Executive Report

2015 Community Health Needs Assessment

Primary Service Area

Prepared for:
Barton Health

By:

Professional Research Consultants, Inc.
11326 P Street Omaha, NE 68136-2316
www.PRCCustomResearch.com

2014-2599-02
© March 2015

Professional Research Consultants, Inc.

Table of Contents

Death, Disease & Chronic Conditions   75

Introduction

Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2012, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Barton Health. 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 an Online Key Informant Survey.

PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Primary Service Area" in this report) is defined as each of the residential ZIP Codes comprising the service area, including 95721, 95735, 96142, 96150, 96151, 96155, 96156, 96158, 89413, 89448, and 89449. This community definition, determined based on the ZIP Codes of residence of recent patients of Barton Health, is illustrated in the following map.
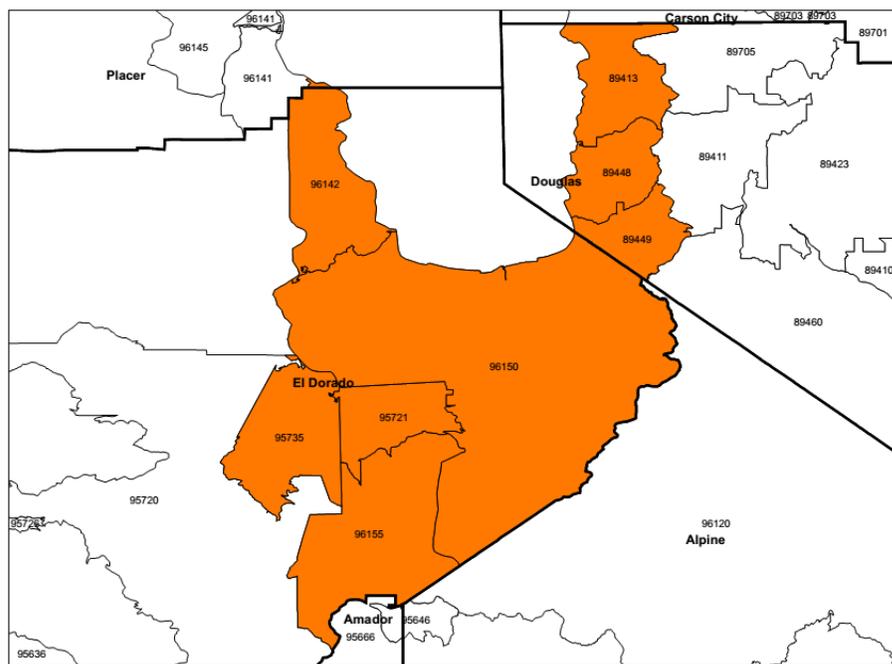
Sample Approach & Design

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).

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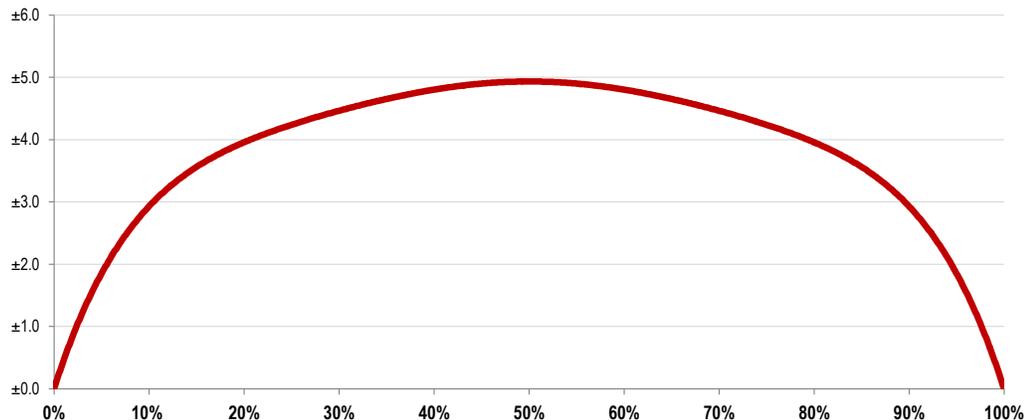
Note: • The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

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 chart outlines 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 & Survey Sample Characteristics
(Primary Service Area, 2015)
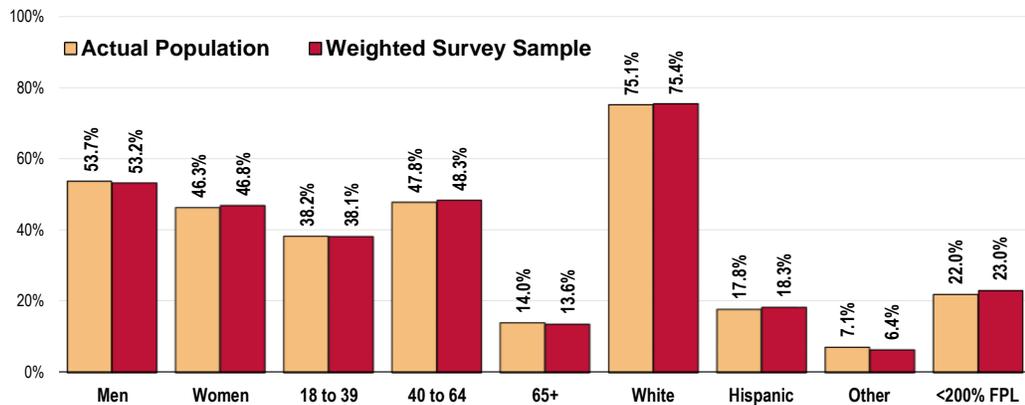
Sources: ● Census 2010, Summary File 3 (SF 3). US Census Bureau.
● 2015 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2014 guidelines place the poverty threshold for a family of four at $23,850 annual household income or lower)*. In sample segmentation: "**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.

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 44 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	**Number Invited**	**Number Participating**
Physician	16	1
Other Health Provider	19	5
Public Health Expert	7	5
Social Services Representative	21	15
Community Leader	35	17
Other/Unknown	3	1

Organizations represented in this Online Key Informant Survey are outlined in the following table.

Participating Organization	Populations Served		
	Low-Income Residents	Minority Populations	Medically Underserved
Alta California Regional Center	✓	✓	✓
Barton Hospital	✓	✓	✓
Boys and Girls Club	✓	✓	✓
Casa El Dorado County	✓	✓	✓
Choices For Children	✓	✓	✓
Christmas Cheer All Year Emergency Food Pantry	✓	✓	
Community Advocate	✓	✓	✓
County of El Dorado Probation Department	✓	✓	✓
El Dorado County Alcohol & Drug Programs Division	✓	✓	✓
El Dorado County Library	✓	✓	✓
El Dorado County Mental Health, South Lake Tahoe	✓	✓	✓
El Dorado County Office of Education	✓	✓	✓
Health and Human Services Agency	✓	✓	✓
Lake Tahoe South Shore Chamber of Commerce			
Lake Tahoe Unified School District	✓	✓	✓
Lakeside Inn and Casino			
Live Violence Free	✓	✓	✓
Mount Tallac High School	✓	✓	✓
National Alliance on Mental Illness SLT			✓
South Lake Tahoe Family Resource Center	✓	✓	✓
South Lake Tahoe Library	✓	✓	✓
South Tahoe Drug Free Coalition	✓	✓	
State of California, Department of Rehabilitation	✓	✓	✓
Tahoe Dream Foundation	✓	✓	✓
Tahoe Magic, First Five	✓	✓	✓
Tahoe Prosperity Center	✓	✓	✓
Tahoe Transportation District	✓	✓	✓
Tahoe Youth and Family Services	✓	✓	✓

Through this process, input was gathered from several individuals whose organizations work with **low-income**, **minority populations** (including abused persons, addicts, African-Americans, American Indians, Asians, Central Americans, the chronically ill, deaf/blind persons, the disabled, the elderly, families in the child dependency court system, Filipinos, people with geographic barriers without transportation, Hispanics, the homeless, homeless youth, residents with low socio-economic status, mentally ill persons, minors, pregnant youth, second-generation immigrants, second language learners, single mothers with multiple children, Spanish-speaking persons with severe mental health concerns, those with special education needs, undocumented immigrants, uneducated residents, uninsured/underinsured persons, women, young parents), or other **medically underserved populations** (including children, parents, children with mental health issues, children without access to dental care, disabled persons, the elderly, Hispanics, the homeless, homeless youth, lesbian/gay/bisexual/ transgender individuals, low-income residents, those with major dental issues, Medicaid/Medi-Cal recipients, medically involved children, the mentally ill [disabled, elderly, homeless, transitional age youth, uninsured/underinsured], pregnant youth, students needing glasses, teens with substance abuse issues, undocumented residents, uninsured/underinsured persons, veterans, young adults).

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

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

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)

- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data for El Dorado County (California) and Douglas County (Nevada).

Benchmark Data

Trending

A similar survey was administered in the Primary Service Area in 2012 by PRC on behalf of Barton Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

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

Healthy People 2020

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

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

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

Determining Significance

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

Information Gaps

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

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

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

IRS Form 990, Schedule H Compliance

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

IRS Form 990, Schedule H	See Report Page(s)
Part V Section B Line 1a *A definition of the community served by the hospital facility*	9
Part V Section B Line 1b *Demographics of the community*	37
Part V Section B Line 1c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	253
Part V Section B Line 1d *How data was obtained*	9
Part V Section B Line 1f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 1g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	19
Part V Section B Line 1h *The process for consulting with persons representing the community's interests*	12
Part V Section B Line 1i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	16

Summary of Findings

Significant Health Needs of the Community

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

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Specific Source for Healthcare
	• Barriers to Access
	  ○ Appointment Availability
	  ○ Finding a Physician
	• Primary Care Physician Ratio
	• Health Professional Shortage Area Designation

Cancer	• *Cancer is the #1 Leading Cause of Death in the Area* • Cancer Incidence ○ Including Lung Cancer, Prostate Cancer, Female Breast Cancer • Skin Cancer Prevalence
Dementia, Including Alzheimer's Disease	• Alzheimer's Disease Deaths
Heart Disease & Stroke	• *Heart Disease is the #2 Leading Cause of Death in the Area*
Infant Health	• Prenatal Care
Injury & Violence	• Unintentional Injury Deaths ○ Including Motor Vehicle Crash Deaths • Firearm-Related Deaths
Mental Health	• Suicide Deaths • Seeking Help for Mental Health • *Mental Health ranked #2 as a "major problem" in the Online Key Informant Survey*
Nutrition, Physical Activity & Weight	• Fruit/Vegetable Consumption • Low Food Access • Obesity • Medical Advice on Weight
Oral Health	• *Oral Health ranked #3 as a "major problem" in the Online Key Informant Survey*
Substance Abuse	• Cirrhosis/Liver Disease Deaths • Overall Alcohol Use • Excessive Drinking • Drinking & Driving • Drug-Induced Deaths • *Substance Abuse ranked #1 as a "major problem" in the Online Key Informant Survey*
Tobacco Use	• Chronic Lower Respiratory Disease (CLRD) Deaths • Use of Cigars • Use of Smokeless Tobacco

Prioritization of Health Needs

On April 17, 2015, roughly 20 members of the Barton Health Community Advisory Committee met to evaluate, discuss and prioritize health issues for the community, based on findings of the 2015 PRC Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. A hospital representative also provided guidance to the group, describing existing activities, initiatives, resources, etc., relating to the Areas of Opportunity. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
  - How many people are affected?
  - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
  - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. **Mental Health**

2. **Substance Abuse**

3. **Access to Healthcare**

4. **Heart Disease & Stroke**

5. **Oral Health**

6. **Infant Health**

7. **Injury & Violence**

8. **Nutrition, Physical Activity & Weight**

9. **Cancer**

10. **Tobacco Use**

11. **Dementias, Including Alzheimer's Disease**

While the hospital will likely not implement strategies for all of these health issues, the results of this prioritization exercise will be used to inform the development of Barton Health's Implementation Strategy to address the top health needs of the community in the coming years.

Summary Tables: Comparisons with Benchmark Data

The following tables provide an overview of indicators in the Primary Service Area, including trend data. 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 trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. 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.

TREND SUMMARY
(Current vs. Baseline Data)

Survey Data Indicators:
Trends for survey-derived indicators represent significant changes since 2012. Note that survey data reflect the ZIP Code-defined Primary Service Area.

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

Social Determinants	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
Linguistically Isolated Population (Percent)	2.2	☀ 10.3	☀ 7.3	☀ 4.9		
Population in Poverty (Percent)	8.4	☀ 15.3	☀ 14.2	☀ 14.9		
Population Below 200% FPL (Percent)	21.9	☀ 35.1	☀ 34.0	☀ 33.6		
Children Below 200% FPL (Percent)	10.6	☀ 21.3	☀ 20.3	☀ 20.8		
No High School Diploma (Age 25+, Percent)	7.0	☀ 19.0	☀ 15.6	☀ 14.3		
Unemployment Rate (Age 16+, Percent)	6.4	☀ 8.9	☁ 6.6	🌧 5.6		🌧 5.1
% Aware of Exposure to Mold	8.3					☀ 12.7
% Aware of Exposure to Radon	10.4					☀ 16.8
% Aware of Exposure to Lead	5.8					☁ 8.7
% Lived w/Friend or Relative Due to Housing Emergency	7.7					☁ 7.3
		☀ better	☁ similar	🌧 worse		

Overall Health	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% "Fair/Poor" Physical Health	12.3	☀ 18.9	☀ 17.3	☁ 15.3		☁ 13.6
% Activity Limitations	20.8	☁ 18.6	☁ 18.8	☁ 21.5		☁ 20.4
		☀ better	☁ similar	🌧 worse		

Access to Health Services	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% [Age 18-64] Lack Health Insurance	14.7	☀ 20.3	☀ 27.3	☁ 15.1	🌧 0.0	☀ 26.2
% [Insured] Went Without Coverage in Past Year	7.6			☁ 8.1		☁ 8.3
% Size of Insurance Deductible Prevented Care	11.2					
% Difficulty Accessing Healthcare in Past Year (Composite)	42.2			☁ 39.9		☁ 40.1
% Inconvenient Hrs Prevented Dr Visit in Past Year	9.2			☀ 15.4		☁ 10.6
% Cost Prevented Getting Prescription in Past Year	10.4			☀ 15.8		☀ 18.5
% Cost Prevented Physician Visit in Past Year	13.1			☀ 18.2		☀ 19.3
% Difficulty Getting Appointment in Past Year	25.7			🌧 17.0		🌧 16.4
% Difficulty Finding Physician in Past Year	20.1			🌧 11.0		🌧 10.6
% Transportation Hindered Dr Visit in Past Year	5.0			☀ 9.4		☀ 9.8
% Skipped Prescription Doses to Save Costs	13.0			☁ 15.3		☁ 15.4
% Difficulty Getting Child's Healthcare in Past Year	4.3			☁ 6.0		☁ 3.7
Primary Care Doctors per 100,000	69.8	🌧 84.0	☀ 63.3	🌧 85.8		☀ 59.4
% [Age 18+] Have a Specific Source of Ongoing Care	73.4			☁ 76.3	🌧 95.0	☁ 77.0
% [Age 18-64] Have a Specific Source of Ongoing Care	73.2			☁ 75.6	🌧 89.4	

Access to Health Services (continued)	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% [Age 65+] Have a Specific Source of Ongoing Care	81.9			⛅ 80.0	🌧️ 100.0	
% Have Had Routine Checkup in Past Year	64.7	⛅ 62.7	⛅ 65.7	⛅ 65.0		☀️ 54.3
% Child Has Had Checkup in Past Year	84.7			⛅ 84.1		⛅ 84.3
% Two or More ER Visits in Past Year	4.1			☀️ 8.9		☀️ 8.6
% Rate Local Healthcare "Fair/Poor"	15.6			⛅ 16.5		☀️ 29.3
Live in a Health Professional Shortage Area (Percent)	64.1	🌧️ 32.8	🌧️ 47.1	🌧️ 37.6		
			☀️ better	⛅ similar	🌧️ worse	

Arthritis, Osteoporosis & Chronic Back Conditions	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% [50+] Arthritis/Rheumatism	24.1			☀️ 37.3		⛅ 24.7
% [50+] Osteoporosis	9.2			⛅ 13.5	🌧️ 5.3	⛅ 10.9
% Sciatica/Chronic Back Pain	18.8			⛅ 18.4		⛅ 22.8
% Migraines/Severe Headaches	9.1			☀️ 18.2		⛅ 9.9
% Chronic Pain (Not Back/Neck)	13.0					
% [Parents of Children <7] Ever Refused Vaccine for Child	14.3					
			☀️ better	⛅ similar	🌧️ worse	

Cancer	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
Cancer (Age-Adjusted Death Rate)	144.1	(similar) 149.9	(better) 166.1	(better) 166.2	(better) 161.4	(better) 164.6
Lung Cancer (Age-Adjusted Death Rate)	33.3	(similar) 33.3	(better) 46.6	(better) 44.7	(better) 45.5	
Prostate Cancer (Age-Adjusted Death Rate)	18.3	(better) 19.8	(better) 21.0	(better) 19.8	(better) 21.8	
Female Breast Cancer (Age-Adjusted Death Rate)	19.9	(similar) 20.6	(better) 22.7	(better) 21.3	(similar) 20.7	
Colorectal Cancer (Age-Adjusted Death Rate)	11.4	(better) 13.6	(better) 17.0	(better) 14.9	(better) 14.5	
Prostate Cancer Incidence per 100,000	152.7	(worse) 122.9	(worse) 123.6	(worse) 123.6		
Female Breast Cancer Incidence per 100,000	130.6	(worse) 122.4		(worse) 122.7		
Lung Cancer Incidence per 100,000	53.2	(worse) 49.5		(better) 64.9		
Colorectal Cancer Incidence per 100,000	42.8	(similar) 41.5		(similar) 43.3		
% Skin Cancer	9.3	(worse) 5.1	(worse) 6.1	(similar) 6.7		(similar) 7.5
% Cancer (Other Than Skin)	5.1	(similar) 6.0	(similar) 6.3	(similar) 6.1		(similar) 7.3
% [Men 50+] Prostate Exam in Past 2 Years	76.6			(similar) 75.0		(similar) 74.8
% [Women 50-74] Mammogram in Past 2 Years	76.9	(similar) 81.8	(similar) 73.1	(similar) 83.6	(similar) 81.1	(similar) 74.7
% [Women 21-65] Pap Smear in Past 3 Years	86.5	(better) 78.3	(better) 72.6	(similar) 83.9	(worse) 93.0	(similar) 78.5
% [Age 50-75] Colorectal Cancer Screening	71.2			(similar) 75.1	(similar) 70.5	(similar) 73.3

Legend: (sun) better (cloud) similar (rain) worse

Chronic Kidney Disease	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
Kidney Disease (Age-Adjusted Death Rate)	5.8	☀️ 7.1	☀️ 14.8	☀️ 13.2		☀️ 6.7
			☀️ better	☁️ similar	🌧️ worse	

Diabetes	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
Diabetes Mellitus (Age-Adjusted Death Rate)	12.2	☀️ 20.7	☀️ 15.3	☀️ 21.3	☀️ 20.5	☀️ 13.1
% Diabetes/High Blood Sugar	5.7	☀️ 10.2	☀️ 9.6	☀️ 11.7		☁️ 5.3
% Borderline/Pre-Diabetes	6.5			☁️ 5.1		
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	47.3			☁️ 49.2		
			☀️ better	☁️ similar	🌧️ worse	

Dementias, Including Alzheimer's Disease	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
Alzheimer's Disease (Age-Adjusted Death Rate)	25.6	☀️ 30.2	🌧️ 16.5	🌧️ 24.0		🌧️ 20.4
			☀️ better	☁️ similar	🌧️ worse	

Educational & Community-Based Programs	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% Attended Health Event in Past Year	25.2			☁️ 23.8		☁️ 19.6
			☀️ better	☁️ similar	🌧️ worse	

Family Planning	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
Teen Births per 1,000 (Age 15-19)	17.0	☀ 34.2	☀ 43.6	☀ 36.6		
		☀ better	☁ similar	🌧 worse		

Hearing & Other Sensory or Communication Disorders	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% Deafness/Trouble Hearing	7.7			☁ 10.3		☀ 11.9
		☀ better	☁ similar	🌧 worse		

Heart Disease & Stroke	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	139.2	☀ 154.7	☀ 194.6	☀ 171.3	☀ 156.9	☀ 174.8
Stroke (Age-Adjusted Death Rate)	25.8	☀ 35.6	☀ 34.5	☀ 37.0	☀ 34.8	☀ 38.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	4.5			☁ 6.1		☁ 3.6
% Stroke	1.7	☁ 2.2	☁ 2.9	☀ 3.9		☁ 1.1
% Blood Pressure Checked in Past 2 Years	91.8			☁ 91.0	☁ 92.6	☁ 91.1
% Told Have High Blood Pressure (Ever)	29.8	☁ 28.7	☁ 30.6	☁ 34.1	☁ 26.9	☁ 30.2
% [HBP] Taking Action to Control High Blood Pressure	92.4			☁ 89.2		☁ 91.1
% Cholesterol Checked in Past 5 Years	86.7	☀ 75.2	☀ 74.0	☁ 86.6	☀ 82.1	☁ 84.0

Heart Disease & Stroke (continued)	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% Told Have High Cholesterol (Ever)	31.1	☀ 37.7	☀ 38.6	☁ 29.9	🌧 13.5	☁ 30.6
% [HBC] Taking Action to Control High Blood Cholesterol	93.1			☀ 81.4		☁ 87.4
% 1+ Cardiovascular Risk Factor	73.4			☀ 82.3		☁ 77.6
		☀ better	☁ similar	🌧 worse		

HIV	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
HIV/AIDS (Age-Adjusted Death Rate)	1.2	☀ 2.6	☀ 2.8	☀ 3.2	☀ 3.3	
HIV Prevalence per 100,000	89.3	☀ 363.0	☀ 310.0	☀ 340.4		
% [Age 18-44] HIV Test in the Past Year	26.8			☁ 19.3		☀ 13.3
		☀ better	☁ similar	🌧 worse		

Immunization & Infectious Diseases	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% [Parents] Would Want All Vaccinations for a Newborn	75.1					
% [Age 65+] Flu Vaccine in Past Year	55.9	☁ 62.5	☁ 51.6	☁ 57.5	🌧 90.0	☁ 54.8
% [High-Risk 18-64] Flu Vaccine in Past Year	36.0			☁ 45.9	🌧 90.0	☁ 44.9
% [Age 65+] Pneumonia Vaccine Ever	63.7	☁ 64.5	☁ 66.8	☁ 68.4	🌧 90.0	☁ 60.6

Immunization & Infectious Diseases (continued)	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% [High-Risk 18-64] Pneumonia Vaccine Ever	36.7			☁️ 41.9	🌧️ 60.0	☁️ 36.2
% Have Completed Hepatitis B Vaccination Series	47.0			☁️ 44.7		☀️ 39.8
		☀️ better	☁️ similar	🌧️ worse		

Injury & Violence Prevention	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
Unintentional Injury (Age-Adjusted Death Rate)	44.0	🌧️ 28.5	☁️ 42.4	🌧️ 39.2	🌧️ 36.4	☁️ 43.1
Motor Vehicle Crashes (Age-Adjusted Death Rate)	12.0	🌧️ 7.9	🌧️ 9.7	🌧️ 10.7	☁️ 12.4	☀️ 17.1
% "Always" Wear Seat Belt	92.9			☀️ 84.8	☁️ 92.0	☁️ 91.2
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	98.0			☀️ 92.2		☁️ 96.7
% Child [Age 5-17] "Always" Wears Bicycle Helmet	66.1			☀️ 48.7		☁️ 55.7
Firearm-Related Deaths (Age-Adjusted Death Rate)	10.5	🌧️ 7.8	☀️ 13.4	☁️ 10.4	🌧️ 9.3	☀️ 11.8
% Firearm in Home	32.1			☁️ 34.7		☁️ 27.8
% [Homes With Children] Firearm in Home	30.6			☁️ 37.4		☁️ 19.6
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	18.4			☁️ 16.8		☁️ 18.6
Homicide (Age-Adjusted Death Rate)	2.8	☀️ 5.9	☀️ 6.3	☀️ 5.7	☀️ 5.5	
Violent Crime per 100,000	218.4	☀️ 423.0	☀️ 607.5	☀️ 386.8		

Injury & Violence Prevention (continued)	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% Victim of Violent Crime in Past 5 Years	3.2			☁ 2.8		☁ 2.2
% Victim of Domestic Violence (Ever)	12.5			☁ 15.0		☀ 19.4
			☀ better	☁ similar	☂ worse	

Maternal, Infant & Child Health	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
No Prenatal Care in First Trimester (Percent)	21.7	☂ 18.1	☂ 7.1	☂ 17.3	☁ 22.1	
Low Birthweight Births (Percent)	6.7	☁ 6.8	☀ 8.2	☀ 8.2	☀ 7.8	
Infant Death Rate	2.8	☀ 4.6	☀ 5.2	☀ 6.0	☀ 6.0	☀ 3.8
			☀ better	☁ similar	☂ worse	

Mental Health & Mental Disorders	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% "Fair/Poor" Mental Health	10.3			☁ 11.9		☁ 8.0
% Diagnosed Depression	15.9			☀ 20.4		
% Symptoms of Chronic Depression (2+ Years)	31.4			☁ 30.4		☁ 29.5
Suicide (Age-Adjusted Death Rate)	16.0	☂ 10.2	☀ 18.4	☂ 12.5	☂ 10.2	☂ 14.6
% [Those With Diagnosed Depression] Seeking Help	77.5			☁ 76.6		

Mental Health & Mental Disorders (continued)	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% Typical Day Is "Extremely/Very" Stressful	8.1			☀ 11.9		☁ 9.7
% Emotionally Abused on a Regular Basis (Ever)	17.0					
% Dr Has Discussed Mental Health Issues	24.2					
% Difficulty Getting Mental Health Services in the Past Year	4.8					
% Child [Age 5-17] Takes Prescription for ADD/ADHD	10.2			☁ 11.3		☁ 4.5
		☀ better	☁ similar	🌧 worse		

Nutrition & Weight Status	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% Eat 5+ Servings of Fruit or Vegetables per Day	40.4			☁ 39.5		🌧 53.6
% "Very/Somewhat" Difficult to Buy Fresh Produce	18.4			☀ 24.4		
Population With Low Food Access (Percent)	32.6	🌧 14.3	🌧 22.3	🌧 23.6		
% Medical Advice on Nutrition in Past Year	39.6			☁ 39.2		☁ 36.5
% Healthy Weight (BMI 18.5-24.9)	41.5	☁ 37.9	☀ 33.4	☀ 34.4	☀ 33.9	☁ 44.8
% Overweight (BMI 25+)	55.2	☁ 60.1	☀ 64.8	☀ 63.1		☁ 53.0
% Obese (BMI 30+)	23.2	☁ 24.1	☁ 26.2	☀ 29.0	☀ 30.5	🌧 15.2
% Medical Advice on Weight in Past Year	21.0			☁ 23.7		☁ 18.1

Nutrition & Weight Status (continued)	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% [Overweights] Counseled About Weight in Past Year	29.7			☁ 31.8		
% [Obese Adults] Counseled About Weight in Past Year	35.0			🌧 48.3		
% [Overweights] Trying to Lose Weight Both Diet/Exercise	40.6			☁ 39.5		☀ 22.6
% Child [Age 5-17] Healthy Weight	72.0			☀ 56.7		
% Children [Age 5-17] Overweight (85th Percentile)	13.4			☀ 31.5		☀ 34.6
% Children [Age 5-17] Obese (95th Percentile)	5.5			☀ 14.8	☀ 14.5	☀ 20.4
		☀ better	☁ similar	🌧 worse		

Oral Health	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% [Age 18+] Dental Visit in Past Year	75.6	☀ 67.0	☀ 60.8	☀ 65.9	☀ 49.0	☀ 62.8
% Child [Age 2-17] Dental Visit in Past Year	90.5			☀ 81.5	☀ 49.0	☁ 81.3
% Have Dental Insurance	66.1			☁ 65.6		☀ 54.5
% Avoided Dental Care/Past Year Due to Insurance	23.6					
		☀ better	☁ similar	🌧 worse		

Physical Activity	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
% No Leisure-Time Physical Activity	13.8	☀ 21.4	☀ 23.7	☀ 20.7	☀ 32.6	☁ 13.8
% Meeting Physical Activity Guidelines	61.4			☀ 50.3		☁ 58.6
% Moderate Physical Activity	41.9			☀ 30.6		
% Vigorous Physical Activity	42.7			☁ 38.0		
Recreation/Fitness Facilities per 100,000	11.4	☀ 8.7	☀ 7.2	☀ 9.4		
% Medical Advice on Physical Activity in Past Year	44.1			☁ 44.0		☁ 40.0
% Child [Age 2-17] Physically Active 1+ Hours per Day	41.9			☁ 48.6		
% Child [Age 5-17] Watches TV 3+ Hours per Day	19.6					
% Child [Age 5-17] Uses Computer 3+ Hours per Day	16.2					
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time	48.1			☁ 54.7		☁ 39.2

☀	☁	🌧
better	similar	worse

Respiratory Diseases	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
CLRD (Age-Adjusted Death Rate)	39.4	⛈️ 35.5	☀️ 52.0	☀️ 42.0		☀️ 43.5
Pneumonia/Influenza (Age-Adjusted Death Rate)	12.3	☀️ 16.1	☀️ 19.1	☀️ 15.3		☀️ 17.3
% COPD (Lung Disease)	5.5	☁️ 4.6	☁️ 6.7	☀️ 8.6		☁️ 7.6
% [Adult] Currently Has Asthma	5.4	☀️ 8.8	☁️ 7.6	☀️ 9.4		☁️ 6.3
% [Child 0-17] Currently Has Asthma	4.6			☁️ 7.1		☁️ 3.2
		☀️ better	☁️ similar	⛈️ worse		

Sexually Transmitted Diseases	Primary Service Area	Primary Service Area vs. Benchmarks				TREND
		vs. CA	vs. NV	vs. US	vs. HP2020	
Gonorrhea Incidence per 100,000	12.7	☀️ 89.1	☀️ 83.1	☀️ 107.5		
Chlamydia Incidence per 100,000	165.5	☀️ 444.9	☀️ 409.0	☀️ 452.2		
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	13.1			☁️ 11.7		☁️ 12.5
% [Unmarried 18-64] Using Condoms	39.2			☁️ 33.6		☁️ 37.3
		☀️ better	☁️ similar	⛈️ worse		

Substance Abuse	Primary Service Area	vs. CA	vs. NV	vs. US	vs. HP2020	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	13.8	worse 11.7	worse 12.2	worse 9.9	worse 8.2	worse 11.8
% Current Drinker	69.7	worse 55.5	worse 54.1	worse 56.5		similar 69.4
% Heavy Drinkers (2+ Daily Drinks for Men/1+ Daily Drink for Women)	17.5					similar 22.3
% Excessive Drinker (Heavy or Binge Drinking)	33.5			worse 23.2		similar 35.2
% Drinking & Driving in Past Month	7.1			similar 5.0		worse 2.1
Drug-Induced Deaths (Age-Adjusted Death Rate)	18.4	worse 11.4	better 21.9	worse 14.1	worse 11.3	worse 14.2
% Illicit Drug Use in Past Month	5.7			similar 4.0	similar 7.1	similar 6.7
% Ever Sought Help for Alcohol or Drug Problem	5.0			similar 4.9		similar 8.1

better (sun) · similar (cloud) · worse (rain)

Tobacco Use	Primary Service Area	vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% Current Smoker	13.9	similar 12.5	better 19.4	similar 14.9	similar 12.0	similar 18.2
% Someone Smokes at Home	7.0			better 12.7		better 12.8
% [Non-Smokers] Someone Smokes in the Home	2.2			better 6.3		
% [Household With Children] Someone Smokes in the Home	3.4			better 9.7		similar 6.6
% [Smokers] Received Advice to Quit Smoking	54.9			similar 67.8		similar 62.2

Tobacco Use (continued)	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% Smoke Cigars	3.5			☁ 4.1	🌧 0.2	☁ 4.8
% Use Smokeless Tobacco	2.2			☀ 4.0	🌧 0.3	☁ 3.9
		☀ better	☁ similar	🌧 worse		

Vision	Primary Service Area	Primary Service Area vs. Benchmarks				
		vs. CA	vs. NV	vs. US	vs. HP2020	TREND
% Blindness/Trouble Seeing	6.3			☁ 8.5		☁ 5.5
% Eye Exam in Past 2 Years	55.5			☁ 56.8		☁ 50.9
		☀ better	☁ similar	🌧 worse		

Community Description

Population Characteristics

Total Population

The Primary Service Area, the focus of this Community Health Needs Assessment, encompasses approximately 2,417 square miles and houses a total population of 227,497 residents, according to latest census estimates.

The population incorporates both El Dorado County (in California) and Douglas County (in Nevada).

Total Population
(Estimated Population, 2008-2012)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
El Dorado County, CA	**180,441**	**1,707.46**	**105.68**
Douglas County, NV	**47,056**	**709.53**	**66.32**
Primary Service Area	**227,497**	**2,416.99**	**94.12**
California	37,325,068	155,738.02	239.67
Nevada	2,704,204	109,752.21	24.64
United States	309,138,709	3,530,997.6	87.55

Sources: ● US Census Bureau American Community Survey 5-year estimates (2008-2012).
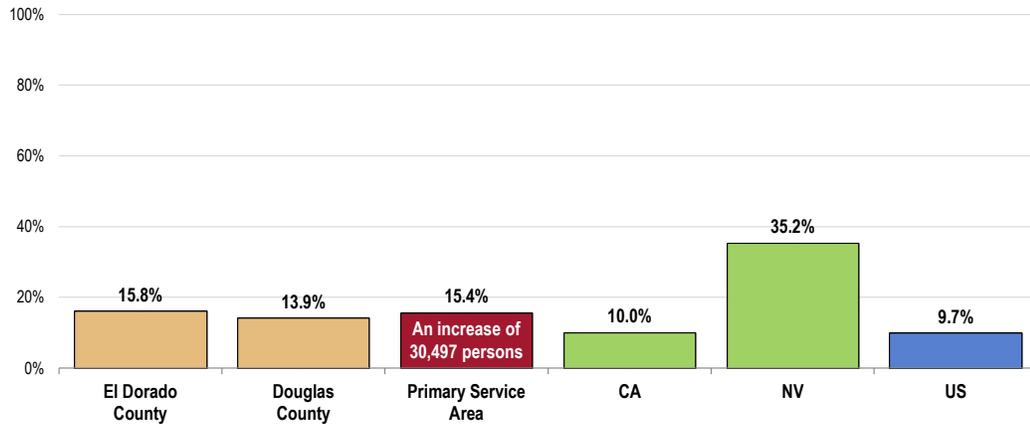　　　　 ● Retrieved March 2015 from Community Commons at http://www.chna.org.

Population Change 2000-2010

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

Between the 2000 and 2010 US Censuses, the population of the Primary Service Area increased by 30,497 persons, or 15.4%.

- A greater proportional increase than seen across California but much lower than the Nevada increase.
- A greater proportional increase than seen nationwide.
- The proportional increase is higher in El Dorado County.

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

|					
El Dorado County	Douglas County	Primary Service Area	CA	NV	US
15.8%	13.9%	15.4% (An increase of 30,497 persons)	10.0%	35.2%	9.7%

Sources: ● Retrieved March 2015 from Community Commons at http://www.chna.org.
● US Census Bureau Decennial Census (2000-2010).
Notes: ● A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Note that the Primary Service Area experienced larger increases in population over the past decade on both the east and west sides of the region.

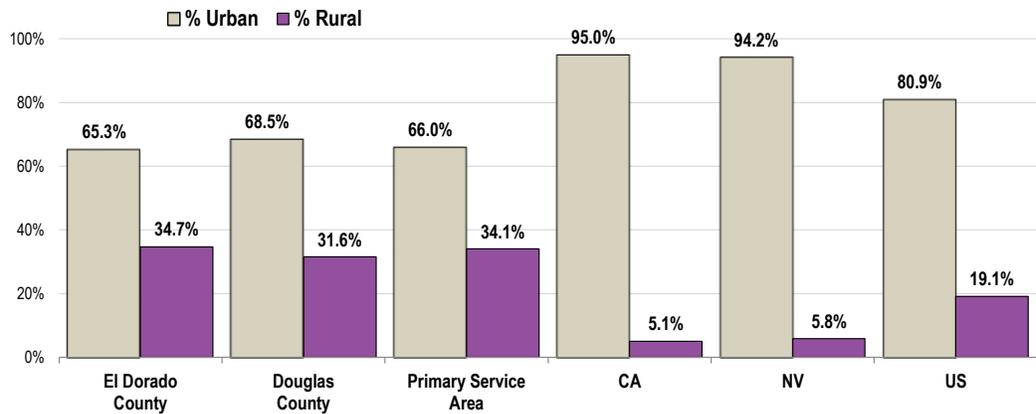## Population Change, Percent by Tract, US Census 2000-2010
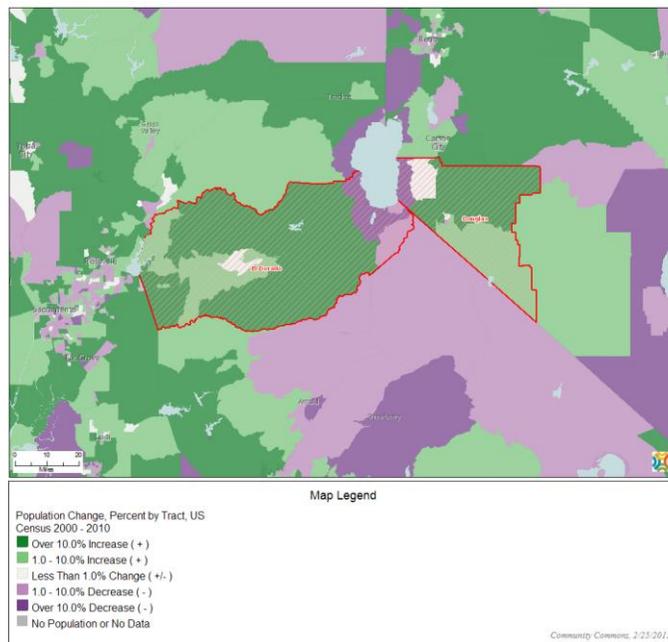
Urban/Rural Population

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

The Primary Service Area is two-thirds urban, with 66.0% of the population living in areas designated as urban.

- Note that a much higher proportion of the state and national populations live in urban areas.

Urban and Rural Population
(2010)

☐ % Urban ☐ % Rural

	El Dorado County	Douglas County	Primary Service Area	CA	NV	US
% Urban	65.3%	68.5%	66.0%	95.0%	94.2%	80.9%
% Rural	34.7%	31.6%	34.1%	5.1%	5.8%	19.1%

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

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

Note the following map outlining the urban population in the Primary Service Area census tracts as of 2010.
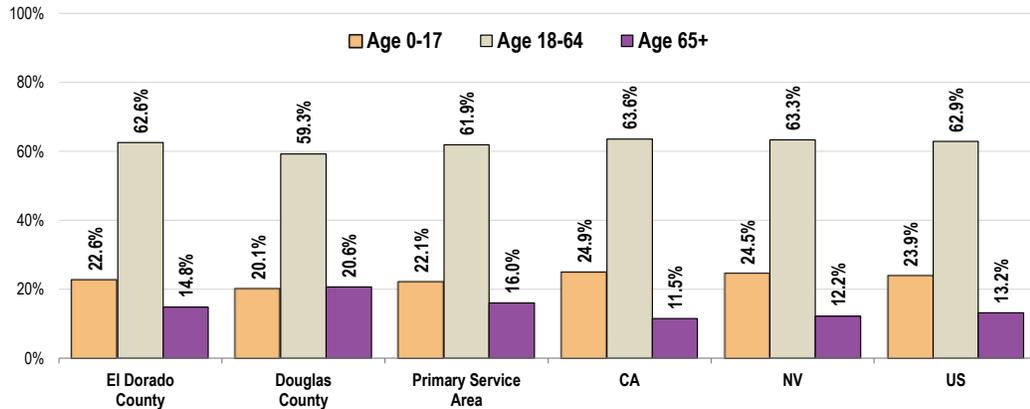
Urban Population, Percent by Tract, US Census 2010
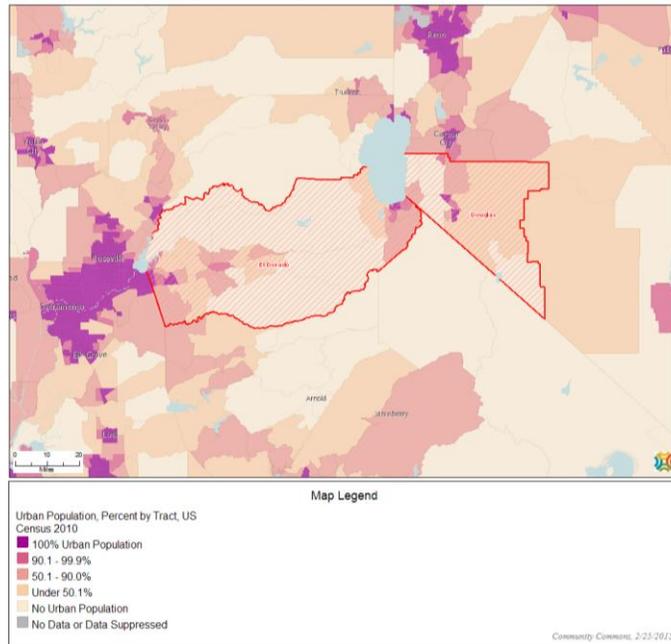
Age

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

In the Primary Service Area, 22.1% of the population are infants, children or adolescents (age 0-17); another 61.9% are age 18 to 64, while 16.0% are age 65 and older.

- The percentage of older adults (65+) is higher than those found statewide.
- The percentage of older adults (65+) is higher than the US figure.
- El Dorado County is "younger" than Douglas County.

Total Population by Age Groups, Percent
(2008-2012)

Bar chart legend: Age 0-17, Age 18-64, Age 65+

	Age 0-17	Age 18-64	Age 65+
El Dorado County	22.6%	62.6%	14.8%
Douglas County	20.1%	59.3%	20.6%
Primary Service Area	22.1%	61.9%	16.0%
CA	24.9%	63.6%	11.5%
NV	24.5%	63.3%	12.2%
US	23.9%	62.9%	13.2%

Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
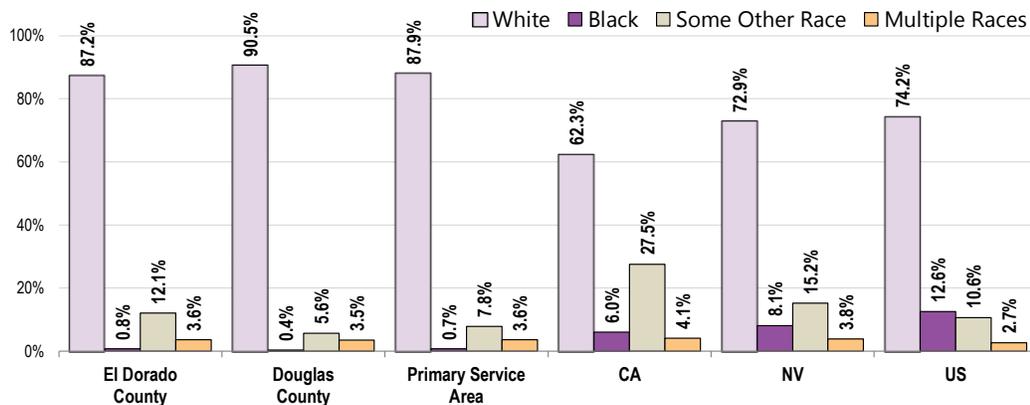- Retrieved March 2015 from Community Commons at http://www.chna.org.

Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 87.9% of residents of the Primary Service Area are White and 0.7% are Black.

- This is a much higher White population than found statewide or nationally.
- Douglas County has a higher White proportion than El Dorado County, while El Dorado County has a higher proportion of "other race" residents.

Total Population by Race Alone, Percent
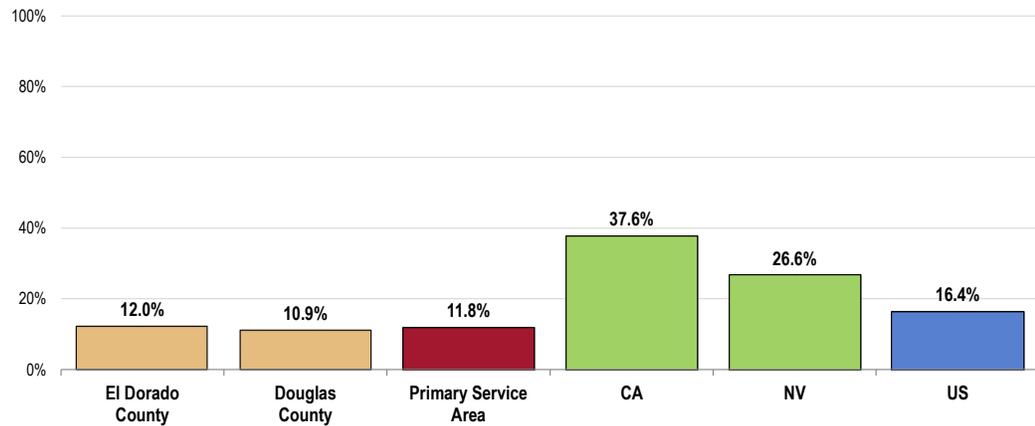### (2008-2012)

Bar chart legend: White, Black, Some Other Race, Multiple Races

	White	Black	Some Other Race	Multiple Races
El Dorado County	87.2%	0.8%	12.1%	3.6%
Douglas County	90.5%	0.4%	5.6%	3.5%
Primary Service Area	87.9%	0.7%	7.8%	3.6%
CA	62.3%	6.0%	27.5%	4.1%
NV	72.9%	8.1%	15.2%	3.8%
US	74.2%	12.6%	10.6%	2.7%

Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved March 2015 from Community Commons at http://www.chna.org.

Ethnicity

A total of 11.8% of Primary Service Area residents are Hispanic or Latino.

- Much lower than found in California and Nevada.
- Lower than found nationally.
- Comparable findings by county.

Percent Population Hispanic or Latino
(2008-2012)

Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved March 2015 from Community Commons at http://www.chna.org.

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

- The Hispanic population appears to be most concentrated on the eastern and western sides of the service area.

**Population Hispanic or Latino, Percent by Tract, ACS 2008-2012**
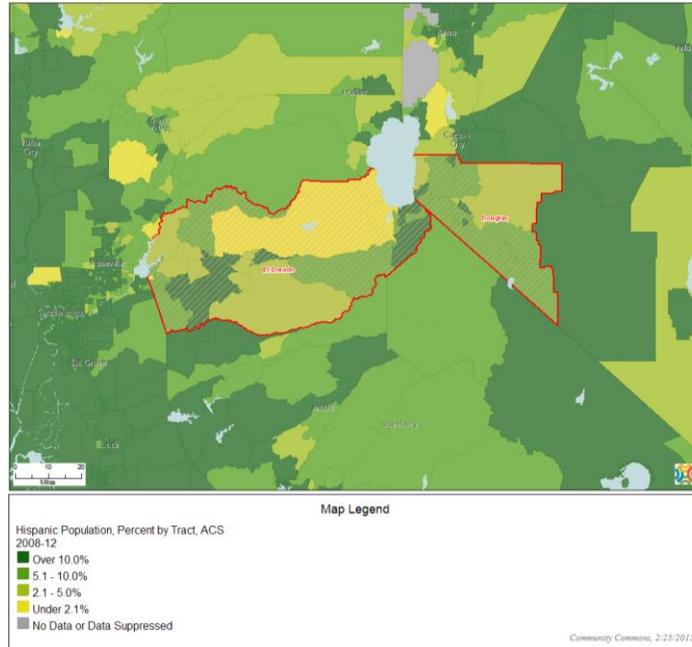
Between 2000 and 2010, the Hispanic population in the Primary Service Area increased by 9,355, or 53.1%.

- Higher (in terms of percentage growth) than found in California but lower than the Nevada percentage.
- Higher (in terms of percentage growth) than found nationally.
- The increase is higher in Douglas County than in El Dorado County.

Hispanic Population Change
### (Percentage Change in Hispanic Population Between 2000 and 2010)
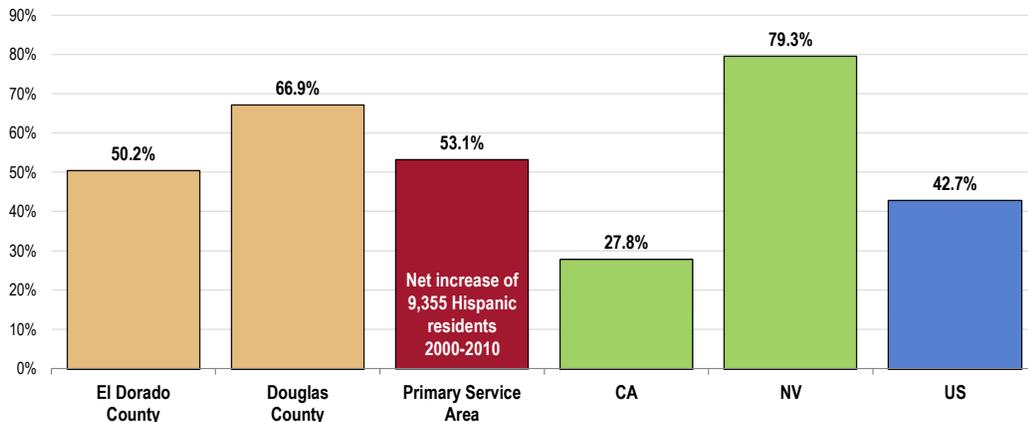
Sources:
- US Census Bureau Decennial Census (2000-2010).
- Retrieved March 2015 from Community Commons at http://www.chna.org.

Linguistic Isolation

A total of 2.2% of the Primary Service Area population age 5 and older live in a home in which <u>no</u> persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

- Much lower than found statewide.
- Lower than found nationally.
- The population is higher in El Dorado County.

Linguistically Isolated Population
(2008-2012)
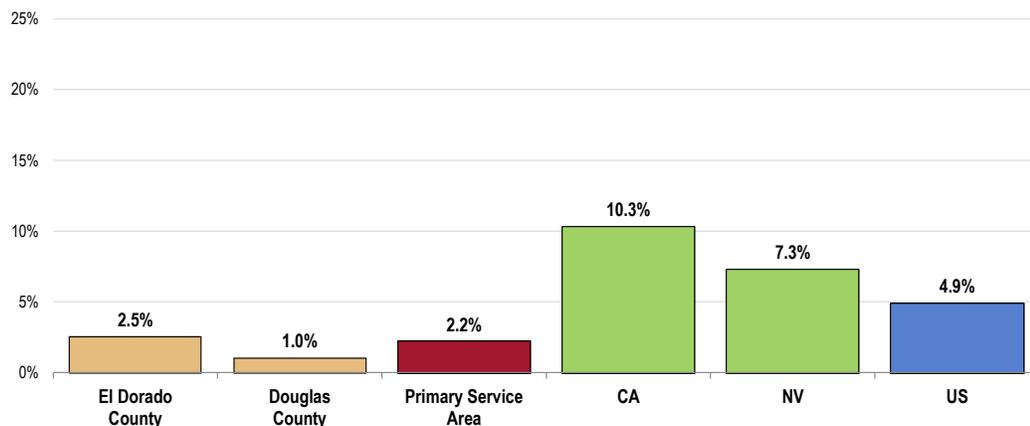
El Dorado County	Douglas County	Primary Service Area	CA	NV	US
2.5%	1.0%	2.2%	10.3%	7.3%	4.9%

Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved March 2015 from Community Commons at http://www.chna.org.

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

- Note the following map illustrating linguistic isolation in the Primary Service Area.

Population in Linguistically Isolated Households, Percent by Tract, ACS 2007-2011
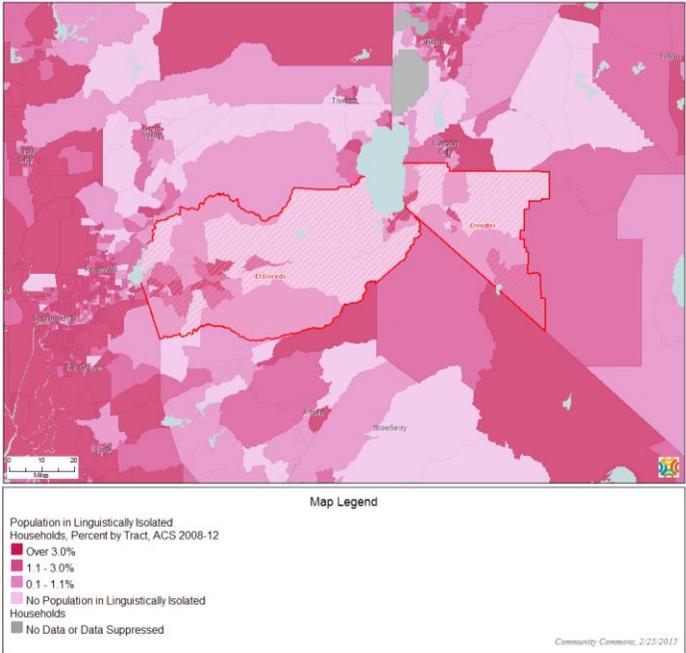
Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.
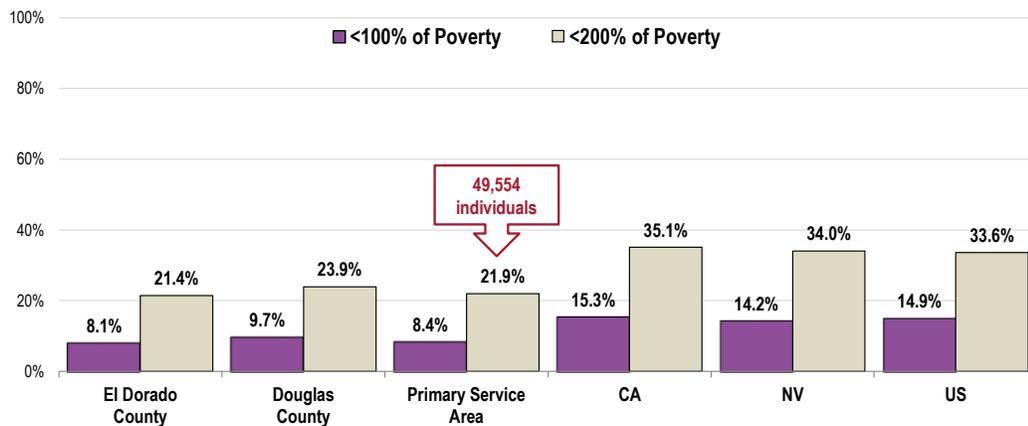
- Healthy People 2020 (www.healthypeople.gov)

Poverty

The latest census estimate shows 8.4% of the Primary Service Area population living below the federal poverty level.

In all, 21.9% of Primary Service Area residents (an estimated 49,554 individuals) live below 200% of the federal poverty level.

- Lower than the proportions reported statewide.
- Lower than found nationally.

Population in Poverty
(Populations Living Below 100% and Below 200% of the Poverty Level; 2008-2012)

Bar chart legend: ■ <100% of Poverty   □ <200% of Poverty

	<100% of Poverty	<200% of Poverty
El Dorado County	8.1%	21.4%
Douglas County	9.7%	23.9%
Primary Service Area	8.4%	21.9% (49,554 individuals)
CA	15.3%	35.1%
NV	14.2%	34.0%
US	14.9%	33.6%

Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved March 2015 from Community Commons at http://www.chna.org.

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

- The following charts provide a visual breakout of the poverty distribution in the Primary Service Area.

Population Below the Poverty Level, Percent by Tract, ACS 2008-2012
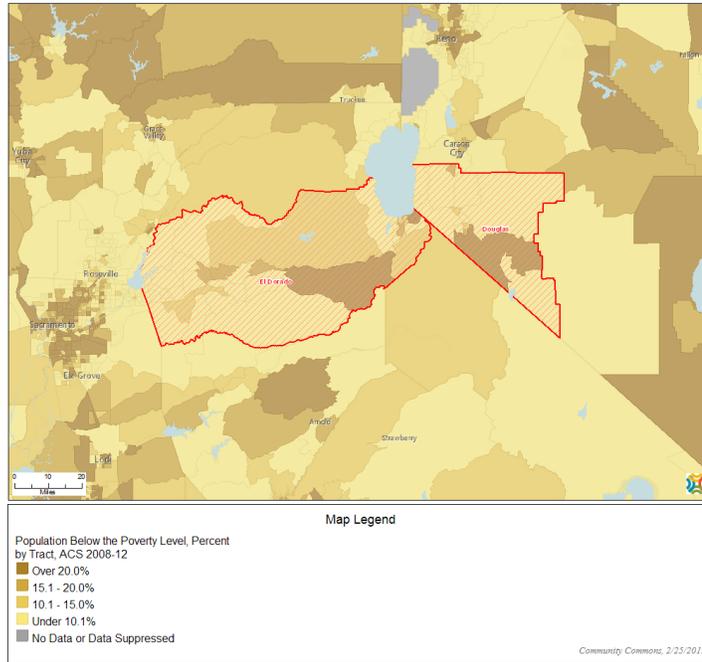
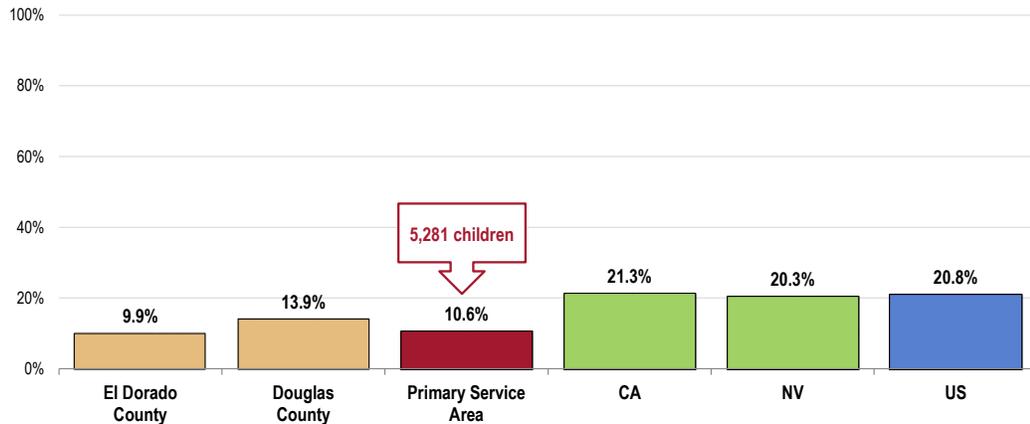**Population Below 200% of Poverty, Percent by Tract, ACS 2008-2012**
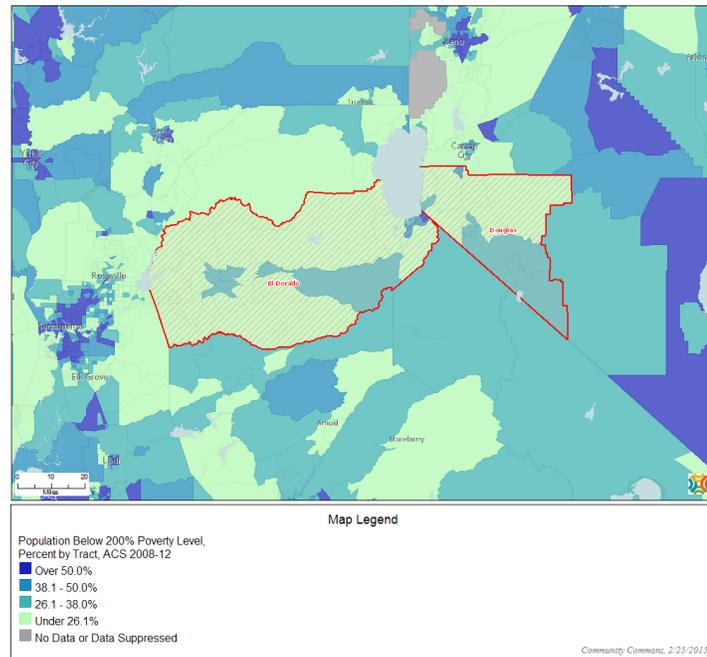
Children in Low-Income Households

Additionally, 10.6% of Primary Service Area children age 0-17 (representing an estimated 5,281 children) live below the 200% poverty threshold.

- Below the proportions found statewide.
- Below the proportion found nationally.
- Higher in Douglas County.

Percent of Children in Low-Income Households
(Children 0-17 Living Below 200% of the Poverty Level, 2008-2012)

[Bar chart showing:]
- El Dorado County: 9.9%
- Douglas County: 13.9%
- Primary Service Area: 10.6% (5,281 children)
- CA: 21.3%
- NV: 20.3%
- US: 20.8%

Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved March 2015 from Community Commons at http://www.chna.org.

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

- Geographically, a notably higher concentration of children in lower-income households is found in the central region of the Primary Service Area.

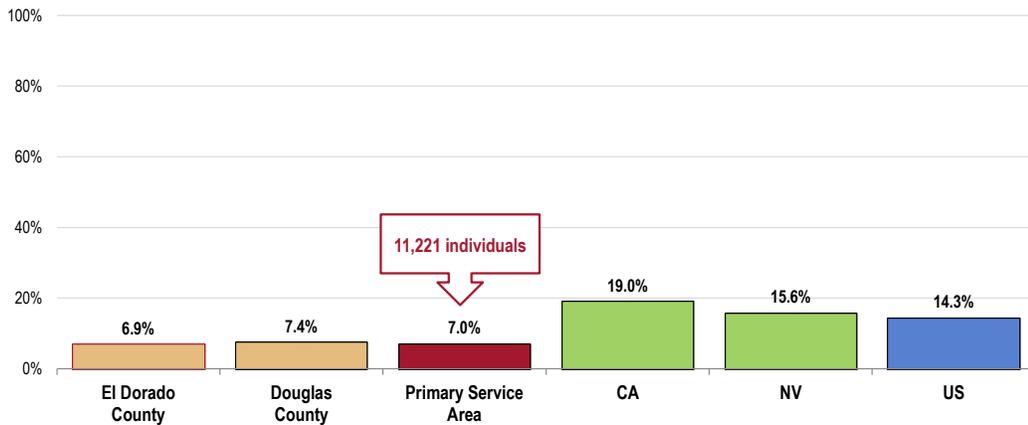**Children (0-17) Living Below 200% of Poverty, Percent by Tract, ACS 2008-2012**
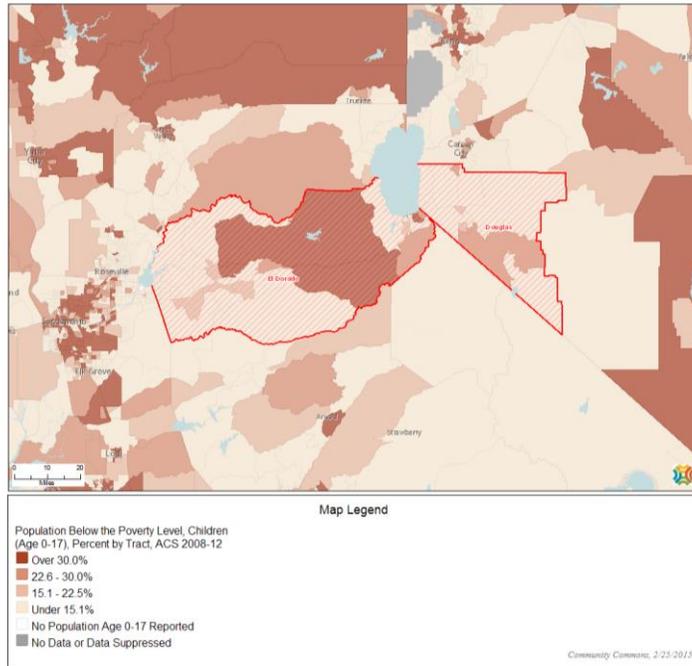
Education

Among the Primary Service Area population age 25 and older, an estimated 7.0% (over 11,200 people) do not have a high school education.

- More favorable than the state figures.
- More favorable than found nationally.
- Similar findings by county.

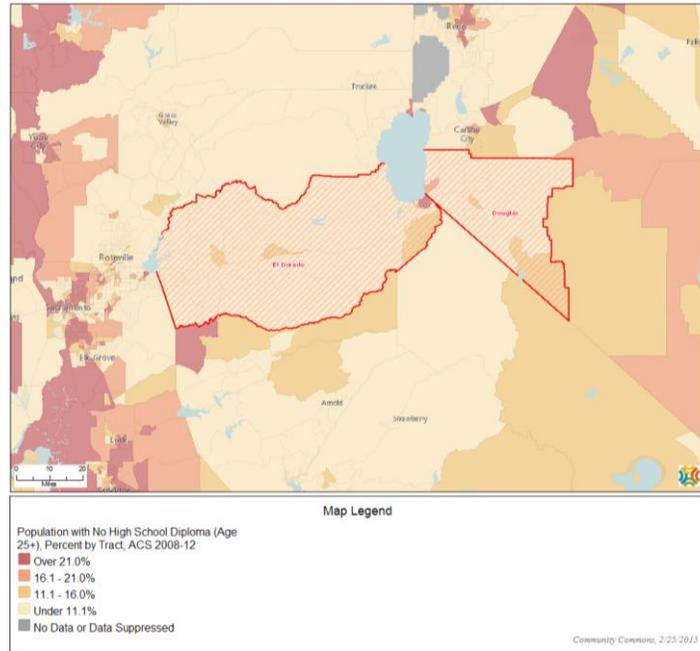## Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2008-2012)

6.9%	7.4%	7.0%	19.0%	15.6%	14.3%
El Dorado County	Douglas County	Primary Service Area	CA	NV	US

11,221 individuals

Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved March 2015 from Community Commons at http://www.chna.org.

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

- Geographically, this indicator is fairly even throughout the service area.

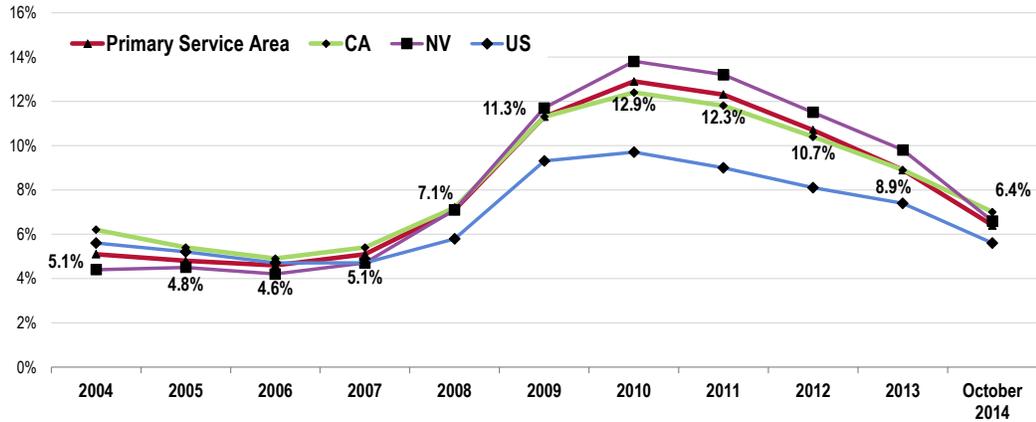**Population With No High School Diploma, Percent by Tract, ACS 2008-2012**

Map Legend

Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2008-12
- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed

Community Commons, 2/25/2013

Employment

According to data derived from the US Department of Labor, the unemployment rate in the Primary Service Area in 2013 was 6.4%.

- More favorable than the California unemployment rate, similar to the Nevada rate.
- Less favorable than the national unemployment rate.
- TREND: Although trending downward in recent years, the service area's unemployment rate is higher than baseline findings.

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

Legend: **Primary Service Area** CA NV US

Data labels visible: 5.1%, 4.8%, 4.6%, 5.1%, 7.1%, 11.3%, 12.9%, 12.3%, 10.7%, 8.9%, 6.4%

X-axis: 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, October 2014

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

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

Living & Working Conditions

Environmental Risks

Asked whether they are aware of any exposure to environmental risks such as radon, mold, or lead at home or at work, the largest share of affirmative responses among survey respondents was for radon (10.4%), followed by mold (8.3%) and lead (5.8%).

- TREND: Note the statistically significant decreases over time in mentions of exposure to radon and mold.

Aware of Exposure to Environmental Risks at Home or Work
(Primary Service Area, 2015)

Legend: 2012 2015

	Radon	Mold	Lead
2012	16.8%	12.7%	8.7%
2015	10.4%	8.3%	5.8%
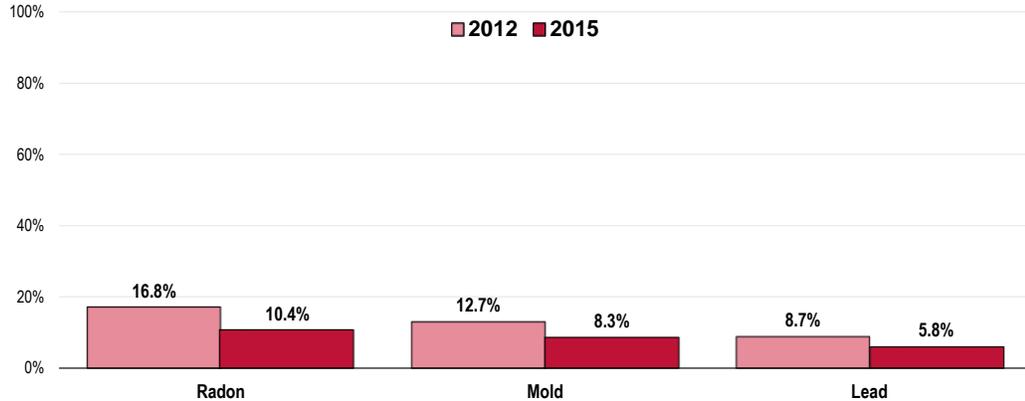
Sources:
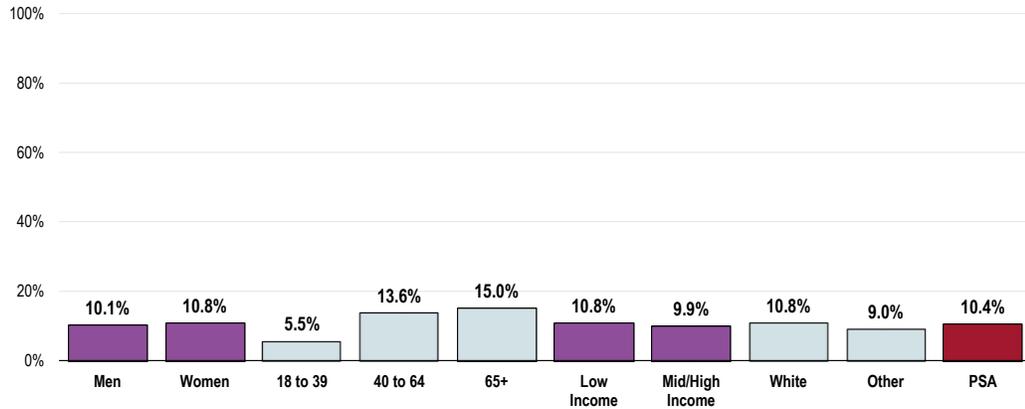- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 315-317]

Notes:
- Asked of all respondents.

Radon

- Residents age 40 and older are much more likely to be aware of exposure to radon at home or at work.

Aware of Exposure to Radon at Home or Work
(Primary Service Area, 2015)

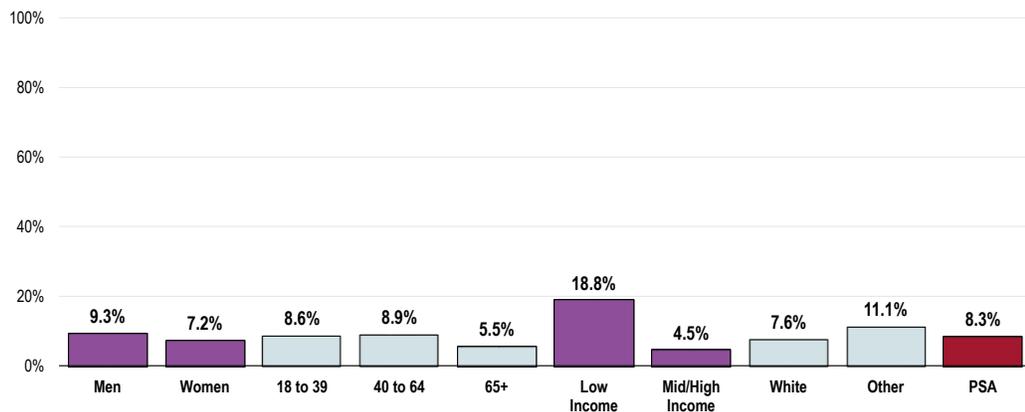|									
Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
10.1%	10.8%	5.5%	13.6%	15.0%	10.8%	9.9%	10.8%	9.0%	10.4%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 317]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

- Adults in low-income households are much more likely to be aware of exposure to mold at home or work.

Aware of Exposure to Mold at Home or Work
(Primary Service Area, 2015)

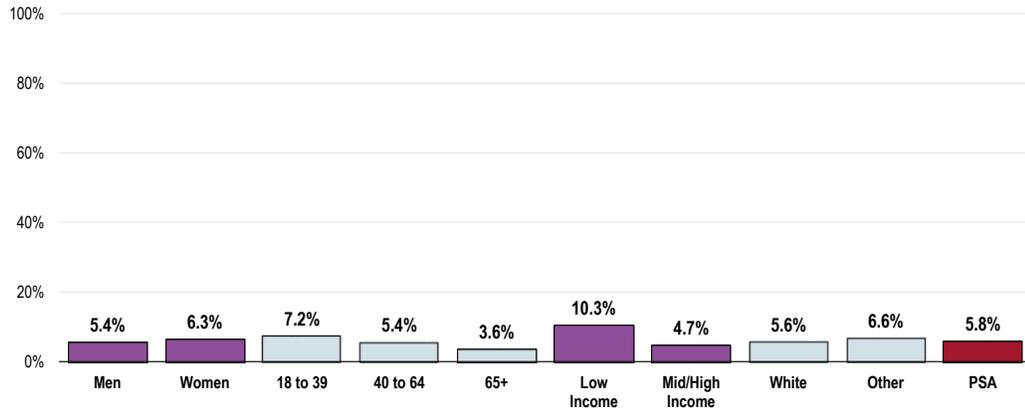|									
Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
9.3%	7.2%	8.6%	8.9%	5.5%	18.8%	4.5%	7.6%	11.1%	8.3%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 315]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

- No statistically significant difference in awareness of exposure to lead when viewed by demographic characteristics.

Aware of Exposure to Lead at Home or Work
(Primary Service Area, 2015)

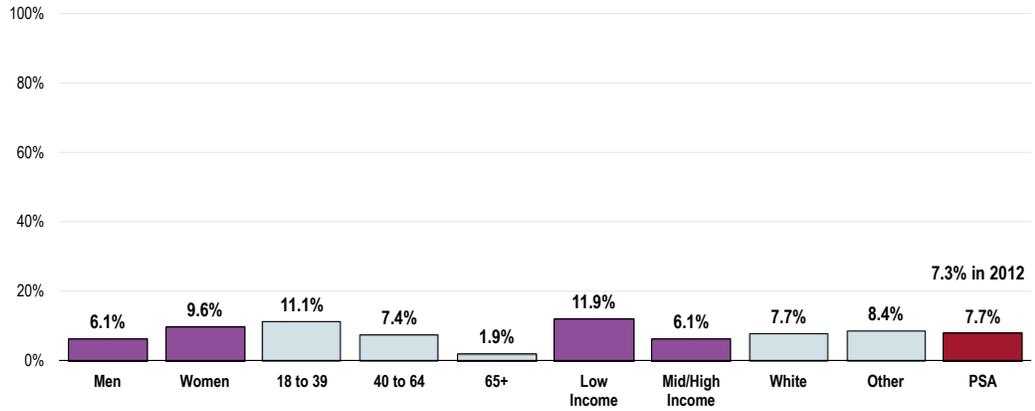|									
Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
5.4%	6.3%	7.2%	5.4%	3.6%	10.3%	4.7%	5.6%	6.6%	5.8%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 316]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Homelessness

A total of 7.7% of survey respondents lived with a friend or relative in the past year due to some type of housing emergency.

- Note the negative correlation with age in the Primary Service Area.
- TREND: Statistically unchanged from 2012 survey results.

Lived With a Friend or Relative
in the Past Two Years Due to a Housing Emergency
(Primary Service Area, 2015)

7.3% in 2012

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
6.1%	9.6%	11.1%	7.4%	1.9%	11.9%	6.1%	7.7%	8.4%	7.7%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 318]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

General Health Status

Overall Health Status

Self-Reported Health Status

A total of 61.6% of Primary Service Area adults rate their overall health as "excellent" or "very good.

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?"

- Another 26.0% gave "good" ratings of their overall health.

Self-Reported Health Status
(Primary Service Area, 2015)
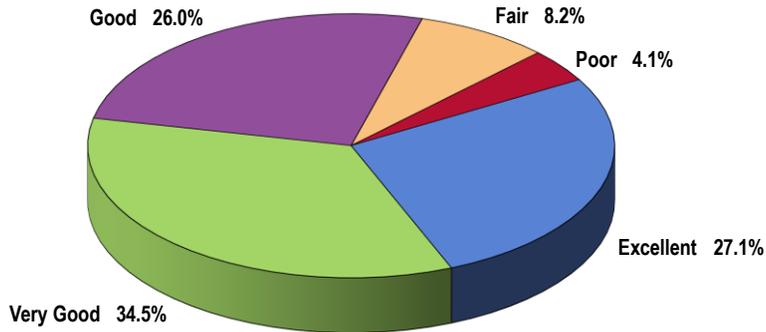
Good 26.0% Fair 8.2% Poor 4.1% Excellent 27.1% Very Good 34.5%

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

However, 12.3% of Primary Service Area adults believe that their overall health is "fair" or "poor."

NOTE:

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

Trends are measured against baseline data – i.e., the earliest year that data are available or that is presented in this report.
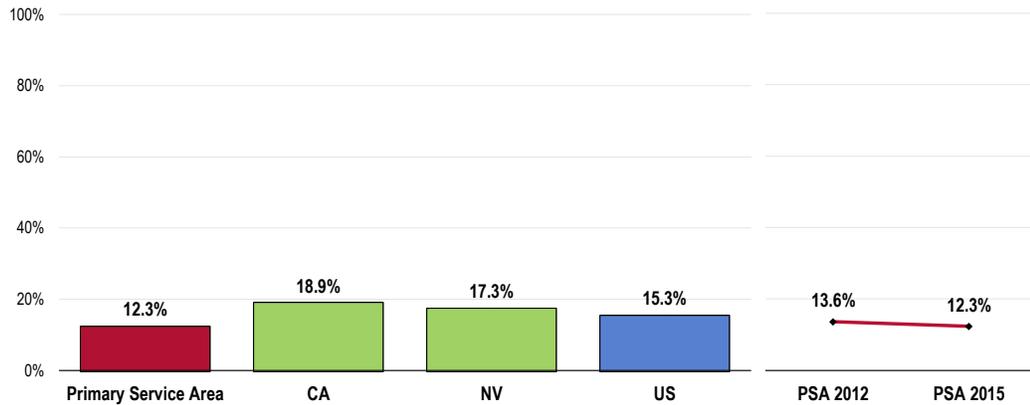
- Much better than statewide findings.
- Similar to the national percentage.
- TREND: No statistically significant change has occurred when comparing "fair/poor" overall health reports to previous (2012) survey results.

Experience "Fair" or "Poor" Overall Health

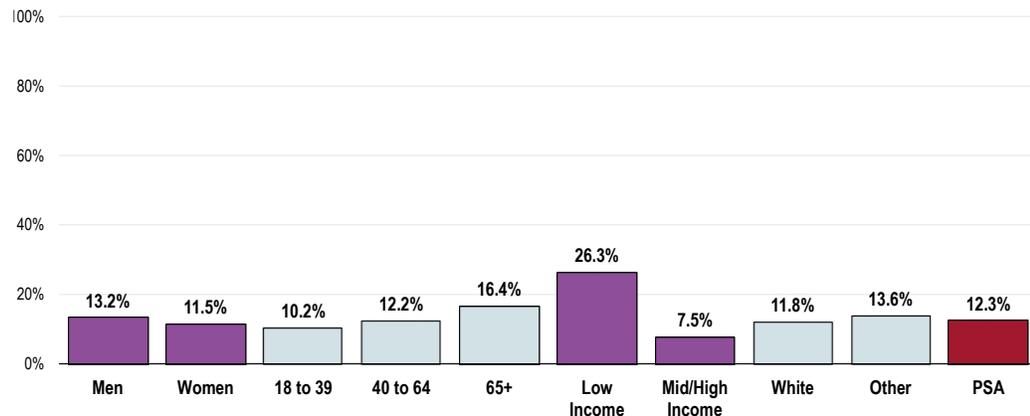|					
Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
12.3%	18.9%	17.3%	15.3%	13.6%	12.3%

Sources: ● PRC Community Health Surveys, 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): 2013 California and Nevada data.
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

- Residents living at lower incomes are much more likely to report experiencing "fair" or "poor" overall health.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

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

Experience "Fair" or "Poor" Overall Health
(Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
13.2%	11.5%	10.2%	12.2%	16.4%	26.3%	7.5%	11.8%	13.6%	12.3%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

About Disability & Health

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

A total of 20.8% of Primary Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Comparable to the state percentages.
- Comparable to the national prevalence.
- TREND: Statistically unchanged over time.

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

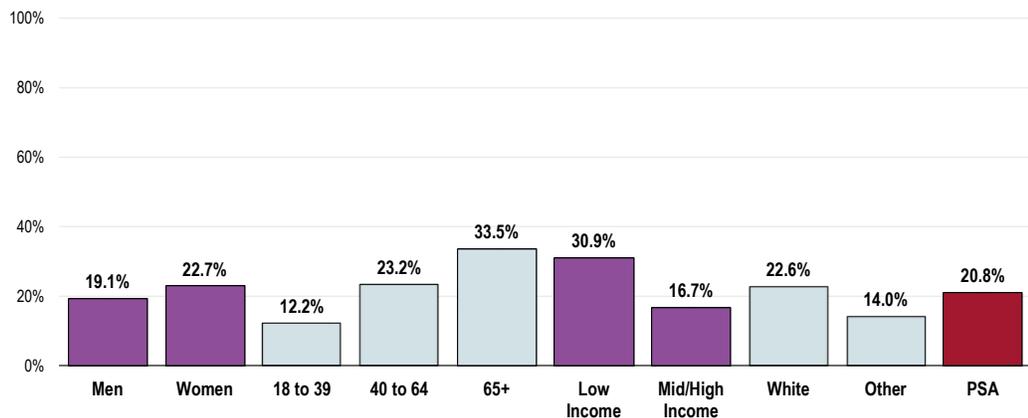|					
Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
20.8%	18.6%	18.8%	21.5%	20.4%	20.8%
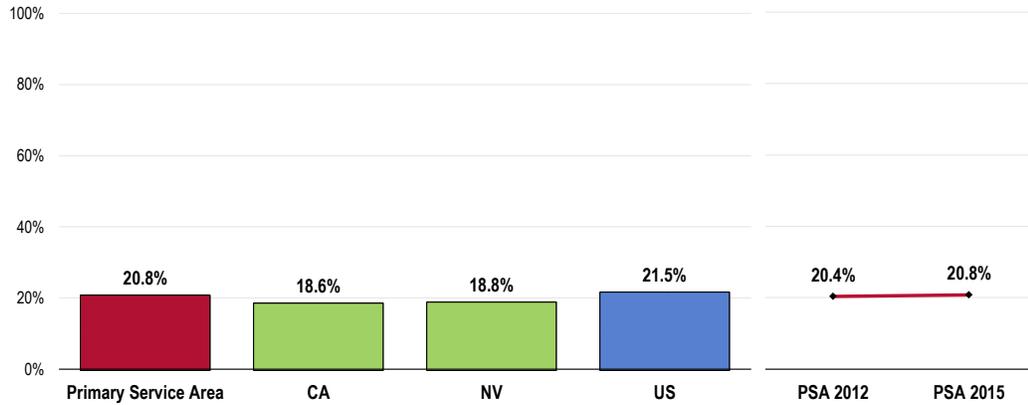
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 105]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

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

- Adults age 40 and older are much more often limited in activities (note the positive correlation with age).
- Low-income residents are more likely than those with higher incomes to report activity limitations.

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

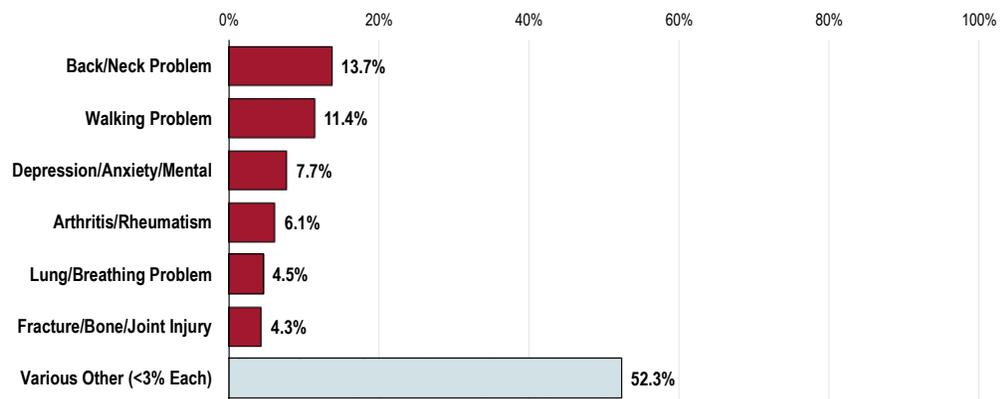| Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
19.1%	22.7%	12.2%	23.2%	33.5%	30.9%	16.7%	22.6%	14.0%	20.8%

Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 back/neck problems, difficulty walking, arthritis/rheumatism, or fractures or bone/joint injuries.

Other limitations mentioned with some frequency include depression/mental health issues (anxiety) and lung/breathing problems.

Type of Problem That Limits Activities
(Among Those Reporting Activity Limitations; Primary Service Area, 2015)

Problem	Percentage
Back/Neck Problem	13.7%
Walking Problem	11.4%
Depression/Anxiety/Mental	7.7%
Arthritis/Rheumatism	6.1%
Lung/Breathing Problem	4.5%
Fracture/Bone/Joint Injury	4.3%
Various Other (<3% Each)	52.3%

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

Mental Health

About Mental Health & Mental Disorders

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

A total of 65.5% of Primary Service Area adults rate their overall mental health as "excellent" or "very good."

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

● Another 24.2% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status
(Primary Service Area, 2015)
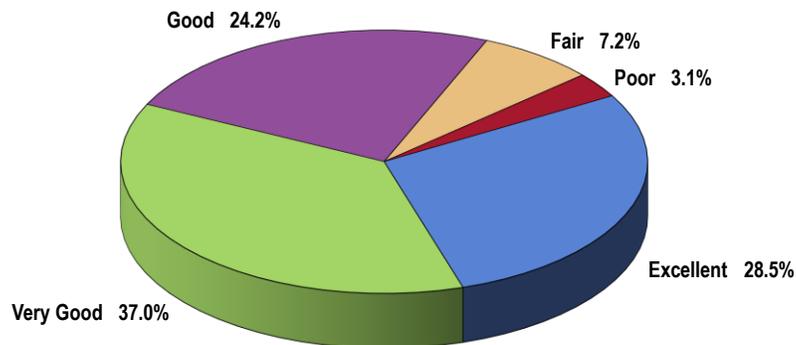
Good 24.2%
Fair 7.2%
Poor 3.1%
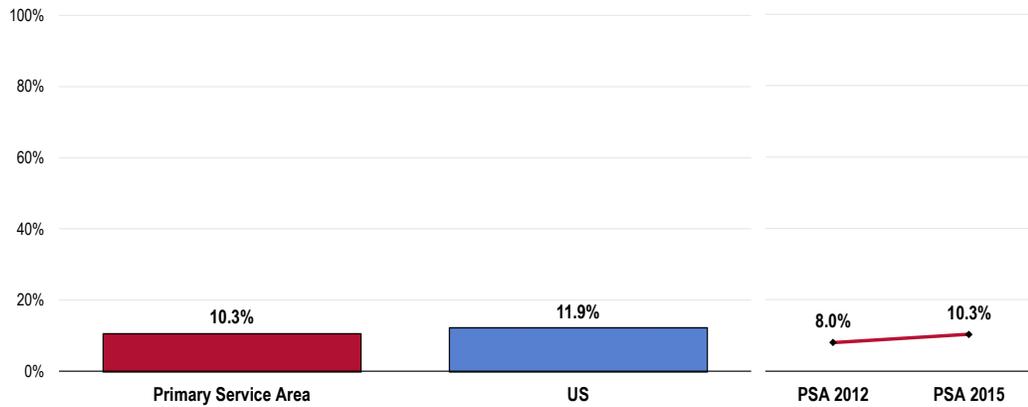Excellent 28.5%
Very Good 37.0%

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

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

● Similar to the "fair/poor" response reported nationally.
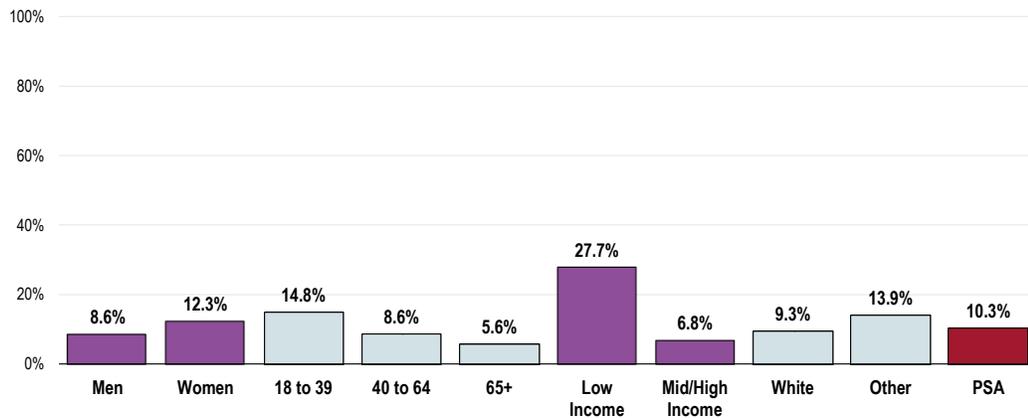● TREND: Statistically unchanged since 2012.

Experience "Fair" or "Poor" Mental Health

Primary Service Area	US	PSA 2012 → PSA 2015
10.3%	11.9%	8.0% → 10.3%

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

- Note the <u>negative</u> correlation between poor mental health and age.
- Low-income residents are <u>much more likely</u> to report experiencing "fair/poor" mental health than those with higher incomes.

Experience "Fair" or "Poor" Mental Health
(Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
8.6%	12.3%	14.8%	8.6%	5.6%	27.7%	6.8%	9.3%	13.9%	10.3%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.
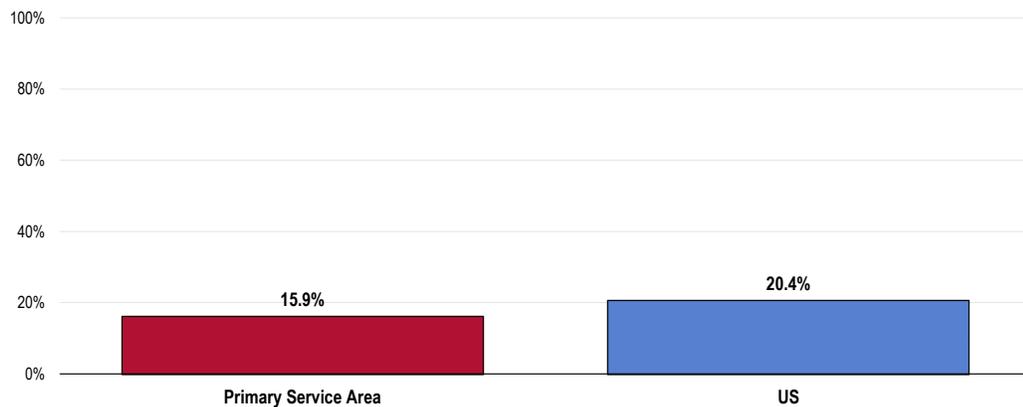
Depression

Diagnosed Depression

A total of 15.9% of Primary Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- More favorable than the national finding.

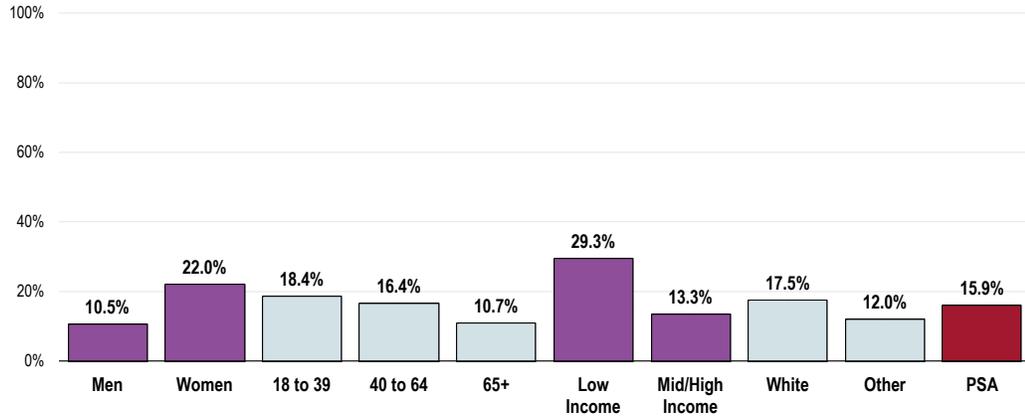### Have Been Diagnosed With a Depressive Disorder

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
      ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
      ● Depressive disorders include depression, major depression, dysthymia, or minor depression.

The prevalence of diagnosed depression is notably higher among:

- Women.
- Community members living at lower incomes.

Have Been Diagnosed With a Depressive Disorder
(Primary Service Area, 2015)

|	Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
	10.5%	22.0%	18.4%	16.4%	10.7%	29.3%	13.3%	17.5%	12.0%	15.9%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: ● Asked of all respondents.
● Depressive disorders include depression, major depression, dysthymia, or minor depression.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 31.4% 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 (symptoms of chronic depression).

- Similar to national findings.
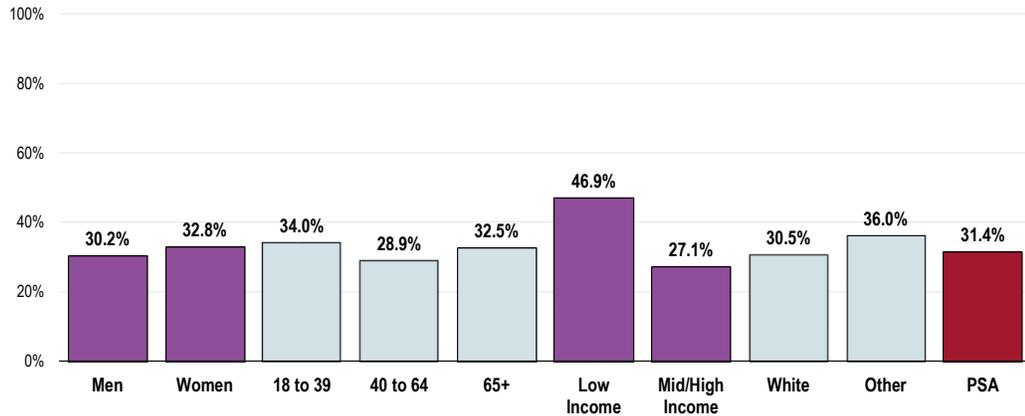- TREND: Similar to that reported in the Primary Service Area in 2012.

Have Experienced Symptoms of Chronic Depression

Primary Service Area	US	PSA 2012	PSA 2015
31.4%	30.4%	29.5%	31.4%
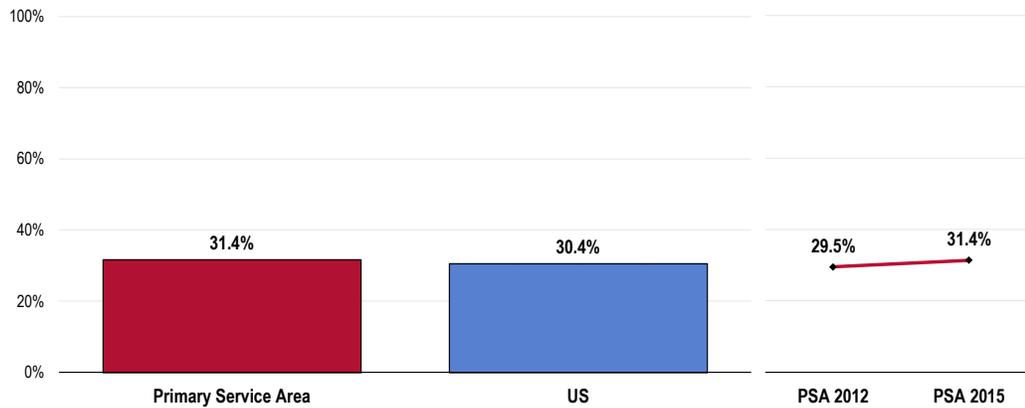
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 101]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

● The prevalence of chronic depression is notably higher among adults with lower incomes.

Have Experienced Symptoms of Chronic Depression
(Primary Service Area, 2015)

Category	Value
Men	30.2%
Women	32.8%
18 to 39	34.0%
40 to 64	28.9%
65+	32.5%
Low Income	46.9%
Mid/High Income	27.1%
White	30.5%
Other	36.0%
PSA	31.4%

Sources: ●   2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
Notes: ●   Asked of all respondents.
            ●   Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
            ●   Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
            ●   Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.
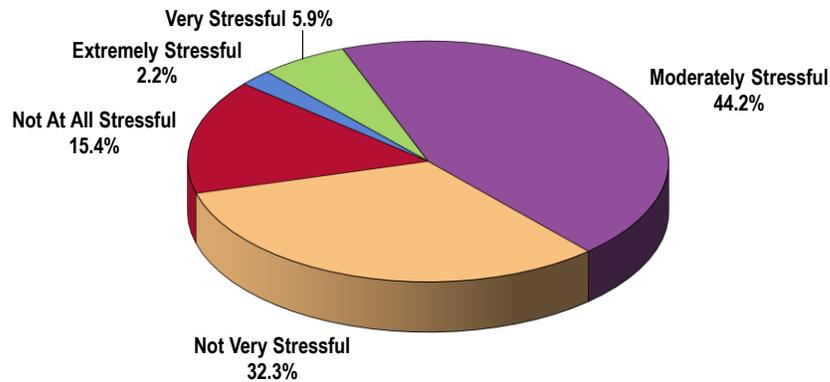
Stress

Nearly one-half of Primary Service Area adults consider their typical day to be "not very stressful" (32.3%) or "not at all stressful" (15.4%).

● Another 44.2% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day
(Primary Service Area, 2015)

- Very Stressful 5.9%
- Extremely Stressful 2.2%
- Not At All Stressful 15.4%
- Moderately Stressful 44.2%
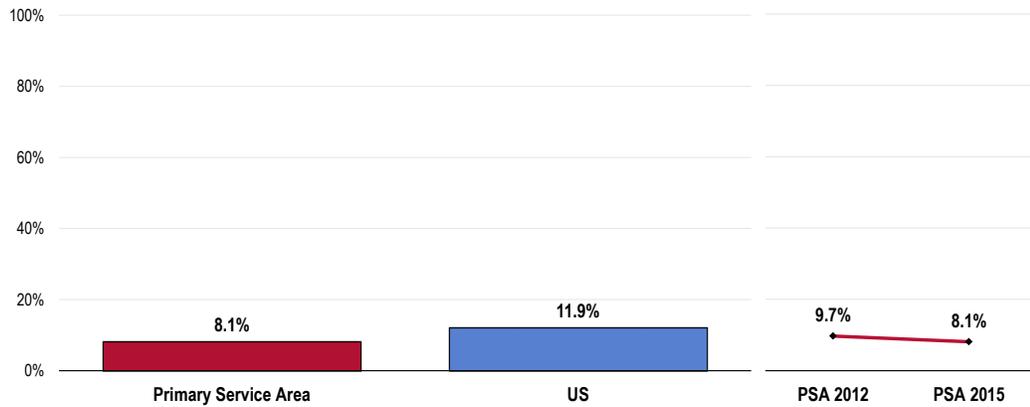- Not Very Stressful 32.3%

Sources: ●   2015 PRC Community Health Survey, Professional Research Consultants, Inc.   [Item 102]
Notes: ●   Asked of all respondents.

In contrast, 8.1% of Primary Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- More favorable than national findings.
- TREND: Statistically similar to the 2012 findings.

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

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

- Note that high stress levels are more prevalent among adults under 65.

Perceive Most Days as "Extremely" or "Very" Stressful
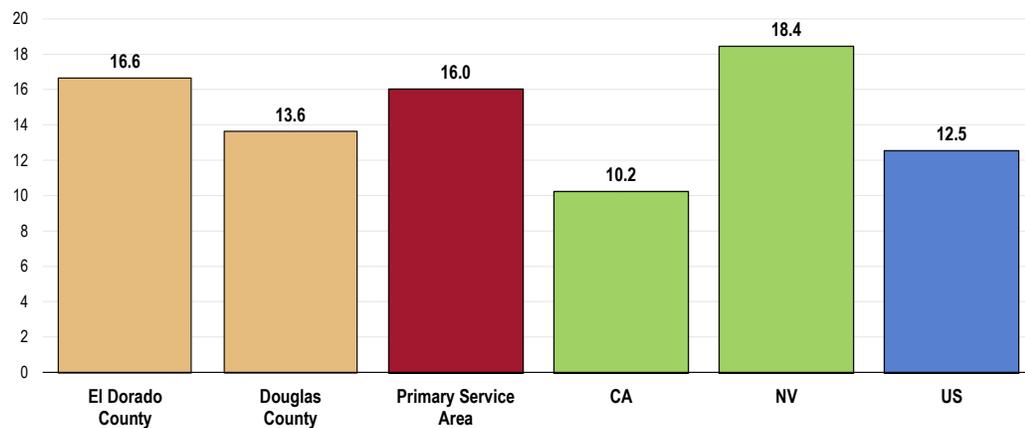(Primary Service Area, 2015)
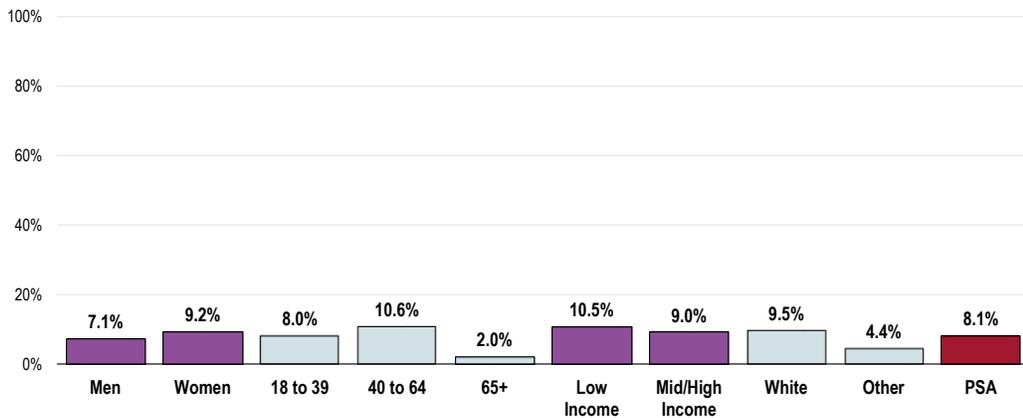
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Suicide

Between 2011 and 2013, there was an annual average age-adjusted suicide rate of 16.0 deaths per 100,000 population in the Primary Service Area.

- Higher than the California rate, lower than the Nevada rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.
- Higher in El Dorado County.

Suicide: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 10.2 or Lower

	El Dorado County	Douglas County	Primary Service Area	CA	NV	US
Rate	16.6	13.6	16.0	10.2	18.4	12.5

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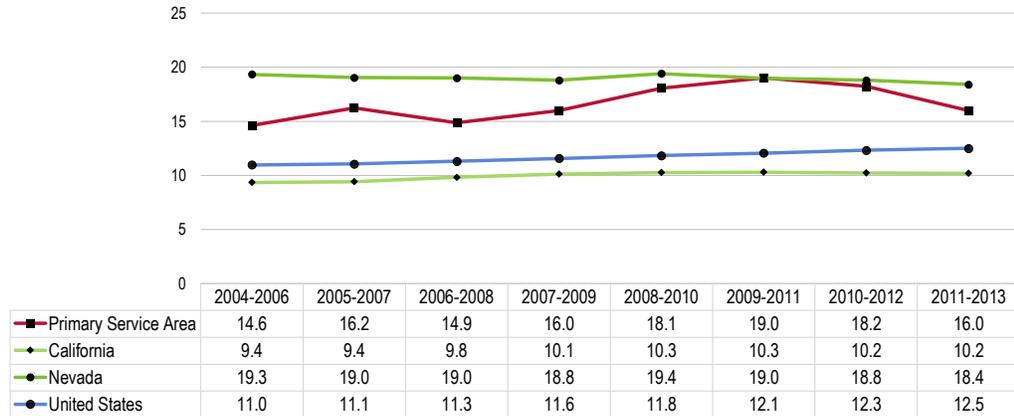- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

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

- TREND: Although fluctuating, the area suicide rate has increased overall. California and the US have trended upward, while the Nevada rate has decreased over time.

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 10.2 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	14.6	16.2	14.9	16.0	18.1	19.0	18.2	16.0
California	9.4	9.4	9.8	10.1	10.3	10.3	10.2	10.2
Nevada	19.3	19.0	19.0	18.8	19.4	19.0	18.8	18.4
United States	11.0	11.1	11.3	11.6	11.8	12.1	12.3	12.5

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
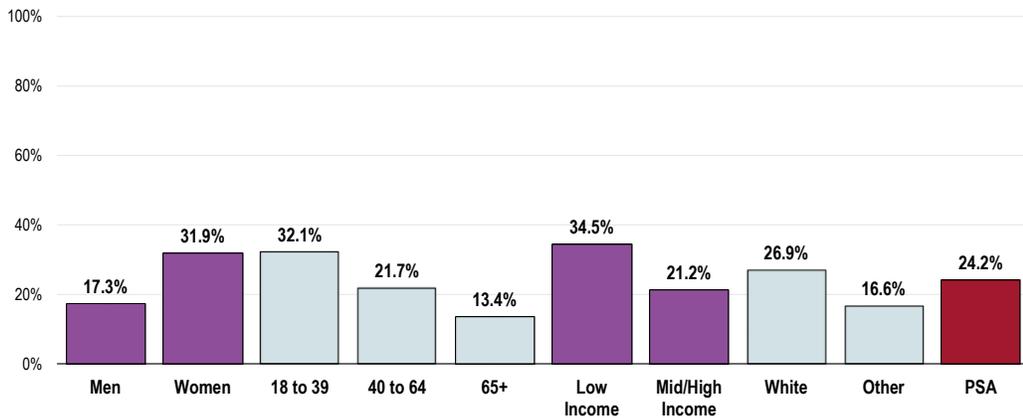● Local, state and national data are simple three-year averages.

Mental Health Treatment

Nearly one in four service area residents (24.2%) has discussed mental health issues with a physician.

- Highest among women, adults under 65, low-income residents, and Whites.

Discussed Mental Health Issues With a Physician
(Primary Service Area, 2015)

| Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
17.3%	31.9%	32.1%	21.7%	13.4%	34.5%	21.2%	26.9%	16.6%	24.2%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 310]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 adults with a diagnosed depressive disorder, 77.5% acknowledge that they have sought professional help for a mental or emotional problem.

- Similar to national findings.

"Diagnosed depressive disorder" includes respondents reporting a past diagnosis of a depressive disorder by a physician (such as depression, major depression, dysthymia, or minor depression).

Adults With Diagnosed Depression Who Have Ever Sought Professional Help for a Mental or Emotional Problem
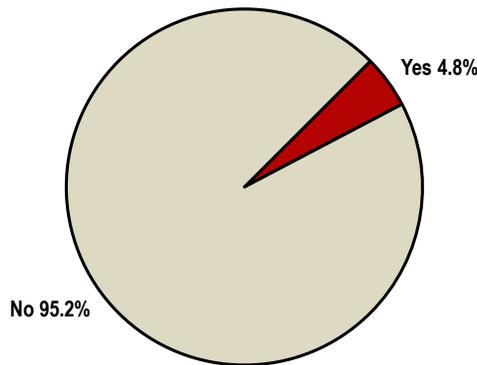(Among Adults With Diagnosed Depressive Disorder)
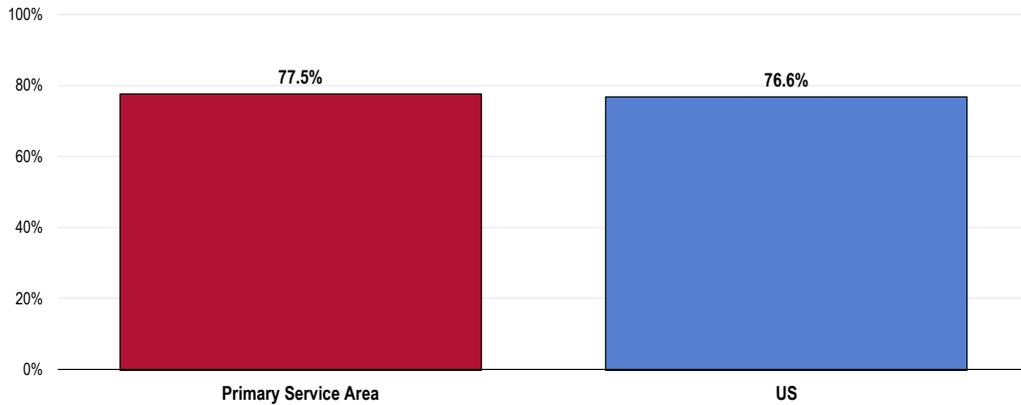
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects those respondents with a depressive disorder diagnosed by a physician (such as depression, major depression, dysthymia, or minor depression).
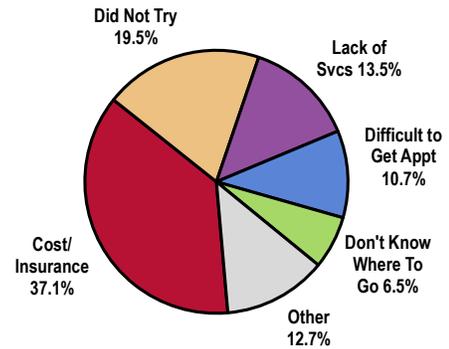
Over the past year, 4.8% of survey respondents had difficulty accessing the mental health services that they needed.

- Reasons for not being able to access the services included **cost or lack of insurance** (mentioned by 37.1%), **lack of services** (13.5%), difficulty getting an **appointment** (10.7%), and **not knowing** where to go (6.5%).

Difficulty Accessing Mental Health Services in the Past Year
(Primary Service Area, 2015)

Yes 4.8%

No 95.2%

Could Not Get the Needed Mental Health Services in the Past Year

Did Not Try 19.5%

Lack of Svcs 13.5%

Difficult to Get Appt 10.7%

Don't Know Where To Go 6.5%

Other 12.7%

Cost/ Insurance 37.1%

Reason for Difficulty Accessing Mental Health Services

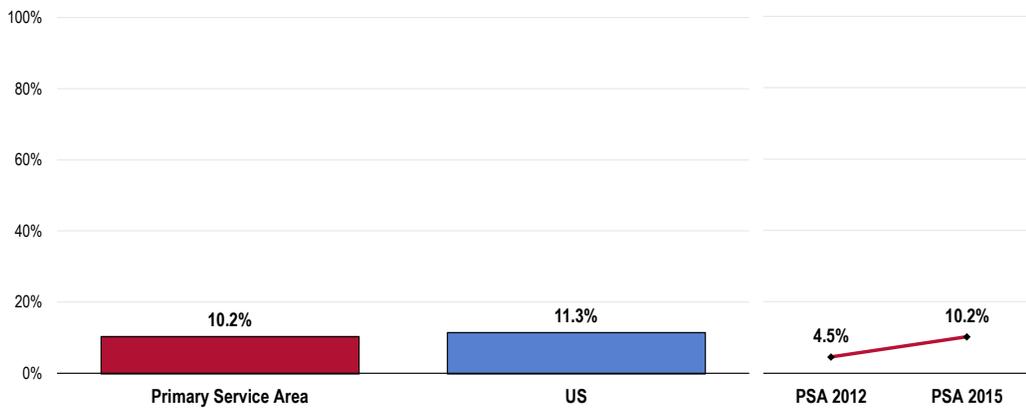Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 311-312]
Notes: ● Asked of all respondents.

Children & ADD/ADHD

Among Primary Service Area adults with children age 5 to 17, 10.2% report that their child takes medication for ADD/ADHD.

- Statistically similar to the national prevalence.
- TREND: Statistically unchanged since 2012.

Child Takes Medication for ADD/ADHD
(Among Parents of Children Age 5-17)

Primary Service Area: 10.2%	US: 11.3%	PSA 2012: 4.5% / PSA 2015: 10.2%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 323]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children age 5 to 17.

Key Informant Input: Mental Health

Nearly 2 in 3 key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.

Perceptions of Mental Health
as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

65.9%	31.7%	2.4%

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

Challenges

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

Lack of Services

There is a lack of safety net services and inability to have a local 5150 hold. – Community Leader

The biggest issue in town and yet not enough resources to fit the needs. Severe issue that is increasing homelessness, substance abuse and other issues. – Social Services Representative

There isn't a good plan or clear resources to help them. – Community Leader

South Lake Tahoe does not have adequate facilities, services, accommodations, family support, crisis support, counseling and housing. We basically have a triage approach for our highest need patients without the infrastructure of ongoing and restorative help for our population and their families. This is a huge challenge for our community. – Community Leader

Timely and local access to mental health therapists for children and psychiatry. – Other Health Provider

For children it is having a child mental health specialist. Limited resources in our community. Issues if parents do not follow up with applications and getting child to appointments. – Other Health Provider

Our County Mental Health Department has cut back their services so much in the past 5 years that many people with significant mental health conditions no longer have regular contact with a professional. Once considered to be stable on medications, people are told they no longer need support services and are referred to Barton and discharged from the County without regular eyeball contact with a mental health professional. Many of these people are at risk for substance abuse and health threatening decomposition related to their mental health problems. In addition, poor management of the local county mental health office has put the wrong people in charge and has caused some excellent clinicians to leave. A number of people who should have been receiving regular mental health services have died in the past few years and this is an unconscionable consequence of this current system! – Social Services Representative

Lack of treatment and support centers. Treated poorly by general community. Lack of community education surrounding mental illness. Get shipped off the hill, away from their community and family for treatment – Community Leader

Mental health practitioners are few and generally do not accept medical insurance. There is not a residential facility in the community. – Community Leader

Access to Services

Prompt access to ongoing care. Lack of resources for individual care. – Physician

Limited accessibility to treatment. Lack of residential facilities. – Social Services Representative

Access to services. No homeless shelter. Limited funds and services available. – Social Services Representative

Access to services. The community has many people who are not being treated and need treatment. The outreach into the community needs to reach these people. Difficult to do. – Community Leader

Access to mental health services. If you are not gravely disabled it is difficult to get services. There are stereotypes about mental health that are still very evident in our community. Often times it is difficult for mental health clients to access psychiatry and afford medications. – Public Health Expert

Takes too long to get in to see someone for help, consistent care is not met for the most ill. Loss of housing because acting out, or not enough funds. No place for them to go if they feel they need help at a given moment except for Emergency Room. – Social Services Representative

Access to resources. Knowing what's available. – Community Leader

Mental Health not able to give services needed in the community so people are not getting their needs met. They are turned away from services if it is felt the individual with mental illness is somewhat stable. Yet it is proven mental illness does not go away. But counseling, treatment, with structure helps an individual to stay stable. There are long waits to see doctors, sometimes if client is late calling in medication, they are last getting refills. The hospital needs Psychiatrists seeing clients as family physicians do not understand the types of medications that are needed and do not like prescribing some of the psychotropic medications that are required. There is no dental care in Tahoe for people who have Medi-Cal so infections are a problem. There are not enough doctors that take Medi-Cal. Social Security is down in Placerville. Transportation is a problem for medical needs for the poor. There is not a place for those going through withdrawal from drugs or alcohol to be placed for treatment in Tahoe. – Social Services Representative

Cost of Insurance

Receiving medications that they can afford, receiving counseling that they afford, helping those with mental health issues get affordable housing. – Other Health Provider

The issue of mental health services is rooted in the lack of support to the mental health providers at the county level. Providers often do not have the means to provide the full array of services to clients in need due to steep budget cuts and lack of staffing. – Social Services Representative

If a person doesn't have Medi-Cal they cannot go to mental health for services. Many don't have medical but also can't afford a private physician. – Community Leader

Lack of Early Intervention

Primary prevention, awareness in the community of the relationship between adverse childhood event and mental health, stigma. Access to care, coordination of care and continuity of care. Barton doing a great work with psychiatrist time in clinic. Need for alternatives to jail, PHF and ER for crisis higher than what can be managed as outpatient. Co-occurring, mental health with alcohol and other drugs, diseases and treatment. Need for chronic management model and more intense case management for some of the clients with mental health issues to achieve better health and care of preventive measures and physical health. Potential for cost savings through ER visits avoided. – Public Health Expert

Stigma

Lack of support from community. Still a large stigma placed on those who suffer from a mental illness in South Lake Tahoe. Large population of homeless individuals living in town with no place to go. – Community Leader

As a community, we need to get over the stigma associated with mental health issues. Families need to have the support early on for diagnosis and support and treatment. Also, the economic connection to people with mental health issues including not being able to attain steady employment, housing, etc. They are all connected. – Community Leader

Homelessness

Homelessness has increased. I'm not sure this fits under mental health, but it is tied together. – Community Leader

A former client was identified homeless. Her previous counselor seems to think she had some mental health challenges incapacitating her. – Social Services Representative

Homeless population. There is no homeless shelter and we live in a climate that has inclement weather and very cold temperatures throughout the year. – Social Services Representative

Substance Abuse

Downward spiral, individuals move here and get wrapped up in a lifestyle that includes drugs and alcohol. This community also tends to attract individuals who are trying to escape reality and work elsewhere. These environmental factors can contribute to not recognizing a need to seek help and an acceptance particularly in a family unit where there may be two adults with a problem. Once recognized there can be challenges to accessing mental health care as these services have been cut back by El Dorado County here in the basin. – Community Leader

Diagnoses

The biggest challenge is getting a diagnosis severe enough to warrant regular services. – Community Leader
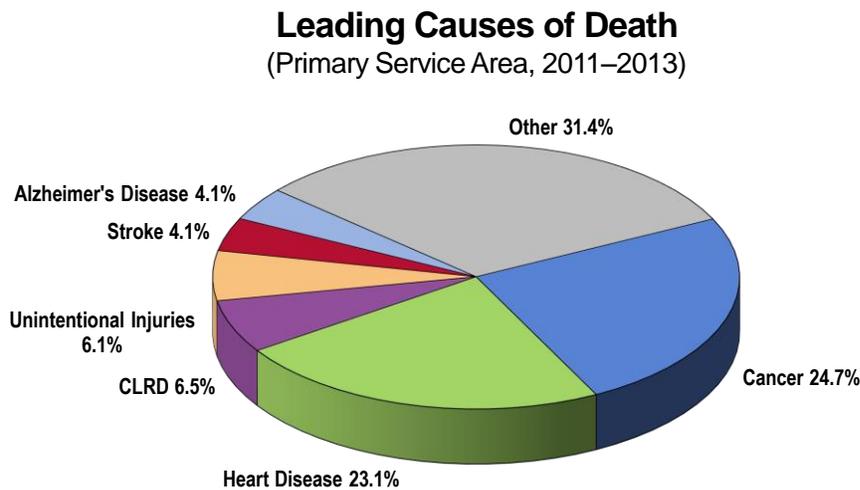
Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for over one-half of all deaths in the Primary Service Area between 2011 and 2013.

Leading Causes of Death
(Primary Service Area, 2011–2013)

- Other 31.4%
- Alzheimer's Disease 4.1%
- Stroke 4.1%
- Unintentional Injuries 6.1%
- CLRD 6.5%
- Heart Disease 23.1%
- Cancer 24.7%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, 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 2011–2013 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.

Note that age-adjusted mortality rates in the Primary Service Area are worse than national rates for suicide, unintentional injuries (including motor vehicle accidents), Alzheimer's disease, cirrhosis, and drug-related 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,

unintentional injuries, firearms, cirrhosis, and drug-related deaths.

Age-Adjusted Death Rates for Selected Causes
(2011–2013 Deaths per 100,000 Population)

	Primary Service Area	CA	NV	US	HP2020
Malignant Neoplasms (Cancers)	144.1	149.9	166.1	166.2	161.4
Diseases of the Heart	139.2	154.7	194.6	171.3	156.9*
Unintentional Injuries	44.0	28.5	42.4	39.2	36.4
Chronic Lower Respiratory Disease (CLRD)	39.4	35.5	52.0	42.0	n/a
Cerebrovascular Disease (Stroke)	25.8	35.6	34.5	37.0	34.8
Alzheimer's Disease	25.6	30.2	16.5	24.0	n/a
Drug-Induced	18.4	11.4	21.9	14.1	11.3
Intentional Self-Harm (Suicide)	16.0	10.2	18.4	12.5	10.2
Cirrhosis/Liver Disease	13.8	11.7	12.2	9.9	8.2
Pneumonia/Influenza	12.3	16.1	19.1	15.3	n/a
Diabetes Mellitus	12.2	20.7	15.3	21.3	20.5*
Motor Vehicle Deaths	12.0	7.9	9.7	10.7	12.4
Firearm-Related	10.5	7.8	13.4	10.4	9.3
Kidney Diseases	5.8	7.1	14.8	13.2	n/a
Homicide/Legal Intervention	2.8	5.9	6.3	5.7	5.5
HIV/AIDS	1.2	2.6	2.8	3.2	3.3

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

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

Cardiovascular Disease

About Heart Disease & Stroke

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

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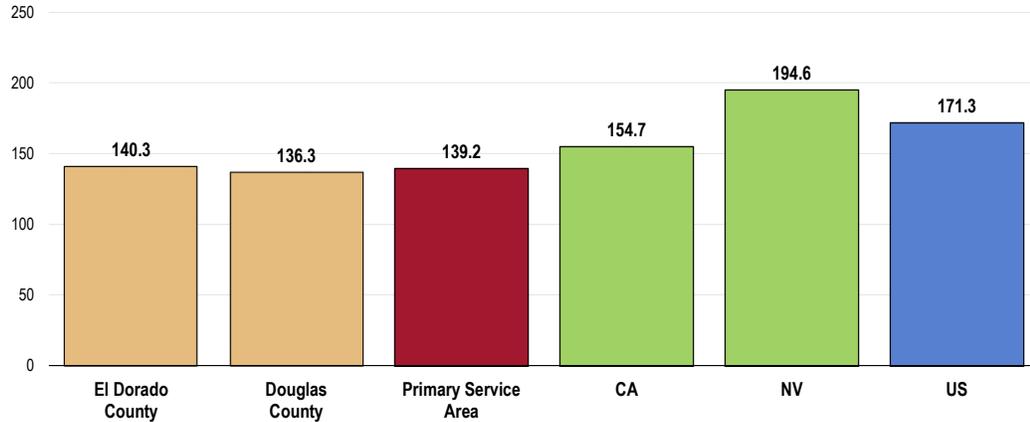
The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2011 and 2013 there was an annual average age-adjusted heart disease mortality rate of 139.2 deaths per 100,000 population in the Primary Service Area.

- Lower than the statewide rates, especially Nevada.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).
- Higher in El Dorado County.

Heart Disease: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 156.9 or Lower (Adjusted)

Bar chart values:
- El Dorado County: 140.3
- Douglas County: 136.3
- Primary Service Area: 139.2
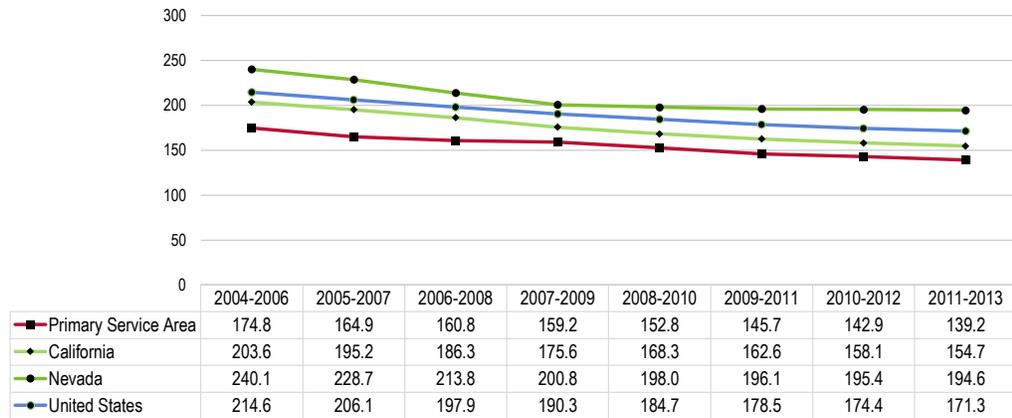- CA: 154.7
- NV: 194.6
- US: 171.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]
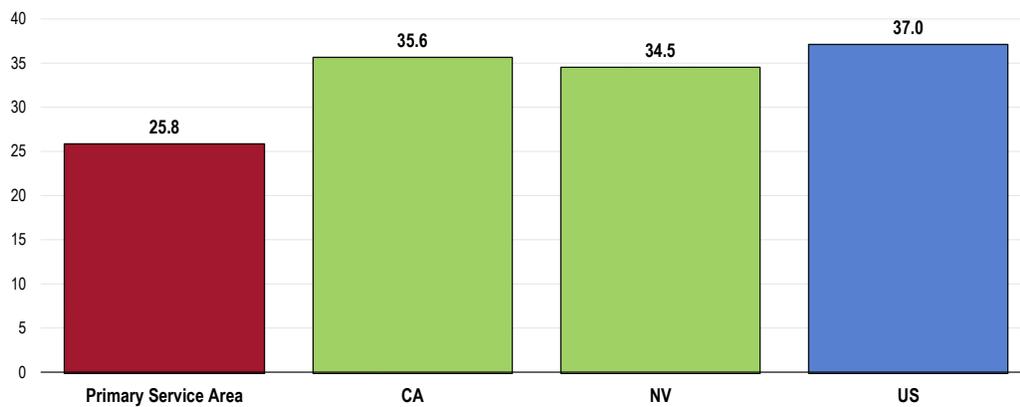
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

- TREND: 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)
Healthy People 2020 Target = 156.9 or Lower (Adjusted)

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	174.8	164.9	160.8	159.2	152.8	145.7	142.9	139.2
California	203.6	195.2	186.3	175.6	168.3	162.6	158.1	154.7
Nevada	240.1	228.7	213.8	200.8	198.0	196.1	195.4	194.6
United States	214.6	206.1	197.9	190.3	184.7	178.5	174.4	171.3

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

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

Stroke Deaths

Between 2011 and 2013, there was an annual average age-adjusted stroke mortality rate of 25.8 deaths per 100,000 population in the Primary Service Area.

- More favorable than the California and Nevada rates.
- More favorable than the national rate.
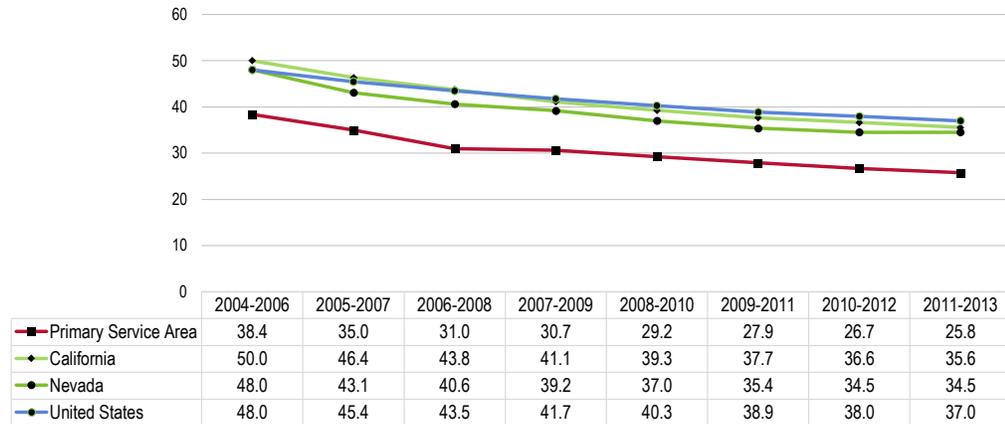- Satisfies the Healthy People 2020 target of 34.8 or lower.

Stroke: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 34.8 or Lower

	Primary Service Area	CA	NV	US
Value	25.8	35.6	34.5	37.0

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

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

- TREND: The stroke rate has <u>declined</u> in recent years, echoing the trends reported across California, Nevada, and the US overall.

Stroke: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 34.8 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	38.4	35.0	31.0	30.7	29.2	27.9	26.7	25.8
California	50.0	46.4	43.8	41.1	39.3	37.7	36.6	35.6
Nevada	48.0	43.1	40.6	39.2	37.0	35.4	34.5	34.5
United States	48.0	45.4	43.5	41.7	40.3	38.9	38.0	37.0

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● Local, state and national data are simple three-year averages.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 4.5% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Similar to the national prevalence.
- TREND: Statistically unchanged since 2012.

Prevalence of Heart Disease

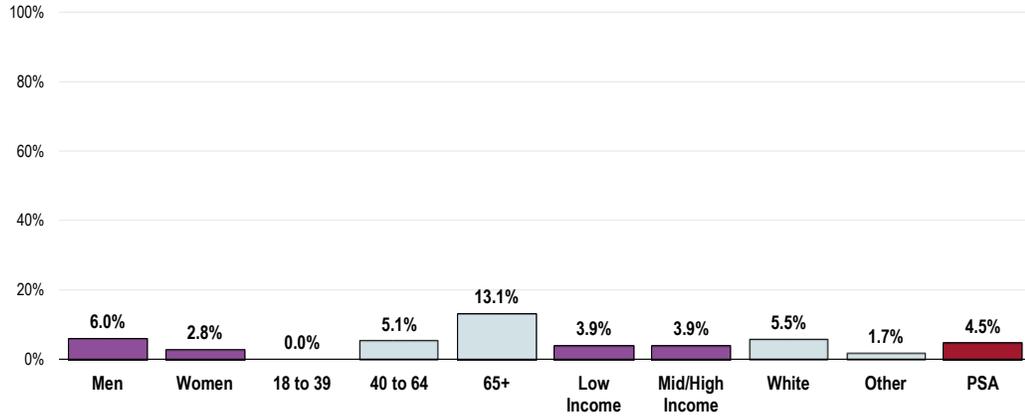|	Prevalence
Primary Service Area	4.5%
US	6.1%
PSA 2012	3.6%
PSA 2015	4.5%
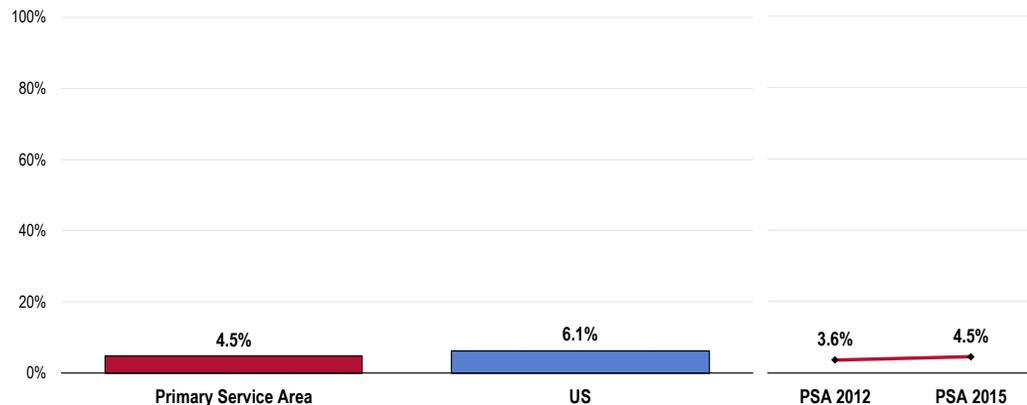
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 124]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Includes diagnoses of heart attack, angina or coronary heart disease.

● Note the positive correlation between age and heart disease in the service area.

## Prevalence of Heart Disease
(Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
6.0%	2.8%	0.0%	5.1%	13.1%	3.9%	3.9%	5.5%	1.7%	4.5%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
Notes: ● Asked of all respondents.
● Includes diagnoses of heart attack, angina or coronary heart disease.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Prevalence of Stroke

A total of 1.7% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

● Similar to statewide findings.
● Lower than national findings.
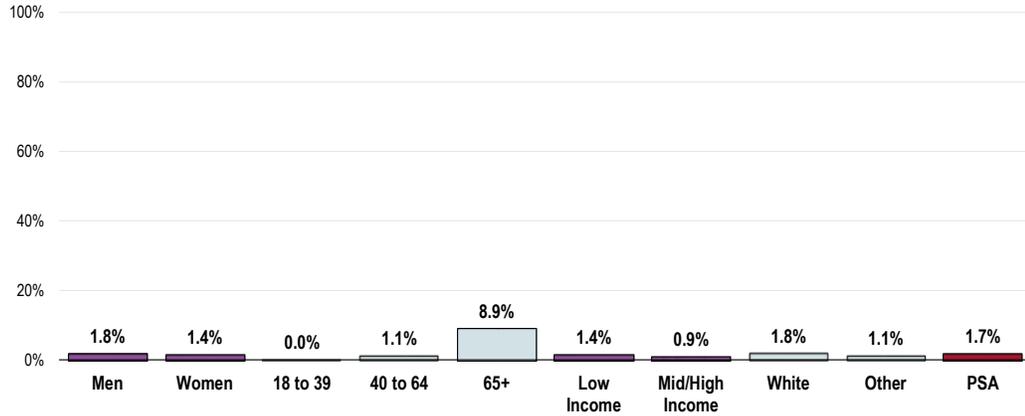● TREND: Statistically unchanged over time.

Prevalence of Stroke

Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
1.7%	2.2%	2.9%	3.9%	1.1%	1.7%
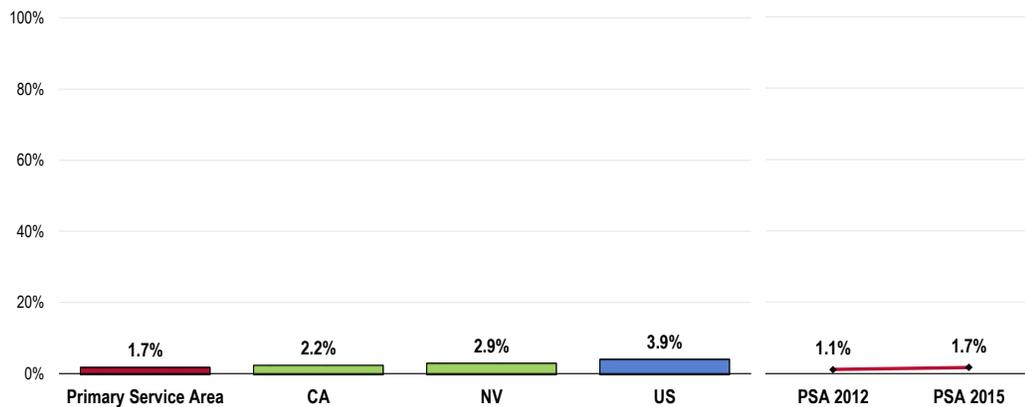
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
Notes: ● Asked of all respondents.

● Note the positive correlation between stroke and age in the service area.

Prevalence of Stroke
(Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
1.8%	1.4%	0.0%	1.1%	8.9%	1.4%	0.9%	1.8%	1.1%	1.7%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

About Cardiovascular Risk

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)

Hypertension (High Blood Pressure)

High Blood Pressure Testing

A total of 91.8% of Primary Service Area adults have had their blood pressure tested within the past two years.

- Similar to national findings.
- Similar to the Healthy People 2020 target (92.6% or higher).
- TREND: Statistically unchanged since 2012.

Have Had Blood Pressure Checked in the Past Two Years
Healthy People 2020 Target = 92.6% or Higher
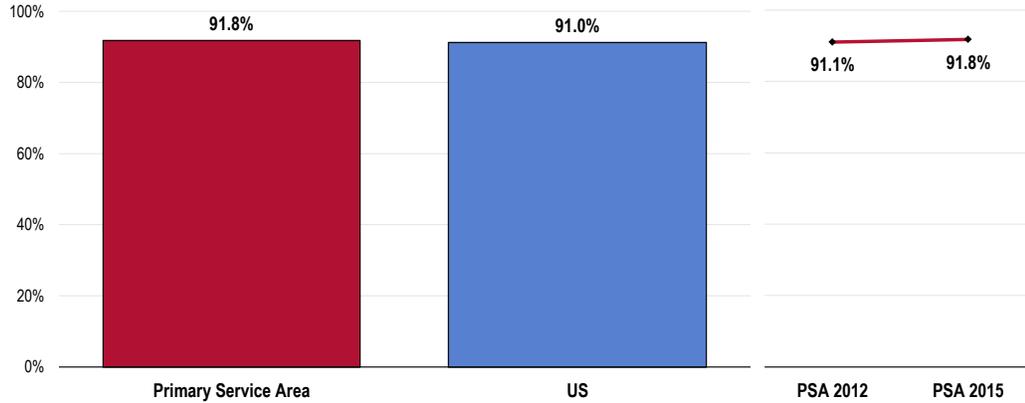
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 45]
       ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
       ● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]
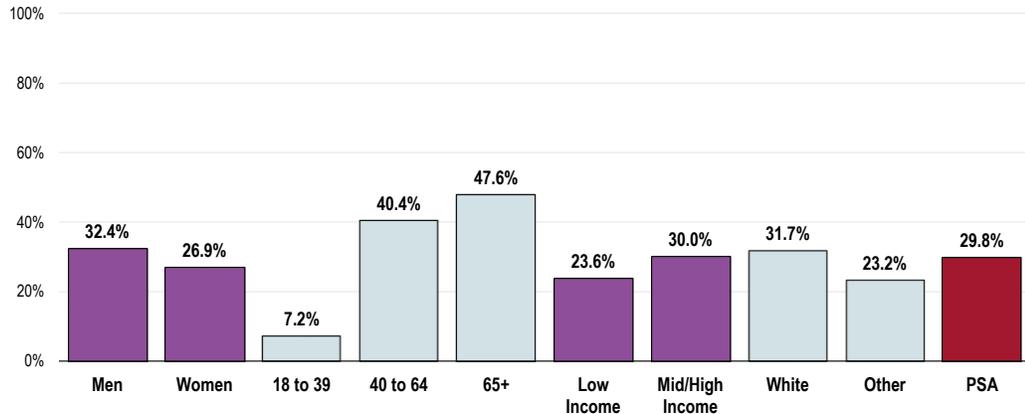Notes: ● Asked of all respondents.

Prevalence of Hypertension

A total of 29.8% of adults have been told at some point that their blood pressure was high.

- Similar to the California and Nevada percentages.
- Similar to the national prevalence.
- Similar to the Healthy People 2020 target (26.9% or lower).
- TREND: Statistically unchanged since 2012.
- Among hypertensive adults, 70.3% have been diagnosed with high blood pressure more than once.

Prevalence of High Blood Pressure
Healthy People 2020 Target = 26.9% or Lower
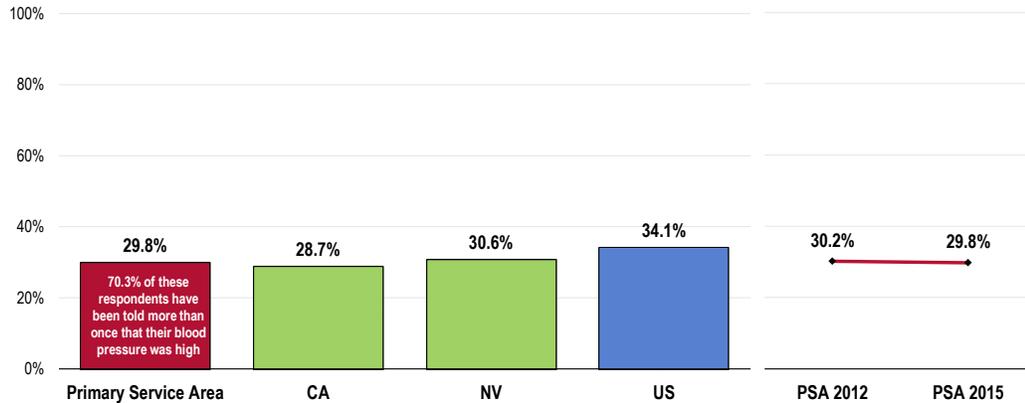
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 43, 125]
       ● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
       ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
       ● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]
Notes: ● Asked of all respondents.

● Hypertension diagnoses are higher among adults age 40 and older, and especially those age 65+.

Prevalence of High Blood Pressure
(Primary Service Area, 2015)
Healthy People 2020 Target = 26.9% or Lower

Men	32.4%	
Women	26.9%	
18 to 39	7.2%	
40 to 64	40.4%	
65+	47.6%	
Low Income	23.6%	
Mid/High Income	30.0%	
White	31.7%	
Other	23.2%	
PSA	29.8%	

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]
● 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. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

Among respondents who have been told that their blood pressure was high, 92.4% report that they are currently taking actions to control their condition.

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?"

● Similar to national findings.
● TREND: Statistically unchanged since 2012.

Taking Action to Control Hypertension
(Among Adults With High Blood Pressure)
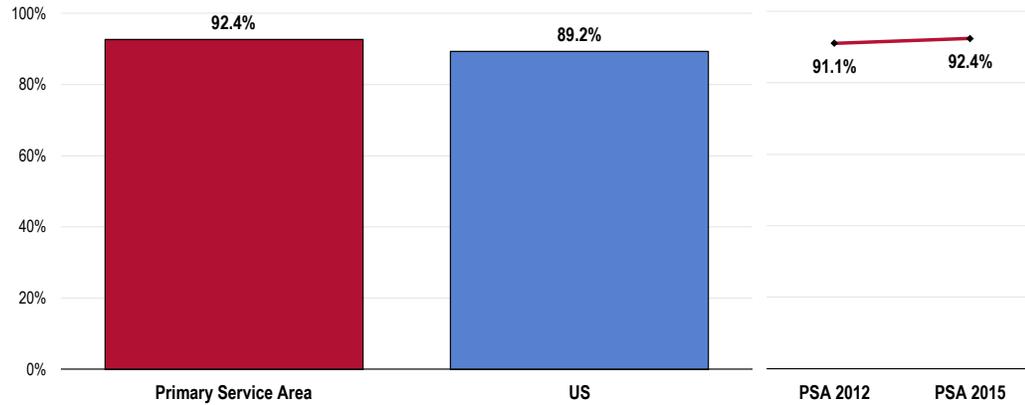
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 44]
　　　　　 ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents who have been diagnosed with high blood pressure.
　　　　 ● In this case, the term "action" refers to medication, change in diet, and/or exercise.

High Blood Cholesterol

Blood Cholesterol Testing

A total of 86.7% of Primary Service Area adults have had their blood cholesterol checked within the past five years.

- More favorable than California and Nevada findings.
- Nearly identical to the national findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- TREND: Statistically unchanged since 2012.

Have Had Blood
Cholesterol Levels Checked in the Past Five Years
Healthy People 2020 Target = 82.1% or Higher

	Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
	86.7%	75.2%	74.0%	86.6%	84.0%	86.7%
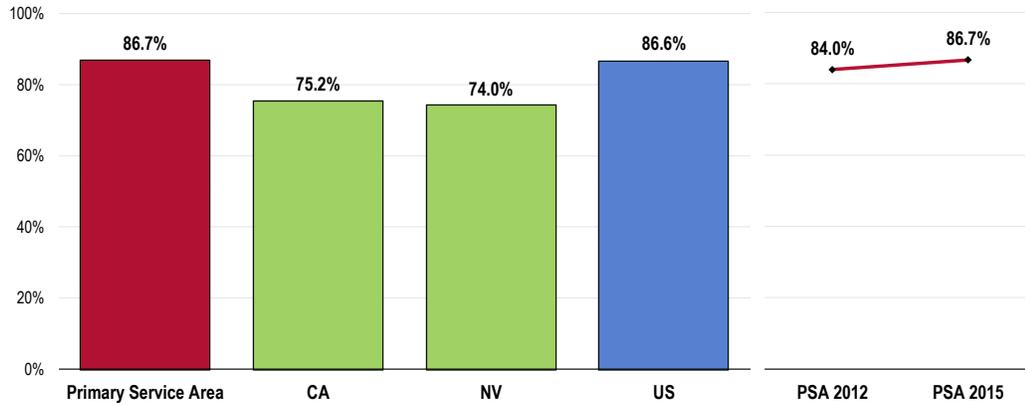
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 48]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

Notes:
- Asked of all respondents.

The following demographic segments report <u>lower</u> screening levels:

- Adults under age 65, and especially those under 40 (positive correlation with age).
- Residents with lower incomes.
- "Other" races.

Have Had Blood
Cholesterol Levels Checked in the Past Five Years
(Primary Service Area, 2015)
Healthy People 2020 Target = 82.1% or Higher

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
85.9%	87.5%	76.8%	91.7%	96.6%	77.1%	89.3%	91.4%	71.2%	86.7%
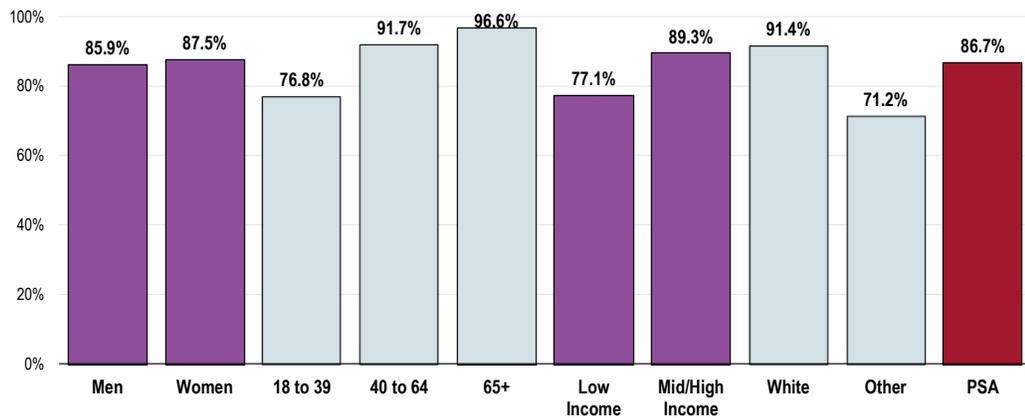
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 31.1% 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.
- Over twice the Healthy People 2020 target (13.5% or lower).
- TREND: Statistically unchanged since 2012.

Prevalence of High Blood Cholesterol
Healthy People 2020 Target = 13.5% or Lower
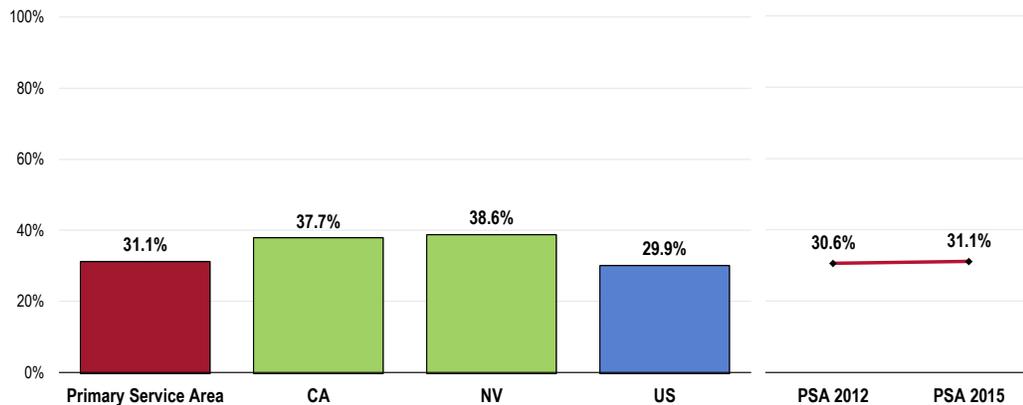
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 126]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

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

Note that 17.5% 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.

Further note the following:

- There is a positive correlation between age and high blood cholesterol.
- There is a higher prevalence among higher-income adults.
- Keep in mind that "unknowns" are relatively high in young adults, lower-income residents, and "Other" races.

Prevalence of High Blood Cholesterol
(Primary Service Area, 2015)
Healthy People 2020 Target = 13.5% or Lower
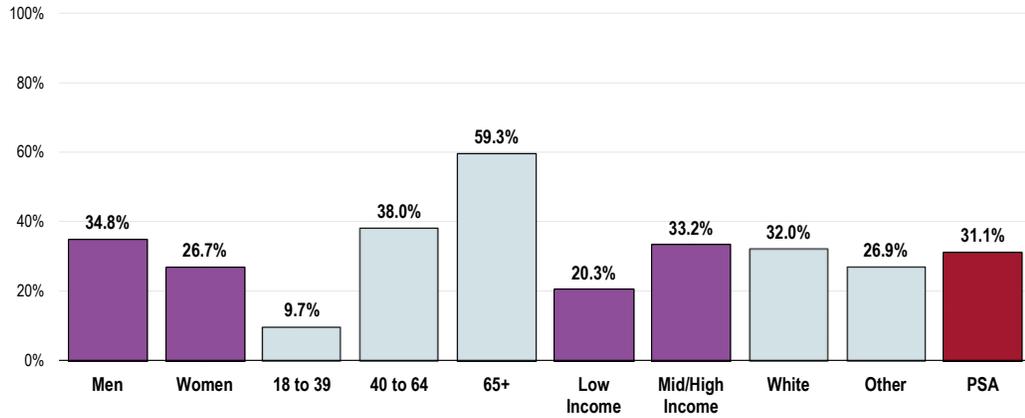
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 126]
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

High Cholesterol Management

Among adults who have been told that their blood cholesterol was high, 93.1% report that they are currently taking actions to control their cholesterol levels.

- More favorable than found nationwide.
- TREND: Statistically unchanged since 2012.

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?"

Taking Action to Control High Blood Cholesterol Levels
(Among Adults With High Cholesterol)
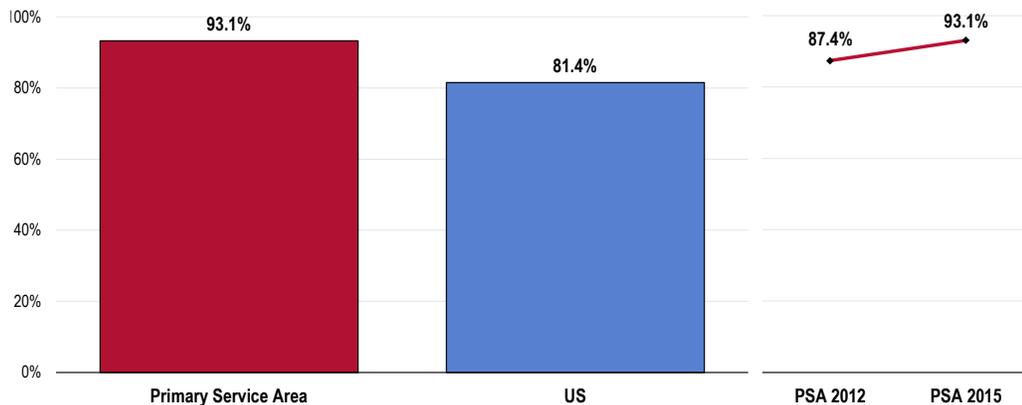
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 47]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents who have been diagnosed with high blood cholesterol levels.
● In this case, the term "action" refers to medication, change in diet, and/or exercise.

About 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
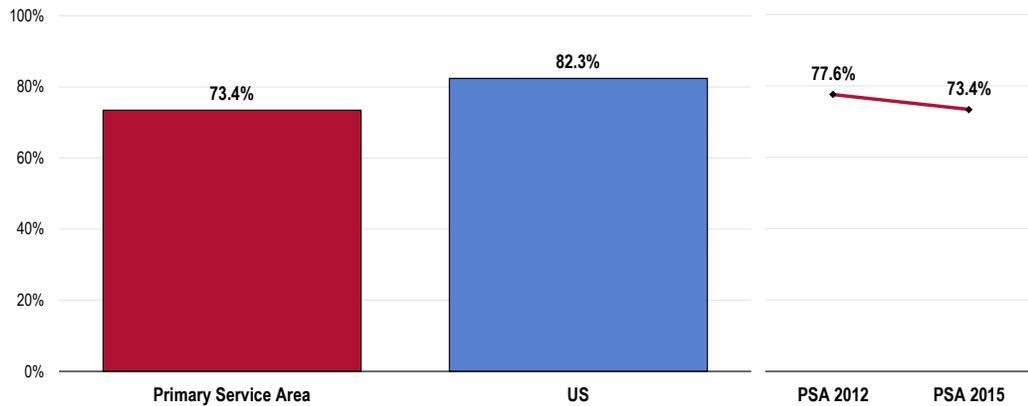
Total Cardiovascular Risk

A total of 73.4% 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.

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

- Notably lower than national findings.
- TREND: Statistically similar to the 2012 findings.

Present One or More Cardiovascular Risks or Behaviors

[Bar chart]

- Primary Service Area: 73.4%
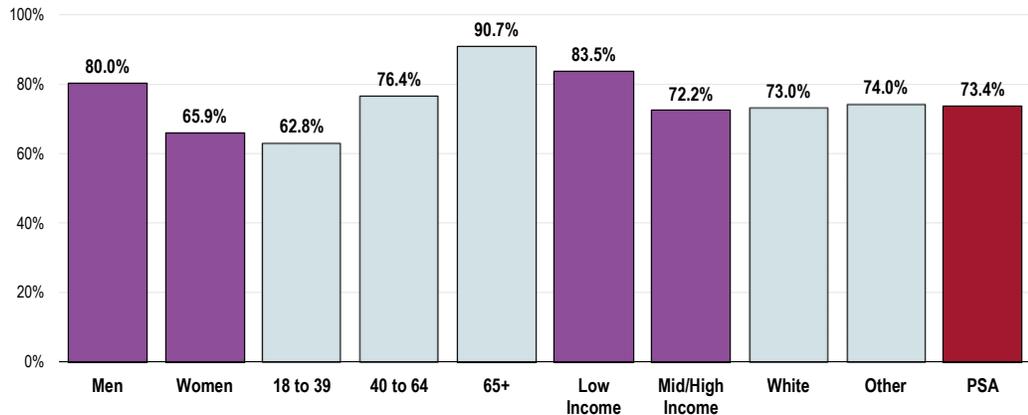- US: 82.3%
- PSA 2012: 77.6%
- PSA 2015: 73.4%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 127]
● 2013 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, especially seniors.
- Low-income respondents.

Present One or More Cardiovascular Risks or Behaviors
(Primary Service Area, 2015)

[Bar chart]

- Men: 80.0%
- Women: 65.9%
- 18 to 39: 62.8%
- 40 to 64: 76.4%
- 65+: 90.7%
- Low Income: 83.5%
- Mid/High Income: 72.2%
- White: 73.0%
- Other: 74.0%
- PSA: 73.4%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
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. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Key Informant Input: Heart Disease & Stroke

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

Perceptions of Heart Disease and Stroke
as a Problem in the Community
(Key Informants, 2015)
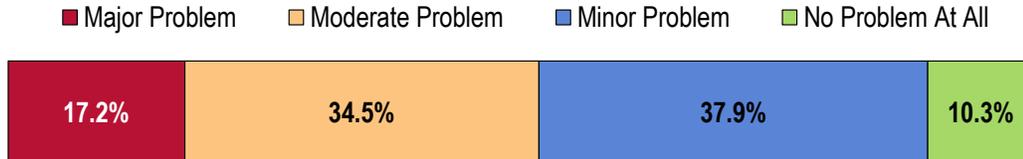
■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

17.2%	34.5%	37.9%	10.3%

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

Top Concerns

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

Aging Population

> *As the general population gets older, heart disease and stroke becomes a bigger problem. People need to understand the importance of proper diet, exercise and stress reduction. – Other Health Provider*

Lack of Facilities

> *Lake of facilities to care. CareFlights necessary. Lack of cardiology specialist in the basin. – Social Services Representative*

Lack of Access

> *Access to rehab services and medical services for residents. – Community Leader*

Cancer

About Cancer

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

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

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

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)
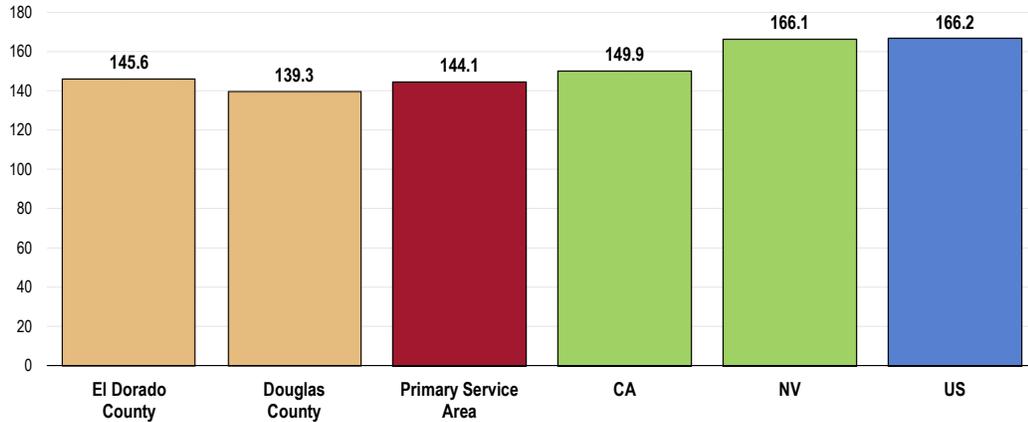
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2011 and 2013, there was an annual average age-adjusted cancer mortality rate of 144.1 deaths per 100,000 population in the Primary Service Area.

- Comparable to the California rate, more favorable than the Nevada rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 161.4 or lower.
- Higher in El Dorado County.

Cancer: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
### Healthy People 2020 Target = 161.4 or Lower

El Dorado County	Douglas County	Primary Service Area	CA	NV	US
145.6	139.3	144.1	149.9	166.1	166.2

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

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

- TREND: Cancer mortality has <u>decreased</u> over the past decade in the Primary Service Area; the same trend is apparent in both states and nationwide.

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 161.4 or Lower
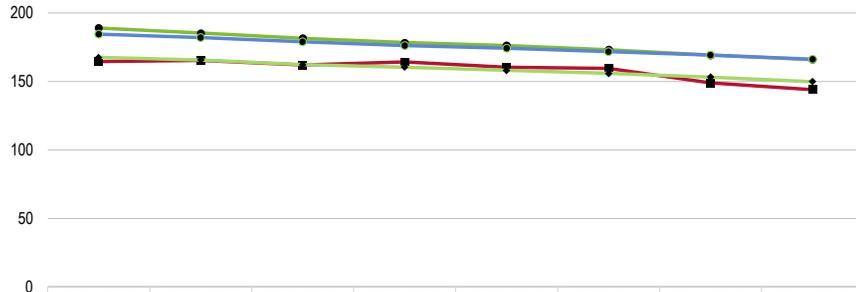
	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	164.6	165.4	162.1	164.4	160.4	159.5	149.0	144.1
California	167.5	165.7	162.4	160.5	158.2	155.9	153.2	149.9
Nevada	189.1	185.4	181.6	178.5	176.3	173.2	169.3	166.1
United States	184.6	182.1	179.2	176.4	174.2	171.8	169.4	166.2

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

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

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the 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 2011-2013 annual average age-adjusted death rates):

- The Primary Service Area **lung cancer** death rate is <u>identical</u> to the California rate and more favorable than the Nevada and national rates.
- The area's **female breast cancer** death rate is <u>similar</u> to the California rate and more favorable than the Nevada and US rates.
- The Primary Service Area **prostate cancer** death rate is <u>lower</u> than both state rates as well as the national rate.
- The Primary Service Area **colorectal cancer** death rate is <u>lower</u> both state rates and also the national rate.

Note that each of the Primary Service Area cancer death rates detailed below satisfies the related Healthy People 2020 target, with the exception of female breast cancer (the service area rate is similar to the 2020 goal).

Age-Adjusted Cancer Death Rates by Site
(2011–2013 Annual Average Deaths per 100,000 Population)

	Primary Service Area	CA	NV	US	HP2020
Lung Cancer	33.3	33.3	46.6	44.7	45.5
Female Breast Cancer	19.9	20.6	22.7	21.3	20.7
Prostate Cancer	18.3	19.8	21.0	19.8	21.8
Colorectal Cancer	11.4	13.6	17.0	14.9	14.5

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

Cancer Incidence

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

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

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

Between 2007 and 2011, Primary Service Area had an annual average age-adjusted incidence rate of <u>prostate cancer</u> of 152.7 cases per 100,000 population.

- Worse than the statewide incidence rates.
- Worse than the national incidence rate.

There was an annual average age-adjusted incidence rate of 130.6 <u>female breast cancer</u> cases per 100,000 in the Primary Service Area.

- Worse than the California incidence rate.
- Worse than the national incidence rate.

There was an annual average age-adjusted incidence rate of 53.2 <u>lung cancer</u> cases per 100,000 in the Primary Service Area.

- Worse than the statewide incidence rate.
- Better than the national incidence rate.

There was an annual average age-adjusted incidence rate of <u>colorectal cancer</u> of 42.8 cases per 100,000 in the Primary Service Area.

- Comparable to the statewide incidence rate.
- Comparable to the national incidence rate.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2007-2011)

Legend: ■ Primary Service Area □ CA □ NV ■ US

Site	Primary Service Area	CA	NV	US
Prostate Cancer	152.7	122.9	123.6	123.6
Female Breast Cancer	130.6	122.4	N/A	122.7
Lung Cancer	53.2	49.5	N/A	64.9
Colon/Rectal Cancer	42.8	41.5	N/A	43.3
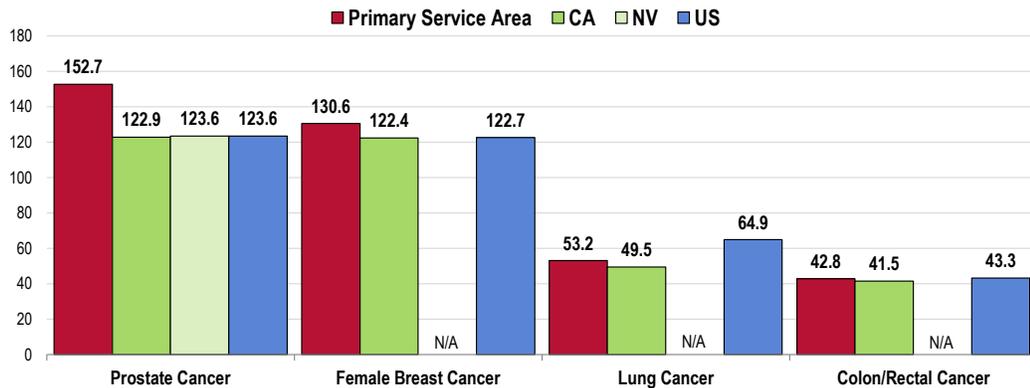
Sources:
- State Cancer Profiles: 2007-11.
- Retrieved March 2015 from Community Commons at http://www.chna.org.

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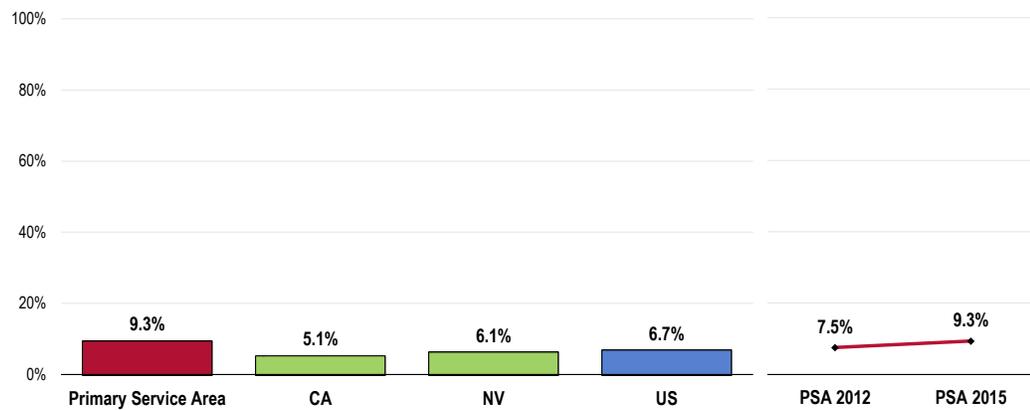
Prevalence of Cancer

Skin Cancer

A total of 9.3% of surveyed Primary Service Area adults report having been diagnosed with skin cancer.

- Higher than both statewide percentages.
- Similar to the national average.
- TREND: The prevalence of skin cancer has remained statistically unchanged over time.

Prevalence of Skin Cancer

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

Notes:
- Asked of all respondents.

Other Cancer

A total of 5.1% of respondents have been diagnosed with some type of (non-skin) cancer.

- Similar to the statewide findings.
- Similar to the national prevalence.
- TREND: The prevalence of cancer has remained statistically unchanged over time.

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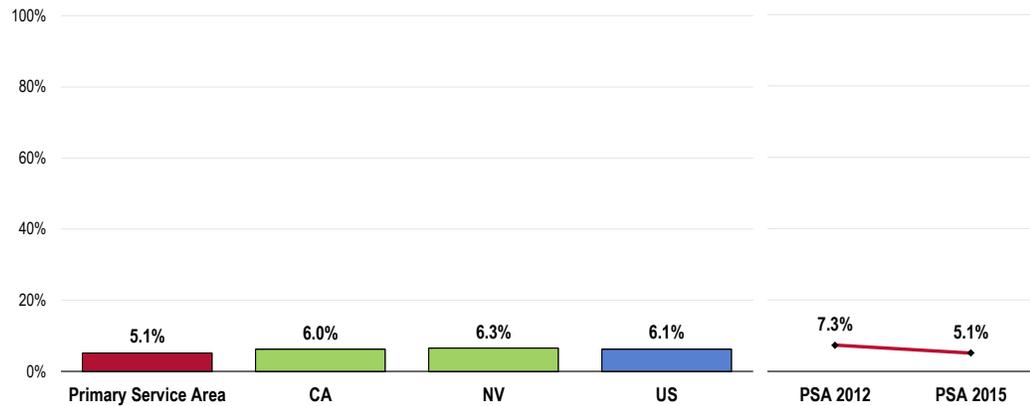
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.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

Notes:
- Asked of all respondents.

Cancer Risk

About Cancer Risk

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

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

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

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

Cancer Screenings

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

Screening levels in the community were measured in the PRC Community Health Survey relative to four cancer sites: prostate cancer (PSA [prostate-specific antigen] test and/or a digital rectal examination); female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Prostate Cancer Screenings

About Screening for Prostate Cancer

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.

PSA Testing and/or Digital Rectal Examination

Among men age 50 and older, more than three-fourths (76.6%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

Note: Since 2008 changes in clinical recommendations against routine PSA testing, most communities are seeing prevalence decline.

- Similar to national findings.
- TREND: Statistically unchanged since 2012.

Have Had a Prostate Screening in the Past Two Years
(Among Men Age 50 and Older)
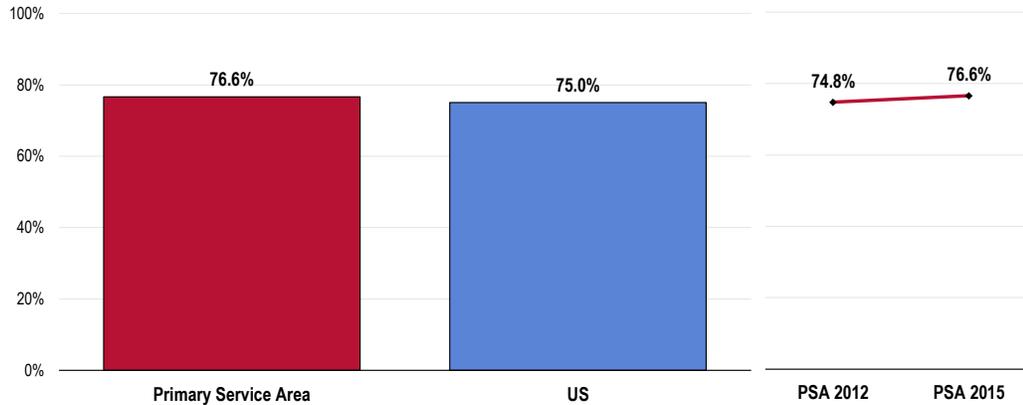
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 183]
　　　　　● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all male respondents age 50 and older.

Female Breast Cancer Screening

About Screening for Breast Cancer

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

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

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

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

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

Mammography

Among women age 50-74, 76.9% have had a mammogram within the past two years.

- Similar to both statewide proportions (which represent all women 50+).
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- Among women 40+, 73.7% have had a mammogram in the past two years.
- TREND: Statistically unchanged since 2012.

Have Had a Mammogram in the Past Two Years
(Among Women Age 50-74)
Healthy People 2020 Target = 81.1% or Higher
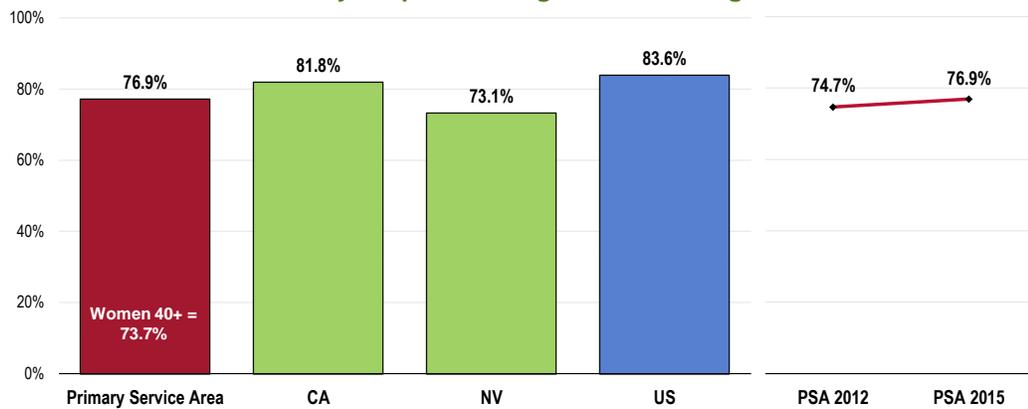
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 128-129]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

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

Cervical Cancer Screenings

About Screening for Cervical Cancer

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

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

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

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

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

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

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

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

Pap Smear Testing

Among women age 21 to 65, 86.5% have had a Pap smear within the past three years.

- More favorable than both state percentages (which represent all women 18+).
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- TREND: Statistically unchanged since 2012.

Have Had a Pap Smear in the Past Three Years
(Among Women Age 21-65)
Healthy People 2020 Target = 93.0% or Higher
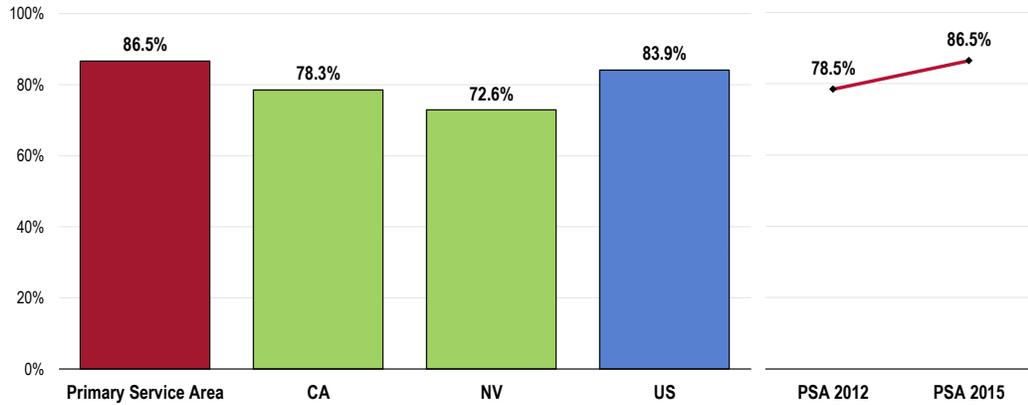
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 130]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

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

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

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

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

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

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

Colorectal Cancer Screening

Among adults age 50-75, 71.2% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years).

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (70.5% or higher).
- TREND: Statistically unchanged over time.

Have Had a Colorectal Cancer Screening
(Among Adults Age 50-75)
Healthy People 2020 Target = 70.5% or Higher

Bar chart showing: Primary Service Area 71.2%, US 75.1%, PSA 2012 73.3%, PSA 2015 71.2%.
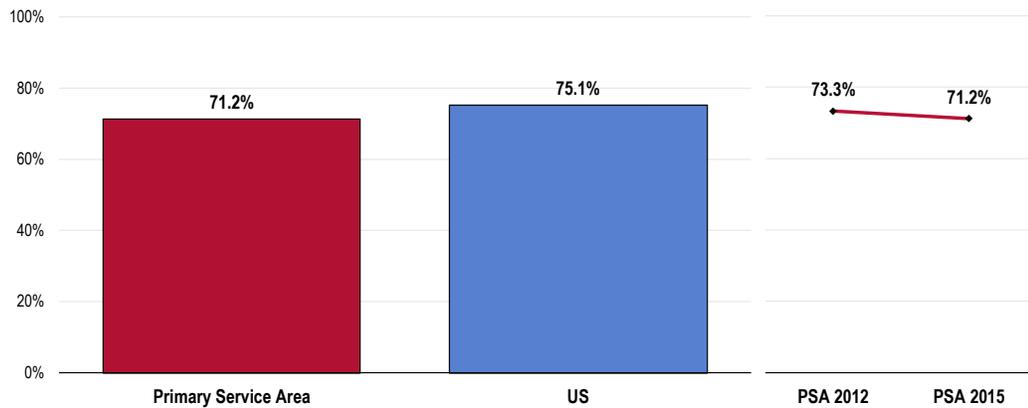
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 133]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

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

Lower Endoscopy

Among adults age 50 and older, more than 7 in 10 (71.4%) have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.

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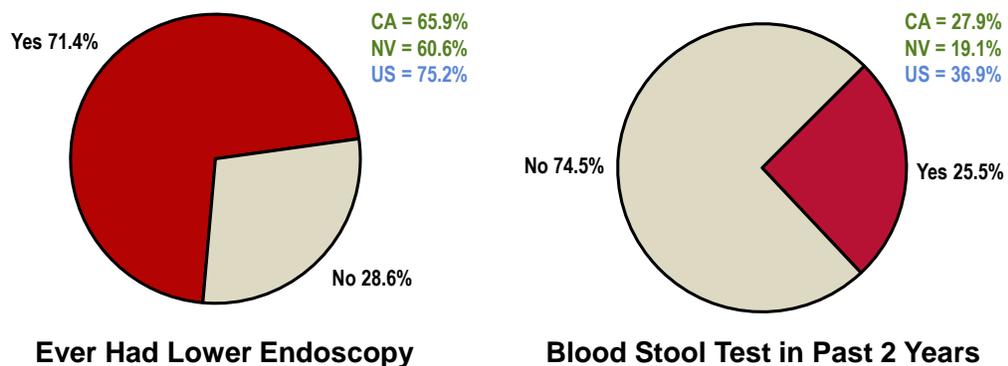- Similar to the national findings.

Blood Stool Testing

Among adults age 50 and older, 25.5% have had a blood stool test (aka "fecal occult blood test") within the past two years.

- Comparable to California findings, better than the Nevada proportion.
- Lower than the national findings.

Colorectal Cancer Screenings
(Among Primary Service Area Adults Age 50 and Older, 2015)

Yes 71.4% No 28.6%
CA = 65.9%
NV = 60.6%
US = 75.2%

Ever Had Lower Endoscopy

No 74.5% Yes 25.5%
CA = 27.9%
NV = 19.1%
US = 36.9%

Blood Stool Test in Past 2 Years

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 131-132]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
Notes: ● Asked of respondents age 50 and older.
● Lower endoscopy includes either sigmoidoscopy or colonoscopy.

Key Informant Input: Cancer

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

Perceptions of Cancer
as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   □ Moderate Problem   □ Minor Problem   □ No Problem At All

21.6%	62.2%	13.5%	2.7%

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

Top Concerns

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

Lack of Healthcare Services

I have known several people with cancer and they all seem to have very little health care options in the area. I have a personal connection with a cancer patient who almost lost their life due to lack of care in South Lake Tahoe. There seems to be more women battling breast cancer lately and it's my understanding that they need to travel out of area or state frequently for treatment. – Public Health Expert

Treatment of cancer is difficult to access in our community. I've known three people in the past year who have sought treatment at the Truckee Cancer Center. Driving over an hour to receive chemo hurts the person seeking treatment and the person struggling to get them there and back. Why don't we have adequate cancer treatment facilities in our community? – Community Leader

We have a lack of adequate services for our residents. Requiring residents to travel for care. – Community Leader

Lack of Specialists

I do not think we have the specialists here in town that make it easy for patients to get the care they need for many types of cancer. It seems that many people I have known have had to drive to Carson or Reno for care. – Community Leader

Very limited access to Oncologists, chemotherapy and advanced clinical support. Low income and elderly population often suffer from lack of in home assistance and transportation. This leads to despair and apathy in following through with care. – Community Leader

Cost of Services

Services must be obtained outside of the Tahoe basin. Cost in the Tahoe basin is extremely high. – Social Services Representative

High Occurrence of Cancer

It just seems like more and more people are being diagnosed. Maybe it's just my circle of friends. – Community Leader

Distance

Patients must travel long distance to receive treatment. – Social Services Representative

Respiratory Disease

About Asthma & COPD

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

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

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

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

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

Risk factors for asthma currently being investigated include:

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

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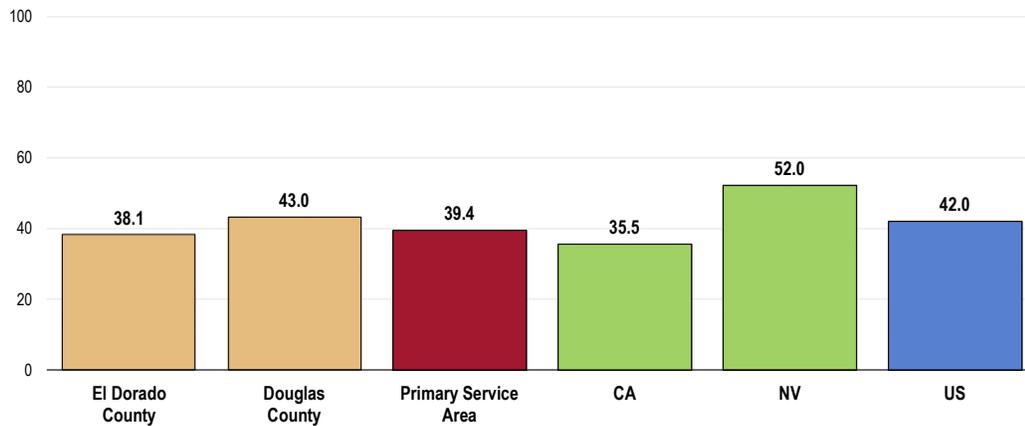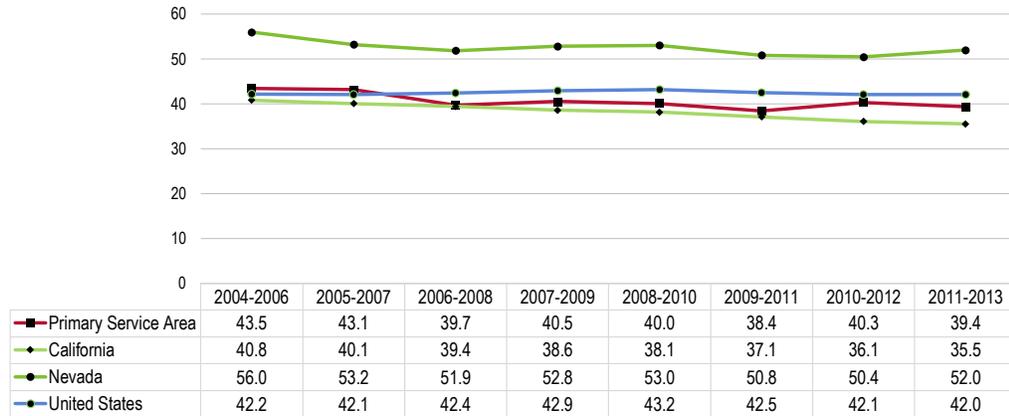
Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

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

Between 2011 and 2013, there was an annual average age-adjusted CLRD mortality rate of 39.4 deaths per 100,000 population in the Primary Service Area.

- Worse than the California rate but better than the Nevada rate.
- Lower than the national rate.
- Higher in Douglas County.

CLRD: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)

El Dorado County	Douglas County	Primary Service Area	CA	NV	US
38.1	43.0	39.4	35.5	52.0	42.0

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

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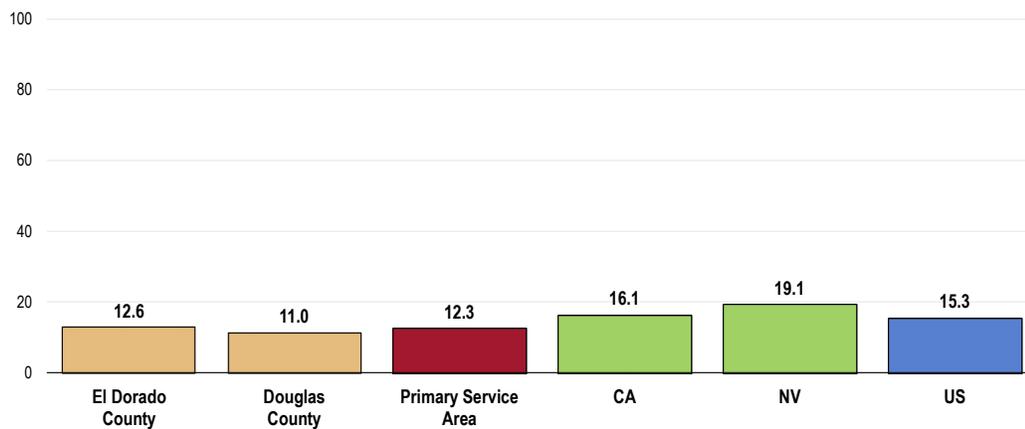- CLRD is chronic lower respiratory disease.

- TREND: CLRD mortality in the Primary Service Area has decreased over time, mirroring the statewide trends (the national rate has been stable).

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

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	43.5	43.1	39.7	40.5	40.0	38.4	40.3	39.4
California	40.8	40.1	39.4	38.6	38.1	37.1	36.1	35.5
Nevada	56.0	53.2	51.9	52.8	53.0	50.8	50.4	52.0
United States	42.2	42.1	42.4	42.9	43.2	42.5	42.1	42.0

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• State and national data are simple three-year averages.
• CLRD is chronic lower respiratory disease.

Pneumonia/Influenza Deaths

Between 2011 and 2013, there was an annual average age-adjusted pneumonia/ influenza mortality rate of 12.3 deaths per 100,000 population in the service area.

- Lower than found in both states.
- Lower than the national rate.
- Higher in El Dorado County.

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

Pneumonia/Influenza: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)

El Dorado County	Douglas County	Primary Service Area	CA	NV	US
12.6	11.0	12.3	16.1	19.1	15.3

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.

● TREND: Pneumonia/influenza mortality has decreased over the past decade.

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

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	17.3	14.8	13.3	12.9	15.1	14.8	12.8	12.3
California	23.4	22.1	20.5	19.0	17.9	17.0	16.1	16.1
Nevada	21.7	21.0	20.6	21.5	21.7	20.9	19.5	19.1
United States	19.9	18.7	17.6	17.0	16.4	15.8	15.1	15.3

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● State and national data are simple three-year averages.

Chronic Obstructive Pulmonary Disease (COPD)

A total of 5.5% of Primary Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

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

● Similar to the state figures.
● Similar to the national prevalence.
● NOTE: in prior data, this question was asked slightly differently; respondents in 2012 were asked if they had ever been diagnosed with "chronic lung disease, including bronchitis or emphysema," rather than "COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema" as is asked currently.

TREND: In comparing to 2012 data, the change in prevalence is not statistically significant.

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)
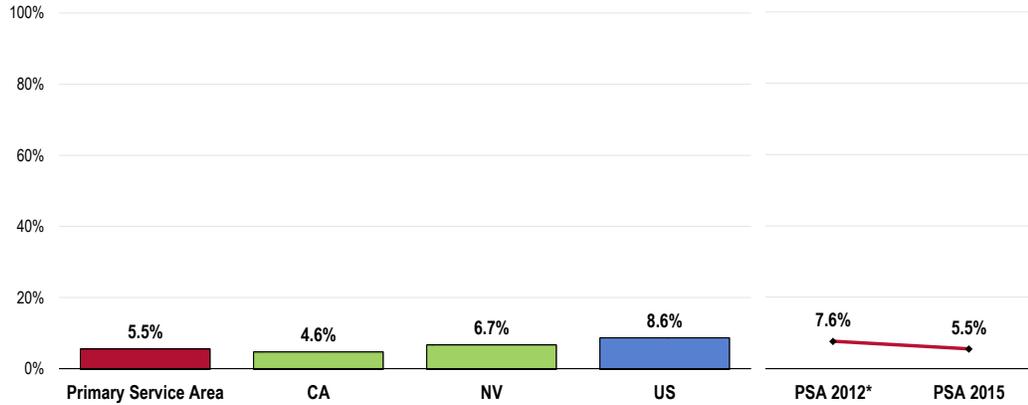
Sources:
● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes:
● Asked of all respondents.
● Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
● *In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Asthma

Adults

A total of 5.4% of Primary Service Area adults currently suffer from asthma.

- Better than the California prevalence, similar to Nevada.
- More favorable than the national prevalence.
- TREND: The prevalence has not changed significantly since 2012.

Adult Asthma: Current Prevalence
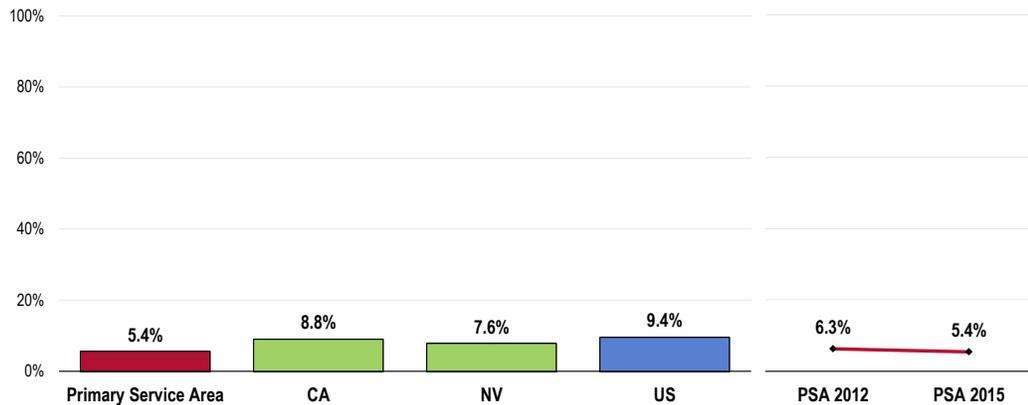
Sources:
● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 134]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
Notes:
● Asked of all respondents.
● Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

● Primary Service Area women are more likely to have asthma.

Currently Have Asthma
### (Primary Service Area, 2015)
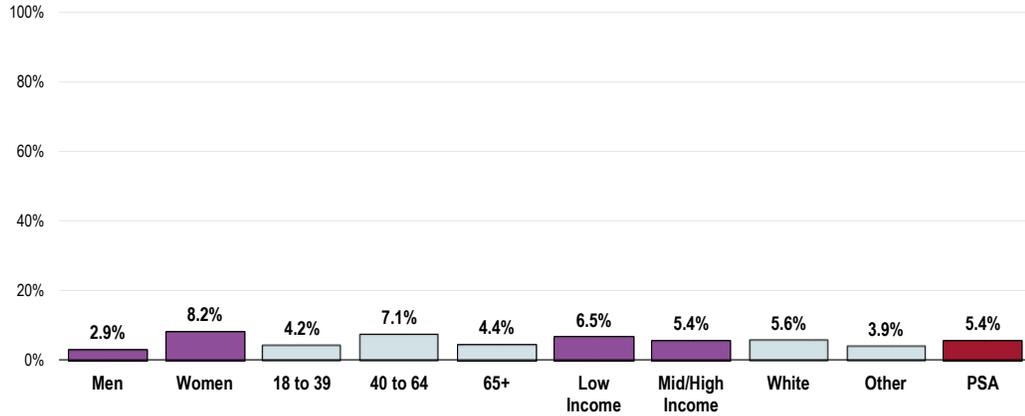
Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
2.9%	8.2%	4.2%	7.1%	4.4%	6.5%	5.4%	5.6%	3.9%	5.4%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 134]
Notes: ● Asked of all respondents.
          ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
          ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 Primary Service Area children under age 18, 4.6% currently have asthma.

● Statistically similar to national findings.

● TREND: The prevalence has not changed significantly over time.

Childhood Asthma: Current Prevalence
(Among Parents of Children Age 0-17)

Primary Service Area	US	PSA 2012	PSA 2015
4.6%	7.1%	3.2%	4.6%
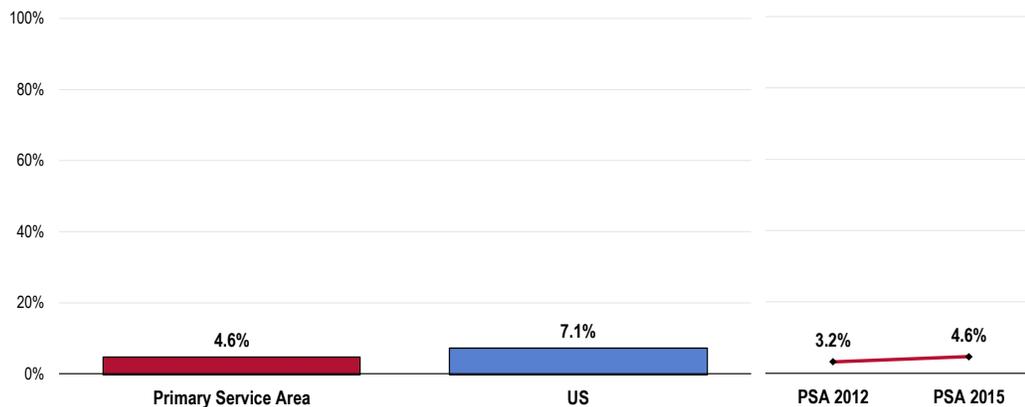
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 135]
          ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.
          ● Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases
as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   □ No Problem At All

14.3%	42.9%	35.7%	7.1%

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

Top Concerns

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

Radon

> *Very high rate of radon in our community. Couple this with a significant portion of people who are in smoke filled casinos and you have a recipe for lung cancer. – Community Leader*

Prevalence of Bronchitis

> *Bronchitis is common during the winter. – Social Services Representative*

Injury & Violence

About Injury & Violence

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

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

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

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

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

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

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

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

Efforts to prevent violence may focus on:

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

- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Poisoning (including accidental drug overdose), motor vehicle accidents, falls, and drowning/submersion accounted for 80.9% of accidental deaths in the Primary Service Area between 2011 and 2013.

Leading Causes of Accidental Death
(Primary Service Area, 2011–2013)
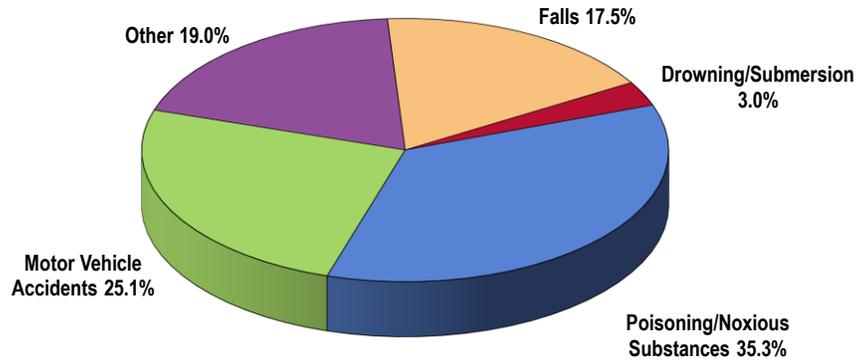
Falls 17.5%

Other 19.0%

Drowning/Submersion 3.0%

Motor Vehicle Accidents 25.1%

Poisoning/Noxious Substances 35.3%

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

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2011 and 2013, there was an annual average age-adjusted unintentional injury mortality rate of 44.0 deaths per 100,000 population in the Primary Service Area.

- Less favorable than the California rate but comparable to the Nevada rate.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target (36.4 or lower).
- Higher in Douglas County.

COMMUNITY HEALTH NEEDS ASSESSMENT

Unintentional Injuries: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 36.4 or Lower

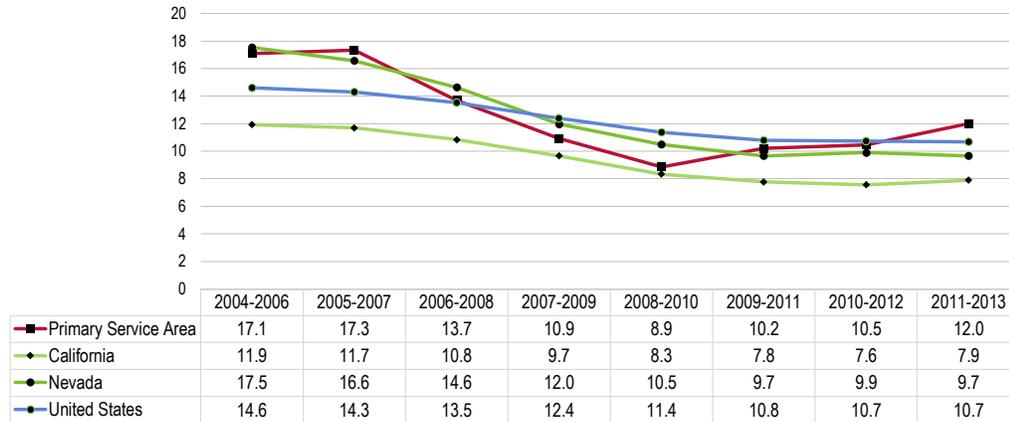| El Dorado County	Douglas County	Primary Service Area	CA	NV	US
43.2	47.5	44.0	28.5	42.4	39.2

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

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

- TREND: The Primary Service Area mortality rate has not shown a clear trend over the past decade.

Unintentional Injuries: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 36.4 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	43.1	48.0	46.7	46.1	43.3	44.5	42.9	44.0
California	31.5	32.0	31.3	30.4	28.9	28.5	28.0	28.5
Nevada	45.5	46.5	45.5	43.7	41.4	41.0	42.2	42.4
United States	39.3	40.0	39.9	39.0	38.2	38.2	38.7	39.2

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

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

Motor Vehicle Safety

Age-Adjusted Motor-Vehicle Related Deaths

Between 2011 and 2013, there was an annual average age-adjusted motor vehicle crash mortality rate of 12.0 deaths per 100,000 population in the Primary Service Area.

- Much higher than found in both states.
- Higher than found nationally.
- Similar to the Healthy People 2020 target (12.4 or lower).
- *Douglas County data not available.*

Motor Vehicle Crashes: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 12.4 or Lower

El Dorado County	Douglas County	Primary Service Area	CA	NV	US
12.2	N/A	12.0	7.9	9.7	10.7

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

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

- TREND: The mortality rate in the Primary Service Area decreased sharply in the late 2000s, but has since begun to increase.

Motor Vehicle Crashes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 12.4 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	17.1	17.3	13.7	10.9	8.9	10.2	10.5	12.0
California	11.9	11.7	10.8	9.7	8.3	7.8	7.6	7.9
Nevada	17.5	16.6	14.6	12.0	10.5	9.7	9.9	9.7
United States	14.6	14.3	13.5	12.4	11.4	10.8	10.7	10.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● Local, state and national data are simple three-year averages.

Seat Belt Usage - Adults

Most Primary Service Area adults (92.9%) 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.
- TREND: No significant change since 2012.

"Always" Wear a Seat Belt
When Driving or Riding in a Vehicle
Healthy People 2020 Target = 92.0% or Higher

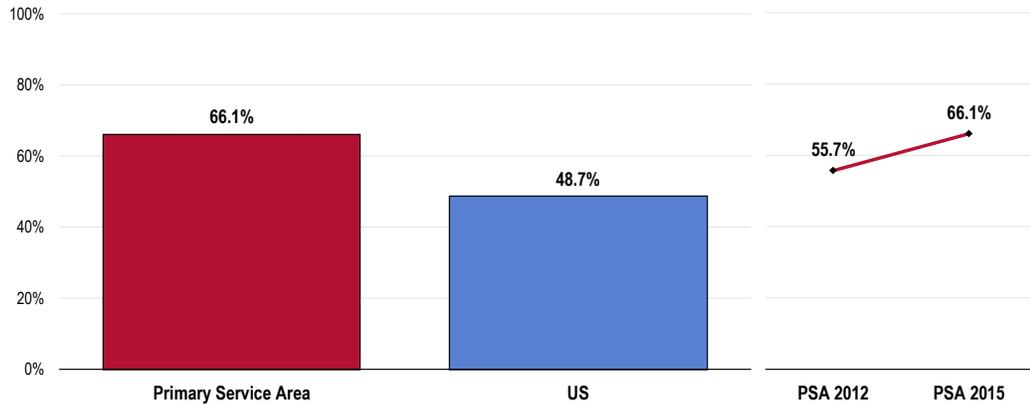| Primary Service Area	US	PSA 2012	PSA 2015
92.9%	84.8%	91.2%	92.9%
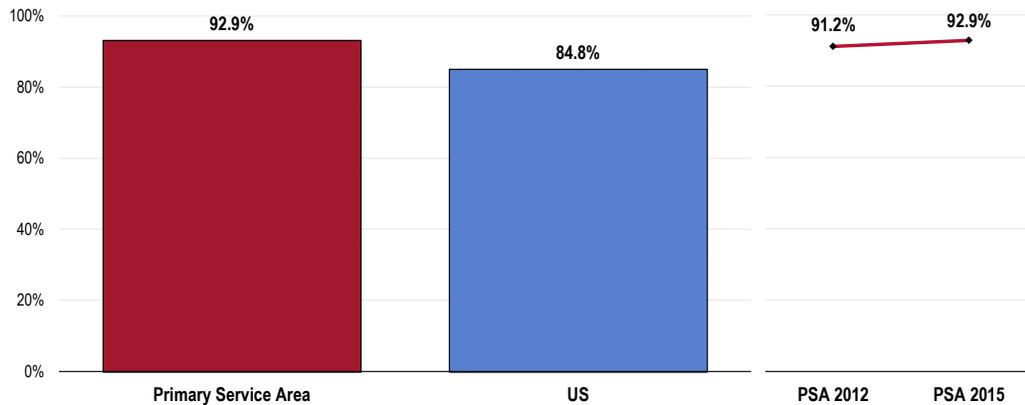
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 49]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-15]
Notes: ● Asked of all respondents.

These population segments are <u>less</u> likely to report consistent seat belt usage:

- Men.
- Adults under age 65 (positive correlation with age).

"Always" Wear a Seat Belt
When Driving or Riding in a Vehicle
(Primary Service Area, 2015)
Healthy People 2020 Target = 92.0% or Higher

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
89.3%	96.9%	90.3%	92.8%	98.0%	87.2%	93.4%	93.1%	91.7%	92.9%
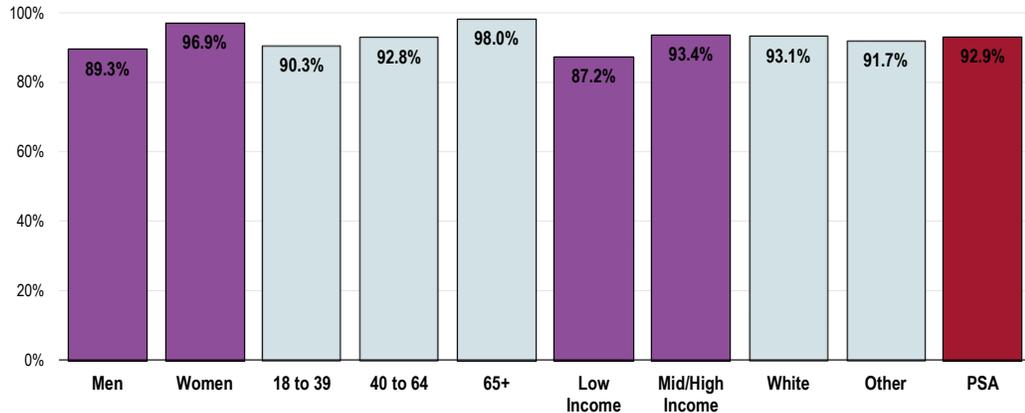
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-15]
Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 98.0% 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.
- TREND: Statistically unchanged since 2012.

Child "Always" Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle
(Among Parents of Children Age 0-17)

	Primary Service Area	US	PSA 2012	PSA 2015
	98.0%	92.2%	96.7%	98.0%
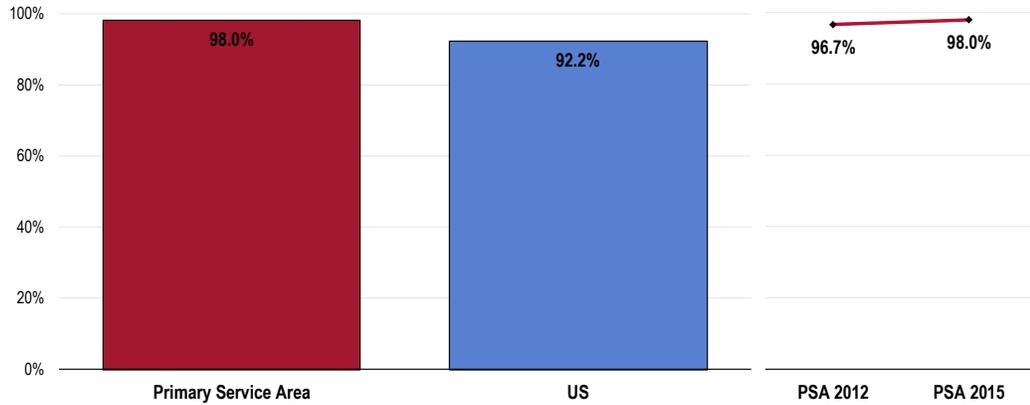
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 122]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Bicycle Safety

Approximately two-thirds of Primary Service Area children age 5 to 17 (66.1%) are reported to "always" wear a helmet when riding a bicycle.

- Much higher than the national prevalence.
- TREND: Statistically unchanged over time.

Child "Always" Wears a Helmet When Riding a Bicycle
(Among Parents of Children Age 5-17)

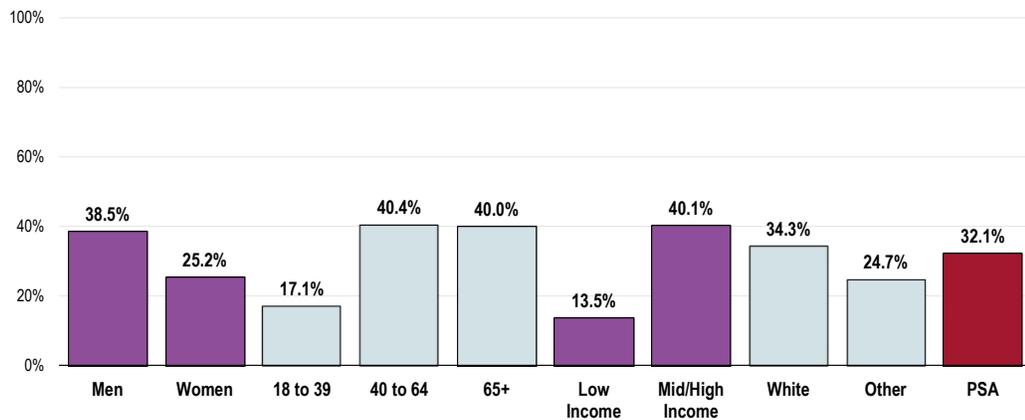|	Primary Service Area	US	PSA 2012	PSA 2015
	66.1%	48.7%	55.7%	66.1%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 121]
● 2013 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 2011 and 2013, there was an annual average age-adjusted rate of 10.5 deaths per 100,000 population due to firearms in the Primary Service Area.

- Higher than found in California but lower than the Nevada rate.
- Similar to the US rate.
- Fails to satisfy the Healthy People 2020 objective (9.3 or lower).
- *Douglas County data not available.*

Firearms-Related Deaths: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 9.3 or Lower

	El Dorado County	Douglas County	Primary Service Area	CA	NV	US
Rate	10.0	N/A	10.5	7.8	13.4	10.4

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

- TREND: The mortality rate in the Primary Service Area has fluctuated over the past decade.

Firearms-Related Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 9.3 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	11.8	12.7	10.5	11.9	12.0	12.7	10.3	10.5
California	9.3	9.2	8.9	8.5	8.1	7.9	7.8	7.8
Nevada	16.4	16.1	15.8	15.4	14.9	14.4	13.7	13.4
United States	10.2	10.3	10.3	10.2	10.2	10.1	10.3	10.4

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

Presence of Firearms in Homes

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."

Overall, nearly one-third of Primary Service Area adults (32.1%) has a firearm kept in or around their home.

- Comparable to the national prevalence.
- TREND: Similar to that reported in 2012.
- Among Primary Service Area households with children, 30.6% have a firearm kept in or around the house (similar to that reported nationally).
- TREND: The prevalence of firearms in households with children is statistically unchanged (not shown).

Have a Firearm Kept in or Around the Home

Households With Children: 30.6% (vs. 37.4% nationwide)

- Primary Service Area: 32.1%
- US: 34.7%
- PSA 2012: 27.8%
- PSA 2015: 32.1%
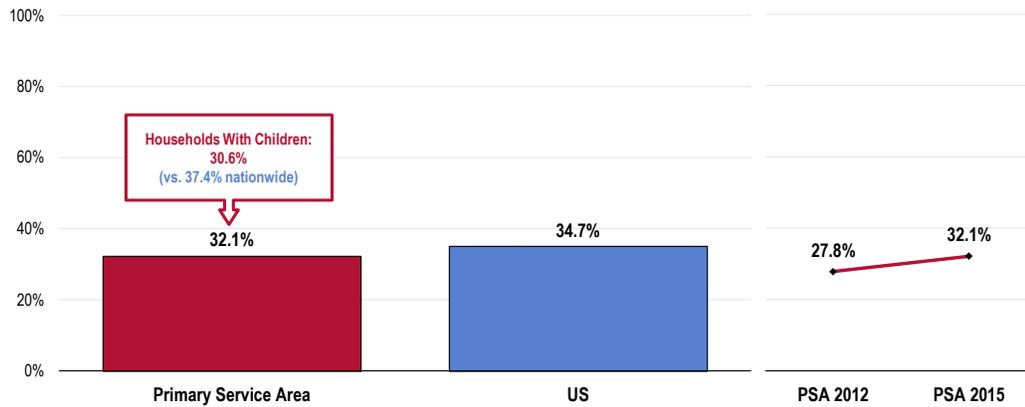
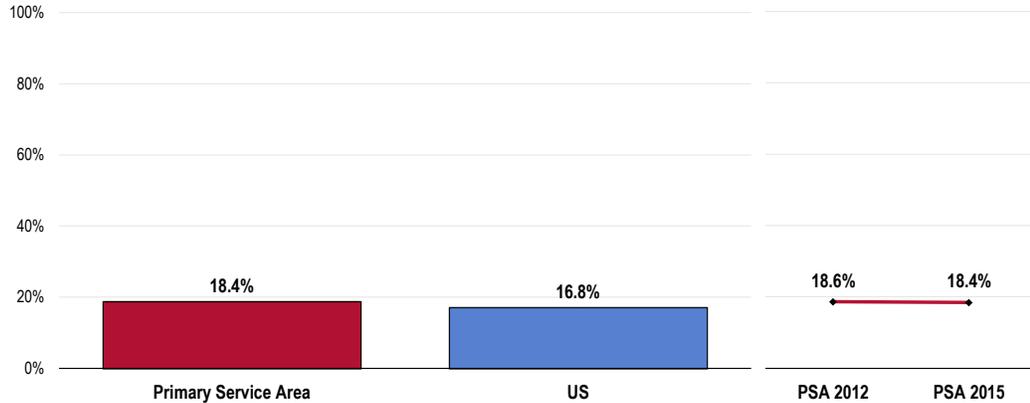Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 52, 137]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

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

- Men.
- Residents age 40 and older.
- Higher-income households.

Have a Firearm Kept in or Around the House
(Primary Service Area, 2015)

- Men: 38.5%
- Women: 25.2%
- 18 to 39: 17.1%
- 40 to 64: 40.4%
- 65+: 40.0%
- Low Income: 13.5%
- Mid/High Income: 40.1%
- White: 34.3%
- Other: 24.7%
- PSA: 32.1%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
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. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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, 18.4% report that there is at least one weapon that is kept unlocked and loaded.

- Statistically similar to that found nationally.
- TREND: Statistically similar to that reported in 2012.

Household Has An Unlocked, Loaded Firearm
(Among Respondents Reporting a Firearm in or Around the Home)

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 138]
      ● 2013 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

Between 2011 and 2013, there was an annual average age-adjusted homicide rate of 2.8 deaths per 100,000 population in the Primary Service Area.

RELATED ISSUE:

See also *Suicide* in the **Mental Health** section of this report.

- 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.
- *Douglas County data not available*.

Homicide: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 5.5 or Lower
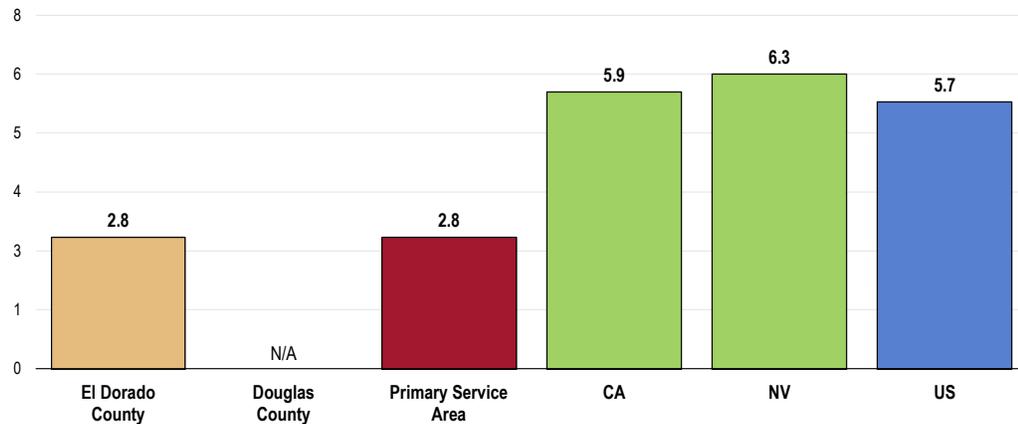
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-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 US Standard Population.
- Local, state and national data are simple three-year averages.

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.

In 2012, there were a reported 218.4 violent crimes per 100,000 population in the Primary Service Area.

- Well below the California and Nevada rates for the same period.
- Well below the national rate.
- Higher in El Dorado County.

Violent Crime
(Rate per 100,000 Population, 2012)

Bar chart values:
- El Dorado County: 245.9
- Douglas County: 112.7
- Primary Service Area: 218.4
- CA: 423.0
- NV: 607.5
- US: 386.8

Self-Reported Violence

A total of 3.2% of Primary Service Area adults acknowledge being the victim of a violent crime in the past five years.

- Statistically similar to national findings.
- TREND: Statistically unchanged over time.

Victim of a Violent Crime in the Past Five Years
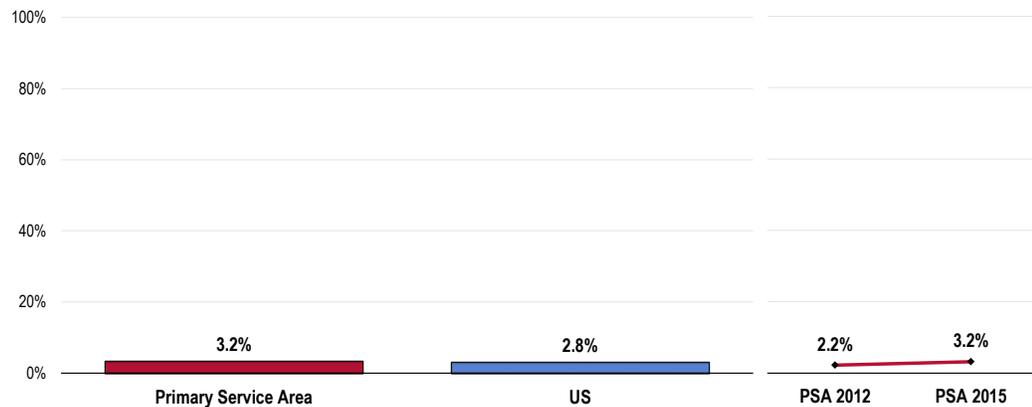
Bar chart values:
- Primary Service Area: 3.2%
- US: 2.8%
- PSA 2012: 2.2%
- PSA 2015: 3.2%

● No statistically significant differences by demographic characteristics.

Victim of a Violent Crime in the Past Five Years
(Primary Service Area, 2015)

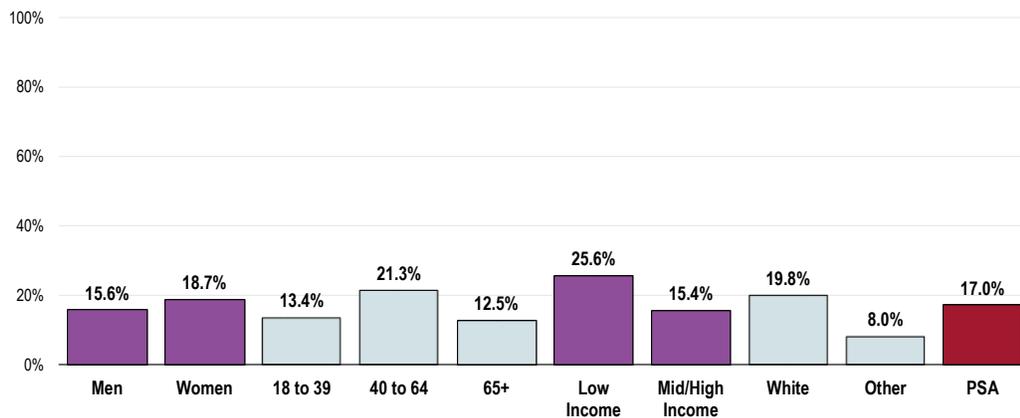|	Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
	4.2%	2.1%	2.7%	4.0%	1.4%	6.9%	2.2%	3.3%	2.3%	3.2%
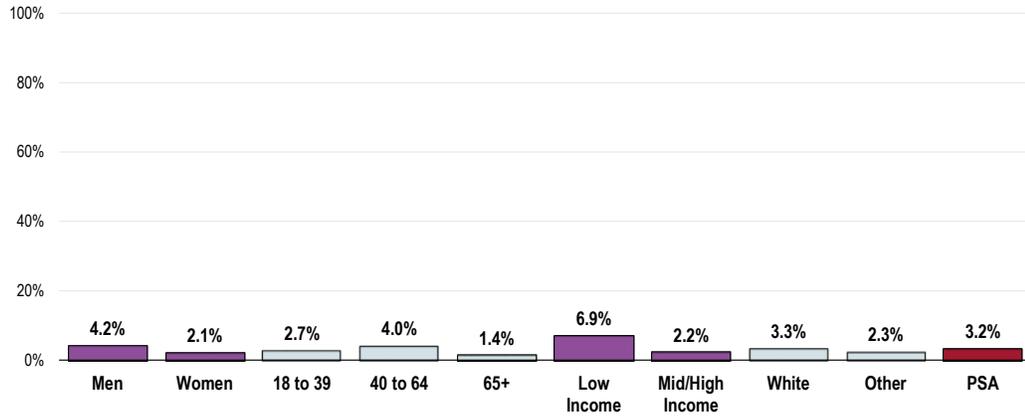
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 12.5% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

● Comparable to national findings.

● TREND: Denotes a statistically significant <u>decrease</u> over time.

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

Primary Service Area	US	PSA 2012	PSA 2015
12.5%	15.0%	19.4%	12.5%
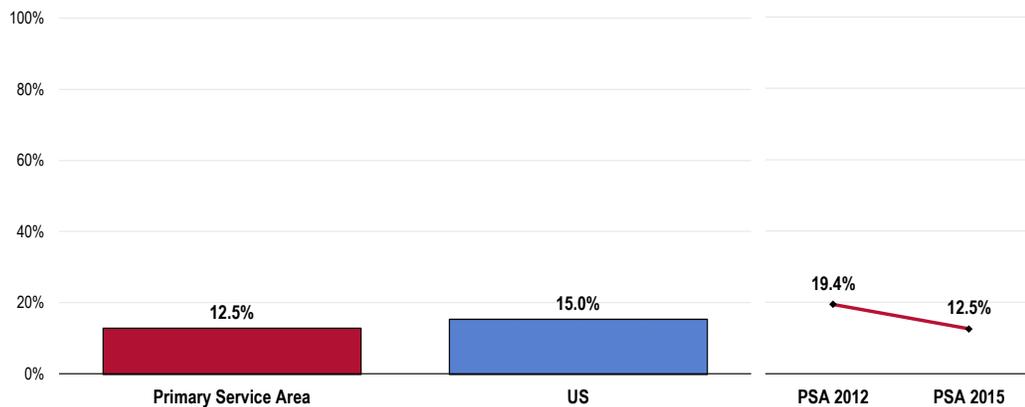
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 51]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

● Reports of domestic violence are notably higher among low-income adults.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner
(Primary Service Area, 2015)

	Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
	10.2%	15.1%	10.2%	15.5%	12.1%	19.5%	9.6%	13.4%	10.2%	12.5%
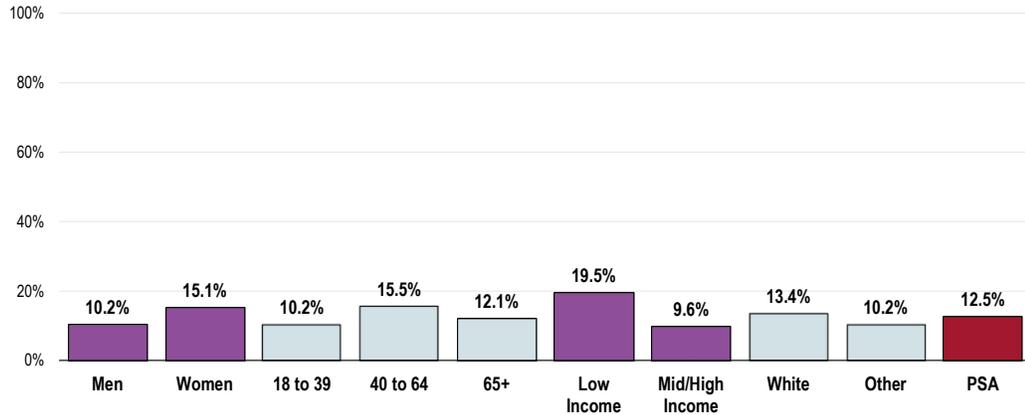
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 51]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

A total of 17.0% of respondents have been emotionally abused in a relationship on a regular basis.

● Statistically more prevalent among those with lower incomes and Whites.

Have Ever Been Emotionally Abused in a Relationship on a Regular Basis
(Primary Service Area, 2015)

	Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
	15.6%	18.7%	13.4%	21.3%	12.5%	25.6%	15.4%	19.8%	8.0%	17.0%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 305]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a "moderate problem" in the community.

Perceptions of Injury and Violence
as a Problem in the Community
(Key Informants, 2015)
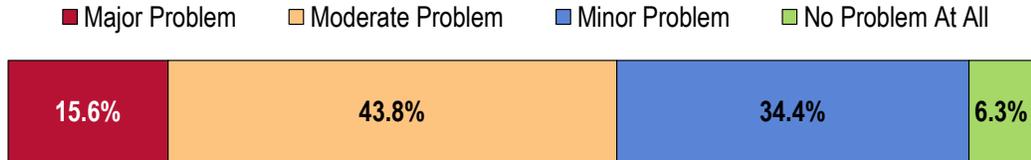
■ Major Problem ☐ Moderate Problem ■ Minor Problem ☐ No Problem At All

15.6%	43.8%	34.4%	6.3%

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

Top Concerns

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

Domestic and Sexual Assault

> *It is a systemic problem in our community that has a huge impact, especially on our youth. Domestic violence, sexual abuse, battery, the weekly police logs reflect the ongoing problem. The courts are challenged in that they mandate a person receive counseling, yet there aren't the resources to ensure that takes place especially if the person can't afford it. We have some great non-profits who offer counseling but we need to find the resources and avenues to get the people who most need it to them. I think we do a pretty good job getting the support to the victims but that is just one part of the equation. We need to address the root of the problem with the perpetrator. Battery is one example that shows that there needs to be a comprehensive treatment to address and help the batterer so that they can be a supporting member of their family. – Community Leader*

> *Law enforcement's lack of priority on domestic violence and sexual assault. – Social Services Representative*

> *Violence, especially domestic abuse is an issue because it often accompanies alcohol or drugs. – Other Health Provider*

Violence

> *There are a lot of fights and people getting hurt all the time due to violence. – Social Services Representative*

Sports Injury

> *Injury is an issue because we live in an area that enjoys so many sports. – Other Health Provider*

Cost

> *Kids often get hurt playing in the snow and parents can't afford to take them to the proper doctor. – Community Leader*

Diabetes

About 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.

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.

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 2011 and 2013, there was an annual average age-adjusted diabetes mortality rate of 12.2 deaths per 100,000 population in the Primary Service Area.

- More favorable than statewide rates.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).
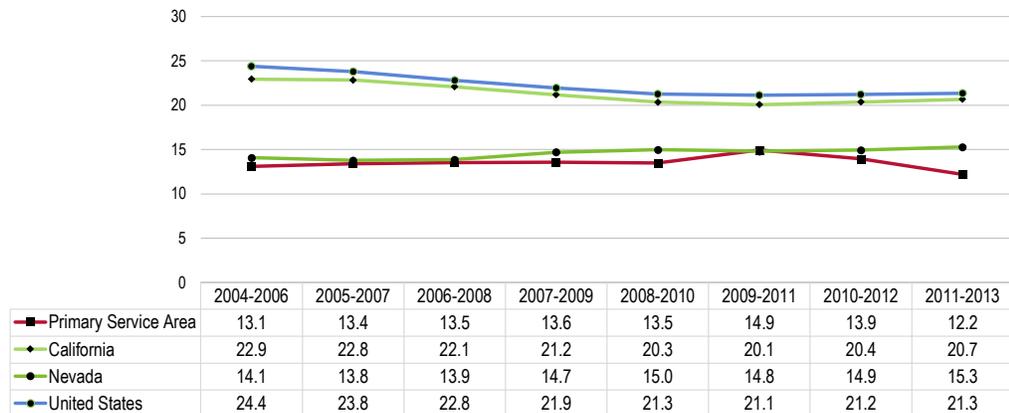- Higher in Douglas County.

Diabetes: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
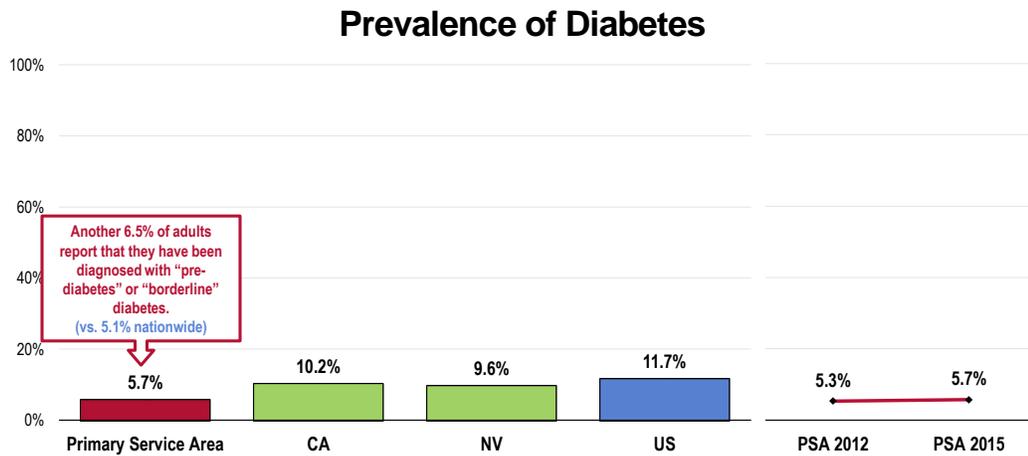**Healthy People 2020 Target = 20.5 or Lower (Adjusted)**

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

- TREND: The diabetes mortality rate has been stable for much of the past decade in the Primary Service Area; however, rates decreased in the latest two reporting periods.

Diabetes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 20.5 or Lower (Adjusted)

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	13.1	13.4	13.5	13.6	13.5	14.9	13.9	12.2
California	22.9	22.8	22.1	21.2	20.3	20.1	20.4	20.7
Nevada	14.1	13.8	13.9	14.7	15.0	14.8	14.9	15.3
United States	24.4	23.8	22.8	21.9	21.3	21.1	21.2	21.3

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

Prevalence of Diabetes

A total of 5.7% of Primary Service Area adults report having been diagnosed with diabetes.

- Better than the state percentages.
- Better than the national proportion.
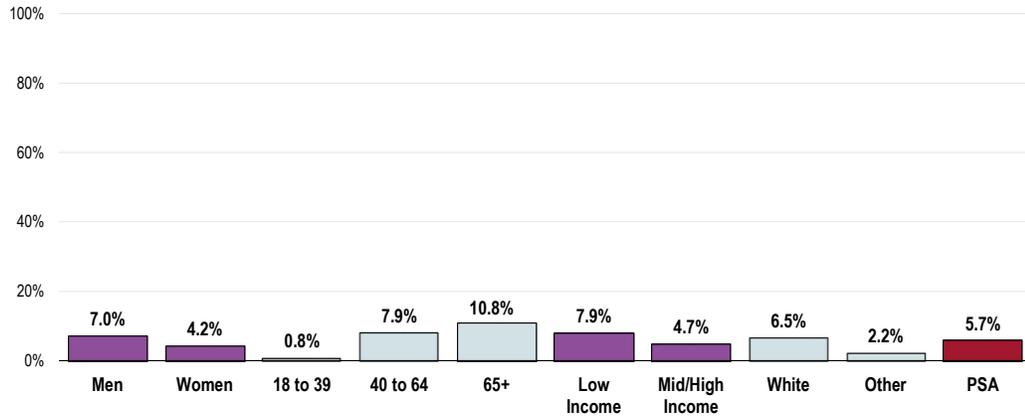- TREND: Statistically unchanged since 2012.

In addition to the prevalence of diagnosed diabetes referenced above, another 6.5% of Primary Service Area adults report that they have "pre-diabetes" or "borderline diabetes."

Prevalence of Diabetes

Another 6.5% of adults report that they have been diagnosed with "pre-diabetes" or "borderline" diabetes.
(vs. 5.1% nationwide)

|	Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
	5.7%	10.2%	9.6%	11.7%	5.3%	5.7%

Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 136]
- 2013 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): 2013 California and Nevada data.

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

- Note the strong positive correlation between diabetes and age, with 10.8% of seniors with diabetes.

Prevalence of Diabetes
(Primary Service Area, 2015)

Bar chart showing percentages:
- Men: 7.0%
- Women: 4.2%
- 18 to 39: 0.8%
- 40 to 64: 7.9%
- 65+: 10.8%
- Low Income: 7.9%
- Mid/High Income: 4.7%
- White: 6.5%
- Other: 2.2%
- PSA: 5.7%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 136]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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).

Diabetes Testing

Of Primary Service Area adults who have <u>not</u> been diagnosed with diabetes, 47.3% report having had their blood sugar level tested within the past three years.

- Similar to the national proportion.

Have Had Blood Sugar Tested in the Past Three Years
(Among Non-Diabetics)

Bar chart showing percentages:
- Primary Service Area: 47.3%
- US: 49.2%
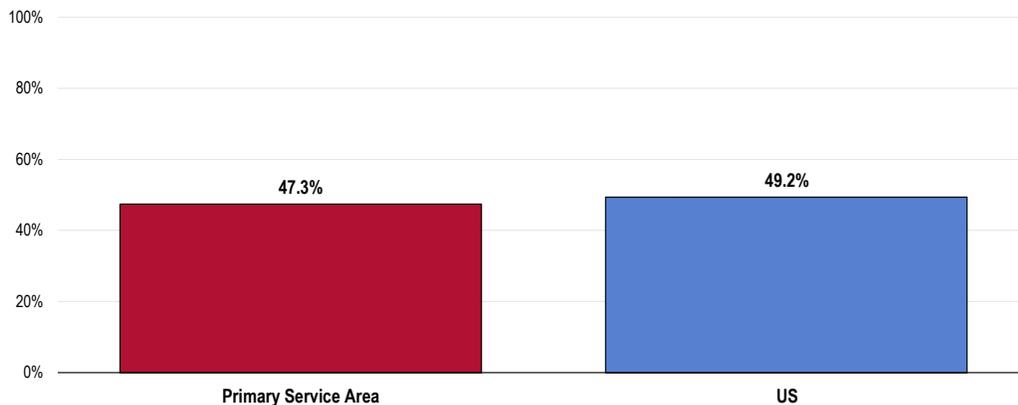
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

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

Perceptions of Diabetes
as a Problem in the Community
(Key Informants, 2015)
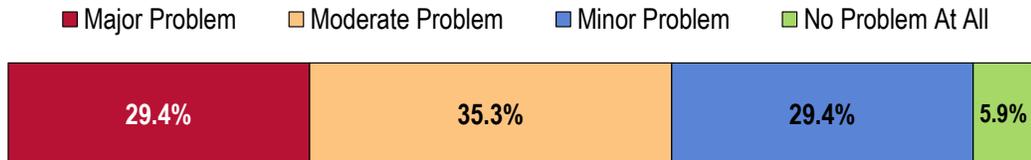
■ Major Problem □ Moderate Problem ■ Minor Problem □ No Problem At All

29.4%	35.3%	29.4%	5.9%

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

Challenges

Among those rating this issue as a "major problem," the biggest challenges for people with diabetes are seen as:

Lack of Education

> *Understanding how important it is to gain knowledge and be educated about the disease. From what I understand of the populations that are susceptible, our community is at risk. Getting families to know if their children are at risk and using preventive measures of diet and exercise to lessen the probability of the onset. – Community Leader*

> *Getting information on proper diet, exercise and medication. – Other Health Provider*

Cost

> *Large low-income population. Cost of treatment is expensive. Limited access to support programs and education. Cost of healthy food is high relative to income. – Community Leader*

Prevalence

> *I think diabetes is becoming a frequent challenge for people not just in our community. – Social Services Representative*

Access to Treatment

> *Access to supportive, preventative treatment. – Social Services Representative*

Community Outreach

> *Community outreach for prevention. – Community Leader*

Alzheimer's Disease

About Dementia

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 2011 and 2013, there was an annual average age-adjusted Alzheimer's disease mortality rate of 25.6 deaths per 100,000 population in the Primary Service Area.

- More favorable than the California rate, less favorable than Nevada.
- Less favorable than the national rate.
- Higher in El Dorado County.

Alzheimer's Disease: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)

El Dorado County	Douglas County	Primary Service Area	CA	NV	US
26.6	22.1	25.6	30.2	16.5	24.0

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

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

- TREND: Despite a recent decline, the Alzheimer's disease mortality rate increased over much of the last decade in the Primary Service Area.

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

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	20.4	21.6	24.1	27.0	29.6	30.1	28.7	25.6
California	24.3	25.2	26.8	27.7	29.2	29.6	30.3	30.2
Nevada	17.4	15.8	14.6	14.4	14.7	15.2	15.1	16.5
United States	23.4	23.8	24.4	24.6	25.0	24.7	24.5	24.0

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Dementias, Including Alzheimer's Disease

More than 4 in 10 key informants taking part in an online survey consider *Dementias, Including Alzheimer's Disease* as a "moderate problem" in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

13.8%	44.8%	34.5%	6.9%

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

Top Concerns

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

Prevalence

> *Incidences of dementia and Alzheimer's disease are increasing with only one neurologist available that I am aware of and only one SNF, Barton, which has a long wait list. No assisted living facilities*

available in our community. – Social Services Representative

Isolation

Families and patients face isolation. No respite care or facilities in the area. Very limited clinical specialists. – Community Leader

Lack of Facilities

No care facilities. – Social Services Representative

Kidney Disease

About Chronic 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 2011 and 2013 there was an annual average age-adjusted kidney disease mortality rate of 5.8 deaths per 100,000 population in the Primary Service Area.

- Better than the rates found statewide.
- Better than the national rate.
- Higher in Douglas County.

Kidney Disease: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)

	El Dorado County	Douglas County	Primary Service Area	CA	NV	US
Rate	4.7	9.4	5.8	7.1	14.8	13.2

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

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

● TREND: Kidney disease mortality has decreased slightly in recent years.

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

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	6.7	7.1	7.8	7.9	7.8	7.2	6.0	5.8
California	7.8	8.1	8.3	8.5	8.5	8.1	7.6	7.1
Nevada	22.2	22.0	21.3	20.1	19.5	18.4	16.8	14.8
United States	14.7	14.8	14.9	15.0	15.2	14.6	13.9	13.2

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

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

Key Informant Input: Chronic Kidney Disease

The biggest share of key informants taking part in an online survey characterized *Chronic Kidney Disease* as a "minor problem" in the community.

Perceptions of Chronic Kidney Disease as a Problem in the Community
(Key Informants, 2015)
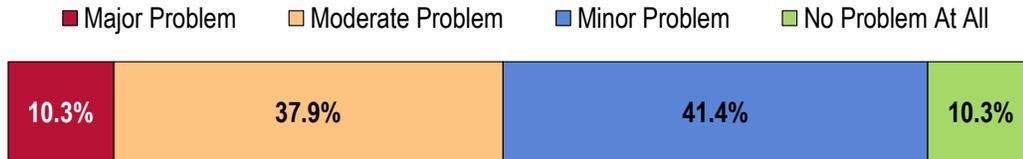
■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

10.3%	37.9%	41.4%	10.3%

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

Top Concerns

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

Casino Environment

The casino environment doesn't create the healthiest life style. – Social Services Representative

Lack of Resources

Lack of local resources without traveling over the mountain. – Social Services Representative

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back 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.

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

Nearly one-fourth (24.1%) of Primary Service Area adults age 50 and older reports suffering from arthritis or rheumatism.

- More favorable than that found nationwide.
- TREND: The prevalence of arthritis/rheumatism is unchanged from 2012.

Prevalence of Arthritis/Rheumatism
(Among Adults Age 50 and Older)
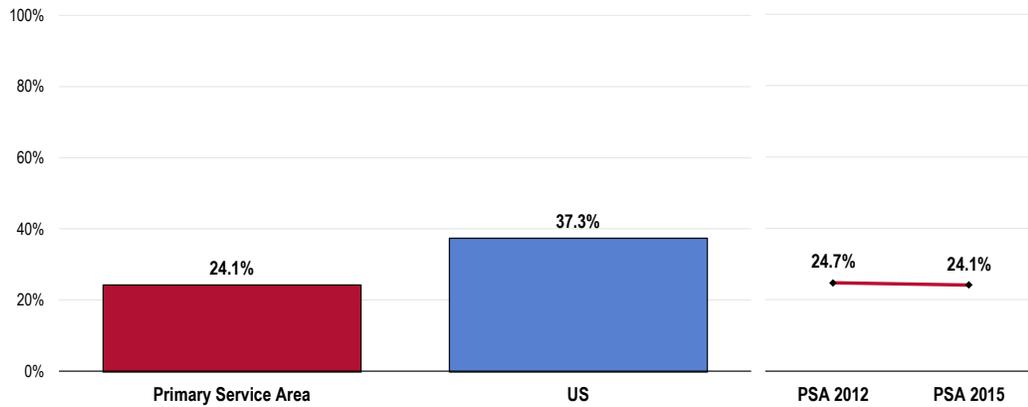
Prevalence of Osteoporosis

A total of 9.2% of survey respondents age 50 and older have osteoporosis.

- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.
- TREND: Statistically unchanged over time.

Prevalence of Osteoporosis
(Among Adults Age 50 and Older)
Healthy People 2020 Target = 5.3% or Lower

Prevalence of Chronic Pain

Sciatica/Chronic Back Pain

A total of 18.8% of survey respondents suffer from chronic back pain or sciatica.

- Comparable to that found nationwide.
- TREND: Statistically unchanged since 2012.

Prevalence of Sciatica/Chronic Back Pain
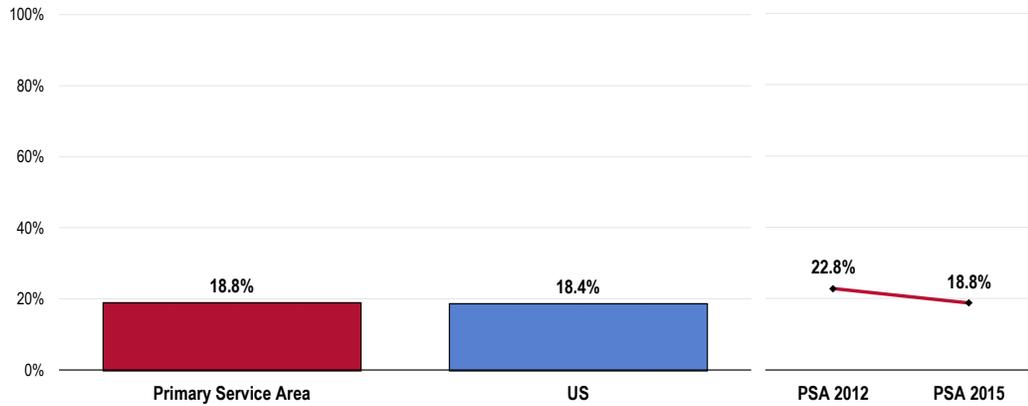
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
          ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Migraines/Severe Headaches

A total of 9.1% of survey respondents suffer from migraines or severe headaches.

- More favorable than that found nationwide.
- TREND: Statistically unchanged over time.

Prevalence of Migraines/Severe Headaches
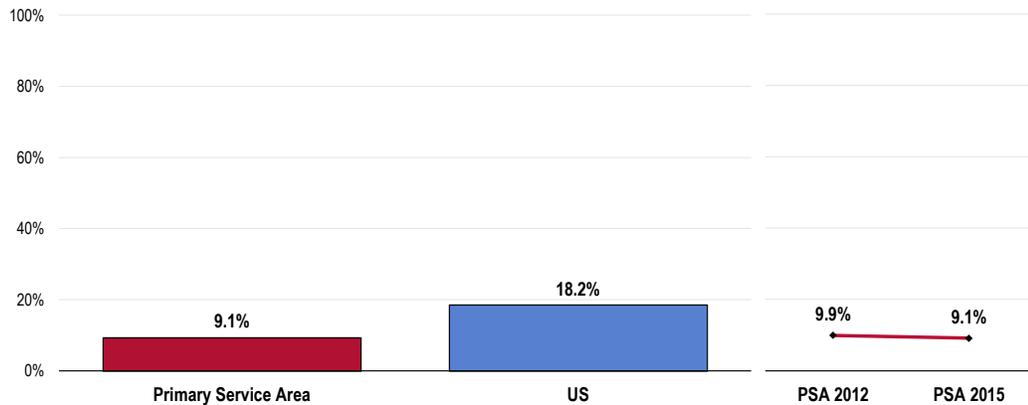
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 303]
          ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Other Chronic Pain

A total of 13.0% of Primary Service Area residents suffer from some other type of chronic pain.

- Highest among residents in low-income households.

Prevalence of Chronic Pain
(Primary Service Area, 2015)

Men	12.6%
Women	13.4%
18 to 39	8.9%
40 to 64	16.1%
65+	10.6%
Low Income	26.3%
Mid/High Income	7.8%
White	12.2%
Other	12.6%
PSA	13.0%
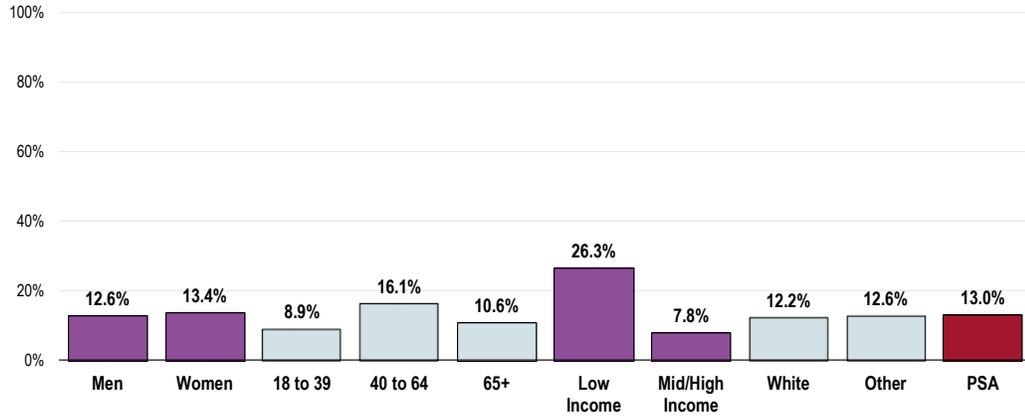
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 304]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The greatest share of key informants taking part in an online survey characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a "minor problem" in the community.

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community
(Key Informants, 2015)
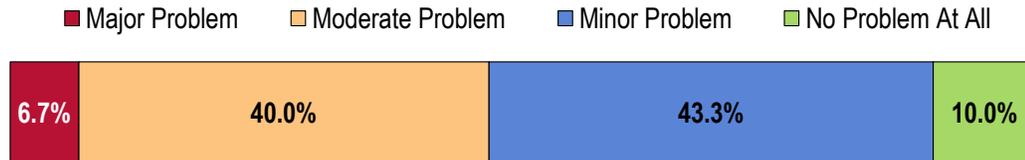
■ Major Problem   ■ Moderate Problem   ■ Minor Problem   □ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
6.7%	40.0%	43.3%	10.0%

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

Top Concerns

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

Prevalence

> *I meet a lot of people with arthritis and back conditions. The majority of the people I see through my work environment have physical jobs. The change of weather, cold temperature and repeated motion affects arthritis. – Social Services Representative*

Climate

> *The climate impacts those with arthritis. As an active community, I know lots of folks with back, etc. issues. – Unknown*

Vision & Hearing Impairment

About Vision

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 6.3% of Primary Service Area adults are blind or have trouble seeing even when wearing corrective lenses.

RELATED ISSUE:

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

- Similar to the prevalence found nationwide.
- TREND: Statistically unchanged over time.
- Among Primary Service Area adults age 65 and older, 12.2% have vision trouble.

Prevalence of Blindness/Trouble Seeing
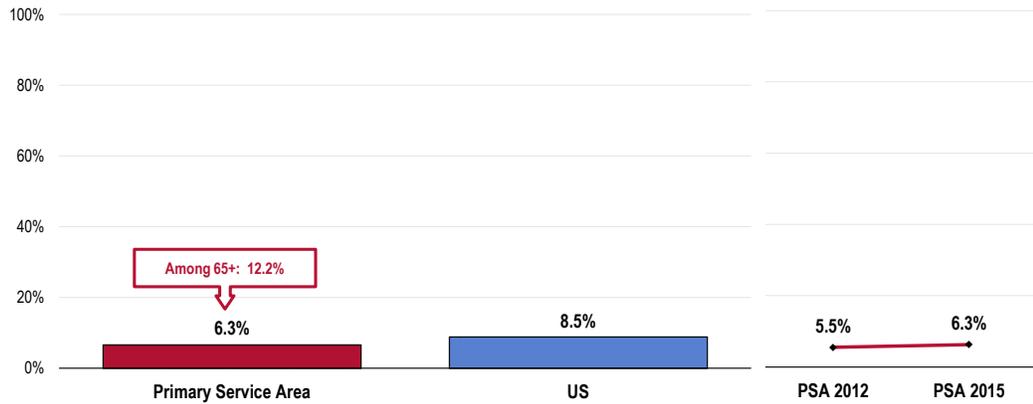
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 26]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

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, 7.7% of Primary Service Area adults report being deaf or having difficulty hearing.

- Similar to that found nationwide.
- TREND: Denotes a statistically significant underline decrease over time.
- Among Primary Service Area adults age 65 and older, 16.5% have partial or complete hearing loss.
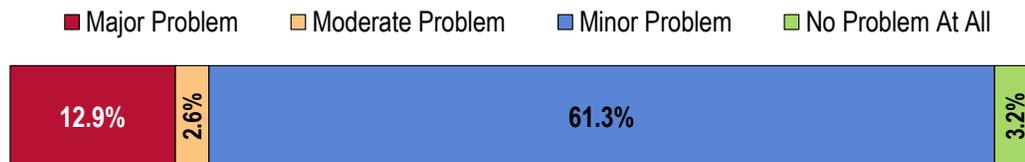
Prevalence of Deafness/Trouble Hearing

Among 65+: 16.5%

Primary Service Area: 7.7%
US: 10.3%
PSA 2012: 11.9%
PSA 2015: 7.7%
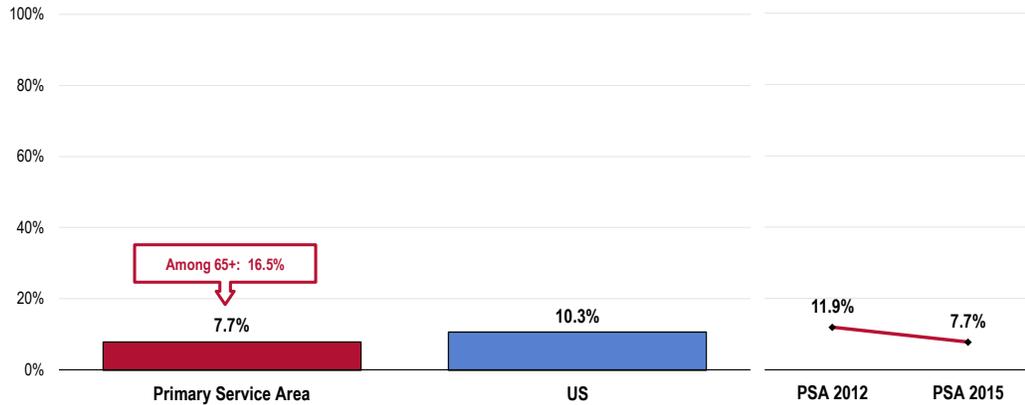
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 27]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Vision & Hearing

A majority of key informants taking part in an online survey characterized *Vision & Hearing* as a "minor problem" in the community.

Perceptions of Hearing and Vision
as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
12.9%	2.6%	61.3%	3.2%

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

Top Concerns

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

Lack of Resources

> *Children are screened at schools in K-2-5-8-10th grade for vision and K-2-5-8 for hearing. There is often difficulties for families who are un-insured or insurance doesn't cover evaluations. – Other Health Provider*

> *Very few resources for low income and elderly population. No free or subsidized sight or hearing programs. Have to travel long distances to obtain hearing aids and glasses. – Community Leader*

Cost

> *Many students need replacement glasses or first time glasses but don't have the money or insurance for them. – Community Leader*
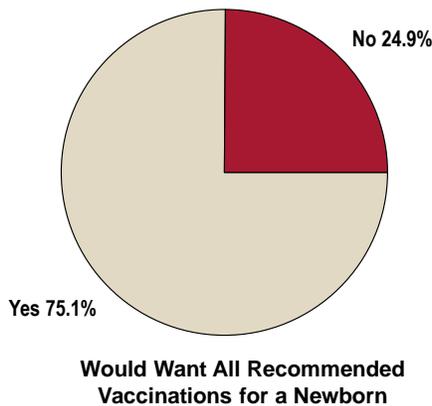
Infectious Disease

Perception of Childhood Vaccinations

Among Primary Service Area parents with children under 18 at home, 75.1% would want all recommended vaccinations if they were to have a newborn.

"If you had a new baby, would you want to get ALL of the recommended vaccines?"

- Asked why they would not want a newborn to receive all recommended vaccinations, 34.5% of these parents mentioned **safety issues** and 25.6% were concerned about **side effects**. **Effectiveness** was mentioned by 8.7%, followed by the **child's age** (8.4%), the **need for more information** (6.9%), the perception that **too many vaccinations** are given already (6.4%), and a **physician's recommendation** (3.6%).

Would Want All Recommended Vaccinations for a Newborn
(Primary Service Area Respondents with Children <18)

Would Want All Recommended Vaccinations for a Newborn

No 24.9%
Yes 75.1%

Main Reason Would Not Get All Required Vaccinations

Dr Recommended 3.6%
Other 1.3%
Uncertain 4.6%
Too Many 6.4%
Need More Info 6.9%
Child's Age 8.4%
Effectiveness 8.7%
Safety 34.5%
Side Effects 25.6%
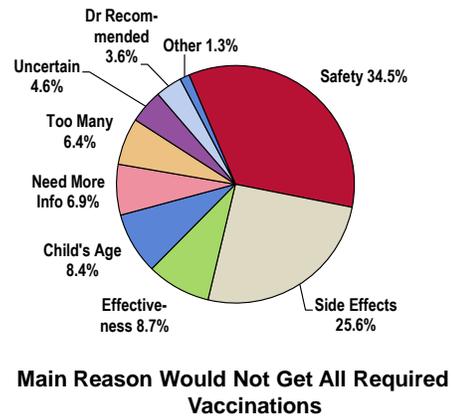
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 328-329]
Notes: ● Asked of all parents with children under 18 at home.

Refusal of Vaccines

Among Primary Service Area parents with children under 7 at home, 14.3% have ever refused or decided not to get a recommended vaccination for the child.

"Have you ever refused or decided NOT to get a recommended vaccine for this child or any other child in the household?"

- When asked who or what had the most influence over this decision, the largest share of these parents gave references to **personal choice** (mentioned by 42.8%), **rumors** about the vaccines (14.0%), an **alternative physician** (11.0%), another **healthcare professional** (11.0%), **books or magazines** (8.4%), **scheduling** (4.5%), and other **parents** (4.4%).

Have Ever Refused or Decided Not to
Get a Recommended Vaccine for Child
(Primary Service Area Respondents with Children <7, 2015)

Yes 14.3%

No 85.7%
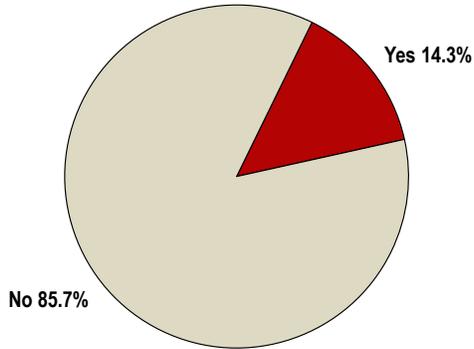
**Refused/Did Not Get Recommended
Vaccine for Child**

Rumors 14.0%

Alternative Dr 11.0%

Other Healthcare Pro. 11.0%

Books/ Magazines 8.4%

Scheduling 4.5%

Other Parents 4.4%

Other 3.8%

Personal Choice 42.8%
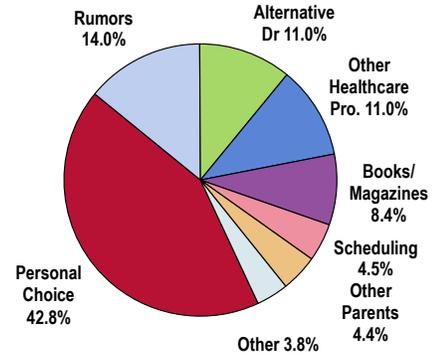
**Biggest Influence on This Decision
("Yes")**

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 326-327]
Notes: ● Asked of all parents with children under 7 at home.

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

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

Among Primary Service Area seniors, 55.9% received a flu shot (or FluMist®) within the past year.

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

- Statistically comparable to the California and Nevada findings.
- Comparable to the national finding.
- Fails to satisfy the Healthy People 2020 target (70% or higher).
- TREND: Statistically unchanged since 2012.

Older Adults: Have Had a Flu Vaccination in the Past Year
(Among Adults Age 65+)
Healthy People 2020 Target = 70.0% or Higher

Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
55.9%	62.5%	51.6%	57.5%	54.8%	55.9%
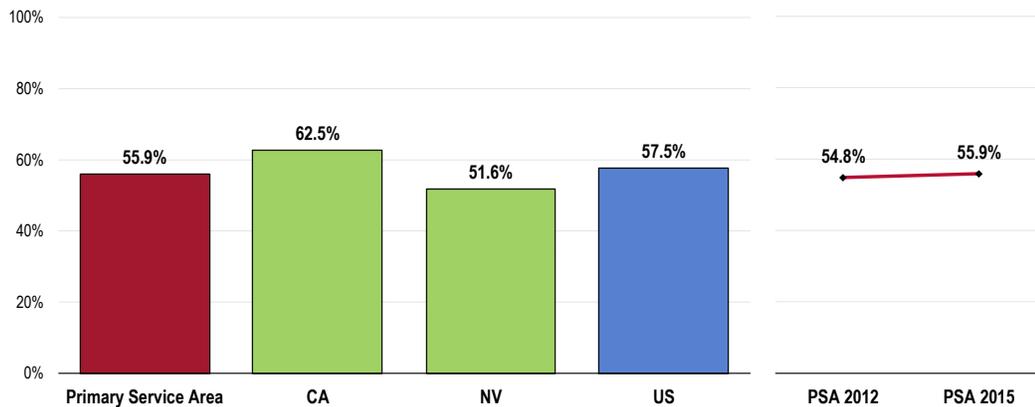
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 141]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

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 36.0% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (70% or higher).
- TREND: Statistically unchanged since 2012.

High-Risk Adults: Have Had a Flu Vaccination in the Past Year
(Among High-Risk Adults Age 18-64)
Healthy People 2020 Target = 70.0% or Higher
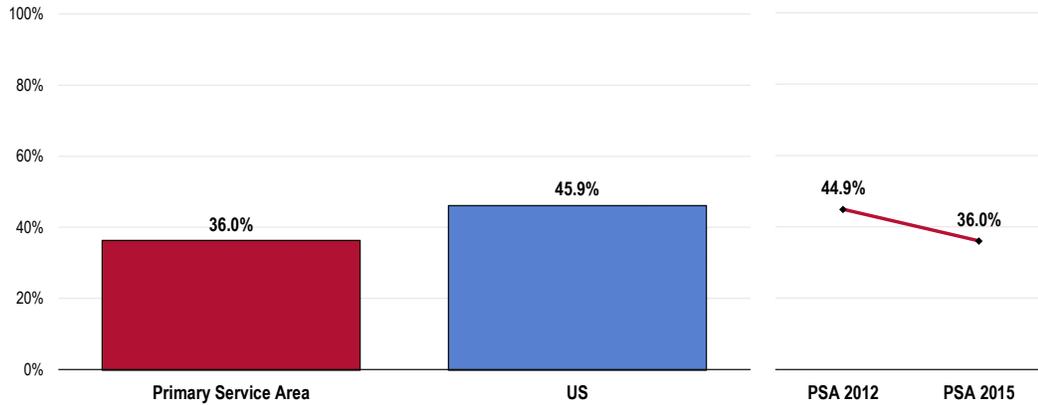
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 142]
           ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
           ● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]
Notes: ● Reflects high-risk respondents age 18-64.
           ● "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
           ● Includes FluMist as a form of vaccination.

Pneumonia Vaccination

Among adults age 65 and older, 63.7% have received a pneumonia vaccination at some point in their lives.

- Comparable to the California and the Nevada findings.
- Comparable to the national finding.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- TREND: Statistically unchanged since 2012.

Older Adults: Have Ever Had a Pneumonia Vaccine
(Among Adults Age 65+)
Healthy People 2020 Target = 90.0% or Higher

Bar chart showing:
- Primary Service Area: 63.7%
- CA: 64.5%
- NV: 66.8%
- US: 68.4%
- PSA 2012: 60.6%
- PSA 2015: 63.7%
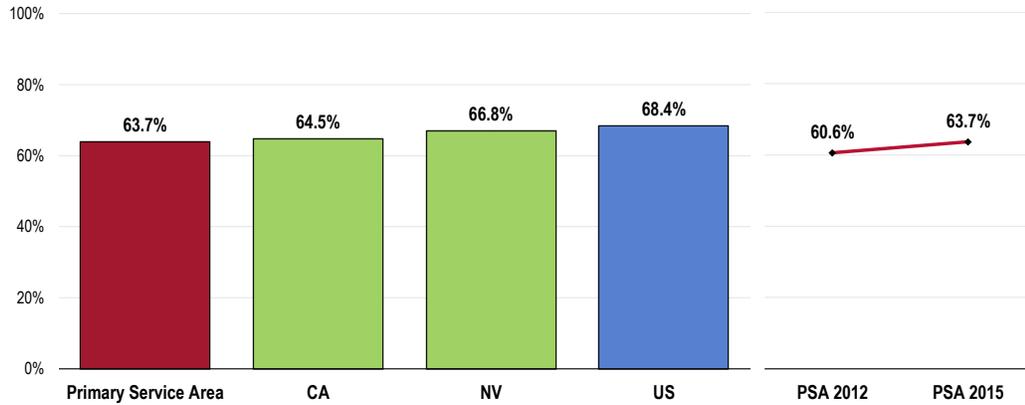
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 143]
　　　　● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
　　　　● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 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 Adults

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

A total of 36.7% 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).
- TREND: Statistically unchanged since 2012.

High-Risk Adults: Have Ever Had a Pneumonia Vaccine
(Among High-Risk Adults Age 18-64)
Healthy People 2020 Target = 60.0% or Higher

Bar chart showing:
- Primary Service Area: 36.7%
- US: 41.9%
- PSA 2012: 36.2%
- PSA 2015: 36.7%
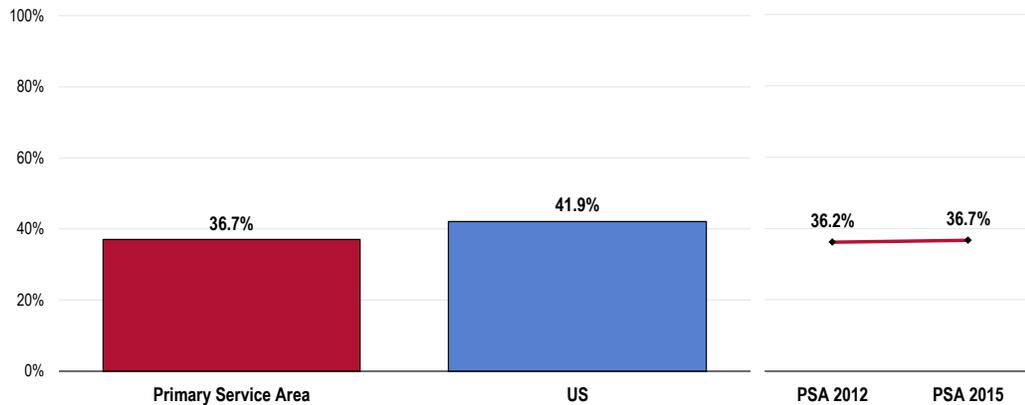
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 144]
　　　　● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
　　　　● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-13.2]
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

About 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 2011 and 2013, there was an annual average age-adjusted HIV/AIDS mortality rate of 1.2 deaths per 100,000 population in the Primary Service Area.

- Lower than found in either state.
- Lower the rate reported nationally.
- Satisfies the Healthy People 2020 target (3.3 or lower).
- *Douglas County data not available.*

HIV/AIDS: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 3.3 or Lower

El Dorado County	Douglas County	Primary Service Area	CA	NV	US
1.3	N/A	1.2	2.6	2.8	3.2
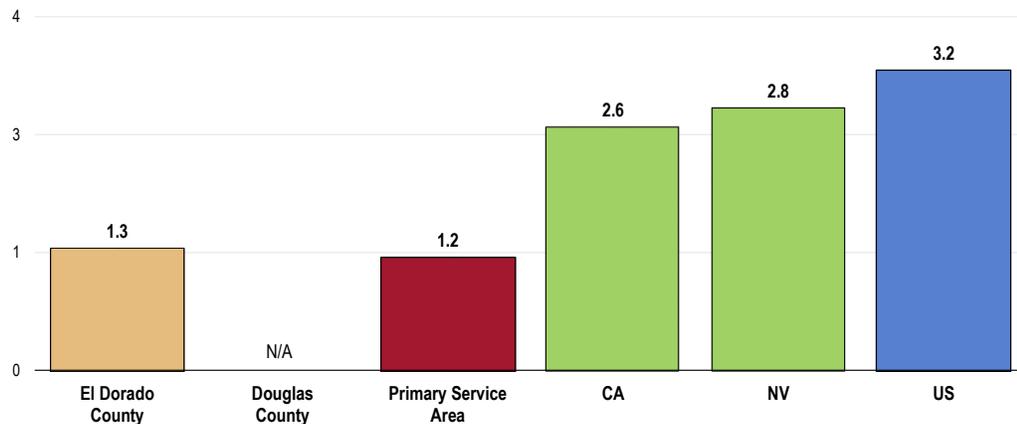
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [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 US Standard Population.

HIV Prevalence

In 2010, there was a prevalence of 89.3 HIV cases per 100,000 population in the Primary Service Area.

- Much more favorable than either statewide percentage.
- More favorable than the national prevalence.
- Similar rates by county.

HIV Prevalence
(Prevalence Rate of HIV per 100,000 Population, 2010)
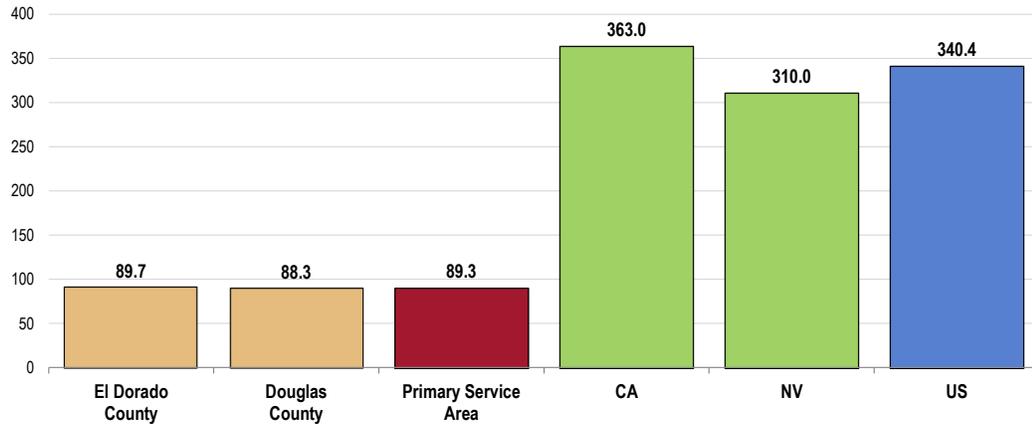

Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.
　　　　● Retrieved March 2015 from Community Commons at http://www.chna.org.
Notes: ● This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

Among Primary Service Area adults age 18-44, 26.8% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Statistically similar to the proportion found nationwide.
- TREND: Note the statistically significant <u>increase</u> in testing since 2012.

Tested for HIV in the Past Year
(Among Adults Age 18-44)
Healthy People 2020 Target = 73.6% or Higher
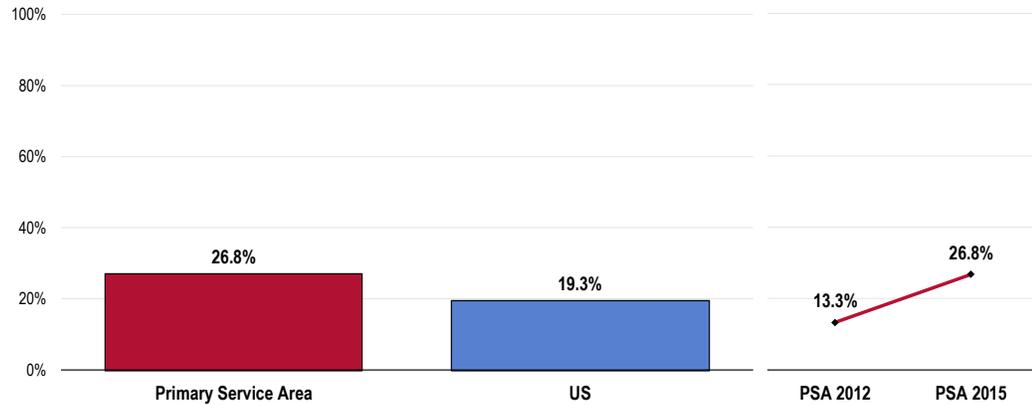
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 145]
　　　　● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
　　　　● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-14.1]
Notes: ● Reflects respondents age 18 to 44.
　　　　● Note that the Healthy People 2020 objective is for ages 15-44.

Key Informant Input: HIV/AIDS

More than half of key informants taking part in an online survey characterized *HIV/AIDS* as a "minor problem" in the community.

Perceptions of HIV/AIDS
as a Problem in the Community
(Key Informants, 2015)
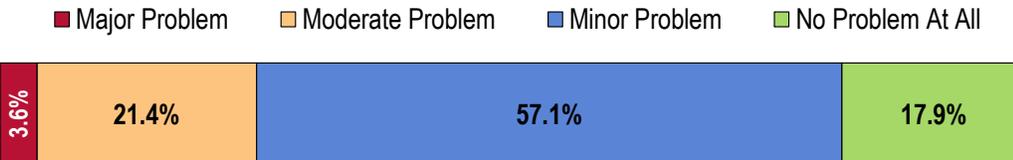
■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All

3.6%	21.4%	57.1%	17.9%

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

Top Concern

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

> *Denial. – Social Services Representative*

Sexually Transmitted Diseases

About 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.

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. 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 these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons "linked" by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

In 2012, the chlamydia incidence rate in the Primary Service Area was 165.5 cases per 100,000 population.
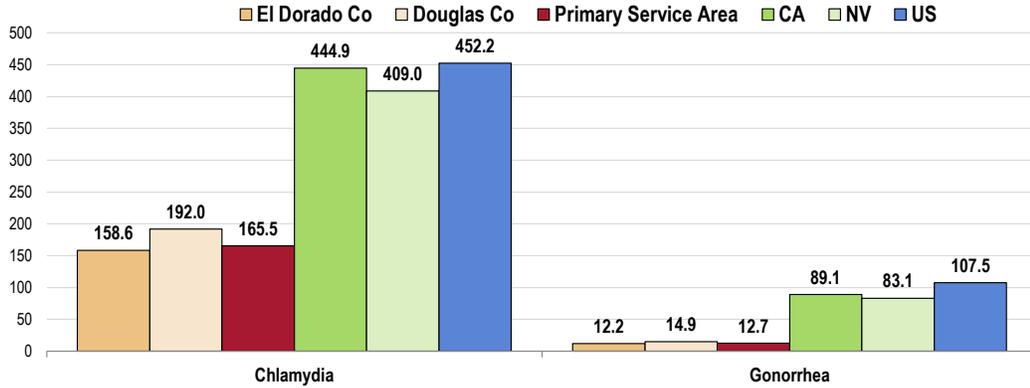
- Notably lower than the California and Nevada incidence rates.
- Notably lower than the national incidence rate.
- Higher in Douglas County.

The gonorrhea incidence rate in the Primary Service Area was 12.7 cases per 100,000 population in 2012.

- Notably lower than the California and Nevada incidence rates.
- Notably lower than the national incidence rate.

● Higher in Douglas County.

Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2012)

Legend: ☐ El Dorado Co ☐ Douglas Co ■ Primary Service Area ☐ CA ☐ NV ■ US

	Chlamydia	Gonorrhea
El Dorado Co	158.6	12.2
Douglas Co	192.0	14.9
Primary Service Area	165.5	12.7
CA	444.9	89.1
NV	409.0	83.1
US	452.2	107.5

Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2011.
● Retrieved March 2015 from Community Commons at http://www.chna.org.
Notes: ● This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Hepatitis B Vaccination

Based on survey data, more than 4 in 10 Primary Service Area adults (47.0%) report having received the hepatitis B vaccination series.

Respondents were told that, to be vaccinated against hepatitis B, a series of three shots must be administered, usually at least one month between shots. They were then asked if they had completed this vaccination series.

● Similar to what is reported nationwide.
● TREND: Marks a statistically significant underline increase over time.

Have Completed the Hepatitis B Vaccination Series

Primary Service Area	US	PSA 2012	PSA 2015
47.0%	44.7%	39.8%	47.0%
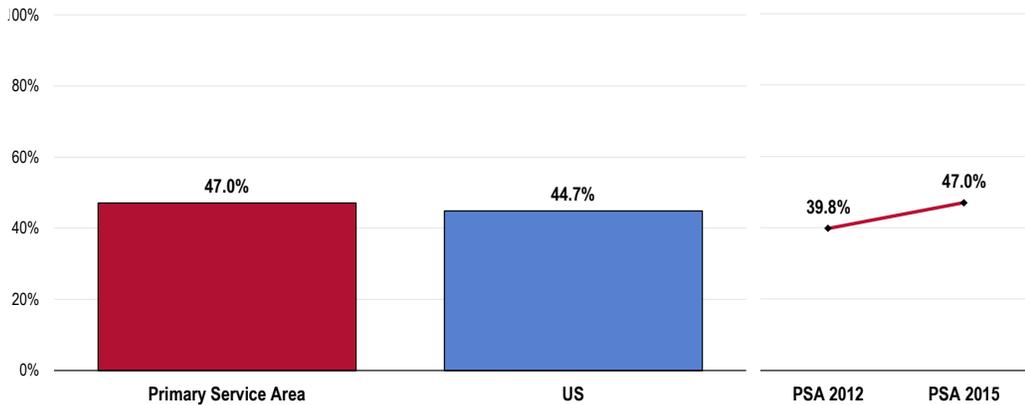
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 70]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Includes a series of three shots, usually administered at least one month between shots

- Men and White residents are less likely to have received the hepatitis B vaccine.
- Note also the negative correlation between age and hepatitis B vaccination.

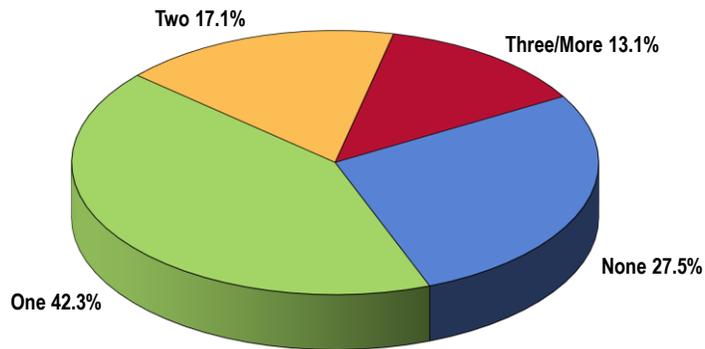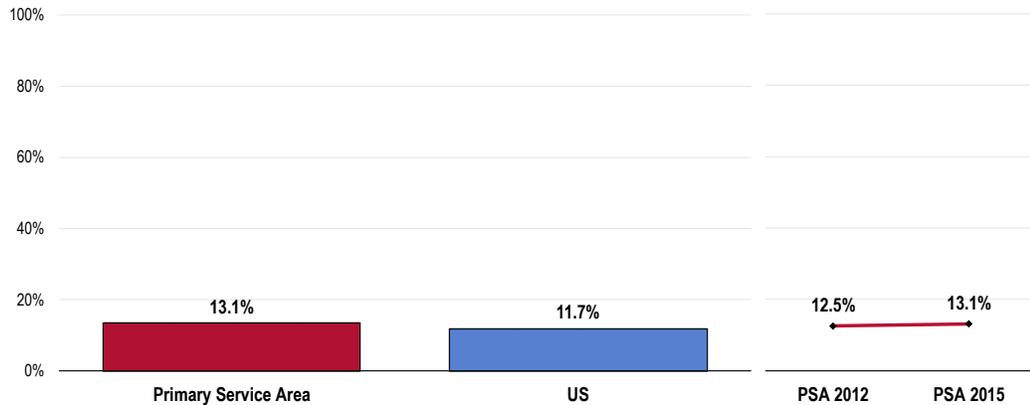## Have Completed the Hepatitis B Vaccination Series
(Primary Service Area, 2015)
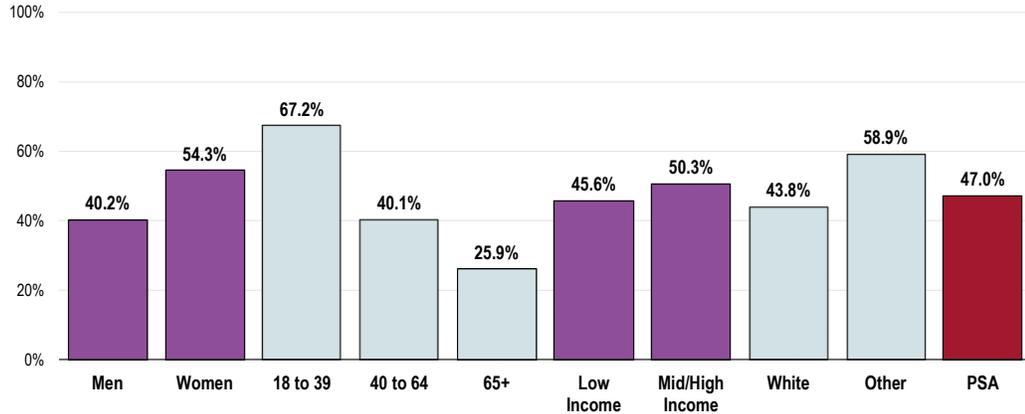
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 70]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Safe Sexual Practices

Sexual Partners

Among unmarried Primary Service Area adults under 65, the majority cites having one (42.3%) or no (27.5%) sexual partners in the past 12 months.

Number of Sexual Partners in Past 12 Months
(Among Unmarried Adults Age 18-64; Primary Service Area, 2015)

Two 17.1%
Three/More 13.1%
None 27.5%
One 42.3%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
Notes: ● Asked of all unmarried respondents under the age of 65.

However, 13.1% report three or more sexual partners in the past year.

- Comparable to that reported nationally.
- TREND: Statistically unchanged since 2012.

Had Three or More Sexual Partners in the Past Year
(Among Unmarried Adults Age 18-64)

Primary Service Area	13.1%
US	11.7%
PSA 2012	12.5%
PSA 2015	13.1%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 86]
● 2013 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, 39.2% report that a condom was used during their last sexual intercourse.

- Statistically similar to national findings.
- TREND: Statistically unchanged since 2012.

Condom Was Used During Last Sexual Intercourse
(Among Unmarried Adults Age 18-64)

Primary Service Area	39.2%
US	33.6%
PSA 2012	37.3%
PSA 2015	39.2%
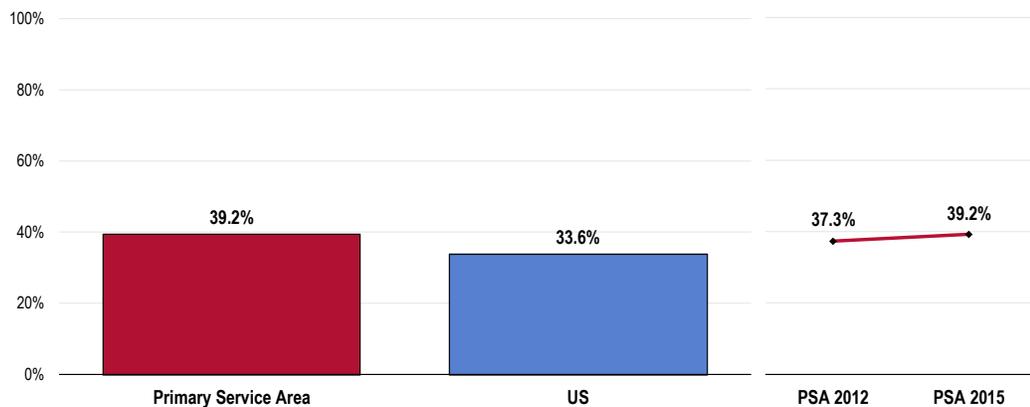
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 87]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all unmarried respondents under the age of 65.

Key Informant Input: Sexually Transmitted Diseases

Just over half of key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a "minor problem" in the community.

Perceptions of Sexually Transmitted Diseases
as a Problem in the Community
(Key Informants, 2015)
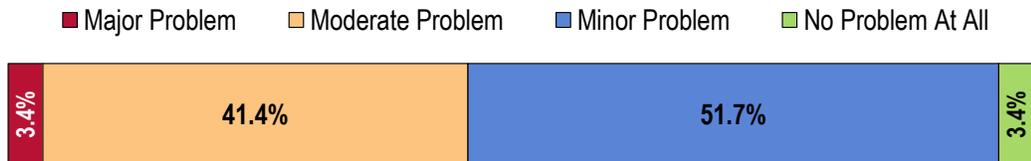
■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

3.4%	41.4%	51.7%	3.4%

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

Top Concern

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

Limited Resources

> *Limited sources for exams, especially teenagers. Long wait times to secure appointments. Barton Community Clinic recently commented high number of students positive for Chlamydia. – Other Health Provider*

Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

Nearly 2 in 3 key informants taking part in an online survey characterized *Immunization & Infectious Diseases* as a "minor problem" in the community.

Perceptions of Immunization and Infectious Diseases as a Problem in the Community
(Key Informants, 2015)
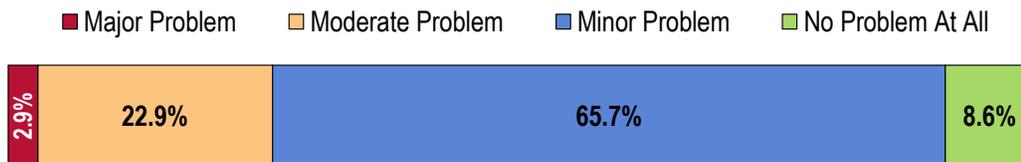
■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

2.9%	22.9%	65.7%	8.6%

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

Top Concerns

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

Lack of Education

Poor education and misinformation leads to families not immunizing. Hourly wage work means that people go to work even when sick and children sent to school even when ill as no one to look after them at home. – Social Services Representative

Births

Prenatal Care

About Infant & Child Health

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).
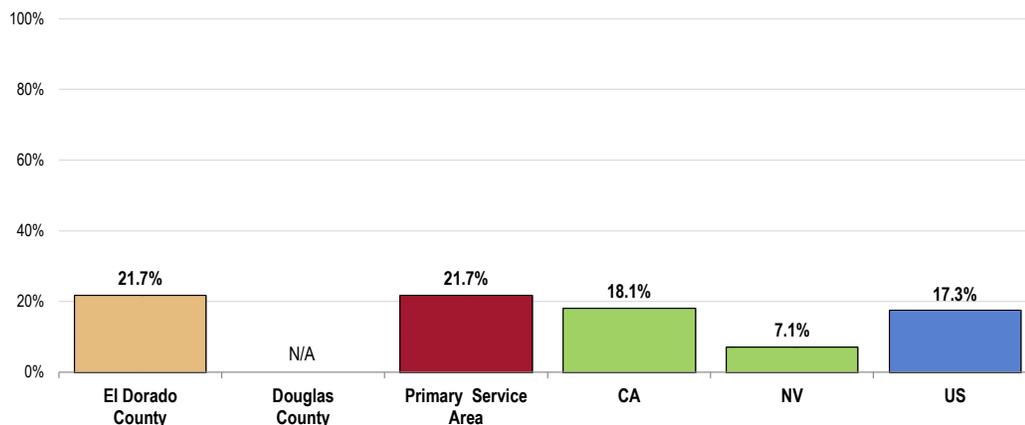
- Healthy People 2020 (www.healthypeople.gov)

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

Between 2007 and 2010, 21.7% of all Primary Service Area births did <u>not</u> receive prenatal care in the first trimester of pregnancy.

- Less favorable than the California and Nevada proportions.
- Less favorable than the national proportion.
- Comparable to the Healthy People 2020 target (22.1% or lower).
- *Douglas County data not available.*

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births, 2007-2010)
Healthy People 2020 Target = 22.1% or Lower

El Dorado County	Douglas County	Primary Service Area	CA	NV	US
21.7%	N/A	21.7%	18.1%	7.1%	17.3%

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics Systems: 2007-10. Accessed via CDC Wonder.
- Retrieved March 2015 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

# Birth Outcomes & Risks

Low-Weight Births

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

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

A total of 6.7% of 2006-2012 Primary Service Area births were low-weight.

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

Low-Weight Births
(Percent of Live Births, 2006-2012)
Healthy People 2020 Target = 7.8% or Lower
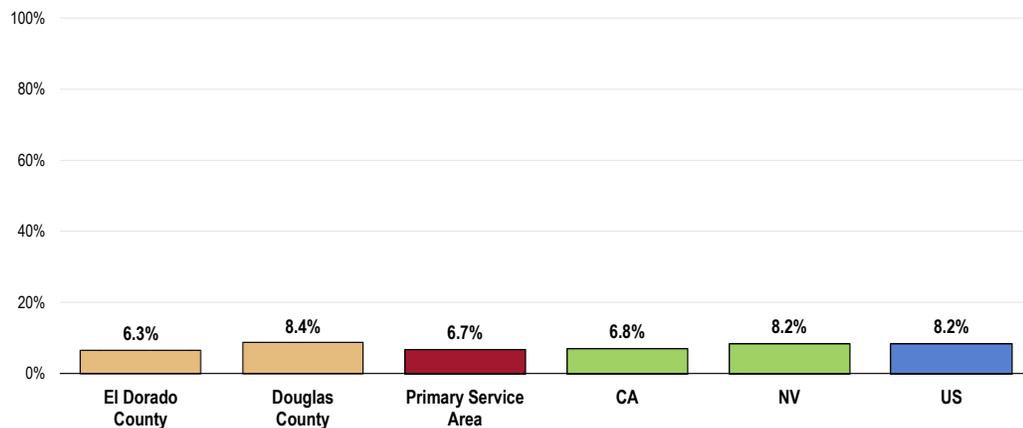
El Dorado County	Douglas County	Primary Service Area	CA	NV	US
6.3%	8.4%	6.7%	6.8%	8.2%	8.2%

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2003-09. Accessed using CDC WONDER.
- Retrieved March 2015 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.
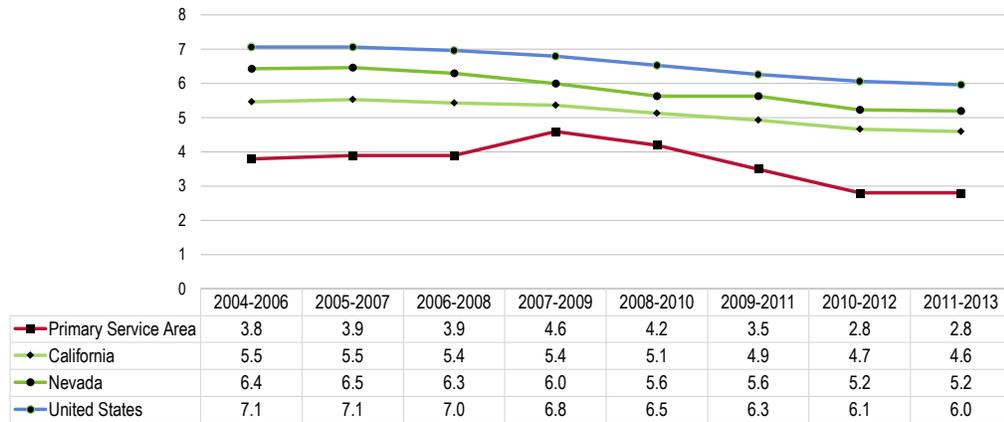
Infant Mortality

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

Between 2011 and 2013, there was an annual average of 2.8 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.
- *Douglas County data not available*.

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2003-2009)
Healthy People 2020 Target = 6.0 or Lower
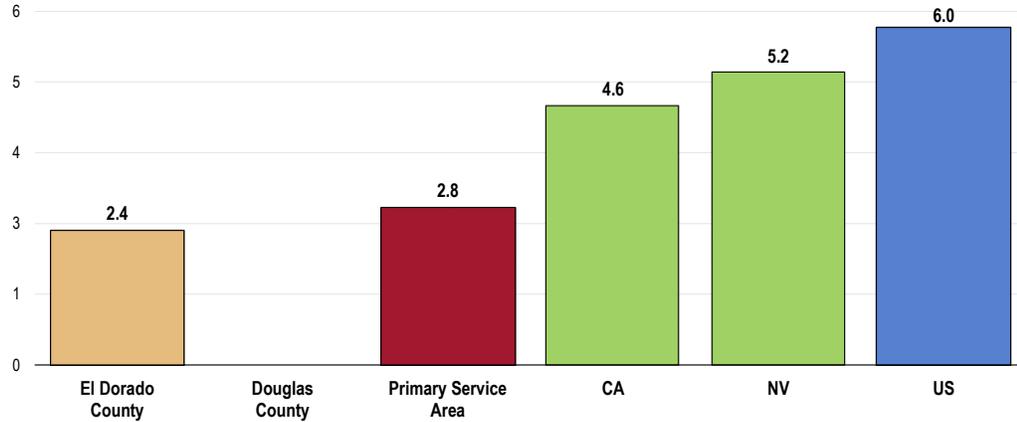
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2003-09. Accessed using CDC WONDER.
- Retrieved March 2015 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- TREND: The infant mortality rate has decreased in recent years in the Primary Service Area, echoing the state and national trends.

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2020 Target = 6.0 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	3.8	3.9	3.9	4.6	4.2	3.5	2.8	2.8
California	5.5	5.5	5.4	5.4	5.1	4.9	4.7	4.6
Nevada	6.4	6.5	6.3	6.0	5.6	5.6	5.2	5.2
United States	7.1	7.1	7.0	6.8	6.5	6.3	6.1	6.0

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

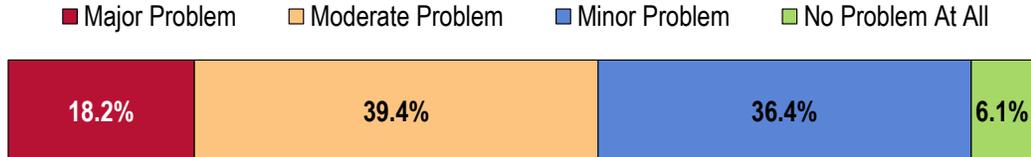Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Key Informant Input: Infant & Child Health

The greatest share of key informants taking part in an online survey generally characterized *Infant & Child Health* as a "moderate problem" in the community.

Perceptions of Infant and Child Health as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

18.2%	39.4%	36.4%	6.1%

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

Top Concerns

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

Lack of Education

> *Information regarding infant and child health needs to be provided in many different venues. – Other Health Provider*

> *Many children need general Medi-Cal care or young mothers need care for their infants but lack knowledge and access to services. – Community Leader*

Vaccinations

> *It is difficult to get all our kindergarteners vaccinated before school starts. Our local community health center fills up with appointments rapidly. The Public Health Department is understaffed. – Other Health Provider*

Regular Source for Care

> *The nature of the population is somewhat transient with legal status as an ancillary issue. It makes it difficult to find and maintain the health provider continuity needed for quality services to infants and children. – Community Leader*

Nutrition

> *Malnutrition from food scarcity and poor food choices. Low rate of immunization for those who do not qualify for free health care they fall into the category of only being able to afford coverage for emergencies. – Social Services Representative*

Prenatal/Postnatal Care

> *Same as family planning, not enough options and support for pre- and postnatal care. – Social Services Representative*

Family Planning

Births to Teen Mothers

About Teen Births

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)

Between 2006 and 2012, there was an annual average of 17.0 births to women age 15–19 per 1,000 population in that age group.

- Well below the California and Nevada proportions.
- Well below the national proportion.
- Higher in Douglas County.

Teen Birth Rate
(Births to Women Age 15-19 Per 1,000 Female Population Age 15–19, 2006-2012)
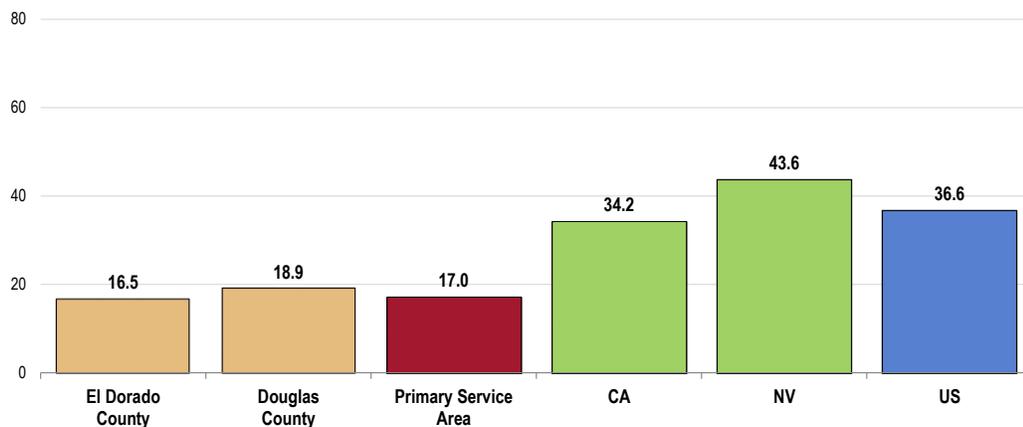
El Dorado County	Douglas County	Primary Service Area	CA	NV	US
16.5	18.9	17.0	34.2	43.6	36.6

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2006-2012. Accessed using CDC WONDER.
- Retrieved March 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Family Planning

More than half of key informants taking part in an online survey largely characterized *Family Planning* as a "moderate problem" in the community.

Perceptions of Family Planning
as a Problem in the Community
(Key Informants, 2015)
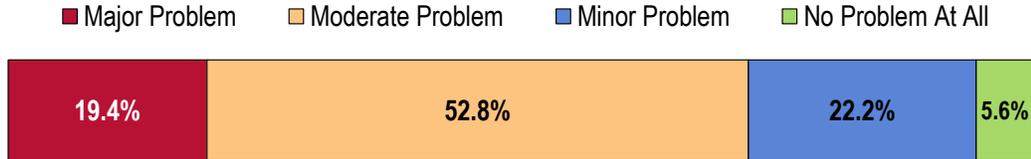
■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

19.4%	52.8%	22.2%	5.6%

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

Top Concerns

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

Lack of Services in the Area

> *We no longer have a planned parenthood in the area. I understand that we have a public health nurse that is often at the high school, but we have not way for women to make appointments. I am pretty sure that women need to travel to Sacramento in order to get an abortion and that access to free birth control in SLT is not an option. – Public Health Expert*

> *We have no low cost/free clinics such as Planned Parenthood for our minors, or lower income individuals. – Social Services Representative*

> *Lack of providers in town, no Planned Parenthood or affordable planning options, lack of education for teens and adults. – Social Services Representative*

> *Family planning is a struggle as there are not many options. If you are on Medi-Cal you can get contraceptive at a good price. The pill is very expensive with and without insurance. When I had insurance I had to make sure my pill fell under a certain tier. Without insurance it's over $100 a month. People's income should not affect their right to preventive care! – Social Services Representative*

> *Difficult getting appointments. Only one site provides access to teenagers. – Other Health Provider*

Single Parents

> *Lake Tahoe has the highest rate of single mothers in the state of California. Many are under age and need a variety of support and service. – Community Leader*

Lack of Education

> *Continued education to young people to prevent teen pregnancy. – Other Health Provider*

Modifiable Health Risks

Actual Causes Of Death

About Contributors to Mortality

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.

Factors Contributing to Premature Deaths in the United States
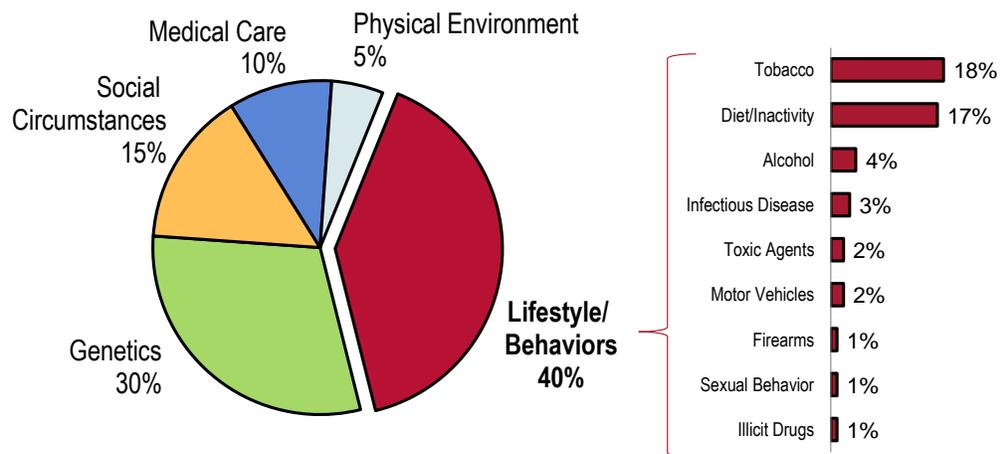
Sources: ● "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002.
"Actual Causes of Death in the United States": (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

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.

Nutrition

About Healthful Diet & Healthy Weight

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 40.4% of Primary Service Area adults report eating five or more servings of fruits and/or vegetables per day.

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.

- Comparable to national findings.
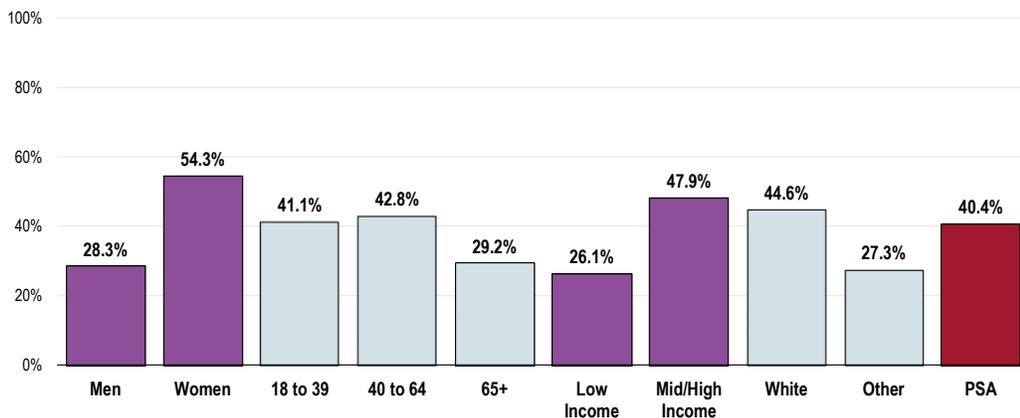- TREND: Fruit/vegetable consumption has <u>decreased</u> significantly since 2012.

Consume Five or More Servings of Fruits/Vegetables Per Day

	Primary Service Area	US	PSA 2012	PSA 2015
	40.4%	39.5%	53.6%	40.4%
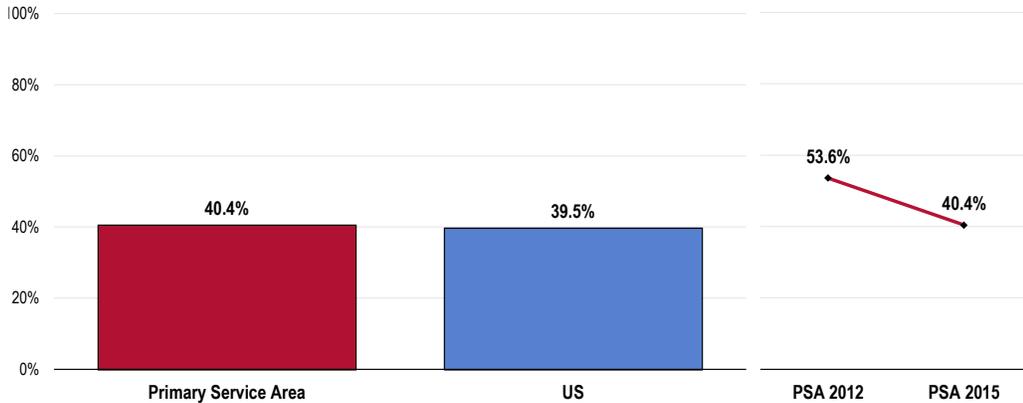
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 147]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● For this issue, respondents were asked to recall their food intake on the previous day.

- Area men are <u>less</u> likely to get the recommended servings of daily fruits/vegetables, as are seniors, low-income adults, and those of "Other" races.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
28.3%	54.3%	41.1%	42.8%	29.2%	26.1%	47.9%	44.6%	27.3%	40.4%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Access to Fresh Produce

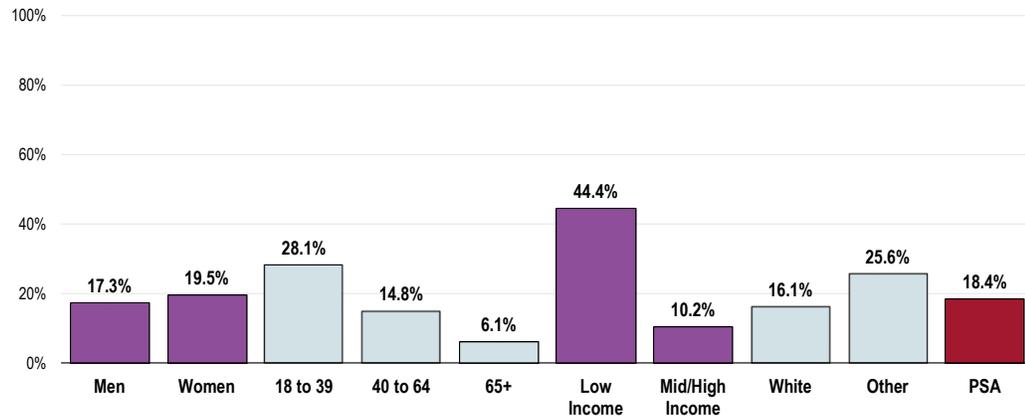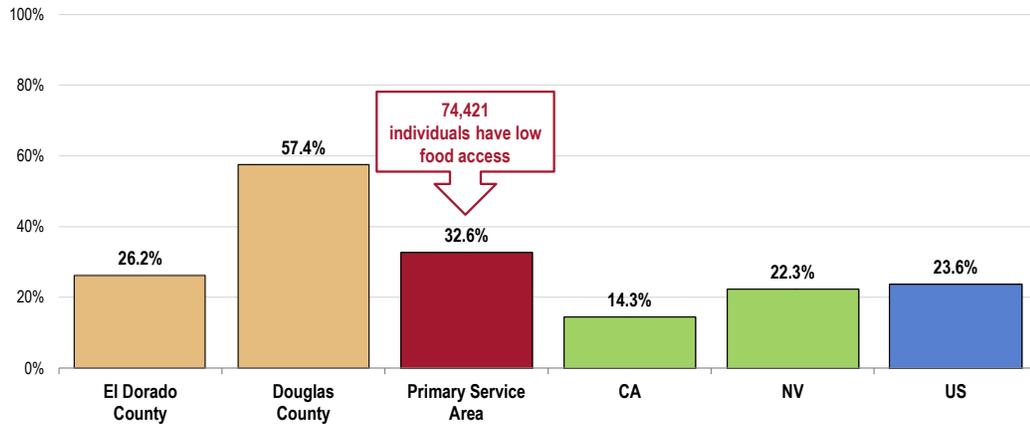### Difficulty Accessing Fresh Produce

While most report little or no difficulty, 18.4% of Primary Service Area adults report that it is "very" or "somewhat" difficult for them to access affordable, fresh fruits and vegetables.

Respondents were asked:

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

Level of Difficulty Finding Fresh Produce at an Affordable Price
(Primary Service Area, 2015)
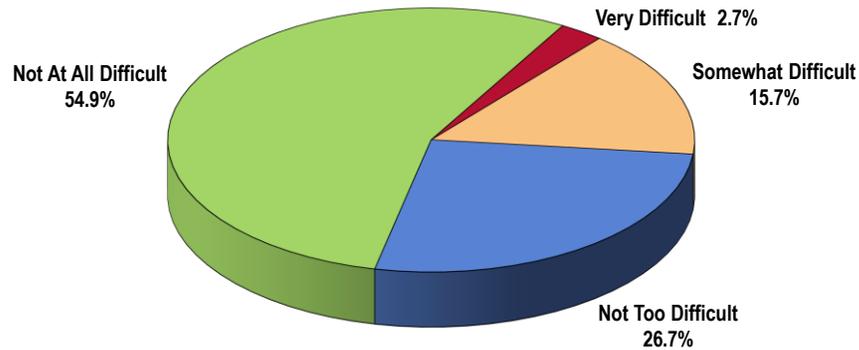
Very Difficult 2.7%
Somewhat Difficult 15.7%
Not At All Difficult 54.9%
Not Too Difficult 26.7%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
Notes: ● Asked of all respondents.

● More favorable than national findings.

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

Primary Service Area	US
18.4%	24.4%
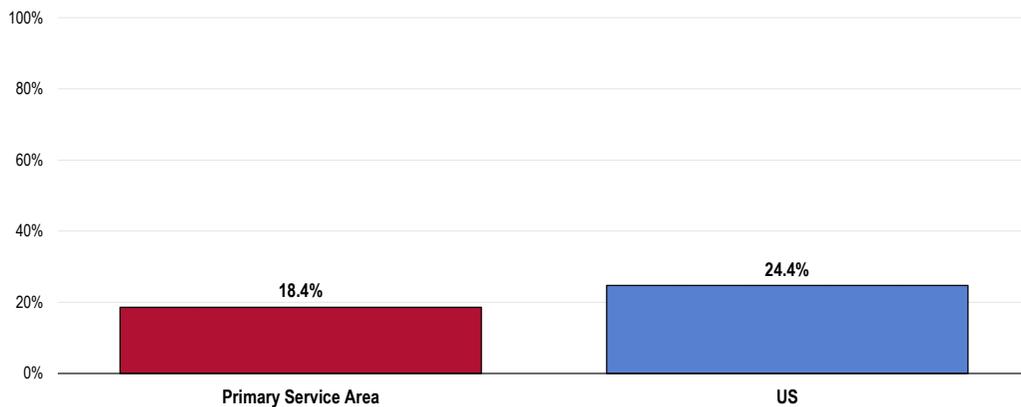
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Those more likely to report difficulty getting fresh fruits and vegetables include:

- Adults under 65 (negative correlation with age).
- Lower-income residents.

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(Primary Service Area, 2015)

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Low Food Access (Food Deserts)

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.
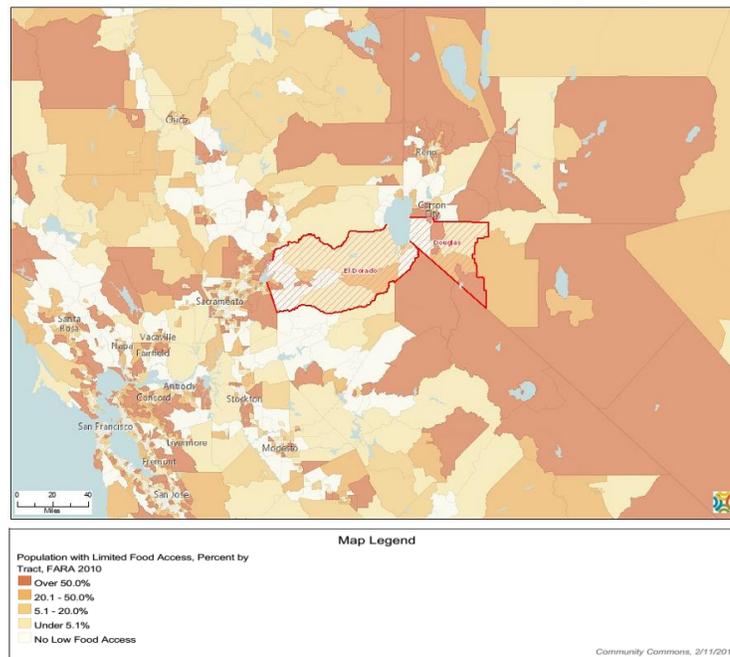
US Department of Agriculture data show that 32.6% of Primary Service Area population (representing over 74,000 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Less favorable than statewide findings.
- Less favorable than national findings.
- Much higher in Douglas County.

Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)

74,421 individuals have low food access

- El Dorado County: 26.2%
- Douglas County: 57.4%
- Primary Service Area: 32.6%
- CA: 14.3%
- NV: 22.3%
- US: 23.6%

Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA): 2010.
- Retrieved March 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts by census tract. Note the large share of residents with limited food access in the eastern portion of the service area.

Population With Limited Food Access, Percent by Tract, FARA 2010

Map Legend

Population with Limited Food Access, Percent by Tract, FARA 2010
- Over 50.0%
- 20.1 - 50.0%
- 5.1 - 20.0%
- Under 5.1%
- No Low Food Access

Community Commons, 2/11/2015

Health Advice About Diet & Nutrition

A total of 39.6% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Nearly identical to national findings.
- TREND: Statistically unchanged since 2012.
- Note: Among overweight/obese respondents, 44.4% report receiving diet/nutrition advice (meaning that over 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)
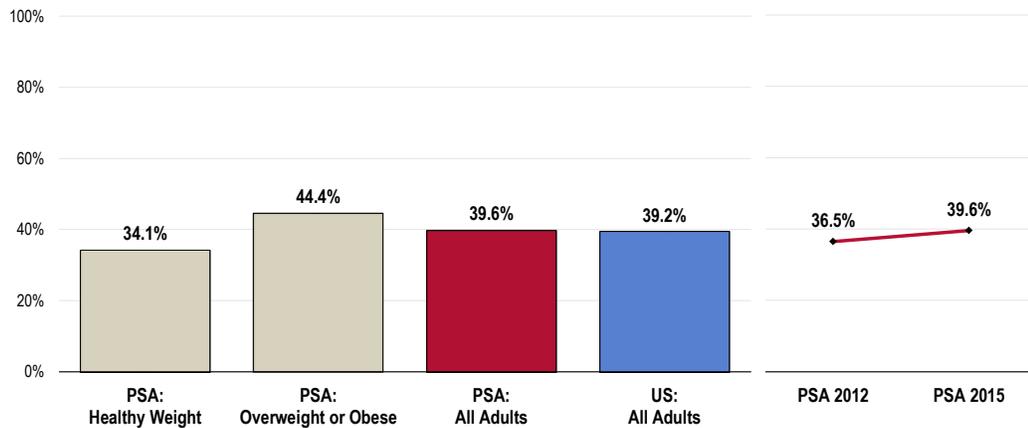
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 18]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Physical Activity

About 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); and 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); and 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)

Leisure-Time Physical Activity

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

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.

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

- Satisfies the Healthy People 2020 target (32.6% or lower).
- TREND: Unchanged since 2012.

No Leisure-Time Physical Activity in the Past Month
Healthy People 2020 Target = 32.6% or Lower

Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
13.8%	21.4%	23.7%	20.7%	13.8%	13.8%
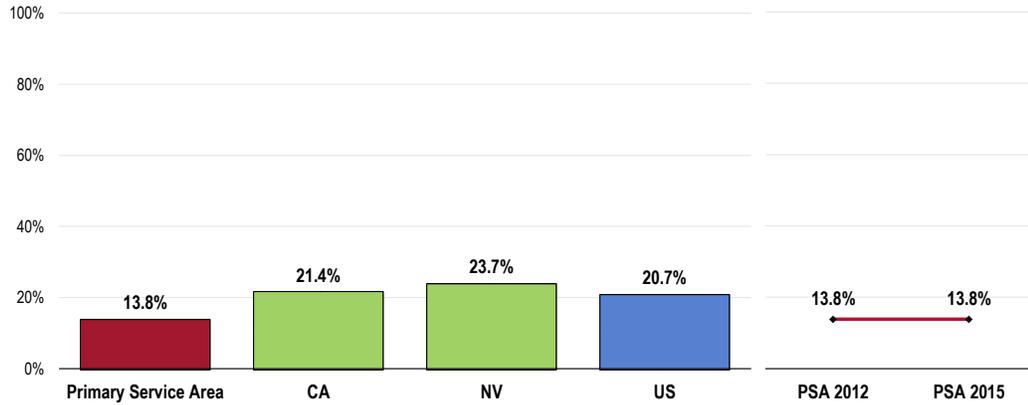
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 92]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

- Seniors.
- Lower-income residents.
- "Other" races.

No Leisure-Time Physical Activity in the Past Month
(Primary Service Area, 2015)
Healthy People 2020 Target = 32.6% or Lower

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
11.2%	16.7%	10.6%	13.0%	27.3%	25.6%	8.4%	9.7%	25.4%	13.8%
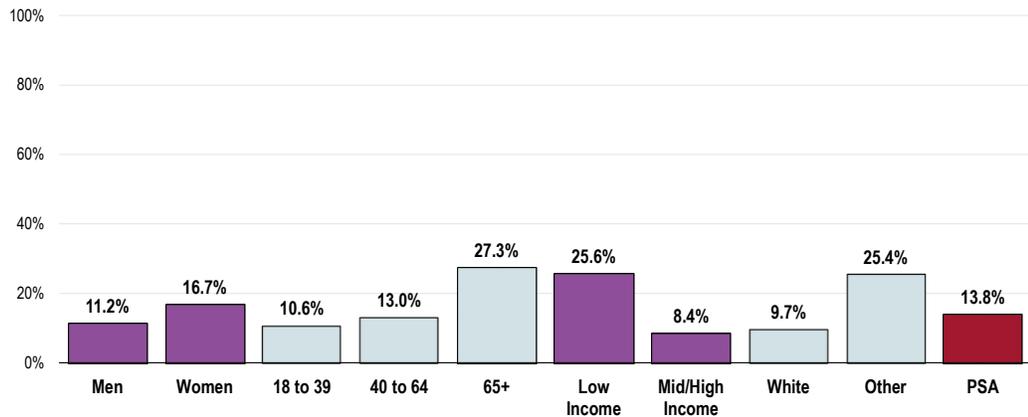
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 92]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

Recommended Levels of Physical Activity

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 61.4% of Primary Service Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- More favorable than national findings.
- TREND: Statistically unchanged since 2012.

Meets Physical Activity Recommendations

Chart: Primary Service Area 61.4%; US 50.3%; PSA 2012 58.6%; PSA 2015 61.4%
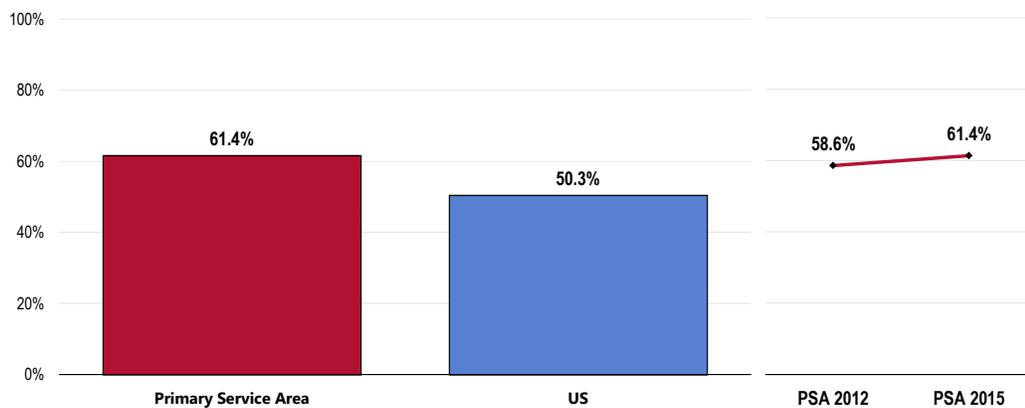
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 148]
　　　　● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
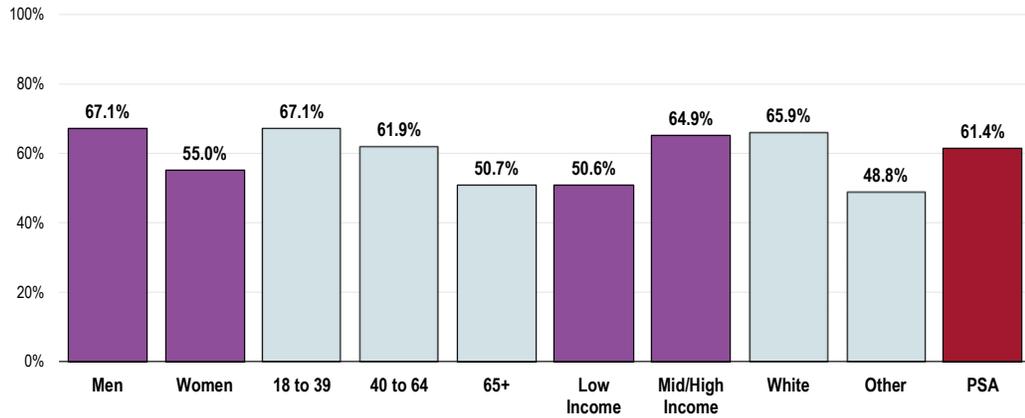Notes: ● Asked of all respondents.
　　　 ● In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes 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.
- Seniors (negative correlation with age).
- Low-income residents.
- "Other" races.

Meets Physical Activity Recommendations
(Primary Service Area, 2015)

Category	Value
Men	67.1%
Women	55.0%
18 to 39	67.1%
40 to 64	61.9%
65+	50.7%
Low Income	50.6%
Mid/High Income	64.9%
White	65.9%
Other	48.8%
PSA	61.4%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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:

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

A total of 41.9% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).
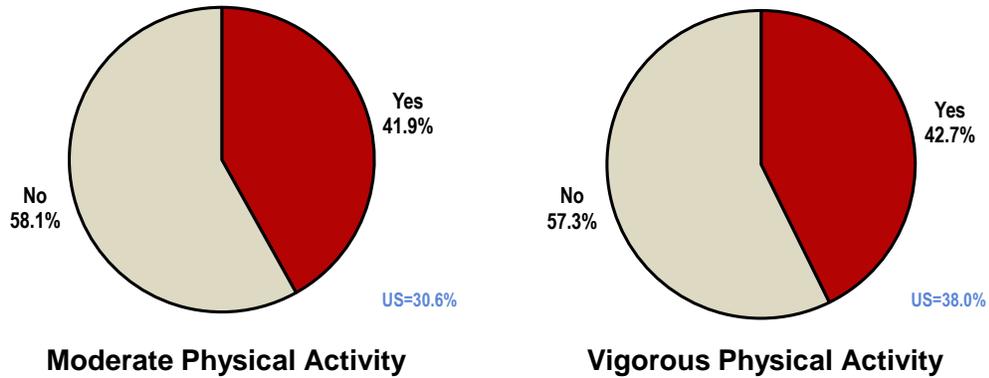
- More favorable than the national level.

A total of 42.7% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- Comparable to the nationwide figure.

Moderate & Vigorous Physical Activity
(Primary Service Area, 2015)

Moderate Physical Activity

Yes
41.9%

No
58.1%

US=30.6%

Vigorous Physical Activity

Yes
42.7%

No
57.3%

US=38.0%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 149-150]
● 2013 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.

Access to Physical Activity

Access to Recreation & Fitness Facilities

In 2012, there were 11.4 recreation/fitness facilities for every 100,000 population in the Primary Service Area.

- Above what is found in both states.
- Above what is found nationally.
- Higher in Douglas County.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access
(Number of Recreation & Fitness Facilities per 100,000 Population, 2012)

	El Dorado County	Douglas County	Primary Service Area	CA	NV	US
	10.5	14.9	11.4	8.7	7.2	9.4
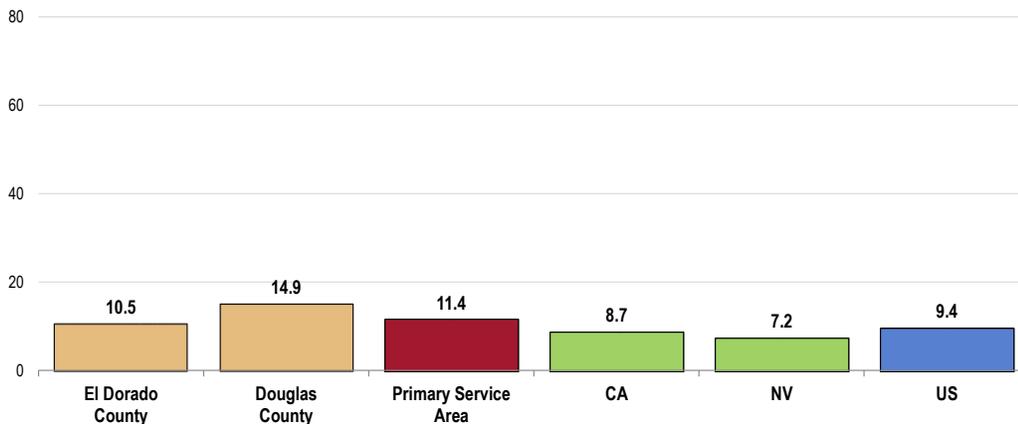
Sources: ● US Census Bureau, County Business Patterns: 2011. Additional data analysis by CARES.
● Retrieved March 2015 from Community Commons at http://www.chna.org.
Notes: ● Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities". Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Preferred Services of 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 services or programs they would most like to see offered at a local wellness center, survey respondents primarily mentioned <u>nutritional education</u> (33.3%) and <u>exercise classes/facilities</u> (18.1%).

- Other amenities mentioned by residents included medical services, classes on weight management, and classes on sports performance.

Type of Service or Program Most Desired in a Wellness Center
(Primary Service Area, 2015)

Exercise Classes & Facilities 18.1%

Other 15.9%

Medical Services 11.2%

Weight Management 12.0%

Sports Performance 6.2%

Nutrition Education 33.3%
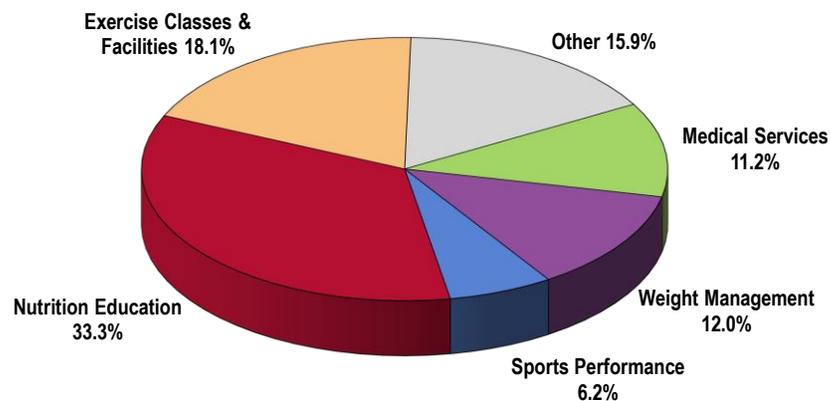
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]
Notes: ● Asked of all respondents. Excludes those who were uncertain or unwilling to provide a response.

Health Advice About Physical Activity & Exercise

A total of 44.1% of Primary Service Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Almost identical to the national average.
- TREND: Similar to 2012 survey findings.
- Note: 50.1% of overweight/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
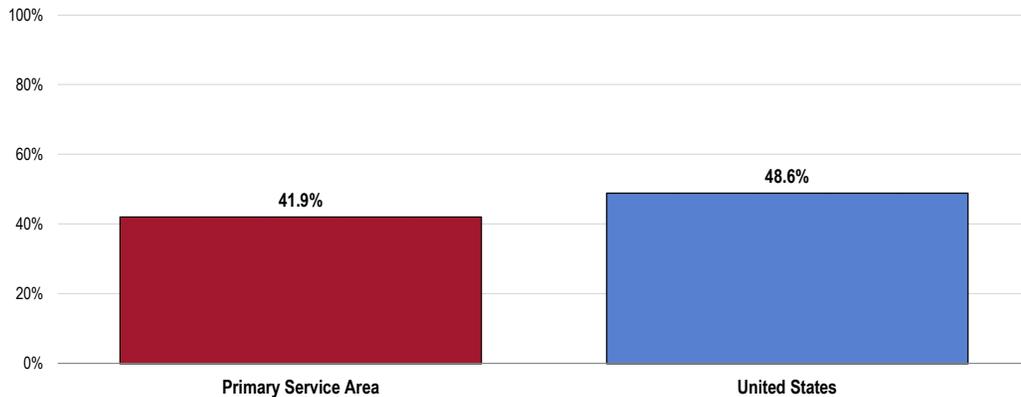(By Weight Classification)
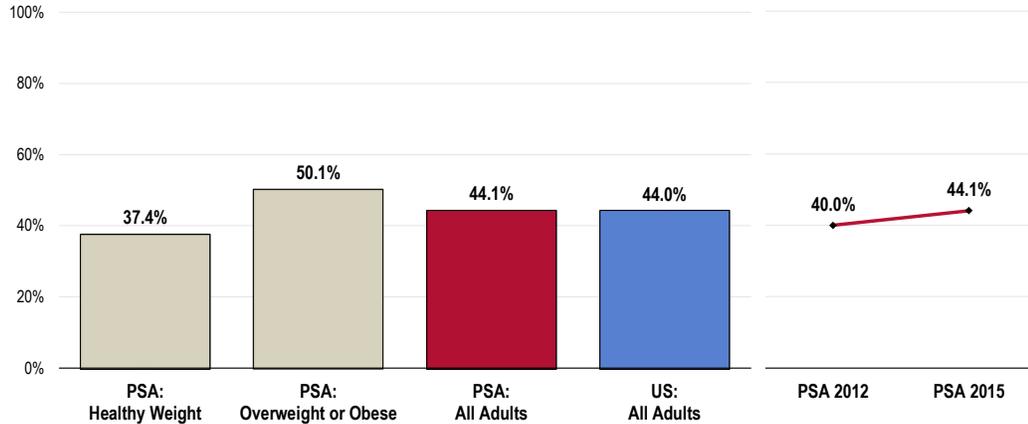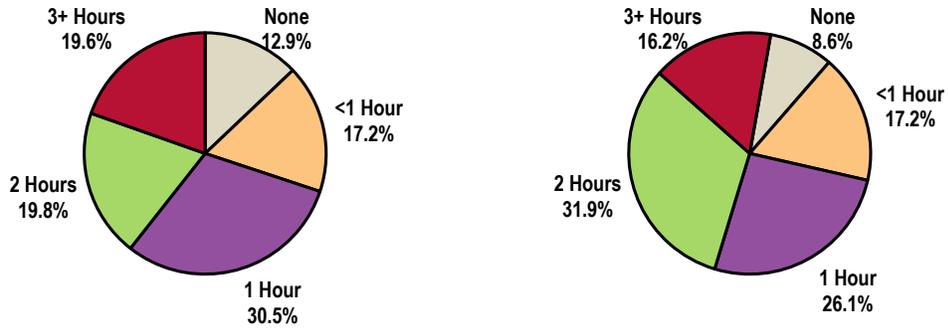

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 19]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Children's Physical Activity

Among Primary Service Area children age 2 to 17, 41.9% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- Statistically similar to that found nationally.

Child Is Physically Active for One or More Hours per Day
(Among Children Age 2-17)

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children age 2-17 at home.
● Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Television Watching & Other Screen Time

Among children aged 5 through 17, 19.6% are reported to watch three or more hours of <u>television</u> per day; 16.2% are reported to spend three or more hours on <u>other types of screen time</u> for entertainment (video games, Internet, etc.).

Children's Screen Time
(Among Parents of Children Age 5-17; Primary Service Area, 2015)

Hours per Day of Television

3+ Hours 19.6%
None 12.9%
<1 Hour 17.2%
2 Hours 19.8%
1 Hour 30.5%

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

3+ Hours 16.2%
None 8.6%
<1 Hour 17.2%
2 Hours 31.9%
1 Hour 26.1%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 151-152, 324-325]
Notes: ● Asked of respondents with a child aged 5 to 17 in the household.

Total Screen Time

When combined, 48.1% of Primary Service Area children aged 5 to 17 spend three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

- More favorable than found nationally.
- TREND: Statistically unchanged from the 2012 survey findings.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]
(Among Parents of Children Age 5-17)
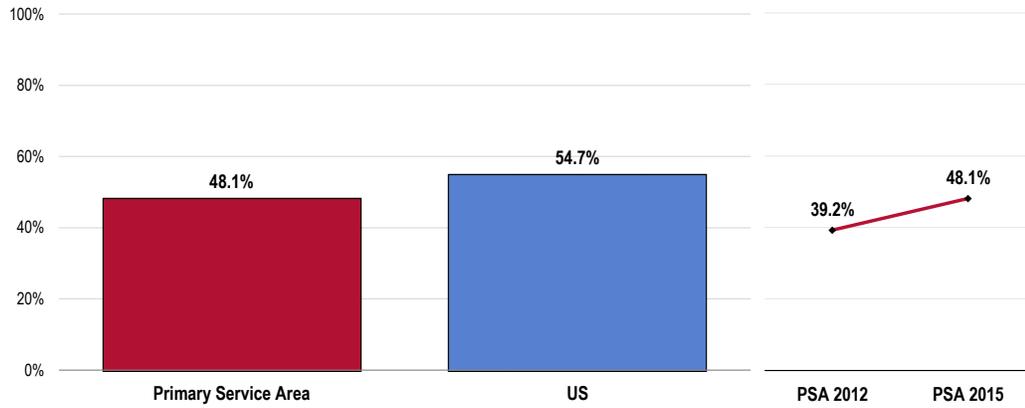
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 153]
        ● 2013 PRC National Children & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 5-17 at home.
      ● For this issue, respondents with children 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.

Weight Status

About Overweight & Obesity

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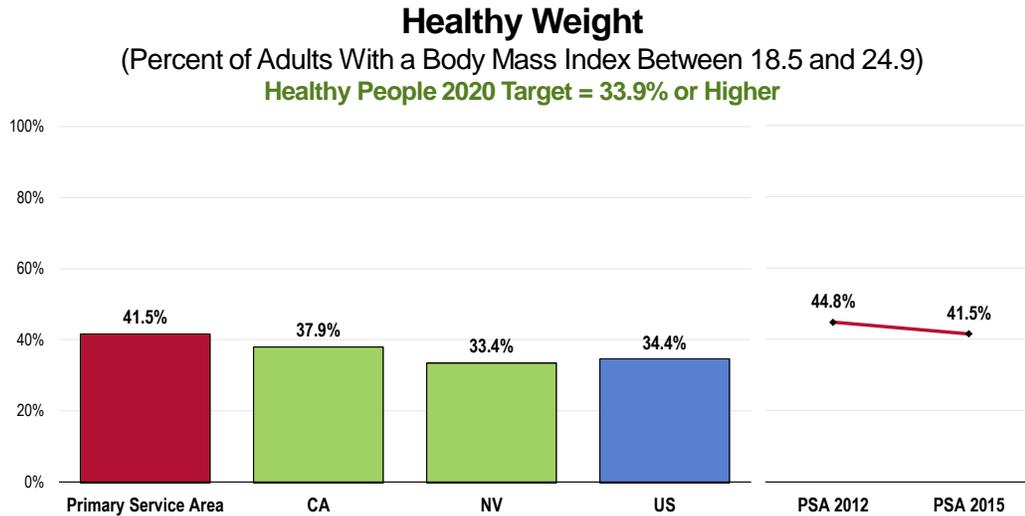
Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

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, 41.5% of Primary Service Area adults are at a healthy weight.

- Similar to the California prevalence, more favorable than the Nevada prevalence.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (33.9% or higher).
- TREND: Statistically unchanged since 2012.

Healthy Weight
(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)
Healthy People 2020 Target = 33.9% or Higher

	Primary Service Area	CA	NV	US		PSA 2012	PSA 2015
	41.5%	37.9%	33.4%	34.4%		44.8%	41.5%

Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]
- 2013 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): 2013 California and Nevada data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-8]

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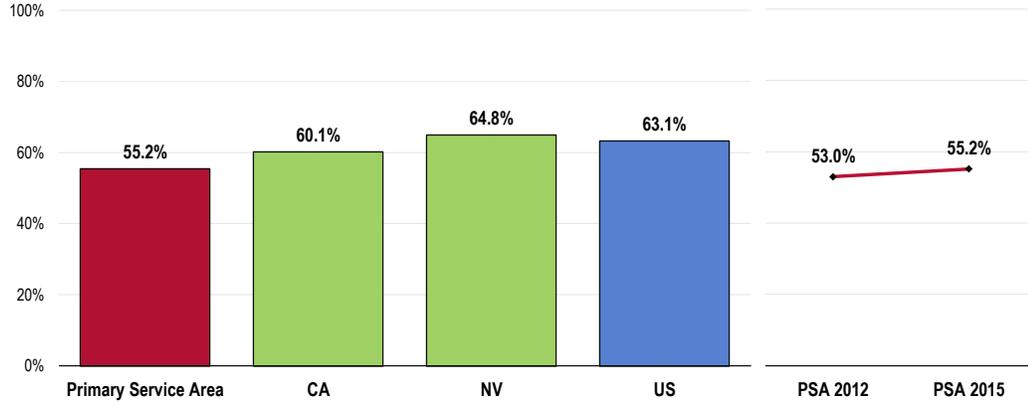
Overweight Status

More than half of Primary Service Area adults (55.2%) are overweight.

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

- Comparable to the California prevalence, better than the Nevada figure.
- More favorable than the US overweight prevalence.
- TREND: Statistically unchanged since 2012.

Prevalence of Total Overweight
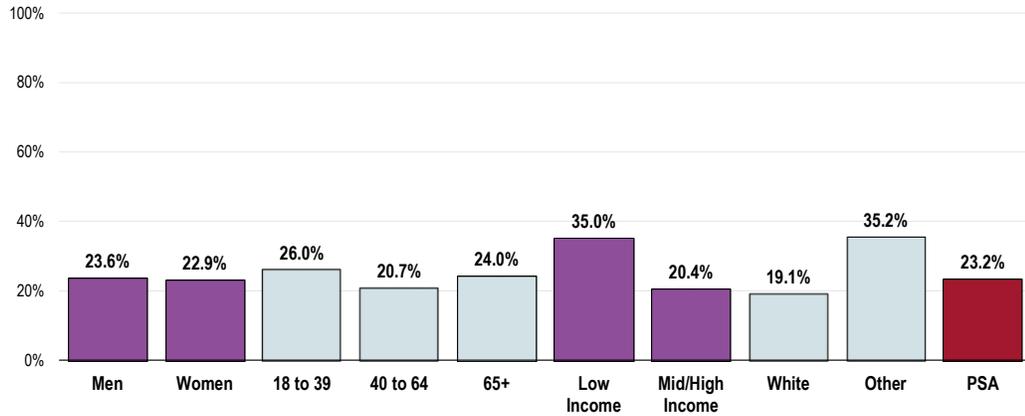### (Percent of Adults With a Body Mass Index of 25.0 or Higher)

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]
● 2013 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): 2013 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.

Further, 23.2% of Primary Service Area adults are obese.

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

- Comparable to state findings.
- More favorable than US findings.
- Satisfies the Healthy People 2020 target (30.5% or lower).
- TREND: Denotes a statistically significant <u>increase</u> in obesity since 2012.

Prevalence of Obesity
(Percent of Adults With a Body Mass Index of 30.0 or Higher)
Healthy People 2020 Target = 30.5% or Lower
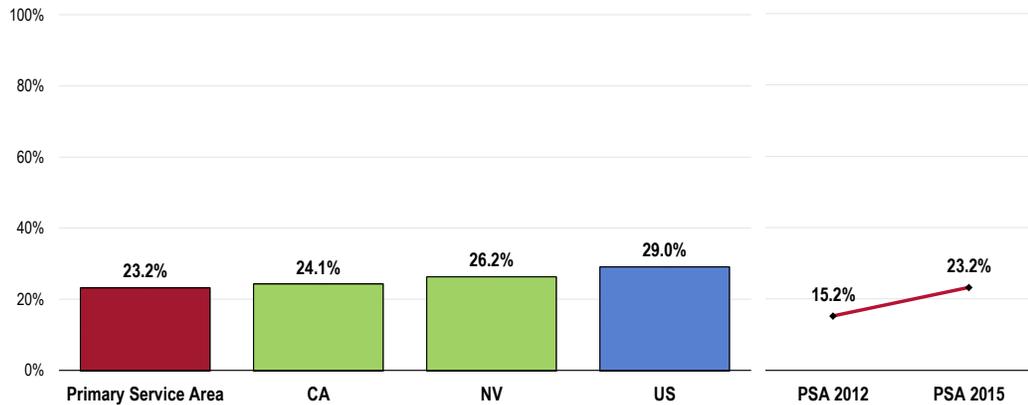
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 155]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 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:

- Respondents with lower incomes.
- Those of "Other" races.

Prevalence of Obesity
(Percent of Adults With a BMI of 30.0 or Higher; Primary Service Area, 2015)
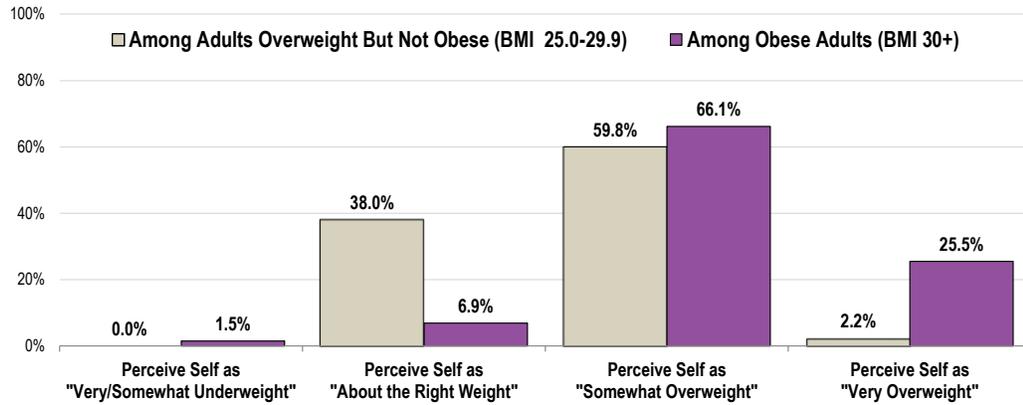**Healthy People 2020 Target = 30.5% or Lower**

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
23.6%	22.9%	26.0%	20.7%	24.0%	35.0%	20.4%	19.1%	35.2%	23.2%

Actual vs. Perceived Body Weight

A total of 6.9% of obese adults and 38.0% of overweight (but not obese) adults feel that their current weight is "about right."

- 59.8% of overweight (but not obese) adults see themselves as "somewhat overweight."
- 25.5% of obese adults see themselves as "very overweight."

Actual vs. Perceived Weight Status
(Among Overweight/Obese Adults Based on BMI; Primary Service Area, 2015)

□ Among Adults Overweight But Not Obese (BMI 25.0-29.9) ■ Among Obese Adults (BMI 30+)

Perceive Self as "Very/Somewhat Underweight"	Perceive Self as "About the Right Weight"	Perceive Self as "Somewhat Overweight"	Perceive Self as "Very Overweight"
0.0% / 1.5%	38.0% / 6.9%	59.8% / 66.1%	2.2% / 25.5%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
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

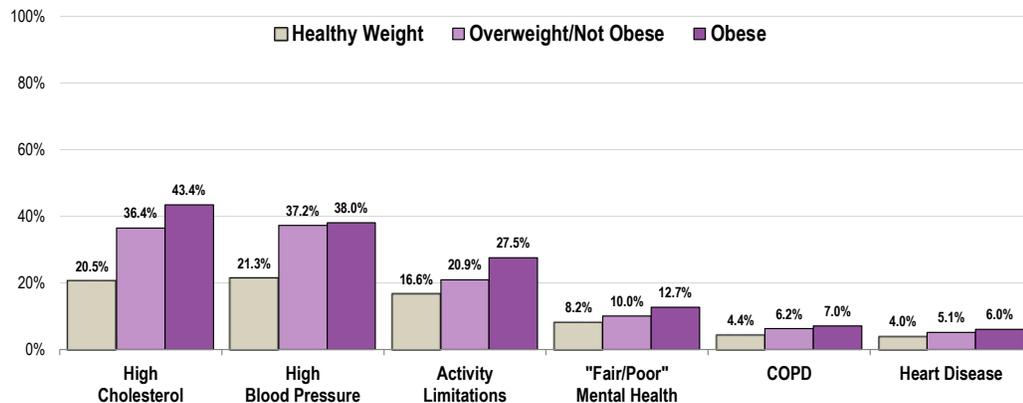Overweight and obese adults are more likely to report a number of adverse health conditions. Among these are:

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

- High cholesterol.
- Hypertension (high blood pressure).
- Activity limitations.
- "Fair" or "poor" mental health.
- COPD (chronic obstructive pulmonary disease).
- Heart Disease.

Relationship of Overweight With Other Health Issues
(By Weight Classification; Primary Service Area, 2015)

□ Healthy Weight ■ Overweight/Not Obese ■ Obese

	High Cholesterol	High Blood Pressure	Activity Limitations	"Fair/Poor" Mental Health	COPD	Heart Disease
Healthy Weight	20.5%	21.3%	16.6%	8.2%	4.4%	4.0%
Overweight/Not Obese	36.4%	37.2%	20.9%	10.0%	6.2%	5.1%
Obese	43.4%	38.0%	27.5%	12.7%	7.0%	6.0%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25, 100, 105, 124–126]
Notes: ● Based on reported heights and weights, asked of all respondents.

Weight Management

Health Advice

A total of 21.0% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Statistically similar to the national findings.
- TREND: Statistically unchanged from that reported in 2012.
- Note that 29.7% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while 7 in 10 have not).

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional
(By Weight Classification)
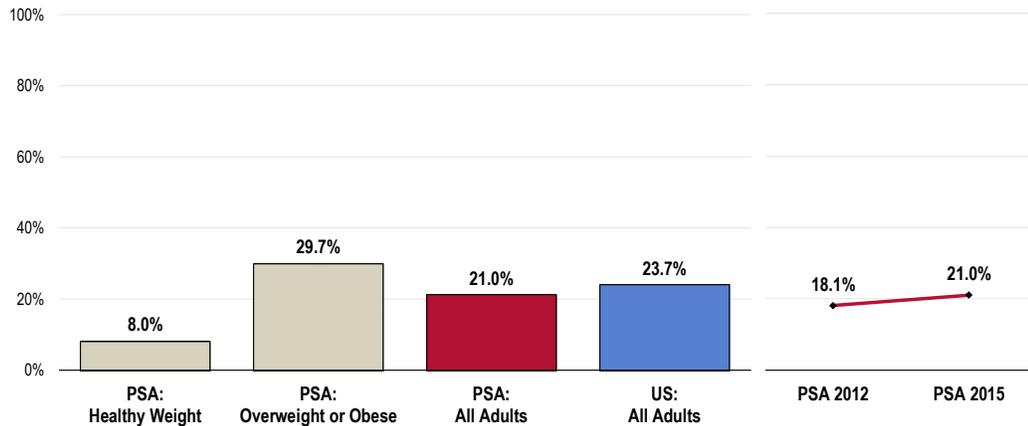
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 98]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Weight Control

About Maintaining a Healthy Weight

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 40.6% 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.
- TREND: Denotes a statistically significant <u>increase</u> among overweight adults in 2012.

Trying to Lose Weight by Both
Modifying Diet and Increasing Physical Activity
(Among Overweight or Obese Respondents)
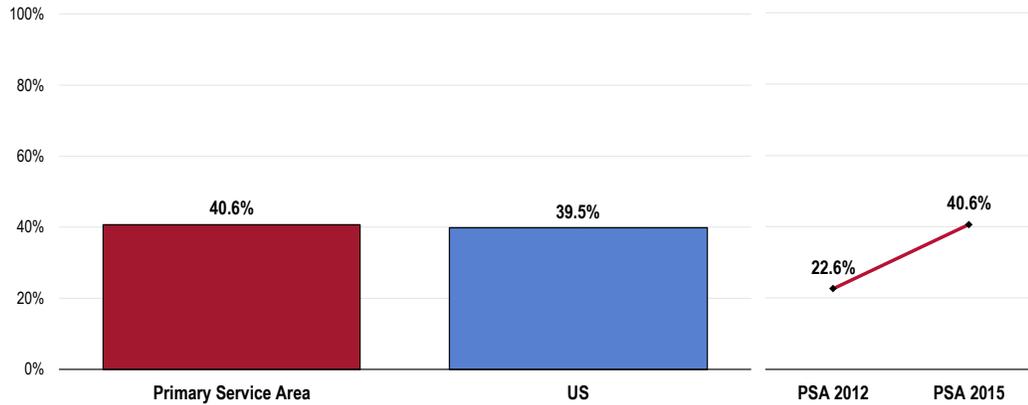
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 156]
          ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Childhood Overweight & Obesity

About Weight Status in Children & Teens

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, 13.4% of Primary Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Much more favorable than found nationally.
- TREND: Marks a statistically significant <u>decrease</u> since 2012.

Child Total Overweight Prevalence
(Children Age 5-17 with BMI in the 85th Percentile or Higher)
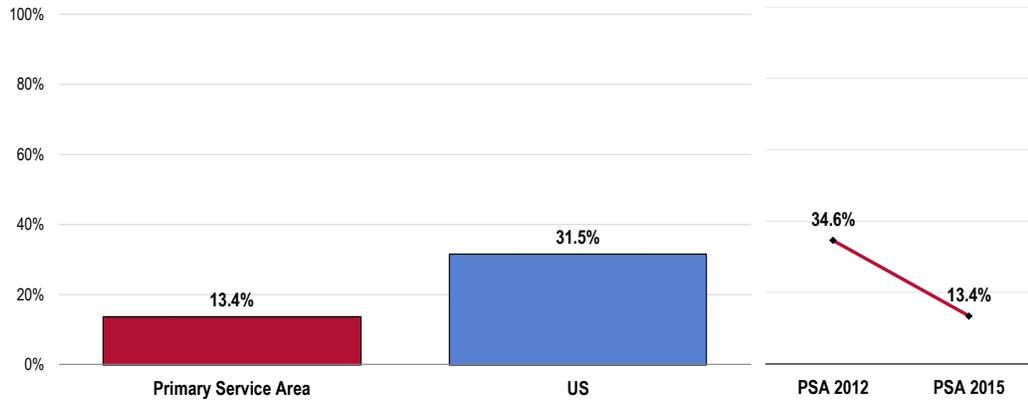
- Primary Service Area: 13.4%
- US: 31.5%
- PSA 2012: 34.6%
- PSA 2015: 13.4%

Further, 5.5% of Primary Service Area children age 5 to 17 are obese (≥95th percentile).

- More favorable than the national percentage.
- Satisfies the Healthy People 2020 target (14.5% or lower for children age 2–19).
- TREND: Marks a statistically significant decrease since 2012.

Child Obesity Prevalence
(Children Age 5-17 with BMI in the 95th Percentile or Higher)
Healthy People 2020 Target = 14.5% or Lower
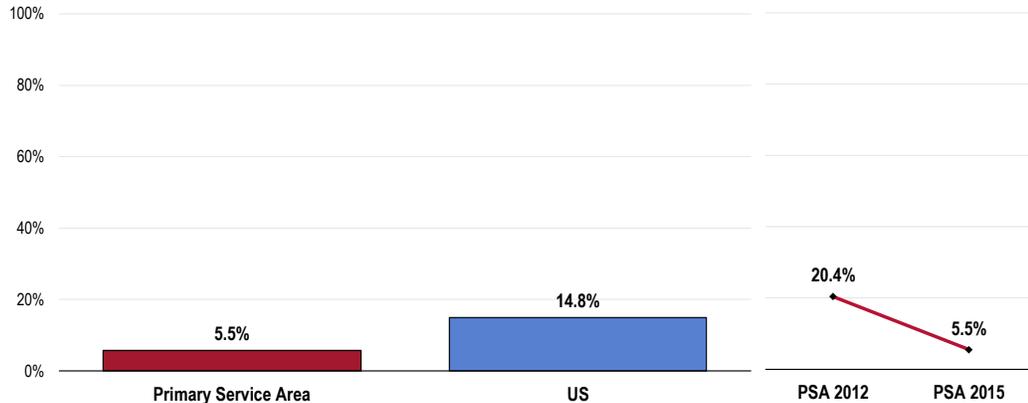
- Primary Service Area: 5.5%
- US: 14.8%
- PSA 2012: 20.4%
- PSA 2015: 5.5%

Key Informant Input: Nutrition, Physical Activity & Weight

The greatest share of key informants taking part in an online survey characterized *Nutrition, Physical Activity & Weight* as a "minor problem" in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

17.6%	32.4%	41.2%	8.8%

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

Top Concerns

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

Nutrition, Lack of Education

Nutrition, many families do not eat a nutritious diet or understand the importance of good nutrition. Lack of education, instruction, motivation, information, financial ability, laziness and generational habits are all contributors to children not having access, interest in, or ability to eat nutritiously. – Community Leader

Malnutrition due to food scarcity and lack of fruits, vegetables, etc. in diet. Poor understanding of nutrition. Low income reducing range of food choices. Cultural norms resulting in high fat, high sugar intake amongst children. Decline of physical activity in school, more sedentary lifestyles. Poverty equals inability to access recreational opportunities. – Social Services Representative

Lack of Time

For many families, not having the time to prepare healthy meals, they rely on fast food, instant meals. Children are fending for themselves in many instances. Some of it is cultural, with a tradition of high-fat, high-calorie meals. Time can be a factor for many for getting physical activity. Access, such as transportation is another. Educating people to some of the simple solutions of using every day, affordable activities to increase their activity level, and maintain healthy weights. Although they try, the school meals are not always the healthiest, they are limited by their funding sources and the requirements. – Community Leader

Affordable Food

Helping people get affordable food that is nutritious, helping people understand the importance of physical activity through classes that are affordable. – Other Health Provider

Low income families can't afford fresh fruits and veggies. McDonald's and Port of Sub is where they eat their meals. Some of the families we serve live in hotels and don't have access to a full kitchen. – Social Services Representative

Lack of Activities

Lack of organized, positive, alternative activities. – Public Health Expert

Obesity, we have too many obese children in our schools and a lack of physical activities being offered that families can afford. – Public Health Expert

Substance Abuse

About Substance Abuse

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

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.
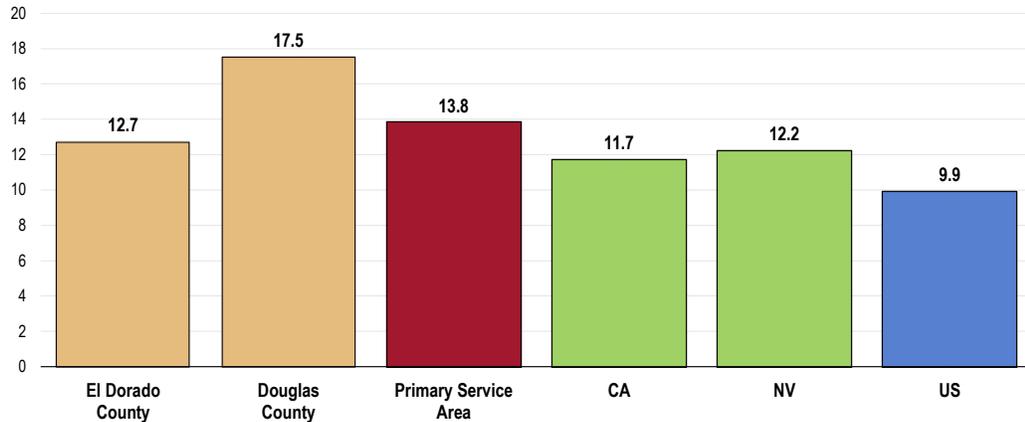
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2011 and 2013, there was an annual average age-adjusted cirrhosis/liver disease mortality rate of 13.8 deaths per 100,000 population in the Primary Service Area.

- Worse than both state rates.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).
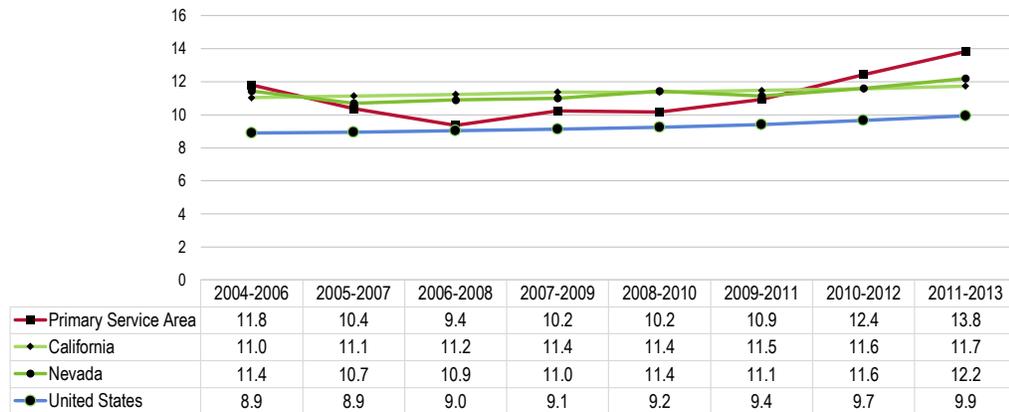- Much higher in Douglas County.

Cirrhosis/Liver Disease: Age-Adjusted Mortality
(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 8.2 or Lower

Location	Rate
El Dorado County	12.7
Douglas County	17.5
Primary Service Area	13.8
CA	11.7
NV	12.2
US	9.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
- 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 US Standard Population.
- Local, state and national data are simple three-year averages.

- TREND: Despite fluctuations, the mortality rate has increased in the region, as have state and US rates over the past decade.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 8.2 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	11.8	10.4	9.4	10.2	10.2	10.9	12.4	13.8
California	11.0	11.1	11.2	11.4	11.4	11.5	11.6	11.7
Nevada	11.4	10.7	10.9	11.0	11.4	11.1	11.6	12.2
United States	8.9	8.9	9.0	9.1	9.2	9.4	9.7	9.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2015.
- 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 US Standard Population.
- State and national data are simple three-year averages.

High-Risk Alcohol Use

Current Drinking

A total of 69.7% of area adults had at least one drink of alcohol in the past month (current drinkers).

"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.

- Much higher than both state figures.
- Much higher than the national proportion.
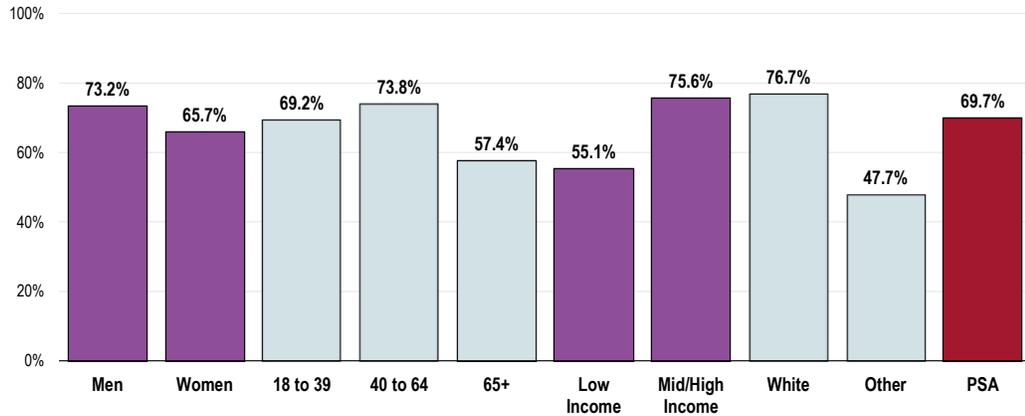- TREND: Statistically unchanged since 2012.

Current Drinkers
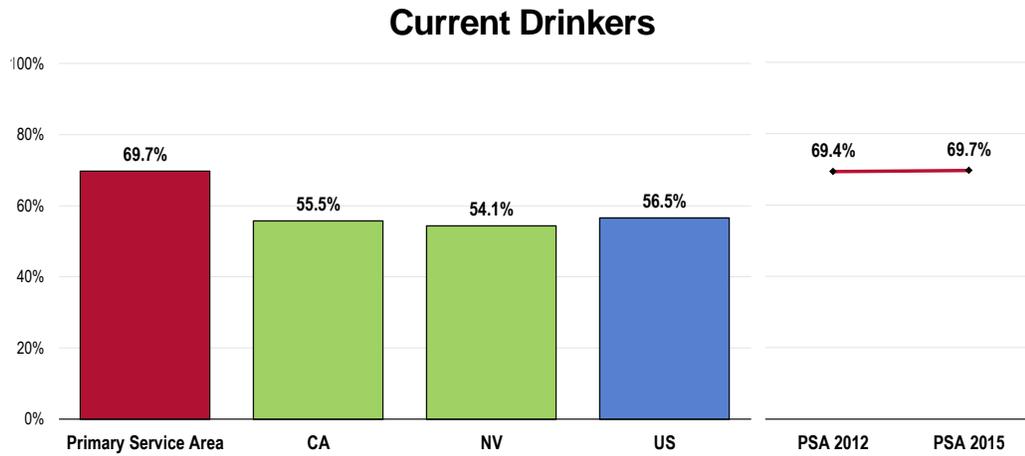
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 164]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 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 adults age 40 to 64, upper-income residents, and Whites.

Current Drinkers
(Primary Service Area, 2015)

Men	73.2%
Women	65.7%
18 to 39	69.2%
40 to 64	73.8%
65+	57.4%
Low Income	55.1%
Mid/High Income	75.6%
White	76.7%
Other	47.7%
PSA	69.7%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 164]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Excessive Drinking

A total of 33.5% of area adults are excessive drinkers (heavy and/or binge drinkers).

- Less favorable than the national proportion.
- TREND: Statistically unchanged since 2012.

"Excessive drinking" includes heavy and/or binge drinkers:

Heavy drinking reflects the number of adults who drank 2+ drinks per day on average (for men) or 1+ drinks per day on average (for women) during the past 30 days.

Binge drinking reflects the number of adults who drank 5+ drinks during a single occasion (for men) or 4+ drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers
Healthy People 2020 Target = 25.4% or Lower

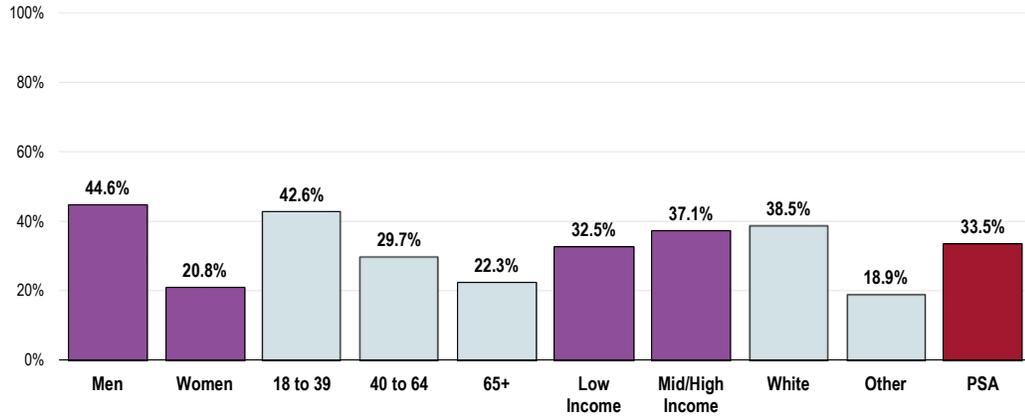| Primary Service Area	US	PSA 2012	PSA 2015
33.5%	23.2%	35.2%	33.5%
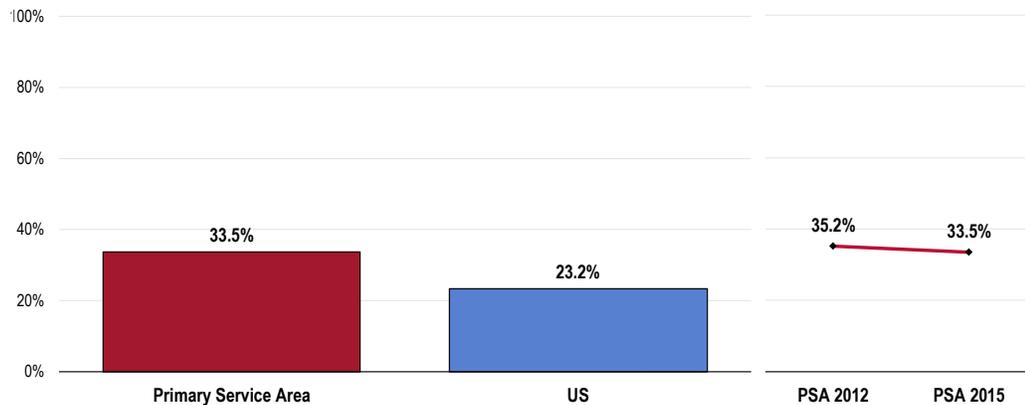
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 182]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]
Notes: ● Asked of all respondents.
● Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

- Excessive drinking is more prevalent among men, younger adults (negative correlation with age), and Whites.

Excessive Drinkers
(Total Area, 2015)
Healthy People 2020 Target = 25.4% or Lower

Category	Value
Men	44.6%
Women	20.8%
18 to 39	42.6%
40 to 64	29.7%
65+	22.3%
Low Income	32.5%
Mid/High Income	37.1%
White	38.5%
Other	18.9%
PSA	33.5%

Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 182]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH 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.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking & Driving

A total of 7.1% of Primary Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

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.

- Similar to the national findings.
- TREND: The drinking and driving prevalence increased significantly since 2012.

Have Driven in the Past Month
After Perhaps Having Too Much to Drink
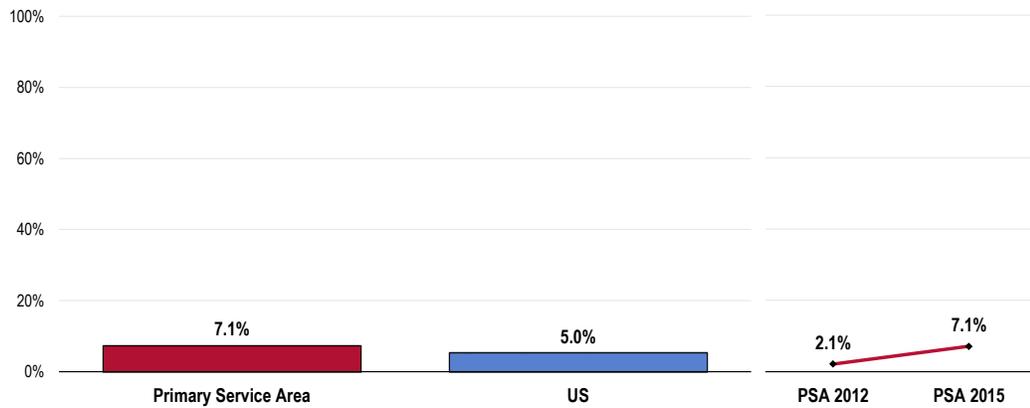
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 65]
　　　　● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
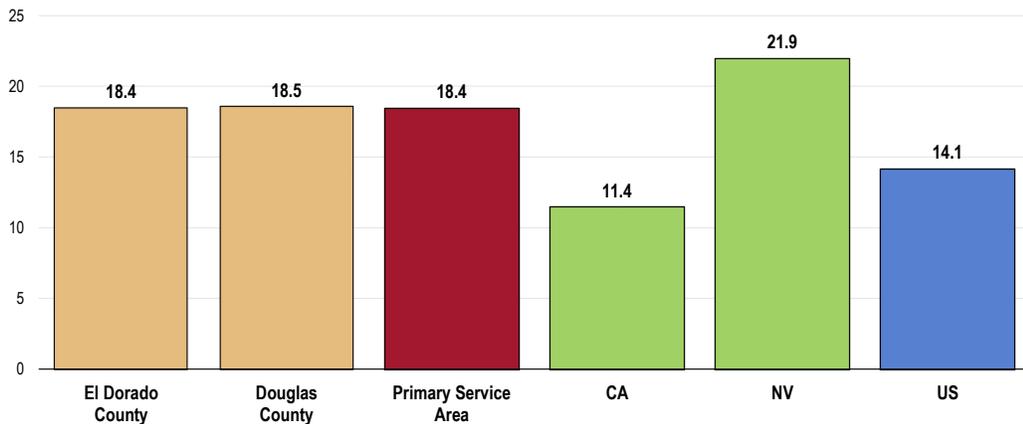Notes: ● Asked of all respondents.

Age-Adjusted Drug-Induced Deaths

Between 2011 and 2013, there was an annual average age-adjusted drug-induced mortality rate of 18.4 deaths per 100,000 population in the Primary Service Area.

- Higher than the California rate, lower than the Nevada rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (11.3 or lower).
- No difference by county.

Drug-Induced Deaths: Age-Adjusted Mortality
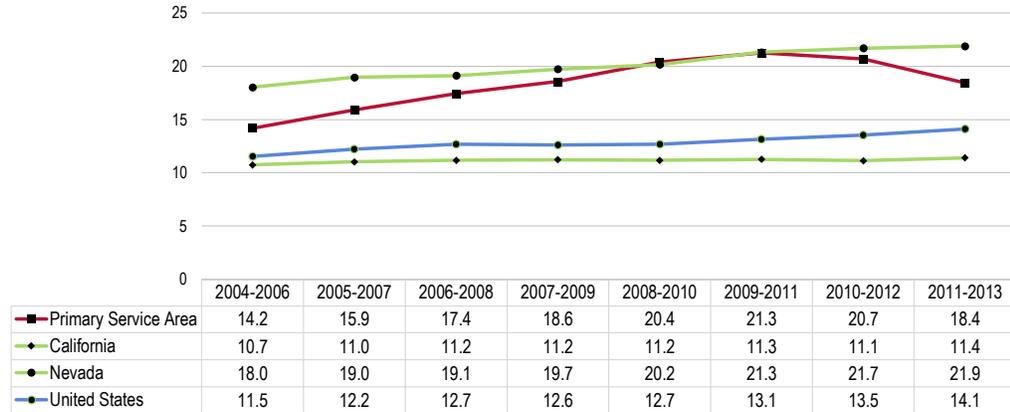(2011–2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 11.3 or Lower

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

- TREND: Although decreasing in most recent years, the service area's mortality rate has generally increased over the past decade. Across California, Nevada, and the US, rates have increased.

Drug-Induced Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 11.3 or Lower

	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Primary Service Area	14.2	15.9	17.4	18.6	20.4	21.3	20.7	18.4
California	10.7	11.0	11.2	11.2	11.2	11.3	11.1	11.4
Nevada	18.0	19.0	19.1	19.7	20.2	21.3	21.7	21.9
United States	11.5	12.2	12.7	12.6	12.7	13.1	13.5	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 March 2015.
- 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.
- County, state and national data are simple three-year averages.

Illicit Drug Use

A total of 5.7% of Primary Service Area adults acknowledge using an illicit drug in the past month.

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.
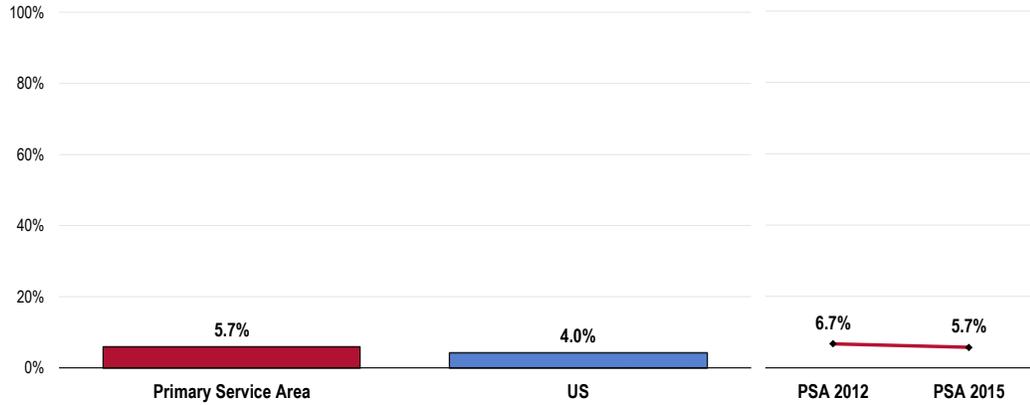
- Similar to the proportion found nationally.
- Similar to the Healthy People 2020 target of 7.1% or lower.
- TREND: Statistically similar to 2012 findings.

Illicit Drug Use in the Past Month
Healthy People 2020 Target = 7.1% or Lower

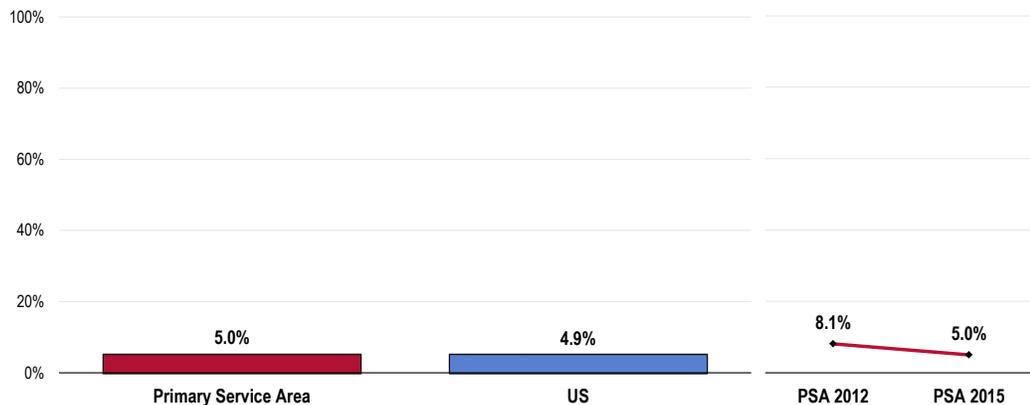|	
Primary Service Area	5.7%
US	4.0%
PSA 2012	6.7%
PSA 2015	5.7%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 66]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]
Notes: ● Asked of all respondents.

Alcohol & Drug Treatment

A total of 5.0% of Primary Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Similar to national findings.
- Statistically unchanged over time.

Have Ever Sought Professional Help
for an Alcohol/Drug-Related Problem

Primary Service Area	5.0%
US	4.9%
PSA 2012	8.1%
PSA 2015	5.0%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 67]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Substance Abuse

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

Perceptions of Substance Abuse
as a Problem in the Community
(Key Informants, 2015)

■ Major Problem ☐ Moderate Problem ■ Minor Problem ☐ No Problem At All

69.2%	25.6%	2.6%	2.6%

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

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Lack of Services

We do not have a credible substance abuse treatment center in South Lake Tahoe. I am not aware of any credible program, either a day center, a residential center, or a counseling center that exists. – Community Leader

I believe that a significant portion of the substance abuse is directly correlated with the lack of mental health safety net services and access to appropriate and consistent medication and coping mechanisms for mental illness. Once mental health services are improved, I am hopeful that substance abuse will decline. – Community Leader

Huge. Access to inpatient care. We no longer have an inpatient facility in South Lake Tahoe, at least one that is affordable. The casinos bring in a ton of drugs. Heroin is an epidemic. Most people do not access treatment until they are court ordered or CPS is involved. – Public Health Expert

Lack of service options. – Social Services Representative

Denial

Coming to terms with the fact they have a problem and shared cost of treatment. – Community Leader

They deny the disease or do not seek treatment. – Community Leader

Their addiction itself, support around them to help them overcome their addiction and lack of awareness about their addiction. – Community Leader

The person not willing to give it up. That fact that there is nothing close by where they can turn if they are even willing. Not enough trained people to handle this problem well. – Social Services Representative

Denial and lifestyle. – Community Leader

Not realizing that they have a problem. Getting services that they can afford. Having programs that provide services for a long period of time. – Other Health Provider

Local Statistics

Alcohol and other drug issues, El Dorado perspective. Percentage of adults aged 18 and older who self-report binge drinking in past month, five plus drinks at one time. El Dorado County 21.6 California 17.6, percentage of teens who have ever tried marijuana, cocaine, sniffing glue, other drugs. El

Dorado County 35.3 California 13.7, percent population heavily consuming alcohol. El Dorado County 17.2 California 15.7. Emergency and hospitalizations visits reflect that problem as the rates are higher for El Dorado County compared to the State of California for substance use Emergency Room visits per 100,000 age 15 to 24, 977 compared to 691. Substance use hospitalizations per 1000 pregnant females, 41.5 compared to 14.2 and its direct consequence more than the double still or live born Infants age 0 to 89 days are substance-affected in El Dorado per 1000 still or live-born infants, 46.6 compared to 20.2 in California. – Public Health Expert

Cultural Acceptance

It is widely accepted in the community from youth and parents. Many citizens are unaware of the consequences or dangers and their perception of harm is at an all-time low. They also do not have knowledge of programs or help centers in town. There are few rehab facilities in town which makes recovery harder. Drugs and alcohol are very easily accessible to youth in schools from older siblings/friends and parents. Liquor stores advertise and sell tobacco and alcohol to youth. – Social Services Representative

The attitude that marijuana is not a problem. No inpatient residential programs in Tahoe for minors. – Community Leader

Easy Access

The casino culture and excessive access to substances. The drug culture and the number of marijuana grow in town. The lack of policies and resources to support this issue. – Social Services Representative

24 hour lifestyle, drinking and gambling atmosphere attracts those who may have a problem. – Social Services Representative

Our bigger problem is the easy access to all drugs and alcohol and a culture that encourages use. – Community Leader

Cost

Financial resources. Getting the person to take responsibility for their abuse and understand the roots of the addiction. – Community Leader

There is no funding available to those that need help and most places do not take insurance. – Social Services Representative

Affordable residential treatment centers. – Public Health Expert

Cost, denial and not knowing appropriate resources for treatment and services. – Social Services Representative

Poverty

People's lifestyle, poverty, and lack of self-esteem. One needs to want help to receive help. There are plenty of agencies offering counseling and chemical dependency programs. – Social Services Representative

Poverty, good resale value for narcotics. – Physician

Cessation

No desire to stop or unable to stop. – Community Leader

They don't want it or are afraid to ask for it and/or don't know how to go about asking for it. – Community Leader

Transportation

Transportation, office hours, personal barriers, friend and family support, cultural stigma and language barriers. – Social Services Representative

Access to Services

Access to services and education for users and their families. – Community Leader

Most Problematic Substances

Key informants (who rated this as a "major problem") most often identified alcohol, marijuana, heroin/other opioids, and methamphetamines/other amphetamines as the most problematic substances abused in the community.

	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	41.7%	20.8%	21.7%	20
Marijuana	16.7%	29.2%	13.0%	14
Heroin or Other Opioids	20.8%	12.5%	17.4%	12
Methamphetamines or Other Amphetamines	16.7%	12.5%	8.7%	9
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	4.2%	0.0%	4.3%	2
Cocaine or Crack	0.0%	16.7%	0.0%	4
Prescription Medications	0.0%	8.3%	26.1%	8
Over-the-Counter Medications	0.0%	0.0%	4.3%	1
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	0.0%	4.3%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. 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.
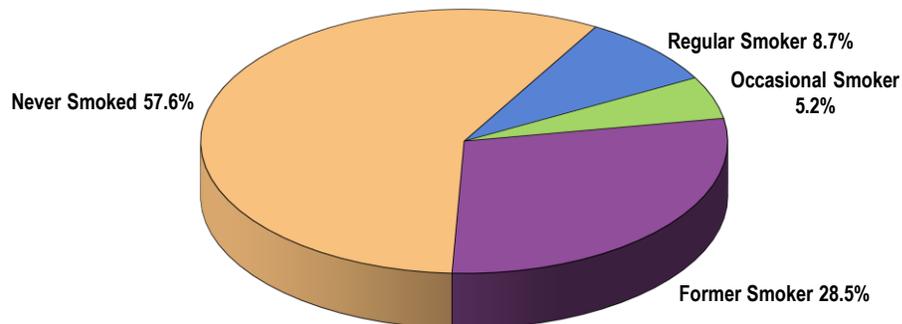
- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 13.9% of Primary Service Area adults currently smoke cigarettes, either regularly (8.7% every day) or occasionally (5.2% on some days).

Cigarette Smoking Prevalence
(Primary Service Area, 2015)

Never Smoked 57.6%
Regular Smoker 8.7%
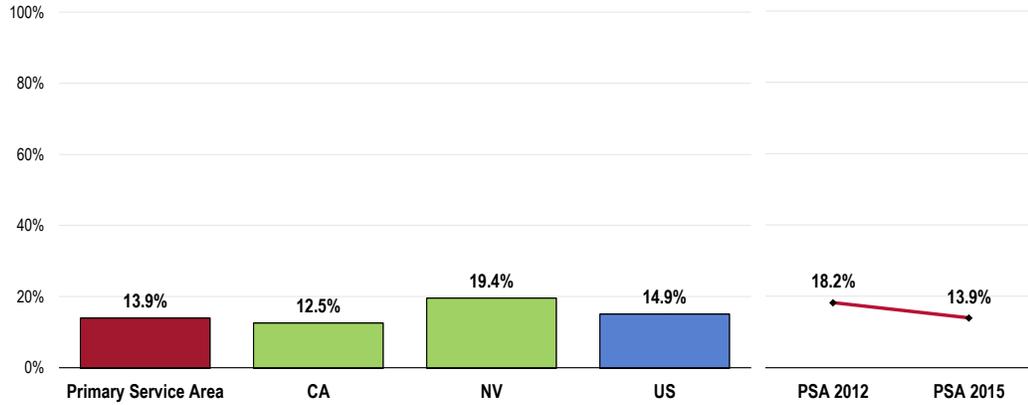Occasional Smoker 5.2%
Former Smoker 28.5%

Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 160]
Notes: • Asked of all respondents.

- Similar to California findings, better than Nevada.
- Similar to national findings.
- Similar to the Healthy People 2020 target (12% or lower).
- TREND: The current smoking percentage is statistically unchanged since 2012.

Current Smokers
Healthy People 2020 Target = 12.0% or Lower

Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 160]
- 2013 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): 2013 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 (those who smoke cigarettes everyday or on some days).
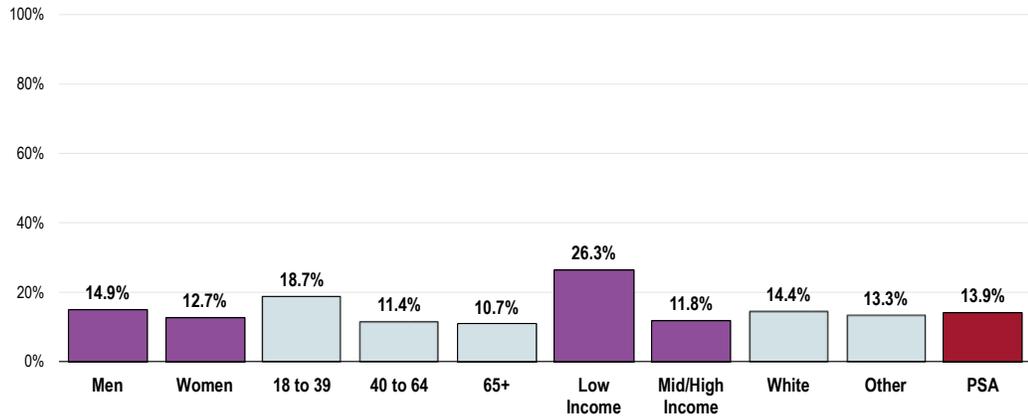
Cigarette smoking is more prevalent among:

- Adults under 40.
- Lower-income residents.

Current Smokers
(Primary Service Area, 2015)
### Healthy People 2020 Target = 12.0% or Lower

Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 160]
- 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. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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).

Environmental Tobacco Smoke

A total of 7.0% of Primary Service Area adults (including smokers and non-smokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- More favorable than national findings.
- TREND: Marks a statistically significant <u>decrease</u> over time.
- Note that 2.2% of Primary Service Area non-smokers are exposed to cigarette smoke at home, better than what is found nationally.
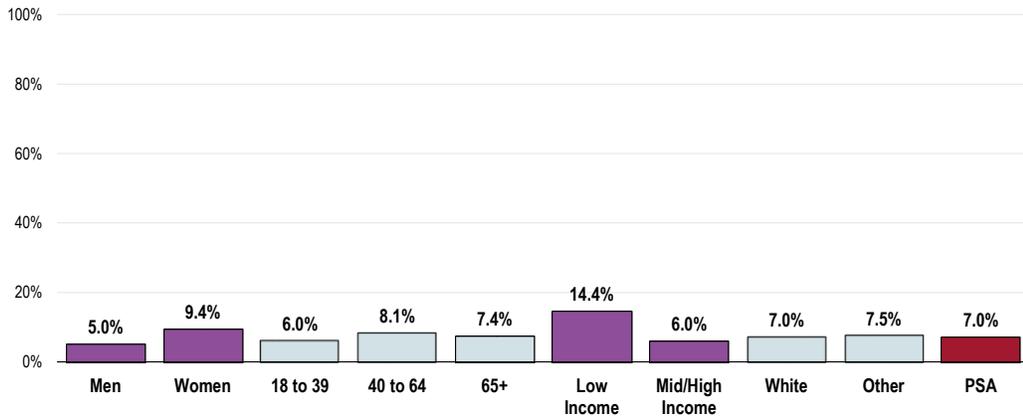
Member of Household Smokes at Home

Non-smokers exposed to smoke in the home: 2.2%
(US = 6.3%)

Primary Service Area	US	PSA 2012	PSA 2015
7.0%	12.7%	12.8%	7.0%
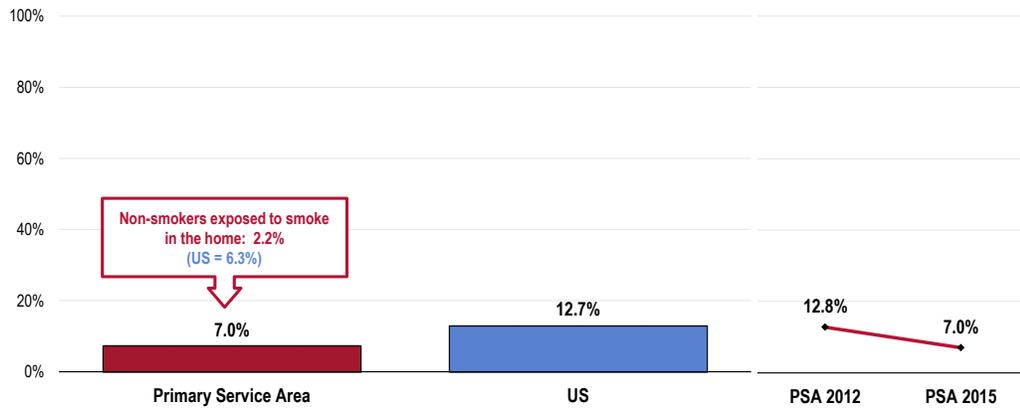
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 59, 162]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among residents with lower incomes.

Member of Household Smokes At Home
(Primary Service Area, 2015)

| Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
5.0%	9.4%	6.0%	8.1%	7.4%	14.4%	6.0%	7.0%	7.5%	7.0%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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, 3.4% have someone who smokes cigarettes in the home.

- More favorable than national findings.
- TREND: Statistically unchanged over time.

Percentage of Households With Children In Which Someone Smokes in the Home
(Among Households With Children)

Bar/line chart showing:
- Primary Service Area: 3.4%
- US: 9.7%
- PSA 2012: 6.6%
- PSA 2015: 3.4%
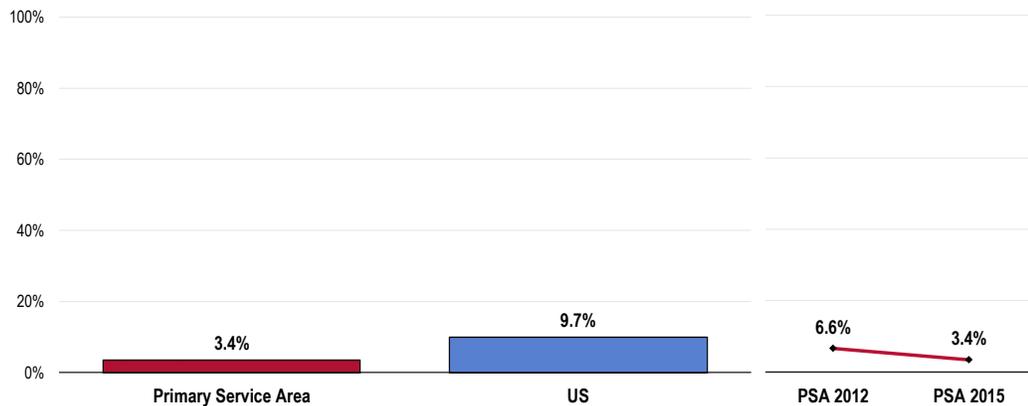
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 163]
   ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects respondents with children 0 to 17 in the household.
   ● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

About Reducing Tobacco Use

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 54.9% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Comparable to the national percentage.
- TREND: No statistically significant change since 2012.

Advised by a Healthcare
Professional in the Past Year to Quit Smoking
(Among Current Smokers)
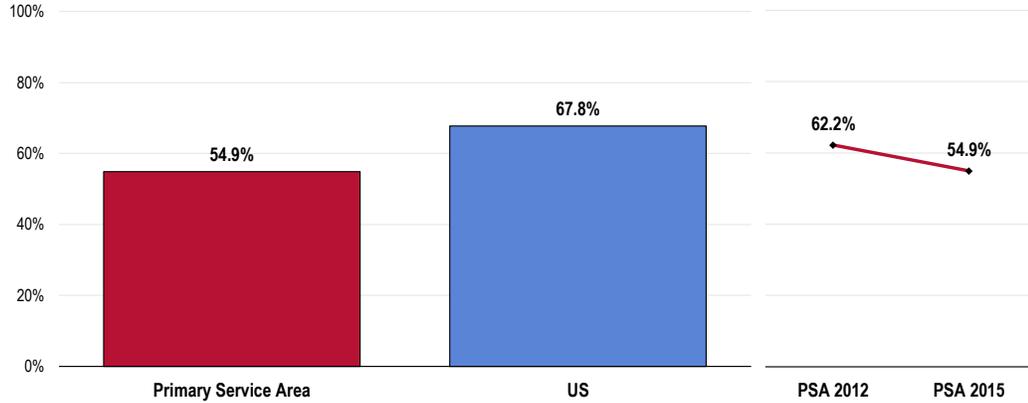
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 58]
  • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
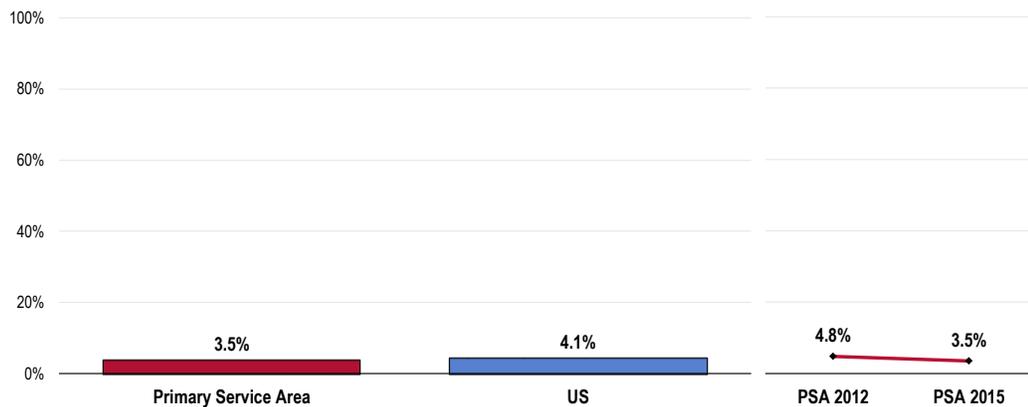Notes: • Asked of all current smokers.

Other Tobacco Use

Cigars

A total of 3.5% 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).
- TREND: No statistically significant change since 2012.

Use of Cigars
Healthy People 2020 Target = 0.2% or Lower

Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 61]
  • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
  • US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.3]
Notes: • Asked of all respondents.

Smokeless Tobacco

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 2.2% of Primary Service Area adults use some type of smokeless tobacco every day or on some days.

- Lower than the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- TREND: Similar to 2012 findings.

Use of Smokeless Tobacco
Healthy People 2020 Target = 0.3% or Lower

|			
2.2%	4.0%	3.9%	2.2%
Primary Service Area	US	PSA 2012	PSA 2015
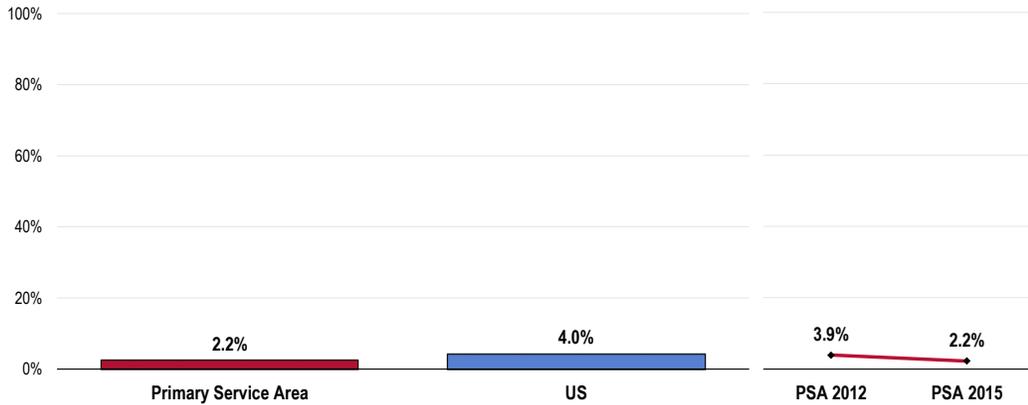
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 60]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.2]
Notes: ● Asked of all respondents.
● Smokeless tobacco includes chewing tobacco or snuff.

Key Informant Input: Tobacco Use

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

Perceptions of Tobacco Use
as a Problem in the Community
(Key Informants, 2015)
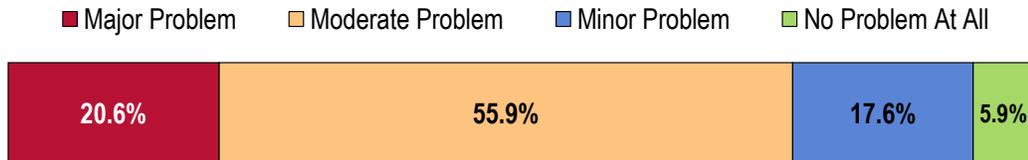
■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

20.6%	55.9%	17.6%	5.9%

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

Top Concerns

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

Casino Culture

> *Many individuals in South Tahoe have developed a smoking habit. It is perpetuated because of South Lake's close proximity to the casinos and other recreational facilities. It impacts the environment as well with cigarette butts littering the beaches and leaching chemicals into the lake and surrounding areas. – Social Services Representative*

> *Close proximity to the casinos, where smoking indoors is permitted. E-cigarette and vaporizer stores throughout our community. – Social Services Representative*

Tax Profit

> *If the government is still thinking about taxing tobacco there must be a population to tax. I see a lot of smoking families accessing subsidized child care. The casino doesn't promote a healthy lifestyle. – Social Services Representative*

Environmental Damage

> *Environmental damage, creates unhealthy environment in town and also to the lake. – Social Services Representative*

Youth

> *More high school students smoke than any other group. – Community Leader*

High Prevalence

> *Still see a lot of people smoking. – Community Leader*

Access to Health Services

Health Insurance Coverage (Adults)

Type of Healthcare Coverage

A total of 66.3% of Primary Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 19.1% report coverage through a government-sponsored program (e.g., Medicaid/Medi-Cal, Medicare, military benefits).

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

Healthcare Insurance Coverage
(Among Adults Age 18-64; Primary Service Area, 2015)
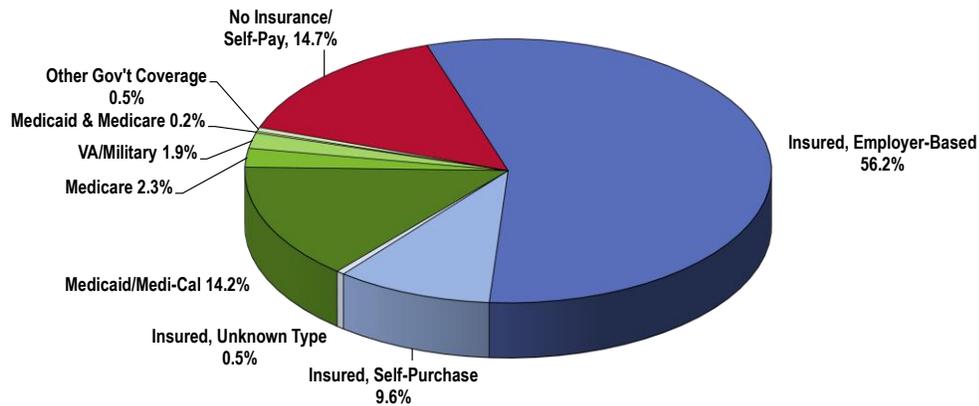
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
Notes: ● Reflects respondents age 18 to 64.

California Health Insurance Exchange (Covered California)

Of those survey respondents with self-purchased insurance coverage, 37.5% indicate that their current coverage is through Covered California or another California insurance exchange.

The California Health Insurance Exchange, or Covered California, is offered as part of the Affordable Care Act and can be accessed through the Healthcare.gov website, as well as through call centers or in-person assistance. It is a resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage.

Covered California also provides information on programs that help people with low to moderate income and resources pay for coverage.

Current Coverage Is Through Covered California
(Or Another California Insurance Exchange)
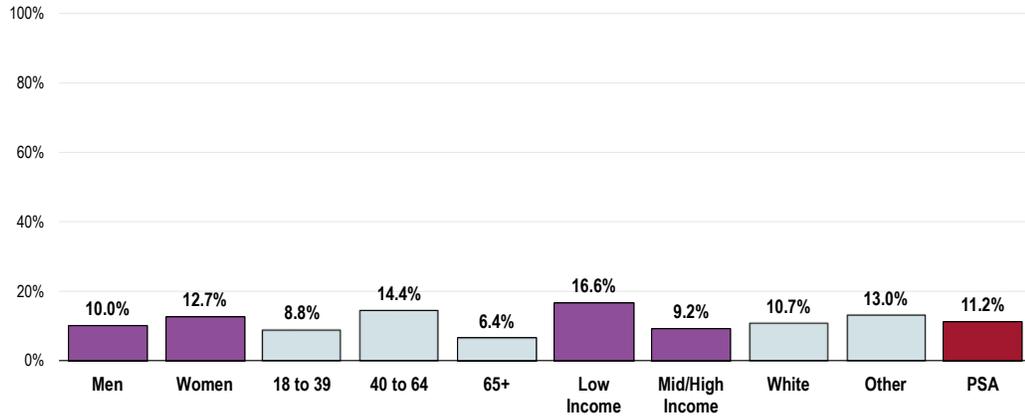(Among Adults with Self-Purchased Coverage; Primary Service Area, 2015)
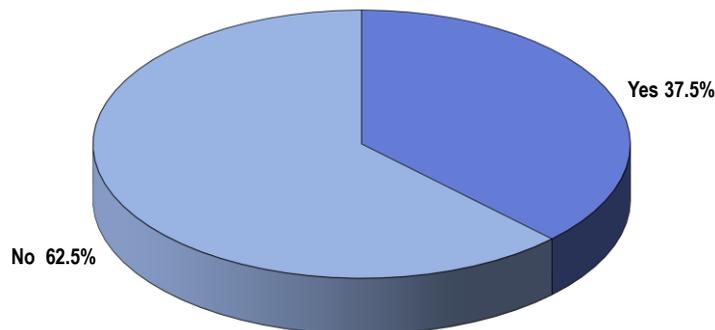
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 306]
Notes: ● Reflects respondents with self-purchased insurance coverage.

Size of Deductible

Among currently insured adults in the Primary Service Area, 11.2% report that the size of their insurance deductible prevented healthcare at some point in the past year.

● The prevalence is highest among adults age 40-64 and lower-income residents.

Size of Insurance Deductible
Prevented Healthcare in the Past 12 Months
(Insured Adults in the Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
10.0%	12.7%	8.8%	14.4%	6.4%	16.6%	9.2%	10.7%	13.0%	11.2%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 301]
Notes: ● Asked of all insured respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Lack of Health Insurance Coverage

Among adults age 18 to 64, 14.7% report having no insurance coverage for healthcare expenses.

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).

- Better than both state figures.
- Similar to the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- TREND: Marks a statistically significant <u>decrease</u> in lack of coverage over time.

Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64)
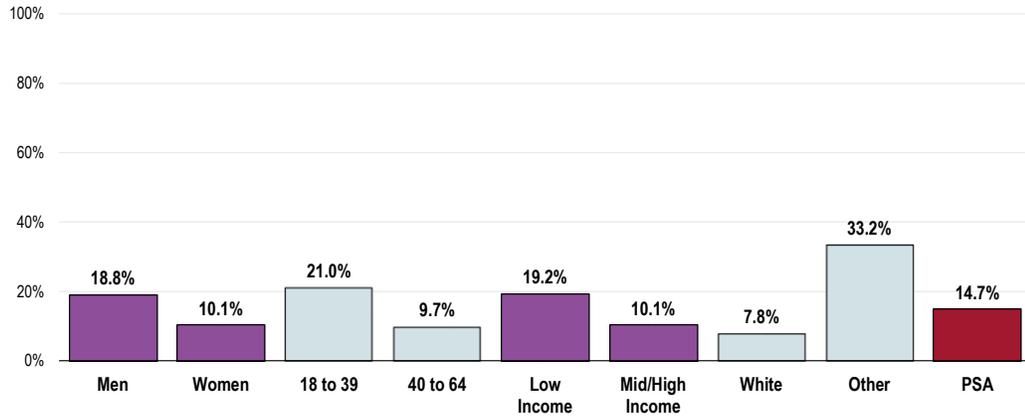**Healthy People 2020 Target = 0.0% (Universal Coverage)**
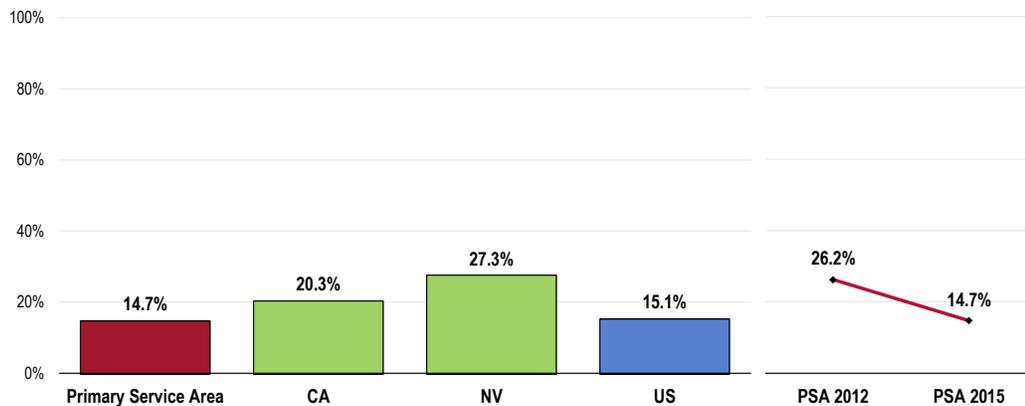
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 168]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective 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:

- Men, young adults, lower-income residents, and "Other" races (note the 33.2% prevalence).

Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64; Primary Service Area, 2015)
Healthy People 2020 Target = 0.0% (Universal Coverage)

|								
Men	Women	18 to 39	40 to 64	Low Income	Mid/High Income	White	Other	PSA
18.8%	10.1%	21.0%	9.7%	19.2%	10.1%	7.8%	33.2%	14.7%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
         ● 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. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
         ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Recent Lack of Coverage

Among currently insured adults in the Primary Service Area, 7.6% report that they were without healthcare coverage at some point in the past year.

- Similar to US findings.
- TREND: No significant change in insurance instability.

Went Without Healthcare Insurance
Coverage At Some Point in the Past Year
(Among Insured Adults)

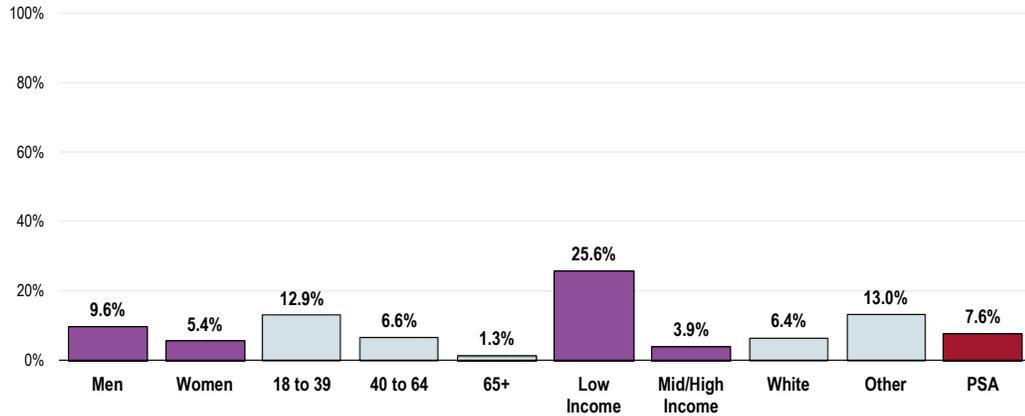|			
Primary Service Area	US	PSA 2012	PSA 2015
7.6%	8.1%	8.3%	7.6%
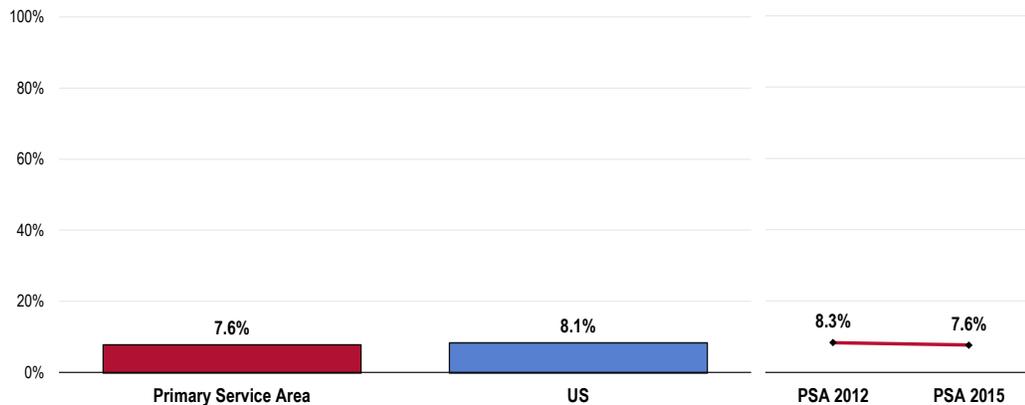
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 79]
         ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all insured respondents.

Among insured adults, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Adults under age 40 (note the negative correlation with age).
- Lower-income residents.

Went Without Healthcare Insurance
Coverage At Some Point in the Past Year
(Among Insured Adults; Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
9.6%	5.4%	12.9%	6.6%	1.3%	25.6%	3.9%	6.4%	13.0%	7.6%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 79]
Notes: ● Asked of all insured respondents.
           ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
           ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 Insurance Coverage (Children)

Survey respondents were asked a series of questions to determine the healthcare insurance coverage they carry for their child, if any, from either private or government-sponsored sources.

Among respondents with children under age 18, 2 in 3 (66.8%) report having private healthcare coverage for their child, while 27.6% report coverage through a government-sponsored program (e.g., Medicaid, Medi-Cal, state-sponsored children's health plan, etc.).

Child's Healthcare Insurance Coverage
(Among Parents of Children <18; Primary Service Area, 2015)

State-Sponsored Children's Health Plan 0.4%

None 5.6%

Medicare & Medicaid/Medi-Cal 2.5%

Private Insurance 66.8%

Medicaid/ Medi-Cal 24.5%

Medicare 0.2%
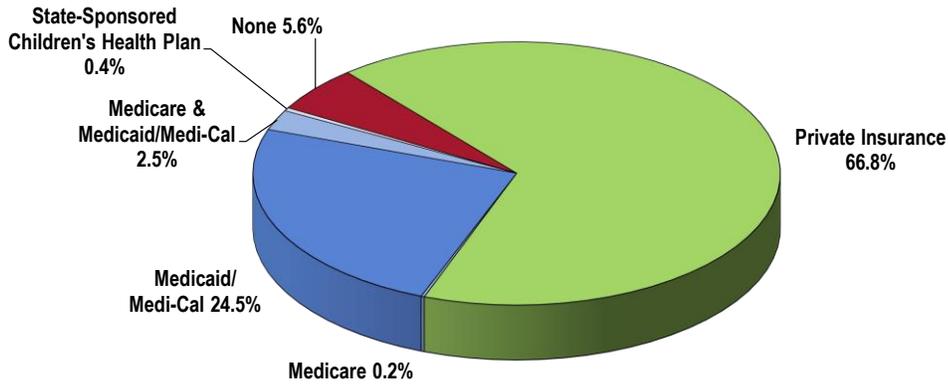
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
Notes: ● Reflects respondents age 18 to 64.

Difficulties Accessing Healthcare

About Access to 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

A total of 42.2% of Primary Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- ● Comparable to national findings.
- ● TREND: Similar to the percentage reported in 2012.

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.

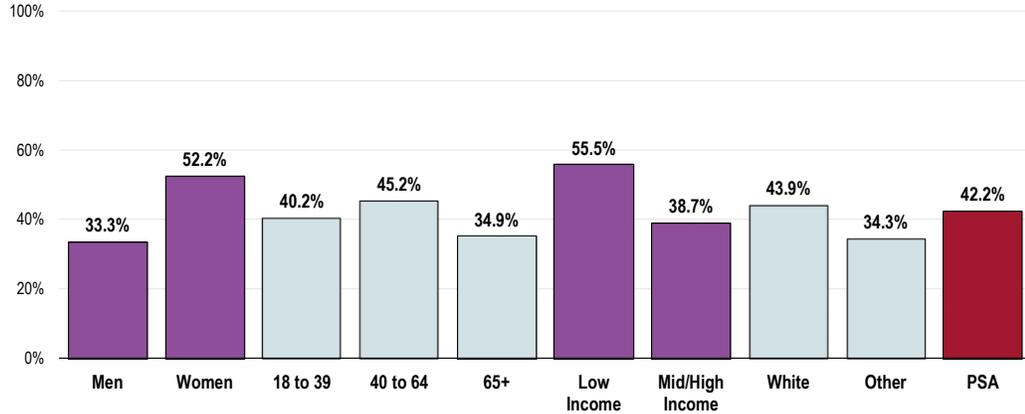### Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
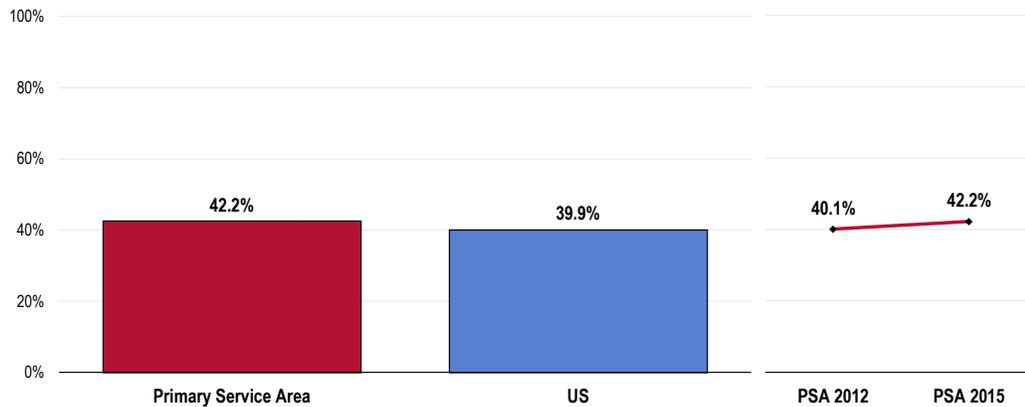
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 172]
●   2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Lower-income residents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
(Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
33.3%	52.2%	40.2%	45.2%	34.9%	55.5%	38.7%	43.9%	34.3%	42.2%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 172]
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. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
             ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.
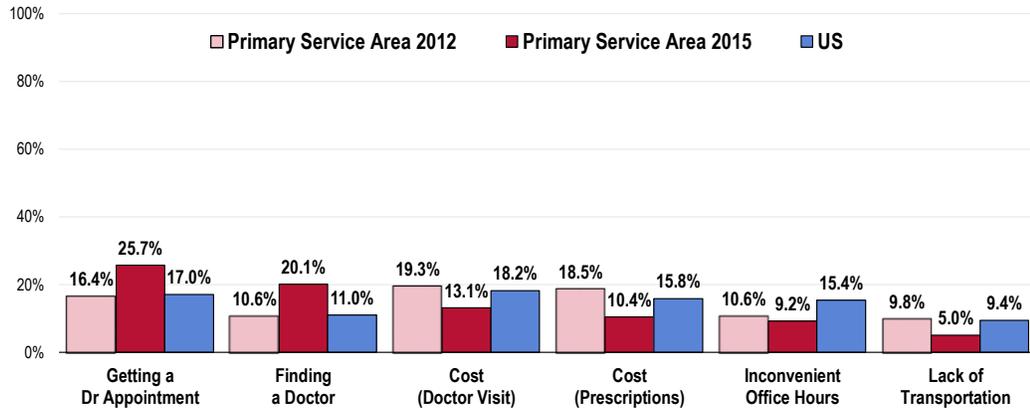
Barriers to Healthcare Access

Of the tested barriers, difficulty getting a medical appointment impacted the greatest share of Primary Service Area adults (25.7%).

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.

- The proportion of Primary Service Area adults impacted was statistically worse than that found nationwide for difficulty finding a physician and getting an appointment.
- TREND: Compared to baseline 2012 data, the Primary Service Area has seen a significant decrease (improvement) with regard to the barriers of **transportation** and **cost of prescriptions**. On the other hand, note the significant increases in the barriers of finding a physician and getting an appointment since 2012.

Barriers to Access Have
Prevented Medical Care in the Past Year

Legend: ■ Primary Service Area 2012   ■ Primary Service Area 2015   ■ US

|	Getting a Dr Appointment	Finding a Doctor	Cost (Doctor Visit)	Cost (Prescriptions)	Inconvenient Office Hours	Lack of Transportation
Primary Service Area 2012	16.4%	10.6%	19.3%	18.5%	10.6%	9.8%
Primary Service Area 2015	25.7%	20.1%	13.1%	10.4%	9.2%	5.0%
US	17.0%	11.0%	18.2%	15.8%	15.4%	9.4%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12]
          ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Prescriptions

Among all Primary Service Area adults, 13.0% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Comparable to national findings.
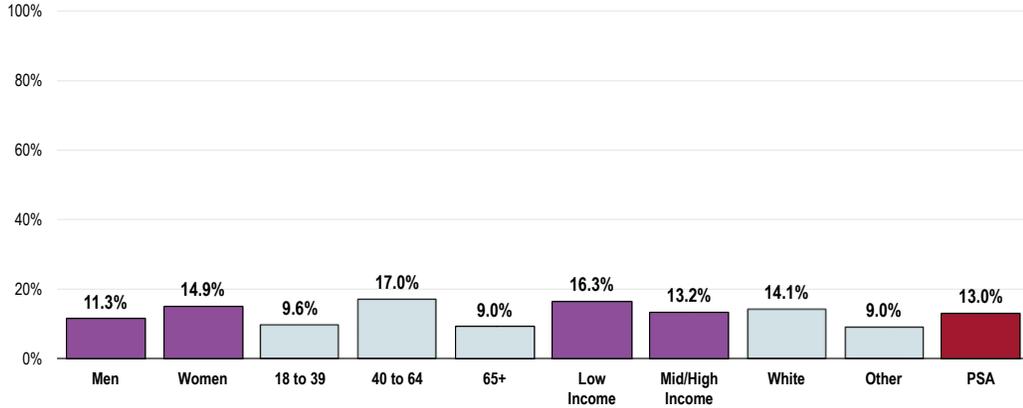- TREND: Statistically similar to 2012 findings.

Skipped or Reduced Prescription Doses in
Order to Stretch Prescriptions and Save Money

Primary Service Area	US	PSA 2012	PSA 2015
13.0%	15.3%	15.4%	13.0%
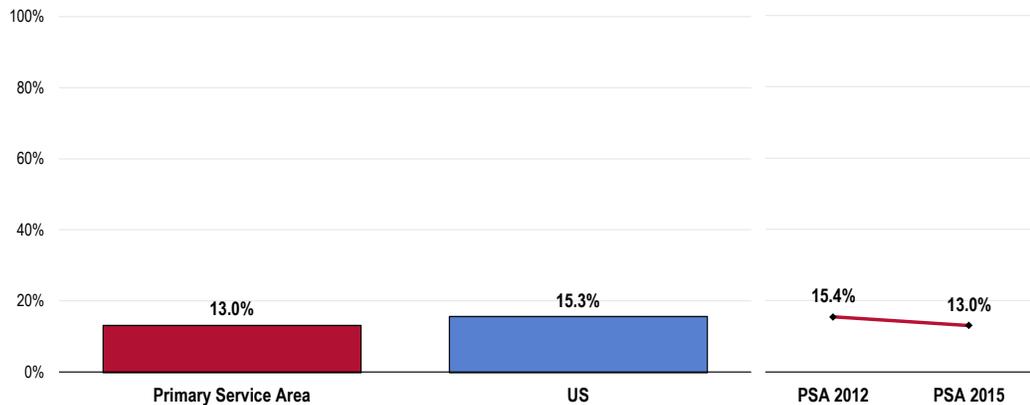
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 13]
          ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Adults age 40 to 64 are more likely to have skipped or reduced their prescription doses.

Skipped or Reduced Prescription Doses in
Order to Stretch Prescriptions and Save Money
(Primary Service Area, 2015)

	Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
%	11.3%	14.9%	9.6%	17.0%	9.0%	16.3%	13.2%	14.1%	9.0%	13.0%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.
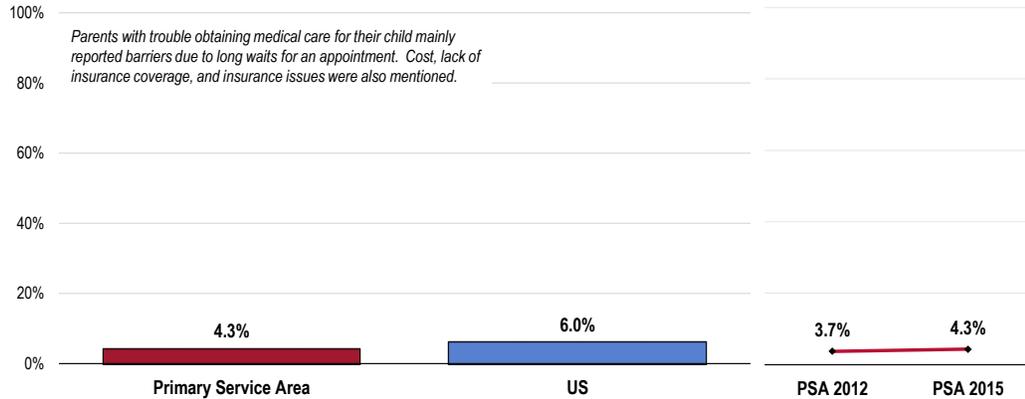
Accessing Healthcare for Children

A total of 4.3% 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.

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.

- Statistically similar to what is reported nationwide.
- TREND: Statistically unchanged since 2012.
- Among the parents experiencing difficulties, the majority cited **long waits for appointments** as the primary reason; others cited cost, lack of insurance coverage, and insurance issues.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Among Parents of Children 0-17)

Parents with trouble obtaining medical care for their child mainly reported barriers due to long waits for an appointment. Cost, lack of insurance coverage, and insurance issues were also mentioned.

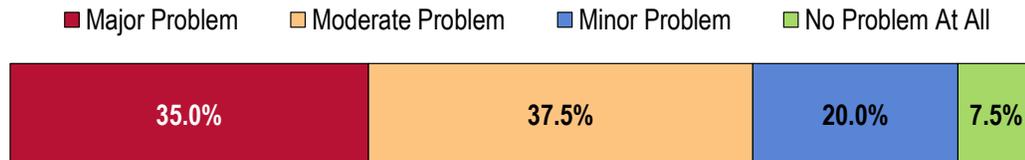|	
Primary Service Area	4.3%
US	6.0%
PSA 2012	3.7%
PSA 2015	4.3%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 111-112]
　　　　　● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Healthcare Services

The largest share of key informants taking part in an online survey characterized *Access to Healthcare Services* as a "moderate problem" in the community.

Perceptions of Access to Healthcare Services
as a Problem in the Community
(Key Informants, 2015)

■ Major Problem　■ Moderate Problem　■ Minor Problem　□ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
35.0%	37.5%	20.0%	7.5%

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

Top Concerns

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

Affordable Healthcare

> *For working families it's meeting their high deductibles so less likely to seek medical attention. For families that qualify for Medi-Cal, it's finding providers especially specialist that will accept Medical especially dental care. Having to go off the hill for specialist. Impacts work, financial hardship with gas and weather issues. Limited access to birth control/ STD treatment for teenagers – Other Health Provider*

> *Lack of affordable health care. – Public Health Expert*

> *Cost and availability. – Social Services Representative*

> *Low income families continue to not have a regular doctor, they access help through the Emergency Room at Barton. Have trouble getting into the clinic or do not take advantage of the clinic. Families do not have access for dental care, emergency or regular preventative. Older people lack transportation*

for special medical needs. Many families are not educated on the pathways available for medical care in their circumstances. – Community Leader

Access to affordable health care plans while living in a rural area are tough. Many plans do not cover doctors in Lake Tahoe. – Unknown

Affordable options when you don't have health care access. Our family has to travel out of town because we have Kaiser Healthcare. That is due to our employer being off the hill. However, if out of pocket expenses weren't so high for lab work, etc. we might opt to do more routine healthcare issues up here rather than drive to Sac. Also, our low-income population should have more options for health care as well. – Unknown

Lack of choice and affordable healthcare for those who do not qualify for Medi-Cal. The cost of health care in the Tahoe basin is higher than in other communities such as Placerville and Carson City. We have little choice in our providers and even with health insurance the fees encourage many families to only seek treatment in emergency situations. – Social Services Representative

Mental Health Services

Mental Health not able to give services needed in the community so people are not getting their needs met. They are turned away from services if it is felt the individual with mental illness is somewhat stable. Yet it is proven mental illness does not go away. But counseling, treatment, with structure helps an individual to stay stable. There are long waits to see doctors, sometimes if client is late calling in medication, they are last getting refills. The hospital needs Psychiatrists seeing clients as family physicians do not understand the types of medications that are needed and do not like prescribing some of the psychotropic medications that are required. There is no dental care in Tahoe for people who have Medi-Cal so infections are a problem. There are not enough doctors that take Medi-Cal. Social Security is down in Placerville. Transportation is a problem for medical needs for the poor. There is not a place for those going through withdrawal from drugs or alcohol to be placed for treatment in Tahoe. – Social Services Representative

Mental health, substance abuse, and access to affordable health care. – Social Services Representative

Youth

Many of our high school students become ill or have medical needs that require immediate care, often they do not have parent support or the proper medical insurance. Students need support staff or advocacy services. – Community Leader

Many of our members are on Medi-Cal via their parents but preventative medicine is always a need, plus access to family planning information and counseling against the use of tobacco and drugs. – Social Services Representative

Great difficulty in children's access to local and timely dental and psychiatric services. – Other Health Provider

Access for Medi-Cal Users

Lack of providers accepting Medi-Cal. Lack of transportation to medical services not available in the Basin. – Social Services Representative

Prompt access to primary care for Medi-Cal patients, drug abuse, mental health care, poverty and homelessness. Lack of local dental care for poorly insured and uninsured patients – Physician

Lack of providers for vision and dental needs who accept Medi-Cal. – Social Services Representative

Transportation and Limited Choices for Providers

Transportation, limited choices for providers due to geographic isolation. Barton/Blue Shield is only hospital, Kaiser not an option for city or county employees. – Community Leader

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified mental health services, dental care, and substance abuse treatment as the most difficult to access in the community.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	53.8%	16.7%	18.2%	11
Dental Care	23.1%	25.0%	18.2%	8
Substance Abuse Treatment	7.7%	33.3%	9.1%	6
Chronic Disease Care	7.7%	8.3%	0.0%	2
Urgent Care	7.7%	0.0%	9.1%	2
Prenatal Care	0.0%	8.3%	18.2%	3
Elder Care	0.0%	8.3%	0.0%	1
Pain Management	0.0%	0.0%	9.1%	1
Preventative Care	0.0%	0.0%	9.1%	1
Specialty Care	0.0%	0.0%	9.1%	1

Primary Care Services

About Primary Care

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).
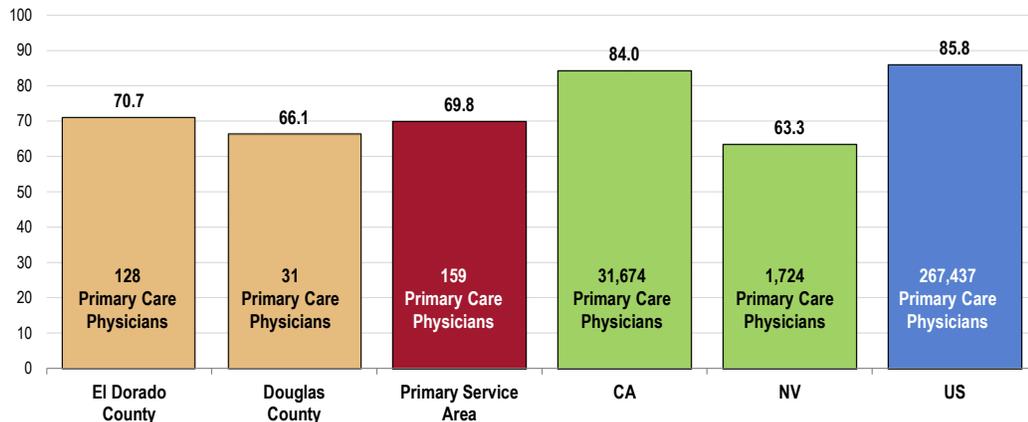
- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

In the Primary Service Area in 2011, there were 159 primary care physicians, translating to a rate of 69.8 primary care physicians per 100,000 population.

- Below the primary care physician-to-population ratio found in California but higher than the Nevada rate.
- Below the ratio found nationally.
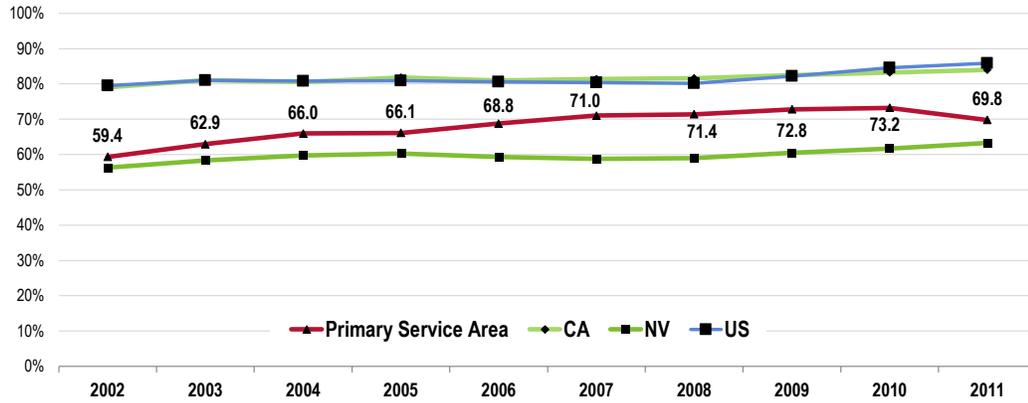- The rate is higher in El Dorado County.

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2011)

	El Dorado County	Douglas County	Primary Service Area	CA	NV	US
Rate	70.7	66.1	69.8	84.0	63.3	85.8
Physicians	128 Primary Care Physicians	31 Primary Care Physicians	159 Primary Care Physicians	31,674 Primary Care Physicians	1,724 Primary Care Physicians	267,437 Primary Care Physicians

Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2011.
- Retrieved March 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

- TREND: Access to primary care (in terms of the ratio of primary care physicians to population) has improved significantly over the past decade in the service area.

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

Legend: Primary Service Area, CA, NV, US

Data labels (Primary Service Area): 59.4, 62.9, 66.0, 66.1, 68.8, 71.0, 71.4, 72.8, 73.2, 69.8

Years: 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011

Sources:
- US Department of Labor, Bureau of Labor Statistics: 2013.
- Retrieved March 2015 from Community Commons at http://www.chna.org.

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

Specific Source of Ongoing Care

A total of 73.4% of Primary Service Area adults were determined to have a specific source of ongoing medical care.

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 objective (95% or higher).
- TREND: Statistically unchanged over time.

Have a Specific Source of Ongoing Medical Care
Healthy People 2020 Target = 95.0% or Higher [All Ages]

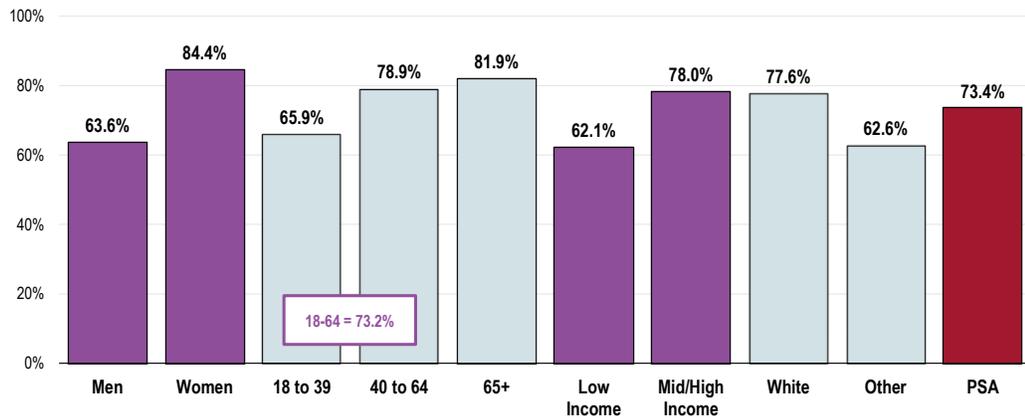| Primary Service Area	US	PSA 2012	PSA 2015
73.4%	76.3%	77.0%	73.4%
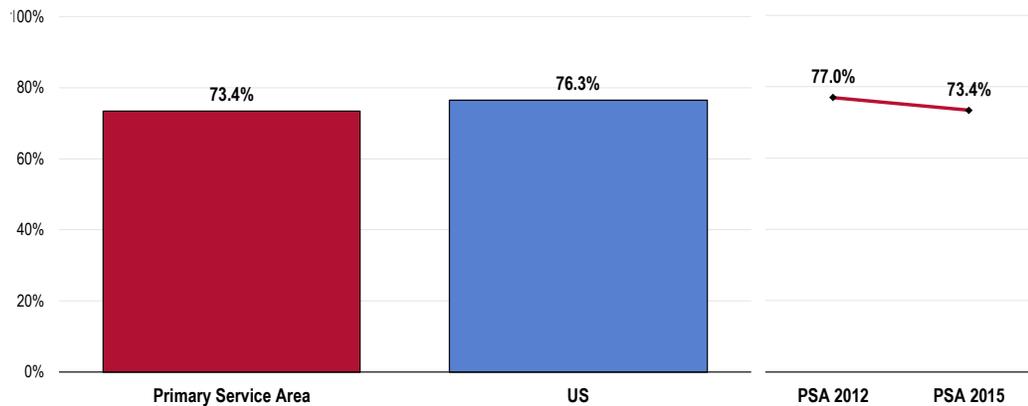
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 169]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes:
- Asked of all respondents.

When viewed by demographic characteristics, the following population segments are <u>less likely</u> to have a specific source of care:

- Men.
- Adults under age 40 (positive correlation with age).
- Lower-income adults.
- "Other" races.
- Among adults age 18-64, 73.2% have a specific source for ongoing medical care, comparable to national findings.
  - Fails to satisfy the Healthy People 2020 target for this age group (89.4% or higher).
- Among adults 65+, 81.9% 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, 2015)
Healthy People 2020 Target = 95.0% or Higher [All Ages]; ≥89.4% [18-64]; 100% [65+]

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
63.6%	84.4%	65.9%	78.9%	81.9%	62.1%	78.0%	77.6%	62.6%	73.4%

18-64 = 73.2%

Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 169-171]
- 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. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

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 (39.9%) identified a particular doctor's office, followed by an urgent-care center (mentioned by 20.9%) and a public health or community center (10.8%).

A total of 3.5% rely on a hospital emergency room, and 1.5% referenced a military or VA facility.

Particular Place Utilized for Medical Care
(Primary Service Area, 2015)
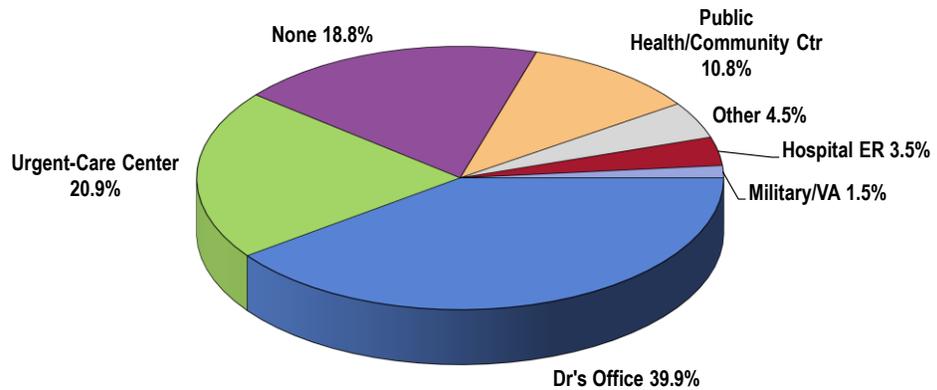
None 18.8%

Public
Health/Community Ctr
10.8%

Other 4.5%

Hospital ER 3.5%

Military/VA 1.5%

Urgent-Care Center
20.9%

Dr's Office 39.9%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]
Notes: ● Asked of all respondents.

Utilization of Primary Care Services

Adults

Nearly two-thirds of adults (64.7%) visited a physician for a routine checkup in the past year.

- Comparable to both state figures.
- Comparable to national findings.
- TREND: Denotes a statistically significant underline increase over time.

Have Visited a Physician for a Checkup in the Past Year

64.7%	62.7%	65.7%	65.0%	54.3%	64.7%
Primary Service Area	CA	NV	US	PSA 2012	PSA 2015
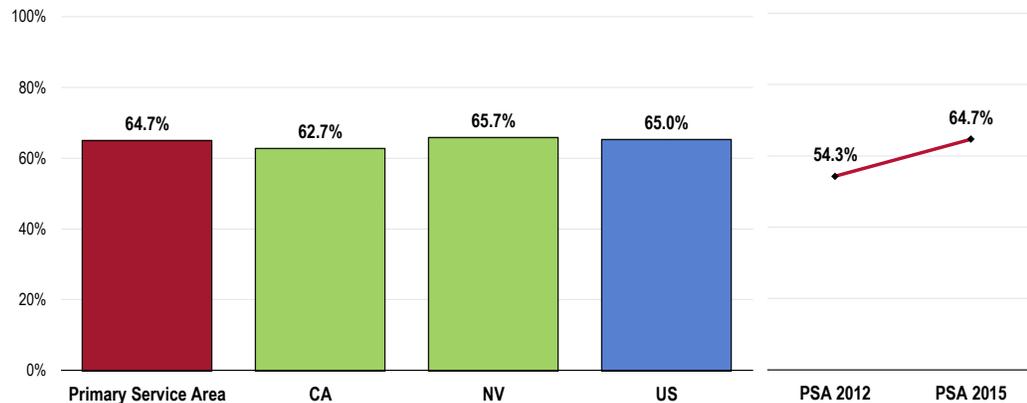
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 17]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 California and Nevada data.
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

● Men and adults under age 40 are <u>less likely</u> to have received routine care in the past year (positive correlation with age), as are lower-income residents and "Other" races.

Have Visited a Physician for a Checkup in the Past Year
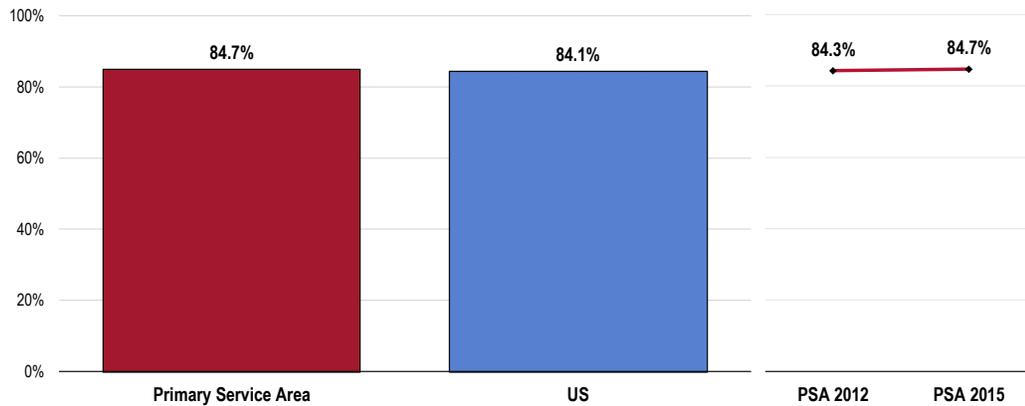### (Primary Service Area, 2015)
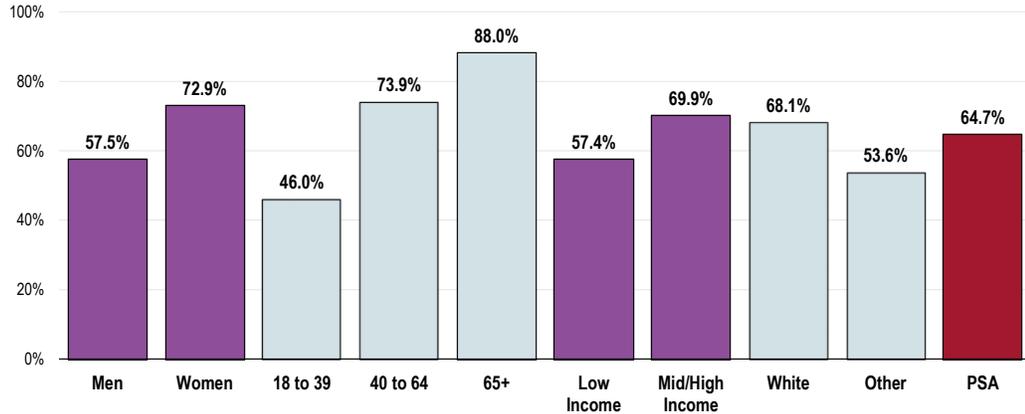
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

84.7% of area parents report that their child had a routine checkup in the past year.

● Similar to national findings.
● TREND: Statistically similar to 2012 findings.

Child Has Visited a Physician
for a Routine Checkup in the Past Year
(Among Parents of Children 0-17)

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 113]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
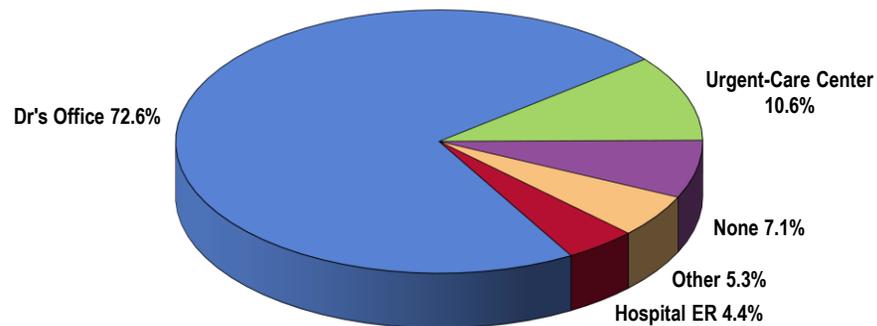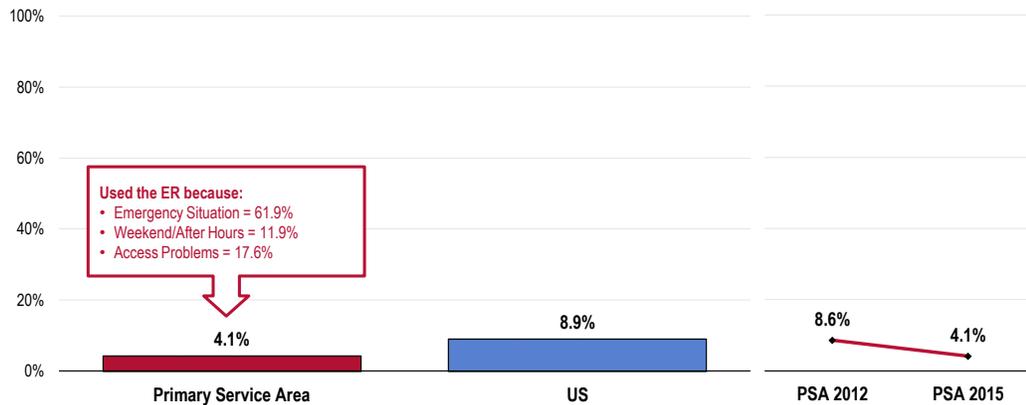Notes: ● Asked of all respondents with children 0 to 17 in the household.

Type of Place Used for Child's Medical Care

When asked where they usually go for their child's healthcare, the greatest share of parents (72.6%) identified a particular doctor's office. A total of 10.6% say they usually go to some type of urgent-care clinic, while 4.4% rely on a hospital emergency room.

- Note that 7.1% of parents do <u>not</u> have a particular place for their child's medical care.

Particular Place Utilized for Child's Medical Care
(Parents of Children <18; Primary Service Area, 2015)

Dr's Office 72.6%

Urgent-Care Center 10.6%

None 7.1%

Other 5.3%

Hospital ER 4.4%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 321-322]
Notes: ● Asked of all respondents with children under 18 at home.

Emergency Room Utilization

A total of 4.1% of Primary Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Much lower than national findings.
- TREND: Denotes a statistically significant <u>decrease</u> over time.

Have Used a Hospital
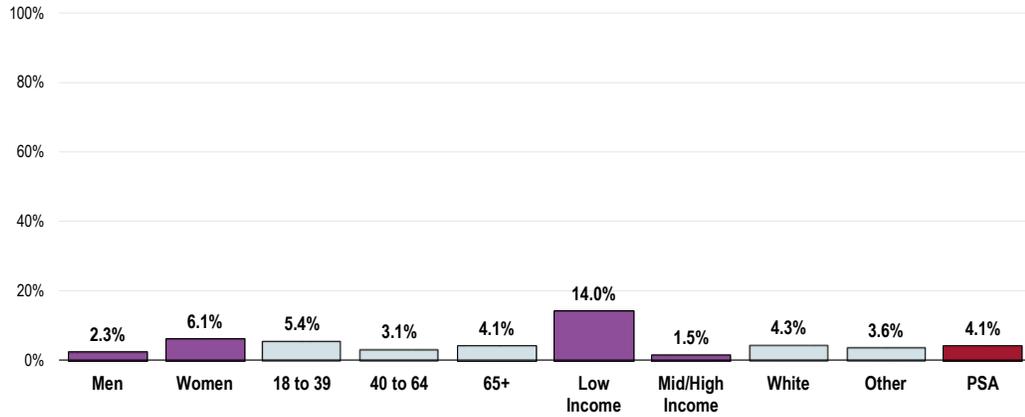### Emergency Room More Than Once in the Past Year

Used the ER because:
- Emergency Situation = 61.9%
- Weekend/After Hours = 11.9%
- Access Problems = 17.6%

Primary Service Area: 4.1%
US: 8.9%
PSA 2012: 8.6%
PSA 2015: 4.1%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 23-24]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Of those using a hospital ER, 61.9% say this was due to an **emergency or life-threatening situation**, while 11.9% indicated that the visit was during **after-hours or on the weekend**. A total of 17.6% cited **difficulties accessing primary care** for various reasons.

- ER use is statistically higher in the low-income population.

Have Used a Hospital Emergency Room
More Than Once in the Past Year
(Primary Service Area, 2015)

Bar chart values:
- Men: 2.3%
- Women: 6.1%
- 18 to 39: 5.4%
- 40 to 64: 3.1%
- 65+: 4.1%
- Low Income: 14.0%
- Mid/High Income: 1.5%
- White: 4.3%
- Other: 3.6%
- PSA: 4.1%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
Notes: ● Asked of all respondents.
           ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
           ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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

About Oral Health

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;** and **poor dietary choices**.

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.

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; and 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.

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)
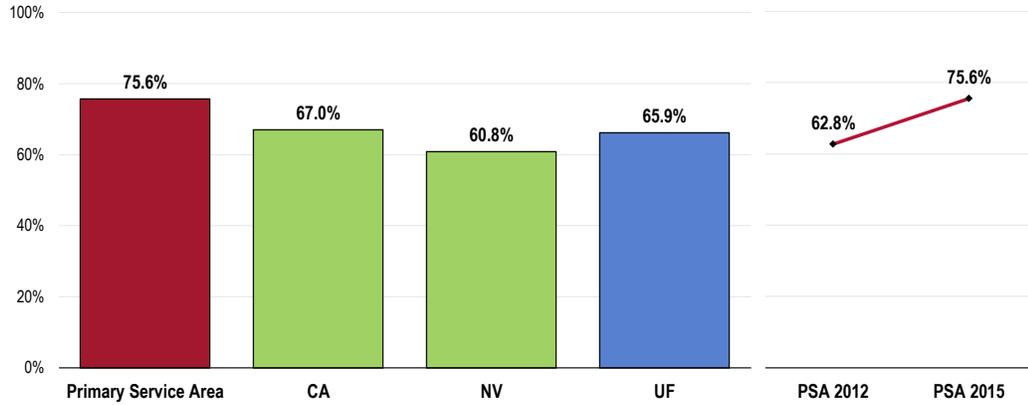
Dental Care

Adults

A total of 75.6% of Primary Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- More favorable than statewide findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- TREND: Marks a statistically significant increase since 2012.

Have Visited a Dentist or
Dental Clinic Within the Past Year
Healthy People 2020 Target = 49.0% or Higher

Chart showing "Have Visited a Dentist or Dental Clinic Within the Past Year":
- Primary Service Area: 75.6%
- CA: 67.0%
- NV: 60.8%
- UF: 65.9%
- PSA 2012: 62.8%
- PSA 2015: 75.6%

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 21]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective 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): 2013 California and Nevada data.
Notes: ● Asked of all respondents.

These population segments are less likely to report recent dental visits:

- Young adults.
- Low-income residents.
- Those without dental coverage.

Have Visited a Dentist or
Dental Clinic Within the Past Year
(Primary Service Area, 2015)
Healthy People 2020 Target = 49.0% or Higher

Chart showing "Have Visited a Dentist or Dental Clinic Within the Past Year (Primary Service Area, 2015)":
- Men: 72.6%
- Women: 79.1%
- 18 to 39: 69.8%
- 40 to 64: 81.3%
- 65+: 72.6%
- Low Income: 56.0%
- Mid/High Income: 82.4%
- White: 77.3%
- Other: 72.6%
- Dental Insurance: 83.2%
- No Dental Insurance: 60.6%
- PSA: 75.6%
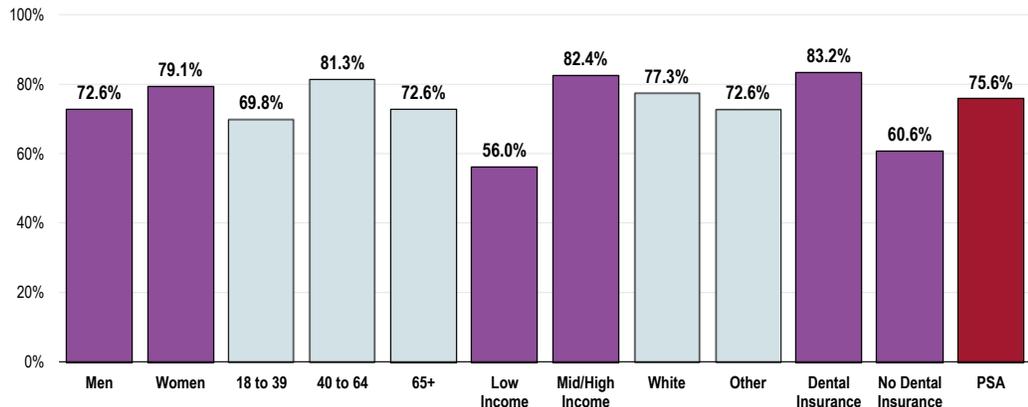
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.
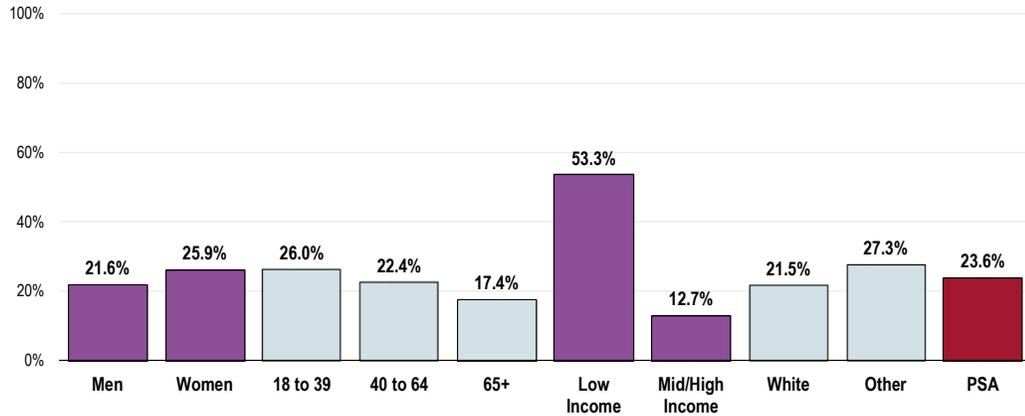
Untreated Dental Needs

Note that 23.6% of survey respondents had a dental need that went untreated over the past year because of lack of coverage or being under-insured.

- Note the 53.3% percentage among adults in low-income households.

Have Dental Needs That Went Untreated in the Past Year Due to Lack of Coverage or Being Underinsured
(Primary Service Area, 2015)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Other	PSA
21.6%	25.9%	26.0%	22.4%	17.4%	53.3%	12.7%	21.5%	27.3%	23.6%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 302]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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 90.5% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Less favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- TREND: Statistically unchanged over time.

Child Has Visited a Dentist or
Dental Clinic Within the Past Year
(Among Parents of Children Age 2-17)
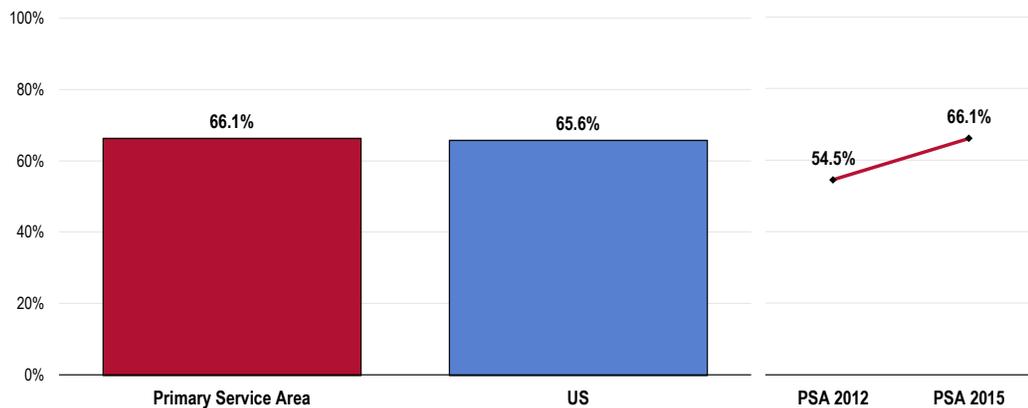**Healthy People 2020 Target = 49.0% or Higher**
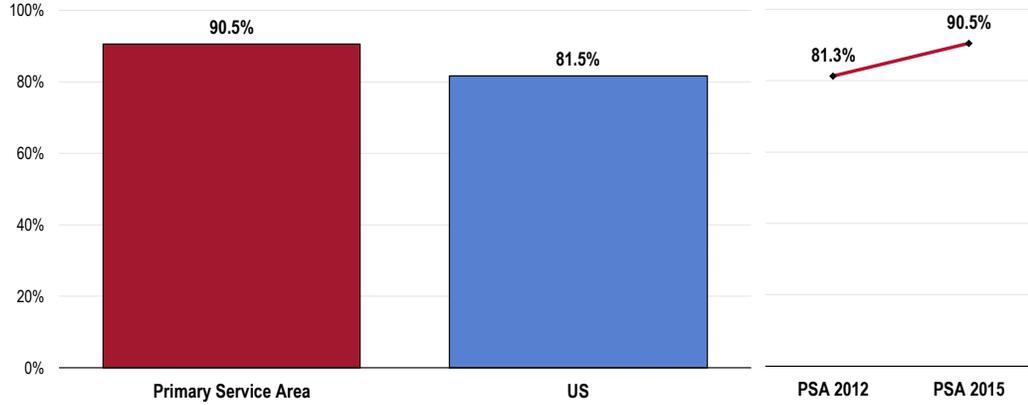
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 116]
       ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
       ● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
Notes: ● Asked of all respondents with children age 2 through 17.

Dental Insurance

Nearly 2 in 3 Primary Service Area adults (66.1%) have dental insurance that covers all or part of their dental care costs.

- Similar to the national prevalence.
- TREND: Marks a statistically significant <u>increase</u> since 2012.

Have Insurance Coverage That Pays
All or Part of Dental Care Costs

Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 22]
       ● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Oral Health

More than half of key informants taking part in an online survey characterized *Oral Health* as a "major problem" in the community.

Perceptions of Oral Health
as a Problem in the Community
(Key Informants, 2015)

■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

| 52.6% | 39.5% | 5.3% | 2.6% |

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

Top Concerns

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

Medi-Cal Users

> *No local provider for Medi-Cal patients. Closest providers are Placerville or Truckee. For low income families it's a hardship for transportation and having to miss a day of work. For families with no insurance, dental is often not a priority in budgets. Missed work for parents and employees. – Other Health Provider*

> *We have no dentists in our area that accepts Medi-Cal. There is a Dental van but it is very sporadic with it's visits to the area. Also children who need anesthesia for severe dental work have to go out of our area to receive these services. Many of these families do not have transportation. We need these services in our community. I know there is at least one dentist who is willing to do this work at Barton Health but Barton has refused. – Community Leader*

> *No local provider for Medi-Cal patients. – Other Health Provider*

> *Currently there are no dentists who accept Medi-Cal/DentiCal in South Lake Tahoe. Patients must travel to Kings Beach or Placerville to see a participating dentist and there are no public transportation services to these locations. – Community Leader*

> *There is no access to dental care for Medi-Cal patients. These folks have to drive great distances for care and many cannot make the trip. This is especially true for children. – Other Health Provider*

> *There are very few dentist that accept Medi-Cal insurance. – Community Leader*

> *There are currently no Denti-Cal providers for minors in the South Lake Tahoe area. The Dental Van has been suspended. – Social Services Representative*

Availability of Dentists

> *Not enough access to proper dental care facilities. Expensive for many locals especially those who rely on seasonal or vocational jobs. – Social Services Representative*

> *Many families have to travel to Placerville to obtain dental services. Many do not have transportation and weather can be a big obstacle. It can take months to be seen. – Community Leader*

> *People are having to travel to another town to get help and sometimes they are taken advantage of. Appointments are too far apart. Some clients waiting to long for infections that are happening. Dentists in Tahoe Charge too much to even pull a tooth. – Social Services Representative*

> *It is hard for medical families to find a dentist in our region that accept Medi-Cal. The dental van is temporary. – Social Services Representative*

No enough affordable dental centers. – Public Health Expert

Cost

Lack of finances to provide care. No provider at the community clinic. – Physician

Many of the students have major dental needs and have never been to the dentist due to cost. – Community Leader

Affordability. – Community Leader

No enough affordable dental centers. – Public Health Expert

Low income families without dental insurance. Very few have insurance, even less have dental insurance. Our dentists do not take patients with DentaCal as the reimbursements are low and or onerous. No access to dental care for these families. Lack of education, knowledge of early preventative dental care. – Community Leader

Low income, medical and access to oral care. – Public Health Expert

Lack of Providers

Lack of dentists and specialist that will accept payments or medical payments. – Social Services Representative

Vision Care

A total of 55.5% of residents had an eye exam in the past two years during which their pupils were dilated.

- Statistically comparable to national findings.
- TREND: Comparable to the 2012 survey findings.

## Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated
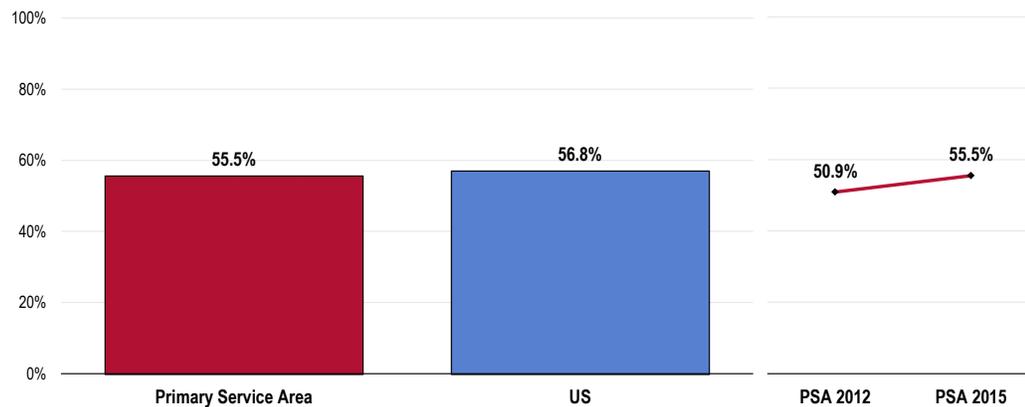
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Recent vision care in the Primary Service Area is <u>less</u> often reported among:

- Men.
- Younger adults (positive correlation with age).
- Low-income adults.

Had an Eye Exam in the Past Two
Years During Which the Pupils Were Dilated
(Primary Service Area, 2015)
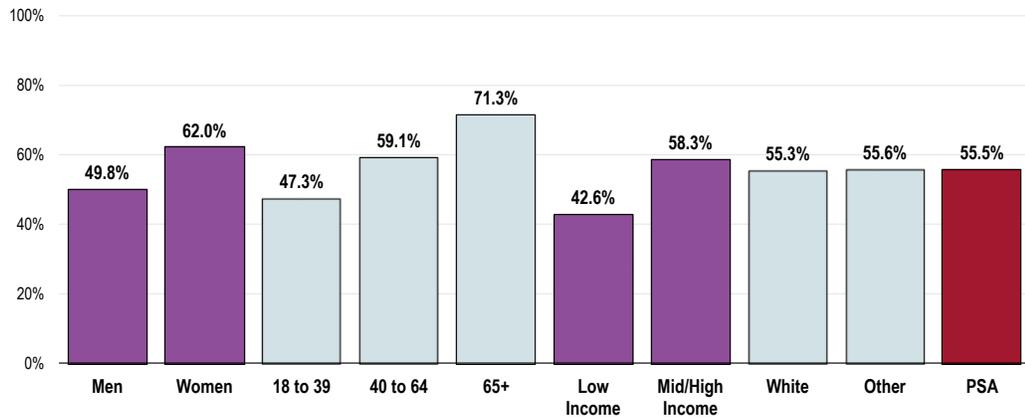
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

- 37.6% of Primary Service Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 30.3%.

Other sources mentioned include hospital publications (6.0%), friends and relatives (4.8%), work (4.3%), and books and magazines (3.7%).

- Just 1.4% of survey respondents say that they do not receive any healthcare information.

Primary Source of Healthcare Information
(Primary Service Area, 2015)

Internet 30.3%
Other 11.9%
Hospital Publications 6.0%
Friends/Relatives 4.8%
Work 4.3%
Books/Magazines 3.7%
Don't Receive Any 1.4%
Family Doctor 37.6%
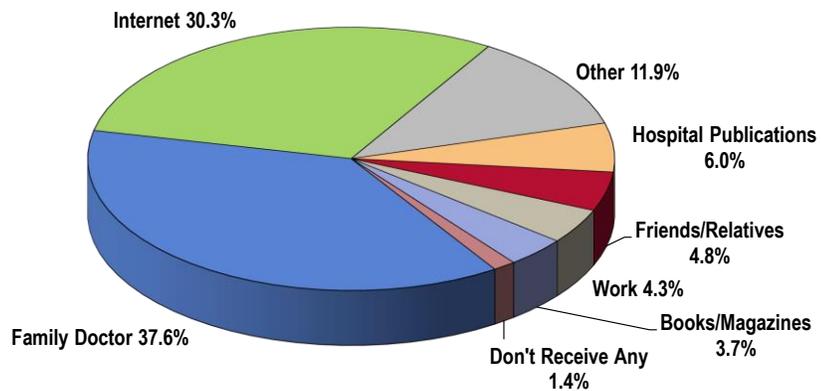
Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: ● Asked of all respondents.

Participation in Health Promotion Events

About Educational & Community-Based Programs

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 25.2% 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.
- TREND: Statistically unchanged since the 2012 survey was conducted.

Participated in a Health
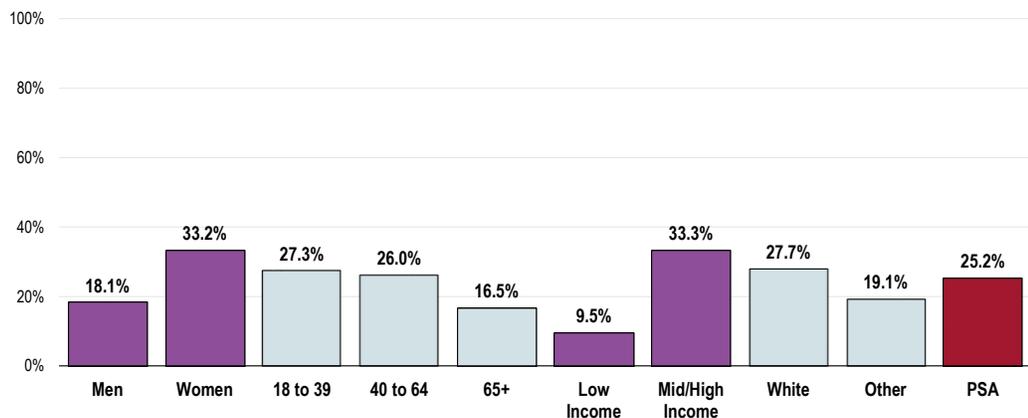## Promotion Activity in the Past Year
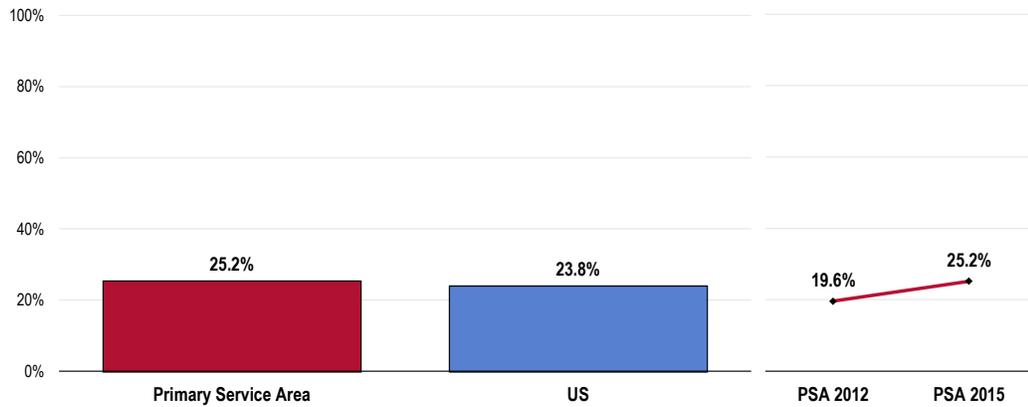
Sources: ● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 314]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

The following chart outlines participation by various demographic characteristics.

● Note that women, adults under 65, and residents with higher incomes more often report participation in health promotion activities.

Participated in a Health
Promotion Activity in the Past Year
(Primary Service Area, 2015)

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 314]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.
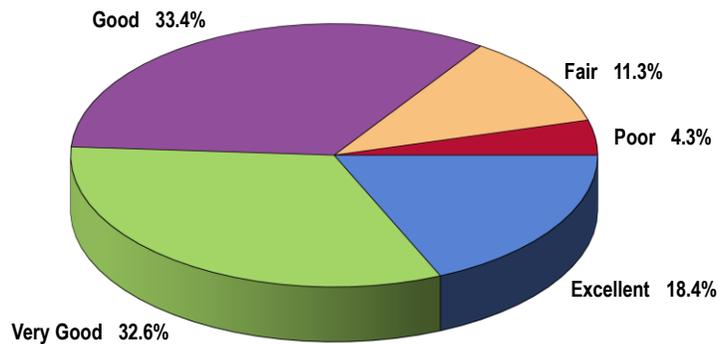
Local Resources

Perceptions of Local Healthcare Services

Just over one-half of Primary Service Area adults (51.0%) rates the overall healthcare services available in their community as "excellent" or "very good."

- Another 33.4% gave "good" ratings.

Rating of Overall Healthcare
### Services Available in the Community
(Primary Service Area, 2015)

Good 33.4%

Fair 11.3%

Poor 4.3%

Excellent 18.4%

Very Good 32.6%

Sources: ● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: ● Asked of all respondents.

However, 15.6% of residents characterize local healthcare services as "fair" or "poor."

- Similar to that reported nationally.
- TREND: Marks a statistically significant <u>improvement</u> in ratings.

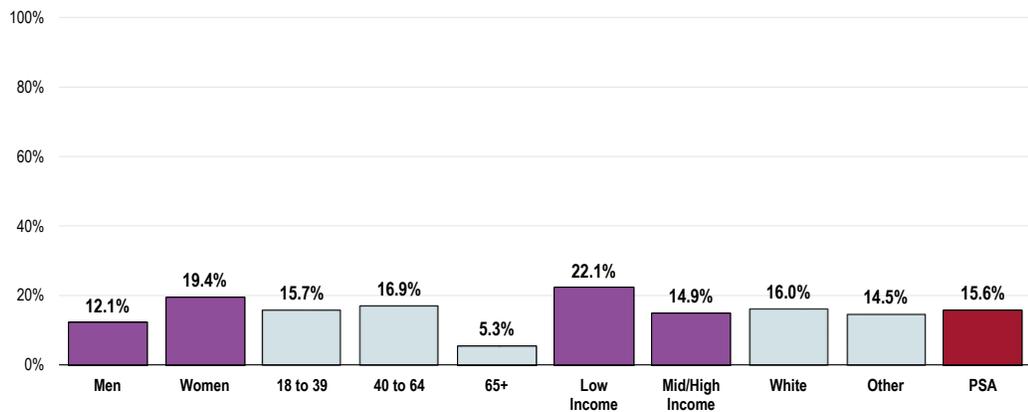## Perceive Local Healthcare Services as "Fair/Poor"
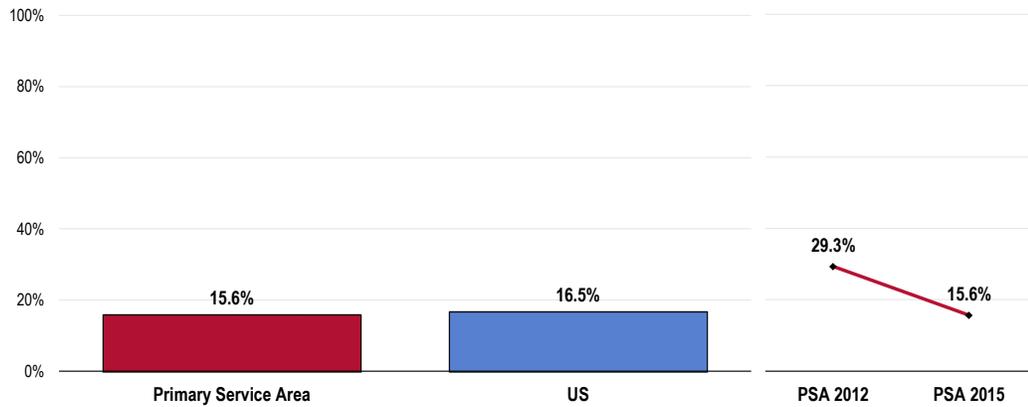
Sources:
● PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]
● 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes:
● Asked of all respondents.

The following residents are more critical of local healthcare services:

● Women.
● Adults under age 65.

Perceive Local Healthcare Services as "Fair/Poor"
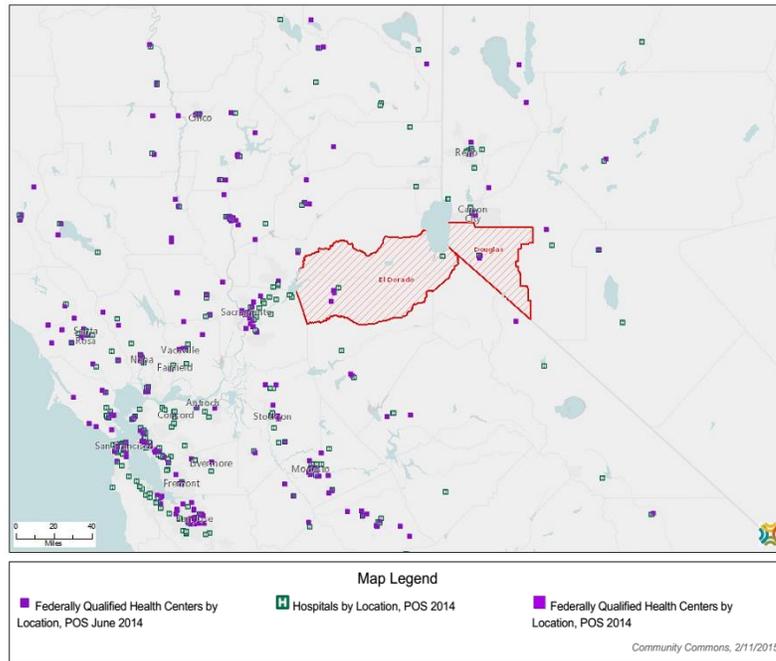### (Primary Service Area, 2015)

Sources:
● 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes:
● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "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.

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map provides an illustration of the hospitals and Federally Qualified Health Centers (FQHCs) available within the Primary Service Area.

Hospitals & Federally Qualified Health Centers, POS 2012-Q4

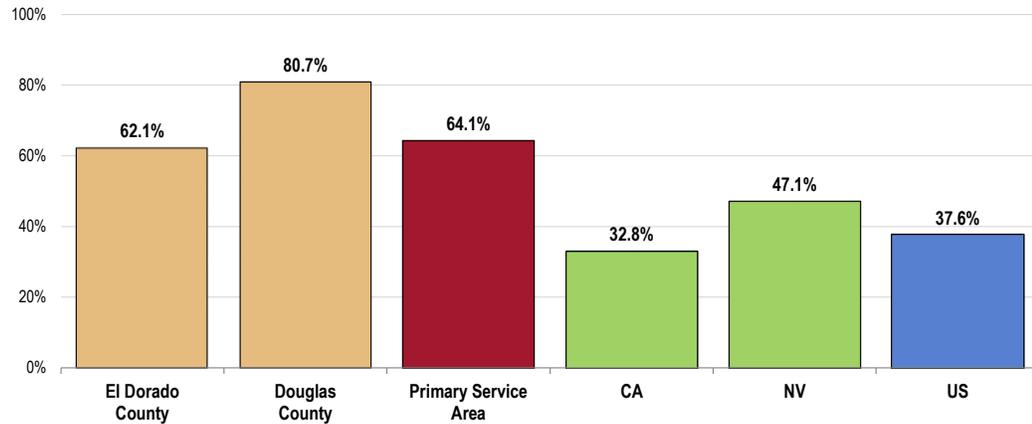## Health Professional Shortage Areas (HPSAs)

A total of 64.1% of the Primary Service Area population lives in an area designated by the US Department of Health and Human Services as a health professional shortage area (HPSA).

A "health professional shortage area" (HPSA) is defined as having a shortage of primary medical care, dental or mental health professionals.

- Much higher than the state percentages.
- Much higher than the US percentage.
- Higher in Douglas County.

## Population Living in a Health Professional Shortage Area (HPSA)
(Percent of Total Population Living in a Geographic Area Designated as Having a Shortage of Primary Medical Care, Dental or Mental Health Professionals, 2015)

	El Dorado County	Douglas County	Primary Service Area	CA	NV	US
	62.1%	80.7%	64.1%	32.8%	47.1%	37.6%

Sources:
● US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas: Oct. 2013.
● Retrieved March 2015 from Community Commons at http://www.chna.org.

Notes:
● This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

The following map provides a visual illustration of the service area population living in a health professional shortage area.

Population Living in a HPSA, Percent, HRSA HPSA Database March 2015
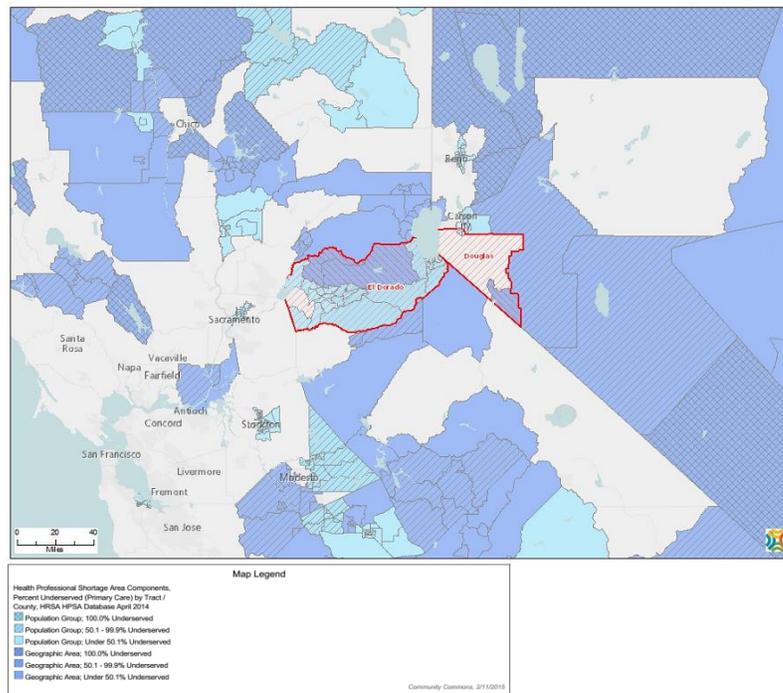
Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- *AA/NA Groups*
- *Barton Clinic*
- *Barton Hospital*
- *Barton Infusion Center*
- *Cancer League*
- *County Mental Health*
- *Covered California*
- *Dental Van*
- *Department of Social Services*
- *Doctor's Office*
- *El Dorado County Health Department*
- *El Dorado County Mental Health Department*
- *Emergency Department*
- *First Five*
- *Lake Tahoe Collaborative*
- *Local Dentists*
- *Medi-Cal*
- *NAMI*
- *Nonprofit Organizations*
- *OPEN*
- *Planned Parenthood*
- *Private Insurance Brokers*
- *Public Health Department*
- *Say No to Drugs*
- *Schools*
- *Sierra Health and Family*
- *South Lake Tahoe Cancer League*
- *Tahoe Magic*
- *Tahoe Transportation District Mobility Manager*
- *Urgent Care*

Arthritis, Osteoporosis & Chronic Back Conditions

- *Acupuncturist*
- *Barton Clinic*
- *Barton Orthopedic Center*

Cancer

- *Barton Home Health and Hospice*
- *Barton Hospital*
- *Barton Infusion Center*
- *Carson Tahoe Cancer Center*
- *Dr. Heifetz*
- *Dr. Perez*
- *Part-time Oncologist*
- *South Lake Tahoe Cancer League*
- *Tahoe Forest Hospital*
- *Tele-Medicine Conference with Barton Healthcare*
- *The Cancer League*

Chronic Kidney Disease

- *Lack of Services Locally*

Dementias, Including Alzheimer's Disease

- *Barton Skilled Nursing*
- *Dr. Sullivan*
- *Support Groups at the Senior Center*

Diabetes

- *Barton Clinic*
- *Barton Diabetes Program*
- *Barton Health*
- *Barton Hospital*
- *Barton Hospital and Clinic*
- *Bike the West Tour de Tahoe*
- *Doctors*
- *Health Department*
- *Urgent Care*
- *Weight Watchers*

Family Planning

- *Barton Clinic*
- *Barton Community Health Center*
- *Barton Health*
- *Barton Women's Health*
- *Doctors*

El Dorado County Health Department
Emerald Bay Center for Women's Health
Emerald Bay Health Center
Insurance Plan
Mount Tallace School
Patty Murphy from the Health Department
Public Health
School Nurse
Tahoe Women's Care
Tahoe Youth and Family Services
Women's Health Center

Hearing & Vision

Barton ENT
CCS Referral for Hearing Evaluation
Health Department
Lake Tahoe Eye Care
School Nurse
Sight for Students Program

Heart Disease & Stroke

Acupuncture
Barton Health Seminars
Doctors
Dr. Young

Immunization & Infectious Diseases

Barton Pediatrics

Infant & Child Health

Barton Clinic
Barton Health
County Health Department
Doctors
El Dorado County Health Department
Family Resource Center
First Five
Midwives
Mobile Dental
School Nurse

Injury & Violence

Barton Clinic
Barton Hospital
Doctors
El Dorado County Mental Health
El Dorado County Sheriff's Office
Family Resource Center
Live Violence Free

Police Department
School Nurse
South Lake Tahoe Police Department
Tahoe Turning Point
Tahoe Youth and Family Services

Mental Health

A Balanced Life
Alcoholics Anonymous
Barton Clinic
Barton Community Health Center
Barton Health
City of South Lake Tahoe Police Crisis Team
Community Health Clinic
County Health Department
County Mental Health Department
County Services
Department of Rehabilitation
Dr. Protell and Dr. Rupp
El Dorado County Human Services
El Dorado County Mental Health
El Dorado County Services
El Dorado County Sheriff
Emergency Room
Family Resource Center
HHSA
Justice System
Live Violence Free
Mental Health
NAMI
National Alliance on Mental Illness
Private Counselors
Private Therapists
Tahoe Magic, Salvation Army, Section 8
Tahoe Turning Point
Tahoe Youth and Family Services
Telehealth Access
The Puff

Nutrition, Physical Activity & Weight

Boys and Girls Club
Christmas Cheer
Family Resource Center
Family Service Center
First 5
Food Bank
Health Clubs
Lake Tahoe Bicycle Coalition

Lake Tahoe Community College
LTUSD
PAL
Private Gyms
Private Yoga Studios
Rec Center
Schools
UC Davis Nutrition Classes

Oral Health

Barton Community Health Clinic
Community-Minded Dentists
Dental Offices
Dental Van
Dr. Mireya Ortega
First 5 Dental Van
Nothing
OPEN
School Nurse
School Programs for Dental Health
Tahoe Magic
Tooth Travelers
Young Tahoe Smiles

Respiratory Diseases

Barton Healthcare
Radon Testing and Mitigation Services
Tahoe Urgent Care

Sexually Transmitted Diseases

Barton Community Health Center
High Schools
School Nurse

Substance Abuse

Alcoholics Anonymous
Barton Community Advisory Committee
Barton Community Clinic
Barton Health
County Alcohol and Drug Division

County Mental Health, Public Health
County Services
Court Mandated Treatment
Drug Free Coalition
El Dorado County
El Dorado County Alcohol and Drug Program
El Dorado County Drug Court Program
El Dorado County Health and Human Services
El Dorado County Mental Health
Emergency Room
Family Resource Center
Government Agencies
Jail
Lake Tahoe Unified School District
Live Violence Free
Narcotics Anonymous
Sierra Recovery Center
SLEDNET
SOS Outreach
South Lake Tahoe Drug Free Coalition
South Lake Tahoe Police Department
Tahoe Turning Point
Tahoe Youth and Family Services
Vitality

Tobacco Use

Anti-Smoking Laws for Indoor Smoking
Barton Health Cessation Program
Barton University
Drug Rehab Center
EDC Health Department
Keep Tahoe Blue
NA/AA
Nothing
Red Ribbon Week
South Tahoe Drug Free Coalition
Tahoe Turning Point
Youth Advisory Council in Schools