

2008 PRC COMMUNITY HEALTH ASSESSMENT

The Living Well Foundation Service Area

Caldwell Parish · Franklin Parish · Jackson Parish · Lincoln Parish ·
Morehouse Parish · Ouachita Parish · Richland Parish · Union Parish

Sponsored By

The Living Well Foundation

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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 a defined geographical region. Subsequently, this information may be used to formulate strategies 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

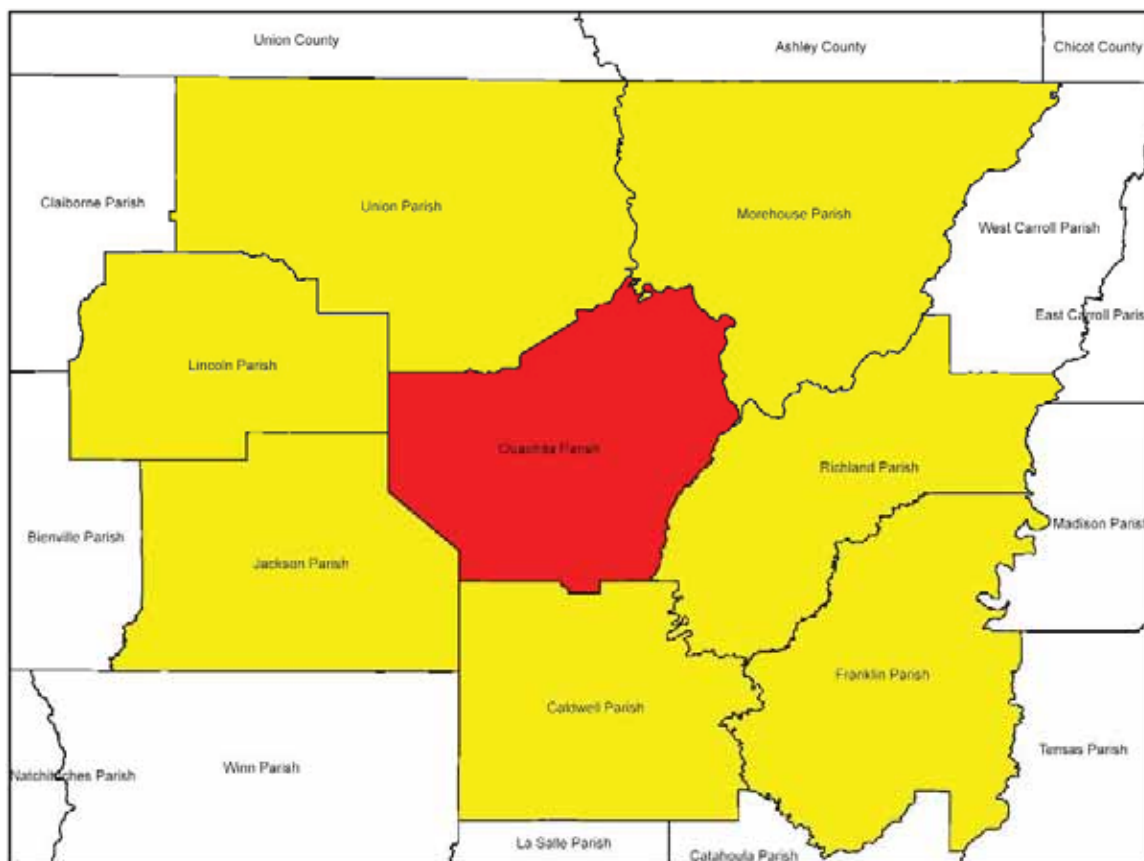
2008 PRC Community Health Survey

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 national health promotion and disease prevention objectives and other recognized health issues.

Community Defined for This Assessment

The study area for this effort is defined as **The Living Well Foundation (LWF) Service Area** in Northern Louisiana. The LWF Service Area includes Ouachita Parish, as well as the following surrounding parishes: Caldwell Parish, Franklin Parish, Jackson Parish, Lincoln Parish, Morehouse Parish, Richland Parish and Union Parish. *[Throughout this report, findings are reported for Ouachita Parish and for all other represented parishes combined; this is due to data availability or data reliability based on population and interviewing levels.]*



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the 2008 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.

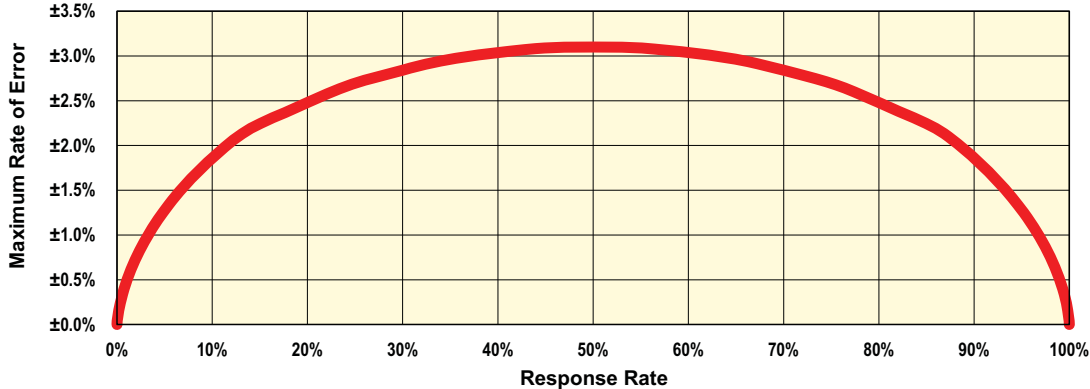
The sample design used for this effort consisted of a stratified sample of 1,000 individuals aged 18 and older in the defined region, including 400 interviews in Ouachita Parish and 600 interviews distributed proportionately among the remaining parishes. Once these data were collected, the sample was weighted in proportion to the actual population distribution at the parish level so that regional estimates reflect the area as a whole. Population estimates were based on census projections of adults aged 18 and over provided in the latest *ESRI BIS Demographic Portfolio*.

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 1,000 respondents is $\pm 3.1\%$ at the 95 percent level of confidence.

Expected Error Ranges for a Sample of 1,000 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 1,000 respondents answered a certain question with a "yes," it can be asserted that between 8.1% and 11.9% (10% \pm 1.9%) of the total population would offer this response.
 • If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.9% and 53.1% (50% \pm 3.1%) of the total population would respond "yes" if asked this question.

Sample Characteristics

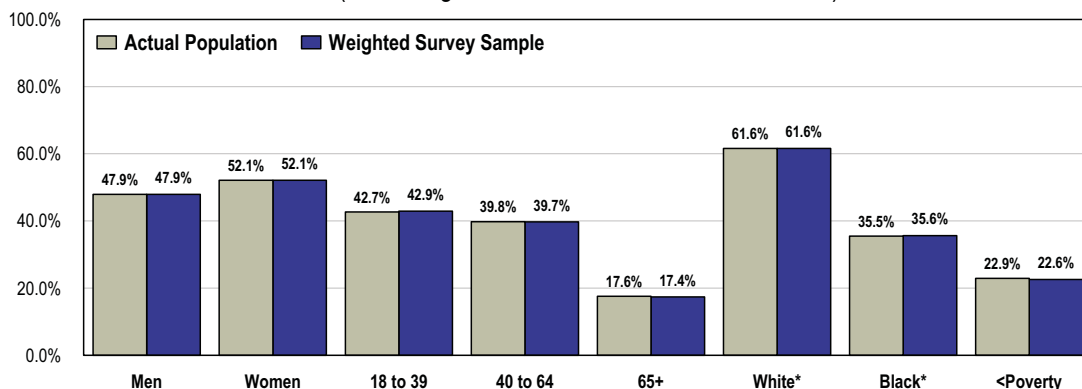
To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight"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

The following chart outlines the characteristics of the 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

(The Living Well Foundation Service Area, 2008)



Source:

- Census 2000, Summary File 3 (SF 3), U.S. Census Bureau.
- 2008 PRC Community Health Survey, Professional Research Consultants.
- Hispanic can be of any race.
- *White and Black sample percentages do not include Hispanic respondents who did not offer a race response.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the U.S. Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2007 guidelines place the poverty threshold for a family of four at \$20,650 annual household income or lower). In sample segmentation: “<FPL” (or “<Federal Poverty Level”) refers to community members living in a household with defined poverty status; “100-199% FPL” includes those households living just above the poverty level, earning up to twice the poverty threshold; and “200%+ FPL” refers to households with incomes more than twice the poverty threshold defined for their 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 LWF Service Area with a high degree of confidence.

Public Health, Vital Statistics and Other Data

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

- ☐ Centers for Disease Control & Prevention
- ☐ ESRI BIS Demographic Portfolio (Projections Based on Census 2000)
- ☐ FBI, Crime in the United States
- ☐ Louisiana State Center for Health Statistics
- ☐ National Center for Health Statistics
- ☐ Prevent Child Abuse Louisiana

Secondary data are based on parish-level data.

Louisiana Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local findings. These are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System)* data postings by the Centers for Disease Control and Prevention and the U.S. Department of Health & Human Services.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2005 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 U.S. population with a high degree of confidence.

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.



Community Focus Groups

As part of the community health assessment, there were five community focus groups held in the area. These focus groups included meetings with Physicians, Other Health Professionals, Business Leaders, Community Leaders and Social Services Providers.

A list of recommended participants for the focus groups was provided by The Living Well Foundation. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

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

DATE	TIME	GROUP	PARTICIPANTS
Dec. 17, 2007	7 AM	Community Leaders	16
Dec. 17, 2007	Noon	Business Leaders	6
Dec. 18, 2007	7 AM	Physicians	10
Dec. 18, 2007	Noon	Social Services Providers	15
Dec. 19, 2007	7 AM	Health Professionals	21

The focus group sessions were recorded on audio tapes from which verbatim comments in the report are taken. After each quote, the speaker's group is denoted; however, aside from this group affiliation, there are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

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

SUMMARY OF ASSESSMENT FINDINGS

COMPARISON WITH NATIONAL BENCHMARKS

Self-Reported Health Status

The LWF Service Area adults' self-reported assessments of their own mental health are similar to what is reported nationwide.

Unfavorable Compared to National Benchmarks

In comparison with national findings, findings in The Living Well Foundation Service Area are unfavorable in regards to:

- ☐ **Overall Health Status.** Area residents' ratings of their own overall physical health are less favorable than Americans overall.
- ☐ **Depression.** Area residents also reported higher prevalence of chronic depression, and fewer depressed persons seeking professional help.
- ☐ **ADD/ADHD.** The prevalence of children taking medication for ADD/ADHD is higher in the LWF Service Area than found nationally.

Death & Disability

Favorable Compared to National Benchmarks

In comparison with national findings, there are many positive indicators relative to injury and disease in the LWF Service Area. Note this finding with regard to **cancer**: the LWF Service Area fares better with regard to the self-reported prevalence of women 40+ receiving mammograms.

Among **injury-related** variables, the community fares better than the nation in terms of: seat belt usage among children, as well as death rates due to suicide.

Regarding **environmental health**, the percentage of the LWF Service Area adults with mold in the home is more favorable than that reported nationally.

With regard to **immunization and infectious disease**, flu shots vaccinations are more prevalent among high-risk community adults aged 18 to 64 when compared with the national proportion. Also, the hepatitis C rate is lower than that found across the United States.

Lastly, with regards to **sexually-transmitted diseases**, the area's primary and secondary syphilis rate is below the national average.

Unfavorable Compared to National Benchmarks

However, the LWF Service Area compares unfavorably to national findings in the following regards:

- ❑ **Arthritis & Osteoporosis.** Community members in the LWF Service Area are more likely than adults nationwide to suffer from arthritis/ rheumatism.
- ❑ **Cancer.** The LWF Service Area cancer death rate is higher than that seen nationally (including lung cancer). Also colorectal screening (blood stool tests) among area adults 50+ is less prevalent than seen nationally.
- ❑ **Crime.** Survey respondents in the LWF Service Area are more likely than adults nationally to have been victims of a violent crime in the past five years. Also, the LWF Service Area homicide rate exceeds that reported across the U.S.
- ❑ **Diabetes.** The area age-adjusted death rate from diabetes is much higher than the national rate. Similarly, area residents are also more likely to have been diagnosed with diabetes.
- ❑ **Heart Disease.** The prevalence of community members with hypertension is less favorable than that reported across the nation. Cholesterol screening levels are less favorable than seen among adults nationwide. Also, the age-adjusted death rate from heart disease is higher in the LWF Service Area than seen nationally.
- ❑ **HIV.** The incidence of AIDS in the LWF Service area is higher than the national incidence.
- ❑ **Injury Control.** Age-adjusted death rates from unintentional injuries (including motor vehicle accidents) are higher in the LWF Service Area when compared with those nationwide. Also, the ratio of LWF Service Area homes with unlocked, loaded firearms exceeds that reported nationally, as well as the proportion of area residents possessing firearms in the home (including homes with children). Also, area children are less likely than their national counterparts to wear a bicycle helmet while riding a bike.
- ❑ **Respiratory Disease.** The LWF Service Area has higher proportions of sinusitis, chronic lung disease, and asthma when compared to the United States overall. Also, the age-adjusted death rate from pneumonia/influenza is higher in the LWF Service Area than seen nationally. Area tuberculosis incidence rates are higher than rates seen nationally.
- ❑ **Sexually Transmitted Disease.** The LWF Service Area has higher hepatitis B, chlamydia, and gonorrhea incidence rates when compared to rates for the United States.
- ❑ **Vision.** Area residents are more likely to suffer from blindness or trouble seeing. Similarly, residents in the LWF Service Area are less likely to have had an eye exam (in which the pupils are dilated) in the past two years.

Births

Unfavorable Compared to National Benchmarks

- ❑ **Birth Outcomes.** The incidence rates of low-weight births and infant deaths are each higher in the LWF Service Area than reported nationally.
- ❑ **Unplanned Pregnancies.** Births to unwed mothers and births to teen mothers are each higher than recorded nationally.

Modifiable Health Risks

Favorable Compared to National Benchmarks

In comparison to national averages, positive findings relating to modifiable health risk behavior in the LWF Service Area include a lower prevalence of current drinking and binge drinking, and a lower death rate due to liver disease/cirrhosis.

Unfavorable Compared to National Benchmarks

In contrast, note the following negative findings:

- ❑ **Child Overweight.** The LWF Service Area ratio of overweight children is more than twice the prevalence reported nationally.
- ❑ **Nutrition.** Area adults are less likely than adults nationwide to report regular vegetable consumption.
- ❑ **Overweight.** Area adults are more likely to be obese when compared to adults nationwide. Similarly, area overweight residents are less likely to report using diet and exercise to lose weight.
- ❑ **Physical Activity & Fitness.** Area residents are less likely to participate in regular, moderate- or vigorous-intensity physical activity compared to their national counterparts. Likewise, the LWF Service Area residents are less likely to meet physical activity recommendations than are Americans overall.
- ❑ **Substance Abuse.** When compared to results nationally, area residents are more likely to report drinking and driving or riding with a driver who has had too much to drink.
- ❑ **Tobacco.** Smokers in the LWF Service Area are less likely than their national counterparts to have received advice from a health professional to quit smoking in the past year. Also, area residents are more likely to use smokeless tobacco products.

Access to Healthcare Services

Access is a key issue for communities across the country. Barriers such as cost, transportation, insurance acceptance, physician and appointment availability, and inconvenient office hours are prohibitive factors for many residents. Further, it is important to understand how these barriers impact various subsegments of the population, particularly low-income residents.

Favorable Compared to National Benchmarks

Positive survey findings related to access in the LWF Service Area include higher ratios of medical checkups for children in the past year. Area children are also more likely to have visited a dentist in the past year.

Unfavorable Compared to National Benchmarks

On the other hand, note the following negative findings in comparison with national benchmarks:

- ❑ **Barriers to Access.** Survey respondents in the LWF Service Area are more likely than adults nationwide to report difficulty accessing healthcare in the past year (especially in the areas of transportation, office hours, availability of physicians, and cost of prescriptions and physician visits).

- ❑ **Dental Health.** Area residents are less likely than adults nationwide to have recently visited a dentist.
- ❑ **Dental Insurance.** The LWF Service Area residents are less likely than adults nationwide to have insurance coverage for their dental needs.
- ❑ **Emergency Room Visits.** Area residents are more likely than adults across the nation to have visited an emergency room for care more than once in the past year.
- ❑ **Health Insurance Coverage.** Area adults (18 to 64) are less likely than U.S. adults to be covered by health insurance. Area Medicare recipients are less likely to have supplemental insurance when compared to Medicare recipients nationwide.
- ❑ **Local Healthcare Ratings.** Adults in the LWF Service area rate healthcare in their community lower than Americans do overall.
- ❑ **Specific Source for Care.** Survey respondents in the LWF Service Area are less likely than U.S. adults to have a specific source for ongoing medical care.

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 area 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

Death, Disease & Disability

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Injury & Violence
- ☐ Depression
- ☐ Respiratory Disease
- ☐ Sexually Transmitted Diseases
- ☐ Vision Care

Maternal, Infant & Child Health

- ☐ Infant Deaths
- ☐ Low-Weight Births
- ☐ Unplanned/Teen Pregnancies

Modifiable Health Risks

- ☐ Physical Activity
- ☐ Nutrition
- ☐ Overweight & Obesity (Children and Adults)

Access to Healthcare Services

- ☐ Barriers to Access (Including Health Insurance Coverage)
- ☐ Emergency Room Services
- ☐ Oral Health

Selecting Health Priorities

There are various mechanisms through which individual organizations may wish to identify priority areas, such as through community direction and feedback, through analyses of primary and secondary data, or through a combination of the two. Regardless of which mechanism is applied, a variety of criteria must be considered when identifying priority areas, and these are outlined below. Keep in mind that no single criterion determines a specific area of need. Rather, the interplay among the different criteria should be considered in identifying priority areas.

Furthermore, it is important to recognize two important facts: 1) that many local efforts are currently active in addressing aspects of several of the outlined issues; and 2) that no individual or organization acting alone can remedy all of the implications of a given issue or problem. In identifying priorities for community action and designing strategies for implementation, a variety of criteria should be applied to the consideration process, including:

- **Impact.** The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Magnitude.** The number of persons affected, also taking into account variance from benchmark data and Year 2010 targets.
- **Seriousness.** The degree to which the problem leads to death, disability or impairs one's quality of life.
- **Feasibility.** The ability of organizations to reasonably impact the issue, given available resources.
- **Consequences of Inaction.** The risk of exacerbating the problem by not addressing at the earliest opportunity.

The following section provides a series of summary tables detailing health indicators for the community.

SUMMARY TABLES

The following tables provide an overview of indicators in the LWF Service Area, including individual analyses of the geographic subareas. These data are grouped to correspond with the Focus Areas presented in Healthy People 2010.

Reading the Summary Tables

- In the following charts, the LWF Service Area results are shown in the larger, blue column.
- The green columns [to the left of the LWF Service Area column] provide comparisons between the geographic subareas, identifying differences as “better than” (☀️), “worse than” (☹️), or “similar to” (☁️) the combined opposing areas.
- The columns to the right of the LWF Service Area column provide comparisons between the LWF Service Area and any available state and national findings, as well as Healthy People 2010 targets. Again, symbols indicate whether the LWF Service Area compares favorably (☀️), unfavorably (☹️), or comparably (☁️) to these external data.

Access to Healthcare Services	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Lack Health Insurance (Aged 18-64)	☁️ 25.4	☁️ 23.6
% Have Supplemental Insurance (Medicare Recipients)	☁️ 60.6	☁️ 68.3
% Healthcare Plan Covers Prescriptions (Among Insured)	☁️ 87.7	☀️ 92.2
% Went Without Healthcare Coverage Last Year (Insured)	☁️ 12.0	☁️ 10.7
% Difficulty Accessing Healthcare in Past Year	☁️ 46.1	☁️ 44.0
% Difficulty Finding Physician in Past Year	☁️ 14.2	☁️ 10.3
% Difficulty Getting Appointment in Past Year	☁️ 16.8	☁️ 18.0
% Inconvenient Hrs Prevented Dr Visit in Past Year	☁️ 18.5	☁️ 16.3
% Transportation Prevented Dr Visit in Past Year	☁️ 11.5	☁️ 11.8
% Cost Prevented Physician Visit in Past Year	☁️ 23.1	☁️ 19.7
% Cost Prevented Getting Rx in Past Year	☁️ 24.1	☁️ 27.0
% Skipped Rx Doses to Save Costs	☁️ 23.4	☁️ 23.1
% Difficulty Getting Child's Healthcare in Past Year	☁️ 8.6	☁️ 3.5
% Have a Specific Source of Ongoing Care	☹️ 69.6	☀️ 80.3
% Have Had Routine Checkup in Past Year	☁️ 68.9	☁️ 69.4
% Child Has Had Checkup in Past Year	☀️ 89.8	☹️ 81.1
% Gone to ER More Than Once in Past Year	☁️ 14.0	☁️ 11.2
% Rate Local Healthcare "Excellent/Very Good"	☁️ 41.2	☁️ 40.1

Note: Ouachita Parish and Other Parishes (combined) are compared against one another.

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
24.4	☁️ 25.4	☹️ 20.0	☹️ 0.0
64.9		☹️ 78.3	
90.1		☁️ 90.6	
11.3		☁️ 8.9	
45.0		☹️ 35.4	☹️ 7.0
12.1		☹️ 8.6	
17.4		☁️ 15.3	
17.3		☹️ 11.7	
11.7		☹️ 6.2	
21.3	☹️ 17.7	☹️ 13.0	
25.6		☹️ 15.5	
23.2			
6.0		☁️ 6.1	
75.2		☹️ 79.9	☹️ 96.0
69.2	☹️ 76.2	☁️ 65.6	
85.4		☀️ 76.6	
12.5		☹️ 5.9	
40.6		☹️ 56.6	

Legend: ☁️ blank no data, ☀️ favorable, ☹️ unfavorable, ☁️ similar

Arthritis, Osteoporosis & Chronic Pain	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Arthritis/Rheumatism	23.6	29.9
% Osteoporosis	5.6	4.7
% Sciatica/Chronic Back Pain	22.8	20.1
% Migraine/Severe Headaches	20.9	19.3
% Chronic Neck Pain	11.4	7.9
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
26.9	26.7	22.7	
5.1		5.4	
21.3		21.0	
20.1		20.5	
9.6		8.6	
-blank-no data favorable unfavorable similar			

Cancer	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
Cancer (Age-Adjusted Death Rate)	194.5	218.5
Lung Cancer (Age-Adjusted Death Rate)	57.6	68.4
Female Breast Cancer (Age-Adjusted Death Rate)	28.9	29.0
% Skin Cancer	6.0	4.9
% Cancer (Other Than Skin)	5.2	5.7
% Sigmoid/Colonoscopy Ever (Aged 50+)	69.9	61.0
% Blood Stool Test in Past 2 Yrs (Aged 50+)	31.0	22.8
% Mammogram in Past 2 Years (Women 40+)	78.8	78.3
% Pap Smear in Past 3 Years (Women)	83.5	79.9
% Prostate Exam in Past 2 Years (Men 50+)	77.3	80.5
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
207.6	220.8	191.1	159.9
63.4	66.5	54.3	44.8
28.7	29.4	28.0	22.3
5.4		4.7	
5.4		6.8	
64.6	49.8	65.4	50.0
26.2	24.2	36.7	50.0
78.5	75.8	70.2	70.0
81.6	84.5	79.2	90.0
79.2		85.1	
-blank-no data favorable unfavorable similar			

Diabetes	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
Diabetes Mellitus (Age-Adjusted Death Rate)	71.8	47.5
% Diabetes/High Blood Sugar	14.1	13.8
%(Diabetics) Taking Insulin/Medication	87.8	69.7
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
57.8	41.0	25.1	15.1
13.9	9.2	10.2	
78.3		78.1	
-blank-no data favorable unfavorable similar			

Disability	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Activity Limitations	19.9	20.5
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
20.2	18.6	19.8	
-blank-no data favorable unfavorable similar			

Education & Community-Based Programs	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Attended Health Event in Past Year (Aged 65+)	8.2	8.9
% Attended Employer-Sponsored Health Event (Employed)	18.7	14.5
<small>Note: Ouachita Parish and Other Parishes (combined) are compared against one another.</small>		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
8.6		7.4	90.0
16.6		13.5	75.0
<small>-blank-no data favorable unfavorable similar</small>			

Environmental Health	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Attribute Illness in Past Year to Indoor Air Quality	16.4	17.4
% Have Mold in the Home	3.5	4.0
% Attribute Illness in Past Year to Outdoor Air Quality	7.0	5.1
<small>Note: Ouachita Parish and Other Parishes (combined) are compared against one another.</small>		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
16.9		18.8	
3.8		6.2	
6.0		7.9	
<small>-blank-no data favorable unfavorable similar</small>			

Family Planning	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% of Births to Unwed Mothers	50.2	44.5
% Births to Teenagers	15.6	17.2
<small>Note: Ouachita Parish and Other Parishes (combined) are compared against one another.</small>		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
47.4	47.9	34.8	
16.4	15.1	10.4	
<small>-blank-no data favorable unfavorable similar</small>			

Heart Disease & Stroke	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
Diseases of the Heart (Age-Adjusted Death Rate)	246.3	298.1
Stroke (Age-Adjusted Death Rate)	52.7	57.2
% Chronic Heart Disease	7.1	8.1
% Stroke	3.9	2.8
% Blood Pressure Checked in Past 2 Years	96.2	95.3
% Told Have High Blood Pressure	37.7	44.3
% Taking Action to Control High Blood Pressure	94.5	94.8
% Cholesterol Checked in Past 5 Years	84.0	79.7
% Told Have High Cholesterol	30.0	28.2
% Taking Action to Control High Blood Cholesterol	83.2	81.8
% 1+ Cardiovascular Risk Factor	88.6	90.4
<small>Note: Ouachita Parish and Other Parishes (combined) are compared against one another.</small>		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
275.2	268.1	233.1	213.7
55.2	61.3	53.2	48.0
7.6	7.9	8.2	
3.3	3.2	2.4	
95.7		94.6	95.0
41.2	29.4	34.2	16.0
94.7		93.4	95.0
81.8	73.9	86.8	80.0
29.1	23.2	32.9	17.0
82.5		81.2	
89.5	85.1	88.5	
<small>-blank-no data favorable unfavorable similar</small>			

HIV	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
HIV (Age-Adjusted Death Rate)	6.0	3.0
AIDS Incidence/100,000	22.9	13.6
% Ever Tested for HIV (Ages 18-64)	55.9	44.2
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
4.5	8.8	4.7	0.7
18.1	20.7	14.8	1.0
49.8	41.8	54.4	

Immunization & Infectious Disease	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
Hepatitis C, non-A non-B Incidence/100,000	0.0	0.0
% Flu Shot in Past Yr (Aged 65+)	72.5	71.3
% Flu Shot in Past Yr (High-Risk Aged 18-64)	40.2	32.8
% Pneumonia Vaccine Ever (Aged 65+)	72.8	72.9
% Pneumonia Vaccine Ever (High-Risk Aged 18-64)	30.6	34.0
Tuberculosis Incidence/100,000	5.4	6.8
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
0.0	0.1	0.3	1.0
71.8	62.4	71.5	90.0
36.2		22.4	60.0
72.9	71.4	74.2	90.0
32.4		26.3	60.0
6.1	5.4	4.8	1.0

Injury & Violence	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
Unintentional Injury (Age-Adjusted Death Rate)	44.9	60.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)	16.7	33.0
% "Always" Wear Seat Belt	84.1	74.5
% Child (Aged 0-4) "Always" Uses Auto Child Restraint	97.5	97.4
% Child (Aged 5-17) "Always" Uses Seat Belt	88.8	85.0
% Child (Aged 0-17) "Always" Uses Seat Belt/Car Seat	91.4	88.5
% Child "Always" Wears Bicycle Helmet (Aged 5-16)	15.6	16.9
% Firearm in Home	51.1	60.4
% Homes With Children With a Firearm	43.6	52.7
% Homes w/Unlocked Loaded Firearm	28.8	22.9
Homicide (Age-Adjusted Death Rate)	7.8	6.7
Suicide (Age-Adjusted Death Rate)	8.6	8.9
% Victim of Violent Crime in Past 5 Years	6.0	0.9
% Victim of Domestic Violence in Past 5 Years	5.8	1.7
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
53.1	49.9	37.2	17.5
25.2	21.7	15.4	9.2
79.0		78.3	92.0
97.5		98.9	100.0
86.9		74.5	92.0
90.0		81.3	
16.2		28.8	
56.1		34.1	
48.3		30.8	
25.4		19.1	16.0
7.3	13.4	6.1	3.0
8.7	11.2	10.9	5.0
3.3		1.5	
3.7		2.7	

Maternal, Child & Infant Health	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Adequate Prenatal Care	81.7	76.5
% of Low Birthweight Births	10.8	10.4
Infant Death Rate	11.3	12.5
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
79.2	80.0	77.2	90.0
10.6	10.5	7.9	5.0
11.9	9.9	6.9	4.5
-blank-no data favorable unfavorable similar			

Mental Health & Mental Disorders	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% "Fair/Poor" Mental Health	13.3	11.5
% Major Depression	11.2	9.8
% Chronic Depression (2+ Years)	35.6	27.6
% Depressed Persons Seeking Help	35.4	40.5
% Typical Day Is "Extremely/Very" Stressful	11.4	10.8
% Child Takes Rx for ADD/ADHD	11.2	9.5
Alzheimer's Disease (Age-Adjusted Death Rate)	25.2	20.0
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
12.4	11.7	11.7	11.7
10.5	9.1	9.1	9.1
31.4	24.9	24.9	24.9
37.8	48.3	48.3	50.0
11.1	8.5	8.5	8.5
10.4	4.2	4.2	4.2
22.1	29.7	21.1	21.1
-blank-no data favorable unfavorable similar			

Nutrition & Overweight	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Eat 5+ Servings of Fruit or Vegetables per Day	31.7	35.5
% Eat 2+ Servings of Fruit per Day	44.4	46.1
% Eat 3+ Servings of Vegetables per Day	30.9	29.7
% Received Advice on Nutrition in Past Year	36.3	32.8
% Unhealthy Weight (BMI <18.5 or 25+)	71.0	68.7
% Overweight	70.7	67.3
% Obese	38.4	35.5
% Overweights Advised to Lose Weight	33.1	30.3
% Overweight Trying to Lose	33.3	34.1
% Children (Aged 6-17) Overweight	35.7	23.8
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
33.7	20.2	36.2	36.2
45.3	46.5	46.5	75.0
30.3	34.6	34.6	50.0
34.4	37.2	37.2	37.2
69.8	66.1	67.9	40.0
68.9	64.6	66.1	66.1
36.8	30.8	27.3	15.0
31.6	30.7	30.7	30.7
33.7	39.4	39.4	39.4
30.1	14.1	14.1	14.1
-blank-no data favorable unfavorable similar			

Oral Health	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Have Visited Dentist in Past Yr (18+)	61.9	53.5
% Child (Aged 2-17) Has Visited Dentist in Past Year	81.6	83.3
% Have Dental Insurance	47.0	48.9
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
57.5	63.5	65.4	56.0
82.5		73.8	56.0
48.0		60.0	
-blank-no data favorable unfavorable similar			

Physical Activity & Fitness	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% No Leisure-Time Physical Activity	37.9	40.9
% Meeting Physical Activity Recommendations	37.8	33.2
% Vigorous Physical Activity	27.8	25.1
% Moderate Physical Activity	20.8	20.1
% Received Advice on Exercise in Past Year	38.2	37.9
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
39.5	33.4	25.5	20.0
35.4	38.3	47.2	
26.4	20.7	33.9	30.0
20.4	27.5	31.8	30.0
38.0		42.0	
-blank-no data favorable unfavorable similar			

Physical Health	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% "Fair/Poor" Physical Health	23.9	23.4
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
23.7	21.2	18.6	
-blank-no data favorable unfavorable similar			

Respiratory Disease	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
CLRD (Age-Adjusted Death Rate)	53.0	36.5
Pneumonia/Influenza (Age-Adjusted Death Rate)	23.1	37.1
% Sinusitis	30.4	26.1
% Nasal/Hay Fever Allergies	31.2	30.1
% Chronic Lung Disease	13.1	9.8
% Asthma	13.7	12.9
% Child Has Asthma	18.0	14.6
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
43.6	40.2	42.6	
31.2	22.7	21.5	
28.1		16.5	
30.7		32.3	
11.3		8.6	
13.3	10.8	10.4	
16.3		11.1	
-blank-no data favorable unfavorable similar			

Sexually Transmitted Diseases	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% 3+ Sexual Partners Last Year (18-64)	4.4	4.7
% Used Condom During Last Intercourse (18-64)	23.1	20.1
Gonorrhea Incidence/100,000	285.7	257.4
Primary & Secondary Syphilis Incidence/100,000	2.5	1.0
Chlamydia Incidence/100,000	534.1	470.3
Hepatitis B Incidence/100,000	3.6	4.1
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
4.6		4.0	
21.6		20.8	
271.0	241.5	115.1	19.0
1.7	7.3	2.7	0.2
500.8	464.1	318.8	
3.9	1.5	2.2	
-blank-no data favorable unfavorable similar			

Substance Abuse	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	8.4	6.8
% Current Drinker	40.2	35.1
% Chronic Drinker	4.2	3.0
% Binge Drinker	15.5	10.2
% Drinking & Driving in Past Month	3.7	2.9
% Driving Drunk or Riding with Drunk Driver	8.8	8.7
% Illicit Drug Use in Past Month	3.1	1.5
% Sought Help for Alcohol or Drug Problem	5.9	2.1
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
7.5	8.2	9.3	3.0
37.5	43.5	58.0	
3.6	5.1	5.3	
12.7	14.0	16.3	6.0
3.3		2.6	
8.7		5.2	
2.3		2.5	2.0
3.9		3.3	
-blank-no data favorable unfavorable similar			

Tobacco Use	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Current Smoker	21.4	21.6
% Received Advice to Quit Smoking (Smokers)	54.5	53.0
% Have Quit Smoking 1+ Days in Past Year (Smokers)	57.9	57.4
% Someone Smokes at Home	19.2	15.2
% Children <18 Exposed to Smoke at Home	19.5	11.6
% Use Smokeless Tobacco	7.8	7.9
% Smoke Cigars	5.3	4.3
Note: Ouachita Parish and Other Parishes (combined) are compared against one another.		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
21.5	23.4	22.2	12.0
53.7		66.2	
57.6	62.5	57.9	75.0
17.1		19.0	
15.4		20.4	
7.9		4.5	0.4
4.8		5.2	2.0
-blank-no data favorable unfavorable similar			

Vision & Hearing	Ouachita vs. Other Parishes	
	Ouachita Parish	Other Parishes
% Blindness/Trouble Seeing	10.8	14.5
% Deafness/Trouble Hearing	10.9	12.9
% Eye Exam in Past 2 Years	49.6	51.1
<small>Note: Ouachita Parish and Other Parishes (combined) are compared against one another.</small>		

LWF Service Area	LWF Service Area vs. Benchmarks		
	vs. LA	vs. US	vs. HP2010
12.8		8.1	
12.0		9.5	
50.3		58.8	
<small>-blank- no data favorable unfavorable similar</small>			

Priorities Among Focus Group Participants

When asked how they might earmark a hypothetical windfall of money to benefit the LWF Service Area community's health, priorities given among focus group participants ranged from free clinics to walking trails to wellness programs. The following highlights the main themes established:

Community Leaders

Community leaders see a wide range of needs in the community, with education at the forefront. Not only are school-based health clinics wanted in every school, but also the education to go along with living a healthy life.

"School-based clinics should include education because the earlier that you can begin to install a drug-free, alcohol-free health focus, the better. It wouldn't necessarily be just for treating illnesses but for educating those children." – Community Leader

The education must also include information about teen pregnancy, which is a significant problem in the area according to community leaders.

"If you could get teen pregnancy diminished greatly, I think that helps to break the cycle of poverty." - Community Leader

The area is also in need of a nurse educator program. The region is seeing a shortage of nurses; there aren't enough nurses who want to become educators of the next generation of nurses. In order to increase the number of nurses in the area, a program is needed to train nurses to become nurse educators.

"The only program is at Grambling and it's a nurse's degree program and most of the folks over there get nurse practitioner degrees, not nurse educator degrees. What we need is more nursing faculty." – Community Leader

Education for people of all ages is an enormous need in the community. The need is at the school level to inform students about obesity and living a healthy lifestyle, about teen pregnancy and drugs and alcohol. It's also at the adult level—educating people about taking care of their health before it's too late.

Business Leaders

The most important need for the region is education – education about everything from what number to call for elderly assistance to how to lead a healthy lifestyle.

"Education to me is more than just putting another program into the schools. The schools are somewhat overwhelmed with programs that they have now with government mandates and everything else they can teach and can't teach. It almost has to be something that's a funded, educational program. We have parents and we have grandparents who need the education desperately." – Business Leader

"We have some very proud white folk that don't have a dollar to their name but they won't go out to the LSU Conway hospital because of some of their own thoughts and beliefs. They sit at home and don't take any medication and let their whole situation deteriorate and then again there's some that you know don't know what to do, who to call. If you spend millions of dollars trying to coordinate businesses, education and medical groups and educate them, you'll spend every nickel of it and then some." – Business Leader

Physicians

The main concern among area physicians is education and the need for a school-based health clinic in every school.

“A school-based health clinic would be great for every one of them, but we need anything that goes towards the education of the mass public—not just our children, but all of the public, such as where access is, how to navigate, what are healthy lifestyles--everything that we can do in regard to getting their attention to what their own problem is.” – Physician

Social Service Providers and Other Healthcare Professionals

Education is a key priority for social service providers and other healthcare professionals. With that education comes prevention, which in turn brings a healthier community.

“The sooner you get to that young family, the better chance you have for the long-term outcome. But I also think that when you look at models that work (like school-based health clinics, workplace health clinics and church-based health clinics), they work to reach people in a consistent way with an institution or a system that is already operating. And to invest in those kinds of models would make a lot of sense too in terms of prevention.” – Social Service Provider

“And where the school-based clinics are concerned, you’ve got a two-prong approach. You’re helping now with issues and you’re educating your future adults.” – Social Service Provider

“If you have preventive medicine where people are getting their annual checkups and doing their follow-ups, then that would decrease a lot of trips to the emergency room--education about preventative measures before they get into a crisis.” – Healthcare Professional

SELF-REPORTED HEALTH STATUS

PHYSICAL HEALTH STATUS

Self-Reported Health Status

The initial inquiry of the 2008 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 majority of LWF Service Area adults (46.3%) rate their overall physical health as "excellent" or "very good."

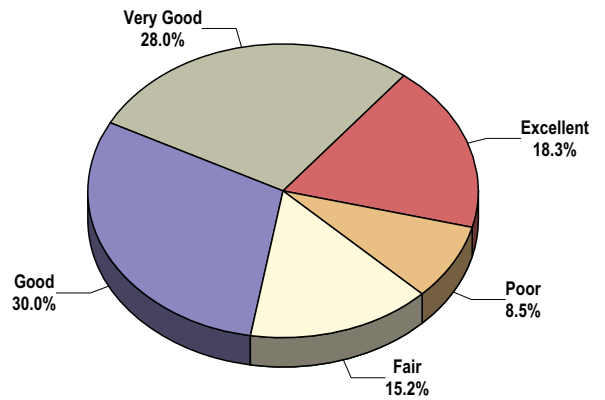
- Another 30.0% of survey respondents gave "good" ratings of their overall health.

In contrast, 23.7% of adults believe that their overall health is "fair" or "poor."

- Similar to Louisiana findings (21.2% "fair/poor").
- Less favorable than the national percentage (18.6% "fair/poor").
- Comparable between Ouachita Parish and the combined Other Parishes.

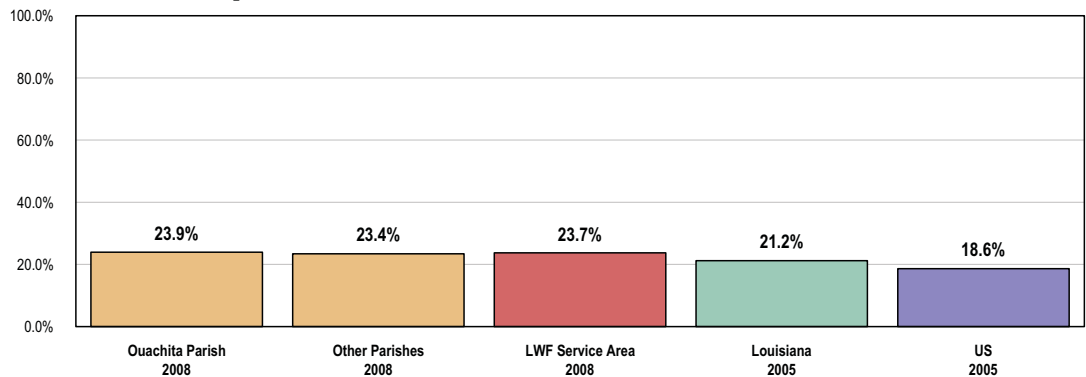
Self-Reported Health Status

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 6]
 Note: • Asked of all respondents.

Experience "Fair" or "Poor" Overall Health

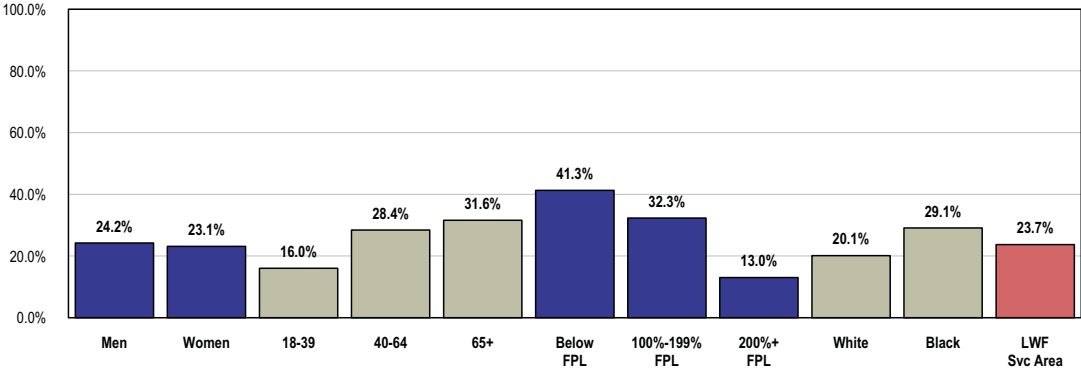


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 6]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.

The following chart further examines self-reported health status by various demographic characteristics. The Living Well Foundation Service Area adults more likely to report experiencing “fair” or “poor” overall health include:

- 👤 Adults 40 and older.
- 👤 Those living below the federal poverty level (a “fair/poor” response three times that found among adults with incomes over 200% of poverty).
- 👤 Blacks.

Experience “Fair” or “Poor” Overall Health (Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 6]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

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 U.S.—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...

- 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.

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...

- There is increasing awareness and concern in the public health sector regarding the impact of stress, its prevention and treatment, and the need for enhanced coping skills...
- 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.

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Self-Reported Mental Health Status

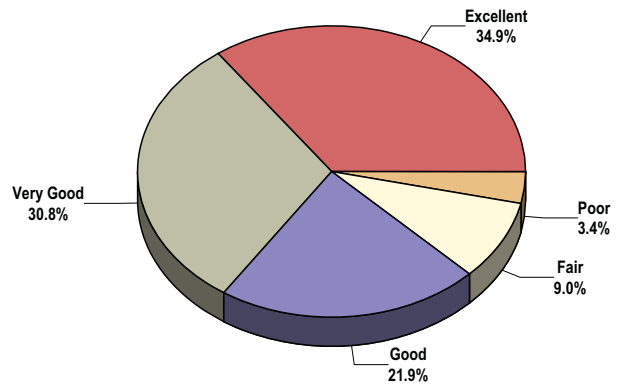
More than six in 10 LWF Service Area adults (65.7%) rate their overall mental health as “excellent” or “very good.”

- ▣ Another 21.9% gave “good” ratings of their own mental health status.

However, 12.4% of adults believe that their overall mental health is “fair” or “poor.”

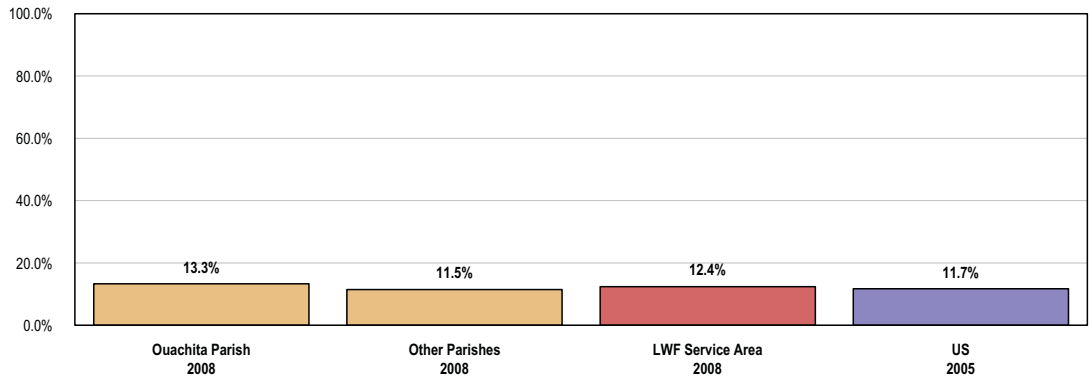
- Statistically similar to the 11.7% “fair/poor” reported across the nation.
- ⊕ Comparable between Ouachita and Other Parishes.

Self-Reported Mental Health Status (Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 110]
 Note: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health



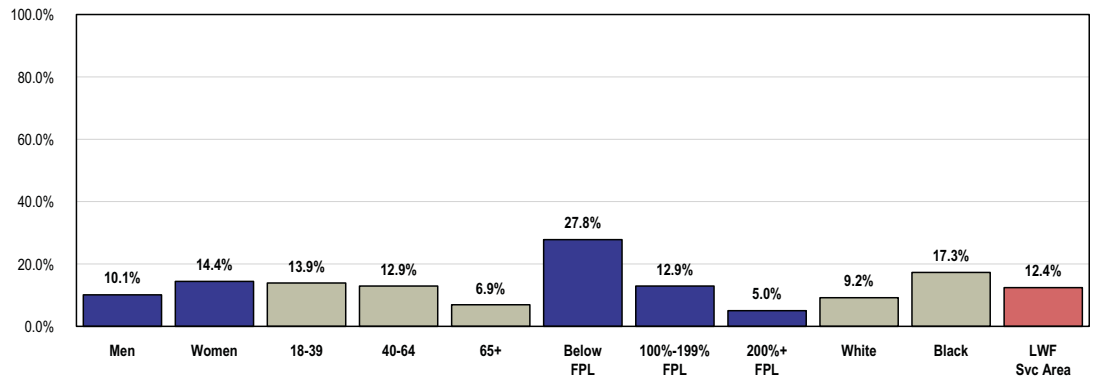
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 110]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.

Adults more likely to report experiencing “fair” or “poor” mental health include:

- 👥 Women.
- 👥 Adults under 65.
- 👥 Those living at lower incomes.
- 👥 Black respondents.

Experience "Fair" or "Poor" Mental Health

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 11Q]

Note: • Asked of all respondents.

• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].

• White and Black are non-Hispanic race categorizations.

Depression

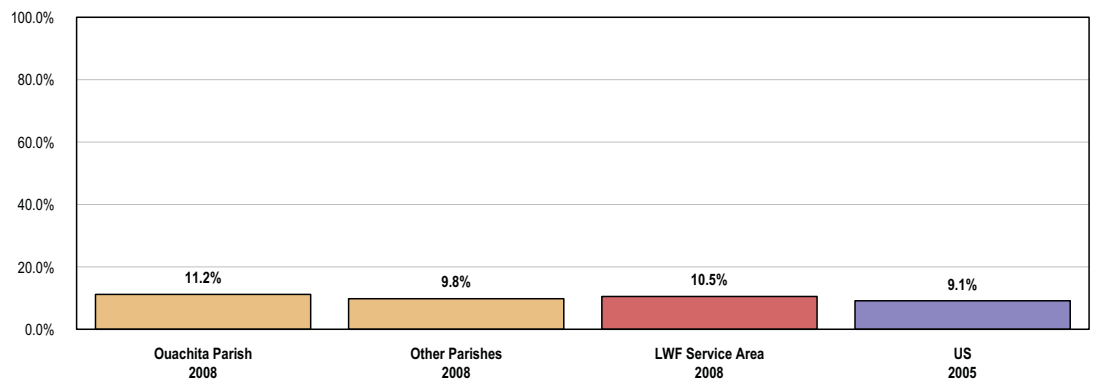
Depression is a serious illness affecting many in the population, whether occasionally or, in many cases, for prolonged periods of time.

Major Depression

Across the LWF Service Area, 10.5% of adults report that they have been diagnosed with major depression by a physician at some point in their lives.

- ☑ Statistically similar to national findings (9.1%).
- ⊕ No significant difference between the sub-areas.

Prevalence of Major Depression



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 3Q]

• 2005 PRC National Health Survey, Professional Research Consultants.

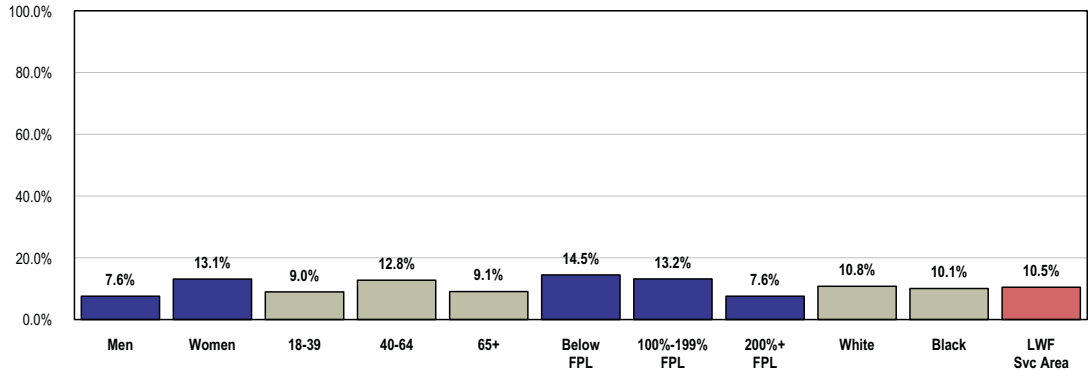
Note: • Asked of all respondents.

• In this case, the term "major depression" refers to self-reported major depression as diagnosed by a physician.

By key demographic characteristics, note the following findings:

- 👤 Women report a higher prevalence of major depression than do men.
- 👤 Note those living below the 200% FPL are nearly twice as likely to report a depression diagnosis.

Prevalence of Major Depression (Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 36]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.
 • In this case, the term "major depression" refers to self-reported major depression as diagnosed by a physician.

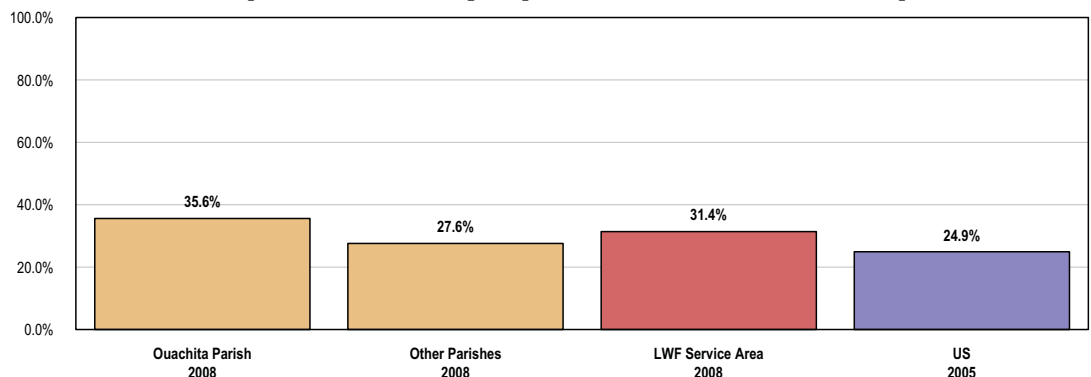
Chronic Depression

Nearly one in three LWF Service Area adults (31.4%) reports that they 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.

- 📍 Less favorable than national findings (24.9%).
- 📍 The prevalence is much less favorable in Ouachita Parish (when comparable to the other parishes in The Living Well Foundation Service Area).

The following chart illustrates differences found among key demographic groups. Note that self-

Have Experienced Symptoms of Chronic Depression

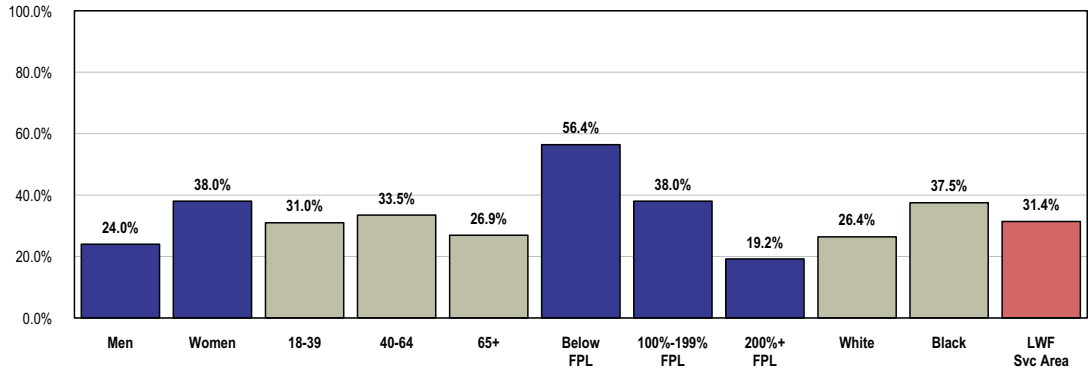


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 111]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.
 • In this case, the term "chronic depression" refers to periods of self-reported depression lasting two years or longer.

reported prevalence of chronic depression is notably higher among:

- 👤 Women.
- 👤 Community members living at lower incomes.
- 👤 Blacks.

Have Experienced Symptoms of Chronic Depression (Living Well Foundation Service Area, 2008)



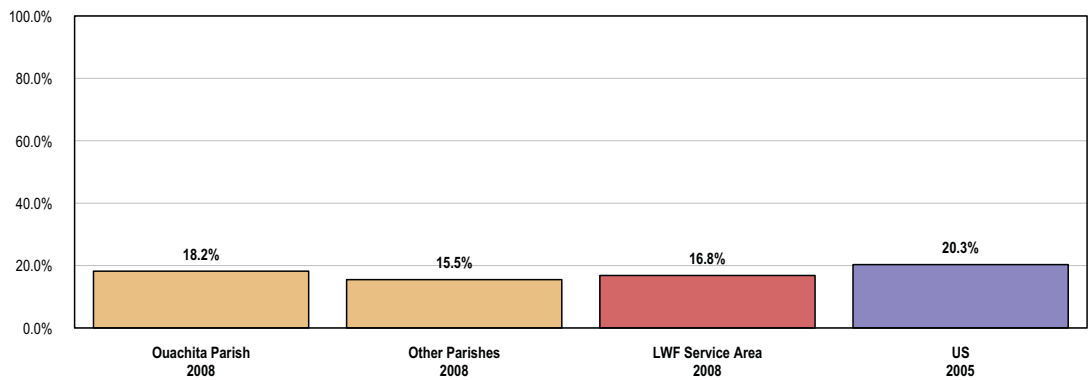
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 111]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level, based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.
 • In this case, the term "chronic depression" refers to periods of self-reported depression lasting two years or longer.

Mental Health Treatment

Among LWF Service Area respondents, 16.8% acknowledge that they have sought professional help for a mental or emotional problem.

- 📍 Less favorable than national findings (20.3%).
- 📍 Similar between the sub-areas.

Have Sought Professional Help With a Mental or Emotional Problem

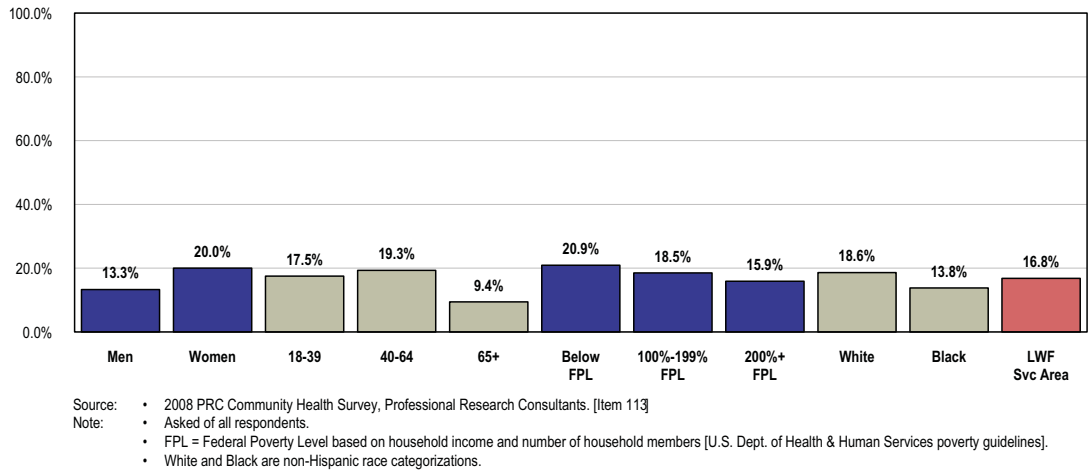


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 113]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.

Adults less likely to have sought professional help for a mental issue include men and seniors.

Have Sought Professional Help With a Mental or Emotional Problem

(Living Well Foundation Service Area, 2008)

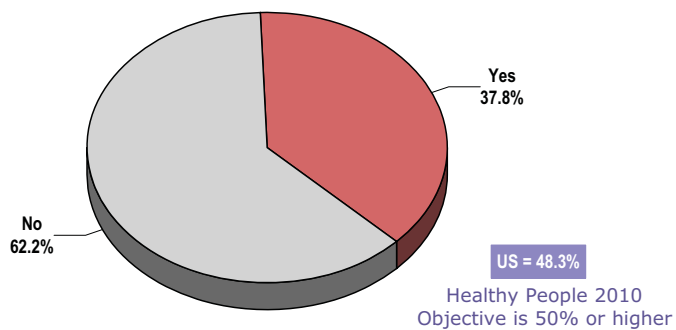


Among LWF Service Area respondents with recognized depression, 37.8% acknowledge that they have sought professional help for a mental or emotional problem.

- ☑ Also less favorable than national findings (48.3%).
- ☑ Fails to satisfy the Healthy People 2010 objective of 50% or higher among adults with recognized depression.

Have Sought Professional Help With a Mental or Emotional Problem

(Among Respondents With Recognized Depression;
Living Well Foundation Service Area, 2008)



- Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 161]
 • 2005 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]
- Note: • Reflects respondents who have been diagnosed with major depression or who have experienced two or more years of depression at some point in their lives.

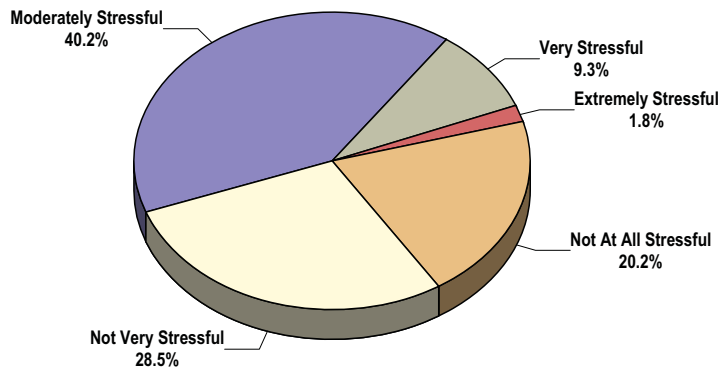
(Related Issue: see also “Substance Abuse.”)

Stress

Nearly one-half (48.7%) of LWF Service Area adults say their level of stress on a typical day is “not very stressful” (28.5%) or “not at all stressful” (20.2%).

- Another 40.2% report “moderately stressful” typical days.

Perceived Level of Stress on a Typical Day (Living Well Foundation Service Area, 2008)

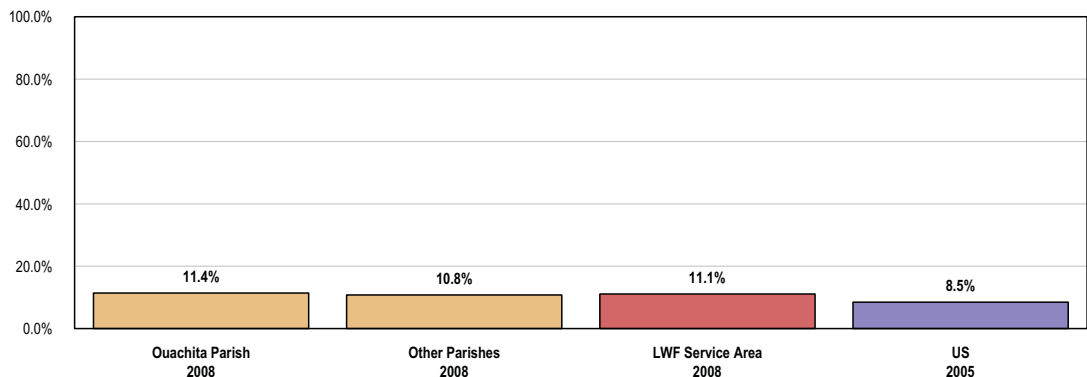


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 112]
Note: • Asked of all respondents.

In contrast, 11.1% say their typical day is “extremely” or “very” stressful.

- Statistically similar to national data (8.5%).
- Statistically similar between sub-areas.

Perceive Most Days as “Extremely” or “Very” Stressful



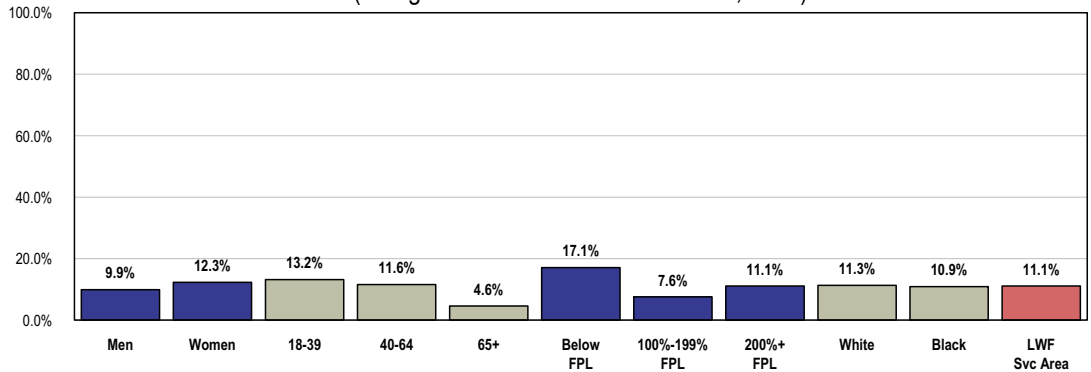
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 112]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

Adults more likely to perceive their days to be “extremely/very stressful” include:

- 👤 Adults under 65.
- 👤 Adults living below the federal poverty level.

Perceive Most Days as “Extremely” or “Very” Stressful

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 112]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.
 • Percentages represent combined “extremely stressful” and “very stressful” responses.

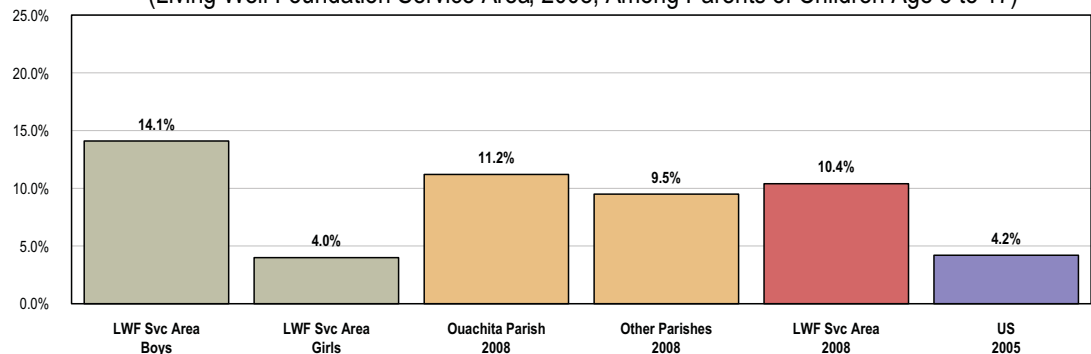
Children & ADD/ADHD

A total of 10.4% of LWF Service Area children take medication for Attention-Deficit/Hyperactivity disorder.

- 📊 Less favorable than national findings (4.2%).
- 👤 Higher among boys (14.1%) than girls (4.0%).
- 🏠 No difference between Ouachita Parish and the other parishes in the service area.

Child Takes Medication for ADD/ADHD

(Living Well Foundation Service Area, 2008; Among Parents of Children Age 5 to 17)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 128]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents with children aged 5 through 17 at home.
 • “ADD/ADHD” refers to “Attention-Deficit Disorder” and “Attention-Deficit/Hyperactivity Disorder.”

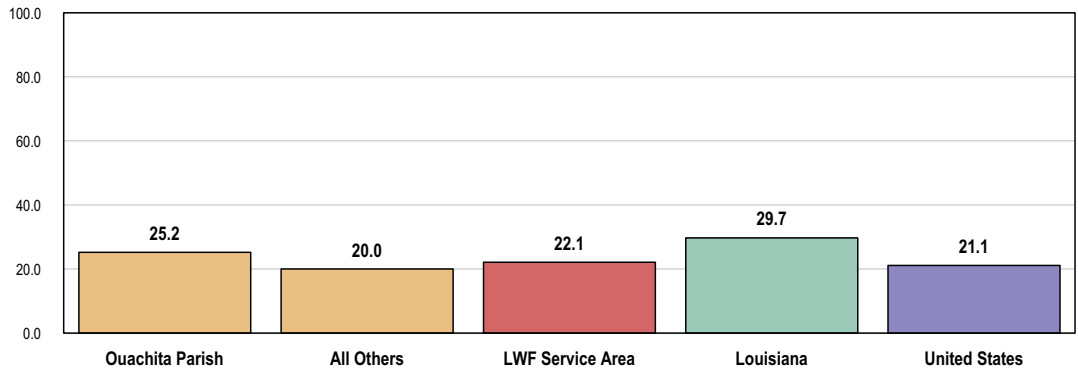
Alzheimer's Disease

Between 2002 and 2004, the age-adjusted mortality rate due to Alzheimer's disease was 22.1 per 100,000 population in the LWF Service Area.

- ☑ More favorable than the 29.7 rate reported across Louisiana.
- ☑ Similar to the 21.1 rate reported nationwide.
- ⊕ Less favorable in Ouachita Parish.

Age-Adjusted Mortality: Alzheimer's Disease

(2002-2004 Annual Average Deaths per 100,000 Population)

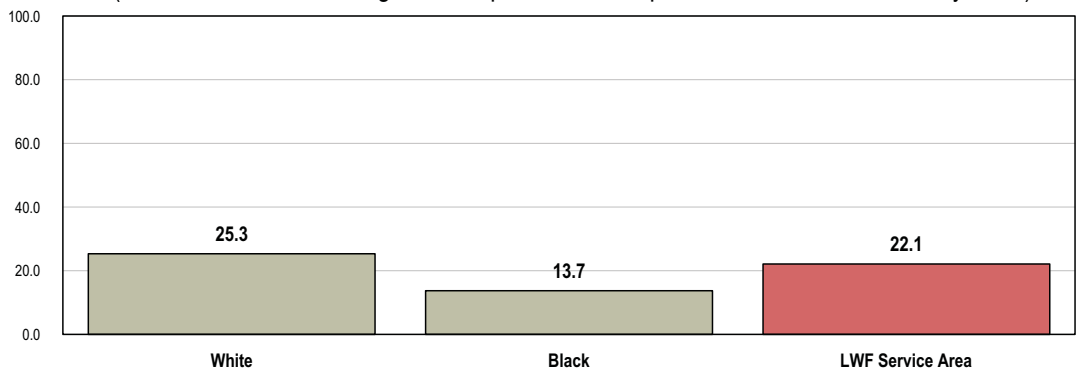


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

- 👤 Viewed by race, Alzheimer's disease mortality appears to be higher for Whites than Blacks within the LWF Service Area.

Age-Adjusted Mortality: Alzheimer's Disease

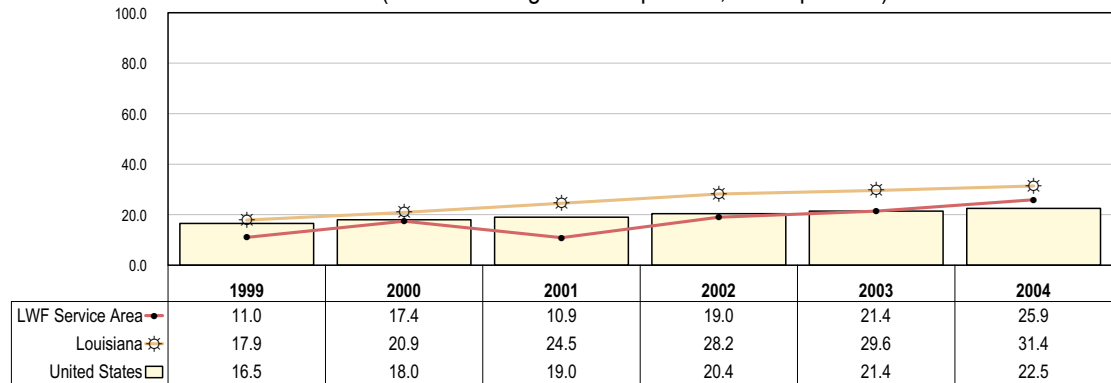
(2002-2004 Annual Average Deaths per 100,000 Population; LWF Service Area by Race)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 Note: • 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.

- Age-adjusted Alzheimer’s disease mortality rates increased in recent years; state- and nationwide, the same increasing trend is also apparent.

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



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Related Focus Group Findings: Mental Health

Community Leaders

According to local community leaders, there aren’t enough outpatient services for anyone whether they are insured or not.

“A lot of insurances frequently don’t pay at all. Even if you have good insurance, you can’t afford to receive care or care longer than maybe even six weeks. And then of course you have the people who have none at all. There are frequently times at the free clinic when it’s six months before you can get an appointment. Then the emergency rooms are inundated and it has to get tragic frequently before it can even reach the emergency room level.” – Community Leader

Physicians

One of the biggest issues needing to be addressed is the lack of mental health resources.

“A number of them will be truly disabled, dangerous to others, unwilling or unable to seek medical attention. They’re just floating around, and there are a lot of them. They wind up in our emergency rooms at night and clog them up.” – Physician

“Any sort of time-sensitive illness is made much worse when you have your emergency room personnel running psychiatric wards throughout the state. And I’m sure to some degree that’s not just is public hospitals—that’s as well the rural hospitals and the major metropolitan hospitals- clogged up with mental health problems that the state has just decided, from a financial standpoint, to ignore. These people are on their own. And they end up in the emergency rooms or harm themselves. And it’s a nightmare for a time-sensitive illness because your personnel are being taken up watching the psychiatric patients run through the ER when they need to be taking care of and concentrating on time-sensitive illnesses.” – Physician

Social Service Providers

Mental Health issues are on the rise in the area.

“This year we are currently seeing twice the number of people that we projected to see with regard to mental health issues (both adults and children), and the need is great and increasing.” – Social Service Provider

DEATH & DISABILITY

LEADING CAUSES OF DEATH

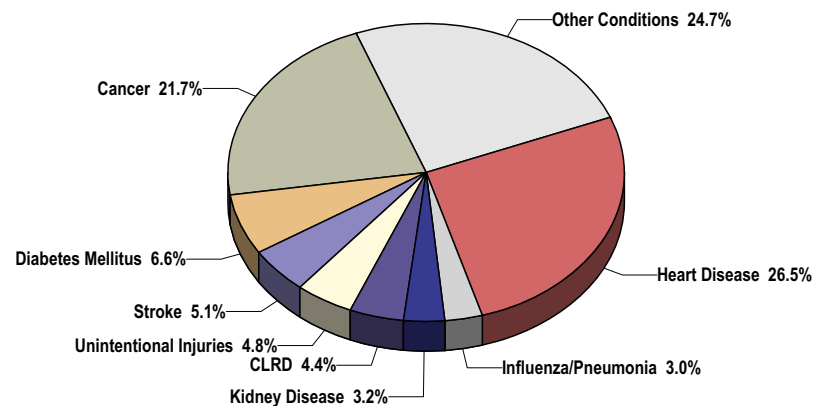
Leading Causes of Death

Together, heart disease (26.5%) and cancers (21.7%) account for nearly one-half of all deaths in the LWF Service Area (2004 data).

- Other leading causes of death include **diabetes mellitus** (6.6%), **stroke** (5.1% of total deaths), **unintentional injuries** (4.8%), and **chronic lower respiratory disease or CLRD** (4.4%).

Leading Causes of Death

(Living Well Foundation Service Area, 2004)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Age-Adjusted Death Rates for All Causes

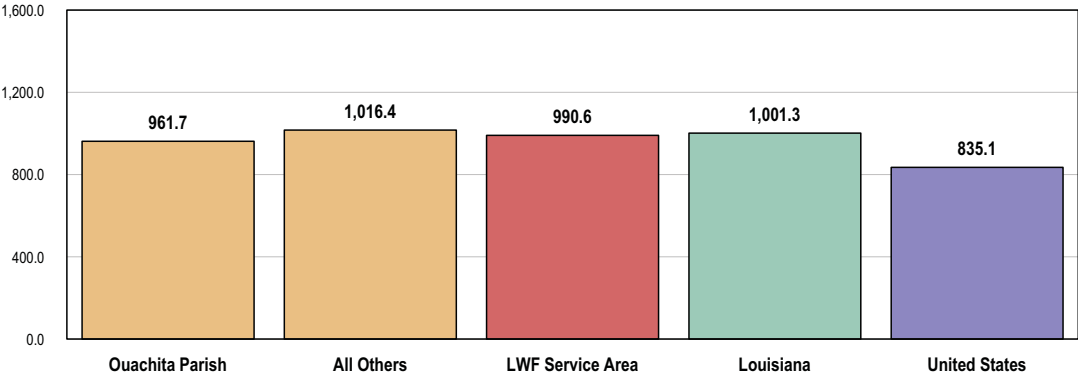
In order to compare mortality in the LWF Service Area with other localities (in this case, Louisiana and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population,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

In the LWF Service Area, the 2002-2004 annual average age-adjusted death rate (for all causes) was 990.6 deaths per 100,000 population.

- ☑ Similar to the Louisiana mortality rate for all causes (1,001.3).
- ☑ Much higher than the United States mortality rate for all causes (835.1).
- ⊕ More favorable in Ouachita Parish.

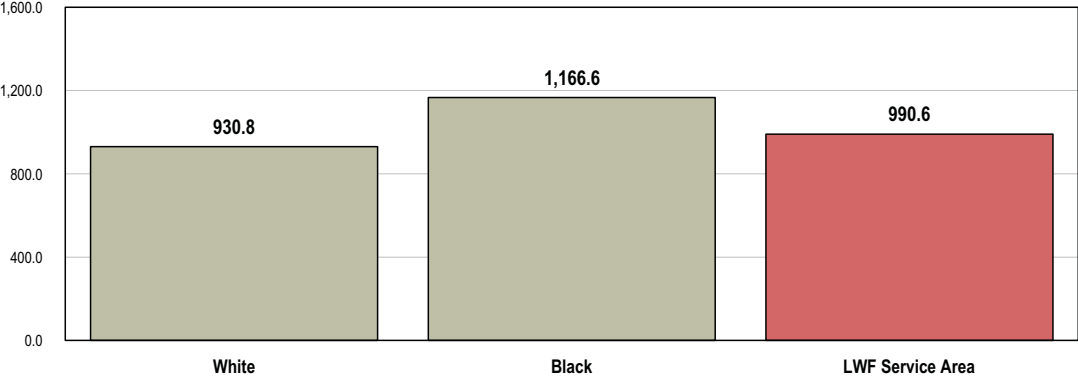
Age-Adjusted Mortality: All Causes
(2002-2004 Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 Note: • 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.

⊕ Viewed by race, age-adjusted mortality in the LWF Service Area is considerably higher among Blacks (1,166.6) when compared with Whites (930.8).

Age-Adjusted Mortality: All Causes
(2002-2004 Annual Average Deaths per 100,000 Population; LWF Service Area by Race)

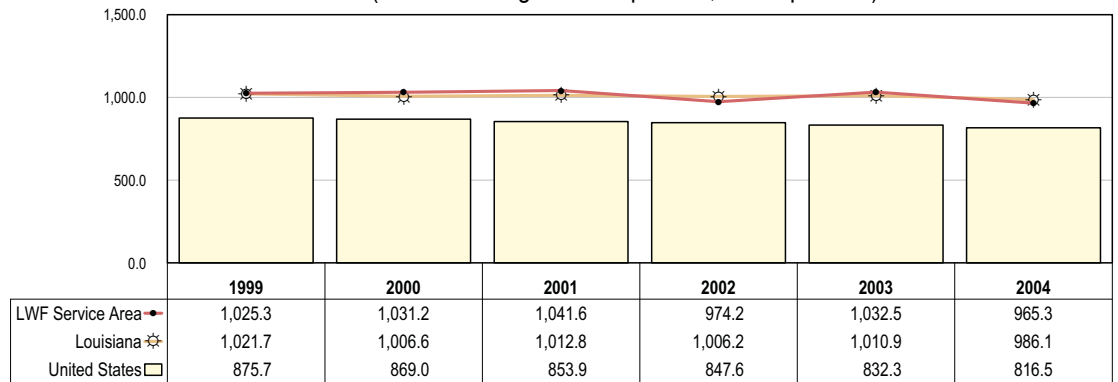


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

- Age-adjusted death rates (for all causes) have declined overall in recent years, mirroring trends seen across Louisiana and the U.S. overall.

Age-Adjusted Mortality: All Causes

(Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.
Data extracted January 2008.

Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Age-Adjusted Death Rates for Selected Causes

The following chart outlines 2002-2004 annual average age-adjusted death rates per 100,000 population for selected causes of death in the LWF Service Area. Note the following comparisons:

- The LWF Service Area death rates compared unfavorably to national rates for the following:
 - Cancer [including Lung Cancer]
 - Diabetes
 - Heart Disease
 - Unintentional Injuries [including Motor Vehicle Accidents]
 - Homicide
 - Pneumonia/Influenza

- The LWF Service Area death rates failed to meet the available Healthy People 2010 objectives for all of the selected causes.

Age-Adjusted Death Rates for Selected Causes

(2002-2004 Annual Average Deaths per 100,000 Population)

	LWF Service Area	Louisiana	United States	HP2010
Diseases of the Heart	275.2	268.1	233.1	213.7*
Malignant Neoplasms (Cancers)	207.6	220.8	191.1	159.9
Chronic Lower Respiratory Diseases	43.6	40.2	42.6	
Diabetes Mellitus	57.8	41.0	25.1	15.1*
Cerebrovascular Disease (Stroke)	55.2	61.3	53.2	48.0
Unintentional Injuries (Accidents)	53.1	49.9	37.2	17.5
Influenza/Pneumonia	31.2	22.7	21.5	
Motor Vehicle Accidents	25.2	21.7	15.4	9.2
Alzheimer's Disease	22.1	29.7	21.1	
Intentional Self-Harm (Suicide)	8.7	11.2	10.9	5.0
Liver Disease/Cirrhosis	7.5	8.2	9.3	3.0
Homicide/Legal Intervention	7.3	13.4	6.1	3.0
HIV	4.5	8.8	4.7	0.7

Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

• 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 Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

(For infant mortality data, see also "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 Americans 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 Americans (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 Americans.
- 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 U.S. 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

Heart Disease

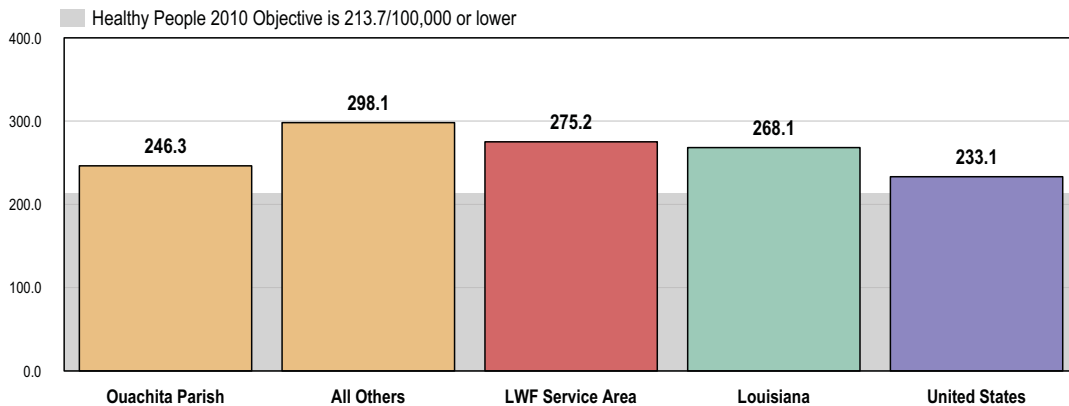
The greatest share of cardiovascular deaths is attributed to heart disease.

The LWF Service Area annual average age-adjusted heart disease death rate for 2002-2004 was 275.2 deaths per 100,000 population.

- ☉ Near the Louisiana rate (268.1 deaths per 100,000 population).
- ☉ Above the U.S. rate (233.1).
- ☉ Fails to satisfy the adjusted Healthy People 2010 objective of 213.7 per 100,000 or lower.
- ⊕ More favorable in Ouachita Parish.

Age-Adjusted Mortality: Heart Disease

(2002-2004 Annual Average Deaths per 100,000 Population)



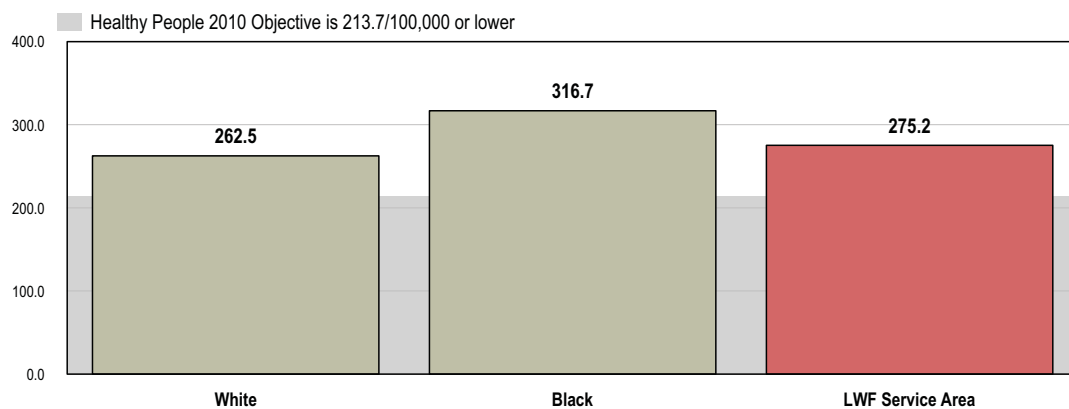
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000.

Note: • 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.
 • The Healthy People 2010 Heart Disease target is adjusted to account for all diseases of the heart [Objective 12-1].

Viewed by race, heart disease mortality rates in the LWF Service Area are higher among Blacks (316.7/100,000) than among Whites (262.5 per 100,000).

Age-Adjusted Mortality: Heart Disease

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)

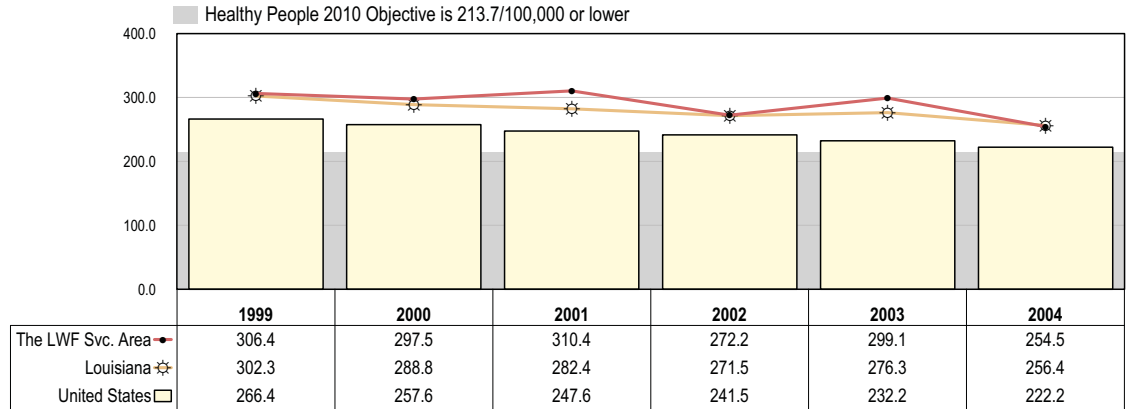


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000.

Note: • 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.
 • The Healthy People 2010 Heart Disease target is adjusted to account for all diseases of the heart [Objective 12-1].

- Heart disease death rates have decreased overall in recent years in the LWF Service Area (despite marginal increases in 2001 and 2003); this downward trend is also evident across Louisiana and the nation as a whole.

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



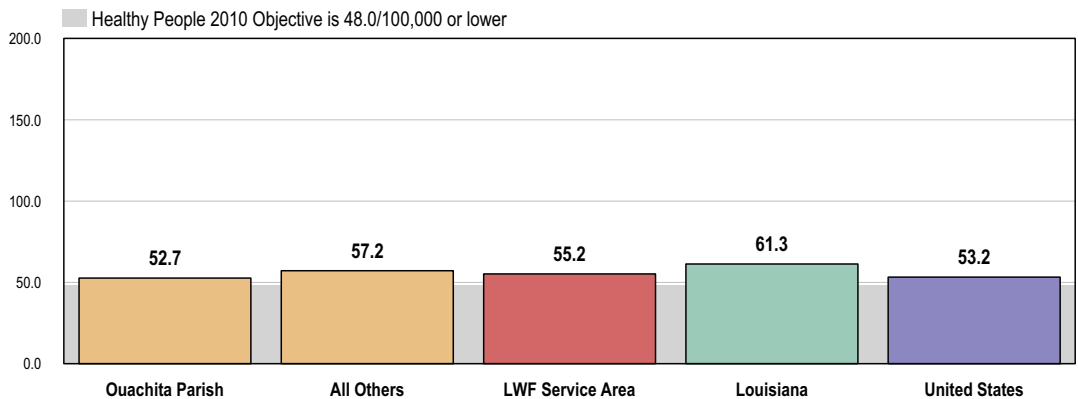
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000.
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • The Healthy People 2010 Heart Disease target is adjusted to account for all diseases of the heart [Objective 12-1].

Stroke Deaths

The 2002-2004 LWF Service Area annual average age-adjusted death rate for stroke (cerebrovascular disease) was 55.2 deaths per 100,000 population.

- Lower than the statewide rate (61.3 deaths per 100,000 population).
- Similar to the U.S. rate (53.2).
- Fails to satisfy the Healthy People 2010 objective of 48.0 per 100,000 or lower.
- More favorable among residents of Ouachita Parish.

Age-Adjusted Mortality: Stroke (2002-2004 Deaths per 100,000 Population)

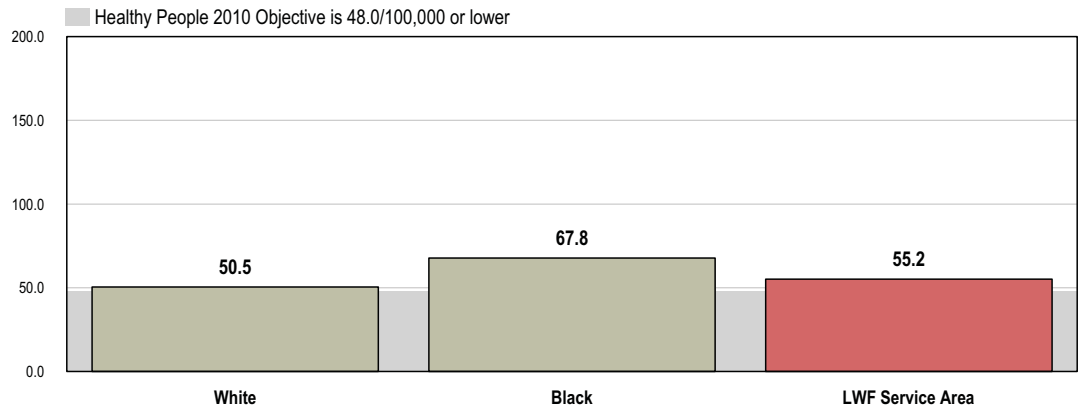


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000. [Objective 12-7]
 Note: • 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.

Blacks in the LWF Service Area experience an age-adjusted stroke mortality rate much higher than that of Whites (67.8 vs. 50.5, respectively).

Age-Adjusted Mortality: Stroke

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)

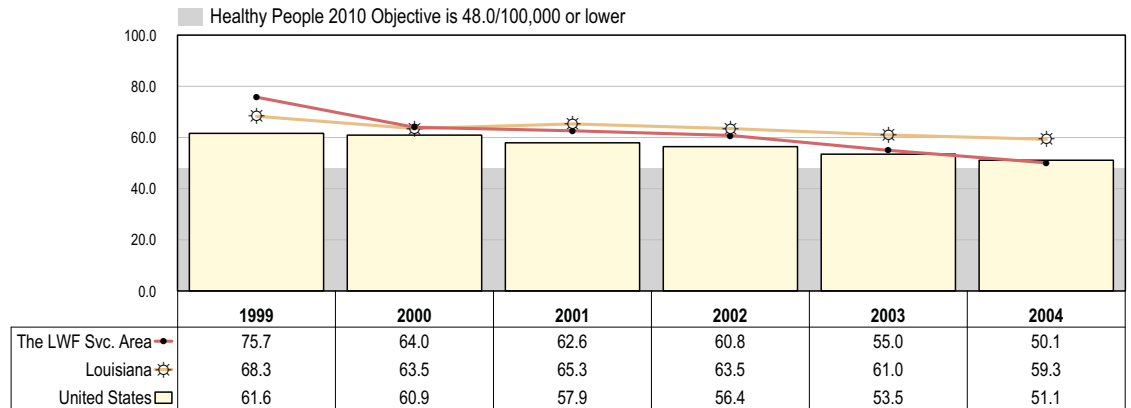


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000. [Objective 12-7]
 Note: • 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.

Area age-adjusted death rates for stroke (cerebrovascular disease) have followed a general decline over the past several years. Steady declines in stroke mortality are also seen across Louisiana and the U.S. overall.

Age-Adjusted Mortality: Stroke

(Annual Average Deaths per 100,000 Population)



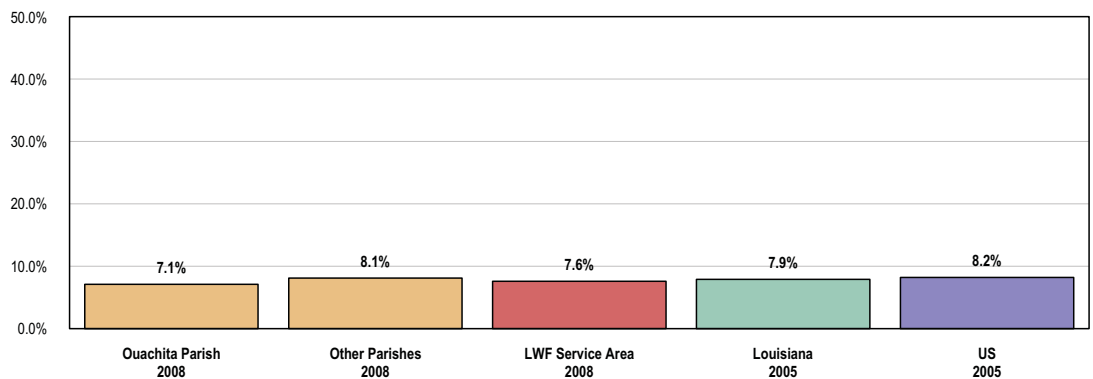
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000. [Objective 12-7]
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Prevalence of Heart Disease

A total of 7.6% of surveyed LWF Service Area adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- ☑ Statistically similar to the Louisiana percentage (7.9%).
- ☑ Statistically similar to the national percentage (8.2%).
- ⊕ Further, no significant differences are found between sub-areas.

Self-Reported Prevalence of Chronic Heart Disease



Source:

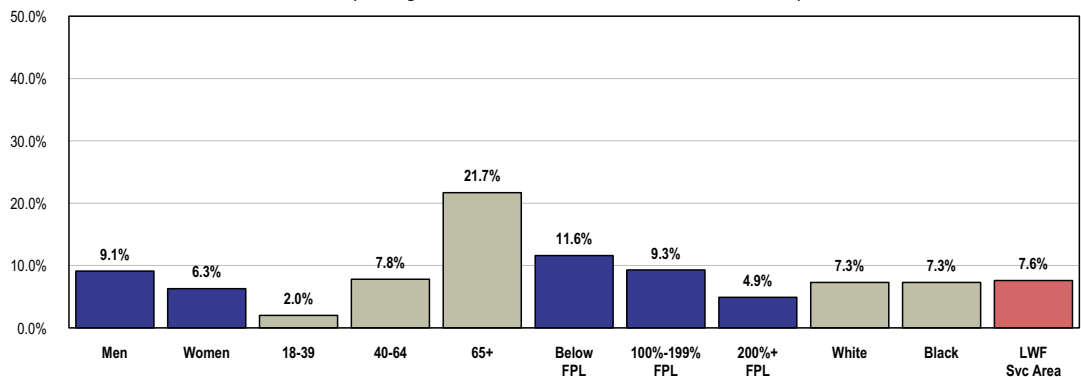
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 3]
- 2005 PRC National Health Survey, Professional Research Consultants.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.

 Note:

- Asked of all respondents.
- Respondents were asked if they have ever been diagnosed with chronic heart disease, including coronary heart disease, angina, or a heart attack.

👤 Adults more likely to have been diagnosed with chronic heart disease include adults aged 65 and older.

Self-Reported Prevalence of Chronic Heart Disease (Living Well Foundation Service Area, 2008)



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 3]

 Note:

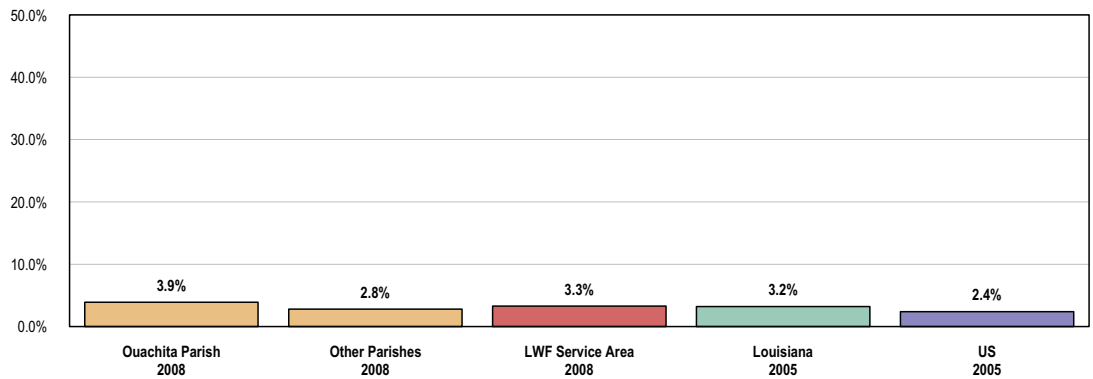
- Asked of all respondents.
- FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
- White and Black are non-Hispanic race categorizations.
- Respondents were asked if they have ever been diagnosed with chronic heart disease, including coronary heart disease, angina, or a heart attack.

Prevalence of Stroke

A total of 3.3% of surveyed LWF Service Area adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- ☑ Similar to statewide findings (3.2%).
- ☑ Similar to national findings (2.4%).
- ⊕ No significant differences are found when segmented by sub-area.
- 👤 Note: Among LWF Service Area residents aged 65 and older, 9.4% have had a stroke.

Self-Reported Prevalence of Stroke



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 32]
• 2005 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); 2005 Louisiana data.

Note: • 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.

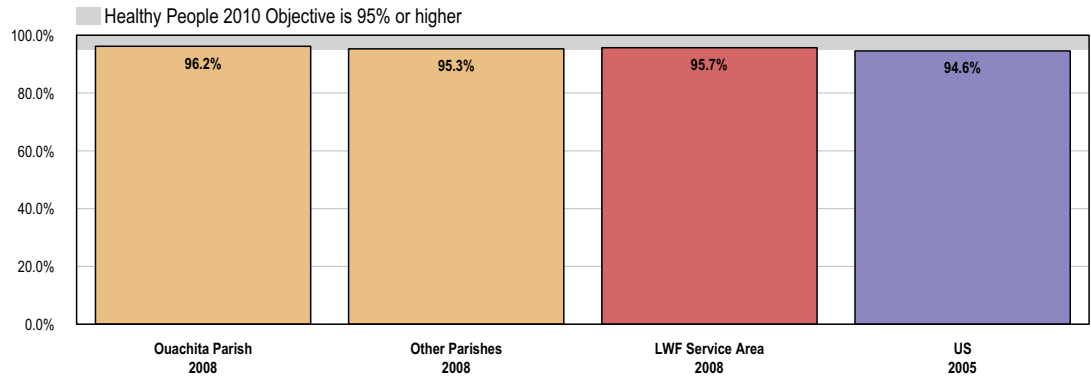
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

High Blood Pressure Testing

95.7% of LWF Service Area adults have had their blood pressure tested within the past two years.

- ☑ Similar to national findings (94.6%).
- ☑ Just above the Healthy People 2010 target (95% or higher).
- ⊕ Similar between the two sub-areas.

Have Had Blood Pressure Checked Within the Past Two Years



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 48]
 • 2005 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]

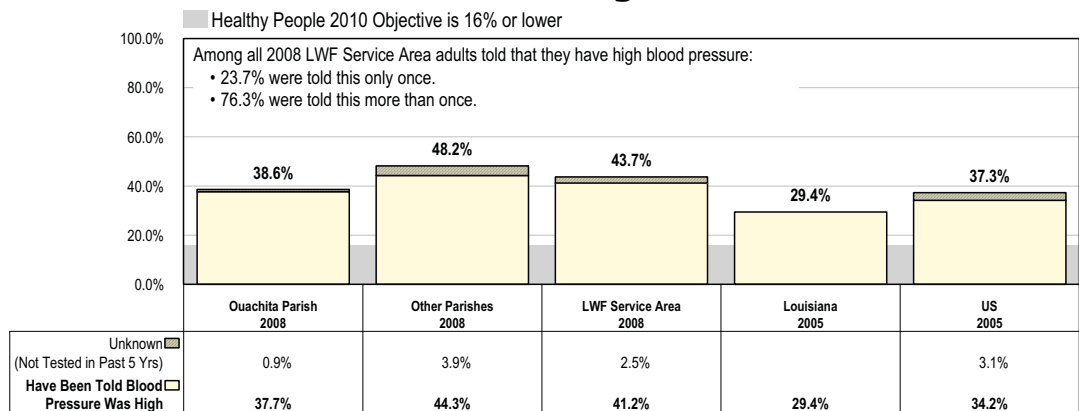
Note: • Asked of all respondents.
 • Excludes uncertain responses.

Prevalence of Hypertension

Four in ten (41.2%) surveyed adults have been told at some point that their blood pressure was high (an additional 2.5% have not been tested in the past five years).

- ❑ Less favorable than the Louisiana prevalence (29.4%) and national findings (34.2%).
- ❑ More than twice the Healthy People 2010 target (16% or lower).
- ⊕ Significantly lower (37.7%) in Ouachita Parish.

Self-Reported Prevalence of High Blood Pressure



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 46,134]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.
 • 2005 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]

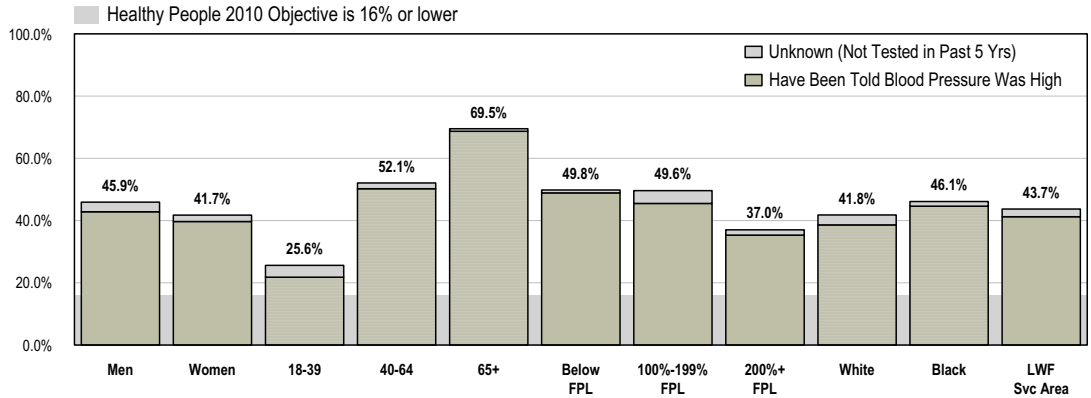
Note: • Asked of the total sample of respondents.
 • HBP refers to adults who have been told they have high blood pressure.
 • "Unknown" includes persons never tested, not tested within the past 5 years, or who were uncertain or did not respond to the testing question.

Hypertension diagnoses are higher among the following populations:

- 👤 Adults aged 40 and older, and especially those aged 65 and older.
- 👤 Respondents living at or near the federal poverty level.

Self-Reported Prevalence of High Blood Pressure

(Living Well Foundation Service Area, 2008)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 134]
 - 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]
- Note:
- Asked of all respondents.
 - FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 - White and Black are non-Hispanic race categorizations.
 - "Unknown" includes persons never tested, not tested within the past 5 years, or who were uncertain or did not respond to the testing question.

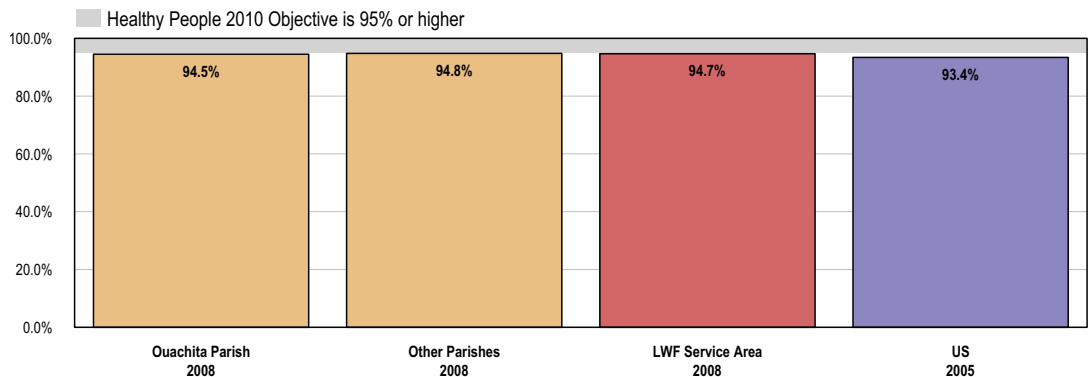
Hypertension Management

Among LWF Service Area respondents who have been told that their blood pressure was high, **94.7% report that they are currently taking actions to control their condition, such as through medication, diet and/or exercise.**

- 👤 Similar to national findings (93.4%).
- 👤 Similar to the Healthy People 2010 target of 95% or higher.
- 👤 Does not vary significantly by sub-area.

Taking Action to Control High Blood Pressure

(Among Respondents With Multiple HBP Readings)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 47]
 - 2005 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]
- Note:
- Asked of respondents who have been told more than once that their blood pressure was high.
 - In this case, "taking action" includes medication, diet modification, and/or exercise.

High Blood Cholesterol

High blood cholesterol is a major risk factor for coronary heart disease that can be modified. More than 50 million U.S. 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.

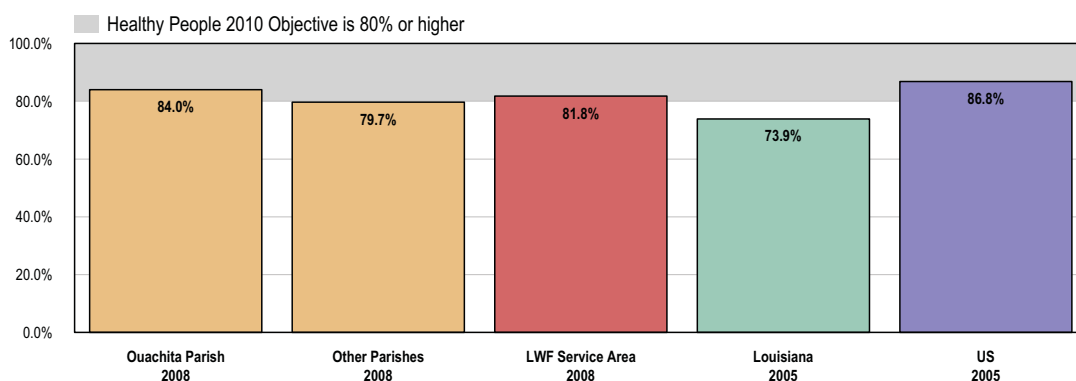
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Blood Cholesterol Testing

A total of 81.8% of LWF Service Area adults have had their blood cholesterol checked within the past five years.

- ☑ More favorable than Louisiana findings (73.9%).
- ☑ Less favorable than national findings (86.8%).
- ☑ Just above the Healthy People 2010 target (80% or higher).
- ⊕ Similar by sub-area.

Have Had Blood Cholesterol Level Checked Within the Past Five Years



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 51]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.
- 2005 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]

Note:

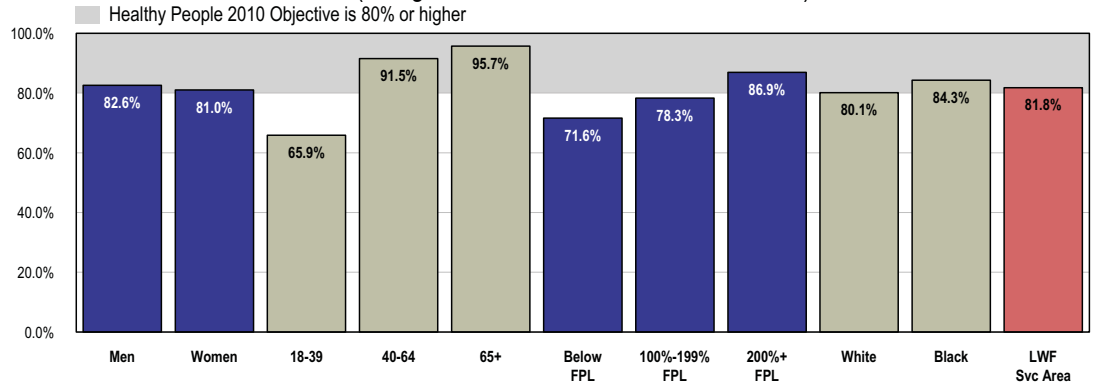
- Asked of all respondents.
- Excludes uncertain responses.

Note that testing levels are notably lower among:

- 👤 Younger adults.
- 👤 Adults living at lower incomes.

Have Had Blood Cholesterol Level Checked Within the Past Five Years

(Living Well Foundation Service Area, 2008)



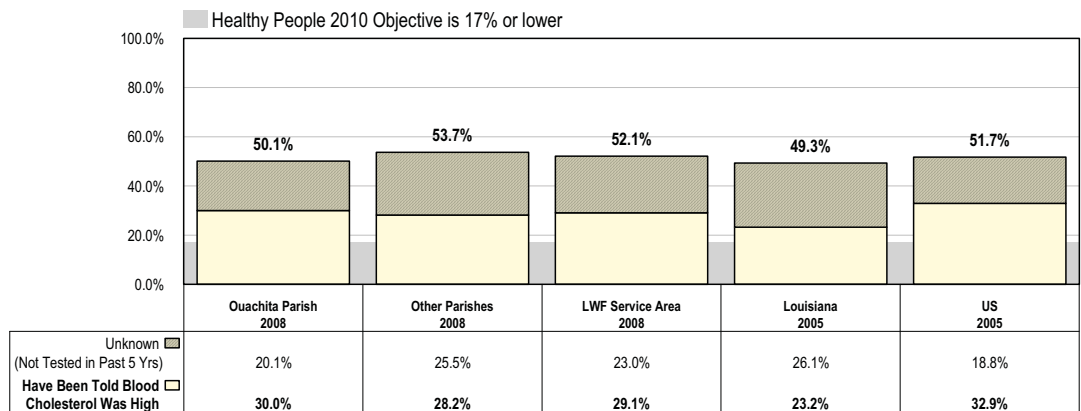
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 51]
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-15]
- Note:
- Asked of all respondents.
 - FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 - White and Black are non-Hispanic race categorizations.
 - Excludes uncertain responses.

Self-Reported High Blood Cholesterol

In all, 29.1% of LWF Service Area adults have been told by a health professional that their cholesterol level was high (note that an additional 23.0% have not had their cholesterol tested in the past five years).

- ☑ Less favorable than the statewide prevalence (23.2%, excluding “unknowns”).
- ☑ Similar to the national prevalence (32.9%).
- ☑ Fails to satisfy the Healthy People 2010 target (17% or lower).
- ⊕ No significant differences between sub-areas.

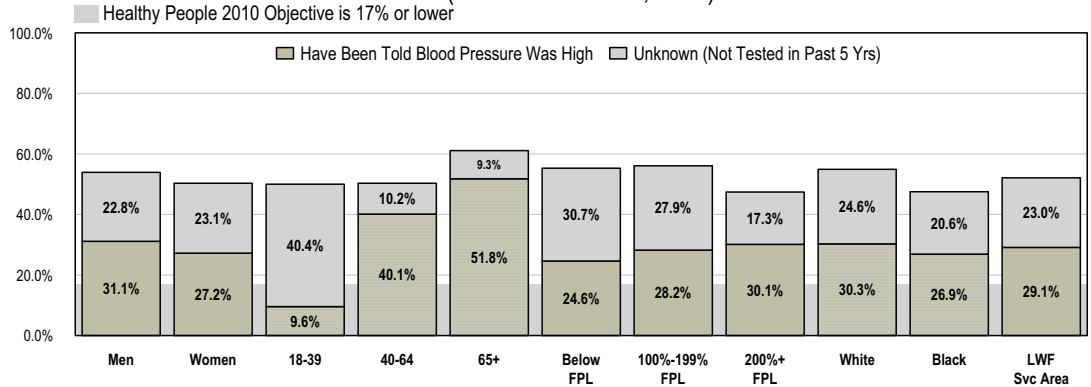
Self-Reported Prevalence of High Blood Cholesterol



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 135]
 - 2005 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]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.
- Note:
- Asked of the total sample of respondents.
 - HBC reflects adults who have been told they have high blood cholesterol.
 - “Unknown” includes persons never tested, not tested within the past 5 years, or who were uncertain or did not respond to the testing question.

- Adults more likely to experience high cholesterol levels include adults aged 40 and older, especially seniors.

Self-Reported Prevalence of High Blood Cholesterol (LWF Service Area, 2008)



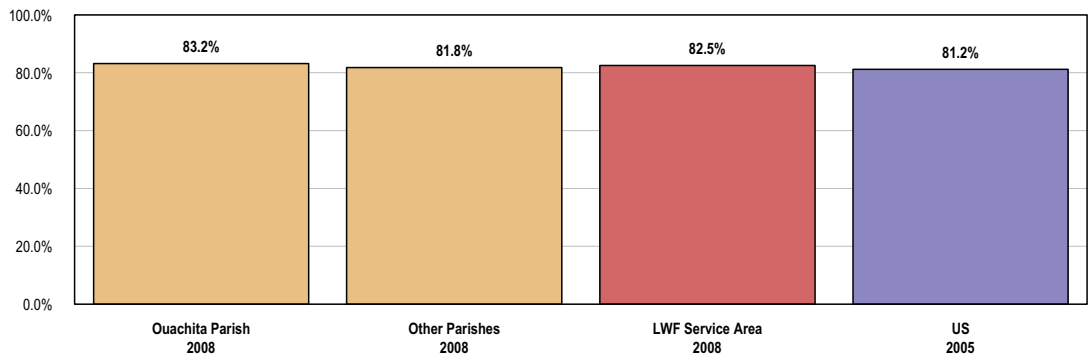
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 13]
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 12-14]
- Note:
- Asked of all respondents.
 - FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 - White and Black are non-Hispanic race categorizations.

High Cholesterol Management

Among LWF Service Area adults who have been told that their blood cholesterol was high, 82.5% report that they are currently taking actions to control their cholesterol levels, such as through medication, diet and/or exercise.

- Similar to national findings (81.2%).
- Statistically similar between the two sub-areas.

Taking Action to Control High Blood Cholesterol (Among Respondents With High Blood Cholesterol)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 50]
 - 2005 PRC National Health Survey, Professional Research Consultants.
- Note:
- Asked of respondents who have been told that their blood cholesterol was high.
 - In this case, "taking action" includes medication, diet modification, and/or exercise.

Total Cardiovascular Risk

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

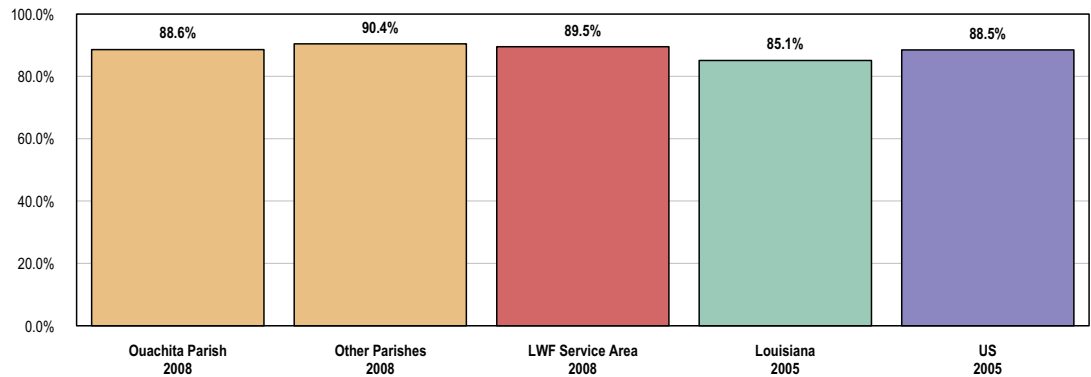
- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

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

In all, 89.5% of LWF Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- ☑ Less favorable than found statewide (85.1%).
- ☑ Similar to national findings (88.5%).
- ⊕ Similar between the sub-areas.

Present One or More Cardiovascular Risk Factors or Behaviors



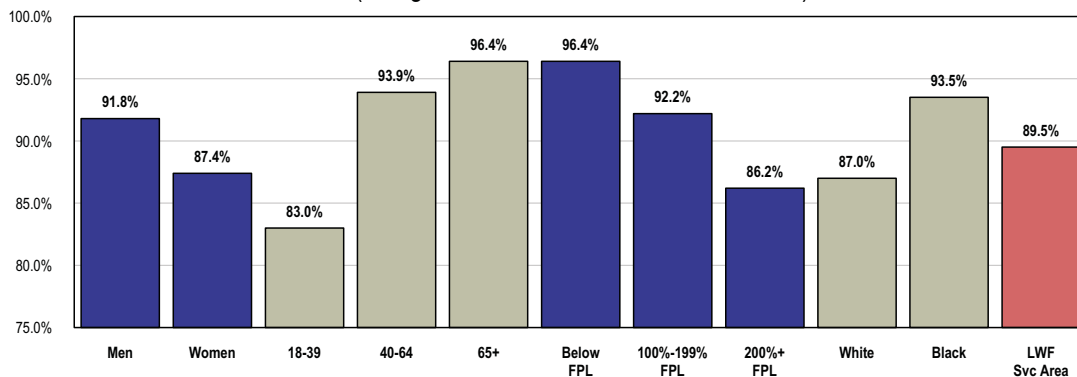
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 133]
• 2005 PRC National Health Survey, Professional Research Consultants.
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
Note: • Includes respondents reporting any of the following: overweight, cigarette smoking, high blood pressure, high cholesterol, or physical inactivity.

The LWF Service Area adults more likely to exhibit cardiovascular risk factors include:

- 👤 Men.
- 👤 Adults aged 40 and older.
- 👤 Residents living at lower incomes, especially those living in poverty.
- 👤 Blacks.

Present One or More Cardiovascular Risk Factors or Behaviors

(Living Well Foundation Service Area, 2008)



- Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 133]
 Note: • Includes respondents reporting any of the following: overweight, cigarette smoking, high blood pressure, high cholesterol, or physical inactivity.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.
 • Includes respondents reporting any of the following: overweight, cigarette smoking, high blood pressure, high cholesterol, or physical inactivity.

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 U.S. 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 U.S. 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 U.S.

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

(Related Issue: See also “Nutrition & Overweight,” “Physical Activity & Fitness” and “Tobacco Use” in the Modifiable Health Risk section.)

CANCER

Cancer, the second leading cause of death among Americans, is responsible for one of every four deaths in the United States. In 2003, over half a million Americans—or more than 1,500 people a day—will die of cancer. Black Americans 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 2002. 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 Americans 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

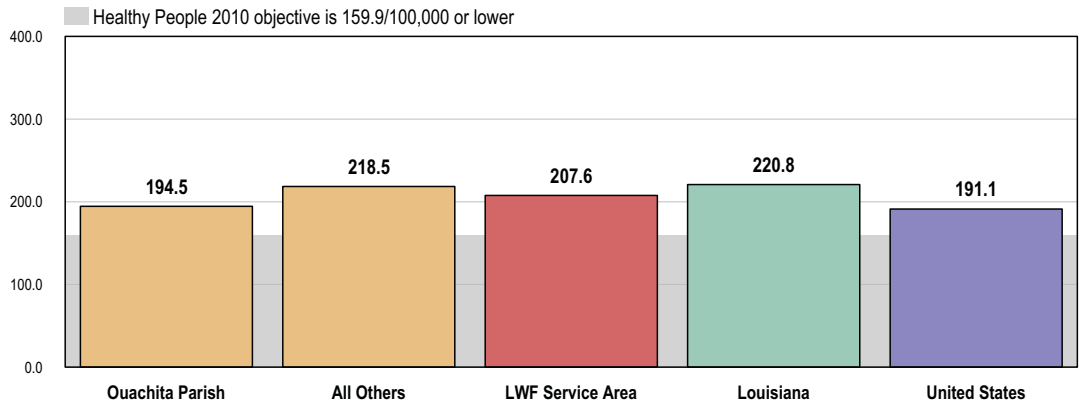
All Cancer Deaths

Between 2002 and 2004, the annual average age-adjusted cancer death rate in the LWF Service Area was 207.6 deaths per 100,000 population.

- ☑ Better than the corresponding Louisiana rate (220.8 deaths per 100,000).
- ☑ Worse than the U.S. rate (191.1).
- ☑ Fails to satisfy the Healthy People 2010 objective (159.9 or lower).
- ⊕ More favorable in Ouachita Parish.

Age-Adjusted Mortality: Cancer

(2002-2004 Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

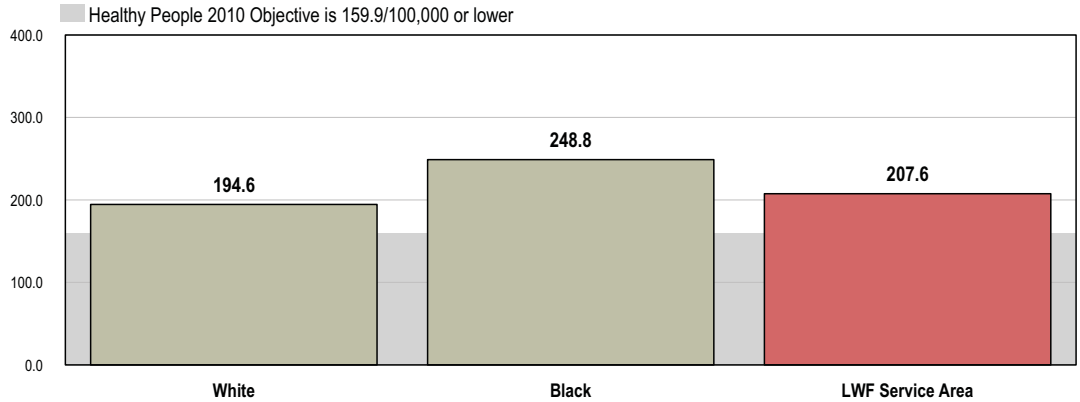
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 3-1]

Note: • 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.

☹ Cancer mortality rates are notably higher among LWF Service Area Blacks than among LWF Service Area Whites.

Age-Adjusted Mortality: Cancer

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)

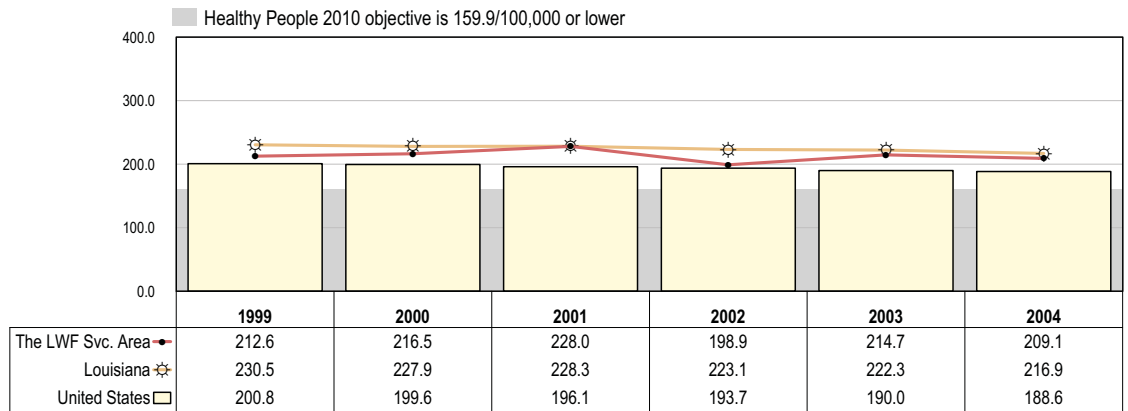


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000. [Objective 3-1]
 Note: • 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.

☹ Over the past decade, the LWF Service Area age-adjusted cancer death rates have shown no clear trend. Downward trends are reported both state- and nationwide.

Age-Adjusted Mortality: Cancer

(Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Lung cancer is by far the leading cause of cancer deaths in the region. 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 2002-2004 annual average age-adjusted rates):

- ☐ The LWF Service Area **lung cancer** death rate is less favorable than the national rate.
- ☐ The **prostate cancer** death rate is worse than state and national rates.
- ☐ The **female breast cancer** death rate is similar to the statewide rate and the national rate.
- ☐ The **colorectal cancer** death rate is better than that found statewide, but similar to nationwide rates.

Age-Adjusted Cancer Death Rates by Leading Sites

(2002-2004 Annual Average Deaths per 100,000 Population)

	LWF Service Area	Louisiana	United States
Lung Cancer	63.4	66.5	54.3
Prostate Cancer (Men Only)	39.7	31.7	20.7
Female Breast Cancer	28.7	29.4	28.0
Colorectal Cancer	18.4	22.7	19.1

Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, EpidemiologyProgram Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

Prevalence of Cancer

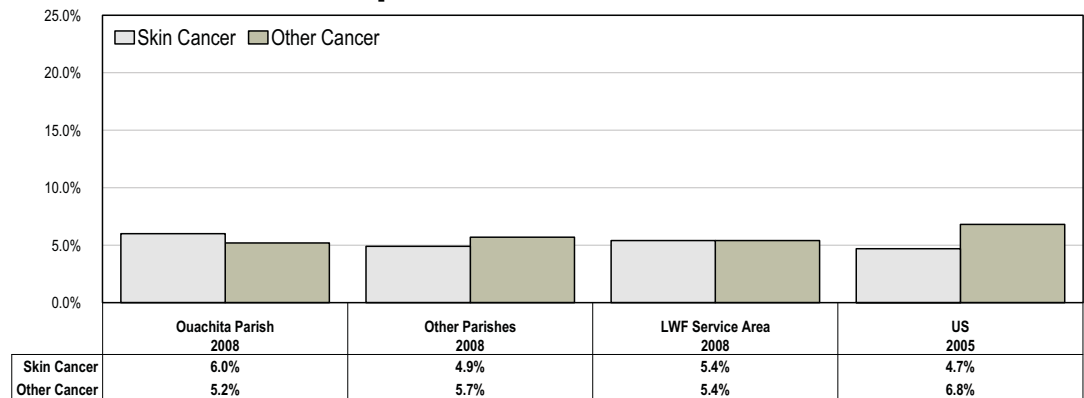
A total of 5.4% of LWF Service Area adults report having been diagnosed with skin cancer.

- ☑ Similar to the national average (4.7%).
- ⊕ No difference between sub-areas.

Similarly, 5.4% of LWF Service Area adults report having been diagnosed with another type of cancer (non-skin).

- ☑ Also similar to the national average (6.8%).
- ⊕ Similar between the sub-areas.

Self-Reported Prevalence of Cancer



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 33,34]
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

Cancer Risk

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

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

(Related Issue: see also “Nutrition & Overweight,” “Physical Activity & Fitness” and “Tobacco Use” in the Modifiable Health Risk section.)

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 LWF Service Area were measured in the survey relative to four cancer sites: colorectal cancer (**sigmoidoscopy** and **fecal occult blood testing**); female breast cancer (**mammography**); cervical cancer (**Pap smear testing**); and prostate cancer (**prostate-specific antigen testing** and **digital rectal examination**).

Colorectal Cancer Screenings

COLORECTAL CANCER

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States. When cancer-related deaths are estimated separately for males and females, however, CRC becomes the third leading cause of cancer death behind lung and breast cancers for females and behind lung and prostate cancers for males.

Risk factors for CRC 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 CRC. Fecal occult blood testing and sigmoidoscopy are widely used to screen for CRC, and barium enema and colonoscopy are used as diagnostic tests.

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

Beginning at age 50, both men and women should follow one of these five testing schedules:

- Yearly fecal occult blood test (FOBT)*
- Flexible sigmoidoscopy every 5 years
- Yearly fecal occult blood test plus flexible sigmoidoscopy every 5 years**
- Double-contrast barium enema every 5 years
- Colonoscopy every 10 years

*For FOBT, the take-home multiple sample method should be used.

**The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.

All positive tests should be followed up with a colonoscopy. People should begin colorectal cancer screening earlier and/or undergo screening more often if they have certain colorectal cancer risk factors.

– American Cancer Society

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

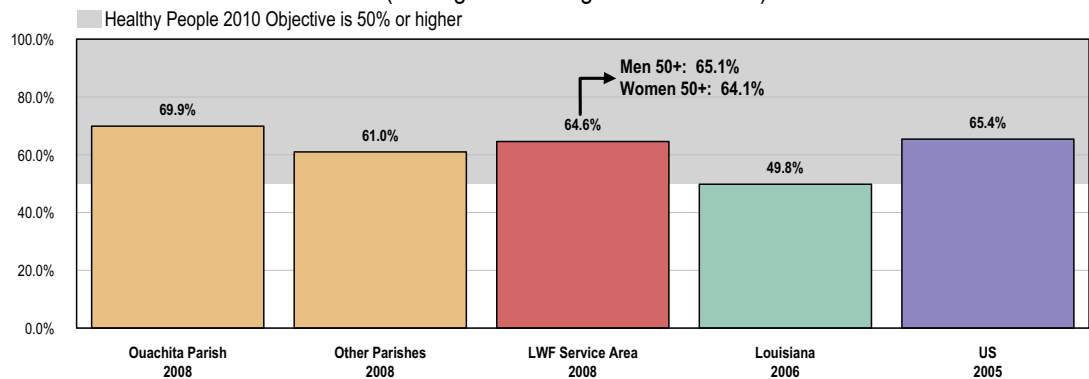
Sigmoidoscopy/Colonoscopy

Among LWF Service Area adults aged 50 and older, 64.6% had a sigmoidoscopy or colonoscopy at some point in their lives.

- More favorable than Louisiana findings (49.8%).
- Similar to national findings (65.4%).
- Satisfies the Healthy People 2010 target (50% or higher).
- More favorable in Ouachita Parish.
- Note: Includes 65.1% of LWF Service Area men 50+ and 64.1% of LWF Service Area women 50+.

Have Ever Had a Sigmoidoscopy/Colonoscopy Examination

(Among Persons Aged 50 and Older)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [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); 2006 Louisiana data.
 - 2006 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]
- Note:
- Asked of all respondents aged 50 or over.

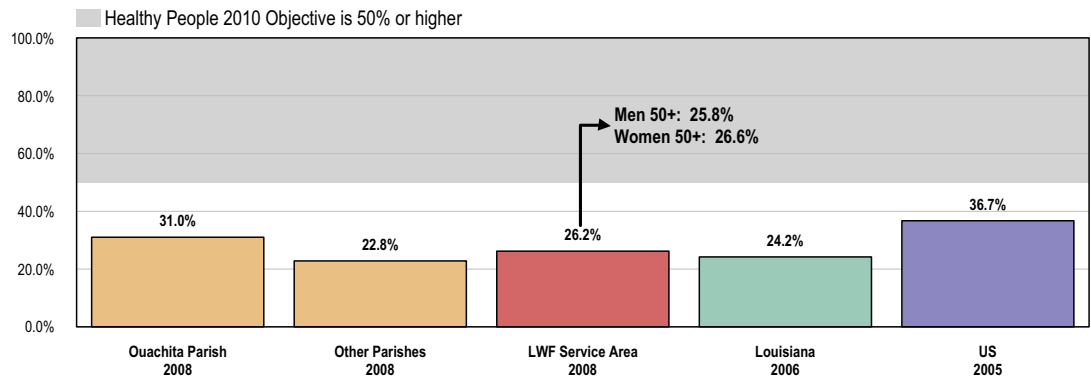
Fecal Occult Blood Testing

Among LWF Service Area adults aged 50 and older, 26.2% had a blood stool test (a.k.a., fecal occult blood test) within the past two years.

- Similar to Louisiana findings (24.2%).
- Worse than national findings (36.7%).
- Fails to satisfy the Healthy People 2010 target (50% or higher).
- More favorable in Ouachita Parish.
- Note: Includes 25.8% of LWF Service Area men 50+ and 26.6% of LWF Service Area women 50+.

Have Had a Blood Stool Test in the Past Two Years

(Among Persons Aged 50 and Older)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 169]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2006 Louisiana data.
 - 2005 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 3-12a]
- Note:
- Asked of respondents aged 50 and older.

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Screenings for female breast cancer are recommended as outlined below:

- Yearly mammograms starting at age 40 and continuing for as long as a woman is in good health.
- Clinical breast exams (CBE) should be part of a periodic health exam, about every three years for women in their 20s and 30s and every year for women 40 and over.
- Women should report any breast change promptly to their healthcare providers. Breast self-exam (BSE) is an option for women starting in their 20s.
- Women at increased risk (e.g., family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of starting mammography screening earlier, having additional tests (e.g., breast ultrasound or MRI), or having more frequent exams.

– American Cancer Society

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

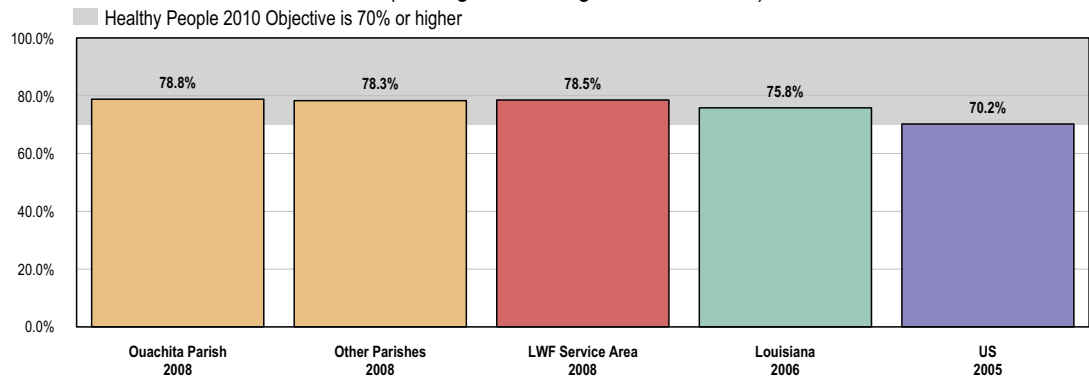
Mammography

Among LWF Service Area women aged 40 and older, 78.5% had a mammogram within the past two years.

- ☑ Similar to statewide findings (75.8%).
- ☑ More favorable than national findings (70.2%).
- ☑ Satisfies the Healthy People 2010 target (70% or higher).
- ⊕ Does not vary significantly between sub-areas.
- 👥 Note that 77.3% of LWF Service Area women aged 65 and older had a mammogram in the preceding two years.

Have Had a Mammogram in the Past Two Years

(Among Women Aged 40 and Older)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 16]
 - 2005 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): 2006 Louisiana data.
 - 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]
- Note:
- Asked of women aged 40 and over.

Cervical Cancer Screenings

Screenings for cervical cancer are recommended as outlined below:

- All women should begin cervical cancer screening about 3 years after they begin having vaginal intercourse, but no later than when they are 21 years old. Screening should be done every year with the regular Pap test or every 2 years using the newer liquid-based Pap test.
- Beginning at age 30, women who have had 3 normal Pap test results in a row may get screened every 2 to 3 years with either the conventional (regular) or liquid-based Pap test. Women who have certain risk factors such as diethylstilbestrol (DES) exposure before birth, HIV infection, or a weakened immune system due to organ transplant, chemotherapy, or chronic steroid use should continue to be screened annually.
- Another reasonable option for women over 30 is to get screened every 3 years (but not more frequently) with either the conventional or liquid-based Pap test, *plus* the HPV DNA test.
- Women 70 years of age or older who have had 3 or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system should continue to have screening as long as they are in good health.
- Women who have had a total hysterectomy (removal of the uterus and cervix) may also choose to stop having cervical cancer screening, unless the surgery was done as a treatment for cervical cancer or precancer. Women who have had a hysterectomy without removal of the cervix should continue to follow the guidelines above.

– American Cancer Society

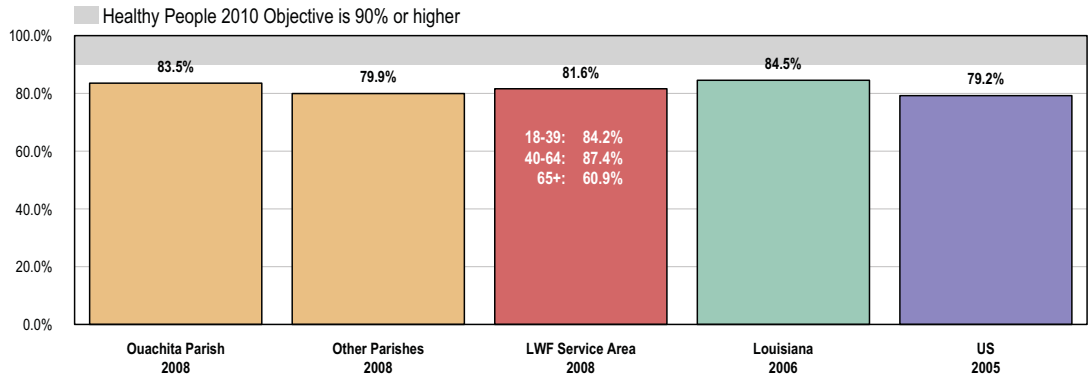
Note that other organizations (e.g., American Academy of Family Physicians, American College of Physicians, National Cancer Institute, US Preventive Services Task Force) may have slightly different screening guidelines.

Pap Smear Testing

Among LWF Service Area women aged 18 and older, 81.6% had a Pap smear within the past three years.

- 📊 Similar the Louisiana percentage (84.5%).
- 📊 Similar to national findings (79.2%).
- 📊 Fails to satisfy the Healthy People 2010 target (90% or higher).
- 📊 No difference between sub-areas.

Have Had a Pap Smear Within the Past Three Years (Among Women Aged 18 and Older)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 9]
 - 2005 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]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2006 Louisiana data.
- Note:
- Asked of all female respondents.

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Guideline Statement: Both prostate-specific antigen (PSA) testing and digital rectal examination (DRE) should be offered annually, beginning at age 50 years, to men who have at least a 10-year life expectancy. Men at high risk should begin testing at age 45 years. Information should be provided to men regarding potential risks and benefits of early detection and treatment of prostate cancer. Men at even higher risk, due to multiple first-degree relatives affected at an early age, could begin testing at age 40. Depending on the results of this initial test, no further testing might be needed until age 45. Information should be provided to men regarding potential risks and benefits of early detection and treatment of prostate cancer.

- Men who choose to undergo testing should begin at age 50 years. However, men in high-risk groups, such as African Americans and men who have a first-degree relative diagnosed with prostate cancer at a young age, should begin testing at 45 years. *[Note: a first-degree relative is defined as a father, brother, or son.]*
- Men who ask their doctor to make the decision on their behalf should be tested. Discouraging testing is not appropriate. Also not offering testing is not appropriate.
- Testing for prostate cancer in asymptomatic men can detect tumors at a more favorable stage (anatomic extent of disease). There has been a reduction in mortality from prostate cancer, but it has not been established that this is a direct result of screening.
- An abnormal Prostate-Specific Antigen (PSA) test result has been defined as a value of above 4.0 ng/ml. Some elevations in PSA may be due to benign conditions of the prostate.
- The Digital Rectal Examination (DRE) of the prostate should be performed by healthcare workers skilled in recognizing subtle prostate abnormalities, including those of symmetry and consistency, as well as the more classic findings of marked induration or nodules. DRE is less effective in detecting prostate carcinoma compared with PSA.

– American Cancer Society

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

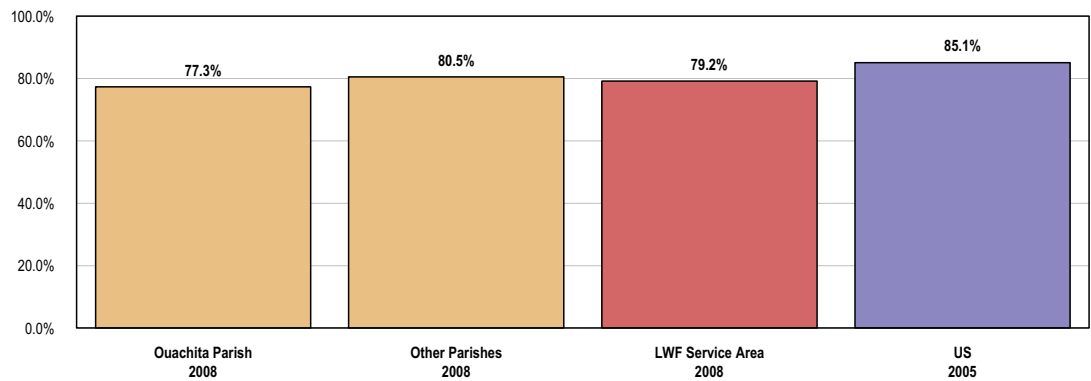
PSA Testing and/or Digital Rectal Examination

Among LWF Service Area men aged 50 and older, 79.2% 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 (85.1%).
- ⊕ No difference between Ouachita Parish and the other parishes in The Living Well Foundation Service Area.

Have Had a Prostate-Specific Antigen (PSA) Test OR a Digital Rectal Exam in Past Two Years

(Among Men Aged 50 and Older)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 163]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of male respondents aged 50 and older.

Related Focus Group Findings: Cancer

Community Leaders/ Business Leaders

Cancer is a significant issue in the area, but people aren't getting to the doctor for annual exams. When many find out about the cancer, it's progressed quite far. Too many people are without insurance to cover routine doctor visits so they don't go. Those who live in outlying areas have the additional issue of having no transportation to get to an appointment.

"Every January we have a breast and cervical screening and the last two years we've had over 300 women come in within four hours and a lot of them have insurance but they have high deductibles so they've put off being screened." – Community Leader

"People wait too long to be diagnosed. They go when their cancer is more advanced." – Business Leader

RESPIRATORY DISEASE

Asthma and COPD (chronic obstructive pulmonary disease) are among the 10 leading chronic conditions causing restricted activity [in Americans]. 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

[Note: Chronic lower respiratory disease (CLRD) was called chronic obstructive pulmonary disease (COPD) prior to 1999 with the issuance of the International Classification of Diseases, Tenth Revision (ICD-10). Healthy People 2010 refers to COPD rather than CLRD.]

Age-Adjusted Respiratory Disease Deaths

Chronic Respiratory Disease Deaths

Between 2002 and 2004, the annual average age-adjusted chronic lower respiratory disease death rate in the LWF Service Area was 43.6 deaths per 100,000 population.

- ☉ Worse than the corresponding Louisiana rate (40.2).
- ☉ Similar to the U.S. rate (42.6).
- ⊕ Less favorable in Ouachita Parish.

Age-Adjusted Mortality: CLRD

(2002-2004 Annual Average Deaths per 100,000 Population)



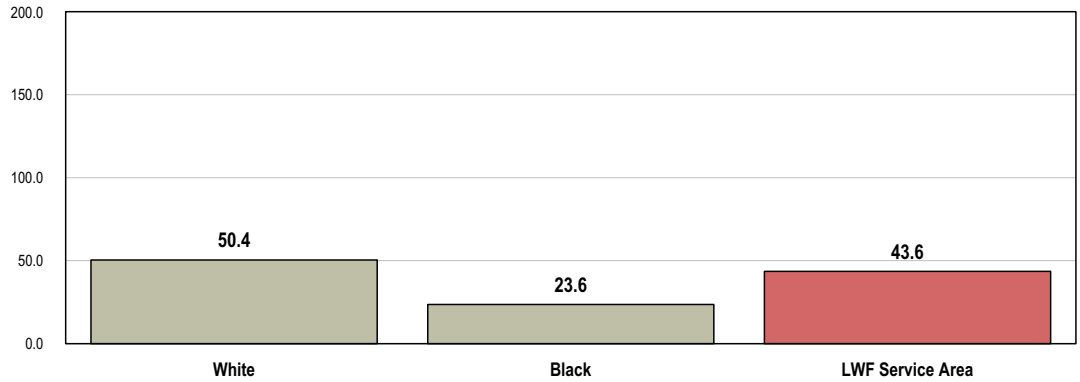
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

Note: • 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.

- ☒ Comparing the LWF Service Area rates by race (White and Black), Whites experienced a higher age-adjusted mortality rate from CLRD than Blacks.

Age-Adjusted Mortality: CLRD

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)

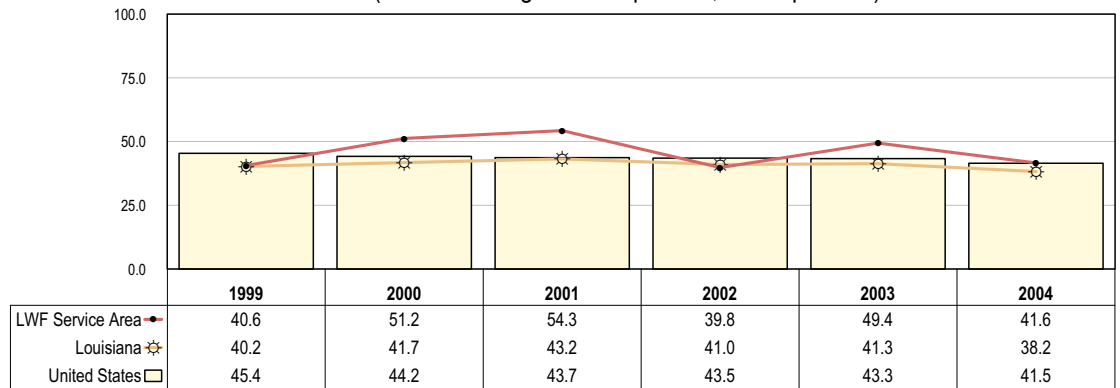


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

- ☒ Statewide and nationally, the age-adjusted chronic lower respiratory disease death rate has trended downward over the past several years; however, this trend is not as clear in the LWF Service Area (increasing between 1999 and 2001, and between 2002 and 2003).

Age-Adjusted Mortality: CLRD

(Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Pneumonia/Influenza Deaths

Between 2002 and 2004, the annual average age-adjusted pneumonia/influenza death rate in the LWF Service Area was 31.2 per 100,000 population.

- ⊗ Much worse than the corresponding Louisiana rate (22.7).
- ⊗ Much worse than the national rate (21.5).
- ⊕ More favorable in Ouachita Parish.

Age-Adjusted Mortality: Pneumonia/Influenza

(2002-2004 Annual Average Deaths per 100,000 Population)



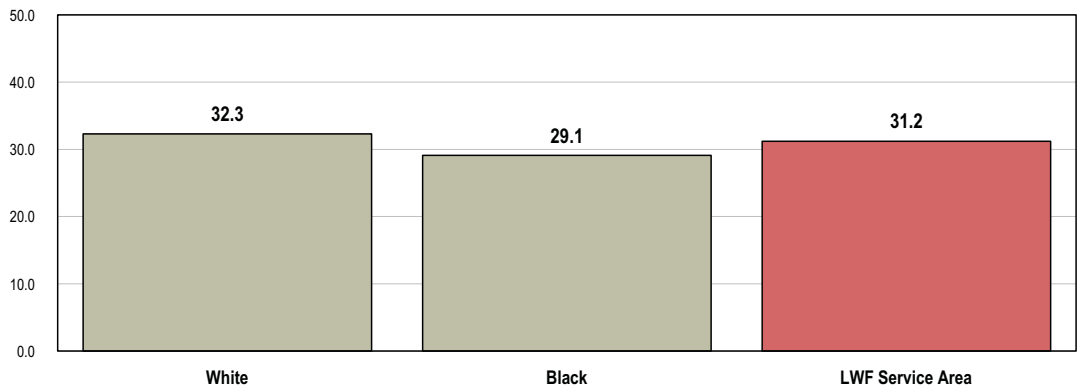
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

Note: • 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.

- 👤 Age-adjusted pneumonia/influenza mortality rates are similar between Whites and Blacks in the LWF Service Area .

Age-Adjusted Mortality: Pneumonia/Influenza

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)



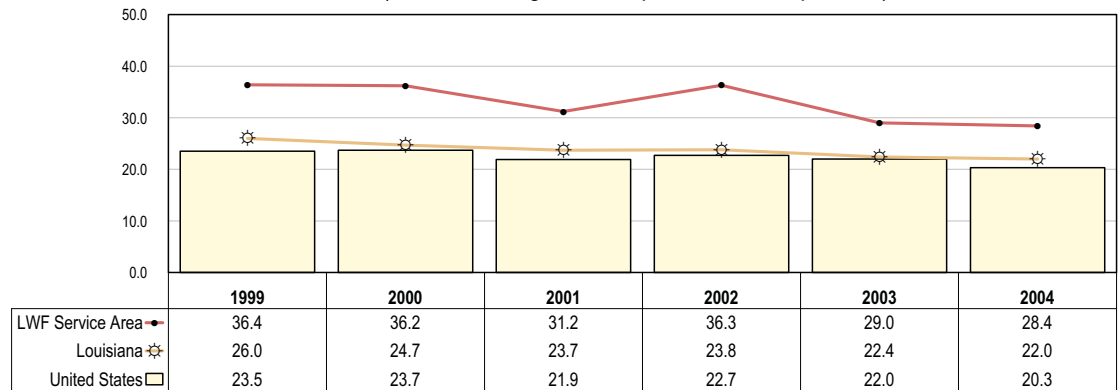
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

Note: • 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.

- Between 1999 and 2004, age-adjusted pneumonia/influenza death rates have declined overall in the LWF Service Area, similar to state and national trends.

Age-Adjusted Mortality: Pneumonia/Influenza

(Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

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

Prevalence of Respiratory Conditions

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

Nearly one out of three LWF Service Area adults (30.7%) reports suffering from nasal or hay fever allergies.

- Similar to national findings (32.3%).

Another 28.1% of survey respondents report suffering from sinusitis.

- Much less favorable than national findings (16.5%).

A total of 13.3% of LWF Service Area adults have ever been diagnosed with asthma.

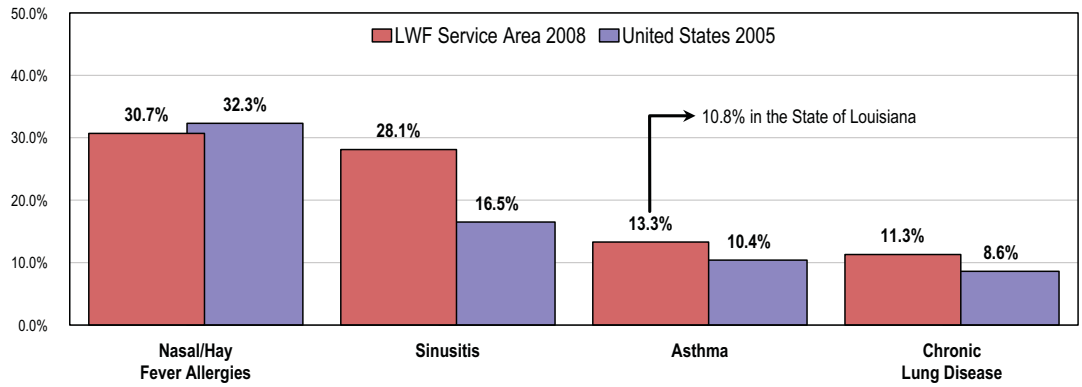
- Less favorable than both statewide (10.8%) and national (10.4%) prevalence reports.

Note: Among adults reporting an asthma diagnosis at some point in their lives, just over one-half (66.2%) report that they still have asthma.

A total of 11.3% of LWF Service Area adults suffer from chronic lung disease.

- Less favorable than the 8.6% found nationally.

Self-Reported Respiratory Conditions

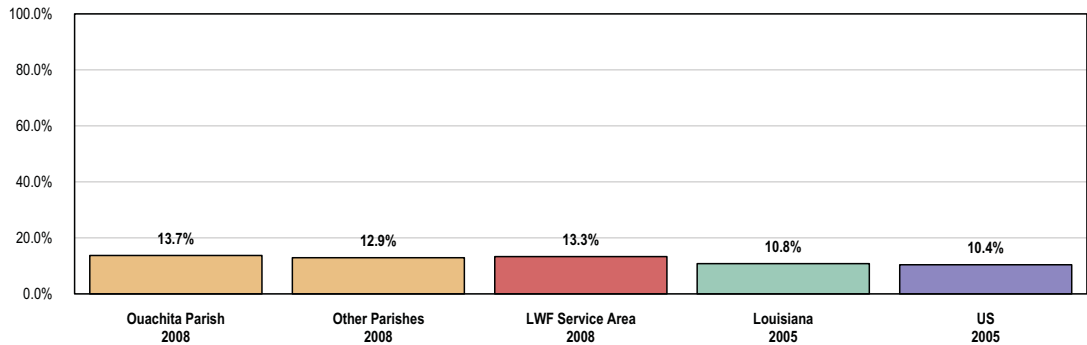


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 26,37,38,41]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

✚ The asthma prevalence is similar among adults in Ouachita Parish and the other parishes in the LWF Service Area.

Prevalence of Asthma



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 41]
 • 2005 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): 2005 Louisiana data.

Note: • Asked of all respondents.

Asthma in 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.

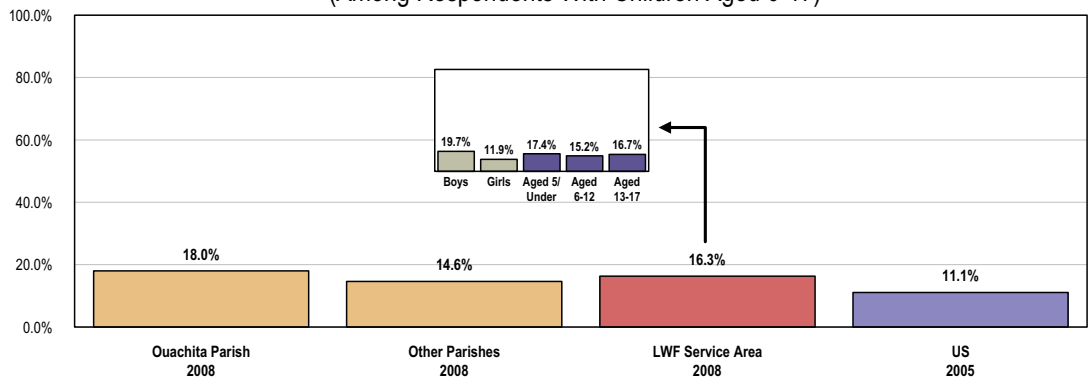
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Among LWF Service Area children under 18, 16.3% are reported to have been diagnosed with asthma.

- ☑ Statistically similar to national findings (11.1%).
- ⊕ Statistically similar between sub-areas.
- 👤 Viewed by age, differences in asthma prevalence are not statistically significant. However, area boys are more likely than girls to suffer from asthma.

Child Has Asthma

(Among Respondents With Children Aged 0-17)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 127]
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of respondents with children aged 0-17.

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, [U.S.] 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 four 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

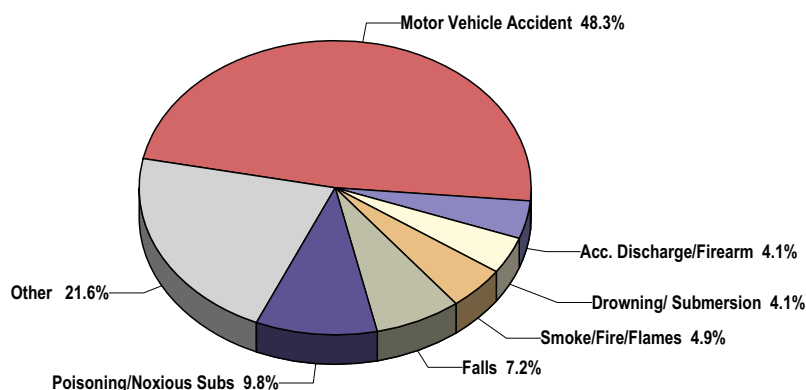
Unintentional Injury

Leading Causes of Unintentional Injury Deaths

Motor vehicle crashes (48.3%), poisoning (9.8%) and falls (7.2%) were the top three causes of accidental deaths in the LWF Service Area between 2002 and 2004.

Leading Causes of Accidental Death

(Living Well Foundation Service Area, 2002-2004)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

Note: • Percentages are of the total accidental deaths in LWF Service Area for 2002-2004.

(Related Issue: see also “Substance Abuse.”)

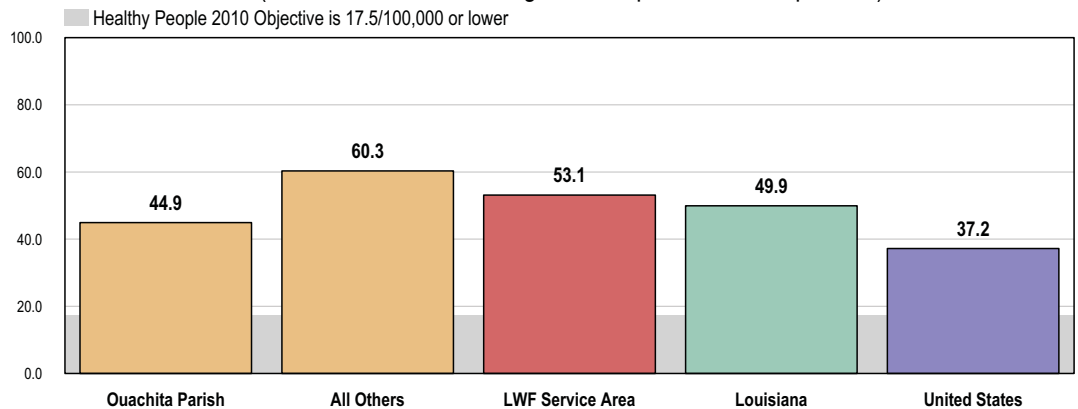
Age-Adjusted Unintentional Injury Deaths

Between 2002 and 2004, the annual average age-adjusted unintentional injury death rate in the LWF Service Area was 53.1 deaths per 100,000 population.

- ❑ Less favorable than found statewide (49.9).
- ❑ Much higher than found nationally (37.2).
- ❑ More than three times the Healthy People 2010 objective (17.5 or lower).
- ⊕ More favorable in Ouachita Parish.

Age-Adjusted Mortality: Unintentional Injuries

(2002-2004 Annual Average Deaths per 100,000 Population)



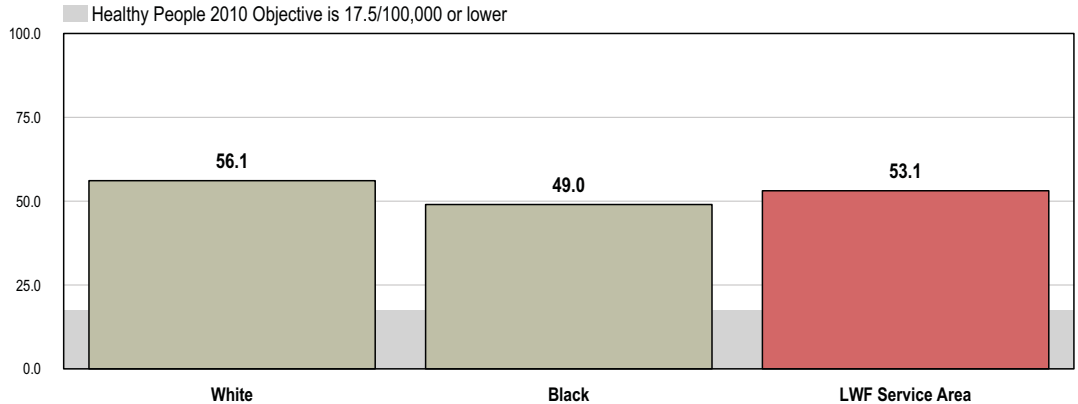
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-13]

Note: • 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.

👤 Viewed by race, unintentional injury death rates are somewhat higher among Whites than Blacks in the LWF Service Area.

Age-Adjusted Mortality: Unintentional Injuries

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)



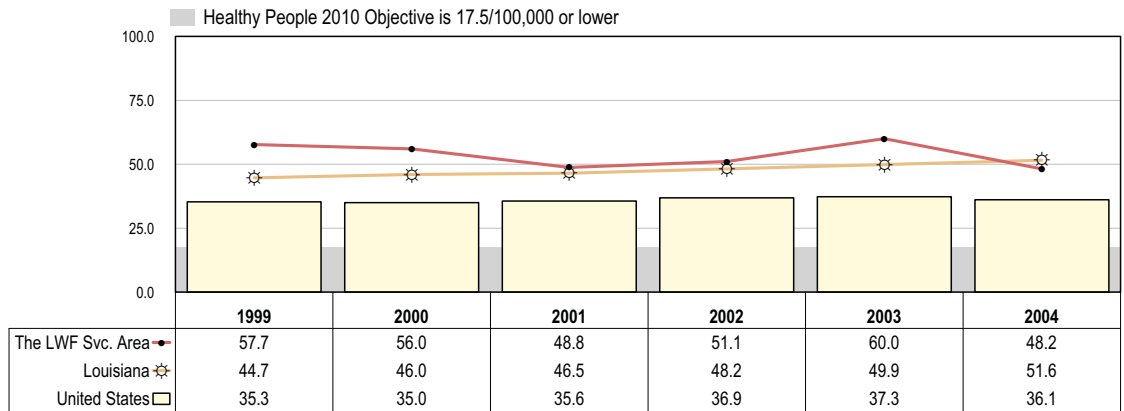
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-13]

Note: • 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.

- ☒ In recent years, the LWF Service Area age-adjusted unintentional injury death rates have shown no clear trend. Statewide rates have increased, more so than found nationwide.

Age-Adjusted Mortality: Unintentional Injuries

(Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000. [Objective 15-13]
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Motor Vehicle Safety

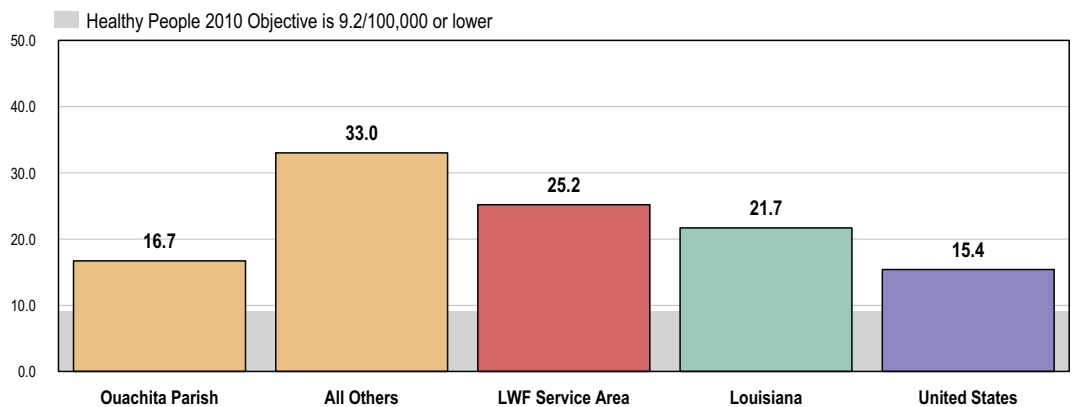
Age-Adjusted Motor-Vehicle Related Deaths

Between 2002 and 2004, the annual average age-adjusted motor vehicle crash death rate in the area was 25.2 deaths per 100,000 population.

- ☒ Less favorable than the Louisiana rate (21.7).
- ☒ Less favorable than the national rate (15.4).
- ☒ More than twice the Healthy People 2010 objective (9.2 or lower).
- ☒ More favorable in Ouachita Parish.

Age-Adjusted Mortality: Motor Vehicle Accidents

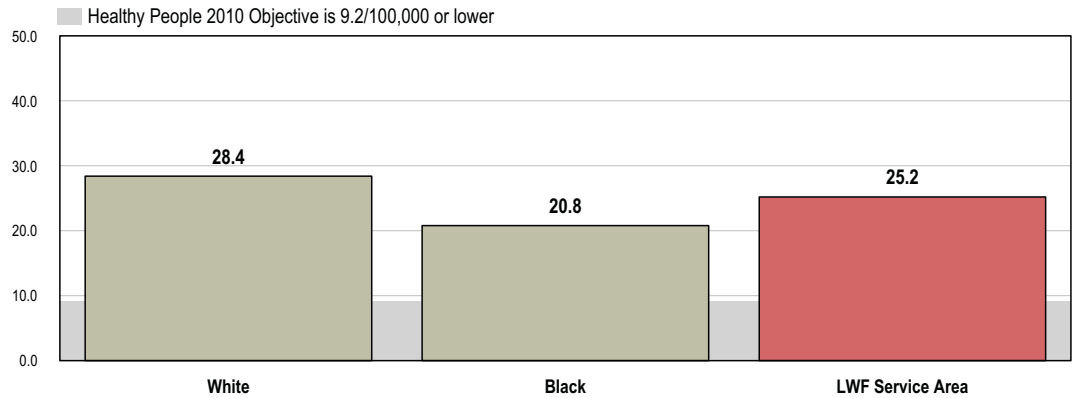
(2002-2004 Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]
 Note: • 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.

Motor vehicle accident mortality is also somewhat higher among Whites than Blacks in the LWF Service Area.

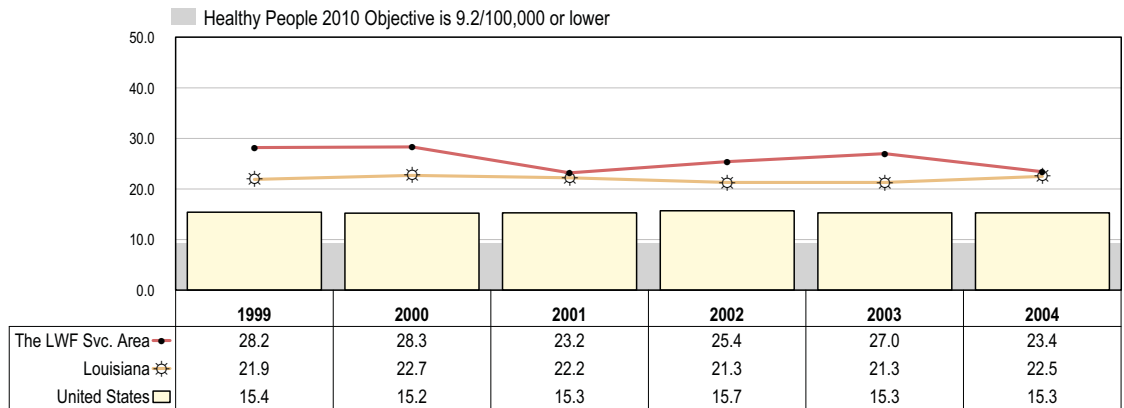
Age-Adjusted Mortality: Motor Vehicle Accidents (2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]
 Note: • 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.

Across the LWF Service Area, overall motor vehicle accident deaths have decreased since 1999.

Age-Adjusted Mortality: Motor Vehicle Accidents (Annual Average Deaths per 100,000 Population)



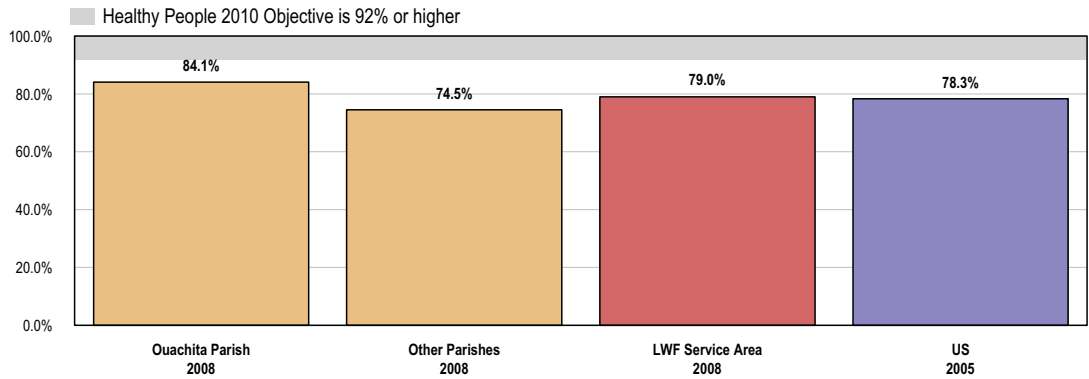
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC:U.S. Government Printing Office, November 2000. [Objective 15-15a]
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Seat Belt Usage - Adults

Most LWF Service Area adults (79.0%) report “always” wearing a seat belt when driving or riding in a vehicle.

- ☑ Similar to found nationally (78.3%).
- ☑ Fails to satisfy the Healthy People 2010 objective of 92% or higher.
- ⊕ Higher in Ouachita Parish (84.1%).

“Always” Wear a Seat Belt When Driving or Riding in a Vehicle



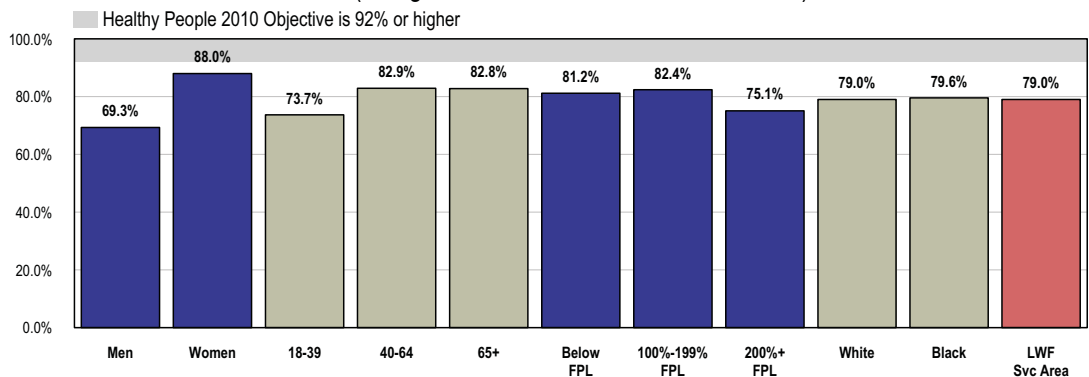
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 55]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19]
 Note: • Asked of all respondents.

The following demographic segments are less likely to report consistent seat belt usage:

- 👤 Men.
- 👤 Young adults (under age 40).
- 👤 Those living in the highest income bracket.

“Always” Wear a Seat Belt When Driving or Riding in a Vehicle

(Living Well Foundation Service Area, 2008)



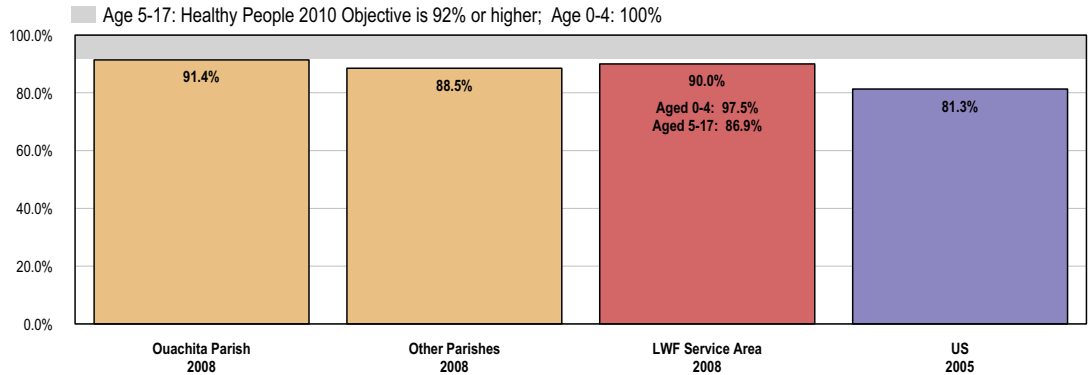
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 55]
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Seat Belt Usage - Children

A total of 90.0% of LWF Service 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.

- ☑ Better than found nationally (81.3%).
- ⊕ Statistically similar among the geographic sub-areas.
- 👥 Much higher among children under 5.

Child “Always” Wear a Seat Belt or Appropriate Restraint When Riding in a Vehicle (Among Children Aged 0 to 17 Years)



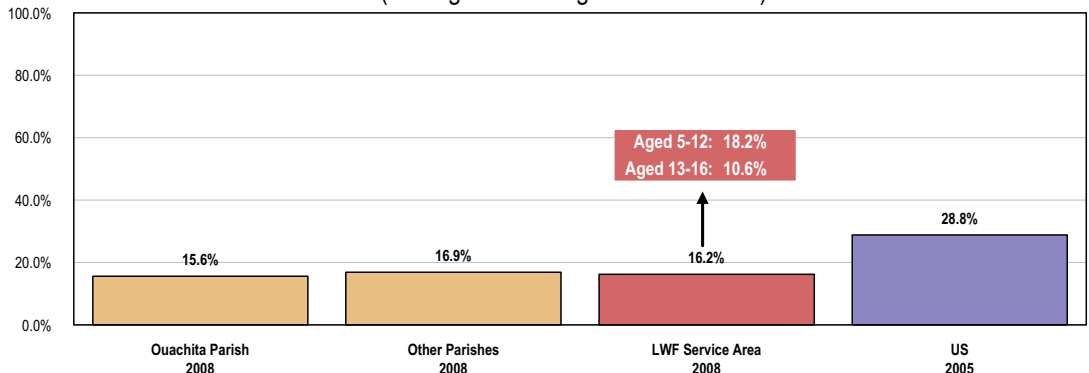
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 129,159,160]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-19]
 Note: • Asked of respondents with children aged 0 to 17 living in the household.

Bicycle Safety

Only 16.2% of LWF Service Area children aged 5 to 16 are reported to “always” wear a helmet when riding a bicycle.

- ☑ Much lower than national findings (28.8%).
- 👥 Note also that helmet usage drops off somewhat past age 12.
- ⊕ Similar between sub-areas.

Child “Always” Wears a Helmet When Riding a Bicycle (Among Children Aged 5 to 16 Years)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 132]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of respondents with children aged 5 to 16.

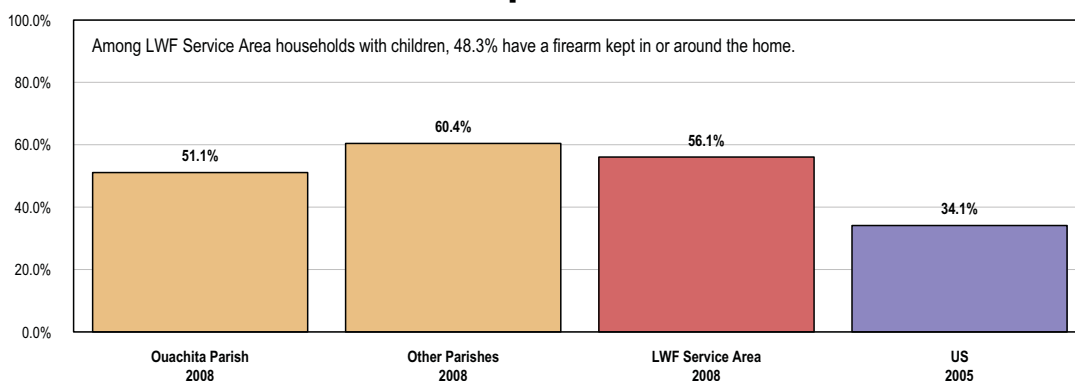
Firearms Safety

Survey respondents were further asked about the presence of weapons in the home: “Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car?” For the purposes of this inquiry, “firearms” include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire.

Overall, 56.1% of LWF Service Area adults have a firearm kept in or around their home.

- 📍 Much higher than the national prevalence (34.1%).
- 📍 Lower in Ouachita Parish.
- 👤 Note that in area households with children, 48.3% have a firearm kept in or around the home (much less favorable than seen nationally, 30.8%).

Have a Firearm Kept in or Around the Home



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 58,157]

• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

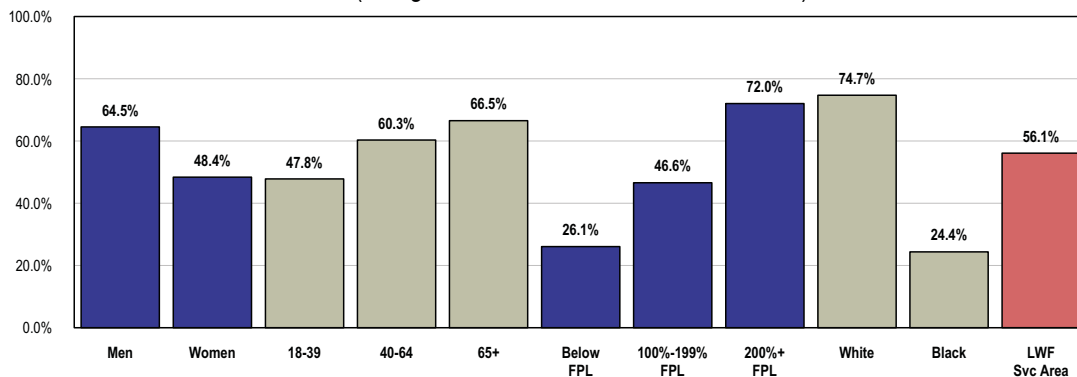
• In this case, the term “firearm” includes pistols, shotguns, rifles, and other types of guns. This does NOT include starter pistols, BB guns, or guns that cannot fire. Guns can be in or around the home, including those kept in a garage, outdoor storage area, truck, or car.

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 Home

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 58]

Note: • Asked of all respondents.

• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].

• White and Black are non-Hispanic race categorizations.

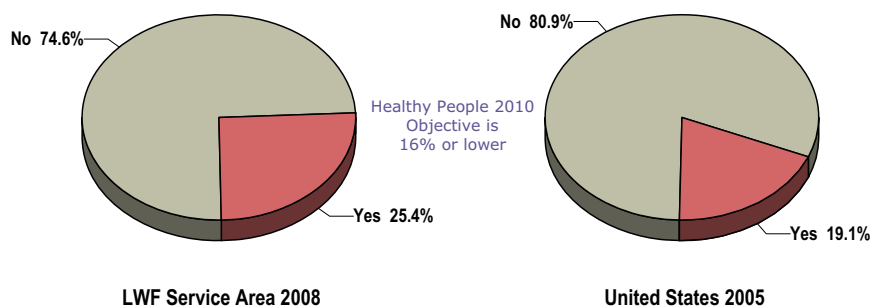
• In this case, the term "firearm" includes pistols, shotguns, rifles, and other types of guns. This does NOT include starter pistols, BB guns, or guns that cannot fire. Guns can be in or around the home, including those kept in a garage, outdoor storage area, truck, or car.

Among LWF Service Area households with firearms, 25.4% report that there is at least one weapon that is kept unlocked and loaded.

- ☐ Less favorable than found nationally (19.1%).
- ☐ Fails to satisfy the *Healthy People 2010* target (16% or lower).

Household Has An Unlocked, Loaded Firearm

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



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 158]

• 2005 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 15-4]

Note: • Among respondents reporting a firearm in or around the home.

• In this case, the term "firearm" includes pistols, shotguns, rifles, and other types of guns. This does NOT include starter pistols, BB guns, or guns that cannot fire. Guns can be in or around the home, including those kept in a garage, outdoor storage area, truck, or car.

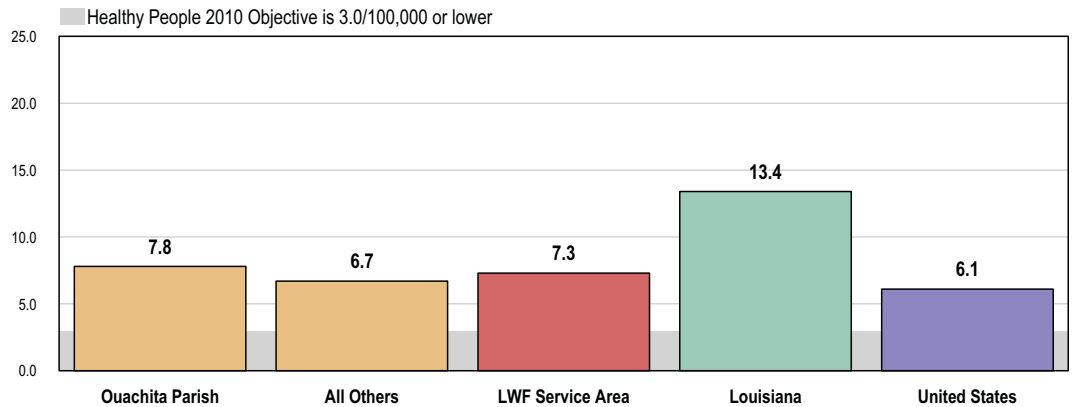
Age-Adjusted Intentional Injury Deaths

Homicide

Between 2002 and 2004, the annual average age-adjusted homicide death rate in the area was 7.3 deaths per 100,000 population.

- ☑ More favorable than the Louisiana rate (13.4).
- ☑ Less favorable than the national homicide rate (6.1).
- ☑ Fails to satisfy the Healthy People 2010 goal of 3.0 or lower.
- ⊕ Less favorable in Ouachita Parish.

Age-Adjusted Mortality: Homicide (2002-2004 Annual Average Deaths per 100,000 Population)

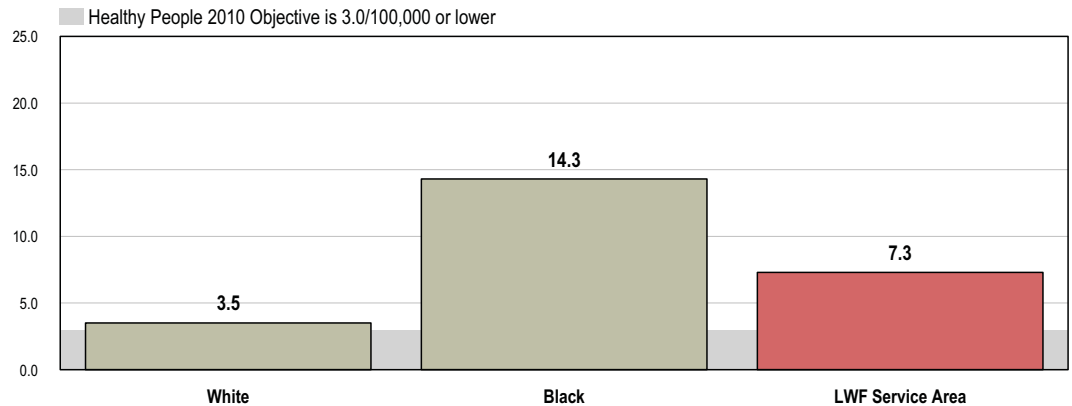


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-32]
 Note: • 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.

👥 The LWF Service Area homicide death rate is exceptionally high (four times higher) among Blacks in the region when compared with Whites.

Age-Adjusted Mortality: Homicide

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)

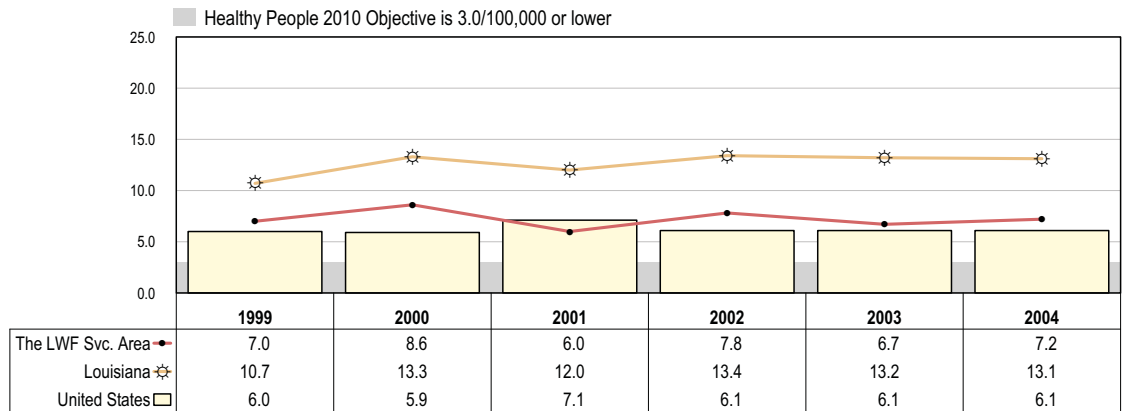


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-32]
 Note: • 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.

- ▣ Homicide death rates in the LWF Service Area show no clear trend over the past several years.

Age-Adjusted Mortality: Homicide

(Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]

Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • The 2001 West Monroe rate is statistically unreliable.

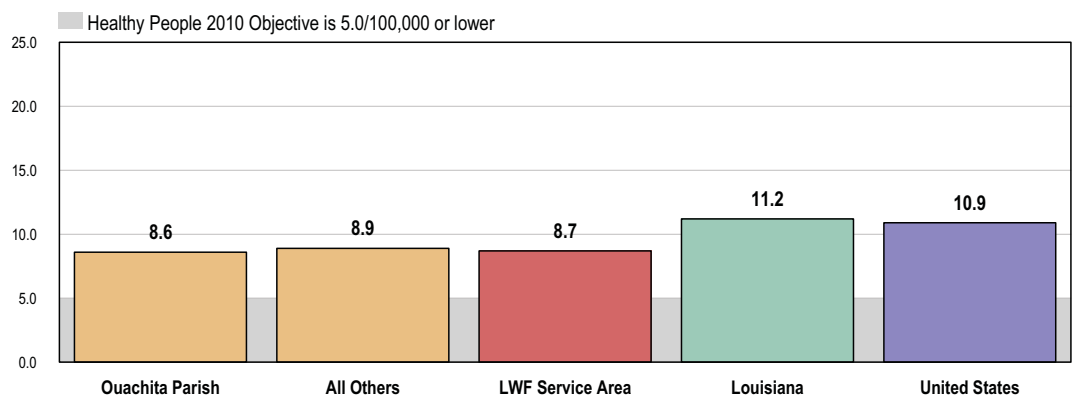
Suicide

Between 2002 and 2004, the annual average age-adjusted suicide death rate in the LWF Service Area was 8.7 deaths per 100,000 population.

- ▣ More favorable than the statewide rate (11.2).
- ▣ More favorable than the national rate (10.9).
- ▣ Fails to satisfy the Healthy People 2010 objective (5.0 or lower).
- ▣ Similar between sub-areas.

Age-Adjusted Mortality: Suicide

(2002-2004 Annual Average Deaths per 100,000 Population)



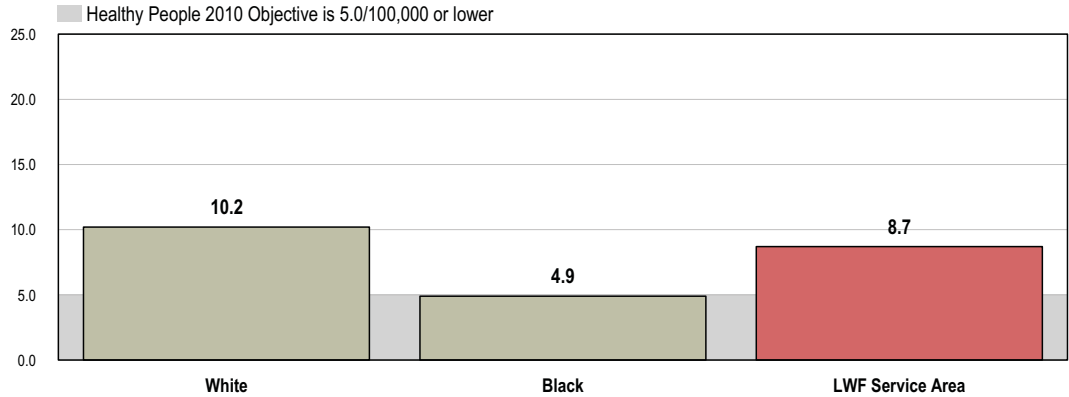
Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office/Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 18-1]

Note: • 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.

☹ Suicide mortality rates in 2002-2004 were over two times higher among Whites in the LWF Service Area than among Blacks.

Age-Adjusted Mortality: Suicide

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)

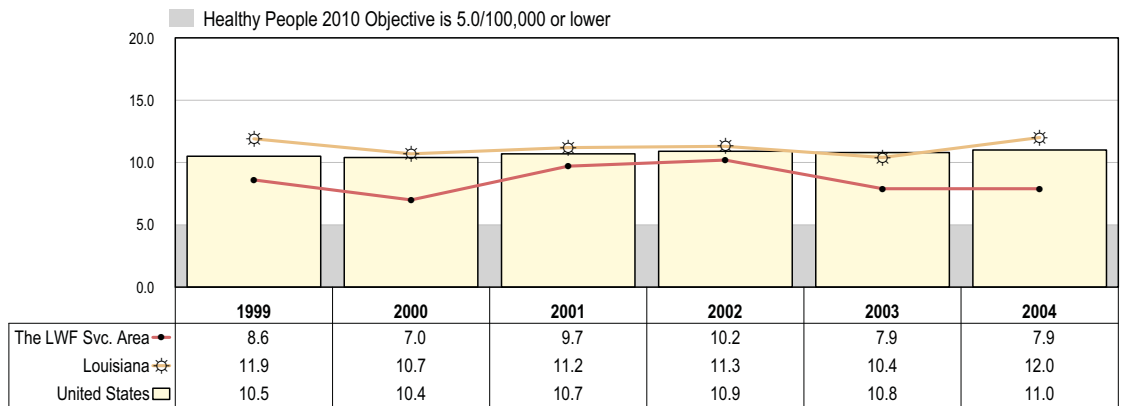


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 18-1]
 Note: • 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.
 • The West Monroe black rate is statistically unreliable.

☹ Over the past several years, no significant trend is apparent in suicide mortality in the LWF Service Area.

Age-Adjusted Mortality: Suicide

(Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]
 Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

(Related Issue: see also “Mental Health.”)

Violent Crime

Violence claims the lives of many of the Nation's young persons and threatens the health and well-being of many persons of all ages in the United States. On an average day in America, 53 persons die from homicide, and a minimum of 18,000 persons survive interpersonal assaults, 84 persons complete suicide, and as many as 3,000 persons attempt suicide.

Youth continue to be involved as both perpetrators and victims of violence. Elderly persons, females, and children continue to be targets of both physical and sexual assaults, which are frequently perpetrated by individuals they know.

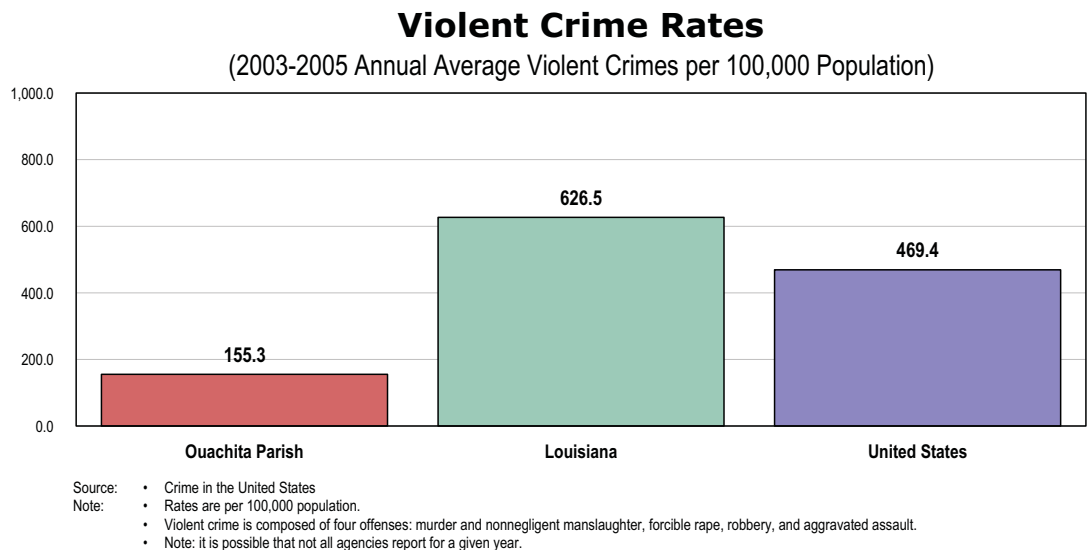
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Violent Crime Rates

The following chart illustrates the violent crime rates as reported in the LWF Service Area between 2003 and 2005. Note that violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault.

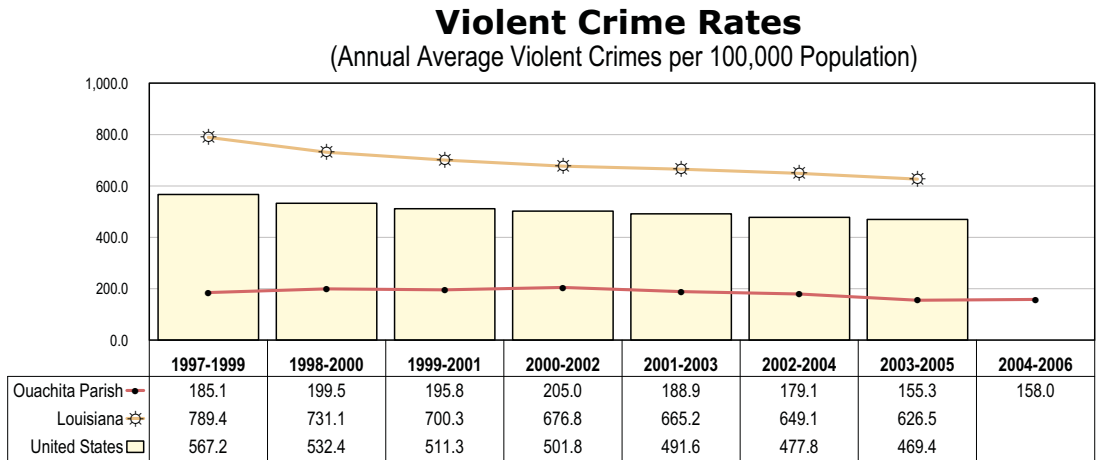
In Ouachita Parish, there was an annual average of 155.3 violent crimes per 100,000 population between 2003 and 2005.

- ☐ More favorable than the corresponding Louisiana rate (626.5).
- ☐ More favorable than that reported nationally (469.4).



Between the 2000-2002 and 2003-2005 reporting periods, the Ouachita Parish violent crime rate exhibited a downward trend.

Note that violent crime rates are declining statewide and nationally.

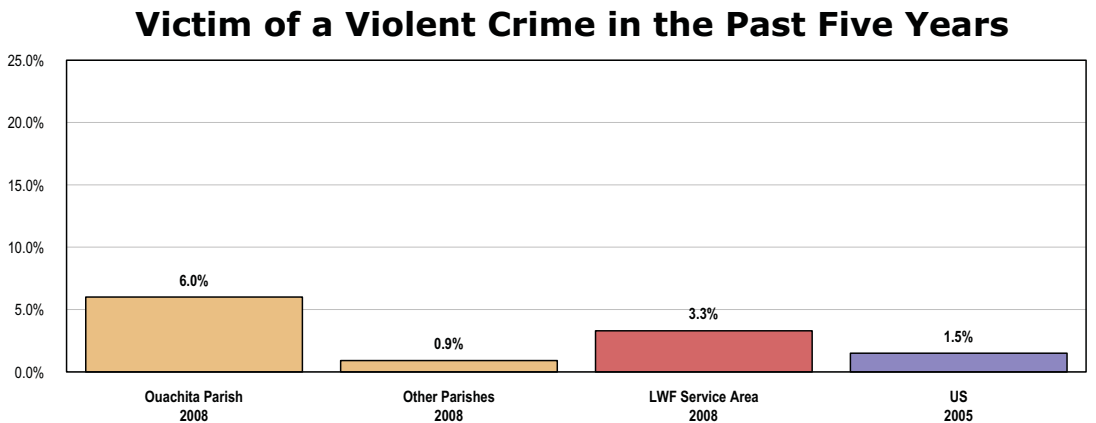


Source: • Crime in the United States
 Note: • Rates are per 100,000 population.
 • Violent crime is composed of four offenses: murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault.
 • Note: it is possible that not all agencies report for a given year.

Self-Reported Violent Crime Victim

Among surveyed adults, 3.3% acknowledged being the victim of a violent crime in the past five years.

- Less favorable than national findings (1.5%).
- Much higher in Ouachita Parish.

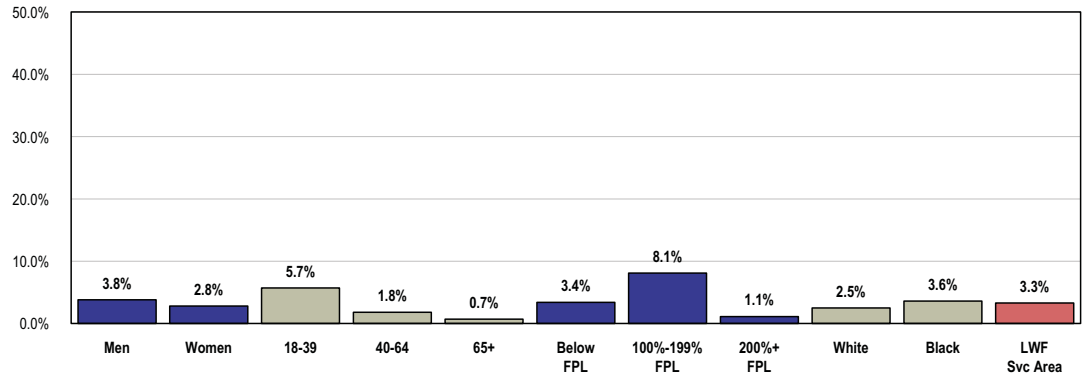


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 59]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.

- ▣ Reports of violent crime victimization are higher among young adults and those living at the middle income level.

Victim of a Violent Crime in the Past Five Years

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 56]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

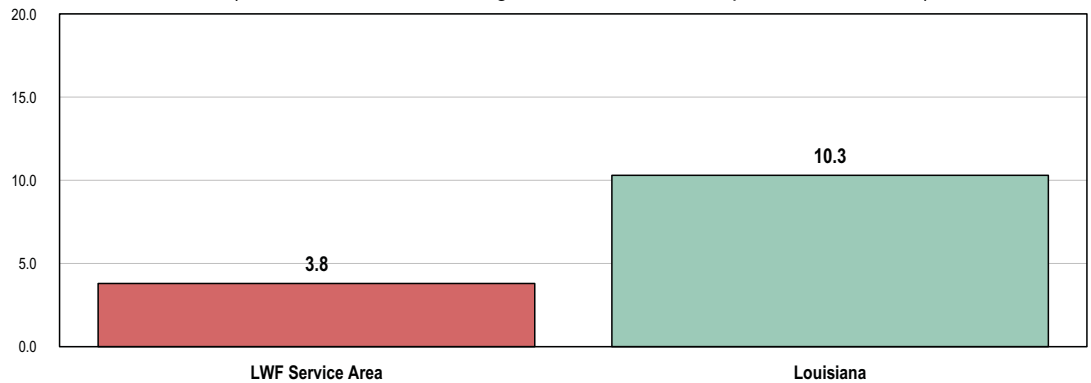
Family Violence

Child Abuse Reports

- ▣ The LWF Service Area rate of child abuse reports (expressed as the number of reports per 1,000 children) is 3.8 per 1,000 children.
- The LWF Service Area rate is much lower than Louisiana rate.

Reported Child Abuse Rates

(2004-2006 Annual Average Child Abuse Cases per 1,000 Children)



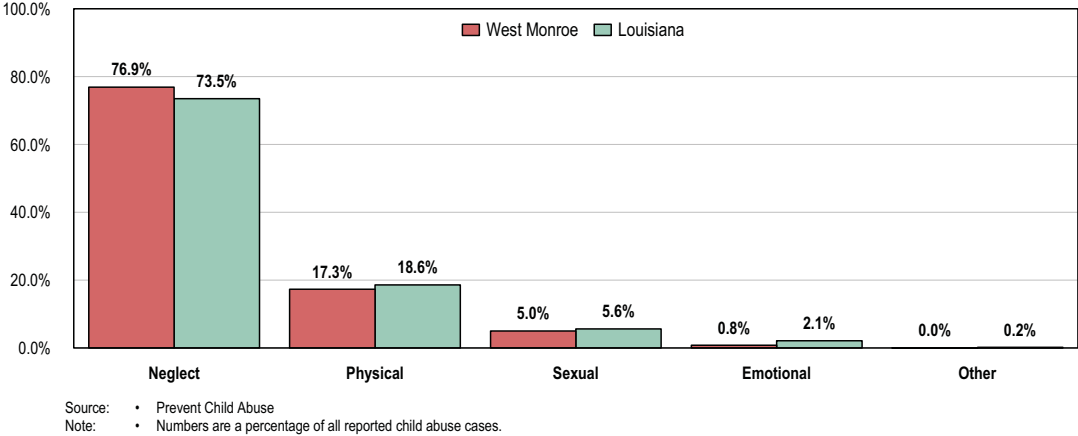
Source: • Prevent Child Abuse
 Note: • Rates are per 1,000 children.

A majority (76.9%) of reported child abuse cases are due to neglect, while 17.3% are due to physical abuse and 5.0% are due to sexual abuse.

☐ These proportions are similar to what is seen statewide.

2006 Reported Child Abuse Rates by Type

(2006 Child Abuse Cases by Type)



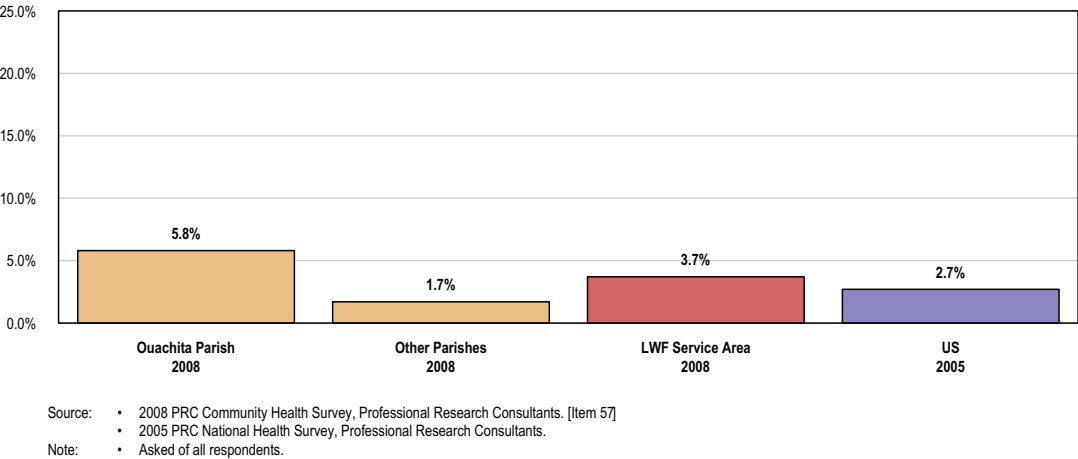
Self-Reported Domestic Violence

Among surveyed adults, 3.7% acknowledged being the victim of domestic violence in the past five years.

☐ Statistically similar to national findings (2.7%).

⊕ Higher in Ouachita Parish.

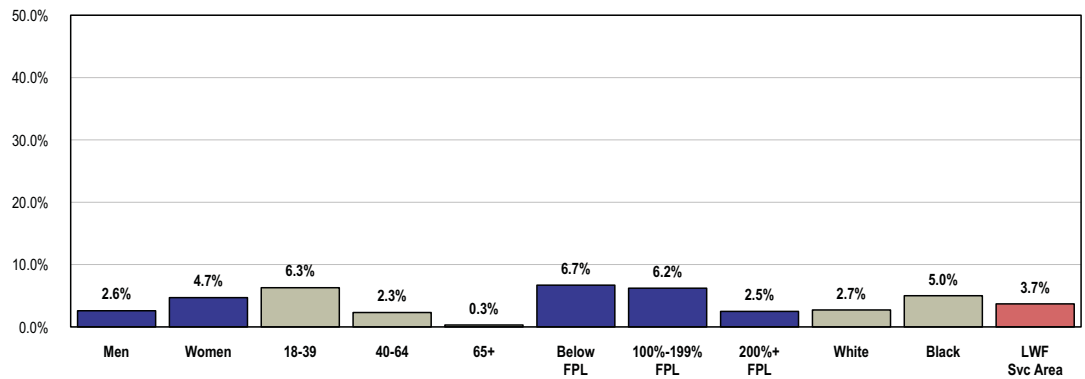
Victim of Domestic Violence in the Past Five Years



👥 Young adults are more likely to experience domestic violence.

Victim of Domestic Violence in the Past Five Years

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 57]

Note: • Asked of all respondents.

• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].

• White and Black are non-Hispanic race categorizations.

Related Focus Group Findings: Injury & Violence

Community Leaders/ Social Service Providers

Often, the community overlooks domestic violence as a health issue. The stresses of trying to make ends meet for families that are very poor are often at the root of domestic violence.

“When you make \$11,000 a year, a lot of stress is on people and their families. There are four or five to a family, so income like that causes a lot of abuse and things like that.” – Social Service Provider

DIABETES

Diabetes affects nearly 16 million Americans 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 Americans are unaware they have the disease.

- Among U.S. 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.
- More than 18% of U.S. adults older than age 65 have diabetes.
- Diabetes affects more women than men.

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

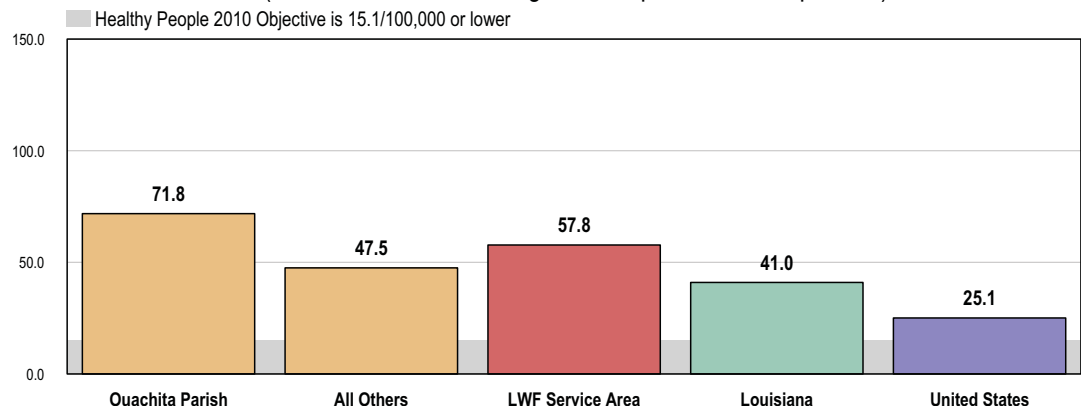
Age-Adjusted Diabetes Mellitus Deaths

Between 2002 and 2004, there was an annual average of 57.8 age-adjusted diabetes mellitus deaths per 100,000 population in the LWF Service Area.

- ☑ Worse than the statewide rate (41.0) and the U.S. rate (25.1).
- ☑ Nearly four times the Healthy People 2010 objective of 15.1 or lower.
- ⊕ Higher in Ouachita Parish.

Age-Adjusted Mortality: Diabetes Mellitus

(2002-2004 Annual Average Deaths per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-13]

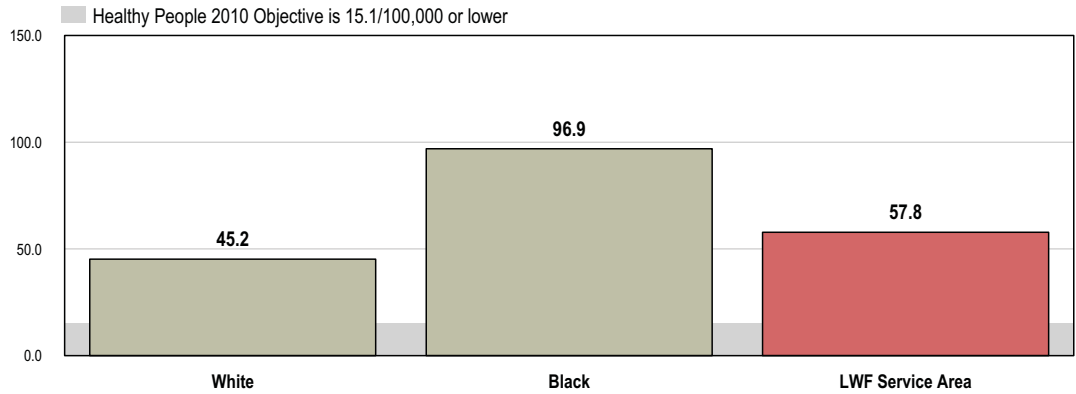
Note: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

• *The Healthy People 2010 target for diabetes is adjusted to account for only diabetes mellitus coded deaths [Objective 5-5].

Diabetes mellitus deaths in the LWF Service Area are much more prevalent among Blacks than Whites.

Age-Adjusted Mortality: Diabetes Mellitus (2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)

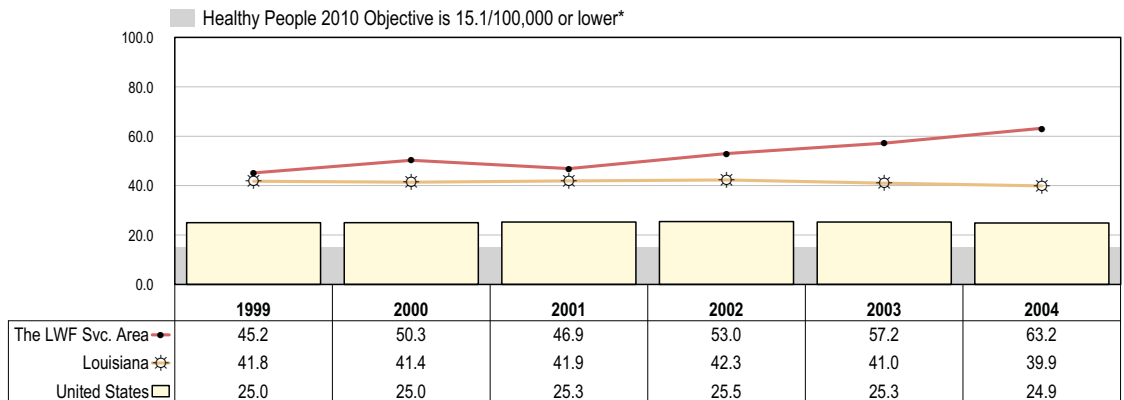


Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-13]

Note: • 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.
 • *The Healthy People 2010 target for diabetes is adjusted to account for only diabetes mellitus coded deaths [Objective 5-5].

Between 1999 and 2004, age-adjusted diabetes mellitus mortality rates increased in the LWF Service Area.

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



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-13]

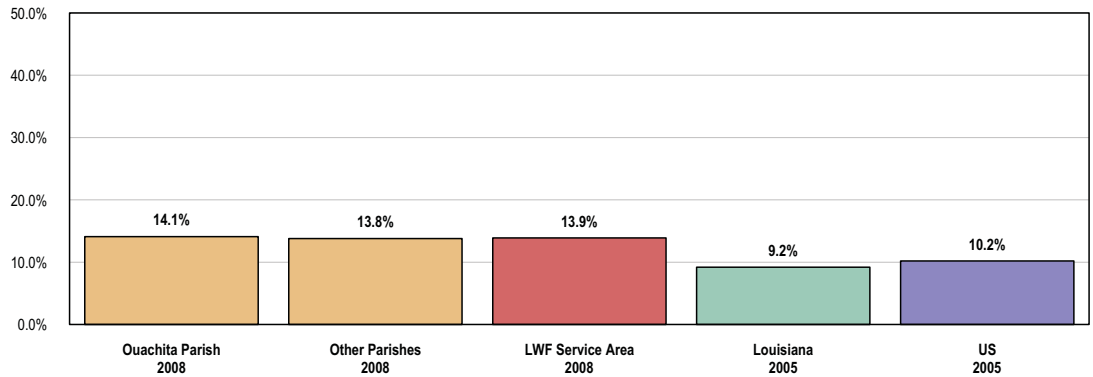
Note: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • *The Healthy People 2010 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths [Objective 5-5].

Prevalence of Diabetes

Among surveyed LWF Service Area adults, 13.9% report having been diagnosed with diabetes.

- Less favorable than the proportion statewide (9.2%) and the national proportion (10.2%).
- ⊕ No difference by geographic sub-area.

Self-Reported Prevalence of Diabetes



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 43]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
 • 2005 PRC National Health Survey, Professional Research Consultants.

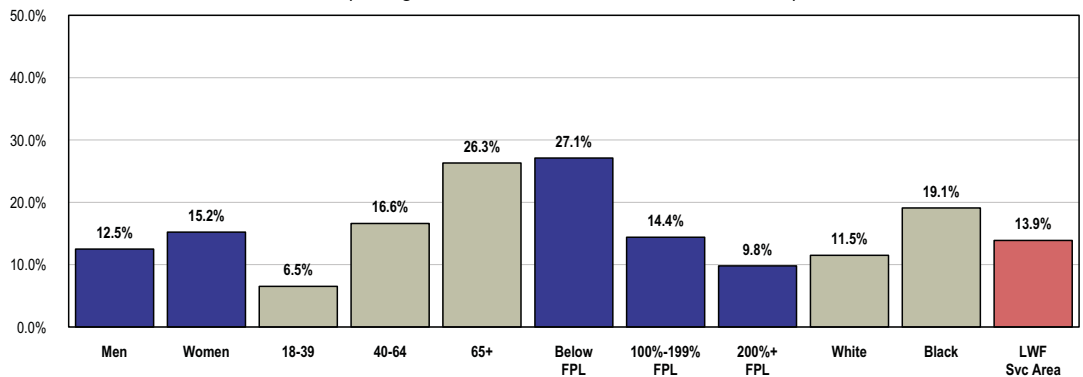
Note: • Asked of all respondents. Excludes gestational diabetes.

A higher prevalence of diabetes is reported among the following demographic groups:

- 👴 Older adults (note a positive correlation with age, with 26.3% of seniors with diabetes).
- 👴 Persons living in poverty.
- 👴 Blacks.

Self-Reported Prevalence of Diabetes

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 43]

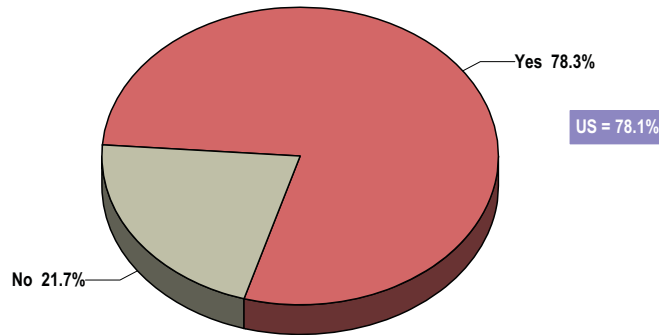
Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Among LWF Service Area adults with diabetes, many (78.3%) are currently taking insulin or some type of medication to manage their condition.

- Similar to the 78.1% found nationally.

Currently Taking Insulin or Other Medicine for Diabetes

(LWF Service Area, 2008; Among Adults With Diabetes)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 44]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of those respondents who have been diagnosed with diabetes.

Related Focus Group Findings: Diabetes

Community Leaders/ Social Service Providers/Other Health Professionals

There is an increasing amount of diabetic patients in the area. People aren't eating healthy foods and in turn are becoming overweight and diabetic.

"We have 'food deserts' all over this area. It means that you're more than four miles from healthy food and an awful lot of children are living in situations where they have no access to healthy food and their parents would have to travel great distances to shop anywhere but a convenience store or place that would have the highly processed foods which accelerate the diabetes." – Social Service Provider

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

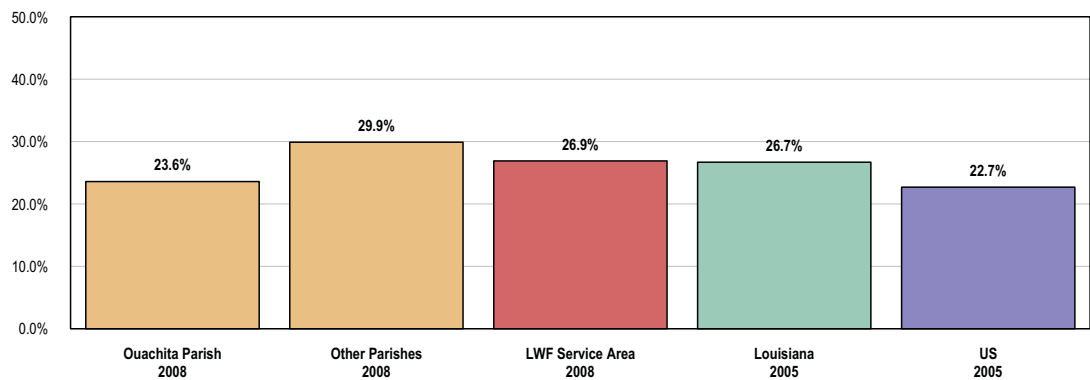
Prevalence of Arthritis & Osteoporosis

Arthritis & Rheumatism

In all, 26.9% of LWF Service Area adults report suffering from arthritis or rheumatism.

- ☑ Nearly identical to the statewide prevalence (26.7%).
- ☑ Less favorable than that found nationwide (22.7%).
- ⊕ Lower in Ouachita Parish.
- 👥 Among LWF Service Area adults aged 65 and older, the prevalence of arthritis or rheumatism is 59.0%.

Self-Reported Prevalence of Arthritis/Rheumatism



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 29]
- 2005 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); 2005 Louisiana data.

Note:

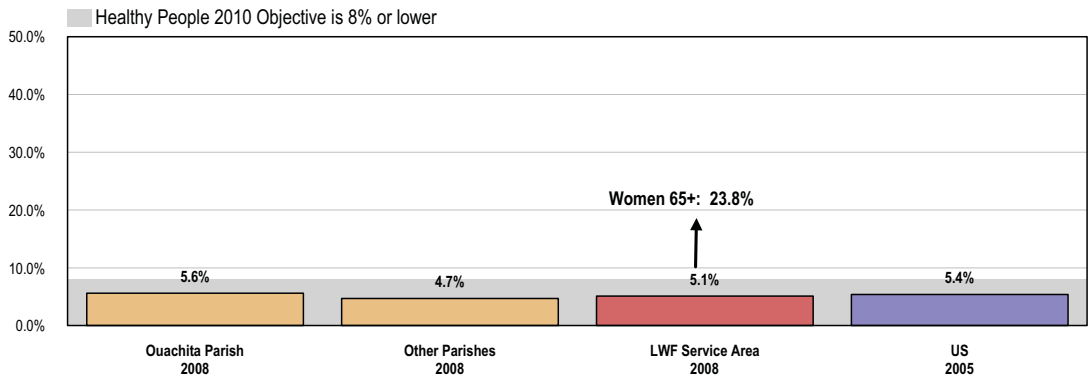
- Asked of all respondents.

Osteoporosis

A total of 5.1% of LWF Service Area adults report suffering from osteoporosis.

- Similar to that found nationwide (5.4%).
- Similar between the sub-areas.
- Further note that osteoporosis is much more prevalent among women aged 65 and older (affecting 23.8% of this segment).

Self-Reported Prevalence of Osteoporosis



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 35]
 - 2005 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): 2005 Louisiana data.
 - 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]
- Note:
- Asked of all respondents.

Prevalence of Chronic Pain

More than one out of five LWF Service Area adults (21.3%) report suffering from sciatica or chronic back pain.

- ☑ Comparable to that found nationwide (21.0%).
- ⊕ No difference among geographic sub-areas (not shown in the following chart).

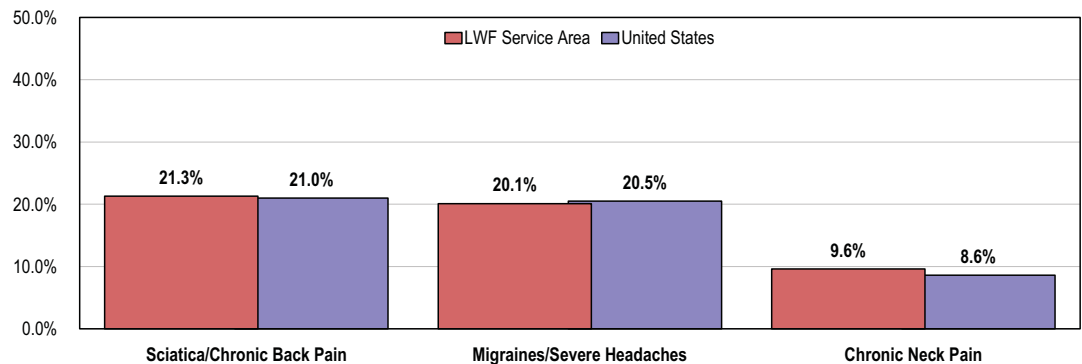
A total of 20.1% of area adults suffer from migraines or severe headaches.

- ☑ Similar to the 20.5% reported across the United States.
- ⊕ Statistically similar by sub-area.

A total of 9.6% of area adults suffer from chronic neck pain.

- ☑ Comparable to that found nationwide (8.6%).
- ⊕ Similar between sub-areas.

Self-Reported Prevalence of Chronic Pain



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 30,39,40]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

ACTIVITY LIMITATIONS

An estimated 54 million persons in the United States, or nearly 20 percent of the population, 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 U.S.] 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.

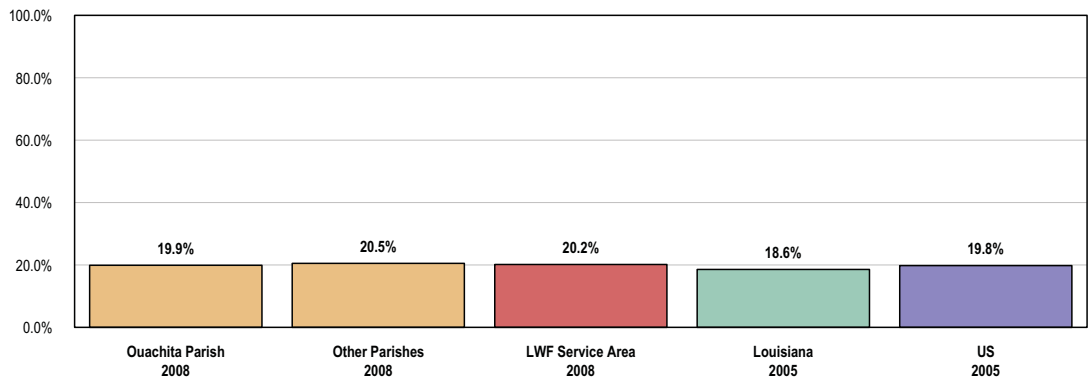
The health promotion and disease prevention needs of people with disabilities are not nullified because they are born with an impairing condition or have experienced a disease or injury that has long-term consequences. People with disabilities have increased health concerns and susceptibility to secondary 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

More than one out of five LWF Service Area adults (20.2%) are limited in some way in some activities due to a physical, mental or emotional problem.

- ☑ Similar to the 18.6% prevalence in Louisiana.
- ☑ Similar to the 19.8% prevalence nationwide.
- ⊕ Similar by geographic sub-area.

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



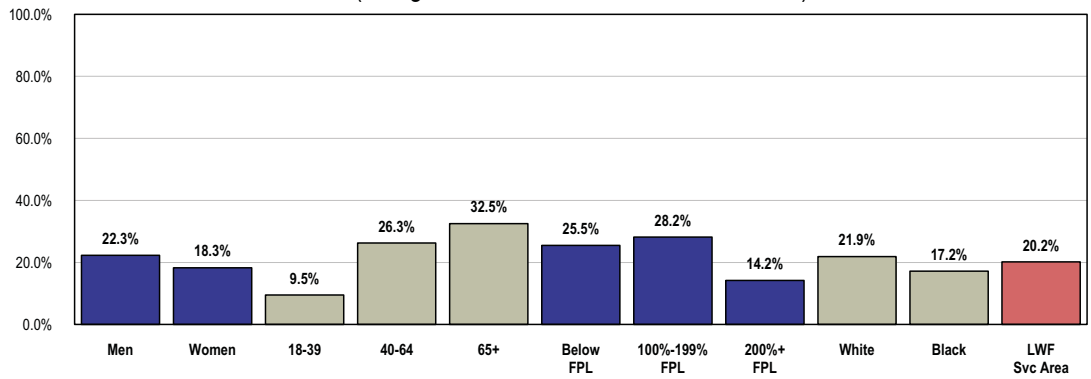
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 114]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

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

- 👥 Adults aged 40 or older are more often limited in activities.
- 👥 Activity limitations are much more prevalent among adults living below the 200% poverty threshold.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (Living Well Foundation Service Area, 2008)

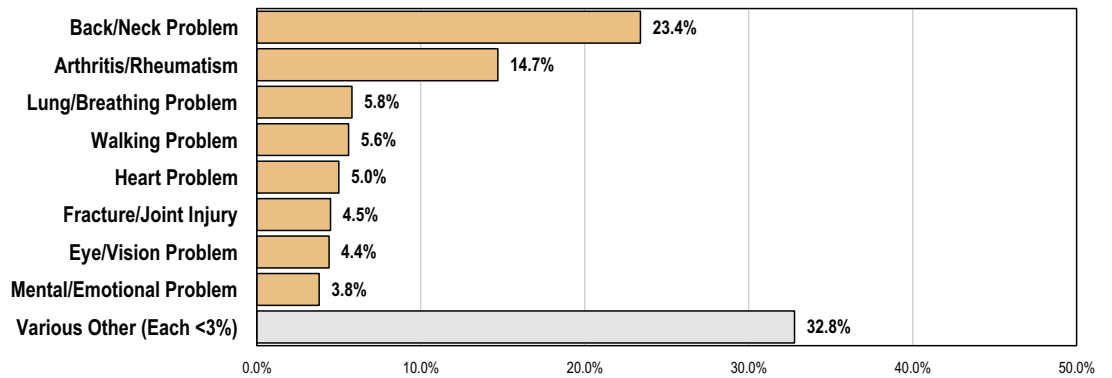


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 114]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

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

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 115]
 Note: • Reflects those respondents who experience activity limitations.

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.

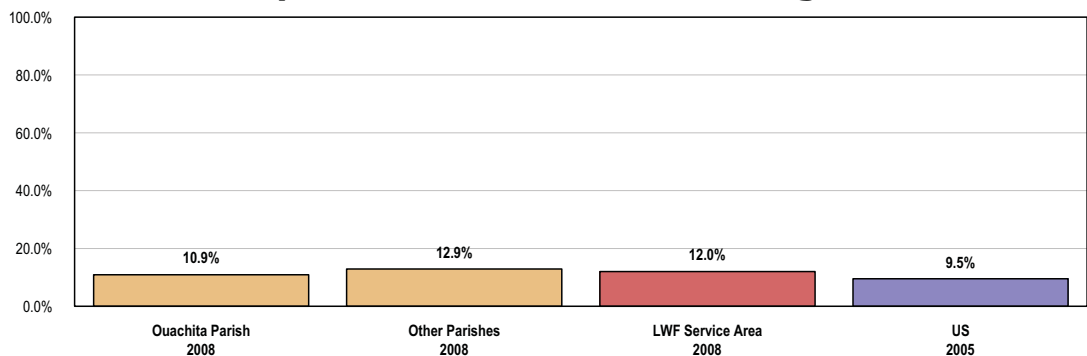
– Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Hearing Trouble

In all, 12.0% of LWF Service Area adults report being deaf or having difficulty hearing.

- Similar to that found nationwide (9.5%).
- ⊕ No difference between the sub-areas.
- 👤 Among LWF Service Area adults aged 65 and older, 28.4% have partial or complete hearing loss.

Self-Reported Prevalence of Hearing Problems



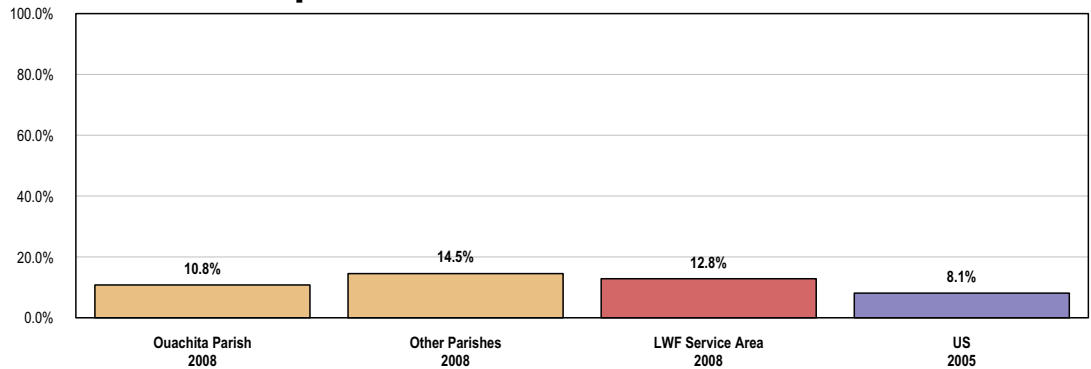
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 28]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

Vision Trouble

A total of 12.8% of LWF Service Area adults are blind, or have trouble seeing even when wearing corrective lenses.

- ▣ Less favorable than found nationwide (8.1%).
- ⊞ No statistical difference by sub-area.

Self-Reported Prevalence of Vision Problems



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 27]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

⊞ Among LWF Service Area adults aged 65 and older, a similar 17.0% have vision trouble.

ENVIRONMENTAL HEALTH

Air Contaminants

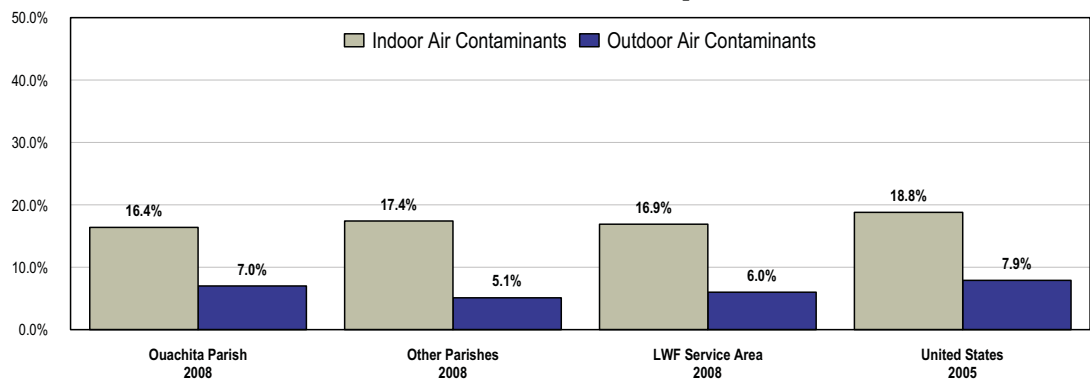
A total of 16.9% of LWF Service Area adults had an illness or symptom in the past year that they believed to be caused by indoor air contaminants (such as dust, mold, smoke or chemicals inside the home or office).

- ☑ Similar to national findings (18.8%).
- ⊕ Similar between the two sub-areas.

Fewer respondents (6.0%) reported an illness or symptom in the past year that they believed to be caused by outdoor contaminants (such as smog, automobile exhaust or chemicals).

- ☑ Similar to that found nationwide (7.9%).
- ⊕ Similar between the two geographic sub-areas.

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

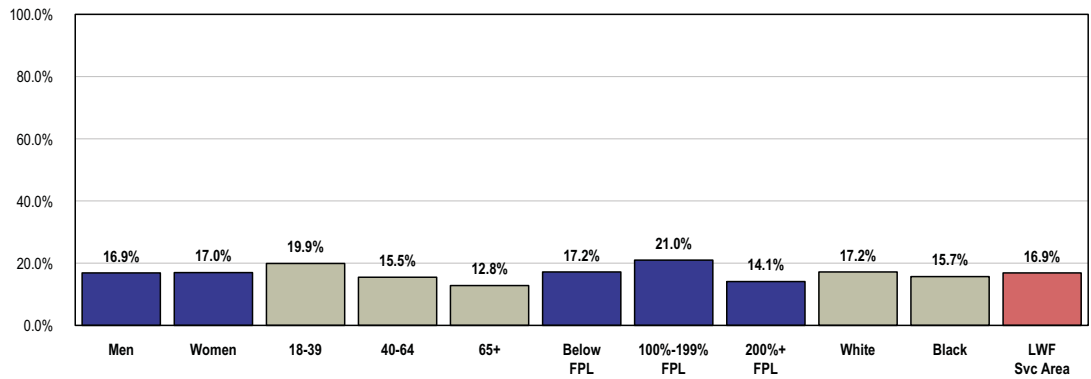


- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Items 52,53]
 - 2005 PRC National Health Survey, Professional Research Consultants.
- Note:
- Asked of all respondents.
 - Examples of indoor air contaminants include dust, mold, smoke and chemicals.
 - Examples of outdoor air contaminants include smog, automobile exhaust and chemicals.

👤 Young adults and those living at the lower income levels more often report symptoms from **indoor contaminants** in the past year.

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

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 52]

Note: • Asked of all respondents.

• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].

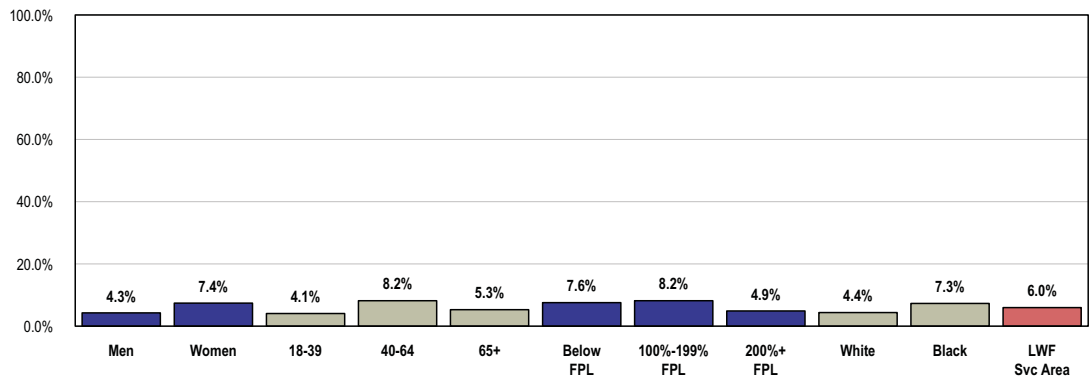
• White and Black are non-Hispanic race categorizations.

• Examples of indoor air contaminants include dust, mold, smoke and chemicals.

Women and middle-aged adults more often report symptoms from **outdoor** contaminants in the past year.

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

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 53]

Note: • Asked of all respondents.

• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].

• White and Black are non-Hispanic race categorizations.

• Examples of outdoor air contaminants include smog, automobile exhaust and chemicals.

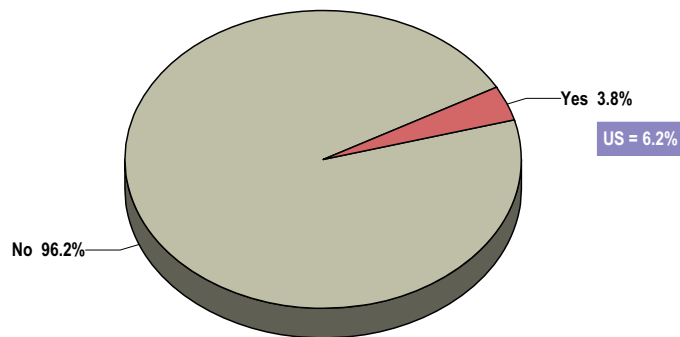
Mold in the Home

A low 3.8% of respondents report having an area of mold in their homes that is greater than the size of a dollar bill.

- Better than found nationwide (6.2%).
- ⊕ Similar between sub-areas (not shown).

Have an Area of Mold in the Home Greater Than the Size of a Dollar Bill

(Living Well Foundation Service Area, 2008)



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 54]
- 2005 PRC National Health Survey, Professional Research Consultants.

Note:

- Reflects the total sample of respondents.

INFECTIOUS DISEASE

IMMUNIZATION & 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Vaccine-Preventable Disease Incidence

Measles, Mumps, Rubella

Between 2004 and 2006, there was only one reported case of mumps and there were no reported cases of measles or rubella in the LWF Service Area.

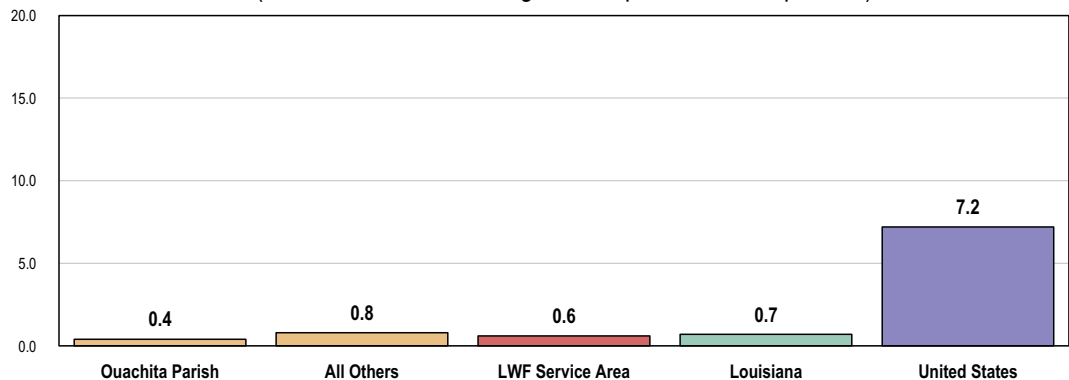
Pertussis

Between 2004 and 2006, the annual average pertussis incidence (new cases per year) in the LWF Service Area was 0.6 per 100,000 population.

- ☐ Similar to the Louisiana incidence rate (0.7).
- ☐ Well below the national pertussis incidence rate (7.2).

Pertussis Incidence

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

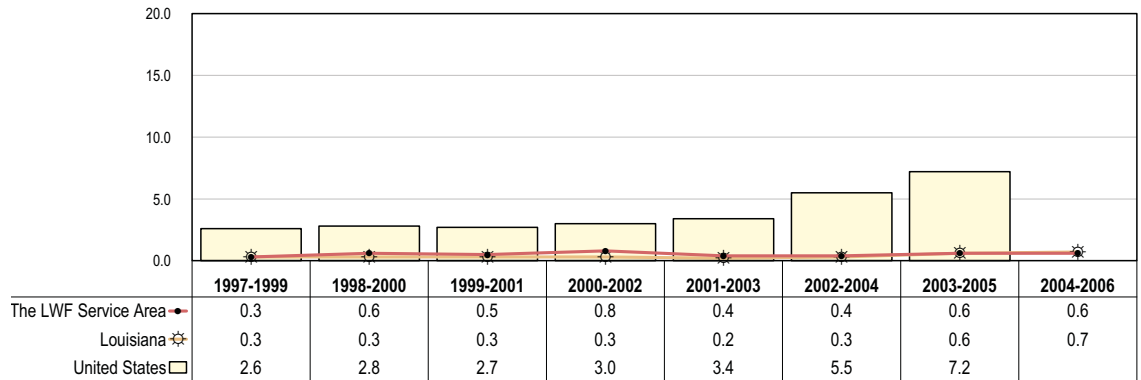


Source: • Louisiana Department of Health and Hospitals
• Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics, Epidemiology Program Office
Note: • Rates are per 100,000 population.

- ▣ Pertussis incidence has shown no clear trend in recent years; state- and nationwide incidence rates have increased.

Pertussis Incidence

(Annual Average Cases per 100,000 Population)



Source: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]
 Note: • Rates are per 100,000 population.

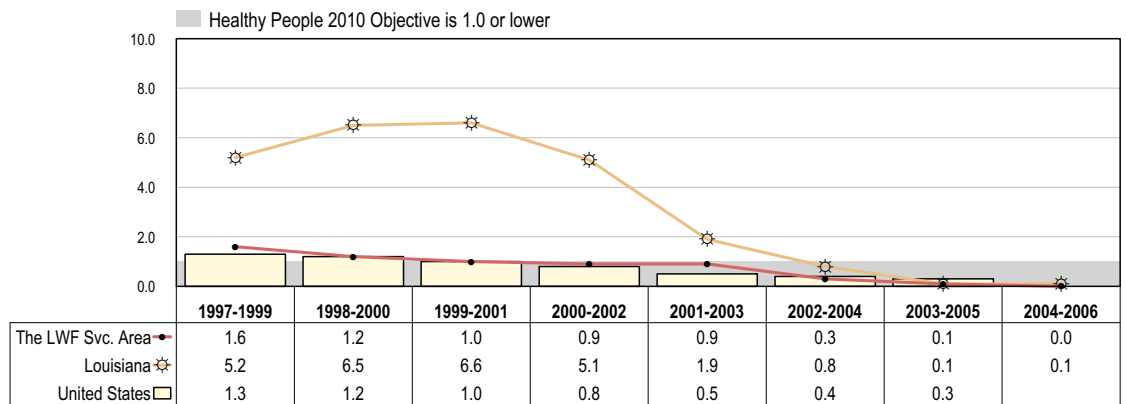
Hepatitis C

Between 2004 and 2006, there were no reported cases of hepatitis C in the LWF Service Area.

- The statewide incidence rate is also low (0.1).
- Better than the national hepatitis C incidence rate (0.3 in 2003-2005).
- Satisfies the Healthy People 2010 objective of 1.0 per 100,000 population.
- ▣ The LWF Service Area hepatitis C incidence rate has increased over the past several years.

Hepatitis C Incidence

(Annual Average Cases per 100,000 Population)



Source: • Louisiana Department of Health and Hospitals
 • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]
 Note: • Rates are per 100,000 population.

Influenza Vaccination

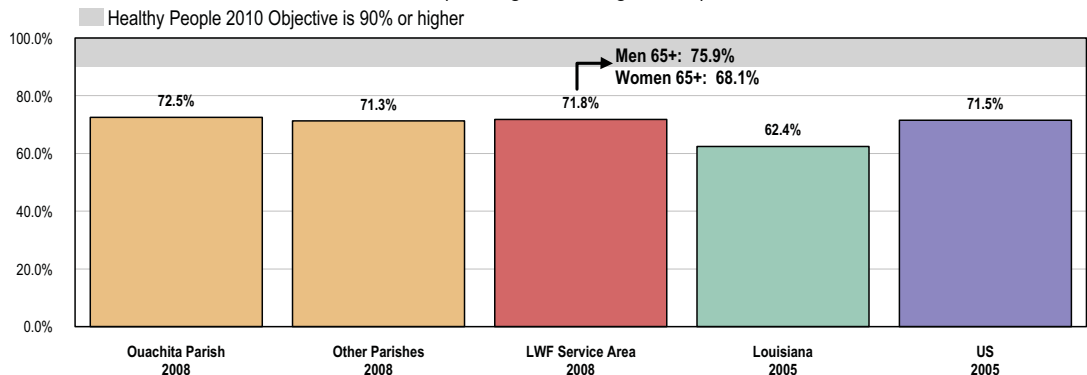
Seniors

Among LWF Service Area adults aged 65 and older, 71.8% received a flu shot within the past year.

- 📍 More favorable than the Louisiana finding (62.4%).
- 📍 Similar to the national finding (71.5%).
- 📍 Fails to satisfy the Healthy People 2010 target (90% or higher).
- 📍 Does not vary significantly by sub-area.
- 👤 Includes 75.9% of men 65+ and 68.1% of women 65+ in the LWF Service Area.

Have Had a Flu Shot in the Past Year

(Among Adults Aged 65+)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 166]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
 - 2005 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]
- Note:
- Asked of all respondents aged 65 and older.

High-Risk Adults*

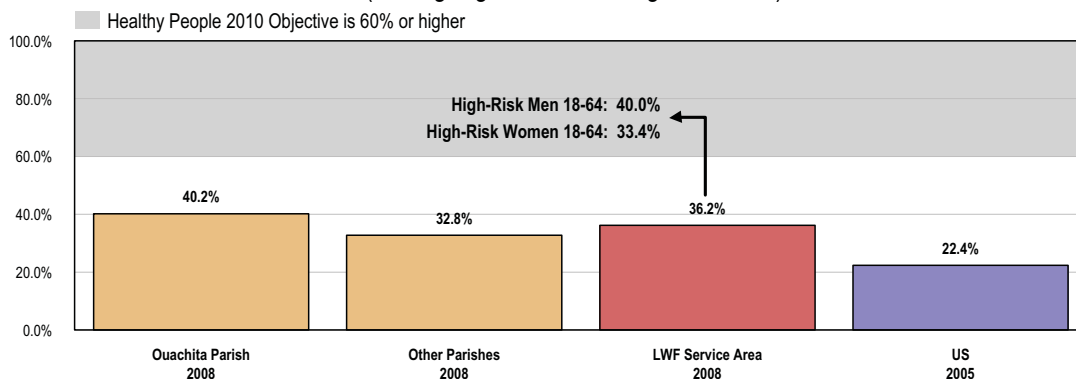
One-third (36.2%) of LWF Service Area high-risk adults aged 18 to 64 received a flu shot within the past year.

- 📍 Better than national findings (22.4%).
- 📍 Fails to satisfy the Healthy People 2010 target (60% or higher).
- 📍 Does not vary significantly by sub-area.
- 👤 Includes 40.0% of high-risk men and 33.4% of high-risk women in the LWF Service Area.

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

Have Had a Flu Shot in the Past Year

(Among High-Risk Adults Aged 18 to 64)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 167]
 • 2005 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]
 Note: • "High-Risk" includes adults aged 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

Pneumonia Vaccination

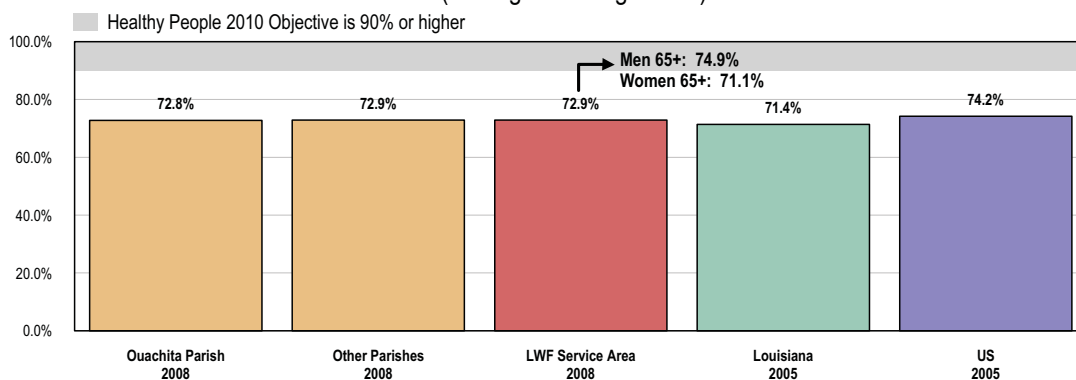
Seniors

A total of 72.9% of LWF Service Area adults aged 65 and older have received a pneumonia vaccination at some point in their lives.

- 📍 Similar to Louisiana findings (71.4%).
- 📍 Also similar to the national finding (74.2%).
- 📍 Fails to satisfy the Healthy People 2010 objective of 90% or higher.
- 📍 Does not vary significantly by sub-area.
- 👤 Includes 74.9% of men 65+ and 71.1% of women 65+ in the LWF Service Area.

Have Ever Had a Pneumonia Vaccination

(Among Adults Aged 65+)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 168]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.
 • 2005 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 14-29b]
 Note: • Asked of all respondents aged 65 and older.

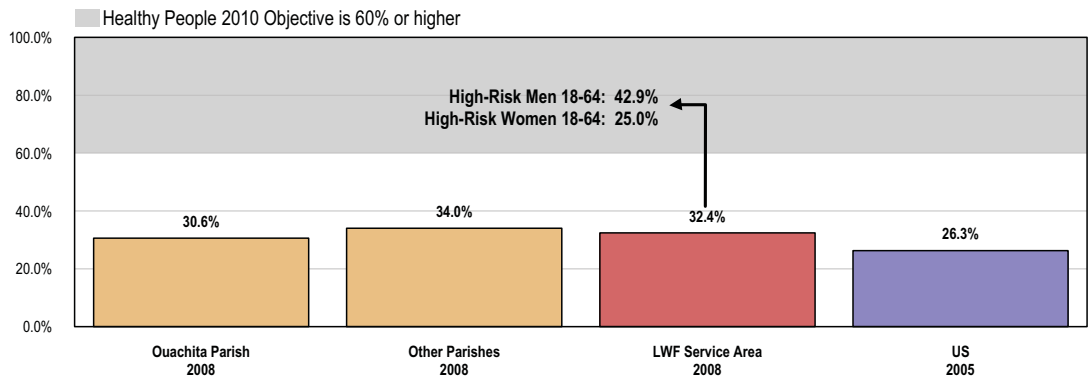
High-Risk Adults*

A total of 32.4% of LWF Service Area high-risk adults aged 18 to 64 have received a pneumonia vaccination at some point in their lives.

- ☑ Statistically similar to national findings (26.3%).
- ☑ Fails to satisfy the Healthy People 2010 target (60% or higher).
- 👤 Includes 42.9% of high-risk men and 25.0% of high-risk women in the LWF Service Area.

Have Ever Had a Pneumonia Vaccination

(Among High-Risk Adults Aged 18 to 64)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 169]
 - 2005 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]
- Note:
- "High-Risk" includes adults aged 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

TUBERCULOSIS

Tuberculosis (TB) is an infectious disease caused by a type of bacteria called *Mycobacterium tuberculosis*. TB is spread from person to person through the air, as someone with active tuberculosis of the respiratory tract coughs, sneezes, yells, or otherwise expels bacteria-laden droplets.

The Institute of Medicine (IOM), an arm of the National Academy of Sciences, released a report in May 2000 that lays out an action plan for eliminating tuberculosis in the United States ... As a key part of the plan, new TB treatment and prevention strategies must be developed that are tailored to the current environment. Among today's hallmarks:

- Tuberculosis now occurs in ever-smaller numbers in most regions of the country.
- Foreign-born people (both legal and undocumented immigrants) coming to the United States from countries with high rates of TB now account for nearly half of all TB cases.
- Higher numbers of cases are concentrated in pockets located in major metropolitan areas, and this increased prevalence is due, in large part, to the increased number of people with or at risk for HIV/AIDS infection.
- Other groups, such as HIV-infected people and the growing population of prison inmates, the homeless, and intravenous drug abusers, are emerging as being at high risk.

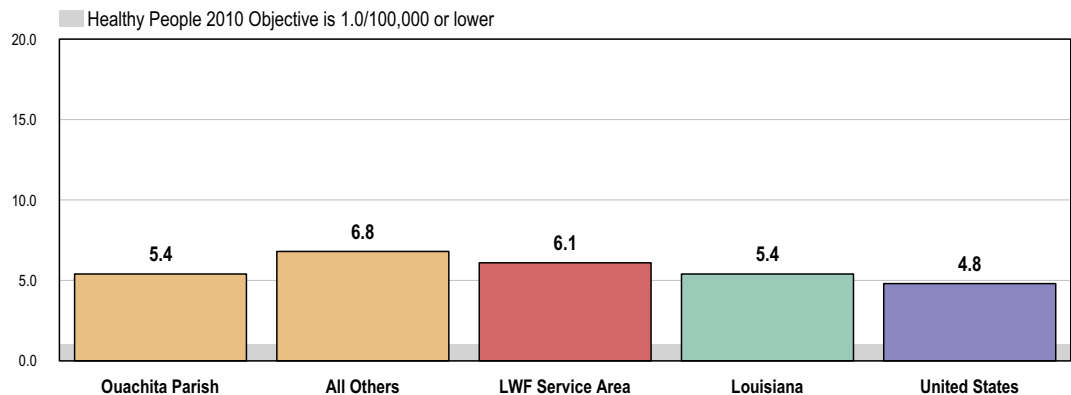
— Ending Neglect: The Elimination Of Tuberculosis In The United States. National Academy of Sciences, Institute of Medicine. Funded by the Centers for Disease Control and Prevention. 2000.

The annual average tuberculosis incidence rate in the LWF Service Area between 2003 and 2005 was 6.1 per 100,000 population.

- ⊗ Less favorable than the rate statewide (5.4).
- ⊗ Worse than the rate nationwide (4.8).
- ⊗ Fails to satisfy the Healthy People 2010 objective of 1.0 or lower.
- ⊕ More favorable in Ouachita Parish.

Tuberculosis Incidence

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



Source:

- Louisiana Department of Health and Hospitals.
- National Center for Health Statistics. Health, United States, 2004.
- Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 15-13]

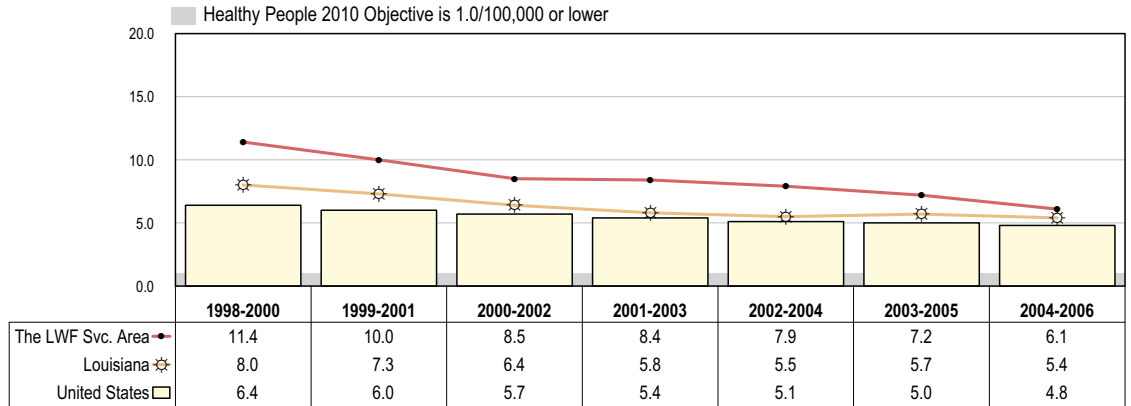
Note:

- Rates are per 100,000 population.

- ▣ Tuberculosis incidence has declined in the LWF Service Area over the past several years, mirroring trends seen statewide and nationally.

Tuberculosis Incidence

(Annual Average Cases per 100,000 Population)



Source:

- Louisiana Department of Health and Hospitals.
- Centers for Disease Control and Prevention.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 14-11]

Note:

- Rates are per 100,000 population.

HIV

In the United States, HIV/AIDS remains a significant cause of illness, disability, and death, despite declines in 1996 and 1997.

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 Americans 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

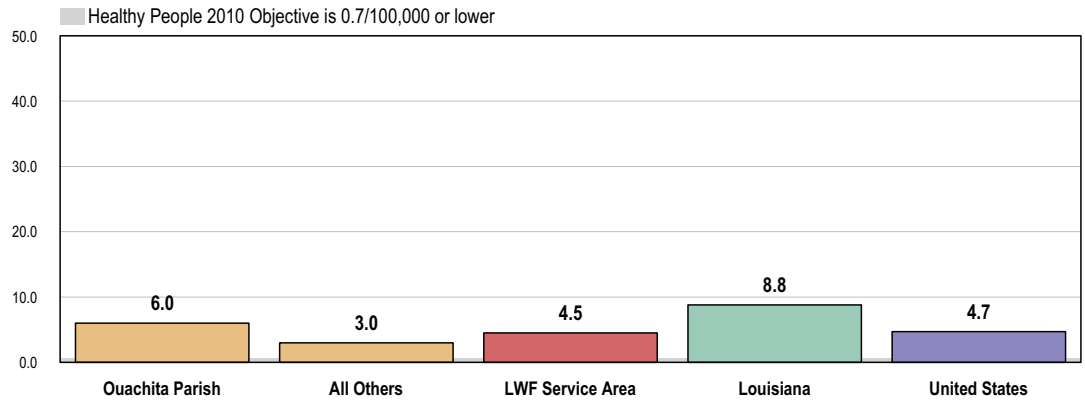
Age-Adjusted HIV/AIDS Deaths

Between 2002 and 2004, there was an annual average of 4.5 HIV/AIDS deaths per 100,000 population in the LWF Service Area.

- ☑ Well below the statewide rate (8.8).
- ☑ Nearly identical to the mortality rate nationwide (4.7 per 100,000).
- ☑ Fails to satisfy the Healthy People 2010 objective (0.7 or lower).
- ⊕ Higher in Ouachita Parish.

Age-Adjusted Mortality: HIV

(2002-2004 Annual Average Deaths per 100,000 Population)



Source:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
- 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]

Note:

- 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.
- The "All Others" rate is statistically unreliable.

HIV/AIDS Cases

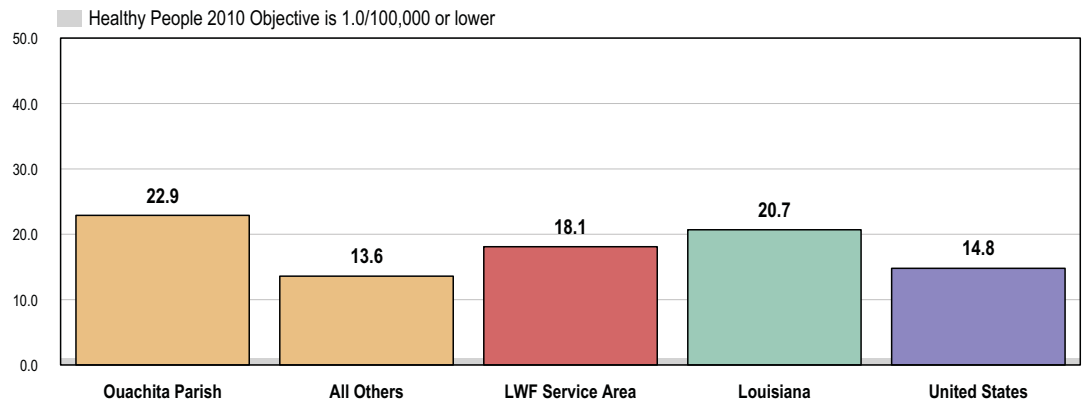
AIDS Incidence

Between 2004 and 2006, the annual average incidence of new AIDS cases was 18.1 per 100,000 population.

- ☑ Lower than the statewide rate (26.9).
- ☑ Higher than seen nationwide (14.8).
- ☑ Much higher than the Healthy People 2010 objective of 1.0 per 100,000.
- ⊕ Higher in Ouachita Parish.

AIDS Case Rates

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



Source:

- Louisiana HIV/AIDS Surveillance Program
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
- 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]

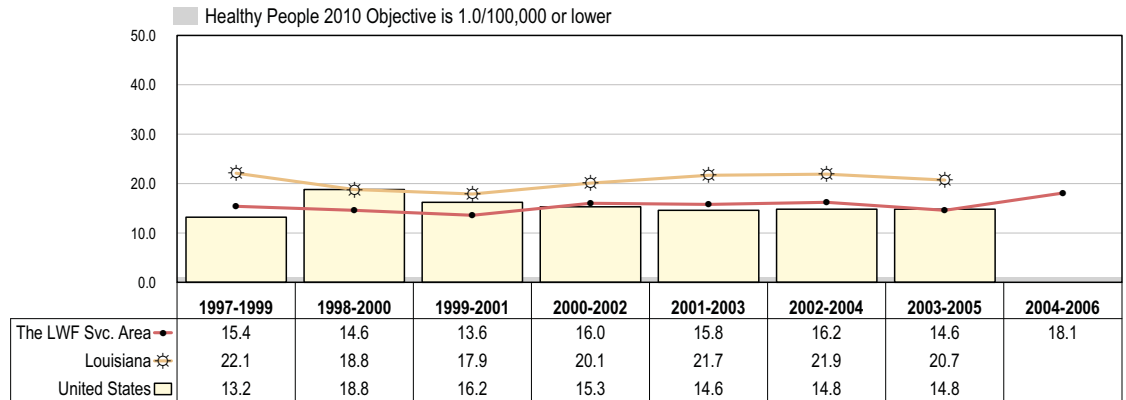
Note:

- Rates are new cases per 100,000 population.
- State and U.S. rates reflect 2003-2005 data.

☒ New AIDS cases have shown no clear trend in recent years.

AIDS Case Rates

(Annual Average Cases per 100,000 Population)



Source: • Louisiana HIV/AIDS Surveillance Program
 • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • 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]

Note: • Rates are new cases per 100,000 population.

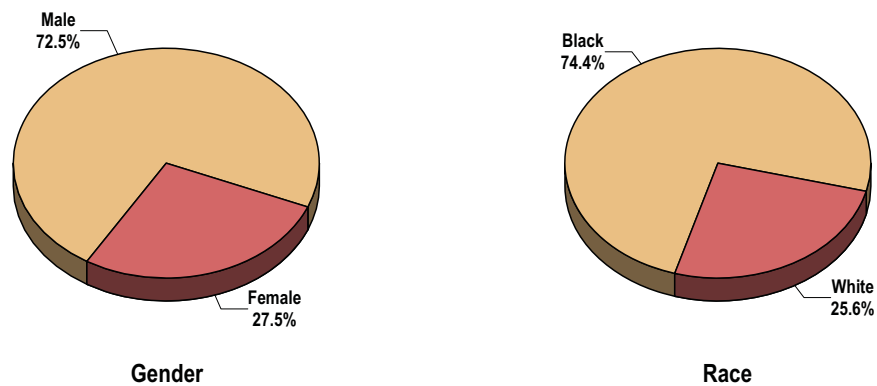
HIV/AIDS Characteristics

The following data represent characteristics of all persons living with AIDS in the LWF Service Area between 2004 and 2006.

- ☒ Blacks are disproportionately represented among the LWF Service Area HIV/AIDS population.
- ☒ Nearly three-fourths of HIV/AIDS cases are among men.

AIDS Cases: Gender and Race Breakout

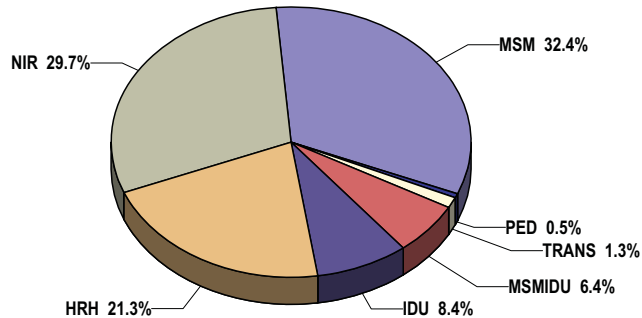
(Living Well Foundation Service Area, 2004-2006)



Source: • Louisiana HIV/AIDS Surveillance Program
 Note: • Represents 2004-2006 AIDS cases in LWF Service Area.

Among AIDS cases, 32.4% were contracted through men having sex with men (MSM) while 21.3% were contracted through high-risk heterosexual contact (HRH).

AIDS Cases: Mode of HIV Transmission (Living Well Foundation Service Area, 2004-2006)



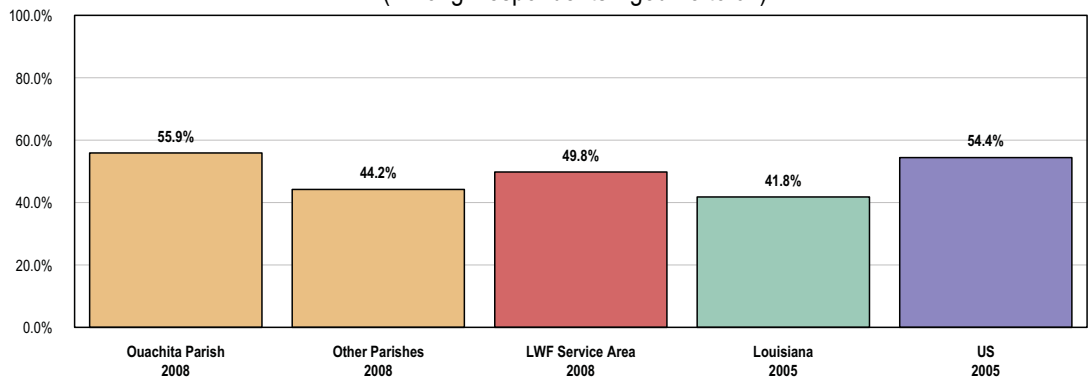
Source: • Louisiana HIV/AIDS Surveillance Program
 Note: • "IDU" refers to "injected drug use," "MSM" refers to "men having sex with men," HRH is "high-risk heterosexual contact," MSM IDU is "men who have sex with men and injection drug use," PED is "pediatric case," TRANS is "transfusion or transplant," and NIR is "no identified risk."

HIV Testing

Among LWF Service Area adults aged 18 to 64 years, 49.8% report that they have ever been tested for human immunodeficiency virus (HIV).

- ☑ Better than the proportion found statewide (41.8%).
- ☑ Similar the proportion found nationwide (54.4%).
- ⊕ Higher in Ouachita Parish.
- 👤 Note that 23.1% of adults aged 18 to 64 report that they had an HIV test within the past year (vs. 18.9% nationally).

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



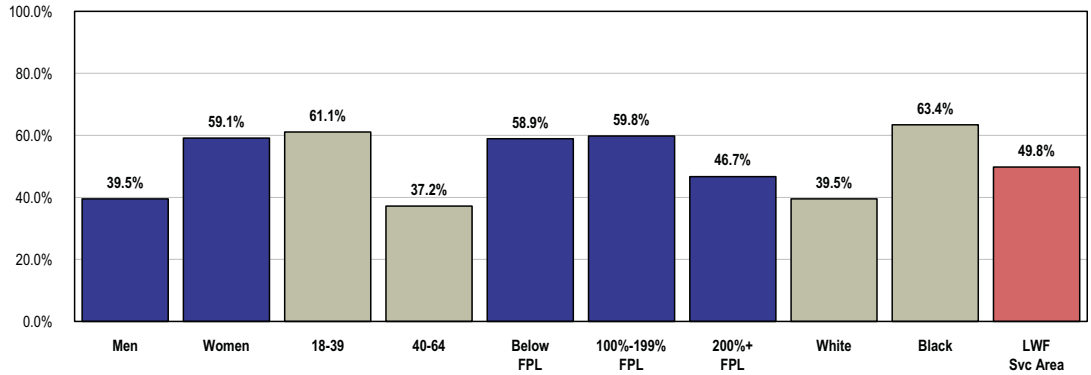
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 98]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
 Note: • Asked of respondents aged 18 through 64.

By demographic characteristics:

- 👤 Women more often report having been tested for HIV than men.
- 👤 A greater proportion of young adults (aged 18 to 39) report that they have been tested for HIV, compared with middle-aged adults (aged 40 to 64).
- 👤 Persons at lower income levels more often report having been tested for HIV.
- 👤 A very high proportion of LWF Service Area Blacks have had HIV testing.

Have Ever Been Tested for Human Immunodeficiency Virus (HIV)

(Among Respondents Aged 18 to 64; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 98]
Note: • Asked of respondents aged 18 through 64.
• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
• White and Black are non-Hispanic race categorizations.

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Just over 6 in 10 Americans (61.6%) believe that **teen pregnancy/STDs** is a “major/moderate” problem in their community.

– 2005 PRC National Health Survey. Professional Research Consultants, Inc. © PRC 2005.

Safe Sexual Practices

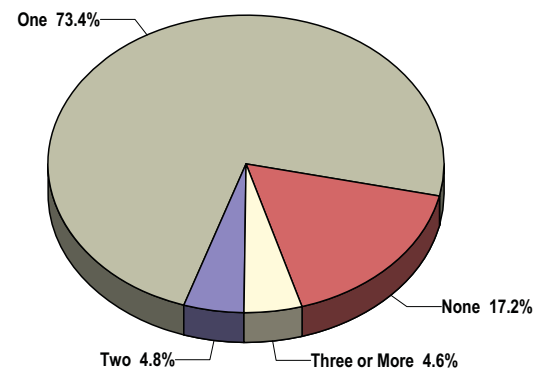
Sexual Partners

Among LWF Service Area adults aged 18 to 64, three-fourths (73.4%) report one sexual partner in the past 12 months.

- Note that 4.6% report three or more sexual partners.
- Similar to national findings (4.0%).
- ⊕ Similar by geographic sub-areas.

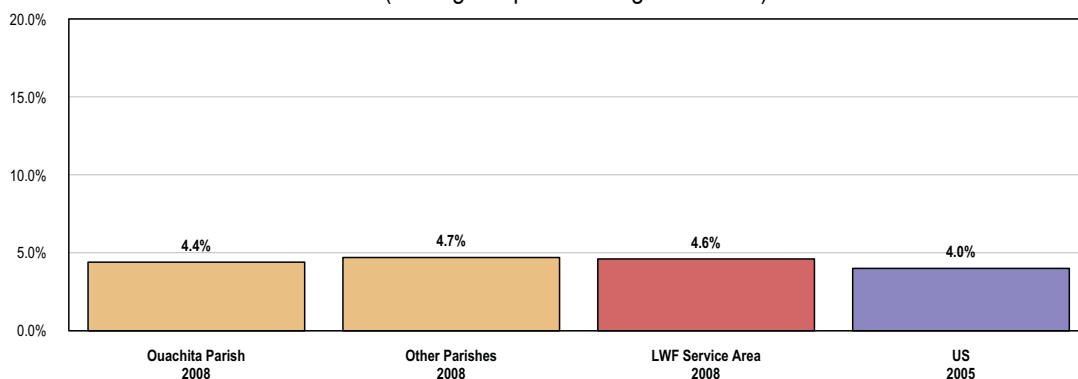
Number of Sexual Partners in the Past 12 Months

(Among Respondents Aged 18 to 64)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 99]
Note: • Asked of respondents age 18 through 64.

Had Three or More Sexual Partners in the Past Year (Among Respondents Aged 18 to 64)

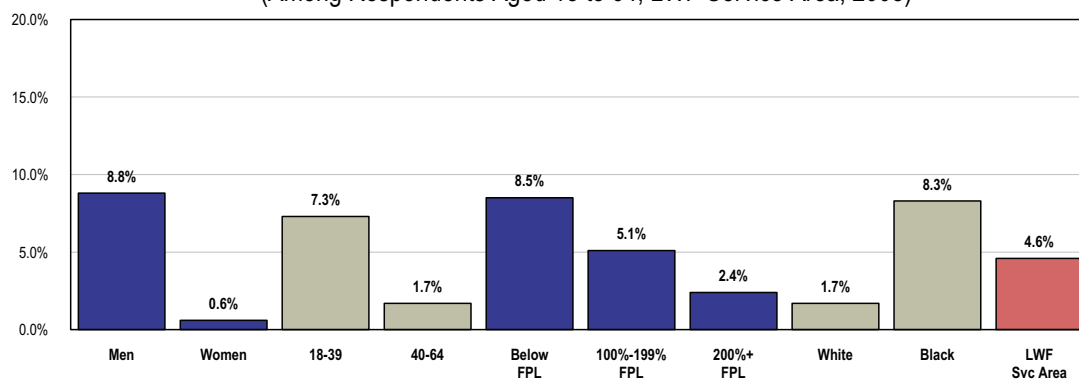


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 9g]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of respondents aged 18 through 64.

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

- 👥 Women.
- 👥 Middle-aged adults.
- 👥 White respondents.
- 👥 Note the negative correlation with income.

Had Three or More Sexual Partners in the Past Year (Among Respondents Aged 18 to 64; LWF Service Area, 2008)



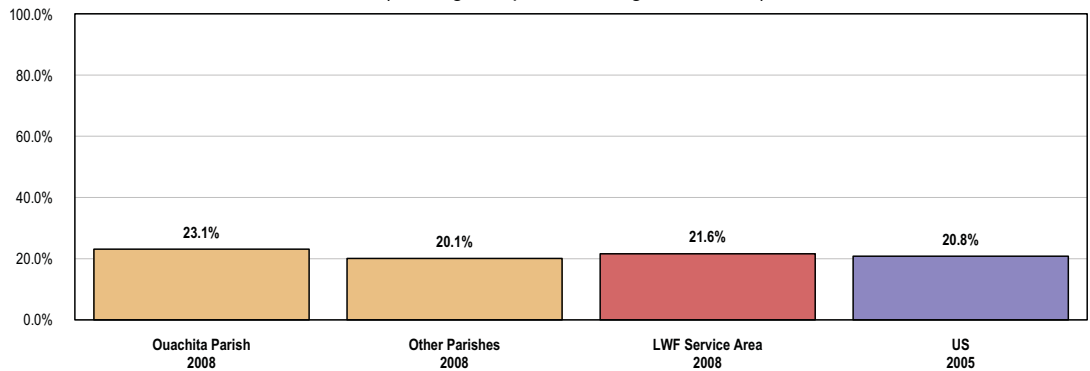
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 9g]
 Note: • Asked of respondents aged 18 through 64.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Condom Use

A total of 21.6% of LWF Service Area adults aged 18 to 64 report using a condom during their last sexual intercourse.

- ▣ Similar to the 20.8% reported nationally.
- ⊞ Does not vary significantly by sub-area.

Used a Condom During Last Sexual Intercourse (Among Respondents Aged 18 to 64)

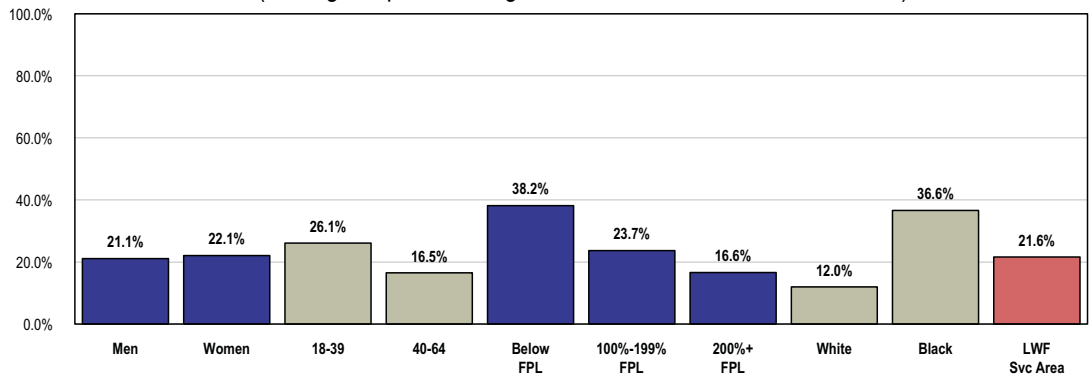


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 97]
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of respondents aged 18 through 64.

- ⊞ This prevalence is lower among adults aged 40 to 64, those living at higher incomes, and Whites.

Used a Condom During Last Sexual Intercourse (Among Respondents Aged 18 to 64; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 97]

Note: • Asked of respondents aged 18 through 64.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

- ⊞ Note that less than one-half (41.6%) of unmarried respondents aged 18 to 64 report using a condom during their last sexual encounter.

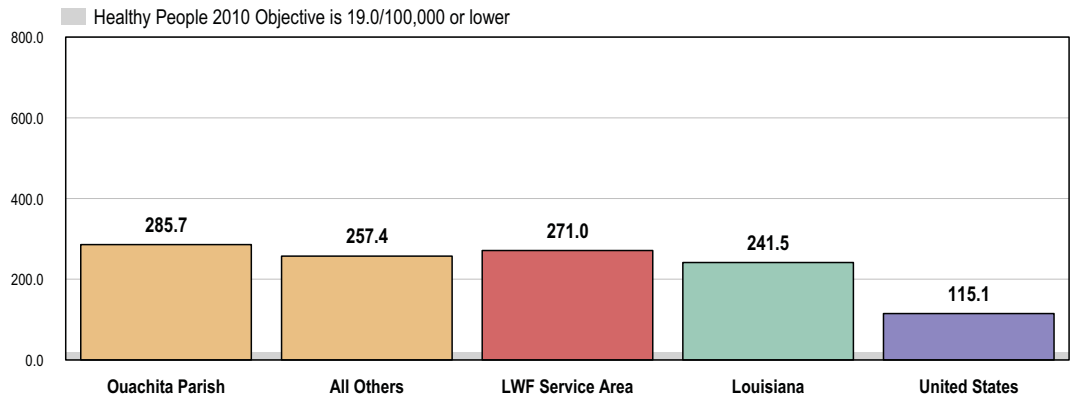
Gonorrhea

Between 2004 and 2006 in the LWF Service Area, there was an annual average incidence of 271.0 cases of gonorrhea per 100,000 population.

- ❑ Worse than found statewide (241.5).
- ❑ Much worse than found nationally (115.1).
- ❑ Fails to satisfy the Healthy People 2010 objective (19.0 or lower).
- ⊕ Higher in Ouachita Parish.

Gonorrhea Incidence

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



Source:

- Louisiana Department of Health and Hospitals
- National Center for Health Statistics. Health, United States, 2004.
- Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
- 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]

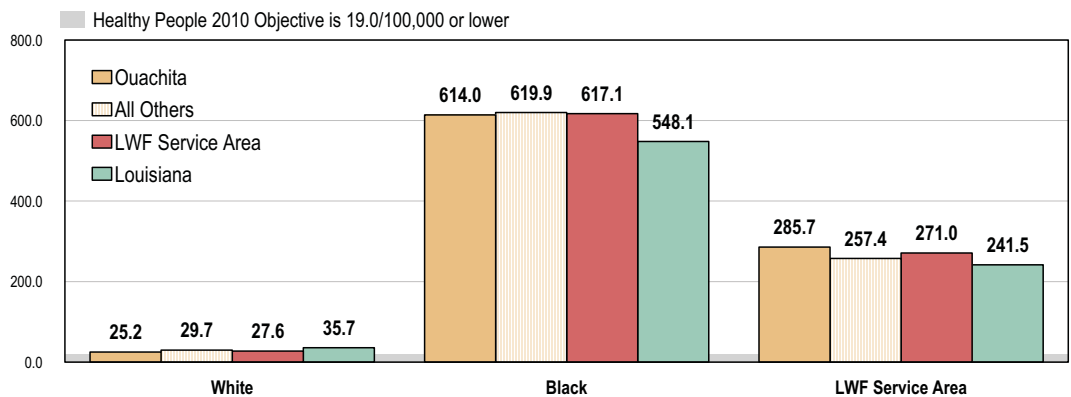
Note:

- Rates are per 100,000 population.
- U.S. figure reflects 2003-2005 data.

⊕ Gonorrhea incidence is much higher among Black community members (with rates more than 20 times those among).

Gonorrhea Incidence

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



Source:

- Louisiana Department of Health and Hospitals
- 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]

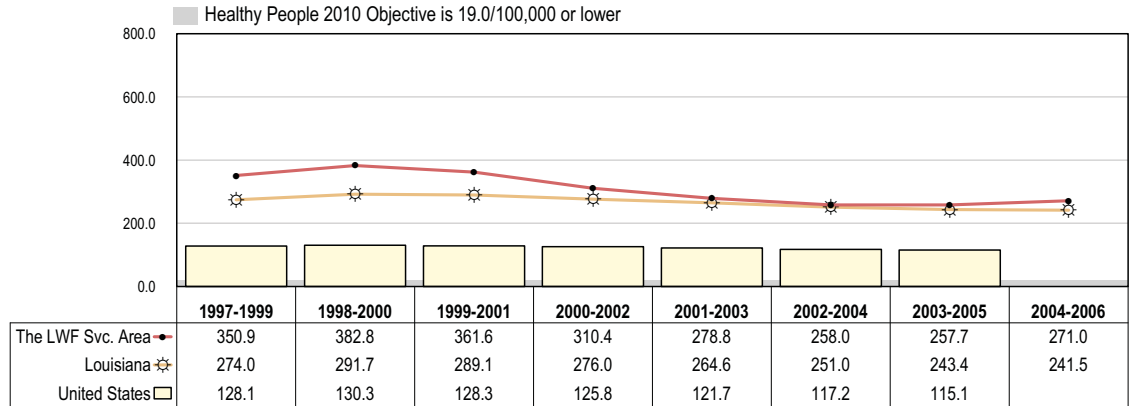
Note:

- Rates are per 100,000 population.

- ▣ Gonorrhea incidence is decreasing in the LWF Service Area, as found statewide and nationally.

Gonorrhea Incidence

(Annual Average Cases per 100,000 Population)



Source:

- Louisiana Department of Health and Hospitals
- Centers for Disease Control and Prevention.
- 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]

 Note:

- Rates are per 100,000 population.

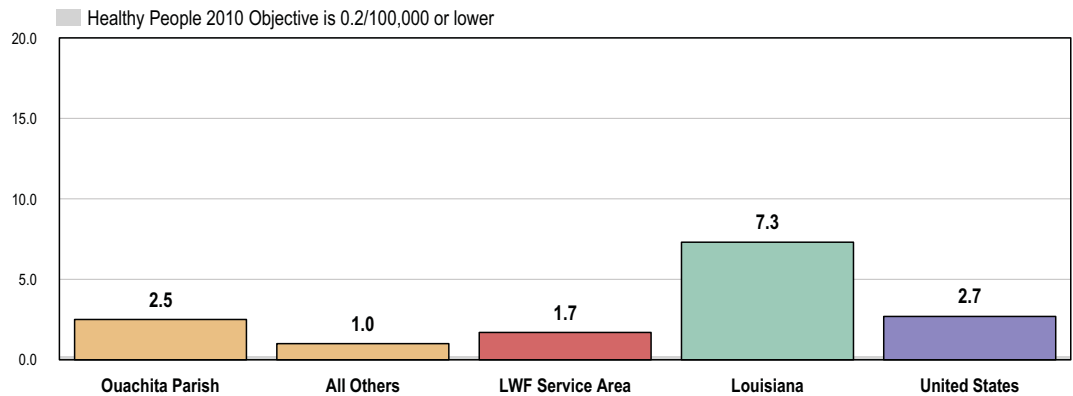
Syphilis

Between 2004 and 2006 in the LWF Service Area, there was an annual average incidence of 1.7 cases of syphilis per 100,000 population.

- ☑ Much better than found statewide (7.3).
- ☑ Better than found nationally (2.7).
- ☑ Fails to satisfy the Healthy People 2010 objective (0.2 or lower).
- ⊕ Higher in Ouachita Parish.

Primary/Secondary Syphilis Incidence

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



Source:

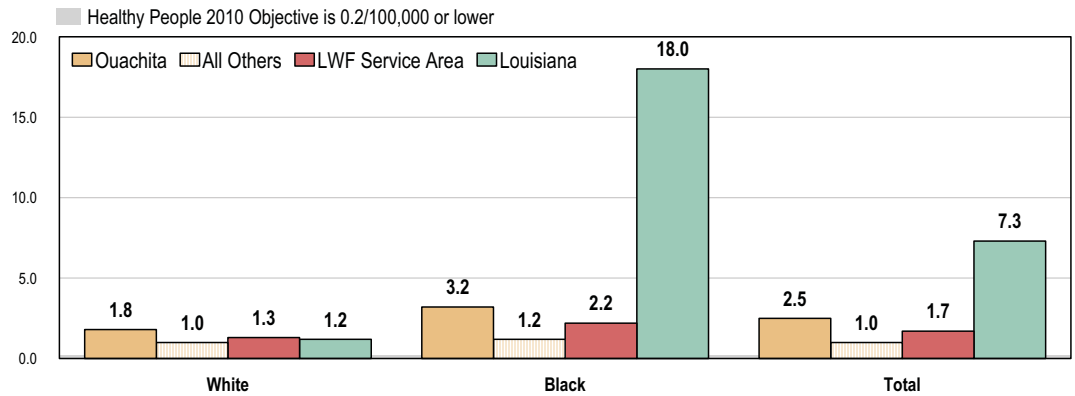
- Louisiana Department of Health and Hospitals
- National Center for Health Statistics. Health, United States, 2004.
- Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 25-3]

 Note:

- Rates are per 100,000 population.
- U.S. figure reflects 2003-2005 data.

Primary and secondary syphilis cases in Ouachita Parish are higher among Blacks. Note the huge disparity among Blacks statewide.

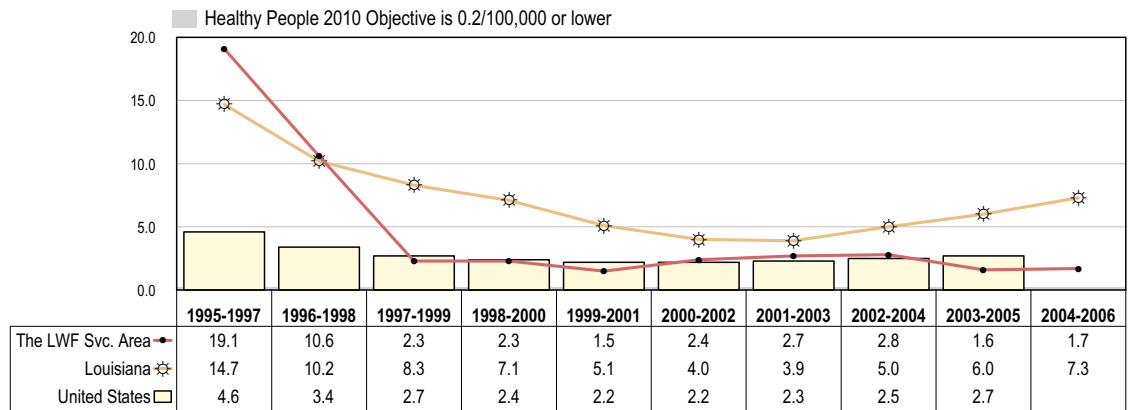
Primary/Secondary Syphilis Incidence (2004-2006 Annual Average Cases per 100,000 Population)



Source: • Louisiana Department of Health and Hospitals
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 25-3]
 Note: • Rates are per 100,000 population.

Syphilis incidence has decreased overall in the LWF Service Area since 1995-1997 (mainly due to a drastic decrease in the initial years).

Primary/Secondary Syphilis Incidence (Annual Average Cases per 100,000 Population)



Source: • Louisiana Department of Health and Hospitals
 • Centers for Disease Control and Prevention.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 25-3]
 Note: • Rates are per 100,000 population.

Chlamydia

Between 2004 and 2006 in the LWF Service Area, there was an annual average incidence of 500.8 cases of chlamydia per 100,000 population.

- ☑ Worse than found statewide (464.1).
- ☑ Much worse than found nationally (318.8).
- ⊕ Higher in Ouachita Parish.

Chlamydia Incidence

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



Source:

- Louisiana Department of Health and Hospitals
- National Center for Health Statistics. Health, United States, 2004.
- Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.

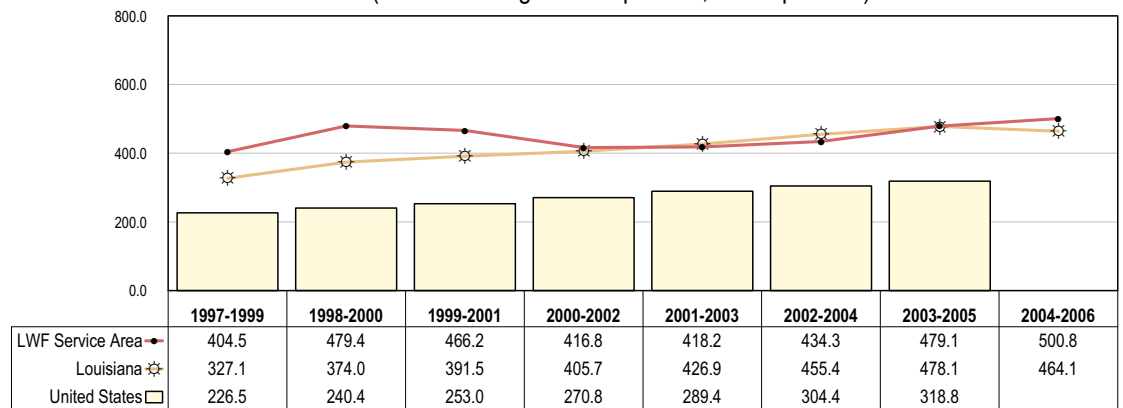
 Note:

- Rates are per 100,000 population.
- U.S. figure reflects 2003-2005 data.

- ⊞ Chlamydia incidence is increasing in the LWF Service Area, as it is statewide and nationwide.

Chlamydia Incidence

(Annual Average Cases per 100,000 Population)



Source:

- Louisiana Department of Health and Hospitals
- Centers for Disease Control and Prevention.

 Note:

- Rates are per 100,000 population.

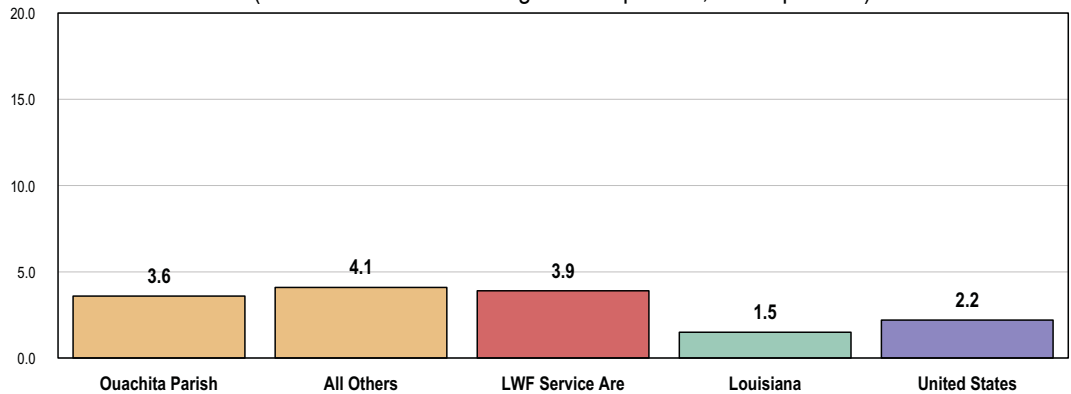
Hepatitis B

Between 2004 and 2006 in the LWF Service Area, there was an annual average incidence of 3.9 cases of hepatitis B per 100,000 population.

- ☒ Worse than found statewide (1.5).
- ☒ Also worse than the nationwide incidence rate (2.2).
- ☒ Lower in Ouachita Parish.

Hepatitis B Incidence

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

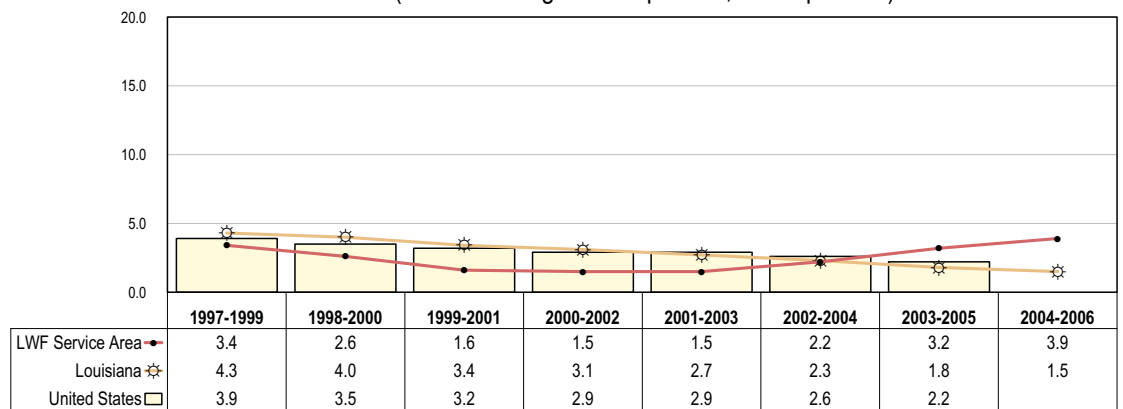


Source:
 • Louisiana Department of Health and Hospitals
 • National Center for Health Statistics. Health, United States, 2004.
 • Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. Summary of Select Notifiable Diseases.
 Note:
 • Rates are per 100,000 population.
 • U.S. figure reflects 2003-2005 data.

- ☒ Hepatitis B incidence increased in the LWF Service Area during the latter 1990s, but has since decreased.

Hepatitis B Incidence

(Annual Average Cases per 100,000 Population)



Source:
 • Louisiana Department of Health and Hospitals
 • Centers for Disease Control and Prevention.
 Note:
 • Rates are per 100,000 population.

BIRTHS

MATERNAL, INFANT & CHILD HEALTH

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 U.S. 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 U.S. 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.

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Birth Rate

Between 2002 and 2004, there was an annual average of 14.5 births in the LWF Service Area per 1,000 population.

- ☐ Identical to statewide rates (14.5).
- ☐ Higher than national rates (14.0).
- ⊕ Higher in Ouachita Parish.

Crude Birth Rates

(2002-2004 Annual Average Births per 1,000 Population)

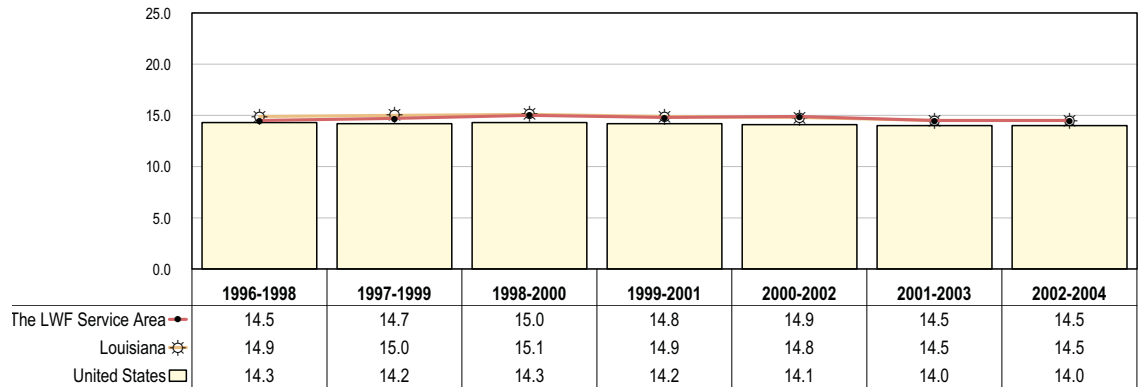


Source:
 • Louisiana State Center for Health Statistics
 • Centers for Disease Control and Prevention, National Center for Health Statistics.
 Note:
 • Rates are per 1,000 population.

Overall, area birth rates have remained stable in recent years.

Crude Birth Rates

(Annual Average Births per 1,000 Population)



Source:
 • Louisiana State Center for Health Statistics
 • Centers for Disease Control and Prevention, National Center for Health Statistics.
 Note:
 • Rates are per 1,000 population.

Prenatal Care

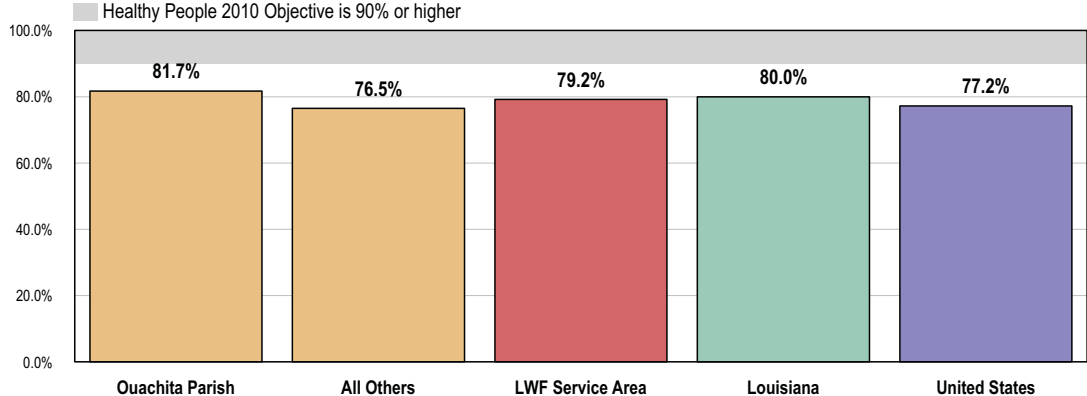
Early and continuous prenatal care is the best assurance of infant health.

Adequate Prenatal Care

Nearly four-fifths (79.2%) of all 2002-2004 LWF Service Area births received at least adequate prenatal care.

- Similar to the proportion statewide (80.0%).
- Also similar to the proportion nationwide (77.2%).
- Fails to meet the Healthy People 2010 target (90% or higher).
- Higher in Ouachita Parish.

Mothers Receiving Adequate Prenatal Care in the First Trimester (2002-2004 Percentage of Live Births; Modified Kessner Index)

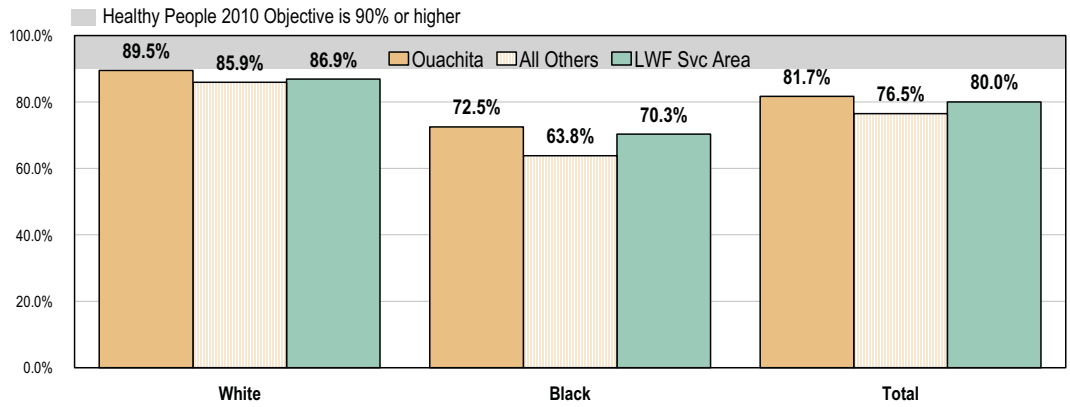


Source: • Louisiana State Center for Health Statistics
• Centers for Disease Control and Prevention, National Center for Health Statistics.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 16-6a].
Note: • Numbers are percentages of live births.

- Adequate prenatal care is notably lower among Black LWF Service Area mothers, when compared with Whites.

Mothers Receiving Adequate Prenatal Care in the First Trimester

(2002-2004 Percentage of Live Births; Modified Kessner Index)

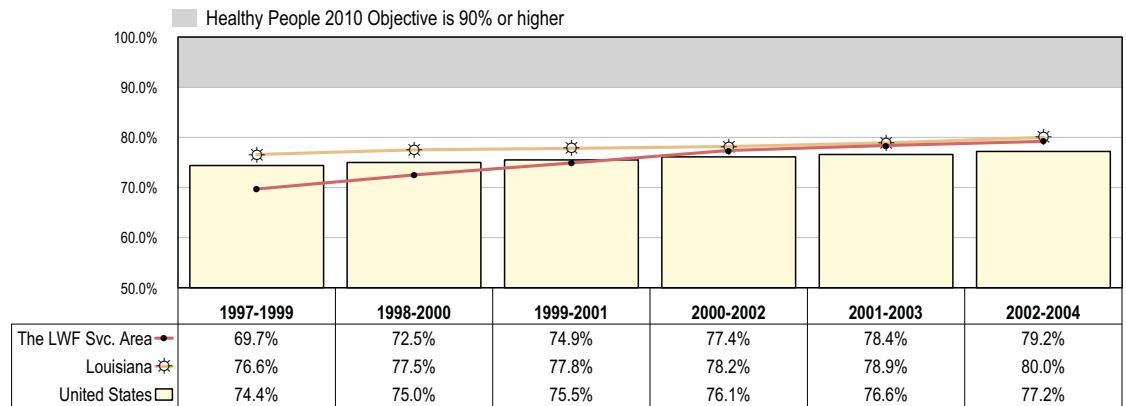


Source: • Louisiana State Center for Health Statistics
 • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 16-6a]
 Note: • Numbers are a percentage of live births.

☒ The proportion of women receiving adequate prenatal care has consistently increased in the LWF Service Area in recent years.

Mothers Receiving Adequate Prenatal Care in the First Trimester

(Percentage of Live Births)



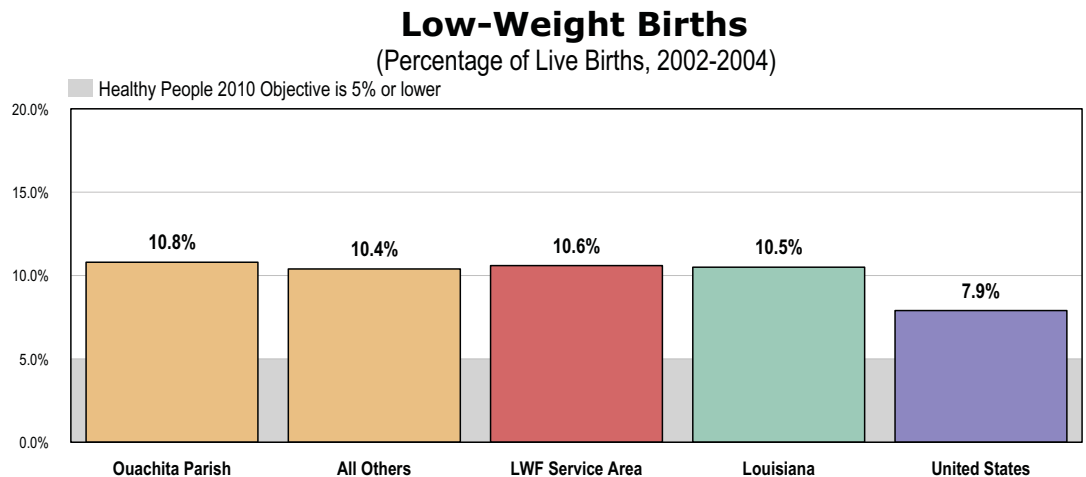
Source: • Louisiana State Center for Health Statistics
 • Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-6a].
 Note: • Numbers are a percentage of all live births within each population.

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.

An annual average of 10.6% of LWF Service Area births between 2003 and 2005 were of low birthweight.

- ☑ Similar to the statewide proportion (10.5%).
- ☑ Higher than the percentage nationwide (7.9%).
- ☑ Fails to satisfy the Healthy People 2010 target (5% or lower).
- ⊕ Similar by geographic sub-area.

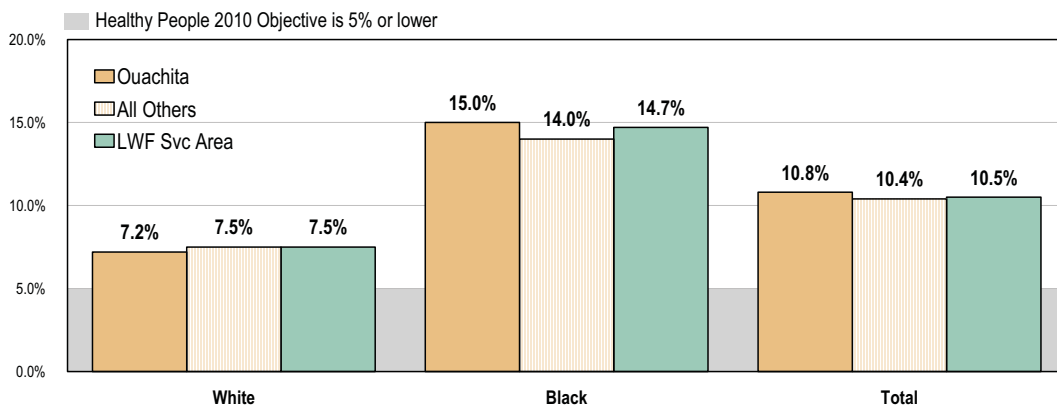


Source: • Louisiana State Center for Health Statistics
 • Centers for Disease Control and Prevention, National Center for Health Statistics.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000 [Objective 16-10a].

Note: • Numbers are percentages of live births.

👥 **Note that low-weight births are more common among Black mothers in the LWF Service Area.**

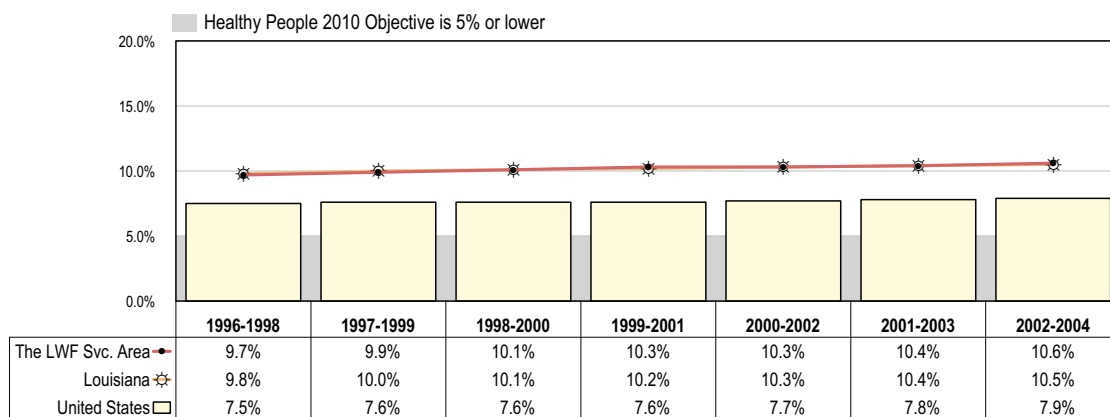
Low-Weight Births (Percentage of Live Births, 2002-2004)



Source: • Louisiana State Center for Health Statistics
 • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 16-10a]
 Note: • Numbers are a percentage of live births.

☒ Low-weight births have been increasing in the LWF Service Area.

Low-Weight Births (Low-Weight Births as a Percentage of Live Births)



Source: • Louisiana State Center for Health Statistics
 • 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 [Objective 16-10a].
 Note: • Numbers are a percentage of all live births within each population.

Infant Mortality

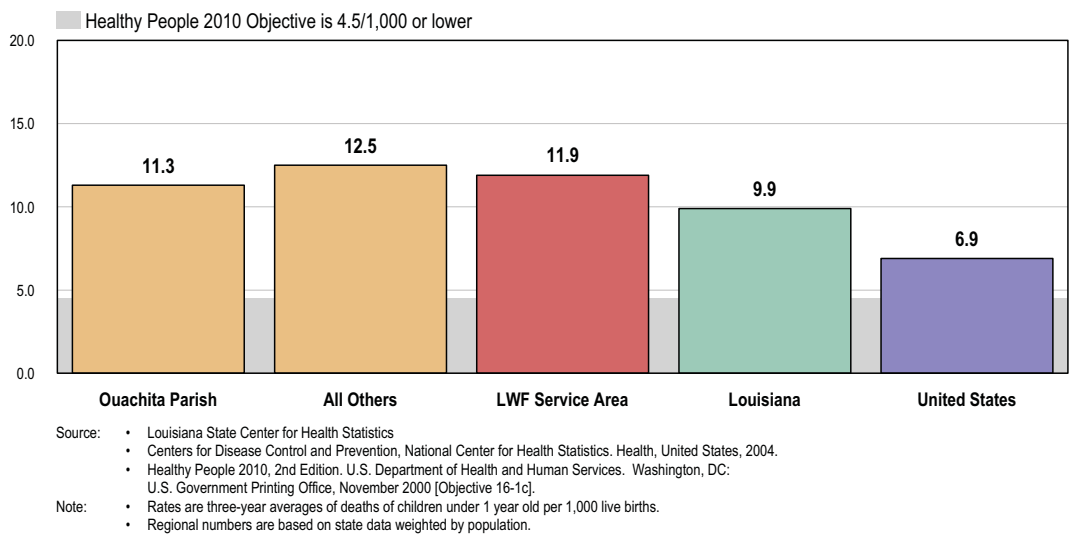
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2002 and 2004 in the LWF Service Area, there was an annual average of 11.9 infant deaths per 1,000 live births.

- ☉ Higher than the Louisiana infant mortality rate (9.9).
- ☉ Much higher than the infant mortality rate nationwide (6.9).
- ☉ Fails to satisfy the Healthy People 2010 target (4.5 per 1,000 live births).
- ⊕ More favorable in Ouachita Parish.

Infant Mortality Rates

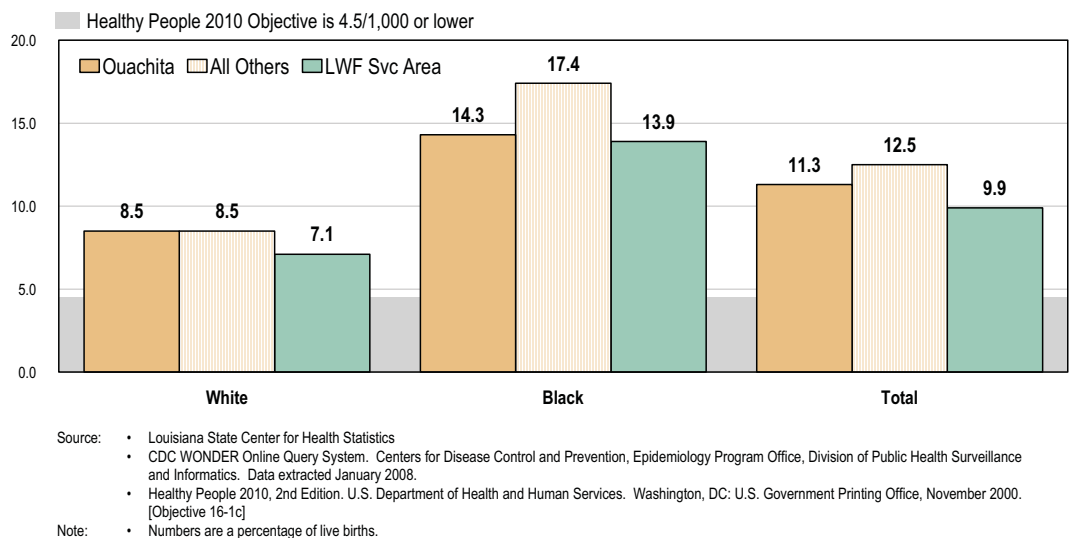
(2002-2004 Average Annual Infant Deaths per 1,000 Live Births)



👥 Note that Black births experience much higher rates of infant mortality.

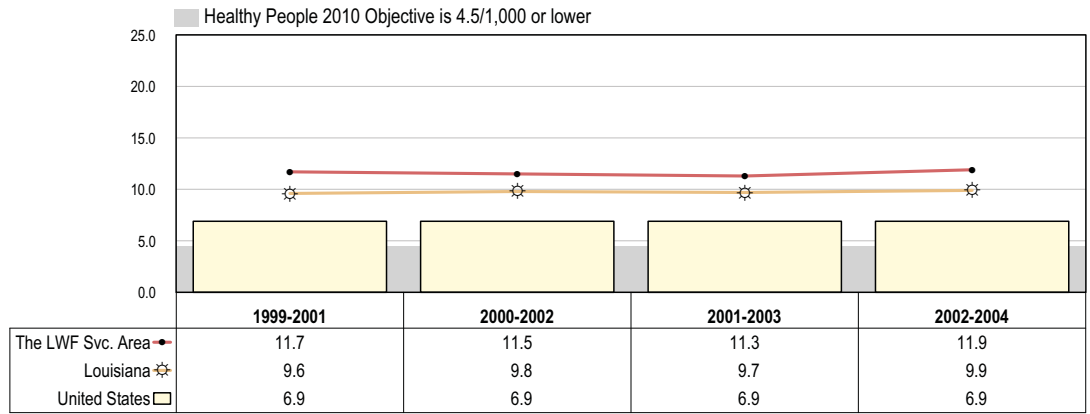
Infant Mortality Rates

(2002-2004 Average Annual Infant Deaths per 1,000 Live Births)



☒ Infant mortality rates are holding steady in the LWF Service Area.

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



Source: • Louisiana State Center for Health Statistics
 • 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 [Objective 16-17c]

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

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

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.

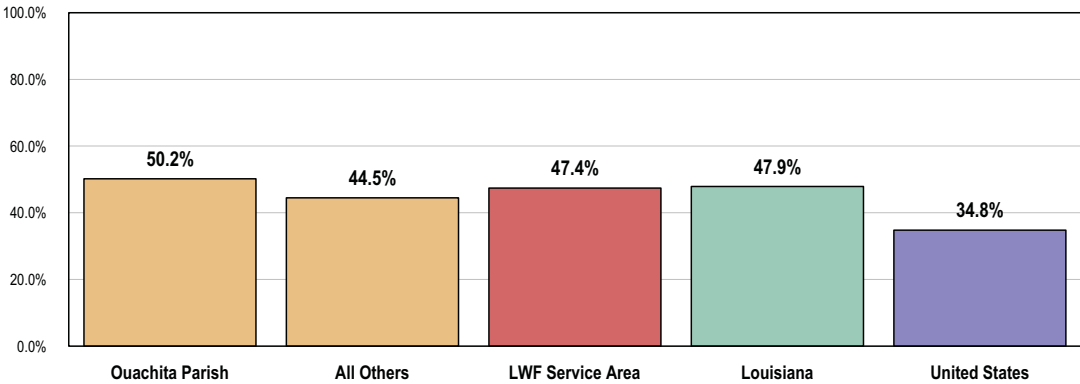
Because it is impossible to measure the true incidence of unintended pregnancy in the U.S., the following indicator looks at births occurring among unmarried mothers as a proxy measure for pregnancies that are not intended (knowing that this is not always the case).

A total of 47.4% of 2002-2004 LWF Service Area births were to unmarried mothers.

- Nearly identical to the proportion statewide (47.9%).
- Higher than the proportion nationwide (34.8%).
- ⊕ Higher in Ouachita Parish.

Births to Unwed Mothers

(2002-2004 Average Annual Percentage of Births to Unwed Mothers)

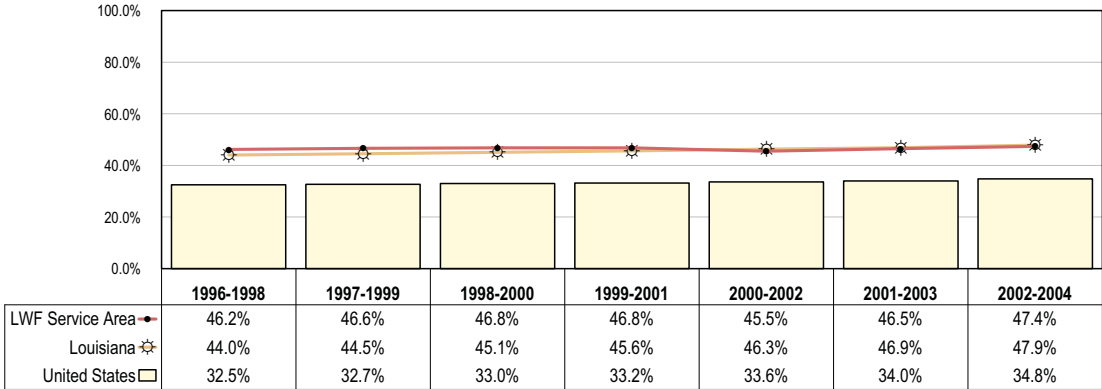


Source: • Louisiana State Center for Health Statistics
 • Centers for Disease Control and Prevention, National Vital Statistics System.
 Note: • Numbers are a percentage of all live births within each population.

- ⊞ Over the past several years, the proportions of births to unmarried women have remained steady (a slight increase is seen at the state level).

Births to Unwed Mothers

(Percentage of Live Births)



Source: • Louisiana State Center for Health Statistics
 • Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2004.
 Note: • Numbers are a percentage of all live births within each population.

Births to Teenage Mothers

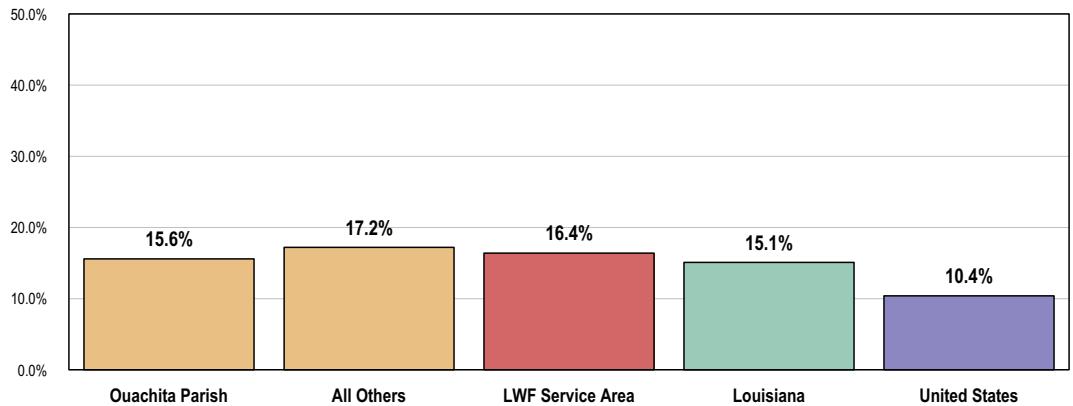
For teenagers, the problems associated with unintended pregnancy are compounded, and the consequences are well documented. Teenaged mothers are less likely to get or stay married, less likely to complete high school or college, and more likely to require public assistance and to live in poverty than their peers who are not mothers. Infants born to teenaged 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Between 2002 and 2004, 16.4% of area births were to women under 20.

- ☑ Higher than statewide percentage (15.1%).
- ☑ Much higher than the proportion seen nationally (10.4%).
- ⊕ Lower in Ouachita Parish.

Births to Teens (Under Age 20) (2002-2004 Percentage of Births to Females Under 20)



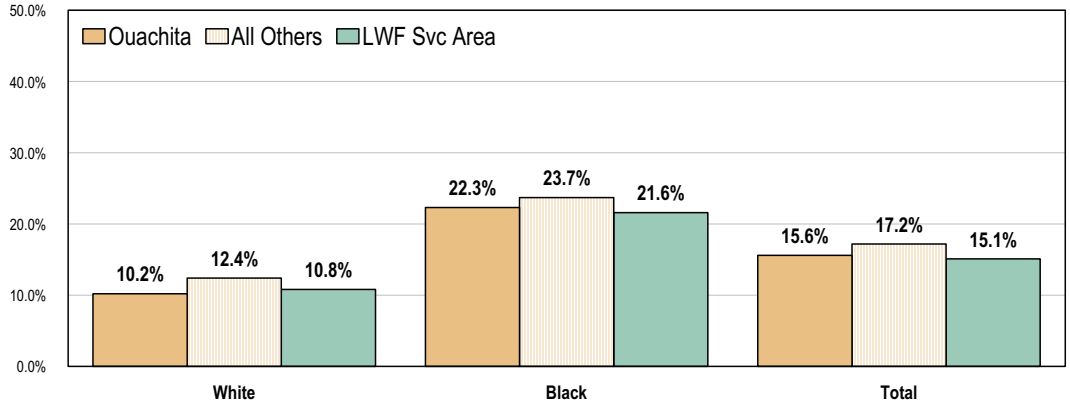
Source: • Louisiana State Center for Health Statistics
• Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.

Note: • Numbers are percentage of births to women under 20.

- ☑ Viewed by race, the proportion of births to Black teens are nearly twice as high as White teens.

Births to Teens (Under Age 20)

(2002-2004 Percentage of Births to Females Under 20)



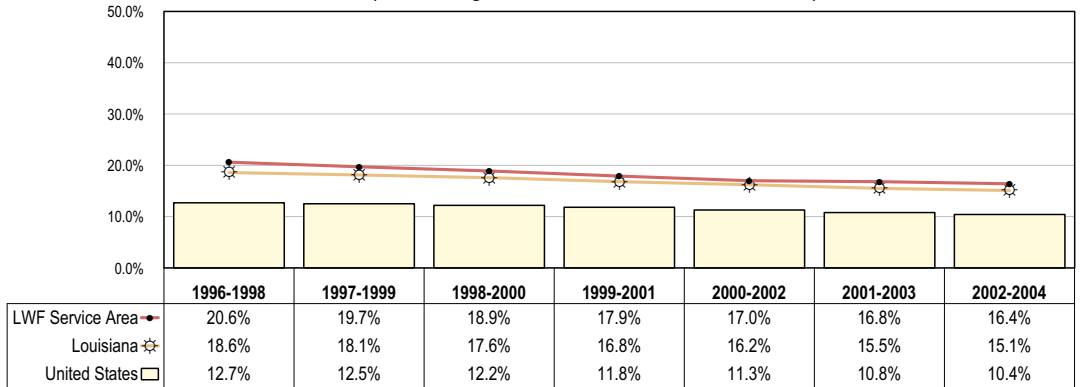
Source: • Louisiana State Center for Health Statistics
 • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.

Note: • Numbers are percentage of births to women under 20.

☒ Teen births are decreasing in the LWF Service Area, echoing the decreasing trend reported across Louisiana and the nation as a whole.

Births to Teens (Under Age 20)

(Percentage of Births to Females Under 20)



Source: • Louisiana State Center for Health Statistics
 • Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004.

Note: • Numbers are percentage of births to women under 20.

MODIFIABLE HEALTH RISKS

ACTUAL CAUSES OF DEATH

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/U.S. Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88-1232.

In particular, a 2002 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.¹

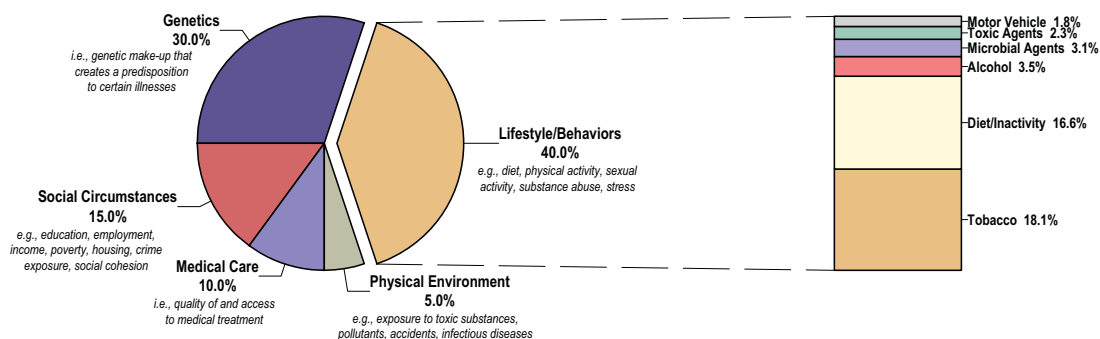
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity patterns** (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual 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 U.S. 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.

¹ “The Case For More Active Policy Attention to Health Promotion”; (McGinnis, Williams-Russo, Knickman) *Health Affairs*, Vol. 21, No. 2, March/April 2002.

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(2004):1238-1245.

NUTRITION & OVERWEIGHT

Nutrition

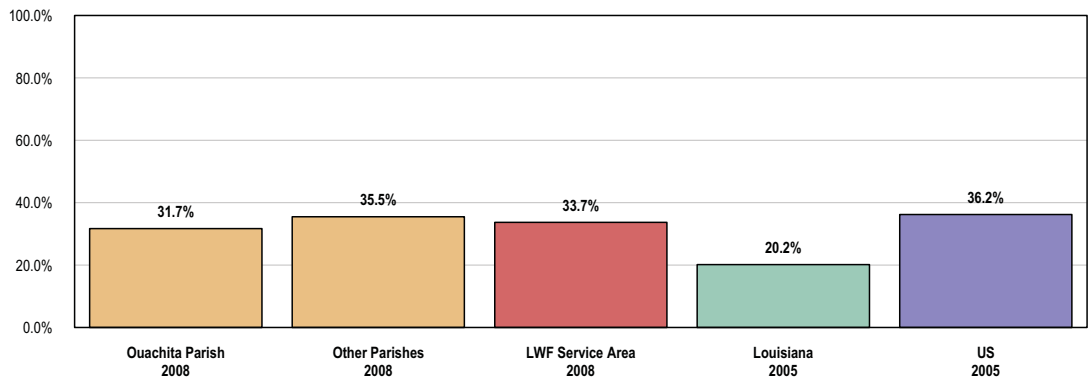
Consumption of Fruits & Vegetables

Daily Recommendation

A total of 33.7% of surveyed LWF Service Area adults report eating five or more servings of fruits and/or vegetables per day.

- ☑ Much higher than the Louisiana (20.2%) percentage.
- ☑ Similar to national findings (36.2%).
- ⊕ Similar between the sub-areas.

Consume Five or More Servings of Fruits/Vegetables per Day

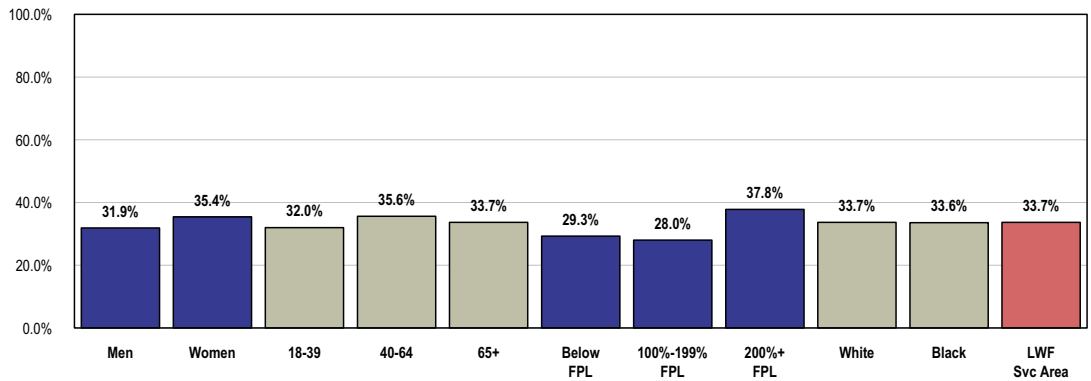


- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 148]
 - 2005 PRC National Health Survey, Professional Research Consultants.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
- Note:
- Asked of all respondents.
 - For this issue, respondents were asked to recall the foods they had eaten on the day prior to the interview.

☑ The following chart further examines fruit/vegetable consumption by various demographic characteristics. As shown, respondents less likely to eat five or more fruits/vegetables per day include residents living at lower incomes.

Consume Five or More Servings of Fruits/Vegetables per Day

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 148]

Note: • Asked of all respondents.

• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].

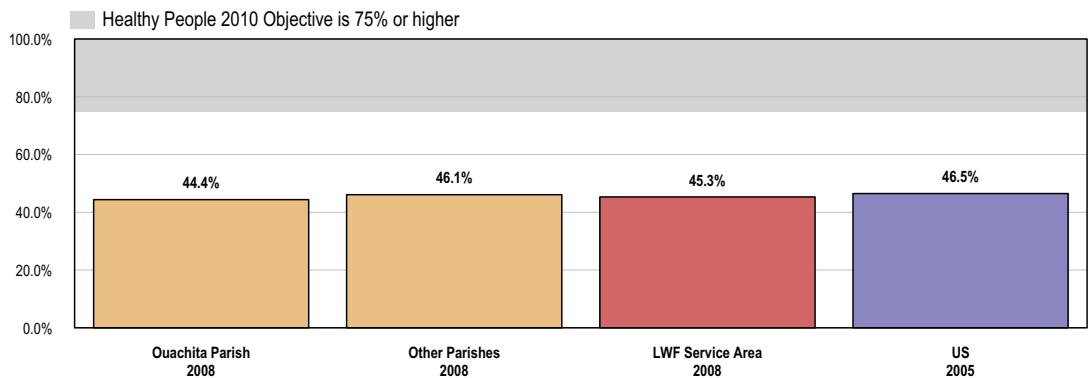
• White and Black are non-Hispanic race categorizations.

Fruits

Less than half of LWF Service Area adults (45.3%) report eating at least two servings of fruit per day.

- ☑ Similar to national findings (46.5%).
- ☑ Fails to satisfy the Healthy People 2010 target (75% or higher).
- ⊕ Does not vary by sub-area.

Consume Two or More Servings of Fruits per Day



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 148]

• 2005 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]

Note: • Asked of all respondents.

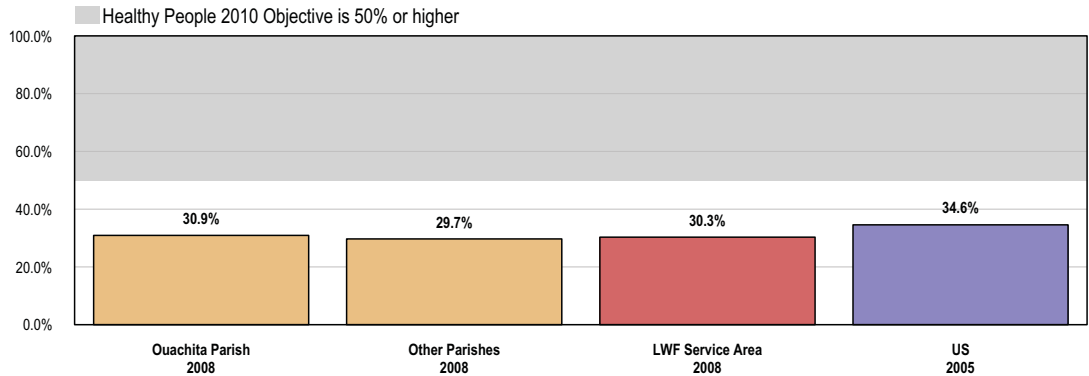
• For this issue, respondents were asked to recall the foods they had eaten on the day prior to the interview.

Vegetables

30.3% of survey respondents report eating three or more servings of vegetables per day, at least one-third of which are dark green or orange vegetables.

- ☑ Less favorable than to national findings (34.6%).
- ☑ Fails to satisfy the Healthy People 2010 target (50% or higher).
- ⊕ No significant differences by sub-area.

Consume Three or More Servings of Vegetables per Day, One-Third of Which Are Dark Green or Orange



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 147]
 - 2005 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]
- Note:
- Asked of all respondents.
 - For this issue, respondents were asked to recall the foods they had eaten on the day prior to the interview.

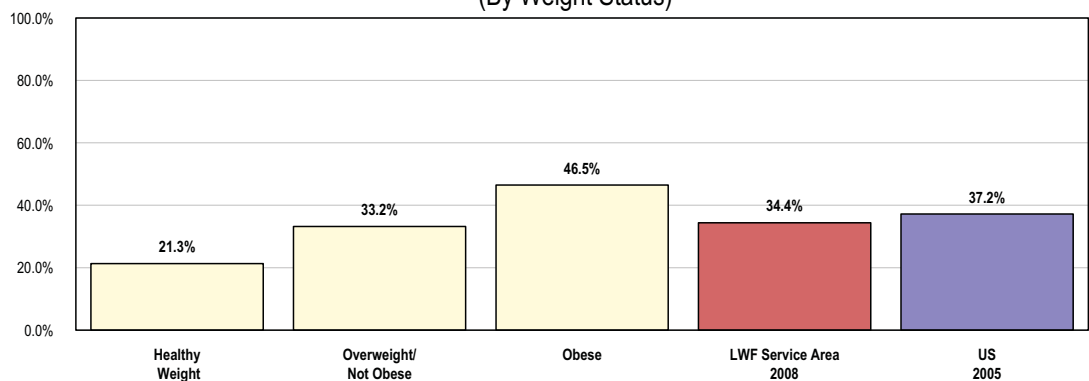
Health Advice About Diet & Nutrition

A total of 34.4% of LWF Service Area respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- ☑ Statistically comparable to national findings (37.2%).
- ⊕ Note: Among LWF Service Area obese respondents, 46.5% report receiving diet/nutrition advice.

Physician Has Asked About or Given Advice Regarding Diet & Nutrition in the Past Year

(By Weight Status)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 19]
 - 2005 PRC National Health Survey, Professional Research Consultants.
- Note:
- 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 (m²). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m² and obesity as a BMI of ≥ 30 kg/m². The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m². The increase in mortality, however, tends to be modest until a BMI of 30 kg/m² is reached. For persons with a BMI of ≥ 30 kg/m², 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/m².

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
Obesity	Obesity Class	
	I	30.0 – 34.9
	II	35.0 – 39.9
Extreme Obesity	III	≥ 40

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.

Over three-fourths (76.7%) of Americans believe that **overweight/obesity prevalence** is a “major/moderate” problem in their community (the **highest** ranked among 10 areas tested).

– 2005 PRC National Health Survey. Professional Research Consultants, Inc. © PRC 2005.

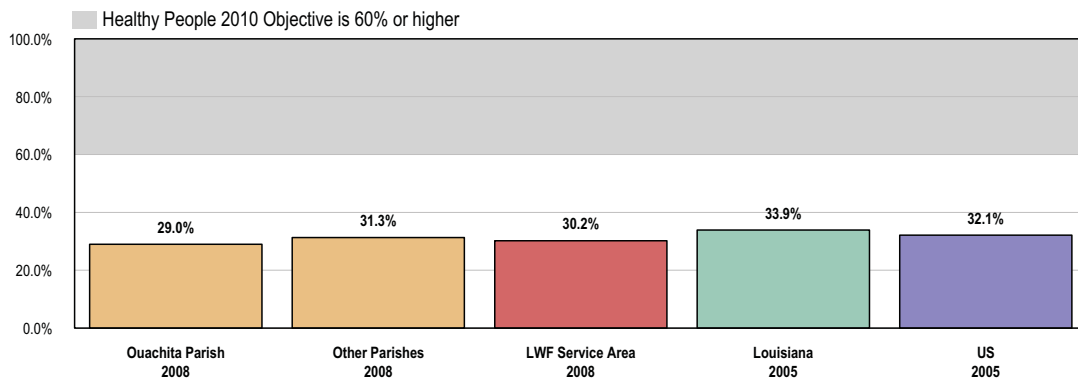
Healthy Weight

Based on self-reported heights and weights, 30.2% of LWF Service Area adults are at a healthy weight (neither underweight nor overweight, BMI = 18.5-24.9).

- Lower than the Louisiana ratio (33.9%).
- Comparable to the national findings (32.1%).
- Far from reaching the Healthy People 2010 target (60% or higher).
- ⊕ No statistical difference by sub-area.

Healthy Weight

(Body Mass Index Between 18.5 and 24.9)



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 138]
- 2005 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); 2005 Louisiana data.
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Note:

- Based on self-reported height and weight, 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.

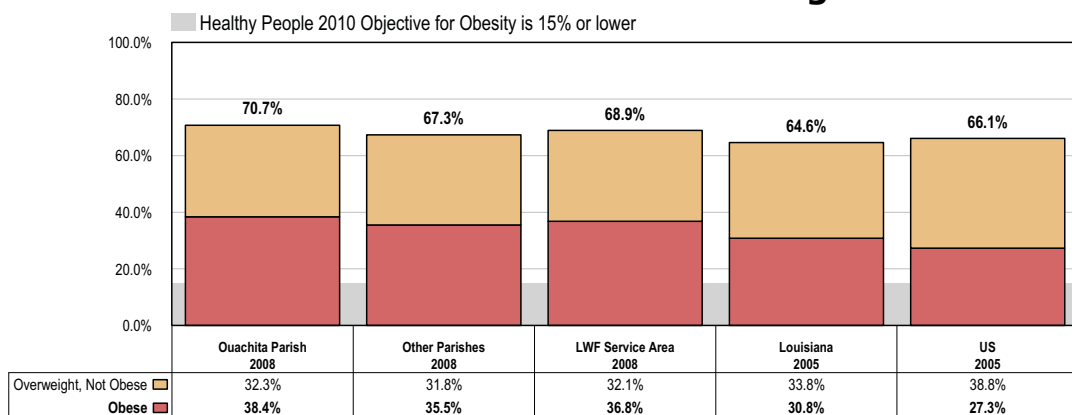
Overweight Status

Adults

In all, 68.9% of LWF Service Area adults are overweight (BMI ≥ 25).

- ☐ Less favorable than the Louisiana percentage (64.6%).
- ☐ Similar to the U.S. overweight proportion (66.1%).
- ⊕ No significant difference by sub-area.

Prevalence of Overweight



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 138]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
- 2005 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 19-2]

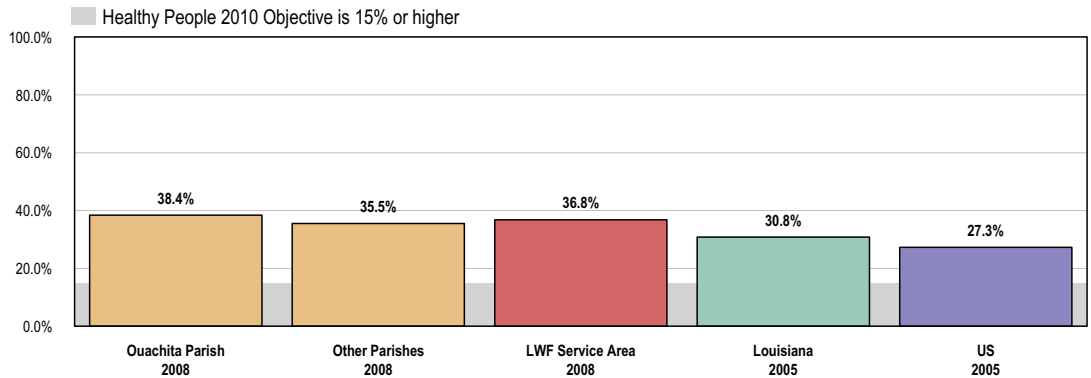
Note:

- Based on self-reported height and weight, 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, 36.8% of LWF Service Area adults are obese (BMI ≥30).

- ☑ Higher than the Louisiana percentage (30.8%).
- ☑ Also higher than U.S. findings (27.3%).
- ☑ Fails to satisfy the Healthy People 2010 target (15% or lower).
- ⊕ Does not vary by sub-area.

Prevalence of Obesity



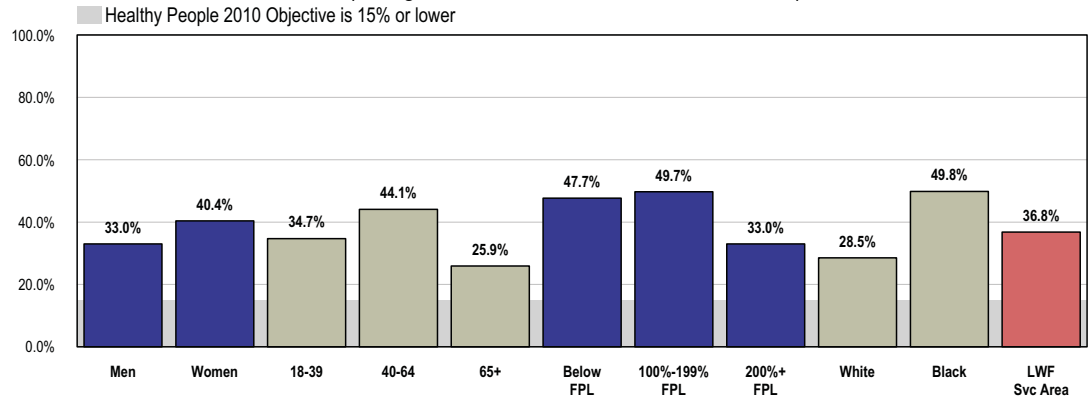
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 138]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-2]

Note: • Based on self-reported height and weight, 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.

☑ Obesity is more prevalent among women, adults aged 40 to 64, residents living at lower incomes, and Black residents.

Prevalence of Obesity

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 138]
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 19-2]

Note: • Based on self-reported height and weight, asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.
 • 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.

Relationship of Overweight With Other Health Issues

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

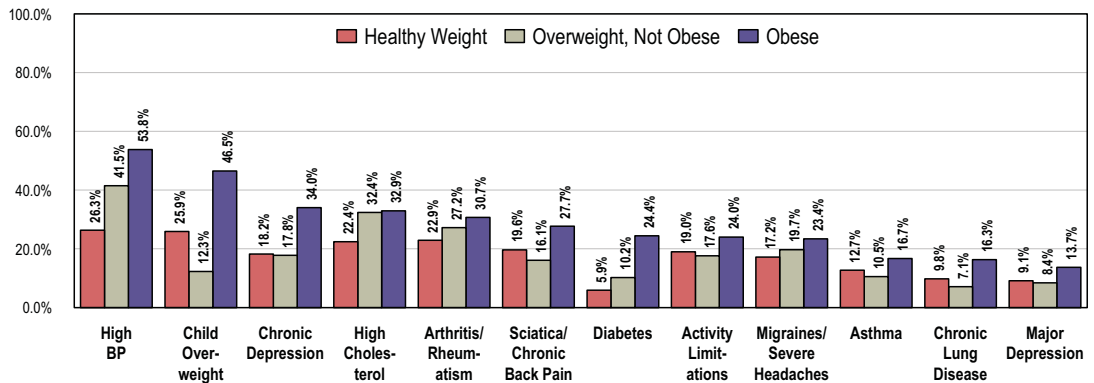
Among LWF Service Area community members, overweight and obese adults are more likely to report a number of adverse health conditions.

These include:

- ☐ Hypertension (high blood pressure).
- ☐ Chronic depression.
- ☐ High cholesterol.
- ☐ Arthritis/rheumatism.
- ☐ Sciatica/chronic back pain.
- ☐ Diabetes.
- ☐ Activity limitations.
- ☐ Migraines/severe headaches.
- ☐ Asthma.
- ☐ Chronic lung disease.
- ☐ Major depression.

In addition, LWF Service Area residents who are obese appear to be more likely to have children who are overweight.

Relationship of Overweight With Other Health Issues
(Living Well Foundation Service Area, 2008)



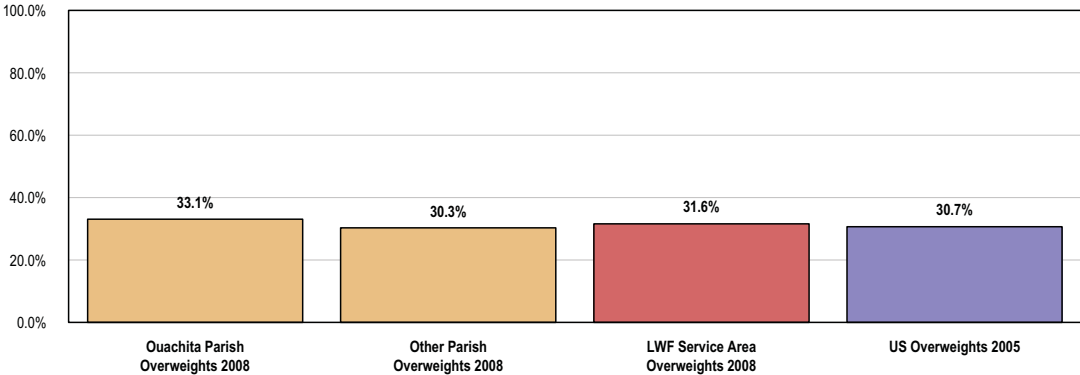
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 6,26,29,30,36,39,41,43,114,134,135,141]
Note: • Reflects responses among all of respondents, segmented by their bodyweight category (categories are mutually exclusive).

Health Advice About Weight Management

31.6% of LWF Service Area overweight adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Nearly identical to the national findings among those overweight (30.7%).
- ⊕ Similar among geographic sub-areas.
- 👥 Note that 41.4% of obese service area adults have been given advice about their weight by a health professional in the past year.

Physician, Nurse or Other Health Professional Has Given Advice About Weight in the Past Year (Among Overweight Adults)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 14Q]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all overweight 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. Total costs (medical costs and lost productivity) attributable to obesity alone amounted to an estimated \$99 billion in 1995.

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

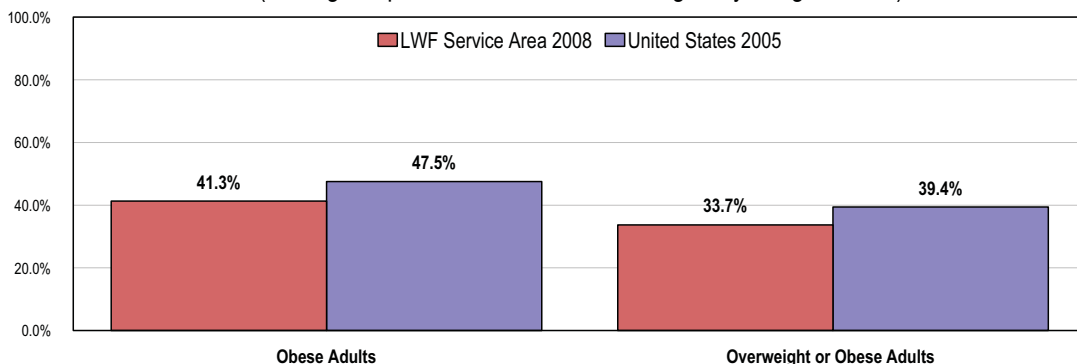
33.7% of LWF Service Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

☐ Less favorable than the national findings (39.4%).

👤 Note: 41.3% of obese service area adults report that they are trying to lose weight through a combination of diet and exercise.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity

(Among Respondents Who Are Overweight; By Weight Status)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 139]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Reflects responses among overweight respondents (categories are not mutually exclusive).

Child Overweight

In children and teens, body mass index is used to assess underweight, overweight, and risk for overweight. Children's body fatness changes over the years as they grow. Also, girls and boys differ in their body fatness as they mature. This is why BMI for children (also referred to as BMI-for-age) is gender- and age-specific. BMI-for-age is plotted on gender specific growth charts. These charts are used for children and teens 2 – 20 years of age. Healthcare professionals use the following established percentile cutoff points to identify underweight and overweight in children.

Underweight	<5th percentile
At Risk of Overweight	85th to 95th percentile
Overweight	≥ 95 th percentile

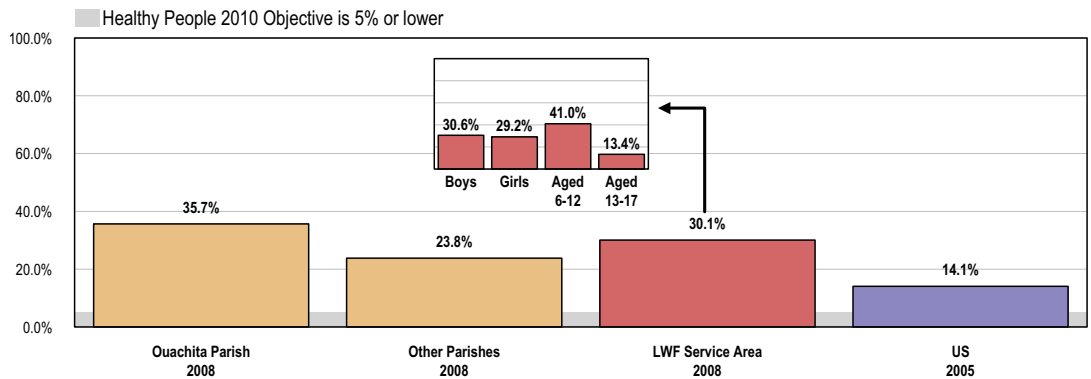
– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Nearly one-third (30.1%) of LWF Service Area children aged 6 to 17 are overweight, based on heights/ weights reported by surveyed parents.

- ☑ More than twice the national ratio (14.1%).
- ☑ Statistically similar by sub-area (use caution when interpreting these results due to small sub-samples).
- 👤 Varies from 41.0% among LWF Service Area children aged 6 to 12 to 13.4% among teens (no statistical difference by gender).

Child Overweight

(Among Children Ages 6 to 17)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 14]
 - 2005 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 19-3a-b]
- Note:
- Asked of all respondents with children aged 6 to 17 at home.
 - Overweight among children is estimated based on children's Body Mass Index status above the 95th percentile of U.S. growth charts by gender and age.

Community Leaders/ Business Leaders/ Physicians/ Social Service Providers/ Other Health Professionals

All groups are concerned about too much eating out, about the obesity problem, and about the lack of nutritious eating in the area. This is not exclusive to the adult population or to any one class—it crosses all lines. The poor seem to be at greater risk because there is an assumption that healthy food is more expensive and more difficult to prepare than that which is unhealthy.

“I’m specifically speaking of the school lunch program at Riverside. They feed the children in the morning and they feed them ‘fat food.’ They feed them at lunch and they feed them ‘fat food.’ I tried to have that changed and have not gotten very far.” – Business Leader

“There are a number of children in our community whose parents don’t cook so their meals are what they get in the morning and at noon. And through a program at the food bank, the kids get a brown bag on Friday afternoon that has food they can open themselves; things that they can prepare themselves over the weekend. Unfortunately they are all pretty high in fat content. But it’s just so that they have something to eat over the weekend.” – Business Leader

“I know in Morehouse Parish our school lunches have gone to the chicken nuggets and the French fries, and everything that’s so easy just to put out for them instead of making a nutritious, balanced lunch.” – Other Health Professional

“There is not a single state now in the United States that does not have obesity problems. Sixty percent of Americans are overweight or obese. And the generation in their 30s now are having their heart attacks, their strokes, their renal disease, and we are beginning to see myocardial infarctions in the late teens now and in children. It’s lifestyle, it’s obesity, it’s hypertensive syndrome.” – Physician

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

A total of 59.7% of Americans believe that **lack of physical activity** is a “major/moderate” problem in their community (ranking sixth-highest among 10 areas tested).

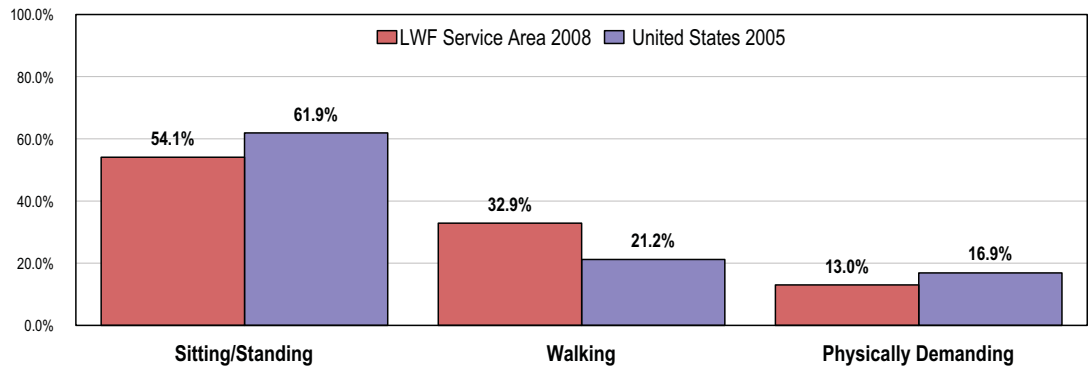
– 2005 PRC National Health Survey. Professional Research Consultants, Inc. © PRC 2005.

Work-Related Activity

A majority of employed service area respondents report low levels of physical activity at work.

- 54.1% of employed LWF Service Area respondents report that their job entails mostly sitting or standing, lower than the U.S. figure (61.9%).
- 32.9% report that their job entails mostly walking (higher than the 21.2% reported nationally).
- 13.0% report that their work is physically demanding (lower than the 16.9% reported across the nation).

Primary Level of Physical Activity at Work (Among Employed Respondents)



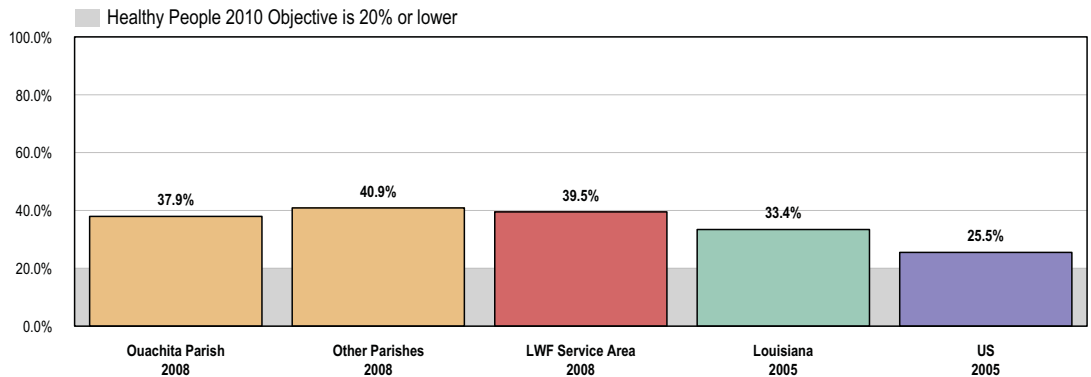
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 102]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all employed respondents.

Leisure-Time Physical Activity

39.5% of LWF Service Area adults report no leisure-time physical activity in the past month.

- ☑ Higher than the 33.4% across Louisiana.
- ☑ Much higher than national findings (25.5%).
- ☑ Fails to satisfy the Healthy People 2010 objective (20% or lower).
- ⊕ Does not significantly vary by sub-area.

No Leisure-Time Physical Activity in the Past Month



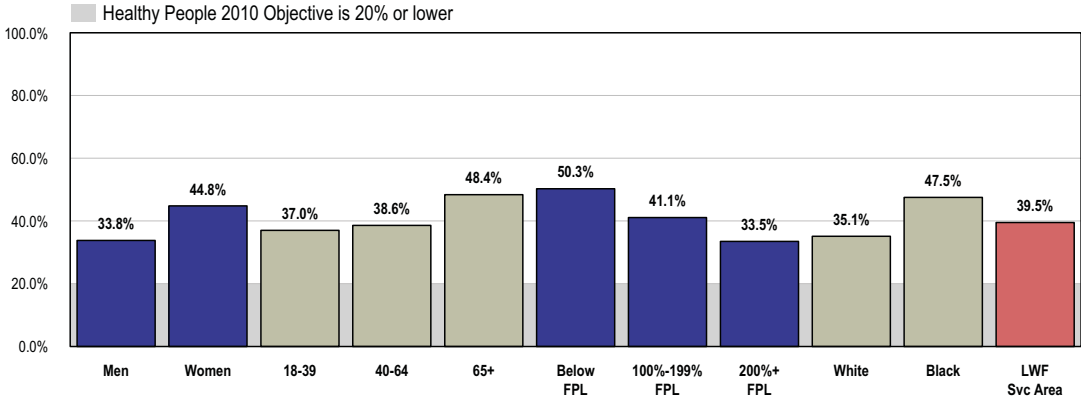
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 103]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
 • 2005 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]
 Note: • Asked of all respondents.

The following chart further examines physical inactivity by various demographic characteristics. Lack of leisure-time physical activity is much higher among the following LWF Service Area adults:

- 👥 Women.
- 👥 Seniors.
- 👥 Residents living at lower incomes.
- 👥 Blacks.

No Leisure-Time Physical Activity in Past Month

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 103]
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective Z2-1]

Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Activity Levels

Effects of Physical Inactivity and 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.

Costs

- The direct medical cost associated with physical inactivity was \$29 billion in 1987 and nearly \$76.6 billion in 2000.
- The annual cost of obesity in the United States is about \$100 billion.
- After controlling for physical limitations and socioeconomic status, researchers found that more than 12% of the annual medical costs of inactive people with arthritis is associated with their inactivity.

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

Recommended Levels of Physical Activity

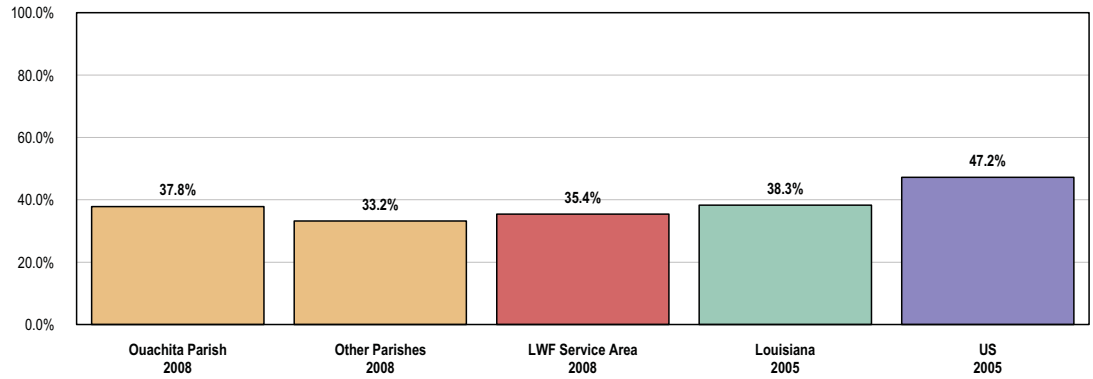
The LWF Service Area adults should strive to meet either of the following physical activity recommendations:

- ☑ 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

A total of 35.4% of LWF Service Area adults participate in regular, sustained moderate or vigorous physical activity.

- ☑ Similar to findings in Louisiana (38.3%).
- ☑ Lower than national findings (47.2%).
- ⊕ Does not vary significantly by sub-area.

Meets Physical Activity Recommendations



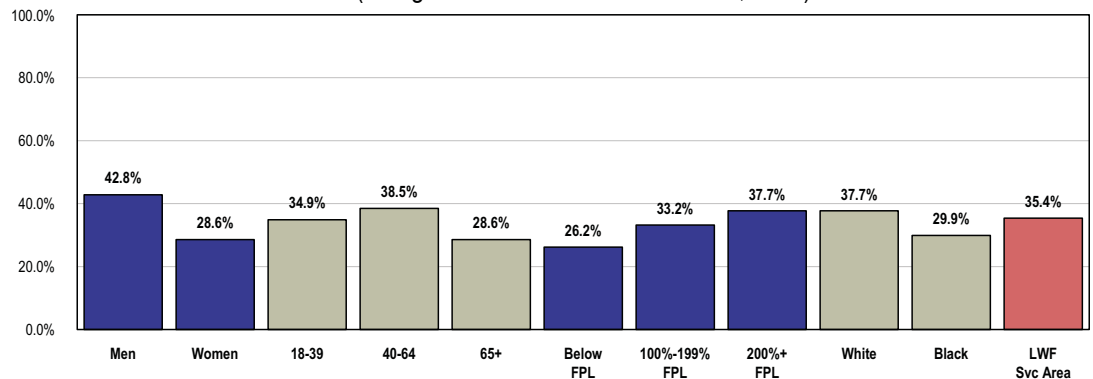
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 145]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.
 - 2005 PRC National Health Survey, Professional Research Consultants.
- Note:
- 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.

The LWF Service Area demographic groups less likely to meet the physical activity recommendations include:

- 👥 Women.
- 👥 Adults aged 65 and older.
- 👥 Residents living at lower incomes.
- 👥 Blacks.

Meets Physical Activity Recommendations

(Living Well Foundation Service Area, 2008)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 145]
- Note:
- Asked of all respondents.
 - FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 - White and Black are non-Hispanic race categorizations.
 - 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 and vigorous physical activity are shown in the following chart.

In the past month:

20.4% of LWF Service Area adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

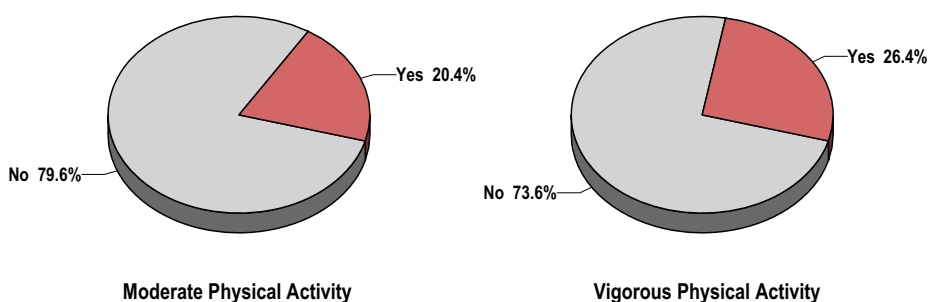
- ☐ Lower than state and national levels (27.5% in Louisiana, 31.8% nationally).
- ☐ Fails to satisfy the Healthy People 2010 objective for moderate activity (30% or higher).

Another 26.4% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- ☐ More favorable than the 20.7% reported across Louisiana but less favorable than the nationwide figure (33.9%).
- ☐ Fails to satisfy the Healthy People 2010 objective for vigorous activity (30% or higher).

Moderate & Vigorous Physical Activity

(Living Well Foundation Service Area, 2008)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Items 143,144]
 - 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]
- Note:
- Asked of all respondents.
 - In this case, the term "moderate physical activity" refers to 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.
 - The term "vigorous physical activity" includes 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.

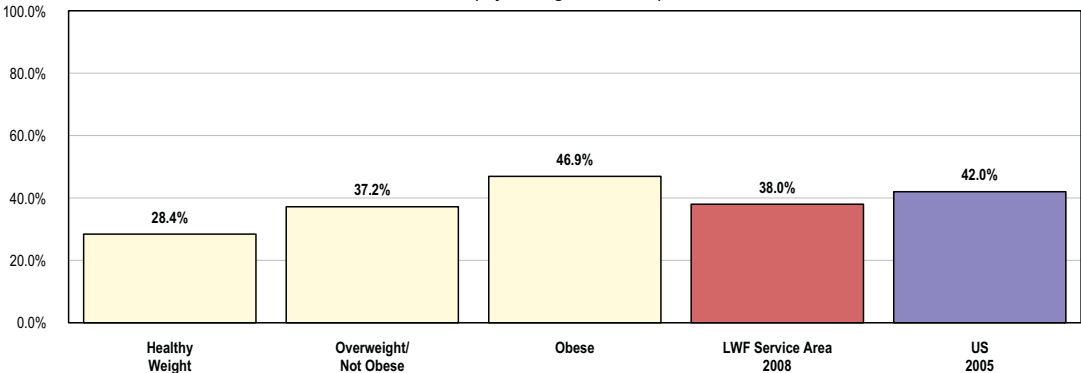
Health Advice About Physical Activity & Exercise

A total of 38.0% of LWF Service Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Similar to the national average (42.0%).
- Note: 46.9% of obese service area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

Physician Has Asked About or Given Advice Regarding Physical Activity/Exercise in Past Year

(By Weight Status)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 20]
• 2005 PRC National Health Survey, Professional Research Consultants.
Note: • Asked of all respondents.

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 ...

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 1997... Drug and alcohol use by youth also is associated with other forms of unhealthy and unproductive behavior, including delinquency and high-risk sexual activity.

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

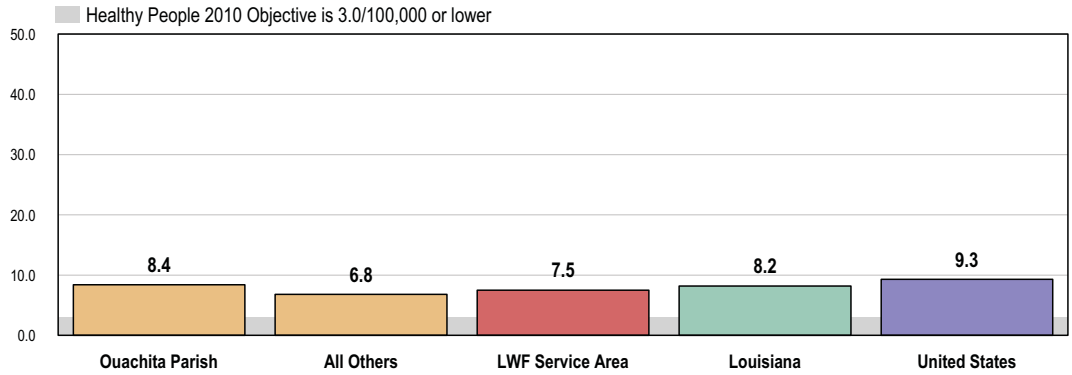
Cirrhosis/Liver Disease

Between 2002 and 2004, the LWF Service Area age-adjusted cirrhosis/liver disease death rate was 7.5 per 100,000 population.

- More favorable the 8.2 rate reported across Louisiana and the 9.3/100,000 rate found nationally.
- Fails to satisfy the Healthy People objective of 3.0/100,000 or lower.
- ⊕ Higher in Ouachita Parish.

Age-Adjusted Mortality: Cirrhosis/Liver Disease

(2002-2004 Annual Average Deaths per 100,000 Population)

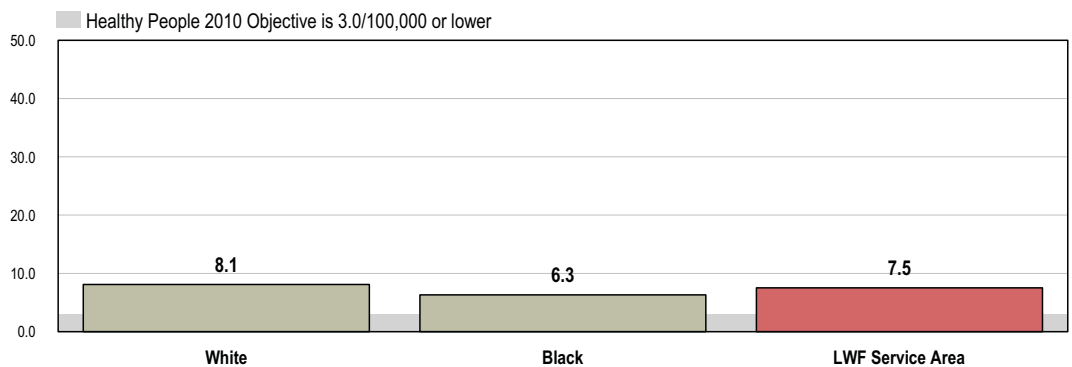


- Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-2]
- Note:
- 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.

Viewed by race, the age-adjusted cirrhosis/liver disease death rate among Whites in the LWF Service Area is somewhat higher than that among Blacks.

Age-Adjusted Mortality: Cirrhosis/Liver Disease

(2002-2004 Annual Average Deaths per 100,000 Population; LWF Svc. Area by Race)



- Source:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2008.
 - 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]
- Note:
- 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.
 - The Black rate is statistically unreliable.

Self-Reported Alcohol Use

Two-thirds (67.7%) of Americans believe that **alcohol and drug abuse** are “major/moderate” problems in their community (the second-highest response among 10 areas tested).

– 2005 PRC National Health Survey. Professional Research Consultants, Inc. © PRC 2005.

High-Risk Alcohol Use

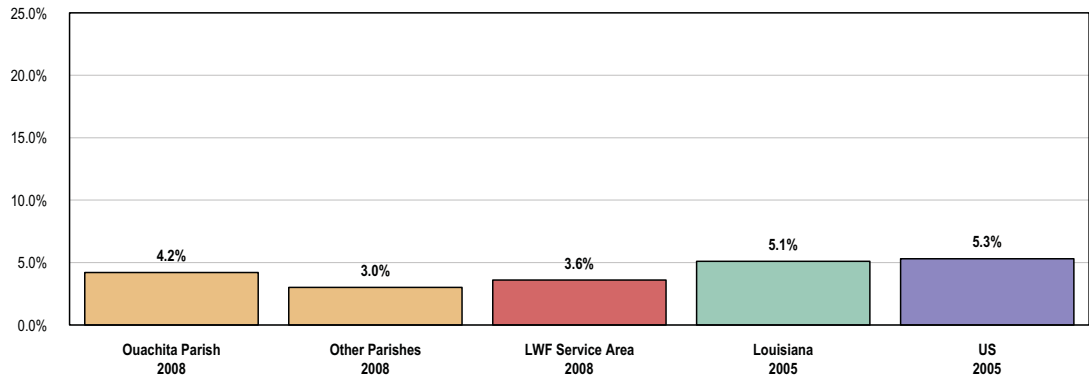
Chronic Drinking

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.

3.6% of LWF Service Area adults report an average of two or more drinks of alcohol per day in the past month.

- ☑ More favorable than the 5.1% reported across Louisiana.
- ☑ Similar to national findings (5.3%).
- ⊕ Does not vary significantly by sub-area.

Chronic Drinkers



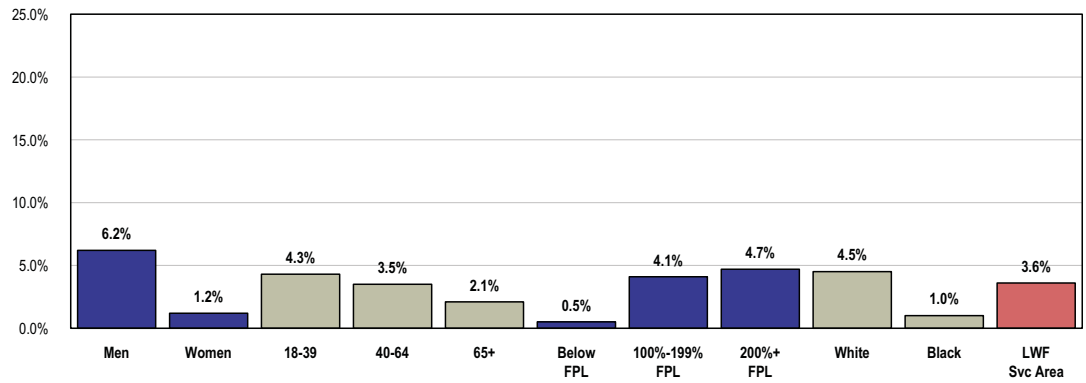
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 153]
 - 2005 PRC National Health Survey, Professional Research Consultants.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
- Note:
- Asked of the total sample of respondents.
 - Chronic drinkers are defined as those who have had at least 60 drinks of alcoholic beverages during the past month.

In the LWF Service Area, chronic drinking is more prevalent among the following population segments:

- ☑ Men.
- ☑ Residents living above the federal poverty level.
- ☑ Whites.

Chronic Drinkers

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 153]

Note: • Asked of all respondents.

• FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].

• White and Black are non-Hispanic race categorizations.

• Chronic drinkers are defined as those who have had at least 60 drinks of alcoholic beverages during the past month.

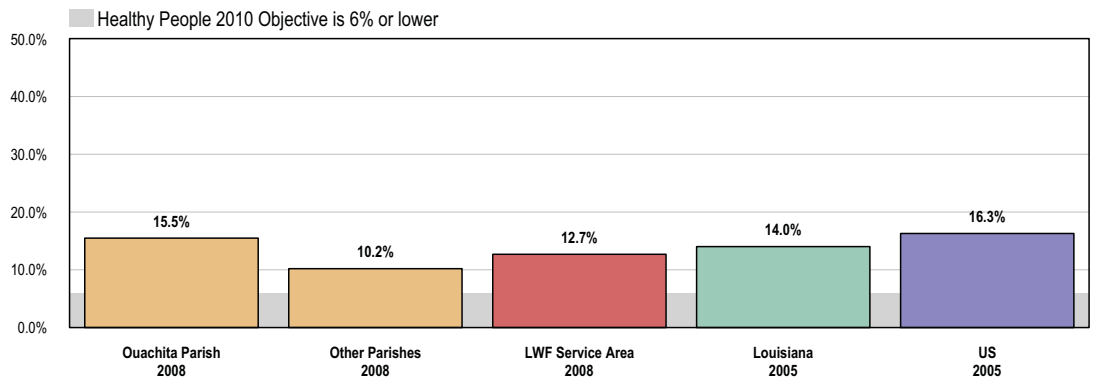
Binge Drinking

Binge drinkers include survey respondents who report that there was one or more times in the past month when they drank five or more drinks on a single occasion.

A total of 12.7% of LWF Service Area adults are binge drinkers.

- ☑ Comparable to the 14.0% in Louisiana.
- ☑ Lower than the 16.3% reported nationwide.
- ☑ Fails to satisfy the Healthy People 2010 target (6% or lower).
- ⊕ Higher in Ouachita Parish.

Binge Drinkers



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [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); 2005 Louisiana data.

• 2005 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]

Note: • Asked of the total sample of respondents.

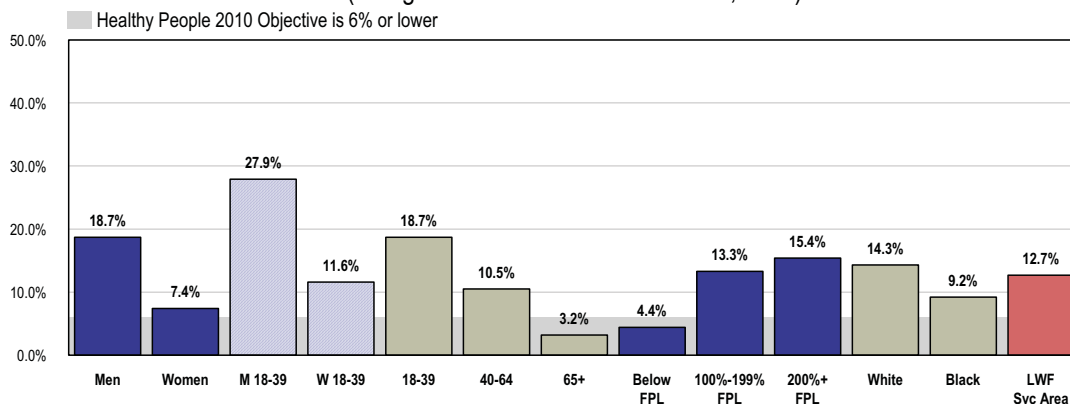
• Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once in the past month.

Most demographic groups fall outside the targeted Healthy People 2010 range. Binge drinking in the LWF Service Area is more prevalent among:

- 👤 Men (especially those under 40).
- 👤 Adults under 65.
- 👤 Those living above the federal poverty level.
- 👤 Whites.

Binge Drinkers

(Living Well Foundation Service Area, 2008)



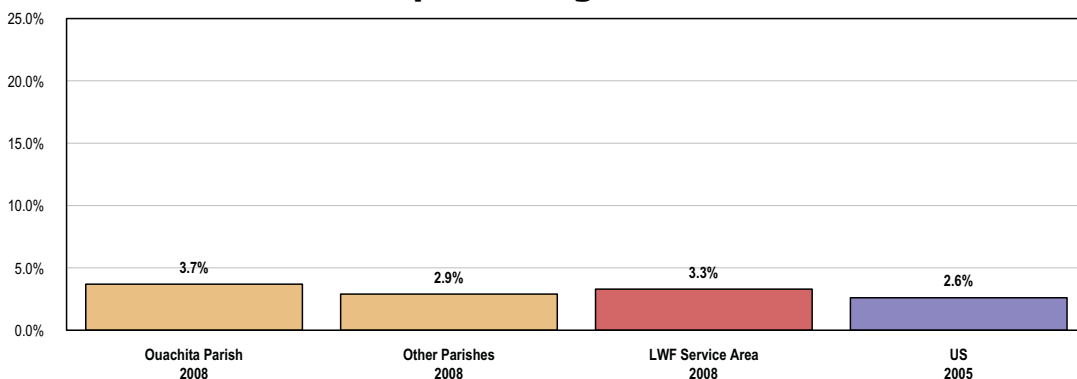
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 154]
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-11c]
- Note:
- Asked of all respondents.
 - FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 - White and Black are non-Hispanic race categorizations.
 - Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once during the past month.

Drinking & Driving

A total of 3.3% of LWF Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- 📍 Statistically similar to national findings (2.6%).
- 📍 Does not vary by sub-area.

Have Driven in the Past Month After Perhaps Having Too Much to Drink

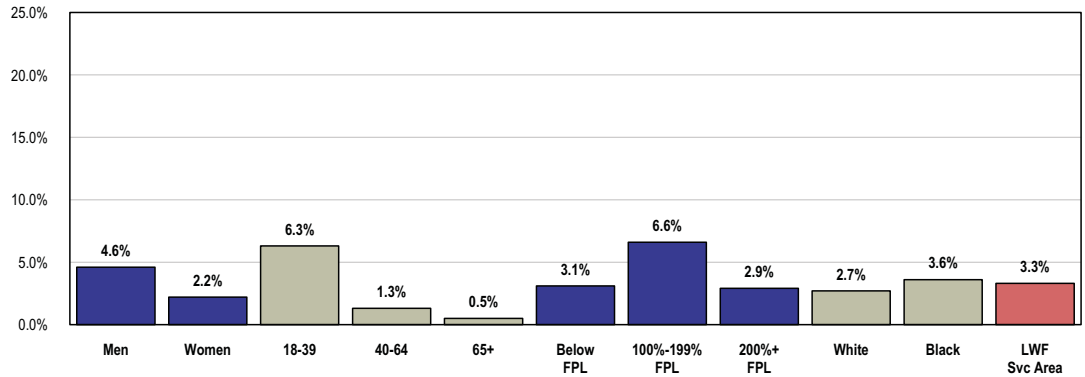


- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 71]
 - 2005 PRC National Health Survey, Professional Research Consultants.
- Note:
- Asked of all respondents.

Drinking and driving in the LWF Service Area is more prevalent among:

- ☺ Men.
- ☺ Young adults.
- ☺ Residents living at the middle income level.

Have Driven During the Past Month After Having Had Too Much to Drink (Living Well Foundation Service Area, 2008)

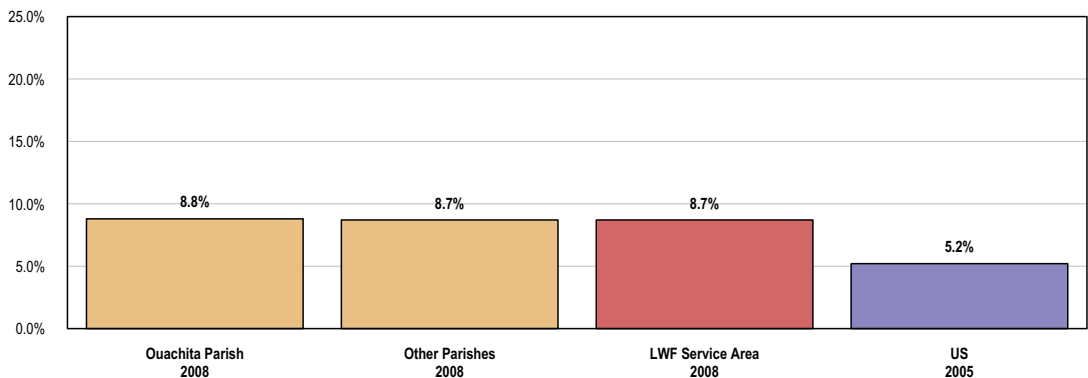


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 71]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

A total of 8.7% of LWF Service Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- ☑ Less favorable national findings (5.2%).
- ☒ Similar by sub-area.

Have Driven Drunk in the Past Month or Ridden With a Driver Who Had Too Much to Drink



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 155]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.

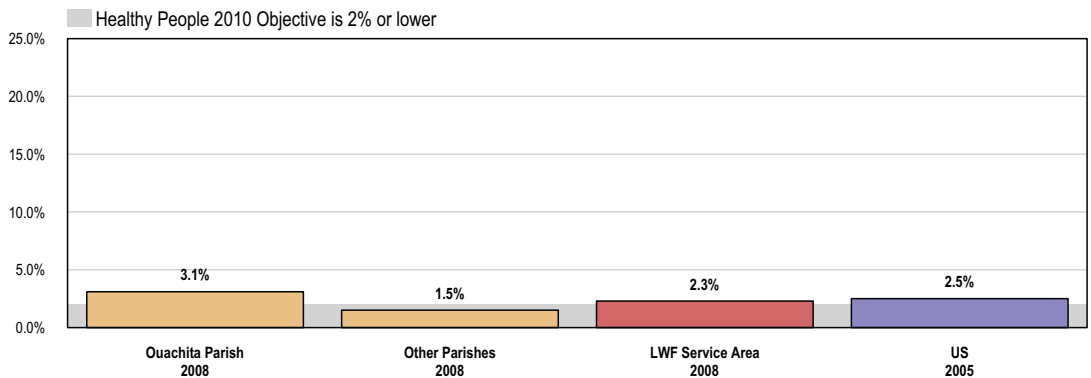
Illicit Drug Use

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

Just 2.3% of LWF Service Area residents acknowledge using an illicit drug in the past month.

- 📍 Statistically similar to the 2.5% reported across the nation.
- 📍 Comparable to the Healthy People 2010 objective of 2% or lower.
- 📍 No significant difference by sub-area.

Self-Reported Illicit Drug Use in the Past Month



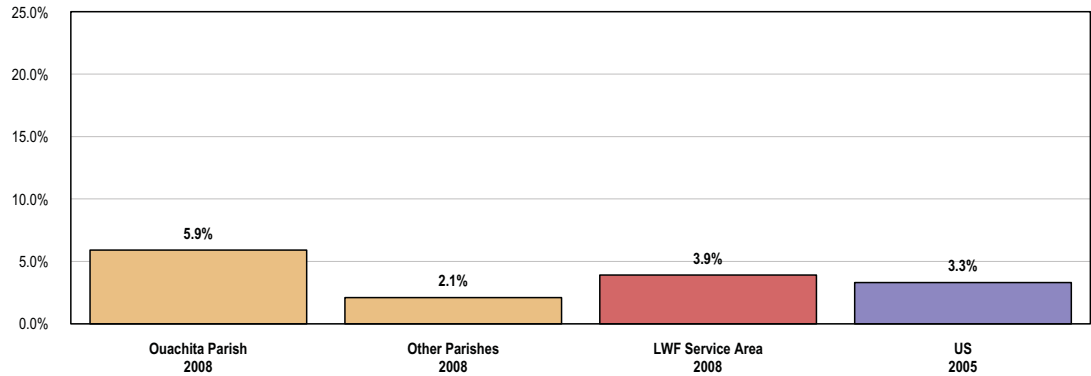
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 73]
 - 2005 PRC National Health Survey, Professional Research Consultants.
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-10c]
- Note:
- Asked of all respondents.
 - In this case, the term “illicit drug use” includes use of an illegal drug and/or use of a prescription drug without a physician’s orders.

Substance Abuse Treatment

3.9% of LWF Service Area adults say that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Statistically similar to the 3.3% reported across the nation.
- Notably higher in Ouachita Parish.

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



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 74]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

Related Focus Group Findings: Substance Abuse

Community Leaders/ Other Health Professionals

Substance abuse is an issue of great concern. Drug use is perceived to be turning up in the elementary schools quite commonly. Not only are illegal drugs being abused, but prescription drugs as well as over-the-counter drugs are being abused. Substance abuse is linked to an increase in crime, and there are no centers available for overcoming an addiction.

“Basically, the only detox we have is jail.” – Community Leader

“With respect to the community, I know that the city links 97% or 98% of their crime to substance abuse.” – Other Health Professional

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 birth weight, 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 U.S.)]; 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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Two-thirds (66.1%) of Americans believe that **tobacco use** is a “major/moderate” problem in their community (ranking fourth-highest among 10 areas tested).

– 2005 PRC National Health Survey. Professional Research Consultants, Inc. © PRC 2005.

Cigarette Smoking

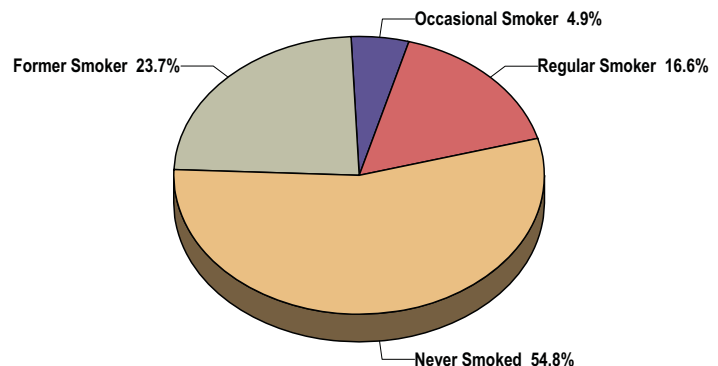
Cigarette Smoking Prevalence

A total of 21.5% of LWF Service Area adults currently smoke cigarettes, either regularly (16.6% every day) or occasionally (4.9% on some days).

- ☑ Similar to that reported across Louisiana (23.4%)
- ☑ Similar to national findings (22.2%).
- ☑ Fails to satisfy the Healthy People 2010 target (12% or lower).
- ⊕ Does not significantly vary by sub-area.

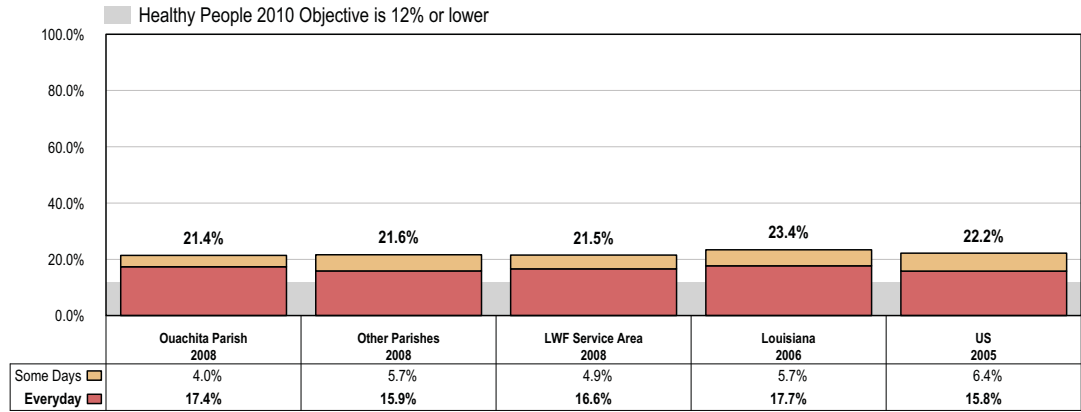
Cigarette Smoking Prevalence

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 149]
Note: • Asked of all respondents.

Current Smokers



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 149]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2006 Louisiana data.
- 2005 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 27-1a]

Note:

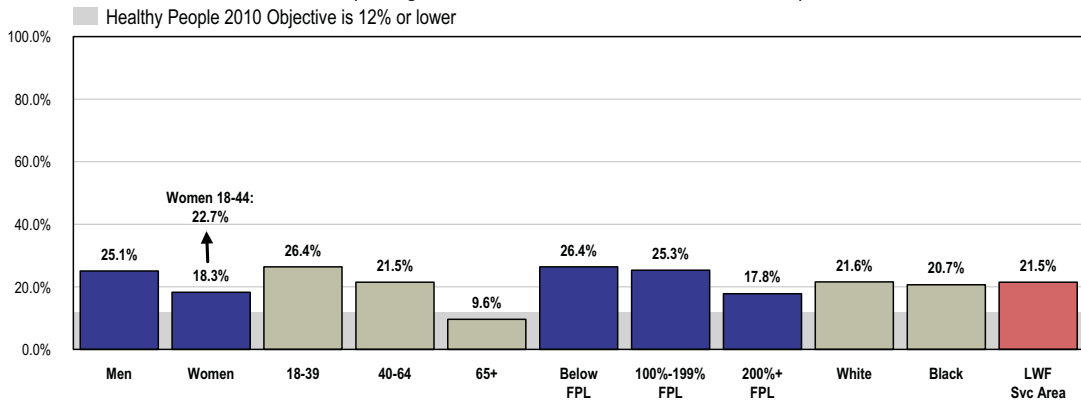
- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

The following chart looks at current smoking prevalence by various demographic characteristics. As shown, cigarette smoking is more prevalent among men, the under-65 population, and residents living under the 200% federal poverty level.

- Note also that 22.7% 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

(Living Well Foundation Service Area, 2008)



Source:

- 2008 PRC Community Health Survey, Professional Research Consultants. [Items 149,150]
- Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-1a]

Note:

- Asked of all respondents.
- FPL = Federal Poverty Level based on household income and number of household members.
- White and Black are non-Hispanic race categorizations.
- Includes those who smoke everyday or on some days.

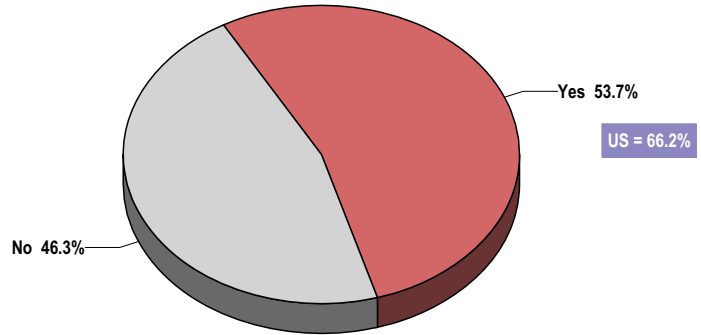
Health Advice About Smoking Cessation

53.7% of LWF Service Area smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Less favorable than the national percentage (66.2%).

Health Professional Has Recommended Quitting Smoking in the Past 12 Months

(Among Current Smokers; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 64]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of current smokers.

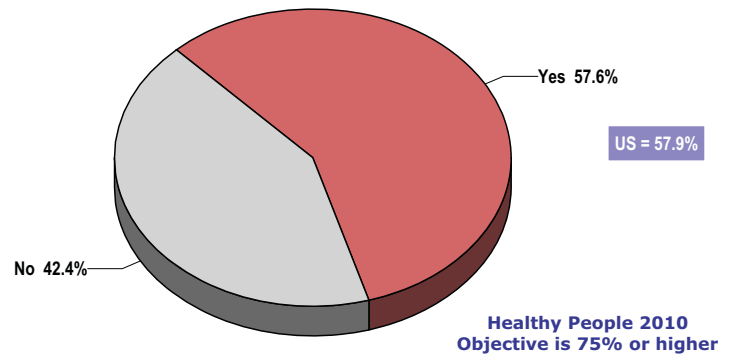
Smoking Cessation Attempts

57.6% of LWF Service Area regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the 62.5% among Louisiana smokers.
- Also similar to the national percentage (57.9%).
- Fails to satisfy the Healthy People 2010 target (75% or higher).
- Does not vary significantly by sub-area.

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Adults Who Smoke Cigarettes Every Day; LWF Service Area, 2008)



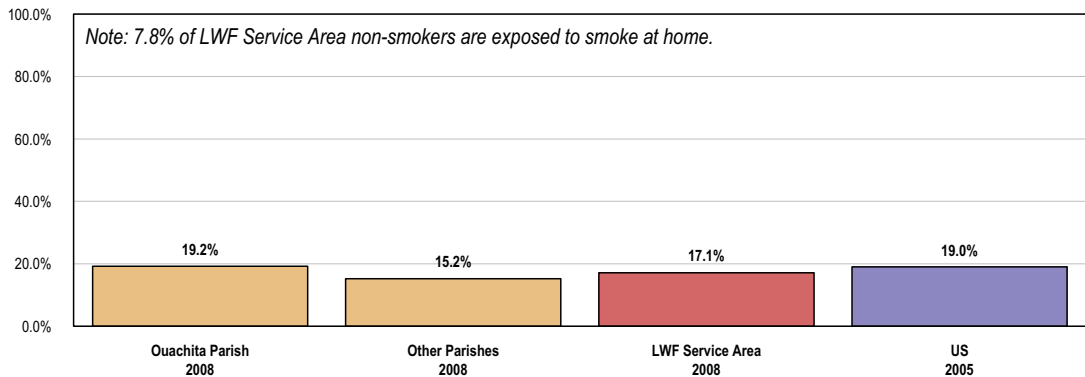
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 63]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 27-5]
 Note: • Asked of regular (everyday) smokers.

Environmental Tobacco Smoke

In all, 17.1% of LWF Service Area adults report that a member of their household has smoked cigarettes in the home in the past month an average of four or more times per week.

- ☑ Similar to national findings (19.0%).
- ☑ No significant difference by sub-area.
- 👤 Note that 7.8% of LWF Service Area non-smokers are exposed to cigarette smoke at home.

Member of Household Smokes at Home

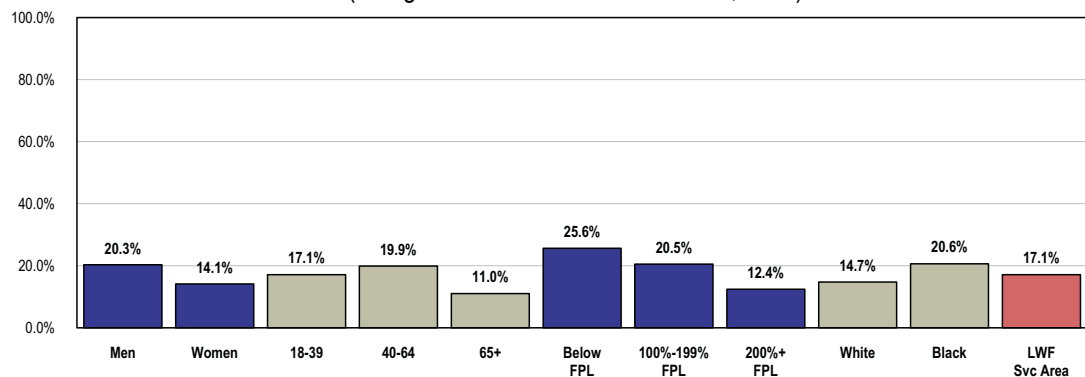


- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 6]
 - 2005 PRC National Health Survey, Professional Research Consultants.
- Note:
- Asked of all respondents.
 - "Smokes at home" refers to someone smoking cigarettes, cigars or a pipe in the home an average of four or more times per week in the past month.

- 👤 Men, residents under 65, and lower-income residents more often report that they live with a smoker in the home.

Member of Household Smokes at Home

(Living Well Foundation Service Area, 2008)



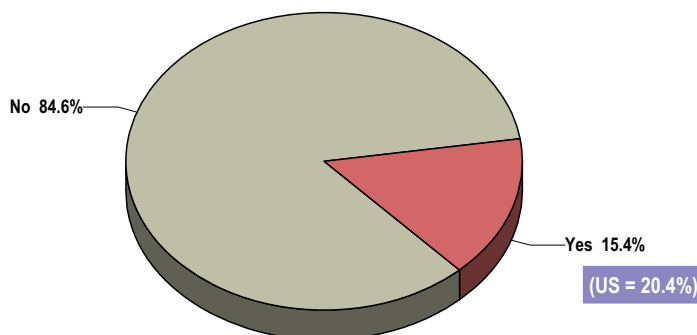
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 6]
- Note:
- Asked of all respondents.
 - FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 - White and Black are non-Hispanic race categorizations.
 - "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 LWF Service Area households with children, 15.4% have someone who smokes cigarettes in the home.

- Statistically similar to national findings (20.4%).

Percentage of Households With Children In Which Someone Smokes in the Home

(Among Households With Children Under 18; LWF Service Area, 2008)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 15]
 - 2005 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]
- Note:
- Reflects respondents with children aged 0 to 17 years old.
 - "Smokes at home" refers to someone smoking cigarettes, cigars or a pipe in the home an average of four or more times per week in the past month.

Other Tobacco Use

A total of 4.8% of LWF Service Area adults smoke cigars every day or on some days.

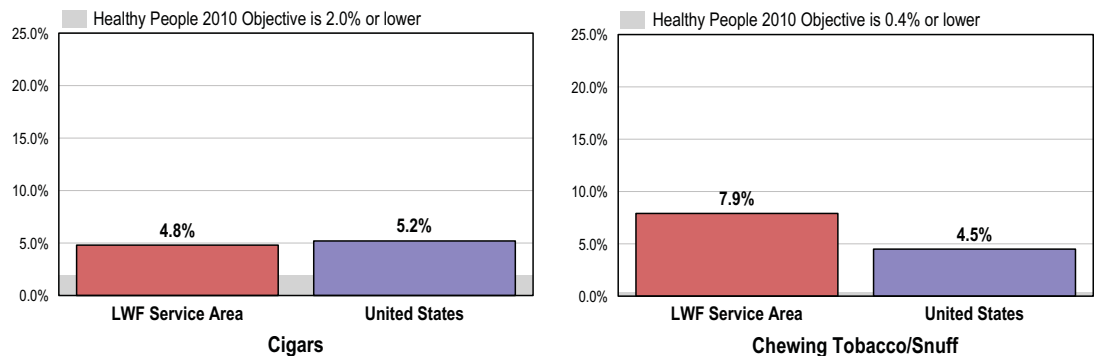
- ☐ Similar to national findings (5.2%).
- ☐ Fails to meet the Healthy People 2010 target (2% or lower).
- ⊕ Statistically comparable among the sub-areas.

Another 7.9% of LWF Service Area adults use chewing tobacco or snuff every day or on some days.

- ☐ Less favorable than the national percentage (4.5%).
- ☐ Fails to satisfy the Healthy People 2010 target (0.4% or lower).
- ⊕ Does not vary by sub-area.

Use of Cigars or Smokeless Tobacco

(2008)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Items 66,67]
 - 2005 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 27-1b and 27-1c]
- Note:
- Asked of all respondents.
 - Includes respondents who smoke cigars or use chewing tobacco/snuff every day or on some days.

Related Focus Group Findings: Tobacco Use

Community Leaders/ Physicians/ Other Health Professionals

There is a high incidence of tobacco use in the community.

“The biggest thing we see as cardiologists is tobacco use. If you split the entire population down the middle - those who have graduated from high school and those who have not graduated from high school - the tobacco use numbers are much higher among the uneducated. You know, I can’t say that there is a direct correlation, but I think it’s too much of a stark contrast to ignore that.” – Physician

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. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.

Two-thirds (66.9%) of Americans believe that **poor access to healthcare services** is a “major/moderate” problem in their community (ranking third-highest among 10 areas tested).

– 2005 PRC National Health Survey. Professional Research Consultants, Inc. © PRC 2005.

HEALTH INSURANCE COVERAGE

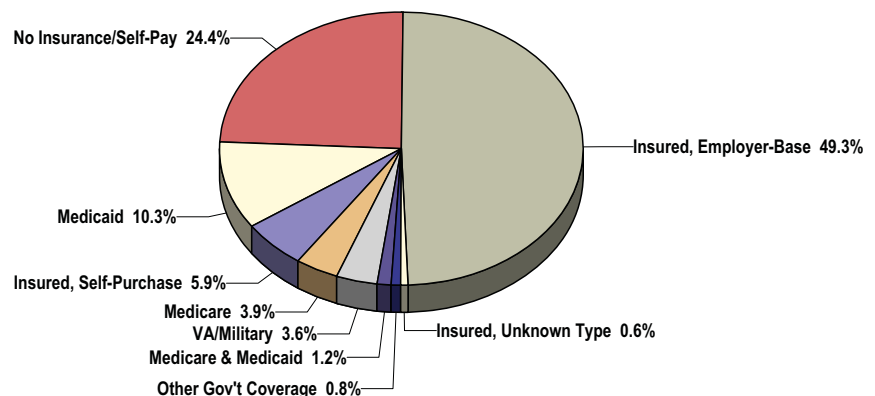
Type of Healthcare Coverage

The majority (55.2%) of LWF Service Area adults aged 18 to 64 report having healthcare coverage through private insurance.

Another 19.8% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults Age 18 to 64; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 17Q]
Note: • Reflects respondents age 18 to 64.

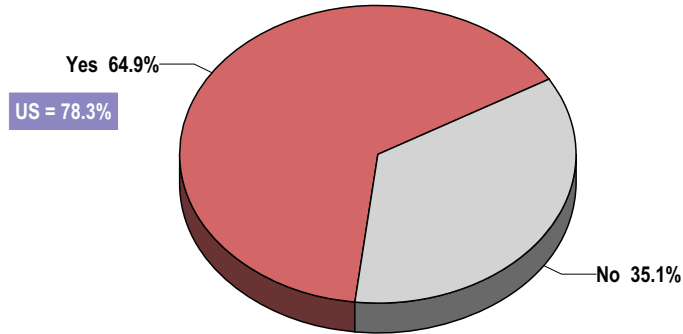
Supplemental Medicare Coverage

Among Medicare recipients, **64.9%** report that they have additional supplemental insurance.

- Lower than the 78.3% among Medicare recipients nationwide.

Have Additional Supplemental Coverage

(Among Recipients of Medicare; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 88]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Reflects those respondents who currently receive Medicare.

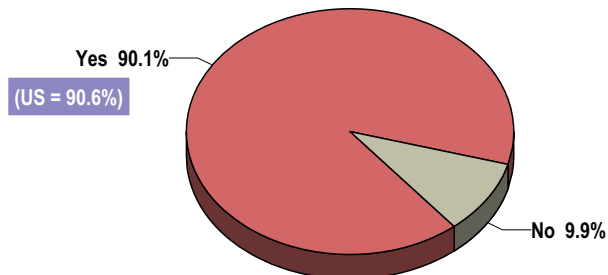
Prescription Drug Coverage

Among all adults with health insurance coverage, the vast majority (**90.1%**) report having prescription coverage as part of their insurance plan.

- Nearly identical to the national prevalence (90.6%).

Current Health Insurance Provides Coverage for Prescriptions

(Among Those With Health Insurance Coverage; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 88]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Reflects those respondents who have health insurance coverage.

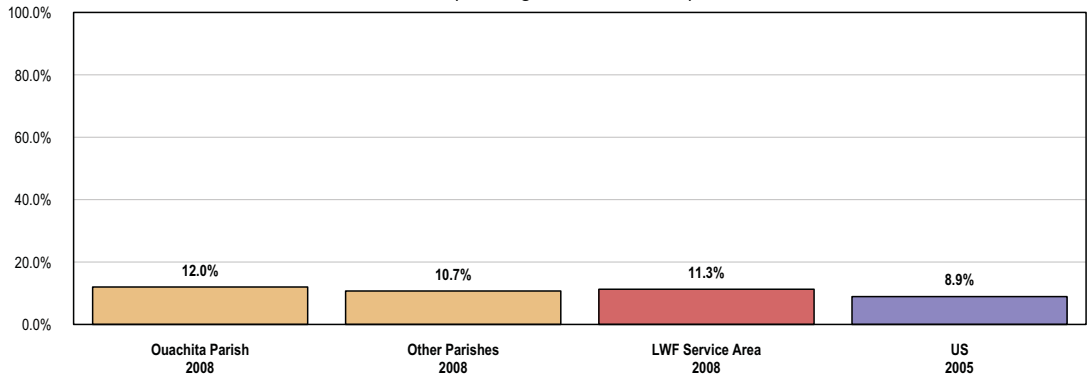
Recent Lack of Coverage

Further, among currently insured adults in the LWF Service Area, 11.3% report that they were without healthcare coverage at some point in the past year.

- 📍 Similar to U.S. findings (8.9%).
- 🏠 Similar by sub-area.

Went Without Healthcare Insurance Coverage at Some Point in the Past Year

(Among Insured Adults)



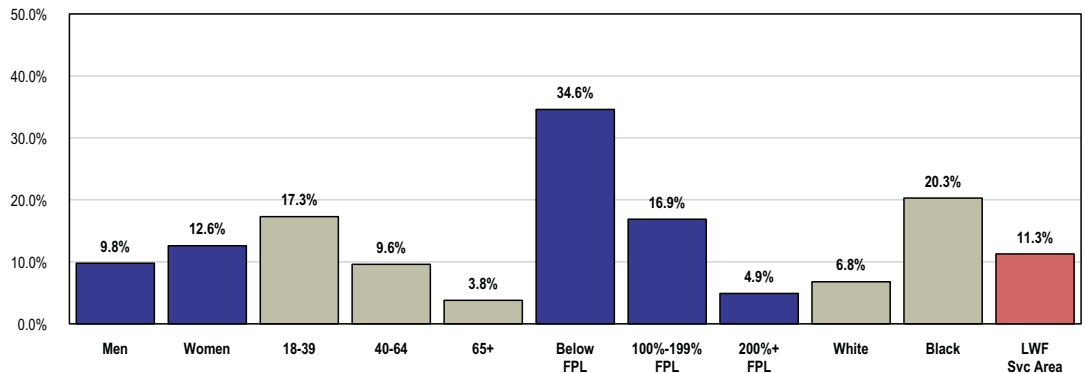
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 87]
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Reflects respondents with healthcare coverage.

👥 Among insured adults, adults under 40, low-income residents, and Blacks 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

(Among Insured Adults; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 87]
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Reflects adults with healthcare insurance coverage.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

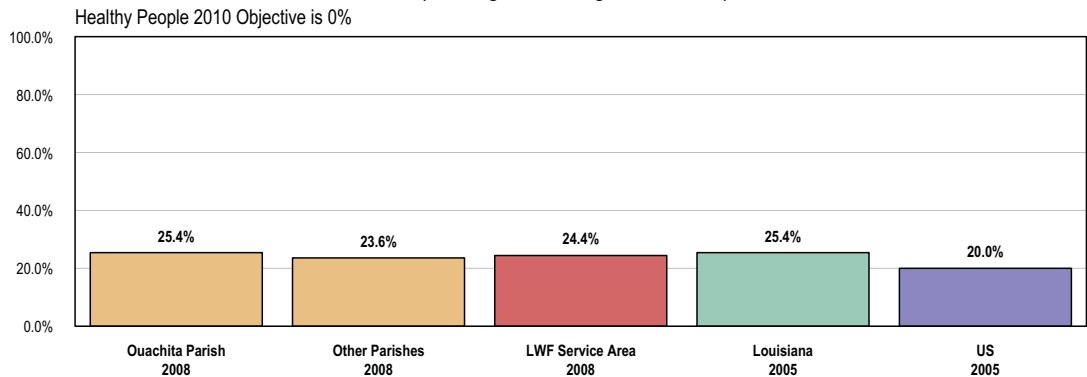
Lack of Health Insurance Coverage

Among LWF Service Area adults aged 18 to 64, 24.4% report having no insurance coverage for healthcare expenses.

- ☑ Similar to Louisiana (25.4%).
- ☑ Less favorable than national findings (20.0%).
- ☑ The Healthy People 2010 target is universal coverage (0% uninsured).
- ⊕ Statistically similar by sub-area.

Lack Healthcare Insurance Coverage

(Among Adults Aged 18 to 64)



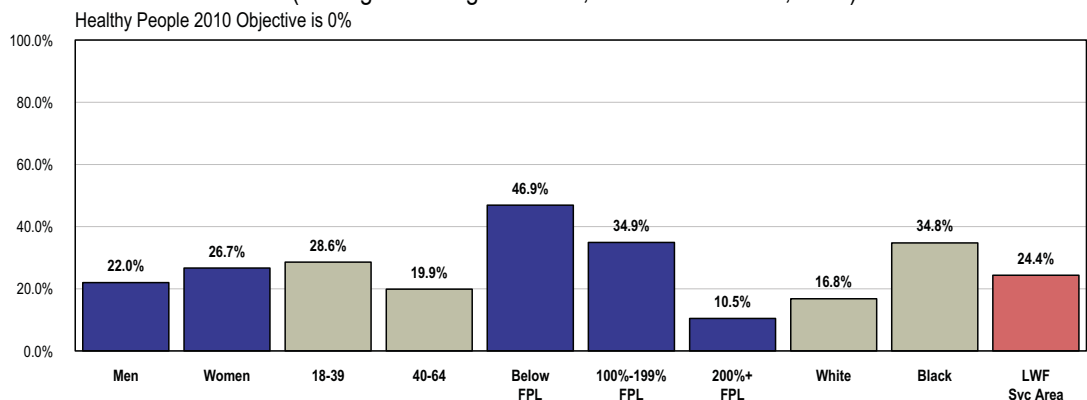
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 17Q]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.
 - 2005 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]
- Note:
- Reflects respondents aged 18 through 64.

The following population segments (under 65) are more likely to be without healthcare insurance coverage:

- 👤 Adults under 40.
- 👤 Residents living at lower incomes.
- 👤 Blacks.

Lack Healthcare Insurance Coverage

(Among Adults Age 18 to 64; LWF Service Area, 2008)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 17Q]
 - 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]
- Note:
- Reflects respondents age 18 through 64.
 - FPL = Federal Poverty Level based on household income and number of household members.
 - White and Black are non-Hispanic race categorizations.

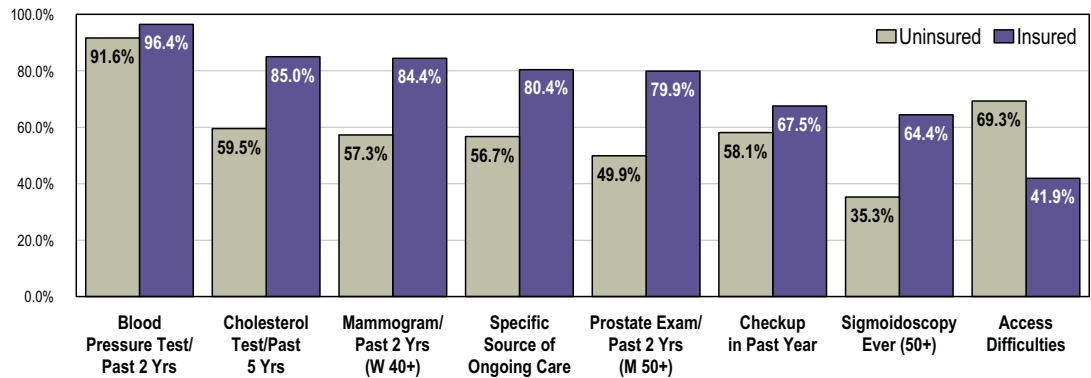
Impact of Poor Access

Persons without health insurance coverage are much less likely to have a regular medical care provider, receive routine care, or receive preventive healthcare screenings.

- ☐ Uninsured adults are also more likely to experience access difficulties in the past year.

Preventive Healthcare

(By Insured Status; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 18,48,51,162-164,171-173]
Note: • Asked of all respondents.
• Insured respondents include those with either private or government-sponsored insurance plans.

Related Focus Group Findings: Health Insurance Coverage

Community Leaders/ Business Leaders/ Physicians/ Social Service Providers/ Other Health Professionals

The area of most concern for all groups is Medicaid/Medicare coverage. Many people are being dropped by the physicians who can't afford to take Medicare/ Medicaid patients because the reimbursement is so low. There is a large contingency of people in the community who have no insurance, so the waiting list at free clinics is quite long. In addition, those who do have some kind of health insurance aren't taking the time off of work to be seen by the doctor until they are really sick.

"I think there's only one pediatrician outside of myself in the area who takes Medicaid. If reimbursements were more appropriate, then we may not have to develop free clinics and we might get into a better source of health care." – Physician

"For working parents, they cannot take off of work to take their sick child to the doctor, because the type of job they have that does not provide health insurance also does not give them any consideration for the needs of their families." – Other Health Professional

"I have run into a lot of people with high blood pressure and high cholesterol and both require medication and many of these people are not able to afford those medications. As a result, they're not even seeing a doctor and that causes strokes, heart attacks and other serious diseases." – Social Service Provider

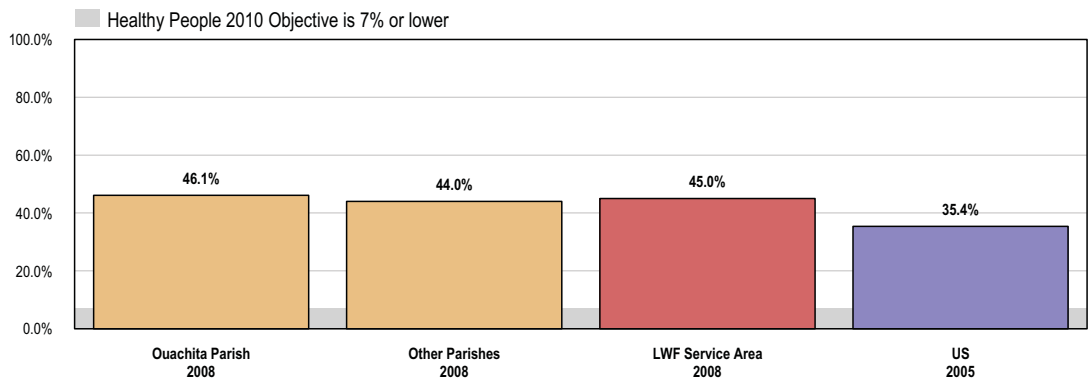
DIFFICULTIES ACCESSING HEALTHCARE

Difficulties Accessing Services

In all, 45.0% of LWF Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- ☑ Less favorable national findings (35.4%).
- ☑ Fails to satisfy the Healthy People 2010 target (7% or lower).
- ⊕ Similar between geographical sub-areas.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



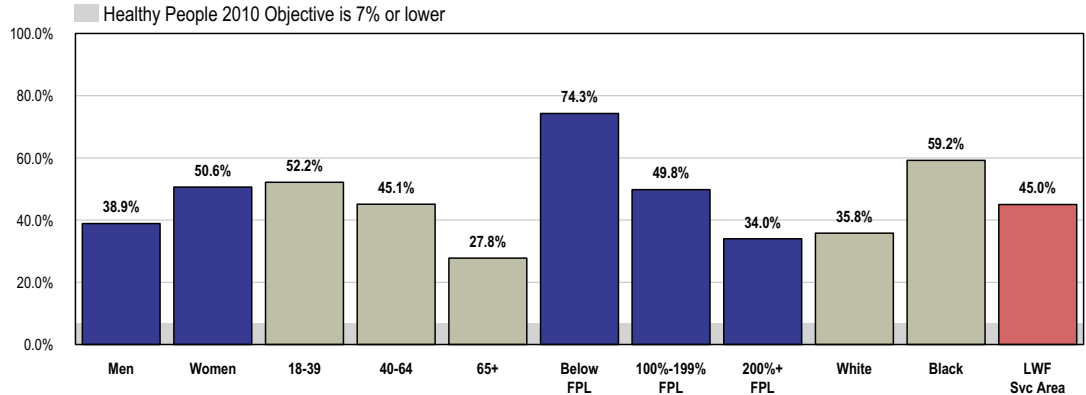
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 17]
 - 2005 PRC National Health Survey, Professional Research Consultants.
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.
- Note:
- Asked of all respondents.
 - Includes difficulties related to availability, cost, office hours, transportation or other unspecified troubles/delays.

The following chart examines access difficulties by respondent demographics. Note:

- 👥 Women more often report access difficulties than do men.
- 👥 Adults under age 65 report difficulties accessing healthcare more often than older adults.
- 👥 As may be expected, adults living at lower incomes are more likely to experience difficulties or delays of some kind in receiving healthcare in the past year.
- 👥 Blacks more often report difficulties when compared with Whites.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(Living Well Foundation Service Area, 2008)



- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 17]
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000.
- Note:
- Asked of all respondents.
 - FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 - White and Black are non-Hispanic race categorizations.
 - Includes difficulties related to availability, cost, office hours, transportation or other unspecified troubles/delays.

Barriers to Healthcare Access

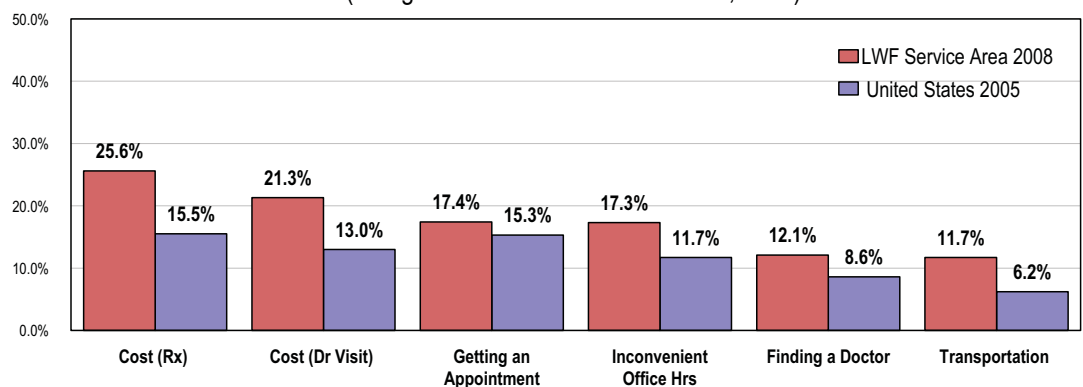
To better understand healthcare access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a prescription in the past year.

Of the tested barriers, cost of prescriptions (25.6%) impacted the greatest share of adults in the LWF Service Area.

- ☐ The proportions of LWF Service Area adults impacted were less favorable to those found nationwide for each of the following:
 - Trouble Affording a Prescription
 - Trouble Affording a Physician Visit
 - Inconvenient Office Hours
 - Trouble Finding a Physician
 - Transportation Prevented a Visit

Barriers to Access Have Prevented Medical Care in the Past Year

(Living Well Foundation Service Area, 2008)



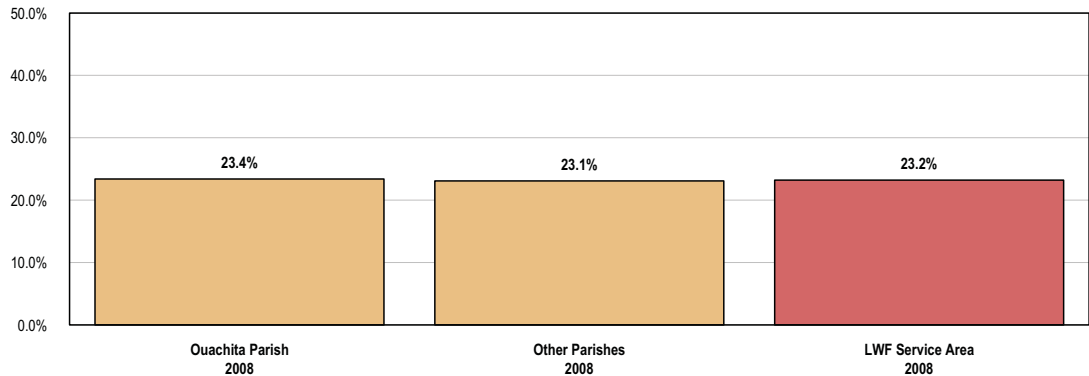
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Items 8-13]
 - 2005 PRC National Health Survey, Professional Research Consultants.
- Note:
- Asked of all respondents.

Prescriptions

Among all LWF Service Area adults, 23.2% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

⊕ Statistically comparable between the sub-areas.

Skipped or Reduced Doses in the Past Year in Order to Stretch Prescriptions and Save Money



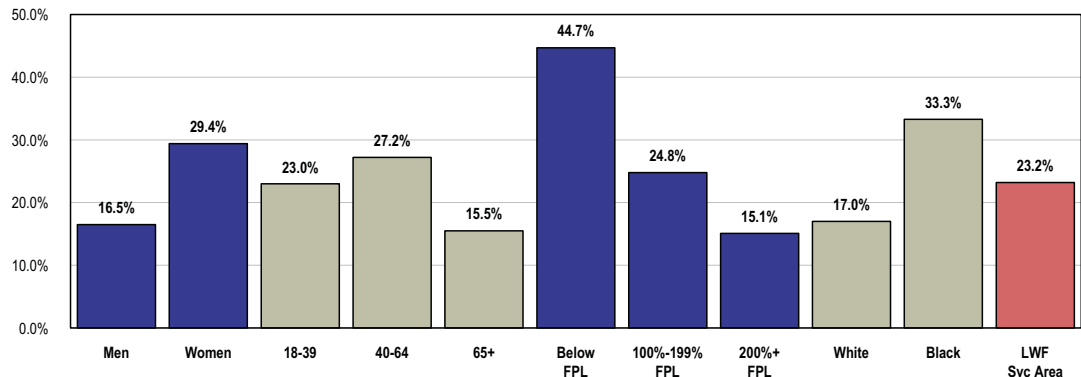
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 14]
 Note: • Asked of all respondents (regardless of whether a prescription was needed or used).

The following chart outlines adults improperly using prescription medicine to save money, segmented by demographic characteristics. Adults more likely to have skipped or reduced their prescription doses include:

- 👩 Women.
- 👩 Adults under 65, especially middle-aged adults.
- 👩 Respondents living at lower-income levels.
- 👩 Blacks.

Skipped or Reduced Doses in the Past Year in Order to Stretch Prescriptions and Save Money

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 14]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble in receiving medical care for a randomly-selected child in their household.

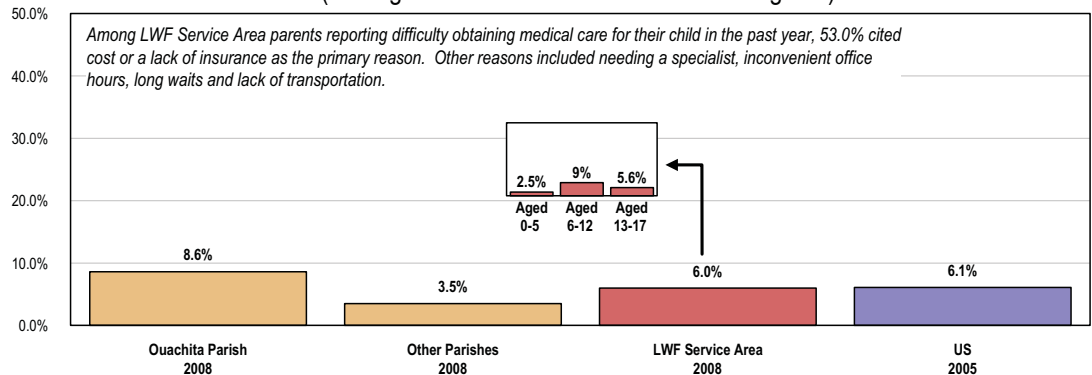
A total of 6.0% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- 📍 Similar to the 6.1% reported nationwide.
- 📊 No statistical difference between sub-areas.
- 👨‍👩‍👧 Higher among children 6 and older.

Among the parents experiencing difficulties, the majority cited **cost or a lack of insurance** as the primary reason. Other reasons included needing a specialist, office hours and transportation issues.

Have Had Trouble Obtaining Medical Care for Child in the Past Year

(Among Households With Children Under Age 18)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 123-124]
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of respondents with children under the age of 18.

Community Leaders/ Business Leaders/ Physicians/ Social Service Providers/ Other Health Professionals

There are many factors contributing to the community's difficulty in accessing healthcare. Transportation is one of the largest issues. People don't have access to transportation to get them to where they need to go. Additionally, there are long wait times to get into free clinics. People end up not showing for their appointments because of these two issues.

"We have a fairly qualified health center but most people don't want to wait. And another big issue that we have is scheduled appointment times. That does not usually mean that the patient will come to their appointment time. I don't know what the number is, but I bet you it is over fifty percent of people who receive free health services do not show up for their visits." – Community Leader

"It's not so much just knowing about services, but it's also being able to have transportation to get to them. That's a big issue with a lot of the social service providers in our community—the services are there but people can't get to them." – Business Leader

"There are probably a lot of single parents who are trying to hold down two jobs or even more. It may be a shift job or it may be at 3 or 4 in the evening and they just can't get loose to take that child to the doctor and you know there are no means. I guess you could always take a taxi but if you don't have enough money to pay a doctor or do some of the other things, you can't afford a taxi either. I think transportation limits a lot of people." – Business Leader

"On the west side of the community, there is no public transportation. On the east side of Ouachita Parish there is, but not on the west side." – Physician

"Transportation is a big issue." – Social Service Provider

"The rural areas are worse; they don't have any transportation." – Social Service Provider

"Some of the hospitals like Franklin Parish Medical Center have actually started an in-service where they will pick up but they're very limited. There have been a few pilots tried like that, but it's too limited and too small a scale to really address the issues." – Social Service Provider

"Some of the services, whether private or public, have such long waits in the waiting rooms that people have to wait far beyond what you would expect in order to address problems." – Social Service Provider

"Transportation is a huge issue, especially in the rural outlying areas. Their chronic illnesses get worse because they don't have the means to get to the doctor." – Other Health Professional

PRIMARY CARE SERVICES

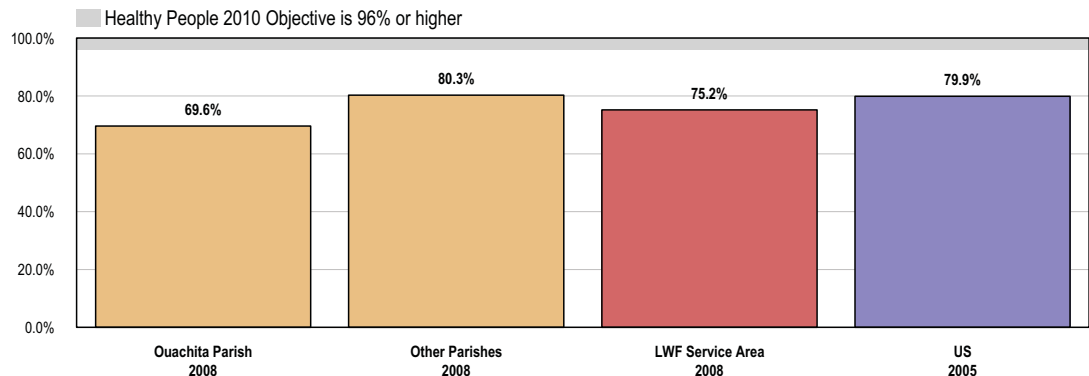
Specific Source of Ongoing Care

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.

75.2% of LWF Service Area adults were determined to have a specific source of ongoing medical care.

- ❑ Less favorable than national findings (79.9%).
- ❑ Fails to satisfy the Healthy People 2010 target (96% or higher).
- ⊕ Lower in Ouachita Parish.

Have a Specific Source of Ongoing Medical Care



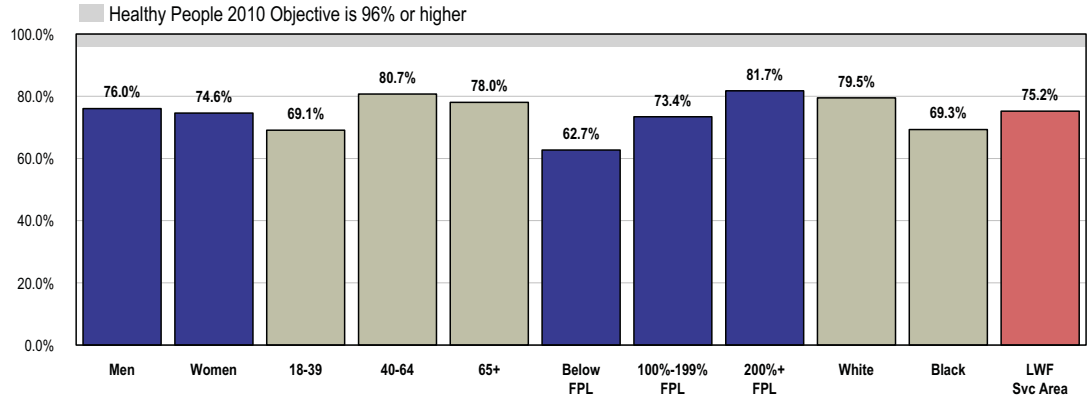
- Source:
- 2008 PRC Community Health Survey, Professional Research Consultants. [Item 17]
 - 2005 PRC National Health Survey, Professional Research Consultants.
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 1-4]
- Note:
- Asked of all respondents.
 - A specific source of ongoing care includes having a doctor's office, clinic, urgent care/walk-in clinic, health center facility, hospital outpatient clinic, HMO (health maintenance organization)/pre-paid group, military/VA healthcare, or some other kind of place to go if one is sick or needs advice about his/her health. A hospital emergency room is NOT considered a source of ongoing care in this instance.

When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- 👤 Young adults.
- 👤 Those living at lower incomes.
- 👤 Blacks.

Have a Specific Source of Ongoing Medical Care

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 17]
 • 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]

Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.
 • A specific source of ongoing care includes having a doctor's office, clinic, urgent care/walk-in clinic, health center facility, hospital outpatient clinic, HMO (health maintenance organization)/pre-paid group, military or other VA healthcare, or some other kind of place to go if one is sick or needs advice about his/her health. A hospital emergency room is NOT considered a source of ongoing care in this instance.

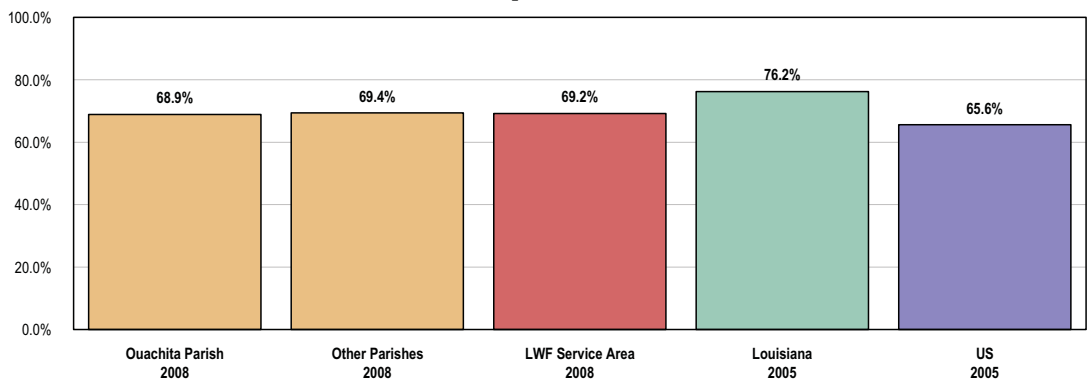
Utilization of Primary Care Services

Adults

A total of 69.2% of LWF Service Area adults visited a physician for a routine checkup in the past year.


- ☑ Less favorable than the 76.2% reported across Louisiana.
- ☑ Similar to national findings (65.6%).
- ⊕ Similar by sub-area.

Have Visited a Physician for a Routine Checkup Within the Past Year

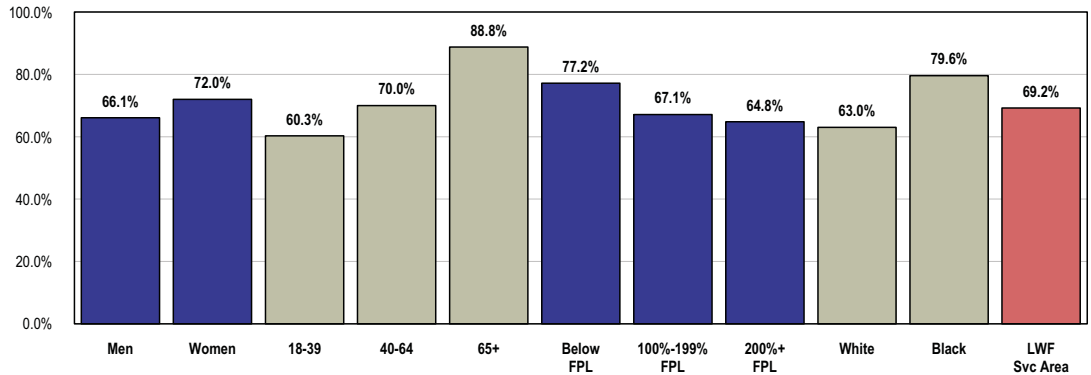


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 18]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2005 Louisiana data.

Note: • Asked of all respondents.

 Routine checkups increase with age in the LWF Service Area, and are higher among women, residents living in poverty, and Blacks as well.




Have Visited a Physician for a Routine Checkup Within the Past Year (Living Well Foundation Service Area, 2008)



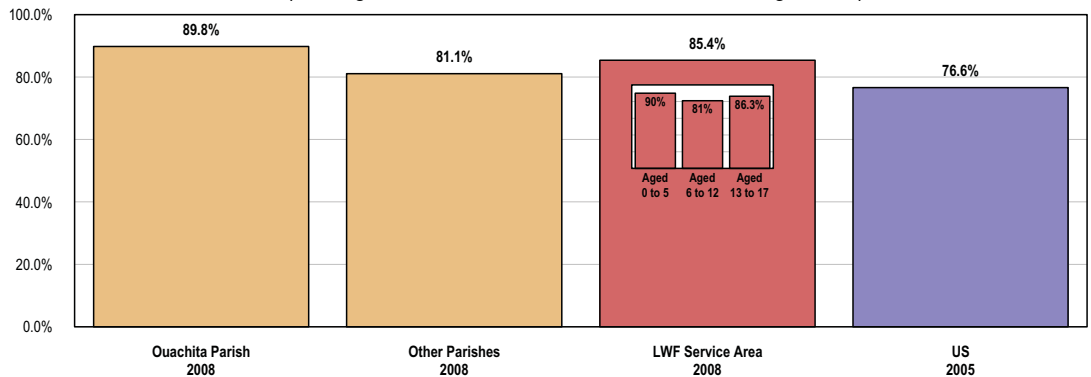
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 18]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Children

Among surveyed parents, 85.4% report that their child had a routine checkup in the past year.

-  Much better than national findings (76.6%).
-  Notably higher in Ouachita Parish.
-  Note that routine checkups are highest among LWF Service Area children under six.

Child Has Visited a Physician for a Routine Checkup Within the Past Year (Among Households With Children Under the Age of 18)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 125]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of respondents with children under the age of 18.

Community Leaders/ Business Leaders/ Social Service Providers/ Other Health Professionals

The main issue with primary care services is that many people in this area aren't getting annual checkups and wait until they are so ill that they have to go to the emergency room. This is seen in those who are uninsured as well as those who are insured.

"I see a lot of people that have insurance but they just won't go to the doctor to get a checkup. They're afraid they're going to find something wrong with them so they lose the benefit of having it cured or prevented before it gets into a longer process. We all know the less illness we have, the less everything is going to cost us." – Community Leader

"One of the things that leads us to the low level of health and functioning in this area is our lack of primary prevention, health education and helping our people understand how to make the choices that will lead to health regardless of what their health problems may be." – Social Service Provider

"If you have preventive medicine where people are getting their annual checkups and doing their follow-ups, then that would decrease a lot of the trips to the emergency room and flare-ups of asthma. There needs to be more towards education about preventive measures before they get into a crisis." – Other Health Professional

However, preventive care is happening in the schools with clinics. These clinics are able to see the children who might not otherwise get to the doctor or dentist.

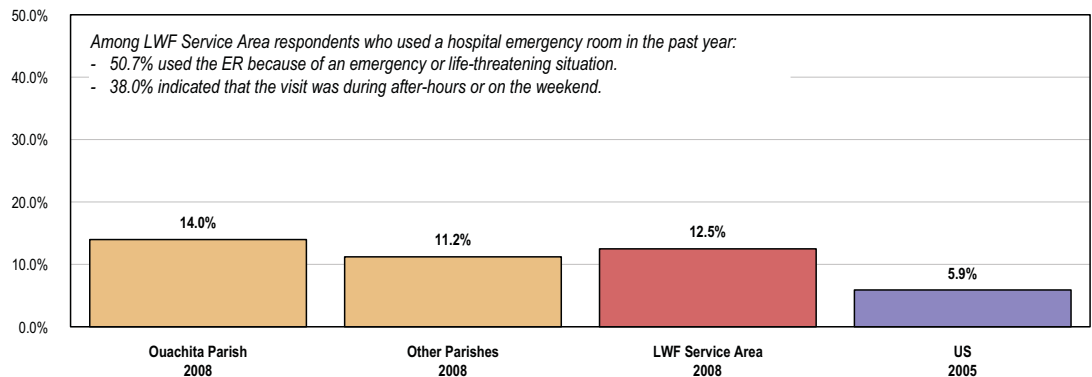
"We've made some strides and I think there are three or four schools that have school-based health care that's had phenomenal results. I think that we could extend that out to some of the other schools, particularly those that are lower-income schools or schools that have a high-risk population." – Business Leader

EMERGENCY ROOM SERVICES

A total of 12.5% of LWF Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- 📍 More than twice the national findings (5.9%).
- 📍 Similar by geographic sub-areas.
- 👥 Of those using a hospital ER, 50.7% say this was due to an emergency or life-threatening situation, while 38.0% indicated that the visit was during after-hours or on the weekend.

Have Used a Hospital Emergency Room More Than Once in the Past Year



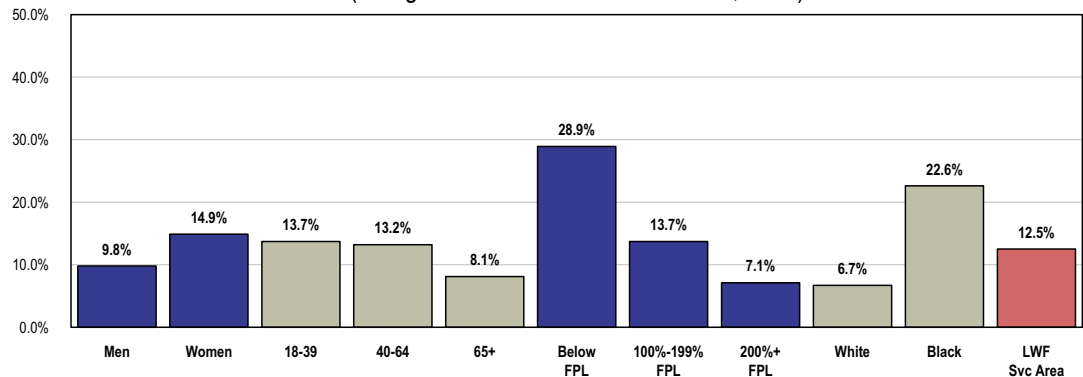
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Items 24,25]
 • 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

Multiple ER visits were most often noted among:

- 👥 Residents living below the federal poverty level.
- 👥 Blacks.

Have Used a Hospital Emergency Room More Than Once in the Past Year (Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 24]

Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Business Leaders

Too many people are using the ER for their primary care. Those who are uninsured know that the ER will serve them even though they can't pay. There is a need for health clinics to be open later to take the burden off the ER so that true trauma patients can be seen in a timely fashion and so that hospitals don't have to write off so many treatments for patients who can't pay.

"Unless they really hurt, the general population is not going to be checked, and then they go to the emergency room, which they never pay for, and hospitals get in trouble because of federal mandates that are under-funded. You've got to see them; you've got to treat them." – Business Leader

ORAL HEALTH

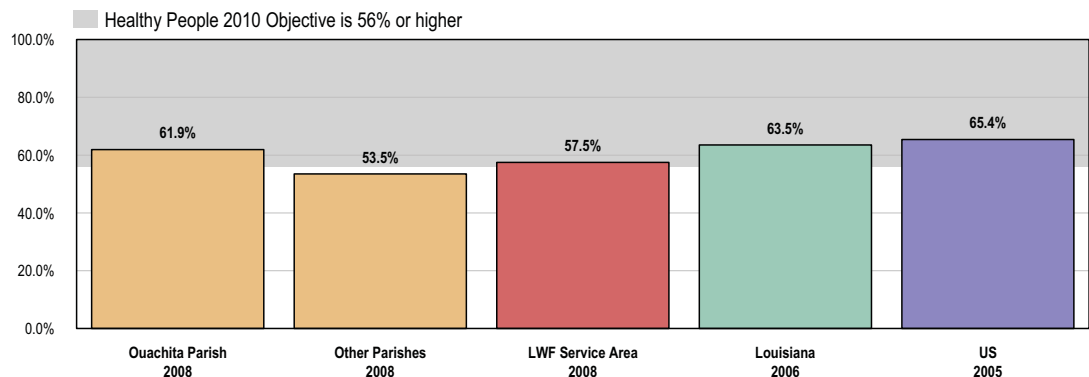
Dental Care

Adults

57.5% of LWF Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- ❑ Less favorable than findings across Louisiana (63.5%).
- ❑ Also less favorable than national findings (65.4%).
- ❑ Close to satisfying the Healthy People 2010 target (56% or higher).
- ⊕ Ranges from 53.5% in the other parishes (not including Ouachita Parish) to 61.9% in Ouachita Parish.

Have Visited a Dentist or Dental Clinic for Any Reason Within the Past Year



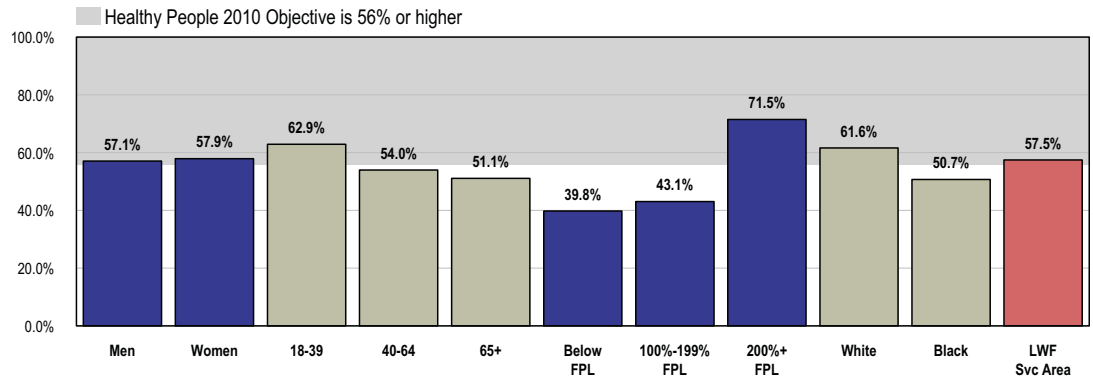
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 22]
• 2005 PRC National Health Survey, Professional Research Consultants.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 21-10]

Note: • Asked of all respondents.

Note the following:

- 👥 Routine dental checkups decrease with age in the LWF Service Area.
- 👥 Persons living in the highest income breakout are report much higher utilization of oral health services (persons living at or near poverty fail to satisfy the Healthy People 2010 objective).
- 👥 Blacks show a particularly low proportion of recent dental visits.

Have Visited a Dentist or Dental Clinic for Any Reason Within the Past Year (Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item Z2]
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 21-10]

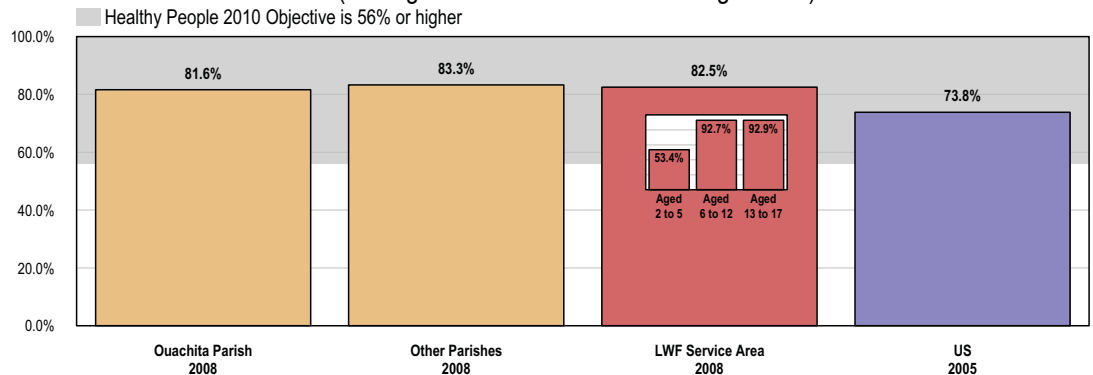
Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Children

82.5% of parents report that their child (aged 2 to 17) has been to a dentist or dental clinic within the past year.

- ☑ Higher than national findings (73.8%).
- ☑ Satisfies the Healthy People 2010 target (56% or higher).
- ⊕ Similar between sub-areas.
- 👪 As may be expected, regular dental care is lowest among children under six.

Child Has Visited a Dentist or Dental Clinic Within the Past Year (Among Households With Children Aged 2-17)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 126]
 • 2005 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 21-10]

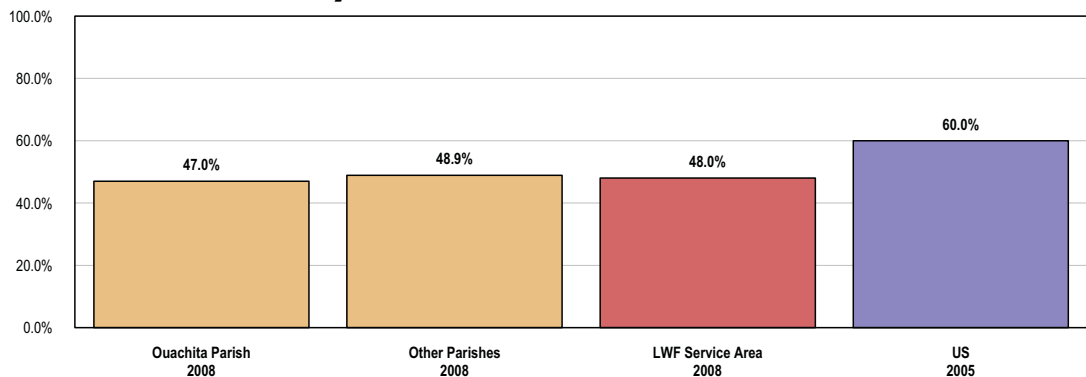
Note: • Asked of respondents with children aged 2 to 17.

Dental Insurance

One-half (48.0%) of LWF Service Area adults have dental insurance that covers all or part of their dental care costs.

- ☐ Less favorable than national findings (60.0%).
- ⊕ Does not vary significantly by sub-area.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 23]
• 2005 PRC National Health Survey, Professional Research Consultants.

Note: • Asked of all respondents.

Related Focus Group Findings: Oral Health

Community Leaders/ Social Service Providers

There are not enough charity facilities that offer dental care. There are a couple of places in the area where people can get basic dental hygiene, but if there is a need for something more, people will have to travel to Shreveport to get it.

“I recently tried to find if there was a dental college or dental facility available and was told that I’d have to call Shreveport. And if you call to get an appointment, it might be a year away.” – Community Leader

“For dental care you almost have to go to Shreveport and you can wait six, eight, then twelve months to get an appointment. And dental care is a huge need.” – Social Service Provider

Other Health Professionals

The school-based clinics in the area have improved dental hygiene for many children.

“Having a school-based dental clinic has been really an asset for the community. We can pull the students from classes and they can have the preventive care and they’re able to have their teeth cleaned. Otherwise, they do not get that type of care anywhere else. Some of our ULM students are the ones who clean the teeth and they’ve come back with rewarding experiences because they, in dealing with children that might not even have a toothbrush and things like that, have come back and told just how rewarding it is.” – Other Health Professional

There are dentists in the area who will see patients free of charge but they can’t see them all.

“I think the majority of the dentists in northeast Louisiana will see patients at no charge. In other words, if one of my patients calls up and says, ‘You know, my domestic helper has a child that can’t pay and is in pain’, we’ll see patients for no charge, but we have to limit it.” – Other Health Professional

There are those who have health insurance but no dental coverage so they still don't have access to dental care.

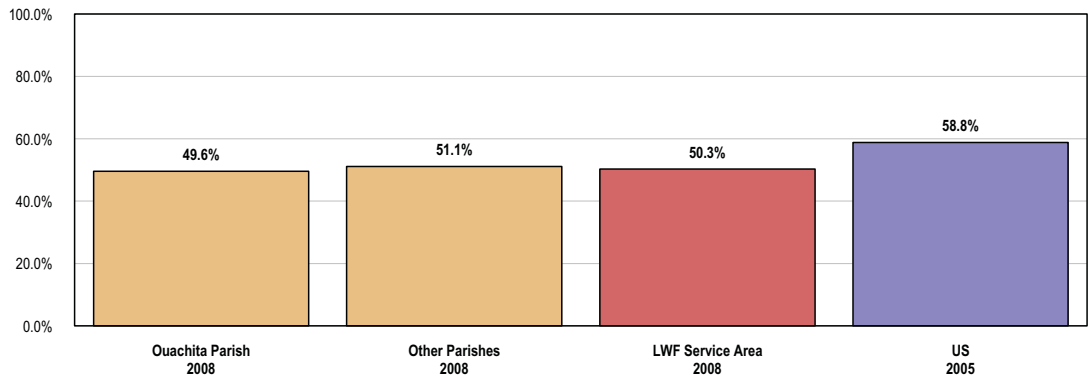
There are a lot of people who don't want to be asked to get free care, but there really isn't access because they don't have insurance. If they have insurance, they have no dental coverage. So there's a huge population of hard-working, salt-of-the-earth people who don't have access to that service.” –
Other Health Professional

VISION CARE

A total of 50.3% of LWF Service Area residents had an eye exam in the past two years during which their pupils were dilated.

- ⊗ Less favorable than national findings (58.8%).
- ⊕ Statistically similar between the two sub-areas.

Have Had a Dilated Eye Examination Within the Past Two Years

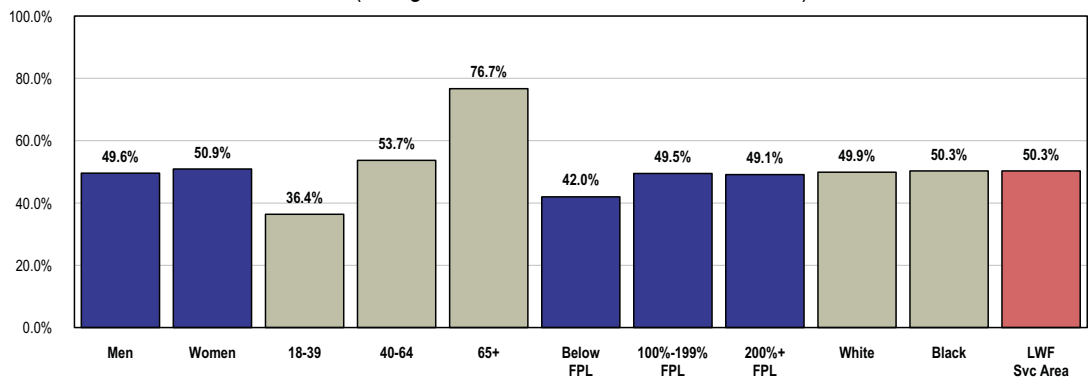


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 21]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2005 Louisiana data.

Note: • Asked of all respondents.

Recent vision care is more often reported among adults aged 40 and older, especially among seniors.

Have Had a Dilated Eye Examination Within the Past Two Years (Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 21]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

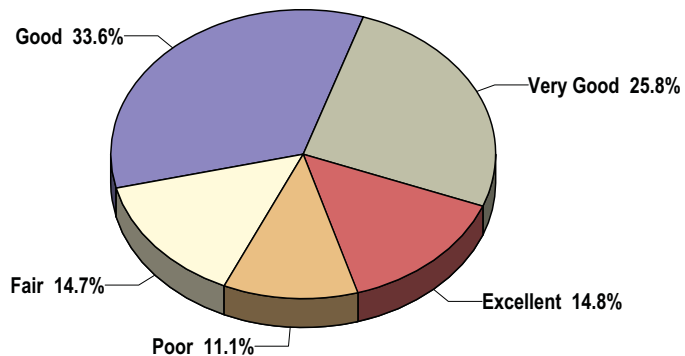
PERCEPTIONS OF LOCAL HEALTHCARE SERVICES

Forty percent of LWF Service Area adults rate the overall healthcare services available in their community as “excellent” or “very good.”

- ☑ Less favorable than the 56.6% reported nationally.
- ☑ Another 33.6% of survey respondents gave “good” ratings of the overall healthcare services available in their community.

Rating of Overall Healthcare Services Available in the Community

(Living Well Foundation Service Area, 2008)

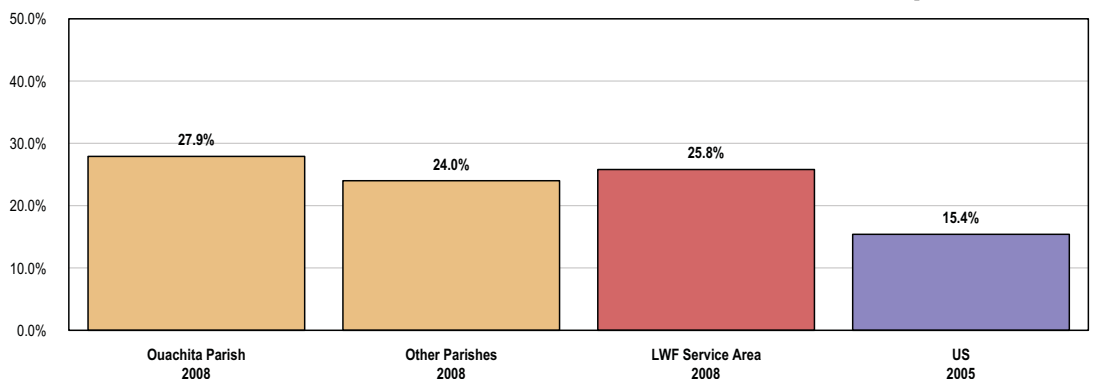


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 7]
 Note: • Asked of all respondents.


However, 25.8% of LWF Service Area residents characterize local healthcare services as “fair” or “poor.”

- ☑ Much higher than national findings (15.4%).
- ⊕ Similar by geographic sub-area.

Perceive Local Healthcare Services as “Fair/Poor”

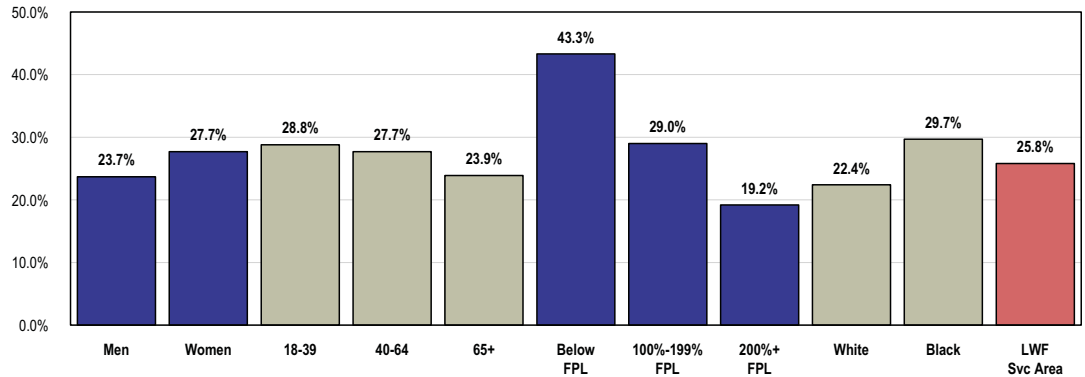


Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 7]
 • 2005 PRC National Health Survey, Professional Research Consultants.
 Note: • Asked of all respondents.

 Note that residents living in poverty and Blacks are more critical of local healthcare services.


Perceive Local Healthcare Services as "Fair/Poor"

(Living Well Foundation Service Area, 2008)



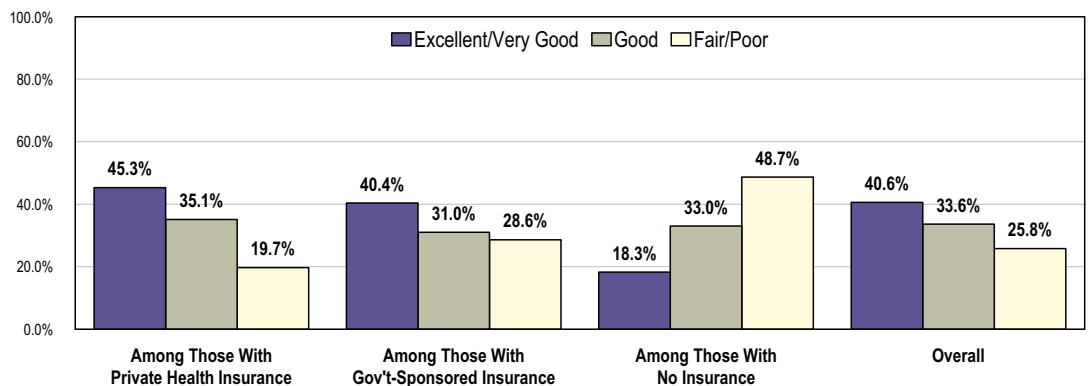
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 7]
 Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.
 • Percentages represent combined "fair" and "poor" responses.

By Insurance Status

 Note in the following chart the correlation between personal insurance status and ratings of local healthcare services. As may be expected, insured adults are more likely to give positive ratings of local healthcare than are the uninsured.

Ratings of Local Healthcare Services

(By Insured Status; LWF Service Area, 2008)



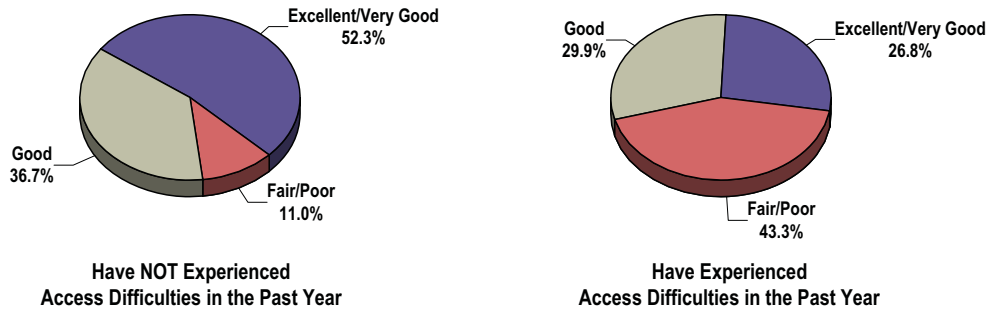
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 7]
 Note: • Asked of all respondents.

By Prevalence of Access Difficulties

☺ The next chart correlates access difficulties with ratings of local healthcare services. The LWF Service Area residents with recent access difficulties gave much lower overall ratings of local healthcare services.

Ratings of Local Healthcare Services

(By Access Difficulties; LWF Service Area, 2008)



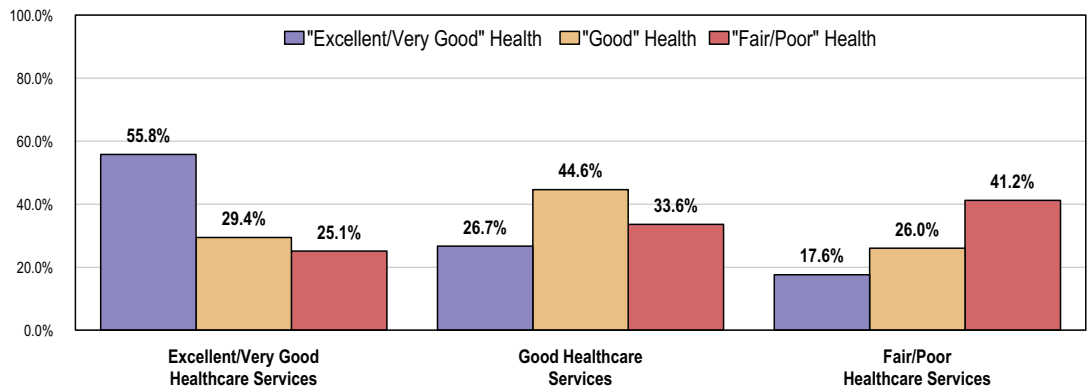
Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 7]
 Note: • Asked of all respondents.

By Personal Health Status

☺ With regard to personal health status, adults in good health standing gave much higher ratings of their local healthcare services when compared with adults in poor health.

Ratings of Local Healthcare Services

(By Self-Reported Health Status; LWF Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 7]
 Note: • Asked of all respondents.

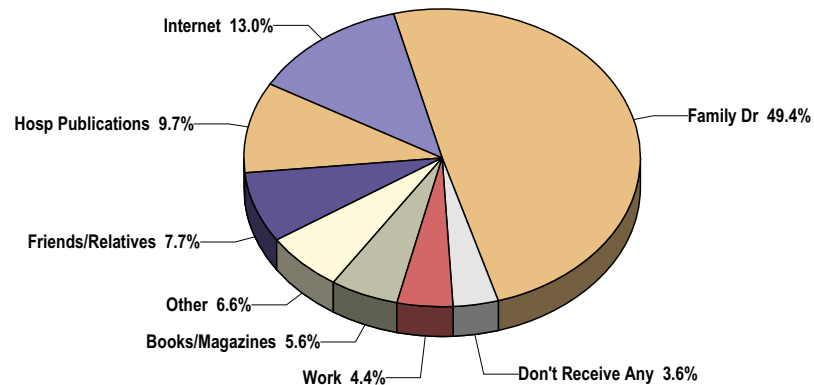
HEALTHCARE INFORMATION SOURCES

Family physicians remain residents' primary source of healthcare information.

- ☐ One-half (49.4%) of LWF Service Area adults cited their family physician as their primary source of healthcare information, much higher than the 26.6% across the United States.
- ☐ The **Internet** received the second-highest response (13.0%), similar to the 12.0% nationally.
- ☐ Other sources mentioned include hospital publications (9.7%), friends and relatives (7.7%), books and magazines (5.6%), and work (4.4%).
- ☐ Note that 3.6% of survey respondents reportedly do not receive any healthcare information.

Primary Source of Healthcare Information

(Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 11g]
Note: • Asked of all respondents.

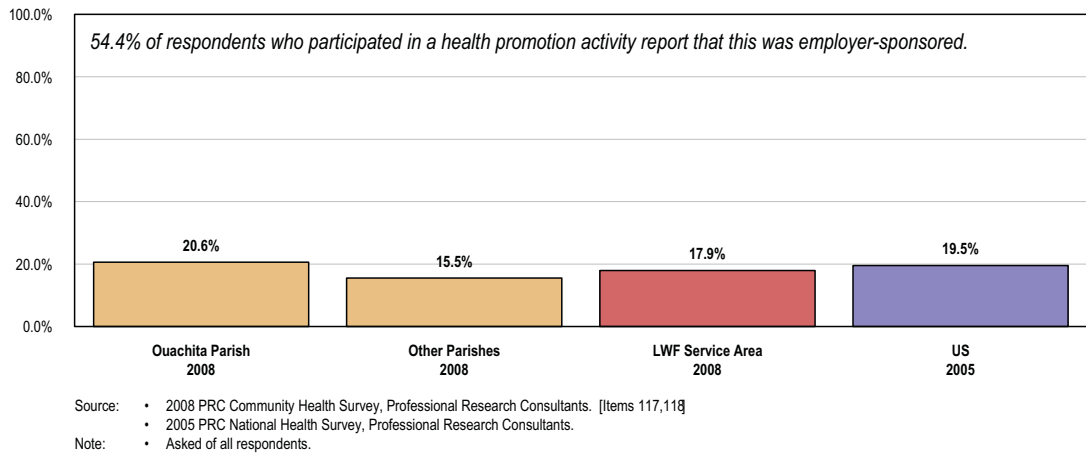
EDUCATIONAL & COMMUNITY-BASED PROGRAMS

Participation in Health Promotion Activities

A total of 17.9% of LWF Service 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 (19.5%).
- ⊕ Higher in Ouachita Parish.
- 👥 Note that 54.4% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer.

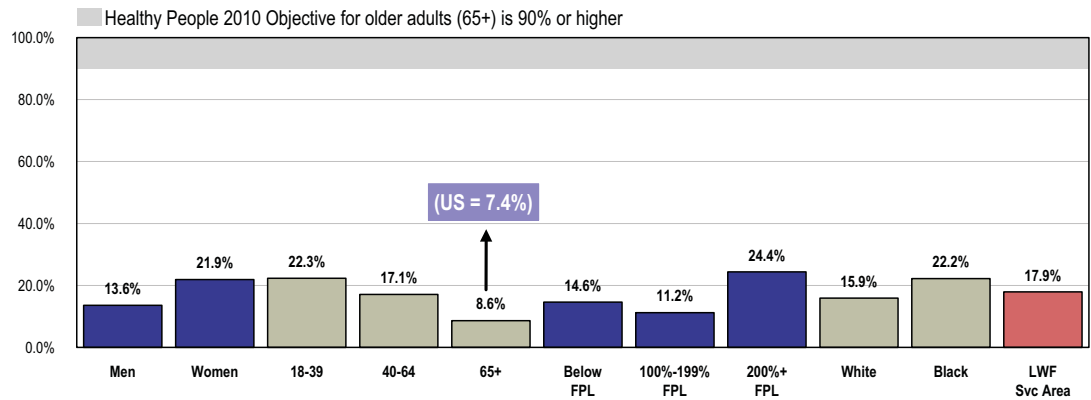
Participated in a Health Promotion Activity in the Past Year



The following chart outlines participation by various demographic characteristics.

- 👥 Note that women, adults under 65, residents with higher incomes, and Blacks 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 LWF Service Area, only 8.6% of older adults acknowledged doing so in the past year (similar to the 7.4% reported nationally).

Participated in a Health Promotion Activity in the Past Year (Living Well Foundation Service Area, 2008)



Source: • 2008 PRC Community Health Survey, Professional Research Consultants. [Item 117]
 • Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 7-12]

Note: • Asked of all respondents.
 • FPL = Federal Poverty Level based on household income and number of household members [U.S. Dept. of Health & Human Services poverty guidelines].
 • White and Black are non-Hispanic race categorizations.

Related Focus Group Findings: Educational & Community-Based Programs

Community Leaders

Even public employees are unaware of programs in the community that are available to the public; they are likewise unaware how to obtain information about resources that are available in the community.

“I work with a crisis intervention team and we’ve trained over 150 officers and 80 dispatchers in 12 parishes and out of those--almost none of them knew about United Way 211 or where to call for help. They never heard of it. So it is helping tremendously to get the word out, but these are people who are out in the world all the time and they didn’t have a clue about that.” – Community Leader

Business Leaders

There is a need for educating the public about health and healthy lifestyles.

“Maybe there could be something emphasized more in our schools, hopefully before the students drop out, teaching folks some health issues. Health-related education on issues such as childbearing, but also education which addresses the overall health.” – Business Leader

“You could go a long way by educating that elderly lady and making her aware that she can call the Council on Aging and say, ‘Can you get me a medical transit bus to get me to the doctor?’” – Business Leader

Physicians

According to physicians in the area, general education is perceived as lacking among residents.

“Everything you’re saying comes back to education, including school-based health centers. We’ve made great progress over there. But if you’re trying to find somewhere to hone in, that may be the place, because everything we’ve discussed comes back to a culture that just doesn’t understand. It’s just not educated.” – Physician

“I really think that this healthcare foundation is going to have to do most of its projects in the area of education, trying to improve kids’ and parent’s knowledge and educational levels.” – Physician

Social Service Providers/ Other Health Professionals

There are free services available in the community that too many people aren’t taking advantage of, such as preventive screenings which might keep people out of the doctor’s office if they were being utilized.

“We give four cancer screenings a year which are absolutely free to anybody. There are no requirements, you don’t have to be poor, you don’t have to be anything. You just come and get the service. And every year one of our biggest problems is getting support from our medical community because they don’t want to give up their Saturday morning, and the second problem is getting the people to come. The majority of them do not have to take off work since it’s on a Saturday but they still don’t come.” – Social Services Provider

“There are some issues that are discovered at the school clinic yet the parents will not take the children and get further treatment for them. There are some parents who will not even turn in the free sign-ups for the free healthcare.” – Social Services Provider

“There are a lot of programs out there that are being used in other parts of the country that I read about all the time but we don’t have any of them here. Things like the Activated Patient Program that was started at Georgetown to teach people how to be better consumers so they would know when to go (to the doctor) and when not to go and how to save their money.” – Social Service Provider

“As we consider what sounds like access, I think a lot of our population is just not aware of the services.” Other Health Professional

“I teach part time at the UMM Dental Hygiene School, and it’s a wonderful source for patients in northeast Louisiana to get almost free dental care. Unfortunately, it’s not restorative but it is preventative and includes education about problems like sugar abuse with soft drinks and soft foods. It’s a wonderful facility and we need more good patients to just show up.” – Other Health Professional

NEEDS OF SPECIAL POPULATIONS

SENIORS

Related Focus Group Findings

Community Leaders

The baby boomer generation will be utilizing more healthcare services as they age and unfortunately, not many providers accept Medicare.

“The baby boomers are now reaching their 60s and this is going to cause a great burden for the medical industry, especially in this area where we have a lot of older people. That group of people reaching 60 is going to be getting sick because they are getting older and that’s a real issue that’s come up for us.”
– Community Leader

“We really don’t have a lot of access points for Medicare beneficiaries; most of the primary care physicians don’t accept new Medicare patients. It’s a challenge.” – Community Leader

Business Leaders

Seniors aren’t aware of everything that’s available to them.

“We try to give the Council on Aging more of a presence so we send their catalog to 36,000 subscribers every month to increase awareness of things that are taking place and fee screenings and things of that nature. We must run literally tons of articles that are on that but you know that doesn’t mean that everybody sees it, that it’s there or that everybody reads it.” – Business Leader

More and more seniors are navigating the healthcare system on their own because their children have moved away.

“We’ve seen a lot of elderly from the rural area moving into our parish and young people are moving away, so you have elderly parents who remain no family members around. They don’t have anyone to take them to services.” – Business Leader

Physicians

Medicare is not covering enough of the cost of healthcare so physicians are not able to continue seeing patients once they start on Medicare.

“We have a real problem with access for our Medicare population in general health. It is a shame that a patient turns 65-years-old and when they call to make their appointment to see the doctor they’ve had for years, they’re told ‘we can no longer take care of you because you’re 65-years-old.’” – Physician

YOUTH

Related Focus Group Findings

Social Service Providers

There is a decrease in physical education and exercise among youth in this area. Too many students are not getting the exercise needed to live a healthy lifestyle.

“I would like to see our educational system emphasize physical fitness again. That’s where a lot of our problems are starting today health-wise. Obesity is just part of the problem ballooning. Lethargic kids are very common; they may be addicted to some of the things but then a lot of them are very addicted to video games inside the air conditioning. I love to take the kids out for more than five minutes in the summer, but that’s about all they can stand because they are too used to the air conditioning.” – Social Service Provider

Substance abuse is perceived as a common problem with the youth in this area.

“Alcohol for this community is another huge issue. It’s definitely a cultural and social issue. As a community we tend to just accept the fact that kids at a certain age are going to experiment, they’re going to drink, they’re going to get drunk, they’re going to waste their first year of college. And it’s just how to celebrate, that’s how you have a good time is to drink alcohol.” – Social Service Provider