2010 PRC Community Health Report

Sponsored by
Carson Tahoe Regional Healthcare Foundation

TOTAL AREA
Carson City, NV • Douglas County, NV •
Lyon County, NV • Storey County, NV •
Washoe County, NV • Alpine County, CA

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INTRODUCTION

The PRC Community Health Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of our community residents.

Project Overview

Project Goals

This Community Health Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of the Carson Tahoe Regional Healthcare Foundation. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A PRC Community Health Assessment provides the 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 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.

Methodology

This assessment incorporates data from primary research (the 2010 PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

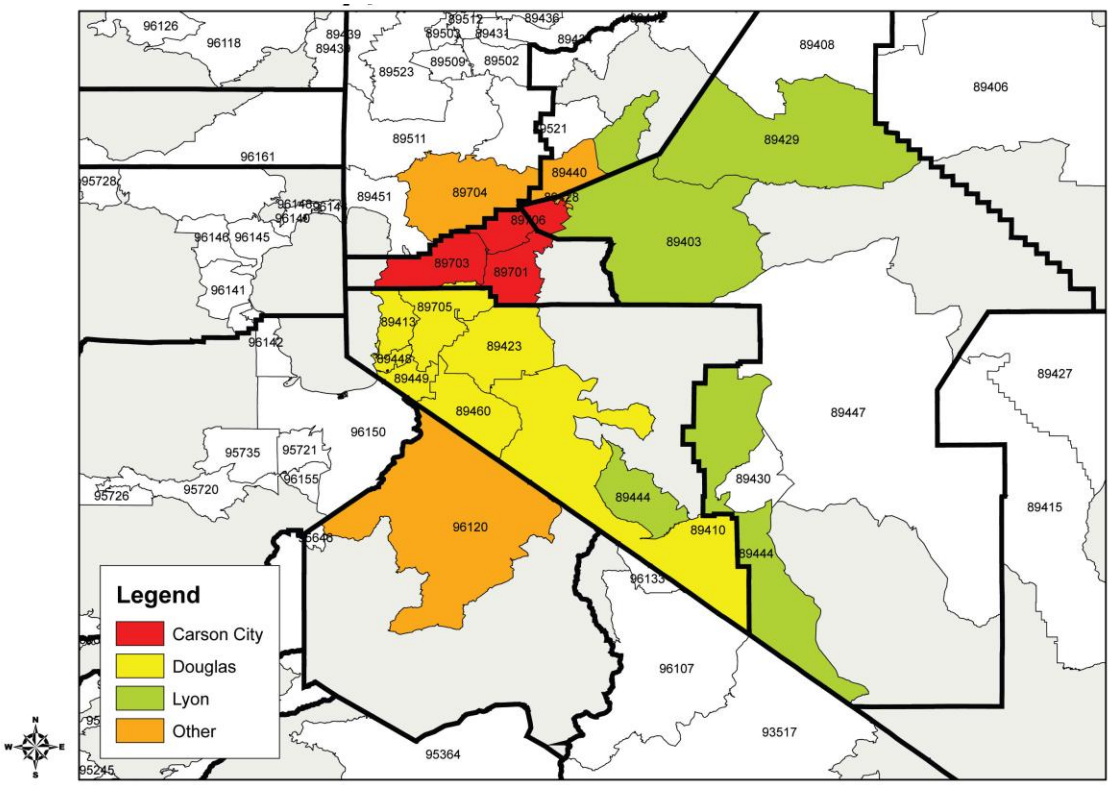
2010 PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the Carson Tahoe Regional Healthcare Foundation and Professional Research Consultants (PRC), and is similar to 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 "Total Area" in this report) is inclusive of ZIP Codes in Carson City and Douglas County, Nevada. It also includes ZIP Codes which comprise portions of Lyon, Storey and Washoe counties in Nevada, and Alpine County in California. A geographical description of the Total Area is illustrated in the following map.



Sample Approach & Design

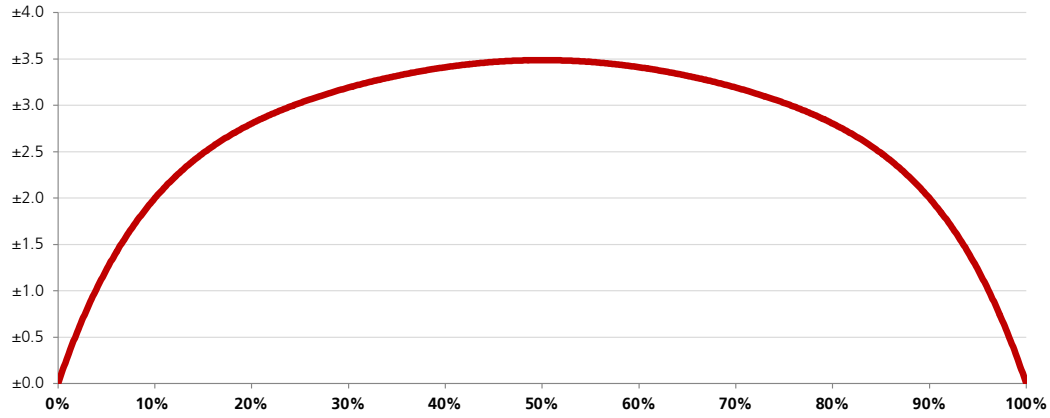
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *2010 PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 800 individuals aged 18 and older in the Total Area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 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.

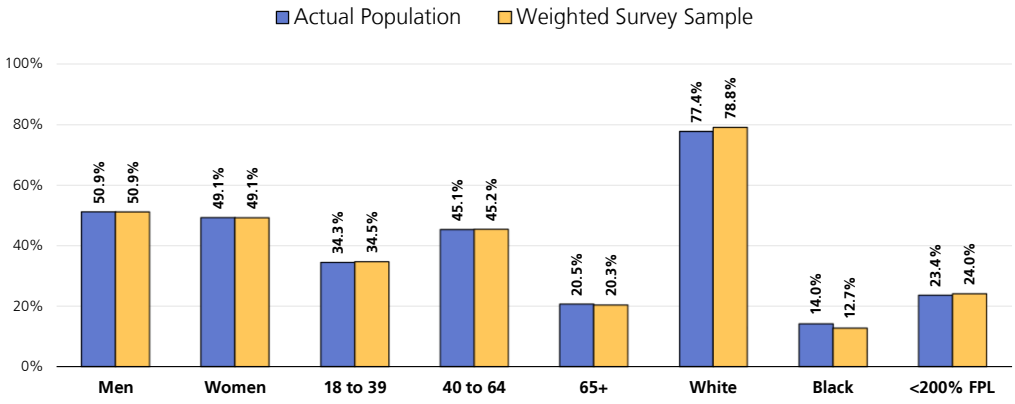
Sample Characteristics

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

Population & Sample Characteristics

(Total Area, 2010)



Sources:
- Census 2000, Summary File 3 (SF 3). U.S. Census Bureau.
- 2010 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 2009 guidelines – the most current available – place the poverty threshold for a family of four at $22,050 annual household income or lower)*. In sample segmentation: "<200% FPL" (or less than twice the Federal Poverty Level) refers to community members living in a household with defined poverty status, along with those households living just above the poverty level, earning up to twice the poverty threshold; and "≥200% FPL" (twice or more the Federal Poverty Level) refers to households with incomes more than twice the poverty threshold defined for the household size.

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.

Public Health, Vital Statistics & Other Data

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

- California Department of Health Services
- Centers for Disease Control & Prevention
- ESRI BIS Demographic Portfolio (Projections Based on the US Census)
- National Center for Health Statistics
- Nevada Department of Health and Human Services
- State of California Department of Justice
- State of Nevada Department of Public Safety

Note that, while survey results reflect the specific ZIP Codes defined for this study, secondary data reflect county-level data (and "Total Area" results for secondary data indicators reflect a composite of these counties).

Benchmark Data

Trending

Similar surveys were administered in portions of the Total Area in 1999 (Carson City) and 2001 (Douglas County) by PRC on behalf of Carson Tahoe Regional Healthcare Foundation. 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 are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2008 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 2010

Healthy People 2010: Understanding and Improving Health is part of the Healthy People 2010 initiative that is sponsored by the U. S. Department of Health & Human Services. Healthy People 2010 outlines a comprehensive, nationwide health promotion and disease prevention agenda. It is designed to serve as a roadmap for improving the health of all people in the United States during the first decade of the 21st century. Like the preceding Healthy People 2000 initiative—which was driven by an ambitious, yet achievable, 10-year strategy for improving the nation's health by the end of the 20th century—Healthy People 2010 is committed to a single, overarching purpose: promoting health and preventing illness, disability and premature death.

Summary of Findings

Areas of Opportunity for Community Health Improvement

The following "health priorities" represent recommended areas of intervention, based on the information gathered through this Community Health Assessment and the guidelines set forth in *Healthy People 2010*. From these data, opportunities for health improvement exist in the region with regard to the following health areas (see also the summary tables presented in the following section). These areas of concern are subject to the discretion of area providers, the steering committee, or other local organizations and community leaders as to actionability and priority.

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	• Routine Preventive Care (Adults & Children) • Cost as a Barrier to Healthcare
Cancer	• Cancer Prevalence (Especially Skin Cancer) • Pap Smear Testing
Diabetes	• Diabetes Prevalence
Disability	• Activity Limitations
Heart Disease & Stroke	• Heart Disease Prevalence • Blood Pressure & Cholesterol
Injury & Violence	• Injury Deaths (Including Motor Vehicle) • Suicide • Firearm Safety
Maternal, Infant & Child Health	• Prenatal Care
Nutrition & Overweight	• Overweight & Obesity
Respiratory Disease	• Chronic Lower Respiratory Disease
Substance Abuse	• Cirrhosis/Liver Disease • Chronic Drinking

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Total Area, including comparisons among the individual county areas, as well as trend data for Carson City and Douglas County. These data are grouped to correspond with the Focus Areas presented in Healthy People 2010.

Reading the Summary Tables

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

The green columns [to the left of the Total Area column] provide comparisons among the four county areas, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the combined opposing areas.

The columns to the right of the Total Area column provide comparisons between the Total Area and any available state and national findings, as well as Healthy People 2010 targets. Again, symbols indicate whether the Total Area compares favorably (), unfavorably (), or comparably () to these external data.

The tan columns to the far right show comparisons with previous data found in Carson City (1999) and Douglas County (2001). Trends are identified as "favorable" (), "unfavorable" (), or "similar" () compared to what was found previously.

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

Access to Healthcare Services	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Lack Health Insurance (Aged 18-64)	21.1	18.0	16.4	15.6	18.8	22.9	17.7	0.0	17.9	16.7
Went Without Health Coverage in Past Year (Insured)	7.0	4.6	9.9	3.8	6.6		10.3			
Have Prescription Drug Coverage	92.2	92.6	93.6	98.9	93.1		94.4			
% Difficulty Accessing Healthcare in Past Year	43.0	32.3	51.6	32.6	40.4		42.4			
% Difficulty Finding Physician in Past Year	12.0	6.8	17.4	5.2	10.9		12.9		5.8	9.1
% Difficulty Getting Appointment in Past Year	14.9	13.7	16.7	5.8	14.3		18.9		12.2	15.9
% Inconvenient Hrs Prevented Dr Visit in Past Year	11.1	12.2	17.4	2.8	12.1		18.8		9.9	10.8
% Transportation Prevented Dr Visit in Past Year	5.3	3.4	12.7	0.0	5.7		8.5		4.2	3.2
% Cost Prevented Physician Visit in Past Year	20.0	15.4	19.6	18.2	18.3	14.4	18.2		8.1	9.6
% Cost Prevented Getting Rx in Past Year	18.9	10.8	20.3	16.0	16.3		19.7		8.7	11.3
% Skipped Rx Doses to Save Costs	18.8	15.9	24.4	17.7	18.9		17.5			
% Difficulty Getting Child's Healthcare in Past Year	5.3	3.7			4.7		7.7			
% Have a Specific Source of Ongoing Care	73.0	67.1	70.9	78.0	70.9		76.8	96.0		
% Have Had Routine Checkup in Past Year	57.2	62.2	47.1	60.2	57.1		65.2		52.0	60.2
% Child Has Had Checkup in Past Year	81.8	78.2			80.1		91.3		75.5	83.2
% Gone to ER More Than Once in Past Year	4.3	7.1	10.5	7.5	6.6		10.6		4.9	8.9
% "Fair/Poor" Ratings of Healthcare Services	21.1	10.4	20.8	6.9	16.4		22.2			

Note: Each county is compared against all others combined.

-blank- no data

favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Arthritis, Osteoporosis & Chronic Pain

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Arthritis/Rheumatism	20.9	27.3	21.1	23.9	23.3	24.3	24.2		21.6	28.9
% Osteoporosis	4.9	6.1	9.8	4.2	6.2		6.7			
% Sciatica/Chronic Back Pain	21.3	22.6	24.9	24.5	22.7		22.2		21.9	26.0
% Migraine/Severe Headaches	16.7	14.3	18.3	14.8	16.1		16.8			
% Chronic Neck Pain	11.3	8.0	14.1	6.4	10.4		12.5			

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Cancer

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Cancer (Age-Adjusted Death Rate)	210.9	164.3	224.5		184.5	193.1	186.6	159.9	208.3	
Lung Cancer (Age-Adjusted Death Rate)					54.7	56.7	52.5	44.8		
Female Breast Cancer (Age-Adjusted Death Rate)					21.9	23.9	24.5	22.3		
% Skin Cancer	7.5	15.0	10.7	15.5	11.2		4.6		9.6	14.4
% Cancer (Other Than Skin)	6.9	9.9	8.1	2.6	7.8		5.8		5.9	5.0
% Sigmoid/Colonoscopy Ever (Aged 50+)	63.1	70.7	66.2		68.0	55.7	64.8	50.0	45.9	52.8
% Blood Stool Test in Past 2 Yrs (Aged 50+)	28.5	30.6	32.3		29.8	18.6	36.5	50.0	51.6	54.4
% Mammogram in Past 2 Years (Women 40+)	67.6	83.7	73.8		75.7	68.0	74.6	70.0	66.7	83.5
% Pap Smear in Past 3 Years (Women)	72.6	77.2	73.2		75.4	78.2	81.3	90.0	78.7	87.1
% Prostate Exam in Past 2 Years (Men 50+)	72.9	84.0	73.1		77.1		73.7		75.6	87.2

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Diabetes

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Diabetes Mellitus (Age-Adjusted Death Rate)	29.9	12.1	21.3		17.2	14.6	24.8	15.1	19.6	
% Diabetes/High Blood Sugar	12.2	13.2	13.6	7.1	12.4	7.9	11.1		7.4	6.0
% (Diabetics) Taking Insulin/Medication					76.5		84.2			

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Disability

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Activity Limitations	20.4	28.3	32.3	26.0	25.8	18.9	21.8		18.8	19.9

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Education & Community-Based Programs

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Attended Health Event in Past Year (Aged 65+)	11.8	10.9			13.0		13.3	90.0		
% Attended Employer-Sponsored Health Event (Employed)	16.9	12.9	11.7		15.3		17.2	75.0		

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Environmental Health

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Attribute Illness in Past Year to Indoor Air Quality	9.6	11.9	15.3	7.5	11.4		19.0			
% Have Mold in the Home	6.0	1.1	2.0	0.0	3.2		6.2			
% Attribute Illness in Past Year to Outdoor Air Quality	9.9	4.9	10.4	2.2	7.8		12.0			

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Family Planning	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% of Births to Unwed Mothers	43.9	26.4	32.5		37.7	35.6	37.7		26.1	
% Births to Teenagers (Ages 15-19)	12.5	7.9	9.7		10.4	10.7	10.3		8.5	

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Heart Disease & Stroke	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Diseases of the Heart (Age-Adjusted Death Rate)	254.1	154.4	226.7		218.8	237.6	220.3	213.7	254.2	
Stroke (Age-Adjusted Death Rate)	54.8	30.0	51.1		44.6	51.6	50.0	48.0	53.3	
% Chronic Heart Disease	11.5	9.4	8.6	13.3	10.3		6.7		6.9	6.0
% Stroke	2.7	3.5	2.4	1.3	2.8	2.4	4.9		2.5	1.4
% Blood Pressure Checked in Past 2 Years	94.7	91.3	87.5	100.0	92.6		94.5	95.0	89.8	97.0
% Told Have High Blood Pressure	31.7	39.3	41.3	34.7	36.3	27.5	34.0	16.0	24.6	27.7
% Taking Action to Control High Blood Pressure	89.3	96.3	92.5		92.4		90.9	95.0		
% Cholesterol Checked in Past 5 Years	84.2	86.0	80.2	83.6	83.9	75.9	87.0	80.0	77.4	83.2
% Told Have High Cholesterol	33.4	41.6	35.9	32.4	36.6	38.5	30.5	17.0	25.0	30.4
% Taking Action to Control High Blood Cholesterol	88.1	90.5	93.6		90.4		90.4			
% 1+ Cardiovascular Risk Factor	84.9	79.6	89.5	80.6	83.8		85.1			

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

HIV	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
HIV/AIDS (Age-Adjusted Death Rate)					2.2	3.7	4.7	0.7		
HIV/AIDS Incidence/100,000					7.7	16.9	18.9	1.0	11.6	
% Ever Tested for HIV (Ages 18-64)	51.1	42.3	46.9	67.1	48.4		52.9		53.3	67.3

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Immunization & Infectious Disease	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Hepatitis C, non-A non-B Incidence/100,000	0.0	0.0	0.0		0.7	0.5	0.3		1.6	
% Flu Shot in Past Yr (Aged 65+)	75.2	59.9			68.3	63.5	73.2	90.0	70.8	49.9
% Flu Shot in Past Yr (High-Risk Aged 18-64)	54.5	58.7			51.6		43.7	60.0		
% Pneumonia Vaccine Ever (Aged 65+)	70.4	65.3			67.3	67.6	69.7	90.0		
% Pneumonia Vaccine Ever (High-Risk Aged 18-64)	33.8	48.5			39.4		36.1	60.0		

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Injury & Violence	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Unintentional Injury (Age-Adjusted Death Rate)	52.9	48.5	59.0		40.9	44.9	38.1	17.5		36.2
Motor Vehicle Crashes (Age-Adjusted Death Rate)	17.4	21.9	29.9		16.2	18.2	15.2	9.2		15.3
Other Accidents (Age-Adjusted Death Rate)	35.5	26.6	29.1		24.7	26.7				20.9
Homicide (Age-Adjusted Death Rate)					4.8	8.0	6.0	3.0		4.2
Suicide (Age-Adjusted Death Rate)	28.1	13.4	29.1		22.4	19.6	10.9	5.0		20.6
% "Always" Wear Seat Belt	90.2	93.5	94.4	70.9	90.9		83.5	92.0	76.7	78.5
% Child (Aged 0-4) "Always" Uses Auto Child Restraint					97.0		97.4	100.0		
% Child (Aged 5-17) "Always" Uses Seat Belt	92.7				93.9		93.0	92.0		
% Child (Aged 0-17) "Always" Uses Seat Belt/Car Seat	93.4	94.9			95.0		94.3		90.6	97.4
% Child "Always" Wears Bicycle Helmet (Aged 5-16)	43.4				42.0		41.7			
% Firearm in Home	40.2	59.3	48.6	47.4	48.7		35.3		48.2	48.6
% Homes With Children With a Firearm	32.2	54.8			40.6		31.2		42.6	51.6
% Homes w/Unlocked Loaded Firearm	15.1	21.5	22.5		20.1		15.2	16.0		
Violent Crime/100,000	384.6	160.3	161.9		448.2	741.3	465.0			414.3
% Victim of Violent Crime in Past 5 Years	1.8	0.0	4.5	0.0	1.6		2.4		2.6	3.5
Verbally Threatened by Partner	14.9	10.7	22.5	14.5	14.9		14.6			
Physically Injured by Partner	14.6	12.1	22.2	12.3	15.1		15.0			

Note: Each county is compared against all others combined.

-blank- no data

favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Kidney Disease

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Kidney Disease (Age-Adjusted Death Rate)	21.0				13.6	21.7	14.1		10.8	

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Maternal, Child & Infant Health

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% No Prenatal Care in 1st Trimester	29.4	20.2	26.2		28.1	34.8	16.3	10.0	17.5	
% of Low Birthweight Births	8.0	9.2	7.9		8.3	12.9	8.2	5.0	7.6	
Infant Death Rate					5.2	6.0	6.9	4.5	6.1	

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Mental Health & Mental Disorders

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% "Fair/Poor" Mental Health	9.9	5.2	13.2	5.9	8.6		12.9			
% Major Depression	8.2	10.7	15.7	8.0	10.5		9.7			
% Chronic Depression (2+ Years)	32.2	21.4	34.6	21.3	28.3		30.3		21.1	23.3
% Depressed Persons Seeking Help	48.9	61.2	62.0		57.1		43.0	50.0	41.0	51.0
% Typical Day Is "Extremely/Very" Stressful	10.3	6.6	9.0	5.3	8.5		13.4			
% Child Takes Rx for ADD/ADHD	8.1				6.1		6.3			
Alzheimer's Disease (Age-Adjusted Death Rate)	19.0	15.8			15.5	17.6	22.1		16.3	

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Nutrition & Overweight	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Eat 5+ Servings of Fruit or Vegetables per Day	46.3	46.5	49.6	44.8	47.0		43.5		35.3	41.7
% Eat 2+ Servings of Fruit per Day	68.8	67.9	59.8	58.4	66.0		58.4	75.0		
% Eat 3+ Servings of Vegetables per Day	34.4	32.8	29.5	40.4	33.3		38.8	50.0		
% Received Advice on Nutrition in Past Year	35.8	44.1	34.1	38.3	38.4		38.2			
% Unhealthy Weight (BMI <18.5 or 25+)	66.4	65.2	73.7	52.6	66.5		68.0	40.0	57.0	56.3
% Overweight	65.9	64.3	73.7	52.5	66.0	63.0	67.4		55.2	52.5
% Obese	21.2	26.8	34.3	21.1	25.6	26.4	29.0	15.0	20.4	17.0
% Overweights Advised to Lose Weight	29.4	31.4	27.0		29.4		33.4			
% Overweight Trying to Lose	43.5	48.1	39.2		42.7		43.0		35.5	35.8
% Children (Aged 6-17) Overweight					28.7		42.7			
% Children (Aged 6-17) Obese					11.7		26.1	5.0		

Note: Each county is compared against all others combined.

-blank- no data

favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Oral Health	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Have Dental Insurance	65.8	61.8	60.6	70.2	63.7		61.7			
% Have Visited Dentist in Past Yr (18+)	63.9	71.9	63.5	80.1	67.6	63.7	63.5	56.0	67.0	74.0
% Child (Aged 2-17) Has Visited Dentist in Past Year	74.7	83.8			80.4		85.1	56.0	70.6	61.8

Note: Each county is compared against all others combined.

-blank- no data

favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Physical Activity & Fitness

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% No Leisure-Time Physical Activity	20.6	15.4	22.9	26.8	19.7	24.4	28.8	20.0	25.3	14.9
% Meeting Physical Activity Recommendations	54.2	59.4	50.6	50.8	55.0	51.4	38.5			
% Vigorous Physical Activity	43.2	43.2	34.6	28.3	40.5	29.8	28.0	30.0		
% Moderate Physical Activity	33.8	34.9	37.9	39.1	35.3		22.6	30.0		
% Received Advice on Exercise in Past Year	40.0	47.1	34.1	41.5	41.3		42.7			

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Physical Health

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% "Fair/Poor" Physical Health	15.2	11.5	22.1	18.6	15.6	15.9	17.4		11.3	10.3

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Respiratory Disease

	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
CLRD (Age-Adjusted Death Rate)	66.7	35.0	69.6		62.3	58.8	42.6		68.2	
Pneumonia/Influenza (Age-Adjusted Death Rate)	16.8	8.7	20.4		16.6	21.9	20.7		18.3	
% Sinusitis	13.2	13.8	20.0	7.7	14.4		18.2			
% Nasal/Hay Fever Allergies	35.3	39.4	32.7	18.9	35.1		28.4			
% Chronic Lung Disease	9.3	8.6	10.5	19.9	10.0		9.9		8.3	10.0
% Asthma	7.0	7.6	14.1	3.4	8.3		8.3			
% Child Has Asthma	7.1	2.7			5.4		11.4			

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Sexually Transmitted Diseases	Each County vs. Remaining Areas Combined: Carson City	Douglas Co.	Lyon Co.	Other Areas	Total Area	Total Area vs. Benchmarks: vs. NV	vs. US	vs. HP2010	TRENDS: Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Gonorrhea Incidence/100,000	27.3	16.2	21.2		44.8	96.0	116.8	19.0	53.6	
Primary & Secondary Syphilis Incidence/100,000	0.0	0.0	0.0		0.8	4.3	3.9	0.2	0.9	
Chlamydia Incidence/100,000	215.1	142.7	183.7		296.8	360.5	372.2		293.0	
Hepatitis B Incidence/100,000	3.0	0.0	0.0		1.3	1.7	1.5		2.6	
Ever Received Hepatitis B Vaccine	33.8	34.5	39.9	35.0	35.3		33.9			

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Substance Abuse	Each County vs. Remaining Areas Combined: Carson City	Douglas Co.	Lyon Co.	Other Areas	Total Area	Total Area vs. Benchmarks: vs. NV	vs. US	vs. HP2010	TRENDS: Carson City (vs. 1999)	Douglas Co. (vs. 2001)
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	18.4		19.3		15.6	11.7	9.1	3.0	15.4	
% Current Drinker	59.0	67.4	51.4	68.1	60.9	53.9	52.6		64.5	70.2
% Chronic Drinker	9.0	6.4	7.5	8.9	7.8	6.8	4.5		8.8	15.0
% Binge Drinker	20.9	17.5	15.5	14.4	18.3	17.4	17.8	6.0	17.7	20.4
% Drinking & Driving in Past Month	5.4	0.6	1.3	5.5	3.0		3.8		4.0	4.5
% Driving Drunk or Riding with Drunk Driver	7.5	2.2	5.9	11.0	5.7		8.6			
% Illicit Drug Use in Past Month	3.4	2.5	1.2	6.5	2.9		2.9	2.0		
% Sought Help for Alcohol or Drug Problem	8.1	2.7	9.0	7.4	6.4		5.5		5.9	4.6

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Tobacco Use	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Current Smoker	16.8	14.4	27.5	21.7	18.4	21.9	19.2	12.0	23.0	22.2
% Received Advice to Quit Smoking (Smokers)	61.5				57.5		61.4			
% Have Quit Smoking 1+ Days in Past Year (Smokers)	43.4				49.3		57.0	75.0		
% Someone Smokes at Home	14.1	5.7	15.6	8.8	11.2		16.3			
% Children <18 Exposed to Smoke at Home	7.9	2.5			7.0		13.3			
% Use Smokeless Tobacco	3.8	4.3	6.6	0.0	4.3		3.9	0.4	3.6	1.0
% Smoke Cigars	4.4	3.4	8.9	0.0	4.7		4.6	1.2		

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

Vision & Hearing	Each County vs. Remaining Areas Combined				Total Area	Total Area vs. Benchmarks			TRENDS	
	Carson City	Douglas Co.	Lyon Co.	Other Areas		vs. NV	vs. US	vs. HP2010	Carson City (vs. 1999)	Douglas Co. (vs. 2001)
% Eye Exam in Past 2 Years	63.2	62.4	62.1	70.0	63.2		59.2			
% Blindness/Trouble Seeing	10.1	6.1	11.9	0.0	8.4		9.1		9.5	6.3
% Deafness/Trouble Hearing	13.1	12.9	7.1	14.2	11.9		11.7		10.8	11.6

Note: Each county is compared against all others combined.

-blank- no data | favorable | unfavorable | similar

Survey data trends are specific to Carson City/Douglas Co. Public health/vital statistics trends reflect all counties combined.

SELF-REPORTED HEALTH STATUS

Physical Health Status

Self-Reported Health Status

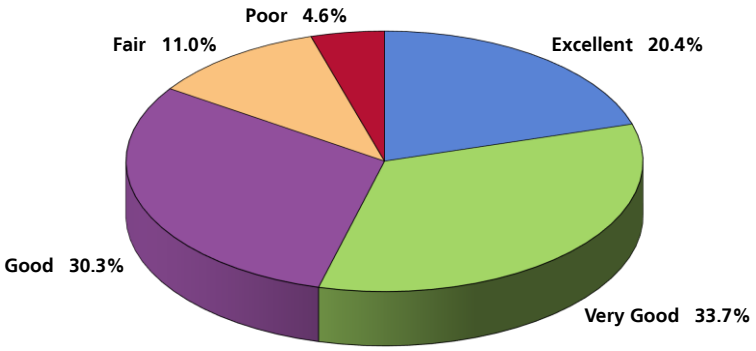
The initial inquiry of the 2010 PRC Community Health Survey asked respondents the following:

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

A total of 54.1% of Total Area adults rate their overall health as "excellent" or "very good."

- Another 30.3% gave "good" ratings of their overall health.

Self-Reported Health Status
(Total Area, 2010)



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

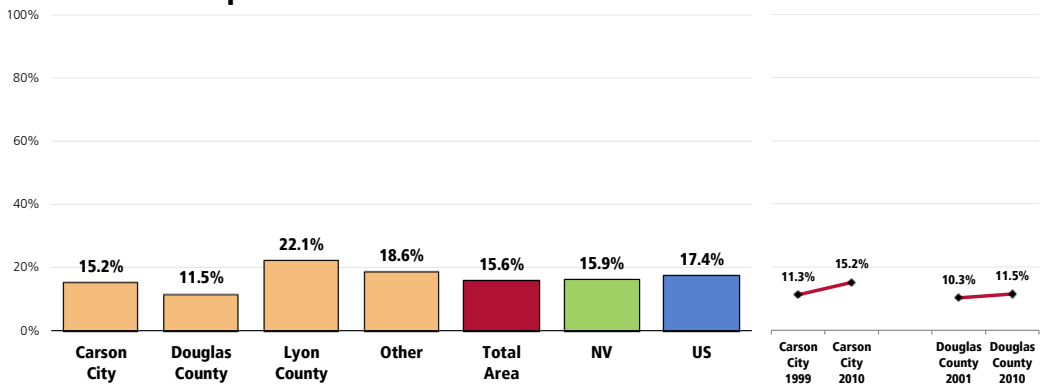
However, 15.6% of Total Area adults believe that their overall health is "fair" or "poor."

- Nearly identical to statewide findings (15.9% "fair/poor").
- Statistically similar to the national percentage (17.4% "fair/poor").
- Least favorable in Lyon County; most favorable in Douglas County.
- No statistically significant change has occurred in either Carson City or Douglas County when comparing "fair/poor" overall health reports to the previous survey results.

NOTE:

- Differences noted in the text represent significant differences determined through statistical testing.
- Where sample sizes permit, county-level data are provided.
- Trends are measured against baseline data – i.e., the earliest year that data are available or that are presented in this report.

Experience "Fair" or "Poor" Overall Health



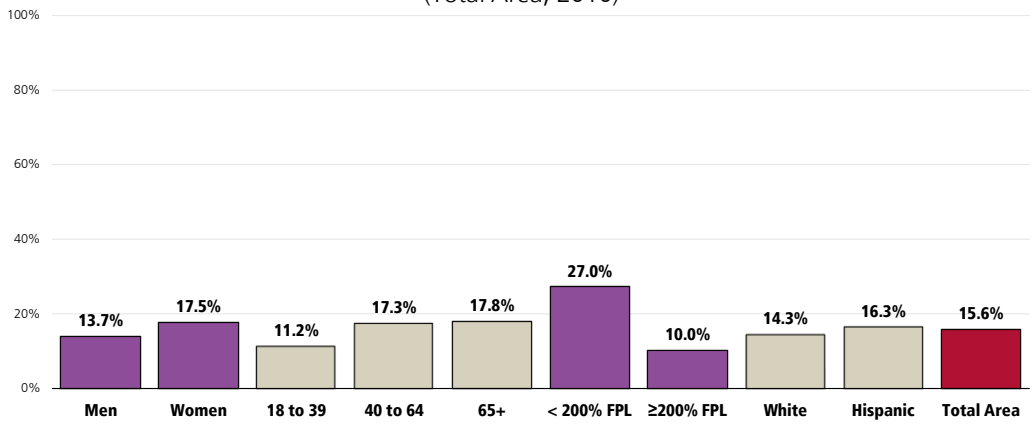
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

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

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

- Adults aged 40 and older.
- Residents living at lower incomes.
- Other differences within demographic groups, as noted in the following chart, are not statistically significant.

Experience "Fair" or "Poor" Overall Health
(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Activity Limitations

An estimated 54 million persons in the United States currently live with disabilities. The increase in disability among all age groups indicates a growing need for public health programs serving people with disabilities.

The direct medical and indirect annual costs associated with disability [in the US] are more than $300 billion, or 4 percent of the gross domestic product. This total cost includes $160 billion in medical care expenditures (1994 dollars) and lost productivity costs approaching $155 billion.

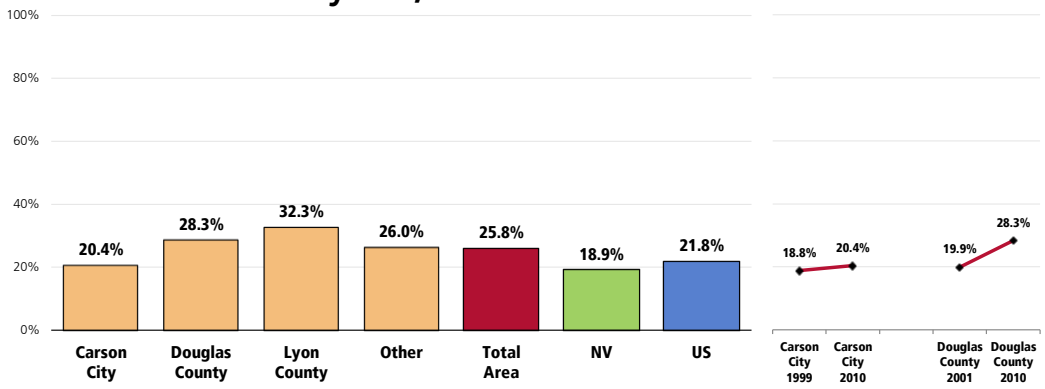
The health promotion and disease prevention needs of people with disabilities are not nullified because they are born with an impairing condition or have experienced a disease or injury that has long-term consequences. People with disabilities have increased health concerns and susceptibility to secondary conditions. Having a long-term condition increases the need for health promotion that can be medical, physical, social, emotional, or societal.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

A total of 25.8% of Total Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Less favorable than the 18.9% prevalence in Nevada.
- Less favorable than the 21.8% prevalence nationwide.
- Ranging from 20.4% in Carson City to 32.3% in Lyon County.
- Statistically unchanged in Carson City since 1999. In Douglas County, residents are significantly more likely to report activity limitations this year when compared with 2001 findings.

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



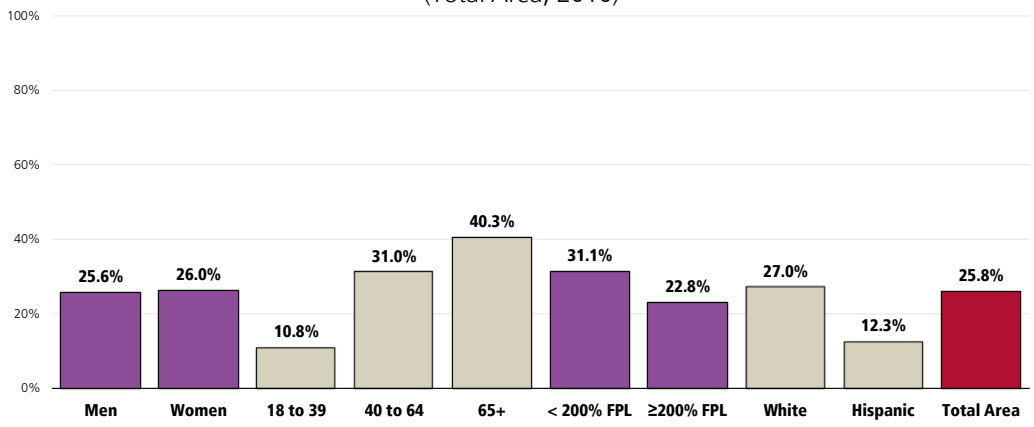
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 120]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

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

- Adults aged 40 or older are much more often limited in activities (note the positive correlation with age).
- Note also that respondents living at lower incomes are more likely to report some type of activity limitation.
- Non-Hispanic Whites are more likely than Hispanics to report activity limitations.

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

(Total Area, 2010)

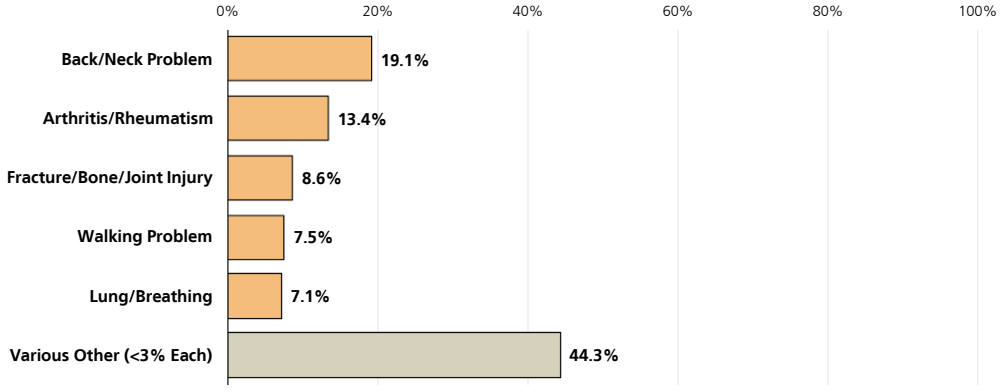


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

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

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; Total Area, 2010)



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]
Notes: • Asked of those respondents reporting activity limitations.

Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof), which are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders.

Mental disorders generate an immense public health burden of disability. The World Health Organization, in collaboration with the World Bank and Harvard University, has determined that the impact of mental illness on overall health and productivity in the United States and throughout the world often is profoundly underrecognized [Global Burden of Disease study]. In established market economies such as the United States, mental illness is on a par with heart disease and cancer as a cause of disability. Suicide—a major public health problem in the US—occurs most frequently as a consequence of a mental disorder.

Mental disorders occur across the lifespan, affecting persons of all racial and ethnic groups, both genders, and all educational and socioeconomic groups.

As the life expectancy of individuals continues to grow longer, the sheer number—although not necessarily the proportion—of persons experiencing mental disorders of late life will expand. This trend will present society with unprecedented challenges in organizing, financing, and delivering effective preventive and treatment services for mental health.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Mental Health Status

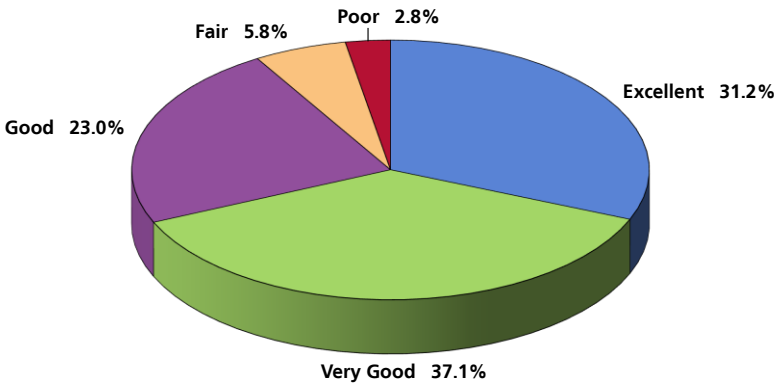
Self-Reported Mental Health Status

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

A total of 68.3% of Total 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
(Total Area, 2010)

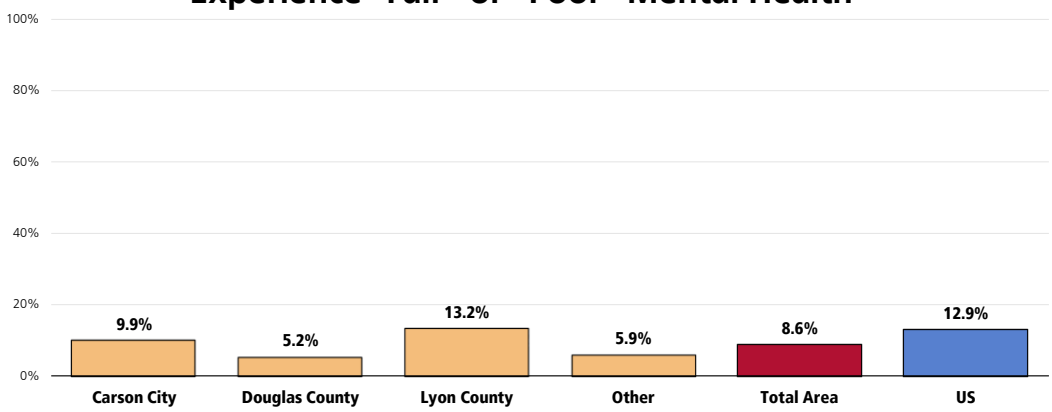


Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.

A total of 8.6% of Total Area adults, however, believe that their overall mental health is "fair" or "poor."

- More favorable than the 12.9% "fair/poor" reported across the nation.
- Least favorable (13.2%) in Lyon County; most favorable (5.2%) in Douglas County.

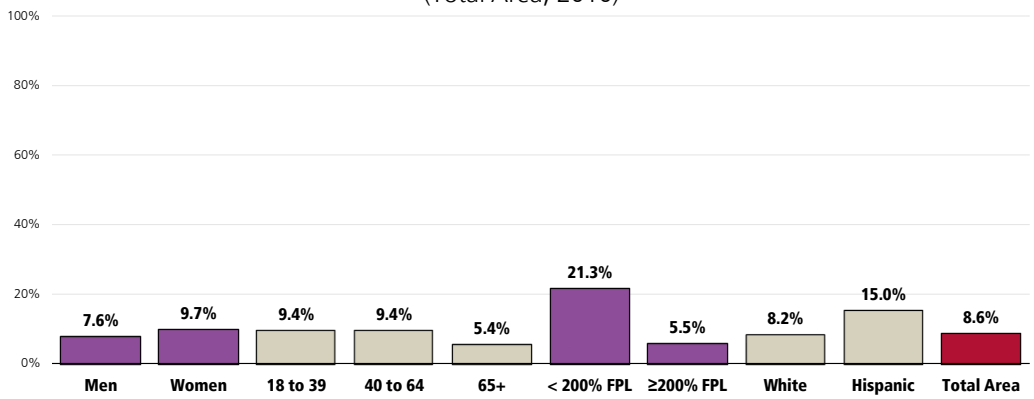
Experience "Fair" or "Poor" Mental Health



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Residents living at lower incomes are <u>much more likely</u> to report experiencing "fair/poor" mental health than those living at higher incomes.

Experience "Fair" or "Poor" Mental Health
(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

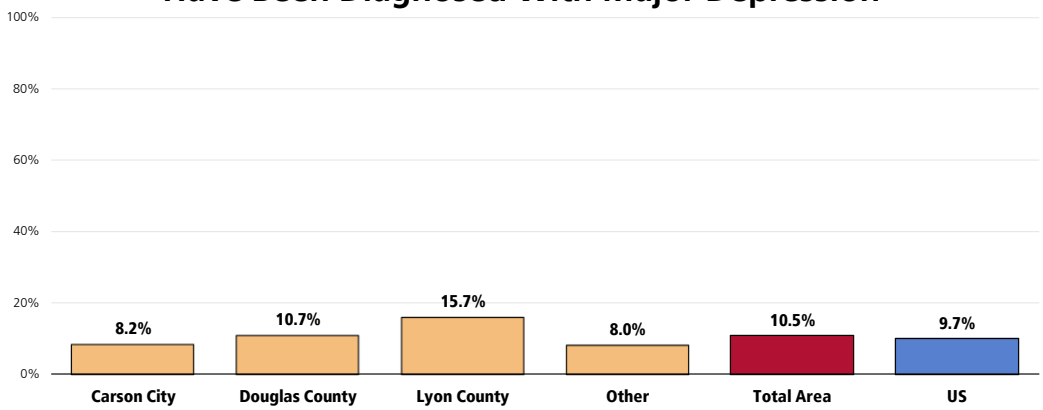
Depression

Major Depression

A total of 10.5% of Total Area adults have been diagnosed with major depression by a physician or other healthcare professional.

- Similar to the national figure (9.7%).
- Notably high in Lyon County (15.7%).

Have Been Diagnosed With Major Depression

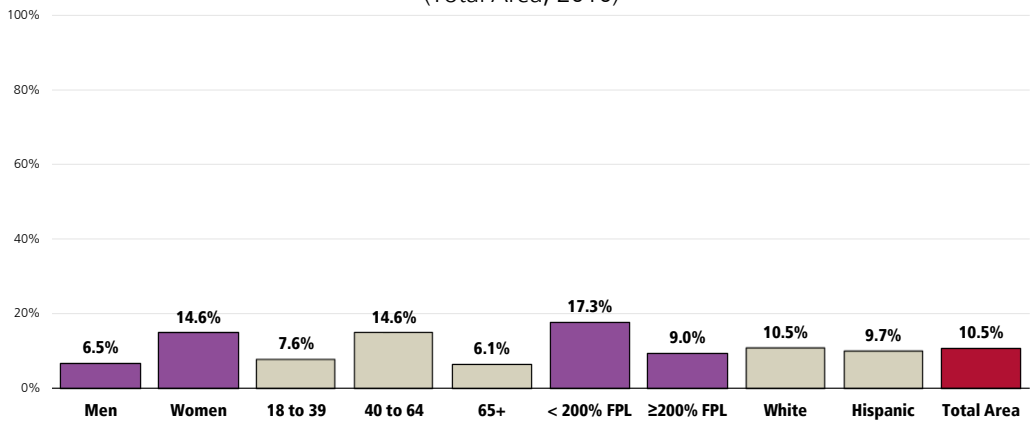


Sources: 2010 Community Health Survey, Professional Research Consultants, Inc. [Item 35]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

The prevalence of major depression is notably higher among:

- Women.
- Adults between the ages of 40 and 64.
- Community members living below the 200% poverty threshold.

Have Been Diagnosed With Major Depression
(Total Area, 2010)



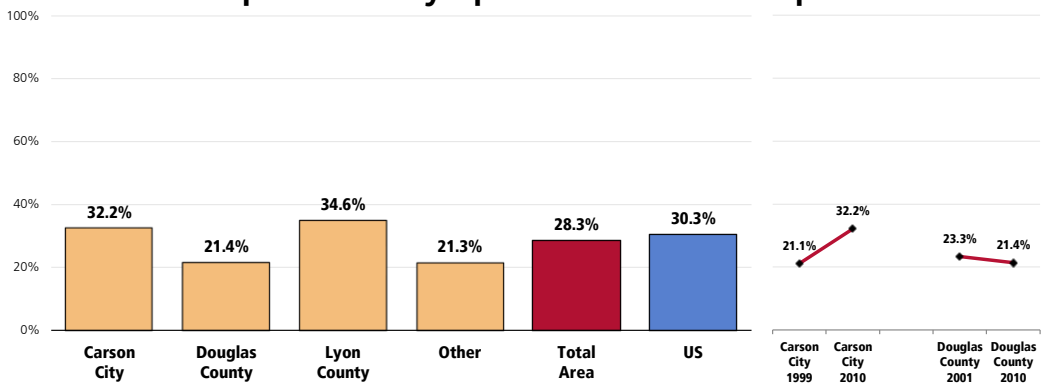
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Symptoms of Chronic Depression

A total of 28.3% of Total Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (chronic depression).

- Comparable to the national findings (30.3%).
- Ranging from 21.4% in Douglas County to 32.2% in Carson City.
- Marks a statistically significant increase in chronic depression among residents of Carson City; statistically unchanged over time among adults in Douglas County.

Have Experienced Symptoms of Chronic Depression

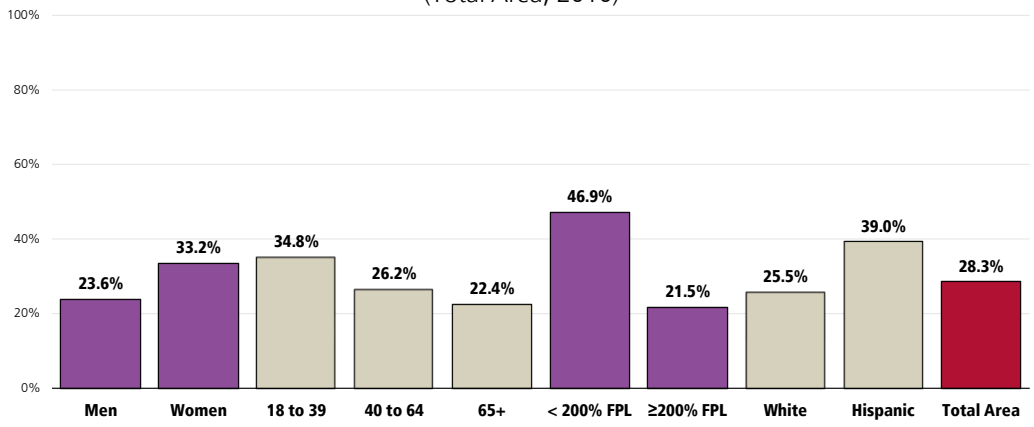


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 117]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

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

- Women.
- Adults under age 40.
- Lower-income adults.
- Hispanics.

Have Experienced Symptoms of Chronic Depression
(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Stress

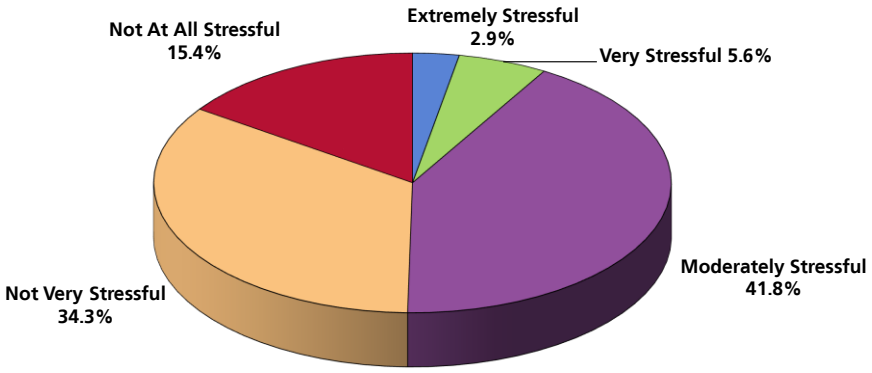
RELATED ISSUE:
See also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Roughly one-half of Total Area adults consider their typical day to be "not very stressful" (34.9%) or "not at all stressful" (15.4%).

- Another 41.8% of survey respondents gave "moderately stressful" evaluations of their typical day.

Perceived Level of Stress On a Typical Day

(Total Area, 2010)

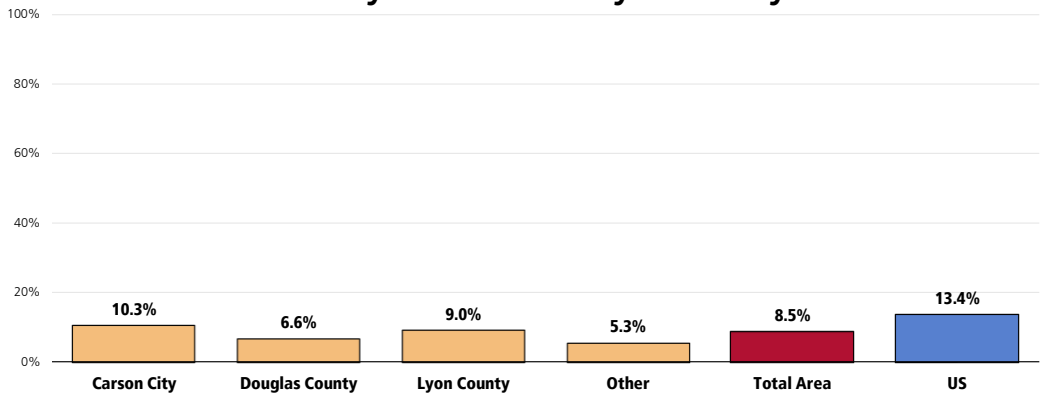


Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
Notes: • Asked of all respondents.

In contrast, 8.5% of Total Area adults experience "very" or "extremely" stressful days on a regular basis.

- More favorable than national findings (13.4%).
- No significant difference when viewed by county.

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

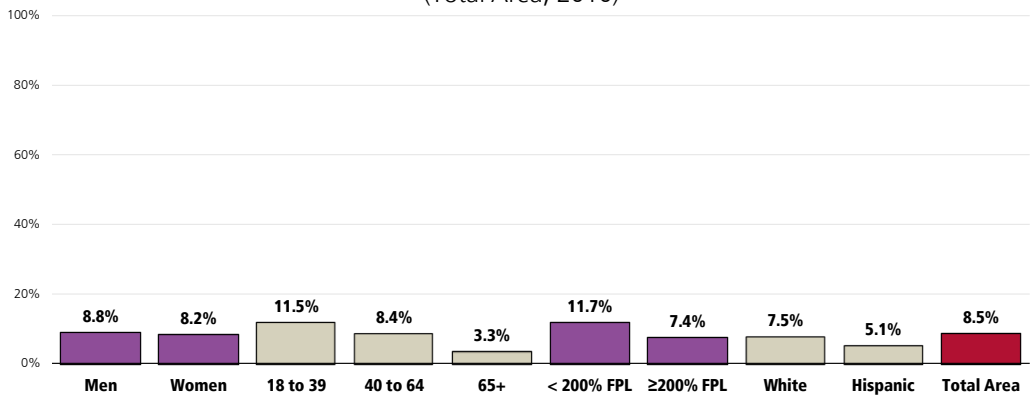


Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Note that high stress levels are more prevalent among adults aged 18 to 39.

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

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Mental Health Treatment

Modern treatments for mental disorders are highly effective, with a variety of treatment options available for most disorders, [however], the majority of persons with mental disorders do not receive mental health services.

Evidence that mental disorders are legitimate and highly responsive to appropriate treatment promises to be a potent antidote to stigma. Stigma creates barriers to providing and receiving competent and effective mental health treatment and can lead to inappropriate treatment, unemployment, and homelessness.

The co-occurrence of addictive disorders among persons with mental disorders is gaining increasing attention from mental health professionals. Having both mental and addictive disorders is a particularly significant clinical treatment issue, complicating treatment for each disorder.

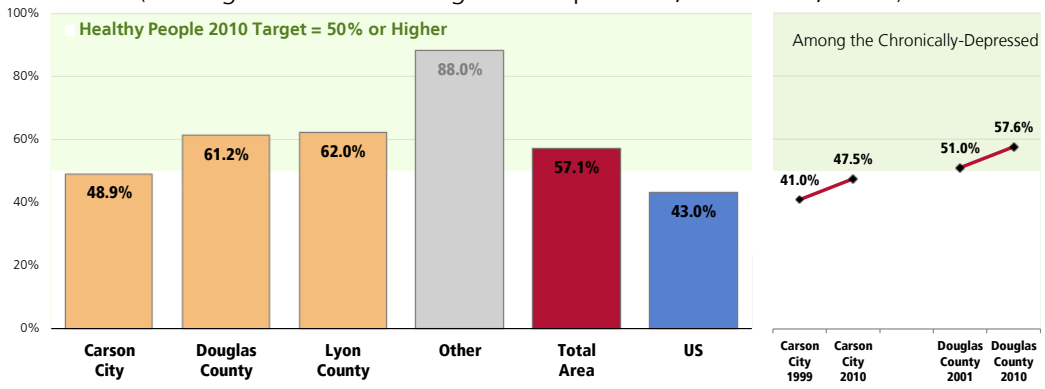
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Among adults with recognized depression (major or chronic depression), **57.1% acknowledge that they have sought professional help for a mental or emotional problem.**

- More favorable than corresponding national findings (43.0%).
- Satisfies the Healthy People 2010 goal of 50% or higher.
- Although higher in the "Other" communities, this is based on a relatively small sample size in this area.
- Lowest (48.9%) in Carson City.
- There has been no significant change over time in either Carson City or Douglas County among adults with chronic depression (*note that the "major depression" item was not asked in 1999 and 2001*).

Have Sought Professional Help for a Mental or Emotional Problem

(Among Those With Recognized Depression; Total Area, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 172]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 18-9b]

Notes: Asked of those respondents with recognized depression.
County areas shown in gray are based on unreliable sample sizes.

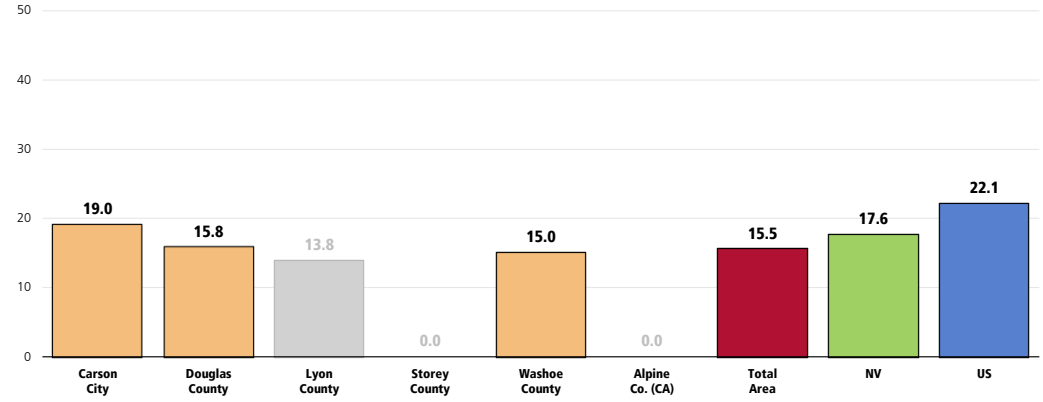
Age-Adjusted Alzheimer's Disease Deaths

Between 2004 and 2006, there was an annual average age-adjusted Alzheimer's disease mortality rate of 15.5 deaths per 100,000 population in the Total Area.

- More favorable than the statewide rate (17.6).
- More favorable than the national rate (22.1).
- Highest in Carson City (19.0).

Alzheimer's Disease: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)

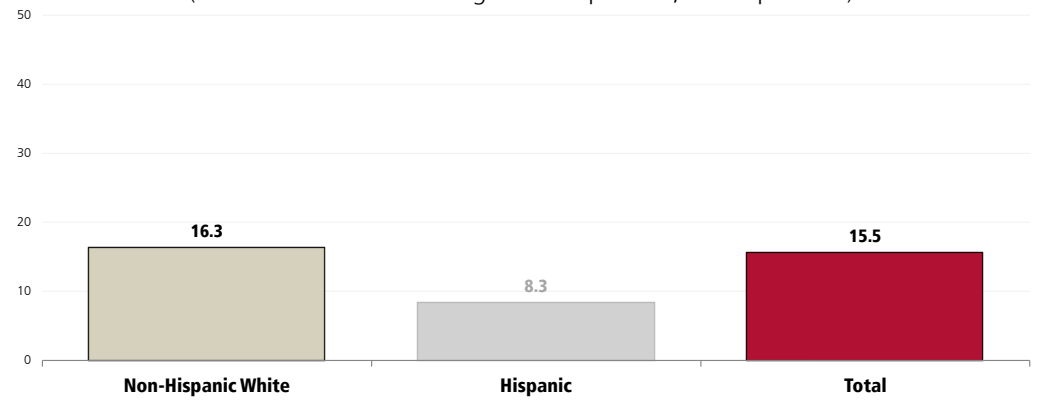


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rates for Lyon County and Storey County, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

Alzheimer's disease mortality rates appear higher among Non-Hispanic Whites, although the Hispanic rate is deemed unreliable due to low number of deaths.

Alzheimer's Disease: Age-Adjusted Mortality by Race

(2004-2006 Annual Average Deaths per 100,000 Population)

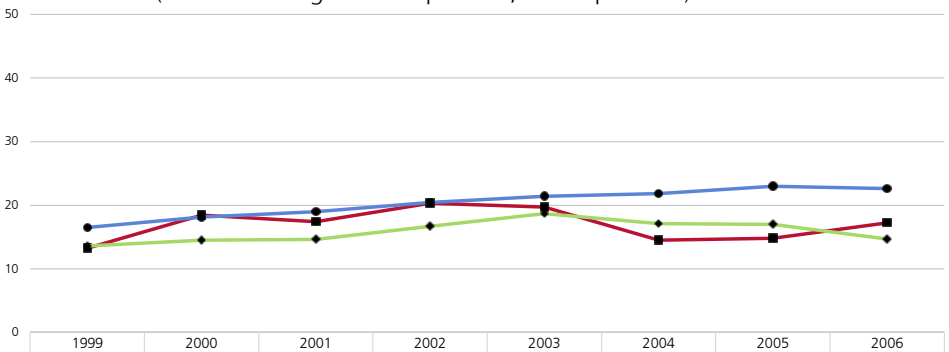


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rate for Hispanics is unreliable due to low number of deaths.

- Alzheimer's disease mortality rates increased in the late 1990s, but have since decreased.

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Total Area	13.2	18.4	17.4	20.3	19.7	14.5	14.8	17.2
Nevada	13.6	14.5	14.6	16.7	18.7	17.1	17.0	14.7
United States	16.5	18.1	19.0	20.4	21.4	21.8	23.0	22.6

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

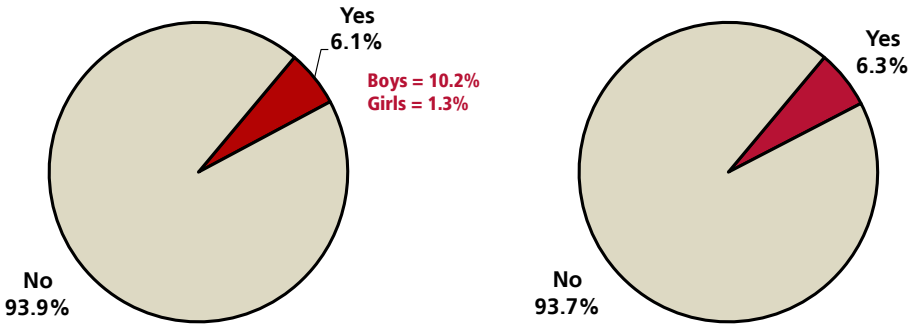
Children & ADD/ADHD

Among Total Area adults with children aged 5 to 17, 6.1% report that their child takes medication for ADD/ADHD.

- Nearly identical to the 6.3% prevalent reported nationally.
- By gender in the Total Area, boys aged 5-17 are much more likely than girls to be taking medication for ADD/ADHD (10.2% vs. 1.3%, respectively).

Child Takes Medication for ADD/ADHD

(Among Parents of Children Aged 5 to 17; Total Area, 2010)



Total Area 2010 **United States 2008**

Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 135]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

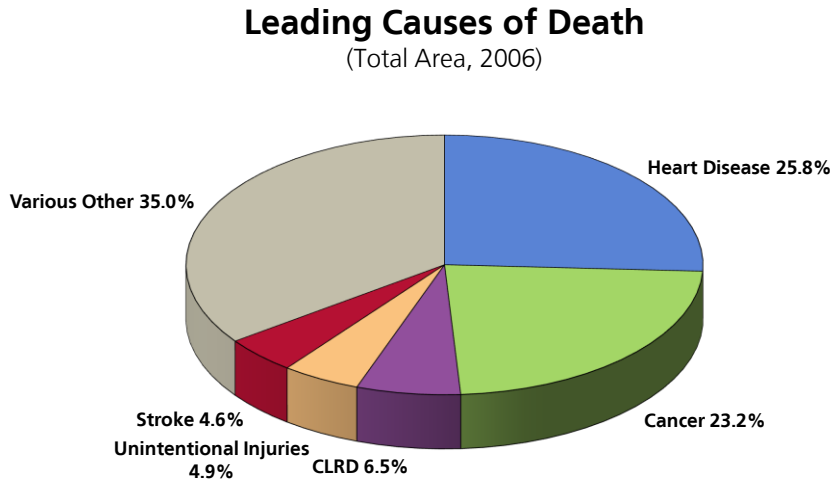
Notes:
- Asked of all respondents with children aged 5 to 17.

DEATH & DISABILITY

Leading Causes of Death

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for nearly one-half of all deaths in the Total Area in 2006.



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
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 2010* targets.

The following chart outlines 2004-2006 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Total Area.

Age-adjusted mortality rates in the Total Area are better than state and national rates for several of the selected causes illustrated in the following table.

However, Total Area death rates are worse than US rates for the following:

- Chronic Lower Respiratory Disease (CLRD)
- Unintentional Injuries (including Motor Vehicle Crashes)
- Suicide
- Cirrhosis/Liver Disease

Of the causes outlined in the following chart for which Healthy People 2010 objectives have been established, only **cerebrovascular disease (stroke)** clearly satisfies the target.

Age-Adjusted Death Rates for Selected Causes

(2004-2006 Deaths per 100,000)

	Total Area	NV	US	HP2010
Diseases of the Heart	**218.8**	**237.6**	**220.3**	**213.7***
Malignant Neoplasms (Cancers)	**184.5**	**193.1**	**186.6**	**159.9**
Chronic Lower Respiratory Disease (CLRD)	**62.3**	**58.8**	**42.6**	n/a
Cerebrovascular Disease (Stroke)	**44.6**	**51.6**	**50.0**	**48.0**
Unintentional Injuries	**40.9**	**44.9**	**38.1**	**17.5**
Motor Vehicle Crashes	16.2	18.2	15.2	9.2
Intentional Self-Harm (Suicide)	**22.4**	**19.6**	**10.9**	**5.0**
Diabetes Mellitus	**17.2**	**14.6**	**24.8**	**15.1***
Influenza/Pneumonia	**16.6**	**21.9**	**20.7**	n/a
Cirrhosis/Liver Disease	**15.6**	**11.7**	**9.1**	**3.0**
Alzheimer's Disease	**15.5**	**17.6**	**22.1**	n/a
Kidney Disease	**13.6**	**21.7**	**14.1**	n/a
Homicide/Legal Intervention	**4.8**	**8.0**	**6.0**	**3.0**
HIV/AIDS	**2.2**	**3.7**	**4.7**	**0.7**

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population and coded using ICD-10 codes.
- *The Healthy People 2010 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.
- County, state and national data are simple three-year averages, the Total Area three-year averages are weighted by population.

(For infant mortality data, see "Maternal, Infant & Child Health.")

Cardiovascular Disease

Heart disease and stroke—the principal components of cardiovascular disease—are the first and third leading causes of death in the United States, accounting for more than 40% of all deaths.

- About 950,000 adults die of heart disease or stroke each year, which amounts to one death every 33 seconds.
- Although heart disease and stroke are often thought to affect men and older people primarily, it is also a major killer of women and people in the prime of life. More than half of those who die of heart disease or stroke each year are women.
- Each year, about 63 of every 100,000 deaths are due to stroke.

Looking at only deaths due to heart disease or stroke, however, understates the health effects of these two conditions:

- About 61 million adults (almost one-fourth of the population) live with the effects of stroke or heart disease.
- Heart disease is a leading cause of disability among working adults.
- Stroke alone accounts for the disability of more than 1 million adults.
- Almost 6 million hospitalizations each year are due to heart disease or stroke.
- About 4.5 million stroke survivors are alive today.

The economic effects of heart disease and stroke on the US healthcare system grow larger as the population ages. In 2001, for example, the [nationwide] cost for all cardiovascular diseases was $300 billion: for heart disease the cost was $105 billion; for stroke, $28 billion. Lost productivity due to stroke and heart disease cost more than $129 billion.

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

Age-Adjusted Heart Disease & Stroke Deaths

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

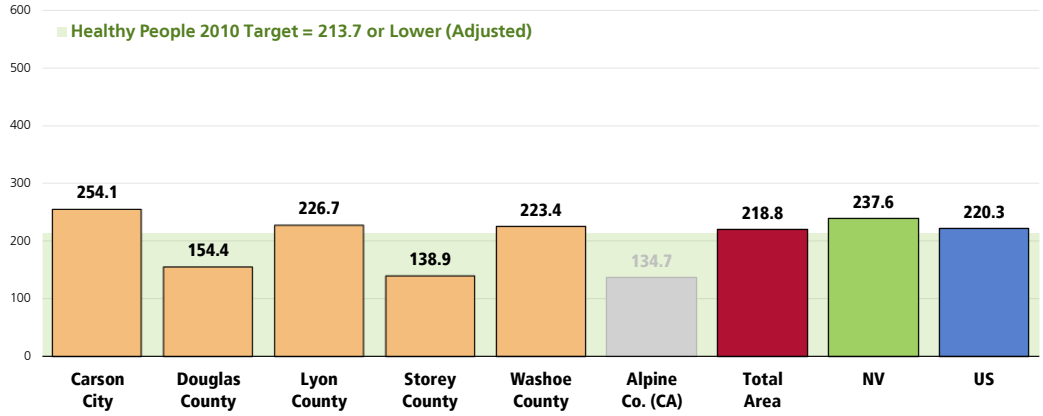
Heart Disease Deaths

Between 2004 and 2006, there was an annual average age-adjusted heart disease mortality rate of 218.8 deaths per 100,000 population in the Total Area.

- Lower than found statewide (237.6).
- Similar to the national rate (220.3).
- Similar to the Healthy People 2010 objective of 213.7 or lower (adjusted to account for all diseases of the heart).
- Highest (least favorable) in Carson City and Lyon County; notably lower in Douglas County and Storey County.

Heart Disease: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



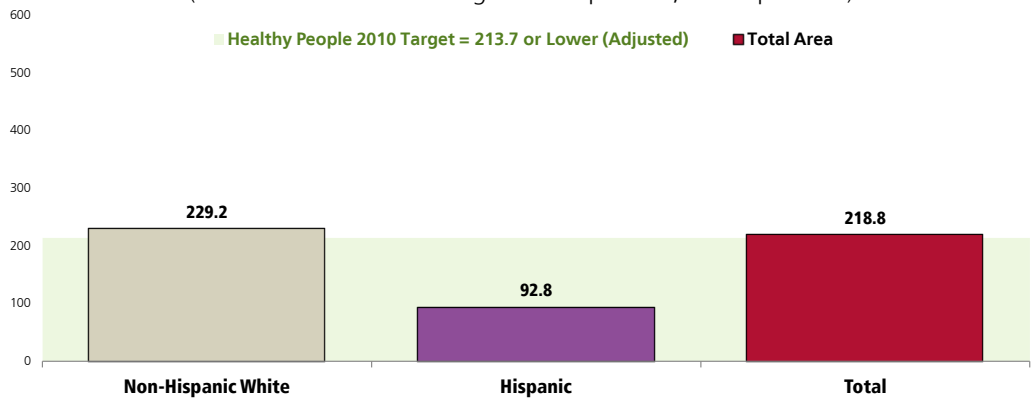
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-1]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
The Healthy People 2010 Heart Disease target is adjusted to account for all diseases of the heart.
Note that the rate for Alpine County, California, is unreliable due to low number of deaths.

By race, heart disease mortality rates are more than twice as high among Non-Hispanic Whites when compared with Hispanics in the Total Area.

Heart Disease: Age-Adjusted Mortality by Race

(2004-2006 Annual Average Deaths per 100,000 Population)



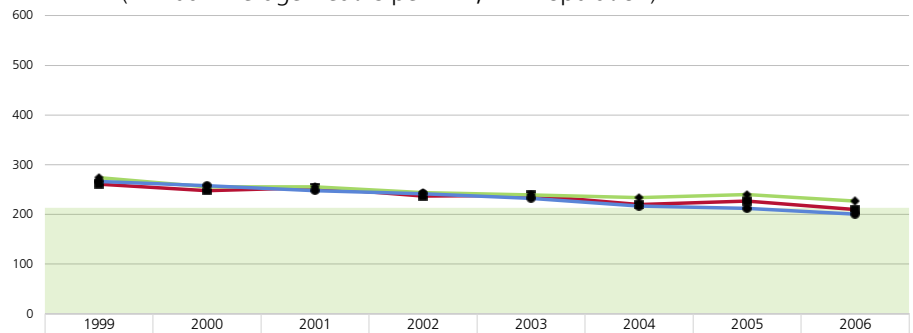
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-1]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
The Healthy People 2010 Heart Disease target is adjusted to account for all diseases of the heart.

- Heart disease mortality rates have decreased across the Total Area over the past decade, echoing the decreasing trends across Nevada and the US overall.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	213.7	213.7	213.7	213.7	213.7	213.7	213.7	213.7
Total Area	261.1	247.6	253.8	236.7	238.8	220.2	226.7	209.9
Nevada	274.3	255.4	255.7	243.6	239.0	233.7	240.1	226.8
United States	266.4	257.8	247.6	241.5	232.3	217.1	211.8	200.3

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-1]

Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
The Healthy People 2010 Heart Disease target is adjusted to account for all diseases of the heart.

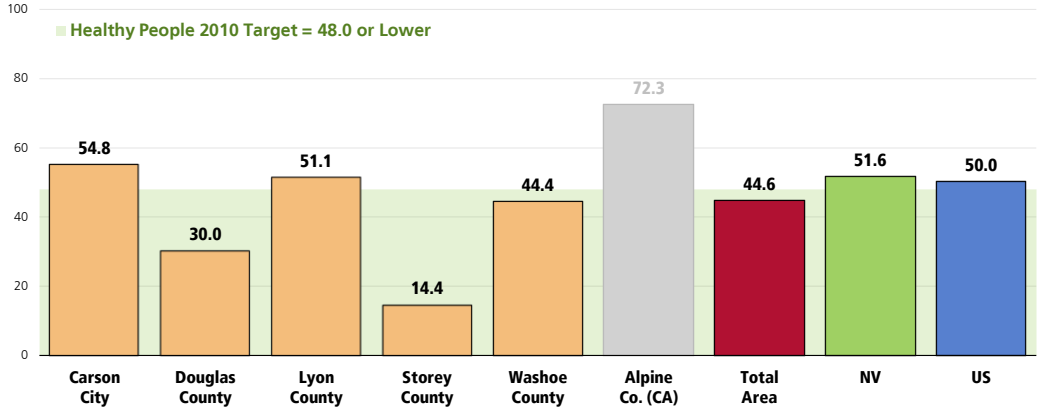
Stroke Deaths

Between 2004 and 2006, there was an annual average age-adjusted stroke mortality rate of 44.6 deaths per 100,000 population in the Total Area.

- More favorable than the Nevada rate (51.6).
- More favorable than the national rate (50.0).
- Satisfies the Healthy People 2010 target of 48.0 or lower.
- Notably higher in Carson City and Lyon County. While Alpine County also experienced a high rate, this rate is deemed unreliable due to a low number of deaths.

Stroke: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



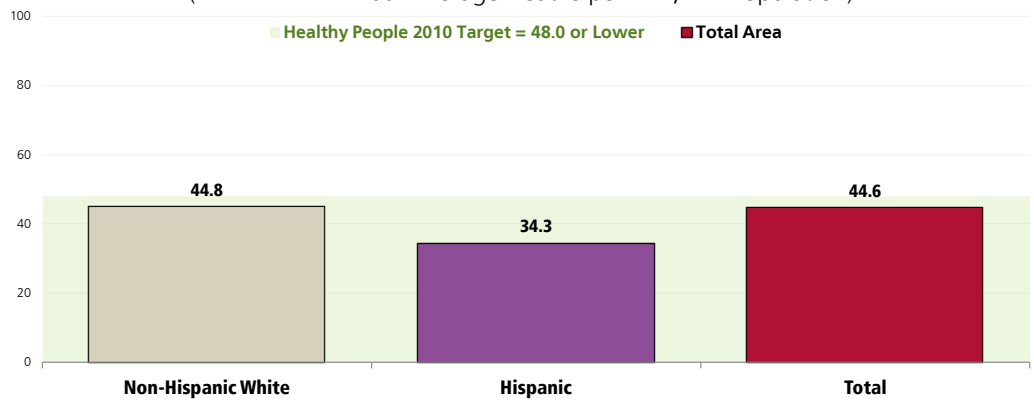
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-7]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rate for Alpine County, California, is unreliable due to low number of deaths.

Stroke mortality is higher among Non-Hispanic Whites when compared with Hispanics.

Stroke: Age-Adjusted Mortality by Race

(2004-2006 Annual Average Deaths per 100,000 Population)

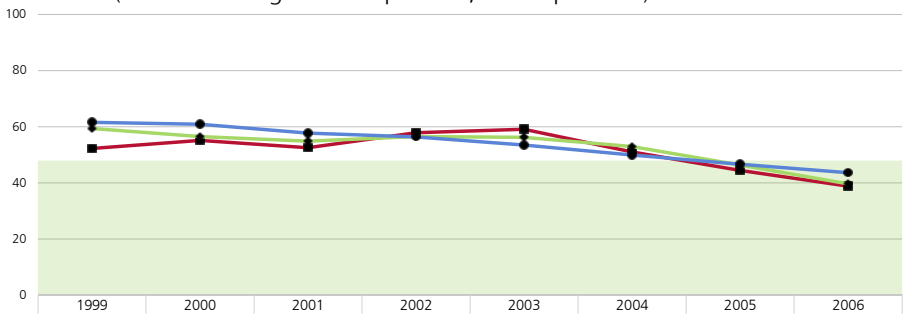


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-7]
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Stroke rates have declined in recent years, echoing the trends reported across Nevada and the US overall.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	48.0	48.0	48.0	48.0	48.0	48.0	48.0	48.0
Total Area	52.3	55.2	52.5	57.9	59.1	51.1	44.5	38.9
Nevada	59.4	56.5	54.9	56.5	56.2	52.9	46.4	39.7
United States	61.6	60.9	57.8	56.4	53.5	50.0	46.7	43.6

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-7]
Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

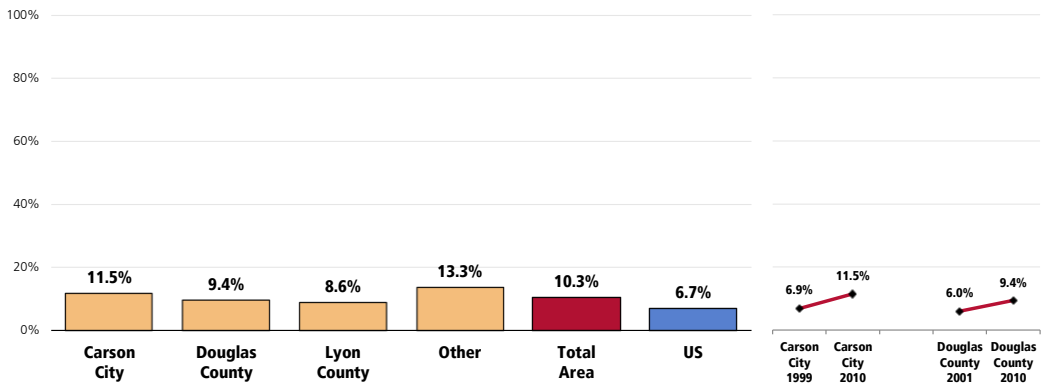
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 10.3% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Less favorable than the national prevalence (6.7%).
- No significant difference by county.
- Note the statistically significant increase in heart disease among Carson City respondents.
- The increase reported for Douglas County, however, is not statistically significant.

Prevalence of Heart Disease

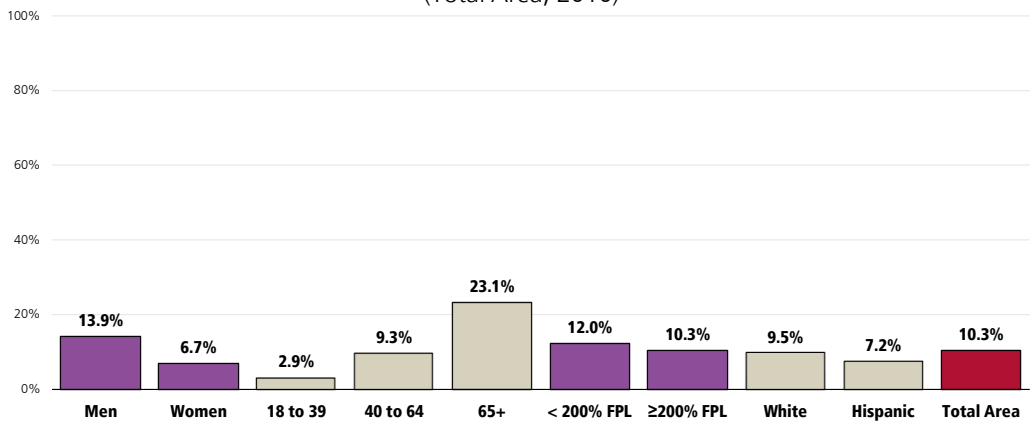


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 145]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

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

- Men.
- Adults aged 65 and older.

Prevalence of Heart Disease
(Total Area, 2010)

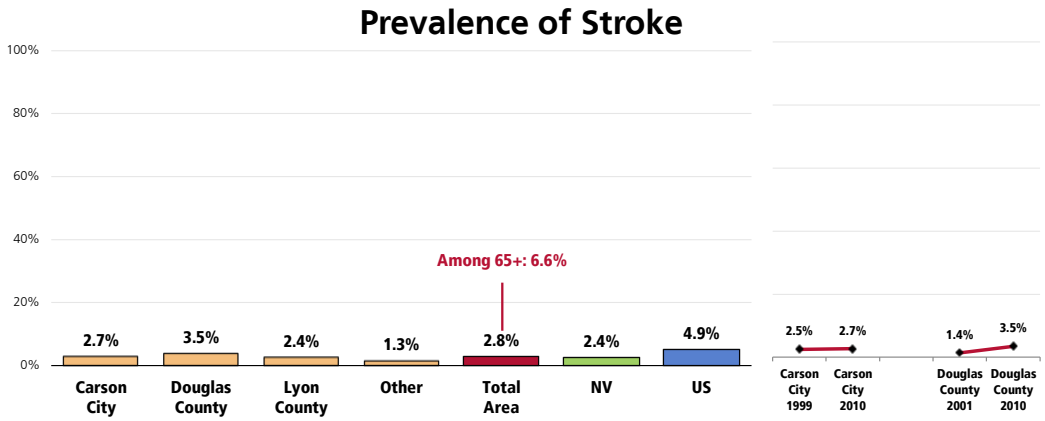


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 145]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Prevalence of Stroke

A total of 2.8% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to statewide findings (2.4%).
- More favorable than national findings (4.9%).
- Statistically similar by county.
- Note: Among Total Area residents aged 65 and older, 6.6% have had a stroke.
- No significant change in the prevalence of stroke is reported for either Carson City or Douglas County.



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 42]
2008 PRC National Health Survey, Professional Research Consultants.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
Notes: Asked of all respondents.

Cardiovascular Risk Factors

Hypertension (High Blood Pressure)

High blood pressure is known as the "silent killer" and remains a major risk factor for coronary heart disease, stroke, and heart failure. About 50 million adults in the United States have high blood pressure.

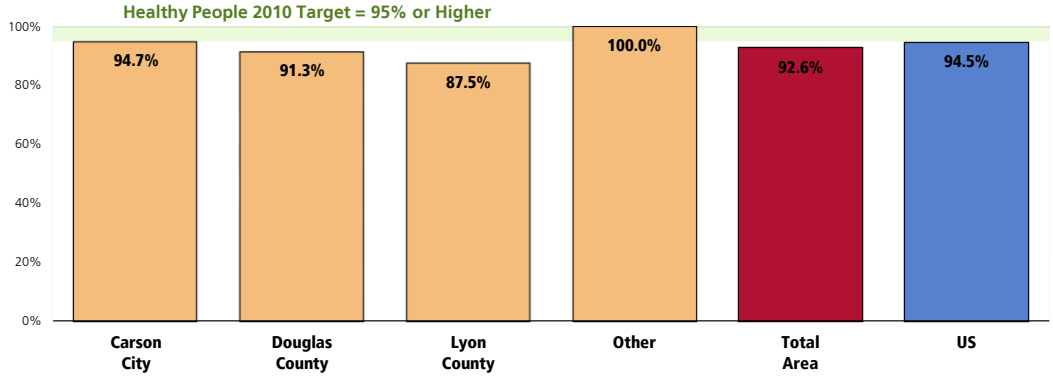
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

High Blood Pressure Testing

A total of 92.6% of Total Area adults have had their blood pressure tested within the past two years.

- Similar to national findings (94.5%).
- Fails to satisfy the Healthy People 2010 target (95% or higher).
- Notably lower in Lyon County; higher in the "Other" counties.

Have Had Blood Pressure Checked in the Past 2 Years



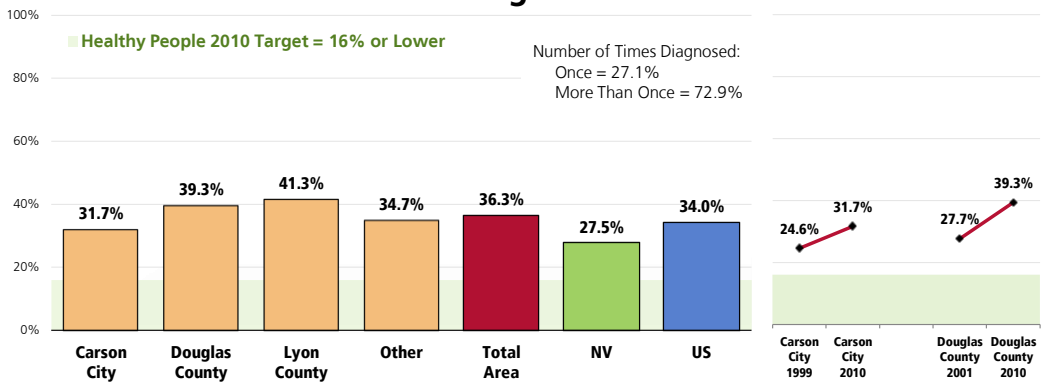
Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-12]
Notes: Asked of all respondents.

Prevalence of Hypertension

A full 36.3% of adults have been told at some point that their blood pressure was high (an additional 2.8% have not been tested in the past five years).

- Less favorable than the Nevada prevalence (27.5%).
- Similar to the national prevalence (34.0%).
- More than twice the Healthy People 2010 target (16% or lower).
- Lowest in Carson City.
- Respondents in both Carson City and Douglas County noted significant increases in the prevalence of hypertension over time.

Prevalence of High Blood Pressure



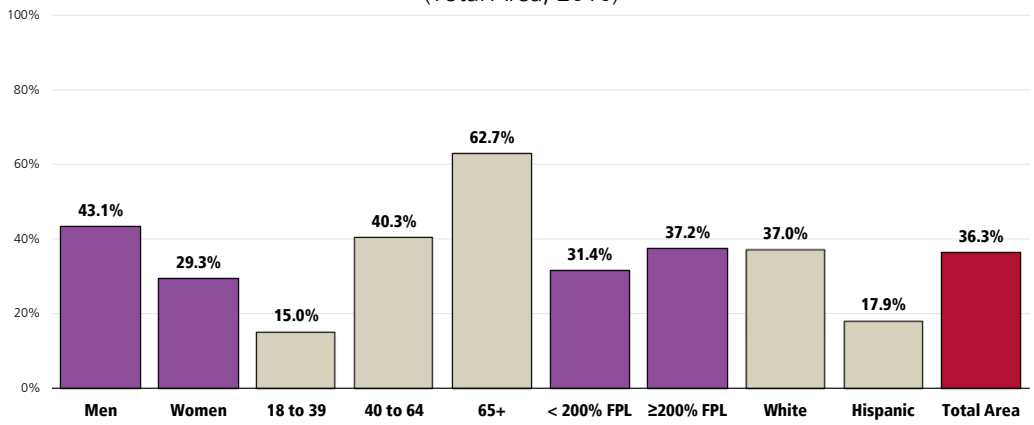
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 47-48, 142]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-9]
Notes: Asked of all respondents.

Hypertension diagnoses are higher among:

- Men.
- Adults aged 40 and older, and especially those aged 65+.
- Non-Hispanic Whites.

Prevalence of High Blood Pressure

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-9]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

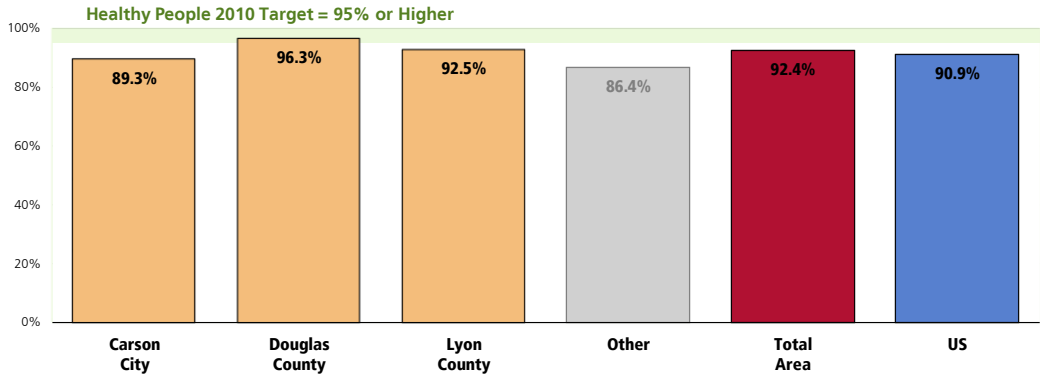
Hypertension Management

Among respondents who have been told that their blood pressure was high, 92.4% report that they are currently taking actions to control their condition, such as through medication, diet and/or exercise.

- Similar to national findings (90.9%).
- Similar to the Healthy People 2010 target of 95% or higher.
- Similar by county.

Taking Action to Control Hypertension

(Among Total Area Adults with High BP, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 49]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-11]
Notes: Asked of all respondents who have been diagnosed with high blood pressure.
In this case, the term "action" refers to medication, change in diet, and/or exercise.
County areas shown in gray are based on unreliable sample sizes.

High Blood Cholesterol

High blood cholesterol is a major risk factor for coronary heart disease that can be modified. More than 50 million US adults have blood cholesterol levels that require medical advice and treatment. More than 90 million adults have cholesterol levels that are higher than desirable. Experts recommend that all adults aged 20 years and older have their cholesterol levels checked at least once every 5 years to help them take action to prevent or lower their risk of coronary heart disease. Lifestyle changes that prevent or lower high blood cholesterol include eating a diet low in saturated fat and cholesterol, increasing physical activity, and reducing excess weight.

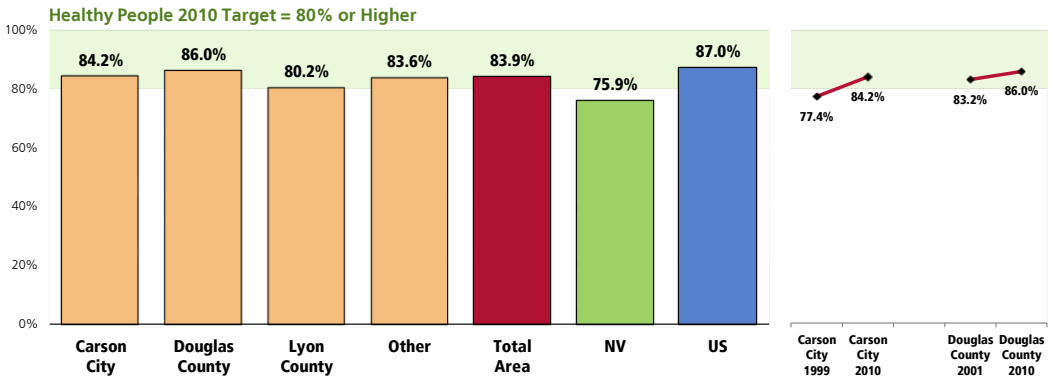
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Blood Cholesterol Testing

A total of 83.9% of Total Area adults have had their blood cholesterol checked within the past five years.

- More favorable than Nevada findings (75.9%).
- Similar to the national findings (87.0%).
- Satisfies the Healthy People 2010 target (80% or higher).
- Similar by county.
- The prevalence of recent cholesterol screenings is significantly higher among Carson City adults this year; unchanged over time in Douglas County.

Have Had Blood Cholesterol Levels Checked in the Past 5 Years



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 53]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-15]

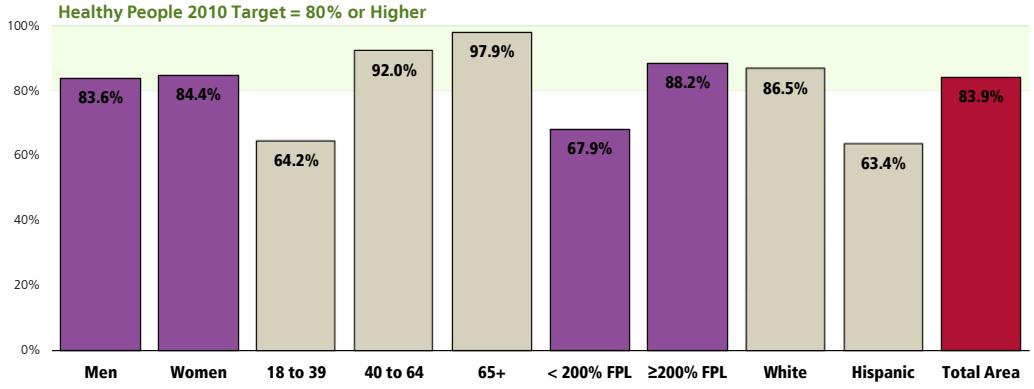
Notes: Asked of all respondents.

The following demographic segments report lower screening levels:

- Adults under age 40.
- Residents with lower incomes.
- Hispanics.

Have Had Blood Cholesterol Levels Checked in the Past 5 Years

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-15]

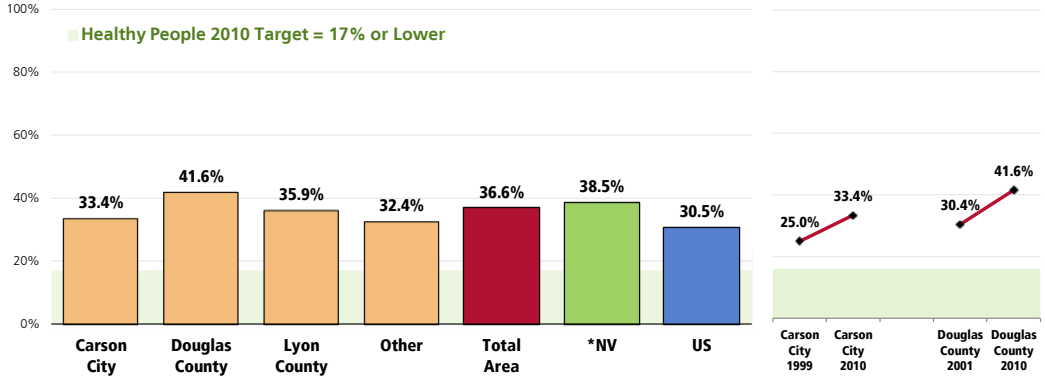
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Self-Reported High Blood Cholesterol

A total of 36.6% of adults have been told by a health professional that their cholesterol level was high (an additional 18.2% have not had their cholesterol tested in the past five years).

- Similar to Nevada findings (38.5%).
- Less favorable than the national prevalence (30.5%).
- More than twice the Healthy People 2010 target (17% or lower).
- Notably higher in Douglas County.
- Over time, the prevalence of high blood cholesterol among adults in both Carson City and Douglas County has increased significantly.

Prevalence of High Blood Cholesterol



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 51, 143]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-14]

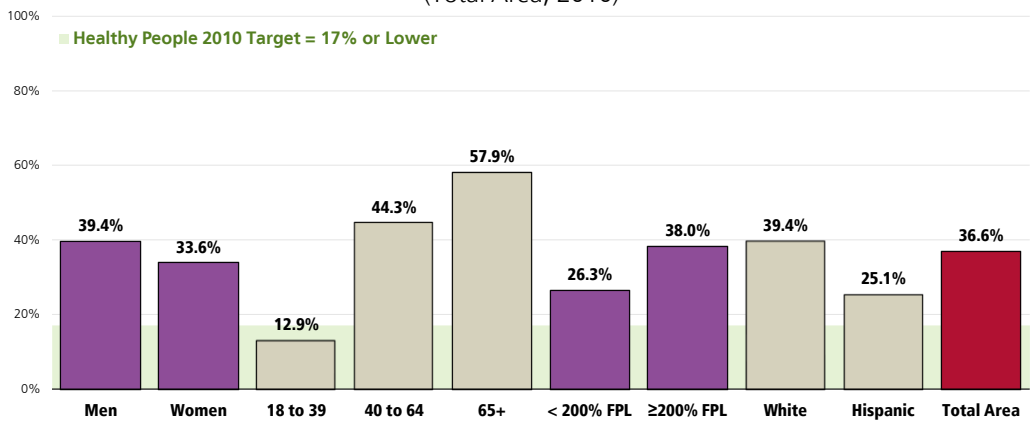
Notes: Asked of all respondents.
*Nevada data reflect the prevalence only among those adults who have been tested.

- Note the positive correlation between age and high blood cholesterol.
- Note the higher prevalence among higher-income adults (*however, these respondents are also more likely to have been tested*).
- Whites report a higher prevalence than Hispanics.

In addition, note that "unknowns" (those not tested in the past five years, if ever) are relatively high in young adults, lower-income residents, and Hispanics.

Prevalence of High Blood Cholesterol

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-14]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

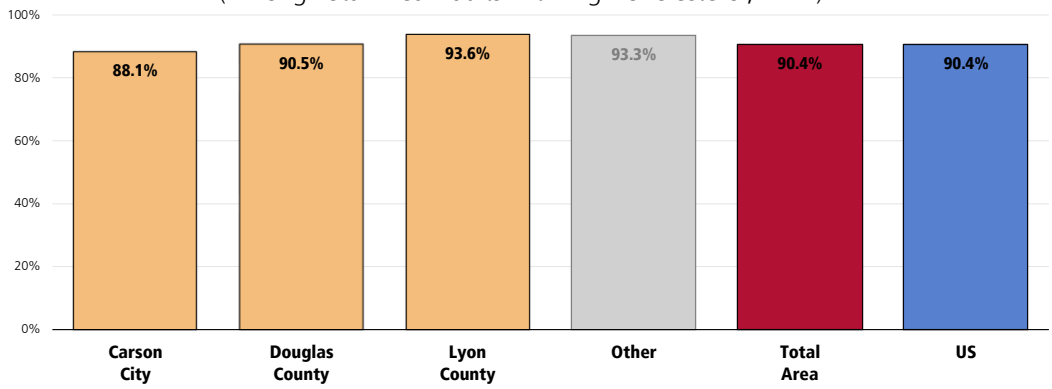
High Cholesterol Management

Among adults who have been told that their blood cholesterol was high, 90.4% report that they are currently taking actions to control their cholesterol levels, such as through medication, diet and/or exercise.

- Identical to the national figure (90.4%).
- No difference by county.

Taking Action to Control High Blood Cholesterol Levels

(Among Total Area Adults with High Cholesterol, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 52]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents who have been diagnosed with high blood cholesterol levels.
In this case, the term "action" refers to medication, change in diet, and/or exercise.
County areas shown in gray are based on unreliable sample sizes.

Total Cardiovascular Risk

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

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

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

Three health-related behaviors contribute markedly to cardiovascular disease:

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

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

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

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

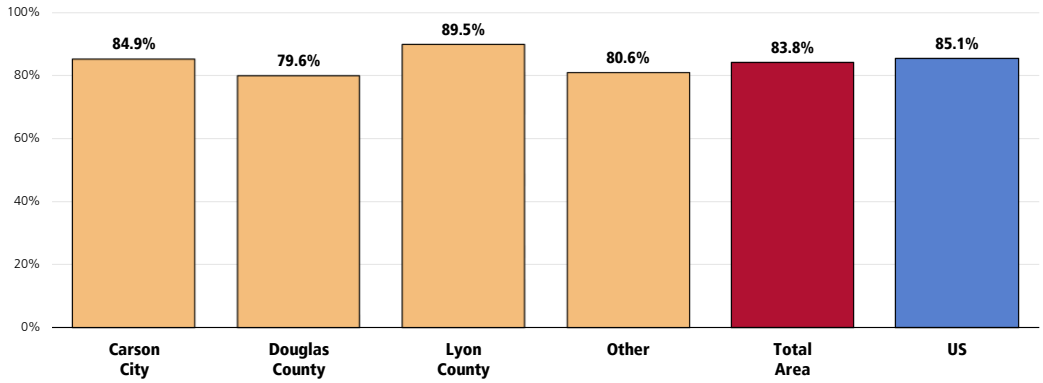
– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

A total of 83.8% of Total 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 (85.1%).
- Highest in Lyon County; lowest in Douglas County.

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

Present One or More Cardiovascular Risks or Behaviors



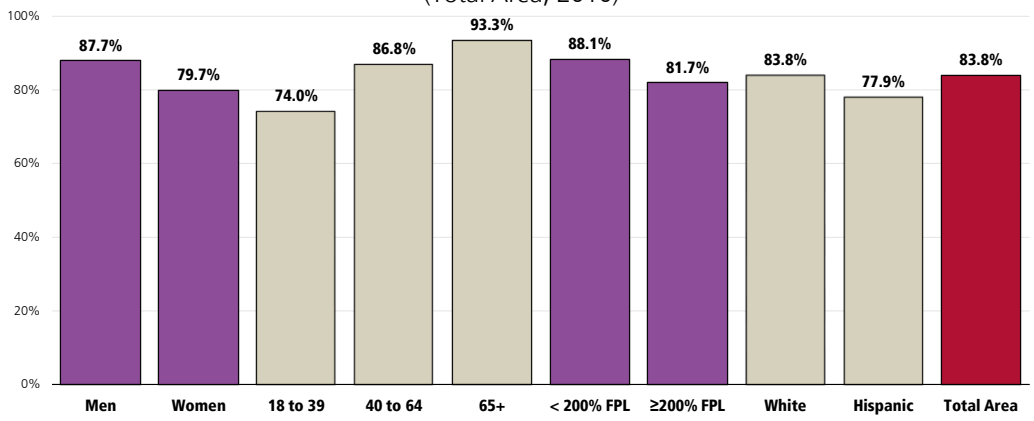
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 141]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Adults more likely to exhibit cardiovascular risk factors include:

- Men.
- Adults aged 40 and older, and especially seniors.
- Residents living on lower incomes.

Present One or More Cardiovascular Risks or Behaviors

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 141]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Cancer

Cancer, the second-leading cause of death among adults, is responsible for one of every four deaths in the United States. In 2003, over half a million adults—or more than 1,500 people a day—will die of cancer. Hispanic adults are more likely to die from cancer than people of any other racial or ethnic group.

The financial costs of cancer are staggering. According to the National Institutes of Health, cancers cost the United States more than $170 billion in 1999. This includes more than $110 billion in lost productivity and over $60 billion in direct medical costs.

The number of new cancer cases can be reduced substantially, and many cancer deaths can be prevented. Healthier lifestyles can significantly reduce a person's risk for cancer—for example, avoiding tobacco use, increasing physical activity, improving nutrition, and avoiding sun exposure. Making cancer screening and information services available and accessible to all adults is also essential for reducing the high rates of cancer and cancer deaths. Screening tests for breast, cervical, and colorectal cancers reduce the number of deaths from these diseases by finding them early, when they are most treatable. Screening tests for cervical and colorectal cancers can actually prevent these cancers from developing by detecting treatable precancerous conditions.

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

Age-Adjusted Cancer Deaths

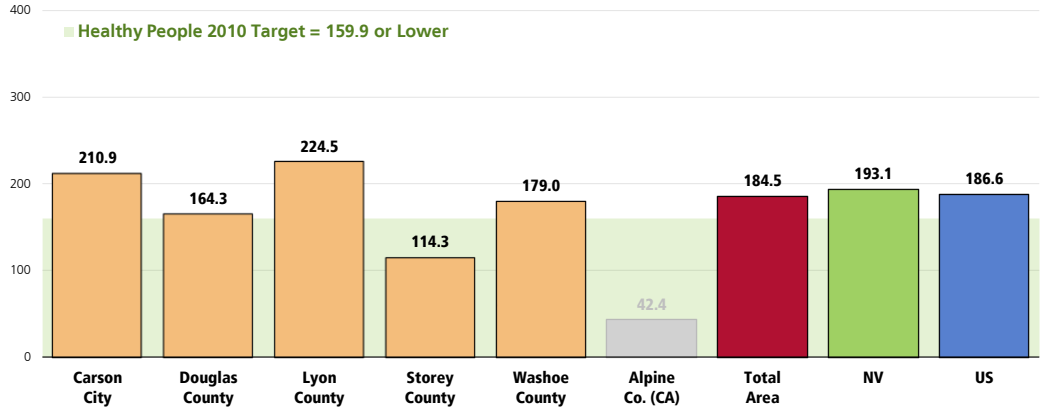
All Cancer Deaths

Between 2004 and 2006, there was an annual average age-adjusted cancer mortality rate of 184.5 deaths per 100,000 population in the Total Area.

- Similar to the 193.1 rate reported across Nevada.
- Similar to the national rate (186.6).
- Far from satisfying the Healthy People 2010 target.
- Higher in Carson City and Lyon County; lower (more favorable) in Douglas and Storey counties (the Storey County rate satisfies the Healthy People 2010 objective). The Alpine County rate is quite low, but unreliable.

Cancer: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



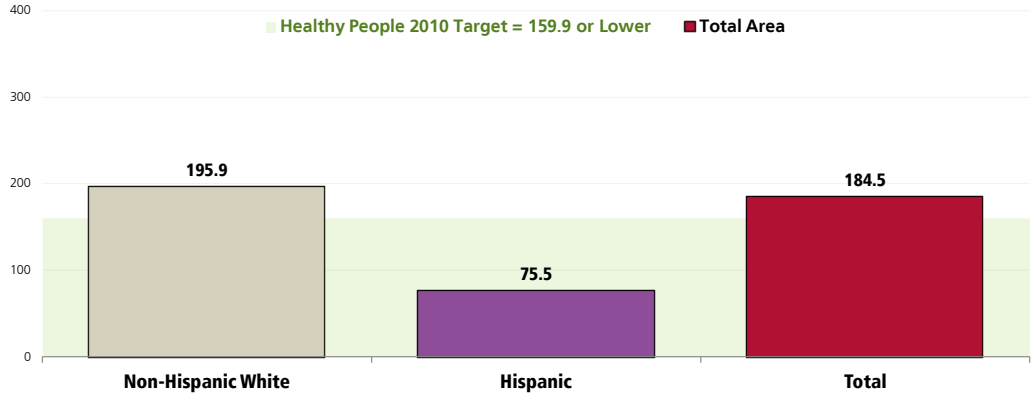
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-1]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rate for Alpine County, California, is unreliable due to low number of deaths.

Cancer mortality rates are notably higher among Non-Hispanic Whites when compared with Hispanics.

Cancer: Age-Adjusted Mortality by Race

(2004-2006 Annual Average Deaths per 100,000 Population)



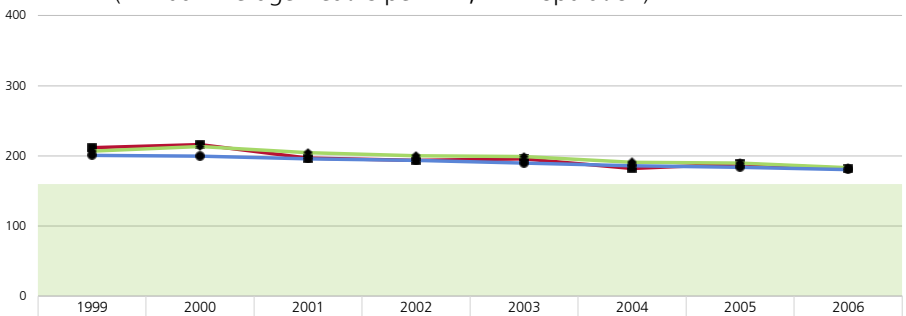
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-1]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Cancer mortality rates have <u>decreased</u> over the past decade across the Total Area; the same trend is apparent both statewide and nationwide.

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	159.9	159.9	159.9	159.9	159.9	159.9	159.9	159.9
Total Area	212.0	216.0	196.9	193.7	195.8	182.1	189.0	182.4
Nevada	206.7	213.7	204.7	200.5	199.2	190.8	189.7	183.1
United States	200.8	199.7	196.1	193.7	190.0	185.9	184.1	180.8

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-1]

Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Cancer Deaths by Site

LUNG CANCER

Lung cancer is the most common cause of cancer death among both females and males in the United States. Cigarette smoking is the most important risk factor for lung cancer, accounting for 68 to 78 percent of lung cancer deaths among females and 88 to 91 percent of lung cancer deaths among males. Other risk factors include occupational exposures (radon, asbestos) and indoor and outdoor air pollution (radon, environmental tobacco smoke). One to two percent of lung cancer deaths are attributable to air pollution. After 10 years of abstinence, smoking cessation decreases the risk of lung cancer to 30 to 50 percent of that of continuing smokers.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

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

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

As can be seen in the following chart (referencing 2004-2006 annual average age-adjusted death rates):

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

Note that lung and colorectal cancer death rates fail to satisfy the related Healthy People 2010 objectives.

Age-Adjusted Cancer Death Rates by Site

(2004-2006)

	Total Area	NV	US	HP2010
Lung Cancer	**54.7**	**56.7**	**52.5**	**44.8**
Prostate Cancer	**26.7**	**24.5**	**25.5**	**28.8**
Female Breast Cancer	**21.9**	**23.9**	**24.5**	**22.3**
Colorectal Cancer	**17.9**	**19.1**	**17.6**	**13.9**

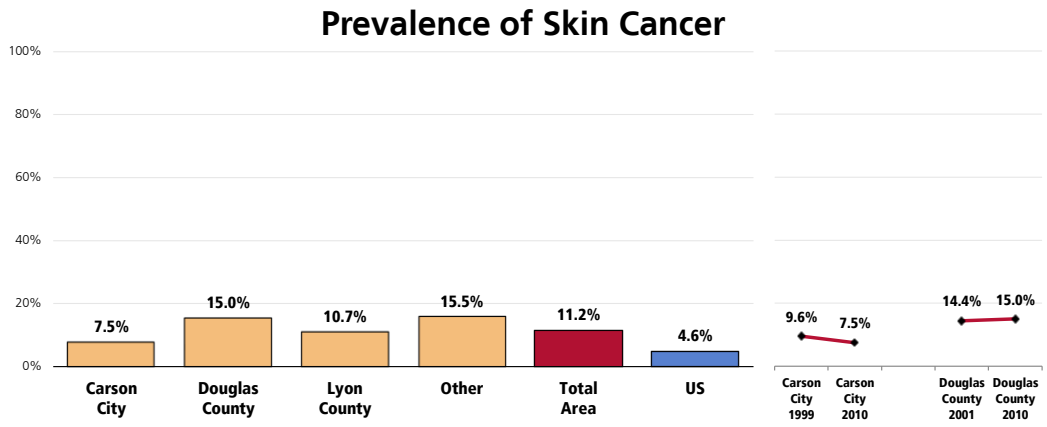
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Prevalence of Cancer

Skin Cancer

A total of 11.2% of surveyed Total Area adults report having been diagnosed with skin cancer.

- Less favorable than the national average (4.6%).
- Significantly high in Douglas County.
- The prevalence of skin cancer has remained statistically unchanged over time in both Carson City and Douglas County.

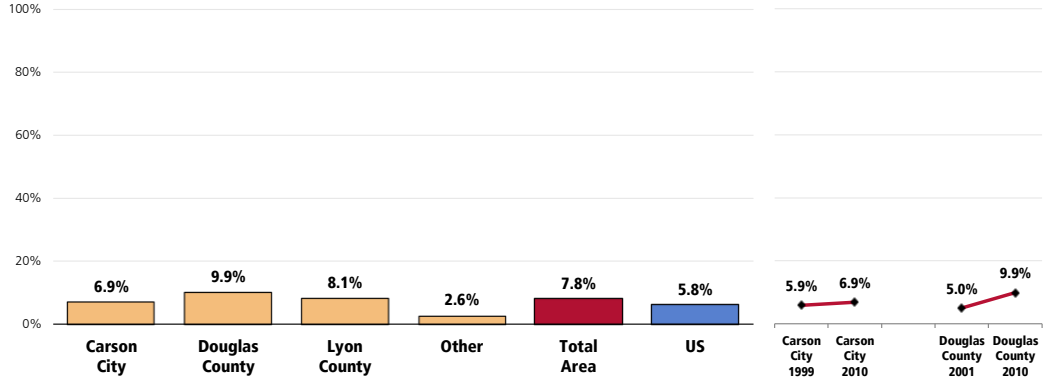


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 33]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Other Cancer

A total of 7.8% of respondents have been diagnosed with some type of (non-skin) cancer.

- Similar to the 5.8% prevalence reported nationally.
- Notably lower in the "Other" counties.
- The prevalence of cancer in Carson City has remained unchanged over time; in contrast, the Douglas County prevalence has increased significantly.



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 32]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

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

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

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

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

Cancer Screenings

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

Screening levels in the community were measured in the 2010 Community Health Survey relative to four cancer sites: prostate cancer (prostate-specific antigen testing and digital rectal examination); female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Prostate Cancer Screenings

PROSTATE CANCER

Prostate cancer is the most commonly diagnosed form of cancer (other than skin cancer) in males and the second leading cause of cancer death among males in the United States. Prostate cancer is most common in men aged 65 years and older, who account for approximately 80 percent of all cases of prostate cancer.

Digital rectal examination (DRE) and the prostate-specific antigen (PSA) test are two commonly used methods for detecting prostate cancer. Although several treatment alternatives are available for prostate cancer, their impact on reducing death from prostate cancer when compared with no treatment in patients with operable cancer is uncertain. Efforts aimed at reducing deaths through screening and early detection remain controversial because of the uncertain benefits and potential risks of screening, diagnosis, and treatment.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

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

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

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

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

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

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

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

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

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

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

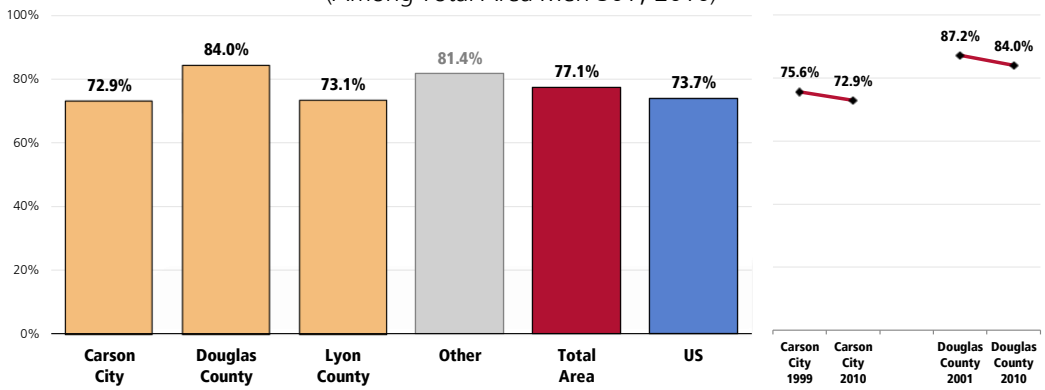
PSA Testing and/or Digital Rectal Examination

Among men aged 50 and older, more than three-fourths (77.1%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

- Similar to national findings (73.7%).
- Notably higher in Douglas County (84.0%).
- Statistically unchanged over time in both Carson City and Douglas County.

Have Had a Prostate Screening in the Past 2 Years

(Among Total Area Men 50+, 2010)



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 175]
2008 PRC National Health Survey, Professional Research Consultants.

Notes: Asked of all male respondents aged 50 and older.
County areas shown in gray are based on unreliable sample sizes.

Female Breast Cancer Screening

FEMALE BREAST CANCER

Breast cancer is the most common cancer [diagnosis] among women in the United States. Death from breast cancer can be reduced substantially if the tumor is discovered at an early stage. Mammography is the most effective method for detecting these early malignancies. Clinical trials have demonstrated that mammography screening can reduce breast cancer deaths by 20 to 39 percent in women aged 50 to 74 years and about 17 percent in women aged 40 to 49 years. Breast cancer deaths can be reduced through increased adherence with recommendations for regular mammography screening.

Many breast cancer risk factors, such as age, family history of breast cancer, reproductive history, mammographic densities, previous breast disease, and race and ethnicity, are not subject to intervention. However, being overweight is a well-established breast cancer risk for postmenopausal women that can be addressed. Avoiding weight gain is one method by which older women may reduce their risk of developing breast cancer.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 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 aged 50-69, the age group generally included in screening trials. For women aged 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 aged 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 aged 40-49.

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

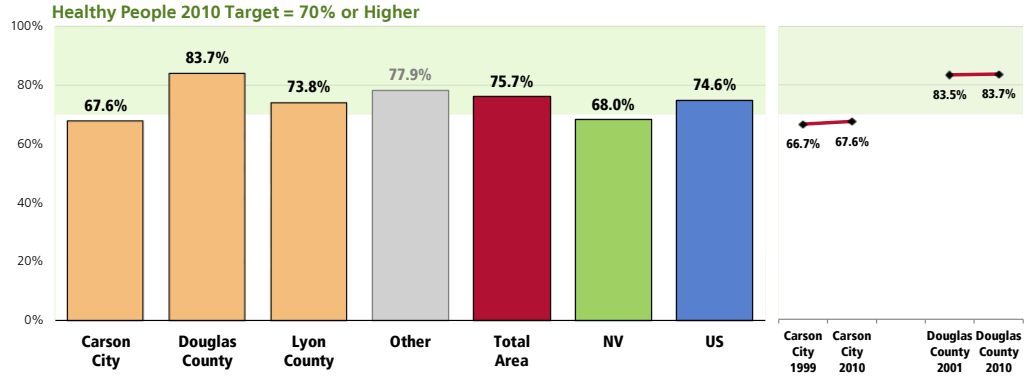
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Among women aged 40 and older, 75.7% have had a mammogram within the past two years.

- Higher than statewide findings (68.0%).
- Similar to national findings (74.6%).
- Satisfies the Healthy People 2010 target (70% or higher).
- Particularly low (67.6%) in Carson City.
- No significant change in Carson City or in Douglas County compared to previous survey results.

Have Had a Mammogram in the Past Two Years

(Among Total Area Women 40+, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 173]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2008 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-13]

Notes: Asked of all female respondents aged 40 and older.
County areas shown in gray are based on unreliable sample sizes.

Cervical Cancer Screenings

CERVICAL CANCER

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

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

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

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

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

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

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

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

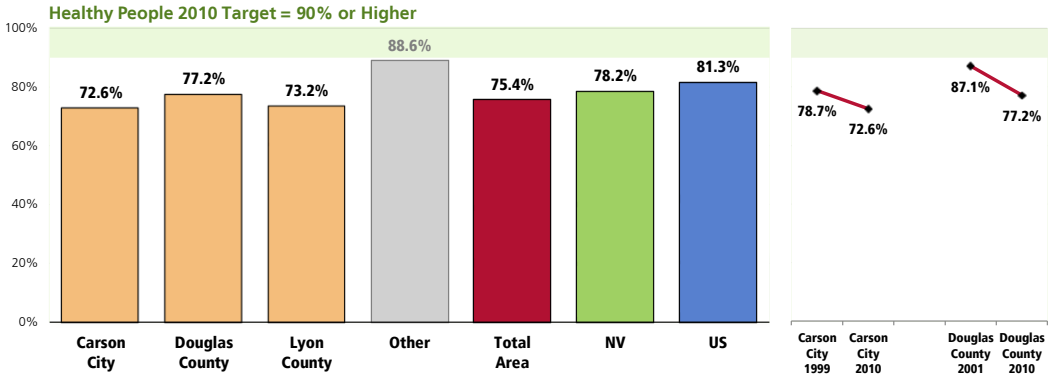
Pap Smear Testing

Among women aged 18 and older, 75.4% have had a Pap smear within the past three years.

- Comparable to the Nevada percentage (78.2%).
- Less favorable than national findings (81.3%).
- Fails to satisfy the Healthy People 2010 target (90% or higher).
- Notably high in the "Other" counties, although this is based on a rather small sample size.
- While the Carson City trend is not statistically significant, there has been a significant decrease in Pap smear testing in Douglas County.

Have Had a Pap Smear in the Past 3 Years

(Among Total Area Women 18+, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 96]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2008 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-11]

Notes: Asked of all female respondents.
County areas shown in gray are based on unreliable sample sizes.

Colorectal Cancer Screenings

COLORECTAL CANCER

Colorectal cancer is the third most common type of cancer and the second leading cause of cancer death in the United States. Current levels of screening in this country lag behind those of other effective cancer screening tests; it has been estimated that attainment of goals for population colorectal cancer screening could save 18,800 lives per year. Colorectal cancer incidence and mortality show health disparities, with a disproportionate burden occurring in certain minority populations, including African American adults and Alaska Natives.

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.

Risk factors for colorectal cancer may include age, personal and family history of polyps or colorectal cancer, inflammatory bowel disease, inherited syndromes, physical inactivity (colon only), obesity, alcohol use, and a diet high in fat and low in fruits and vegetables. Detecting and removing precancerous colorectal polyps and detecting and treating the disease in its earliest stages will reduce deaths from colorectal cancer.

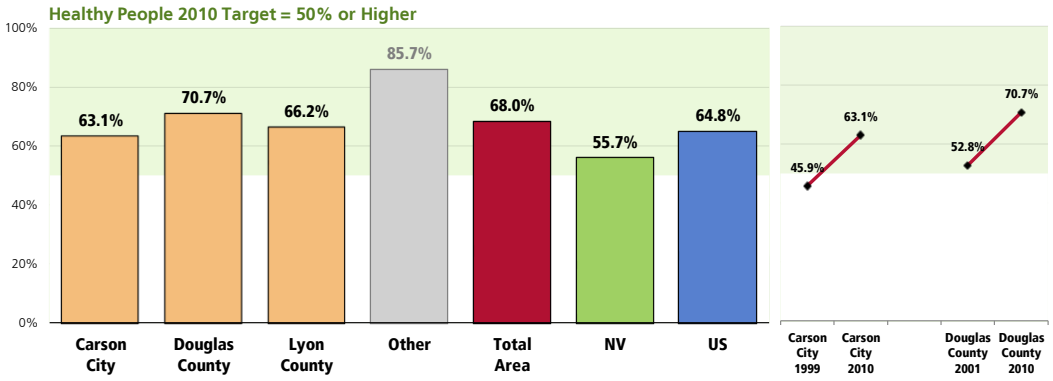
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Among adults aged 50 and older, over two-thirds (68.0%) have had a sigmoidoscopy or colonoscopy at some point in their lives.

- More favorable than Nevada findings (55.7%).
- Similar to national findings (64.8%).
- Satisfies the Healthy People 2010 target (50% or higher).
- Higher in the "Other" counties, although this is based on fewer than 50 respondents.
- The Carson City and Douglas County percentages of sigmoidoscopy/ colonoscopy testing have both increased significantly over time.

Have Ever Had a Sigmoidoscopy/Colonoscopy Exam

(Among Total Area Adults 50+, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 176]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2008 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-12b]

Notes: Asked of all respondents 50+.
County areas shown in gray are based on unreliable sample sizes.

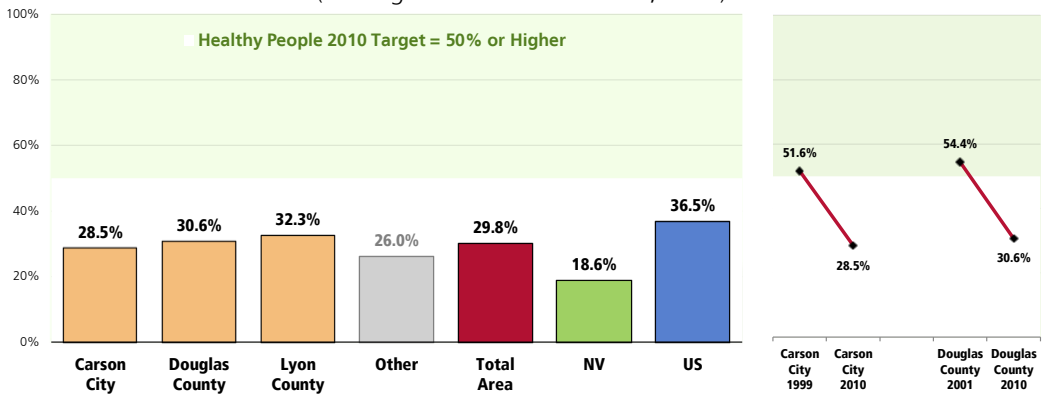
Blood Stool Testing

Among adults aged 50 and older, 29.8% have had a blood stool test (aka "fecal occult blood test") within the past two years.

- Higher than Nevada findings (18.6%).
- Lower than national findings (36.5%).
- Fails to satisfy the Healthy People 2010 target (50% or higher).
- Similar by county.
- Over time, the prevalence of recent blood stool exams has decreased significantly among both Carson City and Douglas County adults 50+.
- Note: the trends of increasing colonoscopy/sigmoidoscopy and decreasing blood stool testing is consistent with what is seen nationally and in most communities.

Have Had a Blood Stool Test in the Past 2 Years

(Among Total Area Adults 50+, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 177]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2008 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-12b]

Notes: Asked of all respondents 50+.
County areas shown in gray are based on unreliable sample sizes.

Respiratory Disease

Asthma and COPD (chronic obstructive pulmonary disease) are among the 10 leading chronic conditions causing restricted activity [in adults]. After chronic sinusitis, asthma is the most common cause of chronic illness in children. Methods are available to treat these respiratory diseases and promote respiratory health.

Asthma is a serious and growing health problem. An estimated 14.9 million persons in the United States have asthma. Asthma is responsible for about 500,000 hospitalizations, 5,000 deaths, and 134 million days of restricted activity a year. Yet most of the problems caused by asthma could be averted if persons with asthma and their healthcare providers managed the disease according to established guidelines.

COPD includes chronic bronchitis and emphysema—both of which are characterized by irreversible airflow obstruction and often exist together. Similar to asthma, COPD may be accompanied by an airway hyperresponsiveness. Most patients with COPD have a history of cigarette smoking. COPD worsens over time with continued exposure to a causative agent—usually tobacco smoke or sometimes a substance in the workplace or environment. COPD occurs most often in older people.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

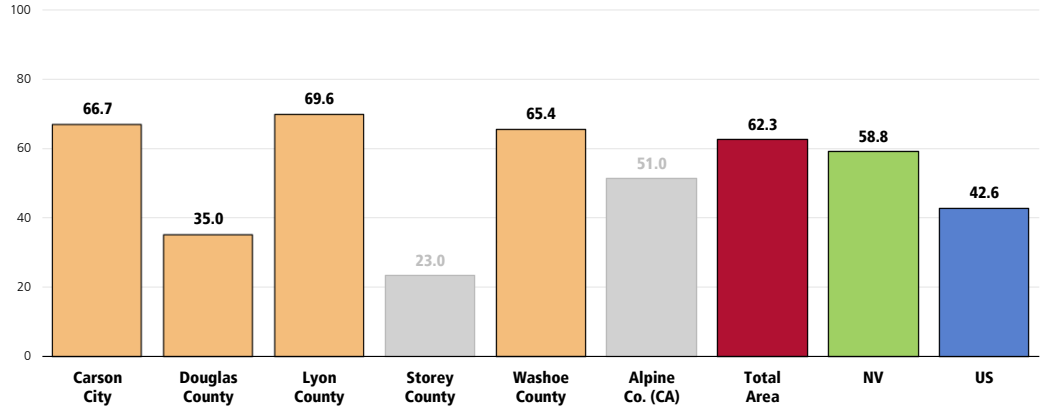
Note: What was previously termed COPD (chronic obstructive pulmonary disease) has been reclassified as CLRD (chronic lower respiratory disease).

Between 2004 and 2006, there was an annual average age-adjusted CLRD mortality rate of 62.3 deaths per 100,000 population in the Total Area.

- Higher than found statewide (58.8).
- Much higher than the national rate (42.6).
- Higher in Carson City, Lyon County and Washoe County; lower in Douglas County. (Note that the Storey and Alpine county rates are unreliable.)

CLRD: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



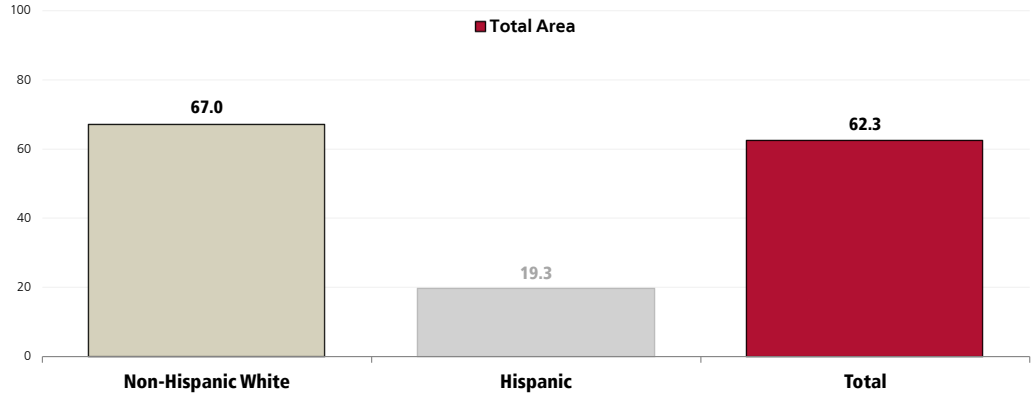
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
CLRD is chronic lower respiratory disease.
Note that the rates for Storey County, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

CLRD mortality appears higher among Non-Hispanic Whites, however, the Hispanic rate is considered to be unreliable.

CLRD: Age-Adjusted Mortality by Race

(2004-2006 Annual Average Deaths per 100,000 Population)



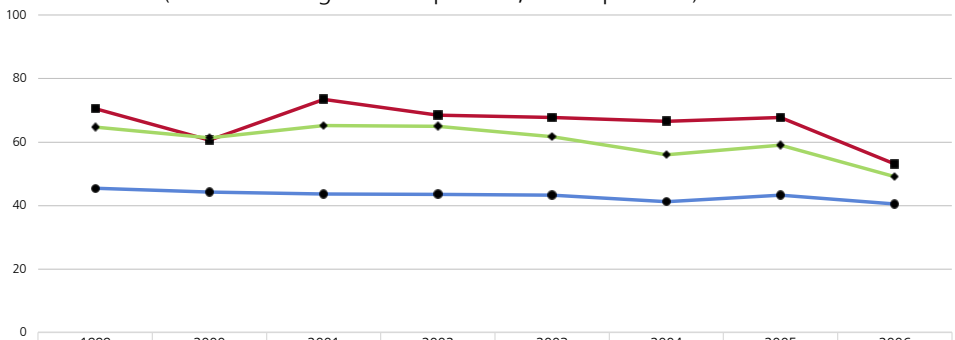
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
CLRD is chronic lower respiratory disease.
Note that the rate for Hispanics is unreliable due to low number of deaths.

CLRD mortality in the Total Area has decreased over time, mirroring the trends reported both statewide and nationwide.

CLRD: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Total Area	70.6	60.6	73.5	68.5	67.8	66.6	67.7	53.1
Nevada	64.7	61.3	65.2	65.0	61.7	56.0	59.0	49.1
United States	45.4	44.2	43.7	43.5	43.3	41.2	43.3	40.5

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
CLRD is chronic lower respiratory disease.

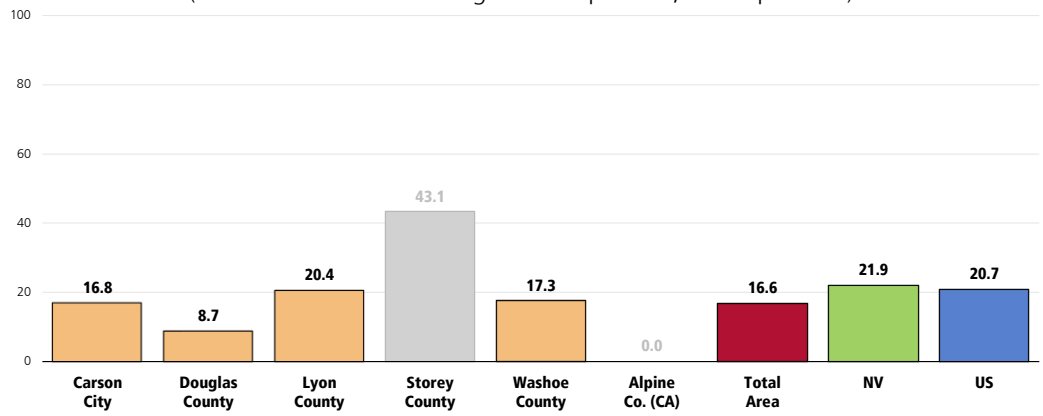
Pneumonia/Influenza Deaths

Between 2004 and 2006, there was an annual average age-adjusted pneumonia/influenza mortality rate of 16.6 deaths per 100,000 population in the Total Area.

- Lower than found statewide (21.9).
- Lower than the national rate (20.7).
- Higher rates are reported in Carson City, Lyon County and Washoe County (the Storey County rate is unreliable); Douglas County reported a lower rate.

Pneumonia/Influenza: Age-Adjusted Mortality

(2004-2006 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 July 2010.

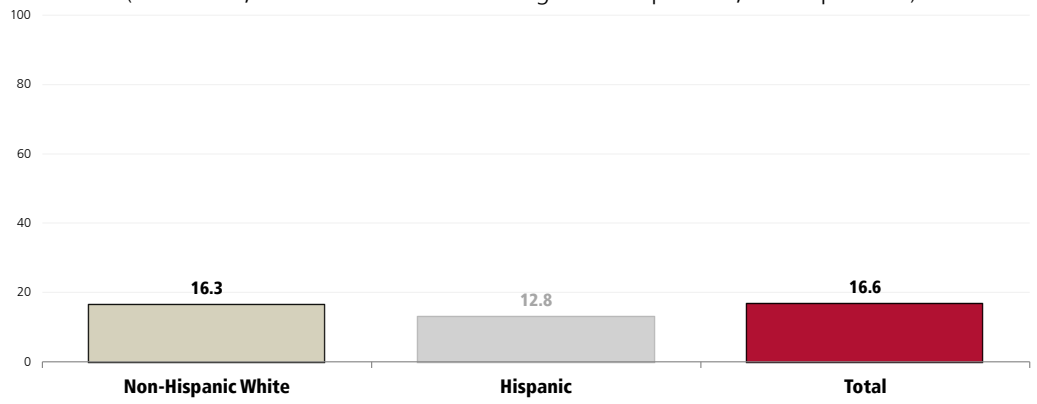
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
CLRD is chronic lower respiratory disease.
Note that the rates for Storey County, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

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

- The pneumonia/influenza mortality rate in the Total Area is higher among Non-Hispanic Whites; note, however, that the rate for Hispanics is deemed unreliable due to the small number of deaths.

Pneumonia/Influenza: Age-Adjusted Mortality by Race

(Total Area; 2004-2006 Annual Average Deaths per 100,000 Population)



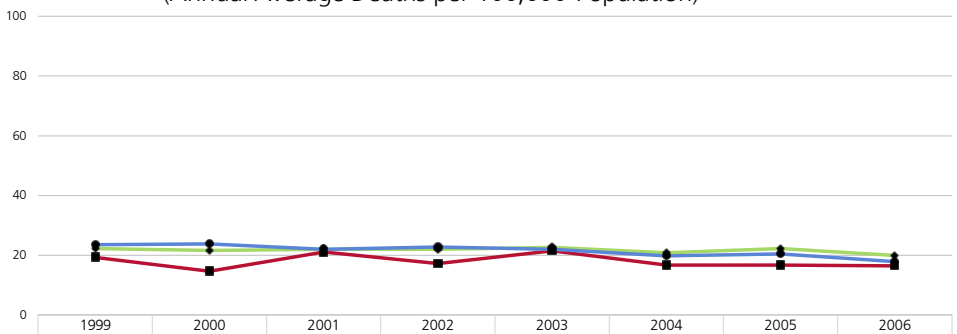
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
CLRD is chronic lower respiratory disease.
Note that the rate for Hispanics is unreliable due to low number of deaths.

- Mortality rates have fluctuated in the Total Area, but have <u>decreased</u> overall since 1999.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Total Area	19.2	14.6	21.1	17.2	21.4	16.6	16.7	16.4
Nevada	22.2	21.5	21.9	22.0	22.6	20.8	22.2	19.9
United States	23.5	23.7	21.9	22.7	22.0	19.8	20.4	17.8

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
CLRD is chronic lower respiratory disease.

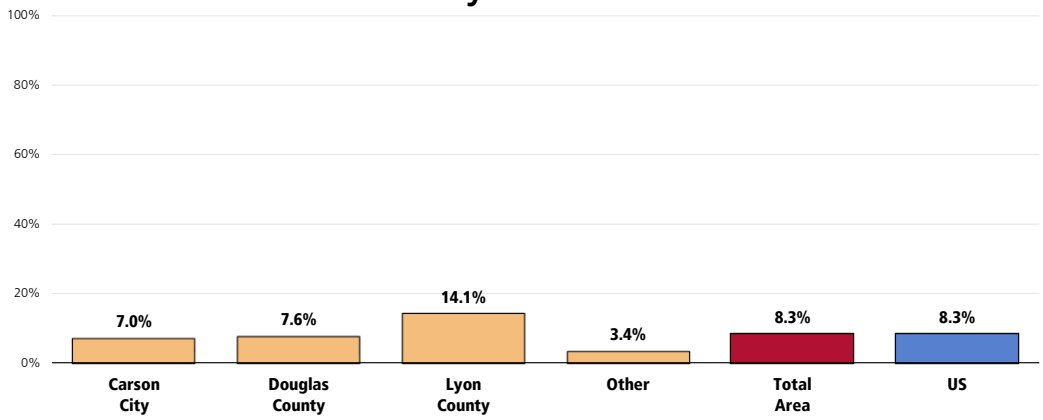
Prevalence of Asthma

Adults

A total of 8.3% of Total Area adults <u>currently</u> suffer from asthma.

- Identical to the national prevalence (8.3%).
- Asthma appears more prevalent in Lyon County (14.1%).

Currently Have Asthma



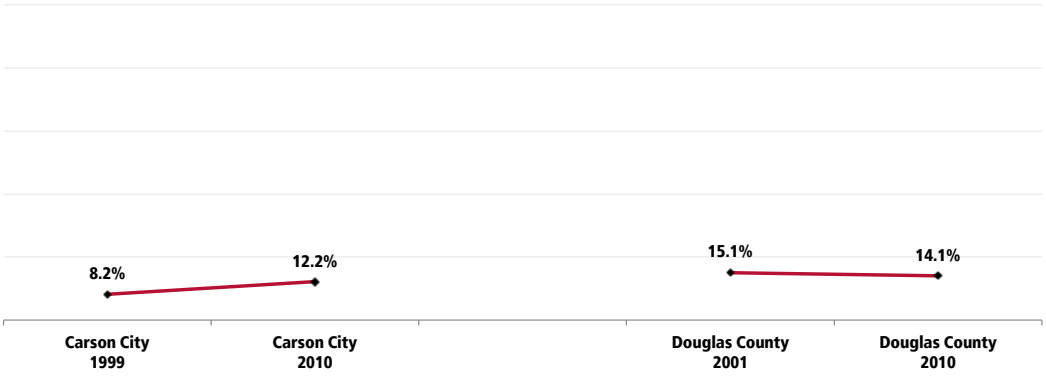
Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Items 146]
2008 PRC National Health Survey, Professional Research Consultants.

Notes: Asked of all respondents.

The prevalence of adults who have ever been diagnosed with asthma has not changed significantly over time in either Carson City or Douglas County.

Ever Diagnosed With Asthma

(Carson City and Douglas County Respondents)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 43]
Notes: Asked of all respondents.

Children

While the number of adults with asthma is greater than the number of children with asthma, the asthma rate is rising more rapidly in preschool-aged children than in any other group.

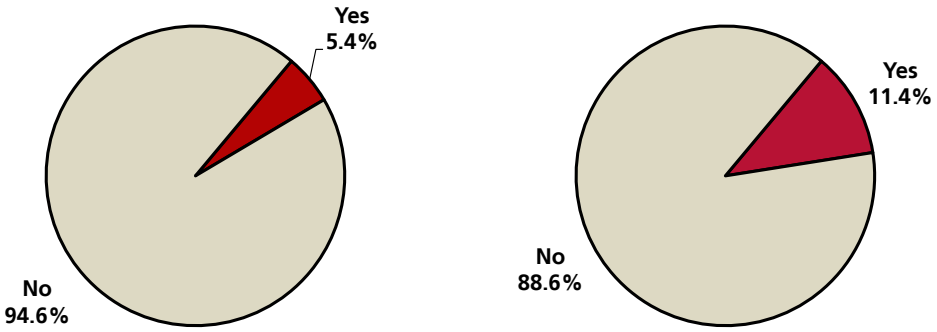
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Among Total Area children under age 18, 5.4% currently have asthma.

- Much lower than national findings (11.4%).
- Viewed by county, age, and gender, differences in asthma prevalence are not statistically significant.

Child Currently Has Asthma

(Among Parents of Children <18; Total Area, 2010)



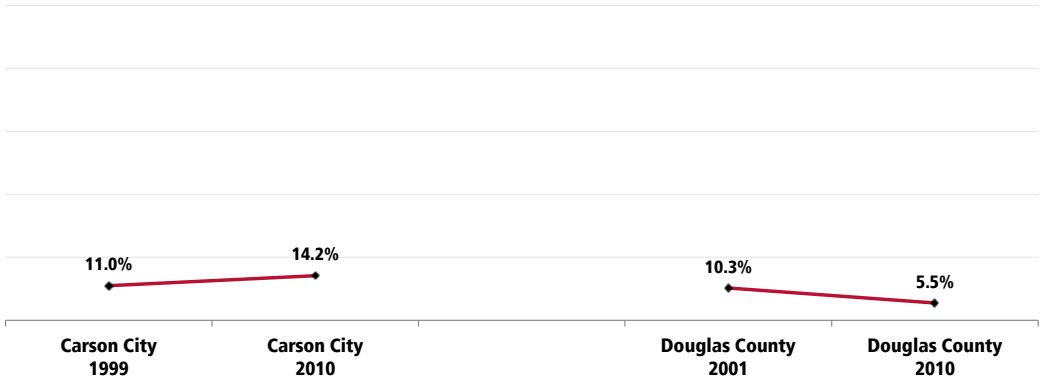
Total Area 2010 | United States 2008

Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children under 18.

The prevalence of children who have ever been diagnosed with asthma has not changed significantly over time in either Carson City or Douglas County.

Child Has Ever Been Diagnosed With Asthma
(Carson City and Douglas County Parents of Children <18)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 133]
Notes: Asked of all respondents with children under 18 at home.

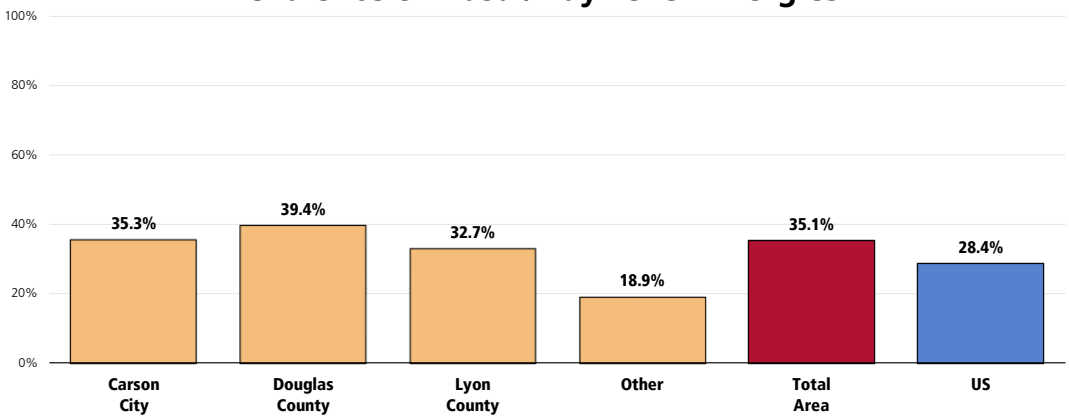
Prevalence of Other Respiratory Conditions

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

More than one-third of Total Area adults (35.1%) report suffering from nasal or hay fever allergies.

- Notably higher than national findings (28.4%).
- Lower (18.9%) in the "Other" counties.

Prevalence of Nasal/Hay Fever Allergies

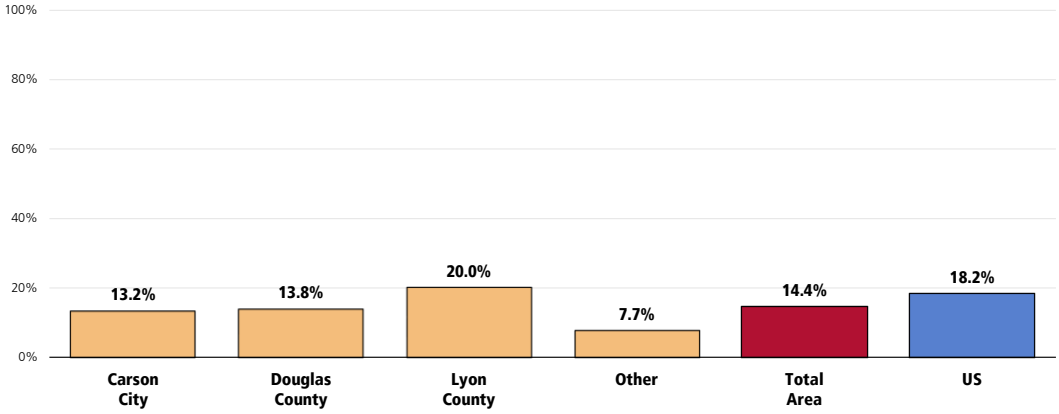


Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 37]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

A total of 14.4% of survey respondents report suffering from sinusitis.

- More favorable than national findings (18.2%).
- Least favorable (20.0%) among residents of Lyon County.

Prevalence of Sinusitis

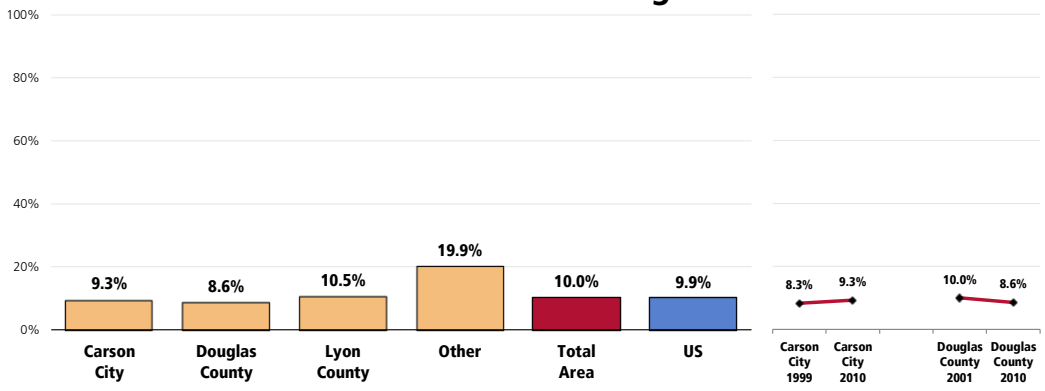


Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

One in 10 Total Area adults (10.0%) suffers from chronic lung disease.

- Nearly identical to the 9.9% percentage reported across the nation.
- Statistically similar by county.
- The prevalence of chronic lung disease has not changed significantly over time in either Carson City or Douglas County.

Prevalence of Chronic Lung Disease



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 27]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Injury & Violence

The risk of injury is so great that most persons sustain a significant injury at some time during their lives. Nevertheless, this widespread human damage too often is taken for granted, in the erroneous belief that injuries happen by chance and are the result of unpreventable "accidents." In fact, many injuries are not "accidents," or random, uncontrollable acts of fate; rather, most injuries are predictable and preventable.

For ages 1 through 44 years, [US] deaths from injuries far surpass those from cancer—the overall leading natural cause of death at these ages—by about three to one. Injuries cause more than two out of five deaths (43 percent) of children aged 1 through 4 years and result in four times the number of deaths due to birth defects, the second leading cause of death for this age group. For ages 15 to 24 years, injury deaths exceed deaths from all other causes combined from ages 5 through 44 years. For ages 15 to 24 years, injuries are the cause of nearly fou8r out of five deaths. After age 44 years, injuries account for fewer deaths than other health problems, such as heart disease, cancer, and stroke. However, despite the decrease in the proportion of deaths due to injury, the death rate from injuries is actually higher among older persons than among younger persons.

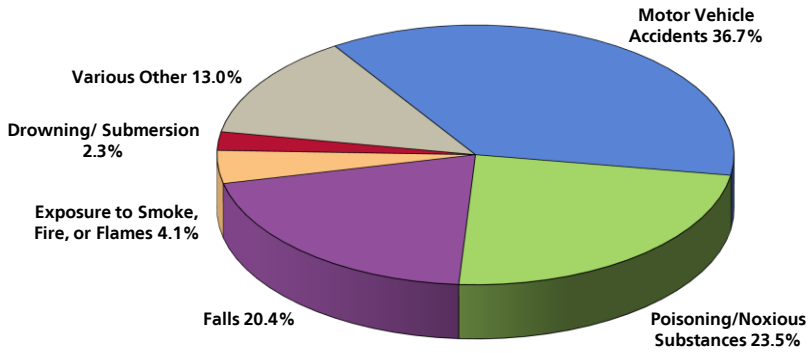
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Leading Causes of Accidental Death

Motor vehicle accidents, poisoning, and falls accounted for 80% of accidental deaths in the Total Area in 2006.

Leading Causes of Accidental Death

(Total Area, 2006)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

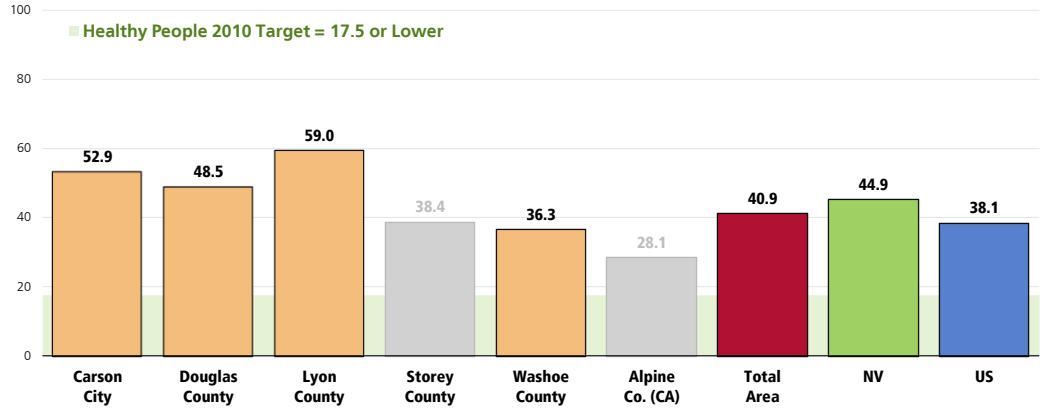
Age-Adjusted Unintentional Injury Deaths

Between 2004 and 2006, there was an annual average age-adjusted unintentional injury mortality rate of 40.9 deaths per 100,000 population in the Total Area.

- More favorable than the Nevada rate (44.9).
- Less favorable than the national rate (38.1).
- More than twice the Healthy People 2010 target.
- Highest in Lyon County.

Unintentional Injuries: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



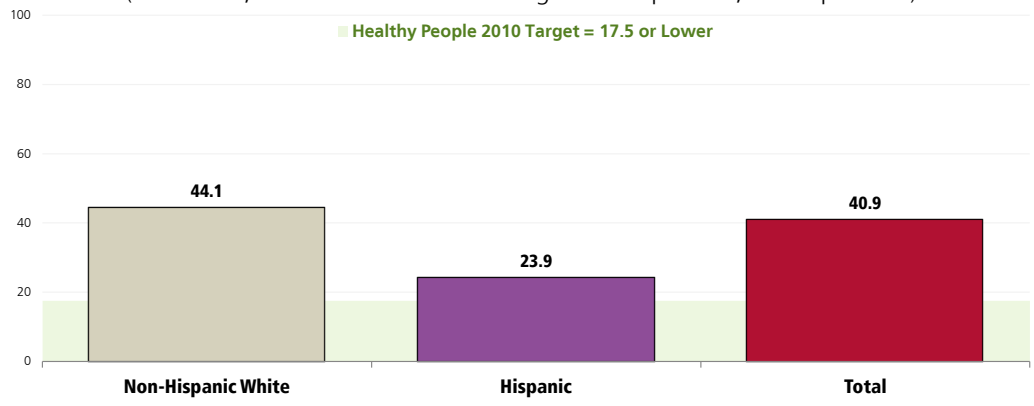
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-3]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rates for Storey County, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

Mortality rates are notably higher among Non-Hispanic Whites when compared with Hispanics in the Total Area.

Unintentional Injuries: Age-Adjusted Mortality by Race

(Total Area; 2004-2006 Annual Average Deaths per 100,000 Population)



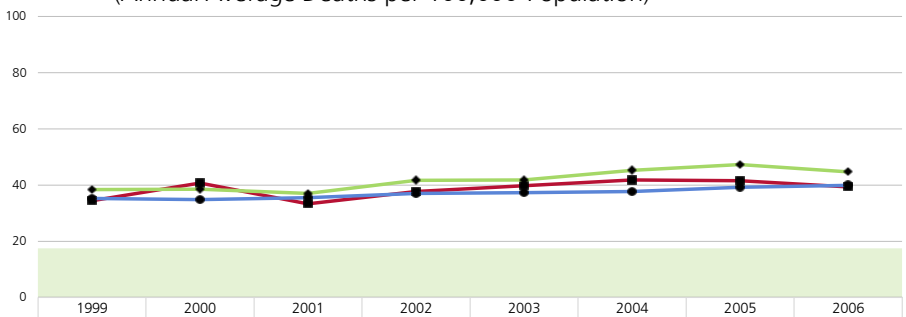
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-3]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

- Unintentional injury mortality rates have increased overall across the Total Area in recent years, echoing the increasing trends reported across Nevada and the US overall.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	17.5	17.5	17.5	17.5	17.5	17.5	17.5	17.5
Total Area	34.5	40.7	33.4	37.8	39.8	41.8	41.6	39.4
Nevada	38.5	38.6	37.0	41.7	41.9	45.3	47.3	44.7
United States	35.3	34.9	35.6	37.0	37.3	37.8	39.2	39.9

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-3]
Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Motor Vehicle Safety

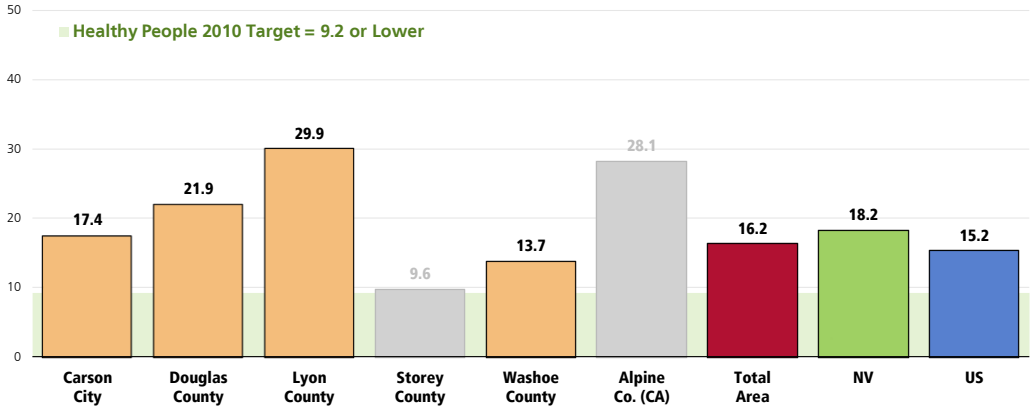
Age-Adjusted Motor-Vehicle Related Deaths

Between 2004 and 2006, there was an annual average age-adjusted motor vehicle crash mortality rate of 16.2 deaths per 100,000 population in the Total Area.

- Lower than found statewide (18.2).
- Higher than found nationally (15.2).
- Fails to satisfy the Healthy People 2010 target.
- Particularly high in Lyon County; lower (more favorable) in Carson City, Douglas County and Washoe County. (Note that Storey and Alpine county rates are unreliable.)

Motor Vehicle Crashes: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)

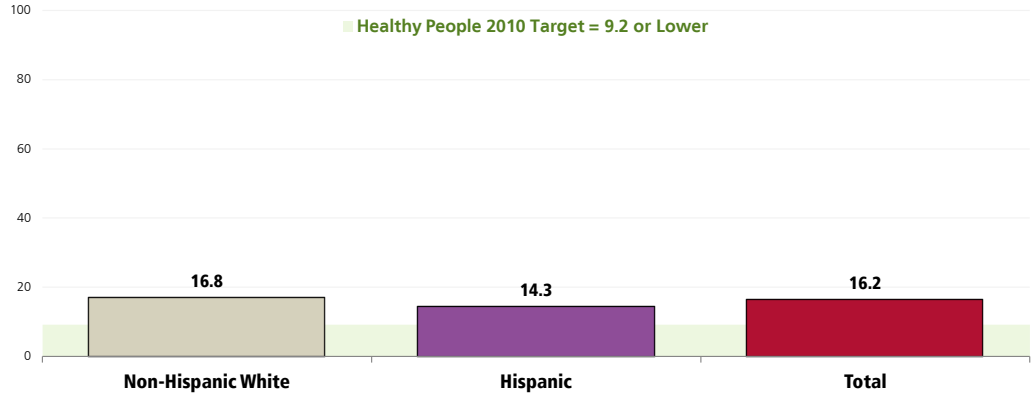


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-15a]
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rates for Storey County, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

The Total Area motor vehicle crash mortality rate is slightly higher among Non-Hispanic Whites than among Hispanics.

Motor Vehicle Crashes: Age-Adjusted Mortality by Race

(Total Area; 2004-2006 Annual Average Deaths per 100,000 Population)

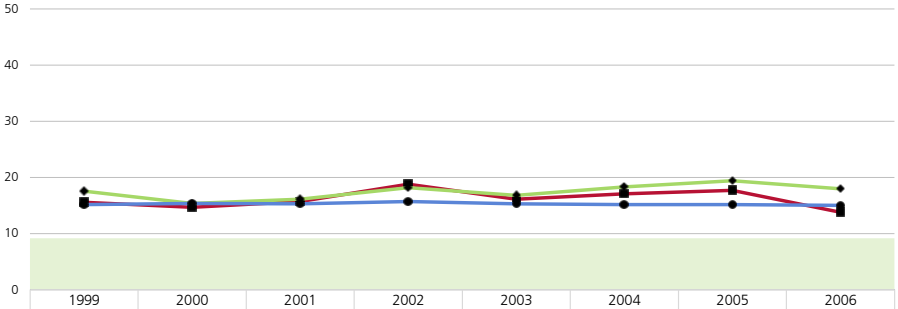


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-15a]
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Mortality rates in the Total Area have fluctuated over the past decade, showing no clear trend.

Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



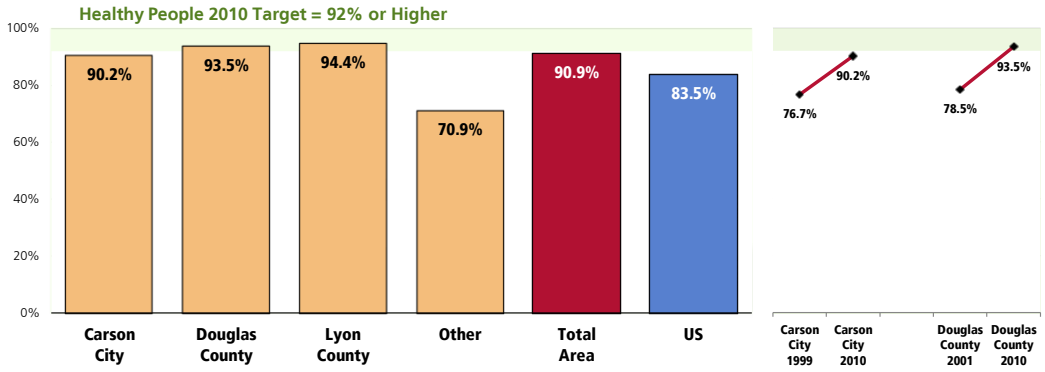
	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	9.2	9.2	9.2	9.2	9.2	9.2	9.2	9.2
Total Area	15.6	14.7	15.7	18.8	16.1	17.1	17.7	13.8
Nevada	17.6	15.4	16.1	18.2	16.8	18.3	19.4	18.0
United States	15.2	15.4	15.3	15.7	15.3	15.2	15.2	15.0

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-15a]
Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Most Total Area adults (90.9%) report "always" wearing a seat belt when driving or riding in a vehicle.

- More favorable than the percentage found nationally (83.5%).
- Similar to the Healthy People 2010 objective of 92% or higher.
- Particularly low (70.9%) in the "Other" counties.
- Over time, the prevalence of consistent seat belt usage has <u>improved</u> significantly in both Carson City and Douglas County.

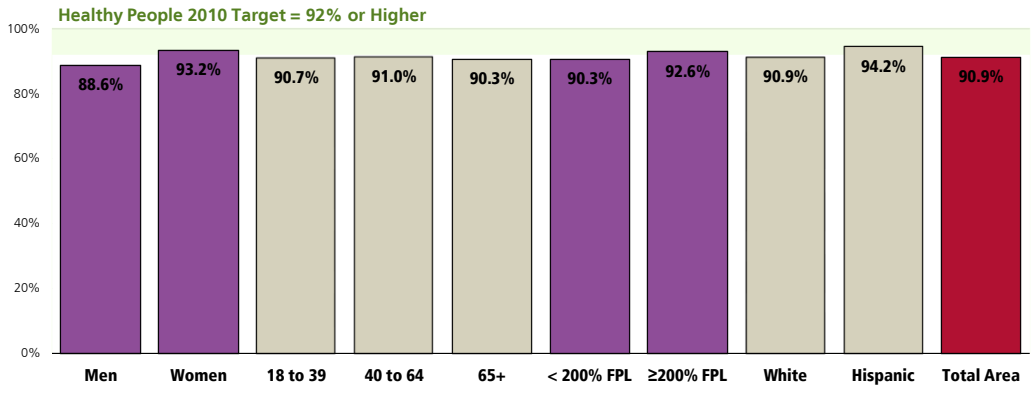
"Always" Wear a Seat Belt When Driving or Riding in a Vehicle



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 57]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19]
Notes: Asked of all respondents.

- Men are less likely to report consistent seat belt usage than are women.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle
(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 57]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

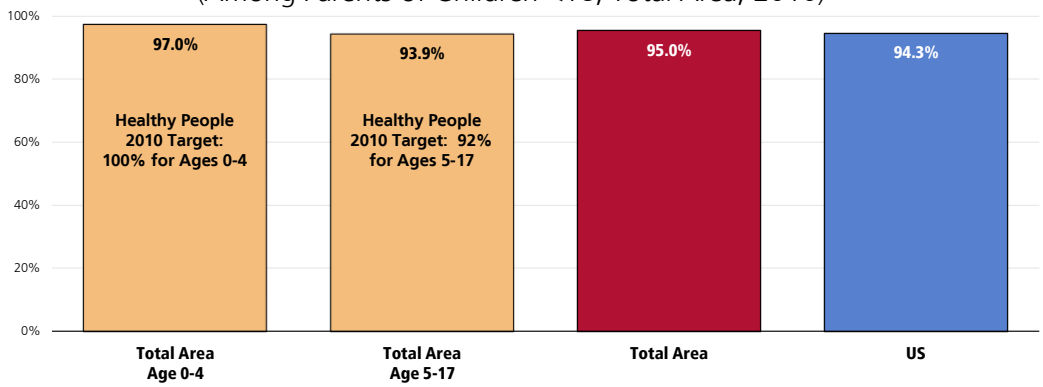
Seat Belt Usage - Children

A full 95.0% of Total Area parents report that their child (aged 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 (94.3%).
- Findings are similar by county (not shown).
- Among children under age 5, 97.0% report consistent safety belt usage, similar to the US prevalence (97.4%) and the Healthy People 2010 objective (100%).
- Among children aged 5-17, 93.9% report consistent safety belt usage, similar to the 93.0% found nationally, as well as the Healthy People 2010 goal of 92.0%.

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

(Among Parents of Children <18; Total Area, 2010)



Sources: 2010PRC Community Health Survey, Professional Research Consultants, Inc. [Items 136, 170-171]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objectives 15-19 and 15-20]

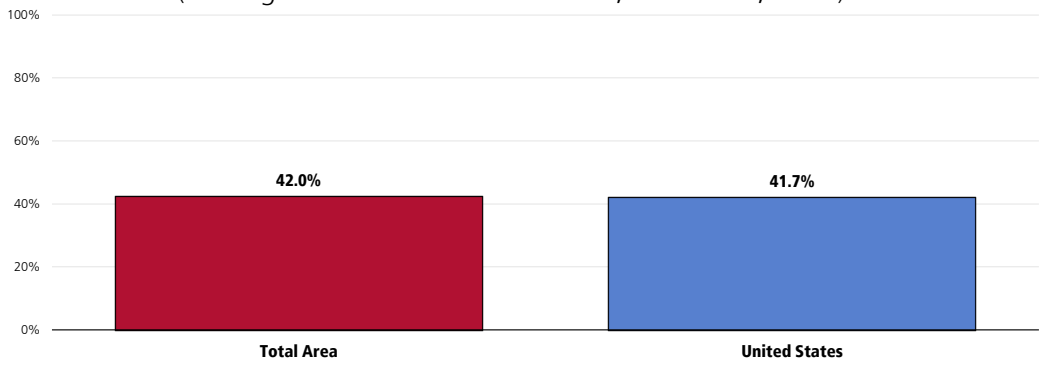
Notes: Asked of all respondents with children under 18 at home.

Bicycle Safety

A total of 42.0% of Total Area children aged 5 to 16 are reported to "always" wear a helmet when riding a bicycle.

- Nearly identical to the national prevalence (41.7%).

Child "Always" Wears a Helmet When Riding a Bicycle
(Among Parents of Children 5 to 16; Total Area, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 139]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents with children aged 5 to 16 at home.

Firearm Safety

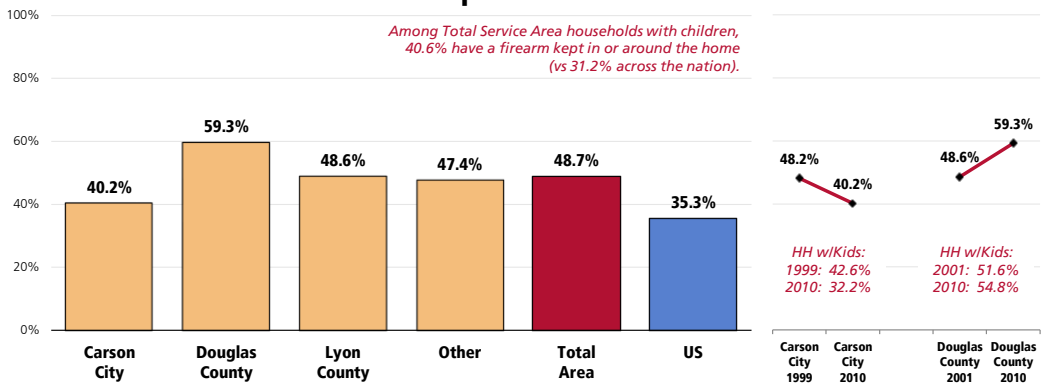
Overall, nearly one-half (48.7%) of Total Area adults have a firearm kept in or around their home.

- Much higher than the national prevalence (35.3%).
- Highest in Douglas County (59.3%).
- The prevalence of firearms in the home has <u>decreased</u> significantly among adults in Carson City, but has <u>increased</u> significantly in Douglas County.

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

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

Have a Firearm Kept in or Around the Home



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 61, 168]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

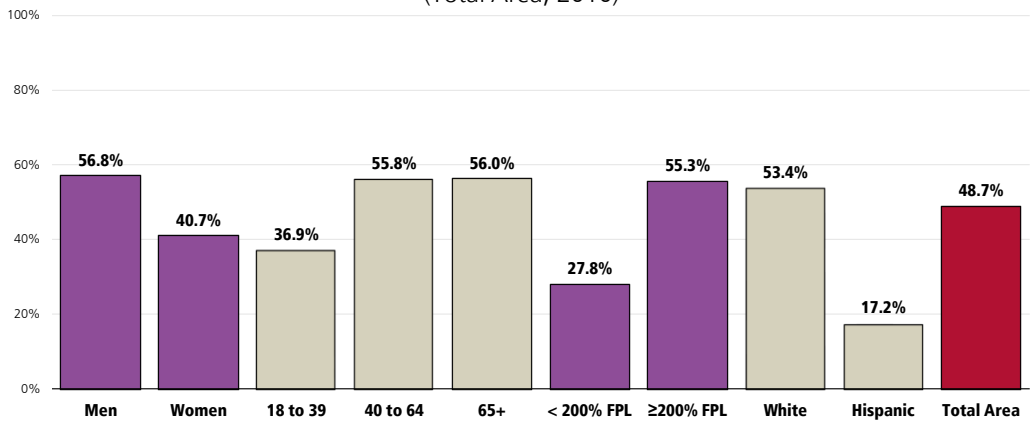
- Among Total Area households with children, 40.6% have a firearm kept in or around the house (notably higher than the 31.2% reported nationally).
- This prevalence has not changed significantly over time in either Carson City or Douglas County.

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

- Men.
- Adults aged 40 and older.
- Higher-income households.
- White respondents.

Have a Firearm Kept in or Around the House

(Total Area, 2010)



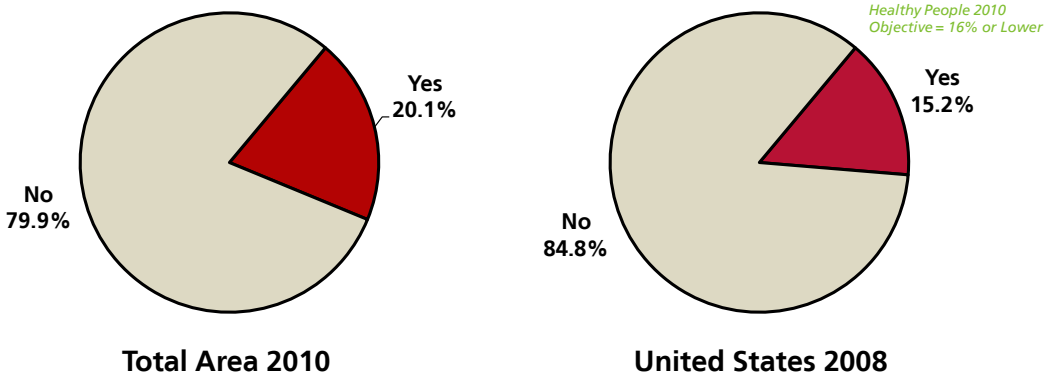
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Among Total Area households with firearms, 20.1% report that there is at least one weapon that is kept unlocked and loaded.

- Statistically similar to that found nationally (15.2%).
- Fails to satisfy the *Healthy People 2010* target (16% or lower).
- Similar by county (not shown).

Household Has An Unlocked, Loaded Firearm

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



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 15-4]

Notes:
- Asked of all respondents with a firearm in or around the home.

Intentional Injury (Violence)

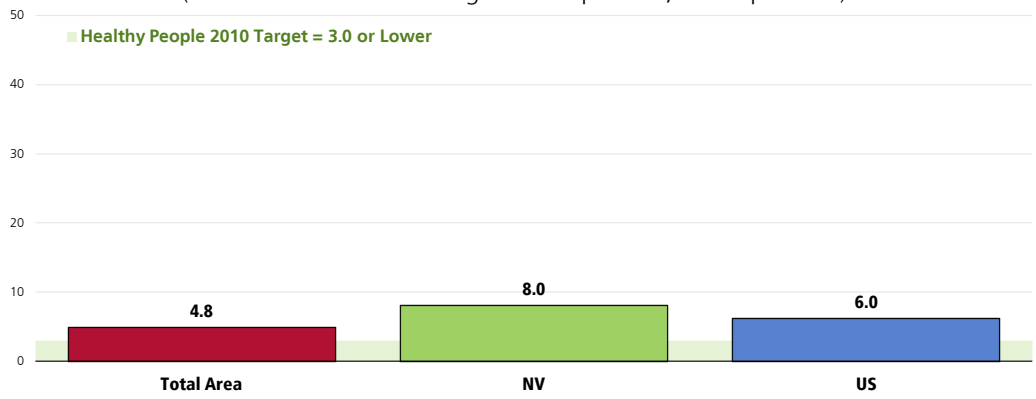
Age-Adjusted Intentional Injury Deaths

Homicide

Between 2004 and 2006, there was an annual average age-adjusted homicide rate of 4.8 deaths per 100,000 population in the Total Area.

- More favorable than the rate found statewide (8.0).
- More favorable than the national rate (6.0).
- Fails to satisfy the Healthy People 2010 target.

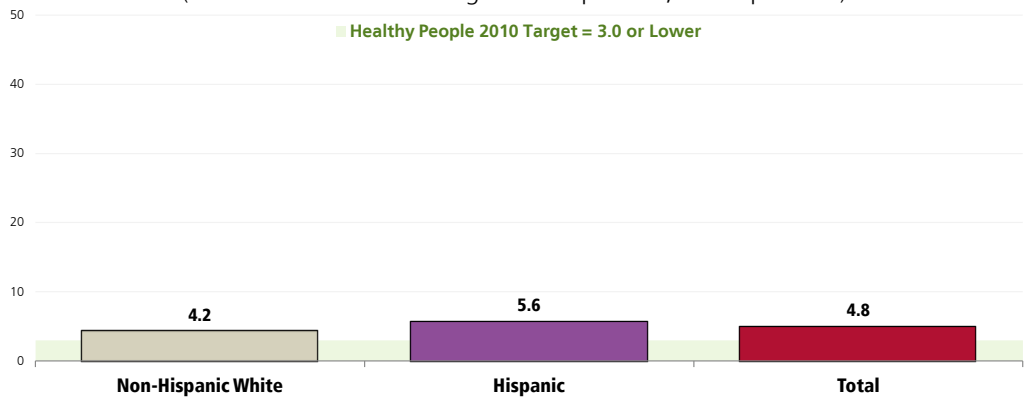
Homicide: Age-Adjusted Mortality
(2004-2006 Annual Average Deaths per 100,000 Population)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-32]
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that individual county rates are unreliable due to low number of deaths.

Homicide rates are slightly higher among Hispanics in the Total Area.

Homicide: Age-Adjusted Mortality by Race
(2004-2006 Annual Average Deaths per 100,000 Population)

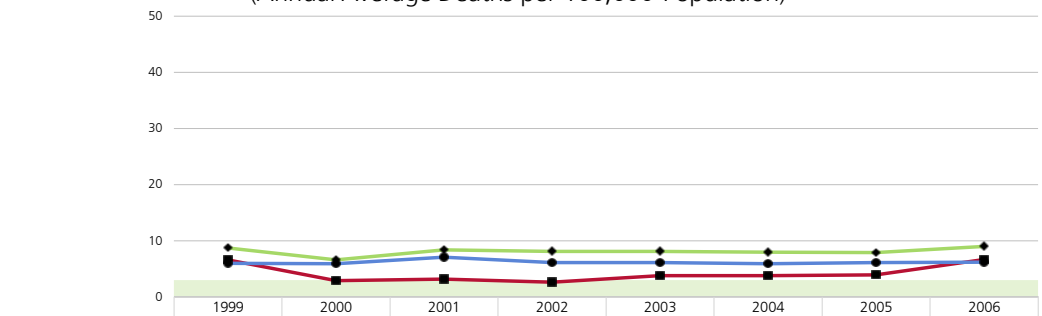


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-32]
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Since 1999, homicide rates in the Total Area decreased in the early 2000s, only to begin to rise again.

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
Total Area	6.6	2.9	3.2	2.6	3.8	3.8	3.9	6.7
Nevada	8.7	6.6	8.4	8.1	8.1	8.0	7.9	9.0
United States	6.0	5.9	7.1	6.1	6.1	5.9	6.1	6.2

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-32]

Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

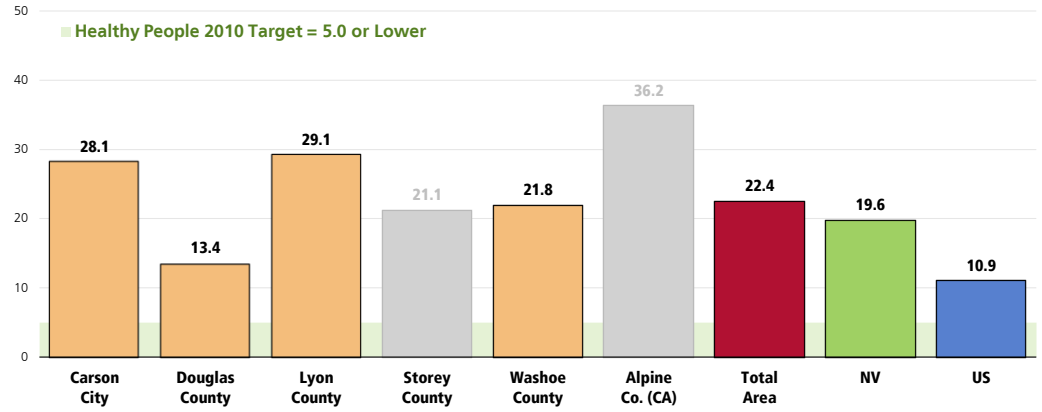
Suicide

Between 2004 and 2006, there was an annual average age-adjusted suicide rate of 22.4 deaths per 100,000 population in the Total Area.

- Higher than the statewide rate (19.6).
- Higher than the national rate (10.9).
- More than *four times* the Healthy People 2010 target.
- By county: suicide rates are particularly high in Carson City and Lyon County. (Note that Alpine County also experienced a high, albeit unreliable, rate.)

Suicide: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



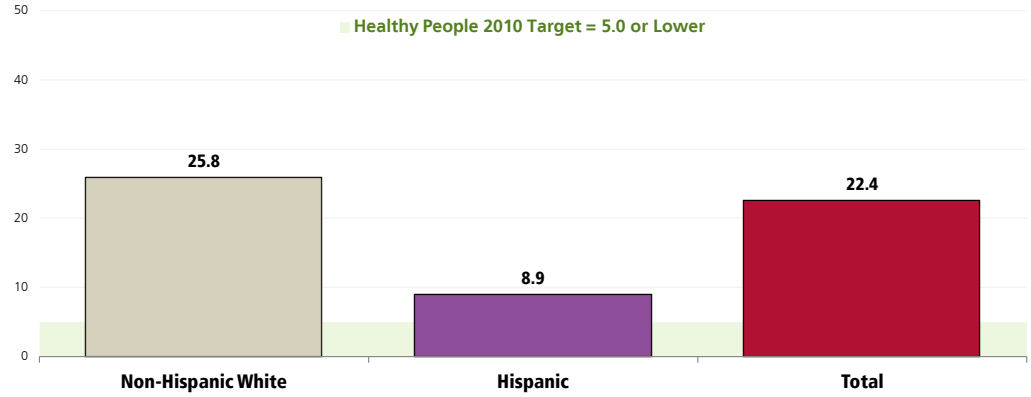
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 18-1]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rates for Storey County, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

Suicide rates in the Total Area are dramatically higher among Non-Hispanic Whites than among Hispanics.

Suicide: Age-Adjusted Mortality by Race

(2004-2006 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 July 2010.
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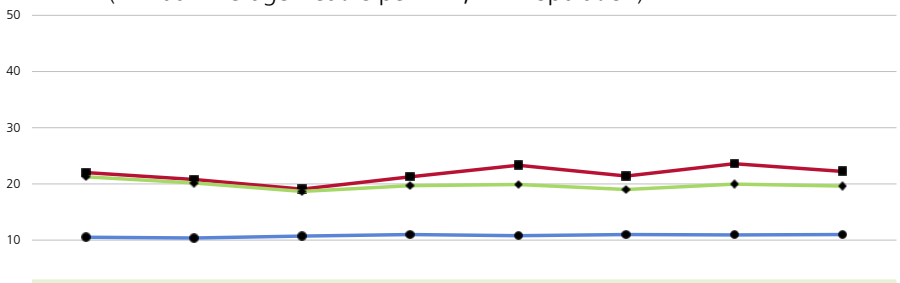
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Suicide rates have <u>trended upward</u> in recent years in the Total Area.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
Total Area	22.0	20.8	19.1	21.3	23.3	21.4	23.6	22.2
Nevada	21.3	20.2	18.7	19.7	19.9	19.0	20.0	19.6
United States	10.5	10.4	10.7	11.0	10.8	11.0	10.9	11.0

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
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Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Violent Crime

Violent Crime Rates

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

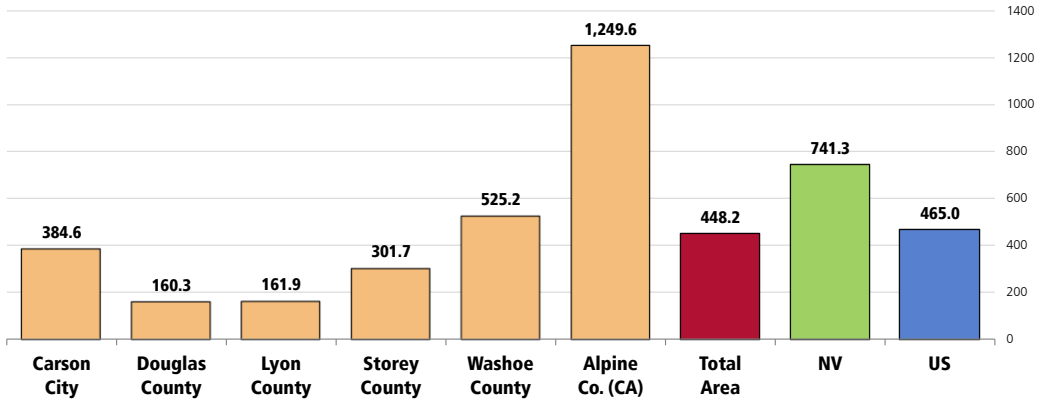
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Between 2006 and 2008, there was an annual average violent crime rate of 448.2 offenses per 100,000 population in the Total Area.

- Lower than the Nevada rate for the same period (741.3).
- Just below the national rate (465.0).
- Rates fluctuate widely from county to county: note that, due to a low county population, the 42 violent offenses in Alpine County (2006-2008) produced an exceptionally high rate for these years; for further comparison, Alpine County experienced only 21 violent offenses in the prior three years (2003-2005).

Violent Crime Rates

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

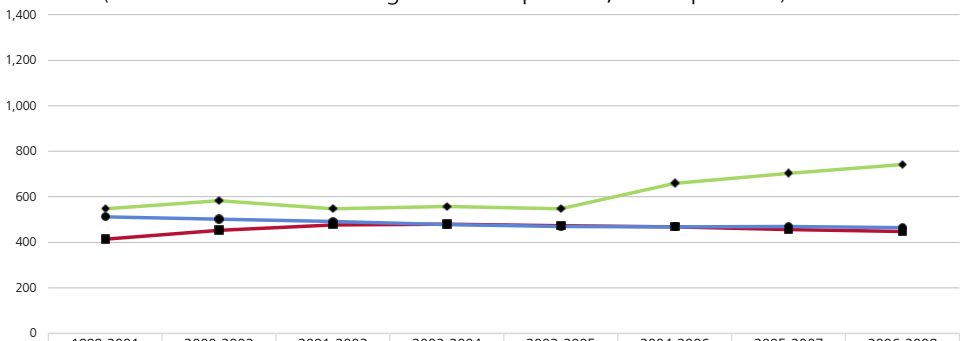


Sources: • State of Nevada Department of Public Safety.
Notes: • Rates are offenses per 100,000 population among agencies reporting.

- Crime rates increased in the Total Area from 1999 to 2002, but have since declined. Interestingly, Nevada rates have been on the rise, while national rates are declining.

Violent Crime Rates

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



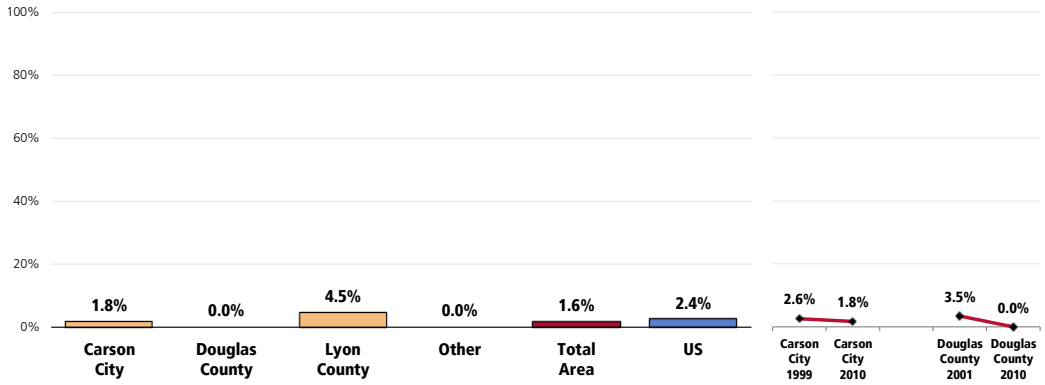
	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Total Area	414.3	452.8	477.1	480.0	473.4	467.4	456.0	448.2
Nevada	547.1	583.0	547.5	557.5	547.4	658.3	703.2	741.3
United States	511.3	501.8	491.6	477.8	469.3	468.6	469.8	465.0

Sources: • State of Nevada Department of Public Safety.
Notes: • Rates are offenses per 100,000 population among agencies reporting.

A total of 1.6% of Total Area adults acknowledge being the victim of a violent crime in the past five years.

- Statistically similar to national findings (2.4%).
- Significantly higher (4.5%) in Lyon County.
- Survey findings have not changed significantly in Carson City since 1999, but they have decreased (to 0.0% currently) in Douglas County since 2001.

Victim of a Violent Crime in the Past 5 Years

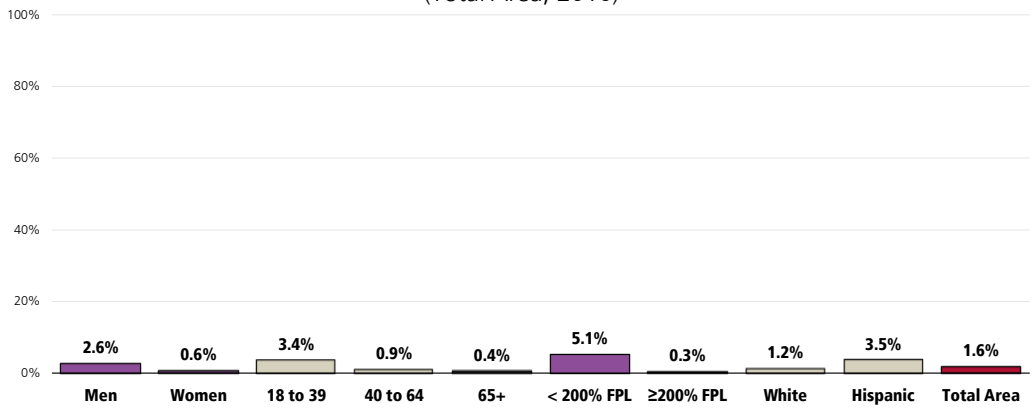


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 58]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Reports of violence are notably higher among:

- Men.
- Residents with lower incomes.

Victim of a Violent Crime in the Past 5 Years
(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Family Violence

Respondents were told:

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

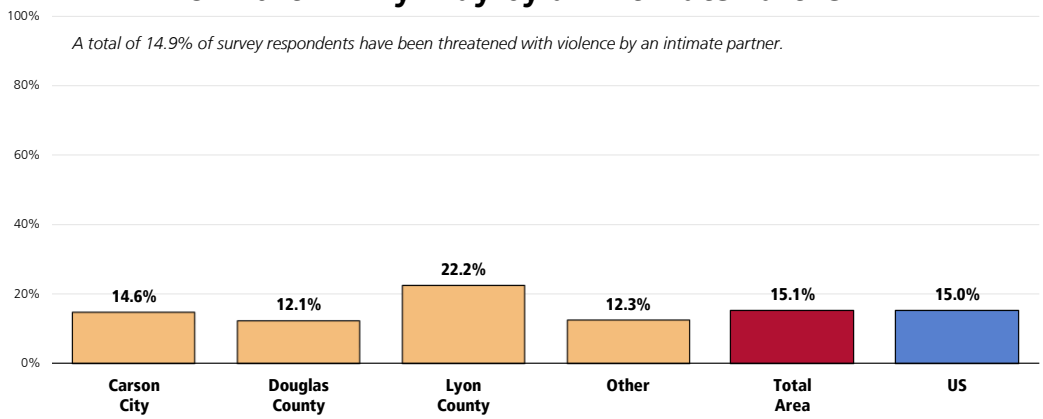
A total of 14.9% of Total Area adults report that they have ever been threatened with physical violence by an intimate partner.

- Comparable to the 14.6% reported nationally.

A total of 15.1% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- Nearly identical to national findings (15.0%).
- Notably higher (22.2%) in Lyon County.

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

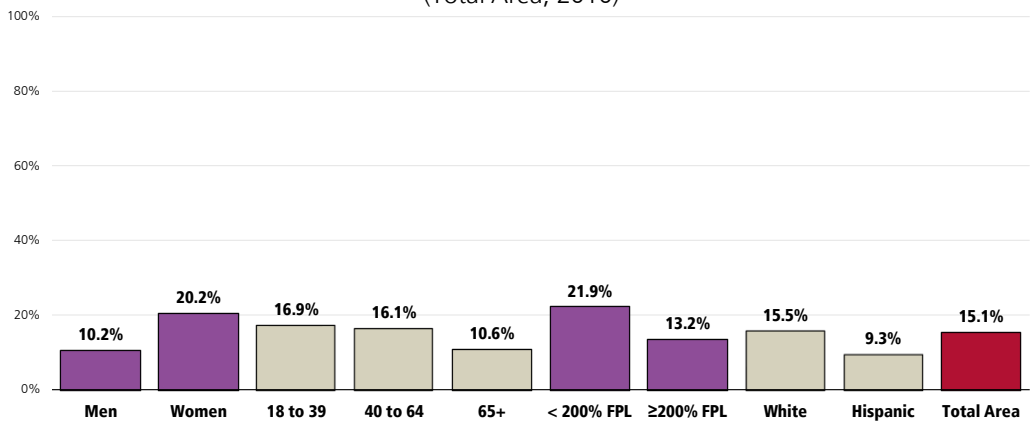


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 59-60]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Reports of domestic violence are also notably higher among:

- Women.
- Adults under the age of 65.
- Those living at lower income levels.

Have Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner
(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 60]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Diabetes

Diabetes affects nearly 16 million adults and contributes to about 200,000 deaths a year. Diabetes can cause heart disease, stroke, blindness, kidney failure, leg and foot amputations, pregnancy complications, and deaths related to influenza and pneumonia. About 5.4 million adults are unaware they have the disease.

Among adults, diagnosed diabetes (including gestational diabetes) increased 49% from 1990 to 2000. The largest increase was among people aged 30–39. Type 2 affects 90%–95% of people with diabetes and is linked to obesity and physical inactivity.

The direct and indirect costs of diabetes in America are nearly $100 billion a year.

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

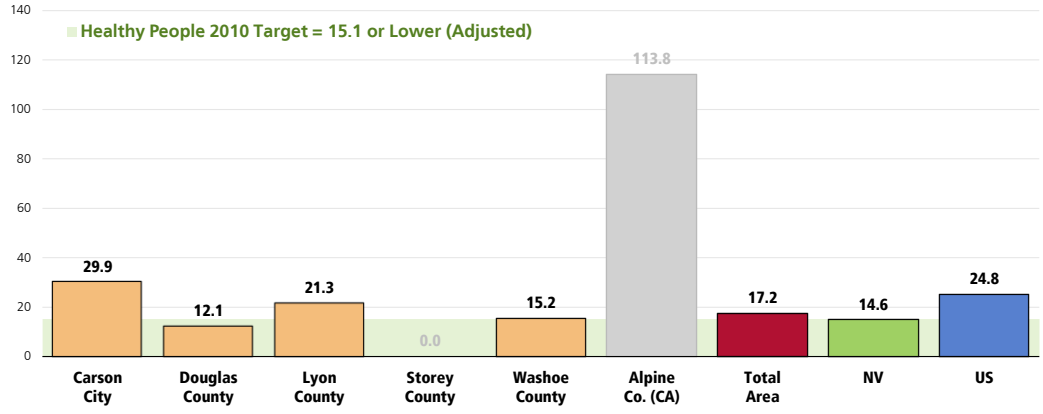
Age-Adjusted Diabetes Deaths

Between 2004 and 2006, there was an annual average age-adjusted diabetes mortality rate of 17.2 deaths per 100,000 population in the Total Area.

- Less favorable than that found statewide (14.6).
- More favorable than the national rate (24.8).
- Fails to satisfy the Healthy People 2010 target.
- Relatively high in Carson City and Alpine County (see below); lower (more favorable) in Douglas and Washoe counties (Storey County rate unreliable).
- Note that the exceptionally high rate shown for Alpine County reflects the instability of the rate due to low population size and relatively few deaths. Looking at a longer time range (1999-2006) produces a rate of 34.7, still relatively high, but much more in line with what is found elsewhere in the region.

Diabetes: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



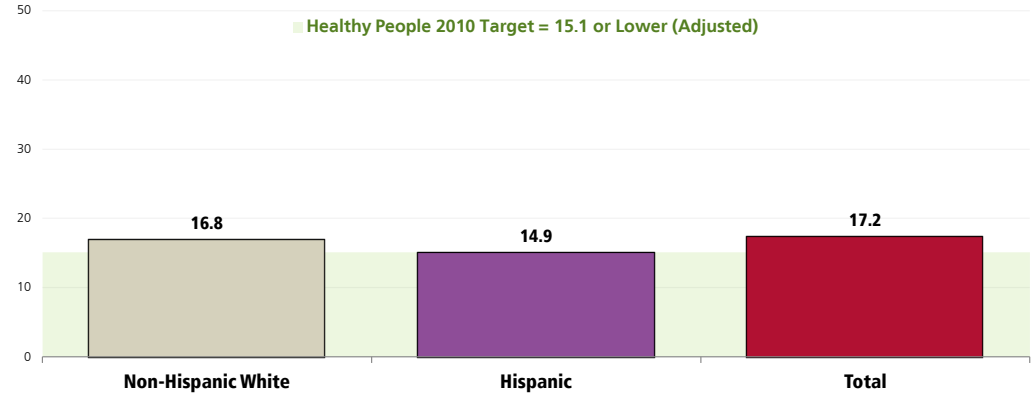
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 5-5]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
The Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
Note that the rates for Storey County, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

Diabetes mortality rates in the Total Area are slightly higher among Non-Hispanic Whites than among Hispanics.

Diabetes: Age-Adjusted Mortality by Race

(Total Area; 2004-2006 Annual Average Deaths per 100,000 Population)



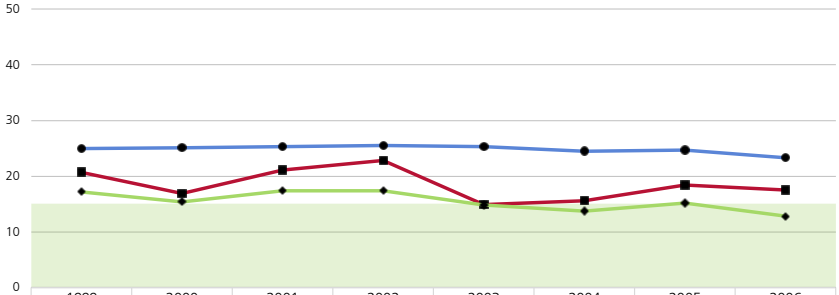
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 5-5]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
The Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Diabetes mortality rates have generally declined across the Total Area in recent years, mirroring the decreasing trend reported across both Nevada and the US.

Diabetes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010 (Adjusted)	15.1	15.1	15.1	15.1	15.1	15.1	15.1	15.1
Total Area	20.7	16.9	21.1	22.8	14.9	15.6	18.4	17.5
Nevada	17.2	15.4	17.4	17.4	14.8	13.7	15.2	12.8
United States	25.0	25.1	25.3	25.5	25.3	24.5	24.7	23.3

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 5-5]

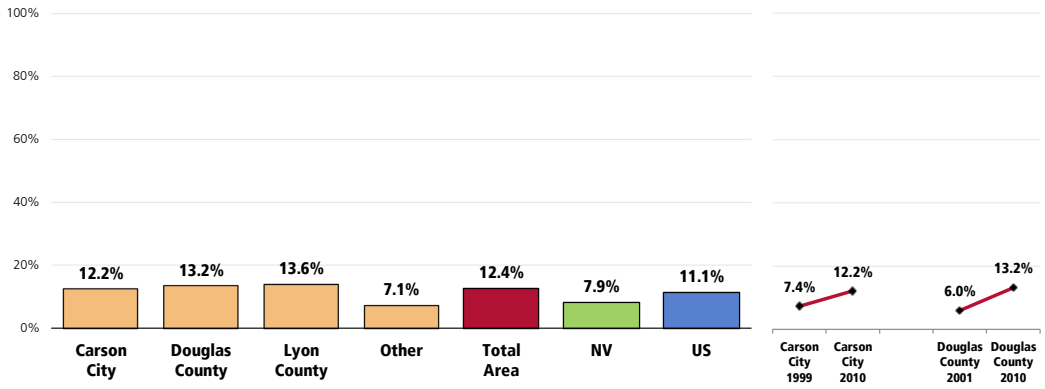
Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
The Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

A total of 12.4% of Total Area adults report having been diagnosed with diabetes.

- Higher than the proportion statewide (7.9%).
- Similar to the national proportion (11.1%).
- Statistically similar by county.
- The diabetes prevalence has increased considerably over the past several years in both Carson City and Douglas County.

Prevalence of Diabetes

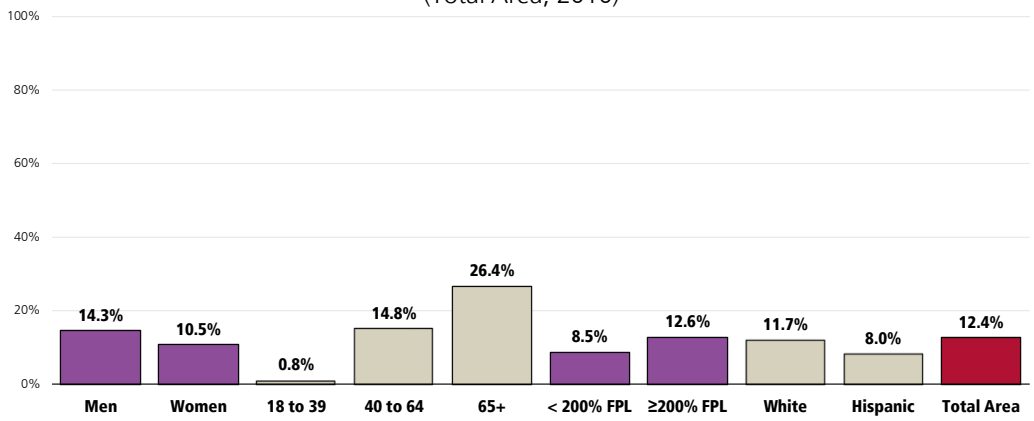


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 45]
2008 PRC National Health Survey, Professional Research Consultants.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
Notes: Asked of all respondents.

- A higher prevalence of diabetes is reported among adults aged 40 and older, and especially those 65 and older (with 26.4% of seniors with diabetes).

Prevalence of Diabetes

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 45]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

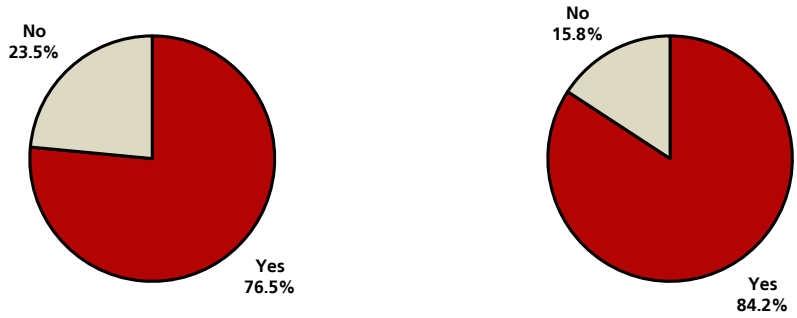
Diabetes Treatment

Among adults with diabetes, most (76.5%) are currently taking insulin or some type of medication to manage their condition.

- Statistically similar to the 84.2% reported nationally.

Taking Insulin or Other Medication for Diabetes

(Among Diabetics; Total Area, 2010)



Total Area Diabetics 2010

US Diabetics 2008

Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all diabetic respondents.

Kidney Disease

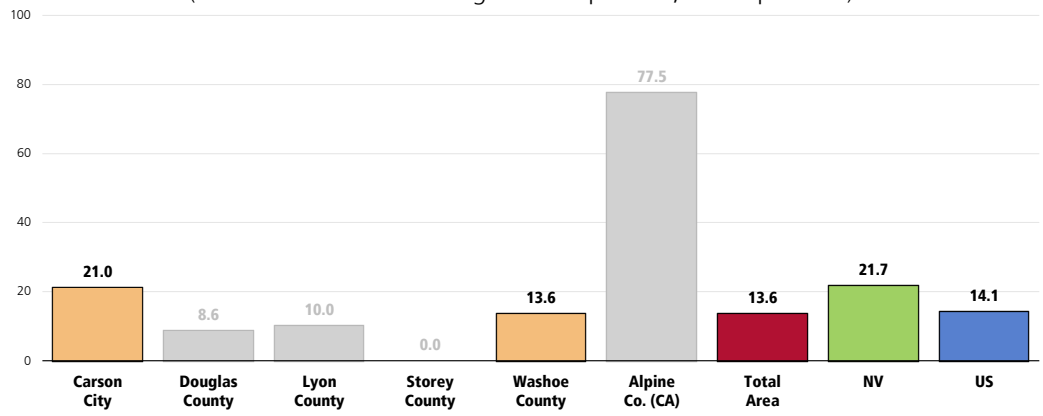
Age-Adjusted Kidney Disease Deaths

Between 2004 and 2006, there was an annual average age-adjusted kidney disease mortality rate of 13.6 deaths per 100,000 population in the Total Area.

- Much lower than the rate found statewide (21.7).
- Comparable to the national rate (14.1).
- Higher (less favorable) in Carson City; lower in Washoe County.
- Note that the high rate shown for Alpine County reflects the instability of the rate due to low population size and relatively few deaths. Looking at a longer time range (1999-2006) produces a rate of 23.1, much more in line with what is found elsewhere in the region.

Kidney Disease: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



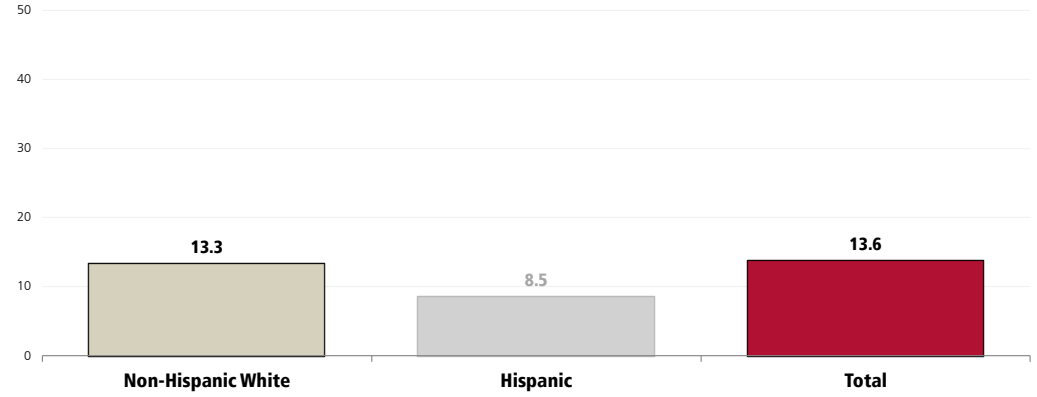
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rates for Douglas, Lyon and Storey Counties, Nevada, and Alpine County, California, are unreliable due to low number of deaths.

Kidney disease mortality rates in the Total Area appear higher among Non-Hispanic Whites, although the rate reported for Hispanics is deemed unreliable due to a low number of deaths.

Kidney Disease: Age-Adjusted Mortality by Race

(2004-2006 Annual Average Deaths per 100,000 Population)



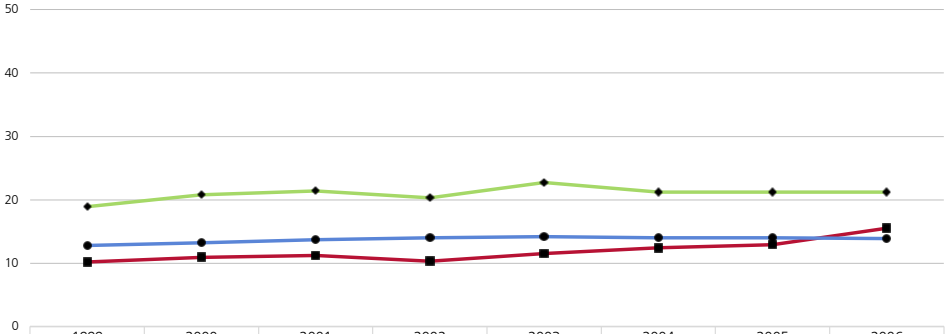
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rate for Hispanics is unreliable due to low number of deaths.

Between1999 and 2006, the age-adjusted kidney disease death rate increased across the Total Area, as did both the Nevada and US rates.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Total Area	10.2	10.9	11.2	10.3	11.5	12.4	12.9	15.5
Nevada	18.9	20.8	21.4	20.3	22.7	21.2	21.2	21.2
United States	12.8	13.2	13.7	14.0	14.2	14.0	14.0	13.9

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

Arthritis, Osteoporosis, & Chronic Pain

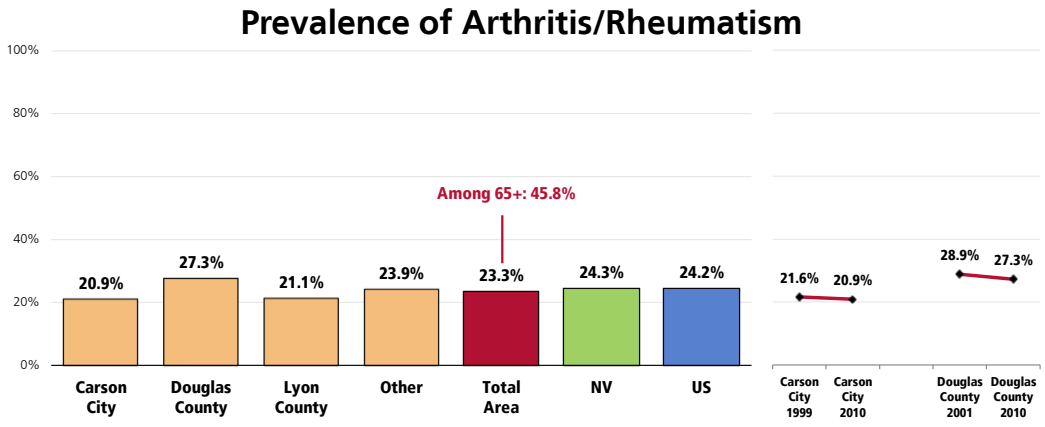
The current and projected growth in the number of people aged 65 years and older in the United States has focused attention on preserving quality of life, as well as length of life. Chief among the factors involving preserving quality of life are the prevention and treatment of musculoskeletal conditions—the major causes of disability in the United States. Among musculoskeletal conditions, arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions have the greatest impact on public health and quality of life.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Prevalence of Arthritis/Rheumatism

Nearly one-fourth (23.3%) of Total Area adults reports suffering from arthritis or rheumatism.

- Similar to the statewide prevalence (24.3%).
- Similar to that found nationwide (24.2%).
- No significant differences by county.
- Among Total Area adults aged 65 and older, the prevalence of arthritis or rheumatism is 45.8%.
- The prevalence of arthritis/rheumatism has not changed significantly over time in either Carson City or Douglas County.

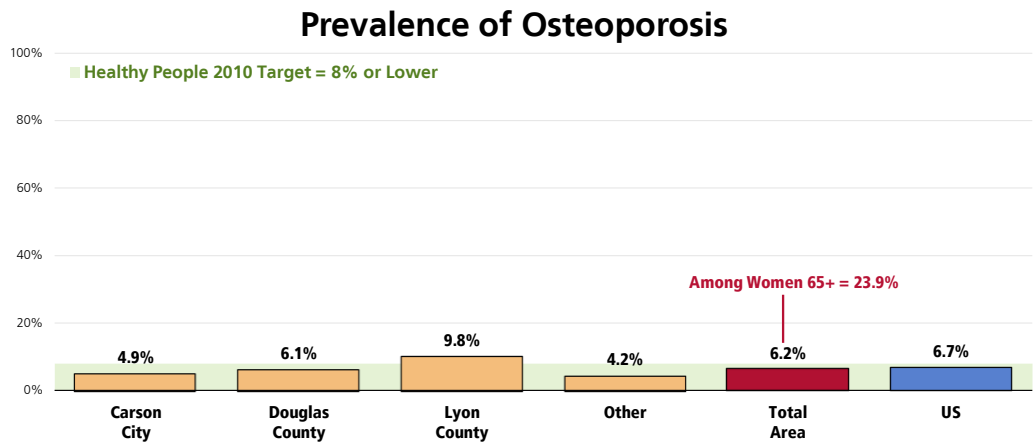


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]
2008 PRC National Health Survey, Professional Research Consultants.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
Notes: Asked of all respondents.

Prevalence of Osteoporosis

A total of 6.2% of survey respondents have osteoporosis.

- Nearly identical to that found nationwide (6.7%).
- No significant differences by county.
- Among Total Area <u>women</u> aged 65 and older, the prevalence of osteoporosis is 23.9%.

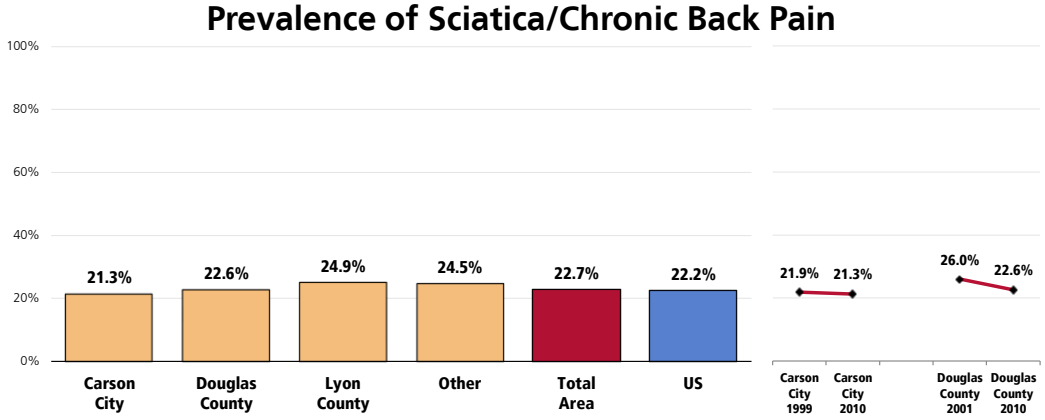


Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 34]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 2-9]
Notes: Asked of all respondents.

Prevalence of Sciatica/Chronic Back Pain

More than one-fifth (22.7%) of survey respondents suffers from chronic back pain or sciatica.

- Nearly identical to that found nationwide (22.2%).
- No significant differences by county.
- No significant change over time in either Carson City or Douglas County.



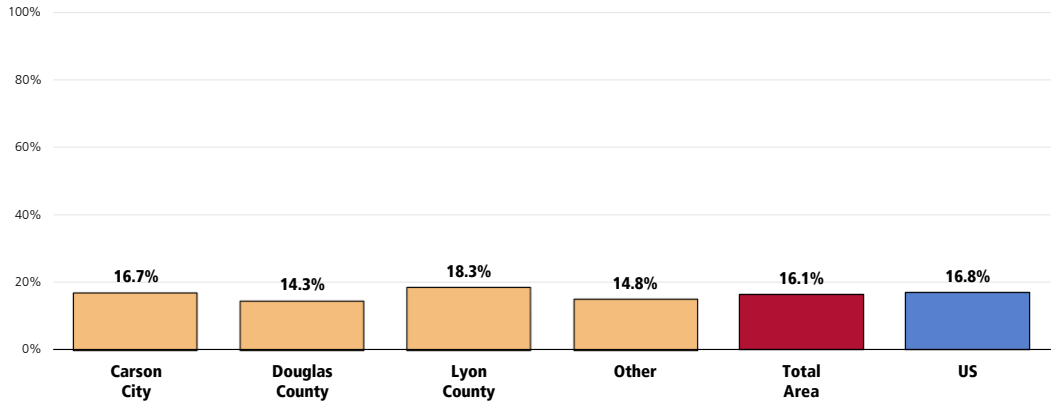
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Prevalence of Migraines/Severe Headaches

A total of 16.1% of survey respondents reports suffering from migraines or severe headaches.

- Nearly identical to that found nationwide (16.8%).
- Statistically similar by county.

Prevalence of Migraines/Severe Headaches



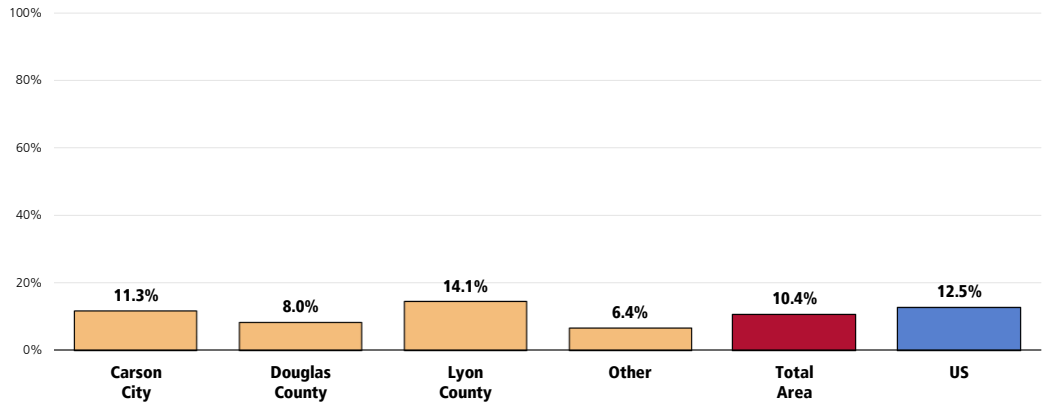
Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 38]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Prevalence of Chronic Neck Pain

A total of 10.4% of survey respondents currently suffer from chronic neck pain.

- Statistically similar to that found nationwide (12.5%).
- Statistically similar by county.

Prevalence of Chronic Neck Pain



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Vision & Hearing

Among the five senses, people depend on vision and hearing to provide the primary cues for conducting the basic activities of daily life. At the most basic level, vision and hearing permit people to navigate and to stay oriented within their environment. These senses provide the portals for language, whether spoken, signed, or read. They are critical to most work and recreation and allow people to interact more fully. For these reasons, vision and hearing are defining elements of the quality of life. Either, or both, of these senses may be diminished or lost because of heredity, aging, injury, or disease. Such loss may occur gradually, over the course of a lifetime, or traumatically in an instant.

Conditions of vision or hearing loss that are linked with chronic and disabling diseases pose additional challenges for patients and their families. From the public health perspective, the prevention of either the initial impairment or additional impairment from these environmentally orienting and socially connecting senses requires significant resources. Prevention of vision or hearing loss or their resulting disabling conditions through the development of improved disease prevention, detection, or treatment methods or more effective rehabilitative strategies must remain a priority.

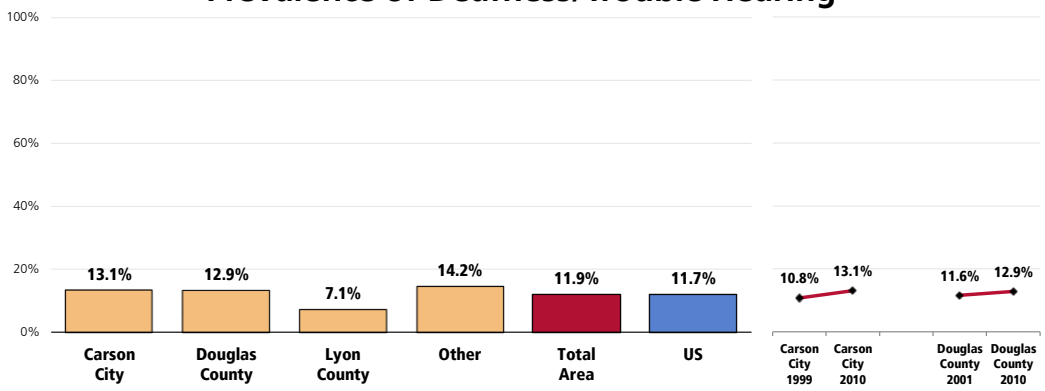
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Hearing Trouble

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

- Similar to that found nationwide (11.7%).
- Lowest (7.1%) in Lyon County.
- Statistically unchanged over time in Carson City and Douglas County.
- Among Total Area adults aged 65 and older, 30.0% have partial or complete hearing loss.

Prevalence of Deafness/Trouble Hearing



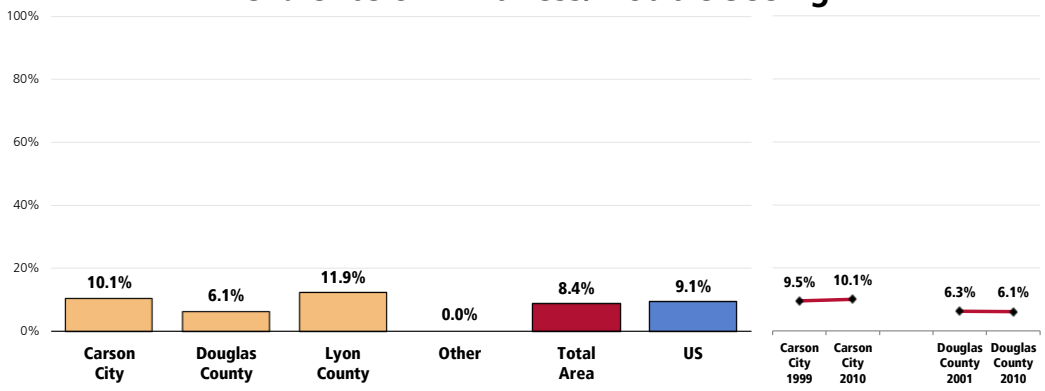
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Vision Trouble

A total of 8.4% of Total Area adults are blind, or have trouble seeing even when wearing corrective lenses.

- Comparable to that found nationwide (9.1%).
- Note the 0.0% prevalence reported in the "Other" counties.
- Statistically unchanged over time in Carson City and Douglas County.
- Among Total Area adults aged 65 and older, 11.4% have vision trouble.

Prevalence of Blindness/Trouble Seeing



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 28]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Environmental Health

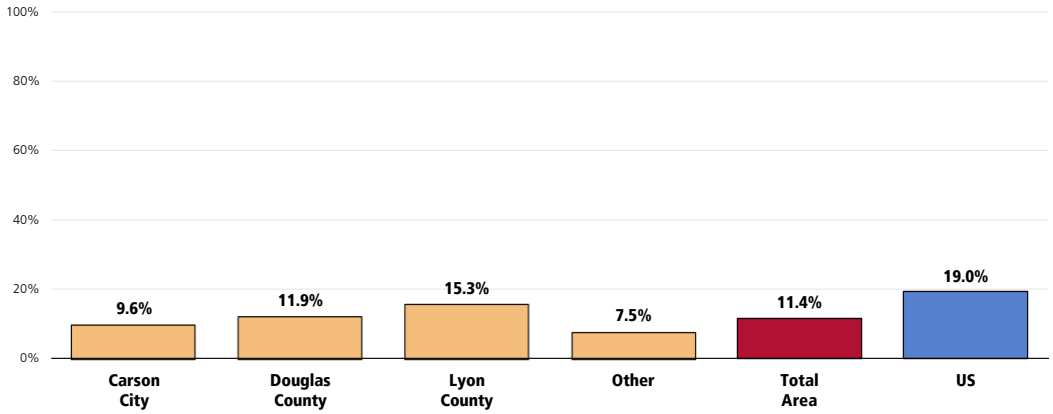
Air Contaminants

Indoor Contaminants

A total of 11.4% of Total Area adults had an illness or symptom in the past year that they believed to be caused by *indoor* air contaminants (such as dust, mold, smoke or chemicals inside the home or office).

- More favorable than national findings (19.0%).
- Similar by county.

Had an Illness or Symptoms in the Past Year Believed to be Caused by Indoor Air Contaminants

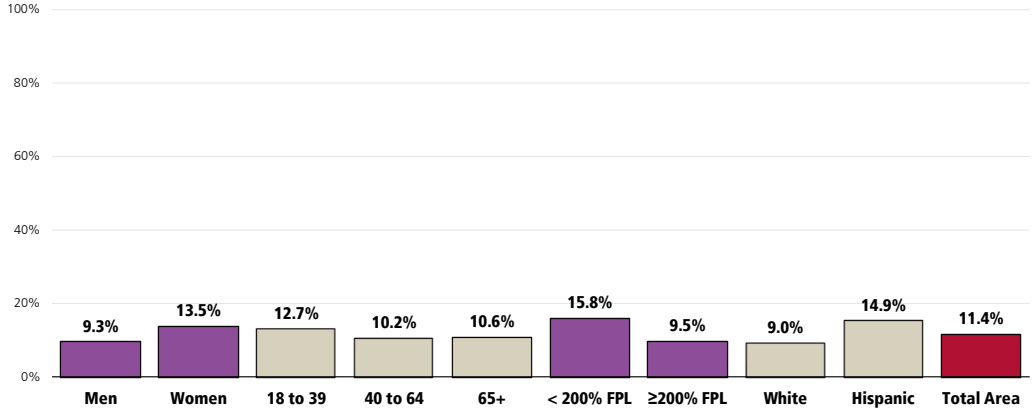


Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.
Examples of indoor air contaminants include dust, mold, smoke, and chemicals.

The following population segment is more likely to have had an illness or symptom caused by indoor air contaminants:

- Residents in the lower income breakout.

Had an Illness or Symptoms in the Past Year Believed to be Caused by Indoor Air Contaminants
(Total Area, 2010)



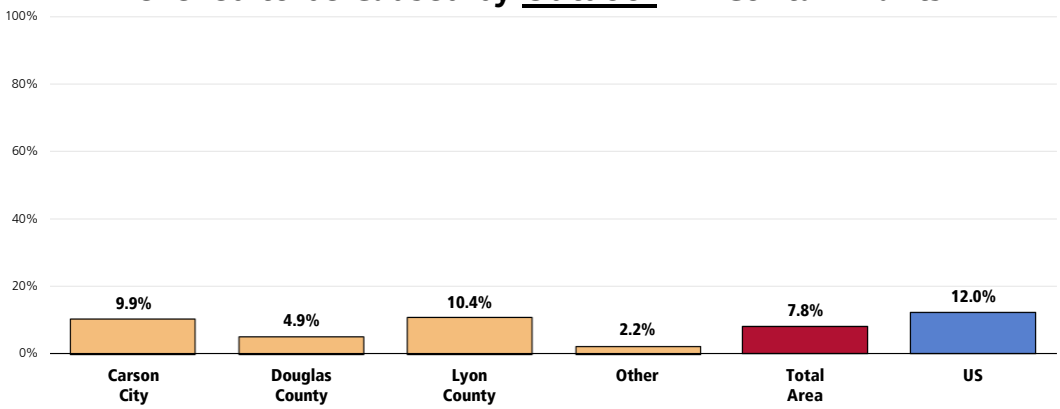
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.
Examples of indoor air contaminants include dust, mold, smoke, and chemicals.

Outdoor Contaminants

A total of 7.8% of Total Area adults had an illness or symptom in the past year that they believed to be caused by outdoor contaminants (such as smog, automobile exhaust or chemicals).

- More favorable than that found nationwide (12.0%).
- Notably lower among Douglas County and "Other" respondents.

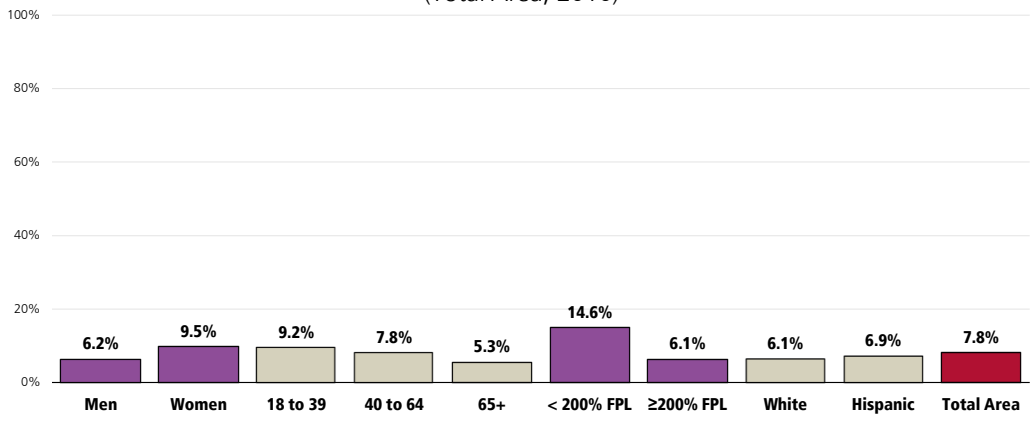
Had an Illness or Symptoms in the Past Year Believed to be Caused by Outdoor Air Contaminants



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 55]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.
Examples of outdoor air contaminants include smog, automobile exhaust, and chemicals.

- Residents in the lower income breakout are more likely to have had an illness or symptom believed to be caused by outdoor air contaminants.

Had an Illness or Symptoms in the Past Year Believed to be Caused by Outdoor Air Contaminants
(Total Area, 2010)



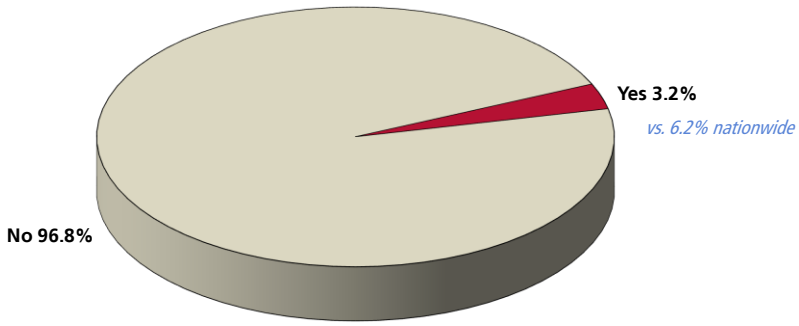
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 55]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.
Examples of indoor air contaminants include smog, automobile exhaust, and chemicals.

Mold in the Home

A total of 3.2% of respondents report having an area of mold in their home that is greater than the size of a dollar bill.

- More favorable than that found nationwide (6.2%).
- Higher (less favorable) in Carson City; lower in Douglas County and the "Other" counties (not shown).

Have an Area of Mold in the Home Greater Than the Size of a Dollar Bill
(Total Area, 2010)



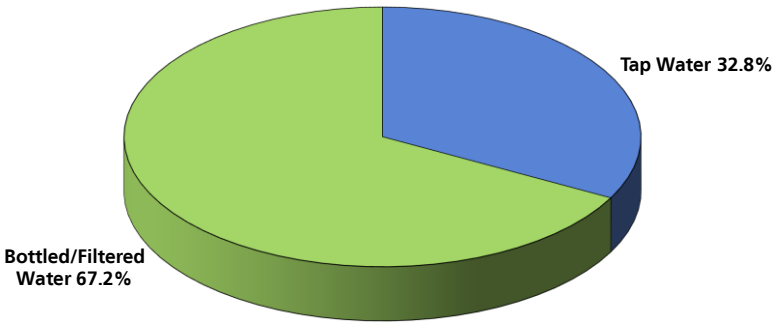
Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Water Consumption

More than two-thirds (67.2%) of survey respondents say they usually drink bottled or filtered water, while only 32.8% usually drink tap water.

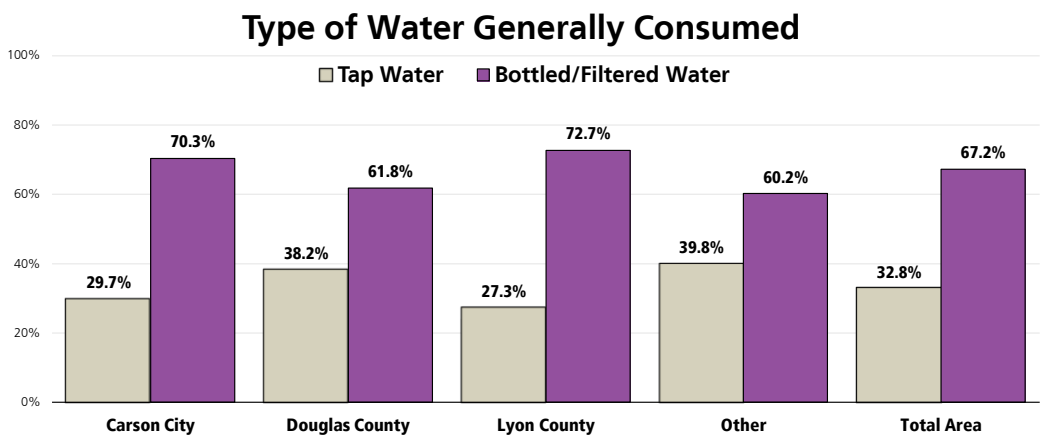
Type of Water Generally Consumed
(Total Area, 2010)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 107]

Notes:
- Asked of all respondents.
- In this case, filtered water can include bottled water or tap water which is filtered through a special pitcher, etc.

- Note the following breakout in water consumption by county:



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 107]
Notes: Asked of all respondents.
In this case, filtered water can include bottled water or tap water which is filtered through a special pitcher, etc.

INFECTIOUS DISEASE

Infectious diseases remain major causes of illness, disability, and death. Moreover, new infectious agents and diseases are being detected, and some diseases considered under control have reemerged in recent years. In addition, antimicrobial resistance is evolving rapidly in a variety of hospital- and community-acquired infections. These trends suggest that many challenges still exist in the prevention and control of infectious diseases.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Vaccine-Preventable Conditions

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

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

Measles, Mumps, Rubella

Between 2007 and 2009, there were no reported cases of measles or rubella in any of the counties in the Total Area. The mumps rate during this time period was 0.2 per 100,000 population.

Reported Case Rates for Vaccine-Preventable Diseases

(2007-2009)

	Total Area	NV	US*	HP2010
Measles	**0.0**	**0.0**	**0.0**	**0.0**
Mumps	**0.2**	**0.3**	**0.9**	**0.0**
Rubella	**0.0**	**0.0**	**0.0**	**0.0**
Pertussis	**1.4**	**1.2**	**4.4**	n/a

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-9]

Notes:
- *US data are 2006-2008 data.
- US measles cases include only those infected while in the United States.

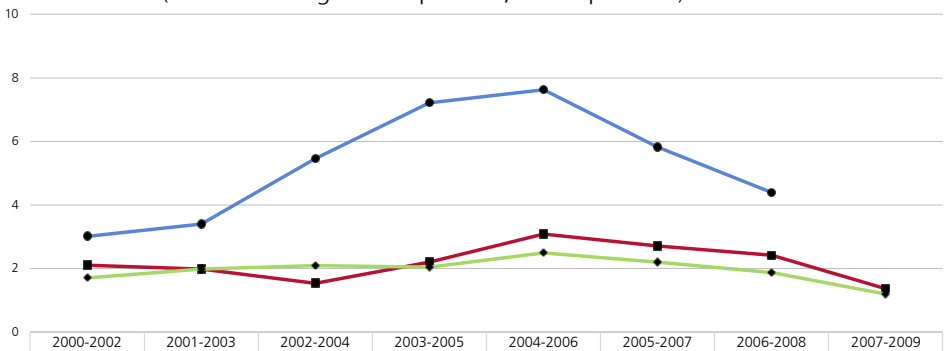
Pertussis

Between 2007 and 2009, the annual average pertussis incidence rate (new cases per year) was 1.4 cases per 100,000 population in the Total Area.

- Above the Nevada incidence rate (1.2).
- Much lower than the national incidence rate (4.4) for the 2006-2008 reporting period (latest data available).
- Incidence has fluctuated over the past several years: after increasing dramatically around 2004, the incidence rate has decreased in recent years across the Total Area.

Pertussis Incidence

(Annual Average Cases per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Total Area	2.1	2.0	1.5	2.2	3.1	2.7	2.4	1.4
Nevada	1.7	2.0	2.1	2.0	2.5	2.2	1.9	1.2
United States	3.0	3.4	5.5	7.2	7.6	5.8	4.4	

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

Notes:
- Rates are annual average new cases per 100,000 population.

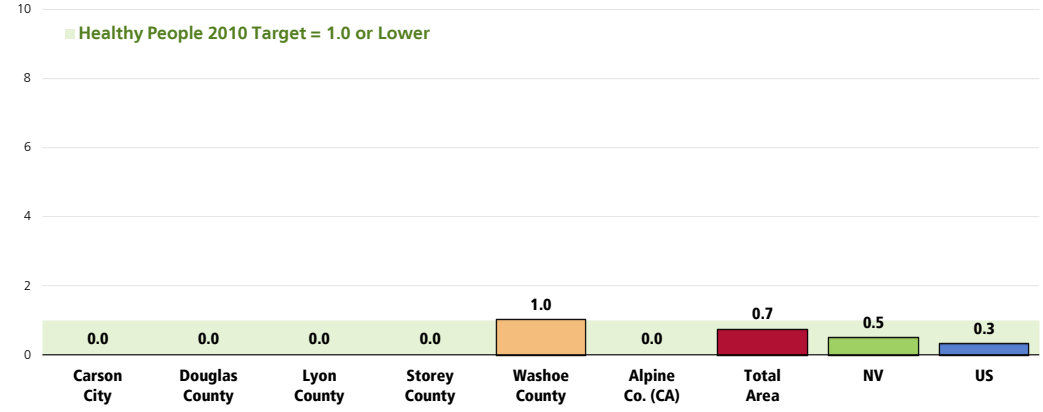
Acute Hepatitis C

The Total Area experienced an incidence rate of 0.7 cases of hepatitis C per 100,000 population between 2007 and 2009.

- The Total Area rate is less favorable than the 0.5 statewide rate and the 0.3 national rate.
- The Total Area rate is solely attributed to a 1.0 case rate in Washoe County. No other cases were reported in the other counties.

Hepatitis C (Acute) Incidence

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



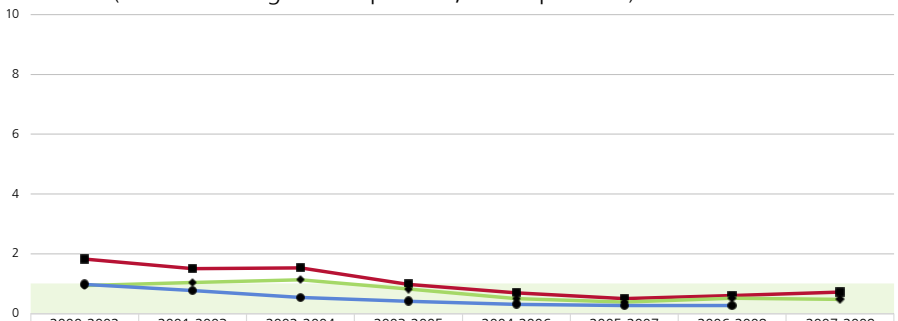
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-9]

Notes:
- Rates are annual average new cases per 100,000 population.
- US data are 2006-2008 data.

- Incidence has declined in the Total Area from the rate of 1.8 reported in 2000-2002.

Hepatitis C (Acute) Incidence

(Annual Average Cases per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2010	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total Area	1.8	1.5	1.5	1.0	0.7	0.5	0.6	0.7
Nevada	0.9	1.0	1.1	0.8	0.5	0.4	0.5	0.5
United States	1.0	0.8	0.5	0.4	0.3	0.3	0.3	

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-9]

Notes:
- Rates are annual average new cases per 100,000 population.

Influenza & Pneumonia Vaccination

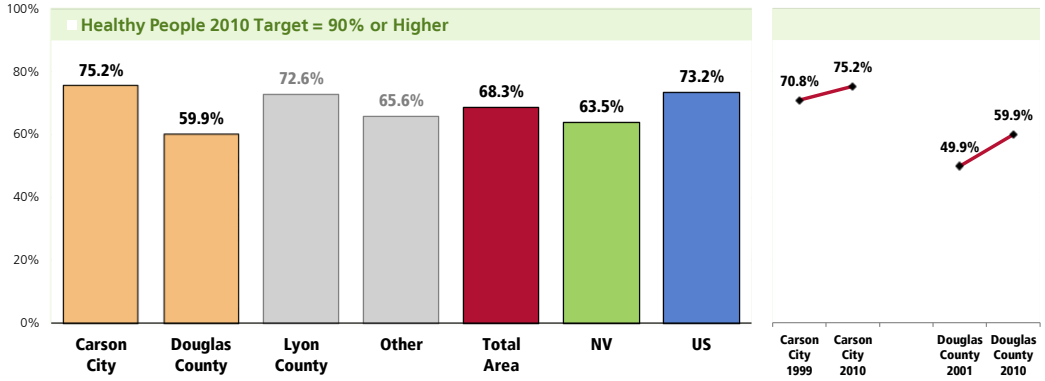
Flu Shots

Among adults aged 65 and older, more than two-thirds (68.3%) received a flu shot within the past year.

- Statistically comparable to the Nevada finding (63.5%).
- Comparable to the national finding (73.2%).
- Fails to satisfy the Healthy People 2010 target (90% or higher).
- Statistically comparable by county.
- Statistically unchanged over time in both Carson City and Douglas County.

Have Had a Flu Shot in the Past Year

(Among Total Area Seniors 65+, 2010)



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 179]
2008 PRC National Health Survey, Professional Research Consultants.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29a]

Notes: Asked of all respondents aged 65 and older.
County areas shown in gray are based on unreliable sample sizes.

High-Risk Adults

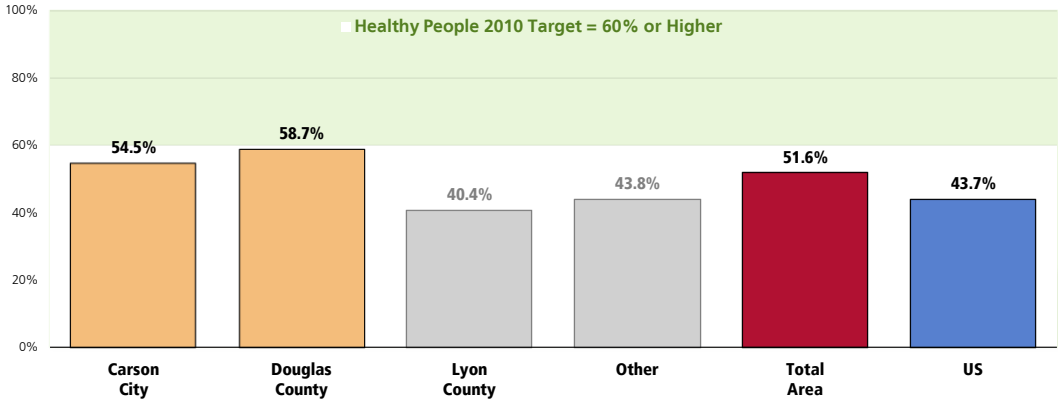
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

Over one-half (51.6%) of Total Area high-risk adults aged 18 to 64 received a flu shot within the past year.

- Similar to national findings (43.7%).
- Fails to satisfy the Healthy People 2010 target (60% or higher).
- Similar when viewed by county.

Have Had a Flu Shot in the Past Year

(Among Total Area High-Risk Adults <65, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29c]

Notes: Asked of all high-risk respondents under 65.
"High-Risk" includes adults aged 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
County areas shown in gray are based on unreliable sample sizes.

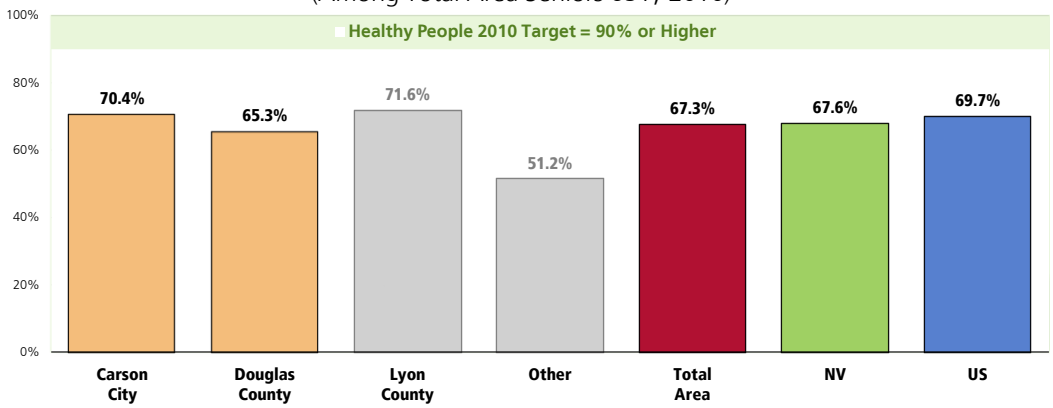
Pneumonia Vaccination

Among adults aged 65 and older, 67.3% have received a pneumonia vaccination at some point in their lives.

- Similar to the Nevada finding (67.6%).
- Similar to the national finding (69.7%).
- Fails to satisfy the Healthy People 2010 objective of 90% or higher.
- Statistically similar by county.

Have Ever Had a Pneumonia Vaccine

(Among Total Area Seniors 65+, 2010)



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
2008 PRC National Health Survey, Professional Research Consultants.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29b]

Notes: Asked of all respondents aged 65 and older.
County areas shown in gray are based on unreliable sample sizes.

High-Risk Adults

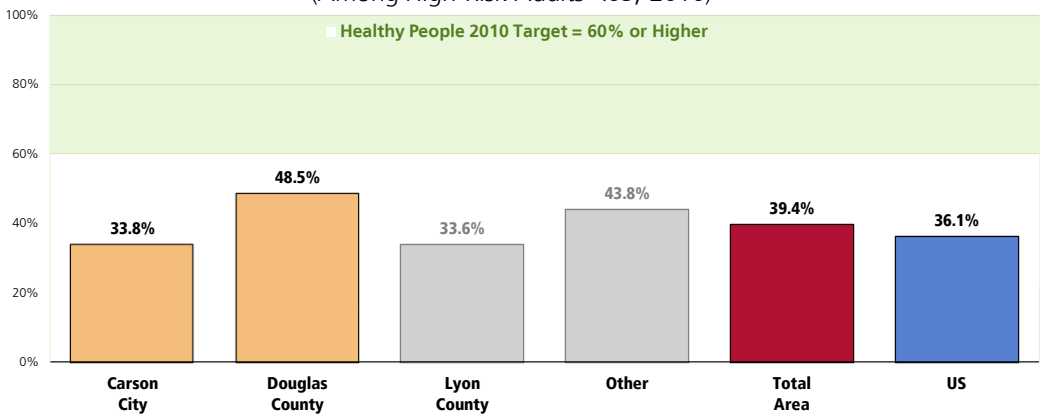
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 39.4% of Total Area high-risk adults aged 18 to 64 received a flu shot within the past year.

- Similar to national findings (36.1%).
- Fails to satisfy the Healthy People 2010 target (60% or higher).
- Similar when viewed by county.

Have Ever Had a Pneumonia Vaccine

(Among High-Risk Adults <65, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 182]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-29d]

Notes: Asked of all high-risk respondents under 65.
"High-Risk" includes adults aged 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
County areas shown in gray are based on unreliable sample sizes.

HIV

In the United States, HIV/AIDS remains a significant cause of illness, disability, and death, despite declines in 1999 and 2001.

Principal health determinants. Behaviors (sexual practices, substance abuse, and accessing prenatal care) and biomedical status (having other STDs) are major determinants of HIV transmission. Unprotected sexual contact, whether homosexual or heterosexual, with a person infected with HIV and sharing drug-injection equipment with an HIV-infected individual account for most HIV transmission in the United States. Increasing the number of people who know their HIV serostatus is an important component of a national program to slow or halt the transmission of HIV in the United States.

For persons infected with HIV, behavioral determinants also play an important role in health maintenance. Although drugs are available specifically to prevent and treat a number of opportunistic infections, HIV-infected individuals also need to make lifestyle-related behavioral changes to avoid many of these infections. The new HIV antiretroviral drug therapies for HIV infection bring with them difficulties in adhering to complex, expensive, and demanding medication schedules, posing a significant challenge for many persons infected with HIV.

Because HIV infection weakens the immune system, people with tuberculosis (TB) infection and HIV infection are at very high risk of developing active TB disease.

Comparing the 1980s to the 1990s, the proportion of AIDS cases in White men who have sex with men declined, whereas the proportion in females and males in other racial and ethnic populations increased, particularly among African adults and Hispanics. AIDS cases also appeared to be increasing among injection drug users and their sexual partners. The true extent of the epidemic remains difficult to assess for several reasons, including the following:

- Because of the long period of time from initial HIV infection to AIDS and because highly active antiretroviral therapy (HAART) has slowed the progression to AIDS, new cases of AIDS no longer provide accurate information about the current HIV epidemic in the United States.
- Because of a lack of awareness of HIV serostatus as well as delays in accessing counseling, testing, and care services by individuals who may be infected or are at risk of infection, some populations do not perceive themselves to be at risk. As a result, some HIV-infected persons are not identified and provided care until late in the course of their infection.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

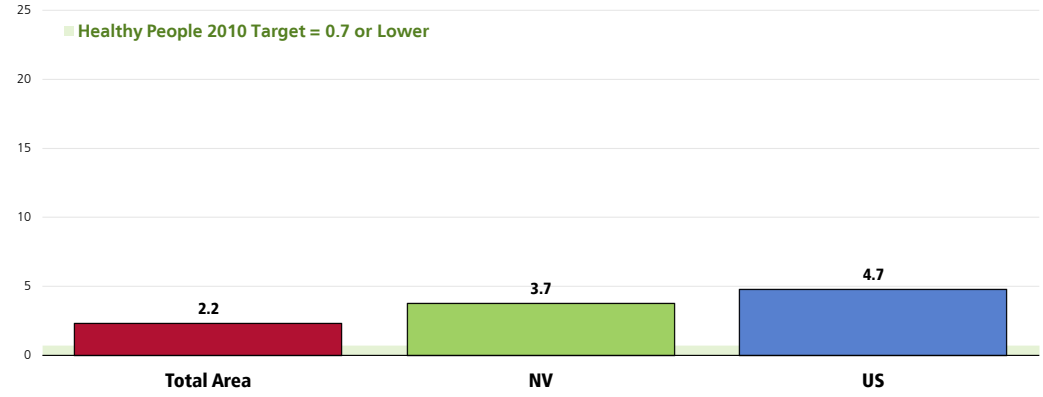
Age-Adjusted HIV/AIDS Deaths

Between 1999 and 2006, there was an annual average age-adjusted HIV/AIDS mortality rate of 2.2 deaths per 100,000 population in the Total Area.

- Lower than found statewide (3.7).
- Less than half the rate reported nationally (4.7).
- Fails to satisfy the Healthy People 2010 target.

HIV/AIDS: Age-Adjusted Mortality

(1999-2006 Annual Average Deaths per 100,000 Population)



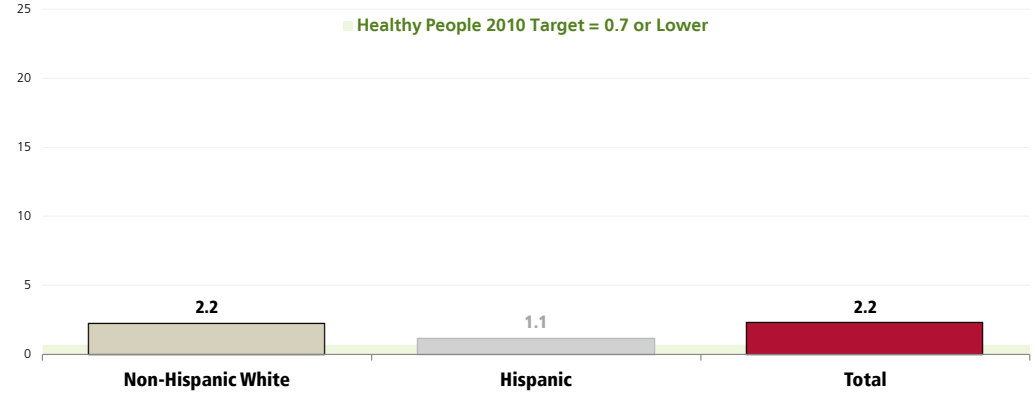
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 13-14]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that individual county rates are unreliable due to low number of deaths.

The HIV mortality rate among Non-Hispanic Whites is twice as high as that reported among Hispanics, although it is important to keep in mind that the Hispanic death rate is deemed unreliable due to low raw numbers.

HIV/AIDS: Age-Adjusted Mortality by Race

(Total Area;1999-2006 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 July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 13-14]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rate for Hispanics is unreliable due to low number of deaths.

HIV/AIDS Cases

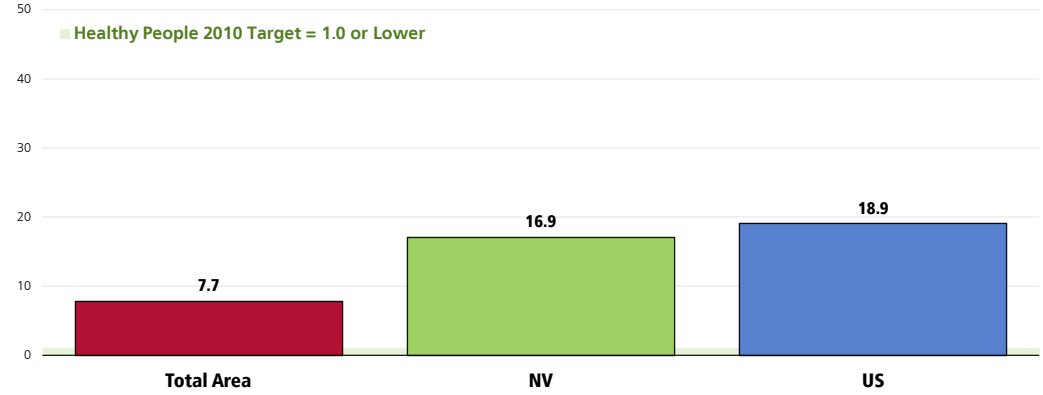
HIV/AIDS Incidence

Between 2006 and 2008, there were 7.7 new HIV/AIDS cases per 100,000 population in the Total Area.

- Notably lower than the Nevada incidence rate (16.9).
- Notably lower than the US incidence rate (18.9).
- Fails to satisfy the Healthy People 2010 target.

HIV/AIDS Incidence

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



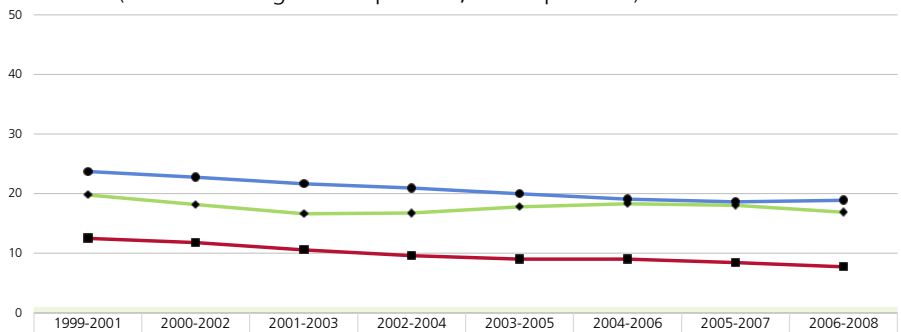
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 13-1]

Notes:
- Rates are annual average new cases per 100,000 population.
- Total Area rate excludes counts from Alpine County (which are not available); the impact on the overall rate is negligible.

The HIV/AIDS incidence rate has decreased since the early 2000s, echoing the statewide and nationwide trends.

HIV/AIDS Incidence

(Annual Average Cases per 100,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2010	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total Area	12.5	11.8	10.6	9.6	9.0	9.0	8.4	7.7
Nevada	19.8	18.2	16.6	16.7	17.8	18.3	18.0	16.9
United States	23.7	22.7	21.7	21.0	20.0	19.1	18.6	18.9

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 13-1]

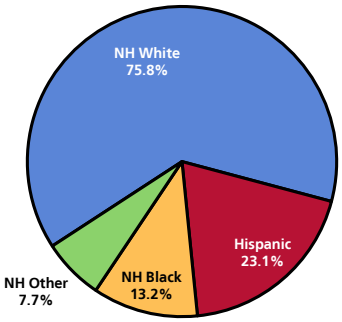
Notes:
- Rates are annual average new cases per 100,000 population.
- Total Area rates exclude counts from Alpine County (which are not available); the impact on the overall rates are negligible.

HIV/AIDS Characteristics

The following chart provides an illustration of the demographic characteristics of new HIV/AIDS cases in the Total Area. Note:

- **White** residents made up three-fourths of new HIV cases.

Characteristics of New HIV Cases by Race
(2006-2008)

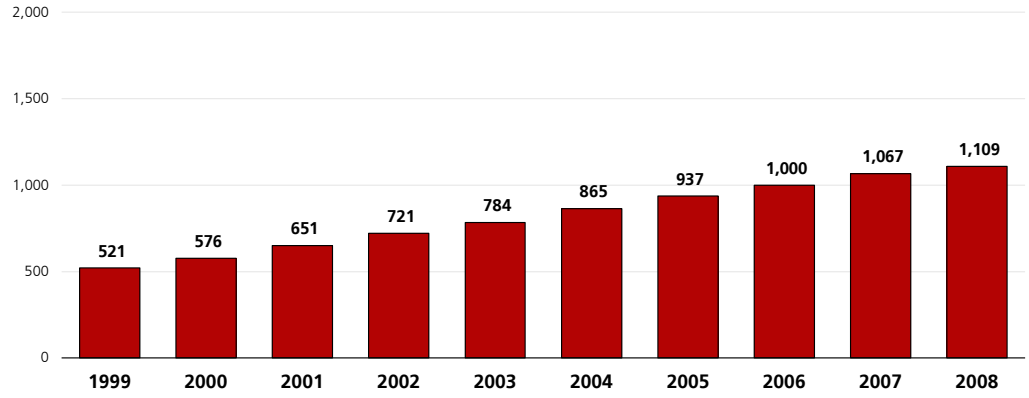


Sources: • Nevada Department of Health and Human Services. California Department of Health Services.

Persons Living With HIV/AIDS

As of the end of 2008, there were 1,109 (cumulative) Total Area residents living with HIV/AIDS.

Persons Living With HIV/AIDS
(Total Area; 1999-2008)



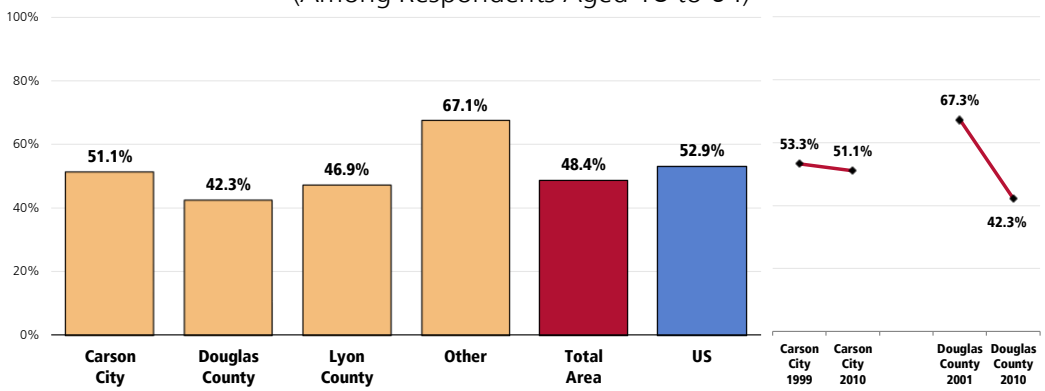
Sources: • Nevada Department of Health and Human Services. California Department of Health Services.

HIV Testing

Among Total Area adults aged 18 to 64 years, 48.4% report that they have been tested for human immunodeficiency virus (HIV).

- Statistically comparable to the proportion found nationwide (52.9%).
- Relatively low (42.3%) in Douglas County.
- Testing among adults 18-64 has remained stable in Carson City over time, but has decreased significantly in Douglas County.

Have Ever Been Tested for HIV
(Among Respondents Aged 18 to 64)

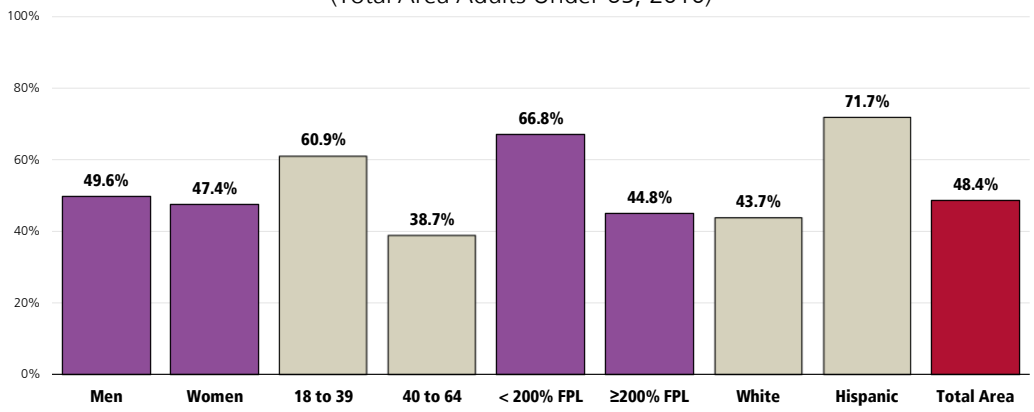


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 183]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents under the age of 65.

By demographic characteristics:

- A greater proportion of young adults (aged 18 to 39) report that they have been tested for HIV, compared with adults aged 40 to 64.
- Persons at lower income levels more often report having been tested for HIV.
- A rather high proportion of Hispanics have had HIV testing.

Have Ever Been Tested for HIV
(Total Area Adults Under 65, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 183]
Notes: Asked of all respondents under the age of 65.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) refer to the more than 25 infectious organisms transmitted primarily through sexual activity. STDs are among many related factors that affect the broad continuum of reproductive health agreed on in 1994 by 180 governments at the International Conference on Population and Development (ICPD). At ICPD, all governments were challenged to strengthen their STD programs. STD prevention as an essential primary care strategy is integral to improving reproductive health.

Despite the burdens, costs, complications, and preventable nature of STDs, they remain a significant public health problem, largely unrecognized by the public, policymakers, and public health and healthcare professionals in the United States. STDs cause many harmful, often irreversible, and costly clinical complications, such as reproductive health problems, fetal and perinatal health problems, and cancer. In addition, studies of the worldwide human immunodeficiency virus (HIV) pandemic link other STDs to a causal chain of events in the sexual transmission of HIV infection.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

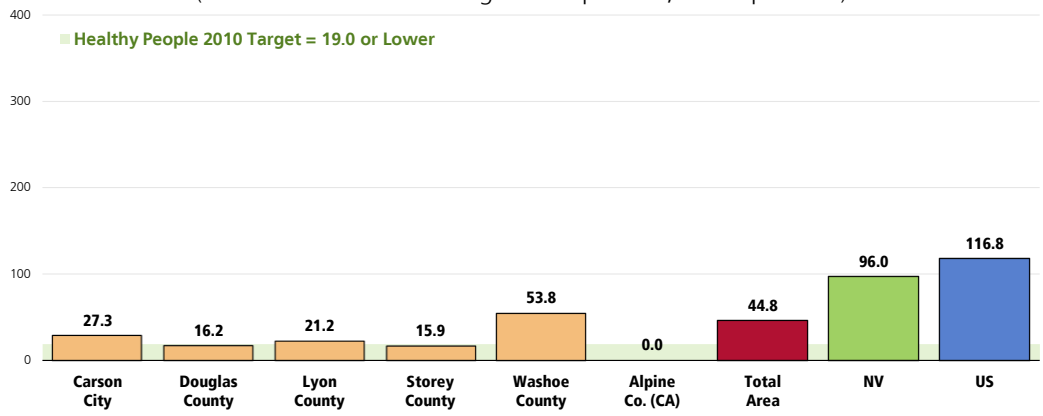
Gonorrhea

Between 2006 and 2008, the annual average gonorrhea incidence rate was 44.8 cases per 100,000 population in the Total Area.

- Notably lower than the Nevada incidence rate (96.0).
- Notably lower than the national incidence rate (116.8).
- Far from satisfying the Healthy People 2010 target.
- Highest in Carson City and Washoe County.

Gonorrhea Incidence

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



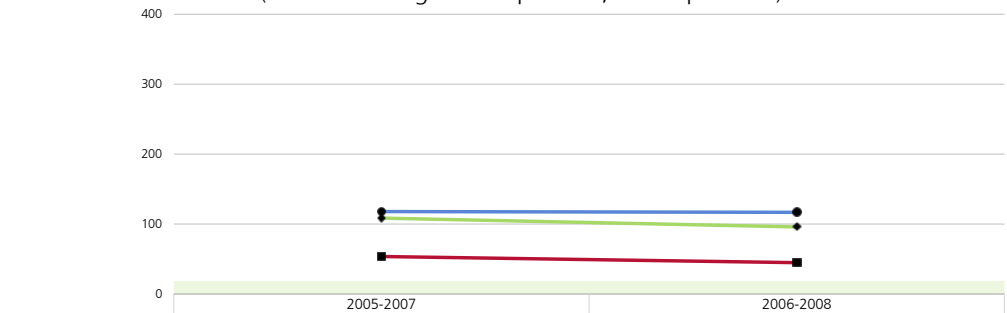
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 25-2]

Notes:
- Rates are annual average new cases per 100,000 population.

- Gonorrhea rates decreased between the 2005-2007 and 2006-2008 reporting periods in the Total Area, similar to the statewide trend.

Gonorrhea Incidence

(Annual Average Cases per 100,000 Population)



	2005-2007	2006-2008
Healthy People 2010	19.0	19.0
Total Area	53.6	44.8
Nevada	108.4	96.0
United States	118.2	116.8

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 25-2]

Notes:
- Rates are annual average new cases per 100,000 population.

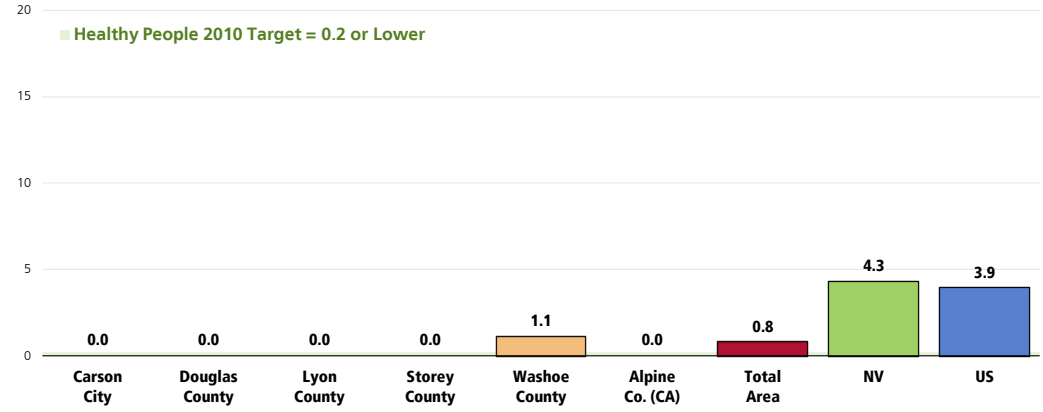
Syphilis

Between 2006 and 2008, the annual average primary/secondary syphilis incidence rate was 0.8 cases per 100,000 population in the Total Area.

- Much lower than the Nevada incidence rate (4.3).
- Much lower than the national incidence rate (3.9).
- Fails to satisfy the Healthy People 2010 target.
- The only cases reported were found in Washoe County.

Primary/Secondary Syphilis Incidence

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



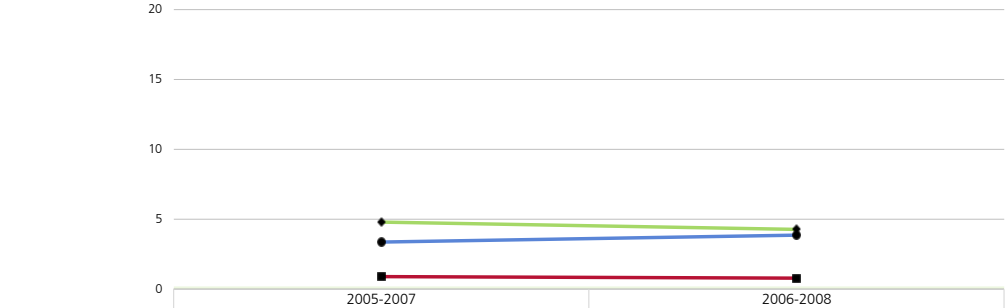
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 25-2]

Notes:
- Rates are annual average new cases per 100,000 population.

- Syphilis incidence remained fairly stable across the Total Area between the 2005-2007 and 2006-2008 reporting periods.

Primary/Secondary Syphilis Incidence

(Annual Average Cases per 100,000 Population)



	2005-2007	2006-2008
Healthy People 2010	0.2	0.2
Total Area	0.9	0.8
Nevada	4.8	4.3
United States	3.4	3.9

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 25-2]

Notes:
- Rates are annual average new cases per 100,000 population.

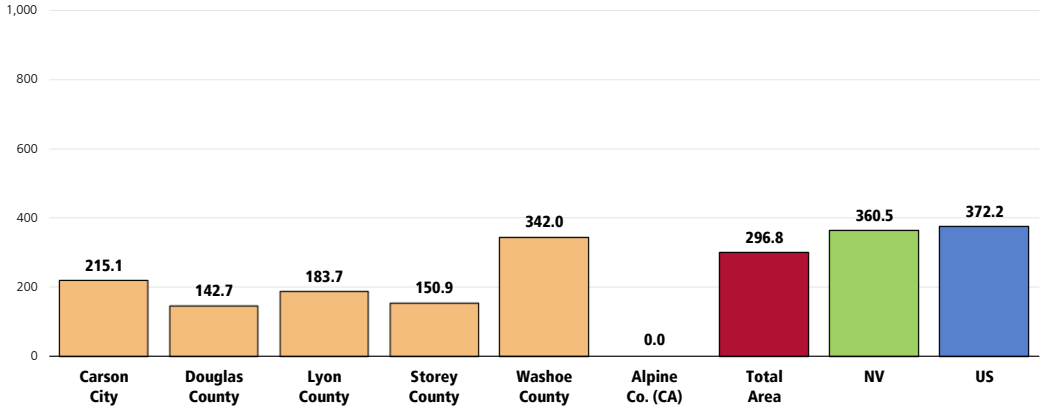
Chlamydia

Between 2006 and 2008, the annual average chlamydia incidence rate was 296.8 cases per 100,000 population in the Total Area.

- More favorable than the Nevada incidence rate (360.5).
- More favorable than the national incidence rate (372.2).
- Washoe County had the highest area rate in 2006-2008.

Chlamydia Incidence

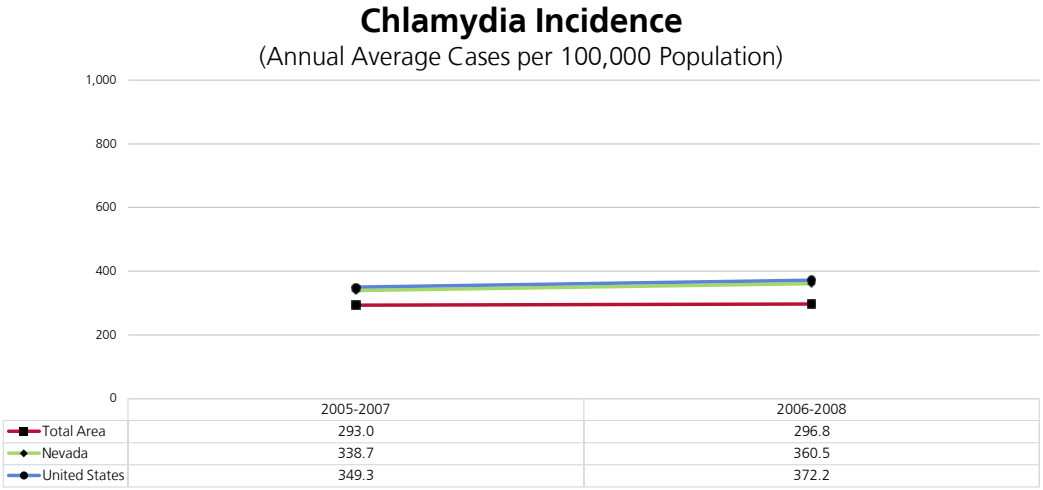
(2006-2008 Annual Average Cases per 100,000 Population)



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

Notes:
- Rates are annual average new cases per 100,000 population.

- Chlamydia incidence increased remained fairly stable between 2005 and 2008 in the Total Area; the increasing trends across Nevada and the US overall were more pronounced during this time.



	2005-2007	2006-2008
Total Area	293.0	296.8
Nevada	338.7	360.5
United States	349.3	372.2

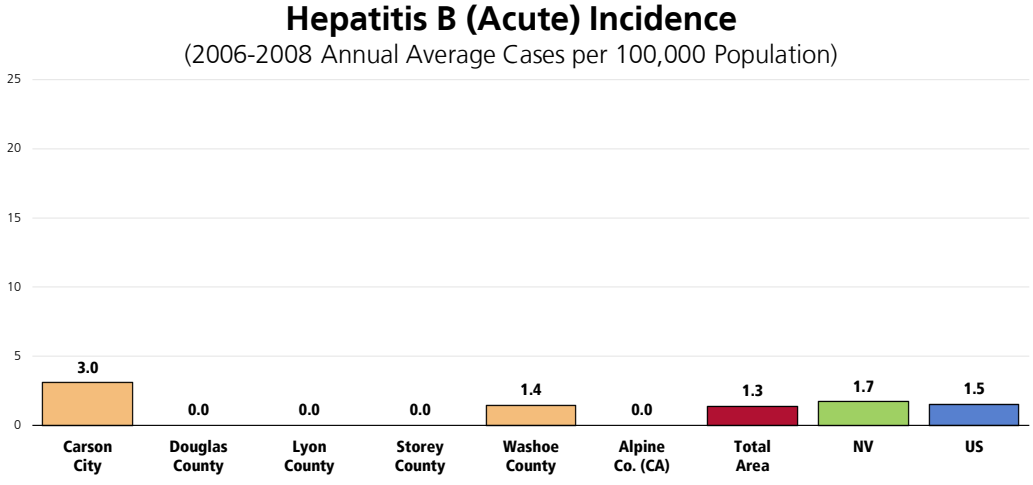
Sources: • Nevada Department of Health and Human Services. California Department of Health Services.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Acute Hepatitis B

Hepatitis B Incidence

Between 2006 and 2008, the annual average hepatitis B incidence rate was 1.3 case per 100,000 population in the Total Area.

- Just below the Nevada incidence rate (1.7).
- Just below the national incidence rate (1.5).
- Hepatitis B cases were found in Carson City and Washoe County.

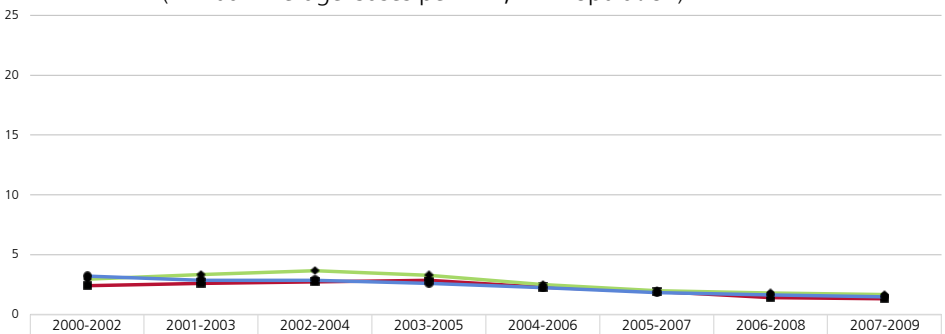


Sources: • Nevada Department of Health and Human Services. California Department of Health Services.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Hepatitis B incidence has decreased in the Total Area; the same decreasing trend is found for Nevada and the US overall.

Hepatitis B (Acute) Incidence

(Annual Average Cases per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Total Area	2.4	2.6	2.7	2.8	2.3	1.9	1.4	1.3
Nevada	2.9	3.3	3.6	3.3	2.5	2.0	1.8	1.7
United States	3.2	2.9	2.9	2.6	2.2	1.8	1.6	1.5

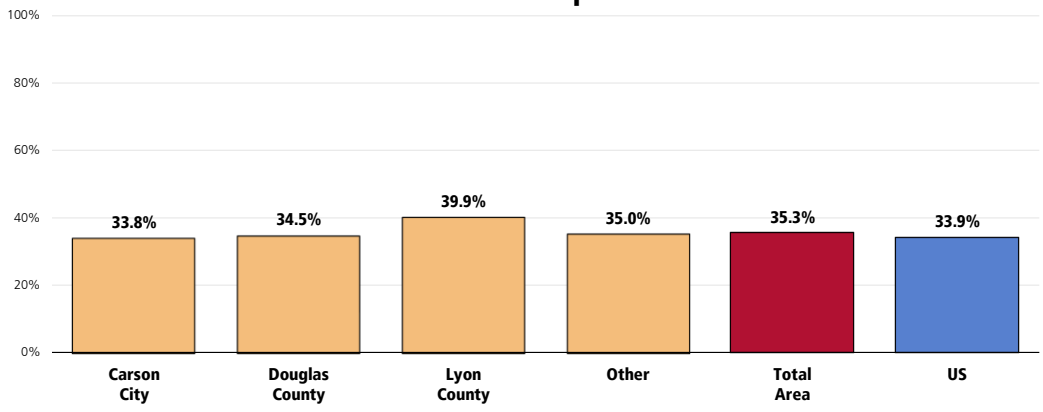
Sources: • Nevada Department of Health and Human Services. California Department of Health Services.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Hepatitis B Vaccination

Based on survey data, just over one-third (35.3%) of Total Area residents report having received the hepatitis B vaccine.

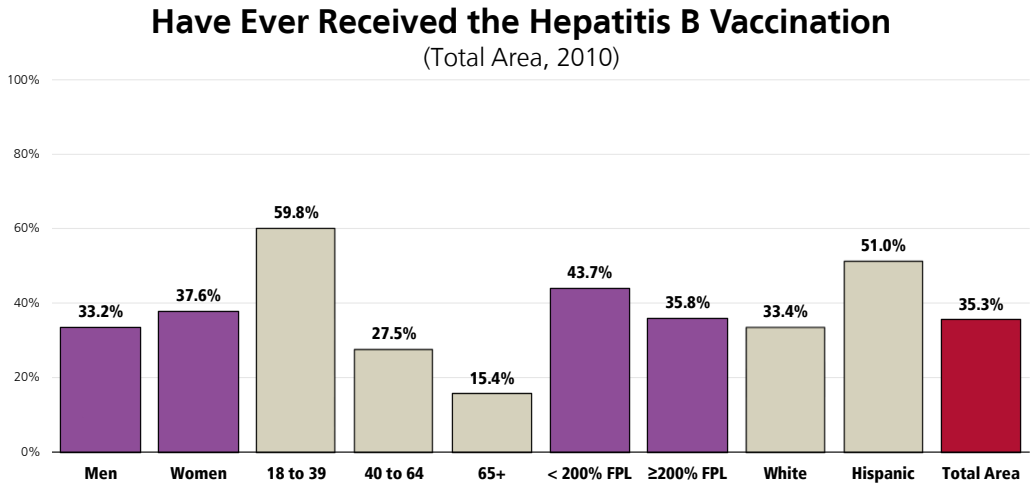
- Similar to the 33.9% reported across the nation.
- Statistically similar among county areas.

Have Ever Received the Hepatitis B Vaccination



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]
PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

- Note the negative correlation between age and hepatitis B vaccination.
- In addition, Hispanics are much more likely than Non-Hispanic Whites to have received the hepatitis B vaccine.

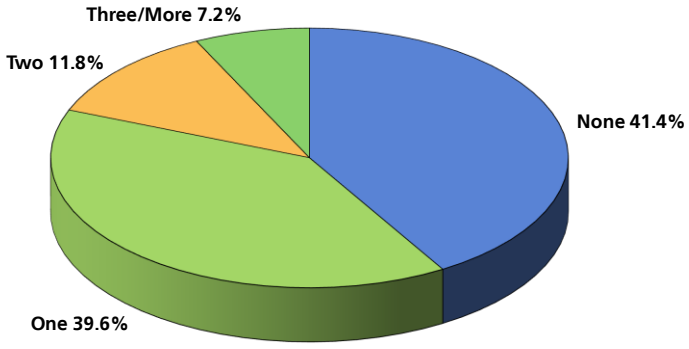


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Safe Sexual Practices

Sexual Partners

Among unmarried Total Area adults under 65, the vast majority cite having one (39.6%) or no (41.4%) sexual partners in the past 12 months.



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]

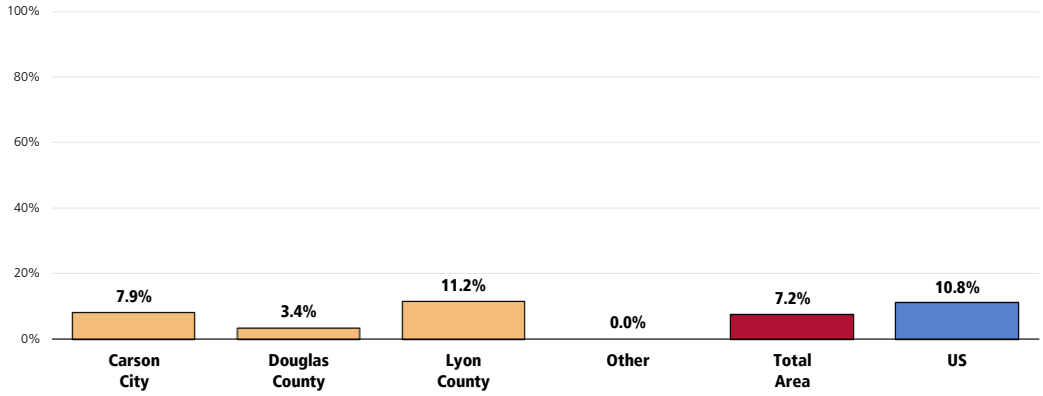
Notes:
- Asked of all unmarried respondents under the age of 65.

However, 7.2% report three or more sexual partners in the past year.

- Comparable to the 10.8% reported nationally among unmarried adults under age 65.
- Ranging from 0.0% in the "Other" counties to 11.2% in Lyon County.

Had 3+ Sexual Partners in the Past Year

(Among Unmarried Respondents Aged 18 to 64)



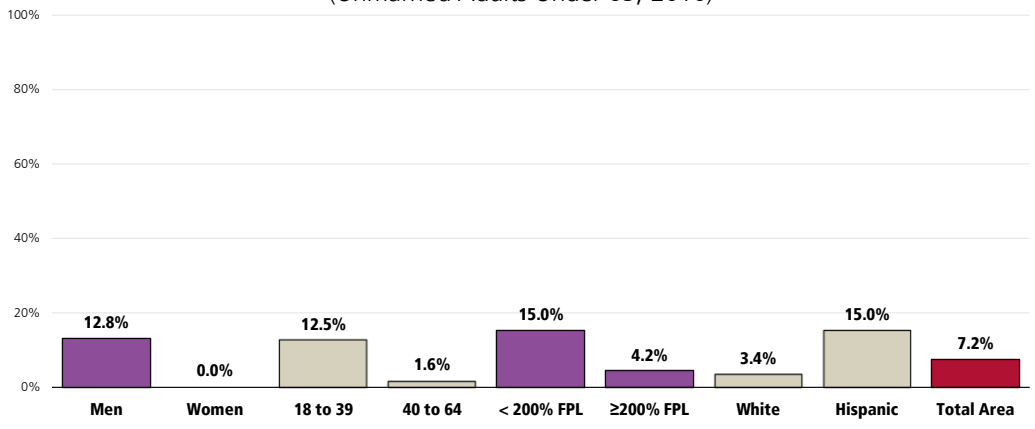
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all unmarried respondents under the age of 65.

Unmarried respondents (aged 18 to 64) less likely to report three or more sexual partners in the past year include:

- Women.
- Residents aged 40 through 64.
- Those with lower incomes.
- Non-Hispanic Whites.

Had 3+ Partners in the Past Year

(Unmarried Adults Under 65, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
Notes: Asked of all unmarried respondents under the age of 65.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

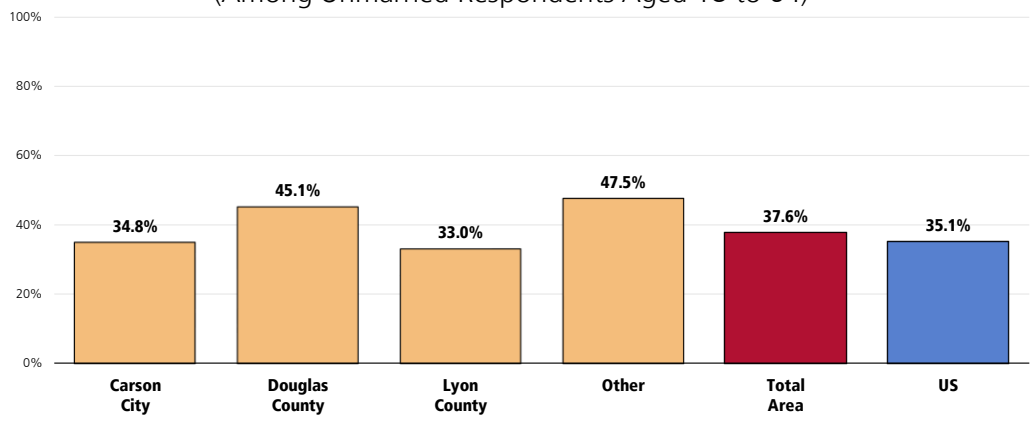
Condom Use

Among Total Area adults who are under age 65 and unmarried, 37.6% report using a condom during their last sexual intercourse.

- Statistically similar to the 35.1% reported nationally.
- Ranging from 33.0% in Lyon County to 47.5% in the "Other" counties.

Used Condom During Last Sexual Intercourse

(Among Unmarried Respondents Aged 18 to 64)



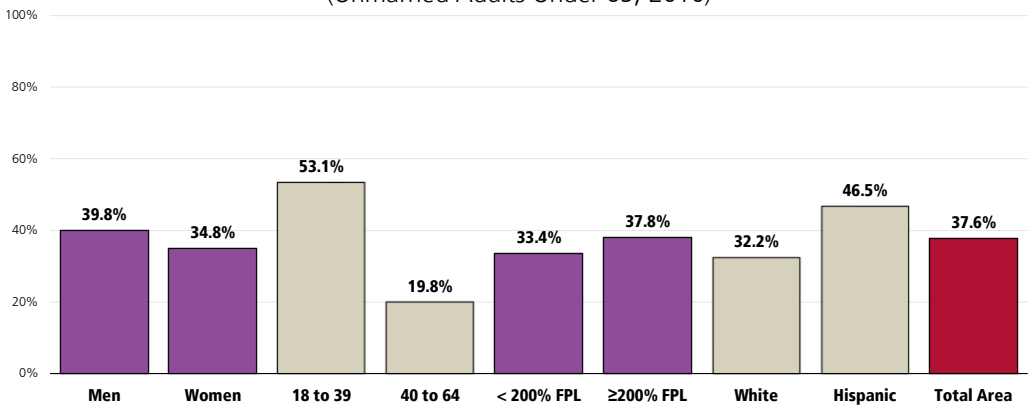
Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all unmarried respondents under the age of 65.

Those <u>less</u> likely to have used a condom during their last sexual intercourse include:

- Residents aged 40 through 64.
- Non-Hispanic Whites.

Used Condom During Last Sexual Intercourse

(Unmarried Adults Under 65, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
Notes: Asked of all unmarried respondents under the age of 65.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

BIRTHS

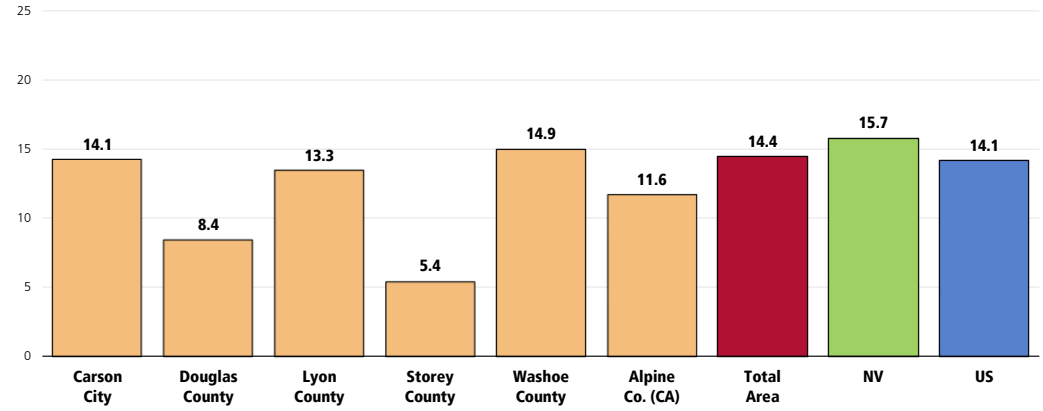
Birth Rates

Between 2006 and 2008, the Total Area experienced a 14.4 birth rate per 1,000 population.

- Lower than the 15.7 reported statewide.
- Similar to the national birth rate (14.1).
- Ranging from 14.9 in Washoe County to 5.4 in Storey County.

Birth Rate

(2006-2008 Annual Average Births per 1,000 Population)

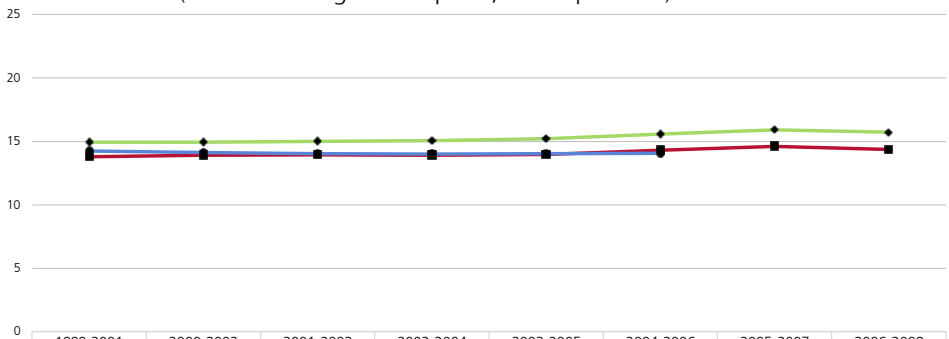


Sources: Nevada Department of Health and Human Services. California Department of Health Services. Centers for Disease Control and Prevention, National Vital Statistics System..
Notes: Rates are births per 1,000 population.
2008 Nevada data are preliminary data.
US data are 2004-2006 data.

The Total Area birth rate increased slightly between the 1999-2001 and 2006-2008 reporting periods. The statewide rate increased as well, while the US birth rate remained relatively constant.

Birth Rate

(Annual Average Births per 1,000 Population)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Total Area	13.8	13.9	13.9	13.9	14.0	14.3	14.6	14.4
Nevada	14.9	15.0	15.0	15.0	15.2	15.6	15.9	15.7
United States	14.2	14.1	14.0	14.0	14.0	14.1		

Sources: Nevada Department of Health and Human Services. California Department of Health Services. Centers for Disease Control and Prevention, National Vital Statistics System..
Notes: Rates are births per 1,000 population.
2008 Nevada data are preliminary data.

Timely Prenatal Care

Many risk factors can be mitigated or prevented with good pre-conception and prenatal care. Prenatal visits offer an opportunity to provide information about the adverse effects of substance use, including alcohol and tobacco during pregnancy, and serve as a vehicle for referrals to treatment services. The use of timely, high-quality prenatal care can help to prevent poor birth outcomes and improve maternal health by identifying women who are at particularly high risk and taking steps to mitigate risks, such as the risk of high blood pressure or other maternal complications.

African American and Hispanic women also are less likely than Whites to enter prenatal care early. For both African American and White women, the proportion entering prenatal care in the first trimester rises with maternal age until the late thirties, then begins to decline … Women in certain racial and ethnic groups also are less likely than White women to breastfeed their infants..

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

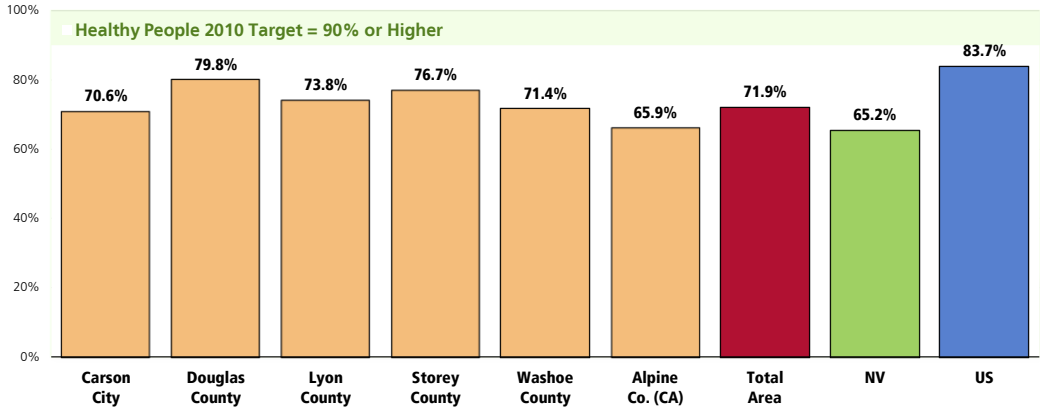
Early and continuous prenatal care is the best assurance of infant health.

Between 2006 and 2008, 71.9% of all Total Area births received prenatal care in the first trimester of pregnancy.

- More favorable than the Nevada proportion (65.2%).
- Less favorable than the 83.7% reported nationally.
- Fails to satisfy the Healthy People 2010 target (90% or higher).
- Timely prenatal care is notably higher (better) in Douglas County.

Mothers Receiving Prenatal Care in the First Trimester

(Percentage of Live Births, 2006-2008)



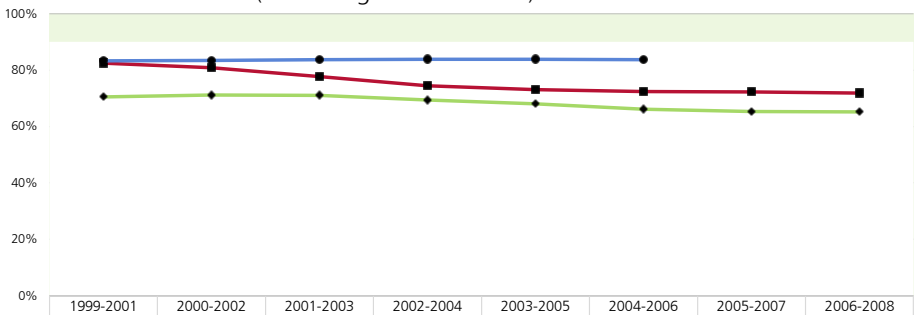
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-6].

Note:
- Numbers are a percentage of all live births within each population.
  2008 Nevada data are preliminary data.
  US data are 2004-2006 data.
- Alpine County data are 2005-2007 data.

- Receipt of prenatal care has decreased significantly over time in the Total Area, echoing the decreasing trend reported across Nevada. Nationally, the prevalence of prenatal care has remained relatively stable.

Mothers Receiving Prenatal Care in the First Trimester

(Percentage of Live Births)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2010	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Total Area	82.5%	80.9%	77.7%	74.5%	73.1%	72.4%	72.2%	71.9%
Nevada	70.6%	71.2%	71.1%	69.4%	68.1%	66.2%	65.3%	65.2%
United States	83.3%	83.4%	83.7%	83.8%	83.9%	83.7%		

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-6].

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

Birth Outcomes & Risks

The health of mothers, infants, and children is of critical importance, both as a reflection of the current health status of a large segment of the US population and as a predictor of the health of the next generation … Infant mortality is an important measure of a nation's health and a worldwide indicator of health status and social well-being. As of 1995, the US infant mortality rates ranked 25th among industrialized nations. In the past decade, critical measures of increased risk of infant death, such as new cases of low birth weight (LBW) and very low birth weight (VLBW), actually have increased in the United States. In addition, the disparity in infant mortality rates between Whites and specific racial and ethnic groups (especially African Americans, American Indians or Alaska Natives, Native Hawaiians, and Puerto Ricans) persists. Although the overall infant mortality rate has reached record low levels, the rate for African Americans remains twice that of Whites.

LBW is associated with long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disabilities … The general category of LBW infants includes both those born too early (preterm infants) and those who are born at full term but who are too small, a condition known as intrauterine growth retardation (IUGR). Maternal characteristics that are risk factors associated with IUGR include maternal LBW, prior LBW birth history, low prepregnancy weight, cigarette smoking, multiple births, and low pregnancy weight gain. Cigarette smoking is the greatest known risk factor.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

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.

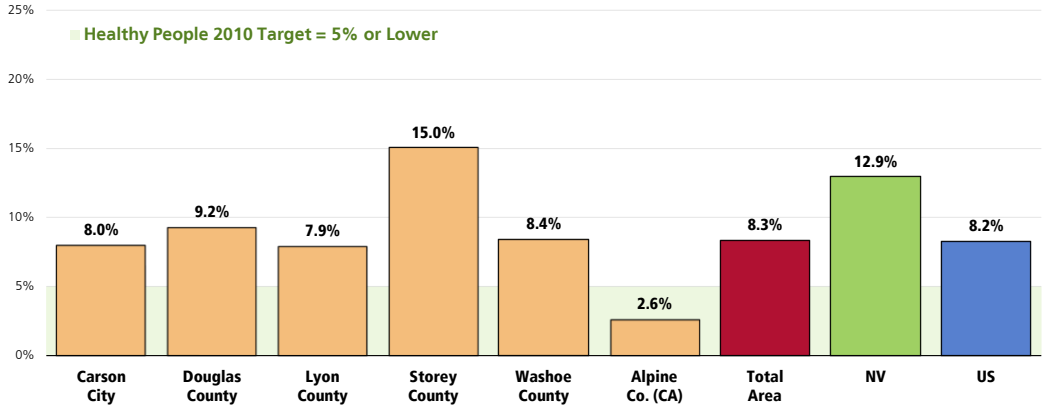
Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 8.3% of 2006-2008 Total Area births were low-weight.

- Better than the Nevada proportion (12.9%).
- Nearly identical to the national proportion (8.2%).
- Fails to satisfy the Healthy People 2010 target (5% or lower).
- Low-weight births were notably more prevalent in Storey County between 2006 and 2008.

Low-Weight Births

(Percentage of Live Births, 2006-2008)



Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-10].

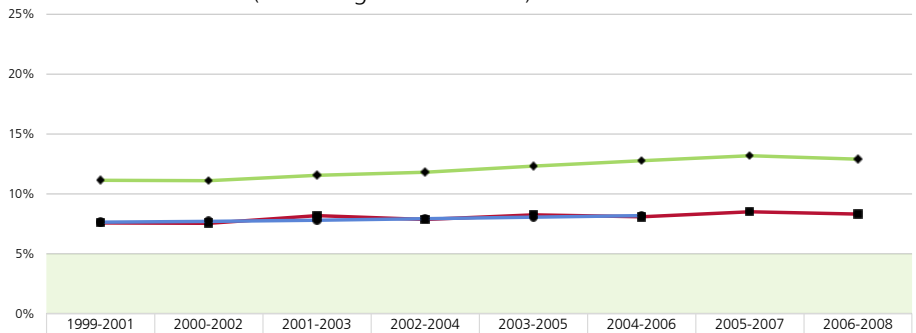
Note:
- Numbers are a percentage of all live births within each population.

2008 Nevada data are preliminary data.
US data are 2004-2006 data.

The proportion of low-weight births has trended upward slightly in the Total Area in recent years; the same can be said for both Nevada and the US.

Low-Weight Births

(Percentage of Live Births)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2010	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Total Area	7.6%	7.6%	8.2%	7.9%	8.2%	8.1%	8.5%	8.3%
Nevada	11.1%	11.1%	11.6%	11.8%	12.3%	12.8%	13.2%	12.9%
United States	7.6%	7.7%	7.8%	7.9%	8.1%	8.2%		

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-10].

Note:
- Numbers are a percentage of all live births within each population.
  2008 Nevada data are preliminary data.

Infant Mortality

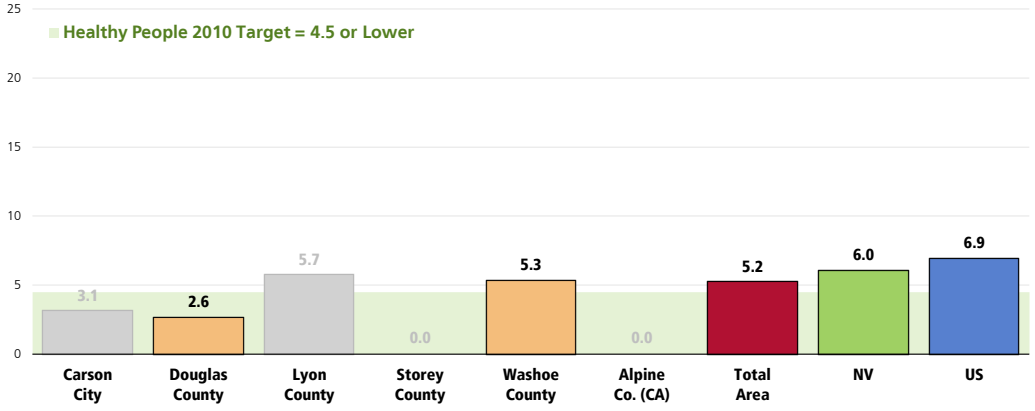
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2004 and 2006, there was an annual average of 5.2 infant deaths per 1,000 live births.

- More favorable than the Nevada rate (6.0).
- More favorable than the national rate (6.9).
- Fails to satisfy the Healthy People 2010 goal of 4.5 per 1,000 live births.
- *Note that many of the individual county rates were unreliable due to the low number of infant deaths.*

Infant Mortality Rate

(2004-2006 Annual Average Infant Deaths per 1,000 Live Births)



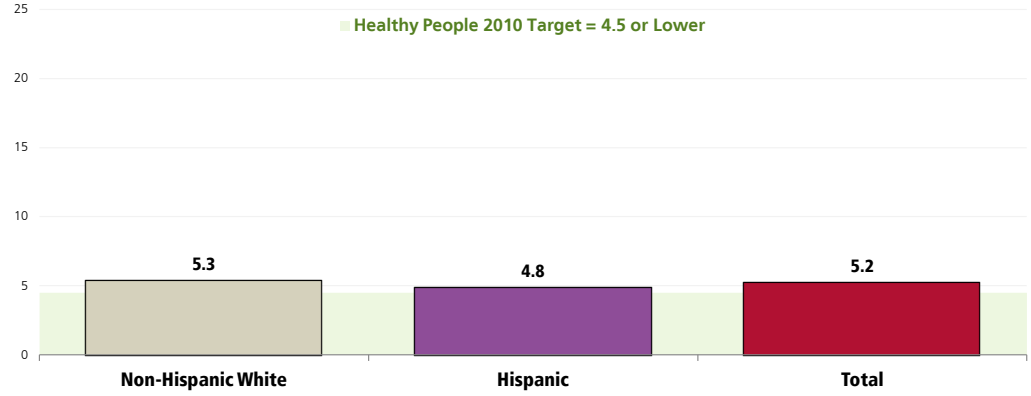
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-1].

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.
  Note that rates for Carson City, Lyon County, Storey County, and Alpine County are unreliable due to low number of deaths.

Infant mortality rates are slightly higher among births to Non-Hispanic White mothers.

Infant Mortality Rate

(Total Area; 2004-2006 Annual Average Infant Deaths per 1,000 Live Births)

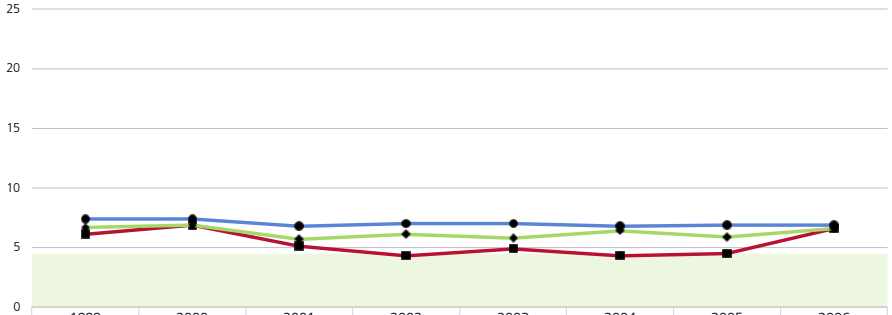


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 16-1]
Notes: Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Infant mortality rates have trended downward slightly in recent years, both regionally and nationally. The statewide trend is less apparent.

Infant Mortality Rate

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



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5
Total Area	6.1	6.9	5.1	4.3	4.9	4.3	4.5	6.6
Nevada	6.7	6.9	5.7	6.1	5.8	6.4	5.9	6.6
United States	7.4	7.4	6.8	7.0	7.0	6.8	6.9	6.9

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-1].

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

Risk Factors

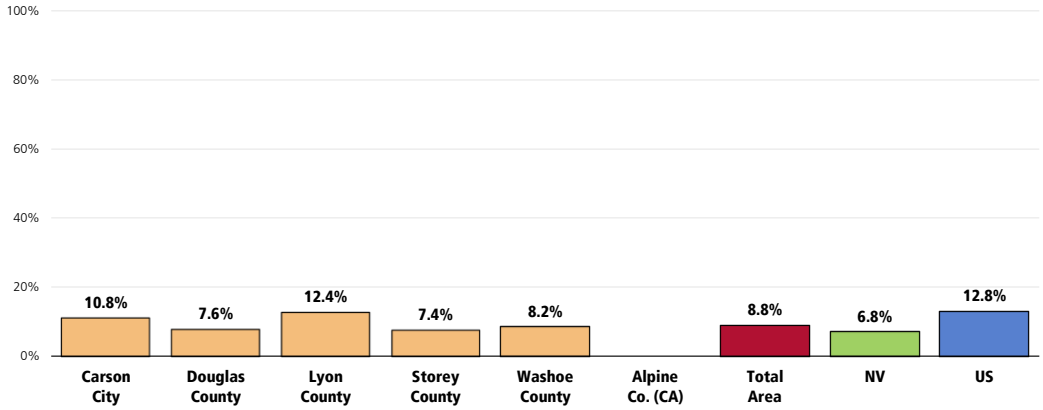
Tobacco Use During Pregnancy

Between 2005 and 2008, a total of 8.8% of births in the Total Area were to mothers who smoked tobacco while pregnant.

- Higher than the 6.8% reported across Nevada.
- Lower than the national percentage (12.8%).
- Ranges from 7.4% in Storey County to 12.4% in Lyon County.

Births to Mothers Who Smoked During Pregnancy

(Percentage of Live Births, 2005-2008)



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

Note:
- Numbers are a percentage of all live births within each population. 2008 Nevada data are preliminary data.
- Total Area proportion excludes counts from Alpine County (which are not available); the impact on the overall proportion is negligible.

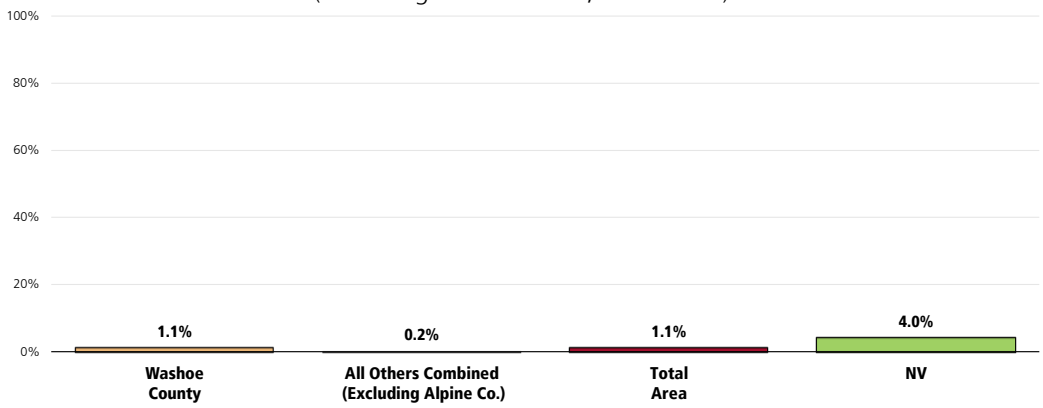
Alcohol Use During Pregnancy

Just 1.1% of mothers who gave birth between 2005 and 2008 drank alcohol during pregnancy.

- Well below the 4.0% reported across Nevada.
- Note the 1.1% prevalence among mothers in Washoe County, compared with a very low prevalence in the combined remaining areas (*which in this case excludes Alpine County, for which data were unavailable*).

Births to Mothers Who Drank During Pregnancy

(Percentage of Live Births, 2005-2008)



Sources: • Nevada Department of Health and Human Services. California Department of Health Services.
Note: • Numbers are a percentage of all live births within each population.
2008 Nevada data are preliminary data.
• Alpine County data not available; the impact of the missing counts on the Total Area proportion is negligible.

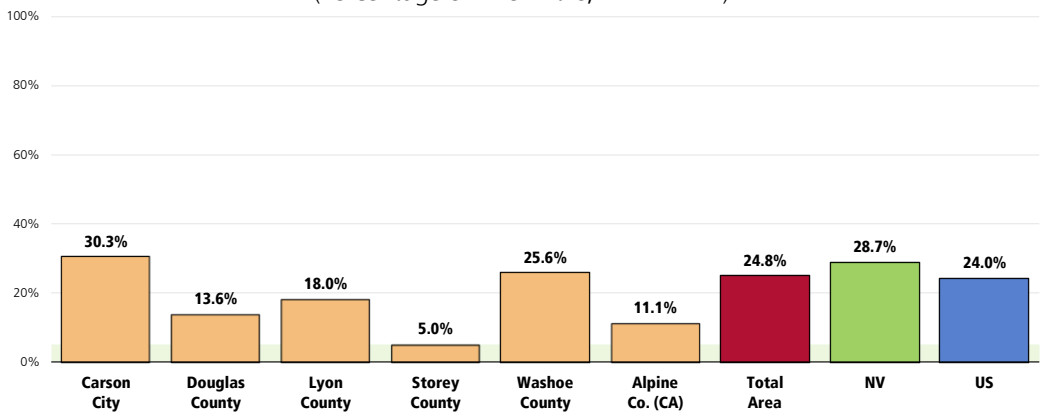
Mothers With Low Educational Attainment

Between 2006 and 2008, one-fourth (24.8%) of births in the Total Area were to mothers without a high school diploma.

- Below the 28.7% reported across the state.
- Nearly identical to the 24.0% reported nationally.
- Notably higher in Carson City and Washoe County.

Births to Mothers Without a High School Diplomas

(Percentage of Live Births, 2006-2008)

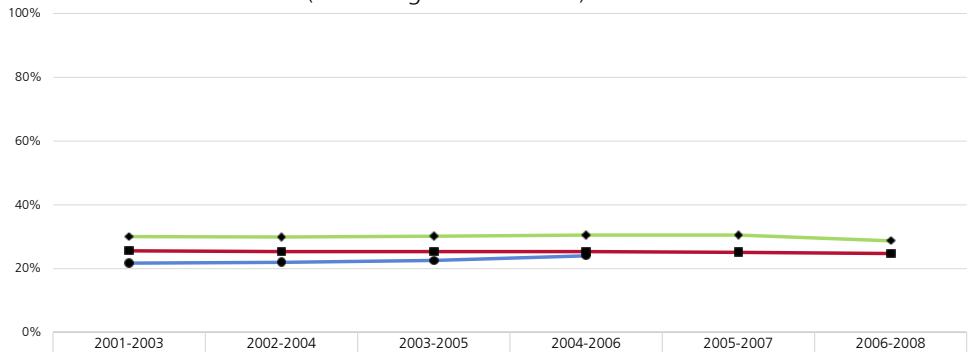


Sources: • Nevada Department of Health and Human Services. California Department of Health Services.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.
2008 Nevada data are preliminary data.
Alpine County data and US data are 2004-2006 data.

Despite a national increasing trend, the prevalence of births to mothers with low educational attainment decreased slightly in the Total Area as well as across Nevada between the 2001-2003 and 2006-2008 reporting periods.

Births to Mothers Without a High School Diplomas

(Percentage of Live Births)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Total Area	25.6%	25.4%	25.4%	25.3%	25.1%	24.8%
Nevada	30.1%	29.9%	30.2%	30.6%	30.5%	28.7%
United States	21.8%	21.9%	22.6%	24.0%		

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.

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

2008 Nevada data are preliminary data.

Family Planning

In an era when technology should enable couples to have considerable control over their fertility, half of all pregnancies in the United States are unintended. Although between 1987 and 1994 the proportion of pregnancies that were unintended declined in the United States from 57 to 49 percent, other industrialized nations report fewer unintended pregnancies, suggesting that the number of unintended pregnancies can be reduced further. Family planning remains a keystone in attaining a national goal aimed at achieving planned, wanted pregnancies and preventing unintended pregnancies.

Socially, the costs can be measured in unintended births, reduced educational attainment and employment opportunity, greater welfare dependency, and increased potential for child abuse and neglect. Economically, healthcare costs are increased … The consequences of unintended pregnancy are not confined to those occurring in teenagers or unmarried couples. In fact, unintended pregnancy can carry serious consequences at all ages and life stages.

With an unintended pregnancy, the mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all. She is less likely to breastfeed and more likely to expose the fetus to harmful substances, such as tobacco or alcohol. The child of such a pregnancy is at greater risk of low birth weight, dying in its first year, being abused, and not receiving sufficient resources for healthy development. A disproportionate share of the women bearing children whose conception was unintended are unmarried or at either end of the reproductive age span—factors that, in themselves, carry increased medical and social burdens for children and their parents. Pregnancy begun without some degree of planning often prevents individual women and men from participating in preconception risk identification and management.

Unintended pregnancies occur among females of all socioeconomic levels and all marital status and age groups, but females under age 20 years and poor and African American women are especially likely to become pregnant unintentionally. More than 4 in 10 pregnancies to White and Hispanic females [nationwide] are unintended; 7 in 10 pregnancies to African American females [nationwide] are unintended. Poverty is strongly related to greater difficulty in using reversible contraceptive methods successfully, with these females also the least likely to have the resources necessary to access family planning services and the most likely to be affected negatively by an unintended pregnancy.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Births to Teenage Mothers

For teenagers, the problems associated with unintended pregnancy are compounded, and the consequences are well documented. Teenage mothers are less likely to get or stay married, less likely to complete high school or college, and more likely to require public assistance and to live in poverty than their peers who are not mothers. Infants born to teenage mothers, especially mothers under age 15 years, are more likely to suffer from low birth weight, neonatal death, and sudden infant death syndrome. The infants may be at greater risk of child abuse, neglect, and behavioral and educational problems at later stages. Nearly 1 million teenage pregnancies occur each year in the United States.

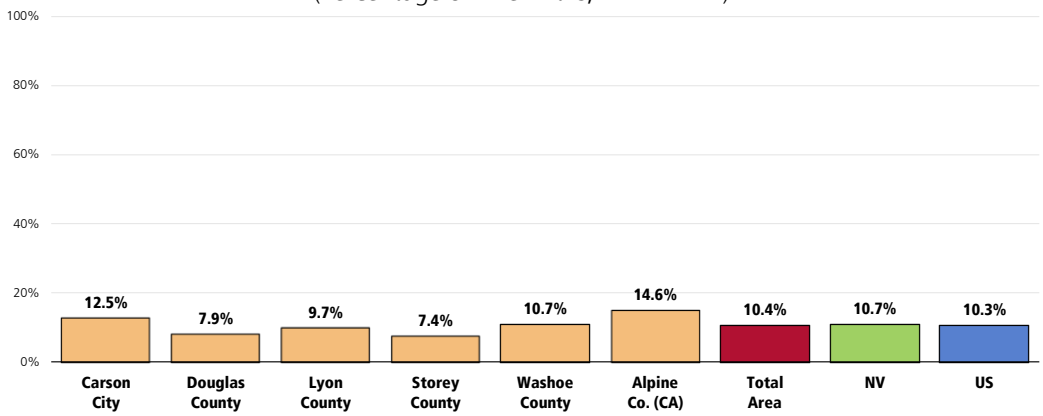
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

A total of 10.4% of 2005-2008 births were to females aged 15 to 19.

- Similar to the 10.7% reported across Nevada.
- Similar to the 10.3% found nationally.
- Highest in Carson City and Alpine County; more favorable in Douglas, Lyon, and Storey counties.

Births to Mothers Aged 15 to 19

(Percentage of Live Births, 2005-2008)



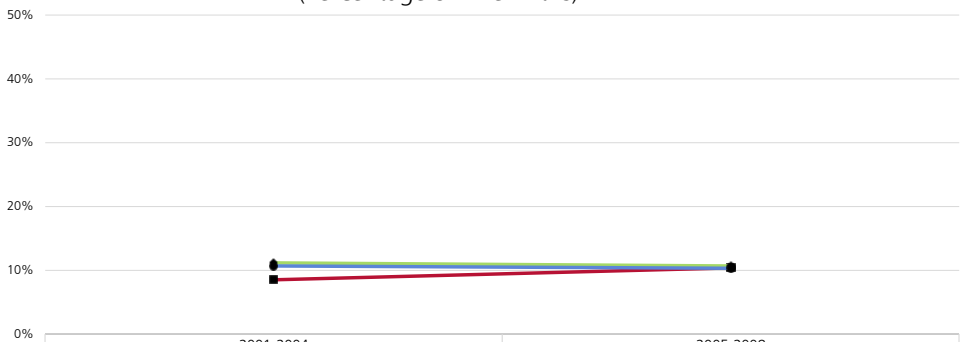
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System.

Note:
- Numbers are a percentage of all live births within each population. 2008 Nevada data are preliminary data.
- Alpine County data are 2005-2007 data.

The percentage of births to teens in the Total Area increased between the 2001-2004 and 2005-2008 reporting periods; in contrast, the percentages decreased slightly both statewide and nationwide.

Births to Mothers Aged 15 to 19

(Percentage of Live Births)



	2001-2004	2005-2008
Total Area	8.5%	10.4%
Nevada	11.2%	10.7%
United States	10.7%	10.3%

Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.

Note:
- Numbers are a percentage of all live births within each population. 2008 Nevada data are preliminary data.

Births to Unwed Mothers

According to the CDC, an unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. It is a core concept in understanding the fertility of populations and the unmet need for contraception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviors during pregnancy that are associated with adverse effects. For example, women with an unintended pregnancy may delay prenatal care, which may affect the health of the infant. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk.

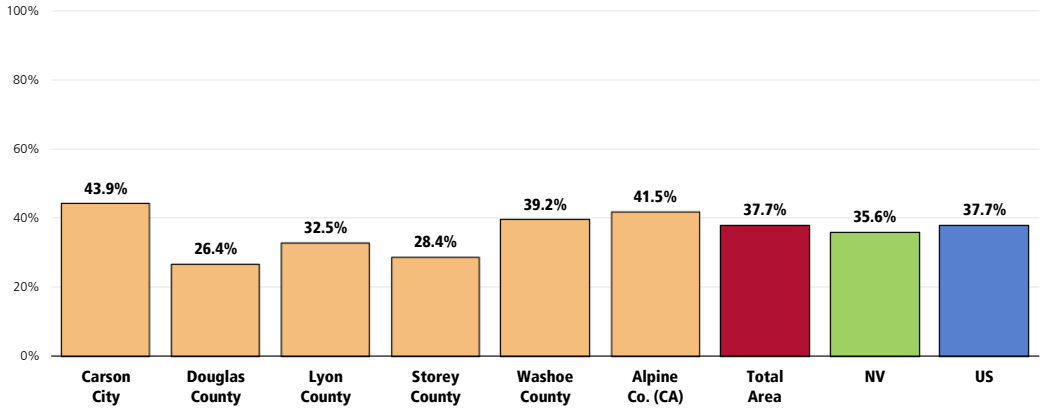
Because it is impossible to measure the true incidence of unintended pregnancy in the US, the following indicator looks at births occurring among unmarried mothers as a proxy measure for pregnancies that are not intended (knowing that this is not always the case).

A total of 37.7% of 2005-2008 Total Area births were to unmarried mothers.

- Slightly higher than the Nevada proportion of unwed mothers (35.6%).
- Identical to the 37.7% reported nationally.
- Notably higher in Carson City.

Births to Unwed Mothers

(Percentage of Live Births, 2005-2008)



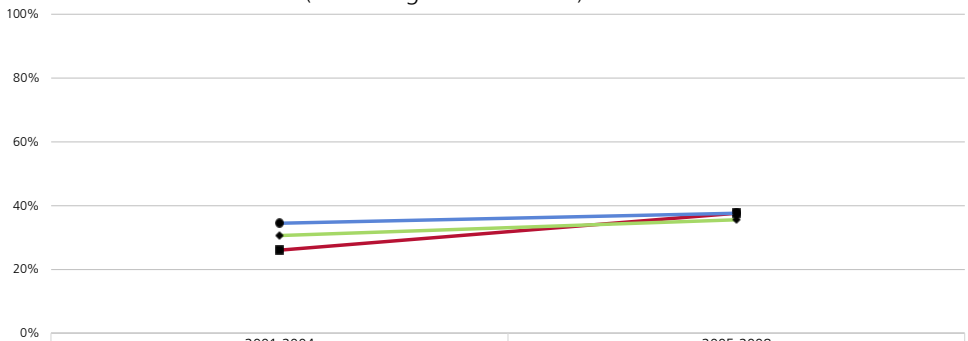
Sources:
- Nevada Department of Health and Human Services. California Department of Health Services.
- Centers for Disease Control and Prevention, National Vital Statistics System.

Note:
- Numbers are a percentage of all live births within each population.
- 2008 Nevada data are preliminary data.
- Alpine County data are 2005-2007 data.

- This percentage increased in the Total Area between the 2001-2004 and 2005-2008 reporting periods; the same can be said for both the state and the nation.

Births to Unwed Mothers

(Percentage of Live Births)



	2001-2004	2005-2008
Total Area	26.1	37.7
Nevada	30.7	35.6
United States	34.5	37.7

Sources: • Nevada Department of Health and Human Services. California Department of Health Services.
• Centers for Disease Control and Prevention, National Vital Statistics System. Births: Final Data for 2002.
Note: • Numbers are a percentage of all live births within each population.
2008 Nevada data are preliminary data.

MODIFIABLE HEALTH RISK BEHAVIORS

It is estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors, such as 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. Behavior patterns represent the single-most prominent domain of influence over health prospects in the US.

– 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.

Actual Causes Of Death

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

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

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

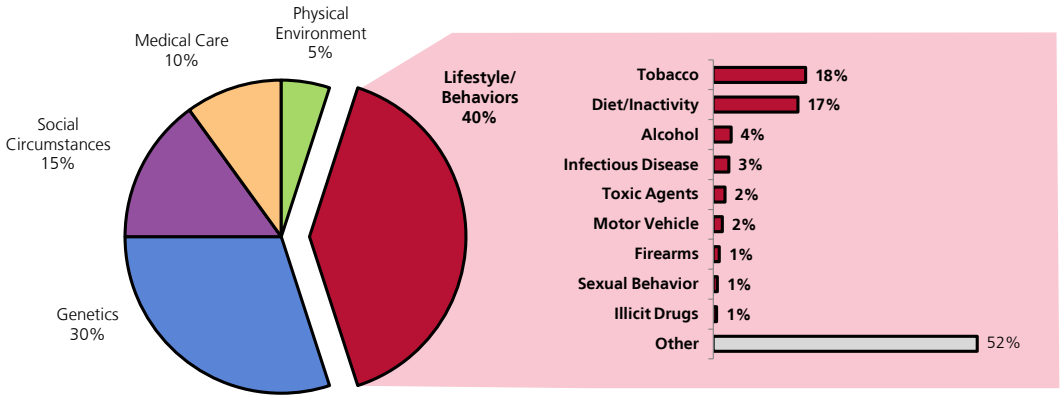
– Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

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

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

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

Factors Contributing to Premature Deaths in the United States



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

Nutrition

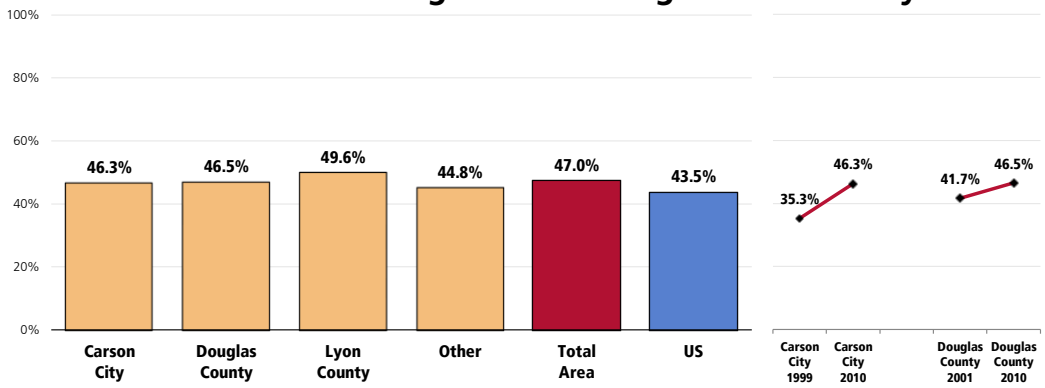
Daily Recommendation of Fruits/Vegetables

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

A total of 47.0% of area adults report eating five or more servings of fruits and/or vegetables per day.

- Similar to national findings (43.5%).
- Similar by county.
- The prevalence of fruit/vegetable consumption has increased significantly in Carson City (the change noted for Douglas County is not statistically significant).

Consume 5+ Servings of Fruits/Vegetables Per Day

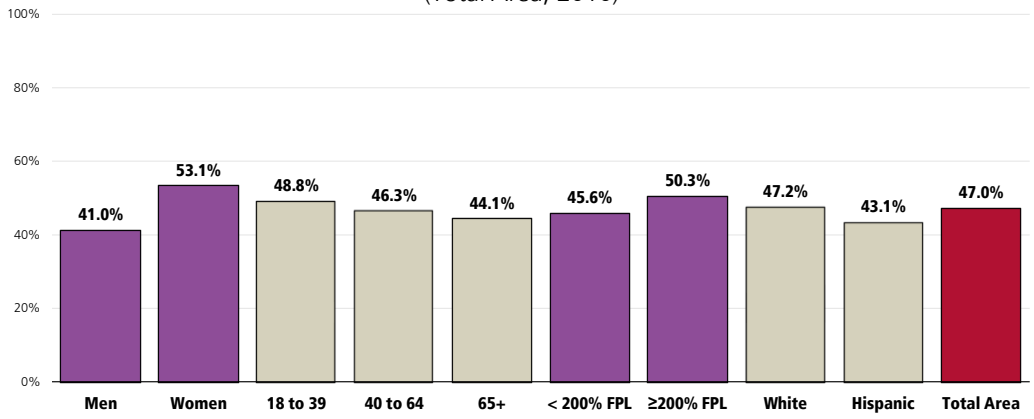


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 159]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.
For this issue, respondents were asked to recall their food intake on the previous day.

- Total Area men are less likely to get the recommended servings of fruits/vegetables per day.

Consume 5+ Servings of Fruits/Vegetables Per Day

(Total Area, 2010)



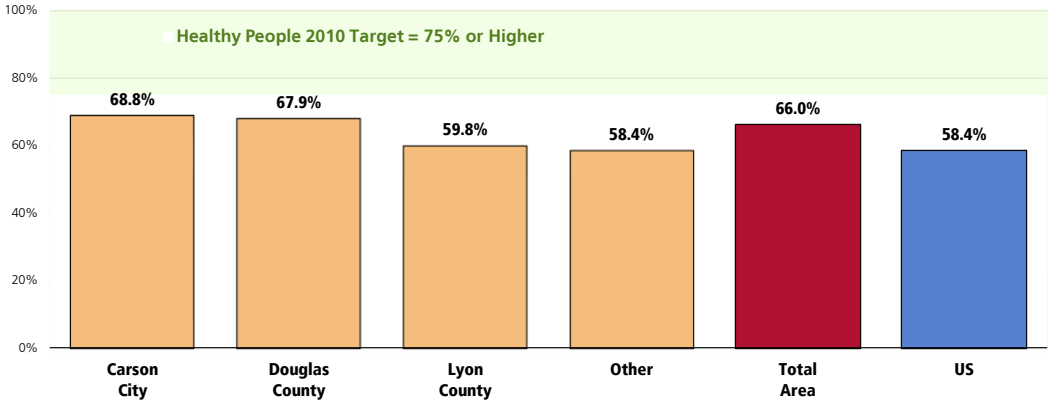
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 159]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.
For this issue, respondents were asked to recall their food intake on the previous day.

Fruits

Two-thirds (66.0%) of Total Area adults report eating at least two servings of fruit per day.

- More favorable than national findings (58.4%).
- Fails to satisfy the Healthy People 2010 target (75% or higher).
- No significant difference by county.

Consume 2+ Servings of Fruits/Fruit Juices Per Day



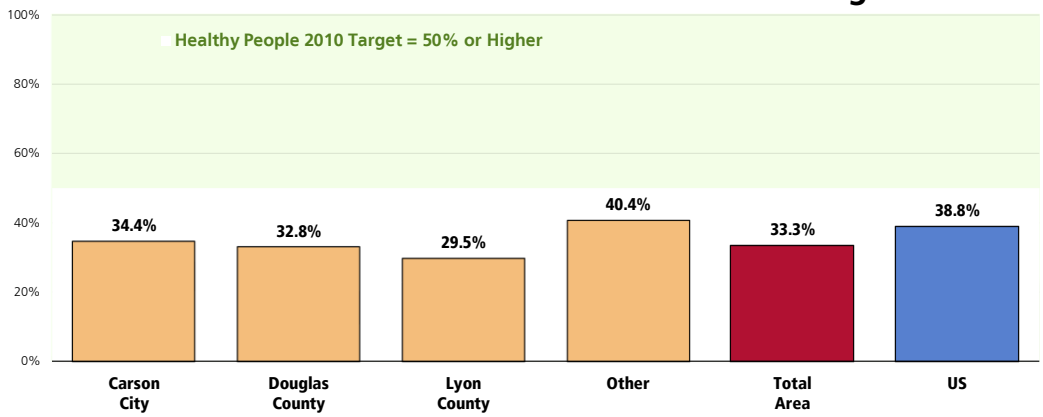
Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-5]
Notes: Asked of all respondents.

Vegetables

One-third (33.3%) of survey respondents reports eating three or more servings of vegetables per day, at least one-third of which are dark green or orange vegetables.

- Less favorable than national findings (38.8%).
- Fails to satisfy the Healthy People 2010 target (50% or higher).
- Similar by county.

Consume 3+ Servings of Vegetables Per Day, One-Third of Which Are Dark Green or Orange



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-6]
Notes: Asked of all respondents.

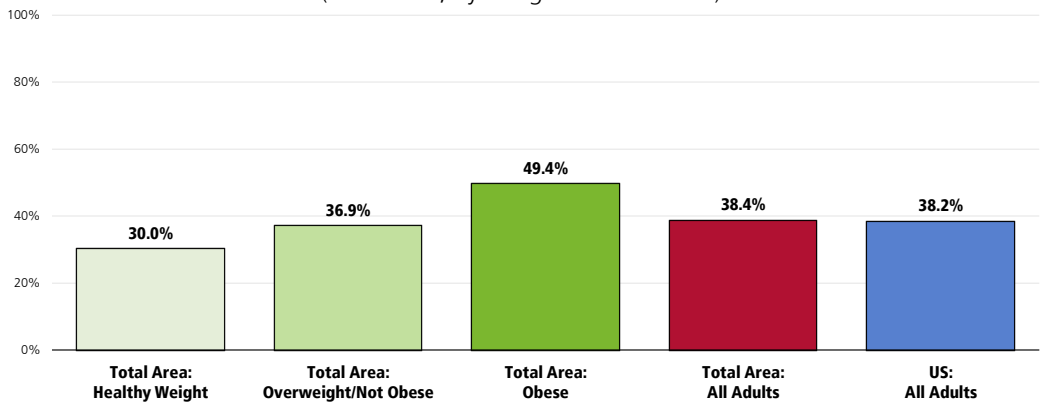
Health Advice About Diet & Nutrition

A total of 38.4% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Nearly identical to national findings (38.2%).
- More favorable (44.1%) in Douglas County (not shown).
- Note: Among obese respondents, 49.4% report receiving diet/nutrition advice (meaning that roughly one-half did not).

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

(Total Area; By Weight Classification)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Physical Activity & Fitness

The 1990s brought a historic new perspective to exercise, fitness, and physical activity by shifting the focus from intensive vigorous exercise to a broader range of health-enhancing physical activities. Research has demonstrated that virtually all individuals will benefit from regular physical activity. A Surgeon General's report on physical activity and health concluded that moderate physical activity can reduce substantially the risk of developing or dying from heart disease, diabetes, colon cancer, and high blood pressure. Physical activity also may protect against lower back pain and some forms of cancer (for example, breast cancer), but the evidence is not yet conclusive.

On average, physically active people outlive those who are inactive. Regular physical activity also helps to maintain the functional independence of older adults and enhances the quality of life for people of all ages.

The role of physical activity in preventing coronary heart disease (CHD) is of particular importance, given that CHD is the leading cause of death and disability in the United States. Physically inactive people are almost twice as likely to develop CHD as persons who engage in regular physical activity. The risk posed by physical inactivity is almost as high as several well-known CHD risk factors, such as cigarette smoking, high blood pressure, and high blood cholesterol. Physical inactivity, though, is more prevalent than any one of these other risk factors. People with other risk factors for CHD, such as obesity and high blood pressure, may particularly benefit from physical activity.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

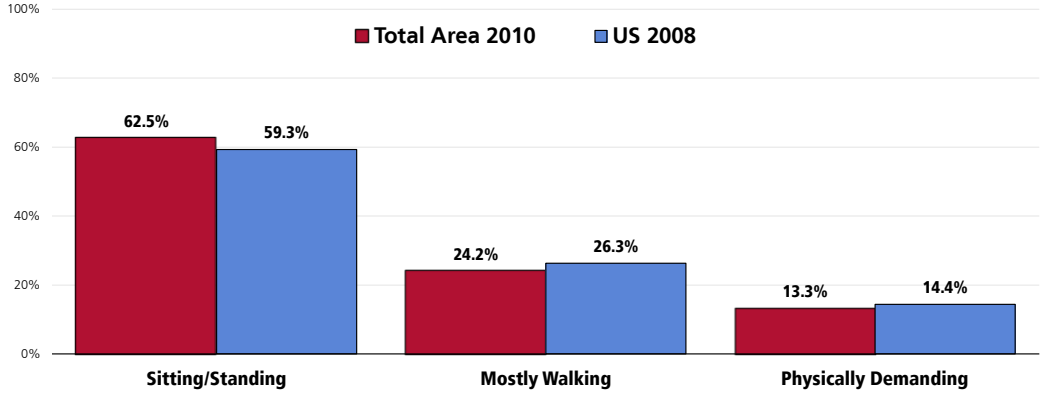
Level of Activity at Work

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

- Nearly two-thirds (62.5%) of employed respondents report that their job entails mostly sitting or standing, similar to the US figure (59.3%).
- 24.2% report that their job entails mostly walking (similar to the 26.3% reported nationally).
- 13.3% report that their work is physically demanding (similar to the 14.4% reported across the nation).

Primary Level of Physical Activity At Work

(Total Area; Among Employed Respondents)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 108]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

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

Leisure-Time Physical Activity

Effects of Physical Inactivity & Unhealthy Diets

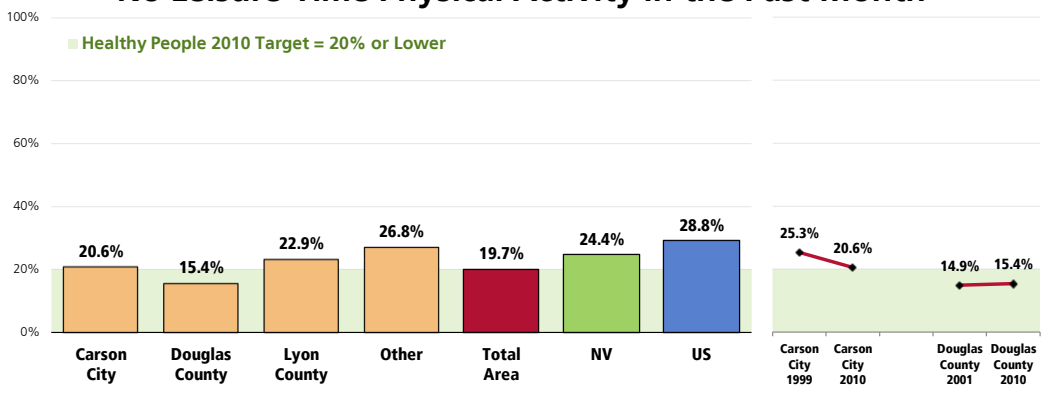
- Poor diet and physical inactivity lead to 300,000 deaths each year—second only to tobacco use.
- People who are overweight or obese increase their risk for heart disease, diabetes, high blood pressure, arthritis-related disabilities, and some cancers.
- Not getting an adequate amount of exercise is associated with needing more medication, visiting a physician more often, and being hospitalized more often.

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

One-fifth (19.7%) of Total Area adults reports no leisure-time physical activity in the past month.

- More favorable than the 24.4% reported across Nevada.
- More favorable than national findings (28.8%).
- Comparable to the Healthy People 2010 objective (20% or lower).
- Most favorable in Douglas County (15.4%).
- Compared to previous surveys, responses have not changed to a statistically significant degree in either Carson City or Douglas County.

No Leisure-Time Physical Activity in the Past Month



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 109]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-1]

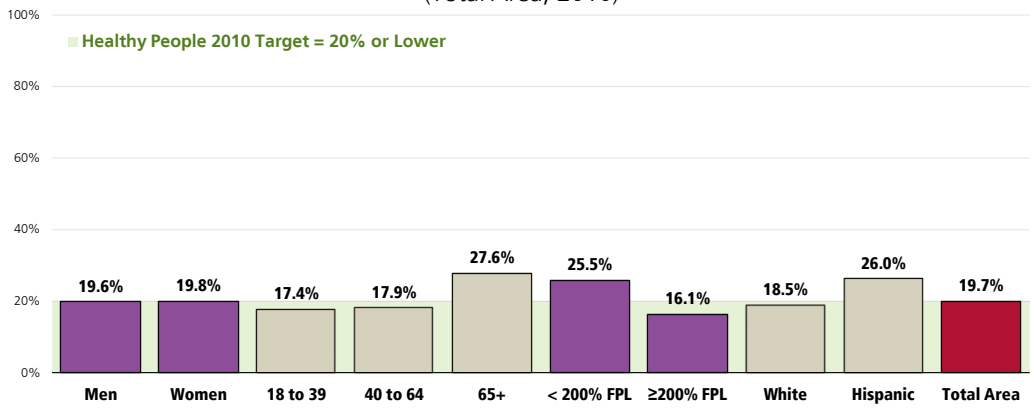
Notes: Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

- Adults aged 65+.
- Lower-income residents.

No Leisure-Time Physical Activity in the Past Month

(Total Area, 2010)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 22-1]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.: very low income" = below poverty; low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.

Activity Levels

All adults should strive to meet either of the following physical activity recommendations:

- **Moderate-intensity physical activities** (inducing only light sweating or a slight to moderate increase in breathing or heart rate) for at least 30 minutes on 5 or more days of the week.

– Centers for Disease Control and Prevention/American College of Sports Medicine

OR

- **Vigorous-intensity physical activity** (inducing heavy sweating or a large increase in breathing or heart rate) 3 or more days per week for 20 or more minutes per occasion.

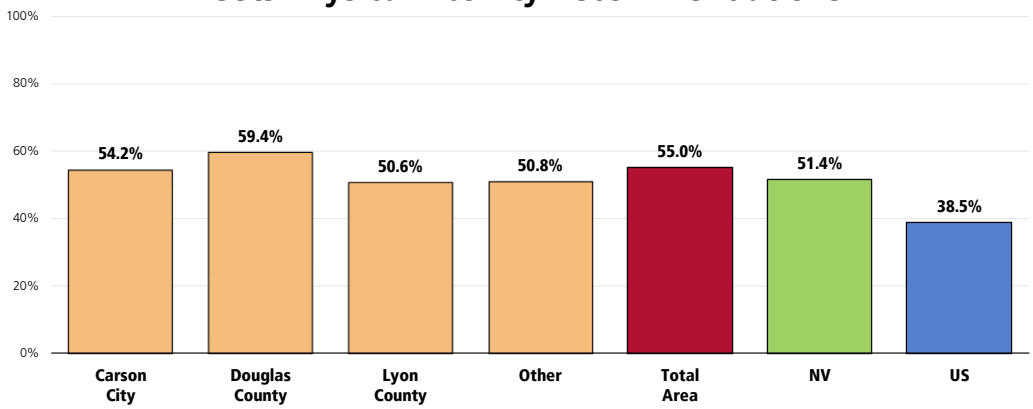
– Healthy People 2010

Recommended Levels of Physical Activity

A total of 55.0% of Total Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- Similar to the 51.4% reported across Nevada.
- More favorable than the national findings (38.5%).
- Similar by county.

Meets Physical Activity Recommendations



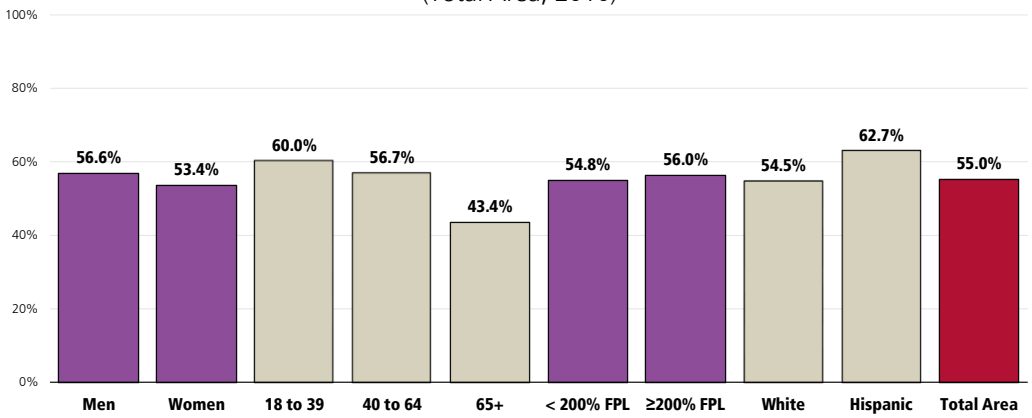
Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.

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

Total Area seniors are less likely to meet physical activity requirements.

Meets Physical Activity Recommendations

(Total Area, 2010)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]

Notes:
- Asked of all respondents.
- FPL = Federal Poverty Level based on household income and number of household members [US Department of Health & Human Services poverty guidelines].
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Moderate & Vigorous Physical Activity

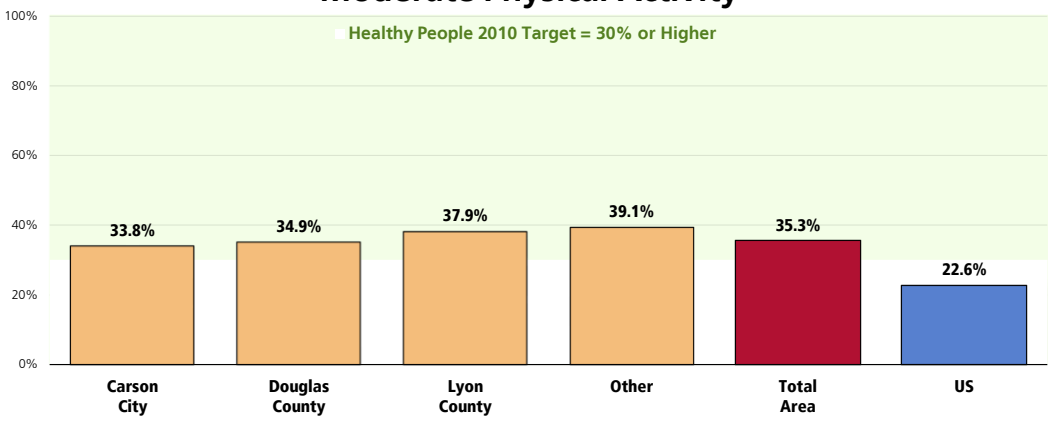
The individual indicators of moderate physical activity, vigorous physical activity, and strengthening activities are shown in the following charts.

In the past month:

A total of 35.3% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

- More favorable than the national level (22.6%).
- Satisfies the Healthy People 2010 objective (30% or higher).
- Similar by county.

Moderate Physical Activity

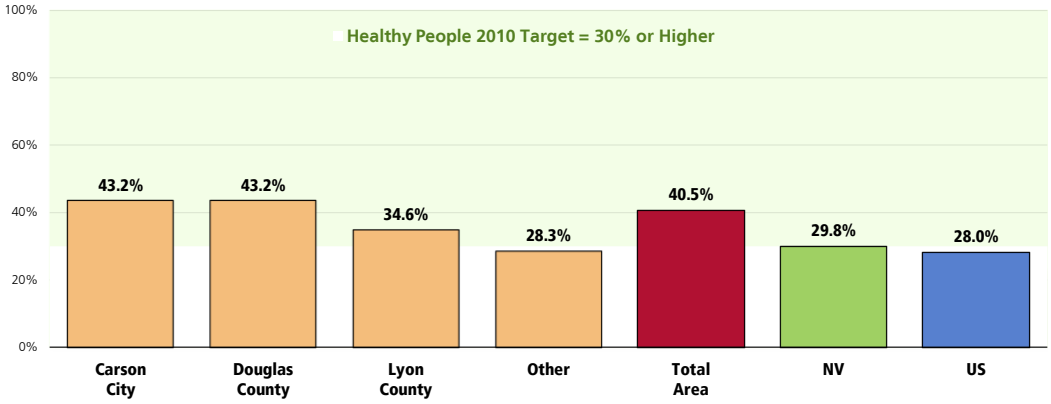


Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-2]
Notes: Asked of all respondents.
Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times a week for at least 30 minutes per time.

A total of 40.5% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- More favorable than the 29.8% across Nevada.
- More favorable than the nationwide figure (28.0%).
- Satisfies the Healthy People 2010 objective (30% or higher).
- Lowest in the "Other" areas.

Vigorous Physical Activity



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 22-3]
Notes: Asked of all respondents.
Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for 20 minutes each time.

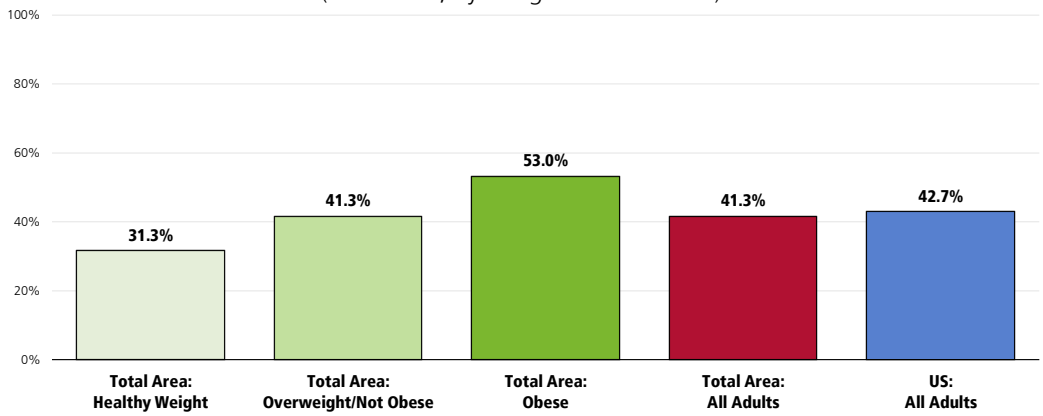
Health Advice About Physical Activity & Exercise

A total of 41.3% of Total Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Comparable to the national average (42.7%).
- Ranging from 34.1% in Lyon County to 47.1% in Douglas County (not shown).
- Note: 53.0% of obese Total Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

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

(Total Area; By Weight Classification)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Body Weight

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 of 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 of 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.

Overweight and obesity result from a complex interaction between genes and the environment characterized by long-term energy imbalance due to a sedentary lifestyle, excessive caloric consumption, or both. They develop in a socio-cultural environment characterized by mechanization, sedentary lifestyle, and ready access to abundant food. Attempts to prevent overweight and obesity are difficult to both study and achieve.

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

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

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

Adult Weight Status

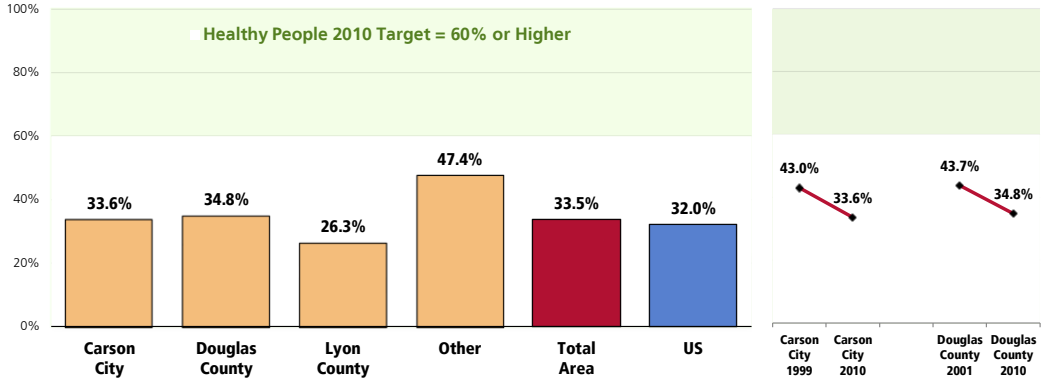
Healthy Weight

Based on self-reported heights and weights, only one-third (33.5%) of Total Area adults is at a healthy weight (neither underweight nor overweight, BMI = 18.5-24.9).

- Similar to national findings (32.0%).
- Far from reaching the Healthy People 2010 target (60% or higher).
- Worst in Lyon County; best in the "Other" counties.
- Marks a statistically significant decrease in healthy weight among Carson City and Douglas County adults.

Healthy Weight

(Body Mass Index Between 18.5 and 24.9)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 19-1]

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

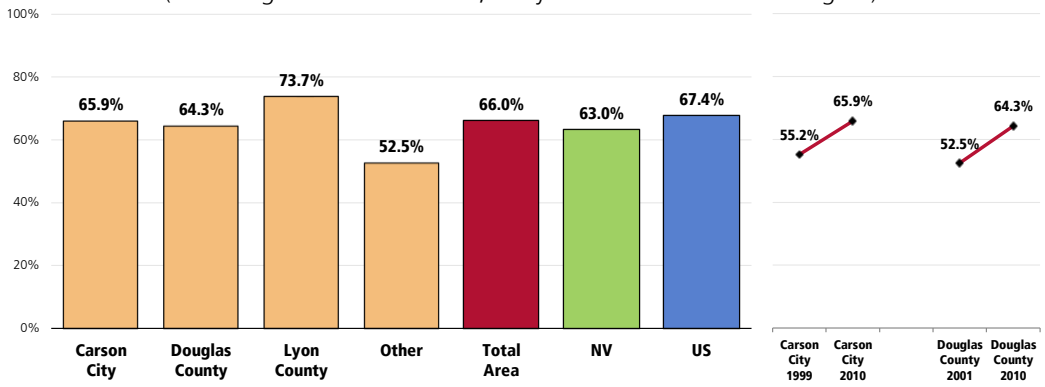
Overweight Status

A full 66.0% of Total Area adults are overweight (BMI ≥25).

- Comparable to the Nevada prevalence (63.0%).
- Comparable to the US overweight prevalence (67.4%).
- Least favorable in Lyon County; most favorable in the "Other" counties.
- Denotes a statistically significant increase in overweight over time among adults in both Carson City and Douglas County.

Prevalence of Total Overweight

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



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 149]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 19-2]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada Data.

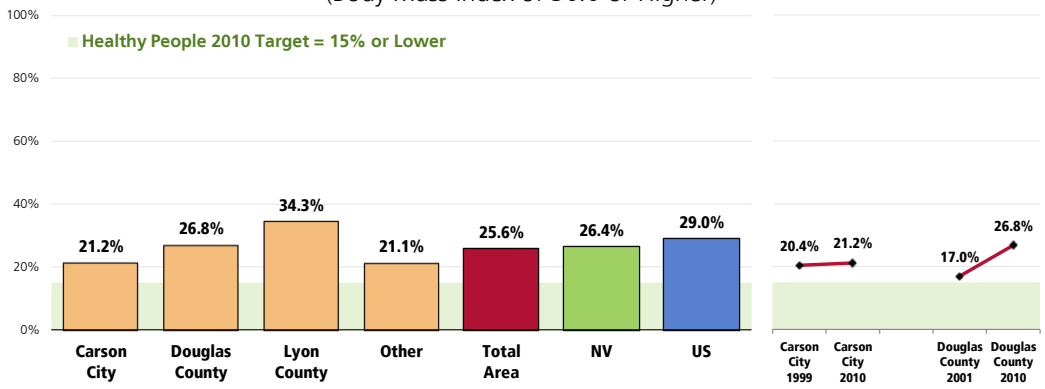
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater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

Specifically, 1 in 4 (25.6%) Total Area adults is obese (BMI ≥30, also included in overweight prevalence discussed previously).

- Similar to the Nevada percentage (26.4%).
- Similar to US findings (29.0%).
- Fails to satisfy the Healthy People 2010 target (15% or lower).
- Ranging from roughly 21% in Carson City and "Other" counties, to 34.3% in Lyon County.
- Statistically unchanged in Carson City over time, but marking a statistically significant increase in obesity in Douglas County.

Prevalence of Obesity

(Body Mass Index of 30.0 or Higher)



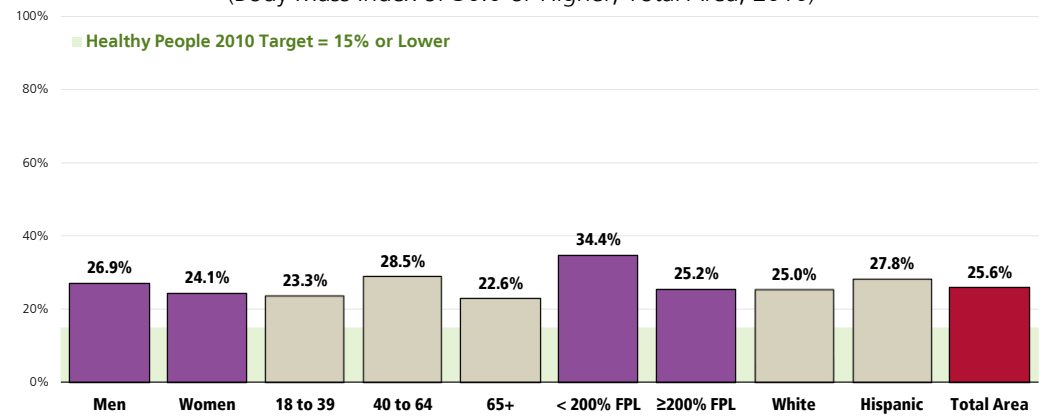
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 149]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 19-2]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada Data.

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

Obesity is notably more prevalent among respondents with lower incomes.

Prevalence of Obesity

(Body Mass Index of 30.0 or Higher; Total Area, 2010)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 19-2]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.: very low income" = below poverty; low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Relationship of Overweight With Other Health Issues

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

Overweight and obese adults are more likely to report a number of adverse health conditions.

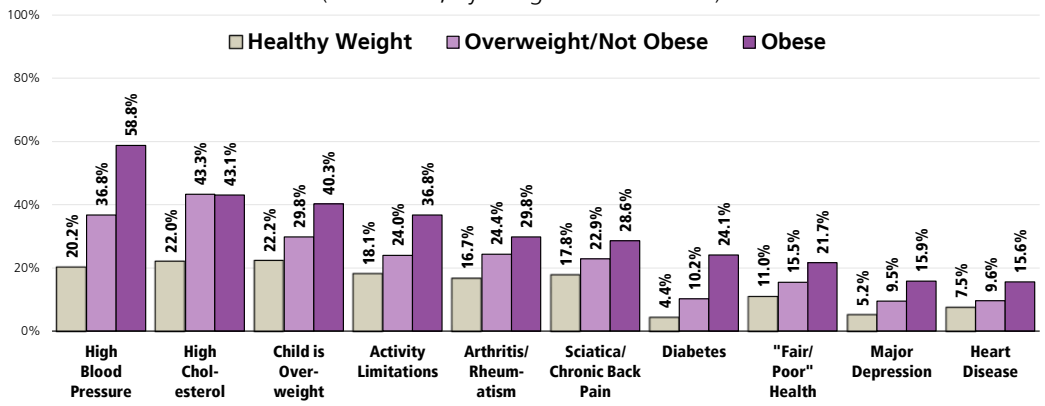
Among these are:

- Hypertension (high blood pressure).
- High cholesterol.
- Activity Limitations.
- Arthritis/Rheumatism.
- Sciatica/chronic back pain.
- Diabetes.
- "Fair" or "poor" physical health.
- Major depression.
- Chronic heart disease.
- Cancer.

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

Relationship of Overweight With Other Health Issues

(Total Area; By Weight Classification)



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 30-32, 35, 45, 120, 142-143, 145]
Notes: • Based on reported heights and weights, asked of all respondents.

Weight Management

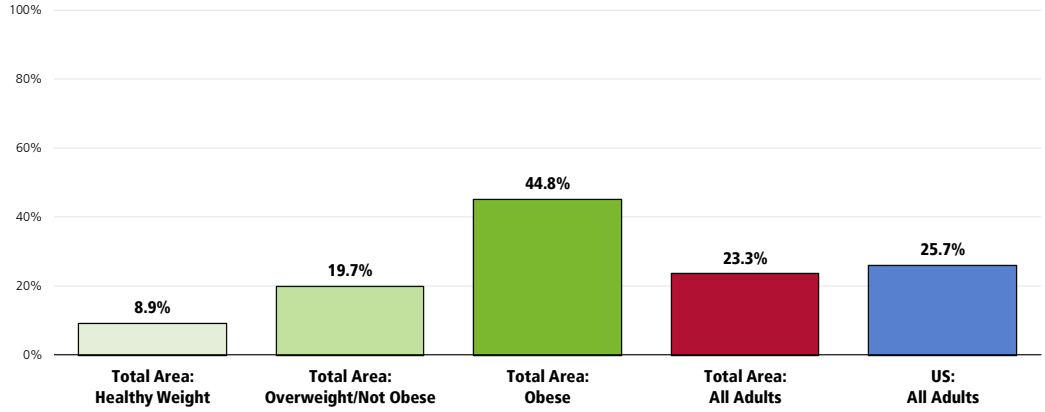
Health Advice

A total of 23.3% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Statistically similar to the national findings (25.7%).
- Note that 44.8% of obese adults have been given advice about their weight by a health professional in the past year (while over one-half have not).

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

(Total Area; By Weight Classification)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 115]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Weight Control

Many diseases are associated with overweight and obesity. Persons who are overweight or obese are at increased risk for high blood pressure, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and some types of cancer. The health outcomes related to these diseases, however, often can be improved through weight loss or, at a minimum, no further weight gain.

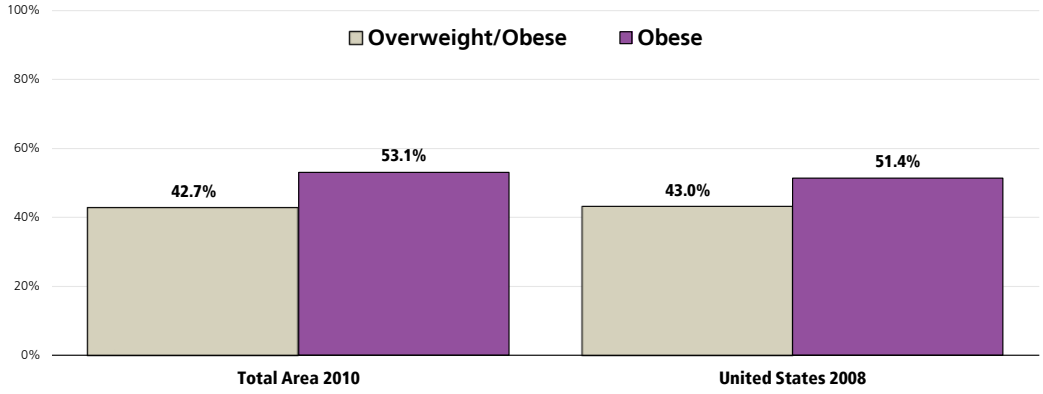
– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

A total of 42.7% of Total Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

- Nearly identical to national findings (43.0%).
- Note: 53.1% of obese Total Area adults report that they are trying to lose weight through a combination of diet and exercise, similar to the 51.4% across the nation.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity

(By Weight Classification)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 150]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

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

Childhood Overweight & Obesity

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

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

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

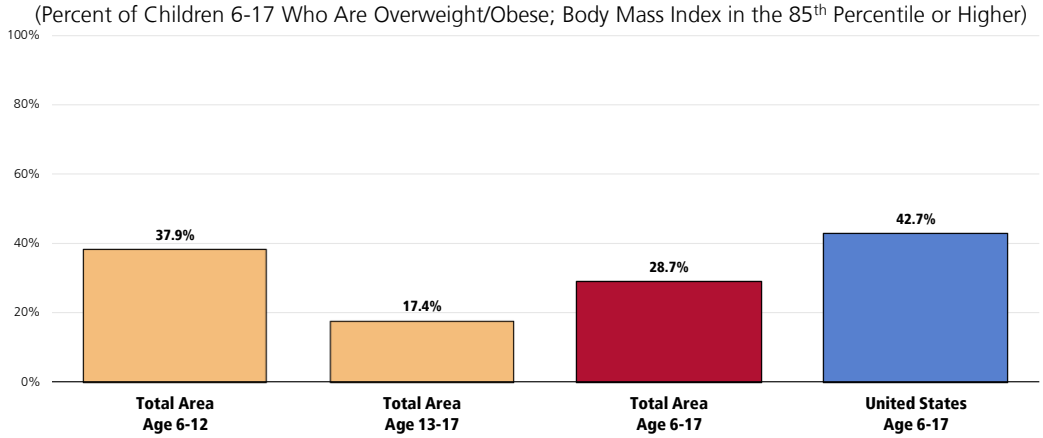
– Centers for Disease Control and Prevention.

Based on the heights/weights reported by surveyed parents, 28.7% of Total Area children aged 6 to 17 are overweight or obese (≥85th percentile).

- More favorable than the 42.7% found nationally.
- Statistically similar by child's gender (not shown).
- Notably higher (37.9%) among children aged 6 to 12 when compared with Total Area teens (17.4%).

Child Total Overweight Prevalence

(Percent of Children 6-17 Who Are Overweight/Obese; Body Mass Index in the 85th Percentile or Higher)



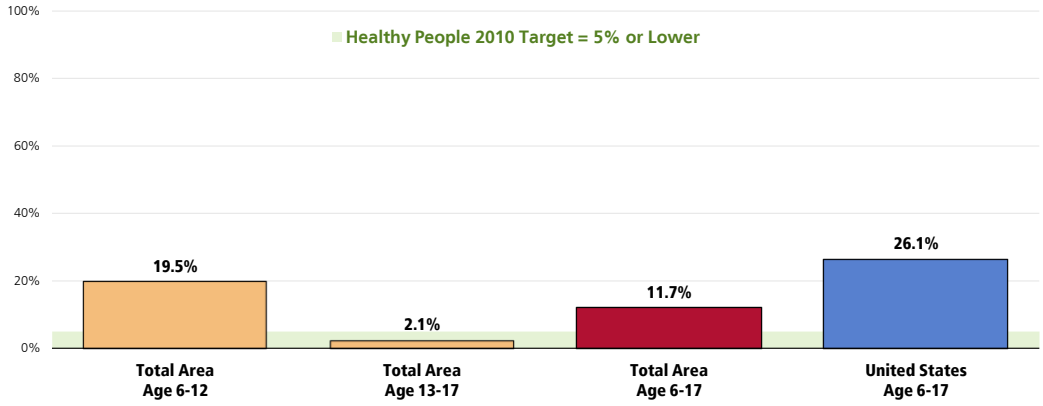
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
2008 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children aged 6-17 at home.
Overweight among children is estimated based on children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Specifically, 11.7% of Total Area children aged 6 to 17 are obese (≥95th percentile).

- More favorable than the national percentage (26.1%).
- Fails to satisfy the Healthy People 2010 target (5% or lower).
- Statistically similar by child's gender (not shown).
- Notably higher among children aged 6-12 (19.5%) when compared with Total Area teens (2.1%).

Child Obesity Prevalence

(Percent of Children 6-17 Who Are Obese; Body Mass Index in the 95th Percentile or Higher)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 19-3]

Notes: Asked of all respondents with children aged 6-17 at home.
Obesity among children is estimated based on children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Substance Abuse

Substance abuse and its related problems are among society's most pervasive health and social concerns. Each year, about 100,000 deaths in the United States are related to alcohol consumption. Illicit drug abuse and related acquired immunodeficiency syndrome (AIDS) deaths account for at least another 12,000 deaths. In 1995, the economic cost of alcohol and drug abuse was $276 billion. This represents more than $1,000 for every man, woman, and child in the United States to cover the costs of healthcare, motor vehicle crashes, crime, lost productivity, and other adverse outcomes of alcohol and drug abuse.

A substantial proportion of the population drinks alcohol. Alcohol use and alcohol-related problems also are common among adolescents. Excessive drinking has consequences for virtually every part of the body. The wide range of alcohol-induced disorders is due (among other factors) to differences in the amount, duration, and patterns of alcohol consumption, as well as differences in genetic vulnerability to particular alcohol-related consequences. Alcohol use has been linked with a substantial proportion of injuries and deaths from motor vehicle crashes, falls, fires, and drownings. It also is a factor in homicide, suicide, marital violence, and child abuse and has been associated with high-risk sexual behavior.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

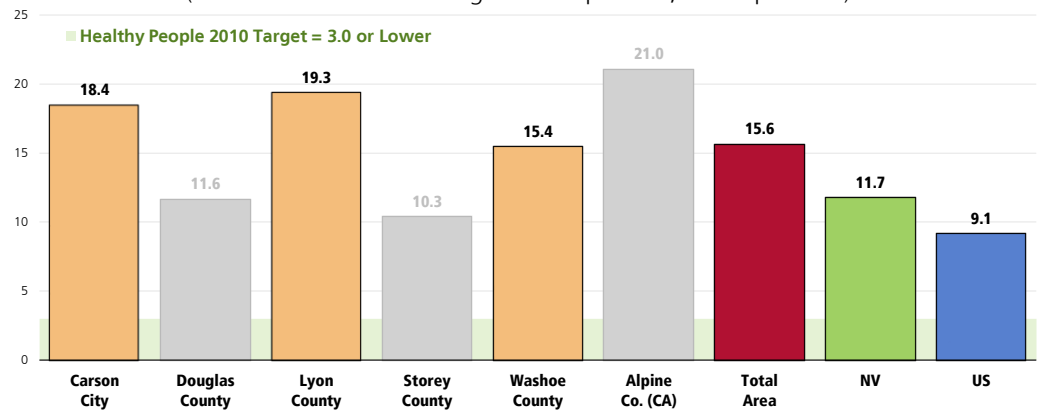
Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2004 and 2006, there was an annual average age-adjusted cirrhosis/liver disease mortality rate of 15.6 deaths per 100,000 population in the Total Area.

- Higher than the 11.7 rate reported across Nevada.
- Higher than the national rate of 9.1.
- Fails to satisfy the Healthy People 2010 target.
- Appears to be higher in Carson City and Lyon County; *however, note that several of the counties have unreliable rates due to low numbers of deaths*.

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2004-2006 Annual Average Deaths per 100,000 Population)



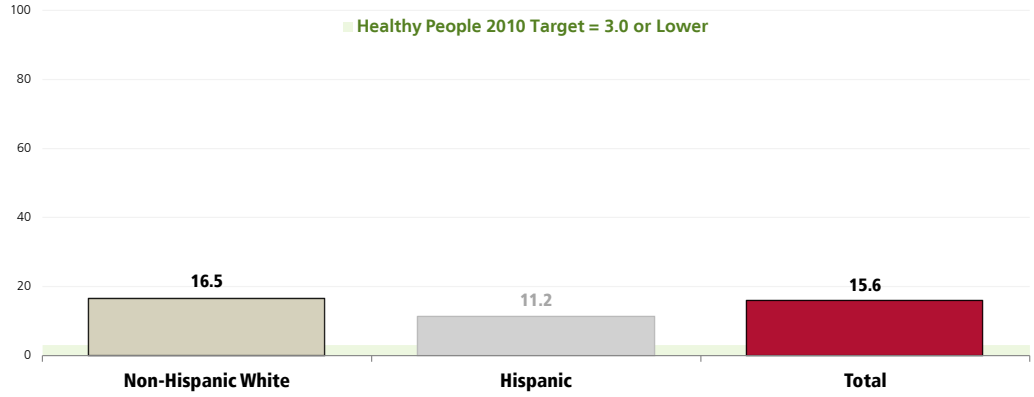
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-2]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rates for Douglas County, Storey County, and Alpine County are unreliable due to low number of deaths.

Cirrhosis mortality rates appear to be higher among Non-Hispanic Whites than among Hispanics (*but note the unreliability of the Hispanic rate*).

Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race

(Total Area; 2004-2006 Annual Average Deaths per 100,000 Population)



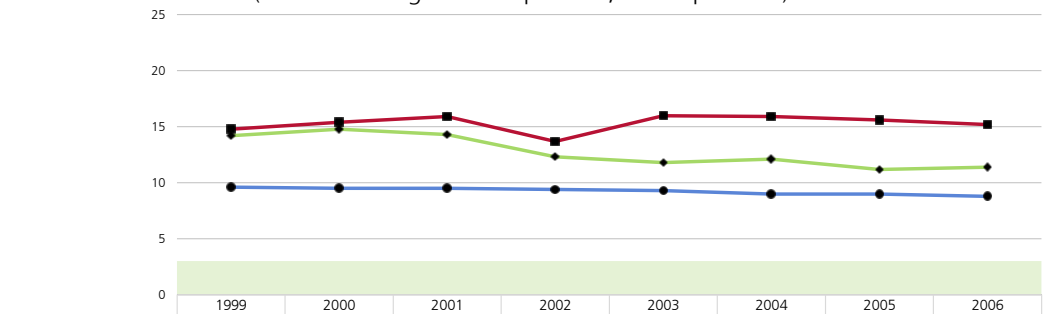
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-2]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
County, state and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.
Note that the rate for Hispanics is unreliable due to low number of deaths.

Mortality rates have fluctuated in the region, showing no clear trend. Statewide and nationwide, rates have decreased.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	1999	2000	2001	2002	2003	2004	2005	2006
Healthy People 2010	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
Total Area	14.8	15.4	15.9	13.7	16.0	15.9	15.6	15.2
Nevada	14.2	14.8	14.3	12.3	11.8	12.1	11.2	11.4
United States	9.6	9.5	9.5	9.4	9.3	9.0	9.0	8.8

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2010.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-2]

Notes: Deaths from 1999 forward are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10); pre-1999 data were coded using ICD-9 coding.
Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
State and national data are simple three-year averages; the Total Area rate reflects combined county rates, weighted by population.

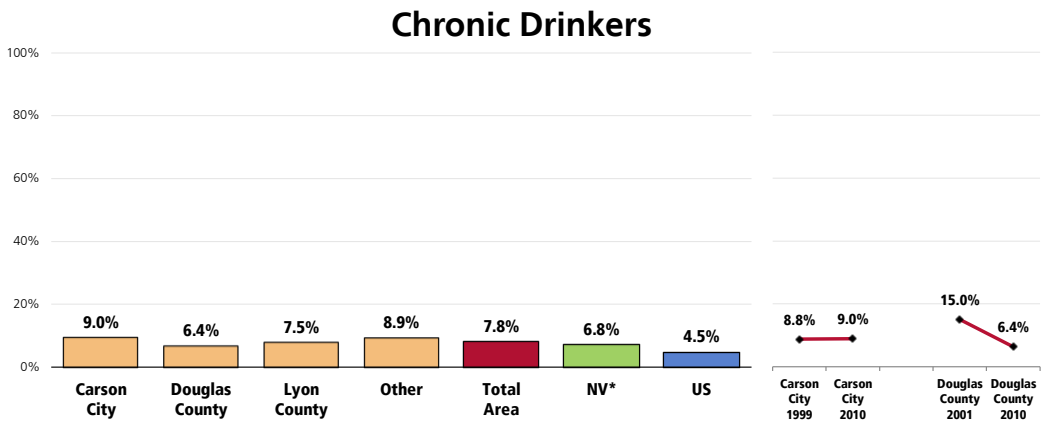
High-Risk Alcohol Use

Chronic Drinking

Chronic drinkers include survey respondents reporting 60 or more drinks of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

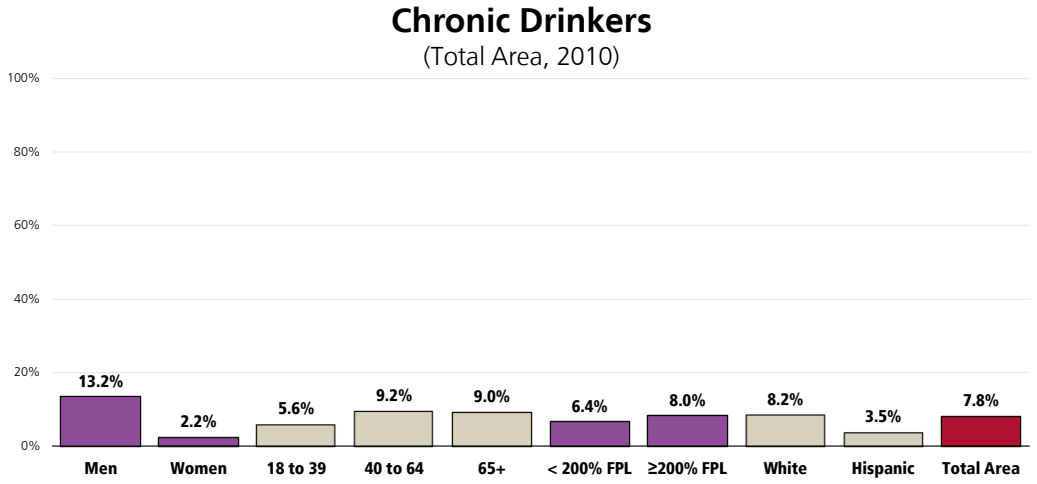
A total of 7.8% of area adults averaged two or more drinks of alcohol per day in the past month (chronic drinkers).

- Similar to the 6.8% across Nevada.
- Less favorable than the national figure (4.5%).
- Similar by county.
- The chronic drinking prevalence has not changed significantly over time across Carson City, but has decreased significantly among adults in Douglas County.



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 164]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.
Chronic drinkers are defined as having 60+ alcoholic drinks in the past month.
*The state definition for chronic drinkers is males consuming 2+ drinks per day and females consuming 1+ drink per day.

- Chronic drinking is more prevalent among men.



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 164]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.
Chronic drinkers are defined as those having 60+ alcoholic drinks in the past month.

Binge Drinking

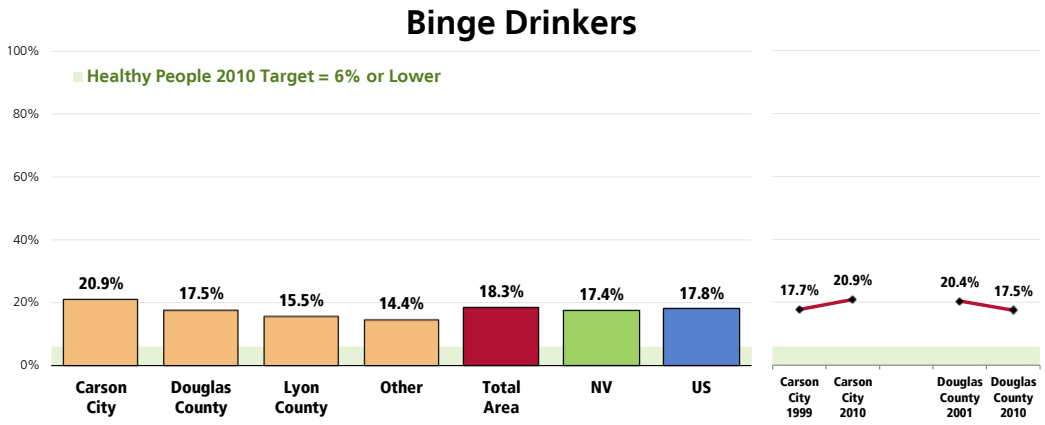
Binge drinkers include:

1) MEN who report drinking 5 or more alcoholic drinks on any single occasion during the past month; and

2) WOMEN who report drinking 4 or more alcoholic drinks on any single occasion during the past month.

A total of 18.3% of Total Area adults are binge drinkers.

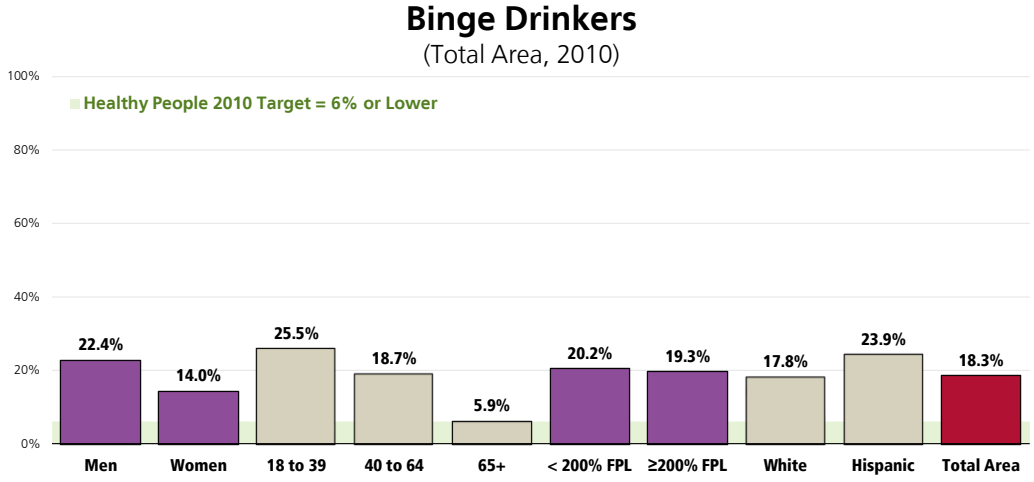
- Similar to the 17.4% in Nevada.
- Similar to the 17.8% reported nationwide.
- Fails to satisfy the Healthy People 2010 target (6% or lower).
- Similar by county.
- Statistically unchanged over time *(note, however, that the previous definition for binge drinking was five or more drinks, regardless of gender)*.



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 165]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-11c]
Notes: Asked of all respondents.
Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.

Binge drinking is more prevalent among:

- Men.
- Adults under age 40.



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-11c]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

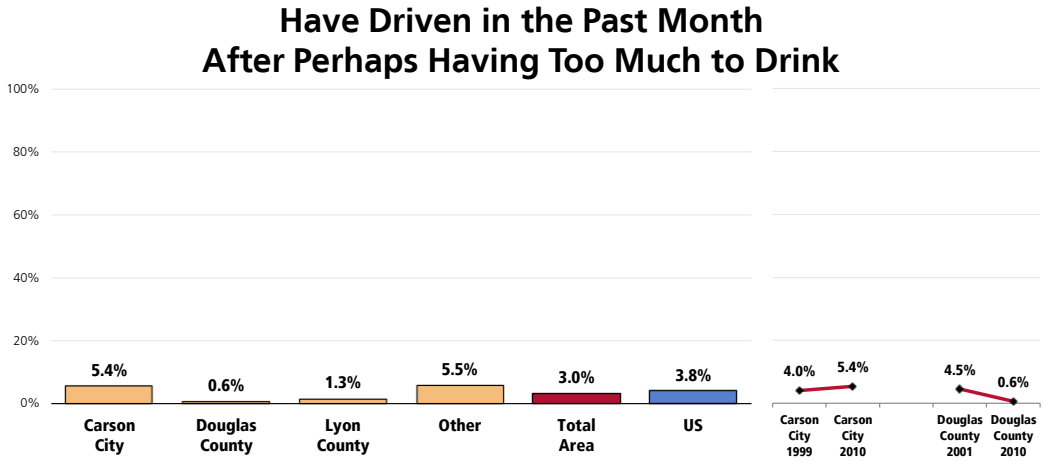
Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion

Drinking & Driving

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

A total of 3.0% of Total Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

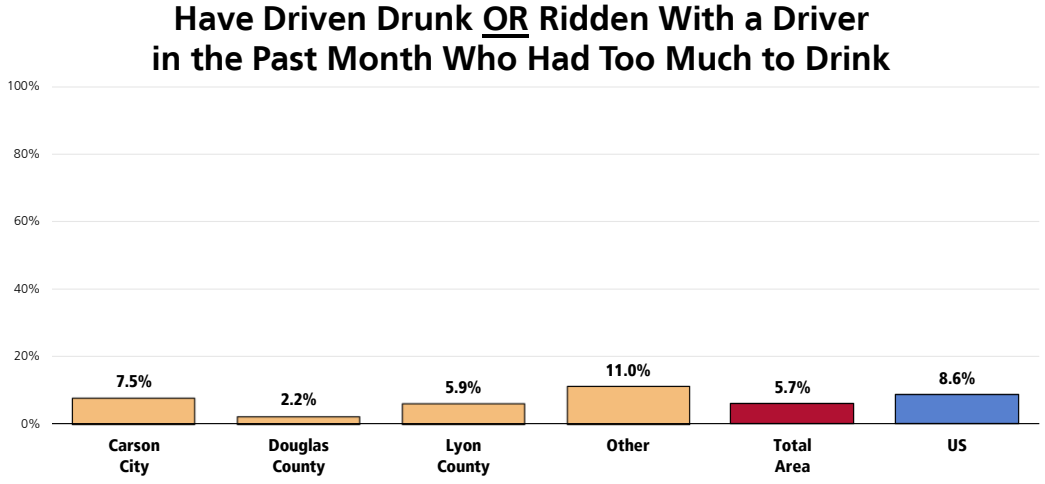
- Similar to the national findings (3.8%).
- Higher in Carson City; notably low in Douglas County.
- The drinking and driving prevalence has not changed significantly in Carson City, but has decreased significantly in Douglas County.



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 74]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

A total of 5.7% of Total Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- More favorable than the national findings (8.6%).
- Lowest in Douglas County.



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 166]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Illicit Drug Use

Illegal use of drugs, such as heroin, marijuana, cocaine, and methamphetamine, is associated with other serious consequences, including injury, illness, disability, and death, as well as crime, domestic violence, and lost workplace productivity. Drug users and persons with whom they have sexual contact run high risks of contracting gonorrhea, syphilis, hepatitis, tuberculosis, and human immunodeficiency virus (HIV). The relationship between injection drug use and HIV/AIDS transmission is well known. Injection drug use also is associated with hepatitis B and C infections. Long-term consequences, such as chronic depression, sexual dysfunction, and psychosis, may result from drug use.

Although there has been a long-term drop in overall use, many people in the United States still use illicit drugs. Drug use among adolescents aged 12 to 17 years doubled between 1992 and 2001. Drug and alcohol use by youth also is associated with other forms of unhealthy and unproductive behavior, including delinquency and high-risk sexual activity.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

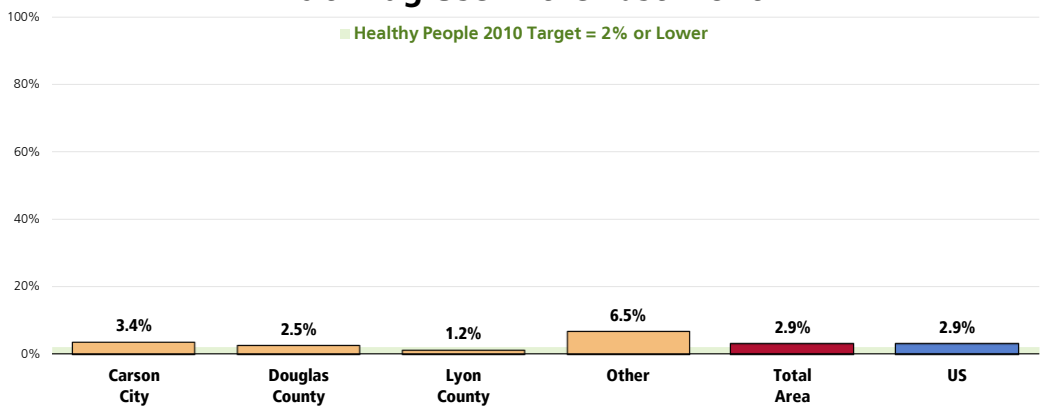
For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

A total of 2.9% of Total Area adults acknowledge using an illicit drug in the past month.

- Identical to the 2.9% reported across the nation.
- Similar to the Healthy People 2010 objective of 2% or lower.
- Statistically similar by county.

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.

Illicit Drug Use in the Past Month



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 76]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-10c]

Notes: Asked of all respondents.
Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.

Alcohol & Drug Treatment

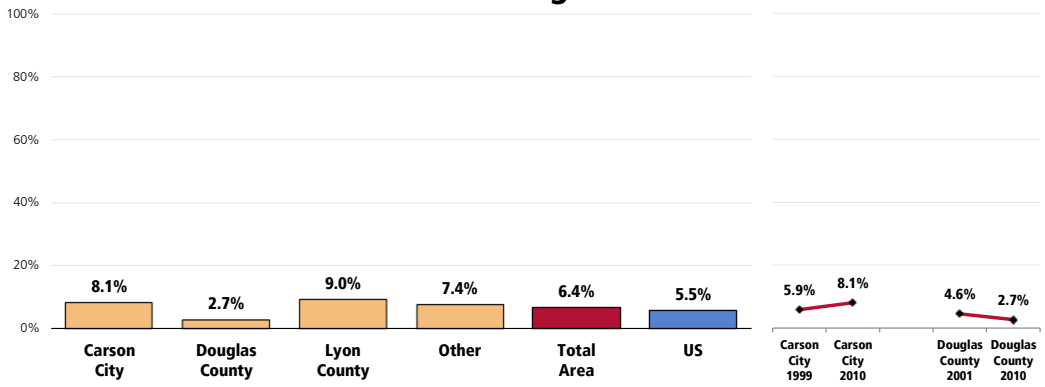
The stigma attached to substance abuse increases the severity of the problem. The hiding of substance abuse, for example, can prevent persons from seeking and continuing treatment and from having a productive attitude toward treatment. Compounding the problem is the gap between the number of available treatment slots and the number of persons seeking treatment for illicit drug use or problem alcohol use.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

A total of 6.4% of Total Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Similar to the 5.5% reported across the nation.
- Lower (2.7%) in Douglas County.
- Statistically unchanged over time in both Carson City and Douglas County.

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



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 77]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Tobacco Use

Cigarette smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth, and bladder), and chronic lung disease. Cigarette smoking also contributes to cancer of the pancreas, kidney, and cervix. Smoking during pregnancy causes spontaneous abortions, low birthweight, and sudden infant death syndrome. Other forms of tobacco are not safe alternatives to smoking cigarettes.

Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States [about 20% of all deaths]… If current tobacco use patterns persist in the United States, an estimated 5 million persons under age 18 years will die prematurely from a smoking-related disease. Direct medical costs related to smoking total at least $50 billion per year [other sources estimate more than $75 billion in 1998 (about 8% of the personal healthcare expenditures in the US)]; direct medical costs related to smoking during pregnancy are approximately $1.4 billion per year.

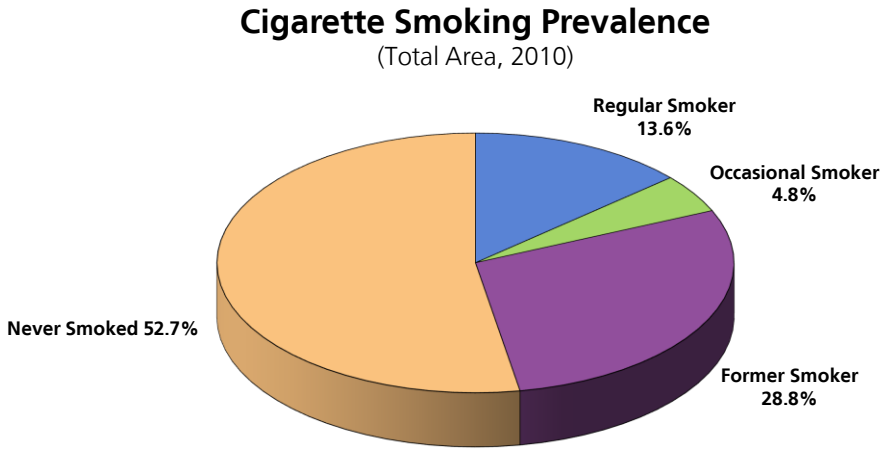
Evidence is accumulating that shows maternal tobacco use is associated with mental retardation and birth defects such as oral clefts. Exposure to secondhand smoke also has serious health effects. Researchers have identified more than 4,000 chemicals in tobacco smoke; of these, at least 43 cause cancer in humans and animals. Each year, because of exposure to secondhand smoke, an estimated 3,000 nonsmokers die of lung cancer, and 150,000 to 300,000 infants and children under age 18 months experience lower respiratory tract infections.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

Cigarette Smoking

Cigarette Smoking Prevalence

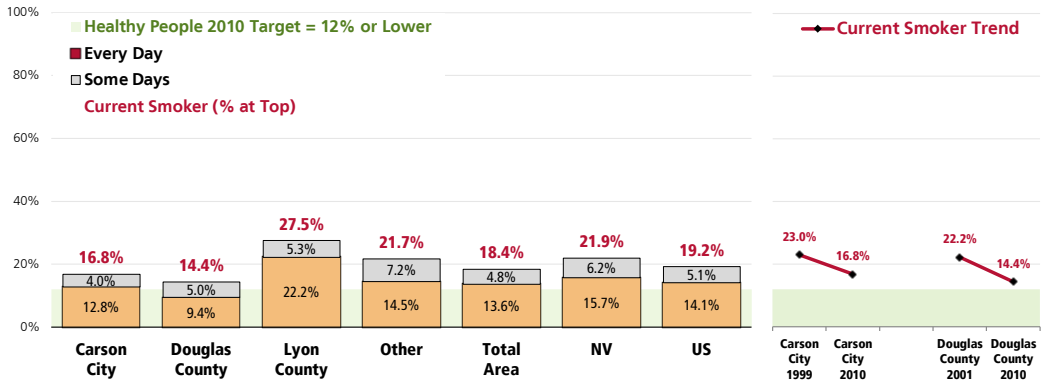
A total of 18.4% of Total Area adults currently smoke cigarettes, either regularly (13.6% every day) or occasionally (4.8% on some days).



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 160]
Notes: • Asked of all respondents.

- More favorable than the 21.9% reported across Nevada.
- Similar to national findings (19.2%).
- Fails to satisfy the Healthy People 2010 target (12% or lower).
- Ranging from 14.4% in Douglas County to 27.5% in Lyon County.
- The current smoking percentage has decreased significantly among adults in both Carson City and Douglas County.

Current Smokers



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 160]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services,
- Centers for Disease Control and Prevention (CDC): 2009 Nevada Data.
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 27-1a]

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

Cigarette smoking is more prevalent among:

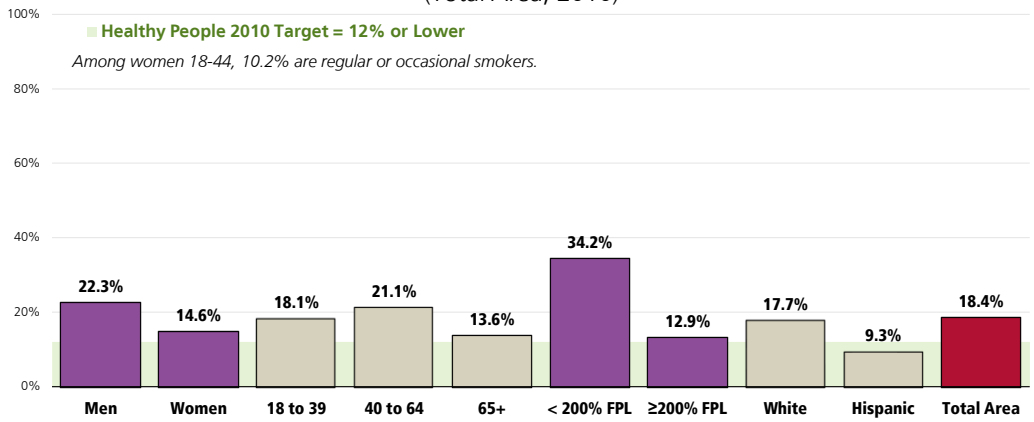
- Men.
- Adults aged 40 to 64.
- Lower-income residents.
- Non-Hispanic Whites.

Note also:

- 10.2% of women of child-bearing age (ages 18 to 44) currently smoke. This is notable given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.

Current Smokers

(Total Area, 2010)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 160-161]
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 27-1a]

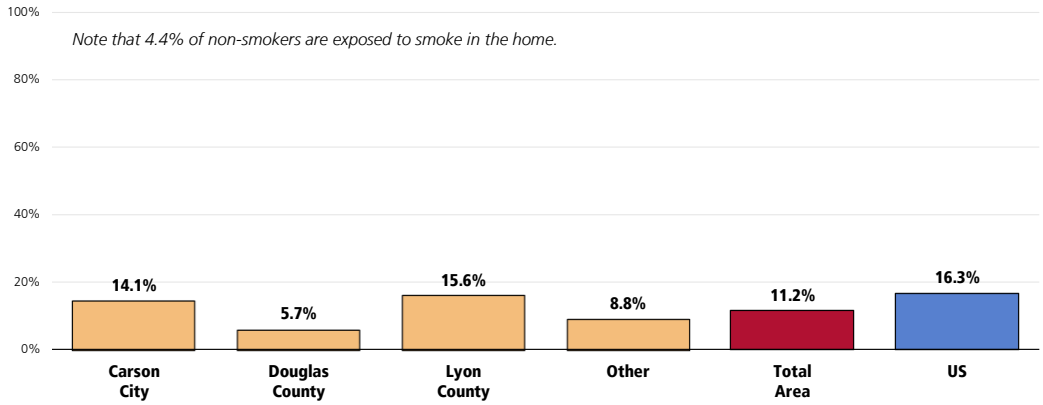
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Environmental Tobacco Smoke

A total of 11.2% of Total Area adults (including smokers and non-smokers) report that a member of their household has smoked cigarettes in the home in the past month an average of four or more times per week.

- More favorable than the 16.3% national findings.
- Significantly high in Carson City; significantly low in Douglas County.
- Note that 4.4% of Total Area non-smokers are exposed to cigarette smoke at home.

Member of Household Smokes at Home

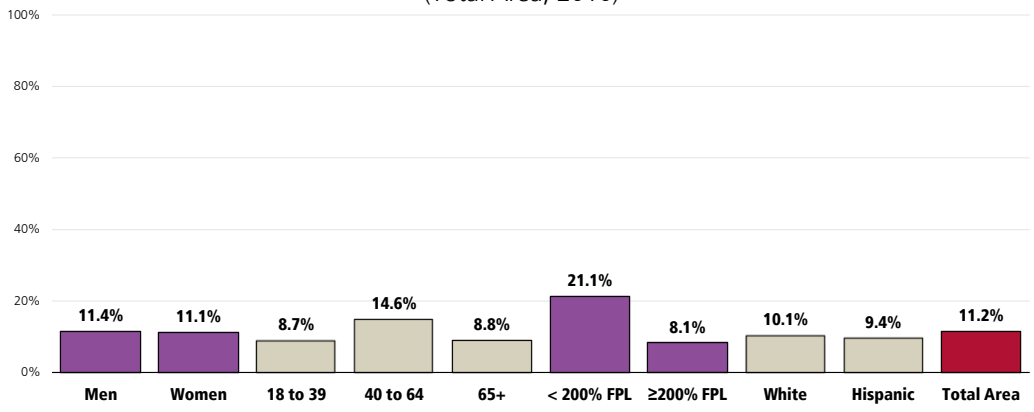


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-5]
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:

- Respondents aged 40 to 64.
- Residents with lower incomes.

Member of Household Smokes At Home
(Total Area, 2010)

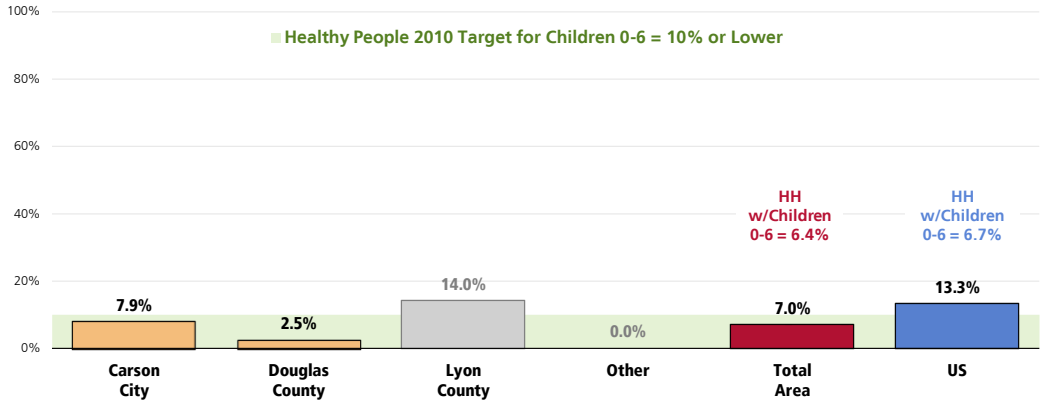


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.
"Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Among households with children, 7.0% have someone who smokes cigarettes in the home.

- More favorable than national findings (13.3%).
- Lower in Douglas County than in Carson City *(note that the other proportions reported are unreliable due to small sample sizes)*.
- Among households with children under age 7, 6.4% report that someone smokes in the home (compared to 6.7% across the US and a Healthy People 2010 objective of 10% or lower).

Percentage of Households With Children In Which Someone Smokes in the Home



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 162]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-9]
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.
County areas shown in gray are based on unreliable sample sizes.

Smoking Cessation

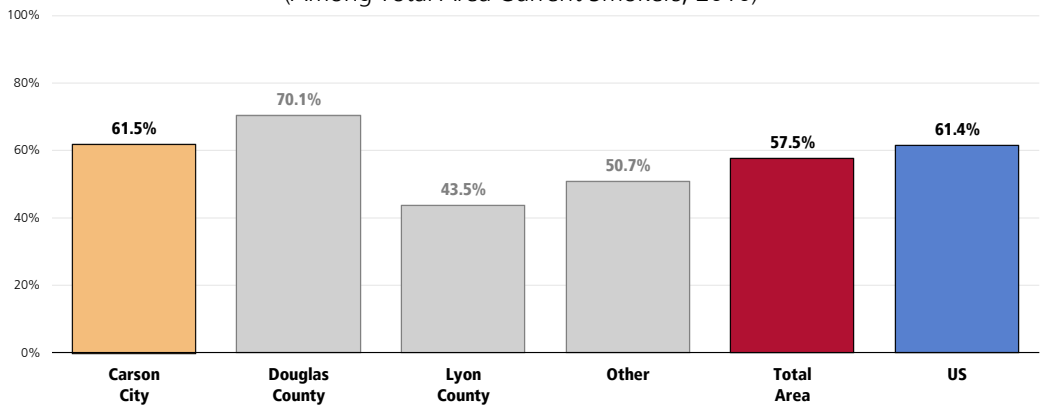
Health Advice About Smoking Cessation

A total of 57.5% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Statistically comparable to the national percentage (61.4%).
- Note that only Carson City had a sample of adequate size to produce reliable county-level results.

Received Advice to Quit Smoking By a Healthcare Professional

(Among Total Area Current Smokers, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all current smokers.
County areas shown in gray are based on unreliable sample sizes.

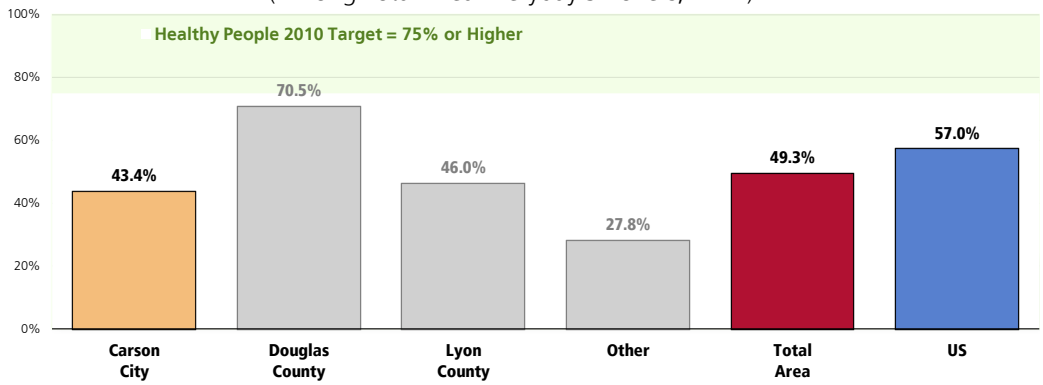
Smoking Cessation Attempts

A total of 49.3% of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the national percentage (57.0%).
- Fails to satisfy the Healthy People 2010 target (75% or higher).
- Note that only Carson City had a sample of adequate size to produce reliable county-level results.

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Total Area Everyday Smokers, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-5]

Notes: Asked of respondents who smoke cigarettes every day.
County areas shown in gray are based on unreliable sample sizes.

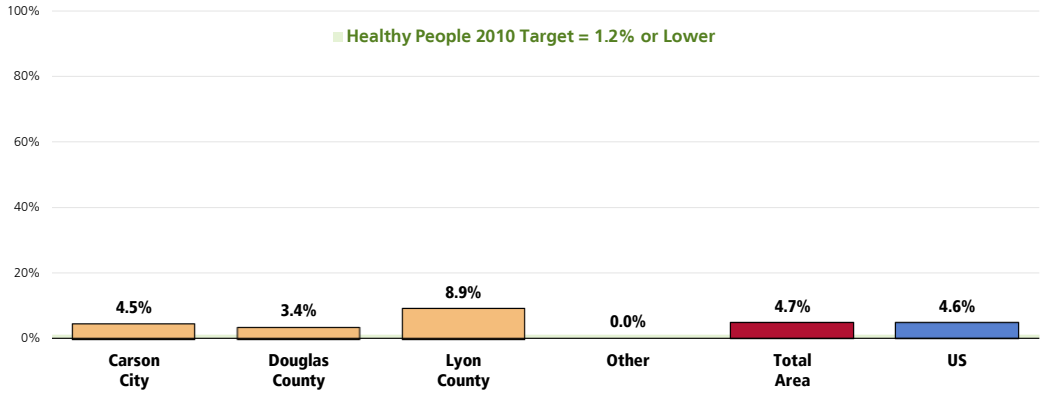
Other Tobacco Use

Cigars

A total of 4.7% of Total Area adults use cigars every day or on some days.

- Nearly identical to the national percentage (4.6%).
- Fails to satisfy the Healthy People 2010 target (1.2% or lower).
- Notably higher in Lyon County; lower in the "Other" counties.

Use of Cigars



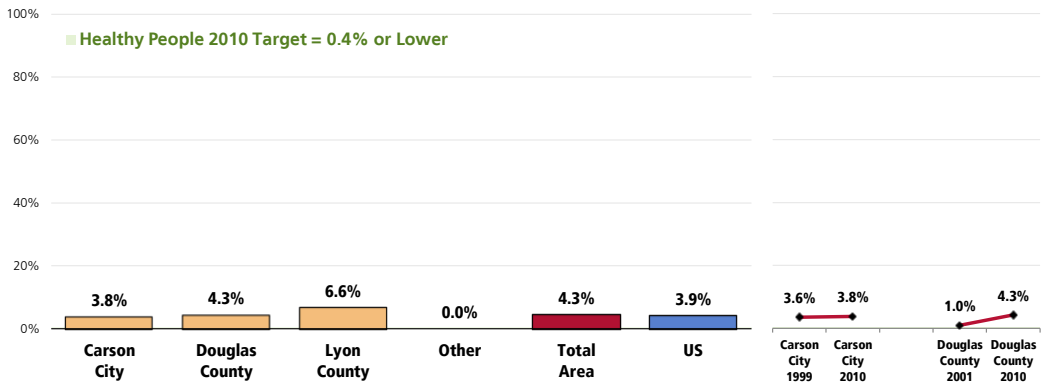
Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 70]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objectives 27-1c]
Notes: Asked of all respondents.

Smokeless Tobacco

A total of 4.3% of Total Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to the national percentage (3.9%).
- Fails to satisfy the Healthy People 2010 target (0.4% or lower).
- Notably lower in the "Other" counties.
- Smokeless tobacco use in Carson City is statistically unchanged since 1999; the prevalence has increased significantly in Douglas County since 2001.

Use of Smokeless Tobacco



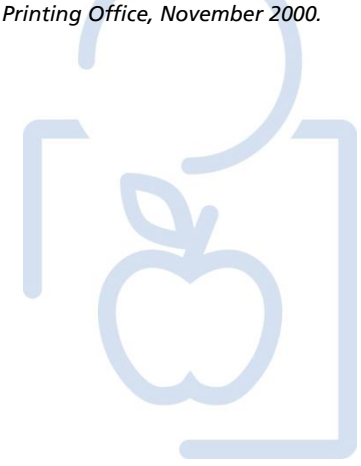
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 69]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objectives 27-1b]
Notes: Asked of all respondents.
Smokeless tobacco includes chewing tobacco or snuff.

ACCESS TO HEALTHCARE SERVICES

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States.

Limitations in access to care extend beyond basic causes, such as a shortage of healthcare providers or a lack of facilities. Individuals also may lack a usual source of care or may face other barriers to receiving services, such as financial barriers (having no health insurance or being underinsured), structural barriers (no facilities or healthcare professionals nearby), and personal barriers (sexual orientation, cultural differences, language differences, not knowing what to do, or environmental challenges for people with disabilities).

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.



Health Insurance Coverage

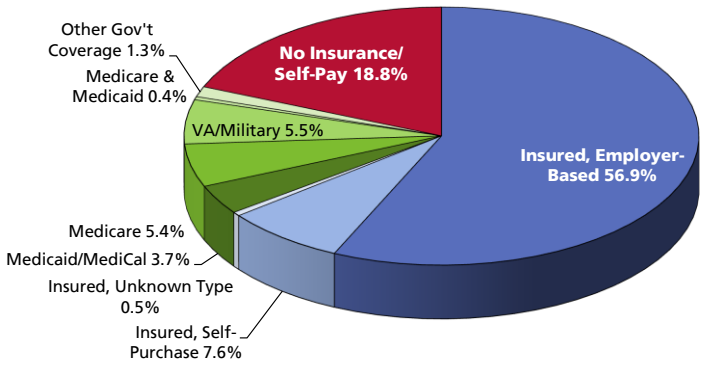
Type of Healthcare Coverage

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 64.5% of Total Area adults aged 18 to 64 report having healthcare coverage through private insurance. Another 16.3% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults Age 18 to 64; Total Area, 2010)



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 184]
Notes: • Reflects respondents aged 18 to 64.

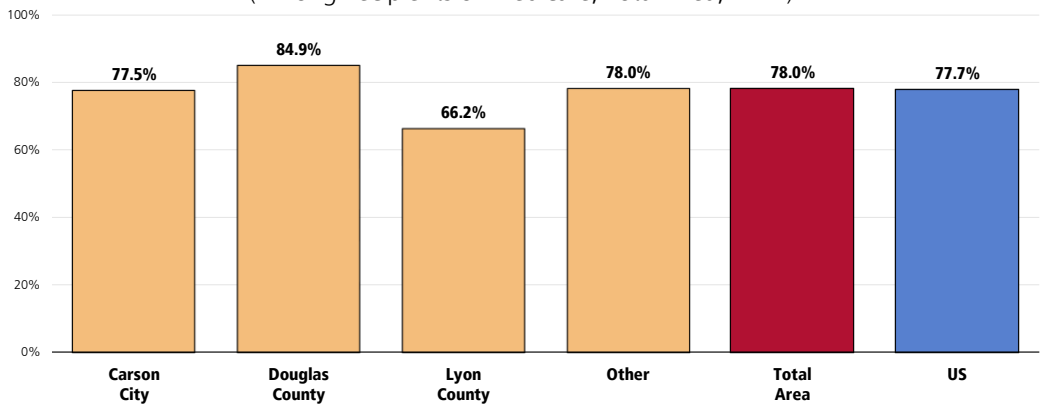
Supplemental Coverage

Among Medicare recipients, the majority (78.0%) have additional supplemental healthcare coverage.

- Nearly identical to the 77.7% reported among Medicare recipients nationwide.
- Ranging from 84.9% in Douglas County to 66.2% in Lyon County.

Have Additional Supplemental Coverage

(Among Recipients of Medicare; Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 90]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents with Medicare coverage.

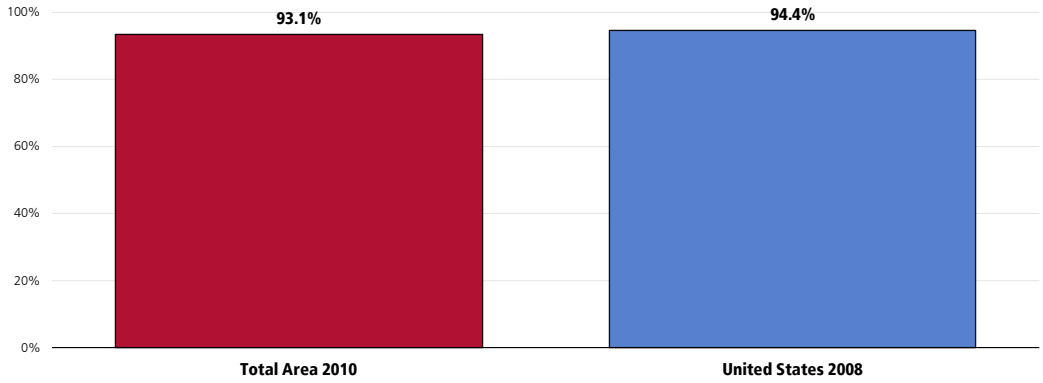
Prescription Drug Coverage

Among insured adults, 93.1% report having prescription coverage as part of their insurance plan.

- Comparable to the national prevalence (94.4%).
- Higher (98.9%) in the "Other" counties (not shown).

Insurance Covers At Least Partial Prescriptions

(Among Insured Respondents; Total Area, 2005-2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents with healthcare insurance coverage.

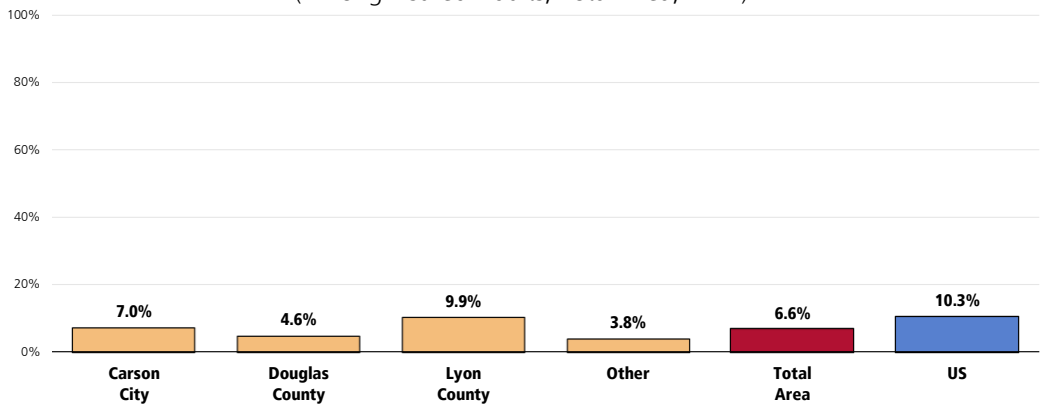
Recent Lack of Coverage

Further, among currently insured adults in the Total Area, 6.6% report that they were without healthcare coverage at some point in the past year.

- More favorable than US findings (10.3%).
- Statistically similar by county.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults; Total Area, 2010)

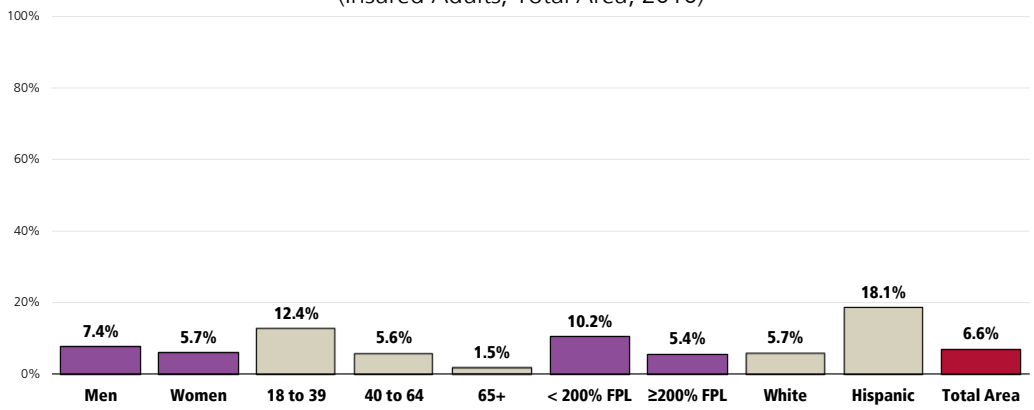


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 92]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all insured respondents.

Among insured adults: adults under age 40 and Hispanics are more likely to have gone without healthcare insurance coverage in the past year.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Insured Adults; Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 92]
Notes: Asked of all insured respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Lack of Health Insurance Coverage

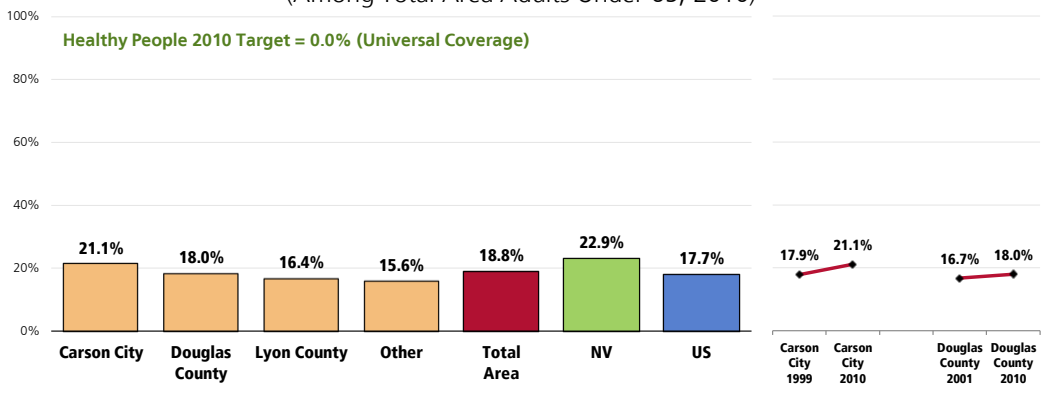
Here, lack of health insurance coverage reflects respondents aged 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults aged 18 to 64, 18.8% report having no insurance coverage for healthcare expenses.

- More favorable than state finding (22.9%).
- Similar to the national finding (17.7%).
- The Healthy People 2010 target is universal coverage (0% uninsured).
- Statistically similar by county.
- Statistically unchanged over time in both Carson City and Douglas County.

Lack of Healthcare Insurance Coverage

(Among Total Area Adults Under 65, 2010)



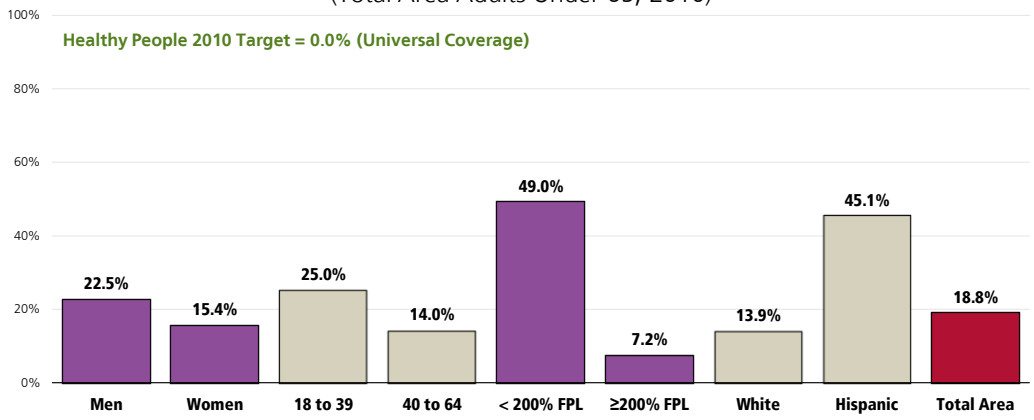
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 184]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Nevada data.
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-1]
Notes: Asked of all respondents under the age of 65.

The following population segments (under age 65) are more likely to be without healthcare insurance coverage:

- Men.
- Adults under age 40.
- Residents living at lower incomes (note the 49.0% uninsured prevalence among adults living below the 200% poverty threshold).
- Hispanics.

Lack of Healthcare Insurance Coverage

(Total Area Adults Under 65, 2010)

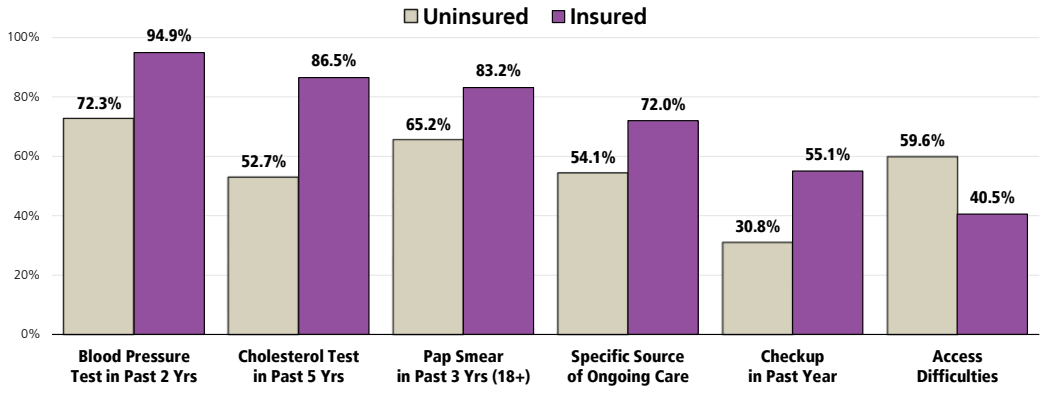


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 184]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-1]
Notes: Asked of all respondents under the age of 65.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

- As might be expected, uninsured adults in the Total Area are less likely to receive routine care and preventive health screenings, and are more likely to have experienced difficulties accessing healthcare.

Preventive Healthcare

(By Insured Status; Total Area, 2010)



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 18, 22, 50, 53, 96, 185, 186]
Notes: • Asked of all respondents.

Difficulties Accessing Healthcare

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States. Access to high-quality healthcare across each of the components in the continuum of care must be improved to realize the full potential of prevention. For example, success in reducing the burden of heart disease and narrowing the gap in heart disease outcomes between different racial groups will depend on several factors. These factors include ensuring access to clinical preventive services, such as blood pressure and cholesterol screening; effective primary care to educate people about modifiable risk factors, such as smoking, and to manage effectively chronic conditions like hypertension; high-quality emergency services to improve outcomes of acute cardiac events; and access to rehabilitative and long-term care for heart disease patients.

Improving access to appropriate preventive care requires addressing many barriers, including those that involve the patient, provider, and system of care. Patient barriers include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive care. Having health insurance, a high income, and a primary care provider are strong predictors that a person will receive appropriate preventive care.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

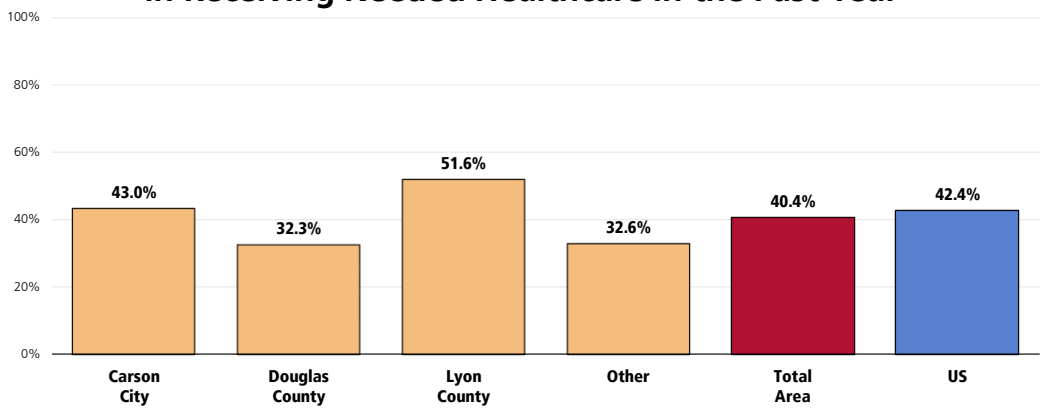
Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 40.4% of Total Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Similar to national findings (42.4%).
- Highest (51.6%) in Lyon County; lowest (most favorable) in Douglas County (32.3%).

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



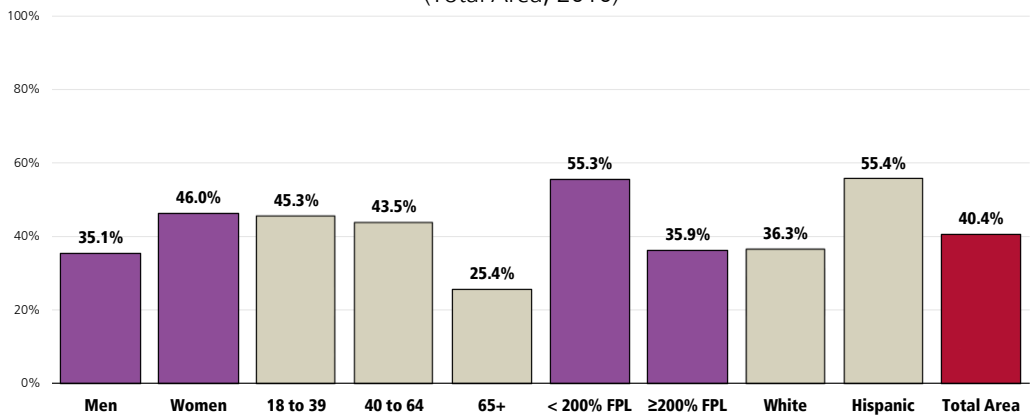
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-6]
Notes: Asked of all respondents.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults under the age of 65.
- Lower-income residents.
- Hispanics.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 186]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-6]

Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Barriers to Healthcare Access

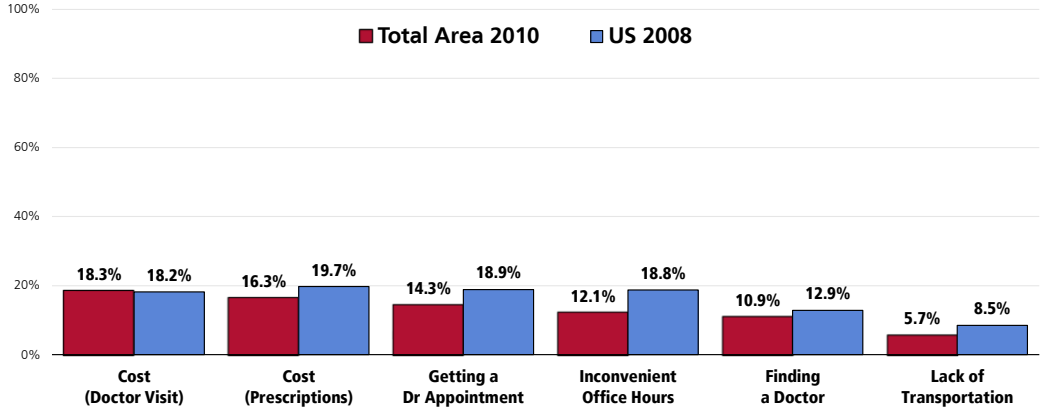
To better understand healthcare access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, cost of a physician visit impacted the greatest share of Total Area adults (18.3% say that cost prevented them from obtaining a visit to a physician in the past year).

The proportion of Total Area adults impacted was statistically comparable to or better than that found nationwide for each of the tested barriers.

Barriers to Access Have Prevented Medical Care in the Past Year



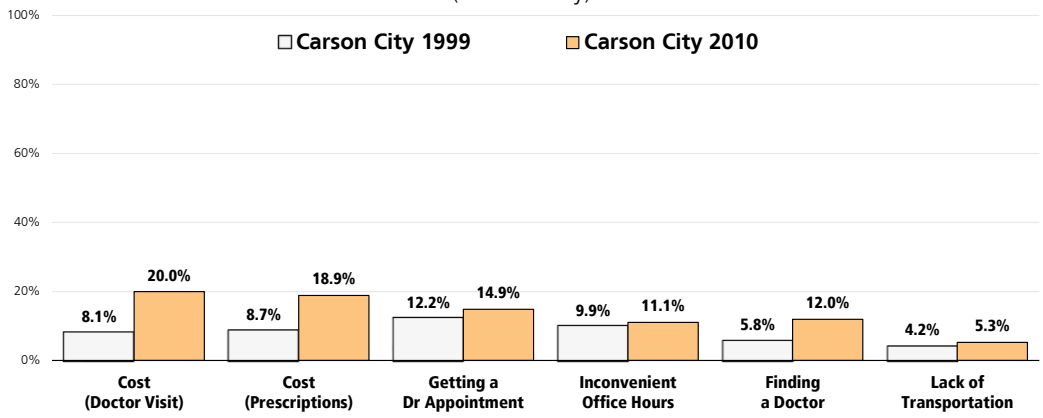
Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Compared to baseline 1999 data, Carson City has seen significant increases with regard to the barriers of **finding a physician** and **cost of both prescriptions and medical appointments**.

Trend in Access Barriers

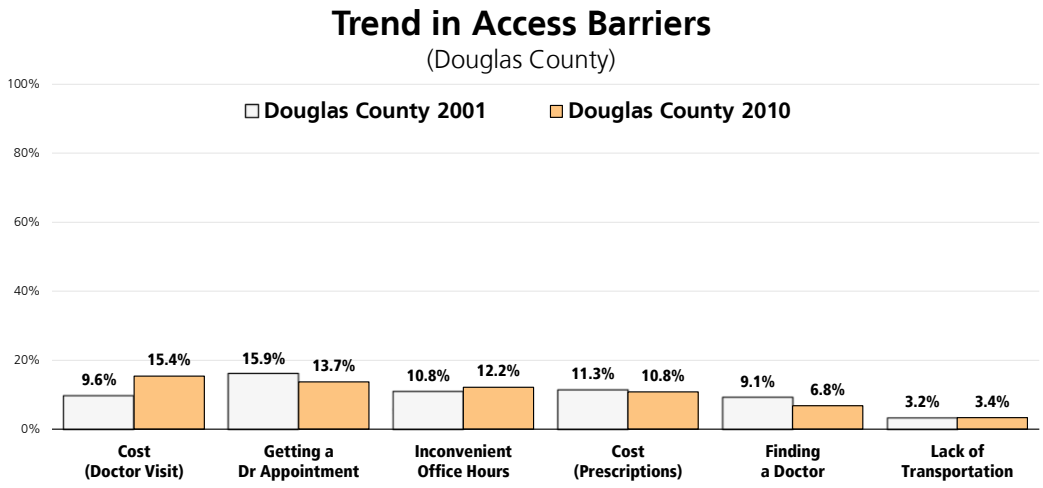
(Carson City)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12]

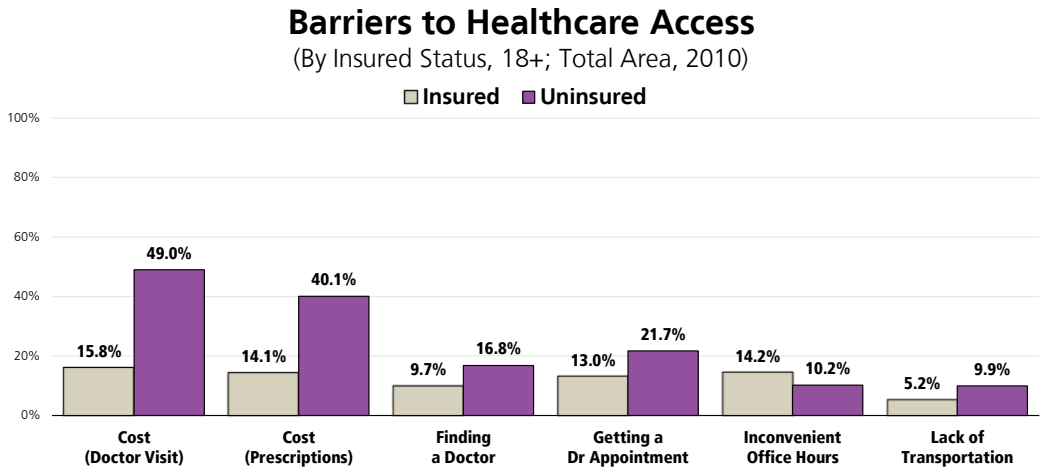
Notes:
- Asked of all respondents.

Compared to baseline 2001 data, Douglas County has seen a significant increase with regard to **cost as a barrier to physician visits**.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

As might be expected, Total Area adults without health insurance are much more likely to report access barriers related to cost when compared to the insured population.



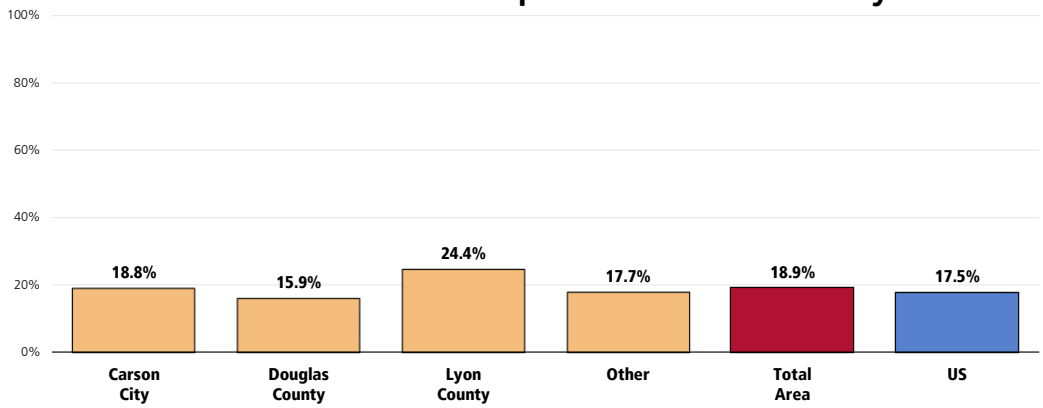
Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

Prescriptions

Among all Total Area adults, 18.9% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Similar to the 17.5% reported nationwide.
- Statistically similar by county.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



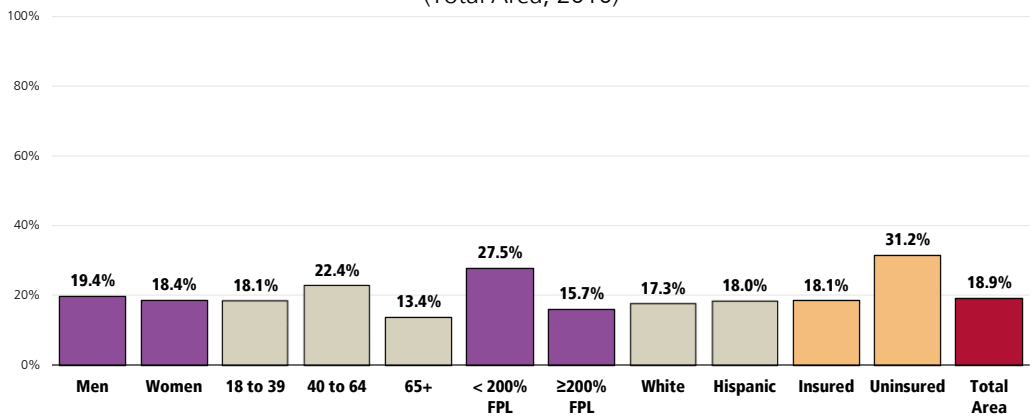
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Adults aged 40 to 64.
- Respondents with lower incomes.
- The uninsured population.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Accessing Healthcare for Children

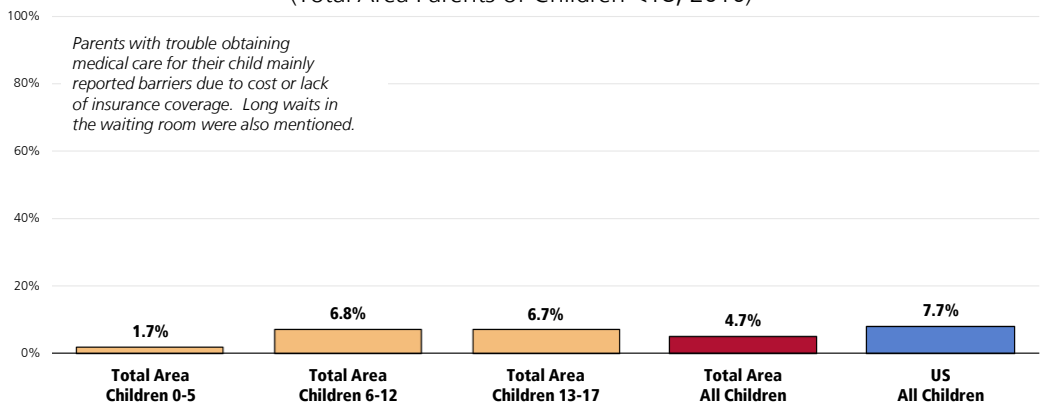
Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

A total of 4.7% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Statistically similar to the 7.7% reported nationwide.
- Similar by county (not shown).
- Lowest (1.7%) among parents of children under age 6.

Had Trouble Obtaining Medical Care for Child in the Past Year

(Total Area Parents of Children <18, 2010)



Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Items 129-130]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents with children under 18 at home.

Among the parents experiencing difficulties, the majority cited **cost or a lack of insurance** as the primary reason; other reasons cited included long waits in the waiting room.

Primary Care Services

Improving primary care across the nation depends in part on ensuring that people have a usual source of care. Having a primary care provider as the usual source of care is especially important because of the beneficial attributes of primary care. These benefits include the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. Increasing the number and proportion of members of underrepresented racial and ethnic groups who are primary care providers also is important because they are more likely to practice in areas where health services are in short supply and in areas with high percentages of underrepresented racial and ethnic populations.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

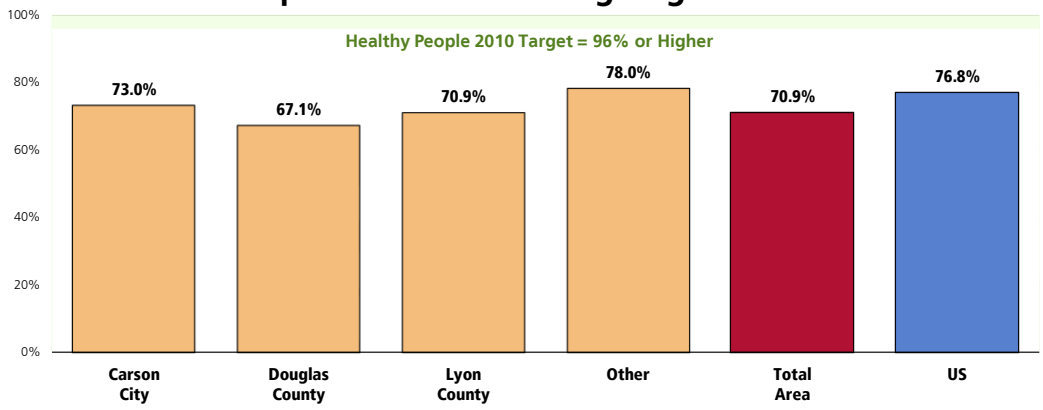
Specific Source of Ongoing Care

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. A hospital emergency room is not considered a source of ongoing care in this instance.

A total of 70.9% of Total Area adults were determined to have a specific source of ongoing medical care.

- Less favorable than national findings (76.8%).
- Fails to satisfy the Healthy People 2010 target (96% or higher).
- Statistically similar by county.

Have a Specific Source of Ongoing Medical Care



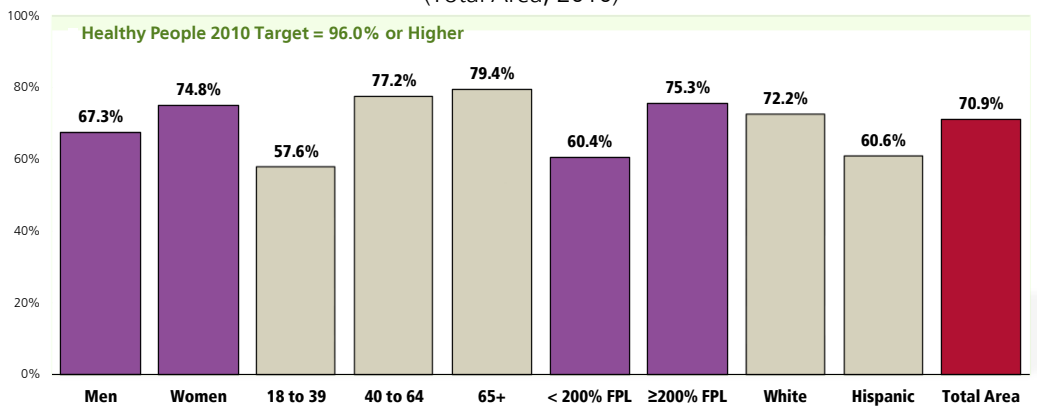
Sources: PRC Community Health Survey, Professional Research Consultants, Inc. [Item 185]
2008 PRC National Health Survey, Professional Research Consultants.
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-4]
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.

Have a Specific Source of Ongoing Medical Care

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 185]
Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-4]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

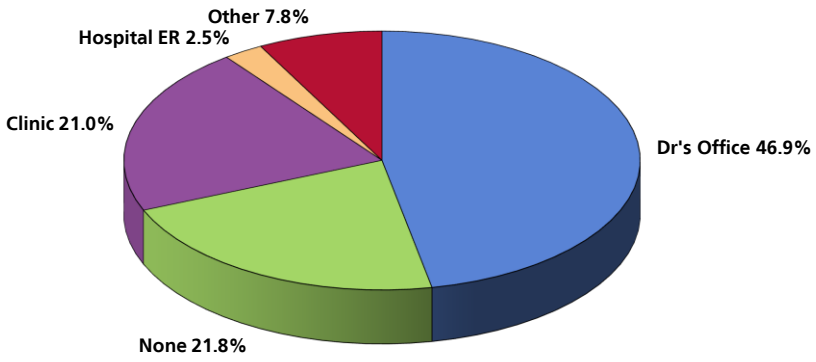
Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (46.9%) identified a particular doctor's office.

A total of 21.0% say they usually go to some type of clinic, while 2.5% rely on a hospital emergency room.

Particular Place Utilized for Medical Care

(Total Area, 2010)



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]
Notes: • Asked of all respondents.

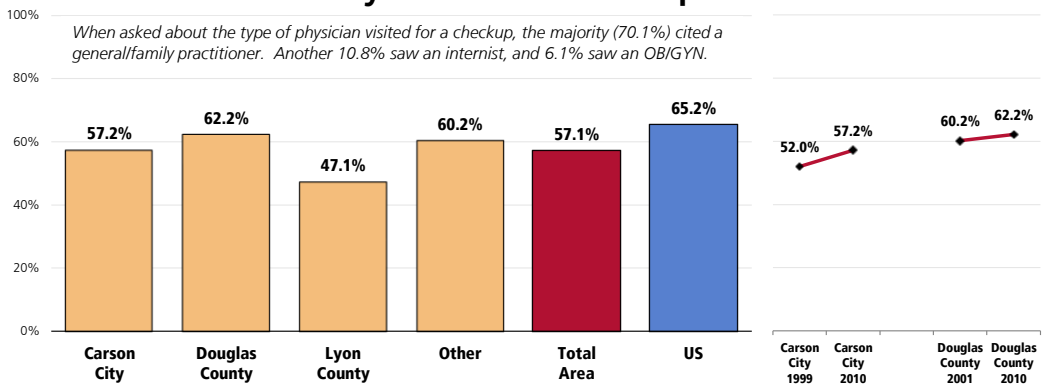
Utilization of Primary Care Services

Adults

A total of 57.1% of adults visited a physician for a routine checkup in the past year.

- Less favorable than national findings (65.2%).
- Highest in Douglas County; lowest in Lyon County.
- Statistically unchanged over time in both Carson City and Douglas County.

Have Visited a Physician for a Checkup in the Past Year



Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 18-19]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

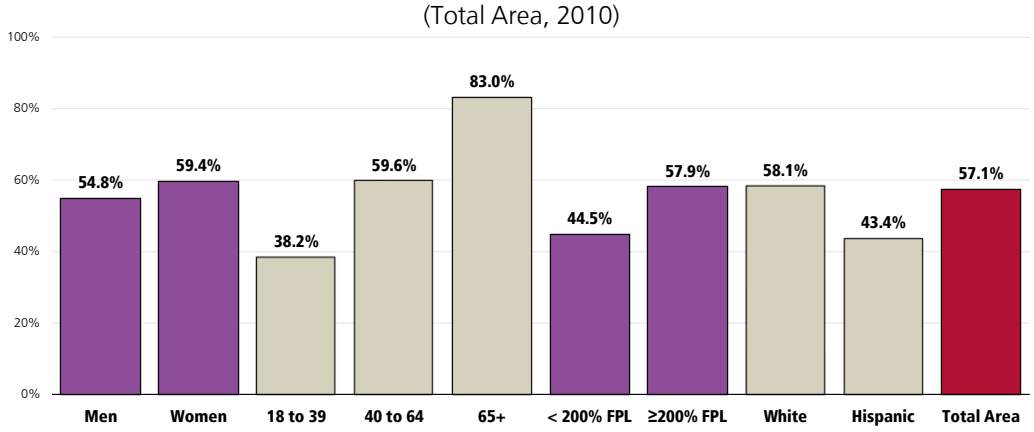
Types of physicians used for routine care primarily included **general/family practitioners** (70.1%), **internists** (10.8%) or **OB/GYNs** (6.1%). A total of 2.8% were uncertain, 2.7% said they used the "first doctor available," and the remainder cited a wide variety of specialists.

When viewed by demographic characteristics, the following populations are <u>less likely</u> to have received routine care in the past year:

- Younger residents (note the positive correlation with age).
- Lower-income respondents.

Have Visited a Physician for a Checkup in the Past Year

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

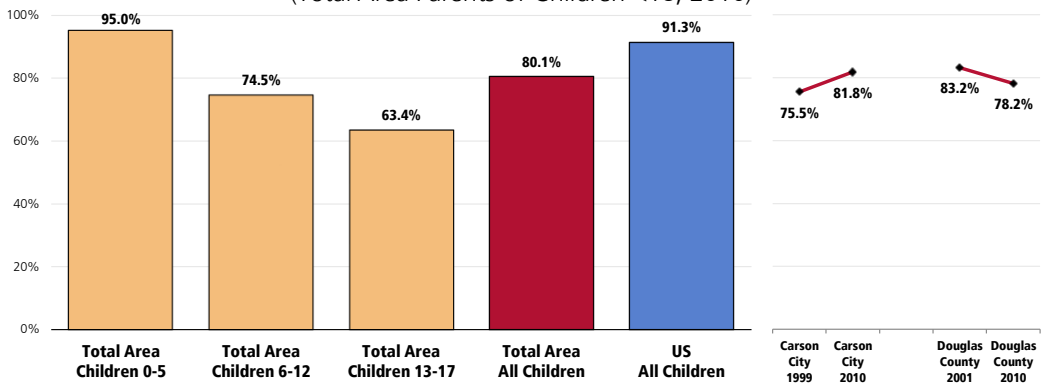
Children

Among surveyed parents, 80.1% report that their child has had a routine checkup in the past year.

- Lower than national findings (91.3%).
- Similar by county (not shown).
- Note that routine checkups are highest in the Total Area among children aged 0-5.
- Statistically unchanged over time among children of Carson City and Douglas County.

Child Has Visited a Physician for a Routine Checkup in the Past Year

(Total Area Parents of Children <18, 2010)



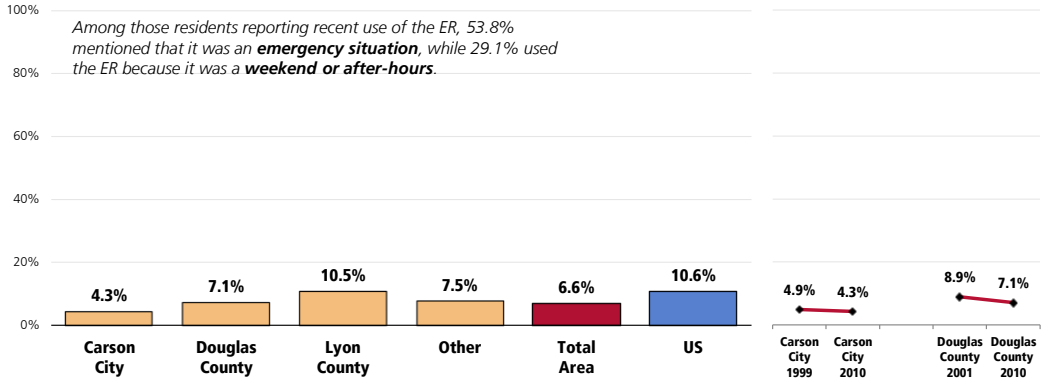
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 131]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents with children under 18 at home.

Emergency Room Utilization

A total of 6.6% of Total Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- More favorable than national findings (10.6%).
- Lowest among residents of Carson City.
- Statistically unchanged over time for both Carson City and Douglas County.

Have Used a Hospital Emergency Room More Than Once in the Past Year



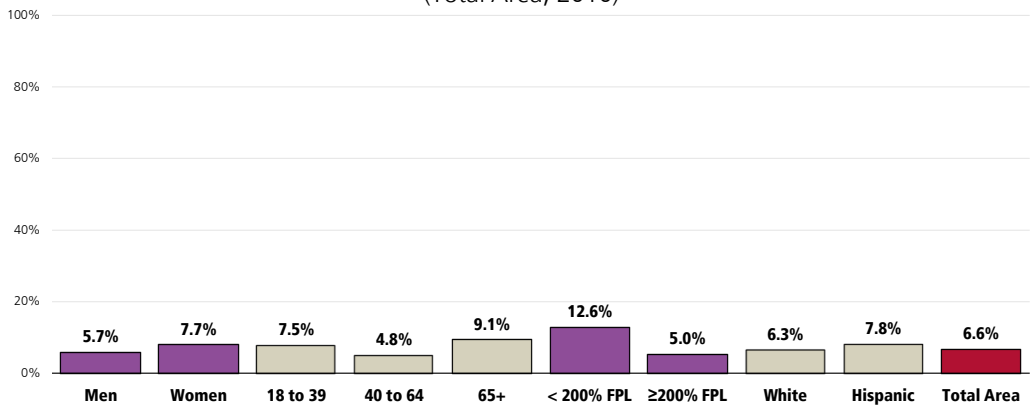
Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 25-26]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Of those using a hospital ER, 53.8% say this was due to an **emergency or life-threatening situation**, while 29.1% 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.

- Multiple ER visits were most often noted among residents living below the 200% poverty threshold.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 25]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

Oral Health

Oral health is an essential and integral component of health throughout life. No one can be truly healthy unless he or she is free from the burden of oral and craniofacial diseases and conditions.

Millions of people in the United States experience dental caries, periodontal diseases, and cleft lip and cleft palate, resulting in needless pain and suffering; difficulty in speaking, chewing, and swallowing; increased costs of care; loss of self-esteem; decreased economic productivity through lost work and school days; and, in extreme cases, death. Further, oral and pharyngeal cancers, which primarily affect adults over age 55 years, result in significant illnesses and disfigurement associated with treatment, substantial cost, and more than 8,000 deaths annually.

Poor oral health and untreated oral diseases and conditions can have a significant impact on quality of life. Millions of people in the United States are at high risk for oral health problems because of underlying medical or handicapping conditions, ranging from very rare genetic diseases to more common chronic diseases such as arthritis and diabetes. Oral and facial pain affects a substantial proportion of the general population.

Many persons in the United States do not receive essential dental services. Through increased access to appropriate and timely care, individuals can enjoy improved oral health. Barriers to care include cost; lack of dental insurance, public programs, or providers from underserved racial and ethnic groups; and fear of dental visits. Additionally, some people with limited oral health literacy may not be able to find or understand information and services.

In general, access to primary preventive and early intervention services must be improved, and barriers to the dental care system should be removed. Many persons of all ages are receiving professional services in the oral healthcare system, but more emphasis must be placed on vulnerable populations who need professional care.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

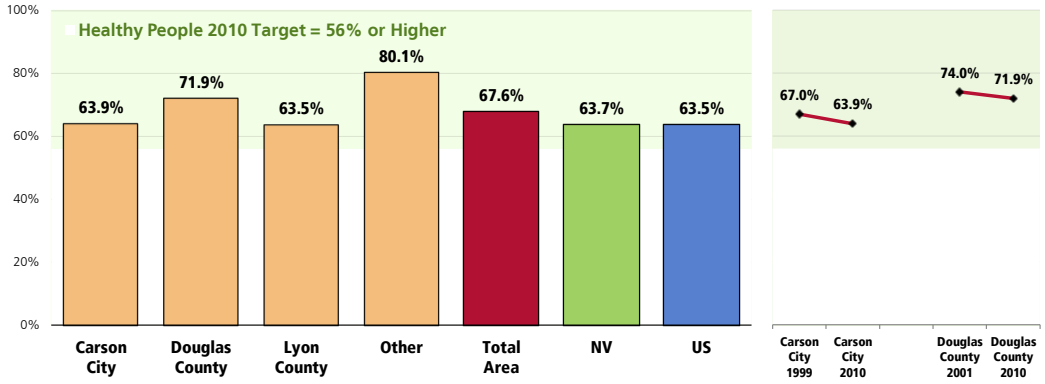
Dental Care

Adults

Just over two-thirds (67.6%) of Total Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- More favorable than the 63.7% reported statewide.
- Statistically similar to national findings (63.5%).
- Satisfies the Healthy People 2010 target (56% or higher).
- Highest (80.1%) among residents of the "Other" counties.
- Statistically unchanged over time in both Carson City and Douglas County.

Have Visited a Dentist or Dental Clinic Within the Past Year



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 23]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 21-10]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2008 Nevada Data.

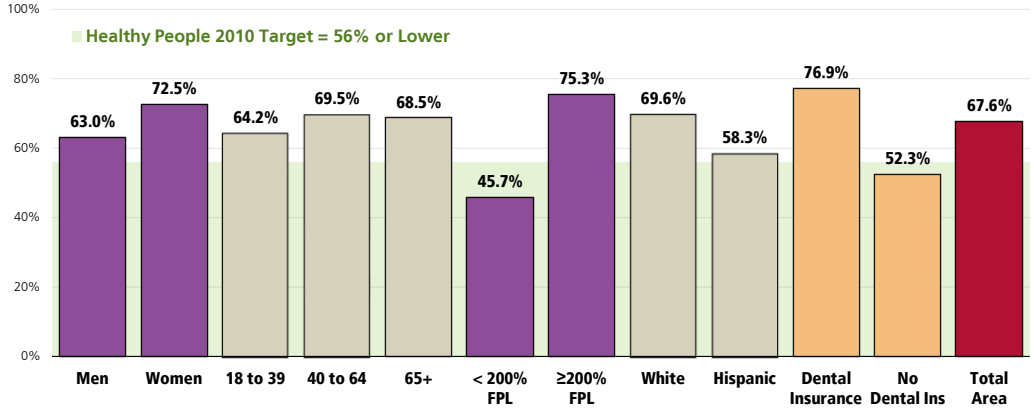
Notes:
- Asked of all respondents.

Note the following:

- Women are more likely than men to report a recent dental checkup.
- Persons living in the higher income category report much higher utilization of oral health services (persons below 200% of poverty fail to satisfy the Healthy People 2010 objective).
- 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

(Total Area, 2010)



Sources:
- 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 21-10]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.: very low income" = below poverty; low income" = 100% to 200% of poverty; "middle/high income" = over 200% of poverty.
- Asked of all respondents.

Children

A total of 80.4% of parents report that their child (aged 2 to 17) has been to a dentist or dental clinic within the past year.

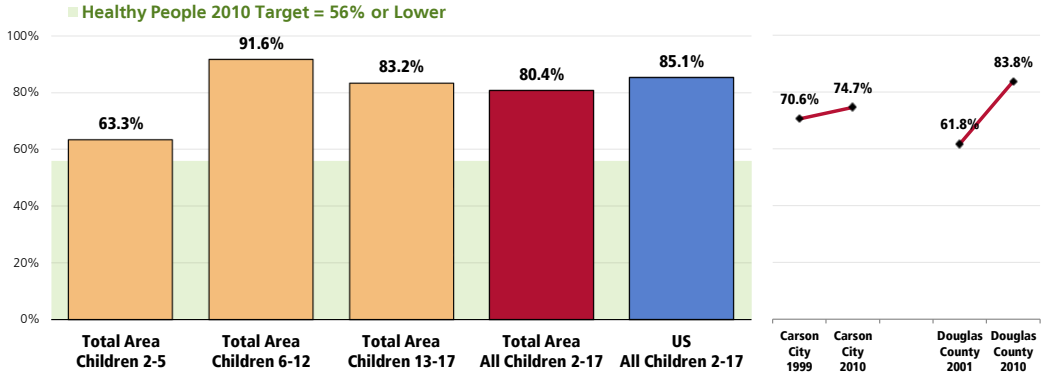
- Statistically similar to national findings (85.1%).
- Satisfies the Healthy People 2010 target (56% or higher).
- Similar among the counties (not shown).

Rregular dental care is notably lower among children aged 2 to 6.

While the prevalence among Carson City children has remained statistically unchanged over time, the Douglas County prevalence has increased significantly.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Asked of Adults With Children Aged 2-17; Total Area, 2010)



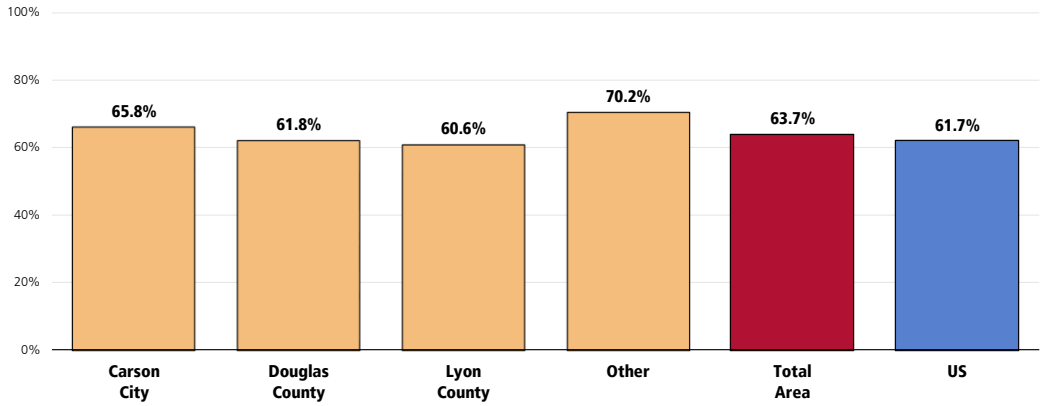
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 132]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.

Dental Insurance

Over 6 in 10 Total Area adults (63.7%) have dental insurance that covers all or part of their dental care costs.

- Similar to national findings (61.7%).
- Similar by county.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

Vision Care

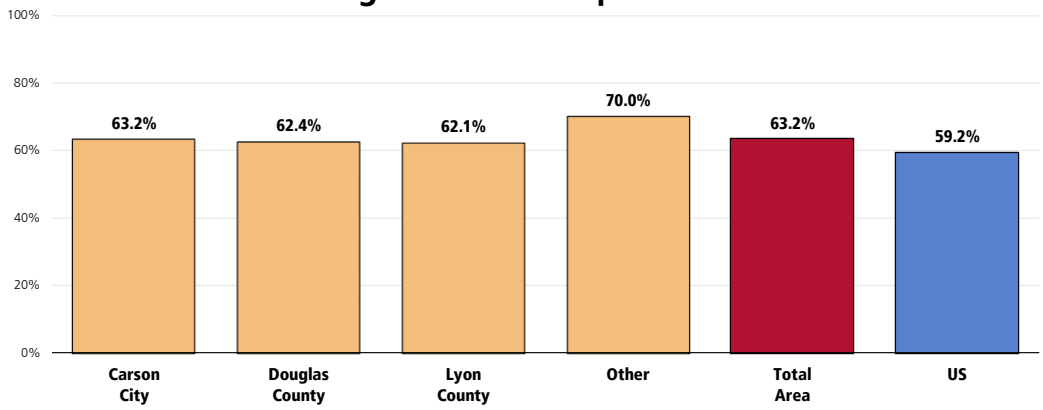
Many barriers still need to be overcome in reducing vision disorders. Among the major prevention strategies are educating healthcare professionals and the general population about the benefits of prevention, improving access to quality healthcare across socioeconomic classes to decrease disparities, and gaining cooperation of families in the screening and treatment of infants and children.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

A total of 63.2% of Total Area residents had an eye exam in the past two years during which their pupils were dilated.

- Statistically comparable to national findings (59.2%).
- Statistically comparable by county.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

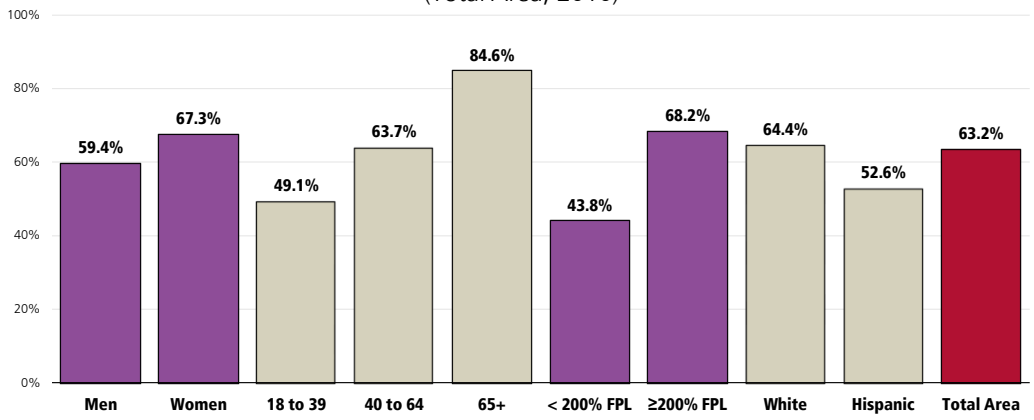


Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

- Recent vision care in the Total Area is more often reported among women and residents in the higher income breakout.
- Note also the positive correlation between age and recent eye exams.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

HEALTH EDUCATION & OUTREACH

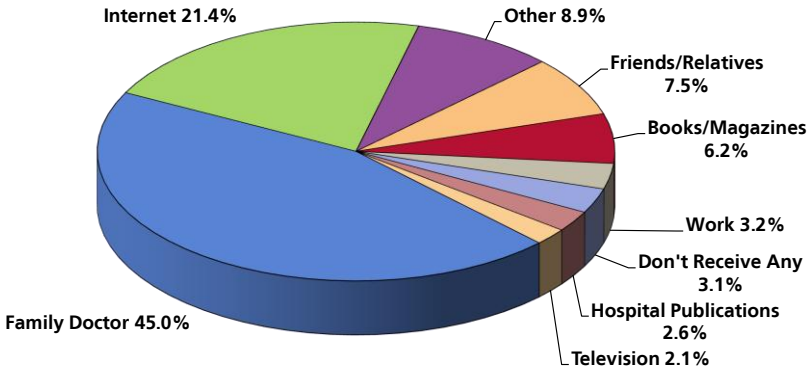
Healthcare Information Sources

Family physicians and the Internet are residents' primary sources of healthcare information.

- 45.0% of Total Area adults cited their **family physician** as their primary source of healthcare information, compared to 36.1% across the United States.
- The **Internet** received the second-highest response (21.4%), higher than the 17.4% nationally.
  - Other sources mentioned include friends and relatives (7.5%), books and magazines (6.2%) and work (3.2%).
- Note that 3.1% of survey respondents say that do not receive any healthcare information.

Primary Source of Healthcare Information

(Total Area, 2010)



Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: • Asked of all respondents.

Participation in Health Promotion Events

Educational and community-based programs have played an integral role in the attainment of Healthy People 2000 objectives and will continue to contribute to the improvement of health outcomes in the United States by the year 2010. These programs, developed to reach people outside traditional healthcare settings, are fundamental for health promotion and quality of life.

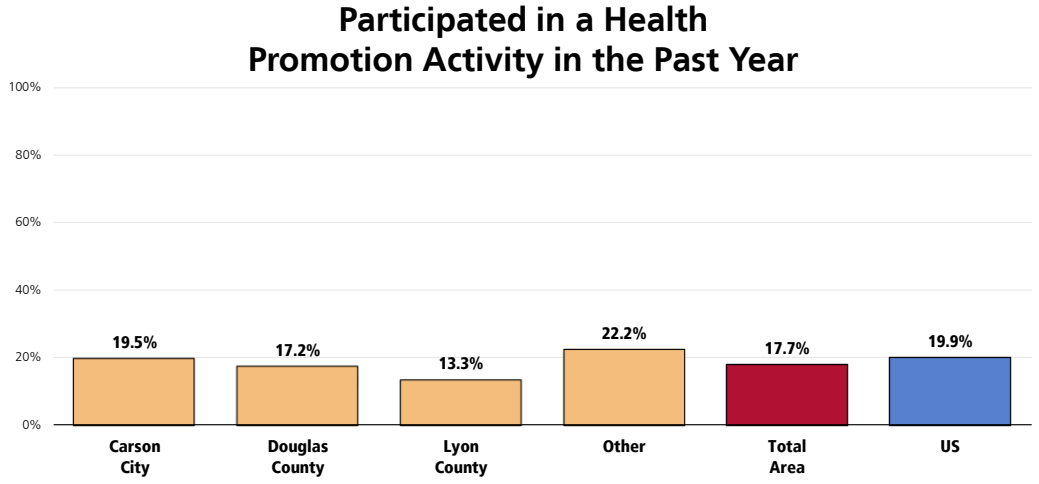
People working together can improve individual health and create healthier communities. Although more research is needed in community health improvement, clearly, the health of communities not only depends on the health of individuals but also on whether the physical and social aspects of communities enable people to live healthy lives.1 Health and quality of life rely on many community systems and factors, not simply on a well-functioning health and medical care system. Making changes within existing systems, such as the school system, can effectively and efficiently improve the health of a large segment of the community. Also, environmental and policy approaches, such as better street lighting and policies to fortify foods, tend to have a greater impact on the whole community than do individual-oriented approaches.

Communities experiencing the most success in addressing health and quality-of-life issues have involved many components of their community: public health, healthcare, business, local governments, schools, civic organizations, voluntary health organizations, faith organizations, park and recreation departments, and other interested groups and private citizens. Communities that are eager to improve the health of specific at-risk groups have found that they are more likely to be successful if they work collaboratively within their communities and if the social and physical environments also are conducive to supporting healthy changes.

– Healthy People 2010, 2nd Edition. US Department of Health and Human Services. Washington, DC: US Government Printing Office, November 2000.

A total of 17.7% of Total Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.

- Similar to the national prevalence (19.9%).
- Ranging from 22.2% in the "Other" counties to 13.3% in Lyon County.
- Note that 54.6% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer (not shown).



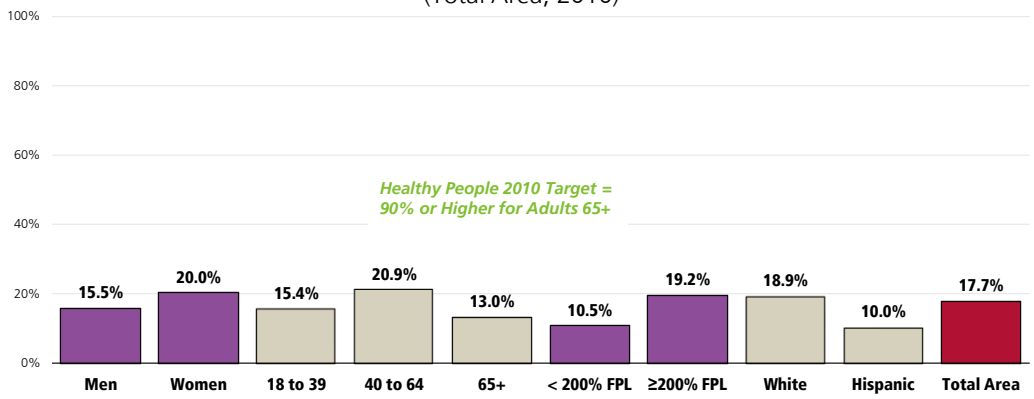
Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

The following chart outlines participation by various demographic characteristics.

- Note that adults aged 40-64, residents with higher incomes, and Non-Hispanic Whites more often report participation in health promotion activities.
- Healthy People 2010 has set a target that 90% or more of older adults (65+) participate in health promotion activities — in the Total Area, only 13.0% of older adults acknowledged doing so in the past year (similar to the 13.3% nationally).

Participated in a Health Promotion Activity in the Past Year

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
- Healthy People 2010. 2nd Edition. US Department of Health & Human Services. Washington, DC: US Government Printing Office, November 2000. [Objective 7-12]

Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.

PERCEPTIONS OF LOCAL HEALTHCARE

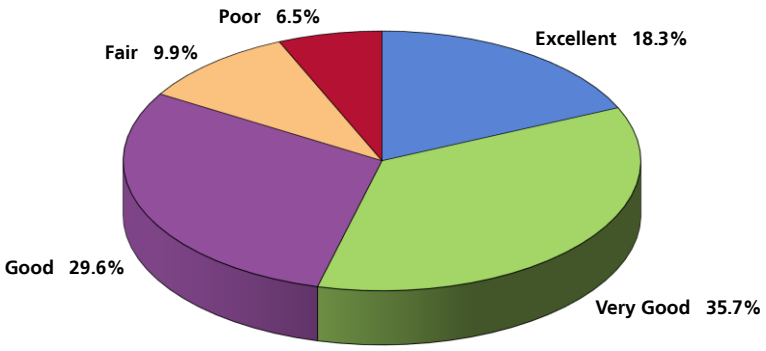
Ratings of Healthcare Services Available in the Community

Just under one-half of Total Area adults (54.0%) rate the overall healthcare services available in their community as "excellent" or "very good."

- More favorable than the 47.7% reported nationally.

Rating of Overall Healthcare Services Available in the Community

(Total Area, 2010)

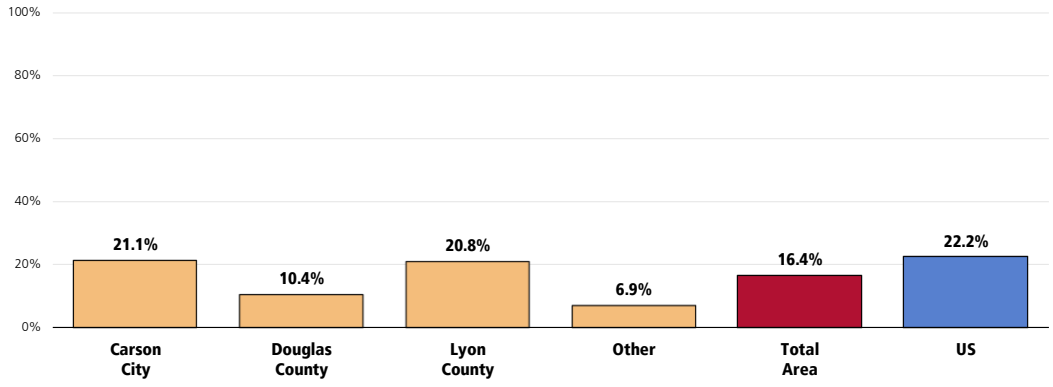


Sources: • 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 16.4% of Total Area residents characterize local healthcare services as "fair" or "poor."

- Much more favorable than the 22.2% prevalence reported nationally.
- Least favorable in Carson City; most favorable in Douglas County and the "Other" counties.

Perceive Local Healthcare Services as "Fair/Poor"

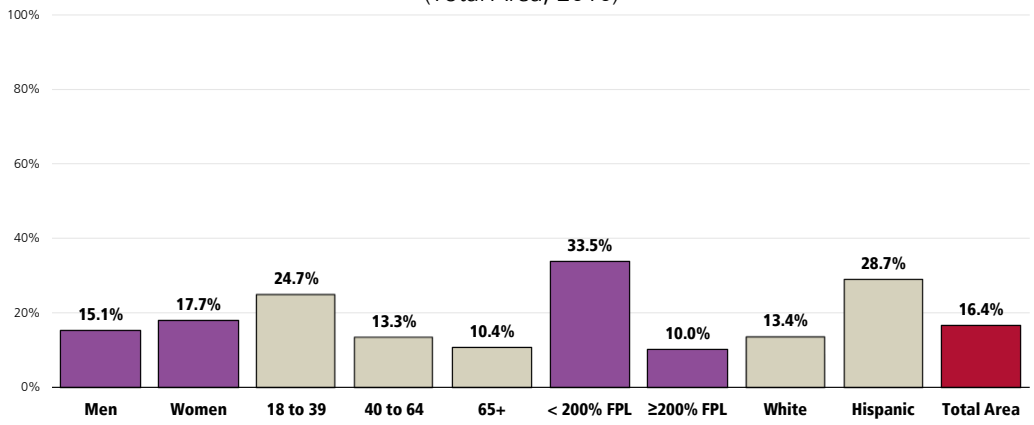


Sources: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]
2008 PRC National Health Survey, Professional Research Consultants.
Notes: Asked of all respondents.

- Note that lower-income residents are especially critical of local healthcare services.
- Higher percentages are also found among adults under age 40 and among Hispanics.

Perceive Local Healthcare Services as "Fair/Poor"

(Total Area, 2010)



Sources: 2010 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: Asked of all respondents.
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.