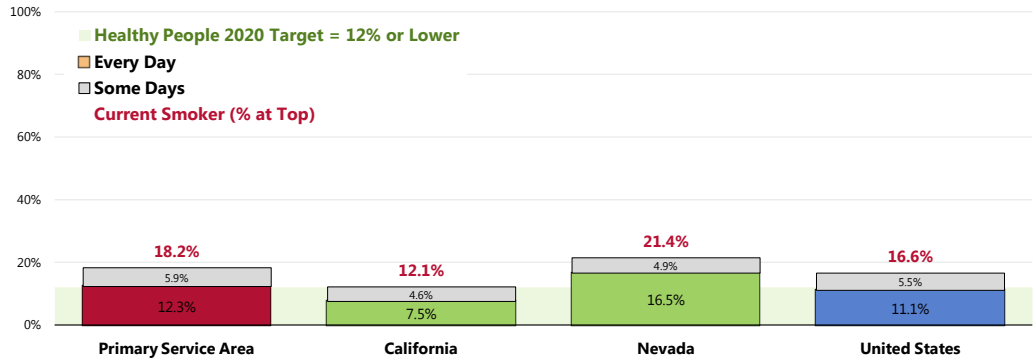
Cigarette Smoking Prevalence
(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]
Notes: • Asked of all respondents.

- Significantly higher than the California percentage, similar to Nevada findings.
- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (12% or lower).

Current Smokers



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

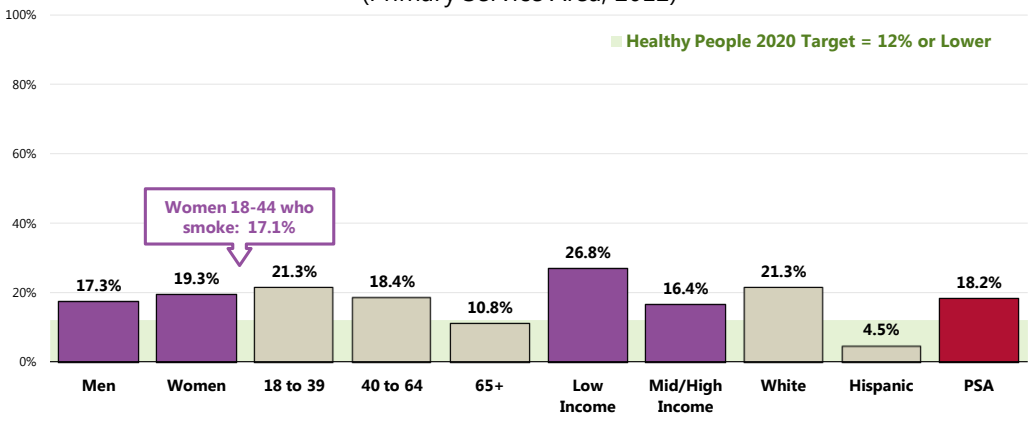
Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

Cigarette smoking is more prevalent among:

- Adults under the age of 65.
- Lower-income residents.
- Non-Hispanic White respondents.
- Note that 17.1% of women of child-bearing age (ages 18 to 44) currently smoke. This is notable given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.

Current Smokers

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-192]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion smokers (everyday and some days).

Smoking Cessation

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

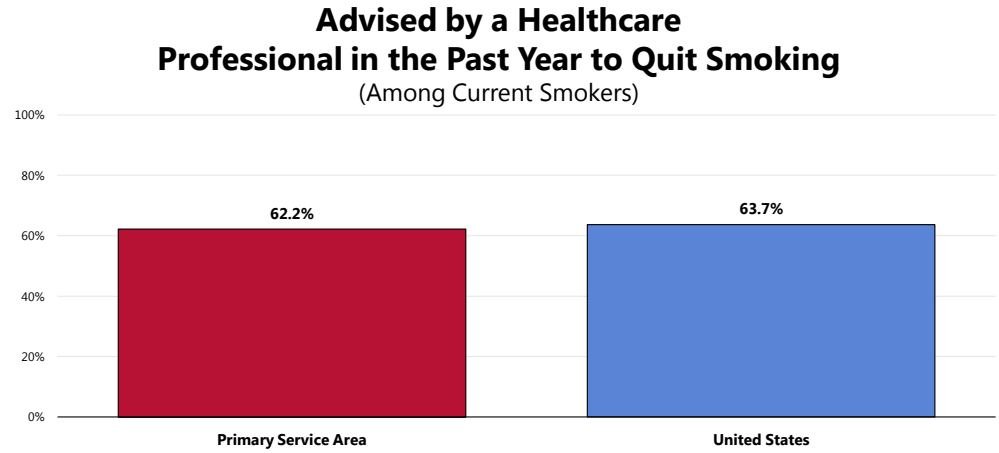
Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

– Healthy People 2020 (www.healthypeople.gov)

Health Advice About Smoking Cessation

A total of 62.2% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Similar to the national percentage.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 63]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all current smokers.

Smoking Cessation Attempts

Nearly one-half (49.4%) of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).

Have Stopped Smoking for One Day or Longer In the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers)

Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 62]
- 2011 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 TU-4.1]

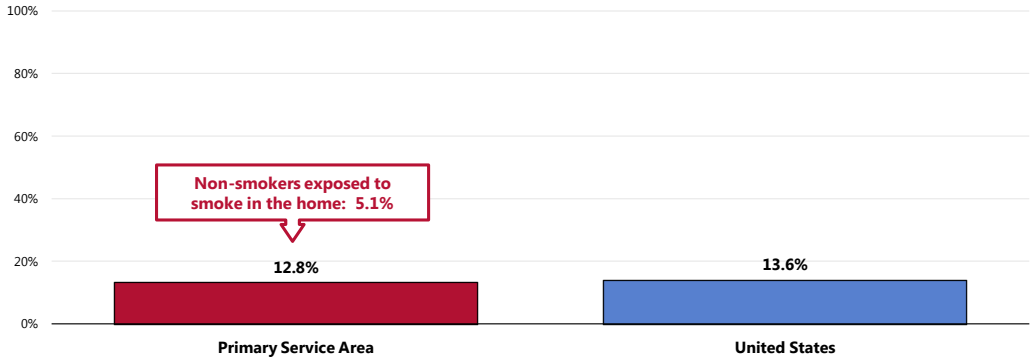
Notes:
- Asked of respondents who smoke cigarettes every day.

Environmental Tobacco Smoke

A total of 12.8% of Primary Service Area adults (including smokers and non-smokers) **report that a member of their household has smoked cigarettes in the home in the past month an average of four or more times per week.**

- Similar to national findings.
- Note that 5.1% of Primary Service Area non-smokers are exposed to cigarette smoke at home.

Member of Household Smokes at Home



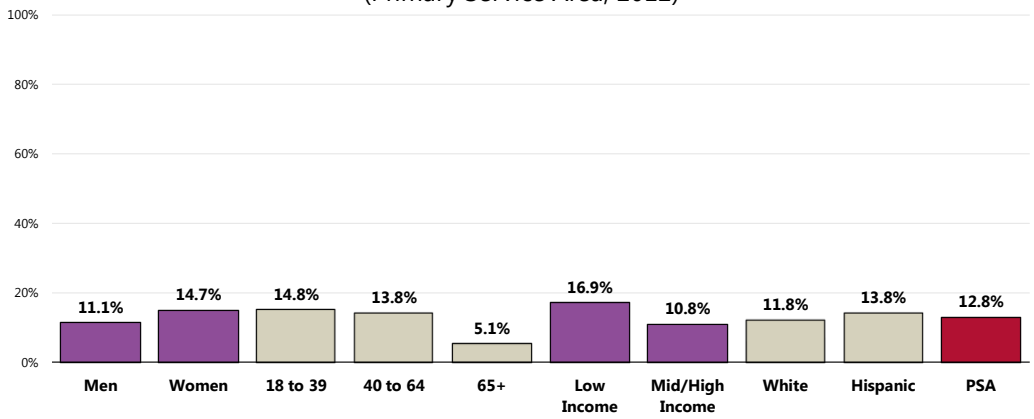
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 64, 193]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among residents under 65.

Member of Household Smokes At Home

(Primary Service Area, 2012)



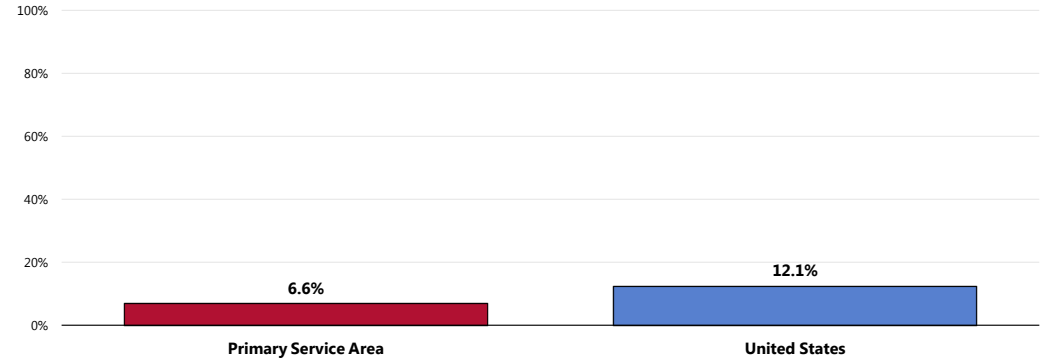
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 64]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Among households with children, 6.6% have someone who smokes cigarettes in the home.

- Statistically comparable to national findings.

Percentage of Households With Children In Which Someone Smokes in the Home



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked among parents of children age 0-17.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

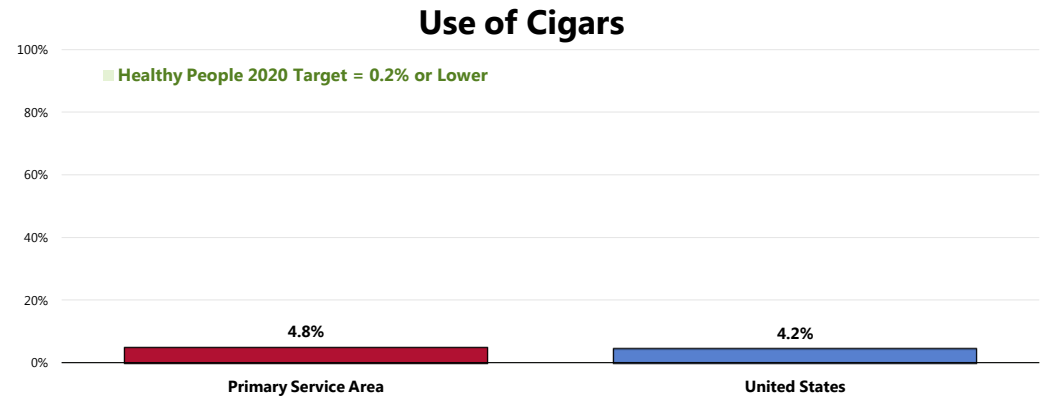
Other Tobacco Use

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

Cigars

A total of 4.8% of Primary Service Area adults use cigars every day or on some days.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).



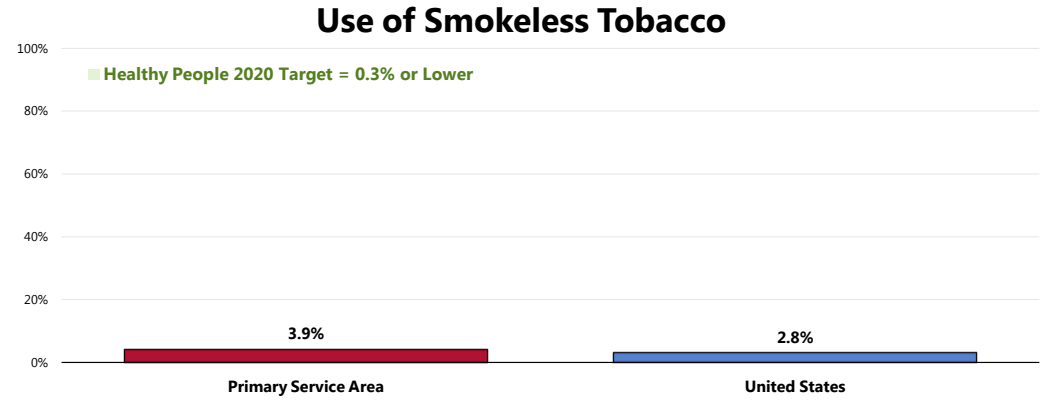
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.3]

Notes:
- Asked of all respondents.

Smokeless Tobacco

A total of 3.9% of Primary Service Area adults use some type of smokeless tobacco (e.g., chewing tobacco, snuff, snus, etc.) **every day or on some days.**

- Comparable to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 65]
- 2011 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 TU-1.2]

Notes:
- Asked of all respondents.
- Smokeless tobacco includes chewing tobacco or snuff.

ACCESS TO HEALTH SERVICES

Health Insurance Coverage

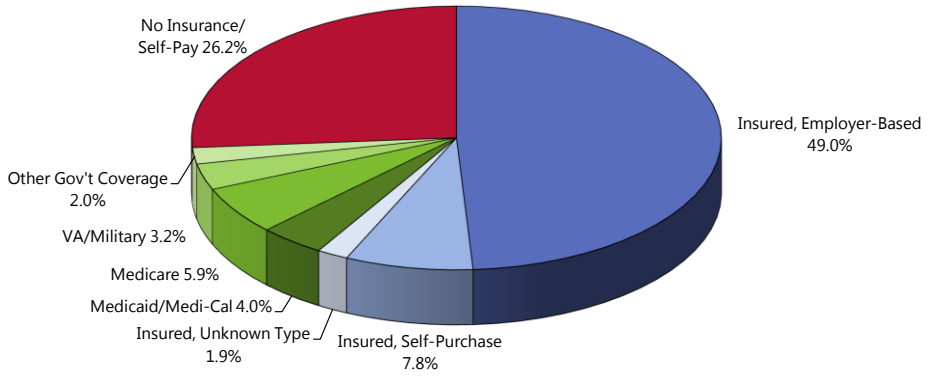
Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 58.7% of Primary Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 15.1% report coverage through a government-sponsored program (e.g., Medicaid, Medi-Cal, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults 18-64; Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]
Notes: • Reflects respondents age 18 to 64.

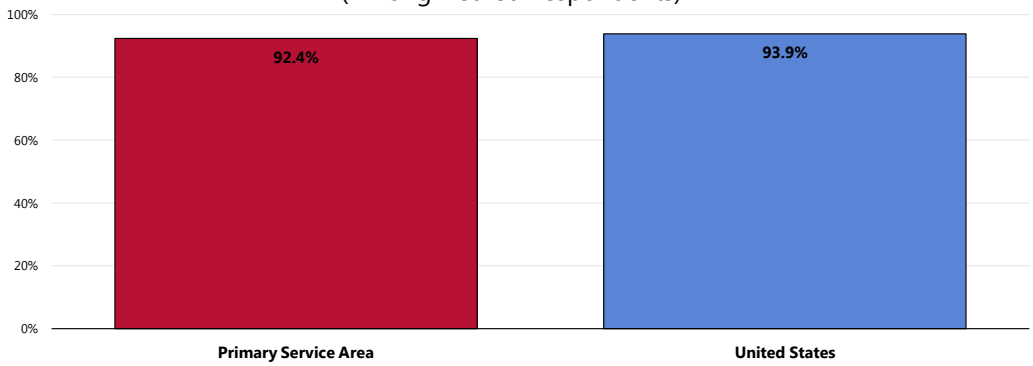
Prescription Drug Coverage

Among insured adults, 92.4% report having prescription coverage as part of their insurance plan.

- Statistically similar to the national prevalence.

Health Insurance Covers Prescriptions at Least in Part

(Among Insured Respondents)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 87]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with healthcare insurance coverage.

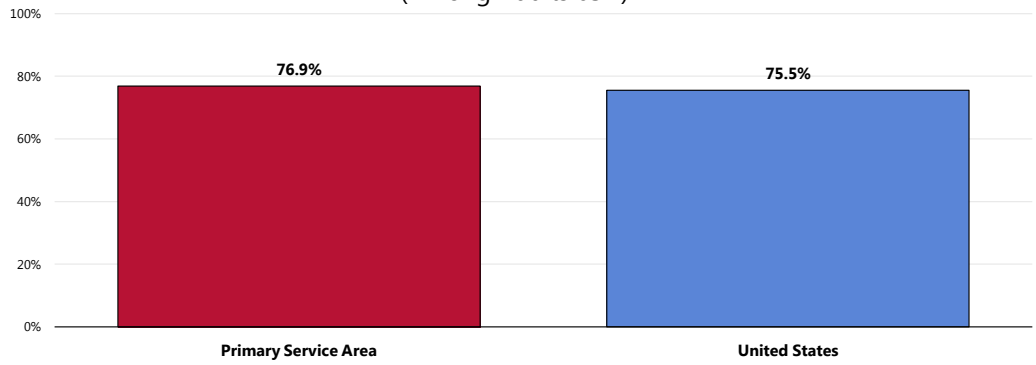
Supplemental Coverage

Among Medicare recipients, the majority (76.9%) has additional, supplemental healthcare coverage.

- Comparable to that reported among Medicare recipients nationwide.

Have Supplemental Coverage in Addition to Medicare

(Among Adults 65+)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of respondents age 65+.

Lack of Health Insurance Coverage

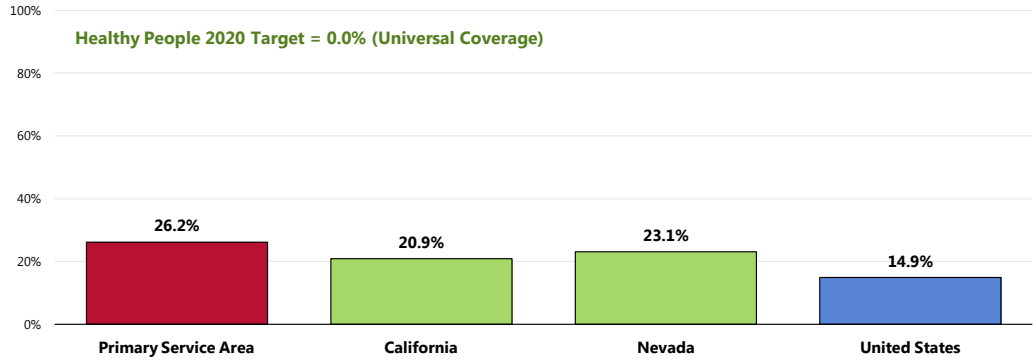
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid or Medi-Cal).

Among adults age 18 to 64, 26.2% report having no insurance coverage for healthcare expenses.

- Less favorable than the California percentage, similar to the Nevada finding.
- Less favorable than the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).

Lack of Healthcare Insurance Coverage

(Among Adults 18-64)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.
- 2011 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 AHS-1]

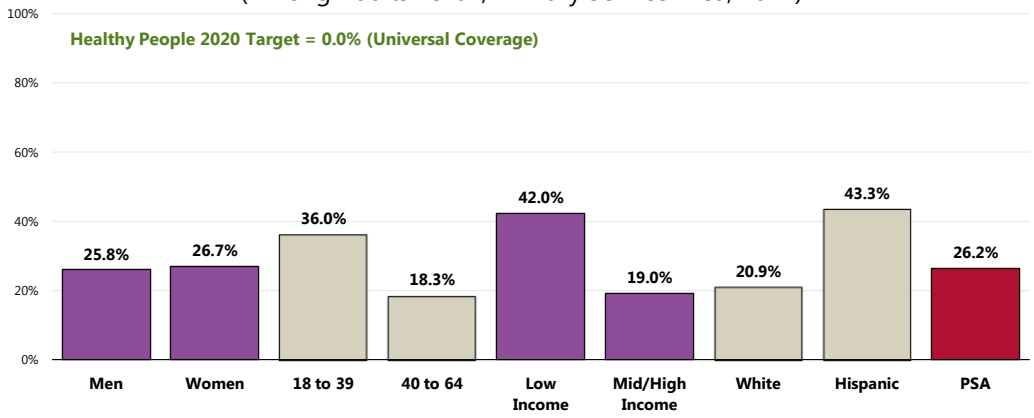
Notes:
- Asked of all respondents under the age of 65.

The following population segments are more likely to be without healthcare insurance coverage:

- Young adults (those under 40).
- Residents living at lower incomes (note the 42.0% uninsured prevalence among low-income adults).
- Hispanics (43.3% uninsured).

Lack of Healthcare Insurance Coverage

(Among Adults 18-64; Primary Service Area, 2012)



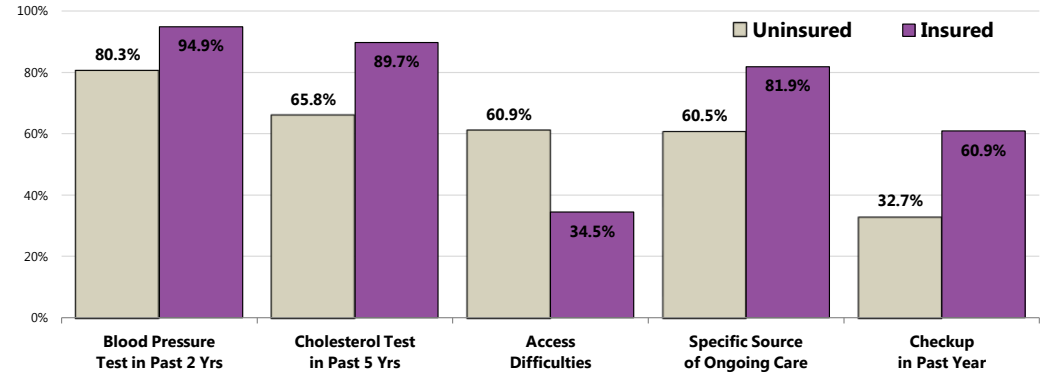
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

- As might be expected, uninsured adults in the Primary Service Area are less likely to receive routine care and preventive health screenings, and are more likely to experience difficulties accessing healthcare.

Preventive Healthcare

(By Insured Status; Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 49, 52, 200, 203]

Notes:
- Asked of all respondents.

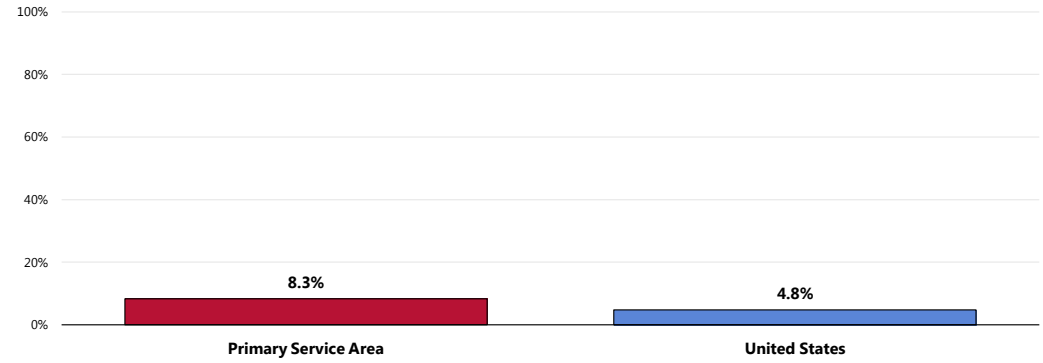
Recent Lack of Coverage (Insurance Instability)

Among currently insured adults in the Primary Service Area, 8.3% report that they were without healthcare coverage at some point in the past year.

- Less favorable than US findings.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults)



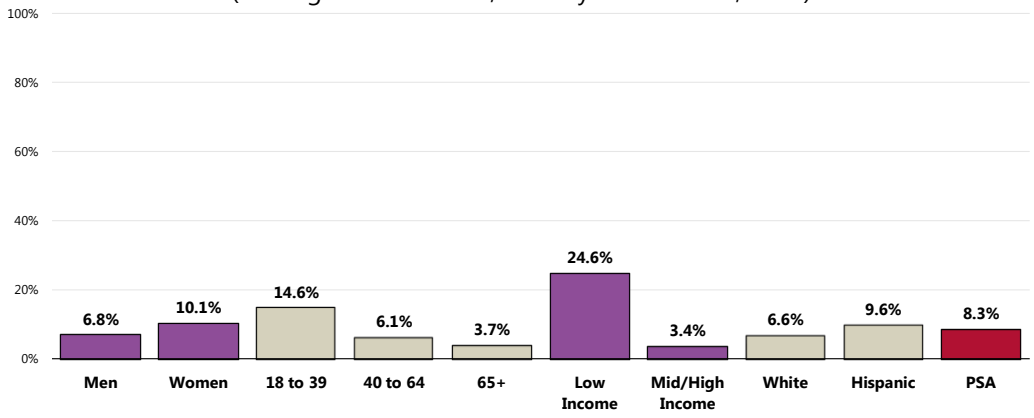
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all insured respondents.

Among insured adults, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Young adults.
- Lower-income residents.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults; Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]
Notes: • Asked of all insured respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Related Focus Group Findings: Access to Healthcare

Many focus group participants are concerned with access to healthcare. The main issues discussed include:

- Barriers to access
  - Uninsured and Under-insured
  - Cost
  - Transportation
  - Office Hours

Focus group participants consider South Lake Tahoe residents to fall at either end of the income spectrum, which polarizes healthcare access. Residents living on lower incomes encounter several **barriers** when trying to **access healthcare services** in the community, especially those families who are **under-insured or uninsured**. There are many "working poor," those residents who may qualify for employer insurance but find the deductibles too high or the monthly employee cost too much, so they elect to go without. Uninsured families may qualify for Medi-Cal, but finding a provider who accepts Medi-Cal can prove difficult. These people forgo regular preventative healthcare. Barton Health provides a sliding-fee health clinic, but the clinic is overwhelmed. As one participant recalls:

> *"And truly Barton does have the clinic, but it's overwhelmed. When I try to help a family call, it's tough. It's tough to get in on Monday morning or the length of time on the phone, so if Mom's trying to get to work, and she's having to wait, they're going to hang up, and they're not going to access anything." — Healthcare Professional*

In addition, public health funding continues to diminish, which eliminated the public health free clinic and family planning services. Participants worry about the individuals who previously utilized these programs. A participant describes:

> *"There is a subset of the population that goes to the Barton Clinic and a subset of the population that doesn't, but those folks would come to public health because we weren't under the same constraints. In other words, we were not concerned really with any kind of reimbursement source, so families that were uncomfortable or marginal or non-Medi-Cal or other coverage would feel less intimidated coming to public health. But since that public health clinic has closed we've eliminated that possibility." — Healthcare Professional*

In addition, the **cost** of healthcare and prescription medication can overburden families, *even those with insurance*. One respondent recalls:

> *"Our young adult families may be carrying high deductibles, so they're not going in when they're ill … Or if their kids get a concussion the parents are saying, 'I went in, but now it's weekly visits. I can't afford $60-$90 every week for the follow-ups.'" — Healthcare Professional*

Several focus group respondents believe limited **transportation** options hinder healthcare access. The public bus system represents one of the only options for public transportation. Bus services run throughout the day, but have **limited routes and hours of operation**. The bus routes travel past Barton Memorial Hospital, but to get to a bus stop may require a lengthy walk. This option may not work for individuals with small

children, mobility issues, or during inclement weather. Respondents also feel the cost of riding the bus can determine if someone's able to access healthcare. Disabled persons, seniors, and Medi-Cal recipients receive fare reduction rates and can request on-demand service with 24-hour notice; however, getting home from these appointments can take a long time. One participant explains his frustration:

> *"You have to call 24 hours in advance, then you've got to figure how long you're going to be at the doctor. Twice a month I have to get an infusion. Sometimes it takes 10 minutes. Sometimes it takes 30 minutes, and then I have to call and get a ride home - I don't mind waiting here because if I run out of oxygen, well, Barton will give me a bottle, but in a lot of places they wouldn't have a bottle of oxygen." — Social Service Provider*

Physician **office hours** can have an effect on a resident's ability to access healthcare. Many residents work jobs with alternative scheduling, which can make seeing a doctor during normal office hours difficult. One member describes:

> *"The schedules in this town with the casinos are like 24 hours. Sometimes they don't have the same day off or sometimes it's a daycare issue." — Healthcare Professional*

Difficulties Accessing Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

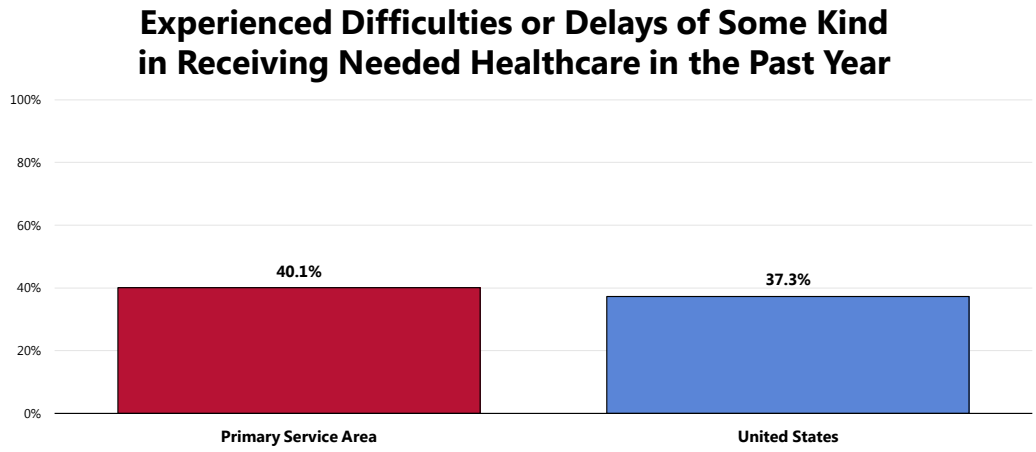
– Healthy People 2020 (www.healthypeople.gov)

Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 40.1% of Primary Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Comparable to national findings.



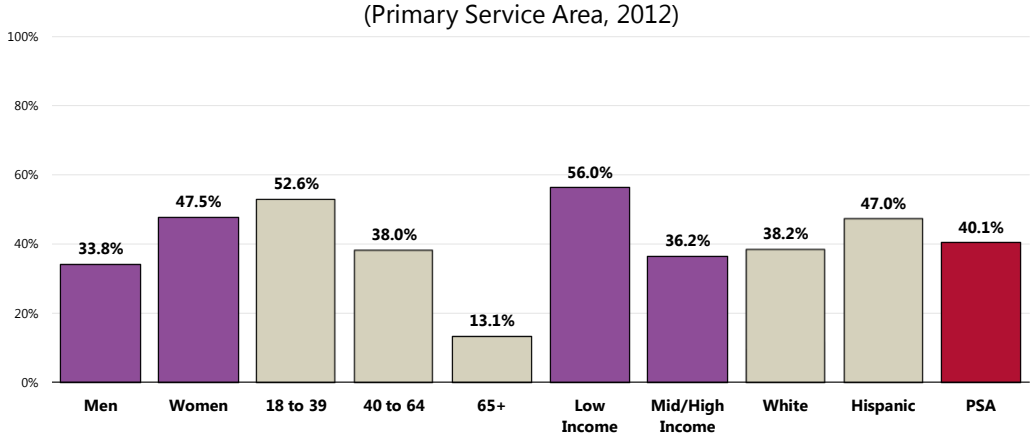
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 203]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Young adults.
- Lower-income residents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 203]

Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Barriers to Healthcare Access

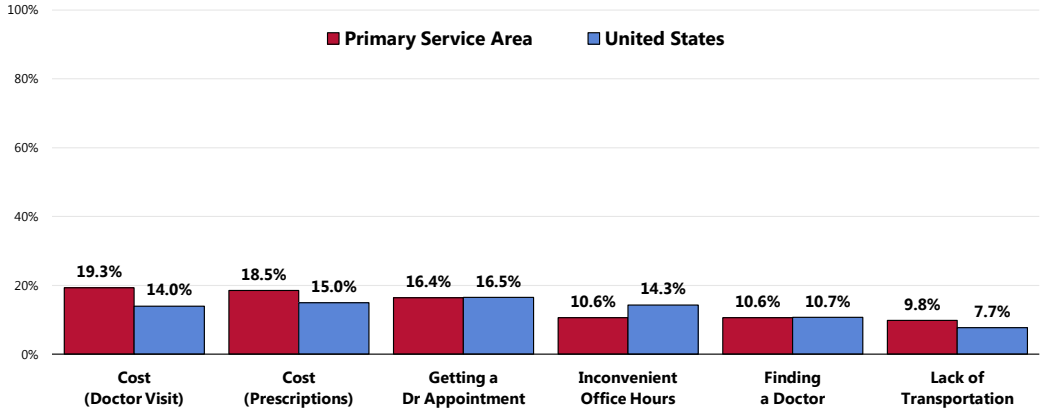
To better understand healthcare access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, cost (of both physician visits and prescriptions) and appointment availability impacted the greatest shares of Primary Service Area adults (over 16% each).

- The proportion of Primary Service Area adults impacted was statistically comparable to that found nationwide for each of the tested barriers, with the exception of the proportion **foregoing a physician visit in the past year because of the cost** (the local prevalence was significantly higher).

Barriers to Access Have Prevented Medical Care in the Past Year

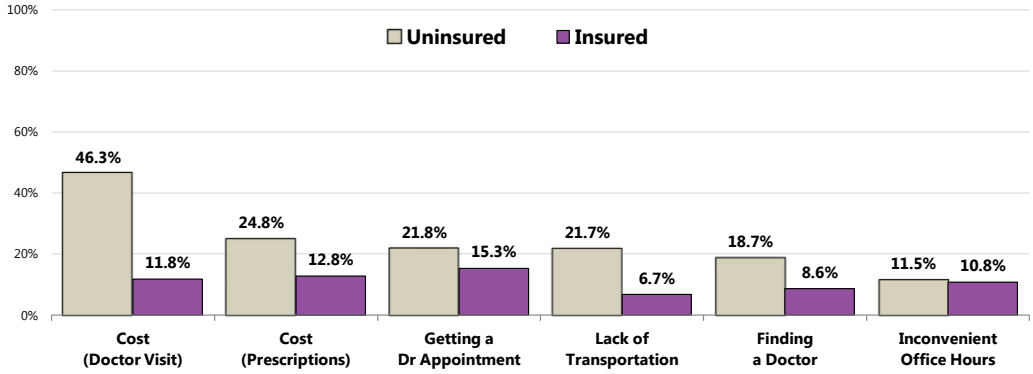


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- As might be expected, Primary Service Area adults without health insurance are much more likely to report access barriers when compared to the insured population, particularly those related to cost and transportation.

Barriers to Healthcare Access
(By Insured Status, Adults 18+; Primary Service Area, 2012)



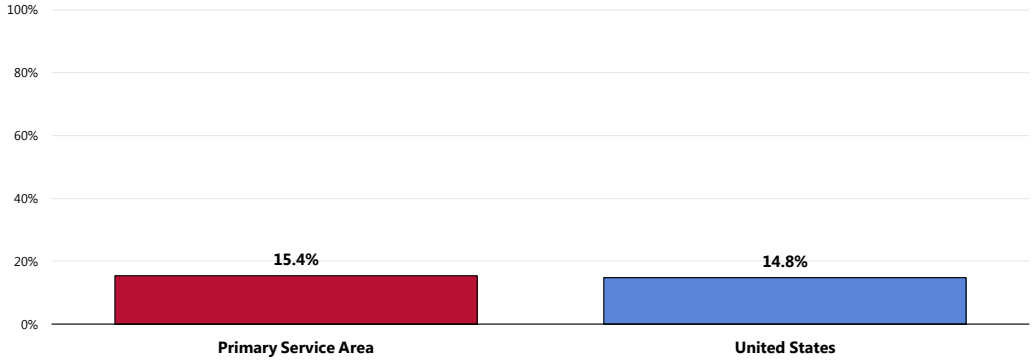
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

Prescriptions

Among all Primary Service Area adults, 15.4% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Comparable to national findings.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



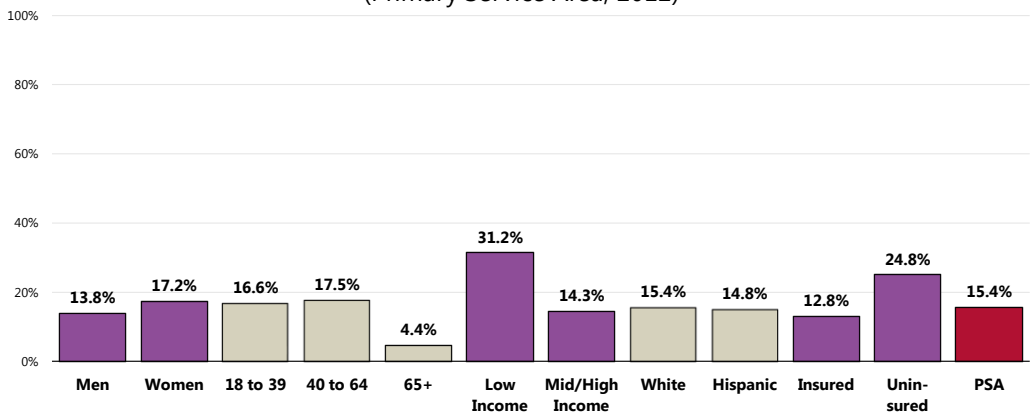
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Adults under 65.
- Respondents with lower incomes.
- Uninsured adults.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

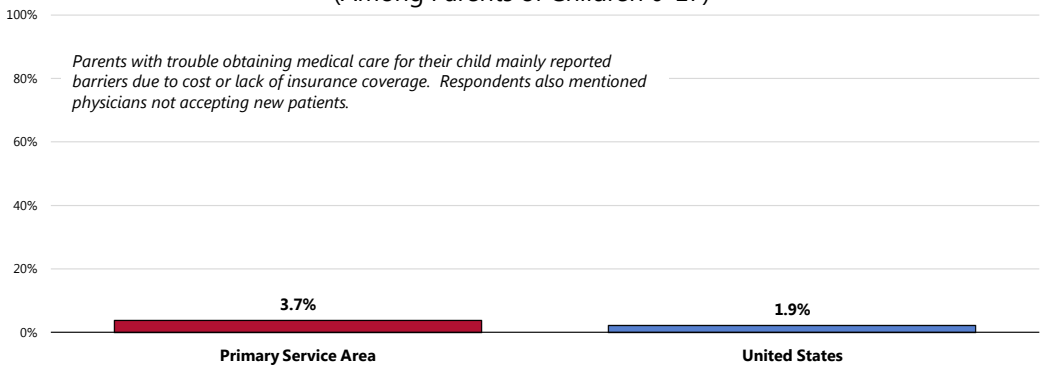
Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

A total of 3.7% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Statistically similar to what is reported nationwide.

Had Trouble Obtaining Medical Care for Child in the Past Year

(Among Parents of Children 0-17)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 132-133]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Among the parents experiencing difficulties, the majority cited **cost or a lack of insurance** as the primary reason; others mentioned physicians not accepting new patients.

Primary Care Services

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

– Healthy People 2020 (www.healthypeople.gov)

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is also known as a "medical home."

A hospital emergency room is not considered a source of ongoing care in this instance.

Specific Source of Ongoing Care

A total of 77.0% of Primary Service Area adults were determined to have a specific source of ongoing medical care (a "medical home").

- Similar to national findings.
- Fails to satisfy the Healthy People 2010 objective (95% or higher).

Have a Specific Source of Ongoing Medical Care

Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 200]
- 2011 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 AHS-5.1]

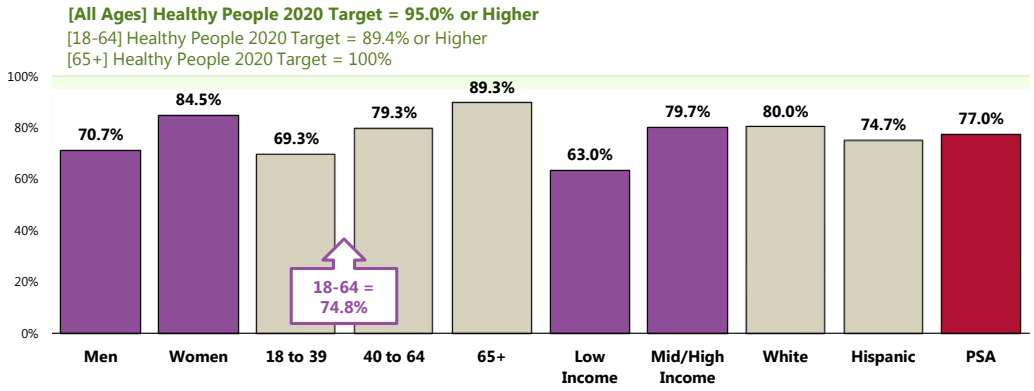
Notes:
- Asked of all respondents.

When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- Men.
- Adults under age 40.
- Lower-income adults.
- Among adults age 18-64, 74.8% have a specific source for ongoing medical care, similar to national findings.
  - Fails to satisfy the Healthy People 2020 target for this age group (89.4% or higher).
- Among adults 65+, 89.3% have a specific source for care, similar to the percentage reported among seniors nationally.
  - Fails to satisfy the Healthy People 2020 target of 100% for seniors.

Have a Specific Source of Ongoing Medical Care

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 200-202]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives AHS-5.1, 5.3, 5.4]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Related Focus Group Findings: Medical Home

Participants also spoke about the need for residents to maintain a **"medical home"** in order to have the best healthcare possible. Currently residents may not know the importance of utilizing only one physician or relaying their complete health history if they see multiple providers. One member explains:

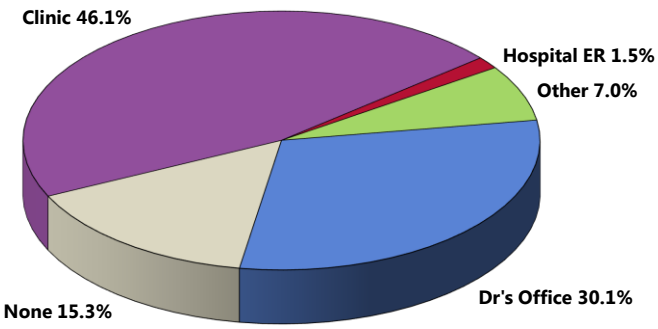
> *"I feel like it's very fragmented — you have one family accessing three or four different providers sometimes in medical settings, and there's no way you can provide good medical care to that family if you don't have cohesiveness." — Healthcare Professional*

Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (46.1%) identified some type of clinic.

A total of 30.1% say they usually go to a particular doctor's office, while 1.5% rely on a hospital emergency room.

Particular Place Utilized for Medical Care
(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]
Notes: • Asked of all respondents.

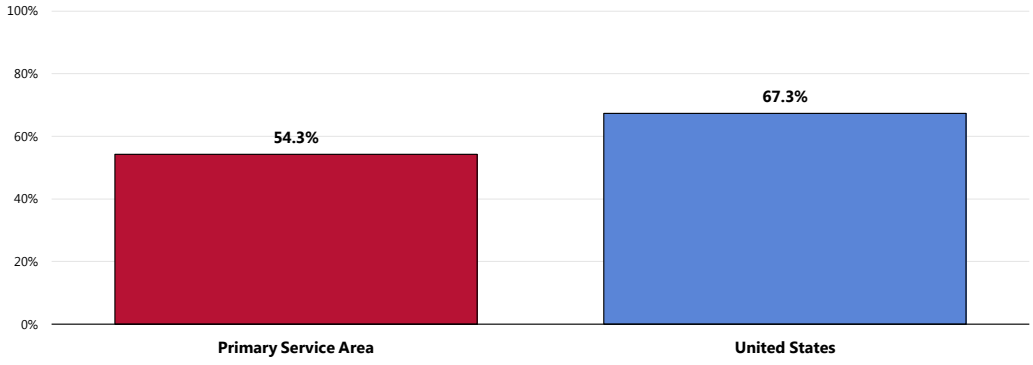
Utilization of Primary Care Services

Adults

Just over one-half (54.3%) of adults visited a physician for a routine checkup in the past year.

- Less favorable than national findings.

Have Visited a Physician for a Checkup in the Past Year

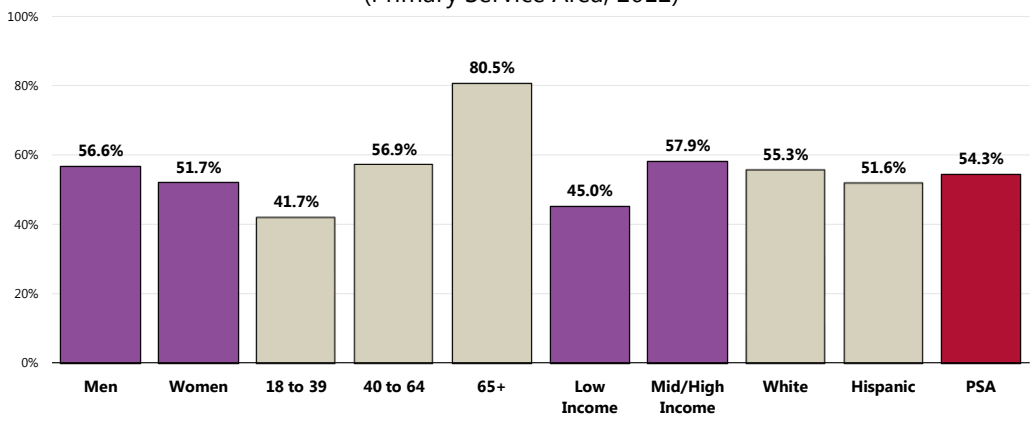


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Adults under age 40 are less likely to have received routine care in the past year (note the positive correlation with age), as are residents in the lower-income breakout.

Have Visited a Physician for a Checkup in the Past Year

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

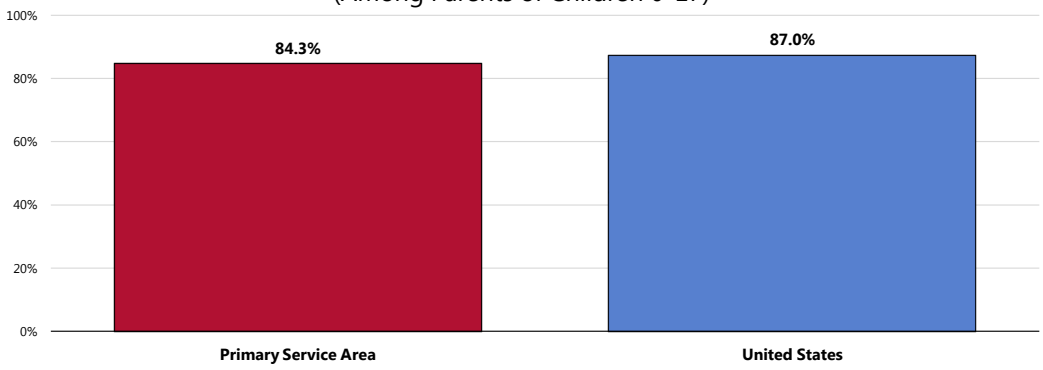
Children

Among surveyed parents, 84.3% report that their child has had a routine checkup in the past year.

- Similar to national findings.

Child Has Visited a Physician for a Routine Checkup in the Past Year

(Among Parents of Children 0-17)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 134]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Specialty Medical Care

Related Focus Group Findings: Specialists

Many focus group participants discussed medical specialties available in the community. The main discussion centered on:

- The need for more local specialists
- Transportation

Most of the focus group participants believe the South Lake Tahoe community **needs more local specialists**. Specific physicians named include diabetes educators, counselors, hematologists, nephrologists, oncologists, pediatricians, psychiatrists, audiologists, neurologists, oral surgeons and dentists.

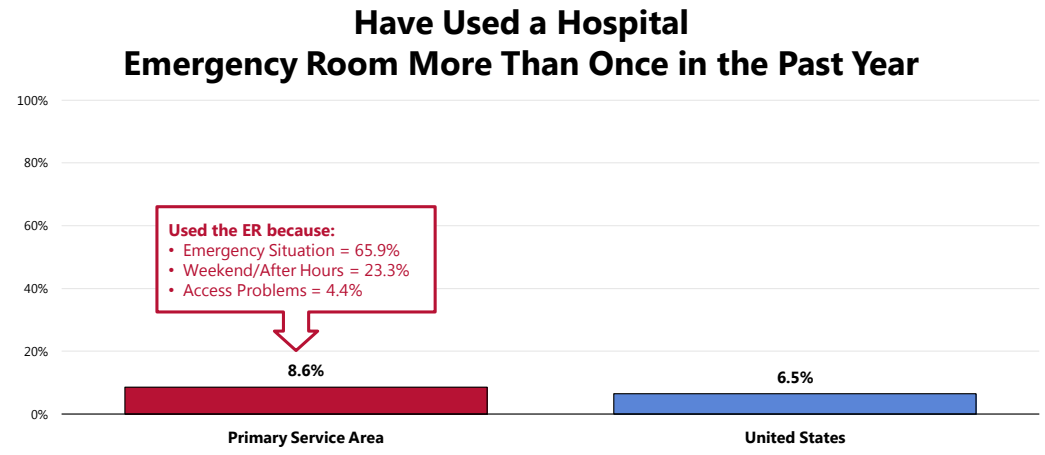
Currently many of the specialists work in either Reno or Placerville, so residents must travel to appointments. **Transportation** acts as a major roadblock to accessing these services. OPEN (Ordinary People with Extraordinary Needs) is the only agency in South Lake Tahoe that will provide transportation out of town, but the program is slowly going away. A participant shares his worries:

> *"I'm on a drug to control my diabetes, which is killing my kidney. A five is perfect; it's now a four. Well, how long before I have to go on dialysis? Praise God I don't and I just go away, but then I would have to travel to Reno … There's only one organization up here that provides transportation off the hill if you can't drive. I really think someone ought to step forward, because the group I belong to is slowly dying, and when it does, there will be no transportation off the hill." — Social Service Provider*

Emergency Room Utilization

A total of 8.6% of Primary Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

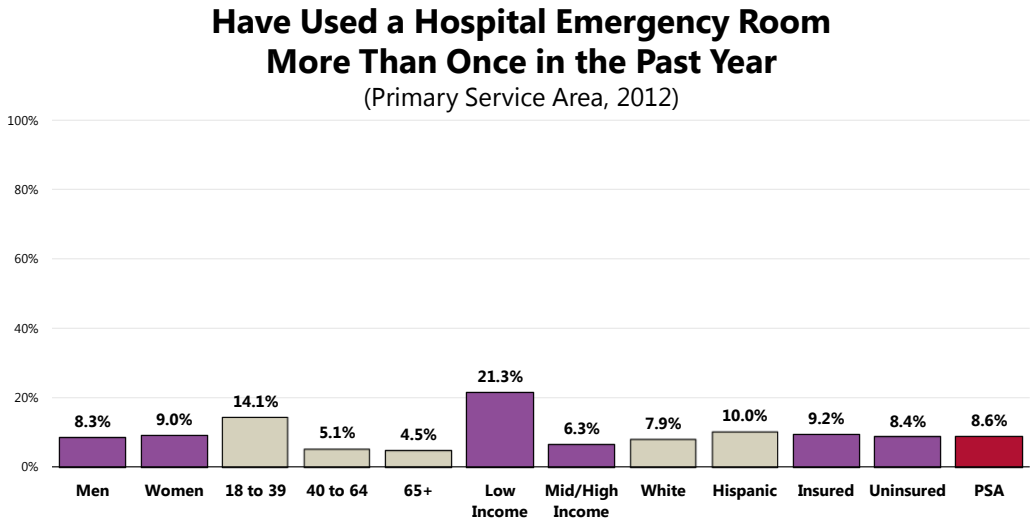
- Comparable to national findings.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 23-24]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Of those using a hospital ER, 65.9% say this was due to an **emergency or life-threatening situation**, while 23.3% indicated that the visit was during **after-hours or on the weekend**. A total of 4.4% cited **difficulties accessing primary care** for various reasons.

- Young adults and lower-income residents are more likely to have visited an ER more than once in the past year.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
Notes: • Asked of all respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Oral Health

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include:

- Tobacco use
- Excessive alcohol use
- Poor dietary choices

Barriers that can limit a person's use of preventive interventions and treatments include:

- Limited access to and availability of dental services
- Lack of awareness of the need for care
- Cost
- Fear of dental procedures

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Community water fluoridation and school-based dental sealant programs are 2 leading evidence-based interventions to prevent tooth decay.

Major improvements have occurred in the nation's oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent CDC publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased.

Lack of access to dental care for all ages remains a public health challenge. This issue was highlighted in a 2008 Government Accountability Office (GAO) report that described difficulties in accessing dental care for low-income children. In addition, the Institute of Medicine (IOM) has convened an expert panel to evaluate factors that influence access to dental care.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

– Healthy People 2020 (www.healthypeople.gov)

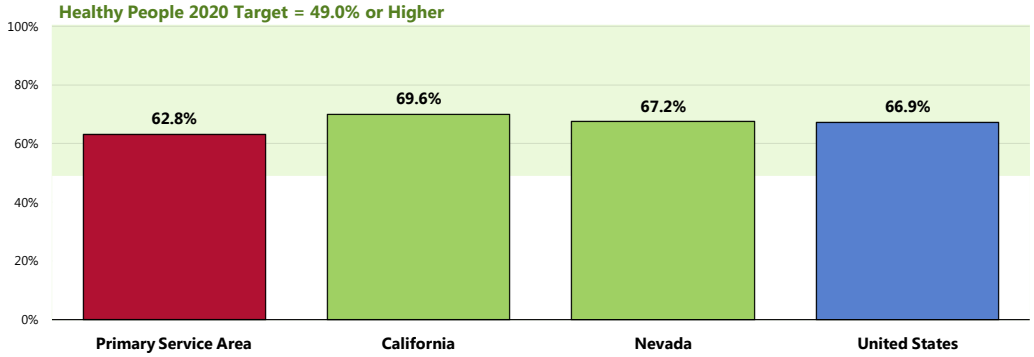
Dental Care

Adults

Just over 6 in 10 Primary Service Area adults (62.8%) have visited a dentist or dental clinic (for any reason) in the past year.

- Less favorable than California findings, similar to the Nevada prevalence.
- Similar to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).

Have Visited a Dentist or Dental Clinic Within the Past Year



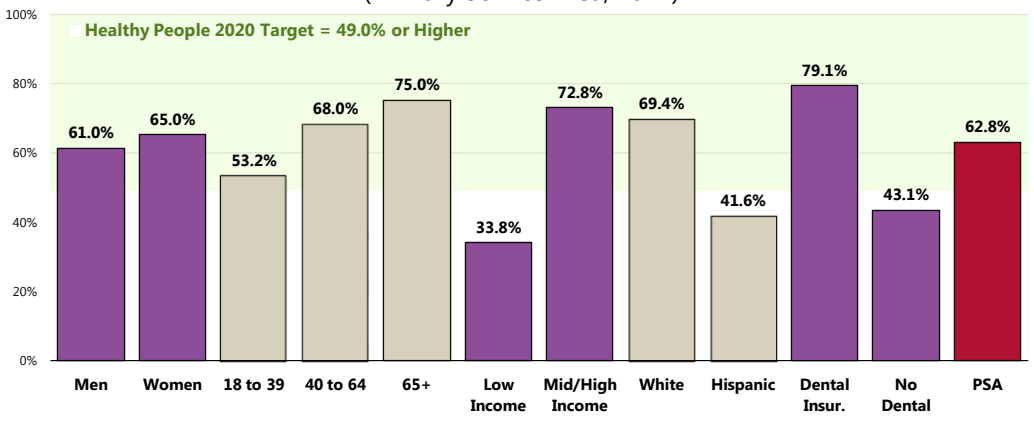
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 California and Nevada data.

Notes:
- Asked of all respondents.

Adults less likely to report recent dental visits include those under 40; lower-income residents (failing to satisfy the Healthy People 2020 target); Hispanics; and persons without dental insurance.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

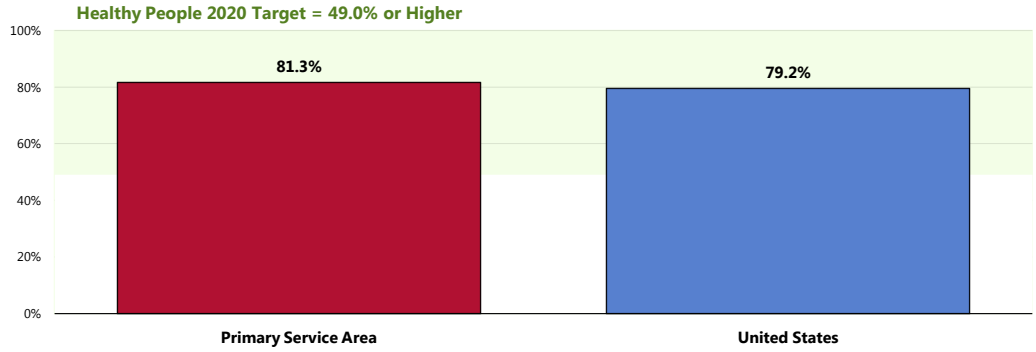
Children

A total of 81.3% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Similar to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children 2-17)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 135]
- 2011 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 OH-7]

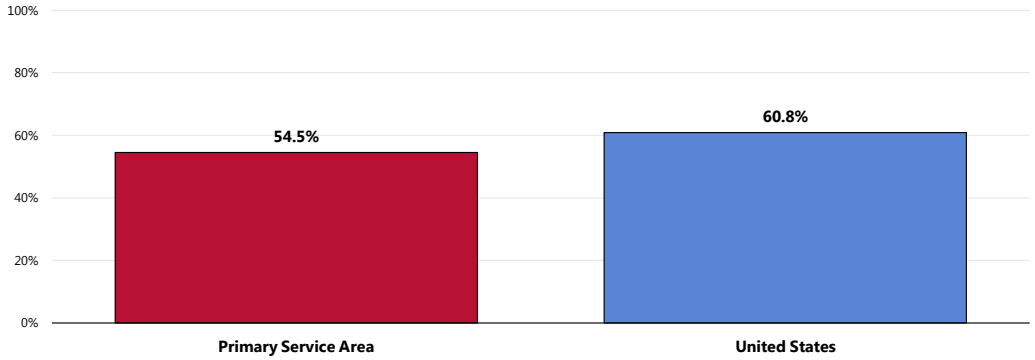
Notes:
- Asked of all respondents with children age 2 through 17.

Dental Insurance

Over one-half of Primary Service Area adults (54.5%) have dental insurance that covers all or part of their dental care costs.

- Lower than the national finding.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Related Focus Group Findings: Oral Health

Many focus group participants discussed oral health in the community. The main issues discussed include:

- Dental insurance
- Dental van

Focus group participants believe that oral health has an effect on a person's overall health and that it is critical to get regular dental care; however, many residents face barriers to accessing dental treatment. Many respondents believe that employed residents have limited dental insurance, if any. Those without **dental insurance** cannot afford preventive care, which can lead to serious oral health issues. Only a few dentists accept Medi-Cal, so access to dental services represents an area of need for many families in the community.

To address this need in children, a **dental van** travels to six local elementary schools biannually to provide dental care for infants and children up to 14 years of age. The dentists accept Medi-Cal insurance. A respondent explains the hope for dental van recipients:

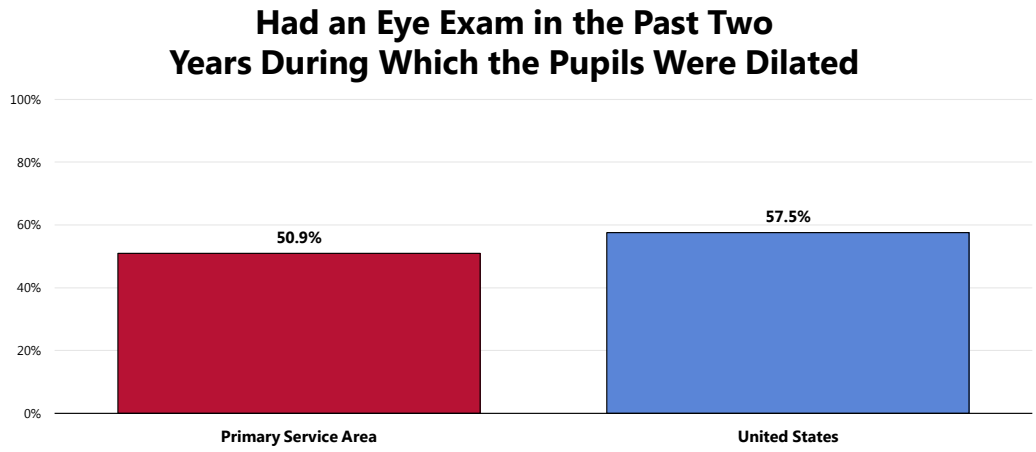
> *"I think it's important too that the dental van is not just something that a child would go to once. The intention is that it does become their dental home, which is a huge positive because when you come up every six months, then you build a clientele and the kids have a dental home with regular dental visits." — Social Service Provider*

Vision Care

RELATED ISSUE:
See also *Vision & Hearing* in the **Deaths & Disease** section of this report.

A total of 50.9% of residents had an eye exam in the past two years during which their pupils were dilated.

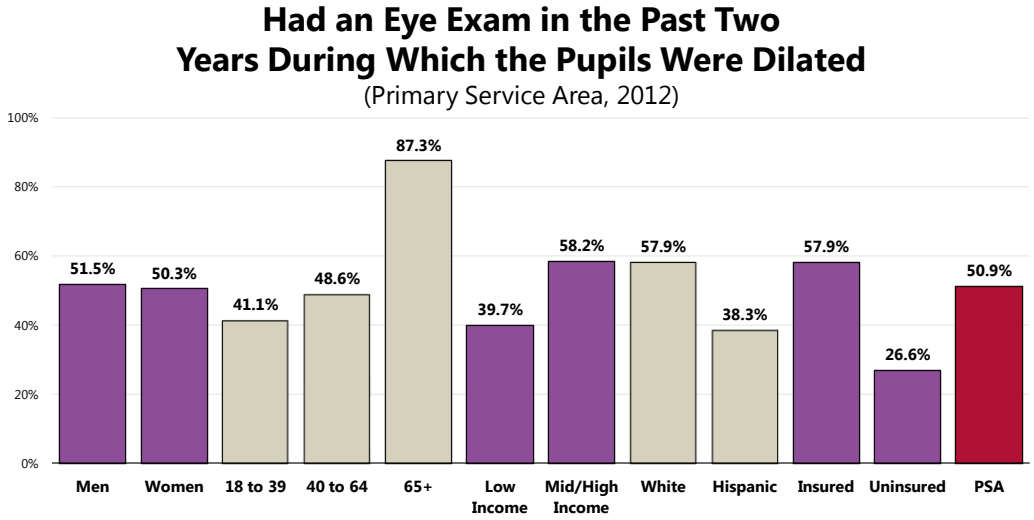
- Less favorable than the national proportion.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Recent vision care in the Primary Service Area is less often reported among:

- Adults under 65.
- Residents with lower incomes.
- Hispanics.
- The uninsured.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
Notes: • Asked of all respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

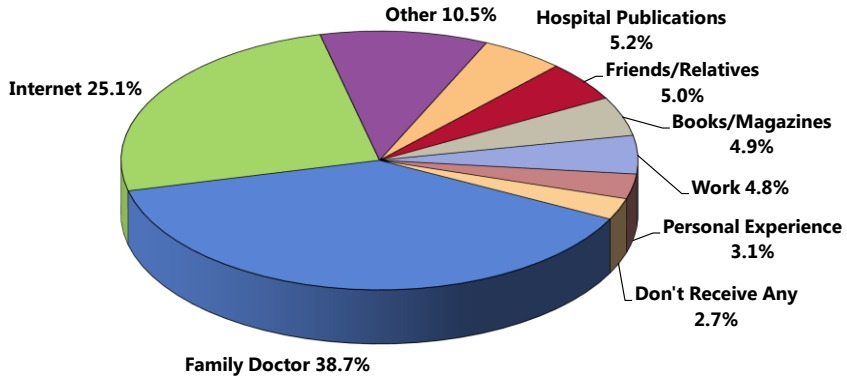
HEALTH EDUCATION & OUTREACH

Healthcare Information Sources

Family physicians and the Internet are residents' primary sources of healthcare information.

- 38.7% of Primary Service Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 25.1%.
  - Other sources mentioned include hospital publications (mentioned by 5.2%), friends and relatives (5.0%), books and magazines (4.9%) work (4.8%) and personal experience (3.1%).
- Just 2.7% of survey respondents say that they do not receive any healthcare information.

Primary Source of Healthcare Information
(Primary Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
Notes: • Asked of all respondents.

Participation in Health Promotion Events

Educational and community-based programs play a key role in preventing disease and injury, improving health, and enhancing quality of life.

Health status and related-health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Education and community-based programs and strategies are designed to reach people outside of traditional healthcare settings. These settings may include schools, worksites, healthcare facilities, and/or communities.

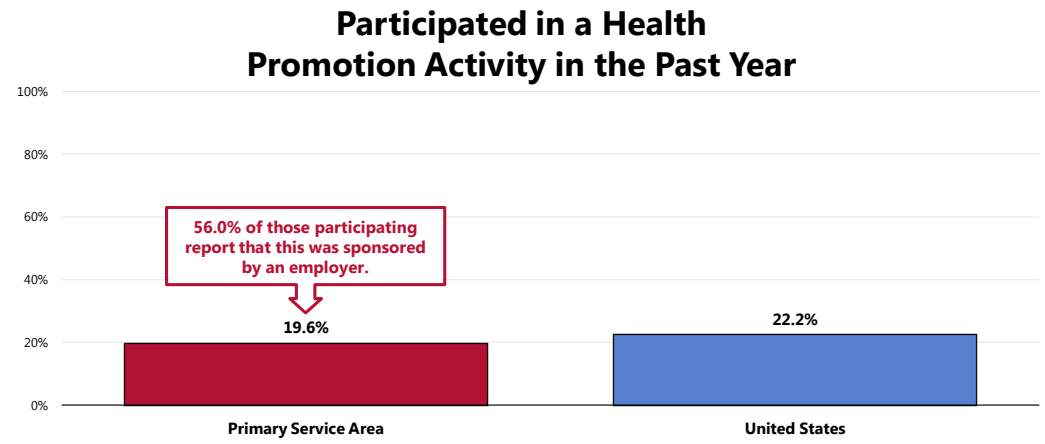
Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

– Healthy People 2020 (www.healthypeople.gov)

A total of 19.6% of Primary Service Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.

- Comparable to the national prevalence.
- Note that 56.0% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 121-122]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

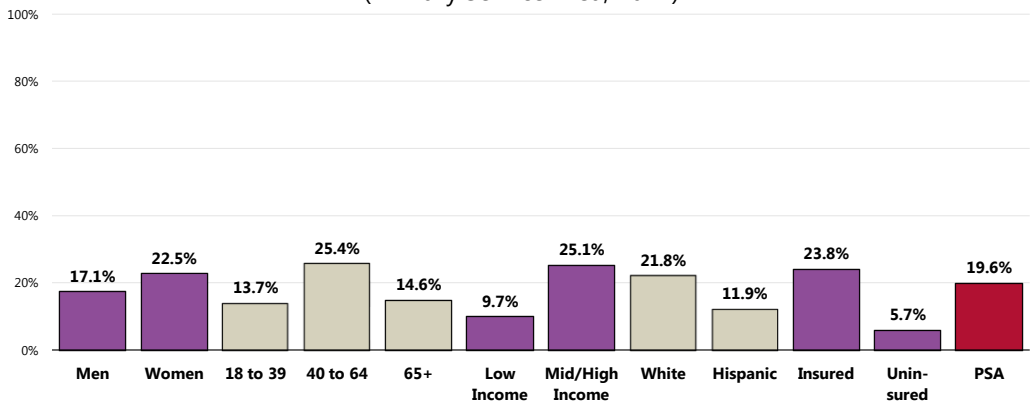
Notes:
- Asked of all respondents.

The following chart outlines participation by various demographic characteristics.

- Note that young adults, seniors, residents with lower incomes, Hispanics and the uninsured less often report participation in health promotion activities.

Participated in a Health Promotion Activity in the Past Year

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

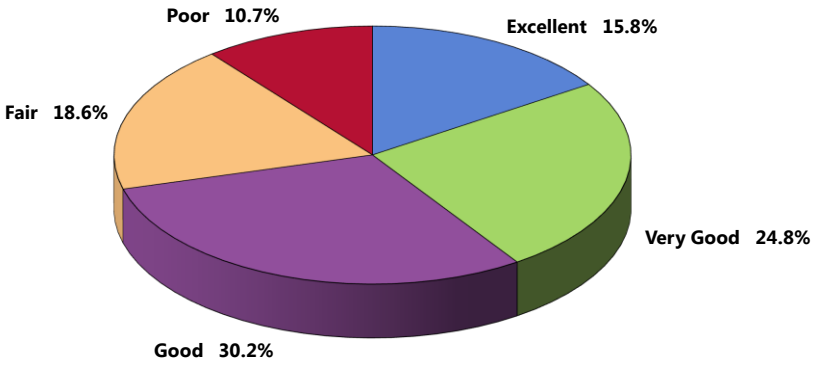
LOCAL HEALTHCARE

Perceptions of Local Healthcare Services

A total of 40.6% of Primary Service Area adults rate the overall healthcare services available in their community as "excellent" or "very good."

- Another 30.2% gave "good" ratings.

Rating of Overall Healthcare Services Available in the Community
(Primary Service Area, 2012)

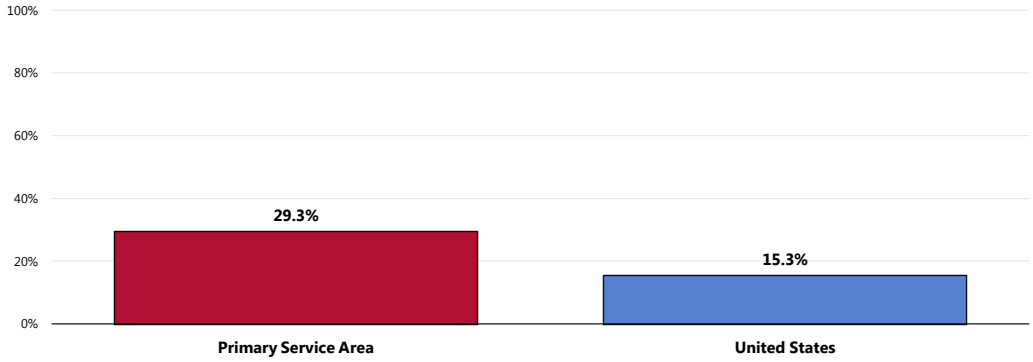


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 29.3% of residents characterize local healthcare services as "fair" or "poor."

- Nearly twice the national proportion.

Perceive Local Healthcare Services as "Fair/Poor"



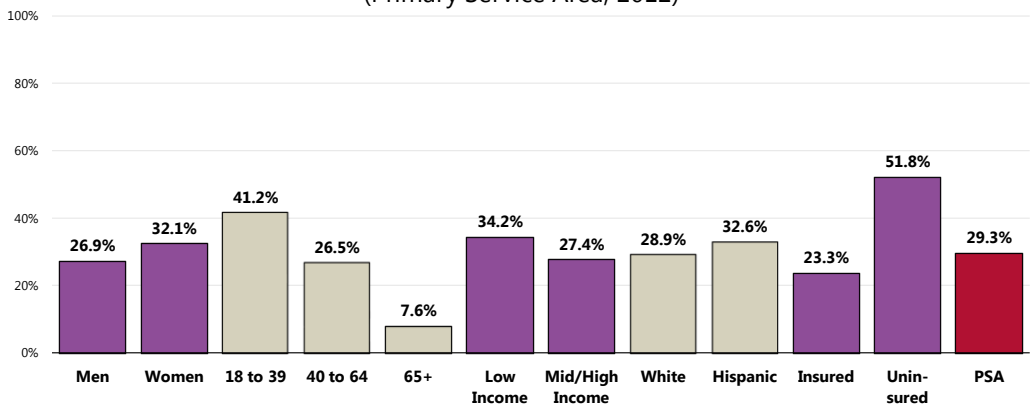
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

The following residents are more critical of local healthcare services:

- Young adults.
- Uninsured residents.

Perceive Local Healthcare Services as "Fair/Poor"

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

LIVING & WORKING CONDITIONS

Environmental Concerns

Are you aware of any exposure to the following health concerns in your current work or living conditions:

Mold?

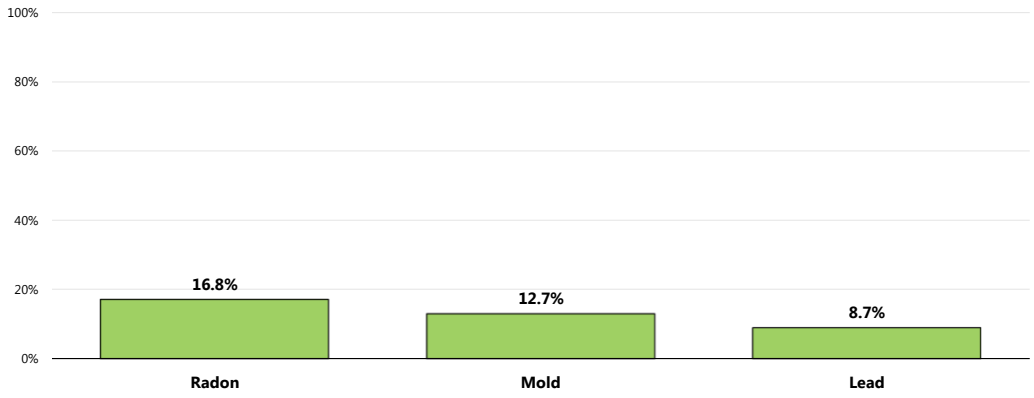
Lead?

Radon?

A total of 16.8% of Primary Service Area adults are aware of radon exposure they have had at work or in the home.

- A total of 12.7% have been exposed to mold (that they are aware of), and 8.7% are aware of lead exposure at home or work.

Aware of Exposure to Environmental Risks at Home or Work



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 123-125]
Notes: • Asked of all respondents.

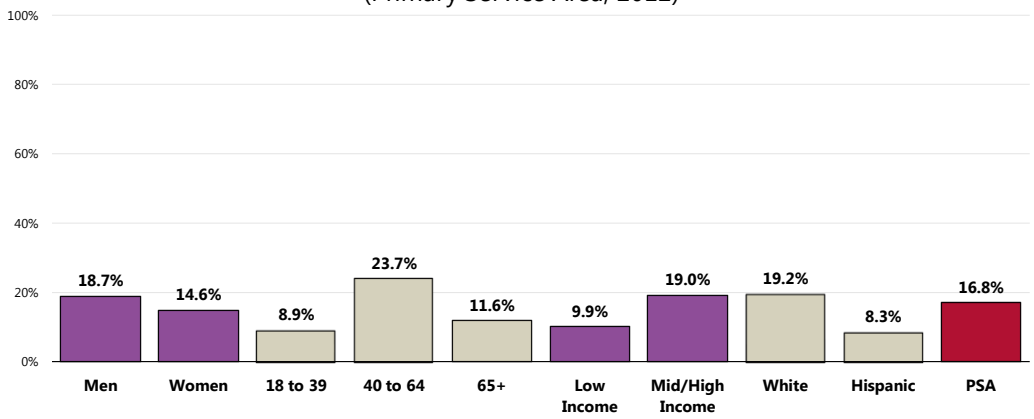
Radon Exposure

The following adults are more likely to be aware of exposure to **radon** at home or work:

- Adults aged 40 to 64.
- Higher-income residents.
- Non-Hispanic White respondents.

Aware of Exposure to Radon at Home or Work

(Primary Service Area, 2012)

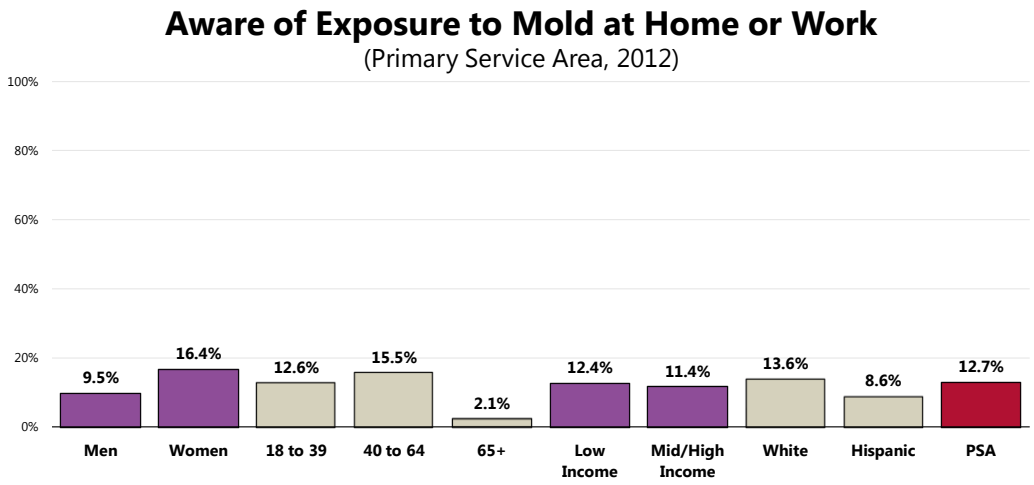


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]
Notes: • Asked of all respondents.
• Hispanics can be of any race (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mold Exposure

The following adults are more likely to be aware of exposure to **mold** at home or work:

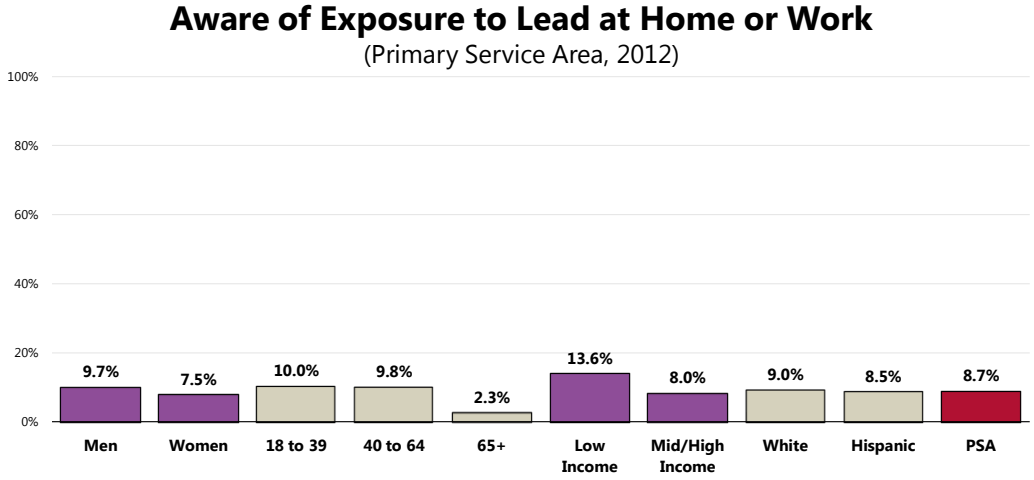
- Women.
- Residents under the age of 65.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
Notes: • Asked of all respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Lead Exposure

- Residents under the age of 65 are more likely to report awareness of exposure to **lead** at home or at work.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
Notes: • Asked of all respondents.
• Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Housing & Homelessness

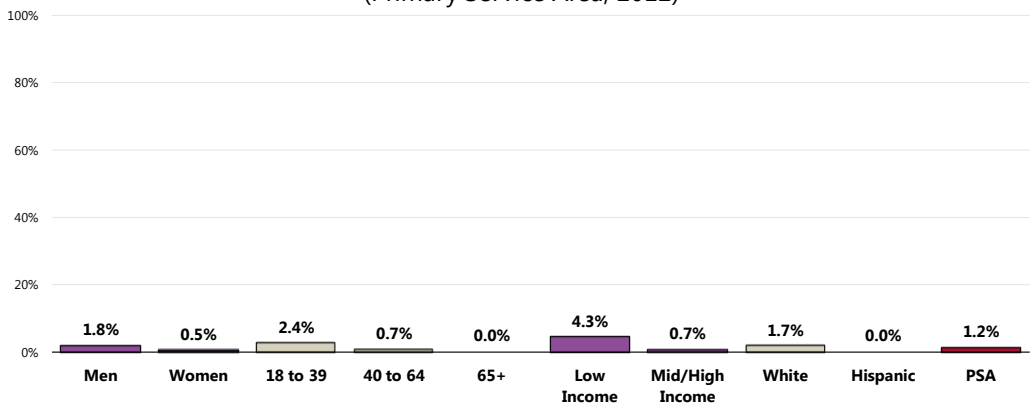
"Has there been any time in the past two years when you were living on the street, in a car, or in a temporary shelter?"

A total of 1.2% of survey respondents (currently housed) have lived on the street, in a car or in a temporary shelter within the past two years.

- Non-Hispanic White respondents and young adults are more likely to report experiencing recent homelessness.

Was Homeless at Some Point in the Past Two Years

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

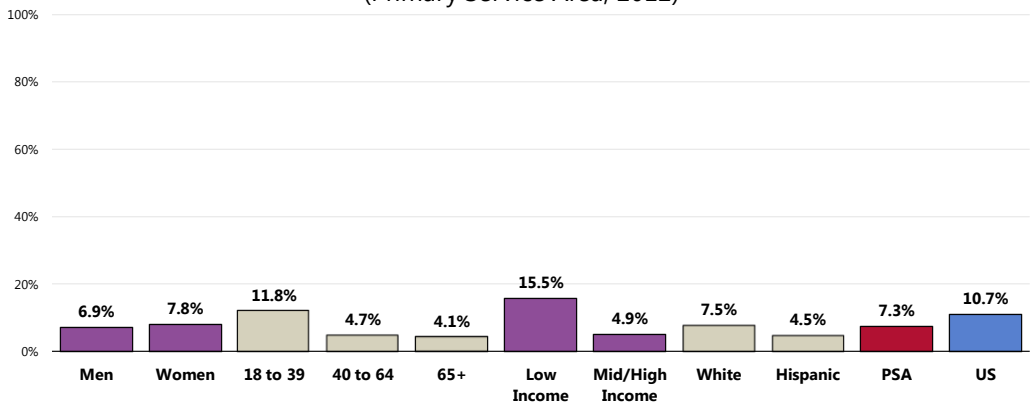
"Because of an emergency, have you had to live with a friend or relative in the past two years, even if this was only temporary?"

In the past two years, 7.3% of Primary Service Area adults lived with a friend or relative (even if only temporarily) because of an emergency.

- More favorable than the prevalence reported nationally.
- Highest among young adults and lower-income residents.

Lived With a Friend or Relative in the Past Two Years Due to a Housing Emergency

(Primary Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 126]
- 2008 PRC National Quality of Life Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Hispanics can be of any race (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. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Related Focus Group Findings: Housing & Homelessness

Focus group participants are concerned with the lack of affordable, quality housing available in the community. The main issues discussed surrounding housing included:

- Substandard Housing
  - Mold
  - Bed bugs
  - Cockroaches
  - Absentee landlords
- Homeless residents and families

Focus group participants believe there is a large amount of **substandard housing** that exists in the South Lake Tahoe community. Many of these homes were built decades ago and now are dilapidated. Local housing agencies report high levels of **mold** and a soaring prevalence of **bed bugs and cockroaches** in these homes. **Absentee landlords** only perpetuate the problems, but residents fear reporting issues because they do not want to lose their homes. One participant recalls her experience working with these families:

> *"I can't even begin to tell you the amount of phone calls I get because of bed bugs. Plus mold is everywhere in South Lake Tahoe. Believe it or not, it's there. Through doing inspections with the building inspector, we get to go inside our citizens' apartments and homes and when I've been there I have seen people just in general, they're sick." — Social Service Provider*

Participants also express concern for **homeless residents and families**. Currently no homeless shelter operates within South Lake Tahoe, which represents a major concern for those with chronic mental illness. Parents allow teenagers to "couch hop," but then no adult monitors their health. Additionally, many families may live together in one home or apartment to save money. Participants believe these families qualify as homeless. A participant explains further:

> *"I know the casinos contract a lot of the labor for the housekeeping, cleaning and stuff from even out of the country, and they bring them here. I think one of the requirements is that they have to have someone to live with. So they end up living two or three families in one home or one apartment, and by definition, you know, if there's two families in one home, one is homeless." — Healthcare Professional*

PROVIDER CONSIDERATIONS

Related Focus Group Findings: Elderly Residents

Many focus group participants discussed the limited number of services available to senior citizens. The main issues included:

- Availability of services or resources for seniors
  - Assisted living facilities
  - Transportation
  - Senior Center
  - Nutritious meals

According to focus group participants, the number of seniors in the community will continue to increase in the coming years and South Lake Tahoe represents an already-older community. Participants feel the community is ill-prepared for the aging baby-boomer generation. Only a **limited number of resources are available** to seniors. These include only one **assisted living facility**, attached to Barton Memorial Hospital, and costly in-home care. Many older residents will have to move out of the community for assisted living care. One member describes:

> *"We have so many folks who are living marginally. And when they become older adults and they're not quite ready to leave their home yet, and they don't qualify for a nursing home, and assisted living is so expensive … Even before we get to assisted living, we have nothing in place for folks who are in transition. It's the gray area folks." — Healthcare Professional*

Limited **transportation** options also hinder senior citizens' ability to access healthcare facilities and other social service agencies. Many seniors do not have family living in town, so they rely heavily on BlueGo for their transportation needs.

South Lake Tahoe does have a **senior center**, but participants worry about the availability of services because of funding cuts. The Meals-On-Wheels program no longer operates in the community, which previously provided meals to older residents. Participants have concerns that seniors may not have access to enough **nutritious meals**, even with the one meal provided through the senior center.

Related Focus Group Findings: Cultural Concerns

Many focus group participants discussed culture and its relationship to healthcare. The following issues were highlighted:

- Risk-taking culture
- Hispanic residents

The focus group participants feel South Lake Tahoe attracts individuals who prefer an active lifestyle, leaning toward a **risk-taking culture** that extends beyond extreme sports. Participants worry that these types of people may participate in illegal activities, drink in excess, and smoke. A participant describes:

> *"Because of our proximity to the gaming industry and all of the things that go along with that (smoking, alcoholism, drug use, that sort of thing), I think we're a community at a greater risk*

and have a population that participates regularly in those kinds of things." — Social Service Provider

Another participant continues:

"We have a population because of our sporting opportunities, there's also a risk-taker type of person that this attracts and those risks don't just extend to skiing fast. They extend to smoking and to marijuana use or drug use, and an attitude of, 'I can get by,' and, 'I won't get caught; I won't get harmed.'" — Healthcare Professional

Focus group members also believe the Latino culture impacts community health. Many **Hispanic residents** work in the hospitality industry and these Spanish-speaking residents face barriers when accessing care. These residents do not know where to go for care, or who to contact. Even calling to make an appointment can prove troublesome. Having someone who can interpret for a non-English speaker is critical both for the physician and the office staff. Participants believe wellness classes offered in Spanish would benefit these families as well.

Related Focus Group Findings: Collaboration

Participants spent time discussing the levels of collaboration occurring in the community between non-profit organizations, faith community, school, healthcare providers, and Barton Health. The three issues surrounding collaboration were:

- Impressions of excellence
- Barton Health
- Referral source list

Many of the focus group respondents feel that **excellent collaboration** occurs in the community between Barton Health, social service agencies, schools, healthcare providers and the faith community. Law enforcement also reports a great relationship with Barton Memorial Hospital, and this relationship allows law enforcement to operate with minimal intrusions. Overall, participants believe organizations know what others do and have a good protocol for not duplicating services. The community agencies work hard to operate "solution-oriented."

Barton Health helps to spearhead the collaborations and initiate the conversations. Currently several collaborative programs operate in the community. The Community Advisory Committee tries to get all of the players at one table from both public and private agencies, along with Lake Tahoe Basin Prosperity Plan and others. Informal interaction occurs regularly as well, as one participant describes:

"So if there is a training coming up or if there's new services with the dental van, the collaborative has their list of people that they get it to but then those people go take it out and it's that nice ripple effect. Then the faith community has been really instrumental, some of the ministers have no problem getting information and sharing that with their congregations on a Sunday." — Social Service Provider

Participants believe that coordinating efforts across different disciplines could be enhanced. For example, domestic violence and substance abuse programs would work well together. Participants also see a need for a **referral source list**, some type of system where agencies and residents can access information about the resources currently available. One participant explains the time-saving benefit of this list:

> *"We really need to put together so that when an individual with a disability, with mental illness, with whatever it may be, they get the right direction and they get help. I mean you wouldn't believe the number of calls I get. I have to refer them to somebody else and most of the time I have no idea who to refer them to."— Social Service Provider*

In addition, agencies need to train employees, so these leaders can step up in the future. This will ensure that South Lake Tahoe continues to have excellent programs and collaborations in place.