

2012 PRC Community Health Needs Assessment Report

Bibb, Houston, Peach, Jones, Twiggs,
Monroe & Crawford Counties

Sponsored by
Medical Center of Central Georgia



Professional Research Consultants, Inc.

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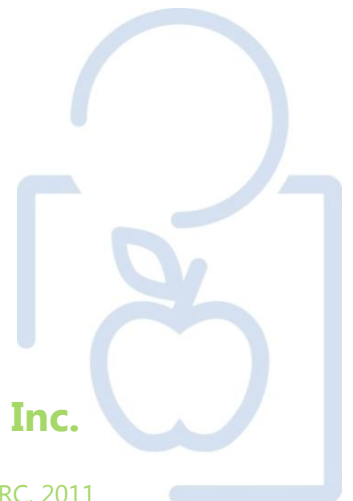


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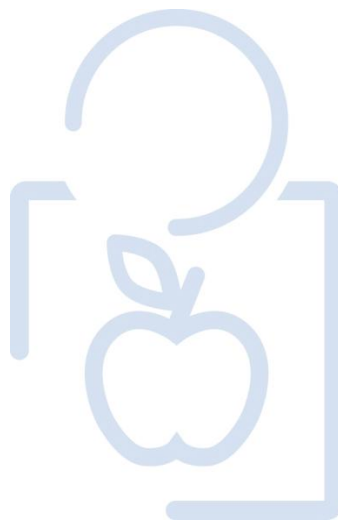
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INTRODUCTION



Project Overview

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the multi-county service area of Medical Center of Central Georgia. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

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

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

This assessment was conducted on behalf of Medical Center of Central Georgia by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

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

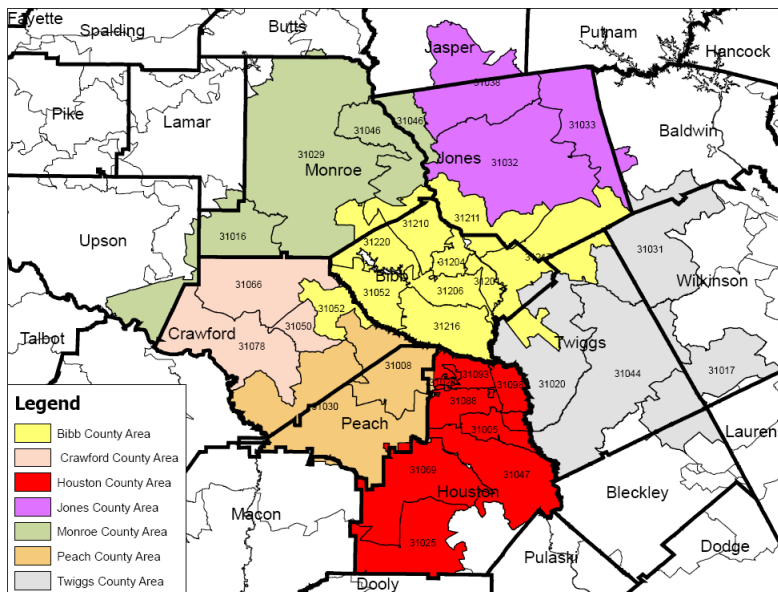
PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Total Area” in this report) includes all residential ZIP Codes associated with Bibb, Houston, Peach, Jones, Twiggs and Monroe counties in Georgia. In the reporting, Jones, Twiggs and Monroe county findings are grouped into a single combined area, referred to as “Other Counties”. A geographic description is illustrated in the following map.



Sample Approach & Design

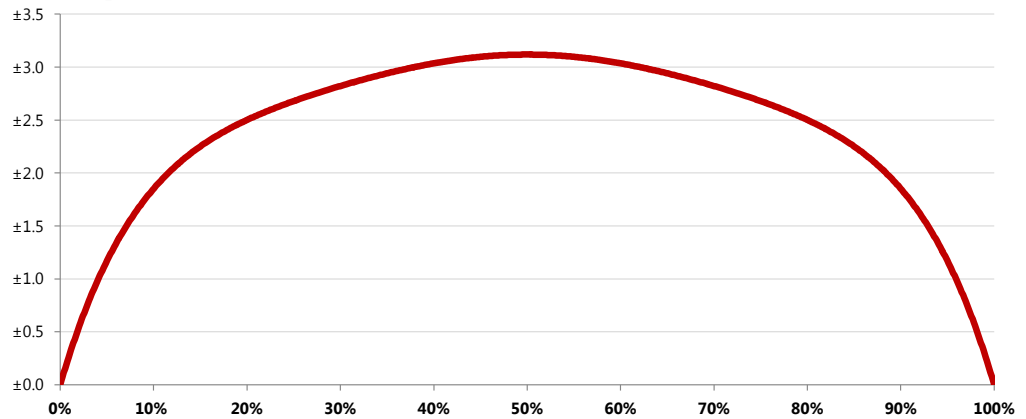
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews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

The sample design used for this effort consisted of a stratified random sample of 1,000 individuals age 18 and older in the Total Area, including 300 in Bibb County, 300 in Houston County, 200 in Peach County, and 200 in the combined area of Jones, Twiggs, Monroe and Crawford counties. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Area as a whole. 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.

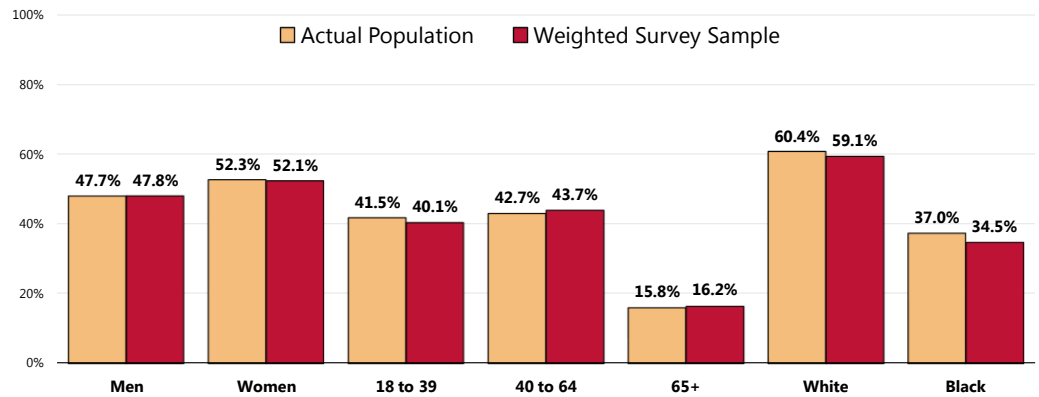
Sample Characteristics

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 geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

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

Population & Sample Characteristics

(Total Area, 2012)



Sources:

- Census 2000, Summary File 3 (SF 3). U.S. Census Bureau.
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g., the 2012 guidelines place the poverty threshold for a family of four at \$23,050 annual household income or lower*). In sample segmentation: **“low income”** refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; **“mid/high income”** refers to those households living on incomes which are twice or more the federal poverty level.

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

Key Informant Focus Groups

As part of the community health assessment, there were five focus groups held in the region. Participants included 34 key informants in the region, including physicians, other health professionals, social service providers, business leaders and other community leaders.

Participant Type	Discussion Focus	Date
Healthcare Providers	Bibb County Needs	March 6, 2012
Other Community Leaders	Bibb County Needs	March 6, 2012
Healthcare Providers/Community Leaders	Peach County Needs	March 6, 2012
Healthcare Providers	Regional Needs	March 7, 2012
Other Community Leaders	Regional Needs	March 7, 2012

A list of recommended participants for the focus groups was provided by the sponsors. 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. Participants included a representative of public health, as well as several individuals who work with

low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

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 a reasonable turnout.

Audio from the focus groups sessions was recorded, from which verbatim comments in this report are taken. 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.

Public Health, Vital Statistics & Other Data

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

- Centers for Disease Control & Prevention
- GeoLytics Demographic Estimates & Projections
- National Center for Health Statistics
- Georgia Bureau of Investigation
- Georgia Department of Public Health
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect county-level data.

Benchmark Data

Georgia Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2011 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to

the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020



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

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

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

Information Gaps

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

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

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

Summary of Findings

Areas of Opportunity for Community Health Improvement

The following “health priorities” represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the region with regard to the following health areas (see also the summary tables presented in the following section).

Central Georgia Region: Areas of Opportunity Identified Through This Assessment

Access to Health Services	<ul style="list-style-type: none"> • Insurance Instability • Supplemental Coverage (65+) • Cost as a Barrier to Prescriptions/Doctor Visits • Prescription Misuse • Difficulty Obtaining Child's Healthcare • Having a Medical Home (Source of Care) • Use of the Emergency Room
Arthritis, Osteoporosis & Chronic Back Conditions	<ul style="list-style-type: none"> • Prevalence of Arthritis (50+) • Prevalence of Chronic Neck Pain • Activity Limitations
Cancer	<ul style="list-style-type: none"> • Lung Cancer Deaths • Prostate Cancer Deaths • Colorectal Cancer Deaths
Chronic Kidney Disease	<ul style="list-style-type: none"> • Kidney Disease Deaths
Diabetes	<ul style="list-style-type: none"> • Prevalence of Diabetes
Heart Disease & Stroke	<ul style="list-style-type: none"> • Heart Disease & Stroke Deaths • Prevalence of Stroke • Hypertension & High Cholesterol • Cardiovascular Risk Factors
Injury & Violence Prevention	<ul style="list-style-type: none"> • Accidental Deaths (Including Motor Vehicle Crashes) • Firearm-Related Deaths • Homicide Rate • Firearms in the Home (Including Homes w/Children) • Unlocked & Loaded Firearms
Maternal, Infant & Child Health	<ul style="list-style-type: none"> • Low Birthweight • Infant Mortality
Mental Health & Mental Disorders	<ul style="list-style-type: none"> • Suicide Rate • Persons w/Depression Seeking Help
Nutrition, Physical Activity & Weight Status	<ul style="list-style-type: none"> • Prevalence of Obesity • Fruit & Vegetable Consumption • Lack of Leisure-Time Activity • Meeting Physical Activity Guidelines • Vigorous Physical Activity • Screen Time (Children 5-17)
Oral Health	<ul style="list-style-type: none"> • Dental Visits
Sexually Transmitted Diseases	<ul style="list-style-type: none"> • Gonorrhea and Chlamydia Incidence • Hepatitis B Incidence • Multiple Sexual Partners
Tobacco Use	<ul style="list-style-type: none"> • Current Smokers • Secondhand Smoke in the Home (Including Homes w/Children) • Use of Smokeless Tobacco • Prevalence of Chronic Lung Disease

Top Community Health Concerns Among Community Key Informants

At the conclusion of each key informant focus group, participants were asked to write down what they individually perceive as the top five health priorities for the community, based on the group discussion as well as on their own experiences and perceptions. Their responses were collected, categorized and tallied to produce the top-ranked priorities as identified among key informants. These should be used to complement and corroborate findings that emerge from the quantitative dataset.

1. Education/Prevention

- Mentioned resources available to address this issue: Georgia Department of Health Services Division of Family & Children Services; social workers; school districts; Boys & Girls Clubs; Macon Chamber of Commerce; medical providers; Middle Georgia Family Connection; Area Agency on Aging; Rainbow Center; Central City Aids; United Way 211.

2. Access/Transportation

- Mentioned resources available to address this issue: Medicaid transport; Macon Transit; Macon Volunteer Clinic; Anderson clinic; local health departments; Medical Center of Central Georgia; First Choice; Peach Regional Medical Center.

3. Mental Health

- Mentioned resources available to address this issue: River Edge; Macon Coliseum Hospital; Medical Center of Central Georgia; HODAC; Phoenix Center; local health departments; Loaves & Fishes Ministry; Macon Rescue Mission; Community Health Works; First Choice Primary Care.

4. Obesity

- Mentioned resources available to address this issue: Veggie Van; farmer's market; local recreation centers; University of Georgia Cooperative Extension.

5. Substance Abuse

- Mentioned resources available to address this issue: River Edge; Macon Coliseum Hospital; HODAC; Georgia Meth Project; Phoenix Center; local health departments; Gateway Cottage Residential Program; DARE program.

































































































Summary Tables: Comparisons With Benchmark Data






























The following tables provide an overview of indicators in the Total Area, including comparisons among the individual communities. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.










































Reading the Summary Tables




























- In the following charts, Total Area results are shown in the larger, blue column.
- The green columns [to the left of the Total Area column] provide comparisons among the four geographic areas, identifying differences for each as “better than” (☀️), “worse than” (🌧️), or “similar to” (☁️) the combined opposing areas.
- The columns to the right of the Total Area column provide comparisons between the Total Area and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the Total Area compares favorably (☀️), unfavorably (🌧️), or comparably (☁️) to these external data.










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

















Access to Health Services	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	 21.4	 13.1	 29.4	 17.1	18.6	 18.7	 14.9	 0.0
% [65+] With Medicare Supplement Insurance	 62.8	 74.5	 65.9	 62.4	65.9		 75.5	
% [Insured] Insurance Covers Prescriptions	 88.4	 95.9	 95.9	 97.8	93.0		 93.9	
% [Insured] Went Without Coverage in Past Year	 8.9	 6.9	 8.4	 5.3	7.6		 4.8	
% Difficulty Accessing Healthcare in Past Year (Composite)	 42.4	 40.0	 44.2	 34.6	40.6		 37.3	
% Inconvenient Hrs Prevented Dr Visit in Past Year	 9.8	 10.3	 16.0	 7.8	10.2		 14.3	
% Cost Prevented Getting Prescription in Past Year	 22.8	 18.3	 29.5	 20.2	21.5		 15.0	
% Cost Prevented Physician Visit in Past Year	 24.4	 17.5	 28.1	 17.1	21.3		 14.0	
% Difficulty Getting Appointment in Past Year	 12.3	 17.0	 15.9	 11.8	14.1		 16.5	
% Difficulty Finding Physician in Past Year	 10.7	 14.2	 15.0	 11.1	12.3		 10.7	
% Transportation Hindered Dr Visit in Past Year	 7.1	 13.3	 10.4	 8.7	9.7		 7.7	
% Skipped Prescription Doses to Save Costs	 20.7	 18.3	 21.6	 18.1	19.6		 14.8	
% Difficulty Getting Child's Healthcare in Past Year	 6.0	 6.2	 0.0	 5.1	5.4		 1.9	
% [Age 18+] Specific Source of Ongoing Care	 67.5	 68.8	 58.9	 74.0	68.3		 76.3	 95.0
% Have Had Routine Checkup in Past Year	 70.7	 67.7	 73.0	 72.3	70.2		 67.3	
% Child Has Had Checkup in Past Year	 84.8	 78.5	 83.2	 89.7	83.1		 87.0	
% Two or More ER Visits in Past Year	 13.8	 12.1	 15.2	 12.8	13.2		 6.5	
% Rate Local Healthcare "Fair/Poor"	 19.0	 11.6	 22.2	 17.7	16.6		 15.3	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse










Arthritis, Osteoporosis & Chronic Back Conditions	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	 46.0	 48.5	 47.7	 47.9	47.1		 35.4	
% [50+] Osteoporosis	 13.0	 11.9	 8.2	 15.1	12.6		 11.4	 5.3
% Sciatica/Chronic Back Pain	 20.5	 19.3	 25.3	 23.0	20.9		 21.5	
% Migraine/Severe Headaches	 17.3	 20.5	 20.2	 18.3	18.8		 16.9	
% Chronic Neck Pain	 10.7	 14.4	 12.5	 9.4	11.8		 8.3	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse









Cancer	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	 191.3	 169.7	 229.0	 190.2	184.3	 177.9	 178.1	 160.6
Lung Cancer (Age-Adjusted Death Rate)					59.2	 44.7	 50.5	 45.5
Prostate Cancer (Age-Adjusted Death Rate)					29.8	 26.9	 23.1	 21.2
Female Breast Cancer (Age-Adjusted Death Rate)					20.1	 22.5	 23.0	 20.6
Colorectal Cancer (Age-Adjusted Death Rate)					21.3	 17.7	 16.8	 14.5
% Skin Cancer	 6.8	 7.0	 6.5	 9.8	7.3		 8.1	
% Cancer (Other Than Skin)	 6.4	 5.4	 4.6	 4.5	5.6		 5.5	
% [Men 50+] Prostate Exam in Past 2 Years	 78.8	 82.3	 79.4	 80.4	80.2		 70.5	
% [Women 50-74] Mammogram in Past 2 Years	 83.2	 76.2	 86.0	 83.2	81.5	 80.8	 79.9	 81.1
















Cancer (continued)	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% [Women 21-65] Pap Smear in Past 3 Years	 80.1	 87.0	 80.6	 73.8	81.5	 86.6	 84.7	 93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	 79.7	 80.0	 78.3	 76.5	79.2	 67.7	 72.0	
% [Age 50+] Blood Stool Test in Past 2 Years	 38.8	 31.9	 45.2	 31.7	36.1	 21.7	 28.3	
% [Age 50-75] Colorectal Cancer Screening	 80.4	 78.7	 80.2	 79.3	79.7			 70.5
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse
















Chronic Kidney Disease	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Kidney Disease (Age-Adjusted Death Rate)	 36.3	 22.1	 34.0	 19.7	28.6	 21.2	 14.6	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse









Diabetes	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Diabetes Mellitus (Age-Adjusted Death Rate)	 25.8	 15.8	 43.0	 20.5	22.0	 19.2	 22.5	 19.6
% Diabetes/High Blood Sugar	 17.0	 14.4	 17.3	 13.8	15.6	 9.7	 10.1	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse







































































Dementias, Including Alzheimer's Disease	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Alzheimer's Disease (Age-Adjusted Death Rate)	 18.6	 23.1	 24.4	 17.7	19.9	 25.5	 23.2	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse













Educational & Community-Based Programs	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% Attended Health Event in Past Year	 18.9	 18.9	 14.3	 21.6	18.9		 22.2	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

































Family Planning	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% of Births to Unwed Mothers	 62.7	 42.1	 49.7	 44.1	51.6	 44.8	 40.4	
% Births to Teenagers (15-17)	 5.0	 3.3	 5.1	 3.2	4.1	 5.5	 3.2	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

















































General Health Status	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% "Fair/Poor" Physical Health	 19.5	 17.5	 23.6	 21.1	19.4	 16.0	 16.8	
% Activity Limitations	 21.2	 18.6	 24.3	 23.1	20.9	 19.3	 17.0	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

































Hearing & Other Sensory or Communication Disorders	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% Deafness/Trouble Hearing	 11.0	 12.7	 11.6	 12.5	11.8		 9.6	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

















Heart Disease & Stroke	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	 240.1	 176.6	 271.5	 247.5	221.3	 202.2	 192.5	 152.7
Stroke (Age-Adjusted Death Rate)	 57.0	 47.4	 62.5	 57.3	53.6	 49.4	 42.2	 33.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	 7.3	 7.9	 6.4	 6.3	7.3	 6.1		
% Stroke	 5.5	 4.0	 5.7	 3.6	4.7	 2.8	 2.7	
% Blood Pressure Checked in Past 2 Years	 97.2	 92.0	 94.5	 95.5	95.0		 94.7	 94.9
% Told Have High Blood Pressure (Ever)	 45.5	 39.6	 39.9	 46.0	43.2	 31.3	 34.3	 26.9
% [HBP] Taking Action to Control High Blood Pressure	 90.5	 94.6	 93.3	 99.0	93.4	 89.1		
% Cholesterol Checked in Past 5 Years	 92.0	 88.3	 91.0	 92.8	90.9	 78.8	 90.7	 82.1
% Told Have High Cholesterol (Ever)	 36.5	 32.0	 32.6	 43.8	35.8	 37.0	 31.4	 13.5
% [HBC] Taking Action to Control High Blood Cholesterol	 90.8	 87.7	 86.8	 85.2	88.5	 89.1		
% 1+ Cardiovascular Risk Factor	 94.5	 87.2	 86.7	 92.2	91.1	 86.3		
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

























HIV	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
HIV/AIDS (Age-Adjusted Death Rate)					6.8	 6.9	 3.9	 3.3
% [Age 18-44] HIV Test in the Past Year	 30.6	 29.6	 29.0	 26.8	29.5		 19.9	 16.9
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse










Immunization & Infectious Diseases	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Pertussis per 100,000	 1.1	 0.5	 2.5	 0.9	0.9	 1.3	 4.5	
% [Age 65+] Flu Shot in Past Year	 66.3	 68.0	 60.0	 71.3	67.2	 61.8	 71.6	 90.0
% [High-Risk 18-64] Flu Shot in Past Year					46.2		 52.5	 90.0
% [Age 65+] Pneumonia Vaccine Ever	 60.7	 69.2	 64.4	 64.1	64.0	 64.4	 68.1	 90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever					38.5		 32.0	 60.0
% Ever Vaccinated for Hepatitis B	 36.9	 45.3	 28.8	 28.0	37.6		 38.4	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

























































Injury & Violence Prevention	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	 47.3	 35.7	 55.0	 51.9	44.8	 43.0	 39.5	 36.0
Motor Vehicle Crashes (Age-Adjusted Death Rate)	 19.0	 13.8	 22.4	 25.5	19.0	 17.7	 14.1	 12.4
% "Always" Wear Seat Belt	 87.5	 86.5	 85.6	 79.2	85.7		 85.3	 92.4
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	 90.3	 90.3	 91.2	 96.8	91.4		 91.6	
% Child [Age 5-17] "Always" Wears Bicycle Helmet					44.9		 35.3	
Firearm-Related Deaths (Age-Adjusted Death Rate)	 20.5	 12.0	 13.3	 11.8	15.8	 12.6	 10.2	 9.2
% Firearm in Home	 43.2	 44.3	 53.4	 72.6	49.0		 37.9	
% [Homes With Children] Firearm in Home	 41.9	 42.4	 52.7	 80.8	49.1		 34.4	
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	 30.4	 29.1	 30.1	 35.0	31.1		 16.9	


















Injury & Violence Prevention (continued)	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Homicide (Age-Adjusted Death Rate)					9.1	 7.5	 6.1	 5.5
Violent Crime per 100,000	 624.6	 338.4	 628.0	 168.5	448.4	 424.3	 431.4	
% Victim of Violent Crime in Past 5 Years	 2.0	 2.3	 6.0	 0.9	2.3		 1.6	
Family Violence Offenses per 100,000	 471.7	 878.7	 930.9	 820.5	710.1	 633.7		
% Ever Threatened With Violence by Intimate Partner	 14.4	 15.3	 18.6	 10.2	14.4		 11.7	
% Victim of Domestic Violence (Ever)	 12.5	 18.0	 19.4	 10.4	14.5		 13.5	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse









































Maternal, Infant & Child Health	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% of Low Birthweight Births	 13.1	 8.8	 9.7	 11.1	11.1	 9.5	 8.2	 7.8
Infant Death Rate	 15.2	 10.2	 12.3		12.5	 8.1	 6.7	 6.0
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse










































Mental Health & Mental Disorders	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	 12.4	 13.2	 10.8	 8.9	12.0		 11.7	
% Major Depression	 9.9	 9.2	 8.8	 9.7	9.5		 11.7	
% Symptoms of Chronic Depression (2+ Years)	 30.2	 21.9	 27.0	 24.5	26.3		 26.5	
Suicide (Age-Adjusted Death Rate)	 10.5	 13.4	 15.1	 11.3	12.5	 10.3	 11.3	 10.2
% [Those With Major Depression] Seeking Help					68.9		 82.0	 75.1





























Mental Health & Mental Disorders (continued)	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% Typical Day Is "Extremely/Very" Stressful	 10.9	 9.5	 8.7	 11.0	10.3		 11.5	
% Child [Age 5-17] Takes Prescription for ADD/ADHD					5.3		 6.5	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

























































Nutrition & Weight Status	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	 40.6	 43.9	 42.2	 36.9	41.3		 48.8	
% Medical Advice on Nutrition in Past Year	 45.5	 43.8	 41.6	 48.4	45.1		 41.9	
% Healthy Weight (BMI 18.5-24.9)	 24.8	 34.3	 25.8	 27.4	28.3		 31.7	 33.9
% Overweight	 74.3	 63.6	 74.2	 69.8	70.2	 65.7	 66.9	
% Obese	 39.0	 30.0	 37.7	 40.1	36.2	 30.4	 28.5	 30.6
% Medical Advice on Weight in Past Year	 30.4	 23.7	 31.9	 32.6	28.7		 25.7	
% [Overweights] Counseled About Weight in Past Year	 37.7	 28.6	 38.3	 41.5	35.7		 30.9	
% [Obese Adults] Counseled About Weight in Past Year	 51.3	 44.8	 56.4	 57.6	51.1		 47.4	 31.8
% [Overweights] Trying to Lose Weight Both Diet/Exercise	 34.2	 36.3	 40.5	 42.7	36.7		 38.6	
% Children [Age 5-17] Overweight					26.4		 30.7	
% Children [Age 5-17] Obese					18.4		 18.9	 14.6
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse





















Oral Health	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	 56.2	 71.7	 51.9	 60.8	61.7	 70.2	 66.9	 49.0
% Child [Age 2-17] Dental Visit in Past Year							 79.2	 49.0
% Have Dental Insurance	 58.0	 70.2	 53.8	 55.4	61.2		 60.8	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse














Physical Activity	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% [Employed] Job Entails Mostly Sitting/Standing	 60.0	 61.2	 76.4	 55.5	60.7		 63.2	
% No Leisure-Time Physical Activity	 35.2	 39.9	 31.3	 31.3		 25.1	 28.7	 32.6
% Meeting Physical Activity Guidelines	 33.4	 37.5	 39.5	 40.9	36.4	 45.7	 42.7	
% Moderate Physical Activity	 22.2	 22.0	 23.7	 25.1	22.7		 23.9	
% Vigorous Physical Activity	 25.8	 28.1	 35.0	 32.2	28.3	 27.5	 34.8	
% Medical Advice on Physical Activity in Past Year	 51.2	 43.9	 46.9	 52.7	48.7		 47.8	
% Child [Age 5-17] Watches TV 3+ Hours per Day							 19.7	
% Child [Age 5-17] Uses Computer 3+ Hours per Day					20.1		 9.9	
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time					61.4		 43.4	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

Respiratory Diseases	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
CLRD (Age-Adjusted Death Rate)	 43.8	 30.3	 49.1	 51.0	41.4	 44.4	 41.8	
Pneumonia/Influenza (Age-Adjusted Death Rate)	 19.7	 22.9	 24.1	 18.5	19.6	 18.9	 17.0	
% Nasal/Hay Fever Allergies	 31.9	 36.8	 29.8	 33.3	33.5		 27.3	
% Sinusitis	 20.7	 24.3	 19.3	 26.6	22.7		 19.4	
% Chronic Lung Disease	 10.7	 10.7	 12.8	 12.8	11.2		 8.4	
% [Adult] Currently Has Asthma	 8.5	 6.4	 10.1	 9.9	8.2	 7.8	 7.5	
% [Child 0-17] Currently Has Asthma	 5.3	 3.3	 6.4	 3.7	4.4		 6.8	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

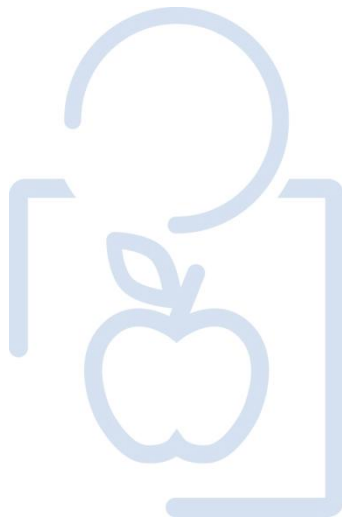
Sexually Transmitted Diseases	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000	 286.2	 112.6	 260.0	 78.5	185.0	 156.2	 103.2	
Primary & Secondary Syphilis Incidence per 100,000	 7.5	 2.7	 4.9	 0.9	4.4	 8.8	 4.5	
Chlamydia Incidence per 100,000	 709.5	 389.5	 818.1	 255.0	519.9	 435.6	 409.8	
Hepatitis B Incidence per 100,000	 2.8	 3.0	 1.2	 0.9	2.4	 1.6	 1.3	
% [Unmarried 18-64] 3+ Sexual Partners in Past Year					14.7		 7.1	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

Substance Abuse	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	 4.9	 7.5	 13.2	 8.5	7.1	 7.4	 9.0	 8.2
% Current Drinker	 48.4	 48.6	 38.8	 38.9	46.2	 47.7	 58.8	
% Chronic Drinker (Average 2+ Drinks/Day)	 3.9	 8.7	 3.0	 5.3	5.6	 3.8	 5.6	
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	 15.1	 18.6	 16.8	 17.1	16.7	 12.4	 16.7	 24.3
% Drinking & Driving in Past Month	 1.7	 2.8	 0.0	 0.6	1.8		 3.5	
% Driving Drunk or Riding with Drunk Driver	 4.3	 5.3	 3.5	 8.5	5.2		 5.5	
Drug-Induced Deaths (Age-Adjusted Death Rate)	 9.2	 7.9		 10.1	9.0	 9.8	 12.6	 11.3
% Illicit Drug Use in Past Month	 2.4	 1.6	 4.6	 3.8	2.5		 1.7	 7.1
% Ever Sought Help for Alcohol or Drug Problem	 3.9	 7.0	 5.6	 4.9	5.2		 3.9	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

Tobacco Use	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% Current Smoker	 22.0	 25.6	 24.4	 21.5	23.2	 17.6	 16.6	 12.0
% Someone Smokes at Home	 18.0	 20.2	 21.4	 18.6	19.1		 13.6	
% [Non-Smokers] Someone Smokes in the Home	 6.9	 11.2	 8.6	 9.0	8.8		 5.7	
% [Household With Children] Someone Smokes in the Home	 21.5	 11.0	 26.1	 11.4	16.6		 12.1	
% [Smokers] Received Advice to Quit Smoking					56.4		 63.7	
% [Smokers] Have Quit Smoking 1+ Days in Past Year					54.2		 56.2	 80.0
% Smoke Cigars	 1.6	 7.3	 8.0	 5.6	4.6		 4.2	 0.2
% Use Smokeless Tobacco	 3.3	 5.7	 3.4	 6.4	4.6		 2.8	 0.3
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

Vision	Each County Area vs. Others				Total Area	Total Area vs. Benchmarks		
	Bibb County	Houston County	Peach County	Other Counties		vs. GA	vs. US	vs. HP2020
% Blindness/Trouble Seeing	 12.1	 12.2	 14.9	 14.0	12.6		 6.9	
% Eye Exam in Past 2 Years	 60.0	 60.6	 59.0	 59.7	60.1		 57.5	
Note: In the green section, each county area is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.						 better	 similar	 worse

GENERAL HEALTH STATUS



Overall Health Status

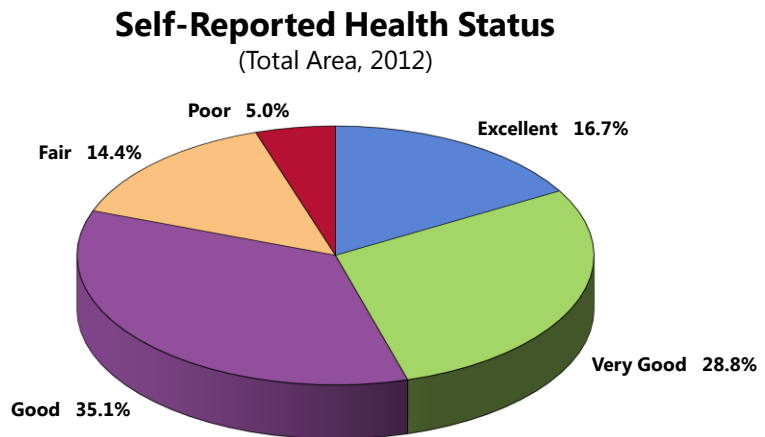
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

Self-Reported Health Status

A total of 45.5% of Total Area adults rate their overall health as "excellent" or "very good."

- Another 35.1% gave "good" ratings of their overall health.

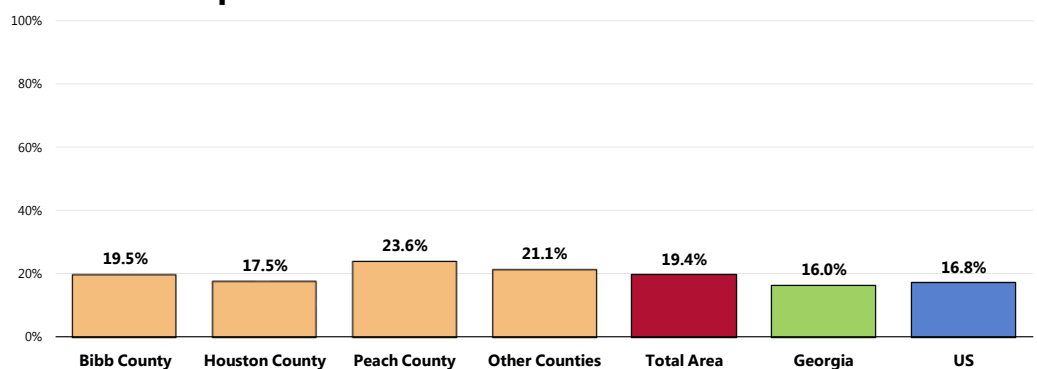


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

However, 19.4% of Total Area adults believe that their overall health is "fair" or "poor."

- Less favorable than statewide findings.
- Statistically similar to the national percentage.
- No statistical difference when viewed by county.

Experience "Fair" or "Poor" Overall Health



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

NOTE:

- Differences noted in the text represent significant differences determined through statistical testing.
- Where sample sizes permit, community-level data are provided.

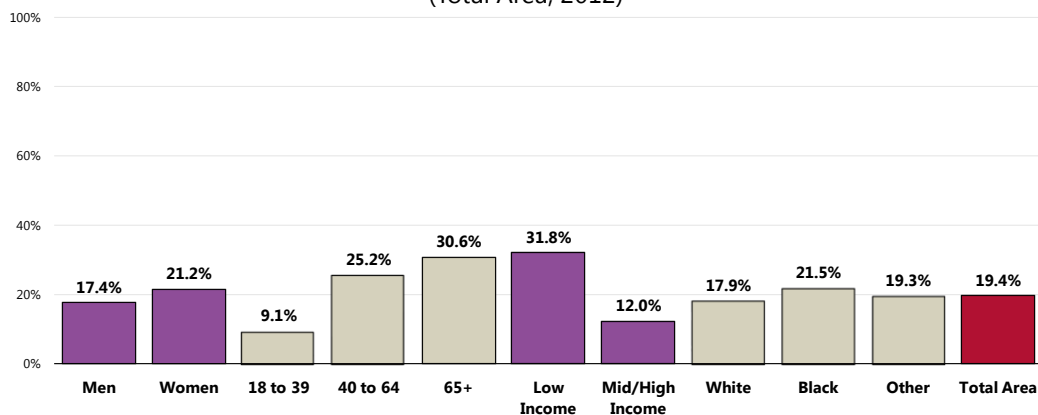
Adults more likely to report experiencing “fair” or “poor” overall health include:

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

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

Experience “Fair” or “Poor” Overall Health

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

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

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

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

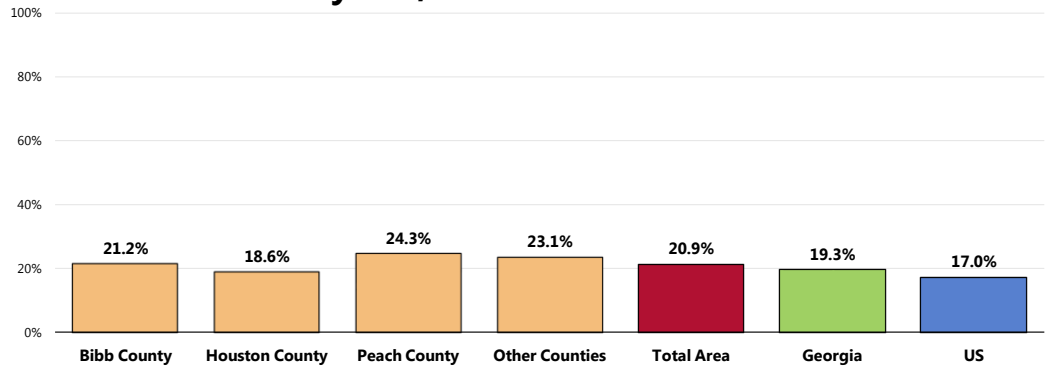
- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.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

– Healthy People 2020 (www.healthypeople.gov)

A total of 20.9% of Total Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Similar to the prevalence statewide.
- Less favorable than the national prevalence.
- Similar by county.

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



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

RELATED ISSUE:

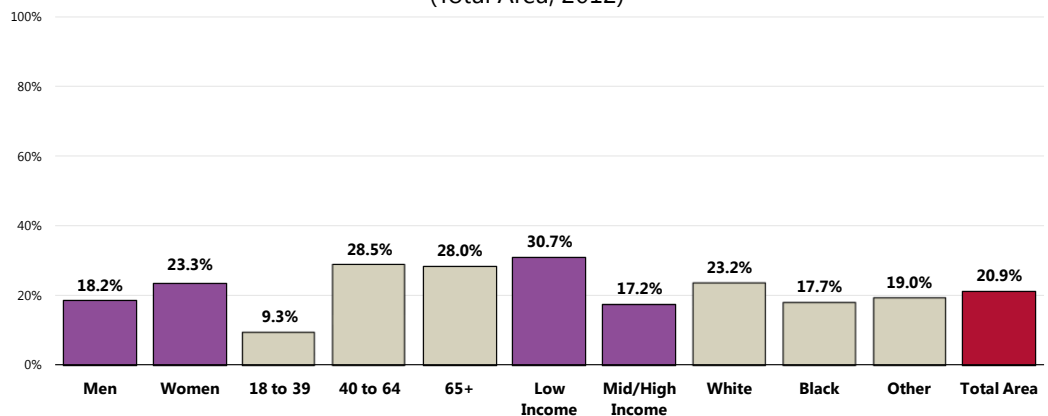
See also
*Potentially Disabling
 Conditions in the Death,
 Disease & Chronic
 Conditions* section of this
 report.

In looking at responses by key demographic characteristics, the following population segments are more likely to be limited in activities:

- 👥 Women.
- 👥 Adults aged 40 and older.
- 👥 Lower-income residents.
- 👥 Whites.

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

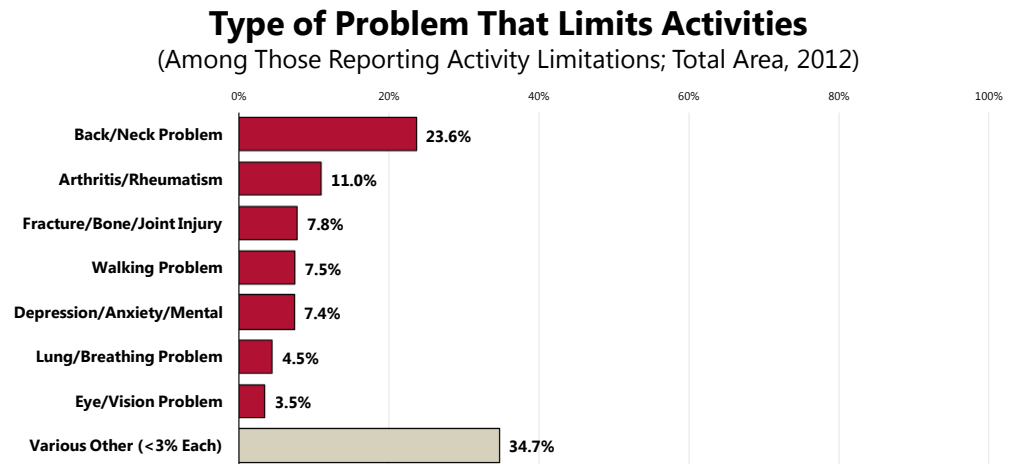
(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
 • Asked of all respondents.

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

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



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
Notes: • Asked of those respondents reporting activity limitations.

Mental Health & Mental Disorders

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

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the national Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

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

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

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

In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

– Healthy People 2020 (www.healthypeople.gov)

Mental Health Status

Self-Reported Mental Health Status

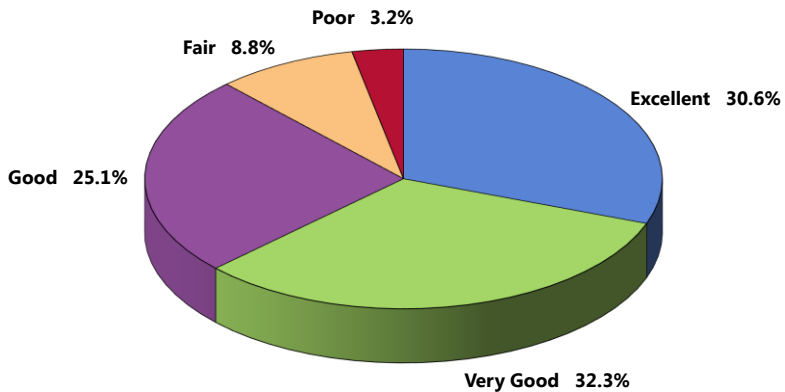
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

A total of 62.9% of Total Area adults rate their overall mental health as "excellent" or "very good."

- Another 25.1% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status

(Total Area, 2012)

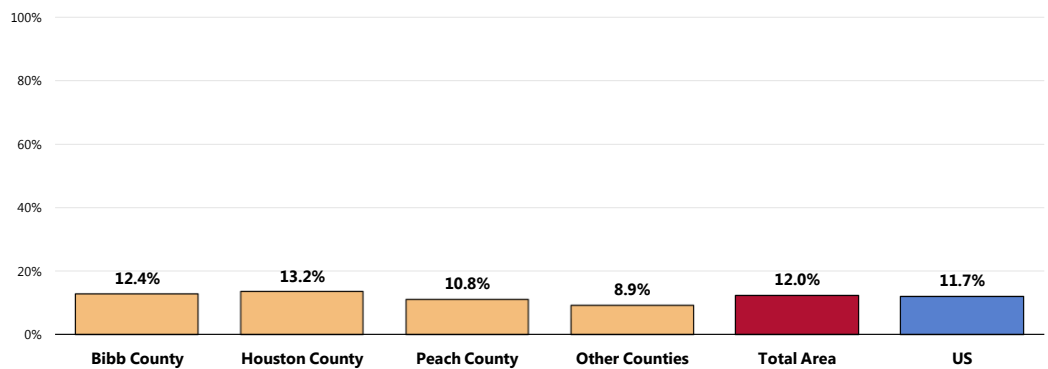


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]
Notes: • Asked of all respondents.

A total of 12.0% of Total Area adults, however, believe that their overall mental health is "fair" or "poor."

- Similar to the "fair/poor" response reported nationally.
- No significant difference when viewed by county.

Experience "Fair" or "Poor" Mental Health



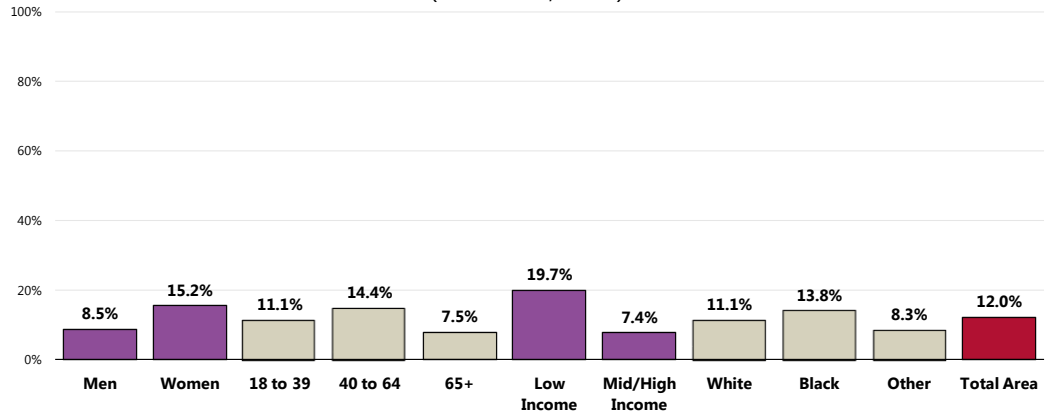
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



Women, adults age 40-64, and lower-income residents are more likely to report experiencing “fair/poor” mental health than their demographic counterparts.

Experience “Fair” or “Poor” Mental Health

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).

• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

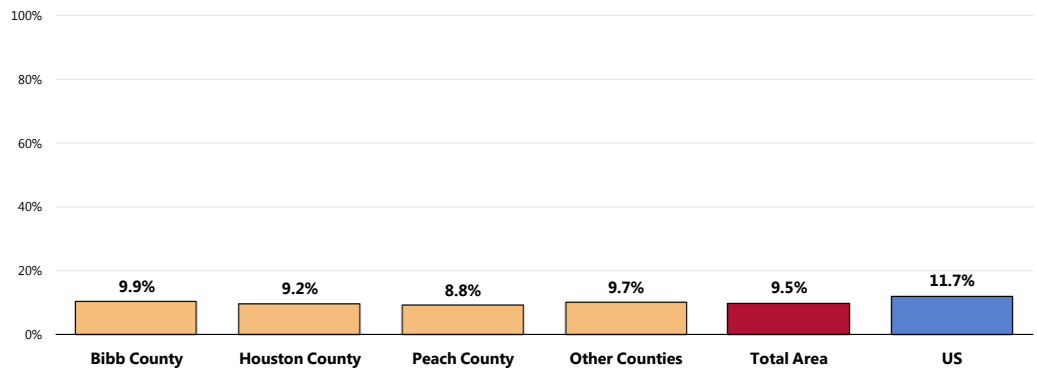
Depression

Major Depression

A total of 9.5% of Total Area adults have been diagnosed with major depression by a physician.

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

Have Been Diagnosed With Major Depression



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]

• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

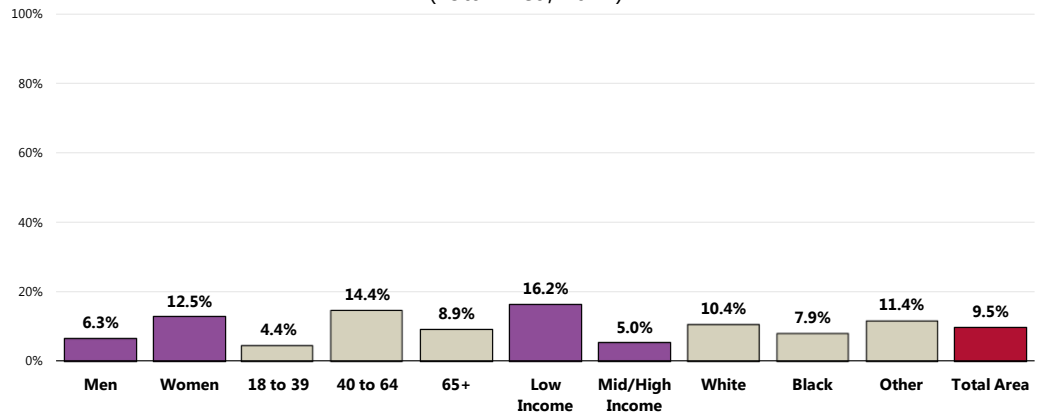
• “Other Counties” includes Jones, Twiggs, Monroe and Crawford counties combined.

The prevalence of major depression is notably higher among:

- 👥 Women.
- 👥 Adults between the ages of 40 and 64.
- 👥 Community members living at lower incomes.

Have Been Diagnosed With Major Depression

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

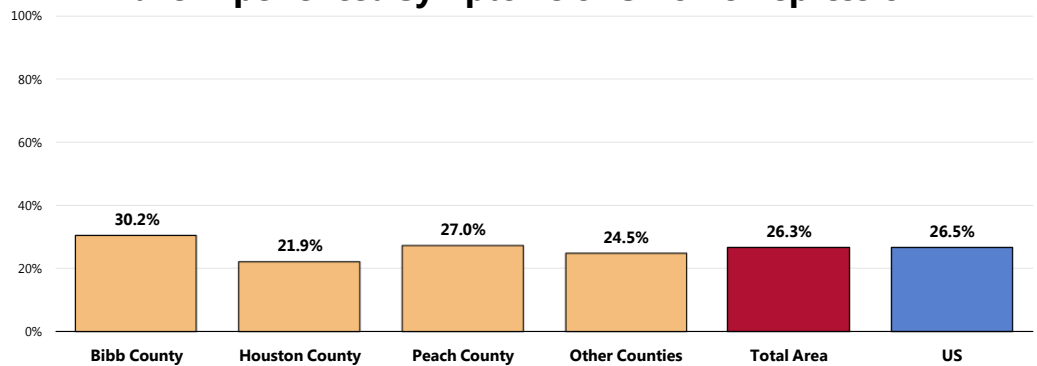
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Symptoms of Chronic Depression

A total of 26.3% of Total Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (chronic depression).

- Nearly identical to national findings.
- Highest in Bibb County; lowest in Houston County.

Have Experienced Symptoms of Chronic Depression







Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 113]

• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

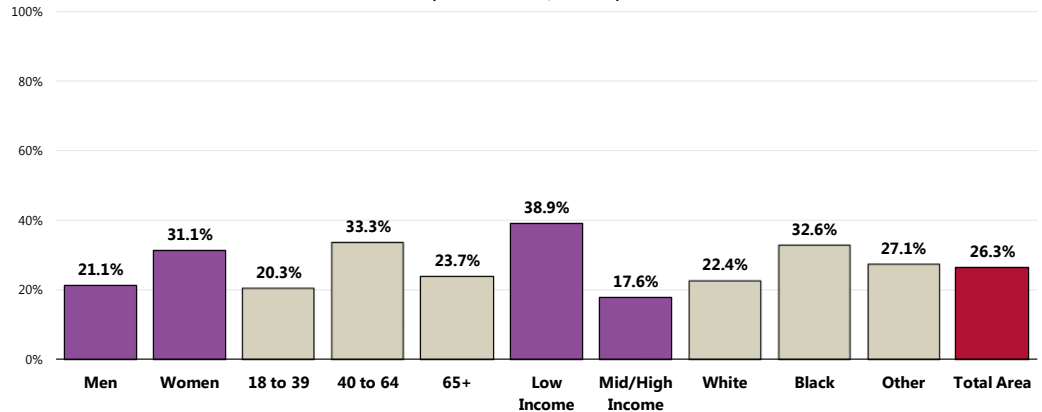
Notes: • Asked of all respondents.

• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

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

-  Women.
-  Adults aged 40 to 64.
-  Adults with lower incomes.
-  Black residents.

Have Experienced Symptoms of Chronic Depression (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 113]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

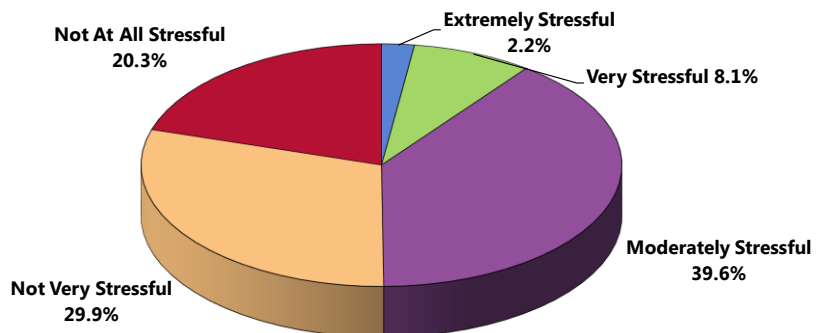
RELATED ISSUE:

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

One-half of Total Area adults considers a typical day to be "not very stressful" (29.9%) or "not at all stressful" (20.3%).

- Another 39.6% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day (Total Area, 2012)



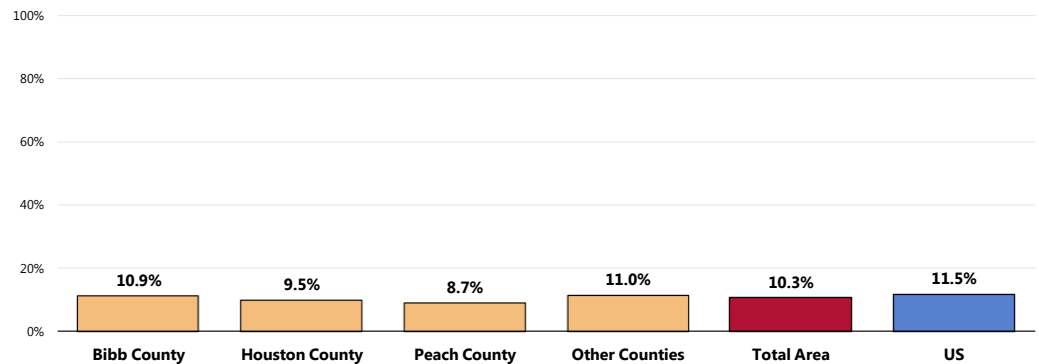
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]

Notes: • Asked of all respondents.

In contrast, 10.3% of Total Area adults experience “very” or “extremely” stressful days on a regular basis.

- Similar to national findings.
- Similar by county.

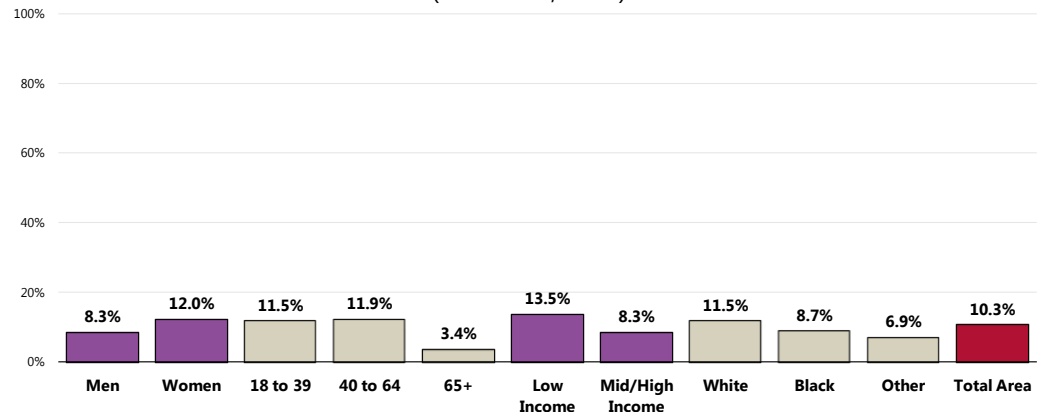
Perceive Most Days As “Extremely” or “Very” Stressful



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • “Other Counties” includes Jones, Twiggs, Monroe and Crawford counties combined.

👤 Note that high stress levels are more prevalent among adults under 65 and those living at lower income levels.

Perceive Most Days as “Extremely” or “Very” Stressful (Total Area, 2012)



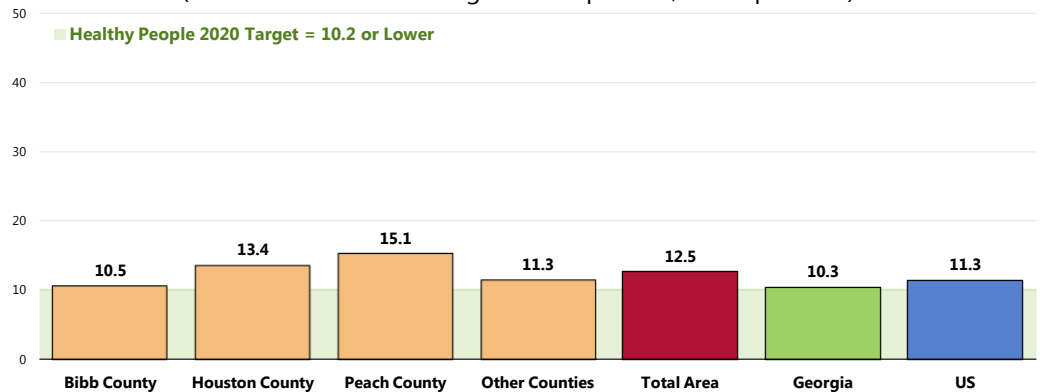
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Suicide

Between 2006 and 2008, there was an annual average age-adjusted suicide rate of 12.5 deaths per 100,000 population in the Total Area.

- Higher than the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.
- Higher in Houston and Peach counties.

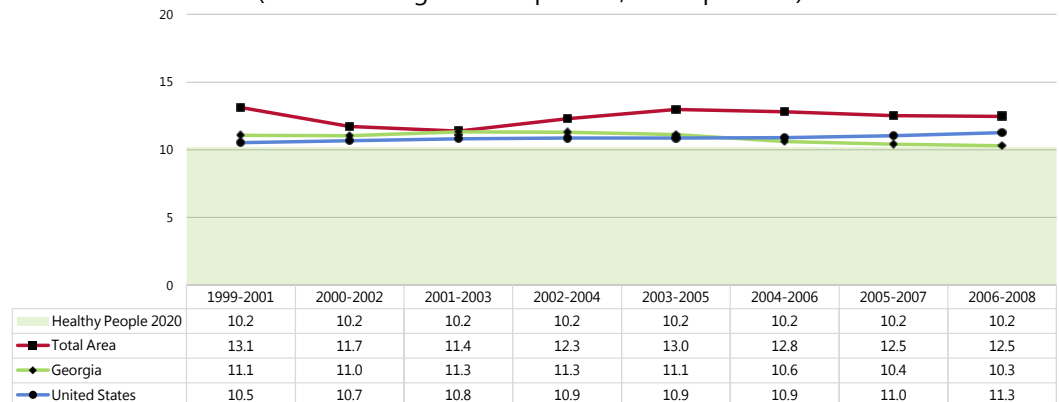
Suicide: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

The Total Area suicide rate has remained relatively stable over the past decade; across Indiana the rate decreased, while increasing somewhat nationally.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.

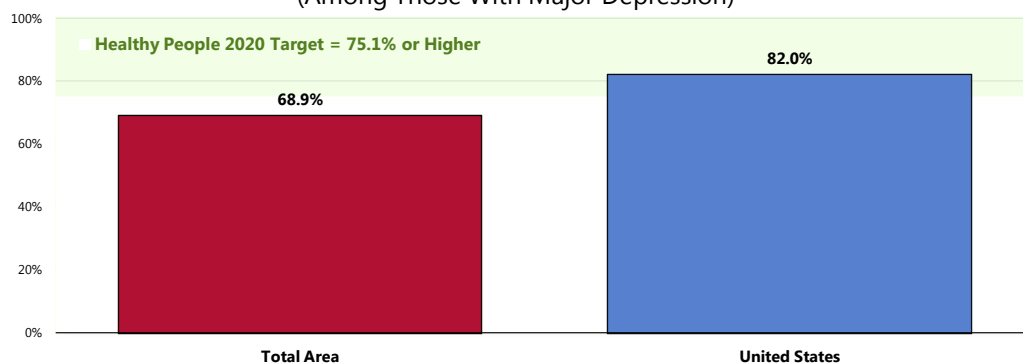
Mental Health Treatment

"Diagnosed depression" includes respondents reporting a past diagnosis of major depression by a physician.

Among adults with diagnosed depression, 68.9% acknowledge that they have sought professional help for a mental or emotional problem.

- Less favorable than national findings.
- Similar to the Healthy People 2020 target of 75.1% or higher.

Have Sought Professional Help for a Mental or Emotional Problem (Among Those With Major Depression)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-9.2]

Notes: • Asked of those respondents with major depression diagnosed by a physician.

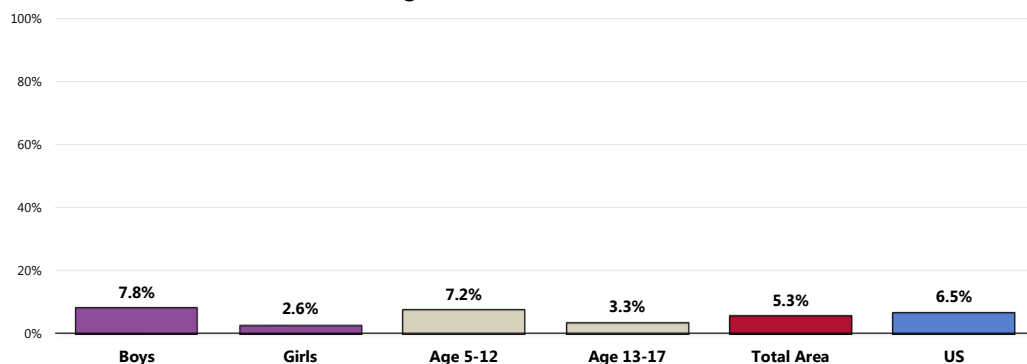
Children & ADD/ADHD

Among Total Area adults with children age 5 to 17, 5.3% report that their child takes medication for ADD/ADHD.

- Statistically similar to the national prevalence.
- The differences in ADD/ADHD prevalence by age and gender are not statistically significant.

Child Takes Medication for ADD/ADHD

(Among Parents of Children 5-17)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 5-17 at home.

Related Focus Group Findings: Mental Health

Many focus group participants discussed mental health in the community. The main issues discussed include:

- Access
- Psychiatrist shortage
- Law enforcement
- Disability services

Throughout the focus groups issues arose surrounding **access** to behavioral healthcare. The participants feel there are not enough mental health resources available for residents, specifically seniors, children, and low-income residents. River Edge and Phoenix Center are community service board agencies, but not all clinics have the same resources available to them. River Edge is the main inpatient facility, but it only has 28 adult beds and 16 youth beds. River Edge provides prevention, treatment, support, and crisis stabilization. It currently operates well over capacity.

"River Edge is over-serving its uninsured contract by about 40 percent, which means that for 40 percent of the work we do, there's not a dime. So at some point you have to say I can't do any more or we're going to go broke." — Bibb County Participant

River Edge has several satellite locations throughout the region, but the crisis stabilization is located in Macon, so distance can be a factor to accessing emergency care. A participant describes:

"Most of our referrals would be to River Edge. We just hired two licensed clinical social workers 'cause in most of these rural areas you have no mental health. By having more small rural mental health clinics, even if they were just open one day a week, that would probably help. 'Cause most of these people, if they have schizophrenia and other things, if they have to travel 30 minutes or even 40 minutes to get to River Edge, they're probably not going to." — Regional Participant

The behavioral health inpatient unit at the Coliseum Medical Center is only for adults. The Phoenix Center in Warner Robins is the closest facility for Peach County residents, but for inpatient care they would need to be transferred to Columbus. A participant explains:

"Well, they start at Phoenix Center and they go on a four-day commitment, usually in Columbus. There was a lady traveling from here all the way to Columbus by a Peach County deputy." — Peach County Participant

Beyond the limited inpatient treatment facilities, there are only a few psychiatrists to provide ongoing outpatient care. In many rural counties there are no private providers. Participants express an urgent need for comprehensive behavioral healthcare.

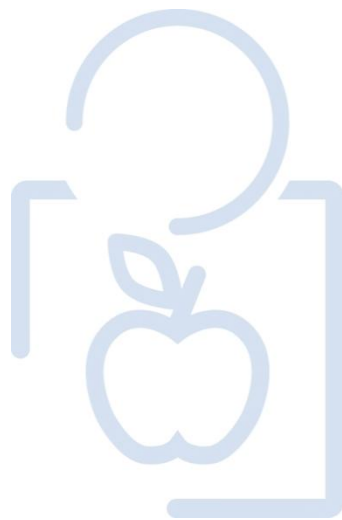
Participants also have concern about the **over-utilization of law enforcement** which is called to handle many situations with the mentally ill. Jail is not the appropriate place for mentally ill persons in crisis, but that is the current trend. Police must transport the person from the jail or hospital to an inpatient facility, which may be as far away as Augusta. This takes away from the available law enforcement personnel. One participant recalls:

"It's a tremendous tax burden because we still have to get the person to a mental facility to be checked. We still have to make sure we get all their medications, and we're having to deal with them with their mental aspects, and law enforcement is not truly prepared to deal on that level every hour, all day long. They're just supposed to keep them alive and keep them healthy to go to court. That is their job, not to try to rehabilitate." — Regional Participant

Disability screening and services are limited in the community as well. There are not enough providers to give appropriate diagnoses. The school system may diagnose, but then there is concern about the availability of resources to help the family. As a focus group member describes:

"Just even trying to diagnose a child is a huge problem in this county because of the shortage. The identifying agent is not the physician, but it is the school system, and the school system is so short-handed, until our children fall through the cracks. So we're sending children on to school who may have speech problems that may not be a result of anything physical, but because of the shortage of people who are available to deal with those children, those children are just being moved on." — Bibb County Participant

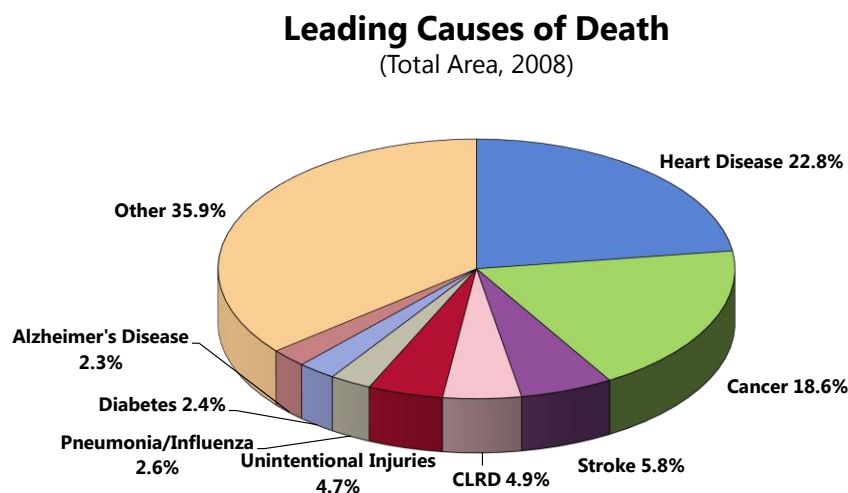
DEATH, DISEASE & CHRONIC CONDITIONS



Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for nearly one-half of all deaths in the Total Area in 2008.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

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

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

The following chart outlines 2006-2008 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Total Area.

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

Age-adjusted mortality rates in the Total Area are worse than national rates for suicide, heart disease, stroke, pneumonia-influenza, unintentional injuries (including motor vehicle crashes), firearm-related deaths, homicide, kidney disease and HIV/AIDS.

Of the causes outlined in the following chart for which Healthy People 2020 objectives have been established, Total Area rates fail to satisfy the related goals for each cause of death listed, with the exceptions of cirrhosis/liver disease and drug-induced deaths (both of which satisfy the related Healthy People 2020 goals).

Age-Adjusted Death Rates for Selected Causes

(2006-2008 Deaths per 100,000)

	Total Area	Georgia	US	HP2020
Diseases of the Heart	221.3	202.2	192.5	152.7*
Malignant Neoplasms (Cancers)	184.3	177.9	178.1	160.6
Cerebrovascular Disease (Stroke)	53.6	49.4	42.2	33.8
Unintentional Injuries	44.8	43.0	39.5	36.0
Chronic Lower Respiratory Disease (CLRD)	41.4	44.4	41.8	n/a
Kidney Disease	28.6	21.2	14.6	n/a
Diabetes Mellitus	22.0	19.2	22.5	19.6*
Alzheimer's Disease	19.9	25.5	23.2	n/a
Pneumonia/Influenza	19.6	18.9	17.0	n/a
Motor Vehicle Crashes	19.0	17.7	14.1	12.4
Firearm-Related	15.8	12.6	10.2	9.2
Intentional Self-Harm (Suicide)	12.5	10.3	11.3	10.2
Homicide/Legal Intervention	9.1	7.5	6.1	5.5
Drug-Induced	9.0	9.8	12.6	11.3
Cirrhosis/Liver Disease	7.1	7.4	9.0	8.2
HIV/AIDS	6.8	6.9	3.9	3.3

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.

• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.

• *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

• Local, state and national data are simple three-year averages.

Cardiovascular Disease

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

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

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

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

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

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

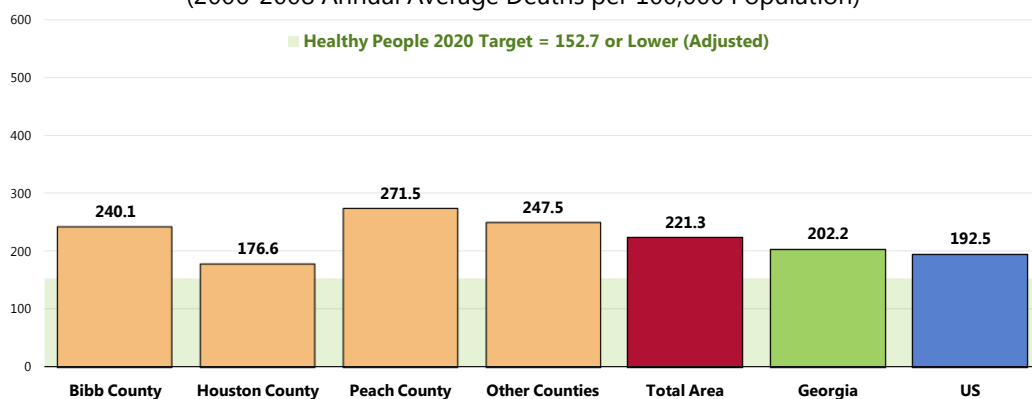
Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

Between 2006 and 2008, there was an annual average age-adjusted heart disease mortality rate of 221.3 deaths per 100,000 population in the Total Area.

- Worse than the statewide rate.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target (as adjusted to account for all diseases of the heart).
- Highest in Peach County; lowest (most favorable) in Houston County.

Heart Disease: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)



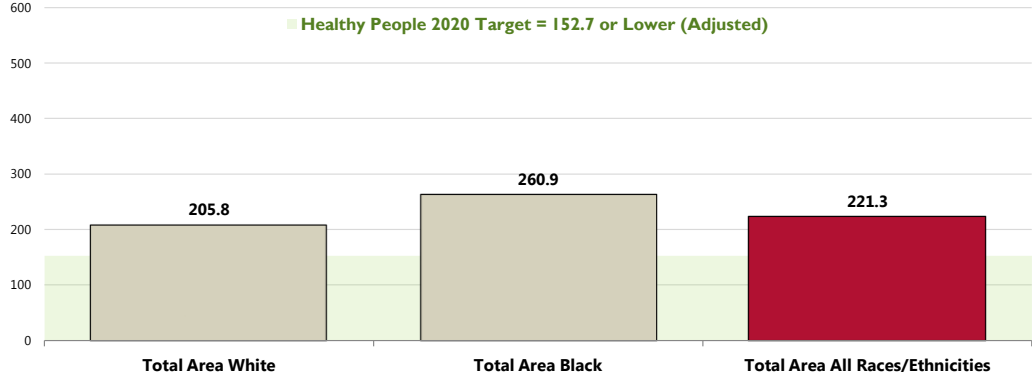
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]

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




By race, the heart disease mortality rate is higher among Blacks than Whites in the Total Area.

Heart Disease: Age-Adjusted Mortality by Race (2006-2008 Annual Average Deaths per 100,000 Population)



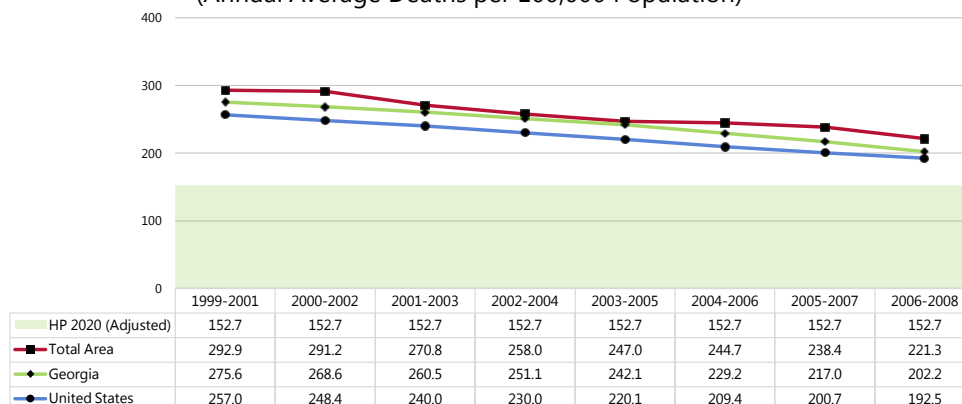
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]

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

-  The heart disease mortality rate has decreased in the Total Area, echoing the decreasing trends across Georgia and the US overall.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 - Local, state and national data are simple three-year averages.
 - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

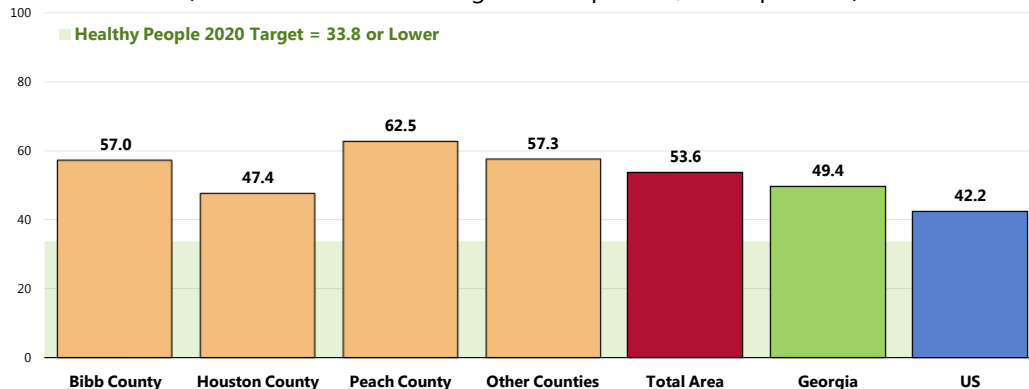
Stroke Deaths

Between 2006 and 2008, there was an annual average age-adjusted stroke mortality rate of 53.6 deaths per 100,000 population in the Total Area.

- Less favorable than the Georgia rate.
- Less favorable than the national rate.
- Fails to satisfy to the Healthy People 2020 target of 33.8 or lower.
- Highest in Peach County.

Stroke: Age-Adjusted Mortality

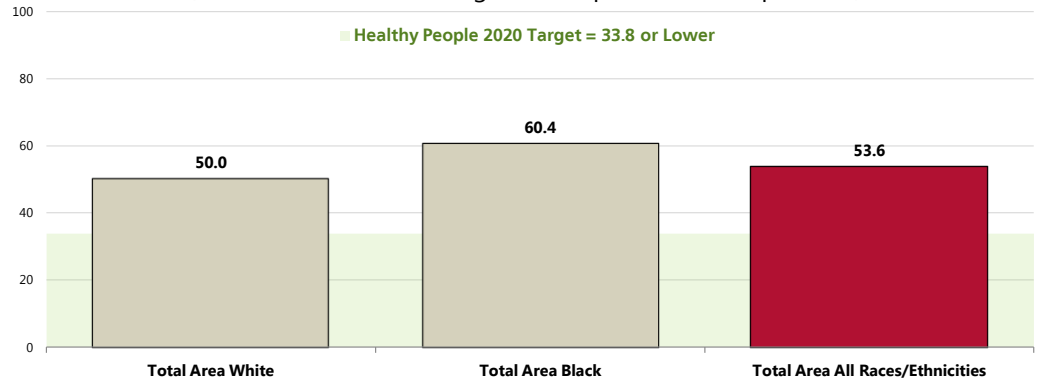
(2006-2008 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 - Local, state and national data are simple three-year averages.
 - "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Stroke mortality is higher among Blacks when compared with Whites in the Total Area.

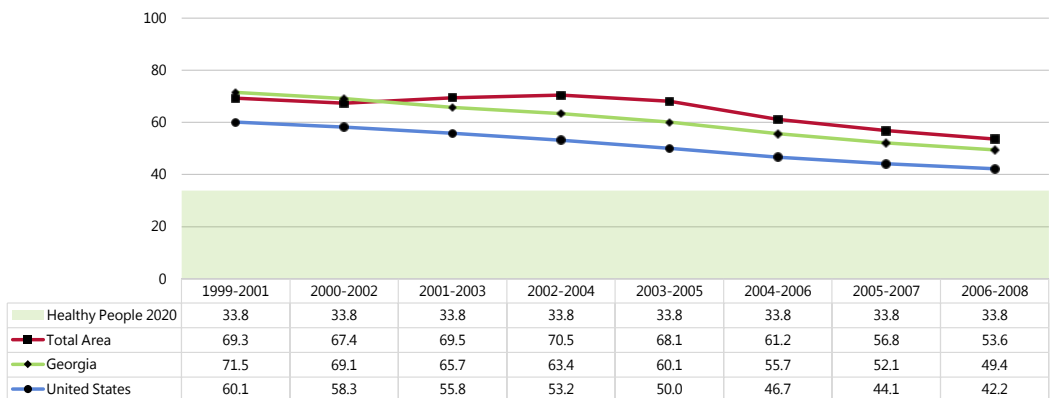
Stroke: Age-Adjusted Mortality by Race (2006-2008 Annual Average Deaths per 100,000 Population)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 Notes: US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
 • 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.
 • Local, state and national data are simple three-year averages.

The stroke rate has declined in recent years, echoing the trends reported across Georgia and the US overall.

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



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 Notes: US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
 • 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.
 • Local, state and national data are simple three-year averages.

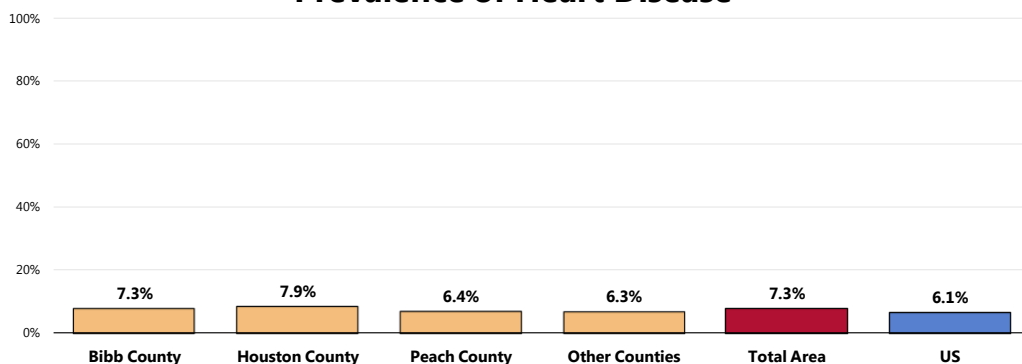
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 7.3% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Similar to the national prevalence.
- Similar by county.

Prevalence of Heart Disease

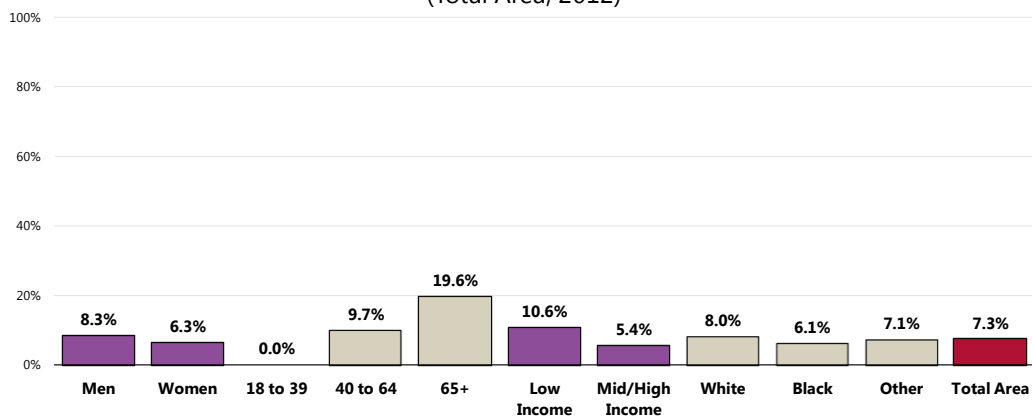


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 141]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

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

- 👤 Adults aged 40 and older.
- 👤 Lower-income residents.

Prevalence of Heart Disease (Total Area, 2012)



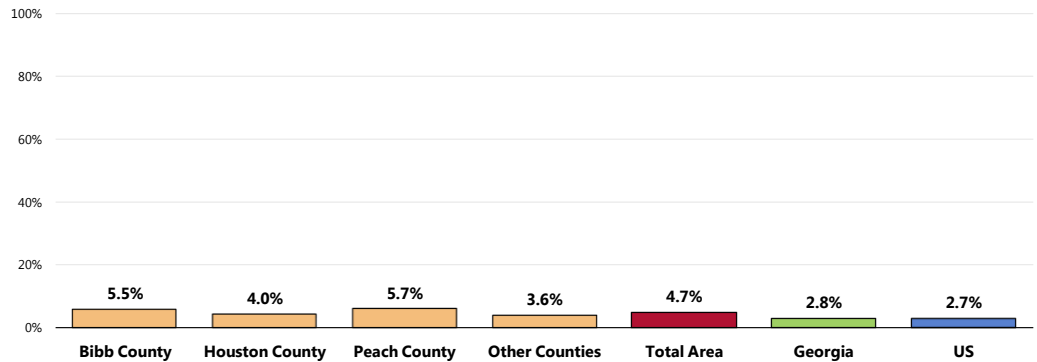
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 141]
Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prevalence of Stroke

A total of 4.7% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Worse than statewide findings.
- Worse than national findings.
- No significant difference by county.

Prevalence of Stroke



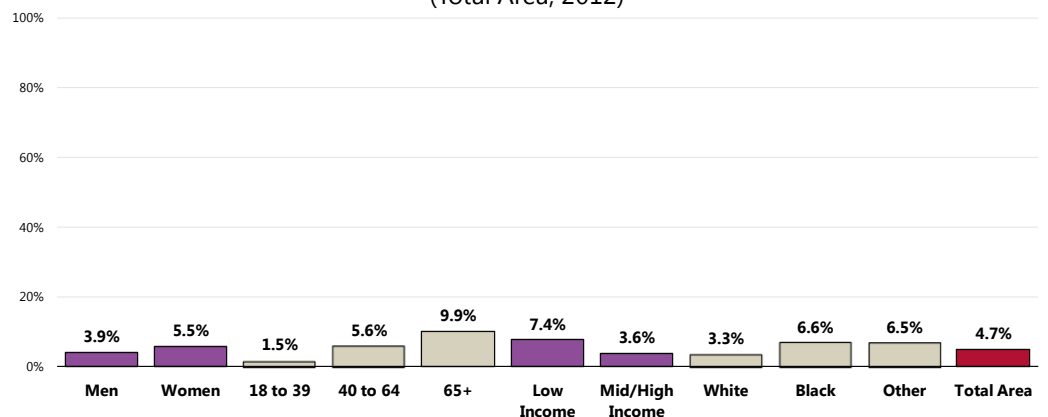
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Georgia data.

Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Adults more likely to have been diagnosed with stroke include:

- Residents aged 40 and older.
- Lower-income adults.

Prevalence of Stroke (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Cardiovascular Risk Factors

Hypertension (High Blood Pressure)

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

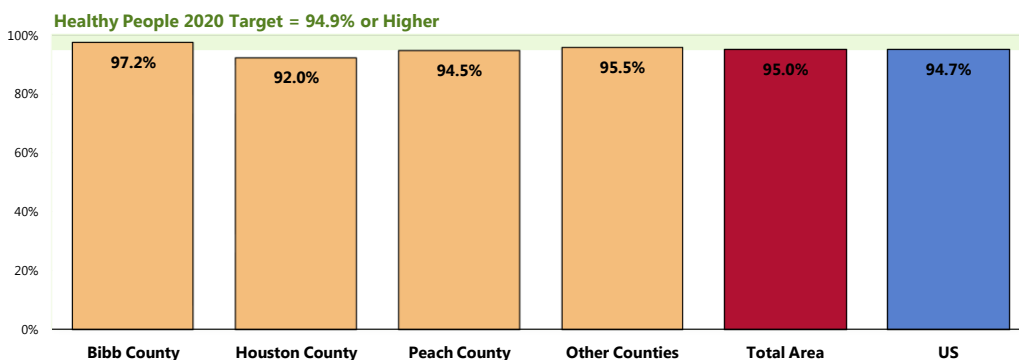
– Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure Testing

A total of 95.0% of Total Area adults have had their blood pressure tested within the past two years.

- Similar to national findings.
- Almost identical to the Healthy People 2020 target (94.9% or higher).
- Highest in Bibb County; lowest in Houston County.

Have Had Blood Pressure Checked in the Past Two Years



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-4]
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

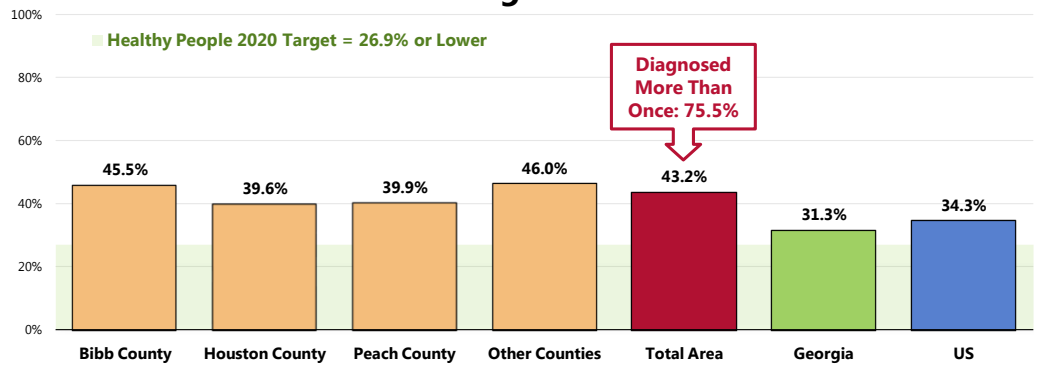
Prevalence of Hypertension

A total of 43.2% of adults have been told at some point that their blood pressure was high.

- Less favorable than the Georgia prevalence.
- Less favorable than the national prevalence.
- Fails to satisfy the Healthy People 2020 target (26.9% or lower).
- Similar by county.

👥 Among hypertensive adults, 75.5% have been diagnosed with high blood pressure more than once.

Prevalence of High Blood Pressure



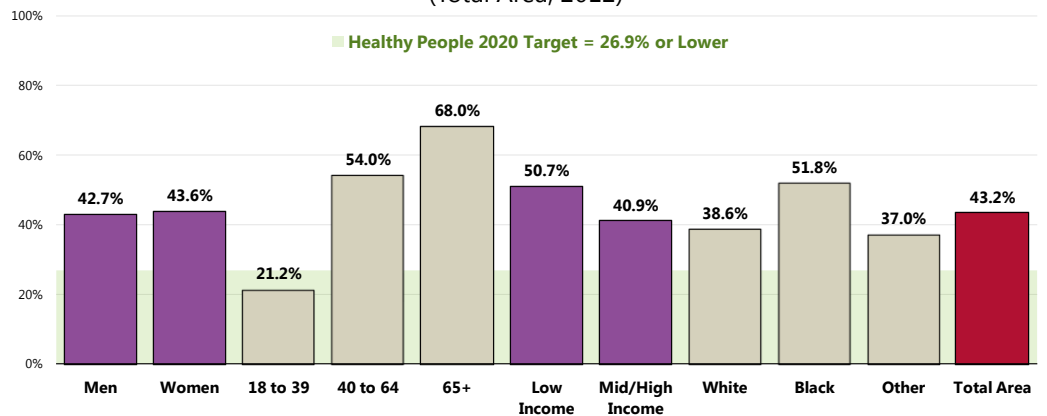
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 47, 142]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2009 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Hypertension diagnoses are higher among:

- 👤 Adults age 40 and older, and especially those age 65+.
- 👤 Lower-income residents.
- 👤 Blacks.

Prevalence of High Blood Pressure

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Respondents reporting high blood pressure were further asked:

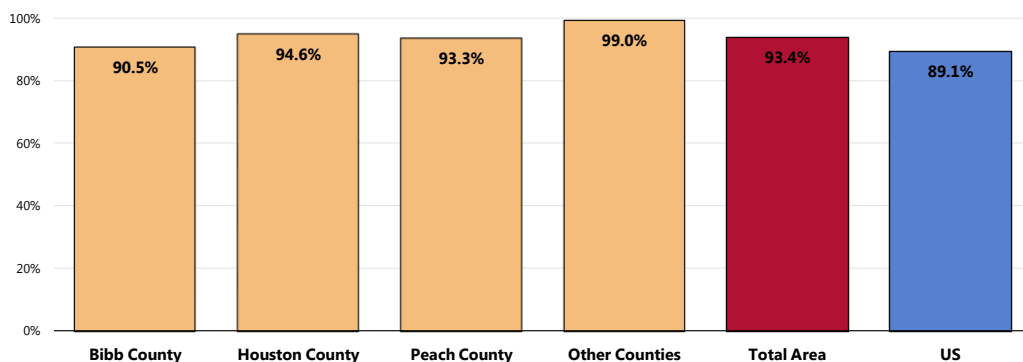
"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"

Hypertension Management

Among respondents who have been told that their blood pressure was high, 93.4% report that they are currently taking actions to control their condition.

- Similar to national findings.
- Most favorable in the Other Counties area.

Taking Action to Control Hypertension (Among Adults With High Blood Pressure)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents who have been diagnosed with high blood pressure.
 • In this case, the term "action" refers to medication, change in diet, and/or exercise.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

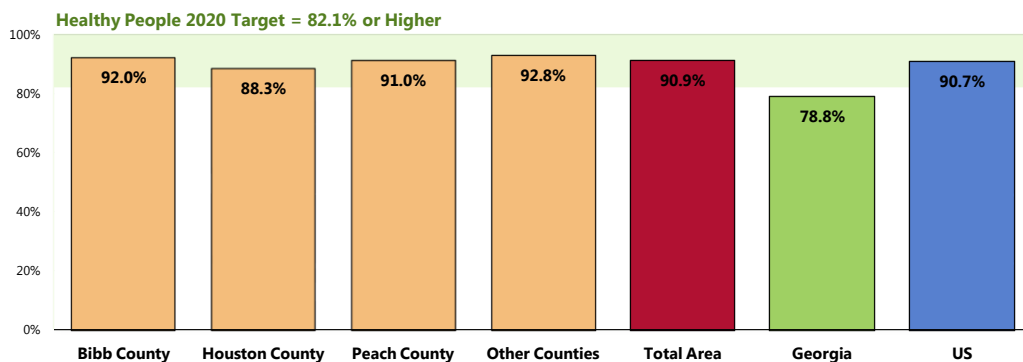
High Blood Cholesterol

Blood Cholesterol Testing

90.9% of area adults have had their blood cholesterol checked in the past 5 years.

- More favorable than Georgia findings.
- Nearly identical to the national findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- No statistical difference by county.

Have Had Blood Cholesterol Levels Checked in the Past Five Years



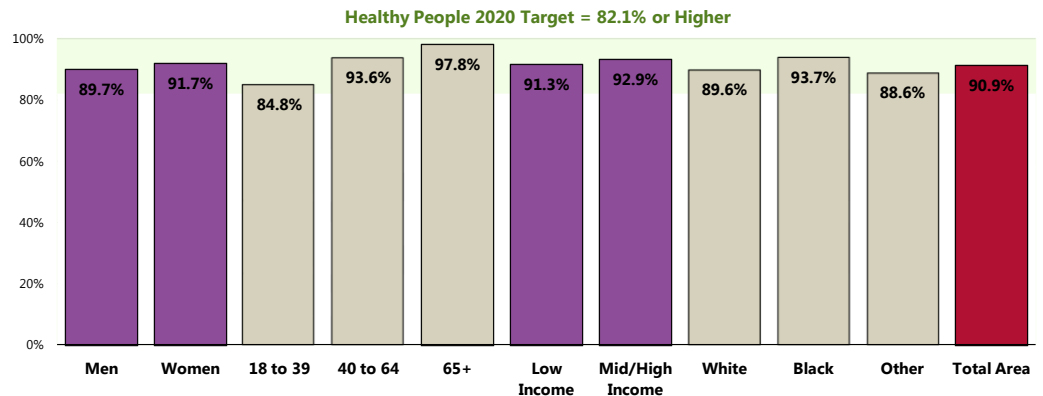
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-6]
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

The following demographic segments report lower screening levels:

- 👤 Adults under age 40 (note the positive correlation with age).
- 👤 Non-Blacks.

Have Had Blood Cholesterol Levels Checked in the Past Five Years

(Total Area, 2012)



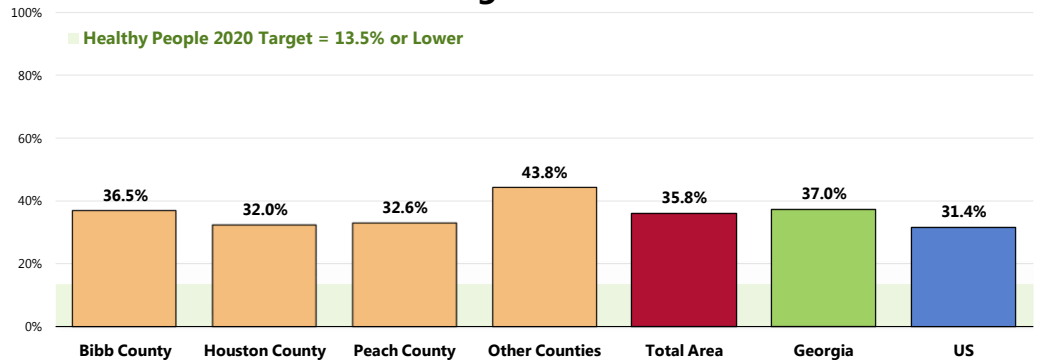
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-6]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Self-Reported High Blood Cholesterol

A total of 35.8% of adults have been told by a health professional that their cholesterol level was high.

- Comparable to Georgia findings.
- Higher than the national prevalence.
- More than twice the Healthy People 2020 target (13.5% or lower).
- Worst in the Other Counties region.

Prevalence of High Blood Cholesterol



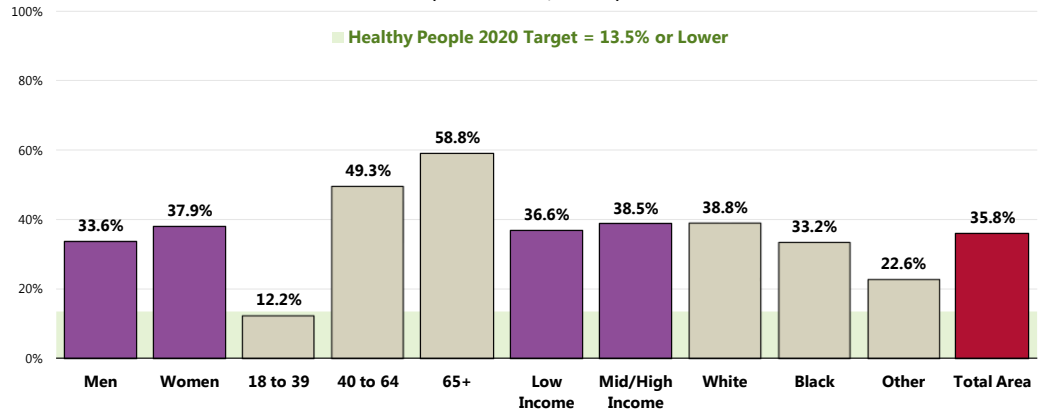
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
 Notes: • Asked of all respondents.
 • *The Georgia data reflects those adults who have been tested for high cholesterol and who have been diagnosed with it.
 • *Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Note that 14.2% of Total Area adults report not having high blood cholesterol, but: 1) have never had their blood cholesterol levels tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

- 👤 Note the positive correlation between age and high blood cholesterol.
- 👤 Whites report a higher prevalence than Blacks and “Other” races.
- 👤 Keep in mind that “unknowns” are quite high (25.3%) in young adults.

Prevalence of High Blood Cholesterol

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

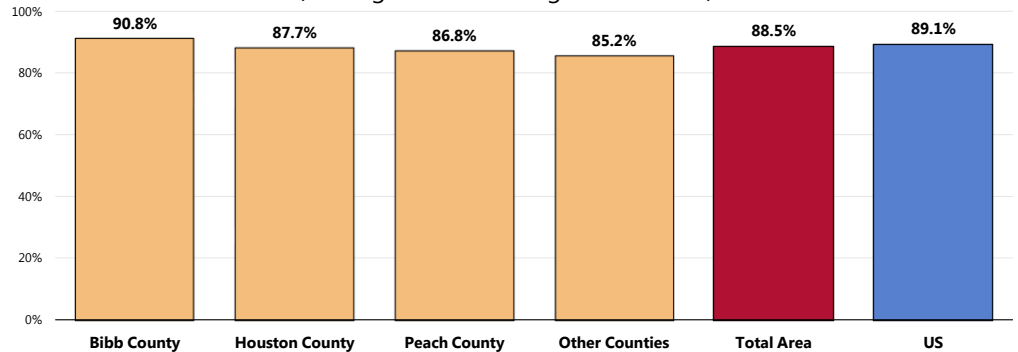
High Cholesterol Management

Among adults who have been told that their blood cholesterol was high, 88.5% report that they are currently taking actions to control their cholesterol levels.

- Similar to that found nationwide.
- Similar by county.

Taking Action to Control High Blood Cholesterol Levels

(Among Adults with High Cholesterol)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 51]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents who have been diagnosed with high blood cholesterol levels.
 • In this case, the term “action” refers to medication, change in diet, and/or exercise.
 • “Other Counties” includes Jones, Twiggs, Monroe and Crawford counties combined.

Respondents reporting high cholesterol were further asked:

“Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?”

Total Cardiovascular Risk

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

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

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

Three health-related behaviors contribute markedly to cardiovascular disease:

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

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

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

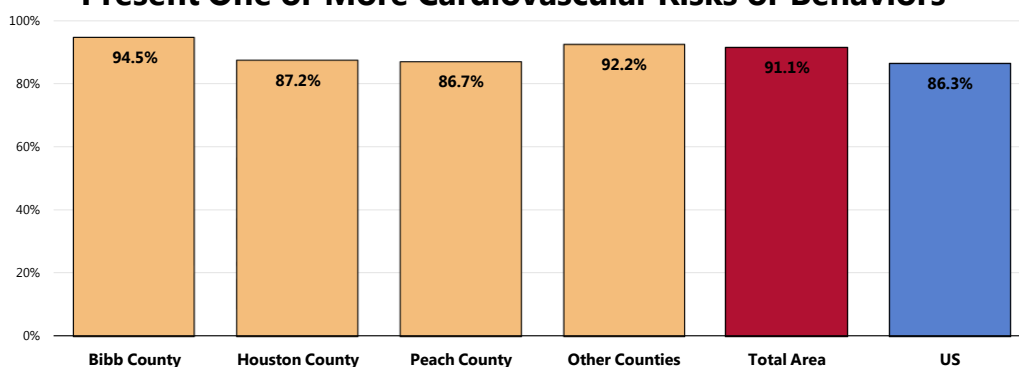
Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as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

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

A total of 91.1% of Total Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Higher than national findings.
- Highest in Bibb County.

Present One or More Cardiovascular Risks or Behaviors



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 144]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

RELATED ISSUE:

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

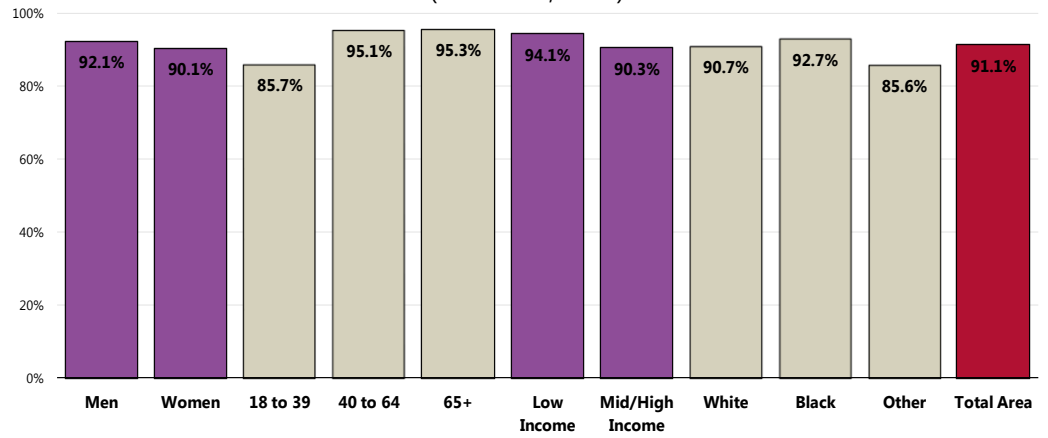
Adults more likely to exhibit cardiovascular risk factors include:

👤 Adults age 40 and older.

👤 Lower-income respondents.

Present One or More Cardiovascular Risks or Behaviors

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 144]

Notes:

- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Cancer

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

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

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

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

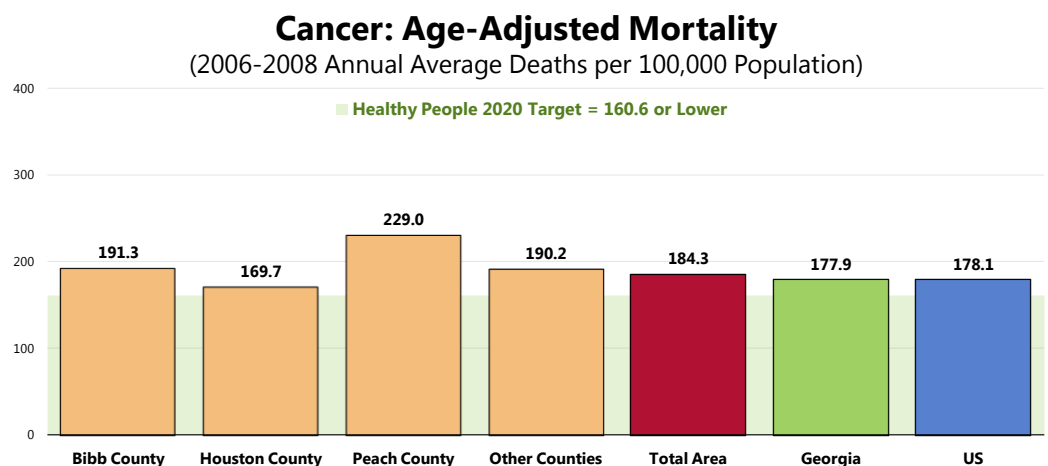
– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths


All Cancer Deaths

Between 2006 and 2008, there was an annual average age-adjusted cancer mortality rate of 184.3 deaths per 100,000 population in the Total Area.

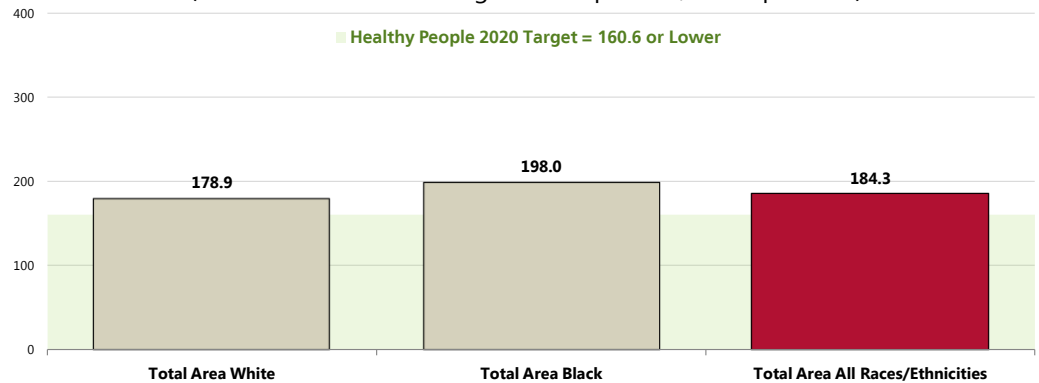
- Statistically similar to the statewide rate.
- Statistically similar to the national rate.
- Fails to satisfy the Healthy People 2020 target of 160.6 or lower.
- Unfavorably high in Peach County; lowest in Houston County.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.
● "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

 The cancer mortality rate is higher among Total Area Blacks.

Cancer: Age-Adjusted Mortality by Race (2006-2008 Annual Average Deaths per 100,000 Population)




Sources:

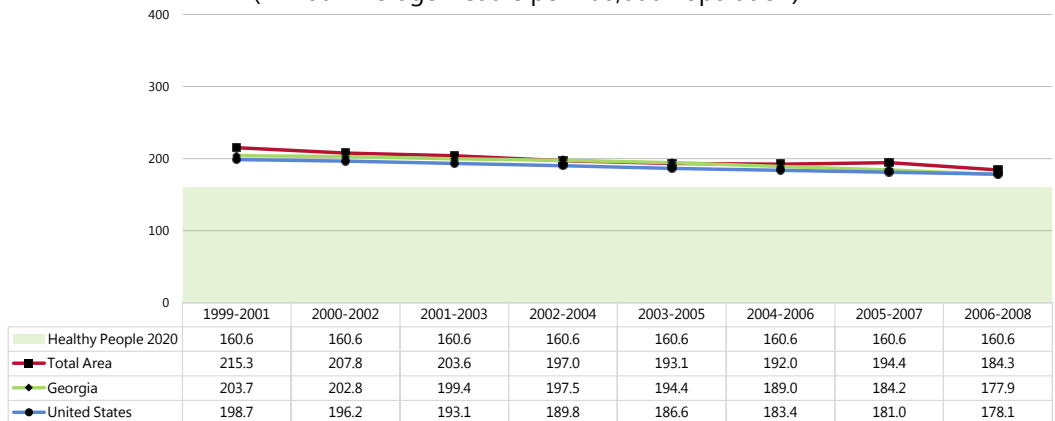
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes:

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

 Cancer mortality has decreased over the past decade in the Total Area; the same trend is apparent both statewide and nationwide.

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



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes:

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

Cancer Deaths by Site

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

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

As can be seen in the following chart (referencing 2006-2008 annual average age-adjusted death rates):

- The Total Area **lung, prostate and colorectal cancer** death rates are higher than the state and US rates.
- In contrast, the Total Area **female breast cancer** death rate is lower than both the Georgia and US rates.

Note that the Total Area lung, prostate and colorectal cancer death rates detailed below fail to satisfy the related Healthy People 2020 targets; the Total Area female breast cancer rate, however, is similar to the related objective.

Age-Adjusted Cancer Death Rates by Site

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

	Total Area	Georgia	US	HP2020
Lung Cancer	59.2	44.7	50.5	45.5
Prostate Cancer	29.8	26.9	23.1	21.2
Colorectal Cancer	21.3	17.7	16.8	14.5
Female Breast Cancer	20.1	22.5	23.0	20.6

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

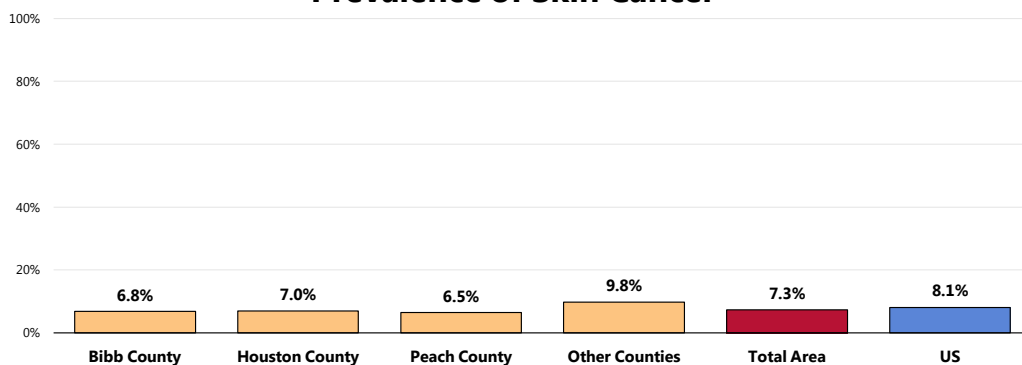
Prevalence of Cancer

Skin Cancer

A total of 7.3% of surveyed Total Area adults report having been diagnosed with skin cancer.

- Comparable to the national average.
- Comparable by county.

Prevalence of Skin Cancer



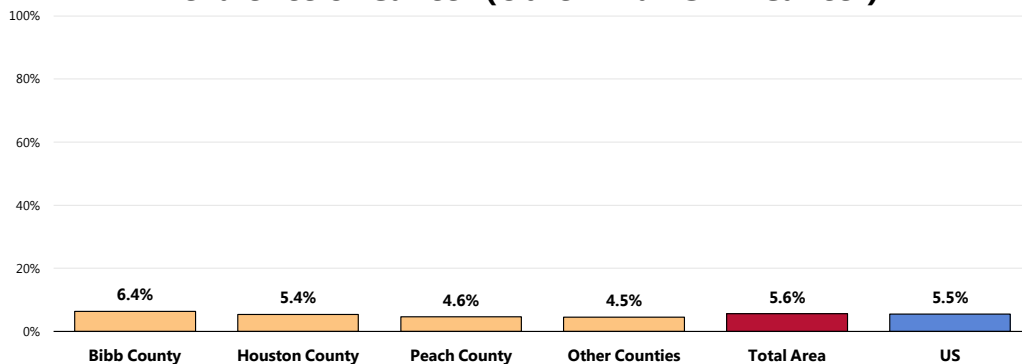
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 31]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Other Cancer

A total of 5.6% of respondents have been diagnosed with some type of (non-skin) cancer.

- Nearly identical to the national prevalence.
- No significant difference by county.

Prevalence of Cancer (Other Than Skin Cancer)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Cancer Risk

RELATED ISSUE:

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

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

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

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

Cancer Screenings

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

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

Prostate Cancer Screenings

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

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

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

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

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

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

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

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

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

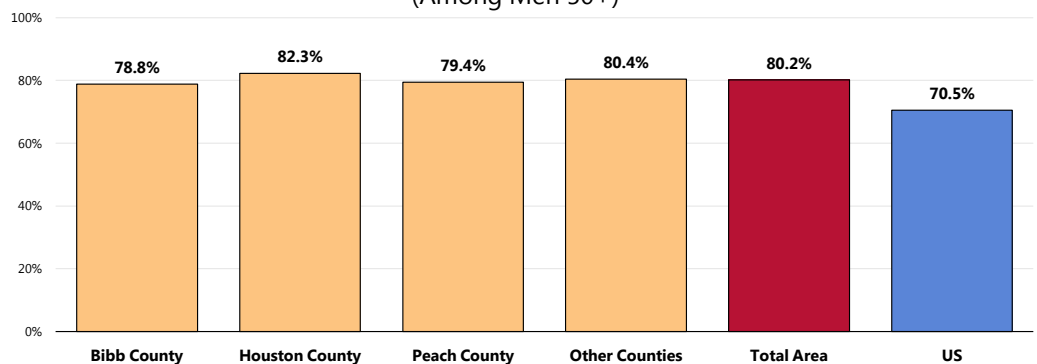
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

PSA Testing and/or Digital Rectal Examination

Among men age 50 and older, 8 in 10 (80.2%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

- More favorable than national findings.
- No significant difference by county.

Have Had a Prostate Screening in the Past Two Years (Among Men 50+)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all male respondents 50 and older.

Female Breast Cancer Screening

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

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

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


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

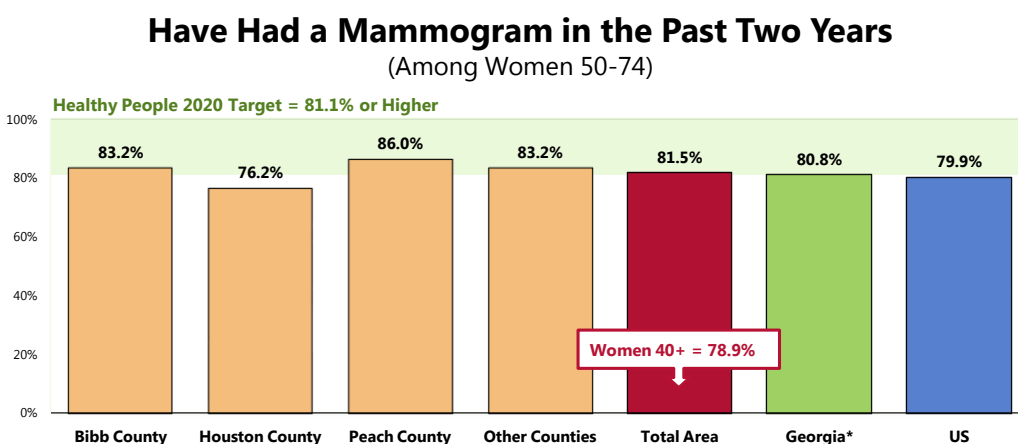
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Mammography

Among women age 50-74, 81.5% have had a mammogram within the past two years.

- Similar to statewide findings (which represent all women 50+).
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- No significant difference by county.

 Among Total Area women 40+, 78.9% had a mammogram in the past two years.



Sources:

- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 145-146]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-17]

Notes:

- Reflects female respondents 50 to 74.
- *Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).
- "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Cervical Cancer Screenings

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

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

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

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

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

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

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

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

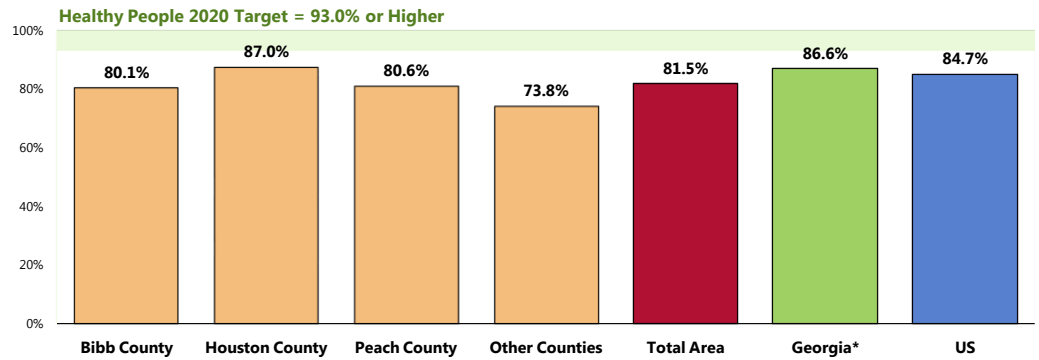
Pap Smear Testing

Among women age 21 to 65, 81.5% have had a Pap smear within the past three years.

- Less favorable than Georgia findings (which represents all women 18+).
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- Favorably high in Houston County.

Have Had a Pap Smear in the Past Three Years

(Among Women 21-65)



- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Georgia data.
 - 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-15]
- Notes:
- Reflects female respondents age 21-65.
 - *Note that the Georgia percentage represents all women 18 and older.
 - "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Colorectal Cancer Screenings

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

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

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

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

Colorectal Cancer Screening

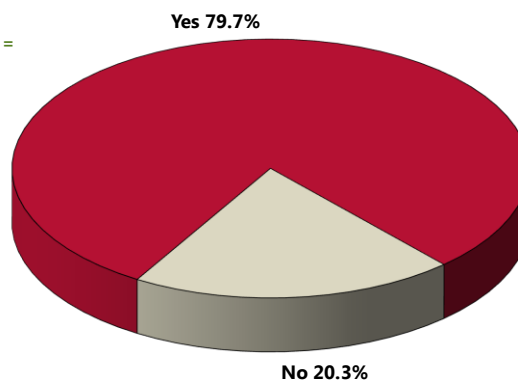
Among adults age 50-75, 79.7% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/ colonoscopy [lower endoscopy] within the past 10 years).

- Satisfies the Healthy People 2020 target (70.5% or higher).
- Comparable by county (not shown).

Have Had a Colorectal Cancer Screening

(Among Total Area Adults 50-75)

Healthy People 2020 Target =
70.5% or Higher



Sources: • Professional Research Consultants, Inc. PRC Community Health Survey. [Item 151]
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-16]
Notes: • Asked of all respondents age 50 through 75.
• In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

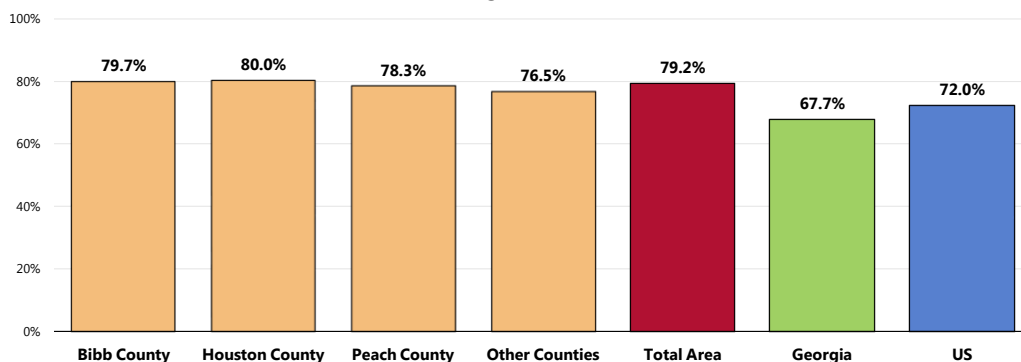
Sigmoidoscopy/Colonoscopy

Among adults age 50 and older, nearly 8 in 10 (79.2%) have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.

- More favorable than Georgia findings.
- More favorable than national findings.
- Similar by county.

Have Ever Had a Lower Endoscopy Exam

(Among Adults 50+)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [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): 2010 Georgia data.
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents 50+.
• Lower endoscopy includes either sigmoidoscopy or colonoscopy.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

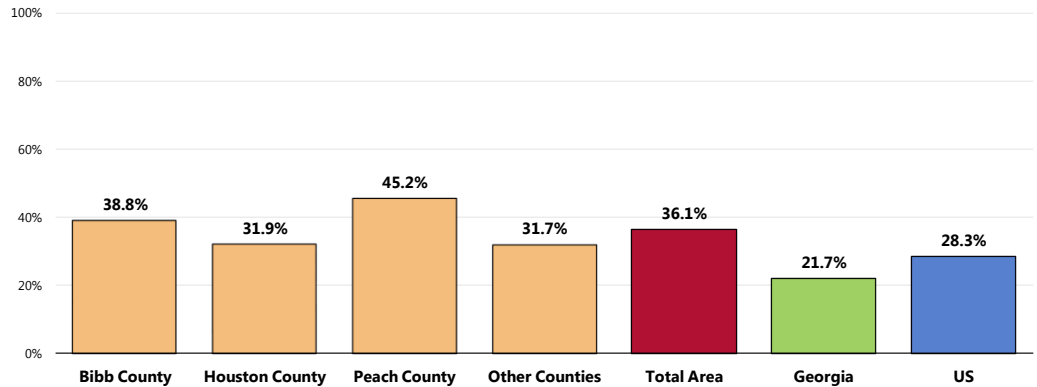
Blood Stool Testing

Among adults age 50 and older, 36.1% have had a blood stool test (aka “fecal occult blood test”) within the past two years.

- More favorable than Georgia findings.
- More favorable than national findings.
- Favorably high in Peach County.

Have Had a Blood Stool Test in the Past Two Years

(Among Adults 50+)



Sources:

- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 150]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Georgia data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:

- Asked of all respondents 50+.
- “Other Counties” includes Jones, Twiggs, Monroe and Crawford counties combined.

Respiratory Disease

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

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

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

Several additional respiratory conditions and respiratory hazards, including infectious agents and occupational and environmental exposures, are covered in other areas of Healthy People 2020. Examples include tuberculosis, lung cancer, acquired immunodeficiency syndrome (AIDS), pneumonia, occupational lung disease, and smoking. Sleep Health is now a separate topic area of Healthy People 2020.

Currently in the United States, more than 23 million people have asthma. Approximately 13.6 million adults have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

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

Risk factors for asthma currently being investigated include:

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

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

Age-Adjusted Respiratory Disease Deaths

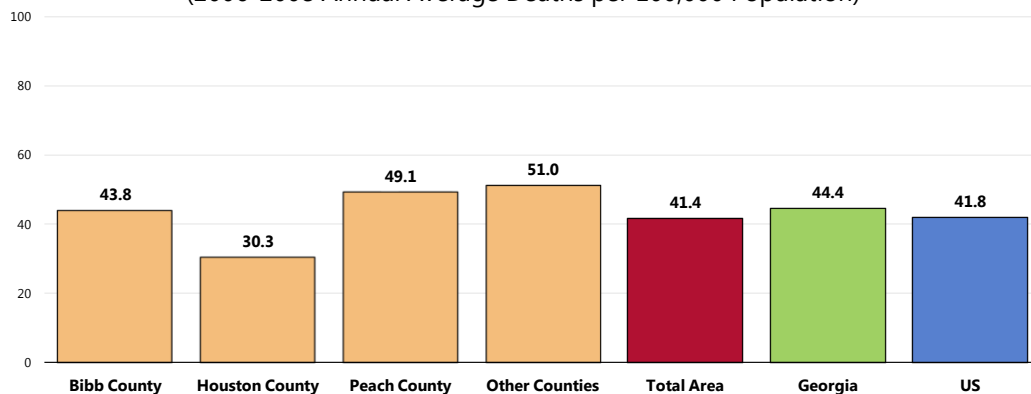
Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2006 and 2008, there was an annual average age-adjusted CLRD mortality rate of 41.4 deaths per 100,000 population in the Total Area.

- Lower than found statewide.
- Nearly identical to the US rate.
- Higher in Peach County and the "Other Counties" combined area.

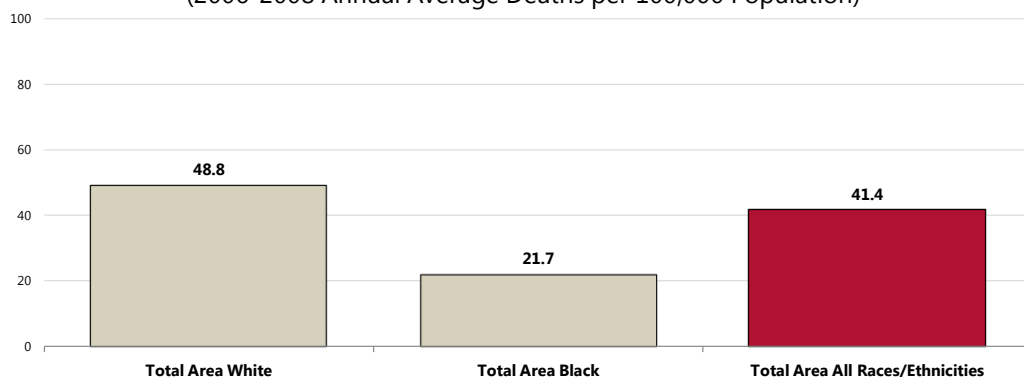
CLRD: Age-Adjusted Mortality
(2006-2008 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• CLRD is chronic lower respiratory disease.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

👤 CLRD mortality is more than twice as high among Whites than Blacks in the Total Area.

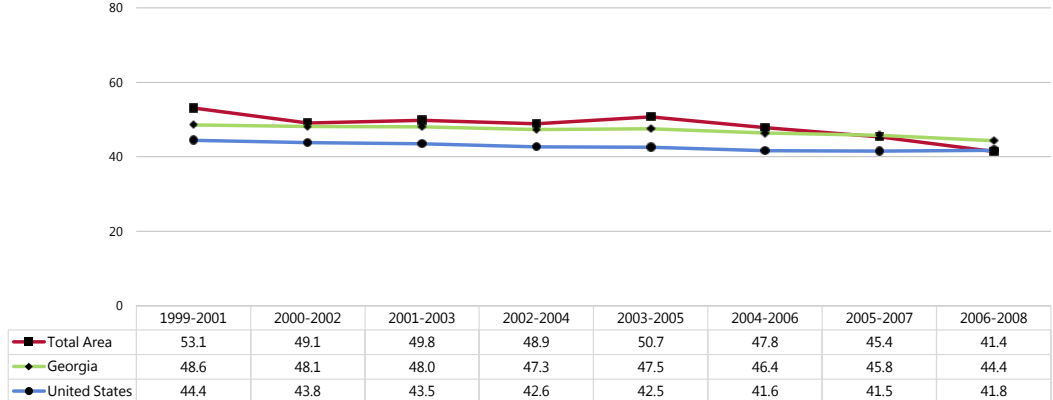
CLRD: Age-Adjusted Mortality by Race
(2006-2008 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• CLRD is chronic lower respiratory disease.

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

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



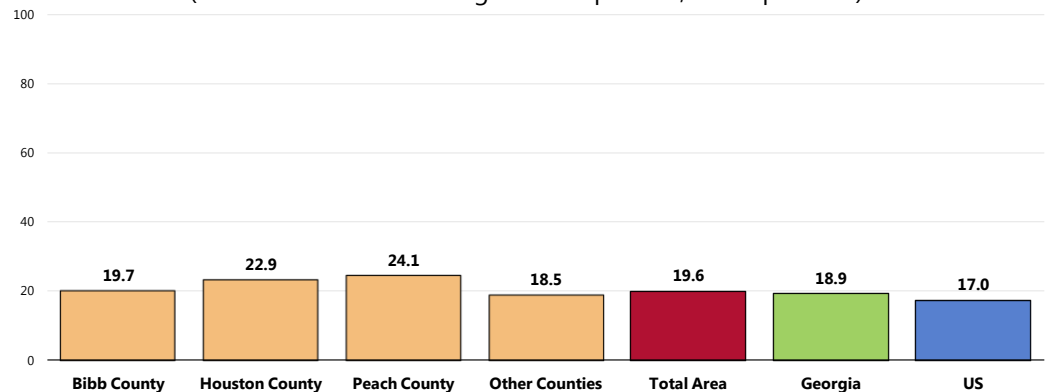
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• State and national data are simple three-year averages.
• CLRD is chronic lower respiratory disease.

Pneumonia/Influenza Deaths

Between 2006 and 2008, there was an annual average age-adjusted pneumonia/influenza mortality rate of 19.6 deaths per 100,000 population in the Total Area.

- Comparable to that found statewide.
- Higher than the national rate.
- Higher in Houston and Peach counties.

Pneumonia/Influenza: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)



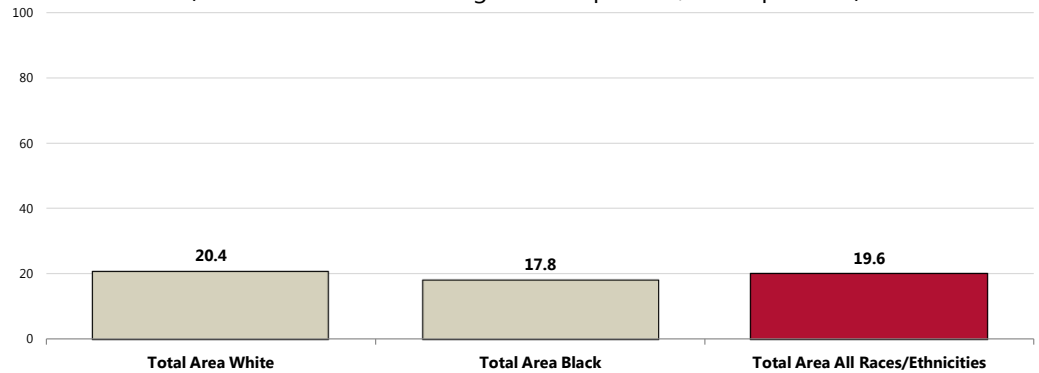
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

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



The pneumonia/influenza mortality rate in the Total Area is slightly higher among Whites.

Pneumonia/Influenza: Age-Adjusted Mortality by Race (2006-2008 Annual Average Deaths per 100,000 Population)

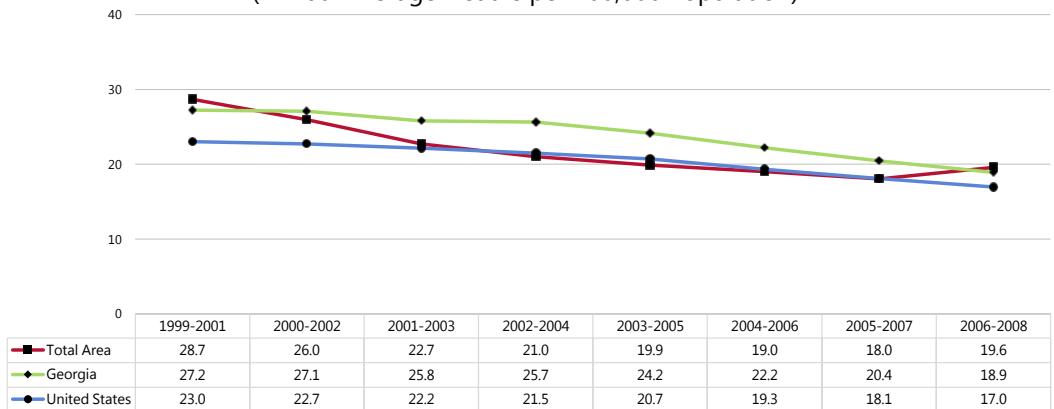


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.



Total Area pneumonia/influenza mortality has decreased over time, echoing the state and national trends.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• State and national data are simple three-year averages.

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

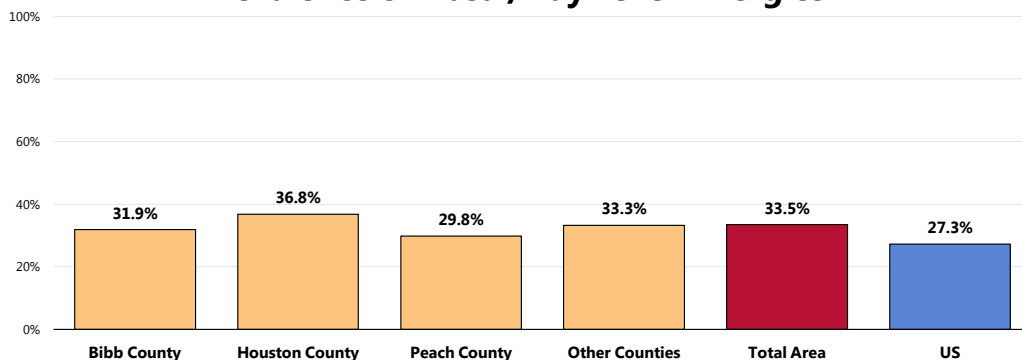
Prevalence of Respiratory Conditions

Nasal/Hay Fever Allergies

One-third (33.5%) of Total Area adults currently suffers from or has been diagnosed with nasal/hay fever allergies.

- Higher than the national prevalence.
- Statistically similar by county.

Prevalence of Nasal/Hay Fever Allergies



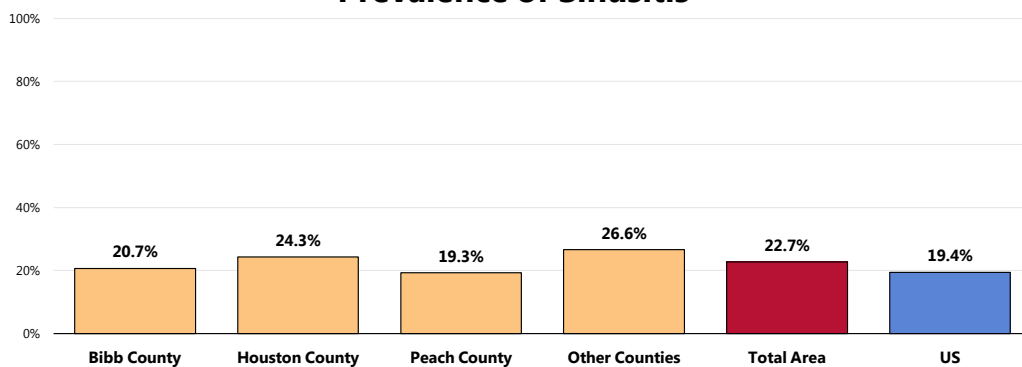
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Sinusitis

A total of 22.7% of Total Area adults suffer from sinusitis.

- Comparable to the national prevalence.
- Comparable by county.

Prevalence of Sinusitis



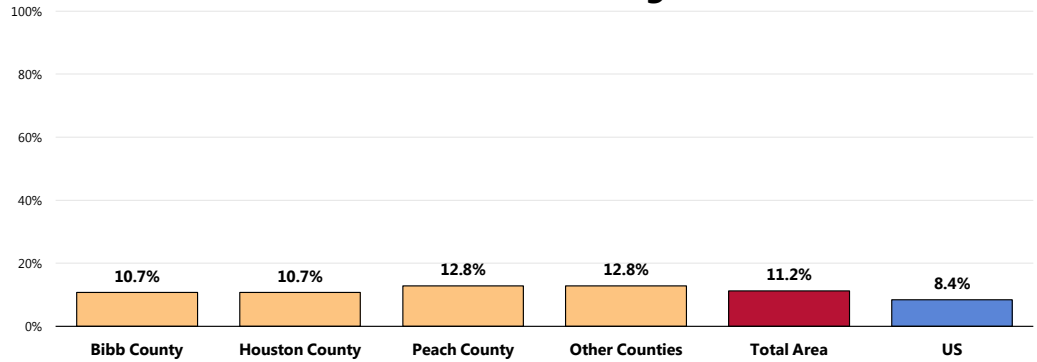
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 34]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Chronic Lung Disease

A total of 11.2% of Total Area adults suffer from chronic lung disease.

- Less favorable than the national prevalence.
- Similar by county.

Prevalence of Chronic Lung Disease



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 25]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

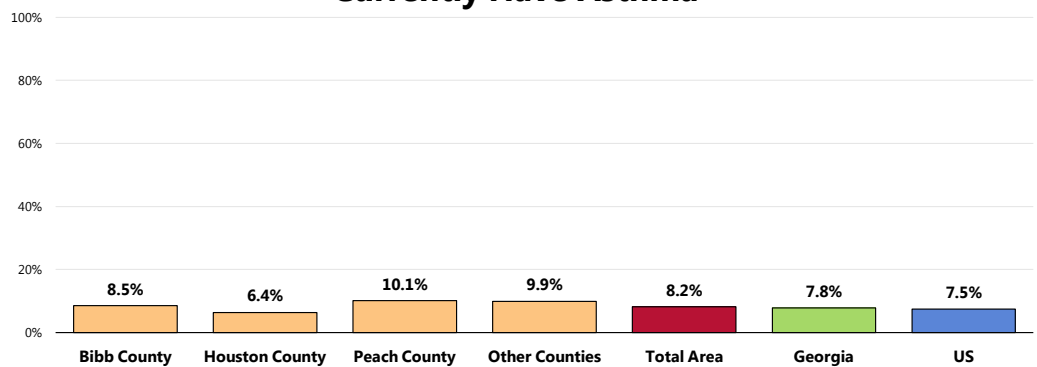
Asthma

Adults

A total of 8.2% of Total Area adults currently suffer from asthma.



- Similar to the statewide prevalence.
- Similar to the national prevalence.
- Statistically similar by county.

Currently Have Asthma

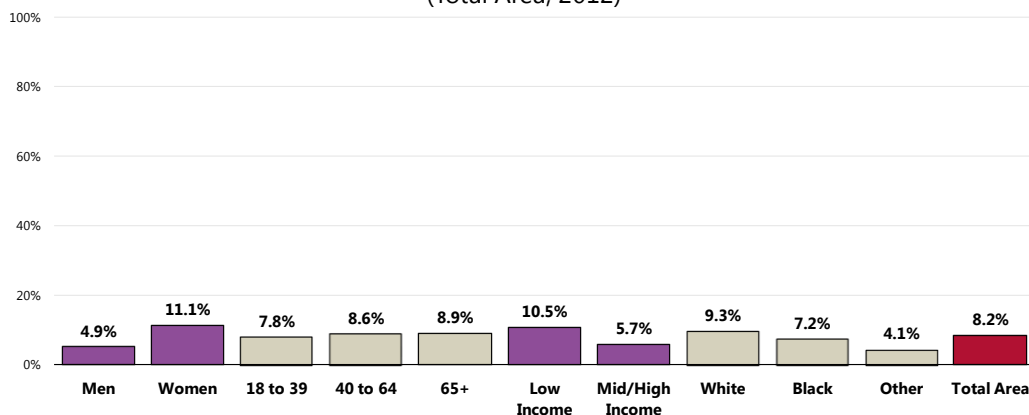


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Georgia data.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

The following adults are more likely to suffer from asthma:

-  Women.
-  Low-income residents.

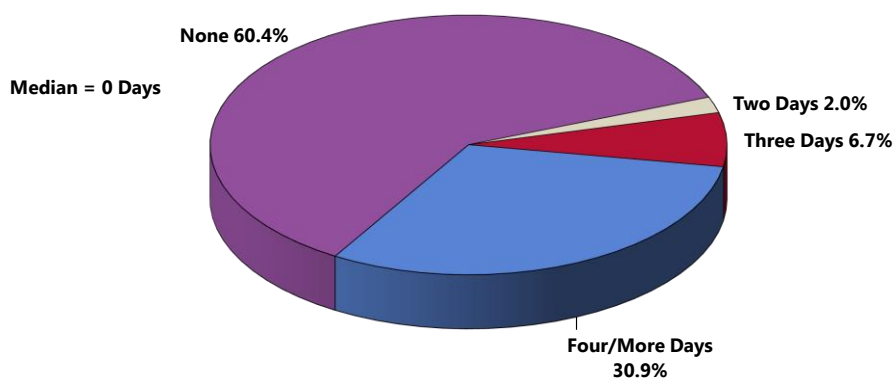
Currently Have Asthma (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Note that 39.6% of respondents with asthma report one or more days in the past year on which they were unable to work or carry out their usual activities because of their asthma.

Number of Days in Past Year on Which Asthma Interfered With Work or Usual Activities (Among Total Area Adults w/Asthma, 2012)



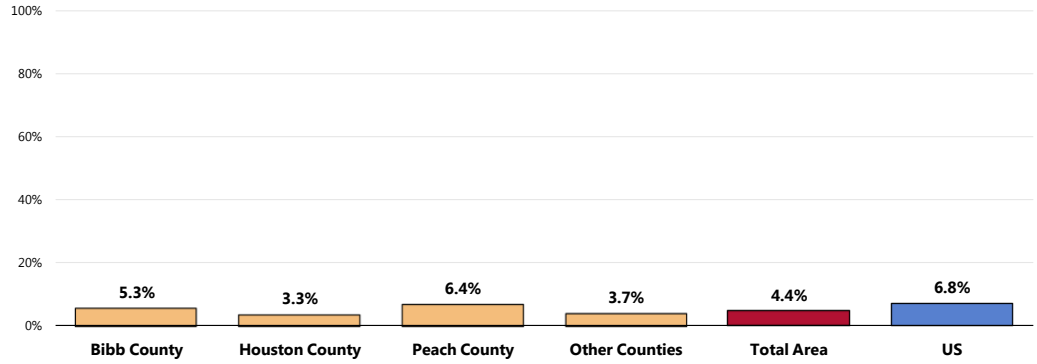
Sources: • 2012 Professional Research Consultants, Inc. PRC Community Health Survey. [Item 43]
 Notes: • Asked of all respondents with asthma.

Children

Among Total Area children under age 18, 4.4% currently have asthma.

- Statistically similar to national findings.
- No statistical difference by county.

Child Currently Has Asthma (Among Parents of Children Age 0-17)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 153]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Injury & Violence

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

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

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

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

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

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

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

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

Efforts to prevent violence may focus on:

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

— Healthy People 2020 (www.healthypeople.gov)

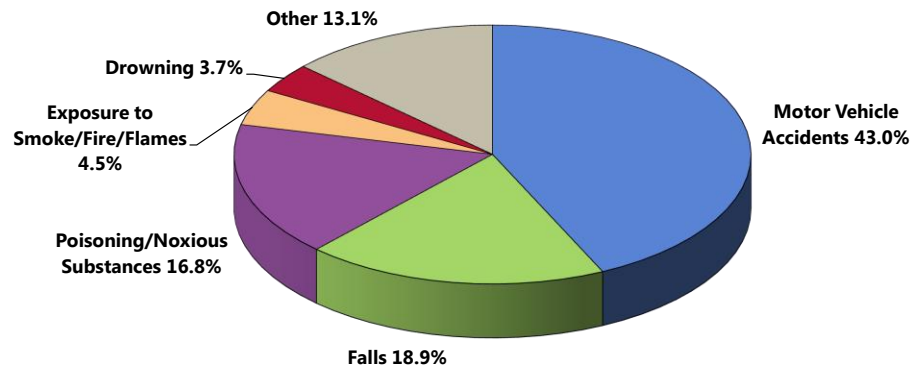
Leading Causes of Accidental Death

Motor vehicle accidents accounted for 43.0% of accidental deaths in the Total Area between 2006-2008.

- Other leading causes of accidental death included **falls** (18.9% of all accidental deaths), **poisoning/noxious substances** (16.8%), **exposure to smoke/flames/fire** (4.5%) and **drowning/submersion** (3.7%).

Leading Causes of Accidental Death

(Total Area, 2006-2008)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

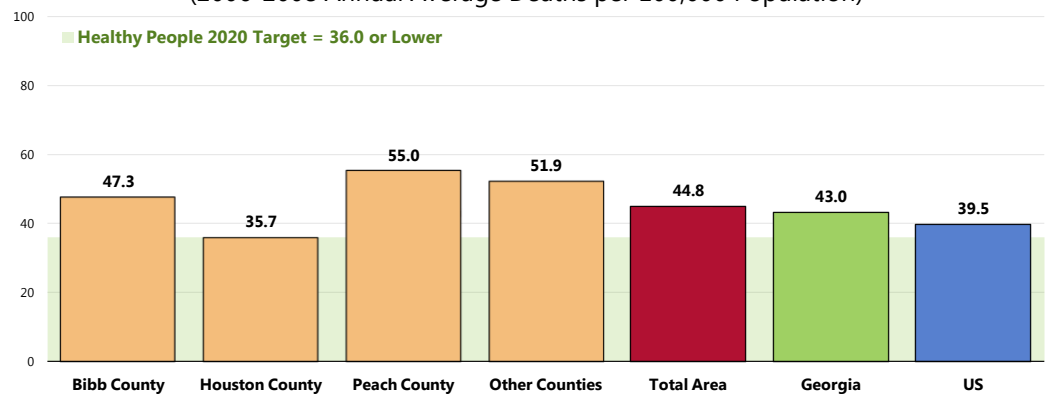
Age-Adjusted Unintentional Injury Deaths

Between 2006 and 2008, there was an annual average age-adjusted unintentional injury mortality rate of 44.8 deaths per 100,000 population in the Total Area.

- Comparable to the Georgia rate.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target (36.0 or lower).
- Highest in Peach County; lowest in Houston County.

Unintentional Injuries: Age-Adjusted Mortality

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



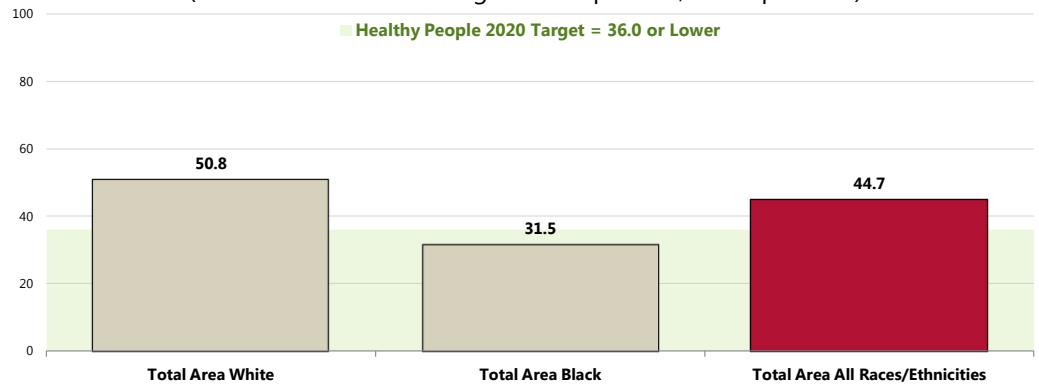
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
• 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.
• Local, state and national data are simple three-year averages.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



The mortality rate is much higher among Total Area Whites.

Unintentional Injuries: Age-Adjusted Mortality by Race

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]

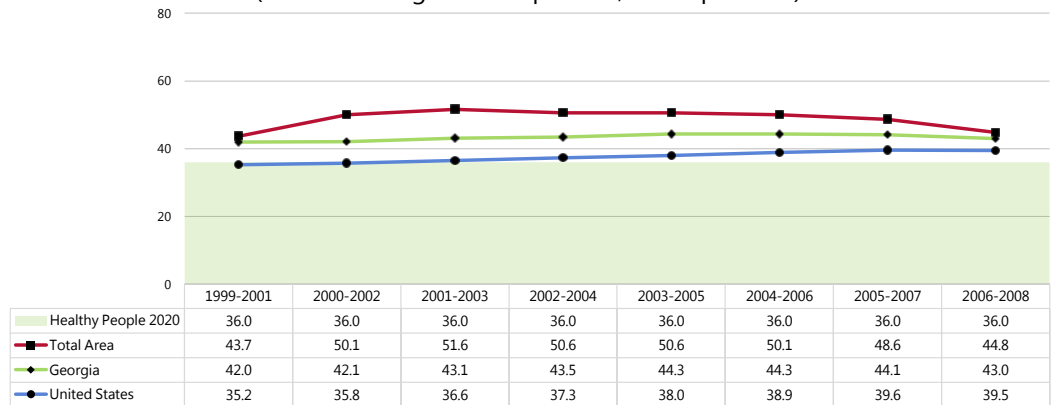
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.



The unintentional injury mortality rate in the Total Area remained largely stable over the past decade, as did the Georgia rate. The US rate increased somewhat during this time.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]

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

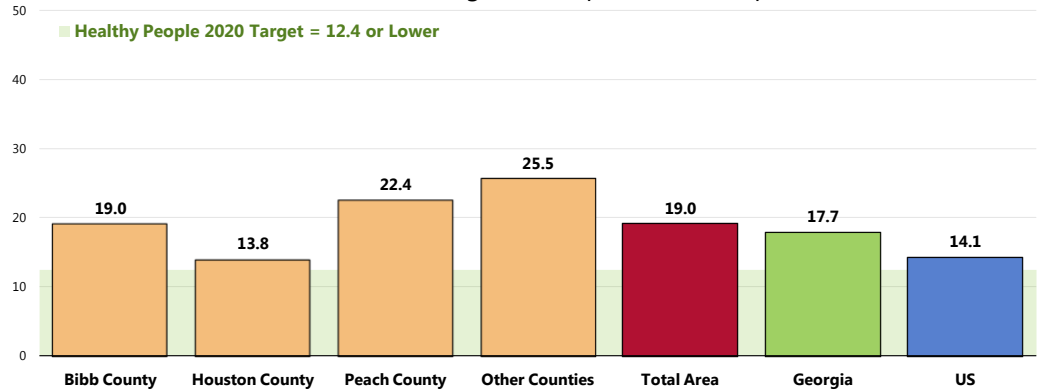
Motor Vehicle Safety

Age-Adjusted Motor-Vehicle Related Deaths

Between 2006 and 2008, there was an annual average age-adjusted motor vehicle crash mortality rate of 19.0 deaths per 100,000 population in the Total Area.

- Higher than found statewide.
- Higher than found nationally.
- Fails to satisfy the Healthy People 2020 target (12.4 or lower).
- Favorably low in Houston County.

Motor Vehicle Crashes: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)

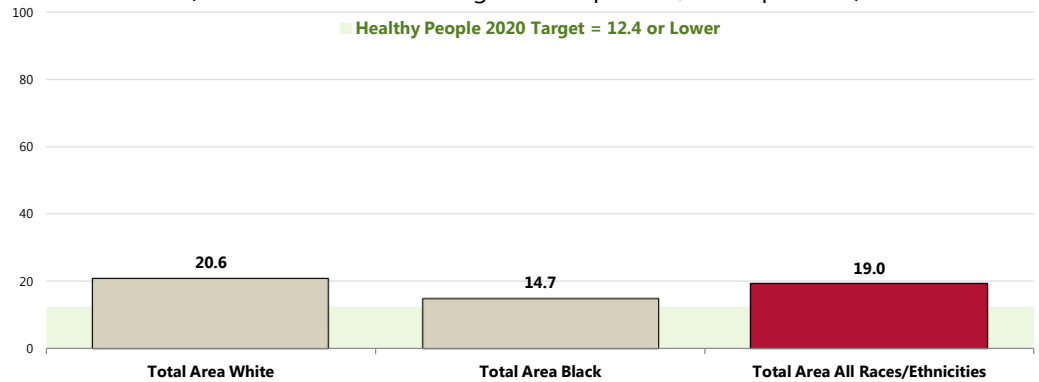


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.




The Total Area motor vehicle crash mortality rate is higher among Whites than Blacks.

Motor Vehicle Crashes: Age-Adjusted Mortality by Race (2006-2008 Annual Average Deaths per 100,000 Population)

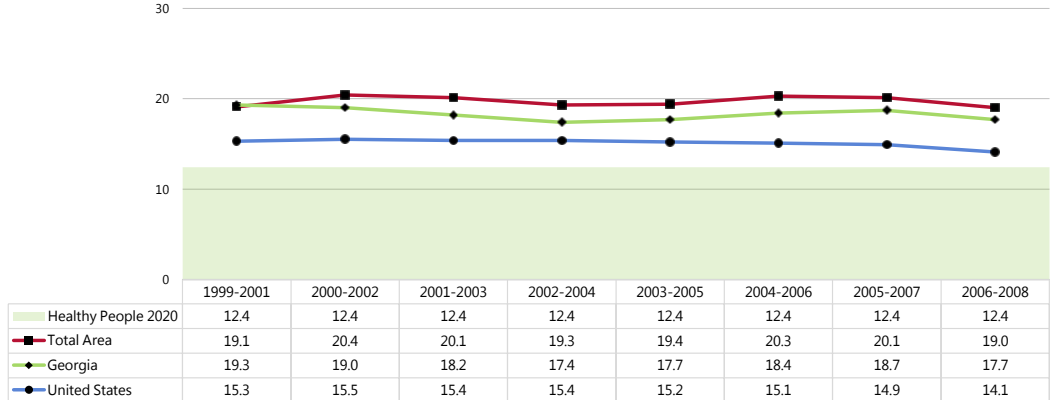


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.

-  The mortality rate in the Total Area remained unchanged over time, while the state and national rates declined over the past decade.

Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1]

Notes:

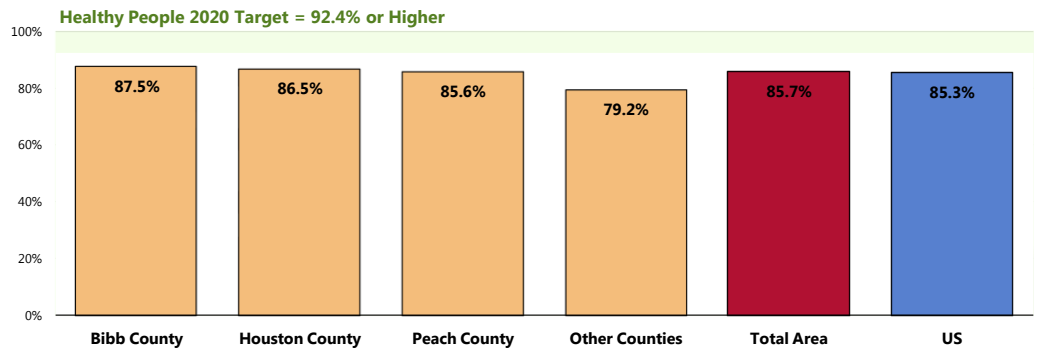
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- County, state and national data are simple three-year averages.

Seat Belt Usage - Adults

Most Total Area adults (85.7%) report “always” wearing a seat belt when driving or riding in a vehicle.

- Nearly identical to the percentage found nationally.
- Fails to satisfy the Healthy People 2020 target of 92.4% or higher.
- Unfavorably low in the Other Counties region.

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



Sources:

- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-15]

Notes:

- Asked of all respondents.
- “Other Counties” includes Jones, Twiggs, Monroe and Crawford counties combined.

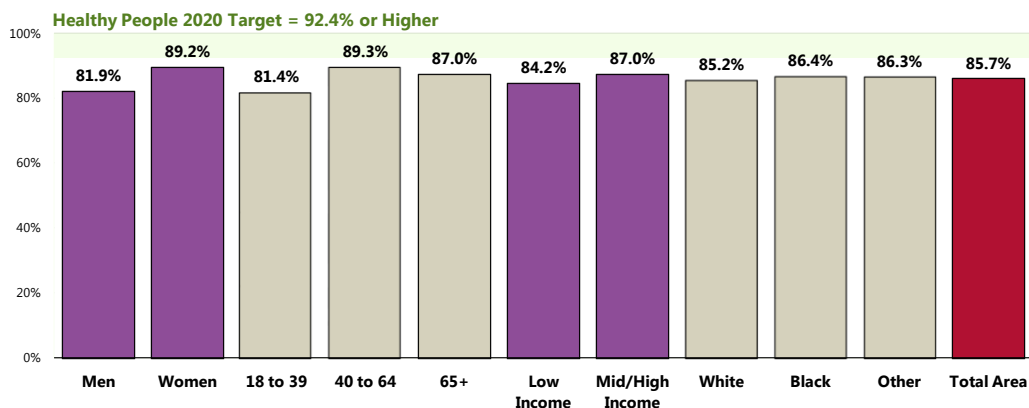
These population segments are less likely to report consistent seat belt usage:

Men.

Young adults.

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

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 53]
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-15]
Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Seat Belt Usage - Children

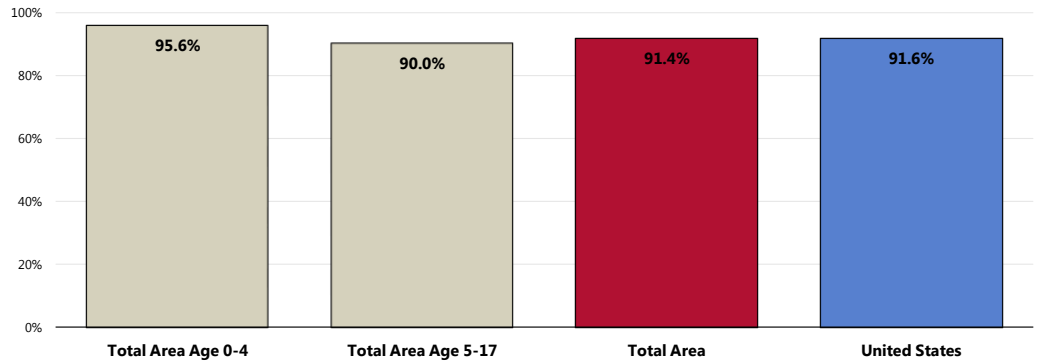
A full 91.4% of Total Area parents report that their child (age 0 to 17) “always” wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

- Almost identical to what is found nationally.
- Highest in the Other Counties (not shown).

Among children under age 5, 95.6% are reported to consistently use appropriate seat belts/safety seats; among those age 5-17, 90.0% report consistent safety belt usage.

Child “Always” Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle

(Among Parents of Children Age 0-17)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 132, 156-157]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

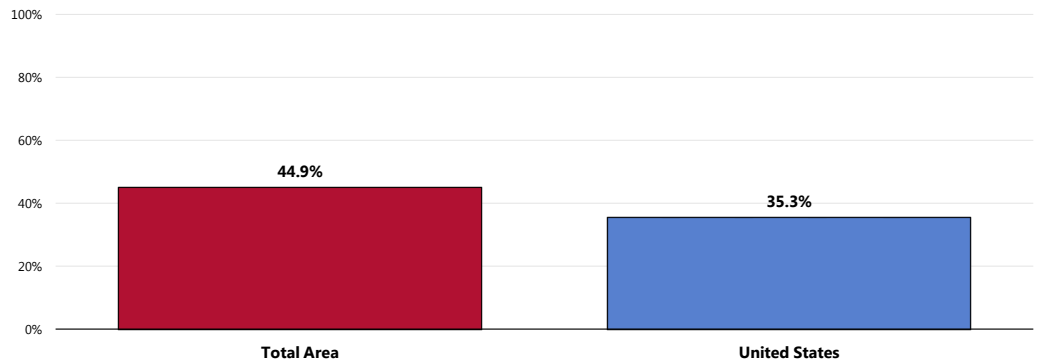
Bicycle Safety

Less than one-half (44.9%) of Total Area children age 5 to 17 is reported to “always” wear a helmet when riding a bicycle.

- Statistically similar to the national prevalence.

Child “Always” Wears a Helmet When Riding a Bicycle

(Among Parents of Children Age 5-17)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 137]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children age 5 to 17 at home.

Firearm Safety

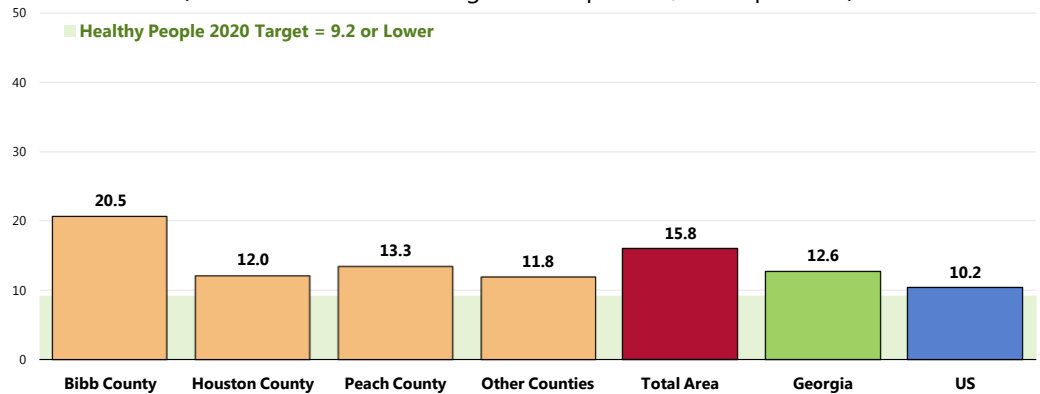
Age-Adjusted Firearm-Related Deaths

Between 2006 and 2008, there was an annual average age-adjusted rate of 15.8 deaths per 100,000 population due to firearms in the Total Area.

- Higher than found statewide.
- Higher than found nationally.
- Fails to satisfy the Healthy People 2020 objective (9.2 or lower).
- Unfavorably high in Bibb County.

Firearms-Related Deaths: Age-Adjusted Mortality

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

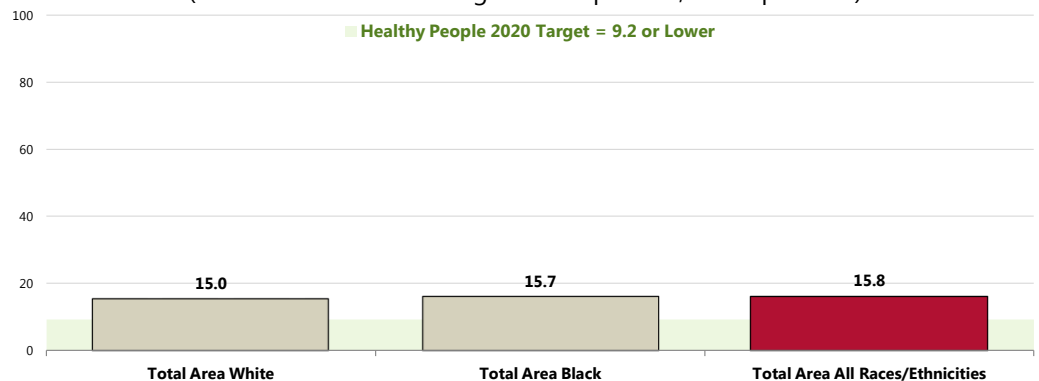


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

👤 The Total Area firearm-related mortality rate does not vary significantly when viewed by race.

Firearms-Related Deaths: Age-Adjusted Mortality by Race

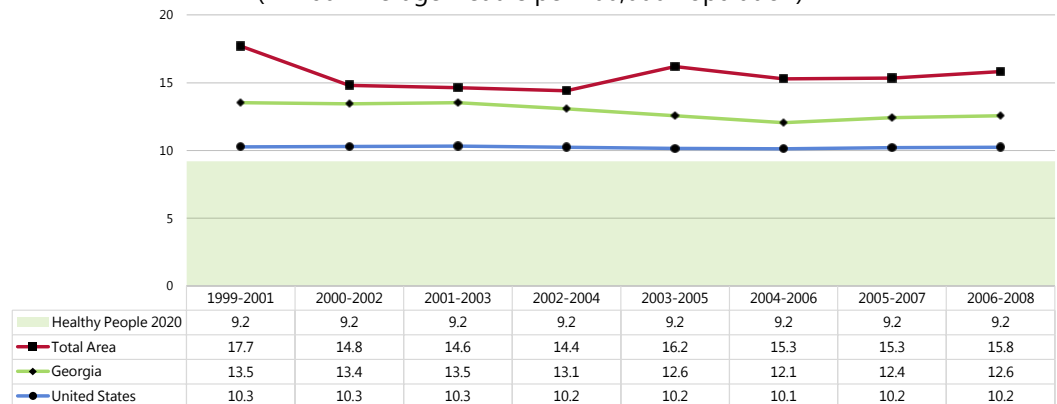
(2006-2008 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.

- Total Area rates have been consistently higher than Georgia or US rates for the past decade.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.

Notes: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]
• Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.

Presence of Firearms in Homes

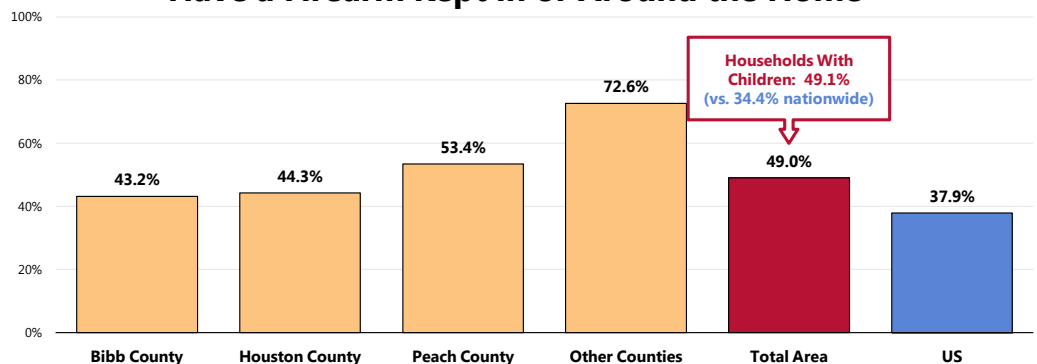
Overall, just under one-half (49.0%) of Total Area adults has a firearm kept in or around their home.

- Higher than the national prevalence.
- Particularly high in the Other Counties; lowest in Bibb and Houston counties.
- Among Total Area households with children, 49.1% have a firearm kept in or around the house (higher than that reported nationally).

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

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

Have a Firearm Kept in or Around the Home



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 57, 154]





Notes: • 2011 PRC National Health Survey, Professional Research Consultants, Inc.

• Asked of all respondents.

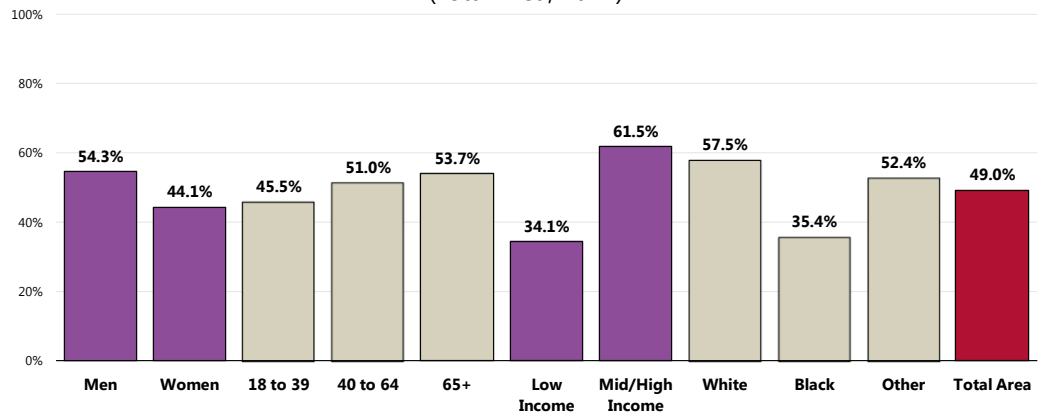
• In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

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

-  Men.
-  Adults 40 and older.
-  Higher-income households.
-  Non-Blacks.

Have a Firearm Kept in or Around the House (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 57]

Notes: • Asked of all respondents.

• In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

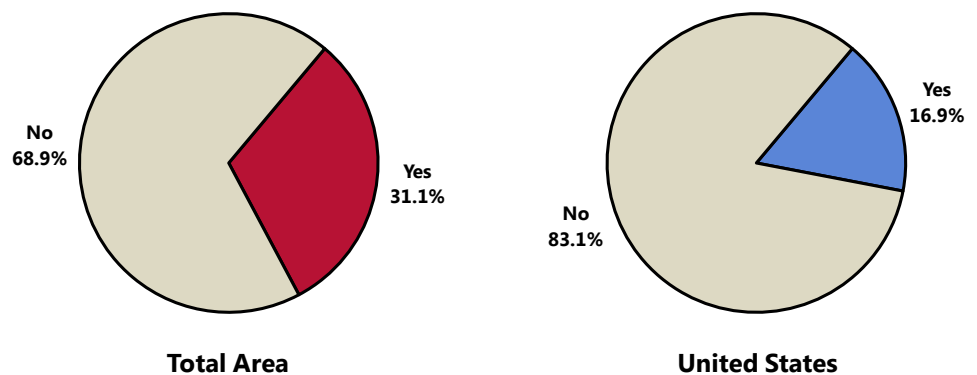
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among Total Area households with firearms, 31.1% report that there is at least one weapon that is kept unlocked and loaded.

- Nearly twice that found nationally.
- No significant difference by county (not shown).

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



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]

• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

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

• In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

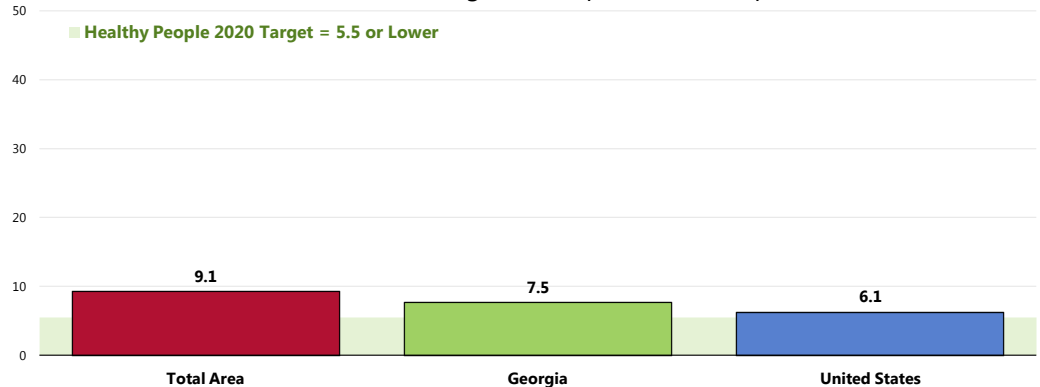
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Between 2006 and 2008, there was an annual average age-adjusted homicide rate of 9.1 deaths per 100,000 population in the Total Area.

- Less favorable than the rate found statewide.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 5.5 or lower.

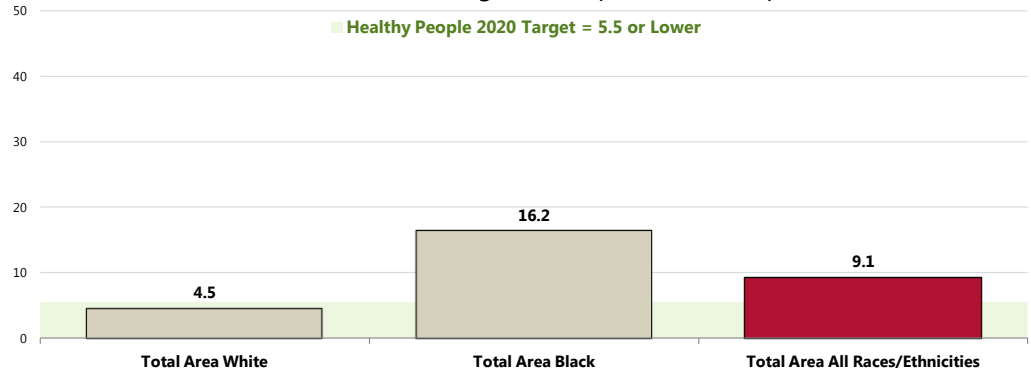
Homicide: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-29]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.


👤 The homicide rate is more than three times as high among Blacks than Whites in the Total Area.

Homicide: Age-Adjusted Mortality by Race (2006-2008 Annual Average Deaths per 100,000 Population)



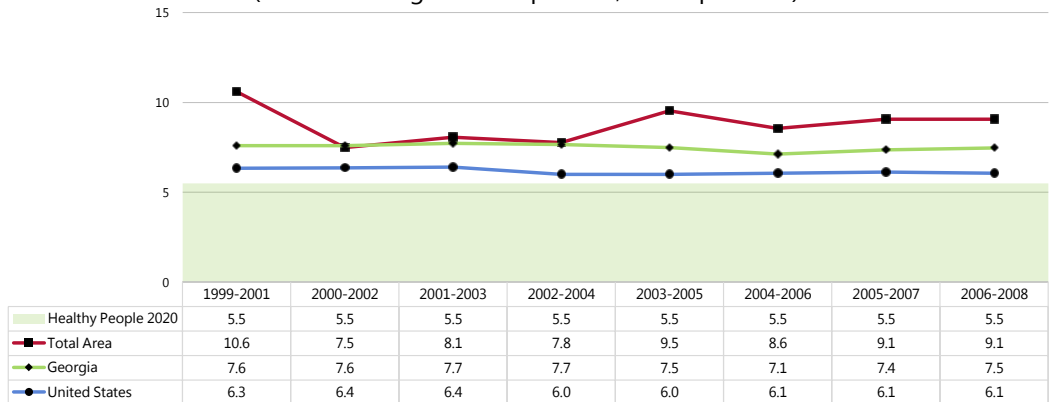
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-29]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

RELATED ISSUE:
See also *Suicide* in the **Mental Health & Mental Disorders** section of this report.

-  The Total Area homicide rate has fluctuated over the past decade, but has been well above the Georgia and US rates for the past few reporting periods.

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-29]

Notes:

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

Violent Crime

Violent Crime Rates

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

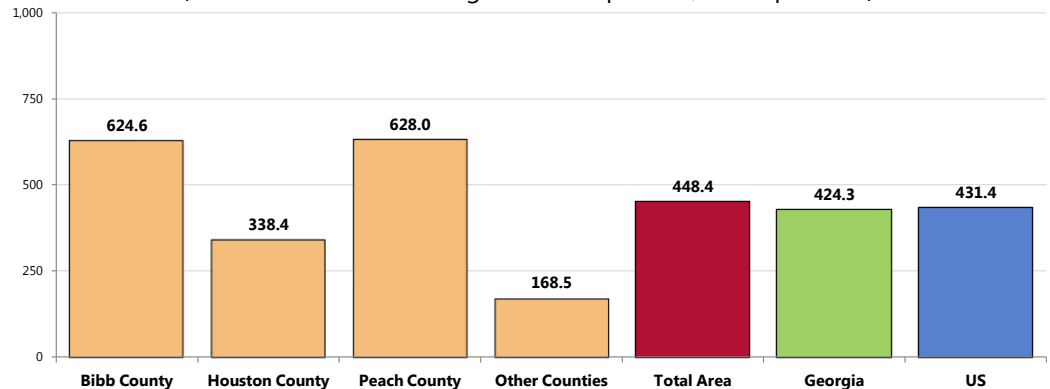
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Between 2008 and 2010, there was an annual average violent crime rate of 448.4 offenses per 100,000 population in the Total Area.

- Statistically higher than the Georgia rate for the same period.
- Statistically similar to the national rate.
- Notably high in Bibb and Peach counties.

Violent Crime Rates

(2008-2010 Annual Average Offenses per 100,000 Population)



Sources: • Georgia Bureau of Investigation.
• US Department of Justice, Federal Bureau of Investigation
Notes: • Rates are offenses per 100,000 population among agencies reporting.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

- ▣ The Total Area crime rate has declined slightly in recent years, echoing the state and national trends.

Violent Crime Rates

(Annual Average Offenses per 100,000 Population)



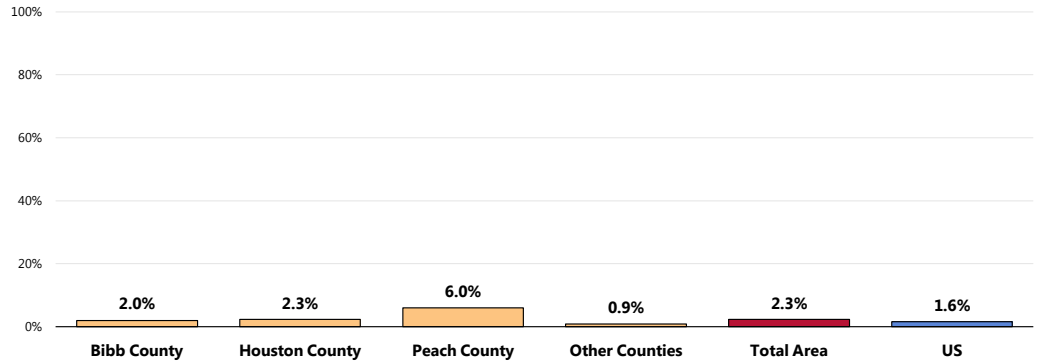
Sources: • Georgia Bureau of Investigation.
• US Department of Justice, Federal Bureau of Investigation
Notes: • Rates are offenses per 100,000 population among agencies reporting.

Self-Reported Violence

A total of 2.3% of Total Area adults acknowledge being the victim of a violent crime in the past five years.

- Statistically similar to national findings.
- Unfavorably high in Peach County.

Victim of a Violent Crime in the Past Five Years



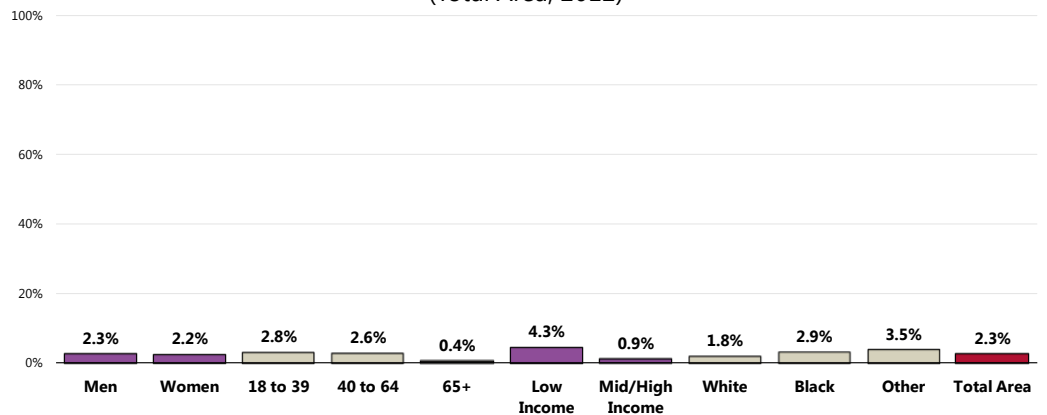
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



Reports of violence are notably higher among residents living in the lower income category.

Victim of a Violent Crime in the Past Five Years

(Total Area, 2012)



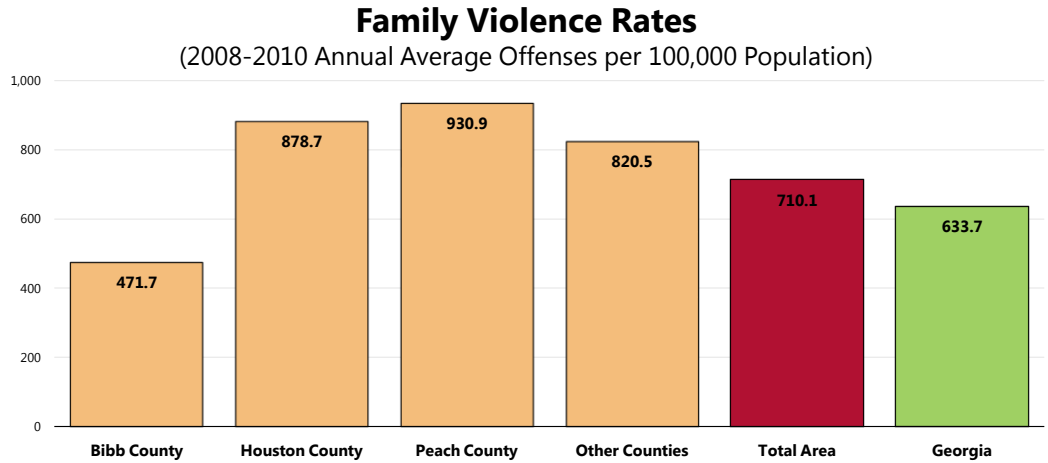
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 54]
Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Family Violence

Note that these family violence data reflect only those incidences reported to law enforcement (offenses).

Between 2008 and 2010, there was an annual average family violence rate of 710.1 offenses per 100,000 population in the Total Area.


- Higher than the Georgia rate for 2008-2010.
- Notably low in Bibb County; highest in Peach County.

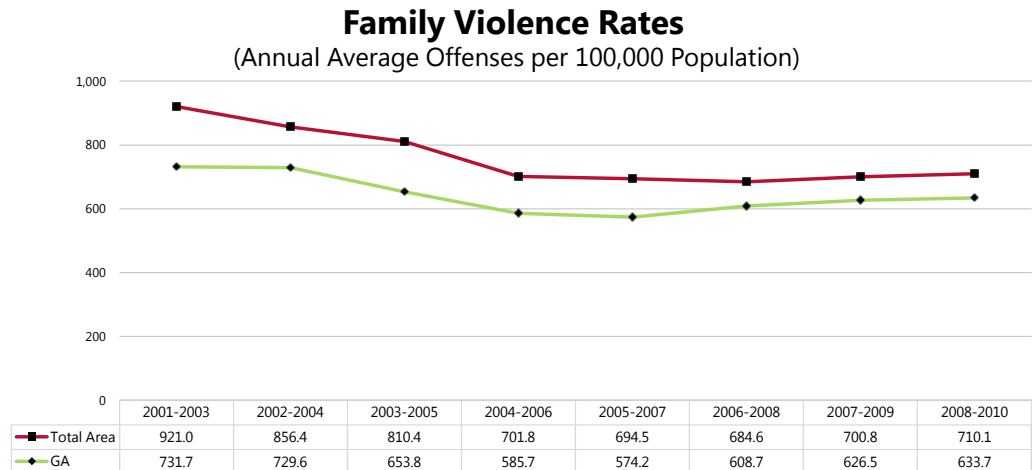


Sources: • Georgia Bureau of Investigation.

Notes: • Rates are domestic calls for assistance per 100,000 population.

• According to Georgia law, family violence means the occurrence of one or more of the following acts between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household: any felony; or commission of offenses of battery, simple battery, simple assault, stalking, criminal damage to property, unlawful restraint, or criminal trespass. The term "family violence" shall not be deemed to include reasonable discipline administered by a parent to a child in the form of corporal punishment, restraint, or detention.

 The family violence offense rate decreased in the Total Area between the 2001-2003 and 2008-2010 reporting periods. The same decreasing trend is evident statewide.



Sources: • Georgia Bureau of Investigation.

Notes: • Rates are domestic calls for assistance per 100,000 population.

• According to Georgia law, family violence means the occurrence of one or more of the following acts between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household: any felony; or commission of offenses of battery, simple battery, simple assault, stalking, criminal damage to property, unlawful restraint, or criminal trespass. The term "family violence" shall not be deemed to include reasonable discipline administered by a parent to a child in the form of corporal punishment, restraint, or detention.

Self-Reported Family Violence

Respondents were told:

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

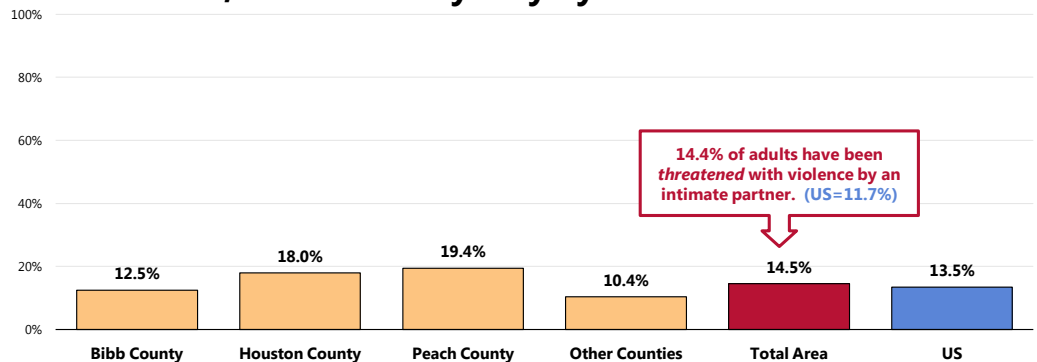
A total of 14.4% of Total Area adults report that they have ever been threatened with physical violence by an intimate partner.

- Statistically similar to that reported nationally.
- Lowest in the Other Counties (not shown).

A total of 14.5% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- Similar to national findings.
- Unfavorably high in Houston and Peach counties.

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

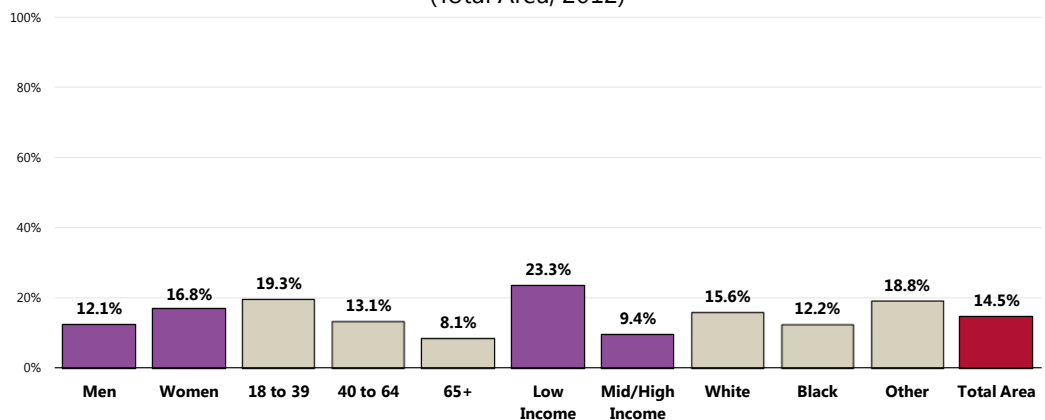


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 55-56]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



Viewed demographically, reports of domestic violence are notably higher among women, young adults and those with lower incomes.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Related Focus Group Findings: Violence

Many focus group participants are concerned with violence in the community. The main issues included:

- Domestic violence and sexual assault
- Child and elder abuse

Participants feel violence is pervasive in both urban and rural communities. According to participants, a major contributor to violence is the frustration fueled by lower income, stress, and substance abuse.

Participants feel victims of **domestic violence and sexual assault** have limited options because they may not have access to a shelter due to limited personal or public transportation. There are also limited choices for shelters because the beds fill up quickly and then the victim must remain in the volatile situation. A participant describes:

"Well, even when you have victims of domestic violence, one of their first questions is certainly, 'Well, what are my choices? Where can I go?' and especially in the rural communities, there aren't any resources or places for them to go, and trying to access the resources in Macon is sometimes a challenge. Those beds fill up quickly. So you often times have people who will remain in the domestic violence situation just because they feel trapped, as part of the dynamics of the issue itself, but of the reality of the limited resources." — Regional Participant

Another participant explains further:

"In Houston County, HODAC does provide victim advocates who work with victims of domestic violence and sexual assault; we have sexual assault nurse examiners. But even when we have a grant to reach out into the rural area of Peach County, that grant was not renewed. So we're limited as to how many victim advocates we have to send to the hospital on callouts." — Regional Participant

Focus group participants have additional concern about **elder and child abuse**. These situations also have limited resources and many people lack knowledge about these crimes. One social service participant explains the difficulties that victims and their family's experience:

"Our main focus is child abuse and mainly child sexual abuse. We just don't have good access in our community or that many resources out there for children who've been victimized or families who have experienced that kind of victimization, and again the uninsured...Not just here but everywhere there's such a problem with child abuse and child sexual abuse and the knowledge base with regard to those issues is very limited." — Bibb County Participant

Diabetes

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

Effective therapy can prevent or delay diabetic complications. However, almost 25% of Americans with diabetes mellitus are undiagnosed, and another 57 million Americans have blood glucose levels that greatly increase their risk of developing diabetes mellitus in the next several years. Few people receive effective preventative care, which makes diabetes mellitus an immense and complex public health challenge.

Diabetes mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. Diabetes mellitus:

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

In addition to these human costs, the estimated total financial cost of diabetes mellitus in the US in 2007 was \$174 billion, which includes the costs of medical care, disability, and premature death.

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

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

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

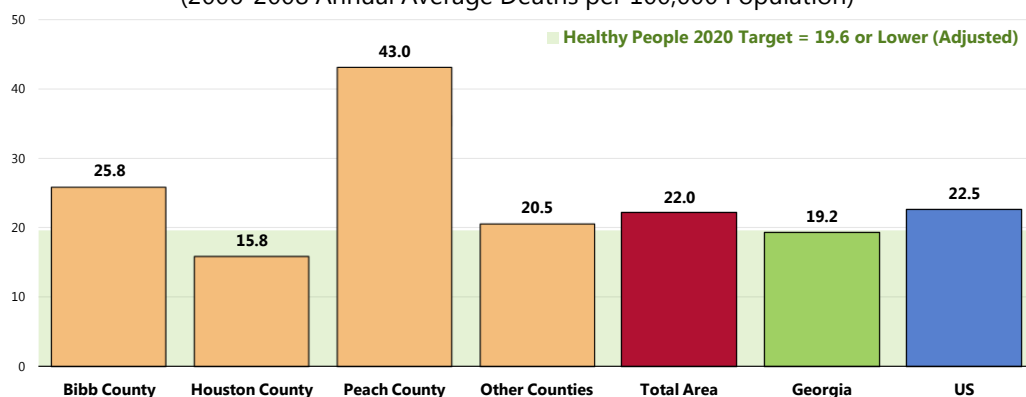
— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Between 2006 and 2008, there was an annual average age-adjusted diabetes mortality rate of 22.0 deaths per 100,000 population in the Total Area.

- Less favorable than that found statewide.
- Similar to the national rate.
- Fails to satisfy the Healthy People 2020 target (19.6 or lower).
- Especially high in Peach County, and also significant in Bibb County.

Diabetes: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)

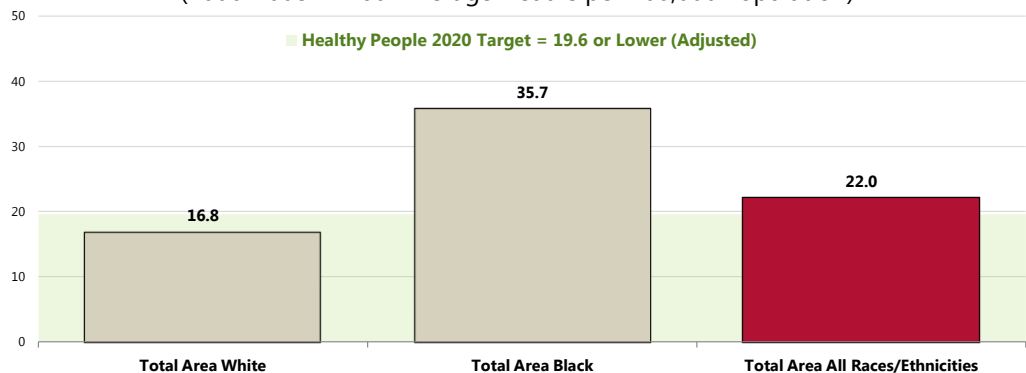


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.
 • The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.




The diabetes mortality rate in the Total Area is more than twice as high among Blacks as among Whites.

Diabetes: Age-Adjusted Mortality by Race (2006-2008 Annual Average Deaths per 100,000 Population)

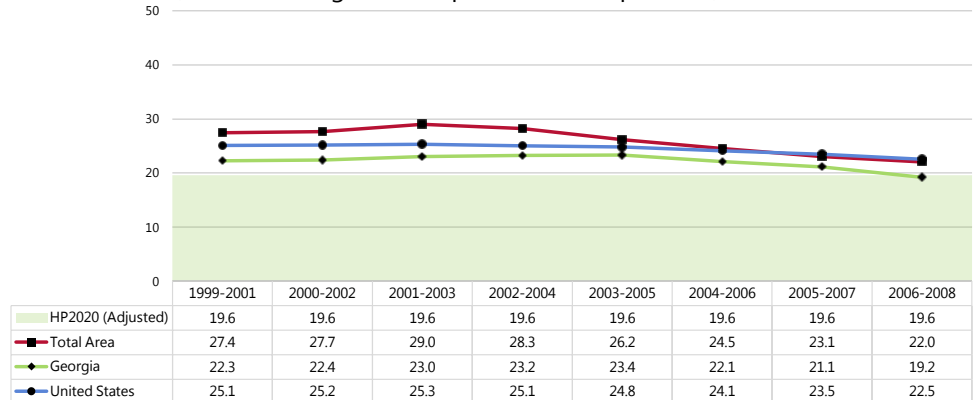


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

-  The Total Area diabetes rate has decreased over the past decade, echoing the state and national trends.

Diabetes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



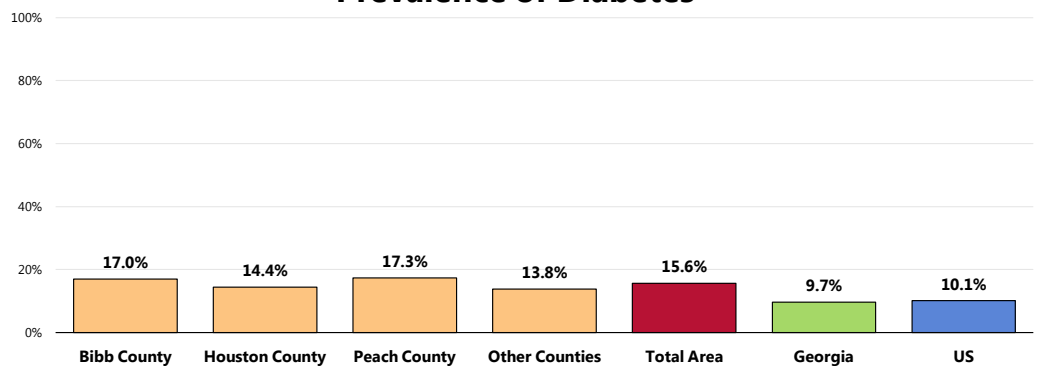
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 - Local, state and national data are simple three-year averages.
 - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

A total of 15.6% of Total Area adults report having been diagnosed with diabetes.

- Much higher than the proportion statewide.
- Much higher than the national proportion.
- Statistically similar by county.

Prevalence of Diabetes



- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]
 - 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Georgia data.
- Notes:
- Asked of all respondents.
 - Local and national data exclude gestation diabetes (occurring only during pregnancy).
 - "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



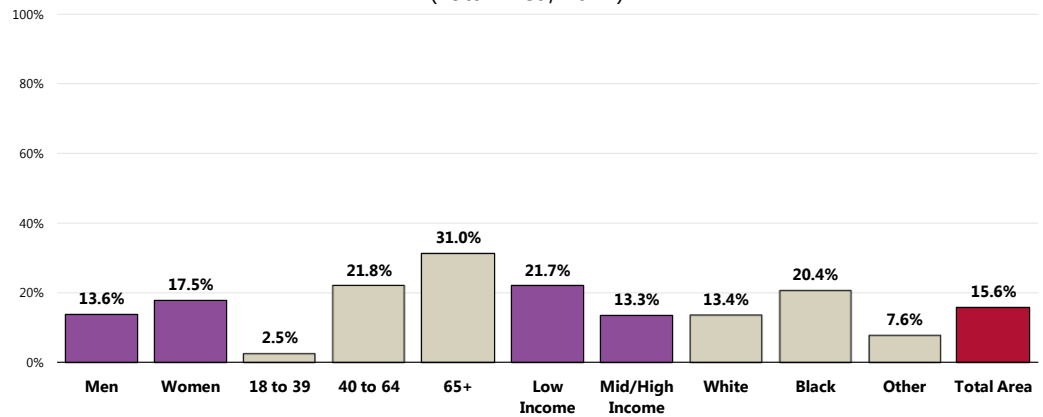
Note the positive correlation between diabetes and age (with 31.0% of seniors with diabetes).



Total Area residents living on lower incomes and Blacks are also much more likely to be diabetic.

Prevalence of Diabetes

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

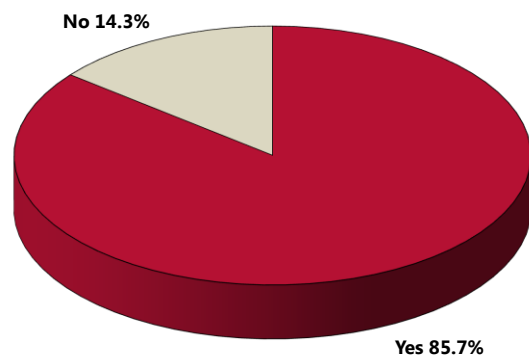
• Excludes gestation diabetes (occurring only during pregnancy).

Diabetes Treatment

Among adults with diabetes, most (85.7%) are currently taking insulin or some type of medication to manage their condition.

Taking Insulin or Other Medication for Diabetes

(Among Total Area Diabetics)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 45]

Notes: • Asked of all diabetic respondents.

Alzheimer's Disease

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

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

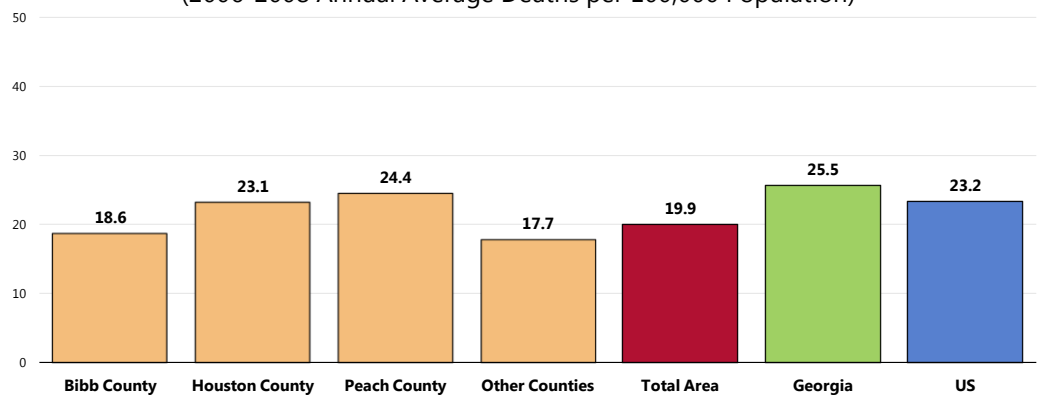
– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2006 and 2008, there was an annual average age-adjusted Alzheimer's disease mortality rate of 19.9 deaths per 100,000 population in the Total Area.

- More favorable than the statewide rate.
- More favorable than the national rate.
- Higher in Houston and Peach counties.

Alzheimer's Disease: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)



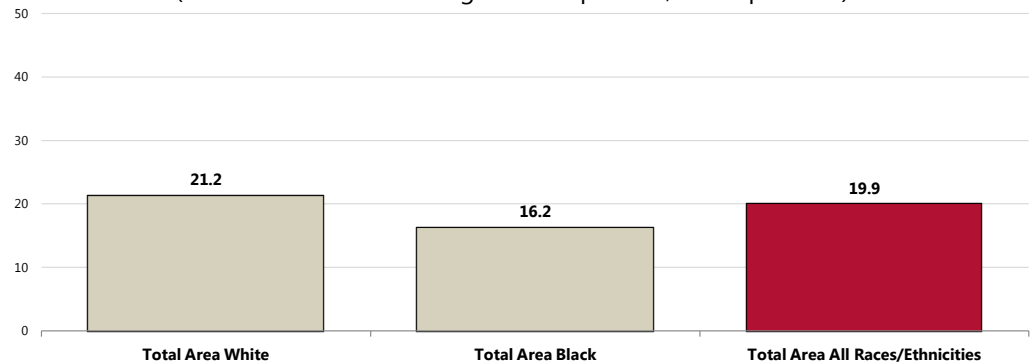
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



The Alzheimer's disease mortality rate appears higher among Whites in the Total Area.

Alzheimer's Disease: Age-Adjusted Mortality by Race

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.

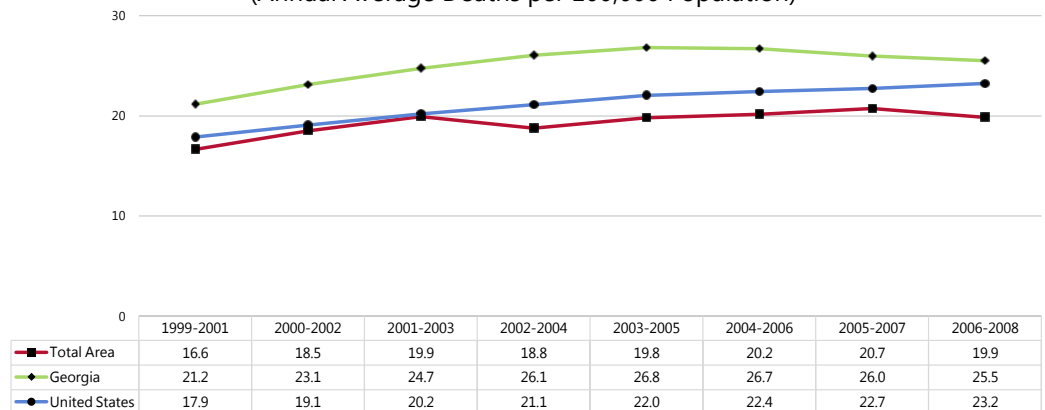
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.



Alzheimer's disease mortality is increasing in the Total Area; the same can be said for Georgia and the US overall.

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.

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

Kidney Disease

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

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

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

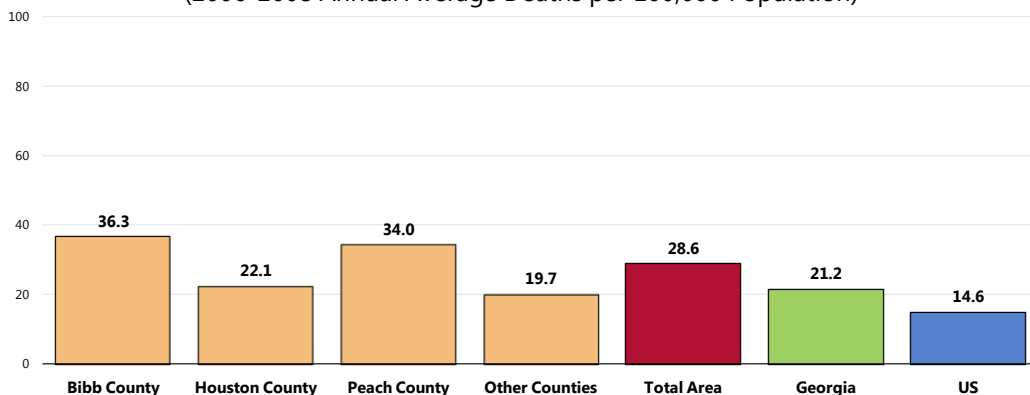
— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Chronic Kidney Disease Deaths

Between 2006 and 2008, there was an annual average age-adjusted kidney disease mortality rate of 28.6 deaths per 100,000 population in the Total Area.

- Higher than the rate found statewide.
- Higher than the national rate.
- Higher in Bibb and Peach counties.

Kidney Disease: Age-Adjusted Mortality
(2006-2008 Annual Average Deaths per 100,000 Population)



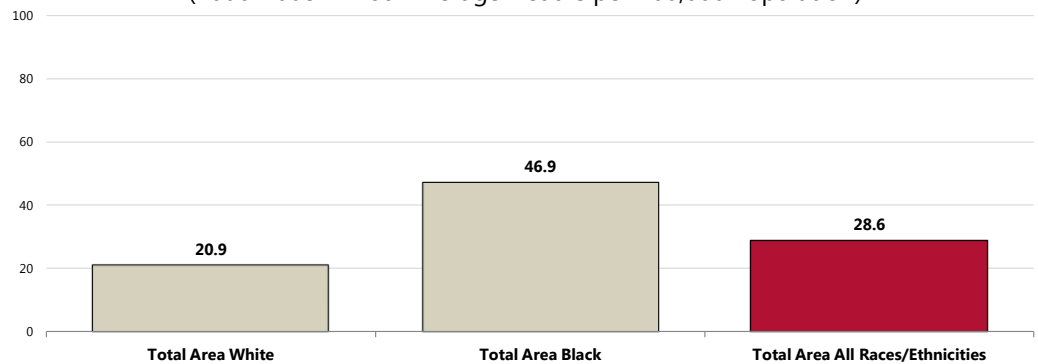
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



The kidney disease mortality rate in the Total Area is more than twice as high among Blacks as Whites.

Kidney Disease: Age-Adjusted Mortality by Race

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



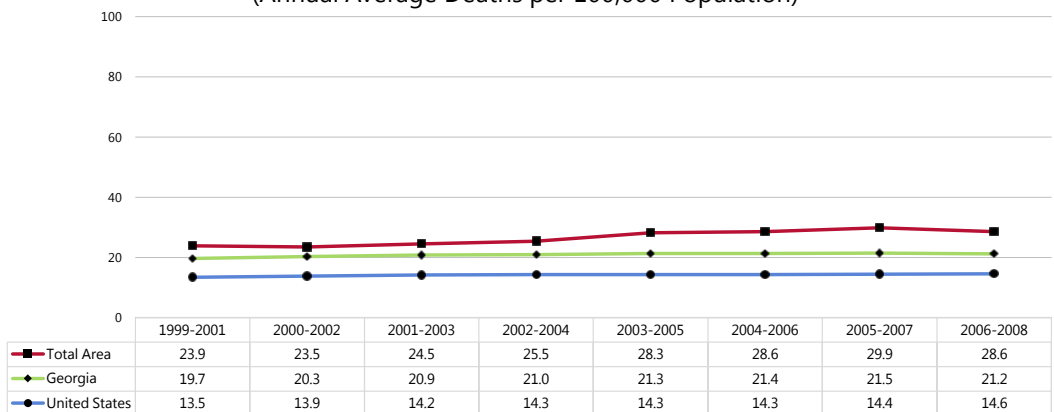
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.



The Total Area age-adjusted kidney disease death rate increased more notably over the past decade than did the Georgia and US rates.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• State and national data are simple three-year averages.

Potentially Disabling Conditions

RELATED ISSUE:

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

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

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

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

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

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Pain

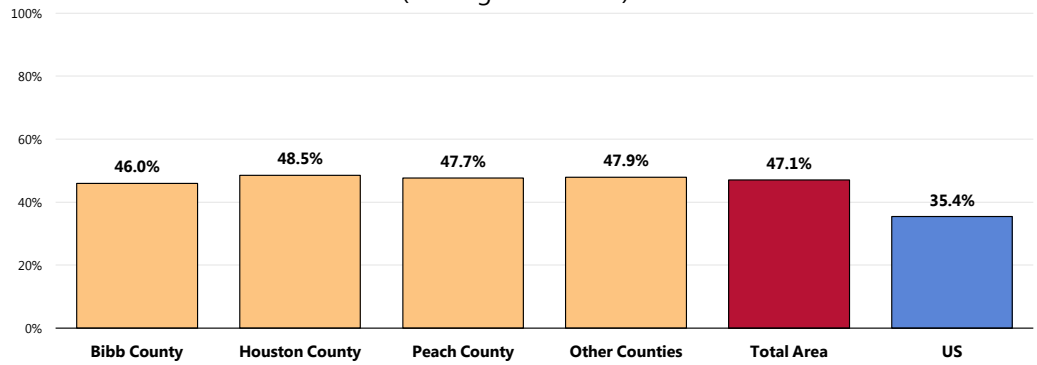
Prevalence of Arthritis/Rheumatism

More than 4 in 10 Total Area adults age 50 and older (47.1%) report suffering from arthritis or rheumatism.

- Less favorable than that found nationwide.
- Statistically similar by county.

Prevalence of Arthritis/Rheumatism

(Among Adults 50+)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Reflects respondents 50 and older.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

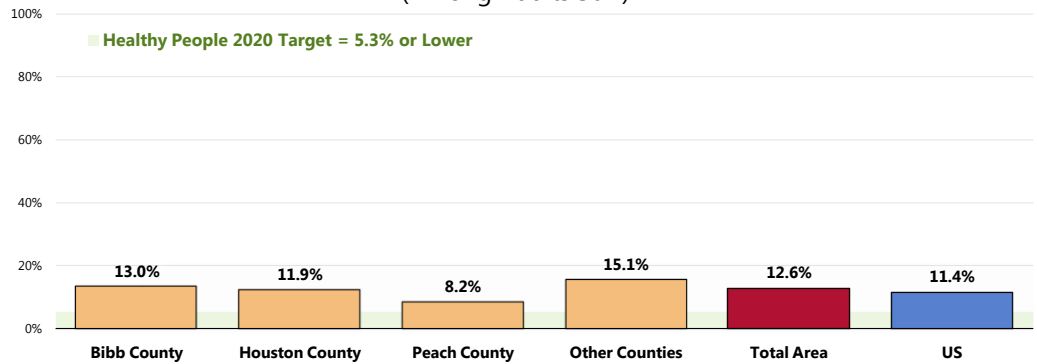
Prevalence of Osteoporosis

A total of 12.6% of survey respondents age 50 and older have osteoporosis.

- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.
- No significant differences by county.

Prevalence of Osteoporosis

(Among Adults 50+)

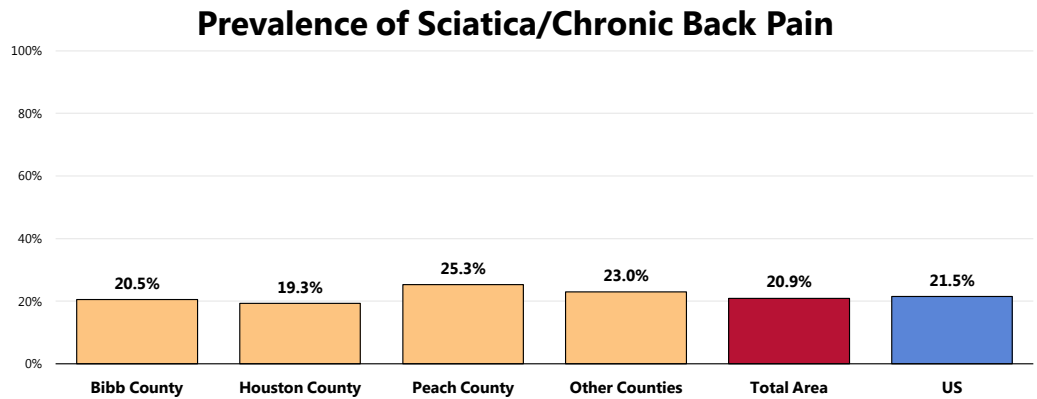


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 159]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]
 Notes: • Reflects respondents 50 and older.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Prevalence of Sciatica/Chronic Back Pain

A total of 20.9% of survey respondents suffer from chronic back pain or sciatica.

- Similar to that found nationwide.
- Similar by county.

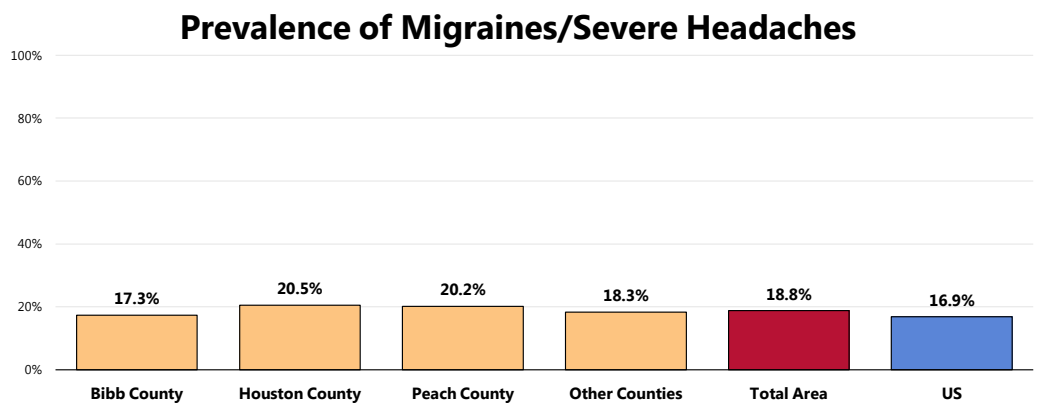


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 29]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Prevalence of Migraines/Severe Headaches

A total of 18.8% of survey respondents report suffering from migraines or severe headaches.

- Similar to that found nationwide.
- No significant difference by county.

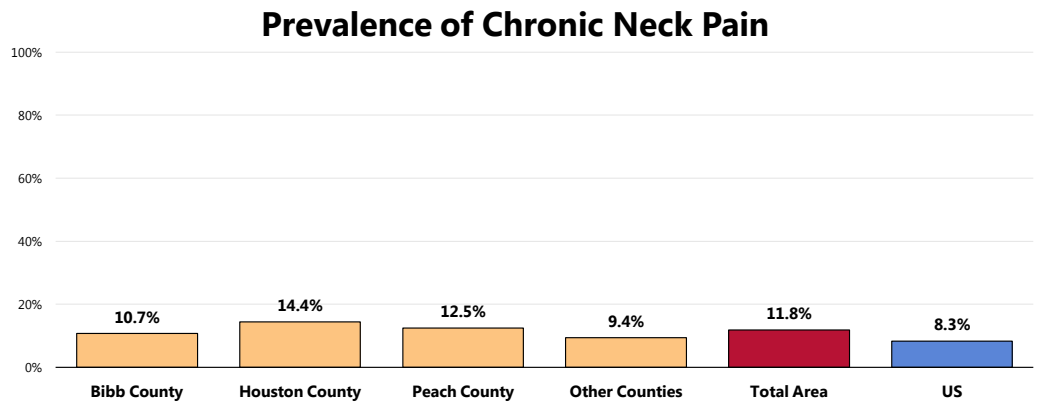


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Prevalence of Chronic Neck Pain

A total of 11.8% of survey respondents currently suffer from chronic neck pain.

- Worse than that found nationwide.
- Statistically similar by county.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 37]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Vision & Hearing Impairment

Vision Trouble

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

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

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

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

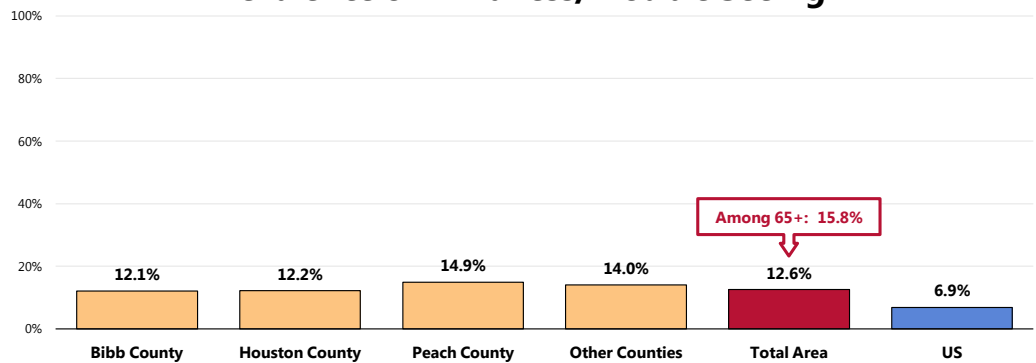
— Healthy People 2020 (www.healthypeople.gov)

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

A total of 12.6% of Total Area adults are blind, or have trouble seeing even when wearing corrective lenses.

- Less favorable than found nationwide.
- No difference statistically when viewed by county.
- 👥 Among Total Area adults age 65 and older, 15.8% have vision trouble.

Prevalence of Blindness/Trouble Seeing



Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 26]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Hearing Trouble

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

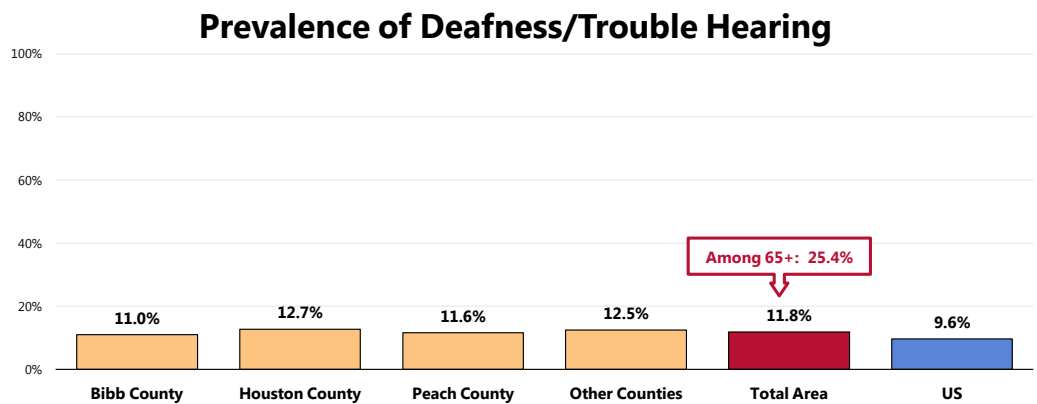
Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition,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

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

— Healthy People 2020 (www.healthypeople.gov)

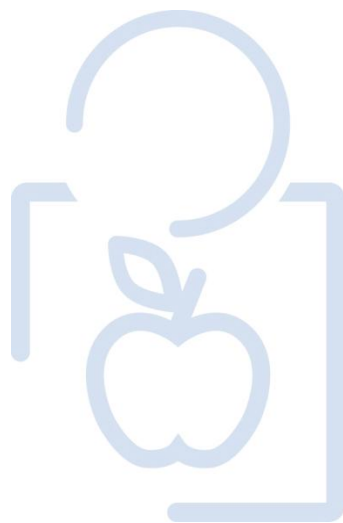
In all, 11.8% of Total Area adults report being deaf or having difficulty hearing.

- Similar to that found nationwide.
- Similar by county.
- 👥 Among Total Area adults age 65 and older, 25.4% have partial or complete hearing loss.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 27]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

INFECTIOUS DISEASE



Vaccine-Preventable Conditions

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by \$9.9 billion.
- Saves \$33.4 billion in indirect costs.

— Healthy People 2020 (www.healthypeople.gov)

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

It is usually expressed as cases per 100,000 population

Measles, Mumps, Rubella

Between 2006 and 2008, there were no reported cases of measles, mumps or rubella in the Total Area.

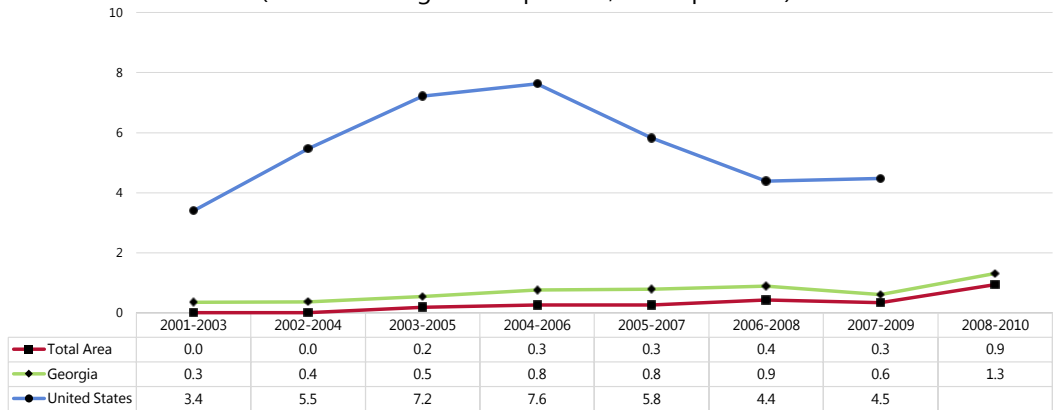
Pertussis

Between 2008 and 2010, the annual average pertussis incidence rate (new cases per year) was less than one (0.9) case per 100,000 population in the Total Area.

- Lower than the Georgia incidence rate.
- Well below the national incidence rate for the 2007-2009 reporting period.
- Higher in Bibb and Peach counties.
- ☒ Incidence has increased over the past several years in the Total Area, echoing the statewide trend. US rates have been much higher and more erratic, as shown.

Pertussis Incidence

(Annual Average Cases per 100,000 Population)



Sources: • Georgia Department of Public Health.
 • Centers for Disease Control and Prevention, National Center for Health Statistics.

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

Influenza & Pneumonia Vaccination

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

— Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

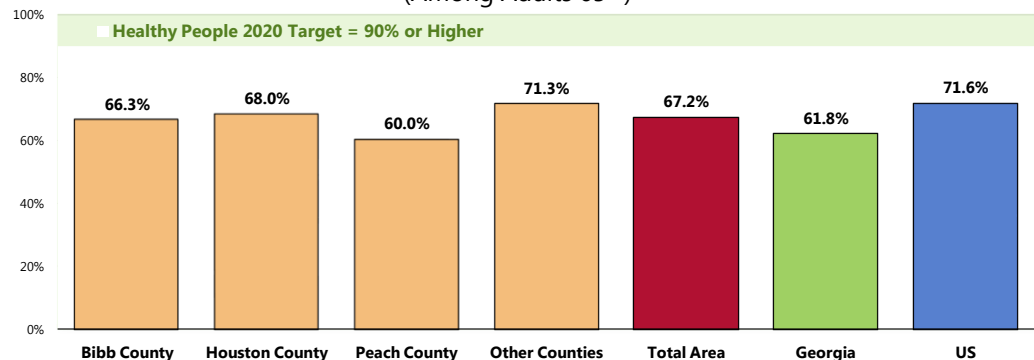
FluMist® is a vaccine that is sprayed into the nose to help protect against influenza; it is an alternative to traditional flu shots.

Among Total Area seniors, 67.2% received a flu shot (or FluMist®) within the past year.

- Statistically comparable to the Georgia finding.
- Comparable to the national finding.
- Fails to satisfy the Healthy People 2020 target (90% or higher).
- Statistically comparable by county.

Have Had a Flu Vaccination in the Past Year

(Among Adults 65+)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 160]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Georgia data.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.7]
Notes: • Reflects respondents 65 and older.
• Includes FluMist as a form of vaccination.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

High-Risk Adults

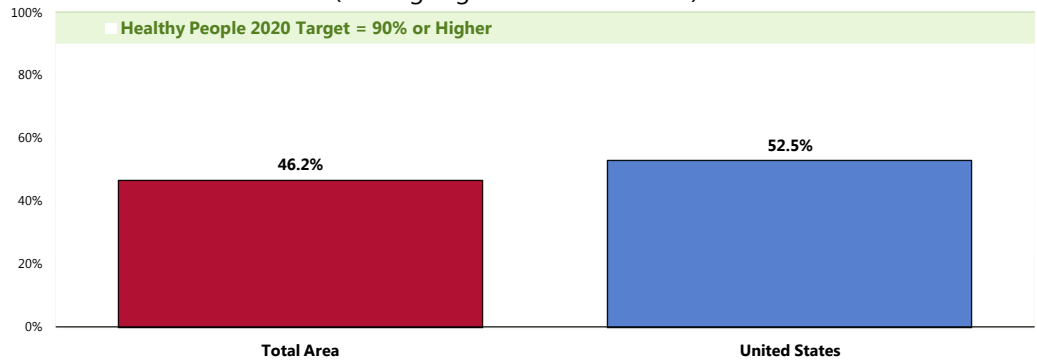
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 46.2% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (90% or higher).

Have Had a Flu Vaccination in the Past Year

(Among High-Risk Adults 18-64)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 161]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.6]
 Notes: • Reflects high-risk respondents age 18-64.
 • Includes FluMist as a form of vaccination.

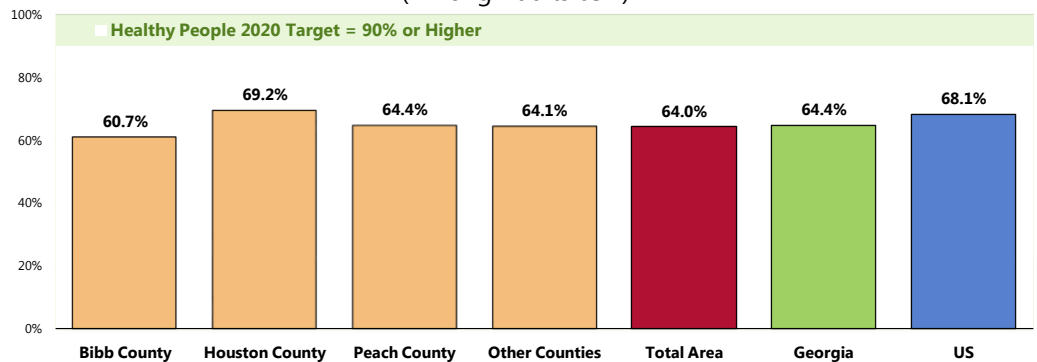
Pneumonia Vaccination

Among adults age 65 and older, 64.0% have received a pneumonia vaccination at some point in their lives.

- Nearly identical to the Georgia finding.
- Similar to the national finding.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- Statistically similar by county.

Have Ever Had a Pneumonia Vaccine

(Among Adults 65+)



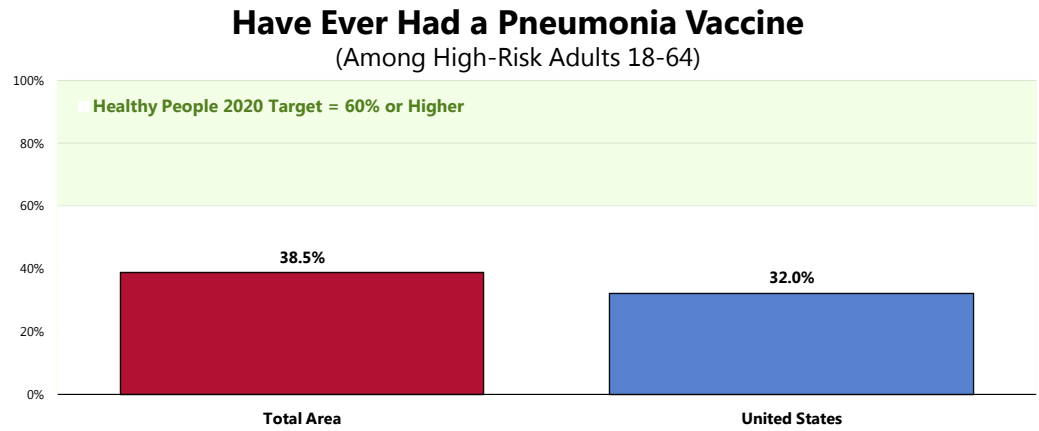
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 162]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-13.1]
 Notes: • Reflects respondents 65 and older.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

High-Risk Adults

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

A total of 38.5% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

- Statistically similar to national findings.
- Fails to satisfy the Healthy People 2020 target (60% or higher).



Sources:

- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-13.2]

Notes:

- Asked of all high-risk respondents under 65.
- “High-Risk” includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

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

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

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

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

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

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

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

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

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

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

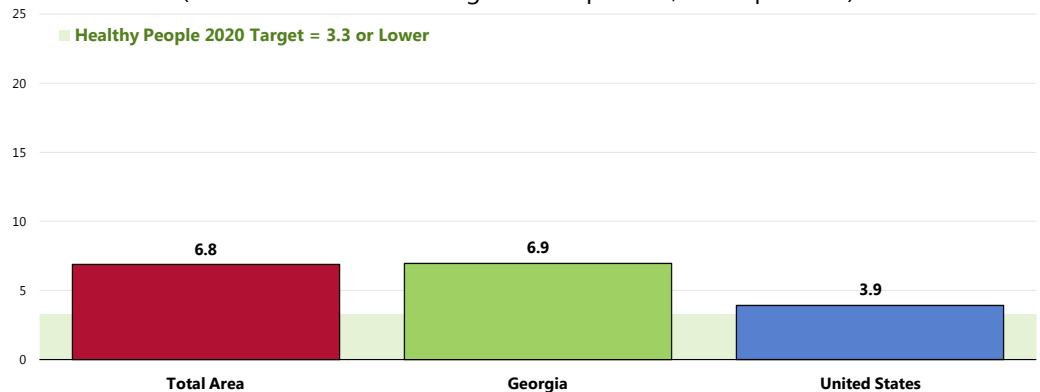
– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted HIV/AIDS Deaths

Between 2004 and 2008, there was an annual average age-adjusted HIV/AIDS mortality rate of 6.8 deaths per 100,000 population in the Total Area.

- Nearly identical to that found statewide.
- Worse than the rate reported nationally.
- Fails to satisfy the Healthy People 2020 target (3.3 or lower).

HIV/AIDS: Age-Adjusted Mortality (2004-2008 Annual Average Deaths per 100,000 Population)

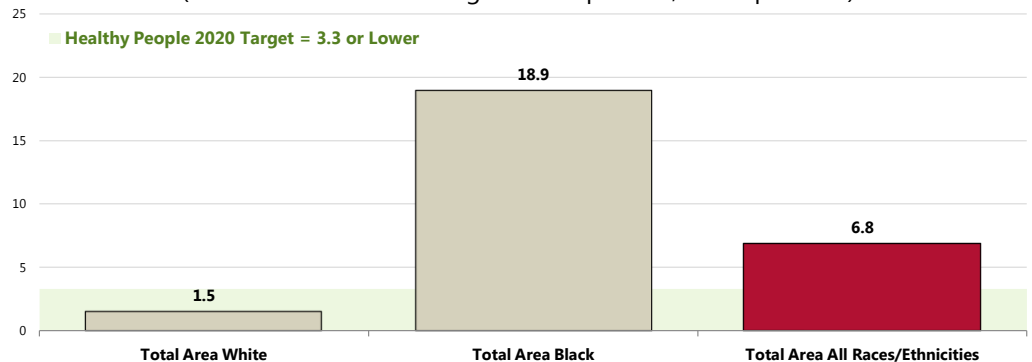


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-12]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.



The HIV mortality rate among Blacks is more than 12 times that among Whites in the Total Area.

HIV/AIDS: Age-Adjusted Mortality by Race (2004-2008 Annual Average Deaths per 100,000 Population)



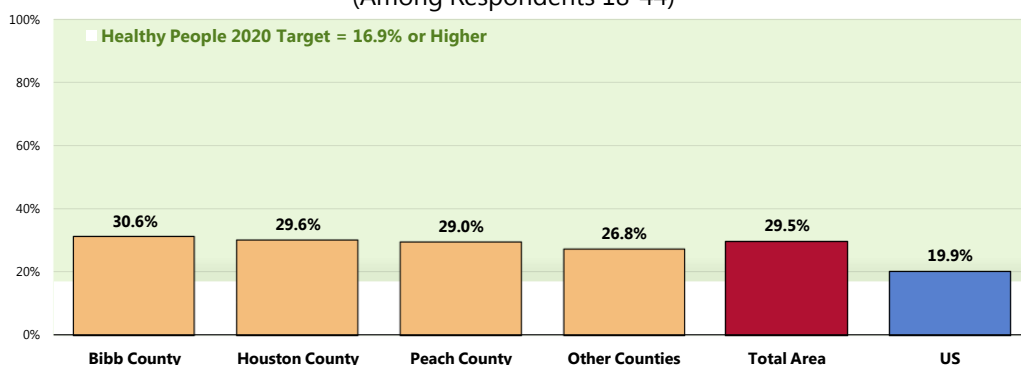
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-12]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

HIV Testing

Among Total Area adults age 18-44, 29.5% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- More favorable than the proportion found nationwide.
- Satisfies the Healthy People 2020 target of 16.9% or higher.
- Similar by county.

Tested for HIV in the Past Year
(Among Respondents 18-44)

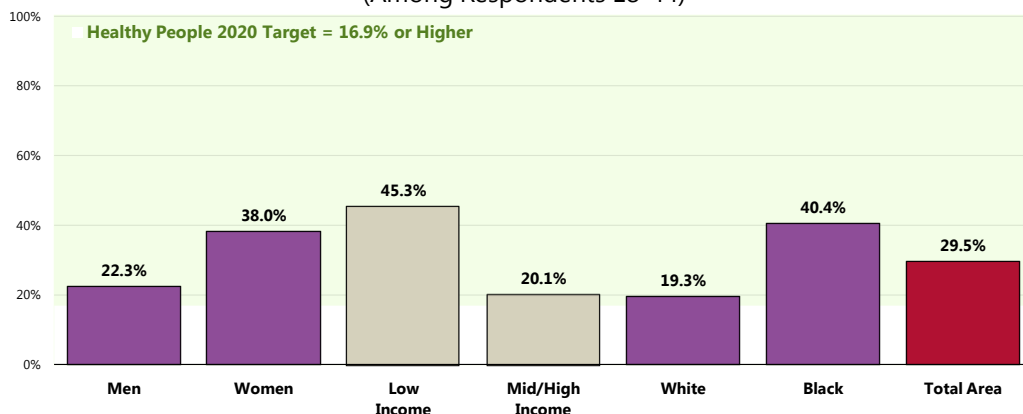


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 166]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-14.1]
 Notes: • Reflects respondents age 18 to 44.
 • Note that the Healthy People 2020 objective is for ages 15-44.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Among adults aged 18 to 44:

👥 Women, lower-income residents and Blacks more often report having been tested for HIV.

Tested for HIV in the Past Year
(Among Respondents 18-44)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 166]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-14.1]
 Notes: • Reflects respondents age 18 to 44.
 • Note that the Healthy People 2020 objective is for ages 15-44.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates the influence of these factors. Social, economic, and behavioral factors that affect the spread of STDs include:

- **Racial and ethnic disparities.** Certain racial and ethnic groups (mainly African American, Hispanic, and American Indian/Alaska Native populations) have high rates of STDs, compared with rates for whites.
- **Poverty and marginalization.** STDs disproportionately affect disenfranchised people and people in social networks where high-risk sexual behavior is common, and either access to care or health-seeking behavior is compromised.
- **Access to health care.** Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for whom access to or use of health services is most limited.
- **Substance abuse.** Many studies document the association of substance abuse with STDs. The introduction of new illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the epidemic spread of STDs.
- **Sexuality and secrecy.** Perhaps the most important social factors contributing to the spread of STDs in the United States are the stigma associated with STDs and the general discomfort of discussing intimate aspects of life, especially those related to sex. These social factors separate the United States from industrialized countries with low rates of STDs.
- **Sexual networks.** Sexual networks refer to groups of people who can be considered “linked” by sequential or concurrent sexual partners. A person may have only 1 sex partner, but if that partner is a member of a risky sexual network, then the person is at higher risk for STDs than a similar individual from a nonrisky network.

— Healthy People 2020 (www.healthypeople.gov)

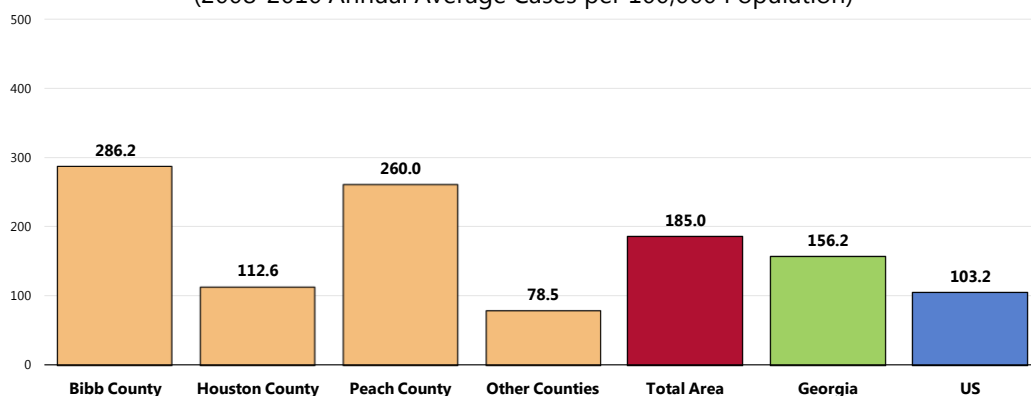
Gonorrhea

Between 2008 and 2010, the annual average gonorrhea incidence rate was 185.0 cases per 100,000 population in the Total Area.

- Higher than the Georgia incidence rate.
- Higher than the national incidence rate.
- Unfavorably high in Bibb and Peach counties.

Gonorrhea Incidence

(2008-2010 Annual Average Cases per 100,000 Population)

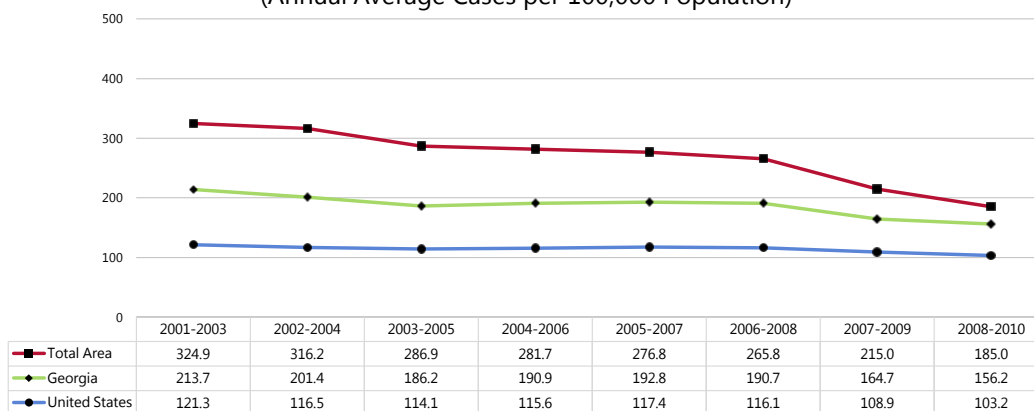


Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

The gonorrhea rate decreased during the past decade in the Total Area, similar to the statewide and national trends.

Gonorrhea Incidence

(Annual Average Cases per 100,000 Population)



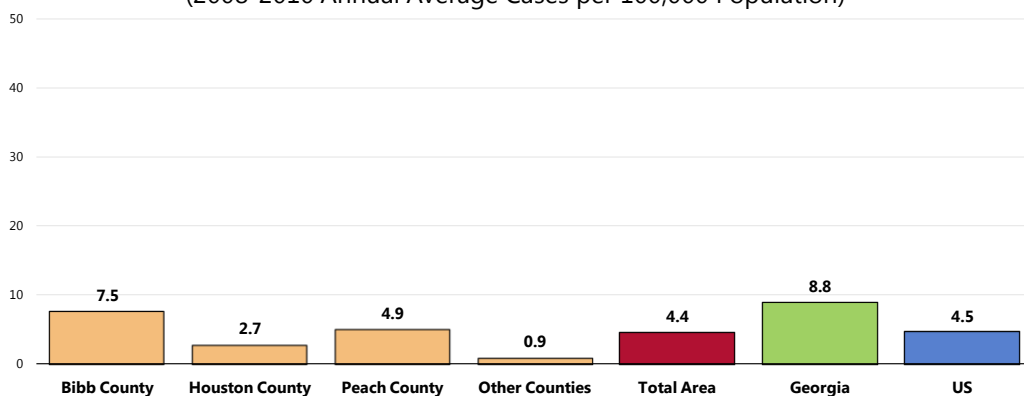
Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Syphilis

Between 2008 and 2010, the annual average primary/secondary syphilis incidence rate was 4.4 cases per 100,000 population in the Total Area.

- One-half the Georgia incidence rate.
- Nearly identical to the national incidence rate.
- Higher in Bibb and Peach counties.

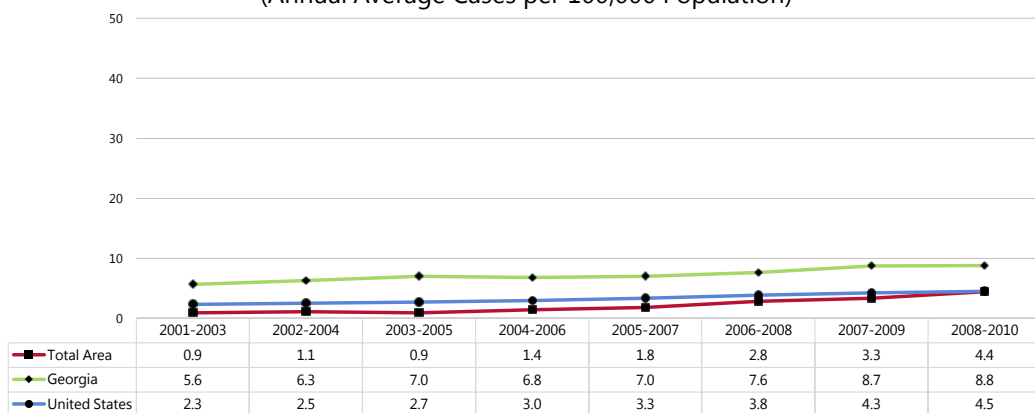
Primary/Secondary Syphilis Incidence (2008-2010 Annual Average Cases per 100,000 Population)



Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

⚠ Syphilis incidence has increased in the Total Area over the past decade. The state and national rates increased as well during this time.

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



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

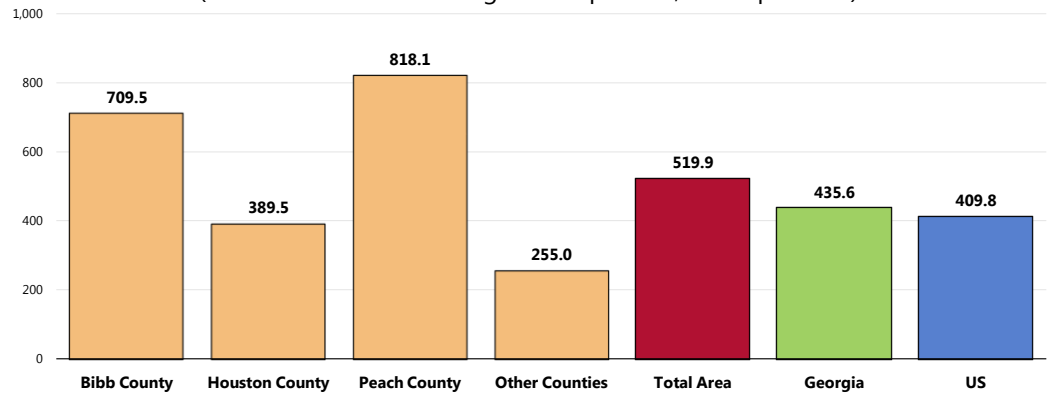
Chlamydia

Between 2008 and 2010, the annual average chlamydia incidence rate was 519.9 cases per 100,000 population in the Total Area.

- Less favorable than the Georgia incidence rate.
- Less favorable than the national incidence rate.
- Dramatically higher in Bibb and Peach counties.

Chlamydia Incidence

(2008-2010 Annual Average Cases per 100,000 Population)

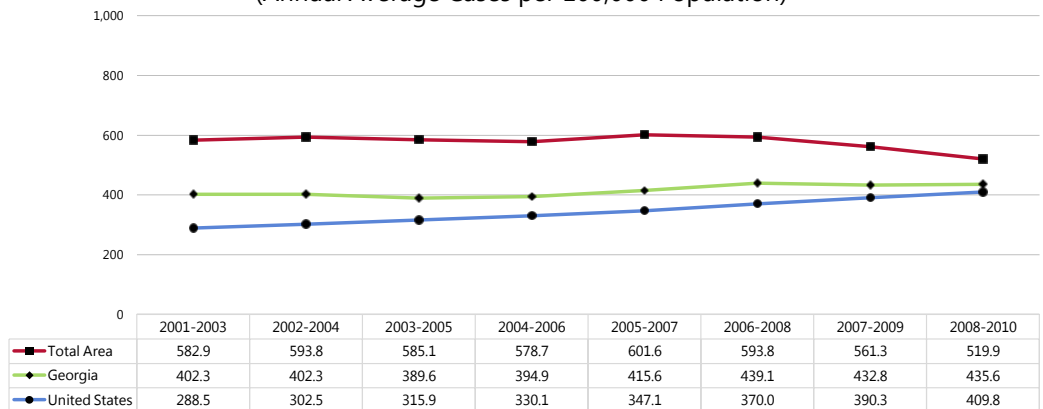


Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Chlamydia incidence has decreased in the Total Area in the last few reporting periods; in contrast, national rates increased during this time.

Chlamydia Incidence

(Annual Average Cases per 100,000 Population)



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

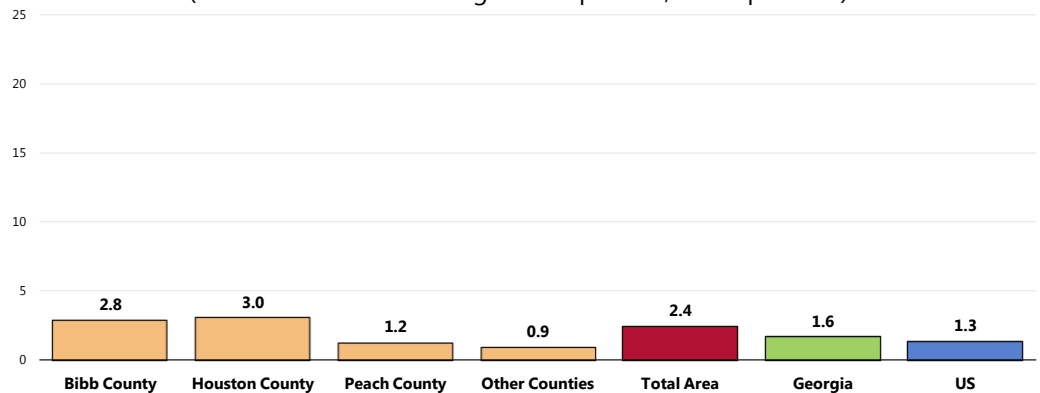
Acute Hepatitis B

Hepatitis B Incidence


Between 2008 and 2010, the hepatitis B incidence rate was 2.4 in the Total Area.

- Worse than the statewide rate.
- Worse than the national rate.
- Higher in Bibb and Houston counties.

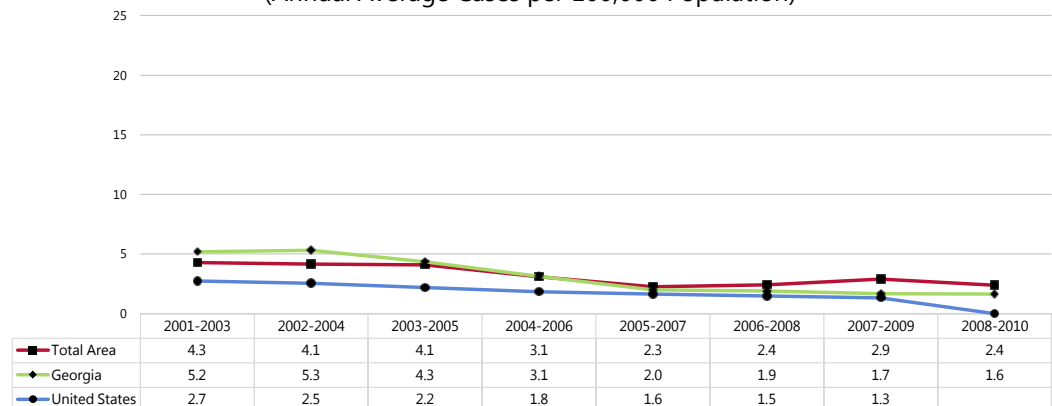
Hepatitis B (Acute) Incidence
(2008-2010 Annual Average Cases per 100,000 Population)



Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.
• US percentage reflects 2007-2009 data.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

 Total Area hepatitis B incidence has decreased overall over the past decade, echoing the downward trend reported both statewide and nationwide.

Hepatitis B (Acute) Incidence
(Annual Average Cases per 100,000 Population)

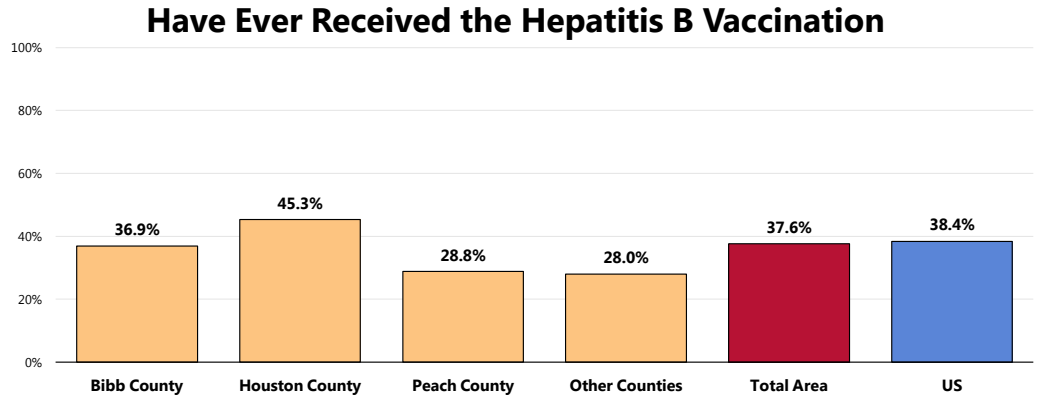


Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Hepatitis B Vaccination

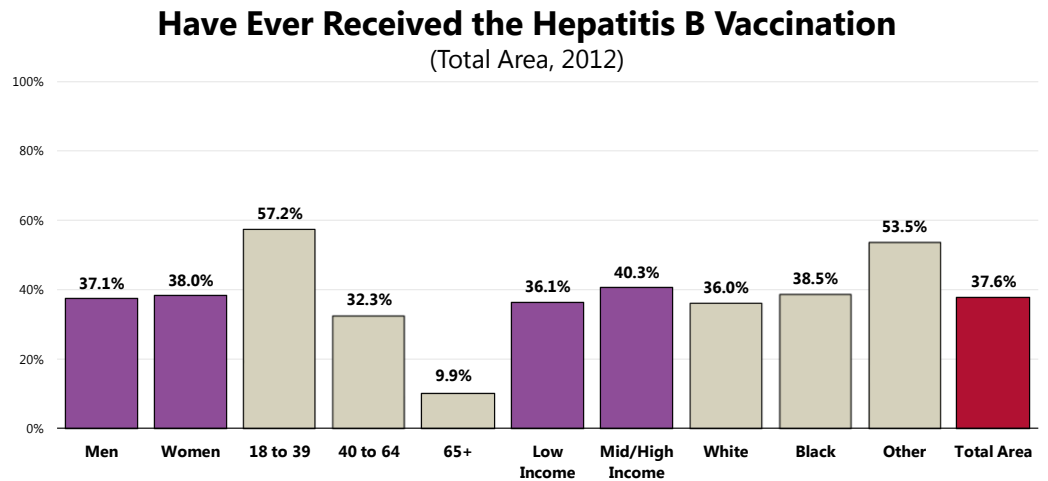
Based on survey data, more than one-third (37.6%) of residents report having received the hepatitis B vaccine.

- Similar to what is reported nationwide.
- Highest in Houston County; unfavorably low in Peach and Other Counties.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 77]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

- 👥 Note the negative correlation between age and hepatitis B vaccination.
- 👥 In addition, White and Black residents are much less likely than residents of "Other" races to have received the hepatitis B vaccine.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 77]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

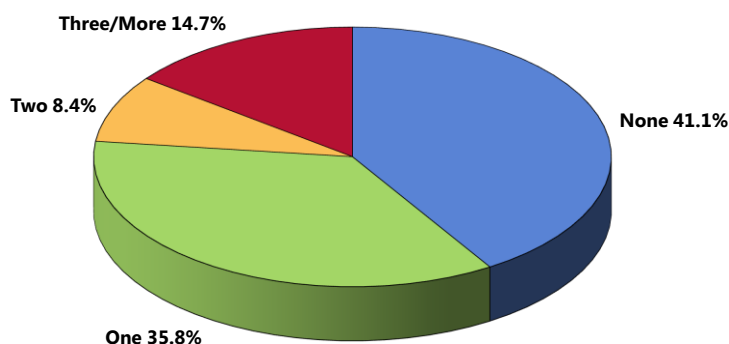
Safe Sexual Practices

Sexual Partners

Among unmarried Total Area adults under 65, the vast majority cites having one (35.8%) or no (41.1%) sexual partners in the past 12 months.

Number of Sexual Partners in Past 12 Months

(Among Unmarried Adults 18-64; Total Area, 2012)



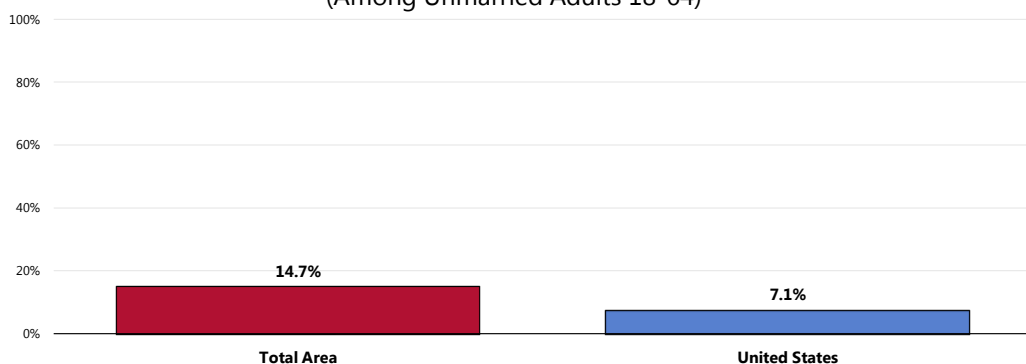
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 97]
Notes: • Asked of all unmarried respondents under the age of 65.

However, 14.7% report three or more sexual partners in the past year.

- Twice that reported nationally.




Had Three or More Sexual Partners in the Past Year

(Among Unmarried Adults 18-64)



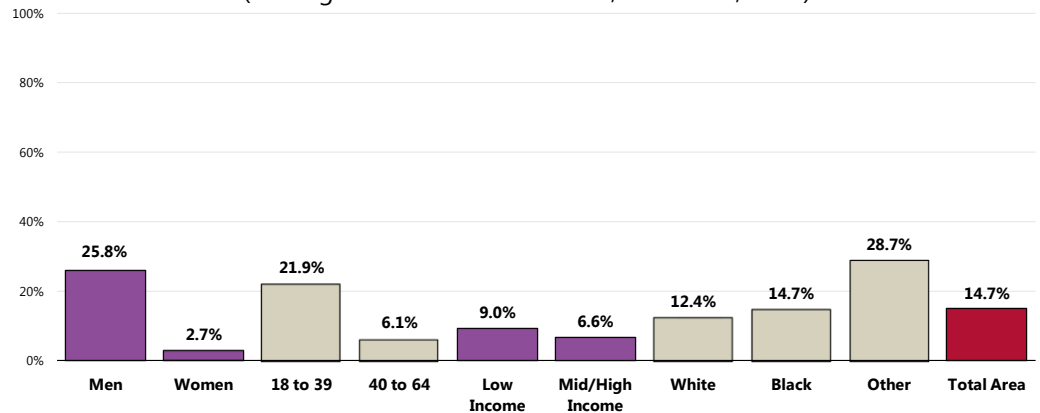
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 97]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all unmarried respondents under the age of 65.

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

-  Men.
-  Young adults.
-  "Other" races.

Had Three or More Sexual Partners in the Past Year

(Among Unmarried Adults 18-64; Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 97]

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

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

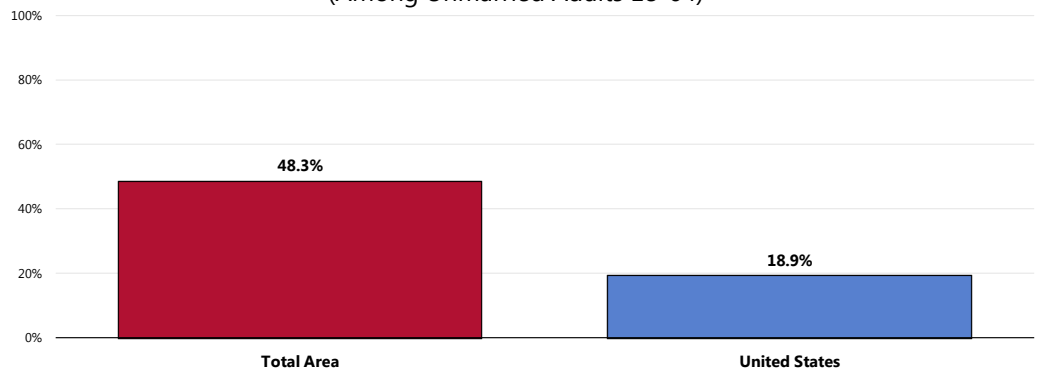
Condom Use

Among Total Area adults who are under age 65 and unmarried, 48.3% report that a condom was used during their last sexual intercourse.

- Much higher than national findings.

Condom Was Used During Last Sexual Intercourse

(Among Unmarried Adults 18-64)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 98]

• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

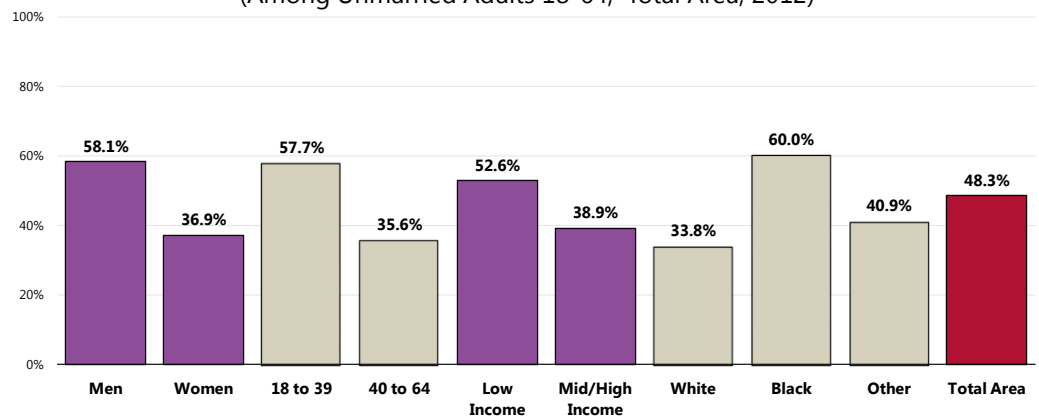
Notes: • Asked of all unmarried respondents under the age of 65.

Those less likely to report that a condom was used during their last sexual intercourse include:

- 👥 Women.
- 👥 Residents age 40 through 64.
- 👥 Respondents with higher incomes.
- 👥 Whites and "Other" races.

Condom Was Used During Last Sexual Intercourse

(Among Unmarried Adults 18-64; Total Area, 2012)



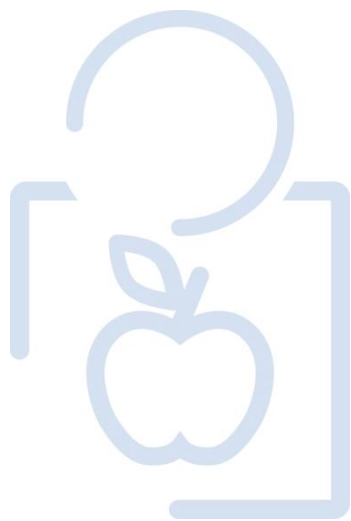
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 98]

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

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

BIRTHS



Birth Outcomes & Risks

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.

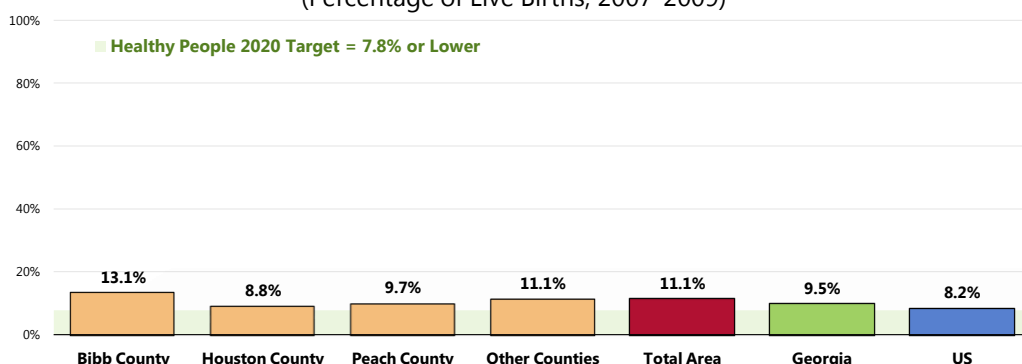
Low-Weight Births

A total of 11.1% of 2007-2009 Total Area births were low-weight.

- Worse than the Georgia proportion.
- Worse than the national proportion.
- Fails to satisfy the Healthy People 2020 target (7.8% or lower).
- Higher in Bibb County and the "Other Counties" combined area.

Low-Weight Births

(Percentage of Live Births, 2007-2009)

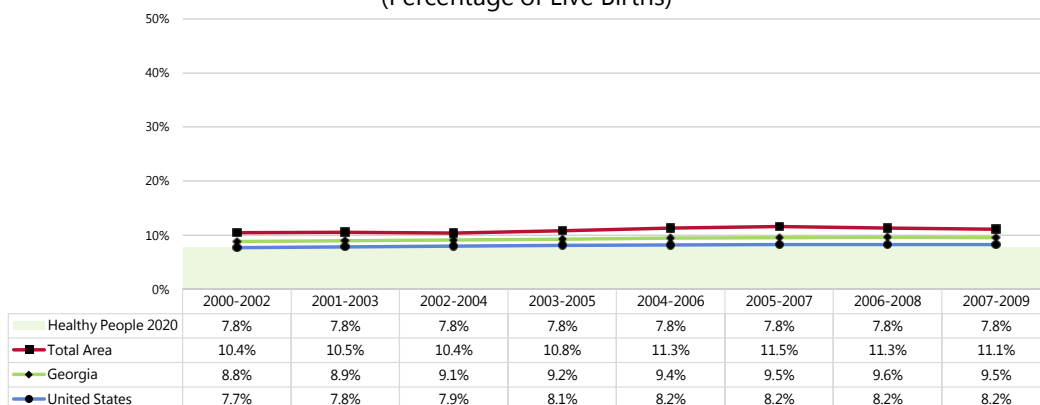


Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
Note: • Numbers are a percentage of all live births within each population.
• Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

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

Low-Weight Births

(Percentage of Live Births)



Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
Note: • Numbers are a percentage of all live births within each population.
• Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

Infant Mortality

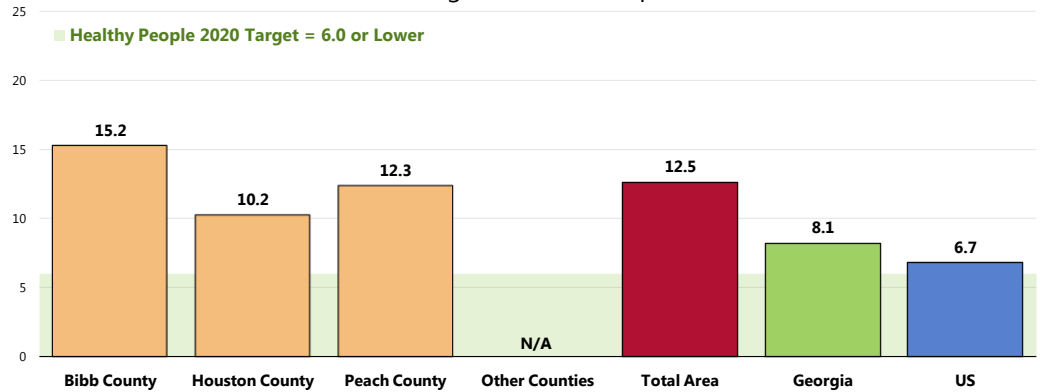
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2006 and 2008, there was an annual average of 12.5 infant deaths per 1,000 live births.

- Less favorable than the Georgia rate.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 6.0 per 1,000 live births.
- Highest in Bibb County.

Infant Mortality Rate

(2006-2008 Annual Average Infant Deaths per 1,000 Live Births)



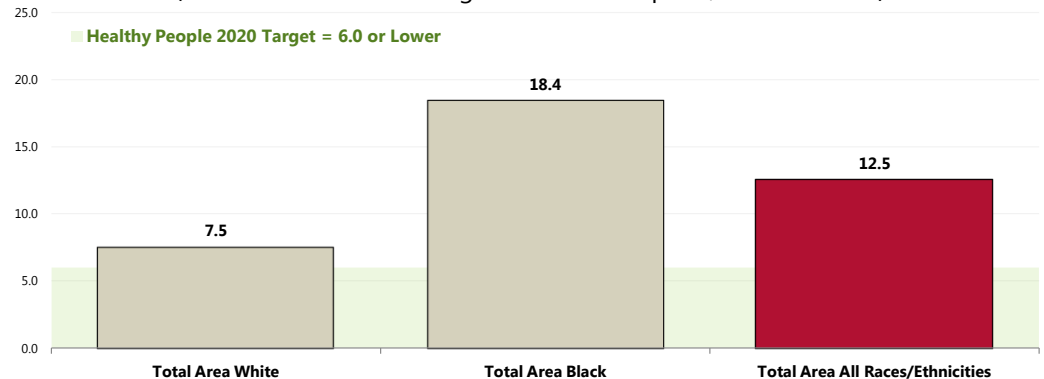
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • Centers for Disease Control and Prevention, National Center for Health Statistics.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
 Notes: • Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.




The infant mortality rate is more than twice as high among Blacks as Whites in the Total Area.

Infant Mortality Rate

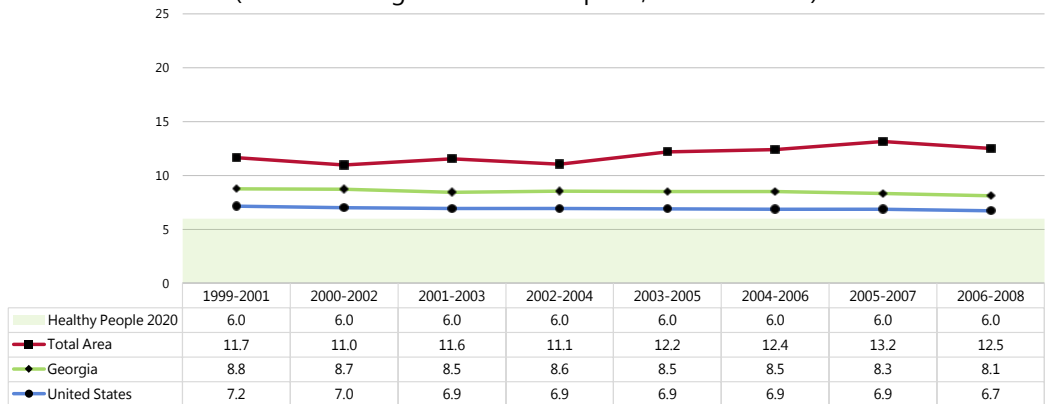
(2006-2008 Annual Average Infant Deaths per 1,000 Live Births)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
 Notes: • Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

-  The infant mortality rate has increased somewhat in recent years in the Total Area, in contrast to the decreasing trends reported for Georgia and the US overall.

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



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]

Notes:

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

Family Planning

Family planning is one of the 10 great public health achievements of the 20th century. The availability of family planning services allows individuals to achieve desired birth spacing and family size and contributes to improved health outcomes for infants, children, and women. Family planning services include contraceptive and broader reproductive health services (patient education and counseling), breast and pelvic examinations, breast and cervical cancer screening, sexually transmitted infection (STI) and HIV prevention education/counseling/testing/referral, and pregnancy diagnosis and counseling. For many women, a family planning clinic is their entry point into the healthcare system and is considered to be their usual source of care. This is especially true for women with incomes below the poverty level, women who are uninsured, Hispanic women, and Black women.

Unintended pregnancies (those reported by women as being mistimed or unwanted) are associated with many negative health and economic outcomes. In 2001, almost one-half of all pregnancies in the US were unintended. For women, negative outcomes associated with unintended pregnancy include:

- Delays in initiating prenatal care
- Reduced likelihood of breastfeeding
- Poor maternal mental health
- Lower mother-child relationship quality
- Increased risk of physical violence during pregnancy

Children born as a result of an unintended pregnancy are more likely to experience poor mental and physical health during childhood and poor educational and behavioral outcomes.

– Healthy People 2020 (www.healthypeople.gov)

Births to Unwed Mothers

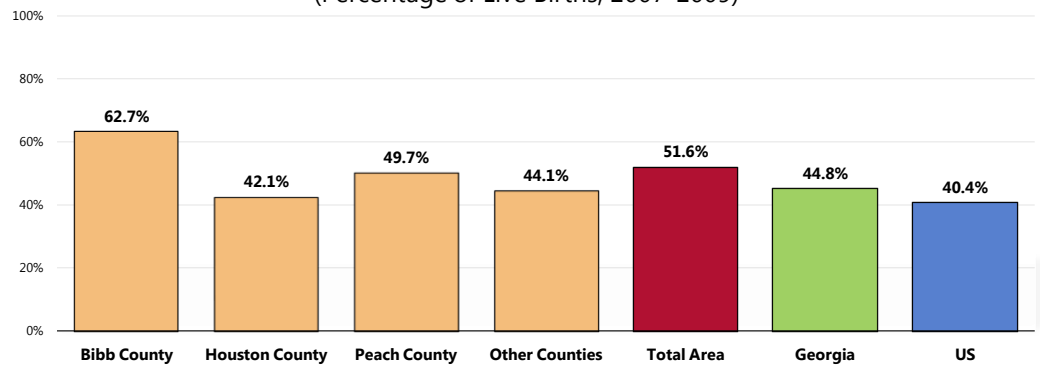
According to the CDC, an unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. It is a core concept in understanding the fertility of populations and the unmet need for contraception. Unintended pregnancy is associated with an increased risk of morbidity for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

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

More than one-half (51.6%) of 2007-2009 births were to unwed mothers.

- Higher than the percentage reported statewide.
- Higher than that found nationally.
- Especially high in Bibb County and also unfavorably high in Peach.

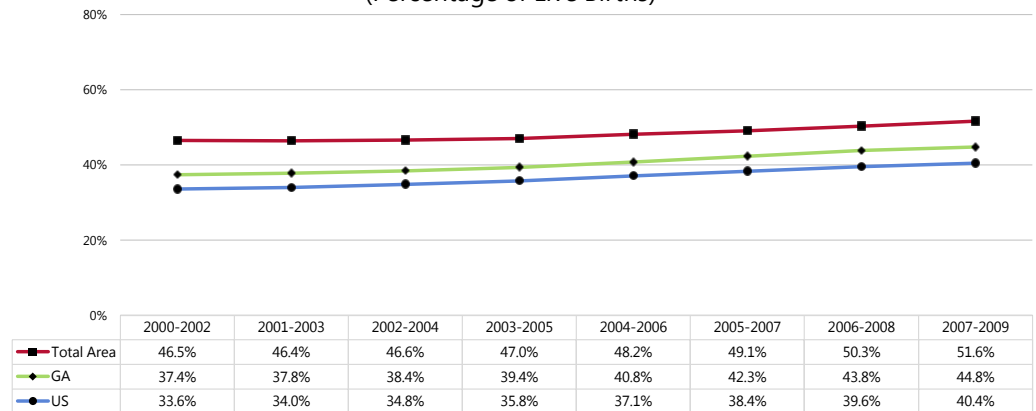
Births to Unwed Mothers (Percentage of Live Births, 2007-2009)



Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.
• US percentage reflects 2004-2006 data.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

The percentage of births to unwed mothers in the Total Area increased over the past decade, echoing the state and national trends.

Births to Unwed Mothers (Percentage of Live Births)



Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

Births to Teen Mothers

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

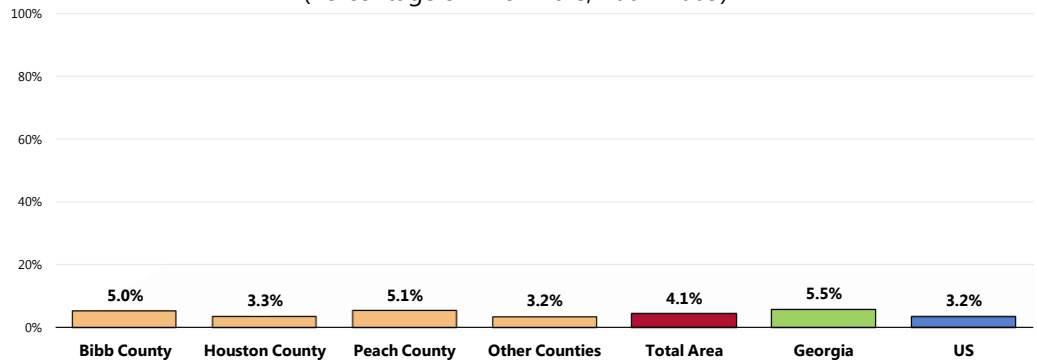
Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

— Healthy People 2020 (www.healthypeople.gov)


A total of 4.1% of 2007-2009 Total Area births were to teenage mothers between the ages of 15 and 17.

- More favorable than the Georgia proportion.
- Less favorable than the national proportion.
- Higher in Bibb and Peach counties.

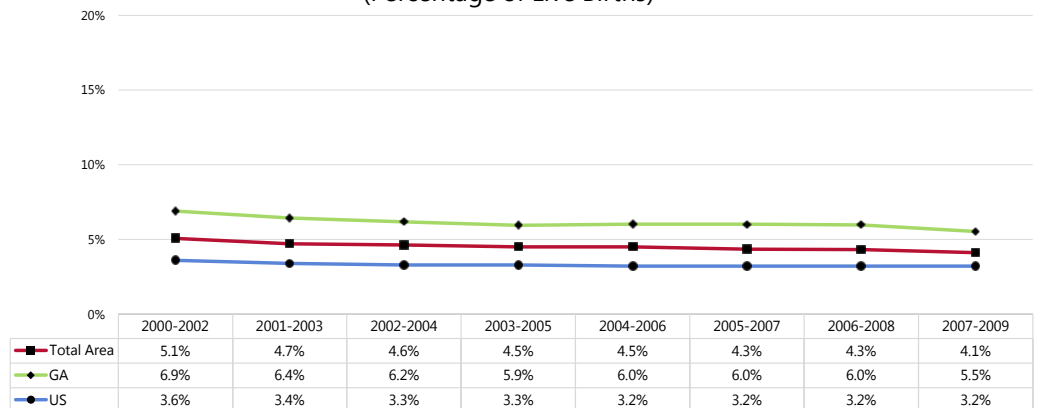
Births to Teen Mothers (15-17) (Percentage of Live Births, 2007-2009)



Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.
• Percentages reflect the number of births to females aged 15 through 17.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

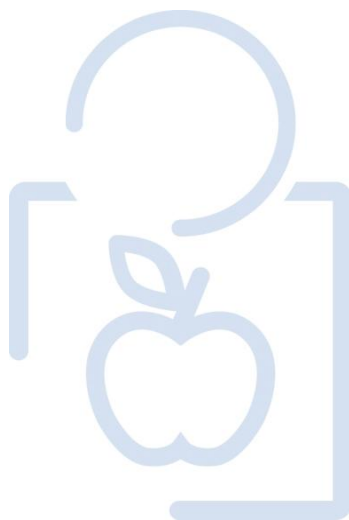
 The percentage of births to girls aged 15-17 decreased in the Total Area in recent years; the same can be said both statewide and nationwide.

Births to Teen Mothers (15-17) (Percentage of Live Births)



Sources: • Georgia Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

MODIFIABLE HEALTH RISKS



Actual Causes Of Death

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were tobacco (an estimated 435,000 deaths), diet and activity patterns (400,000), alcohol (85,000), microbial agents (75,000), toxic agents (55,000), motor vehicles (43,000), firearms (29,000), sexual behavior (20,000), and illicit use of drugs (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

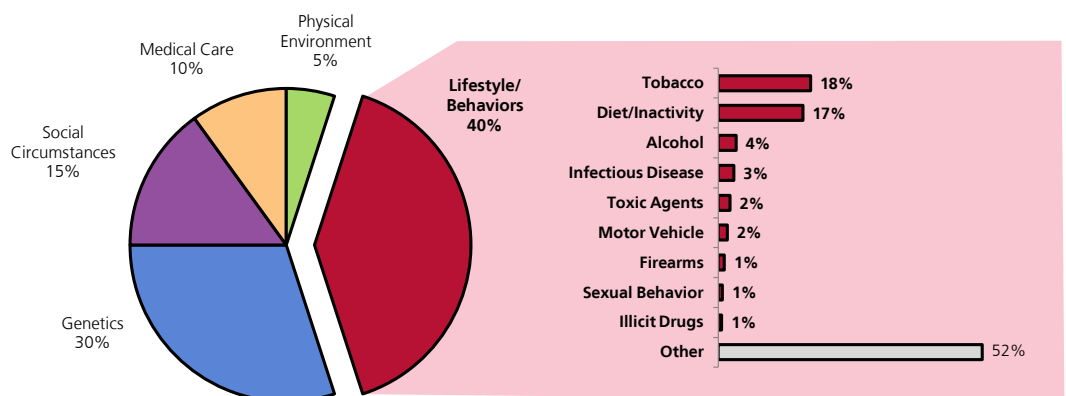
— Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic lung disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88-1232.

Factors Contributing to Premature Deaths in the United States



Sources: "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs, Vol. 21, No. 2, March/April 2002. "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH) JAMA, 291(2000):1238-1245.

Nutrition

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

– Healthy People 2020 (www.healthypeople.gov)

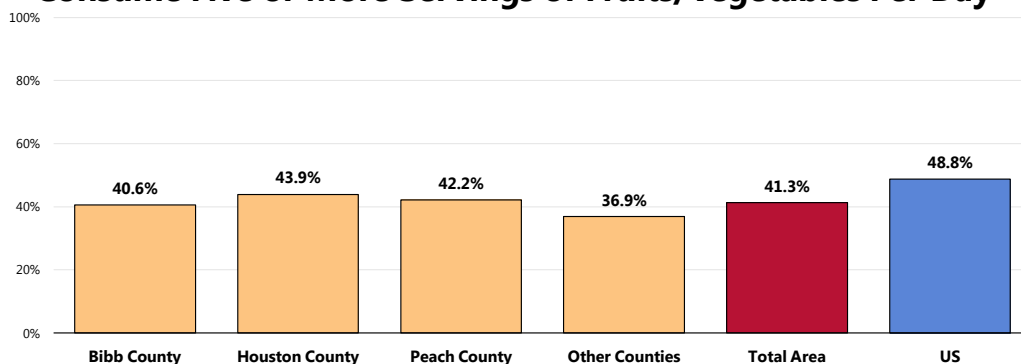
Daily Recommendation of Fruits/Vegetables

A total of 41.3% of Total Area adults report eating five or more servings of fruits and/or vegetables per day.

- Less favorable than national findings.
- Comparable by county.

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

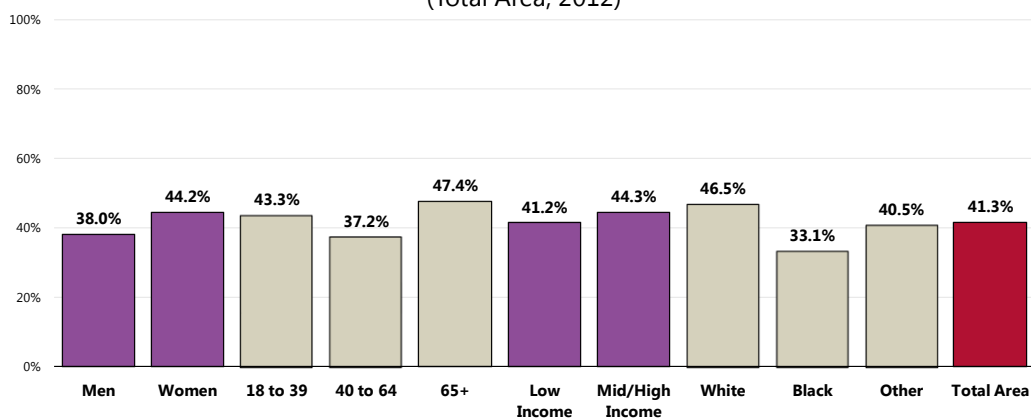
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • For this issue, respondents were asked to recall their food intake on the previous day.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Area men are less likely to get the recommended servings of daily fruits/vegetables, as are adults aged 40-64 and Blacks.

Consume Five or More Servings of Fruits/Vegetables Per Day (Total Area, 2012)




Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • For this issue, respondents were asked to recall their food intake on the previous day.

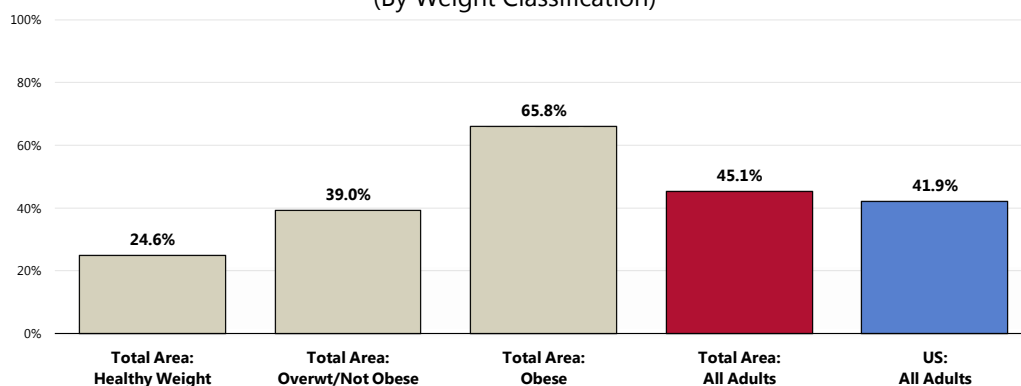
Health Advice About Diet & Nutrition

A total of 45.1% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Statistically similar to national findings.
- Similar by county (not shown).

 Note: Among obese respondents, 65.8% report receiving diet/nutrition advice (meaning that nearly one-third did not).

Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Related Focus Group Findings: Nutrition and Obesity

Many focus group participants discussed nutrition and obesity. The main findings include:

- Food deserts
- Fast food
- Knowledge
- Hunger

Focus group participants believe that poor nutrition leads to obese residents. Poor eating habits stem from a variety of sources in the community. Participants describe downtown Macon and the surrounding rural counties as “**food deserts**.” Small convenience marts are plentiful and represent the only choice in food shopping for residents.

Local food banks and social service agencies work diligently to provide access to fresh food in low-income neighborhoods. Farmer’s markets occur regularly. Also a “veggie van” goes into these neighborhoods and accepts food stamps. Some local companies sponsor weight-loss challenges for their employees to help motivate them, while other

organizations have created community gardens. A participant describes the current solutions:

"There's a local farmer's market that goes around into the at-risk neighborhoods and they will double the value of their food stamps if they buy from the veggie van." — Bibb County Participant

Members believe that **fast food restaurants** are abundant in the community and these restaurants offer unhealthy food. Fast food or microwaveable meals are common choices as quick and easy options for busy parents or those who work multiple jobs. One member notes:

"You go to the Burger King and get something to eat, which will stop the hunger, versus going to the farmer's market and grabbing everything you need for a fresh made salad or to the grocery store. The availability of the fast food in this area is tremendous, versus getting something healthy." — Regional Participant

Focus group participants also feel residents lack nutrition and obesity prevention **knowledge**. Members think nutrition education should target parents and should occur in a variety of settings, including physician offices, the school, and non-traditional settings like grocery stores. Learning how to read labels, nutrition facts, and cooking classes would benefit the entire community because residents do not know how to cook healthy meals for their families. An educational class should also be a requirement for those receiving food stamps and could take place when the recipient gets certified. A participant explains:

"Perhaps when they do that screening for food stamps, could they not have a nutritional class that would teach them what to buy at the grocery and, you know, how to get the most for your money? I think there's a process where they have to go in and re-certify every so often. I mean there's your opportunity. They cannot get their food stamps unless they do that so you've got a very captive audience." — Bibb County Participant

There is much concern about **hunger** in the region. There is a high level of unemployment, so some parents cannot afford to purchase food for their families. Many school-aged children receive free or reduced-cost lunches; some of these children may eat only one meal a day during the school week.

"97 percent of the children getting a free lunch – okay, that's just lunch, what about Saturday, what about Sunday, you know, where is that food coming from? The food banks, I know get utilized quite a bit in this area." — Peach County Participant

Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity:

- Gender (boys)
- Belief in ability to be active (self-efficacy)
- Parental support

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity:

- Parental education
- Gender (boys)
- Personal goals
- Physical education/school sports
- Belief in ability to be active (self-efficacy)
- Support of friends and family

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

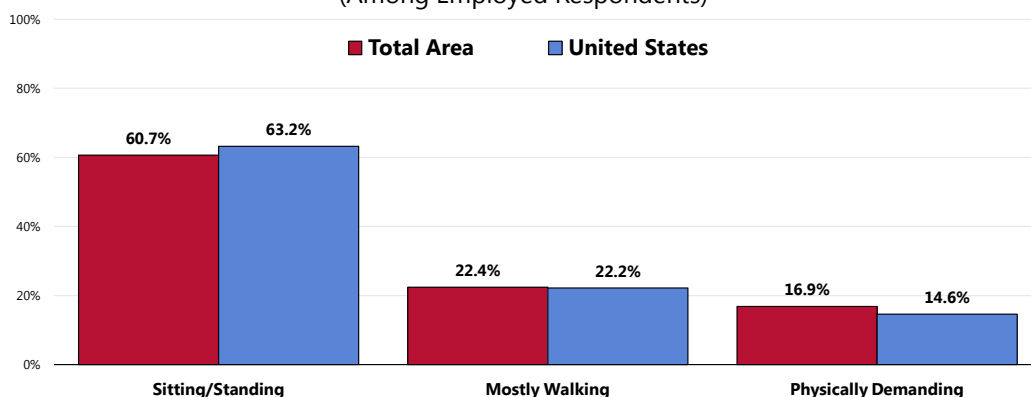
— Healthy People 2020 (www.healthypeople.gov)

Level of Activity at Work

A majority of employed respondents reports low levels of physical activity at work.

- A total of 6 in 10 employed respondents (60.7%) report that their job entails mostly sitting or standing, similar to the US figure.
- 22.4% report that their job entails mostly walking (nearly identical to that reported nationally).
- 16.9% report that their work is physically demanding (similar to the US figure).
- Peach County workers are most likely to hold sedentary jobs (not shown).

Primary Level of Physical Activity At Work (Among Employed Respondents)



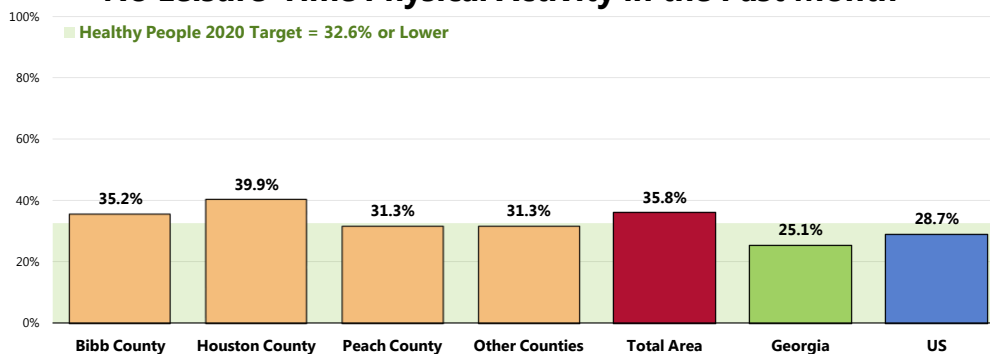
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of those respondents who are employed for wages.

Leisure-Time Physical Activity

35.8% of area adults report no leisure-time physical activity in the past month.

- Less favorable than statewide and national findings.
- Fails to satisfy the Healthy People 2020 target (32.6% or lower).
- Comparable by county.




No Leisure-Time Physical Activity in the Past Month



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2010 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

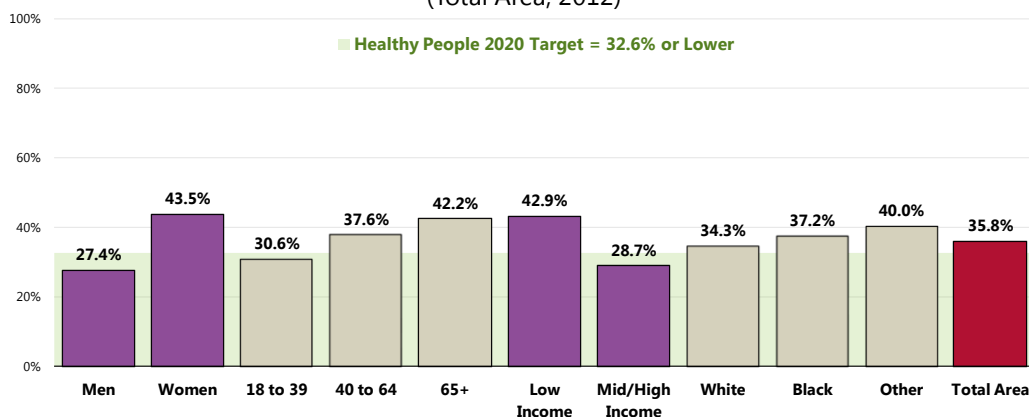
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

Lack of leisure-time physical activity in the area is higher among:

-  Women.
-  Seniors.
-  Lower-income residents.

No Leisure-Time Physical Activity in the Past Month

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Levels

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

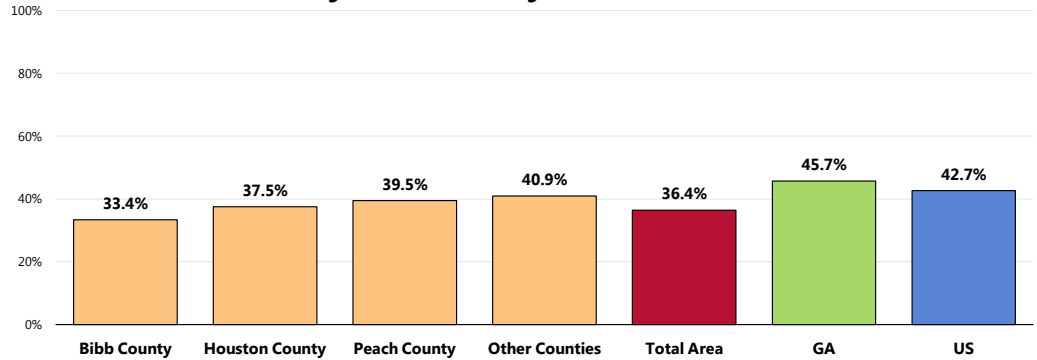
– 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

Recommended Levels of Physical Activity

A total of 36.4% of Total Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- Less favorable than statewide findings.
- Less favorable than national findings.
- Statistically similar by county.

Meets Physical Activity Recommendations



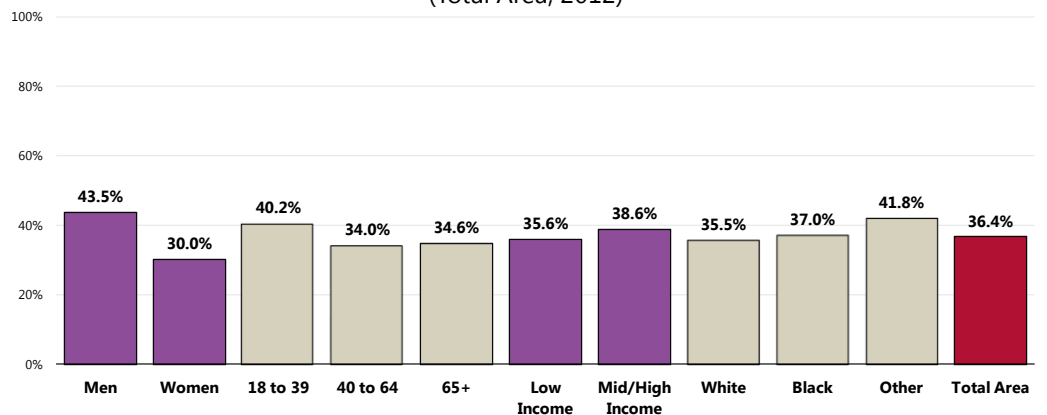
- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 171]
 - 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
- Notes:
- Asked of all respondents.
 - In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.
 - "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.



Total Area women are less likely to meet physical activity requirements.

Meets Physical Activity Recommendations

(Total Area, 2012)



- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 171]
 - Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

The individual indicators of moderate physical activity, vigorous physical activity, and strengthening activities are shown here.

Moderate & Vigorous Physical Activity

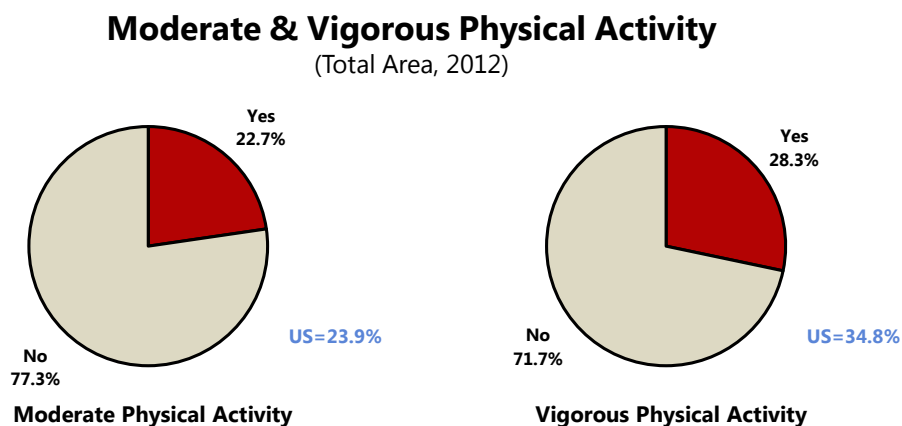
In the past month:

A total of 22.7% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

- Similar to the national level.
- Statistically similar by county (not shown).

A total of 28.3% of adults participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- Less favorable than the nationwide figure.
- Statistically similar by county (not shown).




Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 173-174]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
• Moderate Physical Activity: Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times per week for at least 30 minutes per time.
• Vigorous Physical Activity: Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for at least 20 minutes per time.

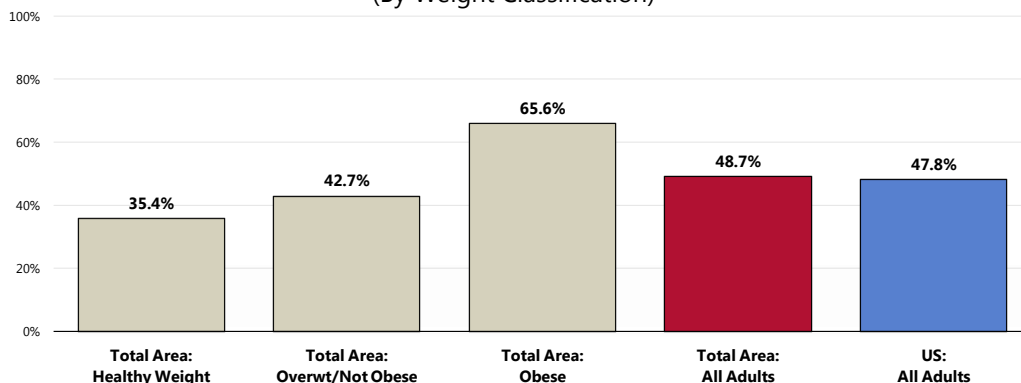
Health Advice About Physical Activity & Exercise

A total of 48.7% of Total 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.
- Houston County adults are least likely to have received advice (not shown).

 Note: 65.6% of obese Total Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Children's Screen Time

Television Watching & Other Screen Time

Among children aged 5 through 17:

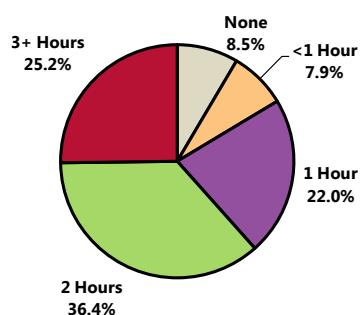
25.2% are reported to watch three or more hours of television per day;

20.1% are reported to spend three or more hours on other types of screen time for entertainment (video games, Internet, etc.).

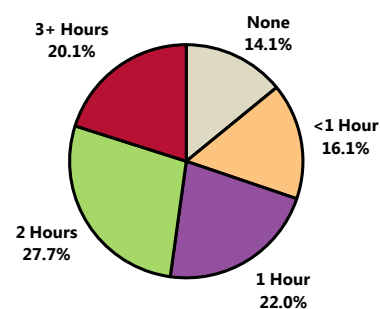
- Compared with the national norm, Total Area school-aged children are twice as likely to spend 3+ hours on the computer daily (no significant difference for time spent watching television).

Children's Screen Time

(Among Parents of Children Ages 5-17; Total Area, 2012)



Hours per Day of Television



Hours per Day of Other Screen Time
(i.e., video games, computer/Internet entertainment)

Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 138-139, 175-176]
Notes: • Asked of respondents with a child aged 5 to 17 in the household.

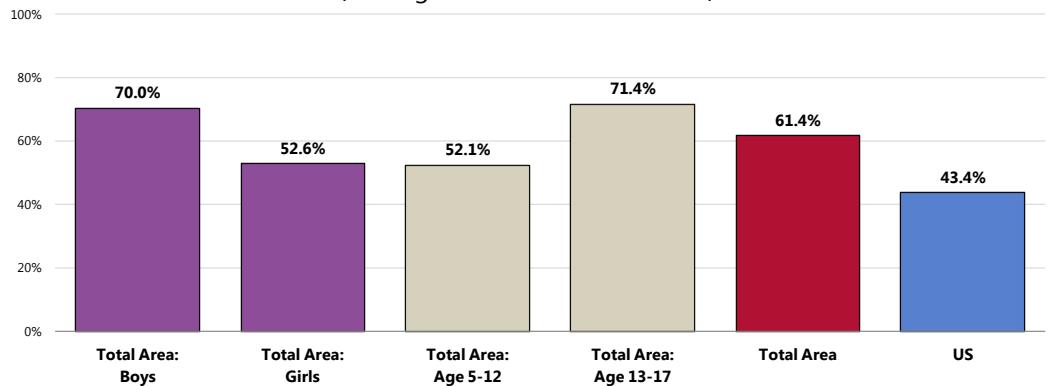
Total Screen Time

When combined, 61.4% of Total Area children aged 5 to 17 have three or more hours of total screen time per day (whether television or computer, Internet, video games, etc.).

- Much higher than found nationally.

👤 By demographics, unfavorably high among Total Area boys and teens.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment] (Among Parents of Children 5-17)



Sources: ● 2012 Professional Research Consultants, Inc. PRC Community Health Survey. [Item 177]

Notes: ● Asked of all respondents with children 5-17 at home.

● For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."

● "Three or more hours" includes reported screen time of 180 minutes or more per day.

Related Focus Group Findings: Physical Activity

Many focus group participants discussed physical activity in the community. The main discussion centered on:

- Safety concerns
- Sedentary lifestyle
- Children

Focus group participants are divided on the number of opportunities for physical activity in the community. In Macon and Warner Robins there are many indoor gyms and walking trails, but community members do not utilize them regularly. In more rural parts of the region, there are limited trails or playgrounds. While opportunities for residents to be active outdoors do exist, some participants express **safety concerns**. Lower-income neighborhood residents may fear even leaving their home, so there where would they exercise? Some community members do not feel safe allowing their children to access the trails, or even play in the street. Sidewalks and street lighting are sparse in many parts of the region. In rural communities even more so, as a participant explains:

"I don't think Twiggs County really has any kind of walking trail except for maybe at the school. I think most people are gonna drive to the track. In a rural community, people live away from the center of town, so I mean you're talking miles... They're not going to walk on the highway."

— Regional Participant

Other participants feel these rural communities offer great cost-free exercise opportunities:

"If you want to walk in Jeffersonville, all you have to do is walk out your front door and take off. If you live in the country, you have a choice of fields." — Regional Participant

In addition to the outdoor physical activity barriers, participants believe many of the residents live a very **sedentary lifestyle**. They express much concern about community residents' inactivity. Adults do not set a good example for their children and focus group members doubt there is even a willingness to change. A respondent recalls:

"Choosing to be inactive, choosing to be lazy, choosing not to go to the doctor when you need to, just personal choices that people are making with their own personal health. And a lot of that, I don't think you can alter." — Peach County Participant

Focus group members feel very strongly that inactivity has a very harmful affect on **children**. A child's day no longer includes regular physical activity. Focus group members think children watch more television and play more video games than ever before, coupled with limited physical education classes in school. There is concern that this generation of children will have more health problems than any generation before and their children will not exercise either. A Peach County participant explains his frustrations:

"NFL is spending millions of dollars with these teams getting on the school bus and encouraging kids to get out in the yard and play 60 minutes a day. My gosh. I used to get three whippings a week for not getting home before the streetlights come on...How did that change? I never remember seeing a 'get outside, kid' commercial on TV. I think it's going to get worse because the kids that we're having to spend millions of dollars every Sunday to tell them to get out and play, are going to start having kids soon." — Peach County Participant

Although there is much frustration about physical activity, participants believe that adding sidewalks, more outdoor lighting, and creating a better transportation network would help decrease inactivity.

"I think if there was a better transportation network within the city that would lead to more walking because then you could walk to the bus stop. I think cars are the obesity machines. So to make transportation easier, that would lead to more walking and less relying on your car." — Regional Participant

Weight Status

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

– Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

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

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

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥ 30.0

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

Adult Weight Status

Healthy Weight

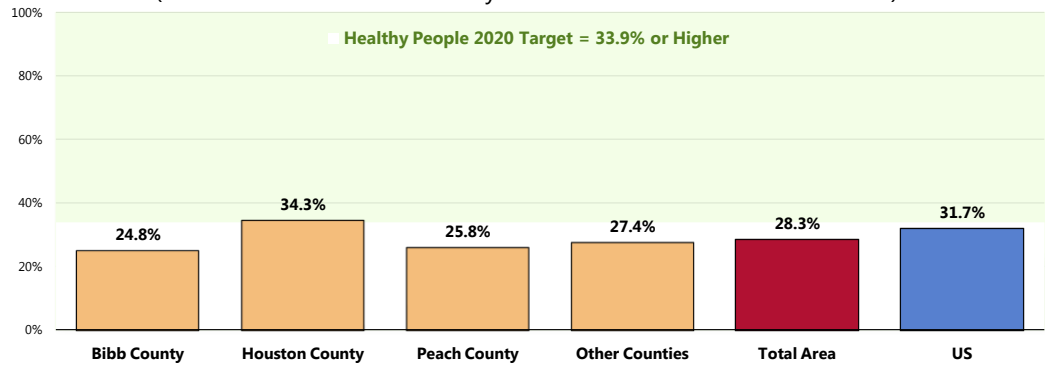
“Healthy weight” means neither underweight, nor overweight (BMI = 18.5-24.9).

Based on self-reported heights and weights, only 28.3% of Total Area adults are at a healthy weight.

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (33.9% or higher).
- Highest in Houston County; lowest in Bibb County.

Healthy Weight

(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 179]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Based on reported heights and weights, asked of all respondents.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-8]
• 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.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Overweight Status

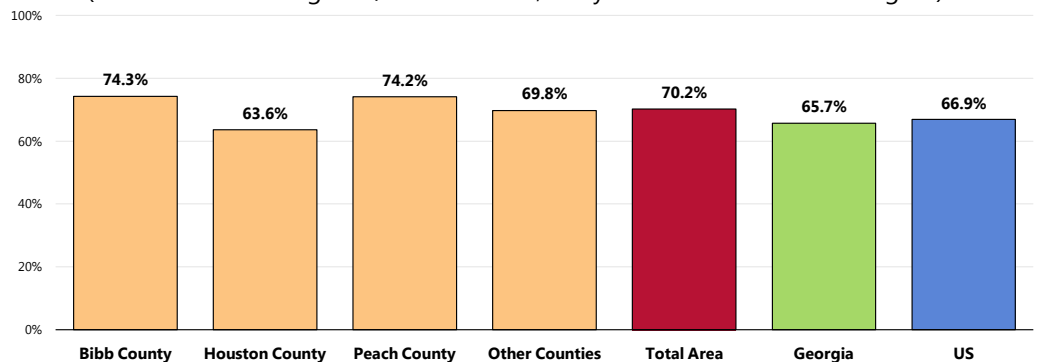
Here, "overweight" includes those respondents with a BMI value ≥ 25 .

A total of 7 in 10 Total Area adults (70.2%) are overweight.

- Worse than the Georgia prevalence.
- Statistically similar to the US overweight prevalence.
- Unfavorably high in Bibb County; lowest in Houston County.

Prevalence of Total Overweight

(Percent of Overweight or/Obese Adults; Body Mass Index of 25.0 or Higher)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 179]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Georgia data.
• Based on reported heights and weights, asked of all respondents.
• The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

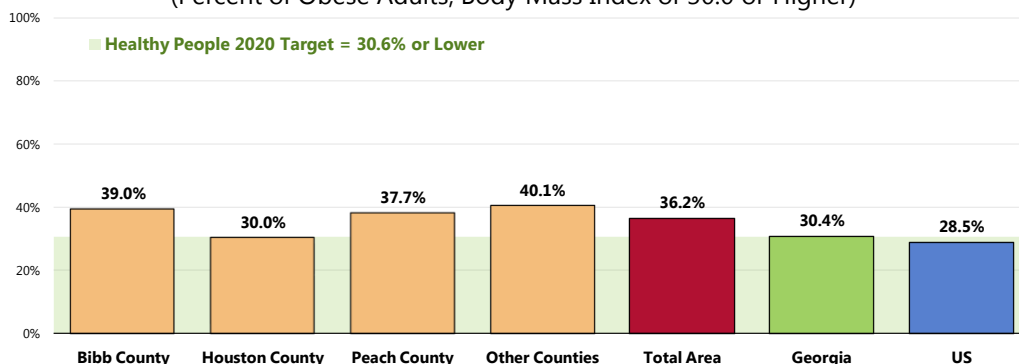
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥ 30 .

Further, 36.2% of Total Area adults are obese.

- Worse than Georgia findings.
- Worse than US findings.
- Fails to satisfy the Healthy People 2020 target (30.6% or lower).
- Lowest in Houston County.

Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher)



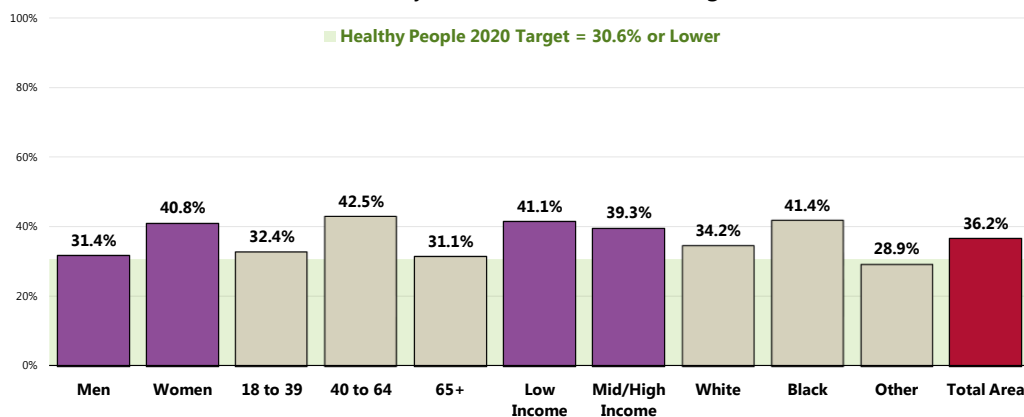
- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 179]
 - 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.
 - "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Obesity is notably more prevalent among:

- Women.
- Those between the ages of 40 and 64.
- Blacks.

Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher; Total Area, 2012)



- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 179]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

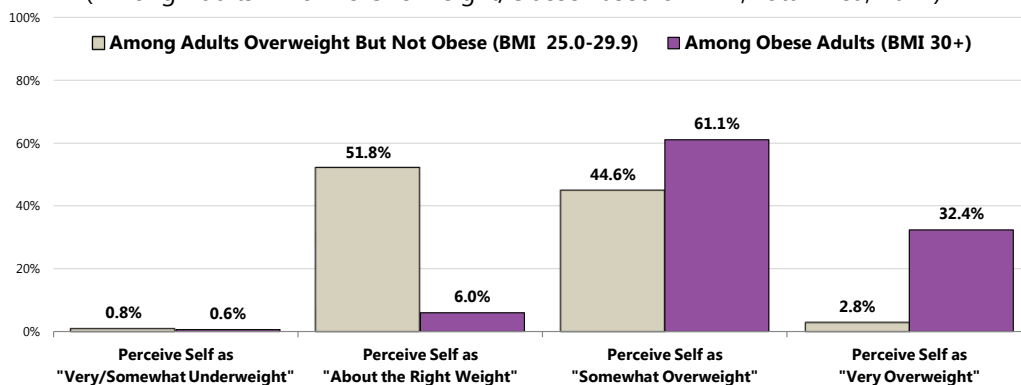
Actual vs. Perceived Body Weight

A total of 6.0% of obese adults and 51.8% of overweight (but not obese) adults feel that their current weight is “about right.”

- 44.6% of overweight (but not obese) adults see themselves as “somewhat overweight.”
- 32.4% of obese adults see themselves as “very overweight.”

Actual vs. Perceived Weight Status

(Among Adults Who Are Overweight/Obese Based on BMI; Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 111]
Notes: • BMI is based on reported heights and weights, asked of all respondents.
• The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

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

Relationship of Overweight With Other Health Issues

Obese adults are more likely to report a number of adverse health conditions.

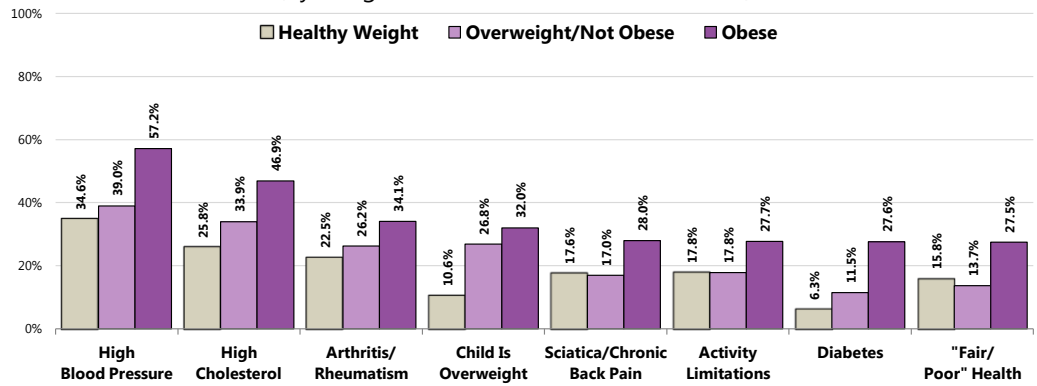
Among these are:

- Hypertension (high blood pressure).
- High cholesterol.
- Arthritis/rheumatism.
- Sciatica/chronic back pain.
- Activity limitations.
- Diabetes.
- “Fair” or “poor” physical health.

Also, overweight/obese residents are more likely to have overweight children.

Relationship of Overweight With Other Health Issues

(By Weight Classification; Total Area, 2012)




Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 28, 29, 44, 116, 143, 183]
Notes: • Based on reported heights and weights, asked of all respondents.

Weight Management

Health Advice

A total of 28.7% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

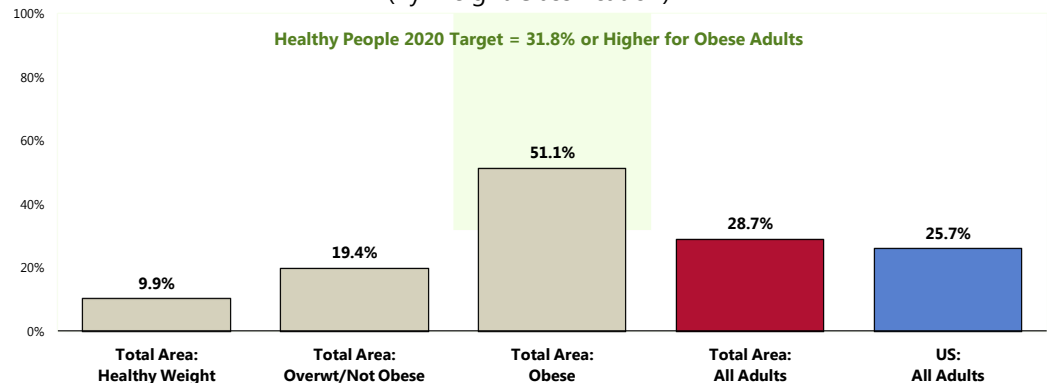
- Statistically similar to the national findings.

 Note that 51.1% of obese adults have been given advice about their weight by a health professional in the past year (while nearly one-half have not).

- This satisfies the Healthy People 2020 target of 31.8% or higher.

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 110, 181-182]
Notes: • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• Asked of all respondents.

- Houston County adults are least likely to have received advice (particularly among overweight adults; not shown in the chart above).

Weight Control

Individuals who are at a healthy weight are less likely to:


- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

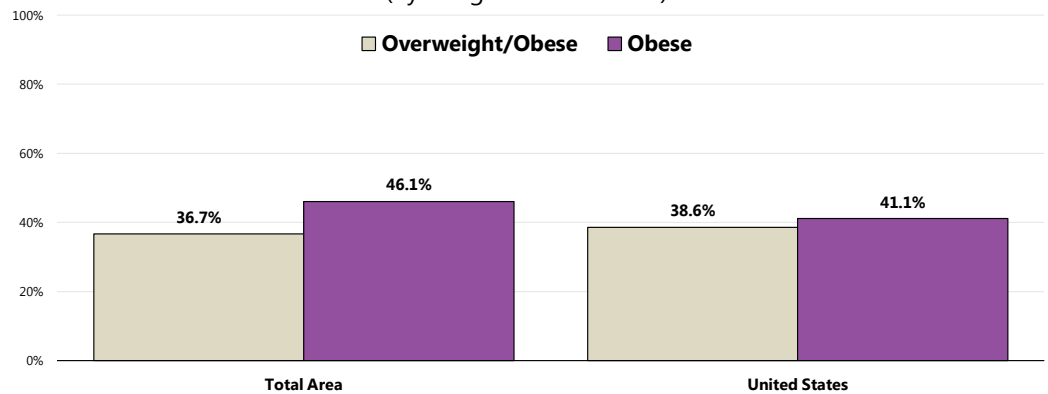
— Healthy People 2020 (www.healthypeople.gov)

A total of 36.7% of Total Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

- Similar to national findings.
- Similar by county (not shown).

 Note: 46.1% of obese Total Area adults report that they are trying to lose weight through a combination of diet and exercise, similar to what is found nationally.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity (By Weight Classification)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Based on reported heights and weights, asked of all respondents.

Childhood Overweight & Obesity

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight..... <5th percentile
- Healthy Weight..... ≥5th and <85th percentile
- Overweight..... ≥85th and <95th percentile
- Obese..... ≥95th percentile

– Centers for Disease Control and Prevention.

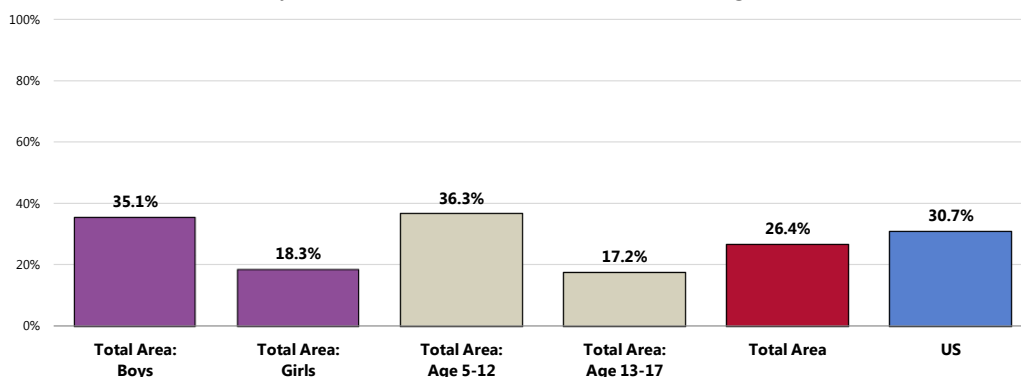
Based on the heights/weights reported by surveyed parents, 26.4% of Total Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Similar to that found nationally.

👤 Statistically higher among Total Area boys and children aged 5 to 12.

Child Total Overweight Prevalence

(Percent of Children 5-17 Who Are Overweight/Obese;
Body Mass Index in the 85th Percentile or Higher)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 183]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents with children age 5-17 at home.
• Overweight among children is estimated based on children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

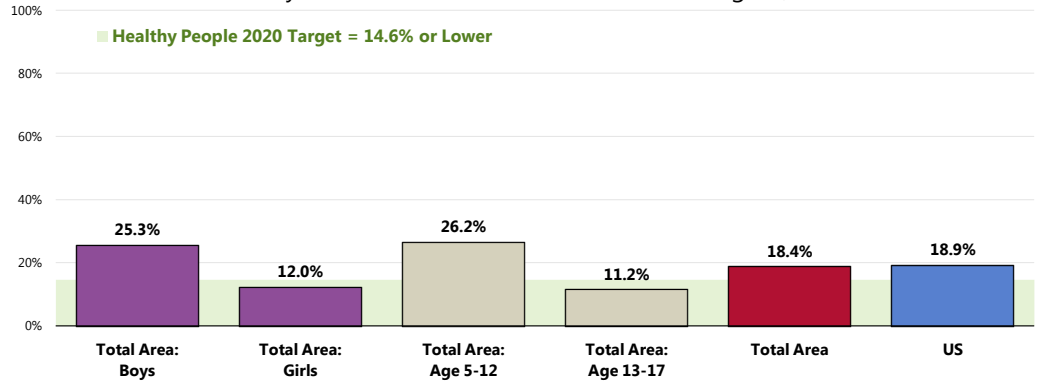
Further, 18.4% of Total Area children age 5 to 17 are obese (≥95th percentile).

- Nearly identical to the national percentage.
- Similar to the Healthy People 2020 target (14.6% or lower for children age 2-19).

👤 Viewed demographically, higher among boys and children aged 5 to 12.

Child Obesity Prevalence

(Percent of Children 5-17 Who Are Obese;
Body Mass Index in the 95th Percentile or Higher)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 183]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

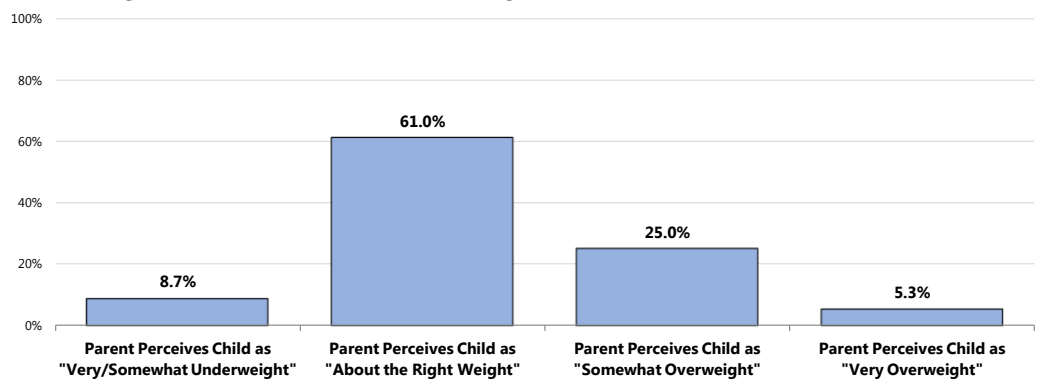
Actual vs. Perceived Body Weight

Interestingly, among parents of children age 5-17 who are overweight or obese, most (61.0%) see their child as being at "about the right weight."

- Only 30.3% perceive their overweight/obese child as "somewhat" or "very overweight."

Children's Actual vs. Perceived Weight Status

(Among Children 5-17 Who Are Overweight/Obese Based on BMI; Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 135]
 Notes: • Asked of all respondents with overweight children age 5-17 at home.
 • Overweight in children is defined as a Body Mass Index (BMI) value at or above the 85th percentile of US growth charts by gender and age.

Discussion of Child's Weight With School Professional

Among parents of overweight/obese children, just 10.3% have been told by a health professional or someone at the child's school that the child is overweight.

Substance Abuse

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

The field has made progress in addressing substance abuse, particularly among youth. According to data from the national Institute of Drug Abuse (NIDA) Monitoring the Future (MTF) survey, which is an ongoing study of the behaviors and values of America's youth between 2004 and 2009, a drop in drug use (including amphetamines, methamphetamine, cocaine, hallucinogens, and LSD) was reported among students in 8th, 10th, and 12th grades. Note that, despite a decreasing trend in marijuana use which began in the mid-1990s, the trend has stalled in recent years among these youth. Use of alcohol among students in these three grades also decreased during this time.

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

— Healthy People 2020 (www.healthypeople.gov)

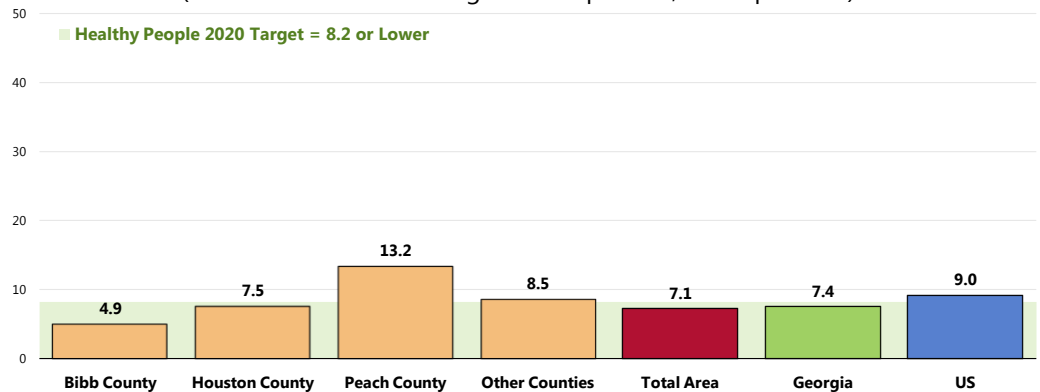
Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2006 and 2008, there was an annual average age-adjusted cirrhosis/liver disease mortality rate of 7.1 deaths per 100,000 population in the Total Area.

- Similar to the statewide rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target (8.2 or lower).
- Notably high in Peach County (13.2).

Cirrhosis/Liver Disease: Age-Adjusted Mortality

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

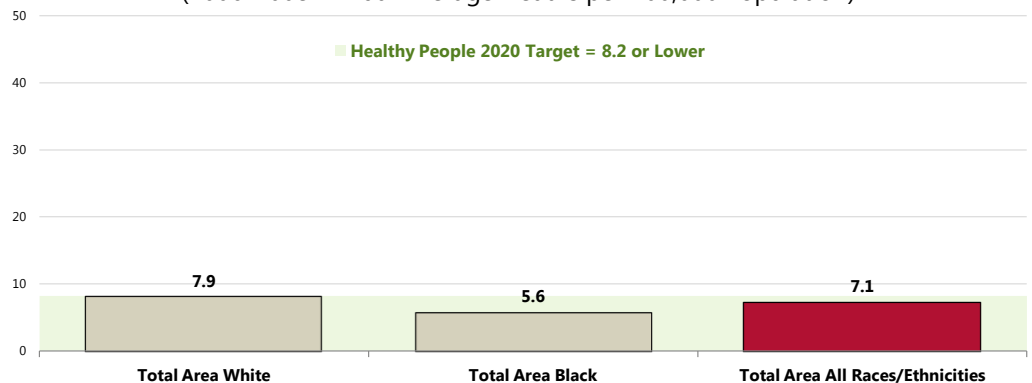


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

👤 The cirrhosis mortality rate is higher among Whites than Blacks in the Total Area.

Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race

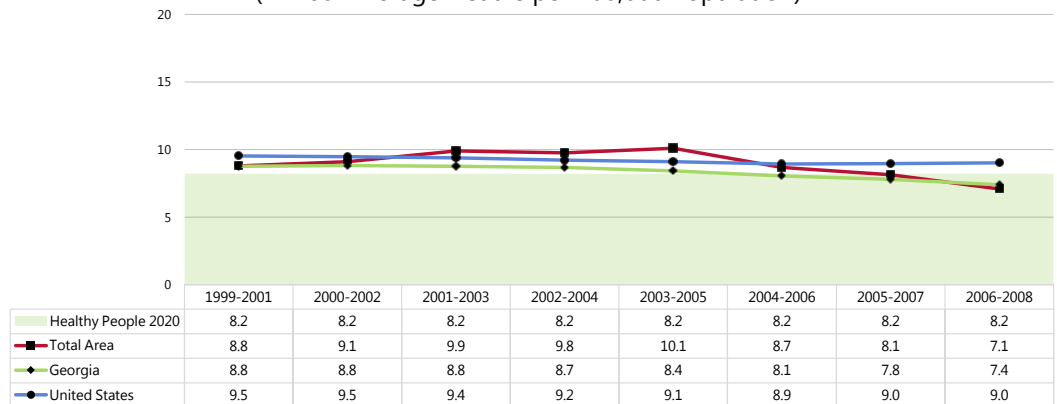
(2006-2008 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.

- ▣ The mortality rate has decreased steadily in the Total Area in recent years; across Georgia and the US, decreases were reported as well.

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



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • State and national data are simple three-year averages.

High-Risk Alcohol Use

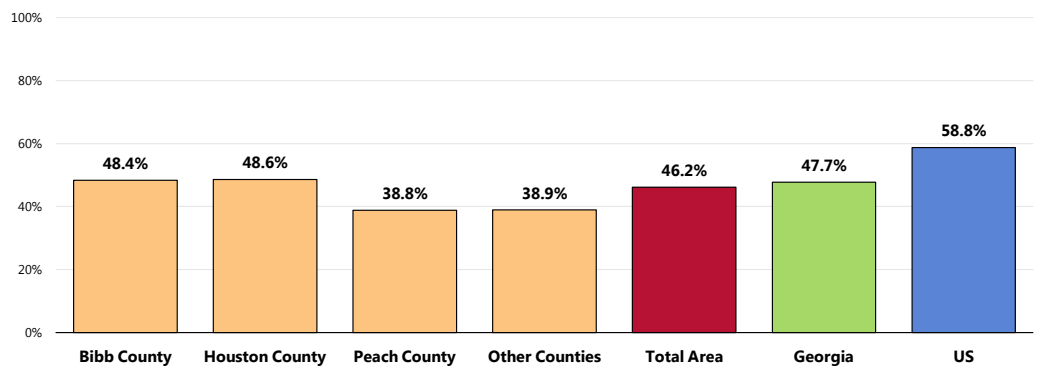
Current Drinking

"Current drinkers" include survey respondents who had at least one drink of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

A total of 46.2% of area adults had at least one drink of alcohol in the past month (current drinkers).

- Similar to the statewide proportion.
- Lower than the national proportion.
- Particularly low in Peach County and the Other Counties combined area.

Current Drinkers

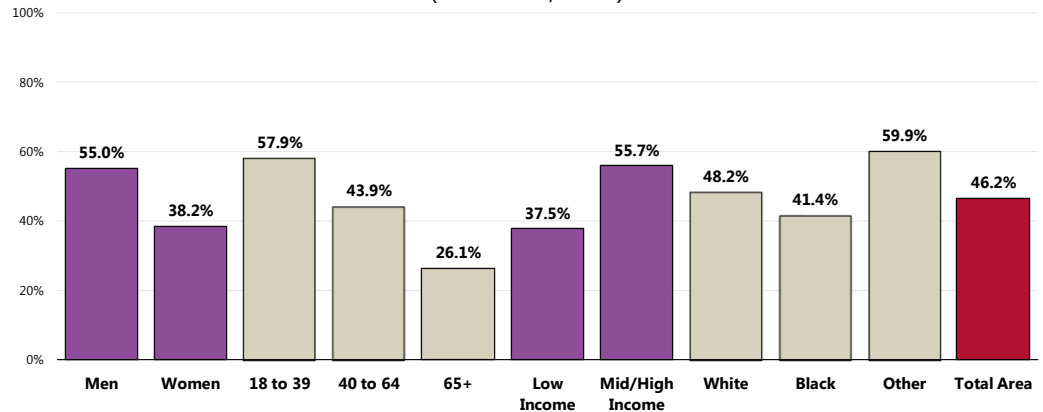


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 188]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • Current drinkers had at least one alcoholic drink in the past month.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Current drinking is more prevalent among men, young adults, higher-income residents and "Other" races.

Current Drinkers

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 188]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

• Current drinkers had at least one alcoholic drink in the past month.

Chronic Drinking

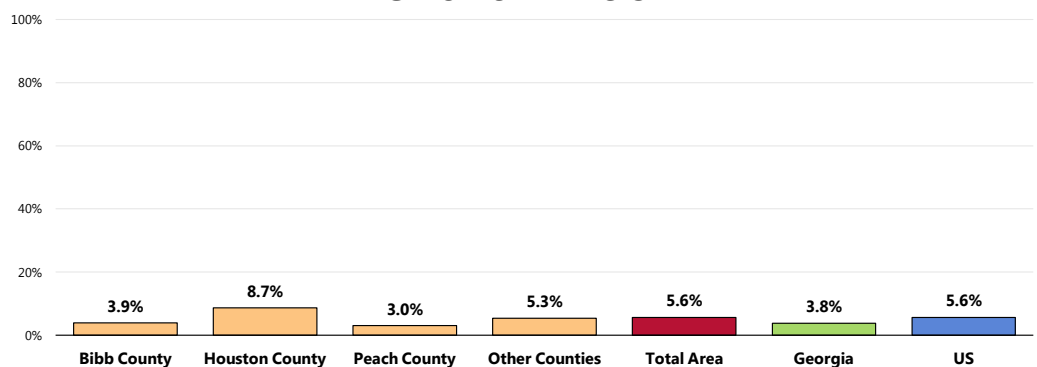
"Chronic drinkers" include survey respondents reporting 60 or more drinks of alcohol in the month preceding the interview.

RELATED ISSUE:
See also *Stress* in the **Mental Health & Mental Disorders** section of this report.

A total of 5.6% of area adults averaged two or more drinks of alcohol per day in the past month (chronic drinkers).

- Less favorable than the statewide proportion.
- Identical to the national proportion.
- Highest in Houston County.

Chronic Drinkers



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]

• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.

• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

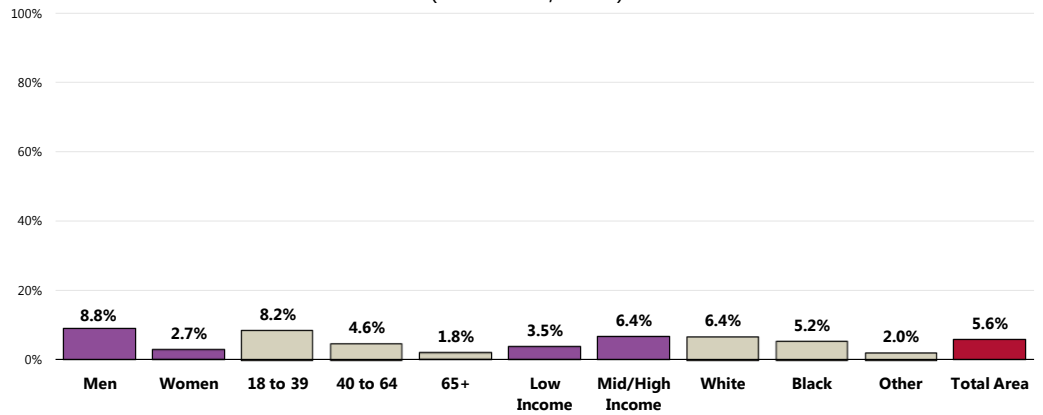
• Chronic drinkers are defined as having 60+ alcoholic drinks in the past month.

• The state definition for chronic drinkers is males consuming 2+ drinks per day and females consuming 1+ drink per day.

• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

👤 Chronic drinking is more prevalent among men, young adults, and Whites.

Chronic Drinkers (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Chronic drinkers are defined as those having 60+ alcoholic drinks in the past month.

Binge Drinking

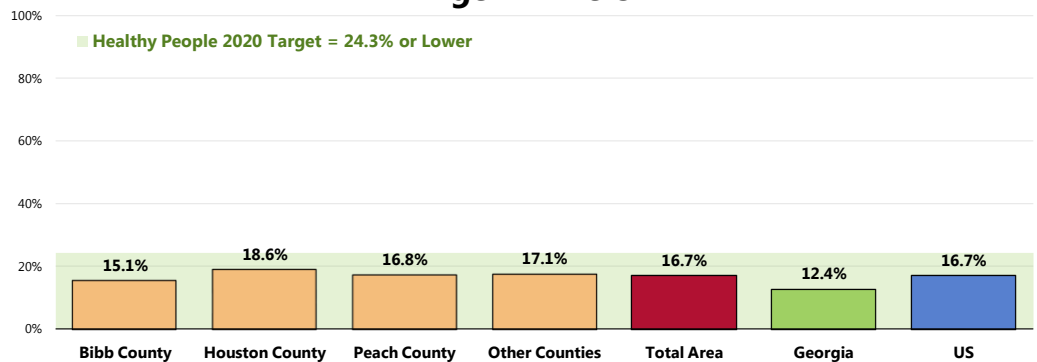
"Binge drinkers" include:

- 1) MEN who report drinking 5 or more alcoholic drinks on any single occasion during the past month; and
- 2) WOMEN who report drinking 4 or more alcoholic drinks on any single occasion during

A total of 16.7% of Total Area adults are binge drinkers.

- Worse than the Georgia percentage.
- Identical to national findings.
- Satisfies the Healthy People 2020 target (24.3% or lower).
- Statistically similar by county.

Binge Drinkers

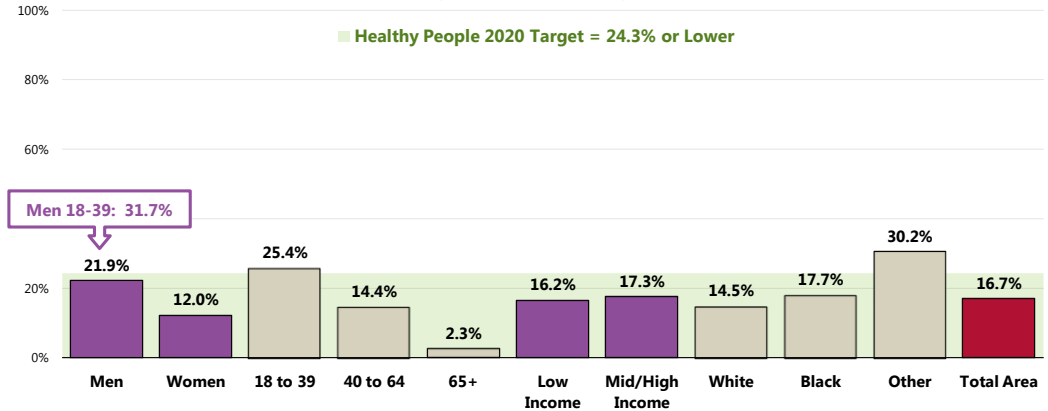


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-14.3]
 Notes: • Asked of all respondents.
 • Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Binge drinking is more prevalent among:

- Men (especially those under age 40).
- Adults under age 40.
- "Other" races.

Binge Drinkers (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-14.3]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion

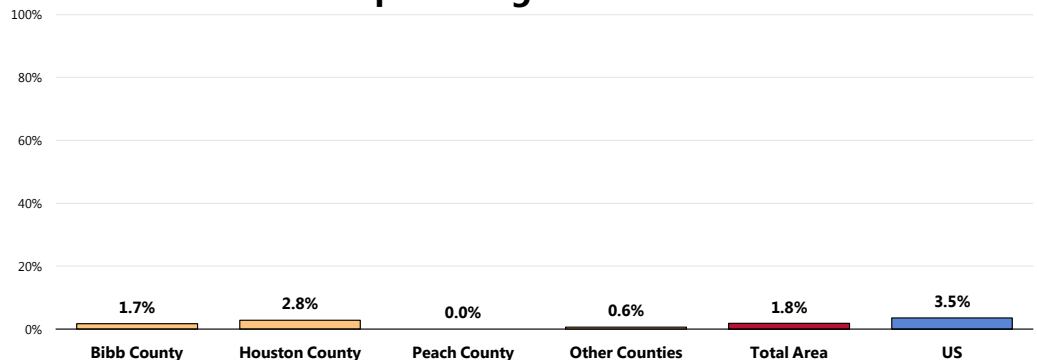
Drinking & Driving

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

A total of 1.8% of Total Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- More favorable than national findings.
- Lowest in Peach County.

Have Driven in the Past Month After Perhaps Having Too Much to Drink

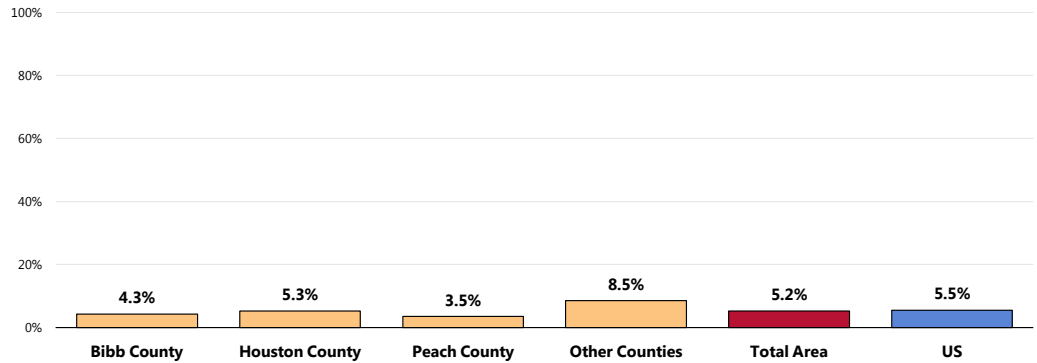


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 70]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

A total of 5.2% of Total Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- Similar to the national findings.
- Similar by county.

Have Driven Drunk OR Ridden With a Driver in the Past Month Who Had Too Much to Drink



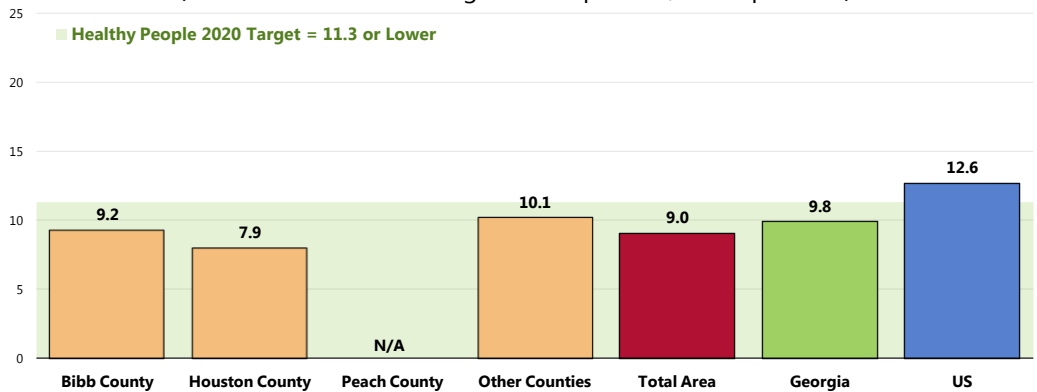
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Age-Adjusted Drug-Induced Deaths


Between 2006 and 2008, there was an annual average age-adjusted drug-induced mortality rate of 9.0 deaths per 100,000 population in the Total Area.

- Better than the statewide rate.
- Better than the national rate.
- Satisfies the Healthy People 2020 target (11.3 or lower).
- Lowest in Houston County.

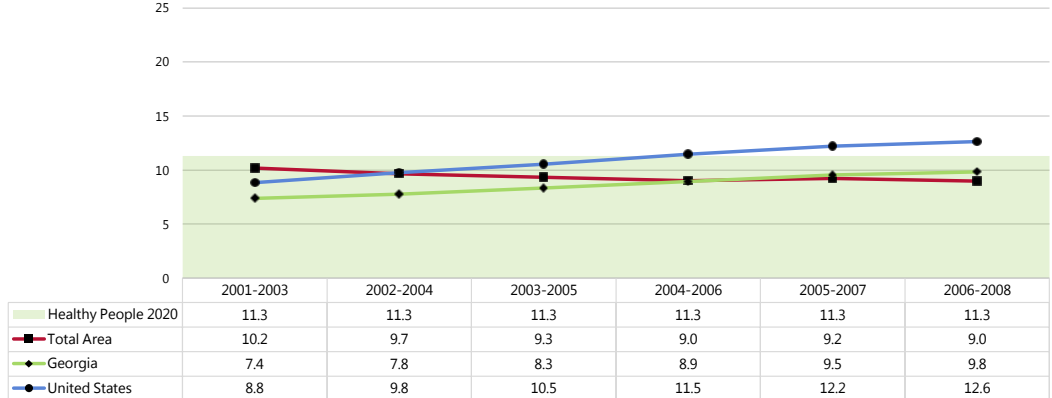
Drug-Induced Deaths: Age-Adjusted Mortality (2006-2008 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 • Local, state and national data are simple three-year averages.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

-  The mortality rate has decreased slightly in the Total Area, in contrast to the increasing trends reported across Georgia and the US as a whole.

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



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2012.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - County, state and national data are simple three-year averages.

Illicit Drug Use

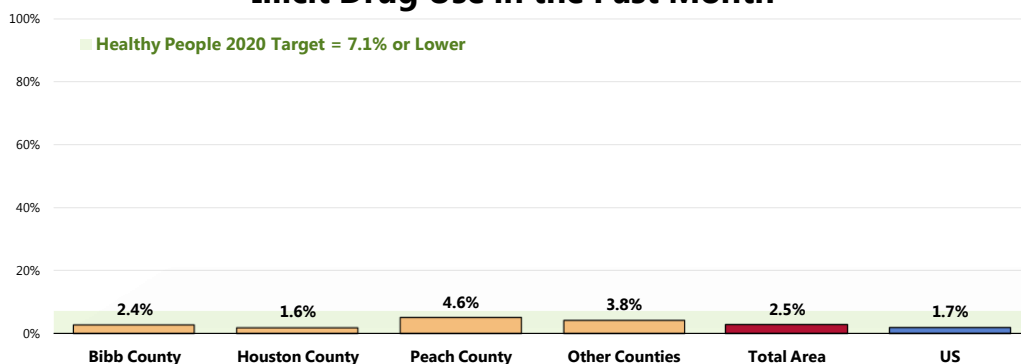
For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

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

A total of 2.5% of Total Area adults acknowledge using an illicit drug in the past month.

- Similar to the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.
- No significant difference by county.

Illicit Drug Use in the Past Month



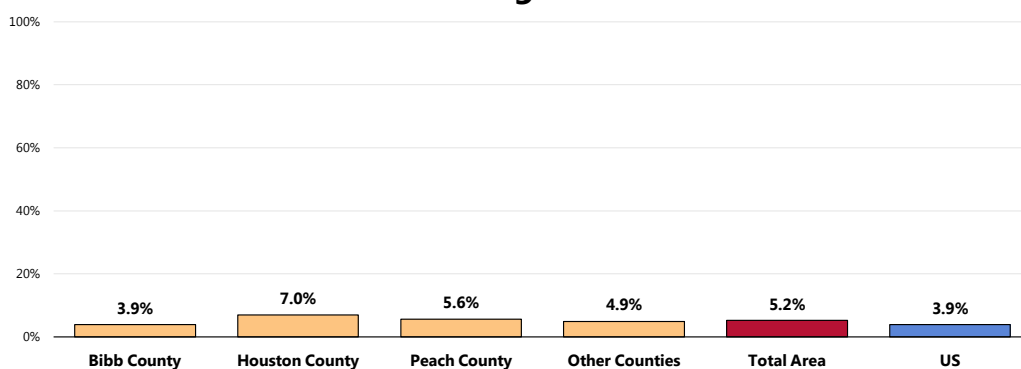
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 72]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Alcohol & Drug Treatment

A total of 5.2% of Total Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Similar to national findings.
- Similar by county.

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



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 73]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Related Focus Group Findings: Substance Abuse

The focus group participants are concerned with substance abuse in the community. The main issues discussed surrounding substance abuse included:

- Prevalence
- Youth access
- Limited treatment facilities

A number of focus group participants express concern with the **prevalence of substance abuse** in the community, specifically prescription drug abuse, marijuana, cocaine, methamphetamines and alcohol abuse. Substance abuse impacts so many aspects of a person's life and has an effect on the level of violence in the community. Participants believe prescription drugs are the drug of choice in the region. People of all ages abuse prescription drugs, as one participant explains:

"There's been a lot more of the school-aged children – you used to go to the school, you might find some marijuana; now they've swapped over and they're using a lot of prescription medication." — Regional Participant

Peach County participants feel prescription drug use is rampant in their community, as one emergency service personnel describes:

"Well, when it comes to drugs, it's not as big – we don't have a lot of problem with illegal drugs no more, it's prescription drugs that have gone wild in Peach County." — Peach County Participant

Youth can access both alcohol and prescription drugs from their own homes, so parents need to be educated to lock up their medication and liquor. Education to the whole family is critical to combat substance use. Currently there is a drug awareness week in the schools and the Georgia Meth Project partners with HODAC in Warner Robins.

There are **limited treatment facilities** for individuals with substance abuse problems. The two public treatment centers only accept insured or private-pay patients, so access is a major obstacle. There are also several methadone clinics. A participant notes:

"I had a patient who needed to get off of alcohol and wanted to stop and she didn't have any insurance...There are some methadone clinics. I know of two in the community. One in Houston County and one in Macon. I mean there needs to be more facilities like that because they just cannot handle the volume that comes to them." — Bibb County Participant

Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the US \$193 billion annually in direct medical expenses and lost productivity.

Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

– Healthy People 2020 (www.healthypeople.gov)

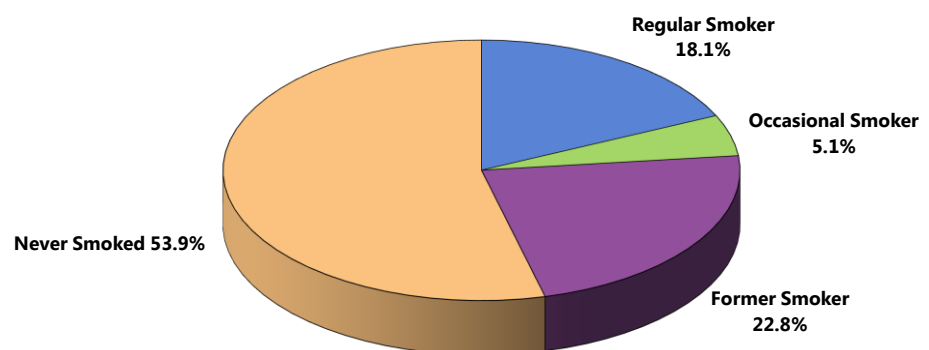
Cigarette Smoking

Cigarette Smoking Prevalence

A total of 23.2% of Total Area adults currently smoke cigarettes, either regularly (18.1% every day) or occasionally (5.1% on some days).

Cigarette Smoking Prevalence

(Total Area, 2012)

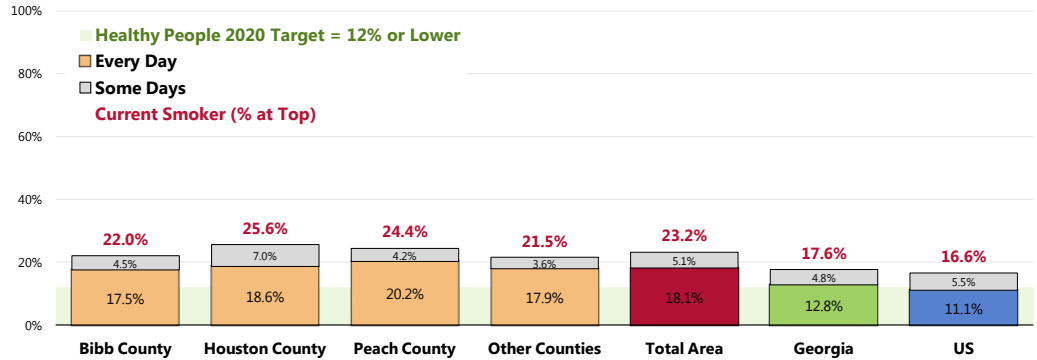


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 184]
Notes: • Asked of all respondents.

- Less favorable than statewide findings.
- Less favorable than national findings.
- Fails to satisfy the Healthy People 2020 target (12% or lower).

- No statistical difference by county.

Current Smokers



- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 184]
 - 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Includes regular and occasional smokers (everyday and some days).
 - "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Cigarette smoking is more prevalent among:

Men.

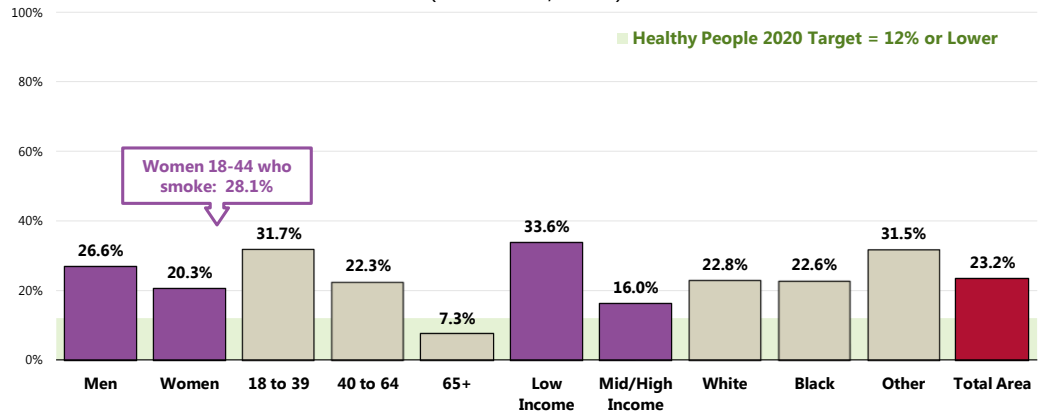
Adults under 40.

Lower-income residents.

Note also that 28.1% of women of child-bearing age (ages 18 to 44) currently smoke. This is notable given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.

Current Smokers

(Total Area, 2012)



- Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 184-185]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

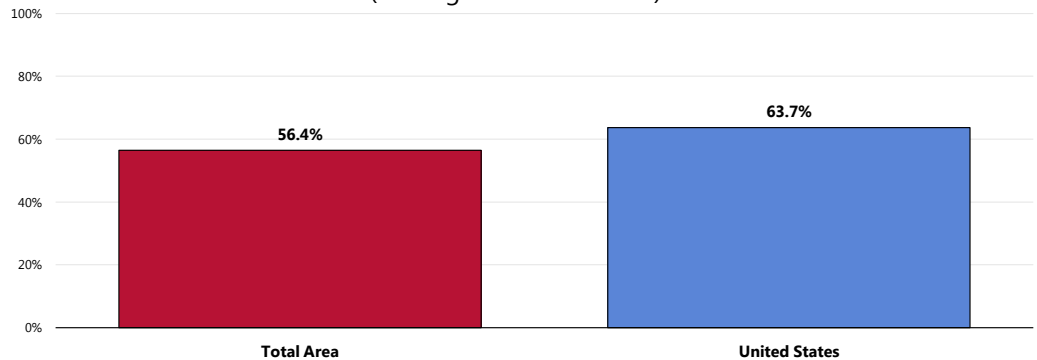
Smoking Cessation

Health Advice About Smoking Cessation

A total of 56.4% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Statistically similar to the national percentage.

Advised by a Healthcare Professional in the Past Year to Quit Smoking (Among Current Smokers)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 63]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all current smokers.

Smoking Cessation Attempts

Over one-half (54.2%) of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Statistically similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).

Have Stopped Smoking for One Day or Longer In the Past Year in an Attempt to Quit Smoking (Among Everyday Smokers)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 62]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-4.1]
• Asked of respondents who smoke cigarettes every day.

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

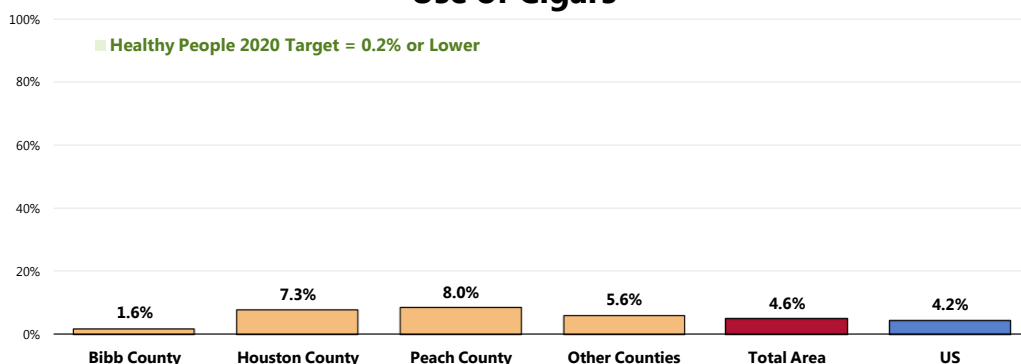
Other Tobacco Use

Cigars

A total of 4.6% of Total Area adults use cigars every day or on some days.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).
- Statistically high in Houston County; lowest in Bibb County.

Use of Cigars



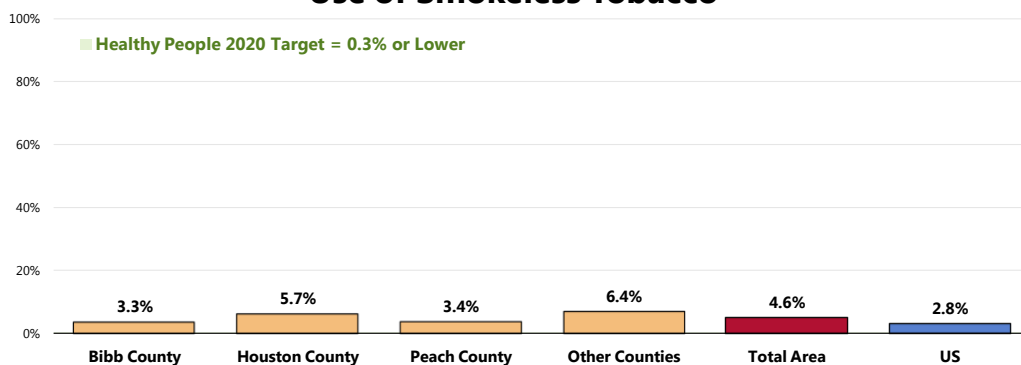
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.3]
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Smokeless Tobacco

A total of 4.6% of Total Area adults use some type of smokeless tobacco every day or on some days.

- Worse than the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- Similar by county.

Use of Smokeless Tobacco



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 65]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.2]
 Notes: • Asked of all respondents.
 • Smokeless tobacco includes chewing tobacco or snuff.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Environmental Tobacco Smoke

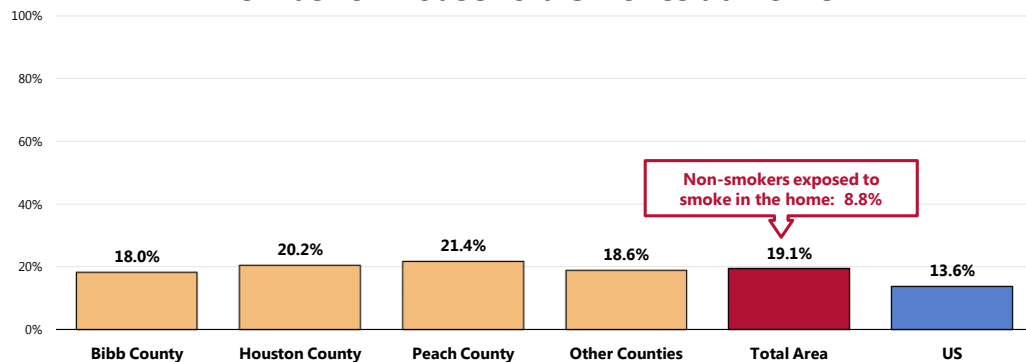
A total of 19.1% of Total Area adults (including smokers and non-smokers) **report that a member of their household has smoked cigarettes in the home in the past month an average of four or more times per week.**

- Less favorable than national findings.

- Similar by county.

👤 Note that 8.8% of Total Area non-smokers are exposed to cigarette smoke at home.

Member of Household Smokes at Home

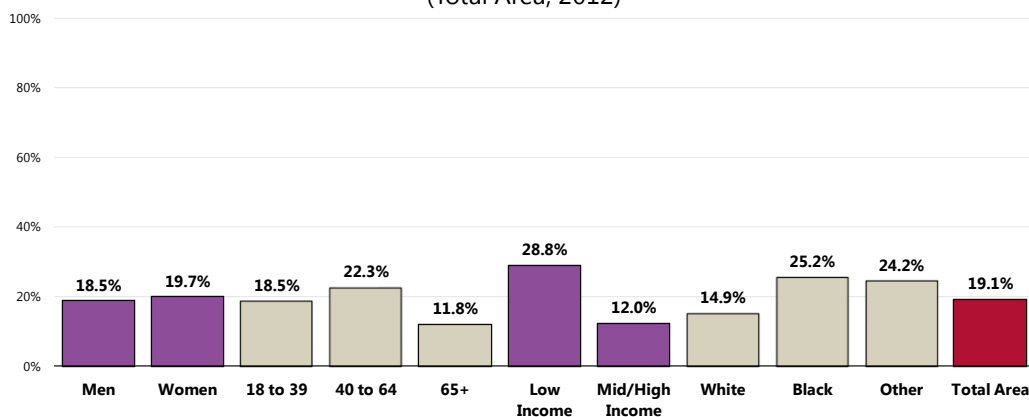


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 64, 186]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
• "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

👤 Notably higher among residents aged 40 to 64, those with lower incomes, and Non-Whites.

Member of Household Smokes At Home (Total Area, 2012)



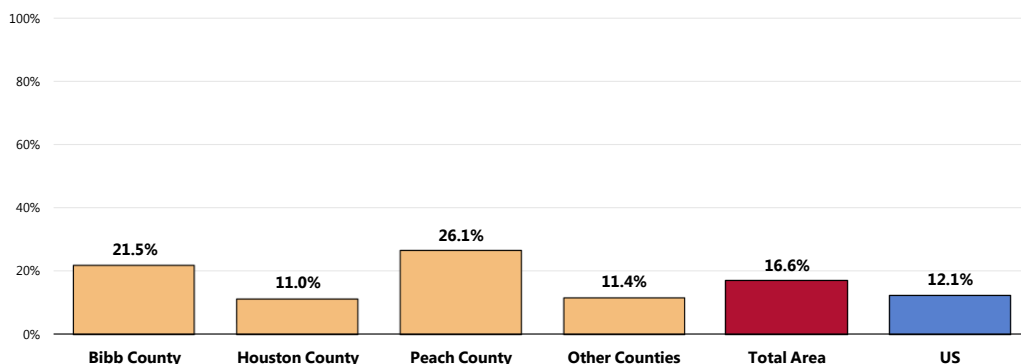
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 64]

Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
• "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Among households with children, 16.6% have someone who smokes cigarettes in the home.

- Similar to national findings.
- Statistically similar by county (*keeping in mind the smaller samples sizes*).

Percentage of Households With Children In Which Someone Smokes in the Home



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 187]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked among parents of children age 0-17.
• "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 Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

— Healthy People 2020 (www.healthypeople.gov)

Related Focus Group Findings: Tobacco

Many focus group participants are concerned with tobacco use in the community. The main issues included:

- Prevalence
- Gateway drug
- Smoking cessation programs

Focus group participants feel that cigarette smoking continues to be an issue in the community. The participants worry about the number of residents that develop lung cancer and emphysema due to smoking. The respondents view tobacco use as **prevalent** throughout the community and that all socioeconomic groups are affected. Some focus group participants believe that tobacco acts as an "escape" for users. Convenience stores in the area will even sell cigarettes individually instead of as a whole pack. One participant describes:

"You buy one or two cigarettes at a time. Now that's illegal. You can't sell 'em that way but they do. Convenience stores primarily in certain areas because the smokers don't want to pay four bucks for a pack of cigarettes but they'll pay \$1.00 for three or four or whatever the going cost is."
— Bibb County Participant

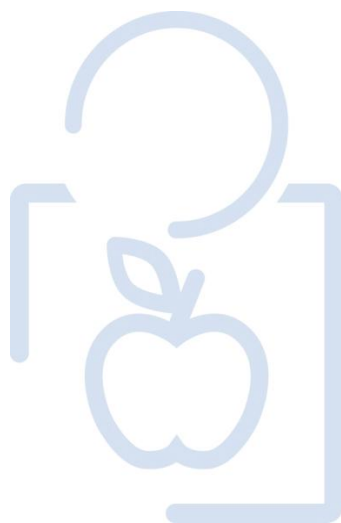
For rural residents (including youth), smokeless tobacco use has become part of the culture. Participants express worry about the possibility that tobacco is a **gateway drug** for youth. One participant explains:

"We know that tobacco use in youth is a gateway to other drugs. The risk factors associated with tobacco use are linked to juvenile delinquency, use of alcohol and other drugs." — Bibb County Participant

Community residents can access **smoking cessation programs** at the state level; however, smokers have to want to quit. There is agreement that many smokers have not reached that stage.

"The state of Georgia has a tobacco quit line. The Medical Center has a class. The Coliseum has a cancer center. I mean there are programs available. You gotta get them to want to. And nicotine's addictive." — Bibb County Participant

ACCESS TO HEALTH SERVICES



Health Insurance Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

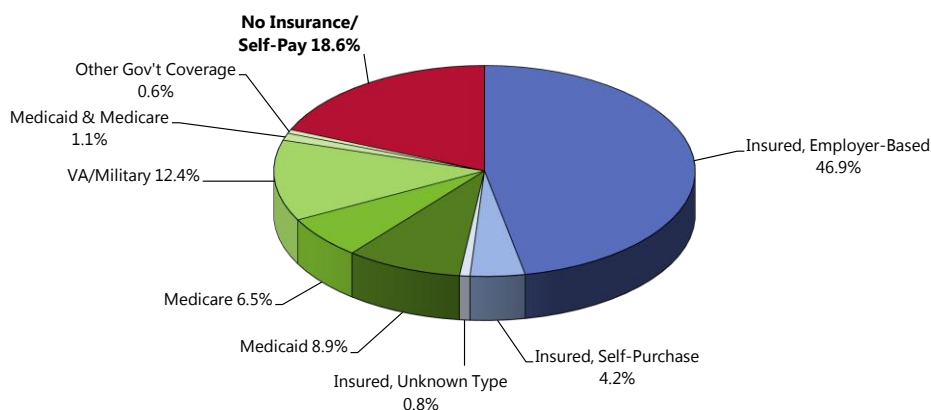
Type of Healthcare Coverage

Insurance Type

A total of 51.9% of Total Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 29.5% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults 18-64; Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 192]
Notes: • Reflects respondents age 18 to 64.

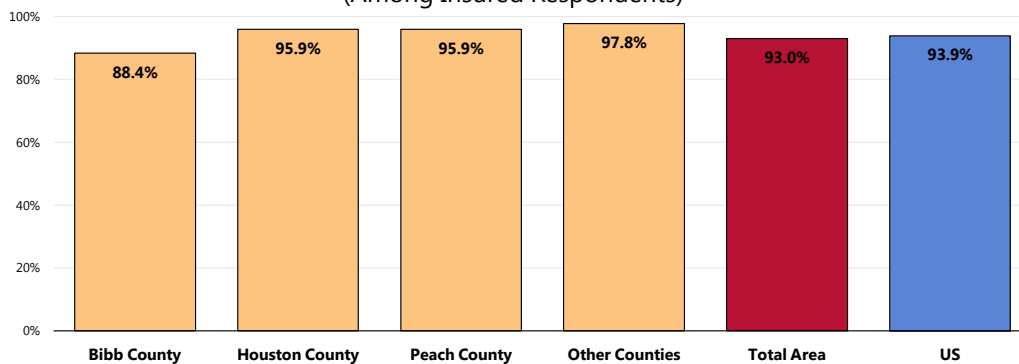
Prescription Drug Coverage

Among insured adults, 93.0% report having prescription coverage as part of their insurance plan.

- Nearly identical to the national prevalence.
- Lower in Bibb County.

Health Insurance Covers Prescriptions at Least in Part

(Among Insured Respondents)



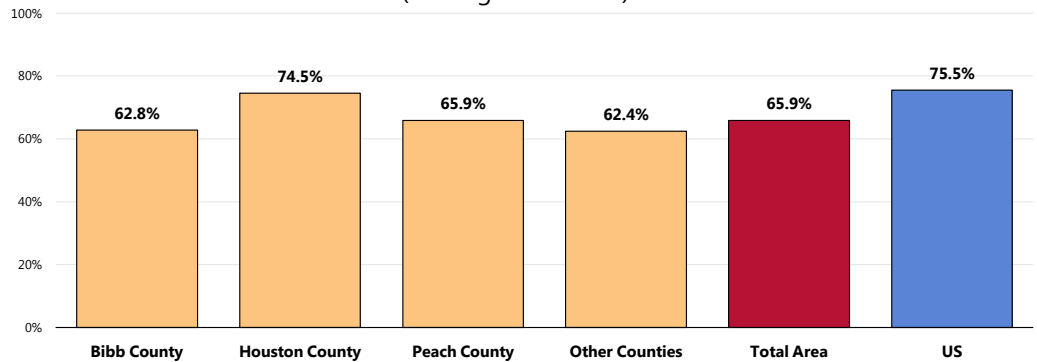
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 87]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with healthcare insurance coverage.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Medicare Supplemental Coverage

Among Medicare recipients, nearly 2 in 3 (65.9%) have additional, supplemental healthcare coverage.

- Less favorable than that reported among Medicare recipients nationwide.
- Similar by county.

Have Supplemental Coverage in Addition to Medicare (Among Adults 65+)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents age 65+.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

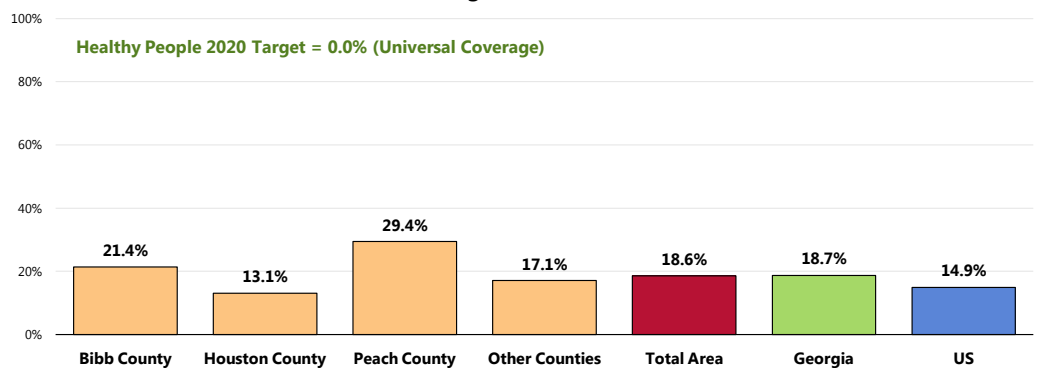
Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 18.6% report having no insurance coverage for healthcare expenses.

- Nearly identical to the state finding.
- Similar to the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Worst in Peach County; best in Houston County.

Lack of Healthcare Insurance Coverage (Among Adults 18-64)



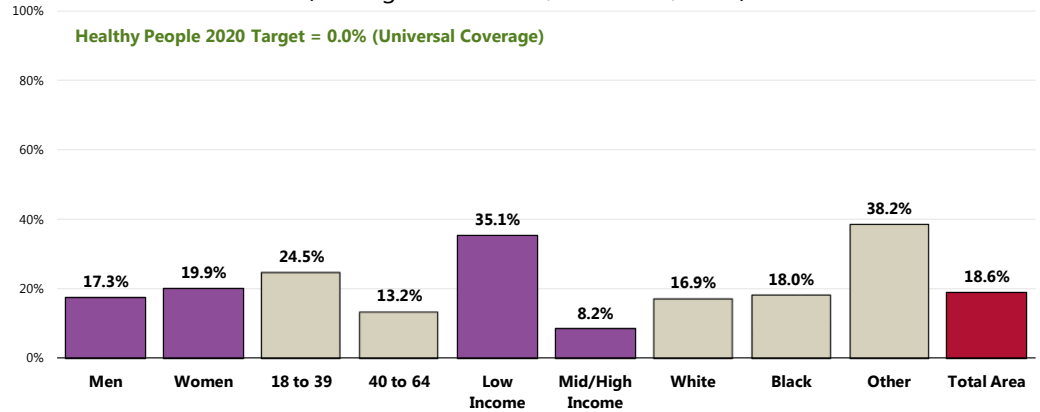
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 192]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2010 Georgia data.
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
 Notes: • Asked of all respondents under the age of 65.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

The following population segments are more likely to be without healthcare insurance coverage:

- 👤 Young adults.
- 👤 Residents living at lower incomes.
- 👤 "Other" races.

Lack of Healthcare Insurance Coverage

(Among Adults 18-64; Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 192]

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]

Notes: • Asked of all respondents under the age of 65.

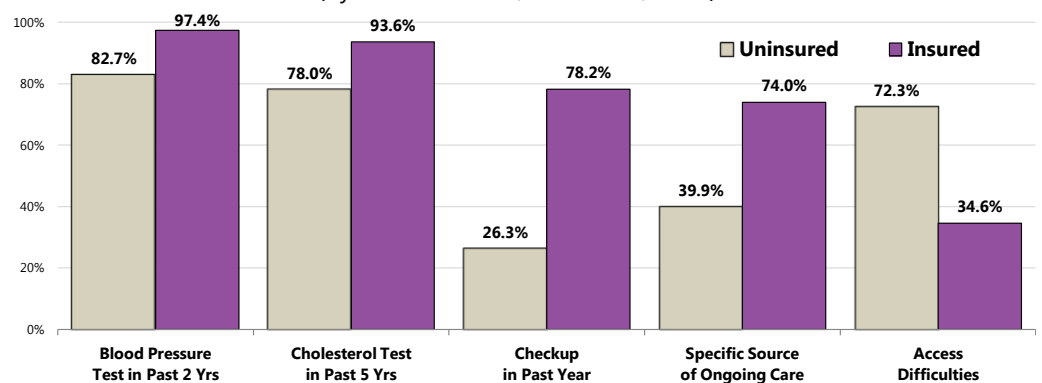
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

- 👤 As might be expected, uninsured adults in the Total Area are less likely to receive routine care and preventive health screenings, and are more likely to have experienced difficulties accessing healthcare.

Preventive Healthcare

(By Insured Status; Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 49, 52, 193, 196]

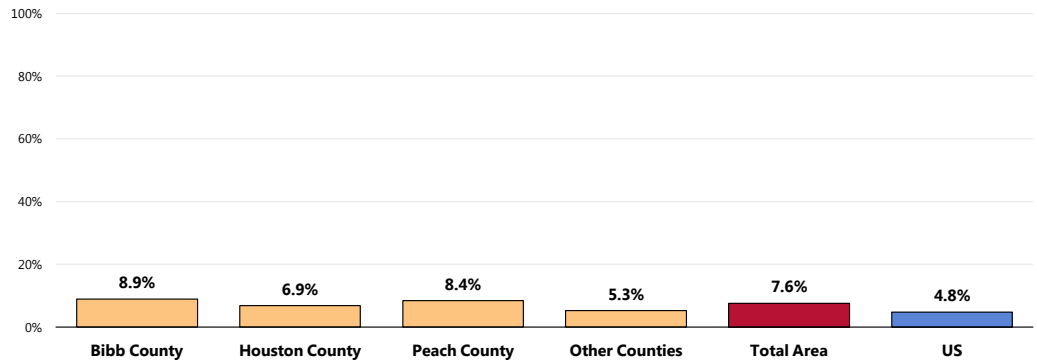
Notes: • Asked of all respondents.

Recent Lack of Coverage (Insurance Instability)

Among currently insured adults in the Total Area, 7.6% report that they were without healthcare coverage at some point in the past year.

- Less favorable than US findings.
- Similar by county.

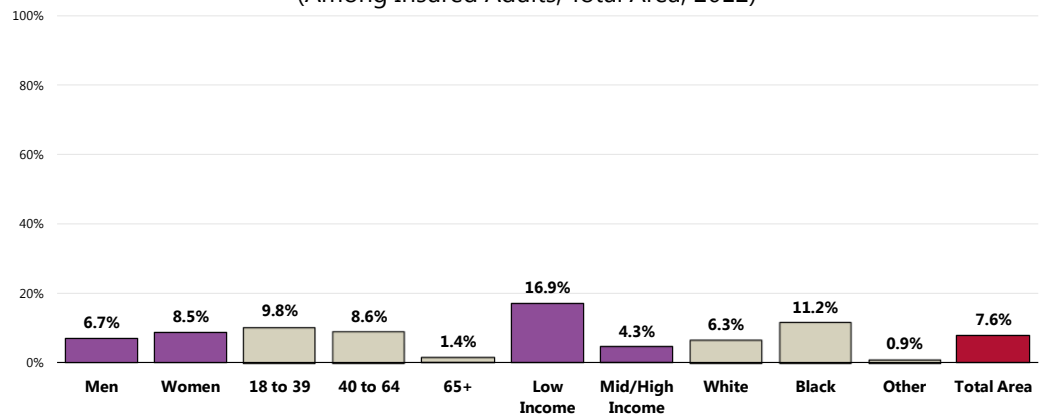
Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all insured respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

For adults with lower incomes and Black residents, those with insurance are more likely to have gone without at some point in the past year.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults; Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]
 Notes: • Asked of all insured respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

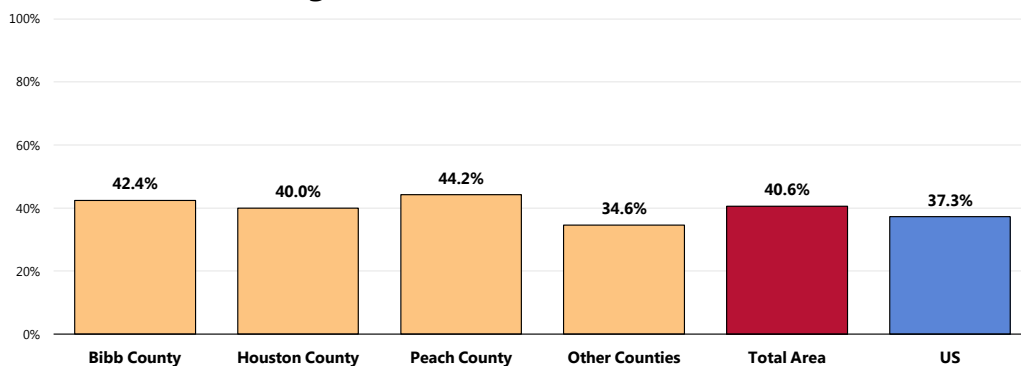
– Healthy People 2020 (www.healthypeople.gov)

Difficulties Accessing Services

A total of 40.6% of Total Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Statistically similar to national findings.
- Statistically similar by county.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year






Sources: ● 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 196]
● 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents.
● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
● "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

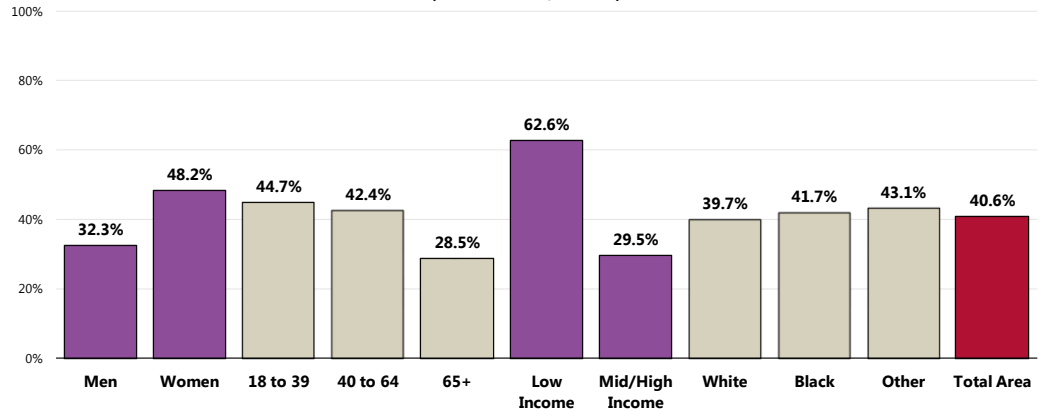
This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

Note that the following demographic groups more often report difficulties accessing healthcare services:

-  Women.
-  Adults under the age of 65.
-  Lower-income residents (over 60%).

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 196]
 Notes: • Asked of all respondents.
 • Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

To better understand healthcare access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

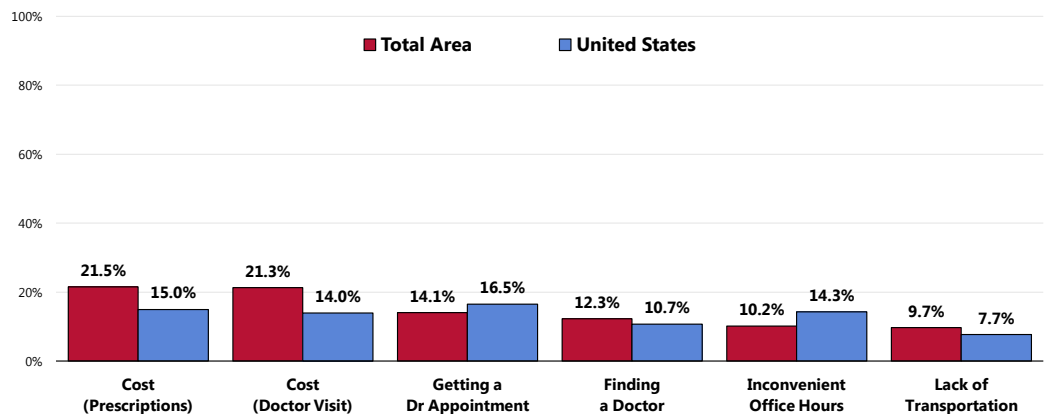
Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Healthcare Access

Of the tested barriers, medical costs impacted the greatest share of Total Area adults (21.5% say that cost prevented them from obtaining a needed prescription in the past year; 21.3% say that cost prevented a doctor visit in the past year).

- Cost-related barriers are significantly more prevalent than found nationally.
- The prevalence of the remaining tested barriers was statistically comparable to or better than that found nationwide.

Barriers to Access Have Prevented Medical Care in the Past Year

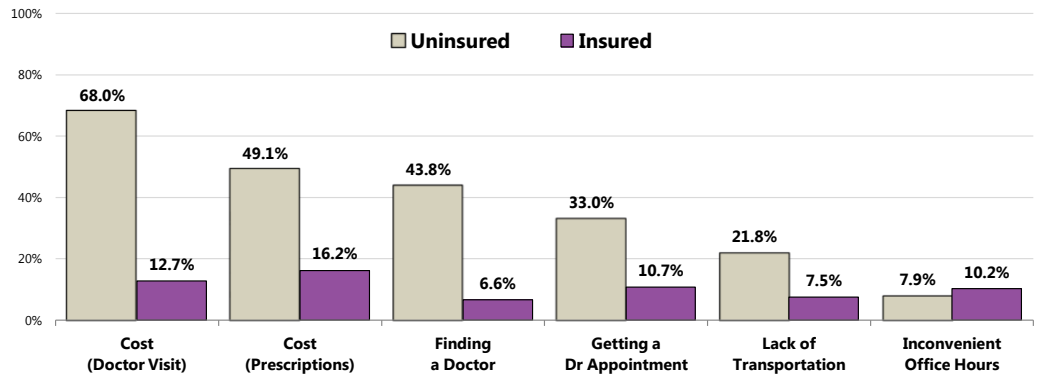


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

As might be expected, Total Area adults without health insurance are much more likely to report access barriers when compared to the insured population, particularly for the cost of doctor visits.

Barriers to Healthcare Access

(By Insured Status, Adults 18+; Total Area, 2012)



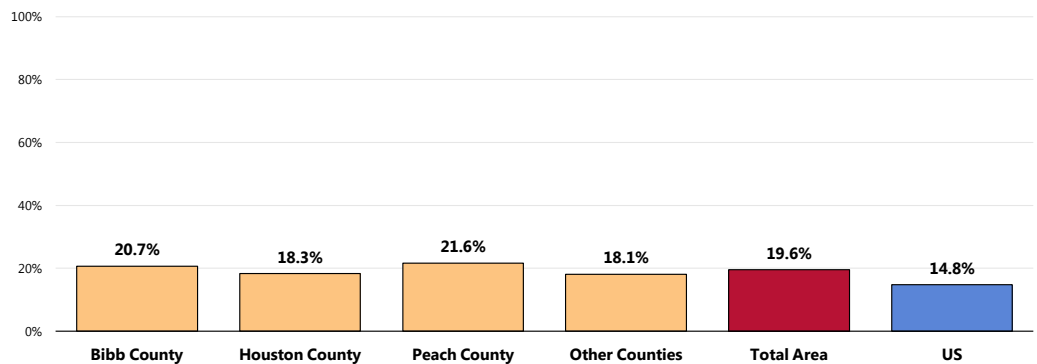
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

Prescriptions

Among all Total Area adults, 19.6% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.





- Less favorable than national findings.
- Statistically similar by county.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

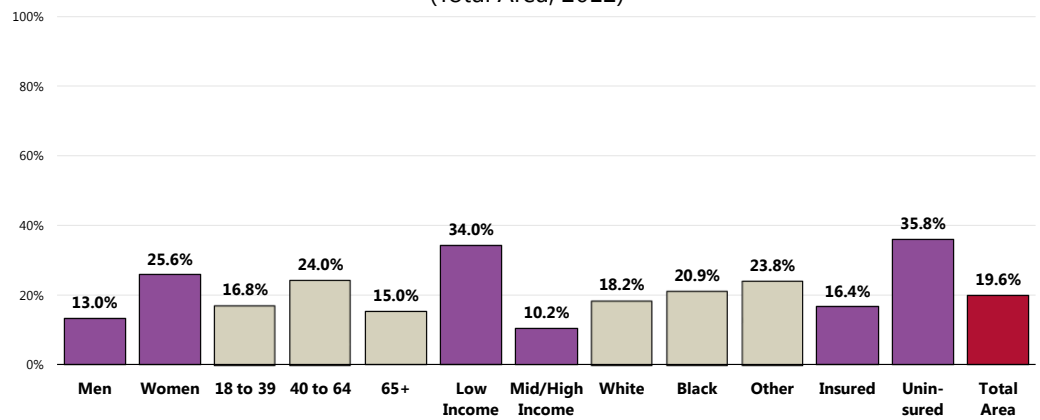


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Adults more likely to have skipped or reduced their prescription doses include:

-  Women.
-  Adults age 40 to 64.
-  Respondents with lower incomes.
-  Uninsured adults.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money (Total Area, 2012)



Sources:

- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]

Notes:

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

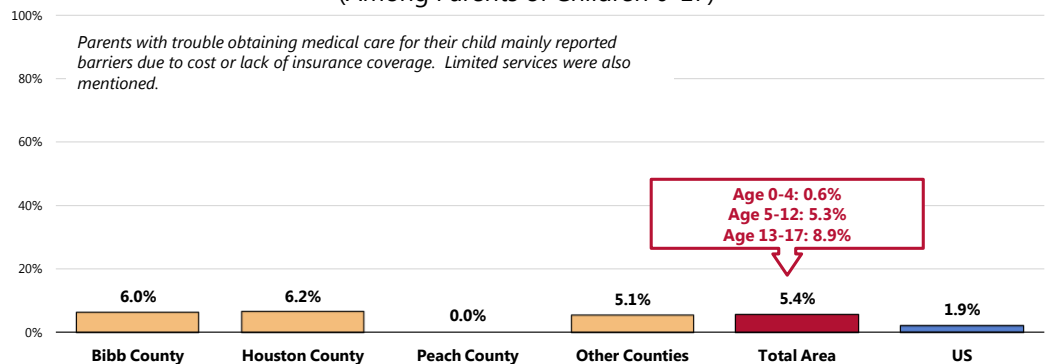
Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

A total of 5.4% 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.

- Less favorable than what is reported nationwide.
- Lowest in Peach County.
- 👨👩👧 By age of child, lowest (0.6%) among parents of children under age 6.

Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 125-126]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Among the parents experiencing difficulties, the majority cited **cost or a lack of insurance** as the primary reason; others cited limited services.

Related Focus Group Findings: Access to Healthcare

Many focus group participants are concerned with access to healthcare. The main issues discussed include:

- Barriers to healthcare services
 - Rural counties
 - Uninsured and under-insured families
 - Cost
 - Transportation
 - Office hours
- Emergency room utilization
- Emergency services

Focus group participants believe residents encounter several **barriers** when trying to **access healthcare services** in the community. Throughout the focus groups, the concept that where you live impacts your ability to access healthcare services arose several times. For residents living in **rural counties**, accessing a medical doctor can be very difficult. Many of these communities lack even primary care physicians, although residents have

access to several community health centers. The community health centers can only serve residents of the counties in which they reside. One participant explains:

"I think the Medical Center and Coliseum actually started the volunteer clinic. It was totally volunteers in terms of the service providers, it's all doctors and dentists who volunteer, and that's a good thing. But it's only available to Bibb County residents. And the Houston County clinic is only available to Houston residents." — Regional Participant

Focus group members have concern for those families who are **under-insured or uninsured** in the community. The underinsured population includes the working poor, those parents who may qualify for employer insurance but the deductibles are too high or the monthly employee cost is too great, so they elect to go without. Others may only carry catastrophic insurance, foregoing preventive care. Uninsured families may qualify for Medicaid, but finding a provider who accepts that insurance can prove difficult. Respondents feel the number of physicians who accept Medicaid has decreased in recent years, due to a low reimbursement rate.

The **cost** of healthcare and prescription medication can be astronomical for community members and residents have gone bankrupt due to medical bills. The cost of prescriptions can also act as a barrier for patients. A community health center can provide the office visit at a low cost, but the medication is too much to afford. The providers frequently utilize the \$4 Walmart prescription list. A physician describes:

"We can give advice and prescribe, but if you don't go home and take it, for whatever reason, that's a problem. If I prescribe a certain medication and it costs my patient, it's their tier three drug and they live check to check and that extra \$60.00 is a big deal, they're not going to take it." — Regional Participant

Getting to the physician's office, community health center, or pharmacy is another obstacle to accessing care. Families may have limited to a personal vehicle, and while the public **transportation** system in Macon (Bibb County) is adequate, surrounding rural counties do not have a public bus system. There are several transit systems that will transport patients to appointments but they must provide 24-hour notice. A Peach County participant explains the options for their residents:

"We normally don't do a same-day call. When I got there, it was always set up to call at least 24 hours ahead of time, or, overnight you can leave a message on the answering machine and then I'll get that in the morning and go ahead and schedule you then... Some have appointments in Macon, but we're not allowed to go into Bibb County, so that kind of puts a damper on it. So what they'll do is call me and I'll recommend someone else – another transportation service that they call to take them there and Atlanta because they sometimes call about that too. So I do have other numbers that I can recommend." — Peach County Participant

Physician office hours can also delay a resident's ability to access healthcare. Many residents work multiple jobs or shift work, which make getting to a doctor appointment during normal office hours difficult. These residents do not want to miss work because of the dock in pay. One member describes:

"Particularly for even a subset of the population who's working, access to care is problematic because when I take time off work I don't get paid. Healthcare operates your traditional bankers' hours." — Bibb County Participant

Focus group participants believe community member over-utilize the local **emergency rooms**. Families go to the emergency room for minor, non-emergent situations, and if the person cannot afford the bill they simply do not pay. An emergency service worker recalls:

"I mean we get called, 'A fever for two hours,' and they had never taken anything to break the fever, or anything, just kid just started running a fever, call an ambulance." — Peach County Participant

Rural county residents express an urgent need for **emergency services**. Jones, Twiggs, and Crawford counties do not have any emergency service personnel or local ambulance services. There is much concern for residents that suffer a medical emergency in these communities. Participants would like a substation ambulance in their community to lower the emergency service's response time. A participant explains:

"The county where I live, Twiggs County, we have no ambulance service call. If you have a heart attack or you hit your leg with an ax and sever an artery, it's 35 minutes from the medical center down to Jeffersonville, farther than that, and then 35 minutes back for some locations. Heart attacks, trauma, don't give you an hour and ten minutes to get there."— Regional Participant

Primary Care Services

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.

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

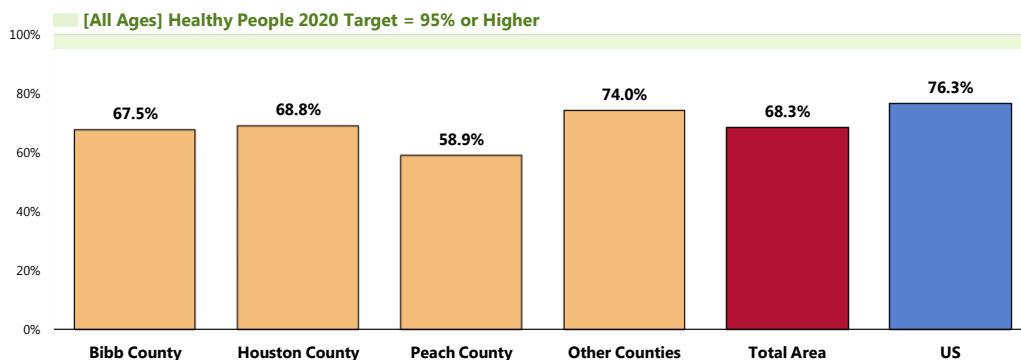
– Healthy People 2020 (www.healthypeople.gov)

Specific Source of Ongoing Care ("Medical Home")

A total of 68.3% of Total Area adults were determined to have a specific source of ongoing medical care.

- Worse than the national proportion.
- Fails to satisfy the Healthy People 2010 objective (95% or higher).
- Lowest in Peach County.

Have a Specific Source of Ongoing Medical Care



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 193]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.1]
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- 👤 Adults under age 40.
- 👤 Lower-income adults.
- 👤 Black residents.

- Among adults age 18-64, two-thirds (66.7%) have a specific source for ongoing medical care, less favorable than national findings.
 - Fails to satisfy the Healthy People 2020 target for this age group (89.4% or higher).
- Among adults 65+, 78.1% have a specific source for care, similar to the percentage reported among seniors nationally.
 - Fails to satisfy the Healthy People 2020 target of 100% for seniors.

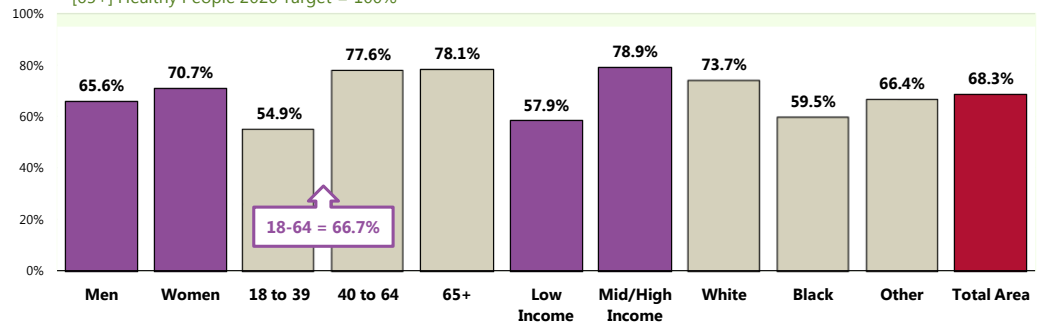
Have a Specific Source of Ongoing Medical Care

(Total Area, 2012)

[All Ages] Healthy People 2020 Target = 95.0% or Higher

[18-64] Healthy People 2020 Target = 89.4% or Higher

[65+] Healthy People 2020 Target = 100%



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 193-195]

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives AHS-5.1, 5.3, 5.4]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

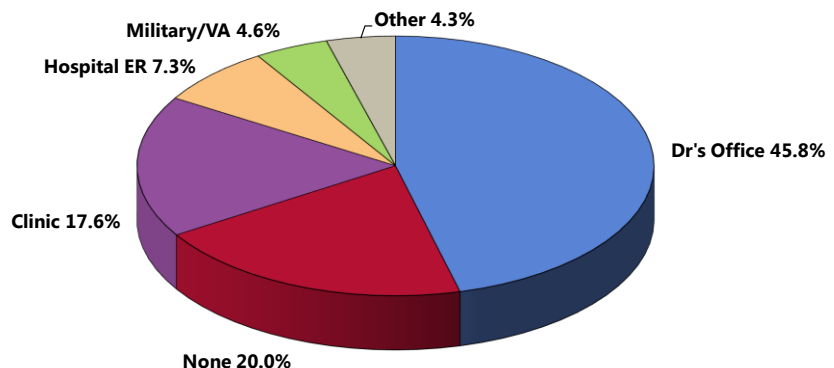
Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (45.8%) identified a particular doctor's office.

- A total of 17.6% say they usually go to some type of **clinic**, while 7.3% rely on a **hospital emergency room**. Another 4.6% of adults rely on **VA/military** benefits.

Particular Place Utilized for Medical Care

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]

Notes: • Asked of all respondents.

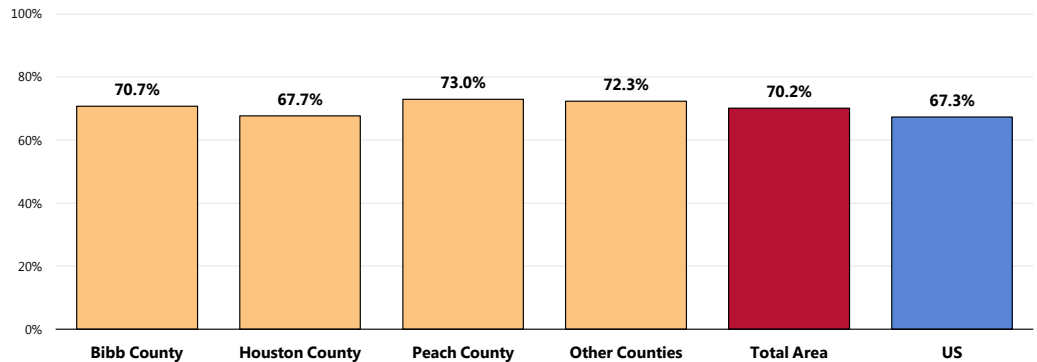
Utilization of Primary Care Services

Adults

A total of 7 in 10 adults (70.2%) visited a physician for a routine checkup in the past year.

- Comparable to national findings.
- Comparable by county.

Have Visited a Physician for a Checkup in the Past Year

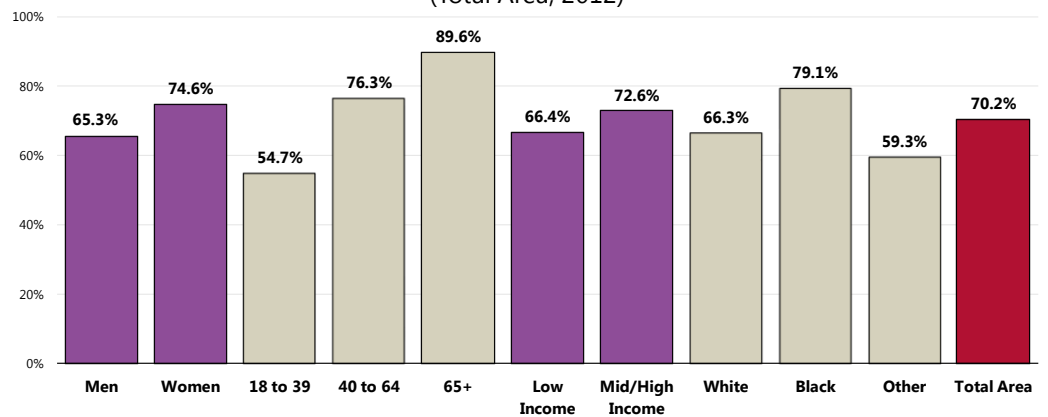


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

👤 Men, young adults and Non-Blacks are less likely to have received routine care in the past year (note the positive correlation with age).

Have Visited a Physician for a Checkup in the Past Year

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]
Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

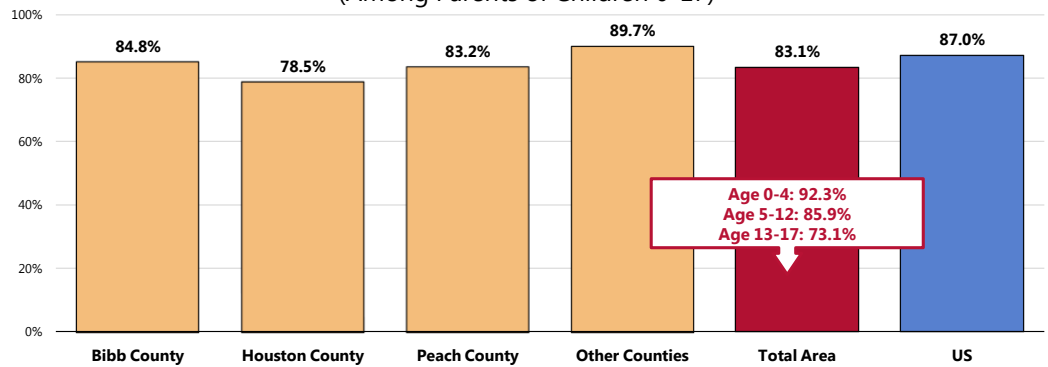
Children

Among surveyed parents, 83.1% report that their child has had a routine checkup in the past year.

- Similar to national findings.
- Similar by county.

👤 As might be expected, routine checkups are highest in the Total Area among children under age 5.

Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)



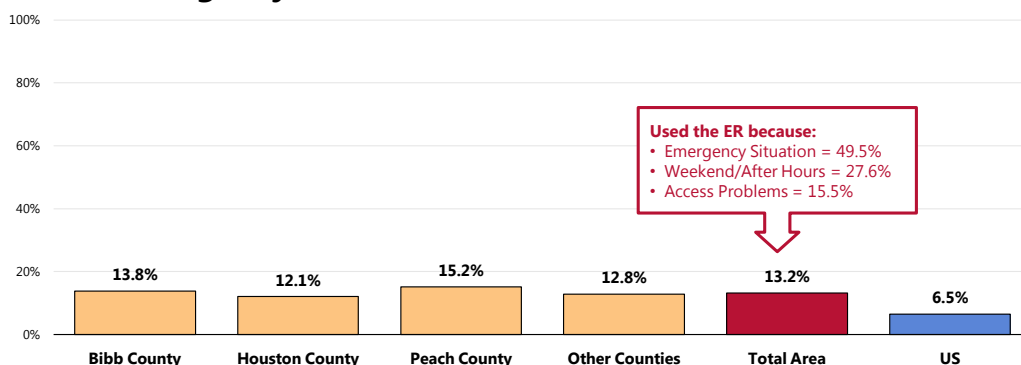
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Emergency Room Utilization

A total of 13.2% of Total Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Twice the national prevalence.
- Similar by county.

Have Used a Hospital Emergency Room More Than Once in the Past Year



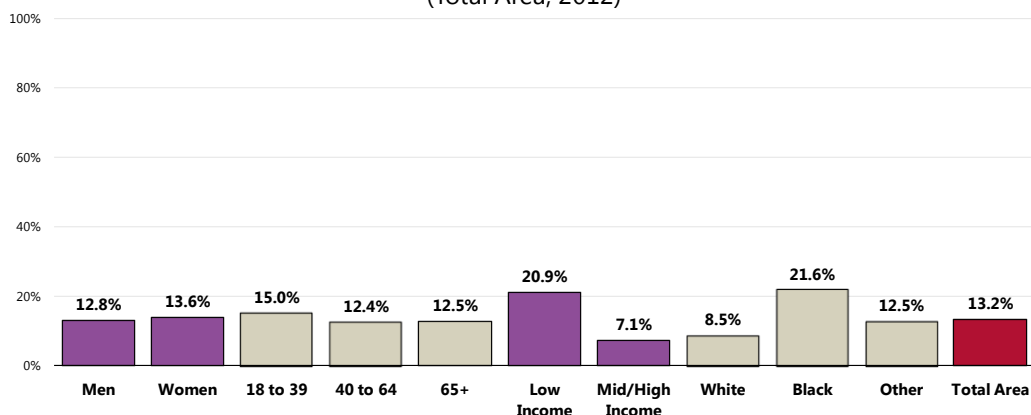
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 23-24]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Of those using a hospital ER, 49.5% say this was due to an **emergency or life-threatening situation**, while 27.6% indicated that the visit was during **after-hours or on the weekend**. A total of 15.5% cited **difficulties accessing primary care** for various reasons.

ER use is highest among lower-income residents and Blacks in the Total Area.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Oral Health

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include:

- Tobacco use
- Excessive alcohol use
- Poor dietary choices

Barriers that can limit a person's use of preventive interventions and treatments include:

- Limited access to and availability of dental services
- Lack of awareness of the need for care
- Cost
- Fear of dental procedures

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Community water fluoridation and school-based dental sealant programs are 2 leading evidence-based interventions to prevent tooth decay.

Major improvements have occurred in the nation's oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent CDC publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased.

Lack of access to dental care for all ages remains a public health challenge. This issue was highlighted in a 2008 Government Accountability Office (GAO) report that described difficulties in accessing dental care for low-income children. In addition, the Institute of Medicine (IOM) has convened an expert panel to evaluate factors that influence access to dental care.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

– Healthy People 2020 (www.healthypeople.gov)

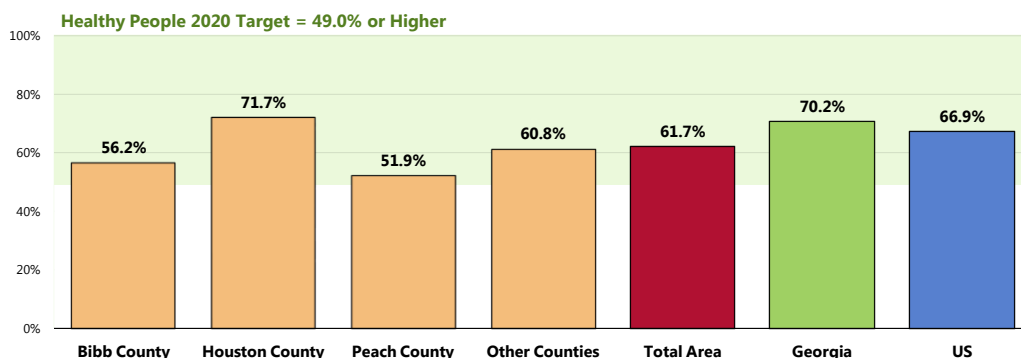
Dental Care

Adults

Just over 6 in 10 Total Area adults (61.7%) have visited a dentist or dental clinic (for any reason) in the past year.

- Less favorable than statewide findings.
- Less favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Highest in Houston County; unfavorably low in Bibb and Peach counties.




Have Visited a Dentist or Dental Clinic Within the Past Year



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2010 Georgia data.

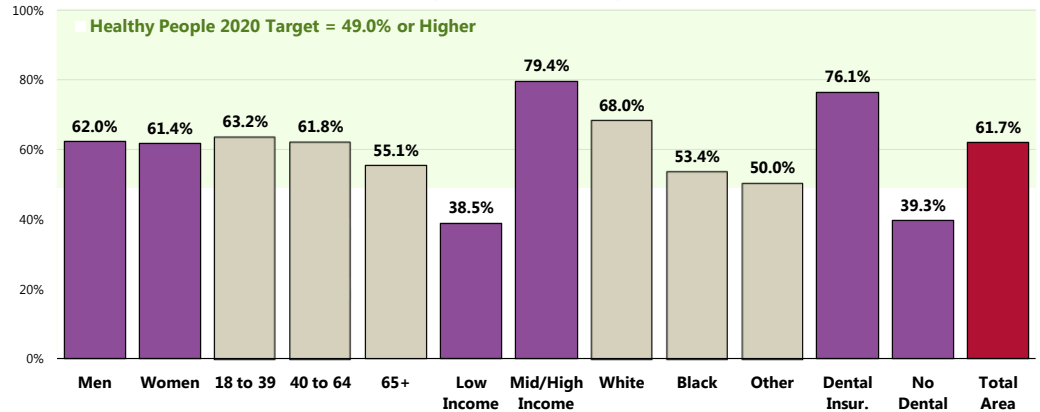
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Note the following:

-  Persons living in the higher income categories report much higher utilization of oral health services (low-income adults fail to satisfy the Healthy People 2020 target).
-  Whites are much more likely than Blacks or "Other" races to report recent dental care.
-  As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
 Notes: • Asked of all respondents.
 • Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

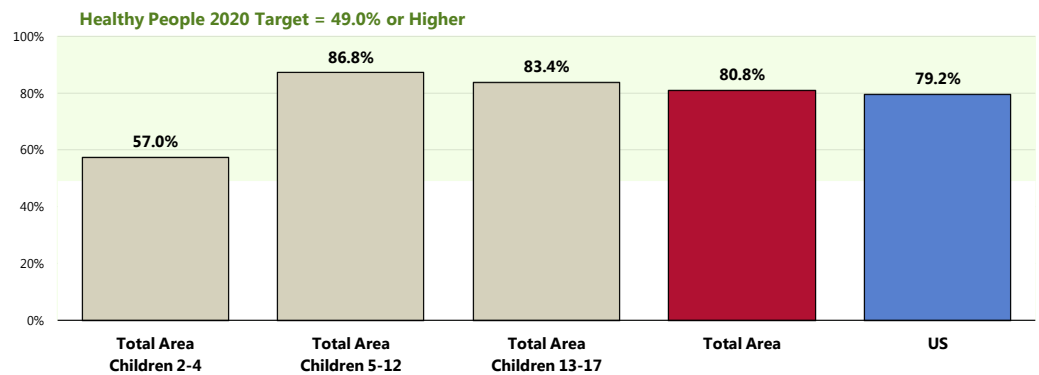
A total of 80.8% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Comparable to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).

Regular dental care is notably lower among children ages 2-4.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children 2-17)



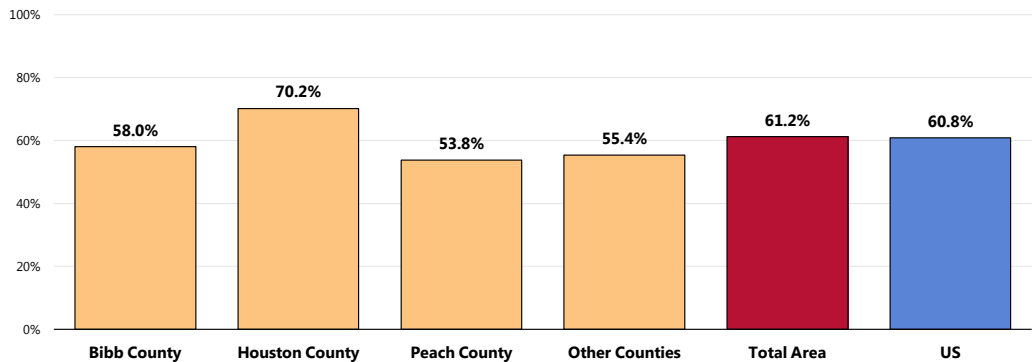
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
 • 2011 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
 Notes: • Asked of all respondents with children age 2 through 17.

Dental Insurance

More than 6 in 10 Total Area adults (61.2%) have dental insurance that covers all or part of their dental care costs.

- Comparable to the national finding.
- Highest in Houston County.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Related Focus Group Findings: Oral Health

Many focus group participants discussed oral health in the community. The main issues discussed include:

- Limited number of dentists
- Uninsured population

Focus group participants believe that oral health has an effect on a person's overall health and that it is critical to get regular dental care. Respondents believe that preventative dentistry is very important to an individual's long-term oral health; however, many families face barriers to accessing dental treatment. Many respondents believe that families with dental insurance (and even those *without*) face barriers to care due to the **limited number of dentists** in the community. Those **without dental insurance** cannot afford preventative care and this causes serious oral health issues. One member describes:

"They don't have enough insurance to pay for the work that needs to be done, and kids that are in middle school are having their teeth pulled because they've gotten so bad because they couldn't have preventive maintenance." — Regional Participant

Dental health options for **uninsured** residents are very limited, but include a small dental clinic and the Volunteer Medical Clinic (both located in Bibb County).

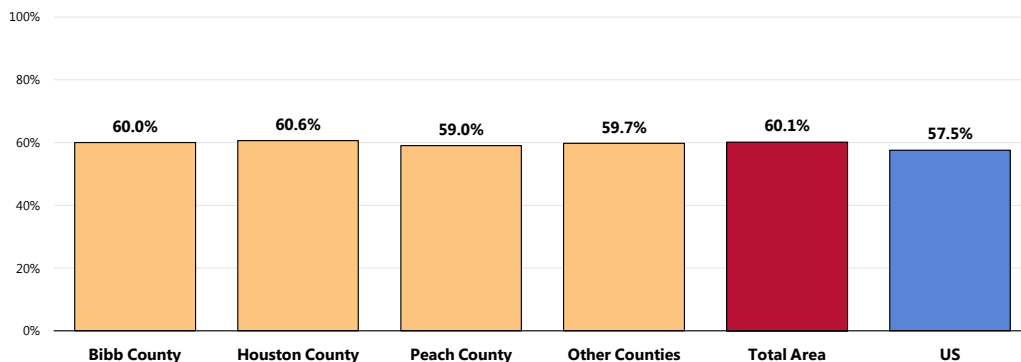
Vision Care

RELATED ISSUE:
See also *Vision & Hearing* in
the **Deaths & Disease**
section of this report.

A total of 60.1% of residents had an eye exam in the past two years during which their pupils were dilated.

- Statistically comparable to national findings.
- Comparable by county.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

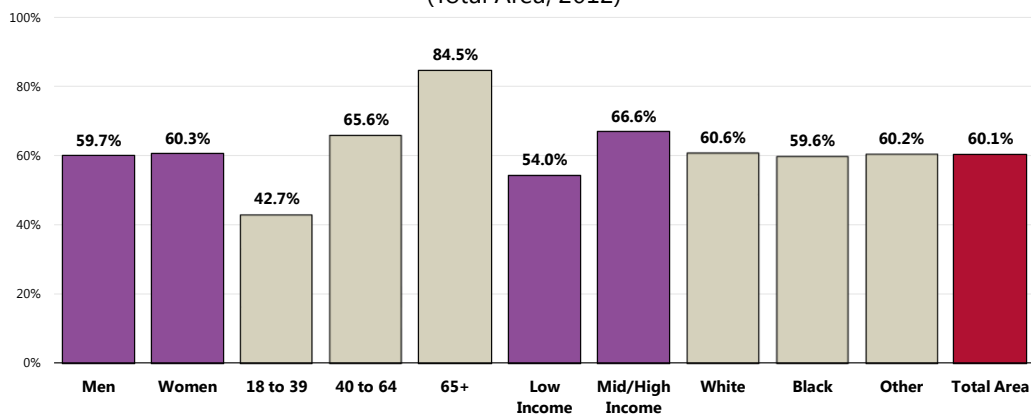


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

Recent vision care in the Total Area is less often reported among:

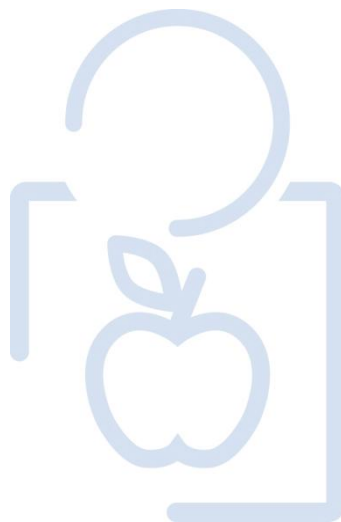
- Young adults.
- Residents with lower incomes.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated (Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
Notes: • Asked of all respondents.
• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

HEALTH EDUCATION & OUTREACH



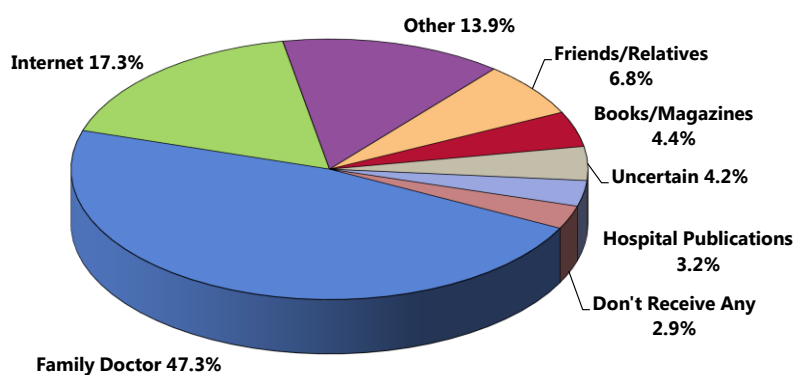
Healthcare Information Sources

Family physicians and the Internet are residents' primary sources of healthcare information.

- 47.3% of Total Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 17.3%.
 - Other sources mentioned include friends and relatives (6.8%), books and magazines (4.4%) and hospital publications (3.2%).
- Just 2.9% of survey respondents say that they do not receive any healthcare information.

Primary Source of Healthcare Information

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]
Notes: • Asked of all respondents.

Participation in Health Promotion Events

Educational and community-based programs play a key role in preventing disease and injury, improving health, and enhancing quality of life.

Health status and related-health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Education and community-based programs and strategies are designed to reach people outside of traditional healthcare settings. These settings may include schools, worksites, healthcare facilities, and/or communities.

Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

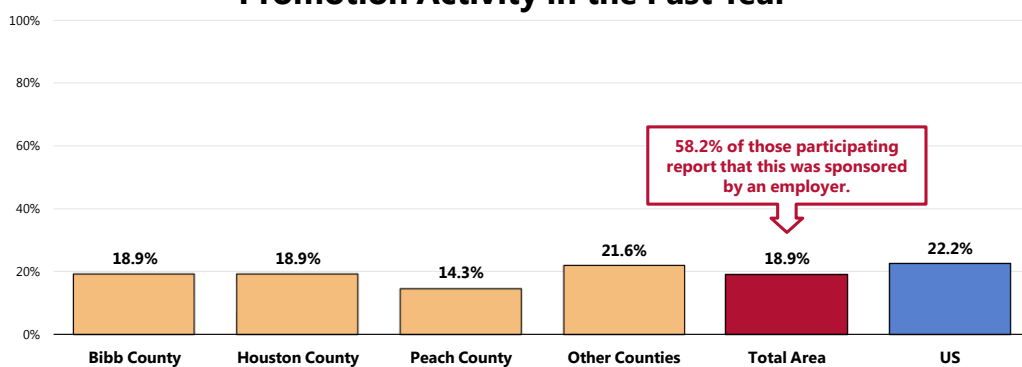
– Healthy People 2020 (www.healthypeople.gov)

A total of 18.9% of Total Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.

- Similar to the national prevalence.
- No significant difference by county.

👤 Note that 58.2% 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



Sources:

- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 119-120]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:

- Asked of all respondents.
- "Other Counties" includes Jones, Twiggs, Monroe and Crawford counties combined.

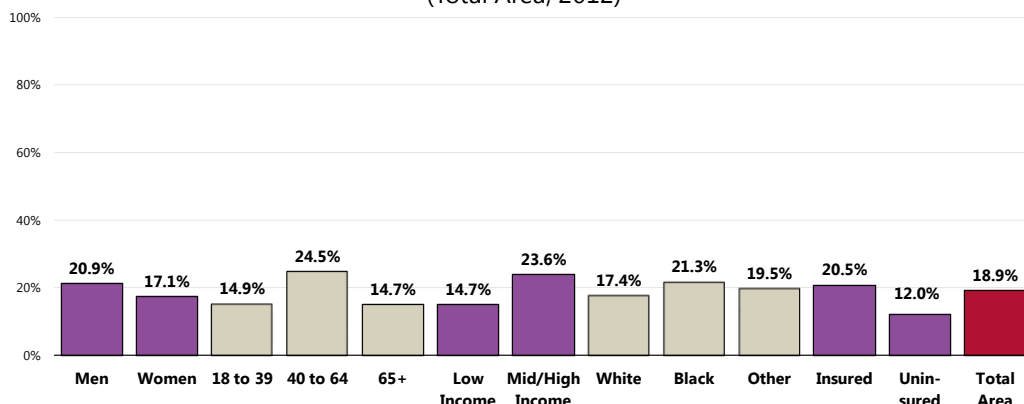
The following chart outlines participation by various demographic characteristics.



Note that young adults, seniors, residents with lower incomes and the uninsured population less often report participation in health promotion activities.

Participated in a Health Promotion Activity in the Past Year

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Related Focus Group Findings: Health Education

Many focus group participants view health education as a critical component in the quest for healthy community members. The discussion focused on:

- Health literacy
- Children and adolescents
- Meeting people where they live, work, and play

Focus group participants feel that health education is an important aspect of prevention and improving the overall health of community members. The Central Georgia Health Network and Community Health Works both seek to promote health through prevention education. Several healthcare organizations offer annual health fairs, but only a handful of residents participate.

Overall **health literacy** levels remain low and urgently need to increase. Health literacy would help residents realize the importance of preventative healthcare, medication management, healthy eating, and consequences of drug use.

"Because prevention is key to avoiding a lot of these life-long problems from prevention of early pregnancy, STDs, not knowing that if you ever try meth, you're really likely to be addicted for the rest of your life. I would put education first and foremost because education lasts a lifetime."—
Regional Participant

The participants believe that many organizations can assist in increasing health literacy levels, but there must be a level of personal responsibility in order to access the education. As one focus group member explains:

"Education is always great, but it's only going to work to a certain extent. If you don't want to get your butt off the couch; you're not going to." — Peach County Participant

The participants believe that education and prevention messaging should target **children and adolescents**. Youth need health lessons early and often. The school system has limited opportunities for this type of education and parents may not have time or the knowledge, so educating youth must come from a variety of organizations. In addition, all aspects of health need to be discussed, including stigmatized topics like teen pregnancy and HIV. A participant explains:

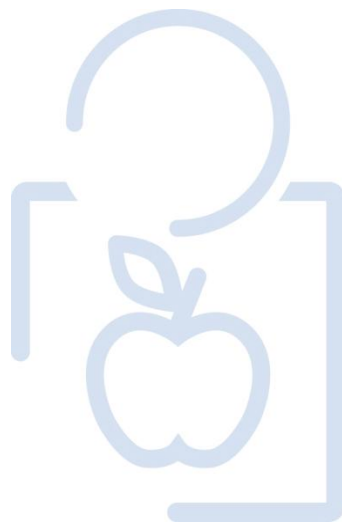
"From my view HIV is another issue that's not brought up in a lot of health services and for instance, we can't even go into the Bibb County school system to talk about it. It's only recently that we've been able to go into some of the churches. We've been in existence since 1985 and it's only between 2008 and now that they're actually opening up their doors to let us in and come and talk... A lot of the people the only education they get is what they hear from their friends. That's not education from my perspective." — Bibb County Participant

Providing education where **people live, work, and play** is critical. The health education messaging must occur regularly and the whole family needs to get involved. It is important to remember that children model parental behavior. A physician describes the current health education atmosphere:

"It is a team effort, but it starts, I guess, in a doctor's office. And I see a lot where my patients will come, they have been diagnosed with diabetes, but no one has even thought about sending them to a diabetic education class. And so they're just kind of out there doing whatever they know to do. And the family needs to be a part of it because it changes their whole diet and everything." — Peach County Participant

Focus group participants think a multi-disciplinary approach would work best, including media, hospitals, primary care physicians, schools and the faith community. Churches can play an important role and act as a non-traditional forum for health education, although in many rural communities even getting one agency to organize these efforts may be difficult.

LOCAL HEALTHCARE

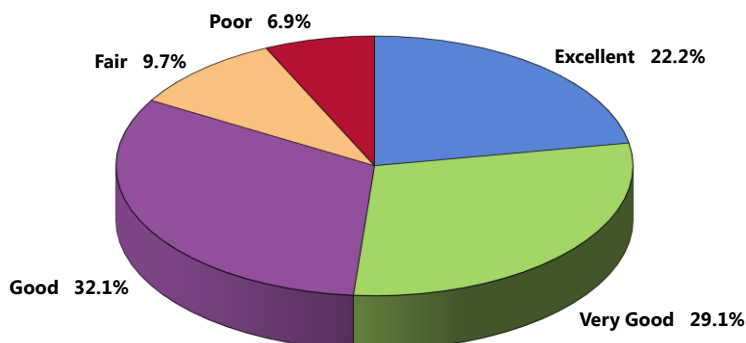


Perceptions of Local Healthcare Services

Just over one-half of Total Area adults (51.3%) rates the overall healthcare services available in their community as “excellent” or “very good.”

- Another 32.1% gave “good” ratings.

Rating of Overall Healthcare Services Available in the Community
(Total Area, 2012)

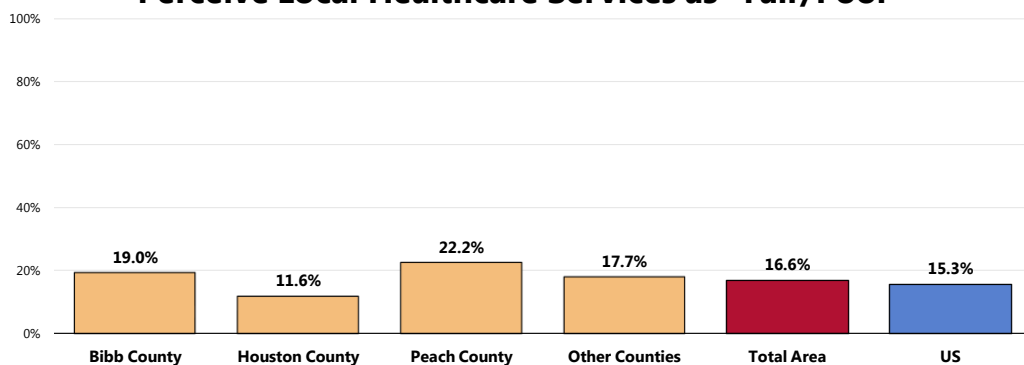


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 16.6% of residents characterize local healthcare services as “fair” or “poor.”

- Comparable to that reported nationally.
- Favorably low in Houston County.

Perceive Local Healthcare Services as “Fair/Poor”



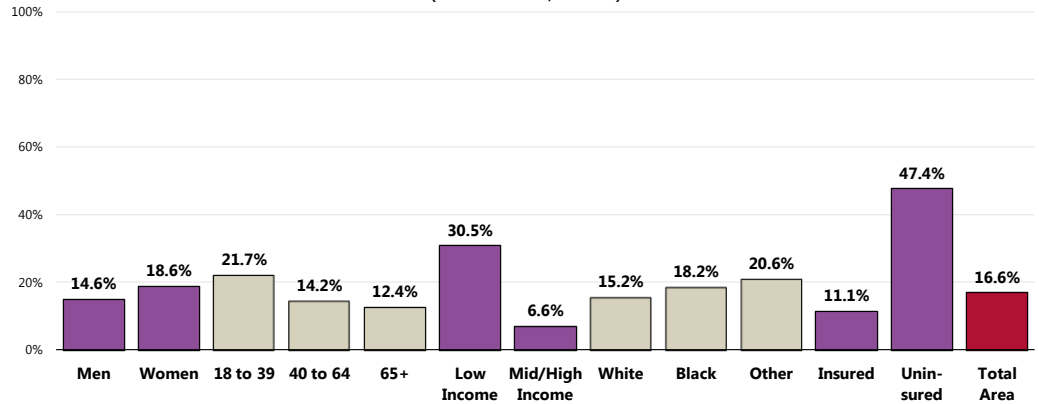
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• “Other Counties” includes Jones, Twiggs, Monroe and Crawford counties combined.

The following residents are more critical of local healthcare services:

- 👤 Young adults.
- 👤 Residents with lower incomes.
- 👤 Uninsured adults.

Perceive Local Healthcare Services as “Fair/Poor”

(Total Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

Notes: • Asked of all respondents.

• Race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Related Focus Group Findings: Specialties

Many focus group participants discussed the difficulties accessing medical specialists in their community. The main discussion centered on:

- Limited number of specialists

Nearly all of the focus group participants feel the community has a **limited number of specialists available**. Respondents believe specialists are needed in the following areas: endocrinology, pediatrics, orthopedics, neurology, rheumatology, pharmacy, dialysis centers, social workers, cardiology, surgery, optometry, emergency medical services and psychiatry. Participants agree that a community member may have access to a basic level of care, but if a patient needs further testing they must travel. A participant describes:

"We provide primary medical care, eye exams, x-rays, labs, and dental care, but our problem is when we need a specialist, like if we need a colposcopy. We have four patients who need colposcopies, we don't have anybody to provide them, and sometimes when you get into something where you need a little bit more definitive care or the next level of care it's not available." — Bibb County Participant

Provider Considerations

Collaboration

Related Focus Group Findings: Collaboration

Participants spent time discussing the varying levels of collaboration occurring in the community between non-profit organizations, law enforcement, faith-based organizations, and healthcare facilities. The issues surrounding collaboration included:

- Desire for collaboration
- Challenge for rural communities
- Long-term plan
- Information clearinghouse

Several focus group participants have a strong desire for **collaboration** in the region and believe the community needs agencies to collaborate. Currently only a few collaborative efforts occur. Many agencies operate in silos and do not communicate with one another. The history of not communicating between agencies can hamper current efforts to collaborate. A participant expresses her frustration with the Head Start program and the local schools:

“Head Start hired three mental health consultants to deal with our 856 children, and part of the barrier that we see in dealing with the school system is that we try to share the information once the child leaves. We spend an enormous amount of money in screening and assessing children, and the schools don’t want it.” — Bibb County Participant

Focus group participants feel collaboration is an immediate need because funding is limited and they do not want to duplicate services. In Bibb and Houston County some collaboration does occur to help reduce costs (i.e. Community Health Works). In the **rural communities** there is no organization to help bring agencies to the table and no infrastructure to maintain collaboration efforts. Many rural county residents remain uninvolved in the community because they only “sleep” there while working in another community. There is no real sense of community because of these situations. A member explains:

“The only time they (residents) ever come into the central town is to pay their taxes and buy their tag, and maybe boat. Because the majority of our residents are located on the periphery of the county...closer to where they work. So that sense of community that you need for those things to be effective, really doesn’t exist.” — Regional Participant

A Peach County participant explains their dilemma:

“The hospital has been very helpful. We had a number of the people in the hospital come out and work. But the community that could help make it better with people, the resources, the mind, and all that, to help make it better, didn’t show up – still don’t show up.” —Peach County Participant

Focus group members believe that collaborations can exist, but there must be a **long-term plan**. Social service agencies, faith-based organizations, schools, and healthcare providers need to come together and make sure the more efficient use of resources is utilized. A participant describes an ideal situation:

“What we call collaboration now is simply telling you what I’m doing and you tell me what you do. For me the true definition of collaboration is: how can my funds be mixed with your funds to meet the goals that we have to meet.” — Bibb County Participant

Participants also see a need for an **information clearinghouse**, some type of system where agencies and residents can access information about the resources currently available. Many participants feel residents simply do not know what resources exist and therefore do not use them. Because of limited funding, social service agencies cannot advertise their services, so a clearinghouse could help get the information to the public.

Special Populations

Related Focus Group Findings: Elderly

Many focus group participants discussed elderly care in the community. The main issues included:

- Alzheimer's disease
- Resources for seniors
- Transportation

Many focus group participants have concern about the prevalence of **Alzheimer's disease** in the community. There is no Alzheimer's-specific facility available, just a few nursing homes. Participants do not feel this is the appropriate setting for patients with advanced disease. In addition, participants express concern that mentally ill patients from Central State are being placed in assisted living facilities with this same elderly population.

"Is there an Alzheimer's daycare center or something like that? Not in most communities and especially not in the rural areas...I've noticed that Central State, because they're kind of downsizing, some of those patients are filtering out into the community. I have a lot of mental health patients that used to be housed at Central State and are now in assisted living homes, which is a whole other issue." — Regional Participant

There is also desire for Alzheimer's disease education. As a physician explains:

"I think Alzheimer's is a huge disease in this community. But instead of families just depending on all the doctors to fix the disease, they need to be educated. You know, just like diabetes. They need to be educated instead of just here's your insulin or don't eat sugar." — Bibb County Participant

Senior citizens may not know of the available **resources**. Source Care Management seeks to keep seniors at home. The program ensures that seniors attend appointments, have suitable living arrangements, provide meals, case management, and cleaning services; however, seniors must choose from a limited number of physicians. Many seniors want to stay with their current physician, so they do not join. **Transportation** is also a huge barrier in accessing resources and medical treatment for seniors. As a participant explains:

"Well with me working with seniors, a lot of their issue is no transportation. So there could be good healthcare in the area, but they can't get to it. A lot of them can't drive and they have no family to take them and they have no income. So that's a major issue." — Bibb County Participant

Related Focus Group Findings: Culture

Many focus group participants discussed culture and its relationship to healthcare. The issues highlighted were:

- Culturally competent providers
- Interpretive services
- Hispanic youth

Focus group members feel that the region is a diverse area. The focus group participants believe that both physicians and social service providers need to possess **cultural competence** to make an impact on an individual's health. Culturally competent providers recognize how culture affects a patient's attitude and can tailor their message accordingly. Having someone who can **interpret** for a non-English speaker is also critical.

"Language is probably the primary thing. Just making sure they understand what you're asking them and know how to take their medicines and when to follow up." — Regional Participant

Respondents feel that the **Hispanic youth** may have additional health issues due to higher levels of teen pregnancy, participation in risky behaviors, prevalence of domestic violence and low self-esteem. These issues may arise from a lack of identity, as a participant explains:

"They don't belong to the country where their parents come from, but they don't belong here...We have a Hispanic youth group at our parish and a lot of the issues that come up there are very different than the issues that come up in the mainstream. One of the other things that you're fighting with Spanish-speaking population is the trust factor. They have to feel that if you're bringing them together, to have some training or education that you're not bringing them there to check their cards to see if they're legally here." — Regional Participant