2016 Community Health Needs Assessment Report

Primary Service Area

Prepared for:

Carson Tahoe Health System

- Carson Tahoe Regional Healthcare, dba Carson Tahoe Regional Medical Center
- Carson Tahoe Continuing Care Hospital, Inc.

By:

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

2015-0793-02

Professional Research Consultants, Inc.

Table of Contents

Introduction

Professional Research Consultants, Inc.

Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted regionally in 2010 and 2013, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the primary service area of Carson Tahoe Health System (CTHS), a Nevada nonprofit corporation, and its wholly owned subsidiaries, Carson Tahoe Regional Healthcare (CTRH), a Nevada nonprofit corporation doing business as Carson Tahoe Regional Medical Center (CTRMC), and Carson Tahoe Continuing Care Hospital, Inc. (CTCCH), a Delaware nonprofit corporation. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

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

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

This assessment was conducted on behalf of CTHS, CTRMC, and CTCCH (collectively, Carson Tahoe Health) by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

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

PRC Community Health Survey

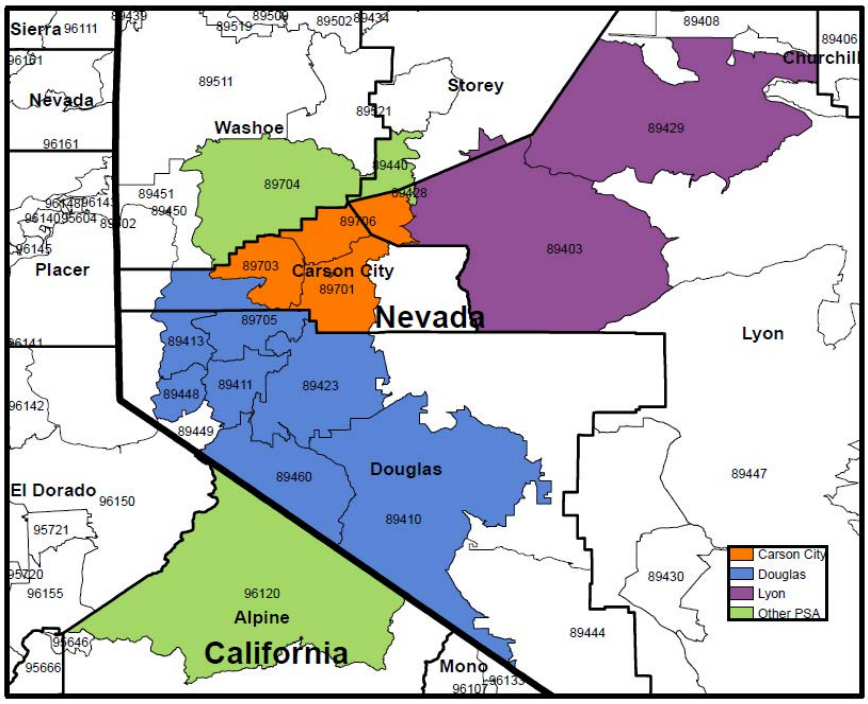
Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Carson Tahoe Health[1] and PRC, and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Primary Service Area" in this report) includes residential ZIP Codes in Carson City and portions of Douglas County, Lyon County, and adjacent areas. This community definition, determined based on the ZIP Codes of residence of recent patients of Carson Tahoe Health, is illustrated in the following map. Note that all of the named facilities (CTHS, CTRMC, and CTCCH) use the same definition of community.

[1] CTHS is the parent corporation having ownership and governance authority over CTRMC, and CTCCH. CTRMC is a Nevada licensed acute care hospital providing a wide variety of services; and CTCCH is a Nevada licensed long-term acute care hospital providing care for patients who on average stay more than 25 days.



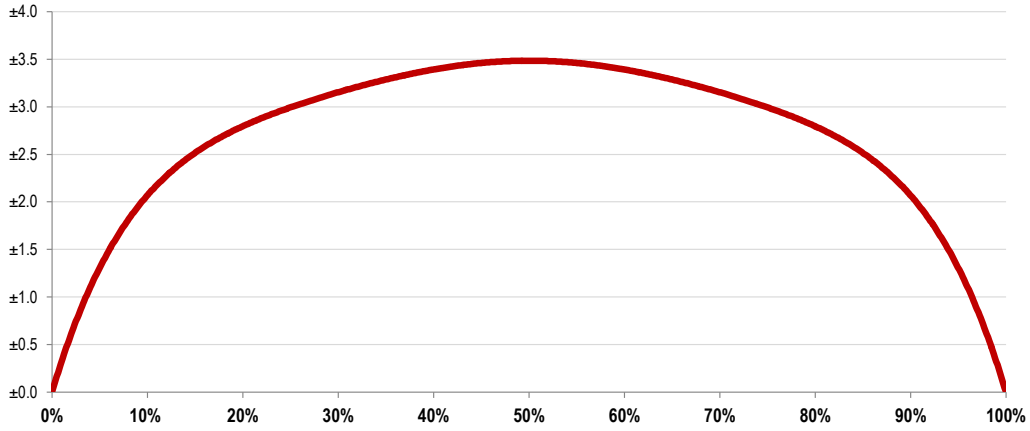
Sample Approach & Design

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

The sample design used for this effort consisted of a random sample of 800 individuals age 18 and older in the Primary Service Area, resulting in 338 surveys in Carson City, 271 in Douglas County, 150 in Lyon County, and 41 in other areas. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 800 respondents is ±3.5% at the 95 percent level of confidence.

Expected Error Ranges for a Sample of 800 Respondents at the 95 Percent Level of Confidence



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

Examples: If 10% of the sample of 800 respondents answered a certain question with a "yes," it can be asserted that between 7.9% and 12.1% (10% 2.1%) of the total population would offer this response.

If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.5% and 53.5% (50% 3.5%) of the total population would respond "yes" if asked this question.

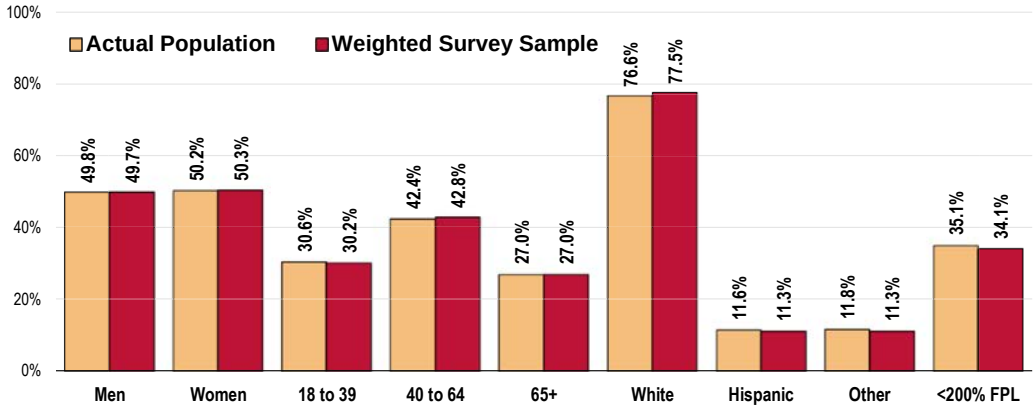
Sample Characteristics

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

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

Population & Survey Sample Characteristics

(Primary Service Area, 2016)



Sources: Census 2010, Summary File 3 (SF 3). US Census Bureau.
2016 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2016 guidelines place the poverty threshold for a family of four at $24,300 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice or more the federal poverty level.

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

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Carson Tahoe 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, 136 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	**Number Invited**	**Number Participating**
Physician	54	22
Public Health Representation	3	2
Other Health Provider	9	5
Social Services Provider	21	10
Community/Business Leader	254	97

Final participation included representatives of the organizations outlined below.

- Advocates to End Domestic Violence
- Aging and Disability Service Division
- Berger Hannafin Architecture, LLP
- Briggs Electric Inc.
- Bullis and Company, LLC
- Capitol Urology
- Carson Car Center
- Carson City Chamber of Commerce
- Carson City Fire Department
- Carson City School District
- Carson Counseling and Supportive Services
- Carson Medical Group
- Carson Nugget Casino and Hotel
- Carson Tahoe Health
- Carson Tahoe Regional Health
- Carson Tahoe Regional Medical Center
- Carson Valley Chamber of Commerce
- Carson Valley Inn
- Casa of Carson City
- City of Carson City
- Community Counseling Center
- Consolidated Municipality of Carson City
- Council of State Governments
- aVita Dialysis
- Douglas County
- Douglas County School District
- Douglas County Social Services
- Dresslerville Community Council Washoe Tribe
- East Fork Fire Protection District
- Edward Jones Financial Advisor
- FISH
- Friends of Carson City Library
- Healthy Communities Coalition of Lyon and Storey Co.
- Immunize Nevada
- In Plain Sight Marketing LLC
- JOIN, Inc.
- Liberty Dialysis
- Lyon County
- Lyon County School District
- Millard Realty
- Morgan Stanley
- NAI Alliance Carson City
- Nevada Appeal
- Nevada Department of Transportation
- Nevada Division of Public and Behavioral Health
- Nevada Mining Association
- Nevada Rural Counties RSVP Program, Inc.

- Nevada State College
- Nevada State Immunization Program
- Nevada State Oral Health Program
- Partnership of Community Resources
- Police Department
- R. O. Anderson Engineering, Inc.
- Ron Wood Family Resource Center
- Ross Medical Clinic of FISH
- Rotary Club of Carson City
- Sierra Lutheran High School
- Soroptimist International of Carson City
- St. Vincent de Paul Society
- State of Nevada
- Tahoe Carson Radiology
- Tahoe Youth and Family Services
- The Capital City CIRCLES Initiative
- Town of Gardnerville

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

Minority/medically underserved populations represented:

> *abuse victims, African-American, Asian, children, disabled, Eastern Indian, elderly, families, Hispanic, homeless, LGBT, low-income, Medicare/Medicaid, mentally ill, non-English-speaking/second language, Middle Eastern, Native American, nursing home patients, pregnant teens, previously incarcerated, rural, substance abusers, trauma patients, undocumented, uninsured/underinsured, veterans, young adults*

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

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

Public Health, Vital Statistics & Other Data

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

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

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

Note that secondary data reflect compilations of city- and county-level data.

Benchmark Data

Trending

Similar surveys were administered in the Primary Service Area in 2010 and 2013 by PRC on behalf of Carson Tahoe Regional Medical Center. 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.

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 *2015 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national

objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to: encourage collaborations across communities and sectors; empower individuals toward making informed health decisions; and measure the impact of prevention activities.

Healthy People strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

Determining Significance

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

Information Gaps

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

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

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

IRS Form 990, Schedule H Compliance

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

IRS Form 990, Schedule H (2015)	
Part V Section B Line 3a *A definition of the community served by the hospital facility*	9
Part V Section B Line 3b *Demographics of the community*	44
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*	256
Part V Section B Line 3d *How data was obtained*	9
Part V Section B Line 3e *The significant health needs of the community*	18
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*	19
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	12
Part V Section B Line 3i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	16

Summary of Findings

Significant Health Needs of the Community

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

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.

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Barriers to Access
	  ○ Cost of Prescriptions
	  ○ Cost of Physician Visits
	  ○ Appointment Availability
	  ○ Finding a Physician
	• Skipping/Stretching Prescriptions
	• Primary Care Physician Ratio
	• Routine Medical Care (Children)
	• Attendance at Health Promotion Event

Cancer	• *Cancer is a leading cause of death.* • Colorectal and Female Breast Cancer Deaths • Skin Cancer Prevalence • Female Breast Cancer Screening • Cervical Cancer Screening
Dementia, Including Alzheimer's Disease	• Alzheimer's Disease Deaths
Diabetes	• Prevalence of Borderline/Pre-Diabetes • *Diabetes ranked as a top concern in the Online Key Informant Survey.*
Heart Disease & Stroke	• *Cardiovascular disease is a leading cause of death.* • High Blood Cholesterol Management
Infant Health & Family Planning	• Infant Mortality
Injury & Violence	• Unintentional Injury Deaths ○ Including Motor Vehicle Crash Deaths • Firearm-Related Deaths

—continued on next page—

Areas of Opportunity (continued)	
Mental Health	• "Fair/Poor" Mental Health • Suicide Deaths • *Mental Health ranked as a top concern in the Online Key Informant Survey.*
Nutrition, Physical Activity & Weight	• Fruit/Vegetable Consumption • Low Food Access • Obesity [Adults] • Healthy Weight [Children]
Oral Health	• Dental Insurance Coverage
Potentially Disabling Conditions	• Activity Limitations • Sciatica/Back Pain Prevalence • Caregiver
Respiratory Diseases	• Chronic Lower Respiratory Disease (CLRD) Deaths • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Flu Vaccination [65+]
Substance Abuse	• Cirrhosis/Liver Disease Deaths • Drug-Induced Deaths • Personally Impacted by Substance Abuse (Self or Other's) • Seeking Help for Alcohol/Drug Issues • *Substance Abuse ranked as a top concern in the Online Key Informant Survey.*

Prioritization of Health Needs

On July 20, 2016, Carson Tahoe Health convened a group of internal and external community stakeholders (representing a cross-section 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 meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Finally, participants were provided an overview of the prioritization exercise that followed.

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

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

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

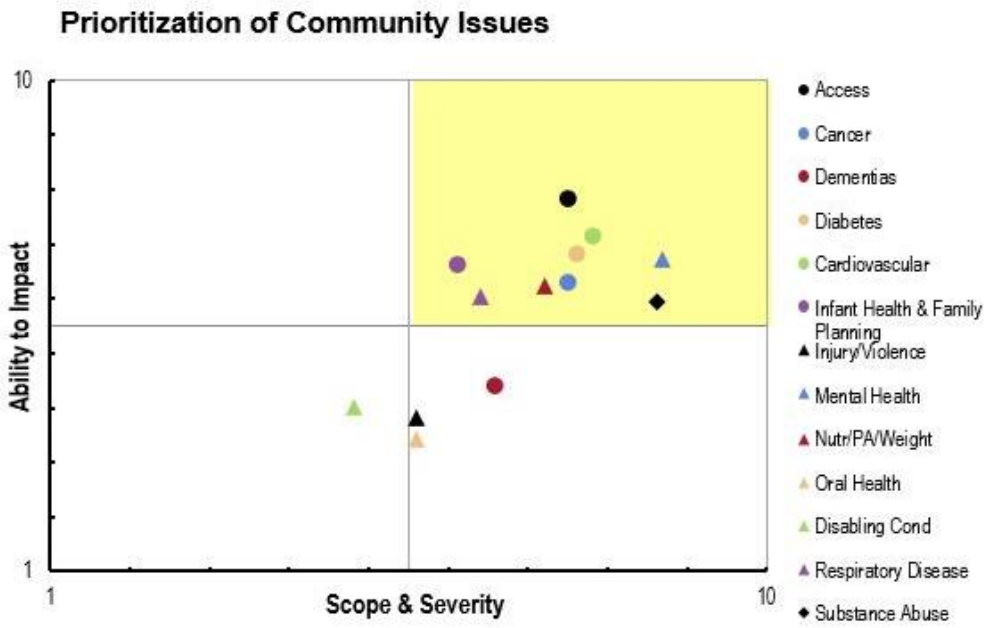
- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability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

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

1. Mental Health
2. Access to Healthcare Services
3. Heart Disease & Stroke
4. Substance Abuse

5. Diabetes
6. Cancer
7. Nutrition, Physical Activity, & Weight
8. Infant Health & Family Planning
9. Respiratory Diseases
10. Dementias, Including Alzheimer's Disease
11. Injury & Violence
12. Oral Health
13. 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 (shaded) quadrant represent health needs rated as most severe, with the greatest ability to impact.



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

Summary Tables: Comparisons With Benchmark Data

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

TREND SUMMARY
(Current vs. Baseline Data)

Survey Data Indicators: Trends for survey-derived indicators represent significant changes since 2010. 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 composite city- and county-level data.

Reading the Summary Tables

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

The green columns [to the left of the Primary Service Area (PSA) column] provide comparisons among the 3 communities, identifying differences for each as "better than" (☀), "worse than" (☁), or "similar to" (⛅) the combined opposing areas.

The columns to the right of the Primary Service Area (PSA) column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether 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.

Social Determinants	Each Sub-Area vs. Others: Carson City	Each Sub-Area vs. Others: Douglas County	Each Sub-Area vs. Others: Lyon County	PSA	PSA vs. Benchmarks: vs. NV	PSA vs. Benchmarks: vs. US	PSA vs. Benchmarks: vs. HP2020	TREND
Linguistically Isolated Population (Percent)	6.7	1.4	1.3	3.2	6.5	4.7		
Population in Poverty (Percent)	17.1	10.5	14.9	14.3	15.6	15.6		
Population Below 200% FPL (Percent)	37.5	27.7	39.5	35.1	36.6	34.5		
Children Below 200% FPL (Percent)	51.6	36.5	52.2	47.7	49.0	44.2		
No High School Diploma (Age 25+, Percent)	13.2	7.0	15.7	12.0	15.2	13.7		
Unemployment Rate (Age 16+, Percent)	8.5	7.9	10.1	8.8	7.9	6.2		
	Note: In the green section, 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	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% "Fair/Poor" Physical Health	21.8	19.8	21.9	20.8	18.5	18.3		15.6
% Activity Limitations	29.6	23.7	34.8	28.4	20.2	20.0		25.8
	Note: In the green section, 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 Services	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% [Age 18-64] Lack Health Insurance	17.2	8.9	0.8	11.4	20.8	10.1	0.0	18.8
% [Insured 18-64] have Coverage Through ACA	12.6	16.3	16.9	14.5		10.8		
% Difficulty Accessing Healthcare in Past Year (Composite)	46.6	39.6	48.6	44.3		35.0		40.4
% Inconvenient Hrs Prevented Dr Visit in Past Year	12.1	12.2	16.3	13.3		14.4		12.1
% Cost Prevented Getting Prescription in Past Year	16.7	9.2	16.3	14.2		9.5		16.3
% Cost Prevented Physician Visit in Past Year	15.8	14.5	20.9	16.3		11.5		18.3

Access to Health Services (continued)	Each Sub-Area vs. Others			PSA	PSA vs. Benchmarks			
	Carson City	Douglas County	Lyon County		vs. NV	vs. US	vs. HP2020	TREND
% Difficulty Getting Appointment in Past Year	25.4	23.3	23.7	24.3		15.4		14.3
% Difficulty Finding Physician in Past Year	13.2	18.0	15.7	15.8		8.7		10.9
% Transportation Hindered Dr Visit in Past Year	9.5	3.3	5.7	6.5		5.0		5.4
% Language/Culture Prevented Care in Past Year	0.4	0.8	0.8	0.6		1.7		
% Skipped Prescription Doses to Save Costs	16.8	15.0	11.0	15.4		10.2		18.9
% Difficulty Getting Child's Healthcare in Past Year				6.2		3.9		4.7
% Have Completed Advance Directive Documents	41.4	46.9	41.0	43.2		33.7		
% Low Health Literacy	11.4	16.1	20.1	18.2		23.3		
% [Age 18+] Have a Specific Source of Ongoing Care	73.4	69.9	73.5	71.9		74.0	95.0	70.9

Access to Health Services (continued)	Each Sub-Area vs. Others			PSA	PSA vs. Benchmarks			
	Carson City	Douglas County	Lyon County	PSA	vs. NV	vs. US	vs. HP2020	TREND
% [Age 18-64] Have a Specific Source of Ongoing Care	71.9	62.6	74.1	69.0		73.1	89.4	
% [Age 65+] Have a Specific Source of Ongoing Care	79.1	84.5	69.8	78.9		76.8	100.0	
% Have Had Routine Checkup in Past Year	65.7	67.0	74.1	68.4	63.8	70.5		57.1
% Child Has Had Checkup in Past Year				79.2		89.3		80.1
% Two or More ER Visits in Past Year	8.2	8.2	13.5	9.1		8.5		6.6
% Rate Local Healthcare "Fair/Poor"	15.5	13.0	22.2	15.5		14.2		16.4
% Member of HH Received Inpatient Care/2 Yrs	37.3	32.0	35.4	34.3				32.9
% Member of HH Received Long-Term Acute Care/3 Yrs	3.4	4.1	6.4	4.7				3.8
% Use Social Media to Find Local Healthcare Info	18.5	15.1	21.1	17.4				9.9

Arthritis, Osteoporosis & Chronic Back Conditions	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% [50+] Arthritis/Rheumatism	34.6	32.9	43.3	35.5		32.0		37.4
% Sciatica/Chronic Back Pain	24.1	25.7	37.3	27.3		19.4		22.7
% Caregiver to a Friend/Family Member	22.8	28.9	30.7	27.1		20.9		
	Note: In the green section, 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	Each Sub-Area vs. Others			PSA	PSA vs. Benchmarks			
	Carson City	Douglas County	Lyon County		vs. NV	vs. US	vs. HP2020	TREND
Cancer (Age-Adjusted Death Rate)	183.0	131.3	182.0	165.2	164.2	163.6	161.4	199.5
Lung Cancer (Age-Adjusted Death Rate)				45.4	45.6	43.4	45.5	
Prostate Cancer (Age-Adjusted Death Rate)				17.8	21.0	19.2	21.8	
Female Breast Cancer (Age-Adjusted Death Rate)				23.4	22.2	20.9	20.7	
Colorectal Cancer (Age-Adjusted Death Rate)				17.5	16.9	14.6	14.5	
% Skin Cancer	11.4	14.5	11.6	12.7	6.3	7.7		11.2
% Cancer (Other Than Skin)	6.6	8.8	9.1	7.9	5.9	7.7		7.8
% [Men 50+] Prostate Exam in Past 2 Years	76.4	81.7	84.1	79.1		75.0		77.1
% [Women 50-74] Mammogram in Past 2 Years	69.7	67.7	65.8	68.5	72.1	80.3	81.1	80.0
% [Women 21-65] Pap Smear in Past 3 Years	65.2	77.8	60.1	68.9	78.1	84.8	93.0	79.6
% [Age 50+] Sigmoid/Colonoscopy Ever	74.4	80.1	75.2	76.1	63.0	75.6		68.0

Cancer (continued)	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% [Age 50+] Blood Stool Test in Past 2 Years	24.1	22.7	29.8	24.4	17.0	31.8		29.8
% [Age 50-75] Colorectal Cancer Screening	69.9	75.8	76.1	73.1		74.5	70.5	68.5
	Note: In the green section, 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	

Chronic Kidney Disease	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Kidney Disease (Age-Adjusted Death Rate)	11.4	10.0		10.3	13.5	13.2		14.8
% Kidney Disease	2.3	3.3	3.1	2.9	3.2	3.6		
	Note: In the green section, 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	

Dementias, Including Alzheimer's Disease	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Alzheimer's Disease (Age-Adjusted Death Rate)	37.2	27.4	25.3	30.7	19.2	24.2		20.0
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr	15.8	15.3	14.6	15.3		12.8		
					better	similar	worse	

Note: In the green section, 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.

Diabetes	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Diabetes Mellitus (Age-Adjusted Death Rate)	22.6	10.5	35.6	21.9	14.0	21.1	20.5	22.6
% Diabetes/High Blood Sugar	13.9	9.9	16.2	12.7	9.6	14.5		12.4
% Borderline/Pre-Diabetes	9.3	9.3	9.5	9.3		5.7		
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	50.4	51.1	63.7	52.9		55.1		
% [Adults w/Diabetes] Taking Insulin				85.5				81.4
					better	similar	worse	

Note: In the green section, 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.

Educational & Community-Based Programs	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% Attended Health Event in Past Year	12.9	18.6	17.0	16.2		23.8		17.7
	Note: In the green section, 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	

Family Planning	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Teen Births per 1,000 (Age 15-19)	50.7	18.9	39.4	37.4	43.6	36.6		48.3
	Note: In the green section, 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	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	191.5	145.6	180.4	172.5	194.9	169.1	156.9	203.9
Stroke (Age-Adjusted Death Rate)	39.3	33.5	41.6	37.7	33.8	36.5	34.8	43.9
% Heart Disease (Heart Attack, Angina, Coronary Disease)	8.9	9.1	6.7	8.4		6.9		10.6

Heart Disease & Stroke (continued)	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% Stroke	4.0	3.0	6.1	4.0	3.2	2.6		2.8
% Blood Pressure Checked in Past 2 Years	89.3	92.5	93.4	91.4		93.6	92.6	92.6
% Told Have High Blood Pressure (Ever)	37.8	41.3	40.3	39.1	30.6	36.5	26.9	36.3
% [HBP] Taking Action to Control High Blood Pressure	93.0	86.6	92.9	90.5		92.5		92.4
% Cholesterol Checked in Past 5 Years	94.7	88.9	94.8	92.1	74.0	87.4	82.1	83.9
% Told Have High Cholesterol (Ever)	35.6	32.9	37.3	34.7		33.5	13.5	36.6
% [HBC] Taking Action to Control High Blood Cholesterol	82.8	85.9	89.2	84.6		84.2		90.4
% 1+ Cardiovascular Risk Factor	85.4	84.0	91.7	85.9		83.0		83.8

Note: In the green section, 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

HIV	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
HIV Prevalence per 100,000	330.0	85.1	80.9	170.2	331.8	353.2		
% [Age 18-44] HIV Test in the Past Year				19.3		21.3		18.9
	Note: In the green section, 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	

Immunization & Infectious Diseases	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% [Age 65+] Flu Vaccine in Past Year	55.1	53.3	30.5	49.4	52.9	58.9	70.0	68.3
% [Age 65+] Pneumonia Vaccine Ever	83.3	82.8	66.9	79.0	71.0	76.3	90.0	67.3
	Note: In the green section, 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 Prevention	Each Sub-Area vs. Others: Carson City	Each Sub-Area vs. Others: Douglas County	Each Sub-Area vs. Others: Lyon County	PSA	PSA vs. Benchmarks: vs. NV	PSA vs. Benchmarks: vs. US	PSA vs. Benchmarks: vs. HP2020	TREND
Unintentional Injury (Age-Adjusted Death Rate)	48.5	42.2	44.8	45.5	41.5	39.7	36.4	49.0
Motor Vehicle Crashes (Age-Adjusted Death Rate)				12.5	10.0	10.6	12.4	21.4
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat				93.9		95.7		95.0
% Child [Age 5-17] "Always" Wears Bicycle Helmet				53.0		46.5		42.0
[65+] Falls (Age-Adjusted Death Rate)				43.3	43.6	57.2		
Firearm-Related Deaths (Age-Adjusted Death Rate)	18.5	14.7	26.6	20.1	13.8	10.4	9.3	15.2
Homicide (Age-Adjusted Death Rate)				3.5	6.2	5.6	5.5	
Violent Crime per 100,000	264.4	121.9	244.0	214.1	622.1	395.5		
	Note: In the green section, 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	

Maternal, Infant & Child Health	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Low Birthweight Births (Percent)	7.0	8.4	7.4	7.5	8.2	8.2	7.8	
Infant Death Rate		13.0	9.5	8.1	5.2	5.9	6.0	
					better	similar	worse	

Note: In the green section, 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.

Mental Health & Mental Disorders	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% "Fair/Poor" Mental Health	13.6	8.8	15.6	12.4		15.5		8.6
% Diagnosed Depression	18.0	16.6	27.0	19.2		17.9		
% Symptoms of Chronic Depression (2+ Years)	30.4	27.0	31.8	29.9		29.9		28.3
Suicide (Age-Adjusted Death Rate)	25.0	17.2	31.9	25.0	18.8	12.7	10.2	20.3
% Taking Rx/Receiving Mental Health Trtmt	14.1	10.3	18.4	13.6		13.6		
% Unable to Get Mental Health Svcs in Past Yr	3.7	1.9	3.4	3.3		4.4		

Mental Health & Mental Disorders (continued)	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% Have Ever Sought Help for Mental Health	26.5	24.8	39.6	28.7		27.4		
% [Those With Diagnosed Depression] Seeking Help				87.9		91.7		
% Typical Day Is "Extremely/Very" Stressful	9.1	9.5	10.2	9.8		11.7		8.5
	Note: In the green section, 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	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% Eat 5+ Servings of Fruit or Vegetables per Day	34.7	42.2	37.2	37.8		27.4		47.0
% "Very/Somewhat" Difficult to Buy Fresh Produce	19.2	15.5	19.3	18.3		21.9		
% Worried About Food in the Past Year	26.7	16.2	21.8	21.8				
Population With Low Food Access (Percent)	20.9	57.4	51.5	42.3	22.3	23.6		
% Medical Advice on Nutrition in Past Year	37.1	33.7	36.3	36.2				38.4

Nutrition, Physical Activity & Weight (continued)	Each Sub-Area vs. Others: Carson City	Each Sub-Area vs. Others: Douglas County	Each Sub-Area vs. Others: Lyon County	PSA	PSA vs. Benchmarks: vs. NV	PSA vs. Benchmarks: vs. US	PSA vs. Benchmarks: vs. HP2020	TREND
% Healthy Weight (BMI 18.5-24.9)	32.8	29.7	25.6	30.4		32.9	33.9	33.5
% Overweight (BMI 25+)	66.0	69.4	71.9	68.4	63.5	65.2		66.0
% Obese (BMI 30+)	30.5	29.7	35.5	31.6	27.7	33.4	30.5	25.6
% Medical Advice on Weight in Past Year	25.9	21.0	23.4	24.5		20.4		23.3
% [Overweights] Counseled About Weight in Past Year	35.0	29.5	27.9	32.7		27.1		29.4
% [Obese Adults] Counseled About Weight in Past Year				45.8		40.8		44.8
% [Overweights] Trying to Lose Weight Both Diet/Exercise	59.6	52.1	63.4	56.5		57.0		42.7
% Child [Age 5-17] Healthy Weight				59.2		67.2		71.3
% Children [Age 5-17] Overweight (85th Percentile)				28.9		24.2		28.7
% Children [Age 5-17] Obese (95th Percentile)				11.0		9.5	14.5	11.7
	Note: In the green section, 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 (continued)	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% No Leisure-Time Physical Activity	22.5	18.1	14.8	19.0	22.5	27.9	32.6	19.7
% Meeting Physical Activity Guidelines	47.8	56.2	57.8	52.6		50.3		55.0
% Moderate Physical Activity	28.3	44.1	43.1	36.8				35.3
% Vigorous Physical Activity	35.3	40.6	40.7	38.2				40.5
Recreation/Fitness Facilities per 100,000	12.7	14.9	7.7	11.7	7.4	9.7		
% Child [Age 2-17] Physically Active 1+ Hours per Day				46.4		47.9		
	Note: In the green section, 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	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% [Age 18+] Dental Visit in Past Year	67.3	71.6	64.7	67.8	59.9	67.2	49.0	67.6
% Child [Age 2-17] Dental Visit in Past Year				86.5		90.7	49.0	80.4
% Have Dental Insurance	56.1	66.0	71.5	62.0		66.5		63.7
	Note: In the green section, 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 Diseases	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
CLRD (Age-Adjusted Death Rate)	58.7	41.6	63.3	54.2	53.0	51.4		53.4
Pneumonia/Influenza (Age-Adjusted Death Rate)	12.5	12.3	22.3	15.0	20.5	15.1		14.7
% COPD (Lung Disease)	13.0	12.4	14.0	12.8	6.9	9.5		10.0
% [Child 0-17] Currently Has Asthma				9.2		6.5		5.4
	Note: In the green section, 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	

Sexually Transmitted Diseases	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Gonorrhea Incidence per 100,000	51.8	12.7	27.2	31.4	84.7	110.7		
Chlamydia Incidence per 100,000	395.7	176.2	271.5	286.1	423.8	456.1		
% Have Never Been Tested for an STD	53.2	60.9	50.5	54.7				
	Note: In the green section, 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	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	21.1	12.5	12.6	15.4	12.7	10.2	8.2	15.5
% Current Drinker	54.7	60.6	59.7	58.2	50.6	59.7		60.9
% Excessive Drinker	21.1	21.2	24.1	22.1		22.2	25.4	23.1
% Drinking & Driving in Past Month	1.9	3.2	0.7	2.1		4.1		3.0
Drug-Induced Deaths (Age-Adjusted Death Rate)	20.7	17.9	17.8	18.9	20.5	14.6	11.3	13.3

Substance Abuse (continued)	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% Illicit Drug Use in Past Month	2.6	4.5	0.7	2.8		3.0	7.1	2.9
% Ever Sought Help for Alcohol or Drug Problem	3.9	4.6	2.9	4.1		4.1		6.4
% Life Negatively Affected by Substance Abuse	43.7	41.2	40.9	43.0		32.2		
	Note: In the green section, 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	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% Current Smoker	12.2	14.3	19.5	14.6	17.0	14.0	12.0	18.4
% Someone Smokes at Home	9.6	9.1	10.2	9.5		10.2		11.2
% [Nonsmokers] Someone Smokes in the Home	4.8	3.9	4.2	4.4		3.9		4.4
% [Household With Children] Someone Smokes in the Home				5.5		10.2		7.0
% [Smokers] Received Advice to Quit Smoking				63.4		76.0		57.5

Tobacco Use (continued)	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% [Smokers] Have Quit Smoking 1+ Days in Past Year				57.3		43.7	80.0	49.3
% [Smokers] Interested in Cessation Classes				46.8				
% [Smokers] Aware of Nevada Quitline				40.5				
% Use Smokeless Tobacco	3.1	0.4	2.8	2.8	3.2	3.0	0.3	4.3
% Currently Use Electronic Cigarettes	6.5	1.7	7.0	4.9		3.8		
	Note: In the green section, 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	

Vision	Each Sub-Area vs. Others: Carson City	Douglas County	Lyon County	PSA	PSA vs. Benchmarks: vs. NV	vs. US	vs. HP2020	TREND
% Blindness/Trouble Seeing	6.8	8.1	5.2	6.9	5.0	7.3		8.4
% Eye Exam in Past 2 Years	62.4	65.5	55.7	61.3		59.3		63.2
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.				better	similar	worse	

Community Description

Professional Research Consultants, Inc.

Population Characteristics

Total Population

The Primary Service Area, the focus of this Community Health Needs Assessment, includes the entirety, or significant portions, of Carson City, Dougal's County and Lyon County. Census data reveal that these three areas combined encompasses 2,855.52 square miles and house a total population of 153,348 residents.

Total Population
(Estimated Population, 2010-2014)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Carson City	54,634	144.66	377.67
Douglas County	47,135	709.72	66.41
Lyon County	51,579	2,001.14	25.77
Combined Area	153,348	2,855.52	53.7
Nevada	2,761,584	109,781.03	25.16
United States	314,107,083	2,531,932.26	88.93

Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

Population Change 2000-2010

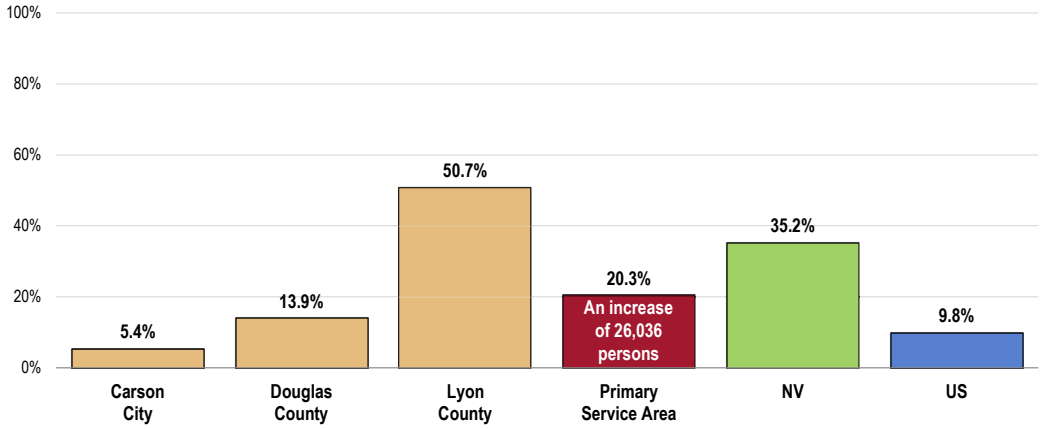
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of the Primary Service Area (here, including the combined areas of Carson City, Douglas County and Lyon County) increased by over 26,000 persons, or 20.3%.

- A smaller proportional increase than seen across the state.
- A greater proportional increase than seen across the nation overall.
- Note the larger percentage increase in Lyon County when compared with Carson City and Douglas County.

Change in Total Population

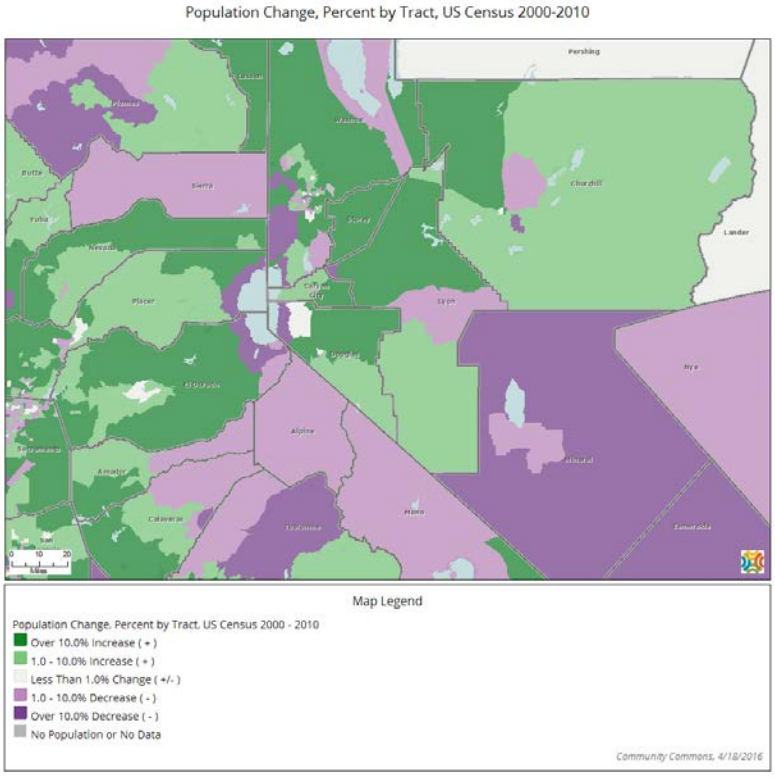
(Percentage Change Between 2000 and 2010)



Sources: Retrieved May 2016 from Community Commons at http://www.chna.org.
US Census Bureau Decennial Census (2000-2010).

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

This map provides a visual illustration of the various increases and decreases in the service area's population between 2000 and 2010.



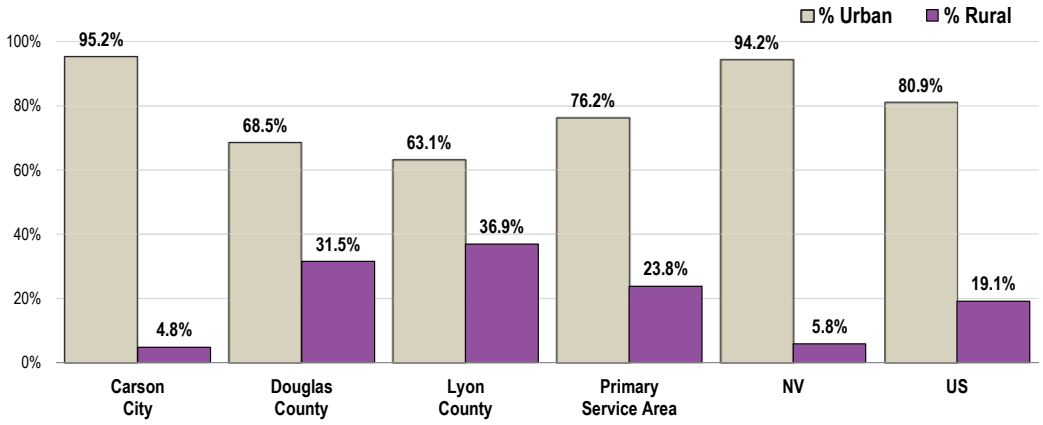
Urban/Rural Population

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 region is predominantly urban, with 76.2% of the population living in areas designated as urban.

- Note that larger proportions of the state and national populations live in urban areas.
- Carson City is the most urban of the 3 communities.

Urban and Rural Population
(2010)

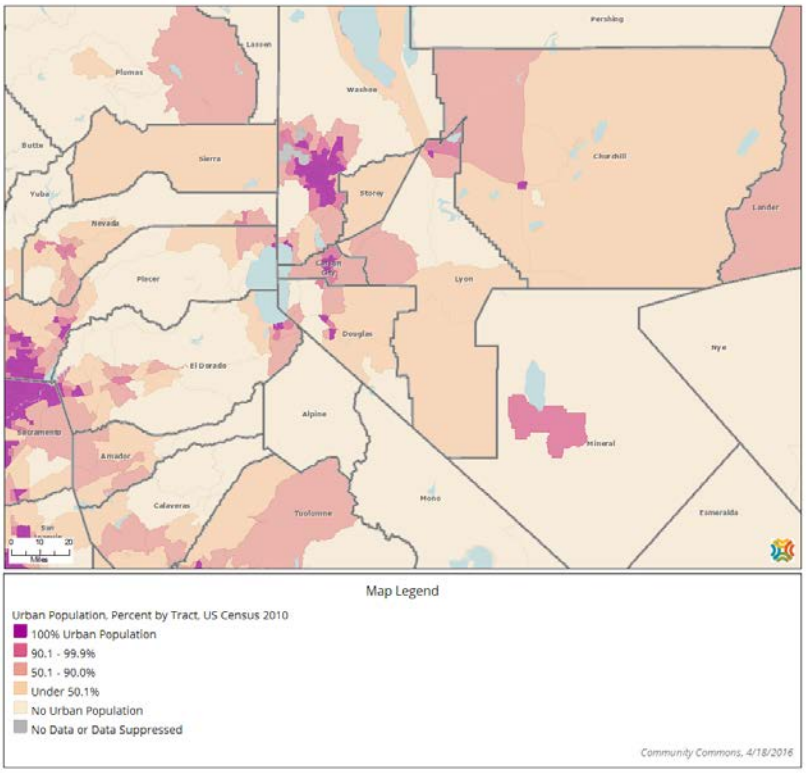


Sources: US Census Bureau Decennial Census (2010).
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

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

Urban Population, Percent by Tract, US Census 2010



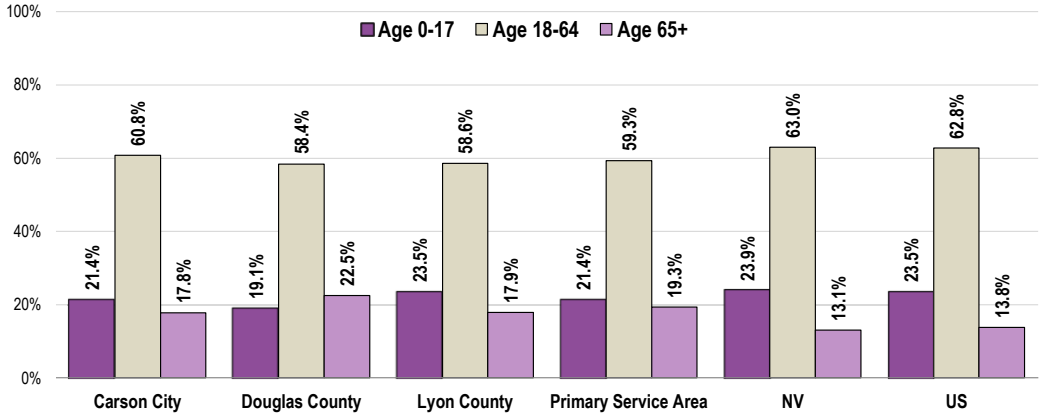
Age

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

A total of, 21.4% of the regional population are infants, children or adolescents (age 0-17); another 59.3% are age 18 to 64, while 19.3% are age 65 and older.

- The percentage of older adults (65+) is much higher than statewide and nationally.
- By area, the percentage of older adults is highest in Douglas County.

Total Population by Age Groups, Percent
(2010-2014)

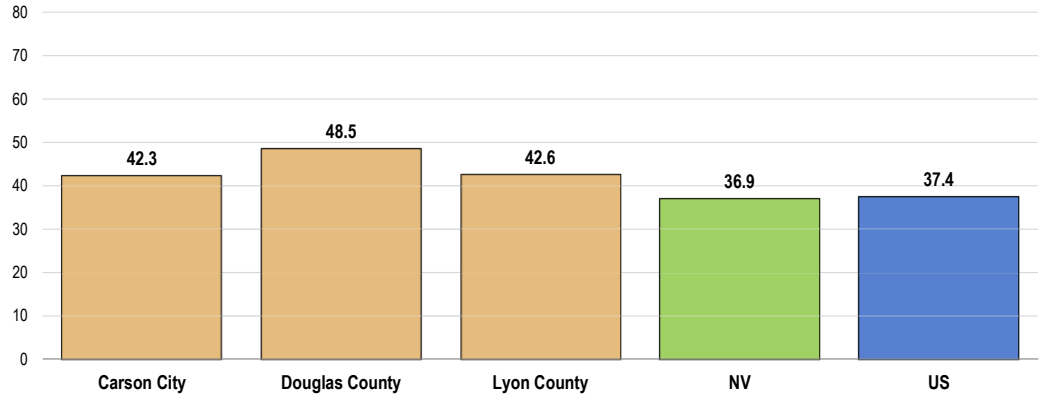


Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

Median Age

The service area is "older" than the state and the nation in that the median ages are higher.

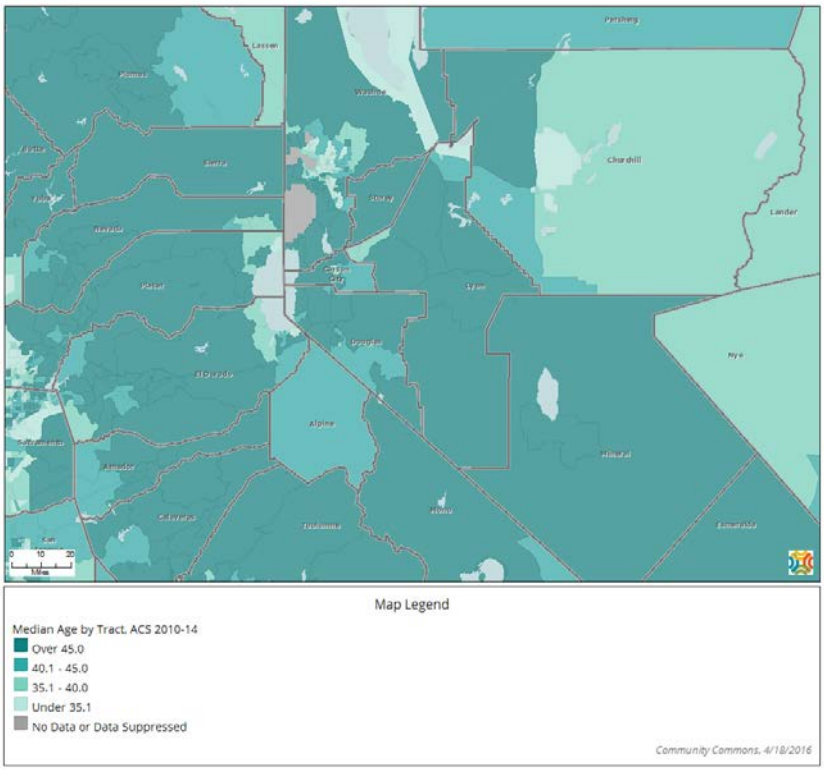
Median Age
(2010-2014)



Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

Median Age, by Tract, ACS 2010-2014



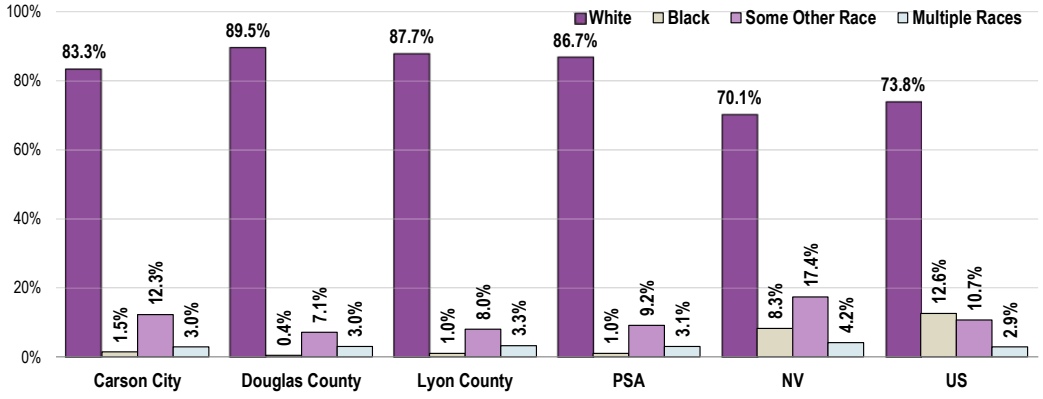
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 86.7% of area residents are White, just 1.0% are Black, and 9.2% are some other race.

- This is generally much less diverse than the state and national racial distributions.
- By area, the largest "some other race" prevalence is in Carson City.

Total Population by Race Alone, Percent
(2010-2014)

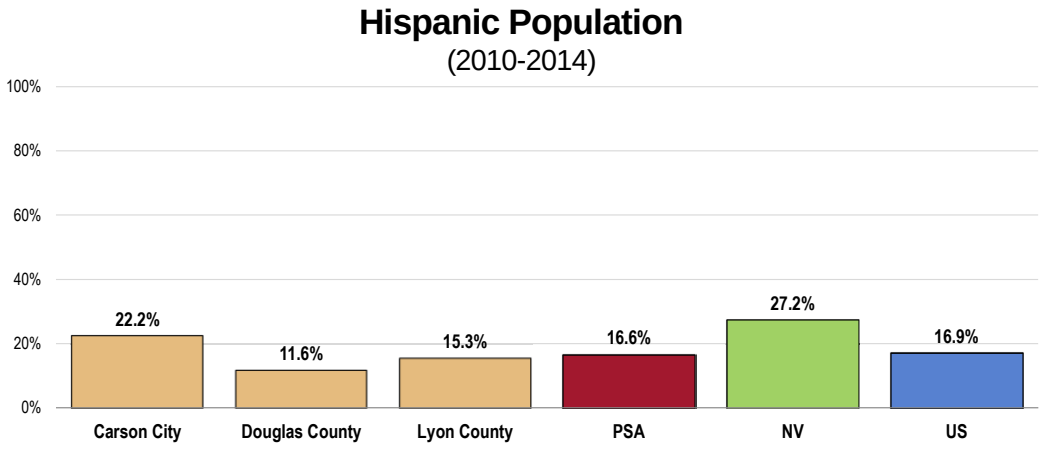


Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

Ethnicity

A total of 16.6% of Primary Service Area residents are Hispanic or Latino.

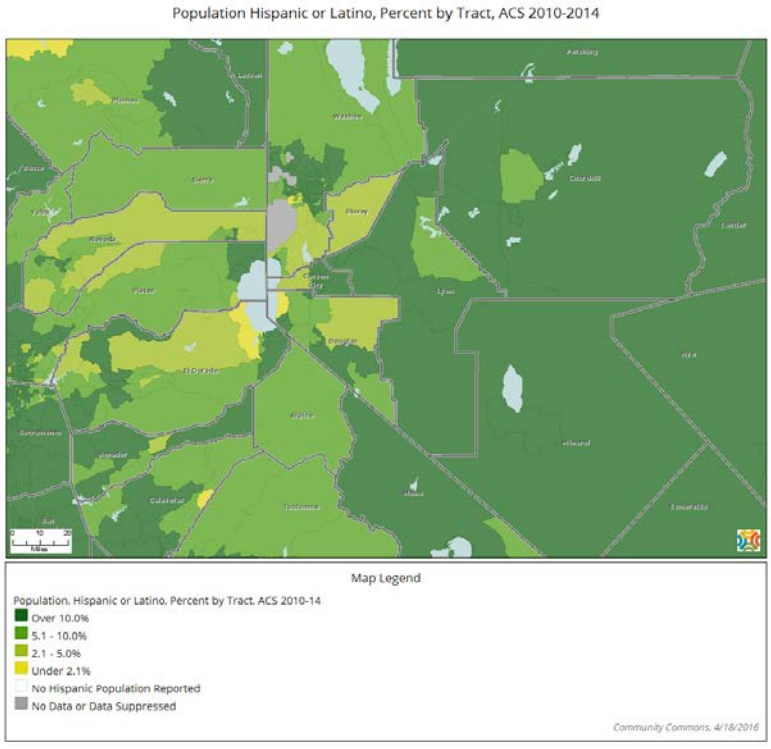
- Lower than state percentage.
- Comparable to the US percentage.
- The proportion is highest in Carson City.



Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

- The following map provides an illustration of the Hispanic population distribution.

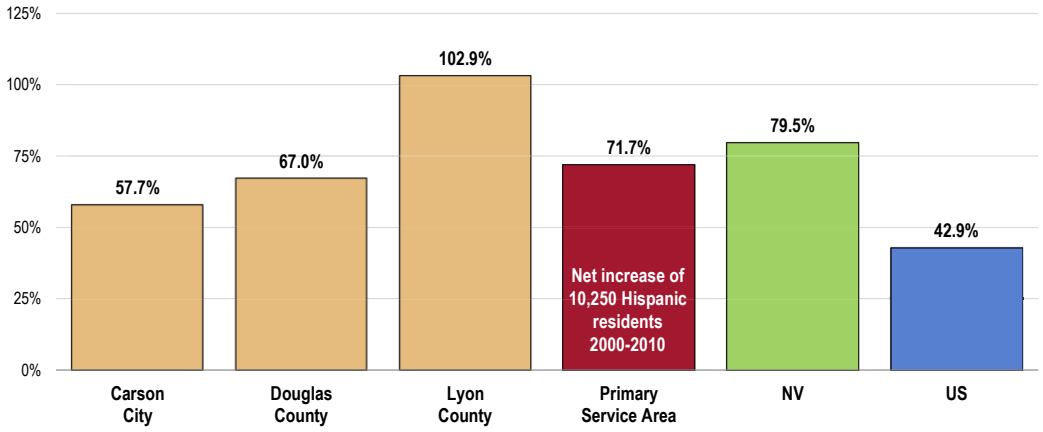


Between 2000 and 2010, the Hispanic population in the area increased by 10,250 or 71.7%.

- Lower (in terms of percentage growth) than found statewide.
- Much higher (in terms of percentage growth) than found nationally.
- The percentage increase was highest (102.9%) in Lyon County.

Hispanic Population Change

(Percentage Change in Hispanic Population Between 2000 and 2010)



Sources: US Census Bureau Decennial Census (2000-2010).
Retrieved May 2016 from Community Commons at http://www.chna.org.

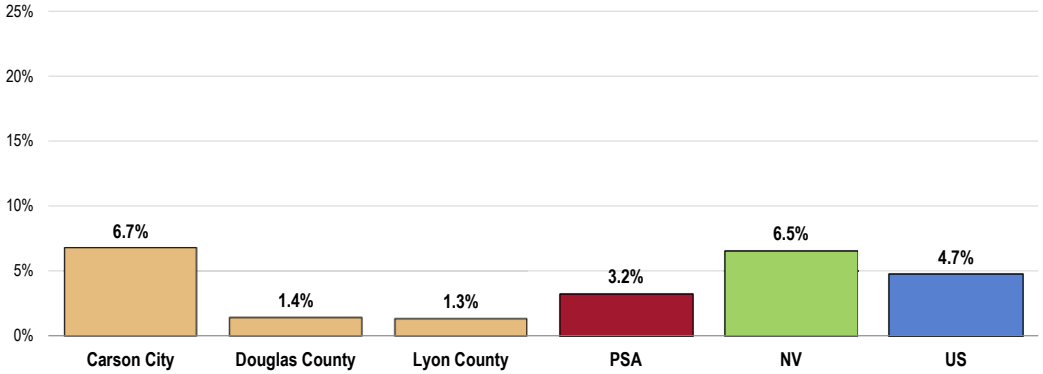
Linguistic Isolation

A total of 3.2% of area residents age 5+ live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

- Lower than found statewide and nationally.
- Particularly high in Carson City.

Linguistically Isolated Population

(2010-2014)

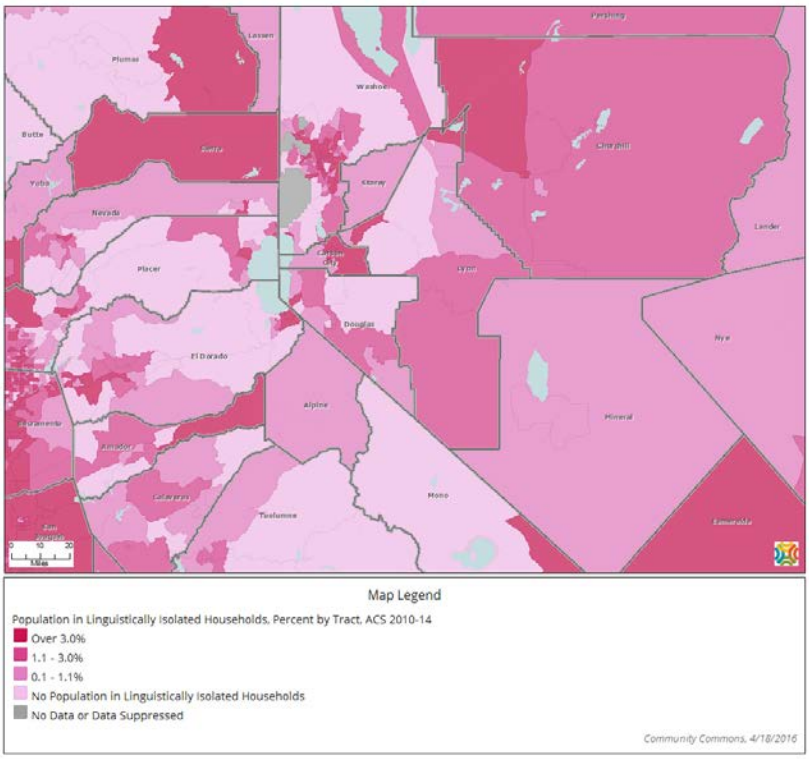


Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

- Note the following map illustrating linguistic isolation in the region.

Population in Linguistically Isolated Households, Percent by Tract, ACS 2010-2014



Social Determinants of Health

About Social Determinants

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

- Healthy People 2020 (www.healthypeople.gov)

Poverty

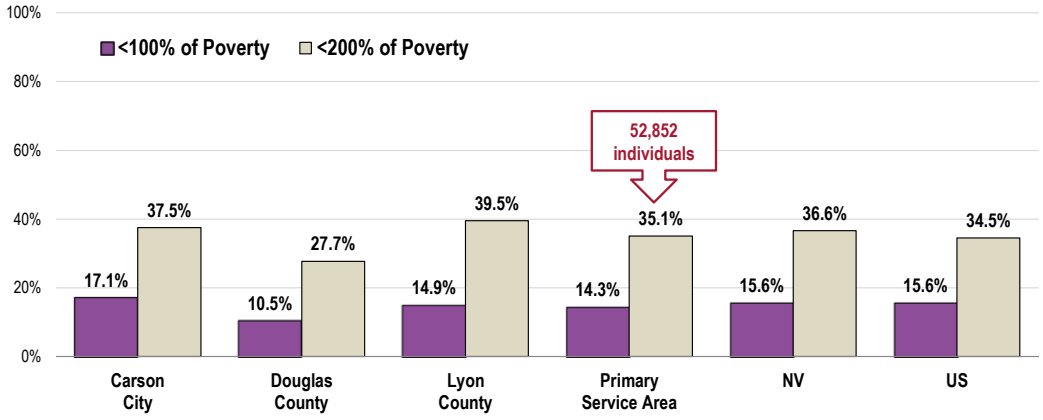
The latest census estimate shows 14.3% of the region's population living below the federal poverty level.

In all, 35.1% of area residents (an estimated 52,852 individuals) live below 200% of the federal poverty level.

- Similar to the proportions reported statewide and nationally.
- Favorably lower in Douglas County.

Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2010-2014)

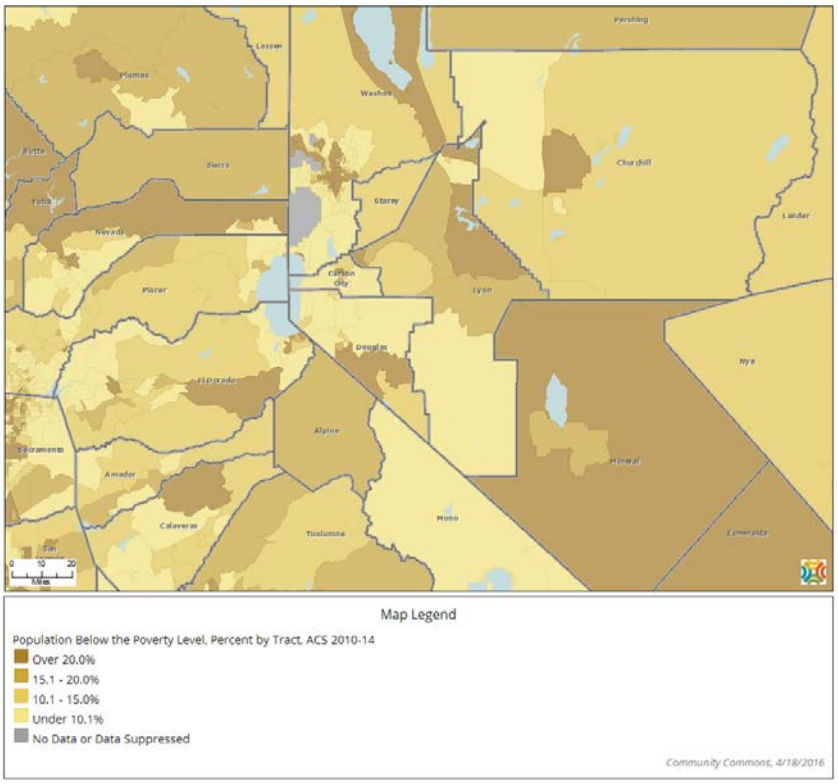


Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

- The following maps provide visual illustrations of the distribution of poverty in the service area.

Population Below the Poverty Level, Percent by Tract, ACS 2010-2014



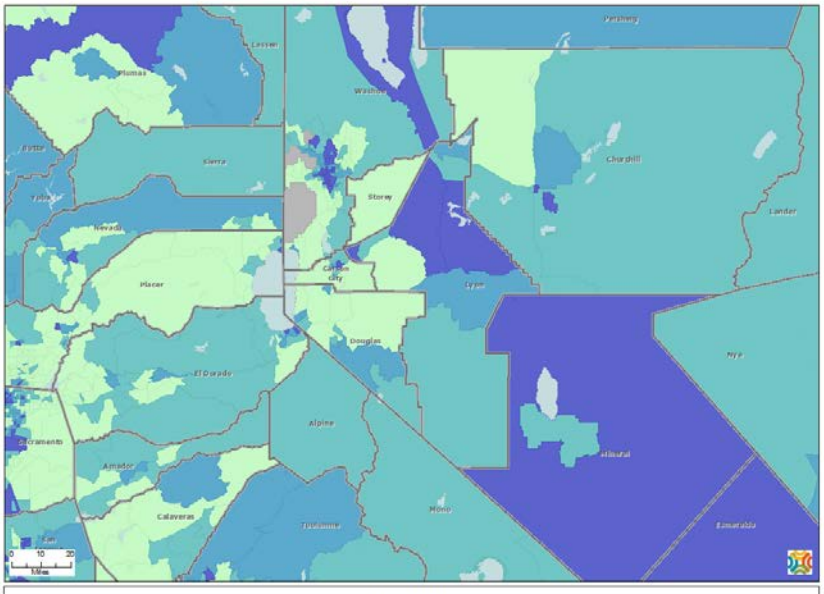
Map Legend

Population Below the Poverty Level, Percent by Tract, ACS 2010-14

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

Community Commons, 4/18/2016

Population Below 200% of Poverty, Percent by Tract, ACS 2010-2014



Map Legend

Population Below 200% Poverty Level, Percent by Tract, ACS 2010-14

- Over 50.0%
- 38.1 - 50.0%
- 26.1 - 38.0%
- Under 26.1%
- No Data or Data Suppressed

Community Commons, 4/18/2016

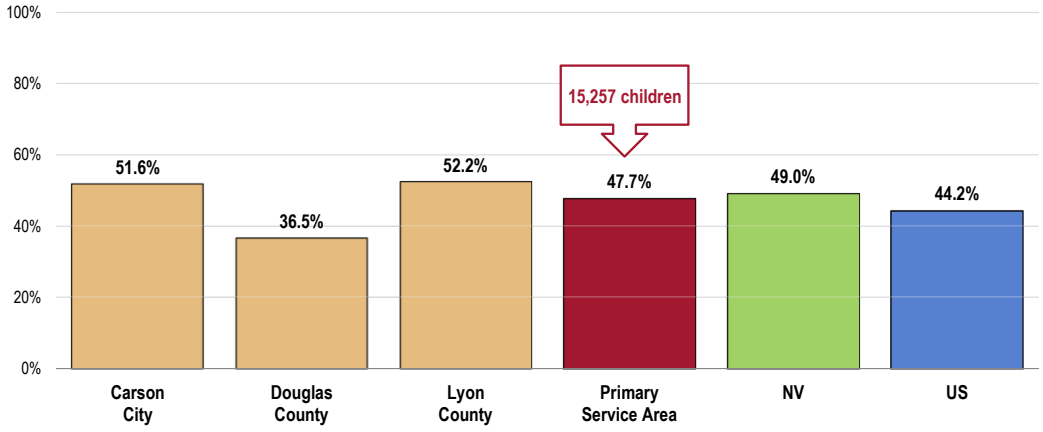
Children in Low-Income Households

Additionally, 47.7% of \ children age 0-17 in Carson City, Douglas County and Lyon County (representing an estimated 15,257 children) live below the 200% poverty threshold.

- Similar to the proportion found statewide.
- Above the proportion found nationally.
- Favorably low in Douglas County.

Percent of Children in Low-Income Households

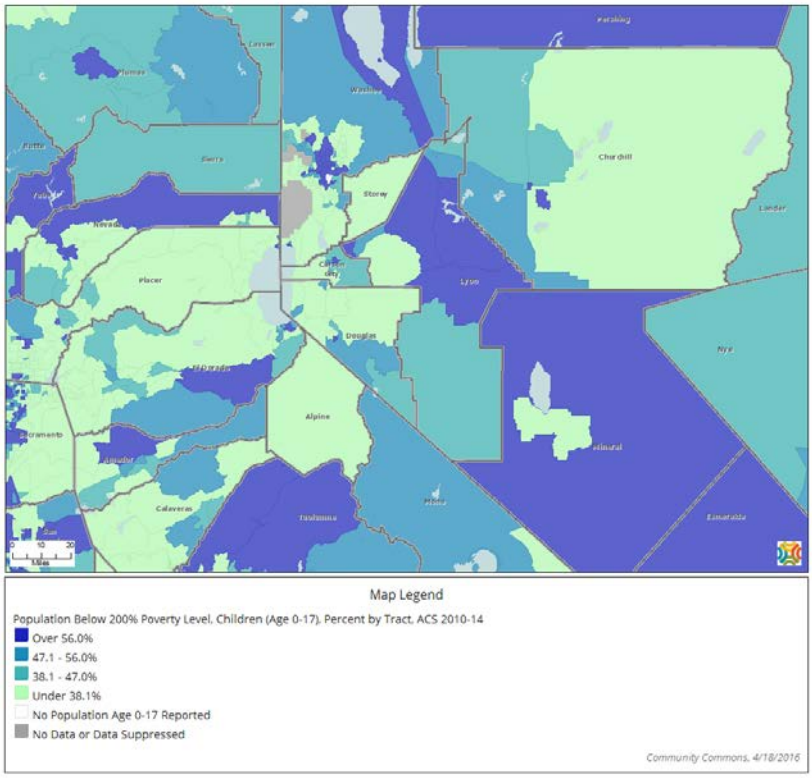
(Children 0-17 Living Below 200% of the Poverty Level, 2010-2014)



Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

Children (0-17) Living Below 200% of Poverty, Percent by Tract, ACS 2010-2014



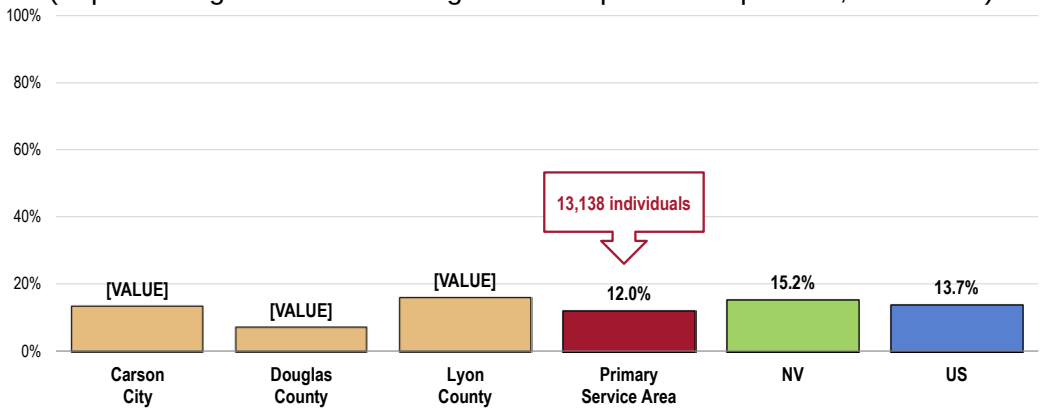
Education

Among the regional population age 25 and older, an estimated 12.0% (over 13,000 people) do not have a high school education.

- More favorable than found statewide and nationally.
- Favorably low in Douglas County.

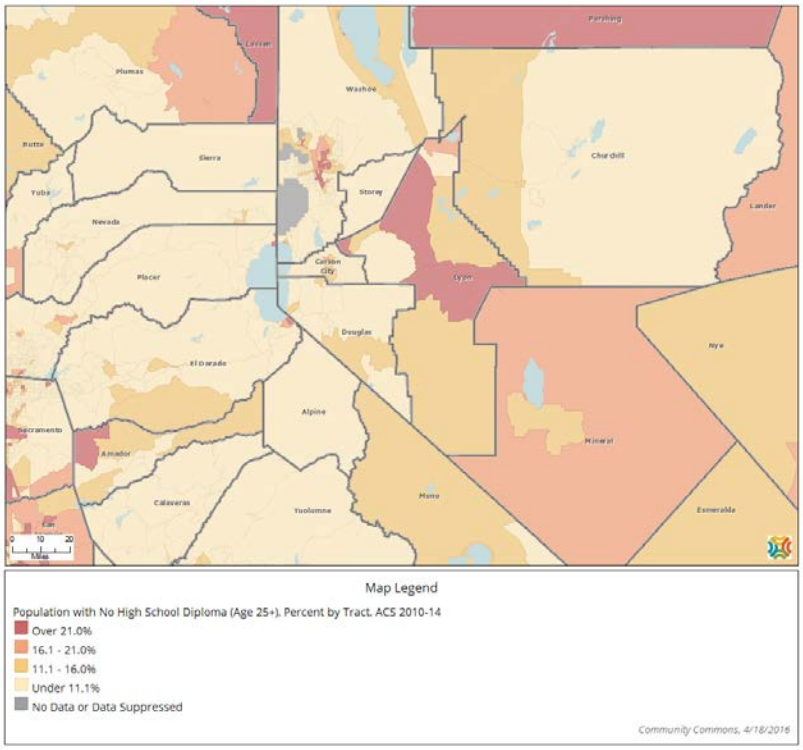
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014)



Sources: US Census Bureau American Community Survey 5-year estimates.
Retrieved May 2016 from Community Commons at http://www.chna.org.
Notes: This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma, Percent by Tract, ACS 2010-2014



Employment

According to data derived from the US Department of Labor, the unemployment rate in the region as of January 2016 was 7.9%.

- Less favorable than the statewide and national unemployment rates.
- TREND: Unemployment for the area has trended downward since 2010, echoing the state and national trends.

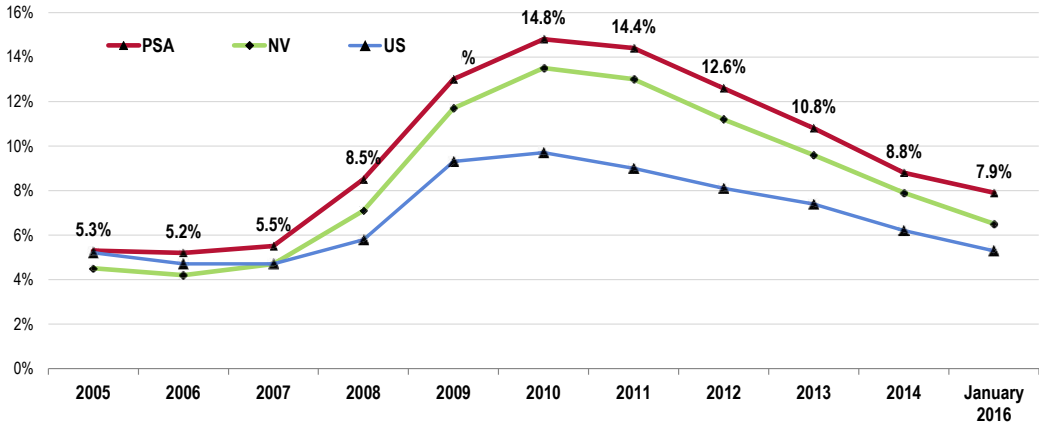
NOTE:

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

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

Unemployment Rate

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



Sources: US Department of Labor, Bureau of Labor Statistics.
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

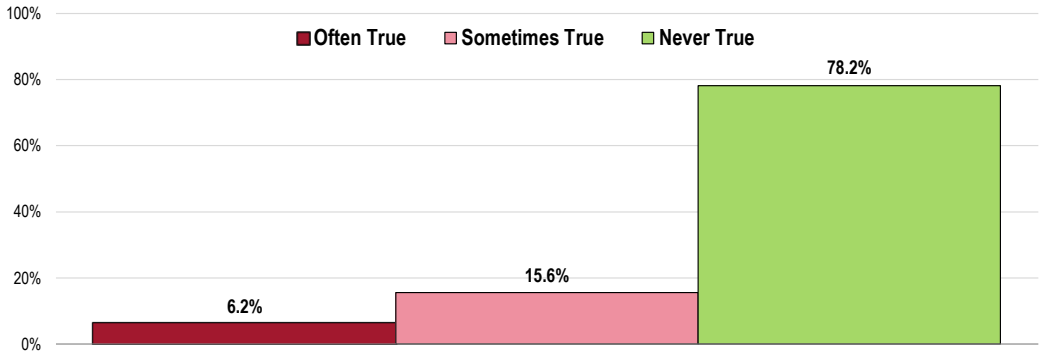
Food Insecurity

In the past year, 21.8% of Primary Service Area adults "often" or "sometimes" worried about whether their food would run out before they had money to buy more.

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

Food Insecurity

(Primary Service Area, 2016)

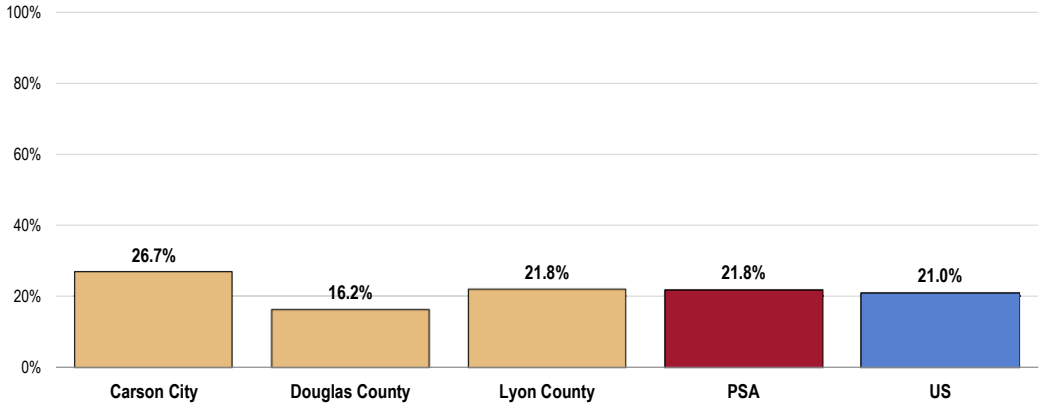


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Reflects the total sample of respondents.

- Compared to US data, the prevalence of adults who worry about their food running out is similar.
- The prevalence is unfavorably higher in Carson City, lower in Douglas County.

"Always/Sometimes" Worried About Food Running Out in the Past Year



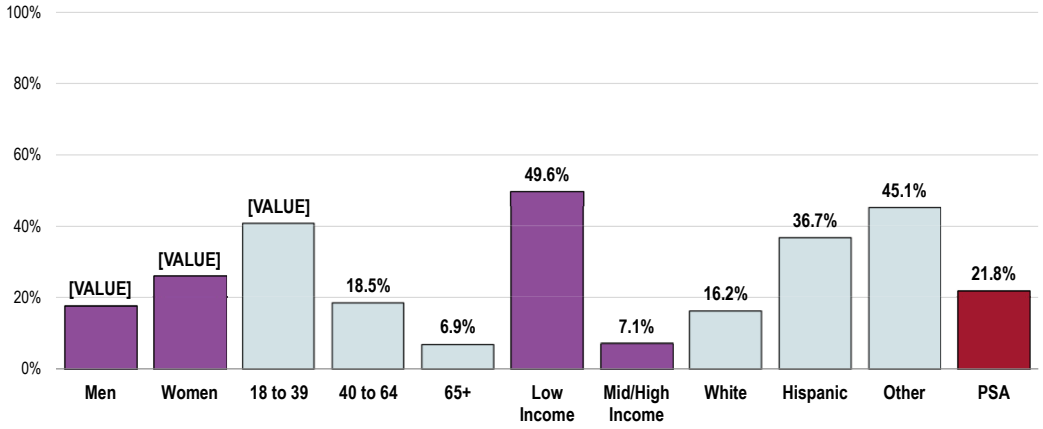
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Adults more likely to have worried about running out of food in the past year include:

- Women.
- Younger adults (negative correlation with age).
- Residents living at lower incomes (especially).
- Hispanics and Other races.

"Always/Sometimes" Worried About Food Running Out in the Past Year

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

General Health Status

Professional Research Consultants, Inc.

Overall Health Status

Evaluation of Health Status

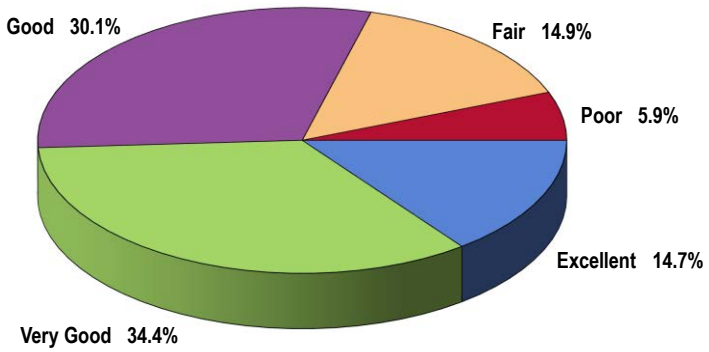
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

A total of 49.1% of Primary Service Area adults rate their overall health as "excellent" or "very good."

- Another 30.1% gave "good" ratings of their overall health.

Self-Reported Health Status
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: Asked of all respondents.

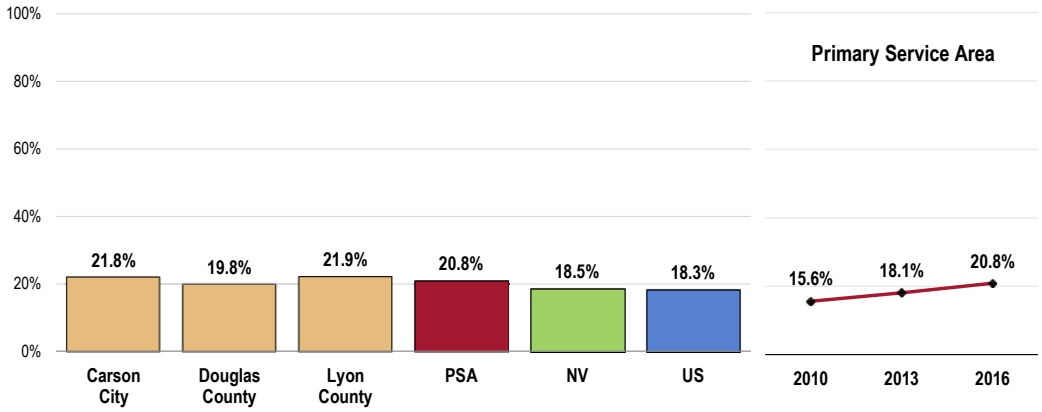
However, 20.8% of Primary Service Area adults believe that their overall health is "fair" or "poor."

NOTE:

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

- Similar to statewide and national findings.
- Similar findings by area.
- TREND: Note the statistically significant increase that has occurred when comparing "fair/poor" overall health reports to 2010 survey results.

Experience "Fair" or "Poor" Overall Health

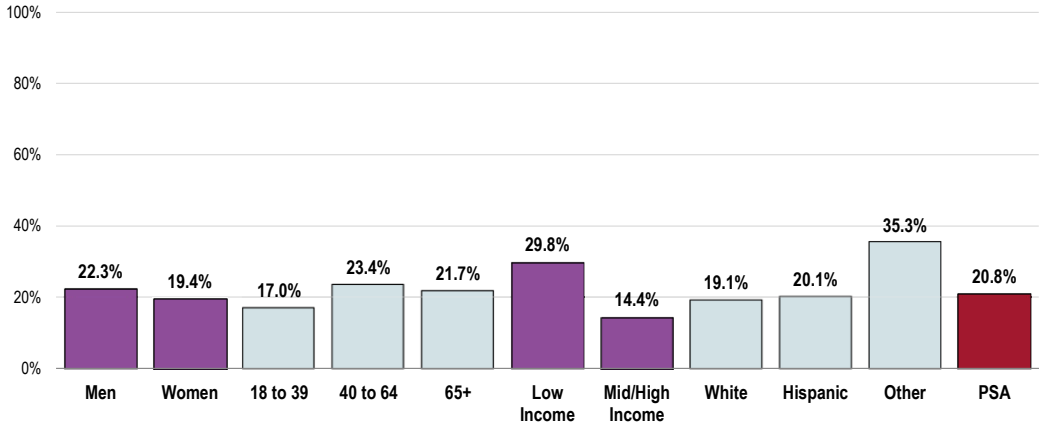


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

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

- Residents living at lower incomes.
- Other races.

Experience "Fair" or "Poor" Overall Health
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

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

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

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

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

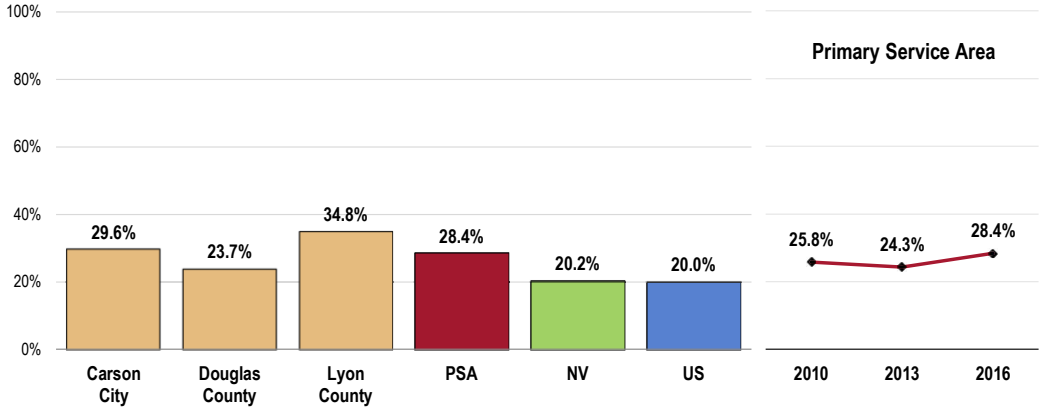
- Healthy People 2020 (www.healthypeople.gov)

A total of 28.4% of Primary Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Less favorable than the prevalence reported statewide and nationally.
- Lower in Douglas County.
- TREND: Statistically unchanged over time.

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

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



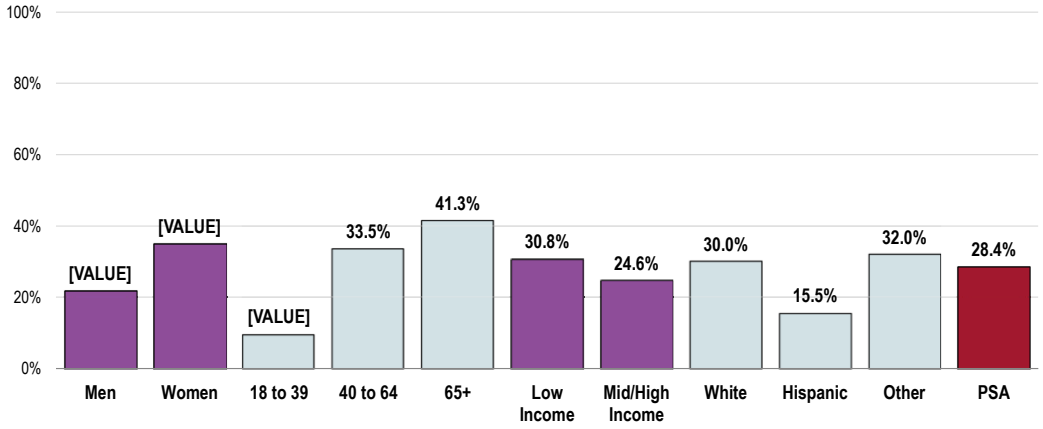
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

In looking at responses by key demographic characteristics, these adults are statistically more likely to report some type of activity limitation:

- Women.
- Adults age 40 and older (note the positive correlation with age).
- Non-Hispanics.

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

(Primary Service Area, 2016)



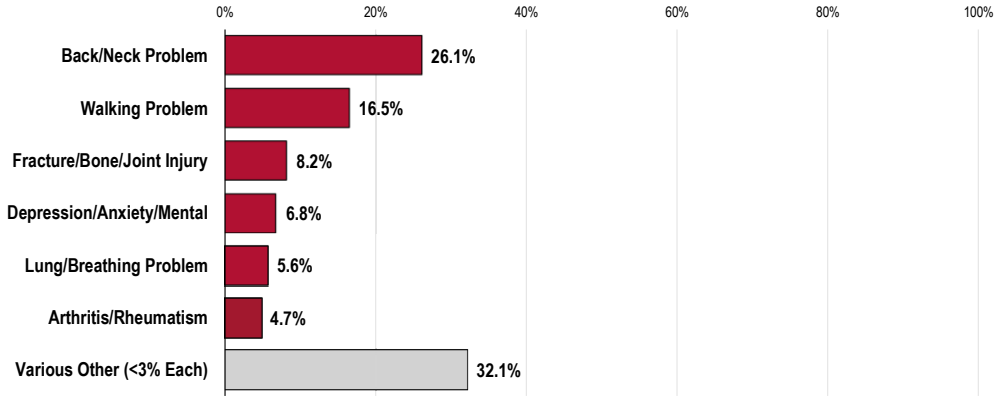
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

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

Other limitations noted with some frequency include those related to mental health (depression, anxiety) and lung/breathing problems.

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 129]
Notes: Asked of those respondents reporting activity limitations.

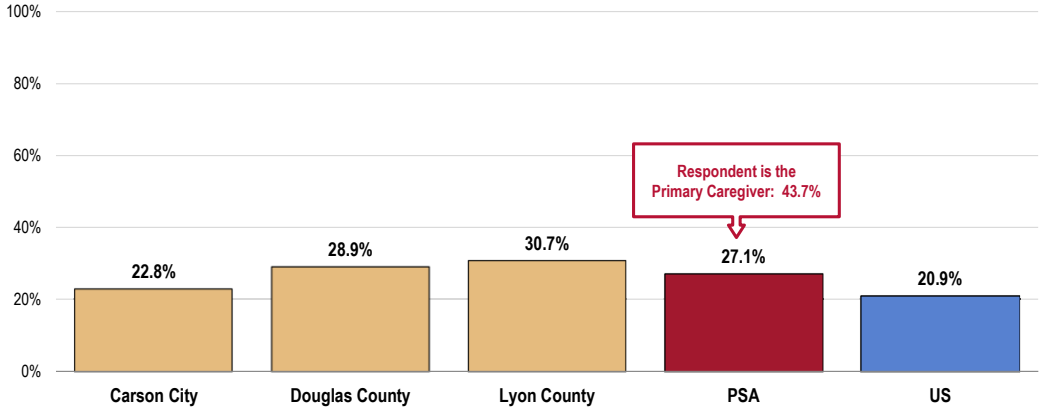
Caregiving

A total of 27.1% 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.

- Higher than the national finding.
- Lowest in Carson City.

Of these adults, 43.7% are the ***primary*** caregiver for the individual receiving care.

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



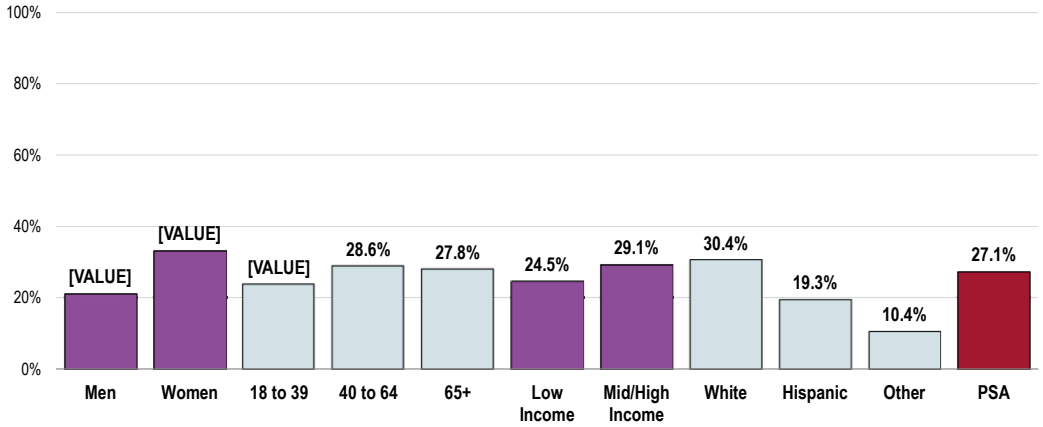
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 130-131]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

The prevalence of caregivers in the community is notably higher among:

- Women.
- Whites.

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 130]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health

About Mental Health & Mental Disorders

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Evaluation of Mental Health Status

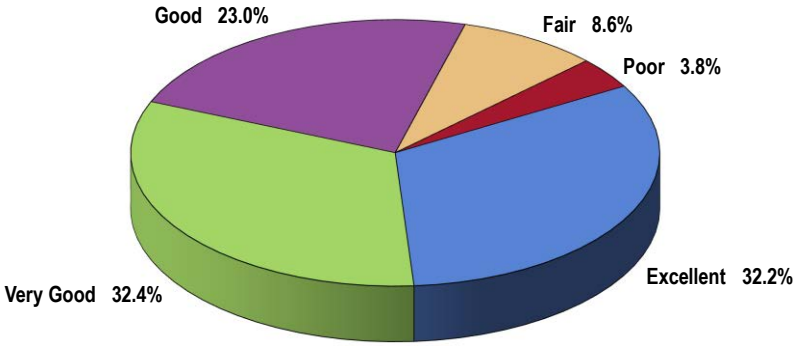
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

A total of 64.6% of Primary Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 23.0% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status

(Primary Service Area, 2016)

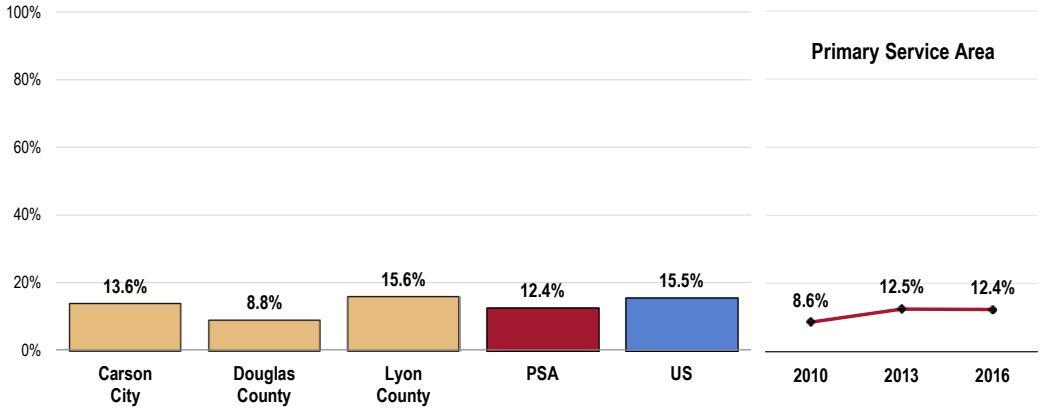


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: Asked of all respondents.

A total of 12.4% of Primary Service Area adults, however, believe that their overall mental health is "fair" or "poor."

- Similar to the "fair/poor" response reported nationally.
- Lowest in Douglas County.
- TREND: Marks a statistically significant increase from 2010 survey findings (similar to 2013).

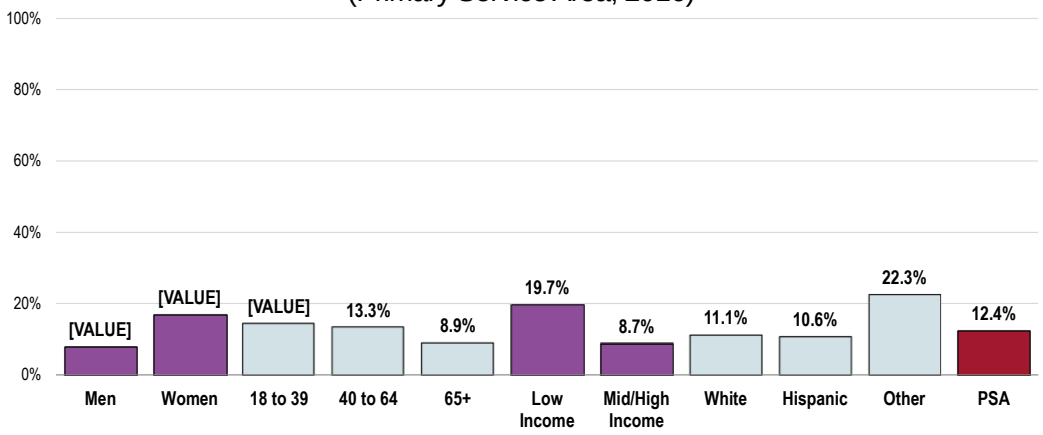
Experience "Fair" or "Poor" Mental Health



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

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

Experience "Fair" or "Poor" Mental Health
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

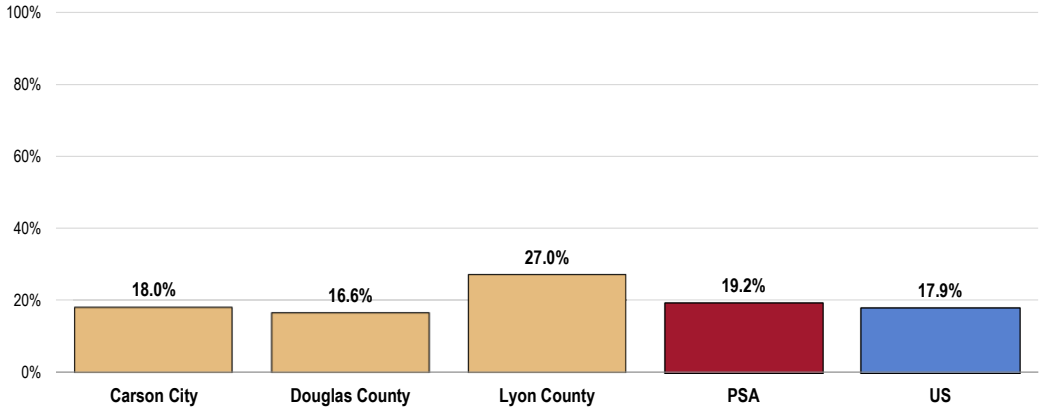
Depression

Diagnosed Depression

A total of 19.2% of area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Similar to the national finding.
- Unfavorably high in Lyon County.

Have Been Diagnosed With a Depressive Disorder



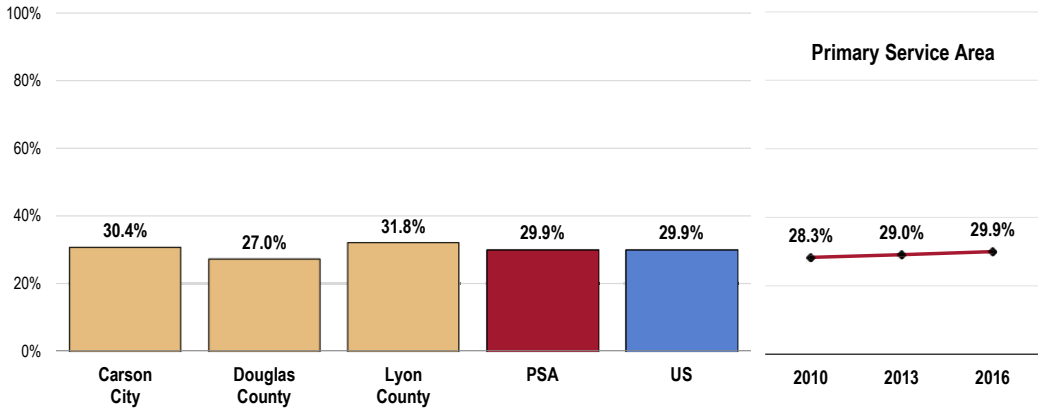
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

A total of 29.9% 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).

- Identical to national findings.
- Similar findings by area.
- TREND: Statistically unchanged over time.

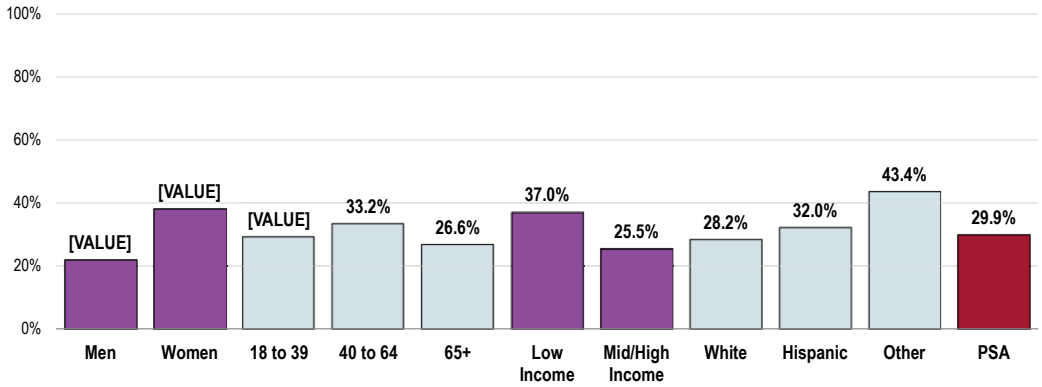
Have Experienced Symptoms of Chronic Depression



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

- The prevalence of chronic depression is higher among women, adults with lower incomes, and Other races.

Have Experienced Symptoms of Chronic Depression
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
Notes: Asked of all respondents.
Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

One-half of Primary Service Area adults consider their typical day to be "not very stressful" (32.7%) or "not at all stressful" (17.2%).

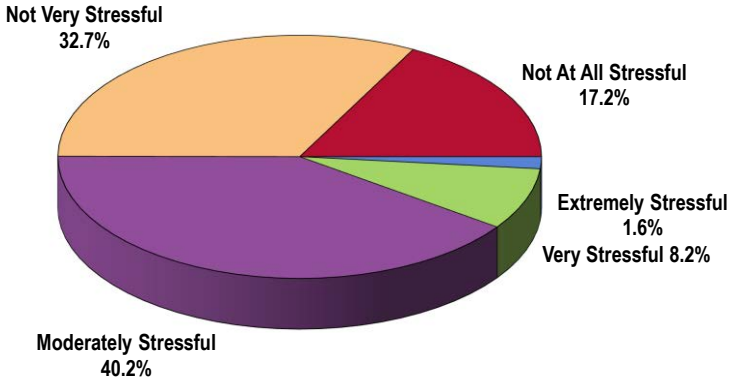
RELATED ISSUE:

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

- Another 40.2% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day

(Primary Service Area, 2016)

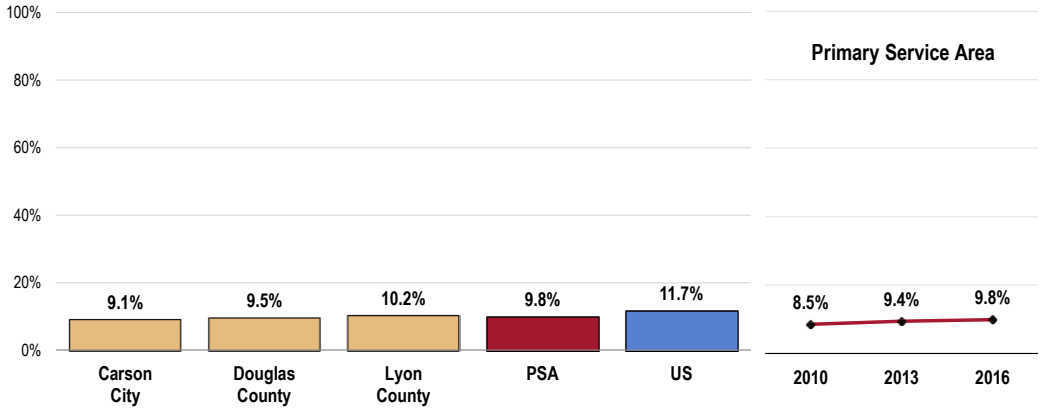


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
Notes: Asked of all respondents.

In contrast, 9.8% of Primary Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Comparable to national findings.
- Comparable findings by area.
- TREND: Statistically similar to the 2010 findings.

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

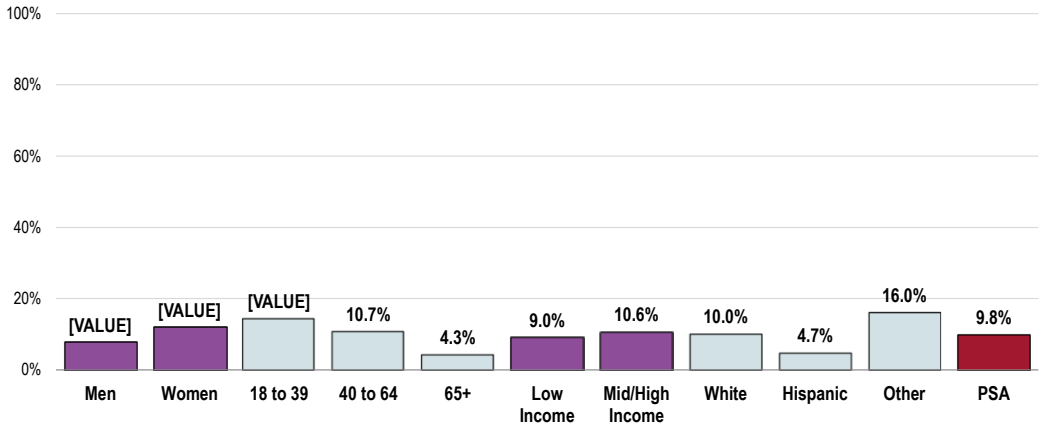


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

- Note that high stress levels are more prevalent among women, adults under 65 (negative correlation with age), and Other races.

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

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Suicide

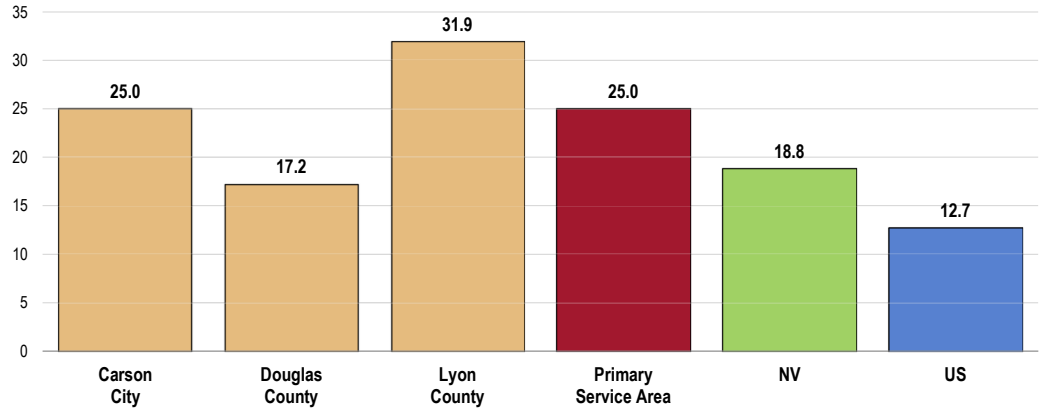
Between 2012 and 2014, there was an annual average age-adjusted suicide rate of 25.0 deaths per 100,000 population in the Primary Service Area.

- Higher than the statewide and national rates.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.
- Highest in Lyon County.

Suicide: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

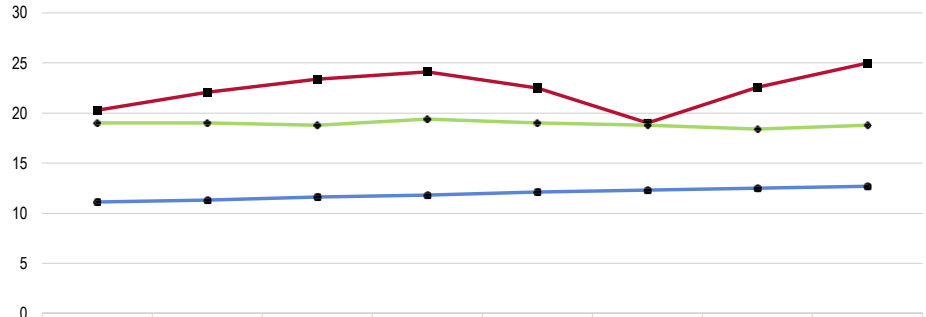
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: Despite declines in 2011 and 2012, the area's suicide rate has overall increased. Nationally, the suicide rate has increased as well (the state's rate has been stable).

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	20.3	22.1	23.4	24.1	22.5	19.0	22.6	25.0
NV	19.0	19.0	18.8	19.4	19.0	18.8	18.4	18.8
US	11.1	11.3	11.6	11.8	12.1	12.3	12.5	12.7

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

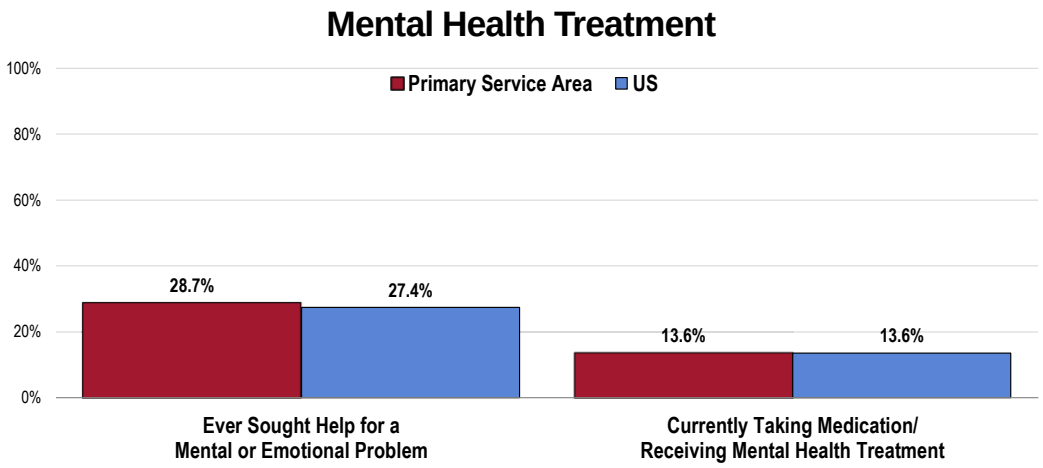
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

A total of 28.7% of Primary Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

A total of 13.6% are currently taking medication or receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

- Both percentages are comparable to their national benchmarks.



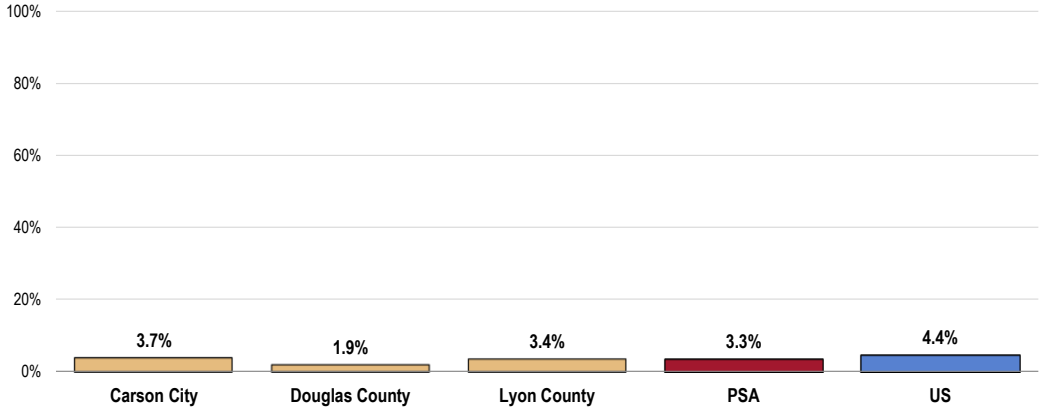
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 120-121]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Reflects the total sample of respondents.

Difficulty Accessing Mental Health Services

A total of 3.3% 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.

- Similar to the national finding.
- Statistically similar by community.

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

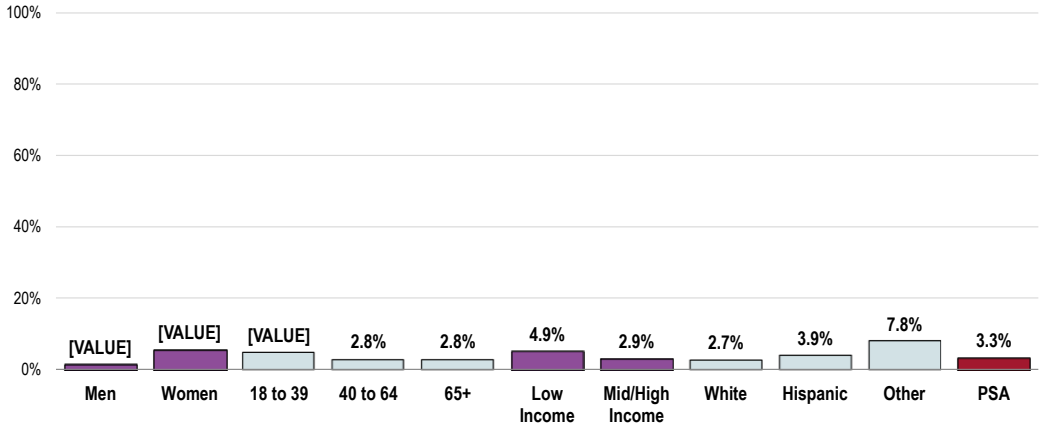


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

- Note that access difficulty is notably more prevalent among women.

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

(Primary Service Area, 2016)

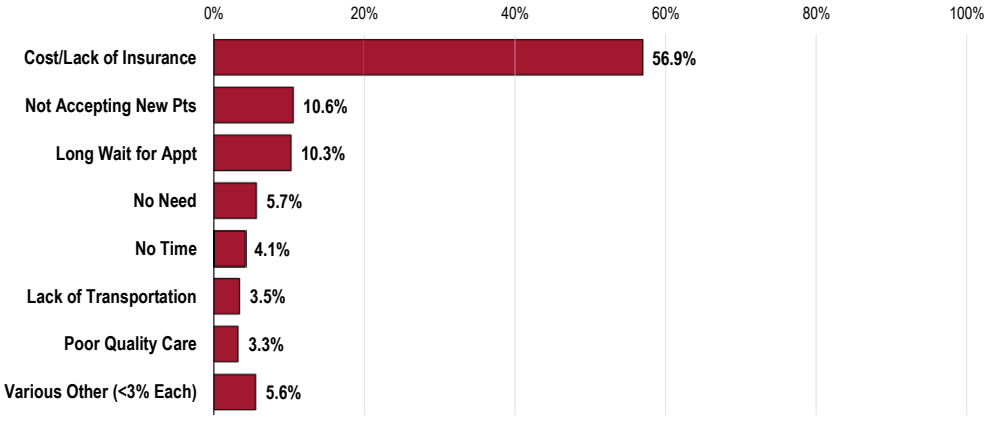


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among persons citing difficulties accessing mental health services in the past year, these are predominantly attributed to **cost or insurance issues** (mentioned by 56.9%); reasons mentioned much less frequently include accepting new patients, long waits for an appointment, need/time, lack of transportation, and poor quality of care.

Barrier to Accessing Mental Health Services in the Past Year

(Among Those Reporting Problems w/Access; Primary Service Area, 2016)



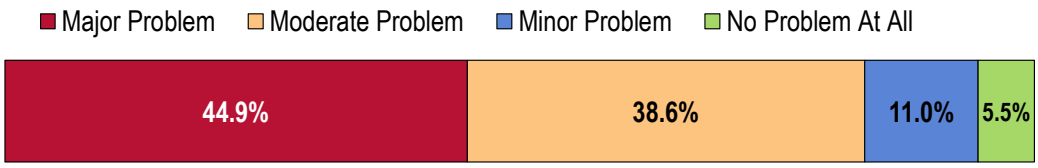
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
Notes: Asked of those respondents reporting problems obtaining mental health services in the past year.

Key Informant Input: Mental Health

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

Perceptions of Mental Health as a Problem in the Community

(Key Informants, 2016)



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

Challenges

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

Access to Care/Services

> *Limited access to help, insurance issues, and long wait times. – Community/Business Leader*
>
> *Poor level of resources dedicated. Insurances don't cover. – Community/Business Leader*
>
> *In Douglas and Carson, more resources exist. In rural Lyon, there are inadequate hours and clinic locations for state rural mental health clinics and few private practices. In Lyon, there are zero group homes or activity centers. – Social Services Provider*
>
> *Access to care. – Physician*
>
> *Lack of bed space. Lack of healthcare professionals. – Community/Business Leader*

Access to care, unhealthy society, stress. – Physician

Lack of resources and the ability to obtain those resources. – Community/Business Leader

Lack of services, long wait lists, few specialists for children. – Social Services Provider

Inpatient mental health access for Medicaid patients is not adequate to community needs. – Physician

There is very little help available to the mentally ill. No treatment or assistance centers in the immediate area, and the local hospital gets rid of them as quickly as they can. – Community/Business Leader

I think that one of the biggest problems is mental health and the difficulty to get access to a counselor. Maybe it's easier than I think, but even though I have good health insurance, it seemed I was limited on a few places I could pick from. – Community/Business Leader

Access to ongoing care. Limited bed space for patients requiring Inpatient management. – Physician

How can they get help? – Community/Business Leader

We need an Outpatient Clinic. – Physician

Access to mental health care. The only provider for suicidal/homicidal people is West Hills in Reno. Would be nice to have local risk assessments and treatment. – Community/Business Leader

Lack of insurance, funding, lack of providers. – Physician

Access to Providers

Inadequate number of providers. – Physician

I think everyone could use some counseling: anger/depression seems to be a major issue. – Community/Business Leader

Provider availability, medication management, keeping folks taking their medications. Inability to force treatment or self-medicating via non-prescribed drugs or alcohol. Cost of medications, reliance on jail for diagnosis and treatment. – Community/Business Leader

Having access to therapists and ongoing services. – Community/Business Leader

Lack of psychiatry/behavioral health providers and Emergency Room visits. – Physician

Lack of doctors and resources to provide assistance. Minimal beds available. – Community/Business Leader

Not enough psychiatrists—virtually none—or psychologists. – Physician

There are a very limited number of mental health professionals in our community. Also, there is a lack of understanding of mental health, which leads to lack of treatment. – Community/Business Leader

Shortage of provider, no pediatric providers. – Physician

The lack of available psychiatrists willing to do Outpatient follow-up for patients in need of consultation or medicine management. – Physician

Minimal providers. – Physician

We have a distinct lack of providers and facilities for those suffering from mental illness. It is a huge problem. – Community/Business Leader

Health Education

There is little public dialog about the social, community, and family stressors associated with many mental health problems. Hence, the remedies tend to be in silos with little holistic prevention or response. – Community/Business Leader

Lack of knowledge about where to go for diagnosis or treatment. Lack of knowledge about what to expect from a visit to a mental health professional. Lack of knowledge about how to actually make an appointment to see and be treated. – Community/Business Leader

Knowing where/who the first call should go. Some type of public awareness of who to call for depression, anxiety, etc. would be effective. Some people may be embarrassed to call, but at least they would have this resource. – Community/Business Leader

Knowledge base. Publicity/centralized Community Mental Health center/services for all insurance types. – Other Health Provider

Emotional/Spiritual Health. This is often neglected as a part of health and is rarely discussed as part of the whole person. – Community/Business Leader

Affordable Care/Services

Finding reasonably-priced therapy, many insurance policies do not cover mental health issues. –

Community/Business Leader

Limited resources for individuals with limited income. Individuals with mental health concerns are incapable of advocating for themselves. These individuals are oftentimes untreated or are unable to receive treatment due to limited resources. – Social Services Provider

Access to no- or low-cost services. Stigma of receiving or seeking mental health treatments. – Community/Business Leader

Denial/Stigma

We have many people who have mental illness and don't take their medications for many reasons. There is a stigma associated with it, and people are afraid to see a doctor. – Community/Business Leader

A lot of families do not recognize mental health problems or are not willing to get help. Are self-medicating with drugs, alcohol, or pain medication. – Community/Business Leader

Prevalence/Incidence

It's a problem nationwide. Enormous waits for inpatient for those without insurance. Even those with insurance have waits that are less than ideal. The ability to get outpatient treatment—even if you have insurance—is very challenging. – Physician

Many in the community have this problem, and many in our jails have this problem. – Community/ Business Leader

Aging Population

Isolation of the elderly and use of abusive drugs. – Community/Business Leader

Seniors isolated by spousal death and prohibitive distances to family. – Community/Business Leader

Stress

Family stress, alcohol and drugs, recession. – Community/Business Leader

Philosophy which promotes stress. – Physician

Vulnerable Populations

It seems that so many of our less-fortunate citizens and homeless people have mental problems, and there needs to be more help for them. And not just put them in jail or leave them to fend for themselves on the street. – Community/Business Leader

Drugs/Alcohol

Substance abuse, depression. – Other Health Provider

Homelessness

Homelessness is the biggest problem. Not enough resources to get someone the help they need. If they get help through the hospital, there's no follow-up. – Social Services Provider

Death, Disease & Chronic Conditions

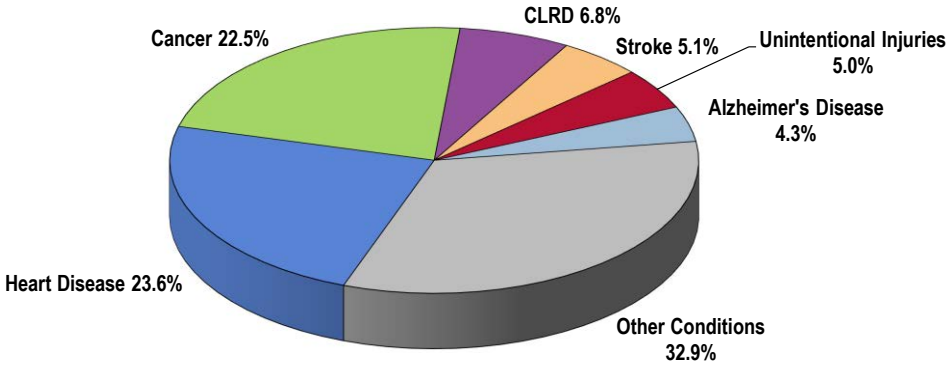
Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for over one-half of all deaths in the Primary Service Area in 2014.

Leading Causes of Death
(Primary Service Area, 2014)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

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

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

The following chart outlines 2012-2014 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

(2012-2014 Deaths per 100,000 Population)

	Primary Service Area	Nevada	US	HP2020
Diseases of the Heart	172.5	194.9	169.1	156.9*
Malignant Neoplasms (Cancers)	165.2	164.2	163.6	161.4
Chronic Lower Respiratory Disease (CLRD)	54.2	53.0	51.4	n/a
Unintentional Injuries	45.5	41.5	39.7	36.4
Cerebrovascular Disease (Stroke)	37.7	33.8	36.5	34.8
Alzheimer's Disease	30.7	19.2	24.2	n/a
Intentional Self-Harm (Suicide)	25.0	18.8	12.7	10.2
Diabetes Mellitus	21.9	14.0	21.1	20.5*
Firearm-Related	20.1	13.8	10.4	9.3
Drug-Induced	18.9	20.5	14.6	11.3
Cirrhosis/Liver Disease	15.4	12.7	10.2	8.2
Pneumonia/Influenza	15.0	20.5	15.1	n/a
Motor Vehicle Deaths	12.5	10.0	10.6	12.4
Kidney Disease	10.3	13.5	13.2	n/a
Fall-Related	6.6	7.5	8.8	n/a
Homicide/Legal Intervention	3.5	6.2	5.6	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 May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

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

Cardiovascular Disease

About Heart Disease & Stroke

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

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

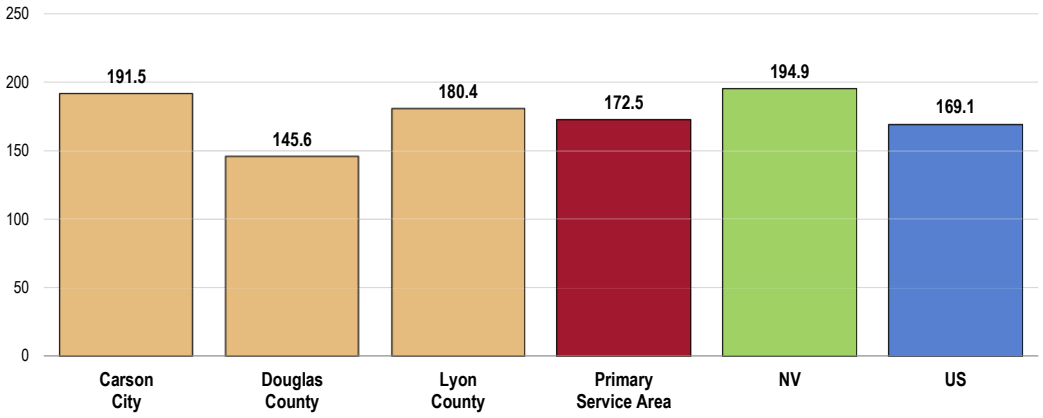
Between 2012 and 2014 there was an annual average age-adjusted heart disease mortality rate of 172.5 deaths per 100,000 population in the Primary Service Area.

- Lower than the statewide rate.
- Comparable to the national rate.
- Fails to satisfy the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).
- Favorably low in Douglas County.

Heart Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

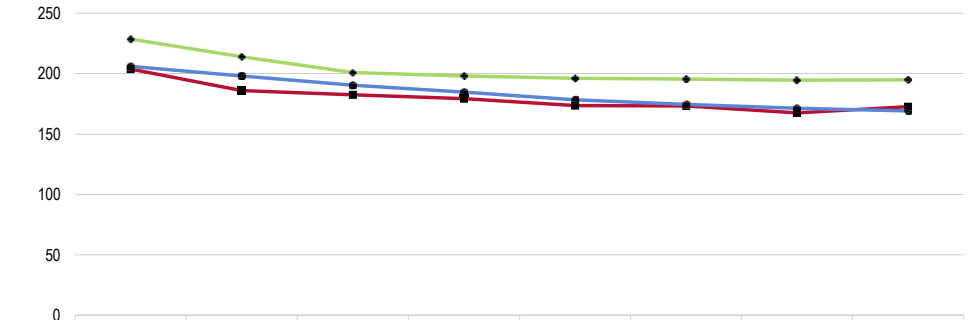
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
The Healthy People 2020 Heart Disease target is adjusted to account for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

- TREND: The heart disease mortality rate has decreased in the Primary Service Area, echoing the decreasing trends across Nevada and the US overall.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	203.9	186.1	182.6	179.4	173.5	173.4	167.6	172.5
NV	228.7	213.8	200.8	198.0	196.1	195.4	194.6	194.9
US	206.1	197.9	190.3	184.7	178.5	174.4	171.3	169.1

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

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

Stroke Deaths

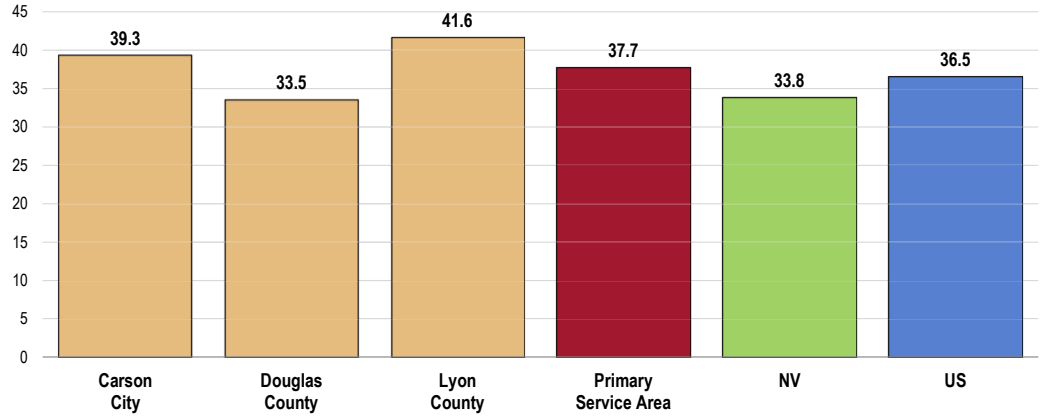
Between 2012 and 2014, there was an annual average age-adjusted stroke mortality rate of 37.7 deaths per 100,000 population in the Primary Service Area.

- Less favorable than the Nevada rate.
- Similar to the US rate.
- Fails to satisfy the Healthy People 2020 target of 34.8 or lower.
- Particularly high in Lyon County.

Stroke: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

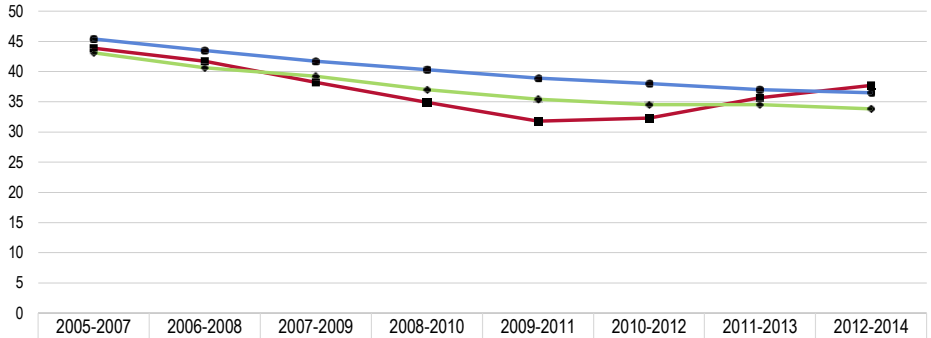
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: After declining steadily for years, the area's stroke rate has increased in recent years, in contrast to the decreasing trends reported across Nevada and the US overall.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	43.9	41.7	38.2	34.9	31.8	32.3	35.7	37.7
NV	43.1	40.6	39.2	37.0	35.4	34.5	34.5	33.8
US	45.4	43.5	41.7	40.3	38.9	38.0	37.0	36.5

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

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

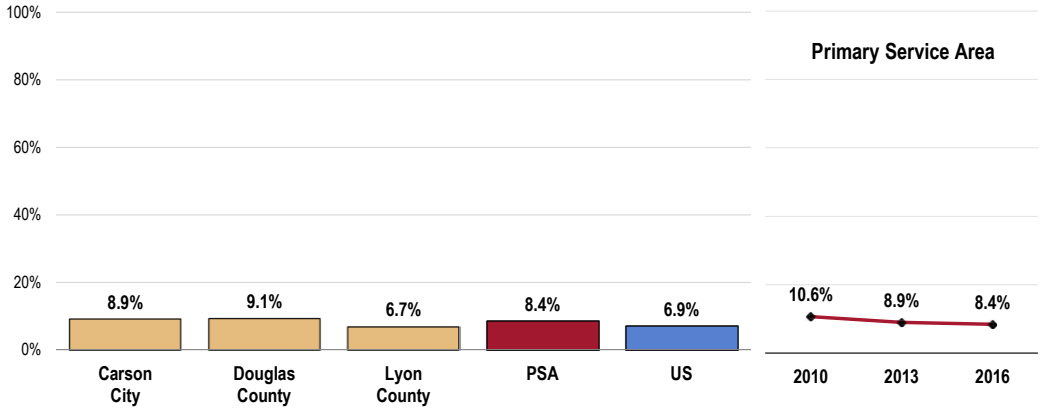
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 8.4% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Comparable to the national prevalence.
- Comparable findings by area.
- TREND: Statistically unchanged from previous findings.

Prevalence of Heart Disease

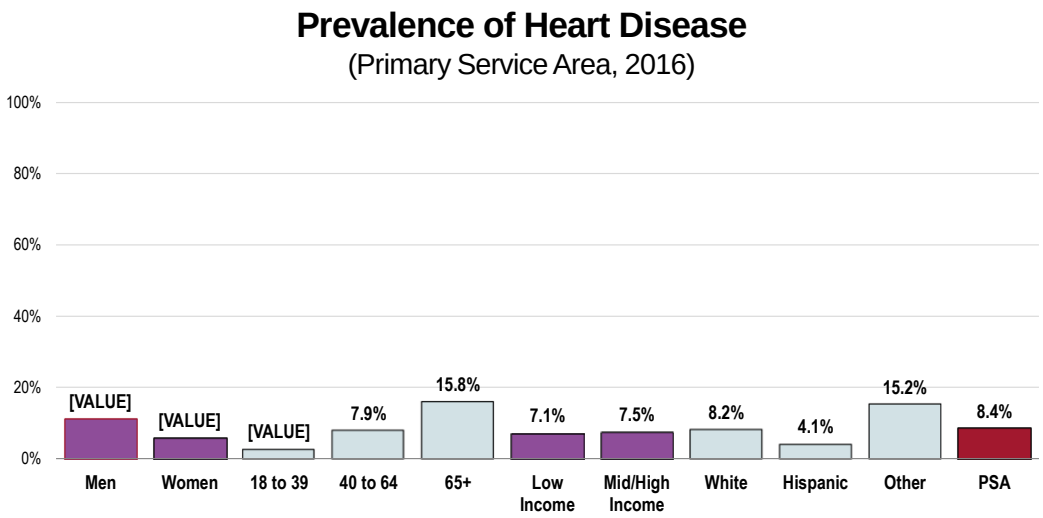


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

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

- Men.
- Other races.
- Note also the positive correlation with age.



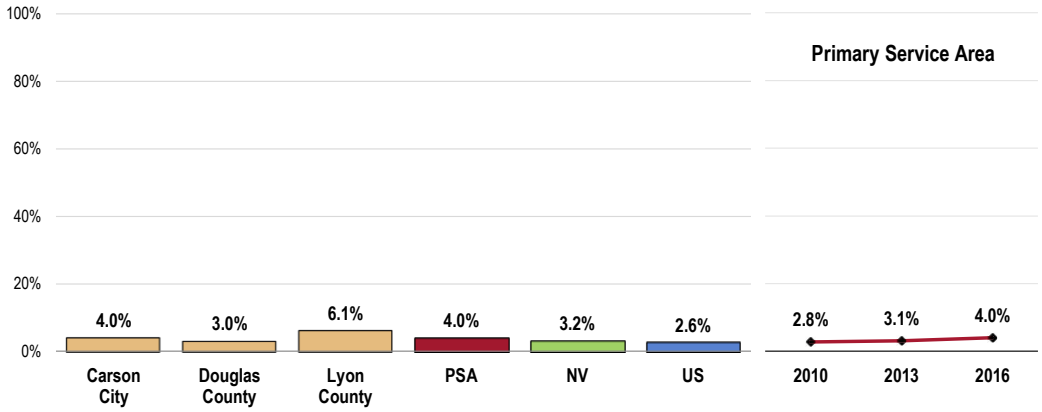
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
Notes: Asked of all respondents.
Includes diagnoses of heart attack, angina or coronary heart disease.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prevalence of Stroke

A total of 4.0% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to statewide and national findings.
- Similar by area.
- TREND: Statistically unchanged over time.

Prevalence of Stroke



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
Notes: Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

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

- Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure

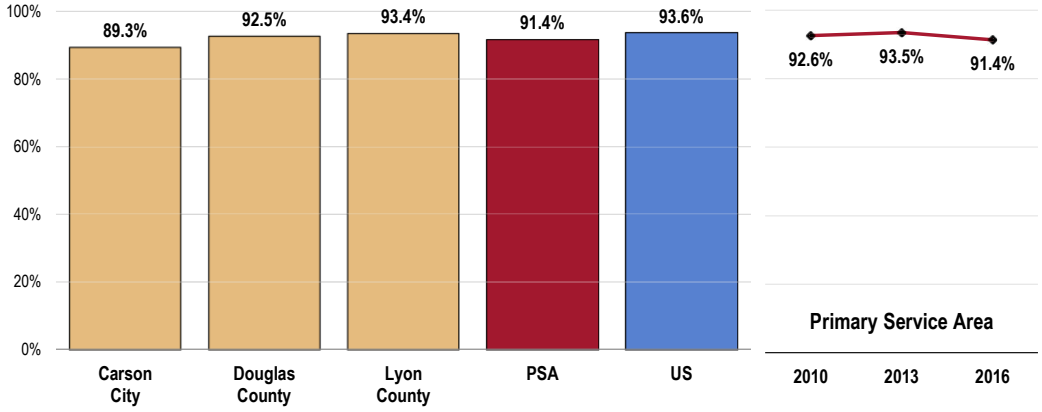
High Blood Pressure Testing

A total of 91.4% of Primary Service Area adults have had their blood pressure tested within the past two years.

- Similar to national findings.
- Similar to the Healthy People 2020 target (92.6% or higher).
- Similar by area.
- TREND: Statistically unchanged since 2010.

Have Had Blood Pressure Checked in the Past Two Years

Healthy People 2020 Target = 92.6% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]
Notes: Asked of all respondents.

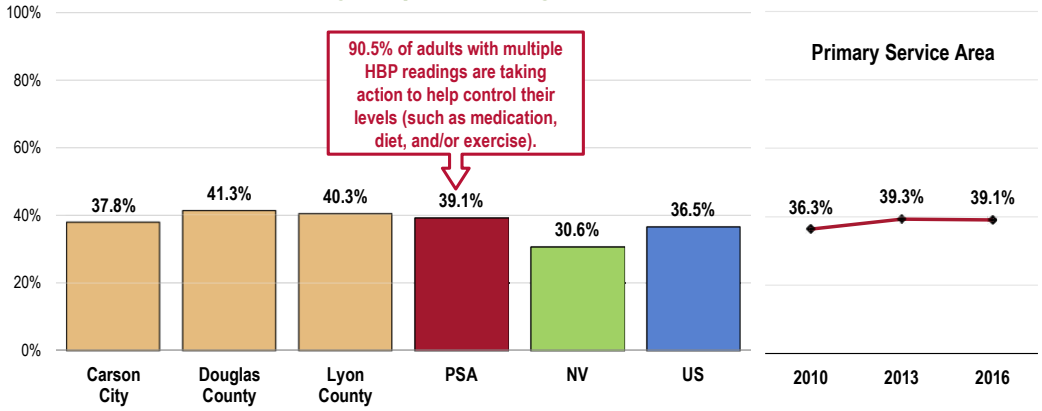
Prevalence of High Blood Pressure

A total of 39.1% of Primary Service Area adults have been told at some point that their blood pressure was high.

- Less favorable than the Nevada prevalence.
- Similar to the national prevalence.
- Fails to satisfy the Healthy People 2020 target (26.9% or lower).
- Similar findings by area.
- TREND: Statistically unchanged since 2010.
- Among adults with multiple high blood pressure readings, 90.5% are taking action to lower their blood pressure (such as medication, change in diet, and/or exercise).

Prevalence of High Blood Pressure

Healthy People 2020 Target = 26.9% or Lower

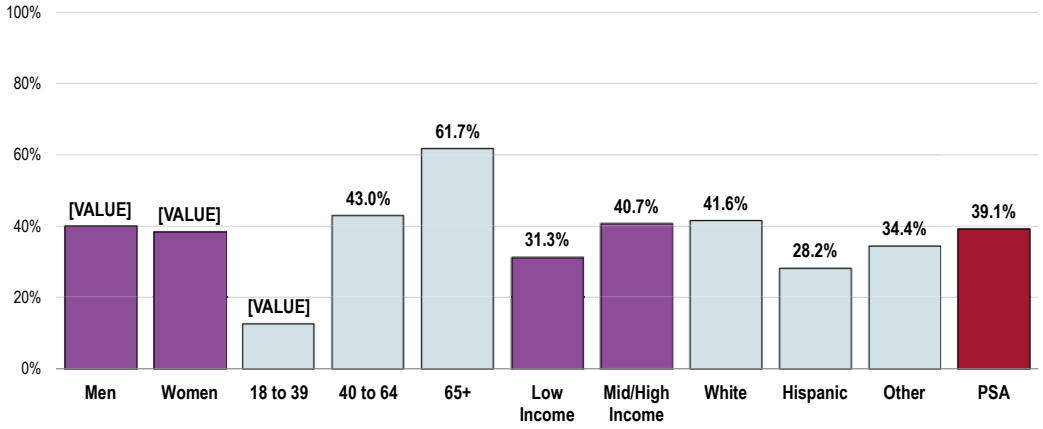


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]
Notes: Asked of all respondents.

High blood pressure is more prevalent among:

- Adults age 40 and older, and especially those age 65+.
- Upper-income residents.
- Whites.

Prevalence of High Blood Pressure
(Primary Service Area, 2016)
Healthy People 2020 Target = 26.9% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

High Blood Cholesterol

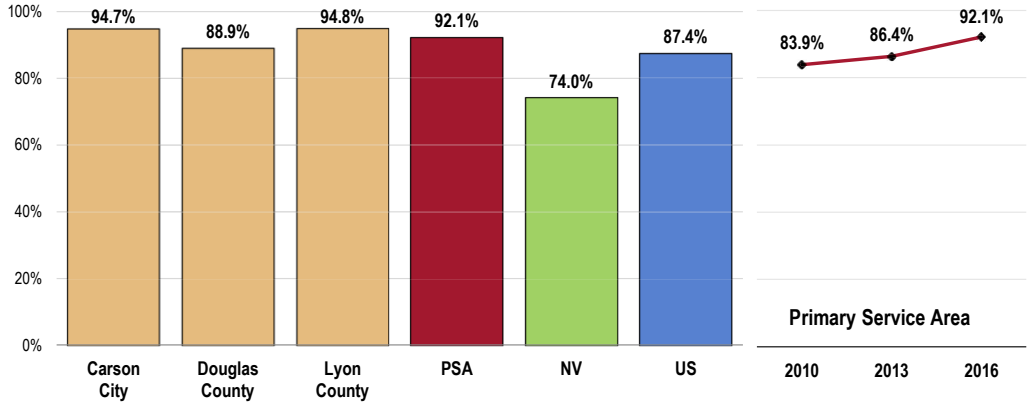
Blood Cholesterol Testing

A total of 92.1% of Primary Service Area adults have had their blood cholesterol checked within the past five years.

- More favorable than Nevada and US findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- Lower in Douglas County.
- TREND: Denotes a statistically significant increase since 2010.

Have Had Blood Cholesterol Levels Checked in the Past Five Years

Healthy People 2020 Target = 82.1% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Nevada data.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]
Notes: Asked of all respondents.

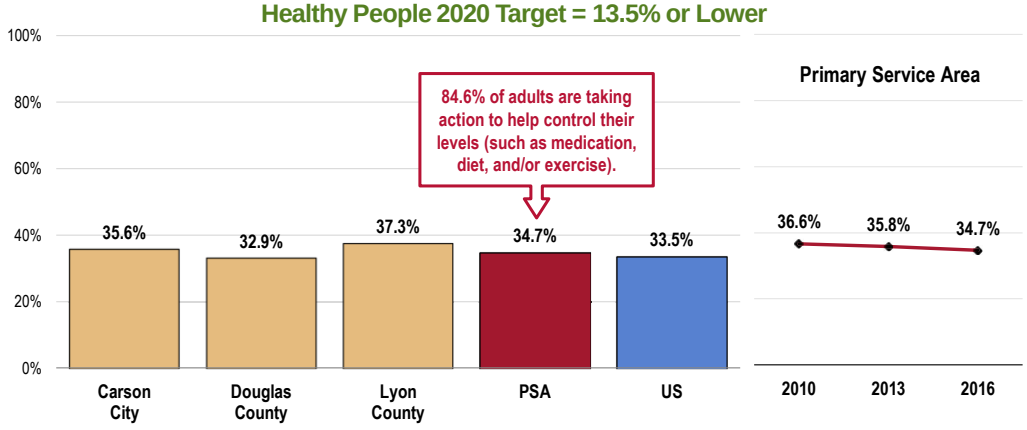
Prevalence of High Blood Cholesterol

A total of 34.7% of adults have been told by a health professional that their cholesterol level was high.

- Similar to the national prevalence.
- Over twice the Healthy People 2020 target (13.5% or lower).
- Similar by area.
- TREND: Statistically unchanged since 2010.
- Among adults with high blood cholesterol readings, 84.6% are taking action to lower their numbers (such as medication, change in diet, and/or exercise).

Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 46, 148]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]
Notes: Asked of all respondents.

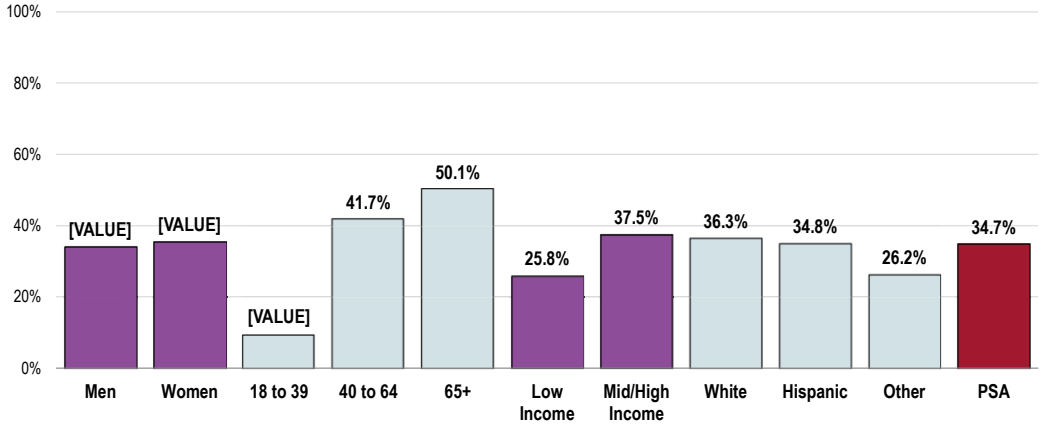
Further note the following:

- There is a very strong positive correlation between age and high blood cholesterol.
- There is a higher prevalence among higher-income adults.

Prevalence of High Blood Cholesterol

(Primary Service Area, 2016)

Healthy People 2020 Target = 13.5% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

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

About Cardiovascular Risk

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

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

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

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese.

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

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

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease.

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

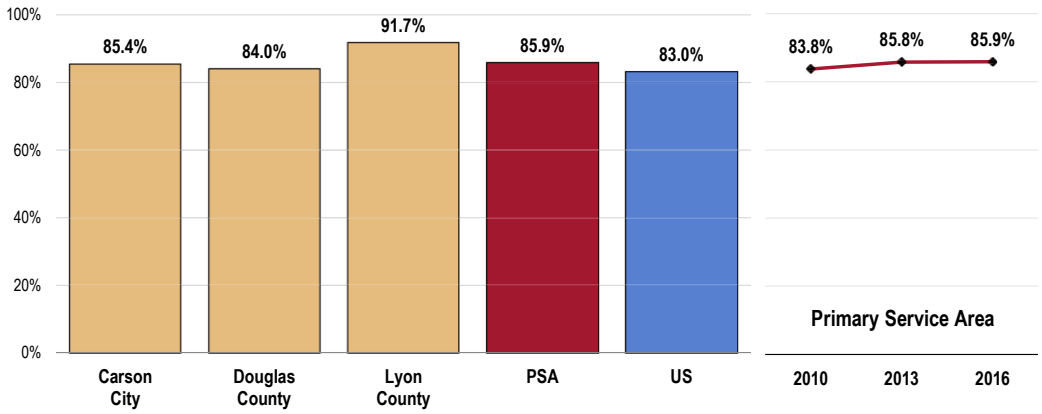
Total Cardiovascular Risk

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

A total of 85.9% 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.

- Comparable to national findings.
- Unfavorably high in Lyon County.
- TREND: Statistically similar to previous findings.

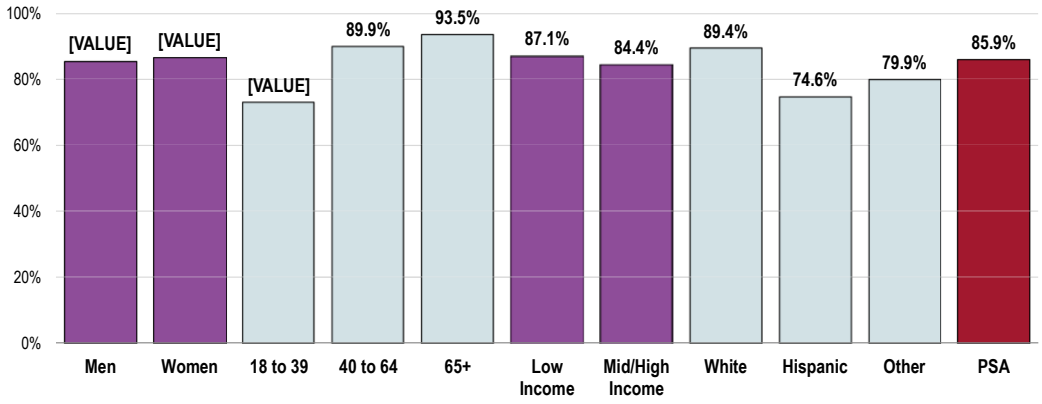
Present One or More Cardiovascular Risks or Behaviors



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

- Whites and adults age 40+ are more likely to exhibit cardiovascular risk factors.

Present One or More Cardiovascular Risks or Behaviors
(Primary Service Area, 2016)



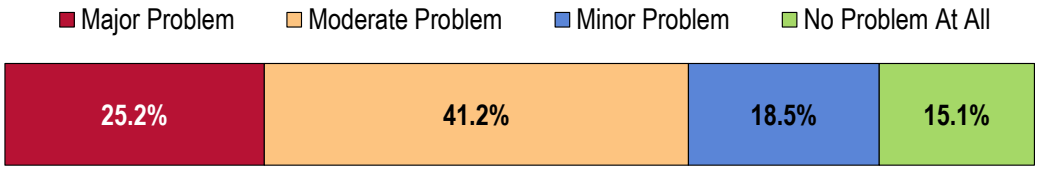
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
Notes: Asked of all respondents.
Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

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

Perceptions of Heart Disease and Stroke as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Lifestyle

Poor general health and poor diet. – Physician

Due to the unhealthy and sedentary lifestyle of the majority of our elderly and middle-aged. – Physician

Poor lifestyle choices and older-than-average population. – Community/Business Leader

Poor health habits related to use and/or consumption of products that could result in heart disease and stroke, as well as the lack of physical exercise to assist in prevention. – Community/Business Leader

Poor diet and a sedentary lifestyle are a problem for people who live in poverty. Access to quality food contributes. – Community/Business Leader

Based on the people that I have met in the community, far fewer have a healthy lifestyle compared to other places where I have lived and visited. This is based on general appearance and habits. Weight, activity level, smoking, excessive eating. – Community/Business Leader

High blood pressure and stress is not handled well with working and older adults. Stress is not always dealt with in a positive way. People do not realize how it is affecting their bodies. – Community/Business Leader

Prevalence/Incidence

It is a common occurrence. I have had employees with this issue, and have heard of several other residents that have this problem and have survived and trying to live better. – Community/Business Leader

Know people with this condition. – Community/Business Leader

This is the most common health problem in the world and likely the local population. Uncontrolled hypertension is the risk factor for poor health outcomes. – Community/Business Leader

Heart disease is one of the most commonly reported illnesses by our clients. Specialty care for stroke patients is not local. One neurologist in Reno. – Social Services Provider

It's one of the things I hear the most about around the community, talking to people, 'someone had a heart attack.' It's really all my perception of the community, though. – Community/Business Leader

Aging Population

Aging population, diet, lack of healthy choices. – Community/Business Leader

Leading cause of death for Americans 55+. Douglas County has a large population of seniors. – Community/Business Leader

Advanced age of the population plus obesity. – Community/Business Leader

Aging population, overall obesity. – Community/Business Leader

Douglas has high percent of seniors. – Community/Business Leader

Older adult population, primarily. – Community/Business Leader

Obesity

We have many overweight people in our community and many people who smoke. – Community/Business Leader

Obesity is the first factor that comes to mind. Lack of commitment to exercise. – Community/Business Leader

Conditions related to obesity are becoming increasingly more common. The impact of heart diseases and strokes on quality of life and morbidity. – Community/Business Leader

Access to Providers

Very prevalent, with limited access to primary care and disease management. – Physician

Only one cardiologist in Carson Valley, one group in Reno/Carson City. Lots of patients. – Community/Business Leader

Leading Cause of Death

Heart disease is the leading cause of death in the United States. Stroke is the third leading cause of death in the United States. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today. – Community/Business Leader

Cancer

About Cancer

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

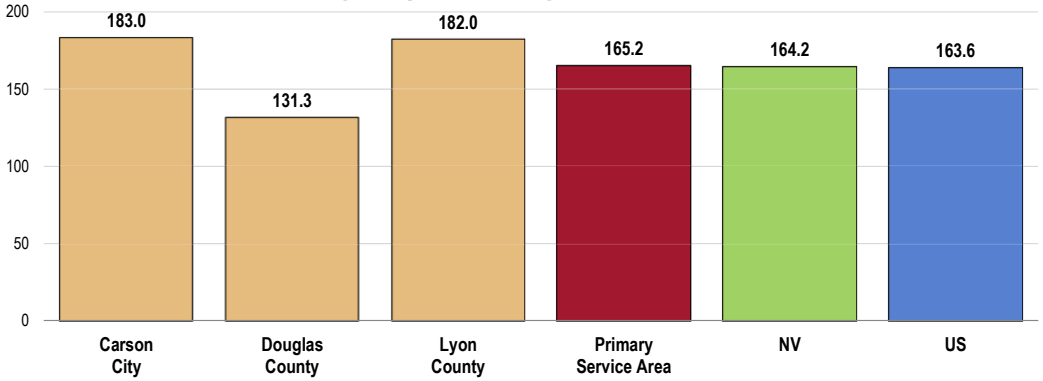
Between 2012 and 2014, there was an annual average age-adjusted cancer mortality rate of 165.2 deaths per 100,000 population in the Primary Service Area.

- Similar to the statewide and national rates.
- Similar to the Healthy People 2020 target of 161.4 or lower.
- Higher in Carson City and Lyon County.

Cancer: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 or Lower



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

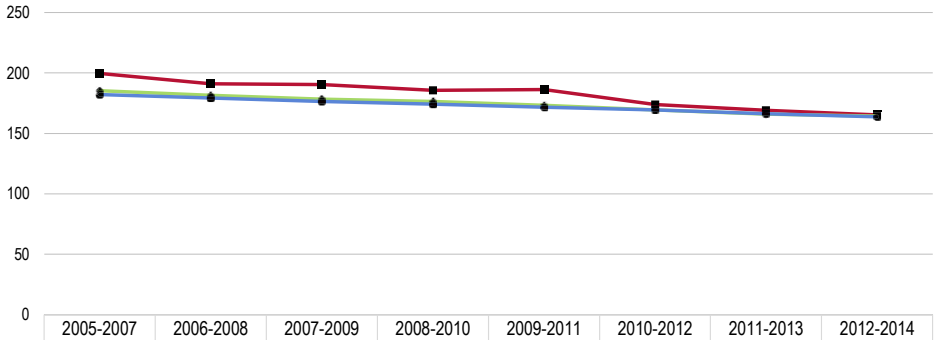
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	199.5	191.0	190.4	185.6	186.2	174.0	169.2	165.2
NV	185.4	181.6	178.5	176.3	173.2	169.3	166.1	164.2
US	182.1	179.2	176.4	174.2	171.8	169.4	166.2	163.6

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

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

Cancer Deaths by Site

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

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

As can be seen in the following chart (referencing 2012-2014 annual average age-adjusted death rates):

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

Note that while the area's prostate cancer death rate satisfies the related Healthy People 2020 target, the female breast cancer and colorectal cancer rates fail to satisfy their respective targets (the prostate cancer rate is similar to its goal).

Age-Adjusted Cancer Death Rates by Site

(2012-2014 Annual Average Deaths per 100,000 Population)

	Primary Service Area	Nevada	US	HP2020
ALL CANCERS	165.2	164.2	163.6	161.4
Lung Cancer	45.4	45.6	43.4	45.5
Female Breast Cancer	23.4	22.2	20.9	20.7
Prostate Cancer	17.8	21.0	19.2	21.8
Colorectal Cancer	17.5	16.9	14.6	14.5

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov

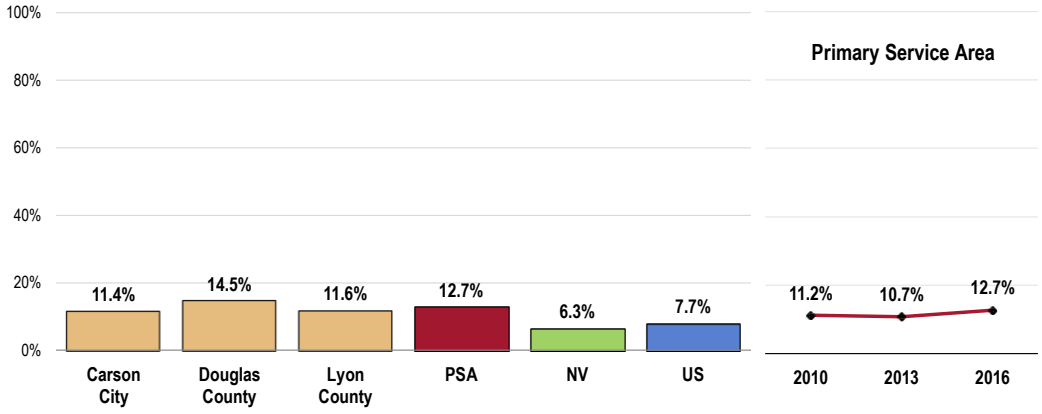
Prevalence of Cancer

Skin Cancer

A total of 12.7% of surveyed Primary Service Area adults report having been diagnosed with skin cancer.

- Less favorable than the state and national averages.
- Similar findings by area.
- TREND: The prevalence of skin cancer has remained statistically unchanged over time.

Prevalence of Skin Cancer



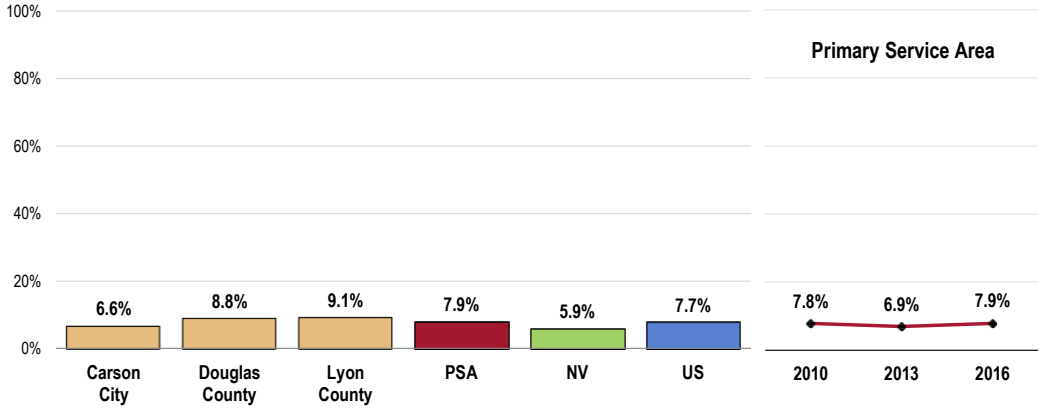
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Other Cancer

A total of 7.9% of survey respondents have been diagnosed with some type of (non-skin) cancer.

- Similar to the statewide and national percentages.
- Similar findings by area.
- TREND: The prevalence of cancer has remained unchanged over time.

Prevalence of Cancer (Other Than Skin Cancer)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, 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): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Cancer Risk

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

About Cancer Risk

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

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

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

Cancer Screenings

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

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

Prostate Cancer Screenings

About Screening for Prostate Cancer

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

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

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

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

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

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

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

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

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

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

PSA Testing and/or Digital Rectal Examination

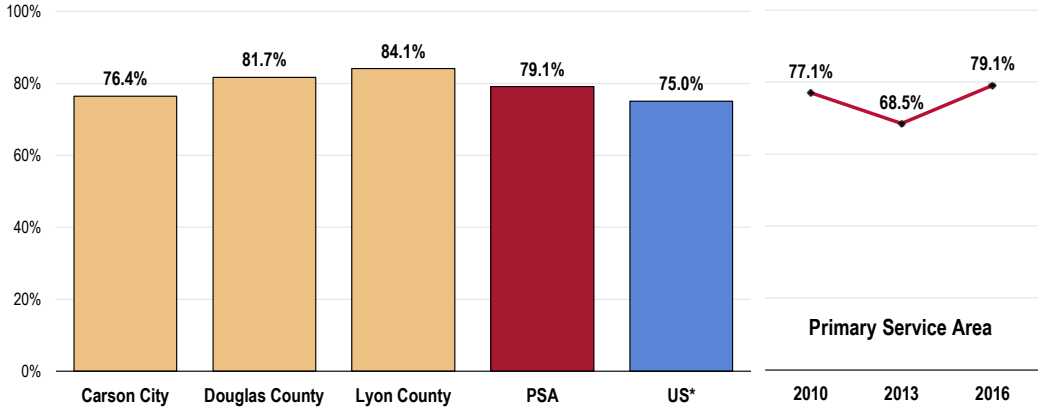
Among service area men age 50 and older, just less than 8 in 10 (79.1%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

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

- Similar to national findings.
- Similar findings by area.
- TREND: Statistically comparable to 2010 survey findings, but marking a significant increase since 2013.

Have Had a Prostate Screening in the Past Two Years

(Among Men Age 50 and Older)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 207]
2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all male respondents age 50 and older.
*US percentage reflects 2013 survey data.

Female Breast Cancer Screening

About Screening for Breast Cancer

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

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

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

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

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

Mammography

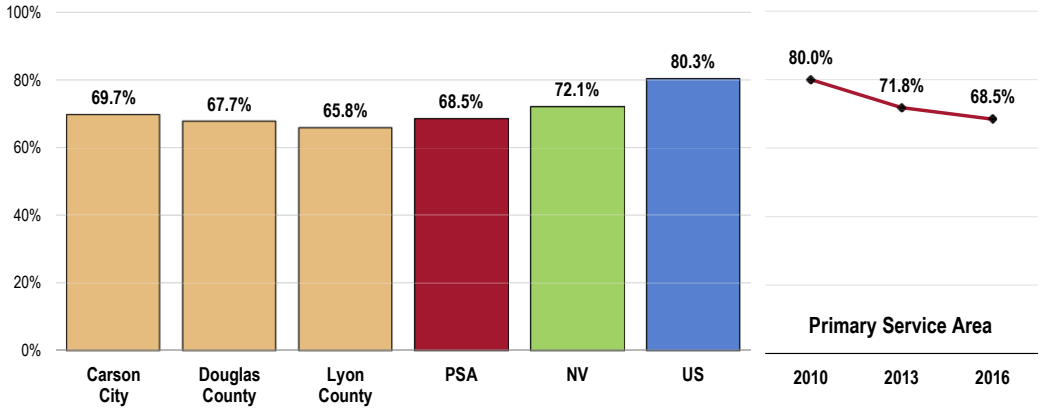
Among women age 50-74, 68.5% have had a mammogram within the past 2 years.

- Similar to statewide findings.
- Worse than national findings.
- Fails to satisfy the Healthy People 2020 target (81.1% or higher).
- Comparable findings by area.
- TREND: Denotes a statistically significant decrease over time.

Have Had a Mammogram in the Past Two Years

(Among Women Age 50-74)

Healthy People 2020 Target = 81.1% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes: Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

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

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

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

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

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

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

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

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

Pap Smear Testing

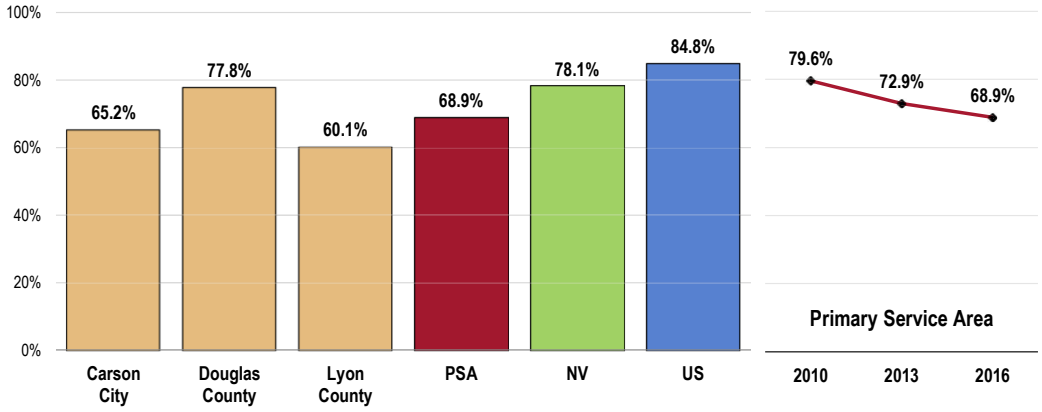
Among Primary Service Area women age 21 to 65, 68.9% have had a Pap smear within the past 3 years.

- Less favorable than state and national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- Favorably high in Douglas County.
- TREND: Marks a statistically significant decrease over time.

Have Had a Pap Smear in the Past Three Years

(Among Women Age 21-65)

Healthy People 2020 Target = 93.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes: Reflects female respondents age 21 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

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

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

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

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

Colorectal Cancer Screening

Among adults age 50-75, 73.1% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years).

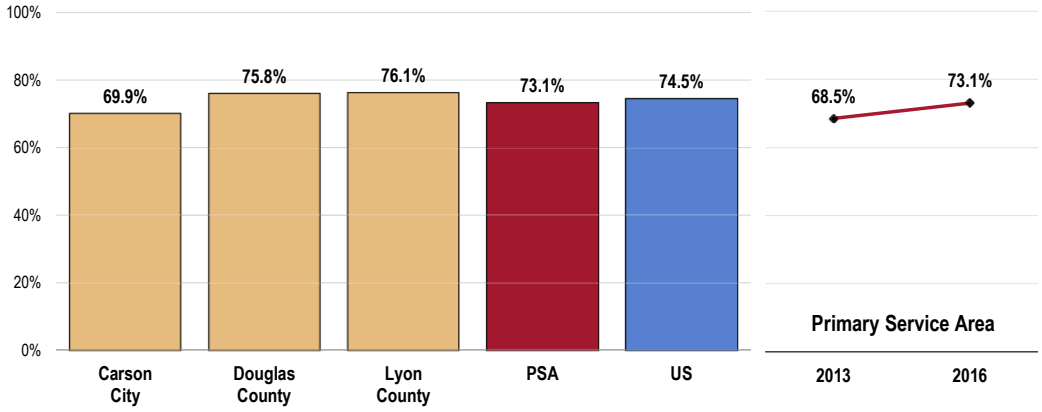
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

- Similar to national findings.
- Similar to the Healthy People 2020 target (70.5% or higher).
- Similar by area.
- TREND: Similar to 2013 survey results.

Have Had a Colorectal Cancer Screening

(Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

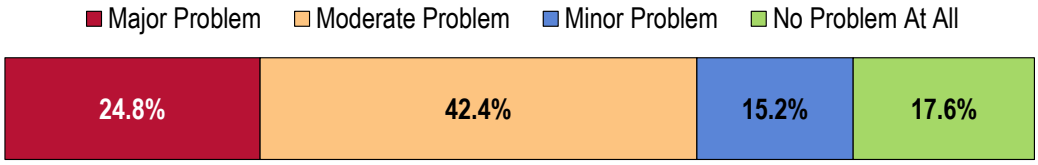
Notes: Asked of all respondents age 50 through 75.
In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

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.

Perceptions of Cancer as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Prevalence/Incidence

Many community members or family members are affected by cancer. We have no education on the early signs of cancer or the local resources to treat cancer. Our members have to travel to IHS Regional Hospital in Phoenix for care, if physically able. – Community/Business Leader

We have a lot of cases of cancer for a town our size. – Community/Business Leader

I believe it is a major problem because of the number of people I know who are currently fighting cancer or have lost the battle to cancer. – Community/Business Leader

Because it affects one out of four people, that says "problem" to me. – Community/Business Leader

Cancer is a major problem in every community. Every type of cancer is different, which makes research challenging. I think you need to not only focus on the disease, itself, but also how the patient and family can deal with the disease. – Community/Business Leader

There appears to be a high prevalence. A substantial amount of cancer care occurs after patients depart the local medical community. – Physician

It seems that more and more people are being diagnosed with cancer, and treatment is often referred to Stanford or somewhere in California. For many, this travel is burdensome. – Community/Business Leader

I have known several people that have been diagnosed or have passed away from various types of cancer. I think cancer is a major problem nationwide. – Community/Business Leader

Cancer is an issue nationwide, particularly the cost of cancer care and it is no different in Carson City. While we have some facilities to address the issues, cost remains a factor. – Community/Business Leader

People move here from all over the country. The Carson Valley is a gorgeous place to retire, and the older population tends to have this issue. Many people die from this problem. – Community/Business Leader

Know many people in community with cancer. – Community/Business Leader

Having a brother who died from cancer at the age of 18 and knowing numerous friends and students who have been diagnosed with cancer, it seems that we have an incredibly high incidence of cancer for a population our size. – Community/Business Leader

So many people tell us someone they know has it, or they have had it, or they are going through treatments for it. It seems to affect every family in some way. – Community/Business Leader

Numbers of cases seem above average, though I'm not sure of the statistics. – Physician

Number of occurrences through all age groups. – Community/Business Leader

Everyone knows someone who has had cancer, presently has cancer, or has had cancer themselves. – Community/Business Leader

Cancer, in one form or another, touches everyone at some point. Our cancer center is a great resource for the area. – Community/Business Leader

Aging Population

Cancer is a major problem in Carson City due to the aging population. And the fact that having one of the finest Cancer Centers in Northern Nevada makes Carson City a mecca for treatment. – Community/Business Leader

Aging population and cancer is common. – Physician

We are a demographically old community. It follows that a high percentage of those folks 65+ would be impacted by cancer. – Community/Business Leader

Lifestyle

Due to diet, environment, life choices and genetic predisposition. All various types of cancer are a major issue in our community as well as others across the country. – Community/Business Leader

Because our community does not have access to affordable screening test, poor nutrition, and lack of physical activities. – Community/Business Leader

Vulnerable Populations

There is an increase of cancer among the Native American communities due to improper diet, tobacco usage, lack of information, pollution, or- for some- the lack of desire to learn preventative methods. – Social Services Provider

Respiratory Disease

About Asthma & COPD

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

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

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

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

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

Risk factors for asthma currently being investigated include:

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

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

Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

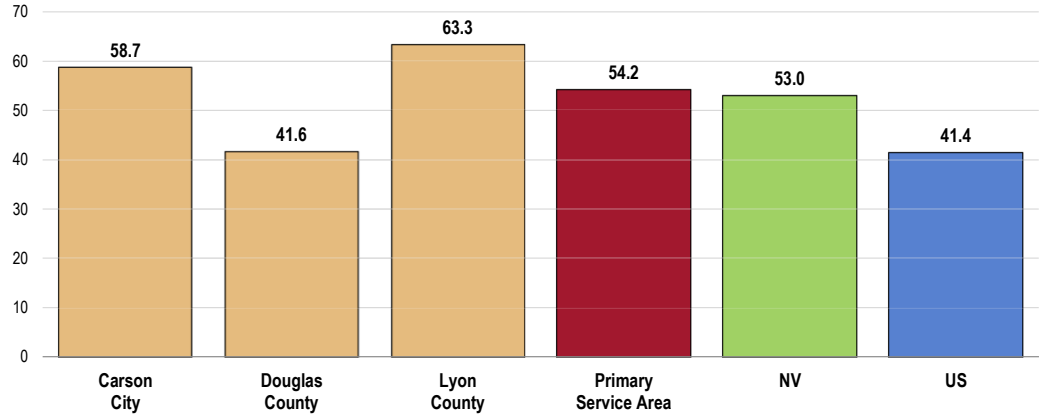
Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

Between 2012 and 2014, there was an annual average age-adjusted CLRD mortality rate of 54.2 deaths per 100,000 population in the Primary Service Area.

- Similar to that found statewide.
- Worse than the national rate.
- Unfavorably high in Carson City and Lyon County.

CLRD: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)



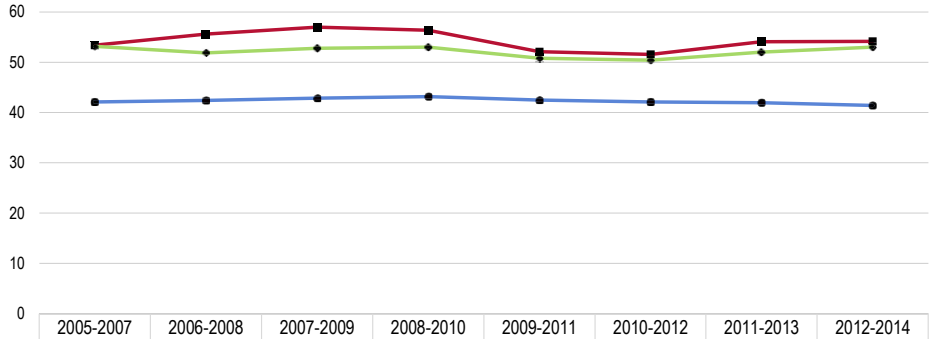
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

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

- TREND: Despite fluctuations, CLRD mortality in the Primary Service Area has over time not shown a clear trend.

CLRD: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	53.4	55.6	57.0	56.4	52.1	51.6	54.1	54.2
NV	53.2	51.9	52.8	53.0	50.8	50.4	52.0	53.0
US	42.1	42.4	42.9	43.2	42.5	42.1	42.0	41.4

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

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

Pneumonia/Influenza Deaths

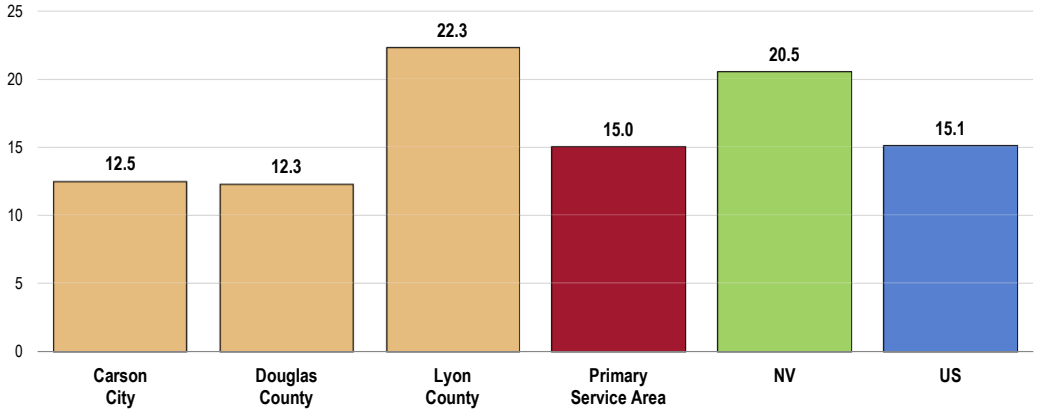
Between 2012 and 2014, the Primary Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 15.0 deaths per 100,000 population.

- Lower than found statewide.
- Nearly identical to the national rate.
- Unfavorably high in Lyon County.

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

Pneumonia/Influenza: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)



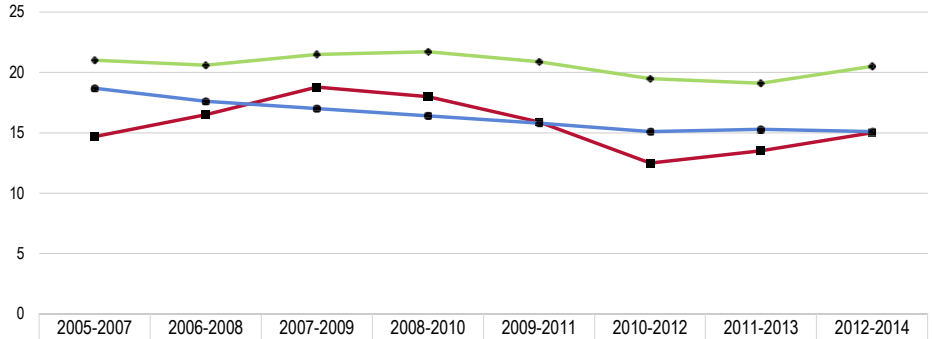
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

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

- TREND: No clear trend in Primary Service Area pneumonia/influenza mortality. Nationally, pneumonia/influenza death rates have decreased.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	14.7	16.5	18.8	18.0	15.9	12.5	13.5	15.0
NV	21.0	20.6	21.5	21.7	20.9	19.5	19.1	20.5
US	18.7	17.6	17.0	16.4	15.8	15.1	15.3	15.1

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

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

Asthma

Children

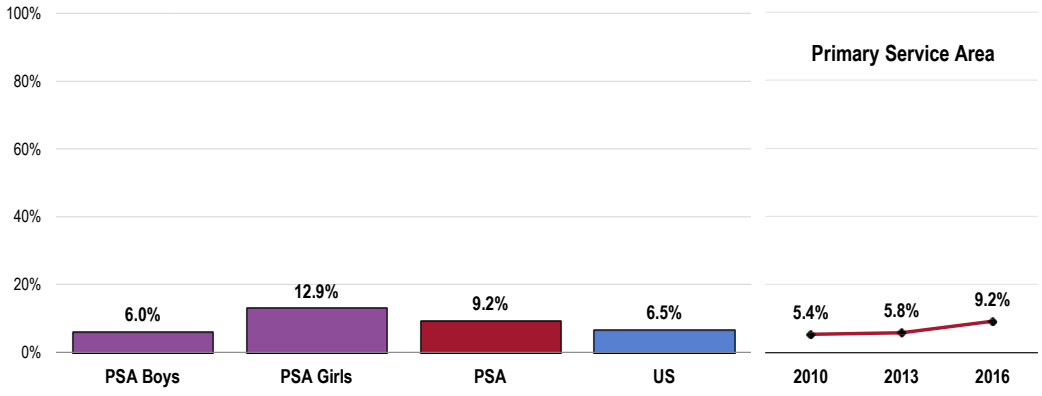
Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including children's asthma and COPD among adults.

Among Primary Service Area children under age 18, 9.2% currently have asthma.

- Statistically similar to national findings.
- TREND: Statistically unchanged over time.
- Viewed by gender, the difference is not statistically significant.

Childhood Asthma: Current Prevalence

(Among Parents of Children Age 0-17)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

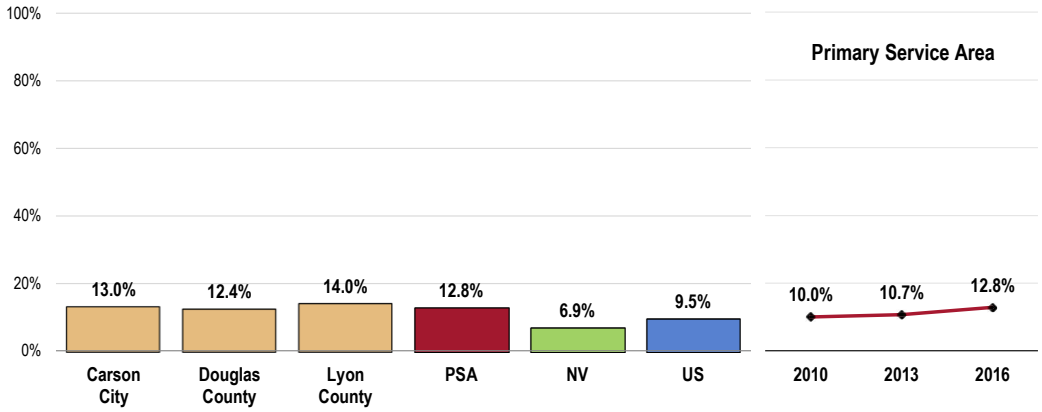
Notes: Asked of all respondents with children 0 to 17 in the household.
Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

A total of 12.8% of Primary Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Higher than the state and national prevalence.
- Similar findings by area.
- TREND: In comparing to previous findings, the change in prevalence is not statistically significant.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, 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): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.

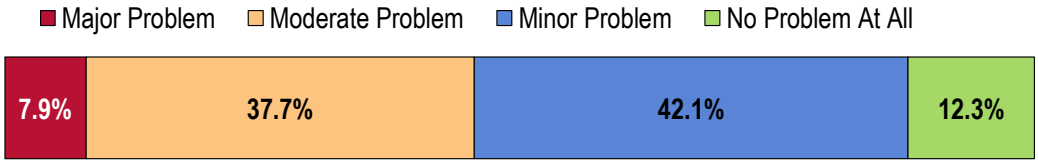
Notes: Asked of all respondents.
Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Tobacco Use

Elevation. Smoking, aging population. – Community/Business Leader

Smoking, and the aging population is naturally more susceptible to respiratory problems. Poor lifestyle choices. – Community/Business Leader

Smoking. – Physician

Smoking, COPD, and asthma are prevalent. Only one pulmonology group in town, and they are overworked. Poor follow-up with patients, difficult to work within getting appointments and referrals, in my experience. – Other Health Provider

Prevalence/Incidence

Respiratory disease is also a primary condition reported among clients at social services. O2 companies requiring credit card autopay for patients leaving the hospital on O2 orders. If the client can't commit to that cost, they cannot have the service. – Social Services Provider

Tobacco products are still widely used in our community, and with the tourists, as well. Walking into any casino will give you secondhand smoke worse than anywhere else. There are 579 listings related to respiratory doctors in Carson City, NV. – Community/Business Leader

Casino workers are subjected to large exposure to secondhand smoke. It is clear this is a health hazard. We have too many teens beginning the nicotine habit at 12 to 15 years of age. Stop smokers in proximity to school grounds. – Physician

Injury & Violence

About Injury & Violence

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

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

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

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

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

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

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

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

Efforts to prevent violence may focus on:

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

- Healthy People 2020 (www.healthypeople.gov)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

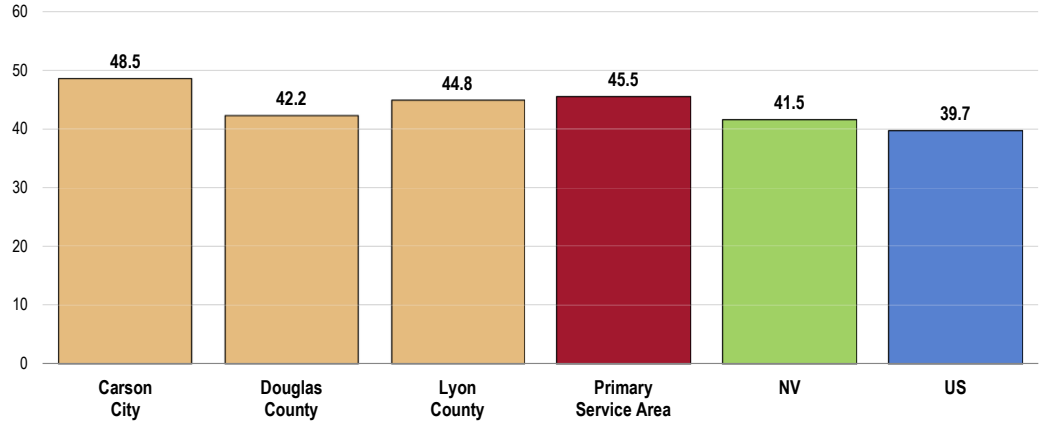
Between 2012 and 2014, there was an annual average age-adjusted unintentional injury mortality rate of 45.5 deaths per 100,000 population in the Primary Service Area.

- Less favorable than the Nevada and US rates.
- Fails to satisfy the Healthy People 2020 target (36.4 or lower).
- Unfavorably high in Carson City.

Unintentional Injuries: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 or Lower



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

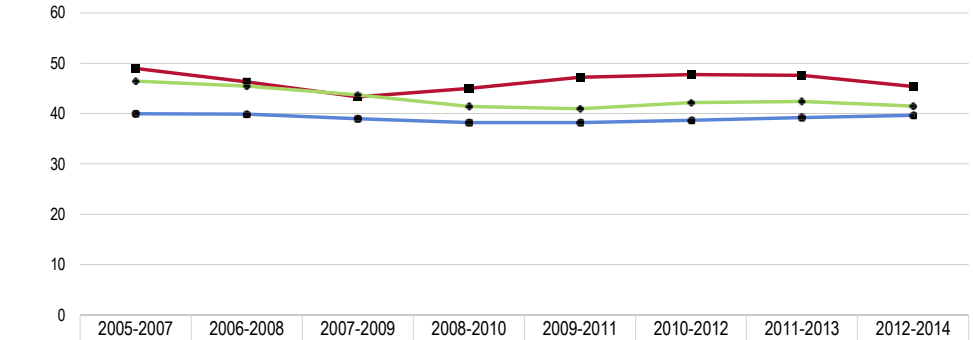
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The unintentional injury mortality rate has risen and fallen over the past decade in the Primary Service Area.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 or Lower



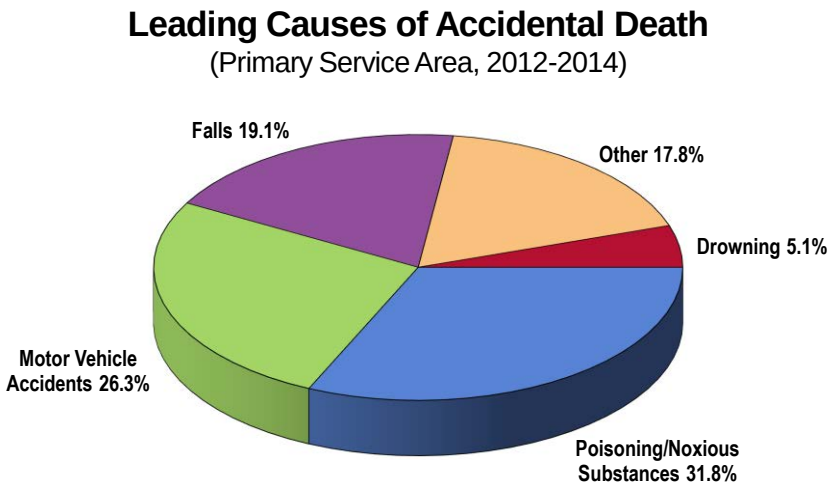
	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	49.0	46.3	43.3	45.0	47.2	47.8	47.6	45.4
NV	46.5	45.5	43.7	41.4	41.0	42.2	42.4	41.5
US	40.0	39.9	39.0	38.2	38.2	38.7	39.2	39.7

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

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

Leading Causes of Accidental Death

Poisoning (including accidental drug overdose), motor vehicle accidents, falls, and drowning accounted for most accidental deaths in the Primary Service Area between 2012 and 2014.



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Selected Injury Deaths

The following chart outlines mortality rates for drug-induced deaths (both intentional and unintentional overdoses), motor vehicle crashes, and falls (among adults age 65 and older).

These Primary Service Area annual average age-adjusted mortality rates are worse than US rates for:

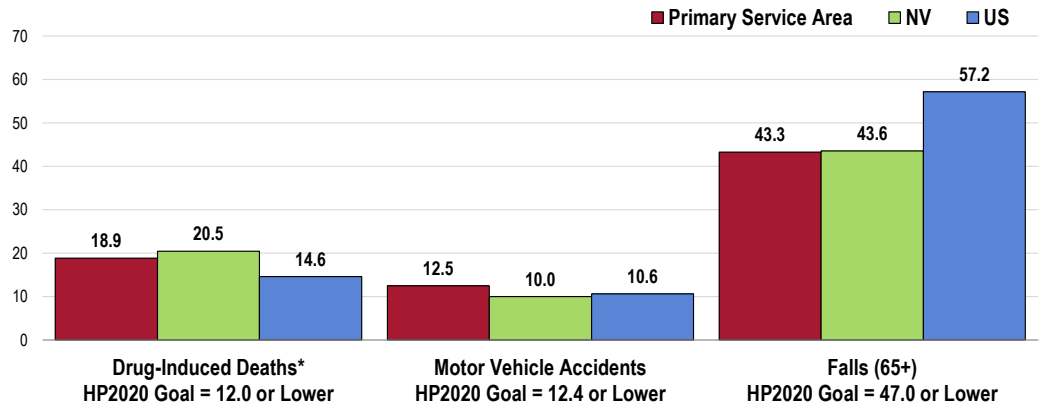
- Drug-related deaths.
- Motor vehicle accidents.

Primary Service Area mortality rates are worse than state rates for:

- Drug-related deaths.

Select Injury Death Rates

(By Cause of Death; Annual Average Deaths per 100,000 Population)



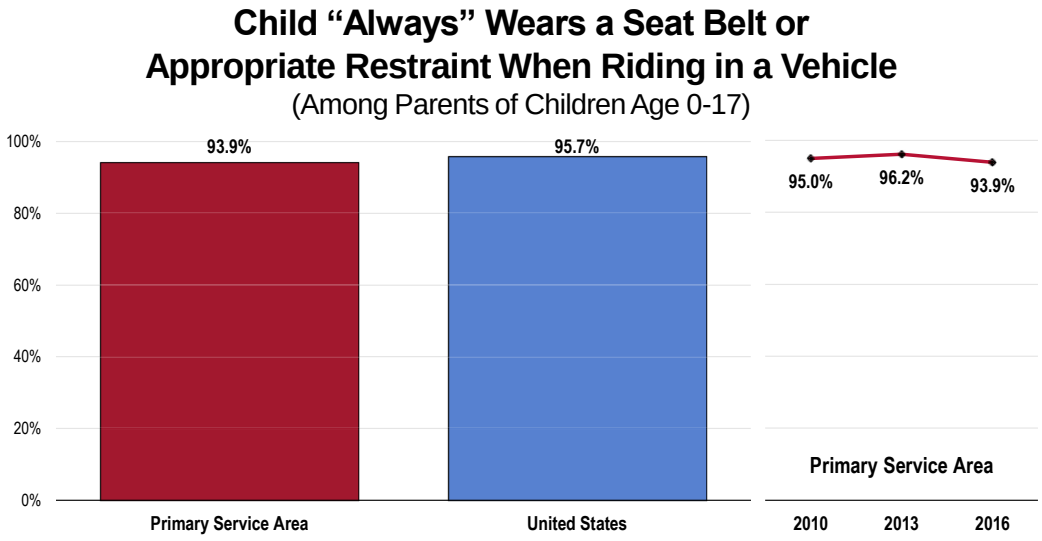
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1, IVP-23.2, SA-12]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
*Drug-induced deaths include both intentional and unintentional drug overdoses.

Seat Belt Usage - Children

A full 93.9% of Primary Service Area parents report that their child (age 0 to 17) "always" wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

- Statistically similar to what is found nationally.
- TREND: Statistically unchanged since 2010.



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 325]
2015 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

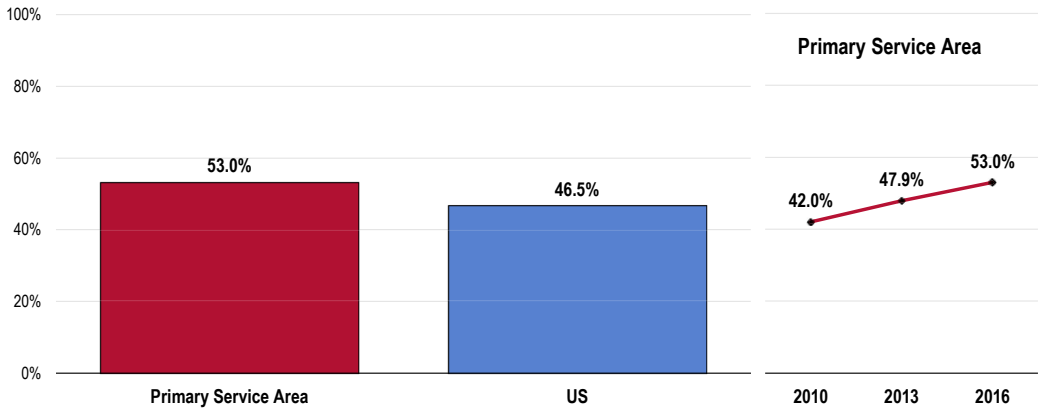
Bicycle Safety

More than half of service area children age 5 to 17 (53.0%) are reported to "always" wear a helmet when riding a bicycle.

- Similar to the national prevalence.
- TREND: The increase over time is not statistically significant.

Child "Always" Wears a Helmet When Riding a Bicycle

(Among Parents of Children Age 5-17)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 326]
2015 PRC National Child & Adolescent Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children age 5 to 17 at home.

Firearm Safety

Age-Adjusted Firearm-Related Deaths

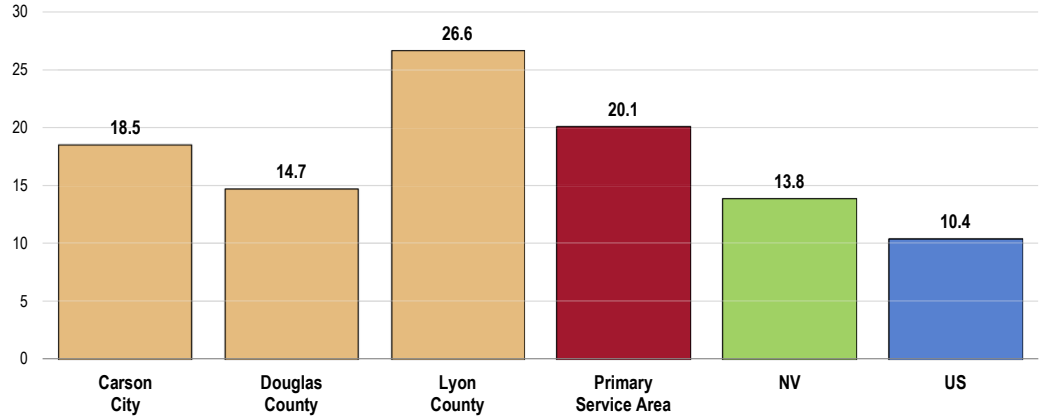
Between 2012 and 2014, there was an annual average age-adjusted rate of 20.1 deaths per 100,000 population due to firearms in the Primary Service Area.

- Higher than found statewide and nationally.
- Fails to satisfy the Healthy People 2020 objective (9.3 or lower).
- Unfavorably high in Lyon County.

Firearms-Related Deaths: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 or Lower



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Between 2012 and 2014, there was an annual average age-adjusted homicide rate of 3.5 deaths per 100,000 population in the Primary Service Area.

- More favorable than the rate found statewide and nationally.
- Satisfies the Healthy People 2020 target of 5.5 or lower.

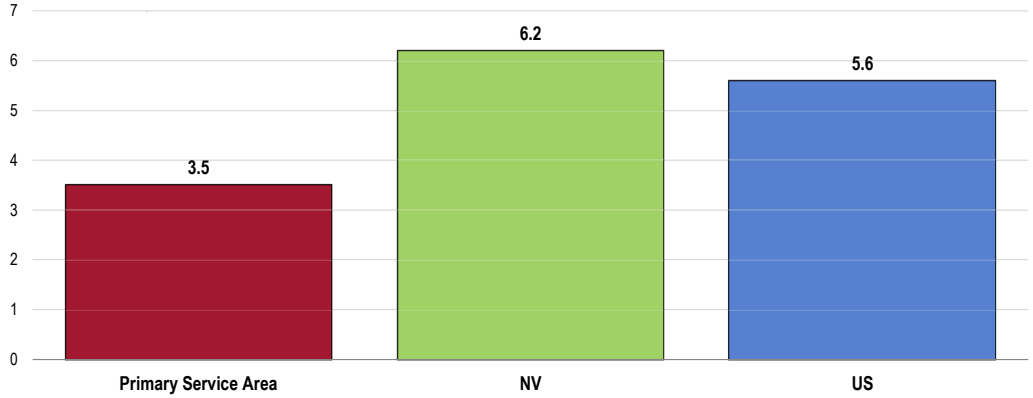
RELATED ISSUE:

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

Homicide: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 5.5 or Lower



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]

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

Violent Crime

Violent Crime Rates

Between 2010 and 2012, there were a reported 214.1 violent crimes per 100,000 population in the Primary Service Area.

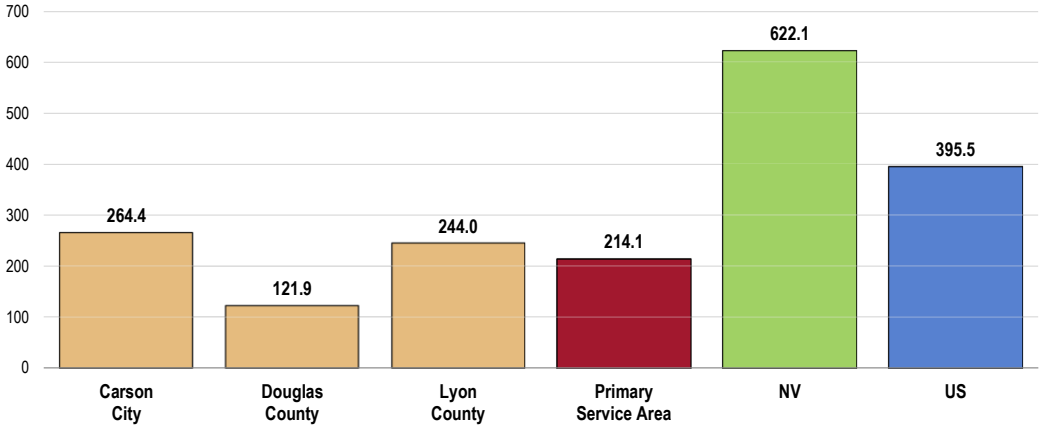
- Well below the state and nation rates for the same period.
- Lowest in Douglas County.

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.

Violent Crime

(Rate per 100,000 Population, 2010-2012)



Sources: Federal Bureau of Investigation, FBI Uniform Crime Reports.
Retrieved May 2016 from Community Commons at http://www.chna.org.

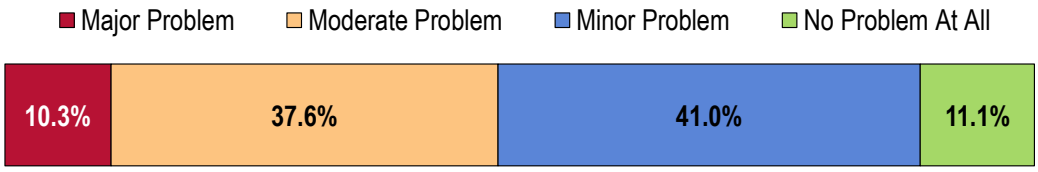
Notes: This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
Participation by 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.

Key Informant Input: Injury & Violence

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

Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Domestic Violence

> *Most violence is family violence. It is integrated into a host of mental and medical problems. However, there is no integrated understanding or understanding of how to address it. – Community/Business Leader*
>
> *I have heard from several law enforcement officials that domestic violence is a problem in this area. – Community/Business Leader*
>
> *Far too many instances of child and intimate partner violence occur. – Community/Business Leader*
>
> *Domestic violence continues to be a social issue that needs focus. – Social Services Provider*

Drugs/Alcohol

> *Substance abuse and behavioral health issues drives our injury/violence problems. – Community/Business Leader*

> *The amount of violence seems significantly high on a per capita basis for a community of this size. I believe a lot of it is drug- and mental health-related. – Community/Business Leader*

Gun Violence

> *High level of gun ownership, low level of safety in the home. – Community/Business Leader*

Vulnerable Populations

> *Large population of lower socioeconomic status residents. Substantial drug problem. – Physician*

Prevalence/Incidence

> *We have had a large number of people killed in traffic accidents this past year. Several people have been murdered in our community. – Community/Business Leader*

Diabetes

About Diabetes

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

Diabetes mellitus:

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

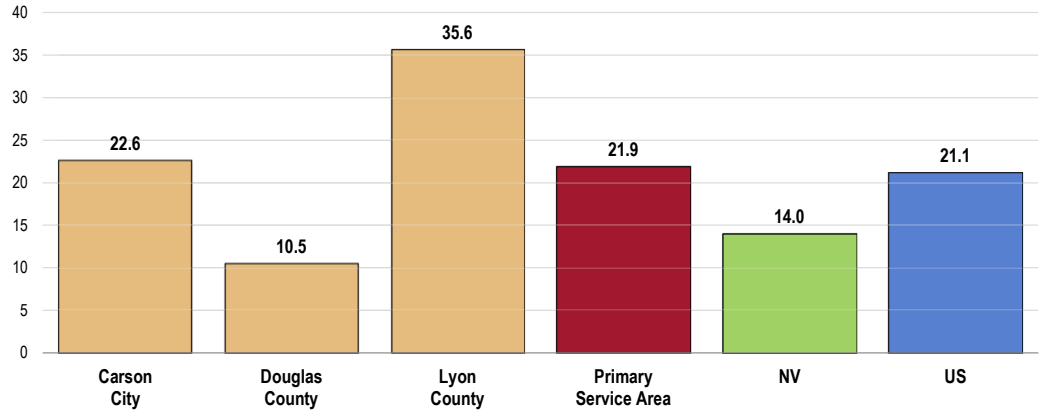
Between 2012 and 2014, there was an annual average age-adjusted diabetes mortality rate of 21.9 deaths per 100,000 population in the Primary Service Area.

- Less favorable than that found statewide.
- Comparable to the US death rate.
- Fails to satisfy the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).
- Unfavorably high in Lyon County.

Diabetes: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

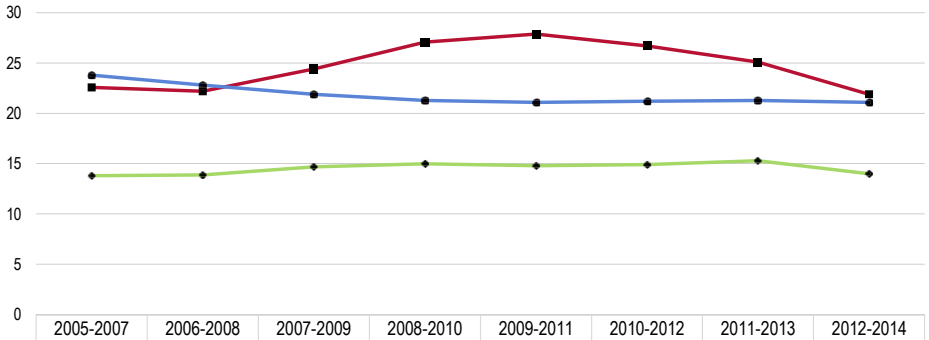
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
The Healthy People 2020 target for diabetes is adjusted to account for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

- TREND: After rising in the late 2000's, the diabetes mortality rate has since declined.

Diabetes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	22.6	22.2	24.4	27.1	27.9	26.7	25.1	21.9
NV	13.8	13.9	14.7	15.0	14.8	14.9	15.3	14.0
US	23.8	22.8	21.9	21.3	21.1	21.2	21.3	21.1

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

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

Prevalence of Diabetes

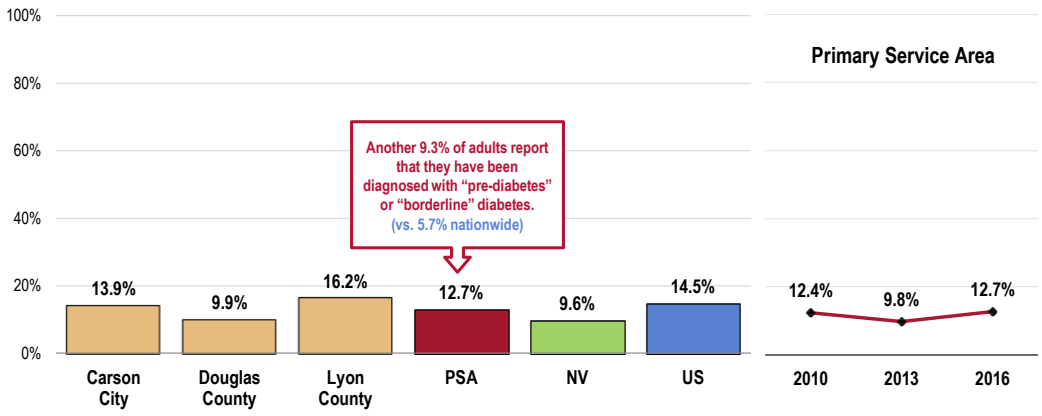
A total of 12.7% of Primary Service Area adults report having been diagnosed with diabetes.

- Worse than the statewide proportion.
- Similar to the national proportion.
- Lowest in Douglas County.
- TREND: Statistically unchanged since 2010.

In addition to the prevalence of diagnosed diabetes referenced above, another 9.3% of Primary Service Area adults report that they have "pre-diabetes" or "borderline diabetes."

- Higher than the US prevalence.
- Similar findings by area (not shown).

Prevalence of Diabetes

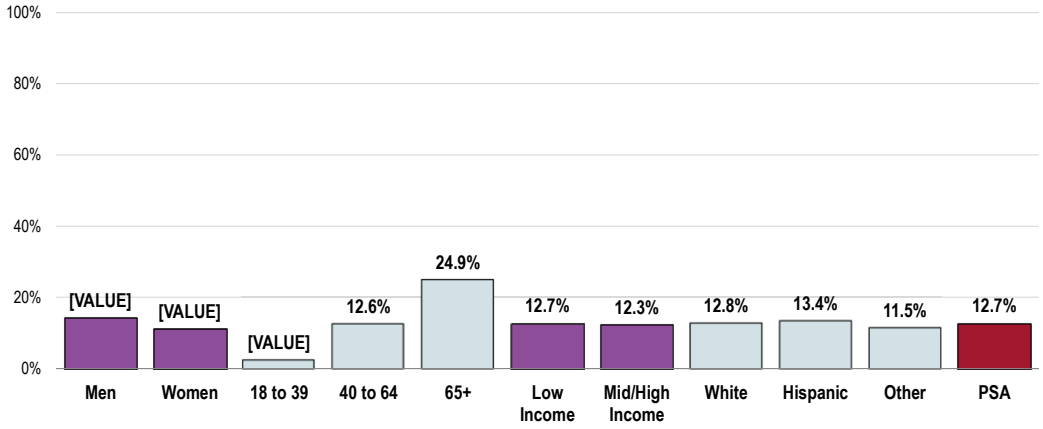


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
Notes: Asked of all respondents.

A higher prevalence of diagnosed diabetes (excluding pre-diabetes or borderline diabetes) is reported among:

- Older adults (note the strong positive correlation between diabetes and age, with 24.9% of seniors with diabetes).

Prevalence of Diabetes
(Primary Service Area, 2016)



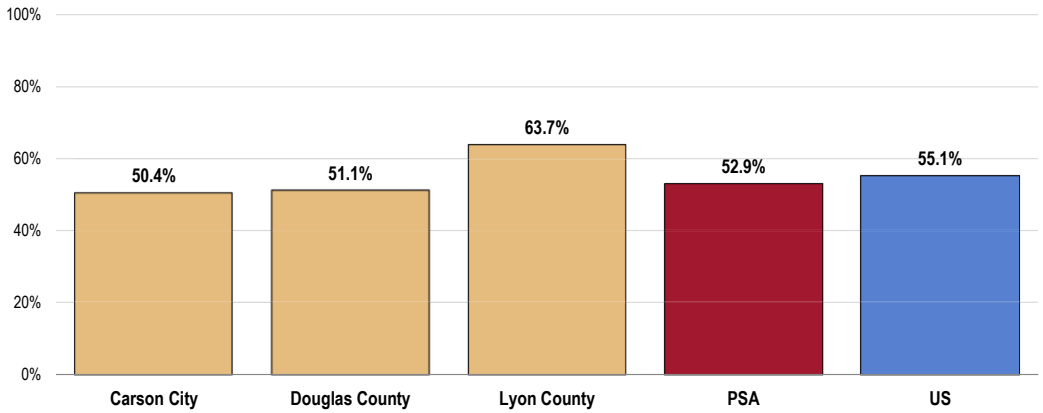
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

Of area adults who have <u>not</u> been diagnosed with diabetes, 52.9% report having had their blood sugar level tested within the past three years.

- Similar to the national proportion.
- Favorably high in Lyon County.

Have Had Blood Sugar Tested in the Past Three Years
(Among Nondiabetics)



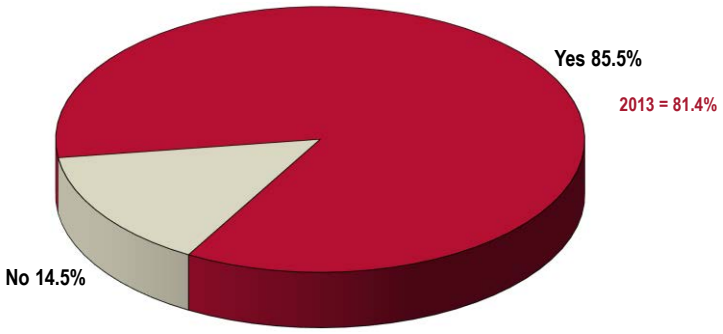
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of respondents who have not been diagnosed with diabetes.

Diabetes Treatment

Among adults with diabetes, most (85.5%) are currently taking insulin or some type of medication to manage their condition.

- TREND: Similar to the prevalence reported in 2013.

Taking Insulin or Other Medication for Diabetes
(Among Primary Service Area Diabetics)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 305]
Notes: Asked of all diabetic respondents.

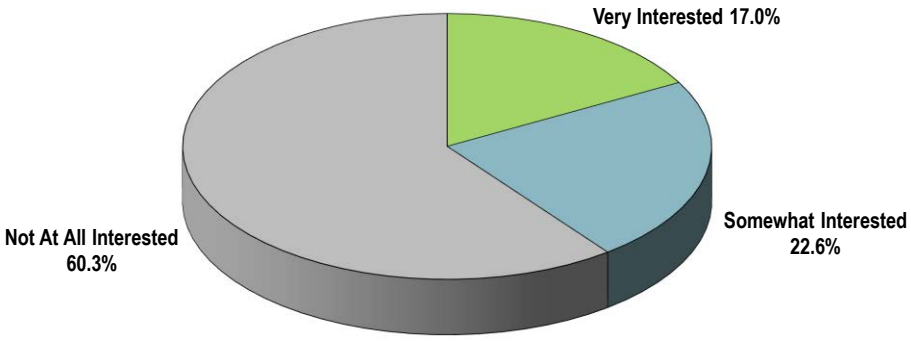
Diabetes Education

Of area adults with diabetes, nearly 4 in 10 are interested in a diabetes education program, including 17.0% who gave "very interested" responses and 22.6% who are "somewhat interested."

- The remaining 60.3% of service area adults with diabetes are "not at all interested" in a diabetes education program.

Level of Interest in Diabetes Education Program

(Among Primary Service Area Diabetics)



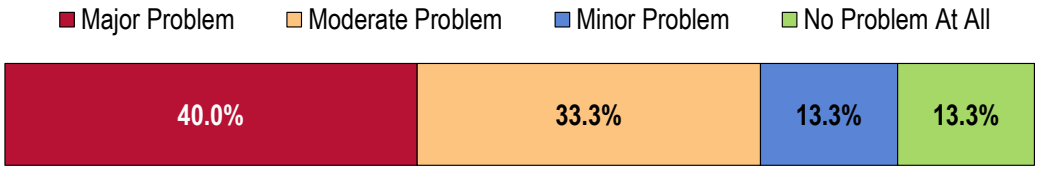
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 306]
Notes: Asked of all diabetic respondents.

Key Informant Input: Diabetes

A high percentage of key informants taking part in an online survey characterized *Diabetes* as a "major problem" in the community.

Perceptions of Diabetes as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Disease Management

> *Diabetic control, education on diabetes and how to adapt a healthy lifestyle to help manage diabetes. Adolescents and diabetes care, along with access to an endocrinologist/pediatric endocrinologist within Carson City. – Community/Business Leader*
>
> *Ongoing support groups and affordable or free coaching is needed. – Community/Business Leader*
>
> *Understanding how to manage the disease, the disease process and how their lifestyle choices affect their long-term success rates. I feel patients would also significantly benefit from a dietitian that specializes in diabetic health. – Other Health Provider*
>
> *The majority of community members lack the self-discipline of breaking lifelong habits of eating unhealthy food or overeating, lack of exercise, and taking advantage of diabetes education or preventative classes. – Social Services Provider*

Lack of appreciation of the severity of their disease as to health impairment by diabetes mellitus. Patients miss appointments or run out of medication and feel it is an option to continue or stop care. Intensive education program is needed. – Physician

Not sure it is something we can control. The people with diabetes choose to not monitor themselves, or make healthy eating/drinking decisions. Also, lack of health checks to even identify if diabetes or childhood diabetes is what is ailing them. – Community/Business Leader

To provide follow-up on patients to make sure they are correcting their diet and maintaining healthy life choices. – Community/Business Leader

Continual support to enable changes in lifestyle and diet. – Community/Business Leader

Health Education

Not having enough education on prevention, management, or resources in our community. – Community/Business Leader

Information about the various types of diabetes. Prevention, maintenance, controlling and reducing the effects of diabetes on patients. – Community/Business Leader

Education. – Community/Business Leader

A lot of people are pre diabetic and do not realize that they need to change their eating habits. – Community/Business Leader

Not enough awareness. More reactive than proactive. – Community/Business Leader

Education about avoiding diabetes, wellness, diet, etc. Education on managing diabetes once one has it. Supportive services to encourage and monitor compliance with protocols. – Social Services Provider

Lack of diabetic educators, time with healthcare professionals to educate patients. Follow-up to ensure they are following primary care provider's orders. – Community/Business Leader

Failure of the individual to recognize the problem and to take steps to minimize the impact. – Community/Business Leader

People don't sign up for classes on how to manage their diabetes. Restaurants don't provide menus that offer sugar-free choices. – Community/Business Leader

Access to education regarding the importance of diet and exercise in controlling and combating diabetes. Access to healthy and/or organic and locally-grown food. – Community/Business Leader

Access to Care/Services

Dialysis places and times that people may go to them. – Community/Business Leader

Access to care and adequate support to making the lifestyle changes that help prevent or manage diabetes. – Physician

Lack of aggressive care other than endocrinology. – Physician

Receiving screenings, preventive care, and treatment from dentists, podiatrists, ophthalmologists, and nutritionists to keep their blood sugar under control. Also, the extreme expense of diabetes drugs, especially insulin. – Community/Business Leader

Limited access to ongoing medical care. Limited Outpatient resources. No Inpatient resources apart from general case management. No diabetes-specific resources. – Physician

Affordable Care/Services

Price of medications, lack of access to qualified providers, unhealthy lifestyles. – Physician

Biggest challenges would be expense of the medications. Also initial diagnosis because of expense of medical care. – Community/Business Leader

Costs to maintain health and personal follow-through. – Community/Business Leader

Lifestyle

People retire to the Valley and come here for a healthier lifestyle. But with the weight issue, diabetes tends to be the problem. – Community/Business Leader

Proper nutrition, exercise and affordable health care. – Community/Business Leader

Diet and exercise. – Community/Business Leader

Unhealthy populous. – Community/Business Leader

Obesity

Obesity among adults and children. Poor food choices, as well as lack of good exercise habits. It goes back to physical education being optional and school lunch/food choices motivated by cost and not by nutrition. – Community/Business Leader

Obesity and poor health overall. – Community/Business Leader

Increase in obesity and DM. – Physician

Out-of-control obesity. – Community/Business Leader

Nutrition

Diet. – Community/Business Leader

Nutrition, lack of knowledge about how to eat properly. Diabetes affects so many areas of health, which requires wound care, insulin, and related medications and kidney care. – Community/Business Leader

Access to Healthy Food

People living in poverty have a difficult time accessing fresh food. In addition, a healthy lifestyle is the last thing on your mind when you are in survival mode. – Community/Business Leader

Aging Population

I don't think there are any great challenges; it just seems more prevalent than most places because of the older population. – Community/Business Leader

Lack of Preventative Care

The burden of diabetes on the health care system mandates efforts to more optimally treat those with the disease and to prevent its development in those at risk. Early, intensive intervention in patients with diabetes reduces the risk of microvascular issues. – Community/Business Leader

Alzheimer's Disease

About Dementia

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

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

- Healthy People 2020 (www.healthypeople.gov)

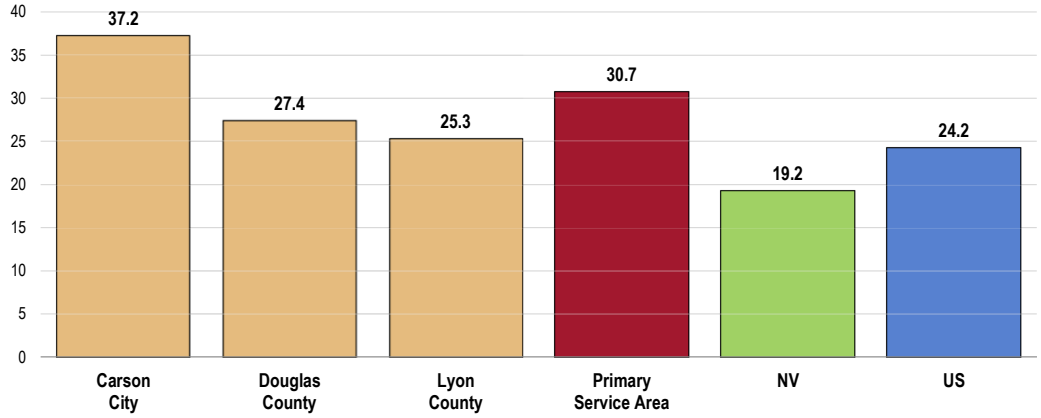
Age-Adjusted Alzheimer's Disease Deaths

Between 2012 and 2014, there was an annual average age-adjusted Alzheimer's disease mortality rate of 30.7 deaths per 100,000 population in the Primary Service Area.

- Less favorable than the statewide and national rates.
- Particularly high in Carson City.

Alzheimer's Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)



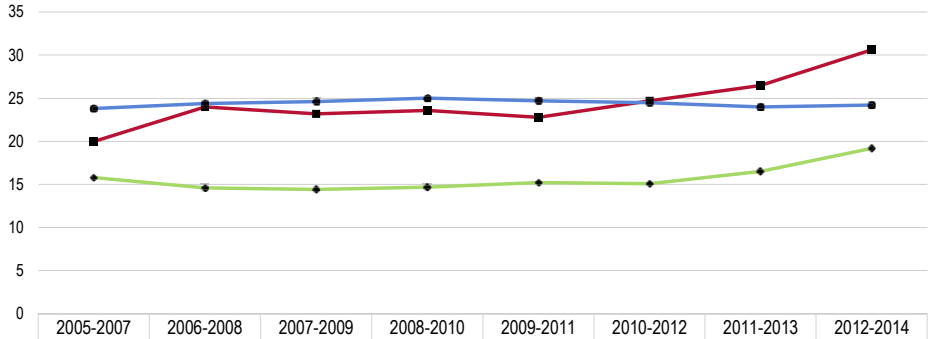
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

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

- TREND: The Alzheimer's disease mortality rate in the Primary Service Area has increased over time. Across Nevada, the rate has increased in recent years (the US rate has been stable).

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	20.0	24.0	23.2	23.6	22.8	24.7	26.5	30.6
NV	15.8	14.6	14.4	14.7	15.2	15.1	16.5	19.2
US	23.8	24.4	24.6	25.0	24.7	24.5	24.0	24.2

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

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

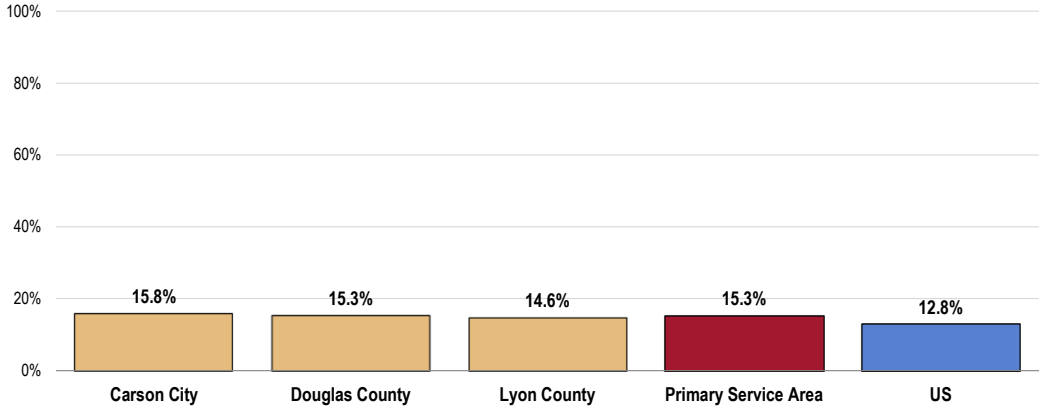
Progressive Confusion/Memory Loss

A total of 15.3% of adults age 45 and older report experiencing confusion or memory loss in the past year that is happening more often or getting worse.

- Comparable to the US prevalence.
- Comparable findings by area.

Experienced Increasing Confusion/Memory Loss in Past Year

(Among Respondents Age 45 and Older)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

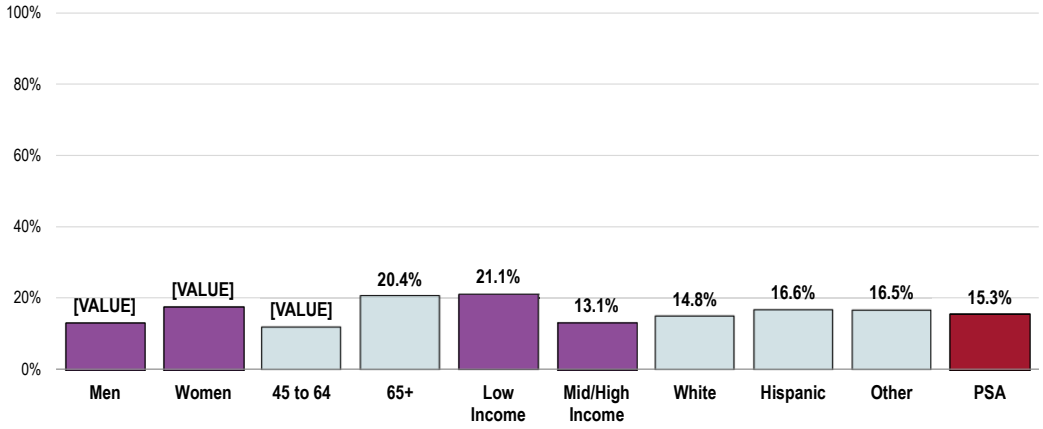
Notes: Asked of those respondents age 45 and older.

A higher prevalence of progressive confusion/memory loss is reported among:

- Older adults.
- Those in lower-income households.

Experienced Increasing Confusion/Memory Loss in Past Year

(Among Respondents Age 45 and Older; Primary Service Area, 2016)



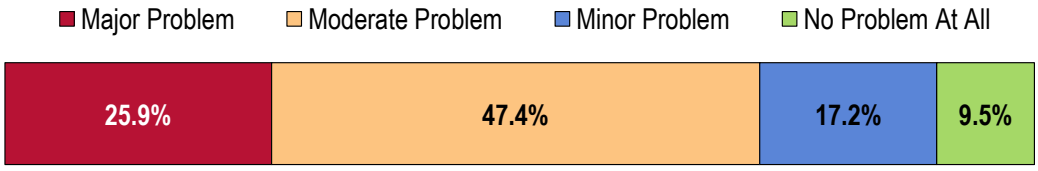
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
Notes: Asked of those respondents age 45 and older.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Dementias, Including Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementias, Including Alzheimer's Disease* as a "moderate problem" in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Aging Population

> *Our area is home to retirees from the entire West Coast. As such, the elderly are a significant demographic. – Community/Business Leader*

This is a very advanced age community. – Community/Business Leader

As we have a large population of aging people, there is a large problem for health care in this issue. People are unaware of the process and availability of resources needed to deal with this disease. – Community/Business Leader

Carson City and surrounding area has a significant senior population. And it seems as though I hear about or read about problems with individuals as a result of this disease. – Community/Business Leader

The population is increasingly aging, and this is factor in the development of more cases of dementia and Alzheimer's. – Community/Business Leader

The aging population of Carson City brings with it the problems of dementia and Alzheimer's disease. – Community/Business Leader

People are living longer and have become more aware of dementia and Alzheimer's disease. No one is sure what causes it. An active mental and physical lifestyle may help to keep the disease at bay; however, it is genetic in some cases. – Community/Business Leader

I see a lot of older customers come in to handle business with the county, and you can tell they should have someone helping them. They don't remember things. They ask the same questions over and over. – Community/Business Leader

Our community is aging. We are also attracting new people to our community that are near/at retirement age. We seem to be attracting more retired persons than younger persons; therefore, our need for memory care is increasing. Unfortunately, the cost. – Community/Business Leader

Carson City has a higher population base of older citizens than Reno, and as this population ages, more issues need to be faced. We do have facilities currently to house these patients. – Community/Business Leader

Access to Care/Services

Very resource-intensive, requires more investment from society. – Physician

I think access to care and medical help is lacking for these patients in this community. Especially help for the families who are trying to care for their loved ones at home. – Community/Business Leader

The lack of available resources for home care assistance and available facilities for Inpatient care in the event of acute or chronic care situations. – Physician

There are very limited residential services in Carson City. – Social Services Provider

Limited resources for comprehensive medical management and caregiver support. Most elderly couples cannot afford caregiver assistance, transportation, day care, expensive medications and having a medical expert in dementia care. – Other Health Provider

Prevalence/Incidence

Increasing number of people affected. – Community/Business Leader

Just feels like more families are dealing with this issue than in the past. – Community/Business Leader

Know a number of people who have relatives or occurrences of dementia/Alzheimer's in their families. – Community/Business Leader

10,000 people per day are retiring in the US, and we are seeing more and more evidence of dementia and Alzheimer's in all ages. Because Northern Nevada is a great place to retire, more and more people are moving in during retirement. – Community/Business Leader

Health Education

It's a heart-breaking disease that is little understood. What are things we can do to slow the progress? How should family members interact with a loved one with dementia? – Community/Business Leader

I believe this disease and all mental health concerns are drastically misunderstood. There is also a fear and uncertainty in how to deal with these conditions. This leads to a lot of people being in denial about the severity and what to do. – Community/Business Leader

Access to Providers

Too few neurologists, and none specialize in dementia. – Physician

Nobody to treat it. – Physician

Kidney Disease

About Chronic Kidney Disease

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

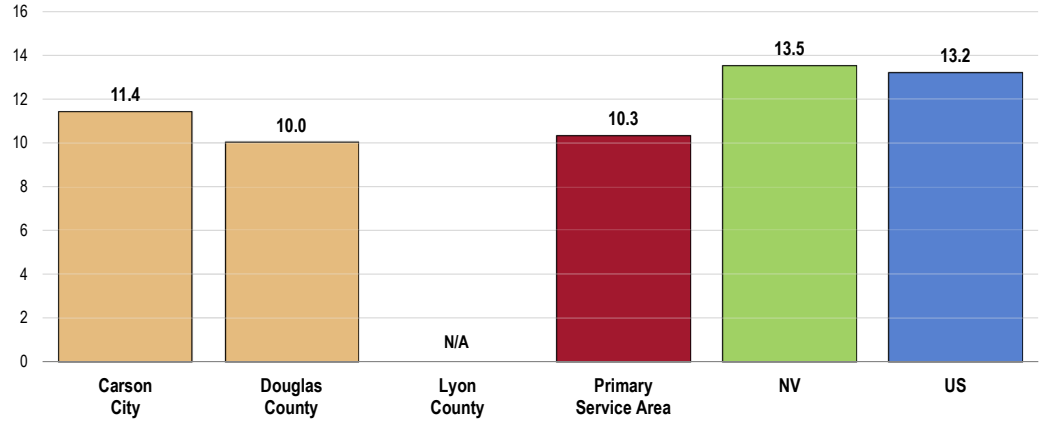
Age-Adjusted Kidney Disease Deaths

Between 2012 and 2014 there was an annual average age-adjusted kidney disease mortality rate of 10.3 deaths per 100,000 population in the Primary Service Area.

- Lower than the rates found statewide and nationally.
- Higher in Carson City.

Kidney Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)



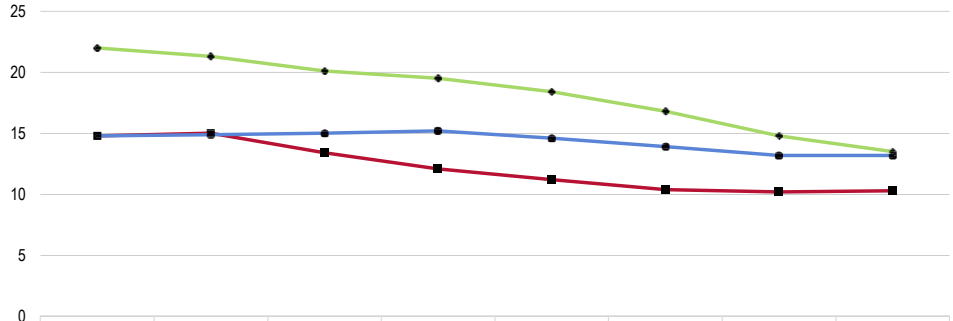
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

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

- TREND: The death rate has decreased over the past decade in the Primary Service Area, echoing the statewide trend.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	14.8	15.0	13.4	12.1	11.2	10.4	10.2	10.3
NV	22.0	21.3	20.1	19.5	18.4	16.8	14.8	13.5
US	14.8	14.9	15.0	15.2	14.6	13.9	13.2	13.2

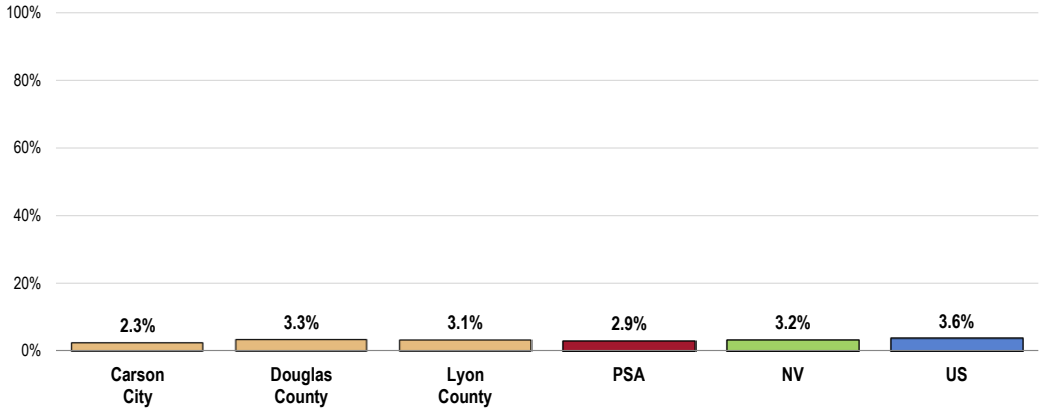
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

A total of 2.9% of Primary Service Area adults report having been diagnosed with kidney disease.

- Similar to the state and national proportions.
- Statistically similar by area.

Prevalence of Kidney Disease

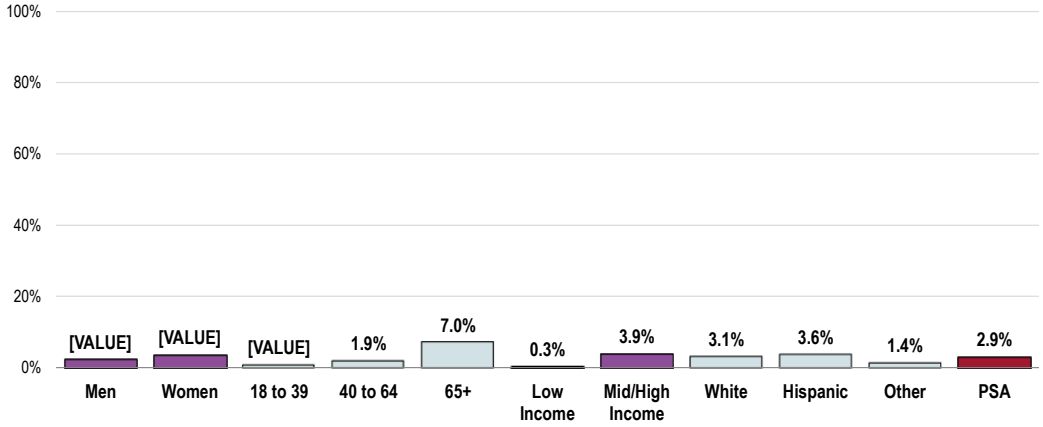


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

- A higher prevalence of kidney disease is reported among older adults and upper-income respondents in the Primary Service Area.

Prevalence of Kidney Disease

(Primary Service Area, 2016)



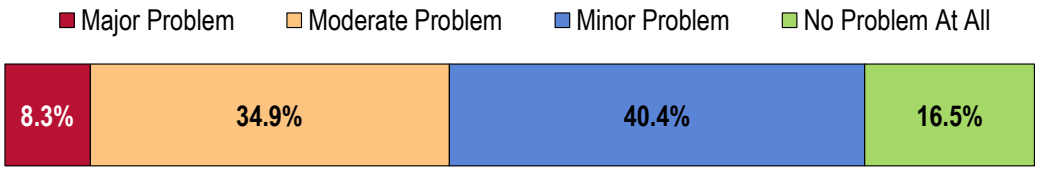
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Chronic Kidney Disease

Key informants taking part in an online survey generally characterized *Chronic Kidney Disease* as a "minor problem" in the community.

Perceptions of Chronic Kidney Disease as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Prevalence/Incidence

> *Most of the people I know either has chronic kidney disease or knows someone who does. As our population ages, I only see that becoming worse. I don't know what the primary cause is but hope someone is finding one. – Community/Business Leader*
>
> *We have a lot of diabetics in our community that have to rely on dialysis to live. – Community/Business*

Leader

Comorbidities

Poor diabetes and blood pressure control. – Physician

Kidney disease affect many Carson City residents, due to diabetes, smoking, and excessive drinking—all of which are very prevalent in Carson City. – Community/Business Leader

Vulnerable Populations

Chronic kidney disease is highest among Native Americans, due to their high rate of diabetes. Despite efforts to educate Native Americans relating to better control of their A1C levels, it is inevitable that chronic kidney disease will follow. – Social Services Provider

Lifestyle

Poor nutrition, lack of healthy lifestyle. – Community/Business Leader

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

Over one-third of Primary Service Area adults age 50 and older (35.5%) reports suffering from arthritis or rheumatism.

RELATED ISSUE:

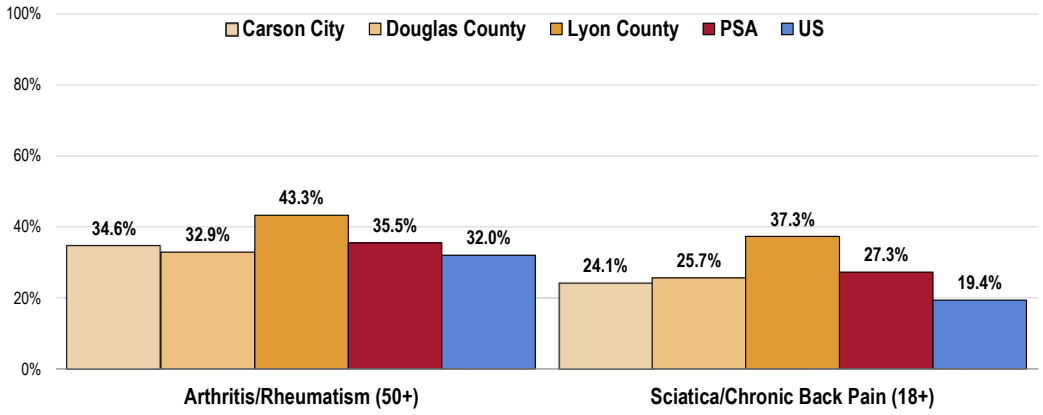
See also *Activity Limitations* in the **General Health Status** section of this report.

- Similar to that found nationwide.
- Statistically similar by community.

A total of 27.3% of Primary Service Area adults (18 and older) suffer from chronic back pain or sciatica.

- Less favorable than that found nationwide.
- Highest in Lyon County.

Prevalence of Potentially Disabling Conditions



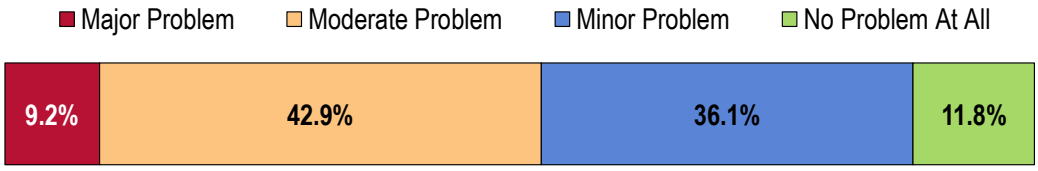
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]
Notes: The sciatica indicator reflects the total sample of respondents; the arthritis column reflects adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

A plurality of key informants taking part in an online survey characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a "moderate problem" in the community.

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Aging Population

We have a large elderly population, and I myself deal with arthritis. – Community/Business Leader

Over 30% of the population of Carson City is over the age of 50. As such, the problems of arthritis, osteoporosis and back conditions along with knee and hip problems is effecting a major percentage of the city's population. – Community/Business Leader

Older adult population possibly due to baby boomers coming of-age. Dry climate and sports injuries that lead to early start of arthritis-related disease. – Community/Business Leader

Prevalence/Incidence

> *Prevalence of diagnosis of lumbago in community. – Community/Business Leader*
>
> *Numbers of cases of compression fractures and associated morbidity and emergency room visits. – Physician*
>
> *Large number of chronic back pain and surgery for same. – Physician*

Diagnosis/Treatment

> *Our community members go into the clinic here with chronic pain and are prescribed pain pills without any kind of alternate pain management. This creates a large amount of members misusing pain medication. – Community/Business Leader*

Drug Use

> *Lots of people with back pain accessing and becoming addicted to pain medications. – Community/ Business Leader*

Obesity

> *Obesity and age of community. – Community/Business Leader*

Vision & Hearing Impairment

About Vision

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Vision Trouble

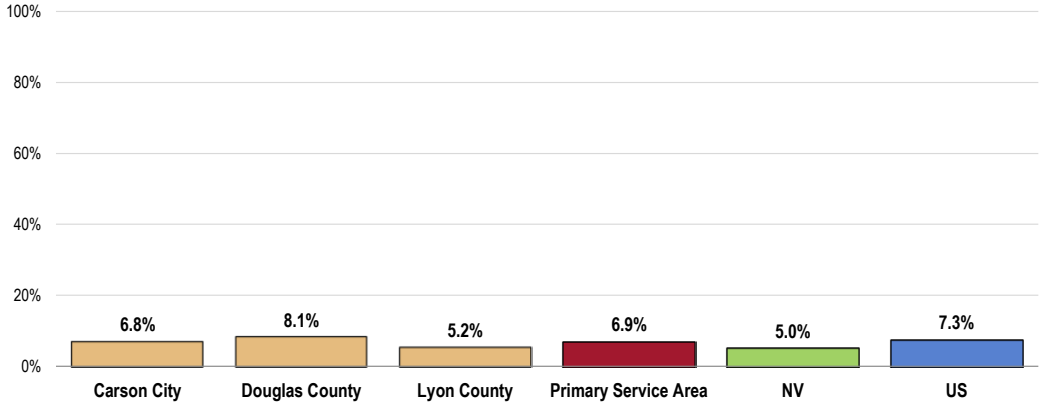
RELATED ISSUE:

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

A total of 6.9% of Primary Service Area adults are blind or have trouble seeing even when wearing corrective lenses.

- Worse than the statewide prevalence.
- Comparable to the US prevalence.
- Comparable findings by area.

Prevalence of Blindness/Trouble Seeing Even With Glasses



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 25]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
Notes: Reflects the total sample of respondents.

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

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

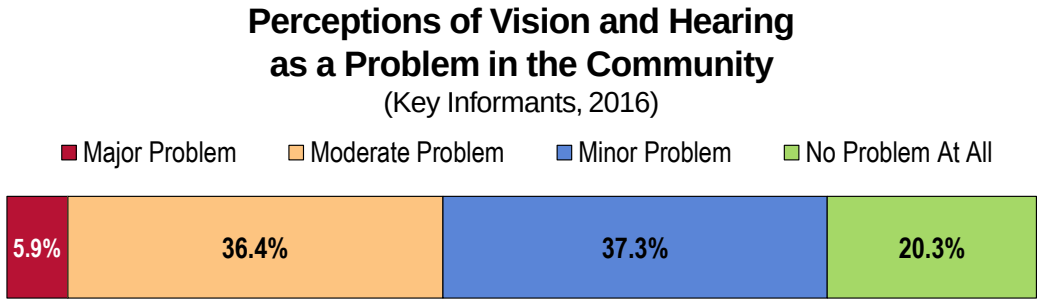
Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition,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

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

- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Vision & Hearing

The largest share of key informants taking part in an online survey characterized *Vision & Hearing* as a "minor problem" in the community, followed closely by the percentage of informants who gave "moderate problem" ratings to the problem.



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

Top Concerns

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

Affordable Care/Services

People who live in poverty cannot afford glasses or hearing devices. – Community/Business Leader

Students in our elementary schools need glasses, and insurance for families or costs seem to be a big issue. – Community/Business Leader

Low median wages. – Community/Business Leader

Because we are old and both sets of symptoms are not very well-covered by most insurance plans. – Community/Business Leader

Aging Population

As people age, particularly men, hearing loss is apparent. While there are hearing centers locally, the cost of hearing aids are out of reach for those living on social security or fixed incomes. Insurances generally do not cover hearing loss. – Community/Business Leader

Getting hearing aids for a senior is almost impossible when they only have Medicare and Medicaid. Same for glasses. – Social Services Provider

Infectious Disease

Professional Research Consultants, Inc.

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

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

- Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

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

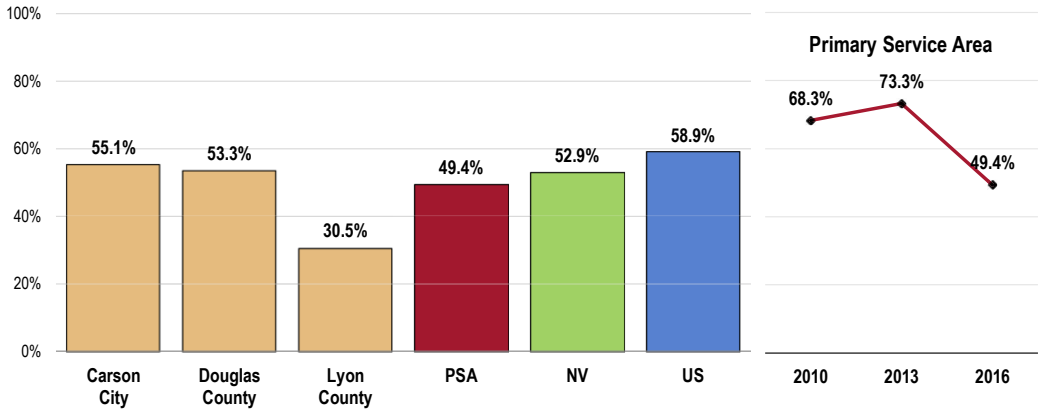
Among Primary Service Area seniors, 49.4% received a flu shot (or FluMist®) within the past year.

- Statistically comparable to the Nevada finding.
- Lower than the national finding.
- Fails to satisfy the Healthy People 2020 target (70% or higher).
- Unfavorably low in Lyon County.
- TREND: Marks a statistically significant decrease from previous survey findings.

Older Adults: Have Had a Flu Vaccination in the Past Year

(Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

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

Pneumonia Vaccination

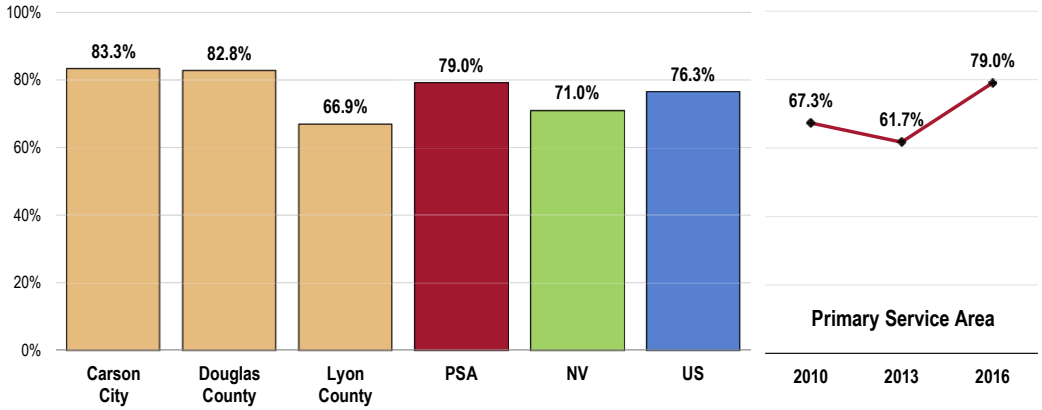
Among Primary Service Area adults age 65 and older, 79.0% have received a pneumonia vaccination at some point in their lives.

- Better than the Nevada finding.
- Similar to the national finding.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- Unfavorably low in Lyon County.
- TREND: Denotes a statistically significant increase from previous survey findings.

Older Adults: Have Ever Had a Pneumonia Vaccine

(Among Adults Age 65+)

Healthy People 2020 Target = 90.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IID-13.1, IID-13.2]

Notes: Reflects respondents 65 and older.

HIV

About HIV

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

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

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

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

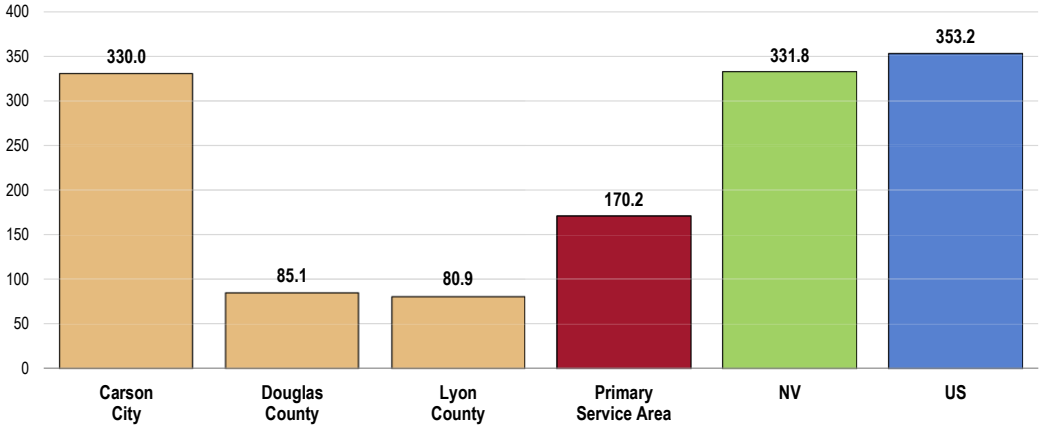
HIV Prevalence

In 2013, there was an Primary Service Area prevalence of 170.2 HIV cases per 100,000 population.

- Well below the state and national prevalence.
- Notably higher in Carson City.

HIV Prevalence

(Prevalence Rate of HIV per 100,000 Population, 2013)



Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes: This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

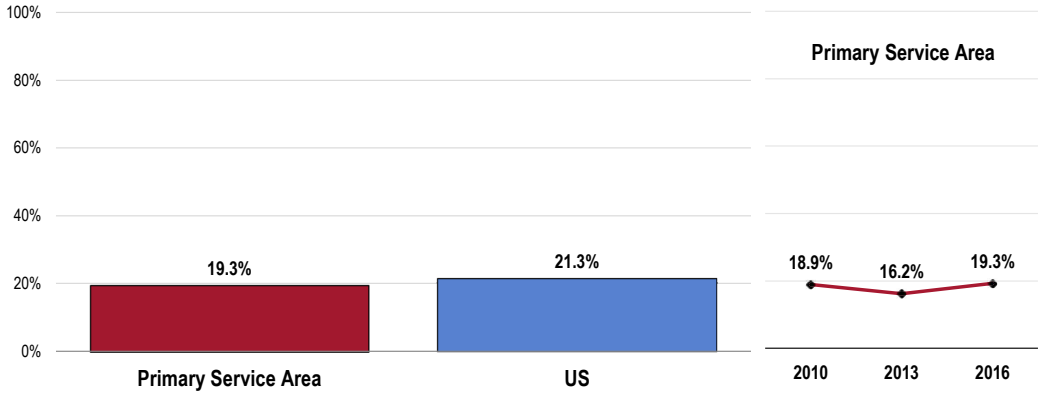
HIV Testing

Among Primary Service Area adults age 18-44, 19.3% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Comparable to the proportion found nationwide.
- TREND: Testing has remained stable over time.

Tested for HIV in the Past Year

(Among Adults Age 18-44)



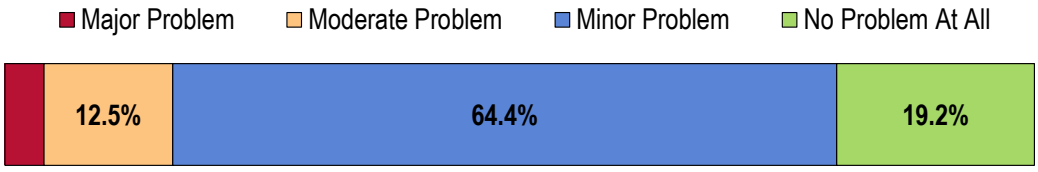
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Reflects respondents age 18 to 44.

Key Informant Input: HIV/AIDS

Key informants taking part in an online survey most often characterized *HIV/AIDS* as a "minor problem" in the community.

Perceptions of HIV/AIDS as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

> *Access to HIV/AIDS prevention and care is a problem in our community, due to lack of private practices. Lack of affordable services, lack of adequate hours and days. Locations of state-funded clinics and lack of education in the schools. – Social Services Provider*

Access to Providers

> *Only one infection control physician. – Community/Business Leader*

Denial/Stigma

> *Concerns over stigma and community support. Especially in regards to working with the LGBTQ community to address this disease. – Social Services Provider*

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

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

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

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

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

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

In 2014, the chlamydia incidence rate in the Primary Service Area was 286.1 cases per 100,000 population.

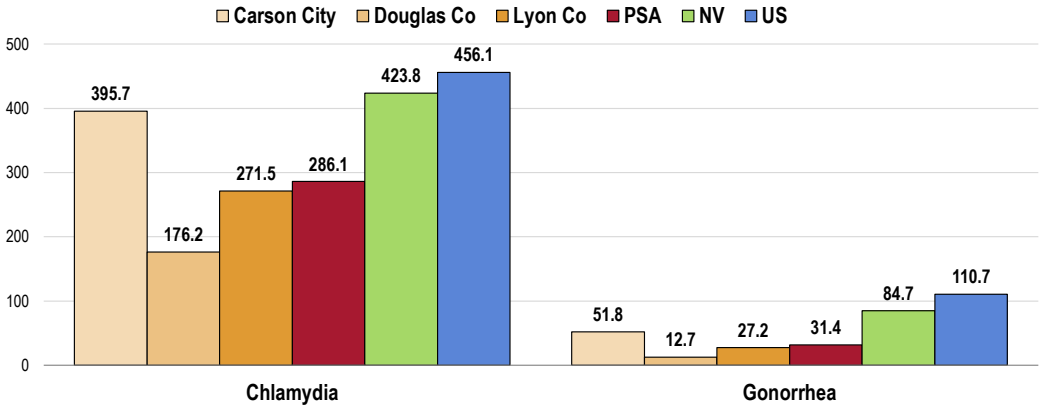
- Notably lower than the Nevada and US incidence rates.
- Significantly higher in Carson City.

The Primary Service Area gonorrhea incidence rate in 2014 was 31.4 cases per 100,000 population.

- Notably lower than the Nevada and US incidence rates.
- Higher in Carson City.

Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2014)



Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2014. Retrieved May 2016 from Community Commons at http://www.chna.org.

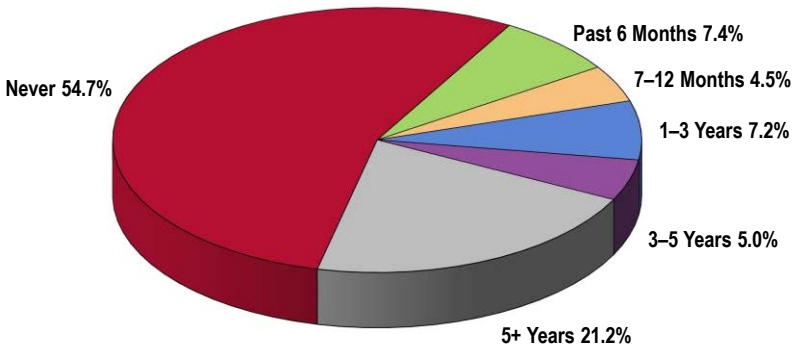
Notes: This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices. The Nevada rate for gonorrhea reflects 2011-2013 data.

STD Screening

While over half of survey respondents (54.7%) have never been tested for a sexually transmitted disease, 11.9% have been screened in the past year (including 7.4% who were screened in the past 6 months).

Most Recent STD Screening

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 312]

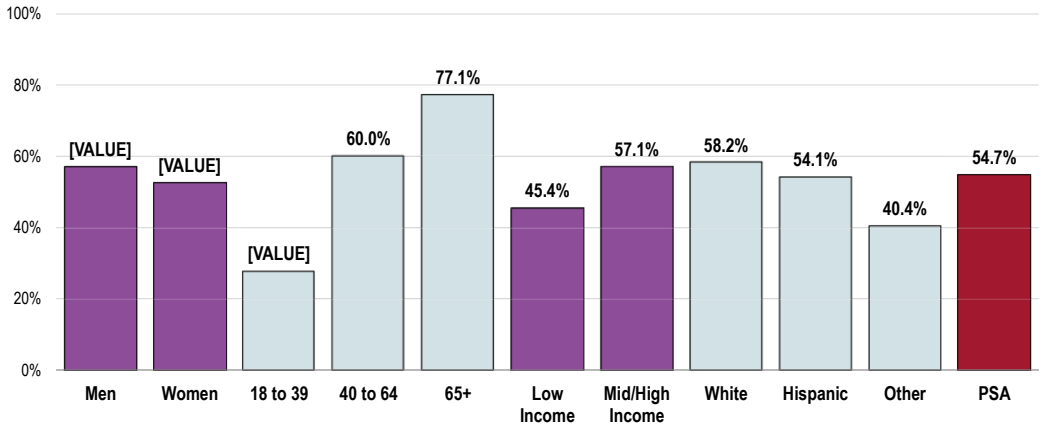
Notes: Asked of all respondents.

These population segments are more likely to have never been screened for an STD:

- Older residents (positive correlation with age).
- Upper-income respondents.
- Whites and Hispanics.

Have Never Been Screened for an STD

(Primary Service Area, 2016)



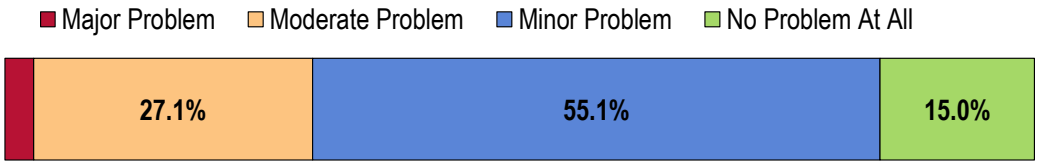
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 312]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Sexually Transmitted Diseases

A plurality of key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a "minor problem" in the community.

Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

> *Lack of clinics. Lack of basic education in schools about the issue. – Social Services Provider*

Health Education

> *Cultural competency regarding STDs. Better investment in education on the subject throughout the community. – Social Services Provider*

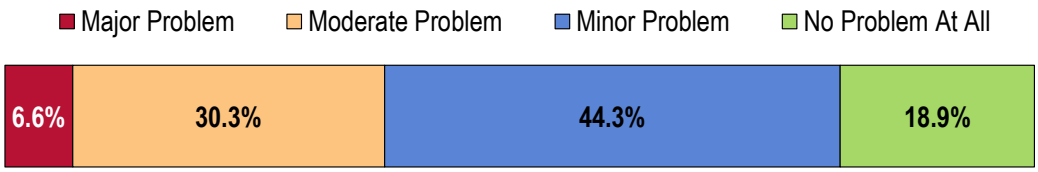
Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

Key informants taking part in an online survey most often characterized *Immunization & Infectious Diseases* as a "minor problem" in the community.

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Care/Services

> *Do not have any resources. – Social Services Provider*

Access to Providers

> *Only one infection control physician. And large growth of healthcare-acquired infections with no good public health/epidemiology program to share details with all. – Community/Business Leader*

Vulnerable Populations

> *It's important to treat the herd to protect the few people who cannot medically get immunized. – Physician*

Language Barrier

> *This issue is in our non-English speaking population, with lack of information in regards to the benefits of these programs. – Community/Business Leader*

West Nile Virus

> *Risk of West Nile Virus infection, present and future. – Community/Business Leader*

Births

Professional Research Consultants, Inc.

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.

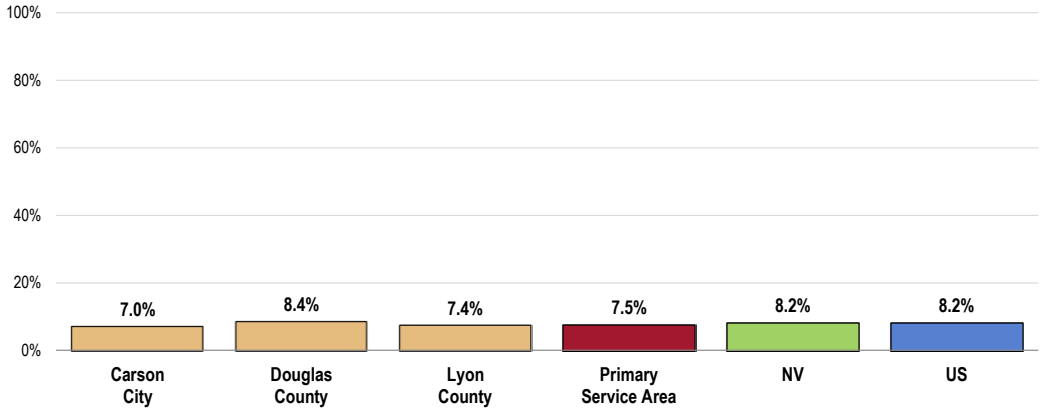
A total of 7.5% of 2006-2012 Primary Service Area births were low-weight.

- Better than the Nevada and US proportions.
- Similar to the Healthy People 2020 target (7.8% or lower).
- Slightly higher in Douglas County.

Low-Weight Births

(Percent of Live Births, 2006-2012)

Healthy People 2020 Target = 7.8% or Lower



Sources: Centers for Disease Control and Prevention, National Vital Statistics System: 2006-12. Accessed using CDC WONDER. Retrieved May 2016 from Community Commons at http://www.chna.org.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note: This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Between 2012 and 2014, there was an annual average of 8.1 infant deaths per 1,000 live births.

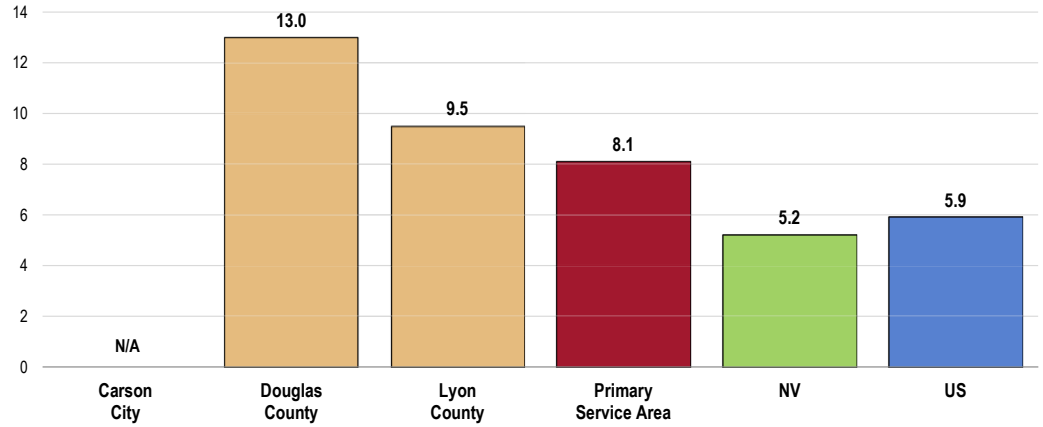
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

- Higher than the state and national rates.
- Fails to satisfy the Healthy People 2020 target of 6.0 per 1,000 live births.
- Particularly high in Douglas County (note that a rate for Carson City is not available).

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2012-2014)

Healthy People 2020 Target = 6.0 or Lower



Sources: Centers for Disease Control and Prevention, National Vital Statistics System: 2012-14. Accessed using CDC WONDER. Retrieved May 2016 from Community Commons at http://www.chna.org.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

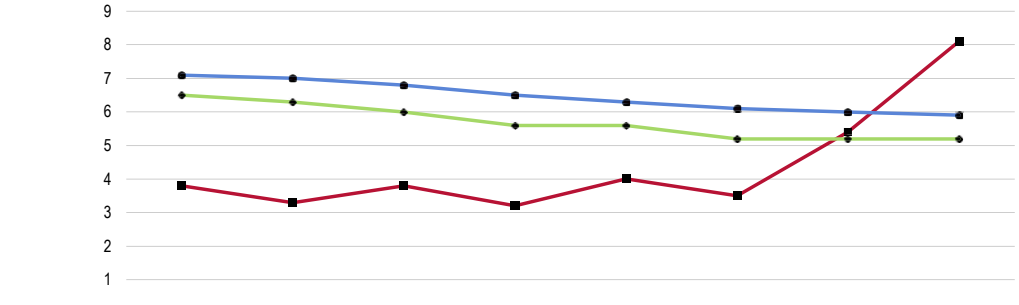
Notes: Infant deaths include deaths of children under 1 year old.
This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- TREND: The infant mortality rate has increased dramatically in recent years in the Primary Service Area, in contrast to the decreasing trends reported statewide and nationally.

Infant Mortality Rate

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

Healthy People 2020 Target = 6.0 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	3.8	3.3	3.8	3.2	4.0	3.5	5.4	8.1
NV	6.5	6.3	6.0	5.6	5.6	5.2	5.2	5.2
US	7.1	7.0	6.8	6.5	6.3	6.1	6.0	5.9

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
Centers for Disease Control and Prevention, National Center for Health Statistics.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

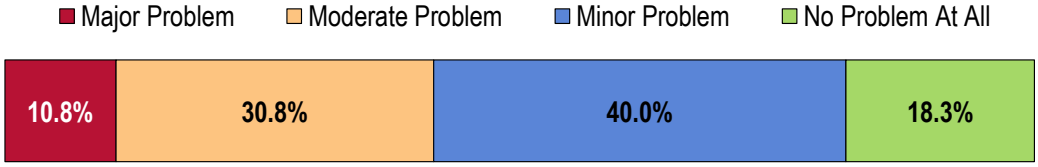
Notes: Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Key Informant Input: Infant & Child Health

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

Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Teen Pregnancy

> *In Lyon County, high rate of teen pregnancy and unplanned pregnancy among adults. High rate of food insecurity and low educational attainment. Higher rate of tobacco and alcohol use among teens and adults. Rate of suicide and mental health issues. – Social Services Provider*

Affordable Care/Services

> *Infant and child health are being very negatively-impacted by economic stress on families that translates into violence in a variety of forms. This sets the stage for a wide array of ensuing mental and medical problems. – Community/Business Leader*

Lack of Recreational Activities

> *Lack of parks and recreational facilities. Also, there are no pediatricians in the area. – Community/Business Leader*

Access to Care/Services

> *Every child needs to access to effective health care to set them on a healthy course to avoid diabetes and other lifestyle diseases. – Physician*

Access to Healthy Food

> *Lack of access to nutritious food, childhood obesity, child neglect/abuse, families in poverty, safe and affordable child care. – Community/Business Leader*

Poverty

> *Lots of children in poverty or borderline poverty. Low percentage of parents with adequate healthcare. – Community/Business Leader*

Access to Providers

> *Lack of pediatricians. – Community/Business Leader*

Prenatal Care

> *Lack of prenatal and child care sought by parents. – Community/Business Leader*

Family Planning

Births to Teen Mothers

About Teen Births

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

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

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

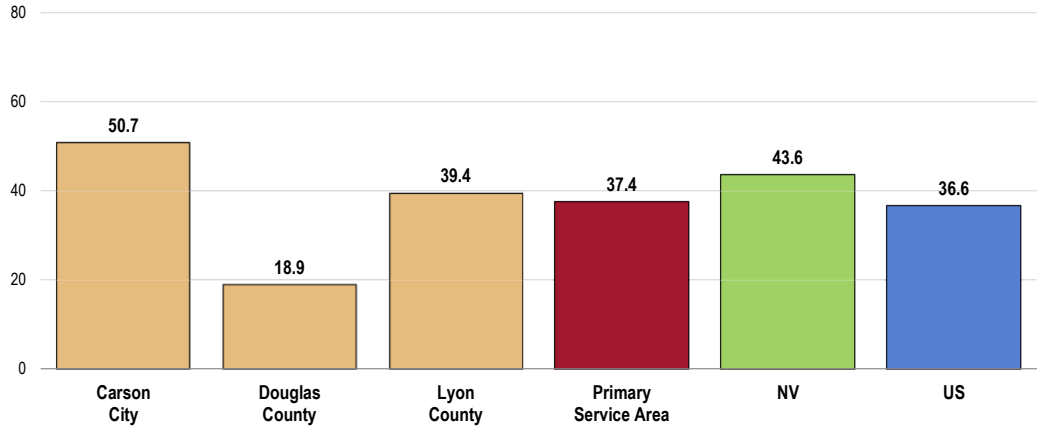
- Healthy People 2020 (www.healthypeople.gov)

Between 2006 and 2012, there was an annual average of 37.4 births to women age 15-19 per 1,000 population in that age group.

- Below the Nevada proportion.
- Comparable to the US rate.
- Favorably low in Douglas County.

Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)



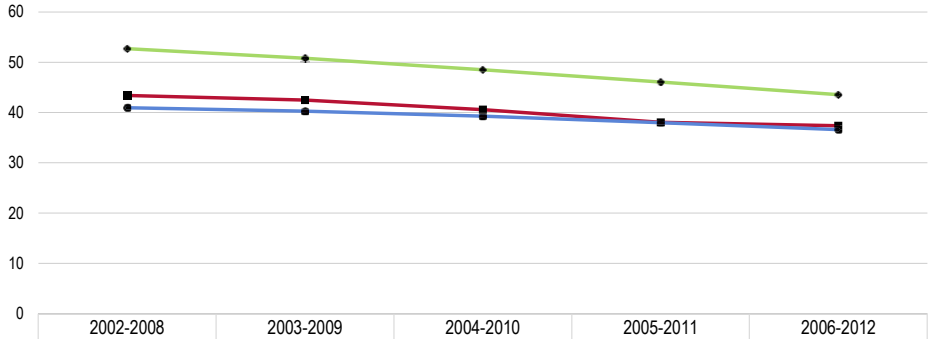
Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER. Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes: This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

- TREND: This rate has decreased over time in the Primary Service Area; the same can be said both statewide and nationwide.

Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19)



	2002-2008	2003-2009	2004-2010	2005-2011	2006-2012
PSA	43.4	42.5	40.6	38.1	37.4
NV	52.7	50.8	48.5	46.1	43.6
US	41.0	40.3	39.3	38.0	36.6

Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER. Retrieved May 2016 from Community Commons at http://www.chna.org.

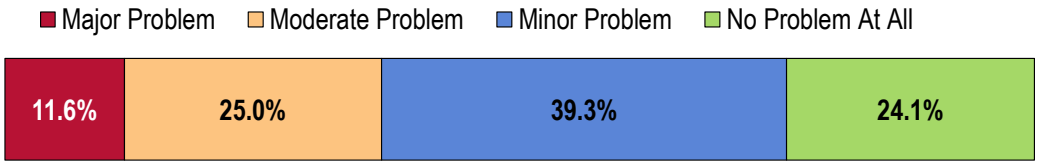
Notes: This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Family Planning

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

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2016)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> *The long-term health and opportunities—educational, economic and social. For young women/couples rely on planning pregnancies and having access to effective contraception. – Physician*
>
> *Carson is a conservative community. I don't know what kind of family planning options are being taught in school. I know of clinics that encourage maintaining pregnancies. I'm not sure how difficult getting an abortion would be. – Community/Business Leader*

Drug/Alcohol Abuse

> *We have a high drug, alcohol, and pain medication abuse in our community. The young people are*

> *having babies, and grandparents raise the children. – Community/Business Leader*

Health Education

> *Have little knowledge of resources of where to refer. – Social Services Provider*

Legislation

> *Lack of state and religion separation. Some of the regional resource guides funded by tax dollars list "crisis pregnancy resources" that are actually groups that provide false information about contraceptives and abortion and discourage women. – Social Services Provider*

Poor Parenting

> *With technology today, kids do not have parent interaction and/or dysfunctional families do not problem-solve, eat dinner together, attend activities, etc. Students are unorganized, and morals and values seem to be lost. – Community/Business Leader*

Poverty

> *Medicaid babies born to people who do not have the money to care for them, no job, and no plan. No family planning. – Physician*

Unplanned Pregnancies

> *Fifty percent of pregnancies are unplanned. – Physician*

Modifiable Health Risks

Professional Research Consultants, Inc.

Actual Causes of Death

About Contributors to Mortality

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

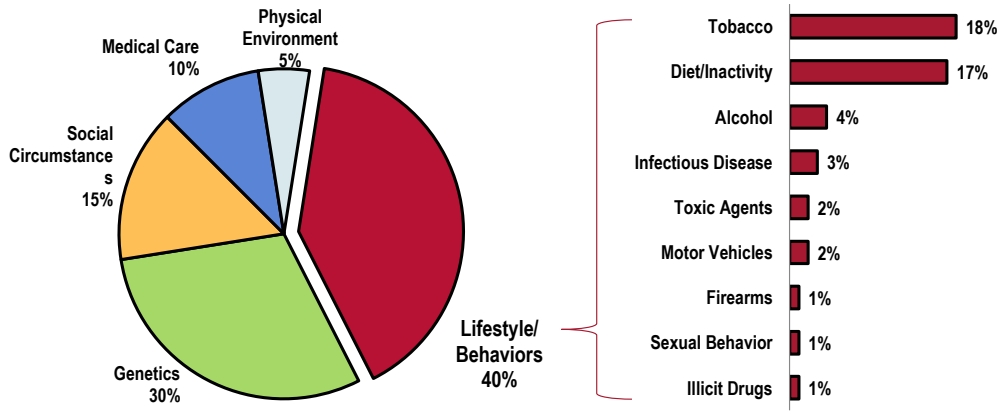
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual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

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

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

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

Factors Contributing to Premature Deaths in the United States



Sources: "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002. "Actual Causes of Death in the United States": (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Nutrition

About Healthful Diet & Healthy Weight

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

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

Americans with a healthful diet:

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

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

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

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

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

Social factors thought to influence diet include:

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

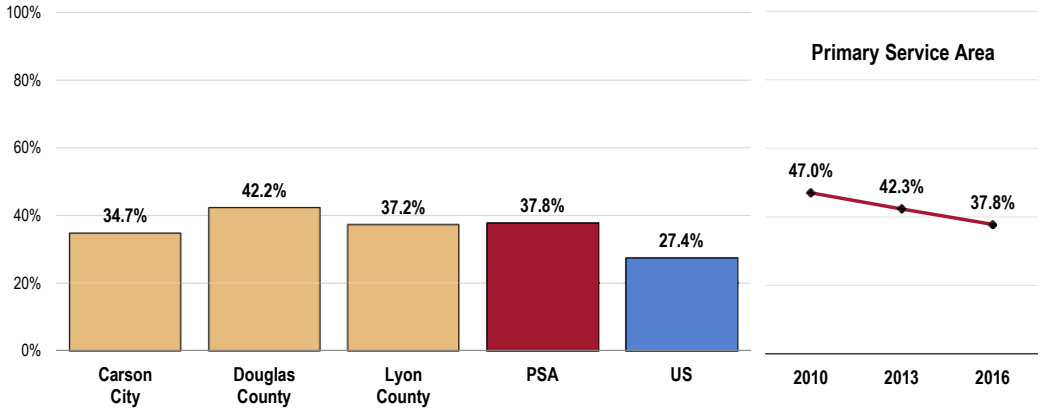
Daily Recommendation of Fruits/Vegetables

A total of 37.8% of Primary Service Area adults report eating five or more servings of fruits and/or vegetables per day.

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

- More favorable than national findings.
- Similar findings by area.
- TREND: Fruit/vegetable consumption has decreased significantly since 2010.

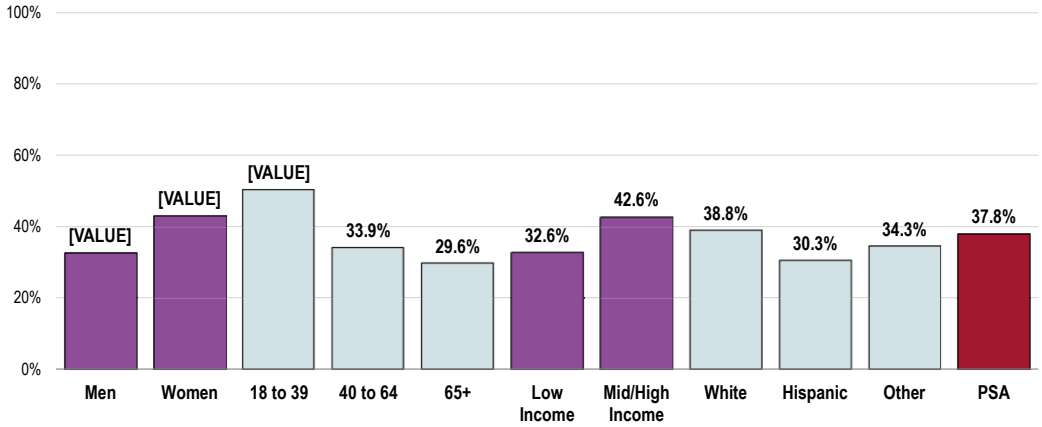
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
For this issue, respondents were asked to recall their food intake on the previous day.

- Area men are less likely to get the recommended servings of daily fruits/vegetables, as are older adults (negative correlation with age) and lower-income residents.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

Difficulty Accessing Fresh Produce

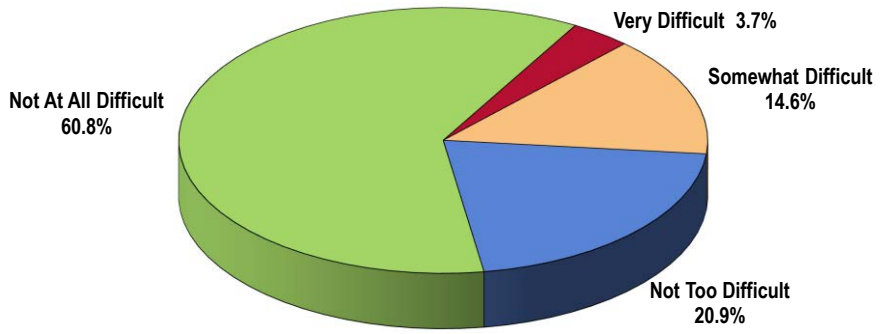
While most report little or no difficulty, 18.3% of Primary Service Area adults find it "very" or "somewhat" difficult to access affordable, fresh fruits and vegetables.

Respondents were asked:

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

Level of Difficulty Finding Fresh Produce at an Affordable Price

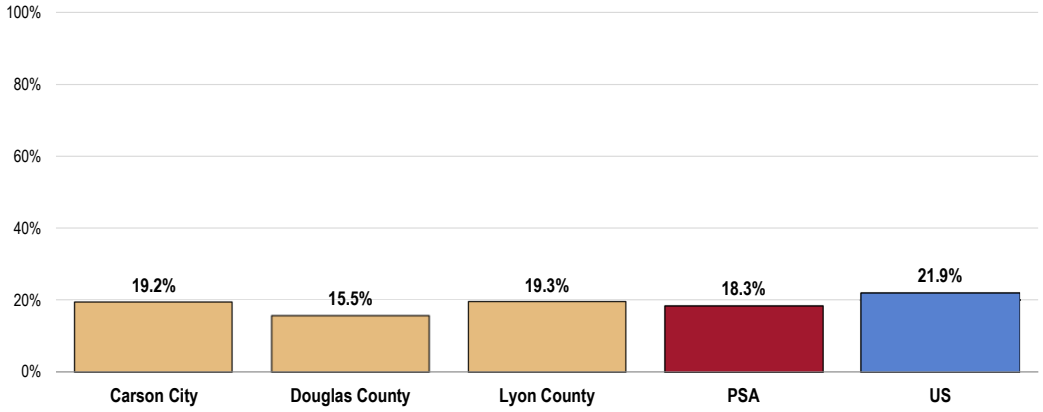
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: Asked of all respondents.

- Similar to national findings.
- Similar findings by area.

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

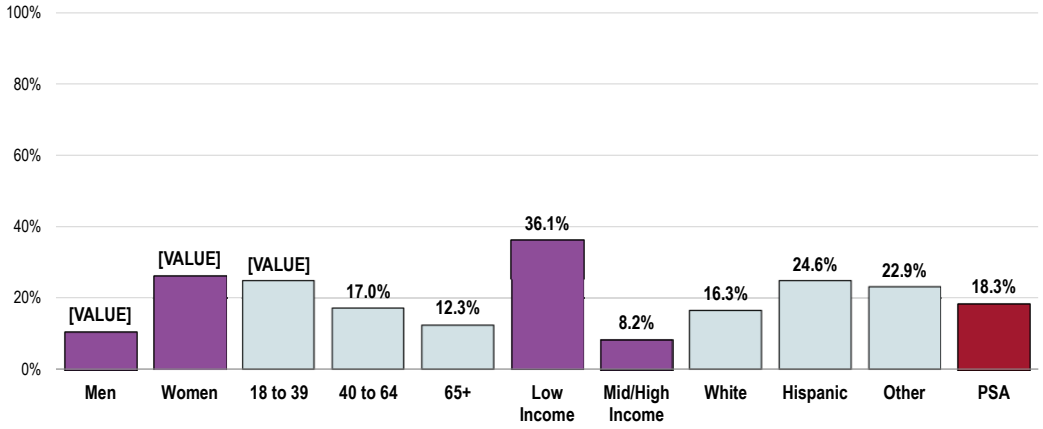


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Those more likely to report difficulty getting fresh fruits and vegetables include:

- Women.
- Younger adults (negative correlation with age).
- Lower-income residents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Low Food Access (Food Deserts)

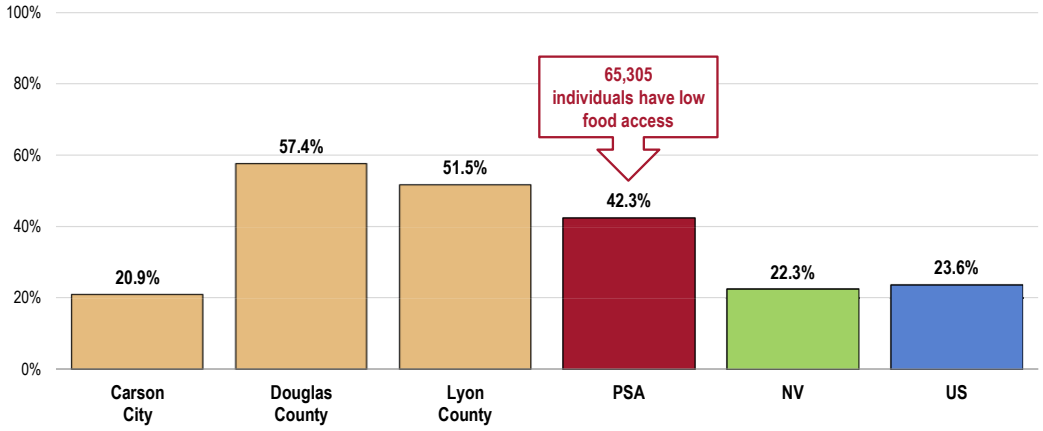
A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

US Department of Agriculture data show that 42.3% of Primary Service Area population (representing over 65,000 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Well above state and US percentages.
- Considerably lower in Carson City.

Population With Low Food Access

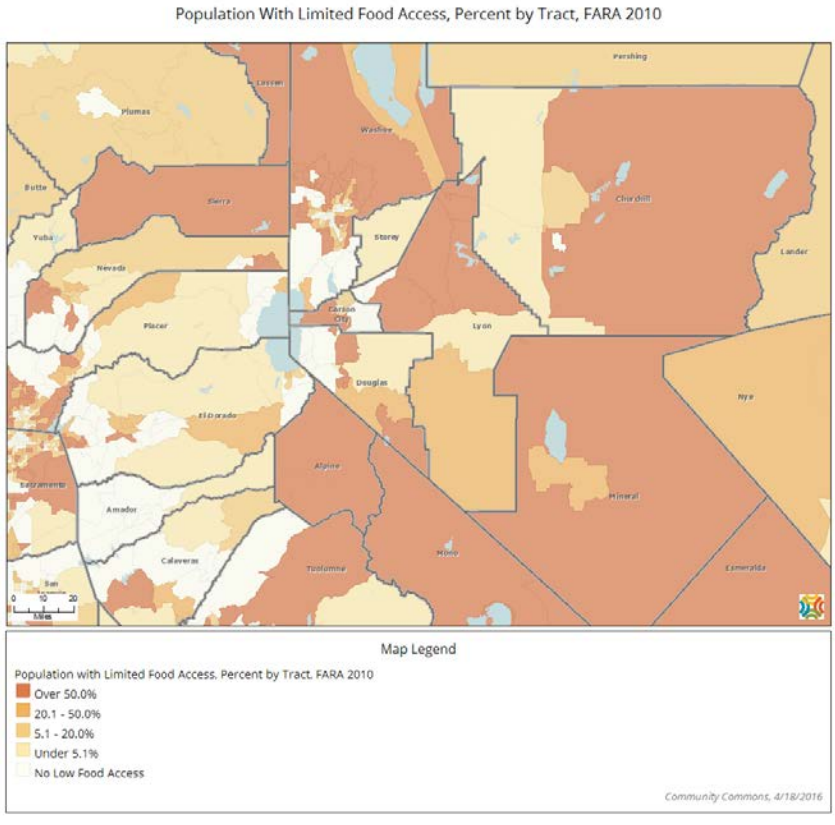
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)



Sources: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA). Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes: This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts in the Primary Service Area by census tract.



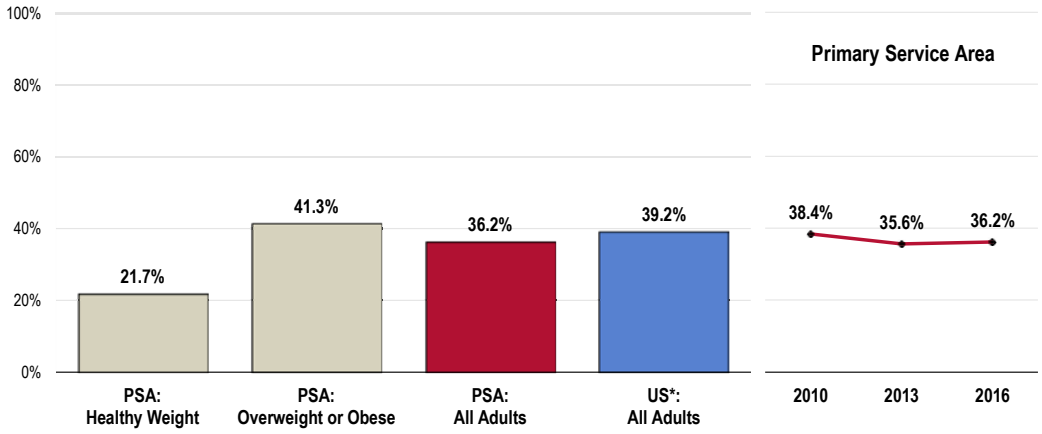
Health Advice About Diet & Nutrition

A total of 36.2% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Comparable to national findings.
- Comparable findings by area (not shown).
- TREND: Statistically unchanged since 2010.
- Note: Among overweight/obese respondents, 41.3% report receiving diet/nutrition advice (meaning that nearly 6 in 10 did not).

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

(By Weight Classification)



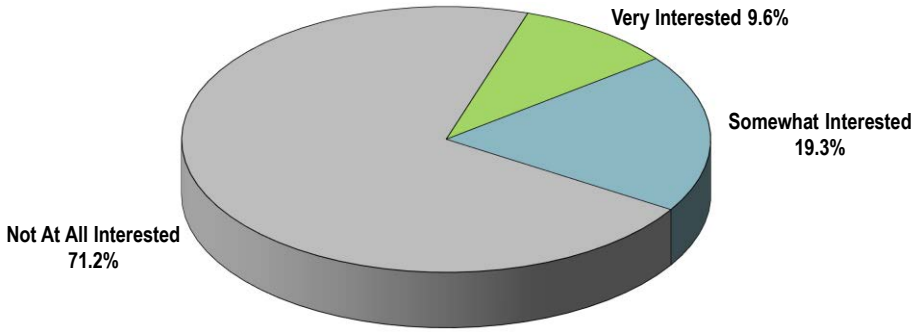
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 304]
2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
*US percentage reflects 2013 survey data.

Interest in Nutritional Counseling

While the majority of survey respondents (71.2%) are "not at all interested" in a nutritional counseling program provided by a local organization, 19.3% of respondents gave "somewhat interested" responses, and 9.6% would be "very interested" in such a program.

Level of Interest in Nutritional Counseling

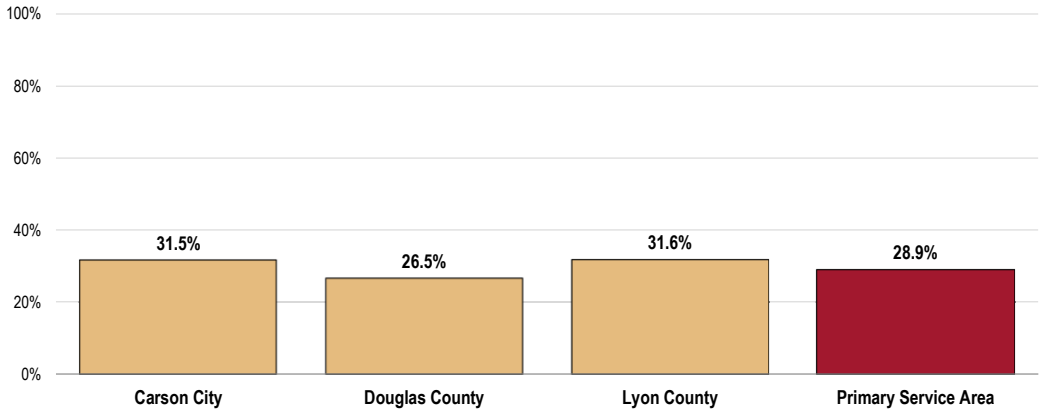
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: Asked of all respondents.

- The prevalence of "very/somewhat" interested responses does not vary by area.

"Very/Somewhat" Interested in Nutritional Counseling



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: Asked of all respondents.

Physical Activity

About Physical Activity

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

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

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

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

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Leisure-Time Physical Activity

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.

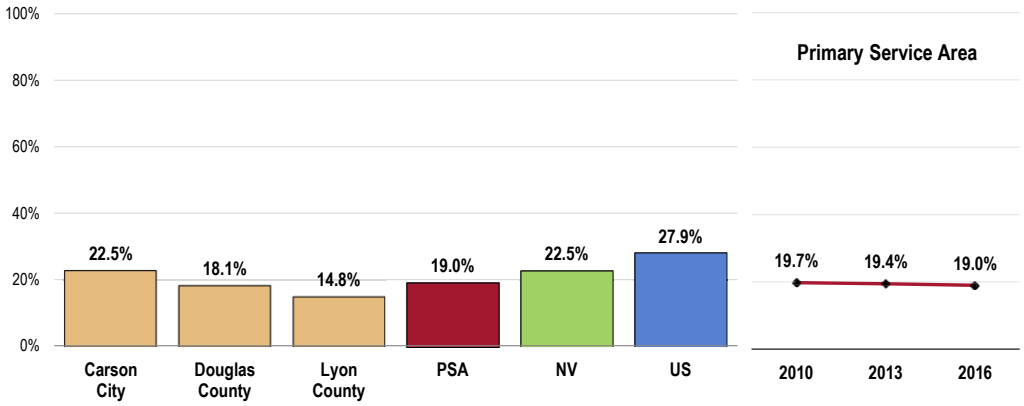
A total of 19.0% of Primary Service Area adults report no leisure-time physical activity in the past month.

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

- Comparable findings by area.
- TREND: Statistically unchanged over time.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes: Asked of all respondents.

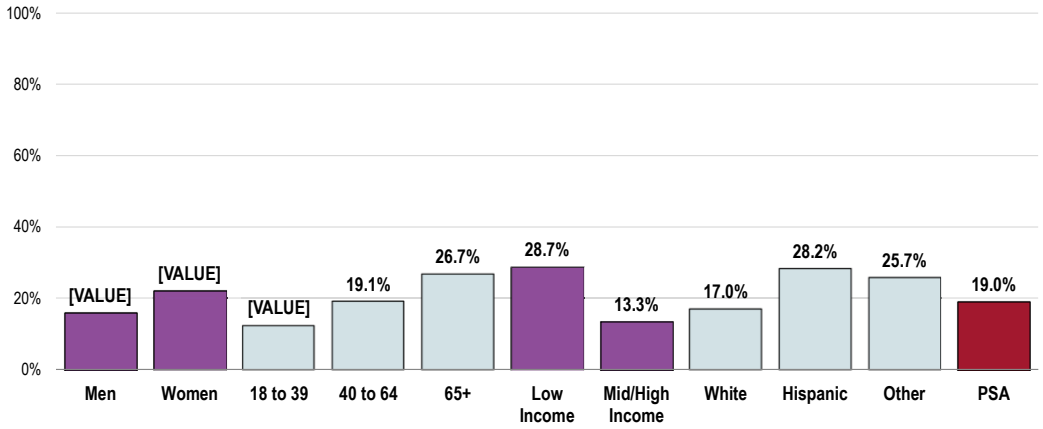
Lack of leisure-time physical activity in the area is higher among:

- Women.
- Adults age 40+ (positive correlation with age).
- Lower-income residents.

No Leisure-Time Physical Activity in the Past Month

(Primary Service Area, 2016)

Healthy People 2020 Target = 32.6% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

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

Activity Levels

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
- Learn more about CDC's efforts to promote walking by visiting http://www.cdc.gov/vitalsigns/walking.

Moderate & Vigorous Physical Activity

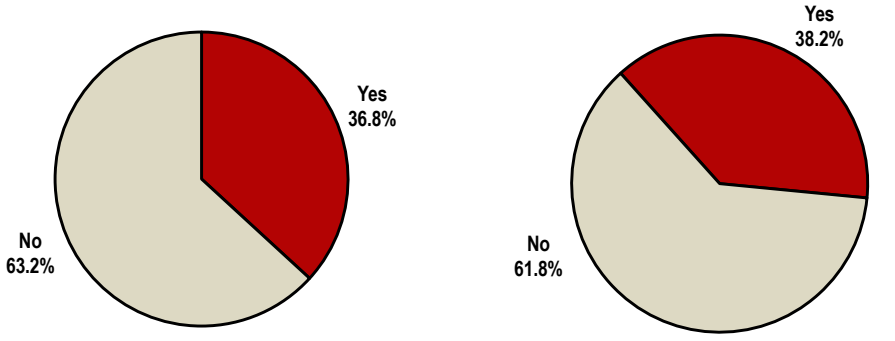
In the past month:

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

A total of 36.8% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

A total of 38.2% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

Moderate & Vigorous Physical Activity
(Primary Service Area, 2016)

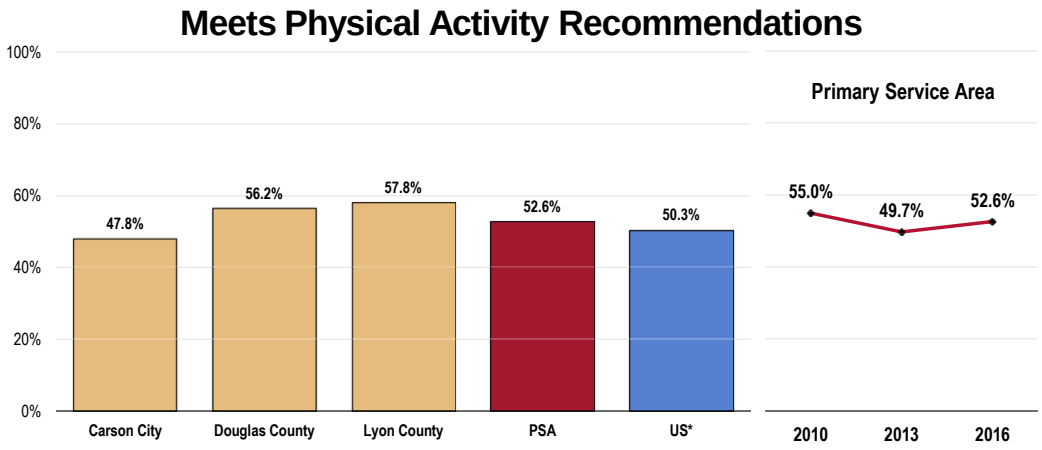


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 171-172]
Notes: Asked of all respondents.
Moderate Physical Activity: Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times per week for at least 30 minutes per time.
Vigorous Physical Activity: Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for at least 20 minutes per time.

Recommended Levels of Physical Activity

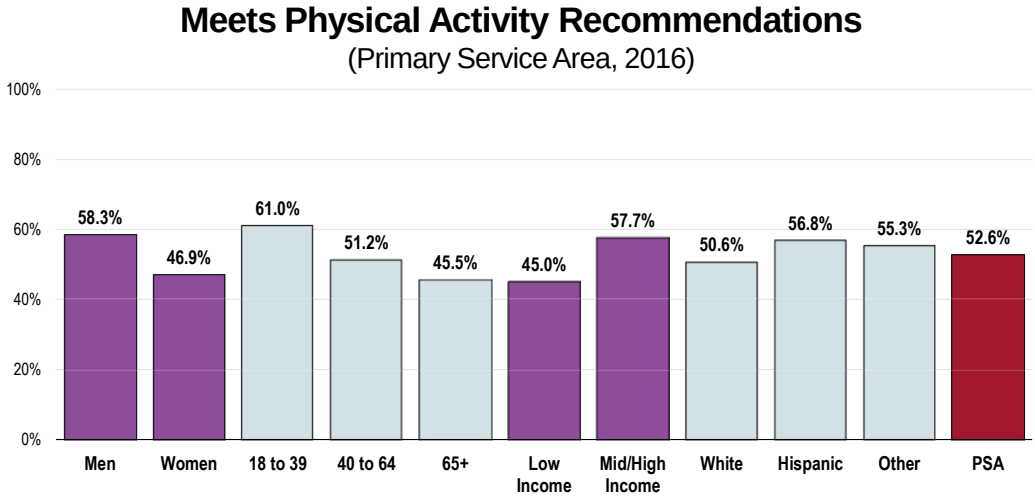
A total of 52.6% of Primary Service Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- More favorable than the 2013 national findings.
- Lowest in Carson City.
- TREND: Statistically similar to previous findings



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]
2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
*US percentage reflects 2013 survey data.
In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

- Women, older adults and low-income residents are less likely to meet physical activity requirements.



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Children

Recommended Levels of Physical Activity

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

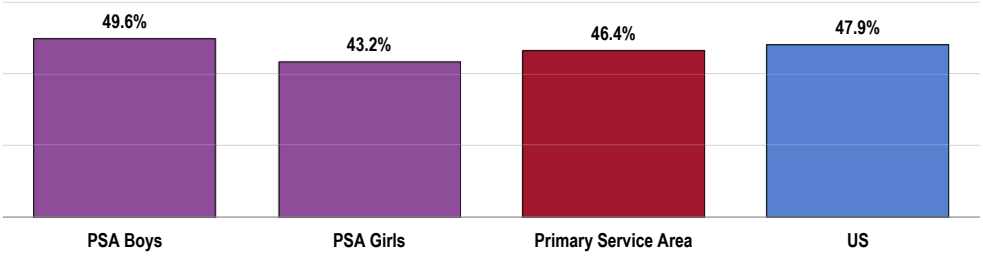
- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among Primary Service Area children age 2 to 17, 46.4% 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).

- Comparable to that found nationally.
- No difference by child's gender.

Child Is Physically Active for One or More Hours per Day

(Among Children Age 2-17)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children age 2-17 at home.
Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

In 2013, there were 11.7 recreation/fitness facilities for every 100,000 population in the Primary Service Area.

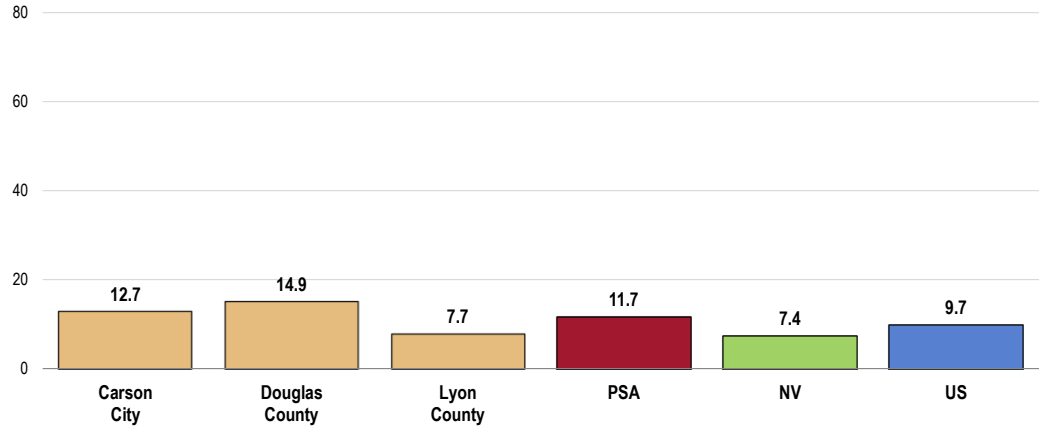
- Above what is found statewide and nationally.
- Lower in Lyon County.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 2013)



Sources: US Census Bureau, County Business Patterns: 2013. Additional data analysis by CARES.
Retrieved May 2016 from Community Commons at http://www.chna.org.

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

Weight Status

About Overweight & Obesity

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

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

- Healthy People 2020 (www.healthypeople.gov)

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

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

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

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

More than 2 in 3 Primary Service Area adults (68.4%) are overweight.

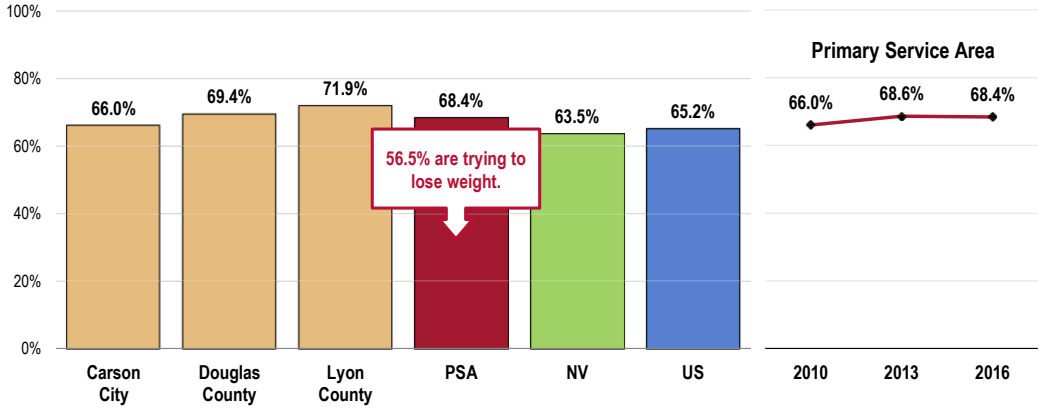
Here, "overweight" includes those respondents with a BMI value ≥25.

- Worse than the Nevada prevalence.
- Similar to the US overweight prevalence.
- Similar findings by area.
- TREND: Statistically unchanged since 2010.

Note that 56.5% of overweight adults are currently trying to lose weight.

Prevalence of Total Overweight

(Percent of Adults With a Body Mass Index of 25.0 or Higher)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 176-177]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.

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

Further, 31.6% of Primary Service Area adults are obese.

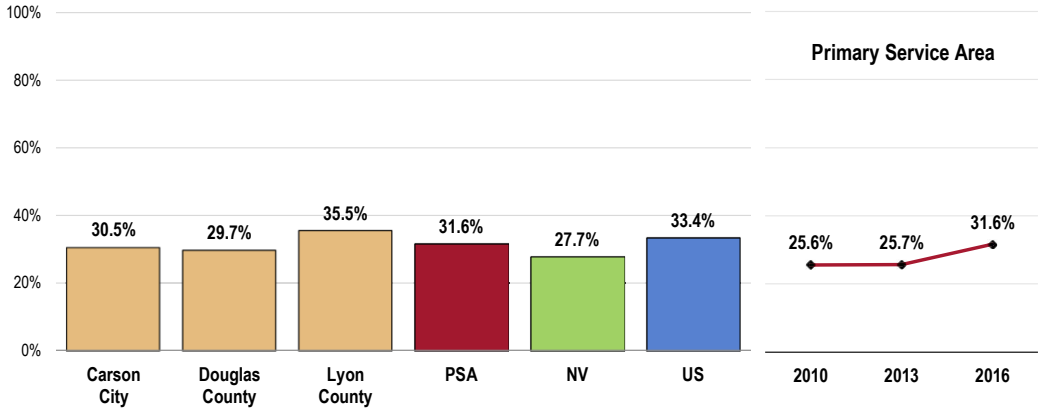
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

- Less favorable than Nevada findings.
- Comparable to US findings.
- Comparable to the Healthy People 2020 target (30.5% or lower).
- Comparable findings by area.
- TREND: Denotes a statistically significant increase in obesity since 2013.

Prevalence of Obesity

(Percent of Adults With a Body Mass Index of 30.0 or Higher)

Healthy People 2020 Target = 30.5% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.

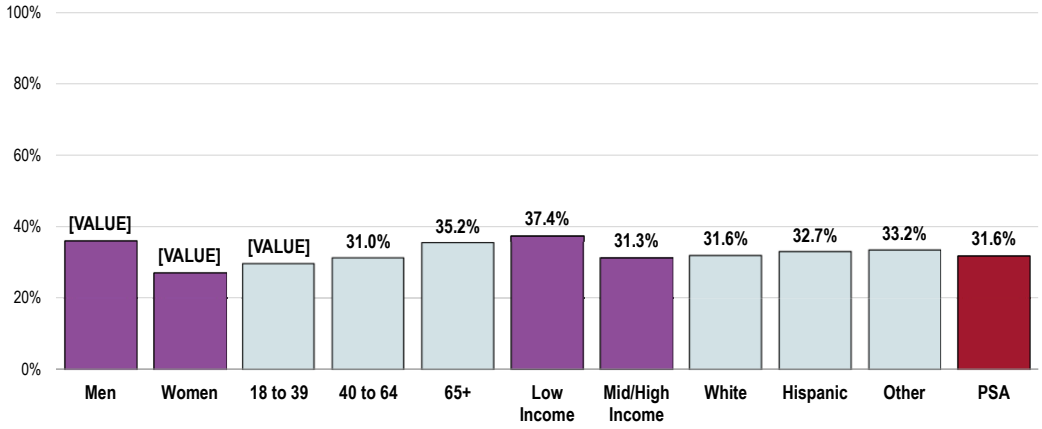
Notes: Based on reported heights and weights, asked of all respondents.
The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

- Obesity is notably more prevalent among males in the Primary Service Area.

Prevalence of Obesity

(Percent of Adults With a BMI of 30.0 or Higher; Primary Service Area, 2016)

Healthy People 2020 Target = 30.5% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

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

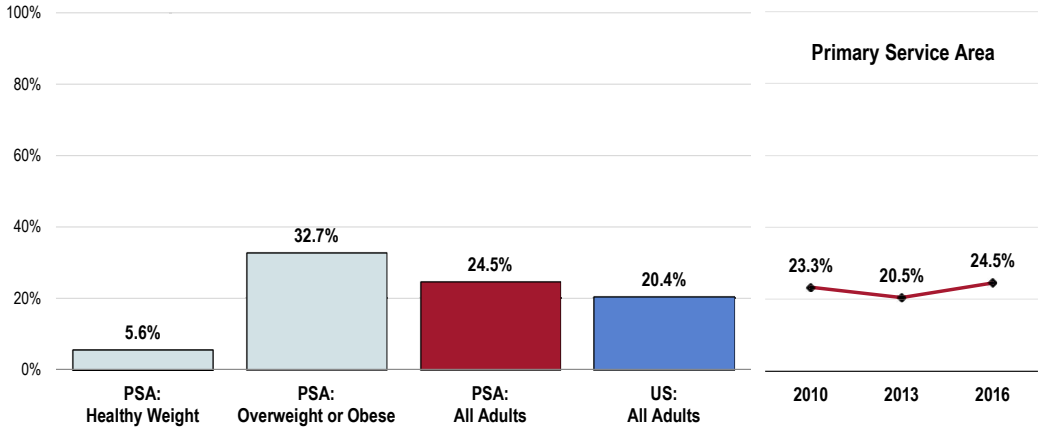
Health Advice

A total of 24.5% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Above the national prevalence.
- TREND: Statistically unchanged over time.
- Note that 32.7% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while the majority has not).

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

(By Weight Classification)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions. Among these are:

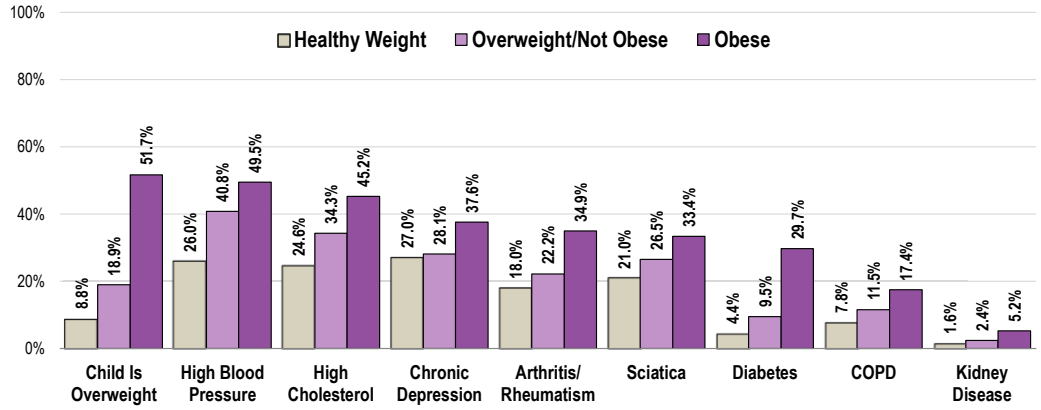
The correlation between overweight and various health issues cannot be disputed.

- High blood pressure
- High cholesterol.
- Chronic depression.
- Arthritis/rheumatism.
- Sciatica/chronic back pain.
- Diabetes.
- COPD.
- Kidney disease.

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

Relationship of Overweight With Other Health Issues

(By Weight Classification; Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 24, 27, 28, 32, 38, 117, 147, 148, 180]
Notes: Based on reported heights and weights, asked of all respondents.

Children's Weight Status

About Weight Status in Children & Teens

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

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

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

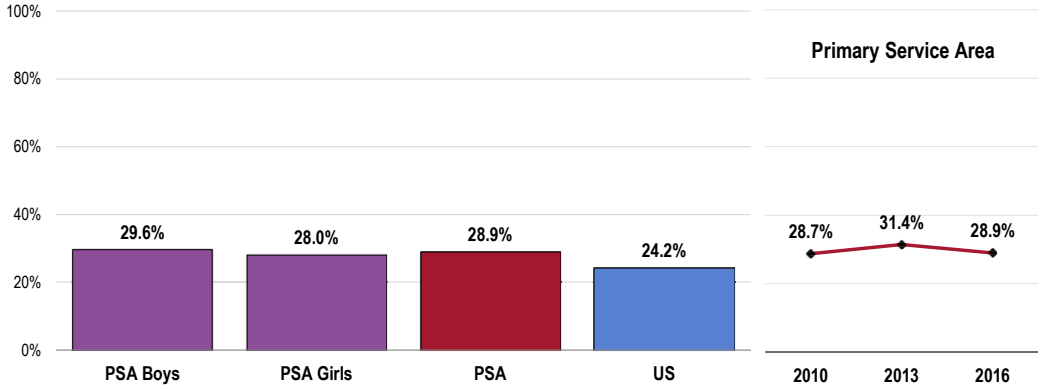
- Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 28.9% of Primary Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Similar to that found nationally.
- TREND: Statistically unchanged since 2010.

Child Total Overweight Prevalence

(Children Age 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

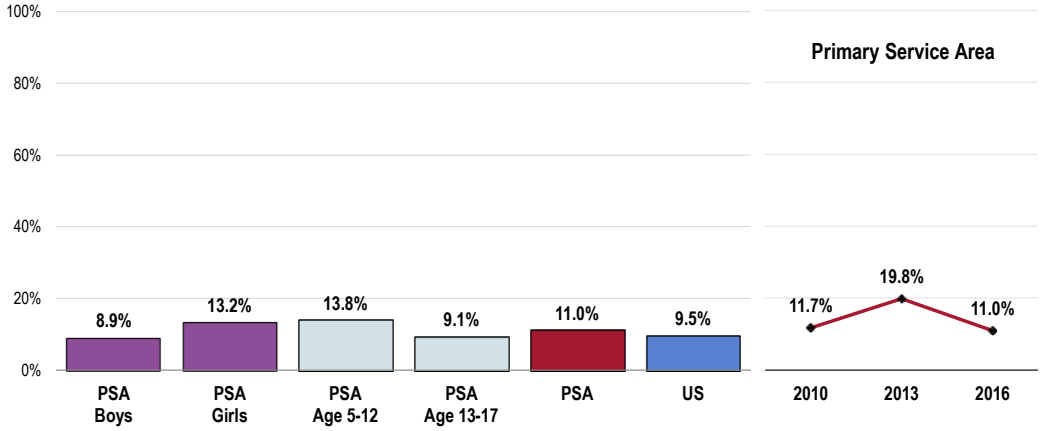
Further, 11.0% of area children age 5 to 17 are obese (≥95th percentile).

- Comparable to the national percentage.
- Comparable to the Healthy People 2020 target (14.5% or lower for children age 2-19).
- TREND: Statistically unchanged from 2010 results (but decreasing since 2013).
- Statistically similar by child's age and gender.

Child Obesity Prevalence

(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2020 Target = 14.5% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-10.4]

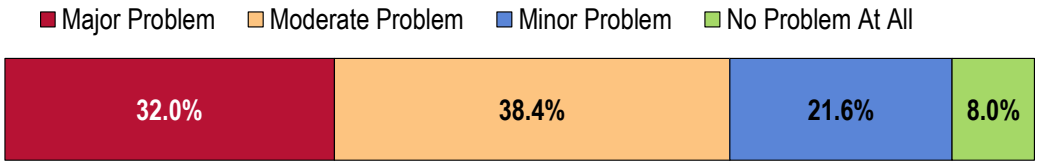
Notes: Asked of all respondents with children age 5-17 at home.
Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

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.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Lack of Physical Activity

Technology is an issue, and students/kids/families would rather sit and watch TV or play video games. – Community/Business Leader

Lack of exercise and dietary suggestions. – Community/Business Leader

It is actually the will of the people that needs motivating. We all need to get off of our computers and exercise. – Community/Business Leader

Physical activity and weight go hand-in-hand, and a lot of people do not make time to exercise. Busy schedules and work take priority over nutrition and exercise. People need to make their health a priority. – Community/Business Leader

Motivation, though much less since the new Community and Senior Center has opened in Douglas—a place that is easy for seniors to take part in exercise programs. – Community/Business Leader

Our community center should provide classes for free. Again physical activity is expensive unless you go to the pool, and they are considering a price increase this year. – Community/Business Leader

Access to indoor swimming pool and nutrition services. – Community/Business Leader

Wind, rain, and snow. Access to indoor facilities for physical activity. Accessible nutritious food that is affordable. Lack of nutritious options for eating out. – Community/Business Leader

Obesity

Obesity. – Physician

Increasing obesity. – Physician

Obesity is an accepted condition, rather than a deplorable state. We need an active program to combat obesity with education and instruction for diet and exercise. – Physician

Obesity and diabetes everywhere you look. – Community/Business Leader

As with the rest of the USA, obesity is a major and increasing problem. – Physician

Though I don't believe it is necessarily worse here than other communities, it is still an issue. – Community/Business Leader

Health Education

More education. Smoking cessation, exercise programs built in to workplace environments, nutritional education literature, education, etc. Changing the community culture about "health care" is key. – Other Health Provider

Education starting in elementary school and focused on throughout the schools at every level. Same for senior centers. Plus, organized walking efforts in every business and making Carson City a walking town. Reno has "Walk with a Doc," maybe corporate. – Community/Business Leader

Many people do not understand the importance of nutrition, physical activity, and their weight. Too many people are working two jobs to survive and they put their personal health issues on the back burner. – Community/Business Leader

There is a lack of quality educational programs directed toward responsible eating habits, promoting physical activity, and maintaining a healthy weight. – Community/Business Leader

Lifestyle

Behavior modification and ready access to healthy foods. – Community/Business Leader

Based on the people that I have met in the community, far fewer have a healthy lifestyle compared to other places where I have lived and visited. This is based on general appearance and habits. Weight, activity level, smoking, excessive eating. – Community/Business Leader

Many families I encounter have two working parents or a single parent with two jobs. Eating habits are whatever works in a hectic lifestyle, which means fast food a lot of the time. There are a lot of activities offered for physical activity. – Community/Business Leader

Poorer families have poor nutrition, lack of exercise, access to medical advice. – Community/Business Leader

Lack of emphasis on nutrition, physical activity, and overweight issues resulting in health concerns. – Social Services Provider

Again, promotion of a healthy lifestyle, non-sedentary. – Physician

People have become too busy and turn to fast food to feed families. The children are playing video games and not participating in outside activities. A lot of our children are overweight and have early signs of health problems. – Community/Business Leader

Access to Healthy Food

Carson City and Douglas have excellent access to local foods, lots of affordable or free options for outdoor and indoor physical activity for all ages. In Lyon, lack of fresh and nutritious foods in the school lunches are problematic. – Social Services Provider

Access to Care/Services

Lack of quality resources. – Community/Business Leader

Access to Primary Care Provider

Lack of access to primary care with the time to address this with their patients. All their time is spent with their backs to patients at a computer. Get them a scribe to do computer/documentation stuff and let them actually talk and examine patients. – Physician

Affordable Care/Services

The cost. – Social Services Provider

Homelessness

Folks that are homeless tend to have a problem getting food. And when they do, it is not always the best for them. – Social Services Provider

Socioeconomic Status

Low educational level and poor outlook. Children born to this person with a poor educational level. – Physician

Substance Abuse

About Substance Abuse

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

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cirrhosis/Liver Disease Deaths

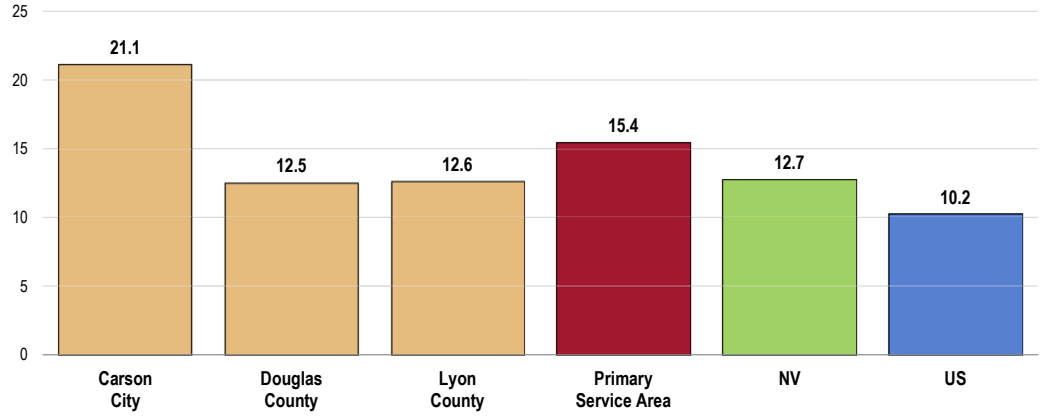
Between 2012 and 2014, the Primary Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 15.4 deaths per 100,000 population.

- Worse than the state and US rates.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).
- Particularly high in Carson City.

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 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 May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

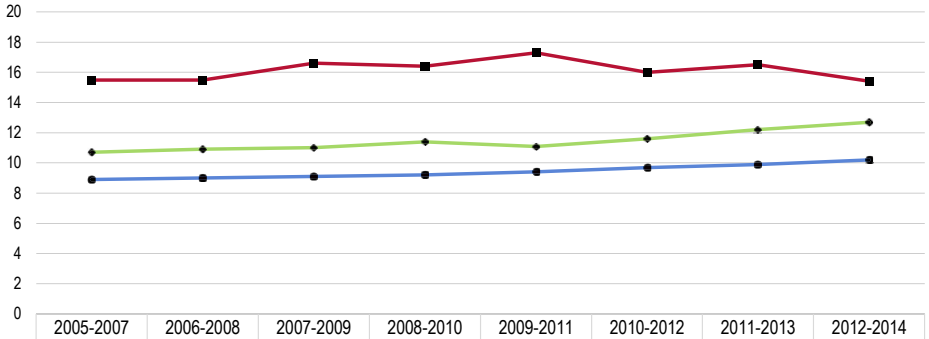
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The mortality rate in the region has been fairly stable over time. Statewide and nationwide, rates have increased.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	15.5	15.5	16.6	16.4	17.3	16.0	16.5	15.4
NV	10.7	10.9	11.0	11.4	11.1	11.6	12.2	12.7
US	8.9	9.0	9.1	9.2	9.4	9.7	9.9	10.2

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

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

Alcohol Use

Excessive Drinking

"**Excessive drinking**" includes heavy **and/or** binge drinkers:

- **Heavy drinkers** include men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **Binge drinkers** include men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

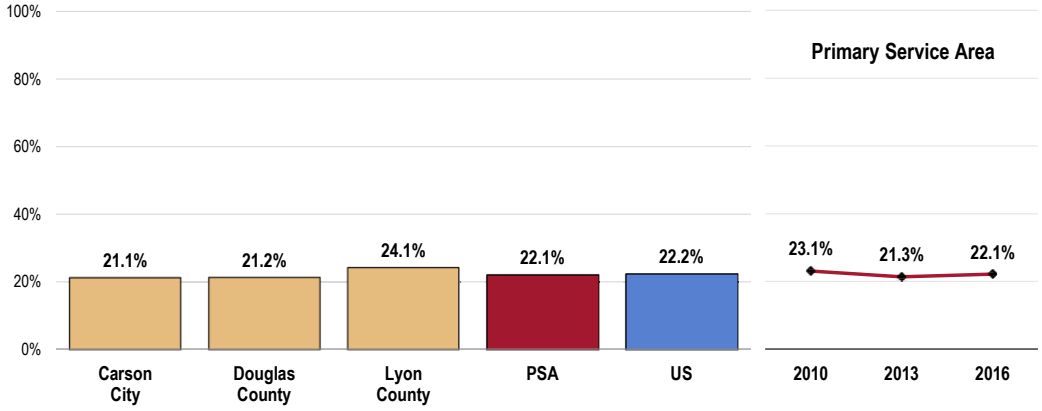
RELATED ISSUE:
See also *Stress* in the **Mental Health** section of this report.

A total of 22.1% of area adults are excessive drinkers (heavy and/or binge drinkers).

- Almost identical to the national proportion.
- Satisfies the Healthy People 2020 target (25.4% or lower).
- Similar findings by area.
- TREND: Statistically unchanged since 2010.

Excessive Drinkers

Healthy People 2020 Target = 25.4% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

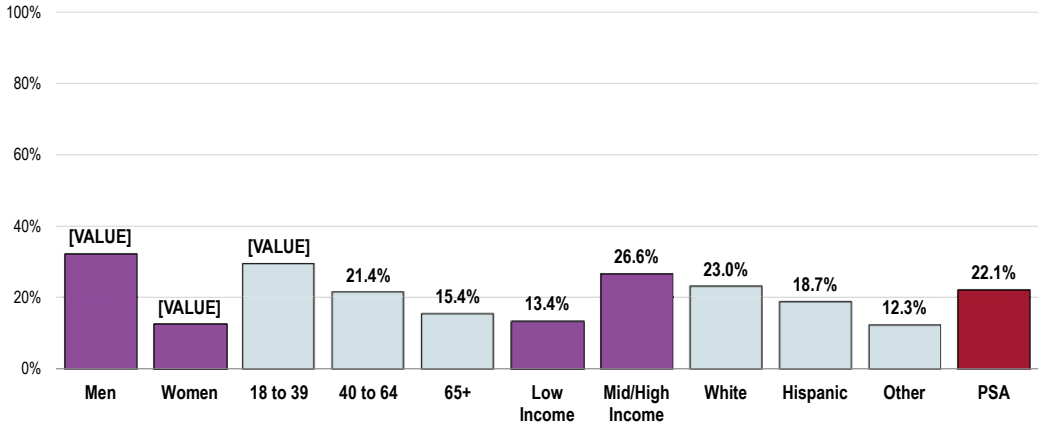
Notes: Asked of all respondents.
Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks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

- Excessive drinking is more prevalent among men, younger adults (negative correlation with age), upper-income residents, and Whites.

Excessive Drinkers

(Primary Service Area, 2016)

Healthy People 2020 Target = 25.4% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

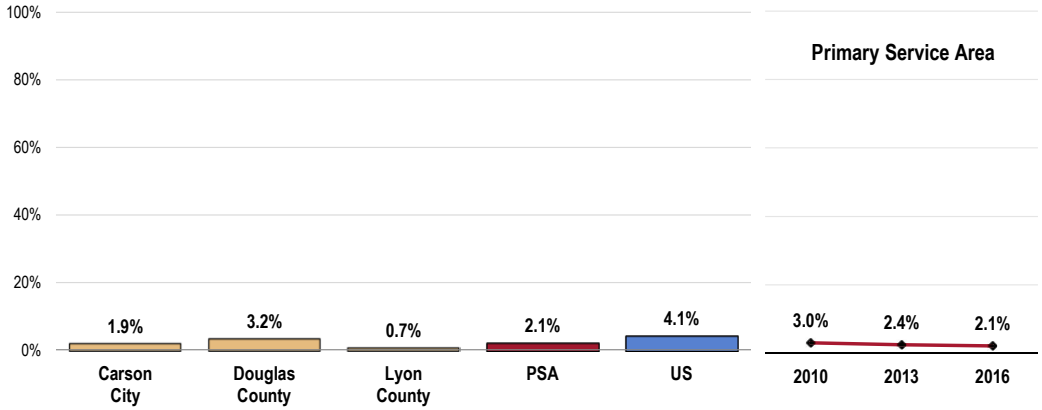
Drinking & Driving

A total of 2.1% of Primary Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- More favorable than the national findings.
- Favorably low in Lyon County.
- TREND: The drinking and driving prevalence has not changed significantly since 2010.

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

Have Driven in the Past Month After Perhaps Having Too Much to Drink



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Age-Adjusted Drug-Induced Deaths

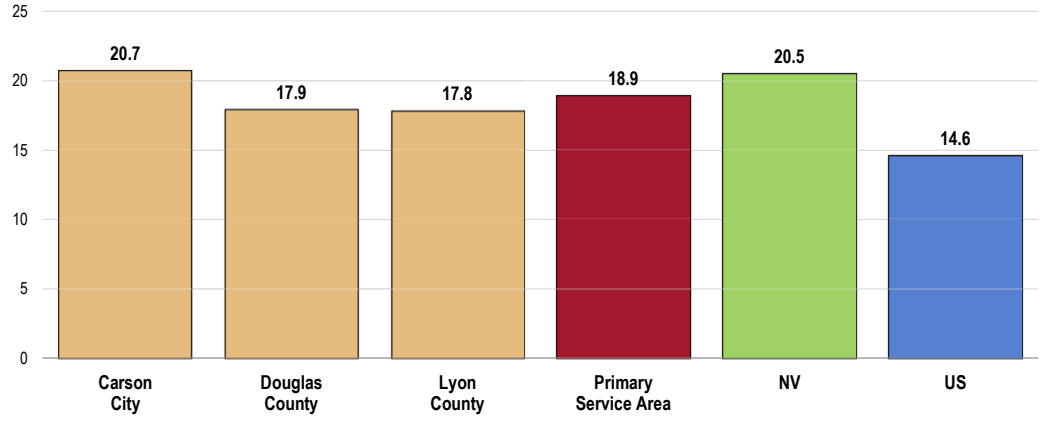
Between 2012 and 2014, there was an annual average age-adjusted drug-induced mortality rate of 18.9 deaths per 100,000 population in the Primary Service Area.

- More favorable than the statewide rate.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target (11.3 or lower).
- Highest in Carson City.

Drug-Induced Deaths: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower



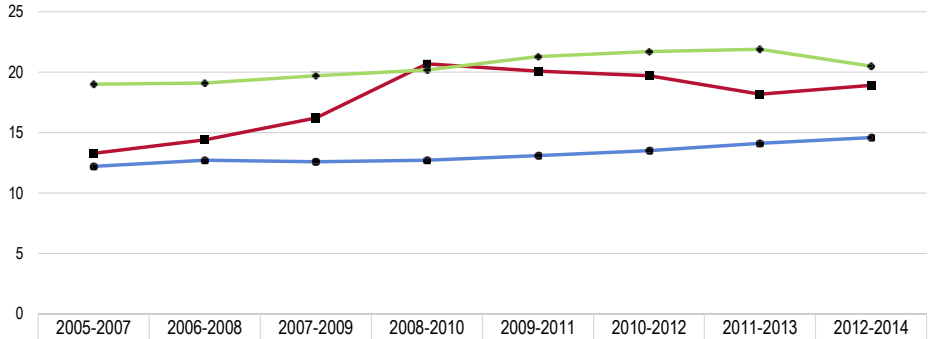
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The mortality rate rose sharply in the late 2000s, but has since abated somewhat. Statewide and nationwide, rates have generally increased.

Drug-Induced Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower



	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PSA	13.3	14.4	16.2	20.7	20.1	19.7	18.2	18.9
NV	19.0	19.1	19.7	20.2	21.3	21.7	21.9	20.5
US	12.2	12.7	12.6	12.7	13.1	13.5	14.1	14.6

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
UD Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12].

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

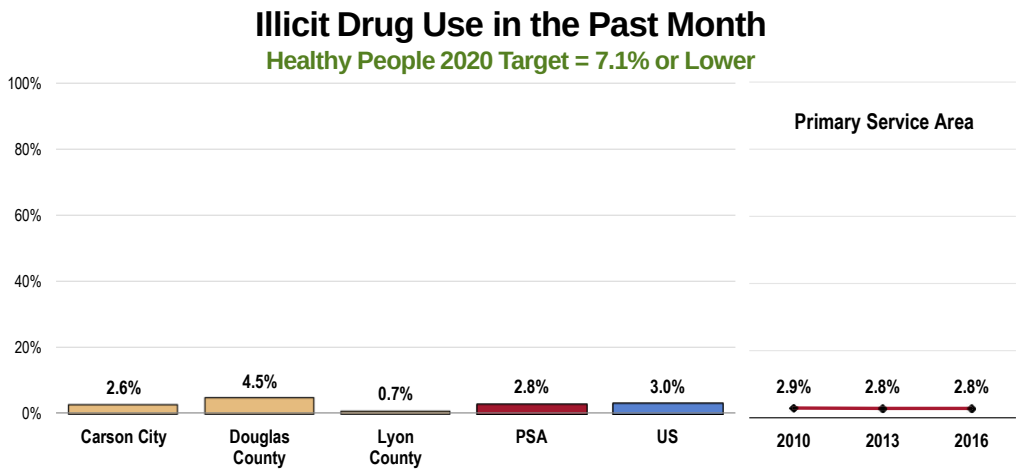
Illicit Drug Use

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.

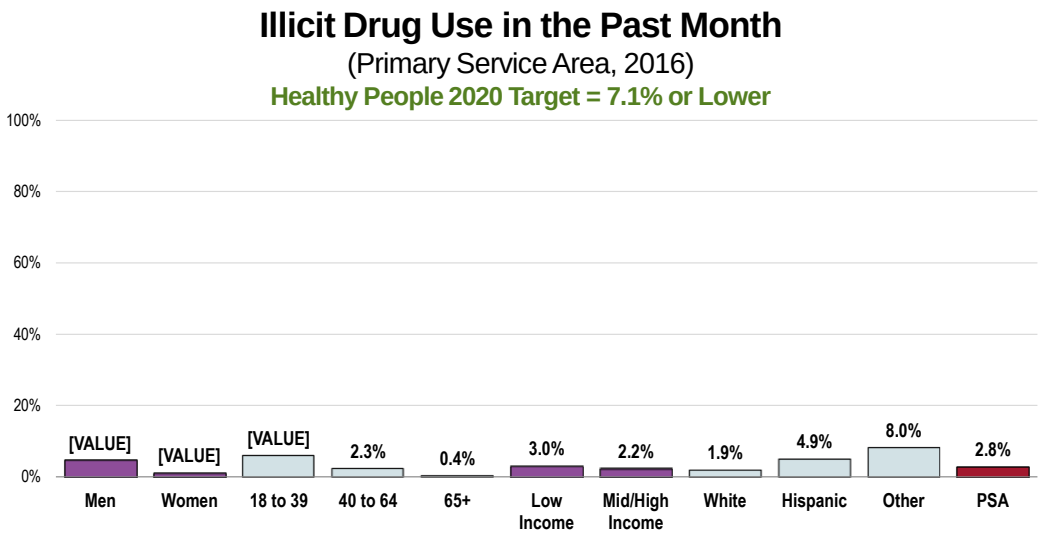
A total of 2.8% of area adults acknowledge using an illicit drug in the past month.

- Similar to the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.
- Lowest in Lyon County.
- TREND: Statistically unchanged over time.



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]
Notes: Asked of all respondents.

- Illicit drug use is more prevalent among men and younger adults (negative correlation with age).



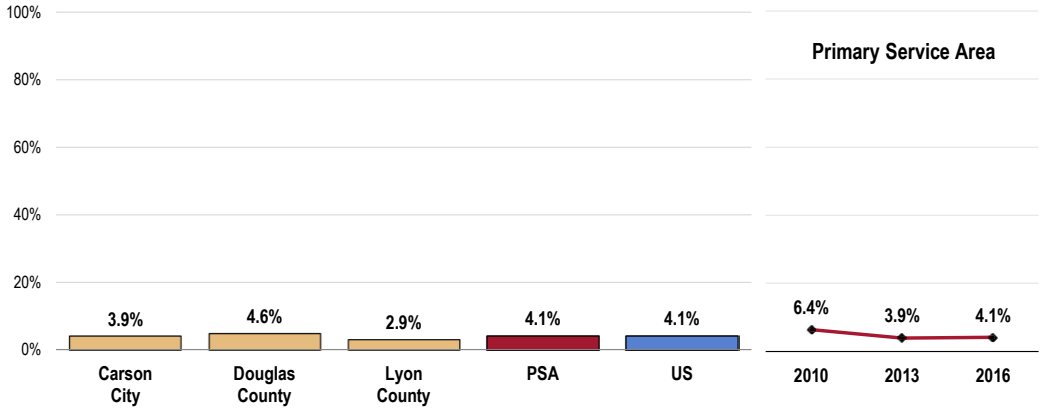
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Alcohol & Drug Treatment

A total of 4.1% of Primary Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Identical to national findings.
- Similar findings by area.
- TREND: Marks a statistically significant decrease over time.

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



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

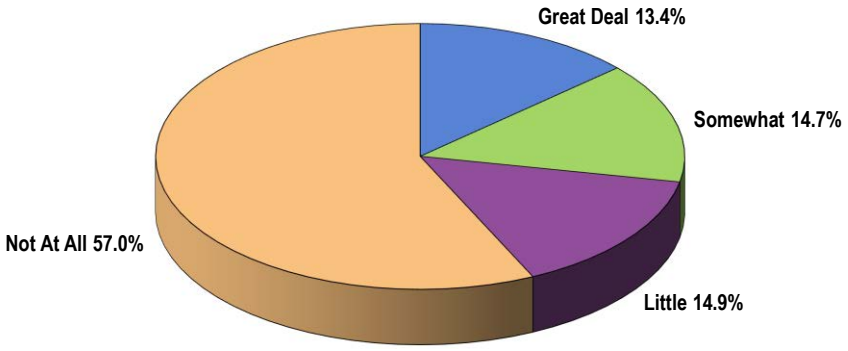
Negative Effects of Substance Abuse

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

In all, most respondents have not been negatively affected (57.0% "not at all" responses).

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

(Primary Service Area, 2016)

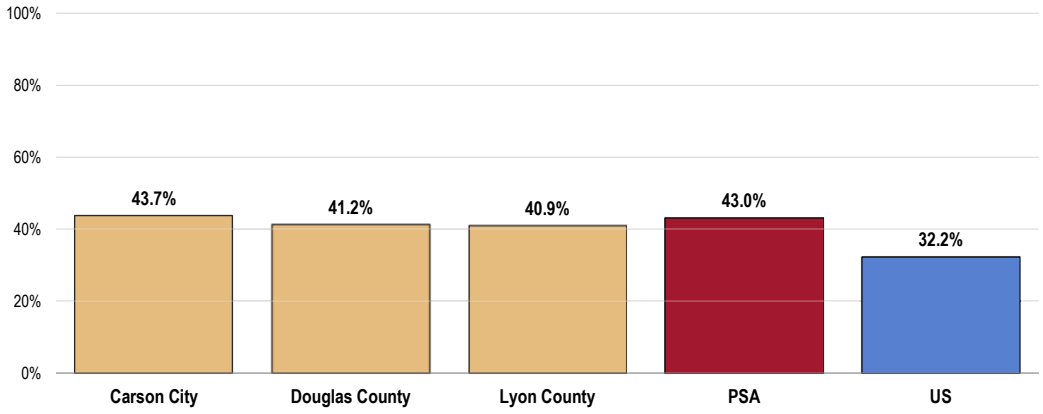


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
Notes: Asked of all respondents.

However, 43.0% of survey respondents indicate that their lives have been negatively affected by substance abuse, including 13.4% who gave "a great deal" responses.

- Higher than the US benchmark.
- Comparable findings by area.

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



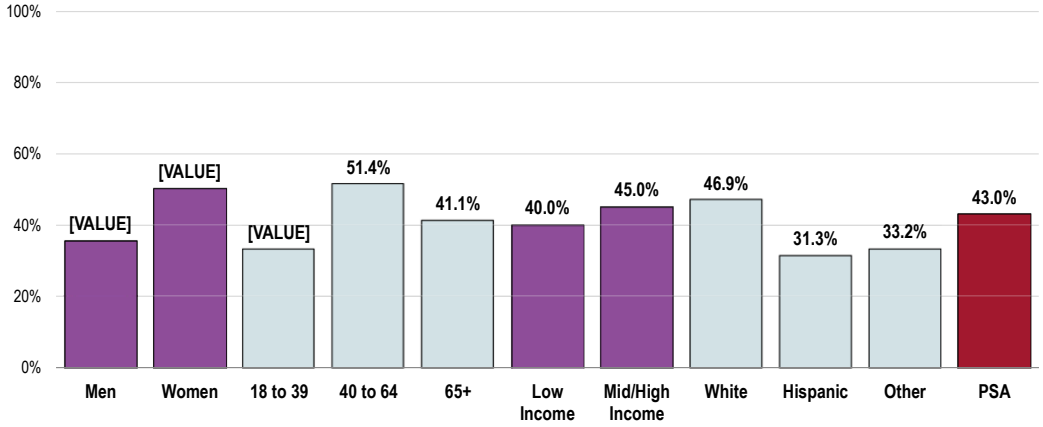
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

The prevalence of survey respondents whose lives have been negatively impacted by substance abuse, whether their own abuse or that of another, is higher among the following:

- Women.
- Adults age 40 to 64.
- Whites.

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

(Primary Service Area, 2016)



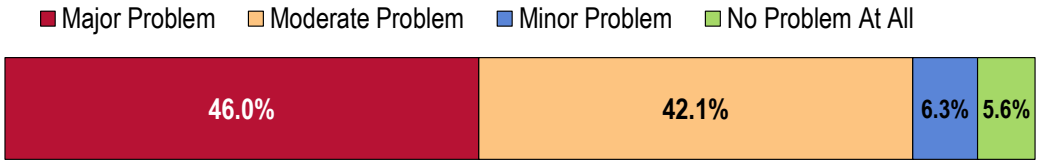
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Substance Abuse

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

Perceptions of Substance Abuse as a Problem in the Community

(Key Informants, 2016)



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

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Denial/Stigma

Their own mental health. There are plenty of opportunities and programs available. People either don't think they need it, or don't want to do the work to make the change. They are afraid of the changes it will bring in their lives. – Community/Business Leader

Awareness and the social stigma of seeking assistance. – Community/Business Leader

I have relatives that have substance abuse problems. They do not seem to have any desire to change their habits and are willing to sacrifice family relationships to continue with their lifestyle. I also believe that there is a genetic component to some. – Community/Business Leader

Fear of incriminating themselves, affordability, denial, reluctance to change. – Community/Business Leader

Lack of desire to change or admit problem. – Community/Business Leader

People don't think they have a problem. The courts usually have to send them for treatment. Money to go for treatment is an issue. – Community/Business Leader

The willingness to start treatment. – Community/Business Leader

Denial or inability to access services. – Social Services Provider

Stigma, lack of affordable treatment. Shortage of residential treatment centers, long waiting list for treatment. Lack of advertising about state/federal resources for treatment. Lack of coordination among state, federal, local agencies. – Social Services Provider

Shame, help in getting into a program, and encouragement to stay with the program for as long as it takes. – Community/Business Leader

Access to Care/Services

Not having adequate facilities to choose from. – Community/Business Leader

Lack of beds, programs, coverage. – Physician

Long term or Outpatient facilities. – Community/Business Leader

This is a big issue, but I'm not sure what barriers exist besides people being people. – Community/Business Leader

Resources are not available in the community. One treatment is not usually effective; they may need help three or four times. – Community/Business Leader

No inpatient residential co-occurring programs. – Social Services Provider

Not enough. What we have, the senior or homeless have a hard time getting to them. – Social Services Provider

Lack of local and affordable providers and treatment centers. – Social Services Provider

Lack of facilities to address this problem, as well as cost. – Community/Business Leader

No clinic. – Physician

Lack of providers and facilities. – Physician

Affordable Care/Services

It takes some work and assistance to get into a substance abuse program. Specifically, they all cost money. There are programs and agencies that will assist with the fee, but you really have to want to quit to jump through all the hoops. – Community/Business Leader

I think that for many people, the barrier that keeps them from accessing treatment is the fact that they cannot afford to pay for their treatment, and they do not know of the available resources that they can access on a sliding scale or no cost. – Community/Business Leader

Lack of money or insurance, and they like the drugs. – Community/Business Leader

Money and desire. – Community/Business Leader

A lack of services, low income or otherwise. – Social Services Provider

Health Education

Alcoholism is a rampant problem. We need more public education as to what excessive drinking is. Current thinking is that more than five alcoholic beverages in a week is excessive drinking. – Physician

The disease itself. Also that the general public is not aware of local resources or treatment locations. – Community/Business Leader

A general public social ignorance of individual mental health as a reflection of social mental health, social conditions, economic conditions, community conditions. There is a "take a hammer and fix it" view of mental and medical health. – Community/Business Leader

Lack of understanding of what is occurring with substance abuse prevalence in our community and society. – Community/Business Leader

Availability

Access to the drugs, alcohol and pain medication is too easy. They do not want to seek the help they need from the health center. – Community/Business Leader

Easy access. – Community/Business Leader

High level of substance abuse, very readily available. – Community/Business Leader

Addiction

Addiction, funding, lifestyles. – Community/Business Leader

Addictive nature of substance abuse. Clients frequently lack the knowledge of where to go for treatment, and lack the motivation to follow-through with treatment programs. – Community/Business Leader

Prevalence/Incidence

This area seems to have more drug use than other areas of the state or neighboring states. The biggest problem seems to be meth, a real destroyer of health and wellness. – Community/Business Leader

Rampant, as in many communities. The resurgence of heroin addiction is particularly troubling. – Physician

Social Norms

The people that surround the abuser, family and friends. The drug culture of communities have a vested interest in keeping people hooked. – Community/Business Leader

Social culture of prison sentencing instead of rehab and community service. – Other Health Provider

Impact on Quality of Life

It kills dreams and ruins lives and families. – Community/Business Leader

Legal System

> *The legal system. – Physician*

Most Problematic Substances

Key informants (who rated this as a "major problem") identified **alcohol** as the most problematic substance abused in the community, followed by **methamphetamines/other amphetamines, prescription medications**, and **heroin/other opioids**.

	Most Problematic	Second-Most Problematic	Third-Most Problematic	**Total Mentions**
Alcohol	40.5%	24.4%	22.0%	**36**
Methamphetamines or Other Amphetamines	31.0%	22.0%	12.2%	**27**
Prescription Medications	7.1%	22.0%	29.3%	**24**
Heroin or Other Opioids	16.7%	12.2%	24.4%	**22**
Marijuana	2.4%	7.3%	4.9%	**6**
Cocaine or Crack	2.4%	4.9%	2.4%	**4**
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	0.0%	4.9%	2.4%	**3**
Over-The-Counter Medications	0.0%	2.4%	0.0%	**1**
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	0.0%	2.4%	**1**

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

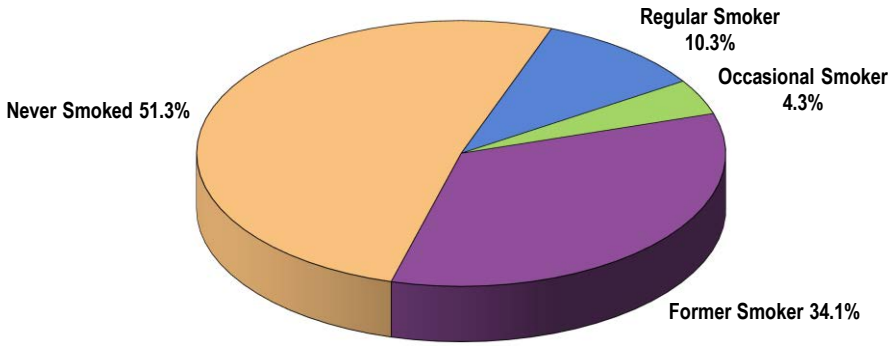
- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 14.6% of Primary Service Area adults currently smoke cigarettes, either regularly (10.3% every day) or occasionally (4.3% on some days).

Cigarette Smoking Prevalence
(Primary Service Area, 2016)

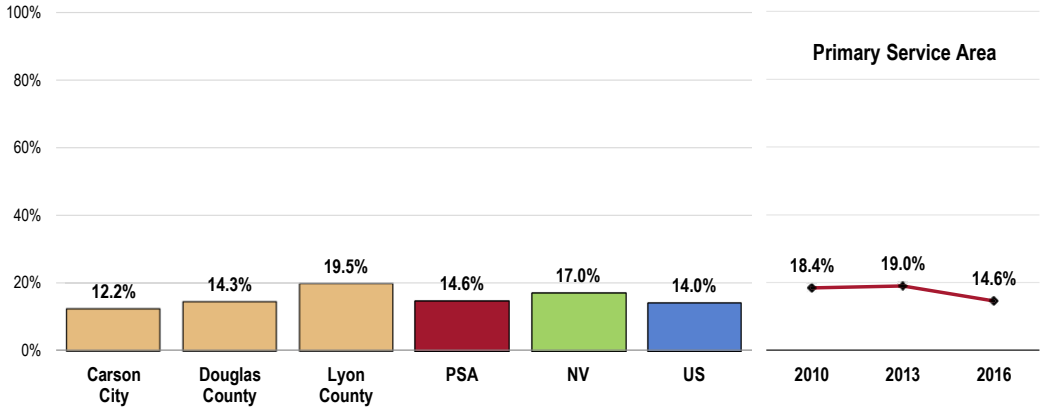


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
Notes: Asked of all respondents.

- Similar to statewide and national findings.
- Fails to satisfy the Healthy People 2020 target (12% or lower).
- Statistically s imilar findings by area.
- TREND: The current smoking percentage has decreased significantly since 2013.

Current Smokers

Healthy People 2020 Target = 12.0% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

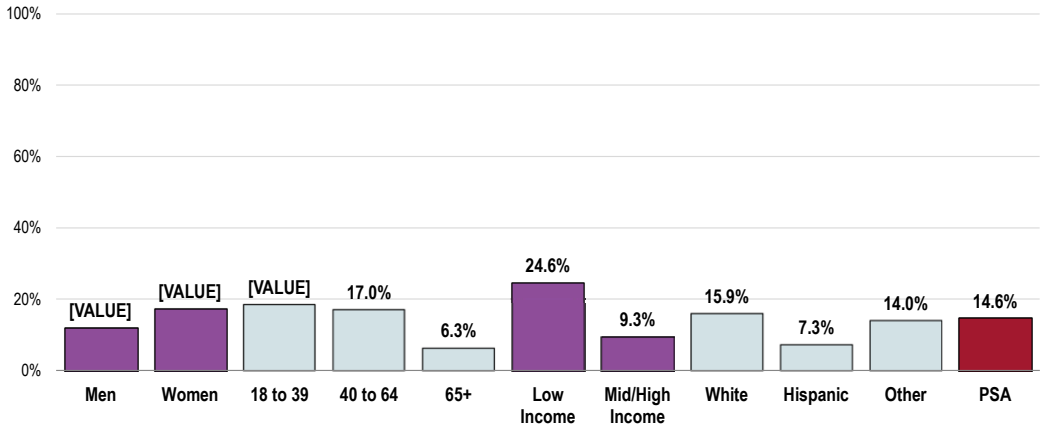
Notes: Asked of all respondents.
Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

- Cigarette smoking is more prevalent among women, adults under 65 (negative correlation with age), lower-income residents (especially), and Whites.

Current Smokers

(Primary Service Area, 2016)

Healthy People 2020 Target = 12.0% or Lower



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

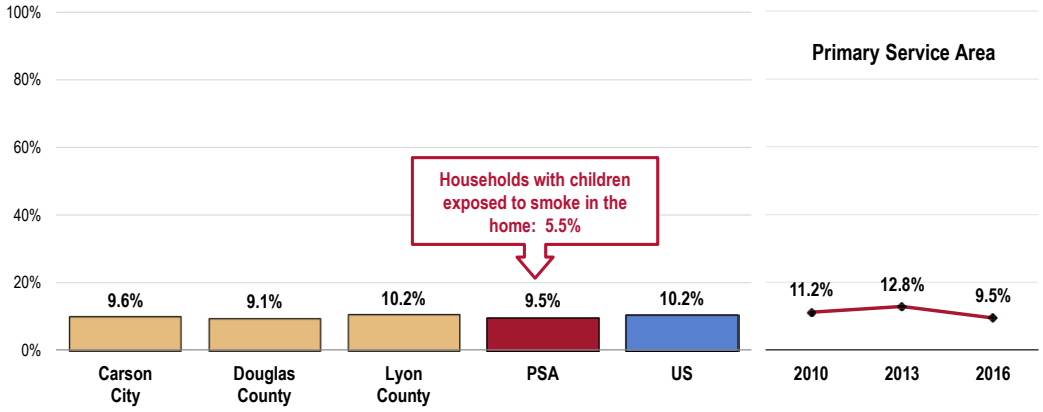
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.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

Environmental Tobacco Smoke

A total of 9.5% of Primary Service Area adults (including smokers and nonsmokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Comparable to national findings.
- Comparable findings by area.
- TREND: Statistically unchanged over time.
- Note that 5.5% of Primary Service Area children are exposed to cigarette smoke at home, similar to what is found nationally.

Member of Household Smokes at Home

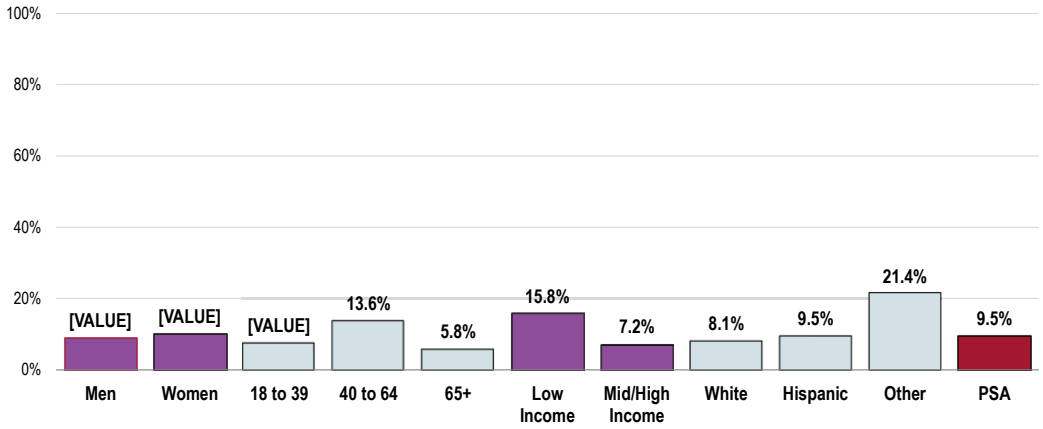


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 58, 184]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
"Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among residents age 40 to 64, those with lower incomes, and Other races.

Member of Household Smokes At Home

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
"Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for

Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

- Healthy People 2020 (www.healthypeople.gov)

Smoking Cessation Attempts

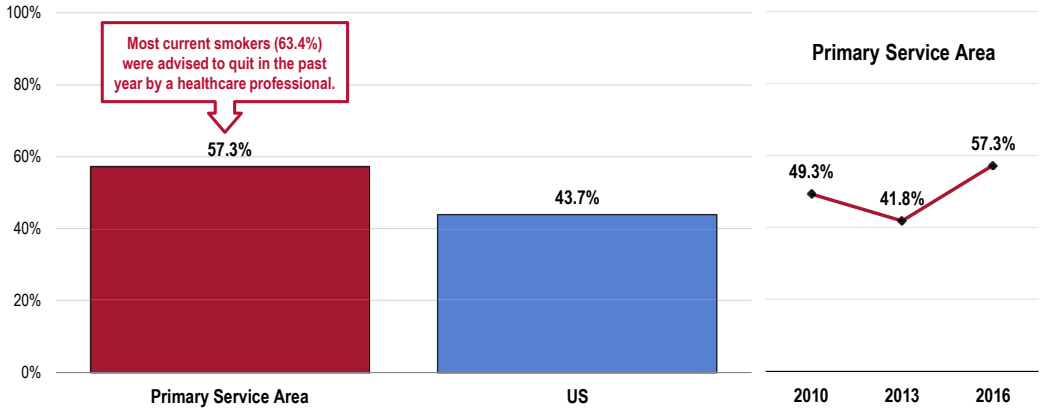
More than half of regular smokers (57.3%) went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).
- TREND: No statistically significant change from 2010 survey results, but increasing significantly from the 2013 percentage.
- Most current smokers (63.4%) have been advised by a healthcare professional in the past year to quit smoking.

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers)

Healthy People 2020 Target = 80.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 56-57]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-4.1]
Notes: Asked of respondents who smoke cigarettes every day.

Interest in Cessation Classes

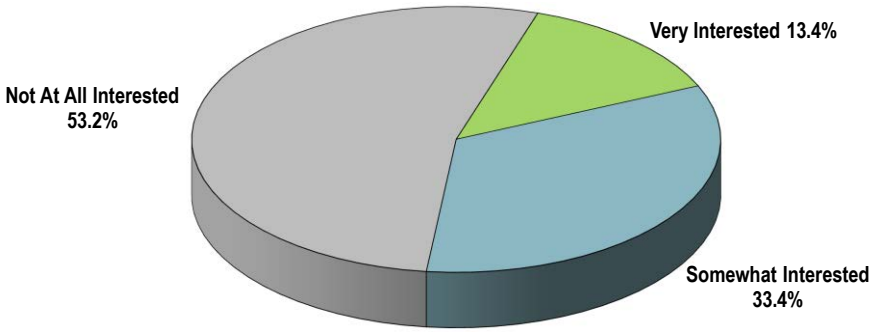
Among Primary Service Area smokers, over half (53.2%) are "not at all interested" in "Freedom from Smoking" classes.

- On the other hand, one-third (33.4%) are "somewhat interested," and 13.4% of area

smokers are “very interested” in the cessation classes.

Level of Interest in “Freedom from Smoking” Classes

(Among Primary Service Area Smokers)

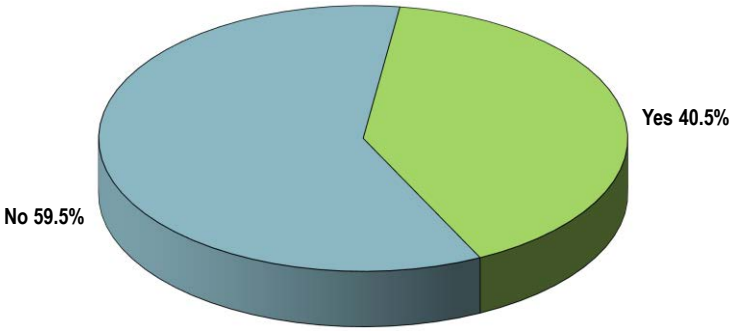


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 307]
Notes: Asked of all smokers.

Awareness of the Nevada Quitline

A total of 6 in 10 local smokers (59.5%) were <u>not</u> aware of the Nevada Quitline before the survey was conducted.

Awareness of Nevada Quitline Before Today
(Among Primary Service Area Smokers)



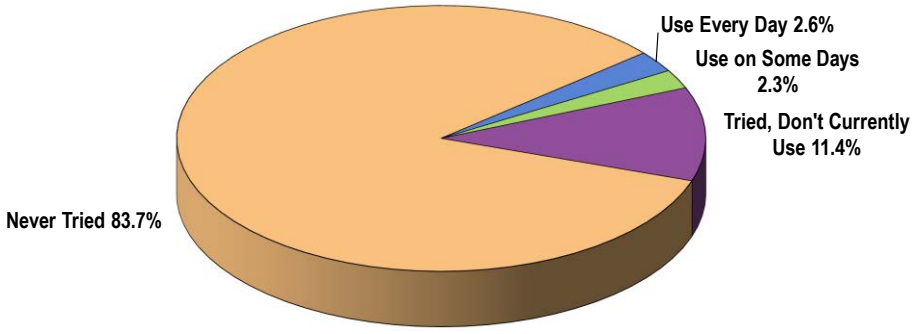
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]
Notes: Asked of all smokers.

Other Tobacco Use

Electronic Cigarettes

A total of 4.9% of Primary Service Area adults currently use electronic cigarettes ("e-cigarettes"), either regularly (2.6% every day) or occasionally (2.3% on some days).

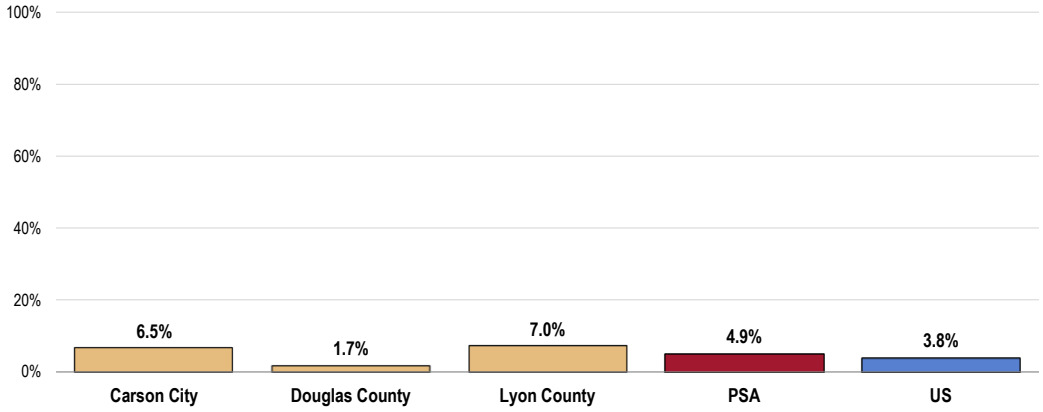
Electronic Cigarette Use
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
Notes: Asked of all respondents.

- Similar to national findings.
- Favorably low in Douglas County.

Currently Use Electronic Cigarettes
(Every Day or on Some Days)

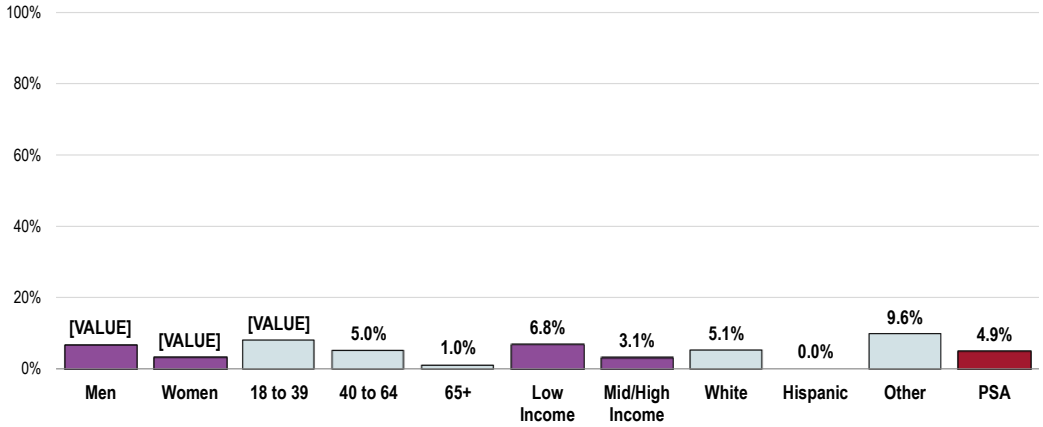


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Electronic cigarette use is more prevalent among:

- Men.
- Adults under 65 (negative correlation with age).
- Whites and Other races.

Currently Use Electronic Cigarettes
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Asked about their primary reason for using e-cigarettes, most mentioned **trying to quit smoking**. Other reasons mentioned include **try something new or are curious**, use them to **smoke where smoking is banned**, **save money**, and **reduce their own cigarette use**.

Smokeless Tobacco

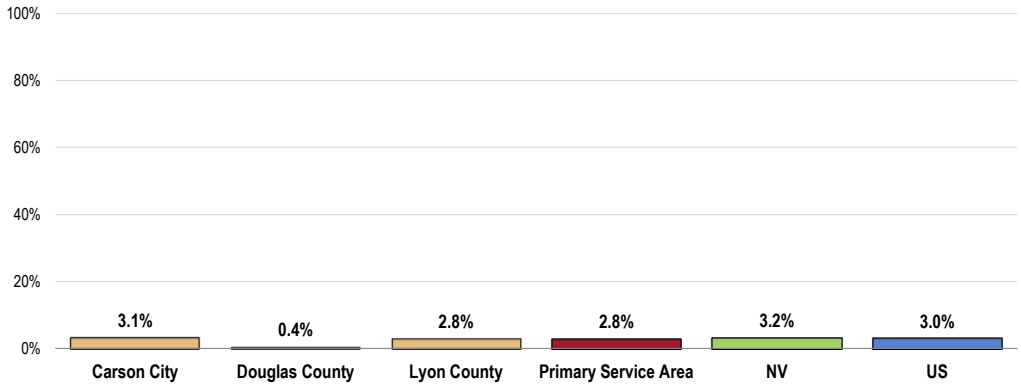
Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 2.8% of Primary Service Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to the state and national percentages.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- Favorably low in Douglas County.

Smokeless Tobacco Use

Healthy People 2020 Goal = 0.3% or Lower



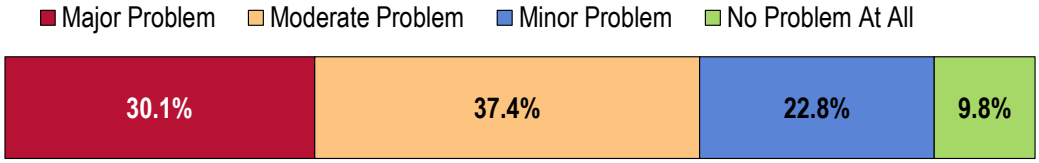
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control

Key Informant Input: Tobacco Use

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

Perceptions of Tobacco Use as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Prevalence/Incidence

Many patients smoke. – Physician

Too many people smoke and suffer the long term health consequences that affect us all in the increased healthcare spending. – Physician

Very high use, in part because of the casino environment. – Community/Business Leader

I believe that tobacco use is a problem because I see a great number of people smoking. I also have seen a lot of teens smoking. – Community/Business Leader

High rate of smoking in Nevada. – Community/Business Leader

Smoking is still very prevalent here in comparison to a lot of other communities. – Community/ Business Leader

As a hospital-based Internal Medicine physician, I see the consequences of this all day, every day. – Physician

Too many smoke, and especially in the casinos. Also even though the national trend is for youth addiction to decline, our local area does not seem to see this result. – Community/Business Leader

Too many smokers. – Physician

Volume of cigarettes sold, number of tobacco/vapor stores. – Community/Business Leader

You still see so many people smoking and spending so much money on tobacco products. – Community/Business Leader

High percentage of smokers and high teenage rate. Need to eliminate hookah lounges. – Physician

Way too many smokers and so many young adults picking up the bad habit. – Community/Business Leader

It seems that a much higher percentage of the people I meet in Carson City are smokers. – Community/Business Leader

This problem never seems to go away. – Community/Business Leader

Addiction

It's an addiction, like all drugs. Homeless people will buy tobacco or alcohol before they eat. – Social Services Provider

The habit is very difficult to overcome. – Community/Business Leader

Students use it, parents use it. It is addicting, bad for your health, and does not model desired habits from our youth. – Community/Business Leader

Social Norms

Elder Nevadans grew up not knowing how bad smoking is and find it very difficult to quit. Nevada is more smoker-friendly than some states because of the casino and gaming industry. Smoking causes illness and poor health in all areas of the body. – Community/Business Leader

I feel people think using tobacco is cool, it's too easy to get hooked once you start, and hard to stop. Secondhand smoke is just as dangerous. Having a parent that smokes makes it look like an adult activity that makes you cool. – Community/Business Leader

I see young kids smoking, it seems to be the "cool thing" to do. – Community/Business Leader

Leading Cause of Death

It kills people, it stinks. It can kill or injure people who are around it and not even smoking. – Community/Business Leader

Use of cigarettes and other tobacco products is a leading cause of severe and preventable health problems in Nevada and across the US – Social Services Provider

E-Cigarettes

Vaping has become widely popular and advertised as a safer alternative to smoking as well as being a tool for quitting. However studies are showing that vaping is in some cases more dangerous. Need education on the subject particularly to youth. – Social Services Provider

Casinos

Casinos. – Community/Business Leader

Comorbidities

This is the primary cause of COPD. COPD is one of the top three causes of death and disability in the USA. – Physician

Access to Health Services

Professional Research Consultants, Inc.

Health Insurance Coverage

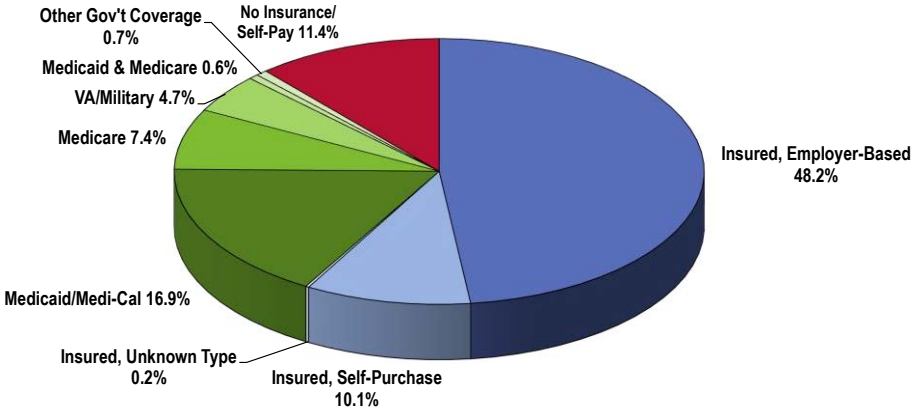
Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 58.5% of Primary Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 30.3% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults Age 18-64; Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
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 healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

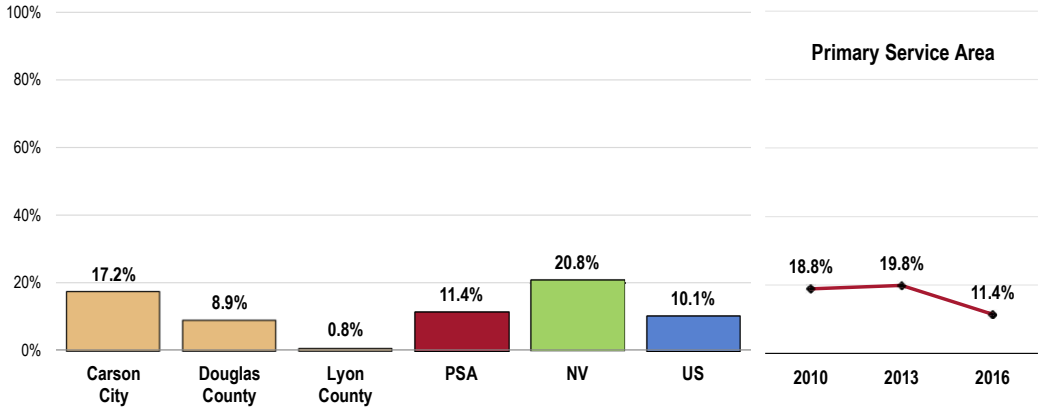
Among adults age 18 to 64, 11.4% report having no insurance coverage for healthcare expenses.

- Below the latest state benchmark; note, however, that state data predate the implementation of the health insurance marketplace.
- Similar to the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Worst in Carson City.
- TREND: Marking a statistically significant decrease from 2013 survey findings.

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

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

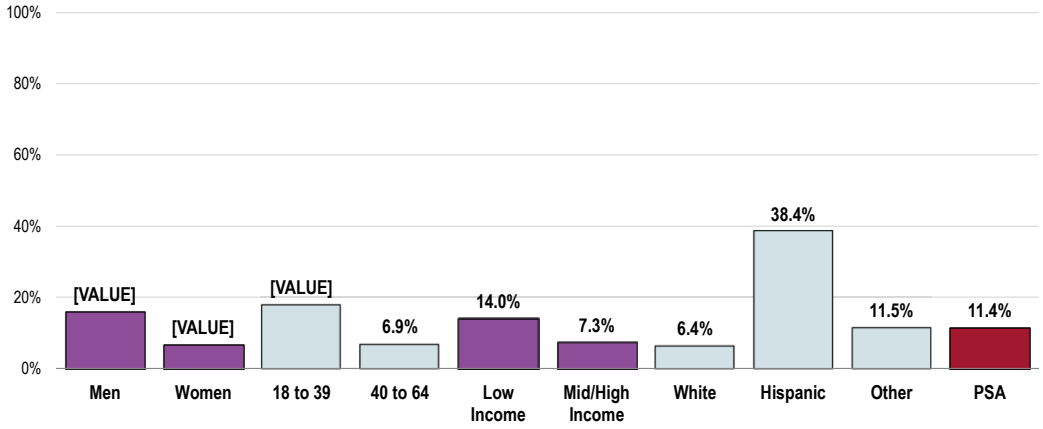
The following population segments are more likely to be without healthcare insurance coverage:

- Men.
- Young adults.
- Residents living at lower incomes.
- Hispanics (note the 38.4% uninsured prevalence).

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64; Primary Service Area, 2016)

Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

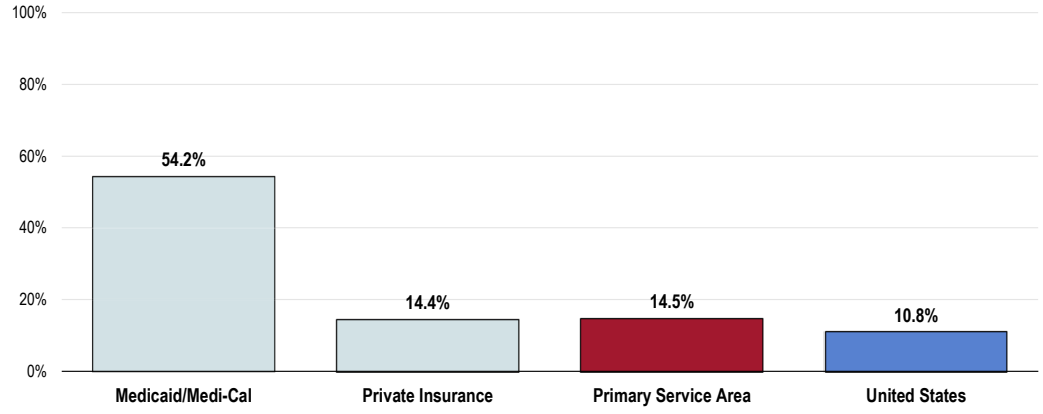
Notes: Asked of all respondents under the age of 65.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

A total of 14.5% of residents under 65 with private coverage or Medicaid secured their coverage under the Affordable Care Act (ACA), otherwise known as "Obamacare."

- Higher than the national finding.
- Note the 54.2% of affirmative responses among adults with Medicaid compared with privately insured individuals (14.4%).

Insurance Was Secured Under the Affordable Care Act/"Obamacare"

(Among Insured Adults, By Type of Coverage; 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 84]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents under 65 with private insurance or Medicaid.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 (www.healthypeople.gov)

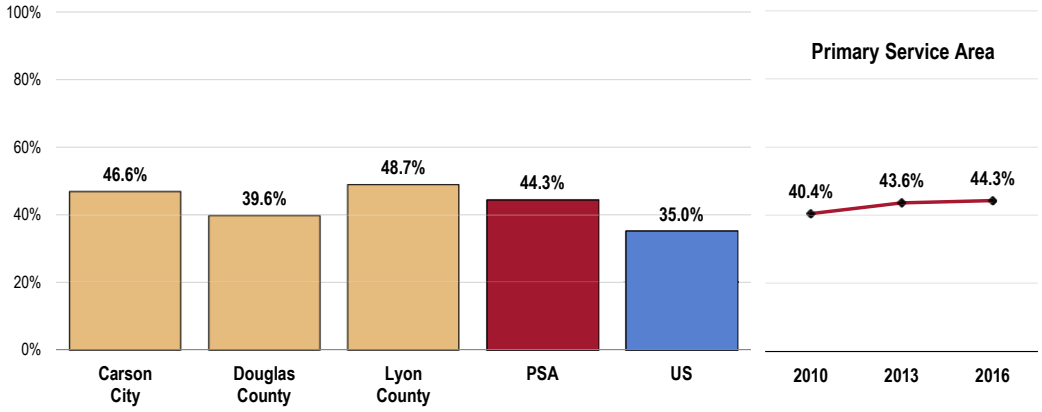
Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 44.3% of Primary Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Less favorable than national findings.
- Lower in Douglas County.
- TREND: Statistically unchanged over time.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



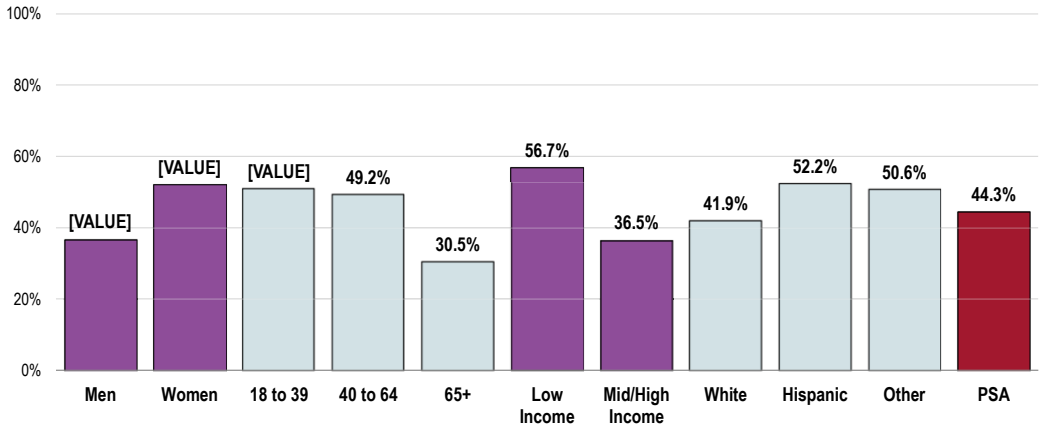
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults under the age of 65.
- Lower-income residents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
Notes: Asked of all respondents.
Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Barriers to Healthcare Access

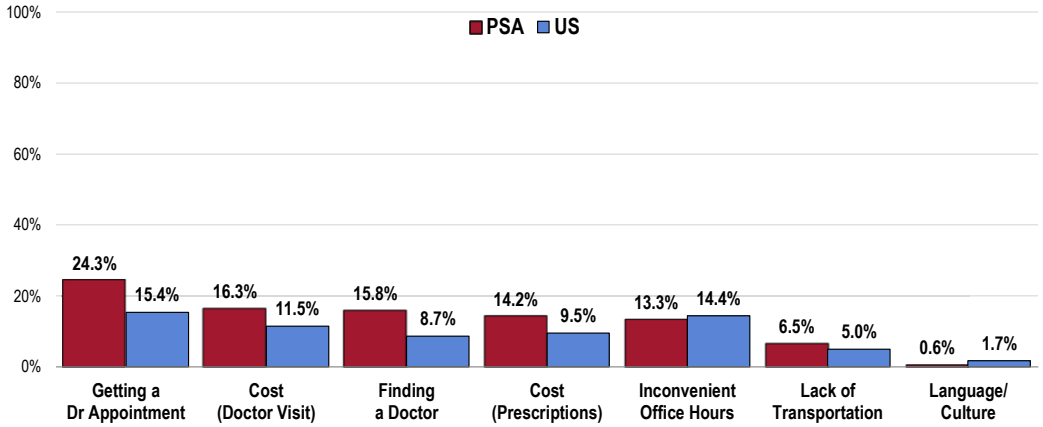
Of the tested barriers, difficulty getting a doctor's appointment impacted the greatest share of Primary Service Area adults (24.3% say that difficulty getting an appointment prevented them from medical care in the past year).

- The proportion of Primary Service Area adults impacted was statistically worse than that found nationwide for cost (doctor visits and prescriptions), getting appointments, and finding physicians.

To better understand healthcare 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



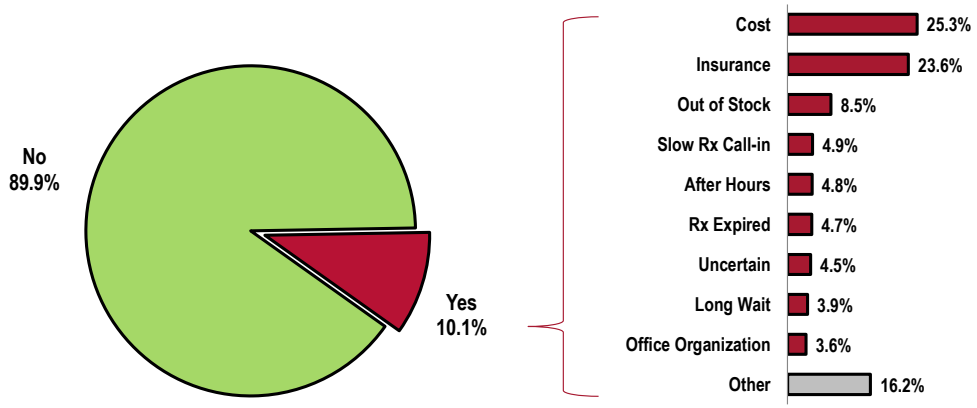
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Prescriptions

Asked if anything other than cost prevented them from obtaining prescription medication in the past year, 10.1% of survey respondents answered affirmatively.

- While one-fourth of these respondents reiterated the problem of cost as a barrier, other barriers mentioned included insurance, prescriptions being out of stock, slow prescription call-in, an after-hours situation, an expired prescription, long waits, and a lack of office organization.

Reason (Other Than Cost) That Prevented Prescription Medication in the Past Year

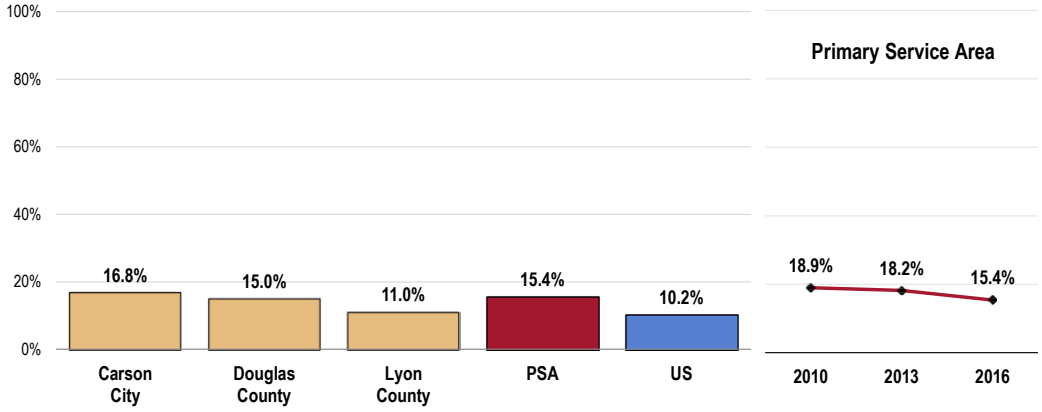


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 301-302]
Notes: Asked of all respondents.

Among all Primary Service Area adults, 15.4% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Less favorable than national findings.
- Similar by area.
- TREND: Statistically similar to previous findings.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



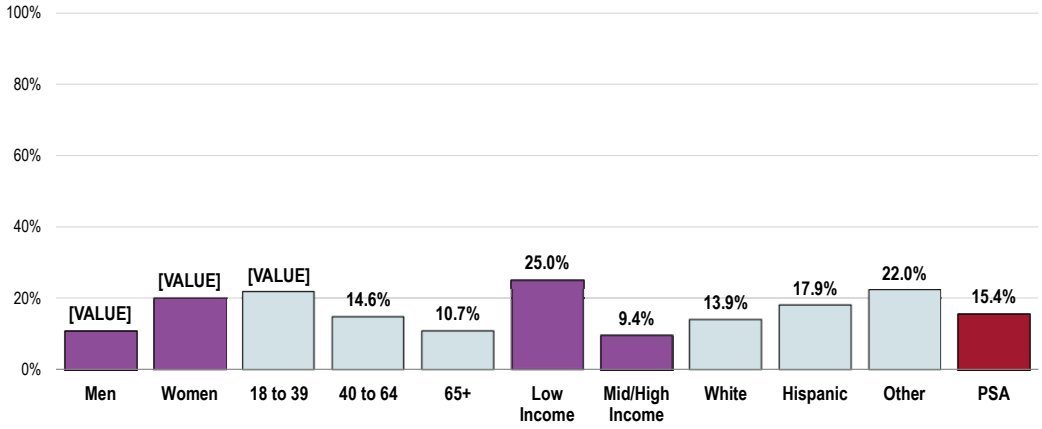
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Women.
- Adults under 65 (negative correlation with age).
- Respondents with lower incomes.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

A total of 6.2% of parents say there was a time in the past year when they needed

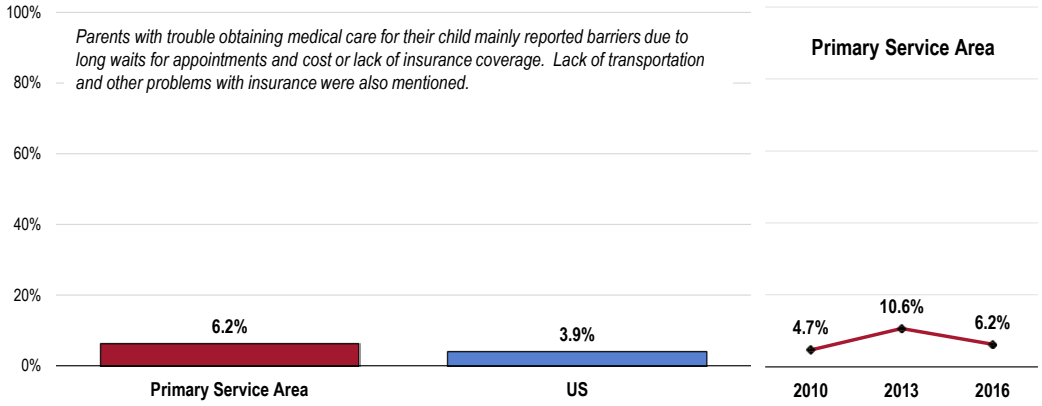
Surveyed parents were also asked if, within the past year, [illegible] randomly selected child in their household.

medical care for their child, but were unable to get it.

- Statistically similar to what is reported nationwide.
- TREND: Statistically unchanged from previous survey findings.

Had Trouble Obtaining Medical Care for Child in the Past Year

(Among Parents of Children 0-17)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 136-137]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

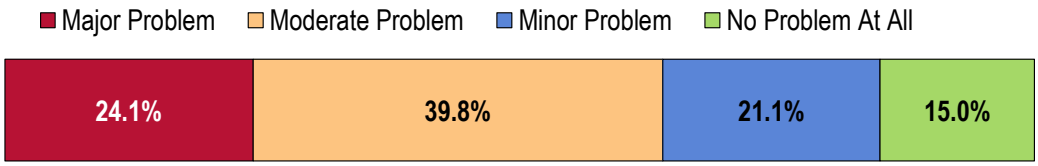
Among the parents experiencing difficulties, the majority cited **long waits for appointments** and **cost or a lack of insurance** as the primary reason; others cited lack of **transportation** and **other problems with insurance**.

Key Informant Input: Access to Healthcare Services

Key informants taking part in an online survey most often characterized *Access to Healthcare Services* as a "moderate problem" in the community.

Perceptions of Access to Healthcare Services as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Access to Providers

I feel having general practice doctors available to take new patients. People in the office are not able to find doctors that take new patients. – Community/Business Leader

Getting an appointment with a primary care physician, especially if you are covered by Medicare, Medicaid or have no insurance. Additionally there are no doctors in Carson City that specialize in Geriatric Medicine. – Community/Business Leader

Not enough primary care doctors. – Physician

There are seemingly not enough general practitioners for a community of our size. Insurance acceptance seems to be an issue as well. – Community/Business Leader

Lack of primary care for all ages, but especially Medicare age. – Physician

The lack of available primary care doctors to accommodate the increasing population of Medicare and Obamacare patients. – Physician

We need more primary care. We also need a health clinic for the underserved. – Physician

Inadequate number of primary care providers. – Physician

Limited number of providers in primary care and specialties. Wait times for new patients to be seen, especially depending on insurance coverage. VA patients have to go to Reno. Specialty care gets referred to Reno or CA. Transportation to out of area. – Social Services Provider

Recruiting and retaining providers and staff for our facility. – Community/Business Leader

Not enough providers. – Community/Business Leader

Primary care providers. – Physician

Lack of adequate subspecialty practitioners in endocrinology, rheumatology, neurology, and pediatric nephrology. – Physician

Access to Care/Services

Access to quality mental health services for children and adults. – Community/Business Leader

Medical expertise, transportation, affordability. – Other Health Provider

The distance to the facilities, as well as sufficient funding to pay for services. Also, a lack of knowledge about healthcare services contributes to the problem. – Community/Business Leader

Lack of access to services. Financial problems keep people from getting the care that they need. Additionally, frail seniors can no longer drive and need transportation to access services. – Community/Business Leader

Dialysis services are available, yet MD/ Vascular surgeons are slow in scheduling, which patients require for best demonstrated practice/safe care. Limited/ poor Mental Health services for varying insurance. Limited/poor transportation options. – Other Health Provider

Douglas is one of the wealthiest counties in the US, and has excellent access to services. Carson has moderate access. – Social Services Provider

The Emergency Department physicians and nurses are great, but they have such limited resources and shortages. A small investment into the Emergency Department would have major ramifications on flow and community satisfaction. – Physician

Attending to the Medicare population and lacking primary care assets. Some not accepting Medicare. Poor behavioral health/psychiatry assets and provider counts. – Physician

Referring patient that have Medicaid to specialist is a major issue in our community. Not a lot of providers are accepting Medicaid patients making it difficult. – Other Health Provider

Lack of insurance; lack of providers. – Physician

Affordable Care/Services

Even with health insurance, the cost remains too high for many to be able to access medical services. For those with Medicaid, there are too few doctors that will accept it. Our clients end up in the ER for minor issues because they cannot get a GP. – Social Services Provider

There are still many uninsured people and providers who don't all take Medicaid as payment. In addition, Medicaid payments aren't always enough to cover treatment costs. – Community/Business Leader

There are a lot of people who are unable to access healthcare in the community because they can't afford to pay for it. More and more doctors are not taking on new patients, and the wait times at the urgent care facilities are very long. – Community/Business Leader

Cost and access. – Physician

Costs. Total out-of-pocket is never explained well, and people are surprised by what they still must pay, even with insurance. – Community/Business Leader

Transportation/Distance

Transportation, lack of local providers. – Community/Business Leader

Transportation and finances. – Community/Business Leader

Outlying communities have to travel a good distance to get health care. Sometimes families don't have a reliable mode of transportation. Also a general lack of health insurance. – Community/Business Leader

Vulnerable Populations

The biggest challenge for the Latino population is that many are undocumented, and they cannot get any type of health care services. – Community/Business Leader

Having enough wraparounds for the person with disabilities. If they get hurt before Medicare kicks in, they have to use the hospital to get treatment. It is hard for this age group to get SSD, and they need to still get treatment. – Social Services Provider

Lack of Preventative Care

Lack of preventative care, basic information about lifestyle, diet, exercise and healthy social and family connections. Ensuing from that, lack of holistic approaches to treatment, integrating diet, exercise, social and family connection into medical. – Community/Business Leader

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified **mental health care, primary care, and substance abuse treatment** as the most difficult to access in the community.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	**Total Mentions**
Mental Health Care	39.3%	16.0%	33.3%	**23**
Primary Care	39.3%	12.0%	12.5%	**17**
Substance Abuse Treatment	0.0%	16.0%	20.8%	**9**
Elder Care	3.6%	12.0%	12.5%	**7**
Specialty Care	3.6%	12.0%	8.3%	**6**
Dental Care	10.7%	8.0%	0.0%	**5**
Chronic Disease Care	0.0%	12.0%	8.3%	**5**
Urgent Care	3.6%	4.0%	4.2%	**3**
Pain Management	0.0%	4.0%	0.0%	**1**
Palliative Care	0.0%	4.0%	0.0%	**1**

Health Literacy

Understanding Health Information

Written & Spoken Information

Respondents were read:

"You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor's office, in clinics, and many other places.

How often is health information **written** in a way that is easy for you to understand?

How often is health information **spoken** in a way that is easy for you to understand?"

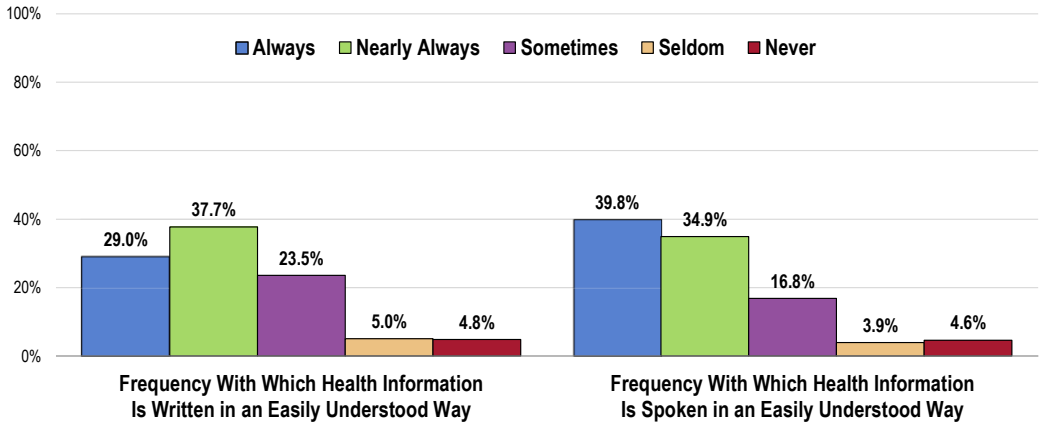
When asked about the frequency with which health information is written in an easily understood way, 66.7% of Primary Service Area adults said "always" or "nearly always."

- On the other hand, 33.3% of Primary Service Area adults consider **written** health information to be difficult to understand, including 4.8% who gave "never" reports.

When asked about spoken health information, 74.7% stated that this is "always" or "nearly always" easy for them to understand.

- On the other hand, 25.3% of Primary Service Area adults consider **spoken** health information to be difficult to understand, including 4.6% who gave "never" reports.

Understanding Health Information
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87, 89]
Notes: Asked of all respondents.

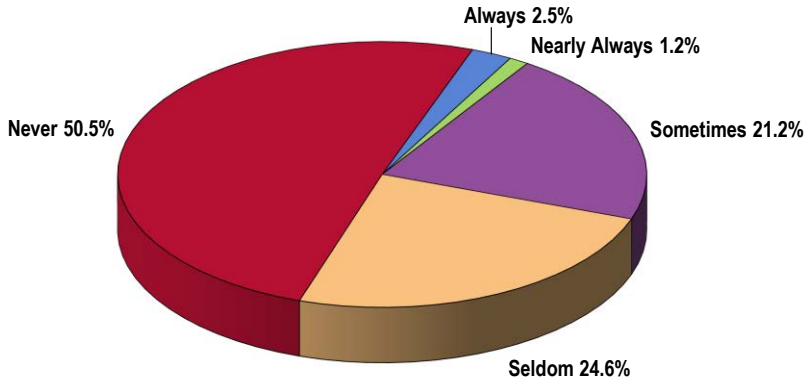
Help Reading Health Information

A total of 75.1% of Primary Service Area adults report "seldom" or "never" needing help reading health information.

- Another 21.2% of community adults "sometimes" need someone to help them read health information.
- Note that 3.7% of residents "always" or "nearly always" need help reading health information.

Frequency of Needing Someone to Help Read Health Information

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]
Notes: Asked of all respondents.

Completing Health Forms

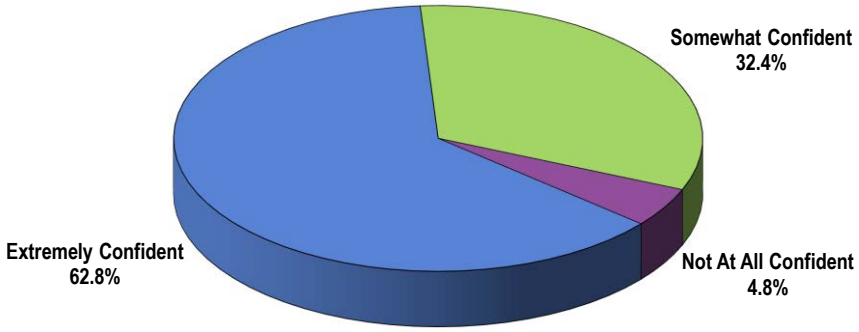
Asked to describe their confidence in filling out health forms, most survey respondents are "extremely confident" (62.8%).

Examples of health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

- Another 32.4% of Primary Service Area adults are "somewhat confident" in their own ability to fill out health forms.
- However, 4.8% of respondents gave "not at all confident" ratings.

Self-Perceived Confidence in Ability to Fill Out Health Forms

(Primary Service Area, 2016)



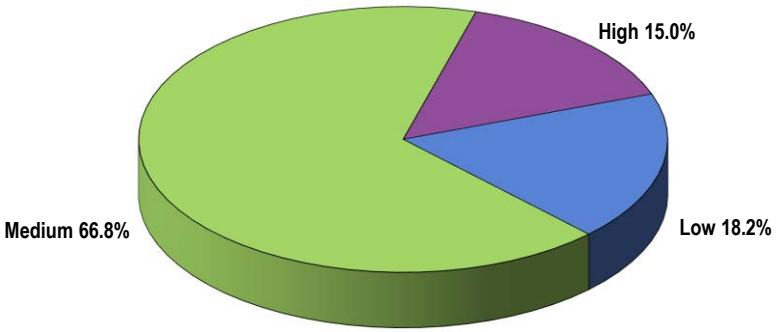
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 90]
Notes: Asked of all respondents.
In this case, health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

Population With Low Health Literacy

Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/ nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Among Primary Service Area survey respondents, 15.0% are considered to be of high health literacy, while 66.8% have medium health literacy, and the remaining 18.2% are considered to be of low health literacy.

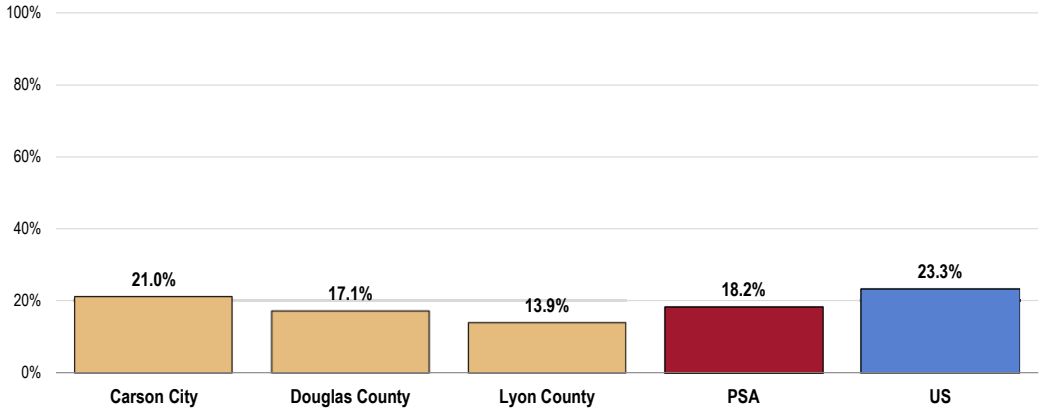
Level of Health Literacy
(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
Notes: Asked of all respondents.
Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

- The prevalence of Primary Service Area adults with low levels of health literacy is more favorable than the national average.
- Statistically similar by area.

Low Health Literacy

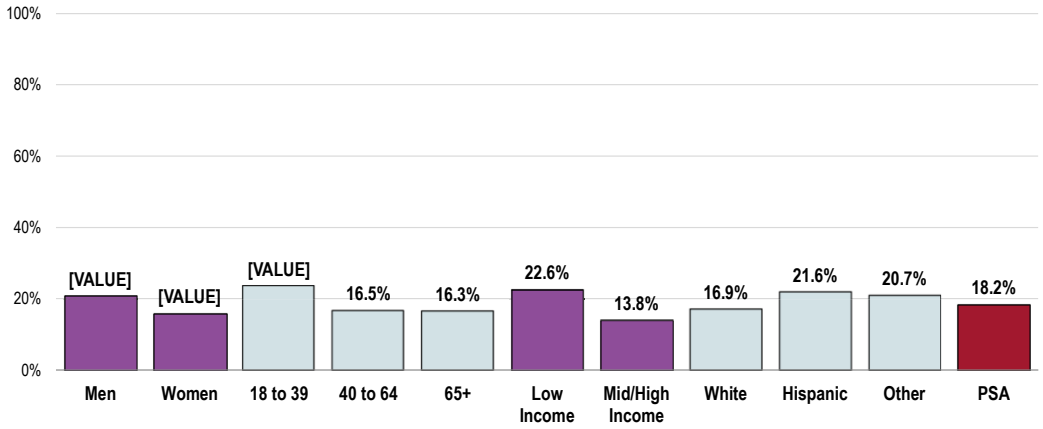


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

- Low-income residents are more likely to have low health literacy levels.

Low Health Literacy

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

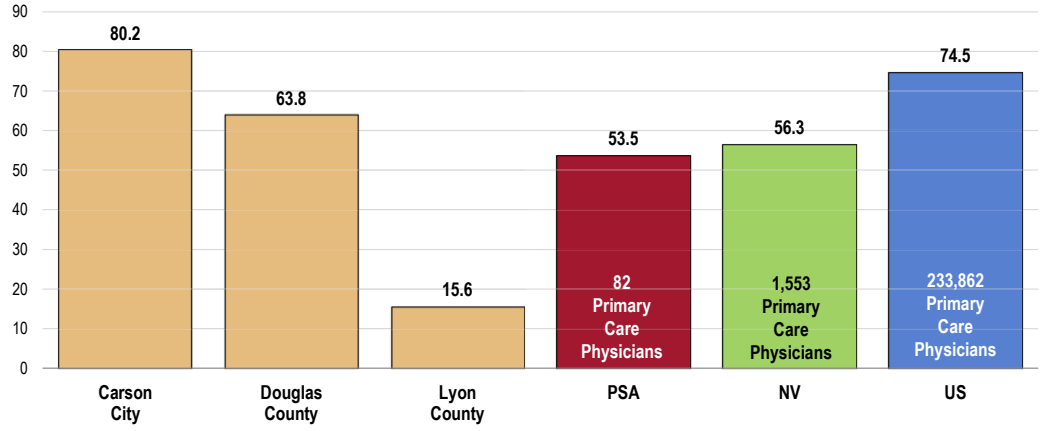
Access to Primary Care

In the Primary Service Area in 2012, there were 82 primary care physicians, translating to a rate of 53.5 primary care physicians per 100,000 population.

- Lower than the primary care physician-to-population ratio found statewide and well below that reported nationally.
- Unfavorably low in Lyon County.

Access to Primary Care

(Number of Primary Care Physicians per 100,000 Population, 2012)



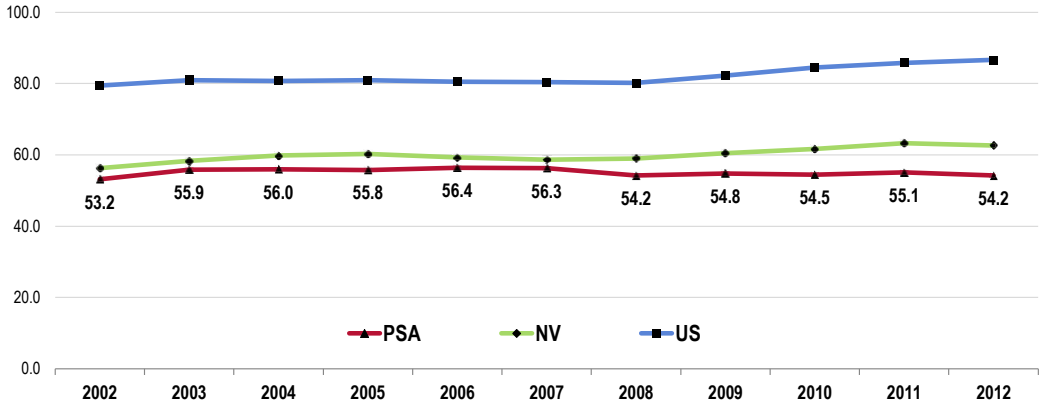
Sources: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2012. Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes: This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

- TREND: Access to primary care (in terms of the ratio of primary care physicians to population) has been largely stable over the past decade in the Primary Service Area.

Trends in Access to Primary Care

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



Sources: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2012. Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes: This indicator is relevant because a shortage of health professionals contributes to access and health status issues. These figures represent all primary care physicians practicing patient care, including hospital residents. In counties with teaching hospitals, this figure may differ from the rate reported in the previous chart.

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).

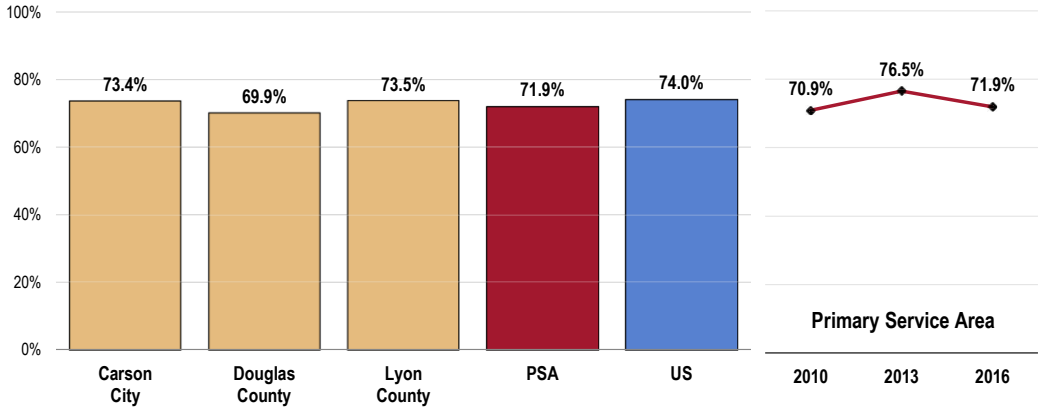
A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 71.9% of Primary Service Area adults were determined to have a specific source of ongoing medical care.

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 objective (95% or higher).
- Similar findings by area.
- TREND: Similar to 2010, but lower than 2013.

Have a Specific Source of Ongoing Medical Care

Healthy People 2020 Target = 95.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes: Asked of all respondents.

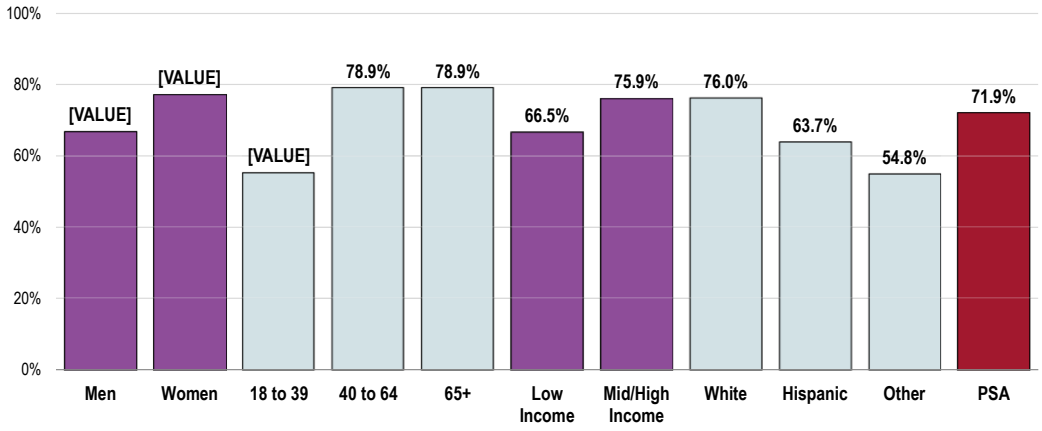
When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- Men.
- Adults under age 40.
- Lower-income adults.
- Hispanics and Other races.

Have a Specific Source of Ongoing Medical Care

(Primary Service Area, 2016)

Healthy People 2020 Target = 95.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

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

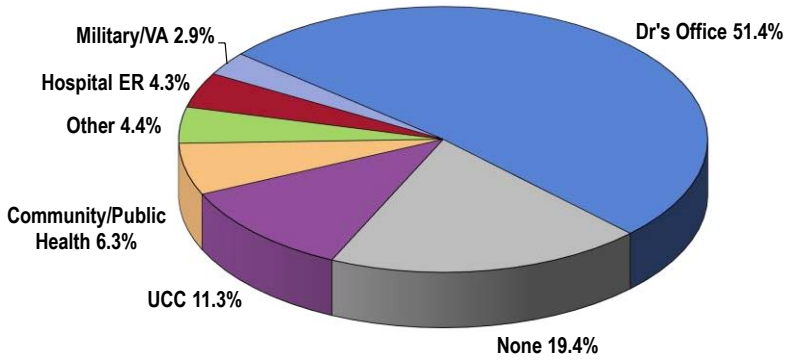
Site for Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (51.4%) identified a particular doctor's office.

A total of 11.3% usually go to an urgent-care clinic, and 6.3% use a community or public health facility. Note that 4.3% rely on a hospital emergency room for their medical care, and 2.9% use some type of military or VA site.

Particular Place Utilized for Medical Care

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 16-17]
Notes: Asked of all respondents.

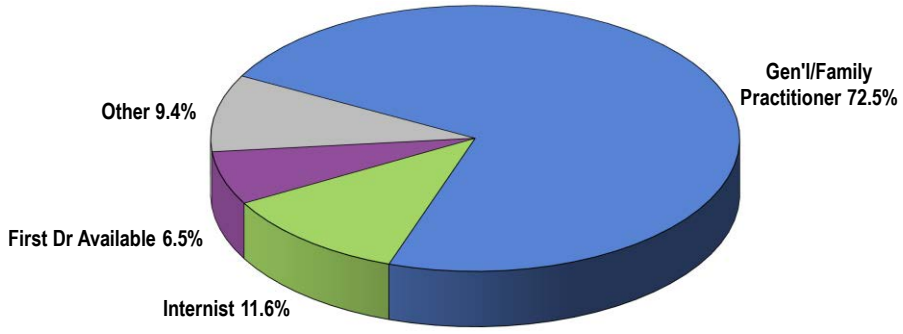
Type of Physician Utilized

Asked about the type of physician generally seen for their healthcare needs, most respondents mentioned a general or family practitioner (72.5%).

Fewer (11.6%) mentioned relying on an internist for their care, followed by mention of the "first available" doctor (6.5%).

Type of Physician Seen for General Healthcare Needs

(Adults Seeking Care in a Dr's Office, Public Health Clinic or Community Health Center, or Military/VA Facility; 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
Notes: Asked of all respondents who seek medical care in a doctor's office, public health clinic or community health center, or a military/VA facility.

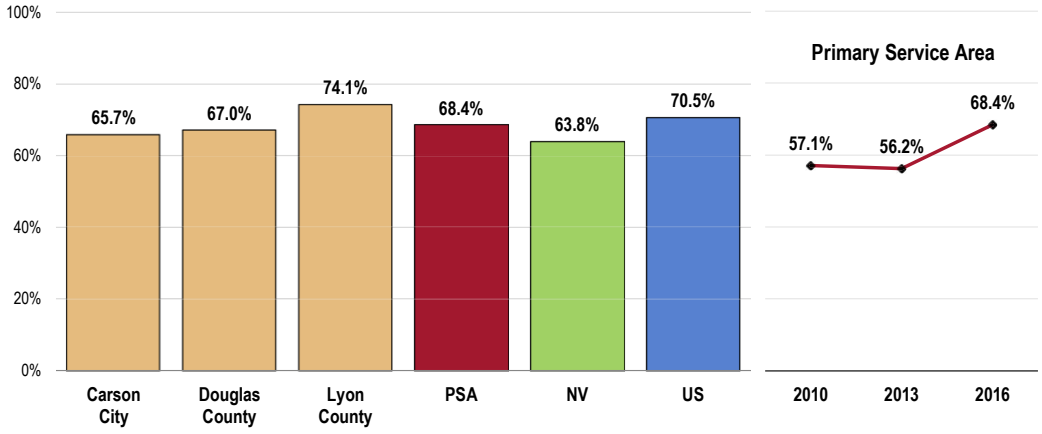
Utilization of Primary Care Services

Adults

Over 2 in 3 adults (68.4%) visited a physician for a routine checkup in the past year.

- More favorable than state findings.
- Comparable to national findings.
- Comparable by community.
- TREND: Denotes a statistically significant increase from previous survey findings.

Have Visited a Physician for a Checkup in the Past Year



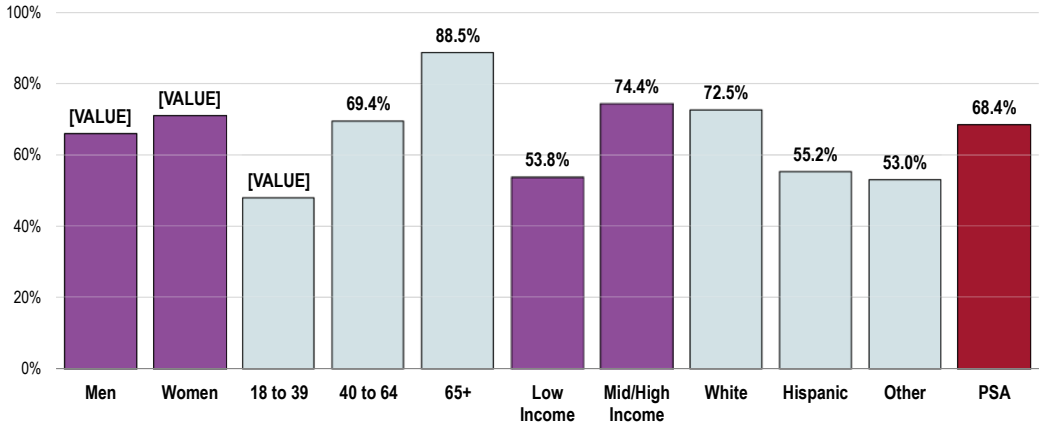
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

- Adults under age 40 are less likely to have received routine care in the past year (note the positive correlation with age).
- Note also the lower prevalence of routine checkups among adults in low-income households, Hispanics, and Other races.

Have Visited a Physician for a Checkup in the Past Year

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

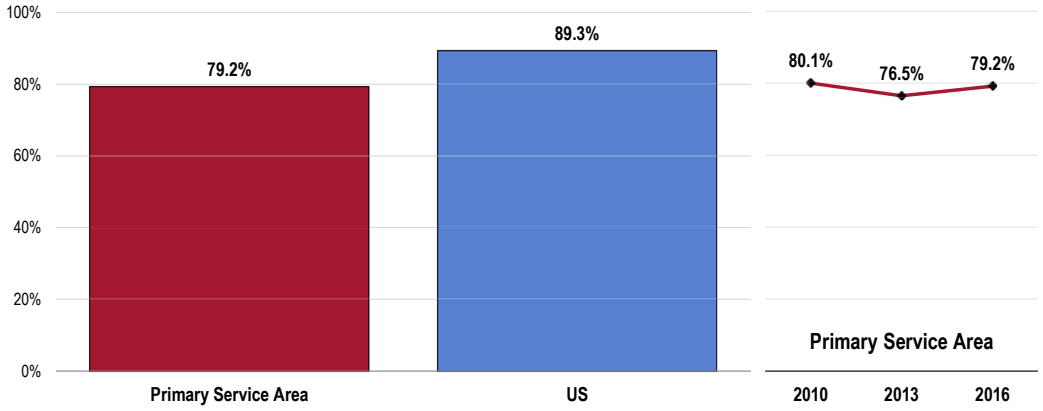
Children

Among surveyed parents, 79.2% report that their child has had a routine checkup in the past year.

- Lower than the US benchmark.
- TREND: Statistically unchanged over time.

Child Has Visited a Physician for a Routine Checkup in the Past Year

(Among Parents of Children 0-17)

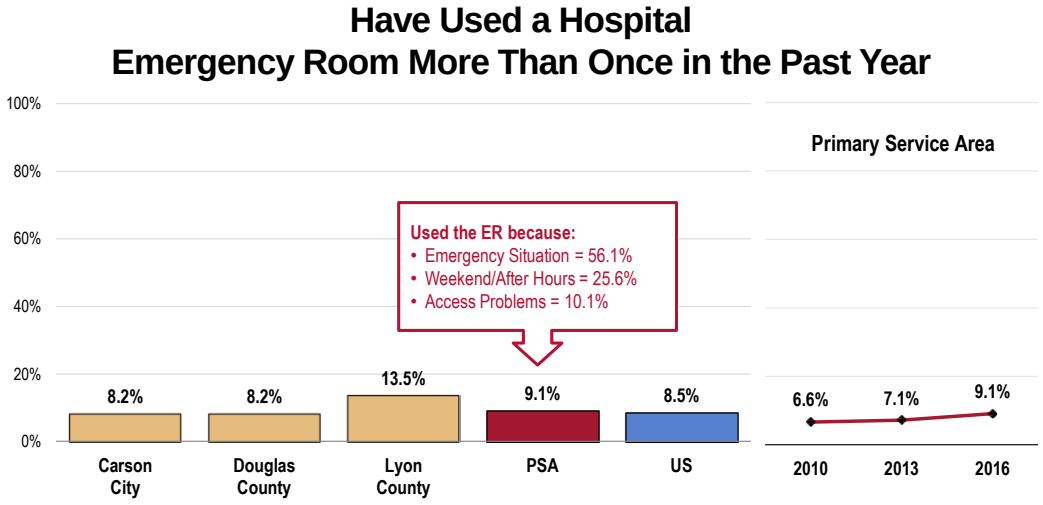


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 9.1% of Primary Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Comparable to national findings.
- Statistically comparable by area.
- TREND: Statistically unchanged over time.



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

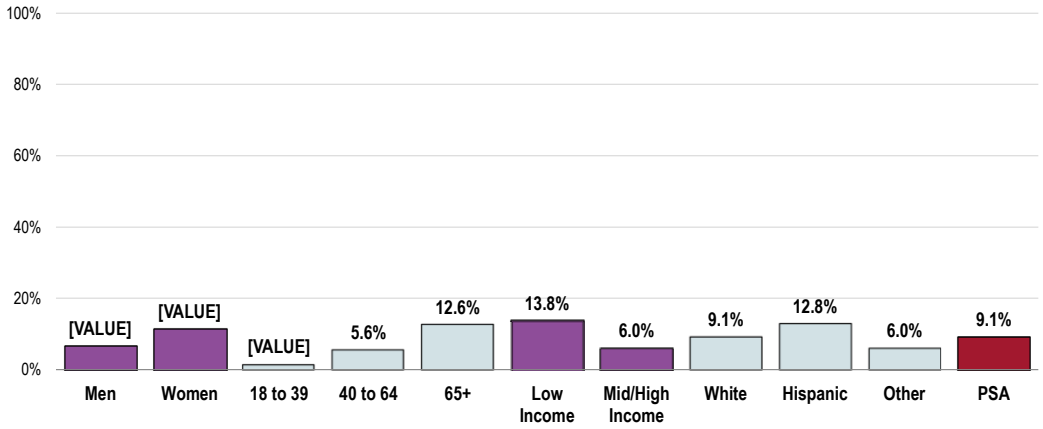
Of those using a hospital ER, 56.1% say this was due to an **emergency or life-threatening situation**, while 25.6% indicated that the visit was during **after-hours or on the weekend**. A total of 10.1% cited **difficulties accessing primary care** for various reasons.

These population segments are more likely to have used an ER for their medical care more than once in the past year:

- Women.
- Older adults (positive correlation with age).
- Low-income adults.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

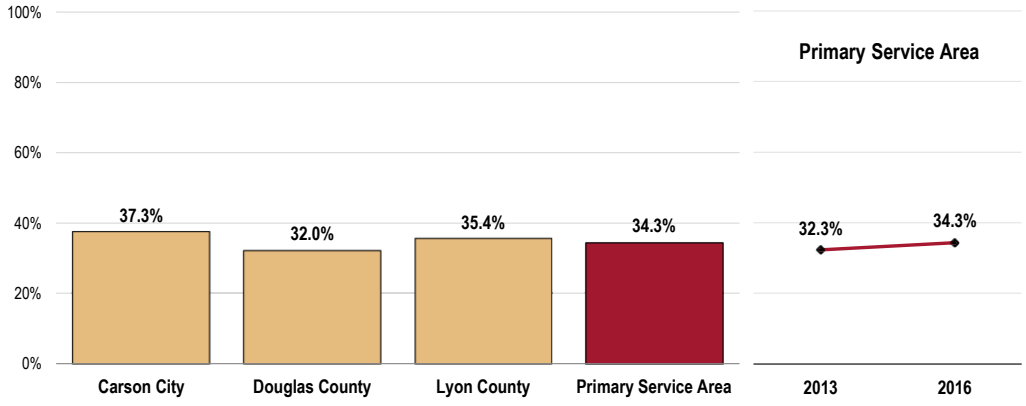
Inpatient & Long-Term Acute Care

Inpatient Care

A total of 34.3% of survey respondents report that they or a member of their household received <u>inpatient</u> care in the past 2 years.

- Similar findings by area.
- TREND: Statistically unchanged from 2013 survey findings.

Member of Household Received Inpatient Care in the Past 2 Years



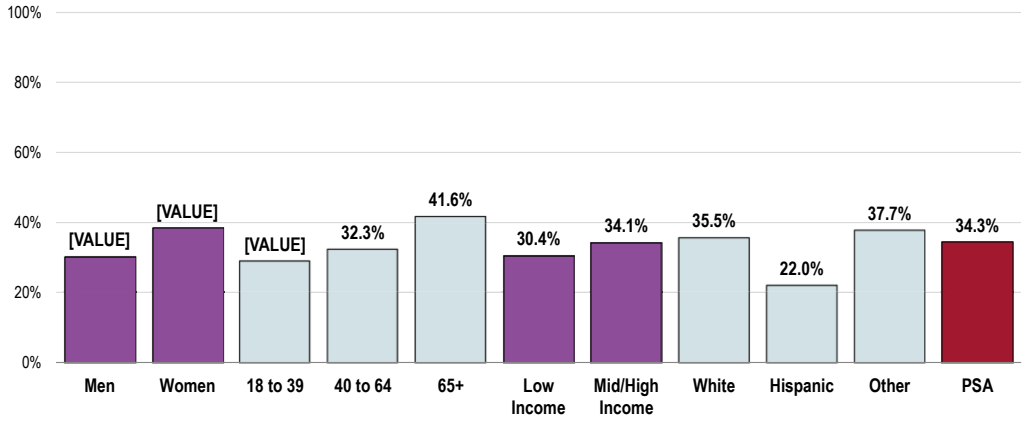
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 321]

Receipt of inpatient care by self or a household member is reported more often among:

- Women.
- Older adults (positive correlation with age).
- Whites and Other races.

Member of Household Received Inpatient Care in the Past 2 Years

(Primary Service Area, 2016)



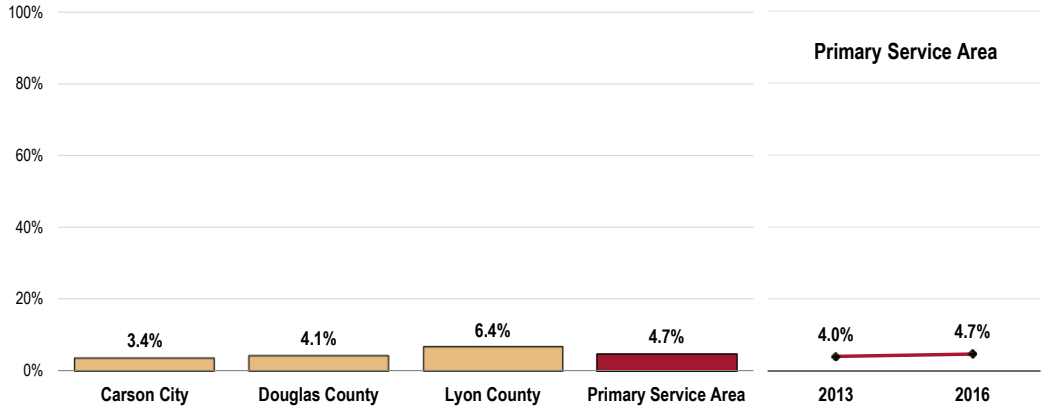
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 321]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households

Long-Term Acute Care

A total of 4.7% of Primary Service Area adults report that they or a member of their household received long-term acute care in the past 3 years.

- Similar findings by area.
- TREND: Statistically unchanged over time.

Member of Household Received Long-Term Acute Care in the Past 3 Years



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 322-323]
Notes: Asked of all respondents.

Of these adults, the greatest share received long-term care in **Carson City**, followed by **Reno**. Other cities mentioned include **Gardnerville**, **Amador City**, and **Sparks**.

Among those with household members receiving long-term acute care, the majority returned

home after their care, while others received further care at another **health facility**, and a few went to **another person's home** for recovery.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

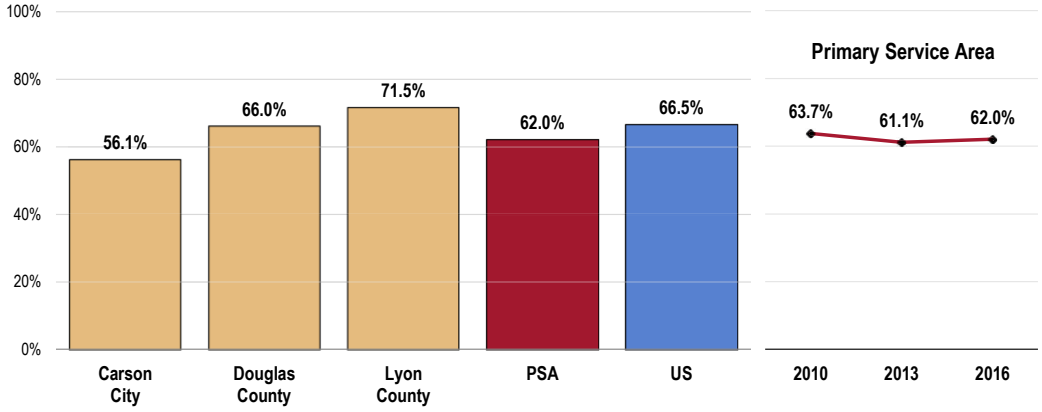
- Healthy People 2020 (www.healthypeople.gov)

Dental Insurance

Over 6 in 10 Primary Service Area adults (62.0%) have dental insurance that covers all or part of their dental care costs.

- Lower than the national finding.
- Lowest in Carson City, highest in Lyon County.
- TREND: Statistically unchanged since 2010.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



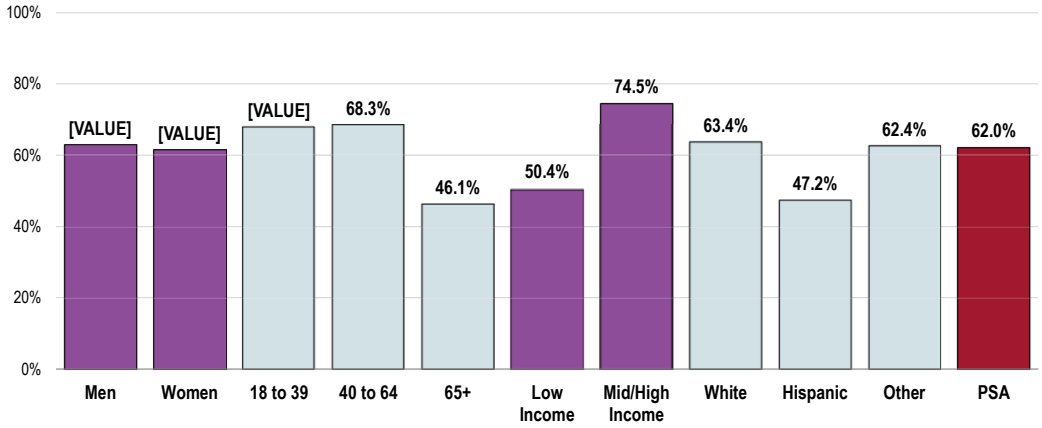
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

These adults are less likely to be covered by dental insurance:

- Seniors (age 65+).
- Adults in low-income households.
- Hispanics.

Have Insurance Coverage That Pays All or Part of Dental Care Costs

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Care

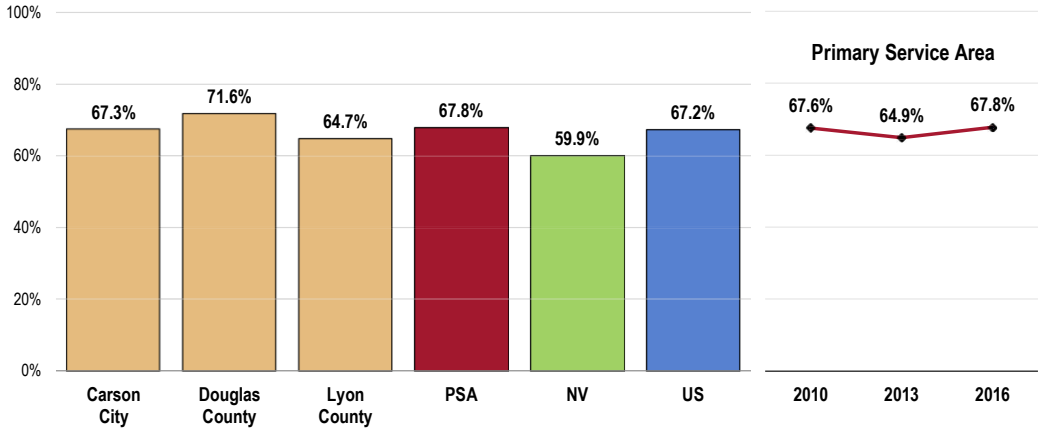
Adults

A total of 67.8% of Primary Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- More favorable than statewide findings.
- Similar to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Similar findings by area.
- TREND: Statistically unchanged over time.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 Target = 49.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Nevada data.

Notes: Asked of all respondents.

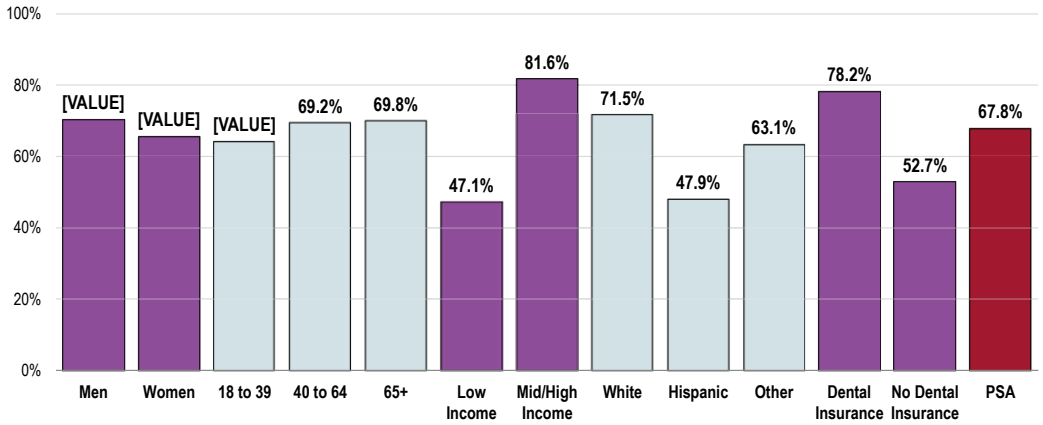
Note the following:

- Persons living in the higher income categories report much higher utilization of oral health services (low-income adults fail to satisfy the Healthy People 2020 target).
- Whites are much more likely than Hispanics to report recent dental care.
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Primary Service Area, 2016)

Healthy People 2020 Target = 49.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

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

Children

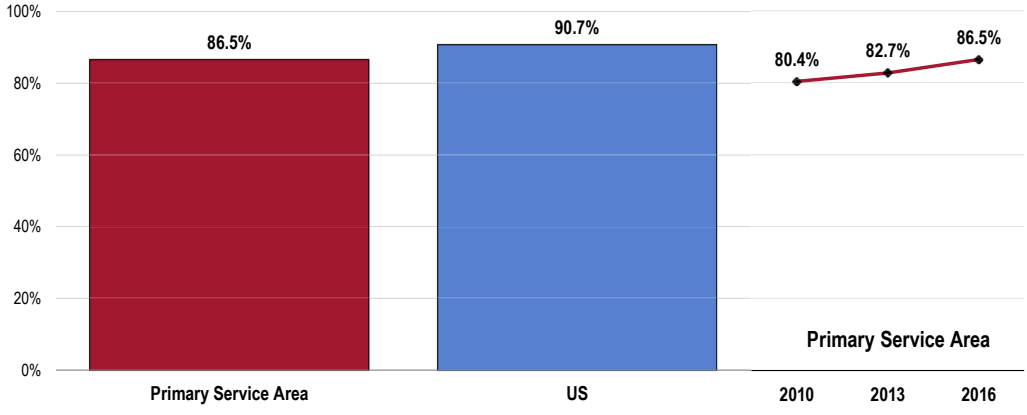
A total of 86.5% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Similar to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- TREND: The increase over time is not statistically significant.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children Age 2-17)

Healthy People 2020 Target = 49.0% or Higher



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 141]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

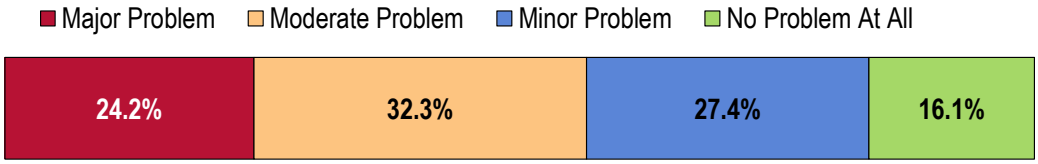
Notes: Asked of all respondents with children age 2 through 17

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2016)



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

Top Concerns

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

Affordable Care/Services

Cost of dental care, results of drug use, personal habits. – Community/Business Leader

No low-cost services in Carson, Lyon or Douglas. – Social Services Provider

Affordable dental care is not available. Many still have no insurance for dental care. Preventative cleanings are not paid for unless you have insurance. – Community/Business Leader

I deal with a lot of lower-income families. The ability to pay for dental care doesn't exist. A lot of these people need their income for life essentials, housing, food, etc., and a dentist is a luxury until a tooth is rotten. – Community/Business Leader

Lack of affordable care. – Physician

Minimal resources for individuals with limited resources. – Social Services Provider

For anyone without insurance, it's very difficult to find anyone to see them in the area. You can go to Reno but that's only if they have a car. – Physician

Affordability. – Community/Business Leader

Oral health and dental care is a major problem in our community because it is super expensive to get dental care, especially for people who do not have dental insurance. Also, even with insurance the cost of dental care is very high. – Community/Business Leader

Difficult for poor to access a dentist. – Physician

Low income for dental care and low educational level. – Physician

Lack of Insurance

Many insurance plans do not cover dental and oral care. For those at poverty level, there are few dentists in our area willing to donate some of their services. For those not at the poverty level but without insurance, this type of care can be cost prohibitive. – Community/Business Leader

Many people have no insurance coverage that includes dental. They have no place to go for low-cost preventative services or dental cleaning. What happens is the need for tooth extraction as a last resort. – Community/Business Leader

Parents/families don't have insurance, refuse to spend the money, or know about the resources that might be available. – Community/Business Leader

Access to Care/Services

Adequate services with limited/no insurance. – Other Health Provider

Access and drug use appear to be the major problems. – Physician

Children who are undocumented with dental problems. Over-prescribing narcotics for pain relief. – Community/Business Leader

The number of illegal immigrants and the prison population put a strain on the availability of health services in Carson City. – Community/Business Leader

Too few dentists. – Community/Business Leader

Medicare/Medicaid

Area dentists do not accept Medicaid, and services are not affordable. Medicare and Adult Medicaid do not cover preventive dental services. – Community/Business Leader

Lack of dentists who accept Medicaid, one in Lyon, four in Carson. Lack of dentists at Emergency Rooms who can attend to dental emergencies so that rather than only receiving antibiotics and pain killers, the underlying abscess or other dental issue. – Social Services Provider

Very few dentists accept Medicaid. – Physician

It is too expensive for seniors and disability folks to pay for dental. The only way they can get Medicaid to pay is if they have full Medicaid. Then we don't have any doctors to see them. – Social Services Provider

Seniors do not have coverage through Medicare and are often prohibited due to the cost of dental care visits. – Community/Business Leader

Environmental Issues

Radon exposure in homes and buildings, earthquake preparedness. – Community/Business Leader

Lifestyle

Sugary drinks and lack of oral hygiene and maintenance. – Community/Business Leader

Prevalence/Incidence

People I meet in the community have really bad teeth. – Community/Business Leader

Vision Care

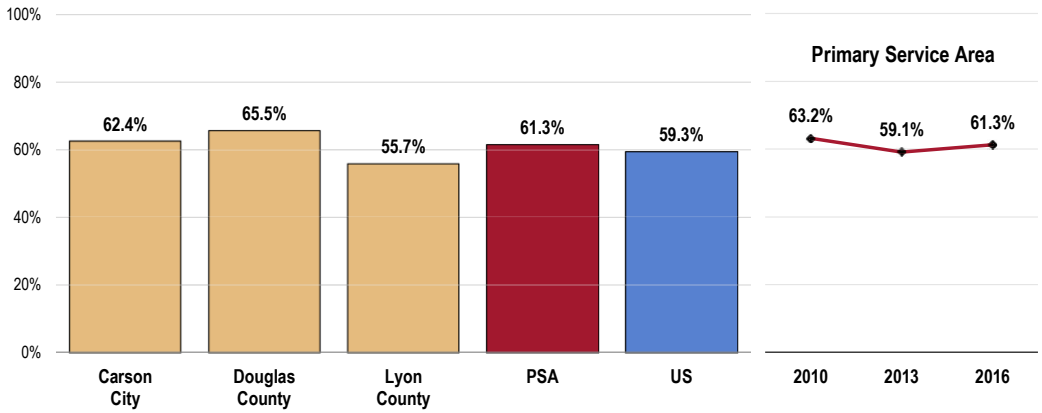
RELATED ISSUE:

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

A total of 61.3% of Primary Service Area residents had an eye exam in the past two years during which their pupils were dilated.

- Statistically comparable to national findings.
- Comparable findings by area.
- TREND: Statistically unchanged over time.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

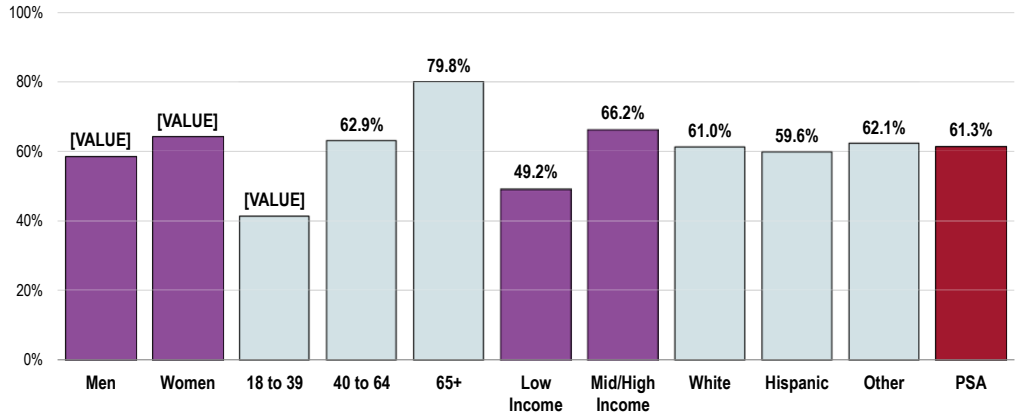


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

- Recent vision care in the service area is more often reported among older adults (positive correlation with age) and upper-income residents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households

Health Education & Outreach

Professional Research Consultants, Inc.

Healthcare Information Sources

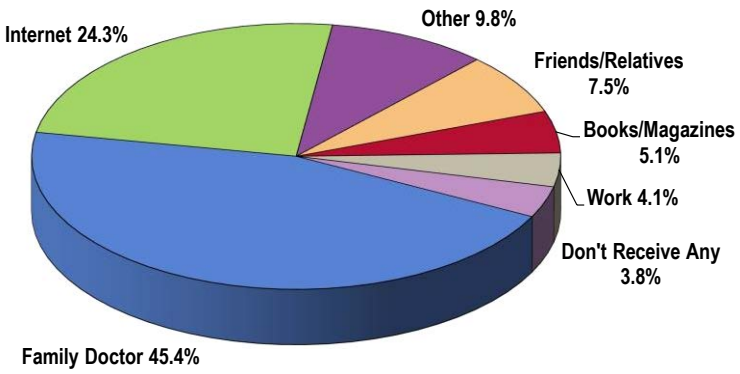
Healthcare Information Sources

Family physicians and the Internet are residents' primary sources of healthcare information.

- 45.4% of Primary Service Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 24.3%.
- Other sources mentioned include friends and relatives (7.5%), books and magazines (5.1%), and work (4.1%).
- Just 3.8% of survey respondents say they do not receive any healthcare information.

Primary Source of Healthcare Information

(Primary Service Area, 2016)



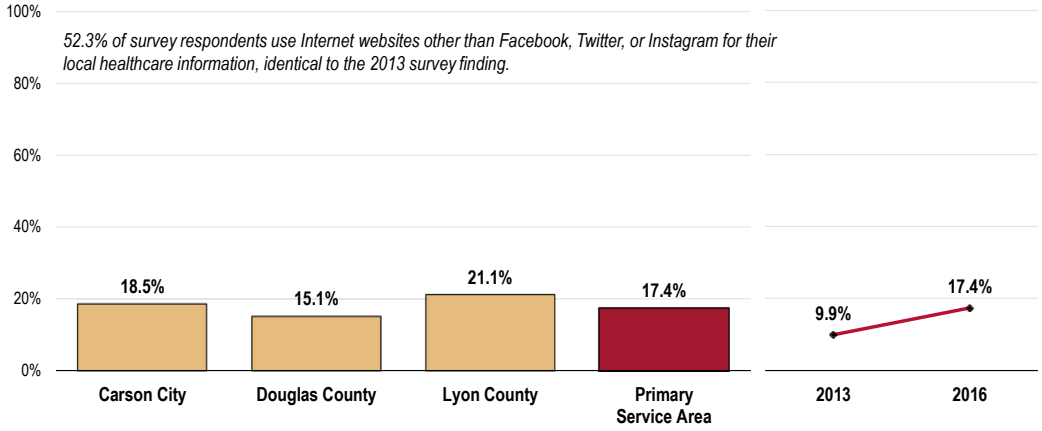
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 316]
Notes: Asked of all respondents.

Use of Social Media

A total of 17.4% of respondents report using social media such as Facebook, Twitter, and/or Instagram for their local healthcare information.

- Statistically similar by area.
- TREND: Marks a statistically significant increase in use since 2013.

Use Social Media Websites (Facebook, Twitter, Etc.) to Obtain Local Healthcare Information



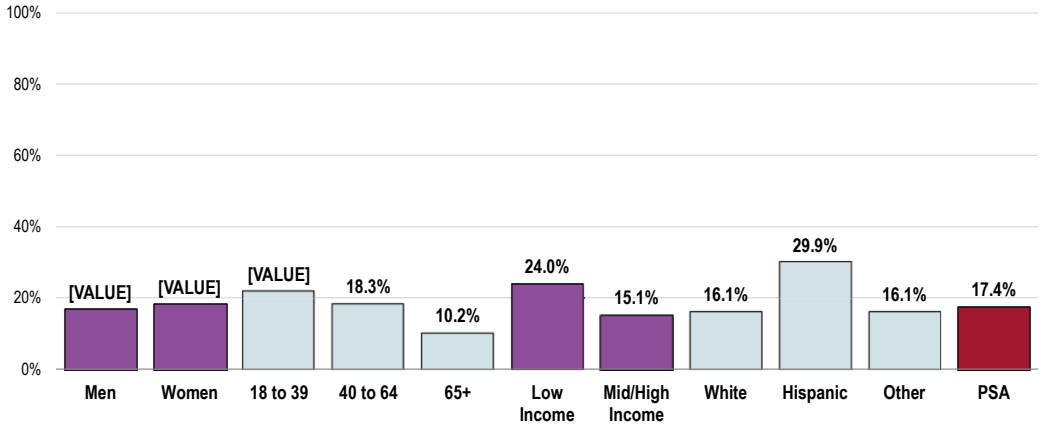
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 317-318]
Notes: Asked of all respondents.

Survey respondents more likely to use social media for their local healthcare information include:

- Young adults (negative correlation with age).
- Those in lower-income households.
- Hispanics.

Use Social Media Websites (Facebook, Twitter, Etc.) to Obtain Local Healthcare Information

(Primary Service Area, 2016)

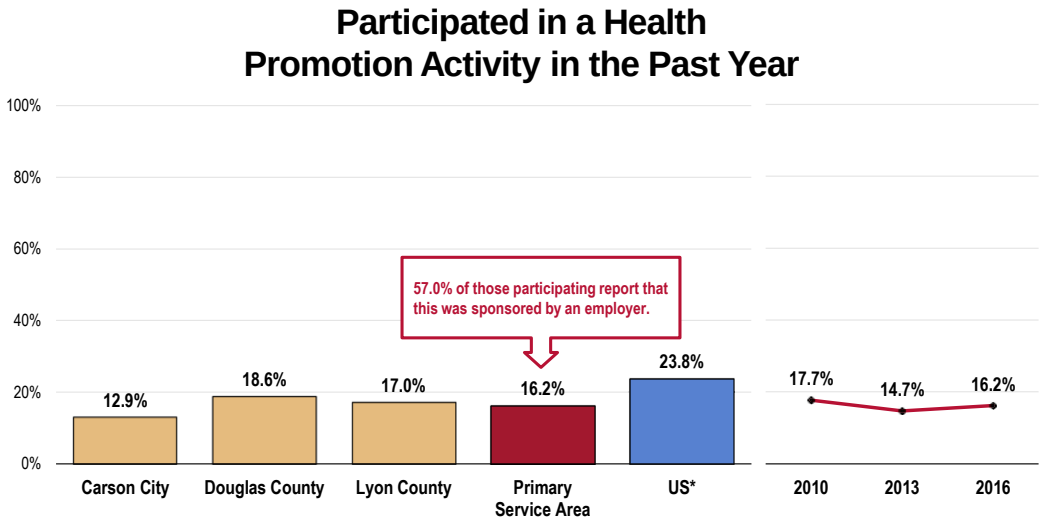


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 317]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Participation in Health Promotion Events

A total of 16.2% of Primary Service Area adults participated in some type of organized health promotion activity in the past year, such a health fairs, health screenings, or seminars.

- Lower than the 2013 US prevalence.
- Lowest in Carson City.
- TREND: Statistically unchanged over time.
- Of those attending, 57.0% report that the event was sponsored by an employer.



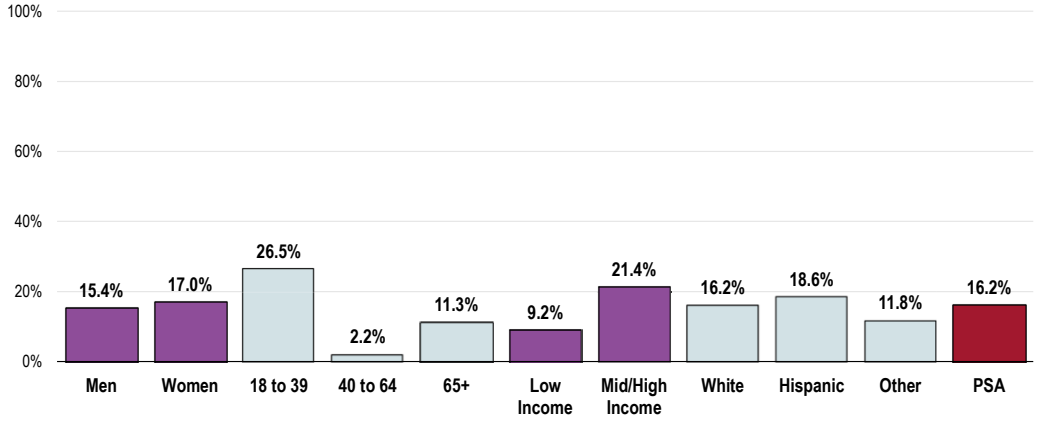
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 319-320]
2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
*US percentage reflects 2013 survey data.

Survey respondents more likely to have participated in a health promotion activity in the past year include:

- Adults under 40.
- Upper-income residents.

Participated in a Health Promotion Activity in the Past Year

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 319]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Advance Directives

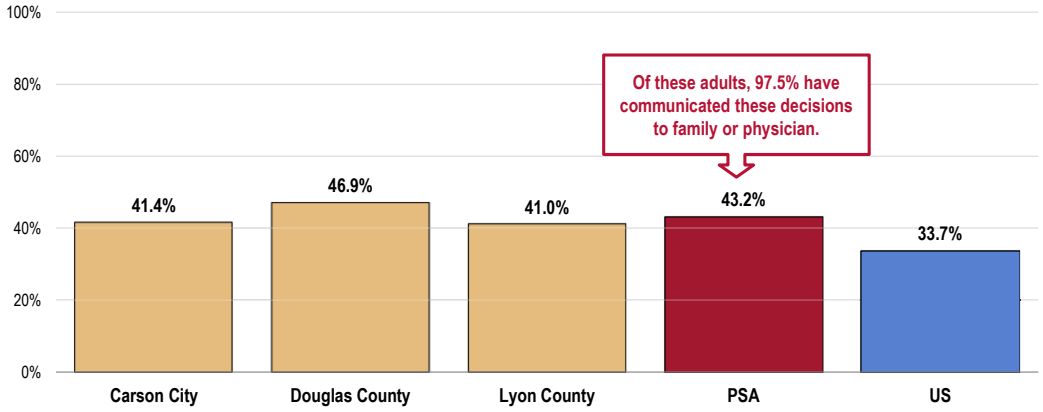
A total of 43.2% of Primary Service Area adults have completed Advance Directive documents.

An Advance Directive document is a set of directions given about the medical health-care a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

- The prevalence is higher than the US figure.
- Statistically similar by area.
- Of those local adults who have completed Advance Directive documents, 97.5% have communicated these decisions to family and/or a physician.

An Advance Directive document is a set of directions given about the medical health-care a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

Have Completed Advance Directive Documents



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 85-86]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

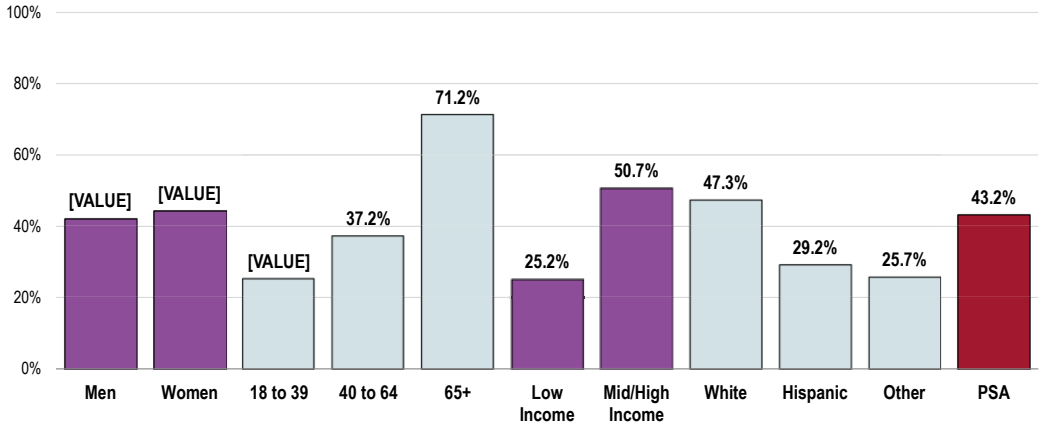
Notes: Asked of those respondents age 45 and older.
An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions.
Formal Advance Directives include Living Wills and Health Care Powers of Attorney.

These survey respondents are <u>less</u> likely to have filled out Advance Directive documents:

- Those under 65 (positive correlation with age).
- Individuals living at the lower income level.
- Hispanics and Other races.

Have Completed Advance Directive Documents

(Primary Service Area, 2016)



Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 85]

Notes: Asked of those respondents age 45 and older.
An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions.
Formal Advance Directives include Living Wills and Health Care Powers of Attorney.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Local Resources

Professional Research Consultants, Inc.

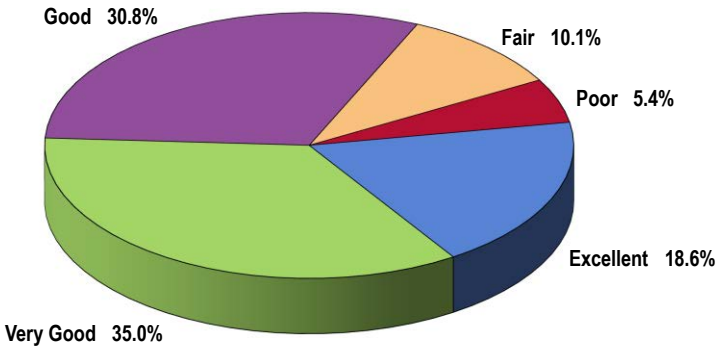
Perceptions of Local Healthcare Services

Over half of Primary Service Area adults (53.6%) rate the overall healthcare services available in their community as "excellent" or "very good."

- Another 30.8% gave "good" ratings.

Rating of Overall Healthcare Services Available in the Community

(Primary Service Area, 2016)

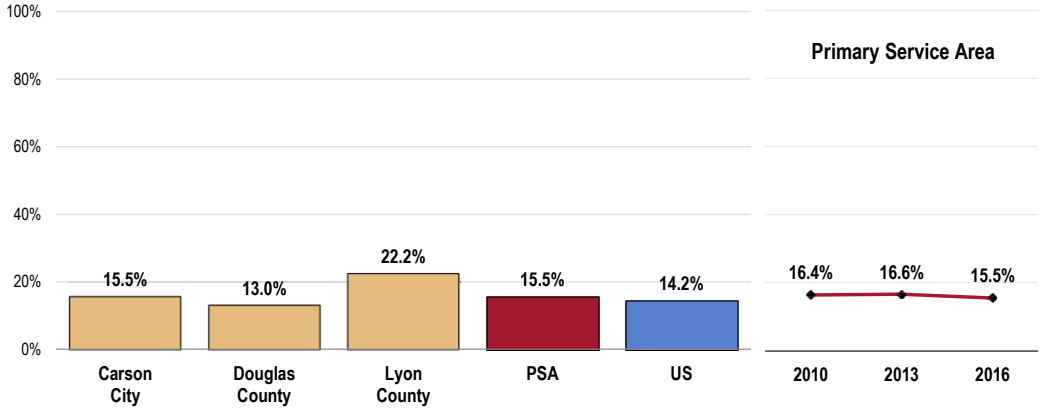


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: Asked of all respondents.

However, 15.5% of residents characterize local healthcare services as "fair" or "poor."

- Similar to that reported nationally.
- Less favorable in Lyon County.
- TREND: Statistically unchanged over time.

Perceive Local Healthcare Services as "Fair/Poor"



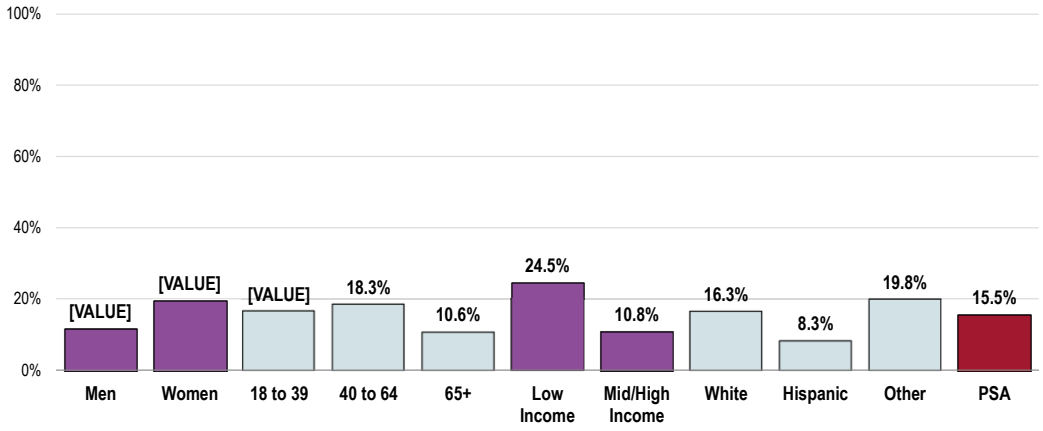
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

The following residents are more critical of local healthcare services:

- Women.
- Adults under age 65.
- Residents with lower incomes.
- Whites and Other races.

Perceive Local Healthcare Services as "Fair/Poor"

(Primary Service Area, 2016)



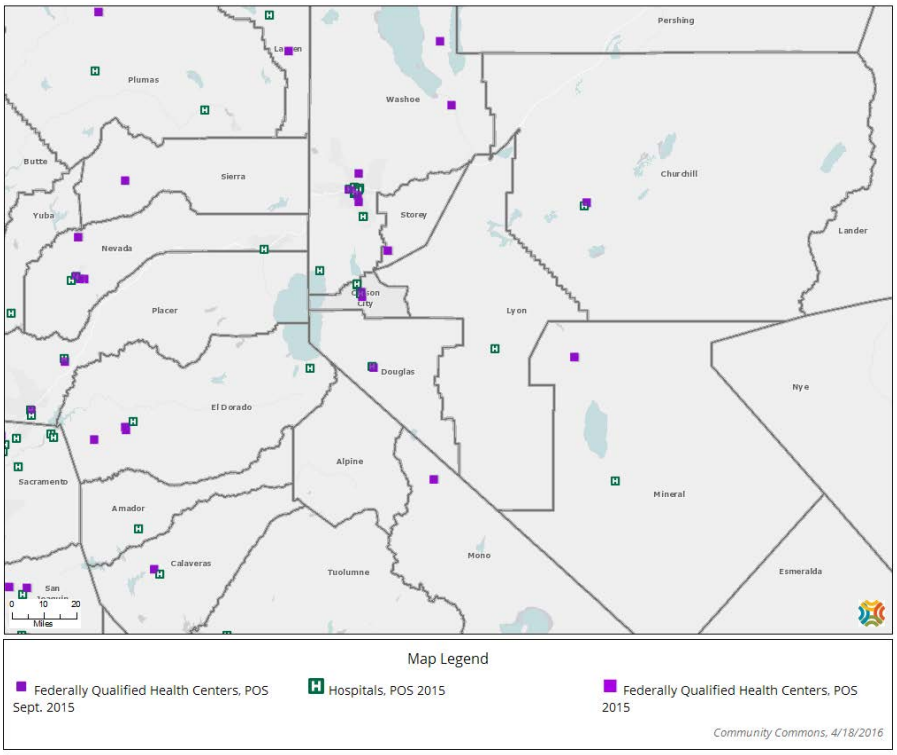
Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map details the hospitals and Federally Qualified Health Centers (FQHCs) within Eastern Nevada and Northern California as of September 2015.

Hospitals and Federally Qualified Health Centers, POS Sept. 2015



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment. This section only outlines those resources mentioned in conducting the Online Key Informant Survey as part of preparing this Community Health Needs Assessment and includes resources that serve areas broader than the Primary Service Area outlined in this assessment.

Access to Healthcare Services

- *Carson City Health and Human Services*
- *Carson Medical Group*
- *Carson Mental Health*
- *Carson Tahoe Regional Medical Center*
- *Carson Valley Medical Center*
- *Community Counseling Center*
- *Community Health Clinic*
- *Community Health Nurse*
- *Community Paramedic*
- *Carson Tahoe Health*
- *DCFS (Douglas County Family Services)*
- *Doctor's Offices*
- *Douglas County Counseling and Supportive Services*
- *Douglas County Health and Human Services*
- *Emergency Room*
- *Family Support Council*
- *Friends in Service Helping, FISH*
- *Health Communities Coalition*
- *Healthcare Guidance Plans*
- *Hospitals*
- *Logisticare Program*
- *Lyon County Health and Human Services*
- *Mental Health Providers*
- *Nevada Health Center*
- *Physician Recruitment Committee*
- *Public Health*
- *Rape Crisis Center*
- *Renown Medical Center*
- *Retired Senior Volunteer Program*
- *Ron Wood Center*
- *School System*
- *Sierra Family Health*
- *Sierra Nevada Health Center*
- *State of Nevada DHHS*
- *Tahoe Youth and Family Services*
- *Urgent Care*
- *Walmart Clinic*
- *Wheelchair Van*

Arthritis, Osteoporosis & Chronic Back Conditions

- *Carson Medical Group*
- *Carson Sierra Surgery Center*
- *Carson Tahoe Regional Medical Center*
- *Carson Valley Medical Center*
- *Carson Tahoe Health*
- *Hospitals*
- *Nevada Health Center*
- *Urgent Care*
- *Washoe Tribe Healing Center*
- *Washoe Tribe Health Chiropractor*

Cancer

- *American Cancer Society*
- *Barton Health*
- *Cancer Center*
- *Cancer Screenings*
- *Carson City Health and Human Services*
- *Carson City Library*
- *Carson Tahoe Cancer Center*
- *Carson Tahoe Regional Medical Center*
- *Carson Tahoe Health*
- *Department of Health and Human Services*
- *Doctor's Offices*
- *Douglas and Carson County Medical*

- *Providers*
- *Douglas County Health and Human Services*
- *IHS Regional Hospital*
- *Indian Health Services*
- *Laser Surgery Center*
- *Lyon County Health and Human Services*
- *Medical Facilities*
- *Oncology Services*
- *Renown Medical Center*
- *Soroptimist International of Carson City*
- *St. Mary's*
- *Washoe Tribe Healing Center*

Chronic Kidney Disease

- *Carson City Health and Human Services*
- *Carson Medical Group*
- *Carson Tahoe Regional Medical Center*
- *Carson Tahoe Health*
- *DaVita CKD Support Groups*
- *Dialysis Center*
- *Doctor's Offices*
- *Douglas and Carson County Medical Providers*
- *Douglas County Health and Human Services*
- *Healthcare Guidance Plans*
- *Indian Health Services*
- *Lyon County Health and Human Services*
- *Nevada Health Center*
- *Sierra Nevada Nephrology Services*
- *State of Nevada DHHS*
- *Washoe Tribe Healing Center*

Dementias, Including Alzheimer's Disease

- *Adult Protective Services*
- *Alzheimer's Association*
- *Alzheimer's Support Group*
- *Arbors Memory Care*
- *Assisted Living*
- *Carson City Health and Human Services*
- *Carson City Senior Center*
- *Carson Tahoe Behavioral Health*
- *Carson Tahoe Regional Medical Center*
- *Convalescent Homes*
- *Carson Tahoe Health*
- *Doctor's Offices*
- *Douglas County Senior Center*
- *Facility in West Carson*
- *Home Instead*
- *Interim HealthCare*
- *Nevada Care Connection Resource Center*
- *Nevada Health Services*
- *Public Health*
- *Retired Senior Volunteer Program*
- *Riverview Nursing Home*
- *Senior Bridges*
- *Senior Center*
- *Senior Pathways*
- *St. Peter's Church Caregiver Support Group*
- *The Lodge Memory Care*

Diabetes

- *911*
- *American Disabilities Act*
- *Carson City Health and Human Services*
- *Carson Endocrinology*
- *Carson Medical Group*
- *Carson Tahoe Regional Medical Center*
- *Carson Valley Medical Center*
- *Community Health Nurse*
- *Carson Tahoe Health*
- *Department of Health and Human Services*
- *Diabetes Clinic*
- *Diabetes Education*
- *Diabetes Prevention and Control Program*
- *Dialysis Center*
- *Doctor's Offices*
- *Douglas County Community Health*
- *Educational Resources*
- *Food Closet*
- *Food Pantries*
- *Health Communities Coalition*
- *Health Insurance*
- *Hispanic Resources*
- *Hospitals*
- *Juvenile Diabetes Foundation*
- *Medical Services for Those with Financial Struggles*
- *New Life Diabetes Centers Inc.*
- *Nutrition Services*
- *Parks and Recreation*
- *Public Health*
- *Renown Medical Center*
- *Ross Medical Clinic*

School System
Sierra Family Health
Sierra Nevada Health Center
State Resources
Vitalcare Diabetes Treatment Centers, Inc.
Washoe Tribe Healing Center

Family Planning

Carson City Health and Human Services
Carson Tahoe Regional Medical Center
Community Health Nurse
Doctor's Offices
Douglas County Community Health
Fernley High School
Health Communities Coalition
Lyon County Health and Human Services
Planned Parenthood
Public Health
School System
State Epidemiology
Washoe Tribe Healing Center
Washoe Tribe Native Temporary Assistance for Needy

Hearing & Vision

Aging and Disability Service Division
Carson City Health and Human Services
Carson City Senior Center
Carson Tahoe Regional Medical Center
Doctor's Offices
Friends in Service Helping, FISH
Health Communities Coalition
Lion's Club Programs
Lyon County Health and Human Services
Ron Wood Center

Heart Disease & Stroke

American Heart Association
Carson City Health and Human Services
Carson Medical Group
Carson Tahoe Regional Medical Center
Carson Valley Medical Center
Community Center
Community Health Nurse
Community Health Programs
Community Paramedic
CTH, Carson Tahoe Health
Doctor's Offices
Douglas County Community Health
Family and Friends
Fitness Centers/Gyms
Healthy People 2020
Heart Safe Community
Hospitals
Nevada Coalition
Nevada State Public Health Program
Parks and Recreation
Public Health
Public Information
Rehab Centers
Renown Heart Institute
Restrictions for Smoking in Public Areas
School System
Social Services
State Resources
Urgent Care
Veterans Affairs

HIV/AIDS

Carson City Health and Human Services
Community Health Nurse
Doctor's Offices
Planned Parenthood

Immunization & Infectious Diseases

Department of Health and Human Services
Doctor's Offices
Hospitals
Infection Control at Healthcare Facilities
Pharmacy
Public Health

Infant & Child Health

Classroom on Wheels
Doctor's Offices
Food Bank
Health Communities Coalition
Healthy Families Nevada
Partnership of Community Resources
Public Health
Ron Wood Center
School System
Welfare/Medicaid
WIC

Injury & Violence

Advocates to End Domestic Violence

Behavioral Health Services
Carson City Sheriff
Carson Tahoe Regional Medical Center
CASA
Educational Resources
Law Enforcement
Police Department
Ron Wood Center
School System

Mental Health

AA/NA
Alcohol and Substance Abuse Counseling
Behavioral Health Services
Carson City Health and Human Services
Carson City Jail
Carson Counseling
Carson Supportive Services
Carson Tahoe Behavioral Health
Carson Tahoe Regional Medical Center
Community Based Programs
Community Counseling Center
Community Health Nurse
Cornerstone
Carson Tahoe Health
DCFS (Douglas County Family Services)
Department of Health and Human Services
Doctor's Offices
Douglas County Community Health
Douglas County Mental Health
Emergency Room
Faith Based Organizations
Family Support Council
Forensic Assessment Strategic Assessment Triage Team
Health Communities Coalition
Hospitals
Mental Health Providers
Nevada Adult Mental Health Services
National Association of Mental Illness
Nevada Behavioral Health
NNMHI
Police Department
Project Success
Public Sector Court Ordered Treatment
Ron Wood Center
Rural Mental Health
School System
Senior Pathways
Serenity
State Mental Health
State Office of Suicide Prevention
Tahoe Youth and Family Services
Veterans Affairs
Vitality
Washoe Tribe Healing Center
Washoe Tribe Law Enforcement
Washoe Tribe Social Services
West Hills
Western National Alliance on Mental Illness

Nutrition, Physical Activity & Weight

Anytime Fitness
Boy Scouts and Girl Scouts
Boys and Girls Club
Carson City Senior Center
Carson City Swimming Pool
Carson Tahoe Regional Medical Center
Community Based Programs
Community Center
Community Harvest
Community Health Programs
Carson Tahoe Health
Doctor's Offices
Douglas County Community Health
Douglas County Senior Center
Educational Resources
Elder Center
Farmer's Market
Fernley High School
Fitness Centers/Gyms
Food Bank
Friends in Service Helping, FISH
Health Communities Coalition
Healthy People 2020
Hospitals
Jackrabbit Junction
Kaia Fit Program
Muscle Power
Nutrition Services
Parks and Recreation
Public Information
Ron Wood Center
School System
Senior Center
Stand Tall
Washoe Tribe Cultural Department

- *Washoe Tribe Diabetes Program Lunch and Learn*
- *Weight Watchers*
- *WIC*

Oral Health

- *Access to Health*
- *Capital City CIRCLES Initiative*
- *Community Health Nurse*
- *Department of Health and Human Services*
- *Desert Valley Dental*
- *Doctor's Offices*
- *Donated Dental*
- *Douglas County Health and Human Services*
- *Draper Dentistry*
- *Federally Qualified Health Centers*
- *Fluoride Varnish Program*
- *Friends in Service Helping, FISH*
- *Happy Smiles*
- *HAWC Clinic*
- *Health Communities Coalition*
- *Healthy Smiles*
- *Hospitals*
- *Lyon County Community Services*
- *Lyon County Dental Clinics*
- *Northern Nevada Dental Program*
- *NOTHINK*
- *Partnership Carson City*
- *Rural Area Medical*
- *School System*
- *Soroptimist International of Carson City*
- *University of Las Vegas Dental School*
- *Veterans Affairs*

Respiratory Diseases

- *Carson City Health and Human Services*
- *Carson Tahoe Cancer Center*
- *Carson Tahoe Regional Medical Center*
- *Doctor's Offices*
- *Douglas County Health and Human Services*
- *Mountain Medical Pulmonary*
- *Nevada Department of Health and Human Services*
- *Oxygen Providers*
- *Respiratory Therapy*
- *Ross Medical Clinic*
- *Social Services*
- *State of Nevada DHHS*

Sexually Transmitted Diseases

- *Carson City Health and Human Services*
- *Community Health Nurse*
- *Planned Parenthood*

Substance Abuse

- *AA/NA*
- *American Comprehensive Center*
- *Behavioral Health Services*
- *Capital City Counseling*
- *Carson City Alcohol Abuse Treatment Centers and Rehab*
- *Carson City Health and Human Services*
- *Carson City Jail*
- *Carson Mental Health*
- *Carson Tahoe Behavioral Health*
- *Carson Tahoe Regional Medical Center*
- *CASA*
- *CC Treatment Center*
- *Community Counseling Center*
- *Court Mandated Programs*
- *Carson Tahoe Health*
- *Doctor's Offices*
- *Douglas County Community Health*
- *Drug Court*
- *Drug/Alcohol Counselors*
- *DUI Workshop*
- *Friends in Service Helping (FISH)*
- *Hospitals*
- *Inpatient Programs*
- *Jail*
- *Law Enforcement*
- *Lyon County Behavioral Health Task Force*
- *Lyon County Council on Alcohol and Other Drugs*
- *Mental Health Providers*
- *Nevada Substance Abuse Treatment Centers*
- *Partnership Carson City*
- *Project Success*
- *Ron Wood Center*
- *Salvation Army*
- *School System*
- *Senior Pathways*
- *Stand Tall*
- *Step Programs*
- *Support Groups*
- *Vitality*
- *Washoe Tribe Healing Center*

Washoe Tribe Law Enforcement
Washoe Tribe Social Services

Tobacco Use

Acute Hospitalization
American Cancer Society
Carson City Health and Human Services
Carson City Nevada Physician Directory
Community Health Nurse
CT Lung Screening
Carson Tahoe Health
Doctor's Offices
Douglas County Community Health
Get Healthy Carson City
Hospitals
Nevada Hypnotherapy
Nevada No Smoke
Nevada State Program
Partnership Carson City
Public Information
Sierra Family Health
Smoking Cessation Classes
Support Groups
Tobacco Quit Line
You Can Quit Smoking

Appendix

Professional Research Consultants, Inc.

Evaluation of Past Work from Caron Tahoe Health's 2013 Community Health Needs Assessment (2013 thru 2015)

Access to Health Services		
ACTIONS	**OUTCOMES**	**ADDITIONAL INFORMATION**
Low Cost Heart Smart Screenings	September 2015 – 516 screened April 2015 – 439 screened September 2014 - 440 screened April 2014 – 589 screened	HeartSmart screenings include ultrasound of the aorta to rule out aneurysm, ultrasound of the carotid arteries to identify stroke risk, Electrocardiogram to identify abnormalities and/or atrial fibrillation and ankle brachial index to identify risk of peripheral vascular disease. HeartSmart screenings are offered in September and April of each year at various locations throughout our primary and secondary service area. Screenings are offered at the low cost of $50.00 per person.
Continuous Primary Care Physician Recruitment	From September 2013 through December 2015, 3 new primary care physicians have started in the community.	Carson Tahoe Health employs primary care physicians and also offers recruitment support to medical practices recruiting new physicians to the community.
Post-CTRH appointments at NV Health Center	Carson Tahoe has direct access to scheduling appointments for Medicaid patients seen in our ED and hospital. This direct access is electronic and Nevada Health Center keeps appointments open specifically for Carson Tahoe use.	
REMSA Triage Call Service Center	CTHS expends $140,000 per year to provide this free service to all patients on a 24 hour basis. The service provides callers with triage medical service to identify potential emergency situations, as well as advice on achieving the appropriate level of care. 6,000 residents per year are served. Patient satisfaction rate is at or above 95%	

$$ to support Ross Clinic, other clinics	2015 - $1,116,381.12 was spent on outside contracts for placement and services of our patients that are under or non-insured 2014 - $515,474.89 was spent on outside contracts for placement and services of our patients that are under or non-insured.	Patients are referred to Nevada Health Centers and we provide voucher medications through Walgreens for people in need. We also have contracts for Nursing home beds with Mountain View, Home Health with Eden Home Health, and equipment from different vendors (Lincare and SOS mainly) for patients who are under or non-insured.
Expanded Services at Wal-Mart Retail Clinics	2015 – 6,778 Visits 2014 – 6,787 Visits 2013 – 6,402 Visits	Wal-Mart Clinics are located in Gardnerville, Carson City, and South Carson City. Expansion of services includes: Practice Protocols were reviewed, revised and improved according to current standards for effective Mid-Level Practitioner guidance and practice; Patients may seek short term temporary primary care for up to three visits while waiting for primary provider visit; Point of Care Flu Testing for rapid treatment in an effort to reduce community contamination; New Local Business Employee Physical contracts which include CTH Employee Physicals for Chemotherapeutic Safety, Lyon County Fire District, Bright Star Home Health and Harbor Freight Tools; Free Blood Pressure Checks with education and resources provided by the Mid-Level Practitioner; Nevada Health Centers Referral and Follow-Up Process defined; Point of Care testing Labs within the Wal-Mart Clinics have been successfully certified for two years.

Cancer

ACTIONS	OUTCOMES	ADDITIONAL INFORMATION
University of Utah Health Care (UUHC) assessment upcoming	CTHS expends $300,000 per year for affiliation programs with UUHC. Currently, these programs are focused on cancer and emergency stroke management.	The emergency stroke management program provides real time assessment and evaluation of stroke patients and provides a subset of them with life saving intervention via telemedicine consults with UUHC. The cancer program provides increased access for patients to second opinions, clinical cancer trials, and oversight of tumor board conferences. There is no cost to patients for this service.
HopeFest Event	Since 2013, HopeFest has raised over $220,000 in net revenue to support cancer patients with their critical needs that extend beyond the hospital walls, like: gas to get to treatment, no-cost lodging, assistance with insurance co-pays, and help with life-saving medications.	The Carson Tahoe Health Foundation raises funds to benefit patients, keep the system current with advances and innovation in treatment and continually provide a safety net for the community we serve. HopeFest is a free benefit concert held annually on the 3rd Friday in August, raising funds for local cancer patients in need. Support is then distributed through the Carson Tahoe Cancer Resource Center.
Lung Cancer program in development	2015 – 36 patients 2014 – 11 patients 2013 – 6 patients	In 2015, Carson Tahoe's Low Dose CT Lung Cancer Screening program was revised to be more comprehensive from patient selection criteria to communication of results to the patient. All patients are referred to a pulmonologist for consultation and review of CT scan results from the radiologist. These low cost screenings are offered at $159.
Redesigning mammography program	In late 2015, Carson Tahoe Health Board approval was received to develop a comprehensive breast imaging center on the main campus at Sierra Surgery. This project will provide state of the art 3-D mammography and biopsy services all in one location. It will be the first center of its kind in Northern Nevada. As part of this project, mammography services in Minden will also be upgraded to 3-D tomosynthesis. Project is expected to be completed Summer of 2016.	

Tobacco cessation classes	2015 – Six, 7-week sessions. 104 took interest; 53 attended first class, 16 repeated two times or more; 34 finished a session; 30 physician referrals; 13 word of mouth referrals; 6 CTH referrals; 4 internet referrals; 3 other referrals; 29 quit at end of session.	The weekly smoking cessation classes are offered to anyone as a supportive and proven way to eliminate the harmful habit of nicotine addiction. A structured class outline provided by the American Lung Association's "Freedom From Smoking" program is followed. Regular classes offer the benefit of a carefully planned and individualized cessation program (class sizes tend to be small, allowing for individual development) but the class is also offered to be open to past participants as a support group.
Pediatric oncology regional collaboration	CTHS expends $100,000 per year to support pediatric oncology services to the region. Patients would alternatively be required to receive care in the Bay Area four hours away. The program serves 1,200 patients per year and there is no charge to patients.	

Diabetes

ACTIONS	OUTCOMES	ADDITIONAL INFORMATION
Public Education Classes	Diabetes Support Group: 2015 (Sept – Dec) – 14 attendees	Diabetes Support Group: In September 2015, CTH implemented a free monthly support group for people with diabetes and their family members. The diabetes support group meets the second Tuesday of each month at the Health & Wellness Institute from 5-6pm. Each meeting focuses on a different topic supporting diabetes self-management such as "On The Road: Traveling with Diabetes" and "Back to Basics, Carb Counting Made Easy".
	Evening Class for Diabetes Education: 2015 (Sept class) – 6 patients and 3 family members	Evening Class for Diabetes Education: Diabetes Education class consists of a total of nine hours – three hours (1-4pm) on Friday afternoons each month. In September 2015, CTH launched an evening class from 5-8pm to accommodate individuals who want to attend, but cannot attend a daytime class. In 2016, we will hold an evening diabetes education class once each quarter. Based on participant feedback from the first evening class, the class will be held from 4-7pm.
	Diabetes Awareness Month Educational Series: 11/19/2015 – 20 people attended 11/12/2015 – 20 people attended 11/5/2015 – 33 people attended	Diabetes Awareness Month Educational Series: November is diabetes awareness month, and in 2015, CTH held three educational series for the community. All series were free to attend. Each series was themed and covered various topics around diabetes. The educational series speakers included an endocrinologist, podiatrist, cardiologist, family practice, registered dietitian, licensed social worker, registered nurses and certified diabetes educators. A Fitbit and comprehensive lab panel were raffled at each series.
	Carson Tahoe Medical Group Monthly Diabetes Wellness Sessions: 2015 – 94 attendees 2014 – 58 attendees 2013 – 10 attendees	Carson Tahoe Medical Group Monthly Diabetes Wellness Sessions: In November 2013, Carson Tahoe Medical Group launched free monthly diabetes wellness sessions for their patients with diabetes. The classes are taught by a registered nurse, who is also a certified diabetes educator. Various topics are discussed each month and build upon the skills a patient needs to know to self-manage their diabetes. Every six months a new calendar is published with the topics to be discussed for the upcoming months.

	CDC National Diabetes Prevention Program: 2015 – 5 staff members trained as lifestyle coaches to teach the CDC's curriculum. The first Diabetes Prevention Program launched in February 2016 with 9 participants.	CDC National Diabetes Prevention Program: The CDC National Diabetes Prevention Program (DPP) is a recognized lifestyle change program developed specifically to prevent type 2 diabetes. It is designed for people who have prediabetes or are at risk for type 2 diabetes, but who do not already have diabetes. A trained lifestyle coach leads small groups of participants in learning about healthy eating, physical activity and other healthy behaviors during 16 sessions over 6 months, then monthly sessions for added support for 6 months in order to help maintain the participants' progress. Carson Tahoe Health is the first hospital system in northern Nevada to offer the CDC National Diabetes Prevention Program.
Diabetic Cooking Classes	See above for results. These are offered through the Diabetes Awareness Month education series.	
Disease Management program for CTHS and PEPB	CTHS: 48% (25 patients) participated in the program; 76 face-to-face patient appointments with the Care Manager & 72 follow-up/telephonic appointments with Care Manager were provided. For patients with an A1c > 7 (uncontrolled diabetes), the average A1c level at program start was 8.7% for combined patients and decreased to 7.2% by program end for combined patients. 19 patients (76%) self-reported lifestyle changes, of which, 14 (56%) of them improved their A1c result post-program. Lifestyle changes included: exercising, blood sugar monitoring, carb counting, portion control, taking diabetes medications consistently, etc. PEPB: 44% (25 patients) participating in program; 92 diabetes education appointments with Care Manager; 0.5% decrease in A1c average for combined patients who have participated in program for > 9 months; and 92% of participants rated the overall program "excellent" in the patient satisfaction survey conducted in November 2015.	CTHS: This pilot program ran from September 2013 – August 2014 for CTH employees and dependents covered under the self-funded health plan, who have diabetes and a primary care physician with Carson Tahoe Physicians Clinic, Carson Medical Group or Tumbleweed Medical Group. These practices were selected since 60% of the population identified with diabetes utilizes them for primary care, which represented 52 individuals. Incentives were provided to both patients and physicians. PEPB: This pilot program launched November 2014 and runs through October 2016. To be eligible to participate, the person must be covered under the PEBP self-funded health plan, have diabetes, and a primary care physician with Carson Tahoe Physicians Clinic (CTPC). Currently, 57 individuals are eligible to participate in the program. The overall goals of the program are: Improve patient and physician compliance with diabetes standards of care, Improve patient diabetes self-management, Improve medication management, and Reduce the overall medical and pharmacy claims spend for the identified diabetic population. If claims savings are recognized, PEBP will share 25% of the savings with CTPC.

Center for Wound Healing	Since October 2013 inception: • 1,421 new patients seen • 13,000 Wound Healing Visits • 3,100 Hyperbaric Oxygen treatments • 83 new patients in hyperbarics • 92% Healing rate (amputation prevention); 25 medium days to heal • 14% outliers (Patients in service greater than 14 weeks) • Patient satisfaction of 92% in 2014, 90% in 2015 In 2014, Carson City center awarded Center of Distinction by Healogics for clinical quality and patient satisfaction. In Dec 2015, expanded wound care services with a new center in South Reno.	Other activities include: in 2014, began teaching part of the group class for diabetes management for ulcer prevention and foot care; in 2014 & 2015, wound care physician participated in 3 community education talks to bring awareness to skin care and diabetic foot care to the community; and in 2014, integrated LTACH wound care team with the outpatient wound care team, improving continuity and communication.

Dementia/Mental Illness		
ACTIONS	**OUTCOMES**	**ADDITIONAL INFORMATION**
Memory Care Facility in development	Certificate of need secured. Architectural plans finalized. Construction to begin 2016 with facility opening 2017.	
Increased inpatient beds in Senior Pathways	In early 2016, Carson Tahoe Health will increase their chemical dependency beds by 6. CTH now has 20 adult psych beds, 16 chemical dependency beds and 16 geri psych beds. The beds are licensed to "swing" depending on community need.	
Participation in regional mental health collaborative	At the request of the State of Nevada and local Counties, a Regional Behavioral Health Coordinator was hired which Carson Tahoe Health oversees (grant funded).	This collaborative includes Carson, Lyon, Douglas, and Churchill Counties. Coordinator is working on the following actions: Improving coordination of care with community partners across the region; coordinates regional mental health meetings; Placement of difficult patients and coordination of community services for "super utilizers" (individuals in constant crisis); Liaison with Northern Nevada Adult Mental Health and Division of Public and Behavioral Health; Stepping Up Initiative/Jail diversion – assisting people with mental health/substance abuse issues in obtaining treatment instead of being placed in jails; Community education on Legal Holds.
Dedicated E.R. Space	Analysis of need completed. Proforma and business case completed. Project included in 2016 Budget. Board approval received to proceed with project.	

Maternal & Infant Health

ACTIONS	OUTCOMES	ADDITIONAL INFORMATION
Baby Friendly Certification	CTH became Nevada's first Baby Friendly designated hospital by UNICEF and the World Health Organization in 2013.	CTH practices the 10 Steps to being Baby Friendly with all the approximately 950 babies born every year. We are a rooming-in hospital that allows mothers and babies to be together 24 hours, promotes skin-to-skin contact immediately for bonding and initiates breast feeding within the hour of birth. By supporting, promoting & educating new mothers through the *10 Steps* program, scientifically proven to benefit the health of the baby, has led to healthier outcomes.
MOMS prenatal clinic	2015 – 1,883 Nurse Visits; 1,962 Doctor Visits; and 401 New Patients 2014 – 2,030 Nurse Visits; 2,012 Doctor Visits; and 402 New Patients 2013 – 1,911 Nurse Visits; 1,979 Doctor Visits; and 381 New Patients	The MOMS clinic takes all applicants that qualify for Medicaid. They provide complete prenatal care, delivery, and postpartum care. All lab testing sonograms and other testing are included. Care of the newborn is also included, and the baby is set up with follow up with a pediatrician or family practice physician.
Health Institute educational programs	Pelvic Floor Strengthening Class 2015 – 96 participants 2014 – 82 participants Cardiac Connection 2015 – 26 participants Yoga 2015 – 1982 participants 2014 – 2056 participants Breastfeeding Support 2015 – 1425 participants 2014 – 1664 participants Bariatric Support Group 2015 – 131 participants 2014 – 122 participants Heart Month Lecture Series 2015 – 235 participants 2014 – 180 participants	Health & Wellness Institute Ongoing Classes and Support Groups: • Pelvic Floor Strengthening Class • Cardiac Connection – Cardiac Rehab Maintenance Program • Yoga • Breastfeeding Support Group • Bariatric Support Group The Health & Wellness Institute hosts "Heart Month" each February. Free educational seminars are provided throughout the month during which the public has access to health experts in the field of cardiology to ask questions and gain knowledge on the subject of heart health.

Expansion of Delivery Service Area	For our Primary Service Area, Market Share for: Obstetrics Other increased to 78.3% in 2015 from 62.4% in 2013 Normal Newborns increased to 77.1% in 2015 from 74.6% Obstetrics Deliveries stayed relatively flat with 74.1% in 2015 and 74.9% in 2013.	

Nutrition and Physical Activity		
ACTIONS	**OUTCOMES**	**ADDITIONAL INFORMATION**
Community Garden	We plant veggies and herbs and donate them to Friends In Service Helping (FISH) & the Eagle Valley Children's Home near the campus. Each year we donate approximately 200 lbs of fresh food. We try to get employees physically involved through donating plants and working at the garden.	
Walking Distance trails on RMC	Walking trail completed 2014. Consists of 3 separate routes of various distances. Employees and many community members walk the 2 mile trail on a daily basis. We implemented a Walk with the Doc series & a weekly Walking Group in 2015 who utilize these trails with approximately 500 participants annually.	
Sponsor of various walk/run events	Hosted CTH 5K in 2013 & 2014, partnered with Tahoe Mountain Milers; Sponsor and employee team participated in the *Rock Tahoe* half marathon in 2015; Sponsor of *Edible Pedal 100* walk/run regional event; Sponsor of the *American Lung Walk*; Sponsor of *Run ED Run*; Sponsor *Carson High Safe Grad* run; Sponsor of *Nevada Classic* run/walk; Sponsor & participate in the Susan G. Komen *Race for a Cure* in both Carson & Douglas Counties.	In addition to annual walk/events, Sponsor of the *Sierra Cup* mountain bike racing series; and Sponsor regional high school sports programs.
Healthy Cooking Classes	<u>Intuitive Eating</u> 2015 – 104 participants 2014 – 80 participants <u>Family Meal Planning</u> 2015 – 62 participants	Health & Wellness Institute Ongoing Classes and Support Groups: • Intuitive Eating • Family Meal Planning

Healthy Meal Alternatives in Café	Healthy meal alternatives now offered are Mrs. Leigh's Stir Fry, Lettuce Wraps, Salad bar, and Specialty Salads which are all made to order.	