2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Primary Service Area Findings

Sponsored by

Barton Health

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the 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 that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Barton Health by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

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

PRC Community Health Survey

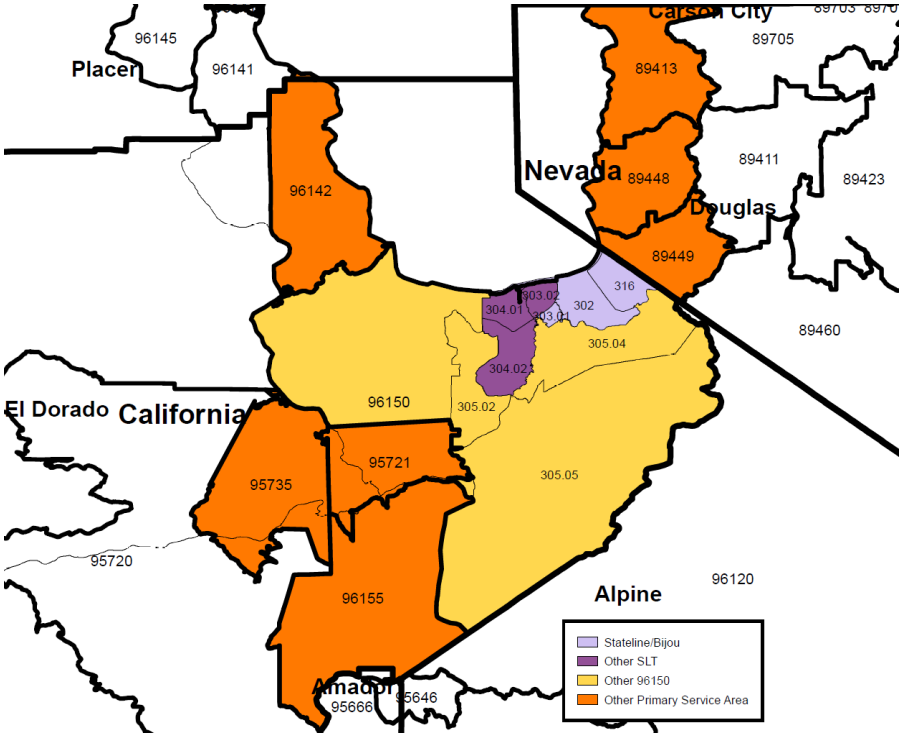
Survey Instrument

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

Community Defined for This Assessment

The study area for the survey effort is defined as each of the residential ZIP Codes comprising the Primary Service Area (PSA) of Barton Health, including 96150, 95735, 96142, 96155, 89413, 89448, 89449, 96151, and 96158. This community definition, determined based on the ZIP Codes of residence of recent patients of Barton Health, is illustrated in the following map.

In reporting, results are further segmented to census tracts associated with the Stateline/Bijou area of South Lake Tahoe, Other South Lake Tahoe ("Other SLT"), Other 96150 ZIP Code ("Other 96150"), and Other Primary Service Area ("Other PSA").

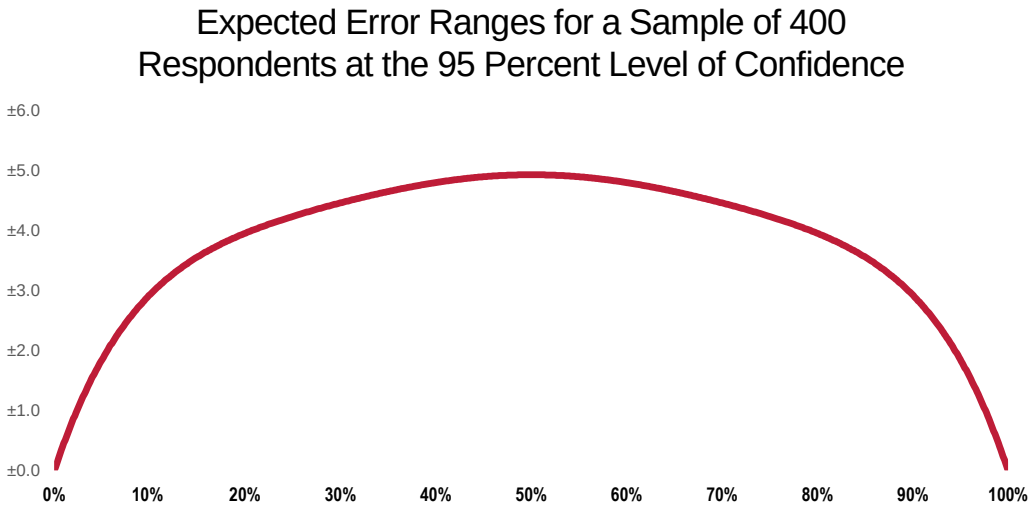


Sample Approach & Design

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

The sample design used for this effort consisted of a stratified random sample of 400 individuals age 18 and older in the Primary Service Area, separated into four sub-communities of interest to Barton Health (including 122 in Stateline/Bijou, 117 in Other SLT, 84 in Other 96150, and 77 in Other PSA). 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 PRC.

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



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

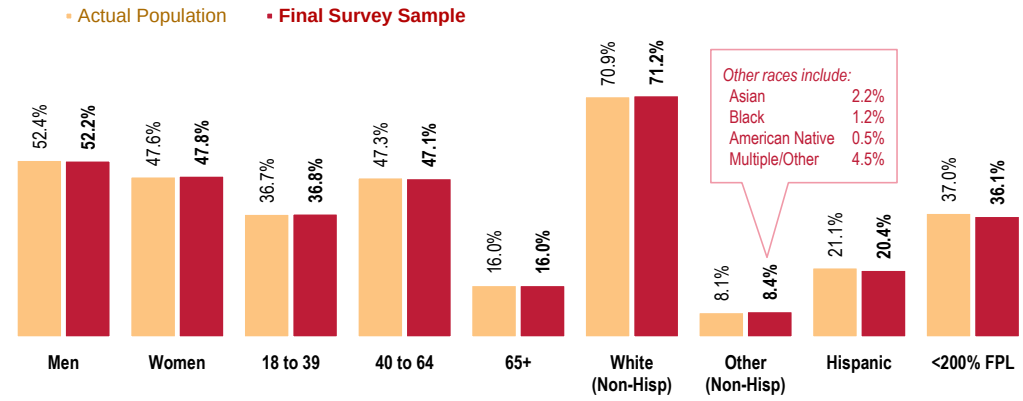
Examples:
- If 10% of the sample of 400 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% (10% ± 2.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that 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. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses 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 health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(Primary Service Area, 2021)



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2021 PRC Community Health Survey, PRC, Inc.

Notes:
- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

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.

INCOME & RACE/ETHNICITY

INCOME ► 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 2020 guidelines place the poverty threshold for a family of four at $26,200 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 (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In this report, "White" reflects non-Hispanic White respondents; "Communities of Color" includes Hispanics and non-White race groups.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by 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, 69 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	14
Public Health Representatives	1
Other Health Providers	10
Social Services Providers	16
Other Community Leaders	28

Final participation included representatives of the organizations outlined below.

- A Balanced Life
- ADVANCE Education
- Alpine Family Practice
- Barton Foundation
- Barton Health
- Boys & Girls Club
- Bread & Broth
- CalFresh
- Catalyst Community
- City of South Lake Tahoe
- City of South Lake Tahoe PD
- EDCOE–Lake Tahoe Unified School District
- El Dorado Community Foundation
- El Dorado County
- El Dorado County Board of Supervisors
- Family Resource Center
- First Five Community Hubs
- Lake Tahoe Coalition for the Homeless
- Lake Tahoe Unified School District
- Live Violence Free
- Mountain High Recovery Center
- Mount Tallac
- NAMI
- PFAC–Patient Family Advisory Council
- Phoenix Food Pantry
- RJ Counseling
- Sierra Child & Family Services
- South Lake Tahoe Library
- SOS Outreach
- Tahoe Chamber
- Tahoe Prosperity Center
- Tahoe Transportation District
- Tahoe Youth & Family Services
- TASK
- Temple Bat Yam
- Zephyr Cove Elementary

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

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

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

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):

- California Department of Public Health, California Comprehensive Master Death File
- California Department of Public Health, Birth Cohort-Perinatal Outcome Files
- Center for Applied Research and Engagement Systems (CARES) , University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, 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
- 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 aggregated, county-level data for El Dorado County (California) and Douglas County (Nevada). For select birth and death indicators, data for Eastern El Dorado County (inclusive of just those ZIP Codes within the Primary Service Area) are also provided.

Benchmark Data

Trending

Similar surveys were administered in the Primary Service Area in 2012, 2015, and 2018 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 & 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 represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. 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 *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

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

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

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

Determining Significance

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

Information Gaps

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

For example, certain population groups — such as the homeless, institutionalized 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 medical conditions that are not specifically addressed.

Public Comment

Barton Health made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Barton Health had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Barton Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For non-profit hospitals, a 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 Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	35
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	176
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	15
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	16
Part V Section B Line 3h The process for consulting with persons representing the community's interests	9
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	182

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Inconvenient Office Hours – Cost of Physician Visits – Appointment Availability – Finding a Physician ▪ Routine Medical Care (Adults) ▪ Emergency Room Utilization ▪ Eye Exams ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Colorectal Cancer Screening [Age 50-75]
DIABETES	▪ Blood Sugar Testing [Non-Diabetics]
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Stroke Prevalence
INFANT HEALTH & FAMILY PLANNING	▪ Prenatal Care
INJURY & VIOLENCE	▪ Motor Vehicle Crash Deaths ▪ Intimate Partner Violence
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Suicide Deaths ▪ Receiving Treatment for Mental Health ▪ Adverse Childhood Experiences ▪ Key Informants: Mental health ranked as a top concern.

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Fruit/Vegetable Consumption ▪ Overweight & Obesity [Adults]
POTENTIALLY DISABLING CONDITIONS	▪ Activity Limitations ▪ High-Impact Chronic Pain
RESPIRATORY DISEASE	▪ Key Informants: COVID-19 ranked as a top concern.
SUBSTANCE ABUSE	▪ Cirrhosis/Liver Disease Deaths ▪ Unintentional Drug-Related Deaths ▪ Personally Impacted by Substance Abuse (Self or Other's) ▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products

Note that, for many of these indicators, issues are more pronounced in the city of South Lake Tahoe, particularly in the Bijou/Stateline neighborhoods.

Community Feedback on Prioritization of Health Needs

On May 14, 2021, Barton Health convened a group of community stakeholders (including members of the Community Health Advisory Committee [CHAC], as well as other representatives of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the online 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. Finally, participants were provided an overview of the prioritization exercise that followed.

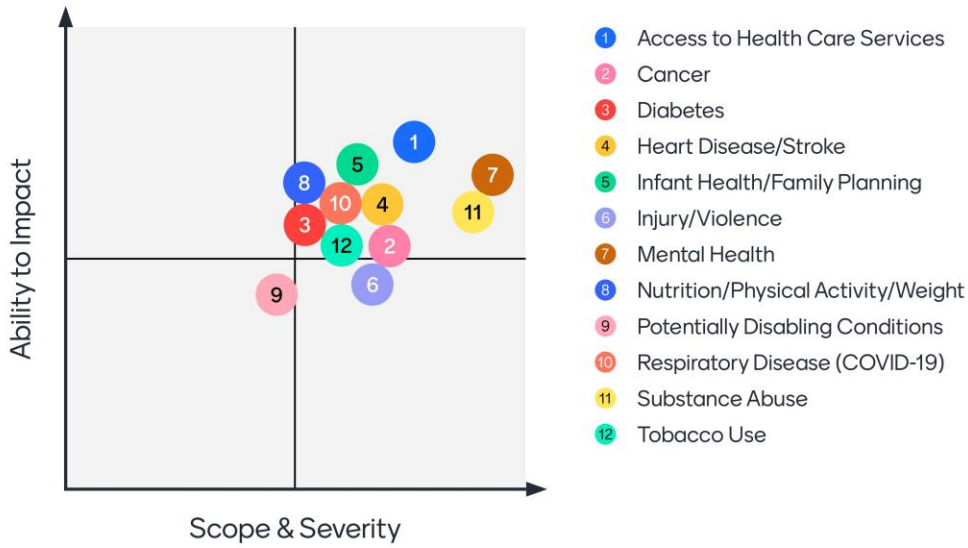
In order to assign priority to the identified health needs (i.e., Areas of Opportunity), an online voting system was used in which each participant was able to register his/her individual ratings. The participants were asked to evaluate each health issue along two criteria:

- 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 Health Care Services
4. Infant Health/Family Planning
5. Heart Disease/Stroke
6. Nutrition/Physical Activity/Weight
7. Diabetes
8. Cancer
9. Respiratory Disease (COVID-19)
10. Injury/Violence
11. Tobacco Use
12. Potentially Disabling Conditions

Plotting these overall scores in a matrix illustrates the intersection of the Scope & Severity and the Ability to Impact scores. Below, those issues placing in the upper right quadrant represent health needs rated as most severe, with the greatest ability to impact.



Hospital Implementation Strategy

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

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

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

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

The columns to the left of the Primary Service Area column provide comparisons among the four community areas (or among the two counties, as available), identifying differences for each as "better than" (🌞), "worse than" (🌺), or "similar to" (☁) the combined opposing areas.

The columns to the right of the service area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the 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.

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

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

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

SOCIAL DETERMINANTS	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)					1.5	2.3	1.7	8.3	5.8	4.4		
Population in Poverty (Percent)					8.9	9.3	9.0	14.3	13.7	14.1	8.0	
Children in Poverty (Percent)					9.5	13.3	10.2	19.5	19.1	19.5	8.0	
No High School Diploma (Age 25+, Percent)					6.9	6.3	6.8	17.1	13.7	12.3		
% Unable to Pay Cash for a $400 Emergency Expense	22.0	17.6	7.2	8.0			14.9			24.6		
% Worry/Stress Over Rent/Mortgage in Past Year	38.9	46.0	15.3	27.6			33.8			32.2		36.4
% Unhealthy/Unsafe Housing Conditions	20.8	12.6	2.6	15.7			13.6			12.2		
% Food Insecure	33.5	21.5	4.9	6.2			19.0			34.1		23.7
% 4+ Adverse Childhood Experiences (High ACEs Score)	22.0	24.7	21.4	21.2			22.4			16.3		

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

better similar worse

OVERALL HEALTH	DISPARITY AMONG SUBAREAS						PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County	PSA	vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	21.6	21.5	12.2	3.4			16.3	18.2	20.9	12.6		13.6

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

better similar worse

ACCESS TO HEALTH CARE	DISPARITY AMONG SUBAREAS						PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County	PSA	vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance							10.2	15.1	20.3	8.7	7.9	26.2
% Difficulty Accessing Health Care in Past Year (Composite)	65.5	47.6	43.4	56.7			54.0			35.0		40.1
% Cost Prevented Physician Visit in Past Year	24.7	12.9	10.9	19.0			17.3	11.9	15.1	12.9		19.3
% Cost Prevented Getting Prescription in Past Year	14.5	10.2	7.8	8.5			10.8			12.8		18.5
% Difficulty Getting Appointment in Past Year	34.4	27.5	28.8	35.5			31.5			14.5		16.4
% Inconvenient Hrs Prevented Dr Visit in Past Year	22.4	15.3	7.3	16.7			16.1			12.5		10.6
% Difficulty Finding Physician in Past Year	29.7	23.5	14.2	27.6			24.3			9.4		10.6
% Transportation Hindered Dr Visit in Past Year	8.4	0.8	1.0	3.9			3.8			8.9		9.8

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% Language/Culture Prevented Care in Past Year	3.6	2.9	2.3	0.0			2.5			2.8		2.4
% Skipped Prescription Doses to Save Costs	18.5	12.9	6.3	7.2			12.2			12.7		15.4
% Difficulty Getting Child's Health Care in Past Year							9.0			8.0		3.7
Primary Care Doctors per 100,000					81.6	58.3	76.9	79.6	57.1	76.6		
% Have a Specific Source of Ongoing Care	71.8	84.4	74.7	83.3			78.2			74.2	84.0	77.0
% Have Had Routine Checkup in Past Year	49.5	57.7	58.8	54.2			54.7	71.8	71.8	70.5		54.3
% Child Has Had Checkup in Past Year							79.1			77.4		84.3
% Used Alternative Medicine in the Past Year	32.8	36.5	35.4	48.2			37.2					40.6
% Two or More ER Visits in Past Year	21.2	15.2	10.8	8.8			15.0			10.1		8.6
% Eye Exam in Past 2 Years	38.0	35.6	40.4	52.6			40.5			61.0	61.1	50.9
% Rate Local Health Care "Fair/Poor"	31.3	27.1	14.5	9.1			22.3			8.0		29.3

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

better similar worse

CANCER	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)					127.1	132.7	128.0	134.4	150.3	149.3	122.7	149.0
Lung Cancer (Age-Adjusted Death Rate)							23.0	25.1	34.7	34.9	25.1	
Prostate Cancer (Age-Adjusted Death Rate)							19.8	19.4	19.1	18.6	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)							14.3	19.0	22.0	19.7	15.3	
Colorectal Cancer (Age-Adjusted Death Rate)							11.8	12.3	14.6	13.4	8.9	
Cancer Incidence Rate (All Sites)					436.5	396.4	427.0	404.6	397.2	448.7		
Female Breast Cancer Incidence Rate					128.7	132.7	129.6	121.5	113.5	125.9		
Prostate Cancer Incidence Rate					101.0	95.8	99.8	93.0	85.5	104.5		
Lung Cancer Incidence Rate					45.2	43.9	44.9	41.5	53.3	58.3		
Colorectal Cancer Incidence Rate					32.4	32.7	32.5	35.1	36.0	38.4		
% Cancer	6.0	12.0	6.3	7.9			8.2	10.4	10.8	10.0		

CANCER (continued)	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% [Women 50-74] Mammogram in Past 2 Years							68.1	81.1	72.3	76.1	77.1	74.7
% [Women 21-65] Cervical Cancer Screening							71.1	79.2	78.9	73.8	84.3	78.5
% [Age 50-75] Colorectal Cancer Screening	52.5	70.5	72.5	73.1			67.1	72.1	61.7	77.4	74.4	73.3

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

better similar worse

DIABETES	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)					12.2	14.0	12.5	21.8	20.2	21.5		13.9
% Diabetes/High Blood Sugar	6.8	7.4	8.6	2.3			6.5	10.1	10.9	13.8		5.3
% Borderline/Pre-Diabetes	7.5	13.4	7.3	4.2			8.6			9.7		6.5
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	43.8	37.8	35.6	37.7			39.2			43.3		47.3

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

better similar worse

HEART DISEASE & STROKE	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)					127.6	129.9	128.9	139.8	196.0	163.4	127.4	142.9
% Heart Disease (Heart Attack, Angina, Coronary Disease)	10.5	7.6	0.0	2.6			6.0	4.7	7.2	6.1		3.6
Stroke (Age-Adjusted Death Rate)					26.9	37.9	29.4	37.3	36.8	37.2	33.4	26.7
% Stroke	11.1	3.1	0.0	5.8			5.5	2.6	3.4	4.3		1.1
% Told Have High Blood Pressure	39.9	25.6	23.9	29.2			30.4			36.9	27.7	30.2
% Told Have High Cholesterol	29.8	25.3	24.3	30.5			27.5			32.7		30.6
% 1+ Cardiovascular Risk Factor	86.6	64.0	79.1	55.5			72.8			84.6		77.6

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

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent)					21.7		21.7	18.1	7.1	17.3		
Low Birthweight Births (Percent)					6.3	8.4	6.7	6.8	8.2	8.2		6.8
Infant Death Rate					2.3	6.8	3.0	4.0	5.8	5.6	5.0	2.8
Births to Adolescents Age 15 to 19 (Rate per 1,000)					10.1	14.5	10.9	19.5	26.6	22.7	31.4	

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

better similar worse

INJURY & VIOLENCE	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)					44.9	39.3	43.8	34.2	46.8	48.9	43.2	42.9
Motor Vehicle Crashes (Age-Adjusted Death Rate)					14.9		13.9	9.7	10.3	11.3	10.1	
[65+] Falls (Age-Adjusted Death Rate)					52.6		52.2	40.6	67.4	65.1	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)					9.2	17.9	11.0	7.5	16.6	11.9	10.7	

INJURY & VIOLENCE (continued)	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Homicide (Age-Adjusted Death Rate)							3.7	4.8	6.9	6.1	5.5	
Violent Crime Rate					184.4	166.2	180.6	440.5	642.7	416.0		
% Victim of Violent Crime in Past 5 Years	4.8	10.0	0.5	0.0			4.5			6.2		2.2
% Victim of Intimate Partner Violence	15.5	33.9	18.2	19.0			22.1			13.7		19.4

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

better similar worse

KIDNEY DISEASE	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)					5.1	11.9	6.7	8.8	8.9	12.9		5.7
% Kidney Disease	2.1	2.8	6.7	1.4			3.2	3.0	3.0	5.0		2.3

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

better similar worse

MENTAL HEALTH	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	31.4	25.6	15.0	13.0			23.0			13.4		8.0
% Lonely	27.3	25.0	17.0	23.1			23.7			23.8		
% Diagnosed Depression	30.7	30.7	9.2	19.9			24.1	14.6	17.7	20.6		15.9
% Symptoms of Chronic Depression (2+ Years)	50.0	44.1	29.7	26.1			39.6			30.3		29.5
% Typical Day Is "Extremely/Very" Stressful	12.8	8.5	4.1	8.5			9.0			16.1		9.7
% Considered Suicide in the Past Year	2.2	13.4	4.0	7.2			6.8					5.2
% [Child Age 5-17] "Fair/Poor" Mental Health							9.6					13.8
Suicide (Age-Adjusted Death Rate)					16.3	35.6	20.0	10.7	20.3	14.0	12.8	18.2
Mental Health Providers per 100,000					107.0	16.7	88.7	49.1	42.2	42.6		
% Taking Rx/Receiving Mental Health Trtmt	19.7	26.9	21.2	9.6			20.3			16.8		11.2
% Unable to Get Mental Health Svcs in Past Yr	9.8	9.2	0.7	3.2			6.5			7.8		4.8

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

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)					25.8	49.1	30.6	13.4	24.1	22.4		
% "Very/Somewhat" Difficult to Buy Fresh Produce	15.0	12.7	2.4	8.1			10.4			21.1		18.4
% 5+ Servings of Fruits/Vegetables per Day	30.1	27.6	35.5	45.3			33.4			32.7		53.6
% No Leisure-Time Physical Activity	15.9	13.5	13.2	4.6			12.5	22.4	25.8	31.3	21.2	13.8
% Meeting Physical Activity Guidelines	39.9	37.4	45.2	45.3			41.3	22.6	20.0	21.4	28.4	29.6
% Child [Age 2-17] Physically Active 1+ Hours per Day							34.1			33.0		41.9
Recreation/Fitness Facilities per 100,000					14.4	14.9	14.5	11.8	10.6	11.8		
% Overweight (BMI 25+)	61.6	48.8	54.6	42.0			52.7	62.8	67.8	61.0		53.0
% Obese (BMI 30+)	22.6	26.8	18.9	14.8			21.6	26.1	30.6	31.3	36.0	15.2

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

better similar worse

ORAL HEALTH	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% [Age 18+] Dental Visit in Past Year	61.9	59.6	73.3	67.1			64.6	67.4	64.7	62.0	45.0	62.8
% Child [Age 2-17] Dental Visit in Past Year							77.9			72.1	45.0	81.3

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

better similar worse

POTENTIALLY DISABLING CONDITIONS	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	35.5	32.5	18.5	23.9			28.9			32.5		30.8
% Activity Limitations	28.3	42.0	23.6	20.1			29.8			24.0		20.4
% With High-Impact Chronic Pain	22.4	21.5	15.4	20.5			20.3			14.1	7.0	
Alzheimer's Disease (Age-Adjusted Death Rate)					27.5	15.6	24.6	37.1	24.2	30.4		28.7
% Caregiver to a Friend/Family Member	24.2	23.5	21.2	24.4			23.4			22.6		27.3

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

better similar worse

RESPIRATORY DISEASE	DISPARITY AMONG SUBAREAS: Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado	Douglas County	PSA	PSA vs. BENCHMARKS: vs. CA	vs. NV	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)					35.6	32.5	35.0	30.7	48.9	39.6		40.3
Pneumonia/Influenza (Age-Adjusted Death Rate)					10.4	10.3	10.4	14.2	16.3	13.8		12.8
% [Age 65+] Flu Vaccine in Past Year							78.4	63.9	61.0	71.0		54.8
% [Adult] Asthma	9.8	8.2	4.6	12.0			8.6	7.8	9.4	12.9		6.3
% [Child 0-17] Asthma							4.8			7.8		3.2
% COPD (Lung Disease)	1.5	11.3	2.7	3.8			5.0	4.4	8.0	6.4		7.6

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

better similar worse

SEXUAL HEALTH	DISPARITY AMONG SUBAREAS: Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado	Douglas County	PSA	PSA vs. BENCHMARKS: vs. CA	vs. NV	vs. US	vs. HP2030	TREND
HIV Prevalence Rate					125.6	111.3	122.7	395.9	402.5	372.8		
Chlamydia Incidence Rate					236.5	248.4	238.9	585.3	584.0	539.9		
Gonorrhea Incidence Rate					50.3	39.3	48.0	200.3	216.0	179.1		

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

better similar worse

SUBSTANCE ABUSE	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)					14.2	18.4	14.9	12.2	13.5	11.1	10.9	12.4
% Excessive Drinker	29.8	22.8	27.6	38.5			28.9	18.3	18.4	27.2		35.2
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)					13.8		13.3	11.8	17.5	18.8		17.0
% Illicit Drug Use in Past Month	0.9	5.9	4.2	8.0			4.4			2.0	12.0	6.7
% Used a Prescription Opioid in Past Year	12.8	18.3	15.3	18.6			16.0			12.9		22.1
% Ever Sought Help for Alcohol or Drug Problem	15.1	8.3	3.2	7.1			9.1			5.4		8.1
% Personally Impacted by Substance Abuse	42.8	55.0	56.3	43.1			49.2			35.8		57.2

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

better similar worse

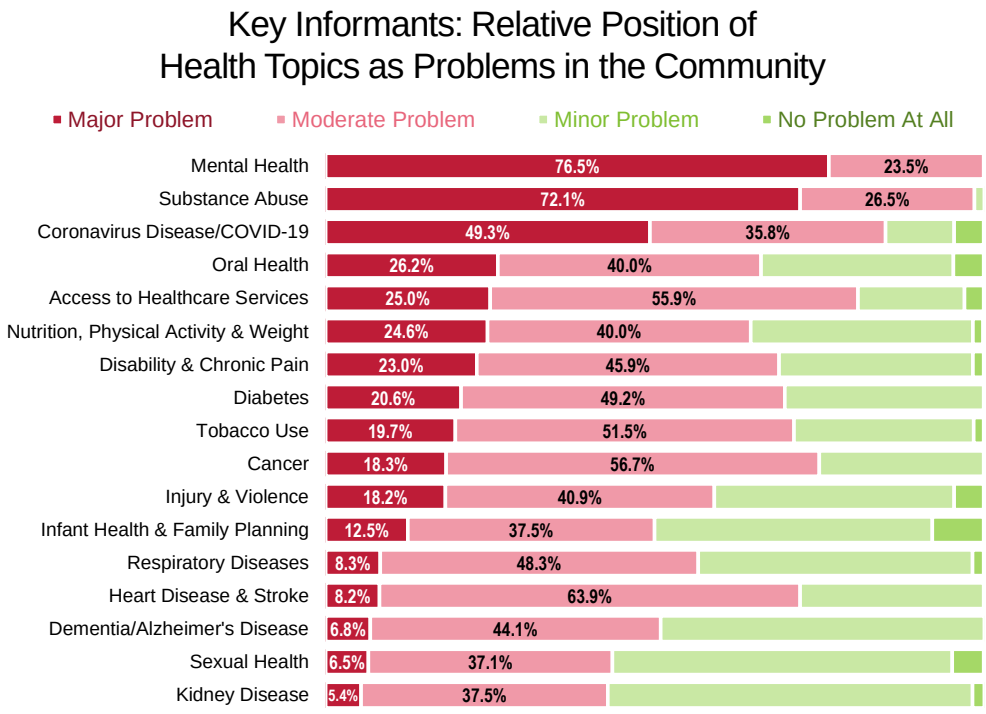
TOBACCO USE	DISPARITY AMONG SUBAREAS						PSA	PSA vs. BENCHMARKS				
	Stateline/ Bijou	Other SLT	Other 96150	Other PSA	El Dorado County	Douglas County		vs. CA	vs. NV	vs. US	vs. HP2030	TREND
% Current Smoker	17.3	8.9	18.1	10.5			13.8	10.0	15.7	17.4	5.0	18.2
% Someone Smokes at Home	15.5	4.8	5.7	2.2			7.9			14.6		12.8
% [Household With Children] Someone Smokes in the Home							0.5			17.4		6.6
% Currently Use Vaping Products	13.9	8.3	16.7	0.0			10.3			8.9		3.1

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

better similar worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The Primary Service Area, the focus of this Community Health Needs Assessment, is predominantly associated with El Dorado County (California) and Douglas County (Nevada), which together encompass 2,417.56 square miles and house a total population of 234,489 residents, according to latest census estimates.

Total Population
(Estimated Population, 2014-2018)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
El Dorado County, CA	186,661	1,707.84	109.30
Douglas County, NV	47,828	709.72	67.39
Primary Service Area (El Dorado + Douglas counties)	**234,489**	**2,417.56**	**96.99**
California	39,148,760	155,792.65	251.29
Nevada	2,922,849	109,780.17	26.62
United States	322,903,030	3,532,068.58	91.42

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

Population Change 2000-2010

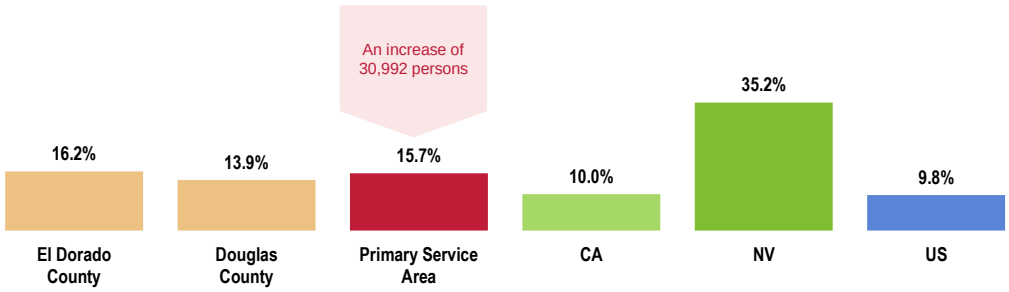
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of the Primary Service Area increased by 30,992 persons, or 15.7%.

BENCHMARK ► Higher than the California and US percentage increases but well below the Nevada percentage.

DISPARITY ► A higher-percentage increase in El Dorado County (CA) than in Douglas County (NV).

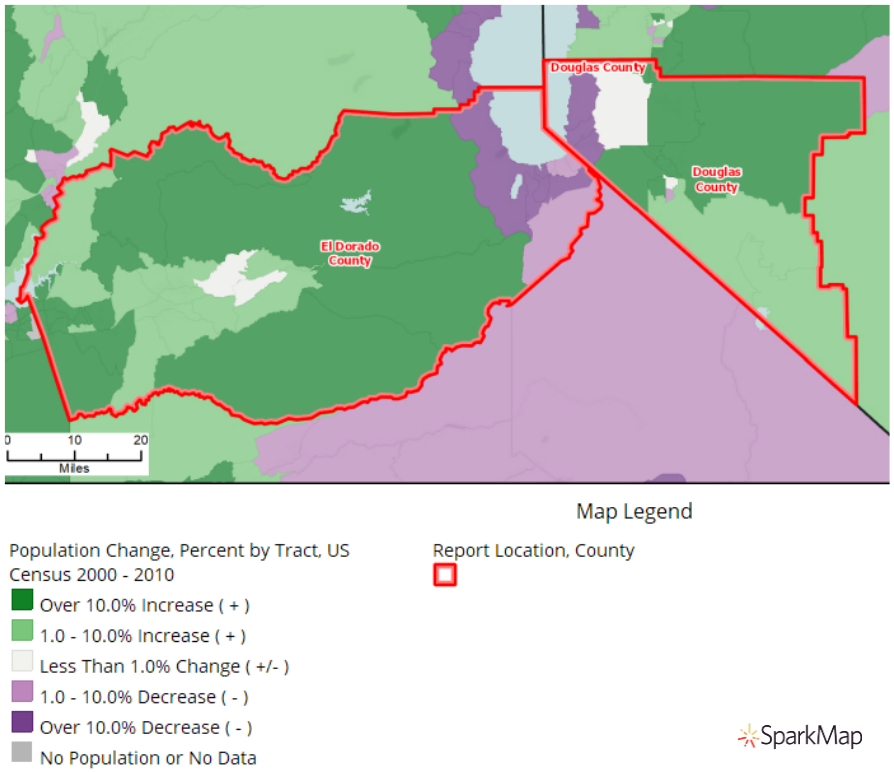
Change in Total Population
(Percentage Change Between 2000 and 2010)



Sources:
- US Census Bureau Decennial Census (2000-2010).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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

This map shows the areas of greatest increase or decrease in population between 2000 and 2010.



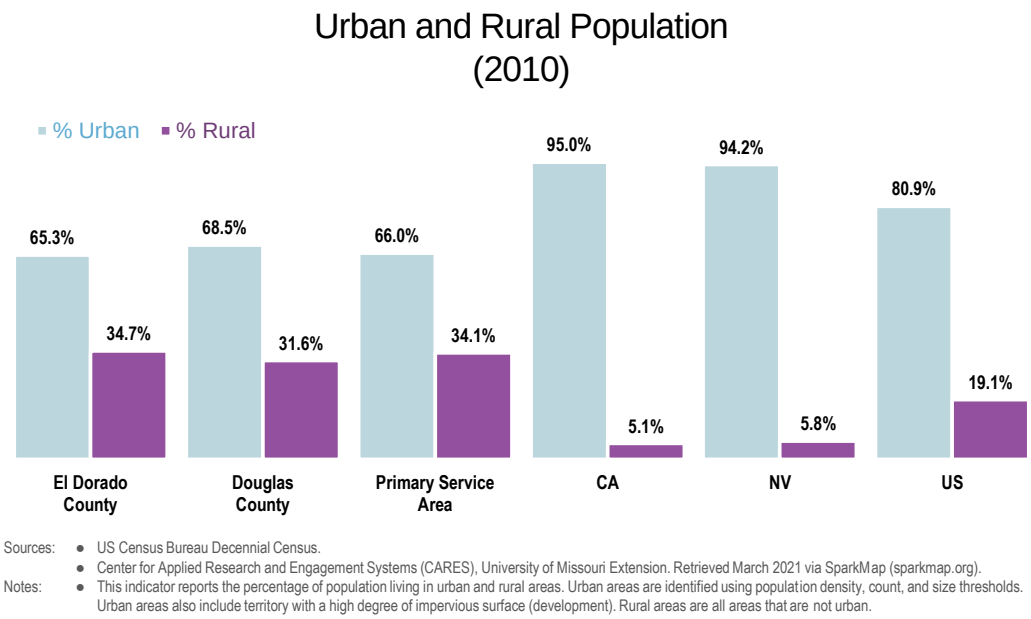
Urban/Rural Population

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 predominantly urban, with 66.0% of the population living in areas designated as urban.

BENCHMARK ► A much lower urban proportion than found statewide and nationally.

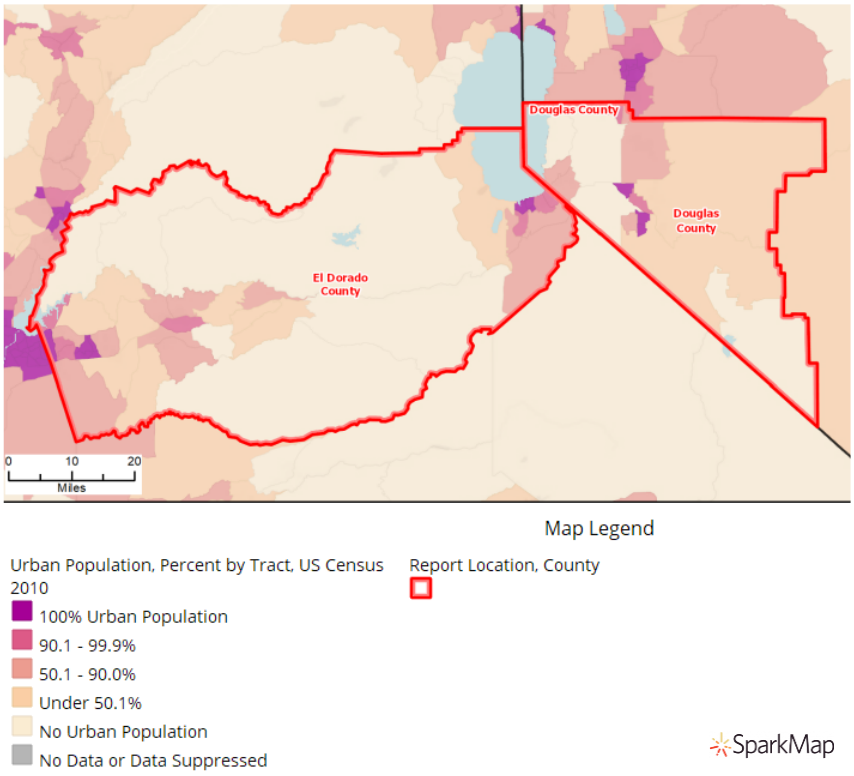
DISPARITY ► A slightly higher urban proportion in Douglas County.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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

Note the following map outlining the urban population in the Primary Service Area.



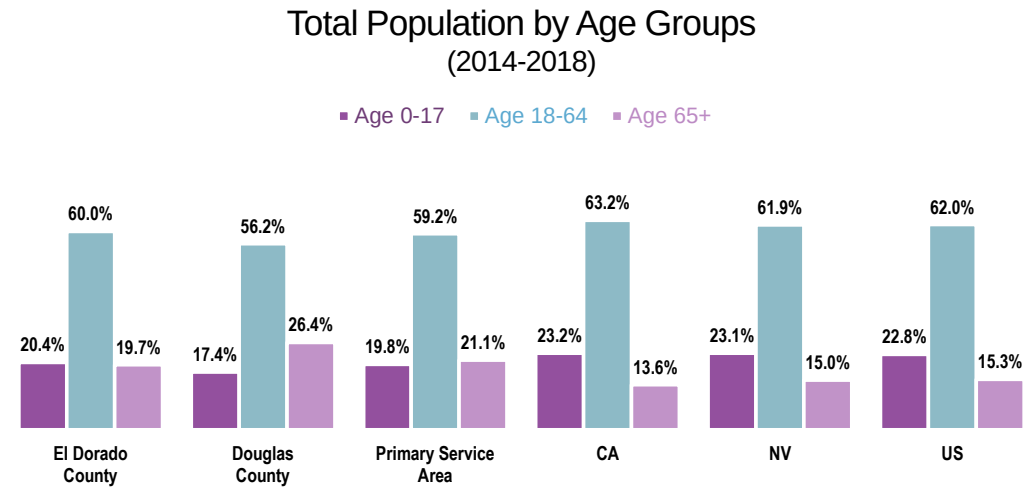
Age

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

In the Primary Service Area, 19.8% of the population are children age 0-17; another 59.2% are age 18 to 64, while 21.1% are age 65 and older.

BENCHMARK ► The senior (age 65+) population is proportionally higher than state and US percentages.

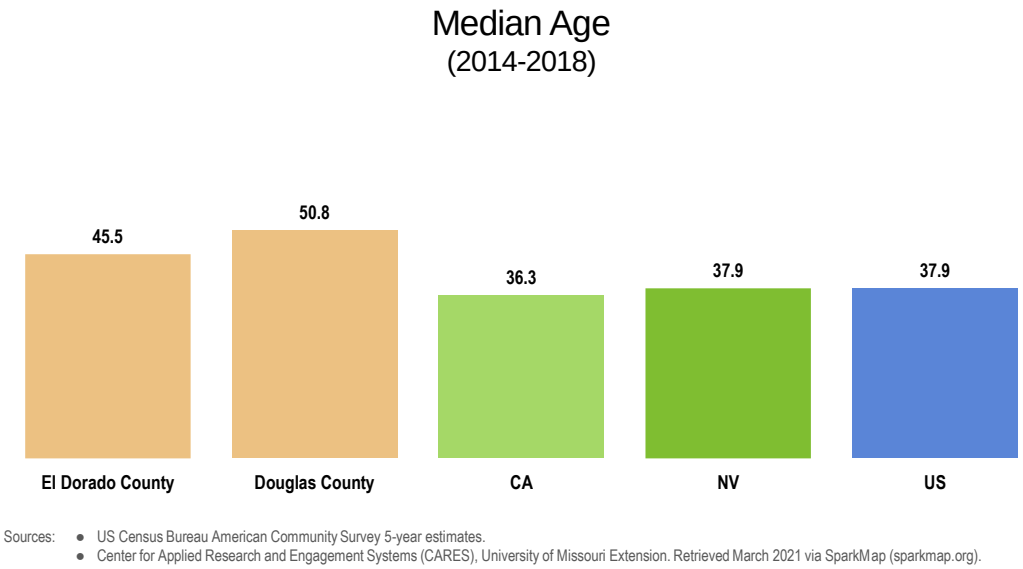
DISPARITY ► Over a quarter of the Douglas County population is age 65+.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

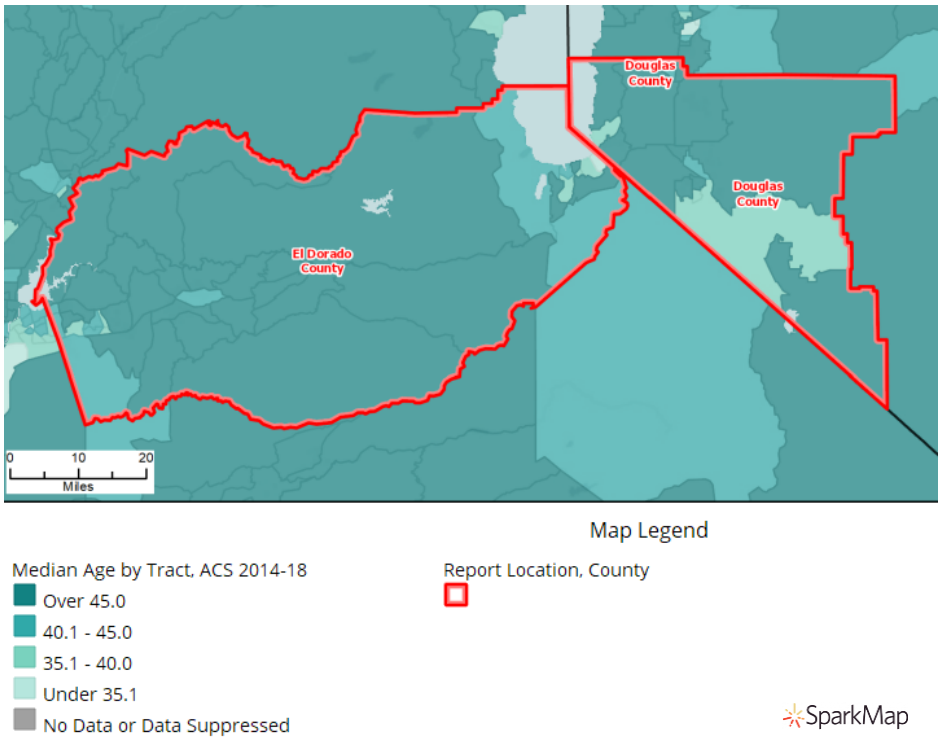
Median Age

El Dorado and Douglas counties are "older" than state and national figures in that the median ages are higher.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age in the Primary Service Area.

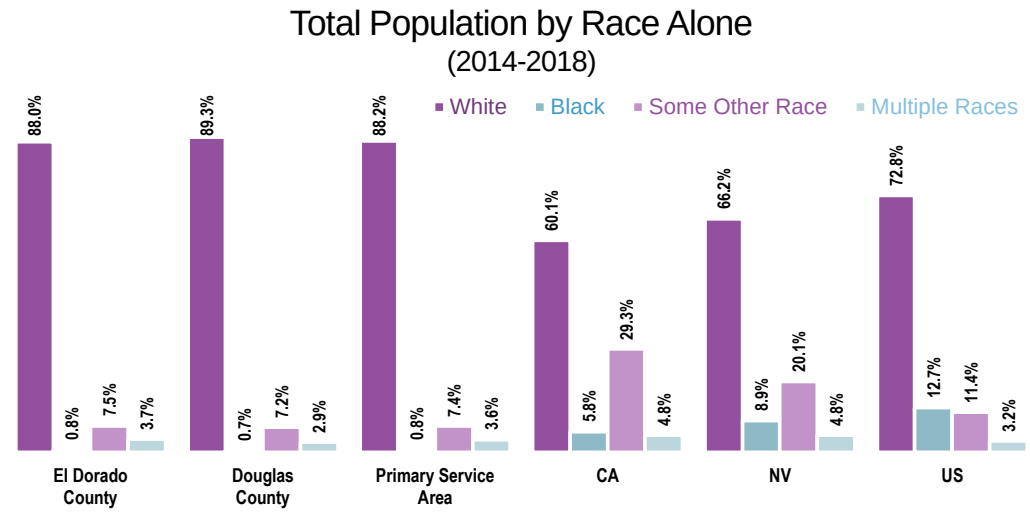


Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 88.2% of residents of the Primary Service Area are White and less than one percent are Black.

BENCHMARK ► The population is much less diverse than those reported throughout California, Nevada, and the US overall.

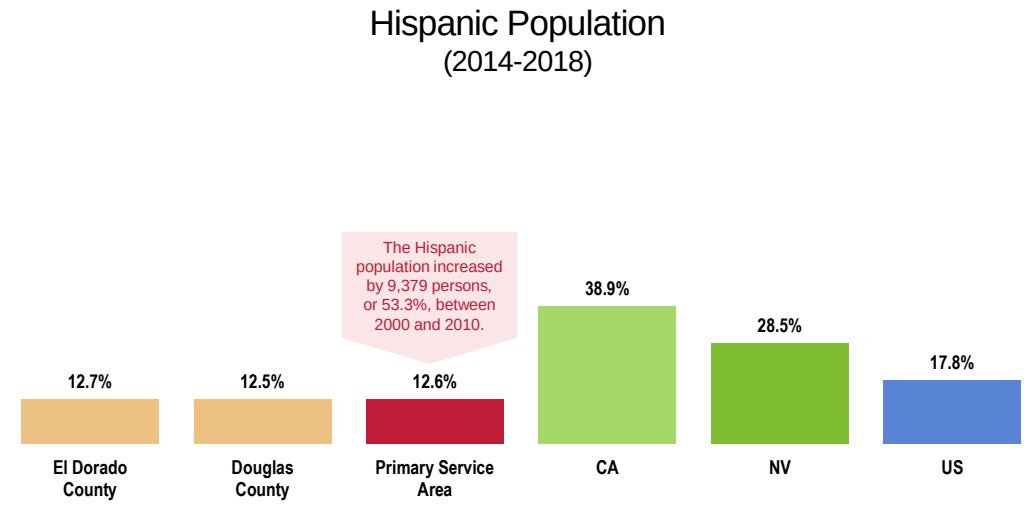


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

Ethnicity

A total of 12.6% of Primary Service Area residents are Hispanic or Latino.

BENCHMARK ► Well below the state and US figures.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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

Linguistic Isolation

A total of 1.7% of the Primary Service Area population age 5 and older live in a home in which <u>no</u> person age 14 or older is proficient in English (speaking only English or speaking English "very well").

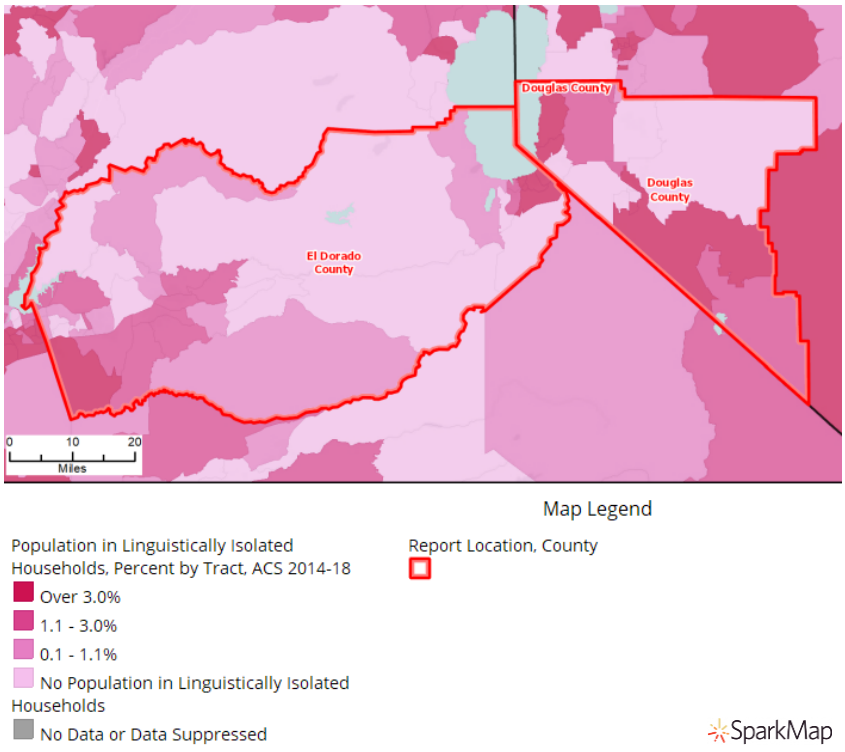
BENCHMARK ► Well below the state and US percentages.

DISPARITY ► Slightly higher in Douglas County.

Linguistically Isolated Population
(2014-2018)

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

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

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

Poverty

The latest census estimate shows 9.0% of the Primary Service Area total population living below the federal poverty level.

BENCHMARK ► Well below the state and national figures.

Among just children (ages 0 to 17), this percentage in the Primary Service Area is 10.2% (representing an estimated 4,639 children).

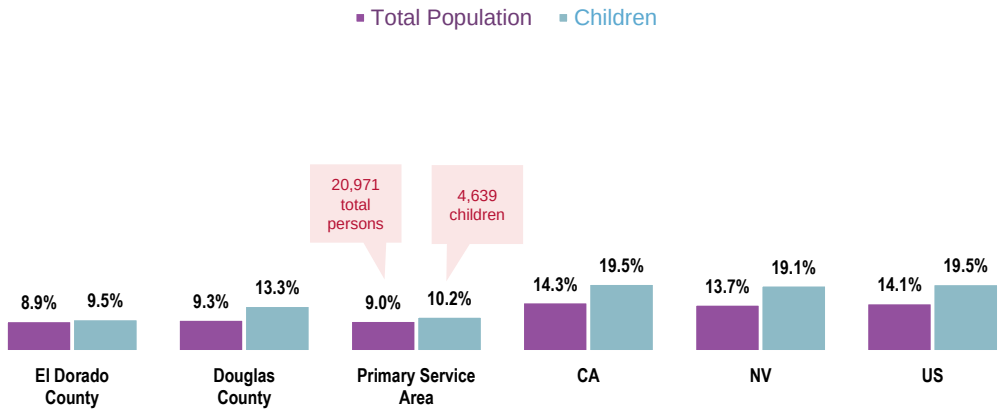
BENCHMARK ► Well below the state and US percentages but fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lower in El Dorado County.

Population in Poverty

(Populations Living Below the Poverty Level; 2014-2018)

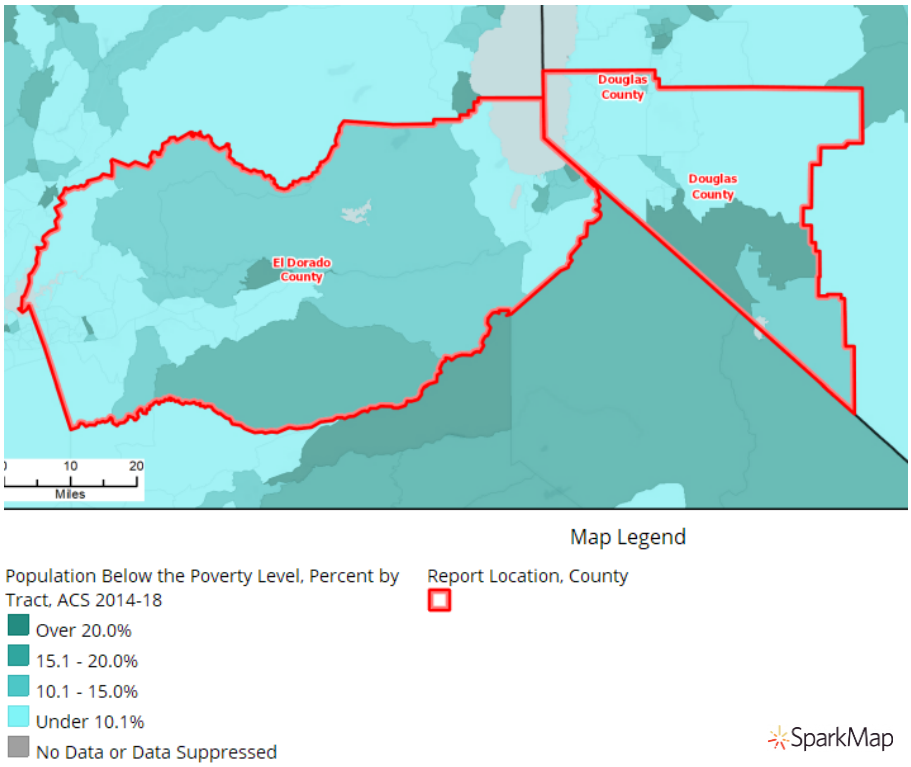
Healthy People 2030 = 8.0% or Lower

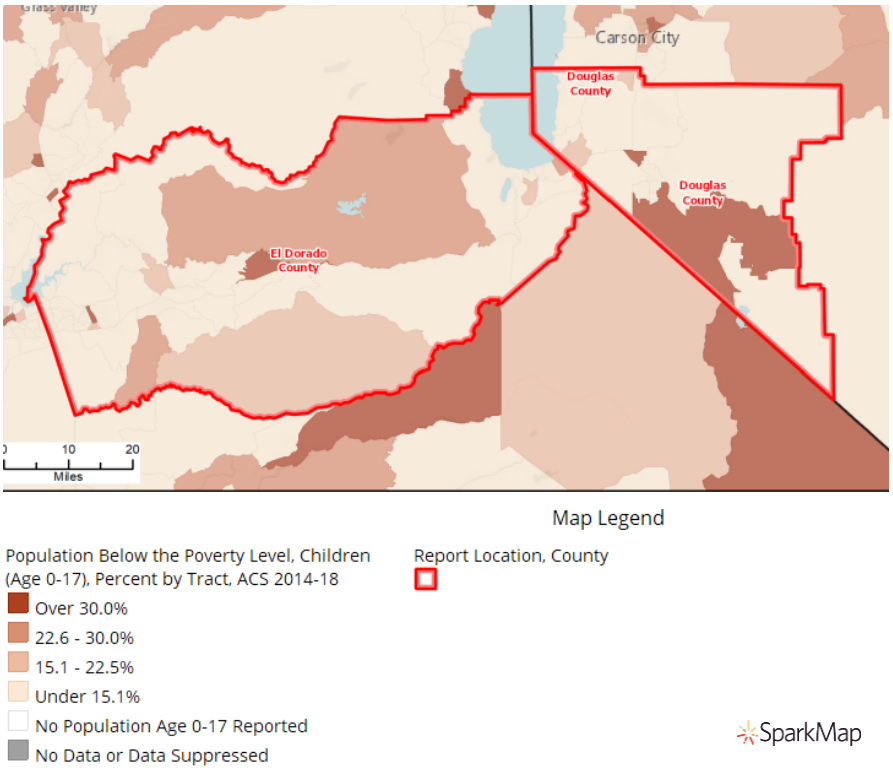


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

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





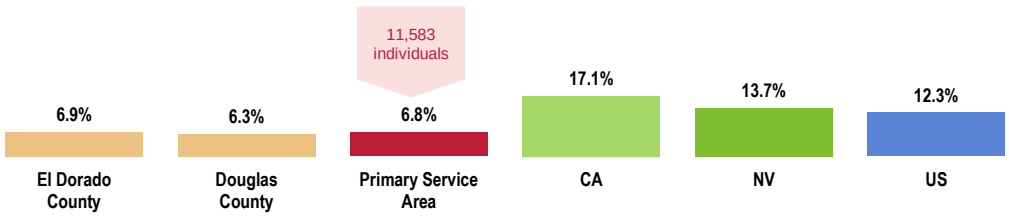
Education

Among the Primary Service Area population age 25 and older, an estimated 6.8% (over 11,500 people) do not have a high school education.

BENCHMARK ► Considerably better than the state and US figures.

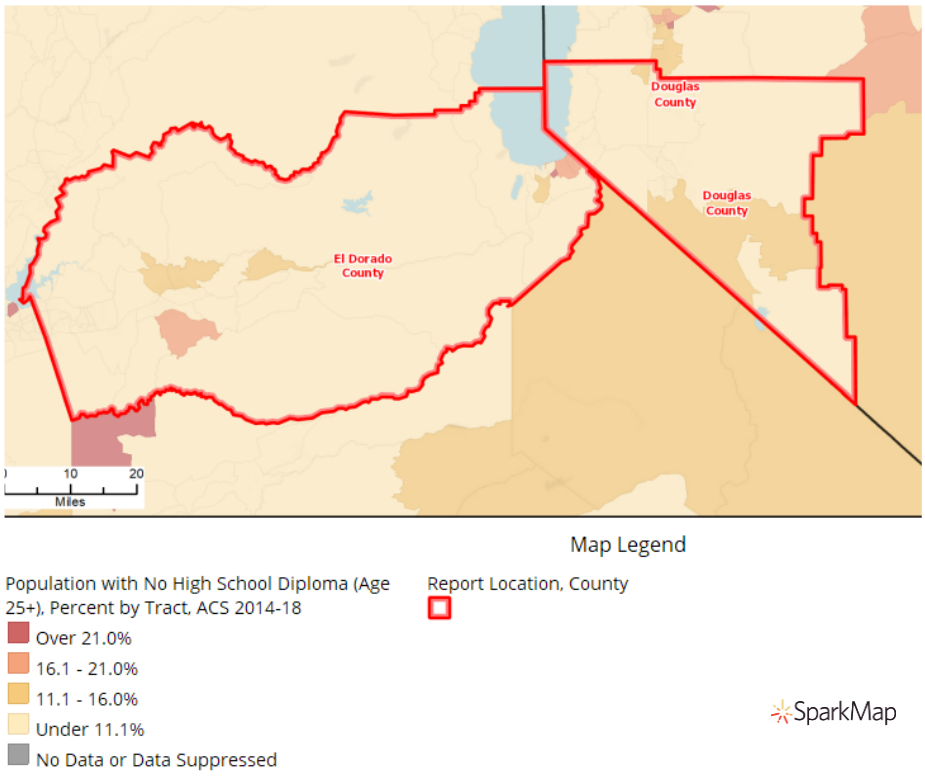
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2014-2018)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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



Financial Resilience

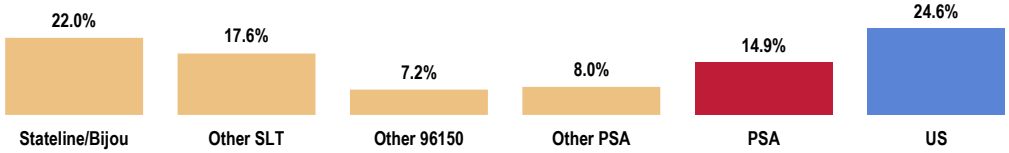
A total of 14.9% of Primary Service Area residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.

BENCHMARK ► Well below the national prevalence.

DISPARITY ► Unfavorably higher in South Lake Tahoe, especially the Stateline/Bijou community. Reported more often among adults age 40 to 64, Communities of Color, and especially low-income respondents.

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

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



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

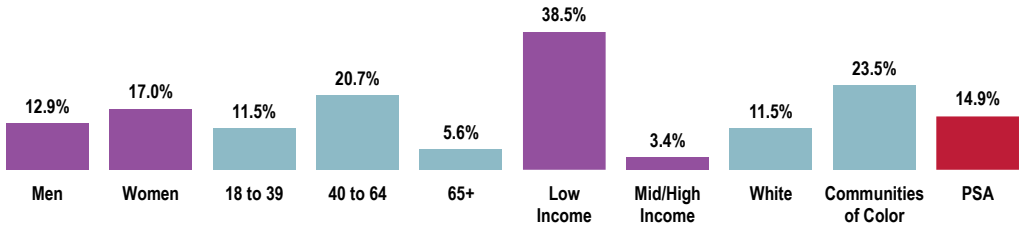
Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

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

Here, "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 (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

In addition, all Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Primary Service Area, 2021)



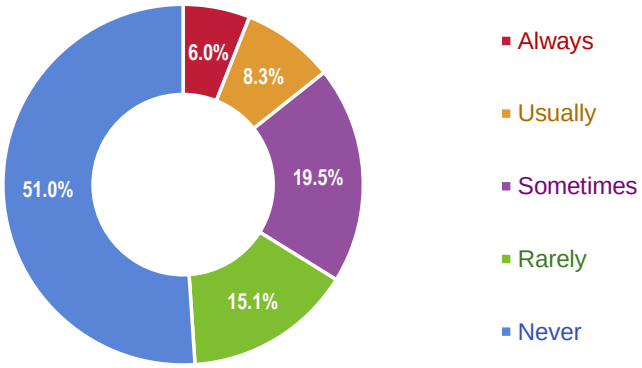
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 63]
Notes: ● Asked of all respondents.
● Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Housing

Housing Insecurity

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

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

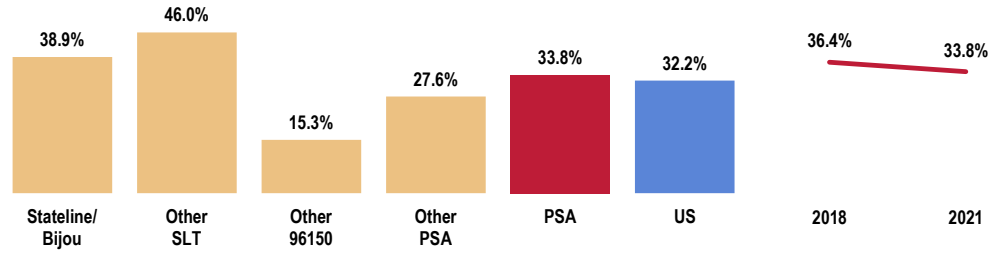
However, a considerable share (33.8%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

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

DISPARITY ► Particularly high in the Other SLT community. Correlates with age and is especially high among low-income residents and Communities of Color.

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

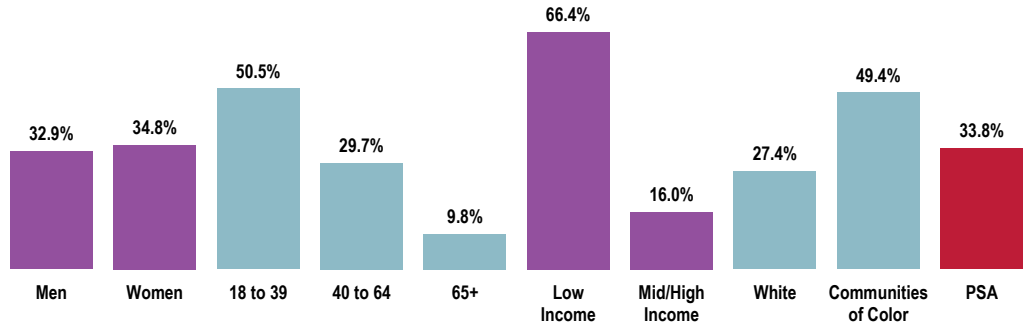
Primary Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

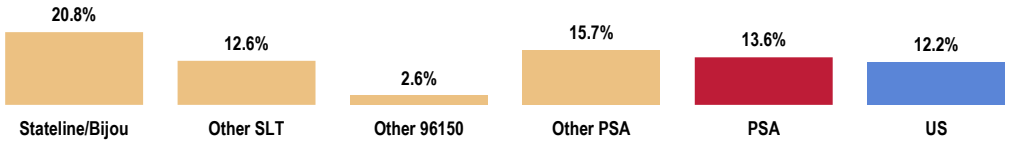
Unhealthy or Unsafe Housing

A total of 13.6% of Primary Service Area residents report living in unhealthy or unsafe housing conditions during the past year.

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

DISPARITY ► Unfavorably high among Stateline/Bijou respondents. Also reported more often among low-income residents and Communities of Color.

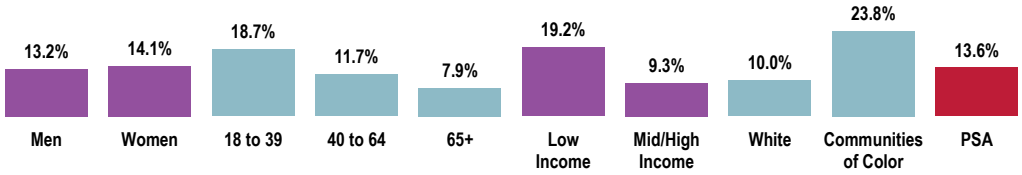
Unhealthy or Unsafe Housing Conditions in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

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

Unhealthy or Unsafe Housing Conditions in the Past Year
(Primary Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 65]

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

Key Informant Input: Housing

The following related comments were captured during the administration of the Online Key Informant Survey:

> Lack of adequate, safe housing that is affordable for the majority of our community is a major local health issue due to its negative impacts on residents. Living in cramped conditions ensures COVID will continue to spike. Living in motel rooms isn't a long-term solution for most residents. Run down trailers and apartment buildings that are falling apart, have unsafe fire protective measures and lack of heat and water are a huge negative impact on our community and the health of the residents who are forced to live there for lack of better options. – Community Leader
>
> Housing. – Other Health Provider
>
> Housing. Lack of affordable housing contributes to poor quality of life, stress, substance abuse, mental health issues, etc. – Physician
>
> Lack of affordable housing. Lack of year-round shelter for the unhoused. – Physician
>
> Lack of adequate and affordable housing that leads to health issues. – Social Services Provider

Food Access

Low Food Access

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* in the **Modifiable Health Risks** section of this report.

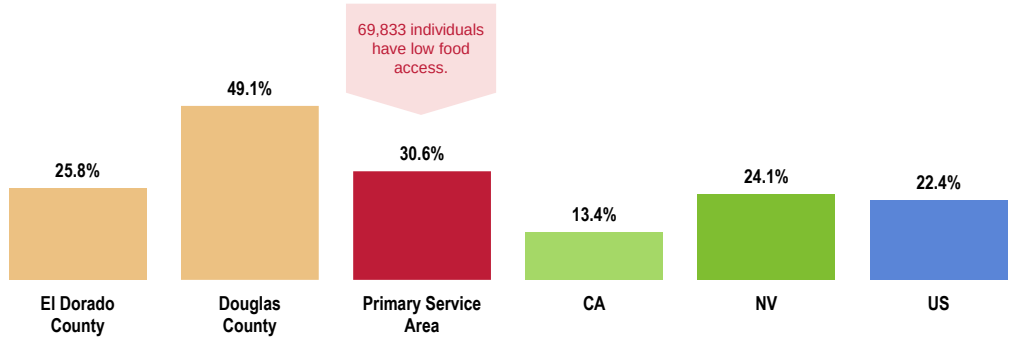
US Department of Agriculture data show that 30.6% of the Primary Service Area population (representing nearly 70,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

BENCHMARK ► Well above the state and national percentages.

DISPARITY ► The percentage is nearly twice as high in Douglas County as in El Dorado County.

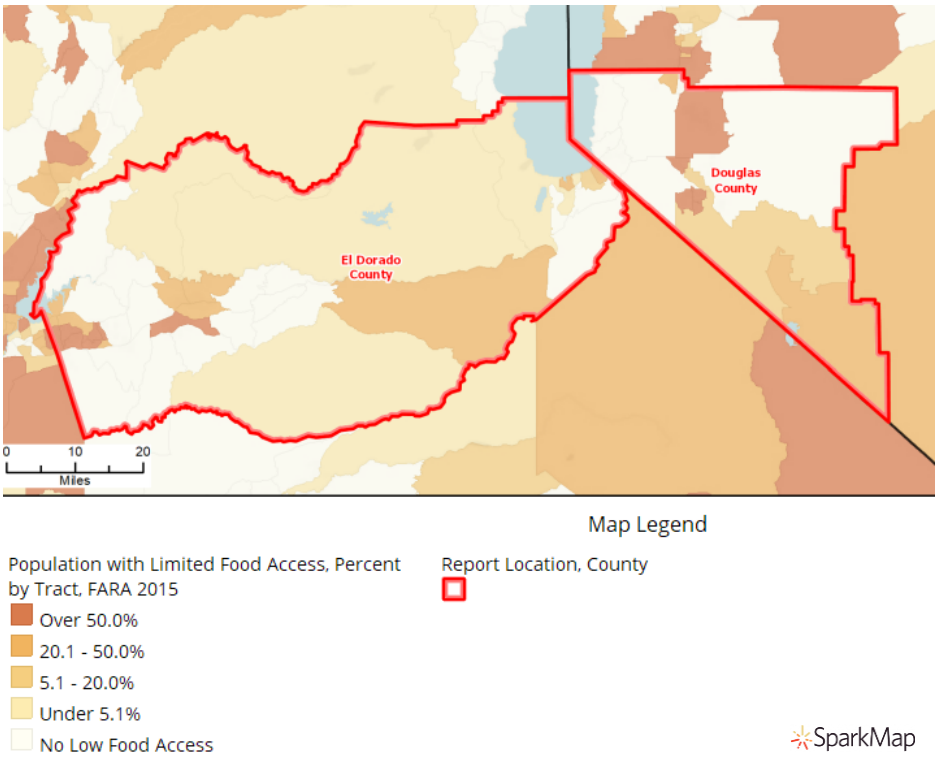
Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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



Food Insecurity

Overall, 19.0% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

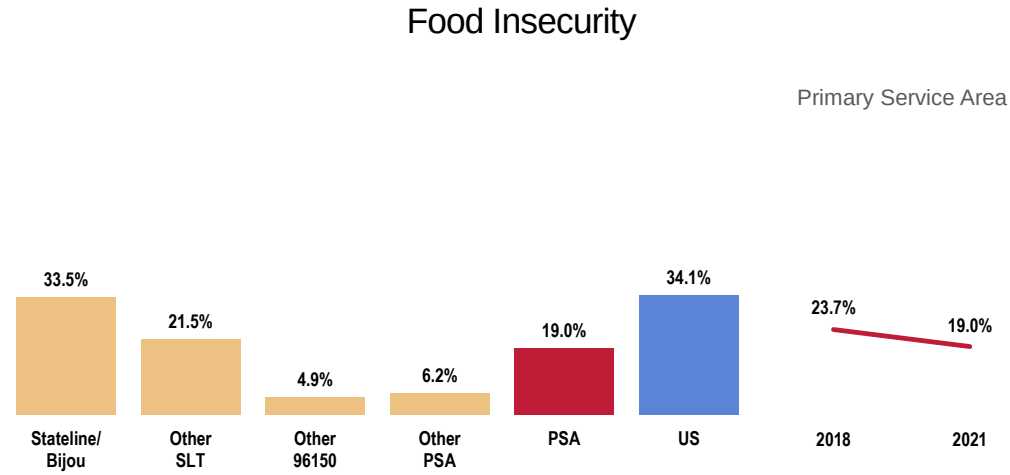
BENCHMARK ► Well below the national prevalence.

DISPARITY ► Highest in the Stateline/Bijou community. Correlates with age and is especially high among low-income residents and Communities of Color.

Surveyed adults were asked: "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "Often True," "Sometimes True," or "Never True" for you in the past 12 months:

- I worried about whether our food would run out before we got money to buy more.
- The food that we bought just did not last, and we did not have money to get more."

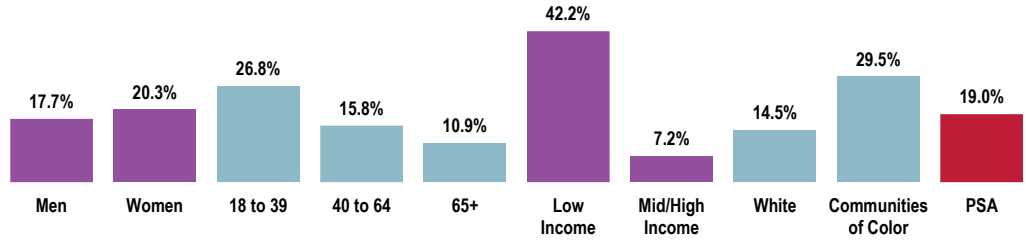
Those answering "Often" or "Sometimes True" for either statement are considered to be food insecure.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

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

Food Insecurity
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Adverse Childhood Experiences (ACEs)

ABOUT ACEs

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

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

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

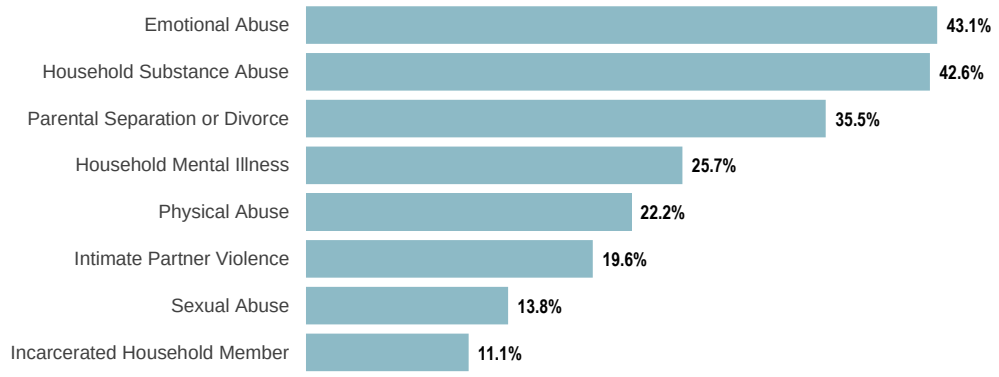
Adverse Childhood Experiences (ACEs)

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

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 308-318]
Notes: ● Reflects the total sample of respondents.

By category, ACEs were most prevalent in the Primary Service Area for emotional abuse (affirmed by 43.1% of respondents), followed closely by household substance abuse (42.6%) and then parental separation or divorce (35.5%).

Adverse Childhood Experiences (ACEs)
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 321-328]
Notes: ● Reflects the total sample of respondents.
● ACEs are stressful or traumatic events, including abuse and neglect. They are a significant risk factor for substance abuse disorders and can impact prevention efforts.

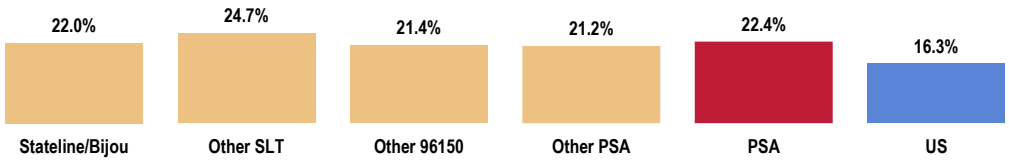
High ACE Scores

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

In all, 22.4% of Total Area residents reported four or more of the adverse childhood experiences tested (a high ACE score).

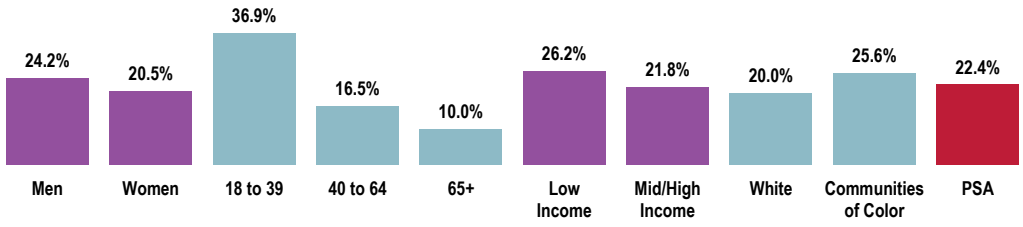
DISPARITY ► Much higher than the US percentage. The percentage is considerably higher among young adults.

Prevalence of High ACE Scores (Four or More ACEs)
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 329]
Notes: ● Asked of all respondents.
● Adults who report four or more ACEs is categorized as having a high ACE score.

Prevalence of High ACE Scores (Four or More ACEs)
(Primary Service Area, 2021)

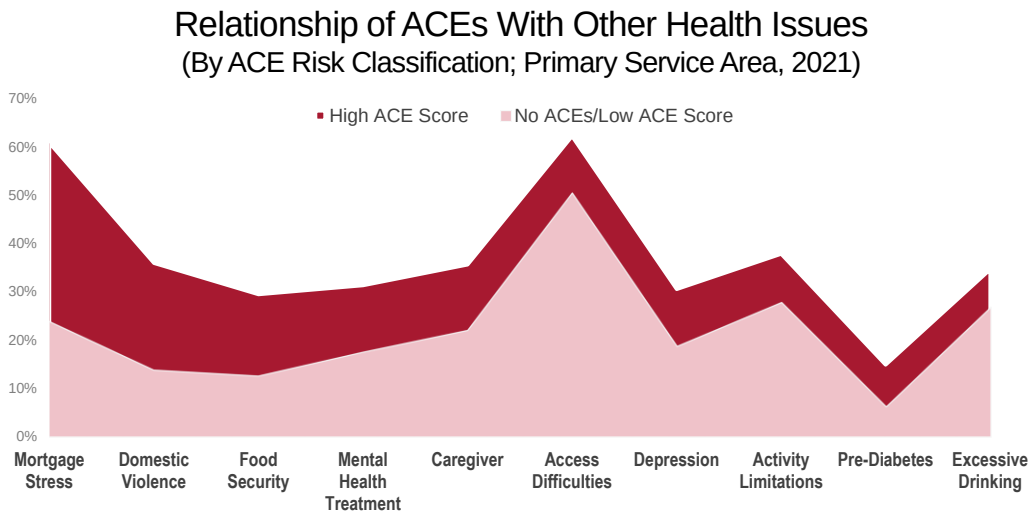


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 329]
Notes: ● Asked of all respondents.
● Adults who report four or more ACEs is categorized as having a high ACE score.

Relationship of ACEs with Other Health Issues

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

Note the following strong correlations of various health indicators in the Primary Service Area, comparing those with no/low ACE risk (0-3 ACEs) and those with high (4+) ACE risk.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Adults with at least one ACE are categorized as having a low score (1 to 3 ACEs) or a high score (4+ ACEs).

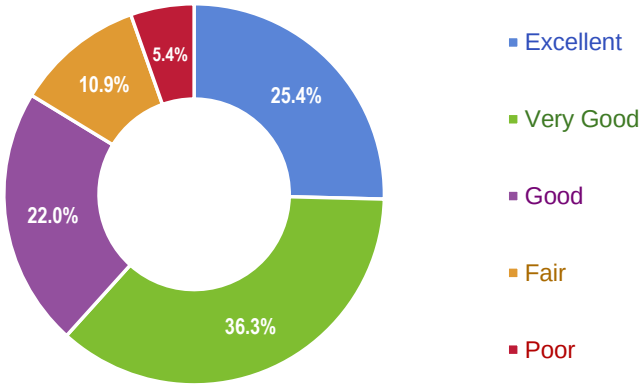
HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"

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

Self-Reported Health Status
(Primary Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

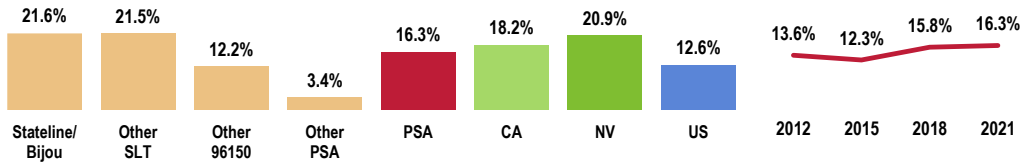
However, 16.3% of Primary Service Area adults believe that their overall health is "fair" or "poor."

BENCHMARK ► Lower than the Nevada prevalence.

DISPARITY ► Lowest in the Other PSA community. Reported more often among low-income respondents and Communities of Color.

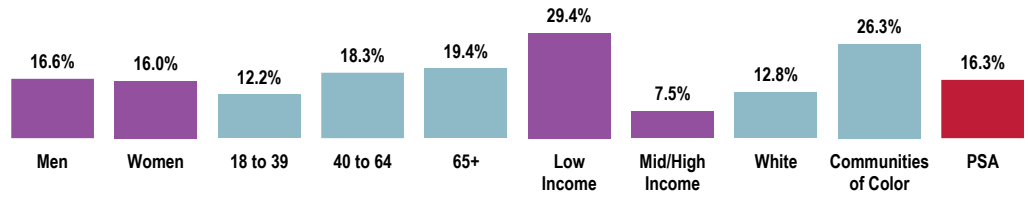
Experience "Fair" or "Poor" Overall Health

Primary Service Area



Sources: • 2021 PRC Community Health Survey, PRC, 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): 2019 California and Nevada California data.
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Primary Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

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

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

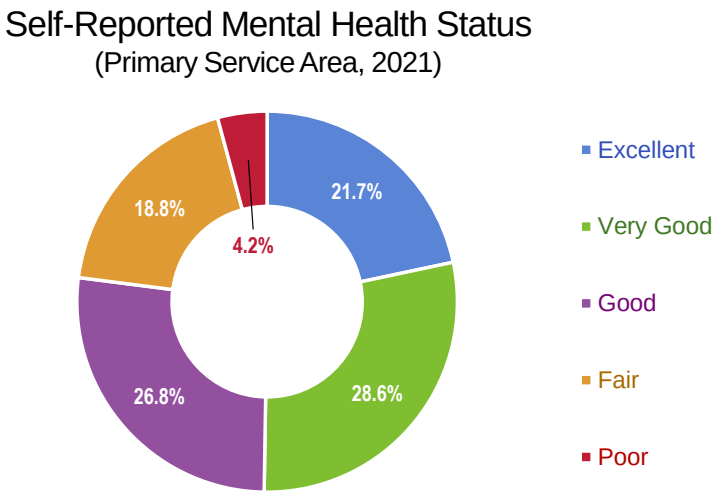
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

Adults

"Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: Excellent, Very Good, Good, Fair, or Poor?"

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



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: ● Asked of all respondents.

However, 23.0% believe that their overall mental health is "fair" or "poor."

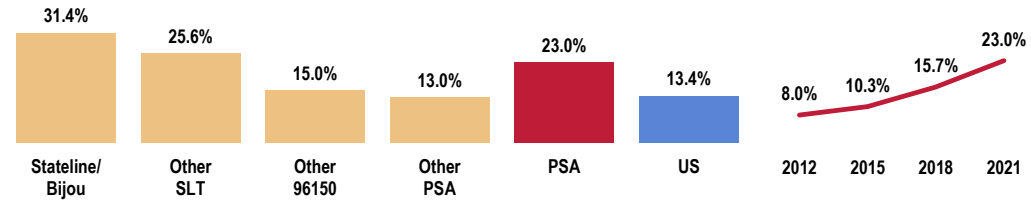
BENCHMARK ► Much higher than the national prevalence.

TREND ► Denotes a statistically significant increase since 2012.

DISPARITY ► Unfavorably high in the Stateline/Bijou community.

Experience "Fair" or "Poor" Mental Health

Primary Service Area



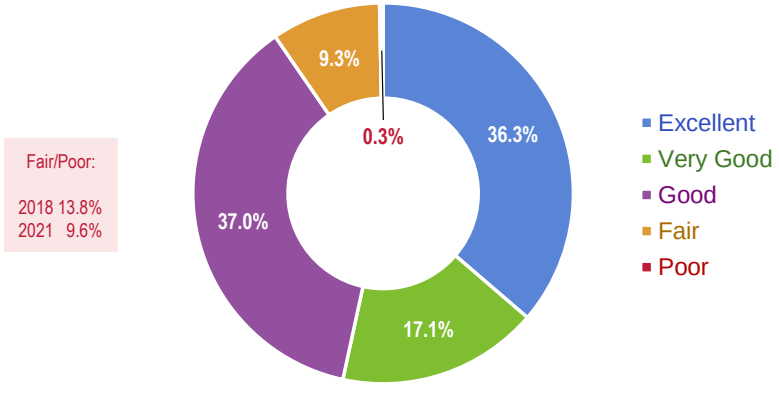
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Children

Among parents of children age 5 to 17 at home, over half consider their child's mental health status to be "excellent" or "very good."

TREND ► The 9.6% of "fair/poor" responses is statistically unchanged from 2018 findings.

Rating of Child's Mental Health
(Primary Service Area Parents of Children Age 5 to 17, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 319]
Notes: ● Asked of all respondents.

Depression

Diagnosed Depression

A total of 24.1% 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).

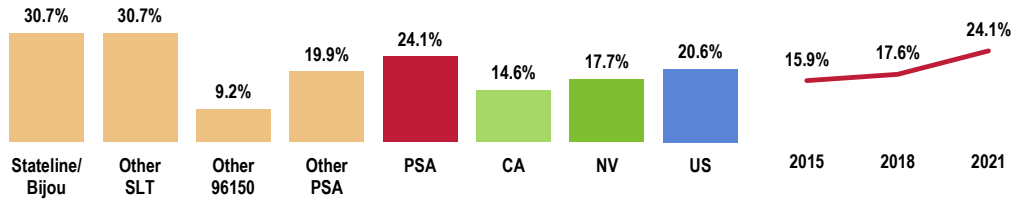
BENCHMARK ► Well above the California and Nevada percentages.

TREND ► Marks a statistically significant increase since 2015.

DISPARITY ► Notably high in the city of South Lake Tahoe.

Have Been Diagnosed With a Depressive Disorder

Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

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

Symptoms of Chronic Depression

A total of 39.6% 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).

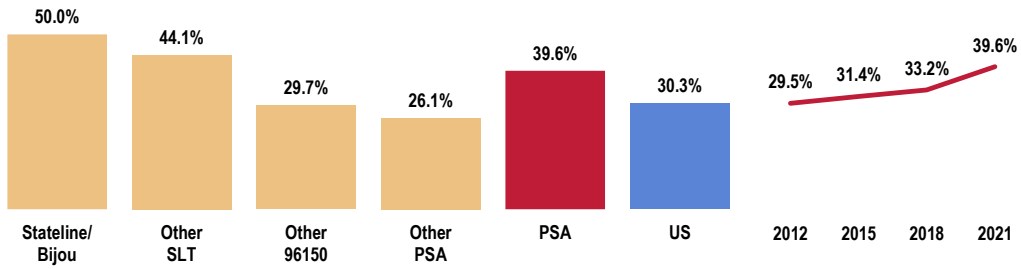
BENCHMARK ► Worse than the national prevalence.

TREND ► Denotes a statistically significant increase from 2012 survey findings.

DISPARITY ► Reported among half of Stateline/Bijou survey respondents. Correlates with age and is reported more often among low-income respondents and Communities of Color.

Have Experienced Symptoms of Chronic Depression

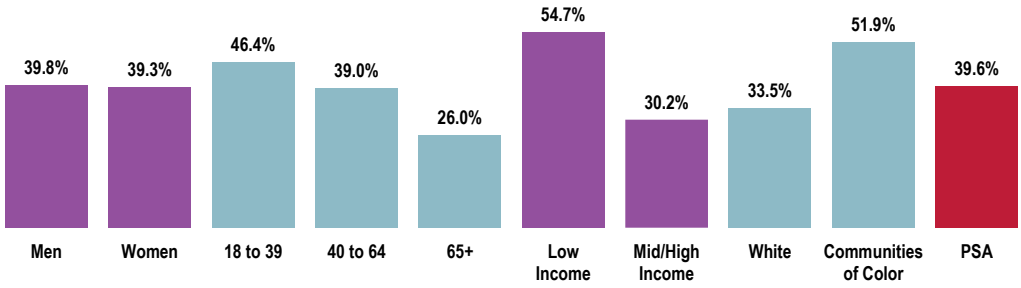
Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

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

Have Experienced Symptoms of Chronic Depression
(Primary Service Area, 2021)



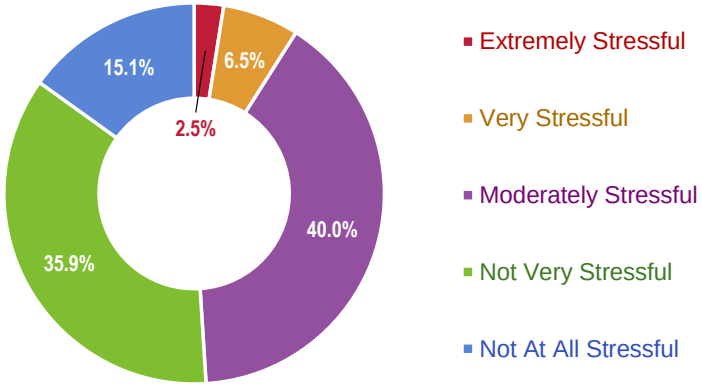
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 91]

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.

Stress

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

Perceived Level of Stress On a Typical Day
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: ● Asked of all respondents.

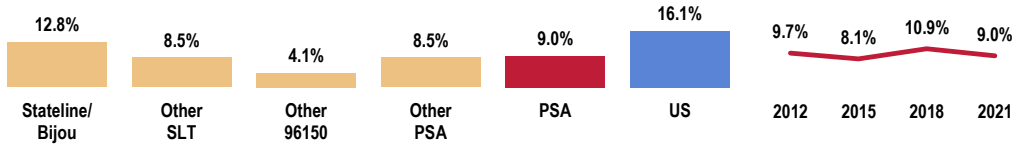
In contrast, 9.0% of Primary Service Area adults feel that most days for them are "very" or "extremely" stressful.

BENCHMARK ► Well below the US percentage.

DISPARITY ► Favorably low in the Other 96150 community.

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

Primary Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Most Days as "Extremely" or "Very" Stressful
(Primary Service Area, 2021)

Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: • Asked of all respondents.

Loneliness

Here, "loneliness" is defined as respondents who score 6-9 points in a series of three questions:

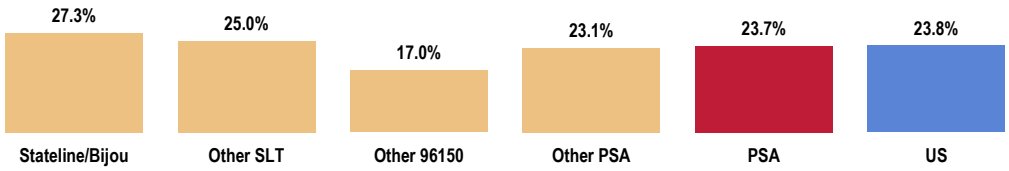
- "How often do you feel that you lack companionship? Would you say Hardly Ever, Some of the Time, or Often?"
- "How often do you feel left out? Would you say Hardly Ever, Some of the Time, or Often?"
- "How often do you feel isolated from others? Would you say Hardly Ever, Some of the Time, or Often?"

Points were awarded based on "hardly ever" (1), "some of the time" (2), or "often" (3) responses.

A total of 23.7% of survey respondents are considered to be lonely (based on a Loneliness Scale of three scored questions).

DISPARITY ► Unfavorably high among men and low-income respondents.

Lonely



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 305-307, 331]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Here, "lonely" is defined as respondents who score 6-9 points in a series of three questions from the Loneliness Scale (regarding lacking companionship or feeling isolated or feeling left out). Points were awarded based on "hardly ever" (1), "some of the time" (2), or "often" (3) responses.

Lonely

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 305-307, 331]

Notes:
- Asked of all respondents.
- Here, "lonely" is defined as respondents who score 6-9 points in a series of three questions from the Loneliness Scale (regarding lacking companionship or feeling isolated or feeling left out). Points were awarded based on "hardly ever" (1), "some of the time" (2), or "often" (3) responses.

Suicide

In the Primary Service Area, there were 20.0 suicides per 100,000 population (2017-2019 annual average age-adjusted rate).

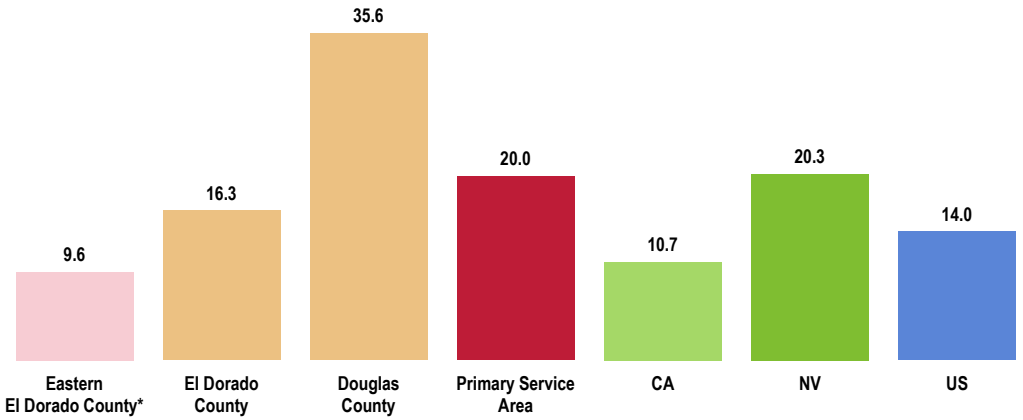
BENCHMARK ► Much higher than the California and US suicide rates. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► The rate is over twice as high in Douglas County as in El Dorado County. Relatively lower in Eastern El Dorado County.

Suicide: Age-Adjusted Mortality

(2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower

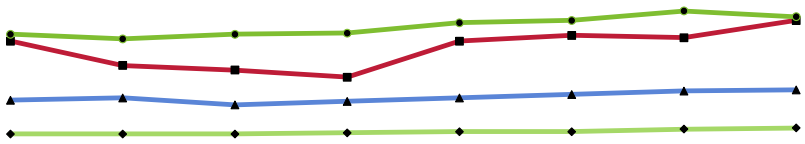


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	18.2	16.1	15.7	15.1	18.2	18.7	18.5	20.0
CA	10.2	10.2	10.2	10.3	10.4	10.4	10.6	10.7
NV	18.8	18.4	18.8	18.9	19.8	20.0	20.8	20.3
US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

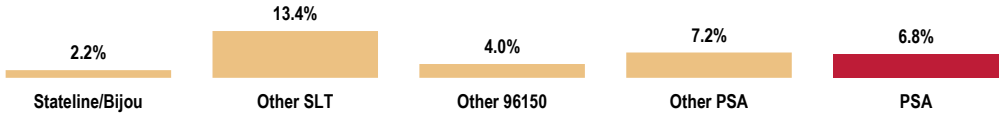
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Suicide Ideation

A total of 6.8% of survey respondents acknowledge that they considered taking their own life at some point in the past year.

DISPARITY ► Unfavorably high in the Other SLT community. Reported most often among Whites.

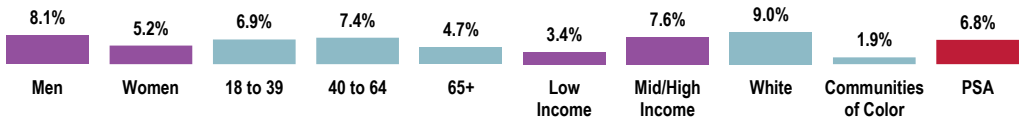
Considered Suicide at Some Point in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 304]

Notes:
- Asked of all respondents.

Considered Suicide at Some Point in the Past Year
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

Mental Health Treatment

Mental Health Providers

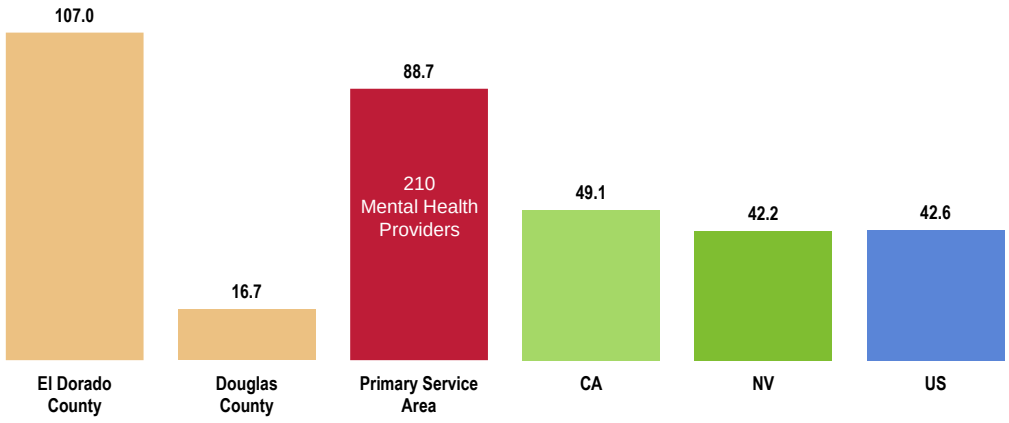
Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the Primary Service Area and residents in the Primary Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

In the Primary Service Area in 2020, there were 88.7 mental health providers for every 100,000 population.

BENCHMARK ► Well above the state and US figures.

DISPARITY ► Dramatically higher in El Dorado County.

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



Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).
Notes: ● This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Currently Receiving Treatment

A total of 20.3% of survey respondents are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

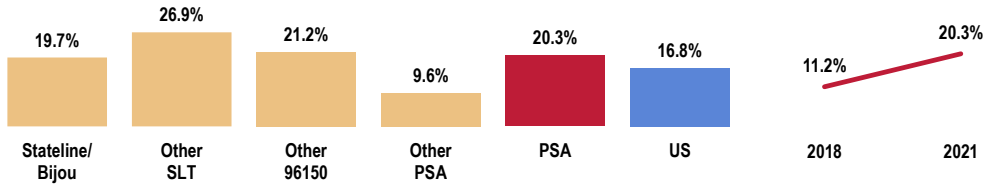
TREND ► Marks a statistically significant increase since 2018.

DISPARITY ► Highest in the Other SLT population.

Currently Receiving Mental Health Treatment

Primary Service Area

Among respondents ever diagnosed with a depressive disorder, 57.4% are currently receiving treatment.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

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

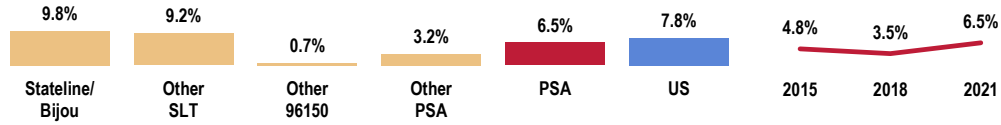
Difficulty Accessing Mental Health Services

A total of 6.5% of Primary Service Area adults report a time in the past year when they needed mental health services but were not able to get them.

DISPARITY ► Favorably low in the Other 96150 area. Reported most often among Whites and adults under 65.

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

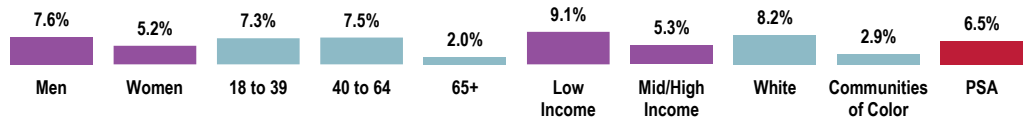
Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unable to Get Mental Health Services
When Needed in the Past Year
(Primary Service Area, 2021)

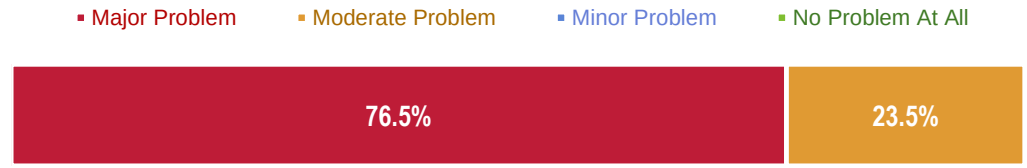


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

Over three in four 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, 2021)



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

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

Access to Care/Services

> Access to services, including therapists and substance use services. – Community Leader
> Access to a doctor, therapists and social workers. – Physician
> Access to care. – Other Health Provider
> No inpatient or intensive outpatient programs here. Lack of mental health professionals. – Other Health Provider
> Lack of behavioral health services. – Community Leader
> Not a lot of resources to refer patients to. – Other Health Provider
> Getting proper care and paying for care. – Community Leader
> Lack of access to mental health care. – Physician
> Not enough access to mental health care. This area is sadly deficient in treatment centers, mental health clinicians and a mental health hospital. There are long wait lists for services. – Community Leader

There are little to no services for adults, and there is only one actual therapist who works with all the schools. Psychiatrist waiting lists are months long. – Other Health Provider

Obtaining treatment full stop and obtaining treatment that is timely and affordable. – Community Leader

Access to initial support, screening and service, especially in "real-time." There is a provider network and the county mental health department, but it seems that the need far outstrips the capacity. – Community Leader

There are a lack of adequate and affordable resources to respond to the mental wellness concerns in our community. – Community Leader

Access to care for all degrees of disease. – Community Leader

No strong system of care. No county investment. – Community Leader

Access to timely care. – Community Leader

Limited resources available locally within the Lake Tahoe Basin. – Community Leader

No access, lack of psychiatry, drug use. – Physician

Access to both long-term and acute care, consistent care. More specifically, getting into therapists is challenging. Having enough and consistent county behavioral health personnel on the East slope of the county is hard. Having timely visits with psychiatrists seems to be a challenge. – Physician

Access to timely care. Wait times from referral to when a client sees a therapist is still too long. Several agencies still have long wait lists. Therapist retention in South Lake Tahoe is a problem. – Social Services Provider

Lack of available substance abuse programs. We have a great new psychiatrist, but he's filling up quickly. – Physician

Inadequate access to psychiatrists, social workers and counselors. Stigma is health care and greater community. – Physician

Access to therapy and psychiatric treatment, access to caregivers. – Physician

Ready access to mental health clinicians. Psychiatry, psychology, and therapy. – Physician

Access to care. – Physician

Lack of Mental Health Providers

The major challenge that I see for people with mental health issues is that there are not enough providers. When a crisis arises, there is no one to offer immediate support. Once the crisis passes, clients are not seeking help until the next crisis. – Social Services Provider

Finding providers (mental health counselors) as there are not enough. For low-income / Medi-Cal there is the possibility to be seen by Behavioral Health but I imagine the wait list is long. Middle-class people on the other hand needs to go through their insurance, however the co-pays are high and many counselors don't take insurance. People therefore often choose not to get help. There is also stigma with getting mental health support, especially among Hispanic families. – Social Services Provider

Insufficient mental health providers of all kinds, especially for children. Lack of therapists, our psychiatrists have long waiting lists. – Physician

Resources for youth are limited. AOD services are limited for adults with mental health issues. – Social Services Provider

Awareness/Education

Awareness of local services, access to local mental health providers. – Other Health Provider

Knowing who to call and where to go for help. Not to mention, how to pay for it. – Other Health Provider

Awareness of and assistance in accessing low-barrier services. Many of our clients face significant mental health issues, compounded trauma, and co-occurring disorders. These multiple challenges make navigating health systems more difficult, and know what services are available can be prohibitive. In addition, many of our clients do not have cell phones, stable mailing addresses or living situations, or cannot arrange for transportation to services. Providing services where people are - in encampments, at SRO motels, with partner organizations, etc. – would help overcome access issues, as would communicating services available and tips for navigating insurance and appointment scheduling. – Community Leader

Contributing Factors

Lack of affordable counseling/therapy services. Lack of enough mental health providers (psychiatry) leading to long wait times. Additional strains of COVID in the community, balancing working from home/unemployment, distance learning for kids. Drug/Alcohol use as coping mechanism. Lack of affordable housing leading to life stressors. – Physician

Access to mental health services, including cost and providers, bilingual mental health providers, support for young people. – Community Leader

> Homelessness is certainly a factor - more people are being priced out of housing, and the pandemic has worsened this with minimum wage workers suffering loss of income. A shortage of social services workers who serve low to no income populations. Stigma is still a big deterrent in seeking assistance for mental health issues. – Community Leader

COVID-19

> Physical isolation is a key risk factor. The economic downturn has impacted individuals and families, causing major stress at all levels. – Public Health Representative
>
> Being isolated, especially in winter is always hard, but it has been a long 9 months of COVID isolation compounding this problem. In addition, our kids not being in school, with friends, teachers and the social environment that provides is extremely challenging and likely impacting our youth negatively. Not being able to access care due to COVID rules exacerbates the problem. – Community Leader

Homelessness

> Homelessness. – Social Services Provider
>
> Homelessness, substance abuse, lack of access to therapists. – Other Health Provider

Affordable Care/Services

> We have several children and families that suffer with mental health issues. We have resources to send them to, but it is sometimes a challenge with payments. – Social Services Provider
>
> Access to affordable mental health services and mental health professionals. – Social Services Provider

Insurance Issues

> Health insurance companies not paying providers enough and not making it easy to get reimbursed if they reimburse at all. Having in the past taken insurance, I know that it takes an entire position to call and follow up with health insurance companies that purposely create many barriers to not reimburse providers and if they do their rates are so low it is not worth it or feasible to accept. This leaves providers not willing to take health insurance. Many people are above the Medi-Cal line but don't make enough to pay for out of pocket providers leaving them in an abyss of accessibility. – Social Services Provider

Incidence/Prevalence

> There is a large number of patients that experience depression, anxiety, PTSD, and other mental health needs. Adult psychiatry and mental health services that can be billed to medical insurance are needed. – Community Leader

Diagnosis/Treatment

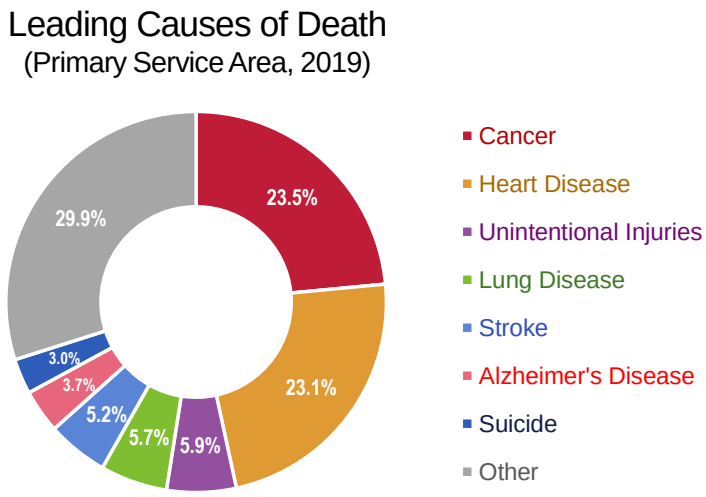
> Lack of a diagnosis. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, cancer and heart disease accounted for nearly one-half of all deaths in the Primary Service Area in 2019.



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 2021.

Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

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

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

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

The following chart outlines 2017-2019 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Primary Service Area.

Each of these is discussed in greater detail in subsequent sections of this report.

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

Age-Adjusted Death Rates for Selected Causes

(2017-2019 Deaths per 100,000 Population)

	Eastern El Dorado County*	El Dorado County (CA)	Douglas County (NV)	Primary Service Area	CA	NV	US	HP2030
Diseases of the Heart	155.9	127.6	129.9	**128.9**	139.8	196.0	163.4	127.4**
Malignant Neoplasms (Cancers)	78.8	127.1	132.7	**128.0**	134.4	150.3	149.3	122.7
Falls [Age 65+]	—	52.6	—	**52.2**	40.6	67.4	65.1	63.4
Unintentional Injuries	27.7	44.9	39.3	**43.8**	34.2	46.8	48.9	43.2
Chronic Lower Respiratory Disease (CLRD)	44.0	35.6	32.5	**35.0**	30.7	48.9	39.6	—
Cerebrovascular Disease (Stroke)	33.0	26.9	37.9	**29.4**	37.3	36.8	37.2	33.4
Alzheimer's Disease	17.5	27.5	15.6	**24.6**	37.1	24.2	30.4	—
Intentional Self-Harm (Suicide)	9.6	16.3	35.6	**20.0**	10.7	20.3	14.0	12.8
Cirrhosis/Liver Disease	20.1	14.2	18.4	**14.9**	12.2	13.5	11.1	10.9
Motor Vehicle Deaths	11.0	14.9	—	**13.9**	9.7	10.3	11.3	10.1
Unintentional Drug-Related Deaths	23.9	13.8	—	**13.3**	11.8	17.5	18.8	—
Diabetes	15.4	12.2	14.0	**12.5**	21.8	20.2	21.5	—
Firearm-Related	7.2	9.2	17.9	**11.0**	7.5	16.6	11.9	10.7
Pneumonia/Influenza	10.3	10.4	10.3	**10.4**	14.2	16.3	13.8	—
Kidney Disease	—	5.1	11.9	**6.7**	8.8	8.9	12.9	—
Homicide/Legal Intervention	1.3	—	—	**3.7**	4.8	6.9	6.1	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

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

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

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

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

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

Age-Adjusted Heart Disease & Stroke Deaths

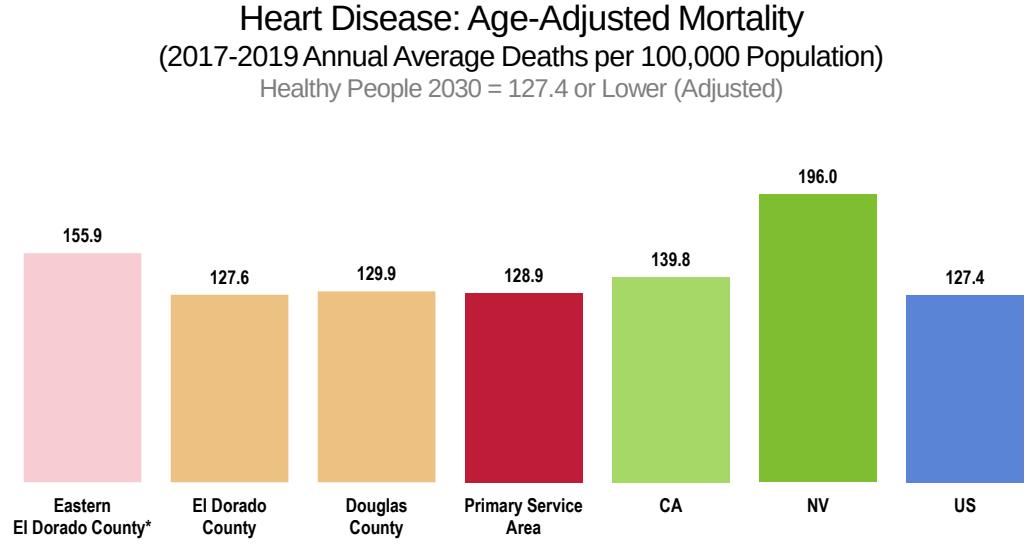
Heart Disease Deaths

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

Between 2017 and 2019, there was an annual average age-adjusted heart disease mortality rate of 128.9 deaths per 100,000 population in the Primary Service Area.

BENCHMARK ► Well below the California and Nevada (especially) death rates.

DISPARITY ► Higher in Eastern El Dorado County (2016-2019 data).



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 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	142.9	139.4	141.6	135.6	136.9	134.2	129.8	128.9
CA	158.1	154.7	149.1	146.5	143.6	143.9	141.9	139.8
NV	195.4	194.6	194.9	197.7	201.3	202.0	198.6	196.0
US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Stroke Deaths

Between 2017 and 2019, there was an annual average age-adjusted stroke mortality rate of 29.4 deaths per 100,000 population in the Primary Service Area.

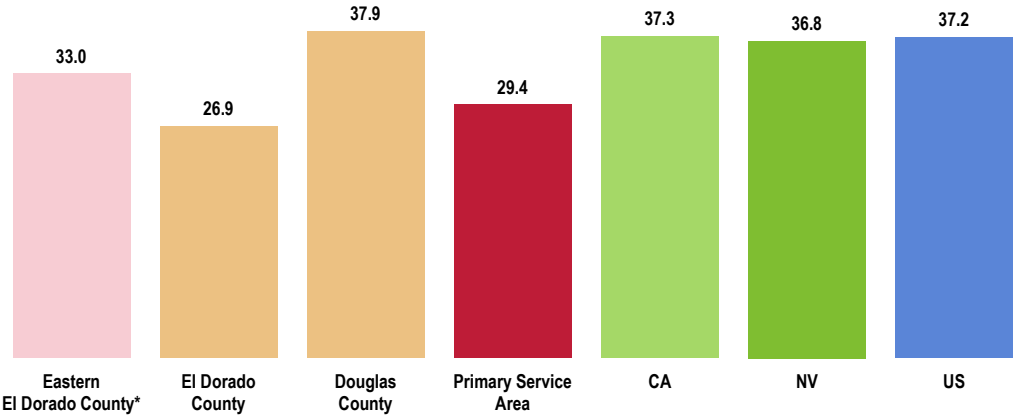
BENCHMARK ► Lower than the state and national rates.

DISPARITY ► The death rate is higher in Douglas County, as well as Eastern El Dorado County.

Stroke: Age-Adjusted Mortality

(2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

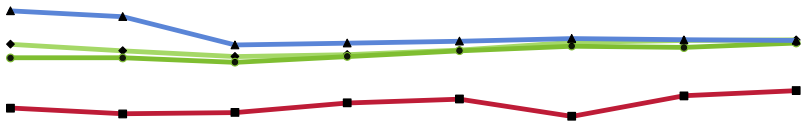


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	26.7	25.8	26.0	27.5	28.1	25.4	28.6	29.4
CA	36.6	35.6	34.7	35.0	35.7	36.9	37.2	37.3
NV	34.5	34.5	33.8	34.7	35.6	36.3	36.1	36.8
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

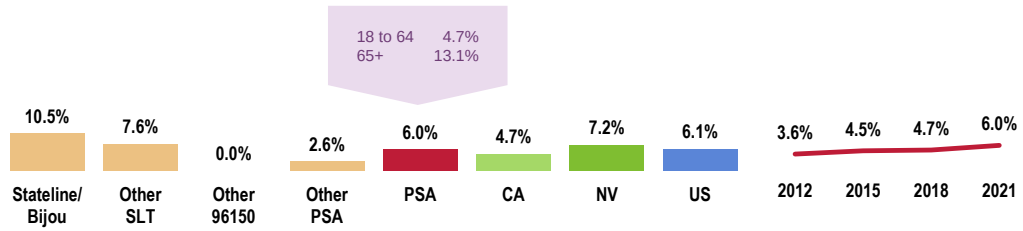
A total of 6.0% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

TREND ► The increase over time is not yet statistically significant.

DISPARITY ► Unfavorably high in the Stateline/Bijou community. Correlates with age among survey respondents.

Prevalence of Heart Disease

Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

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

Prevalence of Stroke

A total of 5.5% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

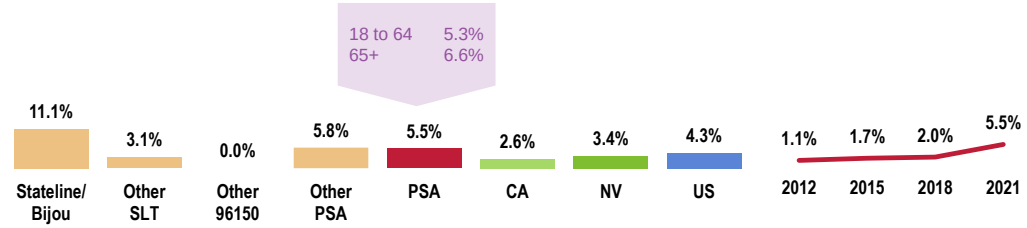
BENCHMARK ► Worse than the California prevalence.

TREND ► Denotes a statistically significant increase since 2012.

DISPARITY ► Unfavorably high in the Stateline/Bijou community.

Prevalence of Stroke

Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

A total of 30.4% of Primary Service Area adults have been told by a health professional at some point that their blood pressure was high.

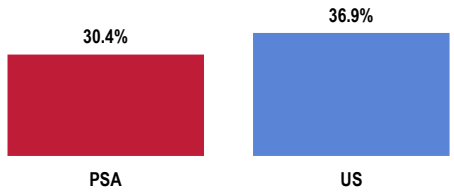
BENCHMARK ► Lower than the national prevalence.

DISPARITY ► Unfavorably high in the Stateline/Bijou community (not shown).

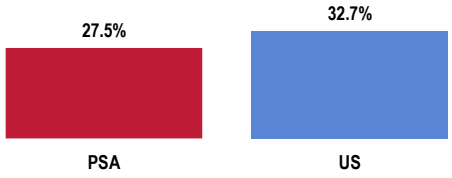
A total of 27.5% of adults have been told by a health professional that their cholesterol level was high.

Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower



Prevalence of High Blood Cholesterol

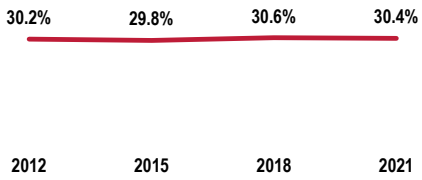


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 35, 36]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

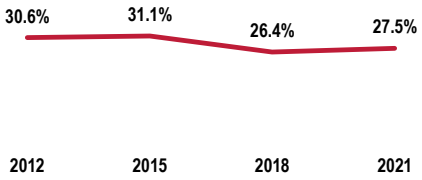
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure (Primary Service Area)

Healthy People 2030 = 27.4% or Lower



Prevalence of High Blood Cholesterol (Primary Service Area)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 35, 36]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

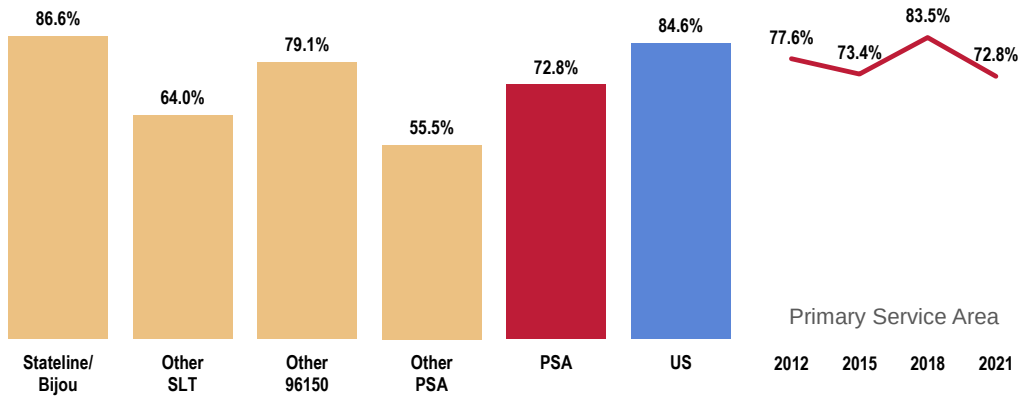
A total of 72.8% of Primary Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

BENCHMARK ► Well below the US prevalence.

DISPARITY ► Unfavorably high in the Stateline/Bijou community. Reported more often among men, older residents, and Communities of Color.

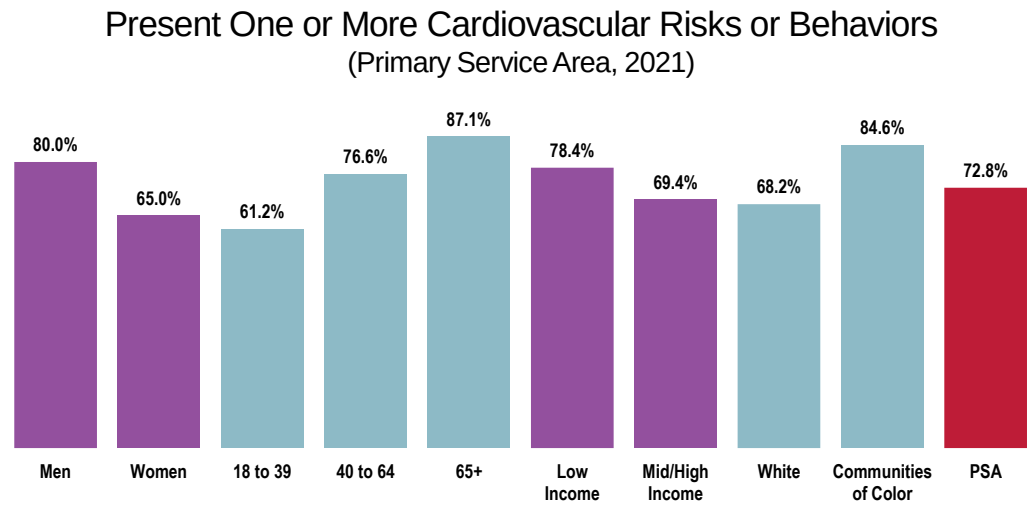
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Present One or More Cardiovascular Risks or Behaviors



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

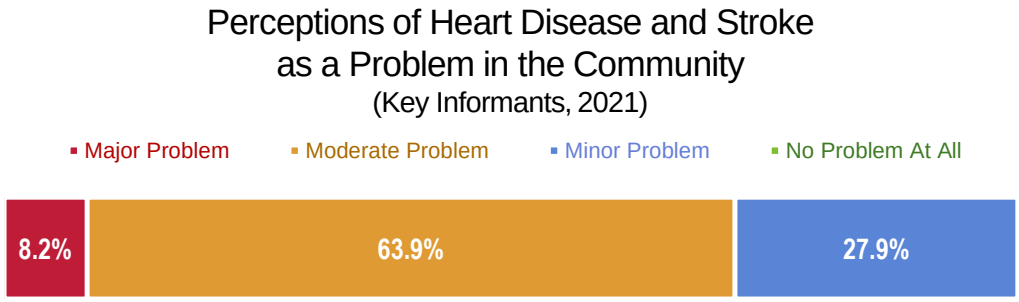
Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 115]
Notes: ● Reflects 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) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

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



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

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

Lack of Local Care

> We don't have the ability to care for heart or stroke patients. – Social Services Provider
>
> Most people have to be flown out for stroke or heart attack. – Social Services Provider

Environmental Contributors

> Altitude possibly, lifestyle, and hereditary diseases. – Social Services Provider

Incidence/Prevalence

> Major problem in the United States. – Community Leader

CANCER

ABOUT CANCER

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

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

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

Age-Adjusted Cancer Deaths

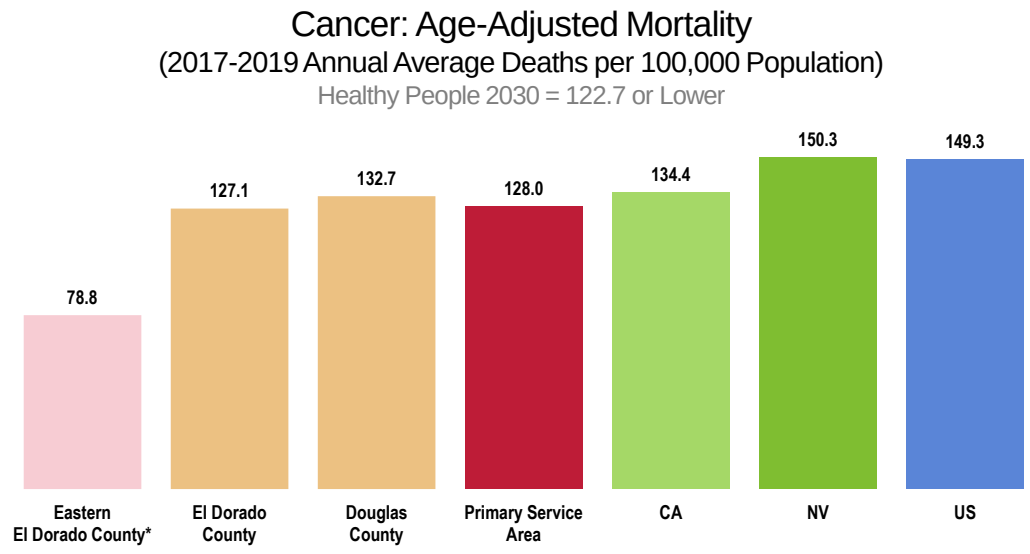
All Cancer Deaths

Between 2017 and 2019, there was an annual average age-adjusted cancer mortality rate of 128.0 deaths per 100,000 population in the Primary Service Area.

BENCHMARK ► Lower than the Nevada and US mortality rates.

TREND ► Note the decreasing trend over the past decade.

DISPARITY ► Notably lower in Eastern El Dorado County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	149.0	144.4	138.6	143.1	139.9	135.2	129.1	128.0
CA	153.2	149.9	147.3	144.6	142.2	139.7	137.1	134.4
NV	169.3	166.1	164.2	162.1	159.7	156.6	153.0	150.3
US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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, female breast cancer, and colorectal cancer (both sexes).

BENCHMARK

Lung Cancer ► Lower than the Nevada and US rates.

Female Breast Cancer ► Lower than both states as well as the US.

Colorectal Cancer ► Well below the Nevada mortality rate. Fails to satisfy the Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site

(2017-2019 Annual Average Deaths per 100,000 Population)

	Eastern El Dorado County*	Primary Service Area	CA	NV	US	HP2030
ALL CANCERS	78.8	128.0	134.4	150.3	149.3	122.7
Lung Cancer	34.3	23.0	25.1	34.7	34.9	25.1
Prostate Cancer	21.1	19.8	19.4	19.1	18.6	16.9
Female Breast Cancer	7.5	14.3	19.0	22.0	19.7	15.3
Colorectal Cancer	19.3	11.8	12.3	14.6	13.4	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Incidence

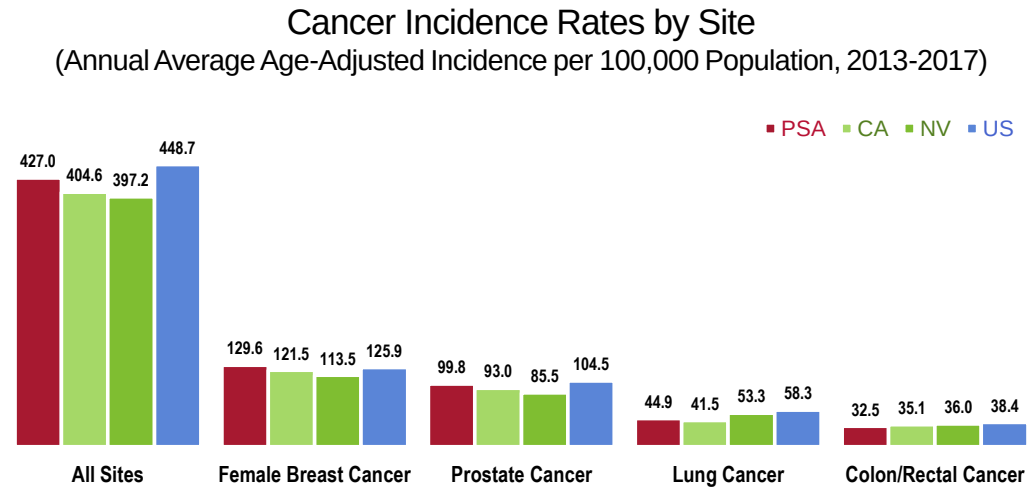
"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

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

BENCHMARK

Lung Cancer ► Lower than both state and national rates.

Colorectal Cancer ► Lower than the national rate.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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

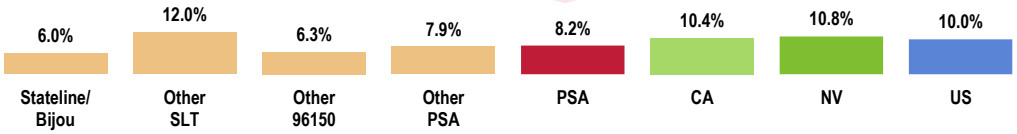
A total of 8.2% of surveyed Primary Service Area adults report having ever been diagnosed with cancer. The most common types include skin cancer, prostate cancer, and breast cancer.

DISPARITY ► Correlates with age and is reported more often among Whites in the service area.

Prevalence of Cancer

The most common types of cancers cited locally include:

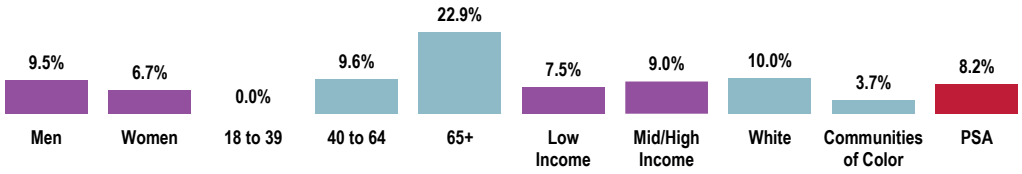
1) Skin Cancer 27.0%
2) Prostate Cancer 14.8%
3) Breast Cancer 11.9%



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Prevalence of Cancer
(Primary Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 25]

Notes:
- Reflects all respondents.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

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

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

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

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.
Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear/HPV testing); and colorectal cancer (colonoscopy/sigmoidoscopy and fecal occult blood testing).

FEMALE BREAST CANCER

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

CERVICAL CANCER

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

COLORECTAL CANCER

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

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

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

Among women age 50-74, 68.1% have had a mammogram within the past 2 years.

BENCHMARK ► Lower than the California screening prevalence. Fails to satisfy the Healthy People 2030 objective.

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

Among Primary Service Area women age 21 to 65, 71.1% have had appropriate cervical cancer screening.

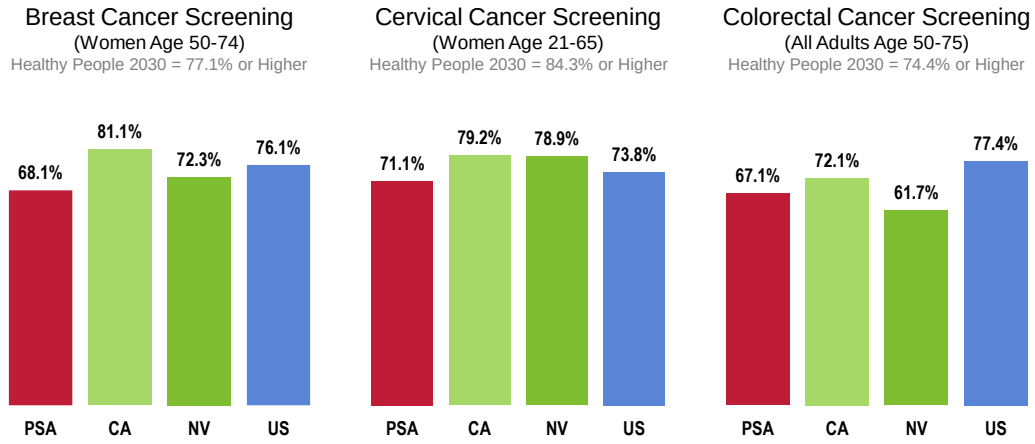
BENCHMARK ► Lower than the California screening prevalence. Fails to satisfy the Healthy People 2030 objective.

Among all adults age 50-75, 67.1% have had appropriate colorectal cancer screening.

BENCHMARK ► Lower than the national prevalence. Fails to satisfy the Healthy People 2030 objective.

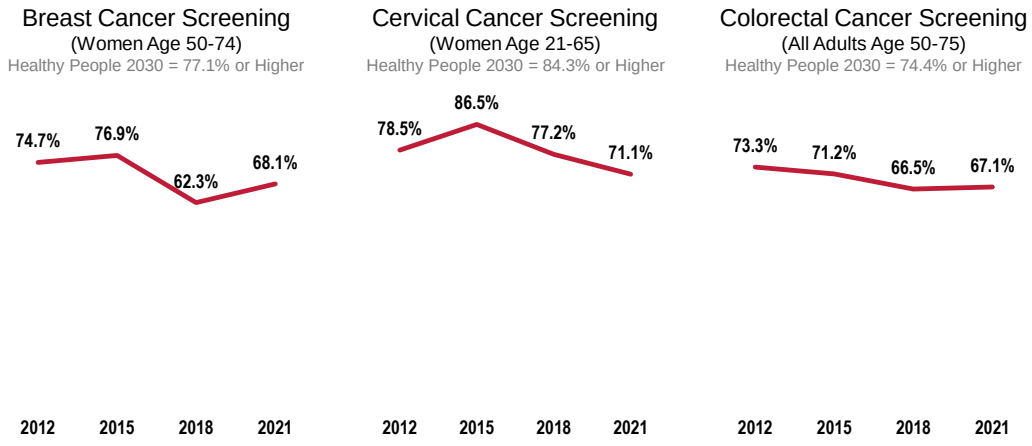
DISPARITY ► Unfavorably low in the Stateline/Bijou community (not shown).

year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 116, 117, 118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

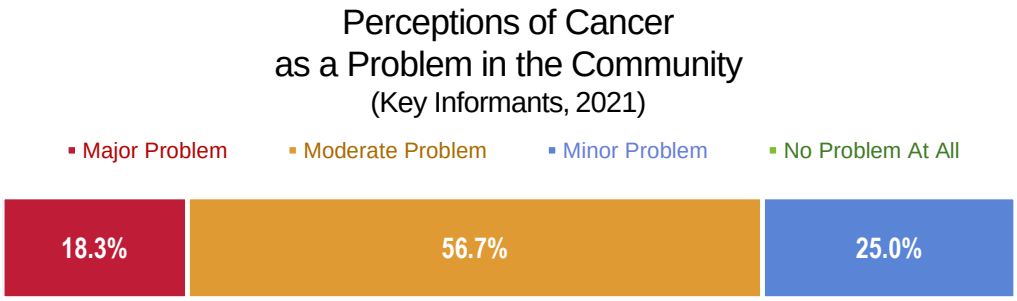
Notes:
- Each indicator is shown among the gender and/or age group specified.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 116, 117, 118]
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: ● Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

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



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

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

Lack of Local Care

> Lack of specific treatments locally. Families must travel out of town for specific cancer diagnosis and treatments. – Social Services Provider
>
> Very few facilities can deal with this. You would have to travel to Truckee and in the winter, it is very hard to do. Barton should have the ability to deal with this, but they tried and failed. – Social Services Provider
>
> No direct care or providers to do treatment in community. – Physician
>
> No oncology services. – Physician
>
> My understanding is that patients need to be transported and/or travel to other communities to have access to a full spectrum of cancer care. – Other Health Provider
>
> No real cancer services such as chemotherapy and radiation. – Other Health Provider
>
> We don't have oncology here, we can't provide most cancer infusions. Patients have to travel off the hill or to Truckee to get infusions. This is really hard on families. – Other Health Provider
>
> South Lake Tahoe does not have a major cancer treatment facility, so those suffering from cancer typically go off the hill for treatment or to the cancer center in Truckee. – Community Leader
>
> Ease of access to care for individuals that do not have a PPO health coverage. – Community Leader

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

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

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

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

Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

Note: Chronic lower respiratory disease (CLRD) includes lung diseases such as emphysema, chronic bronchitis, and asthma.

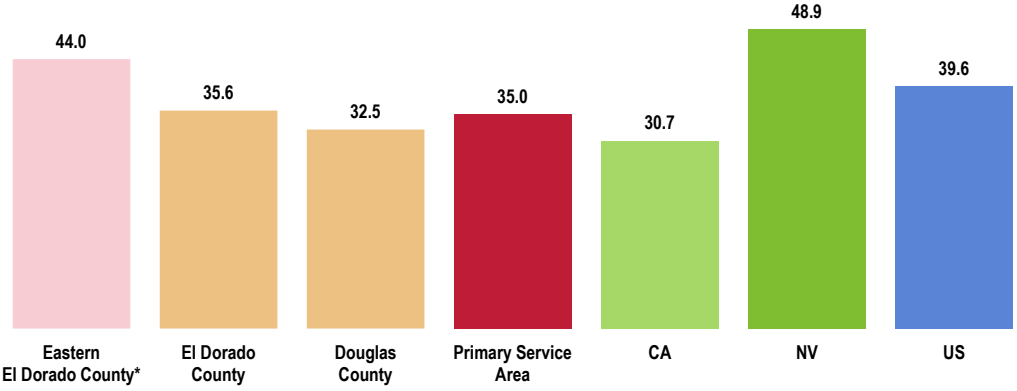
Between 2017 and 2019, there was an annual average age-adjusted CLRD mortality rate of 35.0 deaths per 100,000 population in the Primary Service Area.

BENCHMARK ► Well below the Nevada mortality rate.

TREND ► Note the decreasing trend over the past decade.

DISPARITY ► Notably higher in Eastern El Dorado County.

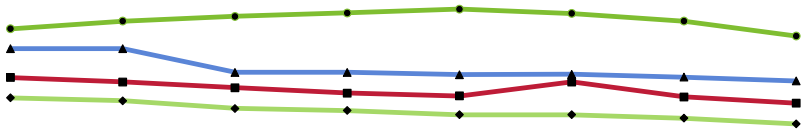
CLRD: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019

Notes:
- CLRD is chronic lower respiratory disease.

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	40.3	39.4	38.2	37.1	36.5	39.4	36.3	35.0
CA	36.1	35.5	33.9	33.5	32.6	32.6	31.9	30.7
NV	50.4	52.0	53.0	53.7	54.5	53.6	52.0	48.9
US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
Notes: ● CLRD is chronic lower respiratory disease.

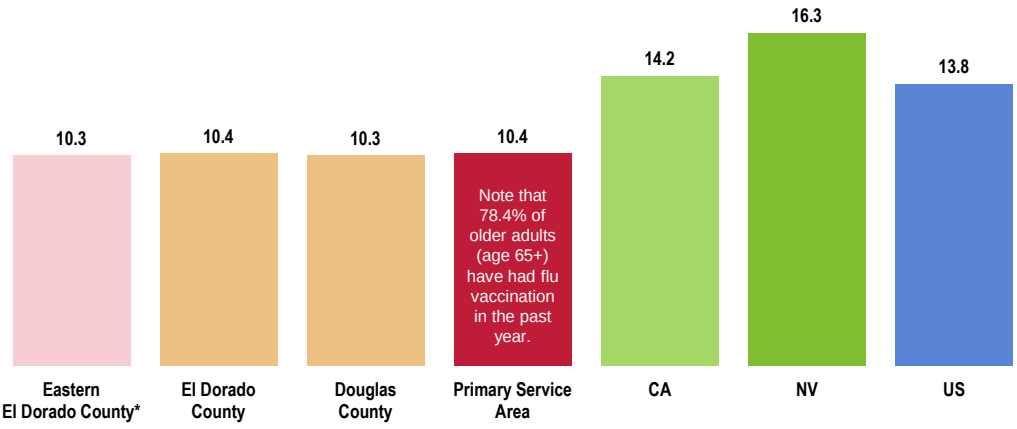
Pneumonia/Influenza Deaths

Between 2017 and 2019, the Primary Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 10.4 deaths per 100,000 population.

BENCHMARK ► Well below the state and national mortality rates.

TREND ► Decreasing in recent years.

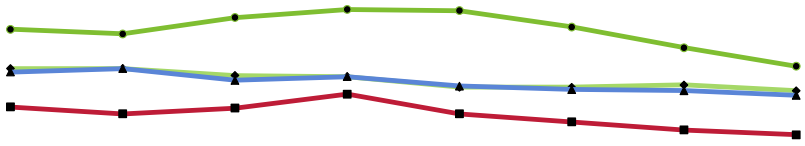
Pneumonia/Influenza: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
● *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	12.8	12.2	12.7	13.9	12.2	11.5	10.8	10.4
CA	16.1	16.1	15.5	15.4	14.5	14.5	14.7	14.2
NV	19.5	19.1	20.5	21.2	21.1	19.7	17.9	16.3
US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.

Prevalence of Respiratory Disease

Asthma

Adults

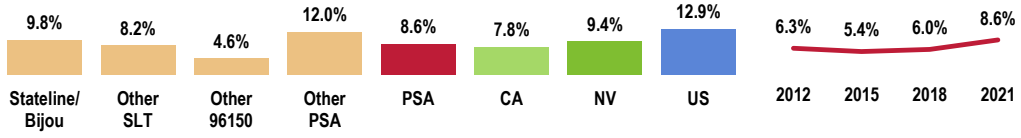
Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

A total of 8.6% of Primary Service Area adults currently suffer from asthma.

BENCHMARK ► Lower than the national percentage.

Prevalence of Asthma

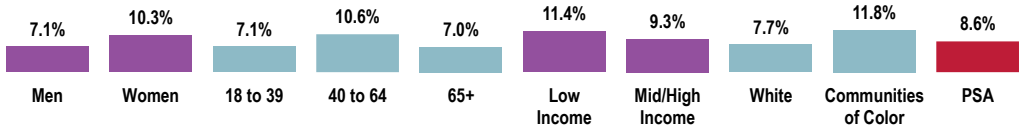
Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

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

Prevalence of Asthma
(Primary Service Area, 2021)



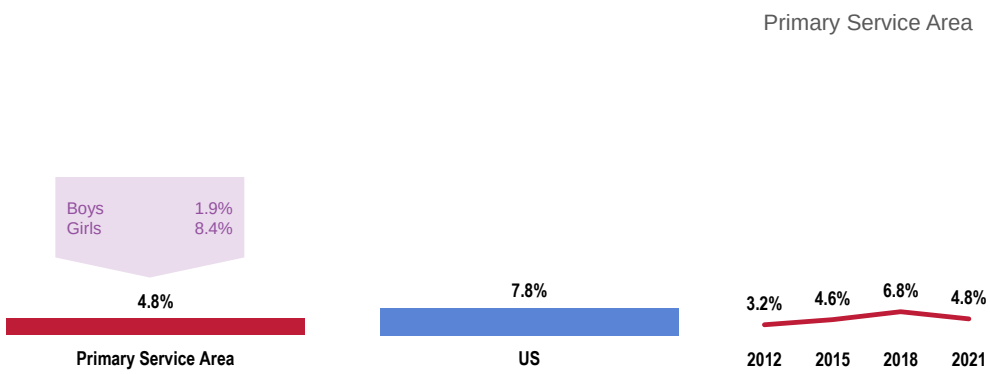
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: ● Asked of all respondents.
● Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Children

Among Primary Service Area children under age 18, 4.8% currently have asthma.

DISPARITY ► Higher among service area girls than boys.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 120]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.
● Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

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

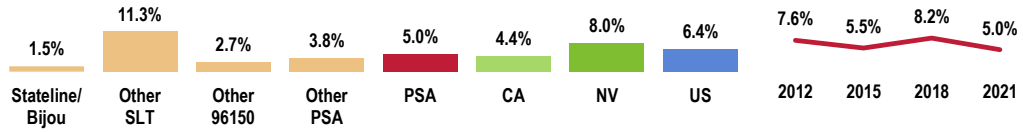
A total of 5.0% of Primary Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

BENCHMARK ► Lower than the Nevada percentage.

DISPARITY ► Unfavorably high in the Other SLT community.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Primary Service Area



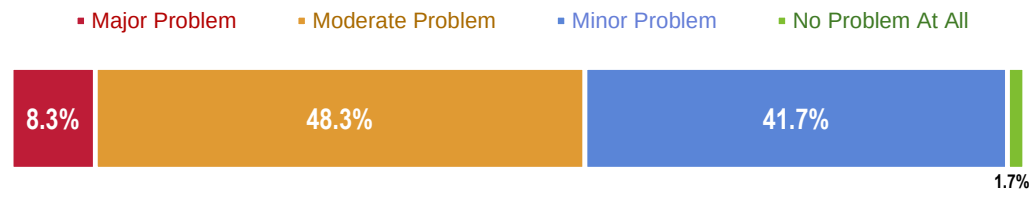
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

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, 2021)



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

Notes:
- Asked of all respondents.

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

Environmental Contributors

> Climate change is going to have significant effects on everyone's health sooner or later. While Tahoe is less likely than other places to have direct health harms from temperature swings, over time, it could become an issue even here. More risky in the short-term, however, are the effects from increased wildfires which can include very unhealthy air quality even from fires that occur many miles away, but also disruption in housing that could occur if a fire like the Angora fire were to recur. Fires and smoke also significantly harm local economies which secondarily harm people's health though economic hardship such as loss of employment or other income sources. – Social Services Provider
>
> Altitude, control burns, and diet. – Social Services Provider
>
> High altitude, no pulmonary expert. – Physician

Contributing Factors

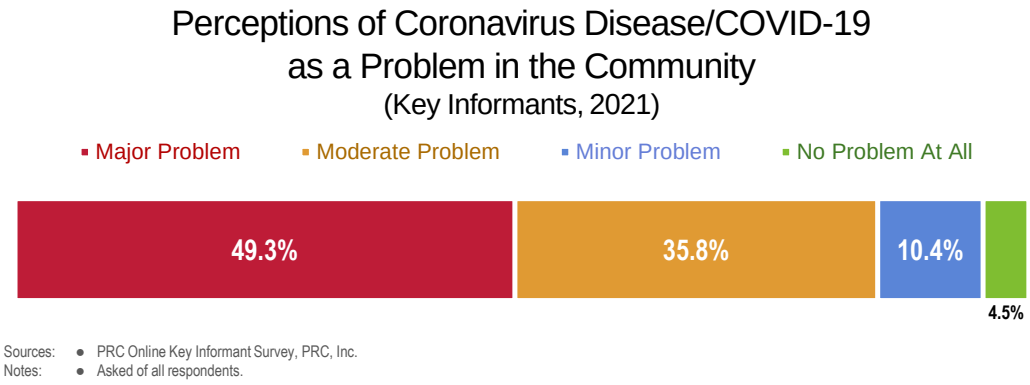
> Weather-related illness and injuries. We have several hundred unsheltered adults in our community, and many unsheltered children and families who suffer from serious respiratory illnesses, pneumonia, flu, hypothermia, frostbite, amputations, lack of sleep, alcoholism, substance use, poor health outcomes, poor school and work performance, and crimes of poverty. The Tahoe winter weather is often severe and represents one of the major preventable burdens on the emergency medical system, including Barton, Fire, PD, TCH, and others. – Community Leader
>
> Long-term effects of COVID infection, cigarette smoking, and vaping. – Other Health Provider

Lack of Providers

> Community does not have a pulmonologist. – Community Leader

Key Informant Input: Coronavirus Disease/COVID-19

The greatest share of key informants taking part in an online survey characterized *Coronavirus Disease/COVID-19* as a "major problem" in the community.



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

Incidence/Prevalence

> Over 500,000 Americans have died. – Community Leader
>
> Our coronavirus numbers have consistently been some of the highest in our County. Access to COVID vaccines has been very limited. Our community serves a tourist based economy. Many of the workers in our community (split between the COVID regulations of California/Nevada) have been forced to work throughout the pandemic if they want to keep their jobs and support their households. As a result, community members are facing greater potential exposure to COVID infection. – Community Leader

COVID-19 is a major problem everywhere. While our hospital has done an excellent job taking care of its employees and the community, our community has been negatively impacted by the virus. Our essential workers, including grocery clerks, front line employees, etc. need to be vaccinated faster. I'm so thankful the hospital staff has been vaccinated and now teachers are, but we need more vaccines! We also have a high tourism population during certain times of the year and given how easily transmissible the virus is, it is no surprise that many local workers have been exposed. – Community Leader

Obviously COVID is, but it's a pandemic and everyone is trying to work on this. This is front-row-center and hopefully fleeting in years to come. – Other Health Provider

I believe that the Coronavirus is a major problem because it is affecting the lives of people with low and limited resources who are unable to work remotely and they live in a home with two or sometimes three families. – Social Services Provider

Throughout most of the pandemic, South Lake Tahoe has experienced the highest rates of COVID-19 in the county and at times some of the highest rates in the state or US, likely due to its many visitors. The casinos in Douglas County that entertain, feed, and house guests almost exclusively indoors are particularly concerning because they often involve drinking alcohol and other activities that result in risk taking. It is hard to adequately protect all workers in those settings. People often gather in South Lake Tahoe after having come from multiple households and geographic locations, creating opportunities for disease transmission. Resort communities may serve as hubs for introduction and dissemination of new strains, both to their own community members and too far away communities whose residents visited South Lake Tahoe. Additional concerns are that because some front-line tourism-industry workers live in crowded, possibly multigenerational homes, they and their household members may be at extra risk. – Social Services Provider

Although recent trends in our community are heading in the right direction, this single issue affects all social and economic levels and has been almost impossible to predict. – Community Leader

High rates of transmission. – Community Leader

Just looking at our numbers, this has been a major issue. Also because the availability of ICU beds is so few for our community. – Community Leader

Tourist Community

We are a destination for many outside of our community and frankly, they aren't as careful as they are on "vacation." – Community Leader

Our community's economic driver is tourism and visitors. A large segment of the work force that serves this tertiary economy is engaged in a situation that demands them working even when exposed or feeling COVID symptoms themselves. There is also a deep concern that our community has not done enough to track visitors and their potential for COVID transmission. I would urge Barton and the city and county to look at models like Aspen, CO.... – Community Leader

Visitor impact on our community is huge. – Public Health Representative. –

Due to the large volume of tourists coming from multiple places, some of which are hot spots. – Social Services Provider

The Tahoe community is has tourist driven economy, thus, many workers in the grocery stores, hotels, casinos, restaurants and ski resorts are exposed continually and have become sick or their family members become sick. Yet, many of our community members who work in these places lack health insurance. – Social Services Provider

Because we are a tourist attraction. We don't take very good precautions. There are too many people up here all the time. We are careless. – Social Services Provider

South Lake Tahoe in particular is a vibrant, sports oriented community with high tourism. Amongst this population, having to restrict how one goes about interacting with others is not a very welcomed prospect. This population tends to disregard safety guidelines. In the larger El Dorado Community, a more conservative attitude prevails, which also leads to parts of the population ignoring safety guidelines. – Social Services Provider

Contributing Factors

Homelessness, depression, and students who are now "missing in action" with distance learning. Our schools have been online and many in our community are not accounted for. We currently have stepped up as a community in providing a path to housing and it's commendable. Many people have lost jobs and the economic situation adds to the depression of many. And I'm concerned with the kids we have lost in this whole situation. Teen depression and suicide continue to weigh on the minds of many. – Community Leader

Many people are not vaccinated and are going to work due to being an essential worker, therefore spreading the virus. – Social Services Provider

There is not consistent approaches to the Public Health management of this disease, additionally there is a stigma associated with having COVID-19 and the community has a much higher exposure rate due to the tourism industry. The undocumented workers in our community and those who do not speak English are especially vulnerable to not seeking care. – Other Health Provider

> Mixed messages in the paper, online, and at the health department about when the vaccine is available, who gets it first, etc. There is a segment of our population who have no access to computers, have language issues and basically are people of low income and of color who don't trust authority. They are afraid to ask for help. – Community Leader

Work Related

> The service industry workers who are forced to work in unsafe conditions. The business owners in many cases do not enforce the California and CDC guidelines for safety i.e.: customers are still served if they refuse to wear masks. Employers are not supplying PPEs. The Latinx community is impacted at a greater percentage due to the fact that many are working in minimum wage jobs, are living with extended or multiple families, if they are COVID-19 positive they are forced to quarantine in the house or apartment that is limited in space. This exposes the remaining all family members to COVID. – Community Leader
>
> There are a lot of frontline jobs in this community and an endless stream of people coming here and not following infection control guidelines. Many frontline workers live in multigenerational households, leading to secondary exposure of high risk individuals. – Physician
>
> I think one of the major factors is being on the border with Nevada where there are less safety protocols and the Casinos. I am aware of many restaurant employees who have gotten COVID one or two times due to the lack of protocols and safety measures being taken. I also am aware of many gatherings that are continuing to happen within families, friends, and community members—especially with those in their 20s who are still having house gatherings/parties of definitely more than 10 and not using social distancing or safety protocols. – Social Services Provider

Access to Care/Services

> We have a small ICU and hospital, lack of vaccine, lack of appointments for vaccinations, and many fear this vaccine. Also, people travel here from all over the world, bringing their diseases with them. I see many tourists not following proper social distancing and not wearing masks. – Other Health Provider
>
> The Coronavirus has impacted several areas of our community, including equitable access to health services, unemployment, inability to access community services, the digital divide, and mental health. – Community Leader
>
> In the past, our positivity rate was quite high and we have limited resources to take care of these patients. – Physician

Vulnerable Populations

> A lot of undocumented and low-income families are dependent on day-to-day jobs. If they can't work as they have to quarantine or because employment is not available or because to have to stay home to take care of their children (as childcares and schools might be closed), they don't have enough income for rent, food, health etc. – Social Services Provider

Economy

> Businesses closed or failing, families split apart from death and financial strain, domestic violence is up, and mental illness and suicide are rising. – Other Health Provider

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

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

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

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

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

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2017 and 2019, there was an annual average age-adjusted unintentional injury mortality rate of 43.8 deaths per 100,000 population in the Primary Service Area.

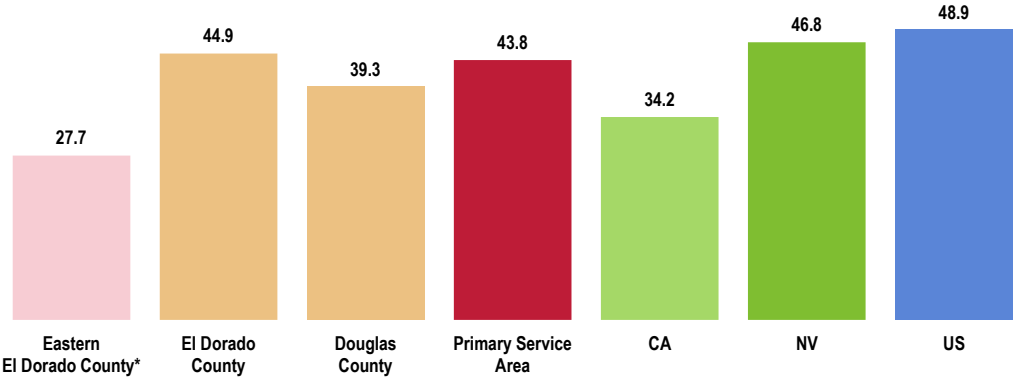
BENCHMARK ► Well above the California mortality rate.

DISPARITY ► The Eastern El Dorado County rate is much lower.

Unintentional Injuries: Age-Adjusted Mortality

(2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower

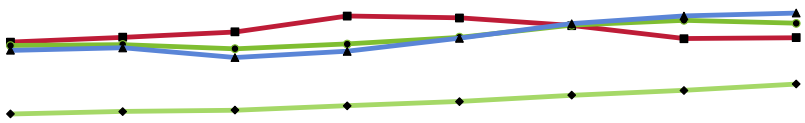


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	42.9	43.9	45.0	48.3	47.9	46.3	43.6	43.8
CA	28.0	28.5	28.8	29.7	30.6	31.9	32.9	34.2
NV	42.2	42.4	41.5	42.5	43.9	46.4	47.4	46.8
US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

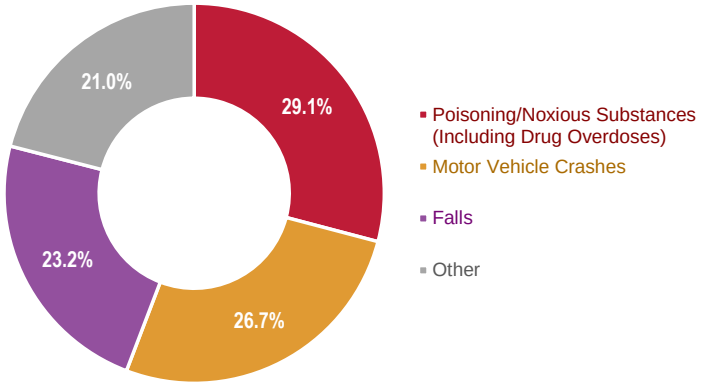
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

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

Poisoning (including unintentional drug overdose), motor vehicle crashes, and falls accounted for most unintentional injury deaths in the service area between 2017 and 2019.

Leading Causes of Unintentional Injury Deaths
(Primary Service Area, 2017-2019)



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 2021.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

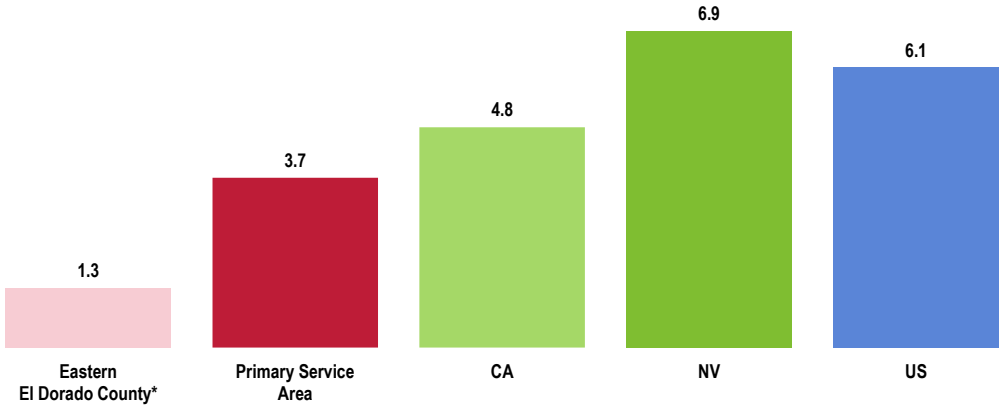
In the Primary Service Area, there were 3.7 homicides per 100,000 population (2017-2019 annual average age-adjusted rate).

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

BENCHMARK ► Well below the state and US rates. Satisfies the Healthy People 2030 goal.

DISPARITY ► Comparatively low in Eastern El Dorado County.

Homicide: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Violent Crime

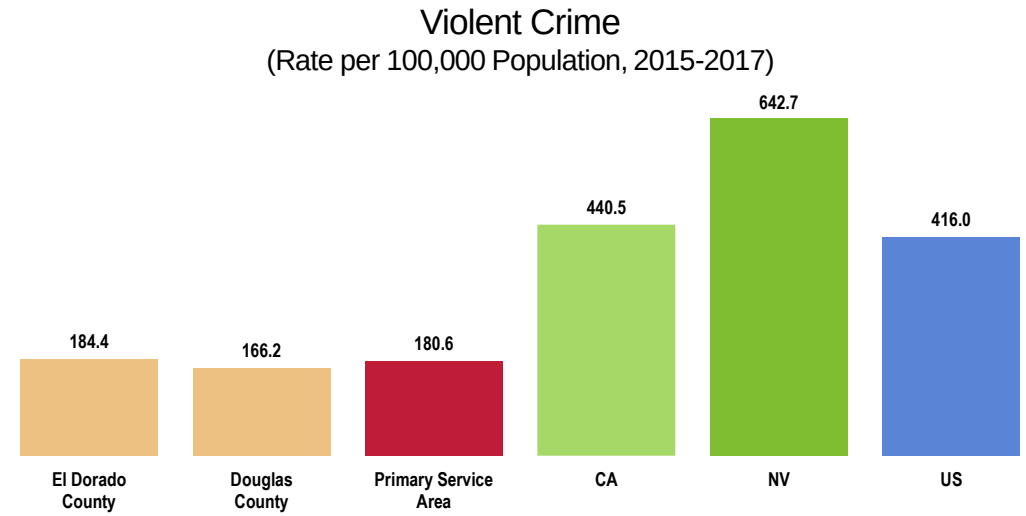
Violent Crime Rates

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

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

Between 2015 and 2017, there were a reported 180.6 violent crimes per 100,000 population in the Primary Service Area.

BENCHMARK ► Well below the state and national crime rates.



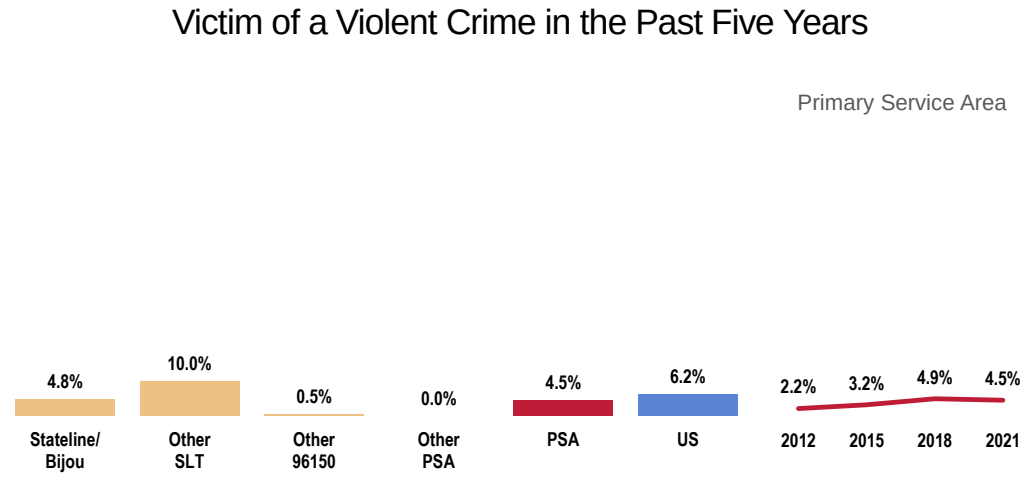
Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

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

Community Violence

A total of 4.5% of surveyed Primary Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

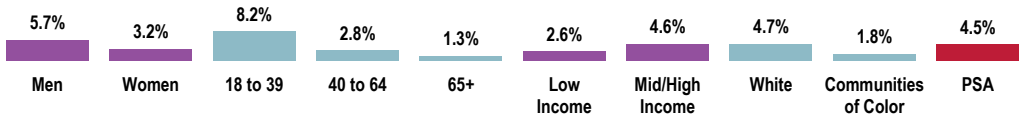
DISPARITY ► Considerably higher in the Other SLT community. Strong correlation with age.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Victim of a Violent Crime in the Past Five Years
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
Notes: ● Asked of all respondents.

Family Violence

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

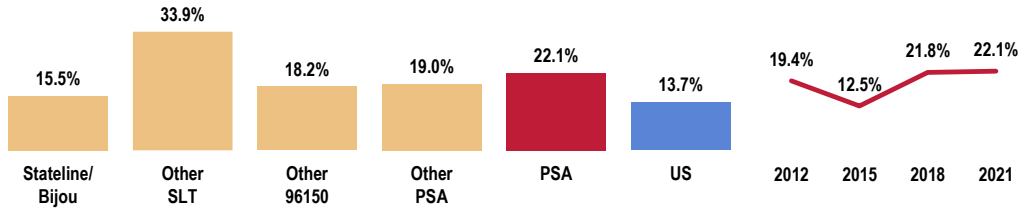
A total of 22.1% of Primary Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

BENCHMARK ► Much higher than the national prevalence.

DISPARITY ► Unfavorably high in the Other SLT community.

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

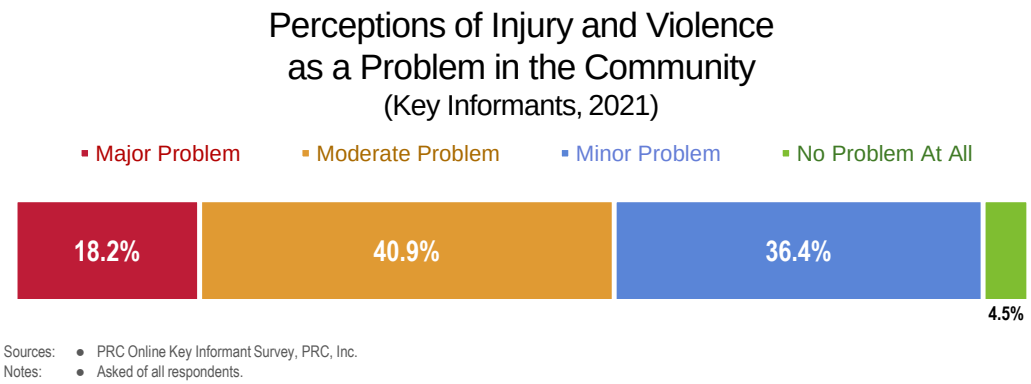
Primary Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 39]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

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



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

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

Domestic Violence

> Because of the present day issues with COVID-19 and stay at home orders, domestic violence and the abuse of drugs and alcohol, violence is climbing. – Social Services Provider
>
> We have several families who have suffered from spousal abuse. – Social Services Provider
>
> I frequently read about domestic violence incidents in our community in the local media and hear from those I know who work at area social service agencies that deal with these issues. I'm also aware we have an element of gang violence in our community, perhaps not to the extent of more urban areas, but a problem here nonetheless. Additionally, I understand we are an area with a significant sex trafficking problem, particularly with young women being taken for such trafficking in other locations. – Community Leader
>
> With COVID, domestic violence issues have increased. I have firsthand knowledge of this issue. For injury issues: weather related car accidents, skiing accidents, and boating accidents. – Community Leader

Incidence/Prevalence

> Providers and staff have discussed the volume of patients who experience injury or violence and seek mental health for PTSD. – Community Leader
>
> Reported through community advocacy groups that sexual violence and assault have increased, as well as concerns regarding violence toward children, throughout the pandemic. – Community Leader
>
> Violence impacts all segments of our community. – Community Leader

Sport-Related Injuries

> We live in a very active community with lots of physical injuries. We don't have a lot of violence per capita. – Community Leader
>
> Injury due to the large numbers who engage in outdoor sports. So skiing injuries, climbing, mountain biking etc. Have no data to support it but my understanding is that domestic violence has increased during lockdown; and we have a number of staff and members of the Club who are victims of domestic violence, online bullying and other forms of mistreatment (physical or mental). – Community Leader

Contributing Factors

> Active community and lack of support services for drug/substance abuse. – Physician
>
> High cost of living, 24-hour town with many negative influences. No place for the nondrinking crowd to hang out in a safe environment. – Community Leader

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

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

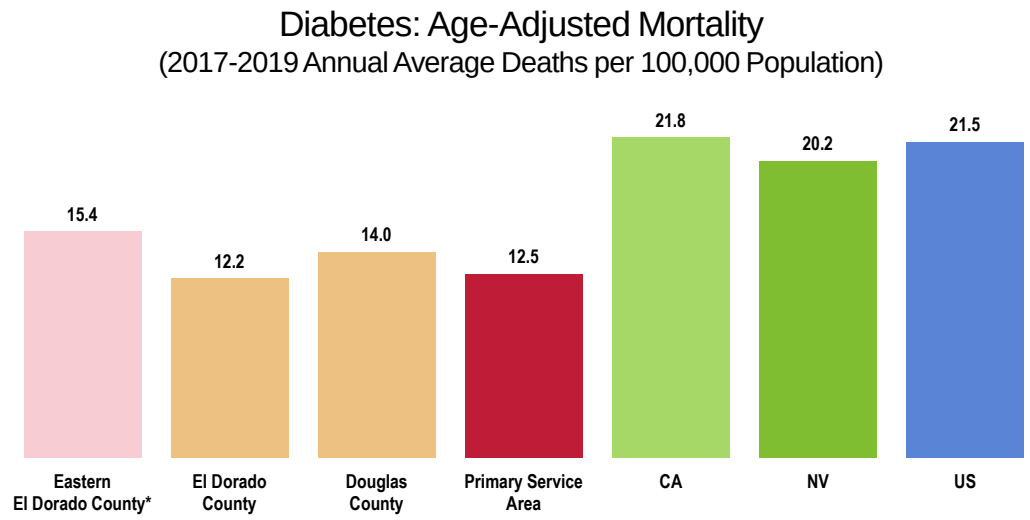
Age-Adjusted Diabetes Deaths

Between 2017 and 2019, there was an annual average age-adjusted diabetes mortality rate of 12.5 deaths per 100,000 population in the Primary Service Area.

BENCHMARK ► Well below the state and national mortality rates.

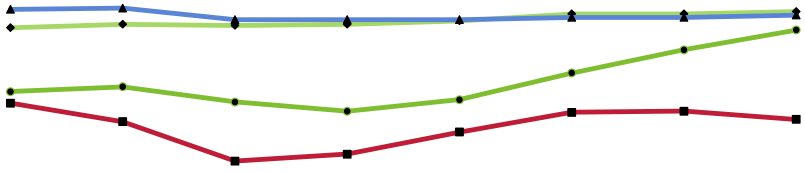
TREND ► Diabetes mortality appears to have stabilized in recent years after an increasing trend.

DISPARITY ► The mortality rate is higher in Eastern El Dorado County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	13.9	12.3	8.9	9.5	11.4	13.1	13.2	12.5
CA	20.4	20.7	20.6	20.7	21.0	21.6	21.6	21.8
NV	14.9	15.3	14.0	13.2	14.2	16.5	18.5	20.2
US	22	22.1	21.1	21.1	21.1	21.3	21.3	21.5

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 2021.

Prevalence of Diabetes

A total of 6.5% of Primary Service Area adults report having been diagnosed with diabetes.

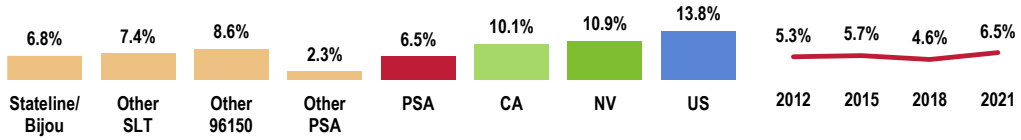
BENCHMARK ► Well below the state and national percentages.

DISPARITY ► Lowest in the Other PSA community. Strong correlation with age.

Prevalence of Diabetes

Another 8.6% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

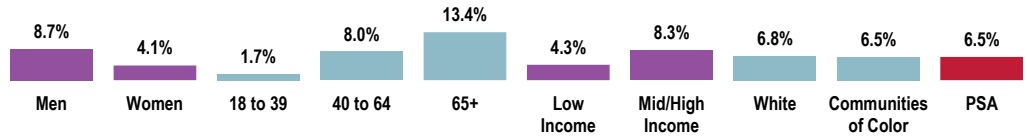
Primary Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 121]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Prevalence of Diabetes
(Primary Service Area, 2021)

Note that among adults who have not been diagnosed with diabetes, 39.2% report having had their blood sugar level tested within the past three years.

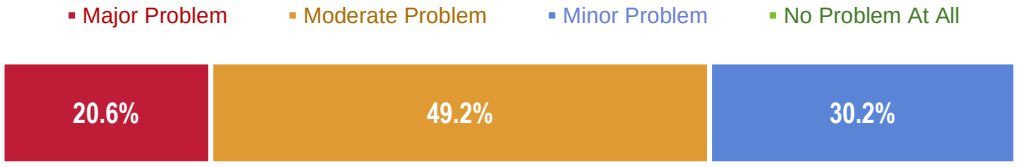


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 33, 121]
Notes: ● Asked of all respondents.
● Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

A high percentage 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, 2021)



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

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

Awareness/Education

> Education and access to care. – Physician
>
> Lifestyle medicine education and implementation. Access to specialty care. – Physician
>
> Lack of education. Lack of access to providers that specialize in this area. Lack of services to help deal with this challenge. Barton had a wellness programs that addressed this, but they shut that down for some reason when they could be providing virtual content and options to help. – Community Leader
>
> Education, access to care, and prevention education. – Community Leader
>
> Access to affordable fresh foods and lack of education about diet and diabetes link. – Physician

Income/Poverty

> Access to care for the low income and the uninsured. – Community Leader
>
> Poverty and lack of resources to be able to access quality, state of the art treatments, such as continuous glucose monitors and insulin pumps. No local endocrinologist. – Other Health Provider

Contributing Factors

> Unfortunately I think maybe due to low paying jobs, poor diet, and not enough exercise, and of course hereditary. – Social Services Provider

Incidence/Prevalence

> I work closely with the community and I have many clients that are diabetic and some of them are unable to obtain medicine due to the high cost. – Social Services Provider

Access to Care/Services

> Access to care. – Physician

Comorbidities

> Heart disease. – Community Leader

Nutrition

> Diet and lifestyle. – Physician

KIDNEY DISEASE

ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

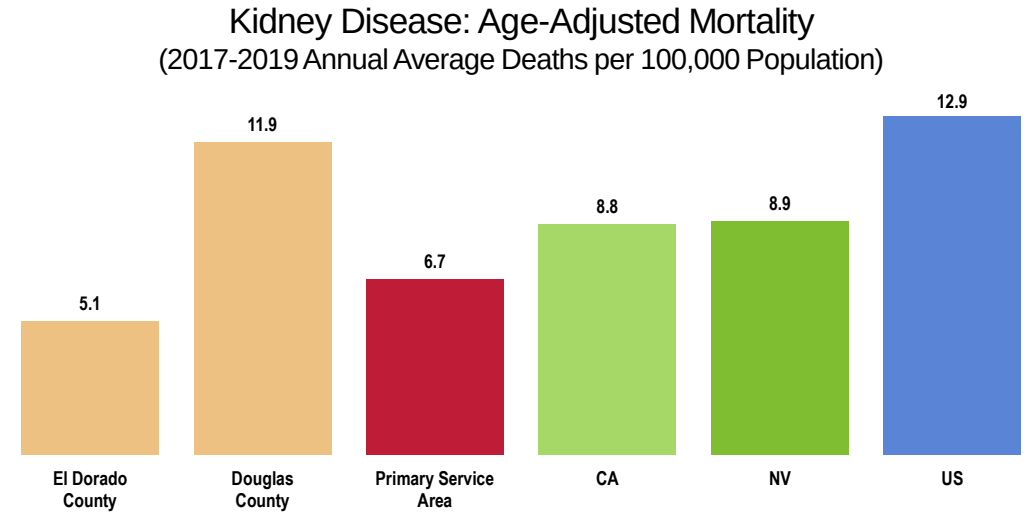
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

Between 2017 and 2019, there was an annual average age-adjusted kidney disease mortality rate of 6.7 deaths per 100,000 population in the Primary Service Area.

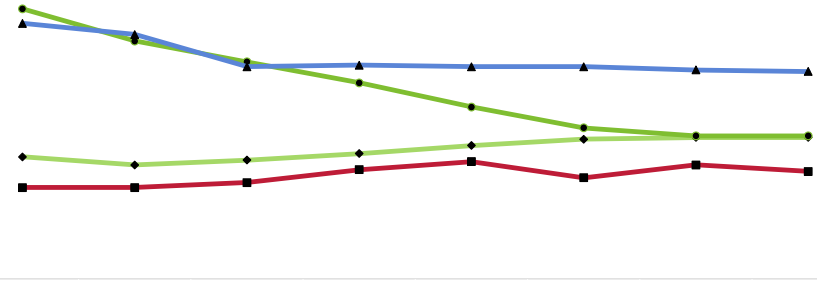
BENCHMARK ► Below the state and national mortality rates.

DISPARITY ► More than twice as high in Douglas County when compared with El Dorado County.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	5.7	5.7	6.0	6.8	7.3	6.3	7.1	6.7
CA	7.6	7.1	7.4	7.8	8.3	8.7	8.8	8.8
NV	16.8	14.8	13.5	12.2	10.7	9.4	8.9	8.9
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

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 2021.

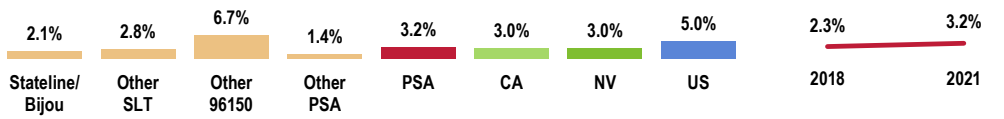
Prevalence of Kidney Disease

A total of 3.2% of Primary Service Area adults report having been diagnosed with kidney disease.

DISPARITY ► Strong correlation with age.

Prevalence of Kidney Disease

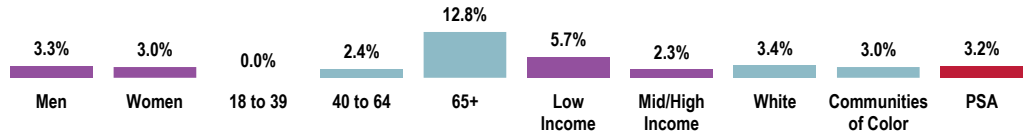
Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Kidney Disease
(Primary Service Area, 2021)

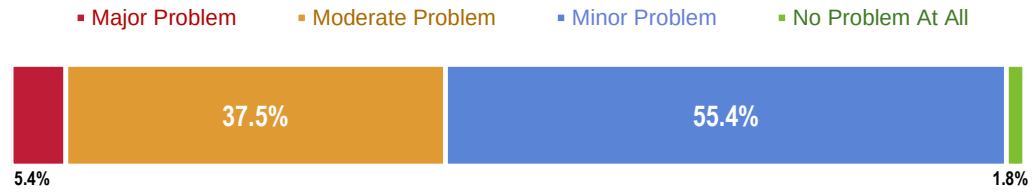


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: ● Asked of all respondents.

Key Informant Input: Kidney Disease

Over half of key informants taking part in an online survey generally characterized *Kidney Disease* as a "minor problem" in the community.

Perceptions of Kidney Disease
as a Problem in the Community
(Key Informants, 2021)



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

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

Lack of Local Care

> Although there is a small number of patients in our community that likely have kidney disease, there are no services locally and transportation to these services may be limited. – Community Leader

> Access to local outpatient nephrology in the community is not available. – Community Leader

Contributing Factors

> Diet, obesity, and diabetes. – Physician

POTENTIALLY DISABLING CONDITIONS

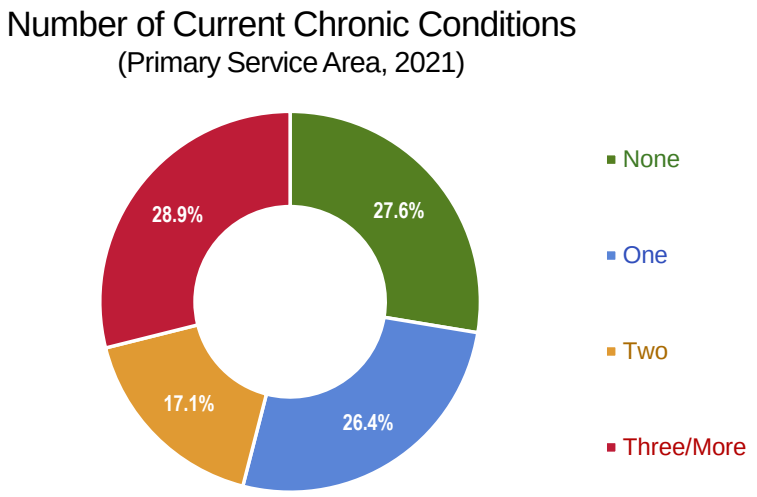
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

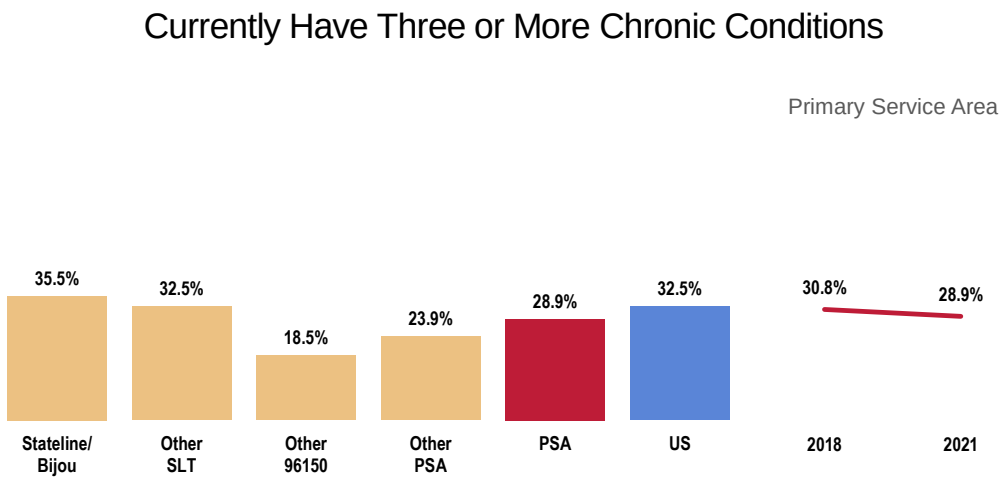
Among Primary Service Area survey respondents, most report currently having at least one chronic health condition.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: ● Asked of all respondents.
● In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

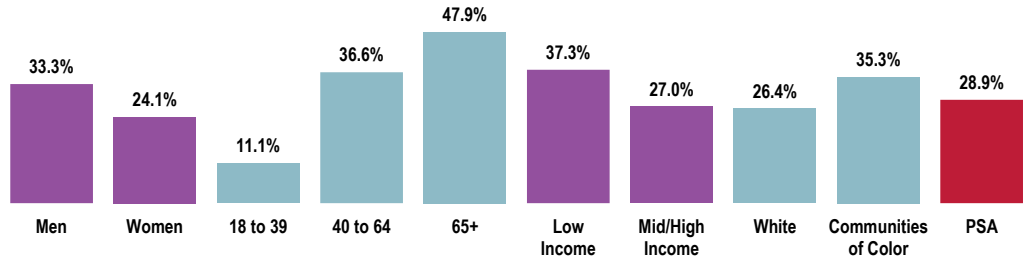
In fact, 28.9% of Primary Service Area adults report having three or more chronic conditions.

DISPARITY ► Lowest in the Other 91650 area. Increases with age and is higher among men.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(Primary Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 123]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

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

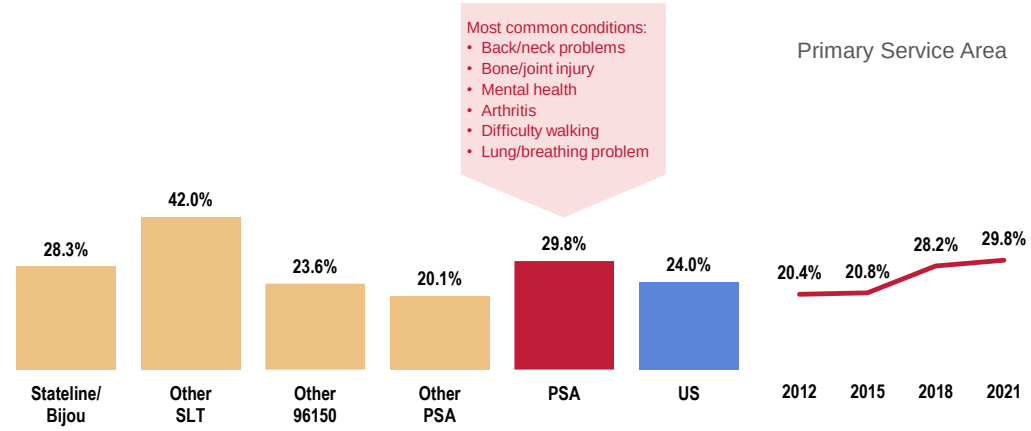
A total of 29.8% of Primary Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

BENCHMARK ► Worse than the national percentage.

TREND ► Denotes a statistically significant increase since 2012.

DISPARITY ► Unfavorably high in the Other SLT community. Highest among seniors (age 65+) and low-income adults.

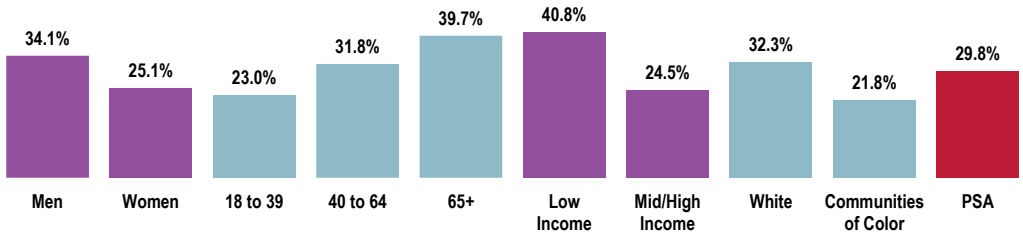
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 96-97]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: ● Asked of all respondents.

Chronic Pain

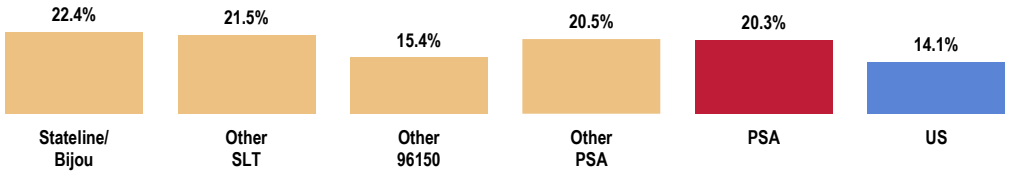
A total of 20.3% of Primary Service Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months.

BENCHMARK ► Well above the US prevalence. Far from satisfying the Healthy People 2030 objective.

DISPARITY ► Correlates with age and is especially prevalent among low-income respondents.

Experience High-Impact Chronic Pain

Healthy People 2030 = 7.0% or Lower



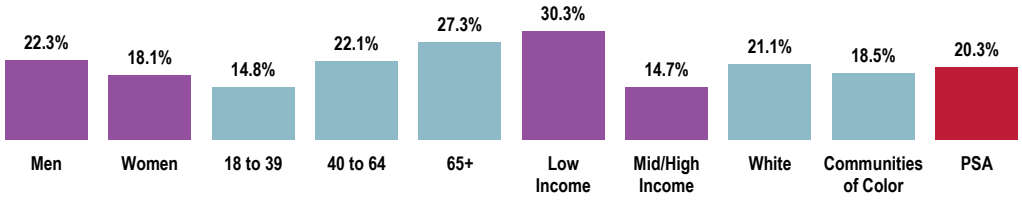
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain

(Primary Service Area, 2021)

Healthy People 2030 = 7.0% or Lower

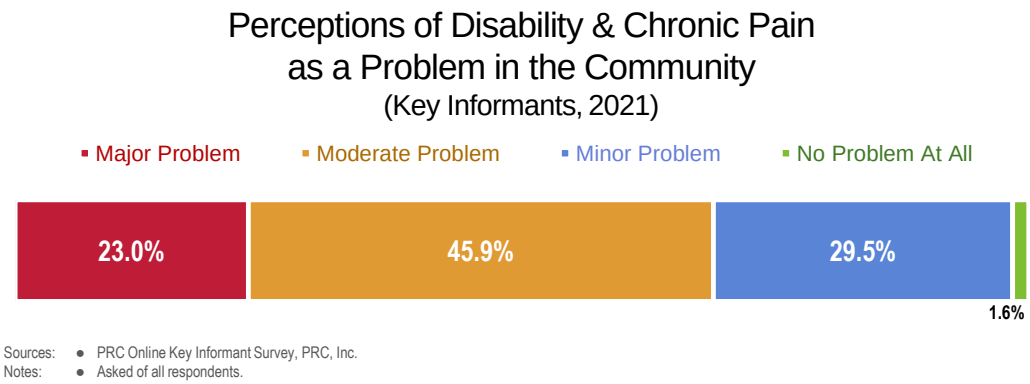


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

Key informants taking part in an online survey most often characterized *Disability & Chronic Pain* as a "moderate problem" in the community.



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

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

Lack of Local Care

> We have a large number of patients who need chronic pain management but there are not enough resources within the Tahoe basin. Many patients have to drive two to three plus hours, which is difficult for most Medi-Cal patients. – Physician
>
> There are no real services for this. – Other Health Provider
>
> Access to care. – Community Leader
>
> No chronic pain providers. – Physician
>
> There are few providers and services that address, treat and support chronic pain. – Community Leader

Vulnerable Populations

> This is a difficult place to live if you are disabled, due to lack of infrastructure. – Physician
>
> Our organization serves the most vulnerable unsheltered and marginally housed clients in the community. Many of them have multiple disabilities that create barriers to accessing services, health care, resources, and other supports that ensure their ability to live healthful, productive lives. Getting disability certifications is very challenging in our work, as Barton doctors are not able to sign the paperwork. Many of our clients live with chronic pain AND manage substance use challenges related to self-medication, both of which also impact mental health. I believe that a focused effort to serve people with disabilities and chronic conditions would reduce suffering, prevent emergency room entries, and help stabilize our clients into supportive housing settings. – Community Leader

Environmental Contributors

> Weather issues make it difficult for disabled people to get to health care facilities if they do not have transportation. Firsthand experience with doctors dealing with chronic pain issues had left me cold. It is rare to find an individual in the health care system who will take the time to understand the issues. I realize that there are people who abuse the system. Health care providers need training in how to spot the abusers and how to listen to the ones who are not abusing the system. – Community Leader

Occupation-Related

> There are many community members employed by the casinos and hotels. These jobs are very demanding physically, yet many of these employees lack health insurance or the means to have paid sick days to recuperate after minor injuries or pains. – Social Services Provider

Injuries

> Injuries. – Social Services Provider

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

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

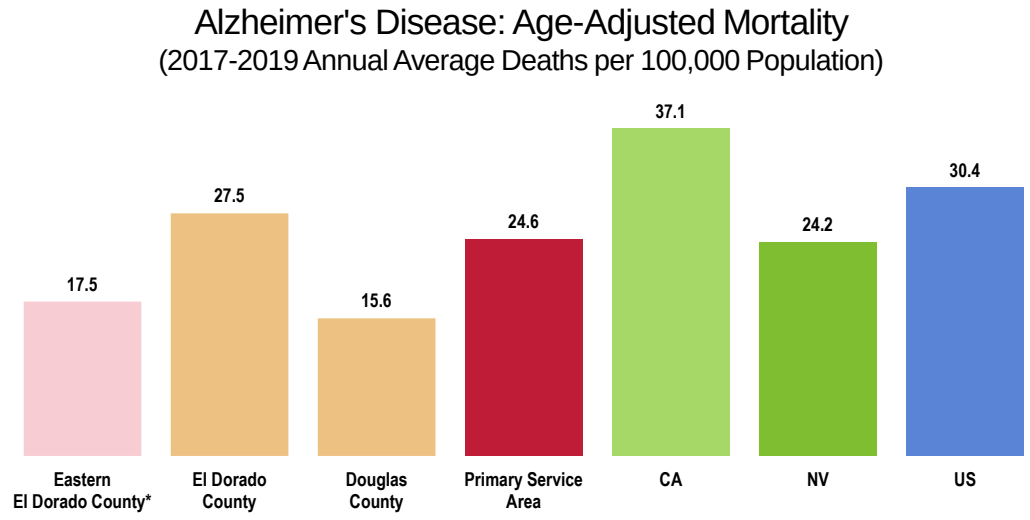
Age-Adjusted Alzheimer's Disease Deaths

Between 2017 and 2019, there was an annual average age-adjusted Alzheimer's disease mortality rate of 24.6 deaths per 100,000 population in the Primary Service Area.

BENCHMARK ► Well below the California and US mortality rates.

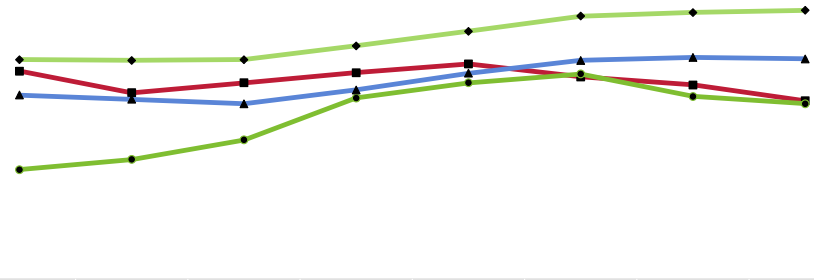
TREND ► Decreasing in recent years.

DISPARITY ► Much higher in El Dorado County than Douglas County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019

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



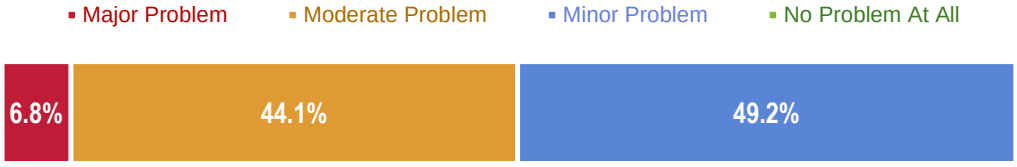
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	28.7	25.7	27.1	28.5	29.7	27.9	26.8	24.6
CA	30.3	30.2	30.3	32.2	34.2	36.3	36.8	37.1
NV	15.1	16.5	19.2	25.0	27.1	28.3	25.2	24.2
US	25.4	24.8	24.2	26.1	28.4	30.2	30.6	30.4

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 2021.

Key Informant Input: Dementia/Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementia/ Alzheimer's Disease* as a "minor problem" in the community, followed closely by "moderate problem" ratings.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, 2021)



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

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

Lack of Local Care

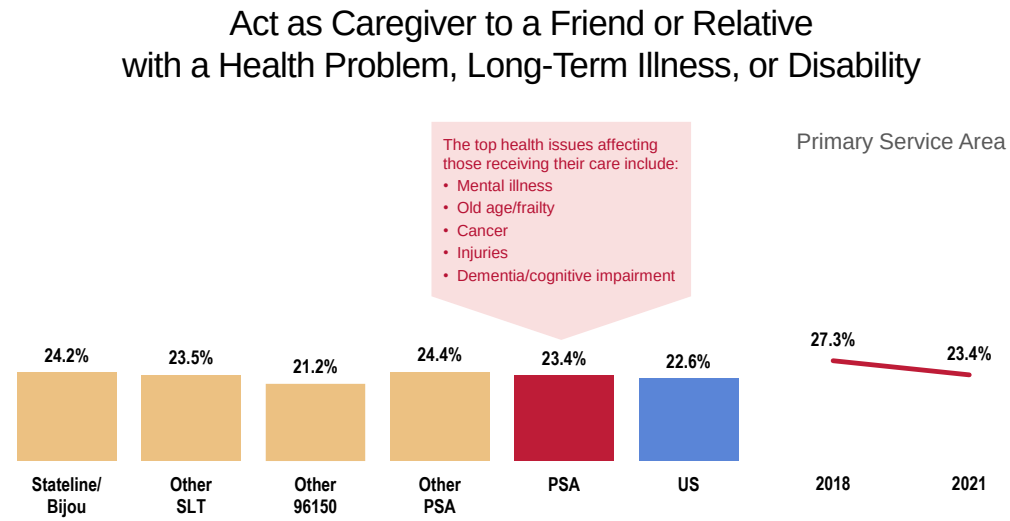
> No memory care in the community, activities to help, adult daycare. – Physician

Language Barriers

> Lack of information, especially for those that are Spanish speakers. – Community Leader

Caregiving

A total of 23.4% of Primary Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 98-99]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

BIRTHS

PRENATAL CARE

ABOUT INFANT HEALTH

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

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

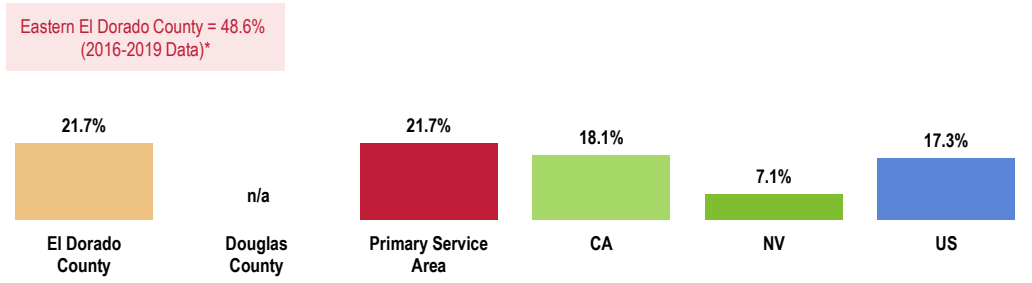
– Healthy People 2030 (https://health.gov/healthypeople)

Between 2007 and 2010, 21.7% of El Dorado County births did <u>not</u> receive prenatal care in the first trimester of pregnancy (data unavailable for Douglas County).

BENCHMARK ► The local percentage is higher than state and national figures.

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

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births, 2007-2010)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted March 2021.
- *California Department of Public Health, Comprehensive Master Birth File, 2016-2019 data.

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.

BENCHMARK ► Lower than the Nevada and US percentages.

DISPARITY ► Lower in El Dorado County overall than in Douglas County (although slightly higher in Eastern El Dorado County).

Low-Weight Births
(Percent of Live Births, 2006-2012)

Eastern El Dorado County = 9.1%
(2016-2019 Data)*

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted March 2021.
- *California Department of Public Health, Comprehensive Master Birth File, 2016-2019 data.

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 2017 and 2019, there was an annual average of 3.0 infant deaths per 1,000 live births.

BENCHMARK ► Lower than the state and national death rates. Satisfies the related Healthy People 2030 goal.

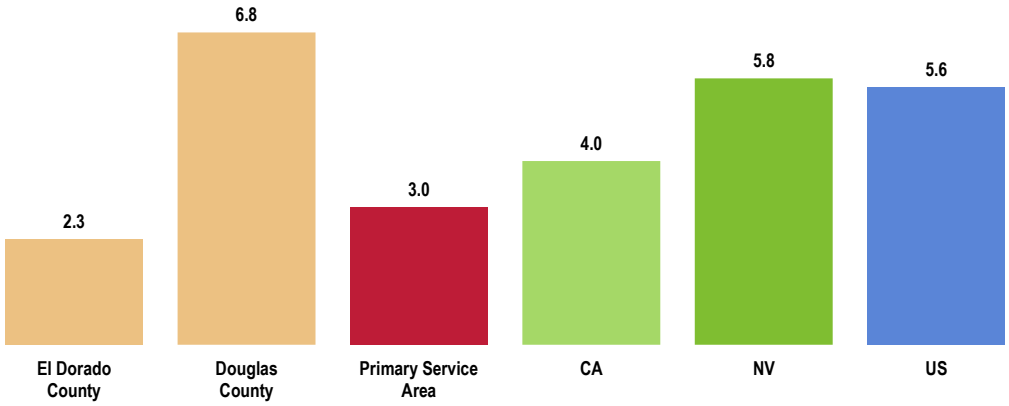
TREND ► Rates show no clear trend over the past decade.

DISPARITY ► Much higher in Douglas County.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2017-2019)

Healthy People 2030 = 5.0 or Lower



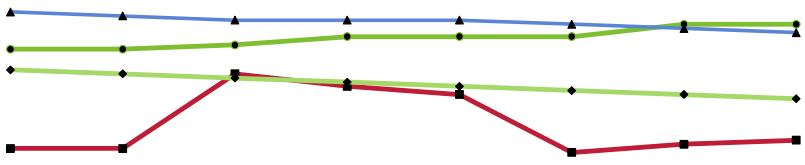
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted March 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.

Infant Mortality Trends

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

Healthy People 2030 = 5.0 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	2.8	2.8	4.6	4.3	4.1	2.7	2.9	3.0
CA	4.7	4.6	4.5	4.4	4.3	4.2	4.1	4.0
NV	5.2	5.2	5.3	5.5	5.5	5.5	5.8	5.8
US	6.1	6.0	5.9	5.9	5.9	5.8	5.7	5.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted March 2021.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

FAMILY PLANNING

ABOUT FAMILY PLANNING

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

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

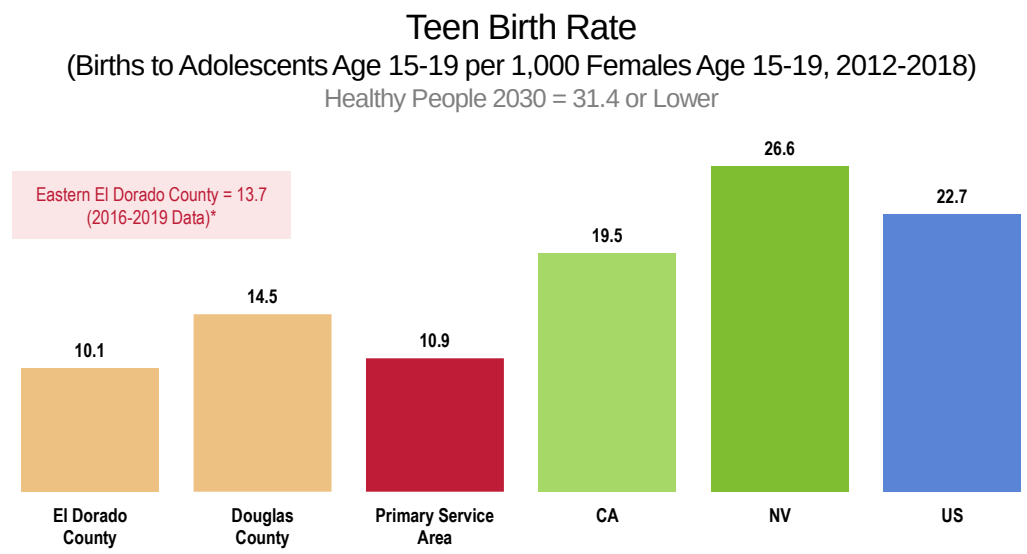
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2012 and 2018, there were 10.9 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Primary Service Area.

BENCHMARK ► Well below state and national rates. Easily satisfies the Healthy People 2030 goal.

DISPARITY ► Higher in Douglas County.

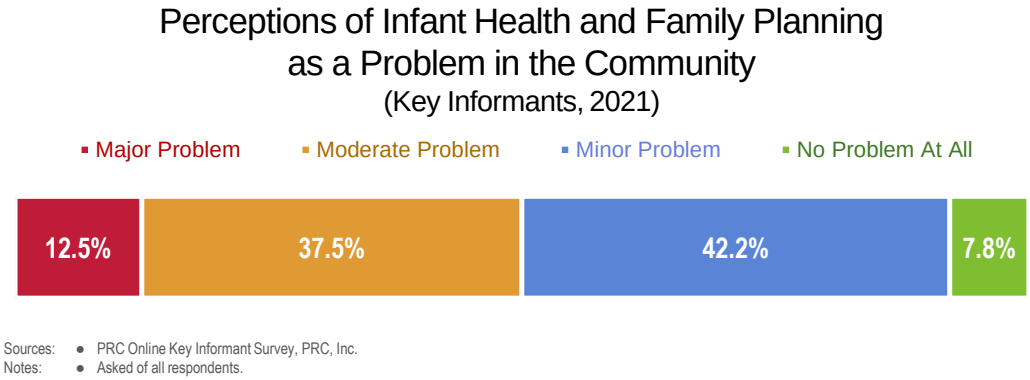


Sources:
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).
- *California Department of Public Health, Comprehensive Master Birth File, 2016-2019 data.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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: Infant Health & Family Planning

Key informants taking part in an online survey largely characterized *Infant Health & Family Planning* as a "minor problem" in the community.



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

Access to Care/Services

> Child care is a critical resources which is lacking in South Lake Tahoe. We also need help with our Community Hub at the library, which brings vital services to the neediest families. – Community Leader

Political Challenges

> The politics of proper family planning remain a problem in this country. Frankly, I'm not sure how much this impacts the availability of family planning services in South Lake Tahoe. – Community Leader

Affordable Care/Services

> Specifically for youth, this is a very popular topic, especially family planning, free/reduced price birth control. – Social Services Provider

Language Barriers

> Lack of information for the Spanish speaking community. – Community Leader

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Daily Recommendation of Fruits/Vegetables

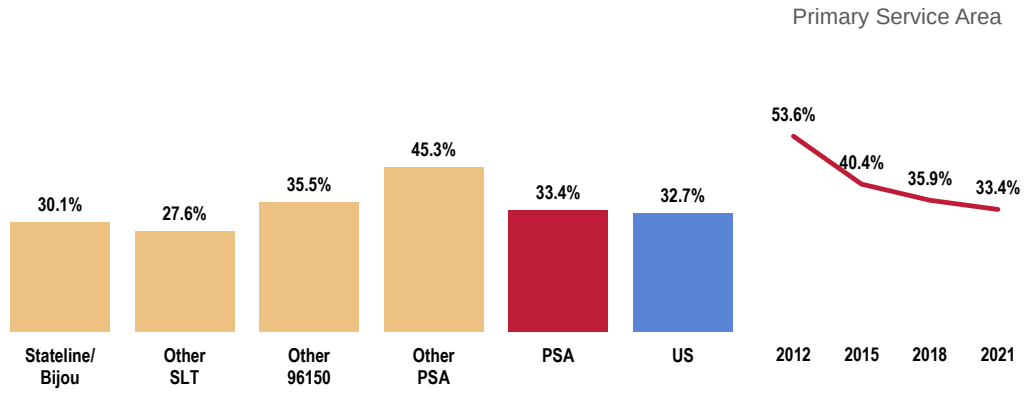
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

One in three (33.4%) Primary Service Area adults report eating five or more servings of fruits and/or vegetables per day.

TREND ► Denotes a statistically significant decrease since 2012.

DISPARITY ► Highest in the Other PSA community. Reported least often among low-income respondents.

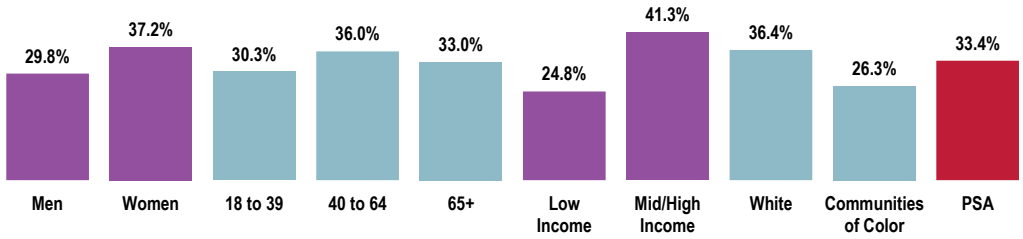
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

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

Consume Five or More Servings of Fruits/Vegetables Per Day
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
Notes: ● Asked of all respondents.
● For this issue, respondents were asked to recall their food intake on the previous day.

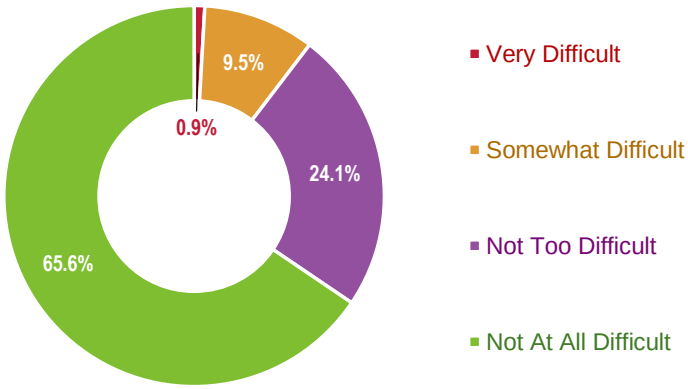
Difficulty Accessing Fresh Produce

Most Primary Service Area adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked: "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

RELATED ISSUE
See also *Food Access* in the **Social Determinants of Health** section of this report.

Level of Difficulty Finding Fresh Produce at an Affordable Price
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

However, 10.4% of Primary Service Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

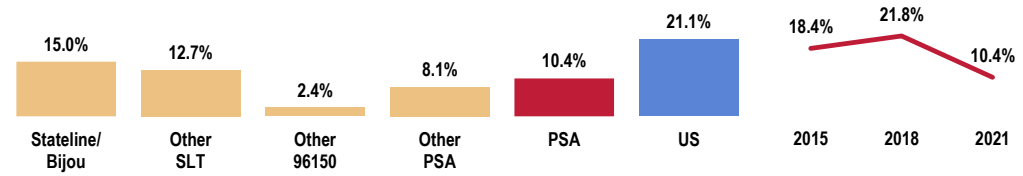
BENCHMARK ► Half the US prevalence.

TREND ► Decreasing significantly from previous survey findings.

DISPARITY ► Lowest in the Other 96150 community. Reported most often among low-income residents.

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

Primary Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

(Primary Service Area, 2021)

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

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

Leisure-Time Physical Activity

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

A total of 12.5% of Primary Service Area adults report no leisure-time physical activity in the past month.

BENCHMARK ► Well below the state and national figures. Easily satisfies the Healthy People 2030 objective.

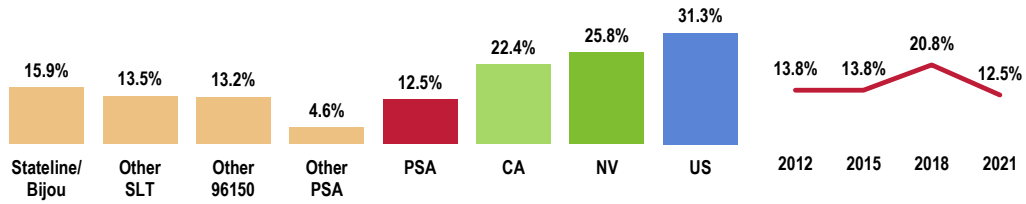
TREND ► Decreasing since 2018 but unchanged from earlier survey administrations.

DISPARITY ► Favorably low in the Other PSA community.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower

Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

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

A total of 41.3% of Primary Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

BENCHMARK ► Twice the state and national figures.

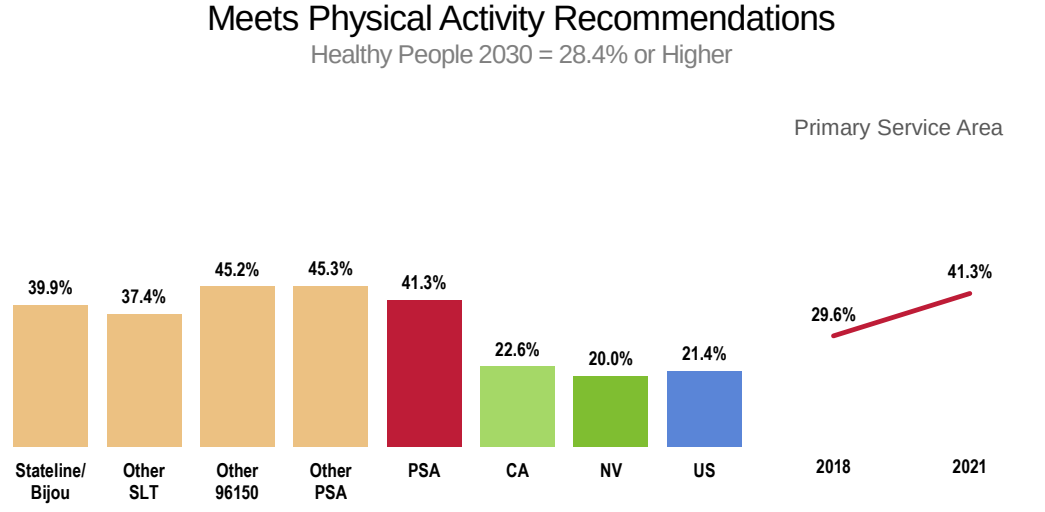
TREND ► Marks a statistically significant increase since 2018.

DISPARITY ► Decreases with age but reported among half of adults in the upper-income category.

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.



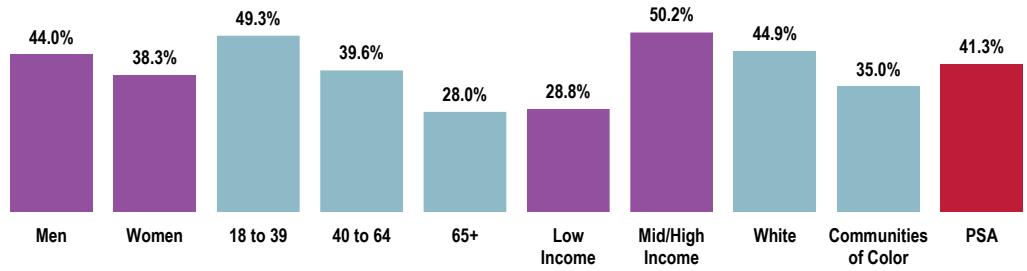
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Meets Physical Activity Recommendations

(Primary Service Area, 2021)

Healthy People 2030 = 28.4% or Higher



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

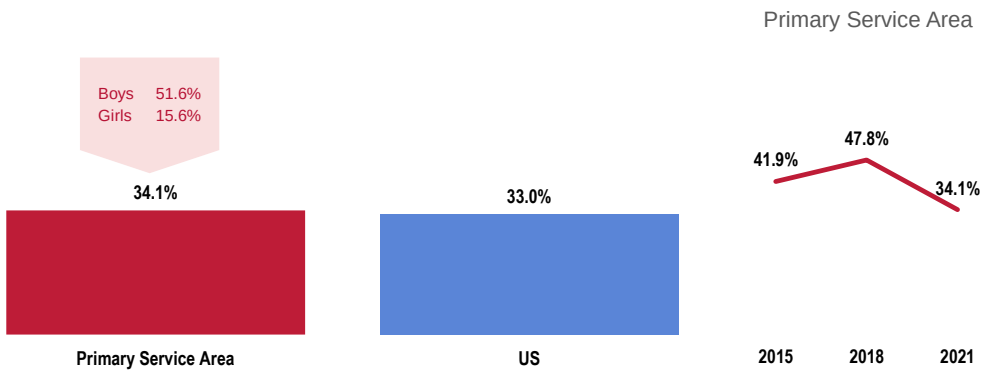
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

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

Among Primary Service Area children age 2 to 17, 34.1% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

DISPARITY ► Considerably higher among boys than girls.

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, 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.

Access to Physical Activity

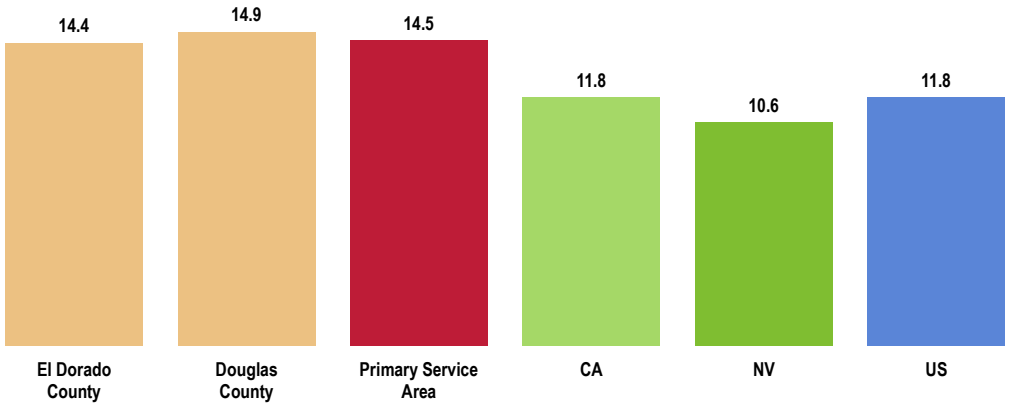
In 2017, there were 14.5 recreation/fitness facilities for every 100,000 population in the Primary Service Area.

BENCHMARK ► Better than state and US ratios.

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, 2017)



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

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

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

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

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

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
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.

Overweight Status

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

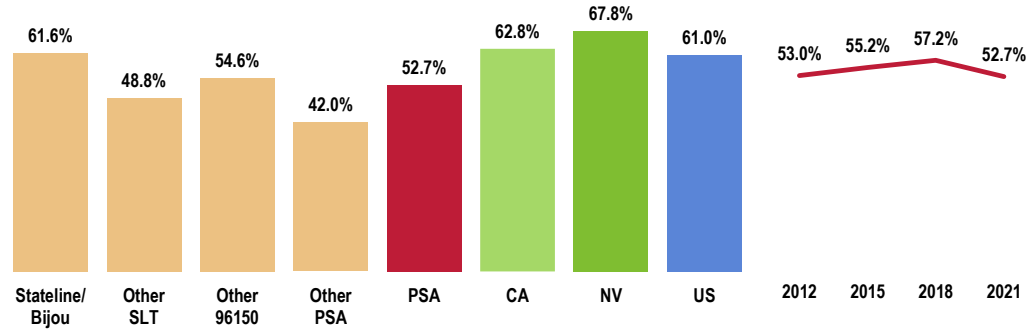
Over half (52.7%) of Primary Service Area adults are overweight.

BENCHMARK ► Well below the state and national percentages.

DISPARITY ► Unfavorably high in the Stateline/Bijou community.

Prevalence of Total Overweight (Overweight and Obese)

Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

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

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

The overweight prevalence above includes 21.6% of service area adults who are obese.

BENCHMARK ► Well below the state and national figures. Satisfies the Healthy People objective.

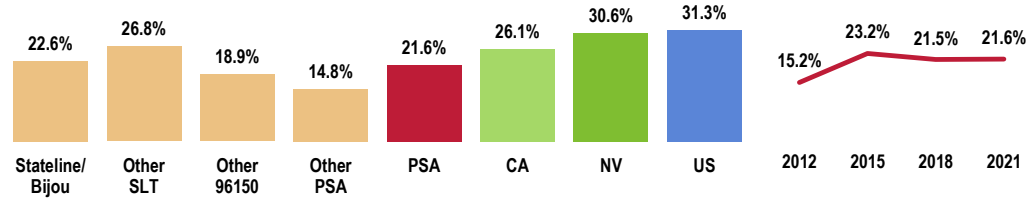
TREND ► Increasing significantly from 2012 survey findings (similar to other previous administrations).

DISPARITY ► Highest among adults age 40 to 64, low-income residents, and Communities of Color.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower

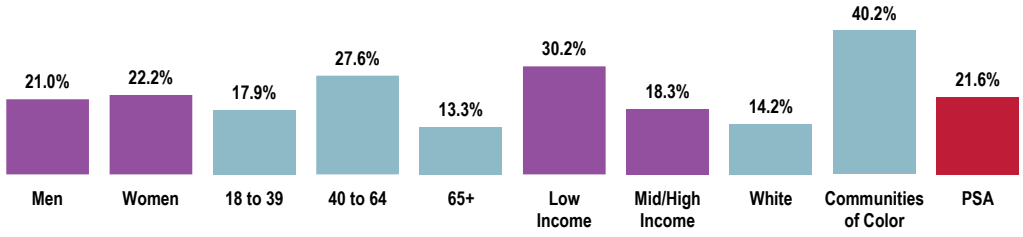
Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Prevalence of Obesity
(Primary Service Area, 2021)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

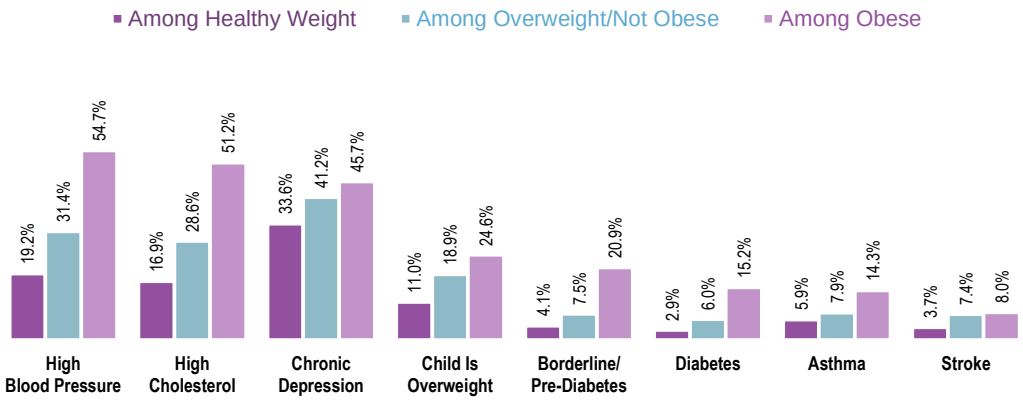
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.

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

Relationship of Overweight With Other Health Issues
(Primary Service Area, 2021)

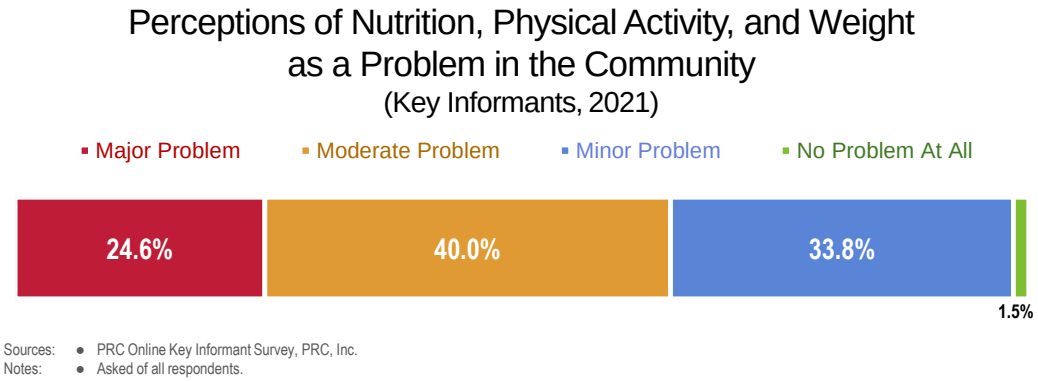


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]

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

Key Informant Input:
Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a "moderate problem" in the community.



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

Contributing Factors

> Although we live in an area known for outdoor recreation, many people are still overweight and live a sedentary lifestyle. Healthier foods are typically more expensive in our area. – Community Leader
>
> Lack of education, lack of affordable fresh health foods for people on fixed income, low wages jobs and high housing prices which then leaves little for healthy eating. Winter weather limiting outdoor activities. Finding time due to work/family obligations. – Physician
>
> Lack of money for healthy food. No affordable exercise programs. – Physician

Awareness/Education

> Lack of nutritional and exercise education overall in the community. The city, the county, local agencies and schools need to promote regular exercise and healthy diets. Entice people to work out and eat better. In Japan, workers are given ample time to work out during their workdays. Physical education in schools needs to be revamped. Kids should work out to the point of sweating at least 5 times per week. – Public Health Representative
>
> Education. – Community Leader

Seasonal Contributors

> During the snowy winter season, many of our community members have a harder time getting out and being physically active due to cold, icy sidewalks and snowy conditions. Also, some families struggle with food, especially right now when their employers have to close due to COVID. – Social Services Provider
>
> Winter. – Community Leader

Access to Affordable Healthy Food

> Most of our low income families cannot afford nutritious food, and obesity and its sequel are a huge issue. – Physician
>
> Food cost. Access for unhoused. – Physician

Access to Care/Services

> Limited programs to help people succeed in lifestyle changes. – Physician
>
> There are no consistent options that help the community address these challenges. Barton had been building comprehensive programs in this area, but they have been suspended. – Community Leader

COVID-19

> Some kids depend on schools for nutritional needs. The economic impact of COVID-19 has directly affected some families. Children are not as physically busy at home, versus being at school. Local youth athletic programs have been closed for almost a year. – Public Health Representative
>
> COVID-19. – Social Services Provider

Hunger

> Poverty and hunger. I see children coming to school hungry all the time. When faced with health issues, I often hear parents say they just can't afford to bring their child to the doctor. – Other Health Provider

Economy

> Parents are working one or more job, which results in fast food and processed food. – Other Health Provider

SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Age-Adjusted Cirrhosis/Liver Disease Deaths

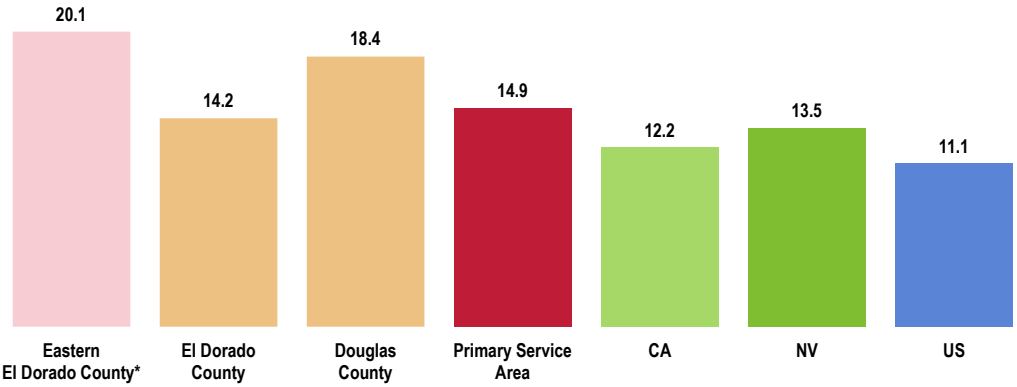
Between 2017 and 2019, the Primary Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 14.9 deaths per 100,000 population.

BENCHMARK ► Worse than the California and US mortality rates. Fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing over time, in keeping with state and national trends.

DISPARITY ► Particularly in Eastern El Dorado County.

Cirrhosis/Liver Disease: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 10.9 or Lower

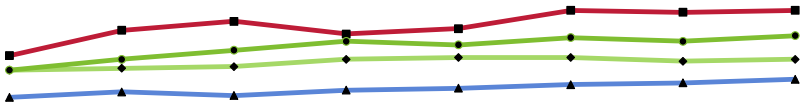


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	12.4	13.8	14.3	13.6	13.9	14.9	14.8	14.9
CA	11.6	11.7	11.8	12.2	12.3	12.3	12.1	12.2
NV	11.6	12.2	12.7	13.2	13.0	13.4	13.2	13.5
US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

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 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Alcohol Use

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

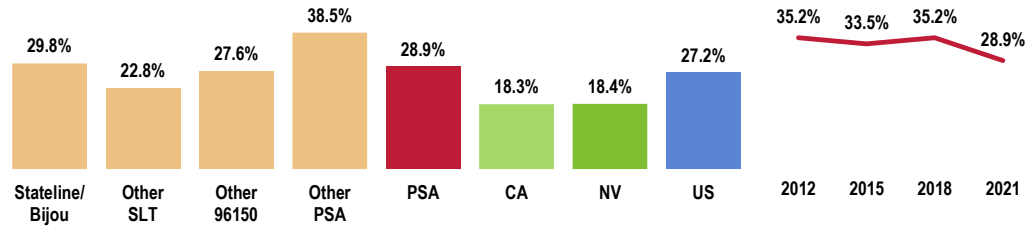
A total of 28.9% of area adults are excessive drinkers (heavy and/or binge drinkers).

BENCHMARK ► Much higher than the state percentages.

DISPARITY ► Reported more often among men, young adults, and Whites.

Excessive Drinkers

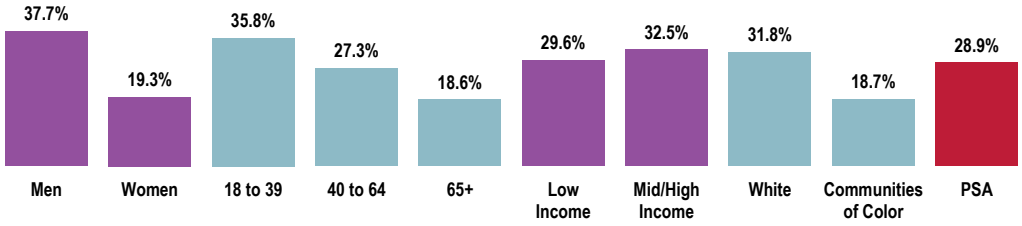
Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers
(Primary Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 136]

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.

Age-Adjusted Unintentional Drug-Related Deaths

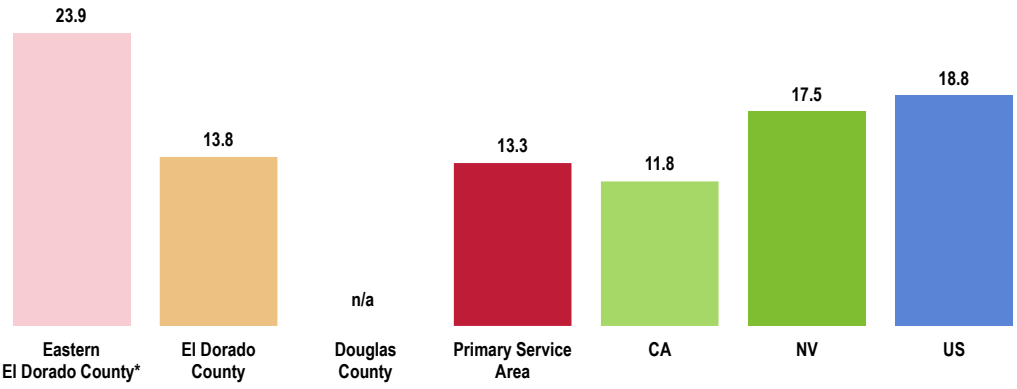
Between 2017 and 2019, there was an annual average age-adjusted unintentional drug-related mortality rate of 13.3 deaths per 100,000 population in the Primary Service Area.

BENCHMARK ► Lower than the Nevada and US mortality rates.

TREND ► Decreasing in recent years.

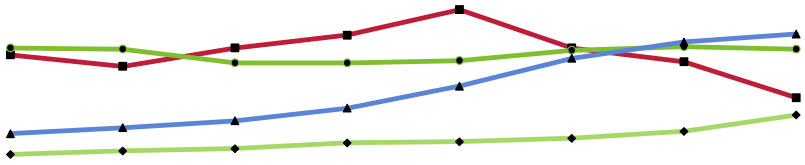
DISPARITY ► Much higher in Eastern El Dorado County.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.
- *California Department of Public Health, California Comprehensive Master Death File (Static), 2016-2019

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



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
PSA	17.0	16.0	17.6	18.7	20.9	17.6	16.4	13.3
CA	8.4	8.7	8.9	9.4	9.5	9.8	10.4	11.8
NV	17.6	17.5	16.3	16.3	16.5	17.4	17.7	17.5
US	10.2	10.7	11.3	12.4	14.3	16.7	18.1	18.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2021.

Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 4.4% of Primary Service Area adults acknowledge using an illicit drug in the past month.

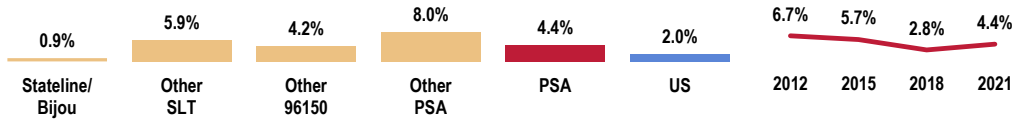
BENCHMARK ► Easily satisfies the Healthy People 2030 objective.

DISPARITY ► Lowest in the Stateline/Bijou community. Reported more often among men and upper-income residents.

Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower

Primary Service Area



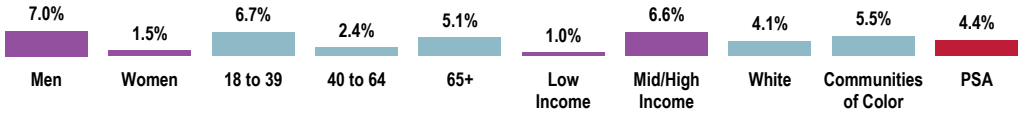
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Illicit Drug Use in the Past Month

(Primary Service Area, 2021)

Healthy People 2030 = 12.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

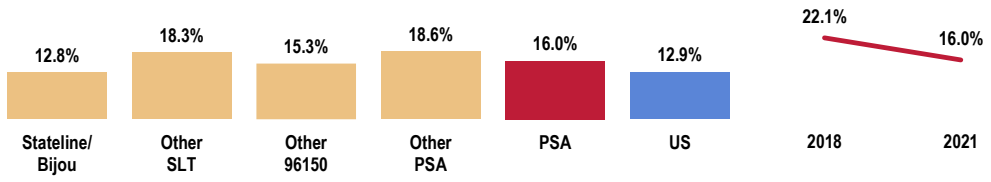
A total of 16.0% of Primary Service Area report using a prescription opioid drug in the past year.

TREND ► Decreasing significantly from 2018 survey findings.

DISPARITY ► Reported more often among White respondents.

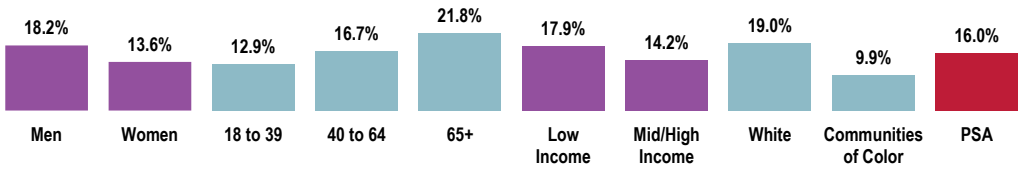
Used a Prescription Opioid in the Past Year

Primary Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Used a Prescription Opioid in the Past Year
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Alcohol & Drug Treatment

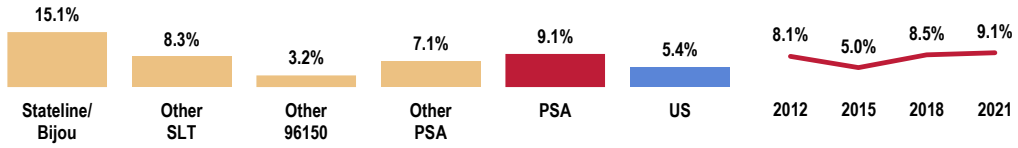
A total of 9.1% of Primary Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

BENCHMARK ► Higher than the US percentage.

DISPARITY ► Highest in the Stateline/Bijou community; lowest in the Other 96150 area.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Primary Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 51]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

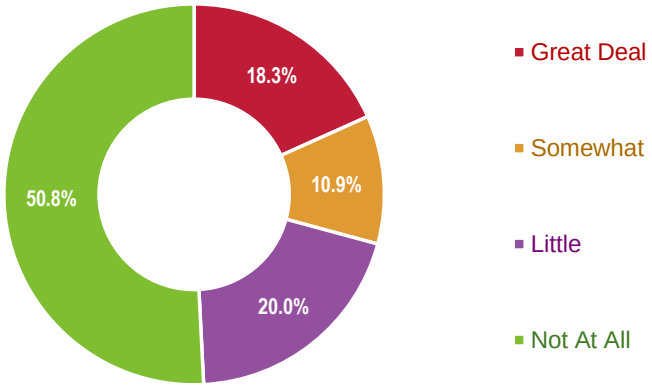
Personal Impact From Substance Abuse

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

Just under one-half of Primary Service Area residents' lives have <u>not</u> been negatively affected by substance abuse (either their own or someone else's).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)

(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.

However, 49.2% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

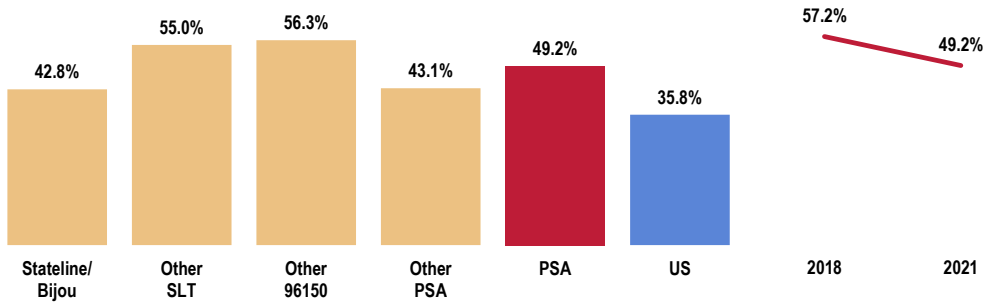
BENCHMARK ► Well above the US prevalence.

TREND ► Decreasing significantly since 2018.

DISPARITY ► Reported more often among young adults in the service area.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

Primary Service Area

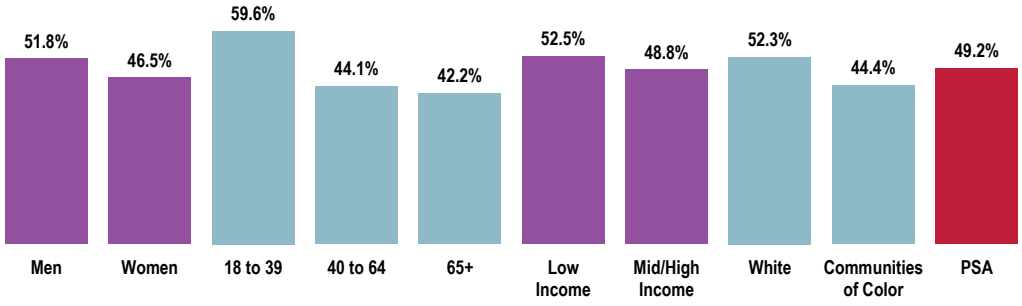


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(Primary Service Area, 2021)

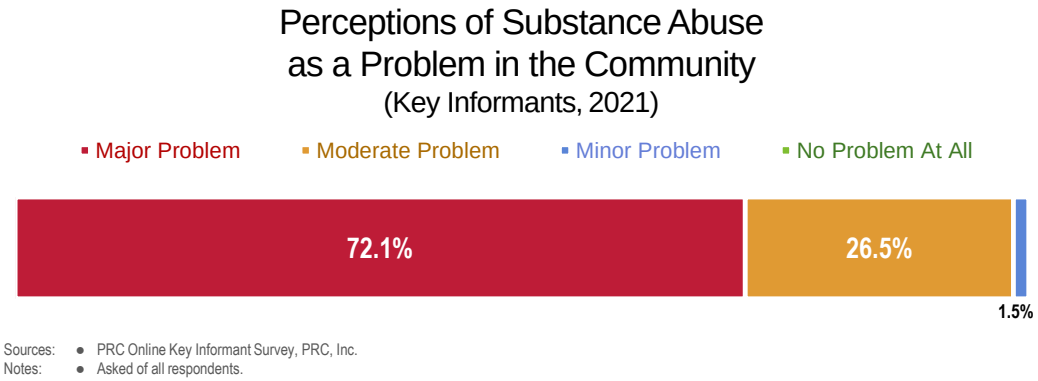


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 52]

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

Most key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.



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

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

Access to Care/Services

Lack of availability. – Physician

Rural area with a lack of services and support in this area. – Community Leader

Local rehab programs. – Community Leader

Capacity is certainly one issue. Another may be the fact that the community was practically founded on indulging addictive behaviors and that even today, there remains a "party" mentality among many residents and tourists. – Community Leader

Lack of treatment programs. – Community Leader

No treatment center and private practice treatment is not favorable. – Community Leader

There seem to be few coordinated services in the local area. – Community Leader

We have no residential treatment programs. We have very few counseling programs, if any. We have a MAT program which is gradually growing, but unclear if the patients receive consistent counseling services to go with it. There is not a great treatment yet for methamphetamine addiction—a big problem here. Stigma is a huge barrier to people seeking help from all income backgrounds. There is a need to educate/convince practitioners and community members alike that addiction is a disease and not a poor life choice. Plus, we have far too few treatment options for those who DO choose to transition out of this life, especially for little to no cost. – Community Leader

There are barely if any substance abuse treatment centers in Tahoe. – Other Health Provider

Not enough outpatient treatment options. – Physician

Lack of mental health services to address issues before they turn into substance abuse. Dual diagnosis treatment. Lack of children/teenage counseling and not residential treatment. – Social Services Provider

We do not have residential treatment available to Medi-Cal patients at the lake. Patients are very reluctant to go to Placerville, especially if there is a delay or waiting period. – Physician

Lack of local treatment options for detox, counseling, and mental health care. – Physician

Inpatient treatment for youth and adults, AA, NA, and al-anon meetings for youth, AOD therapists for youth. – Social Services Provider

Availability of providers. – Social Services Provider

Access to services. – Other Health Provider

Access to care. – Physician

Only two choices for AA, which don't fit everyone. No resources for inpatient rehab if needed. I believe Tahoe Turning Point closed. – Physician

The abuse of substances are rising and there are very few treatment facilities for people to go to. – Social Services Provider

Lack of services, lack of providers who are not Medi-Cal or out of pocket. – Social Services Provider

Lack of insurance to pay for this treatment. – Social Services Provider

> With the closing of Tahoe Turning Point in 2020 we have basically lost the ability of residents to access substance use disorder services. Existing services are too expensive. EDC SUDS remains devoted to assessing and treating clients, but our capacity is limited. – Public Health Representative. –
>
> The only organized program is county services, which means many people make too much money to access, and their programs are somewhat limited as it is. – Physician

Denial/Stigma

> People who don't want to admit they have a problem. – Community Leader
>
> Stigma. Although there is access to treatment, substance use and abuse is still glamorized in Tahoe. – Community Leader
>
> Lack of recognition as a problem by clients. Lack of providers for treatment. – Other Health Provider
>
> Convincing people to try treatment. ACES awareness is low. – Other Health Provider

Lack of Providers

> Lack of alcohol and drug counselors, especially bilingual, Spanish. – Community Leader
>
> Mental health, lack of specialty care. – Physician
>
> This community lacks the professionals to help. There are too few for the need. – Social Services Provider

Awareness/Education

> Understanding that it is a problem and the various types of treatment that in requires. It is not a one size fits all. Having the behavioral health resources to provide support for addictive behaviors. – Other Health Provider
>
> Awareness of services available, ability to navigate health systems for appointment scheduling and insurance, availability of harm reduction tools, access to stable housing and preventative services, rehab beds available, payee services for chronic alcoholics. – Community Leader
>
> Knowing how to access them and how to pay for the services. – Other Health Provider

Contributing Factors

> Lack of inpatient services. The casinos and 'party' culture of South Lake Tahoe make this a very difficult space for people to get or stay clean. – Physician
>
> In the last ten years, we have many new breweries open. As a tourist town, it appears that we promote drinking. Access to substance abuse is the same as behavioral health barriers, long wait for services. – Social Services Provider
>
> Close proximity to the casino corridor. Lack of AOD providers in town. Long wait lists for youth AOD services. – Social Services Provider

Affordable Care/Services

> Money and availability. – Physician
>
> Cost and availability. – Community Leader
>
> There are a lack of available providers that accept Medi-Cal or use a sliding scale for those who are not insured. – Community Leader

Access/Resources for Youth

> I do not know of any resources for our teenagers. – Physician

COVID-19

> Not being able to meet in person to seek help is likely the biggest barrier. – Community Leader

Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **alcohol** as causing the most problems in the community.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a “Major Problem”)	
ALCOHOL	72.7%
HEROIN OR OTHER OPIOIDS	9.1%
MARIJUANA	9.1%
METHAMPHETAMINES OR OTHER AMPHETAMINES	6.8%
PRESCRIPTION MEDICATIONS	2.3%

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

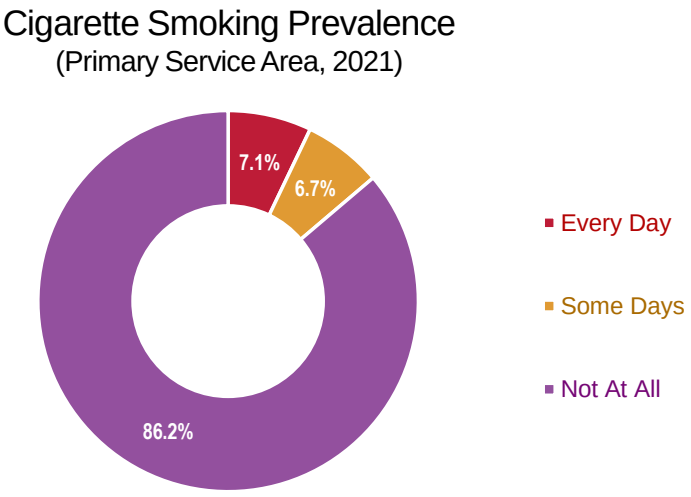
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

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

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 13.8% of Primary Service Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the Primary Service Area.

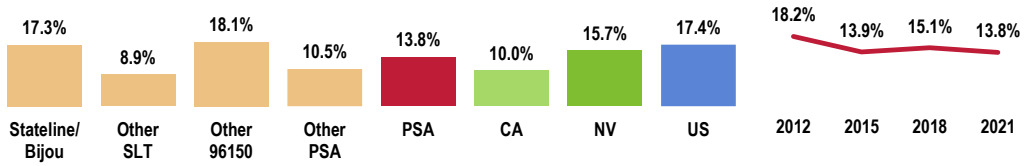
BENCHMARK ► Worse than the California prevalence. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lowest in the Other SLT community. Reported most often among low-income respondents.

Current Smokers

Healthy People 2030 = 5.0% or Lower

Primary Service Area



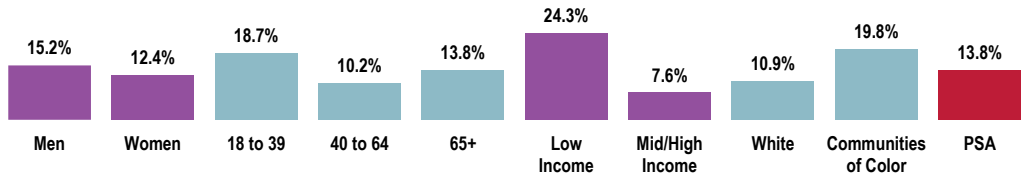
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers

(Primary Service Area, 2021)

Healthy People 2030 = 5.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

Among all surveyed households in the service area, 7.9% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

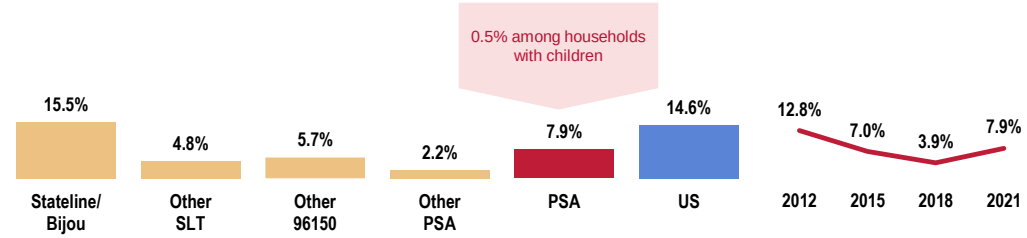
BENCHMARK ► Well below the US prevalence.

TREND ► A significant decrease from 2012 survey findings.

DISPARITY ► Unfavorably high in the Stateline/Bijou community.

Member of Household Smokes at Home

Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

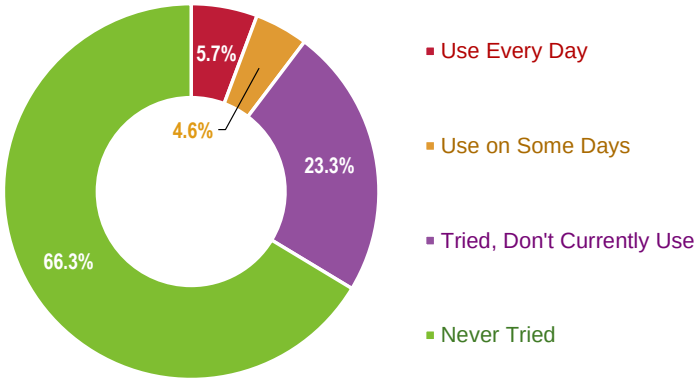
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Other Tobacco Use

Use of Vaping Products

Most area adults have not tried e-cigarettes or other electronic vaping products.

Use of Vaping Products
(Primary Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 135]

Notes:
- Asked of all respondents.

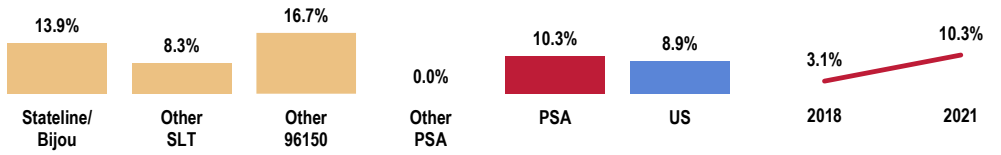
However, 10.3% currently use vaping products either regularly (every day) or occasionally (on some days).

TREND ► Increasing significantly since 2018.

DISPARITY ► Not reported by any respondents in the Other PSA community. Reported more often among men and young adults.

Currently Use Vaping Products
(Every Day or on Some Days)

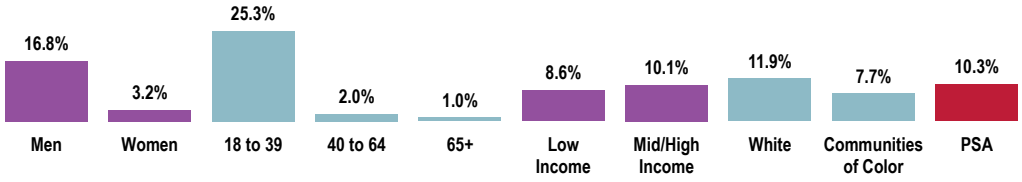
Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Currently Use Vaping Products
(Primary Service Area, 2021)

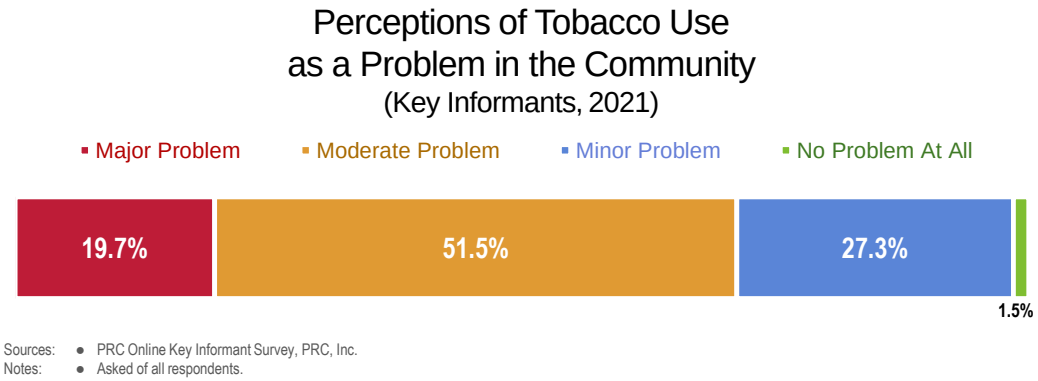


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 135]

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

Just over half of key informants taking part in an online survey characterized *Tobacco Use* as a "moderate problem" in the community.



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

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

Vaping

> With the availability of vaping a lot of teenagers are starting smoking early. Most substances include nicotine and nicotine addiction is on the rise. – Social Services Provider
>
> Vape pens are causing a rise in tobacco use. – Social Services Provider
>
> The vaping epidemic is hitting communities throughout the nation. Our youth are being influenced by the vaping industry, with their big advertising campaigns and lack of accurate information. – Public Health Representative. –
>
> Youth access to vaping products. There are multiple vaping stores and business that sell such products. – Social Services Provider
>
> Access to vaping products. – Physician
>
> Vaping amongst teens. – Community Leader

Occupational Hazards

> Many of the workers in the Casinos are heavily impacted by tobacco smoke, and many of these workers don't even smoke themselves. Also, many tourists who visit leave their cigarette buds on the ground which is toxic to people, environment, and local wildlife. – Social Services Provider

Incidence/Prevalence

> A lot of people still smoke, including young people. They either don't realize the damage this does to their bodies, or they don't care. – Community Leader

Casinos

> Tobacco use is readily accepted in the casinos. – Community Leader

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

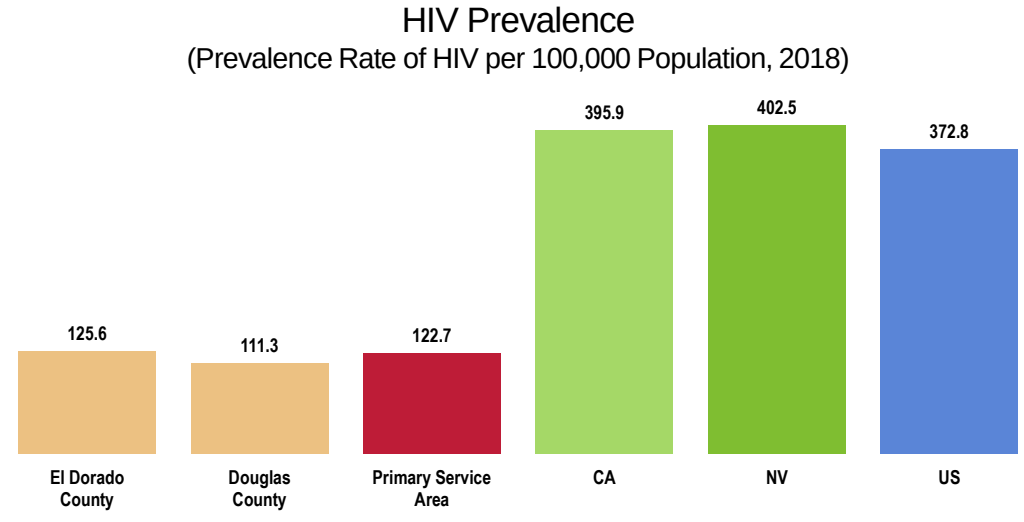
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

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

HIV Prevalence

In 2018, there was a prevalence of 122.7 HIV cases per 100,000 population in the Primary Service Area.

BENCHMARK ► Well below the state and US prevalence rates.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.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.

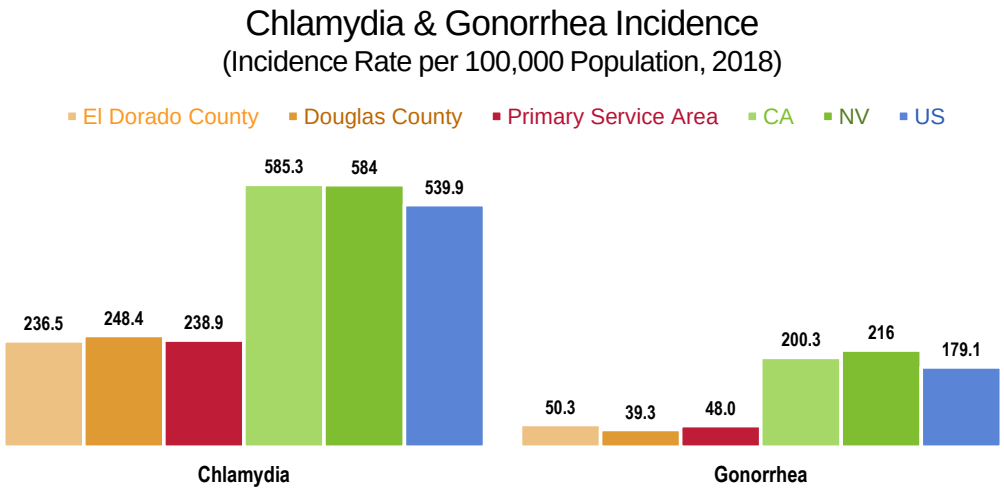
Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in the Primary Service Area was 238.9 cases per 100,000 population.

The Primary Service Area gonorrhea incidence rate in 2018 was 48.0 cases per 100,000 population.

BENCHMARK ► Both rates are dramatically lower than the corresponding state and national incidence rates.

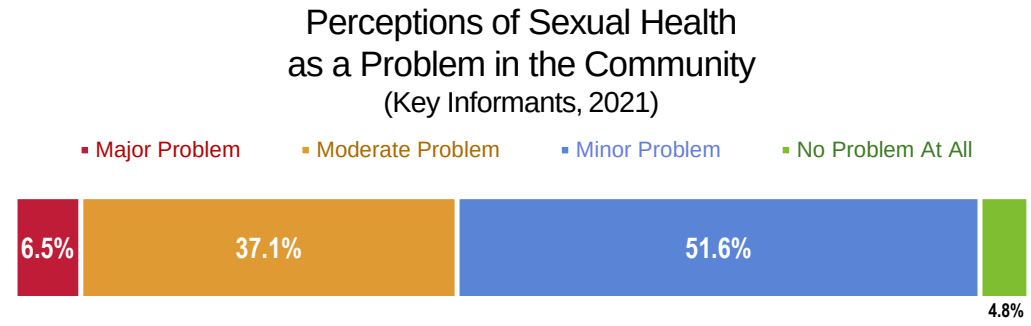


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

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



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

Notes:
- Asked of all respondents.

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

Lack of Parental Involvement

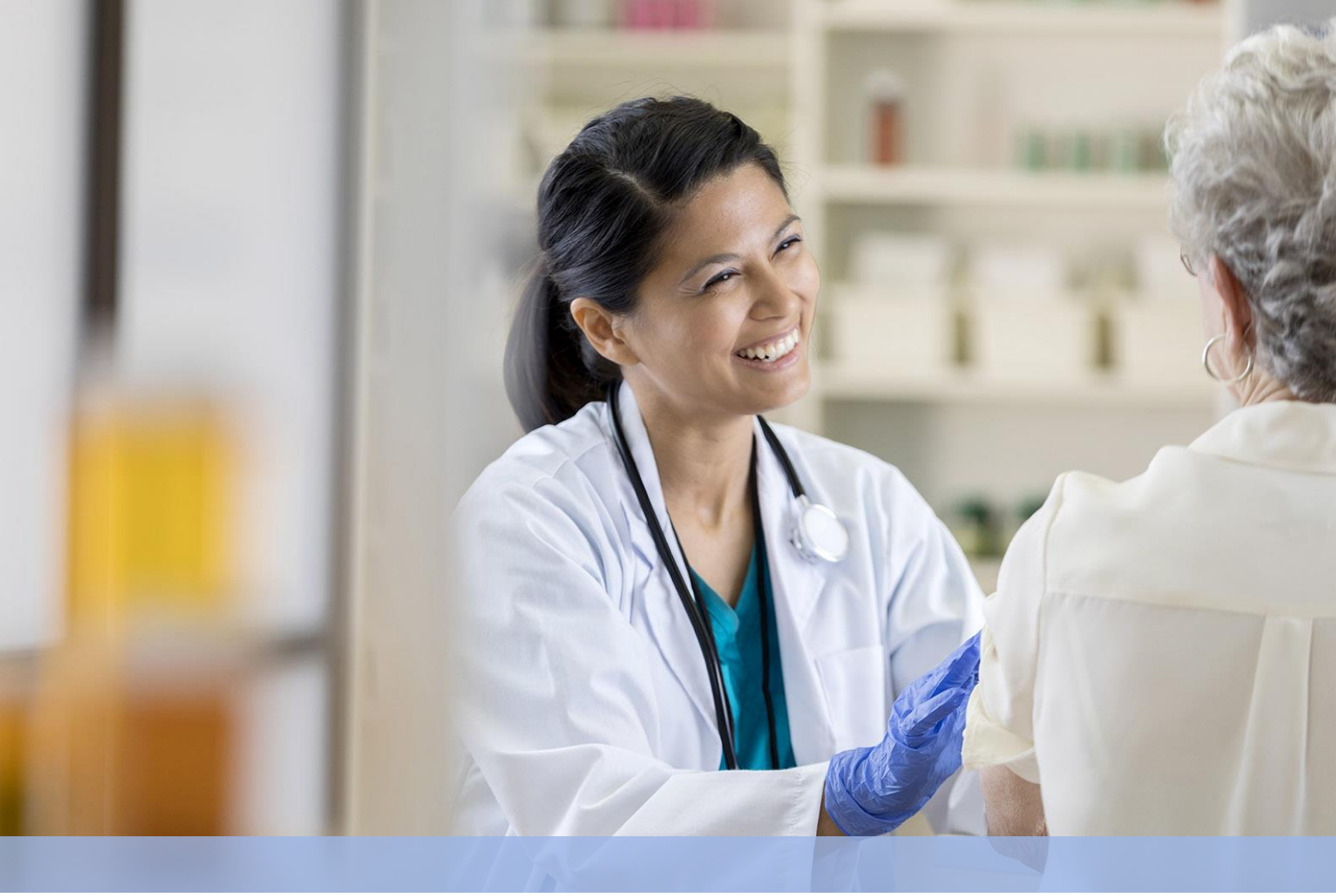
> There seems to be a lack of parental awareness and involvement that stood out to me immediately when I moved into this community. Preventative measures need to be addressed more than, or at least equal to, safe sex. It’s okay to teach about abstinence. It can be done. I have seen it work but we need parent and community buy in. We can do better up here. – Other Health Provider

Access to Care/Services

> There are few resources that are known about for sexual health, especially where youth can go to receive information and resources. – Social Services Provider

Incidence/Prevalence

> Gonorrhea and chlamydia are frequent diagnoses in my clinic, as are undesired pregnancies. – Physician



ACCESS TO HEALTH CARE

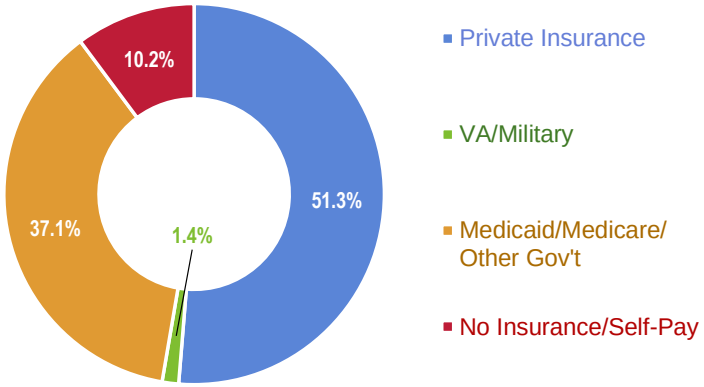
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 51.3% of Primary Service Area adults age 18 to 64 report having health care coverage through private insurance. Another 38.5% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage
(Adults Age 18-64; Primary Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

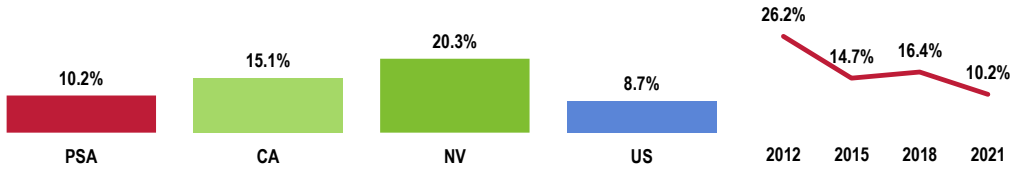
Among adults age 18 to 64, 10.2% report having no insurance coverage for health care expenses.

BENCHMARK ► Lower than the state percentages.

TREND ► Decreasing significantly from 2012 survey findings.

Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower

Primary Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

Lack of Health Care Insurance Coverage
(Adults Age 18-64; Primary Service Area, 2021)
Healthy People 2030 = 7.9% or Lower

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

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

Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

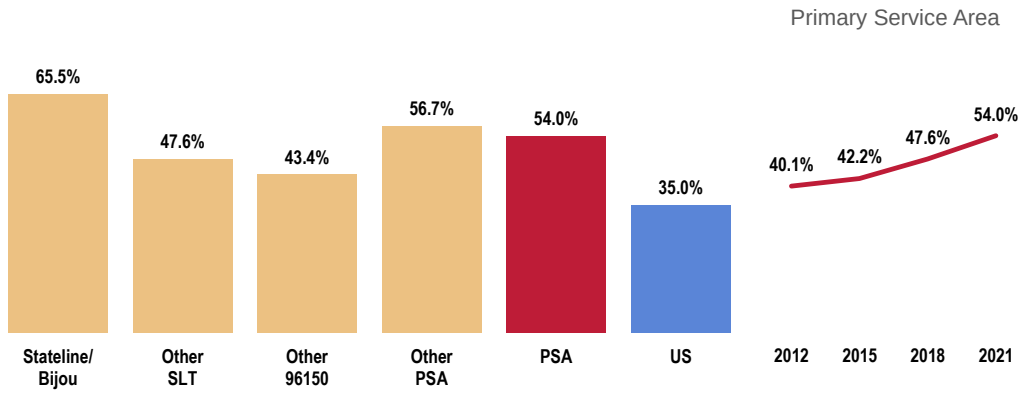
A total of 54.0% of Primary Service Area adults report some type of difficulty or delay in obtaining health care services in the past year.

BENCHMARK ► Much worse than the national prevalence.

TREND ► Increasing significantly (and consistently) since 2012.

DISPARITY ► Unfavorably high in the Stateline/Bijou community. Reported more often among adults age 40 to 64.

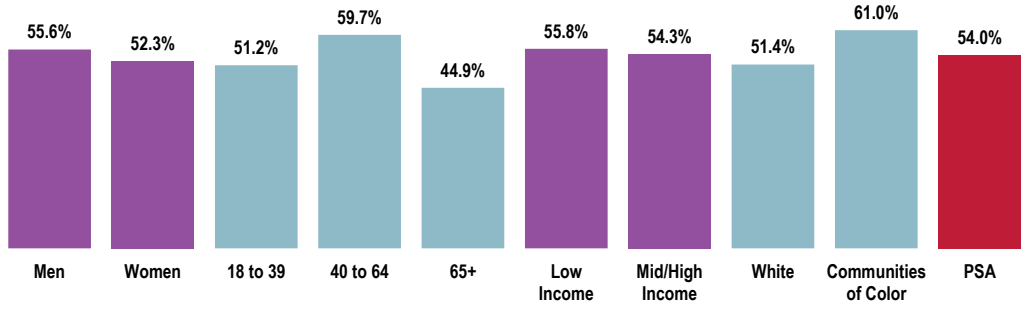
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind
in Receiving Needed Health Care in the Past Year
(Primary Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: ● Asked of all respondents.
● Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Barriers to Health Care Access

Of the tested barriers, appointment availability and finding a physician impacted the greatest shares of Primary Service Area adults.

BENCHMARK ► Worse than the US for appointment availability, cost of a doctor visit, and finding a physician.

TREND ► These access barriers have worsened significantly over time: appointment availability, inconvenient office hours, and difficulty finding a physician.

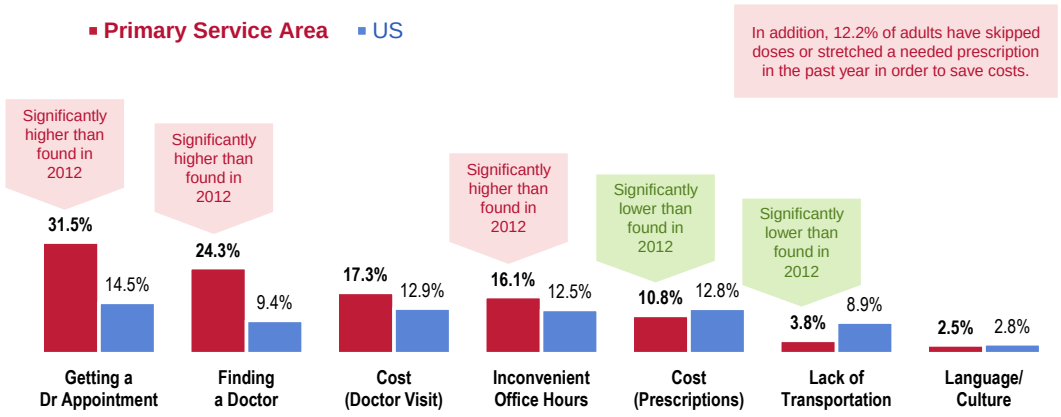
DISPARITY ► Residents of the Stateline/Bijou community are more likely to report issues with cost of doctor visits, inconvenient office hours, and transportation as a barrier to medical care (not shown).

Note also the percentage of adults who have skipped or reduced medication doses in the past year in order to stretch a prescription and save costs (also more prevalent in the Stateline/Bijou community, not shown).

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 7-14]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

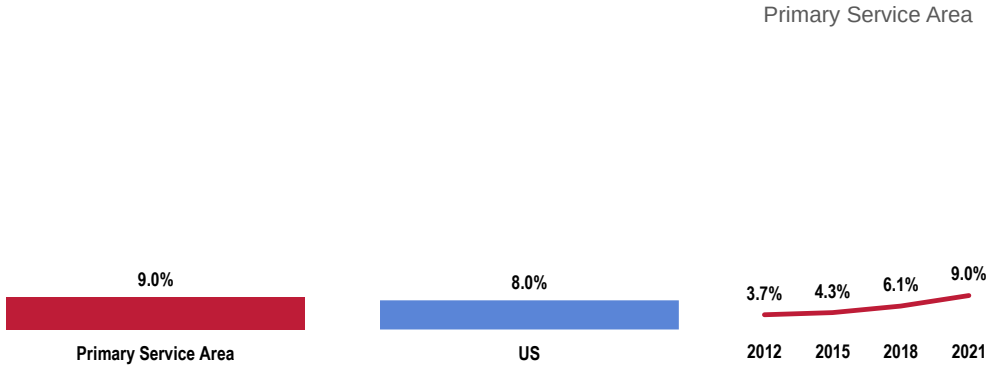
Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

A total of 9.0% 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.

TREND ► The increase over time is not yet statistically significant.

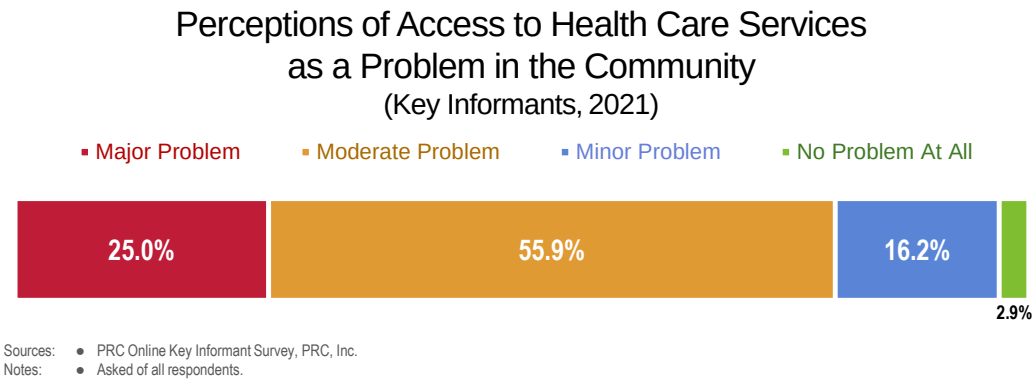
Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 104]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

Over half of key informants taking part in an online survey characterized *Access to Health Care Services* as a "moderate problem" in the community.



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

Access to Care/Services

> Being able to reach the people that have needs and connecting them to services. – Social Services Provider
>
> People who are sick have not been able to get appointments. – Physician
>
> Timely access to basic healthcare services is not available to the majority of the community, especially our Latinx community members. Access to specialty care is also significantly limited to all sectors and at times boils down to getting an appointment because "you know someone" that can get you in. – Community Leader
>
> Access. – Community Leader
>
> Lack of health insurance by families, and lack of providers who accept Medi-Cal and Medicare. – Social Services Provider
>
> Access to high quality specialists in South Lake Tahoe for government payers. – Physician
>
> One of the major problems that I see with access to health care are Barton Clinic does not have enough personal to provide equity health care to low income clients. Barton clinic does not have a pharmacy or program that provide low prices for prescriptions. Barton clinic does not have specialty medicine so clients have to go down the hill for services. – Social Services Provider

Contributing Factors

> Transportation for underserved patients (may not own cars) is difficult, and often working during regular medical office/clinic hours. Undocumented patients not realizing they can receive care, and without money. Cancer patients must travel long distances for treatment. Dialysis patients must travel long distances for treatment. – Community Leader
>
> I believe that access to mental health is issue. Affordable senior care. Access to Coved shots for all ages. Specialists in our area. – Social Services Provider
>
> Lack of insurance, lack of transportation, language issues, long waits for appointments, doctors and nurses are uncaring and don't listen. – Community Leader
>
> Lack of insurance, high cost of healthcare discouraging participation, lack of knowledge about what is covered, what isn't, who is in network etc. Many people get stung once with a high bill and then are hesitant to seek treatment in the future. Lack of dentists that take medical in local area. Major shortage of therapists. – Community Leader

Affordable Care/Services

> Primarily, the problem with access to care is there isn't the financial means for people to access counseling service for substance abuse of mental health services. Because of present-day restrictions, people cannot access doctors without scheduling appointment for weeks or even months out. – Social Services Provider
>
> There is a reluctance to seek care within the community due to costs far exceeding the same services provided elsewhere. Nonprofits should not be setting costs higher than needed. – Other Health Provider
>
> Access to health care for low-income and non-English language speakers have difficulty accessing services. Individuals without health insurance also lack access to health care. – Community Leader

Vulnerable Populations

> Healthcare disparity. Latinx and similar demographic sectors do not have access to the care they need, or they distrust the options that are available, for numerous reasons. – Community Leader
>
> Poverty: South Lake Tahoe is a poverty pocket of El Dorado County and this limits people's ability to maintain all the social determinants of health. – Physician

Pediatric Care

> Pediatric health care is great here, but sometimes it is hard to access because there are so many patients. Our organization requires a physical for each of our students every year. Parents are given a form for the doctor to fill out. The issue is that the form is never filled out at the visit so the parent ends up leaving without it. The parent asks the clinic to FAX it to our organization but it is very rare that we ever receive it. We then have to interrupt services until we get the form. I know we are not the only organization that has this issue. – Social Services Provider

COVID-19

> Currently, fear of going to the doctor, hospital, or other health facilities and contracting COVID. Some services are not available in our community or have only limited availability. – Community Leader

Lack of Providers

> Not enough primary care providers are accepting new patients. – Physician

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

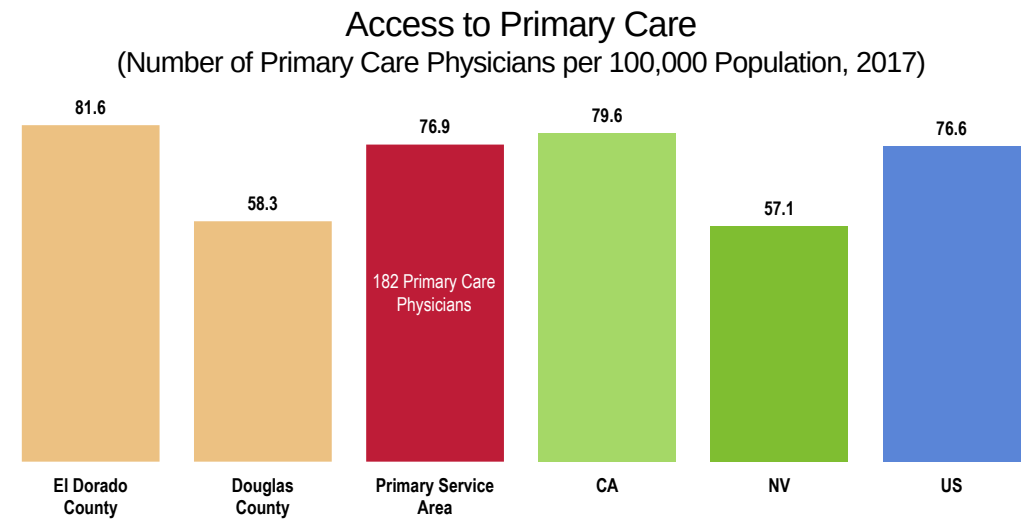
– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

In 2017, there were 182 primary care physicians in the Primary Service Area, translating to a rate of 76.9 primary care physicians per 100,000 population.

BENCHMARK ► Better than the Nevada proportion.

DISPARITY ► Unfavorably lower in Douglas County.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2021 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

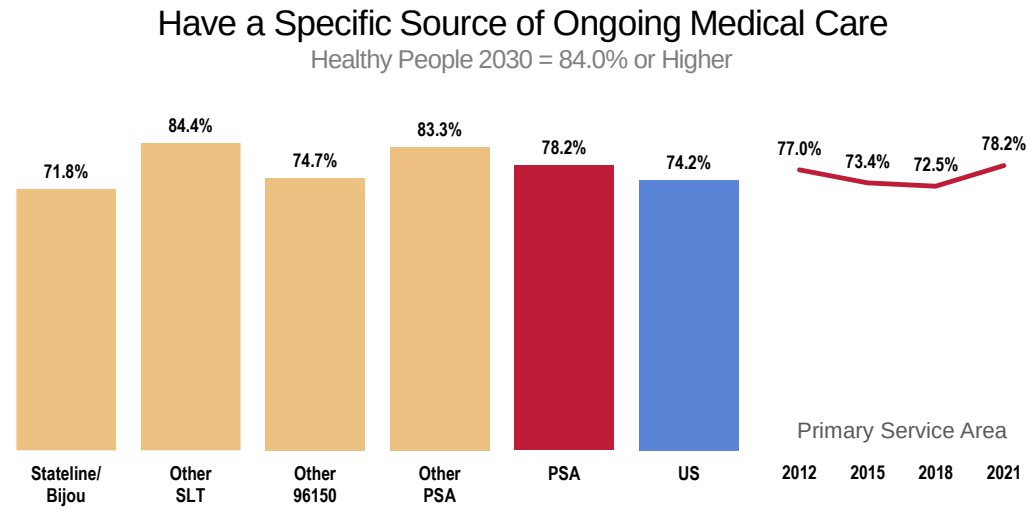
Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. 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.

A total of 78.2% of Primary Service Area adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Unfavorably low in the Stateline/Bijou community.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 139]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Utilization of Primary Care Services

Adults

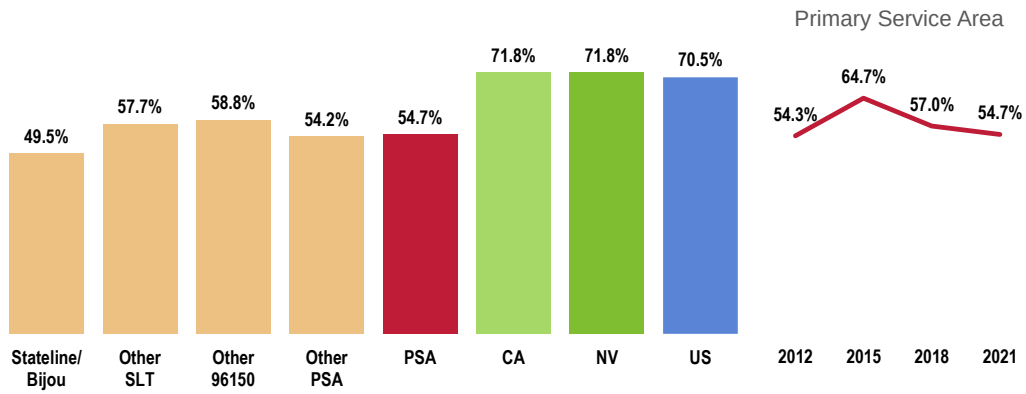
Just over half of adults (54.7%) visited a physician for a routine checkup in the past year.

BENCHMARK ► Well below the state and US figures.

TREND ► Unchanged from 2012 survey findings, despite a spike in 2015.

DISPARITY ► Strong correlation with age.

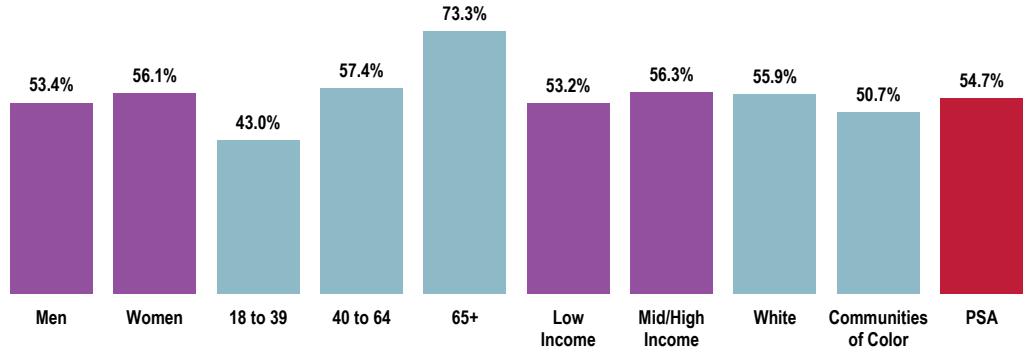
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(Primary Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 18]

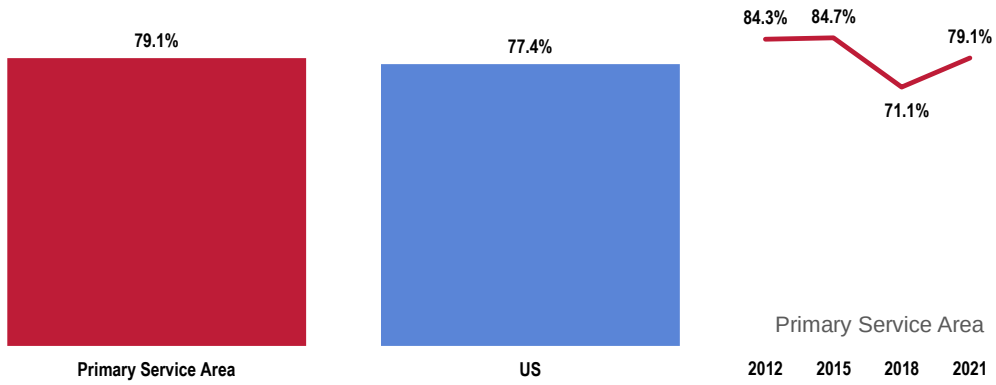
Notes:
- Asked of all respondents.

Children

Among surveyed parents, 79.1% report that their child had a routine checkup in the past year.

TREND ► Increasing from 2018 findings but similar to earlier survey administration results.

Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parents of Children 0-17)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 105]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

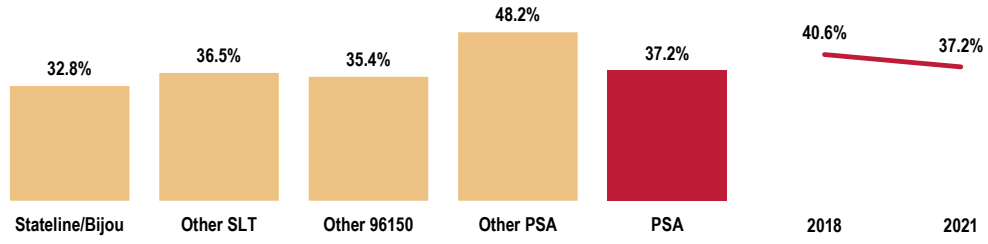
Alternative/Complementary Medicine

Alternative or complementary medicine includes chiropractic care, acupuncture, massage therapy, or vitamin therapy.

Among Primary Service Area adults, 37.2% used some type of alternative or complementary medicine in the past year.

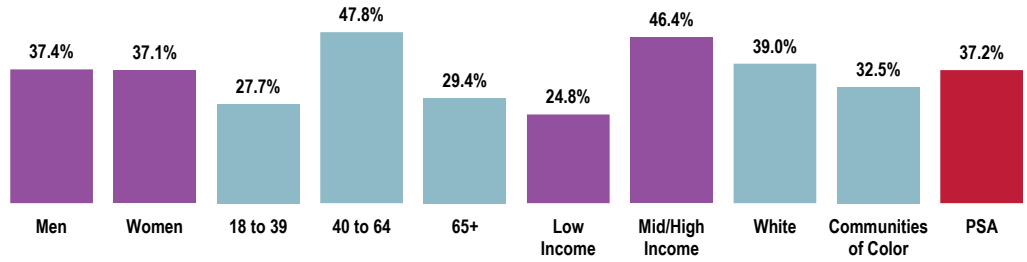
DISPARITY ► Highest in the Other PSA community. Reported more often among adults age 40 to 64 and upper-income respondents.

Used Alternative or Complementary Medicine in the Past Year



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: ● Asked of all respondents.
● In this case, the phrase "alternative or complementary medicine" includes such practices as chiropractic medicine, acupuncture, massage therapy, or vitamin therapy.

Used Alternative or Complementary Medicine in the Past Year
(Primary Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 303]

Notes:
- Asked of all respondents.
- In this case, the phrase "alternative or complementary medicine" includes such practices as chiropractic medicine, acupuncture, massage therapy, or vitamin therapy.

EMERGENCY ROOM UTILIZATION

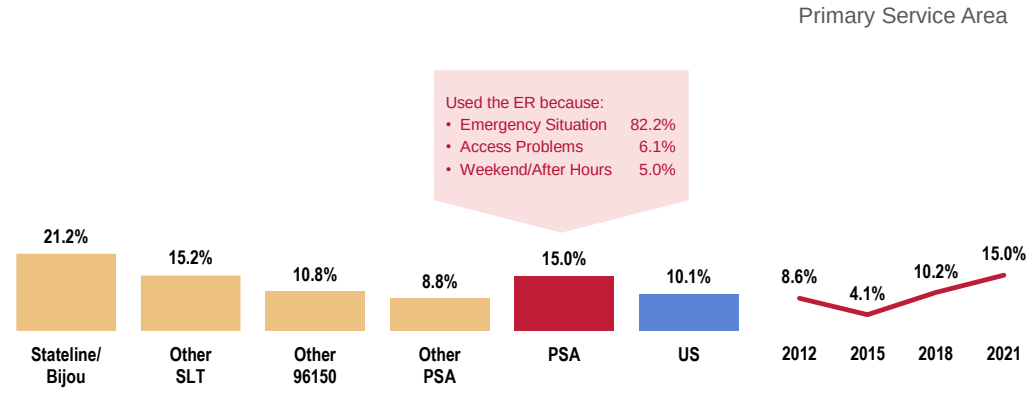
A total of 15.0% of Primary Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

BENCHMARK ► Higher than the national figure.

TREND ► Marks a significant increase from previous survey results.

DISPARITY ► Unfavorably high in the Stateline/Bijou community. Highest among young adults and low-income residents.

Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 22, 302]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(Primary Service Area, 2021)

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 22]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

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

Dental Care

Adults

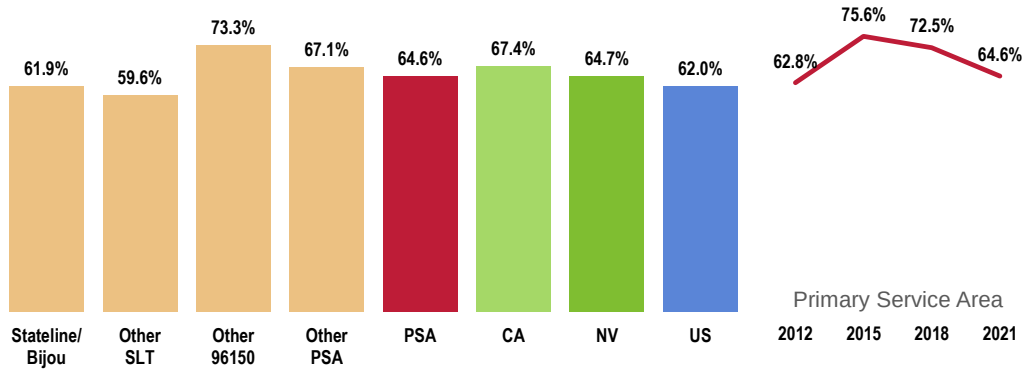
A total of 64.6% of Primary Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

BENCHMARK ► Easily satisfies the Healthy People 2030 objective.

DISPARITY ► Highest in the Other 96150 community. Lowest among adults age 40 to 64 and those in low-income households.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



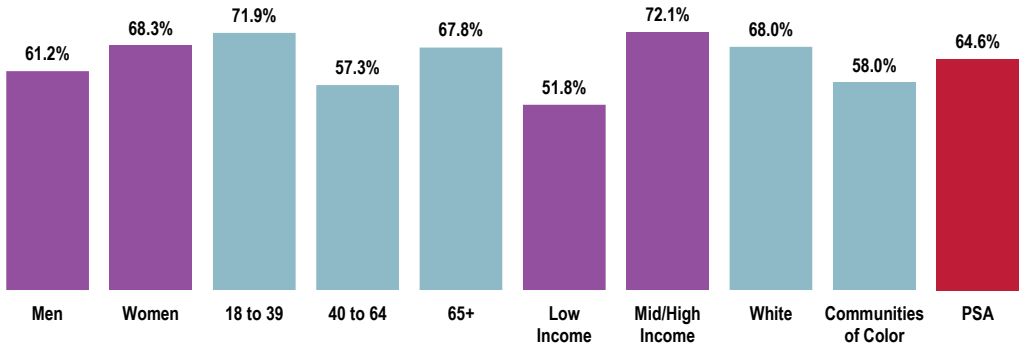
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California and Nevada California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Primary Service Area, 2021)

Healthy People 2030 = 45.0% or Higher



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Children

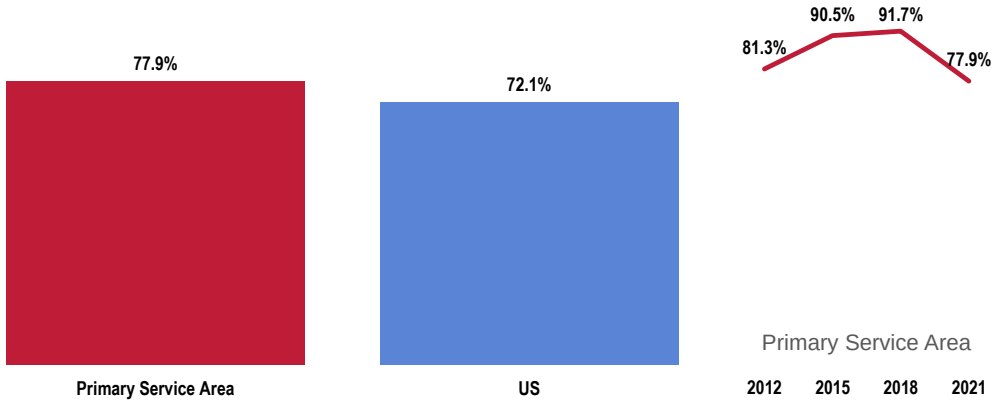
A total of 77.9% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Easily satisfies the Healthy People 2030 objective.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Parents of Children Age 2-17)

Healthy People 2030 = 45.0% or Higher

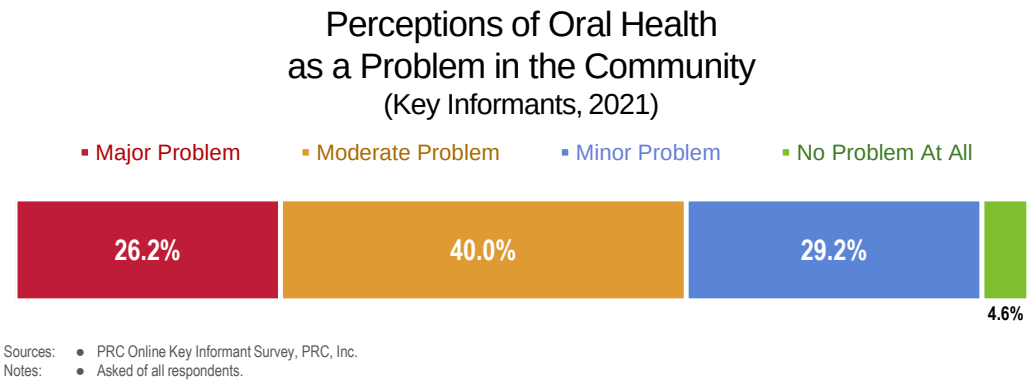


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 108]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.



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

Access for Medi-Cal Patients

> Dentists do not take Medi-Cal and Medicare, patients can't afford it. – Physician
>
> Access to dental services for those on Medi-Cal or Denti-Cal. – Community Leader
>
> Not a lot of providers accept Medi-Cal. – Other Health Provider
>
> I believe there currently is only one dentist who will see Medi-Cal patients. – Social Services Provider
>
> Lack of access especially for those with state sponsored insurance, especially for the children. – Physician
>
> Only one Medi-Cal dentist in South Lake Tahoe. – Physician
>
> Dental health is a problem for the low income adults of Lake Tahoe. There are only two providers that take Medi-Cal, otherwise the client is referred to go to Placerville. For children, there is only basic oral care if the child needs other work done. – Social Services Provider
>
> Not enough Medi-Cal dental providers. – Physician
>
> Only one Denti-Cal provider in town. Need more early intervention at the school sites. Traveling dental van has had inconsistent presence in South Lake Tahoe. – Social Services Provider

Access to Care for Uninsured/Underinsured

> There are none too few oral health services for Medi-Cal patients. – Community Leader
>
> Many of our community members lack dental insurance, which can be a roadblock for many who can't afford such services. Also, the providers that accept Medicare and Medi-Cal are too few for the demand. – Social Services Provider
>
> Lack of access for those uninsured or undocumented. – Community Leader
>
> Lack of dental insurance, lack of money to get dental care, lack of dentists willing to work with the underserved. – Community Leader
>
> The community does not have a free dental clinic where low income people can go to. – Social Services Provider

COVID-19

> Currently, the pandemic has resulted in many people of all ages missing appointments. Oral health and preventative care is also not a priority for many families until it becomes an emergency. – Other Health Provider

Prevention/Screenings

> Prevention and education, support for low income earners. – Community Leader

VISION CARE

A total of 40.5% of Primary Service Area residents had an eye exam in the past two years during which their pupils were dilated.

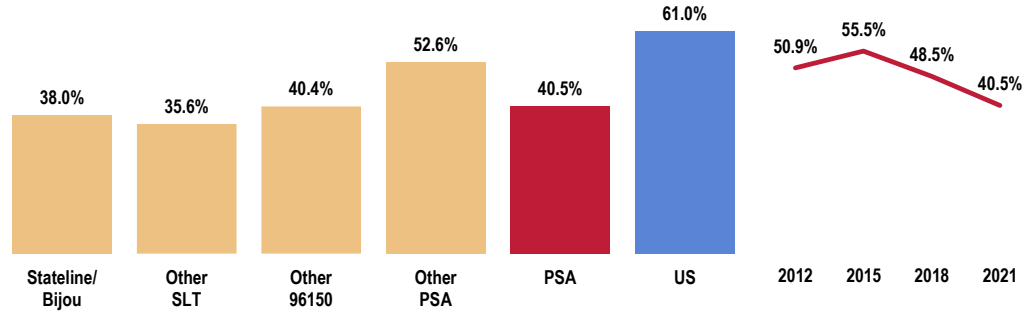
BENCHMARK ► Much lower than the national prevalence. Fails to satisfy the Healthy People 2030 objective.

TREND ► Marks a statistically significant decrease from previous survey findings.

DISPARITY ► Highest in the Other PSA community. Lowest among young adults and low-income residents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

Healthy People 2030 = 61.1% or Higher



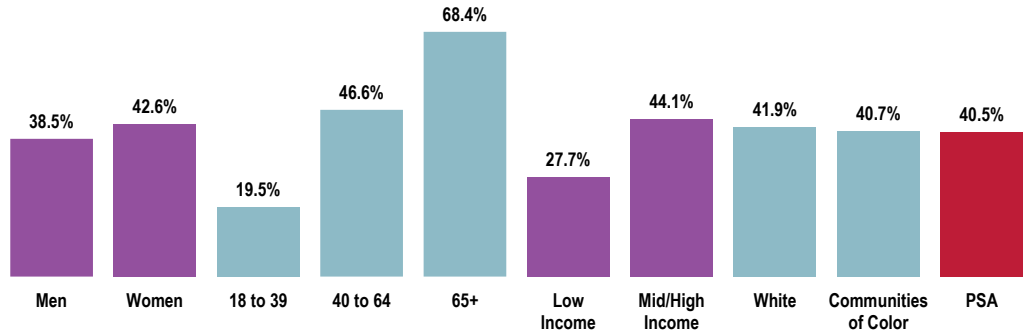
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 19]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Primary Service Area, 2021)

Healthy People 2030 = 61.1% or Higher



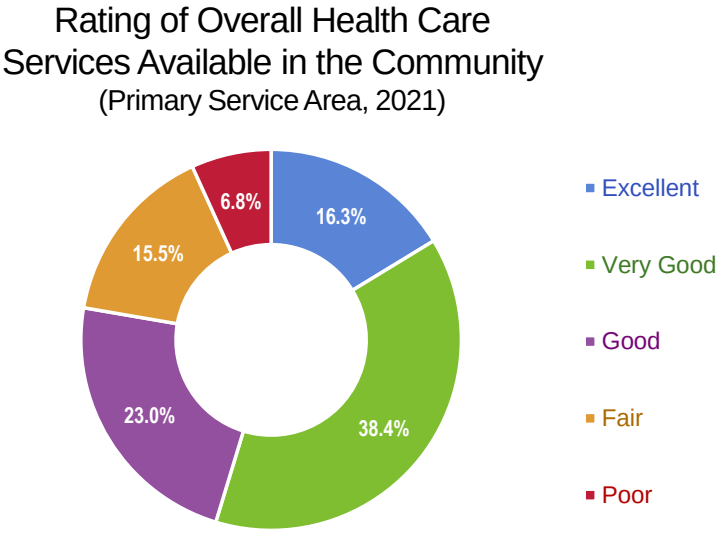
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 19]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

Most Primary Service Area adults rate the overall health care services available in their community as "excellent" or "very good."



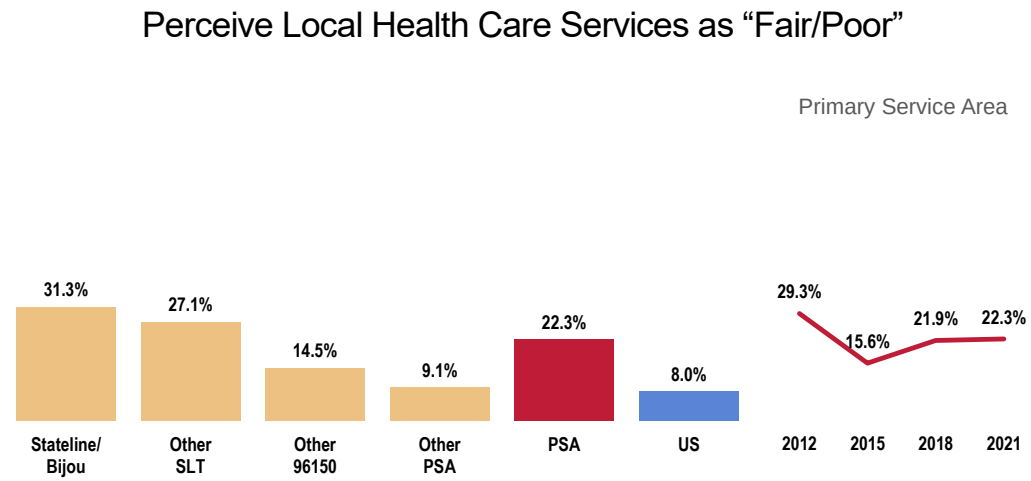
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: ● Asked of all respondents.

However, 22.3% of residents characterize local health care services as "fair" or "poor."

BENCHMARK ► Well above the national percentage.

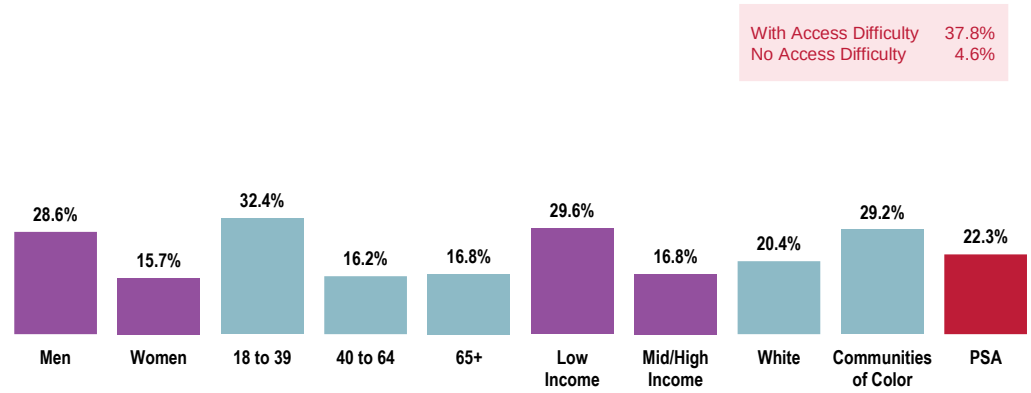
TREND ► Significantly lower than the 2012 percentage (but above the 2015 response).

DISPARITY ► Unfavorably high in the Stateline/Bijou community. "Fair/poor" responses are also reported more often among men, young adults, and low-income residents.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Local Health Care Services as “Fair/Poor”
(Primary Service Area, 2021)

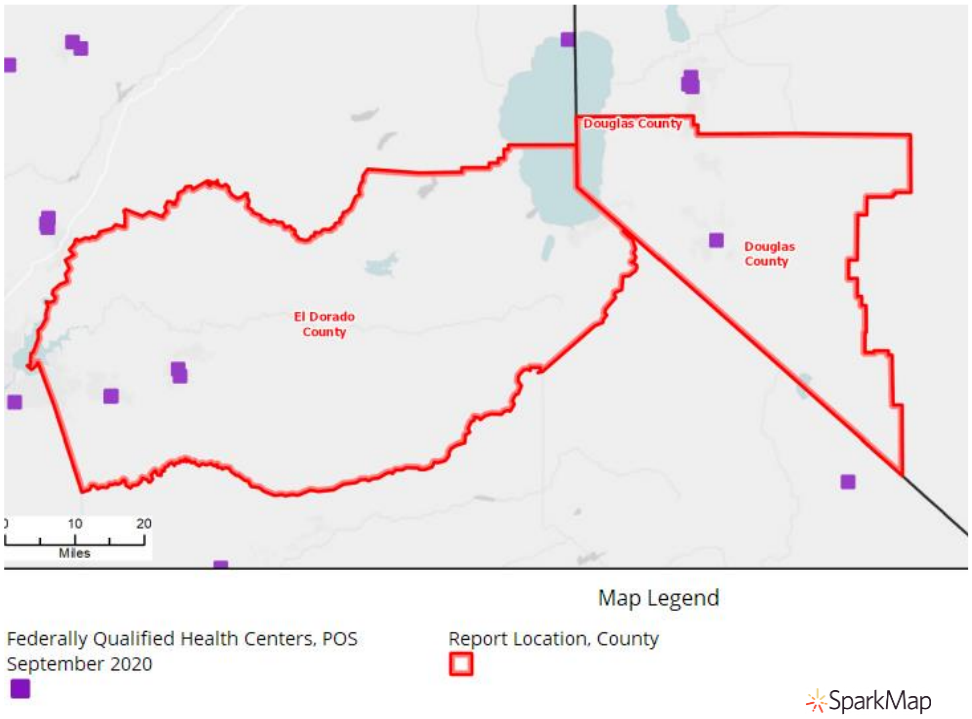


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) in El Dorado and Douglas counties as of September 2020.



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- 211
- A Balanced Life
- Barton Clinic
- Barton Community Health Center
- Barton Family Practice
- Barton Health
- Barton Hospital
- Barton Orthopedics and Wellness Center
- Barton Urgent Care
- Community Hub Program
- Dental Van
- El Dorado County Behavioral Health
- El Dorado County Health Department
- Emergency Room
- Family Resource Center
- Health Fair
- Healthcare System
- High Sierra Dental Care
- Jean Street
- Library
- Nonprofits
- Payment Plans
- Sierra Smiles
- South Tahoe Cancer League
- Stateline Medical
- Tahoe Magic
- Tahoe Smiles
- Urgent Care
- Urgent Care South Lake Tahoe

Cancer

- Barton Health
- Barton Oncology
- Barton Urology
- Cancer League
- Cancer Society of South Lake Tahoe
- Cancer Wellness
- Carson Tahoe Regional Medical Center
- Gene Upshaw Memorial Tahoe Forest Cancer Center
- Home Health
- Infusion Center and Ancillary Services
- Palliative Medicine
- Tahoe Forest Hospital
- Wellness Center

Coronavirus

- Barton Community Health Center
- Barton COVID Hotline
- Barton Health
- Barton Hospital
- Barton Primary Care Clinic
- Bread and Broth
- CalWorks
- City of South Lake Tahoe
- Community College
- Community Hub Program
- COVID Line
- El Dorado Community Foundation
- El Dorado Community Health Center
- El Dorado County
- El Dorado County Public Health
- Emergency Room
- Family Resource Center
- Fire Department
- Health Department
- Hospitals
- Jean Ave
- Lake Tahoe Community College
- Lake Tahoe Prosperity Center
- Lake Tahoe Unified School District
- Live Violence Free
- Local News
- Marshall Medical Foundation
- Negative Pressure Clinics
- NextDoor App
- Phone Apps
- Private Testing Labs
- Public Health
- RoomKey
- RUC
- Safeway
- School System
- Shingle Springs Health and Wellness Center
- South Lake Tahoe City Small Business Grant/Loan
- Tahoe Chamber

- Tahoe Magic
- Tahoe Tribune
- Test Well
- Testing Center

Dementia/Alzheimer's Disease

- Barton Hospital
- El Dorado County Health Department

Diabetes

- American Diabetes Association
- Barton Community Foundation
- Barton Community Health Center
- Barton Health
- Barton Hospital
- Care Management
- Community Health Clinic
- El Dorado County Health Department
- Fitness Centers/Gyms
- Nutrition Services
- Parks and Recreation
- Trainers
- UC Davis Nutrition Program

Disabilities

- Barton Clinic
- Barton Community Clinic
- Barton Community Health Center
- Barton Health
- Barton Hospital
- Barton Orthopedics and Wellness Center
- Barton Spine
- El Dorado County
- El Dorado County Behavioral Health
- IHSS Workers
- In Jesus Name Medical Ministries
- NAMI
- Palliative Medicine
- Physical Therapy
- Tahoe Coalition for the Homeless
- Tahoe Orthopedic Center
- Tahoe Youth and Family Services

Infant Health & Family Planning

- Barton Health
- Barton Home Visiting Program
- Boys and Girls Club
- Choices for Children
- Community Health Center
- El Dorado County Office of Ed Home Visiting Program
- El Dorado County Public Health
- First Five
- Hub 5
- Lake Tahoe Community College
- Tahoe Forest Hospital
- The Community Hub at the Library

Injury & Violence

- Barton Behavioral Health and Psychiatry
- Barton Health
- Barton Hospital
- Barton Orthopedics and Wellness Center
- Barton Urgent Care
- El Dorado County Child Protective Services
- El Dorado County Mental Health Services
- El Dorado County Public Health
- Family Resource Center
- Live Violence Free
- Police Department
- SLTPD
- South Lake Tahoe Family Resource Center
- STPD and EDC Probation
- Tahoe Coalition for the Homeless
- Tahoe Youth and Family Services

Mental Health

- A Balanced Life
- Barton Behavioral Health and Psychiatry
- Barton Community Clinic
- Barton Community Guide
- Barton Community Health Center
- Barton Health
- Barton Hospital
- Behavioral Health Network
- Boys and Girls Club
- Churches
- Community Health Center
- Community Hub Program
- County Behavioral Health
- County Mental Health
- Crisis Line
- Douglas Counseling and Supportive Services
- El Dorado County Behavioral Health
- El Dorado County Mental Health Services
- El Dorado County Substance Use Disorder Services
- Family Resource Center
- Infant Parent Center
- Lake Tahoe Unified School District
- Live Violence Free
- MOST Referral
- NAMI
- Nonprofits
- Public Health
- School System
- Sierra Child and Family Services
- Social Services
- State Mental Health Services
- Suicide Prevention Network
- Tahoe Coalition for the Homeless

- Tahoe Turning Point
- Tahoe Youth and Family Services
- Therapy Services
- Victims Compensation Fund

Nutrition, Physical Activity & Weight

- American Youth Soccer Organization (AYSO)
- Barton Health
- Barton Hospital
- Barton Nutrition Services
- Barton Orthopedics and Wellness Center
- Barton's Maloff Center
- Bijou Community Park
- Boys and Girls Club
- Bread and Broth
- Cal Fresh
- Christmas Cheer
- El Dorado County Health Department
- Family Resource Center
- Grass Roots
- Kahle Community Center
- Lake Tahoe Unified School District
- Live Violence Free
- LTCC
- Moxy/Barton Community Fitness Program
- Nutrition Services
- Private Wellness Businesses and Service Providers
- School System
- Soup Kitchen
- Tahoe Coalition for the Homeless
- Trainers
- UC Davis Nutrition Program
- WIC

Oral Health

- Dental Van
- Dentist's Offices
- El Dorado County Dental Van
- First Five
- High Sierra Dental Care
- MediCal
- The Smile Shop
- Sierra Smiles
- Tahoe Magic
- Tahoe Smiles
- The Smile Shop

Respiratory Disease

- Barton Health
- El Dorado County Substance Use Disorder Services
- Tahoe Youth and Family Services

Sexual Health

- Barton Community Health Center
- Barton Health
- El Dorado County Health Department
- Public Health
- School System

Substance Abuse

- A Balanced Life
- AA/NA
- AAA
- Aegis Treatment Centers
- Barton Clinic
- Barton Community Clinic
- Barton Community Health Center
- Barton Health
- Barton Hospital
- Barton Mediation Assisted Treatment Program
- Barton Suboxone Program
- Behavioral Health Services
- Community Counselors
- Community Hub Program
- County Behavioral Health
- County Mental Health
- CPS
- El Dorado County Behavioral Health
- El Dorado County Mental Health Services
- El Dorado County Opioid Coalition
- El Dorado County Substance Use Disorder Services
- Emergency Room
- Employer Assistance Programs
- Family Resource Center
- Live Violence Free
- Marshall Medical Foundation
- MAT
- Mental Health and Substance Abuse Services
- Mental Health Services
- Progress House
- Public Health
- School System
- South Tahoe Police Department
- Summitview
- Tahoe Alliance for Safe Kids
- Tahoe Coalition for the Homeless
- Tahoe Turning Point
- Tahoe Youth and Family Services
- Teen Treatment Center
- The T House

Tobacco Use

- A Balanced Life
- Barton Health
- El Dorado County
- El Dorado County Behavioral Health
- El Dorado County Health Department
- El Dorado County Substance Use Disorder Services
- Family Resource Center
- Lake Tahoe Unified School District
- Mental Health and Substance Abuse Services
- Prop 10
- Public Health
- Tahoe Youth and Family Services
- Tobacco Use Prevention Program

APPENDIX

EVALUATION OF PAST ACTIVITIES

2018-2021 Impact Report

1. Mental Health	
Community Partners	Members of the Behavioral Health Network and the Community Health Advisory Committee.
Goal	Improve the referral and care flow system and create partnerships for service providers in the community to empower and strengthen the quality of life for South Shore residents.
Timeframe	FY2018-FY2021
Scope	Strategy will focus on residents in the South Shore.
Strategies and Objectives	**Strategy #1: Spearhead community collaboration and engagement to improve the mental health care flow system** ● Through a recently awarded federal grant create a technological platform that supports and strengthens an integrated system of medical and behavioral healthcare by streamlining referrals amongst community partners ✓ The Unite Us platform currently supports 35 community partners and is managed by Lake Tahoe Unified School District. ● Provide resources to maintain a Coordinator for the Behavioral Health Network (BHN) of South Lake Tahoe, whose purpose is to improve the care flow system to empower and strengthen our community ✓ Funding through a community grant continues to support Lake Tahoe Unified School District to facilitate the network and manage the referral platform. ● Attend and facilitate regular meetings of BHN. Host a community-wide forum focused on addressing mental health needs in the area ✓ Monthly BHN meetings continue to take place. Every May, Barton hosts events, such as a mental health webinar, to address and support mental health in our community. ● Recommended strategies and seek resources to support strategies of BHN ✓ This continues to be an ongoing effort. ● Barton's internal mental health task force will coordinate proper treatment and referral options for mental health patients throughout the system including the emergency department and inter-facility transfers ✓ Barton's internal mental health meeting is currently paused but a new task force is developing to re-establish coordinated efforts.

Strategies and Objectives	**Strategy #2: Continue to provide mental health services** ● Barton Health to participate in community technological platform for an improved referral system ✓ Barton continues to support the grant that allows the Unite Us program to function and has extended the contract through 2022. ● Improve depression screening rates at annual wellness visits ✓ Over the past two years, providers at Barton Community Health Center, Barton Pediatrics and Barton Primary Care at Stateline Medical Center worked to increase adult and adolescent depression screening and have screened nearly 55% of their adult and 70% of their adolescent patients ● Employ three licensed clinical social workers to address behavioral health and medical needs for patients. Coordinate counseling services and case management for primary care patients at primary care physicians and Barton Community Health Center locations ✓ We are currently recruiting 3 licensed clinical social workers. A $100,000 Health Net grant provides funding to partner with community licensed clinical social workers. ● Provide tele-psychiatry services for patients through Barton physician offices ✓ Barton continues to provide Telepsychiatry and Telepsychology services. ● Offer adult psychiatry services at Barton Psychiatry through two existing child psychiatrists and an additional adult psychiatrist. ✓ Barton currently staffs one adult psychiatrist and two child psychiatrists. ● Maintain hospice grief counseling and children's bereavement camp (Camp Sunrise) ✓ Barton's Home Health & Hospice continues to offer this program. ● Continue Barton nurses visiting new mothers postpartum to identify postpartum depression and offer resources through support groups ✓ A registered nurse with Barton's Family Birthing Center continues to offer this service as well as a Mommy-and Me Support group and birthing preparation classes. **Strategy #3: Build awareness through education and prevention campaign** ● Implement awareness campaign during Mental Health Awareness Month: poster series, articles, advertisement, web and social media awareness ✓ Mental Health Awareness Month continues to be a priority. ● Conduct a suicide prevention and awareness campaign and support Suicide Prevention Network's efforts ✓ During the month of September, Barton partners with community agencies to educate on suivide prevention.

	• Distribute campaign materials to Barton Health medical practices, hospitals and other community partners ✓ This remains an ongoing effort and commitment. • Incorporate mental health topics into the Wellness Lecture Series and other speaking engagements ✓ Wellness Webinars and community service club presentations on mental and behavioral health continue to be a priority. • Comprehensive mental health resources will be included in the community resource guide and updated annually ✓ The community resource guide and website continue to be updated annually. • Community health grant resources will be allocated to services provided by local non-profit organizations to address unmet mental health needs in the community ✓ Annual community health grants are awarded, with the amount funded being increased to $100,000 in 2020 and 2021.
Anticipated Impact	Reduce stigma and improve access and coordinated care for patients.
Evaluation of Impact	• Track data to support successful behavioral health referrals ✓ Unite Us tracks and provides data to Behavioral Health Network partners. • Identify the barriers with delays in the emergency room for proper transfer of mental health patients. ✓ The Safety Department tracks this information with plans to further assess. • Implement depression screening through annual wellness visits and/or establishing a Barton primary care physician. ✓ Will continue with depression screenings as well as establishing PCP care.

2. Substance Abuse	
Community Partners	Members of the former South Tahoe Drug Free Coalition. New name is Tahoe Alliance for Safe Kids.
Goal	To reduce youth and adult substance use in the South Lake Tahoe region
Timeframe	FY2018-FY2021
Scope	Strategy will focus on residents in the South Shore community.
Strategies and Objectives	**Strategy #1: Enhance internal protocols to reduce prescribing of narcotics and implement a Medication Assisted Treatment program.** • Implement the Medication Assisted Treatment program through the Community Health Center and any supporting programs that help reduce opioid overdose ✓ The Medication Assisted Treatment program has been successfully implemented with 8 waivered providers.

	✓ A Substance Use Navigator was hired to help with the ED Bridge Program--which helps coordinate care from the Emergency Department to Primary Care. ● Barton Health, through the Center for Orthopedics & Wellness, will research and introduce appropriate alternative therapies to patients throughout the Barton Health system including aromatherapy, integrative medicine, meditation, massage therapy and others ✓ Programs such as group acupuncture, mindfulness and alternative therapies were implemented in 2018-2019 through the Wellness Program in the Center. Some services continue to be offered or patients are referred to appropriate resources. ✓ Barton Health will contract with a Pain Management specialist to offer consultations and guidance to chronic pain patients as needed ✓ Actively recruited for this position and currently on hold. **Strategy #2: Participate in the coordinated groups around substance abuse, including the Hub & Spoke effort, the Opioid Coalition and the former Drug Free Coalition** ● Attend community meetings as appropriate ✓ Barton regularly attends community meetings, such as the Opioid Coalition and the former Drug Free Coalition, now known as Tahoe Alliance for Safe Kids (TASK) ● Contribute time, data and other resources to further the mission of prevention and education and ensure successful program outcomes. Particular programs may include: permanent drug take back bins, in-home lock bags, an alternative suspension program at the middle and high schools, and educating parents on the dangers of alcohol and drug use for teenagers. ✓ Many of these programs continue, with the addition of a parent texting network, school and community based presentations on the dangers of opioids and vaping and continued support of the Drug Store Project. ● Support efforts on grant funding which may include data, matching funds, information sharing to the public, and other collaboration as identified ✓ These community efforts continue to be a priority. **Strategy #3: Support community prevention programs** ● Community health grant resources will be reserved for services provided by local non-profit organizations to address substance abuse within the community ✓ Community health grant funding continues to support organizations and projects that are focused on substance use and abuse.

	● Provide staff and financial support for community-wide initiatives such as the Drug Store Project, Every 15 Minutes, Athlete Committed and other local non-profit organizations ✓ Support continued for community-based initiatives during the time these programs were offered. ● Be involved, and express opinions regarding the health of the community at public meetings ✓ Physicians, Administration, and staff continue to participate in public forums.
Strategies and Objectives	**Strategy #4: Conduct outreach and education on the effects of alcohol and drug abuse** ● Implement awareness campaign annually through: poster series, articles, advertisement, web and social media awareness ✓ This continues to be a priority. ● Disseminate appropriate information to Barton staff and physicians and coordinate internal trainings as requested ✓ Working with the Pharmacy Director, CMO and MAT program to disseminate appropriate information internally. ● Substance abuse resources will be included in the health resource guide updated annually ✓ Community Resource Directory continues to be updated annually, adding in new substance use resources.
Anticipated Impact	Build an effective Medication Assisted Treatment program that supports patients who have opioid addiction. Local awareness and recognition of substance abuse problems within the South Shore community.
Evaluation of Impact	● Track visits from drug overdose as reported in Barton's Emergency Dept. ● Established Medication Assisted Program with tracked number of patients on Suboxone ● System wide prescription narcotic protocols for Barton Health physicians ✓ All three items listed have been established and continue today.

3. Access to Healthcare Services	
Community Partners	Members of the Community Health Advisory Committee
Goal	To improve access to primary care and preventative medicine
Timeframe	FY2018-FY2021
Scope	Strategy will focus on residents in the South Lake Tahoe basin.
Strategies and Objectives	**Strategy #1: Improve access and care coordination through meeting criteria for the Patient Centered Medical Home (PCMH) designation** ● Create streamlined operations to ease appointment setting, same-day appointments and appointment reminders ✓ Same day appointment process was implemented to increase access and the number of available same day appointments. Appointment reminders for preventive care were started and almost 10,000 are sent annually. ● Monitor access needs and preferences of primary care patients; including third next available appointment measure, CG-CAHPS survey measures; and other sources such as monitoring complaints related to access. ✓ The 3rd next available appointment and appointment time preferences were monitored over the past several years. This led to a change in policy to reduce no-show appointments. The CG-CAHPS and monitoring access continued and related complaints are now being tracked regularly. ● Increase the number of patients seen for preventative care (immunizations, screenings, annual wellness visits, etc.) ✓ Cervical Cancer Screening and Breast Cancer Screening rates improved up until 2020. Continued efforts to improve immunizations and annual wellness visits continue, with moderate success. **Strategy #2: Increase insurance coverage for the community through outreach for Covered California and Medi-Cal** ● Conduct outreach, training and enrollments regarding the Affordable Care Act, specifically Covered California and Medi-Ca ✓ Covered CA certified enrollment specialists at Barton continue to provide free enrollment support to community members. ● Train and maintain certification for Barton Health System and Barton Health employees to become certified enrollment counselors for Covered California ✓ New employees are supported to become enrollment counselors. ● Act as a resource for the community to answer questions and enroll consumers into medical health coverage ✓ Marketing and educational materials are distributed throughout the year.

	● Ensure website has information and access to inform consumers regarding health insurance options for the South Lake Tahoe region ✓ Website and social media are updated to reflect current opportunities. **Strategy #3: Expand additional or enhanced medical services for the community** ● Explore feasibility of adding or expanding services such as outpatient wound care clinic, expanded OB/GYN services, Gastroenterology, expanded telemedicine services such as tele-perinatology and tele-nephrology, and others as community needs arise ✓ Expanded service lines have been implemented, including Eagle Telehealth offering intensivists through telehealth, neurology, rheumatology and hearing aids. ● Continue programs to improve access to ancillary healthcare services: Labs, EKG, CT Scans, MRI and explore others as need arises ✓ Community outreach programs continue. New Outpatient MRI has been established to improve access. ● Support the new wellness service line in the Center for Orthopedics & Wellness through education and marketing ✓ Marketing and education on new wellness opportunities through the Center continue, including: Health Coaching, Mindfulness Training, Cancer Support Services and more. **Strategy #4: Create and implement an outreach plan for the Latino Community** ● Work with community partners such as Family Resource Center, school districts, Lake Tahoe Community College, El Dorado County Community Hub, El Dorado County Substance Use Disorder and UC Cal Fresh to coordinate ideas and plans to best reach and educate this community. ✓ Supporting the LatinX community is a top priority. Examples include: Community Health Fair at Bijou, translated articles/press releases, increased flu clinics, presentations to Cafecitos, COVID financial support for food insecurity, clothing/gift card opportunities through The Attic, and more. ● Explore hosting and/or participating in community gathering events that best reach and serve our Latino community. ✓ Hosted Community Health Fair at Bijou with the intent to continue this event post-COVID. ● Regularly participate in cafecitos. ✓ Quarterly presentations on vaping, concussions, Covered CA, COVID vaccinations.

Anticipated Impact	Allowing patients to receive care they need in a clear and timely manner leading to improved health.
Evaluation of Impact	● Increased number of patients with assigned Barton Primary Care Providers ✓ Barton added over 2,000 patients assigned to a Barton provider since 2018. ● Increased same-day appointment availability ✓ Same day appointment availability at the two PCMH offices is currently at 2 per day per provider. ● Increase in patients attending annual wellness visits ✓ Our annual wellness patient visits decreased by 2% over the past two years. Our Well Child Visits increased for 3-10 years by 19% and 11-18 by 8%, most recently as a by product of COVID.

Proposed Activities to Address Health Needs

Infant Health & Family Planning	*An educational campaign coordinated between Barton Women's Health and Barton's Family Birthing Center will highlight the importance of early prenatal care. We will continue to offer childbirth classes to be responsive to community health issues. Barton OBGYN's will conduct outreach through wellness lectures and include midwife and doula education so as to include community members considering a home birth. Postpartum home visits will continue for new moms. We will also explore plans to be recognized as a Baby Friendly Hospital which implements policies and care practices that meet the gold standard for mother/baby care practices related to breastfeeding.* ✓ Baby Friendly Designation achieved. ✓ Blue Distinction® Center for Maternity Care ✓ Mommy & Me Support Group for new moms ✓ Women's Health Month lecture in October annually ✓ Childbirth classes and Postpartum Visits
Nutrition, Physical Activity & Weight	*Efforts to promote healthy nutrition and an active lifestyle include: We Can! and Harvest of the Month in elementary schools, Nutrition lectures, diabetes education, dietician access for both inpatient and outpatient, diabetes educator in the Wound Care Clinic, healthy choices in Barton Café, BHealthy Hub Program for employees with the possibility of extending this program to local employers, collaboration with local gyms, kids' fitness camps, and other community collaborations. The new Center for Orthopedics & Wellness will provide classes and education on the CHIP program and Mediterranean Diet. Continued sponsorship of local youth events.* ✓ Harvest of the Month and We Can! programs continued in partnership with LTUSD and Cal Fresh. ✓ Barton Wellness programs included CHIP, Mediterranean Lifestyle and Fighting Cancer with Your Fork. ✓ Barton Cafe offers healthy options for each meal and eliminated sodas. ✓ The BHealthy Program continues for employees to improve their health and wellbeing. ✓ Supporting local youth sporting events as well as community events that promote activity/wellness, continues to be a priority.

Immunization & infectious Disease	*Barton will continue to collaborate with the Infectious Disease Department in collaboration with the Public Health Department and schools on communication about outbreaks. A physician screening process includes high risk diseases. Hospital campaigns include hand washing, mask and flu season education. A pediatric immunization reminder letter will be sent out as part of our commitment to PCMH. A free vaccination program is available through our Community Health Center. We also partner and promote Back to School immunizations with County Public Health.* ✓ The COVID-19 pademinc brought forth the biggest collaboration opportunity, with the county, as well as community partners. ✓ High risk disease screenings conducted in primary office setting ✓ Pediatric Immunization letters are sent monthly ✓ Barton has partnered with the County to distribute the flu vaccine, including a drive-thru clinic in Fall 2020.
Heart Disease & Stroke	*Barton aims to maintain cardiology services, maintain our pulmonologist and maintain sleep medicine education, focusing on sleep apnea. Barton will continue to conduct heart health lectures, healthy heart campaigns, and offer free wellness lab draws. The PCMH Program will include efforts to control blood pressure including an Anthem Outreach Program.* ✓ Cardiology education through lectures and campaigns continue. ✓ Sleep education through lectures and campaigns continue. ✓ Anthem Outreach Program implemented for hypertension.
Injury & Violence	*To reduce recidivism for alcohol-related trauma injuries, Barton Emergency is conducting a Brief Intervention Program along with alcohol screening. Barton will collaborate with anti-violence organizations such as CASA and Live Violence Free. Barton will conduct education on local risks, injury prevention lectures, safety and wellness ads, and collaboration on programs such as "Every 15 Minutes." Barton is also committed to providing on-site event medical coverage to triage and treat emerging medical issues that can be treated successfully with early intervention. Last, we are committed to continuing the Stop the Bleed program to help educate and prepare community members (including first responders, teachers and students) for a mass casualty event. New screening for abuse will be incorporated into annual wellness visits.* ✓ The Brief Intervention program is ongoing for patients that have alcohol/drugs in their system during a trauma. It is a proven actionable moment to help patients prevent further problems from drugs and alcohol. ✓ The Stop the Bleed program continues ✓ A social determinants screening tool was implemented as well as an ACEs screening tool.

Cancer	*Ongoing cancer awareness and prevention services include: lectures on cancer prevention (skin, breast, prostate and others), cancer wellness program, enhanced mammogram technology, ongoing wellness messages, radon education, and ongoing assessment to potentially increase oncology services and partnerships for those with a cancer diagnosis including telemedicine and a partnership with UC Davis and Gene Upshaw Cancer Center. Barton will increase outreach for recommended screenings. A new fundraising effort, Pink Heavenly, will raise awareness and benefit cancer patients.* ✓ Wellness lectures on various cancer topics continue. ✓ Pink Heavenly's event raised over $50,000 for cancer programming
Tobacco Use	*Barton remains committed to decreasing tobacco use within the community through smoking cessation classes, lung cancer CT scans, in-office posters about the dangers of smoking, periodic articles about the dangers of traditional, vaping and e-cigarette use, maintaining a non-smoking campus, and information through the health library.* ✓ Family Nurse Practitioner, Kelly Vial, conducted multiple in-person presentations to high school students, hosted a wellness lecture, Drug Store Project filming and presented to Family Resource Center's Cafecitos program on the risks of vaping. ✓ Continued education through articles, blog posts and social media content continue.
Potentially Disabling Conditions	*Through our Home, Health & Hospice & Palliative Care programs, we provide support groups for caregivers. We also participate in local health fairs for our senior population.* ✓ Home Health continues to offer Patient and Caregiver Education (Diet, Medications, Physical and Social Adaptations, Rehabilitative Training, etc.) ✓ Palliative Care continues to be available at any stage of a serious or terminal illness.